



# **Volunteer Compliance Requirements**

This packet consists of acknowledgements and signature pages which should be obtained by the facility from all volunteers prior to their volunteering in the facility. The policies related to each acknowledgment are listed in the Table of Contents and can be found in the CCG Portal.

# Volunteer Compliance Requirements

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**ACKNOWLEDGEMENT OF CODE OF CONDUCT  
AND COMPLIANCE AND ETHICS PLAN**

I hereby acknowledge that I received a copy of the Facility's Code of Conduct, Corporate Compliance and Ethics Plan, and compliance and ethics program policies and procedures and that I had the opportunity to review them. I understand that I should report any compliance and/or ethics concerns to either the compliance and ethics officer or any other member of the Governing Body. I hereby agree to abide by the requirements of this Code of Conduct, the Compliance and Ethics Plan, the compliance and ethics policies and procedures, and the compliance and ethics program in general. I further understand that adherence to this policy is a condition of my continued business dealings with the Facility.

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Print Name

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Signature

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Company Name (If Contractor)

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Date

## **Acknowledgement of Training and Receipt of Deficit Reduction Act of 2005 Policy and Procedure**

I hereby acknowledge by my signature that I have received and read the Deficit Reduction Act of 2005 Policy and Procedure, agree to comply with it, and understand that:

- This Facility is committed to providing quality care for its residents and submitting reimbursement claims for healthcare services that have been properly provided and that are supported by complete documentation.
- This Facility has a Compliance and Ethics Program that provides support to each employee while providing quality care and adhering to all applicable laws and regulations. I have received a copy of this Facility's Compliance and Ethics Program Manual and I am aware that additional copies are available through the Facility's Administrator or Compliance and Ethics Officer.
- If I have any concerns that may involve a violation of a law or regulation, even if I am unsure if the issue is a violation of any law or regulation, I am encouraged and expected to report such concern without delay.
- Concerns related to this policy may be reported to my manager, the Administrator, or the Compliance and Ethics Officer. Calls may also be made anonymously to the Compliance and Ethics Hotline at **(800) 610-2544**.
- I understand that this Facility will not intimidate me from reporting, nor will I face any retaliation, provided my report was made in good faith.
- This Facility is committed to complying with the Deficit Reduction Act of 2005 as outlined in this Policy and Procedure.
- Vendors and Contractors only: I agree to abide by the standards contained in this Policy and Procedure, and also agree to participate in this Facility's mandatory compliance and ethics training as applicable. I agree to disseminate this Facility's policies to my managers and employees.

Choose one:

☐ Employee

☐ Health Care Provider

☐ Vendor

☐ Other: \_\_\_\_\_

\_\_\_\_\_  
Name of individual (Please print)

\_\_\_\_\_  
Name of company (Please print)

**ACKNOWLEDGEMENT OF RECEIPT OF AND TRAINING IN  
PREVENTION OF FRAUD, WASTE, AND ABUSE POLICIES AND  
PROCEDURES**

I hereby acknowledge that the Facility has provided me with copy of the Facility's Fraud, Waste, and Abuse ("FWA") Policies and Procedures that I have reviewed. I further acknowledge that the Facility has provided me with FWA training in the form of the CMS provided FWA training. I am aware that I must report any compliance and ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_, or as a last resort by calling our Compliance and Ethics Hotline at (800) 610-2544. I hereby agree to abide by the requirements of the FWA Policies and Procedures.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***\* Training must be completed within 30 days of initial hiring and annually thereafter.***

**ACKNOWLEDGEMENT OF RECEIPT OF POLICY AND  
PROCEDURE REGARDING RESIDENT FREEDOM FROM  
ABUSE, NEGLECT, AND EXPLOITATION AND THE ELDER  
JUSTICE ACT**

