

# Tufts Medical Center

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(revised 10/09)

# Tufts Medical Center

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## MISSION STATEMENT

### MISSION

We strive to heal, to comfort, to teach, to learn and to seek the knowledge to promote health and prevent disease. Our patients and their families are at the center of everything we do. We dedicate ourselves to furthering our rich tradition of health care innovation, leadership, charity and the highest standard of care and service to all in our community.

### VALUES

- Respect for Every Individual- we will treat each person we work with and care for with respect.
- Honesty and Fairness - We will be truthful, equitable and open in all our relationships.
- Delivery of the Highest Quality Service - We will always strive to deliver the highest quality service and care to our patients, their families, and our colleagues.
- Constant Pursuit of Excellence - We will continuously strive to meet or exceed our patients' and colleagues' expectations.

### GUIDING PRINCIPLES

- We focus on the patient in everything we do.
- We practice open communication in order to improve our processes and build trust.
- We expect management to lead by example and remove the barriers to meeting our goals.
- We are a learning organization that respects and encourages innovation, creativity and risk-taking.
- We succeed with employee involvement, which is continuously encouraged, recognized and rewarded.
- We collaborate to achieve our goals.
- We embrace cultural diversity.

# Tufts Medical Center

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## SEXUAL HARASSMENT

### I. PURPOSE

This policy:

- 1) Defines what constitutes "sexual harassment"
- 2) Clearly states that sexual harassment of any kind is not tolerated and sets out procedures to investigate and resolve any complaints that may arise.

It is the policy of Tufts Medical Center (TuftsMC) to provide its employees with equal opportunities to perform their work effectively in an environment free of sexual harassment. Sexual harassment in the workplace or in other settings in which employees may find themselves in connection with their employment is unlawful and will not be tolerated. Further, any retaliation against an individual who has complained about sexual harassment or cooperated with an investigation of a sexual harassment complaint is similarly unlawful and will not be tolerated. The Hospital takes allegations of sexual harassment seriously, and will promptly respond to complaints of sexual harassment. Where it is determined that sexual harassment has occurred, the Hospital will act promptly to eliminate the conduct and take corrective action, including disciplinary action up to and including termination.

### II. APPLICATION

All employees and members of the TuftsMC community.

### III. DEFINITION

Sexual harassment is defined by Massachusetts laws as:

Sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

- a) submission to or rejection of such advances, requests or conduct is made either explicitly or implicitly a term or condition of an individual's employment, or is used as the basis for employment affecting such individuals; or
- b) such advances, requests or conduct has the purpose or effect of unreasonably interfering with an individual's work performance by creating an intimidating, hostile, humiliating or sexually offensive working environment.

Under these definitions, direct or implied requests by a supervisor for sexual favors in exchange for actual or promised job benefits such as favorable reviews, salary increases, promotions, increased benefits, or continued employment constitutes sexual harassment.

The legal definition of sexual harassment is broad and in addition to the above examples, other sexually oriented conduct, whether it is intended or not, that is unwelcome and has the effect of creating a work place environment that is hostile, offensive, intimidating, or humiliating to male or female workers may also constitute sexual harassment.

While it is not possible to list all those additional circumstances that may constitute sexual harassment, the following are some examples of conduct, which, if unwelcome, may constitute sexual harassment depending upon the totality of the circumstances including the severity of the conduct and its pervasiveness:

- Sexual advances – whether or not they involve physical touching

- Sexual epithets or jokes; written or oral references to sexual conduct; gossip regarding one's sex life; comment on an individual's body; comment about an individual's sexual activity, deficiencies or prowess
- Displaying sexually suggestive objects, pictures or cartoons
- Leering, whistling, brushing against the body, sexual gestures, suggestive or insulting comments
- Inquiries into one's sexual experiences
- Discussion of one's sexual activities
- Assault or coerced sexual acts

All employees should take special note that, as stated above, retaliation against an individual who has complained about sexual harassment, and retaliation against individuals for cooperating with an investigation of a sexual harassment complaint is unlawful and will not be tolerated by the Hospital.

#### **IV. COMPLAINTS OF SEXUAL HARASSMENT**

The Hospital encourages any employee who feels that s/he has witnessed or experienced sexual harassment, or any conduct that may constitute sexual harassment, to take any of the following measures to address or report his or her concerns, either orally or in writing:

- 1) If the employee feels comfortable, s/he may communicate directly to the person engaging in the offensive conduct that such conduct is offensive and must stop immediately;
- 2) If the employee prefers not to communicate directly with the person, or if his or her efforts at communication have not been successful in stopping the unwanted conduct, the employee should contact either the Employee Relations Manager at Ext. 5670 or the Vice President, Human Resources at Ext. 1495.

In addition, any member of the House Staff (Residents and Interns) who feels that s/he has witnessed or experienced sexual harassment, or any conduct that may constitute sexual harassment, may follow the procedure outlined above, or may report the incident(s) to the Chief Executive Officer, or to the Director of House Staff at Ext. 5197.

#### **V. INVESTIGATION**

Once a complaint has been reported, it will be promptly investigated in a fair and expeditious manner. The investigation will be conducted in such a way as to maintain confidentiality to the extent practicable under the circumstances. This investigation will include, but may not be limited to, an interview with the person filing the complaint (the "claimant"), interview(s) with witness(es) if any, and an interview with the alleged offender.

Upon completion of the investigation, Human Resources will, to the extent appropriate, inform the claimant and the alleged offender of the results of the investigation.

If the investigation upholds the complaint, the Senior Manager responsible for the department in which the alleged offender works and the Vice President of Human Resources will review the findings, act promptly to eliminate the offending conduct, and take any other appropriate action. Action taken will be in accordance with the Hospital's policies and procedures governing discipline and, depending on the seriousness of the offense, may include counseling, warning, suspension, transfer, or termination.

When the alleged offender is not an employee of the Hospital, Human Resources will discuss all available options with the claimant and assist the claimant in taking appropriate action, in addition to conducting an investigation of the reported incident.

#### **VI. RESPONSIBILITIES OF THOSE IN THE NEMC COMMUNITY**

Employees have the responsibility of reporting to their supervisor or manager, or Human Resources, any incident(s) of sexual harassment they have witnessed or experienced. Such incident(s) may involve supervisors, co-workers and other employees or staff members, or non-employees such as patients, vendors and other service providers.

Supervisors have the responsibility of upholding this policy and for communicating this policy to all employees in their department(s). Supervisors must also inform Human Resources about any reports(s) of sexual harassment that s/he has received or incidents that s/her witnesses or experiences, and ensure that this policy is upheld by their employees.

Human Resources has the responsibility to ensure that reports of sexual harassment are promptly and properly investigated and resolved.

It is the Hospital's responsibility to take whatever actions are necessary to prevent sexual harassment and to ensure that the rights of all employees and staff are protected, including the alleged offender, while evidence is being gathered.

## **/II. STATE AND FEDERAL REMEDIES**

Sexual harassment is unlawful under both state and federal law. Using the Hospital's internal complaint procedure does not prohibit employees from filing a complaint with either or both of the following federal and state discrimination enforcement agencies:

- 1) The federal agency which enforces the law is the Equal Employment Opportunity Commission (EEOC). The EEOC's local office is located at: One Congress Street, 10th Floor, Boston, MA 02114. The telephone number is (617) 565-3200.
- 2) The state agency which enforces the law is the Massachusetts Commission Against Discrimination (MCAD). The MCAD's office is located at: One Ashburton Place, Room 601, Boston, MA 02108. The telephone number is (617) 994-6000.

**NOTE:** there is a 300-day time period in which complaints must be filed with either the EEOC or the MCAD.

# Tufts Medical Center

## SECURITY ORIENTATION

### YOUR PERSONAL SAFETY

**Providing a safe and secure environment for our patients and their families, employees, staff, and the physical property of TuftsMC is the goal of our Security Program.** To enable security staff to provide a secure environment, employees are identified by the wearing of ID badges at all times and adhere to the level of access defined by their job description. Others are limited by the circumstances of their individual involvement as a patient or with a patient. All members of the hospital environment are subject to monitoring and inspection as deemed appropriate by security staff in concert with the circumstances that may include security incident, civil disturbance, property damage, a disaster, or media event.

