ID	Work Group	Business Practice Long Description	Impact of Barrier	Solution	Summary of effective practice(s) to be instituted or barrier(s) to be mitigated or eliminated by the plan	Planning assumptions and decisions	Project ownership and responsibilities (identify specific individual and/or organization names and titles)	1) Clearly defined project scope; 2) Identification of tasks required, organized by work breakdown structure	1) Project timeline and milestones; 2) Projected cost and resources required	Means for tracking, measuring and reporting progress	Impact assessment on all affected stakeholders in the state (including small and rural providers)	1) Feasibility assessment; 2) Possible barriers that the implementation plan may face	Single State/Multi State	1) Importance; 2) Ease of accomplishment; 3) Order to be completed
5	HIPAA Education	9 - ED staff do not give hospitals privacy policy to ED patients upon arrival while all other hospital patients do receive this. ED patients may be unaware therefore, of restrictions on releasing their PHI.	ER staff often believe that they cannot release info for treatment without patient consent or knowledge.	1. * HIPAA requires covered entities to provide Notice of Privacy Practice (NPP) on the 1st date of service or as soon as practical in an emergent situation. Providers must post NPP in a prominent location and on any website that provides information about customer services. But this rule does not control the permissible use/disclosure of PHI absent consent or authorization. Education is needed to better understand HIPAA's requirements and eliminate inappropriate barriers to interoperability.	Facilities must have policies and procedures that clearly state when the Notice of Privacy Practices (NPP) must be distributed and, separately, under what circumstances PHI may be disclosed with and without patient consent (required under State law for most disclosures even for TPO) and/or HIPAA-valid authorization. ER staff must then be trained to know when appropriate requirements have been met. This will help to mitigate any uncertainly about when disclosures are permitted, esp. for TPO.	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) the appropriate time(s) to distribute the NPP; and b) when disclosures of PHI may appropriately be made (e.g., without a patient consent, required by NJ law, and/or a HIPAA-valid authorization), esp. for TPO; 2. that representatives from at least 4-5 hospital and/or other-treatment facilities should participate in this P/P development, including the following staff types: , as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing this P/P which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make disclosures of PHI; 5. that this education should include written and oral training, with periodic follow-up; 6. that all facilities in NJ will be encouraged to embrace and acknowledge the importance of uniformity in approach, and to adopt the standard P/P.	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible disclosure of data for TPO purposes. P/P planning team must engage the staff of several facilities/institutions to design and implement P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ hospital society, to assist in facilitating uniform adoption of P/Ps.	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ hospital facility community, regarding a) the timing of distribution of the NPP to emergency patients, and b) the circumstances for appropriate disclosure of PHI without a patient consent (required by NJ law) and/or a HIPAA-valid authorization, esp. for TPO. The project must include education and implementation of 2 Ps/Ps that address and resolve open issues relating to disclosure of PHI in an institutional ER setting. The standard P/P developed in each instance must clearly document when disclosure is permissible absent a consent or HIPAA-valid authorization. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify current NPP distribution practice/PHI disclosure practice and issues; 3. Identify and document when patient is available for delivery of NPP/when PHI is typically requested and needed for emergency and other treatment, as well as from whom PHI will generally be requested; 4. Obtain output on uniform understanding of relevant law; 5. Discuss and determine appropriate and uniform policy and procedure steps; 6. design/draft concise policy and procedure documents; 7. Identify how to facilitate whole-state adoption of P/P; 8. Identify if different grps. require different training and, if so, what those different training approaches include; 9. Identify method of training approach and timing to train;	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to making disclosures may take longest. Over a 12-month period it is expected that the following milestones could be met: assemble appropriate hospital/other-facility staff and SME for P/P planning team, choose group leader, develop timeline for work and specific work assignments (within team), collect relevant data on current practices, reach consensus on relevant policy and procedural issues, draft policy and procedure documents, seek whole-state adoption of P/P, create steps for training/implementation. 2) Projected cost would include: 1. Initial P/P planning team mtg.+ mtg. place; 2. The setting up of subsequent meetings and/or conf. calls (weekly or	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Grp. leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once developed, the standard P/P for each of NPP and permissible disclosures for TPO (esp. treatment) in ER with/without consent (required by State law) or HIPAA-valid authorization will hopefully be adopted by the institutional community. Once adopted and implemented by a majority of the hospital/other treatment facility community, its use may change their current approach and should promote uniformity with respect to this business practice.	1) The creation of standard P/P documents for NPP and appropriate disclosures of PHI in the ER with/without consent and/or authorization is very feasible; however, their adoption as a statewide standard will depend on their acceptability to/adoptability by the institutional community not represented on the P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Grp. Leader and/or team members; 3. Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of grp. to reach consensus on standard policy approach/procedural steps; 5. Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating facilities to adopt the standard Ps/Ps developed.	Could be multi-, but more likely single-State	1) low/med, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.

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6	HIPAA Education	1 - When patient arrives at doctor's office, patient signs a release to provide information for payment, referrals, etc.	Lack of knowledge by doctors of what should be included in consent form, including that it is not required for use and disclosure of PHI for TPO..	1. * Physician and staff must be more aware and knowledgeable about the HIPAA min. necessary rule, and the fact that information can be disclosed for Treatment, Payment and Healthcare Operations (TPO) without either a consent or authorization.	Doctors and other treating providers must have policies and procedures that clearly state when the consent must (and need not) be obtained (per NJ State law), or a HIPAA-valid authorization; as well as, separately, when the HIPAA "minimum necessary" rule must (and need not) be applied. Staff must then be trained to know when appropriate requirements have been met. This will help to mitigate any uncertainly about when disclosures are permitted, esp. for TPO.	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) the appropriate time(s) to apply the HIPAA minimum necessary rule, and when it is not required (such as for treatment); and b) when disclosures of PHI may appropriately be made (e.g., without a patient consent under NJ law, and/or a HIPAA-valid authorization), esp. for TPO; 2. that individual and group practice physicians and office staff and/or other treatment providers should participate in this P/P development, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing this P/P which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make disclosures of PHI; 5. that this education should include written and oral training, with periodic follow-up; 6. that all physicians and other providers in NJ will be encouraged to embrace and acknowledge the importance of uniformity in approach, and to adopt the standard P/P.	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible disclosure of data for TPO purposes (esp. treatment). P/P planning team must engage several provider types to design and implement P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ medical society, to assist in facilitating uniform adoption of P/Ps.	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ physician community, regarding the circumstances for appropriate disclosure of PHI for TPO, esp. treatment, including whether with or without a patient consent (sometimes required by NJ law) and/or a HIPAA-valid authorization; and the circumstances where the HIPAA "minimum necessary" rule applies (or does not, such as for treatment purposes). The project must include education and implementation of 2 sets of Ps/Ps that address and resolve open issues relating to disclosure of PHI in a typical treatment setting, and the applicability of the HIPAA minimum necessary rule. The standard P/P developed in each instance must clearly document when disclosure is permissible absent a consent or HIPAA-valid authorization. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify current disclosure practices and issues; 3. Identify and document when disclosures are made for other purposes than treatment, as well as when PHI is typically requested and needed for treatment purposes (including who is typically involved in such disclosures and requests); 4. Obtain output on uniform understanding of relevant law; 5. Discuss and determine appropriate and uniform policy and procedure steps; 6. design/draft concise policy and procedure documents; 7. Identify how to	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to making disclosures may take longest. Over a 12-month period it is expected that the following milestones could be met: assemble appropriate physician/other provider reps and SME for P/P planning team, choose group leader, develop timeline for work and specific work assignments (within team), collect relevant data on current practices, reach consensus on relevant policy and procedural issues, draft policy and procedure documents, seek whole-state adoption of P/P, create steps for training/implementation. 2) Projected cost would include: 1. Initial P/P planning team mtg.+ mtg. place; 2. The setting up of subsequent meetings	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Grp. leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once developed, the standard P/P for each of the permissible disclosures that can be made for TPO (esp. treatment, or for referral or transfer for treatment) with/without consent (sometimes required by State law) or HIPAA-valid authorization will hopefully be adopted by the physician and other-provider community. Once adopted and implemented by a majority of the individual and group practice physician and other provider community, its use may change their current approach and should promote uniformity with respect to this business practice.	1) The creation of standard P/P documents for minimum necessary rules applicability and appropriate disclosures of PHI for TPO (esp. treatment or referral/transfer for treatment), with/without consent and/or HIPAA-valid authorization is very feasible; however, their adoption as a statewide standard will depend on their acceptability to/adoptability by the physician/provider community not represented on the P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Grp. Leader and/or team members; 3. Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of grp. to reach consensus on standard policy approach/procedural steps; 5. Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating facilities to adopt the standard Ps/Ps developed.	Could be multi-, but more likely single-State	1) Medium, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.

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7	HIPAA Education	1 - Primary care provider refers patient to hospital-affiliated clinic for drug treatment. Information provided should be minimum necessary for effective treatment. Information about medications is crucial. Most physicians treat all information, including substance abuse, in a patient chart as relevant to send to other providers. Physician sends full chart onto drug-treatment facility.	Barrier because physicians have different understandings about what information can/should be provided and about what laws constrain them.	1. * Educate the physicians of the federal law and what it allows for in the case use/disclosure of PHI for Treatment, Payment and Healthcare Operations (TPO).	Doctors and other treating providers must have policies and procedures that clearly state when disclosures of PHi, including substance abuse treatment information, are permitted to be made for TPO (esp. treatment) – including when a consent must (and need not) be obtained (per NJ State law), and when a HIPAA-valid authorization is required. Staff must then be trained to know when appropriate requirements have been met, or not. This will help to mitigate any uncertainly about when disclosures are permitted for TPO (esp. treatment).	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) the appropriate time(s) to apply the HIPAA minimum necessary rule, and when it is not required (such as for treatment, or making a referral for treatment); and b) when disclosures of PHI may appropriately be made (e.g., without a patient consent under NJ law, and/or a HIPAA-valid authorization), esp. for TPO; 2. that individual and group practice physicians and office staff and/or other treatment providers should participate in this P/P development, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing this P/P which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make disclosures of PHI; 5. that this education should include written and oral training, with periodic follow-up; 6. that all physicians and other providers in NJ will be encouraged to embrace and acknowledge the importance of uniformity in approach, and to adopt the standard P/P.	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible disclosure of data for TPO purposes (esp. treatment, as well as circumstances of referral or transfer for treatment), as well as the application of the HIPAA minimum necessary rule. P/P planning team must engage several provider types to design and implement P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ medical society, to assist in facilitating uniform adoption of P/Ps.	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ physician community, regarding the circumstances for appropriate disclosure of PHI for TPO, esp. treatment or referral or transfer for treatment, including whether with or without a patient consent (sometimes required by NJ law) and/or a HIPAA-valid authorization, and including of circumstances of substance abuse treatment; and the circumstances where the HIPAA "minimum necessary" rule applies (or does not, such as for treatment purposes). The project must include education and implementation of 2 sets of Ps/Ps that address and resolve open issues relating to disclosures of PHI made in a context of referral or transfer for treatment, including for substance abuse; and the applicability of the HIPAA minimum necessary rule, esp. in such treatment circumstances. The standard P/P developed in each instance must clearly document when disclosure is permissible absent a consent or HIPAA-valid authorization. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify current disclosure practices and issues; 3. Identify and document when disclosures are made for other purposes than treatment, as well as when PHI is typically requested and needed for treatment purposes (including who is typically involved in such disclosures and requests); 4. Obtain output on uniform understanding	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to making disclosures may take longest. Over a 12-month period it is expected that the following milestones could be met: assemble appropriate physician/other provider reps and SME for P/P planning team, choose group leader, develop timeline for work and specific work assignments (within team), collect relevant data on current practices, reach consensus on relevant policy and procedural issues, draft policy and procedure documents, seek whole-state adoption of P/P, create steps for training/implementation. 2) Projected cost would include: 1. Initial P/P planning team mtg.+ mtg. place; 2. The setting up of subsequent meetings	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Grp. leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once developed, the standard P/P for each of the permissible disclosures that can be made for TPO (esp. treatment, or for referral or transfer for treatment) with/without consent (sometimes required by State law) or HIPAA-valid authorization will hopefully be adopted by the physician and other-provider community. Once adopted and implemented by a majority of the individual and group practice physician and other provider community, its use may change their current approach and should promote uniformity with respect to this business practice.	1) The creation of standard P/P documents for minimum necessary rules applicability and appropriate disclosures of PHI for TPO (esp. treatment or referral/transfer for treatment), with/without consent and/or HIPAA-valid authorization is very feasible; however, their adoption as a statewide standard will depend on their acceptability to/adoptability by the physician/provider community not represented on the P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Grp. Leader and/or team members; 3. Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of grp. to reach consensus on standard policy approach/procedural steps; 5. Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating facilities to adopt the standard Ps/Ps developed.	Could be multi-, but more likely single-State	1) Medium, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.

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8	*HIPAA Education*	1 - Primary care provider refers patient to hospital-affiliated clinic for drug treatment. Information provided should be minimum necessary for effective treatment. Information about medications is crucial. Most physicians treat all information, including substance abuse, in a patient chart as relevant to send to other providers. Physician sends full chart onto drug-treatment facility.	Barrier because physicians have different understandings about what information can/should be provided and about what laws constrain them.	2. * Educate physicians about the permissible sharing of PHI when transferring a patient to another care type setting.	Doctors and other treating providers must have policies and procedures that clearly state when disclosures of PHi, including substance abuse treatment information, are permitted to be made for TPO (esp. when referring or transferring a patient for treatment) -- including when a consent must (and need not) be obtained (per NJ State law), and when a HIPAA-valid authorization is required. In addition, providers need to understand when the HIPAA "minimum necessary" rule must be applied, and when it need not (such as for treatment). Staff must then be trained to know when appropriate requirements have been met, or not. This will help to mitigate any uncertainly about when disclosures are permitted for TPO (esp. when transferring a patient for treatment).	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) the appropriate time(s) to apply the HIPAA minimum necessary rule, and when it is not required (such as when referring or transferring a patient for treatment); and b) when disclosures of PHI may appropriately be made (e.g., without a patient consent under NJ law, and/or a HIPAA-valid authorization), esp. for TPO, and including in circumstances of treatment for substance abuse; 2. that individual and group practice physicians and office staff and/or other providers should participate in this P/P development, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing this P/P which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make disclosures of PHI, esp. in contexts of referring or transferring a patient; 5. that this education should include written and oral training, with periodic follow-up; 6. that all physicians and other providers in NJ will be encouraged to embrace and acknowledge the importance of uniformity in approach, and to adopt the standard P/P.	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible disclosure of data for TPO purposes (esp. in circumstances of referring or transferring a patient for treatment). P/P planning team must engage several provider types to design and implement P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ medical society, to assist in facilitating uniform adoption of P/Ps.	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ physician community, regarding the circumstances for appropriate disclosure of PHI for TPO, esp. treatment or referral or transfer for treatment, including whether with or without a patient consent (sometimes required by NJ law) and/or a HIPAA-valid authorization, and including in circumstances of substance abuse treatment; and the circumstances where the HIPAA "minimum necessary" rule applies (or does not, such as for treatment purposes). The project must include education and implementation of 2 sets of Ps/Ps that address and resolve open issues relating to disclosures of PHI made in a context of referral or transfer for treatment, including for substance abuse; and the applicability of the HIPAA minimum necessary rule, esp. in such treatment circumstances. The standard P/P developed in each instance must clearly document when disclosure is permissible absent a consent or HIPAA-valid authorization. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify current disclosure practices and issues; 3. Identify and document when disclosures are made for other purposes than treatment, as well as when PHI is typically requested and needed for treatment purposes (including who is typically involved in such disclosures and requests); 4. Obtain output on uniform understanding	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to making disclosures may take longest. Over a 12-month period it is expected that the following milestones could be met: assemble appropriate physician/other provider reps and SME for P/P planning team, choose group leader, develop timeline for work and specific work assignments (within team), collect relevant data on current practices, reach consensus on relevant policy and procedural issues, draft policy and procedure documents, seek whole-state adoption of P/P, create steps for training/implementation. 2) Projected cost would include: 1. Initial P/P planning team mtg.+ mtg. place; 2. The setting up of subsequent meetings	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Grp. leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once developed, the standard P/P for each of the permissible disclosures that can be made for TPO (esp. treatment, or for referral or transfer for treatment) with/without consent (sometimes required by State law) or HIPAA-valid authorization will hopefully be adopted by the physician and other-provider community. Once adopted and implemented by a majority of the individual and group practice physician and other provider community, its use may change their current approach and should promote uniformity with respect to this business practice.	1) The creation of standard P/P documents for minimum necessary rules applicability and appropriate disclosures of PHI for TPO (esp. treatment or referral/transfer for treatment), with/without consent and/or HIPAA-valid authorization is very feasible; however, their adoption as a statewide standard will depend on their acceptability to/adoptability by the physician/provider community not represented on the P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Grp. Leader and/or team members; 3. Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of grp. to reach consensus on standard policy approach/procedural steps; 5. Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating facilities to adopt the standard Ps/Ps developed.	Could be multi-, but more likely single-State	1) Medium, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.

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9	*HIPAA Education*	1 - Primary care provider refers patient to hospital-affiliated clinic for drug treatment. Information provided should be minimum necessary for effective treatment. Information about medications is crucial. Most physicians treat all information, including substance abuse, in a patient chart as relevant to send to other providers. Physician sends full chart onto drug-treatment facility.	Barrier because physicians have different understandings about what information can/should be provided and about what laws constrain them.	3. * Physicians need to better understand applicable law on HIPAA in general so that familiarity will foster meaningful interpretation in vague, unfamiliar or conflicting circumstances.	Additional HIPAA education for providers related to consent (for treatment, as required in NJ), authorizations and minimum necessary. HIPAA allows providers to share PHI without applying the minimum necessary standard. In addition, it allows providers and other covered entities to reasonably rely on another covered entities requests for medical record information, and that it the request is for the minimum necessary to meet the purpose of the disclosure. Physicians may relax their usual policies and procedures related to patient authorization when releasing information to other providers.	That education and standard policies and procedures be developed to ensure that all providers in NJ understand both state and federal HIPAA privacy restrictions, and under what situations PHI may be shared without patient consent, authorization or an opportunity to agree or object.								
11	HIPAA Education	5 - Attending physician determines what information to release to law enforcement unless there is a subpoena or court order.	Refusal to provide info based on misunderstanding of HIPAA.	1. * Since doctors may refuse to provide information because they are not sure what is appropriate, education and proficiency in HIPAA appears warranted.	Law enforcement shall specifically request test results to determine if a patient is impaired. If the test is not required by law, then law enforcement must obtain a warrant or other process to require the administration of the test and disclosure of its results. Education of NJ law and HIPAA requirements is necessary for both providers and law enforcement.	Under HIPAA, providers may disclose PHI to law enforcement as required by law and/or pursuant to a court order, warrant, subpoena, or summons Disclosure also may be made to comply with an administrative request, including administrative summons, subpoenas and other processes. If the law enforcement request is not accompanied by any of these processes, or a provider is not required to disclose it by law, only limited information may be shared without patient authorization.	Collaboration between law enforcement and the provider industry is necessary. Participation in a workgroup to develop standards for both law enforcement and providers could include the state Bar, county prosecutors, police associations, hospital associations, medical society.	To develop standard policies and procedures related to law enforcement requests for PHI and healthcare providers' compliance with the requests, and under what circumstances.						

