Annual HIPAA Privacy & Security

Please note that this is not interactive and for reading purposes only. The test is a separate document.

Introduction

Welcome to Annual HIPAA Privacy & Security. In this course, you will learn how to keep patient information secure.

After you successfully complete this course, you should be able to:

- Recognize that privacy and security of sensitive information is your responsibility.
- Identify situations where sensitive information may be handled improperly.
- Identify how you can protect patient and confidential information in common workplace situations.
- Recognize that you will be held responsible for improperly handling sensitive information.
- Determine who to notify if you have questions about the privacy and security of sensitive information.

Once you complete this course, you will take an assessment. If you pass the assessment with 80% or higher, you have successfully completed this course.
Training Overview

This training and some of the examples are oriented toward Wexner Medical Center (OSUWMC), but the requirements detailed in this training apply to all covered components at The Ohio State University.

**Audience:** Faculty, staff, and students who access protected health information at OSUWMC and other parts of the University.

**Prerequisites:** None

**Course Length:** You should be able to complete this course in about 30 minutes.

**Revised:** August 2016

Ohio State University’s Expectations of Employees

Learn about what The Ohio State University expects everyone to do.

Remember you may only access information that is needed to perform your job duties. Failure to do so will result in corrective action up to and including termination. Your activity on your EMR may be audited to determine if you have a business need to review a particular patient’s medical record.
Ohio State University's Expectations of Employees

Click each image below to learn about what The Ohio State University expects everyone to do.

- Protect Patient Information.
- Protect other information such as employee information.
- Follow the University’s and OSUWMC’s privacy and security policies as applicable.

Remember you may only access information that is needed to perform your job duties. Failure to do so will result in corrective action up to and including termination. Your activity on your EMR may be audited to determine if you have a business need to review a particular patient’s medical record.

ABC’s of HIPAA Privacy and Security

The Ohio State University is committed to compliance with HIPAA. As faculty, staff, and students who access protected health information at OSUWMC and other parts of the University, you must:

- Take your responsibility to protect a patient’s privacy very seriously.
- Acknowledge that violations of the applicable policies and procedures related to privacy and security are subject to discipline up to and including termination.

The ABC’s of HIPAA privacy and security are covered in the next three lessons. They include:

- Awareness of patient rights and responsibilities.
- Breach of protected health information.
- Common questions.
Definition of Identity Theft

Identity theft occurs when someone uses another person’s identifying information without permission.

The Ohio State University Wexner Medical Center:

- Prevents
- Detects
- Reduces

the harmful effects of identity theft.

Examples of Identifying Information:

- Name
- Social Security Number
- Medical Insurance Number
- Credit Card Number
- OSU/WMC Badge with Payroll Deduct

Identity Theft Red Flags

An Identity Theft Red Flag is a pattern, practice or specific activity that indicates the possible existence of identity theft.

Examples of identity theft red flags are:

- Records showing medical treatment that is inconsistent with a physical examination.
- Identification that appears to be altered or forged.
- Complaints or questions from a patient about information added to a credit report.
- Patient receives a:
  - Bill for another patient.
  - Bill for a product or service the patient did not receive.
  - Notice of insurance benefits or Explanation of Benefits for health care services never received.
  - Collection notice from a collection agency for services the patient never received.
Identity Theft: Your Responsibility

Learn about your responsibilities regarding identity theft.

[Images of lock, security camera, card]

THE OHIO STATE UNIVERSITY
HIPAA stands for Health Insurance Portability and Accountability Act. It is a federal law that requires organizations which provide health care services, such as The Ohio State University, to:

- Follow certain rules when we use and release patient information.
- Keep patient information private, confidential, safe and accurate.

What is a Hybrid Entity Under HIPAA?

HIPAA allows for large institutions to designate parts that must follow HIPAA called “covered components.” This way, only the parts of the institution that meet certain criteria must follow HIPAA.

At The Ohio State University, only the designated health care components and a few other areas must follow HIPAA. In this training, we refer to these special units as “the University.” These health care components include:

- The Medical Center,
- OSUP,
- College of Dentistry,
- College of Optometry,
- and others.

If you work in a health care component of the University, you help a covered component do their work, you perform research using information from a covered component, or you have access to protected health information from a covered component, this training applies to YOU.

http://compliance.osu.edu/HIPAAprivacyITsecurity.pdf
HIPAA Privacy

We must protect an individual’s Protected Health Information (PHI) that is:

- Created
- Maintained
- Filed
- Used
- Shared

And is:

**Written**

**Spoken**

**Electronic**

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HIPAA and Patients’ Rights

Patients have the right to:

- Review and request a copy of their own medical and billing records
- Ask for an amendment to their records
- Receive a paper copy of the notice of privacy practices
- Review an accounting of disclosures
- Request a restriction on how their PHI is used or disclosed

**Examples of Protected Health Information (PHI) are:**

- A patient’s name, address, birth date, age, phone and fax numbers, e-mail address
- Medical record numbers
- Medical records, diagnoses, x-rays, photos, prescriptions, lab work and test results
- Billing records, claim data, referral authorizations and explanation of benefits
- Certain research records
- Identifiable patient photos (i.e., photos that include the patient’s face)
Recent Changes to HIPAA

In 2013, the HIPAA laws changed. Be informed of the changes.