I hereby acknowledge by my signature that I have received a copy of the Facility's policies and procedures. I hereby agree to abide by the requirements of these policies as well the compliance and ethics program in general. I further understand that adherence to these policies is a condition of employment or continued business dealings with the Facility, and that I have a duty to report any compliance and/or ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_, or as a last resort by openly or anonymously calling our Compliance and Ethics Hotline at (800) 610-2544.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Company Name (If Contractor)

\_\_\_\_\_  
Date

## **Substance Abuse Acknowledgement of Receipt and Review**

I, \_\_\_\_\_, acknowledge that on \_\_\_\_\_, I received a copy of the Facility's Substance Abuse in the Workplace Policy and Procedure and that I read it, understood it and agree to comply with it. I understand that the Facility has the maximum discretion permitted by law to interpret, administer, change, modify or delete this policy at any time, with or without notice. No statement or representation by a supervisor or manager or any other Associate, whether oral or written, can supplement or modify this policy. Changes can only be made if approved in writing by the Compliance and Ethics Officer. I also understand that any delay or failure by the Facility to enforce this policy will not constitute a waiver of the Facility's right to do so in the future.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

## **Acknowledgment of Receipt and Review**

I, \_\_\_\_\_, acknowledge that on \_\_\_\_\_, I received a copy of the Facility's Workplace Searches Policy and Procedure and that I read it, understood it and agree to comply with it. I understand that the Facility has the maximum discretion permitted by law to interpret, administer, change, modify, or delete this policy at any time. No statement or representation by a supervisor or manager or any other Associate, whether oral or written, can supplement or modify this policy. Changes can only be made if approved in writing by the Compliance and Ethics Officer. I also understand that any delay or failure by the Facility to enforce any work policy or rule will not constitute a waiver of the Facility's right to do so in the future.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE



**ACKNOWLEDGEMENT OF RECEIPT OF POLICY AND PROCEDURE  
REGARDING PROTECTING RESIDENT PRIVACY AND PROHIBITING  
MENTAL ABUSE RELATED TO PHOTOGRAPHS AND AUDIO/VIDEO  
RECORDINGS BY STAFF**

I hereby acknowledge by my signature that I have received a copy of the Facility's policy and procedure. I hereby agree to abide by the requirements of this policy as well the compliance and ethics program in general. I further understand that adherence to this policy is a condition of employment or continued business dealings with the Facility, and that I have a duty to report any compliance and ethics concerns to either my manager, the Administrator, the Compliance and Ethics Officer \_\_\_\_\_, or as a last resort by openly or anonymously calling our Compliance and Ethics Hotline at (800) 610-2544.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Company Name (If Contractor)

\_\_\_\_\_  
Date

## **Volunteer Screening Authorization**

I \_\_\_\_\_, hereby authorize the release of criminal background screening reports to the Facility.

Name of Applicant:

Date: \_\_\_\_\_

\_\_\_\_\_

Signature of Applicant:

\_\_\_\_\_

## **GUIDELINES FOR VOLUNTEERS**

Dear Volunteer,

Welcome to the Volunteers Program! As a potential volunteer working with the residents of the Facility, you can be a very important part of our team. Our goal is to provide quality care in an atmosphere that allows both residents and their families to feel at ease during the resident's stay in the facility. Through the efforts of all, the Facility has achieved a solid reputation in the community for providing consistent, quality care for those who reside here.

Listed below are a few qualities that are useful for us to find in our volunteers:

- A solid interest in the elderly
- Dependability
- Courtesy
- Punctuality

Becoming a volunteer will involve:

- Completing an application
- Taking a tour of the facility
- Reviewing the guidelines for volunteers
- Being introduced to staff and/or residents
- Asked to have a TB test (provided by the Facility and/or the Health Department at no cost to you).

Please make special note of Section 8 in the following pages. Thanks for your interest in helping the Facility!

