2010 PROVIDER NEWSLETTER

CENTRAL VISION

A PUBLICATION BY PHYSICIANS' HEALTHWAYS IPA AND ADVANTAGE CARE IPA

A MESSAGE TO OUR PCPs

President's Message

Medicare Population

Healthcare reform will reduce Medicare Advantage (MA) spending by $132 billions and overall Medicare spending by 500 billions over the next 10 years. To achieve this tremendous reduction, CMS has made the following payment reduction to the MA Organizations:

1. Reduces premium payment to MA HMO by 13% over 4 to 6 years starting 2011.
2. Reduces HCC risk score payment by 3.41% starting 2011 and further reduce to 5.46% by 2017

It is estimated that by 2017 that most of the plans will have a reduction of about 18% in their CMS payment. IPA capitation is paid as a percentage of HMO premium, therefore IPA revenues will drop proportionally as the immediate impact. PCP payment from IPA will certainly be affected at that time, if not sooner.

There are only two ways for an MA HMO to improve revenue by small amount:
(1) CMS bonus and (2) Increasing HCC risk score

CMS Bonus – Through "Star System"

CMS allocated about 1% of the plan payment as incentive for quality. Currently, CMS uses a "Star System" to evaluate plan quality of care with 5 stars as the best and 1 star the worse.

A plan with 3 stars or more will be eligible for a 3%-5% bonus from CMS. The Star average score for HMOs throughout the United States is 3.3; Most of the major health plans in Southern California have scored ranging from 2.8 to 3.0. Most of the plans, if not all, are now focusing on improving quality of care based on HEDIS and CMS Chronic Condition Interventions in an attempt to increase their Star scores.

HCC Risk Score:

Other than the CMS Star bonus, the only other way for the HMO/IPA/PCP to increase revenue is through increasing of HCC score. CMS try to counteract the increase in HCC score by a 3.41% reduction starting in 2011 and 5.46% in 2017.

It is important for our Providers to take immediate action and submit patient encounter and HEDIS data as a way to capture viable information. PCPs and Medicare patients will be receiving CMS Screening and Chronic Condition Intervention guidelines shortly.

We encourage our PCPs and our patients to work together to complete these screenings and achieve the chronic condition treatment goals. The future for Medicare is quality and only by working together we can win this Star War.

Medi-Cal Population

Healthcare reform is also happening at the State level and is bringing forth changes to Medi-Cal HMO:

1. Change in Medi-Cal patients population mix: Traditional Medi-Cal patients consist of single families with a mix of adult to pediatric ratio at roughly 30:70. Starting from mid year 2011, there will be about 2 million newly eligible Medi-Cal patients who are mostly single adults that will enter the system. These individuals become eligible for Medi-Cal after Federal government raises the Medicaid eligibility benchmark from 100% to 133% Federal Poverty Level. In addition, about 1 million of the FFS Senior and disabled adults will also be moved into the Medi-Cal HMO by the State around June 2011. As a result of these new enrollees, health delivery system will have to mandate changes to accommodate for adult and senior patients.

2. Change in the State payment to Medi-Cal HMO: State has already implemented a risk adjusted capitation system to pay Medi-Cal HMO in 2010. Like Medicare, HMO is compensated according to the risk score of each individual patient. The higher the risk score, the higher the payment to the HMO. Pediatric patients (especially those between ages 3 to 18) have very low risk scores compare to seniors and adults. One of the health plans in San Bernardino County had implemented “age adjustment capitation” payment to all the IPA in 2010. Similar changes happening to the IPA capitation taking place in Los Angeles County is imminent. We will keep you informed on these changes in 2011.

Sam Kam, MD
CEO
Central Health MSO, Inc.

Central Health MSO, Inc. manages both Physicians’ Healthways IPA and Advantage Care IPA

Provider Affiliation and Information Changes

Our Provider Relations Department is dedicated to the processing of all provider changes in a timely manner. To aid us in expediting your requests, we ask that you follow the below guidelines.

