**Chapter 10**

**Data Security**

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**Real-World Case 10.1**

In 2014, the Department of Health and Human Services reported on its website a $4.8 million HIPAA settlement with New York and Presbyterian Hospital (NYP) and Columbia University following the 2010 breach of thousands of patients’ e-PHI. A Columbia University physician, who was an attending physician at NYP, tried to deactivate a computer server that he owned on the network that contained NYP patient e-PHI. The e-PHI became accessible to the public on Internet search engines because technical safeguards were lacking. A patient’s loved one found e-PHI about the patient on the Internet and filed a complaint.

In addition to the impermissible disclosure, both entities were noncompliant in other ways: (1) no attempts had been made to assure the server was secure; (2) a thorough risk analysis had never been completed that identified all systems able to access the e-PHI of NYP patients and therefore no plan to address potential threats and hazards existed; (3) no appropriate policies and procedures existed regarding authorizing access to its databases; and (4) they did not follow their own policies on information access management (HHS 2014).

This costly mistake, both monetarily and from a reputation standpoint, highlights the negative outcomes that can happen when both technical and administrative safeguards are not followed. It also emphasizes the importance of inventorying all systems and devices that can access an organization’s e-PHI to address threats and an organization’s vulnerabilities. This is not an easy task given the number of personal and mobile devices that access e-PHI, but it is critical.

US Department of Health and Human Services (HHS). 2014 (May 7). Data Breach Results in $4.8 million HIPAA Settlements. http://www.hhs.gov/news/press/2014pres/05/20140507b.html.

# Real-World Case Discussion Questions

1. A risk analysis should include an inventory of all systems and devices that can access an organization’s ePHI (in this case, the breach occurred via a physician’s personal computer server). How can an organization account for all systems and devices on which PHI may be accessed or otherwise present? It should include an internal audit of all systems, questions to all that have access on what items they use to access, there should be only 1 type of item used such as everyone has the same phone, on the same network, with the same security measures. NO personal items should be allowed, or personal data bases. Everything that accesses the system should require a secure logon—and be easily identifiable. Any possible breach or weakness in the system should be reported immediately.

2. What should the risk analysis include? It should include looking at all possible vulnerabilities within the system and closing the gaps and shutting them down. There should be incident detection methods in place to identify malicious events.

3. Should the physician have been the one to deactivate the server? Why or why not? The physician should have been an integral part in making sure it was deactivated by checking within the proper channels to advise them it needed to be deactivated and to give access if needed. He does have a shared responsibility in this matter. The CIO should be included in the process.

**Real-World Case 10.2**

Riverside Health System in Virginia announced in 2014 that the e-PHI of nearly 1,000 patients was breached by a nurse who accessed Social Security numbers and EHRs. The violation was discovered during a random organizational audit. Riverside described its compliance program as robust with ongoing monitoring (McCann 2014). This case raises numerous issues; for example, the fact that humans present one of the greatest threats to data security. When this human threat is internal to the organization, it is heightened by the ability to access information in the course of doing business. The article did not describe what type of access was given to employees; however, a nurse role is likely to result in broad access. The inappropriate access had occurred over a four-year period, which raises the issue of monitoring adequacy. Nonetheless, monitoring was taking place. The nurse was terminated after the breach was discovered. When the perpetrator of the breach was identified, all electronic access for that person should have been terminated immediately as well.

McCann, E. 2014 (January 2). 4-Year Long HIPAA Breach Uncovered. HealthITNews. http://www.healthcareitnews.com/news/four-year-long-hipaa-data-breach-discovered.

# Real-World Case Discussion Questions

1. What red flags does this case raise? A 4 year time span is a long time to go unnoticed. An audit on a regular basis should have been done. This could have caught the incident long before the years.

2. How would you have avoided this breach? There likely was a lack of training. I would make sure there team had a good plan in place for the training of all employees on what it looks like to have a breach and what one would do. The CSO and the CIO would both lead this effort.

3. Alternatively, given limited human resources that most organizations have to conduct audits, is it realistic to conclude that monitoring truly was robust and this breach still occurred, undetected? I do not believe there was a robust monitoring system. There should have been an audit trail in place as well as other safeguards such as intrusion detection, password protection, authentication etc.

