
HIPAA: An Industry Progress Report

HIPAA Summit III

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Conclusions

Conclusions

- The data does not lie: Many HCOs simply will not be ready for the October 2002 transaction compliance deadline.
- Deadline extensions are probably inevitable. However, HCOs that rely on them are placing themselves in grave peril.
- Administrative Simplification may be a tremendous short-term burden on the healthcare industry. However, it is also going to be the best thing to ever happen to the industry.



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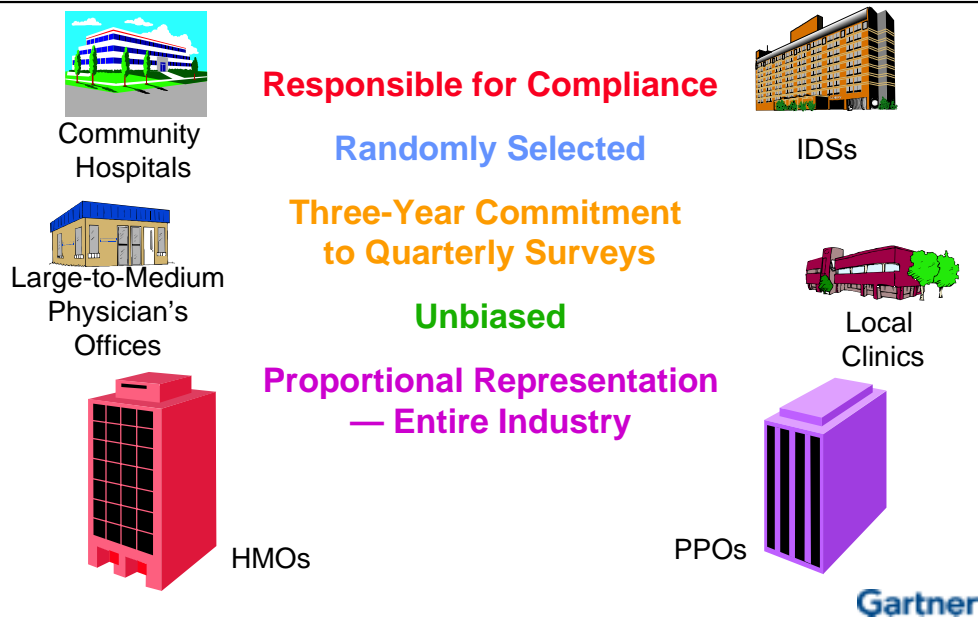
Source: Gartner Research

Gartner's third iteration of its quarterly Health Insurance Portability and Accountability Act (HIPAA) panel survey was completed in June 2001. When our second quarterly iteration was conducted in February 2001, there was widespread speculation — driven by lobbyists and media campaigns — that the HIPAA privacy regulations might be substantially rewritten or even revoked, leading to the possibility of HIPAA Administrative Simplification (AS) itself being rescinded. That contributed to the lack of progress by most healthcare organizations (HCOs), particularly providers, in getting their compliance efforts mobilized.

Because the Bush administration announced that the final privacy regulation would officially take effect on 14 April 2001, we expected to see significant progress demonstrated in this latest quarterly survey, as charted by Gartner's *COMpliance Progress And REadiness (COMPARE)* scale. However, as we will describe in this presentation, that was not the case. It is now apparent that the industry as a whole will not be ready to meet the scheduled transaction/code set deadline of 16 October 2002. However, HCOs must not react to the possibility of being granted extra time by remaining complacent or ambivalent. The mind-set of "we have another 12 months, so I guess we don't need to get started for another year" will very likely place an HCO's business in peril when HIPAA enforcement does begin. As we will explain, the industry must get much more aggressive, not just to avoid sanctions, but to embrace the ultimate prize — lower costs and higher revenue through e-business.

Definition: Gartner's HIPAA Panel Survey was first established in November 2000. Through at least 2003, it will provide the most accurate and reliable accounting of the healthcare industry's compliance progress.

The HIPAA Panel Methodology

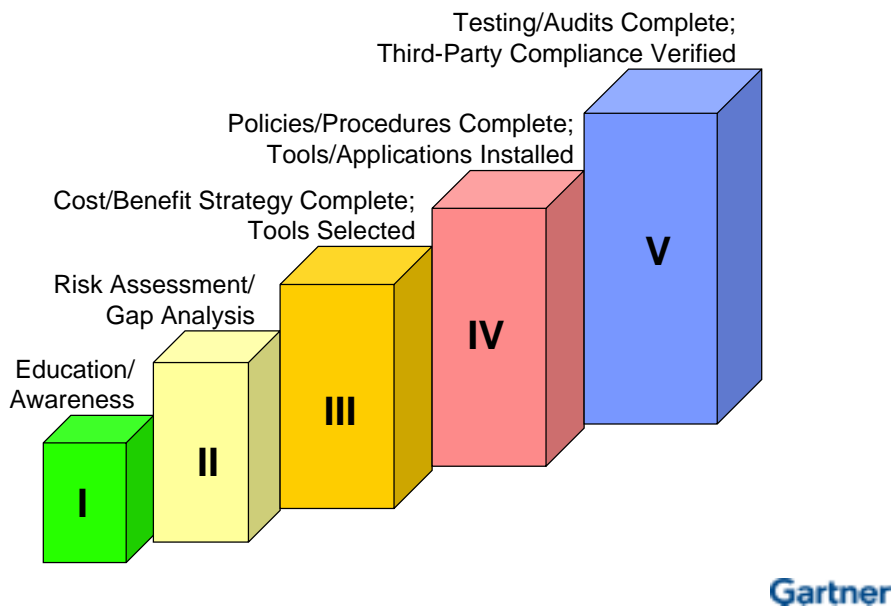


Source: Gartner Research

Conclusion: The healthcare industry is not going to make the current HIPAA transactions deadline. The HIPAA survey seeks to understand how HCOs are responding to the challenges of HIPAA compliance over time by studying, on a quarterly basis, a representative sample of randomly selected providers and payers. There were 191 participants in 2Q01, each selected using a stratified sample of 99 providers — comprising integrated delivery systems (IDSs), stand-alone hospitals with at least 250 beds and physician groups of at least 30 physicians; and 92 payers — comprising health maintenance organizations (HMOs) with more than 10,000 members, large national preferred payer organizations (PPOs), and private health insurers. At these sample sizes, Gartner's provider and payer data are statistically valid to a margin of error of plus or minus 10 percent. One of the aspects that makes this panel study unique is that, unlike most other industry surveys, respondents were chosen randomly in representative numbers and not self-selected, which would have resulted in a sample of HIPAA-savvy respondents fueled by their interest in volunteering for such a survey. For example, some surveys solicit the participation of those individuals who are already subscribed to the sponsoring organization's HIPAA list serve. That approach introduces a degree of bias into survey results, since one can assume that not every HCO has already taken an active interest in learning more about the regulations and their impact. Another unique aspect is that the panelists have agreed to continue participation for three years of quarterly surveys. This will eliminate the introduction of variability into quarterly results and allow accurate reporting of the industry's true progress.

Background/Tutorial: Gartner's COMPARE scale is a methodology defining the detailed milestones necessary in a comprehensive compliance program.

