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Transition to Electronic Health Records, Means Updates to Security Standards

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For providers, patient confidentiality and record security are important components of daily operation. However, many providers may not follow the most current security requirements. The Health Insurance Portability and Accountability Act (HIPAA) standards have been updated to ensure that covered entities (CEs) protect the confidentiality, integrity, and availability of all electronic personal health information (ePHI). This includes protections against anticipated threats or hazards to the security or integrity of ePHI. These updates provide CEs guidance regarding implementation of customized security measures based on the size and complexity of a covered entities technical infrastructure and software security capabilities. This customization is determined by the CEs based on the probability and criticality of the risk potentials determined after analysis.

The Office of Civil Rights (OCR) began Phase 2 audits in July 2016 for CEs and in the Fall of 2016 for business associates (BAs). Audits focused on either Security Rule controls or Privacy and Breach Notification rule compliance. The goal of these audits is to enhance industry awareness of requirements, identify problem areas, develop tools and guidance to assist CEs with compliance evaluation and breach prevention. A breach is the access, use, or disclosure of unsecured protected health information (PHI), by means not permitted by the HIPPA, which poses a risk of financial or other harm to the affected person. Audit processes and results will also be utilized to develop a permanent audit program. Thus, the importance of understanding and implementing the newest standards is of the utmost importance for all CEs and their BAs.

Contact Us

In This Issue

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President

Robin Bleier is a senior healthcare executive and the President of RB Health Partners, Inc., a national Clinical Risk Medicare Operations Consultancy Firm based in Tampa Bay, Florida. Robin has over 30 years of progressive experience with increasing

There are three areas of safeguards that must be reviewed, these are: Administrative, Physical, and Technical. Each area has standards with required and/or addressable implementation specifications. CEs must implement all required specifications and assess the appropriateness of all addressable specifications in relationship to its contribution to protecting the electronic protected health information (ePHI). If implementation of an addressable specification is not reasonable or appropriate the CE must document why and implement an equivalent alternative measurement when possible.

levels of responsibilities focused in LTC to include post-acute & skilled nursing, assisted living, independent, and continuing care facilities. Robin is experienced in acute care and home health to include care management which allows her to integrate such services into her interdisciplinary company's team to meet their client's needs.

The administrative safeguards cover the security management process. This includes the implementation of policies and procedures to prevent, detect, contain, and correct security violations. These policies include workforce security, sanctions, information access management, security and awareness training, disaster recovery and emergency operation planning and incident response and reporting. Implementation specifications also include the completion of a risk analysis. The risk analysis is a detailed and accurate assessment of the potential vulnerabilities to the confidentiality, integrity and availability of ePHI. Another required specification is the appointment of a facility Security Officer. The Security Officer, in conjunction with the Privacy Officer, is responsible for the development and implementation of a facility's privacy and security policies and procedures. Lastly, the administrative safeguards update the requirements of the CE and their BAs. Business associate agreements (BAAs) should be reviewed to ensure that components of the safeguards are addressed and assurance is made that the BA will abide by the requirements.

The next safeguards are related to the physical environment and devices in which the ePHI is maintained and stored. Collectively, these are known as the physical safeguards. CEs should have policies and procedures in place to limit access to the electronic information system and areas where records are stored. This is done by implementation of facility security plans, access controls and contingency operations. Important components of physical safeguards are workstation use and security. Workstation use policies will address the way workstations are used and what applications and programs are acceptable to run while workstation security policies address restrictions to the workstation access. CEs must also address controls for computers and other devices or media where ePHI may be stored. Policies regarding specifications on proper disposal or re-use of any devices which stored ePHI. The final addressable physical specification is related to access control and validation. CEs must review and implement policies and procedures regarding limiting access to ePHI based on a person's role or function, as well as access to their systems and programs for testing and revisions.

The last set of safeguards are those related to the technical applications utilized to secure ePHI and the systems in which it is maintained. The first required standard is the implementation of access and audit controls. CEs are required to ensure that only authorized people are allowed access. This is accomplished by providing each person a unique user identification. The unique user identification allows for identifying and tracking each user. Audit controls are hardware, software or other processes that can record and review activity in the systems containing ePHI. Next, CEs must implement policies to protect the integrity of the ePHI. Policies should address mechanisms in place to ensure that ePHI has not been improperly altered or destroyed. Just as CEs have specific standards regarding how to properly correct entry errors in paper documentations, the same must be done for electronic documentation. Lastly, technical security measures must address the potential unauthorized access of ePHI transmitted via electronic communication networks. This is most often completed through a process called encryption. CEs should implement policies related to when encryption is required and the process for ensuring encryption of ePHI prior to transmission. It is best practice that CEs utilized a HIPAA compliant secure email service with encryption capabilities as specified in the regulatory standards to transmit any form of ePHI.

