OSWEGO COMMUNITY HOSPITAL

HIPAA, PRIVACY & SECURITY TRAINING

COURSE COMPETENCIES
LEARNING OBJECTIVES

- Health Insurance Portability and Accountability (HIPAA) **Privacy and Security Rules**
- HIPPA identifiers that create **protected health information (PHI)**
- How to **recognize situations** that create protected health information (PHI)
- Practical **ways to protect the privacy and security** if sensitive information
- **Employees will be held responsible** if they improperly handle confidential or protected health information

GOALS

- Assure clearly defined policies for the hospital
- Provide a guideline for patient rights
- Protect sensitive and private information
- Limit access of information to small needs
- Establish a process for any exceptions
- Establish deterrents and penalties; including sanctions or retraining

FORMS OF SENSITIVE INFORMATION 1.

Printed

Spoken

Electronic

EXAMPLES OF SENSITIVE INFORMATION 2.

- Social Security Numbers
- Credit card numbers
- Drivers license numbers
- Personnel information
- Research data
- Computer passwords
- Individually identifiable health information

HIPPA PRIVACY & SECURITY RULES 3.

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect a subset of Sensitive Information known as protected health information (PHI).
- In 2009, HIPAA was expanded and strengthened by the HITECH Act (Health Information Technology for Economic and Clinical Health). In January of 2013, the Department of Health and Human Services issued a final rule ("Final Rule") implementing HITECH's statutory amendments to HIPAA. The deadline for compliance is September 23, 2013.
- The HIPAA Privacy Rule
- The HIPAA Security Rule

HIPPA PRIVACY RULE 4.

Covered Entities Have a Duty to Protect PHI

A "covered entity" is any person or organization that furnishes, bills, or is paid for health care services in the normal course of business. Pursuant to HIPAA, individually identifiable health information collected or created by a covered entity is considered "protected health information," or PHI.

PHI 5.

PHI is generally defined as:

Any information that can be used to identify a patient – whether living or deceased – that relates to the patient's past, present, or future physical or mental health or condition, including healthcare services provided and payment for those services.

- Employees may access PHI only when necessary to perform their job-related duties.

HIPAA IDENTIFIERS

- Patient names
- Geographic subdivision
- Telephone numbers
- Fax numbers
- Social Security numbers
- Vehicle identifiers
- E-mail addresses
- Date (except year)
- Web URL's and IP addresses
- Names of relatives
- Full face photographs or images
- Healthcare record numbers
- Account numbers
- Biometric Identifiers (fingerprints, voiceprints)
- Health plan beneficiary number
- Device identifiers
- Certificate/license numbers
- Any other unique number, code that can be linked to an individual

REALITY

In general, HIPAA violations are enforced by the Department of Health and Human Services (HHS). However, pursuant to HITECH, state attorneys general are also permitted to bring civil actions and recover monetary awards that may be shared with harmed individuals.

Affinity Health Plan, Inc. discovered and reported to HHS that it had returned leased photocopiers to the leasing agents without first erasing the data contained on the copier hard drives that included PHI. The breach was estimated to have affected 344,579 individuals. Following an investigation, Affinity entered into a settlement agreement with HHS providing for a $1.2 million payment and a corrective action plan.

In general, HIPAA violations are enforced by the Department of Health and Human Services (HHS). However, pursuant to HITECH, state attorneys general are also permitted to bring civil actions and recover monetary awards that may be shared with harmed individuals.

- Copiers: erase all data from hard drives.
- Faxes: confirm authorization instructions; verify telephone numbers before faxing; when possible, use pre-programmed numbers.
- Devices: encrypt; enable and use password protection.

•A court ordered Walgreens to pay $1.44 million to a customer whose PHI was impermissibly accessed and disclosed by a pharmacy employee. The employee suspected her husband's ex-girlfriend gave him an STD, looked up the ex-girlfriend's medical records to confirm her suspicion, and shared the information with her husband. He then texted his ex-girlfriend and informed her that he knew about her STD.

Multiple state courts have ruled that **HIPAA establishes a standard of care to which healthcare provider offices need to adhere**, and **liability for negligence** may arise when that **standard of care is breached.**

6.

Access Must be Authorized

An employee may only access or disclose a patient's PHI when this access is part of the employee's job duties.

Except in **very** limited circumstances, if an employee accesses or discloses PHI without a patient's written authorization or without a job-related reason for doing so, the employee violates HIPAA.

7.