There were many changes to the HIPAA laws in 2013:

- The university must now honor a patient’s request for us to restrict information that goes to their insurance company if the patient has paid out of pocket in full for their care.
- OSUWMC updated its Notice of Privacy Practices to comply with the new laws. Check out the new NPP here: [Joint Notice of Privacy Practices](#).
  - Please contact your privacy officer for specific information regarding the Notice of Privacy Practices for your unit.
- The university updated its business associate agreements.
- The university must notify patients in the event of a Reportable Breach.
  - Learn more in this eLearning.

To learn more about changes to HIPAA, contact Privacy Officers at:
- OSUP/FGP: (614) 685-1530
- OSUHS & COM: (614) 293-4477
- OSU Health Plan: (614) 292-2542
- Nisonger Center: (614) 688-8544
- College of Dentistry: (614) 292-6983
- College of Optometry: (614) 247-6190
- Wilco Student Health: (614) 688-3628

For additional contact information, click on the Privacy and IT Security Contacts button.

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Patient Authorization

There is one key point to remember about releasing protected health information:

**Releasing Protected Health Information Requires Patient Authorization.**

There are a few exceptions to this rule. Authorized staff may disclose information:

- For treatment, payment, or health care operations.
- To fulfill public health reporting requirements to governmental agencies as required by state, federal or local law.
- For law enforcement requests or for purposes other than listed here:
  - OSUHS & COM: Medical Information Management and/or Legal Services must approve the release of information.
  - OSUP/FGP: The Privacy Officer must approve the release of information.
  - The applicable Privacy Officer, in consultation with the Offices of Legal Affairs and/or University Compliance and Integrity as appropriate, must approve the release of information.
- When a Waiver of HIPAA Authorization has been obtained for research purposes.
Accounting of Disclosures

Disclosures made without patient authorization that were not for treatment, payment or health care operations, but are otherwise permitted under HIPAA must be accounted for (for example, in OSUWMC's eAccounting or Quick Disclosures systems).

Remember to Account for Disclosure of Protected Health Information.

Some examples of when you need to account for a disclosure include:

- Reporting child or adult abuse and neglect to state agencies.
- Reporting communicable diseases as required by law to state agencies.
- Releases to a coroner or medical examiner.
- Reporting adverse events or product defects to the FDA.
- Reporting vital statistics to the Ohio Department of Health.

For the Health System, eAccounting may be accessed via the Privacy Office website located here: [Privacy]

For OSU/PPM, eAccounting may be accessed via the OSU intranet website and is located here: [eAccounting]

In addition, you may utilize the Quick Disclosures function in EHS. To learn more about the Quick Disclosures function, contact the Privacy Office at:

OSU/PPM: 685-1530
OSLHS & COM: 293-4477

To learn more, contact the appropriate Privacy Officer; contact information located here: [Contact]

Corrective Action

If it is found that you have been misusing data or inappropriately accessing systems, then you will face corrective action up to and including termination.

Remember in an investigation into HIPAA violations, both The Ohio State and you may be subject to civil or even criminal penalties. These penalties may include fines and possible jail time.
HIPAA Security and Passwords

A password, along with your Logon ID, is the “key” that protects your identity within information systems. You protect your passwords in the same way that you would protect the key to your home or automobile. Keep your password a secret.

Ohio State, OSUWMC, and OSU IT will NEVER request your password.

- You should not share your passwords with anyone, including co-workers, administrative staff, IT staff, physicians, managers/supervisors or strangers.
- Password sharing is a violation of policy.
- You can reset your own MedCenter Logon ID Password using the Password Change Portal on OneSource (OneSource> MyWorkplace> Password Portal).
- You can reset your university password at my.osu.edu.

You are responsible for all activity that occurs under your log-in and password. These penalties may include fines and possible jail time.

Workstations, Laptops, Smart Phones and Tablets

Learn more about university policies regarding workstations and unsupported devices.
Workstations, Laptops, Smart Phones and Tablets

Learn more about university policies regarding workstations and unsupported devices.

Computers are business tools you may use to access electronic resources required to perform your job.

- Physical security of computers is vital to protecting sensitive information.
- Computers should be used for business purposes only and NOT for personal gain or inappropriate activities.
- Where appropriate, computers should be locked to a stationary piece of furniture.
- Position the computer monitor so that sensitive information displayed on the screen is not visible to an unauthorized observer.
- Smartphones and tablets must be managed by the OSUWMC / OSUP Mobile Device Management System in order to access the OSUWMC Information systems.
- At OSUWMC/OSUP Laptops, including BYOD and department purchased laptops, must be encrypted.
- For the other covered components, no PHI should be stored on a device that is not encrypted.

For additional contact information, click on the Privacy and IT Security Contacts button.

