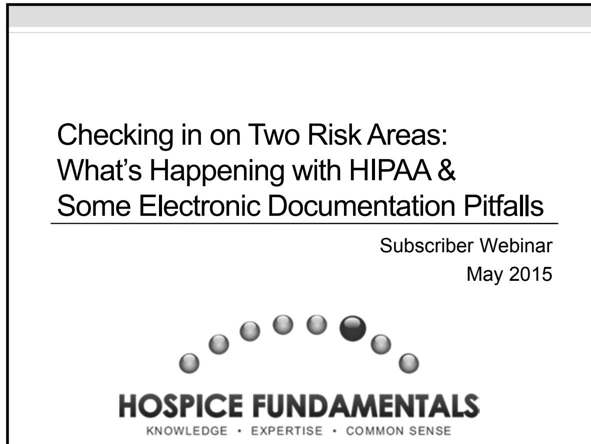

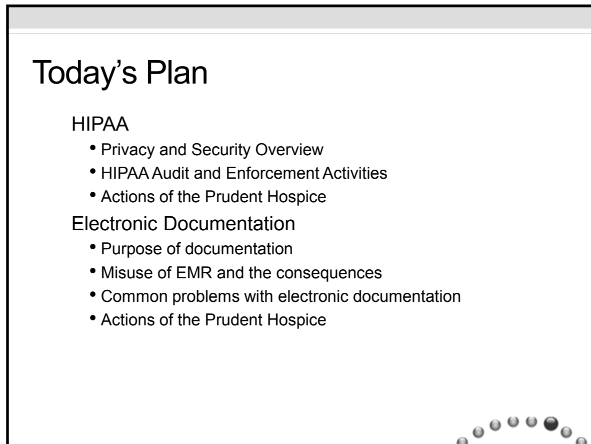

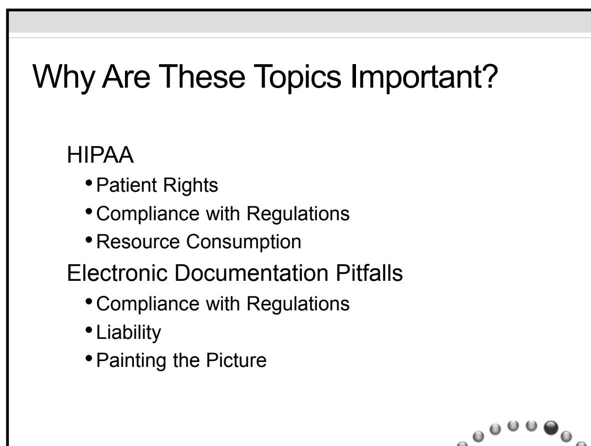

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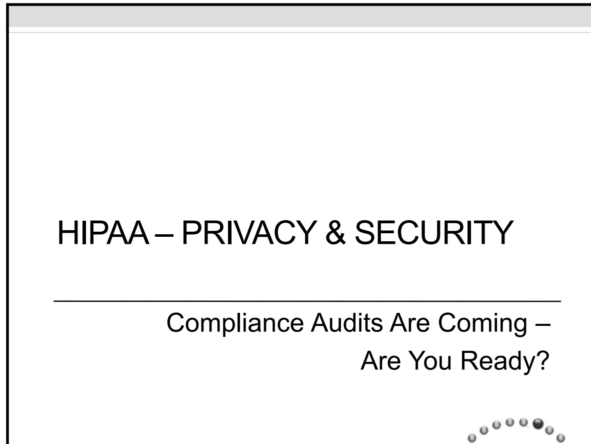

