

CF OPERATING PROCEDURE  
NO. 60-17, Chapter 3

STATE OF FLORIDA  
DEPARTMENT OF  
CHILDREN AND FAMILIES  
TALLAHASSEE, July 15, 2015

Human Resources

HIPAA PRIVACY MONITORING REQUIREMENTS

3-1. Purpose. This operating procedure establishes a uniform process for monitoring activities; and reviewing the compliance of Department of Children and Families (DCF) Programs and Facilities to ensure the privacy of Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA).

3-2. Scope. This operating procedure applies to all employees of DCF sponsored Programs, Facilities, Business Associates and activities involved in providing equally effective and equally accessible quality services to DCF clients or potential clients.

3-3. Authority.

- a. Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- b. 2013 HIPAA Omnibus Rule, 78 FR 5566, No. 17.
- c. Genetic Information Nondiscrimination Act of 2008.
- d. Title 45 C.F.R., Subparts 160, 162 and 164, Security and Privacy of Individually Identifiable Health Information.

3-4. General.

a. HIPAA establishes in law the basic principle that a client's medical records belong to that individual and, with certain exceptions, cannot be used or disclosed without the explicit permission of that individual. HIPAA gives clients the right to:

- (1) An explanation of their privacy rights by service providers;
- (2) See or receive a copy of their medical records;
- (3) Request corrections to these records;
- (4) Control the release of information from their records;
- (5) Request confidential communications;
- (6) Request restrictions for certain uses and disclosures;
- (7) Receive breach notifications; and
- (8) Documented explanations of disclosures by entities that may have access to this information.

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This operating procedure supersedes CFOP 60-17, Chapter 3, dated June 2, 2008.

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b. 45 C.F.R., Part 160.310, requires that DCF, as a covered entity, and its Business Associates and their subcontractors, keep and provide records and compliance reports, in such time and manner and containing such information, as the Secretary of the Department of Health and Human Services (HHS) may determine to be necessary to enable the Secretary to ascertain whether DCF, its Business Associates and their Subcontractors have complied and are complying with the requirements of the HIPAA regulations, to include complaint investigations and compliance reviews.

(1) Access shall be provided during normal business hours to DCF's, Business Associate's and Subcontractor's facilities, books, records, accounts, and other sources of information, including PHI, that are pertinent to ascertaining compliance with the HIPAA regulations.

(2) If the Secretary of Health and Human Services determines that critical circumstances exist, access shall be permitted at any time, without notice.

(3) DCF, its Business Associates and their Subcontractors must certify and set forth what efforts were made to obtain information required for a HHS investigation or compliance review.

(4) If DCF, its Business Associates or their Subcontractors fail or refuse to furnish information required by HHS, DCF, the Business Associate or the Subcontractor must certify all efforts undertaken to obtain the required information.

### 3-5. Policy.

a. HIPAA requires DCF to assure the privacy and confidentiality of client's Protected Health Information (PHI). DCF employees and volunteers shall not permit the unauthorized disclosure of client's PHI except as permitted or required by law.

b. Regional Managing Directors and Hospital Administrators are responsible for ensuring that DCF Programs and Facilities have documented privacy procedures in place to:

(1) Provide adequate notice to clients of their rights and the procedures for exercising their rights with respect to their PHI in accordance with CFOP 60-17, Chapters 1 and 2;

(2) Enable clients to exercise the right of access to his or her own PHI (except where expressly exempted by law);

(3) Give clients an accurate accounting of all disclosures of PHI as long as the information is maintained by DCF Programs or Facilities, except for disclosures made:

(a) To carry out Treatment, Payment and Operations (TPO);

(b) To clients about their own PHI;

(c) For the facility directory (if applicable) or to persons involved in the client's care or other notification purposes permitted by law;

(d) For national security or intelligence purposes;

(e) To correctional institutions or law enforcement officials;

(f) Prior to April 14, 2003; and,

(g) Prior to the compliance date for the covered entity.