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12	HIPAA Education	2 - Physician takes history and if patient discloses substance abuse, office can fax request for information and copy of patient's signed release to substance treatment facility. Physician only requests treatment summary not full chart. When making requests of sub-abuse fac., physician receives information only about 50% of time due to administrative inefficiencies and lost paperwork.	Lack of knowledge by doctors of what information can be released about medical condition and substance abuse.	1. * Education and proficiency in HIPAA appears warranted.	Physicians, medical records staff and unit floor coordinators need to have a predefined protocol or decision pathway on which elements of PHI, particularly which levels of PHI can be shared with certain entities.	Assumption #1: That physicians and other healthcare providers do not have a good understanding of HIPAA . Assumption#2: There are no current pathways in hospitals/institutions have adopted regarding which PHI can be shared and what cannot with and without consent. Decision: Develop materials and scenarios that will lead to formation of decision trees (by NJ-HISPC group) that will lead to implementable pathway documents.	NJ HISPC to partner with provider societies and organizations (MSNJ, NJAFP, ACP NJ, AAP NJ, UMDNJ) etc to develop CME materials for understanding and use of NJ-HISPC generated pathway documents. Project ownership is by NJ-HISPC led coalition. Can be rolled into NJ Health Information Technology Commission (as in current bill A4044) if/when started to manage this project	Project Scope- develop CME/CE materials that providers can get credit for to enhance working HIPAA knowledge and situational decision making. Tasks required: 1) Identify various levels of PHI as defined by HIPAA, 2) Identify various state mandates on health info privacy and security 3) Develop generic decision pathways for different provider settings. Deliverable- CD/DVD with complete CME/CE and protocols included.	Timeline: May 07-Dec 07- organizational timeframe for project group Dec07-Jun08 Development of Pathways with provider Groups, July 08- get CME certifications, July-Dec 08-roll out CME/CE deliverables	Tracking through how many CE/CME credits awarded to providers through respective organizations	Once an HDIE (Health Data Information Exchange) is developed, monitoring an increase in the number of transactions would quantitatively give a rough idea that methods worked. Distributing surveys and doing qualitative analysis would also be of use in evaluation	Feasibility- assessment- depends on relative cost of the development of materials and gaining acceptance and sponsorship from provider societies/academies. Possible barriers to project is that there would be little voluntary support from provider organizations.	Single state initially, multi-state if NJ HISPC standards to be adopted by other states	1) Importance- very important- key to increasing the number of electronic health transactions in an overall HDIE/RHIO by removing key cognitive barriers. Ease of accomplishment- facile with support of key stakeholders. Order to be completed- when federal and state laws are in parallel, would then be next order of business.
13	HIPAA Education	1 - Upon admission to home, resident signs a release for nursing home to share information for payment, referrals, etc. Many times residents will have a power-of-attorney who will be identified at the time of application to home and will sign consent.	Lack of knowledge by providers of what should be included in consent form. No standard form.	1. * Education and proficiency in HIPAA appears warranted.	Drawing from Scenario ID#12, the common development of pathways can then be distilled into consent forms. The forms can have clearly defined subsets of permission to be given to different interests- providers, payors, public health officials, administrators. Barriers could be based in obscure state law in data collection from patients (if it exists)	Assumption #1: Consents can be legally re-formatted to include different conditions and subconditions Assumption#2: Paper obtained consents can be transported into an electronic format with eventual storage in an HDIE.	Project ownership- NJ-HISPC would need to drive a collaboration/consortium with public/consumer interest groups, provider groups, payors/insurers and state entities on development of specific consent forms. This would include, NJ Hospital Association, MSNJ, Nursing Associations, NJ PIRG, etc.	Project Scope- develop model consent forms based on various healthcare environments. Tasks required: 1) Development of decision pathways (see ID#12) 2) Distill pathways into various versions of consents based on environment where forms are to be deployed i.e. hospital, nursing home, rehab facility, dialysis center, surgical center, ambulatory care office, mental health institution	Timeline: Dependent on development of Pathways- May 07-Dec 07- organizational timeframe for project group Dec07-Jun08 Development of Pathways with provider Groups, July 08-December 08- deployment of consent forms. Costs would be for materials needed for production- IT costs, paper costs, to be determined by number of deployable environment scenarios. Deliverables would include model forms for adoption within organizations.	If a compensation model for the use of forms is instituted (organizations pay for consent toolkits to cover production costs) then the number of kits sold would serve as a means of tracking on how many organizations are implementing the model forms. When an HDIE is implemented in the state, an increase in transactions and deposit of electronic consents into a consent database would help determine utilization	Using surveys of patients, providers and payors with qualitative analysis would aid to assess the impact of these interventions. Lowering the latency in health information transactions would result in speeding the delivery of care and reducing costs.	Feasibility assessment- A Pilot study can be employed with volunteer organizations in controlled settings to determine if deploying standard consent forms would decrease the latency of health information transactions- operations research analysis through workflow studies. Barriers would include a lack of volunteers to assist in such a pilot.	Multi-state as consents would invariably need to identify out-of-state permissions to access PHI	Importance- Highest importance, ease of accomplishment- medium difficulty, Order to completed- after HIPAA decision pathways are determined, then consent forms can be designed, tested, deployed.

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17	HIPAA Education	5 - Provider must make judgment about what information is minimum necessary for case manager to authorize treatment. Usually case managers have access to the entire EMR.	May be misunderstanding on part of providers about what can be disclosed to case managers.	1. Education and proficiency in HIPAA appears warranted.	1 A simple uniform criteria needs to be established for what information can and can't be released. 2. Creation of this criteria should include input from the NJ Medical Societies, 2. Providers need to be educated about HIPAA requirements 3. This information needs to be visually accessible to providers either via posters in exam room, on patient charts, in wallet size cards they carry or on their PDAs; 4 Make use of trained health advocates who can act as intermediaries between provider and case manager or patient and case manager	1. Our goal is to create a standard criteria for use at least in the state of New Jersey, to facilitate uniform practice and understanding regarding the disclosure of medical information; 2. By "provider" we mean a physician, facility or the support staff of either; 3. If case manager understands the fact surrounding a request to authorize treatment, they are more likely to approve care if the treatment is deemed appropriate or be able to inform the provider if the request is for a procedure already done, so they can request a copy of the results;. 4. Providers are not knowledgeable about HIPAA requirements and prefer to err on the conservative side	1.Create a team of physicians, hospitals and legal practitioners who can create standardized criteria about what information to give and when to facilitate authorization of treatment. 2. Utilize NJ m medical societies, hospital assoc. need to educate their members. 2. Providers need to disseminate this information staff who may also be involved in attaining authorizations	1. Understanding of this criteria must become part of required continuing education requirements for providers. 2. It should else be part of hospital accreditation, hospitals must show that staff is educated in this area; 3. this could be achieved by the dissemination of easily understandable educational materials, posters required to be visible in all facilities and posted on the front of patient charts	1) Creation of this criteria will depend on a uniform understanding of relevant law and carrier authorization procedures prior to implementation of this solution. The timeline/order of tasks for implementation could be as follows: Agreeing on relevant criteria will take longest because of the need for input from so many different factions (providers, carriers, legal). Over a 12-month period it is expected that the following milestones could be met: assemble appropriate planning team, choose group leader, develop timeline for work and specific work assignments (within team), collect relevant data on current practices, reach consensus on relevant criteria and procedural issues, draft criteria, seek adoption of this criteria, create steps for training/implementation. 2) Projected cost would include: 1. Initial P/P planning team mtg. - mtg. place; 2. The setting up of subsequent meetings and/or conf. calls (weekly or as otherwise determined);	1. Develop detailed project planning document, for entire team to utilize; 2. Assignments give to participants; 3. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 4. Grp. Leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 5. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 6. final policy and procedure documents provided to HISPC and disseminated.	Once disseminated and adopted, this will reduce the time and efforts needed to obtain authorization. In doing so, it will help reduce administrative costs, avoid duplication of procedures, and hopefully shorten the recovery time for the patient	Adoption of a single criteria that all providers could use to release medical information when obtaining authorization seems like a very feasible objective, that would simplify procedures for both providers and carriers. Barriers will include: 1. Agreement on this criteria by providers, carriers and legal. 2. Education and dissemination of this information to providers and their staff; 3. Possible "interpretation" of the criteria; 4. Actual adoption of this criteria in a uniform manner.	Once established, this criteria could be utilized by all states since it will be based on HIPAA legislation which is a federal law. If states wanted to alter the criteria to fit more stringent mandates in their particular state, it would be at their prerogative	

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21	HIPAA Education	3 - Attending doctor decides what info to release to police officer. Usually, blood test results will be provided, but hospital may not release until they receive a subpoena or court order.	Many hospitals appear to be reluctant to release information to law enforcement, perhaps because of fear of litigation.	*** Unless the relevant NJ statute is repealed or significantly modified, it will continue to serve as a barrier with respect to a disclosure of data to law enforcement in this context. Perhaps additional/better education of law enforcement-of the legal requirements that must be met before a disclosure can occur absent a HIPAA authorization might reduce the frequency of experiencing this barrier. In addition, where others have been reasonably determined to be involved in the care or payment for the care of an individual, a disclosure to those others is permissible (see above discussion) and law enforcement might then seek to obtain the records from them.	1 Standardized the criteria for what information can be released, when and to whom. This could be done through a taskforce made up of law enforcement members, hospital administrators and other relevant personnel 2. Educate all staff involved. 3. Create a form that officers must sign off on showing the circumstances for requesting the information. 4 Prominently place posters describing the process that must be gone thought before information can be released	Under HIPAA, there is no need for an authorization or consent to disclose health data to parents if involved in their child's care or payment for his care. Likewise, HIPAA permits disclosure to law enforcement in many circumstances of criminal investigation. However, NJ law limits the circumstances where disclosures are permitted to law enforcement. See N.J.S.A. 26:2B-16 and 17. Hospitals may not disclose medical tests results or other information to law enforcement if no prior request for the specific test was made by police under. Absent such a request, a proper authorization, subpoena or court order must be obtained prior to disclosing test results under N.J.S.A. 26:2B-16 and 17.	1. Create a taskforce of law officers, hospital administrators, and other relevant practitioners (I'm thinking about people who deal with privacy issues and human rights). 2. Outline all of the issues involved in the release of information. 3 Choose an impartial group leader who will create committees to research the ramifications of releasing or withholding inform ton and the charge the group with creating a list of agreed upon criteria, policies and procedures to be followed. 4. Educate both law enforcement members, physicians and hospital staff about these procedures. 5 Make these practices a requirement throughout the state of NJ 6. Consider including this information as part of continuing education requirements and hospital/facility certification	1Form a committee to developed policies and procedures (P/P) to address when and how information is to be released. 2. Committee leader is to schedule meetings, define the breath of the project and follow up with individual subcommittees; 3 Create a timeline for creating P/P, and a plan for education and implementation by practitioners	The majority of the cost for this project with be for the time involved in researching the legal requirements and implications. If a team member is able to volunteer the use of their research software (i.e. westlaw) it should go fairly quickly. Once we have the facts the next hurdle will be to get people from so many different factions with differing points of view to agree on P/P. The educational piece can be included as a requirement of continuing education, presented in special seminars and emailed or snail mailed.	This will be part of the timeline developed by this committee at the onset of this project with the team leader making certain deadlines are met		The biggest barriers will be convincing all involved in the day-to-day operations to change. Change is never easy and part of the educational process will have to sell them on the need for this information being made available		1. Creation of a committee; 2 appointment of a leader; 3 creation of subcommittees; 4. research;5 creation of P/P; 6. Creation of educational materials 7. Creations of distribution channels for these materials 8. testing to see if the results meet expectations

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22	HIPAA Education	5 - If police are present and suspect patient of intoxication, patient refusal to be drug screened will result in arrest. If there is no suspicion of intoxication, patient can refuse and the medical record would have to be subpoenaed by police.	Barrier because standard procedures must be followed.	*** Unless the relevant NJ statute is repealed or significantly modified, it will continue to serve as a barrier with respect to a disclosure of data to law enforcement in this context. Perhaps additional/better education of law enforcement-of the legal requirements that must be met before a disclosure can occur absent a HIPAA authorization might reduce the frequency of experiencing this barrier. In addition, where others have been reasonably determined to be involved in the care or payment for the care of an individual, a disclosure to those others is permissible (see above discussion) and law enforcement might then seek to obtain the records from them.	Under HIPAA, there is no need for an authorization or consent to disclose health data to parents if involved in their child's care or payment for his care. Likewise, HIPAA permits disclosure to law enforcement in many circumstances of criminal investigation. However, NJ law limits the circumstances where disclosures are permitted to law enforcement. See N.J.S.A. 26:2B-16 and 17. Hospitals may not disclose medical tests results or other information to law enforcement if no prior request for the specific test was made by police under. Absent such a request, a proper authorization, subpoena or court order must be obtained prior to disclosing test results under N.J.S.A. 26:2B-16 and 17	Assumptions: 1. Our goal is to create an educational plan which includes law enforcement and healthcare staff that explains the difference of the HIPAA Ruke and the State of NJ's Law that is currently in place surceding the HIPAA Rule. 2. To facilitate a uniform practice and understanding regarding the disclosure of medical charts in a facility treatment setting during times that law enforcement is either present or at a later dates requests data for a suspect; Decisions: 1. To maintain that State law will in fact supersede HIPAA Ruling; 2. To educate all associated with this type of situation (all areas of law enforcement, judicial system and healthcare) of the understanding in the various situations where access may or may not be granted and why.	Dependency exists on teams developing output/solutions for uniform understanding of legal requirements pertaining to permissible disclosure of data for treatment purposes. P/P planning team must engage the staff of several facilities/institutions and various areas of law enforcement to design and implement P/P to ensure that this specific topic is included and shared with all areas of law enforcement. This type of collaboration between areas that share such specific inter-dependencies may then be more apt to following the rule and expectation and understating when they can in fact have access and/or provide access. The P/P planning team leader is required, to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant federal and state laws. Team members must include representation from law enforcement, judicial system and healthcare to assist in facilitating uniform understanding and adoption	Project Scope: 1) To design and create an educational plan that includes both an initial and on-going plan that provides guidance and interpretation of the HIPAA Rule(s) and the State law(s) that mandates/control how access to suspect medical record is or is not granted to law enforcement officials and other judiciary entities when brought a suspect is brought to a treatment facility; 2.) A standard p/p must be created and implemented facilitating the adoption and acknowledgement of such access; This P/P would need to be adopted and followed by the NJ healthcare facilities and the staff, law enforcement and judiciary communities all at times in need of access to suspects medical record. Project Tasks: 1. Identify P/P planning group leader; 2. Identify current chart access practice and issues; 3. Identify and document how/where data is available on who is treating/consulting on the case (who should have access); 4. Obtain output on uniform understanding of relevant law; 5. Discuss and determine appropriate and uniform policy and procedure steps; 6. design/draft concise policy and procedure documents that includes healthcare, law enforcement and judiciary entities; 7. Identify how to facilitate whole-state adoption of P/P; 8. Identify if different grps. require different training and, if so, what those different training approaches include; 9. Identify method of training approach	Time Line: 1) Inter-dependencies exist for the delivery of how and when this access standard (P/P) is utilized; timeline/order of tasks for implementation follow prior heading. Reaching a consensus on a consistent and unified standard that a varied audience would be willing to follow will take the longest time to create and agree. Over a 12-month period it is expected that the following milestones could be met: a.)assemble appropriate hospital/law enforcement/judiciary as core team and SME's for P/P planning team; b.) choose a group leader, develop a work timeline, work plan and specific work assignments (within team); c.) collect relevant data on current practices, reach consensus on relevant policy and procedural issues, draft P/P documents and seek whole-state adoption of P/P in all areas identified; d.) create steps for both initial and on-going training/implementation; e.) complete training and implementation; f.) design	Tracking status: 1. Develop detailed project planning document, for entire team to utilize with clearly defined milestones; 2. Periodic conf. calls pre-arranged or face to face meetings for team discussion, planning and participation to occur; 3. Grp. Leader coordinates team sessions, as needed, manages team to project timelines agreed to by the entire team and project management and completes project plan to ensure milestones are documented and available for review by project management; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once the standard P/P is developed for law enforcement access to suspects medical record at time of arrival to treating facility will hopefully be adopted by the institutional and law enforcement communities; and once adopted and implemented by the majority of impacted entities; its use may change their current approach and should promote uniformity with respect to this access business practice.	1) The creation of a standard to facilitate the handling of suspect medical information to law enforcement is very feasible; however, the adoption of this standard as a statewide initiative will depend on the acceptability to/adoptability by the entities impacted such as healthcare treatment facilities, law enforcement and judicial entities that may have not been represented on the P/P standard planning team. Barriers could include: 1. Failure of a timely delivery of a uniform understanding (standard) with relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Grp. Leader; 3. Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of grp. to reach consensus on standard policy approach/procedural steps; 5. Inability to reach consensus on language of standard policy and procedure documents; 6. Ineffective training plan created and implemented; 7. failure of non-participating entities to adopt the standard P/P developed; 7. Failure to plan an audit process that allows for subsequent review of adoption	multi;	1) med. 2) Difficult due to the impact across several varying lines of jurisdiction and need for information; if appropriate individuals are selected to participate who represent these varying entities, then the planning team may be properly positioned for success; 3) Cannot proceed with delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements is known and understood.
109	HIPAA Education: Insurance Education/Access	7 - Medical claims are submitted to patient auto insurance first and then to medical insurance company as secondary insurer.	State regulations must be followed. Policy is based on NJ no-fault, personal injury protection (PIP) auto coverage laws.	2. Insured's need to know what policies are primary, co-primary, secondary, etc.	Education and training must include the cross over with auto insurance submission for medical expenses after an automobile accident	The legal working group must include the review and understand of the cross over issues between automobile insurance payment of medical expenses and health insurer secondary payment of medical expenses. This understanding will promote a standard P/P guide for all auto. and medical insurers to follow.	Legal working group	1) Review the automobile insurance law and regulations pertaining to payment of medical expenses; 2) review against health insurer law/ regulations / policies for payment of medical expenses incurred during an automobile accident	1) Legal review and education should happen at the beginning of the implementation project; 2) will need volunteer attorneys to assist with this work, and perhaps administrative staff to compile the information	The NJ implementation project will use the standard tracking tools of Microsoft Project, Microsoft Access database functionalities	Knowledge of how automobile insurance and health insurance work together to pay medical expenses will help most providers and health plans	1) This is part of the legal working group and will be an agenda item for the WG leaders at establishment and initiation of the legal WG; 2) the only real barrier to any of the NJ Implementation Plan work is funding	single to begin with	1) quite important; 2) easy to accomplish;

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117	HIPAA: Access/Disclosure Standard	3 - Attending physician shares information with family verbally.	Information from record can be given to parents, but is not sufficient information; must be personal contact so physician can counsel parents.	1. Family has access to medical records and lab results; may get second opinion.	(Without more information it is extremely difficult to determine what the perceived barrier and potential solution is in this scenario. Is the group suggesting that a phone call from the physician to the parents is not sufficient, and information must be shared through other means?)									
100	HIPAA: Release, Consent & Authorization Standard	6 - Medicaid provides electronic data file on CD with specific identifiers from enrollment files which exist in CLPPSS.	Barrier because Medicaid can only disclose information for very limited purposes. Each instance must be evaluated individually.	1. State examination and reform of state Medicaid law to allow for certain type of data sharing.										
14	HIPAA: Access/Disclosure Standard	9 - Only authorized personnel at nursing home may work with charts. Authorization is determined by job title, with clinical staff having first priority for access. Nursing supervisors oversee proper use of charts.	Need to have written policies for access and procedures to ensure only authorized staff have access.	1. Need to have written policies for access and procedures to ensure only authorized staff have access. 2. Education in PHI and HIPAA HIE would help to resolve uncertainty under this scenario.	Facilities must have policies and procedures that clearly state why and how access is handled for staff directly involved and needing access to patient records including visiting practioners and staff/non-staff consultants yet not hampering treatment, payment and operations. Part of the P/P is to have role based access clearly defined and outlined so staff fall into specific areas of access privileges and/or are aware of who and why someone has access. If there are visiting practitioners and/or consultants assisting on a case then clear direction must be contained in the P/P and in the specific patients chart so all having access can have for review when necessary. Disclosure to a provider/staff member should follow the HIPAA Min. Necessary rule which is outlined as a part of the P/P to clearly document and clarify access rights and limitations. This will help to mitigate any uncertainly of who may have access to a specific patient chart or other patient information. [NOTE: Payers likewise need appropriate verification policies and procedures, to ensure that disclosures are only made to actual, treating providers and staff.]	Assumptions/Decisions: 1. The goal is to create a standard Access & Disclosure policy/procedure (P/P) that encompasses all types of access and disclosure in the state of New Jersey which will include such items as a uniform practice, an understanding regarding the HIPAA disclosure of medical charts in a facility treatment setting and access/role based requirements for both direct and consultative staff members; 2. That the creation of this standard includes representatives from at least 4-5 nursing homes, hospitals and/or other-treatment facilities, non-facility treatment/health related entities and consultative individuals; Examples would include pharmacies, consultative physicians/other staff types, home health, labs, etc. all of whom should participate in this P/P development; Individuals that are familiar with drafting P/P and education/training documents; 3. In the planning of this P/P the assigned grp. should utilize and ensure that all participants have an established understanding of governing laws in the state of NJ when preparing and participating in the development of this P/P standard; this state law information should be provided in advance to the assigned group by the HISPC implementation team; 4. As a part of planning and documentation, an educational and training plan must included and mapped out for the initial and on-going management of such a	Interdependencies exist across multi functional teams which should be considered by the team when developing a uniform understanding of legal requirements pertaining to permissible access and disclosure of data for treatment purposes yet still take into consideration payment and operations. P/P planning team must engage staff members from various healthcare entities that fall into possible provider categories to draft, design, implement and train P/P. This will help to ensure that ideas identified, collected and recommended as solutions will "fit" the various environments impacted; and should help to facilitate acceptance and implementation barriers. P/P planning team leader is required, to facilitate team coordination, timelines are met, reporting and data collection is completed correctly and ensure to ensure overall workplan completion and commitment by all involved. Team should also include legal SME's to ensure P/P development is consistent with uniform understanding of relevant	**Project Scope:** To design and implement a uniform policy/procedure (P/P) for adoption by varied NJ healthcare facilities and/or providers having direct/indirect (direct staff vs. consultative staff) access to patient medical records in a treatment setting outlining a standard for appropriate access and disclosure of medical chart information; The P/P planning must include law clarification, role based access requirements for direct and indirect staff/consultants, education/training (initial and on-going) and implementation of a standard that addresses and resolves open issues relating to the access of patient medical data in a treatment setting where a patient chart is maintained on a floor/dept. type setting. Tasks include: 1. Identify P/P planning group leader and team to ensure that members are reflective of the varied healthcare treatment settings where this standard will have impact; 2. Identify current chart access practice and issues; what works and what doesn't work; 3. Identify and document standard of how/where data is available and who is treating/consulting (who should have access); 4. Obtain and discuss the existing understanding of the relevant NJ/federal law; 5. Discuss and determine appropriate and uniform P/P steps; 6. Design/draft concise P/P documents that explain both initial and all on-going requirements to ensure a standard such as this is upheld and	Timelines and Milestones: 1.) Address, define and resolve interdependencies that exist for delivery of this standard which includes any and all relevant law prior to implementation of the overall solution; 2.) include suggested timelines, specific tasks and completion methodology for actual implementation; 3.) Obtain and reach consensus on relevant policy and procedures will take the longest and most effort; 4.) Over a 12-month period it is expected that the following milestones could be met and tasks completed by those assigned a.) team leader must be chosen; b.)core group should include appropriate healthcare direct and indirect staff needing access and/or disclosing information; c.) SME group must include a diverse and varied healthcare background to ensure a more appropriate, implementable and acceptable standard; d.) Team leader must implement the work assignments (within team), implement the associated	The following will be developed to facilitate project status tracking and completion: 1. Develop and maintain a detailed project plan that entire team can utilize and refer to as well as assists the grp. leader manage the work effort; 2. Periodic conf. calls or mtgs. pre-arranged for team discussion, planning and participation to occur; 3. Grp. Leader coordinates team all sessions and calls, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC team and disseminated.	Once developed, this access and disclosure standard P/P for nursing home staff and includes language for any and all consultative/per diem staff as well. This example should be considered and included in the overall access and disclosure standard that is ultimately developed, trained and implemented at a state level.	**1)** The creation of a state P/P standard promoting and enforcing access and disclosure for any and all staff, consultants and/or other health related individuals providing treatment; however, the adoption as a statewide P/P standard will depend on the implement ability/ acceptability to/adoptability by the healthcare community both represented and not represented on this P/P team. **2)** Barriers could include: a.) Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); b.) Challenges in identifying an appropriate Grp. Leader; c.) Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; d.) Inability of grp. to reach consensus on standard policy approach/procedural steps/training & implementation plan; e.) Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating staff and entities to adopt the standard P/P developed.	multi;	**1)** med./high **2)** Access /disclosure P/P finally implemented must include various representatives and all must participate throughout implementation in order to promote and achieve success. **3)** Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements exist.

