HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

Compliance TODAY

February 2016

A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

WWW.HCCA-INFO.ORG

Managing FCPA risks in healthcare

an interview with Tom Fox

Principal, Advanced Compliance

See page 16

by Kimberly Danielson, CHC, CHRC and Walter E. Johnson, CHC, CCEP-I, CHPC

Too close for comfort: Employees (and their families) as patients

» Treating employees as patients can provide significant challenges and risks.
» Many employers accept the challenges and risks to increase revenue.
» Issues with HIPAA, potential conflicts of interest, and curb-siding may arise.
» Collaboration with counsel, Human Resources, Nursing, and physician leadership is important when assessing your organization's challenges.
» Policies, processes, and education are key to successful employee-patient relationships.

Kimberly Danielson *(kimberly_danielson@ssmhc.com), is Regional Corporate Responsibility Officer and HIPAA Privacy Officer for SSM Health's Oklahoma Hospitals and Healthplexes in Oklahoma City.* ***Walter E. Johnson*** *(walter@wejohnson.org) is a Compliance Consultant in North Potomac, MD.*
/in/walter16 *@walter_johnson1*

Every healthcare provider, whether a sole practitioner or a large nationwide healthcare system, has been faced with the issue of whether or not to treat an employee as a patient. Some physician's groups, facilities, and even large healthcare systems financially incentivize this practice or have insurance plans that require employees to seek treatment at their own facility or within their healthcare system, or else pay more expensive out-of-network rates. Whatever operational decisions have been made in this regard, it can (and most certainly will) open up a plethora of compliance challenges. At first glance, operational leadership may shrug off treating co-workers or employees as trivial and become more focused on the financial benefits. However, by assessing the risk and establishing internal controls, compliance officers (CO) on the front end, may help prevent significant problems on the back end.

HIPAA implications


Danielson


Johnson

When COs ponder employees as patients, the first thing that comes to mind are various potential risks related to the Health Insurance Portability and Accountability Act (HIPAA).[1] Some HIPAA issues seem fairly obvious, but others not so much. Certainly there are more HIPAA pitfalls than one could ever possibly begin to list, but here are a few of the more common HIPAA issues that can arise.

Co-worker snooping

Many facilities have policies that prohibit snooping, yet employee snooping and insider misuse of information remain among the biggest privacy threats in healthcare.[2] Here are some common scenarios with employee-patient versus employee personnel issues:

- If an employee becomes extremely ill at work and is taken to the emergency department (ED) within your facility, obviously the personnel records should stay completely separate from the electronic

medical record (EMR) and should remain private. However, it is not uncommon for HR personnel to question whether it is appropriate to share "medical information" with an emergency contact listed in the HR file (e.g., "Mr. Jones, your wife collapsed in the clinic and is in route to our emergency department at this time.") or to look into the employee's EMR to assist with staffing needs. This seems clear-cut to a HIPAA Privacy Officer; it can be very confusing to those outside the compliance realm.

- Concerned employees are seeking guidance on whether they are allowed to go check on or visit an employee who has been taken to your ED or urgent care for treatment during a work-shift, or they want to log into the EMR to see if their co-worker (the employee-patient) was admitted.

Gaining inappropriate knowledge about co-workers

- An office manager requests permission to review an employee's EMR, because she doesn't believe that the employee-patient should have been off work for a certain amount of time. Again, this sounds incredulous to someone in the Compliance profession, but it has happened and no doubt will happen again.
- Co-workers are able to deduce (correctly or incorrectly) a diagnosis of the employee-patient being seen by a certain specialist or in a particular location in the hospital.
- Employees recognizing and/or stopping to talk to an employee-patient during an appointment or an inpatient stay.

