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HOSPITAL HOME HEALTH

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HITECH Act of 2009 expands privacy and security rules

More oversight increases need for HIPAA compliance

Does your home health agency meet all of the requirements for compliance with the privacy and security sections of the Health Insurance Portability and Accountability Act (HIPAA)? Are you in compliance with the Health Information Technology and Economic and Clinical Health (HITECH) Act of 2009? Do you know the specific requirements of the HITECH Act?

When **Heather P. Wilson**, PhD, asks seminar participants to raise their hands if their home health agency is not in compliance with regulations, everyone raises their hands, she says. Wilson is principal of Weatherbee Resources, a Hyannis, MA-based compliance and hospice consulting firm. "Everyone did a great job preparing for the privacy requirements of HIPAA when it was enacted in 1996," she says. "Then, I believe everyone was exhausted and paid less attention to the security requirements."

The HITECH Act is part of the American Recovery and Reinvestment Act of 2009 (ARRA). Because ARRA is designed to accelerate adoption of electronic health records systems, the HITECH Act was developed to expand the scope of privacy and security regulations and to increase enforcement and penalties for noncompliance.

"The HITECH provisions are very far-reaching, and home care agencies and hospices were supposed to be in compliance in February 2010," says Wilson. One of the challenges in meeting HITECH requirements is the fact that not all of the requirements are finalized and some are changing, she says. **(See timeline, page 51.)** "One of the most significant changes that all agencies should have addressed is related to business associate agreements," she points out.

The privacy and security requirements for all business associates are now the same for all covered entities, says Wilson. This means that business associates who use personal health information in the provision of service to a covered entity are now liable for noncompliance with all HIPAA regulations, she explains. "Business associate agreements need to be rewritten to reflect these changes, and all of an agency's business associates need to be educated," she suggests.

Wilson knows that not all agencies are paying attention to this change,

because out of about 100 agencies for which her firm consults, she's received two letters informing her of the change and what it means. "Because of the services I provide, I know about the implications for my firm, but not all business associates will know this," she adds.

One agency that did not wait to address the expanded privacy and security requirements is the Palliative CareCenter & Hospice of Catawba Valley in Newton, NC. "We have updated patient privacy notices for all four services offered by our agency, and we've distributed those new notices to all of our patients," says **Annette Kiser**, RN, MSN, director of organizational integrity for the agency. "We have 260 patients receiving home care, so nurses had to carry the notices and have the patients sign notice receipts when they made their visits," she says.

Specific notification steps identified

One completely new section included in the HITECH Act is the breach notification rule, says Wilson. "There is a step-by-step guide for covered entities to use when a breach of privacy occurs," she says. "Although the previous rule called for the covered entity to notify individuals, it did not specify how and when to notify individuals," she adds. (**See notification requirements, page 52.**)

Although the revision of business associate agreements and distribution of updated privacy notices have not significantly impacted her agency, the breach notification requirements did have an impact, Kiser points out. "Because the breach notification requirements are now very specific and can represent a high cost to implement . . . we decided to further reduce our risk of a breach by encrypting all of the laptops that our staff members use in the field," she says. "The total cost for encryption software and updates to the laptops was $30,000, but we believe it provides an extra layer of protection for patients and costs less than the damage to our agency's reputation if there is a breach."

Retraining staff about new requirements to protect patient information has taken time, but everyone has undergone training, says Kiser. "We were able to explain some of the changes, but because not all of the requirements have been published, we have to let them know that more changes are on the way," she adds.

One area for which agencies are awaiting specific requirements is related to the accounting of disclosures of personal health information (PHI), says Kiser. "We are told that we have to account for every disclosure made for treatment, payment, or health care operations," she says. Previously, disclosures made for the purpose of treatment did not have to be documented, but the concern is that new requirements will include treatment, so that organizations such as pharmacies and equipment providers will have to be documented as having received PHI.

"We are supposed to receive OCR [Office of

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Civil Rights] guidance by June about disclosure accounting, but it will represent a significant administration task," says Kiser. "At this time, we are preparing for the worst-case scenario, assuming that there are no exceptions, so that we can put the process into place quickly," she adds.

Some home care and hospice agencies may not be paying close attention to HITECH due to a combination of reasons, says Wilson. "I do think agencies are HIPAA-tired from so many different regulations and requirements," she says. "I also believe that because there has been so little enforcement of regulations in the past, many agency managers may think that they'll take their chances and just accept the fines as a part of doing business."