Unauthorized Access

It is never acceptable for an employee to look at PHI "just out of curiosity," even if no harm is intended (i.e., retrieving an address to send a 'get well' card).

It also makes no difference if the information relates to a "high profile" person or a close friend or family member – ALL information is entitled to the same protection and **must be kept private**.

These rules apply to all employees, including health care professionals.

Be aware that accessing PHI of someone involved in a divorce, separation, break-up, or custody dispute may be an indication of intent to use information for personal advantage, unless the access is required for the individual to do his job. Such improper behavior will be considered when determining disciplinary action against violators.

Breaches

A breach occurs when information that, by law, must be protected is:

lost, stolen or improperly disposed of (i.e. paper or device upon which the information is recorded cannot be accounted for);

"hacked" into by people or mechanized programs that are not authorized to have access (e.g. the system in which the information is located is compromised through a "worm"), or

communicated or sent to others who have no official need to receive it (e.g. gossip about information learned from a medical record).

Facing the most severe level of HIPAA's criminal provisions – up to 10 years in prison and a $250,000 fine – because the violations involved access and use of PHI for personal gain, an employee of the Seattle Cancer Care Alliance agreed to plead guilty and serve a 16 month prison sentence and pay back both the impacted credit card companies and the patient from whom he stole PHI. The employee accessed and used the patient's name, birth date, and Social Security number from the medical record to fraudulently obtain four credit cards. He then charged about $9,000 in the patient's name.

Individual employees, and not just the "covered entities" for whom they work, are subject to HIPAAs sanctions.

9. Employees Must Report Breaches

Part of your responsibility as an employee is to **report privacy or security breaches involving PHI to your supervisor AND** one of the following persons:

the HIPAA Privacy Officer
the HIPAA Security Officer

Employees, volunteers, students, or contractors of the Hospital may not threaten or take any retaliatory action against an individual for exercising his or her rights under HIPAA or for filing a HIPAA report or complaint, including notifying of a privacy or security breach.

Penalties for Breaches

Breaches of the HIPAA Privacy and Security Rules have serious ramifications for all involved. In addition to sanctions imposed by the Hospital, such breaches may result in civil and criminal penalties.
Statutory and regulatory **penalties for breaches** may include:

Civil Penalties: $50,000 per incident up to **$1.5 million** per incident for violations that are not corrected, per calendar year

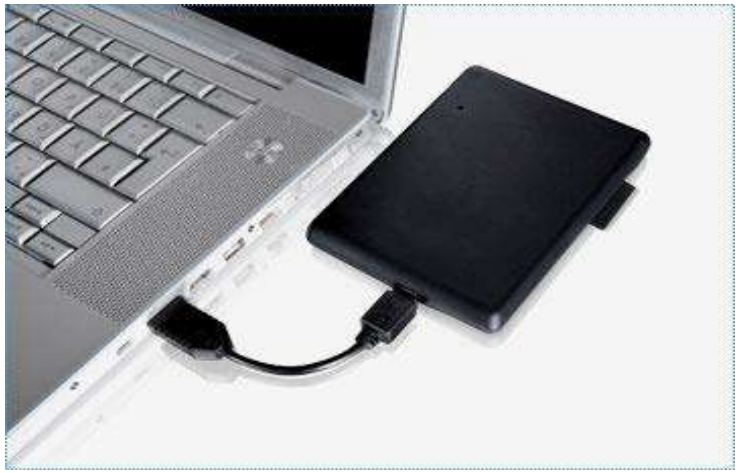
Criminal Penalties: **$50,000** to **$250,000** in fines and up to **10 years in prison**

Breach Notification Requirements

Any impermissible use or disclosure that compromises PHI or other sensitive information may trigger breach notification requirements. Depending upon the results of a risk analysis of the impermissible use or disclosure, breach notification may have to be made.

Letters of explanation describing the circumstances, including responsible parties, may have to be sent. A breach can significantly impact both the economic and human resources of the Hospital. The estimated average cost per compromised record in a data breach can exceed $200. A breach has great potential to harm the reputation of the Hospital, as well.

Massachusetts Eye and Ear Infirmary agreed to pay HHS $1.5 million and retain a independent monitor for HIPAA violations resulting from the theft of an unencrypted laptop containing PHI of patients and research subjects. HHS's investigation determined that the Infirmary failed to take necessary steps to ensure the confidentiality and security of PHI created, maintained, and transmitted using portable devices.



Quick Review 10.

Sensitive information exists in many forms: printed, spoken, and electronic.

