

The HIPAA Security Regulations: It is not too Early to Get Started

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While April 21, 2005 seems a long way off, it will be here before you know it. The final HIPAA Security Regulations were released on February 20, 2003 and it is not too early to get started on understanding and implementing these regulations.

The Security Rule is divided into three categories: (1) Administrative Safeguards, (2) Physical Safeguards, and (3) Technical Safeguards. Generally, the HIPAA Security Rule requires that home health agencies do the following:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information (ePHI) the covered entity creates, receives maintains, or transmits;
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI;
- Protect against any reasonably anticipated uses or disclosure of such information that are not permitted or required under the Rule;
- Ensure compliance with the Rule by its workforce.

Note that ePHI includes PHI stored on a computer disk, computer hard drive, magnetic tape or PHI that is transmitted over the Internet; however, ePHI does not include PHI on paper sent by fax or oral PHI transmitted over the phone. Although only ePHI is covered under the Security Rule, all PHI of this nature is covered under the HIPAA Privacy Rule.

Required and Addressable

CMS has made a commitment to “scalable” and “technology neutral” requirements. Therefore the Security Rule allows flexibility in how a covered entity chooses to meet certain requirements, considering such factors as:

- The cost of a particular security measure
- The size of the covered entity
- The complexity of the approach
- The technical infrastructure and other security capabilities in place



- The nature and scope of potential security risks

Rather than requiring specific technical measures, the Security Rule takes a goal-oriented approach establishing “standards” that all covered entities must meet, accompanied by implementation specifications to guide compliance with each standard.

The implementation specifications are divided into two categories: Required and Addressable. Covered entities must implement all *required* implementation specifications, deemed fundamental to any reasonable security compliance program. For *addressable* implementation specifications, however, a covered entity must assess the reasonableness and appropriateness of each specification to its own security framework. It may decide to implement an alternative security measure or may determine that the particular specification is not applicable to the Agency. Because the Agency must meet the related standard, the Agency must document the rationale for the approach taken to meet the standard.

Implementation Flexibility

The Security Rule allows a covered entity to be flexible in its approach to compliance with the standards. In addition to the factors mentioned above, the agency must also consider the probability and criticality of potential risks to ePHI when determining what measures will be implement-

ed to meet the standards of the Security Rule.

The Agency is expected to manage this flexibility through a comprehensive and consistent Risk Management process that includes:

- 1) Risk identification
- 2) Risk analysis
- 3) Remediation strategy
- 4) Remediation implementation.

These processes will be utilized when assessing the security measures that are practical for the Agency.

Getting Started Tasks

So what can *you* do to get started? The first steps include the performance of basic organizational and data collection tasks. These tasks include:

- Review of security rule and standards
- Assignment of security responsibility
- Assessment of operations security
- Development of a security implementation plan
- Documentation of the HIPAA Security implementation activities.

Where Can You Find ePHI in Your Agency?

1. Server
2. Backup media
3. Desktop Workstations
4. Laptop or PDA Workstations
5. Tele-health devices
6. Cell phone memory
7. Copier memory only
8. Fax Machine memory only

Where You Will Not Find ePHI

1. Paper fax transmission
2. Orally via telephone

Managing Patient Care Episodes through an Appropriate Staffing Model

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Has Medicare PPS caused you to re-think what type of service delivery model your agency uses? There has been an evolution over time in how agencies structure their service delivery to provide quality care within the constraints of reimbursement.

Years ago, when Medicare was first implemented, the majority of the services were skilled nursing with home health aide and limited therapy services. These services were limited because there was a shortage of therapists involved in home care and because there was more restorative nursing services. Often times an agency would have one or two physical therapists that would make visits with the registered nurse to set-up a rehab program of home exercises and ambulation. Then the RN would follow through with the plan of care. The PT would act as a consultant, revisiting occasionally to modify the plan as needed.

As more therapists entered the home health arena and it was apparent that there was an incentive to make more visits with the cost-based system, there was a change to having therapists provide the services directly. Restorative nursing became used less and less. This resulted in the need for a more multidisciplinary approach to the patient's plan of care.

With both the cost-based and the prospective payment systems there are four key service delivery components to look at. They are productivity, utilization of services, efficiencies and case management.

Currently there are three common service delivery models used in home care, each model has many variations. They are Multidisciplinary Team; Discipline Specific Team and Disease Management Team. They are described below including the strengths and weaknesses of each model in relation to the needs of the prospective payment system.