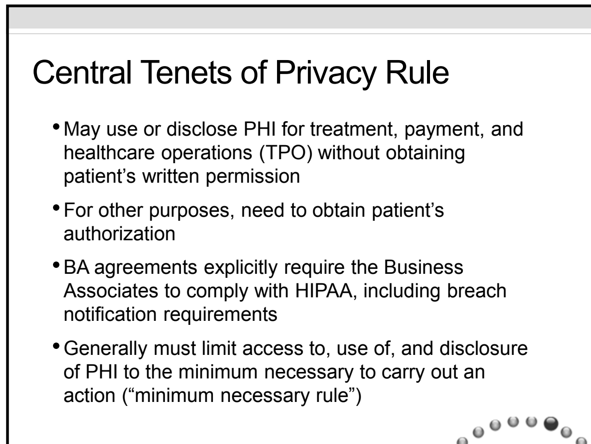

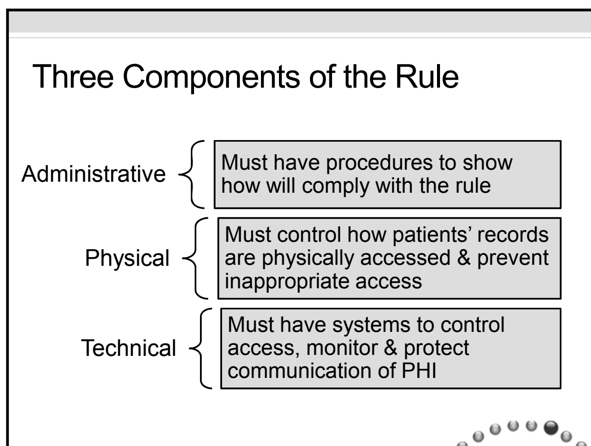

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What Is the Difference?

PRIVACY RULE

Requires covered entities have in place appropriate administrative, physical, technical safeguards & to implement those safeguards reasonably

Applies to all forms of patient's PHI, whether electronic, written, or oral.

SECURITY RULE

Protects subset of information covered by Privacy Rule

Covers only PHI that is electronic in form (e-PHI).

Includes e-PHI that is created, received, maintained or transmitted.

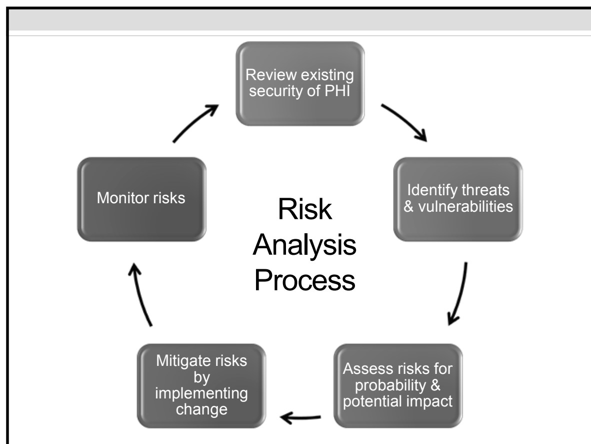
Remember – the clinical record represents a unique and valuable individual, not just a collection of data that you are protecting – it's a life.

CMS 2010

Good patient care means safe record-keeping practices.

Privacy & security are similar to the care planning process that requires

- assessment of risks
- ongoing monitoring and evaluation
- periodic **adjustments**



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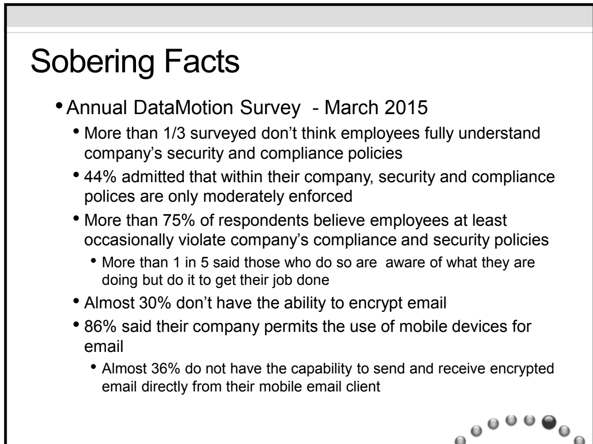

