Reducing Healthcare Costs with Health Literacy

By Terri Ann Parnell, M.A., DNP, RN

Many fear that better healthcare and lower costs are mutually exclusive. However, when well-informed patients and healthcare practitioners effectively communicate and collaborate on a treatment plan, patients often take a more active role in their care and health outcomes improve. These patients and practitioners are skilled at what is known as health literacy.

Research has demonstrated a higher rate of hospitalization and use of emergency services among patients with limited health literacy skills. Studies also report that those with limited health literacy skills are more likely to have chronic conditions, more difficulty managing those conditions, and are more likely to report poor health.¹ This results in higher healthcare costs.

Several states are beginning to implement innovative programs that financially recognize healthcare facilities that improve the quality of care they provide and also ensure access to quality care for all Medicaid members. One example is New York State’s Delivery System Reform Incentive Payment (DSRIP), which offers payouts based on system transformation, clinical management and—best of all—population health.² This waiver rewards hospitals and safety net providers for providing quality care and keeping their patients healthier, which translates into less hospital readmissions and lower costs. Stay tuned, too, because this movement is part of a trend that will likely continue to expand.

I’m thrilled about these changes because it means better care for all patients. Efforts to enhance quality, reduce costs, and decrease disparities cannot succeed without concurrent improvements in health literacy.³ So how can hospitals and practice groups integrate health literacy throughout their organization? The most efficient way is through staff training in health literacy and cultural competency.

When clinicians and staff are trained to communicate clearly and provide culturally and linguistically appropriate care to all patients, satisfaction and safety improves, health outcomes improve and costs decline.

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Changes & Clarification

Requirements for Criminal History and Child Abuse Certifications

On July 1, 2015, Gov. Wolf signed into law a bill (HB 1276) that amended the Child Protective Services Law (CPSL), primarily to clarify changes made to the CPSL in 2013 and 2014. Of particular note to physicians and physician practices, there are changes to the requirements for certain employees and volunteers to have criminal history and child abuse certifications.

Clarification of “direct contact with children” – The list of covered employees includes any paid employee who is 14 years of age or older and has direct contact with children, which is defined as: “The care, supervision, guidance or control of children or routine interaction with children.”

The Department of Human Services (DHS) provided guidance on the meaning of “routine interaction with children,” but there was no definition in the CPSL. It now defines that term, consistent with the DHS guidance, as: “Regular and repeated contact that is integral to a person’s employment … responsibilities.”

This would include physicians and other health care professionals providing direct patient care for children as well as certain other physician office staff, such as those in the front office. There is no threshold number of contacts or patients that requires a background check. When in doubt, it is best to err on the side of child safety serving as the paramount consideration.

Extension of renewal time period – A 2014 amendment to the CPSL mandated that the required certifications be renewed every 36 months. That time period has now been extended to 60 months. If the employee’s certifications were issued prior to Dec. 31, 2014, the employee’s renewal now must be obtained within 60 months of the employee’s oldest certification, or Dec. 31, 2015, if the certification was obtained prior to Dec. 31, 2009.

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Grandfather elimination – DHS had issued guidance that employees with contact with children, who previously were exempt from the certification requirement because they were hired prior to its initial adoption, are no longer grandfathered. This is now explicit in the law. Previously grandfathered employees must obtain initial certifications by Dec. 31, 2015.

Portability – The law now clarifies when certifications obtained for one employer can be used for another employer. If an individual’s certifications obtained for employment purposes are current, the individual may use those certifications for an employment (or volunteer) position, provided that the individual swears or affirms in writing that the individual has not been disqualified from employment under the act in the interim. However, individuals may not use the certifications obtained for volunteer purposes for employment positions.

The Pennsylvania Medical Society (PAMED) has a Quick Consult that provides more detail on the Criminal and Child Abuse History Certification Requirements and related provisions in the CPSL; it has been updated to reflect the recent changes. This is part of PAMED’s suite of resources to help physicians and physician practices understand the changes to the CPSL. - See more at: http://www.pamedsoc.org/MainMenuCategories/Laws-Politics/Analysis/Laws-Analysis/Child-abuse/Criminal-History-and-Child-Abuse-Certifications.html#sthash.Pg9EvpD5.dpuf

DCMS & DCMH to Host Child Abuse CME Program

Presented by the PA Chapter of the American Academy of Pediatrics

Saturday October 17, 2015 ~ 8 am - 10 am

Delaware County Memorial Hospital

Pre-registration Required!

Send address changes to:

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600 North Jackson Street, Suite 201A Media, PA 19063-2563
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The benefits of investing in health literacy and cultural competency training include: more patients taking advantage of preventative health measures, fewer patients with chronic illnesses, better patient management of chronic illness, less hospital visits, lower costs, and an overall patient-centered approach to healthcare.

Here’s what you can do to get started on improved health literacy:

1. **Train staff on how to communicate in plain language.** We all come from different walks of life and have varying degrees of medical knowledge and experience. Communicating clearly in plain language helps to assure that more patients will understand information about their condition and how to improve it. Planning development sessions for practitioners and staff throughout the year to fine-tune clear communication skills can make a big difference.

2. **Revise written materials for patients to be as clear as possible.** Take a look at the brochures and handouts you have in your healthcare facility. Do they use plain language, a user-centered design, and clearly defined medical terminology? If not, take steps to edit them so that they are easy to read, understand and use. Consider engaging someone outside the medical group (or you can even involve a focus group of patients) to critique the material and suggest improvements.

