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Surprise! Joint Commission changes are leading to continual compliance

Unannounced surveys and self-assessments keep facilities on their toes

It's not unlike studying for an exam. You know that the exam is approaching, and you do some studying to prepare; but it's usually at the last minute that you really push yourself to focus on preparation for the exam.

In the home health world, the exam for many agencies is the triennial accreditation survey. While you still need to make sure you comply with the standards for both the Oakbrook Terrace, IL-based Joint Commission on the Accreditation of Healthcare Organizations and the New York City-based Community Health Accreditation Program (CHAP), Joint Commission-accredited organizations will have to undergo some cultural changes in the way they prepare for a survey.

Not only is the Joint Commission asking you to identify your own deficiencies in a self-assessment process called Periodic Performance Review, but starting in 2006, you won't know when the surveyors are coming. Organizations that are scheduled for surveys in 2004 and 2005 can volunteer to participate in the unannounced survey program as the Joint Commission tests the process.

"Of all health care organizations, home care agencies have a tremendous amount of experience with unannounced surveys because all Medicare or state surveys have always been unannounced," says **Maryanne L. Popovich**, RN, MPH, executive director of the home care accreditation division. In fact, the most frequently asked question about unannounced surveys is "What if I'm not here?" she says.

For agency managers concerned about their absence when the surveyor arrives, Popovich points out that the new survey process implemented by the Joint Commission during the past year, Shared Visions — New Pathways, focuses much more on the actual care provided to patients rather than lists of policies and procedures.

"Because we are committed to better communication with our organizations, we will provide a short, concise list of documents that we will need so an agency manager needs to make sure the responsibility for those documents is designated to a couple of people so at least one is available when the surveyor arrives," she says.

"One thing surveyors will want to evaluate is how performance improvement activities and leadership actions impact patient care," says Popovich. For this reason, you should make sure that there is always someone who knows how to access patient records for the surveyor, she adds.

Identify your own deficiencies

Another major change in the Joint Commission survey process is scheduled for implementation for home care organizations slated for survey in and after July 2005. "In October of 2003, these home care organizations will receive their Periodic Performance Review tool that is to be used as a self-assessment of their compliance with Joint Commission standards at the 18-month point between triennial surveys," says Popovich.

An organization has 90 days to complete the Periodic Performance Review and submit it to Joint Commission. The tool is used by accessing a secure web site that is password-protected. The tool basically is the same one used by surveyors that lists standards, rationale for standards, and elements of performance. If the organization determines that it is not in compliance, there is a button that can be clicked to submit a brief plan of action to correct the deficiency.

Once the organization submits the Periodic Performance Review, a group of Joint Commission staff reviews the tool and then arrange a conference call to discuss the self-assessment within one month. Deficiencies that are identified during the Periodic Performance Review do not affect the organization's survey results as long as the deficiency is corrected by the time of the survey.

Home health agencies accredited by CHAP always have had to complete and submit a self-assessment prior to their survey, says **Terry A. Duncombe**, RN, MSHA, president and chief executive officer of the organization. "Our home health agencies use it as a tool to assess their readiness for the survey and to develop a work plan," she adds.

Although home care pilot tests of the Periodic Performance Review still are ongoing, hospital organizations with home health or hospice organizations were involved the first tests.

"The opportunity to assess the organization in a penalty-free environment is very appealing," says **Angie King**, RN, CPHQ, quality management director for Tift Regional Medical Center in Tifton, GA, and one of the participants in the first pilot test for the new accreditation process.

"You either meet the standards or you don't, and the self-assessment gives you an opportunity to develop the policies or implement a program that will bring you into compliance with the standards," she says.

The best news is that you are not penalized for any deficiencies you identify during the self-assessment phase, she points out.

"Once you've identified your own deficiencies, you submit a plan to correct them." Then, you have 18 months to implement those corrections, King says.

Although the tool is designed so that only one person within the organization can submit information, it is set up so that multiple people can access the tool to contribute information. This makes it easy for the coordinator of the review to assign different parts of the self-assessment to the appropriate departments.