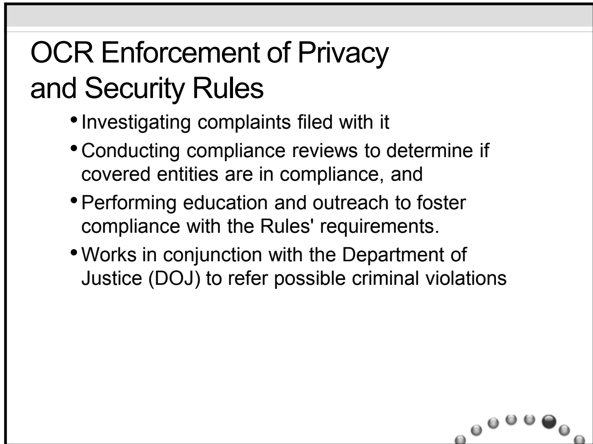

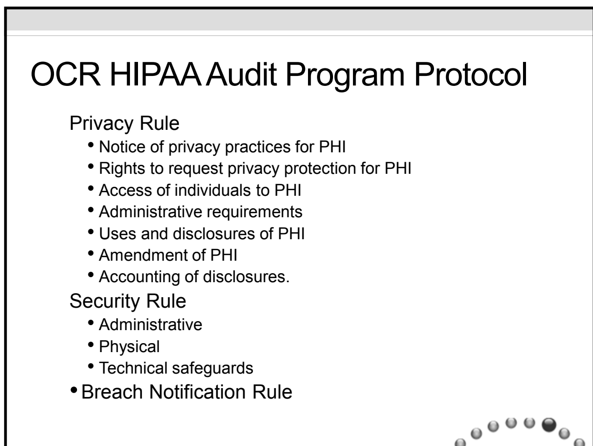

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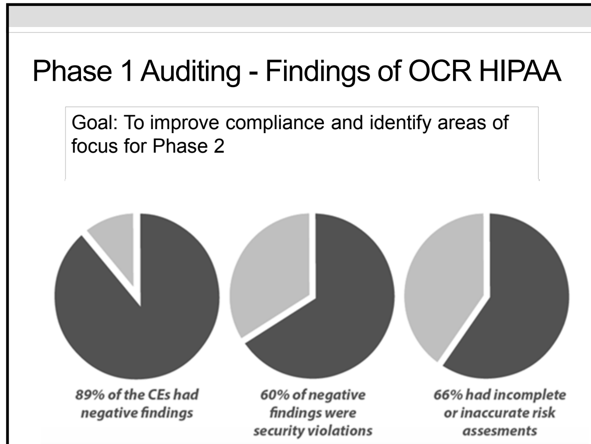

Phase 2 Compliance Audits

- DHHS expected focus of audits
  - Areas of noncompliance or weakness identified in covered entity's processes for access to & security of PHI
  - Recommendations for corrective or preventive action
  - Best practices
- Based on findings expect to be required to submit plan of correction
- Depending on the report – may lead to enforcement investigations & civil money penalties

KPMG Compliance Audit Components

- On site visits
- Interviews with key individuals to include
  - Management
  - Privacy officers
  - Security officers
  - Personnel with access to PHI
- Review of policies and procedures
- Inspection of physical features
- Observation of policy implementation

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Fines and Charges

	Fine Per Incident	Criminal Charges
Reasonable Cause	$100 to $50,000	No
Willful Neglect	$10,000 to $50,000	Yes

Actions of The Prudent Hospice

From *The HIPAA Series: Part 5 – Preparing for an Audit*

1. Read FYI: *The HIPAA Series Part – 4 Steps to Compliance*
2. Risk Analysis
3. Policies and Procedures
4. Key Personnel
5. Evidence that the Security Incident Program is Working
6. Designated Record Set
7. Addressable HIPAA Guidelines
8. Business Associates
9. Staff Training
10. Effective Security Controls
11. Well-Organized Documentation

Actions of the Prudent Hospice

- Make protecting patient information part of your hospice's routine
- Make sure your Notice of Patient Privacy is current as of 9/23/13
  - On website
  - On location
  - Admission packets

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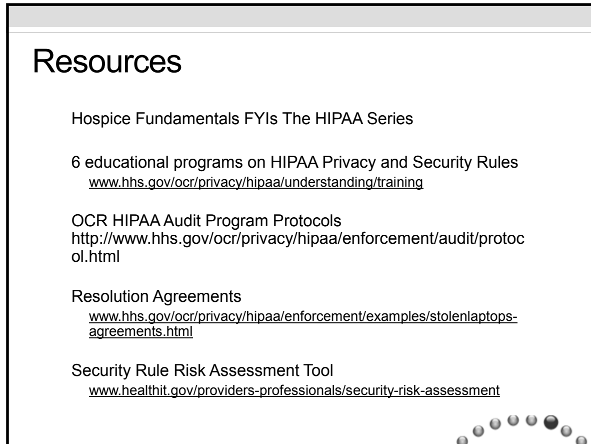

