

Connecticut Children's

Annual Training and Validations Module
Physician and Non-Physician Practitioner

2017



Safety and Security

Environment of Care

Fire Response

- R – rescue
- A – alarm/alert
- C – confine/close doors
- E – extinguish/evacuate
 - Evacuate horizontally then vertically
 - Fire extinguisher use (P.A.S.S.: Pull, Aim, Squeeze, Sweep)
- All personnel are required to participate in fire drills / alarms
- **Emergency Numbers - 88222 Security emergency and 88888 medical emergency**

Interim Life Safety

- Defined as event in which fire safety and other systems may be compromised, resulting in need for additional resource commitment and focus on fire safety
- May include additional fire drills, fire watches, and fire extinguishers

Emergency Codes

- Code Red – fire/smoke
- Code Blue – medical emergency/cardiac arrest
- Code Yellow – bomb threat
- Code Amber – missing child/possible abduction
- Code Orange – external event
- Code Gray – internal event
- Code Purple – lockdown
 - In event of emergency code, review Hospital Emergency Operations Plan to determine role
 - Report to Incident Command Center or Labor Pool if indicated

Safety and Security

Environment of Care

Security- All employees are required to wear ID badges visible and above the waist at all times. Question anyone without identification.

Workplace Violence Prevention

- Warning signs of potentially violent person may include a person who:
 - States intention to hurt someone (can be verbal or written)
 - Displays excessive behavior or unwarranted anger
 - Demonstrates preoccupation with violence
 - Appears argumentative, uncooperative, impulsive, easily frustrated
 - Challenges staff and authority figures
- De-escalation/prevention strategies
 - Do not encourage behavior; report concerns to supervisor, Security, or Admin-on-Call
- **Contact your manager, supervisor, Security or HR to report any workplace violence concerns.**

Back Injury Prevention

- When lifting or carrying materials, keep the load as close to your body as you can .
- Try not to twist when lifting and lowering materials; turn your whole body instead.
- Lift and lower materials in a smooth steady way and try not to jerk the lift.
- When you pick up materials off the ground:
 - Try supporting yourself by leaning on something while lifting
 - Don't bend over; instead, kneel on one knee and pull the load up on to your knee before standing

Occurrence Reporting

- Report all events related to unanticipated outcomes and unusual events, including those that did not reach the patient (e.g., near misses)
- Document occurrence disclosure to patient/legal guardian and in patient's medical record
- Participate in root-cause-analysis, when indicated, to identify underlying cause and development of action plans to prevent reoccurrence

Safety and Security

Environment of Care

MRI Safety

- Based on the American College of Radiology (ACR) recommendations, the MRI suite and screening process is divided into 4 zones. The higher the zone number, the closer the patient is to the magnet.
 - **Zone 1:** This includes all areas accessible to the general public (example: the hallway outside the MR department). This zone is a great first place to alert patients, personnel and staff that they are entering an MR zone.
 - **Zone 2:** There are two areas in Zone 2 – the reception area of the MR suite and the patient holding/exam area. At this point, patients and staff are under the supervision of MR personnel and are not permitted to roam freely. Zone 2 is where the patient interview and screening is conducted.
 - **Zone 3:** Zone 3 is the control room of the MR suite, and everyone needs to have been pre-screened to enter this area. Any ferromagnetic object or undetected implanted device may cause serious injury or death because of its close proximity to the magnet. Individuals will be wanded and searched upon entering.
 - **Zone 4:** This area is the MR scanner room itself. It is clearly marked as being potentially hazardous due to the presence of the strong magnetic fields, with a red light and signage saying “Magnet is Always On.” Anyone entering this area will be under constant direct supervision of trained MR personnel.

Patient Falls

- Highly dependent on the child's developmental stage, fall risk behaviors are likely to change and evolve, and over very short periods
- Reduction strategies include: use of cribs, assistance with ambulation, patient/family education, non-skid footwear, medication and equipment use assessment
- All patient falls must be reported using the online occurrence reports; those resulting in serious injury or disability must be reported to DPH as an adverse event

Patient Safety

National Patient Safety Goals

Anticoagulant Therapy Protocol

- Protocol available online (see *Policy Manager: Clinical Pathways and Protocols*). Goal is to:
 - Understand the risks associated with prescribing, dispensing and administering of anti-coagulants and need to use the established protocol to minimize risks
 - Safely initiate and maintain anti-coagulant therapy (including use of lab studies)
 - Ensure that patients are given clear, concise and accurate advice regarding anti-coagulant treatment and the associated risks

Suicide Prevention

- Optimal practices for the prevention of suicide:
 - Initial and continuing staff evaluation of high risk, and lethality with appropriate response to these findings
 - Previous history of self injury behavior, verbalizations, and concerns by significant others must be elicited and considered in making current treatment plans
 - Measures taken based on professional evaluations must be reasonable and appropriate in the treatment context
 - Efforts to communicate with family or significant others should be apparent in the health records, family recall, or team reviews

Safe Use of Alarms

- Policy available online (see *Policy Manager: Cardiac, Respiratory and Pulse Oximetry Monitoring and Alarm Management*)
 - Goal is to make improvements to ensure that alarms on medical equipment are heard and responded to on time
 - Beginning January 1, 2016, all U.S. Joint Commission accredited hospitals are required to comply with this new National Patient Safety Goal
 - CT Children's developed an overall plan to manage clinical interruptions, such as alarms, alerts and care team interruptions.

Infection Prevention and Vital Behaviors To Improve Hand Hygiene

Hand Hygiene – must be conducted before and after contact with a patient or their environment.

- **Soap and Water**

- Wet your hands with clean, warm running water and apply soap. Rub lather over all surfaces of your fingers and hands, under your nails, and wrists.
- Continue rubbing your hands for at least 20 seconds.
- Rinse your hands well under running water, dry your hands using a clean towel and turn the faucet off with the paper toweling.

- **Hand Sanitizer**

- Dispense one pump of hand sanitizer into palm. Place fingertips into the product. Transfer into other palm and place fingertips of other hand into product.
- Rub all surfaces of the hand until the alcohol evaporates.

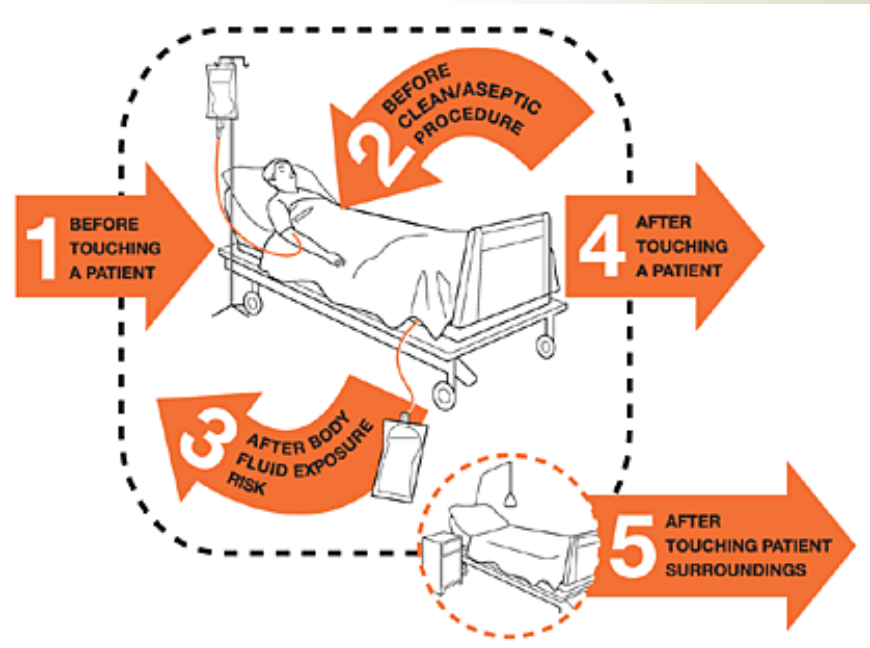
Vital Behaviors to Improve Hand Hygiene

- **Problem** -Despite decades of evidence that appropriate hand hygiene prevents the transmission of infectious agents, secret shopper observations reveal that healthcare providers use hand hygiene approximately 50-60% of the time.
- **Solution** -This year we are focusing on and changing a few vital behaviors that are high-leverage actions that, if routinely enacted, will lead to the results we want.
- **Connecticut Children's is adopting Three Vital Behaviors to Improve Hand Hygiene**
 1. Wash In Wash Out
 2. 200% Accountability for Hand Hygiene
 3. Say "Thank You" and then wash your hands when someone reminds you.

