

Breach Notification Policy

1. Introduction

- a. Clark County has adopted this Breach Notification Policy to comply with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), Subtitle D—Privacy, the Department of Health and Human Services (“DHHS”) security and privacy regulations, and the Joint Commission on Accreditation of Healthcare Organizations accreditation standards, as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.
- b. In addition, this policy will assist Clark County in fulfilling its obligation under the DHHS privacy regulations to mitigate damages caused by breach of individual privacy.

2. Purpose

- a. The purpose of this policy is to provide guidance for breach notification by covered entities when impermissible or unauthorized access, acquisition, use and/or disclosure of the organization’s patient protected health information occurs.

3. Attachments:

- Breach Penalties
- Sample Notification Letter to Patients
- Sample Media Notification Statement/Release

4. Definitions:

Access: Means the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource.

Agent: An agent of the organization is determined in accordance with federal common law of agency. The organization is liable for the acts of its agents. An agency relationship exists if the organization has the right or authority of the organization to control the agent’s conduct in the course of performing a service on behalf of the organization (i.e. give interim instructions, direct the performance of the service).

Breach: Means the acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under the Privacy Rule which compromises the security or privacy of the PHI and is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

- a. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

- b. The unauthorized person who used the protected health information or to the disclosure was made;
- c. Whether the protected health information was actually acquired or viewed; and
- d. The extent to which the risk to the protected health information has been mitigated.

Breach excludes:

- a. Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a Covered Entity (CE) or Business Associate (BA) if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.
- b. Any inadvertent disclosure by a person who is authorized to access PHI at a CE or BA to another person authorized to access PHI at the same CE or BA, or organized health care arrangement in which the CE participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.
- c. A disclosure of PHI where a CE or BA has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Covered Entity: A health plan, health care clearinghouse, or a healthcare provider who transmits any health information in electronic form.

Disclosure: Disclosure means the release, transfer, provision of, access to, or divulging in any manner of information outside the entity holding the information.

Individually Identifiable Health Information: That information that is a subset of health information, including demographic information collected from an individual, and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Law Enforcement Official: Any officer or employee of an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to investigate or conduct an official inquiry into a potential violation of law; or prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Organization: For the purposes of this policy, the term “organization” shall mean the covered entity to which the policy and breach notification apply.

Protected Health Information (PHI): Protected health information means individually identifiable health information that is: transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium (see regulations for complete definition and exclusions)

Unsecured Protected Health Information: Protected health information (PHI) that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology specified by the Secretary in the guidance issued under section

13402(h)(2) of Pub. L.111-5 on the HHS website.

a. Electronic PHI has been encrypted as specified in the HIPAA Security rule by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools should be stored on a device or at a location separate from the data they are used to encrypt or decrypt. The following encryption processes meet this standard.

1) Valid encryption processes for data at rest (i.e. data that resides in databases, file systems and other structured storage systems) are consistent with NIST Special Publication 800-111, Guide to Storage Encryption Technologies for End User Devices.

2) Valid encryption processes for data in motion (i.e. data that is moving through a network, including wireless transmission) are those that comply, as appropriate, with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, and may include others which are Federal Information Processing Standards FIPS 140-2 validated.

b. The media on which the PHI is stored or recorded has been destroyed in the following ways:

1) Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.

2) Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publications 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved. Refer also to HIPAA COW Security Networking Group policy: Device, Media, and Paper Record Sanitization for Disposal or Reuse.

Workforce: Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such entity, whether or not they are paid by the covered entity or business associate.

