**MONTANA STATE HOSPITAL**
**POLICY AND PROCEDURE**

# EMPLOYEE ACCESS TO PROTECTED HEALTH INFORMATION

**Effective Date**: January 29, 2019 **Policy**: HI-14



**I. PURPOSE**: This policy addresses Montana State Hospital (MSH) employee access to Protected Health Information as necessary to conduct their work.

**II. POLICY**: MSH employees will be granted access to the level of Protected Health Information that is necessary for them to accomplish their work.

**III. DEFINITIONS**: For the purposes of this policy, the following definition applies: Protected Health Information means Individually Identifiable Health Information that is transmitted electronically in any medium or maintained in any medium.

**IV. RESPONSIBILITIES**:

A. ***The Director of Health Information is the designated MSH Privacy Officer*** and determines which employees require access to Protected Health Information in order to do their work. Access is granted according to the informational needs of the work position. This includes Protected Health Information held in electronic medium (includes discs, tapes, computers, portable drives, etc.)

B. ***Employees*** will receive Health Insurance Portability and Accountability Act (HIPAA) training regarding Protected Health Information. Employees will be held accountable for their level of access and uses and disclosures outside of that level will be considered grounds for potential sanctions (see MSH PolicyHI-15, Employee Sanctions for Releases of Protected Health Information).

C. Staff Development will document dates of HIPAA training and communicate the training roster to the MSH Privacy Officer.

D. The ***on-site DPHHS network staff*** will work with the MSH Privacy Officer to ensure appropriate computer access for employees.

**V. PROCEDURE**:

A. All employees must sign a confidentiality statement upon hire.

B. The employee will have HIPAA training during new employee orientation and yearly thereafter.

C. Employees will complete a training questionnaire during training. A copy of each employee's questionnaire with date of training and employee's signature will be maintained by the MSH Privacy Officer.
   1. Yearly training will follow established procedures.
   2. Completed and signed CE documentation will demonstrate that training has been fulfilled on a yearly basis.

D. Administrative and technical safeguards will be imposed when employees leave positions at MSH. Such safeguards include:
   1. Retrieval of keys or security access cards or badges; and
   2. Discontinuation of computer access codes and passwords.

**VI. REFERENCES**: Health Insurance Portability and Accountability Act (HIPAA) privacy rules; DPHHS Policy 003 titled Minimum Necessary; DPHHS Policy 007 titled HIPAA Administrative Requirements; and DPHHS Policy 013 titled Physical Security for Protected Health Information.

**VII. COLLABORATED WITH**: DPHHS Privacy Officer.

**VIII. RESCISSIONS**: HI-14, *Employee Access to Protected Health Information* dated October 10, 2014; HI-14, *Employee Access to Protected Health Information* dated November 2, 2009; HI-14, *Employee Access to Protected Health Information* dated October 30, 2006; HI-14, *Employee Access to Protected Health Information* dated June 6, 2003.

**IX. DISTRIBUTION**: All hospital policy manuals.

**X. ANNUAL REVIEW AND AUTHORIZATION**: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

**XI. FOLLOW-UP RESPONSIBILITY**: MSH Privacy Officer.

**XII. ATTACHMENTS**: None.

Signatures:

Kyle Fouts
Interim Hospital Administrator

Melinda Bridgewater
Director of Health Information