

UNIVERSITY PHYSICIANS OF BROOKLYN, INC.

POLICY AND PROCEDURE

No: _____

Subject: SAFEGUARDS FOR INCIDENTAL DISCLOSURES **Page** 1 **of** 3

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Distribution:

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- I. **Purpose:** To ensure that protected health information (PHI) is reasonably safeguarded from intentional or unintentional use or disclosure to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.
- II. **Policy-** UPB will have appropriate administrative, technical and physical safeguards to protect the privacy of PHI. Where possible, medical record number will be used instead of patient name. In addition, on all occasions, minimum necessary guidelines will be followed.

A. Verbal Communications

1. Professional Discussions- UPB staff members must refrain from discussing patient information in public areas.
 - a. When PHI must be discussed with a patient in a waiting room, the patient should be taken to an area with less people and spoken to in low tones.
2. Voice Messages
 - a. Scripts should be developed for repetitive voice messages, such as appointment reminders, to ensure that no information linking the patient to a particular condition or information about services being provided is indicated. For example, the following message would be appropriate:

“ This is Paula Green from University Physicians of Brooklyn. I am calling to remind Mrs. Jones of her appointment with Dr. Smith tomorrow at 1:00 PM.”

- b. Lab and other test results should never be left in a message.
 - c. Dictations should not be made within earshot of other individuals.
 - d. When processing information left on answering machines, the information should not be played over speakerphone.
3. Telephone Requests for Patient Information- The guidelines delineated in the policy Telephone Requests for Patient Information should be followed.
4. Intercom Announcements- Intercom announcements should never reveal the:
- a. Nature of the patient's condition; or
 - b. Specialty of services being provided.
- The patient should be referred to the reception desk if protected health information must be disclosed.

B. Paper Based Data

1. Sign-In Sheets
- a. Sign-in sheets should never contain PHI, such as the reason for visit, chief complaint or diagnosis. Patient name, date and time would be appropriate elements.
 - b. If possible, patients should be given a sticking label to sign-in, where their name, date and time could be documented. The receptionist should then stick the label on the main sign-in sheet maintained by the staff behind the counter. In this manner, the unintended disclosure of the names of the patients who have already signed in will be minimized.
2. Patient Charts
- a. Patient charts should be placed in the trays outside the patient rooms with the name of the patient facing the wall.
3. Leaving PHI
- a. UPB staff members are expected to place any PHI in closed drawers before going on breaks, to lunch and at the close of business each day.
 - b. Information should not be left in conference rooms or on counters where the information may be accessible to the public.
4. Postcards- Postcards sent to patients should not contain any PHI.
5. Closets & Cabinets- All closets and cabinets containing PHI and confidential files must be locked when the area is unsupervised and access must be monitored.
6. Transporting PHI- PHI should be placed in bags or envelopes that are made inaccessible for viewing by the transporter.
7. Shredding- All printed materials and copies, including faxes, emails and reports, containing PHI, including just a patient's name, must be shredded. Under no circumstances may this information be placed in regular trash bins.
8. Faxing- The guidelines delineated in the policy Faxing Patient Information should be followed.

C. Electronic Data

1. Computer Terminals
- a. PC monitors should be turned away from the public.
 - b. For those PC's that are located in high traffic areas that cannot be moved to another location, shields should be placed on the monitors.

- c. UPB staff members are expected to log off of terminals before leaving their workstations.
 - d. Notepad cannot be used for documenting protected health information as it is not password protected.
 - e. Passwords and ID's cannot be shared. Staff will be held liable for all activity occurring under their account.
 - f. The practice supervisor is responsible for ensuring that any protected health information from old PC's that are being removed is deleted appropriately.
2. Diskettes & CD's- PHI on diskettes or CD's must be deleted. UPB practice supervisors are responsible for inspecting the diskettes or CD's for any valuable necessary information and then breaking the diskette film or cutting the CD.
 3. Emails- All emails containing PHI should be encrypted.

D. Physical Security

1. Ample Space
 - a. Ample space should be provided to discuss information with patients and other providers, to answer telephone calls and to conduct other operations involving PHI.
 - b. When ample space cannot be provided, physical barriers should be erected to decrease sound penetration (Ex: cubicle walls, dividers, shields, potted plants).
2. Key Distribution
 - a. Distribution of keys to areas containing PHI must be supervised and controlled.
 - b. Keys, access cards and tokens may not be shared.
 - c. Upon termination, all keys must be returned.
3. Locked Doors- Doors must be locked and access to sensitive work areas must be monitored.

III. Procedure

The development of the procedure section is the responsibility of the respective practice. It is dependent upon the unique needs of each practice's operating structure and shall be advanced and customized accordingly.

- IV. Responsibilities:** It is the responsibility of all medical staff members and practice staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Practice staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the practice.

- V. Reasons for Revision-** Regulatory changes

- VI. Attachments-** None

- VII. References-** Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.530(c)