Sensitive information includes Social Security numbers, credit card numbers, driver's license numbers, personnel information, computer passwords, and PHI.

There are a number of state and federal laws that impose privacy and security requirements.

Two primary HIPAA regulations are the Privacy Rule and the Security Rule.

When used to identify a patient and when combined with health information, HIPAA identifiers create PHI.

An employee must have a patient's written authorization or a job-related reason for accessing or disclosing patient information.

Breaches of information privacy and security may result in both civil and criminal penalties, as well as Hospital sanctions. Employees must report such breaches.

PROGRAM COMPONENTS

- Five HIPAA Program Components
- **1.** Individual (Patient) Rights
- **2.** "Minimum Necessary" Information Standard
- **3.** Procedures for Data Use in Research
- **4.** Limits for Marketing and Fundraising Uses
- **5.** Business Associates

I. Patient Rights II.

To receive a copy of the Hospital's Notice of Privacy Practices.

To request restrictions* and confidential communications of their PHI;

To inspect and/or receive an electronic copy of their healthcare records.

To request corrections of their healthcare records.

To obtain an accounting of disclosures (i.e., a list showing when and with whom their information has been shared).

To file a complaint with a healthcare provider or insurer and the U.S. Government if the patient believes his or her rights have been denied or that PHI is not being protected.

To receive notice of a breach of their unsecured PHI.

* The Final Rule requires that a covered entity **must agree to a request** to restrict the disclosure of PHI to his/her health plan for a health care item or service for which **the patient has paid in full out of pocket**, unless otherwise required by law.

2. Minimum Necessary 12.

Generally, a patient's authorization is required for the use or disclosure of PH1. When a use or disclosure of PHI is permitted, via patient authorization or otherwise, HIPAA requires that only the amount of PHI that is the **MINIMUM NECESSARY** to accomplish the intended purpose be used or disclosed.

Disclosures of PHI

HIPAA regulations **permit** use or disclosure of PHI for:

Employees **may not** otherwise access or disclose PHI *unless*: HIPAA regulations **permit** use or disclosure of PHI for:

- providing medical treatment
- processing healthcare payments
- conducting healthcare business operations
- public health purposes as required by law

- the patient has given written permission
- it is within the scope of an employee's job duties
- proper procedures are followed for using data in research
- required or permitted by law

Note: the Final Rule now protects the PHI of a **deceased individual** for period of **50 years following the death** of that individual.

Imagine that you work with patients to help find ways to pay their medical bills. Through your work, you become aware of a family under substantial financial hardship. You believe that kindhearted members of the community would provide help "If they only knew" of these circumstances. In order to tell this story you must get specific written authorization from the patients or their legal representatives that identifies whom you will tell. In addition, you may communicate only the minimum amount of information necessary to describe the need.

Note: This type of "outreach" needs to be approved in advance by departmental managers and supervisors and must be consistent with institutional policy.

3. Research Data

HIPAA regulates how PHI may be obtained and used for research. This is true whether the PHI is completely identifiable or partially "de-identified" in a limited data set.

A researcher or healthcare provider is not entitled to use PHI in research without the appropriate HIPAA documentation, including an
individual patient authorization or
an institutionally approved waiver of authorization.

Even if a researcher gets a signed "Informed Consent Form" from a research subject, if she does not also get a signed HIPAA Authorization form (or obtain a waiver of authorization from the Institutional Review Board), she may not use data she has collected for her research, presentations or publications.

4. Marketing & Fundraising

- Without first obtaining a patient authorization, the Hospital may not receive payment for the use or disclosure of PHI, nor may the Hospital sell PHI.

- The Hospital may only use demographic information, including name, address, other contact information, age, gender, and date of birth, as well as certain other information about the medical treatment of an individual for fundraising purposes.

- The Notice of Privacy Practices must advise patients of the prohibitions on marketing and the sale of PHI and of their right to "opt out" of being contacted for fundraising purposes.

- Each fundraising solicitation must contain an easy means for patients to "opt out" of receiving such communications in the future.

5. Business Associates 13.

An outside company or individual is a Business Associate of the Hospital when performing functions or providing services involving
the use or disclosure of PHI maintained by the Hospital.

Under the Final Rule, a Business Associate is **directly liable for compliance** with HIPAA Privacy and Security requirements and must:

- enter into a Business Associate Agreement (called a BAA) with the covered entity (the Hospital);
- use appropriate safeguards to prevent the access, use or disclosure of PHI other than as permitted by the contract, or BAA, with the covered entity;
- obtain satisfactory assurances from any subcontractor that appropriate safeguards are in place to prevent the access, use or disclosure of PHI entrusted to it;
- notify the covered entity of any breach of unsecured PHI for which the Business Associate was responsible upon discovery;
- ensure its employees and/or those of its subcontractors receive HIPAA training; and
- protect PHI to the same degree as a covered entity.

