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Infection control

Change policies and culture to discourage providers, others from working while sick

Reduce the likelihood clinicians will spread pathogens to patients by setting clear policies on working while sick and establishing a culture that discourages the practice.

Health care providers are routinely exposed to and contract infections like influenza and norovirus. Such illnesses are unpleasant but nonthreatening for healthy people. However, they can be dangerous to immunocompromised patients.

A study published by the American Medical Association in JAMA Pediatrics last July reported that 83.1% of physicians

(see *infections*, p. 3)

Emergency management

Train new leaders quickly on EOP roles — disaster may happen sooner than later

Be sure to train new hospital leaders on your emergency management plan and incident command structure as soon as possible after hiring because that next emergency — or three — might be just around the corner.

Riverside Tappahannock Hospital in Virginia learned that lesson right after the first of the year when they activated their incident command not once but three times within about a

(see *EOP*, p. 5)

Overpayment final rule lands hard



CMS just issued stringent final requirements for the 60-day overpayment rule. This webinar, **New 60-day Overpayment Rule: Expert guidance to avoid errors and noncompliance penalties**, on March 23, will help your hospital prepare. For more information, visit www.decisionhealth.com/conferences/A2661.

*Infection control***Ensure your infection control strategy includes white coats, nonclinical areas**

Routine office equipment and apparel — including physician white coats and smartphones — are easily contaminated and need to be part of infection control strategy and procedures, experts say.

Most IC efforts focus on clinical settings, but clerical items and everyday actions also spread pathogens.

A 2008 study published by the *American Journal of Infection Control* found that 23% of white coats in a cohort of 149 grand rounds attendees were contaminated with *S aureus* bacteria. Six of the *S aureus* cases involved MRSA.

In addition, several studies have shown that mobile devices and computer keyboards are bona fide breeding grounds for bacteria, thanks in part to regular contact with hands.

This may be a particular red flag given that hand hygiene compliance rates are, despite a raft of scrutiny and compliance efforts, not optimal across much of the health care sector.

Data from the World Health Organization shows that hospital-acquired infections account for complications in 5% to 10% of admissions in developed countries and about 200 deaths per day in the United States. The data also show that compliance with hand hygiene guidelines,

which if properly undertaken can stem the spread of pathogens, is “frequently below 40%.”

Attire and culture part of problem

The doctor’s trademark white coat is a widespread fixture in clinical settings. However, often laundry services are not.

“A lot of physicians still use white coats, but the office, to save money, is not doing laundry anymore,” says Jennifer Searfoss, CEO of SCG Health, a health care consulting firm based in Ashburn, Va. “People think about cost-cutting and not infection control.”

In many cases, in-house laundry is less frequent or the onus falls to the physicians or staff to do their own laundry on their own time — and on their own dime, Searfoss says. This can cause lags.

The best solution from an infection-control perspective may be to get rid of the white coat altogether, but “it’s part of the old culture,” Searfoss says, and may be difficult for some physicians to part with.

In those cases, daily launderings are ideal for optimizing microbial control, but with costs in mind, once a week is probably the most sensible solution in most instances, be it for hospitals or physician offices, Searfoss observes.

Disinfect non-clinical areas too

A computer keyboard, mouse, smartphone or tablet screen, desktop surfaces and other office items are

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President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice President: Tonya Nevin
1-301-287-2454
tnevin@decisionhealth.com

Content Manager: Karen Long
1-301-287-2331
klong@decisionhealth.com

Editor: A. J. Plunkett
1-301-287-2359
aplunkett@decisionhealth.com

Technical Advisers:
Patton Healthcare Consulting, LLC
Kurt Patton, MS, R.Ph.
Jennifer Cowel, MHA, RN
John Rosing, MHA, FACHE

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well-established breeding grounds for pathogens. Even so, they are not yet intuitive parts of infection control, even in hospitals and surgical and ambulatory centers.

Ingrain this kind of IC in office culture by making it a part of the weekly routine. Keep alcohol wipes, antibacterial cleaning agents and other common sterilization items on hand. And set up office IC as a team sport.

“As often as you take out the trash, do infection control,” Searfoss suggests. “As you close the office on Friday, it’s part of how you close the office. It’s about habit.”

With inexpensive household bacterial culture kits and widely available, informally testing office surfaces can be a way to hold employees accountable — or even make a game out of it.

“This stuff can actually be fun,” Searfoss points out. “Sometimes, doctors are jokers. With a staff of 250, swipe a doctor’s phone and see if it tests positive for MRSA. Have contests.”