Information Change (address/telephone/fax change)

- A request for information change must be submitted via letter format addressed to Physicians' Healthways IPA and/or Advantage Care IPA with the provider's signature
- All vendor (billing/mailing) address and corporation/ tax ID changes require an updated W-9 for processing. *In your letter, please indicate the effective date of change and if the effective date is based on the date of service or the date claims payment is issued.*
- All provider information changes are effective the date the change is processed unless otherwise indicated by the provider
- For a PCP and OB/GYN, all changes in address require a Facility Site Review before processing

Termination

- A request for IPA or Health Plan termination must be submitted via letter format addressed to Physicians' Healthways IPA and/or Advantage Care IPA with the provider's signature
- According to your contract, the effective date for a *standard termination* is 90 days from the date of receipt of the termination request
- An *immediate termination,* however, is effective the date the termination is processed. Providers who retire or are no longer employed under a medical group qualify for an immediate termination

Leave of Absence

For Leave of Absence or Vacation, please provide a letter indicating the following information:

1. Physician's period of absence
2. Urgent contact information
3. Covering physician

General Reminder ... Should your request be handwritten, please make sure it is legible.

Eligibility Updates

The Eligibility Department is dedicated to updating all member information efficiently and in a timely manner. Should you require member eligibility to be updated in the system for authorization or claims submission, please call: (626) 388-2300. Provider Relations Department will be assisting over the phone with your inquiries with eligibility. Any issues or members not found will be forwarded to Eligibility Department for further resolution.

When calling, please have the following information ready:

1. Member Name
2. Member ID
3. Health Plan/Line of Business
4. Member Date of Birth
5. Reason for Request (i.e. claims submission, authorization submission, member in office, etc).

All eligibility updates will be updated in the system within 72 hours. Should your request be urgent due to an emergent/urgent referral, we request that you first submit your authorization to the UM fax lines at (626) 388-2336 or (626) 388-2333 to expedite the process.

Do you know the difference?

"Clean Claim":

A clean claim is defined as "one which can be paid as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of services, and billed amounts." If all information necessary to process a claim from non-affiliated providers is available within the health plan, provider group, or hospital, the claim is clean. Emergency services or out-of-area urgently needed services do not require authorization to be considered "clean".

"Unclean Claim":

A claim is "unclean" if it does not have a diagnosis that is immediately identifiable as emergent or out-of-area urgent and it lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergent care. A claim is also considered unclean if it appears to be fraudulent or is in a foreign language or currency.

Medicare Timeline - New Regulations for Claim Submissions

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare fee-for-service (FFS) claims to one calendar year after the date of service.

The following rules apply to claims with date of service prior to January 1, 2010:

a) Claims with date of service before October 1, 2009, must follow the Pre-PPACA timely filing rules.

b) Claims with date of service October 1, 2009 through December 31, 2009, must be submitted by December 31, 2010.

Claims Compliance

In order for Central Health's Claims Department to expedite claims payment to our valued providers, please be reminded that health plan regulations allow the following timeframes for reimbursement:

DEPARTMENT OF MANAGED HEALTH CARE REGULATIONS			
Line of Business	**Contracted Provider Timely Submission From DOS**	**Non Contracted Provider Timely Submission From DOS**	**Reimbursement Timeframe from Date Received**
Medi-Cal	90 Calendar Days	180 Calendar Days	30 Calendar Days
Healthy Family	90 Calendar Days	180 Calendar Days	64 Calendar Days
Commercial	90 Calendar Days	180 Calendar Days	64 Calendar Days
Point of Service	90 Calendar Days	180 Calendar Days	64 Calendar Days

CENTERS FOR MEDICARE AND MEDICAID SERVICES REGULATIONS			
Line of Business	**Contracted Provider Timely Submission From DOS**	**Non Contracted Provider Timely Submission From DOS**	**Reimbursement Timeframe from Date Received**
Medicare - Contracted Providers	90 Calendar Days	Maximum of 27 Months	60 Calendar Days
Medicare - Non-Contracted Providers "Clean Claim"	90 Calendar Days	Maximum of 27 Months	30 Calendar Days
Medicare—Non-Contracted Providers "Unclean Claim"	90 Calendar Days	Maximum of 27 Months	60 Calendar Days

In the event that non-contracted providers take the initiative to call Central Health for claims status inquiries, please allow the appropriate timeframe listed above before calling in to check status.

Check Cashing
Please cash your payment checks within 14 calendar days of receipt.

Direct & Automatic Referrals

In 2009, we modified forms to achieve simplicity in the referral process for selected services. The Direct Referral and Automatic Referral Program (ARP) were redesigned for the convenience of our partners in healthcare. The process of each component allows Primary Care Physicians to oversee member utilization referral within your practice without prior authorization from Physicians' Healthways IPA and Advantage Care IPA.

