

**Testimony to the
National Committee on Vital and Health Statistics
Subcommittee on Privacy and Confidentiality
September 10, 2002, Boston, Massachusetts**

Good afternoon, my name is James Coffee. I am the Director of Information Systems and Technology for the Greater Lawrence Family Health Center (GLFHC) in Lawrence Massachusetts. I am also co-chair of the CHC HIPAA Collaborative, a group of health center members of the Massachusetts League of Community Health Centers who are working together to identify a common approach to all the elements of HIPAA. The Collaborative was formed last year in response to the impending compliance dates for the published Rules and we found early on that this would prove to be a daunting project. Although each rule brings unique challenges, the one that we face with greatest trepidation at present is the Privacy Rule. While my testimony reflects many conversations with health center colleagues and input from many centers across the state, I do not claim that it represents the full range of issues and concerns of all health centers. Thank you for hearing and accepting my testimony.

Community health centers are community-based and community-governed non-profit organizations; in Massachusetts, community health centers provide services to approximately ten percent of the state's population, roughly 600,000 patients, at 104 service sites. Community health centers have a collective mission to: remove barriers to accessing health care; provide high-quality, culturally sensitive, comprehensive primary care and related services; and - by doing both these things - improve individual and community health. Barriers to care that health centers work to remove may be financial, geographic, or ethnic, linguistic or cultural.

I would like to give you a little background on my organization. GLFHC has been providing care in the Merrimack Valley, specifically in Lawrence Massachusetts for 22 years. Our current active patient base of 35,000 people represents nearly half the population of the city of Lawrence and makes GLFHC one of the largest health centers in the state. We have four primary care sites, and eleven other service sites that include a Prevention and Education Library, an AHEC (Area Health Education Center), and a CDC 2010 Project focusing on diabetes and coronary health in a Latino Population. HIPAA is very much on our minds throughout the organization.

As the Director of Information Systems and Technology, it has fallen to my department to spearhead the response to HIPAA and HIPAA compliance. This placement of HIPAA responsibility in the I.S. or I.T. departments appears to be the norm for health centers and I expect that this is also true for other provider organizations. The reason may be as simple as the fact that the Transaction Rule was the first to be published, but it is also obvious that many elements of HIPAA depend directly and indirectly on information technology decisions and changes. My co-chairs on the CHC HIPAA Collaborative are I.T. professionals like myself and it is still the perception in many quarters that all aspects of compliance will be addressed by I.T; we know, as I am sure you know, that there is nothing further from the truth.

Now I would like to directly address the issue of the Privacy Rule. The Privacy Rule was published in final form on August 14, 2002; that leaves eight months to bring all of our organizations into compliance, which is not a long period of time. Although the proposed rule has been public for some time, according to the legislation there should be twenty-four months between the publishing of the final rule and the compliance date. We currently have eight months, and during those eight months, we also must ramp up testing to meet the compliance deadlines of the Transaction Rule with our many private insurance payers, as well as Medicare and Medicaid.

Community health centers have several HIPAA-related challenges that may not be faced to the same degree by other types of provider organizations.

One is our increasingly diverse and multicultural patient population, which includes refugees and undocumented persons. Through multilingual staff and translation services, Massachusetts health centers provide services to a patient population speaking nearly 40 languages, and many patients are illiterate. Some health centers must translate documentation into as many as twenty languages, which is very costly. In addition, many health centers provide services to homeless populations or to people who are substance abusing or are mentally ill. Mentally ill patients already find navigating the health care system especially difficult - requiring them to read and understand language and concepts that many of us find hard to comprehend may cause some patients to become lost to care.

How do we accurately express complicated concepts unique to the U.S. health care system (specifically within the Privacy Rule) in languages that may not contain equivalent terms? Communicating the intent and rights of the Privacy Rule to patients who are anxious about their care is a delicate process. Patients may end up not understanding what they are signing. As I mentioned, health centers' explicit mission includes removing barriers to accessing care whether these barriers are income, geography, insured status, or ethnic, linguistic or cultural background. Centers are concerned that compliance with the Rule does not itself create barriers to care by creating confusion and anxiety in patients who, for a variety of reasons, have trouble understanding what is being communicated.

Staffing and staff training is a very difficult issue. Like other safety net providers, community health centers hire staff from the local community, both because it is appropriate to providing culturally sensitive environments of care for patients and because it makes the center a fuller resource to its community as a local employer. Many staff members who come from the communities that they serve speak English as a second language, and have difficulty with legal concepts that pertain to health care. In addition, one health center provides services to homeless people at seventy sites - training staff at seventy service sites, and developing and maintaining a viable monitoring system for authorization and access tracking, seems frankly overwhelming given the time frame. Many community health centers experience high levels of staff turnover; my own health center has experienced staff turnover rates as high as 22%. The need for constant and on-going training will take valuable resources from other areas and from patient services.

Like other safety-net providers in Massachusetts and other states, health centers are struggling with increasing demand for services and decreasing and less stable reimbursement. With cuts in funding from the FY03 state budget, and lower reimbursement from insurers including Medicare and Medicaid, health centers must be even more vigilant in watching our bottom lines and making best use of limited dollars. Compliance costs are coming at the health centers at a time when maintaining services is increasingly problematic. Community health centers have limited staff resources for writing policies and other documents, and updating, building, and monitoring the systems that will need to be put into place to reach compliance. In most health centers, many staff wear multiple hats and often manage projects that are not obviously connected to a person's title. Many staff responsible for HIPAA compliance do not have line authority over other staff affected by Privacy Rule requirements. In many centers, the I.T

Department and / or the H.R. Department is one person; the Security Officer may also be the Privacy Officer and / or the Corporate Compliance Officer.