5. Policy:

a. Discovery of Breach: A breach of PHI shall be treated as “discovered” as of the first day on which an incident that may have resulted in a breach is known to the organization, or, by exercising reasonable diligence would have been known to the organization (includes breaches by the organization’s business associates). The organization shall be deemed to have knowledge of a breach if such breach is known or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent (e.g. a business associate acting as an agent of the organization) of the organization. Following the discovery of a potential breach, the organization shall begin an investigation (see organizational policies for security incident response and/or risk management incident response), conduct a risk assessment, and based on the results of the risk assessment, begin the process to notify each individual whose PHI has been, or is reasonably believed to be by the organization to have

been accessed, acquired, used, or disclosed as a result of the breach. The organization shall also begin the process of determining what external notifications are required or should be made (e.g., Secretary of Department of Health & Human Services (HHS), media outlets, law enforcement officials, etc.)

- b. Breach Investigation: The Corporation Counsel is the primary individual responsible to investigate a breach along any other individuals deemed necessary. The investigator shall be responsible for the management of the breach investigation, completion of a risk assessment, and coordinating with others in the organization as appropriate (e.g., administration, security incident response team, human resources, risk management, public relations, legal counsel, etc.) The investigator shall be the key facilitator for all breach notification processes to the appropriate entities (e.g., HHS, media, law enforcement officials, etc.). All documentation related to the breach investigation, including the risk assessment and notifications made, shall be retained for a minimum of six years.
- c. Risk Assessment: For an acquisition, access, use or disclosure of PHI to constitute a breach, it must constitute a violation of the Privacy Rule. A use or disclosure of PHI that is incident to an otherwise permissible use or disclosure and occurs despite reasonable safeguards and proper minimum necessary procedures would not be a violation of the Privacy Rule and would not qualify as a potential breach. An “acquisition, access, use, or disclosure in a manner not permitted is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment” of at least the following factors:
 - 1) The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
 - 2) The unauthorized person who used the protected health information or to the disclosure was made;
 - 3) Whether the protected health information was actually acquired or viewed; and
 - 4) The extent to which the risk to the protected health information has been mitigated.
- d. The organization shall document the risk assessment as part of the investigation in the incident report form noting the outcome of the risk assessment process. The organization has the burden of proof for demonstrating that all notifications were made as required or that the use or disclosure did not constitute a breach. Based on the outcome of the risk assessment, the organization will determine the need to move forward with breach notification. The organization may make breach notifications without completing a risk assessment.
- e. Timeliness of Notification: Upon determination that breach notification is required, the notice shall be made without unreasonable delay and in no case later than 60 calendar days after the discovery of the breach by the organization involved or the business associate involved that is acting as the organization’s agent. It is the responsibility of the

organization to demonstrate that all notifications were made as required, including evidence demonstrating the necessity of delay.

- f. Delay of Notification Authorized for Law Enforcement Purposes: If a law enforcement official states to the organization that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, the organization shall:
- 1) If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting of the time period specified by the official; or
 - 2) If the statement is made orally, document the statement, including the identify of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.
- g. Content of the Notice: The notice shall be written in plain language and must contain the following information:
- 1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
 - 2) A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved).
 - 3) Any steps the individual should take to protect themselves from potential harm resulting from the breach.
 - 4) A brief description of what the organization is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.
 - 5) Contact procedures for individuals to ask questions or learn additional information, which includes a toll-free telephone number, an e-mail address, Web site, or postal address.
- h. Methods of Notification: The method of notification will depend on the individuals/entities to be notified. The following methods must be utilized accordingly:
- 1) Notice to Individual(s): Notice shall be provided promptly and in the following form:
 1. Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification shall be provided in one or more mailings as information is available. If the organization knows that the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to the next of kin or personal representative shall be carried out. Limited examples (refer to preamble for more examples):
 - a. The organization may send one breach notice addressed to both a plan participant and the participant's spouse or other dependents under the plan who are affected by a breach, if

