Eight Simple, Inexpensive Tips to Improve Patient Flow

Automation can create opportunities to enhance patient flow, but sometimes it's the little things that make the day run better for you and your patients. None of these tips require any fancy equipment, and most can be done for a few dollars – or no expense at all. Let's review eight simple ideas to not only jump start your day, but also to keep it on track.

Begin at the starting gate. Determine what time you want to start seeing patients – the doctor or advanced practice provider, that is – and back the schedule up by 10 or 15 minutes. Today's schedule is built for the front office; it makes no sense – and means that every day starts off behind the eight ball. For an 8 a.m. start, tell patients: "You have a 7:45 arrival time." Use this technique throughout the day to include the start of the afternoon clinic.

Huddle and sweep. Touch base for a quick five-minute huddle before the day begins, and gather for a "sweep" of the same timeframe later in the afternoon. Focus on quick updates about the coming 24 hours, and discuss challenges as well as strategies to avoid them in the future.

Structure. Create a standard approach to each exam room, with supplies and equipment in the same place. Take pictures of how the exam room should be prepped, including the exact placement of supplies based on the appointment type (e.g., a pelvic exam). Speaking of placement, discuss the recommended positioning of the patient in a chair or exam table so that the physician isn't delayed while the patient is asked to move around.

Construct kits. Develop standard kits for in-office testing, such as continuous glucose monitoring. Buy a large plastic bin, and type out the inventory of the contents. Take a picture of the items in the bin. Tape the written inventory and the picture(s) to the side of the bin, avoiding any confusion about its contents.

Hang a mirror. To "see" around corners, hang a convex mirror. This helps avoid the "blind spots" in a busy clinic that can result in lost or forgotten patients – or frustrated providers. While you have the hammer out, put up some clocks as well. Avoid the ones that tick out loud – they will slowly drive you crazy. It may seem basic, but simply knowing what time it is helps everyone stay on task.

Use color. Signs hanging from the ceiling are common in most practices, but they don't address the challenges of a busy practices with no easy route out. Assisting patients is your responsibility, but it can be overwhelming if most have to ask for directions to the exit. Use color – a red mat at the exit, for example – or a specific visual piece such as a portrait

of a heart – to guide patients and reduce disruptions. Color can also facilitate internal communication – without words; use colorful flags hung on exam room door frames to signal the flow of patients.

Avoid visitors. Schedule guests during non-clinic hours, and never allow a visitor in the clinical area. It's human nature to stop and chat, but even a few minutes here and there can get you off task and schedule.

Use wheels. Although the computer provides the vast majority of the information you require, busy practices still need a form or two (or maybe a multitude of them). Store copies of forms neatly in folders in a rolling cart(s); keep the cart in a designated area in the nurses' station. Roll it into the exam room when you need it. Use the same logic – a rolling cart – for other value-added equipment that such as printers or fax machines (using a wireless connection).

Sometimes the simple fixes are the most effective. Take the time to get back to the basics and you may be surprised at the positive impact these enhancements can have on your flow, efficiency, and organization of your practice.

Physician Burnout: Other Viewpoints

Editor's Note: This is part four in our four-part series on physician burnout. Part I was published in the January 2018 edition of The SVMIC Sentinel; part II was published in the April 2018 edition; and part three was published in our July 2018 edition.

Physician burnout syndrome is a pervasive problem that can impair clinical competence, shorten careers, distress families, and is an independent predictor of reporting a major medical error and being involved in a medical malpractice suit. This will be the fourth and final article in this series about Physician Burnout Syndrome (PBS). The first article discussed the signs and symptoms of PBS using a tragic clinical case for illustration. The second article in this series looked at the causes of PBS and described the three aspects that make up PBS as first described by Christina Maslach in the 1970s: Emotional Exhaustion, Depersonalization, and Low Personal Achievement. The third and most recent article in this series discussed prevention and treatment of PBS.

In this fourth and last article, we will look at burnout from a different viewpoint. Dr. Dike Drummond has written extensively on this subject. I mentioned Dr. Drummond in Part 3 when discussing prevention of PBS by improving physician resilience. His thoughts are that *"physicians are the canary in the coal mine of medicine."* PBS is a reflection on the condition of the practice and business of medicine. Improving the conditions of medicine is much more appropriate than improving the resilience of the physician. It's not the canary that needs help, it's the canary's environment. Likewise, the problem is not the resilience of the physician, but the environment in which the physician is practicing.

