Title: HIPAA Plan

Author:	Effective Date: *Note: The Effective Date is assigned after all approval signatures are obtained*	Supersedes Procedure #
Fran Gersonia	14 Sep 2017	New

Revised By:	Date Revised	Effective (adopted) Date: *Note: The Effective Date is assigned after all approval signatures are obtained*

Approval Signature	Approval Date
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Approval Signature	Approval Date
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Revision History

Policy #	Revision Date	Reason for Revision

I. INTRODUCTION

UR Medicine Lab routinely receives physician orders for testing where specimens are drawn by UR Medicine personnel at a Patient Service Center, private home (house calls) or nursing facility. In addition UR Medicine Lab routinely transports specimens collected in a physician's office or hospital based clinic to the laboratory.

The specimens and associated requisitions/electronic registrations, if applicable contain Protected Health Information (PHI) concerning the patient. Additionally, phlebotomists and couriers may have incidental exposure to patient information, either verbal or written, while performing their duties in a collection center, patient home, nursing facility, physician office or clinic.

UR Medicine Labs Client Services department routinely has contact with health care providers and office personnel. This contact is via incoming or outgoing phone calls. Additionally, client services personnel on some occasions do have contact with a patient.

UR Medicine Labs Outreach Services Representatives have contact with health care provider and office personnel. Often this contact is related to concerns or issues with regard to specimen collection, transport and accessioning. Personnel functioning in this role may have exposure to patient information either verbal or written as a function of their role in managing client expectations.

Accessioning personnel working in the role of Exception Handling have contact with health care providers and office personnel via outgoing and incoming phone calls. Exception Handling personnel may also have contact with a patient in an effort to clarify an exception or notify patient of need for redraw in cases of inadequate, unstable or other specimen integrity issue.

HIPAA regulations allow for the routine release of patient information for purposes of treatment, payment, other health related activities (TPO) or as required by government regulations. Any release of information related to TPO or government regulations is not required to be reported to the patient as an unauthorized disclosure of protected health information. Information released for any other purpose requires patient notification unless written authorization has been received from the patient.

UR Medicine personnel are required to follow steps to protect the confidentiality of patient related information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I. PURPOSE

The purpose of this policy is to provide general guidance related to HIPAA and patient confidentiality.

II. RESPONSIBILITIES

Role	Responsibility
Supervisor/Manager	• Ensure policy is followed. • Ensure compliance with URMC and Affiliates policies.
Personnel	• Follows the confidentiality policy.

URMC and Affiliates has a designated Chief Privacy Officer, who has the overall responsibility for the development and implementation of privacy policies and procedures. In additional, the Chief Privacy Office has designated Privacy Officers who have responsibilities for entities within URMC.

The names and telephone numbers of all Privacy Officers can be found on https://sites.mc.rochester.edu/departments/ hipaa.

Inquiries, complaints, questions should be directed to your department Supervisor. UR Medicine Labs Department Supervisor will work with UR Medicine Labs Senior Leadership and UR Medicine Privacy Officer to resolve issues/complaints, as necessary.

Information on URMC and Affiliates privacy policies, related information (including names and phone numbers) can be found on https://sites.mc.rochester.edu/departments/hipaa.

IV. GENERAL GUIDELINES

UR Medicine Labs will maintain appropriate administrative, technical and physical safeguards to protect the privacy of protected health information (PHI). UR Medicine Labs is committed to comply with standards as applicable to their line of service.

1. In accordance with HIPAA, access to patient information is limited to those individuals having a need of this information for patient care.
2. UR Medicine Labs personnel must reasonably safeguard PHI from any intentional or unintentional use or disclosure that is in violation of the privacy regulations or URMC and Affiliates policies
3. All personnel must follow established privacy and security policies to ensure the confidentiality, integrity and availability of all protected health information
4. UR Medicine labs will follow established entity-wide (URMC and Affiliates) policies in compliance with the Privacy Rule, Health Insurance Portability and Accountability Act of 1996 (HIPAA) ; http://intranet.urmc.rochester.edu/HIPAA/
5. UR Medicine Labs must verify the identity of the person requesting protected health information (PHI).
6. Personnel receive training regarding their responsibilities relative to HIPAA standards upon hire and should be in UR new hire orientation with follow up mandatory education completed in MyPath, or as directed by URMC Affiliate organization.

Safeguards for PHI include, but are not limited to:

- Administrative – polices/procedures
- Technical – appropriate role based/limited system access
- Physical – limited access, secure locations for PHI, encryption safeguards

Laboratory Information System (LIS)

LIS usage is limited to authorized users via passwords. Authorization is determined by individual lab section leadership.

Under no circumstances are user passwords shared.

Physical security

All PHI regardless of its form, mechanism of transmission, or storage is to be kept confidential.