Because the initial pilot test did not address all

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standards, King did not need all departments, such as hospice, to provide information, but that will not be the case when the organization undergoes its actual self-assessment.

"I will coordinate the process, but I will have each department provide information on issues from their area," says King.

All departments will be able to use the web site to see what policies or measurement and monitoring information they must provide, she adds. Then, they can enter it directly on the tool for the coordinator to review and prepare for submission, King explains.

"Most home care organizations already have some sort of ongoing self-assessment program, but even if they don't, completing the Periodic Performance Review should not be a huge burden," says Popovich.

"There is more time involved in the transmission of the document, the conference call, and preparation of action plans if needed, but the benefit of making sure that you are compliant well ahead of your survey will outweigh any extra work," she says.

"The greatest benefit is that you won't be performing your self-assessment in a vacuum," points out Popovich.

"During the pilot tests, Joint Commission staff members discovered that some organizations judged themselves noncompliant in some standards when they really had just misunderstood the intent and did not have to correct anything. In fact, the organizations were much harder on themselves than our surveyors were," she adds.

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Be diligent in efforts to prevent OASIS errors

Chart audits, education, reference books helpful

Everyone makes mistakes; but when mistakes are made routinely by home care nurses gathering information for the Outcomes and Assessment Information Set (OASIS), your agency's bottom line is affected.

"Nurses are not coding specialists, so we have to provide the education that they need to accurately complete OASIS forms," says **Jewel L. Walker**, RN, CNA, MSA, quality improvement and compliance manager for University Home Care Services in Worthington, OH. "Not only should agencies have a mechanism in place to catch errors, but the nurses' education should demonstrate the effect answers on the OASIS have on reimbursement levels," she says.

Walker's agency has coding specialists look at both the OASIS information and the nursing chart within 24 hours of admission and before the information is submitted to Medicare. "We want to make sure the diagnosis is accurate," she says. For example, a diagnosis of senile degenerative brain function, also known as confusion, pays less than a diagnosis of dementia, she says.

"We tell nurses that we don't want them to upgrade a diagnosis if unwarranted, but we do want the nurse to accurately input the diagnosis of dementia if the physician agrees that the patient's condition is more serious than confusion," Walker adds.

In addition to ensuring accurate reimbursement, an accurate diagnosis also ensures that your outcomes are based on realistic expectations, points out **Lisanne Bright**, RN, BSN, MA, process improvement and clinical supervisor for Alliance (OH) Visiting Nurse Association and Hospice.

"Look at the transfer OASIS data," she suggests. "If the patient was admitted to the hospital because of a fall, find out if the fall was the result of a stroke." A patient recovering from a broken hip will have a far different outcome than a patient recovering from both a broken hip and a stroke, Bright adds.

Another problem that Bright's agency has addressed is inconsistency between nurses. "We realized that two different nurses could look at the same wound; and one would classify it a

wound, and the other would classify it a lesion," she says.

To standardize how clinicians answered questions, her agency developed an OASIS booklet that contains the most commonly used codes, along with detailed descriptions of how to apply those codes, Bright says.

"We also require that nurses have their supervisors review their charts at the start of care, resumption of care, and recertification." These checkpoints ensure that inaccurate data are corrected in a timely manner so reimbursement will not be affected adversely, she adds.

Another inconsistency can show up in the same chart, Bright points out. "When reviewing charts, we may see that a patient does not require assistance, but then further down on the form, we see that the patient uses a walker."

Discharge audits are performed regularly to identify recurring errors, she says. In one audit, Bright discovered that the same employee committed half of the 60 OASIS errors committed by one team in a six-week period.

"She was a new employee and thought she was completing the form correctly," she says. After identifying the problem, the supervisor worked with the employee to make sure she knew how to complete the form correctly, and the error rate for that team dropped.

The most common errors found in the audits are omissions where questions are skipped and inaccurate therapy information, says Bright.

"You don't want your nurse guessing how many physical therapy visits are needed," says Walker. "Under PPS [the prospective payment system], 10 or more physical therapy visits mean an additional $2,000, but a nurse may not be able to accurately judge the number needed."