ID	Work Group	Business Practice Long Description	Impact of Barrier	Solution	Summary of effective practice(s) to be instituted or barrier(s) to be mitigated or eliminated by the plan	Planning assumptions and decisions	Project ownership and responsibilities (identify specific individual and/or organization names and titles)	1) Clearly defined project scope; 2) Identification of tasks required, organized by work breakdown structure	1) Project timeline and milestones; 2) Projected cost and resources required	Means for tracking, measuring and reporting progress	Impact assessment on all affected stakeholders in the state (including small and rural providers)	1) Feasibility assessment; 2) Possible barriers that the implementation plan may face	Single State/Multi State	1) Importance; 2) Ease of accomplishment; 3) Order to be completed
15	HIPAA: Access/Disclosure Standard	10 - Physician must request chart at nursing station and unit manager will ask purpose for taking chart. Physician signs out chart but chart cannot leave the unit floor.	Need to have written policies for access and procedures to ensure only authorized staff have access.	1. Need to have written policies for access and procedures to ensure only authorized staff have access.	Facilities must have policies and procedures that clearly state why and how access is handled for staff directly involved and needing access to patient records including visiting practitioners and staff/non-staff consultants yet not hampering treatment, payment and operations. Part of the P/P is to have role based access clearly defined and outlined so staff fall into specific areas of access privileges and/or are aware of who and why someone has access. If there are visiting practitioners and/or consultants assisting on a case then clear direction must be contained in the P/P and in the specific patients chart so all having access can have for review when necessary. Disclosure to a provider/staff member should follow the HIPAA Min. Necessary rule which is outlined as a part of the P/P to clearly document and clarify access rights and limitations. This will help to mitigate any uncertainly of who may have access to a specific patient chart or other patient information. [NOTE: Payers likewise need appropriate verification policies and procedures, to ensure that disclosures are only made to actual, treating providers and staff.]	Assumptions/Decisions: 1. The goal is to create a standard Access & Disclosure policy/procedure (P/P) that encompasses all types of access and disclosure in the state of New Jersey which will include such items as a uniform practice, an understanding regarding the HIPAA disclosure of medical charts in a facility treatment setting and access/role based requirements for both direct and consultative staff members; 2. That the creation of this standard includes representatives from at least 4-5 nursing homes, hospitals and/or other-treatment facilities, non-facility treatment/health related entities and consultative individuals; Examples would include pharmacies, consultative physicians/other staff types, home health, labs, etc. all of whom should participate in this P/P development; Individuals that are familiar with drafting P/P and education/training documents; 3. In the planning of this P/P the assigned grp. should utilize and ensure that all participants have an established understanding of governing laws in the state of NJ when preparing and participating in the development of this P/P standard; this state law information should be provided in advance to the assigned group by the HISPC implementation team; 4. As a part of planning and documentation, an educational and training plan must included and mapped out for the initial and on-going management of such a	Interdependencies exist across multi functional teams which should be considered by the team when developing a uniform understanding of legal requirements pertaining to permissible access and disclosure of data for treatment purposes yet still take into consideration payment and operations. P/P planning team must engage staff members from various healthcare entities that fall into possible provider categories to draft, design, implement and train P/P. This will help to ensure that ideas identified, collected and recommended as solutions will "fit" the various environments impacted; and should help to facilitate acceptance and implementation barriers. P/P planning team leader is required, to facilitate team coordination, timelines are met, reporting and data collection is completed correctly and ensure to ensure overall workplan completion and commitment by all involved. Team should also include legal SME's to ensure P/P development is consistent with uniform understanding of relevant	Project Scope: To design and implement a uniform policy/procedure (P/P) for adoption by varied NJ healthcare facilities and/or providers having direct/indirect (direct staff vs. consultative staff) access to patient medical records in a treatment setting outlining a standard for appropriate access and disclosure of medical chart information; The P/P planning must include law clarification, role based access requirements for direct and indirect staff/consultants, education/training (initial and on-going) and implementation of a standard that addresses and resolves open issues relating to the access of patient medical data in a treatment setting where a patient chart is maintained on a floor/dept. type setting. Tasks include: 1. Identify P/P planning group leader and team to ensure that members are reflective of the varied healthcare treatment settings where this standard will have impact; 2. Identify current chart access practice and issues; what works and what doesn't work; 3. Identify and document standard of how/where data is available and who is treating/consulting (who should have access); 4. Obtain and discuss the existing understanding of the relevant NJ/federal law; 5. Discuss and determine appropriate and uniform P/P steps; 6. Design/draft concise P/P documents that explain both initial and all on-going requirements to ensure a standard such as this is upheld and	Timelines and Milestones: 1.) Address, define and resolve interdependencies that exist for delivery of this standard which includes any and all relevant law prior to implementation of the overall solution; 2.) include suggested timelines, specific tasks and completion methodology for actual implementation; 3.) Obtain and reach consensus on relevant policy and procedures will take the longest and most effort; 4.) Over a 12-month period it is expected that the following milestones could be met and tasks completed by those assigned a.) team leader must be chosen; b.)core group should include appropriate healthcare direct and indirect staff needing access and/or disclosing information; c.) SME group must include a diverse and varied healthcare background to ensure a more appropriate, implementable and acceptable standard; d.) Team leader must implement the work assignments (within team), implement the associated	The following will be developed to facilitate project status tracking and completion: 1. Develop and maintain a detailed project plan that entire team can utilize and refer to as well as assists the grp. leader manage the work effort; 2. Periodic conf. calls or mtgs. pre-arranged for team discussion, planning and participation to occur; 3. Grp. Leader coordinates team all sessions and calls, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC team and disseminated.	Once developed, this access and disclosure standard P/P includes language for any and all employed, consultative and/or per diem staff . This example should be considered and included in the overall access and disclosure standard that is ultimately developed, trained and implemented at a state level.	1) The creation of a state P/P standard promoting and enforcing access and disclosure for any and all staff, consultants and/or other health related individuals providing treatment; however, the adoption as a statewide P/P standard will depend on the implementability/ acceptability to/adoptability by the healthcare community both represented and not represented on this P/P team. 2) Barriers could include: a.) Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); b.) Challenges in identifying an appropriate Grp. Leader; c.) Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; d.) Inability of grp. to reach consensus on standard policy approach/procedural steps/training & implementation plan; e.) Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating staff and entities to adopt the standard P/P developed.	multi;	1) med./high 2) Access /disclosure P/P finally implemented must include various representatives and all must participate throughout implementation in order to promote and achieve success. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements exist.

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16	HIPAA: Access/Disclosure Standard	10 - Physician must request chart at nursing station and unit manager will ask purpose for taking chart. Physician signs out chart but chart cannot leave the unit floor.	Need to have written policies for access and procedures to ensure only authorized staff have access.	2. Development of policy should include comprehensive review of HIPAA complexities and nuances.	Facilities must have policies and procedures that clearly state why and how access is handled for those providers who are directly involved or consulting on a case. The staff must be aware that there is consulting occurring and have it documented in the chart along with any and all other attending provider names, or otherwise be able to determine to that facility's satisfaction that disclosure of data is appropriate and permitted. This will help to mitigate any uncertainly of who may have access to a specific patient chart or other patient information. [NOTE: Payers likewise need appropriate verification policies and procedures, to ensure that disclosures are only made to actual, treating providers.]	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in the state of New Jersey, to facilitate uniform practice and understanding regarding the disclosure of medical charts in a facility treatment setting; 2. that representatives from at least 4-5 hospital and/or other-treatment facilities should participate in this P/P development, including the following staff types: , as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing this P/P which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff having and needing access to medical chart records prior to instituting the P/P; 5. that this education should include written and oral training, with periodic follow-up; 6. that all facilities in New Jersey will be encouraged to embrace and acknowledge the importance of uniformity in approach (esp. if a standard procedure is developed for "verifying" the data-seeking provider in circumstances where documentation is not presented that clearly establishes him/her as a treating provider), and to adopt the standard P/P.	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible disclosure of data for treatment purposes. P/P planning team must engage the staff of several facilities/institutions to design and implement P/P. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. P/P planning team leader is required, to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ hospital society, to assist in facilitating uniform adoption of P/P.	**1)** To design and create a uniform policy/procedure, for adoption by (at least) NJ hospital facility community, regarding the circumstances for appropriate disclosure of medical chart information in a facility treatment situation. The project must include education and implementation of a P/P that addresses and resolves open issues relating to access of patient data in an institutional setting where a chart is maintained in a hospital floor/dept. type setting. The standard P/P developed must clearly document how access is to be handled for all direct treating and medical consultative staff. **2)** Tasks include: 1. Identify P/P planning group leader; 2. Identify current chart access practice and issues; 3. Identify and document how/where data is available on who is treating/consulting on the case (who should have access); 4. Obtain output on uniform understanding of relevant law; 5. Discuss and determine appropriate and uniform policy and procedure steps; 6. design/draft concise policy and procedure documents; 7. Identify how to facilitate whole-state adoption of P/P; 8. Identify if different grps. require different training and, if so, what those different training approaches include; 9. Identify method of training approach and timing to train; 10. Identify how ongoing P/P assessment will occur and issues will be handled post P/P implementation;	**1)** Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations may take longest. Over a 12-month period it is expected that the following milestones could be met: assemble appropriate hospital/other-facility staff and SME for P/P planning team, choose group leader, develop timeline for work and specific work assignments (within team), collect relevant data on current practices, reach consensus on relevant policy and procedural issues, draft policy and procedure documents, seek whole-state adoption of P/P, create steps for training/implementation. **2)** Projected cost would include: 1. Initial P/P planning team mtg. - mtg. place; 2. The setting up of subsequent meetings and/or conf. calls (weekly or as otherwise determined);	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Grp. Leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Grp. leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once developed, the standard P/P for medical chart data interoperability will hopefully be adopted by the institutional community; and once adopted and implemented by a majority of the hospital/other treatment facility community, its use may change their current approach and should promote uniformity with respect to this business practice.	**1)** The creation of the standard P/P documents for appropriate disclosure of medical chart information is very feasible; however, their adoption as a statewide standard will depend on their acceptability to/adoptability by the institutional community not represented on the P/P planning team. **2)** Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Grp. Leader; 3. Consistent and continued availability and participation of planning team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of grp. to reach consensus on standard policy approach/procedural steps; 5. Inability to reach consensus on language of standard policy and procedure documents; 6. failure of non-participating facilities to adopt the standard P/P developed.	multi;	**1)** low/med. **2)** Not too difficult, if planning team is properly represented and all participate throughout implementation. **3)** Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.
37	HIPAA: Access/Disclosure Standard	2 - Physician determines what information is relevant for treatment and faxes previous provider with description of emergency and request for information.	Administrative barrier because other provider may not respond or may have specific form required for request.	2. ******Creating standards related to fax communications . Also, educating stakeholders on HIPAA's TPO (Treatment, Payment and Health Care Operations) clause for disclosures.	May need to adopt law in NJ that expressly requires providers to freely share PHI with other providers unless an exception exists. Alternatively, include a policy verifying that one provider's reliance on another provider's authorization as valid will be deemed a compliant practice under HIPAA and NJ law. In addition, a policy verifying that treating providers do not need to limit PHI to the minimum necessary will help ensure that information is efficiently shared.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.	The New Jersey DHSS, DOBI or Board of Medical Examiners may head project team dedicated to developing standard p/p related to use of sharing PHI among treating providers. Participants should include representation from hospitals, physicians, medical records staff and emergency department nurses and physicians.	Conduct User Training						

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38	HIPAA: Access/Disclosure Standard	2 - Physician determines what information is relevant for treatment and faxes previous provider with description of emergency and request for information.	Administrative barrier because other provider may not respond or may have specific form required for request.	3. Develop generic form to be used by Physicians. Open lines of communication with each provider is necessary in order to obtain consensus.	May need to adopt law in NJ that expressly requires providers to freely share PHI with other providers unless an exception exists. Alternatively, include a policy verifying that one provider's reliance on another provider's authorization as valid will be deemed a compliant practice under HIPAA and NJ law. In addition, a policy verifying that treating providers do not need to limit PHI to the minimum necessary will help ensure that information is efficiently shared.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.	The New Jersey DHSS, DOBI or Board of Medical Examiners may head project team dedicated to developing standard p/p related to use of sharing PHI among treating providers. Participants should include representation from hospitals, physicians, medical records staff and emergency department nurses and physicians.	Implement Project						
77	HIPAA: Access/Disclosure Standard	1 - Marketing/Quality Assurance each meet with IT develop a query to extract information from patient records for specific conditions. Queries are tested on artificial data.	Technical barrier because of need for standard procedures and access by authorized personnel only.	2. A regulation spelling out an accepted method of patient de-identification needs to be created.	There may be some regularly encountered circumstances that give rise to the need to engage deidentification practices in accordance with HIPAA. For these, additional regulation, which might provide guidance for those circumstances, may be helpful. However, even where full deidentification is not required, providers must sometimes comply with the HIPAA minimum necessary rule (although not in the context of treatment) -- such as when carrying out payment and health care operations activities. To eliminate confusion, additional regulation could, esp. through use of examples, provide guidance to demonstrate, In regularly encountered payment/other contexts, how the HIPAA minimum necessary rule may best be applied.	Assumptions: 1. that our goal is to create a regulation that will provide guidance, with examples, ideally through federal regulation, but possibly just in the State of NJ, on a) when circumstances that give rise to the need for deidentification most typically occur, and b) how the minimum necessary rule might be applied in circumstances for which application of the rule is appropriate, especially in payment, health care operations, research and other circumstances regularly encountered by providers, in order to facilitate uniform practice and understanding regarding both i) the appropriate time(s) to apply the HIPAA minimum necessary rule, and when it is not required (such as for treatment); and ii) what disclosures of PHI may appropriately be made (e.g., what parts of standard collected PHI, such as medical history and other chart data, and notes, may generally be disclosed in those circumstances); 2. that the relevant regulators will agree with the need for additional guidance in the form of regulation, will engage the regulatory drafting process and will involve relevant industry representatives in that process; 3. that comments should be obtained from individual and group practice physicians and office staff and/or other treatment providers, as well as payers and others involved in data exchanges in healthcare operations activities, identifying regularly encountered	Dependency exists on federal (or State) regulators to embrace need for promulgation of regulations and willingness to pursue drafting, ideally with input from provider and payer community, as outlined. Team of industry reps providing suggestions and examples for regulators must first develop agreed upon output (for submission to regulator), which must be based upon uniform understanding of existing legal requirements pertaining to deidentification (including when same is appropriate or required) as well as permissible disclosures of data for TPO purposes (esp. treatment), in compliance with the minimum necessary rule. Industry rep team must engage several provider types, as well as payers, to facilitate broad-based input of examples for each regulation to be developed. This will ensure that ideas collected and identified as appropriate for regulatory comment/suggestion will be appropriate to provide guidance in the circumstances intended; and will facilitate acceptance and	1) To develop and draft additional regulations, for adoption federally or, possibly, just by NJ State regulators, that provide guidance, with examples, on a) when circumstances that give rise to the need for deidentification most typically occur, and b) how the minimum necessary rule might be applied in circumstances for which application of the rule is appropriate, especially in payment, health care operations, research and other circumstances regularly encountered by providers, in order to facilitate uniform practice and understanding regarding both i) the appropriate time(s) to apply the HIPAA minimum necessary rule, and when it is not required (such as for treatment); and ii) what disclosures of PHI may appropriately be made (e.g., what parts of standard collected PHI, such as medical history and other chart data, and notes, may generally be disclosed in those circumstances). The project must include input from providers and payers on appropriate examples through which guidance will be provided, as well as what data is most typically required in order to effectively accomplish the purposes for which data is being exchanged. The regulation to be developed in each instance must clearly indicate that they are intended only to provide guidance through examples, while preserving the discretion of each covered entity to determine its compliance with HIPAA rules, as applicable. 2) Tasks include:	1) Dependency exists for delivery of output on uniform understanding of relevant law to industry reps providing comment/suggestions prior to implementation of this solution; also, commitment is needed from relevant regulatory agency to develop additional regulation on this subject matter. Timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant examples for regulatory guidance may take longest; also make not obtain commitment from regulator to promulgate additional guidance in form of regulation. Over an 18-24 month period it is expected that the following milestones could be met: assemble appropriate physician/other reps and SME for team planning comment/suggestions, choose group leader, identify relevant regulatory agency and reach out to same to determine willingness to develop additional regulatory guidance, develop timeline for work and specific work	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Team leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Team leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. suggestions for examples (to be presented to relevant regulator) also to be provided to HISPC and disseminated for collective agreement prior to submission to regulator.	Once finalized, the additional guidance on both a) when circumstances that give rise to the need for deidentification most typically occur (as well as what deidentification will look like in those circumstances), and b) how the minimum necessary rule might be applied in circumstances for which application of the rule is appropriate, especially in payment, health care operations, research and other circumstances regularly encountered by providers will hopefully be adopted and utilized by the physician and payer communities, in appropriate circumstances. Once implemented by a majority of providers (and payers), use of each regulation's guidance in appropriate circumstances may eliminate confusion and will promote uniformity with respect to this business practice.	1) The promulgation of additional federal guidance relating to deidentification and minimum necessary rules applicability may not be feasible, depending on the interest and willingness of regulators to recognize the need for such guidance and commitment to develop such guidance, ideally, with input from providers and payers as to appropriate examples to serve as said guidance. However, if that commitment is obtained, then the adoption of such regulation is very feasible. There will still remain the issue of implementation/use of that guidance, federally and statewide, as the standard to be used in circumstances of the examples contained in those regs. That will depend on the acceptability of that guidance to the provider and payer community not represented on the industry rep team. 2) Barriers could include: 1. Failure of relevant regulators to recognize the need for regulation; 2) timely delivery to the industry rep team of uniform understanding of relevant legal requirements (prior to work on this solution); 3. Challenges in identifying an appropriate team leader and/or team members; 4. Consistent and continued availability and participation of industry rep team members and identified stakeholders, impacting	Could be single-State, but should be multi-(federal)	1) Low, for both regulations. 2) Difficult, if planning team is unable to obtain commitment from relevant regulator; not too difficult, so long as industry rep team is properly represented, all participate throughout implementation, all thoroughly understand existing legal requirements, and all agree on examples that should be presented for inclusion in regulation. 3) Cannot proceed until delivery of solutions to industry rep team relating to creation of standard, uniform understanding of relevant legal requirements.

