CORPORATE COMPLIANCE ORIENTATION TRAINING

UNITY HOUSE OF TROY, INC.

2024

TOPICS

- Introduction to Compliance
- Compliance Issues
- Reporting Compliance Issues
- Compliance Expectations
- Systems for Routine Identification of Issues
- Systems for Responding to Compliance Issues
- UH Compliance Program Operation
- HIPAA & IT Security Overview

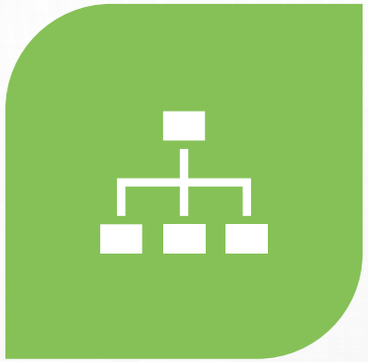
TRAINING OBJECTIVES

To underscore Unity House's commitment to ethical business practice & to complying with the various federal & state laws, regulations, & rules that govern our work.

To reinforce understanding of compliance issues & expectations, & unity house's Standards of Conduct, policies, procedures & compliance program operation.

WHAT IS A COMPLIANCE PROGRAM?

AN ORGANIZATIONAL COMMITMENT.



A MANAGEMENT SYSTEM FOR PREVENTION.

A RESOURCE.

NYS SSL 363-D

1. THE LEGISLATURE FINDS THAT MEDICAL ASSISTANCE PROVIDERS MAY BE ABLE TO DETECT AND CORRECT PAYMENT AND BILLING MISTAKES AND FRAUD IF REQUIRED TO DEVELOP AND IMPLEMENT COMPLIANCE PROGRAMS. IT IS THE PURPOSE OF SUCH PROGRAMS TO ORGANIZE PROVIDER RESOURCES TO RESOLVE PAYMENT DISCREPANCIES AND DETECT INACCURATE BILLINGS, AMONG OTHER THINGS, AS QUICKLY AND EFFICIENTLY AS POSSIBLE, AND TO IMPOSE SYSTEMIC CHECKS AND BALANCES TO PREVENT FUTURE RECURRENCES.

Written Policies, Procedures & Standards of Conduct

Designation of a Compliance Officer & Compliance Committee

Compliance Program Training & Education

Lines of Communication

Disciplinary Standards

Auditing & Monitoring

Responding to Compliance Issues

NYS OMIG MANDATORY COMPLIANCE PROGRAM: SEVEN ELEMENTS

ELEMENT 1: WRITTEN POLICIES, PROCEDURES, & STANDARDS OF CONDUCT

- Articulate the organization's commitment to complying with all federal & state standards
- Describe compliance expectations as embodied in the Standards of Conduct
- Implement the operation of the compliance program
- Provide guidance to employees & others on dealing with potential compliance issues
- Identify how to communicate compliance issues to the compliance officer
- Describe how potential compliance issues are investigated & resolved by the organization
- Include a policy of non-intimidation & non-retaliation for good faith participation in the compliance program and reporting instances of intimidation or retaliation
- Complies with USC 42, section 1396a(a)(68) – state plans for medical assistance

ELEMENT 2: DESIGNATION OF A COMPLIANCE OFFICER & COMPLIANCE COMMITTEE

- Compliance Officer is responsible for the day-to-day operation of the compliance program.
- Compliance Officer reports directly to the CEO & the board of directors & reports out to senior management as appropriate.
- Compliance committee members report directly to CEO and board of directors

ELEMENT 3: COMPLIANCE TRAINING & EDUCATION

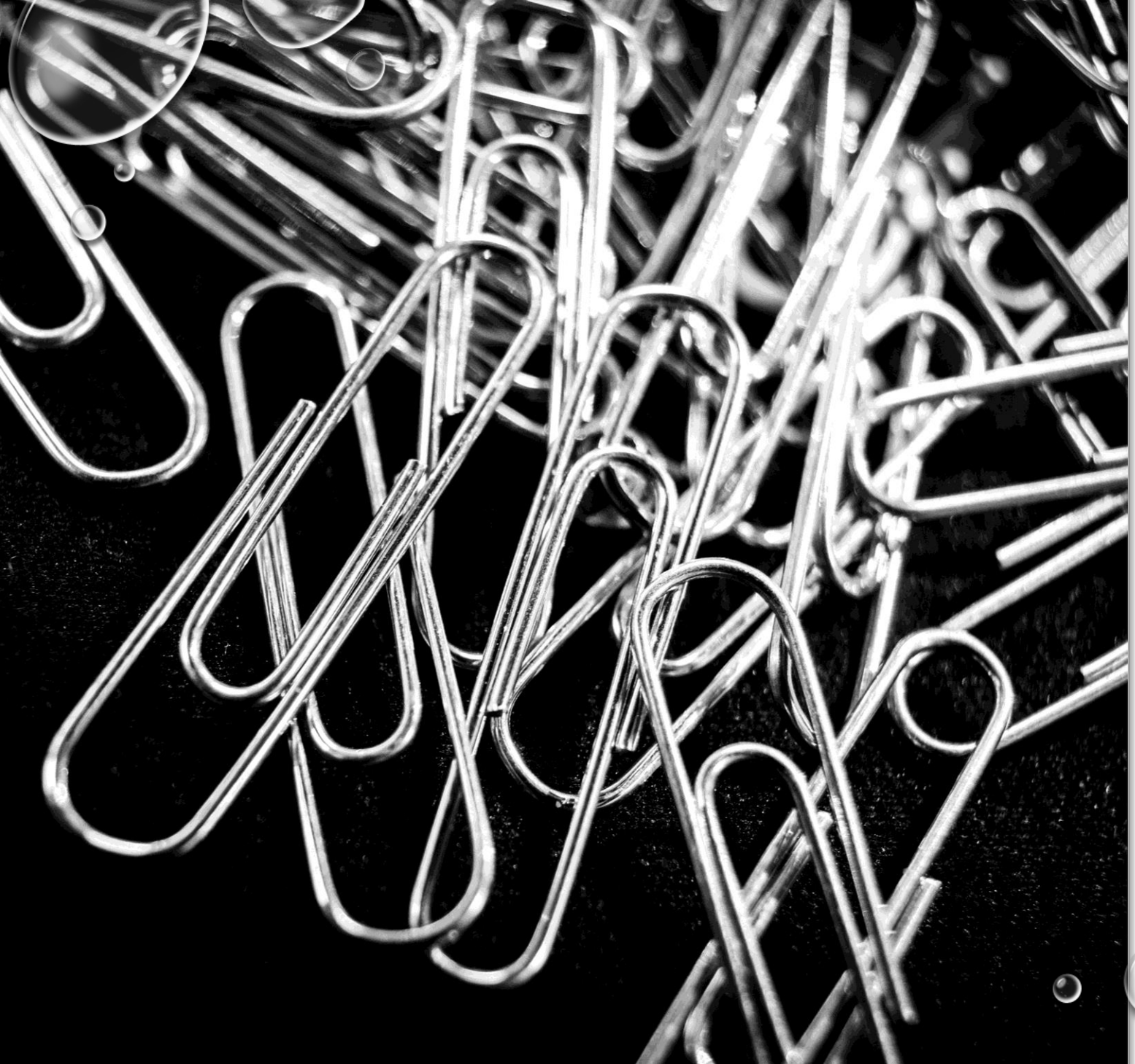
- Establish & implement effective training & education for the compliance officer, employees, CEO, other senior administrators, managers, affected individuals & board members.

- Training must occur at a minimum annually & must be made a part of orientation for new employees & the new appointment of a chief executive, manager, or board member.

