

*Metropolitan Lutheran Ministry*

**SECTION I: HIPAA STANDARDS & PRIVACY POLICY**

The Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict Metropolitan Lutheran Ministry's ("MLM", "Company") abilities to use and disclose protected information (PHI).

*Protected Information.* Protected information means information that is created or received by the Company and relates to the past, present, or future physical or mental condition of a Client/Client ("Participant"); the provision of care to a participant; or the past, present, or future payment for the provision of care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected information includes information of persons living or deceased.

Some examples of PHI are:

- Participant's record number
- Participant's demographic information (e.g. address, telephone number)
- Information providers put in a participant's record
- Images of the participant
- Conversations a provider has about a participant's services with others
- Information about a participant in a provider's computer system
- Billing information about a participant
- Any information that can lead to the identity of an individual or the contents of the information can be used to make a reasonable assumption as to the identity of the individual

It is the Company's policy to comply fully with HIPAA's requirements. To that end, all staff members who have access to PHI must comply with this HIPAA Privacy and Security Plan. For purposes of this plan and the Company's use and disclosure procedures, the workforce includes individuals who would be considered part of the workforce under HIPAA such as employees, volunteers, interns, board members and other persons whose work performance is under the direct control of MLM, whether or not they are paid by MLM. The term "employee" or "staff member" includes all of these types of workers.

No third-party rights (including but not limited to rights of participants, beneficiaries, covered dependents, or business associates) are intended to be created by this Plan. MLM reserves the right to amend or change this Plan at any time (and even retroactively) without notice.

All staff members must comply with all applicable HIPAA privacy and information security policies. If after an investigation you are found to have violated the organization's HIPAA privacy and information security policies, then you will be subject to disciplinary action up to termination or legal ramifications if the infraction requires it.

## **SECTION 1: Responsibilities as Covered Entity**

### **I. Privacy Officer**

The VP/Assistant Executive Director will be the HIPAA Privacy Officer for MLM. The Privacy Officer will be responsible for the development and implementation of policies and procedures relating to privacy, including but not limited to this Privacy Policy and the Company's use and disclosure procedures. The Privacy Officer will also serve as the contact person for participants who have questions, concerns, or complaints about the privacy of their PHI. The Privacy Officer may be contacted at [beckypoitras@mlmkc.org](mailto:beckypoitras@mlmkc.org), or 816.285.3149.

### **II. Incident Response Team**

The Incident Response Team is comprised of the Executive Director, VP, Resource Coordinator, and additional lead staff members deemed appropriate on an ad hoc basis in the reasonable judgment of the Privacy Officer. In the event of a security incident results in a wrongful disclosure of PHI, the Privacy Officer, in conjunction with the Incident Response Team will take appropriate actions to prevent further inappropriate disclosures. If the Privacy Officer and Incident Response Team have not resolved the incident, the Privacy Officer shall involve anyone determined to be necessary to assist in the resolution of the incident. If participants need to be notified of any lost/stolen PHI, the Privacy Officer or their designee will send PHI Theft/Loss Disclosure Letters to all possible affected individuals.

### **III. Workforce Training**

It is the Company's policy to train all members of its workforce who have access to PHI on its privacy policies and procedures. All staff members receive HIPAA training. Whenever a privacy incident has occurred, the Privacy Officer in collaboration with management will evaluate the occurrence to determine whether additional staff training is in order. Depending upon the situation, the Privacy Officer may determine that all staff should receive training that is specific to the privacy incident. The Privacy Officer will review any privacy training developed as part of a privacy incident resolution to ensure the materials adequately address the circumstances regarding the privacy incident and reinforce the Company's privacy policies and procedures.

### **IV. Safeguards**

The Company has established technical and physical safeguards to prevent PHI from intentionally or unintentionally being used or disclosed in violation of HIPAA's requirements. Technical safeguards include limiting access to information by creating computer firewalls. Physical safeguards include locking doors or filing cabinets. Additionally, all staff members can only access digital PHI by using their own login information.

Firewalls ensure that only authorized employees will have access to PHI, that they will have access to only the minimum amount of PHI necessary for their job functions, and that they will not further use or disclose PHI in violation of HIPAA's privacy rules.

### ***Data Storage / Backup / Remote Access***

Currently all data in the local data center is backed up using industry standards with off site cloud storage of media. MLM currently utilizes technology that allows the IT team to quickly remove, disable and start staff member access to PHI.

