Policy

New York University and each covered component strives to protect the confidentiality, integrity, and availability of EPHI by developing, implementing, and reviewing periodically a documented program for providing security training and awareness to New York University workforce members who have access to EPHI Systems, including management, prior to being provided access to EPHI to enable them to appropriately protect EPHI. The security awareness and training program shall include, as appropriate, information concerning guarding against, detecting, or reporting malicious software, monitoring log-in attempts and reporting discrepancies, and creating, changing, and safeguarding passwords. Who is affected by this policy is documented in HIPAA Policy 1 – Overview: Policies, Procedures, and Documentation.

Purpose of this Policy

NYU has the responsibility under the HIPAA Security Regulations for providing and documenting security awareness and training for University workforce members in order that those persons can properly carry out their functions while appropriately safeguarding EPHI. This policy reflects New York University’s commitment to comply with such Regulations.

Scope of this Policy

Affected by these policies are all covered components that may be designated by the University from time to time, including the NYU School of Medicine, NYU College of Dentistry, and the Student Health Center, and areas designated part of the health care component of the University from time to time but only to the extent that each component performs activities that would make such component a business associate of a component of the University that performs covered functions if the two components were separate legal entities (i.e., support components), including the Office of the Bursar, Controller’s Division, including Accounts Payable, NYU Information Technology (NYU IT), Office of Insurance and Risk Management, Internal Audit, Office of Compliance and Risk Management, Office of General Counsel, Office of Sponsored Programs, university Relations and Public Affairs, Public Safety, Treasury Applications, and University Development and Alumni Relations. The NYU School of Medicine follows HIPAA-related policies and procedures created specifically for its environment; School of Medicine compliance with HIPAA is coordinated through Langone Medical Center. These policies affect all NYU workforce members in covered components.

Operational Requirements

A. Each covered component shall provide training and supporting reference materials to workforce members, as appropriate, to carry out their functions with respect to the security of EPHI. The method of delivery of such training shall be determined by the covered component and may include on-site or remote training. After the training has been conducted, New York University will maintain such records as it deems appropriate that confirm that a workforce member received training. Training should include:
1. Awareness of and familiarity with New York University’s and the covered component’s security policies, specifications, and procedures, including:
   a. The secure usage of EPHI, as set forth in Protection from Malicious Software operational specification (see 6.B), Log-in Monitoring operational specification (see 6.C), and Password Management operational specification (see 6.D).
   b. Risks to the confidentiality, integrity, and availability of EPHI.
   c. Legal and business responsibilities of New York University and the covered component for protecting EPHI.

B. New York University’s EPHI Security Officer and each covered component’s EPHI security officer will determine the frequency of the security training and awareness regarding log-in monitoring in accordance with New York University’s Security Awareness and Training policy (HIPAA Policy 6).

C. New York University and each covered component shall make its security policies and procedures available for reference and review by its workforce members with access to EPHI.

D. Each covered component shall provide security information and awareness reminders and updates to its workforce members, as set forth in its Security Reminders operational specification (see 6.A).

E. HIPAA REGULATORY INFORMATION

   CATEGORY: Administrative Safeguards
   TYPE: Standard
   HIPAA HEADING: Security Awareness and Training
   REFERENCE: 45 CFR 164.308(a)(5)(i)
   SECURITY REGULATION STANDARDS LANGUAGE: “Implement a security awareness and training program for all members of its [a covered entity’s] workforce (including management).”

Operational Specifications

6.A Security Reminders

1. New York University’s EPHI Security Officer and each covered component’s EPHI security officer shall be responsible for taking reasonable steps to ensure that New York University workforce members, including those who work remotely, receive security information and awareness reminders periodically and as needed, including:
   a. on information security risks and how to follow New York University’s security policies and procedures.
   b. on how to use EPHI Systems in a manner that reduces security risks, and on selected security topics, including:
      i. New York University security policies and procedures
      ii. New York University security controls and processes
      iii. Significant risks to EPHI Systems
      iv. Legal and business responsibilities of New York University for protecting EPHI Systems
   c. when any of the following events occur:
      i. Substantial revisions are made to New York University’s security policies or procedures.
      ii. Substantial new security controls are implemented at New York University.
      iii. Significant changes are made to existing New York University security controls.
      iv. Substantial changes are made to New York University legal or business responsibilities.
      v. Substantial threats or risks arise against EPHI Systems.

2. Means of providing security information and awareness reminders and updates may include, but are not limited to, e-mail reminders, posters, letters, workforce member meetings, security days, screen savers, information system sign-on messages, newsletter articles, and information posted to a Web site.

3. HIPAA REGULATORY INFORMATION
6.B Protection From Malicious Software

1. New York University and each covered component of New York University will develop, implement, and periodically review a documented process for guarding against, detecting and reporting malicious software that pose risks to EPHI. New York University’s and each covered component’s malicious software prevention, detection, and reporting procedures shall include:
   a. Anti-virus software installed and updated on EPHI Systems.
   b. Procedures for New York University workforce members to report suspected or confirmed malicious software.
   c. Plan for recovering from malicious software attacks.
   d. Process to examine electronic mail attachments and downloads before they can be used on EPHI Systems.

2. New York University workforce members shall not bypass or disable anti-virus software installed on EPHI Systems unless properly authorized to do so.