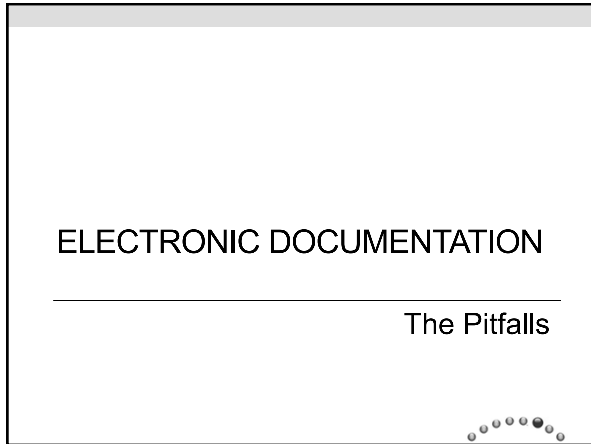

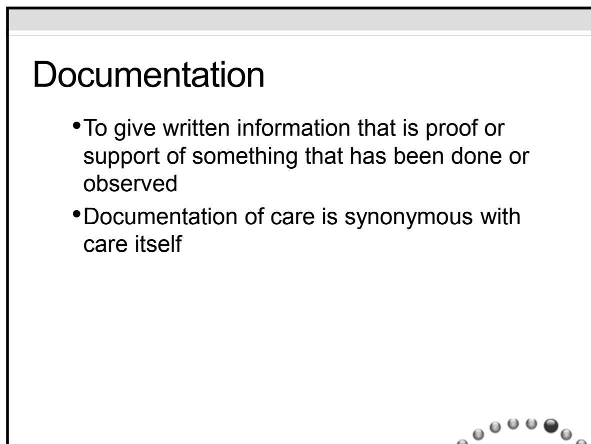

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Documentation: Areas of Focus

Medicare CoPs **State Licensure Rules** Assessment Plan of Care QAPI Professional Management	**Medicare Coverage** Eligibility Plan of Care Levels of Care
Interdisciplinary Group Assessments Care Provision Making a Difference	**Professional Standards** **Licensure Requirements**

Documentation Is…

- The final chapter of the life story of a person
- Subjective description of objective reality
- How we communicate about the patients' and families' needs, goals and care
  - Accurate & detailed documentation reflects their most pressing needs, which in turn should foster good care
- Provides a mechanism for understanding what is working and what still needs to be managed effectively

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Why Documentation Is Important

Legal document
- Only document that chronicles patient's stay
- Assume it will be scrutinized by somebody at some point

Fundamental component of your practice-accountability
- Assessment
- Records professional practice
- Professional judgment
- Critical thinking used

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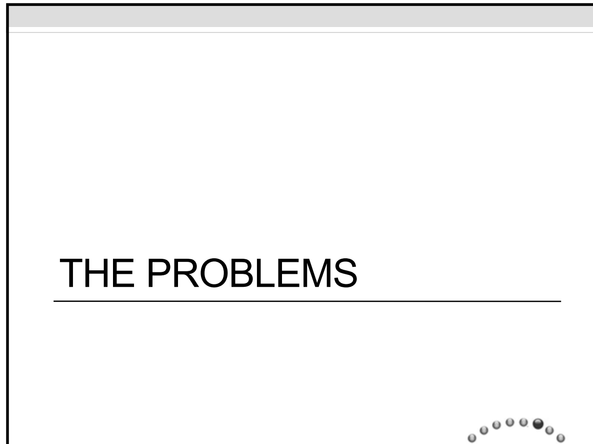