### **V. Privacy Notice**

The Privacy Officer is responsible for developing and maintaining a notice of the Company's privacy practices that describes:

- the uses and disclosures of PHI that may be made by the Company;
- the individual's rights; and
- the Company's legal duties with respect to the PHI.

The privacy notice will inform participants that the Company will have access to PHI. The privacy notice will also provide a description of the Company's complaint procedures, the name and telephone number of the contact person for further information, and the date of the notice.

The notice of privacy practices will be individually delivered to all participants:

- on an ongoing basis, at the time of an individual's enrollment into a Company program or at the time of services; and
- within 60 days after a material change to the notice.

The Company will also provide notice of availability of the privacy notice at least once every three years.

### **VI. Complaints**

The Privacy Officer will be the Company's contact person for receiving complaints. The Privacy Officer is responsible for creating a process for individuals to lodge complaints about the Company's privacy procedures and for creating a system for handling such complaints. A copy of the complaint form shall be provided to any participant upon request.

### **VII. Sanctions for Violations of Privacy Policy**

Sanctions for using or disclosing PHI in violation of this HIPAA Privacy Plan will be imposed in accordance up to and including termination.

### **VIII. Mitigation of Inadvertent Disclosures of Protected Information**

MLM shall mitigate, to the extent possible, any harmful effects that become known to it because of a use or disclosure of an Participant's PHI in violation of the policies and procedures set forth in this Plan. As a result, if an employee becomes aware of a disclosure of protected information, either by a staff member of the Company or an outside consultant/contractor that is not in compliance with this Policy, immediately contact the Privacy Officer so that the appropriate steps to mitigate the harm to the participant can be taken.

## **IX. No Intimidating or Retaliatory Acts; No Waiver of HIPAA Privacy**

No employee may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights, filing a complaint, participating in an investigation, or opposing any improper practice under HIPAA.

No individual shall be required to waive his or her privacy rights under HIPAA as a condition of services.

## **X. Plan Document**

The Plan document includes provisions to describe the permitted and required uses and disclosures of PHI by MLM. Specifically, the Plan document requires MLM to:

- not use or further disclose PHI other than as permitted by the Plan documents or as required by law;
- ensure that any agents or subcontractors to whom it provides PHI received from the Company agree to the same restrictions and conditions that apply to MLM;
- report to the Privacy Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures;
- make PHI available to Participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures;
- make the Company's internal practices and records relating to the use and disclosure of PHI received by the Company available to contracted funding partners upon request; and

## **XI. Documentation**

The Company's privacy policies and procedures shall be documented and maintained for at least six years. Policies and procedures must be changed as necessary or appropriate to comply with changes in the law, standards, requirements and implementation specifications (including changes and modifications in regulations). Any changes to policies or procedures must be promptly documented.

If a change in law impacts the privacy notice, the privacy policy must promptly be revised and made available. Such change is effective only with respect to PHI created or received after the effective date of the notice.

MLM shall document certain events and actions (including authorizations, requests for information, sanctions, and complaints) relating to an individual's privacy rights.

The documentation of any policies and procedures, actions, activities and designations may be maintained in either written or electronic form.

## ***Incident Report***

The Company has developed an Incident Report form. This form is used to document reports of privacy breaches that have been referred to the Privacy Officer from staff members who have reviewed or received the suspected incident.

After receiving the Incident Report form from staff members, the Privacy Officer classifies the incident and its severity and analyzes the situation. Documentation shall be retained by the Company for a minimum of six years from the date of the reported incident.

If the Privacy Officer is able to resolve the incident, the Privacy Officer shall also document the actions taken to resolve the issue in the Incident Report form.

## **XII. Electronic Records**

Just like paper records, Electronic Records must comply with HIPAA, and other state and federal laws. Unlike paper records, electronic records can only be accessed utilizing password protected database systems.

## **XIII. Access Authorization**

MLM will grant access to PHI based on their job functions and responsibilities.

The Privacy Officer in collaboration with IT and senior management is responsible for the determination of which individuals require access to PHI and what level of access they require through discussions with the individual's manager and or department head.

The IT department will keep a record of authorized users and the rights that they have been granted with respect to PHI. IT keeps a record of employees to whom rights are granted.

## **SECTION 2: USE AND DISCLOSURE OF PHI**

### **I. Use and Disclosure Defined**

The Company will use and disclose PHI only as permitted under HIPAA. The terms "use" and "disclosure" are defined as follows:

- *Use.* The sharing, employment, application, utilization, examination, or analysis of individually identifiable information by any person working for or within the Company, or by a Business Associate of the Company.
- *Disclosure.* For information that is protected information, disclosure means any release, transfer, provision of access to, or divulging in any other manner of individually identifiable information to persons not employed by or working within MLM with a business need to know PHI.