Gartner's HIPAA COMPARE Scale



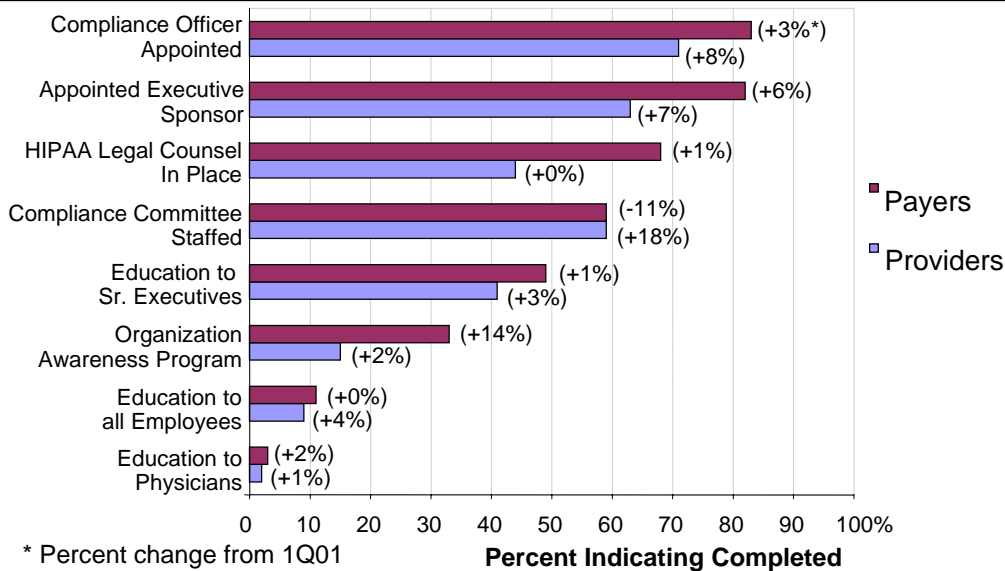
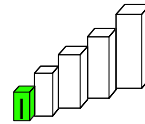
Source: Gartner Research

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To rate the activity and readiness of HCOs, Gartner has developed the COMPARE scale for HIPAA AS. The COMPARE scale is a tool originally developed by Gartner in 1997 for tracking an enterprise's progress with year 2000 compliance. Gartner has subsequently adapted the instrument to track the progress of the healthcare industry's activities and readiness to meet HIPAA AS mandates. *Level I:* At this stage, an HCO has completed its organizationwide general education and awareness program; all preliminary activities are complete. *Level II:* An HCO has completed (internally or with outside assistance) a formal assessment of its vulnerabilities and activities needed to achieve compliance with electronic data interchange (EDI), security and privacy requirements. *Level III:* At this stage, an HCO has quantified tangible and intangible costs and benefits to realize compliance, and used that information to formulate a comprehensive compliance strategy. This strategy will address HIPAA as an enabler for achieving the HCO's overall e-business strategy. *Level IV:* An HCO has completed and communicated policies and procedures for achieving compliance to all affected entities, departments and employees. Selection is complete for all physical tools needed for EDI and security compliance, including upgrade or replacement of applications when necessary; there is nothing left to plan or negotiate. *Level V:* All tools and applications have been implemented and tested. For security and privacy, the HCO has benchmarked the industry and has implemented all measures believed necessary to adequately address requirements. A formal process is in place to address "evolving" requirements and pursue "absolute" compliance.

Market: First, the good news: A substantial majority of payers and providers have finally started the most fundamental tasks in mobilizing their organizations' compliance efforts.

COMPARE Level I Progress (Completed Milestones)



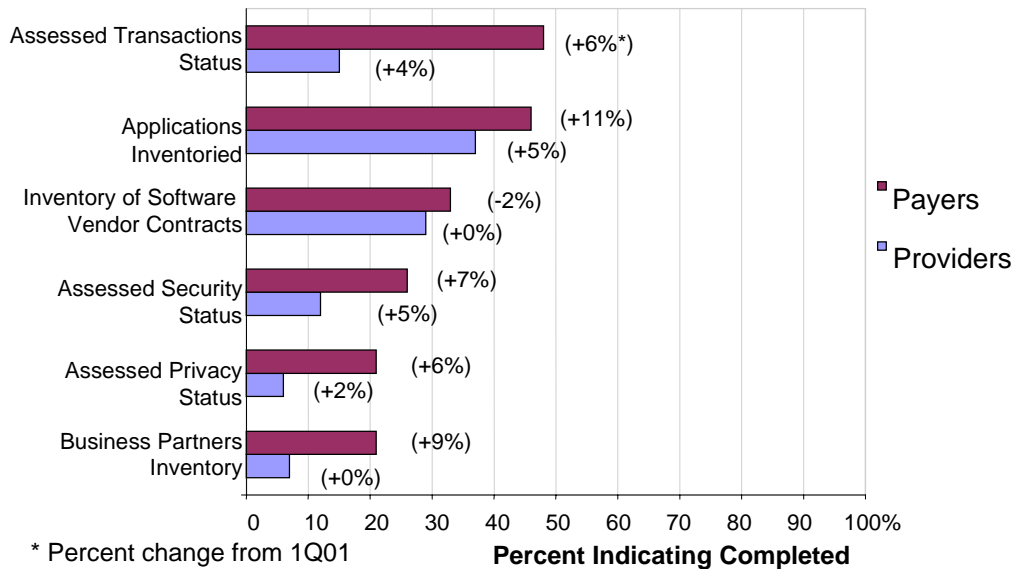
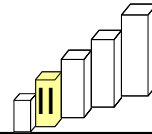
Source: Gartner Research

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Because the transaction/code set regulation has been final for more than a year, we deemed it appropriate to begin reporting on actual completed milestones (vs. on HCOs that have just started each milestone, as with previous survey results). More than 40 percent of surveyed payers and providers have not yet completed staffing their HIPAA compliance committees. If that many organizations have not completed the most fundamental mobilization task of any major initiative, it does not bode well that the industry will meet the scheduled transaction deadline 12 months from now. In addition, fewer than half of the surveyed HCOs have finished conducting an initial education program for their senior executives; management absolutely must be involved in decision making from the start. The lack of completed, formal enterprisewide and physician education programs is forgivable, given the pending status of the remaining regulations. However, to not even have formed a compliance team at this late date is almost inexcusable in all but the smallest HCOs (and the smallest HCOs in our sample are group practices with more than 30 physicians, hospitals with at least 250 beds, and health plans with at least 10,000 members).

Market: Now, the bad news: Although payers are necessarily further ahead of providers in performing assessments, the fact that 85 percent of providers have yet to complete transaction assessments indicates that the industry is unlikely to be ready for compliance in one year.

COMPARE Level II Progress (Completed Milestones)



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Source: Gartner Research

Conclusion: The healthcare industry is not going to make the current HIPAA transactions deadline.

