USE OF PROTECTED HEALTH INFORMATION (PHI) IN EDUCATION

This guidance will describe the criteria for permitted uses of protected health information specific to educational and training purposes. Clinical education and training activities of Learners are fundamental to the IU Health mission. HIPAA permits use of protected health information (PHI) for “conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as healthcare providers.” 45 C.F.R. 164.501. While HIPAA permits the sharing of PHI for education/training purposes, there are limitations on those accesses, uses and disclosures.

The following individuals are collectively referred to as “Teachers”:

- Faculty
- Staff (including without limitation the following roles: nurses, nurse practitioners, physician assistants, pharmacists, social workers, department managers and any other role when serving in a teaching capacity)
- Chief Resident, Fellow, Resident or Medical Student under direction of a Teacher serving in the teaching capacity

The following individuals are collectively referred to as “Learners” while being trained:

- Residents
- Fellows
- Students of all disciplines

I. TREATMENT and NON-TREATMENT:

- TREATMENT:
  - If you are involved in treating the patient rendering direct patient care as part of your training (e.g. inpatient Physician of record), then you are permitted to access the patient’s medical record;
  - If you are involved in treating the patient in the outpatient Clinic as part of your training, then you are permitted to access the patient’s medical record, including to prepare for the upcoming Clinic visit;
  - If you are involved in treating the patient in the outpatient Clinic as part of your training and your patient is admitted as an inpatient, then you are permitted to access the patient’s inpatient medical records for coordination of care and management of their treatment under your care in the outpatient Clinic;
  - If you are supervising someone who is treating the patient (e.g. Residents), then you are permitted to access the patient’s medical record; or
  - If you anticipate receiving a patient (e.g. patient in the Emergency Department) to render treatment on the inpatient unit you are assigned as part of your training, then you are permitted to access the patient’s medical record in anticipation of treatment to prepare even if you may not ultimately have direct patient care responsibilities as you initially anticipated.
    - If you are on-call and have been paged/ notified to respond to the patient/event for treatment purposes as part of your training, then you are permitted to access the patient’s medical records in anticipation of treatment; or
Incident the transition of care, you are entitled to access a patient’s medical records for treatment purposes if you are receiving the “hand-off” of the patient to commence management of their inpatient treatment as part of your training.

Note: The “minimum necessary” standard applicable to learning/training (see below) does not apply to treatment. You are entitled to access all medical records of the patient needed for treatment purposes if you are treating the patient.

• NON-TREATMENT related access: For any purpose outside of treatment as part of your training (e.g. Teachers performing a teaching role; Learners observing/preparing a case study), the MINIMUM NECESSARY STANDARD applies whereby the Teachers/Learners may only access and use the minimum necessary PHI for the purpose of education. Some examples for accessing minimum necessary information include:
  o Teachers who are performing a required teaching role may access and use the minimum necessary PHI of patients not under their care for teaching purposes, without obtaining a patient’s written authorization.
  o Learners may access and use the minimum necessary PHI consistent with educational work/assignments under the supervision of an authorized Teacher. For example, if the Teacher directed a review of the lab results of the diabetic patients on the inpatient unit for the week, then this learning objective would be met by your accessing only the minimum necessary PHI of the patient (e.g. review of only the diabetic patients’ lab results on the unit for the week) and not reviewing other EMR clinical tabs or encounters pertaining to the patient (unless you were also treating the patient, then we would expect to see your access elsewhere in the patient’s medical record as it relates to your treatment activities for the patient). If a Learner is in doubt as to the scope of PHI needed to fulfill the training objective so as to simultaneously access only the minimum necessary PHI to accomplish this purpose, then seek clarity from your Teacher.

Some examples of allowable Non-Treatment access to PHI include:
  o Educational/Training Purposes outside of treatment:
    ▪ Case studies
    ▪ Case files
    ▪ Teaching rounds
    ▪ Educational assessments
    ▪ Multidisciplinary rounds
    ▪ Case Presentations
    ▪ Retrospective Record/Data Reviews for quality improvement projects in the educational context
    ▪ Peer Review activities (e.g. Root Cause Analysis; Adverse Event Analysis; Morbidity & Mortality Conference; Hospital Department Peer Review Committee)
  o Educational/Training Purposes under Supervision of an authorized Teacher: Supervision may be demonstrated by:
• Direction by a Teacher overseeing a team or rotation who has set forth expectations as to the desired learning objectives and types of cases in which to be exposed; or

• Direction by a Teacher to access a specific patient’s medical record (e.g. verbal, written, electronic) either in response to a Learner request or as expressly directed in relation to a specific learning opportunity not previously covered (e.g. unusual case).