Because her physical therapists are required to see the patient between 24 and 48 hours after admission, Walker suggests that her nurses hold their charts until they've consulted with the therapist.

"During our chart review, we also compare the nurse's information with the physical therapist's notes. If the therapist changes the number of visits during treatment or if the therapist's notes conflict with the nurse's notes, we contact the nurse and submit a corrected bill," she adds.

"We usually find that the physical therapist finds a higher acuity level than our nurses because the therapist actually observes the patient," says **Joanne Rogers**, RN, BSN, MA, director of coordinated care for University Hospital Home Care in Warrensville Heights, OH.

"Many times, a nurse will ask patients how well they get around and take their word for it," she adds. For this reason, University Home Care's performance improvement department completes the therapy section of OASIS after consulting with the physical therapist, she explains.

Now that the Centers for Medicare & Medicaid (CMS) will be posting certain home health agency outcomes, it is more important than ever to accurately document the patient's prior condition and current condition, says Walker. **(See "Public to get access to home health quality information thanks to CMS," *Hospital Home Health*, February 2003, p. 13.)**

For example, if you are admitting a patient that has been in the hospital after a cerebrovascular accident, you have to be specific about the patient's condition prior to the home care admission, she says.

Don't just ask the family how the patient was prior to the illness, be specific and focus on the 14-day tim frame that CMS defines as "prior to," and ask questions about walking unassisted, bathing with no assistance, and handling activities of daily living, she says.

If you incorrectly take the family's assurance that "everything was fine" without probing for specifics, you are setting yourself up for a less-than-desirable outcome, she adds.

Ongoing education important

At University Hospital Home Care, OASIS education for nurses is ongoing. "As we conduct random chart reviews, we talk one on one with nurses about their errors," says Rogers.

"We also offer regular programs on new information about OASIS as well as programs that address the errors we most frequently observe," she points out.

Because attending an inservice program not always is convenient for nurses, the home care agency offers continuing education credits as an incentive for everyone to attend programs that are mandatory, she explains. "We also conduct the program at lunchtime to make it easier."

Although OASIS is addressed in orientation, Rogers points out that new nurses may need some extra supervision.

"A lot of times, new nurses don't take the time to read the entire question or find out exactly what is meant. They try to interpret the intent for themselves," she adds.

In addition to quarterly, active chart reviews in which the nurse brings in charts of active patients to review along with a performance improvement specialist, University Home Care also offers telephone consultation to nurses in the field who encounter questions about which they are unsure.

"Nurses are appreciative of our efforts to teach them individually with the active chart reviews, and we always get calls from nurses in the field," says Rogers. "We're glad we can provide the extra support they need to prevent errors and ensure accurate documentation."

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For success, coach young asthma patients carefully

Individualized, creative approaches reach children

It's not just a case of a little breathing problem. There are 6.3 million children younger than 18 with asthma.[1] Asthma rates in children younger than 5 increased more the 160% between 1980 and 1994.[2] In 2000, 4.6 million outpatient visits related to asthma involved children.

During the same year, more than 728,000 visits to emergency departments (EDs) for asthma-related problems and 214,000 hospitalizations involved children.[3]

When you look at these statistics and realize that not only is care of asthmatic children costly for the health care industry (more than $8.1 billion annually[4]) — parents miss work and children miss school — it makes sense to look to home health as one way to reach out to children at risk for asthma to help them learn how to avoid outpatient and ED visits. **(For a description of children at risk for asthma, see box, p. 78.)**

The Visiting Nurse Service of New York (VNSNY) has provided nurses focused on asthma care for 15 years, says **Maryam Navaie-Waliser**, PhD, senior research associate for the Center for Home Care Policy and Research for the New York City-based agency.

"We've always served a large number of children, and about 30% of our clients are children with many of them being seen for asthma-related problems," she says. Of the children her agency sees, between 55% and 60% of them are younger than 5 and have been diagnosed with asthma since they were toddlers, she adds.

Because asthma is the leading referral diagnosis to the agency's pediatric program, VNSNY conducted an evaluation of the program to make sure the care that was provided was effective for the patients and their families, says Navaie-Waliser.

