Inpatient vs. Observation Hospital Status

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Course Objectives

After finishing this course, the reader should be able to:

- Differentiate between the three types of hospital visits
- Describe how observation status impacts insurance reimbursement to hospitals
- Indicate how observation status and inpatient status can impact the patient financially
- Discuss the benefits of both inpatient and observation status
- Recognize how implicit bias may impact healthcare

Background

- **Value-based purchasing (VBP)** is a healthcare model under the **Affordable Care Act (ACA)** that reimburses providers and facilities based on the value provided, instead of the traditional **fee-for-service (FFS)** reimbursement model
- As part of the value-based care initiative, Medicare looks for ways to ensure that healthcare resources are used efficiently
- Observation status can be used as an effort to reduce healthcare costs for Medicare and other insurance companies
- Overall, Medicare pays less when a patient stay is classified as observation
- Observation stays are classified as a type of outpatient stay that requires monitoring, but may not require an inpatient hospital admission
- Admission status may also determine what portion of your stay your insurance policy will cover

The Centers for Medicare & Medicaid Services (CMS)

- **CMS** is the federal government agency that oversees programs to improve health outcomes
- Medicare is the federal insurance system that covers certain populations, including:
  - Individuals 65 and older
  - Individuals under 65 with certain disabilities
  - Individuals with end-stage renal disease (ESRD), regardless of age
- The main goal of CMS is to provide insurance coverage to a large population and manage initiatives that aim to increase equality in healthcare
- CMS is responsible for value-based programs that are part of a larger strategy to manage healthcare costs

Medicare Benefits

Part A

- Covers inpatient services

Part B

- Covers outpatient services

Part C

- Medicare Advantage plans

Part D

- Covers medications

Medicare Part A

- Helps cover inpatient hospital stays
- Helps cover stays in **skilled nursing facilities (SNFs)**, but does not cover custodial or long-term care
- Typically covers short periods of services provided in a skilled nursing facility, such as physical therapy
- Helps cover hospice care
- Helps cover home healthcare
- Paid for through payroll taxes of the patient or their spouse, when employed
- Inpatient admissions will require Medicare beneficiaries to pay Part A deductible
- Medicare beneficiaries are not responsible for separate hospital services such as nursing care, tests, or procedures

Medicare Part B

- Helps cover outpatient or observation care
  - All services are billed separately
  - Patients are responsible for 20 percent of services after Part B deductible
- Helps cover doctors' services
- Typically covers 80 percent of doctors' services provided while admitted into the hospital
- Helps cover some outpatient therapy services like physical therapy, speech therapy, and occupational therapy
- Helps cover some home healthcare services that Part A does not cover
- Helps cover medically necessary services and supplies such as durable medical equipment (hospital beds, wheelchairs, and walkers)
- Helps cover preventive care services (yearly wellness check-ups, vaccines, and screenings)

Medicare Part C

- Medicare Advantage plans
- These plans are approved by Medicare but run by private insurance companies
- They are usually bundled plans, including Part A, Part B, and Part D
- Includes a provider network that typically must be utilized for coverage
- Advantage plans usually boast lower out-of-pocket costs than Original Medicare
- May also offer different benefits not covered by Medicare, such as dental, vision, and hearing plans

Medicare Part D

- Helps cover the cost of prescription drugs
- Includes coverage of several vaccines and shots
- Medicare Part D is combined with Original Medicare or with a Medicare Advantage plan
- Medicare Advantage plans that include Medicare drug coverage are owned by private insurance companies and follow Medicare rules

Other Facts About Medicare Coverage

- Mental healthcare provided in an inpatient setting or psychiatric hospital is covered up to 190 days during a lifetime
- Medicare covers care that is received during an inpatient admission to the following facilities, in addition to acute care hospitals:
  - Inpatient psychiatric facilities
  - Inpatient rehabilitation facilities
  - Critical access hospitals
  - Long-term care hospitals
  - Inpatient care received during any qualifying clinical research study