(4) Enable clients to request amendment or correction of their PHI;

(5) Determine whether the request to amend or correct their PHI should be granted or denied, and,

(6) If granted, disseminate amendments or corrections to DCF Programs, Facilities, Business Associates and their Subcontractors to whom erroneous information has been disclosed, including the amendment of information in all appropriate designated record sets maintained by DCF Programs, Facilities, Business Associates and their Subcontractors.

c. Regional Managing Directors and Hospital Administrators are responsible for ensuring that DCF Programs and Facilities have administrative, physical, and technical safeguards (security procedures/processes) in place to ensure the confidentiality, integrity and availability of all electronic PHI (ePHI). This includes all PHI that is created, received, maintained, or transmitted. Safeguards must protect against anticipated threats or hazards to the security or integrity of such information and against any reasonably anticipated uses or disclosures of such information that are not permitted under the security rule.

3-6. Monitoring Process. Compliance with the policies and processes contained in all Chapters of CFOP 60-17 will be monitored. Notice is further given by including language in each procedure as follows: “The Privacy Officer will collect and analyze information from Regions, DCF Mental Health Treatment Facilities, Business Associates and their Subcontractors annually to determine compliance with this procedure.”

3-7. Roles and Responsibilities for Compliance Office for HIPAA Compliance Monitoring. The Compliance Officer is DCF’s employee assigned to the Office of Civil Rights (OCR). HIPAA Compliance reviews are performed by the HIPAA Compliance Officer or Civil Rights Officer, hereinafter referred to as “Compliance Officer”.

a. The Compliance Officer is responsible for observing, recording, and reporting information about HIPAA compliance as stated in 45 C.F.R. Parts 160 and 164 for DCF.

b. Compliance Officers are not involved in administering disciplinary actions or sanctions based upon the findings in the OCR Report.

c. Compliance Officers may be involved in assisting in the development of Corrective Action Plans based upon the findings in the OCR Report. Compliance Officers are not involved in the implementation of corrective action plans.

d. Compliance Officers may provide technical assistance.

3-8. Approaches Used to Monitor. Monitoring is typically performed by reviewing documents, interviewing individuals, making observations, and self-surveys. The information is analyzed by the Compliance Officers.

a. Document Review. Document Review is the most common monitoring technique. Documents usually reviewed during on-site compliance reviews include client files, medical files, database files, staff personnel files, applicable policies and procedures, reports, and publications.

b. Interviews. Interviews will be conducted with management and direct service staff regarding their role and responsibility in protecting the privacy and security of client’s PHI and their knowledge of HIPAA policies and procedures.

c. Observation. Certain items may be monitored through actual observation of activities. (For example: positioning of computer screens, storefront application processes, status of secure areas/containers, location of required notices, etc.)

d. Self-Surveys. The Self-Survey Tool will be completed by select managers and DCF personnel within each DCF Administrative Office and DCF Direct Service Facility. The Self-Survey will also be completed by DCF Business Associates and their Subcontractors. The Compliance Officer will distribute the Self-Survey Tool and provide a timeframe for when the survey must be returned to the Compliance Officer.

e. Tools. The OCR uses monitoring tools that are based on the scope of the compliance review. Each compliance review must:

- (1) Identify requirements that are based on DCF policy or federal statute;
- (2) Utilize a rating system of "Compliance", "Non-compliance" or "Non-applicable"; and,
- (3) Develop Corrective Action Plans when the DCF Program, Facility, Business Associate or Subcontractor is non-compliant.

3-9. Scope of Monitoring. The Office of Civil Rights (OCR) monitors DCF compliance with applicable laws, rules, regulations, and operating procedures. The scope for OCR monitoring is limited to these areas.

a. All DCF Programs, Facilities and a random sampling of employees from each region will be monitored annually.

b. All Business Associates and Subcontractors will be subject to on-site monitoring or Self-Surveys once every three years.

c. The monitoring period or frequency of the monitoring may be adjusted based on previous monitoring results, complaints or findings of violations.

3-10. Scheduling. For routine monitoring, the OCR will give notice thirty (30) calendar days in advance of the Entrance Conference. In the case of a schedule change, the appropriate point of contact will be notified as soon as possible.

3-11. Management Review Request. Management may request a special compliance review by contacting the Human Resources Director or the Human Resources Manager for Civil Rights at DCF Headquarters.

