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<b>Title:</b>	<b>DPH Privacy and Security Manual</b>
<b>Chapter:</b>	<b>III. Use and Disclosure Policies, Minimum Necessary</b>
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## **Purpose**

The purpose of the Division of Public Health (DPH) Minimum Necessary policy is to establish the DPH requirements to make reasonable efforts to limit the use and disclosure of individually identifiable health information (IIHI) to that which is minimally necessary to support the intent of the use or disclosure. This policy is in compliance with the [DHHS Policy and Procedure Manual, Section VIII, Security and Privacy](#) that establishes the NC Department of Health and Human Services (DHHS) minimum necessary requirements.

*Policy Scope: The policy applies across the Division to all DPH workgroups who maintain, use, have access to, or come into contact with IIHI.*

## **Background**

The HIPAA Privacy Rule requires organizations to make reasonable efforts to limit the use, disclosure of, and requests for IIHI to the minimum necessary to accomplish the intended purpose. To allow flexibility to address their unique circumstances, the Rule requires organizations to make their own assessment of what protected health information (PHI) is reasonably necessary for a particular purpose, given the characteristics of their business and workforce, and to implement policies and procedures accordingly. The HIPAA minimum necessary requirement applies a reasonableness standard that calls for an approach consistent with the practices and guidelines already used within the Division to limit the unnecessary sharing of medical information.

The minimum necessary standard requires DPH workgroups to evaluate their practices and enhance protections as needed to limit unnecessary or inappropriate access to IIHI. The minimum necessary standard is intended to reflect and be consistent with, not override professional judgment and standards. It is expected that the Division will incorporate the input of prudent professionals when implementing the minimum necessary requirement to appropriately limit access to IIHI without sacrificing the quality of the Divisions critical public health mission.

The minimum necessary standard, which is a key protection of the HIPAA Privacy Rule, is derived from confidentiality codes and practices in use today. It is based on sound current practice that health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The Privacy Rule's requirements for minimum necessary are designed to be sufficiently flexible to accommodate the various circumstances of all workgroups with the Division.

### **Minimum Necessary and Public Health**

The following guidance is from the Office of Civil Rights regarding the implementation of the minimum necessary for information that is reported to or shared with public health authorities:

*Generally, covered entities are required reasonably to limit the PHI disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual's authorization, or for disclosures that are required by other law.*

*For disclosures to a public health authority, covered entities may reasonably rely on a minimum necessary determination made by the public health authority in requesting the PHI. For routine and recurring public health disclosures, covered entities may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of PHI that may be disclosed for such purposes.*

*The HIPAA Privacy Rule permits covered entities to disclose the amount and type of PHI that is needed for public health purposes. In some cases, the disclosure will be required by law, in which case covered entities may make the required disclosure. For disclosures that are not required by law, covered entities may disclose, without authorization, the information that is reasonably limited to that which is minimally necessary to accomplish the intended purpose of the disclosure. ... Covered entities may also rely on the requesting public health authority's determination of the minimally necessary information.*

## Policy

DPH workgroups must make reasonable efforts to limit IIHI to that which is *minimally necessary* to accomplish the intended purpose for the use, disclosure, or request for information. DPH workgroups must implement the minimum necessary requirements to limit unnecessary or inappropriate access to IIHI.

DHHS has determined that safeguarding confidential health information should be extended to all DHHS agencies within the Department that maintain IIHI. The Division has applied this policy to all workgroups within the Division that use, maintain, have access to, or come into contact with IIHI.

Controlling the use and limiting access to the minimum necessary applies to all IIHI, whether it is paper-based or contained in computer systems, and applies to information accessed or transmitted in any format including orally (conversation, telephone, etc.).

The minimum necessary requirement **applies** to:

- Uses or disclosures for payment or health care operations;
- Uses or disclosures requiring the client to have an opportunity to agree or object (for example, for facility directories)
- Uses or disclosures that are permitted without the client's permission (except for those required by law or specified otherwise in the DHHS Privacy Policy Manual *and* [DPH Privacy and Security Manual](#))
- Uses or disclosures by External Business Associates.

The minimum necessary requirement ***does not*** apply to:

- Disclosures to or requests by a health care provider for treatment
- Uses or disclosures made to a client to whom the information applies
- Uses or disclosures authorized by the client (or the client's personal representative)
- The Secretary of the United States Department of Health and Human Services for compliance enforcement
- Uses or disclosures required by law
- Uses or disclosures required for compliance with the HIPAA Privacy Rule
- Transmission of the data elements specified in the standards for electronic transactions.

## Implementation

The following protocols are in compliance with the HIPAA Privacy Rule and should be considered when staff share IIHI in the performance of their job responsibilities and when sharing IIHI with individuals outside the Division.

### Minimum Necessary Use Within DPH

Many of the uses and disclosures with DPH fall within the “required by law” category and as such do not fall within the minimum necessary restriction. North Carolina General Statutes and the implementing NC Administrative Rules define the data that are required to be disclosed to the Division and those who are required to disclose this information.