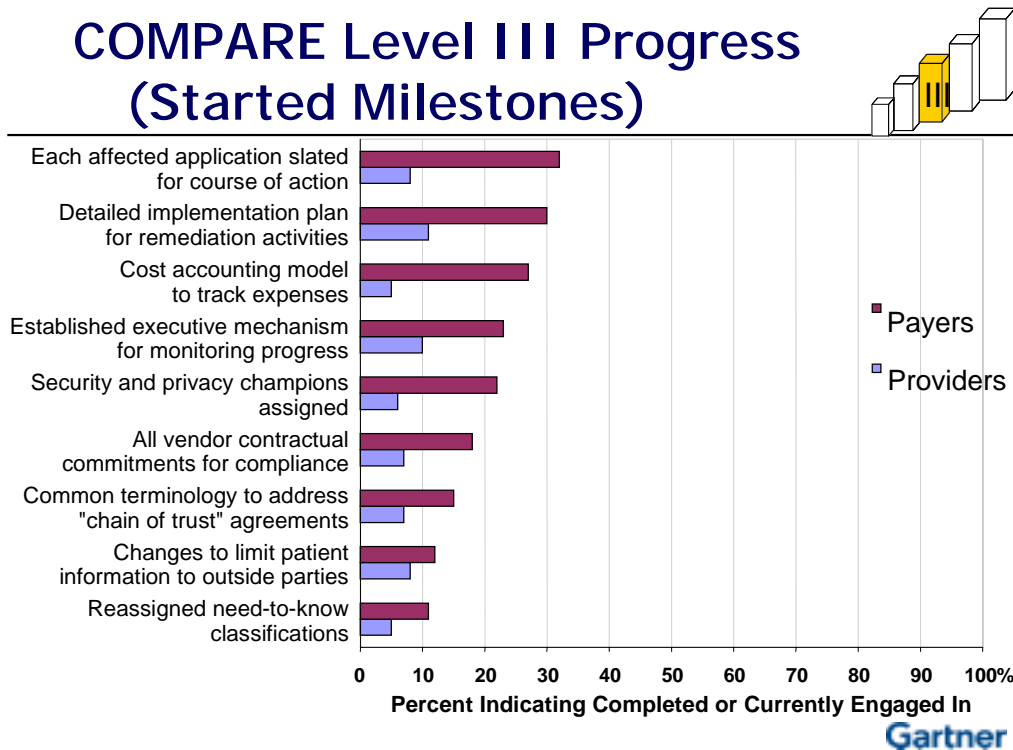
Very few HCOs have actually completed the major tasks of Level II. Interestingly, payers are still more than three times as likely as providers to have completed transaction assessments. This depicts a much broader discrepancy than when only examining which organizations have at least started, and highlights just how far behind most providers are. Unless both segments of the industry are compliant with these regulations, very little of AS's cost-saving objectives can be met.

Another statistic does not bode well for the industry meeting the April 2003 privacy deadline — only 6 percent of providers have finished assessing their vulnerabilities against those regulations.

Many more payers began aggressively inventorying their business associates during this quarter, although no progress at all was seen on the provider side. It is possible that this is the result of many payers having contracts to distribute patient data to research and pharmaceutical enterprises for clinical trials and marketing, which opens them up for new vulnerabilities in de-identifying and protecting that data under HIPAA privacy.

Strategic Planning Assumption: Through 3Q03, 70 percent of healthcare payer organizations will not have achieved full compliance with the full set of final HIPAA standards for transactions, codes and identifiers (0.8 probability).

COMPARE Level III Progress (Started Milestones)



Source: Gartner Research

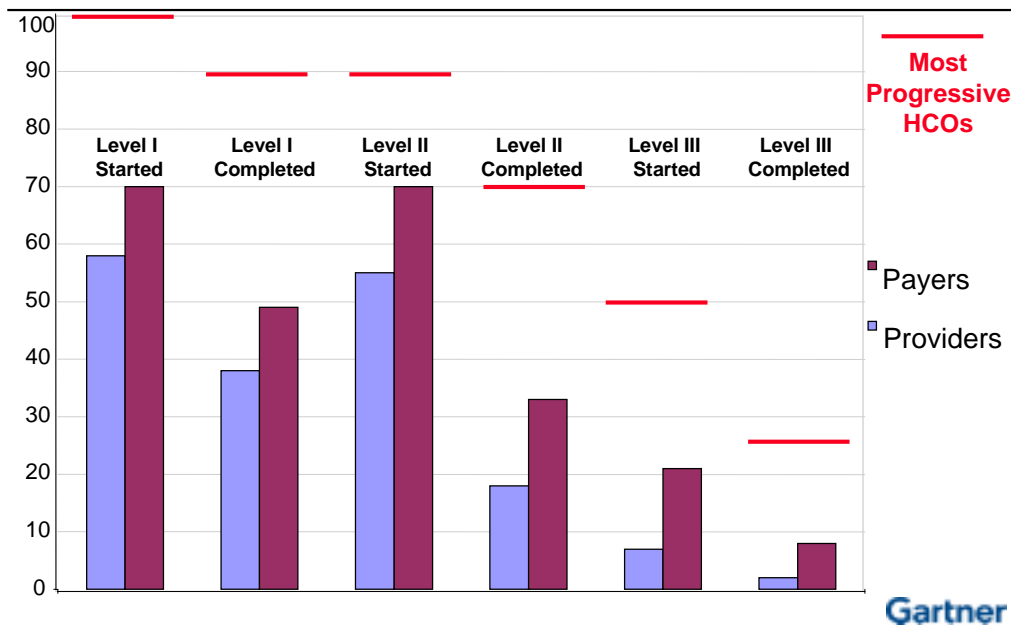
Conclusion: The healthcare industry is not going to make the current HIPAA transactions deadline.

For the first time, the number of HCOs, especially payers, that have at least started most of the strategic planning tasks of COMPARE Level III merits detailed reporting on milestone progress. Given the lead demonstrated by payers in the earlier COMPARE levels, it is not surprising that they are far ahead of providers here as well. Still, virtually no respondents reported having completed any of the Level III tasks, so only “Completed or Currently Engaged In” is reported here. The Level II assessment tasks are likely to encompass greater time and resource requirements than the Level III milestones. However, beyond Level III lies Level IV — Implementation. If the assessment and planning phases take an average HCO (one that is committed and dedicated to those tasks) approximately six months to complete, the implementation and testing phase can be expected to take between 12 and 18 months to complete, especially for larger, complex HCOs.

Action Item: Recognize that regardless of possible deadline extensions, larger payers and providers must be well into implementation and testing by the beginning of 2002 to even have a reasonable chance of achieving full compliance within an extended compliance period.

Strategic Planning Assumption: Through 2003, HCOs that have not achieved full compliance with the HIPAA transaction standards will not experience substantial economic consequences due to explicit government delays of the deadlines, slow enforcement or accepting fines as the cost of doing business; after 2003, they will (0.8 probability).

Overall COMPARE Progress



Source: Gartner Research

Conclusion: The healthcare industry is not going to make the current HIPAA transactions deadline.