### **II. Access to PHI Is Limited to Certain Employees**

All staff who perform Participant functions directly on behalf of the Company or on behalf will have access to PHI as determined by their department and job description and as granted by IT.

These employees with access may use and disclose PHI as required under HIPAA but the PHI disclosed must be limited to the minimum amount necessary to perform the job function. Employees with access may not disclose PHI unless an approved compliant authorization is in place or the disclosure otherwise follows this Plan and the use and disclosure procedures of HIPAA.

Staff members may not access either through our information systems or the participant's record the and/or demographic information for themselves, family members, friends, staff members or other individuals for personal or other non-work related purposes, even if written or oral participant authorization has been given.

In the very rare circumstance when a staff member's job requires him/her to access and/or copy the information of a family member, a staff member, or other personally known individual, then he/she should immediately report the situation to his/her manager who will determine whether to assign a different staff member to complete the task involving the specific Participant.

Your access to your own PHI must be based on the same procedures available to other participants not based on your job-related access to our information systems. You cannot access your own information; you must go through all the appropriate channels as any Participant would have to.

### **III. Disclosures of PHI Pursuant to an Authorization**

PHI may be disclosed for any purpose if an authorization that satisfies all of HIPAA's requirements for a valid authorization is provided by the participant. All uses and disclosures made pursuant to a signed authorization must be consistent with the terms and conditions of the authorization.

#### **IV. Permissive Disclosures of PHI: for Legal and Public Policy Purposes**

PHI may be disclosed in the following situations without a participant's authorization, when specific requirements are satisfied. The Company's use and disclosure procedures describe specific requirements that must be met before these types of disclosures may be made. Permitted are disclosures:

- about victims-of abuse, neglect or domestic violence;
- for judicial and administrative proceedings;
- for law enforcement purposes;
- for public activities;
- for oversight activities;
- about decedents;
- for certain limited research purposes;
- to avert a serious threat to or safety;
- for specialized government functions; and
- that relate to workers' compensation programs.

#### **V. Complying With the "Minimum-Necessary" Standard**

HIPAA requires that when PHI is used or disclosed, the amount disclosed generally must be limited to the "minimum necessary" to accomplish the purpose of the use or disclosure.

The "minimum-necessary" standard does not apply to any of the following:

- uses or disclosures made to the individual;
- uses or disclosures made pursuant to a valid authorization;
- disclosures made to the Department of Labor;
- uses or disclosures required by law; and
- uses or disclosures required to comply with HIPAA.

*Minimum Necessary When Disclosing PHI.* For making disclosures of PHI to any business associate or providers, or internal/external auditing purposes, only the minimum necessary amount of information will be disclosed.

All other disclosures must be reviewed on an individual basis with the Privacy Officer to ensure that the amount of information disclosed is the minimum necessary to accomplish the purpose of the disclosure.

*Minimum Necessary When Requesting PHI.* For making *requests* for disclosure of PHI from business associates, providers or participants for purposes of claims payment/adjudication or internal/external auditing purposes, only the minimum necessary amount of information will be requested.

All other requests must be reviewed on an individual basis with the Privacy Officer to ensure that the amount of information requested is the minimum necessary to accomplish the purpose of the disclosure.

## **VI. Disclosures of PHI to Business Associates**

With the approval of the Privacy Officer and in compliance with HIPAA, employees may disclose PHI to the Company's business associates and allow the Company's business associates to create or receive PHI on its behalf. However, prior to doing so, the Company must first obtain assurances from the business associate that it will appropriately safeguard the information. Before sharing PHI with outside consultants or contractors who meet the definition of a "business associate," employees must contact the Privacy Officer and verify that a business associate contract is in place.

*Business Associate* is an entity that:

- performs or assists in performing a Company function or activity involving the use and disclosure of protected information (including claims processing or administration, data analysis, underwriting, etc.); or
- provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

*Examples of Business Associates are:*

- > A third party administrator that assists the Company with services processing.
- > A CPA firm whose accounting services to care provider involves access to protected information.
- > An attorney whose legal services involve access to protected information.
- > A consultant that performs utilization reviews for the Company.

## **VII. Disclosures of De-Identified Information**

The Company may freely use and disclose de-identified information. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. There are two ways a covered entity can determine that information is de-identified: either by professional statistical analysis, or by removing 18 specific identifiers.