Sincerely,

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Volunteers Coordinator

## THE FOLLOWING IS A GUIDE FOR ALL THE FACILITY VOLUNTEERS

- I. Residents' Right to Privacy
  - A. Medical and personal care are private. Volunteers must respect the privacy of a resident at all times.
  - B. Volunteers may not share information about a resident or his/her care to unauthorized persons without the resident's or an authorized person's permission. A resident has the right to have private visits at any reasonable hour. The only exception is if his/her doctor has ordered limited visits for medical reasons.
- II. Volunteers are not allowed inside the rooms of any residents without express permission from the resident.
  - A. A resident may ask a visitor to leave their personal living area.
  - B. A resident has the right to make and receive phone calls in private.
  - C. The facility must deliver a resident's personal mail promptly, and promptly send mail out for the resident. The facility may not open a resident's personal mail.
- III. Confidentiality
  - A. As a volunteer, you will have direct contact with many of the residents residing in the facility. Depending on your involvement, it is possible you will come to know a significant amount of confidential information about a few, or possibly several, of our residents. This can range from family relationships to their medical history. This information is strictly confidential and should not be discussed with others outside the facility.
- IV. Disaster Preparedness
  - A. If you are present at a time of a disaster, move to a safe place and if possible locate and ask a staff member (preferably a department head or charge nurse) where your help may be needed.
- V. Emergency Response Procedures
  - A. Elopement: The facility has policies and procedures to monitor residents who are at risk for elopement (high risk of leaving the facility without authorization). **Contact a staff member immediately if you believe a resident is in danger of elopement.** There is a list of high risk residents at each nurse's station and the front desk. Anyone taking a resident outside the facility, **MUST** have:
    - i) Family authorization to do so.
    - ii) Nurse's authorization to do so.

- iii) Notified the nurse and the front desk that they are leaving the building (even to sit on the patio or walk around the building).

#### B. Falls

- i) If a resident falls while in the building, **encourage the resident to remain in their current position and notify staff.** Verbally call (YELL) for a staff member. Stay with the resident and wait for a staff member. **Do not attempt to move the resident.**
- ii) If a resident falls outside the nursing home, contact the nursing home immediately so it can be determined if there is a need for them to be taken to an emergency room.

### VI. Infection Control

- A. Use proper hand washing and sanitizing techniques at all time. This is as much a protection for you as it is for our residents.
- B. Hand sanitizer is available throughout the nursing home. Feel comfortable using it; use it often.
- C. Gloves are available on all residential units and the dining room for your use.

### VII. Resident Care

- A. At no time is a volunteer to remove a restraint from a resident.
- B. At no time is a volunteer to move, reposition, or take a resident to the bathroom.
- C. Nursing must be notified to assist the resident with any personal care. **A volunteer must call for assistance from nursing staff for any and all resident care.**
- D. Do not give a resident food or drink, whether or not they ask for something specific, without asking the resident's nurse first.

### VIII. Personal Expectations

- A. Volunteers will dress professionally while volunteering. Clothes can be casual, but tops will not have low necklines and/or advertising on them and need to have sleeves. Flip flops are not allowed.
- B. Volunteers will wear a nursing home provided name badge while volunteering.
- C. Volunteers will not eat food designated as "resident" food, under any circumstances.
- D. Volunteers may not request and/or eat food if it is not offered to them.
- E. Volunteers will not work past 7:30 p.m., Monday through Friday and 4 p.m. on Saturdays and Sundays.

## **ACKNOWLEDGEMENT OF RECEIPT OF TRAINING OF THE FACILITY'S SEXUAL HARASSMENT POLICY AND PROCEDURE**

I hereby acknowledge by my signature that I have received training on the Facility's Sexual Harassment policy and procedure and that I had the opportunity to review them. I understand that I should report any sexual harassment concerns to either the compliance and ethics officer of any other department head. I hereby agree to abide by the requirements of the Facility's Sexual Harassment Policy and Procedure, and the compliance and ethics program in general. I further understand that adherence to this policy is a condition of my continued business dealings with the Facility.