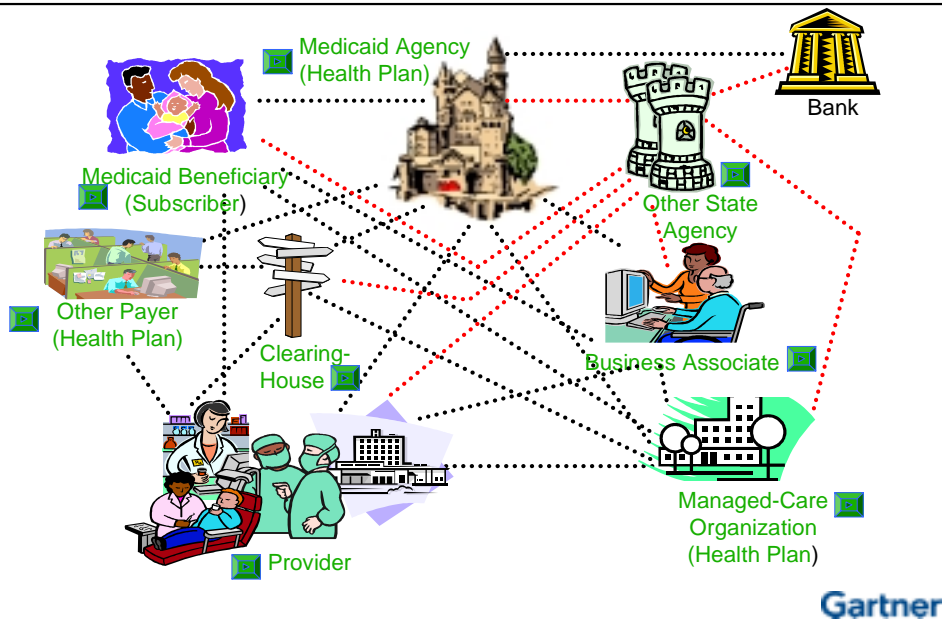
The lack of progress evidenced since February 2001 leads Gartner to an inevitable conclusion — the healthcare industry will not be ready for HIPAA by the 16 October 2002 transaction deadline. Only 12 months remain, and the vast majority of HCOs, especially providers, have not moved past the stages of getting organized and assessing their environments, to taking on the resource-intensive tasks of implementation and testing.

After analyzing these latest survey results, Gartner has recommended to the U.S. Congress that it pass legislation allowing a one-year extension before payers must accept standardized X12 transactions. The legislation also should allow a six-month transition period before all providers must submit EDI transactions in standard formats.

Action Items: Whether or not deadline extensions are granted, an HCO that has not yet completed staffing its compliance committee, performed a readiness assessment or gathered vendor commitments must get very busy, very fast, and enlist outside assistance to help it catch up. HCOs may find that the government will introduce delays if the majority of the industry is not ready. However, those HCOs that fall behind the rest of the industry are taking an unacceptable risk, and face serious consequences and major challenges in suddenly catching up once the mandates go into effect.

Decision Framework: As of August 2001, many U.S. state legislatures have yet to hear formal funding requests for HIPAA activities. In the absence of funding, many state agencies are unable to move beyond early mobilization tasks. Until they complete assessments, they do not know how much funding to request — thus, a conundrum.

The Public Sector Is Even Further Behind (With More Work to Do...)



Source: Centers for Medicare and Medicaid Services

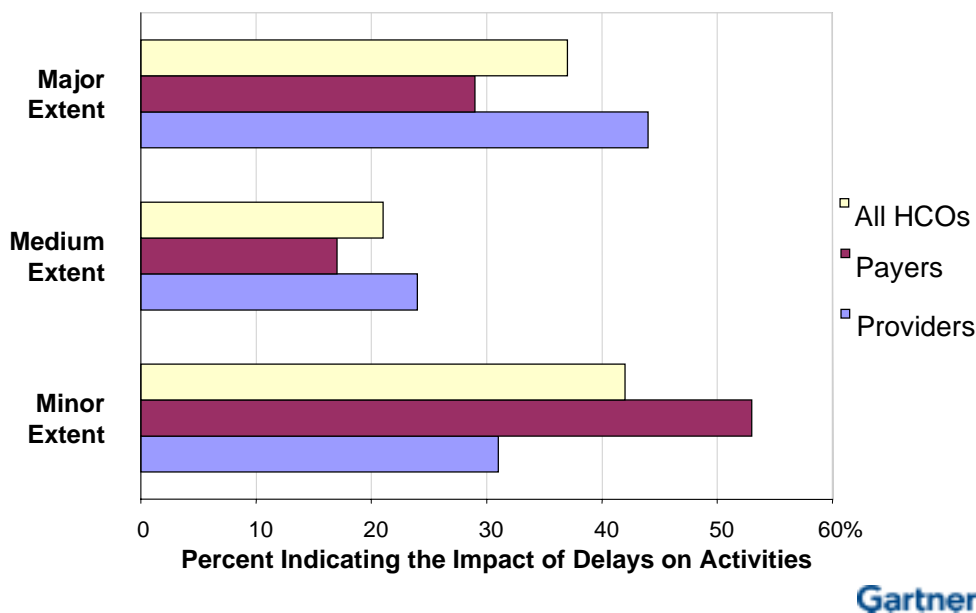
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In a recent (and separate) Gartner survey of state and local government (SLG) agencies, 57 percent of respondents did not even know 1) whether a central HIPAA project management office for their state had been established, or 2) whether an individual had been appointed to oversee all statewide HIPAA compliance activities. Regarding the October 2002 transaction deadline, only 33 percent of respondents reported that it was at least “somewhat likely” that their agency would be ready in time. Nearly 60 percent indicated that they did not know if they would achieve compliance in time. These findings highlight one of the most fundamental reasons that the overall industry is unlikely to be able to achieve compliance within current deadlines — a significant percentage of state and local agencies will be impacted by HIPAA either as covered entities or as business associates, and yet very few states have even moved beyond the basic stages of awareness training or getting organized.

In addition, SLGs face several unique and daunting challenges, including: loss of program data due to standard code sets, acquiring necessary funding through state appropriations processes, interpreting conflicts between state laws and HIPAA (especially privacy), and the fact that some agencies perform the multiple roles of provider, payer, clearinghouse and business associate.

Conclusion: Deadline extensions are likely, but counting on them is a grave mistake.

How Is Ongoing Lobbying Slowing Down Compliance?



Source: Gartner Research

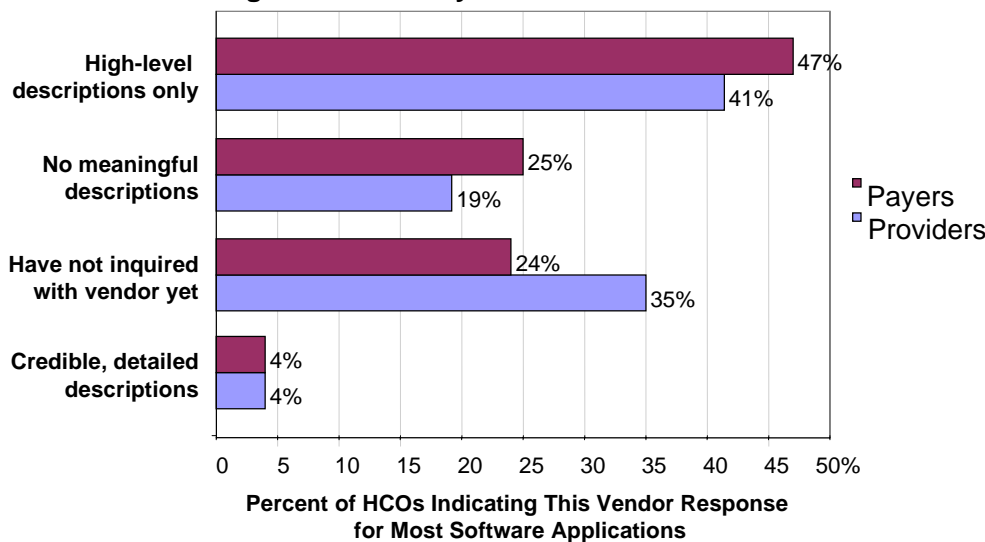
Despite the privacy regulation becoming formal law on 14 April 2001, continuing lobbying efforts have raised doubts at many HCOs about whether current deadlines will be extended. U.S. Senate Bill 836, which was still being debated before the August Congressional recess, would provide an official two- to four-year extension on all HIPAA deadlines, including a synchronization of deadlines for the transaction/code set, privacy and security regulations. This ongoing campaign has had a detrimental impact on the industry's HIPAA progress. Needless to say, given the difficult financial climate they face, many healthcare executives are loath to dedicate financial and personnel resources to a project that they could conceivably postpone or ignore in the absence of deadline pressure. Providers, in particular, have encountered challenges in getting started on HIPAA-compliance because of lingering doubts.

