LAC+USC MEDICAL CENTER POLICY

Subject: PROTECTED HEALTH INFORMATION: MITIGATION	Original Issue Date: 4/14/03	Policy # 400.7
	Supersedes: 11/12/13	Effective Date: 5/9/17

Departments Consulted:	Reviewed & Approved by:	Approved by:
Risk Management Human Resources Health Information Management HIPAA Compliance Office Health Information Committee	Attending Staff Association Executive Committee Senior Executive Council	Chief Medical Officer Chief Executive Officer

PURPOSE

To establish a policy for mitigating harmful effects as a result of use and disclosure of protected health information by workforce members or business associates.

POLICY

It is the policy of LAC+USC 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 (HIPAA), 45 Code of Federal Regulations Parts 160 and 164 (HIPAA Privacy Standards), the Department of Health Services' (DHS) policies and procedures, or those of the Medical Center, for the implementation of HIPAA.

DEFINITIONS

Protected Health Information (PHI) Information that is created or received by a health care provider, health plan, employer, or health care clearinghouse; 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 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 in personnel files by the Medical Center in its role as employer.

Business Associate Contract The contract language between the Medical Center and its business associates that allows the business associate to create or receive PHI on behalf of the Medical Center. This term includes both stand-alone contracts and amendments to existing service agreements, as well as, business associate contract language that is part of a new service agreement. A business associate contract is not required for disclosures by the Medical Center to a health care provider regarding an individual's treatment.

Disclose or Disclosure — With respect to PHI, the release of, transfer of, provision of access to, or divulging in any manner PHI outside of the Medical Center's internal operations or to other than its workforce members.

Use or Uses — With respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such information within the Medical Center's internal operations.

Violation — A violation of DHS or Medical Center privacy-related policies or any of the provisions of HIPAA. The term does not include disclosures by whistleblowers or disclosures by workforce crime victims, as defined in the DHS Policy No. 361.25, "Disclosures of Protected Health Information by Whistleblowers and Workforce Crime Victims."

Workforce or Work-force Members — Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the Medical Center, is under the direct control of the Medical Center, whether or not they are paid by the County.

PROCEDURE

Reports of Suspected Violations

A. All reports of suspected violations of DHS or Medical Center privacy related policies or of the HIPAA Privacy Standards by a workforce member or business associate shall be forwarded immediately to the Medical Center HIPAA Compliance Office.

B. The Medical Center HIPAA Compliance Office shall promptly conduct an investigation of the alleged violation and, as part of that investigation, shall document any violation(s) discovered and any known harmful effects caused as a result of those violations.

C. The Medical Center HIPAA Compliance Office will forward all reports of suspected violations and investigation findings to the DHS Privacy Officer in accordance with DHS Policy No. 361.26.

Document Retention

The HIPAA Compliance Office shall maintain all documents required under this policy for at least six (6) years.

REFERENCES

45 Code of Federal Regulations § 164.530(f)
DHS Policy No. 361.26, "Mitigation"

REVISION DATES

April 10, 2007; September 25, 2008; November 12, 2013; May 9, 2017