- Call Security as soon as possible x 6 -5100 for any security emergency
- Keep personal property and TuftsMC property secured
- Lock up purses, backpacks, briefcases, coats and other personal items while at work.
- Do not bring large amounts of cash, expensive jewelry, credit cards, personal electronic devices or any other item that may be a theft target.
- Ensure that TuftsMC issued equipment used in your workplace is properly secured at all times, especially when left unattended.

#### **Unauthorized person in area - what to do?**

- If appropriate, ask, "may I help you?"
- Otherwise, leave the area and contact Security at x 6 - 5100.
- Remember distinguishing characteristics: height, weight, race, hair length and color, clothing type, etc.

#### **Bomb threat by phone - what to do?**

- Remain calm
- Speak in a normal tone
- Listen for distinguishing characteristics of the caller's voice and background noise
- Write down everything you remember and immediately call and report it to security

#### **Familiarize yourself with security measures in your work area:**

- ID badges for identification and card access - to be worn at all times
- Uniformed TuftsMC security officers
- Card access on entrance doors
- Omni locks, key pad locks, and key locks
- Security dispatch center in Atrium monitoring alarms (door, panic buttons) and CCTV closed circuit TV cameras and monitors
- Take class in **DEFUSE** training (crisis de-escalation); use skills learned to de-escalate agitated patients and family members.

#### **Special Security Focus is provided to the:**

- Emergency Department
- Mother Infant Unit, Labor and Delivery, NICU
- Pediatrics
- Pharmacy
- Psychiatry (inpatient and outpatient)
- Critical Care areas
- "Code Pink" Announcement is an infant/child or abduction

### **How to handle suspicious packages**

A suspicious letter or package may contain white powder, be lopsided, or may have uneven or grease stained packaging. If received through the mail it may have excessive postage, hand written addresses, an unfamiliar or no return address, or incorrect titles or names.

1. DO NOT open or move the letter or package. Close the doors to the area and evacuate staff to safe location.
2. Contact Security x 6 - 5100 to report the situation, they will secure the area until emergency response teams arrive.
3. City emergency response teams (Boston Fire/HazMat/Bomb Squad) will respond to the scene and investigate the situation.
4. Contact Infection Control to report potential exposures to contaminants x 6 - 5921.

### **YOUR PHOTO ID KEY CARD**

All Tufts Medical Center staff and employees are provided with a Photo ID Key Card which should be worn at all times. Currently, these cards perform two important functions:

1. Your Photo ID Card readily identifies you to other employees and staff as members of the Tufts Medical Center community.
2. You may use your Photo ID Card as a Key Card which will allow you to access the Medical Center after hours and on weekends when most entrances are locked for your protection.

### **MEDICAL CENTER DOORS**

The Main Entrance to the North Building Emergency Department at 830 Washington Street is always open twenty-four hours a day, seven days a week.

The Bennett Street and Washington Street entrances to the Atrium Lobby are open 6:00 AM to 8:00 PM every day.

All other entrances are generally open from the early morning to early evening hours during the week and closed on the weekends.

- ◆ During those times when your building entrance is locked, you are expected to use your Photo ID Key Card to gain access.
- ◆ If you forget your Photo ID, or you are having trouble getting it to work, contact the Security Dispatch Officer using the Intercom Station.
- ◆ For the security of other persons in the building, be prepared to identify yourself, your destination, and your reason for working at that hour. The Dispatch Officer will not provide access to those persons who cannot be properly identified.

### **OTHER SECURITY SERVICES**

#### **HAVING KEYS MADE/LOCKS FIXED**

All requests for Security Locksmith Services should be in written form, using a standard Tufts Medical Center Stores Requisition or Purchase Order. All requests may be dropped off at the Security Dispatch Center or mailed to the Security Locksmith care of Box 445.

All requests should be accompanied by an Authorized Signature and Cost Center for building purposes.

Telephone requests for Locksmith Services are not acceptable.

Requesting Departments will be notified when keys, padlocks, and other small items are ready to be picked up at the Security Dispatch Center.

# Tufts Medical Center

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## FIRE SAFETY

### KEEP YOUR WORK AREA SAFE:

- Keep corridors, fire doors and stairways clear at all times
- Do not cover up or obstruct fire sprinklers or smoke detectors in ceilings
- Do not cover up fire alarm panels on walls or fire extinguisher cases.

### WHEN FIRE OR SMOKE IS DISCOVERED:

- Use the *R.A.C.E.* approach to fire response.

*R* – Rescue/Relocate Persons from immediate fire scene/room

*A* – Activate the nearest alarm, and call x6-5100 to give exact location. Note that alarm pull stations are located at the entrance of stairwell doors.

*C* – Contain the fire by closing ALL doors of the room/ area including fire doors

*E* – Evacuation when instructed to do so following the evacuation plan for your are.  
Extinguish fire if it is safe to do so.

- When evacuation is ordered, evacuate patients/employees in the following sequence. Remain at each sequence until directed relocate.

To the next fire zone at the same floor level (horizontal evacuation)

The same floor in another, adjacent building (horizontal evacuation)

Use the stairs (vertical evacuation)

NEVER USE AN ELEVATOR

- The Nurse Manager determines when medical gas shut off valves should be deployed on patient units.

### WHEN YOU HEAR A FIRE ALARM AND THE POINT OF ORIGIN IS NOT YOUR FLOOR

- Pay close attention to the PA system, for further announcements about the status of the fire drill and instructions.
- Be alert for signs of fire or smoke on your floor – if so – follow the *RACE* plan
- If your building is not adjacent to the fire drill, continue your normal work routine.

### YOUR RESPONSIBILITY FOR FIRE SAFETY:

- Familiarize yourself with your specific role during a fire emergency
- Know the designated escape routes for your area (locate evacuation map posted by stairwells)
- Know the location of the nearest fire alarm pull station for your work area.
- Know the location of the nearest ABC extinguisher and how to operate it.  
(ABC extinguishers are multipurpose and used for all types of fires; ordinary combustibles, flammable liquids and electrical equipment and contain a dry chemical)

### When using fire extinguishers, remember P.A.S.S.

- PIN
- AIM
- SQUEEZE TRIGGER
- SWEEP

**Some other points to remember in a fire emergency:**

- **X 6-5100** will call the Fire Emergency line to report a fire
- In addition to the ABC Fire Extinguishers, there are **"A" extinguishers** that are used in paper or trash fires only since they contain water
- **"BC" Extinguishers are red or yellow containers** and are used for chemical or grease fires only
- White plugs will supply power during emergency conditions in the hospital
- Black plugs DO NOT

# Tufts Medical Center

## HIPAA PRIVACY REGULATION USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Issued 10/4/05

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**Article I. PURPOSE**

To delineate the requirements that must be followed by TuftsMC when using or disclosing Protected Health Information for purposes of treatment, payment or health care operations.

**Article II. SCOPE**

This policy applies to all TuftsMC employees and professional staff members.

**Article III. POLICY**

TuftsMC must use or disclose Protected Health Information for treatment, payment or health care operations consistent with this procedure and all federal and state laws and regulations.

**Article IV. DEFINITIONS**

**Treatment:** generally means the provision, coordination or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

**Payment:** encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

In addition to the general definition, the Privacy Rule provides examples of common payment activities, which include, but are not limited to:

- Determining eligibility or coverage under a plan and adjudicating claims;
- Risk adjustments;
- Billing and collection activities;
- Reviewing health care services for medical necessity, coverage, justification of charges and the like;
- Utilization review activities; and
- Disclosures to consumer reporting agencies (limited to specified identifying information about the patient, his or her payment history, and identifying information about the covered entity).