ELEMENT 4: EFFECTIVE & CONFIDENTIAL LINES OF COMMUNICATION

Lines of communication between the Compliance Officer, members of the Compliance Committee, employees, managers, the board of directors, & first-tier downstream providers

Confidential & anonymous options for good faith reporting of potential issues as they are identified



ELEMENT 5: DISCIPLINARY STANDARDS

Discipline procedures must be well publicized & implemented to encourage good faith participation in the compliance program by all affected individuals. The degrees of disciplinary actions for intentional or reckless behavior are subject to more significant sanctions. Sanctions may include oral or written warnings, suspension, and/or termination.

ELEMENT 6: MONITORING & AUDITING

- Establishing & implementing an effective system for routine monitoring & identification of compliance risks.
- Including internal monitoring & auditing &, as appropriate, external audits, to evaluate compliance with Medicaid program requirements & the overall effectiveness of the compliance program.

ELEMENT 7: RESPONDING TO COMPLIANCE ISSUES

- Implementing procedures & a system for promptly responding to compliance issues as they arise.
- Investigating potential compliance issues identified in the course of self-evaluations & audits.
- Correcting such problems promptly & thoroughly to reduce the potential for recurrence.
- Ensuring ongoing compliance with Medicaid program requirements.

NYS OMIG MANDATORY COMPLIANCE PROGRAMS

18 NYCRR SECTION 521-1.3 (D)

Each of the seven elements of the compliance program must be applicable to:

1. Billings
2. Payments
3. Medical necessity & quality of care
4. Governance
5. Mandatory reporting
6. Credentialing
7. Other risk areas that are - or should with due diligence- be identified
8. Ordered services
9. Contractor, subcontractor, agent, or independent contract oversights
10. Additional risk areas specific for MMCO's

Compliance Issues

Conduct that does not conform to the laws, regulations, & rules that govern our work &/or that violates our policies, procedures, or Standards of Conduct.

DEFINING FRAUD, WASTE & ABUSE

- **Fraud:** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the provider, Contractor, Subcontractor, or another person and includes the acts prohibited by section 366-b of the SSL. It also includes any other act that constitutes fraud under applicable Federal or State law. Can constitute crime.
- **Waste:** the overutilization or inappropriate utilization of services that result in unnecessary costs to a governmental program, but without intent to deceive or misrepresent.
- **Abuse:** practices that: are inconsistent with sound fiscal, business, or professional practices, & result in an unnecessary cost to the Medicaid program, payments for services which fail to meet recognized standards for health care. It also includes enrollee practices that result in unnecessary costs to the Medicaid program.

EXAMPLES OF COMPLIANCE ISSUES

- ✓ Billing or accepting payment for:
  - ✓ Goods not delivered or services or teleservices not provided &/or not documented.
  - ✓ Services that are medically unnecessary, non-covered, unallowable, or provided to an individual who is ineligible.
  - ✓ Incorrect level of service.
  - ✓ Services rendered by someone who is not credentialed.

- ✓ Falsification of information in the medical/student record.

This includes, but is not limited to, falsification of progress notes or case notes.

- ✓ Falsification of health care provider credentials.

- ✓ Improper conduct.

- ✓ Inadequate resolution of overpayment.

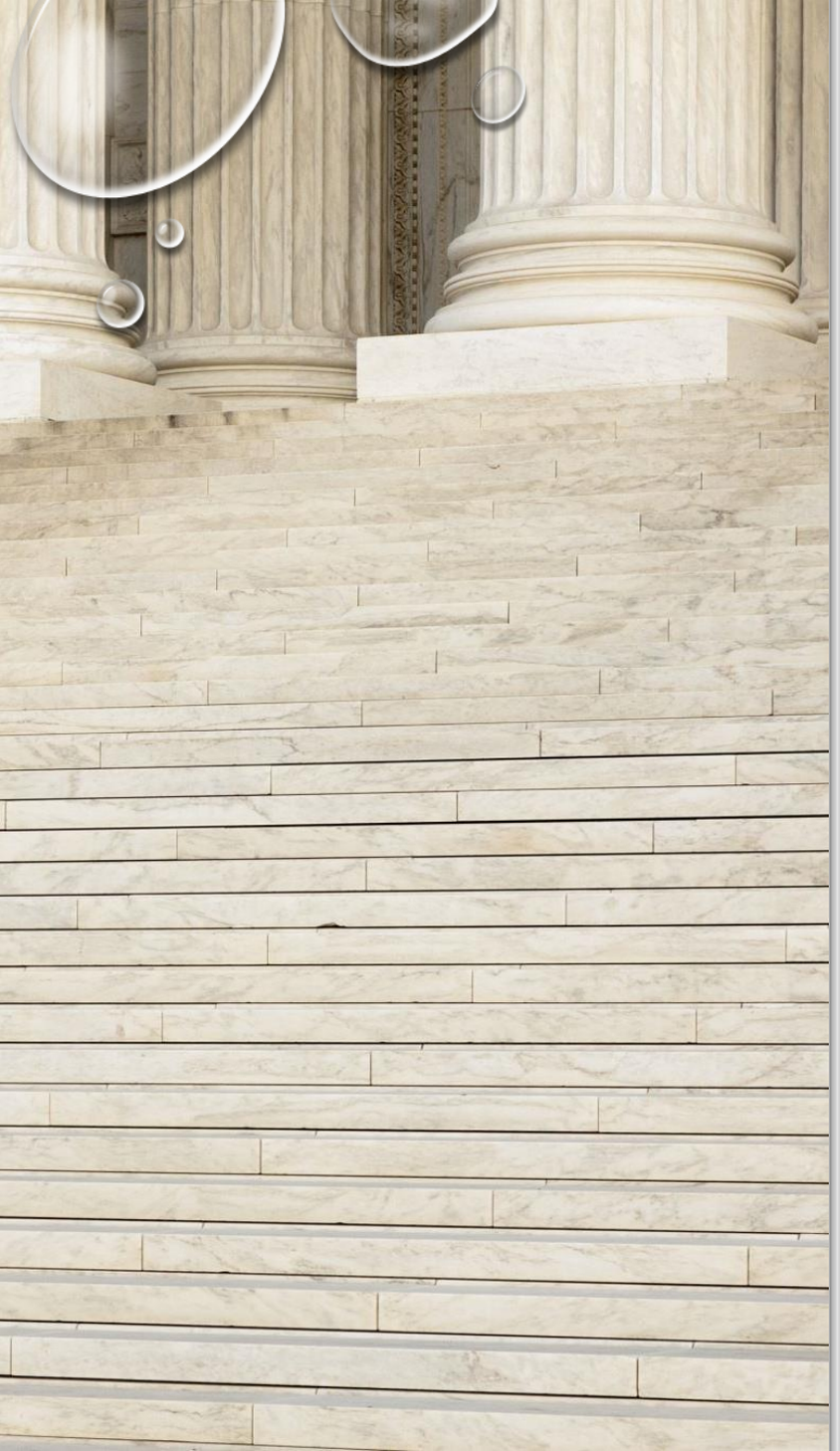
EXAMPLES OF COMPLIANCE ISSUES

- ✓ Knowing misuse of provider identification numbers that result in improper billing.

- ✓ Misrepresenting or falsifying:
  - ✓ Diagnosis to justify payment.
  - ✓ Treatment plans, progress notes, dates of services, or service rendered to justify payment.
  - ✓ The type of goods or services rendered.

- ✓ Soliciting, offering, or receiving a kickback, bribe, or other rebate.

- ✓ Violation of another law
  - ✓ Example: A claim was submitted appropriately, but the service was the result of an illegal relationship between a physician & the provider (kickbacks for referrals).