3. New York University and each covered component will provide periodic training and awareness to its workforce members about guarding against, detecting, and reporting malicious software. Training and awareness for workforce members on protection from malicious software shall include, for example, the following topics:
   a. How to discover malicious software.
   b. How to report malicious software.
   c. How to discover malicious software fraud.
   d. How to not download or receive malicious software including not opening or launching email attachments that may contain malicious software.
   e. How to use anti-virus software appropriately.

4. HIPAA REGULATORY INFORMATION

6.C Log-In Monitoring

1. New York University and each covered component will develop, implement, and periodically review a documented process for monitoring log-in attempts to EPHI Systems and reporting log-in discrepancies. The log-in process may include, for example, the following attributes:
   a. Notification displays upon log-in stating that the system must only be accessed by an authorized New York University workforce member.
   b. Help messages that could assist an unauthorized user are not provided during the log-in process.
   c. Limitations on the number of unsuccessful log-in attempts are implemented.
   d. The system does not state which part of the log-in information is correct or incorrect if there is an error.
   e. Prior to successfully completing the log-in process, information system or application identifying information is not provided.
   f. Limit the time allowed for the log-in procedure.
g. Record failed log-in attempts.

h. After the specific pre-determined number of failed log-in attempts, a time period is documented before permitting further log-in attempts, or any further attempts are rejected until a designated New York University workforce member has given authorization.

i. Upon completion of a successful log-in, the date and time of the previous successful log-in by the workforce member are displayed.

2. New York University will provide training and awareness periodically and as needed to New York University workforce members regarding the procedures for monitoring log-in attempts and reporting discrepancies regarding their access or log-in attempts. The log-in monitoring training and awareness shall include the following topics:
   a. How to detect a log-in discrepancy
   b. How to report a log-in discrepancy
   c. How to successfully use New York University’s secure log-in process

3. HIPAA REGULATORY INFORMATION

   CATEGORY: Administrative Safeguards
   TYPE: ADDRESSABLE Implementation Specification for Security Awareness and Training Standard
   HIPAA HEADING: Log-in Monitoring
   REFERENCE: 45 CFR 164.308(a)(5)(ii)(C)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Implement: ...Procedures for monitoring log-in attempts and reporting discrepancies.”

6.D Password Management

1. Each covered component of New York University shall develop, implement, and review a documented process for appropriately creating, changing, and safeguarding passwords used to verify users’ identities and to obtain access to EPHI. New York University’s password management procedure may include, for example:
   a. Require and force regular password changes (e.g., every 30/60/90 days).
   b. Require and force the use of individual passwords to maintain accountability.
   c. Permit workforce members to select and change their own passwords.
   d. Require unique passwords that meet the standards defined by New York University (e.g., no password re-uses for a minimum period of time).
   e. Require passwords not to be displayed in clear text when inputting into EPHI Systems.
   f. Require passwords to be given to New York University workforce members in a secure manner, through a pre-defined process.
   g. Require changing of default vendor passwords immediately following installation of hardware or software.
   h. Prohibit the use of “Admin” or “Administrator” as login for administrator accounts or of “Demo” for demonstration logins.

2. New York University shall require its workforce members to use the following standards when possible to create strong, secure passwords:
   a. A minimum length of passwords is eight (8) characters
   b. A combination of numeric, non-alphanumeric, and alphabetical characters and of capital and lowercase letters.
   c. Passwords that are not easily guessable or obtained by using personal information such as names, pet’s name, license plate, birthday

3. New York University and each covered component shall provide its workforce members with training and awareness on appropriately creating, changing, and safeguarding passwords used to verify users’ identities and to obtain access to EPHI. Password management training and awareness shall include the following requirements for access to EPHI Systems:
   a. New York University’s password standards and guidelines.
   b. The process for changing temporary passwords when assigned for new log-in.
   c. The importance of avoiding maintaining passwords in a paper record.
The significance of changing passwords and avoiding reusing passwords.

The significance of keeping passwords confidential.

The significance of using different passwords for personal and business accounts.

The importance of not including passwords in any automated log-in process.

The importance of changing passwords when there is an indication of password or information system compromise.

The importance of logging off before leaving workstation.

The importance of selecting a strong password (i.e., one that is of eight characters in length, is not easily guessable, and is a mixture of upper- and lower-case letters, numerals, and special characters.)

4. HIPAA REGULATORY INFORMATION

CATEGORY: Administrative Safeguards
TYPE: ADDRESSABLE Implementation Specification for Security Awareness and Training Standard
HIPAA HEADING: Password Management
REFERENCE: 45 CFR 164.308(a)(5)(ii)(D)
SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Implement: .... Procedures for creating, changing, and safeguarding passwords.”

Policy Definitions

1. Anti-virus software
2. Availability
3. Business associate
4. Confidentiality
5. Covered component
6. Electronic Protected Health Information (or EPHI)
7. EPHI systems
8. HIPAA Security Regulations
9. Information system
10. Integrity
11. Malicious code
12. Malicious software
13. Password
14. Risk
15. Virus
16. Workforce member
17. Worm

Related HIPAA Documents

1. HIPAA Policy 1 – Overview: Policies, Procedures, and Documentation
2. HIPAA Policy 15 – Access Control
3. HIPAA Privacy Regulations covered component’s Minimum Necessary Policy