The Ohio State University

http://compliance.osu.edu/HIPAAprivacyITsecurity.pdf

Workstations, Laptops, Smart Phones and Tablets

Learn more about university policies regarding workstations and unsupported devices.

Devices that are NOT registered or supported by a LAN Manager or OSUWMC IT cannot be attached to the OSUWMC network.

Unsupported devices create vulnerabilities that may lead to virus outbreaks, information exposure, or network performance issues.

If you have a device that you would like to attach to the OSUWMC network, please contact your LAN manager or the OSUWMC IT Help Desk at (614) 293-3861 or the OSUP Help Desk at (614) 784-7812.

The Ohio State University
Software

Only software that is appropriately licensed and approved by your IT department should be installed on devices that are connected to the university network.

The Ohio State University
Malicious Software

Do not install peer-to-peer file sharing applications (e.g., Kazaa, Morpheus, Napster, Limewire) on university workstations. They are often used to spread malicious software—programs that covertly enter information systems with the intent of compromising the confidentiality, integrity and availability of data, applications or operating systems.

Malicious software also known as viruses, worms, trojans and spyware, can:

- Lead to identity theft and the exposure of sensitive information.
- Be spread as e-mail attachments.
  - If an attachment looks suspicious, then do not open it; delete it!
- Be spread through Social Networking Sites such as Facebook and MySpace.

Encryption

What is Encryption?

Encryption is defined as putting data into a secret code so it is unreadable except by authorized users. Encryption uses keys to scramble and unscramble data.

Per OSU and OSUWMC policy a3 PHI must be encrypted when stored on portable devices such as laptop computers, smart phones and flash drives.

Encryption and Remote Access

When working remotely, encryption and wireless security should be considered. Information sent via unencrypted wireless networks can be intercepted by unintended recipients.
OSUWMC Specific Encryption Tools

If you need to send or transmit electronic Protected Health Information outside of the OSUWMC Network to perform your job, data must be encrypted and you must only use approved methods of transmission such as SecureMail or SFTP.

Messages sent and received through the OSUWMC approved email system are scanned for malicious code and for restricted data to protect our patients and OSUWMC’s reputation.

For more information on encryption, please contact your LAN manager or the OSUWMC Help Desk at (614) 293-3861 or the OSUP Help Desk at (614) 784-7812.

Portable Devices

Portable devices such as laptops, flash drives, smart phones and cameras are powerful and convenient business tools. However, they are also highly susceptible to loss and theft.

Unless the portable device is properly encrypted, you must not store sensitive information such as patient data, Social Security numbers, credit card numbers and financial information. At OSUWMC/OSUP ALL laptops carrying PHI or OSUWMC-owned data MUST be encrypted.

For the other covered components, no PHI should be stored on a device that is not encrypted. For additional information, contact your local security contact.

Physically secure all portable devices when left unattended. Examples include a locked office, file cabinet or trunk, or a cable and lock that is secured to a stationary piece of furniture.

Remember:
• Do NOT leave your laptop or tablet unattended.
• Purchase a locking security cable to attach to your laptop around an immovable object to prevent theft.
• Use strong passwords to prevent unauthorized users from accessing your laptop or tablets.

http://compliance.osu.edu/HIPAPrivacyITSecurity.pdf
Data Storage

If you store Protected Health Information (PHI) on a smart phone, laptop, computer, tablet, camera, phone or other storage media, you are the "Data Custodian" for the data and are responsible for its security and proper disposal.

For assistance with properly storing and disposing of sensitive information stored on electronic devices, please contact OSU/WMCIT, OSUPIT, or your local security contact.

http://compliance.osu.edu/HIPAAprivacyITsecurity.pdf
Disclosures to family and Friends

HIPAA permits a patient’s provider to share information with a patient’s family and friends involved in the patient’s health care or payment for the patient’s health care if:

- The patient tells the provider that he or she can do so.
- The patient does not object to sharing the information.
- Using professional judgment, the provider believes that the patient does not object.

Disclosures to family and friends is a tricky topic that warrants more reading.


Minimum Necessary Requirement

HIPAA’s minimum necessary standard means that we are only allowed to release the minimum amount of information necessary to accomplish the intended purpose of the release of patient information.

For example, a patient is being discharged from the hospital. The provider talks with the patient’s family member about when to give the patient’s medication. In this discussion, the provider may only share with the family member the minimum amount of information necessary about that the family member needs to help with the patient’s care at discharge. Nothing more.

OSUWMC Break The Glass

Break-the-glass is a security feature within IHEIS that helps safeguard PHI and assists with privacy auditing.

Break-the-glass (BTG) can be applied in one of two ways:

- At the encounter level – An end user is required to break the glass when opening an encounter with BTG protection.
  Example: Talbot, Harding, Select, NCH
- At the patient level – An end user is required to break the glass when opening a patient record.
  Example: A high profile patient or “person of interest” who has been in the news media and is being treated at OSUWMC.