Three Vital Behaviors

1. Wash In – Wash Out (WIWO)

This behavior includes appropriate hand washing or appropriate use of hand sanitizer every time you enter or leave a patient's room/area, regardless of what you did in the room. We want you to build a hand hygiene habit so that you don't even need to think about it, you just reflexively perform the task. In addition to WIWO, our hand hygiene policy incorporates the WHO hand hygiene expectations and includes a variety of specific contamination risks that will require you to re-wash your hands while in the room.



Three Vital Behaviors

2. 200% Accountability

This phrase means that I am 100% accountable for my behavior and that I am also 100% accountable for your hand washing behavior. Historically, holding others accountable for appropriate hand hygiene practice has been a difficult barrier, especially when a real or perceived “power distance” is present. For example, aides are less likely to correct a nurse and nurses are less likely to correct a physician when they observe non-compliance with hand hygiene. We need to create an environment where people feel comfortable reminding others to wash their hands to protect our patients.

3. Say “Thank You”

This phrase means that when someone reminds me to wash my hands, (even if I have just washed them) I will genuinely thank them for reminding me and wash them again immediately. If I have undergone “Safety Starts With Me” training, I may say, “Thanks for the crosscheck.” I will not get defensive. Instead, I will make it safe and easy for people to remind me.

Most hand hygiene initiative focus exclusively on the first vital behavior when actually the second and third vital behaviors are the key to the first.

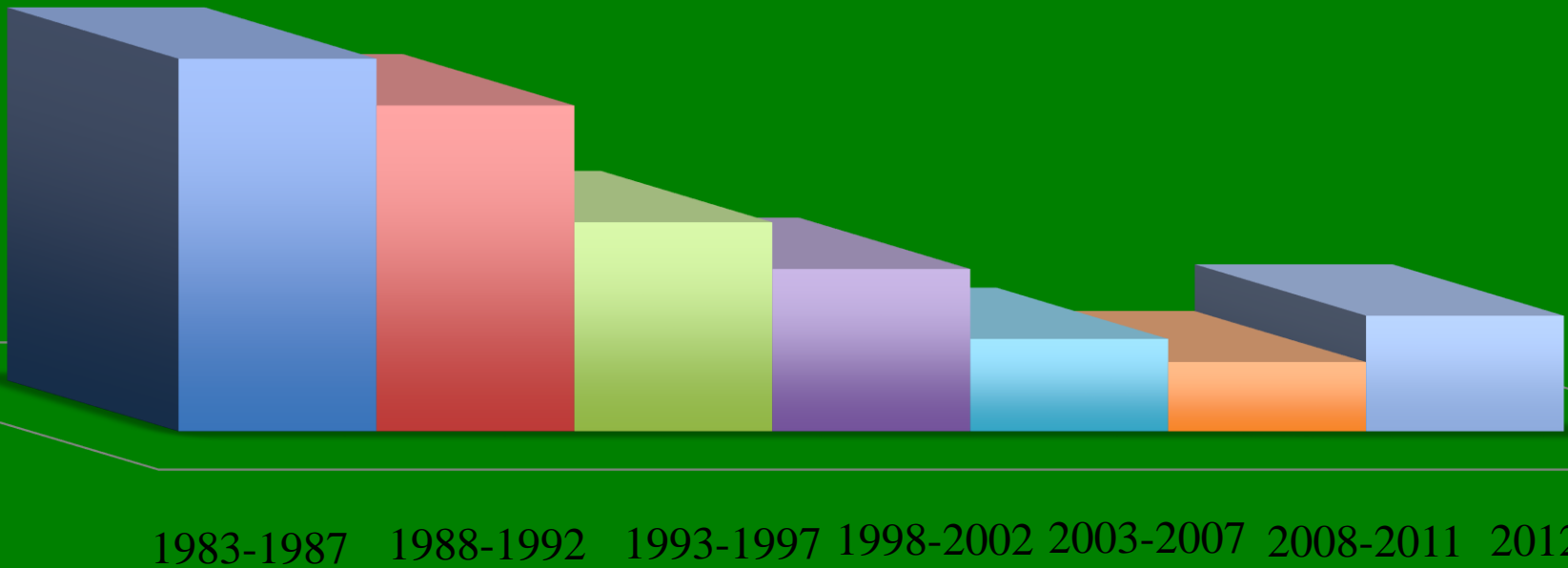
Antimicrobial Stewardship – Joint Commission Requirement

- “ASPs can help prevent the development of multidrug resistant organisms (MDROs), and reduce unnecessary drug use and costs associated with expensive, broad-spectrum therapies used to treat hospital acquired infections.”
- Joint Commission requires Antimicrobial Stewardship by January 1, 2017 including education of prescribers. MM.09.01.01

Mission Statement

- The CT Children's Antimicrobial Stewardship Program (ASP) aims to improve the clinical care of children in the state of Connecticut through the judicious use of antimicrobial therapies, by helping clinical providers with education, investigation, and clinical guidance regarding the use of antimicrobials and the management of pediatric infectious diseases.

Fewer New Antibiotics



Less than 1 new approved antibiotic a year for the last decade

Antimicrobial Stewardship (aka ASP)...

Is about....

- ✓ Using antimicrobial agents appropriately
 - Sufficient (not excessive) empiric coverage
 - De-escalation or escalation once results available, as appropriate
 - Limiting duration
- ✓ Uses local resistance data to determine empiric therapies
- ✓ Optimized the care the patients receive

Is NOT....

- ✓ Just reducing antimicrobial usage for all
- ✓ Just saving money
- ✓ Limiting practitioner autonomy
- ✓ Cookbook medicine

Antimicrobial Stewardship at CT Children's

- Key information including membership and resources available on the CCMC Intranet under “[Find A Department of Service](#)” – “[Antimicrobial Stewardship](#)”
- From that page under “ASP Information and Links” [resources available](#) include:
 - Antibiotic card recommendations for inpatient and outpatients
 - IV to PO recommendations
 - Antimicrobial restrictions (aka- second-sign antimicrobials)
 - Antibiogram (current local resistance rates)
 - Vancomycin per pharmacy protocol
 - Voriconazole dose recommendations
 - Paluvizumab / Synagis protocol

Restricted Antimicrobials

- Antimicrobials that are restricted are referred to at CCMC as **Second Sign Antimicrobials** because they require a second sign-off for an order to become “active”.
- The **current list** of Second-sign medications and any pre-approved conditions for these medications are available on the intranet under **ASP Information & links**
- It is **CRITICAL** if you are ordering a second-sign medication for a non-preapproved indication, to **page the ID attending on call during normal business hours (8:30AM-4:30 PM, M-F)**.