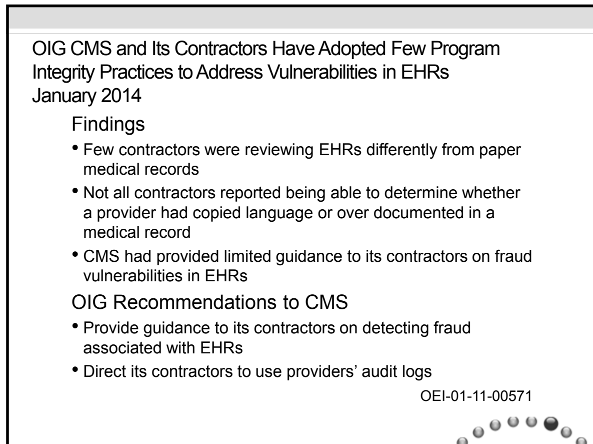

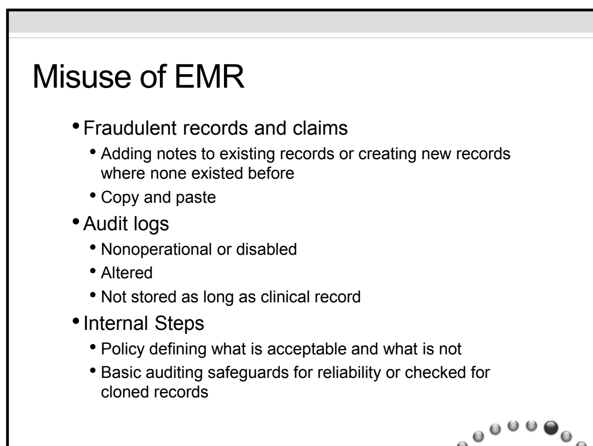

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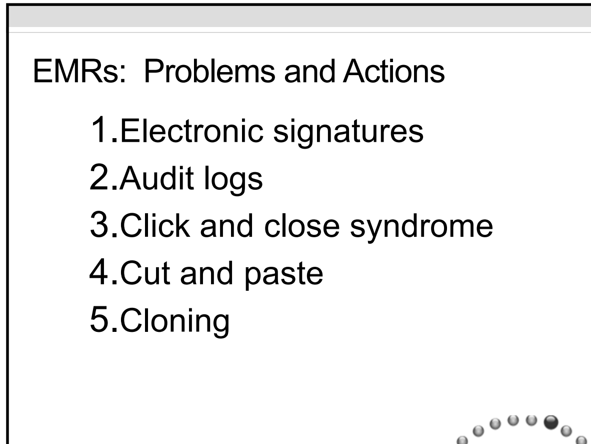

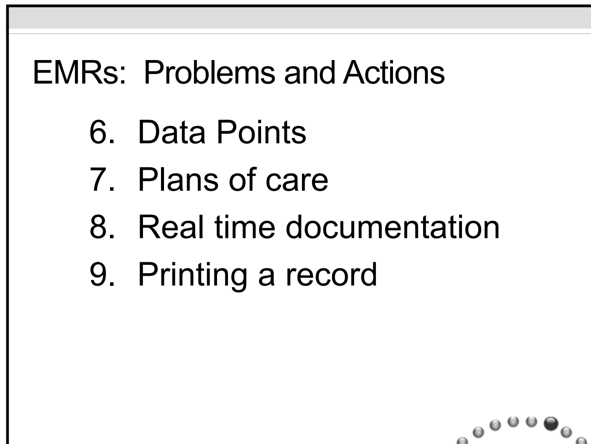

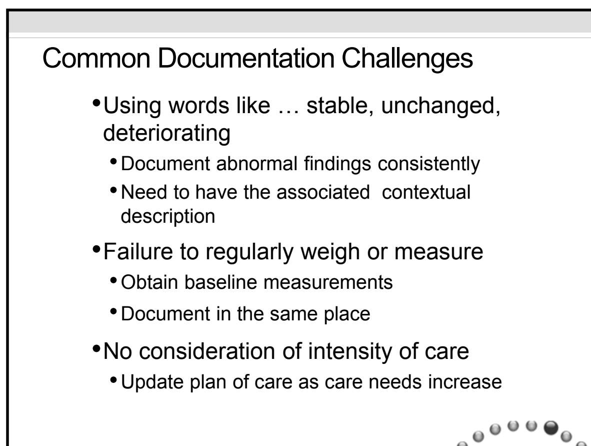

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Common Documentation Challenges

- Admission documentation does not contain description of why hospice/why now and what patient "looked" like 3 to 6 months ago
- Inconsistent
  - FAST 7C but chaplain states patient told him about his Navy days
  - PPS 30% but documentation describes patient ambulating with a walker
  - Weights 121 pounds one month and 142 pounds the next
- Imprecise
  - "Assist with all ADLs"
  - "Weight loss" or "estimated weight"

