HIPAA Compliance; a Clinical Overview

This class provides an overview of the current HIPAA 45 C.F.R. regulations that healthcare agencies need to follow to achieve compliance.

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• Health Insurance Portability and Accountability Act (HIPAA) enacted in 1996
• Under Title II
  ◦ Administrative Simplification
  ◦ Preventing Healthcare Fraud and Abuse
  ◦ Medical Liability Reform
  ◦ Electronic Data Exchange; i.e.: 837, 835
  ◦ Security
    • Administrative, Physical and Technical Safeguards
  ◦ Privacy
- Health Information Technology for Economic and Clinical Health Act
- Included in the American Recovery and Reinvestment Act (ARRA) of 2009
- Contains incentives related to healthcare technology in general and specific incentives designed to accelerate the adoption of electronic health records
- Meaningful Use
- Added “teeth” to HIPAA
- Wall of Shame: https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf
• Notice of Privacy Policies (NPP)
  ◦ Must be given to all clients
• Business Associates (BA) Agreements
  ◦ BA now just as responsible and accountable
• Policies and Procedures
• Training Requirements
• Audits

HIPAA Always Changing
Additional Mandates

- Mandated Breach Notification
- Expanded Privacy and Patient Rights
- Expanded and Mandated Security
- Enforcements and enhanced monetary penalties
- Office of Civil Rights (OCR) enforcement authority
- State Attorneys General enforcement
**Important Definitions**

**Covered Entity**
A Covered Entity is a healthcare delivery option that includes doctors, clinics, hospitals, dentists, nursing homes and pharmacies that transmit data, health plan and healthcare clearinghouses.

**Business Associate**
A Business Associate is any person or organization that functions on behalf of a covered entity that involves use or disclosure of identifiable health information. Examples include billing and coding vendors.
Security Roles are established to provide governance of the HIPAA program
- Security Compliance Officer
- Privacy Officer
- Workforce Security Manager
- IT Security Manager
- Incident/Breach Manager
- Physical Security Manager

Do you know who your Privacy and Security Compliance officers are?
What is Protected Health Information (PHI)?

- Name
- Address
- Dates directly related to patient
- Telephone number
- Fax Number
- Email addresses
- Social Security Number
- Medical Record Number
- Health Plan Beneficiary Number
- Account Number
- Certification/License Number
- Any vehicle license number
- Any device serial number
- Web URL, IP address
- Finger or voice prints
- Photographic images
- Any other unique number, characteristic or code
- Age greater than 89
<table>
<thead>
<tr>
<th><strong>What information is Protected?</strong></th>
<th><strong>What is Included?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medical Records and Other Individually Identifiable Health Information (PHI) Used or Disclosed by a Covered Entity in any Form; Electronic, on Paper or Orally</td>
<td>Individually Identifiable Information that was provided by the client, created by you, created by another and forwarded to you and forwarded to you for payment, treatment or healthcare operations.</td>
</tr>
</tbody>
</table>
A CE is permitted, but not required, to use and disclose PHI without an authorization, for the following purposes:

- To the individual
- Treatment, Payment and Health Care Operations (TPO)
- Opportunity to Agree (having someone in the room during the session) or Object to a facility directory
- Incident to an otherwise permitted use
- Limited Data Set for purposes of research, public health or health care operations
Patient Rights under HIPAA

- To see their medical record
- Obtain a copy of their medical record
- Request amendments to their medical record
- Request disclosure restrictions
  - Private Pay
  - Certain other disclosures, including research and marketing
- To authorize disclosures
- To receive a Notice of Privacy Practices
- To have an accounting of disclosures (not TPO)
- Timely notification of any breaches
- Secure Communications
- Confidential communications when requested
California Laws that protect Medical Information
- The Confidentiality of Medical Information Act (CMIA)
- The Information Practices Act (IPA)
- The Patient Access to Health Records Act (PAHRA)
- The Insurance Information and Privacy Protection Act (IPPA)
| HIPAA permits Covered Entities to use or disclose PHI to the extent such use or disclosure is required by law and complies with the law. Covered Entities must comply with specific disclosures (report abuse, etc) | State law; The CMIA permits disclosure of medical information where such disclosure is compelled by a competent legal authority or process as specified (Civil Code Section 56.10 (b)) | Analysis: HIPAA permits California providers to continue to comply with most required disclosures under CMIA. |
Additional California Law Analysis

- Please refer to the entire CHA paper for additional detailed information on disclosure analysis CMIA compared to HIPAA
- As we already mentioned, the most stringent law takes precedent
- Find the Preemption Analysis Chart; Patients Covered by CMIA in the resources link in the upper right corner of the slide
- Your privacy officer will help you answer any questions
Now, the Rules
According to the Department of Health and Human Services, the HIPAA Security Rule outlines national standards designed to protect individual’s **electronic** PHI (ePHI)

The HIPAA Privacy Rule set a national standard for the protection of certain health information that addresses the use and disclosure of PHI and standards for privacy rights for patients to understand and control how their health information is used.
In May 2005, the Security Rule was implemented. Some of what it covers:

- Access Control-who can access PHI
- Computer protections against viruses, malware
- Strong Passwords
- Remote Access
- Technical Security
- Back up and Recovery
• **Environment**
  ◦ Physical security; locks on doors and file cabinets
  ◦ Is there a networked printer or fax machine that is out in the open?
  ◦ Awareness of who is allowed into the area with PHI
  ◦ How is your computer monitor positioned?
    • Can others see the data on the screen?
  ◦ What paper charts/forms are left out on your desk?
  ◦ Stay alert, stay safe
• **Your devices**
  ◦ Do you have a smart phone, tablet or laptop that accesses your email or your Electronic Health Record?
  ◦ Is your desktop computer secure and safe from someone removing it from your office?

• **Passwords**
  ◦ Make sure your passwords are complex, using letters, numbers and special characters
  ◦ Be sure to change it often (every 90 days or per your agency policy) and after an incident
  ◦ Never write your password down or give to others
What Can I Do?

- Follow your agency’s P&Ps
  - Computers
    - Make sure your monitor is not visible to others
    - Lock your workstation when you leave your desk
  - Mobile Devices
    - Password protect your devices
    - Don’t save PHI to your mobile device
    - Lock up your devices to reduce theft
  - Passwords
    - Change every 90 days or after an incident
    - Don’t write down or share with others
  - Be Careful with emails
    - Phishing attempts
    - Don’t click on links or Download now buttons
    - Be suspicious and think before you take any actions
    - Confirm that the email was sent from your friend/co-worker if there are links included
- Stop, Think and Don’t click the Link!
- Report anything suspicious to your security compliance officer
Communicating with clients must be secure
Includes emails and texting
- Yahoo and gmail are insecure
- Texting is insecure unless you have a technology that securely sends your texts
  - 3 issues with texting
Have to manage the requests from clients that may put you at risk of a breach
- Portals
  - Request a release of information to allow insecure communications if there is no other option
Discuss using secure emails and texting solutions with your IT group
- TigerText
- OhMD
- DocHalo
- Cortext by Imprivata
- A security incident is the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.
  - Includes access to the client’s record - minimum necessary
  - Includes loss of a device that has access to PHI
  - You must report anything you do yourself, you observe or that you are concerned about
  - IT will initiate monitoring tools to assist
- You should report anything suspicious to your Security Compliance Officer
The goal of the HIPAA Privacy Rule is to properly protect individual’s health information and to use PHI appropriately while protecting the privacy of people who seek care and healing.
• Privacy covers paper, oral communication and electronic data
• When PHI is used and/or disclosed and when you need an authorization
• Notice of Privacy Practices
• Administrative requirements

What’s covered in Privacy?
In December 2012, Leon Rodriguez, then-director of the US Department of Health and Human Services’ Office of Civil Rights (OCR) warned “We’ve now moved into an area of more assertive enforcement.”
• **Breach Definition**

An impermissible use or disclosure under the Privacy Rule of PHI is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised.

Breaches of more than 500 patient records must be reported to the news media and are posted on the Wall of Shame.
Key Findings:

- May sees a 62% reduction in reported data breaches compared to April.
- However, those breaches affected 72% more people than in April.
- The number of breach victims reported for May, 2015 is already 59% higher than May, 2014.
- 110 healthcare data breaches have been reported to the OCR so far in 2015.
- Year to date figures show a fall in reported data breaches of 16% compared to 2014.
- Hackers have stolen 92,920,060 records so far in 2015. This time last year the figure was just 462,670 records.
- 42% fall in reported thefts for the year and an 87% reduction in the number of breach victims.
- Only 2 Business Associates have reported data breaches in 2015, a fall of 95% year on year.
Following a breach of unsecured PHI, Covered Entities must provide notification of the breach to the affected individual, the Secretary, and in certain circumstances, to the media.

- Business Associates must notify the Covered Entity of a breach.
- Provided without unreasonable delay, no later than 60 days following the discovery of the breach.
  - **CA requires a 15 day maximum**

You will follow your agency policy and procedures for incident/breach reporting.
- Criminal Penalties-Covered Entities and specified individuals whom “knowingly” obtain or disclose PHI can face up to $50,000 fine, as well as up to one year in prison.
- Offenses committed under false pretenses allow penalties to be increased to a $100,000 fine and up to five years in prison.
- Offenses committed with the intent to sell, transfer to use info for personal gain has fines up to $250,000 and up to 10 years in prison.
<table>
<thead>
<tr>
<th>HIPAA Violation</th>
<th>Minimum Penalty</th>
<th>Maximum Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual did not know (and by exercising reasonable diligence would not have known) that he/she violated HIPAA</td>
<td>$100 per violation, with an annual maximum of $25,000 for repeat violations (Note: maximum that can be imposed by State Attorneys General regardless of the type of violation)</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation due to reasonable cause and not due to willful neglect</td>
<td>$1,000 per violation, with an annual maximum of $100,000 for repeat violations</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation due to willful neglect but violation is corrected within the required time period</td>
<td>$10,000 per violation, with an annual maximum of $250,000 for repeat violations</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation is due to willful neglect and is not corrected</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
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Core Values of 42 CFR, Part 2

- Promote Access to Treatment
- Reduce Stigma
- Confidentiality
- Nurture the Doctor-Patient Relationship
42 CFR Part 2 (commonly referred to as "Part 2") are the federal regulations governing the confidentiality of drug and alcohol abuse treatment and prevention records.