FEDERAL FALSE CLAIMS ACT (FCA)

- ✓ Imposes liability on persons & entities who "knowingly" defraud federal programs (i.e., Medicaid, Medicare, grant programs).
  - Federal government's **primary litigation tool** in combatting fraud.
  - **Civil penalties** between $12,537 & $25,076 per false claim, plus three times the amount of damages suffered by the government.
  - **Possible criminal liability &/or program exclusion**.
- ✓ Qui tam provisions - allows persons/entities with evidence of fraud against federal programs/contracts to sue the wrongdoer on behalf of the US government (even when whistleblower is not personally injured).
- ✓ Whistleblower protections.

A PERSON ACTS KNOWINGLY IF HE OR SHE:

- Has actual knowledge of the information,
- Acts in deliberate ignorance of the truth or falsity of the information, OR
- Acts in reckless disregard of the truth or falsity of the information.

WHISTLEBLOWER DEFINED

An individual who discloses mismanagement, corruption, illegality or some other wrongdoing made by a person to the public or to those in authority.

FCA ANTI-RETALIATION PROVISION

- Whistleblowers who expose companies, individuals, & contractors who have defrauded the government are protected from:
  - ✓ Being discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms & conditions of employment.

Employees discriminated or retaliated against because of lawful acts in furtherance of an action under the federal FCA are **entitled to all relief necessary to become whole**, which may include:

- Reinstatement with comparable seniority but for the discrimination,
- Double pay back,
- Interest on back pay, &
- Compensation for any special damages, including litigation costs & reasonable attorneys' fees.

FEDERAL PROGRAM FRAUD CIVIL REMEDIES ACT

If a person/entity submits a claim that they know is false or contains false information or omits material information, then the federal agency receiving the claim may impose a penalty of up to $11,181 up to $22,363 for each claim & recover twice the amount of the claim.

Unlike the FCA:

- Is an administrative action.
- A violation occurs when a false claim is submitted, not when it is paid.

NYS FALSE CLAIMS LAWS & WHISTLEBLOWER PROTECTIONS

Civil & Administrative Laws

- NY False Claims Act (state finance law, §§187-194)
- Social Services Law §145-b false statements
- Social Services Law §145-c sanctions

Whistleblower Laws

- NY False Claim Act (State Finance Law §191)
- New York Labor Law §740
- New York Labor Law §741

Criminal Laws

- Social Services Law §145, Penalties
- Social Services Law § 366-b, Penalties for Fraudulent Practices
- Penal Law Article 155, Larceny
- Penal Law Article 175, False Written Statements
- Penal Law Article 176, Insurance Fraud
- Penal Law Article 177, Health Care Fraud

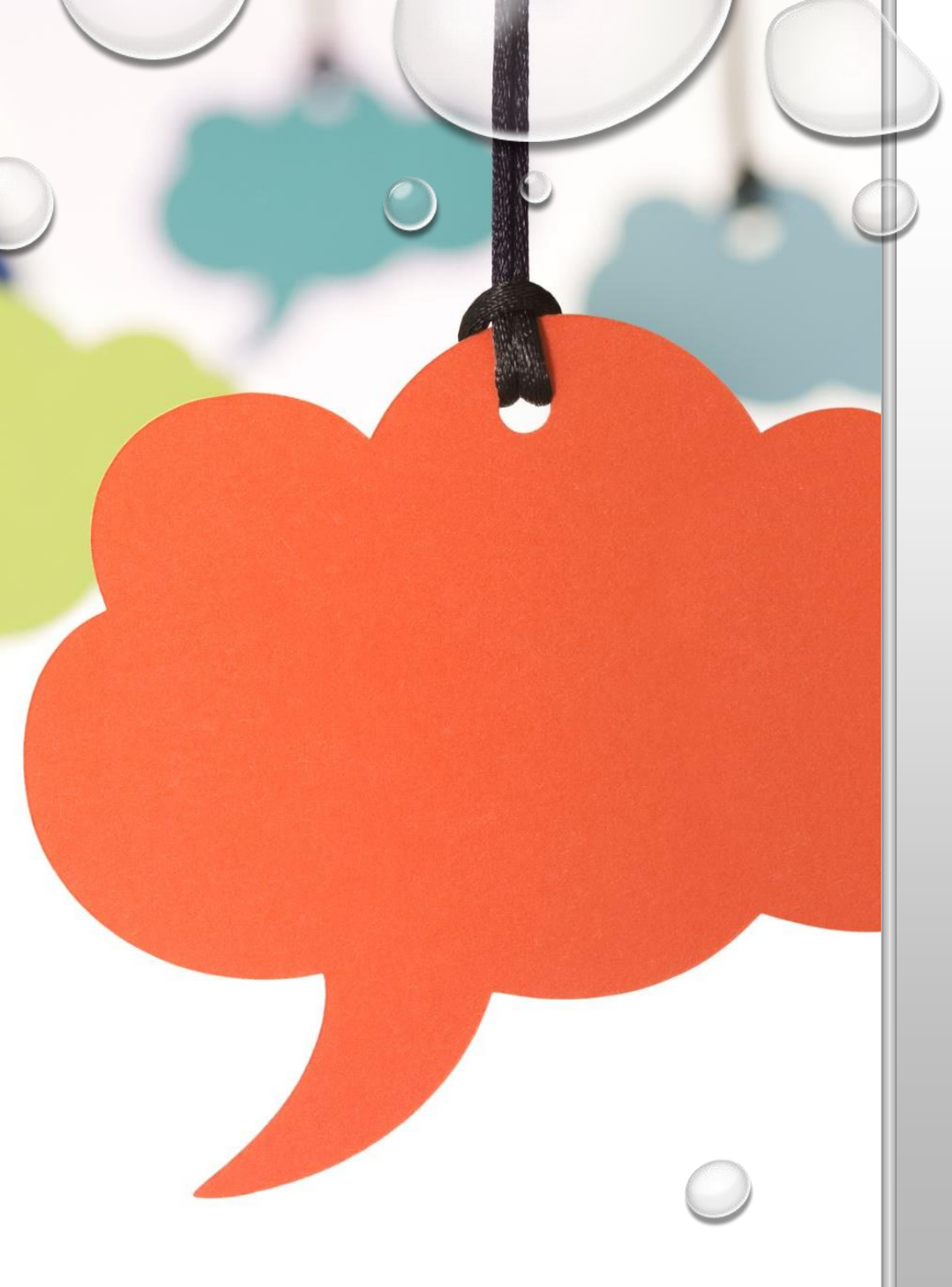
See the False Claims & Reporting Policy Appendix for summaries of federal & state fraud & whistleblower laws

ANTI-KICKBACK VS. STARK LAW

	Anti-Kickback	Stark Law
Prohibition	Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business	Prohibits: • a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies • the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral
Referrals	Referrals from anyone	Physician self-referral, referral from a physician to his/her immediate family members
Items/Services	Any items or services	Designated health services
Intent	Intent must be proven (knowing & willful)	• No intent standard for overpayment (strict liability) • Intent required for civil monetary penalties for knowing violations

ANTI-KICKBACK VS. STARK LAW

	Anti-Kickback	Stark Law
Penalties	**Criminal** • Fines up to $25,000 per violation • Up to a 5 year prison term per violation **Civil/Administrative** • False Claims Act liability • Potential $50,000 civil monetary penalty per violation & program exclusion • Civil assessment of up to 3 times amount of kickback	**Civil** • Overpayment/refund obligation • False Claims Act liability • Potential $15,000 civil monetary penalty for each service & program exclusion *for knowing violations* • Civil assessment of up to 3 times the amount claimed
Exceptions	Voluntary safe harbors	Mandatory exceptions
Federal Health Care Programs	All	Medicare/Medicaid



REPORTING & ADDRESSING COMPLIANCE ISSUES

FALSE CLAIMS & REPORTING POLICY

- ✓ All employees, managers, executives, board members, volunteers, interns, contractors, & other agents have an affirmative duty to report anything that a reasonable person might think is a violation of the compliance plan, the Standards of Conduct, other policies & procedures, or the rules, regulations, or laws that govern our work.

