Risk Matters: Telehealth Regulatory Changes Coming Soon

By Justin Joy, JD, CIPP

The expiration of the COVID-19 national public health emergency on May 11, 2023 brought a number of changes in healthcare. Among those changes was a significant shift in telehealth regulatory compliance risk. In March 2020, the US Department of Health and Human Services Office for Civil Rights (OCR) announced that it was exercising enforcement discretion and waiving potential penalties related to HIPAA violations for the use of "everyday communications technologies" in telehealth during the pandemic. These common video communication applications included Apple FaceTime, Facebook Messenger video chat, and other popular video chat applications.

However, with the expiration of the public health emergency, OCR is ending its enforcement discretion and waiver period after a 90-day transition between May 12 and August 9, 2023. Following this transition period, OCR may once again impose penalties for the use of communication technologies that are not HIPAA compliant. To be compliant, the application should be encrypted, and developers must sign a business associate agreement. For practices and providers still relying on OCR's enforcement

discretion and waiver, now is the time to become compliant with the proper use of communication technology in telehealth.

OCR has issued guidance on this topic which may be accessed here.

Additionally, SVMIC has a number of resources on this topic for its policyholders which are available in your Vantage® portal.

The Hidden Dangers of Online Trackers

By Brian Johnson

Recent events have drawn attention to the widespread use of online trackers and raised privacy concerns for healthcare organizations. The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has issued a bulletin following filed complaints, class action lawsuits, breach notifications, and investigations that bring attention to this issue. The bulletin specifically addresses the collection of protected health information (PHI) by online trackers and the possibility of unauthorized data sharing with third parties. It is essential that healthcare organizations take proactive measures to ensure that the data collected by these trackers and shared with third parties comply with the regulations set forth in the Health Insurance Portability and Accountability Act (HIPAA).

In a previous Sentinel article titled "The Dangers of Using Meta Pixel on Your Website," we discussed the presence of the Meta-supplied tracker and provided guidance on removing it from your website. [1] In this article, we expand the topic of online trackers, highlight the key concerns outlined in the OCR bulletin, and provide guidance on mitigating potential risks.

An online tracker is a computer code placed within a website that is designed to collect information about a visitor's interactions with the site. Most trackers are supplied to website owners free of charge by third-party vendors such as Meta and Google. The trackers are generally invisible to website users. When the code runs, it sends the collected data to the tracking vendor for analysis. A common practice is to collect usage data to identify areas for improvement and provide a better experience for visitors. This includes collecting data on page load times, most visited pages, downloads, number of clicks, time spent and keyword searches. Additionally, trackers are often used to collect information on conversion rates, for example, the number of visitors who completed the process to schedule an appointment after clicking the "schedule now" button. Tracking vendors also benefit from the presence of the tracker. The collected data is often used for marketing and online ads. Website owners should be aware that in the presence of tracking technology any content on the page can be consumed by the tracking vendor. This can have unintended consequences for pages that include health data.

The concern for healthcare organizations is when trackers collect health data that leads to impermissible data sharing. According to HIPAA regulations, PHI data can only be shared with third parties when explicit permission has been granted, or in the case of permissible uses and disclosures not requiring patient authorization, such as for recognized health care operations or when a business associate agreement (BAA) has been executed with the third-party tracking vendor. [2] To address the issue, OCR issued a bulletin titled, "Use

of Online Tracking Technologies by HIPAA Covered Entities and Business Associates." [3] The bulletin provides guidance on tracking technologies, types of data collected, common usage scenarios, and compliance with the Privacy Rule.

The bulletin distinguishes between unauthenticated pages, such as the homepage of a publicly accessible website for a medical group, and user-authenticated pages, such as a patient portal. The former contains generic information about a practice and has less risk when a tracker is present. The latter requires users to log in and often contains individually identifiable health information (IIHI) such as patient name, address, phone number, appointment times, health history, prescriptions, and lab results. The presence of a tracker on a user-authenticated page likely has access to PHI and introduces the potential of impermissible sharing with third parties.

The OCR bulletin stresses that "Regulated entities are required to comply with the HIPAA rules when using tracking technologies." [3] This means that Covered Entities and Business Associates must obtain explicit permission to share information with tracking vendors for marketing purposes. Otherwise, if the tracking vendor meets the requirements of a business associate, a business associate agreement (BAA) must be in place. However, simply providing protected health information (PHI) to a tracking vendor or having a signed BAA does not automatically make them a business associate. [3] The tracking vendor must meet the explicit definition of a business associate, otherwise HIPAA compliant authorizations are required. The bulletin also cautions against the use of website banners that require visitors to accept the usage of tracking technologies, as this does not meet the requirements for HIPAA authorization. It is important for regulated entities to ensure that they are compliant with HIPAA rules when using tracking technologies to protect the privacy and security of PHI.