Quick Review

Under HIPAA, patients have the right to:

- receive a copy of the Hospital's Notice of Privacy Practices
- receive a copy of their healthcare records in electronic form
- ask for corrections to their healthcare records
- receive an accounting of when and to whom their PHI has been shared
- restrict how their PHI is used and shared
- authorize confidential communications of their PHI to others
- receive notice of a breach of their unsecured PHI
- file a HIPAA complaint

Quick Review

- The Hospital may use or share only the minimum necessary information to perform its duties.
- Patients must sign an authorization form before the University can release their PHI to a third party not involved in providing healthcare.
- A researcher or healthcare provider is not entitled to use PHI in research without the appropriate HIPAA authorization or a waiver of authorization.
- The University must obtain an individual's specific authorization before using his or her PHI for the sale of PHI, marketing, and some fundraising efforts.
- A contractor providing services involving PHI is called a Business Associate.
- A covered entity and business associate must enter into a Business Associate Agreement ("BAA").
- Business Associates are directly liable for HIPAA compliance and must ensure that their employees or subcontractors receive HIPAA training and employ appropriate safeguards for PHI.
- HIPAA protections apply to a deceased person's PHI for 50 years after they have died.

HIPPA SECURITY RULE

- The HIPAA Security Rule concentrates on safeguarding PHI by focusing on the confidentiality, integrity, and availability of PHI.

- Confidentiality means that data or information is not made available or disclosed to unauthorized persons or processes.
- Integrity means that data or information has not been altered or destroyed in an unauthorized manner.
- Availability means that data or information is accessible and useable upon demand only by an authorized person.

Security Standards/Safeguards

The Hospital is required to have administrative, technical, and physical safeguards to protect the privacy of PHI.

Safeguards must:

- Protect PHI from accidental or intentional unauthorized use/disclosure in computer systems (including social networking sites such as Facebook, Twitter and others) and work areas;
- Limit accidental disclosures (such as discussions in waiting rooms and hallways); and
- Include practices such as encryption, document shredding, locking doors and file storage areas, and use of passwords and codes for access.

Irritated by a patient who was always late to her pre-natal appointments, a Missouri doctor posted to her personal Facebook page, "may I show up late to her delivery?" A reader took a screen shot of the doctor's comment and posted it to the employing hospital's Facebook page for expectant mothers where many wrote to demand the doctor's termination.

The doctor's post revealed the patient's induction date and that she had previously suffered a stillbirth making identification likely. The employing hospital publicly issued a comment decrying the incident.

Malicious Software

Viruses, worms, spyware, and spam are examples of malicious software, sometimes known as "malware".

Employees should utilize antivirus and anti-spyware software, and update it regularly with patches.

Safe Internet browsing habits can also reduce the likelihood of an infection; do not open email or click on embedded links from an unknown or untrusted site.

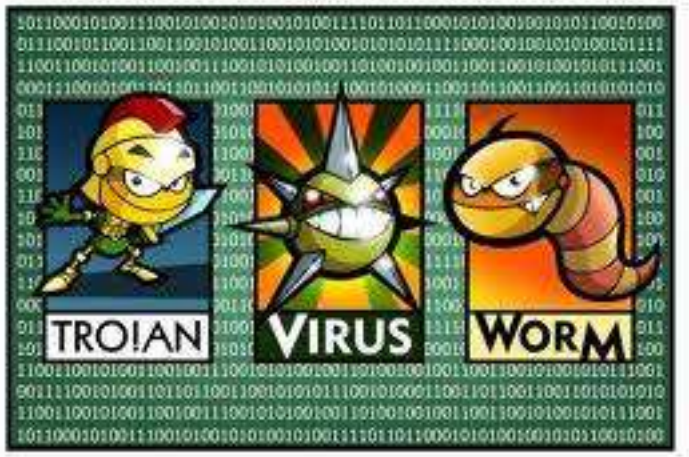
If the computer or mobile device you are using stores work-related sensitive information, personal use of the web is not recommended.

Viruses

Another major threat to the Hospital's information system and to your data is computer viruses.