Unfortunately, for managers willing to risk noncompliance, the HITECH Act includes significantly higher penalty fees for noncompliance and a greater emphasis on enforcement, says Wilson. "CMS [Centers for Medicare & Medicaid Services] has been responsible for enforcing the HIPAA security rule, but the Office of Inspector General issued a report on how poorly the agency enforced the rule," she says. "Now, HITECH designates the Office of Civil Rights to enforce the security rule, as well as the privacy rule that they have always overseen," she adds.

Another change that will increase scrutiny of agency compliance is the fact that state attorneys general now have authority to pursue investigations and prosecution of noncompliant agencies within their states. "This provision further expands the enforcement oversight for compliance," Wilson adds.

"It remains to be seen how strictly HIPAA requirements will be enforced," Wilson says. "I don't know if it will be complaint-driven, or if there will be random audits conducted," she says. Because the goal of the ARRA is to move to a national health care system based upon electronic medical records, there is more money to support enforcement, she points out.

"We may see that the larger agencies or health care providers receive the most scrutiny, but all home care providers need to remember that compliance with federal regulations is one requirement of the CMS Conditions of Participation," says Wilson. For this reason, everyone — agencies and their business associates — should be careful to comply, she says. "We've always been careful about protecting patients' private information; now we need to be paranoid about protecting it."

SOURCES

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- Heather P. Wilson PhD, Principal, 259 North Street, Hyannis, MA 02601. Telephone: (508) 778-0008 or (866) 969-7124. Fax: (508) 778-8899.

RESOURCE

The following resources are available as guidance for compliance with all aspects of Health Insurance Portability and Accountability Act and the enhancements included in the Health Information Technology and Economic and Clinical Health Act of 2009:

- A free online source of information can be found at www.hipaasurvivalguide.com/. ■

HITECH Act timeline

Pay attention to deadlines to ensure compliance

On Feb. 17, 2009, the Health Information Technology and Economic and Clinical Health Act of 2009 (HITECH) was enacted. On that date, tiered civil monetary penalties were put into place for violations following the enactment, and state attorneys general were given the authority to enforce the act.

On Feb, 18, 2010, all business associates were to be compliant with new regulations.

Future deadlines for compliance include:

- **Jan. 2, 2011:** Initial deadline for complying with new accounting for disclosure rules for entities implementing electronic health systems after January 1, 2009.
- **Feb. 18, 2011:** Department of Health and Human Services required to impose civil monetary penalties in cases of "willful neglect."
- **2013:** Extended deadline for older systems to comply with the new accounting for disclosure rules.

Although these are the deadlines published in the initial act, it is important to stay on top of changes and new deadlines, points out **Heather P. Wilson**, PhD, principal, Weatherbee Resources, a Hyannis, MA-based compliance and hospice consulting firm. "Throughout this process, HHS has missed deadlines, and health care providers have found themselves with little time to implement changes." ■

Breach notification process spelled out

HITECH is very specific about actions to take

Although prior privacy requirements called for home health agencies to notify patients when a breach of privacy was discovered, the Health Information Technology and Economic and Clinical Health Act of 2009 (HITECH) specifically identifies time frames and content of notifications.

Once a home health agency discovers a breach of unsecured protected health information, each individual whose PHI has been or is reasonably believed to have been accessed, acquired, used, or disclosed, must be notified no later than 60 days after discovery.

Notifications must include:

- a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
- a description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
- any steps individuals should take to protect themselves from potential harm resulting from the breach;
- a brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches;
- contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

All of the notifications must be made in writing, and they must be written in plain language.

The notifications can be mailed or, if the individual has approved electronic communications, sent by e-mail.

Special circumstances, such as death of the individual, incorrect mailing address, or urgent need to contact individual also are addressed in the requirements. ■

Lack of adherence in heart failure therapy

Educate and monitor to improve results

When research suggests changes in standard medical practice, the public health community expects physicians and hospitals to adopt the new way and help improve patient outcomes.

But occasionally, as one study recently found, the medical community is very slow in adopting new treatment recommendations.

A good example of this is what has happened with hospitalized heart failure patients who are eligible for aldosterone antagonist therapy, according to a large database study, published in the *Journal of the American Medical Association*.[1]

The study found more than 12,000 patients who were eligible for this therapy, which research has shown would have improved their health outcomes. But only about one-third of these patients had received the therapy, which was recommended in several national guidelines.[1]

The research was limited by what physicians had documented with regard to contraindications, says **Nancy M. Albert**, PhD, CCNS, CCRN, NE-BC, FAHA, FCCM, director of nursing research and innovation in the Nursing Institute, and a clinical nurse specialist at the Kaufman Center for Heart Failure in Cleveland.

