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Sharpen your pencils: Nurses writing more as abbreviations disappear

No more 'd/c, u, Q.D., or Q.O.D.' on Joint Commission's list

Old habits are hard to break. But the Joint Commission on Accreditation of Healthcare Organizations is asking home health nurses to break some habits they've had since nursing school.

National Patient Safety Goal #2 requires health care organizations to standardize abbreviations, acronyms, and symbols and to develop a list of do-not-use abbreviations. **(For more information, see *Hospital Home Health*, January 2004, p. 3.)**

The list includes abbreviations that most commonly are misinterpreted and likely to cause an adverse outcome. All Joint Commission-accredited organizations were required to have a minimum list of do-not-use abbreviations in place by Jan. 1 of this year and have until April 1 to add at least three other abbreviations pertinent to the organization to the list. **(See list of abbreviations, p. 27.)**

"Home health agencies are struggling with this requirement more than other areas of health care for several reasons," says **Patricia W. Tulloch**, RN, BSN, MSN, senior consultant with RBC Limited, a health care management consulting firm in Staatsburg, NY.

"This requirement significantly affects organizations that have not automated their documentation methods. Our studies have shown that between 40% and 60% of home health agencies still have staff members handwriting patient-specific information such as assessments, chart entries, and patient instructions," she says.

"We also have nurses with an average age of 48, which means they have been using these abbreviations for [more than] 20 years," Tulloch adds.

"Use of some of the abbreviations, such as d/c for discharge, is an ingrained behavior for many of these nurses," she explains. "Add the extra amount of writing required when abbreviations can no longer be used and you've got a real challenge to change the behavior."

There are five items on the minimum required list developed by Joint Commission and seven items on the list of additional abbreviations to consider when expanding the do-not-use list.

"When we reviewed the additional list, we realized that they were all

abbreviations we regularly use, so we included all of them to come up with 12 items on our do-not-use list," says **Sue Gibson**, RN, director of Midwest Home Health Services in Del City, OK.

The short length of the list was a positive aspect that Gibson used to introduce the new requirement to nurses.

"Previously, we had a huge list of approved abbreviations that nurses had to flip through, so we promoted the new list as only 12 abbreviations that you have to remember not to use," she continues.

Be sure to explain the *why* of the change, Tulloch recommends. "If nurses hear that we have 100,000 deaths each year in this country due to medication errors as a result of illegible writing, they will immediately understand the importance of this change," she says.

Mandatory inservices to explain the list and patient safety factors involved were presented before implementing the do-not-use list in January, but Gibson's nurses also received a laminated card with all 12 abbreviations to place on their clipboards so that information would be available.

A tool, such as a laminated card, is essential to making sure nurses will comply with the requirement, Tulloch points out.

"There must be a visual reminder such as the card, signs on the bulletin board, and a flyer to hang above the desk if we are to help nurses remember not to use these abbreviations," she says.

Don't rely upon one inservice to get the message across, either, Tulloch suggests. "You must plan to reinforce this lesson in staff meetings, patient conferences, chart reviews, and other inservices," she says.

Review looks for compliance

Monitoring adherence to this policy also is important, especially in these first few months, Tulloch says.

"Setting a goal of 100% compliance is unrealistic, so I recommend that an agency start with a goal of 80% compliance and then improve from that point," she says. "Unfortunately, the agencies of which I'm aware have not reached 80% yet," she adds.

"We always review 100% of our records every month during our billing audits," points out Gibson. "We added the do-not-use abbreviations as another item on the audit tool used by our staff," she says.

As staff begin to audit the first month's records, they will note who is and isn't using the correction terminology, and the agency will schedule one-on-one retraining, she adds.

Gibson also has asked the nurses reviewing the records to look for any other commonly used abbreviations that might be misinterpreted.

"We are going to use our findings from the first several months of audits to identify any other abbreviations that should be included on the list," she explains.

"It is important not to make the chart review process result in any punitive actions against nurses," Tulloch explains. "The ideal review would involve a nurse reviewing a chart, noticing an abbreviation that should not be used, then directly contacting the nurse to remind her of the new requirement."

(Continued on page 28)

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Joint Commission's List of Do-Not-Use Abbreviations

The Joint Commission on the Accreditation of Healthcare Organizations issued the following list of five abbreviations that should not be used in patient-specific documentation, including discharge or medication instructions.

