RISK MANAGEMENT TRAINING FOR NHCAC

North Hudson Community Action Corporation

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SUBJECT AREAS

- NHCAC's Mission
- Documentation
- Communication
- Liability and Risk Management
- Late Entries/Addendums
- Compliance with Policies and Procedures
- Credentialing and Privileging
- HIPAA Confidentiality

NHCAC's Mission, Vision, and Goals

- To promote and improve the **quality of life**, and to eliminate factors leading to **poverty**, for northern New Jersey residents by providing **comprehensive health** and social services with compassion, through collaborations and partnerships, in a culturally sensitive environment.

FQHC AND HRSA

- The **Health Resources and Services Administration** funds almost 1,400 health center grantees that operate more than 10,400 clinics and mobile medical vans, delivering primary and preventive care to over 16 million low-income patients in every state, Washington D.C., Puerto Rico, the U.S. Virgin Islands, and U.S. possessions in the Pacific.

- **HRSA** is an agency of the U.S. Department of Health and Human Services . It is the primary federal agency for improving access to health care services for people who are **uninsured, isolated or medically vulnerable.**

DOCUMENTATION

DOCUMENTATION –THE BASICS

- **Date, time, and sign** every entry
- **Make entries immediately** or soon after care is given
- Be **thorough, accurate, and objective**
- Only used approved abbreviations

DOCUMENTATION

- *"If it's not documented in the medical record then it didn't happen."*

- Risk Management does not necessarily advocate to write more, but rather to record the facts and findings regarding patient care **so that the record reads like a book.**

DOCUMENTATION

BE OBJECTIVE

- The patient's chart is about continuum of care.
- If a record is **well documented** to facilitate care then there is no worry that the record will be a liability if there ever should be a claim.

- *"Defensive" documentation should not drive how a chart is generated*.

DOCUMENTATION

- Document **all** interactions with or about the patient, face-to-face or over the phone.
- The record serves as a log of not only treatment and care but also **communication** providing insight into:

- *What was said;*
- *When it was said;*
- *Specifically to whom it was said and;*
- *Their response.*

DOCUMENTATION *REMEMBER:*

- Sloppy documentation is equated with sloppy care.
- Sloppy documentation can result in sloppy continuum of care.
- The record is a **legal document -W**hat you write is memorialized ***permanently***. What you don't write is questioned forever.

MEDICAL SCRIBES

- The Joint Commission defines a medical scribe as an unlicensed individual hired to enter information into the electronic health record (EHR) or chart at the direction of a physician or licensed independent practitioner.
- A scribe's core responsibility is to capture accurate and detailed documentation (handwritten, electronic, or otherwise) of the encounter in a timely manner.
- Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider.

MEDICAL SCRIBES

- MEDICARE RULES:
- Scribes are never providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/NPP's signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided.
- Reviewers are only required to look for the signature (and date) of the treating physician/NPP on the note.
- Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.
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THE GENERAL DUTIES OF A SCRIBE

- Assisting the provider in navigating the EHR
- Responding to various messages as directed by the provider
- Locating information for review (*i.e., previous notes, reports, test results, and laboratory results*)
- Entering information into the EHR as directed by the provider
- Researching information requested by the provider

DUEL ROLES AS SCRIBES AND CLINICAL ASSISTANTS

- It is possible for a provider to select a clinical assistant (non-licensed clinical staff) who has performed clinical duties and worked with the provider to perform scribe services. It is not recommended, however, to allow an individual to fill the role of scribe and clinical assistant simultaneously during the same encounter. This practice raises legal and other issues regarding job role and responsibilities.

DUEL ROLES AS SCRIBES AND CLINICAL ASSISTANTS

- EHR security rights (role-based access) for a scribe and clinical assistant are different. When a scribe is also acting as a clinical assistant during the same encounter, the scribe will log in with one set of security rights as a clinical assistant, log out, and then log back in with another set of rights to perform the scribe duties.
- The dual role results in the scribe logging in and out between roles multiple times during one encounter-wasting valuable time and resources.
- It is best to limit the scribe to filling only one role during a single encounter.

MID-LEVEL PROVIDERS

- Advanced practice nurses and midwifes (referred to as mid-level providers) can also direct MA's with the scope of their collaborative agreements.