"Maybe a patient had a contraindication, and the doctor knew it but didn't document it," Albert says. "If they didn't document a contraindication with therapy, we would assume the patient was eligible to receive therapy."

The analysis began in January 2005, and continued through December 2007, and there was a steady trend from baseline of improvement in the guideline-recommended use of aldosterone antagonist therapy from 28%, when the study began, to 34% when it ended, Albert says.

"The American Heart Association and American Cardiology Association gave their stamp of approval for using aldosterone in patients in 2005," Albert says. So investigators expected to see increased use of aldosterone antagonist therapy after the guidelines were updated. But they were surprised it was only a small increase, she adds.

This lackluster response to changing to using aldosterone antagonist therapy might have been due partly to a small discrepancy in how the guidelines were worded in 2005, Albert says.

"The guidelines should have said the treatment was recommended, but instead said it was reason-

able to use an aldosterone antagonist, and that doesn't have as strong a connotation," she explains.

Although a correction was published in 2006, it's possible that many physicians didn't see the correction, she adds.

Also, none of the national performance measures for hospitalized heart failure patients include aldosterone antagonist therapy as a core measure yet, Albert notes. "It could be that hospitals were so focused on doing what they had to do based on The Joint Commission's performance measures and other expectations that they didn't take the next step of doing what was right based on the guidelines," she says.

Another factor is that one aldosterone antagonist is a generic drug that has been available as a potassium-sparing diuretic for years, Albert says.

"When we use it as an aldosterone antagonist, it's at a different dosage and it's for a different reason," she says. "Because the drug has been available for many years, there has been no drug company marketing of the drug, so maybe lack of use is that it's out of sight and out of mind."

Some physicians might have been reluctant to prescribe aldosterone antagonist therapy because of the drug's side effect profile, Albert says.

If the patient is already on some other therapies that are used to treat heart failure (such as an ACE inhibitor or angiotensin receptor blocker), they might have a higher risk of increased serum potassium and creatinine levels, she explains.

"So, maybe some health care providers were focusing on providing ACE-1 or ARB therapies, and maybe they had intended to start aldosterone antagonist therapy after the patient went home," she says.

The database did not yield information about therapies initiated after discharge, she adds.

The point is that while there are numerous reasons why providers might not have followed the national guidelines, the fact is that for most patients deemed eligible for the treatment, the guidelines should have been followed, leading to improved patient outcomes over time, Albert says.

Since this is an area that has fallen through the cracks, it would be a worthwhile quality improvement project for discharge planners to raise awareness about the treatment and include information about aldosterone antagonists in discharge planning paperwork for patients who meet criteria for use, he notes.

"Hospitals could monitor the use of the therapy in patients with systolic heart failure," Albert says. "If you have a registry or database, then you could keep track of your own data, and over time you should see the frequency of aldosterone antagonist use increase in patients who meet recommended criteria for receiving it."

REFERENCE

1. Albert NM, Yancy CW, Liang L, et al. Use of aldosterone antagonists in heart failure. *JAMA*. 2009;302(15):1658-1665. ■

JOURNAL REVIEW

Hospitalization linked to cognitive decline

Older adults with critical illness suffer impairment

Older patients hospitalized for acute care or a critical illness are more likely to experience cognitive decline compared to older adults who are not hospitalized, according to a study in the Feb. 24, 2010, issue of the *Journal of the American Medical Association*.[1]

Although previous studies suggested that survivors of critical illness suffer long-term cognitive impairment, no study had previously measured cognitive function before a critical illness.

Researchers analyzed data from a study that was conducting cognitive testing on older adults, and examined administrative data from hospitalizations to determine whether hospitalizations for acute illness or critical illness were associated with cognitive decline and dementia. The study included data from 1994 through 2007 on 2,929 individuals 65 years old and older without dementia at the beginning of the study.

During an average follow-up of 6.1 years, 1,601 participants had no hospitalizations while enrolled in the study; 1,287 study participants were hospitalized for non-critical illness; and 41 participants were hospitalized for a critical illness.

There were 146 cases of dementia among those never hospitalized during the study. Among those experiencing one or more non-critical illness hospitalizations but no critical illness hospitalizations during study participation, there were 228 cases of dementia. There were five cases of dementia among those experiencing one or more critical illness hospitalizations during the study.

