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| **TITLE: Security Incident Response Policy** | | |
| **DEPARTMENT: Information Technology, Finance, Operations, Marketing** | | |
| **Effective Date:** | **Revised Date:** | **Next Review Date:** |
| **05/31/22** |  |  |
| **Prepared by: Donny Friday, Dir. Of Technology** | | **Date: 05/31/21** |
| **Administrative Approval:** Chief Executive Officer, Chief Information Officer, and Compliance Officer | | |
| CEO: Joe LaRue | | Date: 05/31/22 |
| CIO: Tony Yi | | Date: 05/31/22 |
| CO: Sharon Grambow | | Date: 05/31/22 |
| **All other related polices/procedures/protocols:** | | |

SEE LAST PAGE FOR REVIEW HISTORY



**Purpose:**

To establish and maintain Security Incident response capabilities and procedures.

**Scope and Applicability**

This policy applies to all Information Systems and components.

**Policy Statement**

Policies and procedures shall be implemented to address security incidents, including the identification of, and response to, suspected or known security incidents; mitigate, to the extent possible, harmful effects of security incidents that are known to Sun Health or it’s business associates; and document security incidents and their outcomes.

**Procedures**

**General**

1. Security Incident response capabilities shall be established and maintained to address Security Incidents, including theft, misuse of data, intrusions, hostile probes, malicious software, and malicious intent of Sun Health Information Systems activities.
2. In compliance with federal, state and HIPAA regulations, Security Incidents shall be documented and escalated as appropriate.
3. Breach risk assessment procedures shall be established and activated for Security Incidents that have the potential to result in the unauthorized disclosure of ePHI or other Sensitive information.

**Roles and Responsibilities**

1. The Sun Health HIPAA Security Officer shall be responsible to take a lead role in the response to Security Incidents, including:
   1. Ensuring compliance with this policy, and, to maintain all records of incident reports, investigations, and resolutions;
   2. Coordinating the response to Security Incidents and activating resources as appropriate;
   3. Informing management of significant Security Incidents and their potential impact.
2. The Sun Health VP of Legal Affairs shall be responsible for the coordination of all communications related to external law enforcement.
3. The Sun Health Marketing Department shall be responsible for the coordination of all public statements regarding Security Incidents.
4. The Sun Health Human Resources shall assist in the investigation of Security Incidents potentially caused by Workforce Member misconduct or failure to follow policies and procedures.

**Reporting of Security Incidents**

1. Workforce Members shall report all potential and identified Security Incidents to their respective supervisors, Director of Technology or a HIPAA Officer.
2. A service ticket should immediately be opened to track a potential incident.
3. The Director of Technology shall notify the HIPAA Security Officer upon receipt of Security Incident reports.
4. The Chief Information Officer shall be notified of all documented Security Incidents.
5. Human Resources shall be notified for any Security Incidents suspected to have been caused by Workforce Members.
6. Reported Security Incidents shall be classified based on the potential severity of the incident.
7. Review and assessment reports shall be issued to responsible management as appropriate.

**Security Incident Procedures**

1. A Security Incident response team should be established to respond and manage Security Incidents, adapting to the scope and scale of each incident.
2. The HIPAA Security Officer, CIO and Director of Technology shall assign responsibility for investigation and resolution of Security Incidents to the appropriate resources.
3. The Help Desk service ticket(s) shall be used to document activities, tasks, and resolutions to Security Incidents.
4. Suspicious activity or threats shall be evaluated to determine the need to escalate the incident.
5. Immediate steps shall be taken to contain the potential impact of a Security Incident.
6. Established forensic procedures shall be followed to investigate and document Security Incidents.
7. All evidence, data or information associated with a Security Incident shall be collected, analyzed, and protected.
8. Appropriate steps shall be taken to remove or mitigate any vulnerabilities pertaining to an incident.
9. Information Systems impacted by a Security Incident shall be restored to normal operations as quickly as feasible and affected Users shall be notified of the status.
10. Periodic training, testing, review, and revision of Security Incident procedures shall be conducted.

**Review and Analysis**

1. All Security Incidents shall be reviewed to determine that appropriate actions and necessary reporting requirements were met during the handling of the incident.
2. The review shall identify potential impacts, evaluate effects of operational changes, identify mitigating actions, and identify additional concerns.
3. The HIPAA Security Officer shall determine whether or not to perform additional risk analysis based on the severity and impact of the incident.

**Enforcement & Exception Handling**

Failure to comply with this policy, associated procedures and guidelines may result in disciplinary actions up to and including termination of employment or termination of contracts. Legal actions also may be taken for violations of applicable regulations and laws.

Request for exceptions to this policy must be submitted in writing. Prior to official approval of any exception, this policy must continue to be observed.

**Definitions**

**ePHI -** Protected Health Information that is stored in electronic format.

**Information System** -Meansany combination of [information technology](http://en.wikipedia.org/wiki/Information_technology) and people's activities that support operational, management and decision making processes. A system normally includes hardware, software, information, data, applications, communications, and people.

**Workforce Member** -Means employees and other persons whose conduct, in the performance of their work, is under the direct control of the organization, whether or not they are paid by the organization. This includes full and part time employees, contractors, affiliates, associates, students, volunteers, and staff from third party entities who provide services.

**Security Incident** - The attempted or successful unauthorized access, use, modification, destruction, or interference with Information Systems.

**Distribution**

This policy should be distributed to applicable Workforce Members. Recipients of this policy must acknowledge their receipt and understanding of this policy by referring any questions or problems with the policy within ten days of the issue date to the Director of Technology, CIO or HIPAA Security Officer. If no questions or problems are stated, it will be assumed that the policy has been read and understood.

**Applicable Regulations**

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| **HIPAA Security Rule** | **45 CFR Part 160 and Subparts A and C of Part 164** |
| Security Incident Procedures | §164.308(a)(6)(i) |
| Response and Reporting | §164.308(a)(6)(ii) |

**Revision History**

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| Date: | Reviewed/Revised by: | New Changes | No Change | Revision(s): State reason for revision | INITIALS |
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