The *DPH Privacy Policies, Use and Disclosures* and [Authorizations and Use and Disclosures](#) provide guidelines on disclosures of IIHI. DPH staff must understand the federal and state laws and regulations that apply to their program regarding use and disclosure of IIHI required by law to be reported. The Division of Public Health Program/Function Legal Reference table summarizes the general reporting requirements for DPH workgroups and programs. This table can be accessed on the DPH HIPAA web site at <http://www.schs.state.nc.us/hipaa/>.

Members of DPH workgroups within the program areas where reporting is required by law are authorized to use the IIHI to fulfill their job functions and the legal requirements related to the reporting of the data.

For uses and disclosures permitted under the HIPAA Privacy Rule, but are not required by law, DPH workgroups are expected to review their program requirements, the public health purposes that the IIHI serve, grant reporting requirements and other relevant information to substantiate the minimum amount of IIHI necessary to fulfill the public health purposes.

### Access to IIHI within the Division of Public Health

For uses of IIHI by DPH’s own workforce, the following standard protocol applies:

- Identifies the persons or groups of persons who need access to IIHI to carry out their job functions
- Identifies the type of IIHI to which each person or group needs access, as well as the conditions under which they need the access
- Makes reasonable efforts to limit the access of its staff to only the information appropriate to their job functions.

The HIPAA Privacy minimum necessary standard requires DPH workgroups to identify persons or classes of persons in its workforce who need access to IIHI and the categories of information to which access is needed.

All DPH workgroups must identify staff who have a “need-to-know” in order to accomplish their job responsibilities, and establish standards that *reasonably* limit inappropriate access to IIHI.

Each program manager or unit supervisor is responsible for defining the minimum use requirements for their workgroups. The Branch Head, and in some cases, Section Chief, should review the requirements to ensure that access to IIHI is required to fulfill statutory or other legal requirements, meet program purposes, or achieve specific public health objectives. The Branch Head, or Section Chief, is responsible for authorizing the minimum use requirements for the workgroups within their area.

The access requirements are defined within the Division based on the following:

- North Carolina General Statutes
- North Carolina Administrative Rules
- Public Health program reporting requirements, as defined by the public health program enabling legislation or government oversight organization
- Public Health grant documentation and reporting requirements, as defined by the grantor
- DPH Job Descriptions – Each DPH employee has an individualized job description that outlines the activities required to perform their designated job function
- Individual Staff Work Plans – Each DPH employee has an individualized job function work plan that annually identifies specific tasks required to complete the general activities defined in their job description
- Public Health program standard operating procedures maintained by staff for the specific programs
- DPH Management, which further assigns job responsibilities and the IIHI access required to accomplish the assigned activities on a program-by-program and individual case-by-case basis.

The standard DPH protocol for minimum necessary is contained in the above documentation. The above documentation substantiates the access and use of IIHI that is minimally necessary for the DPH workforce to meet the public health purposes of the data.

### **Access to Automated Information**

Each DPH workgroup shall determine which workforce members, or classes of workforce members based on job responsibility, require access to IIHI. Privileges shall be established on a “need to know” basis for each user relative to their specific relationship with clients and specified business needs for accessing IIHI. It is the responsibility of each workgroup to determine the level of IIHI detail a workforce member can access, such as an entire record, department files, individuals’ files, workstation, software applications, electronic data, electronic report files, etc. The access level of IIHI granted to an individual should be the minimum necessary needed to do his/her job.

Within the Division, access to computer systems containing IIHI is limited through reasonable access controls wherever technically feasible:

- Business owners are responsible for each application and they coordinate access control with the appropriate staff responsible for supporting the specific application.
- The appropriate administrators responsible for managing the technical environment and applications containing IIHI implement access controls.
- Users are assigned the applicable access rights based on their job function when they are set up to use the specific application.
- Users access rights are changed when necessary and as appropriate based on changes in their job function or responsibilities.

### **Define Minimum Necessary for Disclosures of Individually Identifiable Information**

All DPH workgroups must make reasonable efforts to limit the disclosure of IIHI to that which is minimally necessary to support the intent of disclosure. Before disclosing IIHI, staff must evaluate the source and purpose of the disclosure and determine what is the minimum amount of IIHI required to fulfill the intent of the disclosure. Staff should not disclose more than is required to fulfill the purpose of the disclosure. When requesting and using IIHI, staff should understand their program requirements and objectives and not request or access more detailed IIHI than required to complete their job responsibilities.

Each DPH workgroup who discloses IIHI should identify their **routine and recurring** disclosures to ensure that the disclosure is limited to the amount reasonably necessary to achieve the purpose of the disclosure. The identification should:

- Describe what information is reasonably necessary for the purpose of the request
- Limit the request for IIHI to that information.

Each program manager or unit supervisor is responsible for defining the minimum use requirements for their workgroups. The Branch Head, and in some cases, Section Chief, should review the requirements to ensure that access to IIHI is required to fulfill statutory or other legal requirements, meet program purposes, or achieve specific public health objectives. The Branch Head, or Section Chief, is responsible for authorizing the minimum use requirements for the workgroups within their area.