The researchers found that patients who had a hospitalization for an acute care or critical illness had lower CASI scores at follow-up compared to those who were not hospitalized. Also, after adjusting for various factors, patients hospitalized for a non-critical illness had a 40% higher risk of dementia.

The researchers add that the mechanisms through which critical illness may contribute to neurocognitive impairment are multiple, with evidence suggesting that hypoxemia (decreased partial pressure of oxygen in blood), delirium, hypotension, glucose dysregulation, systemic inflammation, and sedative and analgesic medications all may potentially play a role.

The authors conclude, "Among a cohort of older adults without dementia at baseline, those who experienced acute care hospitalization and critical illness hospitalization had a greater likelihood of cognitive decline compared with those who had no hospitalization."

REFERENCE

1. Ehlenbach WJ, Hough CL, Crane PK, et al. "Association between acute care and critical illness hospitalization and cognitive function in older adults" *JAMA* 2010;303[8]:763-770. ■

Hospital, skilled nursing facilities collaborate

Continuity-of-care department spearheads effort

By working closely with a carefully chosen network of skilled nursing facilities, The Methodist Hospital in Houston has smoothed the transitions in care for patients being discharged to the facilities.

The hospital created a continuity of care department two years ago with the mission of improving the quality and safety of transitional care.

"I was a director of case management and social work for many years, and I know that all hospitals work very hard at making things go smoothly when we discharge patients, but the truth is, we don't know what happens after patients leave the hospital setting," says **Lynda Collins**, MSSW, LCSW, director of continuity of care at the 900-bed hospital.

Sometimes patients and post-acute agencies have the perception that hospitals are just dumping their patients, she says.

"I know this is wrong, but it seems to patients and community agencies that we just discharge patients with no help. I felt that we needed to make formal connections to those places where we discharge the patients," she says.

The department was organized partly in response to a throughput problem, which often led to patients being held in the emergency department or the post-acute anesthesia care unit when there were no acute care beds available.

"We had patients who were ready to move to the next level of care but were still in the hospital. We know that patients in the emergency department or the PACU are definitely sicker than patients at the end of their stay. We needed to find out why the patients were staying when they were ready to be discharged," she says.

The hospital created an advisory council that includes Collins, a geriatrician, a PhD nurse with many years of experience in the long-term care arena, two managers from the case management department, and an operational vice president of nursing.

SNF horror stories

Collins and her team analyzed the throughput issue to determine the reason that patients were staying when they were ready to be discharged.

With almost 90 skilled nursing facilities in the area, the team knew that the problem was not a capacity issue.

"What we found was a hesitation on the part of the physicians to refer patients to a skilled nursing facility and a lot of reluctance among patients and family members to leave the hospital for a skilled nursing facility. They had heard a lot of SNF horror stories," she says.

The team looked for ways to address concerns about quality and to address the fact that some patients are harder to place than others. They wanted a way to educate the physicians and families that skilled nursing facilities can provide the kind of care that some patients need.

"I know from personal experience that when the time comes for a loved one to go to a skilled nursing facility, it's difficult even though you know it's the right thing to do," she says.

The hospital invited about 150 skilled nursing facilities in Harris County and the surrounding counties to come to a meeting.

"We let them know that we were going to affiliate with a small number of skilled nursing facilities

that were interested in working closely with us to make sure the transition was smooth and safe, that the patients received high-quality care and didn't bounce back to the hospital," she says.

A combination of two or more members of the advisory council visited every skilled nursing facility before they were accepted into the network and researched quality data and other information about the facilities before signing them up.

SNF network created

The hospital ultimately signed an affiliation agreement with 26 skilled nursing facilities, creating the Methodist Skilled Nursing Facility Network. The agreement says both sides will work together to improve care and ensure a smooth transition.

The network met frequently in the first year of the program and now meets quarterly.

"We got a lot of feedback from the skilled nursing facility representatives, and we learned a lot about some things we could do better on our end. The SNFs agreed to take patients six days a week and for longer hours. We offered clinical education for the staff at each facility and, because of the size of the hospital, they knew they would get a high volume of patients," she says.

The arrangement has been a win-win proposition for all involved, Collins says.

The hospital now sends more patients to the SNFs in the network than in the past and the SNFs make the decision to accept patients more quickly.

"Our physicians are more comfortable, because they know that we are monitoring the quality at these facilities; and we don't lose sight of the patients we send there," she says.

