Briefings on The Joint Commission

Standards year in review (part 2 of 2)

Continuing Education Objectives

After reading this article, you will be able to:

• Identify medication management issues for 2013
• Describe the continued challenges for hospitals under the facilities management standards
• Discuss which HR standards were most problematic for hospitals in 2013
• Identify the top Medical Staff standard challenges in the previous year

Last month, we began our review of the year’s most-cited Joint Commission standards by discussing the top 10 most challenging issues of 2013. This month, we continue our analysis and look at the remaining most-cited standards for 2013 so far, led by BOJ advisor Jodi Eisenberg, MHA, CPHQ, CPMSM, CSHA, manager of accreditation, clinical compliance, and policy management for Northwestern Memorial Healthcare in Chicago.

Although the top 10 was largely facilities-based, focusing on Life Safety, Environment of Care, and Infection Control, there is more variety in items 11–20.

Case in point: The list begins with Provision of Care. This particular standard aligns with CMS Condition of Participation (CoP) 482.23(B)(4) and targets the plan of care.

End-of-life care
BOJ advisor Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, takes an in-depth and personal look at how hospitals can improve their approach to end-of-life care and patient dignity.

EMS and the emergency department
Guest columnist Patrick Planezza, MHA, discusses the importance of good communication between the ED and EMS services.

Guilty until proven innocent
This month, BOJ columnist Roger Shindell discusses staff education to prevent breaches in patient information.

Annual index
BOJ continues its annual tradition of providing an index of the year’s topics and discussions.

The Medication Management standard addressing medication orders listed as the #12 most-cited standard for the past year.

The amount of ED traffic arriving via emergency medical services.

The percent of patient data breaches caused by unintentional employee actions.
Joint Commission releases latest Speak Up video

The Joint Commission has revealed the latest in its line of Speak Up™ videos aimed at patient education and awareness. The video, “Ask Your Advocate to Speak Up,” focuses on the patient advocate’s role in ensuring quality care; it also educates the advocate on supporting the patient during care and acting on behalf of the patient’s best interests.

JointCommission.org: http://tinyurl.com/a9lb9dt

Preferred language standard clarified

The Joint Commission has issued a clarification on two standards, PC.02.01.21 and RC.02.01.01, both of which deal with the requirements for addressing the patient’s preferred language.

This clarification addresses the use of “primary language” or other terminology when identifying the language the patient prefers when communicating with his or her provider. It identifies and addresses some confusion as to how organizations can identify that language in their policies and documentation.

JointCommission.org: http://tinyurl.com/qqg8g4ex

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FROM THE FIELD

“The Joint Commission was quick to point out that the plan of care doesn’t necessarily need to be located in a single location—the key is that it is accessible by the team, provides an individualized plan and set of goals for the patient, and is updated as the plan changes.”

Jodi Eisenberg, MHA, CPHQ, CPMSM, CSHA

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“The plan of care must be individualized for every patient,” says Eisenberg. “The Joint Commission was quick to point out that the plan of care doesn’t necessarily need to be located in a single location—the key is that it is accessible by the team, provides an individualized plan and set of goals for the patient, and is updated as the plan changes.”

Many organizations have begun using the power of the electronic medical record to pull appropriate portions of caregiver assessments and plans into a single location, allowing the multidisciplinary team to see at a glance the plan for a given patient, Eisenberg notes. The details then “live” in various locations specific to each discipline.

“One of the challenges that organizations face is ensuring that the plans are individualized and don’t just rely on canned language embedded in the record,” says Eisenberg. “The key is to leverage the power of the electronic record as well as the power of the clinician in capturing the plan of care as appropriate to the status of the patient, their needs, and their progress. The focus needs to be on meeting the needs of the patient rather than meeting the standard.”

**MM.04.01.01**

Medication Management standard MM.04.01.01, which addresses medication orders, is next up. “Say what you do, do what you say,” explains Eisenberg. “You need to define content and implementation of medication orders in organizational policy and follow that policy. Integrate appropriate direction around timeliness and parameters of administration, titration, dosing, and more.”

It is important, she notes, for organizations to adopt a process for managing order sets. “When is the last time you reviewed your order sets or protocols? Are they current and approved by medical staff as appropriate? Organizations should have a process in place for order sets which is akin to the process for managing policies.”

**EC.02.05.07**

In the first of several appearances, the environment of care returns to the list, here with the emergency power system testing frequency standard.