- Any questions relating to MA scope of practice should be directed to the practitioner or the Medical Director

DELEGATION OF SELECTED NURSING TASKS (NJAC 13:37-6.2)

- The registered professional nurse is responsible for the nature and quality of all nursing care including the assessment of the nursing needs, the plan of nursing care, the implementation, and the monitoring and evaluation of the plan.
- The registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel.
- Ancillary nursing personnel shall include but not be limited to: aides, assistants, attendants and technicians.

DELEGATION OF SELECTED NURSING TASKS (NJAC 13:37-6.2)

- A registered professional nurse may not delegate the performance of a nursing task to persons who have not been adequately prepared by verifiable training and education.
- No task may be delegated which is within the scope of nursing practice and requires:
  - The substantial knowledge and skill derived from completion of a nursing education program and the specialized skill, judgment and knowledge of a registered nurse;
  - 2) An understanding of nursing principles necessary to recognize and manage complications which may result in harm to the health and safety of the patient.

COMMUNICATION

COMMUNICATION AMONG PROVIDERS, STAFF, AND COMMUNITY PARTNERS

- . Communication among healthcare professionals takes many forms:
- Collaborating with colleagues and coordinating care;
- Building relationships with external partners;
- Preparing for response to emergencies.
- *Communication breakdowns, either between physicians or between other clinicians and the patient, can lead to patient mistrust, dissatisfaction, and anger.*

LARGEST SOURCE OF ADVERSE ACTIONS

- Communication breakdown is a primary contributing factor in medical errors, has a negative effect on patient-provider relationships, and can lead to malpractice lawsuits and loss of licensing and privileges.

CASE STUDY

- Michael is a 35-year-old man with relapsing-remitting multiple sclerosis. He presents to the health center with complaints of increased weakness in his legs, and several recent falls.
- Dr. Jones, his primary physician, suspects that Michael's disease may be worsening into secondary-progressive multiple sclerosis. Dr. Jones directs Michael to follow up with his neurologist. Michael attempts to do so, but there is a six-month wait for appointments—Michael's neurologist is the only one accessible by public transportation who also accepts his insurance.

CASE STUDY

- Two weeks later, Michael needs stitches for a laceration sustained in another fall. Dr. Jones instructs his medical assistant, Robert, to call the neurologist's office and request an urgent appointment. Robert does so without success, and does not mention this to Dr. Jones.
- One week later, Michael falls again and sustains a major head injury that results in a significant increase in his disability.

QUESTIONS FOR DISCUSSION

- What should Robert have done differently?
- What should Dr. Jones have done differently?
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- If Michael were a patient at NHCAC, how do you think this situation would have been handled?

FUNCTIONAL ILLITERACY

- Nearly half of the United States adult population—90 million people—have low literacy skills, and 40 million of these are considered *functionally illiterate*

COMMUNICATION IS A HEALTH AND SAFETY ISSUE

- Navigating consumer health information, which often includes complex concepts, medical language, and numbers or calculations, can be overwhelming to even literate, normal-functioning people.

- The ability to understand and act upon health information is called ***health literacy***.

- **Low health literacy** is of great concern because the inability to understand instructions or advice from health care providers can lead to adverse health outcomes

PATIENTS CAN BE SMART AND WISE, BUT NOT HEALTH LITERATE

- *Examples*:
- Adults who can read the sports section and understand the highlights of last night's baseball game may not be able to read and understand instructions for taking medicine
- Adults who will talk for hours about their favorite T.V. show may be reluctant to talk about their health condition
- College-educated adults with superior learning skills may "tune out" when it comes to medical or health issues

FUNCTIONAL ILLITERACY

- On average, adults read 3-5 grade levels lower than the years of school they have completed. Reading skills atrophy when they are not used regularly.

- Thus, someone who may have completed the 12th grade may actually read at the 7th-9th grade reading level.

- The elderly, teenagers, the poor, and persons with lower cognitive ability have a high prevalence of low literacy.
- In addition, a person's *culture or beliefs* may influence how they perceive a message.
- A foreign-born patient may have very high literacy and/or education in his native tongue, but not English.

ASSESS WHAT THE PATIENT WANTS TO KNOW

- Not all patients with the same diagnosis want the same level of detail in the information offered about their condition or treatment.

- Studies have categorized patients on a continuum of information-seeking behavior, from those who want very little information to those who want every detail the physician can offer.