At the outset, the team worked with representatives from the skilled nursing facilities to determine what kind of information the receiving facilities want when a patient is transferred.

They developed a new easy-to-read transfer form based on the information the facilities said they needed. Collins is working with the hospital's information technology department to develop a way to transmit the form electronically.

"When we talked with representatives from the SNFs, they talked about the problems they face such as what happens if a patient comes late in the day or if the facility doesn't have complete clinical information. We learned a lot about the impact on the patient's transition if we don't do everything on our end to give them the information they need," she says.

The facilities in the network have assigned a clinical liaison so that staff have one person to work with when patients are transferred. Many of the facilities send the liaison to the hospital to assess the patients and collect the clinical information.

"They give us a lot of attention and respond very quickly," she says.

In the past, the skilled nursing facilities sometimes sent patients back to the emergency department if the clinical picture wasn't what they expected.

For instance, in the past, the staff would fax over clinical information and lab values, but sometimes patients developed other symptoms before they arrived at the SNF or the lab values changed.

Now, the SNFs have contact information for the patients' nursing unit and Collins so they can work through the issues without bringing the patient back.

"We want to do the right thing for the patients, but moving them back and forth is not the best way to handle any problems that arise. In the past, nobody's job was to look at the overall picture. Now we can answer questions and address things without having to move the patient back," she says.

The hospital has created a web-based map with the locations of all 26 facilities. Case managers can use the map to show the families facilities in their neighborhood so they can visit before making a choice.

"The feedback from our patients and the SNFs has been very positive. This program has benefited everyone," she says.

(For more information, contact: Lynda Collins, MSSW, LCSW, director of continuity of care, The Methodist Hospital, Houston, e-mail: LCollins@tmhs. org.) ■

Nonadherent patients may not understand

Keep your message easy to comprehend

When patients don't follow their discharge instructions and end up back in the hospital, it may be that they simply don't understand what they were supposed to do at home.

"Today's health care professionals are busy and

give the discharge information quickly without making sure that the patient gets it. Patients want to do what they need to do to get better. When they are noncompliant, it may be that they just don't understand," says **Gloria Mayer**, RN, EdD, CEO for the Institute for Healthcare Advancement based in LaHabra, CA.

People who are discharged from the hospital are still really sick and have a difficult time learning and remembering a lot of material, adds **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA, firm.

"That's why case managers must make sure that patients and family members understand what they should do after discharge and why it's important," she adds.

Keep jargon to minimum

Medical professionals tend to use medical jargon when they speak to patients, which creates a tremendous health care literacy problem, Mayer says.

"When patients aren't familiar with the terminology the case manager uses, they miss the message and they don't understand what they need to do; so that translates into nonadherence," she says.

For instance, people who are told they have "hypertension" sometimes think that means they are hyperactive, but they may understand the term "high blood pressure."

Instead of using terms such as "myocardial infarction," use "heart attack" and say "X-ray" instead of "radiology," Mayer suggests.

When you talk to patients, avoid medical jargon and technical terms you don't need to use, Osborne suggests.

"On the other hand, case managers have a responsibility to use the correct word when it's needed and explain it clearly," she says.

For instance, words such as "chemotherapy" or "dialysis" are complicated words, but there are times when people need to know what they mean, Osborne adds.

Remember that idiomatic terms such as "draw your blood" may not be understood by people who are new to the language.

Confirming understanding is an essential step in communication and one that often gets left out, Osborne says.

Teach patients as clearly and simply as you can, and ask open-ended questions on key points to make sure that they understand, she says.

Using the teach-back technique is key in ensuring that your patients understand what they should do when they leave the hospital, Osborne says.

"We as health professionals do our best to use plain language, but doing that alone is not sufficient. We need to make sure our message is understood," she says.

When you talk to your patients and their family members, create a feeling of partnership. Use phrases such as, "I want to make sure we're on the same page," or "Let's work together to make sure you do everything you need to do after discharge."

Assess your patients' comprehension after you give them key points or new information.

Always ask open-ended questions, putting the responsibility for comprehension on you.

Say, "I want to make sure I've given you the right information."

Don't say, "Do you understand?" because the only answer is yes.

Narrow your focus when you ask questions, Osborne suggests. For instance, say, "The doctor said you need to be on a high-fiber diet. When you go grocery shopping, which cereals would you buy?"

After the patient and family members repeat what you've told them, reinforce that they have the information correct, or correct it if their answer indicates that they don't understand, Osborne says.