In conclusion, CEs must take an active role in identifying areas of potential risks and vulnerabilities to the confidentiality and integrity of ePHI. Then implement security measures reduce the likelihood of these potential risks and vulnerabilities will lead to a breach of ePHI. Compliance with HIPAA standards protect the CE and their patients from potential threats to ePHI and ensures that patient confidentiality and record security continue to be important components of daily operation.

For more information about this or related topics or health information management consultant services please contact the author at heather@rbhealthpartners.com or Robin A. Bleier, President of RB Health Partners, Inc. at robin@rbhealthpartners.com.

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Section GG - Discharge Goals

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As part of the SNF Quality Report Program (QRP), CMS implemented Section GG on the Minimum Data Set (MDS) October 1, 2016. The purpose of section GG is to collect data for the quality measure, "Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)," as set forth by the IMPACT Act of 2014. Under the QRP reporting requirements, SNFs must submit required quality measure data with an 80% or greater compliance rate. Additionally, SNFs that do not submit quality measure data at the required compliance rate may be subject to a two-percentage point reduction in their annual payment update (APU). Data collected October 1, 2016 - December 31, 2016 will impact APU for FY 2018.

Section GG assesses the resident's usual ability to perform specific self-care and mobility activities, with focus placed on:

- Admission performance.
- Discharge goals.
- Discharge performance.

Related to section GG, we find that the most frequent asked questions relate to coding discharge goals. Three factors to remember when coding discharge goals are:

1) The three codes to indicate task as not performed. (07, 09, 88) are not used for this item set.
2) While the use of a dash (-) should be rare, it is allowed for this item without affecting APU determination.
3) Goals may be coded higher, lower, or the same as the resident's admission performance based on the clinician's assessment.

For any questions related to this article please feel free to contact Nathan Shaw at nathan@rbhealthpartners.com or Robin Bleier at robin@rbhealthpartners.com.

To Isolate or Not ...

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Isolation is an important aspect of the professional infection Preventionist role and to support the avoidance or spread of nosocomial or in-house developed infection. The CDC recommends using standard precautions for the care of all patients/residents regardless of the presence of illness or infection status. Standard precautions go beyond protecting health care workers from exposure to blood borne pathogens and includes body substances that may contain potentially infectious microorganisms and applies to: blood; all body fluids, secretions and excretions except sweat regardless of whether or not they contain visible blood; non-intact skin; and mucous membranes.

In addition to standard precautions, it is prudent for health care facilities to implement transmission-based precautions. Transmission-based precautions are additional prevention measures that need to be implemented when a resident is suspected of or has colonization/infection due to a highly infectious or epidemiologically significant organism in order to interrupt transmission to others. The three types of transmission-based precautions are contact, droplet, and airborne isolation. Contact isolation includes the use of gowns and gloves when in the immediate patient care environment, droplet precautions requires the use of a mask when within three-six feet of the patient, and airborne isolation requires the use of an N95 mask in addition to the patient being placed in a negative pressure room. At times, more than one type of isolation may be necessary in order to interrupt transmission of infection. For example, some respiratory illnesses, such as those due to multi-drug resistant organism or adenovirus, require both contact and droplet precautions. Disseminated shingles or someone who is immunocompromised is another example that requires two types of isolation, airborne and contact.

Isolation precautions can be challenging in the long-term care environment, especially when it comes to determining when isolation precautions can be discontinued. The Healthcare Infection Control Practices Advisory Committee (HICPAC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings is the "go-to" resource for recommendations on the type and duration of isolation required for infections, however there are times when the guidelines do call for evaluation of the patient and environment in order to make a decision on discontinuing isolation. This is scenario is often encountered when a resident has an infection due to a multi-drug resistant organism (MDRO) such as MRSA, ESBL, or MDR-Pseudomonas. To determine when to discontinue isolation precautions consider:

- Is the resident symptomatic?
- Has the resident been treated for their infection?
- Does the resident have any draining wounds or uncontained body fluids?
- Are there currently other residents with this type of infection making it more challenging to prevent transmission to others?
- Does the resident have the ability to maintain good hand hygiene or can staff ensure that the resident performs hand hygiene prior to leaving their room?

An important note: residents who are colonized or have an infection due to an MDRO, must be asymptomatic, have all body fluids contained, and hand hygiene performed in order to discontinue isolation.

In summary, the decision to isolate or not is an important one! We encourage you to do so with the best support and science available to not only protect your residents/patients, staff, and visitors but also reduce your organizational risk. Promising care practices include inclusion of CDC and or APIC guidelines for evidence based guidance. We at RB Health Partners, Inc. are also pleased to provide infection prevention and control support to you by

our experienced clinical team. Please feel free to call A.C. at ac@rbhealthpartners.com and or Robin Bleier at robin@rbhealthpartners.com.