- ✓ Failure to report may result in disciplinary action up to & including termination.

- ✓ The compliance officer or a designee (as appropriate) will review, investigate, &/or address any reported violations.

- ✓ Individuals who make reports &/or participate in subsequent investigations or audits are protected by the non-intimidation & non-retaliation policy.

Reports can be made in a variety of ways,
Including confidentially & anonymously...

CONTACT YOUR SUPERVISOR OR ANOTHER MANAGER.

To the extent they are not involved.

CONTACT THE COMPLIANCE PROGRAM DIRECTLY.

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Compliance Officer

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** Confidential method**

ACCESS UNITY HOUSE'S CONFIDENTIAL COMPLIANCE HOTLINE.

- 24 hours/day 365 days/year.
- Operated by Lighthouse Services, an impartial third-party vendor.
- Confidential.
  - When a report is made to the compliance hotline, lighthouse notifies the compliance officer.
  - All reports to the compliance hotline will be kept strictly confidential, unless the matter must be turned over to law enforcement or other governmental entity. *confidential means the compliance officer is the only person who will know the identity of the reporter.*
  - If a report made to the compliance hotline requires an investigation, the compliance officer will not specifically identify the reporter & will take steps to proactively protect the reporter's identity.
- Option to make an anonymous report.
  - No identifying information about the reporter is collected, & lighthouse notifies the compliance officer of the content of the report only.
  - Reporter may elect to continue to communicate anonymously with the compliance officer through the hotline's messaging system.
  - Anonymous reports will be investigated as warranted – just like any other type of report.

- Toll-free hotline:

  (800) 401-8004 (English speaking)

  (800) 216-1288 (Spanish speaking)

- Hotline on the web:

  https://www.lighthouse-services.com/unityhouseny

- Hotline via e-mail:

  reports@lighthouse-services.com (must include "unity house" in the report)

- Hotline via fax:

  (215) 689-3885 (must include **"Unity House Troy, NY"** in the report)

****Exceptions to Confidentiality**

If the matter is:

1. Subject to a disciplinary proceeding;
2. Referred to, or under investigation by, MFCU, OMIG or law enforcement; or
3. Disclosure is required during a legal proceeding.

NON-RETALIATION & NON-INTIMIDATION POLICY

Sets forth a strict prohibition of intimidation &/or retaliation against anyone who, in good faith, participates in the compliance program, including not limited to:

- Reporting potential compliance issues
- Conducting/participating/cooperating in investigations
- Conducting self-evaluations, audits, & remedial actions
- Reporting to any government entities.

Intimidating &/or retaliatory acts are themselves a violation of the compliance program & Standards of Conduct & are, therefore, subject to disciplinary action up to & including termination.

NON-RETALIATION & NON-INTIMIDATION POLICY

- Intimidation is an act to manipulate another person &/or is an intentional behavior that causes a person of ordinary sensibilities to have feelings of fear or inadequacy.
- Retaliation is an adverse action taken against an individual because the individual's good faith report of a compliance concern or participation in the compliance program.

- Adverse actions do not include:

✓ Any employment action(s), disciplinary action(s), & termination(s) taken as a result of the individual's own violation(s) of laws, rules, policies, or procedures, or

✓ Negative comments in an otherwise positive or neutral evaluation that are justified by the individual's poor work performance or history.

NON-RETALIATION & NON-INTIMIDATION POLICY

Good faith participation in the compliance program means an employee makes a sincere effort to comply with the standards & provisions set forth in the compliance plan, Standards of Conduct, policies, procedures, rules, regulations, & laws.

A good faith report of a compliance issue is one that's made with honest intent & motive – the employee has a sincere & reasonable belief that a violation may have occurred. Reporting can be made in good faith but be wrong about the facts.

INVESTIGATION POLICY

- Potential compliance violation is reported or detected through other routine monitoring or auditing.
- CO completes initial screen.
- CO identifies appropriate investigator or team of investigators.
- Arrangements may be made during active investigations.
- Prompt – goal of completing investigation within 5 to 10 business days.

INVESTIGATION POLICY

- Document review.
  - Must cooperate with document requests. Failure to do so may result in termination
- Interviews.
  - Employees, managers, executives, board members, contractors & other agents required to participate in good faith. Failure to do so may result in termination.
- Individuals/entities checked against exclusion lists &/or state central registry.
- Violations - subject to discipline in accordance with policy.
- Violation findings - reported by CO to MT, CEO, BoD & government oversight agencies, as appropriate.
- Corrective & remedial action.

Corrective action may include:

- ✓ Referral to criminal &/or civil law enforcement authorities with jurisdiction over such matter,
- ✓ Self disclosure of overpayments
- ✓ Revised policies, procedures, &/or systems/internal controls,
- ✓ Additional education/training,
- ✓ Enhanced QA, &/or
- ✓ Appropriate disciplinary action.

INVESTIGATION POLICY

INVESTIGATION POLICY

Investigation records will include, but may not be limited to:

- Documentation of the alleged violation
- A description of the investigative process
- A log of witnesses interviewed
- Copies of interview notes
- A log of documents reviewed
- Copies of key documents
- The results of the investigation
- Disciplinary action taken
- Corrective action plan

DISCIPLINE POLICY

What triggers discipline:

- Non-compliant behavior or encouraging, directing, facilitating or permitting non-compliant behavior.
- Failure to report, disclose, &/or to assist in an investigation or audit of suspected fraud, waste, abuse, or other potential wrongdoing.
- Individuals who, by virtue of their position in the organization, should have known but failed to detect or act on such conduct.

The discipline policy will be enforced firmly & fairly & will apply equally to all affected persons (i.e., Staff, managers, contractors, executives, & board members).

DISCIPLINE POLICY

Level of discipline will vary in relation to severity of violation & may consist of:

- ✓ Extending an orientation period,
- ✓ Verbal warning,
- ✓ Written warning,
- ✓ Suspension from employment with or without pay for a period of up to ten (10) regularly scheduled workdays,
- ✓ Demotion, &/or
- ✓ Termination.

** There is no pre-determined sequence of type or number of disciplinary actions prior to termination of employment. Nor is unity house required to follow progressive discipline in disciplining &/or discharging an employee.*

DISCIPLINE POLICY

Who resolves compliance-related discipline:

- **UH employees, managers, volunteers, & interns** - HR, service director, &/or CO.
- **UH Executives** - CEO, Dir. Of HR, CO (to extent not involved), & board when appropriate.
- **UH board members** – executive committee (to the extent not involved).

**Unity House may seek legal counsel for guidance*

as it relates to compliance-related discipline.