Access will be terminated for personnel who leave employment.

Patient Service Centers:

1. Notice of Privacy Practices (NPP)
   UR Medicine Labs is required to provide adequate notice to individual of the uses and disclosures that may be made regarding PHI. UR Medicine Labs must post the URMC and Affiliates Notice of Privacy Practices (NPP) in all Patient Service Centers. It is the responsibility of the Phlebotomy Department Supervisors to ensure the current approved version of the NPP is posted and visible to all patients. In addition copies should be available for distribution as requested.

Couriers:

1. To the extent possible, all couriers shall limit their visual inspection of all PHI
2. Couriers shall limit the viewing or discussion of patients, their specimens and their requisitions only to the minimum extent necessary to ensure proper handling/transport of the specimens/requisitions
3. Patient reports that are delivered via courier to a physician office are in privacy envelopes and situated such that only the physician name/address are viewable
4. Couriers must every possible effort to ensure that specimens/requisitions/reports are not misplaced/lost during the course of their transport
5. Courier cars shall be locked at all times when left unattended
6. Every effort must be made to place specimens/requisitions/reports in the vehicle to maintain patient confidentiality
7. The Courier department is responsible for generating department specific procedures to ensure compliance with established entity-wide (URMC and Affiliates) policies, if applicable.

Road Techs:

1. Road techs may become aware of PHI concerning while performing their duties in a patient home or in a nursing home.
2. Road Techs shall limit the viewing or discussion of patients, their specimens and their Requisitions, if applicable only to the minimum extent necessary to ensure proper conduct of the phlebotomy, and subsequent transport of the specimens and requisitions
3. Road Techs must every possible effort to ensure that specimens/requisitions are not misplaced/lost during the course of their transport
4. Road Tech cars shall be locked at all times when left unattended
5. Every effort must be made to place specimens in the vehicle to maintain patient confidentiality
6. The Phlebotomy department is responsible for generating department specific procedures to ensure compliance with established entity-wide (URMC and Affiliates) policies, if applicable.

Outreach Services:

1. Outreach representatives shall limit the viewing or discussion of patients, their specimens and their requisitions only to the minimum extent necessary to ensure proper follow up of client specific concerns

Client Services and Exception Handling:

1. Healthcare Provider identity must be determined prior to verbal/fax release of patient results.
2. Patient identification must be confirmed with the provider prior to verbal/fax release of patient results.
3. Limited information may be provided when attempting to call a patient to schedule a re-draw.
   a. Positive patient identification must be determined prior to discussing the purpose of the call.
   b. Only limited information may be left on an answering machine when attempting to reach a patient.
5. The Client Services department is responsible for generating department specific procedures to ensure compliance with established entity-wide (URMC and Affiliates) policies, if applicable.

V. DISPOSAL OF SPECIMEN CONTAINERS / DOCUMENTS CONTAINING PHI

Documents or specimen containers that contain protected health information (PHI) are NOT to be discarded in regular trash.

Specimen Containers:
All specimen containers that are labeled with PHI are discarded as regulated medical waste.

Documents:
UR Medicine Labs participates in a paper recycling program. Confidential documents are placed in a secure bin, removed and shredded by a private vendor.

Unused labels:
Order entry into the LIS may results in additional, unnecessary labels being printed. This can occur at any UR Medicine location that has label printing capability. Extra labels are discarded either with the regulated medical waste or in the paper recycling bins.

VI. BREACH PROTECTED HEALTH INFORMATION (PHI)

All UR Medicine personnel have a legal and ethical duty to maintain the privacy, security and confidentiality of Patient Health Information (PHI). Any incident/breach of a patient's PHI will be reported immediately to the department supervisor. The department supervisor will contact the appropriate UR Medicine Lab Leadership and Privacy Officer and begin an incident investigation.

Information on URMC privacy policies, related information (including names, phone numbers) can be found on https://sites.mc.rochester.edu/departments/hipaa

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VII. HIPAA HIGHLIGHTS

URMC and Affiliates Privacy Office issues monthly informational updates in the form of "HIPAA Highlights'. These documents provide ongoing education for workforce members to reinforce awareness of Privacy policies and best practices.

Lab Management for each individual lab section/department should review each HIPAA Highlights to determine if the content is applicable to services provide. All applicable documents must be reviewed by department personnel. Documentation of employee review should be maintained within the department.

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Training or Read/Review Signature Log

Document Title:	HIPAA Plan		
Document Number:	UR.CP.QL.plc.0027.0001		
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Brief Description:

Revised: NEW

Trainer(s): N/A
(if applicable, or NA)

Your signature below indicates that you have read/been trained and understood the information.

Name (print)	Signature	Date (mmm/dd/yyyy)