Explore these ideas

Other ideas for better infection control around the office, according to Searfoss, include:

- **Purchase antimicrobial keyboard covers** for nonclinical as well as clinical staff. According to online searches, covers cost about \$18 apiece;
- **Switch cleaning products** from week to week or month to month to deter resistance and target different contaminants; and
- **Ramp up hand-washing.** Encourage participation with signs, alcohol-based cleaning stations and other compliance efforts. “We’re still not doing a good job,” Searfoss asserts. *(For tips on improving your hand hygiene program, see IJC 2/8/16, 1/25/16, 1/11/16.)*

Update cleaning crew contracts

For janitorial crews contracted to clean nonclinical areas of an ambulatory center, surgical center or other facility, update contracts with IC standards and check on IC procedures and progress.

“If they are training on security issues, they can train in IC too,” Searfoss says. “Ask vendors what training their employees receive.”

Find out what kind of training, if any, janitorial crews receive and stay in contact with the employer on compliance.

“Get the infection control specifics in the contract,” Searfoss advises. “And talk to them about how they’re doing once a year.” — *Scott Harris (ijc_editors@decisionhealth.com)*

infections

(continued from p. 1)

who responded to a survey said they worked sick at least once in the previous year. While 95.3% of respondents reported they believed working while sick posed a risk to patients, 9.3% admitted they did so at least five times in the same time frame.

Attempting to persevere through an illness rather than calling out sick is a prevalent practice across the workforce. In health care, physicians say that mindset is particularly ingrained.

“I think it extends all the way back to training,” says Dr. Kimberly Becher, a family physician who practices in Clay County, W.Va. “In most medical schools, you can’t miss more than two days on any rotation or you have to repeat it.”

There also is a desire not to leave patients and fellow clinicians in the lurch. The JAMA Pediatrics study found that fear of letting down colleagues and patients, respectively, were the top two reasons for working while sick.

Culture must change

Additionally, nearly half of the study’s respondents cited fear of ostracism as another reason. That speaks to a need to change organizational culture so that calling in sick is an accepted, even desired, action when circumstances justify it.

“People call it the culture of the hero,” explains Kelley Boston, MPH, regulatory and accreditation director at Infection Prevention and Management Associates Inc., a Texas-based medical consultancy, and a member of the communications committee of the Association for Professionals in Infection Control and Epidemiology (APIC), a national professional organization.

“You always want to help. ... But leaders need to articulate that there are no social repercussions for calling in sick. You’re staying home to protect patients. You can think about it in positive ways instead of negative ways. You’re doing what you needed to do.”

Managers from the front line to the C-suite must lead by example, calling in sick themselves when infections are present and offering respect to subordinates who do the same. Moreover, encouraging or even compelling sick employees to go home or stay home is an important managerial task.

“Leading by example is huge,” Becher asserts. “You can’t tell everyone else to go home when you don’t yourself. ... Call people out and make them go home.”

Offering to help pick up the slack left by absent colleagues also can help, as can taking concerted personal responsibility for your own health.

“If I’m working and don’t feel 100%, I’ll have another doctor see patients that are especially immunocompromised,” Becher says. “When others call out, I volunteer to help do their work for them. Step up for others and offer to help.”

Policy changes are necessary too

Culture change can help, but putting the right policies in place may be the key to preventing this risky behavior.

“Staff need clear guidance,” Boston asserts. “What do you do when you’re sick? What is too sick to come to work? Is it a fever? Allergy attack? Vomiting? What are our rules?”

There is no definitive set of standards to determine whether a sick clinician is “safe” to come to work, although typical signs of symptoms of being particularly contagious — fever, diarrhea, vomiting — can be useful bellwethers.

The flu also is one of, if not the, most problematic of the common infectious diseases. As a result, APIC developed a position paper recommending influenza vaccination as a condition of employment for health care personnel, unless the vaccination is medically contraindicated.

“If you work in health care, you’re going to get the flu,” Boston says. “Get the flu vaccine.”

Under Infection Control standard **IC.02.04.01**, hospitals must offer flu vaccinations to licensed independent practitioners and staff. **EP 2** requires that practitioners and staff receive education about prevention measures, transmission and the impact of influenza, with a note that refers to Human Resources standard **HR.01.04.01, EP 4**. That EP says that upon orientation, staff must be told about their specific job

duties related to infection prevention and control and that the orientation must be documented.