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Print Name

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Signature

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Date

## **Compliance and Ethics Training and Education/ Basics of the Compliance and Ethics Program**

I. Per federal and state requirements, this facility has a mandatory compliance and ethics program which is applicable to and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others ("Associates"). The compliance and ethics program is designed to:

1. Ensure Associates' compliance with all federal and state laws, rules and regulations;
2. Help Associates understand and meet the legal and ethical standards expected by the facility;
3. Emphasize the facility's commitment to accurate and lawful documentation and submission of all claims for services to Medicare, Medicaid, and other third-party payors;
4. Promote the prevention, detection and resolution of any acts that do not conform to applicable federal and/or state laws, rules, and regulations;
5. Minimize, through early detection and reporting, any potential loss to the government from erroneous claims; and to
6. Provide for seamless interaction and communication between the governing board and staff, which helps in correcting any compliance and/or ethics issues and in keeping the facility in compliance with all applicable federal and states statutes and regulations.

II. The Compliance and Ethics Program consists of the following eight elements.

### **1. Compliance and Ethics Officer**

A. The Compliance and Ethics Officer is an employee of the facility who handles the responsibility of managing the day-to-day operation of the compliance and ethics program. This facility's Compliance and Ethics Officer is \_\_\_\_\_. The Compliance and Ethics Officer interacts with, and communicates compliance-related matters to, the governing board through periodic written and/or verbal communications and reports.

### **2. Policies and Procedures**

A. The facility has policies and procedures which are accessible to all Associates that are designed to ensure the facility's commitment to compliance and ethics by, among other things, describing compliance and ethics expectations for Associates, and establishing protocols to be followed prior to an occurrence of non-compliance. Examples of policies and procedures are those that address:

- a. the implementation of the compliance and ethics program;
- b. training and education for all Associates on the compliance and ethics program and potential compliance and ethics issues as part of the orientation process and at least annually thereafter;
- c. the facility's commitment of quality of care;
- d. the prohibition against retaliation and intimidation for reporting compliance and/or ethics concerns;
- e. the prohibition on unlawful harassment and discrimination;
- f. the requirement for all Associates to report fraud, waste and abuse;
- g. how to deal with compliance and/or ethics issues as they come up;
- h. how to properly investigate and resolve compliance and/or ethics issues;
- i. the information contained in this training document.

### **3. Education/Training of Associates**

A. The facility, as required, provides new orientation and annual compliance and ethics training to all Associates in the form of this training document. All Associates should be aware of the following:

- a. The facility has a Corporate Compliance and Ethics Plan, Code of Conduct, and other policies and procedures that implement the

compliance and ethics program through an adoption and resolution, describe the facility's compliance and ethics expectations for Associates, and which provide detailed guidance on dealing with compliance and/or ethics issues. Specifically:

i. Associates have a duty to report any questionable conduct, questionable practices, and actual or suspected violations of the compliance and ethics program to their supervisor, the compliance and ethics officer, or the compliance and ethics hotline. When a reporter requests confidentiality, the report will be provided solely to the compliance and ethics officer or his/her designee(s).

ii. Potential compliance and/or ethics problems are investigated and resolved. The Compliance and Ethics Officer will initiate investigations to ascertain if an allegation of non-compliance received through a compliance and ethics reporting channel represents a possible violation of applicable laws, rules, regulations or the compliance and ethics program. The extent of the investigation will vary depending upon the nature of the concern. The facility will take necessary remedial action to the extent it is warranted. The compliance and ethics officer will develop a remediation plan on a case-by-case basis when a compliance and/or ethics violation is detected. The plan will be designed to prevent a recurrence of the violation and is a key factor in evaluating the success of the overall compliance and ethics program. Associates are expected to fully cooperate with and assist the facility in the resolution of reported compliance and/or ethics issues.

iii. The facility expects all Associates at all times (1) to act in a way that meets the requirements of the mandatory compliance and ethics program laws and regulations, and (2) to conduct business in a manner that supports the facility's integrity in operations.

