What is HIPAA?

"No, it’s not a female Hippopotamus. Anyone else know?"
Cartoon by Dave Harbaugh
HIPAA in a nutshell

A **covered entity** (Ochsner) may not use or disclose **protected health information**, except as permitted or required.

Protected Health Information (PHI) is anything you see or hear about a specific patient, for example:

**PHI Examples**
- Name and Medical Record Number
- Address and Phone Number
- Social Security Number
- Phone Number
- Date of Service
Compliance is Everyone’s Job

Who is responsible for the privacy and security of Protected Health Information at Ochsner?

- All Employees
- All Physicians
- All Students
- All Volunteers
- All Part-time and Temporary Workers
- All 3rd Party Personnel
- All those who have been given access to Ochsner information or systems
As a Student at Ochsner, How Can You Keep Patient Information Safe?

As a student at Ochsner, you may have access to confidential medical information. You are expected to protect this information from anyone who does not need to know it.

- Respect the privacy of Ochsner’s patients
- Do NOT discuss information about Ochsner’s patients with anyone
- Do NOT remove documents containing patient information from the premises
- Do NOT use your Smartphone to take pictures of patients.
- Patient information should NOT be posted to social media sites.
- Patient information should NOT be sent via text messaging.
Student Guidelines for the Access and Use of Patient Health Information

- Access only the information of patients for whom you are journaling
- Use only the minimum necessary de-identified information needed to complete your journal
- Do not share or discuss any patient health information with other students at their school, friends or family members
- Do not photocopy patient health information
Student Guidelines for the Access and Use of Patient Health Information

- **Do not** record patient information on class assignments including but not limited to:
  - Name or Medical Record Number
  - Date of Birth
  - Address
  - Phone Number
  - Social Security Number

If you have questions about the access or use of patient information, contact your Educator/Program Coordinator.
What Do You Do if You Know or Suspect a Privacy Violation?

You must report any know or suspected violations of patient privacy or security as well as any other concerns to:

- Your Educator/Program Coordinator
- Your Chaperone
- Compliance and Privacy Department at 504-842-9323
- Ochsner’s Anonymous Compliance Line or Web Reporting
You are volunteering at the hospital and you see your best friend’s mom leaving a clinic.

- Is it okay to say hello?
  - **Yes!** Be friendly, but don’t discuss her medical care.

- Is it okay to tell your friend that you saw her mom?
  - **No!** Your friend’s mom may not have told her family that she had an appointment. This would be a violation of her privacy.

- Is it okay to tell your parents that you saw your friend’s mom?
  - **No!** Like any other patient, your friend’s mom has a right to privacy when seeking health care and you should not tell anyone, even your family, that you saw someone at Ochsner, even if you know them.
Scenario 2

You find some unattended paperwork in the hallway with patient information on it. What should you do with it? Should you leave it where you found it?

No! If there is patient information on the paper, return it to the place where it came from, if you can find out.

If you can’t determine where the paperwork came from, dispose of it in a shred bin, not a regular trash can. If you need to find a shred bin, ask an employee who will be able to find you one.
Scenario 3

Kelly, a second year resident, see the famous actress Holly Woods at the coffee stand at Ochsner. Kelly really wants to take a picture and post it on Instagram and Snapchat this celeb sighting.

#workingwiththestars

— Can Kelly take to take a selfie with Holly Woods?

**No.** This could be a potential HIPAA violation especially if the patient does not consent to the photograph. Additionally, this is a violation of the Ochsner cell phone and social media policy.
Reminders

1. Protected Health Information (PHI) is anything you see or hear about the health of a specific patient.

2. You must be protect the privacy of patient health information.

3. It is your duty to report anything that goes against Ochsner policies and procedures.

4. Read, sign and return the “Student Confidentiality Statement” form to document your HIPAA training.
HIPAA HINTS

- **P** Passwords and usernames should never be shared
- **A** Access the minimum PHI necessary to complete your work
- **T** Talk in lower voices when having conversations in non-private areas
- **I** If leaving a voicemail, keep it brief and do not discuss PHI
- **E** Emails from unknown senders with unrecognized attachments should never be opened
- **N** Never leave your workstation unsecured
- **T** Think before you share PHI verbally
The Compliance & Privacy SharePoint site gives you easy access to information about:

- HIPAA
- Policies
- Standards of Conduct
- Education Resources
- Contact Information, including the Compliance Line
Know Your Responsibilities for the Privacy and Security of Patient Health Information

As a student at Ochsner, you may have access to confidential medical information.

It is your responsibility to comply with federal and state laws which protect the privacy and security of this information.