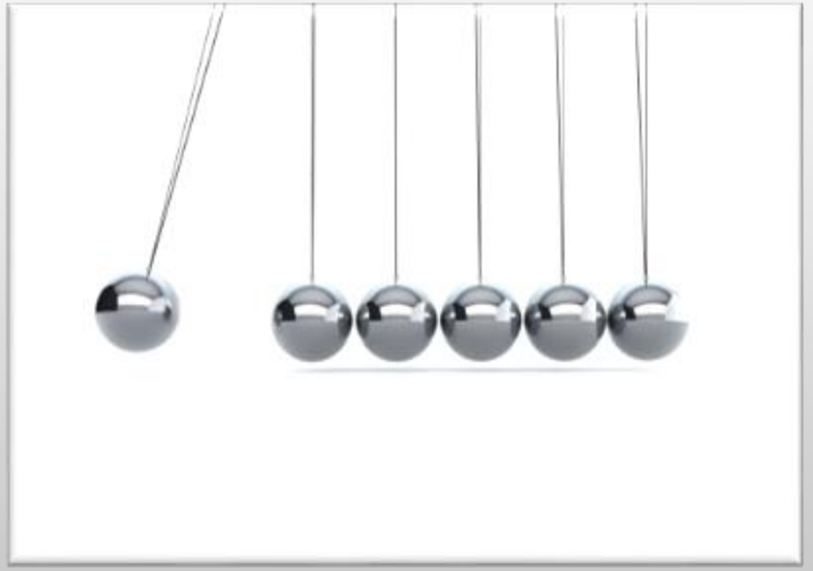
COMPLIANCE EXPECTATIONS

TRAINING & EDUCATION POLICY

- ✓ **Orientation** for board, staff, volunteers, & interns (w/in 30 days of start date)
- ✓ Individualized, **mandatory annual training** for:
  - ✓ Board
  - ✓ Management,
  - ✓ Staff, volunteers, interns, affected individuals, other agents
- ✓ **Program-level training & education** efforts are coordinated through compliance dept.
- ✓ Disbursement & marketing of **program materials**:
  - ✓ Compliance plan, policies & procedures, Standards of Conduct emailed upon hire & as amended/updated
  - ✓ Intranet (Compliance SharePoint page)
  - ✓ Website
  - ✓ Hotline posters – displayed in every UH site in staff accessible areas

FROM THE STANDARDS OF CONDUCT

It is Unity House's expectation that all stakeholders function with honesty & integrity in their work for the agency & with the people we serve, as well as with other providers, oversight agencies, internal & external auditors, vendors & all others with whom unity house does business.



FROM THE STANDARDS OF CONDUCT

EMPLOYEES ARE NOT PERMITTED TO:

- Refer a client to a discharge setting in which the employee has a proprietary interest. The employee or family member cannot benefit financially from the referral.

- Invite a present or former client to live with the employee after leaving the agency's employ.

YOU MUST…

- ✓ Act in the best interests of the individuals we serve & the agency.
- ✓ Comply with all applicable laws, rules, & regulations pertinent to your work.
- ✓ Understand & comply with the Standards of Conduct & policies & procedures.
- ✓ Employ good judgment & adhere to sound business, professional, & clinical practices.
- ✓ Ask your supervisor or the compliance officer for clarification &/or assistance if you are unsure how to proceed in carrying out your duties.
- ✓ Report, in good faith, potential compliance violations.
- ✓ Assist in internal & external investigations, monitoring, & auditing.
- ✓ Implement issued corrective or remedial actions.

STANDARDS OF CONDUCT

Conflicts of Interest

- Procurement or other sensitive matters
- Disclosure – relationships w/ vendors, physicians, landlords etc.

Solicitation

- Prohibits borrowing or lending money, favors, or services from clients
- Prohibits favor – all clients treated equally & with dignity

Gifts*

- Prohibits acceptance of gifts from vendors (with limited exceptions)
- Prohibits acceptance of gifts of more than minimal value from clients

Supervisor notification is required. Notification procedure & other guidance can be found on pgs. 8 – 10 in the code

Integrity of decisions

- Treatment & client care is based on holistic assessment
- Cannot take unfair advantage of professional relationships for personal gain

Anti-kickbacks

STANDARDS OF CONDUCT

Referrals

- Referrals for client admission based solely on individual need, UH's ability to offer or provide appropriate services; admission criteria strictly & consistently followed & adhered to
- Prohibited from:
    - Making/accepting payments for referrals to/from UH
    - Soliciting or receiving anything of value, directly or indirectly, in exchange for referrals to other providers/physicians
    - Steering or directing referrals to a private practice in which professional personnel, consultants, or their immediate families may be engaged.

Corporate honesty in all facets of business including:

- Accurate financial reporting & accounting practices
- Proper & accurate documentation
- Meeting all regulatory requirements
- Using agency resources appropriately
- Employees shall not participate in, condone, or be associated with dishonesty, fraud, or deception
- Must not accept/encourage illegal or unacceptable behavior of staff or clients

STANDARDS OF CONDUCT

Care & Rights of Individuals We Serve

- Client Confidentiality
- HIPAA, HITECH, FERPA, VAWA, Article 27-f, NYS Shield Act
  - Health, DV status, HIV/AIDS-related info, student info, mental health, developmental disabilities, etc.

Informed Consent

Access to Appropriate Services

- All behavioral health, other clinical, education, & legal services offered/delivered by appropriately licensed/qualified personnel
- Eligibility requirements
- Quality of care

Equal Opportunity for all Clients & Employees

Whistleblower Protections

UH COMPLIANCE PROGRAM OVERVIEW

COMPLIANCE OFFICER

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ACCESSIBILITY TO THE COMPLIANCE OFFICER

CO reports directly to CEO & Board & reports out to senior management as appropriate.

Compliance Committee members report to CEO and the board of directors.

CO provides virtual training; the compliance department visits programs for audits & other events.

Familiar & friendly face to board – staff – volunteers – interns.

All program documents, materials, & marketing provide contact info for CO.

UH COMPLIANCE PROGRAM

- ✓ Develops, reviews, updates, & implements compliance plan & associated policies, procedures, & work plan.
- ✓ Facilitates training & education.
- ✓ Ensures compliance with Medicaid program & federal grant program requirements.
- ✓ Incident management.
- ✓ Investigates claims of fraud, waste, abuse, retaliation, & other misconduct/wrongdoing.
- ✓ Internal monitoring & auditing.
- ✓ External monitoring & auditing.
- ✓ Corrective action planning & follow-up.
- ✓ Program assessment, goal planning, program development.
- ✓ Risk assessments.

COMPLIANCE MATERIALS

Annual compliance plan, Standards of Conduct, & policies & procedures:

- ✓ Emailed to new employees upon hire.
- ✓ Hard copies available upon request from supervisor, HR, or Compliance Officer.
- ✓ Also available on our website: www.unityhouseny.org
- ✓ Check out the Compliance Page on SharePoint!

SYSTEMS FOR ROUTINE IDENTIFICATION OF COMPLIANCE ISSUES

- Self-assessment
- Reports/incident management
- Internal monitoring & auditing
- External monitoring & auditing
- Results of root cause analysis
- Corrective, remedial action plan follow-up
- Issued guidance

RISK ASSESSMENT

Completed at least annually with ongoing & regular analysis.

Measures: frequency; likelihood of negative outcome; impact on service delivery, other contracts & operations; financial impact.

Informs: workplan, policies, procedures, training & education efforts, & resource allocation.

SYSTEMS FOR RESPONDING TO COMPLIANCE ISSUES

- Internal audits (responsive)
- Investigations
- Corrective & remedial action plans
  - Discipline
  - Enhanced training
  - Implementation of new/revised policies, procedures, & systems to reduce potential of recurrence
  - Reporting issues to internal/external oversight
  - Reporting & returning overpayments
- Self re-assessment
- Continuous risk analysis

IS IT HIPPA, HIPPO OR HIPAA?

- HEALTH
- INSURANCE
- PORTABILITY AND
- ACCOUNTABILITY
- ACT

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (1996)

THE INTENT OF THIS ACT IS TO:

- PROTECT CLIENTS
- PROTECT HEALTH INSURANCE COVERAGE FOR WORKERS AND THEIR FAMILIES WHEN THEY CHANGE OR LOSE THEIR JOBS
- REDUCE FRAUD
- IMPROVE QUALITY OF HEALTH CARE
- AND TO SET STRICT STANDARDS FOR HOW PRIVATE INFORMATION ABOUT CLIENTS IS TRANSMITTED

PROTECTED HEALTH INFORMATION (PHI)

- PHI IS ANY INFORMATION (PAST, PRESENT OR FUTURE) ABOUT HEALTH STATUS, PROVISION OF HEALTH CARE, PAYMENT, AND MEDICAL RECORDS IN ANY FORM. BASICALLY, ANYTHING THAT IDENTIFIES AN INDIVIDUAL.
- NAME, ADDRESS, NAME OF RELATIVES, NAME OF EMPLOYERS, DATE OF BIRTH, TELEPHONE NUMBER, FAX NUMBER, EMAIL ADDRESS, URL, PHOTOGRAPHIC IMAGES, AND ANY OTHER UNIQUE IDENTIFYING CODE OR CHARACTERISTIC.
- WHICH EVEN MEANS USING THE WORD “BLONDE” IN AN ELEVATOR COULD BE A VIOLATION IF SOMEONE KNOWS THE IDENTIFY OF THE PERSON YOU ARE SPEAKING ABOUT.