18 specific elements listed below - relating to the participant, employee, relatives, or employer - must be removed, and you must ascertain there is no other available information that could be used alone or in combination to identify an individual.

1. Names
2. Geographic subdivisions smaller than a state
3. All elements of dates (except year) related to an individual - including dates of admission, discharge, birth, death - and for persons >89 y.o., the year of birth cannot be used.
4. Telephone numbers
5. FAX numbers
6. Electronic mail addresses
7. Social Security Number
8. Record numbers
9. plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Device identifiers and serial numbers
14. Web URLs
15. Internet protocol addresses
16. Biometric identifiers, including finger and voice prints
17. Full face photos, and comparable images
18. Any unique identifying number, characteristic or code

A person with appropriate expertise must determine that the risk is very small that the information could be used alone or in combination with other reasonably available information by an anticipated recipient to identify the individual. AND this person must document the methods and justification for this determination.

### **VIII. Disclosures to Family, Friends or Others-Participant Location**

There are instances when a participant's friend or family member contacts MLM to ask about the location of a client or whether the client has been seen at MLM. Following is guidance provided to assist staff in providing appropriate responses for specific situations that commonly occur. In rare cases of emergency, at the discretion of senior management the minimum of information may be released in order to assist in resolving an emergency situation.

#### ***Guidance***

**Situation: Friends or family are concerned about the whereabouts of a person. They contact the company to ask if a person is at MLM or has been seen as a participant recently.**

#### ***Response:***

If the person is not currently an MLM participant, the caller may be told that the person is not at MLM. If the person is currently receiving services, staff should take the name of the caller, their purpose for calling on behalf of the participant and tell them that they will check. Staff should then ask the participant if it is okay to provide information to the caller and what information to provide. If the client does not want the

staff to provide information, staff should tell the caller that they are unable to provide information about the participant due to privacy rights and suggest that the caller contact the participant directly for information.

If the caller is asking for historical information about visits or services provided and the participant has not either provided an authorization to share this information with this person pertaining to their involvement in the MLM program, the caller should be informed that due to HIPAA confidentiality requirements, information about participant services is not provided without participant authorization.

## **IX. Removing PHI from Company Premises**

When MLM deems it necessary for an employee to work from a location other than one of our sites, PHI may be accessed and/or removed under the following circumstances:

1. Before removing PHI from MLM for company business you must receive the approval from your supervisor.
2. MLM will only allow the paper (participant records, reports) removal of PHI when transported in a secure container/case.
3. MLM will provide laptop computers for employees to work offsite and access PHI in a non-MLM setting. Any files saved on these computers are saved to the network and are therefore secure.
4. The electronic removal of PHI (using flash drives) for the purposes of working from a non-MLM setting may be approved by a supervisor. In the very rare circumstance that it becomes necessary, the PHI should be rigorously safeguarded physically as well as electronically, including *employee-performed* encryption of all files. Most flash drives have the capability to assign a password.

5. The following safeguards are required of all employees when working from a non-MLM site:

- When outside the facility, only work on information in a **secure private environment**.
- Keep the information with you **at all times** while in transit.
- Do not permit others to have access to the information.
- Never email participant information.
- Don't save participant information to your home computer.
- Do not print records of any type.
- Do not record login information on or near the computer.
- Return all information the next business day or as soon as required.

MLM will immediately investigate any incident that involves the loss or theft of PHI that was taken off-site.

### **X. Faxing PHI**

Each fax should be accompanied by an MLM fax cover sheet. Faxing of highly confidential information is not recommended. Faxing of highly confidential information is only permitted if the sender first calls the recipient and confirms that the recipient or his/her designee can be waiting at the fax machine, and then, the recipient or his/her designee waits at the fax machine to receive the fax and then calls the sender to confirm receipt of the document. Both the sender and the recipient must be attentive to the sensitive nature of highly confidential information.

If the fax was transmitted to the wrong recipient, in all cases follow these steps:

Fax a request to the incorrect fax number explaining that the information has been misdirected and ask that the materials be returned or destroyed. Document the incident on an Incident Report Form and notify the HIPAA Privacy Officer. Verify the fax number with the recipient before attempting to fax the information again.

## **SECTION 3: PARTICIPANT INDIVIDUAL RIGHTS**

### **I. Access to Protected Information and Requests for Amendment**

HIPAA gives participants the right to access and obtain copies of their PHI that the Company or its business associates maintains. HIPAA also provides that participants may request to have their PHI amended. The Company will provide access to PHI and it will consider requests for amendment that are submitted in writing by participants.