The disclosure requirements are defined within the Division based on the following:

- North Carolina General Statutes
- North Carolina Administrative Rules
- Public Health program reporting requirements, as defined by the public health program enabling legislation or government oversight organization
- Public Health grant documentation and reporting requirements, as defined by the grantor
- Public Health program standard operating procedures maintained by staff for the specific programs.

The standard DPH protocol for minimum necessary is contained in the above documentation. The above documentation substantiates the disclosure of IIHI that is minimally necessary for the DPH workforce to meet the public health purposes of the data.

The following guidelines are used to determine the minimum necessary for routine, recurring disclosures of IIHI that occurs from within DPH to entities outside DPH:

Review the routine and recurring disclosures made to other entities outside the Division (other agencies, providers, partners, CDC, universities, etc.). The Business Information Flow Assessment (BIFAs) completed by the DPH workgroups identifies the disclosures made by each workgroup. The DPH BIFAs are on file in the DPH Office and available for review on the DPH HIPAA website at <http://www.schs.state.nc.us/hipaa/>.

1. Review the type of information disclosed against the purpose of the disclosure (for example, programmatic requirements, statutory requirements, and public health activities).
2. Determine whether the information disclosed is the minimum necessary for the intended purpose. Determine whether the purpose can be achieved with either de-identified data or with a limited subset of the information.
3. In the internal operating procedures, define the DPH workgroup process by which the routine disclosure occurs, who discloses the information, and the frequency of the disclosure and who has authorized the routine, recurring disclosure.
4. Review the standards for the routine disclosure with your staff to ensure that they do not disclose more information than is minimally necessary.

Many routine and recurring disclosures are either required by law or are related to treatment (including program referrals, case management, care coordination). The minimum necessary standard does not apply to these disclosures. However, even in these situations, staff should evaluate the type and amount of information disclosed and restrict it that required by law or essential for the treatment-related purposes.

Note: Certain disclosures must also be accounted for, as defined in the [DPH Privacy Policy, Accounting for Disclosures](#).

## Standard Criteria for Non-Routine Disclosures

For non-routine, non-routine disclosures of IIHI DPH has:

- Developed reasonable measures to limit information to the minimum necessary to accomplish the purpose of the disclosure
- Uses these measures to review non-routine disclosures on an individual basis.

## Requests for Disclosures of Individually Identifiable Health Information

DPH Section Chiefs, Branch Heads, Unit Supervisors, and Program Managers have the authority to determine whether requests for information to be disclosed is limited to what is reasonably necessary to accomplish the specific purpose of the request for disclosure. The DPH Privacy Official is available for consultation regarding minimum necessary for disclosures.

DPH may rely on a request for disclosure of IIHI as being limited to the IIHI that is minimally necessary, if:

- Disclosure is to a public official who represents that the request is for the minimum necessary information
- The request is from another HIPAA covered health care component
- The request is from a professional within DPH, from a business associate, or from a public health partner and the professional represents that the request is for the minimum necessary information
- The requestor provides appropriate HIPAA-compliant documentation that the disclosure is for research purposes.
- You can verify the identify of the public official and validate the content of the information being requested
- You can verify that the identity and professional standing of the requestor.

For all other non-routine disclosures of IIHI, including **non-routine requests** to disclose IIHI, DPH program managers, unit supervisors, or designated staff members must review every non-routine request for disclosure of IIHI on an individual basis against the following criteria

- Specificity of the request
- Purpose and importance of the request
- Impact to the client – could disclosure potentially harm the client or could the disclosure help the client, for example by improving quality of care or services provided to the client.
- Impact to DPH or DHHS
- Extent to which the disclosure would extend the number of those who would have access to the IIHI

- Likelihood of the information being re-disclosed by the requestor
- Ability to achieve the purpose of the disclosure with either de-identified information or with a limited subset of information.

Next, determine whether the purpose be met with de-identified, aggregate date, or a limited data set. If the answer is no, based on the review of the request against the above criteria and based on sound professional judgment, make the informed decision about whether to disclose the information requested.

Note: Certain disclosures must also be accounted for, as defined in the [DPH Privacy Policy, Accounting for Disclosures](#).

### **Standard Protocol Regarding the Entire Client Record**

Each workgroup within DPH who has a requirement to either request or disclose an entire client record must document the reasons for requiring access or disclosure of the record. The reason should identify who has the authority to request or access the client medical record and under what conditions the entire medical record can be accessed or disclosures.

### **External Business Associates**

Individuals or entities external to NC DHHS that perform specific HIPAA-defined activities or functions, such as Utilization Review, on behalf of a DPH covered health care component as defined by the HIPAA Privacy Rule, are considered External Business Associates of a DPH. As such, External Business Associates are required to comply with the Minimum Necessary requirement as specified in the HIPAA Privacy Rule.

**Reference: DHHS Directive Number III-11; DHHS Policy and Procedure Manual, Section VIII, Security and Privacy, 42 CFR 164.502(b), 42, CFR 164.514(d), DPH HIPAA Compliance Statement, NC General Statutes 130A, 10 NCAC**

For questions or clarification on any of the information contained in this policy, please contact the DPH Privacy Office at [HIPAA.DPH@ncmail.net](mailto:HIPAA.DPH@ncmail.net).