Set	Item	Abbreviation	Potential Problem	Preferred Term
1	1	U (for unit)	Mistaken as zero. four or cc.	Write "unit."
2	2	IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten).	Write "international unit."
3	3 4	Q.D. Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".	Write "daily" and "every other day."
4	5 6	Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg).
5	7 8 9	MS MSO_4 $MgSO_4$	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write "morphine sulfate" or "magnesium sulfate."

Each Joint Commission-accredited organization also must add at least three other do-not-use abbreviations that apply to the organization no later than April 1, 2004. The list below includes several items that should be considered. **(Also, see editor's note, p. 28.)**

Abbreviation	Potential Problem	Preferred Term
µg (for microgram)	Mistaken for mg (milligrams) resulting in one thousandfold dosing overdose.	Write "mcg"
H.S. (for half-strength or Latin abbreviation for bedtime)	Mistaken for either half-strength or hour of sleep (at bedtime). q.H.S. mistaken for every hour. All can result in a dosing error.	Write out "half-strength" or "at bedtime."
T.I.W. (for three times a week)	Mistaken for three times a day or twice weekly resulting in an overdose.	Write "3 times weekly" or "three times weekly."
D/C (for discharge)	Interpreted as discontinue whatever medications follow (typically discharge meds).	Write "discharge."
c.c. (for cubic centimeter)	Mistaken for U (units) when poorly written.	Write "ml" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears)	Mistaken for OS, OD, and OU, etc.	Write: "left ear," "right ear," or "both ears"; "left eye," "right eye," or "both eyes."

Source: Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

"If the audit and follow-up is peer to peer rather than peer to supervisor to nurse, the process is less threatening," she says. The contact between peers to report an error also should occur immediately so that the nurse who made the error can correct the records and stop making the error as he or she goes forward, she adds.

CHAP standards address terminology

Organizations accredited by the Community Health Accreditation Program (CHAP) in New York City do have to ensure that patient records and instructions are legible, accurate, and easily understood, but they don't have to develop a specific list of abbreviations to avoid, says **Harriett Olson**, RN, MNEd, vice president of CHAP.

CHAP standards address these issues in several sections of both their core standards that apply to all organizations and in sections that are applicable to home health, she says.

"Our surveyors will look for a policy that designates acceptable medical terminology and abbreviations, but we do not issue a list that we require be used," Olson continues. "We describe the outcome, such as a process to ensure accurate, legible, records, and we let the home health agency staff determine the best way to reach the outcome for their agency," she adds.

When evaluating the abbreviations you plan to add to your do-not-use list, or even your acceptable abbreviations' list, be sure to coordinate your list with the hospital with which you're affiliated, or the hospitals from which you get many of your patients, Gibson suggests.

"It's common for many home health patients to go from home care into the hospital and back to home. If you make sure you are all documenting in the same manner, the communication between different providers improves, and we ensure quality, safe patient care," she explains.

[Editor's note: For more information about the Joint Commission requirements, go to www.jcaho.org and click on National Patient Safety Goals in the "Top Spots" section. The web site contains a list of frequently asked questions about the do-not-use abbreviation list and other patient safety goals-related issues.

The Joint Commission also recommends that organizations review a list of dangerous abbreviations relating to medication use that the Institute for Safe Medication Practices has published. The list is available at www.ismp.org.

For more information about the abbreviations in home health, contact:

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Hands-on classes = effective learning

Don't rely on books or videotapes for education

Employees spread over a large geographic area, people who don't like sitting in one place for any length of time, patient visits that don't always follow a "normal" schedule, and a lengthy list of educational classes that staff members must take are just a few of the challenges faced by home health managers as they address staff education.

"Home health agencies also use a lot of per diem nurses so managers find themselves trying to figure out how to pay nurses for required inservices," says **Glenda A. Burke**, RN, owner of Alternatives . . . An Education & Consulting Service in Panama City, FL.

"Not only are home health nurses and aides required to obtain a certain number of educational credits to maintain licensure and certification, but the agency also has to ensure that certain topics are presented to meet requirements of accreditation and government regulatory organizations," she explains.

"This means that managers have to be creative as they plan and schedule inservices," Burke adds.

The switch from a cost-based reimbursement to the prospective payment system also meant a reduction in the number of staff members available to conduct educational programs, she says.