Designating records as "sensitive" or "confidential"

Many organizations mark the medical records of their employees as sensitive or confidential, others only treat the medical records of senior leaders as confidential, and some organizations don't specifically designate either as confidential. Strong arguments can be made for any of the three choices. The most common complaint in this regard is that it is sending the wrong message to employees and patients if their records are not safe from snoopers unless they are marked "confidential"? (i.e., How can patients feel that their medical records are safe from snoopers if senior leaders don't even trust a facility's own staff not to snoop?)

Complicating tenuous employee-family member-patient situations

One investigation involved an 18-year-old patient who was the son of an employee. This young man specifically presented a facility with a written request ardently stating that his mother (a facility employee) was not to access the son's medical records under any circumstances, and the son asked for continuous monitoring of the record. The mother was advised verbally of this request. Failing to adhere, the mother was given a written warning. When an audit revealed the unauthorized access a second time, the mother was terminated from her position. Later that week, the son passed away. The mother had known that her son was extremely ill and wanted to be able to track his treatment since they were estranged.

Self-looking

Employees often access their own EMR (i.e., "self-looking") for a number of reasons. Even facilities that have a patient portal still experience the employees going into their EMR rather than utilizing their patient portal. Sometimes it can be as innocent as wanting to print out their medication lists. Some facilities allow this, others don't. Miscellaneous studies show that about half of all facilities that prohibit self-looking actually conduct routine audits for this type of access. One of the most common compliance issues that arises out

of self-looking is that employees look up test results for themselves or their minor children. Although this is not a HIPAA violation, it is a policy violation, if the facility does not allow it.

Here's an example from personal experience: An employee announced to coworkers that she was dying and disrupted the entire work unit for the day. This disruption included coworkers crying, only to be told later that she had misread the test results and that she was actually completely fine. Although this case is extreme, employees looking up and interpreting their own test results is quite common and can be very risky.

Other issues include employees who looked up test results for themselves or their minor children, even though they knew it is against policy (and not a HIPAA violation), because they couldn't wait until the doctor provided the test results. This type of "I knew it was wrong, but I was just so worried that I couldn't control myself" mentality is often overlooked or excused with few or no ramifications from operational leadership. In some cases, the CO is made out to be insensitive or overzealous for bringing the policy violation to the forefront.

The final example of a high risk of self-looking is another egregious scenario, but possible at any facility. A couple of years ago, an employee altered her medical records to reflect that she was prescribed a medication and she documented side-effects to the medication throughout office visits. Afterwards, the employee printed the records and provided them to an attorney, so that she could join a class action lawsuit against a pharmaceutical manufacturer. Because the large physician practice didn't establish an audit for self-looking or have any internal controls to prevent an employee from altering their own record, this behavior was not caught until much later. Although this is flagrantly dishonest behavior, it represents another possible risk to consider, if employees are able to alter their own medical records.

Potential medical conflict of interest

Another possible risk to ponder is whether or not the treatment of the employee-patient lends itself to a medical conflict of interest. The American Medical Association's Opinion 8.19, entitled: "Self-Treatment or Treatment of Immediate Family Members" advises physicians to not treat themselves or family members.[3] Although employees or co-workers of physicians are not mentioned in Opinion 8.19, many of the reasons stated by the AMA still seem to apply to the situation of treating a co-worker or employee as a patient. Those include but are certainly not limited to the following:

Although employees or co-workers of physicians are not mentioned in Opinion 8.19, many of the reasons stated… still seem to apply…

- Professional objectivity may be compromised.
- The physician's personal feelings may unduly influence his/her professional medical judgment, thereby interfering with the care being delivered.
- Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination.
- Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination.
- When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training.