Note: Care should always be taken to refrain from accessing the medical record of high profile patients, friends and family members to avoid a perception of inappropriate access (e.g. curiosity or concern) unless you are directly assigned to the patient as part of the care team rendering treatment or your Teacher directly requested your review for a legitimate learning objective.

o Initially Treatment then Non-Treatment for Educational/Training Purposes:

• If you are involved initially in treating the patient as part of your training (e.g. Resident on the Wards Team and render IU Health inpatient care to patient) with no expectation to manage the patient’s care after discharge and you transfer the patient to another IU Health facility for specialized care (or you transfer the patient to another unit for which you are not assigned or you transfer to a different service), then with the approval of your Teacher you may access the minimum necessary PHI within the patient’s medical record at the new IU Health facility or unit for a learning opportunity (e.g. was my course of treatment appropriate? was I correct on the ultimate diagnosis? could I have done anything differently to improve the patient’s outcome?). Under this same scenario, a Teacher performing a teaching role may also access the minimum necessary PHI of the patient to provide educational instruction to the Learner. The Teacher supervising or approving the learning activity may be your current Teacher or the Teacher rendering supervision at the time of your treatment (e.g. past rotation).

o Research: A Hospital/Physician Practice/Covered Entity may only use or share PHI for research purposes:
  • With the patient’s permission evidenced by an Authorization; or
  • With a Waiver of Authorization approved by the IRB/Privacy Board; or
  • If an exception applies. If an exception applies, you do not need an Authorization or a Waiver of Authorization:
    a. Recruitment:
      o You may recruit from your own patients but only for recruitment to aid in identifying study participants, and the PHI may not leave IU Health (see IU Health’s Clinical Research Recruitment policy, ADM 2.19)
    b. Data is provided in a limited data set (e.g. 18 required identifiers are removed) pursuant to a written Data Use Agreement (see IU Health’s Access to Health Data and Information for Research Purposes policy, HIPAA 1.38)*
    c. Data is provided in a de-identified data set. PHI that is de-identified by removal of mandatory identifiers in accordance with HIPAA is no longer considered to be PHI, and, therefore, HIPAA no longer applies (see IU Health’s De-Identification of Protected Health Information policy, HIPAA 7.06)*
*Note: Exceptions b & c above only apply if the data is provided by IU Health in that format. If you are creating the limited data set or de-identifying the data both pursuant to IU Health policy, then you must have a Waiver of Authorization for the PHI initial access granted by the IRB/Privacy Board.

- **Health Care Operations:** It is permissible to access PHI for health care operations purposes. Health care operations are certain administrative, financial, legal, and quality improvement activities of IU Health that are necessary to run its business and to support the core functions of treatment and payment. For example, a Resident may be invited to participate in a week long Rapid Improvement Event (RIE) at an IU Health Hospital aimed at improving the door-to-doc time in the Emergency Department. As part of the RIE, Hospital personnel may request the Resident to review the medical records of all patients treated in the Emergency Department for the past week to calculate the door-to-doc time as part of the Hospital’s quality improvement initiative, which review by the Resident would be permissible under the health care operations exception to HIPAA.

**II. SELF-DIRECTED REVIEW OF MEDICAL RECORDS WITHOUT TEACHER SUPERVISION IS PROHIBITED:**

Under HIPAA, access to the minimum necessary PHI for training and educational purposes for Learners must be under the supervision of Teachers. As such, it is never permissible to:

- Start “trolling” through medical records looking for interesting cases on your own initiative that do not correspond to a Teacher learning objective previously given to you.
- Look at every Emergency Department patient’s medical records for the day because you have completed your ICU Ward patient care duties and have time to spare.

  - Conversely, however, if your Teacher directed you to look at the medical record of all patients currently in the Emergency Department with a diabetes diagnosis as part of your training, then it would be permissible to look at the minimum necessary PHI of the current Emergency Department patients with a diabetes diagnosis to meet the training objective.

**III. GENERAL GUIDELINES:**

All access and use of PHI for education and training purposes are subject to the guidelines below in addition to all applicable HIPAA Privacy and Security policies:

1. **INTERNAL USE**

   Only the minimum necessary PHI required to achieve the learning objectives may be accessed, used and shared within IU Health to IU Health-affiliated Learners under the supervision of an authorized Teacher. Additionally, Teachers and Learners must use discretion when discussing a patient’s condition during rounds, speaking quietly and avoiding conversations in public areas where patients, families and other persons are present.

2. **EXTERNAL USE**
Disclosure of PHI external to IU Health or IU’s Health Science Schools is not permitted for any reason, including for professional meetings, conferences and lectures, etc. absent a patient’s written authorization for this specific use. Patient identifiers must be removed in external educational presentations (such as in-house case presentations attended by non-affiliated physicians, visiting clinicians, non-enrolled students, etc.) rendering it acceptable for use in these settings (i.e. it is no longer PHI once de-identified).

3. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

Medical Record of Friends, Family, Celebrities and High Profile Patients
Do not access the medical information/PHI of friends, family, colleagues, celebrities, athletes, or high profile patients out of curiosity or concern.

Own Medical Record
Do not access your own medical records in the electronic medical record (EMR). Visit the Patient Portal (MylIUHealth.org), request a copy from Health Information Management, or discuss your care with your Provider. Using your provider/user credentials to access the EMR is permitted under HIPAA for your treatment of patients, payment and health care operations. It is not permissible to access the EMR for personal reasons.

Maintain the Confidentiality of the Patient and Protected Health Information – Social Media
Always use caution when discussing your training and never give any detail that another person could use to identify a patient. You must safeguard and maintain the confidentiality of all PHI accessed whether for treatment or training purposes. Never discuss patients on social media platforms (e.g. Facebook, Twitter, YouTube), never post pictures or videos of patients and never post diagnostic images of patients on social media. Anything posted that can identify a patient is considered PHI and entitled to HIPAA confidentiality protections.

Storage of Protected Health Information
Only store PHI in secure and encrypted locations as approved by IU Health and IU (e.g. do not store PHI on personal laptops/devices/phones, personal e-mails, unencrypted USB, unencrypted cloud-based storage locations, etc.). PHI may not be stored on your personal devices even if encrypted. If you do not know the secure and encrypted locations approved by IU Health and IU for storage of PHI, then contact helpdesk@iuhealth.org, ithelp@iu.edu, or HIPAA@iuhealth.org for guidance. See also the IU GME Ted Talk at: https://iu.mediaspace.kaltura.com/media/HIPAA+TEDMED+06052017+1517/1_a75vp910.

Publications
Never publish information about patients/PHI without a signed patient authorization (see IU Health’s Authorization to Release and Disclose Patient Information) or another HIPAA exception has been satisfied (e.g. data has been de-identified and no longer PHI in accordance with HIPAA and IU Health’s De-Identification of Protected Health Information policy, HIPAA 7.06). And, while a Waiver of Authorization approved by the IRB/Privacy Board allows access to PHI for research purposes, the research publication must present de-identified data in the aggregate and identifiable data should not be included in the research publication or presentation.
Transmission of Electronic Protected Health Information – Text and E-mail

Text messages or pages are not secure. The Diagnotes application, which may be downloaded from the App Store, is the only IU Health-approved secure and encrypted method for sending PHI electronic messages. Use your IU Health log-in credentials to access Diagnotes where electronic messages from provider to provider or team member to team member may occur in a secure environment, including the sending of photographs and videos via Diagnotes. You may not take a photo/video of a patient/PHI on your personal phone/device, and you may not text PHI or a patient photo/video to another from your personal phone/device – only Diagnotes may be used to text PHI.

If you need to send PHI via email for legitimate business reasons, then you may send PHI via email from an IU Health email account to another IU Health email account. In addition, PHI may be sent via email from an IU Health email account to an IU Faculty, Resident, Fellow or Medical Student email account or an Eskenazi email account as we have secured these communications. If you are using your IU Health/IU Faculty, Resident, Fellow or Medical Student/Esklenazi email account to send PHI to a non-IU Health/non-IU Faculty, Resident, Fellow or Medical Student/non-Esklenazi email account (e.g. Gmail, Yahoo, Comcast, AOL, etc.), then you must place only the words “Secure Message” in the Subject line of the email to direct our systems to encrypt the email to send PHI securely via email outside of IU Health/IU. You may not use your personal email account or a non-IU Health/non-IU/non-Esklenazi email account to transmit PHI. Indiana University undergraduate and graduate student email accounts are not approved for transmission of PHI unless otherwise specified above.

Presentations

Never open the electronic medical record at a public, educational conference and project PHI on a screen to efficiently show a patient’s course of treatment.

Proactive Electronic Medical Record Audit Tool Software

As required by law, IU Health uses an automated software tool to proactively review the audit logs of its electronic medical records (EMR). On a daily basis, the software reviews actions in the EMR and uses machine learning to flag out-of-ordinary behaviors based on the user’s activities, job codes and other factors. If a behavior is flagged, which for example could be a user who only treats minors is flagged in an adult record, then a daily report will be sent to the Privacy Office for investigation with area management. A tool is also available to run an audit log of all user access or access into the EMR of a selected patient pending review – we leave an electronic footprint, time and date stamped, for each and every action in the EMR, which is being monitored on a continuous basis.

