LOS ANGELES COUNTY **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: INVESTIGATION AND NOTIFICATION OF COMPLAINTS OR ALLEGED VIOLATIONS OF PROTECTED HEALTH INFORMATION (PHI)

POLICY NO: 728

PURPOSE:
To establish a process for the investigation and notification of complaints involving alleged inappropriate access, or unauthorized use or disclosure of Protected Health Information (PHI) at Harbor-UCLA Medical Center.

POLICY:
It is Harbor-UCLA Medical Center's policy to protect the privacy of PHI in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), and other applicable state and federal laws, as well as Los Angeles County Department of Health Services and Harbor-UCLA Medical Center's policies and business practices. All complaints or suspected violations related to the privacy or security of PHI will be investigated and resolved. Workforce members who violate the HIPAA Privacy Rule, State law, Los Angeles County Department of Health Services, and/or Harbor-UCLA Medical Center's policies and procedures will be subject to disciplinary action, up to and including discharge.

Harbor-UCLA Medical Center's Workforce Members are required to immediately report privacy or security breaches involving PHI or confidential information to their supervisor or to the Facility Privacy Coordinator. In accordance with California Health and Safety Code, Section 1280.15, upon determination that inappropriate access to or unauthorized use or disclosure of a patient's health information has occurred, the facility will report the identified breach of information to the patient and the California Department of Public Health, State Licensing and Certification Division within five (5) calendar days.

Complaints may be filed against Harbor-UCLA Medical Center's members, and/or members of Harbor-UCLA Medical Center's business associates' workforce for violations of Harbor-UCLA Medical Center's policy and procedure. Complaints and allegations of privacy-related violations may be reported anonymously through the County or DHS Fraud Hotline; however, anonymous complaints that do not contain sufficient detail may delay, hinder, or prevent a full investigation. As appropriate, Harbor-UCLA Medical Center will keep the complainant(s) informed of the complaint investigation and resolution.

Harbor-UCLA Medical Center may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against its Workforce, including whistleblowers and patients or their representatives, for exercising their rights under HIPAA, or for filing a HIPAA report or complaint.

EFFECTIVE DATE: 04/03 **SUPERSEDES:**
REVISED: 10/09, 03/14
REVIEWED: 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.

Workforce members who file a complaint in good faith shall not be subject to disciplinary action or retaliation, as provided for in DHS Policy 361.25, *Disclosures of PHI by Workforce Members or Workforce Crime Victims*.

GUIDELINES:

1. Complaints or allegations of HIPAA/privacy violations can include, but are not limited to, complaints filed by individuals (e.g., patients, visitors, or Workforce Members) concerning:

   - Potential violation of Harbor-UCLA Medical Center's privacy or security policies and procedures
   - Disagreement with Harbor-UCLA Medical Center's privacy or security policies and procedures
   - Suspected inappropriate access or unauthorized use, disclosure, or disposal of their PHI
   - Denial of access to their PHI
   - Denial of amendments to their PHI
   - Retaliatory or threatening behavior
   - Any other non-compliance with the requirements of the HIPAA

   Additionally, potential privacy violations may be identified by the Facility or Program through audits, incident reports, or other oversight activities.

2. Disclosures by Whistleblowers/Workforce Members. Harbor-UCLA Medical Center will not be considered to have violated the HIPAA Privacy Regulations when a whistleblower/workforce member discloses PHI provided that:

   - The workforce member or business associate believes in good faith Harbor-UCLA Medical Center has engaged in unlawful conduct or otherwise violated professional or clinical standards, or that care, services, or conditions provided by Harbor-UCLA Medical Center potentially endangered one or more patients, workers, or the public; and

   - The disclosure is to:
     i. A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of Harbor-UCLA Medical Center or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by Harbor-UCLA Medical Center; or

     ii. An attorney retained by or on behalf of the Workforce member or business associate for the purpose of determining the legal options of the Workforce member or business associate with regard to the conduct described in this section.

DEFINITIONS:

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 an individual other than a member of its workforce.

Complaint Form is the document to be completed that contains initial information about a privacy-related complaint.

Privacy Breach is defined as any unlawful or unauthorized access to and/or use or disclosure of a patient's protected health information in any format (e.g., spoken, printed, or electronic).

Protected Health Information *("PHI")* means 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) i.e., patient name and medical record number. PHI does not include employment records maintained by Harbor-UCLA Medical Center's personnel files in its role as employer.

PROCEDURE:

I. Receipt and Documentation of Complaints

All Complaints or alleged violations of PHI received by the facility will be processed through the Facility Privacy Coordinator.

A. Complaints filed through the facility's official complaint/grievance process (ATTACHMENT B):

1. The Facility Complaint Coordinator will receive and document privacy-related complaints using the facility Complaint Form (ATTACHMENT A), in accordance with the facility's complaint/grievance policy; and

2. Immediately forward all HIPAA/privacy related complaints received to the Facility Privacy Coordinator for investigation, Bldg N-6, ext. 8049.

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B. Complaints received by the Facility Privacy Coordinator, allegations of suspected privacy violations made by a Workforce Member, or suspected privacy violations identified through internal audit or review:

1. The Workforce Member or supervisor shall immediately report the allegation or suspected violation to the Facility Privacy Coordinator for investigation.

C. The Facility Privacy Coordinator will initiate a Privacy Complaint Investigation Report. (ATTACHMENT C).

II. Investigation and Notification of Complaints or Suspected Privacy Violations

The Facility Privacy Coordinator is responsible for initiating the investigation into all suspected privacy-related violations.

A. Investigation of suspected privacy or security violations identified through internal facility audit activities, incident reports, other oversight activities, or reported by a Workforce member must be initiated within five (5) calendar days of receipt of the initial complaint/report (ATTACHMENT A).

