




**DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE**

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MITIGATION OF HARM	506.01	04/14/2003	1 of 4
APPROVED BY:  Director	SUPERSEDES 500.17 04/14/2003	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 1

PURPOSE

- 1.1 It is the policy of the Los Angeles County Department of Mental Health (DMH) to mitigate, to the extent practicable, any harmful effects that arise out of the use or disclosure of Protected Health Information (PHI) by either members of its workforce or its business associates in violation of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 (HIPAA Privacy Standards) or the hospital’s policies and procedures to implement HIPAA (HIPAA Policies).

GENERAL ACCOUNTABILITY

- 2.1 This policy and procedure applies primarily to DMH and the Privacy Officer, although all members of the workforce must be aware of the provisions of this policy.

DEFINITIONS

- 3.1 **“Business Associate Contract”** means the contract language between DMH and its business associates that allows the business associate to create or receive PHI on behalf of DMH. The term “Business Associate Contract” includes both stand-alone contracts and amendments to existing services agreements, as well as Business Associate Contract language that is part of a new services agreement. A Business Associate Contract is not required for disclosures by DMH to a health care provider regarding an individual’s treatment. (See policy on HIPAA Business Associates)
- 3.2 **“Disclose”** means, with respect to PHI, the release of, transfer of, provision of access to, or divulging in any manner, PHI outside of DMH internal operations or to other than its workforce members.



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- 3.3 **“Protected Health Information” (PHI)** means information that (i) is created or received by a health care provider, health plan, employer or health care clearinghouse; (ii) relates to the past, present or future physical or mental health or 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 (iii) identifies the individual (or for which there is a reasonable basis for believing that the information can be used to identify the individual). PHI does not include employment records maintained by DMH personnel files in its role as employer.
- 3.4 **“Workforce Members”** means all full or part time paid staff, including students, interns and volunteers.
- 3.5 **“Use”** means, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such information within DMH internal operations.
- 3.6 **“Violation”** means behaviors demonstrating indifference or disregard of DMH Privacy-Related Policies or any of the provisions of HIPAA. The term “violation” does not include disclosures by whistleblowers or disclosures by workforce crime victims, as defined in the policy on *Workforce Sanctions*.

PROCEDURE

4.1 Reports of Suspected Violations

- (a) All reports of suspected Violations of DMH Privacy-Related policies or of the HIPAA Privacy Standards by a Workforce Member or a Business Associate shall be forwarded immediately to the designated Privacy Officer.
- (b) The Privacy Officer, or his/her designee, shall promptly conduct an investigation of the alleged violation and, as part of that investigation, shall document any known violation(s).
- (c) The designated Privacy Officer, in consultation with outside legal counsel as deemed appropriate, shall take steps, as reasonably practicable, to mitigate the harmful effects of such violation to the individual whose PHI is at issue. Such steps may include, but are not limited to, imposing sanctions against



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Workforce Members in accordance with the Workforce Sanctions Policy, in a form that could inure to the benefit of the harmed individual, such as requiring specific types of restitution. To the extent that the individual harmed is aware of the harm, such as when the individual initiated a complaint, the designated Privacy Officer shall discuss any proposed mitigation with the individual in accordance with the Complaint Policy. If the individual is not aware of the harm, the general practice should be to inform the individual of the harm and to discuss options for mitigation.¹ However, in usual circumstances where it seems that informing the individual of the harm could be more harmful than helpful to the individual, County’s Chief Information Privacy Officer should be consulted for a recommendation.

- (d) The designated Privacy Officer shall document all actions taken under this policy.
- (e) When the violation was caused by a business associate, the contract shall be reviewed for possible indemnification or other form of recovery against the business associate, at least as to the costs of the mitigation.

4.2 Review of Complaints and Audits

- (a) Violations identified through the designated Privacy Officer’s review of all privacy-related complaints shall be analyzed for mitigation according to this policy.
- (b) Violations identified through the designated Privacy Officer’s review of internal audit reports shall be analyzed for mitigation according to this policy.
- (c) The designated Privacy Officer shall take steps, as reasonably practicable, which may include, but not be limited to, the actions identified in Section 4.1(c) in this policy, to mitigate any harmful effects of violations discovered pursuant to this Section.

¹ NOTE: HIPAA does not explicitly require that the harmed individual be informed of the harm. Because it seems unlikely that “silent” mitigation would be deemed sufficient mitigation, at least in many cases, this section recommends informing the harmed individual. However, again, this is not an explicit HIPAA requirement. More guidance may come in this area with the eventual release of the enforcement regulations.



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DOCUMENT RETENTION

5.1 All document required under this Policy shall be maintained by the Office of the Chief Deputy.

AUTHORITY

HIPAA 45 CFR Section 164.530(f)