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88	HIPAA: Access/Disclosure Standard	2 - Hospital Marketing Department can obtain data to inform individuals about the new pediatric wing, to solicit registrations for parenting class, and to request donations. Data provided must be minimum necessary for business purpose. Hospital policy is not to sell patient data to any third party.	Technical barrier because of need for standard procedures and access by authorized personnel only.	1. Development of a separate marketing database.	Facilities must have policies and procedures that clearly state 1) when disclosures of PHi, including treatment/medical information, can be made available for various facility purposes with and without a (sometimes) NJ-required consent, a HIPAA-valid authorization, or other "release", including for marketing, fundraising and other purposes -- and should possibly retain all records of them in a single repository (such as a database); and 2) what constitutes "marketing" and "fundraising" such as may give rise to the need to obtain an authorization under HIPAA before use or disclosure of PHI may occur. (It is also understandable that a covered entity (facility) would take the policy approach not to sell PHI; however, such organizations taking a different approach must understand the implications and requirements of a different policy.) In conjunction with the above, and in appropriate circumstances, facility staff must fully understand how and when to obtain a required authorization, as well as, ideally, be provided with standard authorization language for that purpose (although that is not the subject of this solution). Furthermore, better understanding is needed around the applicability of the HIPAA minimum necessary rule for TPO. Staff must then be trained to know when appropriate requirements have been met (or not) such as will	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" -- which purpose requires a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose -- including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment); 2. that facility providers, IT staff and/or others involved in activities contemplated in the BP as "marketing" (whether or not such activities meet the HIPAA definition of "marketing") should participate in the development of each P/P, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing each P/P, which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make use and disclosures of PHI in the contexts contemplated; 5. that this education	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible use and disclosure of data for TPO purposes (without authorization), as distinguished from circumstances defined as "marketing" under HIPAA, as well as proper application of HIPAA's minimum necessary rule. Each P/P planning team must engage the staff of several facilities/institutions to design and implement each set of P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. Each P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ hospital society, as well as facility IT staff -- esp. if development of a database is desirable -- and others who	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ hospital facility community, regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of applying the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment). The project must include development of (and then be succeeded by education and implementation of) 2 sets of Ps/Ps that address and resolve open issues relating to disclosure of PHI in an institutional setting for various situations, including those that some may mistakenly characterized as "marketing" under HIPAA. The standard P/P developed in the first set must clearly document when disclosure is permissible absent a (consent or) HIPAA-valid authorization, and should include examples; in the second set, it should likewise include helpful examples -- of how the minimum necessary rule would be applied in typical facility use/disclosure situations. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to which marketing-type activities are appropriately characterized as TPO v. "marketing" defined by HIPAA may take longest, although determination of which elements of data are appropriately minimum necessary to accomplish various purposes (including marketing under HIPAA) may also prove challenging, timewise, as may development of a database to maintain data on marketing-type (or actual marketing) activities for which PHI is used, should that solution be pursued. Furthermore, and again, if it is part of this solution project, developing standard guidance on what should be included in a HIPAA-valid authorization when one is needed, or in either a consent (which is	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Team leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Team leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated, ideally prior to adoption.	Once developed, the standard P/P for each of a) how HIPAA differentiates and treats activities performed by a facility that are TPO v. what HIPAA defines as "marketing" for purposes of applying the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, (possibly including how and when to obtain any such needed authorization, and what must be included in one (when one is needed), or in either a consent (which is sometimes required by NJ State law) or a release (which, presumably, is obtained for risk liability reasons v. legal requirements), which form standardization is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) will hopefully be adopted by the facility community. Once adopted and implemented by a majority of facilities, their use of each P/P may change their current	1) The creation of standard P/P documents for a) how HIPAA characterizes many typical activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of applying the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, (possibly including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution)); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) is feasible, as is the development of a database to maintain data on marketing-type (and actual marketing) activities, if one is desired. The success/feasibility of each depends, however, on the ability of the facility reps and others to agree on how to characterize regularly encountered circumstances and activities (such as for TPO v. HIPAA-defined "marketing"), among other issues of regulatory interpretation and risk tolerance; however, their adoption as a statewide standard will also depend on their acceptability to/adoptability by the institutional community not represented on each P/P planning team. 2) Barriers could include: 1.	Could be multi-, but more likely single-State	1) Low to medium, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate cooperatively throughout development and implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.
90	HIPAA: Access/Disclosure Standard	2 - Hospital Marketing Department can obtain data to inform individuals about the new pediatric wing, to solicit registrations for parenting class, and to request donations. Data provided must be minimum necessary for business purpose. Hospital policy is not to sell patient data to any third party.	Technical barrier because of need for standard procedures and access by authorized personnel only.	3. HIPAA minimum necessary rule needs to be incorporated into policy & procedures. Marketing needs to follow those protocols.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88.

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91	HIPAA: Access/Disclosure Standard	3 - Information is transmitted between the hospital IT group and other departments by encrypted email or placed into shared network files.	Technical barrier because of need for standard procedures and access by authorized personnel only.	1. Usage of de-identified patient data whenever possible.										
114	HIPAA: Access/Disclosure Standard	7 - If bioterrorism is suspected, first responders are notified and offered inoculation if they have not already had it. Information will be provided about location of incidents, reasons why it appears to be bioterrorism, and information about what to look for.	Barrier because it is not clear who should be informed and what procedures are to protect PHI from inappropriate disclosure.	1. Information access to be granted on temporary basis to workers in the first responders.	Hospitals and other providers will continue to comply with NJ requirements related to notification of cases of suspected poisoning or exposure to hazardous substance. First responders are considered providers and as such are allowed access to PHI as necessary to perform their duties, including protecting themselves and others from additional exposure. Education for providers related to emergency preparedness & bioterrorism may be effective (and timely) to remind industry about both federal and state provisions related to event reporting, emergency treatment and use/access to PHI.	Hospitals and other providers will continue to comply with NJ requirements related to notification of cases of suspected poisoning or exposure to hazardous substance. First responders are considered providers and as such are allowed access to PHI as necessary to perform their duties, including protecting themselves and others from additional exposure. HIPAA and NJ provisions related to protecting PHI, including p/p related to staff access to records, use of minimum necessary procedures and others are not affected.	NJHA and DHSS have done extensive project planning related to emergency preparedness, and would be a good resource to tap for education of the provider community, including county health departments, emergency transport agencies (ambulance companies) and others.							
131	*HIPAA: Access/Disclosure Standard*	2 - Business associate agreements are in place between some providers and payers to permit sharing of data. Patients are notified of this in Joint Notice of Privacy Practices.	Need to have appropriate business agreements in place and notice of privacy practices to patients. Otherwise, PHI will not be exchanged without concerns of violating those rights.	2. Technical considerations should include stages of payor access, on a least-detail necessary basis so that only info necessary to make the medical necessity decision is made available to the payor.	Ensure use of existing HIPAA transaction and code sets by payors to maintain proper amount of data is being asked for and used by payors.									

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132	*HIPAA: Access/Disclosure Standard*	2 - Business associate agreements are in place between some providers and payers to permit sharing of data. Patients are notified of this in Joint Notice of Privacy Practices.	Need to have appropriate business agreements in place and notice of privacy practices to patients. Otherwise, PHI will not be exchanged without concerns of violating those rights.	3. Patients should be made aware that payors have accessed their PHI, and should retain the ability to correct any incorrect information.	Existing HIPAA laws in place now allow patients to request information on who has accessed their information. Covered entities are currently responsible for maintaining this data. Not all electronic systems in place 'log' this information. In addition, any development of a statewide RHIO (either in whole or partial) must include ability to log/track access to patient data, and allow patients the ability to access that information. These RHIO components should be addressed as part of the RHIO solutions described above.	1) All electronic systems in place today do not include transaction logging.	1) For transaction logging, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Ensure compliance of transaction logging for systems currently containing patient health information. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 1 year period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take two year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation, 1 year to allow preparation by existing vendors of electronic systems containing ePHI. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) All existing electronic systems would need to be modified or expanded to incorporate a statewide patient identification number	multi;	1) High 2) High due to need to modify existing systems.
145	*HIPAA: Access/Disclosure Standard*	1 - Patient must sign an authorization permitting release of information to employer.	Barrier because patient must sign authorization. Some home health agencies report that they require certification that employee is free of communicable disease before returning to work.	2. Since this is not an emergent situation, interoperability is not critical under this scenario. Upon discharge for the ED, the processing agent can merely provide the patient with a note certifying ability to return to work, especially where communicable disease or public health issues are not present.	Same as item 144	Same as item 144								
146	*HIPAA: Access/Disclosure Standard*	1 - Patient must sign an authorization permitting release of information to employer.	Barrier because patient must sign authorization. Some home health agencies report that they require certification that employee is free of communicable disease before returning to work.	3. Where the employee is required to obtain PHI, the ED or discharging physician can provide PHI directly to the patient, who then remits it to the employer. Since under this scenario the ED is releasing info to the patient, consent would not be required.	Same as item 144	Same as item 144								

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147	HIPAA: Access/Disclosure Standard	2 - Attending physician writes script or note clearing employee to return to work. Information provided may include diagnosis, but usually only certifies that employee is able to return to work. If there was communicable disease, physician may need to certify that employee is free of communicable disease if employee does direct patient care.	Barrier because employers are not sure how to determine whether information comes from a valid health provider.	1. Since this is not an emergent situation, interoperability is not critical under this scenario. Upon discharge for the ED, the processing agent can merely provide the patient with a note certifying ability to return to work, especially where communicable disease or public health issues are not present.	Same as item 144	Same as item 144								
10	HIPAA: BA Agreement Standard	One state agency would be designated as lead agency by the Governor's office, and that agency would enter into a business agreement with the university, which would include agreements about data exchange, use and storage.	Barrier to assure that business agreements take into account relevant law and protect privacy of PHI.	1. It is unclear what barrier was meant to be expressed in the BP. One possible solution may involve additional/better education about HIPAA on business associate (BA) contracting, trading partner agreements and what defines a BA. Perhaps better education would facilitate the process of establishing such contracts. However, there is no solution to obtaining a BA contract where one is required under HIPAA.										

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34	HIPAA: BA Agreement Standard	7 - If information is not needed immediately, ED physician contacts medical records department at other hospital. Will be asked name, department, and license number by staff. Sometimes sending hospital will require a form verifying identity to be completed, signed, and faxed. Information will be received by fax hours later.	Barrier because of need for procedures to verify identity and maintain security of fax.	4. Creating standards related to fax communications . Also, educating stakeholders on HIPAA's TPO (Treatment, Payment and Health Care Operations) clause for disclosures.	While HIPAA allows the release of information without patient authorization for treatment, payment and operations, states may have more restrictive requirements related to the disclosure of PHI. For example, in New Jersey, hospital licensing regulations at N.J.A.C. 8:43G-4.1(a)(21) prohibit the sharing of PHI without patient authorization unless it is during a patient transfer or required by law. May need to adopt national standards related to disclosure of PHI that preempt states' laws. Alternatively, may need to adopt law in NJ that expressly requires providers to freely share PHI with other providers unless an exception exists.	Assumptions: 1. That our goal is to create a standard policy/procedure (P/P) for use at least in the state of New Jersey, to facilitate uniform practice and understanding regarding the disclosure of PHI between providers. 2. Adoption of new standard policies and procedures by providers will depend on the perceived risk of violating disclosure laws. For example, following the adoption of HIPAA privacy rules, some organizations implemented p/p that appear to be more stringent than those necessarily required as a means of ensuring the provider is protected from liability. 3. Providers that spent a great deal of time and resources developing HIPAA-compliant p/p may be reluctant to adopt new p/p without a mandate or other incentive.	The New Jersey DHSS, DOBI or Board of Medical Examiners may head project team dedicated to developing standard p/p related to use of sharing PHI among treating providers. Participants should include representation from hospitals, physicians, medical records staff and emergency department nurses and physicians.							
50	*HIPAA: BA Standard*	4 - Psychiatrist may make short handwritten notes in patient record. Most facilities have a form to fill out for consulting specialists which is sent by mail or fax to facility medical director and a copy is placed in patient file. Larger facilities may have on-site transcription service for consulting specialist to use.	Technical barrier due to need to combine information from different sources. Staff are used to paper files and need training in electronic systems.	2. Standard Business Associate Agreements need to be developed. Also, educating stakeholders on HIPAA's TPO (Treatment, Payment and Health Care Operations) clause for disclosures.										

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95	*HIPAA: BA Standard*	1 - Provider sends specimen to lab for testing; additional cases might go to state lab.	Technical barrier due to need for secure transmission.	2. Creating standard Business Associate Agreements. Also, educating stakeholders on HIPAA's TPO clause for disclosures "Treatment, Payment and Health Care Operations". Also a minimum encryption mechanism needs to be identified.										
135	HIPAA: BA Standard	1 - Company has business agreement with current PBM to process claims. An outside plan has a specific amendment detailing who at company is the group plan administrator and can receive information about company's claim experience. Legitimate and appropriate purposes for exchanging information are detailed.	Barrier because proper business agreements must be in place.	1. Establish and require adherence to business association agreements.	Development of annual compliance form to be sent to Department of Health regarding Business Associate Agreements. All covered entities would need to report their existing BAA's in place, and identify any missing BAA's.	1) Department of Health would have authority to enforce sanctions against organizations currently not in compliance.	1) Task force selection of state health officials, law enforcement, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to agree to BAA compliance process..	1) Development of statewide BAA compliance process, including electronic tutorials on state website. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations including 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process.

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136	HIPAA: BA Standard	2 - Current PBM asks for group plan administrator to specify the information they want, preferably in writing on company letterhead. Request is reviewed with Chief Privacy Officer to determine whether it is permissible. Information provided is aggregated as much as possible and personal identifiers are removed to the extent possible. Some PBMs would ask the company to sign a hold harmless agreement.	Barrier because decision must be made as to what information will be provided and whether the proper agreements are in place and are being followed.	1. Where a business associate agreement (BA) exists, the exchange of pharmacy PHI should be based on the minimum necessary rule. Such a BA would necessarily include permissible release of types of medications, costs and costly per capita, dosages, longevity, etc, all such data should be aggregated, with deducted information on individual healthcare plan members/insureds.	Development of statewide Business Associate Agreement. All covered entities would need to replace existing BAA's with mandatory form.	1) Department of Health would have authority to enforce sanctions against organizations currently not in compliance.	1) Task force selection of state health officials, law enforcement, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to agree to BAA development process..	1) Development of statewide BAA development process, including electronic tutorials on state website. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations including 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take two years total, 3 months for initial work, 3 months for comment period, 18 months for modifications, implementation and switching to new form. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process.
137	*HIPAA: BA Standard*	2 - Current PBM asks for group plan administrator to specify the information they want, preferably in writing on company letterhead. Request is reviewed with Chief Privacy Officer to determine whether it is permissible. Information provided is aggregated as much as possible and personal identifiers are removed to the extent possible. Some PBMs would ask the company to sign a hold harmless agreement.	Barrier because decision must be made as to what information will be provided and whether the proper agreements are in place and are being followed.	2. BA under solution above would require confidentiality agreements, as well as notice that any personal information that was mistakenly exchanged must be reported to the payor and returned or destroyed.	Confidentiality agreements would be included in the statewide BAA process described above.									

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138	*HIPAA: BA Standard*	2 - Current PBM asks for group plan administrator to specify the information they want, preferably in writing on company letterhead. Request is reviewed with Chief Privacy Officer to determine whether it is permissible. Information provided is aggregated as much as possible and personal identifiers are removed to the extent possible. Some PBMs would ask the company to sign a hold harmless agreement.	Barrier because decision must be made as to what information will be provided and whether the proper agreements are in place and are being followed.	3. Where a BA is not in effect, one should be established.	Described above in BAA verification process.									
139	*HIPAA: BA Standard*	2 - Current PBM asks for group plan administrator to specify the information they want, preferably in writing on company letterhead. Request is reviewed with Chief Privacy Officer to determine whether it is permissible. Information provided is aggregated as much as possible and personal identifiers are removed to the extent possible. Some PBMs would ask the company to sign a hold harmless agreement.	Barrier because decision must be made as to what information will be provided and whether the proper agreements are in place and are being followed.	4. BA's should be standardized and enforceable.	Described above in BAA development process.									

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130	HIPAA: BA Standard	2 - Business associate agreements are in place between some providers and payers to permit sharing of data. Patients are notified of this in Joint Notice of Privacy Practices.	Need to have appropriate business agreements in place and notice of privacy practices to patients. Otherwise, PHI will not be exchanged without concerns of violating those rights.	1. There should be some type of user access agreement that would delineate authorized uses, recipient use rights, provider obligations, technical requirements and mutual security assurances. However, inasmuch as it does not appear that the parties in this scenario are "business associates" as defined by HIPAA, the Payer in this scenario would NOT require that particular type of contract for this scenario. (45 CFR 160.103.) This statute could be amended to include this type of exchange under business associate agreements.	Implementation of 'user access agreement', and modification to 45 CFR 160.103 as necessary.	1) 'User access' exchange of data would need to follow HIPAA regulations for encryption.	1) For standard agreement development, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard. Appropriate state parties as needed for review and proper modification of state law.	1) Development of statewide 'user access form', to be used between medical providers, in both paper and electronic formats. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process, having covered entities use newer technologies in place of existing practices.
1	HIPAA: Release, Consent & Authorization Standard	1 - ER staff attempts to determine whether patient is capable of informed consent & patient will sign authorization if capable. If patient is not capable, attending physician decides if situation is an emergency and whether to request information based on need for treatment without patient consent.	ER staff may confuse consent and authorization for treatment with consent to share PHI.	1. This scenario appears to be referring more to an issue of consent to treat than to an issue of releasing PHI. However, if the treating physician needed PHI for treatment, he/she would not need a consent or n authorization from the patient because it would be for Treatment, Payment and/or Healthcare Operations (TPO). Staff need to be properly educated.										

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2	HIPAA: Release, Consent & Authorization Standard	6 - If law enforcement do not suspect intoxication, ED staff would not provide any test results to police.	Confusion about what information can be provided; concerns about hospital liability.	1. Hospital must follow its authorization and consent policies and procedures which the patient must be made aware of. Under HIPAA, providers may disclose PHI to law enforcement as required by law and/or pursuant to a court order, warrant, subpoena, or summons Disclosure also may be made to comply with an administrative request, including administrative summons, subpoenas and other processes. If the law enforcement request is not accompanied by any of these processes, or a provider is not required to disclose it by law, only limited information may be shared without patient authorization.	Law enforcement shall specifically request test results to determine if a patient is impaired. If the test is not required by law, then law enforcement must obtain a warrant or other process to require the administration of the test and disclosure of its results	Our goal is to implement standard policies and procedures related to law enforcement requests for PHI. In addition, an analysis of HIPAA and NJ law with respect to providers' obligations and responsibilities in complying with law enforcement requests can assist in developing standard policies and procedures for hospitals and other providers.	Collaboration between law enforcement and the provider industry is necessary. Participation in a workgroup to develop standards for both law enforcement and providers could include the state Bar, county prosecutors, police associations, hospital associations, medical society.	To develop standard policies and procedures related to law enforcement requests for PHI and healthcare providers' compliance with the requests, and under what circumstances.						

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3	HIPAA: Release, Consent & Authorization Standard	6 - If law enforcement do not suspect intoxication, ED staff would not provide any test results to police.	Confusion about what information can be provided; concerns about hospital liability.	2. Law Enforcement is not privy to this information if the hospital is aware unless the patient has given authorization to share or the patient might be placed or was involved in some type of danger/situation that places others in danger then the hospital/physician has a choice to make whether or not to disclose this information. Providers may disclose PHI to law enforcement in accordance with the law or pursuant to a subpoena or other order, as noted above. If these conditions are not met, providers may supply certain limited information to law enforcement the purpose of identification and location of a suspect, missing person, material witness. Disclosures may also be made about an individual who is or may be a victim of crime.	Providers may disclose PHI to law enforcement in accordance with the law or pursuant to a subpoena or other order, as noted above. If these conditions are not met, providers may supply certain limited information to law enforcement the purpose of identification and location of a suspect, missing person, material witness. Disclosures may also be made about an individual who is or may be a victim of crime. 2. Law Enforcement is not privy to this information if the hospital is aware unless the patient has given authorization to share or the patient might be placed or was involved in some type of danger/situation that places others in danger then the hospital/physician has a choice to make whether or not to disclose this information.								
4	HIPAA: Release, Consent & Authorization Standard	8 - If patient is not able to give consent, daughter would be asked to give "administrative consent" and sign any necessary forms to request information.	Hospital Emergency Department staff realize administrative consent does not exist in law but is necessary in emergency situations.	1. ED Staff must be educated on when an authorization is or isn't required for release of PHI. In this case, except for psychotherapy notes, the staff does not need the daughter's consent or authorization to disclose PHI because the PHI is for Treatment, Payment and/or Healthcare Operations (TPO).										

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18	HIPAA: Release, Consent & Authorization Standard	1 - Principal Investigator decides whether the new study is sufficiently different to require a new IRB protocol or whether to file an amendment to original protocol. May need revision to, or new, informed consent documents. IRB must meet and approve protocol.	Barrier due to need to protect human subjects of research.	1. ** Development of standard consent form and/or HIPAA authorization form.										
19	HIPAA: Release, Consent & Authorization Standard	2 - Principal investigator gives additional researchers named in protocol permission to access portion of secure server where study data is kept. PI authorizes and computing manager executes appropriate permission level.	Technical barrier due to need for appropriate security policy and procedures in place.	1. ** Development of standard consent form.and/or HIPAA authorization form.										

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20	HIPAA: Release, Consent & Authorization Standard	2 - Attending doctor asks patient if it is okay to share information with parents.	Physician does not always have patient sign release, but assumes verbal consent is okay.	*** Unless the relevant NJ statute is repealed or significantly modified, it will continue to serve as a barrier with respect to a disclosure of data to law enforcement in this context. Perhaps additional/better education of law enforcement-of the legal requirements that must be met before a disclosure can occur absent a HIPAA authorization might reduce the frequency of experiencing this barrier. In addition, where others have been reasonably determined to be involved in the care or payment for the care of an individual, a disclosure to those others is permissible (see above discussion) and law enforcement might then seek to obtain the records from them.	Current state law protects against inappropriate disclosures to law enforcement. Current statute needs to be included in education of health professionals. Also, such educational efforts should be extended to law enforcement/EMS.	Under HIPAA, there is no need for an authorization or consent to disclose health data to parents if involved in their child's care or payment for his care. Likewise, HIPAA permits disclosure to law enforcement in many circumstances of criminal investigation. However, NJ law limits the circumstances where disclosures are permitted to law enforcement. See N.J.S.A. 26:2B-16 and 17. Hospitals may not disclose medical tests results or other information to law enforcement if no prior request for the specific test was made by police under. Absent such a request, a proper authorization, subpoena or court order must be obtained prior to disclosing test results under N.J.S.A. 26:2B-16 and 17.	NJ-HISPC should develop education materials for health providers and institutions regarding what law enforcement can and cannot request. A distillate of this can be prepared for law enforcement agencies that detail what can be requested of health providers. Identification of state and federal law authorities (local and State Police, FBI, ATF, DEA) and collaboration with NJ-HISPC would be essential.	Project Scope: Development of NJ relevant HISPC algorithm for law enforcement to use with providers. Tasks required: 1) Work with law enforcement stakeholders to define the most common scenarios where they need access to PHI for investigational/enforcement reasons. 2) Define environments where PHI would need to be used 3) Develop relevant tools (PDA program, pocket cards etc) for law enforcement officials and officers.	Project Timeline: 1) Jun-Dec 07- identify and meetings between NJ-HISPC and law enforcement reps. 2) Dec0-7 Jun-08 development of materials for law enforcement officials and provider. 3) July 08- roll out materials 4)Dec 08 assessment of law enforcement and providers	Qualitative analysis of surveys given to representative cross sections of law enforcement and provider community	Using an health data information exchange would be facilitate impact assessment through measurement of transactional data when law enforcement is given appropriate access and authentication.	Feasibility- educational intervention often is very effective and can minimize/eliminate difficult decisions when providers and law enforcement interface in order to exchange PHI.	NJ only w/Fed	Importance- moderate 2) ease of accomplishment moderate, 3) Order to be completed- one of the last educational interventions when corpus of material is generated.