Statistics

- 2018 State of Hospital Medicine study showed:
  - 80.7 percent of hospitalist patients were discharged under inpatient status
  - 19.3 percent of hospitalist patients were discharged under observation status
- Observation status billed under Medicare Part B typically requires a 20 percent coinsurance payment with no spending limit, which can impact patients' finances significantly
  - Coinsurance payment is the portion of hospital stay cost that the patient is responsible for

Financial Facts

Inpatient status billed under Medicare Part A requires only a deductible. According to CMS:

- The deductible amount is $1,556
- A coinsurance for days 1-60 is $0
- The coinsurance for days 61–90 is $389 daily
- The coinsurance for days 91 and after, or “lifetime reserve days,” is $778 daily
- A **lifetime reserve day** is each day after day 90 of an inpatient hospitalization, for each benefit period
- Medicare allows you 60 lifetime reserve days for your entire life
- The patient will be responsible for all costs every day after lifetime reserve days are depleted

Length of Stay

- **Length of stay (LOS)** is a performance metric based on how many midnights a patient stays in the hospital
- Hospital billing is accrued when a patient is occupying a hospital room at midnight
- Inpatient LOS starts when a doctor's order states that you are admitted into the hospital
- Inpatient LOS ends the day before you are discharged as this is the last midnight that a patient will remain in the hospital

Benefit Period

- Medicare starts your benefit period the day that you are admitted as an inpatient to a hospital or into a skilled nursing facility (SNF)
- Your period ends when there has not been any inpatient hospital or SNF stays for 60 consecutive days
- Once you are admitted to a hospital or SNF, a new benefit period will be started
- Your deductible must be paid with each benefit period
- There is not a limitation on the number of benefit periods

Medicare Summary Notice (MSN)

A quarterly listing of all services that Medicare provided during this period

Lists all covered and noncovered services and items

Sent only to Original Medicare recipients, not for Medicare Advantage plans

What Medicare Covers During Your Hospitalization

- During an inpatient hospitalization, Medicare covers:
  - A semi-private room (if available)
  - All meals provided by the hospital
  - Any nursing care provided
  - Any medications given during hospital stay
  - All other items and services used during your inpatient hospitalization

What Medicare Does Not Cover During Your Hospitalization

- NOT covered by Medicare:
  - Nursing care provided by private-duty companies
  - Private rooms, unless there are no available semi-private rooms, or a private room is medically necessary
  - Phones or televisions when these items have a separate charge
  - Any additional personal care items, such as socks or razors

3 Types of Hospital Visits

Outpatient

- Patients or conditions that require tests, simple treatments, or minor surgery
- Conditions that are expected to only require a few hours or maybe overnight in the hospital

Observation

- Conditions that could require an inpatient stay if there is a serious change
- Conditions that are expected to require less than a 24-hour hospital stay

Inpatient

- Conditions may involve surgery or complicated treatments
- Patients or conditions that require longer treatment time from a healthcare team
- Conditions that are expected to require more than one night of hospitalization

Observation Facts

- **Observation status** is a method of billing that was created by insurance companies to decrease reimbursement owed to acute care hospitals
- Patients who are not ill enough to meet inpatient status criteria, but still require care in the hospital, may fall into Medicare observation status
- Insurance payers define observation as they see fit, and rarely do different payers define this status by the same criteria
- Observation status is an alternative to inpatient status but does not change the level of care provided in the hospital
- The care provided in the hospital is often the same whether your stay is brief or a longer course of hospitalization is required

How Does Observation Status Affect the Patient?