**Health Care Operations:** certain administrative, financial, legal and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, which are limited to the activities listed in the definition of "health care operations" at 45 CFR 164.501, include:

- Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination;
- Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing or credentialing activities;

- Underwriting and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims;
- Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity; and
- Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

**Article V. PROCEDURES**

**Section 5.01** Except with respect to uses or disclosures that require an Authorization (see policy on *Authorization for Use and Disclosure of Protected Health Information*) here prohibited by state or federal laws (see #4 below), TuftsMC may use or disclose Protected Health Information for treatment, payment or health care operations without permission from a patient for the following purposes:

- (a) Treatment, payment or health care operations within TuftsMC.
- (b) Treatment activities of another health care provider, to which disclosure is made.
- (c) Payment activities of another covered entity or health care provider, to which disclosure is made.
- (d) Health care operations of another covered entity, to which disclosure is, provided that:
  - (i) Both covered entities have or had a relationship with the patient who is the subject of the Protected Health Information;
  - (ii) The Protected Health Information pertains to that relationship; and
  - (iii) The disclosure is for a purpose listed below:
    - i. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development; case management and care coordination; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.
    - ii. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance; reviewing health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers; training of non-health care professionals; accreditation, certification, licensing or credentialing activities.
    - iii. For the purpose of health care fraud and abuse detection or compliance.

1)

**Section 5.02** Any use for treatment, payment or health care operations must be consistent with the policies and practices stated in TuftsMC Notices of Privacy Practices. If the use or disclosure falls outside of treatment, payment or health care operations, a signed valid authorization is required. (See *Authorization to Use and Disclose Protected Health Information Policy*.)

**Section 5.03** Refer to Policy and Procedure on *Compliance with Minimum Necessary Standards for additional guidelines regarding uses and disclosures for Treatment, Payment and Health Care Operations*.

**Section 5.04** TuftsMC is also subject to state and federal laws that give special protection to certain types of health information. These laws may require Authorization, even before disclosure for Treatment,

**Payment or Healthcare Operations, and TuftsMC should be careful to comply with these laws if applicable. These laws relate to:**

- (a) HIV testing or test results.**
- (b) Genetic testing and test results.**
- (c) Sensitive information such as sexual assault counseling records or communications between you and a social worker, psychologist, psychotherapist or licensed mental health nurse clinical specialist.**
- (d) Psychotherapy notes.**

# Tufts Medical Center

## ETHICS CONSULTATION SERVICE

The Ethics Consultation Service responds to consultation requests for ethical and procedural issues relating to *individual* patients and their families. A consultation request can be recommended by any member of the medical team (doctors, nurses or social workers) or by the patient or his/her family. However, the formal request should be made with the agreement of the Attending Physician.

Any member of the Medical Center community may contact the Ethics Committee for information and advice regarding general issues of medical ethics. For advice and assistance on individual cases, the Ethics Consultation Service should be used.

The consulting team consists of two to three members drawn from the designated group of ethics consultants. At least one member of the Hospital Ethics Committee is included on each consulting team. The Ethics Coordinator makes the necessary arrangements for the meeting. The other participants should include the Attending Physician, one to two members of the House Staff, the Primary Nurse, and perhaps the Head Nurse and the Social Worker. The Hospital Counsel is notified of all such meetings and may wish to attend. It is important that the group remains relatively small, no more than eight to ten people, if possible. In addition, one to three family members should be present, including the next-of-kin and/or a family spokesperson. (It is recognized that in some situations the patient and/or an appropriate family member cannot or should not be present for this meeting.)

The avenue should be a quiet conference room, where the meeting can proceed in a tranquil, uninterrupted manner. Such a consultation generally requires 1 1/2 hours, so everyone should budget sufficient time for full attendance.

The Ethics Consultation Team appoints a Chairperson for this meeting. At the end of the meeting, each member of the consultation team should express a judgment, and the Chairperson is responsible for summarizing the consensus; individual team members are encouraged to voice a minority opinion. The Team may wish to have an executive session before making its recommendation. The final judgment of the consultation team is a non-binding recommendation, which can be accepted or rejected, in total or in part, by either the medical team or the family. Minutes are kept only for use in preparing a summary report to the Hospital Ethics Committee. A note should be written in the Patient's chart which documents the date of the consult and the attendees.

### CONSULTATION PROCEDURE

#### I. Identify the facts of the case.

A. What is the reason for the consultation request?

B. The medical history and diagnosis, briefly summarized.

C. The prognosis -- is the patient terminally ill (life expectancy reckoned to be less than one year)? or hopelessly ill (in a chronic vegetative state)?

D. What active therapies are available or are being considered?

E. Is the patient competent to make a decision about the issue under discussion? If incompetent, is there a next-of-kin or a family member or a "significant other"? Can they be considered a "loving family," acting in the patient's best interest? Is the family "competent" to make the decision? Is it appropriate for the patient to make this decision? If there are several family members with equal legitimacy about the decision, are they in substantial agreement? Have they appointed a spokesperson?

F. If the patient is currently incompetent, is there knowledge of the patient's prior views, either through written statements or by discussions with family members, doctors, nurses, or others, about the present issue? Stated in another way, can the next-of-kin or family make a "substituted judgment," based on information concerning the patient's own views on the matter under discussion?

II. State the available options under consideration, e.g., aggressive (define) therapy, surgery, dialysis, ventilator, feeding, hydration, "comfort only", "do not resuscitate", move out of an ICU, send the patient home or to nursing home, etc. What are

the benefits (utility) versus the burdens (pain, suffering) of the decision? Or, rephrasing the issue, is the decision appropriate or inappropriate for the stated goal? (Inappropriate could be defined as useless and/or imposing a grave burden.)

III. Deliberate on the issues and try to reach a consensus. If a consensus has been reached, the consultation team should engage in a final few moments of self-criticism of their decision. The members should be aware that a consensus approach has two intrinsic flaws with regard to considering divergent opinion:

- 1) A consensus may emerge because alternative solutions have not been given enough serious consideration, and
- 2) A dissident voice may be stifled by the collective imperative to arrive at resolution.

To guard against an easy, albeit ill-considered, leap to judgment, the team should engage in a form of Socratic dialogue, raising objections to its collaborative wisdom. At this point, after reviewing reasonable disagreements, the final opinion can be rendered.

## EMERGENCY ETHICS CONSULTATION

Emergency consultations can be arranged by contacting the Ethics Coordinator on Page No. 1211, or through the Hospital Page Operator, Ext. 5114.

## ETHICAL PRINCIPLES

The issues of the particular case should be placed, to the extent possible, within a framework of moral principles, so that each individual problem is seen in a general context of ethical decisions within the institution. An ethics consultation usually is sought because of conflicting moral values. The eventual decision represents a balancing act between the pluralism of legitimate principles, determining how the weight of morality should rest. The following moral principles should be considered in each situation:

### A. Autonomy - The principle of self-governance.

Three features characterize an autonomous decision; it is intentional; it is based on an understanding of the issues; and it is not controlled by outside influences.

A patient may be in a state of "reduced autonomy," due to fear, ambivalence about various treatments, depression, etc. However, contemporary biomedical ethics and the American legal system have held that the principle of autonomy, or at least substantial autonomy, should prevail as a prima facie moral rule.

A comatose or incompetent patient cannot make an autonomous decision. In this setting, the family acts on the parent's behalf. When the patient has expressed in writing or by verbal communication his/her views on the issue in question, the family can act as a "bonded surrogate", in order that the patient's prior autonomous decision be respected.

### B. Beneficence and do no harm (nonmaleficence) - The principles of promotion of benefit to the patients and avoiding harm.

These are two ancient moral traditions in the caring professions with roots in the earliest writings guiding the professional standard of doctors and nurses. However, beneficence and medical judgment may conflict with a patient's views on an issue. For example, there are situations in which members of the medical team believe that a patient is making a poor judgment regarding a treatment or procedure and, acting in the patient's decision. This is an example of paternalism, i.e., the intentional judgment of beneficence. Whose opinion should prevail depends on the particular circumstance, for neither autonomy nor beneficence is an absolute rule.

In the case of an incompetent patient, a family may have its views on the patient's best interest which may be in conflict with the medical team. When the patient's opinions are known to the family through prior discussions, the family should follow these directions, that is, a form of "substituted judgment", in which the family acts as the patient's surrogate. Without knowing the patient's views, as often happens, the family makes its decision based on the principles of beneficence and nonmaleficence, maximizing the patient's benefits and minimizing the burdens. The family's interpretation of these principles may, however, conflict with that of the patient or medical team, raising a potential ethical dilemma.