Try different strategies and ways of learning, such as bringing in pictures or giving examples, she says.

"If you find the person really does not understand, try to determine why they are having so much trouble. Is the issue hearing, language, anxiety, or learning skills? Think of alternate ways to teach the patient. Make another appointment and invite the family members to participate or arrange for a few visits from a home care nurse who can reinforce the teaching," she says.

Keep it short on topics

Remember that patients can absorb only two or three things at a time. If multiple items need to be covered, break them into small portions, Mayer suggests.

"If people are sick, they are even less likely to understand everything you are telling them," she adds.

Limit your teaching to three concepts at a time and include the family whenever possible, Mayer suggests.

"If medication is the most important thing, teach them about medication. If they need a follow-up appointment, write down the name and telephone number of the doctor and be very specific. Tell them to call Monday and see the doctor within a week," Mayer says.

Be specific with your instructions, she says.

For instance, with congestive heart failure patients, go beyond saying, "Weigh yourself every day," because weight can vary depending on the time of day and what the patient is wearing.

Say, "Weigh yourself when you get up in the morning before you put on your clothes."

Make sure that your written instructions are simple and legible. Keep in mind that people who are just learning to read English may not recognize script and print the instructions, Mayer suggests.

Most health education materials are written between the eighth grade and college level, and about 90 million Americans read at the fifth-grade level or below, Mayer says.

Don't use pharmaceutical company handouts. They tend to be far too complicated for the average person to understand, she adds.

Mayer suggests that hospital case managers review the materials they are handing out and make sure they are simple and to the point, so every client can understand them.

"Some people argue that college-educated patients would be insulted by easy-to-read materials, but in fact, nobody ever complains that something is too easy to understand," she says. ■

Communication ensures safety post-discharge

Timely information needed at next level of care

Whether patients are being discharged from the hospital to home, another level of care, or transferred to the care of another health care provider, communication is crucial to ensure a safe discharge or transition, says **Hussein Tahan**, DNSc, MSN, RN, CNA, executive director, international health services at New York-Presbyterian Hospital in New York City.

"Good communication among all the parties involved in patient care within and outside of the hospital is a key component to ensuring a smooth and safe transition of care. Case managers need to make sure that communication is effective, whether it's between members of the treatment team, the patient and family or caregiver, the payer, or anyone else who is involved directly or indirectly in the care of the patient," he says.

Any communications between the hospital and clinicians or caregivers at other levels of care also should be documented in the medical record, Tahan says.

Tahan, a member of the National Transitions of Care Coalition convened by the Case Management Society of America, helped come up with a model for communication during transitions of care as patients move through the health care continuum.

Successful communication means that an accountable clinician transmits accurate and complete information in an easy-to-understand form in a timely manner to the proper person at the next level of care, and ensures that the person receives the information and understands it, he says.

Key information must include a summary of what happened at the hospital and what needs to happen post-discharge as well as medications, treatment regimens, results of tests, allergies, personal preferences, status of advance directives, and insurance benefits, Tahan adds.

This means that the person who assumes care of the patient after discharge from the hospital has all the information he or she needs to maintain continuity and consistency in care and to make sure that nothing falls through the cracks, he notes.

"The information should be put together in a clear and concise way that is direct and to the point to allow the clinician at the next level of care to understand why it is being shared and what to do with it, especially as the patient's care transitions to those at the next level of care. Such communication enhances continuity of care and prevents unnecessary readmissions to the hospital," he says.

For instance, the post-acute facility, the home health agency, or the family member caring for the patient needs to know about follow-up appointments and if there are tests or procedures that weren't appropriate in the hospital setting that need to be completed after discharge, he adds.

In the hospital setting, the clinician responsible for communicating with the next level of care is likely to be the case manager.

"In fact, the case manager is the best person suited to assume such a role. As they work with the treatment team and manage patient care activi-

ties, case managers almost always are involved in transition of care activities. This means they are a strategic player in preventing medical errors and other problems that can occur with the handoffs of care between care settings and when providers are not managed effectively or properly," Tahan explains.

The person receiving the care-related information may be a case manager at another facility, a physician in the community, a home care nurse, or the patient's caregiver in the home setting, he adds.

Case managers must ensure that the information necessary for effective patient care goes to a specific accountable person at the next level of care who can communicate the information to the rest of the care team, Tahan says.

"In the past, the case manager might have faxed whole or parts of the medical record to the skilled nursing facility but didn't necessarily follow up to make sure the right person got the information or that he or she received it in a timely manner and was aware of how to use such information. Today, direct communication between providers of care at transferring and receiving facilities is a necessity to ensure safe and effective transitions and care outcomes," he says.