- Privacy protections afforded to alcohol and drug abuse patient records
- Motivated by the understanding that stigma and fear of prosecution might dissuade persons from seeking treatment
Who is Covered?

- 42 CFR Part 2 applies to any individual or entity that is federally assisted and provides alcohol or drug abuse treatment or referral for treatment (42 CFR § 2.11)
- Consider funding, treatment provided and clinical licenses that are at the federal level (DEA license)
• Restrict the disclosure and use of alcohol and drug client records
• Any information disclosed by a covered program that “would identify a patient as an alcohol or drug abuser” (42 CFR §2.12(a) (1)
• With limited exceptions, 42 CFR Part 2 requires client consent for disclosures of PHI even for the purposes of TPO. Consent must be in writing
Includes the electronic codes of federal regulations

Introduction, General Provisions, Disclosures with Patient Consent, Disclosures without Patient Consent, Court Orders Authorizing Disclosure and Use

http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

42 CFR Changes coming

The primary way in which patient substance abuse information may be disclosed is with a patient’s written consent. Substance abuse programs and providers must give patients a written summary of the federal laws and regulations that protect the confidentiality of patient substance abuse records and a description of the circumstances when the patient’s information may be disclosed without his/her consent.
For all other disclosures, consent must be obtained using a written consent form. A single consent form may authorize disclosure to multiple parties or for multiple purposes.

Consent forms must contain specific elements (see right column):

- Patient Name
- Agency making disclosure
- Agency name of the person or agency to which disclosure is made
- Nature and amount of information to be disclosed (minimum necessary)
- Purpose of the disclosure (as specific as possible)
- Effective and expiration dates and event or condition upon which the consent expires
- Language explaining the consent process and may include a statement about possible denial of services if not signed for purposes of treatment, payment or healthcare operations
- And signatures of client, authorized representative and description of authority to sign on the client’s behalf
Exceptions—Always work with Privacy Officers

- Program Communications
- To communicate with Qualified Service Organizations (QSO)
  - Similar to other covered entities or business associates
- Medical Emergencies
- Response to a crime against program personnel or on program premises
- Research activities (approved by IRB)
- Audit and Evaluation
- Report suspected child abuse or neglect
- Circumstances involving certain minors or incompetent patients
- Response to a valid court order
- Cause of death
• Substance use programs must comply with both HIPAA 45 CFR and 42 CFR Part 2
• If there is a conflict, the more stringent rule applies
• http://blog.outcomesresource.com/?p=236
• You begin to see that addiction treatment providers fall under the more stringent laws of 42 CFR, Part 2, in most cases.
• However, there are requirements of HIPAA that must be put into place on specific forms that previous laws didn’t address or mandate.
The Substance Abuse and Mental Health Services Administration (SAMHSA) provides great information and support on 42 CFR Part 2

- Spearheading efforts to change 42 CFR Part 2 to accommodate sharing info in EHRs/HIEs
• Must be current and reference 45 CFR for both privacy and security
• Agency must have an interconnected set of polices, plans, procedures and security roles assigned to have the end result be a secure, compliant and auditable environment
Your agency policies need to include HIPAA.
Do you know where to find the policies about workforce training, incident response or sanctions/violations?
• Procedures need to focus on HIPAA
• Where are your agency procedures for how to handle a client’s request to view and get a copy of their chart?
• Your responsibility is to make sure you understand your role
• Each agency needs to have a Business Continuity/Disaster Recovery Plan
• Clinicians need to understand the procedures for how to respond if the plan is activated
• Client safety/services
• Downtime procedures
HIPAA requires that all staff receive HIPAA privacy and security training when hired, annually and to have subsequent trainings or reminders throughout the year.

These trainings are not to torture you, but to help create a Culture of Compliance.
• What we covered today
  ◦ HIPAA, HITECH and the Privacy and Security Rules
  ◦ Protected Health Information (PHI)
  ◦ California regulations and HIPAA
  ◦ Computers and Data Protection
  ◦ Communicating with Clients
  ◦ What you can do to protect PHI
  ◦ Breaches and penalties
  ◦ 42 CFR and HIPAA
  ◦ Agency P&Ps
• Go to www.xpiohealth.org/cibhs and register to take the HIPAA for Clinicians exam. Use the coupon codes as described in the “how to register” document
• Print out your certification of completion and feel proud of your success!
• Remember to share your HIPAA knowledge with others in your agency, create that culture of compliance