### C. Legitimate third-party interests.

In any ethical issue, there are important third-party interests founded in principles of beneficence and justice that must be weighed in the moral deliberations. The following third parties are representative, but not all-inclusive:

1. Medical or nursing professional standards, which are subject to individual interpretation

2. Doctors' and nurses' own moral principles
3. The hospital and its policies
4. The State and its interests, according to laws and contemporary court decisions
5. Public Health Issues
6. Family concerns - e.g., dependent minor children
7. Religious or moral community -- e.g., Jehovah's Witnesses
8. The employer - e.g., the Military
9. Economic or logistic factors (availability of blood products, ICU beds)

# Tufts Medical Center

## Guidelines for Medication Order Writing

Do NOT Use These Abbreviations	Correct Way	Section 5.05 Potential Error
MS or MgSO <sub>4</sub> or MS04	Write out "magnesium sulfate" or "morphine sulfate". Always write out the full name of drugs.	<i>Article VI. <u>Can be confused for one another</u></i>
"µg"	Write "microgram"	"µg" Can be misread as milligram (mg).
Decimal points	"1 mg", terminal or trailing zeroes should <u>not</u> be used.	Zero after decimal points (e.g., "1.0 mg") can be misread as "10" milligram (mg).
	"0.1" mg, always use a leading zero before a decimal point.	No zero before decimal point (e.g., ".1 mg") can be misread as "1 mg".
Q.D., q.d., QD, qd	Write out "daily" or "per day".	Can be misinterpreted as "QID" (four times a day).
Q.O.D., QOD, q.o.d., qod	Write out "q other day".	Can be misinterpreted as "QD" (daily) or "QID" (four times daily).
U, IU, u, iu	Write out "units".	Can be misread as zero (0), four (4) or cc.
d	Write out " days".	Never use "d" as an abbreviation, since it can be misinterpreted as dose or day. Can be mistaken for "three doses".
R, or L	Write: "Left ", or "Right " or "Both ".	Any abbreviation for right, left or both can be misread

# Tufts Medical Center

## PATIENT RIGHTS AND RESPONSIBILITIES ISSUED 3/2005

### **I. Purpose**

The purpose of this policy is to describe patients' rights established by Massachusetts Law as implemented at Tufts-Medical Center ("TuftsMC" or the "Medical Center").

### **II. Eligibility**

This policy applies to all employees and members of the medical staff.

### **III. Policy**

Every patient admitted to TuftsMC is given information regarding his or her rights under both state and federal law. In addition, because we believe that effective patient care begins with the establishment of a partnership between the patient (and his or her family) and staff, every patient admitted is also given a statement of patient responsibilities as a partner in their care at the Medical Center.

The rights and responsibilities information provided to patients admitted to the Medical Center is reproduced below. The Massachusetts "Patients' Bill of Rights" also appears in its entirety at the end of this policy. Copies of the Patients' Bill of Rights are posted at entrances to the Medical Center and are available in the Admitting Department.

In addition, patients have specific rights under federal law relating to the privacy of their health information. As required by the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule, all patients are provided with a copy of the Medical Center's "Notice of Privacy Practices" which describes how the Medical Center may use and disclose patient health information, as well as the rights that patients have with respect to their health information, including how patients may access their information. Copies of the Notice of Privacy Practices are posted in prominent locations throughout the Medical Center and are available in the Admitting Department and at Registration areas, as well as on the TuftsMC website. The Medical Center has adopted specific policies to implement patients' rights under the "HIPAA" Privacy Rule.

The staff at Tufts Medical Center is committed to providing excellent medical care and delivering this care with respect for patients' rights.

Patients have, among other rights, the right to:

- Be treated considerately and with respect and to have your questions or requests for information answered courteously
- Be informed of your health status and participate in the development and implementation of your plan of care
- Request the name and specialty of the doctor responsible for coordinating your care and the role of all others involved in that care
- Make informed decisions regarding your care
- Refuse diagnostic and treatment procedures while still receiving the best help that your health care team can offer you under the circumstances

- Be given a full explanation of any research study or training program before you agree to participate in it, as well as the right to refuse to participate
- Personal privacy
- Receive care in a safe environment and to be free from all forms of abuse or harassment
- Formulate advance directives and have hospital staff comply with these directives to the extent provided by law
- Have a family member or personal representative and your own physician notified of your admission to the hospital
- Be free from restraints and seclusion of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff
- Obtain assistance in planning for personal safety and accessing protective services
- Examine a copy of your itemized hospital bill and receive an explanation of it
- Inquire about the possible financial aid available to help in paying your bill and to receive prompt and courteous assistance in obtaining any aid for which you are eligible
- Confidentiality of all records and communications to the extent provided by law
- Informed consent to the extent provided by law
- Upon request, to inspect and receive a copy of medical records
- File a written or verbal grievance about care rendered in the hospital
- Receive prompt life-saving treatment in an emergency without discrimination on account of economic status or source of payment
- Complete information on alternative treatments, which are medically viable, if you are a breast cancer patient.

### **Your Responsibilities as a Partner in Your Care**

As a patient of the Medical Center, you have, among other responsibilities, the responsibility to:

- Be on time for scheduled appointments and telephone the Medical Center when you are late or have to reschedule an appointment
- Bring with you information about your present and past illnesses, hospitalizations, medications, and other matters relating to your health. Be open and honest with us about your health and your medical history, so that, together, we can make informed decisions about your care.
- Ask any questions you or your family members may have regarding your health, and we will be pleased to answer them. Tell us immediately if you do not understand any information or instructions you receive regarding your health, or if you think you will be unable to carry out any instructions
- Follow your physician's advice and instructions and take all medications as prescribed. Let us know immediately about any changes in your symptoms or general condition. We are partners in your care during your stay in the hospital as well as after you leave
- Promptly pay your Medical Center bill and provide us with any information you have about your health insurance so that we can process your bill quickly and appropriately
- Be considerate of other patients and their needs
- Observe "No Smoking" rules

## **Massachusetts Patients' Bill of Rights**

### **Massachusetts General Laws, Chapter 111, Section 70E**

**Section 70E.** As used in this section, "facility" shall mean any hospital, institution for the care of unwed mothers, clinic, infirmary maintained in a town, convalescent or nursing home, rest home, or charitable home for the aged, licensed or subject to licensing by the department; any state hospital operated by the department; any "facility" as defined in section three of chapter one hundred and eleven B; any private county or municipal facility, department or ward which is licensed or subject to licensing by the department of mental health pursuant to section nineteen of chapter nineteen or by the department of mental retardation pursuant to section fifteen nineteen B; any facility as defined in section one of chapter one hundred and twenty-three; the Soldier's Home in Holyoke, the Soldier's Home in Massachusetts; and any facility set forth in section one of chapter nineteen or section one of chapter nineteen B.

The rights established under this section shall apply to every patient or resident in said facility. Every patient or resident shall receive written notice of the rights established herein upon admittance into such facility, except that if the patient is a member of a health maintenance organization and the facility is owned by or controlled by such organizations, such notice shall be provided at the time of enrollment in such organizations, and also upon admittance to said facility. In addition, such rights shall be conspicuously posted in said facility.

Every such patient or resident of said facility shall have, in addition to any other rights provided by law, the right to freedom of choice in his selection of a facility or a physician or health service mode, except in the case of emergency medical treatment or as otherwise provided for by contract, or except in the case of a patient or resident of a facility named in section fourteen A of chapter nineteen; provided, however, that the physician, facility, or health service mode is able to accommodate the patient exercising such right of choice.

Every such patient or resident of said facility in which billing for service is applicable to such patient or resident, upon reasonable request, shall receive from a person designated by the facility an itemized bill reflecting laboratory charges, pharmaceutical charges, and third party credits and shall be allowed to examine an explanation of said bill regardless of the source of payment. This information shall also be made available to the patient's attending physician.