### **II. Accounting**

An individual has the right to obtain an accounting of certain disclosures of his or her own PHI. This right to an accounting extends to disclosures made in the last six years, other than disclosures:

- to individuals about their own PHI;
- incident to an otherwise permitted use or disclosure or pursuant to an authorization;
- as part of a limited data set; or
- for other national security or law enforcement purposes.

The Company shall respond to an accounting request within 60 days. If the Company is unable to provide the accounting within 60 days, it may extend the period by 30 days, provided that it gives the participant notice (including the reason for the delay and the date the information will be provided) within the original 60-day period.

The accounting must include the date of the disclosure, the name of the receiving party, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure (or a copy of the written request for disclosure, if any).

The first accounting in any 12-month period shall be provided free of charge. The Privacy Officer may impose reasonable production and mailing costs for subsequent accountings. The Privacy Officer is responsible for responding to a request for Accounting.

### **III. Requests for Alternative Communication Means or Locations**

Participants may request to receive communications regarding their PHI by alternative means or at alternative locations. For example, participants may ask to be called only at work rather than at home. Such requests may be honored if, in the sole discretion of MLM, the requests are reasonable.

However, MLM shall accommodate such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. The Privacy Officer in collaboration with managers has responsibility for administering requests for confidential communications.

#### **IV. Requests for Restrictions on Uses and Disclosures of Protected Information**

A participant may request restrictions on the use and disclosure of the participant's PHI. It is the Company's policy to attempt to honor such requests if, in the sole discretion of the Company, the requests are reasonable. The Privacy Officer is charged with responsibility for processing requests for restrictions.

#### **V. When a Participant Requests a Copy of his/her Record**

A participant can request a copy of his/her record by completing a Request for Accessing/Inspecting/Copying Information form and submitting it to the Department that maintains the information being requested. The Department in collaboration with the Privacy Officer must process and respond to the request.

Participants can receive this form from Client Services or by going directly to the department that maintains their records.

#### **VI. Acceptable Methods of Verification of Identity for Release of Personal Information (PHI):**

*When the Requestor is the Participant*

The Company will take reasonable steps and exercise professional judgment to verify the identity of the individual making a request for access to his/her own PHI.

- a. **If the request is made in person**, verification of identity may be accomplished by asking for photo identification (such as a driver's license). A copy of the I.D. must be attached to the request and placed in the Participants record.
- b. **If the request is made over the telephone**, verification will be accomplished by requesting identifying information such as social security number, birth date, and record number and confirming that this information matches what is in the participant's record. Or, verification will occur through a callback process using phone numbers documented in the participant record to validate the caller's identity.
- c. **If the request is made in writing**, verification will be accomplished by requesting a photocopy of photo identification if a photocopy of the ID is not available, the signature on the written request must be compared with the signature in the participant record. In addition, MLM will need to verify the validity of the written request by contacting the participant by telephone.

### **VIII. When the requestor is the Participants Legally Authorized Representative**

Verification of identity will be accomplished by asking for a valid photo identification (such as driver's license) if the request is made in person. Once identity is established, authority in such situations may be determined by confirming the person is named in the record or in the participant's profile as the participant's legally authorized representative. Or, if there is no person listed in the record as the participant's legally authorized representative, authority may be established by the person presenting an original of a valid power of attorney for care or a copy of a court order appointing the person guardian of the participant and a valid photo I.D. A copy of the I.D. and legal notice must be attached to the request and placed in the Participants record.

### **IX. Other Methods**

The Company may use any other method of verification that, in the Company's discretion, is reasonably calculated to verify the identity of the person making the request. Some acceptable means of verification include, but are not limited to:

- d. Requesting to see a photo ID
- e. Requesting a copy of a power of attorney
- f. Confirming personal information with the requestor such as date of birth, or social security number
- g. Questioning a child's caretaker to establish the relationship with the child
- h. Calling the requestor back through a main organization switchboard rather than a direct number

## **PHI Breach Reporting**

The purpose of this section is to address the Company's privacy requirements for reporting, documenting, and investigating a known or suspected action or adverse event resulting from unauthorized use or disclosure of individually identifiable information.

A privacy breach is an adverse event or action that is unplanned, unusual, and unwanted that happens as a result of non-compliance with the privacy policies and procedures of the Company. A privacy breach must pertain to the unauthorized use or disclosure of information, including 'accidental disclosures' such as misdirected e-mails or faxes.