"Not all agencies can afford an educational coordinator, performance improvement coordinator, or infection control nurse on staff to be able to develop and present courses," Burke continues. Because accreditation and regulatory requirements have focused more on performance improvement in recent years, agencies are beginning to add performance improvement coordinators and those people can be responsible for coordinating education efforts, she adds.

"Don't expect one person, however, to be able to develop and present courses that meet all staff members' needs," Burke warns. "It takes a lot of time to create a course, and you can't present the same class more than once to any group of employees," she says.

For this reason, agency educators should look outside for help from experts on different topics, Burke suggests.

Tap into other resources

In addition to education consultants such as herself, Burke recommends that home health agencies tap into resources offered by specialists such as wound care nurses, diabetes educators, and respiratory therapists. "To find experts in your area, talk with other home health managers, check with your local home health association, and look at who is presenting topics at national or regional conferences," she suggests.

"Don't forget to check with your vendors, either," Burke points out. "Many suppliers of wound care or diabetes products offer free educational programs that can address specific needs in your agency. Some may also include continuing education credits which is a bonus for your staff members who need the credits to maintain licensure," she adds.

Whether you use in-house staff members to present educational programs, or use outside instructors, there are a few points to keep in mind to guarantee an effective inservice, Burke notes:

- **Make the class interactive.**

"No one looks forward to sitting still for a one-hour lecture." The nature of home health means that people in the industry are energetic and want to be in control of their schedule, she points out.

"You have to find a way to make them enjoy the class, and that means you have to find a way for them to participate," Burke says.

"In one of my classes on Occupational Safety and Health Administration [OSHA] regulations, I start the class with a demonstration and explanation of some of the safety items OSHA requires for employee safety," she explains. "After the discussion, I divide the class in two groups and we have a relay race."

Each team is given instructions to find items used for certain purposes, then they have to go, one by one, to the table and pick up the item. "The first team to successfully find all of their items wins," she says.

Because the interactive component is essential to a staff member learning the material, Burke cautions home health managers not to rely solely upon audio- or videotapes.

"If you choose to incorporate a videotape into a class, that's fine, as long as there is a moderator who can comment upon content of the video and ask questions to make sure the class understands the material," she explains.

- **Use real-life demonstrations.**

Show students how your lecture applies to their everyday job by demonstrating the points you are making with a situation they regularly encounter, Burke states.

Observing patient's environment

In a class on assessments, Burke discusses the need to observe the patient and the patient's environment closely to make an accurate assessment. She demonstrates how nurses and aides can miss an obvious sign of a problem by relying only on answers from the patient or family member and following a checklist by having the students assess a "patient" Burke has brought into the class.

"I watch nurses ask questions about medications, symptoms, and general health, but almost every nurse forgets to ask about or indicate incontinence on the assessment form," she says. "Although the "patient" doesn't volunteer the information that he or she is incontinent, the patient is sitting on a blue, or incontinence pad," she adds.

- **Choose instructors who have comparable experience.**

Don't ask a business manager to talk about clinical issues, Burke says. "A nurse wants to learn from a nurse," she points out.

An instructor with a similar background to those of his or her audience can use examples and tell stories from real experiences to make the class more interesting and more applicable to the audience, she explains.

"Home health aides love continuing education, but they want to learn from other more experienced aides or other home health-experienced staff who understand what the aides do on a daily basis," Burke explains.

So look for instructors who are experienced home health nurses, diabetes educators, wound care nurses, or physical therapists, she adds.

"If your staff is attending a class on OASIS [Outcome and Assessment Information Set], make sure the instructor has completed OASIS forms in the home," Burke says. If the instructor can't relate to the challenges of working independently and working in a patient's home, the audience can quickly dismiss the information as not relevant to them, she adds.

- **Take advantage of conferences and seminars.**

"Too many home health agencies send managers or supervisors to conferences, then never use the information gathered at the conference," Burke says.

She recommends that agencies plan to send different employees rather than the same few managers, and that the agency require the conference attendee to present information from the conference to other staff members as an inservice.

"This approach rewards a variety of employees by sending them to a meeting and ensures that the agency gets the most out of their investment by sharing the information with all staff members," Burke stresses.