SEVEN PATIENT RIGHTS REGARDING PRIVACY OF PHI

INDIVIDUALS HAVE THE RIGHT TO:

- RECEIVE NOTICE OF AN AGENCY'S PRIVACY PRACTICES (REQUIRED TO BE POSTED IN COMMON AREA).
- KNOW THAT AN AGENCY WILL USE ITS **PHI ONLY** FOR TREATMENT, PAYMENT, OPERATIONS (TPO), CERTAIN OTHER PERMITTED USES AND USES AS REQUIRED BY LAW.
- CONSENT TO AND CONTROL THE USE AND DISCLOSURES OF THEIR PHI.
- ACCESS THEIR PROTECTED HEALTH INFORMATION (PHI), EXCEPT FOR PSYCHOTHERAPY NOTES (THEY MIGHT BE CHARGED A FEE FOR COPIES).
- REQUEST AMENDMENT OR ADDENDUM TO THEIR PHI (NOT ALWAYS GRANTED).
- RECEIVE ACCOUNTINGS OF DISCLOSURES.
- FILE PRIVACY COMPLAINTS TO AGENCY PRIVACY OFFICER.

HIPAA PRIVACY NOTICE

- PROVIDES INFORMATION TO CLIENTS ABOUT THEIR PRIVACY RIGHTS AND HOW THEIR INFORMATION MAY BE USED.
- MUST GIVE TO CLIENTS AT FIRST SERVICE ENCOUNTER AND OBTAIN SIGNED ACKNOWLEDGEMENT OF RECEIPT.
- THE NOTICE MUST STATE THE COVERED ENTITY'S DUTIES TO PROTECT PRIVACY, PROVIDE A NOTICE OF PRIVACY PRACTICES, AND ABIDE BY THE TERMS OF THE CURRENT NOTICE.
- THE NOTICE MUST DESCRIBE INDIVIDUAL'S RIGHTS, INCLUDING THE RIGHT TO COMPLAIN TO HEALTH AND HUMAN SERVICES (HHS) AND TO THE COVERED ENTITY IF THEY BELIEVE THEIR PRIVACY RIGHTS HAVE BEEN VIOLATED.

WHO HAS ACCESS TO PHI? THE 'NEED-TO-KNOW' PRINCIPLE

- PHI SHOULD BE SHARED WITH AS FEW INDIVIDUALS AS NEEDED TO ENSURE PARTICIPANT CARE AND THEN ONLY TO THE EXTENT DEMANDED BY THE INDIVIDUAL'S ROLE.

HIPAA RIGHT OF ACCESS

- OFFICE OF CIVIL RIGHTS (OCR) CREATED AN INITIATIVE TO SUPPORT INDIVIDUALS' RIGHTS TO TIMELY ACCESS TO THEIR HEALTH RECORDS AT A REASONABLE COST UNDER THE HIPAA PRIVACY RULE.

- HIPAA GIVES THE RIGHTS TO PEOPLE TO SEE AND OBTAIN COPIES OF THEIR HEALTH INFORMATION FROM THEIR HEALTHCARE PROVIDERS AND HEALTH PLANS. AFTER RECEIVING A REQUEST, AN ENTITY REGULATED BY HIPAA (WHICH WE ARE) HAS 30-DAYS TO PROVIDE AN INDIVIDUAL OR THEIR PERSONAL REPRESENTATIVE WITH THEIR RECORDS IN A TIMELY MANNER.

MINIMUM NECESSARY STANDARD

- ACCESSED INFORMATION SHOULD ONLY BE THE MINIMUM AMOUNT OF INFORMATION NECESSARY TO PERFORM YOUR JOB AND TO ACCOMPLISH THE INTENDED PURPOSE OF THE USE, DISCLOSURE, OR REQUEST.

PERMITTED DISCLOSURES OF PHI

- WHEN THE DISCLOSURE IS TO THE INDIVIDUAL TO WHOM THE PHI PERTAINS.
- FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS (TPO) AS PERMITTED BY AND IN COMPLIANCE WITH HIPAA. [45 C.F.R. § 164.506]
- AN INCIDENTAL USE OR DISCLOSURE THAT COULD NOT HAVE BEEN PREVENTED, WAS LIMITED IN NATURE, AND OCCURRED AS A BY-PRODUCT OF AN OTHERWISE PERMITTED USE OR DISCLOSURE.
- WHEN THE COVERED ENTITY RECEIVES A VALID AUTHORIZATION AS PERMITTED BY HIPAA. [45 C.F.R. § 164.508]
- WHEN THE COVERED ENTITY HAS OBTAINED THE INDIVIDUAL'S ORAL AGREEMENT OR IS OTHERWISE PERMITTED UNDER HIPAA. [45 C.F.R. § 164.510]WHEN THE COVERED ENTITY IS PERMITTED TO USE OR DISCLOSE PHI WITHOUT THE WRITTEN CONSENT OR AUTHORIZATION OF THE INDIVIDUAL, OR WHEN AN OPPORTUNITY FOR THE INDIVIDUAL TO OBJECT OR AGREE TO THE USE OR DISCLOSURE IS NOT REQUIRED. [45 C.F.R. § 164.512]

WHEN AUTHORIZATION IS NOT REQUIRED FOR DISCLOSURE OF PHI

- FOR JUDICIAL AND ADMINISTRATIVE PROCEEDINGS
- AS REQUIRED BY LAW
- TO CORRECTIONAL INSTITUTIONS AND OTHER LAW ENFORCEMENT ENTITIES IN CUSTODIAL SITUATIONS
- FOR USES AND DISCLOSURES ABOUT VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE FOR SPECIALIZED GOVERNMENT FUNCTIONS
- FOR PUBLIC HEALTH ACTIVITIES
- FOR HEALTH OVERSIGHT ACTIVITIES
- TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY
- FOR DISASTER RELIEF (SUCH AS TO THE AMERICAN RED CROSS)
- TO OTHER HEALTH PLANS OR HEALTH CARE PROVIDERS FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS (TPO)
- TO BUSINESS ASSOCIATES
- FOR RESEARCH PURPOSES
- WHEN PHI HAS BEEN DE-IDENTIFIED (TO CREATE A COLLECTION OF INFORMATION THAT CAN NO LONGER BE TRACED BACK TO THE INDIVIDUAL)
- FOR USES AND DISCLOSURES ABOUT DECEDENTS
- FOR CADAVERIC ORGAN, EYE, OR TISSUE DONATION
- FOR WORKERS' COMPENSATION

PROTECTING PHI

- TAKE ALL REASONABLE STEPS TO MAKE SURE THAT INDIVIDUALS WITHOUT THE "NEED TO KNOW" DO NOT OVERHEAR CONVERSATIONS ABOUT PHI.
- **DO NOT** CONDUCT DISCUSSION ABOUT PHI IN ELEVATORS, CAFETERIAS…ANY PUBLIC SPACE.
- KEEP ALL DOCUMENTS CONTAINING PHI OUR OF SIGHT-DO NOT LEAVE THEM LYING AROUND.
- DOCUMENTS WITH PHI OR CONFIDENTIAL INFORMATION TO BE DISCARDED SHOULD BE SHREDDED-NOT PUT IN WITH REGULAR TRASH.
- KEEP RECORDS LOCKED AND SECURE AT ALL TIMES.