All the King's Horses and All the King's Men:

Sometimes residents can't be helped no matter what you do. How to get the message across.

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and

Rob J. Becht, MBA, JD

Notre Dame

This is a requested reprint from Nursing Homes, Sept, 2006 per client request as it remains valid. Please pardon the time frames as they refer to when originally written.

Ronald Reagan...Christopher Reeve... How can nursing homes be "perfect" when even the "best" have bad outcomes?

A few years ago, America lost two great men in a relatively brief period. The first was former President Ronald Reagan, stricken by Alzheimer's disease. The second was actor Christopher Reeve, well known as Superman, suffering from pressure ulcers related to his quadriplegia. This article asks how each man's tragic condition and subsequent death might have been judged had either been a skilled nursing facility resident, and the implications of the answer.

Similar, yet Different
Each man's medical circumstances varied. President Reagan was an elderly man living with a severe chronic disorder affecting first his cognitive functions and then his physical functioning. Reagan's chronic medical condition slowly robbed him and his family of his wonderful memories and cognitive function, and his ability to complete the simplest activities of daily living, such as bathing, walking, and eating. On the other hand, Christopher Reeve was a middle-aged man, completely disabled following an accident occurring at the prime of his life. His injury resulted in mass physical decline and deterioration, yet he remained cognitively intact. Even though the two men had completely different medical and psychosocial factors, there were commonalities experienced by both.

Each received healthcare services which, from all accounts, were extraordinary, readily described as "the best that money could buy." Both men had positive, optimistic outlooks on life before and during their illnesses. Both had incredible family support. However, neither could overcome his individual medical plight. Regardless of the significant financial resources that were aggressively directed to manage their medical conditions, care, and services, each experienced falls, fractures, alteration in skin integrity, and infections during their medical treatment course.

And that's with the best that money could buy!

Unfortunately, certain diseases and conditions cannot be reversed. Certainly this is no one person's or institution's fault. Often, these medical conditions and their related declines cause other comorbidities that result in unavoidable patient/resident declines, anticipated negative outcomes and, ultimately, death.

Yet sadly, often family members and loved ones become bitter when a patient/resident's outcome does not end the way they desired. When the result is pain and suffering or even death, the proverbial finger of guilt is frequently pointed at the healthcare provider, even when logic and medical information indicate otherwise. While death by natural causes can still be found on death certificates, many consider death someone's fault-something that could have been avoided. This is especially true when a patient/resident resides in a skilled nursing facility. Family members often harbor unrealistic expectations of patient/resident prognosis in a healthcare setting. Statements such as "they should have known" or "they

should have prevented this" come forth, even when medical indications or a medical prognosis justifies the clinical care that was delivered and the patient/resident's ultimate outcome.

"All the king's horses and all the king's men" could not put either Ronald Reagan or Christopher Reeve back together again. Had either of these men resided in a skilled nursing facility with the same medical conditions and outcomes, how would the care they received have been judged? The recently revised Centers for Medicare & Medicaid Services (CMS) Federal Interpretative Guidelines for Pressure Ulcers (F314) state that healthcare facilities, specifically skilled nursing facilities, may be cited for deficiencies when residents experience medical outcomes similar to those suffered by Reagan and Reeve. A conclusion from this might be that unrealistic expectations are placed on skilled nursing facilities through implementation of the new federal Interpretative Guidelines. As a result, facilities might be placing themselves at risk for deficiencies simply by accepting individuals for admission who have alteration in skin integrity or are at risk for this.

Perception Drives Litigation

Television, radio, newspaper, and billboard advertisements suggest that if a nursing facility resident's outcome did not end the way desired, then someone did something wrong and "they" should pay. The ongoing negative perception of care delivered in skilled nursing facilities, coupled with the maladies of chronic medical conditions experienced by patient/residents, leads many to initiate professional liability or malpractice actions against skilled nursing facilities. Facility ownership, administrative staff, corporate staff, and even facility clinical staff are often named in such lawsuits.

Ronald Reagan...Christopher Reeve... How can nursing homes be "perfect" when even the "best" have bad outcomes?

Had either Reagan or Reeve been a skilled nursing facility resident, would the skilled nursing facility have been subject to litigation because of the maladies experienced by each of these men? Instead of the perception of care being "the best that money could buy," Reagan's or Reeve's hypothetical skilled nursing facility care would have been judged much more harshly, given public sentiment and the regulatory environment. Therefore, one must ask whether the threat of future license and certification citations and professional liability litigation subjects skilled nursing residents, with chronic conditions like Reagan and Reeve, to not being accepted to the facility of their choice because of the risks to the facility posed by their chronic ailments, clinical risk for skin alteration, or other maladies resulting from chronic medical conditions. Skilled nursing facilities dedicated to serving their local community and meeting the needs of their residents must obviously find a way to cope with these factors and still accept such chronically ill individuals.