The Privacy Officer shall immediately investigate and attempt to resolve all reported suspected privacy breaches.

Staff members are required to verbally report to his/her supervisor any event or circumstance that is believed to be an inappropriate use or disclosure of a participant PHI. If the supervisor is unavailable, the staff member must notify the Privacy Officer within 24 hours of the incident. If the manager determines that further review is required, the manager and staff member will consult with the Privacy Officer to determine whether the suspected incident warrants further investigation. In all cases an Incident Report must be filled out and submitted to the appropriate reviewer.

The Privacy Officer will document all privacy incidents and corrective actions taken. Documentation shall include a description of corrective actions, if any are necessary, or explanation of why corrective actions are not needed, and any mitigation undertaken for each specific privacy incident. All documentation of a privacy breach shall be maintained with the Privacy Officer and shall be retained for at least six years from the date of the investigation. Such documentation is not considered part of the participant's record.

If the participant is not aware of a privacy incident, the Privacy Officer shall investigate the incident thoroughly before determining whether the participant should be informed. If the participant is aware of a privacy incident, the Privacy Officer shall contact the participant within three (3) business days of receiving notice of the incident. The method of contact is at the discretion of the Privacy Officer, but resulting communications with the participant must be documented in the incident report. In addition, any privacy incident that includes a disclosure for which an accounting is required must be documented and entered into accounting.

Staff who fail to report known PHI/security incidents, or fail to report them promptly, may be subject to disciplinary action up to termination.

### **I. Breach Notification Requirements**

Following a breach of unsecured protected information, covered entities must provide notification of the breach to affected individuals if necessary and in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.

- *Individual Notice*

Covered entities must notify affected individuals following the discovery of a breach of unsecured protected information. Covered entities must provide this individual notice in written form by

first-class mail, or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. If the covered entity has insufficient or out-of-date contact information for 10 or more individuals, the covered entity must provide substitute individual notice by either posting the notice on the home page of its web site or by providing the notice in major print or broadcast media where the affected individuals likely reside. If the covered entity has insufficient or out-of-date contact information for fewer than 10 individuals, the covered entity may provide substitute notice by an alternative form of written, telephone, or other means.

These individual notifications must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include, to the extent possible, a description of the breach, a description of the types of information that were involved in the breach, the steps affected individuals should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity. Additionally, for substitute notice provided via web posting or major print or broadcast media, the notification must include a toll-free number for individuals to contact the covered entity to determine if their protected information was involved in the breach.

- *Media Notice*

Covered entities that experience a breach affecting more than 500 residents of a State or jurisdiction are, in addition to notifying the affected individuals, required to provide notice to prominent media outlets serving the State or jurisdiction. Covered entities will likely provide this notification in the form of a press release to appropriate media outlets serving the affected area. Like individual notice, this media notification must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include the same information required for the individual notice.

- *Notice to the Secretary*

In addition to notifying affected individuals and the media (where appropriate), covered entities must notify the Secretary of breaches of unsecured protected information. Covered entities will notify the Secretary by visiting the HHS web site and filling out and electronically submitting a breach report form. If a breach affects 500 or more individuals, covered entities must notify the Secretary without unreasonable delay and in no case later than 60 days following a breach. If, however, a breach affects fewer than 500 individuals, the covered entity may notify the Secretary of such breaches on an annual basis. Reports of breaches affecting fewer than 500 individuals are due to the Secretary no later than 60 days after the end of the calendar year in which the breaches occurred.

- *Notification by a Business Associate*

If a breach of unsecured protected information occurs at or by a business associate, the business associate must notify the covered entity following the discovery of the breach. A business associate must provide notice to the covered entity without unreasonable delay and no later than 60 days from the discovery of the breach. To the extent possible, the business associate should provide the covered entity with the identification of each individual affected by the breach as well as any information required to be provided by the covered entity in its notification to affected individuals.



## II. Complaint/Concerns Reporting

Concerns about the Company's privacy practices may arise in a variety of contexts and may be received by many different persons at the Company. It is important that the Company responds to concerns and complaints in a timely manner. When a staff member hears or receives a complaint/concern, he/she should ask the complainant whether or not the complainant wishes to file a formal complaint and offer to assist the complainant with the form. Even if the person does not wish to file a complaint or provide identifying information, the staff member should proceed with the procedures outlined below.