DATA SECURITY

- STRONG PASSWORDS CONTAIN UPPER AND LOWER CASE, ARE CRYPTIC/NOT EASILY GUESSED (OR YOUR PET'S NAME) AND CONTAIN AT LEAST 8 OR MORE ALPHA NUMERIC CHARACTERS.
- PROTECT INFORMATION ON COMPUTERS-LOCK COMPUTER WHEN NOT IN USE.
- DEFEND SITES AGAINST INTRUSION-NEVER OPEN ATTACHMENTS UNLESS BUSINESS RELATED, EXPECTED; AND YOU KNOW THE PERSON WHO SENT IT.
- PROTECT AGAINST UNAUTHORIZED INFORMATION ACCESS, USE, DISCLOSURE, LOSS AND DESTRUCTION.
- MAKE SURE SCREENS ARE NOT VISIBLE TO PASSERS-BY.

HIPAA BREACHES

- AN IMPERMISSIBLE USE OR DISCLOSURE UNDER THE PRIVACY RULE THAT COMPROMISES THE SECURITY OR PRIVACY OF THE PROTECTED HEALTH INFORMATION SUCH THAT THE USE OR DISCLOSURE POSES A SIGNIFICANT RISK OF FINANCIAL, REPUTATIONAL, OR OTHER HARM TO THE AFFECTED INDIVIDUAL.
- ALL SUSPECTED BREACHES MUST BE REPORTED TO YOUR COMPLIANCE/PRIVACY OFFICER IMMEDIATELY

FINES AND PENALTIES FOR VIOLATING HIPAA STANDARDS

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ISSUES REGULATIONS AND THROUGH THE OFFICE FOR CIVIL RIGHTS (OCR), HANDLES HIPAA VIOLATIONS.

CIVIL PENALTIES

THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 CREATED A TIERED PENALTY CONFIGURATION FOR HIPAA VIOLATIONS. BUT IT IS THE OCR THAT DETERMINES THE AMOUNT OF EACH PENALTY, AND IT IS DEPENDENT UPON THE NATURE AND EXTENT OF HARM THAT RESULTS FROM THE BREACH. FOR EXAMPLE:

- THE MINIMUM PENALTY FOR A VIOLATION WHERE THE PERSON DID NOT KNOW AND WOULD NOT HAVE KNOWN BY EXERCISING REASONABLE DILIGENCE IS $100 PER VIOLATION NOT TO EXCEED $25,000 PER CALENDAR YEAR.
- THE MINIMUM PENALTY FOR A VIOLATION DUE TO REASONABLE CAUSE IS $1,000 PER VIOLATION NOT TO EXCEED $100,000 PER CALENDAR YEAR.
- THE MINIMUM PENALTY FOR A VIOLATION DUE TO WILLFUL NEGLECT THAT IS TIMELY CORRECTED IS $10,000 PER VIOLATION NOT TO EXCEED $250,000 PER CALENDAR YEAR
- THE MINIMUM PENALTY FOR A VIOLATION DUE TO WILLFUL NEGLECT THAT IS **NOT** CORRECTED IS $50,000 PER VIOLATION NOT TO EXCEED $1,500,000 PER CALENDAR YEAR .

MORE FINES AND PENALTIES FOR VIOLATING HIPAA STANDARDS

A PRIVACY RULE INFRACTION CAN BE CONSIDERED CRIMINAL AND MAY LEAD TO PROSECUTION BY THE DEPARTMENT OF JUSTICE IF SOMEONE DELIBERATELY ACQUIRES OR DISCLOSES A PERSON'S HEALTH INFORMATION; THE FINE IS $50,000 AND UP TO ONE YEAR IN JAIL. WHENEVER AN OFFENSE IS COMMITTED THROUGH DECEPTION, THE FINE IS $100,000 AND THE JAIL TIME IS 5 YEARS. AND, IF PERSON'S HEALTH INFORMATION WAS SOLD, TRANSFERRED OR USED FOR PROFIT-MAKING, OR ANY TYPE OF PERSONAL GAIN OR INTENT TO HARM, THE FINES CAN GO AS HIGH AS $250,000 WITH IMPRISONMENT FOR UP TO 10 YEARS.

OTHER SANCTIONS

- INSTITUTIONAL REPUTATION – LOSS OF BUSINESS, PROFITS
- EXCLUSION
- EMPLOYEE SUSPENSION OR TERMINATION
- LOSS OF LICENSE TO PRACTICE

DO NOT…

- CREATE EASY-TO-REMEMBER PASSWORDS.
- USE OBVIOUS PASSWORDS RELATED TO COMMON INFORMATION SUCH AS A CHILD'S OR PET'S NAME, OR YOUR FAVORITE SPORTS TEAM.
- USE PASSWORDS THAT SOMEONE CAN GUESS, USING YOUR SOCIAL MEDIA INFORMATION.
- WRITE DOWN YOUR PASSWORD IN A PLACE THAT IS ACCESSIBLE TO OTHERS.
- SHARE YOUR PASSWORD WITH ANYONE.

WORKSTATION SECURITY

- PHYSICALLY SECURE YOUR AREA AND DATA WHEN UNATTENDED.
- SECURE YOUR FILES AND PORTABLE EQUIPMENT.
- UNITY HOUSE PROHIBITS USING MEMORY STICKS FOR PHI.
- SECURE LAPTOP COMPUTERS AND TABLETS IN A LOCKED CABINET WHEN NOT IN USE.
- NEVER SHARE YOUR ACCESS CODE, CARD, OR KEY.
- LOCK YOUR COMPUTER SCREEN.

WI-FI NETWORKS

- IT'S IMPORTANT TO REMEMBER THAT MALICIOUS ACTORS COULD BE LURKING IN THE FREE WI-FI NETWORKS THAT YOU MAY BE ACCUSTOMED TO ACCESSING WHILE AT YOUR LOCAL COFFEE SHOP, OR WHILE TRAVELING. DO NOT EXPOSE YOUR UNITY HOUSE DEVICES TO UNNECESSARY SECURITY RISKS BY CONNECTING TO FREE UNSECURE WI-FI NETWORKS SUCH AS YOUR HOME WI-FI OR HOTSPOT DEVICES (MOBILE PHONE/TABLET).

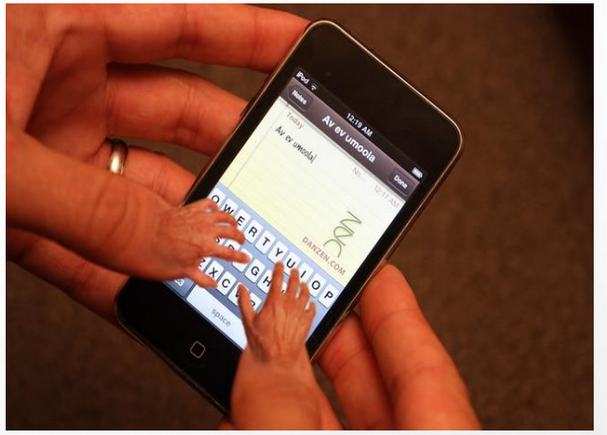
FAX DATA SECURITY

- FAX MACHINES SHOULD BE LOCATED IN PRIVATE AND SECURE AREAS AWAY FROM PUBLIC VIEW.
- FAX COVER SHEETS WILL INCLUDE A “CONFIDENTIALITY DISCLAIMER” INDICATING WHAT TO DO IF SENT TO THE WRONG NUMBER.
- VERIFY THE RECIPIENT OF THE FAX. GET THE FAX AND PHONE NUMBER OF THE FACILITY AND CALL BACK TO VERIFY THAT IT’S THE RIGHT PLACE, AND THAT SOMEBODY IS STANDING AT THE FAX MACHINE WAITING FOR THE FAX TO COME IN.