“The primary issue within this standard includes issues with elements of performance [EP] 4 through 7. Surveyors are identifying a lack of written inspection, testing, and maintenance frequencies,” says Eisenberg. In some cases, continuous monitoring by a building automation system is acceptable. However, for generator testing, which must be conducted 12 times per year, each emergency generator must be tested with a load of at least 30% of the nameplate. Every three years, a four-hour test must be conducted using all the components.

“Good news: there are proposed changes in the works,” says Eisenberg—namely, changes to the required intervals between tests. Rather than the current requirement of not less than 20 days and not more than 40 days, the new time frames will simply state “at least monthly,” says Eisenberg.

Additionally, “the EPs which contain specific requirements for emergency generators have been changed to specify diesel-powered emergency generators,” she says. “For non-diesel-powered generators, tests need only be conducted with the available load.”

Times are being redefined in the EC chapter as well:
- Daily, weekly, monthly: calendar references
- Quarterly: once every three months plus or minus ten days beginning January 2014
- Semiannual: six months from the last scheduled event month, plus or minus 20 days
- Annual: 12 months from the last scheduled event month, plus or minus 30 days
- Three years: 36 months from the last scheduled event month, plus or minus 45 days

“It is important to note that the above does not apply to required frequencies,” says Eisenberg.

**EC.02.05.09**

The environment of care makes a second appearance in the top 20, this time dealing with issues surrounding medical gas systems. “The primary issues with [this standard is] EP 3, which are being cited to include appropriate labeling of the medical gas systems, contents of piping, and areas served,” says Eisenberg. “The other issue that has come to light is related to obstructions—equipment being stored in front of medical gas systems. Medical gas systems need to be accessible.”

**HR.01.02.05**

The Human Resources chapter makes a rare appearance in the top 20 with HR.01.02.05, which focuses on primary source verification. When licensure,
 certification, or registration is required by law or regulation, primary source verification must be verified at the time of hire and also at renewal.

“This appears to be purely a documentation issue,” says Eisenberg. “Organizations are required to complete the primary source verification before the expiration. If not done by the expiration, there should be evidence that the licensed professional was not scheduled to work.”

**PC.01.02.03**

Provision of Care makes its second appearance with PC.01.02.03, which examines patient assessment and reassessment and documentation of this activity within the specified time frame. This standard parallels CMS CoPs 482.22(c)(5)(ii) (medical staff); 482.24(o)(2)(i)(b) (medical records); and 482.51(b)(1)(ii) (surgical services).

The EP requires a history and physical (H&P) no more than 30 days prior, or within 24 hours after registration or inpatient admission but prior to a surgery or procedure requiring anesthesia. For patients undergoing surgery, an update is required prior to surgery that must include any changes since the H&P was conducted.

“A key element required by the CoPs, which is being missed in the documentation, is the fact that the patient was examined,” says Eisenberg. “Many organizations simply document the update by stating there were no changes. CMS requires the documentation to reflect that the patient was examined. Essentially, the document can reflect: ‘patient examined and no changes noted (or changes noted) since full H&P was conducted.’”

**EC.02.03.01**

Environment of Care continues its march across the top 20 most-cited standards with EC.02.03.01, addressing fire safety and fire plans. “This is particularly focused on staff knowledge and the ability to articulate their response,” says Eisenberg.

Issues include those related to electrical safety, such as identification of open junction boxes, as well as oxygen storage. “Remember the oxygen requirements—if surveyors find more than 300 cubic feet of nonflammable medical gases open to an egress corridor, this will result in a Requirement for Improvement,” she adds.

Another area of focus is fire safety with the OR suite. “As part of the review of the OR, surveyors are asking staff what they do to prevent fires in an OR and how they would respond to a fire should it occur,” says Eisenberg. “When staff in the OR have difficulty articulating what they will do, this EP will be cited. Surveyors are finding a lack of training and knowledge.”

**MS.01.01.01**

The one Medical Staff standard in the top 20 should come as no surprise: the oft-maligned and always challenging MS.01.01.01, addressing staff bylaws. “The good news is the number of RFIs linked to these EPs are decreasing,” says Eisenberg.

The bylaws must include the requirements in EPs 12–36. “Additionally, for deemed status, medical staff bylaws must include requirements for completing the H&P,” she says.

**PC.03.01.03**

Provision of Care rounds out the top 20 this year with the standard designed to address moderate sedation.