### **4. Reporting/Communication of suspected non-compliance**

A. All Associates must report any identified potential compliance and/or ethics other issues as they arise. Reports can be made to an Associate's direct department head, any department head, the compliance and ethics officer directly, or via the CCG hotline (800-610-2544). The hotline number is posted throughout the facility and calls can be anonymous and confidential. Any Associate receiving any such report is required to report such issues to the appropriate compliance and ethics personnel, such as the compliance and ethics officer or his/her designee(s). An Associate who fails to promptly report any such activity will be subject to disciplinary action, which may include termination of employment or contract.

B. If a reporter requests confidentiality, the report will be provided solely to the Compliance and Ethics Officer or his/her designee(s), and confidentiality shall be maintained unless the matter is turned over to law enforcement or disclosure is required during a legal proceeding.

C. The facility has a zero-tolerance policy for intimidation, retaliation, or retribution against any Associate who, in good faith, reports suspected non-compliance, misconduct, or fraud, waste, and abuse by any Associate. All forms of unlawful retaliation are prohibited, including any form of discipline, reprisal, intimidation, or other form of retaliation taken against an Associate for participation in any activity protected by law.

D. Both the law and facility policy protect whistleblowers.

### **5. Discipline**

A. The facility has policies and procedures that outline disciplinary standards that are fairly and firmly enforced. Disciplinary action shall be administered on a fair and equitable basis, appropriate to the seriousness of the violation and consistent with the facility's policies and

procedures. Enforcement of disciplinary action will be consistent across all levels and rankings within the facility. Depending on the severity of the violation, progressive steps in the disciplinary action process may be omitted in order that immediate corrective measures, including termination, can be taken. The disciplinary policies are used to encourage and facilitate the reporting of non-compliant behavior, and to fairly and consistently deal with compliance and/or ethics violations, which includes non-reporting of compliance and/or ethics issues by applicable Associates. Associates who (1) participate in non-compliant behavior; (2) encourage, direct, facilitate, or permit non-compliant behavior; (3) or do not report suspected compliance and/or ethics violations shall be subject to disciplinary measures ranging from an oral reprimand to termination of employment or relationship.

B. Associates are expected to assist, as appropriate, in the resolution of compliance and/or ethics issues.

### **6. Auditing and Monitoring**

A. In order to evaluate its program and identify potential compliance and/or ethics issues and to self-evaluate identified risk areas, the facility conducts periodic reviews and external and/or internal audits. The facility also continuously monitors internal processes to ensure the proper identification of compliance and ethics risk areas to enable proper monitoring of potential compliance and ethics issues.

### **7. Responding to detected offenses**

A. The facility has a mechanism to respond to potential compliance and ethics issues, which is outlined in the facility's written policies and procedures. Specifically:

- a. the facility has a system in effect (1) for responding to compliance and ethics issues as identified in the course of audits and self-evaluations through investigations and corrective actions to ensure that compliance and ethics issues are resolved promptly and thoroughly; (2) for reducing the potential for the recurrence of compliance and ethics issues through proper training, education, and disciplinary actions; (3) for identifying and reporting compliance and ethics issues to the Department of Health and other state agencies; (4) for refunding Medicaid/Medicare overpayments; and (5) for responding to compliance and ethics issues as they are raised through investigations and remedial actions.

### **8. Reassessment**

A. The facility will periodically reassess the compliance and ethics program to evaluate its effectiveness and to make any necessary adjustments.

***By signing below, I acknowledge that I have received, read, and understood the materials covered in this training. I have had the opportunity to ask questions and receive responses related to the content of this training, and I understand that active participation in the compliance and ethics program is mandatory.***

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## 1. Introduction

**a.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect a subset of Sensitive Information known as Protected Health Information (PHI).