#### **Every Patient or Resident of a Facility Shall Have the Right:**

- (a) upon request, to obtain from the facility in charge of his care the name and specialty, if any, of the physician or other person responsible for his care or the coordination of his care;
- (b) to confidentiality of all records and communications to the extent provided by law;
- (c) to have all reasonable requests responded to promptly and adequately within the capacity of the facility;
- (d) upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution insofar as said relationship relates to his care or treatment;
- (e) to obtain from a person designated by the facility a copy of any rules or regulations of the facility which apply to his conduct as a patient or resident;

- (f) upon request, to receive from a person designated by the facility any information, which the facility has available relative to financial assistance and free health care;
- (g) upon request, to inspect his medical records and to receive a copy thereof in accordance with section seventy, and the fee for said copy shall be determined by the rate of copying expenses, except that no fee shall be charged to any applicant, beneficiary or individual representing said applicant or beneficiary for furnishing a medical record if the record is requested for the purpose of supporting a claim or appeal under any provision of the Social Security Act or federal or state financial needs-based benefit program, and the facility shall furnish a medical record requested pursuant to a claim or appeal under any provision of the Social Security Act or any federal or state financial needs-based benefit program within thirty days of the request; provided, however, that any person for whom no fee shall be charged shall present reasonable documentation at the time of such records request that the purpose of said request is to support a claim or appeal under any provision of the Social Security Act or any federal or state financial needs-based benefit program;
- (h) to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care and attention;
- (i) to refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;
- (j) to privacy during medical treatment or other rendering of care within the capacity of the facility;
- (k) to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment unless such delay can be imposed without material risk to his health, and this right shall also extend to those persons not already patients or residents of a facility if said facility has a certified emergency care unit;
- (l) to informed consent to the extent provided by law;
- (m) upon request to receive a copy of an itemized bill or other statement of charges submitted to any third party by the facility for care of the patient or resident and to have a copy of said itemized bill or statement sent to the attending physician of the patient or resident; and
- (n) if refused treatment because of economic status or the lack of a source of payment, to prompt and safe transfer to a facility which agrees to receive and treat such patient. Said facility refusing to treat such patient shall be responsible for: ascertaining that the patient may be safely transferred; contacting a facility willing to treat such patient; arranging the transportation; accompanying the patient with necessary and appropriate professional staff to assist in the safety and comfort of the transfer, assure that the receiving facility assumes the necessary care promptly, and provide pertinent medical information about the patient's condition; and maintaining records of the foregoing.

**Every Patient or Resident of a Facility Shall be Provided by the Physician in the Facility the Right:**

- (a) to informed consent to the extent provided by law;

- (b) to privacy during medical treatment or other rendering of care within the capacity of the facility;
- (c) to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological or other medical care and attention;
- (d) to refuse to serve as a research subject, and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;
- (e) to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of source of payment unless such delay can be imposed without material risk to his health;
- (f) upon request, to obtain an explanation as to the relationship, if any, of the physician to any other health care facility or educational institutions insofar as said relationship relates to his care or treatment, and such explanation shall include said physician's ownership or financial interest, if any, in the facility or other health care facilities insofar as said ownership relates to the care or treatment of said patient or resident;
- (g) upon request to receive an itemized bill including third party reimbursements paid toward said bill, regardless of the sources of payment;
- (h) in the case of a patient suffering from any form of breast cancer, to complete information on all alternative treatments which are medically viable.

Except in cases of emergency surgery, at least ten days before a physician operates on a patient to insert a breast implant, the physician shall inform the patient of the disadvantages and risks associated with breast implantation. The information shall include, but not be limited to, the standardized written summary provided by the department. The patient shall sign a statement provided by the department acknowledging the receipt of said standardized written summary. Nothing herein shall be construed as causing any liability of the department due to any action or omission by said department relative to the information provided pursuant to this paragraph. The department of public health shall:

1. develop a standardized written summary, as set forth in this paragraph in layman's language that discloses side effects, warnings and cautions for a breast implantation operation within three months of the date of enactment of this act;
2. update as necessary the standardized written summary;
3. distribute the standardized written summary to each hospital, clinic and physician's office and any other facility that performs breast implants; and
4. provide the physician inserting the breast implant with a statement to be signed by the patient acknowledging receipt of the standardized written summary.

Every maternity patient, at the time of pre-admission, shall receive complete information from an admitting hospital on its annual rate of primary caesarian sections, annual rate of repeat caesarian sections, annual rate of total caesarian sections, annual percentage of women who have had a caesarian section who have had a subsequent successful vaginal birth, annual percentage of deliveries in birthing rooms and labor-delivery-recovery or labor-recovery-postpartum rooms, annual percentage of deliveries by certified nurse-midwives, annual percentage which were continuously externally monitored only, annual percentage which were continuously internally monitored only, annual percentage which were monitored both internally and externally, annual percentages utilizing intravenous, inductions, augmentation, forceps, episiotomies, spinals, epidurals and general anesthesia, and its annual percentage of women breast-feeding upon discharge from said hospital.

A facility shall require all persons, including students, who examine, observe or treat a patient or resident of such facility to wear an identification badge which readily discloses the first name, licensure status, if any, and staff position of the person so examining, observing or treating a patient or resident, provided, however, that for the purposes of this paragraph, the word facility shall not include a community day and residential setting licensed or operated by the department of mental retardation..

Any person whose rights under this section are violated may bring in addition to any other action allowed by law or regulation, a civil action under sections sixty B to sixty E, inclusive, of chapter two hundred and thirty-one. No provision of this section, relating to confidentiality of records shall be construed to prevent any third party reimbursor from inspecting and copying, in the ordinary course of determining eligibility for or entitlement to benefits, any and all records relating to diagnosis, treatment, or other services provided to any person, including a minor or incompetent, for which coverage, benefit or reimbursement is claimed, so long as the policy or certificate under which the claim is made provides that such access to such records is permitted. No provision of this section relating to confidentiality of records shall be construed to prevent access to any such records in connection with any peer review or utilization review procedures applied and implemented in good faith.

No provision herein shall apply to any institution operated by and for persons who rely exclusively upon treatment by spiritual means through prayer for healing, in accordance with the creed or tenets of a church or religious denomination, or patients whose religious beliefs limit the forms and qualities of treatment to which they may submit.

No provision herein shall be construed as limiting any other right or remedies previously existing at law.

**Responsibility of:**

Administration/General Council



# **Article VII. HIPAA PRIVACY REGULATIONS**

## **Section 7.01 Self Study Guide**

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## **How to Use This Guide**

**This self -study guide is designed to help you learn to comply with HIPAA privacy regulations.**

As your review the guide please read each section carefully and answer the questions at the end of the document. If you encounter difficulty answering a question at or series of questions, please turn reread the material.

## **Introduction to HIPAA**

As a healthcare worker, you grapple daily with patient privacy issues. Should you, for example, have mentioned Mary Smith's plan of care while two visitors were in the room? Was that man who called asking about Mary's discharge date really her brother-in-law? Or was he an insurance claims examiner?

Tufts Medical Center's obligations and your obligations, as an employee or member of the workforce of Tufts Medical Center, with respect to patient health information were more strictly defined on April 14, 2003, the compliance date for the Privacy Regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **Who is covered by HIPAA privacy rule?**

You are covered by the HIPAA rule and termed a "covered entity" – if you are:

- Health Care Provider (who transmits any health information in electronic form)
- Health Plan
- Healthcare clearinghouse

The Privacy Regulations govern how healthcare providers, including nurses, doctors, hospitals, and health plans, can use and disclose a patient's "protected health information", which is health information that could potentially reveal the identify of the patient.

Clearly, you'll need to have a good working knowledge of what you can and can't do with patients' protected health information, called PHI, in HIPAA terms.

## ***QUESTIONS***

### **1.) Who is covered by the HIPAA Privacy Rule?**

## **Privacy Rule Explained**

HIPAA is a federal law passed in 1996. One of its goals was to establish more stringent regulation of medical information management, including coding, reimbursement, electronic medical records, and patient privacy.

The regulations implementing HIPAA have been phased in gradually; the patient privacy rule is the latest piece. The government began enforcing the Privacy Regulations on April 14, 2003.

Although states have their own rules regarding health information privacy, HIPAA creates the first comprehensive federal regulation to give patients broad protection over the privacy of their medical records.

The HIPAA Privacy Regulations are concerned with controlling the use and disclosure of Protected Health Information, or PHI.