Multidisciplinary Team

The multidisciplinary team consists of personnel representing all disciplines providing care to a patient within a specific geographic area. One manager supervises all the personnel and the patients on the team. In most agencies there is a lead therapist or therapy consultant available for expert knowledge related to the specific discipline. Patients are assigned to the team based on geographic area and to Case Manager based on geography, skill and/or discipline. The

MULTIDISCIPLINARY TEAM	
<p>Strengths</p> <ul style="list-style-type: none"> • Continuity of Care • Ability to develop good team relationships • Episode management including line authority to manage all disciplines providing care and discipline mix • OASIS completion by all Case Managers and by those providing ongoing care • Decreased mileage reimbursement 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Not all disciplines will be supervised by their own discipline • Staff to Supervisor ratio may be high • OASIS completion by all case managers which many increase inconsistencies • Need to share expert resources between multiple teams, i.e., Wound Care Specialist, Disease Specialist, etc • Balancing of team census by geography may be more difficult
DISCIPLINE SPECIFIC TEAM	
<p>Strengths</p> <ul style="list-style-type: none"> • Disciplines are supervised by personnel with their specific training and expertise • Staff to Supervisor ratio is lower • Discipline focused teams which encourages best practices 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Much more difficult to manage all services provided within the episode • Continuity of care may not be as consistent • Much more difficult to develop patient-centered multidisciplinary team relationship • Need to share resources between multiple teams • Geographic duplication amongst teams • Potential for poor customer services as too many people involved in managing care • Difficulty managing team size
DISEASE MANAGEMENT TEAM	
<p>Strengths</p> <ul style="list-style-type: none"> • All staff treating patients would have disease specific expertise • Build referral relationships around disease management • Ability to easily standardize treatment plan with Care Maps and Best Practices 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Entire service area coverage which leads to increase in travel time and overlap of multiple teams servicing geographic area • Disciplines not being supervised by their own discipline • Need for multiple disease management teams with potentially small censuses • OASIS completion by all case managers which may lead to inconsistencies • Difficulty in balancing team censuses due to diagnoses of patient population • Need to share resources between teams

Case Manager is responsible for coordinating care with other disciplines.

Discipline Specific Team

Staff is assigned to teams made up of all the same discipline, i.e., nursing teams, therapy teams and HHA teams. The teams are usually geographically based and have a larger service area. The patient's case manager could be either an RN or a Therapist depending on if the patient required only therapy services. Patients are assigned to staff based on openings/availability and

skills. One patient could be serviced by multiple teams within the agency. Coordination of all services a patient receives would be the responsibility of the Case Manager.

Disease Management Team

Teams are developed to provide disease specific care such as a cardiopulmonary team which cares for only patients with diagnoses which fit that description. Often the team has a multidisciplinary approach. Staff is assigned by disease

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Ready Or Not: Home Care Compare

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On November 3, 2003, the Department of Health and Human Services announced the national implementation of the Home Health Quality Initiative with the launch of Home Health Compare. The home health industry is now able to compare patient outcomes among agencies using consistent and measurable data. Through Home Health Compare, scores for patient outcomes in eleven measures are now available for public viewing via a link from www.medicare.gov. Prior to the development of the OASIS instrument which is utilized by all certified agencies, the industry had no standardized mechanism to compare how patients' outcomes may have differed from one agency to another.

Customer satisfaction surveys allow us to compare how patients feel about the delivery of services. However customer satisfaction surveys do not measure hard data. For instance, the patient may have been "unhappy" with the care but the care may have met his/her needs appropriately. An example of this would be the diabetic who loved sweets. The home health aide wouldn't give the patient sweets; therefore the patient may have been "unhappy" with the care, but she may have achieved the desired goal of stable blood sugars. Additionally, customer satisfaction surveys only measure the satisfaction of the patients at one agency. Only if the survey questions are exactly the same at all agen-

cies can we use the responses to compare patient satisfaction among agencies.

The use of anecdotal data, which may clearly describe how patients responded to care either positively or negatively, is not comparable or measurable. Given this, agencies now more than ever must concentrate their efforts on how to maximize the opportunities and minimize the risks associated with their use of the OASIS data set as the tool for measuring and comparing outcomes.

What should agencies do to increase their prospects of achieving good patient outcomes and scoring well in comparison to their competitors?

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Managing Patient Care Episodes

specific specialized training. Case Managers can be either NRN or Therapist depending on services provided. The Case Manager is responsible for coordinating care with other disciplines.

For each type of model there are additional advantages and disadvantages in relation to cost and quality which need to be considered. The advantages from a cost and quality perspective for all three models are listed below:

Multidisciplinary Team:

Cost Advantages:

- Better episode management
- Opportunities to develop standard guidelines for care including visits by discipline by HHRG
- Decreased travel time with smaller geographic service areas
- Potential for increased productivity

Quality Advantages:

- Patient outcome improvement
- Better coordination of care
- Better continuity of care
- Knowledge exchange between team members
- All Case Managers develop OASIS expertise

Discipline Specific Team:

Cost Advantages:

- Increased Supervisor to staff ratio
- #### Quality Advantage:
- Clinical oversight with discipline supervising own discipline

Disease Management Team:

Cost Advantage:

- Refinement of utilization management by disease process
- Employee satisfaction/retention
- Better episode management
- Enhanced Referral relationships

Quality Advantage:

- Better patient outcomes
- Increased marketing strategies
- Better continuum of care with facilities
- Better coordination of care
- Better continuity of care
- Opportunities for knowledge exchange

Each model also has disadvantages in both cost and quality. They are as follows:

Multidisciplinary Team:

Cost Disadvantages:

- Discipline specific expert consultation needed to support all disciplines on the team
- Decreased Supervisor to staff ration

Quality Disadvantages:

- All Case Managers complete OASIS

Discipline Specific Team:

Cost Disadvantages:

- Increased travel time
- Decreased productivity
- Fragmented episode management
- Need for formalized case conferencing
- Documentation of communication between all disciplines involved with specific patient
- Lack of coordination at discharge and hospitalization causing non-billable visits to be made

Quality Disadvantages:

- Coordination of care
- Care delivered with a silo mentality
- Patient confusion

Disease Management Team:

Cost Disadvantages:

- Increased travel time-larger geographic service area
- Decreased productivity
- Duplication/inefficiencies for patients with co-morbidities

Quality Disadvantages:

- Care of patients with co-morbidities

There also are several additional variables for each model that should be considered. If your agency is considering moving from one model to another, particularly from the discipline specific to the multidisciplinary do you have enough therapists to staff the teams? Can your staff learn to work as a multidisciplinary team and can they accept change? Can your existing supervisors manage other disciplines?

In considering a change to a disease management team, do you have the ability to recruit/train staff with disease specific expertise? Can you adequately serve the entire geographic area and can you develop the necessary collaboration with physician groups and/or facilities to ensure enough referrals to maintain the disease specific teams?

Change is always difficult. But the reimbursement methodology has changed and it is more important than ever that you look at your agency's service delivery model to ensure that it enhances both quality of care and reimbursement is more important than ever.

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Ready Or Not: Home Care Compare
First and foremost the agency must:

Assure that there is consistent interpretation of each OASIS question and that all staff members use a consistent approach in assessing patients and responding to each OASIS item.

Assure that the data being collected is reflected in the plan of care and that quality care is consistently implemented based on the plan of care.

It is vital to ensure that agency staff is well trained on how to interpret the OASIS questions and that all staff are consistent in their interpretations of each question. There are numerous mechanisms that can accomplish this. One method would be to have only one or two members of the staff responsible for all initial and ongoing training for OASIS documentation. Another method would be to have staff that are not involved in direct care to the patient, such as a PI nurse or a supervisor from another team, review the OASIS and the other clinical documentation to ensure that there is verifying information on the 485 and visit notes to reflect the scoring on the OASIS. For instance if the OASIS is scored that the

patient has dyspnea when walking less than 20 feet, it should be verified that this is also documented on the 485 and/or on the ongoing visit notes?

Since the scores for the Home Care Compare project are derived by comparing the initial OASIS assessment document with the OASIS discharge document it is essential that the OASIS be completed consistently during both timeframes. Not all patients can show improvement in the all of the outcome measures but certainly neither should they frequently show deterioration. The goal of care is usually to show some improvement this should be reflected in your outcome data.

Once you are sure your agency is completing the OASIS document thoroughly and consistently, and you are still not scoring well, then you must look at the clinical interventions provided. Are you providing “best practices” protocols for each problem that you are addressing? Is your patient receiving the maximum education and training to improve their outcomes? Are family members being instructed in how to ensure that patients become as independent as possible yet remain safe in their home environment?

Agencies need to develop and consis-

tently implement “best practice” protocols that have been shown to be effective. Once they are implemented it is essential that supervisors and managers ensure compliance amongst their staff with the protocols. The “best practice” protocols need to be monitored and modified if they are not making the impact that is expected when the agency is confident they are being implemented consistently.

The objective of the National Home Health Compare Project is two-fold:

1. To empower consumers with quality of care information to make more informed decisions about their health care.
2. To stimulate and support providers and clinicians to improve the quality of health care.

These objectives require all staff in the agency to be involved and aware of the overall impact of the care the agency is providing on its clients. Sharing how the agency scores compared to its competition should help motivate staff to provide the highest level of care possible. If you are scoring higher than your competitors you need to continue to operate at your current level. If you are not scoring as well, then this should encourage harder work by the staff to improve your patient’s outcomes.

<p>PRESENTATION SCHEDULE</p> <p>Texas Association for Home Care Winter Conference Dallas, TX 1/21/2004</p> <p>Advanced Budgeting and Ways to Reduce Home Care Costs Ron Barrera</p>	<p>Catholic Continuing Care Ministry Symposium St. Pete Beach 2/10/2004</p> <p>Lost Revenue Opportunities through Management Improvement Ron Barrera</p>	<p>...home health line Las Vegas, NV 2/18/2004</p> <p>Use OASIS to Trigger Private Duty Referrals Betty Gordon</p> <p>Hollywood, FL 6/2/2004</p> <p>Use OASIS to Trigger Private Duty Referrals Betty Gordon</p>
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