3-12. On-Site Monitoring.

a. Entrance Conference. The Compliance Officer will conduct an Entrance Conference with Management and/or other appropriate individuals at the start of the on-site monitoring. The Entrance Conference usually includes:

- (1) Introduction of participants;
- (2) Purpose, scope, and schedule of the on-site monitoring; and,
- (3) OCR monitoring processes.

b. On-Site Process. Compliance Officers complete the approved monitoring tools through Document Review, Staff Interviews, and Observations and analyzes the results relative to compliance requirements. Each item is rated for compliance, non-compliance, or as non-applicable.

c. Adjustments to Scope During On-Site Monitoring. During the course of monitoring, the Compliance Officer may become aware of a compliance issue in an area that was not originally

included in the scope. When this happens, the Compliance Officer will consult with the Human Resources Manager for Civil Rights to determine if additional activities will be conducted to monitor performance related to the new or additional issue or concern, and if so, the extent of activities. Information about the compliance concern will be discussed in the final report.

d. Exit Conference. The Exit Conference is conducted by the Compliance Officer with Management and/or other appropriate individuals and represents the conclusion of the on-site monitoring activity. The Exit Conference may be conducted on-site, by phone or other method(s).

3-13. Compliance Monitoring Reports.

a. The Compliance Officer shall report the findings of their monitoring activities to the Privacy Officer using a prescribed format.

b. The Privacy Officer and Human Resources Director shall review results and provide feedback to the Compliance Officer prior to distribution to the Regional Managing Director, Program Director, Contract Manager, Business Associate management or Subcontractor management as appropriate.

3-14. Compliance with Monitoring Procedure. The Privacy Officer will collect and analyze information from Regions, DCF Mental Health Treatment Facilities, Business Associates and their Subcontractors annually to determine compliance with this procedure.

BY DIRECTION OF THE SECRETARY:

*(Signed original copy on file)*

STEPHANIE REAVES  
Human Resources Director

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

This operating procedure has been updated to reflect the current requirements of the 2013 HIPAA Omnibus Rule. Specifically, language to reflect responsibilities of Business Associates and their Subcontractors; and additional client rights. Roles, Responsibilities, and Approaches for HIPAA Compliance Monitoring have been added.

## GLOSSARY OF TERMS

- a. Accounting of Disclosures. A log that is maintained for each client listing all disclosures that have been made of his or her PHI.
- b. Alternative Communication Means. Information or communications delivered to clients by the facility in a manner different than the normal practice of the facility. For example, the client may ask for delivery at an alternative address, phone number or post office box; or that discussion of PHI is limited when specified people are present.
- c. Amend / Amendment. An amendment to PHI will always be in the form of information *added to* the existing PHI. This additional information may contain items that substantially change the initial PHI, make parts of the initial PHI more precise, or show some of the original PHI to be incorrect. However, the original PHI is never altered. Changes are indicated by the addition of the amended information.
- d. Authorization. A client's statement of agreement to the use or disclosure of PHI to a third party. See also "conditioned authorization".
- e. Breach. The unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.
- f. Business Associate (BA). An individual or organization that creates, receives, maintains, or transmits PHI on behalf of the Department. A business associate might also be an individual or entity that provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services involving the use or disclosure of PHI.
- g. Civil Monetary Penalty. The amount of money the Department or Business Associate would have to pay where a violation of a HIPAA Rule has been found.
- h. Client. As used in this operating procedure includes patient.
- i. CMS – Centers for Medicare and Medicaid Services. The agency formerly known as HCFA (Health Care Financing Administration) that regulates and enforces Federal Regulations for Medicare in Long Term Care and other health care entities.
- j. Conditioned. An authorization is "conditioned" if a client cannot obtain treatment or service unless he or she signs that authorization.
- k. Covered Entity. A business or agency such as DCF, who transmits health care information using one of the transaction standards defined by the Department of Health and Human Services. An example of this would be billing Medicare and Medicaid electronically for services the Department, a Business Associate, or a Contracted Client Services provider provides to a client.
- l. Covered Functions. Functions of a covered entity, the performance of which make the entity a health plan, a health care clearinghouse, or a health care provider.
- m. De-Identification. The process of converting individually identifiable information into information that no longer reveals the identity of the client. Information may be de-identified by statistical de-identification or the safe harbor method of de-identification.
- n. Department of Health and Human Services (HHS). The federal agency charged with the development, statement and implementation of the Health Insurance Portability and Accountability Act.