- Thus, physicians should assess whether the patient desires, or will be able to comprehend, additional information.

BE EMPATHIC

- Empathy is a basic skill physicians should develop to help them recognize the indirectly expressed emotions of their patients.
- Once recognized, these emotions need to be acknowledged and further explored during the patient-physician encounter.
- Further, physicians should not ignore or minimize patient feelings with a redirected line of inquiry relentlessly focused on “real” or “more important” symptoms.

KEEP IT SIMPLE

- Physicians should avoid engaging in long monologues in front of the patient.
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- Far better for the physician to keep to short statements and clear, simple explanations.
- Those who tailor information to the patient's desired level of information will improve comprehension and limit emotional distress

TELL THE TRUTH

- It is important to be truthful. In addition, it is important that physicians not minimize the impact of what they are saying.
- Certain medical language can be interpreted by an anxious family member as having a completely different meaning than that intended by the physician
- Physicians must effectively communicate the particular circumstance in a manner that minimizes confusion.

SLLOWWW DOWN…

- Providing information in a **slow and deliberate** fashion allows time for patient comprehension.
- A good technique is **pausing frequently** and reinforcing silence with appropriate body language. A slow delivery with appropriate pauses also gives the listener time to formulate questions, which the physician can then use to provide further bits of targeted information.
- Thus, a dialogue punctuated with pauses leads to **deeper comprehension on both sides**

DELIVERING BAD NEWS

- In situations involving the delivery of **bad news**, the technique of simply stating the news and pausing can be particularly helpful in ensuring that the patient and patient's family fully receive and understand the information.

- Allowing this time for silence, tears, and questions can be essential.

FOCUSING ON KEY ISSUES

- ***Focus on key messages*** and repeat these messages often.
- Whether communicating in a verbal or written manner, it is important to limit your information to 1-3 key messages per visit. Reviewing and repeating each point will help reinforce the messages.

- EX: *"Remember your medicine"*
- *"Remember your diet"*
- *"Let me know if symptoms change"*

AVOID TECHNICAL JARGON

- Instead of: Use:
- x Analgesic…… pain killer
- x Angina…… chest pain
- x Atherosclerosis…… blood clot
- x Benign…… not cancer
- x Carcinoma…… cancer
- x Immunization…… shot, vaccine
- x Hyperlipidemia…… fat in the blood
- x Hypertension…… high blood pressure
- x “Negative” test…. normal test

LIABILITY AND RISK MANAGEMENT

CLAIMS MANAGEMENT

- Claims management requires involvement and collaboration among staff, legal counsel, compliance officer and the Department of Health and Human Services Office of the General Counsel (OGC). An unusual event or serious patient injury should alert providers and staff to the potential for a liability claim or legal action. Providers and staff should *immediately* alert the organization's risk manager, who will initiate the claims management process and work with counsel to ensure that the organization avails itself of all appropriate legal protections (e.g., the attorney-client privilege) at every step.

CASE STUDY

- Dr. Miller's patient, Marva, is hospitalized for severe gastrointestinal bleeding following failure to identify increased clotting time. Dr. Miller calls Marva to see how she is doing. Marva's husband Jack answers her phone and states angrily, "I'm going to sue everyone involved in this mess!" Dr. Miller panics and independently begins an investigation without considering potential discoverability of the information he gathers. He interviews the nurse responsible for managing laboratory results and identifies two problems: the test result was not returned for seven days, and the nurse did not follow up with the laboratory because the office has no written policy to do so.

CASE STUDY

- Dr. Miller documents all of this information in Marva's medical record instead of in an incident report. He then reports his findings to Beth, the risk manager. Beth immediately calls the organization's counsel, but it is too late—Dr. Miller's documentation of his investigation in the medical record is ultimately discoverable, and reflects poorly on the health center. Marva experiences many complications and never fully recovers. She sues, and the case settles for $1 million.

QUESTIONS FOR DISCUSSION

- What was Dr. Miller's first mistake?
- What is the first thing that Dr. Miller should have done after learning of Marva's hospitalization?
- What would you do if you ever heard a patient or family member threaten to sue?

INSURANCE COVERAGE FOR NHCAC

- **Federal Tort Claims Act is** the legal mechanism for compensating people who have suffered personal injury due to the negligent or wrongful action of employees of the U.S. government. It applies to NHCAC **employees in certain circumstances**. Employees of FQHCs may be deemed to be Federal Employees qualified for protection under the FTCA.

