UNIVERSITY OF WYOMING

HIPAA POLICY 1.1

HIPAA GENERAL POLICY AND ADMINISTRATIVE REQUIREMENTS

I. Background: The University of Wyoming ("UW"), through Presidential Directive PD3-2015-1, "HIPAA Hybrid Entity Designation", has designated itself a hybrid entity pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These HIPAA policies apply to all designated UW healthcare components ("UW Covered Component"), including the business associate components as identified by UW. All UW Covered Components must ensure the confidentiality of identifiable health information as required by HIPAA, in addition to complying with any other applicable state or Federal privacy laws.

II. Policies and Procedures: Pursuant to HIPAA, the University of Wyoming has developed a series of written policies and procedures that are consistent with the HIPAA Privacy and Security Rules. Only the designated Covered Components of UW must comply with these policies and procedures.

a. Changes: The UW HIPAA policies and procedures shall be changed as necessary and appropriate to comply with changes in the laws and regulations or in accordance with University of Wyoming policies or regulations, provided that the changes are documented and implemented in accordance with HIPAA documentation requirements.

b. Applicability of Policies: The use and/or disclosure of Protected Health Information, both within any UW Covered Component and outside of a UW Covered Component, including disclosure to another UW department, shall occur according to these policies and procedures. The procedures set forth by a UW Covered Component to accompany these policies may vary, taking into account the size of and the type of activities that relate to PHI undertaken by the UW Covered Component.

III. Safeguards: Each UW Covered Component must have in place appropriate administrative, technical and physical safeguards to protect the privacy of PHI.

IV. Sanctions: The University of Wyoming has a policy for sanctions against workforce members who violate its HIPAA policies and procedures (See UW HIPAA Policy 3.5, Sanctions).

V. Mitigation: Each UW Covered Component will make good faith efforts to mitigate, to the extent practicable, any harmful effect that is known to have occurred as a result of a use or disclosure of PHI by the UW Covered Component in violation of these policies or privacy regulations.

i. The following factors will be evaluated to determine the best mitigation strategies:

1. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

2. The unauthorized person who used the PHI or to whom the disclosure was made;
3. Whether the PHI was actually acquired or viewed; and
4. The extent to which the risk to the PHI has been mitigated.

ii. After investigation, if mitigation is required, departments and/or individuals involved in the privacy breach may be asked to assist in mitigating harmful effects.

iii. Mitigation efforts may include, but are not limited to, containing the damage and stopping further use or disclosure; retraining employees to prevent future mistakes or errors; applying discipline or sanctions as required by UW policy; using the violation as a means to identify systemic problems; and informing the individual patients, government agencies or the media, when required, of any improper use or disclosure arising from a violation of HIPAA.

VI. Privacy/Security Personnel: Each UW Covered Component must designate in writing a Privacy and Security Officer responsible for the development, monitoring and enforcement of the UW Covered Component's HIPAA policies and procedures, receiving complaints, and providing individuals with information on the UW Covered Component's privacy practices. The UW Covered Component may attach this designation to this policy. Each UW Covered Component shall also work and consult regularly with the appointed UW-wide HIPAA Privacy Officer and Security Officer and the Office of General Counsel, as needed.

VII. Training: HIPAA training is required of every member of each of the UW Covered Components' workforce as necessary and appropriate to carry out his or her duties in compliance with these University of Wyoming HIPAA policies and procedures.

a. **Definition of Workforce:** A UW Covered Component's workforce includes employees, volunteers, trainees and any other person whose conduct is under the direct control of the UW Covered Component.
b. **New Members of the Workforce:** Each UW Covered Component shall provide training to each new member of the workforce within 30 days of the workforce member's start date and shall be completed by the new member before that individual is granted access to PHI.
c. **Ongoing Training:** Members of the UW Covered Component's workforce whose functions are affected by a material change in policies shall be re-trained within a reasonable period of time after the material changes to HIPAA policies and procedures are effective. The UW Covered Component shall also re-train or provide refresher courses or awareness training to workforce members as reasonably necessary to ensure adequate continuing knowledge or compliance at a minimum of every two years or when the individual's job function changes to include increased and/or different access to PHI.
d. **Content:** The content of the training shall meet the federal requirements and be approved by the UW-wide Privacy and Security Officers in consultation with the Office of General Counsel.

e. **Documentation:** Each UW Covered Component shall maintain written documentation of what HIPAA training has been provided to each member of its workforce. This list shall be provided to the UW-wide Privacy and/or Security Officer or the Office of General Counsel upon request.

VIII. Data Safeguards: Each UW Covered Component must maintain reasonable and appropriate administrative, technical and physical safeguards to prevent intentional or unintentional use or disclosure of PHI in violation of the HIPAA Privacy Rule and to limit any incidental uses or disclosures to otherwise permitted or required uses or disclosures. .

IX. Refraining from Intimidating or Retaliatory Acts: UW Covered Components shall not intimidate, threaten, coerce, discriminate against, or take any other retaliatory actions against an individual for the exercise of the individual of any right under, or for participation by the individual in any process established under HIPAA, including the filing of a complaint; assisting in an investigation by the Department of Human and Health Services or another appropriate authority, or for opposing an act or practice that the individual believes in good faith violates the Privacy Rule.

X. Documentation and Record Retention: HIPAA requires that certain documentation be retained by the covered entity relating to PHI and uses and/or disclosures of PHI.

a. **Required by HIPPA:** Each UW Covered Component must maintain the following for a period of six years from the date of its creation or when it was last in effect, or as required by other state or federal laws or University Regulations, whichever is later:

i. All HIPAA policies or procedures-document local policies and procedures and any changes to the policies and procedures;
ii. Business Associate Agreements- all signed Business Associate Agreements;
iii. Patient Authorizations-all signed Patient Authorizations and, if appropriate, verification of the persons' right to sign on behalf of patient;
iv. Waiver of Authorizations for Research Purposes-certification from the researcher requesting PHI that the IRB has approved a Waiver of Authorization and met the HIPAA-required criteria for a Waiver of Authorization;
v. Notices of Privacy Practices, including written acknowledgement of receipt and documentation of good faith effort to obtain written acknowledgement when the patient refuses to provide written acknowledgement;
vi. Patient's Request for Restrictions- all agreed-to restrictions;
vii. Access or copying of the Designated Record Set (DRS)- [*UW Covered Entity*] should document the DRS that is subject to access by individuals and the titles of the persons or offices responsible for receiving and processing requests for access by individuals; document responses to requests for access or copying, as required;

viii. Amendment- document the titles of persons or offices responsible for receiving and processing requests for amendments by individuals; document responses to request for an amendment;
ix. Accounting of Disclosures- document the information required to be provided if an accounting of disclosures is requested;
x. Personnel Designations, i.e. the Privacy and Security Officer and person responsible for receiving complaints;
xi. Training, including documentation for each workforce member that has completed training;
xii. Complaints/Investigations- document all complaints received and their disposition, if any;
xiii. Sanctions- document any sanctions that are applied against members of the workforce who fail to comply with HIPAA policies and procedures, if any;
xiv. Any other communication, action, activity or designation that, under the Privacy Rule, must be maintained in writing or otherwise documented.
xv. Documents the UW Covered Component requires be retained for the 6 year period, if any.

XI. REFERENCES/APPLICABLE LAW

a. 45 C.F.R. Section 164.530

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