[For more information about home health staff education, contact:

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HIPAA privacy rule: Myths and facts

Expert responds to 13 persistent HIPAA myths

During testimony late last year before the Department of Health and Human Services' (HHS) National Committee on Vital and Health Statistics' Subcommittee on Privacy and Confidentiality, **Janlori Goldman**, director of the Health Privacy Project (HPP) in Washington, DC, presented 13 myths that persist about the Health Insurance Portability and Accountability Act's (HIPAA) privacy regulation and facts addressing those myths. (For more information, go to the HPP web site: www.healthprivacy.org.)

1. **Myth:** One doctor's office cannot send the medical records of a patient to another doctor's office without the patient's consent.
   Fact: No consent is necessary for one doctor's office to transfer a patient's medical records to another doctor's office for treatment purposes.

2. **Myth:** The HIPAA privacy regulation prohibits or discourages doctor/patient e-mails.
   Fact: The privacy regulation allows providers to use alternative means of communication, such as e-mail, with appropriate safeguards.

3. **Myth:** A person cannot be listed in a hospital's directory without his or her consent, and the hospital is prohibited from sharing a patient's directory information with the public.
   Fact: The privacy rule permits hospitals to continue the practice of providing directory information to the public unless the patient has specifically chosen to opt out.

4. **Myth:** Members of the clergy no longer can find out whether members of their congregation or their religious affiliation are hospitalized unless they know the person by name.
   Fact: The regulation specifically provides that hospitals may continue the practice of disclosing directory information "to members of the clergy," unless the patient has objected to such disclosure.

5. **Myth:** A hospital is prohibited from sharing information with a patient's family without the patient's express consent.
   Fact: Under the privacy rule, a health care provider may "disclose to a family member, other relative, or close personal friend of the individual, or any other person identified by the individual," medical information directly relevant to such person's involvement with patient's care or payment related to patient's care.

6. **Myth:** A person's family members no longer can pick up prescriptions for a patient.
   Fact: Under the regulation, a family member or other individual may act on a patient's

behalf to "pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information."

7. **Myth:** The privacy regulation mandates all sorts of new disclosures of patient information.
   Fact: HHS has said that disclosure is mandated in only two situations — to an individual patient upon request, or to the secretary of the HHS for use in oversight investigations.

8. **Myth:** The HIPAA privacy regulation imposes so many administrative requirements on covered entities that the costs of implementation are prohibitive.
   Fact: Officials at the White House project a net saving of $12 billion to the health care system over 10 years as a result of implementation of the standards. The cost of implementing privacy over 10 years is estimated at $17 billion and savings from putting transaction standards in place are estimated at $29 billion over 10 years. Additional long-term savings are expected as patients develop more faith in the health care system and thus are less likely to withhold vital information from their doctors and will seek care more readily.

9. **Myth:** Patients can sue health providers for not complying with the HIPAA privacy regulation.
   Fact: The regulation does not give people the right to sue. They must file a written complaint with the HHS Office for Civil Rights. Although the agency has authority to assess civil penalties, it has said that enforcement will be complaint-driven, and penalties will be imposed only for willful violations.

10. **Myth:** Patients' medical records can no longer be used for marketing.
    Fact: Use or disclosure of medical information is explicitly permitted for certain health-related marketing activities under the regulation.

11. **Myth:** If a patient refuses to sign an acknowledgement of receipt of a health care provider's notice of privacy practices, the provider can, or must, refuse to provide services.
    Fact: The regulation grants patients a "right to notice" of privacy practices for protected health information, and requires that providers make a "good-faith effort" to get patients to acknowledge that they have received the notice. But the law does not give providers either the right or the obligation to refuse to treat people who do not sign the acknowledgement, nor does it subject the provider to liability if a good-faith effort is made.

12. **Myth:** The regulation imposes many new restrictions on hospital fundraising efforts, making it almost impossible.
    Fact: According to the rule, a hospital may use, or disclose to its "business associate" or an institutionally related foundation, demographic information, and the dates of health care provided to an individual "for the purpose of raising funds for its own benefit, without an authorization" from the patient. Such use or disclosure is not permitted unless disclosed in the notice of privacy practices.

13. **Myth:** The press no longer can access vital public information from hospitals about accidents or crime victims.
    Fact: HIPAA allows hospitals to continue to make public, including to the news media, certain patient directory information, including the patient's location in the facility and condition in general terms, unless the patient has specifically opted out of having such information publicly available. ■

JCAHO strengthens infection standards

Renewed interest in HAIs spurs agency to action

The Joint Commission on Accreditation of Healthcare Organizations has approved revised standards to help prevent the occurrence of deadly health care-associated infections (HAIs).