- By providing **medical malpractice protection** to health centers that meet annual program requirements, the Health Center FTCA Program saves Health Center Program grantees millions of dollars yearly that they can then invest to increase health care services and fund quality improvement activities, with the federal government acts as their primary insurer.

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JOINT COMMISSION
NATIONAL PATIENT SAFETY GOALS
(2020)

I. IDENTIFY PATIENTS CORRECTLY

- Use **at least two ways** to identify patients.
  Ex: Use the patient's name *and* date of birth.
  Vital in making sure that each patient gets the correct medicine and treatment, or that the correct patient gets the correct blood for a transfusion.

- Carefully check names against other data (Ex: There are MANY people named John Williams, Carol Jones, Jose Perez, Jeff Smith)

II. USE MEDICINES SAFELY

- Before a procedure, label all medicines that are unlabeled. (*Ex: Meds in syringes, cups and basins)*. Do this in the area where medicines and supplies are set up.
- Take extra care with patients who use blood-thinning medication.
- Find out **what medicines the patient is taking**.
- **Compare** those medicines to new medicines given to the patient.
- Make sure the **patient knows which medicines** to take when they are at home.
- Tell the patient it is important to bring their **up-to-date list of medicines** every time they visit a doctor

TRACKING SYSTEMS FOR TESTS, REFERRALS, ETC.

- Tracking of diagnostic tests, referrals, and hospitalizations is an area of high risk in ambulatory care since the **processes related to ordering and following up are complex and involve multiple individuals**(patients, physicians, other providers, administrative staff, and laboratory personnel) errors can occur.
- Such errors may result in **missed or delayed diagnoses or delayed interventions** to improve care, increasing patients' risk for adverse outcomes.
- Failure to implement **effective tracking systems** can result in patient harm, death, liability, and loss of reputation for the health center.

CASE STUDY

- Jorge is a known patient at the Health Center who has been treated for diabetes and long-term complications of a spinal cord injury that left him disabled.
- During a follow-up appointment with Ann, a nurse practitioner, Steven reports feeling sad and unusually tired for the past few months, and tells her he is having a hard time participating in his usual activities. They agree that Steven will try amitriptyline, an antidepressant.
- Ann completes a comprehensive informed consent discussion with Steven, orders baseline liver function tests (LFTs), and recommends regular monitoring of liver function because of the risk of liver damage associated with amitriptyline, especially in combination with Steven's other prescriptions. He has baseline labs drawn with normal results.

CASE STUDY

- At his six-week follow-up appointment, Steven reports a minimal improvement in his mood, but he continues to report fatigue and decreased appetite. Noting the normal baseline LFTs, Ann increases Steven's amitriptyline dosage and instructs him to have his blood drawn again in six weeks.
- Steven follows Ann's instructions, but Ann is on leave when his follow-up labs are drawn. Ann set up coverage with her colleague Bill before she left, but because of a family crisis, Bill is called away from work suddenly and no one else is assigned to cover for Ann. When she returns from leave, Ann discovers a notification that Steven was hospitalized for drug-induced liver failure as well as an unaddressed critical LFT result.

QUESTIONS FOR DISCUSSION

- How could this situation have been prevented?
- What do you think Ann should do when she discovers the lab result?
- Do you think that something like this could happen in our organization? Why or why not?

LATE ENTRIES OR ADDENDUMS TO PROGRESS NOTES

LATE ENTRIES CANNOT BE AVOIDED

- Any clinical provider documenting within the health record may need to enter a late entry. The organization should clearly define how this process occurs within their system. Tracking and trending within the electronic record will be dependent on the system; the organization should clearly understand this process.

FALSIFIED DOCUMENTATION

- Providers are reminded that deliberate falsification of medical records is a felony offense. Examples of falsifying records include:
- Creation of new records when records are requested
- **Back-dating** entries
- **Post-dating** entries
- **Pre-dating** entries
- **Writing over, or**
- **Adding** to existing documentation (*except as described in late entries, addendums and corrections*)

LATE ENTRIES

- When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

ADDENDUM

- An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.
- Document the date and time on which the addendum was made.
- Write “addendum” and state the reason for creating the addendum, referring back to the original entry.
- When writing an addendum, complete it as soon as possible after the original note.