“The Joint Commission was quick to point out that this is an area where they exceed the CMS CoPs,” says Eisenberg. “Recall that CMS CoPs were revised with a focus on anesthesia. However, The Joint Commission felt that focus on patient risk related to moderate or deep sedation was as important as the risk related to anesthesia. Therefore, the risk and EPs have not changed.” Because of this, issues continue to be cited under this standard.

“This is one of those standards where the value in exceeding CMS CoPs is the right thing to do for the patient,” she says. “Organizations continue to struggle with complete and documented pre-sedation and pre-anesthesia assessment, documentation of the plan for sedation or anesthesia, and the immediate reassessment. The key is to create a process that enables efficient and consistent documentation of the required element for every patient every time.”

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We at BOJ value and welcome your feedback and opinions. Do you have a response to any of this month’s articles? An idea for a best practice or success story you’d like to share, or a recent survey experience you would like to recount? We would love to hear from you.

Contact Senior Managing Editor Matt Phillion
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End-of-life care: What we can and should do better

Editor’s note: The following report was authored by BOJ advisor Elizabeth Di Giacomo-Geffers, RN, MPH, CSIA, a healthcare consultant in Trabuco Canyon, Calif., and former Joint Commission surveyor.

I recently recounted the story of James Di Giacomo, SJ, to a colleague. Fr. James, a Jesuit priest, was a huge Chicago Cubs fan, and he had taken very ill late in life. The Cubs had, at that point, not won the National League pennant in 90 years, but were on their way to the post-season. Fr. James, with his signature grace and humor, wrote a note to a fellow Jesuit: “Do not resuscitate unless the Cubs win the pennant.”

It’s a funny story about a man at ease with his own health and mortality, but it got me thinking about our own current state of end-of-life care, and how we could better address the need for dignity and humane experiences as our sick and elderly come to terms with the ends of their own lives.

This is BOJ, so we should take a perfunctory look at where and how The Joint Commission weighs in on end-of-life care. Specifically, the accrediting body discusses this under RI.01.05.01, which provides requirements for the patient’s decisions at the end of life in terms of care and services.

Hospitals must have written policies on advance directives and the patient’s desires with regard to life support and whether the patient wants to withhold, forgo, or withdraw life-sustaining services. Hospitals must also determine which of their outpatient settings will honor those advance directives. Additionally, hospitals are responsible for educating patients about advance directives and what the patient’s options are regarding life support and other life-sustaining services. They must also educate the patient upon admission about the hospital’s abilities and policies regarding advance directives.

Now that we have the standards out of the way, what can we as healthcare providers do to help our patients at this time of need?

Nurses

Cindy Hylton Rushton, DNSc, RN, FAAN, assistant professor of nursing and clinical nurse specialist in ethics with the Bioethics Institute at Johns Hopkins and the Children’s Center in Baltimore, weighed in with wise words in her recent column, “What role can nurses play in improving the care of the dying?” (The column is available at www.thirteen.org/bid/es-nurses.html.)

“When cure is no longer available, dying people primarily need good nursing care,” she writes.

Nurses are firsthand witnesses to patients who are in the process of dying—our profession provides a unique window into this part of the patient’s life, and with it come unique observations about the methods and kinds of care we provide.

Hylton Rushton says, astutely, that nurses act as leaders in end-of-life care. Proper, humane, and dignified care is not possible without good nursing. But what, specifically, can nurses contribute to this process? She makes several suggestions, including the following:

• Creative partnerships with patients and other professionals to address end-of-life care
• Documentation of the needs of dying patients and their families
• Participation in interdisciplinary groups to help develop better end-of-life care standards
• Advocacy of accountability for all areas addressing the needs of the dying
• Identification and communication of threats to the patient-provider relationship
• Participation in the interdisciplinary education of students and practitioners to help these caregivers provide the best end-of-life care possible
• Collaboration with patients to promote and improve understanding around end-of-life care
• Advocacy for providers and patients to resolve disputes and help build toward “ethically defensible decisions and practices”

Issues to address

There are many troubling components to end-of-life care that we as an industry still need to resolve. Sadly, the 2009 New York Times piece by Jane E. Brody, “End-of-Life Issues Need to Be Addressed,” still rings true even nearly five years later. (View Brody’s article at www.nytimes.com/2009/08/18/health/18brod.html.)