- they all reside at a single address and all individuals to which the notice applies are clearly identified on the notice. When a plan participant (and/or spouse) is not the personal representative of a dependent under the plan, however, address a breach notice to the dependent himself or herself.
- b. In the limited circumstance that an individual affirmatively chooses not to receive communications from a health care provider at any written addresses or email addresses *and* has agreed only to receive communications orally or by telephone, the provider may telephone the individual to request and have the individual pick up their written breach notice from the provider directly. In cases in which the individual does not agree or wish to travel to the provider to pick up the written breach notice, the health care provider should provide all of the information in the breach notice over the phone to the individual, document that it has done so, and the Department will exercise enforcement discretion in such cases with respect to the “written notice” requirement.
2. Substitute Notice: In the case where there is insufficient or out-of-date contact information (including a phone number, email address, etc.) that precludes direct written or electronic notification, a substitute form of notice reasonably calculated to reach the individual shall be provided. A substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative.
 - a. In a case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then the substitute notice may be provided by an alternative form of written notice, telephone, or other means.
 - b. In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then the substitute notice shall be in the form of either a conspicuous posting for a period of 90 days on the home page of the organization’s website, or a conspicuous notice in a major print or broadcast media in the organization’s geographic areas where the individuals affected by the breach likely reside. The notice shall include a toll-free number that remains active or at least 90 days where an individual can learn whether his or her PHI may be included in the breach.
 3. If the organization determines that notification requires urgency because of possible imminent misuse of unsecured PHI, notification may be provided by telephone or other means, as appropriate in addition to the methods noted above.

- 2) Notice to Media: Notice shall be provided to prominent media outlets serving the state and regional area (of the breached patients) when the breach of unsecured PHI affects 500 or more of the organization's patients of a State or jurisdiction.
 1. The Notice shall be provided in the form of a press release.
 2. What constitutes a prominent media outlet differs depending upon the State or jurisdiction where the organization's affected patients reside. For a breach affecting more than 500 individuals across a particular state, a prominent media outlet may be a major, general interest newspaper with a daily circulation throughout the entire state. In contrast, a newspaper serving only one town and distributed on a monthly basis, or a daily newspaper of specialized interest (such as sports or politics) would not be viewed as a prominent media outlet. Where a breach affects more than 500 individuals in a limited jurisdiction, such as a city, then a prominent media outlet may be a major, general-interest newspaper with daily circulation throughout the city, even though the newspaper does not serve the whole State.
- 3) Notice to Secretary of HHS: Notice shall be provided to the Secretary of HHS as follows below. The Secretary shall make available to the public on the HHS Internet website a list identifying covered entities involved in all breaches in which the unsecured PHI of more than 500 patients is accessed, acquired, used, or disclosed.
 1. For breaches involving 500 or more individuals, the organization shall notify the Secretary of HHS as instructed at www.hhs.gov at the same time notice is made to the individuals.
 2. For breaches involving less than 500 individual, the organization will maintain a log of the breaches. The breaches may be reported during the calendar year or no later than 60 days after the end of that calendar year in which the breaches were discovered (e.g., 2012 breaches must be submitted by 3/1/2013 – 60 days). Instructions for submitting the logged breaches are provided at www.hhs.gov.
- i. Maintenance of Breach Information/Log: As described above and in addition to the reports created for each incident, the organization shall maintain a process to record or log all breaches of unsecured PHI regardless of the number of patients affected. The following information should be collected/logged for each breach (see sample Breach Notification Log):
 - 1) A description of what happened, including the date of the breach, the date of the discovery of the breach, and the number of patients affected, if known.
 - 2) A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, etc.).
 - 3) A description of the action taken with regard to notification of patients, the media, and the Secretary regarding the breach.
 - 4) The results of the risk assessment.
 - 5) Resolution steps taken to mitigate the breach and prevent future occurrences.