Providers indicate that deadline uncertainties (and in some cases, doubt as to whether HIPAA would endure), have had an impact on their capability to get their organizations motivated and mobilized. A large majority (68 percent) believe that lingering doubts have had at least a moderate impact, and 44 percent believe that the impact has been dramatic.

Strategic Imperative: Get your software vendors to commit to their compliance strategies now. Use your legal counsel, or seek specialized legal assistance.

Remember Those 'HIPAA Compliant' Banners at HIMSS?

Remediation Strategies Provided by Vendors



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Source: Gartner Research

Conclusion: Deadline extensions are likely, but counting on them is a grave mistake.

Two data points shed some insight on why many HCOs have not made more substantial progress in their transaction assessment tasks:

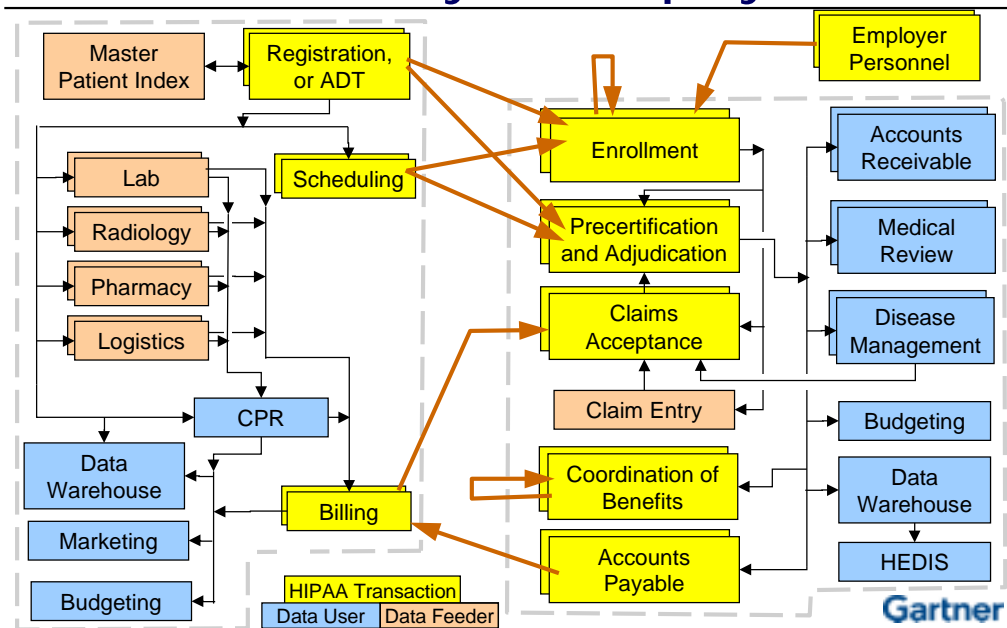
- By an overwhelming margin (84 percent to 16 percent), panelists expect their software vendors to provide HIPAA-compliant solutions under current service/support agreements.
- Fifty-four percent of providers and 49 percent of payers have not asked their vendors to provide remediation strategies, or have received no meaningful communications from their vendors on how they will achieve HIPAA compliance for their applications.

Many HCOs are still under the misconception that HIPAA is a technology-driven, rather than a process-driven, initiative. They are also falling prey to the mentality (reinforced by seeing “HIPAA-Compliant” banners at every industry trade show) that a simple software upgrade will accomplish most of what they need to become compliant with HIPAA. This is especially true for smaller community hospitals and group practices.

There is also a perception shared by many providers that they can rely on clearinghouses and integration brokers to accomplish most of the work needed on the transaction/code set standards. Although these solutions can mitigate some of the need for software remediation, they are not a panacea to achieve compliance.

New Rules/New Realities: Healthcare organizations must assess the impact of the HIPAA standard on all systems that provide to or use data from the systems that actually create or receive the HIPAA transactions. Most will require some remediation.

The System of Systems: Providers, Payers, Employers



As enterprises assess the requirements for compliance with the HIPAA transaction, code and identifier standards, they evaluate the impact on three categories of application systems: 1) those that are the source or recipient of the HIPAA transactions (“transactors”), 2) those that gather data and pass it to the transactors (“data feeders”), and 3) those that make downstream use of information gathered by the transactors (“data users”). Data feeder systems may have to be changed to collect data that was not previously required, such as the birthdate and gender of the subscriber. Data user systems may have to adjust to different codes as the transactors are remediated for HIPAA.

In provider and payer enterprises, there are many kinds of application systems that fit these categories — e.g., patient registration systems are transactors for eligibility, pre-certification and referrals; at the same time, they are data feeders for the billing system. In a large enterprise, for each kind of application there may be several or as many as a dozen distinct instances of application system. These distinct instances are usually different products, each of which must be assessed and remediated separately. In total, large integrated delivery networks may have to assess 100 or more distinct systems and payer enterprises that have grown through acquisition may have to assess dozens.

Strategic Planning Assumption: By 1Q02, DHHS will revise its standards to remove the requirement for using NDC codes, except in pharmacy claims (0.8 probability).

The Devil Is in the Details

	Provider			Payer		
• Data elements						
– new	○	◐	○	○	●	◐
– new situations	○	◐	○	○	◐	○
– revised lengths	○	◐	○	○	●	◐
• Identifiers						
– formats	◐	○	◐	○	●	●
– no overloaded information	○	○	○	○	●	●
• Standard Codes						
– eliminate HCPCS 3	◐	○	○	○	●	●
– eliminate other local codes	○	○	○	○	●	●
– NDC	●	●	◐	○	●	●
– Prepare for ICD-10	○	◐	●	●	●	●
• HIPAA + pre-HIPAA Processing						
	○	○	○	○	●	◐

HIPAA Transaction	Impact: Major	Routine	Minimal
Data User	Data Feeder	●	◐
		○	



Source: Gartner Research

The rules in adjudication systems are complex, reflecting payment policies of the payers and sponsors, state and federal regulations, and negotiated arrangements with providers. They lump individual services into bundles that are specially priced by diagnosis-related group (DRG) or other criteria. Payers have created special codes for services, revenue centers and denial reasons to simplify their programming. The rules are generally implemented in explicit program statements, often with literal code values. HIPAA does not require that the policies change, but it requires that the transactions be expressed using national-standard code sets and that the remittance advice be expressed using the same enumeration of services that was in the claim. The previous practice was to express the remittance advice in terms of bundled services. Other problems include a new system of identifiers that decouples the identifier of a provider with its specialty, fields that are much longer than before, and new fields. The new codes, full length of the fields and new fields must be echoed from the claim to the remittance advice. A further complication is that the remediated systems must continue to process paper claims in the old formats.

The payer systems that process other transactions face the same challenges on a smaller scale. Provider billing systems, having been designed to fulfill the conflicting requirements of different payers, have less trouble adapting to the standard codes. They do have to be modified to collect new data or support longer data fields.