Consider these policy components

Components of an effective policy to prevent clinicians from working sick, according to Boston and Becher, include:

- **Revisit the number of leave days allotted to employees**, particularly front-line providers, Boston says. There is no consensus on an appropriate number of days, but more leave days can directly reduce incidents of working sick and indirectly signal support for staying home when sickness calls for it.

- **Group vacation and sick leave days together** so employees have more flexibility in how they use the leave they’ve accrued.

- **Plan ahead.** For example, build cushions into staff margins or set up relationships with staffing agencies during seasons when flu or other illnesses are more prevalent.

- **Create an extra layer of physician backups.** “Have someone on call to be on call,” Becher explains. “Which partner will be available for whom and when?”

- **Set up tools within an electronic health records system so that clinicians can easily communicate remotely with colleagues.** “Our EHR has real-time communication in the system, so there are ways to keep working without direct patient contact,” Becher says.

- **Identify non-clinical tasks for clinicians willing or able to work off site while sick.** “You can get caught up on things like messages and refills at home,” Becher says.

- **Apply policies across the board.** Environmental services staff, lab clinicians and customer service staff are an integral part of the health care team and come into contact with patients and with doctors, nurses and others who are providing more direct, hands-on care.

Bring policy and culture together by communicating expectations and options to employees before they get sick.

“Tell everyone ‘here’s what happens when you’re sick, and what we will do to take care of your colleagues and patients,’” Boston advises. — *Scott Harris (jic_editors@decisionhealth.com)*

Resources:

- ▶ APIC Position Paper: Influenza Vaccination Should Be Condition of Employment (PDF) http://www.apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/APIC_Influenza_Immunization_of_HCP_12711.PDF

EOP

(continued from p. 1)

month, responding to a massive snow storm, a patient surge in the Emergency Department involving more than a dozen local prisoners and a tornado.

Less than two weeks after the tornado, the hospital is in the process now of setting up incident command training to get its new leadership on board with how to activate it and what to do in the event of an emergency, says Kate Lim, the director of quality for the 67-bed facility in Virginia's Northern Neck, about two hours south of Washington, D.C.

On the positive side, in activating and evaluating the effectiveness of their Emergency Operations Plan, which The Joint Commission (TJC) requires at least twice a year, the hospital found that their plans were largely well executed, notes Lim.

“What we did well especially for inclement weather is to review our preparedness plan to ensure we are able to handle the impending disaster, if any,” she observes.

TJC's expectations specific

TJC's Emergency Management standard **EM.01.01.01** calls for hospitals to plan for potential emergencies that might “affect demand for hospital services” and requires hospitals to conduct a hazard vulnerability analysis (HVA) to identify such potentialities. The HVA must include the role community partners will play in an emergency, how to mitigate events in a disaster and a documented inventory of resources and assets that might be needed.

The resulting EOP must be evaluated for effectiveness under **EM.03.01.03**, including activating that plan at least twice a year under **EP 1**. Based on the evaluation, the hospital must also take action to make improvements before the next activation can count toward that twice-a-year requirement.

For Riverside Tappahannock, meeting those particular requirements were not a problem this year.

Under the best circumstances, the activation of the EOP is done through a planned exercise that includes community partners such as first responders and local government, but TJC in a note to EP 1 says a response to an actual emergency will count.

And the hospital had the emergencies to count.

“This year has been quite a challenge for us,” acknowledges Lim.

Hospital's plan now storm-tested

In the Northern Neck, the potential hazards are those faced by many East Coast communities. A half-hour's drive from the Chesapeake Bay, the hospital is more likely to face a hurricane or damaging windstorm than, say, a blinding snowstorm. Other disasters can be of the manmade variety: a chemical or environmental disaster or a major traffic accident in the seven-county, largely rural area served by the acute care hospital.

In the first disaster of 2016 — the historic snowstorm in late January — it wasn't that there was snow, but that there was so much of it, says Lim.

With plenty of warning of the approaching winter storm, the hospital had prepared, evaluating resources at hand and ensuring that there was enough staff scheduled to work. Whether hurricane or snow, the hospital usually has no problem with staffing because workers stay on campus or live so close that transportation is not an issue, Lim says.

But the hospital ended up having to clear 15 inches of snow from the campus, a safety task mandated not only by disaster response but also by Life Safety standard **LS.02.01.20**. The standard calls for hospitals to maintain the integrity of the means of egress; under **EP 13**, exits to the outside must be kept clear of impediments such as snow and ice.