- j. Business Associate Responsibilities: In 2013, the Omnibus Rule extended liability for compliance to the HIPAA Privacy and Security Rules to business associates and their subcontractors. With these modifications, business associates are now directly liable for impermissible uses and disclosures, provision of breach notification to the covered entity, completing breach risk assessments, breach documentation requirements, and civil and criminal penalties for violations. The business associate (BA) of the organization that accesses, creates, maintains, retains, modifies, records, stores, transmits, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, without unreasonable delay and in no case later than 60 calendar days after discovery of a breach, notify the organization of such breach (when the business associate is an agent of the organization, this notification must be provided within a shorter timeframe as specified in the Business Associate Agreement policy). Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the BA to have been, accessed, acquired, or disclosed during such breach. The BA shall provide the organization with any other available information that the organization is required to include in notification to the individual at the time of the notification or promptly thereafter as information becomes available. Upon notification by the BA of discovery of a breach, the organization will be responsible for notifying affected individuals, unless otherwise agreed upon by the BA to notify the affected individuals (note: it is the responsibility of the Covered Entity to document this notification).
- k. Workforce Training: The organization shall train all members of its workforce on the policies and procedures with respect to PHI as necessary and appropriate for the members to carry out their job responsibilities. Workforce members shall also be trained as to how to identify and promptly report breaches within the organization, as well as return or destroy PHI, as appropriate for the incident. Workforce members that assist in investigating, documenting, and resolving breaches are trained on how to complete these activities.
- l. Complaints: The organization must provide a process for individuals to make complaints concerning the organization's patient privacy policies and procedures or its compliance with such policies and procedures. Individuals have the right to complain about the organization's breach notification processes.
- m. Sanctions: The organization shall have in place and apply appropriate sanctions against members of its workforce who fail to comply with privacy policies and procedures.
- n. Retaliation/Waiver: The organization may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for the exercise by the individual of any privacy right. The organization may not require individuals to waive their privacy rights under as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

ATTACHMENTS

Breach Penalties

Penalties for Breach: Penalties for violations of HIPAA have been established under HITECH as indicated below. The penalties do not apply if the organization did not know (or by exercising reasonable diligence would not have known) of the violation or if the failure to comply was due to a reasonable cause and was corrected within thirty days. Penalties will be based on the organization's culpability for the HIPAA violation. The Secretary of HHS will base its penalty determination on the nature and extent of the violation. The Secretary still will have the discretion to impose corrective action without a penalty in cases where the person did not know (and by exercising reasonable diligence would not have known) that such person committed a violation.

The maximum penalty is \$50,000 per violation, with a cap of \$1,500,000 for all violations of an identical requirement or prohibition during a calendar year.

The minimum civil monetary penalties are tiered based upon the entity's perceived culpability for the HIPAA violation, as follows:

Tier A – *If the offender did not know*

- \$100 for each violation, total for all violations of an identical requirement during a calendar year cannot exceed \$25,000.

Tier B – *Violation due to reasonable cause, not willful neglect*

- \$1,000 for each violation, total for all violations of an identical requirement during a calendar year cannot exceed \$100,000.

Tier C – *Violation due to willful neglect, but was corrected.*

- \$10,000 for each violation, total for all violations of an identical requirement during a calendar year cannot exceed \$250,000.

Tier D – *Violation due to willful neglect, but was NOT corrected.*

- \$50,000 for each violation, total for all violations of an identical requirement during a calendar year cannot exceed \$1,500,000.

Sample Notification Letter to Patients – Document to be Reviewed and Customized Prior to Use

[Date]

[Name here]

[Address 1 Here]

[Address 2 Here]

[City, State Zip Code]

Dear [Name of Organization Patient or Patient Name]:

I am writing to you with important information about a recent breach of your personal information from [Name of Organization]. We became aware of this breach on [Insert Date] which occurred on or about [Insert Date]. The breach occurred as follows:

Describe event and include the following information:

- 1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
- 2) A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved).
- 3) Any steps the individual should take to protect themselves from potential harm resulting from the breach.
- 4) A brief description of what the organization is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.
- 5) Contact procedures for individuals to ask questions or learn additional information, which includes a toll-free telephone number, an e-mail address, Web site, or postal address.