Many community health centers remain at the mercy of their practice management system software vendors, who at this time are focused on the Transaction Rule and its impending deadlines. It is important to remember that - compliance or not - the Transaction Rule will affect all our bottom lines. The Protected Health Information concept in the Privacy Rule is fairly straightforward and easy to understand: just don't give out patient identifiable information. It is the implementation details that will prove difficult: tracking the granting of and revocation of consent for care will require extensive and multiple system changes. I know that my system vendor is not currently looking at how to change his product for the tracking of consents, and is just starting to look at audit trails of record access; as I said, I am at his mercy as to when this feature will be designed, tested and available and I don't know the price. And many health center organizations are appropriately moving towards an Electronic Medical Record, which entails enormous system and organizational challenges, and requires priority status as an IS project.

I would like to offer a few comments on some of the specific questions I understood the Subcommittee to have an interest in.

Who needs technical assistance and or implementation guidance? What type? What difficulties are providers and plans experiencing coming into compliance?

I believe that the provider community needs more guidance with the regulations from HHS. A big part of the process of compliance is the interpretation of the Rules, as many parts are ambiguous and could lend themselves to many interpretations - and every consultant is entitled to their own opinion as well. Having a standardized GAP assessment tool would help move implementation along. Resources for technical assistance to train staff are definitely needed and there are many distinct groups of staff that need training including front desk staff, line clinicians, and senior managers. Since all provider organizations are looking toward the same goals, having the Federal Government provide resources for engaging value-added vendors, products, and services, would be invaluable.

The regulations talk about a "good faith effort": what is a good faith effort? The term is open to many interpretations. One organization has developed a draft privacy notice in excess of ten pages that staff felt was needed to cover all the bases and to demonstrate a good faith effort. Obviously, this is far too complicated a notice to give to the average patient.

What best practices are being done in the industry?

For community health centers I believe developing the CHC HIPAA Collaborative has been a "best practice". It was created because there were issues specific to health centers as a provider group including the fact that we are very short on staff and cash, both of which are needed to implement the HIPAA Privacy Rule. The idea was that by collaborating, we would not all have to tackle the whole of HIPAA alone. Individual staff could give more attention to an area with which we are more familiar, and use the resources of other health centers to help in areas with which we are not as familiar. There are several working groups like the CHC HIPAA Collaborative that have formed to support HIPAA implementation, including the HIPAA Education Coordinating Committee (HECC), supported by the Massachusetts Health Data Consortium; and the New England HIPAA Workgroup (NEHW). CHC HIPAA Collaborative members are also members of these groups and facilitate the exchange of information to the Collaborative. I do not say this to criticize any of these efforts, but with HIPAA compliance dates looming, there is now so much activity that it can be difficult if not impossible to work effectively with all available resources and or potential partners.

What resources (especially no or low cost ones) are entities relying upon to come into compliance? What helpful websites are entities using? What other work has been done and is in the public domain?

The resources that the CHC HIPAA Collaborative uses include: our own web site for posting messages, discussion threads, and document templates created by the group; the Massachusetts Health Data Consortium website and materials from the HECC, NEHW, and WEDI-SNIP; materials from a recent Health Care Compliance Association conference in Boston, the “HIPAA-DOCS” website; and the HHS, CMS, and OCR web sites which are all good resources – they are well-organized and contain timely information.

How are covered entities approaching the Privacy Rule training mandate?

The CHC HIPAA Collaborative formed 4 workgroups, to correspond to the Transactions and Codesets, Privacy, Security and Training elements of HIPAA. The Training Workgroup has been developing training materials based on the Rules as they are published. We are using Power Point software and tailoring the presentations to different health center audiences; such as senior management, to include the boards of directors; front desk, line employees, physicians and other clinicians. These presentations are provided to the Collaborative’s membership through our website.

What is the accuracy and quality of vendors and consulting organizations?

The accuracy and quality of vendors and consultants varies widely. As is obvious HIPAA has generated its own cottage industry of consultants and new products. We have joked about the materials claiming to “solve your HIPPA requirements.” Through the CHC HIPAA Collaborative workgroups and meetings of the co-chairs, we have tried to wade through mountains of vendor information in an attempt to keep each center from having to evaluate each vendor and to weed out those that do not present a clear solution or direction. Unfortunately, health centers have had experience with promises that were not kept, and products that did not exist. With the passage of time, more vendors are offering more products and services, and evaluating the quality of vendors or products is taking increasing amounts of time just as the compliance timeline is shortening. No one can really claim a long track record of providing successful HIPAA solutions to customers precisely because HIPAA, and the final Rules of its component parts, is a new mandate.

In closing I would like to leave you with several thoughts. First, HIPAA is still thought by many in the industry to be an Information Technology issue, when in fact it is a health care issue. The Federal Government mandates providers to train employees and become compliant with the regulations, but in the end health centers will be training our patients and the general public as well. The Federal Government should take more steps to educate the public directly on the basic principles behind the legislation and the regulations. Patients already think that health care is buried under a mountain of paper, and now we are going to be adding to it. With staff at our health centers working at and sometimes beyond their limits, it is often difficult to look to the future positively or see the positive purpose behind another Federal Regulation. Speaking for health centers, we need more resources for staff and systems to really “do it right”; eight months does not provide enough time to gain an understanding of the regulations, write policies and procedures, and train staff and patients, and also prepare to test HIPAA-compliant transactions with all our vendors.

This concludes my testimony, and thank you for this opportunity to provide it. I am happy to answer any questions I can.