The standards retain many of the concepts embodied in existing standards but sharpen and raise expectations of organizational leadership and of the infection control program itself. The requirements for ambulatory care, behavioral health care, home care, hospital, laboratory, and long-term care organizations will take effect January 2005.

"There has been, over the last number of years, renewed interest in the amount of HAIs in the country," notes **Robert Wise**, MD, vice president of

the division of standards at the Joint Commission. "The CDC [Centers for Disease Control and Prevention] continues to publish data that show somewhere between 2 million and 4 million health care-associated infections exist, with 90,000 deaths per year associated with those HAIs."

A CDC guideline published in October 2002 for hand hygiene in the health care setting — the culmination of 20 years of data — indicates that one of the main ways to stop cross-infection is, in fact, hand washing.

"Yet health care professionals are doing an abysmal job of washing their hands," Wise asserts. "And we have more and more people in hospitals who are susceptible, immunocompromised, and at greater mortality and morbidity risk."

For years, the health care profession had recognized HAIs were too high but had argued about how many were preventable, he points out. "But now we have identified a method that can clearly reduce them — just by washing our hands. So if even the basic things are not being done, we realized we needed to look at overall strategies."

An extensive dialogue

This laid the groundwork for a group of experts to have an extensive dialogue on the topic, Wise says. The group was formed in early 2003.

"There are two ways we vet standards," he explains. "With something as technical as this, we go out and find the people who are experts in the area [infection-control practitioners, hospital epidemiologists, physicians, nurses, risk managers, and other health care professionals] such as John Boyce, one of the main authors of the CDC guideline for hand hygiene, as well as health care organizations and major stakeholders. Then, it will be put out [to all accredited organizations] for field review across the country."

The field review will include two new issues — emerging antimicrobial resistance and the management of epidemics and emerging pathogens — that have been identified since the group began its work.

For the Joint Commission, prevention represents one of the major safety initiatives that a health care organization can undertake. The revised standards focus on the development and implementation of plans to prevent and control infections, with organizations expected to take these steps:

- Incorporate an infection control program as a major component of safety and performance improvement programs.
- Perform an ongoing assessment to identify risks for the acquisition and transmission of infectious agents.
- Effectively use an epidemiological approach, which includes conducting surveillance, collecting data, and interpreting the data.
- Effectively implement infection prevention and control processes.
- Educate and collaborate with leaders across the organization to effectively participate in the design and implementation of the infection control program.

Another key aspect of the revised standards is an increase in the pressure placed upon top-level management in health care organizations.

"This is a pretty important point," Wise points out. "One of the issues that kept coming up concerning the problems with infection control programs is that they are too low down in the organization. The practitioners who run them don't reach the people who are high enough to help; they have trouble getting resources and training. So what you get is a nice program on paper, but [one that is difficult] to implement. You *need* a leadership voice; this is not a program that sits in a single unit or department — it only works if it is organizationwide."

Taking a realistic approach

The Joint Commission is expecting a lot from health care organizations, but it also is being realistic when it comes to those expectations.

"There is no organization today that has the amount of money needed to handle every infection problem, and we appreciate that," Wise says.

"There is, however, an expectation that each organization understands where its greatest vulnerabilities are. We expect a thoughtful plan to be put together that indicates it knows exactly where its greatest threats exist. It could be surveillance data, not being able to get the proper staff, or training problems; whatever they are, they need to be addressed," he explains.

Essentially, the process improvement must include an understanding of what the goals are, why the facility chose those goals, a description of the problems within the organization, an attempt to fix those problems, and if they are not fixed, an explanation as to why they were not fixed, Wise says.

The revised infection controls standards will not be a part of the scored survey until January 2005, he notes.

"But because they are so important, we will release them in July 2004," Wise stresses. "If an organization is surveyed in the last half of the year, there will be consultations on these standards, indicating how they might have been scored and what problems would have been cited."

The Joint Commission also has made the CDC's recently updated hand-washing guidelines a 2004 National Patient Safety Goal for all accredited organizations.

Further, the Joint Commission has advised accredited organizations that HAIs resulting in death or serious injury also should be voluntarily reported to the Sentinel Event database.