- Because they aren't really treated differently, patients may not be aware of their observation status or what this designation could mean
- Observation designation can impact insurance coverage, reimbursement, and cost-sharing of expenses, especially in the Medicare population
- Observation stays are covered under Medicare Part B
- Deductibles and copayments can apply under Medicare Part B

Common Observation Diagnoses

ABDOMINAL PAIN

CHEST PAIN

MIGRAINE HEADACHE

SYNCOPE

CMS “Two-Midnight” Rule

- If a stay is expected to cross two midnights, it is reasonable to assume an inpatient admission is medically necessary
- This inpatient stay will be reimbursed under Medicare Part A
- If a stay will probably span less than two midnights, these stays are usually considered outpatient or observation, and will be billed and paid under Medicare Part B
- Certain stays that are less than two midnights can be reimbursed under part A on a case-by-case basis; it is based on documentation and medical decision making by the attending physician

Benefits of Inpatient Status

- Inpatient stays are covered under Medicare Part A
- The patient will be responsible for one co-payment and one deductible
- Patients that have three inpatient hospital days are eligible for skilled nursing facility coverage under Medicare Part A

CMS 3-Day Rule

This rule from The Centers for Medicare & Medicaid Services (CMS) mandates that a patient must be admitted as an inpatient for at least three days for Medicare to pay for skilled nursing facility care

Any observation days will not count towards these inpatient days

Inappropriate Inpatient Admissions

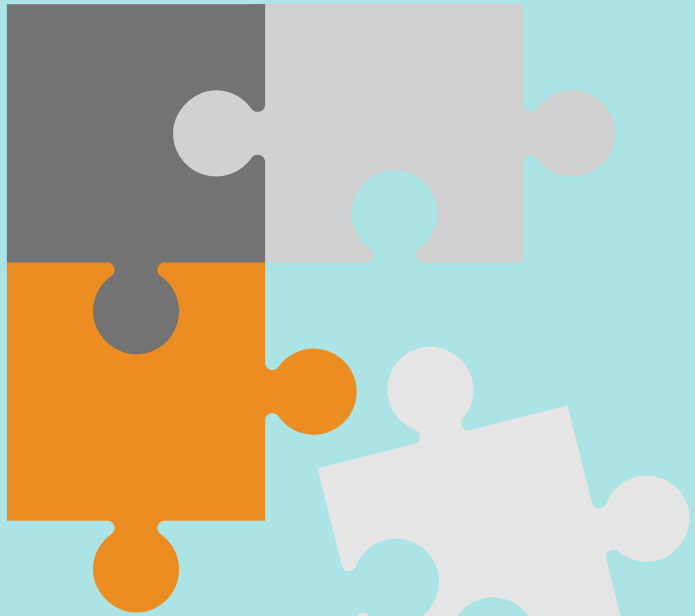
- Medicare reviews short stays using **recovery audit contractors (RACs)**
- These reviews find opportunities to classify stays as observation instead of inpatient admissions, which can save insurance companies money, but may involve out-of-pocket costs for the patient
- If a patient is admitted inappropriately as an inpatient, your insurance company may deny the claim if they determine that the stay should have been under observation status
- Your insurance company may send a letter well after discharge from the hospital stating that your claim was denied

Hospital Condition Code 44

Retroactively changes a stay to observation status when inpatient status is not appropriate.

Medicare Outpatient Observation Notice (MOON)

- Result of the **Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act)**, which was enacted in 2015
- This act requires hospitals and **critical access hospitals (CAHs)** to provide notice to Medicare recipients that have been under observation status for 24 hours
- This notice warns them about the financial consequences of being placed under observation
- It should be given to the patient with verbal explanation within 36 hours of the patient being placed on observation status
- The **MOON Notice** should be signed by the patient, patient representative, or hospital representative if the patient refuses to sign as proof of receipt



Case Management

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Utilization Review +
Discharge Planning

Utilization Review Committee

- Reviews all patient cases to determine whether they are more appropriate for inpatient status or observation status
- This review ensures that the insurance payor will reimburse hospitals appropriately for medical services provided
- This review process also helps to maintain cost efficiency

Utilization Review (UR) Facts

The goal of the utilization review process is to ensure patients are receiving needed care, and that care is administered using evidence-based practices by the most appropriate providers in the most appropriate setting