o. Designated Record Set. A group of medical records and billing records relating to an individual, maintained and used by the Department or health care provider to make decisions about the client. In this context a record is any item, collection, or grouping of information that contains PHI and is maintained, collected, used or disclosed by the Department. The Designated Record Set also includes billing information that may contain ICD-9-CM codes that represent health conditions of the client and which are part of the clients PHI.

p. Directory Information. The four pieces of information that are considered “Directory Information” include:

- (1) Client name;
- (2) Location in the facility (room/bed number);
- (3) Condition described in general terms (e.g., “He is not feeling well.” or “She is having a good day.”);
- (4) Religious affiliation (available only to members of the clergy).

NOTE: You would not want to post or display more than the client’s name and room/bed number on your facility directory.

q. Disclosure. To release, transfer, provide access to or divulge in any way a client’s health information to third parties. Disclosures are either permissible or impermissible.

- (1) Permissible – Disclosure of health information that does not require an authorization or an opportunity to agree or object before the disclosure is made. Permissible disclosures include, but are not limited to, those made for treatment, payment and operation or required by law.
- (2) Impermissible – A disclosure of health information that is prohibited under the privacy rule without first obtaining the client’s authorization. An impermissible disclosure is presumed to be a breach unless the covered entity or business associate demonstrates through a risk assessment that there was a low probability that the PHI had been compromised.

r. Electronic Protected Health Information (ePHI). Any individually identifiable health information protected by HIPAA that is transmitted by or stored in electronic media.

s. Financial Records. Admission, billing, and other financial information about a client included as part of the Designated Record Set.

t. Financial Remuneration. The direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any payment for treatment of an individual.

u. Fundraising. An organized campaign by a private, non-profit or charitable organization designed to reach out to certain segments of the population or certain identified populations in an effort to raise monies for their organization or for a specific project or purpose espoused by their organization.

v. Health Care Operations. Any of the following activities of a covered entity or mental health treatment facility:

(1) Conducting quality assessment and improvement activities, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; protocol development, case management and care coordination, contacting of health care providers and clients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating employee and facility performance, conducting training programs under supervision to practice or improve skills, training of non-health care professionals, accreditation, certification, licensing or credentialing activities;

(3) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(4) Business planning and development such as conducting cost-management and planning related analyses related to managing and operating facility;

(5) Business management and administrative activities of a covered entity, including, but not limited to:

(a) Customer service;

(b) Resolution of internal grievances;

(c) Due diligence in connection with the sale or transfer of assets to a potential successor in interest;

(d) Creating de-identified health information, fundraising for the benefit of the covered entity and marketing for which an individual's authorization is not required.

w. Health Care Provider. An entity that provides health care, service or supplies related to the health of an individual, e.g., medical, dental, physical therapy, or chiropractic clinics; hospitals, etc.

x. Health Oversight Agency. A governmental agency or authority, or a person or entity acting under a grant of authority from or a contract with such public agency, including the employees or agents of the public agency, its contractors and those to whom it has granted authority, that is authorized by law to oversee the public or private health care system or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights for which health information is relevant.

y. HIPAA. The Health Insurance Portability and Accountability Act of 1996, including the portion of the act known as Administrative Simplification (Subpart F) dealing with the privacy of individually identifiable health information.

z. Hybrid Entity. A single legal entity that is a covered entity whose business activities include both covered and non-covered functions and who designates health care components in accordance with law.

aa. Indirect Treatment Relationship. A relationship between an individual and a health care provider in which the health care provider delivers health care to the individual based on the orders of another health care provider and the health care provider typically provides services or products, or

reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

bb. Individually Identifiable Health Information (IIHI). Any information, including demographic information, collected from an individual that:

- (1) Is created or received by a health care provider, health plan, or employer; and
- (2) Relates to the past, present or future physical or mental health or condition of an individual; and
  - (a) Identifies the individual; or
  - (b) With respect to which there is reasonable basis to believe that the information can be used to identify the individual.

cc. Law Enforcement Official. A public employee from any branch of government who is empowered by law to investigate a potential violation of the law or to prosecute, or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

dd. Limited Data Set (LDS). A data set that includes elements such as dates of admission, discharge, birth and death as well as geographic information such as the five digit zip code and the individual's state, county, city or precinct but still excludes the other 16 elements that "de-identify" information. In addition, this limited data set can only be used if a covered entity enters into a "data use agreement" with the data recipient similar to the agreements entered into between covered entities and their business associates.

ee. Marketing.