WHAT IS "LATE"

- Medicare expects the documentation to be generated at the time of service or shortly thereafter.
- Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.

TEMPLATES

- Templates certainly are useful tools, but providers must use caution when applying “templated” language. Specifically, it may seem obvious, but providers must ensure that what is being represented in the medical record actually took place and is not something that the provider normally does but may not have done for that particular patient.

COMPLIANCE TO POLICIES AND PROCEDURES

WHAT IS COMPLIANCE?

- Healthcare compliance is the process of following rules, regulations, and laws that relate to healthcare practices.
- Compliance in healthcare can cover a wide variety of practices and observe internal and external rules. But most healthcare compliance issues relate to **patient safety, the privacy of patient information, and billing practices.**

COMPLIANCE IS VITAL

- Government rules and regulations require healthcare providers to have a compliance program in place.
- An effective healthcare compliance program is important to help providers avoid costly penalties, fines or more.
- Furthermore, it can help increase their staff communication, patient care and even improve morale.

REPORTING OF EVENTS

- New Jersey's Patient Safety Act was signed into law on April 27, 2004, became effective on October 24, 2004, and established a **mandatory adverse event reporting system** for most health care facilities licensed under the DHSS and for Psychiatric Hospitals licensed under the Department of Human Services.

NJ PATIENT SAFETY ACT

- To **encourage disclosure** of these events so that they can be analyzed and used for improvement, it is critical to create a **non-punitive** culture that focuses on improving processes rather than assigning blame. Health care facilities and professionals must be held accountable for serious preventable adverse events. Punitive environments are not particularly effective in promoting accountability and increasing patient safety, and may be a **deterrent** to the exchange of information required to reduce the opportunity for errors to occur in the complex systems of care delivery. **Fear of sanctions induces health care professionals and organizations to be silent** about adverse events, resulting in serious under-reporting.

DISCLOSURE OF UNANTICIPATED OUTCOMES

- Two major reasons are cited in support of disclosure:
- The **ethical** imperative to tell the truth
- The need to develop **safer systems** of health care delivery.

- Several institutions have reported a further benefit of open disclosure, namely, that the costs of litigation are reduced by **prompt disclosure and apology** to patients for medical error.

STAFF MEMBERS' ROLES WHEN INVOLVED IN AN ADVERSE EVENT

- Proper **Documentation**;
- Full **reporting**;
- Retention and **preservation** of records;
- Availability for **follow-up**;
- **Confidentiality** and disclosure to individuals only with need to know.
- Regarding events that involve **more than one service,** know whom to report to and discuss the event with.

LIABILITY AND RISK MANAGEMENT REGULATORY REPORTING SYSTEM

- National Practitioners Data Bank
- State Licensing Board
- Clinical Privileges
- Specialty Board Certifications
- CDS/State of NJ Dispensing Privileges
- Professional Society Membership
- Third Party Payer Provider Status

ROOT CAUSE ANALYSIS

- **Root Cause Analysis** (RCA): – Is a process intended to help organizations delve deeper into processes (not people).

BASICS OF A ROOT CAUSE ANALYSIS

- What was the **intended** process flow?
- Were there any steps in the process that **did not occur as intended**?
- What **human factors** were relevant to the outcome?
- Did **equipment performance** affect the outcome?
- What **controllable environmental factors** affected the outcome?
- What **uncontrollable external factors** influenced the outcome?
- Were there **any other factors** that directly influenced this outcome?
- What are the **other areas in the health care organization** where this could happen?
- Was **staff properly qualified and currently competent** for their responsibilities?
- How did **actual staffing level compare with ideal level**?
- What is the **plan for dealing with staffing contingencies**?
- Were such **contingencies a factor** in this event?
- Did **staff performance** during the event meet expectations?

HOW TO HANDLE A SUBPOENA OR SUMMONS WHEN YOUR NAME IS ON IT

- ***GET IT TO NISHIE PEREZ ASAP!***

- **Physician-patient privilege and HIPAA Issues**
- **Preservation of the physician-patient privilege and HIPAA should be the primary concern in any situation where outside parties are seeking information relating to a NHCAC patient.**
- Communications between a patient and physician for the purposes of evaluation, diagnosis, and treatment are privileged .
- The improper disclosure of privileged information exposes the medical provider to a claim by the patient for damages (*This privilege, however, may be waived. The waiver may come from the patient or an authorized representative. This waiver can be express, by execution of an authorization , or implied, by filing a legal claim that is based, at least in part, on the patient's medical condition).*

- This implied waiver of the privilege is limited to matters that are relevant to the claim and is discussed in further detail below.