Imperative: Incorporate tactical remediation activities into a plan that balances expedience against strategic benefits and composes a long-term strategy for the fundamental data model and process improvements necessary to be competitive.

'You Take the High Road; I'm Busy Fighting the Alligators'

- The high road: Finally a corporate data model
 - HIPAA standards provide a rare opportunity to standardize data elements and codes
 - consolidate duplicate systems
 - the adoption of Internet technologies
 - straight-through processing and reduced latency
- The low road: wrap, map, and hack
 - minimize the renovation of transaction systems
 - eliminate impacts on downstream systems
 - ostensibly required by HIPAA deadlines

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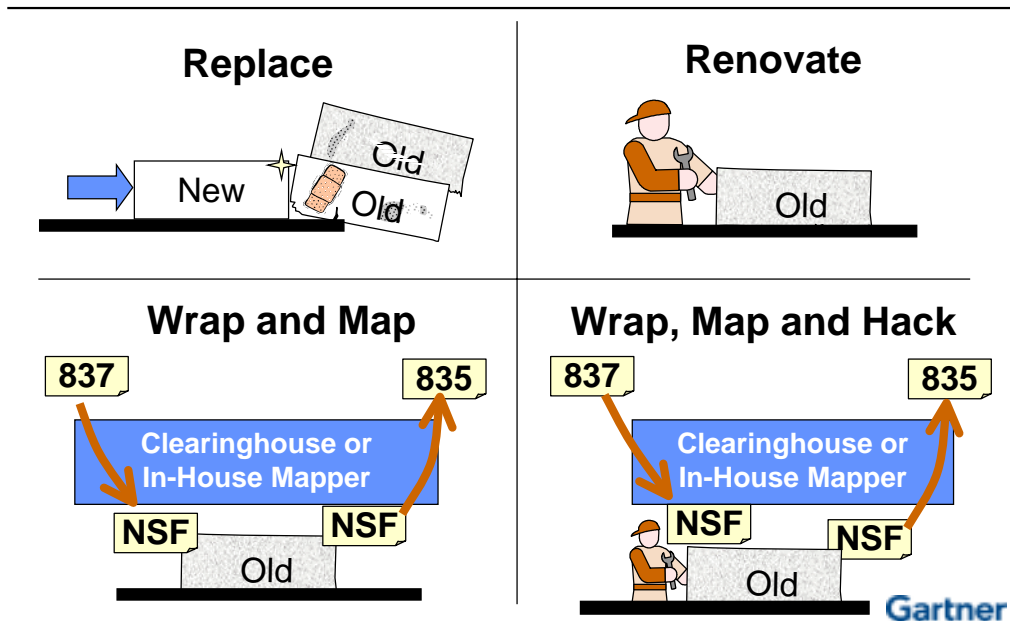
There are two approaches to HIPAA transaction compliance — tactical and strategic. Each provides a different ROI, with vastly different investments. *The tactical approach* focuses on the fastest and most cost-effective (in the short term) route to HIPAA transaction compliance. The solution includes a heavy reliance on translation and auditing tools, employing internal or outsourced clearinghouse mapping technologies. Few changes to the back-end processing environment or data model are planned. Although ROI results will be tangible, they are short-term only. As all healthcare organizations must comply with these standards, so there is no specific competitive advantage for minimal compliance. This approach does nothing to address current processing inefficiencies and costs, which include process inefficiencies such as dumping electronic transaction to paper and then rekeying them, poor internal data models, and continuing translation or clearinghouse vendor costs.

The strategic approach focuses on improved data models and business processes that will better position the health plan to reap the administrative benefits *and* position HIPAA investments as the catalyst to better healthcare outcomes and new business opportunities. This will enable quicker adjudication, customer response, better reporting, improved successes with Internet initiatives and better use of data from external sources.

By 2005, healthcare organizations that rely solely on tactical HIPAA remediation will lose market share because of process inefficiency and inflexibility (0.8 probability).

Definition: “Wrap and map” remediation approaches use mapping software to transform data in the new format to look like the old format before presenting it to the application, and transform the output data from the old format to the new.

Remediation Approaches

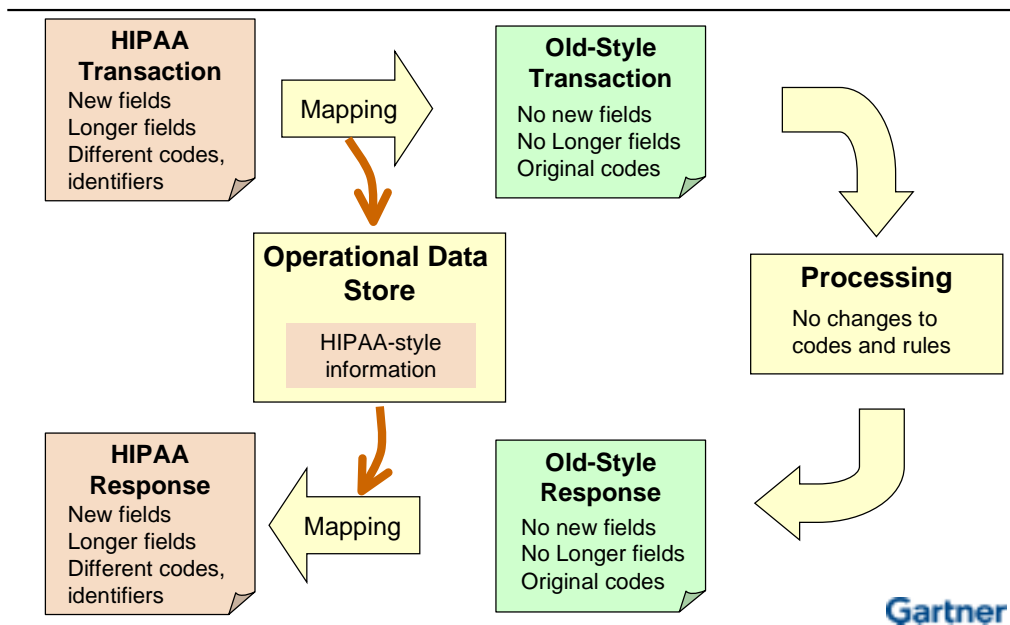


There are four alternatives for remediation of an individual system.

- *Replace* the current system by acquiring a vendor solution that can process and produce the HIPAA solutions. When the time is available to select, acquire and implement a new system, this approach allows for substantial long-term efficiencies by replacing multiple separate applications that perform the same function with a single product that reduces the latency time for processing, upgrades the technology platform and provides a solid basis for future changes.
- *Renovate* the current system with a Y2K-like inspection of source code, repairing or replacing modules that deal with data elements and codes that are changed by the HIPAA standards.
- “*Wrap and map*” the old system by using software mapping tools or a clearinghouse to convert the HIPAA transactions to the old-style format, presenting the old-style format to the old system and translating the old-style output to the HIPAA response. Where feasible, this approach minimizes the short-term costs associated with HIPAA compliance.
- “*Wrap, map, and hack*” the old system, using the wrap-and-map technique to minimize the renovation that is required in the old system. Where a simple wrap-and-map solution is not feasible, this approach represents the minimal short-term costs.

Tenets/Principles: Short-term remediation approaches can produce long-term maintenance problems.