- (1) To provide information about a product or service that encourages recipients of the communication to purchase or use the product or service, unless the communication is made:
  - (a) To describe a health-related product or service (or payment for such product or service) that is provided by or included in a plan of benefits of the covered entity making the communication, including communications about the entities participating in a health care provider network or health plan network; replacement of, or enhancement to, a health plan; and health-related products or services available only to a health plan enrollee that add values to, but are not part of, a plan of benefits;
  - (b) For treatment of that individual; or
  - (c) For case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers or settings of care to the individual.
- (2) An arrangement between a covered entity and any other entity whereby the covered entity discloses PHI to the other entity in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

ff. Medical Record. The collection of documents, notes, forms, and test results, etc. which collectively document the health care services provided to an individual in any aspect of health care delivery by a provider; individually identifiable data collected and used in documenting healthcare services rendered. The medical record includes records of care used by healthcare professionals while

providing client care services, for reviewing client data, or documenting observations actions or instructions. The medical record is included as part of the Designated Record Set.

gg. Minimum Necessary. The least amount of PHI needed to achieve the intended purpose of the use or disclosure. Covered Entities are required to limit the amount of PHI it uses, discloses or requests to the minimum necessary to do the job. Use or disclosure of more than the minimum necessary may constitute a breach and subject the covered entity to sanctions.

hh. Notice of Privacy Practices. A document required by HIPAA that provides the client with information on how the covered entity generally uses a client's PHI and what the client's rights are under the Privacy Rule.

ii. Operations. Health Care Operations includes functions such as: quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, conducting or arrange for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities.

jj. Payment. The activities undertaken by a health care provider to obtain or provide reimbursement for client health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.

kk. Personal Representative. A person who has authority under law to make decisions related to health care on behalf of an adult or an emancipated minor, or the parent, guardian, or other person acting in loco parentis who is authorized under law to make health care decisions on behalf of a child or unemancipated minor. For purposes of the Privacy Rule a covered entity must treat a personal representative as having the same rights as the client unless there is a reasonable belief that the personal representative has subjected the client to abuse or neglect, or treating the person as the personal representative could endanger the client.

ll. Privacy Officer. A position mandated by HIPAA. The person designated by the organization who is responsible for development and implementation of the HIPAA policies and procedures and is responsible for reviewing and investigating reported HIPAA privacy incidents and violation of privacy policies. Within the Department, the Human Resources Manager for Civil Rights has been designated the HIPAA Privacy Officer.

mm. Privacy Rule. The regulation issued by the Department of Health and Human Services entitled Standards for Privacy of Individually Identifiable Health Information.

nn. Protected Health Information (PHI) (if electronic may be referenced as "ePHI"). Individually identifiable information that relates to the past, present or future physical or mental 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

(1) That identifies the individual; or

(2) There is a reasonable basis to believe the information can be used to identify the individual.

PHI does not include the following:

(1) Individually identifiable health information in education records covered by the Family Education Rights and Privacy Act (20 U.S.C. 1232g); and

(2) Employment records held by a covered entity in its role as an employer.

oo. Psychotherapy Notes. Notes that are recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session. Psychotherapy notes must be kept separate from the rest of the client's medical record.

pp. Public Health Authority. A governmental agency or authority, a person or entity acting under a grant of authority from or a contract with such public agency, including the employees or agents of the public agency, its contractors and those to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

qq. Reasonable Cause. An act or omission in which a covered entity or business associate knew, or by exercising reasonable diligence would have known, that the act or omission violated an administrative simplification provision, but in which the covered entity or business associate did not act with willful neglect.