When an end user attempts to open an encounter or record that is protected with BTG, a warning box will appear:

The end user must enter their username, password, and a reason for entering. The Privacy Office is notified of all attempts at breaking the glass and performs daily audits of the breaks:

- An end user is considered to have “bumped the glass” when he/she receives the warning box above and cancels out, times out, or fails to authenticate with their username/password. Such is the case if an end user searches for a patient, receives the warning box, and then cancels out. The Privacy Office is notified of all “bumps” and includes them in their routine BTG audits.
- If you receive the BTG warning while attempting to perform your job duties, you should feel comfortable breaking the glass.

Reasonable Safeguards

The university must make it a practice to be sure that we take reasonable safeguards to protect patient information such as:

- Speaking quietly when talking about patients with family members in a waiting room or other public area.
- Avoid using patients’ names in public hallways and elevators.
- Isolating or locking file cabinets or rooms containing patient information on paper.

Access this website HERE
Proper Disposal of Trash

- Shred ALL Paper – all paper should be placed in a locked shredding bin. This includes magazines, mailing information, and patient information. The Shred-it bin must be locked at all times and key access is limited to Managers only.
- DO NOT overstuff Shred-it bins; sensitive documents can be easily retrieved if bins are completely full.
- DO NOT place paperwork containing PHI in a “shred box” on your desk or in a blue recycling bin under your desk. Promptly discard all paperwork in Shred-it bins.
- Email secure@osumc.edu or call your local facilities representative with questions about shredding.

Marketing and Fundraising

Question:
I want to mail out letters to previous patients of the university to inform them of a new procedure being offered at the Ross Heart Hospital. Can I send the letter to previous patients of the university without receiving authorization from the patients?

Answer:
It depends on whether the letter is for the purpose of marketing or fundraising.

If the purpose of the letter falls within the definition of "marketing," a signed authorization must be obtained from the patient, unless an exception applies. If one of the following exceptions apply, a signed authorization is NOT necessary:

- Communication about the university’s own products or services.
- Communication made for the Treatment of the Individual.
- Communication made for Case Management or Care Coordination of a patient.
- Face-to-Face Marketing Communication.

If the purpose of the letter falls within the definition of "fundraising," the university may use, or disclose to a business associate or to an institutionally related foundation, the following PHI for the purpose of raising funds for its own benefit, without authorization:

- Demographic information relating to an individual, including name, address, other contact information, age, gender, and date of birth.
- Dates of health care provided to an individual.
- Department of service information.
- Outcome information.
- Health Insurance Status.

In addition, the university must state its Notice of Privacy Practices, the possible uses, and disclosures of PHI for fundraising purposes. The university must provide the individual with a clear and conspicuous opportunity to elect not to receive any further fundraising communications. The university may NOT make fundraising communications to an individual under this paragraph where the individual has elected not to receive such communications.
**HIPAA Breach Notification Rules**

In 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) brought changes to HIPAA. The Breach Notification Provisions is one change to HIPAA. Take a moment to review these changes.

If you suspect a breach has occurred, please contact Privacy Officers at:

- OSUP/FGP: (614) 685-1530
- OSUHS & COM: (614) 293-4477
- OSU Health Plan: (614) 292-2542
- Nisonger Center: (614) 688-8544
- College of Dentistry: (614) 292-6983
- College of Optometry: (614) 247-6190
- Wilke Student Health: (614) 688-3628

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**Breach Notification Provisions:**

- Where there is a Breach of patient information as defined by the regulation (a Reportable Breach), the university must notify the patient.
- For Reportable Breaches involving more than 500 patients, the university must also notify the press.
- For all Reportable Breaches, the university must notify the Department of Health and Human Services, Office for Civil Rights.

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**Summary**

To summarize what you’ve learned:

- Under new HIPAA laws we must notify patients and the federal government when we have a breach of patient information.
- Inappropriate access to patient information qualifies as a Breach under the new laws.
- You must do all you can to keep patient information secure.
Suspicious Behavior Scenarios

HIPAA Violation Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>What is Wrong</th>
<th>What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate Social Security Number (SSN)</td>
<td>Two patients with the same SSN is an Identity Theft Red Flag.</td>
<td>Take one of the following actions:</td>
</tr>
<tr>
<td>Colleague’s Suspicious Behavior</td>
<td>Your colleague has access to patient and staff SSNs. Recently, you notice that your colleague is placing stacks of papers in envelopes and sending them out in the mail or taking the information home. This is not something your colleague needs to do as part of her job duties.</td>
<td>* Notify your manager who will complete an initial investigation. If your manager is unavailable, then notify the Privacy Officer:</td>
</tr>
<tr>
<td>Colleague’s Suspicious Behavior</td>
<td>Your colleague’s behavior is an Identity Theft Red Flag. The worst case scenario is that your colleague is stealing patient information and selling it for misuse by identity thieves. This type of theft has occurred at other hospitals.</td>
<td>* OSU Physicians, Inc. (OSUP) and Faculty Practice Group (FPG): (614) 885-3330</td>
</tr>
<tr>
<td>Colleague’s Suspicious Behavior</td>
<td></td>
<td>* OSU Health System (OSUHS) &amp; College of Medicine (COMD): (614) 294-4007</td>
</tr>
</tbody>
</table>