Utilization review is typically performed by nurses using specific protocols that include evaluating for appropriate admission status (inpatient versus observation), evidence-based treatment plans, and evaluation of probable timeframe for patient stay

These protocols are compared to current treatment and changes are recommended to the provider as warranted

Regular communication with the insurance UR department will occur throughout the patient stay to evaluate patient condition and progress

Importance of UR in a Hospital Setting

The UR process is an important piece of the value-based care initiative which ensures that healthcare services are being appropriately and efficiently utilized

The UR process helps in preventing denials from insurance companies by ensuring alignment with treatment and admission status protocols that are outcome-driven

Hospitals are only allowed to participate in Medicare and Medicaid by having an effective UR process in place

Utilization Review Process

- Utilization review (UR) nurse discusses medical necessity of episode of care with insurance UR nurse
- Discussion about status of patient will ultimately determine payment or reimbursement to healthcare facility for services provided
- If discussion between UR nurses does not result in agreement, hospital physician will discuss the case and medical necessity with insurance physician through a peer-to-peer conference
- If no agreement can be made between physicians, the hospital appeals department will appeal the case with the insurance company
- The **Code of Federal Regulations** along with the **Medicare Benefit Policy Manual** provide guidelines for inpatient versus observation status

Important Documentation for UR Process

Objective information is important in determining status, and, therefore, reimbursement, so, it is imperative that the following information is documented:

- Past medical history
- Current treatments and interventions
- Previous treatment and interventions (Did this patient fail outpatient treatment?)
- Oxygen usage, saturation, and administration mode
- Patient condition, including current vital signs
- Intensity of pain
- Intake/output amounts
- Abnormal signs and symptoms
- Plan of care

When Can UR Process Be Used?

Concurrent review

- Occurs while care is being given

Retrospective review

- Occurs after care has been completed

Prospective review

- Occurs as part of the prior authorization process that grants or denies approval before a treatment or test is performed

What if a Claim Is Denied?

If a claim is denied by insurance based on inappropriate admission status, the hospital may fight the denial by showing that they used **InterQual Criteria** or **Milliman Clinical Guidelines**

If the hospital fails to appeal the denial, you may be billed

Denial Appeals Process

- Hospitals are provided with an appeals process by individual insurance payors
- This process is applied when a claim is denied by the payor because the insurance payor feels that admission status was incorrect or inappropriate
- Denials typically occur after the patient is discharged from the hospital
- Appeals processes differ from payor to payor
- The terms of the appeal process are outlined in contracts between hospitals and payors
- These terms include details such as:
  - What type of claims can be appealed
  - Who can file appeals
  - Time frame in which appeal should be submitted
  - Different levels of appeals

Steps in Denial Appeals Process

1. Reconsideration
   - Insurance payor will review supporting arguments from hospital to reconsider denial decision
   - If payor upholds denial in this initial stage, the appeal process will advance to the next step
2. Peer-to-peer conference
   - These conversations require the hospital physician overseeing the case to speak with the insurance company physician to discuss the details of the case
   - Hospital physicians can defend their choice of inpatient status; conferences are required to take place within a specific time frame
   - If payor continues to uphold the denial, the appeal process will advance to the last step
3. Written appeal
   - Written arguments are submitted to insurance payors to further support inpatient status decision
   - This is the last step in the denial appeal process

Inpatient Versus Observation Determination Guidelines

- CMS publishes a set of guidelines in the Medicare Benefit Policy Manual, which describes what patients should be assigned inpatient status, and what patients should be assigned observation status
- This set of guidelines changes yearly and is very complex
- Third-party services are typically hired by healthcare facilities to interpret these guidelines and develop policies to assign appropriate admission status
- These policies are standardized between hospitals and insurance companies using InterQual Criteria and Milliman Clinical Guidelines

Standardized Guidelines

InterQual

Milliman

These guidelines ensure alignment between hospitals and insurance companies when deciding patient stay status