CMs, social workers liaisons

At North Hills Hospital, the case managers and social workers are responsible for communicating with the liaison at the next level of care and making sure that pertinent pieces of the medical record accompany patients to the next level of care, says **Cynthia Lawson**, RN-BC, MBA, CPHQ, director of case management at North Hills (TX) Hospital.

If the patient is going to a skilled nursing facility, long-term acute care hospital, or another institution, the staff make sure that the most recent progress notes, the orders, and any reports from a consultant also accompany the patient to the receiving facility.

"The receiving facility should have a complete picture of patients' conditions when they arrived at the hospital, as well as what happened immediately prior to them being transferred," Lawson says.

In addition, the primary care nurses communicate with their counterparts at the post-acute facility just as if it were a shift handoff, she says.

"Most of the post-acute providers who work with us have liaisons who come to the facility to assess the patients and collect their own information, but that doesn't eliminate the need for the nurse-to-nurse report," she says.

If patients are going home with home care, the case managers make sure the home care agency has the history and physical and a reconciled medication list, as well as the doctor's orders, she says.

"Many patients are cared for by hospitalists instead of their community-based physician during their hospital stay. This means the community physician often has no idea what happened during the hospital stay or what kind of follow-up care the patient needs," Tahan says.

Hospitals need to develop ways to communicate with primary care physicians after their patients are hospitalized to inform them about what follow-up needs to be done after discharge, he adds.

Make sure that the patient's primary care physician gets a discharge summary quickly, so he or she will be prepared when the patient comes in for a follow-up visit, suggests **Beverly Cunningham**, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital and health care consultant and partner in Case Management Concepts LLC.

"In addition, the primary care physician needs to know what was prescribed (medication, tests, treatments) for the patient in the hospital, so he or she won't end up repeating the same or be unaware of certain important nuances in the care of the patient to maintain safety and prevent deterioration of the patient's condition," Tahan says.

Information may be faxed, mailed, or sent electronically to the community physician, but someone on the team must be accountable for seeing that it is communicated to the proper person at the physician practice and that it is clear and understood, he says.

Case managers should communicate with the patient and family and encourage them to actively participate in the decisions about the next level of care, Tahan says.

COMING IN FUTURE MONTHS

- The impact of health care reform on HHAs
- How will the outlier cap affect you?
- Teach all employees to "sell" agency
- Tips to reduce re-hospitalizations

"Patients need to know where they are going, and when, what is going to happen at the next level of care, and they must be in agreement for the discharge to succeed," he says.

Patients are in the hospital such a short period of time, and it's often hard to catch up with the family, Cunningham points out.

"We have to look for windows of opportunity and adjust the way we communicate, such as e-mailing the family members," she says.

Let your patients know what to expect when they get home and what symptoms to watch for that indicate they should call the doctor, says Cunningham.

Make them aware that they need to follow up with their primary care physician within a week or so and, if possible, help them make an appointment before they are discharged.

At North Hills Hospital, if the patient is going home with home health services, the home health liaison visits the patient's room, explains the services, and how things are going to work.

"It's also a benefit to the patients to help them understand what is coming next and minimizes their apprehension about post-acute care," Lawson says.

Educate your physicians on the need for patients who go home without services to have referral for home care so a nurse can reinforce the discharge planning and make sure the patient can manage at home, Cunningham adds.

Medication reconciliation is an important part of ensuring that patients safely transition to another level of care, Tahan adds.

Case managers need to make sure that patients understand how and when to take their medication. They need to be aware of whether they should keep taking the medication they were taking before they were hospitalized or substitute another medication prescribed during their hospital stay, he adds.

(For more information, contact: Beverly Cunningham, RN, MS, vice president, clinical performance improvement, Medical City Dallas Hospital, e-mail: Beverly.Cunningham@hcahealth care.com; Cynthia Lawson, RN-BC, MBA, CPHQ, director of case management, North Hills Hospital, e-mail: Cynthia.Lawson@hcahealthcare.com; Hussein Tahan, DNSc, MS, RN, CNA, executive director, international health services, New York Presbyterian Hospital, e-mail: hut9001@nyp.org.) ■