The Identity Theft Red Flag Response Team will investigate the situation.
# Checking Patient Information Scenarios

## HIPAA Violation Scenarios

<table>
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<th>Scenario</th>
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</tr>
</thead>
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<tr>
<td><strong>Reviewing Family Member Records</strong></td>
<td>You did not need to access your family member’s record for a job-related reason.</td>
<td>You must only access patient information as needed to perform your job duties. Failure to do so will result in corrective action up to and including termination.</td>
</tr>
</tbody>
</table>
| **Checking Patient Information When Not In Your Care** | You did not need to know whether Famous Football Player was admitted to the hospital to perform your job. Looking up this information is a violation of hospital policy and may be a violation of state and federal laws. | Accessing patient information is monitored. You are responsible for all that occurs under your login and password. If you have any questions about whether access to patient information is appropriate, ask your supervisor and/or contact:  
- OSUMC/OhioHealth: (614) 292-2952  
- OSU Health Plan: (614) 292-2962  
- Nisonger Center: (614) 688-8544  
- College of Dentistry: (614) 292-6983  
- College of Optometry: (614) 347-0390  
- Wills Student Health: (614) 688-3628  
- Your local Privacy Office. |

## Paper Handling PHI Scenarios

<table>
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<tr>
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</table>
| **Removing PHI on Paper from University Premises** | Rita inappropriately took PHI from the hospital, exposing information to risk of loss or theft. PHI on paper is easily lost or stolen and you are responsible for ensuring that it remains secure by properly disposing of the information when it is no longer needed. | PHI must be kept secure at all times. Never leave PHI on paper and how to properly secure it or dispose of it, ask your supervisor and/or contact:  
- OSUMC/OhioHealth: (614) 292-2952  
- OSU Health Plan: (614) 292-2962  
- Nisonger Center: (614) 688-8544  
- College of Dentistry: (614) 292-6983  
- College of Optometry: (614) 347-0390  
- Wills Student Health: (614) 688-3628  
- Your local Privacy Office. |
| **Securing PHI Paperwork** | It’s a dangerous practice to transport medical records yourself. You are responsible for the security of the information when it is in your possession. Paper medical records transport between university sites should be handled by dedicated medical record couriers. | |
### Paper Handling PHI Scenarios (cont ...)

<table>
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</tr>
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<tbody>
<tr>
<td>Fax Machines and Printers</td>
<td>The clinic has fax/machines located in an unsafe location. The machines are</td>
<td>Fax machines and printers that receive PHI must be kept in a secure area. They must be accessible and attended to only by authorized university staff. PHI sent to these machines must be removed promptly. If you have questions about faxing or printing PHI and how to properly secure it, ask your supervisor and/or contact the Privacy Office.</td>
</tr>
</tbody>
</table>
| Patient Addresses, Zip Codes and Medical Record Numbers | As part of Andrew's job, he prints out information that includes patient addresses and zip codes. He thinks that he should place these documents in the shredder bin, but whenever he goes there, it's either full or locked. Andrew decides that because there is no patient name on the papers, that it is okay to throw the papers in the regular trash. | Place paperwork with PHI and any sensitive information in a shredding container. Where paper is kept in a box under your desk to be emptied into a shredding bin, you must empty the box at the end of each day into a shredding bin and mark the box as “Shredding—Do Not Throw in the Regular Trash.” If the shredding container in your area is full or all full, notify:  
  - OSU: Environmental Services (614) 292-4250  
  - OSU: FGP (614) 686-1550  
  - OSU: OMNI (614) 293-4477  
  - OSU Health Plan (614) 282-3342  
  - Nisonger Center: (614) 688-8544  
  - College of Dentistry: (614) 686-6800  
  - College of Optometry: (614) 292-6900  
  - Wills Student Health: (614) 686-3638  
  - Your local Privacy Office. |

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### Paper Handling PHI Scenarios (cont ...)

Learn what to do in these situations before proceeding to the next page.