Restricted Antimicrobial Ordering

- When you put in a second-sign order, you will **NOT be able to “see” the order** from the time you enter the order **until it is second-signed** by the ID physician (normal business hours) or pharmacist (off hours, or pre-approved conditions)
- There is a Care Navigator - **tips and tricks** available under the ALL Inpatient Providers and Surgeon Education Materials on “Ordering Medications that require Second-Sign” to help.
- Note there are **TWO orders** for second-sign medications and **BOTH must be completed**
 - First order allows for pharmacists off hours to put through the first order for non-preapproved indications, which is for 18 hours of medication.
 - Second order, ID physician will follow-up the next day to review.
- If you have questions regarding if it went through correctly, you will **need to check with pharmacy or ID**

ASP QUESTIONS PLEASE EMAIL US AT:

CCMCASP@CONNECTICUTCHILDRENS.ORG

Infection Prevention

Multi-Drug Resistant Organisms (MDRO)

- MDRO are organisms that are closely monitored and form the acronym: ESKAPE. These organisms include:
 - *Enterococcus species*
 - *Staphylococcus aureus*
 - *Klebsiella pneumoniae*
 - *Acinetobacter baumannii*
 - *Pseudomonas aeruginosa*
 - *Enterobacter species*
- Hand hygiene, adhering to Isolation Precautions, and appropriate cleaning and disinfection of patient equipment can prevent transmission of MDRO
- Appropriate antimicrobial administration can reduce the incidence of MDRO

First Identified Case of CRE at Connecticut Children's

- In March 2013, Connecticut Children's identified our first Carbapenem-resistant Enterobacter (CRE) which was isolated from an abdominal swab.
- Rapidly identifying patients colonized or infected with these organisms and placing them in Contact Precautions when appropriate, using antibiotics wisely, and minimizing device use are all important parts of preventing CRE transmission.
- Additional information on CRE is available at:

<http://www.cdc.gov/hai/organisms/cre/cre-clinicians.html>

Infection Prevention

- Prevention Standards are a group of evidence-based interventions for patients that, when implemented together, result in substantially better outcomes.
- Connecticut Children's has implemented Prevention standards for
 - Central Line Associated Bloodstream Infection
 - Both Insertion and Maintenance of CVL are used
 - Catheter Associated Urinary Tract Infection
 - Both Insertion and Maintenance of Foley Catheter are used
 - Surgical Site Infection
 - Ventilator Associated Pneumonia

Central Line Insertion Prevention Standard

- Insertion training for all providers
- Insertion checklist utilized every time with staff empowerment to stop non-emergent procedure
- Wash hands immediately prior to performing insertion
- Use maximum sterile barriers
 - Hair caps and masks worn by all persons participating at bedside
 - Sterile gown and gloves worn by the inserter
 - Large drape used to cover patient's full body and sterile field
- Prep skin with CHG scrub if ≥ 2 months of age
 - 30 second scrub or 2 minutes for Femoral followed by 30-60 second dry time
- Apply sterile transparent dressing after procedure along with CHG barrier to cover insertion site

Central Line Maintenance Prevention Standard

- ❑ **Daily discussion of line with medical team:**
 - ❑ Discuss continued necessity of line
 - ❑ Discuss the function of the line
 - ❑ Discuss the frequency of access- consider bundling labs/line entries
 - ❑ Document these discussions in the EMR daily
- ❑ **Regular assessment of dressing to assure:**
 - ❑ Dressing is clean (change if soiled)
 - ❑ Dressing is dry (change if damp/wet)
 - ❑ Dressing is occlusive (change if any area is loosened/non-adherent)
 - ❑ Document findings in EMR
- ❑ **Standardize access procedure:**
 - ❑ Perform hand hygiene with alcohol-based hand sanitizer
 - ❑ Disinfect cap before all line entries by scrubbing with an appropriate antiseptic (alcohol; CHG) OR removing Curo Cap that has been in place greater than 5 minutes
- ❑ **Standardize dressing, cap & tubing change procedures/timing:**
 - ❑ Scrub skin around site with CHG for 30 seconds (2 minutes for Femoral line) or Povidone-iodine if <2 months of age
 - ❑ Change tubing no more frequently than every 96 hours unless clinically appropriate
 - ❑ Change tubing used to administer blood products at least every 24 hours
 - ❑ Change tubing used for lipid infusions (including Ambisome) every 24 hours
 - ❑ Change caps exposed to blood products, lipids (including Ambisome) or Propofol within 24 hours
 - ❑ Change caps not exposed to above no more frequently than every 96 hours (ideally with tubing change)
 - ❑ Document date that dressing/cap/tubing was changed AND is next due
 - ❑ When the hub of the catheter or insertion site are exposed, providers wear a mask and patient's face is shielded with mask/drape

Catheter Associated Urinary Tract Infection Insertion Prevention Standard

- Obtain sterile closed system insertion kit and choose the smallest size catheter possible
- Perform hand hygiene and don gloves
- Cleanse perineum with Castille soap
- Perform hand hygiene with alcohol-based hand sanitizer
- Prepare a sterile field with drapes provided in the catheter insertion kit
- Maintain aseptic technique and don sterile gloves
- Cleanse perineum with Povidone-iodine
- One insertion attempt per catheter (use provided lubrication)
- Inflate balloon with indicated amount of water
- Place bag below level of bladder (not on floor)
- Secure catheter to patient with securement device (use skin prep)
- Label drainage bag with insertion date/time
- DOCUMENT INDICATION FOR INSERTION in EMR
 - Hemodynamically unstable patient with need for close monitoring of output
 - Medically complex patients with need for stick I&O (i.e. DI, DKA)
 - Chemically paralyzed or deeply sedated patient who is unable to void spontaneously
 - Epidural protocol
 - Patient with wound/breakdown in sacral/genital area
 - Patient with physical obstruction of bladder
 - Patient at end of life
- Document plan for catheter removal in EMR

Catheter Associated Urinary Tract Infection Maintenance Prevention Standard

- ❑ Ensure medically appropriate need for catheter
 - ❑ Discuss need for catheter daily
 - ❑ Remove as soon as possible
 - ❑ Consider using alternatives to indwelling urethral catheterization (straight cath, bladder scan, weigh diapers)
- ❑ Perform hand hygiene prior to all contact with the urethral drainage system; utilize Standard Precautions (i.e. gloves) as necessary
- ❑ Ensure perineal care is completed daily, after each bowel movement and as needed. Document in EMR
- ❑ Ensure catheter and tubing has not become disconnected or kinked.
- ❑ Maintain unobstructed urine flow. Extra drainage tubing is lying on the bed, not hanging over the side (NO Dependant Loops!)
- ❑ Catheter is secured to the patients leg
- ❑ Collection bag and tubing remain below the level of the bladder and are not in contact with the floor.
- ❑ Educate patient/family on CAUTI prevention and document in EMR.

Surgical Site Prevention Standard

Surgical site infection (SSI) prevention strategies include:

- Appropriate surgical hand Scrub prior to case
- Team adherence to aseptic technique
- Antibiotic prophylaxis with appropriate pre-operative timing and dosing, re-dosing during longer cases and appropriate post-operative antibiotic duration
- Pre-Operative CHG bathing
- Proper skin/site preparation
 - Use clippers to remove hair if necessary – No shaving
 - Prep surgical site with appropriate solution (i.e., CHG, Betadine)
- Maintaining proper body temperature control
- Maintaining proper OR environment (i.e., surgical dress, traffic flow, cleaning, instrumentation sterilization, air-flow)
- Educate patient/family on proper post-op wound care

Ventilator-Associate Pneumonia Prevention Standard

- Meticulous hand hygiene before and after patient contact
- Daily assessment (and documentation) of readiness to extubate
- Elevation of head of bed (HOB):
 - Patients <1 year of age: HOB 15-30 degrees
 - Patients >1 year of age: HOB 30-45 degrees
 - Reverse Trendelenburg for infants in warmers or if medically indicated
- Provide oral hygiene using oral care kit as directed Q4hrs with tooth/gum brush every 12 hours
- Use dedicated oral care suction tubing
- Maintain dedicated and closed in-line endotracheal suction system. Change when soiled
- Drain ventilator circuit prior to moving patient and as needed.
- Always position ventilator circuit in dependent position.
- Suction only when indicated by examination
- The routine use of normal saline instillation with suctioning is not recommended.

Airborne Precautions

- When a patient is known or suspected of having a communicable disease, we must initiate isolation precautions immediately. This quick action protects other patients and healthcare facility workers from transmission.
- Airborne Precautions are used when a patient is known or suspected of having an organism that is capable of being transmitted in the air. For this reason, patients on Airborne Precautions are placed in rooms with special ventilation known as “Negative Pressure” rooms.
- Air in these rooms comes in through the door and is directly exhausted outside. The air in these rooms is never re-circulated. Staff must wear N95 masks.

AIRBORNE PRECAUTIONS
PRECAUCIONES DE VIA AEREA

Applies to everyone entering the room, every time.
Se aplica a todos los que entran al cuarto, cada vez.

If you have any questions please see your nurse.
Si usted tiene preguntas por favor vea a su enfermera.