Student Guidelines for the Access and Use of Patient Health Information:

▪ Students may access only the information of patients for whom they are journaling.
▪ Students may use only the minimum necessary de-identified information needed to complete their journal.
▪ Students may not share or discuss any patient health information with other students at their school, friends or family members.
▪ Students may not photocopy patient health information.
▪ Students may not record patient information on class assignments including but not limited to:
  – Name
  – Date of Birth
  – Address
  – Phone Number
  – Social Security Number

If you have questions regarding the access and use of patient health information, contact your Mentor/Program Coordinator.

HIPAA Acknowledgement

My signature below acknowledges that I have read and understand:
1. HIPAA 101 Student Training
2. HIPAA for Students – Quick Review

My signature below acknowledges that I understand:

▪ There are civil and criminal penalties for the unauthorized access and/or use of confidential patient information.
▪ The requirements listed under Ochsner’s Student Guidelines.

Student Signature

Print Student Name

Date

Parent / Guardian Signature (if under 18)

Print Parent/ Guardian Name

Name of Affiliated School

Copy this form for your own records before returning to Ochsner.

Note to OCF Mentor/Program Coordinator:
Maintain the original signed brochure within your department.
Ochsner Clinic Foundation - Health Career Exploration
Parent/Guardian Agreement

Your child, has been selected to participate in one or more education and career exploration days ("Program" or "Programs") at Ochsner Clinic Foundation and its Affiliates (together "Ochsner").

Demographic information. I am voluntarily providing my child’s demographic information below to assist Ochsner in characterizing the population served by their educational Programs. I understand that failing to provide this information does not affect my child’s ability to participate in this or any future Program offered by Ochsner Academic Outreach.

<table>
<thead>
<tr>
<th>Date of Birth (MM/DD/YY):</th>
<th>/  /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity (check all that apply):</td>
<td>□ Hispanic or Latino   □ Non-Hispanic or Latino   □ Rather not specify</td>
</tr>
<tr>
<td>Race (check all that apply):</td>
<td>□ American Indian or Alaskan Native □ Asian □ Black or African American □ Hawaiian or Pacific Islander □ Multiracial □ White □ Other □ Rather not specify</td>
</tr>
<tr>
<td>Student Gender:</td>
<td>□ Female □ Male □ Rather not specify</td>
</tr>
</tbody>
</table>

In order to confirm your child’s participation, please read, sign, and return the below agreement and the waiver attached hereto. If you have any questions, please call Allison F. Sharai, (504) 842-4712.

I, __________________________________________, understand that my child, ________________________________, has been selected to participate in education and career exploration Programs at Ochsner Clinic Foundation and hereby give permission for my child to participate in the Programs.

I agree to support my child in participating in any Program at Ochsner. I also give permission to have my child photographed and/or videotaped while participating in any Program by Ochsner Clinic Foundation and all its affiliates and Elmwood Fitness Center (together “Ochsner”) for use by Ochsner in all public relations activities, including use by or for news media, and further authorizes the use of my child’s name with said photos, film, print or tape in all advertising activities, including television commercials, print ads, brochures, web sites, and outside billboards.

Release. In consideration of my child being allowed to participate in the Program, I hereby release Ochsner Clinic Foundation ("Ochsner"), its subsidiaries, Affiliates, successors, officers, directors, employees and agents from any and all liability for any injury or damage which may occur as a result of the child’s participation in the Program including all risk connected therewith, whether foreseen or unforeseen; and further, agree to save and hold harmless Ochsner, its Affiliates, subsidiaries, officers, employees, directors and agents from any claim by the parent/guardian individually or on behalf of the child, his/her family, estate, heirs or assigns arising out of my child’s participation in the Program.

In the event of an injury requiring medical attention, I hereby grant permission to Ochsner Clinic Foundation to attend to my son/daughter. If the injury warrants further medical attention, I expect every effort will be made to contact me to receive my specific authorization before action is taken. If efforts to contact me are unsuccessful, I grant permission for necessary medical treatment to be given. In addition, I hereby give my permission to the supervising instructor (s) or Ochsner staff (including medical staff) to take my child to the appropriate medical department for treatment within the hospital or, if a physician, to administer treatment if an accident or serious illness occurs on the trip and I cannot be reached. In the event that a student must leave the program for reasons of health, accident, failure to conform to rules established by the instructor in charge, etc., we agree to accept full responsibility for and to pay for the cost of medical care, transportation and other incidental expenses.

__________________________________________
Parent/Guardian Signature

__________________________________________
Date

Home Phone____________________ Work Phone____________________ Cell Phone____________________