Remediation Considerations

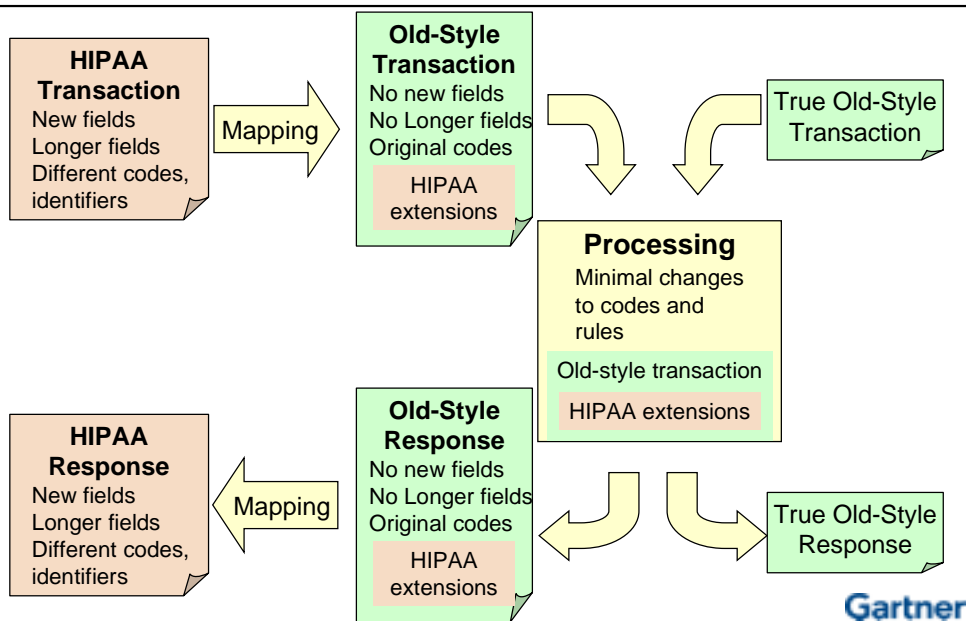


At best, the wrap-and-map approach is more difficult than is usually described, because the HIPAA transaction must echo the unbundled services, new and longer fields, and standard codes and identifiers. The standard codes are usually more or less numerous than the prior codes. Either way, a mapping from new to old, to new loses information, creating a response that is not an echo of the input. A similar problem exists with new and longer fields. Information will be lost if the new fields and extra length is omitted in mapping to the old format. Accordingly, current designs add an *operational data store* to the process. This represents a cache that can hold the original transaction until the old-style response is available. This may only be a few seconds, but frequently it will hold the cached data for days.

Some strengths of the wrap-and-map approach are that it eliminates the need to remediate feeder and data user systems and it allows the HCO to operate with both HIPAA and pre-HIPAA style transactions. This is necessary for payers to deal with paper transactions and if the HCO wants to have an interim period supporting trading partners that have not all switched to the HIPAA format. There are also substantial weaknesses. It does not deal correctly with data in the transaction that is manually updated while it is in suspense and, where the old codes are more numerous than the standard codes, the decision rules will be affected by the limited set of old codes that come out of the mapping.

Tenets/Principles: Moderate levels of investment can provide short-term results while keeping future options open.

Advanced Wrap, Map and Hack



A particular approach to “wrap, map and hack” can overcome the limitations of the wrap-and-map approach, and yet it may limit the extent of renovation that is required of an application. This approach extends the data set an application uses to represent a transaction. The extended data set includes the mapped old-style transaction and redundantly includes all data from the HIPAA transaction that is changed by mapping.

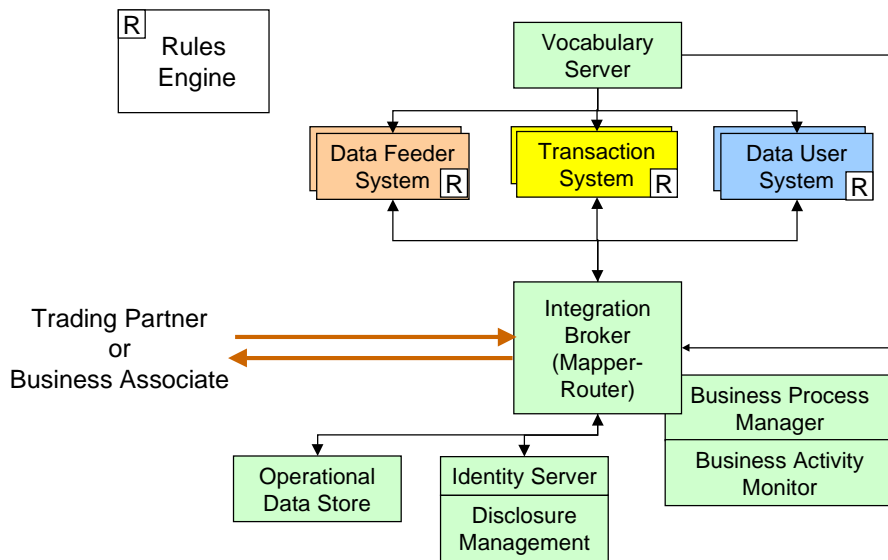
Renovations are applied to the target application to deal with updates that are created manually while the transaction is in suspense. The updates are applied to the old-style data and to the HIPAA-style data, which is stored redundantly. On a case-by-case basis, the HCO may renovate some decision-making code to deal with most difficult code-mapping issues and produce optimal decisions based on the new code.

The *operational data store* is retained, if at all, to deal with bundling. It also provides an opportunity to deal with consumer requests for copies of their data on an ad hoc basis.

This approach retains many of the advantages of wrap and map. It minimizes renovation, supports a mixture of old-style and new-style transactions, and minimizes the requirement to remediate feeder and data user systems.

Imperative: Externalize and centralize the administration of codes and rules to the maximum extent practical.

