LOMA LINDA UNIVERSITY
MEDICAL CENTER

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OPERATING POLICY

CATEGORY:	PATIENTS' RIGHTS	**CODE:**	P-16
		EFFECTIVE:	04/2018
SUBJECT:	PROTECTION OF PATIENT PRIVACY	**REPLACES:**	04/2015
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Related Documents:
Medical Records: Composition, Management, and Access (D-4)
Uses and Disclosures of Protected Health Information (D-5)
Breach Notification (E-1)
Managing Privacy and Information Security Risks (E-2)
Information Classification and Protection (E-12)
Disposal and Destruction of Confidential Media (G-34)
Privacy and Security Rules of Conduct

Definitions:

Protected health information (PHI):

Individually identifiable health information that includes any of the following:

- It is maintained or transmitted in any form or medium, e.g., written, verbal, electronic,
- It is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse,
- It relates to the past, present, or future physical or mental health or condition of an individual,
- It describes the past, present, or future payment for the provision of health care to an individual,
- It identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Confidential information:

Information whose loss, corruption, or unauthorized disclosure would be a violation of federal or state rules/regulations any LLUMC contracts, legal privilege, or evidentiary privilege, e.g., peer review. Patient data by default is considered confidential.

Use:

With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Disclosure:

The release, transfer, provision of access to, or divulging in any other manner, of information outside the entity holding the information.

Record:

Any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for LLUMC.

Designated record set:

Patient records (medical and billing) that are maintained by or for LLUMC and used to make decisions pertaining to the patient's health care or payment for health care.

Minimum Necessary:

Minimum amount of information that may be used or disclosed to accomplish the authorized intended purpose

1. General Provisions

1.1 All LLUMC employees, members of the medical staff, house staff, volunteers, faculty, and students, shall be responsible for maintaining the confidentiality of patient information. This responsibility shall include personal observations, oral conversations, the designated record set and its contents, and any other electronically stored or written patient or patient-related data.

1.2 All employees, including contract employees, and all volunteers shall be required to read and sign a confidentiality agreement. The signed agreements shall be kept on file in the Human Resource Management (HRM) Department and each signatory shall receive a copy.

2. Written Information

2.1 When possible, patient names shall be kept out of public view. If doing so will compromise patient care, the following shall be required:

a. The patient's first name and last initial shall be used rather than the patient's full name.

b. No other clinical or demographic information shall be posted with the name.

2.2 Only employees with job-related purposes shall have access to written PHI and those employees shall access only the minimum necessary information to perform their job functions (reference Policies Medical Records: Composition, Management, and Access (D-4) and Information Classification and Protection (E-12)).

2.3 Use/disclosure of PHI shall be done only according to the provisions of Policy Uses and Disclosures of Protected Health Information (D-5).

2.4 Paper charts, copies of charts, and all other protected health information (PHI) shall, when unattended, be placed only in secure locations, e.g., not accessible to unauthorized persons.

a. Paper charts with patients' names on them shall be placed out of public view when possible. The names shall be in small print so as not to be easily read by unauthorized persons.

b. When it is necessary to place charts in locations that are more visible to the public, the patients' names shall appear upside down or face away from public view.

c. Unknown and not properly identified persons who attempt to read charts shall be approached in a polite manner and asked their reasons for accessing charts. Those who do not offer appropriate identification and/or reasons for viewing charts shall not be allowed access.

2.5 Distributed lists and reports containing PHI, e.g., ADT list, census, medical record information, shall be delivered/distributed as follows:

a. Only to authorized persons or to secured designated receptacles

b. For printed information, in an envelope or with a cover sheet marked "confidential" or "restricted" as indicated, to preclude viewing of contents by unauthorized persons

c. Delayed if necessary to avoid unauthorized access to the materials.

2.6 Faxed medical information shall be managed according to Policy Fax Security (A-42).

2.7 All PHI that is to be discarded shall be placed in a recycle container or shredded, not placed in the regular trash (reference Policy Disposal and Destruction of Confidential Media (G-34)).

3. Transport of PHI.

Business practices sometimes require that protected health information (PHI), other than the patient's medical record, be transported offsite (e.g., between LLUMC facilities, to offsite clinics or to another pre-authorized location(s)).

NOTE: For removal and transport of patient's medical records refer to Policy Medical Records: Composition, Management, and Access (D-4).

3.1 PHI transported from one campus location to another or to an offsite facility or location shall be based on department business purposes only.

a. Confidential Information, including PHI, is not to be removed from LLUMC by members of the workforce including employees, residents, volunteers, trainees, and temporary workers, without prior approval from the department head.

3.2 Only designated individuals may transport PHI on or off campus.

3.3 Transportation of protected health information (PHI) should be limited to the "minimum necessary" to accomplish the authorized, intended purpose.

3.4 PHI must be safeguarded during transportation and shall not be left unattended in vehicles in publicly-accessible locations. Containers or envelopes with PHI shall:

a. Be kept safe from viewing through the vehicle's window by unauthorized persons (including passers-by), and
b. Be removed from vehicles immediately upon reaching the intended destination, or if vehicle is left unattended for an extended period of time in a private or publicly-accessible location (e.g. overnight).