Documenting your access into the Cerner Electronic Medical Record:

When entering the Cerner electronic medical record (EMR) for treatment purposes, you are prompted to confirm your treatment status access. For all other entries into EMR, while not presently required, you may opt to document the reason for your access as follows: Once you have entered the EMR, from the top tool bar, select “Chart”. A drop down menu will appear. From the menu, select “Chart Accessed By” and then “Most Recent”. You will then be given a box. The box contains date, time, user, position, and comment. You can put in your reason to be in the record in the comment. “Save” your comment and hit “Close”.
4. **PHOTOS, VIDEO, OTHER PATIENT IMAGES (radiological, ultrasound) and Non-Textual Patient Data (physiologic tracings, slides, etc.)** A patient’s written authorization is required if either of the following criteria applies to the photo, video or other patient image:

1) The patient data is determined to be data that a patient would recognize as their own or anyone else could use to identify the patient;
   or
2) The patient data has NOT been de-identified under HIPAA standards. See:
   a. IU Guidance document HIPAA-G02 – Safeguarding Patients’ Photographs and Recordings
   b. IU Health’s De-Identification of Protected Health Information policy, HIPAA 7.06
   c. IU Health’s *Photography and Recordings* policy, HIPAA 2.07 and accompanying *Photography and Recording Consent Form*

For example, if you desire to take a photograph or and/or audio or video recording of a patient to be used as part of a future educational presentation, then you will be required to obtain the patient’s written consent by completion of the *Photography and Recording Consent Form*, which should be filed in the patient’s medical record with a copy provided to the patient.

IV. **EXAMPLES / HYPOTHETICALS:**

**Case Study Example:**

An on-campus formal lecture or prepared in advance educational offering, where *only* the IU Health or IU’s Health Science School’s Teachers and Learners are present includes a radiologic image of a patient who ingested a foreign body. The patient’s name, medical record number, or other identifying information is not necessary to conduct the educational training, so care should be taken to remove or redact this PHI from the presentation. Individuals not directly treating the patient may not request identifying information to access the images subsequent to the lecture unless directed by a Teacher for further training purposes. On the other hand, if this case is presented while immersed in clinical care, an example being viewing radiology films in the reading room, identifying information may be portrayed to facilitate the learning experience.

**Hypotheticals:**

**Q:** A Resident treats a patient with a rare disease on the inpatient service. Several months later, the Resident desires to re-access the patient’s chart in order to present an internal education presentation. Can the Resident do this?

**A:** Yes, if the presentation part of the Resident’s training program under supervision of a Teacher. Only the minimum necessary PHI of the patient may be accessed for training purposes, and the Resident should de-identify the PHI for the presentation. See IU Health’s Policy HIPAA 7.06 De-Identification of Protected Health Information.

**Q:** A Resident treats a patient with a rare disease on the inpatient service. Several months later, the Resident desires to re-access the patient’s chart in order to learn from the clinical course of the patient. Can the Resident do this?

**A:** Yes, if the Resident’s Teacher has directed the Resident to review the patient’s chart whereby the Resident may access only the minimum necessary PHI of this patient to fulfil the educational objective as part of their training program.
Q: I am a Resident assigned to a Critical Care service team as part of my training, and we just collectively rounded on Patient A. I am not directly treating Patient A; however, after rounding on Patient A, I did not fully understand the differential diagnosis jointly discussed. Can I access Patient A’s medical record to further my learning?
A: Yes, as long as you access only the minimum necessary PHI of Patient A to further learning objectives and understanding of what was observed during rounding as part of the service team.

Q: I am the Resident scheduled to be on-call tonight. Can I open the medical record of a patient in the Emergency Department that I foresee will be coming to my service before I leave the Hospital?
A: Yes, as the on-call Resident, you may review the patient’s medical record in anticipation/preparation of treating the patient even if circumstances change and you ultimately do not receive the patient.

Q: May I open the medical record of three different John Does listed to see which John Doe with asthma exacerbation is coming to my service for treatment?
A: You should exhaust all reasonable means to identify the correct patient, such as encounter dates, demographic information, or other searchable identifiers, before exploring each patient’s chart.

Q: If I’m a Resident having lunch with my peers, may I enter the medical record to show them an interesting x-ray for which they may learn something new?
A: If are charged with the teaching responsibility over those in which you are having lunch, then in your role as a Teacher, you may share the minimum necessary PHI (e.g. x-ray) for a learning/educational purpose; however, if your lunch group is that of your peers for which you have no teaching responsibility, then you should consult with a Teacher for approval to share the x-ray.

Q: If I am presenting at a clinical case conference, may I open the medial chart of a patient that I did not personally care for, in order to use a clinical case for the formal education conference?
A: If you are presenting a clinical case on-campus where only the IU Health or IU’s Health Science School’s Teachers and Learners are present, then you may share the minimum necessary information about the patient to further the learning objective; however, since the case conference is prepared in advance, it is expected that direct access to the medical record would not occur and that the presentation would have patient identifiers (e.g. name, MRN or other identifying information) removed. If, however, the presentation is public, you may not open the medical record of the patient in a public setting, and you may not share any details that would identify a patient during the presentation.