Workers had some issues clearing the sidewalks, Lim admits, but the problems were identified in after-action reports and are being addressed. *(For tips on dealing with snow emergencies, see IJC 2/8/16.)*

Working with law enforcement

Less anticipated was the arrival of 13 inmates who had to be evaluated for injuries after the wreck of a local prison van on Feb. 16.

Not only did the hospital have to care for an influx of patients in the emergency room, but staff also had

to manage care around the large number of state and local law enforcement and emergency medical service personnel who responded to the incident, says Lim.

Given advance notice of the arrival of the inmates via radio from EMS, the hospital was able to prepare the treatment bays in the emergency room for the accident patients. And fortunately, there were only minor injuries.

Upon the arrival of the ambulances, each carrying two prisoners and accompanying guards, law enforcement officials took inmates in two at a time, leaving the other inmates in the ambulances with EMS and law enforcement officers until it was their turn to be evaluated and treated, if necessary, says Lim.

Law enforcement, working with hospital security, was so well organized there was never an issue with the inmates, she notes. The number of law officers on scene, however, did cause a bit of a stir for other visitors and patients in the ER area.

That's where clear communication came into play, Lim observes. Security and hospital leadership maintained a perimeter between the inmates and other visitors and answered the questions and concerns of the other visitors and patients.

It helped that the hospital just a few months before, as one of their required disaster exercises for last year, had drilled on handling a mass casualty event involving a school bus that also included community participation. The hospital also had an active-shooter drill, says Lim.

No sooner had hospital personnel recovered from those back-to-back emergencies when word came on the last Wednesday in February of a storm system moving up through the south that was spawning damaging winds and potentially deadly tornados.

A new month, a new storm

Riverside Tappahannock participates each year along with other hospitals and state and local agencies in mock tornado drills, Lim notes. The hospital is one of eight in the Riverside Health System, which keeps its health care organizations connected in an emergency through a mass communication system.

As storms headed for Virginia that morning, the hospital's director of plant operations, who is also the safety officer, reminded hospital leaders at Riverside Tappahannock to review the tornado response plan with staff.

Just as had been practiced before, the ER manager reviewed resources, went over the plan with staff and divided the ER, which has 10 treatment bays, into defined areas designed to facilitate patient flow, with a lead nurse assigned to each area. Radio contact was established with local EMS officials, just in case.

The hospital had 16 inpatients that day, and the plan called for any patients in rooms with windows to be evacuated into inner hallways to protect them from flying glass and other debris. While the ER is in an inner area away from windows, the plan also has provisions for what to do with people in the reception area, which is vulnerable to flying glass and debris.

Keeping watch

With the incident command team on standby, the director of plant operations and others kept in contact with Riverside system officials and monitored weather reports as the tornado watches and then various tornado warnings were set.

For hours, the hospital team waited, as reports came in of tornados on the ground to the south and west, including one in the late afternoon that killed three people in Waverly, Va., almost two hours south of Tappahannock.

As the last of the storms appeared to move east into the Chesapeake Bay or north toward Washington, D.C., Lim did one last check of the weather and left the hospital about 6:15 p.m., she says.

By the time she reached home and checked the news less than a half-an-hour later, the first reports of a tornado in the Tappahannock area were coming in. The twister, later estimated to be up to the strength of EF3, cut a 28-mile swath to the north of the hospital.

Lim called the hospital's director of plant operations. As planned, when the tornado warning had been issued, nurses and staff moved patients and visitors into the inner protected areas. Incident command had already been set up, and staff, alerted by EMS via radio, was preparing to receive the first patients.

An automatic message was sent to all of Riverside Tappahannock's personnel that the EOP had been activated because of the tornado. Physicians, nurses, surgeons, radiology staffers and others began to show up at the hospital to handle the anticipated patient surge.

Patients were triaged and those with deep wounds or fractures were taken to surgery, while others were treated in the ER or stabilized for transport to more advanced trauma hospitals in the state.

As often happens in tornados, friends, neighbors and families of victims also began showing up at the hospital. But unlike the inmate van wreck several days before, there was little need for crowd control or information management, Lim says. A small community, the visitors waited patiently for information on their loved ones, knowing that it would come eventually, observes Lim.

In all, 19 patients were treated at the ER, with eight ultimately transferred elsewhere, six admitted to the hospital and the rest treated and released.

After-action reports

In the aftermath, just as she had after the other two incidents, Lim launched an after-action evaluation of how the hospital did.

The main lesson learned from that EOP activation involved patient information, Lim says. “One of things we could have done better was the medical records,” she notes.