Clean hands with soap and water or Purell upon entering and leaving room or area		Limpiese las manos con agua y jabón o con Purell al entrar y salir del cuarto o área.
N95 Respirator Required		Se requiere un Respirador N95
Doors to Negative Pressure Room Must Remain Closed		Las puertas del cuarto de presión negativa tienen que permanecer cerradas

Please remove **N95 Respirator** as you leave the room/area
Por favor remuévase el **Respirador N95** al salir del cuarto/área

TRANSPORTING PATIENTS

- Communicate isolation requirements to receiving unit
- Patient must wear mask during transport
- Medical record must be physically carried


Connecticut Children's
MEDICAL CENTER

EN 1002

Reasons Given for Failure to Place Patients on Airborne Precautions

- Knowledge deficit (i.e., I didn't know the patient had to be on isolation when I ordered the PPD)
- It's a hassle for nurses to put a patient in a negative pressure room, especially when they have to move patients around and clean their rooms.
- TB is pretty low on the differential but I just wanted to have a complete assessment
- I didn't automatically write an order for airborne isolation when I ordered the:
 - PPD
 - Quantiferon test
 - Gastric Aspirates
 - Sputum culture for TB



Entering Isolation Orders

Airborne Precaution isolation orders must be entered as soon as possible to reduce the possibility of transmission. Isolation may be discontinued when tuberculosis is ruled out.



Infection Control and Airborne Precautions

Reasons to Isolate Promptly

- Prompt identification and isolation prevents the transmission of infection.
- It protects our staff, patients, and our reputation in the community.
- It's the right thing to do.

Risk Factors for TB in Children

- Known contact with a case of TB
- Foreign birth or travel to a TB-endemic area
- Contact with adults at high risk for TB (those who are infected with HIV, homeless, incarcerated, and illicit drug users)
- HIV infection in a child

Signs and Symptoms of TB

➤ Cough

- Cough is the most well-known sign of tuberculosis.
- Coughs associated with TB often last three weeks or longer.
- Those infected with tuberculosis may cough up sputum or blood.
- Diagnosis is sometimes made by testing sputum.

➤ Chest Pain

- May be associated with breathing or coughing.

➤ Fatigue/Weakness

➤ Weight Loss and Loss of Appetite

➤ Fever and Chills

- May also experience night sweats.

Diagnostic Tests

PPD (Purified Protein Derivative)

- Also ordered as Tuberculin skin test (TST)
- Placed intra-dermal
- Read in 48-72 hrs.
- Measure induration (not redness)
- “Positive” depends on size, age, risk factors, immune status – 5, 10 or 15mm
- Also positive from non-TB mycobacteria

Quantiferon

- Quantitative Interferon test
- Measures T cell response to TB antigens
- Blood test: reported in a few days
- Reliable over 12 yrs. of age
- Some data in kids over 5yrs of age
- Unreliable in younger children/infants
- Less false positive results than PPD

Diagnostic Tests

Gastric Aspirates

- Early morning (before breakfast) for 3 days
- Used in younger children
- Lab looks for acid-fast organisms and culture
- May detect TB and non-TB mycobacteria
- Almost always done to diagnose TB
- Invasive, requires hospitalization, NG tube

AFB stain/culture

- Typically done along with bacterial cultures
- Sputum difficult to obtain in younger children
- May also be performed on deep specimens (abscess, BAL, biopsy)
- May also be performed on non-pulmonary specimens (bone, abdominal abscess, skin, brain, CSF)

Airborne Precautions and Communication

Airborne Precautions are required when:

- A PPD is ordered
- A Quantiferon test is ordered
- Gastric Aspirate for TB Culture or smear are ordered



General Communication

- Identify potential TB cases as soon as possible and place patient on Airborne Precautions immediately
 - If a negative pressure room is not available, request an “Air Scrubber” HEPA filter unit.
- Adhere to the instructions on the Airborne Precaution sign
- Instruct patient/family on the need to wear masks in the room

**IF YOU SEE
SOMETHING,
SAY
SOMETHING.**

Uncertainty or Disagreement Among Clinical Staff

- Any uncertainty or disagreement among the clinical staff concerning initiation and/or ongoing use of negative pressure respiratory isolation requires an immediate consultation with the hospital Infection Prevention Department.
- The hospital Infection Prevention Department, representing the Infection Prevention Committee, has **final authority** in these matters.

Summary

- Isolation protects patients and staff from communicable diseases.
- Airborne Isolation must be ordered for all patients with PPD, Gastric Aspirate for TB or Quantiferon orders until TB is ruled out.
- The Infection Prevention Department has final authority when a disagreement regarding isolation is raised.

Provision of Care

Restraints and Seclusion (See Policy Manager: Restraints & Seclusion)

- Restraints may be used to reduce risk of harm related to threatening or harmful behavior, however, restraint use should always include an assessment and use of the least restrictive device
- **Violent restraint (previously called Behavioral restraint) orders must be time limited based on patient age; Non-Violent restraints (previously called non-behavioral restraint) may be ordered and applied per hospital policy.**
- A face-to-face assessment of patient must occur within one hour of restraint application
- **Patient Abuse and Neglect**
 - Definition - any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm
 - Anyone suspecting that a child is being abused must report orally to the Department of Children and Families' (DCF) Hotline or a law enforcement agency within 12 hours and must submit a written report (DCF-136 form) to DCF within 48 hours of making the oral report. Note - DCF is required to tape record all reports to the Hotline.

Communication/Collaboration/Coordination of Care

- As medical care becomes more complex, collaborative efforts between physicians and nurses become more important for achieving positive outcomes for patients
- Connect with staff and other practitioners. Promote a sense of belonging by forming a community of people who genuinely care about each other. The work environment is a product of your relationships.
- Acknowledge positive behavior and relationships. If there are individuals with whom you enjoy working, send thank you notes and list specific reasons why you enjoy working with them. Send copies of the notes to the medical staffing office.
- Communication must be physician to physician (in accordance with the Medical Staff Bylaws)
- Use a standardized hand off approach for every patient hand off event

Provision of Care

Waived Testing

- Individuals who perform waived testing must be trained for each test which he/she will perform, including use and maintenance of instrument (if applicable). If a physician is performing testing, he/she must be assessed for competency.
- Individuals must document quality control for the tests that they perform. Specifically, in addition to patient results, daily positive and negative control results should be recorded. A requirement for external controls depends upon the presence of internal controls and manufacturer instructions. Controls must be run as often as the manufacturer requires, but no less frequently than once each patient day. In the case of Hemoccult cards, for example, internal positive and negative controls should be performed with each test card development.

Dying Patients

- Palliative care for children aims to improve quality of life for the pediatric patient as well as for their family. This is done through expert management of pain and other physical symptoms such as shortness of breath, nausea, vomiting, and anxiety. It is also done through emotional and spiritual support services, offering the patient and family specialized counseling to help them cope with the roller coaster of emotions that result from dealing with a serious illness or condition.

Organ Donation

- LifeChoice Donor Services is dedicated to fostering community and professional support of organ and tissue donation, providing compassionate care for families, and saving and improving lives. **860-286-3120 OR 1-800-874-5215**
- Potential donors: age newborn – 70 years old, mechanical ventilation and circulation intact with declaration of brain death present or pending, or anticipated withdrawal of support, no sepsis (most localized, treated infections are acceptable), transmissible diseases or high risk factors will be evaluated on a case by case basis using CDC guidelines, and no recent cancers (except for primary brain tumors and some treated skin cancers)

Connecticut Children's Urgent/Emergent Response Systems Overview

Medical Emergency Team

- A response team that can be activated by any staff or family member that will provide urgent medical evaluation to the bedside of in-patients experiencing a decline in condition.

Rapid Response System

- A response system to assist visitors, staff, or an out-patient who are experiencing a medical issue.)