# Application Exercises

*Instructions:* Answer the following questions.

1. Search the Internet for news about security breaches in healthcare and other industries in the last three years. Make a summary of each case. Identify the principal threats in each of these cases and what could have been done to minimize the threats.

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On Nov. 13, 2015, the FBI notified MaineGeneral that agents had detected MaineGeneral data on an external website that is not accessible by the general public.

The data affected includes the dates of birth and emergency contact names, addresses, and telephone numbers for certain patients referred by a treating physician to MaineGeneral Medical Center for radiology services since June 2009.

It also includes the names, addresses, and telephone numbers of certain employees, as well as similar information for certain prospective donors. The data did not include social security numbers.

Firewall protection would have helped with this as well as audit trails and regular monitoring of the information coming and going. The principal threats are people in this matter.

Because of poor PHI protection a San Juan pr Based insurance holding company pays 3.5 million in fines.  "This case sends an important message for HIPAA Covered Entities, not only about compliance with the requirements of the Security Rule, including risk analysis, but compliance with the requirements of the Privacy Rule, including those addressing business associate agreements and the minimum necessary use of protected health information," she continued.

Physical and technical safeguards were missing. New policies and procedures need to be put in place along with extensive training around the responsibilities of protecting PHI.

2. Search the Internet for as many sites as you can that are concerned with health information privacy and security. Make a list of the sites and provide a two- or three-sentence description of each. What are the biggest security concerns expressed on each site? Share and compare the sites during a classroom session with your classmates.

<https://www.hhs.gov/hipaa/> this covers what a covered entity is, your rights under HIPAA, and enforcement highlights.

http://healthinformatics.uic.edu/resources/articles/confidentiality-privacy-and-security-of-health-information-balancing-interests/ this is a website with a wide range of information and articles.

<https://www.ncbi.nlm.nih.gov/books/NBK9579/> this talks about the privacy and how it impacts the individual and the professional

3. View the security breaches affecting 500 or more individuals posted on the Office for Civil Rights website at <https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf>. Instruct the students to categorize the breaches by type and location of breached information. Are most large breaches intentional or negligent? Most are intentional--theft What medium presents the greatest risk for a breach? Laptops and paper Have the students select three cases and list ways (using HIPAA security rule requirements and news articles about the breaches) that these breaches might have been avoided.

City of Hope National Medical Center CA Healthcare Provider 5900 11/23/2009 Theft Laptop

The computer should have multiple ways to access such as identification, authentication, passwords biometrics and include a two factor authentication.

Brooke Army Medical Center TX Healthcare Provider 1000 10/21/2009 Theft Paper/Films

These records should not have been left in an unsecure spot such as a car. They should have been lucked with multiple forms of protection

Advanced NeuroSpinal Care CA Healthcare Provider 3500 02/23/2010 Theft Network Server

Security cameras, protected entry ways, audit controls

4. Inventory the security policies of a healthcare organization in your area. Use the following table to help organize your inventory. Share your inventory during a class session or in a class presentation with your classmates. Compare and contrast how these policies meet HIPAA security provisions.

|  |  |  |
| --- | --- | --- |
| **Policy name and**  **date of policy** | **Summary of policy** | **Complies with which HIPAA sections** |
| Payments | Must have a release of information and consent on file | yes |
| Accessing information | Multiple sign on, passwords that change regularly, authentificaiton | Yes |

**Review Quiz**

*Instructions:* For each item, complete the statement correctly or choose the most appropriate answer.

1. Data security includes protecting data availability, privacy, and \_\_\_\_\_\_\_\_.

a. Suitability

**b. Integrity**

c. Flexibility

d. Quality

2. Within the context of data security, protecting data privacy means defending or safeguarding \_\_\_\_\_\_\_\_\_.

**a. Access to information**

b. Data availability

c. Health record quality

d. System implementation

3. The greatest threat category to electronic health information is which of the following?

a. Natural disasters

b. Power surges

c. Hardware malfunctions

**d. Humans**

4. The first and most fundamental strategy for minimizing security threats is which of the following?

a. Establish access controls

b. Implement an employee security awareness program

**c. Establish a secure organization**

d. Conduct a risk analysis

5. Administrative safeguards include policies and procedures that address which of the following regarding computer resources?