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23	HIPAA: Release, Consent & Authorization Standard	4 - An associates agreement is required to share any PHI with non-medical employers. Random employers of patients in ED would not likely have such agreements with hospital therefore no PHI would be released directly to employer. Return to work documents are given directly to patient only. ED would never deal with employer human resources departments or email document.	Not seen as a barrier since employers seldom require PHI, only certification of ability to return to work. Only issue arises when there are limitations of ability to work.	Since it seems there may be some misunderstanding about the need for a contract in this BP, perhaps additional education about the HIPAA rules would help here. In addition, education of the employer group making this request - of the need to submit a HIPAA-valid authorization before such a request can really even be entertained - may also help produce the frequency of experiencing this barrier. This solution will require that a direct contact(s) at the employer or vendor be designated to receive the information. This would be similar to a plan designee list.	A HIPAA - valid authorization must be obtained from the patient and then HIPAA minimum necessary rules should be followed when disclosing to the individual employer's HR or otherwise.	Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. Employers may have a checklist of the type of information required for an employee to return to work, but PHI would not be disclosed without completion of the provider-specific authorization. The employer's checklist should include the name and contact information of the person designated to receive this information, as an authorization must list the individual authorized to receive PHI pursuant to the form. More information/education for employers must be distributed to avoid delays in completing authorizations to allow employees to return to work.	Business and industry representatives, human resources and other employer-related groups must engage legal counsel and/or provider representatives to conduct education on the limitations of an employers' access to employee medical information.	To conduct education sessions for the employer community about state and federal medical privacy laws, and how the requirements impact an employer's access to employee medical information. Educate on the use of an authorization form indicating the patient permits the provider to supply certain PHI to employer.					

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24	HIPAA: Release, Consent & Authorization Standard	6 - Most employers stated that a note on letterhead or a prescription pad from the doctor is sufficient for four days out of work. A few employers require the doctor's license number on the form. However, a small number of companies said that their short-term disability starts after three days and that they would require a disability claim form from the employee and physician.	Barrier if disability forms need to be filed.	Additional/better education about HIPAA regarding the disclosure rules and the need for a valid authorization before a disclosure can be made may help reduce the frequency of experiencing this barrier. In addition, a "return-to-work checklist" and a standard form "out on disability" note could be created and used by doctors. It could have the most-needed fields, including a return-to-work date, practice and individual provider name, and the NPI for the individual provider. The patient is responsible to know and advise the provider what is required for his/her return to work, and how their disability coverage works. Education could also occur through a simple, user-friendly pamphlet, made for doctor' office use as well as employers (distributed through HR), that describes these concepts and the legal requirements.	A HIPAA - valid authorization must be obtained from the patient and then HIPAA minimum necessary rules should be followed when disclosing to the individual employer's HR or otherwise.	Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. Employers may have a checklist of the type of information required for an employee to return to work, but PHI would not be disclosed without completion of the provider-specific authorization. The employer's checklist should include the name and contact information of the person designated to receive this information, as an authorization must list the individual authorized to receive PHI pursuant to the form. More information/education for employers must be distributed to avoid delays in completing authorizations to allow employees to return to work.	Business and industry representatives, human resources and other employer-related groups must engage legal counsel and/or provider representatives to conduct education on the limitations of an employers' access to employee medical information.	To conduct education sessions for the employer community about state and federal medical privacy laws, and how the requirements impact an employer's access to employee medical information. Educate on the use of an authorization form indicating the patient permits the provider to supply certain PHI to employer.					

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25	HIPAA: Release, Consent & Authorization Standard	4 - Treatment facility will not release any information to shelter about treatment, since shelter is not likely to be a covered entity. Some units will not acknowledge that patient is at facility. However, a pay phone is provided for patients, which is not answered by staff. If facility calls that phone and it is answered by a resident, the call can be taken by the patient.	Barrier because there is no need to share information for treatment purposes and no other purpose is recognized as legitimate.	Additional/better education about HIPAA rules is needed. That would help eliminate this barrier, since it reflects a more conservative approach than HIPAA requires. Some providers may still decide to take a more conservative approach, for liability risk reasons. In those instances, shelter staff requesting information on a patient would be required to obtain and submit a valid authorization signed by the patient. The specific designee must be documented on each of the HIPAA authorization forms. In those cases, it might be advisable for the provider to engage in dialogue with local shelters and other, similar seekers of patient information, to advise them in advance of their disclosure practices so they will be more apt to submit the needed documentation when such circumstances arise.	HIPAA permits disclosure of minimum necessary information for TPO and certain other (public good-type) purposes, without the need for a HIPAA authorization and so long as a reasonable verification procedure is employed The second part of this scenario relies on the fact that a proper HIPAA verification procedure will be performed. If one is performed the disclosure would only be to the patient or a personal representative and, therefore, would be permissible under HIPAA.	Assumption: That shelters do not need to know the medical condition of their residents. This is a fallacy since both psychiatric conditions as well as infectious disease have an environmental impact on shelters. Decision: Treatment facilities should have a provision for release of different kinds of information to shelter facilities.	NJ HISPC should reach out to groups that run shelters (like Catholic Charities) to assess the information needs of the shelter. Information about the transactions with health care providers and facilities should be studied.	Project Scope- Determine the privacy and security variations amongst the indigent, transient/homeless population. Tasks required- 1) Identify the differences in health information between residential and transient individuals. 2- What are the information needs of the shelter about its residents 3- How shelters can work with facilities to improve health information transactions.	Project Timeline-- December 07-Jun08- meet with shelters and facility representatives (NJHA and Mental Health Society of NJ) to determine health information exchange between shelters and facilities. Costs would be for materials developed as a result of these meetings and the results of concurrent NJ HISPC education projects	Qualitative analysis of surveys given to shelters, residents and facilities during the evaluation phase of an implemented project. Determining the implementation phase is difficult since this project has several contingencies based on other NJ HISPC HIPAA education projects	The means of tracking through surveys can give a qualitative idea on how effective interventions are. If a Health Data Information Exchange is implemented, then health data queries amongst shelters and facilities can be gauged	Feasibility:- Very feasible given that the other HIPAA education efforts are completed (on time). Barriers- getting facilities to work with shelters as facilities are wary of giving an impression of promoting charity care.	Single state-NJ	Importance- moderate 2) ease of accomplishment moderate, 3) Order to be completed- one of the last educational interventions when corpus of material is generated.

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85	HIPAA: Release, Consent & Authorization Standard	1 - IT meets with Marketing to develop a query to extract aggregate information from patient records for birth outcomes. Query is tested on artificial data.	Technical barrier because of need for standard procedures and access by authorized personnel only.	1. HIPAA is pretty clear here- should be adhered to. Patient consent should be obtained prior to any marketing done. Creating new business should not be at the cost of compromising patient's PHI without consent.	Facilities must have policies and procedures that clearly state when disclosures of PHi, including treatment/medical information, such as relating to birth outcomes, can be made available for various facility purposes with and without a (sometimes) NJ-required consent, a HIPAA-valid authorization, or other "release", including for marketing purposes, as well as what constitutes "marketing" such as gives rise to the need to obtain an authorization under HIPAA before use or disclosure of PHI may occur. Moreover, if HIPAA-defined "marketing" is contemplated, facility staff must fully understand how and when an authorization must be obtained such as will permit such activities, as well as be provided with standard authorization language for that purpose (although that is not the subject of this solution). Furthermore, better understanding is needed around the applicability of the HIPAA minimum necessary rule for TPO (esp. for treatment). Staff must then be trained to know when appropriate requirements have been met, or not, such as will permit use and disclosure for commonplace activities contemplated by the facility, including "marketing-type" activities that may actually not constitute "marketing" as defined by HIPAA. This will help to mitigate any uncertainly about when disclosures are permitted for such TPO activities,	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment); 2. that facility providers, IT staff and/or others involved in activities contemplated in the BP as "marketing" (whether or not such activities meet the HIPAA definition of "marketing") should participate in this P/P development, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing each P/P, which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make use and disclosures of PHI in the contexts contemplated; 5. that this education	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible use and disclosure of data for TPO purposes (without authorization), as distinguished from circumstances defined as "marketing" under HIPAA, as well as proper application of HIPAA's minimum necessary rule. Each P/P planning team must engage the staff of several facilities/institutions to design and implement each set of P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. Each P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ hospital society, as well as facility IT staff and others who perform marketing-type functions, to assist in	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ hospital facility community, regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of applying the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment). The project must include development of (and then be succeeded by education and implementation of) 2 sets of Ps/Ps that address and resolve open issues relating to disclosure of PHI in an institutional setting for various situations, including those that some may mistakenly characterized as "marketing" under HIPAA. The standard P/P developed in the first set must clearly document when disclosure is permissible absent a (consent or) HIPAA-valid authorization, and should include examples; in the second set, it should likewise include helpful examples -- of how the minimum necessary rule would be applied in typical facility use/disclosure situations. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to which marketing-type activities are appropriately characterized as TPO v. "marketing" defined by HIPAA may take longest, although determination of which elements of data are appropriately minimum necessary to accomplish various purposes (including marketing under HIPAA) may also prove challenging, timewise, as may development of standard guidance on what should be included in a HIPAA-valid authorization when one is needed, or in either a consent (which is sometimes required by NJ State law) or a release (which, presumably, is obtained for risk liability reasons v. legal requirements) although that aspect is beyond the scope of this solution. Over an 18-	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Team leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Team leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated, ideally prior to adoption.	Once developed, the standard P/P for each of a) how HIPAA differentiates and treats activities performed by a facility that are TPO v. what HIPAA defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what must be included in one (when one is needed), or in either a consent (which is sometimes required by NJ State law) or a release (which, presumably, is obtained for risk liability reasons v. legal requirements), which form standardization is beyond the scope of this solution; as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) will hopefully be adopted by the facility community. Once adopted and implemented by a majority of facilities, their use of each P/P may change their current	1) The creation of standard P/P documents for a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) is feasible, depending on the ability of the facility reps and others to agree on how to characterize regularly encountered circumstances and activities (such as for TPO v. HIPAA-defined "marketing"); however, their adoption as a statewide standard will also depend on their acceptability to/adoptability by the institutional community not represented on each P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Team Leader and/or team members; 3. Consistent and continued	Could be multi-, but more likely single-State	1) Low, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate cooperatively throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.
86	HIPAA: Release, Consent & Authorization Standard	1 - IT meets with Marketing to develop a query to extract aggregate information from patient records for birth outcomes. Query is tested on artificial data.	Technical barrier because of need for standard procedures and access by authorized personnel only.	2. The key here is what the information is being used for and this may relate to education. If information is being only used for internal analysis then I don't see any reason for waiver. If marketing department want to utilize the information outside the walls of the organization then a standard waiver for patients needs to be created.	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85	see response to #85; project plan is identical to that for #85

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89	HIPAA: Release, Consent & Authorization Standard	2 - Hospital Marketing Department can obtain data to inform individuals about the new pediatric wing, to solicit registrations for parenting class, and to request donations. Data provided must be minimum necessary for business purpose. Hospital policy is not to sell patient data to any third party.	Technical barrier because of need for standard procedures and access by authorized personnel only.	2. Standard patient waiver is required and patients must be flagged in system as accepting or not accepting. This is clearly utilizing patient information in order to market to them directly.	see response to #88; project plan is identical to that for #88. In addition, for those circumstances that require (consent or) HIPAA-valid authorization, such as for activities defined as "marketing" under HIPAA, development of a database or other method to maintain data on those patients (members) from whom an authorization was not obtained is essential, so the facility does not violate HIPAA with respect to its activities and those patients' PHI. Development of a model database or other method will be beneficial to those facilities that wish to engage in those activities and need a blueprint or other guidance to build such a database/method. Any such project must necessarily include training on use of that database/method, once implemented.	see response to #88; project plan is identical to that for #88. In addition, it is assumed that: 1) any facility wishing to implement a database/method to maintain data on those patients (members) from whom an authorization was not obtained must be engaged in activities for which said database is needed; 2) any facility using the model database accepts the interpretation taken by the post-HISPC legal team of the need (or not) for a HIPAA-valid authorization upon which basis the model was built; 3) any facility implementing a database has the information system and staff sufficient to properly maintain it; 4) any facility staff who will be involved in activities relevant to the database's purpose will be properly trained on its use.	see response to #88; project plan is identical to that for #88. In addition, it will be critical to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained) that staff members with IT skills and knowledge be included on the planning team.	see response to #88; project plan is identical to that for #88. In addition, with respect to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained), tasks involving the writing of business requirements for proper database development must occur prior to its building, to ensure that it will function fully for its intended purpose.	see response to #88; project plan is identical to that for #88. In addition, with respect to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained), additional costs will be involved to develop, build and test the database, including possibly other IT resources. If this project involves the building of such a model database, must necessarily contemplate sufficient time to properly develop, build and test said database before it can be presented for statewide use.	see response to #88; project plan is identical to that for #88. In addition, with respect to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained), tracking and measuring project progress must necessarily include status updates throughout the development, building and testing of the database.	see response to #88; project plan is identical to that for #88. In addition, with respect to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained), stakeholders who engage in activities for which the model database is contemplated will now have a blueprint from which to build its own such database, thus helping to ensure its compliance with HIPAA's disclosure (subject to authorization) rules.	see response to #88; project plan is identical to that for #88. In addition, with respect to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained), feasibility will depend on the ability of the team to obtain and retain sufficient IT-knowledgeable resources as team members, as well as the cooperation of those members in developing uniform format, content, functionality, etc. for that database.	see response to #88; project plan is identical to that for #88.	see response to #88; project plan is identical to that for #88. In addition, with respect to that aspect of this project involving development and implementation of a model database (to maintain data on those patients (members) from whom an authorization was not obtained), there will be additional (and possibly significant) challenges to that aspect.
99	HIPAA: Release, Consent & Authorization Standard	5 - Local health department provides case management to family of child with elevated blood lead levels.	Seen as practical barrier since all information cannot be provided electronically and personal contact is required.	1. Families/patient's affected would need contact with case/manager or provider and give authorization for a) treatment and b) sharing of PHI with entities being specified.	Culturally sensitive information packets should be developed to education families on lead poisoning. Portable media, like a DVD can be sent with basic forms educating patients to have contact with a case manager and provider.	Assumption- Family is of legal resident status (citizen, green card holder, permanent or temporary worker status). Undocumented aliens may not come forward even with such intervention.	Project ownership- NJ Dept of Health or Dept of Human services. Epidemiology group responsible for intervention- NJ HISPC may work as consulting body to clarify HIPAA rules	Project scope- Identify current materials and complement with portable media and necessary tracking forms. Families at risk that don't voluntarily follow up has a visit from a case-worker.	Timeline- to be determined by NJ Dept of Health or Dept of Human Services	Tracking- seeing if intervention increased the number of cases identified and treated but current epidemiological methods that state of NJ employs	Impact assessment- looking at an increase in lead testing/treatment in other ages (i.e. adolescents, adults and elderly)	Feasibility assessment- needs to be determined within State of NJ ability to do so within budgetary limits. Barriers include departmental and executive branch delays	NJ only	Importance- high 2) ease of accomplishment- difficult, order to be completed- as per NJ lead screening programs priorities

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102	HIPAA: Release, Consent & Authorization Standard	4 - Out-of-state provider policy determines what particular patient information to release to the requesting physician (e.g. mental health status). In NJ, hospital may require patient to sign its own release form and return by fax before releasing any PHI. Unless patient has signed a specific release referencing Federal disclosure law, no mental health information will be provided, except to PACT team or intensive case manager, if there is a signed affiliation agreement.	Hospital may be unclear about impact of laws in another state; verification may be perceived as too onerous. Hospitals also appear to be confused about whether they need to provide minimum necessary information.	1. State mandate on type of information shared and type of authentication needed for interstate health transactions.	While HIPAA allows the release of information without patient authorization for treatment, payment and operations, states may have more restrictive requirements related to the disclosure of PHI. For example, in New Jersey, hospital licensing regulations at N.J.A.C. 8:43G-4.1(a)(21) prohibit the sharing of PHI without patient authorization unless it is during a patient transfer or required by law. May need to adopt national standards related to disclosure of PHI that preempt states' laws. Alternatively, confirm HIPAA's assumption that one provider's reliance on another provider's authorization as valid will be deemed a compliant practice under HIPAA and NJ law. In addition, a policy verifying that treating providers do not need to limit PHI to the minimum necessary will help ensure that information is efficiently shared.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.	Implementation of a national policy or amendment to HIPAA rules relating to providers' sharing of PHI would require action on the part of national standard setting organizations or Department of Health and Human Services.							
106	HIPAA: Release, Consent & Authorization Standard	3 - All participants in an approved study must sign informed consent before participating on form approved by IRB at beginning of study or when substantial changes are made in protocol.	Barrier due to need to protect human subjects of research.	1. This cannot be significantly changed in content, but web portal usage may streamline process.										

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107	HIPAA: Release, Consent & Authorization Standard	6 - All test results go to 19 year old, not parents. Parents do not have automatic rights to medical information for their children over 14.	State law for sharing medical test and treatment information.	1. Having a comprehensive consent signed by patients prior to receiving treatment. (NJHA believes this solution identified by the working group must be fleshed out. Did the working group envision a consent that would, similar to a Notice of Privacy Practices, indicate that the provider may choose to share PHI with family members and include a space for the patient to agree or object?)	Continue compliance with state laws related to age of majority, and HIPAA restrictions on sharing PHI without the patient's authorization or opportunity to agree or object. HIPAA allows providers to disclose PHI to a patient's family members, friend or other person identified by the patient, for the purpose of assisting in the patient's care and if the patient agrees (certain restrictions apply). However, the sharing of test results with the parents of an adult child isn't likely to be considered assisting in the care and treatment of the patient, so not likely to be permitted under HIPAA rules. In addition, states may have more restrictive requirements related to the disclosure of PHI. For example, in New Jersey, hospital licensing regulations at N.J.A.C. 8:43G-4.1(a)(21) prohibit the sharing of PHI without patient authorization unless it is during a patient transfer or required by law. Develop standard policies and procedures related to the sharing of information with parents, family and personal representatives. Develop fact sheet or pamphlet related to disclosure requirements that may be shared with the patient's friends and family. If the proposed solution of developing a standard consent for treatment is implemented, providers and patients must clearly understand the rights and responsibilities involved.	Standard policies implemented statewide would help educate parents, friends and families about what information they are entitled to, and under what situations, and would ensure that the same practices are encountered wherever the patient may be treated, allowing for consistency of the message.								