Code Blue Team

- Immediate response to a life threatening change in clinical status by a team of physicians and non-physicians

Critical Airway Response Team

- Immediate response to a critical airway by specialists trained in medical and operative establishment of a definitive airway

Activations are reviewed in order to facilitate performance improvement

Connecticut Children's Urgent/Emergent Response Systems - Rapid Response System

Medical Emergency Response Team

- The MET team consists of the PICU resident, PICU RN, RT and PICU Attending (if needed)
- Can be activated by any care provider or family member to provide timely increase in care to the bedside in order to improve a patient's clinical course (by calling 8-8888)

Rapid Response System

- Provides care in the event that a staff member or visitor or an out-patient has an urgent medical need while on the Connecticut Children's campus
- Team of MDs, RNs and RTs can be activated to respond in order to improve the clinical course by calling 8-8888

Connecticut Children's Urgent/Emergent Response Systems

Code Blue Team

- Immediate response to a life threatening change in clinical status of anyone (patient or non-patient) on the Connecticut Children's campus by a team of physicians, nurses and respiratory therapists
- Activated by pressing the Code Blue button or calling 8-8888 and notifying the Resource Center of a Code Blue event and location
- Team comprised of senior pediatric residents, PICU nurses and Respiratory therapists
- Other PICU staff, including the PICU attending will respond unless clinically unavailable

Critical Airway Response Team (CART)

- Immediate response to a critical airway by specialists trained in medical and operative establishment of a definitive airway
- Activated by PEM, NICU, PICU or Anesthesia attending who determines that there is a Active or Potential critical airway by calling 8-8888 and notifying the Resource Center of a CART activation
- An activation mobilizes anesthesia, surgical, ENT, PICU and if required, OR services and continues until the airway is secure
- Involves the transport of an advanced airway cart to the bedside of the patient with a critical airway

Risk Management - Defined

- Risk Management is a planned and systematic process to reduce or eliminate the probability that losses will occur.
- Staff at all levels of the organization are responsible for engaging in Risk Management activities, including;
 - Reporting of actual or near miss safety events and unanticipated outcomes through electronic occurrence reporting system.
 - Participating in Root Cause Analysis and other case reviews to identify and address, and resolve systems issues.
 - Promoting a culture of safety through transparency and accountability.

Risk Management for Providers

- **Informed Consent**

- A thorough informed consent process can help reduce the likelihood of a claim following an unanticipated outcome or complication. The informed consent process includes obtaining parent/guardian signature via the consent form, having a well documented conversation of the risks, benefits, and alternatives, and providing patients/families with an opportunity for questions and clarifications. See “Informed Consent” policy for more information.

- **Disclosure of Unanticipated Outcomes**

- Early disclosure of an unanticipated outcome reduces the likelihood of a claim, helps to maintain trust, and fosters open and honest communication with patients and families. The disclosure should reveal the nature of the event, but should avoid speculation. Please reach out to member of the Risk Management team for more information.

EMTALA

EMTALA

- **Hospitals have three (3) main obligations under EMTALA:**
 - Any individual who comes to the emergency department (or anywhere on the hospital campus within 250 yards of the main hospital building) and requests examination or treatment must receive a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment cannot be delayed to inquire about methods of payment or insurance coverage.
 - If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.
 - Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.
- Under the law, a patient is considered stable for transfer if the treating physician determines that no material deterioration will occur during the transfer between facilities.
- EMTALA does not apply to the transfer of stable patients; however, if the patient is unstable, then the hospital may not transfer the patient unless:
 - A physician certifies the medical benefits expected from the transfer outweigh the risks OR
 - A patient makes a transfer request in writing after being informed of the hospital's obligations under EMTALA and the risks of transfer.
- In addition, the transfer of unstable patients must be "appropriate" under the law, meaning that (1) the transferring hospital must provide ongoing care within its capability until transfer to minimize transfer risks, (2) the transferring hospital must provide copies of medical records, (3) the transferring hospital must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.

Connecticut Children's Compliance Program

Seven (7) core elements of the Compliance Program as required by the Office of the Inspector General (OIG):

1. Compliance Officer and Compliance Committee

- Oversees and monitors the Compliance Program on a daily basis

2. Written Policies and Procedures (including Code of Conduct)

- Posted on the Connecticut Children's intranet.
- Address issues and activities that present risk or are governed by legal requirements/guidance or accreditation standards

3. Open Lines of Communication

- We encourage staff to communicate compliance concerns and to ask questions when something does not seem "right"

4. Training and Education

- Ongoing Compliance and HIPAA education is provided to faculty, administrators and staff

5. Internal Monitoring and Auditing

- Proactive monitoring to detect and prevent fraud and abuse and other compliance issues

6. Investigation and Remediation

- Reactive response, full investigation and comprehensive remediation of a known or suspected compliance issue

7. Enforcement of Disciplinary Standards

- Ensure consistency in the enforcement of standards and apply applicable disciplinary measures

Connecticut Children's Code of Conduct

Code of Conduct “*Connecticut Children's CONDUCT Excellence*”

“*Core behaviors*” applicable to all staff. *Examples:*

- **Comply** with applicable laws and regulations
- Maintain patient **confidentiality**
- **No misleading or false or fraudulent claims** to the government or commercial payers
- No accepting or asking for **gifts or gratuities** from patients or vendors. (Non-monetary gifts should be shared with co-workers and must not exceed \$50/year.)
- **No discrimination** against, or harassment of staff, patients or families
- **No misuse of Connecticut Children's assets or resources**
- **Disclose** potential and actual **conflicts of interest**, and **manage conflicts appropriately**
- **Report** (i.e., to a supervisor, the Compliance Officer or the Compliance Hotline) **concerns** about quality, patient safety, fraud and abuse, policy violations, etc.
- ***Good faith reporters will not be subject to retaliation***

Conflicts of Interest

- **Conflict of Interest (COI)** involves a situation in which Medical and Allied Health Professional staff or students have financial or other personal considerations that may compromise, or have the appearance of compromising, their professional judgment or integrity in teaching, clinical care, conducting or reporting research, or performing other Connecticut Children's obligations.
- **Decision-making** about the core missions of Connecticut Children's—patient care, education, and research—should be unfettered by relationships with industry and the conduct of Connecticut Children's employees and trainees should avoid even the appearance of a COI.
- Medical and Allied Health Professional staff who engage in clinical care **must disclose** their financial relationships with commercial companies to the Compliance Department on an annual basis, and must update their disclosures immediately upon entering a new or revised financial relationship.

Documentation and Coding Guidelines- Level of Service Selection

- **Medical Decision Making(MDM)** which is made up of the presenting problems, workup/data reviewed and/or the table of risk is the key factor in selecting the correct **Level of Service(LOS)**.
- Once the correct LOS has been selected, the appropriate level of History and/or Exam needs to be documented to support the MDM.
- Please remember that all visits must be medically necessary and the quality of the documentation must support the medical necessity.
- Billing on Time- visits that are billed on time must include a statement that “I have spent over 50% of a ____ minute visit face to face with the patient counseling and/or coordinating care on the above/below issues:”

Documentation and Coding Guidelines- Attestation Statements

- Supervising Physicians **must attest** to the note when it is written by the resident/fellow. The attestation statement must reflect that they personally participated in the evaluation and care of patient in addition to the resident/fellow in order to bill for the services performed.

Example:

- “ I reviewed OR discussed AND saw OR examined the patient with the resident/fellow. I agree with the history, physical exam, medications and plan of care as documented by the resident/fellow with the following exceptions: (** OR None)”

Documentation and Coding Guidelines - E&M Restrictions

- The E&M Guidelines are based on a face to face visit between a patient and a provider. In the event that the patient is **NOT** present at the visit when counseling or coordination of services are performed, the service is a non-billable service due to the restrictions of the E&M guidelines. In these cases, please use the Y0131-Parent Conference code as the LOS.
- **However**, if the patient is present to initiate the visit, and then is removed to another room for the remaining portion of the visit with a caretaker, for the purpose of counseling and/or coordination of care, the provider could continue speaking with only the parents (or guardian) for the remaining time of the visit. By doing so, this would then qualify as a billable service and the billing on time statement would be used.

Billing Standards of Conduct

It is the policy of Connecticut Children's Medical Center and Connecticut Children's Specialty Group, Inc. (Connecticut Children's) to ensure that Connecticut Children's billing practices comply with federal and state laws, regulations, guidelines and policies, follow practices outlined in Centers for Medicare & Medicaid (CMS) and commercial insurance manuals, and meet guidance issued by the Office of the Inspector General by following the billing compliance standards .



Providers and the Revenue Cycle

Revenue Cycle Staff includes, but is not limited to, any staff who are involved in billing systems design and maintenance or the generation, submission, processing, oversight, and/or management of bills to third parties, as well as any employees who manage staff who perform such functions. Examples include, but are not limited to, **providers**, registration, coding, charge entry, scheduling, IT billing analysts, and billing/collection/denial.