Steps to Consider

A skilled nursing facility's first priority is to provide the level of care and services required by its residents. But how does the skilled nursing facility protect itself from the above noted threats while focusing on healthcare delivery for all appropriate residents? Suggestions include:

- Document any anticipated negative outcome(s). It is often known that a patient/resident's disease process or condition may result in a particular negative outcome, or even death. The patient/resident may be declared terminal. "Terminal" is a condition and diagnosis that declares that the patient/resident's anticipated negative outcome is death. Health practitioners should follow state statutes for proper terminal declaration. Although sometimes unpleasant, declaring a patient/resident terminal does not mean a facility does not provide care, nor does it imply that the patient/resident or family approve the terminal status.
- Consider documentation revisions for the patient/resident's treatment plan indicating that plans are in place to help counter potential negative outcomes and the patient/resident's response to that treatment. Once the potential negative outcomes are identified, even if only palliative approaches are desired by the patient/resident, plans may be implemented to reduce negative outcomes.
- Ensure that attending physicians and physician extenders are involved in treatment planning activities for anticipated negative outcomes. Physician documentation should include statements that anticipated negative outcomes, when they do occur, are not facility-related or "under the facility's control." Physicians might consider documenting that the negative outcome occurred despite the appropriate care and services provided.

Conclusion
Patient/residents, regardless of where they reside, may encounter conditions, diseases, and circumstances that result in negative outcomes. These conditions must be assessed and addressed. Skilled nursing facilities should continue accepting such patient/residents for admission. If appropriate care is delivered and documented, skilled nursing facilities should not fear citations and litigation.

The lesson learned from the examples of Reagan and Reeve is that even the best care that money can buy often results in negative outcomes anyway. Skilled nursing facilities can help counter the negative perception of the industry and its regulatory ramifications by following appropriate care coupled with defensive documentation by the facility's interdisciplinary team (nurse, social worker, physician, therapist, dietitian, physician extender, and other professionals). This can help to ensure that patient/resident maladies will not be attributed to "poor care and treatment" and thus reduce improper citations and unfair litigation.

Money and services alone cannot alter the outcome of disease processes, but improved and targeted documentation may be the best defense against allegations stemming from those outcomes. This includes creating a record that outlines what might be anticipated, including potential negative outcomes. Skilled nursing facilities will find it far easier and less costly to develop such a system, as opposed to fighting devastating survey deficiencies and protracted medical litigation for something they weren't responsible for.

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Top Coding Errors Related to "Short Stay" Assessments

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A Medicare PPS "Short Stay" (SSA) MDS assessment is one that allows a rehab Resource Utilization Group (RUG) classification when a resident discontinues Medicare Part A within the first eight days and did not receive five "distinct days" of therapy when specific criteria are met. Although section Z 0100C of the MDS asks the question, "Is this a Medicare Short Stay Assessment?," the "yes" response can only be triggered (automatically by the software) if the assessment meets all (eight) criteria (i.e. the MDS Coordinator cannot manually code the "yes" response). Thus, during facility audits we often find MDS assessments that should have met criteria for the SSA; however, contained coding errors, which prevented the SSA trigger. This article discusses the top three coding errors that may prevent the SSA trigger and discusses the two most common reasons why the SSA might not trigger (even if coded correctly). For a listing of all eight conditions that must be met for the SSA one may refer to RAI manual chapter six page 6-21.

Following are the most common coding errors:

1) In addition to coding the Medicare 5 day reason for assessment, the assessment must also be coded as a Start of Therapy (SOT) assessment. This may also be combined with discharge assessments (ND and NPE) as appropriate.

2) The assessment reference date (ARD) must match the Medicare End Date (A2400C). Periodically, we find that the Medicare End Date has been miscoded. We highly recommend that coders familiarize themselves with RAI manual chapter three page A-37, which displays an algorithm for correct coding of A2400C. Additionally, we often find that A2400C has been coded with dashes where a date is needed.

3) The therapy end date should be coded as dashes (ongoing) if the resident discharged as unplanned and therapy had not discontinued the resident. This is a key issue as one condition for the SSA is that rehab must continue thru the last day of the Part A stay.

Additional reasons why the SSA may not trigger, even if the assessment is coded correctly are:

1) The non-therapy component of the RUG "index maximizes" higher than the rehab RUG classification (i.e. HE2 vs. RMC). Thus, the SOT reason for assessment should not be coded.

2) The start date of therapy is greater than four days from the Medicare end date.

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