CNE QUESTIONS

5. What is the most immediate requirement of the Health Information Technology and Economic and Clinical Health Act of 2009 that home health agencies should already meet, according to **Heather P. Wilson**, PhD, principal, Weatherbee Resources, a Hyannis, MA-based compliance and hospice consulting firm?
A. Staff education
B. Breach notification
C. Implementation of electronic medical records
D. Revision of business associate agreements

6. What step did her agency take to reduce the risk of a data breach, according to **Annette Kiser,** RN, MSN, director of organizational integrity for Palliative CareCenter & Hospice of Catawba Valley in Newton, NC?
A. Limited patient information available to staff
B. Encrypted laptops used in the field
C. Asked patients to sign privacy notices
D. Implemented notification program

7. According to the Health Information Technology and Economic and Clinical Health Act of 2009, what is the time frame for notifying individuals whose personal health information might have been accessed or used inappropriately?
A. 24 hours
B. 10 business days
C. No later than 60 days
D. Within 90 days

8. What percentage of home health agencies will see a reduction in payments for care if the Medicare Payment Advisory Commission's (MedPAC) 2010 Report to Congress is used to set reimbursement policy, according to the National Association for Home Care & Hospice?
A. 30%
B. 50%
C. 70%
D. 90%

Answer Key: 5. D; 6. B; 7. C; 8. C

NEWS BRIEF

Method to access PS&R changed

Home health agencies now must register to receive a copy of the Provider Statistical and Reimbursement Report (PS&R), which is used to settle the final or audited cost report. Previously, the PS&R was sent to home health agencies by their Medicare intermediary or Medicare administrative contractor.

The report will no longer be automatically sent to a provider. Every home health agency must register at www.cms.hhs.gov/iacs. Most agencies use the PS&R summary to report Medicare settlement data when they file their Medicare cost reports.

It does take up to one month for registration to be completed, and registration must be made by a home health agency, not a designee such as an outside accountant. ■

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify the clinical, ethical, legal, or social issues particular to home health care.
2. Describe how the clinical, ethical, legal, or social issues particular to home health care affect nurses, patients, and the home care industry in general.
3. Integrate practical solutions to the problems faced by home health professionals into daily practices. ■

CNE INSTRUCTIONS

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **September** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Hospital Home Health

2010 Reader Survey

In an effort to learn more about the professionals who read *HHH*, we are conducting this reader survey. The results will be used to enhance the content and format of *HHH*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope by **July 1, 2010.**

In future issues of *HHH*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. Medicare legislation & regulation	O A	O B	O C
2. prospective payment system	O A	O B	O C
3. compliance and anti-fraud initiatives	O A	O B	O C
4. legal and ethical issues	O A	O B	O C
5. home care industry trends	O A	O B	O C
6. provider-based status	O A	O B	O C
7. how to become and stay accredited	O A	O B	O C
8. human resources management/ recruiting and retention issues	O A	O B	O C
9. information management	O A	O B	O C
10. outcomes and benchmarking	O A	O B	O C

Please rate your level of satisfaction with the following items.
A. excellent B. good C. fair D. poor

11. quality of newsletter	O A	O B	O C	O D
12. article selections	O A	O B	O C	O D
13. timeliness	O A	O B	O C	O D
14. length of newsletter	O A	O B	O C	O D
15. overall value	O A	O B	O C	O D
16. customer service	O A	O B	O C	O D

17. On average, how many people read your copy of *HHH*?

O A. 1-3
O B. 4-6
O C. 7-9
O D. 10-15
O E. 16 or more

18. How would you rate your overall satisfaction with your job?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

19. How would you describe your satisfaction with your subscription to *HHH*?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

20. What is your title?

O A. supervisor
O B. director
O C. manager
O D. administrator
O E. other_____

21. What is the highest degree that you hold?

O A. ADN (2-year)
O B. diploma (3-year)
O C. bachelor's degree
O D. master's degree
O E. other_____

22. *Hospital Home Health* has been approved for 15 nursing contact hours using a 60-minute contact hour by the American Nurses Credentialing Center's Commission on Accreditation. If you participate in this CNE activity, how many hours do you spend in the activity each year? _____

23. Do you plan to renew your subscription to *HHH*?

O A. yes
O B. no If no, why not? _____

_____

24. To what other publications or information sources about home health do you subscribe?

25. Including *HHH*, which publication or information source do you find most useful, and why?

26. Which web site related to your position do you use most often?

27. Please list the top three challenges you face in your job today.

28. What do you like most about *HHH*?

29. What do you like least about *HHH*?

30. What are the top three things you would add to *HHH* to make it more valuable for your money?

Contact information