Protected health information is any information a hospital receives or creates that may be used to identify a patient, the patient's health, or the health care services the patient receives, whether in the past, present or future. Some examples of protected health information are:

- information about the patient's health condition (such as a disease the patient may have);
- information about health care services the patient has received or may receive in the future (such as an operation);
- information about the patient's health care benefits under an insurance plan (such as whether a prescription is covered);
- demographic information (such as the patient's name, address or insurance status);
- unique numbers that may identify the patient (such as a social security number, phone number, or driver's license number); and
- other type of information that may identify who the patient is.

Therefore, the use and disclosure of all information in a patient's chart is subject to the HIPAA Privacy Regulations.

## ***QUESTIONS***

**2.) What is HIPAA?**

**3.) What constitutes Protected Health Information (PHI)?**

## **Patient's Right: Notice and Authorization**

In broad terms, the privacy rule requires the following:

- Hospitals, doctors, and other entities covered by the rule must give patients written notice of their privacy practices and patients' privacy rights. Patients will be asked to acknowledge that they received the Notice of Privacy Practices. This acknowledgement form must be dated, and kept on record. If such acknowledgment cannot be obtained, a good faith effort to obtain it must be documented. This notice must be given to the patient upon first service delivery after April 14, 2003, and thereafter upon request of the patient.
- Patients must give a signed authorization before healthcare providers can disclose his or her Protected Health Information (PHI) for purposes other than:
  - Treatment
  - Payment
  - Healthcare Operations
  - To comply with the law and meet important public needs (such as public health activities, health oversight activities, law enforcement purposes, and to avert a serious threat to health or safety; refer to Tufts-New England Medical Center's Notice of Privacy Practices for a detailed list)
- Nurses, doctors, and other healthcare providers covered by the privacy rule may talk to the patient about treatment options or disease management programs that involve third-party products or services as long as the discussion is related to the patient's treatment.
- Patients have the right to inspect and copy their PHI and request amendment or correction of their PHI (we do not have to comply with this request, but we must respond in a specified time frame; relevant Hospital policies specify the procedures).
- Patients have the right to receive (generally within 60 days) an accounting of disclosures of their PHI that were made to third parties without their authorization except for disclosures for treatment, payment and health care operations, and certain other disclosures.
- Patients have the right to request that PHI be communicated to the patient by Tufts Medical Center at alternative locations or by alternative means if possible (e.g., at a specific address or phone number).
- Patients have the right to request that our use or disclosure of their PHI is restricted (but we do not have to comply).
- Patients may file complaints about alleged violations of their rights with the Tufts Medical Center Privacy Officer or with the federal Department of Health and Human Services.

Authorization forms for use or disclosure of PHI must meet specific HIPAA requirements. Patients should be directed to the Medical Records Department for the Hospital's HIPAA-compliant authorization form.

In what other circumstances is authorization not required?

PHI can be used/disclosed without authorization, unless the patient objects, for the following reasons:

- Maintain TuftsMC patient directory
- Inform family members or other identified persons involved in the patient's care, of the patient's location, condition or death
- Inform appropriate agencies during disaster relief efforts to help us notify these persons.

Other permitted uses/disclosures to further public policy objectives that do not require patient authorization include:

- Public health activities related to disease prevention and control
- To report victims of abuse, neglect, or domestic violence
- Health oversight activities such as audits, legal investigations, licensure or for certain law enforcement purposes or government functions
- For coroners, medical examiners, funeral directors or tissue/organ donations

Reminder: When you send a letter or a copy of a routine discharge summary to a referring clinician or a referral form to another facility or the VNA (or other home care agency), as such communication is explicitly for treatment purposes, **no authorization is required, unless the information being disclosed contains specially-protected information, such as HIV testing information, mental health information, or certain genetic testing information.** Similarly the reporting of a test or a procedure result to a referring clinician for treatment purposes can be sent as usual to the referring or receiving clinician and **no authorization is required, unless the information being disclosed includes specially-protected information, such as in the examples above.**

## ***QUESTIONS***

**4.) What is the notice of privacy practices required by HIPAA?**

**5.) When is authorization required?**

## **Disclosures of the Designated Record Set (DRS)**

- Patients have a right to inspect and request a copy of their health information maintained in our DRS.
- Our DRS includes the paper and electronic records, any database with information not duplicated elsewhere in the DRS, shadow charts in clinics and offices not duplicated in the medical record, hospital billing records, etc. which contain patient Protected Health Information.
- The DRS includes records used by or for TuftsMC to make decisions about patients.
- Physicians must ensure that any e-mail that should be in the medical record is copied to their shadow charts, the hospital charts, or to the Medical Records Department.
- As we need to track and account for certain disclosures, ALL requests for copies of medical records or parts thereof relating to care at TuftsMC should go through the Medical Records Department.
- Because requests for disclosure or release of information will come through the Medical Records Department, it is critical that physicians' offices and clinics respond rapidly to the Medical Records Department's requests for copies of the shadow chart and other data. Generally, TuftsMC will have a 30-day window to respond to requests for records maintained in the DRS.

## **Incidental Disclosures**

Upon first hearing of HIPAA's privacy rule, some clinicians worried that they would not be permitted to discuss a patient's treatment at the nurses' station, in the hallway, or in the patient's room, in case anyone not connected to the case could overhear. Such "incidental disclosures," however, are allowed as long as the facility has reasonable safeguards in place to protect the patient's privacy and employs the "minimum necessary" standard.

## **Some Do's and Don'ts**

- Do not discuss PHI in public places, e.g., elevators, hallways, restaurants, etc.
- Do not use your cell phone to discuss PHI in public places.
- Speak softly when another patient or other individuals are nearby (e.g., double rooms, ICUs, etc).
- In clinics, speak to your patients in private rooms, not in the waiting room.  
It is OK to call a patient by name from a waiting room or keep a patient list containing only their names. A patient list or sign-in sheet, however, may not display medical information that is not necessary for the purpose of signing in (e.g., the medical problem for which the patient is seeing the physician).
- Keep charts, mail, test results, etc in protected areas.
- If necessary for patient care and safety, limited disclosure may be made (e.g., identifying a patient as being on precautions).

Keep in mind that HIPAA does not intend to interfere with a covered entity's engaging in communications as required for quick, effective, and high quality health care. For example, in an emergency situation, in a loud emergency room, or where a patient is hearing impaired, it may not be possible to speak softly so as to avoid incidental disclosures to other individuals.

## **Disclosure of Patient Information to the Media**

Members of the media or the Public Affairs and Communications office will occasionally contact floors seeking information about a patient's condition, often a patient who has been involved in an accident or other trauma. If a member of the media (such as a reporter or producer) calls, they should immediately be directed to the Public Affairs office. **Do not give a member of the media the information yourself.** During weekdays such a call should be directed to 617-636-0200. On nights or weekends, you can always page a number of the Public Affairs staff by paging beeper # 1440.

The beeper is rotated among the following staff members:

- *Julie Jette, Media Relations Manager*
- *Leigh Lucas, Public Affairs Manager*
- *Brooke Tyson-Hynes, Vice President of Public Affairs and Communications* is also available at beeper #3214

As long as the patient has not requested that information be withheld or kept out of the Hospital Directory, **you may release the patient's one-word condition to members of the Public Affairs and Communications team.** Public Affairs will typically check with Admitting before contacting the floor to confirm that the patient has not decided to opt-out of the Hospital Directory. If there is intense media interest in a patient, you may receive more than one call from Public Affairs during a shift. Please be as responsive as possible when you are contacted by Public Affairs.

## **Condition**

For the one-word condition, the following terms are acceptable:

**Undetermined** - Patient is awaiting physician and/or assessment. Often the case in the Emergency Department

**Good** - Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.

**Fair** - Vital signs are stable and within normal limits. Patient is conscious, but may be uncomfortable. Indicators are favorable.