Like many syndromes, PBS has many consequences. As we've seen, these consequences include quality of care issues, decreased patient satisfaction, decreased patient compliance, increased medical errors leading to increased malpractice risk, increased use of alcohol and illicit drug use, and increased number of suicide attempts and suicide completions. PBS can be especially lethal if not acknowledged or treated. Physicians are masters at denying their own problems, something that we encounter every day at the Tennessee Medical Foundation Physician's Health Program (TMF-PHP). Their focus is never on their own health, which is why physicians seldom ask for help. They are generally forced to get help by a peer, spouse, or superior in the workplace. However, the leaders of organized medicine, including the National Academy of Medicine, American Medical Association, Federation of State Medical Boards, and other national groups, are taking aim at PBS to find effective prevention and treatment that doesn't focus on fixing the canary.

PBS is a low-energy state analogous to functioning with a depleted energy store – not the type of energy manufactured from glucose and carried around in ATPs; this energy source is better described as transcendent or spiritual. Dr. Drummond makes the analogy of an energy that is more like "The Force" in the *Star Wars* movies than anything measurable with units of energy.[1] Drummond describes an energy account, much like a bank account where deposits and withdrawals are made. Rest, relaxation, and rewarding relationships are positive deposits in the energy account. Withdrawals of energy are made by life activities that are not rewarding or pleasant such as illness, unpleasant or difficult relationships, or unrewarding types of work. For example, being named in a malpractice lawsuit or making a medical error are quick ways to drain one's energy account. Having little to no autonomy or control over your work environment also depletes this type of energy but at a slower rate. Burnout is likely to occur when an energy account remains depleted or in the negative over a period of weeks to months.

Using the energy analogy described above, Dr. Drummond describes the five main causes of burnout he sees most:

1. The practice of clinical medicine is a difficult task that utilizes a lot of energy. However, this can be very rewarding to physicians and can be a net gain of positive energy. After all, we attended medical school to join the healing arts, but at some level dealing with sickness and death can erode that positive energy.
2. On a more basic level, the personal aspects of a practice situation such as specialty, call rotation, compensation, office personalities, location, and the type of practice can all influence the type of energy – positive or negative – that is produced.
3. The lack of work-life balance. This balance is necessary to recharge your energy. Work-life balance was not taught in medical school or residency. Actually, the opposite was reinforced, that is, to disregard your home life, your emotions, your spiritual connections, or anything that keeps you out of the hospital and gets in the way of your education. The old joke, "The problem with every-other-night call is that you miss half the good cases," isn't funny because it is or was the mindset of our medical education system. A home life that is healthy and nurturing is important to have and to use to help replete this type of energy. Unfortunately, some types of home life can cause energy depletions, such as illness, conflicts with spouse or children, and financial problems. When looking for causes of PBS, it is important to include the home as a potential etiology.
4. Dr. Drummond describes four character traits that create good physicians but leave them vulnerable to burnout and other mental health disorders: the workaholic, the superhero, the perfectionist, and the lone ranger. The *workaholic* uses work and more work to overcome any difficulty. The *superhero* faces every challenge alone, not needing or asking for help. The *perfectionist* can't make a mistake and demands the same from everyone else. The *lone ranger* is unable to delegate responsibility and is a micromanager. In 1985, Dr. G. Gabbard described three characteristics that physicians have – doubt, guilt feelings, and an exaggerated sense of responsibility – that he called the "triad of compulsiveness."[2] This triad can easily lead to PBS or negative energy. These characteristics are present in most physicians but they do

come with a cost.

5. One of the most direct causes of PBS is the leadership skill set of the physician's immediate supervisor. Unfortunately, most physicians either do not receive or innately have good or effective leadership qualities. In the medical education world, the immediate supervisor is the person with one more year of experience. Thus, the medical student answers to the intern, who answers to the resident, who answers to the chief resident, to the junior attending, to the department chair, up the chain of command to the Dean. Research and attracting grant money are the usual prerequisite for promotion, so the top dog may produce Nobel-winning research but have terrible leadership skills, making everyone in the department miserable, which results in mass resignations.

Physician Burnout Syndrome is a real and potentially lethal problem that is increasing in prevalence. When a physician becomes burned out, it is noticeable as they proceed from happy to indifferent, from engaged to apathetic, from a high-energy state to a depleted state. The repercussion of burnout can be devastating to the physician and to their patients. Quality of care suffers, as does patient satisfaction. Everyone suffers.

