



North Carolina
Department of Health and Human Services
Division of Medical Assistance
ARA and Managed Care

1985 Umstead Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary Fuquay, Acting Director

DATE: October 23, 2003

TO: Health Check Coordinators, Supervisors, and Local Care Managers

FROM: Jeffrey Simms
Assistant Director, Managed Care

RE: Protected Health Information

The Division of Medical Assistance Health Check Unit and the Office of Rural Health Access II and III (Community Care of North Carolina) are working on a collaborative effort to educate families about the advantages of establishing a medical home as well as care coordination by a primary care provider. An important goal in this effort is to decrease Emergency Department visits for non-emergent conditions.

We are aware in many counties both Health Check Coordinators and Access II and III Local Care Managers work together using real-time data to identify recipients who are receiving services in Emergency Departments. Health Check Coordinators follow-up with families of children enrolled in the Health Check Program to provide education regarding primary care provider office hours and after-hours availability, transportation to visits, etc. Local Care Managers identify recipients, both adults and children, who need case management of medical and social needs.

The Department of Health and Human Services HIPAA Office has been consulted regarding the exchange of Protected Health Information (PHI) obtained from hospitals between entities such as Health Check Coordinators and Local Care Managers. Exchange of information is vital to avoid duplication of efforts. The HIPAA Office referenced regulations in 45 CFR, Part 164 - Privacy and Security, Subpart E - Privacy of Individually Identifiable Health Information, that permits the exchange of such information:

164.506 Uses and disclosures to carry out treatment, payment, or health care operations.

(a) Standard: Permitted uses and disclosures. Except with respect to uses or disclosures that require an authorization under § 164.508(a)(2) and (3), a covered entity may use or disclose protected health information for treatment, payment, or health care operations as set forth in paragraph (c) of this section, provided that such use or disclosure is consistent with other applicable requirements of this subpart.

(b) Standard: Consent permitted.

(1) A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment or health care operations.

(2) Consent of an individual under this paragraph shall not be effective to permit a use or disclosure of protected health information that is not otherwise permitted or required by this subpart.

(c) Implementation specifications: Treatment, payment, or health care operations.

(1) A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations.

(2) A covered entity may disclose protected health information for treatment activities of another health care provider.

(3) A covered entity may disclose protected health information to another covered entity or health care provider for the payment activities of the entity that receives the information.

(4) A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if both entities have a relationship with the individual who is the subject of the protected health information, and the disclosure is:

(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

(ii) For the purpose of health care fraud and abuse detection or compliance.

Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

We hope this information will facilitate and enhance the success of this medical home and primary care coordination project. Please contact Terri Pennington at 919-857-4222 if you have questions.