The following are guidelines for Direct Referral and Automatic Referral Program:

Type of Referral	Qualification Criteria	Applicable Services (NO AUTHORIZATION REQUIRED)	Product Lines & Health Plans applicable (for specialist initial consultation)	Follow-Up allowed?
Direct Referral	All PCPs	1. X-Ray - upper/lower extremities or chest 2. Orthopaedic Care for Fracture – initial consult, 1 follow up, and X-Ray 3. Annual mammography 4. Annual Retinal Exam for members with Diabetes 5. Specialist Initial Consults - *commercial and senior members only*	All Commercial and Senior lines of business	No (except for fracture care)
Automatic Referral Program (for PHW only)	PCPs who meet: 1. Minimum of 200 members 2. PCP referral rate • Pediatric - 3% • Family Practice - 5% • Internal Medicine - 7%	All specialists initial consultations and follow up visits for all PHW participating providers	All Product Lines & Health Plans	Yes

* Guidelines applicable to all contracted providers

Reminder for Specialist:

Copies of all progress notes must be sent to the patient's Primary Care Physician.

Spread The Word!

The National Guideline Clearinghouse™ (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents. NGC is an initiative of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. You can access and search this database at www.guideline.gov.

OB Ultrasound

An obstetrical ultrasound is the visualization of the inner structures by recording the reflections of pulses of ultrasonic waves directed into the tissues. Ultrasound performed for routine screening during pregnancy and its reimbursement is included in the obstetrical fee. Ultrasound during pregnancy is reimbursable only when used for the diagnosis or treatment of specific medical conditions and we require prior authorization.

Such medical justification would include, but not limited to:

- Increased risk factors (e.g., personal or family history of congenital anomalies)
- High risk factors (e.g., maternal diabetes, alcohol/drug addiction, malnutrition)
- Elderly primigravida
- Suspected abnormalities of pregnancy (e.g., hydatidiform mole, ectopic pregnancy, threatened/missed abortion, placenta previa, abrupt placenta, vaginal bleeding)
- Pre/Post amniocentesis studies
- Suspected abnormal presentation of fetus
- Suspected multiple fetuses
- Suspected fetal demise
- Gynecologic or other pelvic masses
- Significant fetal growth abnormality as indicated by a discrepancy of fetal size and estimated age

California Children's Services Medical Eligibility

California Children's Services (CCS) is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. We are mandated by our partnered Health Plans to direct members with CCS eligible conditions to receive medical services from a CCS paneled provider. We need your assistance in becoming familiar with CCS eligible conditions and when specialty consultation is needed to direct your member to the appropriate CCS paneled provider. You can access the overview of CCS eligibility list at this web link http://ww.dhcs.gov/services/ccs/Pages/medicaleligibility.aspx and provider list at http://www.dhcs.gov/services/ccs/Pages/CCSProviders.aspx.

Improvement Project: Bone Density Screening

Physicians' Healthways recently implemented a new improvement project focusing on increasing the screening rate for osteopenia and osteoporosis through bone density exams and we need your assistance.

The healthier your patient's bones are now, the fewer problems they may face later. Loss of bone density is certain as people grow older, but the sooner deteriorating bone health can be identified, the sooner it can be treated. Talking to them is the first step. Please remember to follow U.S. Preventive Task Force recommendations, listed below.

Recommended Adult Preventive Screening: Bone Density Exams	
WOMEN	• 65 and older screening once every 2 years • 60 and older if at increased risk for osteoporotic fracture • At any age for a woman at high risk • Risk factors for osteoporosis ~ Family history of osteoporosis ~ Tobacco use ~ Exceptionally thin or have a small body frame ~ Early menopause ~ Eating disorder ~ Long term use of corticosteroid medications ~ Thyroid replacement ~ SSRI use ~ History of breast cancer
MEN	Assessment and screening as determined by the provider

Coordination of Care

In today's complicated healthcare environment, it is critical that primary care physicians and specialist communicate with each other so they can better coordinate patient care. Good practice of Patient's Coordination of Care will improve clinical outcomes, enhance the quality of care, and improve patient satisfaction.