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<th>Scenario</th>
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<tr>
<td>You are a PCA who checks out patients. Part of this check out includes printing a copy of the AUP for the visit and handing it to the patient. You forgot to give the previous patient (Patient A) her After Visit Summary (AUS) and included it with the AUS printed and given to Patient B.</td>
<td>When providing Protected Health Information to a patient, you are responsible for ensuring the information being provided to each patient is correct. Each page should be confirmed prior to providing information to the patient.</td>
<td>If you are contacted by a patient who has received another patient’s information in error, ask the patient to hold the information. Send this patient a self-addressed, stamped envelope to return the information back to us. Also include an Attestation form to the patient to sign that states while the information was in possession, it was not used or disclosed in any way. Explain all of this to the patient before making the FHI disclosure. If you have any questions, contact the Privacy Office.</td>
</tr>
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</table>
**Electronic Handling of PHI Scenarios**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Social Media</strong></td>
<td>Information about patients must not be posted to any social media site,</td>
<td>With the use of social media, you are responsible for</td>
</tr>
<tr>
<td></td>
<td>including but not limited to blogs, wikis, instant messaging, email</td>
<td>protecting your patients and yourself every day.</td>
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<tr>
<td></td>
<td>outside of the university, social networks and video-hosting sites.</td>
<td>If you have questions about the proper use of social media,</td>
</tr>
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<td></td>
<td></td>
<td>consult the Medical Center’s social media policy and/or contact the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Privacy Office.</td>
</tr>
<tr>
<td><strong>Phishing Attempts</strong></td>
<td>Phishing is where people send an email to a user falsely claiming to be a</td>
<td>If you receive suspected phishing e-mail, please report it to</td>
</tr>
<tr>
<td></td>
<td>legitimate requestor. Phishing tries to scam a user into surrendering private</td>
<td><a href="mailto:report.phish@ouhs.edu">report.phish@ouhs.edu</a>, if in doubt as to the legitimacy of an e-mail,</td>
</tr>
<tr>
<td></td>
<td>information. The university it will</td>
<td>please contact your local IT support, the IT Service Desk at (614) 688-HELP (4657), the OSUIMC IT Help Desk at (614) 293-3861, or the OSUP Help Desk at (614) 764-3132 for verification and advice.</td>
</tr>
<tr>
<td><strong>Sharing Passwords</strong></td>
<td>Both staff members violated policy. You are responsible for all activity</td>
<td>Do NOT share your passwords with anyone. Password sharing is a</td>
</tr>
<tr>
<td></td>
<td>that occurs under your login and password.</td>
<td>violation of policy. Violations of policy may result in corrective</td>
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<td></td>
<td>action up to and including termination. If your manager or supervisor</td>
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<td></td>
<td></td>
<td>asks you to change your password with a new employee, tell them this is</td>
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<tr>
<td></td>
<td></td>
<td>NOT permitted per HIPAA security rules and internal policies. If they still insist, contact the OSUIMC Privacy Officer. If you have questions about computer access to PHI, ask your supervisor or contact your local IT support, the IT Service Desk, OSUIMC IT Help Desk, or OSUP Help Desk.</td>
</tr>
</tbody>
</table>

**Securing PHI on Devices Scenarios**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>What is Wrong</th>
<th>What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equipment Registration</strong></td>
<td>Researcher Ron’s assistant is not a LAN manager and is NOT part of OSUIMC IT.</td>
<td>Devices that are NOT registered and supported by a LAN manager or OSUIMC IT cannot be attached to the OSUIMC network.</td>
</tr>
<tr>
<td></td>
<td>therefore, she is not authorized to maintain and support equipment attached</td>
<td>If you have questions about attaching computer to the OSUIMC network or accessing OSUIMC applications using non-OSUIMC issued devices, ask your supervisor and/or contact the OSUIMC IT Help Desk: (614) 293-3861.</td>
</tr>
<tr>
<td></td>
<td>to the OSUIMC network. Computer equipment that is not properly maintained may</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lead to virus outbreaks, information exposure and network performance issues.</td>
<td></td>
</tr>
<tr>
<td><strong>Installing Software</strong></td>
<td>Installing unauthorized software can introduce a virus or malicious code into</td>
<td>STOP Delete the email</td>
</tr>
<tr>
<td></td>
<td>the university computer network and compromise sensitive information.</td>
<td></td>
</tr>
</tbody>
</table>