"Years ago, the nurse would see an asthma patient and the family over a course of seven to 10 visits, but now we only see them three times," she explains. "This makes it critical that we make sure we are making the best use of time."

The large number of children under the age of 5, pointed out the importance of providing education that involves the parent, according to Navaie-Waliser.

"Not only do we make sure the nurse explains how to use an inhaler, when to use different medications, or what signs of an impending attack to notice, but the nurse now has the parent demonstrate the skill or knowledge by showing how to use the inhaler, or describing the signs," she continues.

With children ages 11 and older, nurses not only educate the children but involve the parents as well, explains Navaie-Waliser. "We discovered that older children benefit most when their parents can also remind them how to control their asthma, especially during an attack when the child might be anxious and forget what has been taught," she adds.

Family-specific plans most effective

Although there may be only three visits, each visit is between one and two hours long, says Navaie-Waliser. The nurse's first visit includes a lengthy and detailed assessment that addresses

the child's health history, use of medications, timing of attacks, and environmental factors.

"During our evaluation of asthma patient charts, we realized that the quality and detail of the environmental factor assessment was key to the development of a successful asthma care plan," she says.

If asthma triggers can be identified and minimized in the home, the number of attacks will decrease, she adds.

"We design each treatment plan for the individual," says Navaie-Waliser. "One family may require education about control of roaches while another family needs to learn about the dangers of cigarette smoke around an asthmatic child," she explains.

The pediatric asthma program at Sentara Home Care Services in Chesapeake, VA, provides a longer period of follow-up, but the nurses also start out by developing an asthma treatment plan based on a thorough assessment of the patient and the environmental triggers, says **Rhonda Chetney**, RN, MS, director of clinical operations.

"Once the treatment plan is developed and approved by the physician, the follow-up occurs by telephone or in person as needed," she says.

Pediatric asthma patients stay in the program for one year with the greatest number of visits occurring in the first month to stabilize the child and to thoroughly assess the environment, she adds. "After the first month, most follow-ups are conducted by telephone; and the nurse will schedule a visit if there is any indication that one is needed," she explains.

Sentara's home care nurses act as "Life Coaches" for about 600 asthmatic patients each year, explains Chetney. "Our goal is to help patients manage asthma and reduce the number of acute episodes they experience over their lifetime," she says.

Pediatric asthma patients are referred to emergency department, clinic, or hospital, she adds.

Demographic factors also can increase a child's risk of developing asthma, says Navaie-Waliser. Of the 400 to 600 children seen by the Visiting Nurse pediatric asthma program, 64% are male, 35% to 40% are Hispanic, and 20% to 25% are African-American, she says. The ethnic breakdown of the patient population is typical of the urban population served by her agency, she adds. "Children living in an urban environment are more likely to develop asthma because they are surrounded by more environmental triggers," she explains.

Factors within the home that are likely to trigger asthma attacks include molds, roaches, rodents, stuffed animals, pets, and cigarette smoke, says **Rhonda Chetney**, RN, MS, director of clinical operations for Sentara Home Care Services in Chesapeake, VA.

"Once we've identified triggers, we suggest ways to minimize their effect on the child's asthma," she says. "Vacuuming frequently, not leaving food out to attract roaches, and keeping the family pet out of the child's room are a few suggestions," she explains. Although pets are a major trigger for many children's asthma, it is not feasible to tell every family to get rid of the pet, she says. "We just explain that minimizing contact is important," she adds.

Because many children are as attached to their stuffed animals as to their family pets, Chetney does not suggest throwing all stuffed animals out either. "If you place the stuffed animals in the freezer for 24 hours, the mites will be killed," she explains. Also, reduce the number of stuffed animals the child actually keeps in the bed at night, she suggests. ■

Education and environment contribute to asthma risk

A thorough health assessment is necessary for any home care patient, but the assessment of a pediatric asthma patient needs to look at a wide range of issues to make sure the treatment plan is effective, according to experts interviewed by *Hospital Home Health.*

Lack of education about medications and symptoms increases the risk that a child will experience an acute asthma attack. A common reason for repeated asthma attacks is a misunderstanding of the medication, says **Maryam Navaie-Waliser**, PhD, senior research associate for the Center for Home Care Policy and Research for the New York City-based Visiting Nurse Service of New York.