- Viruses "infect" your computer by modifying how it operates and, in many cases, destroying data.
- Viruses spread to other machines by the actions of users, such as opening infected email attachments.
- Viruses can forward PHI to unauthorized persons by attaching themselves to documents, which are then emailed by the virus.
- Newer viruses have their own email engines, enabling them to send email without having to use an email client or server.
- Many viruses also install a "backdoor" on affected computer systems allowing for unauthorized access and collection of Sensitive Information.

Worms



Worms are programs that can:

- run independently without user action;
- spread complete working versions of themselves onto other computers on a network within seconds; and
- quickly overwhelm computer resources with the potential for data destruction as well as unauthorized disclosure of sensitive information.

Spyware

Spyware is software that is secretly loaded onto your computer, monitors your activities, and shares that information without your knowledge.

Malicious websites
can install spyware on every computer
that visits those sites.

Spam and Phishing

Spam is an unsolicited or "junk" electronic mail message, regardless of content.

Spam usually takes the form of bulk advertising and may contain viruses, spyware, inappropriate material, or "scams."

Spam also clogs email systems.

Phishing is a particularly dangerous form of spam that seeks to trick users into revealing sensitive information, such as passwords.

Safe Browsing Habits

Safeguard sensitive information

Look for signs of security when providing sensitive information (i.e. the web address starts with "https" or a padlock icon is displayed in the status bar).

Keep browser updated and use security settings Stay current with browser updates and application updates such as Adobe Flash and Acrobat.
Enable browsing security settings to alert you to threats to your computer like popups, spyware, and malicious cookies.

Use security software

There are a number of free and easily available software products to protect your computer from malware, spyware, and virus threats. Talk to your IT support personnel to find out which software best fits your needs.

Safe downloading & streaming When in doubt just don't do it! If a download looks too good to be true, it might be malware.
Downloaded files like software or other media can contain hidden malware.
Streaming media Web sites might seem harmless, but watching or listening to streaming media may require downloading a special media player that may contain malware.

Mobile Devices

Never leave mobile computing devices unattended in unsecured areas. Immediately report the loss or theft of any mobile computing device to your supervisor and the Information Security Office. Remember, for any mobile device, **encryption** is the best defense!

Employees must utilize the following security controls when storing and transmitting sensitive information:

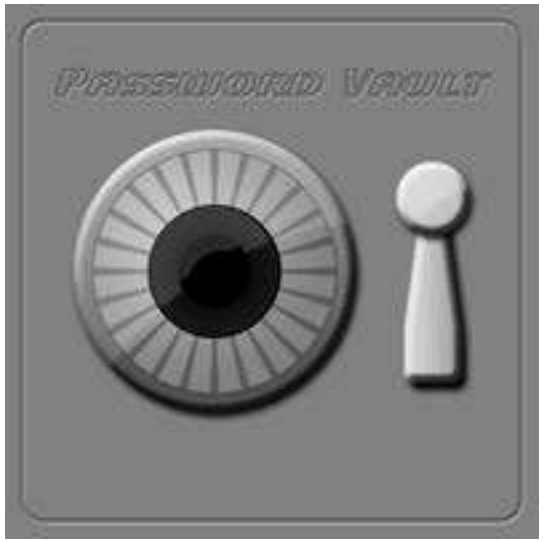
- strong power-on passwords
- automatic log-off
- display screen lock at regular intervals while the device is inactive
- **encryption**

Password Control

- Use strong passwords where possible (at least 8 characters, containing a combination of letters, numbers, and special characters).
- Change your passwords frequently (45-90 days) to prevent hackers from using automated tools to guess your password.
- It is a violation of Hospital Policy to share your password with anyone. Electronic audit records track information based on activity associated with user IDs .
- Many security breaches come from within an organization and many of these occur because of bad password habits.

Password Management

With the growing trend for web sites and services to require visitors to create new user IDs and passwords to access the site, people are finding it difficult to safely manage a large number of accounts. One solution is to use a "password vault," which provides an easy method to store all of one's passwords in an encrypted format.



Keepass (http://keepass.info/)
Roboform (www.roboform.com).

Communications in Public Areas

Be aware of your surroundings when discussing Sensitive Information, including PHI. Do not discuss Sensitive Information or PHI in public areas such as in cafeterias or restaurants, while walking on campus, or while riding the bus.

Use caution when conducting conversations in:

- semi-private rooms
- waiting rooms
- corridors
- elevators and stairwells
- open treatment areas.

15.

Appropriate Disposal of Data

Observe the following procedures for the appropriate disposal of Sensitive Information, including PHI.