2019 Ohio State University
Securing PHI on Devices Scenarios (cont...)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>What is Wrong</th>
<th>What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHI Data Storage</td>
<td>Carla is placing the data on her C: drive which is an unsafe place for</td>
<td>Patient information must be saved to a folder on the network (P: drive)</td>
</tr>
<tr>
<td></td>
<td>patient information.</td>
<td>or to a secure network shared folder.</td>
</tr>
<tr>
<td></td>
<td>If you need assistance with properly storing and disposing of</td>
<td>If you need assistance with properly storing and disposing of</td>
</tr>
<tr>
<td></td>
<td>of sensitive information, contact your local IT support, the</td>
<td>sensitive information, contact your local IT support, the</td>
</tr>
<tr>
<td></td>
<td>IT Service Desk at (513) 688-HELP (4457), your LAN</td>
<td>IT Service Desk at (513) 688-HELP (4457), your LAN</td>
</tr>
<tr>
<td></td>
<td>manager, or the OSUWMC Help Desk (614) 293-3863 or the OSUWMC Help</td>
<td>manager, or the OSUWMC Help Desk (614) 293-3863 or the OSUWMC Help</td>
</tr>
<tr>
<td></td>
<td>Desk (614) 794-7832.</td>
<td>Desk (614) 794-7832.</td>
</tr>
<tr>
<td>Storing PHI on Portable</td>
<td>Devices such as laptops, smart phones and flash drives are</td>
<td>Contact your local IT support or OSUWMC IT to have the device</td>
</tr>
<tr>
<td>Devices</td>
<td>easily lost or stolen. They must be encrypted to protect restricted data</td>
<td>properly encrypted and secured before accessing the</td>
</tr>
<tr>
<td></td>
<td>such as PHI per OSUWMC policy.</td>
<td>university’s electronic resources.</td>
</tr>
<tr>
<td></td>
<td>If you have questions about storing PHI or other restricted data on</td>
<td>If you have questions about storing PHI or other restricted data on</td>
</tr>
<tr>
<td></td>
<td>portable devices, ask your supervisor and/or contact your local</td>
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</tr>
<tr>
<td></td>
<td>IT support, the IT Service Desk at (513) 688-HELP (4457), your supervisor,</td>
<td>IT support, the IT Service Desk at (513) 688-HELP (4457), your</td>
</tr>
<tr>
<td></td>
<td>or the OSUWMC Help Desk (614) 293-3863 or the OSUWMC Help Desk</td>
<td>supervisor, or the OSUWMC Help Desk (614) 293-3863 or the OSUWMC Help</td>
</tr>
<tr>
<td></td>
<td>(614) 794-7832.</td>
<td>Desk (614) 794-7832.</td>
</tr>
<tr>
<td>Encryption of PHI</td>
<td>Dr. Jones was using an unsecured flash drive to store PHI. Portable</td>
<td>Per OSUWMC and OSUWMC policy, all PHI must be encrypted when stored on</td>
</tr>
<tr>
<td></td>
<td>equipment is easily lost or stolen and must be encrypted in order to</td>
<td>portable devices such as laptop computers, smart</td>
</tr>
<tr>
<td></td>
<td>protect restricted data such as PHI.</td>
<td>phones and flash drives.</td>
</tr>
<tr>
<td></td>
<td>If you have questions about encrypting PHI on portable devices, ask your</td>
<td>If you have questions about encrypting PHI on portable</td>
</tr>
<tr>
<td></td>
<td>supervisor and/or contact your local IT support, the IT Service Desk at</td>
<td>devices, ask your supervisor and/or contact your local IT</td>
</tr>
<tr>
<td></td>
<td>(513) 688-HELP (4457), your supervisor, or the OSUWMC Help Desk.</td>
<td>support, the IT Service Desk at (513) 688-HELP (4457), your supervisor,</td>
</tr>
<tr>
<td></td>
<td>(614) 293-3863 or the OSUWMC Help Desk (614) 794-7832.</td>
<td>or the OSUWMC Help Desk (614) 293-3863 or the OSUWMC Help Desk</td>
</tr>
</tbody>
</table>

Criminal Activity Scenarios

PAA Violation Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>What is Wrong</th>
<th>What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Releasing Patient Information for</td>
<td>Stop! You may do more harm than good by releasing information inappropriately.</td>
<td>Giving out patient information in violation of hospital policies will</td>
</tr>
<tr>
<td>a Criminal Investigation</td>
<td>Releasing patient information without signed patient authorization could be</td>
<td>subject you to corrective action up to and including termination.</td>
</tr>
<tr>
<td></td>
<td>a violation of federal HIPAA laws and multiple state laws.</td>
<td>Where there is a reportable breach of patient information under HIPAA</td>
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<tr>
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<td></td>
<td>regulations, we must notify the patient in writing of the breach and</td>
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<tr>
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<td></td>
<td>notify the federal government as well. OSUWMC employees should call Legal</td>
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<tr>
<td></td>
<td></td>
<td>Services, Risk Management (paper 2003) and others should call their</td>
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<td></td>
<td>Privacy Officer and/or the Office of Legal Affairs to ask for help before</td>
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<tr>
<td></td>
<td></td>
<td>releasing information in these situations.</td>
</tr>
<tr>
<td>Patient Assault on Another Patient</td>
<td>Your patient was involved in an assault of another patient while in the</td>
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<td></td>
<td>hospital. Your patient has several diagnoses including anemia, edema,</td>
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<td>hypertension and depression. The police come to the patient’s room to</td>
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<tr>
<td></td>
<td>investigate the assault. The police officer asks you about the situation.</td>
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</tbody>
</table>
# Reporting Breach of PHI Scenarios

## HIPAA Violation Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
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</table>
| Reporting Breach of PHI | Dr. Holland was watching news reports about a prominent local news anchor who was involved in a severe car crash. He noticed that the news anchor was admitted to the hospital where he works. Dr. Holland logged onto the hospital's medical record to see if the news reports were true. Dr. Holland was not involved in the news anchor's care. Out of curiosity, Sarah, a registration clerk, and Carmen, a clinic nurse, also viewed the patient's medical record. Dr. Holland, Sarah, and Carmen do NOT need this information to do their jobs. Their curiosity may be considered a breach under the new regulations. | The university must assess all potential breaches of its PHI. All reportable breaches must be reported to the Federal Government annually. When a situation like this occurs, the university must also write a letter to the patient to tell the patient:  
- PHI information has been breached.  
- The date and time of the breach.  
- What the university has done to prevent future occurrences.  
- Contact information about where she can get further information. |

| Misdirected Email Containing PHI | Jennifer Smith receives an email from Dr. Donna. Jennifer often receives misdirected emails because there are at least four other Jennifer Smiths that work at the university. Jennifer notices that she is not the intended recipient of Dr. Donna's email. Jennifer Smith works in a lab at the College of Medicine and does not use patient information to do her job. Patient information is in the wrong hands and could be compromised. | |