The article is couched in the discussion of health-care reform and alarmist rhetoric regarding “government-encouraged euthanasia.” As Brody writes, such language demonstrates a “profound misunderstanding of how most people say they want to be treated when their chances for meaningful survival are nil.”

The crux of the issue, however, is that few patients at that time had their wishes in writing, or, as Brody notes, had even discussed what those wishes would be with family or doctors, which leaves those caregivers without a clear answer about the patients’ wants when they cannot answer for themselves.

Brody brings up the concept of “a death prolonged,” as described in the book of the same name by Jeff Gordon, MD. In his book, Gordon fictionalizes accounts of stories he has witnessed as a physician in Columbus, Ohio. Gordon writes in his introduction that “today’s high-tech medical care can sustain technical life—the beating heart—but utterly fails to restore real quality of life for many. There comes a point when physicians can prolong dying, but not provide quality living.”

Brody also brings up a relevant point described in a report by the Hastings Center (a research organization based in Garrison, N.Y.) called “Improving End-of-Life Care: Why Has It Been So Difficult?” The report states: “Despite 30 years of litigation, laws, and efforts by a range of groups to improve treatment for those near death, too many Americans still receive poor care at life’s end and are dying ‘bad’ deaths without adequate palliative care or dignity.”

Perhaps most alarming, Brody notes, is that there are no strong industry interests advocating for end-of-life care.

She highlights a number of key, crucial questions that Gordon discusses to ensure that patients have left adequate instructions for their care at end of life:
• If the patient can no longer be fed by mouth, should a feeding tube be installed?
• When should a ventilator be attached? When breathing independently becomes difficult?
• For a patient with severe dementia, should antibiotics be used to combat pneumonia?
• Under what circumstances should cardiopulmonary resuscitation be used if the patient’s heart stops beating?
• Or in any of these cases, should the patient simply be treated for comfort (pain, nausea, anxiety, depression) but be allowed a natural death?

Where do we stand now, though? With only about a third of Americans with instructions in place should they become incapacitated or unable to speak for themselves, we still exist in a medical community where physicians err on the side of caution, providing expensive and often excessive care even without an opportunity for quality of life afterward. How often have we seen patients put on life support when they were unable to speak for themselves?

Brody discusses in her piece the story of a friend who was intimidated by a doctor who wanted to provide her father with a feeding tube. The physician, stating that he did not believe in starving his patients, had the tube inserted. The patient would go on to experience several complications and repeat hospitalizations due to the tube. Simply put, according to the Hastings Center report, “physicians unwilling to give up and indifferent to patient desires are still with us.”

Gordon cites a New England Journal of Medicine piece that points to some 30% of Medicare dollars being spent during the last year of a patient’s life, with half of that dollar amount spent in the last 60 days. Worse yet, the costs spent in this manner inhibit the funding of preventive care and other methods of improving patient health long before the end of life. And the consequences to the patient can be staggering, including:
• Cost
• Infections
• Mental deterioration
Pain and suffering

Brody quotes Gordon in saying that “we keep people comfortable and let nature take its course. Given the opportunity, most people would not choose a pro-
longed, painful death. Instead, they would choose a natural, dignified death.”

The New Yorker ran a piece in September 2013 about New York University president John Sexton. In the article, writer Rachel Aviv recounts a story about Sexton interacting with Fr. James at the home for ailing Jesuits at Fordham University’s Murray-Weigel Hall. The story recounts Sexton chatting about TV and baseball with Fr. James, who had been Sexton's debate coach at Brooklyn Prep. Fr. James had had Sexton’s class translate “Meet the Mets” into Latin. Sexton began to sing the song in Latin, coaxing Fr. James to join in.

He did.

We as healthcare providers are surrounded by such great talent and such powerful machines for the saving and continuing of life. But we must always take care to remember the value of that which we work so hard to save, and help each patient retain their dignity and experience their life’s end in the manner with which they desire.

This article is dedicated to family, friends, and colleagues who passed away in 2013.

The importance of strong ED and EMS relationships

Continuing Education Objectives

After reading this article, you will be able to:

- Discuss the interactions between emergency medical services and emergency departments

When considering community perception of your organization, patient experience, and hospital volume, how often does the conversation encompass EMS?

Pre-hospital care is an essential portion of all ED volumes. On average, nearly 20%–30% of all ED traffic is literally driven to the doorstep by emergency medical services (EMS). So the question remains, how well do your hospital and local EMS agencies interact?