3.5 The following shall apply to patient identifiable documents:

a. Patient identifiable documents include, but are not limited to:

1) Encounter forms and other billing documents
2) Copies of any portion of the patient chart
3) Surgery schedules, census and other reports
4) Note: Does not include transport of the patient medical record (reference Policy Medical Records: Composition, Management, and Access (D-4)).

b. When transporting patient identifiable documents, a confidentiality disclaimer as noted in section 3.6 shall be placed on the outside of any of the following containers used to safeguard the documents:

1) Sealed or closed envelopes marked "Confidential." Envelopes may be of different sizes and reusable (e.g., manila clasp, string/button, self-sealing)
2) Shoulder carrying bags or briefcases with locking mechanisms
3) Containers designated as confidential with locking mechanisms

c. Patient identifiable documents shall be delivered directly to the intended recipient, department, or secure location.

d. The workforce member is responsible for maintaining the privacy and security of all PHI they may be transporting or using off-site.

NOTE: The carrying of notes jotted down on post-its or other informal medium for use as personal reminders e.g., as reminders of schedules, callbacks, etc. should be avoided. If absolutely necessary to facilitate patient care, efforts should be taken to minimize identifiable information jotted down and to prevent inadvertent or accidental disclosure that could occur from notes falling from hands, pockets, etc.

3.6 Health care items shall be managed as follows:

a. Health care items that may be labeled or marked with patient identifiers include, but are not limited to:

1) Specimens
2) Slides
3) Medication bottles and other items that have labels with patient identifiers

b. Health care items labeled or marked with patient identifiers shall be safeguarded during transport using one or a combination of the following methods:

1) Covered bags, cases or containers marked confidential
2) Confidential notices placed in the holding bags or containers that are immediately visible upon opening

c. Health care items labeled or marked with patient identifiers shall be delivered directly to the intended recipient, department, or secure location.

3.7 The following disclaimer, or similar, shall be used on the Confidentiality Notice:

The documents contained herein are the property of Loma Linda University Medical Center (LLUMC) or Loma Linda University Health (LLUH) and are CONFIDENTIAL in nature. If you are the intended recipient, you are required to protect the documents from unauthorized use, access or disclosure. If you are not the intended recipient, please immediately return the documents unopened to the Compliance Department located at the LLUH Support Services building (101 East Redlands Boulevard, Suite 1400A, San Bernardino, CA 92408) or call 909-651-4200 and an authorized employee will arrange to pick-up the documents.

3.8 Any loss/theft or evidence of tampering of PHI during transport shall be immediately reported to the department manager and to the Compliance Department.

3.9. The carrying of portable devices or removable media with PHI shall be done only in accordance with the Privacy and Security Rules of Conduct (located on HIPAA One Portal under "Forms and Documents." .

4. Management of Electronic Information (reference Policy Information Classification and Protection (E-12))

4.1 Computer screens used to display PHI shall, when possible, be located/positioned so they are not visible to the public.

4.2 When space allocation and/or patient care needs do not allow for computer screens to be placed away from public view, the following measures shall be used:

a. A screen cover or other similar device shall be used to preclude viewing of the screen from side angles.

b. Those using the screens shall be alert to the possibility of public viewing and prevent unauthorized viewing.

4.3 PHI shall not be left on display when the user has finished using the information.

4.4 Electronic patient records shall be accessed only by authorized persons who have: (Reference Policy D-4)

a. Appropriate security clearance and passwords and

b. Job-related reasons to view such records and view the minimum information necessary to perform job functions.

4.5 PHI shall not be downloaded to/stored in personally-owned or LLUMC-owned computer or laptop hard drive, i.e., c: drive, unless previously authorized and encrypted via an IS approved methodology.

4.6 PHI contained in electronic devices, to include but not be limited to, personal electronic devices, shall be password protected and afforded the same protection as all other electronic PHI.

4.7 Electronic devices used to convey PHI are required to operate according to the applicable provisions listed in Policy E-12.B.

5. Oral Communications

5.1 Employees shall provide the maximum possible privacy for conversations with patients/families and make every effort to prevent sensitive information from being overheard.

5.2 Employees shall not discuss PHI in public areas, e.g., hallways, cafeteria, elevators.

5.3 PHI shall not be discussed during phone conversations unless absolutely necessary and the LLUMC caregiver is certain of the identity of the person with whom he or she is speaking.

a. Use of phones in public areas shall be avoided if possible.
b. If total privacy is not possible, the person using the phone shall keep the conversation to a minimum and make every effort to avoid being overheard.

5.4 Messages that include PHI shall not be left on patients' answering machines unless delay in contacting the patient would likely cause harm. Minimum necessary standard applies. A direct phone number to allow the patient to contact the caller back must be provided.

6. Breach of Privacy Policies and/or Regulations (reference Policies E-1 and E-12)

6.1 Incidents of inadvertent/unauthorized disclosures of PHI shall be evaluated by the Compliance Department with assistance as needed from:

a. General Counsel
b. Information Systems
c. Health Information Management
d. Administrative persons as indicated by incident:
    1) Vice President for Public Relations
    2) President, Medical Staff
    3) Department Heads
    4) Vice Presidents
    5) Clinical Risk Manager/designee
    6) Quality Resource Management Director

6.2 Actions shall be taken according to the following (reference Policy Privacy and Information Security Violations (E-15):

a. The findings of the investigation
b. Regulatory requirements
c. LLUMC policy requirements
d. The patient's best interest
e. Ethical business practices.

APPROVED: Hospital Executive Leadership, LLUMC Chief Executive Officer, LLUMC Chief Nursing Officer, LLUMC Medical Staff President and Chair of MSEC