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113	HIPAA: Release, Consent & Authorization Standard	6 - If bioterrorism is suspected, FBI is notified. Information will be provided about location of incidents and reasons why it appears to be bioterrorism, along with all identifying information required for investigation.	This is a barrier because electronic transmission of health record will not provide all of the information needed for law enforcement investigation. Epidemiologist's findings are relevant. Commission of DHSS has latitude to inform other state entities in cases of emergency.	1. (NJHA does not agree with the proposed solution. HIPAA allows the use and disclosure of PHI for public health and health oversight activities- including investigations- without patient authorization. New Jersey regulations at N.J.A.C. 8:57-1.3 and 8:57-1.4 require reporting of specific diseases and/or infectious agents, including anthrax. Since it is required by law, patient consent or authorization is not required).	Federal investigators and the state's Department of Health and Senior Services have wide latitude in investigating criminal activity that poses a threat to public health. Providers may share PHI with law enforcement or agency officials without patient authorization or consent. Providers must comply with existing accounting of disclosure requirements and list any such public health/oversight disclosures.									
122	HIPAA: Release, Consent & Authorization Standard	6 - Because of difficulty of receiving information from substance abuse facilities, physician may ask patient to get his/her record and bring to office.	Seen as barrier because facility will not release information and doctor needs to know about all meds.	1. If patient is ambulatory and competent, he/she can always sign an authorization. However, if patient is unable to complete an authorization, disclosure is not prohibited since this situation constitutes information necessary for treatment. An interoperative solution is to create a RHIO that collects an exchanges this type of info with other health care provider/institutions as applicable and warranted. This accelerates the actual treatment process.	While NJ waits for a statewide RHIO or Health Information Data Exchange, a patient should be consented by either patient or patient's representative on admission to substance abuse facilities prior to admission to have medication information sent to providers participating in patients care.	Assumptions:- That providers do not have current information exchange relationships with substance abuse facilities. If previous relationship exist, this scenario may not apply	Project ownership- NJ HISPC in association with Mental Health Association of NJ and provider groups to develop a standard consent clause to be considered for use by substance abuse facilities	Clearly defined project scope- substance abuse facilities need to work out a protocol for sharing medication and substance abuse information with key providers- primary care physicians, neurologists, surgeons, dentists and psychologists. Tasks required 1) examination of current consent forms, 2) examination of current information exchange protocol with verification mechanism 3) Modify workflow based on needs of outside providers that is HIPAA and NJ statute compliant. 4) Implement solutions in educational program/toolkit form	1) Project timeline- Jun 07-Dec 07- assemble NJ HISPC members with representatives of substance abuse treatment centers and representatives from provider groups.Dec 07-Jun 08- identify workflow issues and recommend changes Jun 08-Dec 08- Changes incorporated into educational program and toolkits	Tracking and assessment- through qualitative surveys of providers and substance abuse facilities. These can be qualitatively analyzed for determining improvement in processes	Impact assessment- looking at survey results deployed repeatedly over time. When a health information data exchange is implemented- tracking realtime changes between substance abuse facilities and providers can be tracked.	Feasibility- while worthwhile, feasibility is proportionate to barriers encountered- Possible barriers are HIPAA misunderstanding by substance abuse facilities- they will need to be educated again	multistate	Importance- critical, Ease of accomplishment- difficult, Order to be completed- one of the first tasks by NJ HISPC in implementation program

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124	HIPAA: Release, Consent & Authorization Standard	5 - Separate business agreement with facility/network authorizes office staff of network physicians to access patient data through web portal. Out of network doctor's offices do not have access.	Need for business agreements and privacy policies and procedures.	1. Create cooperative at the electronic level, e.g., RHIO or patient-centric portal where the patient can give permission/access to the out-of-network provider. This would eliminate the need for specific BAA and would center around consent and authorization by the patient.	(NJHA believes this issue is more appropriately handled by security and interoperability; little related to privacy/access)									
127	HIPAA: Release, Consent & Authorization Standard	1 - Releasing entity in NJ must have signed authorization from patient or can release without authorization to physician directly involved in treatment. Will not release HIV status to Imaging Center.	Aids Assistance Act prohibits disclosure without prior written consent, except for personnel directly involved in diagnosis and treatment of the person	1. Since this scenario is non-emergent, the physician in state A should require a completed, patient authorization form that can be submitted to the other state facility via encrypted portal. Once the authorization has been received, the state B facility can then submit the radiology images and reports to state A.	National standards must be implemented that confirm a provider's reliance on another provider written authorization form is deemed compliant under HIPAA. Otherwise, facility B will likely request the patient to complete its form before releasing information, rather than releasing records pursuant to facility A's authorization form.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.	Implementation of a national policy or amendment to HIPAA rules relating to providers' sharing of PHI would require action on the part of national standard setting organizations or Department of Health and Human Services.							
128	HIPAA: Release, Consent & Authorization Standard	3 - Releasing clinic in NJ will fax or mail to doctor if patient requests or give records to patient to hand carry.	No consistent understanding of what request form should contain. Verification procedures are often seen as too onerous.	1. Implement national standards on consent/authorization for content and use. This should be done in conjunction with facility medical records staff and IT staff, under the premise that the authorization can be submitted electronically, along with the PHI. Use of encrypted portal would facilitate this process.	National standards must be implemented that confirm a provider's reliance on another provider written authorization form is deemed compliant under HIPAA. Otherwise, facility B will likely request the patient to complete its form before releasing information, rather than releasing records pursuant to facility A's authorization form.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.	Implementation of a national policy or amendment to HIPAA rules relating to providers' sharing of PHI would require action on the part of national standard setting organizations or Department of Health and Human Services.							

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133	HIPAA: Release, Consent & Authorization Standard	1 - Patient signs release allowing information exchange for treatment at time of admission.	No standard form for release. Treatment consent and consent to exchange PHI are confused by providers.	1. Education program regarding consent requirements and applicability of waivers should be a condition of retaining NPI in good standing. In this scenario, providing toxicology results to law enforcement would be considered legal. However, disclosure to the parents is not so clear, as this info (blood alcohol level) is potentially extraneous to the actual treatment that would ensue due to injuries sustained in the motor vehicle accident. This should be the subject of model laws and education.	Development of education process by Department of Health regarding consent. Education would be mandatory for all covered entities and related organizations (such as law enforcement) that are affected by HIPAA consent standards.	1) Department of Health would have authority to provide education to organizations currently not defined as covered entities.	1) Task force selection of state health officials, law enforcement, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to agree to consent process and develop education materials.	1) Development of statewide consent education process, including electronic tutorials on state website. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations including 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process.
140	HIPAA: Release, Consent & Authorization Standard	4 - Practice for patient authorization was either (1) Patient must sign an authorization which includes permission to solicit donations, meets HIPAA guidelines, and does not lead patient to believe that refusing will jeopardize care; or (2) Patient must notify Privacy Officer in writing that he/she does not want information used for fundraising.	Need for written policy and procedure and patient notification.	1. If patient agrees, patient must be required to sign an authorization which includes permission to solicit donations, meets HIPAA guidelines, and does not lead patient to believe that refusing will jeopardize care. The authorization should state all information that will be provided to the third party entity.	Standard statewide BAA form, as described above, would include proper authorization requirements.									

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142	HIPAA: Release, Consent & Authorization Standard	4 - Practice for patient authorization was either (1) Patient must sign an authorization which includes permission to solicit donations, meets HIPAA guidelines, and does not lead patient to believe that refusing will jeopardize care; or (2) Patient must notify Privacy Officer in writing that he/she does not want information used for fundraising.	Need for written policy and procedure and patient notification.	3. Authorizations to be processed by non-medical staff. Medical staff should not be made aware of the patient's decision to participate or to decline participation. This should be made clear in the authorization.	Process to support statewide BAA must include education for healthcare providers to check anhy authorization opt-outs requested by patient.									
143	HIPAA: Release, Consent & Authorization Standard	4 - Practice for patient authorization was either (1) Patient must sign an authorization which includes permission to solicit donations, meets HIPAA guidelines, and does not lead patient to believe that refusing will jeopardize care; or (2) Patient must notify Privacy Officer in writing that he/she does not want information used for fundraising.	Need for written policy and procedure and patient notification.	4. PHI that is in fact exchanged in accordance with the agreement is to be destroyed after the study has been completed.	Should be included as part of statewide BAA form.									

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144	HIPAA: Release, Consent & Authorization Standard	1 - Patient must sign an authorization permitting release of information to employer.	Barrier because patient must sign authorization. Some home health agencies report that they require certification that employee is free of communicable disease before returning to work.	1. In this scenario, the ED sends the entire EHR (containing diagnosis, meds and other private info) directly to the employer, necessitating an authorization, when in fact the employer may only need a certification that the employee is healthy enough to return to work (and thereby not necessarily requiring an authorization. ED could cease its practice of remitting the entirety of the record, as it may not always be necessary and therefore not subject to consent. Hospital releases only the information necessary to complete the employer's return-to-work form or verification. Hospital determines whether any PHI is necessary for completion of the return-to-work. If so, obtains authorization from patient. (NJHA disagrees with the solution proposed by the workgroup: hospital EDs do not release records - this is done by hospital medical record departments, in compliance with existing policies and procedures. In no instance would the entire ED or medical record be released to an employer.)	Hospital releases only the information necessary to complete the employer's return-to-work form or verification. Hospital determines whether any PHI is necessary for completion of the return-to-work. If so, obtains authorization from patient. (NJHA disagrees with the solution proposed by the workgroup: hospital EDs do not release records - this is done by hospital medical record departments, in compliance with existing policies and procedures. In no instance would the entire ED or medical record be released to an employer.) In this scenario, the ED sends the entire EHR (containing diagnosis, meds and other private info) directly to the employer, necessitating an authorization, when in fact the employer may only need a certification that the employee is healthy enough to return to work (and thereby not necessarily requiring an authorization. ED could cease its practice of remitting the entirety of the record, as it may not always be necessary and therefore not subject to consent.	Hospital releases only the information necessary to complete the employer's return-to-work form or verification. Hospital determines whether any PHI is necessary for completion of the return-to-work. If so, obtains authorization from patient. Employers may have a checklist of the type of information required for an employee to return to work, but PHI would not be disclosed without completion of the provider-specific authorization. The employer's checklist should include the name and contact information of the person designated to receive this information, as an authorization must list the individual authorized to receive PHI pursuant to the form.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.						

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79	HIPAA: Release, Consent/Authorization Standard	2 - IT provides hospital Marketing Department only names, addresses, telephone numbers and dates of service. Privacy and Security Officer meets with quality assurance personnel to determine the minimum amount of information necessary to meet the business purpose of analyzing patient encounters.	Technical barrier because of need for standard procedures and access by authorized personnel only.	1. When patient seeks treatment, get a release of certain types of information and state it is for marketing purposes and have patient either reserve/waive rights.	Facilities must have policies and procedures that clearly state when disclosures of PHi, including demographic and treatment/medical information, can be made available for various facility purpose, including marketing, as well as what constitutes "marketing" such as gives rise to the need to obtain an authorization under HIPAA before use or disclosure of PHI may occur. Moreover, if HIPAA-defined "marketing" is contemplated, facility staff must fully understand how and when an authorization must be obtained such as will permit such activities, as well as be provided with standard authorization language for that purpose (although that is not the subject of this solution). Furthermore, better understanding is needed around the applicability of the HIPAA minimum necessary rule for TPO (esp. treatment) -- including when a consent must (and need not) be obtained (per NJ State law), and when a HIPAA-valid authorization is required. Staff must then be trained to know when appropriate requirements have been met, or not, such as will permit use and disclosure for commonplace activities contemplated by the facility. This will help to mitigate any uncertainly about when disclosures are permitted for such TPO activities, as well as the stricter requirements around what HIPAA defines as "marketing."	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment); 2. that facility providers, IT staff and/or others involved in activities contemplated in the BP as "marketing" (whether or not such activities meet the HIPAA definition of "marketing") should participate in this P/P development, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing each P/P, which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make use and disclosures of PHI in the contexts contemplated; 5. that this education	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible use and disclosure of data for TPO purposes (without authorization), as distinguished from circumstances defined as "marketing" under HIPAA. Each P/P planning team must engage the staff of several facilities/institutions to design and implement each set of P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. Each P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ hospital society, as well as facility IT and other staff who perform marketing-type functions, to assist in facilitating uniform development and adoption	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ hospital facility community, regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment). The project must include education and implementation of 2 Ps/Ps that address and resolve open issues relating to disclosure of PHI in an institutional setting for various commonplace situations, including those that some may be mistakenly characterizing as "marketing" under HIPAA. The standard P/P developed in the first instance must clearly document when disclosure is permissible absent a consent or HIPAA-valid authorization; in the second, it should include helpful examples of how the minimum necessary would be applied in facility settings. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify current use/disclosure practices and issues; 3. Identify and document when a patient authorization must be obtained	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to which marketing-type activities are appropriately characterized as TPO v. "marketing" defined by HIPAA may take longest, although determination of which elements of data are appropriately minimum necessary to accomplish various purposes (including marketing under HIPAA) may also prove challenging, timewise. Over an 18-24 month period it is expected that the following milestones could be met: assemble appropriate hospital/other-facility staff, including appropriate IT and "marketing" department staff, as well as SME for each P/P planning team, choose team leader, develop timeline for work and specific work assignments (within team), collect relevant data on	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Team leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Team leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents for each P/P subject to be provided to HISPC and disseminated, ideally prior to adoption.	Once developed, the standard P/P for each of a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) will hopefully be adopted by the facility community. Once adopted and implemented by a majority of facilities, their use of each P/P may change their current approach and should promote uniformity with respect to this business practice.	1) The creation of standard P/P documents for a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) is somewhat feasible, depending on the ability of the industry to agree on its interpretation of the characterization of such activities; however, their adoption as a statewide standard will also depend on their acceptability to/adoptability by the institutional community not represented on each P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Team Leader and/or team members; 3. Consistent and continued availability and participation of planning team members and	Could be multi-, but more likely single-State	1) Low, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate cooperatively throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.

ID	Work Group	Business Practice Long Description	Impact of Barrier	Solution	Summary of effective practice(s) to be instituted or barrier(s) to be mitigated or eliminated by the plan	Planning assumptions and decisions	Project ownership and responsibilities (identify specific individual and/or organization names and titles)	1) Clearly defined project scope; 2) Identification of tasks required, organized by work breakdown structure	1) Project timeline and milestones; 2) Projected cost and resources required	Means for tracking, measuring and reporting progress	Impact assessment on all affected stakeholders in the state (including small and rural providers)	1) Feasibility assessment; 2) Possible barriers that the implementation plan may face	Single State/Multi State	1) Importance; 2) Ease of accomplishment; 3) Order to be completed
80	HIPAA: Release, Consent/Authorization Standard	2 - IT provides hospital Marketing Department only names, addresses, telephone numbers and dates of service. Privacy and Security Officer meets with quality assurance personnel to determine the minimum amount of information necessary to meet the business purpose of analyzing patient encounters.	Technical barrier because of need for standard procedures and access by authorized personnel only.	2. The key here is what the information is being used for and this may relate to education. If information is being only used for internal analysis then I don't see any reason for waiver. If marketing department want to utilize the information outside the walls of the organization then a standard waiver for patients needs to be created.	Facilities must have policies and procedures that clearly state when disclosures of PHi, including demographic and treatment/medical information, can be made available for various facility purposes with and without a HIPAA-valid authorization (or release), including marketing, as well as what constitutes "marketing" such as gives rise to the need to obtain an authorization under HIPAA before use or disclosure of PHI may occur. Moreover, if HIPAA-defined "marketing" is contemplated, facility staff must fully understand how and when an authorization must be obtained such as will permit such activities, as well as be provided with standard authorization language for that purpose (although that is not the subject of this solution). Furthermore, better understanding is needed around the applicability of the HIPAA minimum necessary rule for TPO (esp. treatment) -- including when a consent must (and need not) be obtained (per NJ State law), and when a HIPAA-valid authorization is required. Staff must then be trained to know when appropriate requirements have been met, or not, such as will permit use and disclosure for commonplace activities contemplated by the facility. This will help to mitigate any uncertainly about when disclosures are permitted for such TPO activities, as well as the stricter requirements around what	Assumptions: 1. that our goal is to create a standard policy/procedure (P/P) for use at least in NJ, to facilitate uniform practice and understanding regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment); 2. that facility providers, IT staff and/or others involved in activities contemplated in the BP as "marketing" (whether or not such activities meet the HIPAA definition of "marketing") should participate in this P/P development, as well as others who are familiar with drafting P/P documents; 3. that the planning should utilize an established understanding of governing laws in preparing each P/P, which will be provided in advance to the P/P planning team by the HISPC implementation team; 4. that planning should contemplate the education of all staff in a position to make use and disclosures of PHI in the contexts contemplated; 5. that this education	Dependency exists on team developing output/solutions for uniform understanding of legal requirements pertaining to permissible use and disclosure of data for TPO purposes (without authorization), as distinguished from circumstances defined as "marketing" under HIPAA. Each P/P planning team must engage the staff of several facilities/institutions to design and implement each set of P/Ps. This will ensure that ideas collected and identified as solutions will "fit" the environment intended; and will facilitate acceptance and implementation. Each P/P planning team leader is required to facilitate team coordination and ensure workplan completion. Team should also include legal SME, to ensure P/P development is consistent with uniform understanding of relevant law. Team should consider representation from NJ hospital society, as well as facility IT staff and others who perform marketing-type functions, to assist in facilitating uniform development and adoption of	1) To design and create uniform Ps/Ps, for adoption by (at least) NJ hospital facility community, regarding both a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment). The project must include education and implementation of 2 Ps/Ps that address and resolve open issues relating to disclosure of PHI in an institutional setting for various commonplace situations, including those that some may be mistakenly characterizing as "marketing" under HIPAA. The standard P/P developed in the first instance must clearly document when disclosure is permissible absent a consent or HIPAA-valid authorization; in the second, it should include helpful examples of how the minimum necessary would be applied in facility settings. 2) Tasks include: 1. Identify P/P planning group leader; 2. Identify current use/disclosure practices and issues; 3. Identify and document when a patient authorization must be obtained	1) Dependency exists for delivery of output on uniform understanding of relevant law prior to implementation of this solution; timeline/order of tasks for implementation follow prior heading. Reaching consensus on relevant policy considerations relating to which marketing-type activities are appropriately characterized as TPO v. "marketing" defined by HIPAA may take longest, although determination of which elements of data are appropriately minimum necessary to accomplish various purposes (including marketing under HIPAA) may also prove challenging, timewise, as may development of standard guidance on what should be included in a HIPAA-valid authorization, when one is needed (although that aspect is beyond the scope of this solution). Over an 18-24 month period it is expected that the following milestones could be met: assemble appropriate hospital/other-facility staff, including appropriate IT and	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Team leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Team leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated, ideally prior to adoption.	Once developed, the standard P/P for each of a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) will hopefully be adopted by the facility community. Once adopted and implemented by a majority of facilities, their use of each P/P may change their current approach and should promote uniformity with respect to this business practice.	1) The creation of standard P/P documents for a) how HIPAA characterizes many commonplace activities performed by a facility as TPO, as distinguished from what it defines as "marketing" for purposes of complying with the requirement to obtain a HIPAA-valid authorization prior to use or disclosure of PHI for that purpose, including how and when to obtain any such needed authorization, and what it must contain (although that aspect is beyond the scope of this solution); as well as b) how and when to appropriately apply the HIPAA minimum necessary rule (and when it is not required, such as for treatment) is feasible, depending on the ability of the facility reps to agree on interpretation of how to characterize regularly encountered circumstances and activities (such as for TPO v. HIPAA-defined "marketing"); however, their adoption as a statewide standard will also depend on their acceptability to/adoptability by the institutional community not represented on each P/P planning team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Team Leader and/or team members; 3.	Could be multi-, but more likely single-State	1) Low, for both Ps/Ps. 2) Not too difficult, if planning team is properly represented and all participate cooperatively throughout implementation. 3) Cannot proceed until delivery of solutions relating to creation of standard, uniform understanding of relevant legal requirements.

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26	Interoperability	1 - Any laboratory which performs a blood lead screening is required to electronically submit results to Childhood Lead Poisoning Prevention Surveillance System.	Not seen as barrier per se due to statutory requirement; however, unity in electronic exchange protocols may present barriers as national initiative are implemented to achieve uniformity.	1. ****Childhood Lead Poisoning Prevention Surveillance System should be able to receive and process data in same format.	Standard protocols, data elements and a standard patient identifier must be developed to allow for the exchange of information between CLPPSS and other systems. Standard protocols, data elements and a standard patient identifier must be developed to allow for the exchange of information between CLPPSS and other systems. A common software solution for the cleansing of data obtained from systems needs to be selected and implemented so that when data is needed to execute or validate a match between CLPPSS and other data the match process will use standardized data.	Create standard policy, procedures and protocols to facilitate information exchange across systems. A national workgroup such as WEDI needs to work with the state and industry to develop the standards.	State of New Jersey Department of Health and Senior Services. DHSS is the agency that is responsible for the collection of lead screening exam results from all in-state laboratories and for housing this data in a common database. DHSS or their designated IT agent will be responsible for the expansion of the lead screening database to include the collection and retention of supplemental patient demographic data including social security number data. The State of New Jersey Department of Human Services Division of Medical Assistance and Health Services has Medicaid Program administration responsibilities. DMAHS staff, working in conjunction with DHSS staff, will enhance data collection and matching software that attempts to link laboratory reported blood lead screening exams to Medicaid beneficiary eligibility files. Workgroup for Electronic Data Interchange (WEDI) can provide a forum for facilitating the development of strategies, definition of standards, and	The scope of this project is to define, develop and implement to allow for the exchange of data. Major tasks are: Select Project Manager Assemble Project Team Assess Legislative Limitations/Required Legislative Action Develop Project Plan Define Encryption Requirements for the storage of any PHI data Define standard data content for reporting Define primary and secondary match processes Prepare and Secure Approval of System Design Document Develop/Test Application Document Application Conduct User Training Implement Project Post Implementation Project Monitoring	A project schedule will be developed that will define two major phases of the project. The first phase of the project will be the design, development and implementation phase with key project deliverables defined for each critical work task. The second phase of the project will be a post implementation phase where regularly scheduled measurements will be taken to determine if the expansion of the data element set is necessary. For each work task on the project plan both projected and actual start and completion dates will be maintained. In addition, required resources will be projected for each defined work task that will include the agency or entity that will be responsible for delivering the resource.	The project manager, during the initial phase, will measure progress against the established project plan, tracking actual project schedule against proposed project schedule and actual resource utilization against projected project resource needs. The project manager, during the post implementation phase, will gather statistics from CLPPSS regarding match rates and data reporting errors subsequent to project implementation to the same rates prior to project implementation to assess the overall impact of the project.	CLPPSS may have to enhance any existing capabilities they have developed to support existing electronic reporting to include the requirement for the collection and reporting of other data.	The creation of a standard set of data elements to be reported by laboratories for all blood lead screening tests performed is feasible. Creation of both an electronic transaction for batch reporting as well as the development and deployment of a web based solution for laboratory reporting would give reporting laboratories the ability to select the method for submission of test results that they feel is most appropriate to their internal operations. Barriers to this solution could include the unwillingness to allow for the secure use of social security number to identify either the patient or the adult custodian of the patient based on confidentiality concerns or identity theft concerns. There is no other unique individual identifier that exists that could be used as an alternative to the social security number and there does not appear to be any interest at the national level to pursue the assignment and use of a unique patient identifier under HIPAA. Relying on use of non-unique secondary identifiers such as patient name, date of birth, gender and physical street address will have a significant adverse impact on the accuracy of reporting.	Single State	Project Importance: Medium, Ease of Accomplishment: From both a technical and a business process perspective this project is not complex. Order to be Completed: There are several critical actions that need to be taken before significant effort can and should be invested in this project. The first action is to assess existing legislation to determine if existing legislation defines the specific data elements required for reporting where new legislation would have to be introduced to define the updated set of data elements required for reporting. The second action is to obtain project buy in from the State Department of Health and Senior Services, the State Department of Human Services and WEDI.