**Serious** - Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.

**Critical** - Vital signs are unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.

**Please note: The term "stable" should not be used as a condition.**

## **QUESTIONS**

**6.) A patient requests their medical record after seeing their physician in clinic -- what do you do?**  
**A patient requests that his or her clinician communicate with his or her referring clinician about the treatment received – what do you do?**

**7.) List at least three situations when disclosures of health information constitute “ incidental disclosures” that are acceptable under HIPAA.**

**8.) I’m working as the charge nurse in the SICU when I receive a call from the External Affairs Department checking on a condition of one of my patients for WBZ Radio. What should I do?**

### **Minimum Necessary Requirement**

PHI can be used without seeking authorization (unless the patient has requested and we have agreed to a specific restriction to such use) for **treatment, payment or for healthcare operations** purposes (sometime referred to as "T, P or O").

However, even when using PHI for treatment, HIPAA requires us to use the minimum amount of information required to accomplish the intended purpose.

The minimum necessary standard is a key protection of the HIPAA Privacy Rule. It is derived from confidentiality codes and practices in common use today. It is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function.

If it is unclear how much PHI is necessary in a treatment context our rule of thumb should always be - ***Safety and Patient Care Come First.*** However please distinguish between the *need to know* and *right to know*.

Only access PHI based on your need to know the information in any given situation.

TuftsMC has classified its staff and employees based on their job descriptions and will provide access to PHI based on such descriptions and job needs, although special exceptions are possible.

*The minimum necessary standard does not apply to the following:*

- Disclosures to or requests by a health care provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an individual’s authorization.

Uses or disclosures that are required by law.

As a rule of thumb as you go about your work, ask yourself these questions to help determine what is the minimum necessary use and disclosure of a patient's protected health information: Do I need to use or disclose PHI to perform this task? If so, what health information is essential to my performing this task?

In most situations, the common sense answers to these questions will guide you to act in compliance with the minimum necessary standard in the HIPAA Privacy Rule.

## ***QUESTION***

9.) It is “Minimum Necessary” under the HIPAA Privacy Rule?

## **Implications For Patient Care**

### ***Teaching***

- In a teaching institution, teaching is a key part of our operations, and bedside rounds, teaching rounds, conferences, clerkships, etc are all part of these operations.
- On the wards or in the clinics, take measures to minimize incidental disclosures, such as speaking softly.
- At conferences, try to minimize disclosure of patient identifiers as much as possible without compromising the educational goals.

### ***Physical Environment***

- Keep PHI in protected areas if possible.
- White boards are an essential tool in the provision of safe and efficient patient care. We will continue to use white boards but will need to modify the information contained on them to meet the requirements of HIPAA. The following information can be placed on the white board located at the nurses station:
  - The first initial and last name of the patient.
  - Name of resident and or intern
  - Name of primary nurse/associate nurse

This minimum amounts of information will further the goal of maintaining privacy and will allow for efficient hospital operations.

- **Most white boards should not contain diagnoses or clinical information. Most will not list the attending (which may imply the diagnosis).**  
White boards that have any more information should be in protected, non-public areas.
- In clinics, keep appointment schedules in a protected area.
- Protect your password. Do not share it. Change it if it may be compromised.
- Log off your computer or the application when you are done with your task.
- Position the monitor screen on your computer so it cannot be easily viewed by casual passers-by as you are working.

## QUESTIONS

**10.) What kind of information is allowable on White Boards? Will our current practice have to change to meet the requirements of HIPAA?**

### *Disposal of PHI*

- Health care workers should use care in destroying PHI that may be contained in such forms as prescriptions, labels, identification bracelets, meal descriptions, or any other item that has information identifying a patient's name or address, social security number, date of birth, or age. Items containing such information must be disposed of appropriately.
- Nurses may be responsible for putting this material through shredders or into locked receptacles for shredding and incineration later. Nurses may also be responsible for erasing computer files from the hard drive containing calendars, surgery schedules, or other daily records that include PHI.
- Tufts-NEMC has placed shredding receptacles or other disposal receptacles for PHI in clinical spaces.
- In your offices, you should also utilize shredders for any PHI no longer needed.

### *Using E-Mail*

***TuftsMC's "Guidelines for E-Mail Communication of Protected Health Information" are available on the TuftsMC Intranet site.***

Communications conducted by e-mail that contain PHI which the clinician believes should be part of the medical record should be stored in the patient's medical record.

Generally speaking, e-mail should be a part of the medical record

IF it is used in any way to make clinical decisions.

- Generally, e-mail to and from patients (save for administrative correspondence like appointments) should be copied to the medical record (either the clinic shadow record, your office record or the main medical record).
- Generally, any e-mail to and from clinicians (at TuftsMC or outside TuftsMC) which is not substantially duplicated in the medical record should be placed in the medical record.
- Any e-mail in your shadow clinic record and certainly any sent/copied to medical records must include the patient's name and medical record number to be filed.

- Unlike e-mail sent within TuftsMC that remains within our firewall, any e-mail sent outside of TuftsMC (including e-mail sent to Tufts University School of Medicine or the HNRC) travels over the internet and therefore runs the risk of being intercepted, potentially resulting in unauthorized disclosure of Protected Health information (unless it is specially encrypted).

— **Do NOT forward your Tufts-NEMC e-mail outside of Tufts-NEMC if it MIGHT contain any PHI.**

- We have no way to provide for encryption of e-mail sent from Tufts-NEMC at this time.
- Because of the nature of unencrypted e-mail transmission and the risk of privacy breaches, the use of e-mail that contains PHI (note: the patient's email address is one of the 18 patient identifiers specified in HIPAA) outside of TuftsMC's network firewall requires the patient's explicit written consent.
- It must be completed in writing and signed by the patient and witnessed (see the Patient Consent Form for e-mail Communication, which you may access on the Intranet), **even for you to e-mail to the patient's referring physicians outside of Tufts-NEMC.** (Sorry—this is better than a blanket “no e-mail” policy!)
- The original signed consent (with the patient's name and medical record number) should be sent to Medical Records. Place a copy in your chart.
- The consent applies only to you!
- Every TuftsMC clinician e-mailing PHI outside of TuftsMC must have a separate signed consent that authorizes that clinician to communicate PHI via e-mail. If the patient has two TuftsMC clinicians using e-mail, two consents are required.
- When obtaining the consent, review the risks of using e-mail with the patient (e.g., privacy, timeliness of response). These risks are listed in the Consent Form.
- Ask patients to include their names and medical record numbers in any e-mail they send to you.
- E-mail sent from TuftsMC will automatically include a notice of confidentiality added at the bottom by the e-mail system, which reads :

*“The information transmitted in this email is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged information. Any review, Retransmission, dissemination or other use of or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you received this email in error, please contact the sender and delete the email and any attached material immediately. Thank you.”*

## **QUESTION**

- 11. Describe the procedure required before PHI can be e-mailed to a patient or clinician outside of TuftsMC?**

## ***PHONE CALLS AND FAXES***

- Be certain you know to whom and to where you are phoning or faxing before disclosing PHI.
- Fax cover sheets should contain a confidentiality notice such as:

"Note: The information contained in this facsimile may be privileged and confidential and protected from disclosure. If the reader of this facsimile is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying, or other use of this facsimile is strictly prohibited. If you have received this facsimile in error, please notify the sender immediately by telephone at \_\_\_\_\_ and destroy this facsimile. Thank you."

- Be wary of making calls in public areas.  
Speak as softly as possible.
- Be aware that cell phone conversations on non-digital phones can be intercepted.

Receiving fax machines should be in a secure location.

## **What Do I Do If I Suspect A HIPAA Violation?**

If you are concerned about a potential violation of the HIPAA rule, you may call the HIPAA Privacy Officer at ext. 4422. You may also report a suspected violation to your manager, or make an anonymous report by calling the confidential TuftsMC compliance line at ext. 2894.

## ***What Are The Penalties For Non-Compliance?***

There are civil and criminal penalties for violations of the HIPAA rules, including a \$100 civil penalty up to a maximum of \$25,000 per year for each standard violated, and a criminal penalty for knowingly disclosing PHI, a penalty that may escalate to a maximum of \$ 250,000 for conspicuously bad offenses.

## **RESOURCES AT TUFTSMC**

Privacy Officers:

For physician groups: Steve Pauker, MD

For TuftsMC: Jeffrey Weinstein, Vice President, Legal Affairs

Privacy officers will clarify issues, answer questions and adjudicate problems.

