BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 13	**Corporate Compliance**		
Section: 1	**HIPAA**		
Topic: 10	**Reasonable Safeguards for Protected Health Information**		
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to ensure reasonable efforts are made to prevent uses and disclosures of protected health information (PHI) not permitted under the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. Reasonable safeguards will be taken to prevent use and/or disclosure of information beyond that which is minimally necessary and to prevent disclosure of information to persons without a need to know.

Purpose

This policy and procedure is in place to establish the reasonable safeguards necessary to prevent impermissible uses and/or disclosures of PHI, and uses and/or disclosures to persons without the need to know and beyond that which is minimally necessary.

Education Applies to:

☒ All BABHA Staff
☐ Selected BABHA Staff, as follows:
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure

Definitions

Disclosure: The release of PHI to a person served, his/her legal representative, and/or to an outside entity or individual.

Electronic Equipment: Includes desktops, laptops, tablets, smartphones, copiers, and any other electronic device that can potentially store PHI data.

Electronic Media: (1) Electronic storage media includes memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; video tapes; audio tapes; and removable storage devices such as USB drives; or (2) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic

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media, because the information being exchanged did not exist in electronic form before the transmission.

Mobile Devices: A generic term used to refer to a variety of hand-held or plug-in devices that allow people to access and/or download data and information just as if they were using a conventional computer. This includes such devices as cell phones, smart phones, tablets, USB drives, flash drives, etc.

Protected Health Information (PHI): Individually identifiable health information transmitted by or maintained in an electronic media format or transmitted or maintained in any other form or medium, including oral and/or paper.

Procedure

1) BABHA will make reasonable efforts and put reasonable safeguards in place to prevent uses and disclosures that are not permitted under the HIPAA Privacy Rule. In determining what safeguards are "reasonable", BABHA will use the viewpoint of a prudent health care professional.
2) Staff are required to report any suspected loss, theft of, or unauthorized access, to PHI in any of its forms, to the CCO, or designee, and concurrently to their immediate supervisor. See C13-S02-T01 Internal Reporting-Hotline for more information.
3) Avoiding Unnecessary Exposure of PHI
    a) Staff are responsible for taking reasonable precautions to ensure the PHI of persons receiving services is out of view of other individuals who do not have a need to know the PHI.
    b) Visitors to BABHA Sites
        i) Management will ensure that at each BABHA site where persons receiving services are routinely present, all visitors will be directed to a reception desk where staff can check them in either on a verbal or written basis. Visitors should not be allowed to wander freely about and should be escorted by staff to the room where their business will be conducted and then escorted back out afterwards.
        ii) If sign-in sheets are used, staff will keep PHI de-identifiable as they will fully cross out the person's name as soon as possible.

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iii) Staff must have a release of information to provide information about persons served to friends and family members (including the parents of adult children) who visit BABHA sites.

iv) A release of information or other documentation must be on file in the BABHA EHR for friends or family members (who are not the responsible party) to pick-up children/adolescents attending appointments at BABHA sites.

v) If a release is not on file, verbal permission may be obtained and documented from the responsible party for the person served. See C13-S01-T07 Personal Representatives for more information about responsible parties for persons served.

vi) It is the responsibility of all BABHA staff who are hosting visitor(s) to anticipate the potential exposure of PHI and ensure that PHI is not exposed for viewing by:

(1) Turning on their screen savers or logging off desktop or laptop computers;

(2) Storing paper documents in a desk drawer, cabinet, etc.;

(3) Leaving any type of PHI or mobile devices with accessibility to PHI, such as cell phones, laptops, etc., unattended;

(4) Escorting their visitor(s) to and from their designated meeting room/site.

vii) Staff should ensure that verbal conversations which include PHI cannot be overheard by other staff or by visitors without a need to know. This means staff should refrain from discussing PHI on elevators, in hallways, reception areas, etc.

viii) If staff should notice that any PHI has been accessed or is missing once a visitor(s) has left, staff should notify the Corporate Compliance Officer, or designee, immediately as well as their respective supervisors.

c) PHI in the Community

i) Staff will only transport PHI into locations that BABHA would normally consider appropriate such as; to other BABHA sites, to a contracted service provider's site, to a consumer's home, etc.

ii) Staff will neither transport nor discuss PHI in non-office locations such as a restaurant, park or other public area, unless it is necessary to meet the needs of the person served, such as may be needed for a person-centered planning meeting.

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(1) It is the responsibility of the workforce member to ensure that documents containing PHI cannot be seen by anyone else and that any discussions regarding PHI cannot be overheard by others, who are not part of the meeting or do not have a need to know.