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27	Interoperability	7 - CLPPSS matches Medicaid information to its data base using common identifiers to identify children who have had blood lead screening.	Barrier due to difficulty of accurately matching identifiers.	1. ****Childhood Lead Poisoning Prevention Surveillance System should design its database to Medicaid database specs.	The introduction of the use of a standard patient identifier needs to be introduced in order to allow for a more accurate matching of CLPPSS data to New Jersey Medicaid data. Currently, the match calls for use of patient demographic data that includes patient name, patient date of birth and patient address data within the CLPPSS environment to Medicaid beneficiary demographic data that originates from a number of different federal, state and county based eligibility determination offices and is maintained by the State Medicaid Agency. While New Jersey Medicaid data includes a New Jersey Medicaid beneficiary identification number that uniquely identifies the beneficiary and the beneficiary's social security number, CLPPSS data does not include a unique identifier such as the individual's social security number. The New Jersey Immunization Registry currently maintains a Medicaid ID and interfaces with CLPPSS. This could be used to build a three-way interface between systems. The NJ immunization Registry assigns a Unique Identifier at the creation of the record which could in turn be used as a basis for developing a Patient Identifier. The data element set collected by CLPPSS needs to be expanded to include the collection of a set of data elements must include sufficient patient or responsible	Patient and/or responsible custodian social security number will be permitted to be collected as part of the standard set of data elements with requirements that all social security numbers be encrypted prior to their storage on any online database.	State of New Jersey Department of Health and Senior Services. DHSS is the agency that is responsible for the collection of lead screening exam results from all in-state laboratories and for housing this data in a common database. DHSS or their designated IT agent will be responsible for the expansion of the lead screening database to include the collection and retention of supplemental patient demographic data including social security number data. The State of New Jersey Department of Human Services Division of Medical Assistance and Health Services has Medicaid Program administration responsibilities. DMAHS staff, working in conjunction with DHSS staff, will enhance data collection and matching software that attempts to link laboratory reported blood lead screening exams to Medicaid beneficiary eligibility files. State of New Jersey Office of Information Technology maintains the Master Medicaid Eligibility File. If the scope of the project continues to include	The scope of this project is to define, develop and implement enhancements to the existing data matching process that attempts to link CLPPSS and Medicaid beneficiary eligibility data in support to monitoring the case management of Medicaid beneficiaries whose lead levels from blood lead screening exams exceed established parameters. The project must include all business processes from the point that a blood lead screening is ordered by a physician to the receipt of the blood lead screening results by DHSS where attempts are then made to match this data to Medicaid beneficiary data. Major tasks are: Select Project Manager Assemble Project Team Assess Legislative Limitations/Required Legislative Action Develop Project Plan Define Encryption Requirements for the storage of any PHI data Define standard data content for laboratory reporting Define primary and secondary match processes between CLPPSS and Medicaid Prepare and Secure Approval of System Design Document Develop/Test Application Document Application Conduct User Training Implement Project Post Implementation Project Monitoring	A project schedule will be developed that will define two major phases of the project. The first phase of the project will be the design, development and implementation phase with key project deliverables defined for each critical work task. The second phase of the project will be a post implementation phase where regularly scheduled measurements will be taken to determine if the expansion of the data element set to include social security number data has enhanced the accuracy of the reporting and tracking of lead screening exam results. For each work task on the project plan both projected and actual start and completion dates will be maintained. In addition, required resources will be projected for each defined work task that will include the agency or entity that will be responsible for delivering the resource.	The project manager, during the initial phase, will measure progress against the established project plan, tracking actual project schedule against proposed project schedule and actual resource utilization against projected project resource needs. The project manager, during the post implementation phase, will gather statistics from CLPPSS and Medicaid regarding match rates and data reporting errors subsequent to project implementation to the same rates prior to project implementation to assess the overall impact of the project.	Laboratories will have to enhance any existing capabilities they have developed to support existing electronic reporting to include the requirement for the collection and reporting of social security number data. Ordering physicians will need to enhance their process for ordering lab work to include social security number data as part of the ordering process or to be prepared to handle telephone inquires from laboratory facilities requiring social security number data to satisfy lead screening reporting requirements.	The creation of a standard set of data elements to be reported by laboratories for all blood lead screening tests performed is feasible. Creation of both an electronic transaction for batch reporting as well as the development and deployment of a web based solution for laboratory reporting would give reporting laboratories the ability to select the method for submission of test results that they feel is most appropriate to their internal operations. Barriers to this solution could include the unwillingness to allow for the secure use of social security number to identify either the patient or the adult custodian of the patient based on confidentiality concerns or identity theft concerns. There is no other unique individual identifier that exists that could be used as an alternative to the social security number and there does not appear to be any interest at the national level to pursue the assignment and use of a unique patient identifier under HIPAA. Relying on use of non-unique secondary identifiers such as patient name, date of birth, gender and physical street address will have a significant adverse impact on the accuracy of reporting.	Single State	Project Importance: Medium. Ease of Accomplishment: From both a technical and a business process perspective this project is not complex. Order to be Completed: There are several critical actions that need to be taken before significant effort can and should be invested in this project. The first action is to assess existing legislation that limits the use of social security number as a patient identifier to determine if the existing legislation would require change in order to permit for the collection of the social security number as part of the lead screening exam reporting process. The second action is to assess the enabling legislation that placed blood lead screening reporting requirements on State laboratories to determine if the language in the enabling legislation is so specific that any change to the content and format of the data elements being collected would require further legislative action.
28	Interoperability	7 - CLPPSS matches Medicaid information to its data base using common identifiers to identify children who have had blood lead screening.	Barrier due to difficulty of accurately matching identifiers.	2. Software needs to be developed that will be universal. Matching identifiers should be simplified. HIPAA security rules need to be followed.	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above	Same as above

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29	Interoperability	11 - Linking patient information between different agency systems is extremely difficult because of a lack of common identifiers, duplicate records, and common errors in identifiers.	This is not a legal or policy barrier, but is an important practical problem requiring complicated solutions.	1. Specify a single data standard to be used in all state agencies for PHI and exchange of health information.	A standard set of data elements needs to be established that constitute the reporting transaction that needs to be prepared and submitted by any laboratory for the reporting of all blood lead screening tests performed. This standard set of data elements will become the baseline from which a standard electronic transaction can be defined for use for those laboratories who wish to submit blood lead screening tests results electronically as batch transactions. The standard set of data elements will become the baseline from which a web-enabled solution is developed to allow for the real time direct data entry of blood lead screening test results by laboratories to the reporting State agency. Security of the web application is essential so that only authorized entities are permitted to record the results of blood lead screening tests. The standard set of data elements must include sufficient patient or responsible custodian data to allow for the unique identification of the individual receiving the blood leading screening test (See Interoperability Items 27 and 28) . The standard set of data elements should leverage the use of Logical Observation Identifier Names and Codes (LOINC) for the reporting of actual test results to take advantage of the anticipated use of LOINC within the anticipated HIPAA	The State agency responsible for the collection of blood lead screening test results or their designated agent will be responsible for the design, development, implementation and operation of a web based solution that laboratories can use for the input of blood lead screening test results. Logical Observation Identifier Names and Codes (LOINC) are proposed as the standard code set for the reporting of the actual test results. The proposed use of this code set is based on the increased acceptance of this code set within the health care industry based on the assumption that this code set will be named within the HIPAA electronic claim attachment rule. Patient and/or responsible custodian social security number will be permitted to be collected as part of the standard set of data elements with requirements that all social security numbers be encrypted prior to their storage on any online database.	State of New Jersey Department of Health and Senior Services. DHSS is the agency that is responsible for the collection of lead screening exam results from all in-state laboratories and for housing this data in a common database. DHSS or their designated IT agent will be responsible for the expansion of the lead screening database to include the collection and retention of supplemental patient demographic data including social security number data.	The scope of this project is to define, develop and implement enhancements to the existing electronic reporting of blood lead screening test results. These enhancements include establishing a common electronic standard reporting transaction that would be used by all parties responsible for the submission of blood lead screening test results to the State Department of Health and Senior Services. The project must consider all business processes from the point that the blood lead screening is ordered by a physician to the receipt of the blood lead screening results by DHSS to ensure that data defined to be included in the standard reporting transaction are available to the reporting laboratory. Major tasks are: Select Project Manager Assemble Project Team Assess Legislative Limitations/Required Legislative Action Develop Project Plan Define Encryption Requirements for the storage of any PHI data Define standard data content for laboratory reporting Define web pages (format and content) Define web access security requirements Prepare and Secure Approval of System Design Document Develop/Test Application Document Application Conduct User Training Implement Project Post Implementation Project Monitoring	A project schedule will be developed that will define all major units of work to be performed as part of this project. The first phase of the project will be the design, development and implementation phase with key project deliverables defined for each critical work task. The second phase of the project will be a post implementation phase to assess compliance with the new standard reporting requirements. For each work task on the project plan both projected and actual start and completion dates will be maintained. In addition, required resources will be projected for each defined work task that will include the agency or entity that will be responsible for delivering the resource.	The project manager, during the initial phase, will measure progress against the established project plan, tracking actual project schedule against proposed project schedule and actual resource utilization against projected project resource needs. The project manager, during the post implementation phase, will gather performance statistics regarding web throughput performance statistics, error rates for transactions submitted electronically and statistics regarding timeliness of reporting.	Laboratories will have to enhance any existing capabilities they have developed to support existing electronic reporting to include the requirement for the collection and reporting of social security number and other data. Ordering physicians will need to enhance their process for ordering lab work to include social security number data as part of the ordering process or to be prepared to handle telephone inquires from laboratory facilities requiring social security number and other data to satisfy lead screening reporting requirements.	The creation of a standard set of data elements to be reported by laboratories for all blood lead screening tests performed is feasible. Creation of both an electronic transaction for batch reporting as well as the development and deployment of a web based solution for laboratory reporting would give reporting laboratories the ability to select the method for submission of test results that they feel is most appropriate to their internal operations. Barriers to this solution could include the unwillingness to allow for the secure use of social security number to identify either the patient or the adult custodian of the patient based on confidentiality concerns or identity theft concerns. There is no other unique individual identifier that exists that could be used as an alternative to the social security number and there does not appear to be any interest at the national level to pursue the assignment and use of a unique patient identifier under HIPAA. Relying on use of non-unique secondary identifiers such as patient name, date of birth, gender and physical street address will have a significant adverse impact on the accuracy of reporting.	Single State	Project Importance: Medium. Ease of Accomplishment: From both a technical and a business process perspective this project is not complex. Order to be Completed: There are several critical actions that need to be taken before significant effort can and should be invested in this project. The first action is to assess existing legislation that limits the use of social security number as a patient identifier to determine if the existing legislation would require change in order to permit for the collection of the social security number as part of the lead screening exam reporting process. The second action is to assess the enabling legislation that placed blood lead screening reporting requirements on State laboratories to determine if the language in the enabling legislation is so specific that any change to the content and format of the data elements being collected would require further legislative action.

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30	Interoperability	11 - Linking patient information between different agency systems is extremely difficult because of a lack of common identifiers, duplicate records, and common errors in identifiers.	This is not a legal or policy barrier, but is an important practical problem requiring complicated solutions.	2. A standard patient identifier needs to be created.	A standard patient identifier is needed to allow critical health care data maintained by different agencies for the same patient to be linked. The absence of a standard patient identifier severely restricts the ability for separate entities that retain critical health information from a patient from exchanging this data with this inability to exchange this data having a potential adverse impact on the health of the patient. Attempts to establish a unique patient identifier under the Health Insurance Portability and Accountability Act of 1996 did not succeed to in large part due to concerns over patient privacy. At this time there is no suggestion that opponents to a national patient identifier will permit the adoption of a rule that would establish this identifier. As a result, it will be left up to individual states or regions comprising multiple states to establish a process for the assignment and use of unique patient identifiers in order for this initiative to move forward.	It is assumed that this project will not go forward unless legislative action is taken to establish the responsibility for the assignment on a unique patient identifier to New Jersey residents.	The State of New Jersey Department of Banking and Insurance would be the logical state agency to spearhead this effort based on their regulatory authority over third party health plans in the State.	The scope of this project is to establish the regulatory authority for the assignment of unique patient identifiers, develop automated mechanisms for enumeration of the existing population, develop the capability to assign unique patient identifiers to individuals new to the State and implement the use of this unique patient identifier within the health care community. Major tasks are: Select Project Manager Identify Project Team Needs Determine State Agency Ownership Prepare/Submit Regulations for Legislative Action Assemble Full Project Team Develop Project Plan Define Enumeration Strategy Define Education Strategy Prepare and Secure Approval of System Design Document Develop/Test Application Document Application Conduct User Training Implement Project Post Implementation Project Monitoring	A project schedule will be developed that will define two major phases of the project. The first phase of the project will focus on defining the project team skill set needed, the determination of which State agency is best suited to handle both the initial enumeration process as well as handle the identification and assignment of unique patient identifiers on an ongoing basis. Additionally, the final task to be completed as part of this first phase will be the crafting of legislation for action on the part of the legislature to enact the legislation needed for the implementation and use of a new unique patient identifier for health care services. The second phase of the project will be to define, develop and implement a system so support both initial enumeration of residents of the State as well as to develop the infrastructure necessary to assign unique patient identifiers to new residents on an ongoing basis. Business processes	The project manager, during both phases, will measure progress against the established project plan, tracking actual project schedule against proposed project schedule and actual resource utilization against projected project resource needs.	This project has a large number of stakeholders all of whom will be impacted to some degree by this project. The first stakeholder group is the general population of the State of New Jersey. State residents would be issued a unique New Jersey patient identifier that they would be expected to share with the health care provider community. The second stakeholder group is the health care provider community. Health care providers would be expected to report the new patient identifier on a variety of health care transactions. The third stakeholder group is the health plan community. This community would be expected to accept the new patient identifier on a variety of health care transactions in lieu of or in addition to patient identifiers that are specific to the health plan. The fourth stakeholder group is government agencies that are responsible for a myriad of administrative, regulatory and public health functions.	There is no dispute over the feasibility and benefits of establishing a unique patient identifier to facilitate the exchange and matching of health care data between two or more entities. Ultimately the whole concept of a complete and comprehensive health care record that can "move" with the patient will demand a unique patient identifier in order to be truly effective. However, it can be expected that the same issues that have stalled attempts to establish a unique patient identifier at the national level will be presented as reasons why the State of New Jersey should not move forward with the initiative to assign a unique patient identifier to residents of the State.	Single State	Project Importance: High. Ease of Accomplishment: This project is an extremely complex project, affecting the general population, the health care provider community, the health care payer community as well as numerous state, county and local agencies. There will be many obstacles that will need to be overcome in order for this project to be successfully implemented. The first task is to determine what State agency would be best suited as the agency responsible for the assignment of unique patient identifiers. Since a significant portion of New Jersey residents are born within the State and many of the significant health care events that need to be tracked are for children, it may make sense on a go forward basis to initiate the assignment of the unique patient identifier at the time that the birth of the individual is recorded with the State. The second task is to establish the regulatory authority to establish a unique
32	Interoperability	7 - If information is not needed immediately, ED physician contacts medical records department at other hospital. Will be asked name, department, and license number by staff. Sometimes sending hospital will require a form verifying identity to be completed, signed, and faxed. Information will be received by fax hours later.	Barrier because of need for procedures to verify identity and maintain security of fax.	2. Central data storage (Health Data Information Exchange or HDIE) would solve disconnect between ED and late/unavailable PCP.			State of New Jersey Department of Human Services	Define standard data content for reporting						

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42	Interoperability	8 - When physician uses EMR for referrals, sends request for patient referral to referral department, which creates an electronic referral and sends to specialist through secure web portal. If specialist is not in EMR network, referral department will print out copy of electronic version and fax to specialist. After faxing, perhaps weeks or months later, physician will receive letter that patient was seen by specialist and description of the assessment and treatment plan.	Technical barrier due to need for security policies and procedures for web portal.	1. State to mandate web portal use for all referrals and time frame upon which specialist report to Primary Care Physician should be sent.	This is not a good "Solution." 1. If "referrals" mean a primary care doctor wanting a patient to go to a specialist then you don't need anything electronic - the patient just calls the specialist and makes an appointment. However, if "referral" means the insurance company permission for the patient to see a specialist then that already exists electronically - no need to reinvent it. 2. The reason some specialists take a long time to respond to referring doctors is that there is a shortage of specialists. The shortage is due to an aging population (both doctors and patients), state mandates e.g., medical facility tax, a notorious atmosphere for malpractice, and decreasing payments.									
47	Interoperability	2 - If physician is part of LTC facility's network, patient discharge summary (includes final diagnosis, medications w/ dosage and instructions), lab tests, etc. can be accessed through web portal, using password, and can be downloaded from web portal. If doctor is out of network, little or no data will be shared.	Technical barrier due to need for security policies and procedures for web portal. May be problem with consistent identifiers for patients.	3. NPI must be mandated for all providers to utilize for identification purposes, not just HIPAA covered providers.										

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48	Interoperability	2 - If physician is part of LTC facility's network, patient discharge summary (includes final diagnosis, medications w/ dosage and instructions), lab tests, etc. can be accessed through web portal, using password, and can be downloaded from web portal. If doctor is out of network, little or no data will be shared.	Technical barrier due to need for security policies and procedures for web portal. May be problem with consistent identifiers for patients.	4. A procedure needs to be developed that covers the mandate in 45 CFR 162. Consistent identifiers should not be a problem, once a universal procedure is accepted and followed.	Out of network doctors will have access to patient data through web portal which is already available on the internet and administered by the patient.	1. Patients want doctors to have access to their records. 2. Making the web portal patient-centric avoids the issue of in or out of network. 3. Universal patient and provider numbers essential.	Medem, Inc. 649 Mission Street, 2nd Floor San Francisco, CA 94105 or Medfusion, Inc. 1318 Dale St., Suite 220 Raleigh, NC 27605	1. Will require data input from all medical providers (hospitals, doctors, labs, etc.). 2. Will require all medical providers to have access to the internet. 3. Will require financial incentives to medical providers to implement.					MultiState	
49	Interoperability	4 - Psychiatrist may make short handwritten notes in patient record. Most facilities have a form to fill out for consulting specialists which is sent by mail or fax to facility medical director and a copy is placed in patient file. Larger facilities may have on-site transcription service for consulting specialist to use.	Technical barrier due to need to combine information from different sources. Staff are used to paper files and need training in electronic systems.	1. Requiring intra-institutional uniformity of data recording (all written, all dictated, or all EMR typed).	All acute, long-term and ambulatory care facilities must migrate to an all-electronic patient and provider medical record processing and retention system to facilitate centralized access by these treatment providers.	Assumptions: 1) that consensus and agreement can be achieved for all acute, ambulatory and long-term care facilities with respect to unified hardware and software that accurately records provider notes and instructions; 2) that this e-record system will be cost-effective and affordable; c) that facility staff will in fact utilize this e-system; d) that an intra-hospital pilot program can demonstrate overall utility in terms of economy, ease of use and improved patient care while preserving and securing PHI.	A pilot project should be administered by regulatory bodies that govern the activity of hospitals (NJDHSS), physicians (NJ Board of Medical Examiners), payors who maintain PHI (NJDOBI), patient's rights organizations regarding HIPAA (NJDOBI, NJ Public Advocate) and hospitals (acute and long-term care facilities such as Virtua, St. Barnabas, UMDNJ, Cooper CentraState). Pilot project would specifically address the assumptions listed under Planning Assumptions and Decisions, i.e., consensus, cost effectiveness, utilization, economy, improved patient care and secure use of PHI.	1. Project Scope - migration from combination paper/electronic medical/chart records to unified electronic record that is interoperable between acute, long-term and ambulatory facilities. Acute care facility work unit should be limited in pilot stage to emergency department only; long-term care facility work unit should include emergency transfers to acute care facilities; ambulatory care facility work unit should be limited in pilot stage to emergency transfers to acute care facilities. 2. Tasks Required - First Stage: develop stakeholder (acute, long-term and ambulatory) subgroups (Cooper, Virtua, Lourdes, St. Barnabas Hospital Systems) to develop universal definition of medical records to include activity of all care provider notes (by physician, nurse, medical technologist), official facility records, logs of treatment, physician orders, medication dosing and any other information deemed necessary by the pilot research group that encompasses a medical record. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used across acute, long-term and ambulatory care facilities and resident care providers in a manner that permits interoperable and secure transmission of PHI. Third Stage: integrate established definition of medical record with electronic media recording and transmission platforms in	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, as well as definition of medical record; iv) establish test input, throughput and output exchanges of medical record information at the institutional level, e.g., emergency department physician in mental health section orders course of medication by typing name and dosage into hardware, software retains and encrypts to centralized, secure hub, and transfers to hardware on floor of admission for assessment nurse for review and availability by patient visiting primary care physician based on proper authorization and identity; v) create test exchange of	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on facilities, as electronic systems are already in place in many NJ treatment centers. Local physician access to facility mainframes or networks may be problematic. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory.	Single State	1: Importance - high due to potential for enhanced health care and reduction in med record errors; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware and software conventions.

