Quest for Patients' Trust Only Just Begun

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by Dan Rode, MBA, FHFMA

Some saw the final rule on HIPAA privacy, published in August 2002, as a crowning achievement after years of efforts to secure patient privacy. Others took a more negative view, claiming that big business had finally ensured unhampered access to patient data. HIM professionals, however, should see the final rule as an acknowledgment of the crucial role of HIM in privacy, confidentiality, and release of information functions--and in helping the healthcare industry reestablish trust with patients.

It is also clear that while the HIPAA privacy rule is a foothold, the struggle to maximize patient trust and preserve necessary confidentiality, while also implementing a national healthcare information infrastructure, will be an opportunity for HIM involvement in the years to come.

All in Favor?

The final rule reflects many of the changes proposed by the Bush administration in March 2002. Most of the more than 11,000 comments appeared to be in favor of the proposed changes, with the only modifications generally appearing where the Office for Civil Rights (OCR) had asked specifically for suggestions, such as in the area of a limited data set. Much press was given to the decision to make "consent" optional for treatment, payment, and operations as well as for the use of information for marketing. But largely, the media ignored the changes that helped facilitate better protections for the individual, leaving the public waiting to see what the industry will do next.

The OCR has determined that the provider's delivery of its notice of privacy practices will now replace a consent requirement and serve as the "initial moment"--the point when some understanding will exist between the patient and the provider on the privacy practices of the provider and the individual rights of the patient. The new requirement of a "good faith" delivery of the notice and a signed acknowledgment of receipt (not necessarily understanding) by the patient demonstrates that this initial moment occurred.

How a healthcare provider writes its notice, delivers it to the patient, and receives the patient's acknowledgment of receipt will establish a basis for trust. In April 2003, the press and public interest groups will be making patients aware of their right to receive this notice, and provider staff members will be expected to respond to questions concerning not only the notice itself but also the privacy practices it describes.

Similarly, the modified privacy rule has clarified and to some degree simplified the authorization and accounting requirements. But complying with these requirements and interacting with the patient will be key to establishing trust in the provider's protection of privacy. Both these requirements are generally processed in an organization's HIM department; therefore, that department is key to establishing this trust.

Remember, the rule itself was never written to include the internal requirement for HIM involvement, nor do its authors fully understand the role that HIM has played in the past regarding releases of information and privacy protection. Nevertheless, HIM directors and department staff must move forward to establish practices and policies that will meet these requirements.

Minimum Necessary

A key issue in the modifications involves the "minimum necessary" requirement. The modifications note that when there is appropriate patient authorization, the concept of minimum necessary is waived. But the preamble to the modifications notes that the provider has the authority to refuse to accept an authorization, and the provider also has the responsibility to ensure that authorizations are written and processed correctly.

Clearly, there is an expectation that someone at the provider site will exercise judgment on just how much information to provide under the use and disclosure requirements, especially outside the area of treatment. This is clearly an HIM responsibility. Given the lack of preemption of state law, it calls for guidance from those implementing both HIPAA and state requirements.

The OCR will be watching to see how providers handle their responsibilities in the area of minimum necessary and authorization processing. HIM departments must ensure that any observation only highlights the values of our education, certification, and experience.

Statements for Now and Later

In September, the AHIMA Board of Directors approved a position statement on privacy and confidentiality. The position statement, which is posted at www.ahima.org and will be published in the January *Journal of AHIMA*, acknowledges developments in the area of privacy and confidentiality, the role of HIM, and what needs to happen in the future. It does not accept that the HIPAA rule is the final declaration on an individual's privacy. Rather, it notes that today, trust has not been established, healthcare information is in a period of transition (paper to electronic), and the HIPAA privacy rule has created a "floor for privacy protection rather than raised it to a national ceiling."

The AHIMA statement also identifies when privacy and confidentiality of health information will be achieved. Even under HIPAA, it has taken almost seven years to implement the beginnings of a national privacy requirement. That national requirement, the privacy rule, is just the beginning of rebuilding trust with patients. While HIM professionals have worked to ensure as much protection of an individual's health information privacy and confidentiality as possible, a new challenge to reestablish trust under HIPAA (and improve HIPAA itself) awaits us.

In 2003, look to the Association to assist you in the implementation of HIPAA and to work with you to ensure an even better understanding of privacy and confidentiality practices in the future.

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