COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR UCLA MEDICAL CENTER

SUBJECT: MITIGATION **POLICY NO. 724**

PURPOSE:
To establish a policy and procedure for mitigating harmful effects as a result of Use and Disclosure of Protected Health Information (PHI) by workforce members or Business Associates.

POLICY:
It is the policy of Department of Health Services (DHS)/Harbor-UCLA Medical Center to mitigate, to the extent practicable, any harmful effects that are known to it, which arise out of the Use or Disclosure of Protected Health Information ("PHI") by either members of its Workforce or its Business Associates in Violation of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 ("HIPAA Privacy Standards") or the Hospital's policies and procedures to implement HIPAA ("HIPAA Policies").

DEFINITIONS:
Business Associate Contract means the contract language between DHS/Harbor-UCLA Medical Center and its Business Associates that allows the Business Associate to create or receive PHI on behalf of DHS. The term "Business Associate Contract" includes both stand-alone contracts and amendments to existing services agreements, as well as Business Associate Contract language that is part of a new services agreement. A Business Associate Contract is not required for Disclosures by Harbor-UCLA Medical Center to a Health Care Provider regarding an individual's Treatment.

Disclose* or *Disclosure means, with respect to PHI, the release of, transfer of, provision of access to, or divulging in any manner of PHI outside of Harbor-UCLA Medical Center's internal operations or to other than its Workforce Members.

Protected Health Information *(PHI)* means information that (1) is created or received by a Health Care Provider, Health Plan, employer or Health Care Clearinghouse; (2) relates to the past, present or future physical or mental health or condition of an individual; the provision of Health Care to an individual, or the past, present or future Payment for the provision of Health Care to an individual; and (3) identifies the individual (or for which there is a reasonable basis for believing that the information can be Used to identify the individual). PHI does not include employment records maintained by Harbor-UCLA Medical Center's personnel files in its role as employer.

EFFECTIVE DATE: 04/14/03 **SUPERSEDES:**
REVISED:
REVIEWED: 12/08, 03/14, 07/17
REVIEWED COMMITTEE: N/A

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Patricia Soltero Sanchez, RN, BSN, MAOM
Chief Nursing Officer

Signature(s) on File.

Use or Uses means, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such information within Harbor-UCLA Medical Center's internal operations.

Violation means a violation of Harbor-UCLA Medical Center's Privacy-Related Policies or any of the provisions of HIPAA. The term Violation does not include Disclosures by Whistleblowers or Disclosures by Workforce Crime Victims, as defined in DHS Policy No. 361.25, "Disclosures of Protected Health Information by Whistleblowers and Workforce Crime Victims".

Workforce* or *Workforce Member means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for Harbor-UCLA Medical Center, is under its direct control, whether or not they are paid by Harbor-UCLA Medical Center.

PROCEDURE:

I. REPORTS OF SUSPECTED VIOLATIONS

A. All reports of suspected Violations of Harbor-UCLA Medical Center's (HUCLA) Privacy-Related policies or of the HIPAA Privacy Standards by a Workforce Member or a Business Associate shall be forwarded immediately to Harbor-UCLA Medical Center's Privacy Coordinator in Building D3.5.

B. The HUCLA's Privacy Coordinator or designee, shall promptly conduct an investigation of the alleged Violation and, as part of that investigation, shall document any Violation (s) discovered and any resulting harmful effects of those Violations of which she knows.

C. The HUCLA's Privacy Coordinator and the DHS Privacy Officer, in consultation with the Department of Human Resources and County Counsel as deemed appropriate, shall take steps, as reasonably practicable, to mitigate the harmful effects of such Violation to the individual whose PHI is at issue. Such steps may include, but are not limited to, imposing disciplinary actions against Workforce Members in accordance with the DHS Policy No. 361.10, "Disciplinary Actions for Failure to Comply with Privacy Policies and Procedures" and DHS Policy No. 747, "Disciplinary Action". To the extent that the individual harmed is aware of harm, such as when the individual initiated a complaint, the HUCLA Privacy Coordinator and/or the DHS.

Privacy Officer shall discuss any purposed mitigation with the individual in accordance with DHS Policy No. 361.11, "Complaints Related to the Privacy of Protected Health Information (PHI)". If the individual is not aware of the harm, the

general practice should be to inform the individual of the harm and to discuss options for Mitigation. [1] However, in unusual circumstances where it seems that informing the individual of the harm could be more harmful than helpful to the individual, County Counsel should be consulted for a recommendation.

D. The HUCLA Privacy Coordinator shall document all actions taken under this Policy.

E. When the Violation was caused by a Business Associate, the contract shall be reviewed for possible indemnification or other form of recovery against the Business Associate, at least as to the costs of mitigation.

II. REVIEW OF COMPLAINTS AND AUDITS

A. Violations identified through the HUCLA Privacy Coordinator's review of all privacy-related complaints shall be analyzed for mitigation according to this Policy.

B. Violations identified through the HUCLA Privacy Coordinator's review of internal audit reports shall be analyzed for mitigation according to this Policy.

C. The Privacy Officer shall take steps, as reasonably practicable, which may include, but not be limited to, the actions identified in Section 1.C, above, to mitigate any harmful effects of Violations discovered pursuant to this Section 2.

III. DOCUMENT RETENTION

All documents required under this policy shall be maintained for at least six (6) years.

REFERENCES:

45 Code of Federal Regulations. § 164.530(f)
DHS Policy No. 361.10, "Disciplinary Action for Failure to Comply with Privacy Policies and Procedures"
DHS Policy No. 361.11, "Complaints Related to the Privacy of Protected Health Information (PHI)"
DHS Policy No. 361.25, "Disclosures of Protected Health Information by Whistleblowers and Workforce Crime Victims"
DHS Policy No. 747, "Disciplinary Action"

[1] NOTE: HIPAA does not explicitly require that the harmed individual be informed of the harm. Because it seems unlikely that "silent" mitigation would be deemed sufficient mitigation, at least in many cases, this section recommends informing the harmed individual. However, again, this is not an explicit HIPAA requirement. More guidance may come in this area with the eventual release of the enforcement regulations.