rr. Reasonable Diligence. Is the care and attention that is expected from and is ordinarily exercised by a reasonable and prudent person under the same circumstances.

ss. Re-Identification. The process of converting de-identified health information back to individually identifiable health information. Re-identified health information does reveal the identity of the client and must be treated as PHI under the HIPAA Privacy Rule.

tt. Research. A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge.

uu. Revoke. To cancel or withdraw an authorization to release medical information.

vv. Role Based Access. Access to PHI based on the duties of employees. The facility will identify persons or classes of persons in its workforce who need access to PHI to carry out their duties and make a reasonable effort to limit access of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

ww. Safeguarding. To ensure safekeeping of PHI for the client.

xx. Sanctions. Penalties associated with the unauthorized or impermissible access, release, transfer, or destruction of a client's health information. Federal regulations require the development and enforcement of a strict sanctions policy.

yy. Security Officer. A position mandated by HIPAA. The responsibilities of this person are to oversee implementation of the requirements mandated by the Final Security regulation and any security requirements included in the other sections of the HIPAA regulation. Within the Department, the Information Security Manager has been designated the HIPAA Security Officer.

zz. State Operations Manual (SOM). Federal Regulations that govern all skilled nursing facilities that receive federal funding from Medicare and/or Medicaid.

aaa. Security Incidents. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system. As defined by Security Standards, a "Security Incident" includes all of the unsuccessful "hacking" attempts that might take place. Security incidents require a report be made to the security officer within a reasonable period of time.

bbb. Subcontractor. Is a person to whom a business associate has delegated a function, activity, or service the business associate has agreed to perform for the Department. A subcontractor is then a

business associate where that function, activity, or service involves the creation, receipt, maintenance, or transmission of Protected Health Information (PHI).

ccc. Subpoena (2 types). A process to cause a witness to appear and give testimony, commanding him to lay aside all pretenses and excuses, and appear before a court or magistrate therein named at a time therein mentioned to testify for the party named under a penalty thereof.

(1) Duces Tecum – A request for witnesses to appear and bring specified documents and other tangible items. The subpoena *duces tecum* requires the individual to appear in court with the requested documents, or simply turn over those documents to the court or to counsel requesting the documents.

(2) General Subpoena (AKA *Ad Testificandum*) – A command to appear in court at a certain time and place to give testimony regarding a certain matter, for example, to testify that the record was kept in the normal course of business.

ddd. TPO. (See Treatment, Payment, and Operations.)

eee. Treatment. The provision, coordination or management of health care and related services by the facility, including the coordination or management of health care by the Facility with a third party; consultation with other health care providers relating to a client; or the referral of a client for health care between the facility and another health care provider.

fff. Treatment, Payment and Operations (TPO) Exclusion. The Privacy Rule allows sharing of information for purposes of treatment, payment and health care operations. Treatment includes use of client information for providing continuing care. Payment includes sharing of information in order to bill for the care of the client. Health care operations are certain administrative, financial, legal, and quality improvement activities that are necessary for your facility to run its business and to support the core functions of treatment and payment.

ggg. U. S. Department of Health and Human Services (HHS). The federal agency charged with the development, statement and implementation of the HIPAA Privacy Rule. ([www.hhs.gov/](http://www.hhs.gov/))

hhh. U.S. Department of Health and Human Services (HHS) Office of Civil Rights. The federal agency that has responsibility for enforcement of the HIPAA Privacy Rule. ([www.hhs.gov/cr/](http://www.hhs.gov/cr/))

iii. Unconditioned. Research that does not condition treatment or services upon signing an authorization.

jjj. Unsecured Protected Health Information. Is PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111–5.

kkk. Use. To share, apply, use, examine or analyze health information within the facility. (See also Disclosure).

III. Whistleblower. A person, usually a staff member, who reveals wrongdoing within an organization to the public, government agencies or to those in positions of authority.

mmm. Willful Neglect. Conscious, intentional failure or reckless indifference to comply.

nnn. Workforce. Employees, volunteers, trainees and other persons whose conduct, in the performance of work for the Facility, is under the direct control of the facility, whether or not they are paid. Members of the workforce are not business associates.