### *Filing a Complaint*

**a. Participant's** complaints of alleged privacy rights violations may be forwarded through multiple channels, such as telephone calls, letter via mail/email, in person. If these complaints are received by a staff member the person receiving the complaint will:

- In response to a Telephone Call or In-Person Request to File a Complaint – Complete the Privacy Complaint Form and immediately forward to the Privacy Officer. Offer to forward a copy of the complaint form to the complainant.
- In response to a Letter or Email (print out) – Complete the Privacy Complaint Form and immediately forward to the Privacy Officer. Attach the written complaint to the complaint form.
- In response to an Anonymous Complaint– Complete the Privacy Complaint Form based on the information provided and immediately forward to the Privacy Officer. When possible, explain to the complainant that the Company has an obligation to follow up on complaints whether or not they are anonymously filed.

**b. Staff Members** – Call the Privacy Officer at (925) 201-6038. Staff members may also complete the Privacy Complaint Form and forward to the Privacy Officer. Staff members can also fill out the complaint form and put it in the Privacy Officers mail box located at 4361 Railroad Avenue, Suite E. Upon receipt of a complaint, the Privacy Officer will initiate primary investigation.

- **Initial review** – All complaints will be initially reviewed by the Privacy Officer or his/her designee to determine if the complaint alleges a violation of established policies and procedures or other known regulations regarding the protection of individually identifiable information. If there is no legitimate allegation, the Privacy Officer will, when possible, contact the Complainant by letter and inform him/her of this finding within 60 days. All documentation will be maintained as prescribed in this policy.
- **Complaints requiring further review** – If there is a legitimate allegation, the Privacy Officer or his/her designee will conduct a detailed investigation by reviewing the covered University unit practices, contacting employees, students, or volunteers as needed, working with the Security Officer (as applicable), and utilizing other University resources as needed. Upon conclusion of the investigation, the Privacy Officer will, when possible, contact the Complainant by letter and inform him/her of the finding within 60 days.

**c. 60-day time frame** – In the event that this 60-day period cannot be met, the Privacy Officer shall, when possible, communicate this determination to the Complainant in writing and include an estimated timeframe for completion of the investigation.

**d. Outcome of Investigation** - The purpose of the investigation is to determine the compliance of the Company's policies and procedures implementing the privacy standards mandated by HIPAA. The Company will mitigate, to the extent practicable, any harmful effect that is known of a use or disclosure of PHI in violation of the Company's policies and procedures or HIPAA's privacy requirements by the Company or any of its Business Associates. In the event that disciplinary action is recommended, the Privacy Officer or his/her designee will coordinate any action with management.

**e. Documentation** - All complaints sent to the Privacy Officer shall be documented in a format that includes all of the information contained on the Privacy Complaint Form. The Privacy Officer will maintain all completed complaints' documentation for six years from the initial date of the complaint.

### **III. Non-Retaliation**

The Company shall not intimidate, threaten, coerce, discriminate against, or take any other form of retaliatory action against any person who has reported a privacy incident.

## Summary Guidelines for Safeguarding the Privacy of Information

These are guidelines centered on how to safeguard information and ensure confidentiality when using normal business communications, such as conversations, telephone, faxes, mail, and electronic mail. Wherever practical, the material containing Protected Information (PHI) should be labeled as confidential on the document, diskette, CD, or other medium. PHI maintained electronically should be password-protected in all media.

Also, when using and disclosing PHI, you must take reasonable measures to ensure the information is protected. Below are simple safeguarding tasks that should be used when communicating in a work environment that necessitates access to and use and disclosure of PHI. Remember to limit your communications of PHI to the minimum necessary for the intended purpose. Restrict your communications to those who have a valid "need to know" the information. If you have questions about these safeguards and how to protect PHI communications, please discuss them with your supervisor.

### **Oral Conversations – in person**

- Discuss participants PHI in private. Use an office with a door whenever possible or leave areas where others can overhear.
- Be aware of those around you and lower your voice when discussing participants information.
- If possible, point out information on paper or on-screen non-verbally when discussing participants information.

### **Oral Conversations - telephone**

- Follow the above guidelines for "Oral Conversations"-in person"
- Don't use names instead say; "I have a question about a client".
- Never give PHI over the phone when talking to unknown callers but call back and verify information.
- Never leave PHI on voice messages; instead leave a message requesting a return call to discuss a participant giving only your name and phone number.
- Do not discuss PHI over unencrypted cellular or portable (wireless) phones or in an emergency, as the transmissions can be intercepted.