ENCRYPTION

- ENCRYPTION IS THE PROCESS OF ENCODING MESSAGES OR INFORMATION IN SUCH A WAY THAT ONLY AUTHORIZED PARTIES CAN READ IT. ENCRYPTION DOES NOT PREVENT INTERCEPTION, BUT DENIES THE UNAUTHORIZED PERSONS AND SOFTWARE THE ABILITY TO INTERPRET THE MESSAGE CONTENT. UNITY HOUSE POLICY REQUIRES FILES CONTAINING PHI TO HAVE ENCRYPTION ENABLED WHILE IN TRANSFER AND WHILE STORED. EMAILS THAT CONTAIN PHI MUST HAVE ENCRYPTION ENABLED BEFORE THE SENDER SENDS THEM. ENCRYPTION IS THE DEFAULT SETTING AND SHOULD NOT BE REMOVED IF ANY PHI IS CONTAINED IN THE THREAD OF THE EMAIL.

TEXTING



- PHI OR OTHER SENSITIVE INFORMATION SHOULD NEVER BE INCLUDED IN TEXT MESSAGES- INSTEAD KEEP IT SIMPLE:

"HI, JUST A REMINDER YOUR APPOINTMENT IS TOMORROW AT 1:00. I'LL PICK YOU UP A 12:30. SEE YOU THEN!"

EMAIL ENCRYPTION

- EMAILS SENT TO SOMEONE OUTSIDE OF UNITY HOUSE AUTOMATICALLY HAVE THIS DISCLAIMER ATTACHED, IN THE EVENT THAT THE EMAIL IS SENT TO AN INCORRECT EMAIL ADDRESS:

IMPORTANT NOTICE:
THIS E-MAIL IS MEANT ONLY FOR THE USE OF THE INTENDED RECIPIENT. IT MAY CONTAIN CONFIDENTIAL INFORMATION WHICH IS LEGALLY PRIVILEGED OR OTHERWISE PROTECTED BY LAW. IF YOU RECEIVED THIS E-MAIL IN ERROR OR FROM SOMEONE WHO WAS NOT AUTHORIZED TO SEND IT TO YOU, YOU ARE STRICTLY PROHIBITED FROM REVIEWING, USING, DISSEMINATING, DISTRIBUTING OR COPYING THE E-MAIL. PLEASE NOTIFY US IMMEDIATELY OF THE ERROR BY RETURN E-MAIL AND DELETE THIS MESSAGE FROM YOUR SYSTEM. THANK YOU FOR YOUR COOPERATION.

- ANY PHI OR OTHER SENSITIVE INFORMATION THAT NEEDS TO BE EMAILED OUTSIDE THE AGENCY MUST BE ENCRYPTED.
  - ❑ TO SEND AN ENCRYPTED EMAIL TO SOMEONE OUTSIDE OF UNITY HOUSE (LIKE CLIENTS, CLINICIANS, PROVIDERS), SIMPLY INCLUDE [ENCRYPT] (TYPE: BRACKET CHARACTER, THE WORD ENCRYPT, BRACKET CHARACTER) ON THE SUBJECT LINE.
  - ❑ EXAMPLE: [ENCRYPT]

SPAM…AND HOW TO RESOLVE IT

FROM THE UNITY HOUSE IT DEPARTMENT:

- **IT HAPPENS – KNOW WHAT TO DO IF YOU CLICK ON SOMETHING YOU SHOULDN'T HAVE – HOPEFULLY BY MISTAKE – BE SUSPICIOUS – ALWAYS CHECK URL'S AND BE SLOW TO CLICK! DO NOT FORWARD ANY SUSPICIOUS EMAILS TO ANYONE, INCLUDING IT. HACKERS CAN ACCESS THE SYSTEM EVEN WHEN FORWARDING AN EMAIL.**
- **IF YOU HAVE CLICKED ON A SPAM EMAIL LINK THAT HAS TAKEN YOU TO A SUSPICIOUS WEBSITE, YOU HAVE TO ACT PROMPTLY.** HERE ARE THE THINGS YOU HAVE TO DO WITHOUT DELAY:
- **DISCONNECT YOUR DEVICE** – TURN OFF COMPUTER/LAPTOP AND UNPLUG THE POWER FROM YOUR COMPUTER WITHOUT CLICKING ON ANYTHING FURTHER OR USING YOUR KEYBOARD (HANDS OFF) AND DISCONNECT ETHERNET CABLE (IF YOU ARE ON A WIRELESS CONNECTION, MOVE TO #2)
    - **THE MOMENT YOU REALIZE THAT YOU HAVE CLICKED ON A POTENTIALLY HARMFUL LINK, YOU SHOULD DISCONNECT YOUR COMPUTER OR MOBILE DEVICE FROM THE INTERNET.** DISCONNECTING YOUR DEVICE FROM THE NETWORK WILL LOWER THE RISK OF MALWARE SENDING SENSITIVE DATA FROM YOUR DEVICE, SPREADING TO YOUR SYNCED DEVICES ON THE SAME NETWORK, AND ENABLING SOMEONE TO ACCESS YOUR DEVICE REMOTELY.
- **CALL IT DEPT. ASAP** AFTER #1 IS COMPLETE. PUT IN A WORK ORDER OR HAVE SOMEONE ELSE PUT ONE IN FOR YOU. HTTPS://UNITYHOUSENY.SHAREPOINT.COM/
- **IT WILL DIRECT YOU ON FUTURE ACTIONS**. DO NOT TURN ON COMPUTER/LAPTOP UNLESS DIRECTED BY IT.
- GOOD POLICY IS TO CHANGE ALL YOUR PASSWORDS.

SOCIAL MEDIA

IT'S CRITICAL THAT YOU UNDERSTAND THE THREATS YOU MAY ENCOUNTER WHEN USING YOUR SOCIAL MEDIA ACCOUNTS. MALICIOUS ACTORS MAY OFTEN PRETEND TO BE A COWORKER, A "FRIEND," OR TO HAVE A COMMON SOCIAL MEDIA INTEREST IN AN EFFORT TO GAIN YOUR TRUST SO THAT THEY CAN OBTAIN UNAUTHORIZED ACCESS TO INFORMATION AND INFORMATION SYSTEMS.

- **DO NOT** TAKE PHOTOS OR VIDEOS OF CONSUMERS ON YOUR PERSONAL DEVICES-DO NOT SHARE THEM ON SOCIAL MEDIA.
- **AS A GENERAL POLICY, WE CANNOT COMMUNICATE WITH CONSUMERS AND/OR FAMILIES BY SOCIAL MEDIA NOR ARE WE PERMITTED TO ACCEPT "FRIEND REQUESTS." STAFF ARE REQUIRED NOT TO RESPOND TO SUCH REQUESTS.**
- •BE CAREFUL WHEN ASSOCIATING YOUR EMPLOYMENT AT UNITY HOUSE WITH YOUR SOCIAL MEDIA ACCOUNTS.
- •DO NOT INCLUDE TOO MUCH IDENTIFYING INFORMATION.
- •A SOCIAL ENGINEER MAY AGGREGATE AND USE MULTIPLE POSTS ABOUT YOUR JOB WITH MALICIOUS INTENT.
- •BE MINDFUL OF WHAT YOU TWEET, INSTANT MESSAGE (IM), OR POST ONLINE BECAUSE ONCE IT'S ON THE INTERNET IT'S ON THE INTERNET **FOREVER**!

THANK YOU

Colleen Hanaway Seeley

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