(2) In addition, the documents must remain in the possession of BABHA staff at all times.

d) Keeping PHI within the Electronic Health Record

i) Staff will use the schedule/calendar and dashboard functions in the BABHA electronic health record to track service appointments and documentation due dates. Staff will not use wall or desk calendars to record appointments related to persons served, or leave caseload lists or other documents containing PHI exposed in their work space.

ii) Staff will avoid printing paper copies of documents containing PHI unless absolutely necessary. Printing will only occur when no secure electronic alternative is available or feasible.

iii) Staff that generate and maintain documents or notes that contain PHI that are not part of a person's record, such as psychotherapy notes and psychological testing notes, must ensure that the documents or notes are secured in a locked file cabinet or desk.

iv) Staff who receive paper documents containing PHI from persons served or others on their behalf, such as the courts or schools, will ensure such documents are scanned into the electronic health record as soon as possible and the paper originals are returned to the source or shredded in accordance with BABHA procedures. Until these activities can be completed, the documents will be secured in a locked file cabinet or desk.

v) The BABHA Medical Records Associate is the BABHA workforce member authorized to retain paper records containing the PHI of persons served, if necessary, to fulfill BABHA operational needs, such as maintaining records of subpoenas, compiling documents for record requests and so on. The Medical Records Associate will ensure paper documents and/or records related to PHI are controlled and physically safeguarded in locked file cabinets until the data is

transferred to an electronic format or otherwise disposed consistent with BABHA retention policies.

e) Handouts, Faxes and US Mail

i) BABHA will only send correspondence, such as appointment reminders, in envelopes and not on exposed postcards.

ii) Where warranted, staff will use envelopes that do not name BABHA in the return address to protect the privacy of the person served.

iii) To ensure PHI for persons served are not sent to the wrong person, BABHA staff will double check mailings, use windowed envelopes or have a second staff (with a need-to-know) confirm name, addresses and phone numbers match before sending US mail or faxes.

f) Phone and Video Contacts

i) Staff should not leave messages on answering machines unless permission has been given by the person served.

ii) Where warranted, staff should use two identifiers to verify the identity of the person they are speaking to. Staff should also confirm that the person served is in a private location to avoid exposing PHI to someone without a need-to-know.

iii) Where warranted to protect the person served's safety, staff may arrange a a 'safe' word that the person may invoke if their privacy is not protected, or they are otherwise at risk during the contact.

g) Social Media

i) Staff are responsible for preventing the use and/or disclosure of PHI when posting information on the Internet (e.g., direct communications, discussion groups, list serves, etc.).

ii) See the BABHA Employee Handbook and C03-S03-T06 Photographing, Video Recording, Audio Taping and Fingerprinting Recipients for additional guidance regarding use of social media.

4) <u>The Need-to-Know</u>

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a) Staff are responsible for ensuring they are not being overheard when talking on the phone and discussing a person's PHI.

b) Staff will avoid discussing PHI in common areas such as reception areas, waiting rooms, hallways, elevators, etc. Staff are responsible for taking individuals to a private area and speaking quietly when discussing PHI.

c) Staff will not assume all other members of their program have the need-to-know PHI for all persons served who are assigned to the program. Discussion of PHI should be avoided when other personnel/ individuals are present who do not have a need to know in order to perform their job duties. An exception is made for evidence-based practices employing team-based treatment models, such as Assertive Community Treatment, where all staff share in the support and treatment of all persons served.

d) Staff will comply with federal and state privacy and confidentiality regulations and adhere to professional ethics and codes of conduct by respecting the privacy of all persons served.

i) Staff are not permitted to discuss a person's PHI for reasons unrelated to payment, treatment and operations, such as meeting staff's emotional needs. Support to address compassion fatigue should be obtained from supervisory staff or through other workforce support programs where PHI protections can be preserved.

ii) Under no circumstances will the PHI of persons served be discussed by staff with that staff's family, friends, neighbors and other acquaintances.

5) Minimum Necessary

a) Staff will take reasonable precautions to safeguard information so that only the minimal amount of information necessary to serve the stated purpose is either used or disclosed.

b) Names, or any other identifying PHI, should not be used unless the communication is encrypted

6) Safeguarding Electronic Information

a) In addition to the HIPAA Privacy Rules, the HIPAA Security Rules require that technical safeguards be put in place to safeguard EPHI (see BABHA Policies and Procedures, Chapter 9, Sections 3 and 4 for technology safeguards).

7) Confidentiality Agreement

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a) Staff are required to sign a confidentiality agreement stating they will only access the information systems for information they need to know and will not attempt to access the information systems if not authorized to do so.

8) Remote Work Sites:
   a) The safeguards for protected health information identified in this policy and procedure pertain to any remote work location.
   b) Review and assessment of any remote work site may be conducted at any time.

Attachments

N/A

Related Forms

Security/Confidentiality and "Need to Know" Agreement

Related Materials

N/A

References/Legal Authority

45 CFR Parts 160, 162 and 164

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SUBMISSION FORM				
AUTHOR/ REVIEWER	APPROVING BODY/ COMMITTEE/ SUPERVISOR	APPROVAL/ REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION If replacement, list policy to be replaced
M. Bartlett	J. Pinter	8/20/09		Updated to add "paper PHI"
M. Bartlett	Corporate Compliance OPS Committee	10/28/10	Revision	Revised to reflect HIPAA compliance and updated to current practices.
M. Wolber, J. Pinter	CCP/SLT	6/27/13	Revision	Revised to allow email transmissions with consumer IDs only.
M. Wolber	Janis Pinter, CCO	3/24/14	Revision	Remove references to business associates as they are required per the BAA to create their own policies.
J. Pinter	Janis Pinter, CCO	6/10/15	No Changes	
J. Pinter	Corporate Compliance Committee	09/21/21	Revised	Incorporate content from C13-S02-T15 Confidentiality & Privacy of PHI – Non-Employees and remove redundancies with Chapter 9 Security procedures.
K. Amon	Corporate Compliance Committee	1/30/25	Revisions	To include Remote Work expectations.