TRAINING UPDATE

Lab Location:	GEC, SGMC & WAH	**Date Distributed:**	8/12/2015
Department:	Mgmt & QA	**Due Date:**	8/19/2015
		Implementation:	**8/19/2015**

DESCRIPTION OF PROCEDURE

Name of procedure:

HIPAA Audit GEC.QA236, SGAH.QA920, WAH.QA912 v0
HIPAA Compliance Assessment AG.F331.0

Description:

This is a new SOP and Form to describe the process to monitor compliance with the patient privacy policy.
It is needed to meet CAP requirements.

This SOP and Form will be implemented on August 19, 2015

Document your compliance with this training update by taking the quiz in the MTS system.

Approved draft for training

Non-Technical SOP

Title	**HIPAA Audit**	
Prepared by	Leslie Barrett	Date: 7/17/2015
Owner	Cynthia Bowman-Gholston	Date: 7/17/2015

Laboratory Approval		
Print Name and Title	**Signature**	**Date**
Refer to the electronic signature page for approval and approval dates.		
Local Issue Date:	Local Effective Date:	

Review:		
Print Name	**Signature**	**Date**

Form revised 3/31/00

TABLE OF CONTENTS

1. PURPOSE

This procedure outlines the process to monitor compliance with the patient privacy policy.

2. SCOPE

This procedure applies to annual HIPAA audits

3. RESPONSIBILITY

Laboratory management and quality assurance staff may perform this procedure.

4. DEFINITIONS

HIPPA - Health Insurance Portability and Accountability Act

5. PROCEDURE

A. Audit
   1. Obtain the HIPAA Compliance Assessment form
   2. Observe and assess work practices listed on the form
   3. Record findings

B. Corrective Action
   1. If any confidentiality or compliance failures are identified, corrective action must be initiated
   2. The auditor will report findings to the director and area supervisor via email.

Form revised 3/31/00

3. The supervisor will submit an email corrective action response including a timeline for completion.

C. Documentation
1. File the assessment form and correction action email electronically on the shared drive at G\AHC_Lab\Quality Assurance\Reports\HIPAA Audits.

6. RELATED DOCUMENTS

HIPAA Compliance Assessment (AG.F331)
HIPAA Policy, general laboratory policy

7. REFERENCES

N/A

8. REVISION HISTORY

Version	Date	Reason for Revision	Revised By	Approved By

9. ADDENDA AND APPENDICES

None

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☐ Washington Adventist Hospital

HIPAA Compliance Assessment

Location / Site ID _____

Completed by (name) _____ Date _____

Title _____

Protected Health Information (PHI)				
Oral Communication Safeguards		**Y**	**N**	**NA**
1	Speaker telephones are not used in areas accessible to public and/or patients			
2	Patient / test order information is discussed privately, not in the waiting area			
3	Employees are patient privacy conscious when conversing in areas accessible to public and/or patients [with regard to level and tone of voice]			
Area Safeguards		**Y**	**N**	**NA**
4	Computer screens are turned away from public view			
5	Privacy screens are used on computer screens where necessary			
6	Computer / LIS users log off when equipment is not in use			
7	Unattended computers switch to a password enabled screen saver			
8	Employees comply with user name / password protection policy (do not share)			
9	Records / reports containing PHI are not in public view			
10	Printers / fax machines are placed in secure locations to avoid access or view by public and/or patients			
11	Labeled specimens are not visible to public and/or patients			
12	Access doors are locked and/or secure. Doors are not propped open			
13	Vendors and non-employees are escorted			
14	Employee family, friends, children are not permitted in restricted access areas			
15	Records containing PHI are not removed from premises by laboratory personnel			
Mail, Fax, Email Safeguards		**Y**	**N**	**NA**
16	All mailed documents / reports containing PHI are sealed in an envelope for personal / confidential delivery			
17	If Fax (report containing PHI) is requested by ordering MD or their agent, the fax # is verified with the requestor.			
18	The standard fax cover sheet in use contains the required Confidentiality Notice (statement)			
19	All documents / reports containing PHI, if sent electronically, are sent via a secure connection or are encrypted through secure email			
Disposal Safeguards		**Y**	**N**	**NA**
20	All documents / reports containing PHI are placed in a secure bin for shredding			
21	All specimen vials / containers disposed of as Medical Waste (containing PHI) are destroyed in a manner that renders the PHI unreadable			
22	Electronic equipment (computers, instrument managers, thumb drives, disks, etc.) are 'scrubbed' of PHI prior to disposal, or data is rendered 'unreadable'			
Release of Test Results and Disclosure Reporting		**Y**	**N**	**NA**
23	Telephone callers, requesting test results / PHI, are authenticated			
24	Patient requests are appropriately documented using Request for Access (form)			
25	Instances of Accidental Disclosure and/or Inappropriate Access are reported as per company policy			

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For each assessment # with an "N" determination (No) – document corrective action taken below.

#	**Corrective Action**