As mentioned, there are changes being discussed by the leadership of our national organizations to reverse this trend. However, those changes are not occurring overnight. If you are struggling or know someone who is struggling with burnout, please give the TMF-PHP a call, or encourage them to call. 615-467-6411) All calls are strictly confidential; getting help does not mean getting reported. We have the expertise to identify causative problems and initiate changes to help remedy the situation. Please think of the TMF as a resource, not a punishment. Asking for help is a sign of strength.

The Tennessee Medical Foundation can be contacted at 615-467-6411.

The Federation of State Physician Health Programs provides a comprehensive listing of state programs here.

1. Drummond D. Physician Burnout: Its Origin, Symptoms, and Five Main Causes, *Fam Pract Manag.* 2015 Sep-Oct;22(5):42-47.

2. Gabbard GO. The Role of Compulsiveness in the Normal Physician. JAMA. *1985* Nov 22-29;254(20):2926-9.

Contemporaneous Documentation

An old Chinese proverb says that *“the faintest ink is more powerful than the strongest memory.”*

Timely documentation is critical in order to ensure an accurate and complete record of the patient encounter. Office notes and dictated procedure notes should be completed, reviewed and signed within 24 to 48 hours of seeing the patient. Late completion of notes puts you and your colleagues at risk. Memory interferes with accuracy and efforts to “catch up” often lead to incomplete documentation. Any intervening adverse event prior to completion of notes makes late documentation appear self-serving.

One of the”Golden Rules” of documentation is that the medical record be prepared as contemporaneously with treatment as possible to avoid confusion and to ensure accuracy. The defense of malpractice lawsuits has taught us that juries often assume that undocumented events never happened. It is also important not to document actions or treatment before they actually occur.

Consider the following case: A female infant was seen by her pediatrician for a routine, initial well-baby visit, which included immunizations. The exam was unremarkable, and the child’s chart was documented indicating that all immunizations had been administered. Later, during a follow-up office visit, the child was seen by the same clinic and again, documentation noted the infant had received all necessary vaccines. The parents were instructed to return in four weeks.

Subsequently, the infant was seen by the same clinic a third time but treated by a different healthcare provider. The infant had an elevated temperature and an elevated white blood cell (WBC) count. Additional labs were obtained and the infant was subsequently diagnosed with pneumococcal meningitis/septic shock and admitted to ICU. She had seizure activity and required intubation. After a month-long admission, the child was diagnosed with a seizure disorder and significant developmental delay.

The parents filed a medical malpractice lawsuit against the pediatric clinic and its physicians alleging ‘negligence for failing to immunize the child’ and ‘failing to accurately chart the fact that immunizations were not given.’ An investigation of the events revealed that documentation in the medical records was sloppy and inaccurate. A medical assistant had documented the various immunizations that were ordered to be administered prior to actual administration. When the medical assistant realized the clinic was out of the PCV-13 immunization, he failed to update the medical record.

This was a very sympathetic case given the unfortunate and life-altering effects to this baby. This claim was not defensible. As fate would have it, the infant contracted the very

disease that the PCV-13 vaccine was designed to prevent.

This case reinforces the “Golden Rule” that one should never document a medical record until the medical care has been completed. The lesson is short and simple: documentation should reflect the action(s) taken. Premature documentation is just as dangerous as untimely or late documentation, and both can prove detrimental, or in a worst-case scenario, deadly.

After Hours Calls Documentation

Contemporaneously documenting care is particularly crucial when documenting after hours. Calls from a patient outside of normal office hours are often of a serious nature. Without contemporaneous documentation, the physician has to rely on memory to recall the advice or recommendation given. Documenting telephone encounters should be treated with the same level of importance as documenting in-person visits. Telephone conversations, particularly those that occur after-hours, are a major area of liability risk.

Every after-hours telephone exchange should be documented at the time of the call, even if the medical record is not available. This documentation should include the name of the patient or person calling on their behalf, date, time, specific complaint, advice given, medication advised or prescribed, and any referral to other providers or facilities. This note should then be documented in the medical record as soon as possible.

Keep in mind, with many patients using mobile phones, records of a phone call being placed are easy to retrieve. Although they do not confirm the conversation, they will give details about the time and length of the call.