Families don't understand the difference between medications that relieve asthma symptoms during an attack and medications that control symptoms at all times, she says.

"We find patients that are using relievers on a continuous basis rather than controllers," Navaie-Waliser explains. This continuous use can exacerbate an attack, she adds.

Another area in which families lack knowledge is the identification of symptoms at the beginning of an attack during which relievers can be very effective and recognition of relief of the attack, according to Navaie-Waliser.

When the family and child can't recognize when to use the medication most effectively, the attack escalates into an acute episode that requires a trip to the

Sentara's program by the corporation's health plan, says Chetney.

"High-risk children are identified through the plan by several mechanisms, including utilization of [EDs], hospitalizations, physician office visits, and prescriptions filled," she says.

When it appears that the asthmatic child is not managing the asthma, the home care agency receives the referral, she adds.

Flexibility is key to success

"The toughest part of our job is finding many of these children," Chetney says. "Most of the children are in the Medicaid HMO plan, and we often find that telephones are disconnected or no one is home during the day because of work schedules, so we've become creative in how we reach them," she explains.

"We're most successful with our drive-bys where the nurse just goes to the home to see if anyone is there," says Chetney.

"If no one is home, we leave information with the reason we came and how to get in touch with us. We also make it clear that we can make the visits at night or on the weekends, whichever is best for the parent's schedule," she says.

If it is too difficult to visit the child at home, nurses will go to after-school programs to gather information, but it is critical to get inside the home at some point to identify environmental factors that may be causing the acute episodes, says Chetney.

Another way the pediatric asthma program has partnered with the school system to help asthmatic children is the TeleCoach that has taken up residence in the school nurse's office at one middle school where there are 200 asthmatic children. This innovative program has resulted in a 64% decrease in hospitalizations, a 33% decrease in ED visits, and a 65% drop in patient care costs for the 40 children involved.

"The monitor sits on a cart that is dressed in a warm-up suit and has a head and hat on top," says Chetney.

TeleCoach comes equipped with a stethoscope, blood pressure cuff and two-way live audiovisual capabilities using a telephone line.

The nurse who is conducting the televisit from the agency office finds out how well the children are managing their asthma, how the medications are working, and if there are any gaps in the children's knowledge. She also answers any questions the children may have.

"We've had the program in place for about 1½ years, and it's very successful," she says.

Forty children have scheduled times to meet with the "coach" every one or two weeks, usually during gym class, says Chetney.

"We offer incentive prizes for keeping their appointments," she adds. One of the reasons for success is the combination of technology that interests the children and a fun way to present information, she adds.

"Children don't willingly go to a traditional asthma class because it's boring, but they will come talk to the coach," Chetney explains.

Is information appropriate for your audience?

Make sure that all of your educational information, even traditional printed material, is appropriate for your audience, Navaie-Waliser suggests.

"Between 50% and 60% of our patients are Hispanic, so we have to provide bilingual care," she says.

Her agency's educational materials are printed in English, Spanish, French, and Chinese to reflect the populations they serve, she adds.

"We also make sure the material is written at a fourth-grade level to make sure everyone can understand," she says.

Because asthma is more prevalent in an urban environment and very often in a lower income environment, it's important to be creative and flexible when planning services for a pediatric asthma program, says Chetney.

"When you add the environmental factors to the reality that your patient may not be talking yet, you have to thing outside the box and look for nontraditional ways to reach and care for patients," she explains.