Some pointers to remember in coordinating patient care in the office setting:

- If referring to a specialist, contact the specialist before the patient's appointment. Have staff set up a quick phone appointment. Fax over the patient's medical history.
- Remind the Specialist that you would need the consultation or follow-up visit report within 10 days.
- Keep track by using a Referral Log of specialty services referrals. Know if Specialist will submit the referral request directly to the IPA to avoid delay in service.

Comprehensive Perinatal Services Program (CPSP)

The law requires all OB practitioners to provide a comprehensive risk assessment to all pregnant women that include medical/obstetrical, nutritional, psychosocial, and health education needs for our Medi-Cal Managed Care Members.

The CPSP provides a wide range of culturally-appropriate services to expectant women, from conception through 60 days postpartum, in accordance with the current guidelines of the American College of Obstetricians and Gynecologist (ACOG).

For perinatal services, OB providers implement a Department of Health Care Services (DHCS) approved comprehensive assessment tool comparable to the ACOG standard and the CPSP standards, per Title 22, CCR, Section 51348.

Patient participation in the comprehensive perinatal services program is voluntary. However, all OB practitioners must ensure that each eligible patient is informed about the services in the program, the potential risks and benefits of participation, and alternative obstetrical care if she chooses not to participate in the program.

ER Visits, Wait Time on the Rise ...

In a collaborative effort by many California health plans to keep emergency room (ER) wait times and non-emergent visits under control, the health plans have launched several marketing campaigns aimed at educating the members on appropriate use of the emergency room. Education materials were mailed out to members to encourage parents to talk to their Primary Care Physician (PCP) and to provide detailing basic tips on caring for a sick child and illness prevention. As importantly, health plans realized that the needed driving force that can alter the course of the patients' behavior lies within the PCPs. The health plans are asking for your help in educating your patients about the appropriate use of the ER, in raising their awareness of the resources available to them.

Central Health managed IPAs continue to monitor Primary Care Providers on their Patient's Emergency Room usage. To decrease overall ER utilization rate, we will be mailing a list of your members that were seen in the ER every 6 months. This is to help you focus your care to address your patient's problem as to prevent future ER visits.

Overcrowding in emergency rooms can compromise patient care; you can help to eliminate the unnecessary trips to the ER by educating your patients. We encourage that providers re-direct members to your office or Urgent Care Centers on conditions that would not warrant Emergency Room visits. For a listing of our contracted Urgent Care Centers please visit our website at: www.phwipa.org.

The following ICD-9 codes are all applicable service/procedure codes that may be directed to Urgent Care Centers or PCPs instead of the ER:

IPA ER Avoidable Diagnosis ICD – 9 Codes - 2009	ICD-9 Code Decimal
Candidiasis	112
Candidiasis Site NEC/NOS	112.89/112.9
Acariasis	133
Scabies	133.0
Disorders of Conjunctiva	372
Acute & Serous Conjunctivitis	372.0/372.01
Other and unspecified conjunctivitis	372.3
Suppurative and unspecified otitis media	382
Acute suppurative otitis media without spontaneous rupture of ear drum	382.00
Acute suppurative otitis media	382.0
Chr Sup Otitis Media NOS	382.3
Ac Mastoiditis-compl NEC	383.02
Acute nasopharyngitis	460
Acute pharyngitis	462
Acute laryngopharyngitis	465.0
Acute upper respiratory infections of multiple or unspecified sites	465
Acute Bronchitis	466.0
Acute bronchitis and bronchiolitis	466
Chronic rhinitis	472.0
Chronic pharyngitis and nasopharyngitis	472
Chronic Pharyngitis	472.1
Chronic Nasopharyngitis	472.2