At a minimum, the following types of phone calls need to be documented in the medical record:

1. All phone calls in which test results are reported to patients, noting if the patient was advised to return or seek other medical attention;

2. All phone calls in which the patient is advised to return or seek other medical attention, including instructions to go to the emergency room; and

3. All phone calls in which a patient requests medical advice or prescription refills.

An example of the importance of recording any advice given after hours is seen in a synopsis of a closed case: The scenario involves an undocumented late-night call with instructions given to a mother to take her child with a 104.5 fever and history of kidney transplant to the hospital ER. The child was not taken until the next day when she became nonresponsive. She further deteriorated in the hospital and died from septic shock secondary to a urinary tract infection. The physician’s recollection of the conversation was that he advised the child be seen in the emergency department. However, he did not phone ahead or make any note about the call. Her mother claimed that she was told the child likely had a virus and that there was no reason to take her to the emergency room.

Often, these undocumented conversations become a “he said/she said” dispute and prolong a claim’s resolution. A simple note jotted down and then recorded in the medical record on the front end can save a lot of heartache on the back end. Contemporaneous documentation of the provider’s instructions would have greatly aided in the defense of the case.

Applications for QPP Exception Due Soon

The financial impact of the Quality Payment Program will soon be felt. On January 1, 2019, the reimbursement for Medicare will be shifted based on your performance in 2017. Although it's too late to avoid the 2019 penalty of 4%, you have until December 31, 2018, to possibly dodge the 2020 sanction, or at least a portion of the program's requirements. The Centers for Medicare & Medicaid Services (CMS) includes a change in EHR system vendors, as well as a natural disaster, as "Extreme and Uncontrollable Circumstances," allowing you to avoid the penalty for those reasons alone - but you must submit the application.

Simply being a "small practice" - defined as 15 eligible clinicians or less - will dismiss you from the "Promoting Interoperability" (PI) requirements (the new name for the 'Advancing Care Information' category), but the application is required. If you are on the fence as to your success in participation, consider applying just to hedge your bets. According to the FAQs posted by CMS, "You may still report on the Promoting Interoperability performance category, and if you choose to report, your data will be scored. If you have a pending or approved hardship exception application and choose to report on the Promoting Interoperability measures, your hardship exception application will be dismissed and the category will not be reweighted." There is really no downside to applying; if you wait until January (when the 2018 reporting opens) and discover a problem with your submission, it will be too late to apply for the exemption.

If you are part of an Accountable Care Organization (ACO) that qualifies as a Merit-based Incentive Payment System Alternative Payment Model (MIPS APM), you will need to report the PI category to CMS directly, or deploy this option if you meet the exception and submit an application.

Regardless of the reason, applications are required each year. You can apply for the exception here.

Judge a Man by His Questions Rather Than by His Answers

Communication is one of the most important facets of human life and interaction. The ability to exchange information is a skill learned early on in our lives. Yet, despite our early introduction to communication and the vital role it continues to play in our lives as we mature, it is frequently underestimated.

Non-communication or the failure to exchange or solicit information by not asking questions and to an extent, the right question, is often encountered in everyday life. The consequences of this can result in misfortunate outcomes for the parties involved, one of which includes the breakdown of collaborative efforts in the medical treatment arena. Such is the case with the death of Ann Thomas,[1] a 26-year-old student. She presented to the emergency room in the late evening over the weekend with a chief complaint of left abdomen and lower quadrant pain. No cardiac, respiratory or acute stress was noted. The patient had a pain level of 9/10, BP 141/67, HR 89, O2 saturation at 97%.

The emergency room physician, Dr. Harrison, began a workup ordering an abdominal/pelvis CT with contrast and an ultrasound. The CT returned an impression of an 11cm left-sided pelvic mass arising from the patient's left ovary. The ultrasound findings were consistent with a large ovarian cystic lesion. During the initial assessment while in the emergency department, Ms. Thomas never conveyed her history of severe sleep apnea nor her use of a CPAP device. Following the emergency room workup, Dr. Harrison, contacted the on-call OBGYN, Dr. Strobl. The emergency physician testified in her deposition that during the phone conversation, she detailed Ms. Thomas' symptoms and findings, including the patient's stable condition. She conveyed the test results and the physicians agreed upon a plan to admit the patient for pain management. Dr. Harrison testified that she mentioned she had given a dose of morphine (8mg) to the patient, but was not sure when it was given. Dr. Harrison wrote the admitting orders and then admitted Ms. Thomas under Dr. Strobl's care. According to both providers, it was Dr. Strobl's intention to have Ms. Thomas admitted to the floor overnight, and he would evaluate her in the morning and likely perform a surgical procedure absent a contrary indication.