**b.** In 2009, HIPAA was expanded and strengthened by the HITECH Act (Health Information Technology for Economic and Clinical Health). In January of 2013, the Department of Health and Human Services issued a final rule ("Final Rule"), also known as the Omnibus Rule, implementing HITECH's statutory amendments to HIPAA. These latest updates improved patient privacy protections, gave individuals new rights to their health information, and strengthened the government's ability to enforce the law. As technology changes, and covered entities and their associated Business Associates implement new systems, the Omnibus Rule accounts for, and keeps pace with, these advancements and developments.

**c.** In general, HIPAA violations are enforced by the Department of Health and Human Services (HHS) Office of Civil Rights (OCR). However, pursuant to HITECH, state attorneys general are also permitted to bring civil actions and recover monetary awards that may be shared with harmed individuals.

**d.** Facilities that are subject to HIPAA regulations are called "covered entities" (CEs). Nursing homes, ALFs, other healthcare providers, insurance companies and hospitals are examples of covered entities. (There is no section of the Rule which is *specific* to any specific type of entity.) In addition to maintaining and enforcing the protection of its PHI, CE's are also required to execute written Business Associate Agreements (BAA's) with certain organizations and non-workforce individuals with whom they share Protected Health Information (PHI). Business Associates are outside organizations or non-workforce individuals who perform some function or service, *outside* of providing medical care or treatment, for the CE that makes them likely to have access to PHI (e.g. shredding services, computer hardware/software vendors, third-party billing vendors, etc.) Failure to have compliant BAA's can and has led to civil penalties of tens of thousands up to several million, dollars.

## 2. What is Protected Health Information (PHI)

**a.** PHI is defined as:

i. Any information that can be used to identify a resident – whether living or deceased – that relates to the resident's past, present, or future physical or mental health or condition, including healthcare services provided and payment for those services.

**b.** The following categories are examples of PHI:

- i. Resident names
- ii. Addresses
- iii. Telephone numbers
- iv. Account, record or Social Security numbers
- v. Dates such as date of birth or date of death
- vi. Full face photographs or images
- vii. Any other information, number, code, or characteristic that can be linked to an individual.

**c.** Medium – Identifiable patient information is considered to be PHI in any format – verbal, written, or electronic.

- i. PHI maintained in an electronic form is called e-PHI.

## 3. Allowable Uses

**a.** Facilities are allowed to use or view PHI for three purposes: Treatment, Payment, Operations (TPO).

i. Treatment – Facilities can access PHI for the care and treatment of a resident.

ii. Payment – Facilities can access PHI in order to get paid for treating the resident.

iii. Operations – Facilities can access PHI for certain administrative operations, such as Quality Assurance/Quality Improvement activities.

iv. Certain DOH or other legally allowed requests.

**b.** Individuals may access PHI only for permitted, work-specific purposes.

i. Minimum Necessary guidelines prohibit access (including viewing or using) to PHI for non-permissible reasons. Minimum necessary guidelines may result in an individual being allowed to access only certain sections of a medical record.

**c.** Incidental use, or minor disclosures of PHI in the process of an allowable TPO use, is acceptable.

i. An example of incidental use is the posting of resident names outside resident rooms.

**d.** Proper authorization from each patient is required to disclose PHI for most non-TPO activities. The authorization must be clear as to any limitations on the level of disclosure and must include a statement that the individual may revoke their permission at any time of their choosing, among other required elements. When an authorization is needed, a standardized form should be used.

## 4. Social Media

**a.** Although there may be *general* benefit to healthcare organizations to use social media to attract new clients and interact with their current patients, it is important to be aware of the considerable potential for violating HIPAA Rules and patient privacy on these networks. It is critical to never

disclose unauthorized PHI on social media. Once posted, the digital trail can never be controlled by the original poster.