InterQual and Milliman Criteria Overview

- Evidence-based criteria used by healthcare providers and insurance providers to help determine medical necessity
- These criteria are not a substitute for physicians' professional opinions, but can offer some guidance
- Healthcare providers will benefit from knowing both sets of criteria
- CMS does not endorse either set of criteria

Consequences of Incorrect Status

- Denials of cases with incorrect admission status can result in denials from insurance companies, which causes significant financial burden on the healthcare facility
- Out-of-pocket costs to patients can also be significant
- Hospitals can file appeals with insurance companies, which can also be time-consuming and costly for the healthcare facility
- The appeals process can also result in payment delays
- Costs of the appeals process can be higher than lost reimbursement of the case
- There can also be financial and legal penalties for physicians and hospitals that assign the incorrect or inappropriate admission status to a hospitalization case

When Medicare Denies a Claim

- Before you appeal a claim, ensure that the proper **ICD-10 diagnostic code** was applied to your case by checking with the healthcare provider office
- By correcting the diagnostic code, coverage may be approved, and an appeal may not be necessary
- If this is not the case, you will want to contact your healthcare provider's office to check if a Medicare **Advance Beneficiary Notice of Non-coverage (ABN)** was signed for the service in question
- If you signed this, ask for a copy
- If you did not sign this form, you are not eligible to appeal

Submitting an Appeal

- Gathering information related to your appeal should be done prior to submission
- Obtaining a letter of support from your medical provider and other appropriate medical records may be necessary
- All documents that you submit should include your Medicare number, and copies of all submitted documents should be kept
- Appeals are pursued through Medicare in one of the following three ways:
  1. Letter written to company that processed your claim, including the reason for your appeal request, service that was denied, your name, and Medicare number
  2. Your **Medicare Summary Notice (MSN)** has instructions to appeal process, and a copy of any requested documents, along with a copy of the MSN, should be sent to the company that processed your claim
  3. The Centers for Medicare and Medicaid Services (CMS) offers a Redetermination Request Form to be completed and sent to the company that processed your claim

Medicare Appeal Levels

The Medicare appeals process has five different levels. If your appeal is approved, this process stops. If your denial is upheld, you can choose to move to the next level.

1. Redetermination by the company that processed your Medicare claim
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. Hearing before an Administrative Law Judge
4. Review by the Medicare Appeals Council
5. Judicial review by a Federal District Court

First Level

Redetermination by the company that processed your Medicare claim

- Fill out a **Redetermination Request Form** for a Level One decision
- This redetermination should be made within 60 days
- If appeal is denied, you have 180 days to proceed with the next level

Second Level

Reconsideration by a **Qualified Independent Contractor (QIC)**

- Complete a Reconsideration Request Form or send a letter for a Qualified Independent Contractor to review your case
- Determination at second level is to occur within 60 days
- If the QIC does not make their determination within this time frame, you can submit a request to proceed to the next level
- If your appeal is denied by the QIC, you may request a hearing with a judge within 60 days

Third Level

Hearing before an **Administrative Law Judge**

- As of 2022, the denied services must meet a minimum financial requirement of $180 to be eligible for a Level Three appeal
- Complete a **Request for Medicare Hearing by an Administrative Law Judge (ALJ) Form**, or submit a written request to the **Office of Medicare Hearings and Appeals (OMHA)** Central Operations, which is listed on your Level Two denial letter
- If the ALJ cannot provide a determination within a sensible amount of time, you can submit a request to proceed to the next level
- If your appeal is denied by the ALJ, you will have 60 days to request review with a Medicare Appeals Council at the next level

Fourth Level

Review by the **Medicare Appeals Council**

- Complete a Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal Form or send a written request to the Medicare Appeals Council for a review of the claim
- No deadline exists for the Appeals Council's decision, but if a decision is not made in a sensible time, you can submit a request at the next level
- If your appeal is denied by the Medicare Appeals Council, you can request a Level Five review with a federal district court within 60 days