The bulletin does not mention specific trackers or vendors by name; however, Meta Pixel (formally Facebook Pixel) has been the subject of multiple class action lawsuits related to its tracking technology. An investigation by The Markup found thirty-three of the top one hundred healthcare providers using the tracking technology with evidence of sensitive data being shared through patient portals and online schedulers.[4] One example demonstrated the use of an appointment scheduler sending Facebook the name of the doctor, including her specialty, along with the patients' first name, last name, email address, phone number, zip code and city. To help healthcare organizations identify the presence of Meta Pixel's tracking technology on their websites, The Markup has developed a tool called Blacklight.[5] This tool can scan a website and alert healthcare organizations if Meta Pixel is present. If a healthcare organization finds the tracker on their website, they should investigate its presence.

It is crucial for healthcare organizations to assess their websites for all tracking technologies and evaluate compliance with HIPAA regulations. To achieve this, organizations should first identify where health data is displayed or collected from visitors. They should then search for the presence of trackers within those sections of the website. If trackers are found, organizations should determine what data they are collecting and if

it's necessary to share with the tracking vendor. If the trackers have no value, they should be removed. However, if they are necessary, organizations must ensure that the trackers disclose the minimum necessary PHI, and that appropriate BAAs and authorizations are in place. Lastly, recurring examination of tracker technologies should be added to the risk analysis and risk management procedures for the organization.

In conclusion, the use of online trackers has raised privacy concerns for healthcare organizations. The previously discussed OCR bulletin addresses this issue, specifically focusing on the collection of protected health information (PHI) and the possibility of unauthorized data sharing with third parties. Practices must take proactive measures to ensure that the data collected by these trackers and shared with third parties comply with HIPAA regulations. The OCR bulletin provides guidance on tracking technologies, types of data collected, common usage scenarios, and compliance with the Privacy Rule. If you have questions about cybersecurity or access to these resources, call 800-342-2239 or email Contact@svmic.com.

If you experience a cybersecurity incident, contact SVMIC as soon as possible by calling 800-342-2239 and ask to speak with the Claims department.

Other individuals in your organization, such as your administrator, privacy or security officer, or information technology professional, may benefit from these articles and resources. They can sign up for a Vantage account here.

1. The Dangers of Meta Pixel on Your Websites | SVMIC
2. 45 CFR 164.502(e) - Uses and disclosures of protected health information
3. Use of Online Tracking Technologies by HIPAA Covered Entities and Business Associates | HHS.gov
4. Facebook Is Receiving Sensitive Medical Information from Hospital Websites – The Markup
5. Blacklight – The Markup

Supervision Requirements for Diagnostic Tests
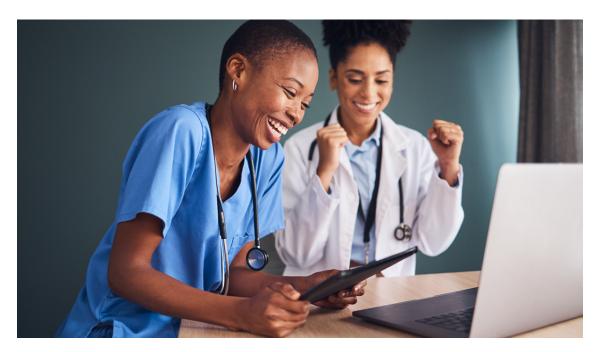

By Jackie Boswell, FACMPE

On March 16, 2023, Medicare issued MLN Matters - MM13094 which clarified language related to the January 1, 2021 rule that expanded the list of providers who can supervise diagnostic tests to include Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs) and Physician Assistants (PAs). The rule clarifies that "when NPs, CNSs, and PAs personally perform diagnostic tests as provided under Section 1861(s)(2)(K) of the Act, the supervision/collaboration requirements under Section 1861(s)(3) of the Act and 42 CFR 410.32 don't apply. Rather, these practitioners are authorized to personally perform diagnostic tests under the supervision/collaboration requirements applicable to their practitioner benefit category pursuant to state scope of practice laws and under the applicable state requirements." These services should be billed to Medicare under the practitioner's own provider number and may not be billed as "incident to."

MM13094 may be found here.

Staffing Strategies that Work

By Elizabeth Woodcock, MBA, FACMPE, CPC

Despite looming predictions about the economy, employment rates have still not stabilized in the health care industry. Medical practices remain challenged by staffing shortages – and high turnover rates. There is no end in sight, so it pays to brush up on recruitment and retention tactics to ensure you're taking advantage of every opportunity to get – and keep – the best employees.