While still in the emergency department and after the call with Dr. Strobl, Ms. Thomas had continued complaints of pain. In response to this, Dr. Harrison ordered another dose of morphine. The second dose ordered was 5 mg. Ms. Thomas was then admitted to the floor. When she arrived on the floor at 01:20 am, one of the nurses, Nurse Petty, completed her floor assessment of the patient. She asked Ms. Thomas about her medical history wherein she noted that the patient was obese, suffered from severe sleep apnea, and was noncompliant with her use of a CPAP device. This is the first time Ms. Thomas

told any of the providers that she had severe sleep apnea. Her oxygen saturation level was charted as 98%. Ms. Thomas's vitals were checked later at 03:25 am. At this time, it was noted that her oxygen saturation level was at 90% and that it had been 98% two hours earlier. This drop was never communicated to anyone. During this check, Ms. Thomas requested more pain relief, as her pain was a 7/10. At 03:45 am, Nurse Petty contacted Dr. Strobl and advised him that Ms. Thomas was requesting stronger pain relief. Dr. Strobl testified in his deposition that he knew the patient received a dose of morphine, but did not receive any information on dosage. During the call, Dr. Strobl ordered a stronger medication, Dilauded 1mg. During Nurse Petty's testimony, she explained that she did not provide Dr. Strobl with a pain score level or other information, including her history of sleep apnea. She simply explained the situation stating that the Morphine was not working. She told Dr. Strobl that Ms. Thomas had received Morphine, but provided no additional information. Nurse Petty had no recollection of any transfer of information besides that. Nurse Petty administered the Dilaudid. She checked on Ms. Thomas 30 minutes after administering the medicine and she woke her up to obtain the pain score. She checked on Ms. Thomas again at 05:20 am and saw that she was okay. In a later safety check at 07:10 am, Nurse Petty found Ms. Thomas unresponsive and a code was called. When Dr. Strobl arrived at 07:30am, he learned that a code had been called and that patient's respiratory suppression was likely caused by the opiates in the context of her sleep apnea condition. Unfortunately, Ms. Thomas expired shortly thereafter

Ms. Thomas's estate filed a lawsuit against the hospital, Dr. Harrison, and Dr. Strobl, alleging that Ms. Thomas died from hypoxia and cardiopulmonary arrest caused by respiratory depression, which was exacerbated by sleep apnea and the administration of Morphine and Dilaudid in the six hours prior to the code. The plaintiff alleged that the providers prescribed narcotics that were too strong and then failed to take appropriate measures to monitor Ms. Thomas after administering them to an opiate naïve patient with sleep apnea.

What can be learned from this case and Dr. Strobl's failure to solicit information from fellow providers?

1. The need to ask questions, to solicit information from others who are treating your patient. What medications were given, what were the doses, what were the vitals, is there a significant or noted change, what was the medical history? If necessary, dig for information;
2. Know your patient's condition before prescribing medications;
3. Ultimately, don't rely on others to give you the information you may need to get a full and clear clinical picture. It may be necessary to go into the hospital to check on the patient if there has been a phone call or two requesting your assistance on your patient.

The most profound lesson to be learned from this case is that you may be judged by what you should have known instead of what you actually did know. The debate may not be about what information you were given as a provider, but about what information you

inquired about in your treatment of the patient. Failing to ask questions can produce culpability. As a provider, you should proactively inquire into the patient's medical history, types of medications administered, dosages, and any marked change in vitals that will alert you to an overall change in the patient's condition, as the information given may not be all the information needed to obtain a full clinical picture. It may still be necessary to ask more questions. The plaintiff's overriding theme in this case was non-communication. Although Ms. Thomas's history of sleep apnea was the genesis of the problem, the failure to solicit the necessary information to treat the patient creates an issue that will leave a jury to decide whether the medical care was appropriate, despite being based on an incomplete clinical picture. It is always an uncomfortable position in litigation when you are defending actions based on an incomplete clinical picture that could have been complete had the right questions been asked. In the end, as the provider, you will bear the responsibility for relying on someone else to give you the information you need to provide care to your patient. Dr. Strobl made the comment in his deposition "it would have been nice to have known" that Ms. Thomas had severe sleep apnea. Although he testified he would have ordered the same analgesic, he did say that he may have ordered monitoring for the patient. It is not difficult for a jury to assume that had he asked Nurse Petty, he would have known. This could have made all the difference. The hospital and ER physician settled the case prior to trial. Dr. Strobl went to trial with expert support. The jury found him to be liable for a small percentage of a six-figure verdict.

[1] Names and identifying details have been changed for confidentiality.