Fifth and Final Level

Judicial review by a **Federal District Court**

- As of 2022, the denied services must meet a minimum financial requirement of $1,760 to be eligible for a Level Five appeal
- Claims may be combined to meet this dollar amount if necessary
- The decision of this Federal District Court is final

Best Practices to Increase Appropriate Observation Status

- Admission status algorithms placed within easy view of providers to increase provider knowledge of appropriate status
- Regular provider education on Milliman Clinical Guidelines (MCG) and InterQual Criteria for appropriate status determination, impact of correct and in correct status determination, and the Medicare Two-Midnight Rule
- Frequent assessment of observation patients and necessary changes in circumstances for potential change in admission status
- Correct and complete documentation

Reflection

In your nursing practice, when have you seen a patient admitted inappropriately, either as an observation status admission that should have been inpatient, or as an inpatient admission that should have been observation?

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The following slides address the California BON regulation that, beginning January 2023, all continuing education providers shall ensure compliance with the requirement that continuing education courses contain curriculum that includes the understanding of implicit bias.

Implicit Bias

How does it affect healthcare?

Why does implicit bias matter?

Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. (Hall et al., 2015)

Implicit (subconscious) bias refers to the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. (The Joint Commission, 2016)

Why does implicit bias matter?

Implicit biases affect behavior through a two-phase process: biases are activated in the presence of a member of a social group and then are applied so that they affect the individual's behavior related to that group member. In the healthcare context, for instance, implicit biases may be activated when a provider is interacting with an African American patient, particularly under conditions that tax her cognitive capacity (e.g., stress, time-pressure, fatigue, competing demands), and can then influence how she communicates with and makes decisions about her patient. (Burgess et al, 2017)

Why does implicit bias matter?

Implicit (unconscious) biases can create gaps between good intentions and good outcomes in the health care field. (The Ohio State University, 2020)

Based on the available evidence, physicians and nurses manifest implicit biases to a similar degree as the general population. The following characteristics are at issue: race/ethnicity, gender, socio-economic status (SES), age, mental illness, weight, having AIDS, brain injured patients perceived to have contributed to their injury, intravenous drug users, disability, and social circumstances. (FitzGerald & Hurst, 2017)

Why does implicit bias matter?

The implicit biases of concern to health care professionals are those that operate to the disadvantage of those who are already vulnerable. Examples include minority ethnic populations, immigrants, the poor, low health-literacy individuals, sexual minorities, children, women, the elderly, the mentally ill, the overweight, and the disabled. However, anyone may be rendered vulnerable given a certain context. (FitzGerald & Hurst, 2017)

Why does implicit bias matter?

Implicit biases among health care providers are associated with the following negative effects on patient care:

- inadequate patient assessments
- inappropriate diagnoses and treatment decisions
- less time involved in patient care
- patient discharges with insufficient follow-up

Why does implicit bias matter?

The terms "health care disparities" and "health care inequities" refer to the poorer health outcomes observed in minority and other vulnerable patient groups compared with those observed in majority or dominant patient populations. Disparate patient outcomes are associated with age, sex, religion, socioeconomic status, sexual orientation, gender identification, disability, and stigmatized diagnoses (for example, HIV, obesity, mental illness, and substance abuse). (Narayan, 2019)

Why does implicit bias matter?

Implicit bias isn't limited to race. The Implicit Association Test (IAT) measures attitudes and beliefs that people may be unwilling or unable to report.

For example, when the IAT was administered at an obesity conference, participants implicitly associated obese people with negative cultural stereotypes, such as "bad, stupid, lazy and worthless."

Implicit gender bias among physicians also may unknowingly sway treatment decisions.

Why does implicit bias matter?

Women are three times less likely than men to receive knee arthroplasty when clinically appropriate. One of the stereotypical reasons for this inequity and underuse problem is that men are viewed as being more stoic and more inclined to participate in strenuous or rigorous activity.

(The Joint Commission, 2016)

Why does implicit bias matter?

