August 2013

ICP ConsultantConnection

Institutional Care Pharmacy • Tiffin, Ohio • Mason, Ohio • Sharpsville, Pennsylvania

Business Associates and HIPAA Final Rule Compliance Date

At the beginning of the year, the Office for Civil Rights (OCR) of the Department of Health and Human Services published new regulations that extend the privacy and security, enforcement, and breach notification rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. The new regulations often referred to as "The Final Rule" became effective March 26, 2013 with compliance required by September 23, 2013.

The Final Rule extends to the companies that do business with the healthcare industry, otherwise known as "business associate". A business associate is an individual or organization acting on behalf of a HIPAA covered entity that creates, receives, maintains, or transmits protected health information (PHI) in connection with a function or activity regulated by HIPAA. Business associates include a wide range of companies, including those providing certain software products, electronic health records, cloud computing services, outsourcing services, data centers and claims processing.

When the Final Rule takes effect, business associates and their subcontractors will be responsible, along with the covered entities they serve, for health data breaches and HIPAA non-compliance issues. The responsibility of a business associate has been raised to almost that of a covered entity.

Business associates had privacy and security obligations under their contractual agreements with covered entities before but under the HIPAA Final Rule, business associates will now have obligations for how they can use and disclose PHI on behalf of a covered entity and they are responsible for having their own policies and procedures. They potentially could face investigations and hefty financial penalties from the Department of Health and Human Services for noncompliance.

A business associate agreement that is compliant with pre-Final Rule HIPAA requirements need not be amended, if it is not renewed or modified until September 23, 2014; but new business associate agreements entered into after January 25, 2013 must contain the newly required provisions by September 23.

Martha Somers – Administrator of IT

Contents

Web: www.icppharm.com
email: icp@icppharm.com

Tiffin Main Line: 800.228.8278

Tiffin Pharmacy: 877.447.5539
Fax: 800.325.9826

Business Office: 800.252.1679
Fax: 800.338.8593

Medical Supplies: 877.228.8278
Fax: 800.208.6809

ICP Southern Region: 866.544.5433
Fax: 513.573.9628

PA Pharmacy: 888.203.8965
Fax: 888.431.4924

Pharmacy Services:
Subacute Care
Long Term Care
Assisted Living
Alternative Living
Correctional Facilities

Consulting Services:
Consultant Pharmacists
Nurse Consultants
Respiratory Therapists
Medical Record Experts
Reimbursement Authorities
MDS Specialists
Wound Care Certified Consultants

Additional Services:
Respiratory Equipment and Supplies
Medicare Part B Billing
Inventory Bar Coding Program
Enteral / Nutritional Program
Medical Supplies
Incontinence Products
Wound Care Products

Mission Statement:
ICP is committed to exceeding our customers' and employees' expectations through quality health-care service, continuous education, and effective communication.

Decreasing Heart Failure Readmissions

Overall, 30 day re-hospitalization rates for residents of long term care facilities have steadily risen in the United States. This is largely due to the average hospital length of stay has been reduced and patients discharged to long term care facilities sooner than in the past.

A frequently observed example is a resident with arteriosclerotic heart disease in addition to congestive heart failure that requires close observation by all staff for signs of decompensating, abnormal fluid balance or adverse effects resulting from prescribed medication.

Case managers/admission coordinators and nursing staff play key roles in reducing heart failure readmissions, beginning with admission to the long term care facility. Reviewing the resident's medical information prior to arrival is vital and reviewing again after admission is just as important.

- Link each medication with a diagnosis, appropriate clinical and laboratory monitoring and document.
- Identify weight parameters and protocol for weight gain.
- Identify sodium restricted/specialized diet.
- Establish physician visit within 3 to 5 days of hospital discharge with appropriate primary care or specialist physician.

There are several basic steps in developing effective chronic disease management and care within the facility. An initial step is to develop materials and processes that describe the signs and symptoms in easy, understandable terms to ensure residents, families and staff (i.e., STNA, activity staff, dietary aides, housekeeping, etc.) can communicate their understanding of the basic disease process.