The hospital’s system depends on a birthdate or other such identifying information to create an electronic health record, and in the emergency of the moment, sometimes that exact information was not available from the patient or the person accompanying them to the ER.

Unable to create electronic medical records, the hospital reverted quickly to paper records. “That’s one thing to improve on,” Lim says. — *A.J. Plunkett (aplunkett@decisionhealth.com)*

Note to readers: Because of space considerations, the continuation of a chart on training and education requirements promised in the last *Inside the Joint Commission* has been moved to an upcoming issue.

HIPAA

Use these tips to handle patient requests for records without violating HIPAA

Prepare for more patients and their families to ask for copies of their medical records. HHS’ Office for Civil Rights (OCR) recently issued guidance reminding consumers they’re entitled to the documentation.





In addition, providers should understand that OCR is going to be more likely to punish those who don’t comply. OCR’s guidance should serve as a road map for handling medical records requests — and excuses for failing to follow that guidance will not be tolerated, says attorney Elizabeth Litten with Fox Rothschild in Princeton, N.J.

Providers that don’t comply could face financial penalties. The penalties vary based on the extent of the violation and the intent.

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PAS 2016

For many years, rather than punishing providers who refused to give medical records to patients who sought them, OCR offered education.

But now that OCR has issued the new guidance, providers have no excuse for errors.

They “need to be primed for this,” warns attorney Michael Kline, also with Fox Rothschild. Providers that don’t comply will be “set up for enforcement actions.”

HIPAA gave patients the right to access their health records when the law was first enacted in 1996. However, many providers have refused to honor these requests, much to OCR’s frustration. The office notes that this is one of the five top complaints it receives, according to Deven McGraw, deputy director of OCR’s health information privacy division.

Much of the problem stems from providers’ reluctance to share information that could be used against them in court and/or fear of violating HIPAA by sharing too much, Litten says.

Major components of OCR’s road map

Guidance released Jan. 7 is more detailed and reiterates the major components of the rights to access under HIPAA. These include:

- Patients and their personal representatives (such as a legally appointed guardian or executor of a patient’s estate) are entitled access to almost all of their records in a provider’s possession, such as medical, billing and payment information, also called a “designated record set.”

They’re not entitled some data, such as psychotherapy notes or information compiled by the provider for anticipation or use in a civil, criminal or administrative proceeding. A request can be denied in limited situations.

- Providers need to take reasonable steps to verify the identity of the person requesting access but not steps so onerous that it would make it difficult for the person to obtain the records. Examples of what would be unreasonable: Requiring requests only via a portal because not all patients have Internet service or requiring a response by mail because patients may want their information sooner.

- The record needs to be provided in the form and format requested, if readily producible that way. If not, it needs to be produced in an alternative, agreed-to form and format. A summary or explanation is acceptable, so

long as the patient chooses to receive the summary or explanation and agrees to pay any fees for it.

- The provider can charge only the reasonable costs for the labor to make the copy, supplies for creating it, postage if it’s being mailed and preparation for any summary or explanation.

- The patient must receive the record within 30 days of the request. If the provider can’t meet the deadline, it’s entitled to a one-time 30-day extension so long as it notifies the patient why it can’t make the initial deadline.

- The patient can direct the provider to send the record to a third party, so long as that request is in writing, signed by the patient and identifies where the record is to be sent.

Tips to comply with HIPAA

- **Make sure you keep only appropriate information in a patient’s file.** For instance, if your facility reasonably anticipates being sued and has begun to compile documents to defend itself, those records should not be in the record that the patient can request, Litten says.

- **Make sure any business associate holding patient records on your behalf is familiar with the rules.** The right to access extends not only to providers and other covered entities but also to their business associates, such as a billing or storage company.

- **Tread carefully if you want to ask patients why they want their records.** You’re not supposed to ask that, and you can’t penalize patients by withholding their records if, say, you’re concerned that they’ll be used against you in a lawsuit, Kline says. If you do want to ask that, make sure that patients understand that such information is to be provided voluntarily.

- **Use caution when calculating costs for copies.**

While HIPAA limits the costs that can be charged for records, states’ laws set those fees, and they vary significantly, Litten says. HIPAA and state requirements need to be taken into account and reconciled. — *Marla Durben Hirsch (ijc_editors@decisionhealth.com)*

Resources:

- ▶ OCR guidance for patients seeking copies of medical records: <http://1.usa.gov/1K0jEkj>

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