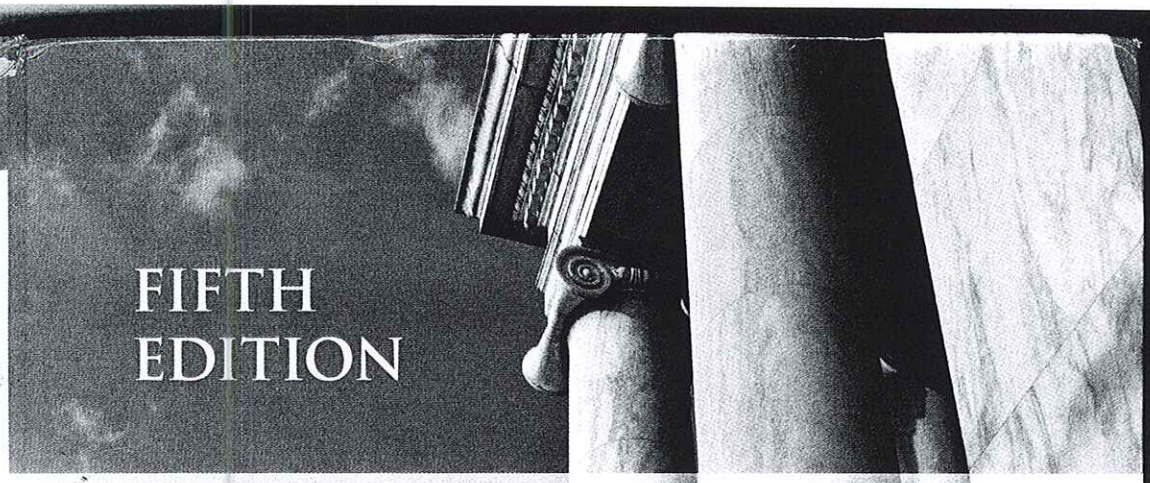

FIFTH EDITION

# HEALTH POLICY AND POLITICS

## A NURSE'S GUIDE

JERI A. MILSTEAD

ACCESS CODE INSIDE

NAVIGATE 2 ADVANTAGE ACCESS™

## CASE STUDY 1: (IN)SECURE COMMUNICATION?

Annie Lewis, a registered nurse, takes a prescribed daily beta blocker to combat a rapid heart rate. Annie was running low with no refills on her prescription, so she called her primary care provider APRN, who provided her with a month's supply. At the same time, Annie scheduled her yearly wellness visit. When Annie arrived at the APRN's office, she was given instructions to access her records in the practice's new electronic record so she, the patient, could receive results and messages in a timely manner. Annie was examined, had routine labwork completed, and requested a refill of her beta blocker, although she did tell the APRN that she still had some medication remaining, so she wouldn't need the prescription called in yet. After about 2 days, Annie received her first email alerting her that there was new information in her electronic record. When she accessed the record, she found a narrative of her visit, with a diagnosis of dysuria. The next day another email arrived, and she found that her urine had been sent for a culture and came back positive, although she had no symptoms of a UTI. The day after that lab result, Annie received an automated call from the pharmacy that her prescription was ready. Thinking that the APRN had filled her beta blocker prescription early, she was tempted to ignore the pharmacy call. However, Annie did call the pharmacy and she learned that the prescription waiting for pickup was an antibiotic, apparently for her UTI. Knowing that it was a hassle to call regarding this, Annie decided to pick up the antibiotic and begin therapy, because she knew how to read the lab tests and assumed she should be treated for the UTI, despite having no physical symptoms. Annie never had any phone conversations with anyone from the APRN's office after her well-visit appointment. Another factor to note: the urine sample was collected in the APRN's office, not the lab, where Annie had labeled the specimen container in the lavatory using a black marker .

### Discussion Points

1. Discuss what might have transpired if Annie did not have a nursing background.
2. List the breakdowns in communication that occurred and the potential ramifications.
3. Did the APRN's office fulfill the meaningful use stage 2 requirement of providing secure electronic communication between the patient and healthcare provider? Why or why not?

### Discussion Points

1. Discuss what migh
   nursing backgrounc
2. List the breakdown
   potential ramificati
3. Did the APRN's offi
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## CASE STUDY 2
## VA

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syndrome, and the influenz
father concurs and cites "a
including webpages and di
recognize. The APRN is fac
than run counter to her ow
because the parents sincere
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