**b.** Social media channels can be used for posting health tips, details of events, new medical research, bios of staff, and for marketing messages, provided no PHI is included in the posts. Sharing images or videos has in many cases determined to be considered abuse and has, in some cases, even resulted in jail time on top of heavy fines. Do not assume that what you might consider innocent/casual sharing activity will be determined as such by an authority. No one can guarantee that a complaint will not be filed. There should be a facility policy in place with respect to executing a proper authorization which will determine what PHI may be shared and where it may be posted.

**c.** Resident PHI may never be posted on a staff member's personal social media account.

## 5. Unauthorized Access

**a.** It is never acceptable for an employee to look at PHI for non-TPO purposes, even if no harm is intended (e.g., retrieving an address to send a 'Get Well' card).

**b.** Unauthorized access to PHI is illegal and against company policy, regardless if the information relates to a "high profile" person or a close friend or family member – ALL information is entitled to the same protection and must be kept private.

**c.** HIPAA regulations and PHI restrictions apply to all employees.

**d.** Be aware that accessing PHI of someone involved in a divorce, separation, break-up, or custody dispute may be an indication of intent to use information for personal advantage. If you are accessing this information for a legitimate TPO purpose, you may want to review minimum necessary documentation guidelines with your supervisor or your facility's HIPAA Privacy Officer.

**e.** Using PHI for personal benefit is prohibited.

Individual employees, and not just the "covered entities" for whom they work, may be subject to HIPAA sanctions. Individuals found guilty of accessing PHI for personal gain have been subject to fines and jail time

## 6. Disposal

**a.** PHI must be disposed of properly

i. Paper PHI must be shredded or otherwise rendered illegible

ii. It is not sufficient to delete files containing electronic PHI. Media must be wiped clean and made irretrievable. This includes hard drives, flash drives, smart phones and other electronic devices, as well as some printers and copy/fax machines. Speak to your



facility's Compliance Officer or HIPAA Security Officer for more information.

## 7. Common Risk Areas / Standards of Reasonable Care / Policies & Procedures Required

### a. Paper records:

i. Are referrals or other paperwork being left unsecured? Are binders with patient information left unattended? e.g., med carts, exposed counter at nurses' stations

### b. Copiers:

i. Is unprotected PHI being left at copy machines?

ii. Is the copier hard drive erased properly before disposal or return to the leasing company?

### c. Faxes:

i. Should be situated in protected area

ii. Are authorization instructions confirmed?

iii. Are fax numbers verified before sending? When possible, use pre-programmed numbers.

iv. Confidentiality statements should be included on all PHI communications.

### d. Electronic PHI:

i. Are devices and emails properly guarded and encrypted?

ii. Is electronic PHI protected by individually assigned passwords and are log-in histories kept? Is there a BAA for technicians maintaining e-devices?

iii. Is PHI being saved on USB or other portable devices? Is there an inventory of all devices?

iv. Are employees trained to be aware of phishing scams?

v. Are screen savers automatically in place when a computer is unused?

vi. Is a process in place which requires lost devices to be reported immediately?

### e. Phone calls / Texts:

i. Phone conversations should not be loud enough for non-authorized bystanders to hear.

ii. Transmitting text messages related to patient information (to either other employees/providers or family members) from any cellular device is highly discouraged. If absolutely needed, the message should be limited to minimum information necessary e.g. appointment confirmations, instructions to call the office to receive test results, etc.

### f. Audio-Visual Recordings

i. Are allowed only in limited circumstances.

## 8. Breaches

a. An impermissible access, use or disclosure is generally considered to be a breach when the security or privacy

of the PHI is improperly exposed, unless the covered entity can demonstrate, through an extensive risk assessment, that there is a low probability that the PHI has been compromised. These risk assessments will generally include the following factors (a) the nature and extent of the PHI involved (b) the person who used or received the PHI (c) whether the PHI was actually acquired or viewed (d) the extent to which the risk to the PHI has been mitigated (e) the date of discovery (f) a brief description of what happened (g) how the incident was discovered (h) a description or listing of types of PHI included in the incident (i) a description or summary of who received the PHI and what the recipient did with the PHI, if applicable (j) any other relevant information.