## QUESTION

### 12.) Who are the Privacy Officers and how do you contact them?

#### **Conclusion and Basic Rules**

❖ No Use or Disclosure of PHI without patient authorization *except*:

- For treatment, payment and health care operations

—In a teaching hospital, teaching is a part of our health care operations.

- Or when a specific regulatory exception under HIPAA applies, e.g., public health reporting, in emergencies/ disasters, to identify patients or locate family members; and as required by law.

*Keep in mind, there are special requirements under state law for the use and disclosure of certain categories of highly confidential information (e.g., HIV information, genetic testing information, alcohol and drug abuse treatment information, and mental health treatment information). In most circumstances, disclosures of these types of information require the patient's written authorization.*

❖ Employ the “minimum necessary” standard: Only use the PHI that you need to accomplish the intended purpose, but keep in mind that if you are unsure what the appropriate amount of PHI is, patient care and safety come first.

- Ask yourself: “Do I need to know this to carry out a particular function?”
- Keep in mind that the minimum necessary standard, a key protection of the HIPAA Privacy Rule, is derived from confidentiality codes and practices in common use before HIPAA. It is based on the practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function.

## **ANSWERS**

### **1.) Who is covered by the HIPAA Privacy Rule?**

You are covered by the HIPAA rule and termed a covered entity – if you are:

- Health Care Provider
- Health Plan
- Healthcare clearinghouse

ALL TuftsMC employees, and members of its workforce, INCLUDING HEALTH CARE PROVIDERS, must comply with the Privacy Regulations and take reasonable measures to protect against unauthorized uses and disclosures of a patient's Protected Health Information.

**THIS MEANS YOU!**

### **2.) What is HIPAA?**

HIPAA stands for the Health Insurance Portability and Accountability Act. All health care providers in the United States who transmit health information in electronic form must comply with this federal mandate designed to protect patient privacy. HIPAA sets in place standards for proper use of patients' protected health information, defines a patient's right to access and control this information and requires a hospital to adopt written privacy procedures, train employees in these procedures and designate a privacy officer to ensure that these procedures are followed. The law applies to disclosure of health information whether by electronic, paper or verbal communication.

### **3.) What constitutes Protected Health Information (PHI)?**

Protected Health Information is individually identifiable health information that is transmitted or maintained in any form or medium by the HIPAA covered entity or health care provider. PHI can relate to the physical or mental health of an individual or payment for an individual's health services. PHI can be in the form of paper copies, member files, telephone calls, voice mail, and verbal communication, fax transmissions and e-mails. In short, PHI is anything you see or hear that lets you know about the health of a specific individual.

### **4.) What is the notice of privacy practices required by HIPAA?**

The Notice of Privacy Practices is to inform patients of the Hospital's privacy practices and the patient's rights with respect to their PHI at the first date of service after April 14, 2003. Patients are asked to sign to acknowledge receipt of this information. If a patient chooses not to sign that he or she has received the Notice of Privacy Practices, we document the fact that we made a good faith effort to obtain a written acknowledgement of receipt of the notice and the reason why the acknowledgement was not obtained. The fact that the patient receives the Notice of Privacy Practices will be noted on the SMS system. It will be available in other languages such as Chinese, Vietnamese, and Spanish. The notice will be presented at the patient's first encounter at Registration, Admitting, or clinical setting.

**5.) When is authorization required?**

- Patients must give a signed authorization before any covered entity uses or discloses his or her Protected Health Information (PHI) for purposes other than:
  - Treatment
  - Payment
  - Healthcare Operations
  - Certain public policy objectives and to meet important public needs, examples of which are listed below

**6.) A patient requests his or her medical record after seeing the physician in clinic – what do you do? A patient requests that his or her clinician communicate with his or her referring clinician about the treatment received – what do you do?**

- ALL requests for copies of medical records or parts thereof relating to care at TuftsMC should go through the Medical Records Department.
- An exception is when you send a letter or a copy of a routine discharge summary to a referring clinician or a referral form to another facility or the VNA (or other home care agency), as such communication is explicitly for treatment purposes.
- Similarly the reporting of a test or a procedure result to a referring clinician for treatment purposes is not an accountable disclosure and can be sent as usual to the referring or receiving clinician.

**7.) List at least three situations when disclosures of health information constitute “incidental disclosures” that are acceptable under HIPAA.**

- When you must speak to a patient and another patient is nearby (e.g., double rooms, ICUs, etc), and you speak softly so as to limit any incidental disclosure.
- When you call a patient by name from a waiting room or keep a patient list containing only their names, not other information such as the medical reason for the appointment.
- When safe patient care requires that you identify a patient as being on precautions, even though this may result in an incidental disclosure to other individuals, as long as reasonable safeguards and the minimum necessary standard are employed.

**8.) I’m working as the charge nurse in the SICU when I receive a call from the External Affairs Department checking on a condition of one of my patients for WBZ Radio. What should I do?**

As long as the patient has not requested that information be withheld or kept out of the Hospital Directory, you may release the patient’s one-word condition to External Affairs. External Affairs will check with Admitting to confirm that the patient has not opted out of inclusion in the Hospital Directory. If you question who may be calling, you can always page the EA staff member directly at Beeper # 1440.

## 9.) What is “Minimum Necessary” under the HIPAA Privacy Rule?

The HIPAA Privacy Rule requires that the amount of Protected Health Information (PHI) used or disclosed be limited to the minimum necessary for the intended purpose. To ensure compliance, each staff member and employee should access only the amount of Protected Health Information required to accomplish his or her job. Disclosure and use of information must be restricted to the minimum amount of PHI necessary for the intended purpose; for instance, if part of a medical record will suffice to satisfy a particular purpose, only the relevant pages of a medical record should be used or disclosed, as compared to the entire medical record.

*The minimum necessary standard does not apply to the following:*

- Disclosures to or requests by a health care provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an individual’s authorization.
- Uses or disclosures that are required by law.

## 10.) What kind of information is allowable on White Boards? Will our current practice have to change to meet the requirements of HIPAA?

White boards are an essential tool in the provision of safe and efficient patient care. We will continue to use white boards but will need to modify the information contained on them to meet the requirements of HIPAA.

The following information may be placed on the white board located at the nurses' station:

- First Initial and last name of patient
- Name of resident and/or intern
- Name of primary nurse/associate primary nurse

This minimum amounts of information will further the goal of maintaining the patient’s privacy and will allow for efficient hospital operations.

## 11.) Describe the procedure required before PHI can be e-mailed to outside TuftsMC?

- Because of the nature of unencrypted e-mail transmission and the risk of privacy breaches, the use of e-mail that contains PHI outside of TuftsMC’s network firewall requires the patient’s explicit written consent.
- The E-Mail Communication Consent Form must be completed in writing and signed by the patient and witnessed, even for you to e-mail to the patient’s referring physicians outside of TuftsMC.
- The original signed consent (with the patient’s name and medical record number) should be sent to Medical Records. Place a copy in your chart.

- The consent applies only to you! Every TuftsMC clinician e-mailing PHI outside of TuftsMC must have a separate signed consent authorizing that clinician to send e-mail containing PHI. If the patient has two TuftsMC clinicians using e-mail, two consents are required.
- When obtaining the consent, review the risks of communicating by e-mail with the patient (e.g., privacy, timeliness of response). The risks are described in the Consent Form.
- Ask patients to include their names and medical record numbers in any e-mail they send to you

## 12.) Who is the Privacy Officer and how do you contact them?

If you are concerned about a potential violation of the HIPAA rule, you may call the HIPAA Privacy Officer at ext. 4422. You may also report a suspected violation to your manager, or make an anonymous report by calling the confidential TuftsMC compliance line at ext. 2894.

### *Compliance Officers:*

For the physician groups: Steve Pauker, MD  
For TuftsMC: Jeffrey Weinstein, Legal Affairs

Privacy officers will clarify issues, answer questions and adjudicate problems.



**Completion of HIPAA Self Study Guide**

Please sign and date below indicating that you have completed the mandatory requirement for HIPAA training. Keep the packet for future reference and submit this form to the Program Coordinator with your Rotation Documentation.

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**Rotator SIGNATURE**

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**PRINT NAME**

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**DATE**