3. **Look into hiring a health literacy expert to partner with your hospital or practice.** Health literacy experts are not only familiar with how to train groups on health literacy and cultural awareness, but they are knowledgeable about standards, regulations and reimbursement policies. Consider bringing in an expert to: develop a health literacy and cultural competency strategy; assess your strengths and weaknesses; and implement initiatives that can shift the culture toward becoming a health literate organization with a patient-centered approach to healthcare. The investment upfront will be minimal compared to the cost savings and improved care that will result. I’ve done this type of work for hospitals and group practices and would be happy to help.

It may take some time and organization, but keep in mind that any efforts to improve health literacy and cultural competency will likely lead to improved patient satisfaction, and enhanced health outcomes for your patients and overall lower costs.


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Terri Ann Parnell, MA, DNP, RN is Principal and Founder of Health Literacy Partners, LLC and Adjunct Faculty at Adelphi University, College of Nursing and Public Health. With over thirty years experience including roles in patient education and healthcare administration, she is well known for innovation in the area of health literacy. Visit the Health Literacy Partners, LLC website at [www.healthliteracypartners.com](http://www.healthliteracypartners.com).

October is Health Literacy Month - stay tuned for more details about how you can use our health literacy tips to ensure great communication with patients in your practice! For more information about the Delco Health Literacy Coalition and our work locally to enhance health literacy please contact David McKeighan at the DCMS office (610) 892-7750.

Practicing medicine with a good understanding of health literacy challenges is at the core of quality care!
EMV Migration – What Liability Will Your Medical Practice Have?

By Mary Ann Robinson, TransAct

How is accepting credit cards for payment in person changing? Perhaps, you have heard all of the buzz about EMV? Chip Cards? A chip card is very similar to today’s magnetic stripe cards. The new cards have a microchip embedded in the card that is virtually impossible to duplicate. Worldwide there are over 130 countries and 2.4 billion EMV cards in circulation so this is not brand new technology that the US is finally bringing to market.

What has brought the change to the US?

The reason the US is migrating towards these cards is based on the level of fraudulent and stolen cards that issuing banks (banks that send out the cards to cardholders for usage) see on a regular basis and merchants may or may not have seen through the Chargeback process. The newer technology heightens the security in processing with a stronger authentication algorithm that reduces the value of stolen data.

How could it affect my business and how we process payment?

Today, the major card brands (Visa, MasterCard, Discover, and American Express) have all recommended terminal implementation solutions. Please note – they have all recommended; NOT mandated or required merchants to do so. The catch is actually two-fold. The first part of the EMV migration is that all banks have to re-issue all the credit cards in circulation today, and replace the magstripe cards with chip based cards. The new cards will contain both an EMV chip and a magstripe so that a business could process either way. So now the question any good practice manager should ask is “what is our liability?”

As of October, for example, Visa has shared:

• If a card has an embedded chip but you choose to swipe the credit card using the magstripe instead, and it is a counterfeit card, you will be responsible for the dollar value loss of that swiped transaction. (The liability shift does not pertain to lost or stolen cards per Visa).

• If you insert the chip into the machine and it is a counterfeit card you will NOT be responsible for the dollar value loss of that transaction.

• If you swipe a credit card that does not have the chip and it is a counterfeit card you will NOT be responsible for the dollar value loss of that transaction.

• If you insert the chip into the reader and chip reader fails there is a fallback procedure.

Next Steps

The next steps should be a conversation with your practice’s partner in merchant services processing as there are many factors that need to be considered when considering an equipment change. The equipment change and the environment in which the cards are being processed also need to align with the PCI security standards that are dynamic and changing during this process as well.

Finally, this is simply a high level overview of how the marketplace is changing when it comes to the acceptance of credit cards. More than ever it is essential for a medical provider to have a partnership with their processor to provide the education and communicate the changes as they occur on a timely basis.

Mary Ann Robinson is the founder and CEO of TransAct (www.transactcc.com) a merchant service company that delivers personalized merchant credit services to small and mid-sized businesses. As a former Senior Business Analyst for the Electronic Data Interchange, NACHA, and ACH financial processing standards for a major health insurance company, her expertise lies in communication and consistently bridging business owners’ needs with the latest technology. She has years of experience working with medical organizations of all sizes in varied markets, and understands the value, processes, advantages and disadvantages of establishing credit card processing procedures for small and medium sized businesses.

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Complying with Stark Law:
Can you bill Medicare when treating your family members?

By Jill Brooks, MD 1st Healthcare Compliance

The treatment of family members falls under General Exclusions from Coverage under Medicare. No payment will be made for items or services for a family member when the charge is from an immediately related provider, any of their associates or their professional corporations.

As part of Stark I in 1989, self-referrals for clinical laboratory services were the first to be barred. The ban for other designated health services was expanded in 1993 and final modifications to the Stark Law published in 2007 as part of the Social Security Act.

The physician self-referral law also referred to as Stark Law:

1. Prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.
2. Prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services.
3. Establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

The definition of a family member as related to Stark Law is broad and extends to spouses, parents, children, siblings, step-parents, step-children, step-siblings, children-in-law, siblings-in-law, grandparents, grandchildren, and spouses of grandparents and spouses of grandchildren.

Designated Health Services included in the Stark Law are:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services

The AMA Code of Medical Ethics states that physicians should not treat themselves or members of their immediate family unless in an emergency setting or for short-term minor problems. According to the AMA Opinion, a family member’s illness may obscure physician judgment and lead to provision of services that are not considered reasonable and necessary or standard of care. Patient autonomy and informed consent may also be at risk. Minors may not feel comfortable refusing care from their parents.

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