[Editor's note: For more information about the Sentara Home Care Services' Life Coach program, including a copy of an asthma treatment plan, see: Axelrod RC, Zimbro KS, Chetney RR, et al. A disease management program utilizing 'Life Coaches' for children with asthma. Journal of Clinical Outcomes Management *2001; 8:38-42.*

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Telehealth and home health risk management

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[Editor's note: This is the first of a two-part LegalEase column that addresses home health agency risk management concerns related to telehealth. This column presents information on liability related to negligence and offers tips on how home health agency managers can protect their agencies. ***(For more information about telehealth in home care, see* Hospital Home Health*, March 2002, p. 25.)***

Next month's column will discuss how agencies can protect themselves from charges of abandonment.]

Home care providers are beginning to seriously explore the use of telehealth devices in home health care.

As providers examine exciting new possibilities in telehealth, they must remain cognizant of possible risks associated with the use of these devices. They must also take practical steps to avoid potential liabilities associated with the advent of telehomecare.

There are two potential types of liability that providers must avoid in the use of telehealth: liability for negligence and liability for abandonment. Agencies run the risk of liability for negligence whenever they provide services to patients.

To prove these types of liability, patients must show all of the following:

1. Providers owed patients a duty of reasonable care.

2. Providers breached their duty of reasonable care to patients. Agencies can breach their duties to patients in one of two ways:
- Agency staff members do something they should not.
- Practitioners fail to do something they should have done.

3. Providers' breach(es) of duty caused injury or damage to patients. The best way to define "cause" is in terms of "but for." But for the providers' breach of duty, patients would not have been injured or damaged. To prove injury or damage, patients must show physical injury or damage, or extreme and outrageous conduct on the part of providers. Extreme and outrageous conduct is behavior that is barbaric, shocking, cannot be tolerated in civilized society, and causes one to gasp.

Patients must prove all three of those requirements. If they fail to prove even one of them, providers will defeat patients' lawsuits based on negligence.

The use of telehealth devices includes the potential for instances of negligence in addition to potential liabilities associated with hands-on or in-person services. Equipment malfunction or failures are an example of types of negligence specifically associated with the use of telehealth.

Liability also may result when practitioners, primary caregivers and/or patients do not thoroughly understand how to use equipment involved in the provision of telehealth services.

Physicians have observed, for example, that the use of telehealth devices to view and prescribe treatments for patients with wounds is limited severely by staff members, primary caregivers, and/or patients who really do not understand how to use telehealth equipment.

Most agencies are extremely concerned about maintenance of telehealth devices. Stories about

persistent bugs in devices, systems that crash or are completely inoperative for days at a time, and unresponsive vendors are alive and well within the industry.

Negotiate good contracts

Managers must gain as much control as possible over the timing and quality of vendors' responses when staff members report problems. Accountability by both agency and vendor personnel is absolutely crucial to the avoidance of potential liability.

Specifically, the process for reporting problems must be described carefully in written contracts or agreements between agencies and telehealth vendors.

The following questions must be addressed with as much detail as possible in such contracts:

- Who should receive reports of problems with equipment at the agency?
- When is it appropriate to make reports of malfunctioning equipment to vendors?
- What are appropriate time frames for making such reports?
- In what form should reports to vendors be made?
- How and to whom should reports to vendors be communicated?

Likewise, the obligations of vendors with regard to problems also should be delineated. Specifically, contracts should establish detailed time frames for both responses from vendors and resolution of problems.

Reductions in monthly maintenance fees may be appropriate when vendors' failure to meet delineated standards for problem resolution is documented.

It may be appropriate to establish a method to triage problems in contracts. In other words, certain types of problems deserve more immediate attention than others. Inoperative systems/devices will receive the highest priority in most instances. But other minor difficulties may withstand delays.

As part of the process of negotiating contracts, agencies and vendors should engage in detailed discussions about how equipment malfunctions and failures will be handled.

These discussions should be reduced to writing. When vendors have developed standard contracts and do not wish to deviate from them, agreements about how to handle problems with hardware may be detailed in exhibits to standard agreements. In addition, when agency staff members, patients' primary caregivers, and/or patients do not adequately understand how to operate telehealth devices, liability for negligence may result.

Again, these issues may be addressed in some detail in written agreements between agencies and vendors. Training of staff members, primary caregivers, and/or patients must be carefully described in contracts.