- If tensions develop, perhaps as a result of a negative medical outcome, such difficulties may be carried over.
- Concerns regarding patient autonomy and informed consent are also relevant.
- An employee-patient may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

Curb-siding

When it comes to treating employees as patients, there is a term all too familiar with physicians. "Curb-siding" (also known as hallway medicine) occurs when a person is seeking a diagnosis or prescription refill without an appointment. If a physician is curb-sided by an employee whom they routinely work with, it can put the physician in an awkward position, but it can also create patient safety issues as well. Many physicians have experienced aggressive employees tracking them down in all areas of the hospital for unofficial medical treatment. Physicians may complain of feeling cornered, harassed, or even pressured to provide a diagnosis, treatment, or prescription without the ability to perform a thorough physical examination or review a complete history and medications. Curb-siding limits the physician's ability to simultaneously review and/or update the medical record.[4] Not only is this uncomfortable for the physicians, but it presents an extremely dangerous risk—particularly when medications are being prescribed. Some facilities prohibit curb-siding and require providers to report policy offenders.[5]

The patient experience

Oddly, on the other side of this dilemma—and the exact opposite of curb-siding—is the common complaint lodged by employee-patients claiming that they felt rushed or that they wound up "talking shop" during the appointment. Imagine that, as a compliance officer, you are in the middle of a gynecological exam and your physician asks you for guidance on a compliance issue. Rarely will an employee brag that they felt like they received preferential treatment, because they are "one of the family."

Because employee-patients' confidentiality is at greater risk than that of an average patient, they may not feel that they can be forthcoming with the physician and/or facility about their medical history, sexual history, substance abuse, alcohol consumption, or even smoking.[6]

Employee-patients may also feel less apt to complain. Imagine an issue related to incorrect claims processing or billing wherein the employee-patient receives an Explanations of Benefits (EOB) and realizes that it is fraught with errors or includes billing for services not rendered, but the employee-patient doesn't want to get their co-worker in trouble. And, because it didn't change the amount of the employee-patient's copay, they remain quiet.

Other challenges that can arise from employee-patient relationships

Although one can never anticipate all of the scenarios or challenges that could potentially arise from the treatment of the employee-patient relationship, other issues can certainly create a cause for concern:

- Does the facility/provider offer discounts for these employee-patients?
  - If so, is this formally or informally?
  - Are these discounts distributed evenly across the board?
  - Are the employee-patients being incentivized to come here because of the discount?
- Should the appointment be allowed on or off the clock?
  - If off the clock, do the employees wait in the lobby area?
  - If off the clock, what if the employee is needed to perform a job-related function (e.g., answering a phone)?

- Billing issues
  - Job security issues for employees who owe large amounts or are sent to collections
  - Conflicts of interest if employees have payment plans and payroll deductions to pay off larger balances
- What happens when a physician disaffiliates from the organization?
  - Employee-patients must change physicians or not receive the "in-network" benefits when their physician leaves the organization
- Employees coding their own claims
- Employees calling in their own prescriptions
- Employees calling in prescriptions for family members
- Potential malpractice issues
- Insider knowledge of a practice or facility's weaknesses

With so many risks and challenges, can either side (employee-patient or physician/provider) really treat an employee-patient relationship objectively? Yes, but with certain well-defined processes, education, and behavioral expectations.

One of the key takeaways from this article is that it is imperative that employee-patients feel that they are able to openly raise concerns without any fear of retaliation or ramifications. It is also imperative that employee-patients should not just "feel free" but should actually be encouraged and praised for bringing forth any issues with regard to incorrect claims processing or any other compliance issue that they may witness. And finally, both sides must anticipate some of the challenges that this employee-patient relationship presents and be well-prepared for those challenges.

What can COs do specifically?

Risk assessment

To estimate the amount of risk facing their organization, COs should conduct a targeted risk assessment, which should isolate each of the identified risk categories instead of maintaining one large category. Some of the tasks may be similar to those mentioned in a privacy and security risk assessment, and that's okay. For COs with limited resources, the risk assessment can be separated into phases. For example, the initial phase assesses risk from a broad perspective and the second phase focuses on the details of each risk category. Identify subject matter experts who can provide responses to the risk assessment.