**a. Management**

b. Maintenance

c. Modification

d. Manipulation

6. The individual responsible for ensuring that everyone follows the organization’s data security policies and procedures is which of the following?

a. Chief executive officer

b. Chief information officer

c. Chief privacy officer

**d. Chief security officer**

7. An employee accesses PHI on a computer system that does not relate to her job functions. What security mechanism should have been implemented to minimize this security breach?

a. Access controls

b. Audit controls

c. Contingency controls

d. Security incident controls

8. A visitor to the hospital looks at the screen of the admitting clerk’s computer workstation when she leaves her desk to copy some admitting documents. What security mechanism would best have minimized this security breach?

a. Access controls

b. Audit controls

**c. Automatic logoff controls**

d. Device and media controls

9. A laboratory employee forgot his user ID badge at home and uses another lab employee’s badge to access the computer system. What controls should have been in place to minimize this security breach?

a. Access controls

b. Security incident procedures

c. Security management process

d. Workforce security awareness training

10. A dietary department donated its old microcomputer to a school. Some old patient data were still on the microcomputer. What controls would have minimized this security breach?

a. Access controls

b. Device and media controls

c. Facility access controls

d. Workstation controls

11. HIPAA requires that policies and procedures be maintained for a minimum of \_\_\_\_\_\_\_.

a. Seven years

b. Six years from date of creation

c. Six years from date of creation or date when last in effect, whichever is later

d. Seven years from date when last in effect

12. A visitor walks through the computer department and picks up a CD from an employee’s desk. What security controls should have been implemented to prevent this security breach?

a. Device and media controls

b. Facility access controls

c. Workstation use controls

d. Workstation security controls

13. Threats to data security are most likely to come from which of the following?

a. Employees

b. Natural disasters

c. Compromised firewalls

d. Hackers outside an organization

14. These are automatic checks that help preserve data confidentiality and integrity.

a. Access controls

b. Audit controls

c. Application controls

d. Incident controls

15. An employee in the physical therapy department arrives early every morning to snoop through the EHR for potential information about neighbors and friends. What security mechanism should have been implemented that could minimize this security breach?

a. Audit controls

b. Facility access controls

c. Facility access controls

d. Workstation security

16. An employee observes an outside individual putting some computer disks in her purse. The employee does not report this security breach. What security measures should have been in place to minimize this threat?

a. Access controls

b. Audit controls

c. Authentication controls

d. Security incident procedures

17. Locks on computer room doors illustrate a type of \_\_\_\_\_\_\_\_\_.

a. Access control

b. Workstation control

c. Physical control

d. Security breach

18. An admission coordinator consistently enters the wrong patient gender while entering data in the MPI. What security measures should be in place to minimize this security breach?

a. Access controls

b. Audit trail

c. Edit checks

d. Password controls

19. Which of the following statements is true regarding HIPAA security?

a. All institutions must implement the same security measures.

b. HIPAA allows flexibility in the way an institution implements the security standards.

c. All institutions must implement all HIPAA implementation specifications.

d. A security risk assessment must be performed every year.

20. For HIPAA implementation specifications that are addressable, the covered entity \_\_\_\_\_\_\_\_\_.

a. Implements the specification

b. May choose not to implement the specification if it is too costly to execute

c. Must conduct a risk assessment to determine if the specification is appropriate to its environment

d. Does not have to implement the specification if it is a small hospital

21. A user recently opened a file that they thought would help them with their job but it copied files to unsecure ares of the computer. What thpe of malware was activated?

a. Rootkit

b. Computer virus

c. Computer worm

d. Trojan horse

22. Training that educates employees on the confidential nature of PHI is known as which of the following?

a. Awareness

b. Risk

c. Incident

d. Safeguard

23. “Something you have” is demonstrated by:

a. CAPTCHA

b. Retinal scan

c. Password

d. Token

24. Policies are which type of safeguards?

a. Technical

b. Application

c. Administrative

d. Network

25. A hospital is looking to use something to act as a buffer between two networks. What should be recommended?

a. Application control

b. Cryptography

c. Firewall

d. Digital certificate