Provide a lot of information about training

The more details that are included in agreements regarding training, the greater protection from potential risk for agencies.

Consequently, agreements, at a minimum, should spell out answers to the following questions:

- Who will provide training on behalf of the vendor?
- What training will the vendor provide?
- What is the specific schedule for training conducted by vendor personnel?
- Who will monitor training provided by vendors on behalf of the agency to help ensure effectiveness?
- What mechanisms such as post-tests will be used to evaluate effectiveness of training provided by vendors?
- What recourse do agencies have if it appears that training provided by vendors is inadequate or ineffective?
- What process will be followed when agencies document deficits in knowledge after initial training has been completed successfully?

Again, it is crucial for representatives of vendors and agencies to spend time before agreements are signed to be able to include detailed answers to these questions in written agreements.

If agencies and vendors fail to address these crucial issues of equipment function and training in contracts, their risks of liability for negligence due to injury or damage to patients is likely to be enhanced.

Both agencies and vendors will clearly benefit from careful consideration of these issues before telehealth devices are used in the field.

[A complete list of Elizabeth Hogue's publications is available by contacting: Elizabeth E. Hogue, Esq., 15118 Liberty Grove, Burtonsville, MD 20866. Telephone: (301) 421-0143. Fax: (301) 421-1699. E-mail: ehogue5@comcast.net.] ■

HIPAA Q & A

[Editor's note: This is a periodic column that will address specific questions related to the Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to Sheryl Jackson, Hospital Home Health*, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: Will we need to buy new computers in order to run security software that is compliant with the security rule?

Answer: No. The HIPAA security rule is technologically neutral, says **Robert W. Markette, Jr.**, an attorney with Gilliland & Caudill, a health care law firm based in Indianapolis. "Health and Human Services [HHS] realized that it would be foolhardy to dictate technology in a rule that would not go into effect for two years. Therefore, the security rule requires security policies and procedures that cover certain specific points, but the rule does not dictate how a covered entity should go about complying with the rule," he says. A covered entity needs to perform a risk assessment and implement the requirements, but the decision to upgrade hardware or software is a decision based upon the entities' application of the regulation.

Question: Will we need to be certified as compliant with the security rule?

Answer: No. HHS has not made certification part of the security rule, points out Markette. "They will not consider a third-party certification evidence of compliance, and HHS has not designated any entity to provide such certification," he adds.

Question: Will we need to implement trading partner agreements with our business associates?

Answer: No. The trading partner agreement was part of the original security rule, Markette says. Under the new rule, when a covered entity shares electronic protected health information (EPHI) with a business associate, the rule simply requires some additional provisions in the contract that impose certain safeguarding requirement upon the business associate, he explains.

Question: Will we need to purchase special software to ensure that none of our EPHI is altered without authorization?

Answer: Again, the answer is no. "Although the rule requires covered entities to ensure EPHI in its possession is not altered without permission, it does not require that the method for ensuring the integrity of information be electronic," explains Markette.

"In fact, HHS said that for a smaller provider, a reasonable method of ensuring integrity might be to maintain paper copies of documents," he adds. That way, if a question about the integrity of the data ever came up, the entity could simply refer to the paper copy in its file.

Question: Does the security rule affect private health information (PHI) in our paper files?

Answer: No, the security rule only applies to PHI maintained in electronic form, says Markette. However, PHI maintained on paper is subject to the privacy rule, he adds.

Question: It appears that there will some overlap between our privacy policies and our security policies. Can we borrow from our privacy policies to implement security policies?

Answer: Yes, there is a great deal of overlap in the two rules. "HHS set out to rewrite the security rule to harmonize with the privacy rule and they succeeded. HHS has said that a covered entity should feel free to borrow from its privacy policies when implementing the security rule policies and procedures," he says.

Question: Does the security rule require us to perform background checks on employees before allowing them to access EPHI?

Answer: No. Though the security rule does require provider to ensure that an employee's access to EPHI is appropriate, this does not mandate a criminal background check. HHS said in the comments to the rule that "the need of and extent of a screening process is normally based on an assessment of risk, cost, benefits, and feasibility as well as other protective measure in place."