B. The Facility Privacy Coordinator shall:

1. Contact the Complainant, as necessary, to obtain any additional information needed to conduct the investigation.

2. Conduct an investigation, including identifying and interviewing individuals who are or may be in possession of relevant information, to develop a record of the facts and circumstances surrounding the complaint.

3. Document the findings on the Privacy Complaint Investigation Report and, upon the conclusion of the investigation, review the investigation and findings with the DHS Privacy Officer/designee.

4. If it is determined during the course of the investigation that a privacy breach has occurred, the facility must provide notification to the patient(s) and the State Department of Public Health within five (5) calendar days from the date of detection.

5. Notify the complainant in writing of the status of the investigation if the investigation cannot be concluded within 30 business days.

6. Refer any unresolved privacy-related complaints to the DHS Privacy Officer/designee.

III. Response to Complainant and Corrective Action

A. Upon completion of the investigation, the Facility Privacy Coordinator shall:

1. Contact the Complainant, in writing, within 30 business days regarding the findings and disposition of the complaint.

2. Initiate any corrective actions that may be required to address either the confirmed breach or other issues that may have been identified through the investigation.

B. The DHS Privacy Officer/designee will conduct a review of any referred issues and resolve privacy-related disputes if needed. Upon closure of the matter, the DHS Privacy Officer/designee will provide the results to the Facility Privacy Coordinator for placement in the complaint file.

C. The DHS Privacy Officer/designee will escalate to the County Chief Privacy Officer any issues that he/she cannot resolve.

IV. Reporting Complaint Investigations

The Facility Privacy Coordinator will report all complaint investigations to the DHS Privacy Officer/designee on a quarterly basis for use in identifying trends and potential area requiring corrective action. The DHS Privacy Officer/designee will track the handling and disposition of privacy-related complaints and corrective actions, and submit a HIPAA Complaint report to the County Chief Privacy Officer quarterly.

A. The DHS Privacy Officer/designee will monitor to ensure appropriate corrective actions are taken to address each privacy violation.

B. All documentation shall be maintained for six (6) years, as required by law.

REFERENCES:

45 Code of Federal Regulations: 45 C.F.R. § 164.530(d)
California Health and Safety Code, Section 1280.15
California Civil Code, Section 56.36
California Health and Safety Code, Division 109
Administrative Penalties and Patient Information, Chapter 605, Statutes of 2008
Harbor-UCLA Policy No. 729 "Disciplinary Actions for Failure to Comply with Privacy Policies and Procedures"

Sample Complaint Form

If you have questions, comments or concerns regarding how we protect your privacy, please complete this form and send it to_____. If you prefer to speak directly with a representative, please call our Facility Complaint Coordinator at _____.

1. Name of person submitting this Form:

   MIS Number/Date of Birth: _____

2. Name of person whose privacy is involved (if different from the above):

3. Street address:

4. Town, Country and Zip code:

5. Phone Number(s):

6. E-mail Address (optional):

7. A brief summary of your privacy-related question or complaint:

_____
_____
_____
_____
_____

8. Please provide a detailed description of the issue, including date(s) of important event(s), the type(s) of information involved, and the name(s) of any employees you believe were involved or who may have information about the issues. Please use additional pages as necessary, and attach any relevant documents:

9. Please describe your desired resolution of this matter:

10. Date Complaint Form Completed:

Sample Complaint Handling Procedure

The following Complaint Handling Procedure will be explained to the Complainant, as requested.

Step 1: Complete and submit the Complaint form.

Step 2: Receive a communication within four (4) business days from us acknowledging receipt of your complaint. (We are assuming three (3) business days for mail delivery, for this Step and for step 3).

Step 3: Receive a communication from the DHS facility Privacy Coordinator assigned to investigate your concern within eight (8) business days of the day you receive the communication from the facility acknowledging receipt of your complaint.

Step 4: The facility will conduct an investigation into your complaint. During this process, you may receive additional communications from the DHS Facility Privacy Coordinator.

Step 5: The DHS Facility Privacy Coordinator will contact you within thirty (30) business days from the date he or she first contacted you to discuss a proposal resolution to your concern. If you agree with the proposed resolution, then you and the DHS Facility Privacy Coordinator will work together to close the matter. If you do not agree, then the matter will be escalated to the DHS Privacy Officer.

Step 6: The DHS Privacy Officer will take steps to resolve the matter. Within thirty (30) business days of the escalation, the Privacy Officer will contact you to propose a resolution.

Step 7. If you agree to the resolution, then you will work with the DHS Privacy Officer to close the matter.

Step 8. If you and the DHS Privacy Officer do not agree to resolution, we will take the matter to the County's Chief Information Privacy Officer for resolution.

If you have any questions, please contact the DHS Facility Privacy Coordinators at _____.

Harbor – UCLA Medical Center
Privacy Complaint Investigation Report

Complaint#_____

Date Complaint Received: _____ Complaint Received By: _____

Complainant:

Last Name First MI Street Address Apt#

Phone Number City Zip Code

Type of Complaint:

- ☐ Disagreement with DHS privacy policies and procedures
- ☐ Suspected violation in the use, disclosure or disposal of their PHI
- ☐ Denial of access to their PHI
- ☐ Denial of amendment to their PHI
- ☐ Retaliatory or intimidating actions
- ☐ Other

Summary of Complaint:

_____
_____
_____
_____
_____

Date Complaint Received _____ Privacy Coordinator _____

Summary of Results and Disposition of Investigation:

_____
_____
_____
_____
_____

Action Taken:

_____
_____
_____
_____

Date Complaint Resolved: _____ Date Report Sent to P.O.:_____

DHS Privacy Office

Date Report Sent to CIPO: _____ Date Investigation Closed: _____