Find the best. Locating talent is tough because every hospital, health system, nursing home, etc., is searching for the same employees you are. Climb up the hiring ladder by getting closer to the applicants' decision point. Months before a potential employee completes their education or training, they look for a job. If they have had on-the-job training, they typically look for employment there first. Why? It's familiar – and hopefully, they liked the environment. The training site typically makes offers to the best trainees, letting the rest go to the market. Serving as a training site is optimal for recruiting and provides an opportunity for an employer to review the skills of trainees and hire the best candidates. Look around for a program, and volunteer as a preceptor, externship site, etc. For administrative employees, don't be shy about hiring from other industries. Someone in hospitality or retail can make a great receptionist. While it may take some time to educate

a new employee in the steps to schedule an appointment or post a charge, it's impossible to teach someone to smile. The "fit" of a new hire can be more important than experience.

Be creative. Historically, medical practices have hired employees for on-site, forty-hour work weeks. The pandemic has changed the traditional work environment. Are there tasks that don't require an employee to be on-site? It's difficult to hire and start someone in a remote position, however it's a great opportunity for a trusted employee who must leave because their spouse was transferred out of state for work, for example. They can schedule appointments from California, just as easily as they can from your physical office. Before a star employee walks out the door, consider making them an offer to work remotely.

Another area of creativity that is rarely used in medical practices is part-time work. Consider hiring two employees, 20 hours each. Why? It lessens the blow to your operations if one leaves (because one is still there); it opens a pool of potential employees who can't or don't want full-time work – and are often highly educated and skilled; and you can more easily adjust the hours for the practice's peak times (e.g., hire *both* part-timers to work on Mondays[!]). Finally, two part-timers are often less expensive per worked hour because of the reduced benefits offered.

Clean house. There's never been a better time to take a good look at your team. Do you have the best employees – or are you keeping employees who are no longer contributing (or never did)? Given the staffing shortages, some employees have taken advantage of the situation. They are a "butt in the seat," as one office manager put it to me. They are not, however, effective at their duties. It's not uncommon for an under-performing employee to be tolerated by a practice owner who considers the employee to be bad at their job, but rationalizes that at least they show up for work. However, the negative ripple effect reaches far beyond that employee's workstation. Because a medical practice requires a team approach for basically every function provided – from scheduling to rooming to orders to payment – an ineffective employee drags everything (and everyone) down. If necessary, hire someone else for the position before letting go of the poor employee. Pre-hiring is a technique that is used in many businesses; it costs a little more but is certainly worth it if the situation dictates.

Keep the team motivated. Money has traditionally been the go-to reward for good employees, however research has demonstrated that workplace flexibility, personal well-being, and professional development should be the focus of retention strategies. While an hour off on a Friday afternoon may not excite you, paid time off is a great reward for employees. If you can't afford an hour off, consider allowing employees the ability to swap time. Let's say one of your receptionists needs two hours to attend their child's middle school graduation next Thursday; provide a Google spreadsheet that allows them to place the request for the time and another employee to pick it up for a swap. This exchange system requires some administration, but the flexibility can be terrific for retention. Look for means to deliver workplace flexibility. Well-being is another key pillar for retention; small appreciation gifts may include bringing lunch into the office or having family-sized

casseroles delivered for employees to take home for dinner. Tickets for the movies or a local sporting event are likewise appreciated. Consider ways to provide for the employee inside the workplace, but also opportunities to support them holistically without crossing personal boundaries. Finally, seek out training opportunities for employees. It helps them and supports your practice with higher-skilled employees.

Great employees make great medical practices. It's an opportune time to evaluate your team – and make sure that you're delivering the optimal environment to create, nurture, and maintain the best employees.

We encourage you to check out SVMIC's very helpful HR Toolkit to help with your staffing challenges.

Closed Claim: A Recipe for a Medical Emergency

By Jeff Williams, JD

Readers of this article may be familiar with the medication error case that resulted in a fatality at Vanderbilt University Medical Center back in 2017. That medication error involved a nurse who gave the patient vecuronium, a muscle paralytic instead of Versed, a sedative, which resulted in the death of a patient. Not only was Vanderbilt sued in civil court by the family of the patient, but the nurse was convicted of criminally negligent homicide due to the death of the patient. While most medication errors do not result in death, the following story should serve as a reminder that medical providers and administrators should implement, consistently follow, and continuously review medication protocols to ensure patient safety and to avoid negative outcomes.

Mary White,[1] was 28 years of age and at the end of a full-term pregnancy. She presented to the hospital's labor and delivery department for a planned induction of labor and was also scheduled for a post-partum tubal ligation. The anesthesia team on duty consisted of Buddy Michaels, M.D. and Terry Lawler, CRNA.