Collaborating with HR, general counsel, nursing leadership, and physician leadership is beneficial. Work with the Information Technology (IT) staff to determine their ability to generate reports of employees accessing their own records or, at the very least, altering their own records. An ideal forum for this discussion may be at a Compliance Committee meeting. Although some subject matter expects may not be members, they can be invited to a Compliance Committee workgroup identified for assistance with identifying and remediating or minimizing potential risks.

Be aware that, depending on the organization's culture, the risk assessment may not capture the risks associated with social behavior. For example, an employee's disappointment or reaction to not being included on a physician's panel when their coworker was included can lead to questions of inconsistency, at minimal. Morale and HR issues may develop that may begin reducing the ethical culture. Evaluating the compliance infrastructure before and after remediation can provide insight to program effectiveness.

Policy and procedure

The risk assessment will confirm whether or not a policy and procedure exists for this type of relationship. If it does, the CO should review and determine whether revisions are necessary to provide guidance on potential

risks. Ensure the policy and procedure are easily accessible and that compliance with those policies, as well as behavioral expectations, are communicated to both providers and employees.

Auditing and monitoring

The CO should include Employees as Patients on the auditing and monitoring work plan. They should document the audit parameters, sample size, and review frequency for routine and non-routine audits. When conducting audits, COs should review billing and coding. Among errors and inconsistencies, review items that appear to be of self-interest and require further documentation or investigation.[7]

Internal controls

As mentioned above, collaborating with IT and Internal Audit is essential. IT can help with monitoring access by establishing system indicators and routinely generating queries to assist with analysis. These can include co-worker snooping, self-looking, and altering one's own EMR. Internal Audit can provide assistance establishing internal controls. The information provided by both departments can be shared during Compliance Committee meetings, and compliance reports should be shared with the board of directors.

Training

Routine training is necessary to eventually improve the ethical culture. Training heightens awareness among all employees and emphasizes the organization's commitment to ethical business behavior. COs should incorporate the topic of employees and family members as patients in the annual compliance training and conduct in-person target-based training. Employees should be aware that there will be audits and ongoing monitoring of EMR systems to ensure compliance. During training, COs should remind employees of the compliance hotline and other communication channels to express concerns or report misconduct. A significant lesson is that employee-patients should expect to receive the same treatment and follow similar protocols as non-employee patients.[8] Likewise, physicians should expect employee-patients to comply and demonstrate ethical behavior, which influences an environment beneficial to the facility.

Conclusion

Regardless of size and complexity of the institution, employee-patient relationships present several compliance risks, but these challenges are not insurmountable. COs are not the sole decision-makers for these relationships, but we are accountable for locating and escalating the risk, establishing policies, educating on those policies, auditing and monitoring to ensure compliance, and establishing internal controls to limit risk associated with the potential scenarios. COs can protect both their organization and employee-patients by including this item on their annual compliance work plan and using metrics to actively monitor the risk.

If operational leadership makes the decision to allow or even financially incentivize employees to receive treatment at your physician's office, facility, or healthcare system, be confident that it can and will work, but not without a hiccup or two from time to time.

1. Medical Group Management Association: Treating Medical Practice Employees As Patients. March 3, 2010. Available at http://bit.ly/1OsPqra
2. Erin McCann: "Snooping staff still a top security issue" *Health IT News*, 2014. Available at http://bit.ly/1OsPrvh
3. American Medical Association: AMA's Code of Medical Ethics, 2015. Available at http://bit.ly/1ZBXaPF
4. Ibid, Ref. #1
5. Wendy Kaliszewski: "Risks of treating employees" *Trends MD*, March 9, 2012. Available at http://bit.ly/1IEd4F7
6. Physicians Practice blog: "Employee Patients" June 1, 2007. Available at http://bit.ly/1Jg0ETK
7. Stephen M. Perle: "The Ethics of Treating Friends, Family, Colleagues and Employees" *American Chiropractic Association*, 2015. Available at http://bit.ly/1Pxhv5M
8. Ibid, Ref. #1