Other Optional Considerations:

To help ensure that this information is not used inappropriately, [Name of Organization] will cover the cost for one year for you to receive credit monitoring. To take advantage of this offer, [Need to document the process for how this would work].

We also advise you to immediately take the following steps:

- Call the toll-free numbers of anyone of the three major credit bureaus (below) to place a fraud alert on your credit report. This can help prevent an identity thief from opening additional accounts in your name. As soon as the credit bureau confirms your fraud alert, the

other two credit bureaus will automatically be notified to place alerts on your credit report, and all three reports will be sent to you free of charge.

- Equifax: 1-800-525-6285; www.equifax.com; P.O. Box 740241, Atlanta, GA 30374-0241.
 - Experian: 1-888-EXPERIAN (397-3742); www.experian.com; P.O. Box 9532, Allen, TX 75013.
 - TransUnion: 1-800-680-7289; www.transunion.com; Fraud Victim Assistance Division, P.O. Box 6790, Fullerton, CA 92834-6790.
- Order your credit reports. By establishing a fraud alert, you will receive a follow-up letter that will explain how you can receive a free copy of your credit report. When you receive your credit report, examine it closely and look for signs of fraud, such as credit accounts that are not yours.
 - Continue to monitor your credit reports. Even though a fraud alert has been placed on your account, you should continue to monitor your credit reports to ensure an imposter has not opened an account with your personal information.

We take very seriously our role of safeguarding your personal information and using it in an appropriate manner. [Name of Organization] apologizes for the stress and worry this situation has caused you and is doing everything it can to rectify the situation.

We have established a toll-free number to call us with questions and concerns about the loss of your personal information. You may call [Insert Toll Free Number] during normal business hours with any questions you have.

We have also established a section on our Web site with updated information and links to Web sites that offer information on what to do if your personal information has been compromised.

[Insert Closing Paragraph Based on Situation]

Sincerely,

[Insert Applicable Name/Contact Information]

Sample Media Notification Statement/Release – Document to be Reviewed and Customized
Prior to Use

[Insert Date]

Contact: [Insert Contact Information Including Phone Number/E-Mail Address]

IMMEDIATE RELEASE

[INSERT NAME OF ORGANIZATION] NOTIFIES PATIENTS OF BREACH OF
UNSECURED PERSONAL INFORMATION

[Insert Name of Organization] notified [Insert Number] patients of a breach of unsecured personal patient protected health information after discovering the following event:

Describe event and include the following information as communicated to the victims:

- A. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
- B. A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, disability code or other types of information were involved).
- C. Any steps the individual should take to protect themselves from potential harm resulting from the breach.
- D. A brief description of what the organization is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.
- E. Contact procedures for individuals to ask questions or learn additional information, which includes a toll-free telephone number, an e-mail address, Web site, or postal address.

In conjunction with local law enforcement and security experts, [Name of Organization] is working to notify impacted patients to mitigate the damages of the breach. [Name of Organization] has in place safeguards to ensure the privacy and security of all patient health information. As a result of this breach, steps are underway to further improve the security of its operations and eliminate future risk.

In a notification to patients, [Name of Organization] has offered their resources as well as [Insert as Applicable]. [Name of Organization] also has encouraged its patients to contact their financial institutions to prevent unauthorized access to personal accounts.

[Name of Organization] has trained staff available for patients to call with any questions related to the data breach. Patients may call [Insert Phone Number Here] from [Insert Hours] with any questions. In addition, patients may visit [Name of Organization's] Web site at [Insert Web Address] for further information.

[Name of Organization] understands the importance of safeguarding our patients' personal information and takes that responsibility very seriously," said [Insert Name], President and CEO. "We will do all we can to work with our patients whose personal information may have been compromised and help them work through the process. We regret that this incident has occurred, and we are committed to prevent future such occurrences. We appreciate our patients support during this time.

Please direct all questions to [Enter Contact Information].