CRNA Lawler was responsible for placing the epidural catheter and administering the obstetric anesthesia. The baby was delivered without any complications. After the delivery, and in anticipation of the tubal ligation, CRNA Lawler injected the patient's epidural catheter with two medications. The medications to be given were midazolam (Versed) and ondansetron (Zofran), to prevent nausea. When CRNA Lawler began to push what was believed to be Versed through the I.V., the patient complained that her I.V. site was burning and asked for it to be stopped. Mrs. White soon complained of a severe headache and generally feeling bad. She began to vomit and then lost consciousness. CRNA Lawler immediately called for Dr. Michaels who quickly responded to assess the situation. A nurse noted that the patient's blood pressure was elevated, and her heart rate was low. Auscultation revealed an irregular heart rhythm.

Time was of the essence given the patient's deteriorating condition. Believing that the patient had experienced an allergic reaction to the anesthesia, the patient was given a reversal agent for the Versed. Dr. Michaels requested an immediate EKG and a cardiology consult. A CT scan of the brain was obtained as the patient continued to complain of a persistent headache. Due to the quick intervention, her vital signs eventually stabilized. Mrs. White continued to complain of a headache and not feeling well. Her troponin level was elevated, and a telemetry strip showed a sinus rhythm with sinus bradycardia. After her discharge, it was necessary for Mrs. White to continue seeing a cardiologist for monitoring to be sure she did not sustain any permanent cardiac injuries.

After this incident, the anesthesia team reflected upon the process of how the medication was delivered to the floor for its use in this case and came to the realization that the patient was most likely given a large dose of phenylephrine, a vasoconstrictor that increases blood pressure, when she was supposed to be given Zofran. The method in which the medication was delivered to the labor and delivery floor from the pharmacy aided in the confusion. Two separate medication boxes were provided to CRNA Lawler. One box contained anesthetic medications. The second box contained medications required for labor and delivery. The Zofran was placed near the phenylephrine. Notably, both vials were of similar size, and the color of the caps were the same. In a high pressure and fast-paced environment like labor and delivery, the medications should not have been presented in this manner. Placing the different medications right next to each other was the recipe for a medical emergency.

A lawsuit was filed on behalf of Mrs. White alleging that the negligent administration of phenylephrine caused the cardiac event resulting in permanent physical, mental, and emotional injuries. In addition to Dr. Michaels and CRNA Lawler being sued, the hospital was named in the suit alleging failure to properly store the vials of medication in an appropriate location and manner. More specifically, the suit alleged that it was a deviation from the standard of care to present medications that were not easily distinguishable from each other in such close proximity.

Part of Plaintiff's theory of negligence in the case was focused on how the drugs were administered. Another theory focused on how the medications were obtained from the

pharmacy, as there was no notation made in the chart regarding whether the drugs were stored near the operating room in an automated dispensing cabinet or if the drugs were delivered to the operating room from the pharmacy. A key takeaway here is that plaintiffs' counsel often tends to exploit what is *not* noted in the chart and then make the omission a key element of its case. Medical record documentation is an issue in many medical malpractice cases. Appropriate charting should always be a priority.

The defense of the case was developed through written discovery, the retention of expert witnesses, and depositions. It became clear that Dr. Michaels was not involved in the physical selection or administration of the medications that led to this incident. Eventually, he was dismissed from the case. Further, the defense was able to develop evidence that the patient did not suffer long-term cardiac damage due to this unfortunate event.

The proximity of the medications being placed in similar looking containers does not excuse the fact that the incorrect type of medicine was given to the patient. Yet, better protocols in this situation likely would have produced a more favorable outcome. In hindsight, which is the way most of these stories are told, this unfortunate event could have been avoided if only a few safeguards had been in place in the labor and delivery department on that day.

Whether you practice in a hospital or office setting, consider the tips below to avoid medication errors.

- First, if you have concerns about how prescription medications are being presented for use at the facility where you practice, alert administration of your concerns. Solid risk management begins with open lines of communication from those doing the work on the ground-level up to administration.
- Slow Down and take a personal time out! This can be a challenge in a busy medical practice, but taking time to be sure you follow the "Five Rights" can avert serious harm. In other words, ensure you have the right patient, right drug, right dose, right route, right time.
- Store medications with look-alike containers and/or sound-alike names in separate physical locations. Additionally, medications that are organized in a container or tray label-up vs. cap up can help prevent the type of error that occurred in this case.

With a defense in place regarding the lack of permanent damages, the parties agreed to submit the matter to a mediator for settlement negotiations. Thereafter, the case settled without the necessity of a trial.

For more information on this topic see "Safe Medication Practices in the Physician Office" [2] by Julie Loomis, R.N., J.D., Assistant Vice President of Risk Education.

[1] Names and identifying details have been changed for confidentiality.

[2] Safe Medication Practices in the Physician Office by Julie Loomis, RN, JD - https://www.svmic.com/resources/newsletters/119/safe-medication-practices-in-the-physician-office

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