[For more information, contact:

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LegalEase

Understanding Laws, Rules, Regulations

Nonmonetary gifts for referrals? Know the law

Elizabeth E. Hogue, Esq.
Burtonsville, MD

Discharge planners and case managers certainly cannot accept cash payments from providers in exchange for referrals of patients. But what about noncash items that have a relatively low value and that providers who receive referrals are not obligated to provide to case managers? Can case managers accept such items?

The key area that must be considered to answer these questions involves a federal statute that prohibits illegal remuneration or kickbacks and rebates in the Medicare and Medicaid and other federal and state health care programs.

This federal statute makes it a crime for providers to offer to give or actually give anything to anyone in order to induce referrals.

Case managers and providers who violate this federal statute may be guilty of criminal conduct and may go to jail or be forced to pay large amounts of money in the form of fines or civil monetary penalties. They also may be excluded from participation in the Medicare/Medicaid and other state and federal health care programs. If case managers are licensed, they also face loss of licensure.

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, has said that regulations will be published that will help to define what items of nonmonetary value may be accepted from providers who receive referrals.

Until specific guidance on these issues is provided by the OIG, providers and case managers may be wise to apply final regulations under the Stark laws, even though the Stark laws technically apply only to physicians.

Specifically, the regulations indicate that free items of relatively low monetary value are unlikely to cause overuse, if provided within reasonable limits. The regulations further state that as long as all of the following criteria are met, such nonmonetary compensation will not violate the Stark laws:

- The annual aggregate value of nonmonetary gifts does not exceed $300.
- Providers that give nonmonetary compensation must make it available to those similarly situated, regardless of whether they refer patients to the provider for services.
- The compensation is not determined in any way that takes into account the volume or value of referrals to the provider.

Providers and case managers should also be aware of the following limitations under the Stark laws:

- Protection from violations of the Stark laws is not available for gifts that are solicited.
- The exception for nonmonetary compensation up to $300 only protects gifts to individuals.

At least in theory, providers and case managers could comply with the requirements of the Stark laws regarding nonmonetary compensation to physicians, but still violate the kickback and rebate statute describe above.

At this point, however, it seems unlikely that the OIG will conclude that case managers received kickbacks and rebates, if the requirements of the Stark regulations described above are met. In other

words, compliance with the requirements of the final Stark regulations may provide protection to case managers with regard to nonmonetary compensation received from providers who get referrals from them.

Providers and case managers should, of course, monitor developments in this area, especially since the OIG has stated that specific regulations that apply to all practitioners will be published in the near future.

The temptations are many, but there is a great deal to be lost. ■

Two-page advance beneficiary notice gone

Throw away the two-page advance beneficiary notice that you've had the option of using since 2002.

The Centers for Medicare & Medicaid Services has said that the only advance beneficiary notice it will accept is the single-page notice (CMS-R-296).

The form, used to tell beneficiaries they are refusing or reducing physician-ordered care, can be accessed at www.cms.gov/medicare/bni/. Scroll down to Home Health Advance Beneficiary Notice. You can access the form in English and Spanish, as well as instructions.

This requirement became effective for services ordered on or after Jan 1, 2004. ▼

New Jersey offers caregiver web site

New Jersey has launched a caregiver web site that contains information about services and resources available to state residents who care for elderly or disabled family members.

The site provides links to a variety of state and federal organizations as well as community support groups. Tools such as a daily task assessment form for patients as well as a home safety checklist, a medication list, a caregiver self-assessment form, and a caregiving record are available.

To view the site, go to: www.state.nj.us/caregivernj/index.shtml. ▼

MedPAC: No payment update for home health

Federal advisors were generous with recommendations to update Medicare payments to physicians and hospitals in 2005, but they were showing no generosity to the home health sector. Commissioners on the Medicare Payment Advisory Commission (MedPAC), based in Washington, DC, voted in late January to recommend to Congress that physician services receive a 2.5% update for FY 2005, but voted against a payment update for home health services.

The commissioners further recommended that Congress continue to monitor access to care for home health services.

The commission also recommended that skilled nursing facilities receive no payment update. In addition, MedPAC recommended in its January report that U.S. Department of Health and Human Services Secretary Tommy Thompson should instruct skilled nursing facilities to report nursing costs separate from other costs, such as drugs and medical supplies.