Providers on the scene have the “power of transport,” meaning unless a patient meets certain clinical criteria or the patient requests to go to a specific location, the EMTs and paramedics decide where to go—and they do not always choose the closest facility.

Furthermore, in 2008 Professional Research Consultants (PRC) did a nationwide survey of patients who utilized EMS services. PRC discovered that patients rate their overall experience with their EMS provider at 88.4%. The survey also found that EMS patients rated their care higher in the EDs if they were transported by EMS.

There are simple ways to strengthen this critical relationship. Many organizations round on patients and staff; why not round on the EMS providers that are coming through your doors as well? Require ED staff, specifically managers and directors, to do periodic ridealongs with the local agencies. Don’t just talk to the supervisors—speak to the frontline EMTs and paramedics. This firsthand experience will allow your organization to see some of the day-to-day frustrations that influence EMS decisions on where to transport patients. Just as importantly, have a mechanism where EMS providers can bring up issues or ideas to your hospital.

Celebrate EMS Week in a meaningful way to validate the profession. Create a space for providers to complete paperwork, have bottled water readily available, or simply ensure that the radio is answered quickly.

When considering throughput in the ED, make sure to consider EMS offloading time—in other words, the time from when an ambulance comes through the door to the time EMS can discharge the patient to the

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HIPAA training: Why am I here and why should I care?

Continuing Education Objectives

After reading this article, you will be able to:

• Identify what HIPAA requires to be compliant with regulations that address training
• Discuss why typical HIPAA training fails to reduce breaches
• Describe a culture of compliance
• Identify better training models for increased HIPAA awareness

Editor’s note: Roger Shindell is CEO of Carosh Compliance Solutions, which specializes in HIPAA compliance consulting with small to midsized U.S. companies (www.carosh.com). He can be reached at rshindel@carosh.com.

The Office of Civil Rights (OCR) has announced the items of focus during 2014’s random audits. Number two on the list is training (the first being security risk assessments). Why the attention on training? The Ponemon Institute’s Third Annual Benchmark Study on Patient Privacy & Data Security, published in December 2012, says it all. The most prevalent origin of patient data breaches—43% of them—can be attributed to unintentional employee actions. And when it comes to preventing these breaches, “Employee training is the most common activity but does not seem to be effective in reducing insider negligence.”

How can this be? After all, the vast majority of healthcare organizations comply with the “letter of the law”: conducting the required annual or periodic HIPAA privacy and security awareness training of all staff. So why is the result ineffective?

To start, let’s take a look at what the regulations say and what a typical OCR resolution says about the training OCR believes to be adequate; after that we’ll dive into what the regulations mean and how to make training more effective.

The training requirements are defined in the HIPAA Privacy Rule (see AHIMA’s HIPAA Privacy and Security Training). Section 164.530 of the Privacy Rule states:

(b) 1. Standard: training. A covered entity must train all members of its work force on the policies and procedures with respect to PHI required by this subpart, as necessary and appropriate for the members of the work force to carry out their function within the covered entity.

(b) 2. Implementation specifications: training. i. A covered entity must provide training that meets the requirements of paragraph (b) (1) of this section, as follows:

To each member of the covered entity’s work force by no later than the compliance date for the covered entity

Thereafter, to each new member of the work force within a reasonable period of time after the person joins the covered entity’s work force...
To each member of the covered entity’s work force whose functions are affected by a material change in the policies or procedures required by this subpart, within a reasonable period of time after the material change becomes effective in accordance with paragraph (i) of this section.

ii. A covered entity must document that the training as described in paragraph (b)(2)(i) of this section has been provided, as required by paragraph (j) of this section. And,

(j) 1. Standard: documentation. A covered entity must:
   i. Maintain the policies and procedures provided for in paragraph (i) of this section in written or electronic form
   ii. If a communication is required by this subpart to be in writing, maintain such writing, or an electronic copy, as documentation
   iii. If an action, activity, or designation is required by this subpart to be documented, maintain a written or electronic record of such action, activity, or designation

(j) 2. Implementation specification: retention period. A covered entity must retain the documentation required by paragraph (j)(1) of this section for six years from the date of its creation

Memory retention pyramid

After 2 weeks, we tend to remember ...