IPA ER Avoidable Diagnosis ICD – 9 Codes - 2009	ICD-9 Code Decimal
Chronic Maxillary sinusitis	473.0
Chronic sinusitis	473
Chronic Sinusitis NEC/NOS	473.8/437.9
Chronic tonsillitis and adenoiditis	474.0
Chronic disease of tonsils and adenoids	474
Chronic Tonsils & adenoids	474.02
Chr T & A Dis NEC/NOS	474.8/474.9
Cystitis	595
Acute cystitis	595.0
Cystitis NEC/NOS	595.89/595.9
Urinary tract infection, site not specified	599.0
Inflammatory disease of cervix, vagina, vulva	616
Cervicitis and endocervicitis	616.0
Vaginitis and vulvovaginitis	616.1
Pruritic Conditions NEC/NOS	698.8/698.9
Lumbago	724.2
Backache NOS	724.5
Disorders of coccyx	724.7
Other Back Symptoms	724.8
Headache	784.0
Follow up examination	V67
Surgery Follow-up	V67.0
Fu Exam Treatd Healed Fx	V67.4
Following other treatment	V67.5
Follow-up Exam NEC	V67.59
Comb Treatment Follow-up	V67.6
Follow-up Exam NOS	V67.9
Referral-no Exam/treat	V68.81
Administrative Encount NOS	V68.9
General medical examination	V70
General Medical Exam NEC/NOS	V70.8/V70.9
Special investigations and examinations	V72
Eye & Vision Examination	V72.0
Ear & Hearing Exam	V72.1
Other examinations of ears and hearing	V72.19
Gynecologic Examination/Routine	V72.3/V72.31
Encounter for papanicolaou cervical smear to confirm findings of recent normal pap smear following initial abnormal pap smear	V72.32
Preg Exam-preg Unconfirm	V72.4
Radiological Exam NEC	V72.5
Laboratory Examination	V72.6
Skin/sensitization Tests	V72.7
Examination NEC	V72.8
Encounter blood typing	V72.86
Examination NOS	V72.9

Notes:
NOS - Not Otherwise Speficied
NEC - Not Elsewhere Classified

Health Education

The Health Education (HE) Department is an excellent resource for assisting providers in promoting health improvement and wellness of our IPA members. Through health education and promotion, we can assist our providers in meeting the state-mandated and health plan requirements for health education. For available health education materials that you can distribute to members, please contact our Health Education Department.

Initial Health Assessment (IHA)

IHA is a state mandated comprehensive assessment that enables the PCP to evaluate and manage the acute, chronic, and preventive health needs of the member. For adults, please use the UD Preventive Services Task Force (USPSTF) for providing preventive screening, testing, and counseling services. For members below 21 years of age, preventive services are specified by the American Academy of Pediatrics (AAP) age-specific guidelines and periodicity schedule.

Individual Health Education Behavioral Assessment - IHEBA ("Staying Healthy")

During an Initial Health Assessment visit, it is imperative that the members complete an IHEBA in the appropriate age category for them. The IHEBA can help you identify risk and health behavior to promote a positive lifestyle.

Important California WIC Changes Benefits Patients

Beginning October 1, 2009, the WIC food packages will change in California. New WIC foods will support both the American Academy of Pediatrics feeding guidelines and Dietary Guidelines for Americans.

New WIC Food Packages and Breastfeeding Incentive

- For the first time, fruits and vegetables are available to all WIC participants.

- Incentives for breastfeeding include reducing the formula allowance for partially breastfed infants and expanding the amount of food for nursing mothers.
- Infants 6 to 11 months old will receive less formula and more baby food items.
- Infants will no longer receive juice.
- Allowances for milk, eggs, and juice have been reduced.
- Soy-based beverages and tofu can be substituted for milk and cheese.

Documentation Requirements:

Due to the greater number and variety of WIC foods, you must now use WIC's revised WIC Referral Form to document both the type and amounts of WIC foods to issue to infants and children with special needs. Also, a qualifying condition will be required for children who receive soy milk or tofu from WIC.

For more information about the new WIC benefits, please email MD-WIC@cdph.ca.gov or contact your local WIC dietician at www.wicworks.ca.gov.

Cultural & Linguistics

Language Assistance Program (LAP):

Effective January 1, 2009, Senate Bill 853 requires our Primary Care Physician and Specialist network to offer patients a language assistance program that is available through materials in their preferred language and access to interpreter services.

Language access for patients with limited English proficiency is not only the law; it also improves patient care and satisfaction. Interpreters are available by phone without advance notice and in person with a minimum of 7 days notice.

The following LAP services are offered at no cost to you and our members:

- ***Telephonic interpreter services***
  - ~ Professional interpreters' available 24-hours/ 7-days a week
- ***Translated materials into threshold language upon request***
  - ~ Material translated to 11 language threshold that are member-specific

Best Practice - Medical Records Documentation Requirements:

- Member's preferred spoken and written language
- Use or refusal of professional interpreters
- Communication aid used for the visit (professional interpreter, family, friend, office staff)
- Grievances related to cultural & linguistics

Important Telephone numbers to remember when accessing language assistance. Please call the health plans' Member Services department for interpreter services.