The commission felt that a 3.4% update was adequate for inpatient hospital services and hospitals not furnishing quality data to the Centers for Medicare & Medicaid Services would be subject to a 0.4% reduction.

"What we've learned in the past is that a recommendation for an increase to all hospitals is not an efficient way to keep Medicare up to par," explained commission chair **Glenn Hackbarth**, an independent consultant based in Bend, OR. "Rural hospitals aren't treated as fairly with every hospital getting an increase.

"I think the recommended updates are appropriate because there are a lot of uncertainties this year with the new Medicare legislation. It doesn't mean we won't be back next year saying that we should be making another adjustment," he added.

The commission spent a considerable amount of time debating whether a 1.8% overall margin

increase was adequate for all hospitals.

"This recommendation doesn't flow with what we know," said **David Durenberger**, director of the National Institute of Health Policy at the University of St. Thomas in Minneapolis.

"We need to figure out the rationale on using the Medicare margin as a proxy for quality and access data," he said.

"I'd like to remind you that this would be for one year only, and that the overall margin is only one factor determining Medicare payments," said **Julian Pettengill**, a staff analyst for MedPAC. ▼

CMS describes HIPAA authorization form

The Centers for Medicare & Medicaid Services (CMS) offers a preview of a privacy authorization form that includes the core elements and necessary statements required in the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA).

CMS is in the process of developing a standard authorization form for Medicare beneficiaries to use. Although the form will not be available for several months, the program memorandum offers a guide to the elements necessary for a valid privacy authorization.

The core elements of a valid authorization must contain at least the following elements:

- a description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- the name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
- the name or other specific identification of the person(s) or class of persons, to whom the covered entity may make the requested use or disclosure;
- a description of each purpose of the requested use or disclosure. The statement, "at the request of the individual" is a sufficient description of the purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- an expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;
- the signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided.

Although the HIPAA privacy rule only requires a description of the representative's authority to act for the individual, CMS requires that documentation showing their authority, such as a power of attorney, be attached to the authorization.

The memorandum also includes examples of wording that may be used to place an individual on notice that he or she can revoke the authorization and the process that must be followed to revoke authorization.

To see the program memorandum, go to: www.cms.gov/manuals/pm_trans/AB03147.pdf. ▼

Medicare covers test for colorectal cancer

Medicare beneficiaries age 50 and older will qualify for coverage for annual screening immunoassay fecal-occult blood tests that are more patient-friendly than the previously covered guaiac fecal-occult blood test.

The immunoassay test requires the collection of fewer specimens than the guaiac test and does not require the dietary restrictions that are necessary to ensure accuracy of the guaiac test.

"The immunoassay fecal-occult blood test appears to be both accurate and easy to use, but is not yet covered by most payers. Medicare reimbursement for this test should lead to reduced morbidity and mortality for colorectal cancer," says **Sean Tunis**, MD, the Centers for Medicare & Medicaid Services chief medical officer. ■

CE *questions*

This concludes the CE semester. A CE evaluation form has been included with this issue. **Please fill out and return in the envelope provided.** If you have any questions, call customer service at (800) 688-2421.

21. According to Patricia W. Tulloch, RN, BSN, MSN, senior consultant with RBC Limited, a health care management consulting firm in Staatsburg, NY, what, in addition to inservice education, does a home health manager need to offer to nurses to ensure compliance with a do-not-use abbreviation list?
    A. contests and awards
    B. the threat of punitive action
    C. a copy of the agency's policy regarding documentation
    D. a laminated card with the do-not-use abbreviations

22. What is one factor that increases an instructor's credibility with home health agency staff, according to Glenda A. Burke, RN, owner of Alternatives . . . An Education & Consulting Service in Panama City, FL?
    A. flexible schedule
    B. low, or no, fees charged
    C. comparable experience to the audience's experience
    D. use of videotape in the class

23. The HIPAA privacy regulation prohibits or discourages doctor/patient e-mails.
    A. true
    B. false

24. As part of the revised Joint Commission infection control standards, organizations will be expected to:
    A. Incorporate an infection control program as a major component of safety and performance improvement programs.
    B. Provide monthly reports on infection control efforts in each area of their organization.
    C. Effectively use an epidemiological approach, which includes conducting surveillance, collecting data, and interpreting the data.
    D. A and C
    E. all of the above

Answer Key: 21. D; 22. C; 23. B; 24. D

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■