- 10% of what we READ
- 20% of what we HEAR
- 30% of what we SEE
- 50% of what we SEE & HEAR
- 70% of what we SAY
- 90% of what we DO

Source: Effective Adult Learning: A Toolkit for Teaching Adults. Northwest Center for Public Health Practice, School of Public Health, University of Washington.
or the date when it last was in effect, whichever is later.

To translate from the legalese, the letter of the law says:

1. All members of your workforce need ongoing and periodic training
   a. Training should include temp workers, volunteers, and nonclinical staff
   b. You might even want some basic training for support service contractors who are not business associates, to adequately protect PHI

2. Training must occur:
   a. For new employees within a reasonable period of time
   b. Whenever a material change occurs in your policies and procedures (i.e., the implementation of a new patient registration process), or your operating environment (i.e., the installation of a new EHR system, or moving to a new location)

3. Training must be documented, and:
   a. The content of the training (what was covered) should be addressed in the documentation, as well as how the training occurred (in person, via computer, etc.)
   b. Training materials should be utilized
   c. Documentation must be retained for six years from the creation date or date of last use

Additional guidance can be gleaned from reading the OCR resolution agreements. These are the agreements OCR enters into as part of remediating breaches that are investigated. The agency publishes some of these agreements; they can be found on the OCR website. As an example, the guidance from one resolution agreement includes the following:

1. All workforce members who use or disclose PHI shall receive specific training related to the Policies and Procedures, within ninety (90) days of the implementation of the Policies and Procedures.
2. Training should be provided to each new member of the workforce within thirty (30) calendar days of the workforce member’s beginning as a workforce member.
3. Each workforce member who is required to attend training shall certify, in electronic or written form, that he or she received the training. The training certification shall specify the date training was received. All course materials shall be retained in compliance with section VII.
4. SRMC shall review the training at least annually, and, where appropriate, update the training to reflect any changes in federal law or HHS guidance, any issues discovered during audits or reviews, or any other relevant developments.
5. SRMC shall not involve any member of its workforce in the use or disclosure of PHI if that workforce member has not signed or provided the written or electronic training certification as required by paragraph 2 of this section.

Notice that in the resolution agreement, OCR gives guidance as to when training must occur: within 90 days of implementation of policies and within 30 days of the onboarding of new hires.

What is lacking in the OCR’s guidance is an understanding of why such training is so ineffective. To understand, let’s turn briefly to adult learning models (see the graphic on p. 9). Given that the typical HIPAA training consists of a once-a-year lecture or an online training course, after two weeks we can expect staff to recall maybe 30% of what was presented in the training. Should we be surprised our current models are so suboptimal?

So what are we to do? Meredith Phillips, chief privacy officer for Henry Ford Health System, is a strong advocate for the proposition that the risk of a breach decreases with the creation of a culture of compliance. (For more on Phillips, see “Got Privacy? — Creating a Culture of Confidentiality” at http://tinyurl.com/qycataq.) The idea behind this culture of compliance is that privacy needs to be recognized not as a regulatory issue, but rather as good business. It is not secondary to delivering care, but rather is part of the delivery of care.

Although training is not the be-all and end-all of creating a culture of compliance, it is the cornerstone. So how does an organization use training to begin the process? Our recommendations to our clients are:

- Training should be ongoing and routine. It should consist of both annual overview training on HIPAA, and short repetitive training on internal policies
and procedures. We recommend these repetitive trainings be integrated into routine staff meetings where policies and procedures are reviewed, either singly or in groups.

- Training should be integrated into your onboarding process for staff, volunteers, and contract support staff. For your contract support staff, these training sessions can be brief and limited to how to deal with incidental disclosures.

Embracing the concepts on information retention presented above, these trainings should be interactive and participatory. We recommend presenting example privacy scenarios and making use of role-playing, moving as far away as possible from the lecture type of presentation that we all have had to keep awake for.

**Conclusion**

So why should you care? Simple: Training relieves stress and anxiety. Knowing you have a trained workforce goes a long way to decreasing organizational risks. Your organization may have great privacy and security policies and procedures, but a lack of competent, engaging training makes those policies and procedures null and void. Remember, 43% of breaches are due to employee actions. Although the regulations and OCR can determine the “technical” requirements of training, these entities fail to identify a specific training regime. Thus, it falls to the organization to define successful training that works for its employees. This training needs to engage the participants in ways that incorporate the information into their day-to-day activities, creating a culture that embraces privacy as part of the delivery of care.

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