Integration Architecture and Infrastructure for HIPAA

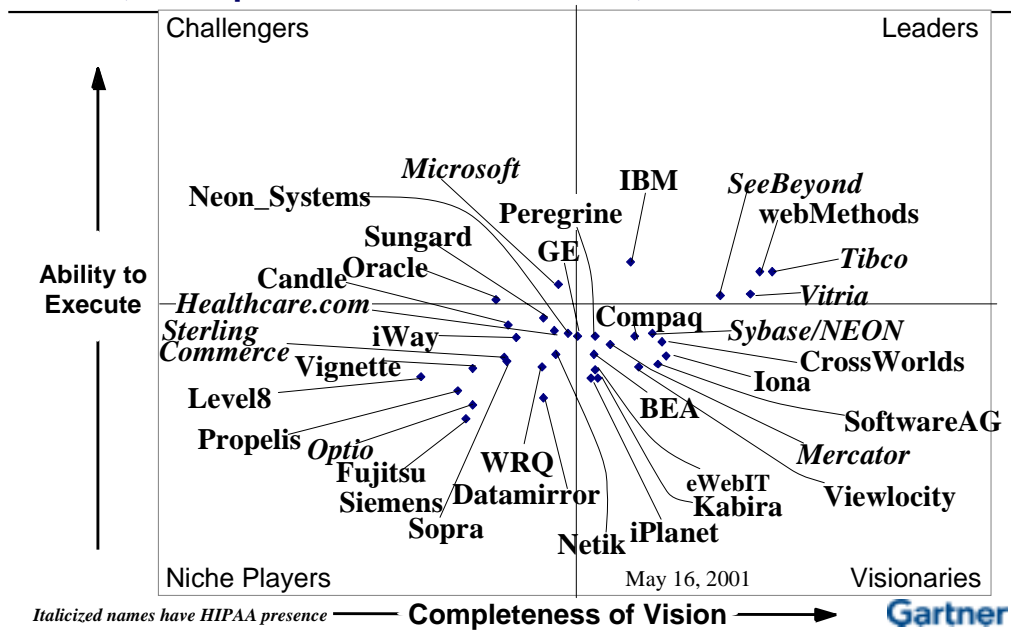


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The integration architecture and infrastructure for HIPAA remediation will have several important components. An *integration broker* (IB) is the hub of the operation, providing software mapping as well as other services that are equally important, including transaction routing with the flexibility associated with business process management concepts. For scalability and to deal with geographically dispersed organizations, the IB may comprise multiple physical processors, but its metadata must be centrally managed. The IB is the gateway to the *operational data store*. An ongoing issue with the operational data store will be dealing with transactions that remain in suspense across times of transitions. XML repositories, such as those offered by Oracle, Software AG and Sequoia Software, provide particularly good flexibility for this issue. An *identity server* is a generalization of a “master member” or “master patient” index that can be used for mapping the identities of providers and other entities when dealing with transactions in mixed formats. As application systems are renovated or replaced, they should rely on external *rules engines* such as those offered by Computer Associates, Brokat/Blaze, ILog, & Haley rather than in-line program statements. This greatly simplifies maintenance. They should also support *vocabulary servers*, a new tool not that has not previously been applied to healthcare administrative applications. These products, such as those offered by Apelon and 3M HIS, offer the same ability to simplify and externalize maintenance of code sets.

Strategic Planning Assumptions: By 2003, ninety percent of large HCOs will have some form of an internally-managed integration broker in production as part of their HIPAA remediation architecture (0.8 probability).

Integration Broker Vendors (Not specific to healthcare)



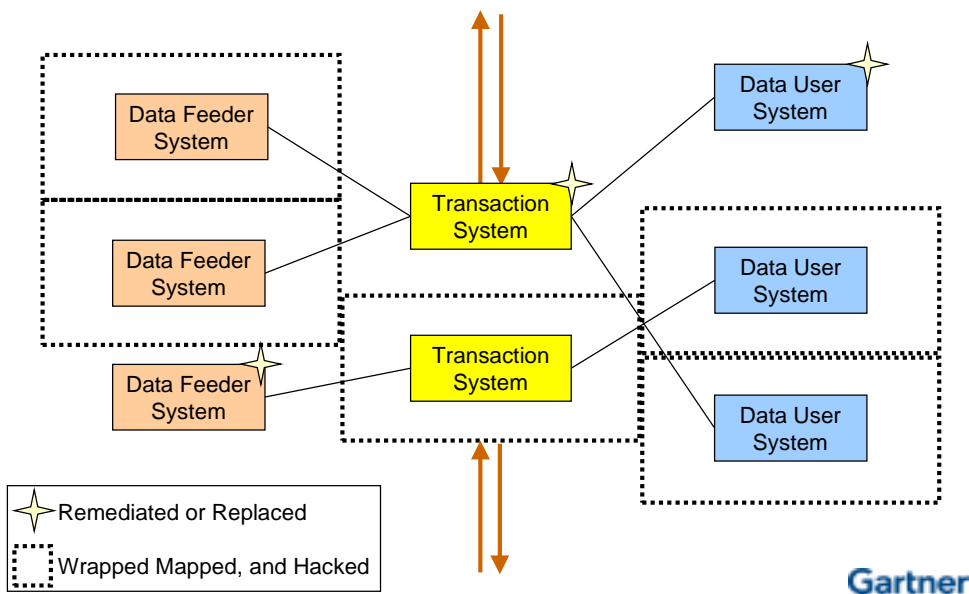
The Gartner Magic Quadrant for Integration Brokers

The horizontal axis assesses how well vendor management understands the market’s technical and marketing issues and their ability to innovate, differentiate their products and grow their business. The vertical axis rates the vendors on their ability to execute that vision. This assessment takes into account technical expertise, current technology assets and product features, as well as the financial and marketing resources that the vendor allocates to the development and support of the product. Note that a large vendor does not always receive a high rating on its ability to execute; for example, it may not dedicate sufficient resources and management focus to this market to ensure success.

All of these products are centered on an integration broker, but our ratings cover more than the broker component itself. The ratings consider transformation, routing, process management, transport (including file transfer, database gateways, messaging, B2B and other middleware), administration and management, adapters, message warehouse capabilities, vendor management, vendor financing, sales and marketing capability, installed base and sales momentum. The placement of vendors on this quadrant is *not* a direct indication of the relative value of that vendor’s product, however. The quadrant rates vendors, not products.

Tenets/Principles: An integration architecture with centralized administration of codes, rules, transformation and routing provides a healthcare organization with the ability to choose tactical or strategic remediation on a case-by-case basis, and to evolve the overall “system of systems” to a strategic solution over time.

An Incremental Transition From 'Get it Done' to 'Do it Right'



John Lennon said, “life is what happens while you are making other plans.” This observation applies to the world of HIPAA remediation where the pressure of deadlines seems to eliminate any real choice between tactical solutions and strategic improvements in the IS organization environment. Such a life would involve an increasingly ossified and difficult to maintain “system of systems,” despite futile plans that would achieve the a more flexible business environment on a technological platform more suited to e-health.

Introducing an application integration architecture and infrastructure provides the means to break this pattern. It provides a means to evolve toward a “high road,” strategic architecture even as the HCO is “fighting the alligators.” The HCO can start with tactical decisions to wrap, map and possibly hack individual applications relying on software mapping to minimize the initial impact on feeder and data user systems. On a strategic basis, it can renovate or replace applications moving toward an environment where the HIPAA standards provide a basis for a corporate data model. As strategic portion of the environment expands, the HCO experiences an increased ability to use its data for improved decision making, more efficient and timely processes, and the flexibility to deal with e-health and other business opportunities.

Recommendations

- If any HCO, but especially a large or complex provider or payer organization, thinks that possible deadline extensions mean that it can delay aggressive HIPAA compliance activities, it is setting itself up for business failure.
- Plan for people problems: the rapid implementation of transactions will stress the poorly documented procedures in many care delivery organizations
- Industrywide adoption of standards, coupled with consumers' confidence that their information will be protected on the Internet, will lead to inevitable improvements in efficiency and new business opportunities. Those HCOs that embrace these concepts now, however, stand the best chance of transforming their businesses first and reaping the competitive rewards.
- HIPAA AS (all of it — not just standards, not just privacy) represents what any HCO should want to do anyway, not just because it faces sanctions for noncompliance.

Source: Gartner Research

Recommendations

Fear, uncertainty and doubt (FUD) have been the dominant reactions of many HCOs to HIPAA. Any HCO that is allowing fear over punitive damages to drive its HIPAA compliance strategy is not thinking strategically. Any HCO that is allowing uncertainty over the timing of the regulations derail its mobilization efforts is wasting critical time. Any HCO that doubts for a second that HIPAA is here to stay is fooling itself.

It is time for the healthcare industry to replace any lingering FUD mind-set with one of aggressive, “just do it” strategic thinking. Do not be distracted by ongoing polemics in the U.S federal government. Embrace the opportunities HIPAA presents to your organization — to improve efficiencies in the short term, and to enhance competitive standing in the long term. Even if HIPAA mandates had never been passed, AS is simply the right thing for the healthcare industry to do, and this is the right time to do it.