### b. Response to the breach may include:

i. Mandated notifications without unreasonable delay to government agencies, individuals affected, and the news media.

ii. Statutory and regulatory Civil penalties:

1. \$50,000 per incident up to \$1.5 million per incident for violations that are not corrected, per calendar year.

iii. Statutory Criminal Penalties:

1. \$50,000 to \$250,000 in fines and up to 10 years in prison.

c. An employee who becomes aware of a potential breach must report it to the Compliance Officer or HIPAA Privacy Officer immediately. A thorough incident report must be completed. Potential breaches must be investigated and, if applicable, reported within a specific time frame. Missing the deadline for investigating and reporting is in and of itself a violation of HIPAA and may incur fines.

## 9. Risk Analysis and Risk Management.

a. Prevention is the best cure. The law requires a periodic risk analysis be performed to prevent potential breaches. The analysis is designed to ensure that standards of reasonable care are practiced in every area, including Administrative, Physical, and Technical. A proper analysis is designed to identify security risks, vulnerabilities, and threats. It will generally include the following steps:

i. Identifying the Scope of the Analysis

ii. Gathering Data

iii. Identifying and Documenting Potential Risks, Vulnerabilities, and Threats

iv. Assessing Current Security Measures

v. Determining the Likelihood of Threat Occurrence

vi. Determining the Potential Impact of Threat Occurrence

vii. Determining the Level of Risk

viii. Identifying Reasonable Security Measures and Documenting/Implementing a Comprehensive Security Plan

b. To decrease the likelihood of penalties and/or sanctions, facilities should demonstrate the review and implementation of proper safeguards, reasonable care, and appropriate compliance trainings.

c. The facility must also conduct an additional analysis upon the occurrence of a significant event or change in the Facility's organization or environment.

## 10. Additional Topics

a. Rules apply to *anyone* performing services, who by virtue of their position are likely to obtain access to PHI. i.e. employees, volunteers, trainees, and others under direct control of persons working on behalf of covered entity, even if not a contractor or business partner.

### b. Privacy

- General confidentiality
- Training requirements
- Resident rights (general)
- Reporting known or suspected breaches
- Sanctions
- E-mail
- Faxing
- Complaints
- Use of social media
- Reporting potential privacy or security violations

### c. Security Topics

- General security policies
- Physical and workstation security
- Periodic security reminders
- Virus protection
- Importance of monitoring log-ins
- Password management / log-in monitoring
- Audits
- Overlooking *minor* details can lead to *major* problems

***Please refer to the facility's Privacy and Data Security Policies and Procedures for further information.***

*I understand and acknowledge that the Facility is committed to meeting all federal and state privacy and data security laws, rules, and regulations, including, but not limited to, HIPAA. I hereby acknowledge that I have received HIPAA privacy and security training, including a review of Policies and Procedures related to the handling, security, and confidentiality of resident/patient information, and have been afforded the opportunity to ask questions or seek clarification and all of my questions have been answered.*

*I understand that my obligations, as set forth above, will continue throughout my employment with the Facility and even after the termination of my employment. I understand that, to the extent that I violate my obligations hereunder or under any state or federal law, regulation or rule, I will be subject to disciplinary action, which may include termination, and I may also be subject to civil and criminal penalties under state and federal laws, regulations, or rules. By signing this form, I acknowledge that I understand the foregoing and will abide by the Facility's HIPAA Policies and Procedures.*

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PRINT NAME

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TITLE/DEPARTMENT

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SIGNATURE

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DATE

***Thank you for your partnership in keeping our residents' protected health information confidential and secure, and for recognizing its importance in facilitating quality health care!***