Key points regarding CHF may include:

- Congestive heart failure means the heart is not pumping enough blood to meet the body's needs.
- Blood may back up in the lungs causing shortness of breath and increased coughing
- Blood may also back up in other parts of the body, which can cause swelling in the legs, feet or abdomen.
- Diminished blood flow in the body may increase fatigue and promote loss of appetite.

Disease monitoring and intervention coordination by licensed nursing staff and STNA's is crucial. Management of CHF requires regular assessments that are most effective when completed consistently by a nurse and STNA who are knowledgeable about the resident and their disease pattern. This can be accomplished by regular staff assignments.

Communication of an acute episode to a primary physician can be challenging. A thorough assessment before contacting the physician is paramount. The assessment should consist of the following: collecting vital signs, apical pulse, lung sounds assessment, O2 saturation, allergies, recent change in medication, mental status change, fatigue, etc. By providing the appropriate communication tools and holding competency and practice skill labs will make the licensed nursing staff proficient in providing accurate and timely communication.

Work together with the primary physician and demonstrate nursing staff is equipped with the knowledge and tools to monitor and treat acute CHF episodes at the facility. Effective management of CHF is important for all skilled nursing facilities. Many tools are available, such as INTERACT III or you can develop your own, but remember the key is consistency and education.

Written by: Irene Sours, RN, WCC ICP, Nurse Consultant

Bibliography

Peters, Diane, RN, NHA, MS. *Improving care for Residents with Congestive Heart Failure.*

AHRQ. *Evidence-based Practice Center Systematic Review Protocol Project Title.* http://effectivehealthcare.ahrq.gov/ehc/products/510/1409/heart-failure-readmission-protocol-130610.pdf

Vitamin D Supplementation

Vitamin D supplementation has become commonplace among adults, with increasing popularity among elderly individuals for a multitude of reasons. It has been shown to not only have positive benefits in osteoporosis prevention and treatment by aiding calcium absorption and improving balance, but is also linked with improved muscle strength and CV function, lowered cancer risk (breast, colon, and prostate), and positive effects on immune-oriented diseases (MS, T1DM, and RA). The seemingly endless availability of vitamin D to consumers also makes it convenient to supplement. It can be found in different strengths allowing for a wide range of dosing frequencies, from multiple times daily to once monthly, OTC or Rx only, and alone, or in multi-vitamin formulations.

Screening for low levels of vitamin D should only occur in those patients who are at risk or have a compelling medical history such as: persistent musculoskeletal pain, osteoporosis, Rheumatoid arthritis, malabsorption syndromes, CV disease, elderly (patients >71 years old), persons with dark skin, chronic corticosteroid use, history of insufficient sun exposure, lack of vitamin D in the diet and only possibly if the patient has a positive history of: obesity, T2DM, CKD, hyperparathyroidism, and depression. Once the at-risk patient has been identified, the preferred test is the serum 25-hydroxyvitamin D (25OHD) assay. Acceptable levels would be greater than 30 ng/mL, an insufficiency would be in the 21-29 ng/mL range, and a deficiency would be a value of less than 20 ng/mL. Testing of the 25 (OH) levels should only be preformed every 3 months; this is due to vitamin D having a half life of almost 1 month and a new steady state being reached in approximately 3 months.

Recommended intake of vitamin D for the high-risk elderly population is anywhere from 800-1000 IU daily, which is enough to see benefits in bone and muscle, but could be as much as 1500-2000 IU daily. This amount is known as the maintenance dose, but it's unsure if the patient will benefit from the non-skeletal effects of vitamin D at this dose. For patients with AIDS, on chronic corticosteroid therapy, or taking anti-convulsants, or anti-fungals the daily dose of vitamin D should be anywhere from double to triple the normal suggested value for that patients age group. If the patient would happen to be deficient, the suggested replacement regimen is 50,000 IU of vitamin D2 or D3 orally once weekly for 6-8 weeks followed by the routine maintenance dose. This may vary based on patient specific parameters such as absorption. For every 100 IU of vitamin D3 given to the pt, it is expected to increase the 25 (OH) lab value by 1 ng/mL.