Sensitive information and PHI should never be placed in the regular trash!

Hard copy materials such as paper or microfiche must be properly shredded or placed in a secured bin for shredding later. Magnetic media such as diskettes, tapes, or hard drives must be physically destroyed or "wiped" using approved software and procedures.

CD ROM disks must be rendered unreadable by shredding, defacing the recording surface, or breaking.

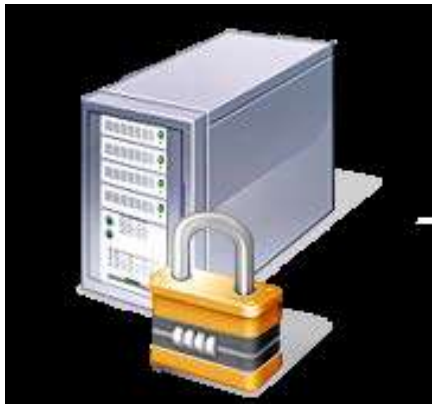
Physical Security

Computer screens, copiers, and fax machines must be placed so that they cannot be accessed or viewed by unauthorized individuals.

Computers must use password-protected screen savers.

PCs that are used in open areas must be protected against theft or unauthorized access.

Servers and mainframes must be in a secure area where physical access is controlled.



Equipment such as PCs, servers, mainframes, fax machines, and copiers must be physically protected.

What if there is a breach of confidentiality?

Breaches of the Hospital's policies or an individual's confidentiality
must be reported to the employee's **supervisor AND** one of the following persons:

the **HIPAA Privacy Officer**;
the **HIPAA Security Officer**;

The Hospital is required to take reasonable steps to lessen harmful effects of a confirmed breach involving compromised PHI.

This includes notifying individuals whose information has been breached. The Hospital must report breaches both to the Secretary of Health and Human Services and to the state at least once a year.

16.

Disciplinary Actions

Individuals who violate the Hospital's Information Security Policy* will be subject to **appropriate disciplinary action** as outlined in the Hospital's personnel policies, as well as subject to possible **criminal or civil penalties**.

Best Practice Reminders

- **DO** keep computer sign-on codes and passwords secret, and **DO NOT** allow unauthorized persons access to your computer. Also, use locked screensavers for added privacy.
- **DO** keep notes, files, memory sticks, and computers in a secure place, and be careful **NOT** to leave them in open areas outside your workplace, such as a library, cafeteria, or airport.
- **DO NOT** place PHI or PII on a mobile device without required approval. **DO** use encryption when sending or storing PHI or PII on mobile devices, including "thumb" or "flash" drives.
- **DO** hold discussions of PHI in private areas and for job-related reasons only. Also, be aware of places where others might overhear conversations, such as in reception areas.
- **DO** make certain when mailing documents that no sensitive information is shown on postcards or through envelope windows, and that envelopes are closed securely.
- **DO NOT** use unsealed campus mail envelopes when sending sensitive information to another employee.
- **DO** follow procedures for the proper disposal of sensitive information, such as shredding documents or using locked recycling drop boxes.
- When sending an e-mail**, DO NOT** include PHI or other sensitive information such as Social Security numbers, unless you have the proper written approval to store the information and use encryption.

WHAT IS THE HOSPITAL DOING

- Hospital Assessment (HIPAA GUARD, REBOOT)
- Implement assessment finding through policies and procedures
- Training
- Compliance
- Sanctions
- Reporting (everyone has to report breaches when they see them)

HIPAA requires that you perform regular Risk Assessment of your practice. A Risk Assessment is a compulsory exercise that identifies the strengths and weaknesses of your practice.

SAFETY OFFICERS 17. 18.

Joyce Hiben

- The Privacy Officer shall oversee all on going disciplinary administrative activities related to the development, implementation, and maintenance of the Hospital and its outpatient clinics policies and procedures, in accordance with applicable federal and state laws. HIPAAGUARD/HITECH Updates and new implementations will be informed and discussed through weekly group conference calls.

The Privacy Officer will inform, and update on HIPAA GUARD/HITECH compliance, policy and procedures.

SECURITY OFFICER 17. 18.

Tom Pryor

- HIPAA security officer must have a process in place to take immediate action in the event a security breach occurrence. The officer will establish an incident response, if necessary, and assign specific role and responsibilities to all members. Response procedures include investigation of the event, and breach, action and solution to the existing and/or future breach occurrence.

Security Officer will provide PHI Security as high priority, audit security, conduct investigation and report in the event of a breach


TEST