MU MONTHLY

August 2013

VA AND IHS COLLABORATE ON BCMA IMPLEMENTATIONS

In CMS's *Stage 2 Final Rule*, one of the core objectives specifies that EHs and CAHs should automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR). Specifically, the measure reads:

> More than 10 percent of medication orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.

(Note that any EH or CAH with an average daily inpatient census of fewer than 10 patients may be excluded from meeting this measure.)

As part of ongoing efforts to address the measure and thus promote Meaningful Use, IHS's EHR Deployment Team, Veterans Health Administration's (VHA) Bar Code Resource Office (BCRO), VHA Employee Education System (EES), and VA's OIT are moving forward with their plans to implement Bar Code Medication Administration (BCMA) within the IHS System in 2013. BCMA assistive technology is a software application used by the VHA to document medication administration and reduce medication errors. Implementing this technology in IHS/tribal hospitals will assist IHS and tribes in meeting MU Stage 2 requirements.

In FY 2013, IHS intends to implement BCMA in two sites, one of which is Cherokee Indian Hospital Authority in Cherokee, N.C., where a previous version of BCMA had been in operation. During the week of June 24, the site received remote support for their configuration, test, and upgrade. Three weeks later, during the week of July 15, representatives from the IHS OIT EHR Deployment Team, VA and VHA provided on-site support for staff training and Go-Live.

Contents of This Issue

VA and IHS Collaborate on BCMA Implementations 1

Making Patient Records Secure through Risk Analysis 2

Important Dates 2

If you'd like to see a specific topic covered, feel free to email coleen.maddy@ihs.gov with your suggestion.

The second tribal site chosen to implement BCMA during FY 2013 is Choctaw Nation Health Services Authority in Talihina, Okla. Since Choctaw is not running a current version of BCMA, the facility will undergo the entire BCMA configuration process, including drug file cleanup, quality/performance improvement process, installation/configuration of scanning equipment, and configuration/test activities (scheduled for the week of September 9). During the week of September 16, representatives from the VA, VHA, and the IHS OIT EHR Deployment Team will provide on-site support for the facility's training and Go-Live activities.

Both facilities will participate in bi-monthly web-based conference calls throughout FY 2013 as a means of follow-up for the BCMA implementations. IHS OIT has forecasted that 13 of 14 IHS/Tribal facilities will be required to implement BCMA in FY 14 to meet Stage 2 Meaningful Use. The VA/IHS BCMA collaboration is a highly valued partnership that not only benefits IHS and Tribal customers but also improves the administration safety of patient medications in American Indian/ Alaskan Native hospital settings.

Reference: VA Office of Informatics and Analytics (Summer 2013). Department of Veterans Affairs (VA) and Indian Health Service (IHS) Bar Code Medication Administration (BCMA) Collaboration Effort.

Retrieved on July 23, 2013, from https://VHA10P2ABCROMESSENGER@va.gov.

MAKING PATIENT RECORDS SECURE THROUGH RISK ANALYSIS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule 45 Code of Federal Regulations (CFR) 164.308(a)(1)(ii)(A) requires medical entities to "conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI) held by the covered entity." Likewise, one of the MU core objectives requires medical entities to conduct or review a security risk analysis in accordance with the requirement under 45 CFR 164.308(a)(1), implement security updates as necessary, and correct identified security deficiencies as part of its risk management process. Simply stated, medical entities must perform a security review of their electronic health care system and correct any identified deficiencies. This review must be done on an annual basis and includes the electronic health record, internal network, external connections, and software and hardware that are interconnected. Any deficiencies or vulnerabilities must be prioritized and corrective plans created. Management must review and approve all corrective action plans.

Within IHS, the OIT Division of Information Security created two templates. The first one, called the Risk Analysis Template, should be used for internal D1 active directory sites. This template will walk the site's risk analysis team through a series of checks and provide many of the enterprise-level tools and reports needed for completion. The second one, called the External Risk Analysis Template, should be used for any site not on the D1 active directory domain and can be found at http://www.ihs.gov/meaningfuluse/index.cfm?module=toolkit (scroll to the bottom of the page). The External Risk Analysis will walk risk analysis team members through the same series of checks, but it does not provide site-specific tools and cannot provide specific practices. Tribal and urban sites that have adopted IHS enterprise policies should include those polices with any site-specific policies in use.

After completing the Risk Analysis Template, it becomes the Risk Analysis Report—a roadmap for mitigating any identified deficiencies or vulnerabilities.

The overarching goal is to ensure patients that IHS adheres to industry standards in protecting their information. Patients who feel their electronic health information is secure tend to provide a more complete history to the medical personnel treating them. Better histories allow staff to provide better patient care, which is our ultimate purpose.

IMPORTANT DATES

EHs

- **September 30, 2013:** FY 2013 reporting year ends for EHs/CAHs
- **October 1, 2013:** Reporting period begins for EHs for FY 2014 (90 days for all participants, regardless of stage)
- **November 30, 2013:** Last day EHs can register and attest to receive an incentive payment for FY 2013

EPs

- **October 3, 2013:** Last day for EPs in their first year of Stage 1 to begin their 90-day reporting period for CY 2013 (EPs in their second or third participation year must demonstrate MU for the entire CY)
- **December 31, 2013:** CY 2013 reporting year ends for EPs
- **January 1, 2014:** Reporting period begins for EPs for CY 2014 (90 days for all participants, regardless of stage)
- **February 28, 2014:** Last day EPs can register and attest to receive an incentive payment for CY 2013

Note: 2014 is the last year that EPs can begin the Medicare EHR Incentive Program.