As with any medication, there are associated risks that accompany the benefits. Although vitamin D toxicities are rare, it is a possibility with the ingestion of large amounts of high strengths of the vitamin. When 25 (OH) levels are >150 ng/mL the patient is at risk for hypercalcemia, hypercalciuria, kidney stones, calcification of the kidney with renal failure, which can ultimately lead to death. Also before recommending any medication, it is important to obtain a complete medication list that includes prescription, OTC, herbals, and supplements which could also contain vitamin D. Caution should be used with vitamin D2 supplementation in patients with impaired kidney function/kidney stones, high phosphate, calcium, or vitamin D levels, malabsorption syndrome, CV disease, hypersensitivity/allergy to components of the drug. These recommendations are only meant to serve as template of treatment for the supplementation of vitamin D and therapy should be individualized to each specific patient with collaboration of the physician, pharmacist, or other health care provider.

Jordan Dimmerling, Pharm D Candidate, Ohio Northern University

References:

Holick MF, Binkley NC, Bischoff-Ferrari HA, Gordon CM, Hanley DA, Heaney RP, Murad MH, Weaver CM, Endocrine Society. Evaluation, treatment, and prevention of vitamin D deficiency: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2011 Jul; 96(7):1911-30.

Lexicomp Online [database on the internet]. Hudson (OH): Lexicomp. 2013 [cited 2013 June 25]. Available from: http://0-online.lexi.com.polar.onu.edu/lco/action/home;

O'Connell MB, Vondracek SF. Chapter 99. Osteoporosis and Other Metabolic Bone Diseases. In: DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey LM, eds. *Pharmacotherapy: A Pathophysiologic Approach*. 8th ed. New York: McGraw-Hill; 2011. http://0-www.accesspharmacy.com.polar.onu.edu/content.aspx?aID=7996689. Accessed June 25, 2013

University of Texas at Austin, School of Nursing, Family Nurse Practitioner Program. Recommendations for the diagnosis and management of vitamin D deficiency in adults. Austin (TX): University of Texas at Austin, School of Nursing; 2009 May. 16 p.

Same address as before, whole new site.

visit:

http://www.icppharm.com

To sign up to receive the electronic version of the Consultant Connection!

Opioid Induced Constipation

With pain now being monitored as frequently as vital signs, and regulatory standards placing focus on pain management, prescriptions for opioid analgesics increased 700% from 1997-2007. Opioid's are often the only option for pain management for some patients, however they do not come without adverse effects. Major reasons for discontinuing opioids are gastrointestinal effects such as nausea, vomiting, and constipation, in addition to CNS effects. Because opioid receptors are widely distributed throughout the body, they have a broad range of effects. Factors such as age, gender, and race can contribute to adverse effects of opioid analgesics. The GI tract is dense with receptors that opioid analgesics target, and patients rarely become tolerant of this adverse effect making it the most debilitating and common adverse effect occurring in 45%-95% of patients. Activation of these GI receptors inhibits gastric emptying, reduces mucosal secretions, and increases fluid reabsorption. These conditions result in hardened and dry stool and consequently constipation. Prevention is the key to opioid constipation treatment.

Nonpharmacologic approaches to opioid constipation:

The risk of constipation can be reduced by increasing fluid and fiber intake, increasing physical activity if possible, and establishing a regular toileting routine. Caution should be taken when increasing fiber however, because too much fiber with inadequate fluids can exacerbate constipation and lead to an obstruction.

Stimulant laxatives:

Stimulant laxatives are the most common type of laxative used to treat opioid induced constipation. These agents work by triggering intestinal-wall muscles to tighten, squeezing the stool allowing it to pass easily.

Stool softener:

Stool softeners reduce surface tension of the oil-water interface of the stool. This enhanced incorporation of water and fat results in softened stools, and ease of passing stool. Use of stool softeners alone is not often effective in treating opioid induced constipation, therefore the use of a scheduled stimulant with a stool softener is usually recommended.

In summary, Opioids are a frequently prescribed medication effective for pain management. The most common adverse effect is constipation, which can be quite severe. Non-pharmacologic interventions should be taken upon initiation of the medication especially increasing fluid intake. Stimulant laxatives in addition to a stool softener are the most effective means of treating opioid induced constipation and should be initiated as soon as constipation becomes evident if not at the initiation of the prescription.

Heidi Trautwein CGP,PharmD, RPh