There may be some situations where a background check is appropriate, but that would be a decision for an entity based on its risk analysis, says Markette. "Of course, some state laws require criminal background checks for certain employees as part of its licensing regulations," he emphasizes.

Question: Can our privacy officer also be our security officer?

Answer: Yes. The main reason for requiring a security office is to ensure that final responsibility for security compliance rests with one individual, explains Markette.

"Most organizations will want to designate somebody who will be comfortable dealing with the technology issues inherent in the security rule, but there is no reason an entity's privacy officer cannot be the security officer as well," he adds.

[For more information about the HIPAA security rule, contact:

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Help from children keeps elderly parents at home

One-third of people age 70 and older with physical limitations received regular help from their children with basic personal care such as eating, bathing, dressing, or maneuvering around their home, although only 7% received help most of the time. About 11% receive both personal care and help with shopping and chores according to a recent study.

The study findings underscore the importance of family caregiving. Researchers found that disabled Americans age 70 and older who received help from their adult children with basic personal care were 60% less likely to use nursing home care over a two-year period than similar elders who did not receive assistance. The likelihood that people would receive help increased with the number of adult children.

Black and Hispanic elders were substantially more likely than whites to receive help from their children.

Initiatives such as respite care, tax breaks for family caregivers, and requirements that employers offer time off or flexible schedule for workers with caregiving responsibilities could reduce costly nursing home admissions by encouraging families to provide care for their elderly parents, wrote **Anthony T. Lo Sasso**, PhD, research associate professor in the Institute for Health Services Research and Policy Studies at Northwestern University in Evanston, IL, and **Richard W. Johnson**, PhD, research associate of the Urban Institute in Washington, DC.[1]

Lo Sasso and Johnson analyzed data on elderly health, assistance from family members, characteristics of adult children, and nursing home admissions from a nationally representative longitudinal survey of more than 7,000 Americans age 70 and older.

Reference

1. Lo Sasso AT, Johnson RW. Does informal care from adult children reduce nursing home admissions for the elderly? *Inquiry* 2002; 39:279-297. ▼

JCAHO re-approved as hospice accrediting body

The Centers for Medicare & Medicaid Services (CMS) approved the Joint Commission on Accredi-tation of Healthcare Organizations to continue accrediting hospice facilities seeking to participate in Medicare or Medicaid programs.

COMING IN FUTURE MONTHS

- Help your staff deal with illness and loss
- Tips for dealing with pets in the home
- Proactive performance improvement can make your life easier
- How safe are your employees?
- What to do when clients express preferences for caregivers

The Joint Commission requested re-approval in January 2003. The final notice is effective June 19, 2003.

For more information, go to the CMS web site: http://cms.hhs.gov/. ■

CE questions

13. What is one of the appealing aspects about the Joint Commission's Periodic Performance Review, according to Angie King, RN, CPHQ, quality management director for Tift Regional Medical Center?
    A. the lengthy period of time in which you have to complete it
    B. the fact that you don't have to submit the assessment to anyone
    C. the ability of one person to handle the assessment without involvement from other departments
    D. the opportunity to assess your organization in a penalty-free environment

14. In addition to ensuring appropriate reimbursement levels, what else does an accurate diagnosis ensure for your home health agency, according to Lisanne Bright, RN, BSN, MA, process improvement and clinical supervisor for Alliance Visiting Nurse Association and Hospice?
    A. realistic expectations for outcomes
    B. less paperwork to complete
    C. faster turnaround time for chart reviews

15. What percentage of pediatric asthma patients seen by the Visiting Nurse Service of New York are younger than 5?
    A. 30% to 35%
    B. 42% to 46%
    C. 55% to 60%
    D. 68% to 72%

16. Why should home health agencies address training needs in vendor contracts for telehealth equipment, according to Elizabeth E. Hogue, Esq.?
    A. to save money on staff education
    B. to compare one company to another
    C. to ensure maximum insurance reimbursement
    D. to reduce agency liability for negligence risks

Answer Key: 13. D; 14. A; 15. C; 16. 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. ■