### **Fax**

- Put fax machines in a safe location, not out in the open or in a public or area with high-traffic or easy access and visibility.
- Use a cover sheet clearly identifying the intended recipient and include your name and contact information on the cover sheet.
- Include a confidentiality statement on the cover sheet of faxes that contain PHI.
- Do not include or reference PHI on cover sheet.
- Confirm fax number is correct before sending.
- Send fax containing participant information only when the authorized recipient is there to receive it whenever possible.
- Verify that fax was received by authorized recipient; check the transmission report to ensure correct number was reached and when necessary contact the authorized recipient to confirm receipt.
- Deliver received faxes to recipient as soon as possible. Do not leave faxes unattended at fax machine.

### **Email**

- Do not include PHI in Subject-line or in Body of email.
- Transmit PHI only in a password-protected attachment (MS Word and MS Excel provide password protection).
- Include a confidentiality statement on emails that contain any PHI in email attachments.
- Do not send attachment passwords in the same email as the attachment.
- Include your contact information (name and phone number minimum) as part of the email.
- Set email sending options to request an automatic return receipt from your recipient(s).
- Request that email recipients call to discuss specific participant data.
- Do not store emails or email attachments with PHI on your hard drive but copy and store to a secure server. Delete the email and the attachments when they are no longer needed.

### **Courier and Regular Mail**

- Use sealed secured envelopes to send PHI.
- Verify that the authorized person has received the package.
- Deliver all mail promptly to the recipient.
- Mailboxes must be in safe areas and not located in public or high-traffic areas.

### **Inter-Office Mail**

- Put PHI in closed inter-office envelopes. As an added precaution, put PHI in a sealed envelope inside the inter-office envelope.
- Identify recipient by name and verify mail center address.
- Distribute inter-office mail promptly to recipients. Do not leave unattended in mailboxes.
- Where practical, use lockable containers (e.g. attaches) to transmit correspondence that contains participant PHI.

### **Computer Workstations**

- Use password protected screen savers, turn off the computer, or log out of the network when not at your desk.
- Position screens so they are not visible to others.
- Secure workstations and laptops with password.
- Change passwords on a regular basis.
- Do not leave laptop or work-related participant PHI visible or unsecured in a car, home office, or in any public areas.
- Ensure that all PHI used outside work premises is protected using appropriate measures such as locked desks, file cabinets.
- Never remove original copies of PHI from the agency without your supervisor's approval for specific purposes.
- Store files that contain PHI on a secure server, not on your workstation hard drive.

### **Disposal of PHI**

- Shred all hard copies containing PHI when the copies are no longer needed.
- Place hardcopies to be recycled in locked recycle bins if available.
- Delete all soft copy files containing PHI from your computer and from the server when the information is no longer needed within the record retention requirements.
- Destroy all disks, CDs, etc., that contained PHI before disposing them.
- Do not reuse disks, CDs that contained PHI without sanitizing them first.
- Contact IT before transporting or transferring equipment for proper procedures to move equipment and to sanitize hard drives and other media.
- Return the PHI to the sender, if this requirement is stipulated in any contractual agreements.

### **Work Areas**

- Do not leave PHI (files, records, Rolodex, reports) exposed, open, or unattended in public areas, conference rooms, mailboxes, wall trays, etc.
- Store all PHI securely in locked file cabinets, desk drawers, offices, or suites when you are not in your work area.

**THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**Our pledge to protect your privacy:**

MLM is committed to protecting the privacy of your information. Your care and treatment is recorded in a record. So that we can best meet your needs, we share your record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern care. We will not use or disclose your information for any other purpose without your permission.

**Participant Rights - You have the following rights regarding your information:**

- to request to inspect and obtain a copy of your records, subject to certain limited exceptions;
- to request to add an addendum to or correct your record;
- to request an accounting of MLM's disclosures of your information;
- to request restrictions on certain uses or disclosures of your information;
- to request that we communicate with you in a certain way or at a certain location;
- and to receive a copy of the full version of our Notice of Privacy Practices.

**We may use and disclose information about you for the following purposes:**

- to provide you with services;
- to bill and receive payment for the services you receive;
- for functions necessary to run MLM and assure that our participants receive quality services;
- to provide basic contact information (no information is provided) to our development office for purposes of fundraising for MLM;
- and as required or permitted by law.

**There are additional situations where we may disclose information about you without your authorization, such as:**

- for workers' compensation or similar programs;
- for public activities (e.g., reporting abuse or reactions to medications);
- to a oversight agency, such as Mid-America Regional Council;
- in response to a court or administrative order, subpoena, warrant or similar process;
- to law enforcement officials in certain limited circumstances.
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*Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices, your rights regarding your information, and pertinent contact information.*