ORGANIZATION POLICY

POLICY TITLE: ONSLOW MEMORIAL HOSPITAL RESOLUTION OF HIPAA COMPLAINTS

POLICY NUMBER: 184

It is the policy of OMH to make a mechanism available to individuals to report any matter relating to an issue of non-compliance with OMH's HIPAA Privacy Policies and Procedures. OMH and its employees and agents, shall not threaten, intimidate or retaliate against any individual filing a complaint. With respect to such matter, every person within OMH has direct access to, and is encouraged to consult, with OMH's Privacy Officer.

PROCEDURE:

A. Employee Reporting

An employee or agent of OMH who acquires information that may give rise to a reasonable belief that another employee or agent is engaged in conduct that violates an provision of the HIPAA Privacy Policies and Procedures that an agent, representative or other person of firm representing OMH in any transaction is engaged in conduct which does not meet the standards set forth in the HIPAA Policies and Procedures shall promptly report such information to the Privacy Officer.

Report to the Privacy Officer shall be made in person, by telephone, by voice mail or by mail to the Privacy Officer. A sample "report" form that may be used by the reporting person is attached hereto as Exhibit A.

The Privacy Officer shall maintain a "log" of all reports regarding Privacy matters. These reports shall be assigned a sequential file identification number by the Privacy Officer for the specific year and shall be used for new or additional information on the same matter. The caller/author shall not be required to provide his/her name or any other facts that may give away his/her identity. The caller/author shall be encouraged to provide as much information as possible to assist with the investigation of the matter. The caller/author shall also be advised that the Privacy Officer will attempt to keep the identity of the caller/author confidential; however, there may be a point in time when the individual's identity may become known or may have to be revealed.

The Privacy Officer shall conduct an investigation of the report; make a record in the log of the results and the specific actions taken after completion of the investigation. The specific facts and circumstances surrounding the report must be kept confidential and any discussions regarding the complaints should be limited to those parties with a "need to know" during the investigation. Upon final resolution of a problem, the Privacy Officer shall provide feedback to OMH Management regarding the possible

need for a policy or procedure change. In addition, the Privacy Officer shall prepare periodic reports to be submitted to OMH Management on the status of OMH's compliance with the HIPAA Privacy Policies and Procedures.

In accordance with OMH's Policy, no employee shall suffer penalty or retribution for the good faith reporting of any suspected instance of wrongdoing, regardless of whether or not such wrongdoing ultimately is determined to exist following the investigation.

B. Privacy Investigation and Log

As indicated above, it is the Privacy Officer's responsibility to document, adequately investigate (or oversee the investigation of) and, in accordance with the direction of OMH Management, appropriately respond to each in-person disclosure, telephone call of voice message, and written correspondence, report form, or e-mail message concerning Privacy matters. The Privacy Officer is to communicate the number of complaints and resolutions to the Compliance Officer and the Board of Directors of the hospital. The Privacy Officer shall maintain a Privacy log which documents the following items in connection with the Privacy matter inquiry."

- Sequential file identification number, date of report of potential Privacy or other wrongdoing is received, whether the reporter has identified himself or herself, whether the reporter has brought the matter to the attention of his or her immediate supervisor (and if not, why not) and description of the incident;

- Identification of person designated as being primarily responsible for investigating the incident, and identification of any outside counsel or external consultants retained to assist in evaluation and investigation of the incident;

- Current status of the investigation, as periodically updated;

- Date matter is resolved and type of resolution, including corrective action taken, where appropriate, and

- Date matter is reported to Compliance Officer/Board, or reason why not reported.

All information surrounding the complaint and resolution system shall be kept in a secure location for a period of at least six years. Only the Privacy Officer and OMH Management shall have access to this information.

EFFECTIVE DATE: June 2005

REVIEW DATE: November 2008, November 2011
December 2017

REVISION DATE: December 2014

APPROVED BY:

Penney Burlingame Deal, DHA, RN, FACHE
President and Chief Executive Officer

Regina Lanier, MSN, MAEd, RN
Senior Vice President, Chief Nursing Officer

Scott Johnston, M.D.
Chief of Staff

Exhibit A

PRIVACY REPORT OF POTENTIAL WRONGDOING

Name of Reporting Person (*optional*):_____

Position Held by Reporting Person (*optional*):_____

Date of this Report:_____

1. Please describe the possible wrongdoing, including the name(s) of the person(s) involved and, if known, the date(s) of the relevant incident(s):

_____
_____
_____

2. Please describe when and how you became aware of this activity:

_____
_____
_____

3. Please describe any evidence that exists to prove the wrongdoing or other means available to verify relevant incident(s):_____

_____
_____
_____

4. Please list any other person(s) inside or outside of OMH who may be able to verify the relevant incident(s):

_____
_____

5. Have you discussed the relevant incident(s) with any other person(s) inside or outside of OMH? Yes_____ No_____. If "Yes", please list the identity of such person(s):

_____
_____

6. Would you be willing to discuss the potential wrongdoing with OMH's Privacy Officer or legal counsel?

   Yes_____ No_____

SENT TO: _____ _____ _____
NAME TITLE PHONE#