PROTECTION OF EVIDENCE
(RECORDS, LOGS, MEDICAL EQUIPMENT, FILM, STAFF SCHEDULES, TRAINING RECORDS, ETC.)

- It's the LAW. All records and documentation relating to an adverse event must be preserved and protected in its original form. To do otherwise is a violation of law.

CREDENTIALING AND PRIVILEGING

CREDENTIALING

- Credentialing is the process of assessing and confirming the license, certification, education, training, and other qualifications of a healthcare professional. It also includes verifying reference checks, claims history, and findings of professional review organizations.

PRIVILEGING

- Privileging is the process of authorizing a professional's specific scope and content of patient care services. Privileging involves an assessment of the professional's skills, competencies, and performance; it also includes verification of fitness for duty, immunizations, communicable disease status, and current clinical competence.

CASE STUDY

- Mitchell is a physician assistant with 30 years' experience in clinical practice, specializing in outpatient cardiology. He recently joined Upstate Health Center on a part-time basis as his "retirement job," changing his specialty to primary care in the process. Upstate Health Center's privileging policy states that providers who are recent graduates or changing specialties must be proctored for three months. Mitchell was not assigned a proctor because of low staffing levels—clinical leaders felt lucky to hire someone with his experience and did not feel that a proctor was necessary.

CASE STUDY

- During his third week at the health center, Mitchell is assigned to see a patient who has diabetes and a sebaceous cyst in need of drainage. He has not performed an incision and drainage (I & D) procedure for many years. He decides to perform a less invasive procedure using a needle instead, because he feels more comfortable with that approach. However, the less invasive approach is not effective in draining the cyst. The patient develops sepsis and has a complicated healing process; she complains about Upstate Health Center to anyone who will listen—including the state licensing board.

QUESTIONS FOR DISCUSSION

- Were there any "red flags" in this situation?
- What should Mitchell have done when he realized that he was not comfortable performing the most appropriate procedure for the patient?
- What might have changed if a proctor had been present during the procedure?

HIPAA

HIPAA AND CONFIDENTIALITY (PRIVACY RULE)

- Health care practitioners have a duty to take reasonable steps to keep personal medical information confidential consistent with the person's preferences. For example, doctor-patient medical discussions should generally occur in private and a patient might prefer that the doctor call their cell phone rather than home. Even well-meaning family members are not necessarily allowed to have information about a loved one's medical condition

HIPAA (CONT'D)

- All people are entitled to confidentiality unless they give permission for disclosure. A federal law called the Health Insurance Portability and Accountability Act (HIPAA) applies to health care practitioners and its regulation, known as the **Privacy Rule**, sets detailed rules regarding privacy, access, and disclosure of information. For example, HIPAA specifies the following:

HIPAA (CONT'D)

- People should normally be able to see and obtain copies of their medical records and request corrections if they find mistakes.
- Anyone legally authorized to make health care decisions for a person lacking such capacity has the same right of access to the person's personal medical information.
- Health care practitioners should routinely disclose their practices regarding privacy of personal medical information.

HIPAA (CONT'D)

- Health care practitioners may share the person's medical information, but only among themselves and only as much as is necessary to provide medical care.
- Personal medical information may not be disclosed for marketing purposes.
- Health care practitioners should take reasonable precautions to ensure that their communications with the person are confidential.

REQUIRED REPORTING

- Health care practitioners are sometimes required by law to disclose certain information, usually because the condition may present a danger to others. For example, certain infectious diseases, such as human immunodeficiency virus (HIV) infection, syphilis, and tuberculosis, must be reported to state or local public health agencies.

REQUIRED REPORTING

- Health care practitioners who notice medical signs of child, adult, or elder mistreatment, abuse, or neglect normally must report such information to protective services. Conditions that might seriously impair a person's ability to drive, such as dementia or recent seizures, must be reported to the Department of Motor Vehicles in some states.

SOCIAL MEDIA ISSUES

- Many lawsuits and regulatory adverse actions come from health care practitioners careless use of social media. Be sure never to use names, photos, images or other identifying data relating to a patient.