Provider's Responsibility within the Revenue Cycle

Any **provider** who identifies any potential billing, coding, payment, or reimbursement discrepancies with respect to claims already submitted to government, private payers, or self-pay patients/families is required to report such discrepancies immediately either to his or her Division Head, Director of Compliance, Executive Management Team (EMT) member or through the Connecticut Children's Hotline.

Integrity of Documentation

- Charge entry data will not be altered in any way by Revenue Cycle Staff, including adding or deleting codes or inserting modifiers, except for staff specifically trained and authorized to initiate or modify certain discrete elements under the direction of the Compliance Department and Revenue Cycle Senior Leadership and in accordance with all applicable laws.

Integrity of Documentation

- Any discrepancies found within medical record documentation, coding, and billing will be sent back to the responsible party (i.e. provider/coder) for correction. This includes, but is not limited to, procedural or diagnosis codes, modifiers, charges, place of service, department, provider information, etc.
- Knowingly or willfully manipulating coding to maximize payment (i.e. use of multiple procedure codes for a group of procedures that are covered by a single comprehensive code) is prohibited, unless otherwise required by established coding guidelines.

Policy Information

- The Billing Standards of Conduct can be found on the Connecticut Children's intranet under the Policy and Procedure section.
 - <https://connecticutchildrens.ellucid.com/documents/view/1277>

False Claims Act (FCA)

- Every **billing provider** is responsible for accurately documenting, coding and billing for the service(s) that are being rendered at each visit.
- Under the FCA, billing twice for the same service, billing a higher level of service when a lower level was provided, and unbundling of charges are all examples of false or fraudulent claims.
- Any suspected or known violations of the FCA are required to be reported to the Compliance Department.

APR-DRGs

- Abbreviation for All Patients Refined, Diagnostic Related Groups

It's a number. e.g. 225.1 (Appendectomy)

- It was developed by NACHRI, the National Association of Children's Hospitals and Related Institutions (CCMC is a member) and 3M® Health Information Systems

(As Pediatric diagnoses were not well represented in earlier diagnosis coding systems)

APR-DRG

It is a number: e.g. 225.1 (Appendectomy)

- The intent is to reflect hospital-care quality, including complications and re-admissions.
- Also to quantify hospital-resource use, including LOS.
- Incorporates patient diagnosis, procedures, age, sex, co-morbidities, birth weight etc.
- Used to 'quantify' the patient care we provide and compare with other Pediatric Hospitals.
- *From Jan 01 2015 CT Medicaid uses it to determine payment & LOS for in-patient care*

APR-DRGs

APR-DRG: *Incorporates patient diagnosis, procedures, age, sex, co-morbidities, birth weight.*

So it's important to have the *correct APR-DRG*

- To get it correct, we have a Clinical Documentation Improvement (CDI) team & Health Information Management (HIM) coders.
- They ensure that all the information needed to accurately determine the APR-DRG and to describe/code your patient is present in the EMR.

Generally the patient/medical record

Has many users/readers

But only a few "Authors"

APR-DRG



Epic



Insurance
Reader...

AUTHORS



Legal
Reader...



Coder
Reader...

Documentation for APR-DRG

The 'rules' the coders have to follow are *not* theirs or yours...

We all have to survive government documentation rules...when using the APR-DRG system!

E.g. ***“Urosepsis!”***

Is this ‘UTI’ or ‘Systemic Sepsis due to UTI?’

CDI team IDs the correct not the most costly diagnosis

	LOS
<i>UTI</i>	<i>2.2 days</i>
<i>Systemic Sepsis due to UTI</i>	<i>2.8 days</i>

Documentation for APR-DRG

CDI team IDs the correct not the most costly diagnosis

“Low sodium” is not a diagnosis

“Hyponatremia” is a diagnosis for coders(but only if it is being actively treated during the stay)

Hypothyroidism is a diagnosis for coders (if the patient is on active Rx for it, even if it's not directly related to the principal hospital diagnosis)

APR-DRG and CMI

Case Mix Index ... (also a number) =

Sum of all patient APR-DRGs / Total number of all patients (*for a given time period*)

So CMI *broadly correlates* with patient illness severity.

A higher CMI reflects more complicated patients or a facility where complex care is provided.

(CMI is usually in the range of 0.6-1.7)

APR-DRG and CMI

So CMI *broadly correlates* with patient illness severity.

A higher CMI reflects more complicated patients or a facility where complex care is provided.

(CMI is usually in the range of 0.6-1.7)

So it is important,

If/when we compete for blocks of patients through efficiency-based contracts,

to accurately represent our patients' complexity in our CMI.

State Law for ‘Observation Status’

...Effective 10/01/2014

“Each hospital....shall provide oral and written notice to each patient that the hospital places **in observation status** ...not later than twenty-four hours after such placement....notices shall include: ⁽¹⁾ ***A statement that the patient is not admitted to the hospital but is under observation status***; (2) a statement that observation status may affect the patient's Medicare, Medicaid or private insurance coverage for (A) hospital services, including medications and pharmaceutical supplies, or (B) home or community-based care or care at a skilled nursing facility upon the patient's discharge; and (3) a recommendation that the patient contact his or her health insurance provider or the Office of the Healthcare Advocate to better understand the implications of placement in observation status.

'Observation Status'-New rules

- *Watch your ~~language~~ verbs now....*
- A patient is **ADMITTED** as an INPATIENT
- A patient is **PLACED** in **OUTPATIENT OBSERVATION** Status

‘Observation Status’-New rules’

- CCMC’s definition of Observation Status is....

“There’s a reasonable chance this patient will be in the hospital < 24 hours”

It is a clinical estimatebased on intensity of service, severity of illness & arises from processes placed by the patient’s insurer

'Observation Status' in EPIC Orders

▼ General

▼ ADT

- Admit to Inpatient
- Place Patient in Observation(Unplanned Event, <24 hr stay)
- Place Patient in OP Surg Ext Stay-MS
- Place Patient in OP Surg Ext Stay-PICU

'Observation Status'-New rules

So Observation status is

➤ An educated guess on initial evaluation
(It's an initial estimate of LOS as < 24 hrs)

➤ However it's known at discharge
(Obs is defined by LOS, LOS is defined by discharge time)

So, PLEASE REVIEW PATIENT STATUS @ d/c

And change it, if needed before discharge

'Observation Status'-New rules

An easier 'definition' for Obs

- **Observation** = < 24 hrs stay *
- = *Unplanned* event
- (There are no elective observation admits)
- = Discharge priority

* Connecticut Children's definition

'Observation Status'-New rules

Patient needs a hospital bed

Planned

(e.g. Elective-op,
chemo)

Inpatient:

Pre-Authorized
>~24 hrs (est)

Outpt Surg:

Extended Stay
MS/PICU
+/-Pre-auth
<~24 hrs (est)

Unplanned

(e.g directly from
office, ED, or OR)

Inpatient:

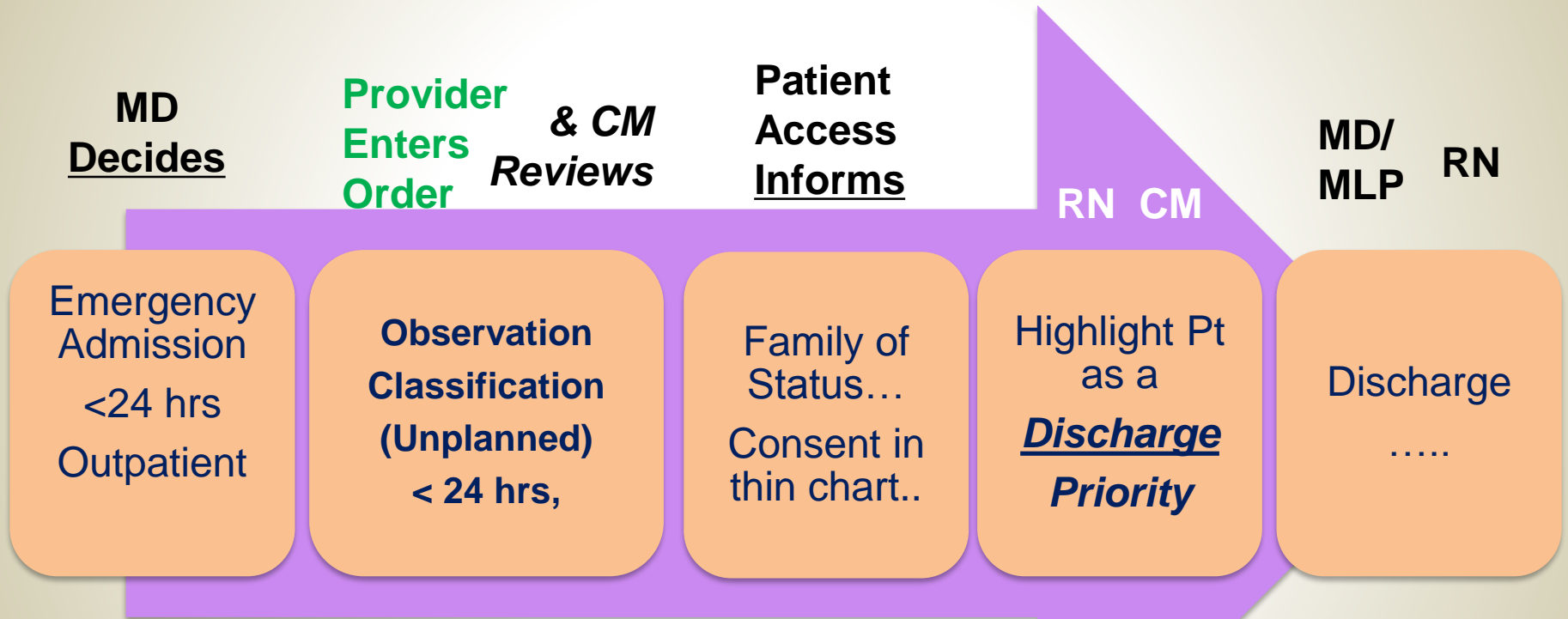
>~24 hrs stay
(est)

**Outpatient:
Observation**

<~24 hrs stay
(estimate)

**Discharge
Priority!!**

Process to Decide, Inform & Discharge Patients



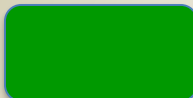


At Week-ends: CM is available via Intelidesk/pager (8am-12noon)

‘Observation Status’-New rules

- Observation should not be used for:
 - Routine prep for diagnostic testing
 - Therapeutic procedures such as blood transfusion, chemotherapy or dialysis that are routinely performed in an outpatient setting
 - Routine recovery from outpatient procedures
 - Procedures designated as “inpatient only”
 - Hospital, physician or patient convenience

'Observation Status'

Indicator on our Whiteboards

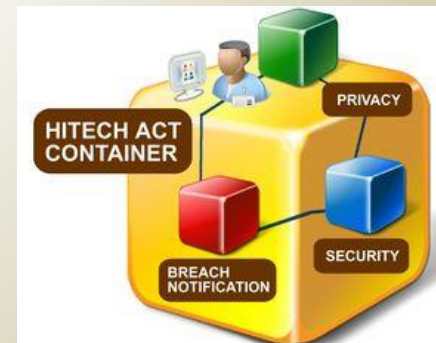
 = <21 hrs
  = 21-23 hrs
  = > 24hrs

Room			Alerts		Display Name	FVN	HIPAA		
303	I				DRY,PAPILLON				M
601	I				HIM VALIDATE,BJ				M
605	OBS				WB,SHTWO				M
608	OBS				ZZZ,CPMWALDO				F
610	I				TEST,MIKEY				M
618	I				STERLING,PETER				M
722	OBS				STALK,BEAN				M
812	OBS				RESPIRATORY,RANDY		HIPAA		F

HIPAA -Overview

- **HIPAA** is an acronym for *Health Insurance Portability and Accountability Act of 1996*
- Different Rules Under HIPAA:
 - **Privacy** – Goal is to keep protected health information (PHI) confidential unless exceptions apply
 - **Security** – Implement necessary safeguards to keep PHI secure. Includes administrative, technological and physical safeguards
 - **Breach Notification** – Require notification to individuals of breaches of unsecured PHI
 - **HITECH Act** – Revise privacy requirements and broaden applicability of security rules
 - State Attorney General Enforcement Powers
 - **HIPAA Omnibus Rule** – Expands upon and provides further clarification to the HITECH Act relating to HIPAA Privacy, Security, and Enforcement

Health
Insurance
Portability
Accountability
Act



It is the policy of Connecticut Children's Medical Center, and all affiliates and subsidiaries of CCMC Corporation, that paper and other media containing confidential information that's no longer needed **MUST BE** disposed of by shredding, pulverizing, or other means of physical destruction to prevent disclosure of the information. The methods used for the destruction of confidential information shall ensure that confidentiality is fully maintained.

1. It is the responsibility of all staff to dispose of confidential materials in confidential waste bins immediately after it's no longer needed or being utilized
2. Staff, who generate confidential material continuously, may obtain an approved portable shredding container, by placing a request with their manager.
 1. *The manager must contact the Environmental Services department to order the container(s).*
 2. *Employees must empty their portable shredding containers into a confidential waste bin at the end of their scheduled shift.*
 3. *Do not leave confidential materials unsecured to the general public for any reason. In areas open to the general public, place the container in a location that prevents unauthorized individuals from gaining access to the confidential materials, for example, under or behind a desk, out of the sight and reach of customers.*
 4. *Use these portable shredding containers for confidential documents only. Do not place trash in them.*
3. *All questions regarding the disposal of confidential Materials can be brought to the Manager of Environmental Services. 860-545-8579*



HIPAA Breaches

- **A breach is defined as any unauthorized use or disclosure of unsecured PHI. All breaches have to be reported to the Office of Civil Rights (OCR).**
- ***Common examples of a breach:***
 - Sending a chart note to another party for whom the note was not intended
 - Loss of an unencrypted computer or hard drive containing PHI
 - Wrong prescription given to another patient's family
 - Emailing the incorrect clinical letter to a family
 - Staff inappropriately accessing PHI in EPIC
- ***Risks of a breach to Connecticut Children's includes:***
 - Damage to reputation
 - Patient retention
 - Lawsuits and sanctions
 - Federal and state penalties
 - Costly credit monitoring and breach notifications
 - Investigations are costly
- ***If you suspect a breach, immediately notify the Risk Management Department and complete a Quantros report.***



Breaches in Connecticut

- **UCONN**

- March 14, 2013 —“The University of Connecticut Health Center has notified some 1,400 patients of a healthcare data breach after discovering in January that a former employee had accessed patient records inappropriately.”
- *Between 2010-2014, Connecticut has seen at least 18 data breaches, involving at least 500 individuals per breach. These 18 breaches have affected more than 210,000 patients. Six of these breaches were caused by a Business Associate.*

- **Hartford Hospital**

- July 31, 2012 – “A security breach at Hartford Hospital has officials scrambling after someone stole an un-encrypted laptop with the personal information of nearly 10,000 patients.”
- “The hospital was notified June 26 after an outside vendor doing data analysis informed hospital officials that an employee laptop had been stolen.”
- “...information -- like names, addresses, Social Security numbers and sensitive medical information of hospital patients and VNA HealthCare clients -- was un-encrypted.”
- “...the hospital has notified the some 10,000 patients whose personal information was on that laptop.”

