Procedure A-3: Administrative Requirements

I. Personnel Assignments

See Attachment 4: SBC Organization Chart: Privacy

A. This administrative policy documents the MDHFS personnel designated to the SBC.

B. The SBC is a covered component of the City of Minneapolis hybrid entity.

C. The City of Minneapolis passed a resolution establishing a HIPAA Steering Committee with delegated authority related to HIPAA decisions including approving SBC HIPAA policies and procedures.

D. MDHFS has designated the SBC Manager as both the Privacy and Security Coordinator responsible for developing and implementing policies and procedures regarding HIPAA for the SBC.

E. MDHFS has designated the Privacy and Security Coordinator as responsible for receiving complaints from individuals who believe that SBC has violated federal or state laws governing PHI.

II. Training

A. Responsibilities

1. School Based Clinic Manager

   a. It is the responsibility of the MDHFS, through the SBC Privacy Coordinator, to provide privacy training to all SBC personnel who produce, transcribe, store, transmit or otherwise have access to PHI.

   b. The training shall consist of but not be limited to:

      i. Basic health privacy awareness training as part of new SBC employee orientation.

      ii. Annual in-service specialized SBC health privacy policy training.

      iii. Updates and review at monthly SBC staff meetings as needed.

2. SBC Personnel

      i. All SBC personnel are required to complete SBC HIPAA Privacy and Security training.

      ii. New SBC personnel must complete privacy and security training as part of their orientation within the first 30 days of employment.

      iii. All members of the SBC staff will complete a written post test with a passing grade of 80%. If this is not achieved, then a repeat review of the HIPAA presentation with a retake of the quiz is required.

      iv. SBC personnel are responsible for notifying their managers or site supervisors of any unmet specialized health information privacy training needs that come to their attention.

B. Training Documentation

1. The SBC manager is responsible for documenting that personnel have completed privacy training.

2. Documentation will be kept for at least six years on all members who have been trained on the privacy and security policies and practices.

III. Complaints to SBC

A. Under the Privacy Rule, a client may file a complaint with the SBC, City HIPAA coordinator as well as with the Secretary of the US Department of Health and Human Services.

1. SBC Privacy Coordinator shall document all complaints received regarding management of PHI and document the disposition of those complaints. Documentation shall be retained by SBC as required by law.
2. SBC shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who files a complaint with SBC or with the Department of Health and Human Services.

B. Complaint Process

1. *Communicating Process to Individuals*. The SBC's Notice of Privacy Practices (the "Notice") shall direct individuals to submit a complaint regarding management of PHI to the SBC Privacy Coordinator. The Notice shall also indicate that a complaint can be made directly to the Secretary of Health and Human Services (HHS).
2. The SBC Privacy Coordinator shall receive and review all complaints to SBC regarding the management of an individual's PHI. The information gathered should include the following: Name of complainant, date the complaint was filed, date and time of the incident (if applicable), clinic location, names of workforce who were involved, short summary of the dispute.
3. The SBC Privacy Coordinator shall, in consultation, with a supervisor(s), develop and maintain an investigation/disposition report that identifies any privacy deficiencies discovered in the investigation and the steps taken.
4. Within ten (10) working days, the Privacy Coordinator shall notify the complainant to the extent permitted by law in writing of the disposition of the complaint. The Privacy Coordinator may need to redact data and a copy of the redacted disposition sent to the client will be maintained for a minimum of six years.

C. Disposition of Complaint

1. **No Action Taken**
   If the review determines that the complaint is without merit, no action will be taken. This disposition shall be noted on the complaint form and the complainant so informed.
2. **Further Investigation Required**
   If the Privacy Officer determines that a breach of policy or procedure has occurred or that the complaint identifies a potential for process improvement, the complainant shall be notified that further review of the complaint is required and a final disposition will be delivered at a later date. The Privacy Coordinator shall refer the complaint to the appropriate department for follow-up (e.g. MDHFS Directors, human resources for investigation of the breach and possible sanctions; or quality improvement for review and possible modification to a process). When the investigation has been completed and the matter resolved, the Privacy Coordinator shall notify the complainant to the extent permitted by law. If a breach of policy or procedure has resulted in an unauthorized use or disclosure of PHI, the Privacy Officer shall immediately implement steps to mitigate any potential harm to the individual.
3. All complaints to SBC, regarding management of PHI and documentation of the disposition of those complaints, shall be filed in the office of the SBC Privacy Coordinator in a manner conducive to retrieval for review and/or audit. The documentation shall be retained for a period of six years from the date of the complaint.

IV. Policies & Procedures

A. SBC shall develop, implement and enforce policies and procedures consistent with the Health Insurance Portability and Accountability Act of 1996.

B. When necessary, SBC will revise these policies and procedures and update its training program to reflect these revisions.

C. SBC shall document all procedures consistent with state and federal requirements.

V. Administrative Safeguards to Protect PHI

A. SBC shall monitor operational procedures to secure all SBC records that contain PHI, and implement safeguards to limit access to those employees whose job requires such access.

B. The SBC Privacy Coordinator shall work collaboratively with the Chair of the City HIPAA Steering committee to insure that proper safeguards are in place to insure the use, access and disclosure of PHI is consistent with HIPAA, Federal, State, and local regulations.

C. These safeguards shall include (but are not limited to) effective review and audit protocols to monitor individual, use, access and disclosure of PHI maintained in any form across SBC.

D. The SBC Privacy Coordinator shall report quarterly to the HIPAA Steering Committee Chair on the results of the application of these sampling techniques and procedures.