Remember: Documentation Should

- Be specific to that individual patient
- Document what distinguishes the patient as terminal and not chronic
- Have narrative notes to explain information noted on a checklist - use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Compare current to previous
- Exacerbation and resulting decline/deterioration
- Purpose and need for aggressive palliative treatments

"As Evidenced By…"

When you use descriptors like: cachectic, anorexic, non-ambulatory, dyspnea (at rest or on exertion), weight loss, poor appetite, fragile, failing, weaker…

Always follow up with "as evidenced by.." to fully describe what you see

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Actions of a Prudent Hospice

- Provide comprehensive education on proper use of EMR
- Ensure policies address cloning, audit logs
- Know how your audit logs work and how they are accessible
- Establish standards of when and where to document data points
- Audit real time documentation & hold staff accountable to documenting at the bedside
- Monitor compliance and enforce policies related to documentation

To Contact Us

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Charlene Ross
602-740-0783
Charlene@HospiceFundamentals.com

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Electronic Medical Records: Problems, Results and Actions

The Category	The Problems	The Results	The Actions
Electronic Signatures	• Insufficient controls • Sharing of unique identifiers	• Records not created by the signer • Records which can be altered by someone else	• Proper policies and procedures • Ability to produce evidence these are electronic signatures
Audit Logs	• Nonoperational or disabled • Altered • Not stored as long as clinical record	• Cannot retrieve or recreate who created what document at what time frames • Cannot validate the integrity of the record	• Understand how it works in your EMR • Do not allow to be disabled • Ensure you can produce if requested
Click & Close Syndrome	• Quality of documentation • Just checking boxes with no other descriptors	• All patient records read the same • Poor communication of patient needs and plan of care • Does not paint the picture of eligibility	• Educate and hold accountable for making narrative comments • Audit for individualized care plans • Audit for eligibility
Cut and Paste	• Staff creating shortcuts • Copying and pasting of inaccurate or outdated information • Redundant information • Inability to identify when the documentation was first created	• Dissemination of false information • Difficulty identifying current information • Unnecessarily lengthy notes that don't tell the current story • Invalidates the story	• Determine if your EMR has this capability and if so determine if it can be controlled or eliminated • Implement policies • Audit
Cloning	• Current note/entry or IDG summary starts with last entry and you change from there • Carrying forward	• Dissemination of false information • Difficulty identifying current information • Documentation difficult to follow for eligibility and care delivery	• Determine if your EMR has this capability and if so determine if it can be controlled or eliminated • Implement policies • Audit

The Category	The Problems	The Results	The Actions
Data Points	• Documenting objective data (i.e., weights, MAC, FAST, PPS, etc.) in more than one place • Not documenting objective data in the proper place	• Inconsistencies in the data • Conflicting data points • Inability to trend for decline	• Determine EMR capabilities to run trending reports and where the data must be documented • Educate staff where to document and hold accountable
Plans of Care	• Not interdisciplinary but discipline specific • Choosing too many problems, goals and interventions • Hard to update or change • Using only predetermined/ prepopulated goals which aren't measurable • Frequencies are based on benefit period	• Plan of care is not interdisciplinary • Difficult to follow/lack of connection to care delivery • Difficult to show coordination of care with the nursing facility • Not realistic • Difficult to show changes / intensity of care needs • Frequencies are all the same	• Understand how your EMR plan of care works, how much you can customize and how much you have to live with or develop work around • Update plans of care as patient need change (close goals and interventions when achieved)
Real Time Documentation	• Lack of point of service documentation • Connectivity issues	• Not accurately capturing visit time • Difficult to read the story as does not always flow chronological • Inaccuracy of the record as details are forgotten • Unhappy staff because they are charting after hours • Not accessible to other IDG members real time •	• Set a standard of when documentation must be completed, run reports against the standard and hold staff accountable • For connectivity issues, explore options •

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The Category	The Problems	The Results	The Actions
Printing a Record	• Not understanding how to print a record • Surveyor wants a paper record • Record request with limited time to submit	• Scrambling to figure out how to print • Not including all components • Not all records print first in, first out so difficult to put in order • Excessive number of pages to print • Uses up valuable time leaving less time for record review before submission	• Do a dry run of printing record for an ADR and for a surveyor to work out process. Review the print out to ensure all components are present • Work with your EMR company to make this effective and efficient

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