	Medi-Cal	Commercial
Aetna	1-800-525-3148	1-800-525-3148
Anthem Blue Cross	1-888-285-7801	1-888-254-2721
Blue Shield of California	1-800-541-6652	1-866-346-7198
Care 1st	1-800-605-2556	1-800-544-0088
CHMP	1-866-314-2427	-
Cigna	1-800-244-6224	1-800-244-6224
Community Health Plan	1-800-475-5550	1-800-475-5550
Health Net	1-800-977-3073	1-800-522-0088
IEHP	1-800-440-4347	1-800-440-4347
LA Care Health Plan	1-888-839-9909	1-888-839-9909
Molina	1-888-665-4621	1-888-665-4621
PacifiCare	1-800-624-8822	1-866-867-0700

Hearing/Speech Impaired call California Relay Service: 1-888-877-5379

Deaf/Disabled: TTY 1-877-735-2929 or 711

OTHER RESOURCES

- On-line Cultural Competence Training from DHS Office of Minority at www.thinkculturalhealth.org
- Health Care Interpreting (short course for Bilingual Health Care Workers who interpret for patients) www.lacare.org
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations www.iceforhealth.com

For additional information, please contact our Cultural & Linguistics Department at 626-388-2300 ext. 2221.

The Importance of Behavioral Health Referrals

PCPs and behavioral health practitioners need to join forces in order to maximize the effectiveness of treatment.

Coordination of care between primary care physicians and behavioral health practitioners is important for members with behavioral health conditions. It can facilitate accurate diagnosis and maximize the effectiveness of treatment for the member.

Providers are encouraged to make referrals when patients show presence of acute or severe symptoms, a complex mixture of depression and substance abuse, or a long history of mental health and psychosocial difficulties.

Referral information should include the following:
- Substance abuse history and concerns
- Medications
- Risk (suicidal, homicidal)
- Co-morbid medical issues

Consent from the member may be required for specialists to release information to the PCP. Therefore, the PCP and the member should discuss the benefits of sharing clinical information when the referral is issued. HIPAA regulations permit disclosure of protected health information for the purpose of care coordination.

Healthy HIPAA habit - Protect Patient Confidentiality

Privacy regulations contained in the Health Insurance Portability and Accountability Act ("HIPAA") can greatly impact the daily operations of physician practices. Whereas physicians and staff were once free to discuss medical cases in informal setting, HIPAA had added new restrictions to such discussions as they relate to patients' Protected Health Information ("PHI"). In adopting healthy HIPAA habit, physician practices can ensure compliance and promote patients' right to privacy and confidentiality.

Remember, sensitivity in dealing with privacy issues is appropriate behavior for physicians and medical staff and important for managing your medical practice liability. New HIPAA rules have changed the way the office handles privacy violations.

For more information about HIPAA and Protected Health Information, please call our QM Department at 626-388-2300.

ON THE TELEPHONE…

"You're Mrs. Jackson's daughter and you want a copy of her test result? Okay, I'll fax it right over… what's your fax number?

Healthy Habit:

Never release Personal Health Information (PHI) to anyone other than the patient, unless the patient has authorized you to do so in writing.

AT THE FRONT DESK…

"Hello, Ms. Lopez, please sign in. You called and said you were having stomach problems... what kind of problems?

Healthy Habit:

Never compel a patient to discuss his or her symptoms in front of other. These questions are best left to be asked in the examination room.

ON THE ANSWERING MACHINE…

"Julia Harris, this is the Fertility Clinic calling to remind you of your exam tomorrow morning at 10 a.m."

Healthy Habit:

Exercise discretion when leaving reminders or messages. Others can overhear or intercept the message and patients may not want family members, business associates or others to know about their office visit or health care issues.

IN THE WAITING ROOM…

"Is Mary Smith her for her HIV test?"

Healthy Habit:

Never call out a patient's name with the reason for the visit or other Protected Health Information (PHI) in a waiting room or other open space.

IN THE MEDICAL OFFICE ELEVATOR…

"Alicia Gomez, who works in the eye clinic, came in today asking about Prozac. Do you think she might be depressed?

Healthy Habit:

Never discuss patients in public places. Someone who may know the patient may overhear.