HIPAA Myths and Misconceptions

Trying to comply with HIPAA can be a challenge for healthcare providers, especially when there is so much confusion about specific aspects of the Rules. On almost a daily basis, policyholders contact SVMIC for assistance with HIPAA-related issues. In fielding those calls and emails, some commonalities have been identified. In an effort to clear up this confusion and bust some of these HIPAA "myths", a few of the most commonly asked questions are provided below with answers backed by the Department of Health and Human Services (HHS), the entity responsible for enforcement of HIPAA Rules.

When a patient requests a copy of their medical record, may a practice release records that were received from another healthcare provider?

Yes. Excluding records with special protections by state or other federal law, such as psychotherapy notes and notes related to substance abuse treatment, practices are permitted to release other healthcare providers' records. For example, a primary care practice receives a request from a patient for copies of all of their medical records. The PCP has records from the patient's cardiologist and gastroenterologist included in their medical record. The PCP may release all of this information to the patient.

The following information is from the guidance provided by HHS on the topic of patient access to their protected health information:

*The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity…Individuals have a right to access this PHI for as long as the information is maintained by a covered entity…regardless of the date the information was created; whether the information is maintained in paper or electronic systems onsite, remotely, or is archived; or where the PHI originated (e.g., whether the covered entity, another provider, the patient, etc.).*https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

Is it a requirement for the patient to sign an authorization or consent when releasing information to another healthcare provider for the purpose of treatment, payment or healthcare operations?

No. HIPAA does not require anything in writing from the patient when disclosing PHI for treatment, payment or healthcare operations. HIPAA does require that the patient's identity be verified to ensure that the correct individual receives the information. This can be done

in a number of ways such as verifying the patient's date of birth, last four digits of their social security number and/or current mailing address. This process may be done over the phone, in person or electronically through secure email or the patient portal.

https://www.hhs.gov/hipaa/for-professionals/faq/271/does-a-physician-need-written-authorization-to-send-medical-records-to-a-specialist/index.html

Is using a sign-in sheet or calling a patient by their first and last name a HIPAA violation?

No. Using a sign-in sheet is not a HIPAA violation as long as the information on the sign-in sheet is kept to the minimum necessary. For example, a sign-in sheet with the patient's name, appointment time and the physician being seen would meet the minimum necessary standard. Practices should avoid asking the patient to put their reason for visit or contact information on the sign-in sheet, since this information can be captured in another, more confidential manner. Keep in mind that certain specialties may choose not to have a sign-in sheet simply due to the sensitive nature of their practice.

Calling patients by their first and last name is sometimes necessary due to patients having the same first or last name or similar names. Again, this is not a HIPAA violation, but instead is a considered an incidental disclosure as long as reasonable safeguards are in place.

https://www.hhs.gov/hipaa/for-professionals/faq/199/may-health-care-providers-use-sign-in-sheets/index.html

May a practice communicate with individuals involved in the patient's care or payment for their care?

Yes. Communicating with individuals involved in a patient's care or payment for care is permitted under HIPAA if the patient agrees, or when given the opportunity, does not object.

The HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient's care or payment for health care. If the patient is present, or is otherwise available prior to the disclosure, and has the capacity to make health care decisions, the covered entity may discuss this information with the family and these other persons if the patient agrees or, when given the opportunity, does not object. The covered entity may also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment, that the patient does not object. https://www.hhs.gov/hipaa/for-professionals/faq/488/does-hipaa-permit-a-doctor-to-discuss-a-patients-health-status-with-the-patients-family-and-friends/index.html

Is an authorization form required to disclose protected health information to another treating provider?

No. HIPAA permits healthcare providers to share information with other treating providers, without the patient's written authorization, even in situations when the provider releasing the information did not refer the patient. Here is information from the HHS FAQ that addresses this type of disclosure.

The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See 45 CFR 164.506 and the definition of "treatment" at 45 CFR 164.501. https://www.hhs.gov/hipaa/for-professionals/faq/271/does-a-physician-need-written-authorization-to-send-medical-records-to-a-specialist/index.html

Navigating HIPAA Privacy, Security and Breach Notification Rules can be difficult at times. HHS has provided a multitude of resources on their website at www.hhs.gov/HIPAA. SVMIC is also a good place to find answers to HIPAA-related questions. The Education Center on the SVMIC website has on demand self-studies, including HIPAA Training for the Medical Office, along with sample forms. For more information about HIPAA compliance or to ask a general HIPAA question, contact Rana McSpadden at RanaM@svmic.com.