People of color face disparities in terms of morbidity, mortality, and health status. Black, Hispanic, and Indigenous Americans have higher infant mortality rates than White and Asian Americans. The premature death rate from heart disease and stroke is highest among Black Americans. Race and ethnicity are not the only demographic factors associated with disparity in health outcomes. Women are more likely to experience delayed diagnosis of heart disease compared to men, as well as inferior heart attack treatment. Sometimes, these disparities intersect, as in the case of childbirth, where the United States is one of the few countries experiencing a rise in the maternal mortality rate, and Black women are nearly four times as likely to die during childbirth as are White women. (Whitmer, 2020)

Why does implicit bias matter?

Healthcare providers in a certain geographic area may equate certain races and ethnicities with specific health beliefs and behaviors (e.g., “these patients” engage in risky behaviors, or “those patients” tend to be noncompliant) that are more associated with the social environment (like poverty) than a patient’s racial/ethnic background or cultural traditions. (Stanford University, 2020)

How does implicit bias develop?

The ability to distinguish friend from foe helped early humans survive, and the ability to quickly and automatically categorize people is a fundamental quality of the human mind. Categories give order to life, and every day, we group other people into categories based on social and other characteristics.

This is the foundation of stereotypes, prejudice and, ultimately, discrimination.

Social scientists believe children begin to acquire prejudices and stereotypes as toddlers.

How does implicit bias develop?

Once learned, stereotypes and prejudices resist change, even when evidence fails to support them or points to the contrary.

People will embrace anecdotes that reinforce their biases, but disregard experience that contradicts them. The statement "Some of my best friends are _____" captures this tendency to allow some exceptions without changing our bias. (Learning for Justice, 2022)

How does implicit bias develop?

Scientific research has demonstrated that biases thought to be absent or extinguished remain as "mental residue" in most of us. Studies show people can be consciously committed to egalitarianism, and deliberately work to behave without prejudice, yet still possess hidden negative prejudices or stereotypes.

A growing number of studies show a link between hidden biases and actual behavior. In other words, hidden biases can reveal themselves in action, especially when a person's efforts to control behavior consciously flags under stress, distraction, relaxation or competition. (Learning for Justice, 2022)

How does implicit bias develop?

Research has frequently focused on the amygdala, a structure in the medial temporal lobes. The amygdala receives direct input from all sensory organs, enabling it to respond rapidly to immediate threats in advance of more elaborative cognitive processing. It plays a central role in arousal, attentiveness and triggering the flight-or-fight response, reacting to social threats in exactly the same way it reacts to physical ones. Unconscious bias, then, is the immediate, reflexive, defensive reaction to the "other." (Korn Ferry Institute, 2022)

How do I recognize implicit biases?

One way to discover implicit biases is to pay attention to gut feelings.

Nurses can ask themselves if they anticipate unpleasant experiences when caring for any particular group of patients, or if any particular group of patients makes them feel uncomfortable, anxious, or fearful.

Such feelings may indicate implicit bias and prompt self-reflection. Thoughtfully reflecting on the meaning and origin of such feelings and whether they influence the quality of relationships with patients can help nurses acknowledge and control previously unrecognized biases. (Narayan, 2019)

How do I recognize implicit biases?

Take one or more of the free Implicit Association Tests (IATs) available at Project Implicit (https://implicit.harvard.edu/implicit/education.html). Developed by Harvard, there are 14 instruments for measuring some of the most prevalent biases—those related to race, ethnicity, skin color, religion, age, gender, overweight or obesity, sexual orientation, or disability.

Learning about potential biases can enable people to employ strategies to reduce them or mitigate their effects on future interactions. The IATs are reliable and valid research instruments, and should not be used to diagnose bias but rather as educational tools.

How do I recognize implicit biases?