## More Scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
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</table>
| Lost Flash Drive Containing PHI | Terry lost his flash drive a few days ago. Terry kept patient information on the flash drive, including patient names, admission dates, copies of patient prescriptions and clinic patient lists. Terry didn’t notify anyone that his flash drive was lost because he thought it would turn up one day. Over two weeks has past and Terry has not located his lost flash drive. | Terry should not store PHI unless it has been encrypted. He should have notified the Privacy Officer about the lost device ASAP after noticing it was lost. Do not store PHI on devices unless it is encrypted. If a device with PHI on it is lost, notify the Privacy Officer ASAP:  
- CSU Intranet: (654) 655-1234  
- CSUI & COM: (641) 253-8177  
- GSI Health Plan: (641) 253-8152  
- W stepped Center (654) 253-8154  
- College of Dentistry: (641) 253-8158  
- College of Optometry: (654) 253-8150  
- College of Health: (654) 989-8285  
- Your Local Privacy Office.  

The clock is ticking! Once the employee discovers a potential breach, the university has no more than 60 days to notify the patients of the breach. | |

| Papers Found Containing PHI | Joe is a faculty member at the College of Medicine and works primarily in a research lab. He meets his friends for lunch at the hospital cafeteria. When Joe sits down, he finds papers on the cafeteria table. On the papers, he sees a list of patient names with notes about each patient. | PHI might have been compromised and needs to be returned to the Privacy Office. If you find papers with PHI on them, notify the Privacy Officer ASAP. |

The Privacy Office will ask you to return the information ASAP, investigate further, and present the investigation to the potential breach committee to determine the likelihood that the data has been compromised. |
Common Questions

Does HIPAA allow a health care provider to discuss the patient’s health information with the patient’s family, friends, or others involved in the patient’s care or payment for care?

May a health care provider discuss a patient’s health information over the phone with a family member, friend, or others involved in the patient’s care or payment for the patient’s care?

How should the university employees protect paper documents that contain sensitive information about our staff, patients and vendors?

What if patients or family members overhear or are talking about other patients in a shared or open patient care setting?

Answer #1

If the patient is present and has the capacity to make health care decisions, then a health care provider may discuss the patient’s health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object.

A health care provider may share information with those persons if, using professional judgment, the provider decides that the patient does not object.

In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient’s care or payment for care.

• If there is a frequent visitor in the room when the physician (or other staff) comes in, the health care provider should ask the patient (or the patient’s legal representative) if a private conversation is preferable.

• Use professional judgment, but make it comfortable for the patient to say, “I’d like to keep this discussion private.”

Common Questions

Does HIPAA allow a health care provider is allowed to share a patient’s health information in person, information may be shared over the phone as well.

However, proceed with caution:

• If the patient has asked you not to share information with a family member, then you must not share the information.

• If you are uncertain whether the patient would want you to, then do not share the information.

• If you are uncertain of the identity of the caller, then do not share the information.

If you work in the hospital, know your unit’s policy. Many units use code numbers or words that signal to staff that the caller has been identified as someone with whom you may share information.
Common Questions

**Does HIPAA allow a health care provider to discuss the patient’s health information with the patient's family, friends, or others involved in the patient’s care or payment for care?**

**May a health care provider discuss a patient’s health information over the phone with a family member, friend, or others involved in the patient’s care or payment for the patient's care?**

**How should the university employees protect paper documents that contain sensitive information about our staff, patients and vendors?**

**What if patients or family members overhear or talking about other patients in a shared or open patient care setting?**

**Answer:**

Documents that contain sensitive information such as patient information should be maintained behind a locked door so which other staff do not have access after hours. If other staff have access to your desk after hours, then sensitive information must be placed in a locked drawer.

**In shared or open patient care settings, use reasonable safeguards to make sure that the patient's privacy rights are respected:**

- Monitor the volume of your conversation and pull curtains whenever possible.
- When sharing sensitive results or discussing sensitive information with patients, offer a private setting whenever possible.
- Don’t talk about patients in elevators, the cafeteria, or other public places.
Conclusion

You have completed Annual HIPAA Privacy & Security.

After reviewing this course, you should now be familiar with:

- Recognizing that privacy and security of sensitive information is your responsibility
- Identifying situations where sensitive information may be handled improperly
- How you can protect patient and confidential information in common workplace situations
- Recognizing that you will be held responsible for improperly handling sensitive information
- Determining who to notify if you have questions about the privacy and security of sensitive information