Source for UCONN breach - <http://www.healthcareitnews.com/news/connecticut-hipaa-breach-affects-1400>

Source for Connecticut Breaches- <http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/breachtool.html>

Source for Hartford Hospital breach - http://www.wtnh.com/dpp/news/hartford_cty/laptop-with-hartford-hospital-patient-info-stolen

Security Standards

Administrative Safeguards include, but not limited to:

- Business Associate Agreements – Guidelines for our relationships with our vendors
- Policies and Procedures – Guidelines for our day to day work duties
 - Password Management and Acceptable Use
- Security Awareness Training – Periodic education on best security practices

Physical Safeguards include but are not limited to:

- Facility Controls – Keypads, Badges, and Locks
- Asset Management – Computer Inventory Controls
- Physical Security Planning – Security Guards

Technical Safeguards include but are not limited to:

- Automatic Logoff from Workstations – Screen Saver Timeouts for inactive workstations
- Security Audits – Periodic reviews of employee access on workstations and applications
- User Authentication – Unique ID and Password for employees
- Encryption – Safeguarding data at rest and in transmission

Guide for Maintaining HIPAA Privacy/Security

- **Never** view patient records outside of your scope of work.
Remember that our systems are auditable.
Failure to comply will result in the initiation of the Performance Improvement Process.
- **Do not leave** documents containing Protected Health Information (PHI) in any public areas.
 - All documents containing PHI must be kept under your control at all times.
- **Secure e-mails** containing PHI and/or other sensitive information, that is being sent to outside recipients, by using the word **SECURE** in the subject line of the e-mail



Guide for Maintaining HIPAA Privacy/Security (cont.)

- **Use** locked zipper bags when transporting documents containing PHI from one location to another.
 - Yellow zipped locked bags and locked blue bins are used when transporting patient charts with PHI between a department and HIM.
- **Avoid** patient related discussions when in the elevator, shuttle bus, cafeteria, etc.
- **Use** Confidential Waste disposal bins to dispose of any documents containing PHI.



Guide for Maintaining HIPAA Privacy (cont.)

- Use two patient identifiers, i.e., full name and date of birth or medical record number to ensure that we are providing the right PHI to the right patient's family.
- Always check every sheet of paper to ensure that the PHI to be provided to the patient belongs to that patient.
- Always use a Connecticut Children's cover sheet when transmitting information by fax.
- Never share or post patient clinical information on social media sites.
- **Attention to detail at all times is one of the best ways to prevent HIPAA breaches.**



Golden Rules of Information Security

- **Protect** your computers and mobile devices from theft and unauthorized use.
- **Check** with the Information Security Officer if you have any questions about Information Security.
- **Do not** connect equipment (mobile devices, thumb drives, external hard drives, etc.) to the Organization network without authorization.
- **Do not** use unlicensed software on your computer.
- **Use** your computer only for purposes directly connected to your work.
- **Do not** share User IDs and/or passwords.
- **Keep** your passwords a secret from everyone. Choose your password carefully and according to guidelines.
- **Do not** open e-mail attachments or click on links unless you are certain of the source.
- **Beware** of viruses and malware hidden in e-mail attachments and new software. If you suspect you have a computer virus, contact the IS Help Desk at 860-545-8090.
- **Take as much care** with Internet e-mail messages as you would with letters on Connecticut Children's stationery.
- When including sensitive information or PHI in an email, **assure** the email is encrypted by placing the word **SECURE** at the beginning of the subject line.
- **Do not** transmit or store unencrypted ePHI on devices that may travel or reside outside of the organization (includes laptops, mobile devices, Internet storage, text messaging, etc.).
- All data **should** be stored on a network drive which is backed-up daily.

Golden Rule

Remember that Information Security is important, it's your responsibility!! Security is in Your Hands!

Highlighted New Regulations- Public Act 13-172

- Effective June 21, 2013
- All prescribers in possession of a Connecticut Controlled Substance Registration issued by the state of Connecticut must register as a user with the Connecticut Prescription Monitoring and Reporting System (CPMRS).
- Designed for prescribers and pharmacists to use as a tool to reduce addiction and overdose.
- www.ctpmp.com
- Only for controlled substances dispensed by the practitioner or their practice.
- Does not include samples or prescriptions that are subsequently dispensed from a licensed pharmacy.
- Excludes any controlled substances dispensed to hospital inpatients from an institutional pharmacy or pharmacist's drug room operated by a facility.
- Failure to comply may result in civil penalties or action against your Controlled Substance Practitioner (CSP) license.

Highlighted New Regulations –Affordable Care Act (ACA) and Ordering, Prescribing, Rendering Provider (OPR)

- Sections 6401 and 6501 of the Affordable Care Act (ACA) mandates that ordering/prescribing/referring (OPR) providers who render services to patients enrolled in the State of Connecticut Medical Assistance Program (CMAP) must be either credentialed as a fully enrolled Medicaid provider or enrolled as a non-participating Medicaid OPR only provider.
- As of November 1, 2013, any services ordered/prescribed/referred by a non-enrolled/non-participating OPR Medicaid provider will be denied.
- The State of Connecticut Department of Social Services (DSS) requires the Medicaid OPR enrollment for all unlicensed interns/residents/fellows enrolled in a teaching program.
- The provider's NPI number is the sole piece of information that is instrumental to ensuring that the right provider is being selected for any out-patient orders, prescriptions or referrals placed for Connecticut Medicaid patients. Therefore, all out-patient orders, prescriptions and referrals must have the provider's name and NPI number to eliminate non-eligible Medicaid provider rejections.

Physician Open Payments Act (Formerly Sunshine Act)-Background

- Section 6002 of the Affordable Care Act (ACA).
- Establishes a National Physician Payment Transparency Program (Open Payments).
- Arose from public concerns of physician and industry relationships and the perceived/actual influences and/or conflicts of interest these relationships could have in the areas of research, education and clinical decision-making.
- Aimed at increasing public awareness and fostering understanding and overall transparency of financial relationships between physicians/teaching hospitals and pharmaceutical and medical device companies.
- Provides one national public website for information on financial interactions to be reported and monitored.

Physician Open Payments Act (Formerly Sunshine Act)-Background

- All manufacturers of covered drugs, devices, biological and medical supplies who operate in the U.S. (physical location) must report payments or other transfers of value made to either a physician or teaching hospital to the Centers of Medicare and Medicaid (CMS).
- All manufacturers and group purchasing groups (GPOs) who operate in the U.S. must report to CMS certain ownership or investment interests held by physicians or their immediate family members.
- Medical Residents and all Mid-Level Providers are excluded from the Sunshine Act.
- In the month of April, Physicians and Teaching Hospitals will have forty-five days to review, validate and refute reported information from the previous calendar year.
- Physicians and Teaching Hospitals will need to be prepared for any patient questions regarding reportable “open payment” financial interactions

Physician Open Payments Act (Formerly Sunshine Act)-Reportable Financial Transfers

- **Direct-** Applicable manufacturers will be required to report to CMS any direct payments and/or transfers of value made to a physician or teaching hospital that is ten dollars or more.
- **Indirect-** Applicable manufacturers will also be required to report any indirect payment and transfers of value that are not directly made to the physician or teaching hospital but provided to another person or organization on behalf of the physician (i.e. mid-level providers). An indirect transfer can also occur when an entity transfers value to a physician by way of a third party. An example would be a pharmaceutical company that makes a payment to an organization that is to be provided to a specific physician.
- **Ownership** – Applicable manufacturers and GPOs must report to CMS certain ownership interests held by a physician and/or their immediate family member(s).
- **Examples of payments and/or transfers of value to be reported to CMS include, but are not limited to:** consulting fees, honoraria, gifts, entertainment, education, travel and lodging, research, charitable contributions, and/or compensation for serving as faculty or as a speaker for either accredited or un-accredited continuing education.

Physician Open Payments Act (Formerly Sunshine Act)-Reporting Exemptions

- **Examples of payments and/or transfers of value that are exempt from being reported to CMS include but are not limited to:**
 - Certified and accredited CME
 - Buffet meals serviced at a large-scale conference or similar large-scale event
 - Product samples that are not intended for sale
 - Educational materials that directly benefit patients and/or intended patient use. Note: textbooks and article reprints are not excluded.
 - The loan of medical equipment for short-term trial, not to exceed 90 days.
 - A transfer of value under \$10 that is under \$100 annual aggregate.

Physician Open Payments Act (Formerly Sunshine Act)-Steps to Ensure Accurate Reporting

- Regularly update your financial and conflict of interest disclosures required by Connecticut Children's, advisory and research funding entities to ensure that they are current, accurate and complete.
- Validate all information, including your specialty, that is associated with your listed National Provider Identifier (NPI) is correct, accurate and complete.
- Maintain a personal file of any potential reportable "open payments."
- Request that all applicable manufacturers you are associated with disclose any reportable information to you for review prior to their mandated CMS reporting deadline.
- Review your annual consolidated "open payment" report for accuracy as soon as it becomes available.