Implicit bias is different from prejudice. Implicit bias means we have the instinctive tendency to evaluate other groups against the norms of our own groups. Prejudice, on the other hand, means that one feels consciously and overtly that some groups are inferior, an attitude that can be used to justify discriminatory actions. (Narayan, 2019)

But I really don't think I'm biased

There's a reason it's called unconscious bias.

It's because hard-wired biases operate at a level that is beneath our conscious awareness. Even if we sincerely believe we're being fair and objective, stereotypes may still be influencing our opinions -without us being aware of it. (Stanford University, 2020)

We may consciously reject negative images and ideas associated with disadvantaged groups (and may belong to these groups ourselves), but we have all been immersed in cultures where these groups are constantly depicted in stereotyped and pejorative [derogatory] ways. (FitzGerald & Hurst, 2017)

Challenges in reducing implicit biases

Some types of interventions focus more on declarative knowledge – what you know – than on procedural knowledge – knowing how to do something.

Understanding implicit bias as a score on the IAT also may engender the view of implicit bias as a fixed trait that one can do little about.

Issues of race and racism are emotionally fraught and politically charged. The idea that healthcare providers may contribute to racial disparities may contradict their core beliefs and values, including beliefs that they treat everyone equally and that racial inequality is a thing of the past. (Burgess, 2017)

How to reduce implicit bias

1. **Stereotype replacement** — Recognizing that a response is based on stereotype and consciously adjusting the response
2. **Counter-stereotypic imaging** — Imagining the individual as the opposite of the stereotype.
3. **Individuation** — Seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor's office or health center)
4. **Perspective taking** — "Putting yourself in the other person's shoes"

How to reduce implicit bias

5. **Increasing opportunities for contact with individuals from different groups** — Expanding your network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present
6. **Partnership building** — Reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person

How to reduce implicit bias

7. **Emotional regulation** — People who have good emotional regulation skills and who experience positive emotion during clinical encounters may be less likely to view patients in terms of their individual attributes, and to use more inclusive social categories. It's easier to empathize with others when people view themselves as being part of a larger group. (The Joint Commission, 2016).
8. **Mindfulness** — A "mode of awareness" that can be enacted in different situations, including those which are emotionally challenging (Burgess, 2017).

How to reduce implicit bias

9. **Habit replacement** — Implicit bias is like a habit that can be broken through a combination of awareness of implicit bias, concern about the effects of that bias, and the application of strategies to reduce bias. (Devine et al, 2012)

10. **Take care of yourself** — Protect your mental resources. Do things to protect your mental energy, such as getting sufficient sleep, finding ways to reduce stress and taking mental breaks throughout the day to refocus on being present with your patients. (van Ryn, 2016)

The Institute for Healthcare Improvement (2017)

How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

- Have a basic understanding of the cultures your patients come from.
- Don’t stereotype your patients; individuate them.
- Understand and respect the tremendous power of unconscious bias.
- Recognize situations that magnify stereotyping and bias.

How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

- Know the National Culturally and Linguistically Appropriate Services (CLAS) Standards. (Available at https://thinkculturalhealth.hhs.gov/clas/standards)
- Do a "Teach Back." Teach Back is a method to confirm patient understanding of health care instructions that is associated with improved adherence, quality, and patient safety.
- Assiduously practice evidence-based medicine.

Recommended viewing

Institute for Healthcare Improvement. (2020)

- How Does Implicit Bias Affect Health Care? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-How-Does-Implicit-Bias-Affect-Health-Care.aspx
- What Are the Harms of Not Addressing Bias in Health Care? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-What-Are-the-Harms-of-Not-Addressing-Bias-in-Health-Care.aspx

Recommended viewing

Institute for Healthcare Improvement. (2020)

- What Is Bias, and What Can Medical Professionals Do to Address It? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-What-Is-Bias,-and-What-Can-Medical-Professionals-Do-to-Address-It.aspx
- Why Shouldn't Providers Judge Patients' Choices? http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Nia-Zalamea-Why-Shouldnt-Providers-Judge-Patients-Choices.aspx

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Inpatient vs. Observation Hospital Status

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