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51	Interoperability	4 - Psychiatrist may make short handwritten notes in patient record. Most facilities have a form to fill out for consulting specialists which is sent by mail or fax to facility medical director and a copy is placed in patient file. Larger facilities may have on-site transcription service for consulting specialist to use.	Technical barrier due to need to combine information from different sources. Staff are used to paper files and need training in electronic systems.	3. Standardized consultation forms can be used to combine medical record data from different sources, including transcriptions.	All acute, long-term and ambulatory care facilities must migrate to an all-electronic standardized provider consultation form to facilitate centralized access by these treatment providers.	Assumptions: 1) that consensus and agreement can be achieved for all acute, ambulatory and long-term care facilities with respect to unified and standardized consultation forms that can be completed electronically and in a manner that accurately records provider notes and instructions; 2) that this e-record consultation form system will be cost-effective and affordable; c) that facility staff will in fact utilize this e-record consultation system; d) that an intra-hospital pilot program can demonstrate overall utility in terms of economy, ease of use and improved patient care while preserving and securing PHI.	A pilot project should be administered by regulatory bodies that govern the activity of hospitals (NJDHSS), physicians (NJ Board of Medical Examiners), payors who maintain PHI (NJDOBI), patient's rights organizations regarding HIPAA (NJDOBI, NJ Public Advocate) and hospitals (acute and long-term care facilities such as Virtua, St. Barnabas, UMDNJ, Cooper CentraState). Pilot project would specifically address the assumptions listed under Planning Assumptions and Decisions, i.e., consensus, cost effectiveness, utilization, economy, improved patient care and secure use of PHI when standardized consultation forms are utilized.	1. Project Scope - migration from combination paper/electronic consultation form to unified electronic record that is interoperable between acute, long-term and ambulatory facilities. Preliminary suggestion is utilization of laptop and/or palm-pilot interface. Acute care facility work unit should be limited in pilot stage to emergency department only; long-term care facility work unit should include emergency transfers to acute care facilities; ambulatory care facility work unit should be limited in pilot stage to emergency transfers to acute care facilities. 2. Tasks Required - First Stage: develop stakeholder (acute, long-term, ambulatory, physicians) subgroups (Cooper, Virtua, Lourdes, St. Barnabas Hospital Systems, cross-section of medical providers in New Jersey, including physicians and clinicians) to develop universal content of consultation. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used across acute, long-term and ambulatory care facilities and resident care providers in a manner that permits interoperable and secure transmission of consultation forms. Third Stage: integrate established consultation form with electronic media recording and transmission platforms in a manner that safeguards the exchange of information contained on the	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, as well as content material for consultation form; iv) establish test input, throughput and output exchanges of medical record information at the institutional level, e.g., provider/consultant access laptop or palm-pilot, enters observations and recommendations for diagnosis and prognosis, software retains, submits and encrypts to centralized, secure hub, and transfers to hardware on floor of admission for assessment nurse for review and availability by patient visiting primary care physician based on proper authorization and identity; v) create test exchange of	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on facilities, as electronic systems are already in place in many NJ treatment centers. Local physician access to facility mainframes or networks may be problematic. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care and reduction in treatment record errors; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware/software conventions and content of standardized consultation form.
56	Interoperability	8 - Physician use of EMR eliminates the need for dictation. Patient assessment is entered directly into EMR at time of visit and no separate dictation is done. When system is down, doctors wait until system returns and then enter notes into each electronic record.	Need to maintain policies and procedures for security of system.	2. Minimum encryption and authentication standards need to be developed for all web portals related to medical information.	No doctor is going to wait for an EMR system to come back up to enter a note. There is too great a risk that something said during the encounter will be forgotten. Physician will use a telephone based dictation system to record the patient encounter. When the EMR comes back up the note will be scanned into the EMR.									

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58	Interoperability	12 - Although all email is encrypted by EMR system, health care system IT directors discourage sending any PHI via email. Instead, they encourage viewing patient information through the secure web portal.	Technical barrier due to need to maintain security of electronic system.	1. Email (regardless of encryption) not to be used for provider-to-provider communication. Auditing of email is far more difficult than database-driven messaging. Email may be reserved for provider-patient interaction in secure environment.	The development and distribution of guidelines for exchange of health information in email and recommended minimum encryption method for such exchange. Already available through Medem and MedFussion to name two providers.	PHI is currently being exchanged in email. Guidelines will make clear that email is not the preferred method for exchanging PHI and should only be used when clearly necessary. Minimum encryption security guidelines will be recommended for cases when PHI is sent in email.	The NJ Department of Banking and Insurance, in collaboration with the NJ Departments of Health and Senior Services and Human Services, will lead the email encryption guideline project	The project scope will encompass the development and release of security guidelines for encryption of email messages containing PHI. Specific activities are: 1) Convene stakeholder group committee to discuss current email practices and software requirements. Stakeholders should include: physicians and groups, long term care facilities, hospitals and systems, clinics, home care agencies, labs, pharmacies and PBMs, payers, and health IT experts 2) Committee review of existing encryption technology including VPN or SSL 128-bit and consensus on method to recommend to stakeholders 3) Draft guidelines for minimum security required for sharing of PHI in email 4) Distribute guidelines to stakeholders and post to appropriate websites (DOBI, DHSS, NJHA, etc.)	18 months. Y1 Q1) Hold initial stakeholder committee meeting and create project meeting schedule Y1 Q2) Determine current provider email practices and review existing technology Y1 Q3) Develop consensus on technology and draft guidelines Y1 Q4) Distribute guidelines through mailings and website postings Y2 Q1-2) Monitor use of guidelines through webpage and survey of providers 2) Project will require primarily administrative resources for meeting logistics and communication efforts	Completion of guideline document will be measure of success of project. After website posting, downloads of guidelines and webpage hits will be monitored	Follow-up survey with stakeholders to assess use of guidelines in their organizations, practices, etc.	Because project involves guideline development and not regulatory or legislative changes, it is very feasible. Because the guidelines will not be mandated, however, adherence by providers to them, may be limited. Strong efforts will be made to distribute guidelines widely and encourage their adoption.	Multi-state - Because industry standards for encryption exist, guidelines will be applicable across states. Stakeholders from NJ's bordering states will be invited to collaborate on guideline development and to use finalized documents within their states	1) Moderately important - not of highest priority because most PHI is NOT being shared through email, however, guidelines needed for cases of such exchange 2) This project is easily accomplished because of existing standards and the focused scope

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59	Interoperability	12 - Although all email is encrypted by EMR system, health care system IT directors discourage sending any PHI via email. Instead, they encourage viewing patient information through the secure web portal.	Technical barrier due to need to maintain security of electronic system.	2. A minimum encryption method for PHI in E-mail should be created. Also, 128 Secure Sockets Layer (SSL) seems to be a reasonable solution to me. Also, we may want to look at some of the audit requirements that the Sarbanes-Oxley Act of 2002 "SOX" places on financial firms related to e-mail. This could be beneficial as well.	The development and distribution of guidelines for exchange of health information in email and recommended minimum encryption method for such exchange. Already available through Medem and MedFussion to name two providers.	PHI is currently being exchanged in email. Guidelines will make clear that email is not the preferred method for exchanging PHI and should only be used when clearly necessary. Minimum encryption security guidelines will be recommended for cases when PHI is sent in email.	The NJ Department of Banking and Insurance, in collaboration with the NJ Departments of Health and Senior Services and Human Services, will lead the email encryption guideline project	The project scope will encompass the development and release of security guidelines for encryption of email messages containing PHI. Specific activities are: 1) Convene stakeholder group committee to discuss current email practices and software requirements. Stakeholders should include: physicians and groups, long term care facilities, hospitals and systems, clinics, home care agencies, labs, pharmacies and PBMs, payers, and health IT experts 2) Committee review of existing encryption technology including VPN or SSL 128-bit and consensus on method to recommend to stakeholders 3) Draft guidelines for minimum security required for sharing of PHI in email 4) Distribute guidelines to stakeholders and post to appropriate websites (DOBI, DHSS, NJHA, etc.)	18 months. Y1 Q1) Hold initial stakeholder committee meeting and create project meeting schedule Y1 Q2) Determine current provider email practices and review existing technology Y1 Q3) Develop consensus on technology and draft guidelines Y1 Q4) Distribute guidelines through mailings and website postings Y2 Q1-2) Monitor use of guidelines through webpage and survey of providers 2) Project will require primarily administrative resources for meeting logistics and communication efforts	Completion of guideline document will be measure of success of project. After website posting, downloads of guidelines and webpage hits will be monitored	Follow-up survey with stakeholders to assess use of guidelines in their organizations, practices, etc.	Because project involves guideline development and not regulatory or legislative changes, it is very feasible. Because the guidelines will not be mandated, however, adherence by providers to them, may be limited. Strong efforts will be made to distribute guidelines widely and encourage their adoption.	Multi-state - Because industry standards for encryption exist, guidelines will be applicable across states. Stakeholders from NJ's bordering states will be invited to collaborate on guideline development and to use finalized documents within their states	1) Moderately important - not of highest priority because most PHI is NOT being shared through email, however, guidelines needed for cases of such exchange 2) This project is easily accomplished because of existing standards and the focused scope

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60	Interoperability	12 - Although all email is encrypted by EMR system, health care system IT directors discourage sending any PHI via email. Instead, they encourage viewing patient information through the secure web portal.	Technical barrier due to need to maintain security of electronic system.	3. Software development to address encryption standards needs to be part of the administrative plan and in accordance with HIPAA Privacy & Security Rules.	The development and distribution of guidelines for exchange of health information in email and recommended minimum encryption method for such exchange. Already available through Medem www.medem.com and MedFusion www.medfusion.net to name two providers.	PHI is currently being exchanged in email. Guidelines will make clear that email is not the preferred method for exchanging PHI and should only be used when clearly necessary. Minimum encryption security guidelines will be recommended for cases when PHI is sent in email.	The NJ Department of Banking and Insurance, in collaboration with the NJ Departments of Health and Senior Services and Human Services, will lead the email encryption guideline project	The project scope will encompass the development and release of security guidelines for encryption of email messages containing PHI. Specific activities are: 1) Convene stakeholder group committee to discuss current email practices and software requirements. Stakeholders should include: physicians and groups, long term care facilities, hospitals and systems, clinics, home care agencies, labs, pharmacies and PBMs, payers, and health IT experts 2) Committee review of existing encryption technology including VPN or SSL 128-bit and consensus on method to recommend to stakeholders 3) Draft guidelines for minimum security required for sharing of PHI in email 4) Distribute guidelines to stakeholders and post to appropriate websites (DOBI, DHSS, NJHA, etc.)	1) 18 months. Y1 Q1) Hold initial stakeholder committee meeting and create project meeting schedule Y1 Q2) Determine current provider email practices and review existing technology Y1 Q3) Develop consensus on technology and draft guidelines Y1 Q4) Distribute guidelines through mailings and website postings Y2 Q1-2) Monitor use of guidelines through webpage and survey of providers 2) Project will require primarily administrative resources for meeting logistics and communication efforts	Completion of guideline document will be measure of success of project. After website posting, downloads of guidelines and webpage hits will be monitored	Follow-up survey with stakeholders to assess use of guidelines in their organizations, practices, etc.	Because project involves guideline development and not regulatory or legislative changes, it is very feasible. Because the guidelines will not be mandated, however, adherence by providers to them, may be limited. Strong efforts will be made to distribute guidelines widely and encourage their adoption.	Multi-state - Because industry standards for encryption exist, guidelines will be applicable across states. Stakeholders from NJ's bordering states will be invited to collaborate on guideline development and to use finalized documents within their states	1) Moderately important - not of highest priority because most PHI is NOT being shared through email, however, guidelines needed for cases of such exchange 2) This project is easily accomplished because of existing standards and the focused scope
62	Interoperability	13 - Only physicians at particular level within health care system, for example attending level, can access secure web portal from home. Doctors must go through a lengthy orientation and configure their computers properly before installing system software.	Technical barrier due to need to maintain security of electronic system.	2. Minimum encryption and authentication standards need to be developed for all web portals related to medical information.	Already available through Medem www.medem.com and MedFusion www.medfusion.net to name two providers.									

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64	Interoperability	2 - Patient is asked to bring previous mammogram to Imaging Center, or to request that images be sent by previous facility by mail or messenger.	Eliminates need to verify other provider and transmit information. However, physical information lacks portability, can be lost/damaged by patient, misfiled by facility causing identity errors and PHI exchange oiin the wrong patient.	1. Physical information is hard to share or exchange- sharing via DICOM is easier. CDs are good, but HDIE exchange would be better.										
65	Interoperability	3 - Process to provide case managers with access to medical information varies: Usually provider faxes information from medical record (with telephone contact to insure that information is going to the correct place), but some providers can give authorized access to medical record on a secure web portal, through encrypted email or sending a tape with patient records.	Hospitals appear to provide access to their electronic records mainly for members of their networks. Issues include the need for business associate agreements with many types of payers, the need to maintain security for users from many organizations, and	1. Payors need to define what data needs to be obtained to make reimbursement decisions. These data need to then be acceptable to providers and ultimately patients to release applicable info.	In consultation with NJ Dept of Banking and Insurance, providers, consumer advocates and hospitals, payors should develop standard protocols to be utilized when determining what information is needed for reimbursement. A starting point for discussion purposes could include unique patient identifier, date of service, diagnosis, prognosis, CPT codes, benefit package in general, claim disposition (paid, denied, adjusted).	Assumptions: 1) that consensus and agreement can be achieved among all payors and providers (hospitals, physician, etc) to identify and define PHI/medical information that is needed for case managers to obtain reimbursement; and 2) that patients would agree to the release of this medical information where HIPAA does not expressly permit such exchange without patient authorization.	A pilot project should be administered by regulatory bodies that govern the activity of hospitals (NJDHSS), physicians (NJ Board of Medical Examiners), payors who maintain PHI (NJDOBI), patient's rights organizations regarding HIPAA (NJDOBI, NJ Public Advocate) and hospitals for the purposes of determining what PHI/medical info in necessary to permit efficient processing of claims and reimbursement. Pilot project would specifically address the assumptions listed under Planning Assumptions and Decisions. The ultimate goal of this project is to develop collection, maintenance and safeguarding of information necessary to increase quality of service/treatment and correct/timely payment by payors to providers.	1. Project Scope - payors to develop a comprehensive description of information that is needed from case managers to process claims and reimbursements. 2. Tasks Required - First Stage: develop stakeholder (health payors, auto Personal Injury Protection payors, physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, etc) to develop universal list of covered events (illnesses, injury, treatment plans, etc) and information necessary to establish entitlement to reimbursement/benefits. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used across payor, acute, long-term and ambulatory care facilities and resident care providers in a manner that permits interoperable and secure transmission of PHI necessary to establish entitlement to benefits. Third Stage: integrate established description of claim entitlement information with electronic media recording and transmission platforms in a manner that safeguards the exchange of PHI. This stage is the key to establishing unified and consistent recordation and transmission protocols, as well as meeting minimum standard of information necessary to obtain reimbursement. Consensus in development and use of hardware (PC versus macro-platforms, cable/phone line encryption, network portals, etc)	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols and/or e-mail-based protocols, as well as content material that constitutes minimum information necessary to demonstrate that benefits are due; iv) establish test input, throughput and output exchanges of medical record/benefit entitlement information at the institutional/provider level; v) create test exchange of information between acute care, long term care, ambulatory facilities and private physician practices that enter the pilot project; vi) review extent to which the test platform results in timely and accurate	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities and payors, as electronic systems are already in place in many NJ treatment centers and virtually all payors. Local physician access to facility mainframes or networks may be problematic. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care, greater access to health care due to payor efficiencies. Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware/software conventions and content of standardized consultation form.

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67	Interoperability	4 - Provider's IT department gives each case manager a logon id and password to access the medical record on the web portal. Robustness of security varies between systems.	Need to maintain security of electronic system.	1. State mandate for uniformity of specific security protocols as minimum standards for all healthcare institutions.	In consultation with NJ Dept of Banking and Insurance, providers, consumer advocates and hospitals, a test pilot should be established to develop a uniform and standard security protocol for accessing, maintaining and exchanging PHI at all care facilities (long term, acute, ambulatory, diagnostic testing) and private physician practices. A starting point for discussion purposes could include unique patient identifier, date of service, diagnosis, prognosis, CPT codes, benefit package in general, claim disposition (paid, denied, adjusted).	Assumptions: 1) that consensus and agreement can be achieved among all providers (hospitals, physician, etc) to identify and define minimum standards for secure collection, maintenance and exchange of PHI/medical information; 2) that agreed-upon methodologies can be effectively and economically implemented.	A pilot project should be administered by regulatory bodies that govern the activity of hospitals (NJDHSS), physicians (NJ Board of Medical Examiners), payors who maintain PHI (NJDOBI), patient's rights organizations regarding HIPAA (NJDOBI, NJ Public Advocate) and hospitals for the purposes of establishing security protocols. Pilot project would specifically address: 1) patient consent (standard form to be developed); 2) role-based medical records access at medical facilities and physician offices based on need to know; 3) utilization of encrypted web-based portal with secure identity verification (e.g., physician use of NPI as identification number, as well as unique password); 4) the need to establish a RHIO or other entity that collects, maintains and exchanges a depository of PHI from medical facilities and physician offices; 5) the need to create oversight and surveillance of RHIO and facilities.physician offices to assure that safeguards are maintained; 6) create legislation that mandates	1. Project Scope - establish technical parameters of secured web-based portal and database on PHI; 2) develop legislation that mandates collection, access, use and exchange of PHI in a manner that safeguards PHI, while at the same time enhancing patient care and fostering economy. 2. Tasks Required - First Stage: develop stakeholder (health payors, auto Personal Injury Protection payors, physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, consumer groups, etc, legal analysts) to develop standard consent form, define the parameters that would establish a secure web-based portal system; and mandate its use and how it is used. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used across payor, acute, long-term and ambulatory care facilities and resident care providers in a manner that permits interoperable and secure transmission of PHI. Third Stage: integrate established web-based portal methodology with electronic media recording and transmission platforms in a manner that safeguards the exchange of PHI. This stage is the key to establishing unified and consistent recordation and transmission protocols, as well as meeting minimum standard of information necessary to obtain reimbursement. Consensus in	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols, as well as content material that constitutes minimum information necessary; iv) establish test input, throughput and output exchanges of PHI at the institutional/provider level; v) create test exchange of information between acute care, long term care, ambulatory facilities and private physician practices that enter the pilot project; vi) review extent to which the test platform results in secure and accurate exchange of PHI. 2. Projected costs - in-kind for stakeholders, with potential for systems funding through grant process. However, project assumption is to	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities and payors, as electronic systems are already in place in many NJ treatment centers and virtually all payors. Local physician access to facility mainframes or networks may be problematic. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care and reduction in med record errors; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware and software conventions.

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69	Interoperability	1 - If doctor uses an electronic prescribing system, the doctor can use PDA to submit a request for a drug which is not on formulary. If not electronic, PBM sends an authorization form to prescribing physician by email or fax. Doctor completes form and faxes back to PBM.	Technical barrier - security policies should be in place and implemented.	1. PBMs can build in a generic form on the PDA to fill out instead of generating email or fax trail. PBMs should be held to same HIPAA and state standards.	In consultation with NJ Dept of Banking and Insurance, NJ Dept of Health and Senior Services, pharmacy benefit managers and pharmacy groups in general, physicians and hospitals, a pilot test should be established to develop an electronic, uniform and standard generic form that physicians can use to order medications via PDA. Migration to PDA should be encouraged to replace fax or call-in method. A starting point for discussion purposes could include unique patient identifier, NPI, unique PBM identifier, standardized list of meds/drugs and their abbreviation or taxonomy.	Assumptions: 1) that consensus and agreement can be achieved among all providers (hospitals, physician, etc) and pharmacies to identify and define minimum standards and standardization of PDA form for ordering prescriptions in a manner that protects PHI/medical information; 2) that agreed-upon methodologies can be effectively and economically implemented.	A pilot project should be administered by regulatory bodies that govern the activity of hospitals (NJDHSS), physicians (NJ Board of Medical Examiners), payors who maintain PHI (NJDOBI), patient's rights organizations regarding HIPAA (NJDOBI, NJ Public Advocate), hospitals and pharmacies for the purposes of establishing a uniform and standard PDA form for ordering medications. Pilot project would specifically address: 1) patient consent (standard form to be developed); 2) minimum information necessary; 3) utilization of encrypted web-based portal with secure identity verification (e.g., physician use of NPI as identification number, as well as unique password) as a means to order medications via PDA.	1. Project Scope - establish technical parameters of secured web-based portal and use of PDA's to order meds. 2. Tasks Required - First Stage: establish stakeholders (pharmacy benefit managers, physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, consumer groups, etc, legal analysts, information technology experts) to develop standard electronic prescription forms for use in PDA's. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used across payor, acute, long-term and ambulatory care facilities and resident care providers in a manner that permits interoperable and secure prescriptions of medications. Third Stage: integrate established web-based portal methodology with electronic media recording and transmission platforms in a manner that safeguards the ordering of medications and preserves patient confidentiality. This stage is the key to establishing unified and consistent recordation and transmission protocols, as well as developing minimum, standard information necessary to order medications in a secure electronic environment. Consensus in development and use of hardware (PC versus macro-platforms, cable/phone line encryption, network portals, etc) and software (method of interface	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols, as well as content material that constitutes minimum information necessary; iv) establish test input, throughput and output exchanges of ordered medications via PDA; v) create test exchange of information between acute care, long term care, ambulatory facilities and private physician practices that enter the pilot project; vi) review extent to which the test platform results in secure and accurate ordering of medications. 2. Projected costs - in-kind for stakeholders, with potential for systems funding through grant process. However, project assumption is to	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities, payors, as electronic systems are already in place in many NJ treatment centers and virtually all payors. Local physician access to facility mainframes or networks may be problematic. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care and reduction in medication errors; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware and software conventions.

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78	Interoperability	1 - Marketing/Quality Assurance each meet with IT develop a query to extract information from patient records for specific conditions. Queries are tested on artificial data.	Technical barrier because of need for standard procedures and access by authorized personnel only.	3. Software needs to be developed that will be universal. This will provide access by authorized personnel only, and standardize procedures.	Based on role-level access, develop universal, standard software and procedures to permit exchange and use of patient information for marketing purposes. Utilize internet and intranet email exchange protocol through use of proprietary software, such as Secure Sockets Layer (A.K.A 128 SSL). This would serve the encryption function. Authentication can be achieved through password and NPI number as a user ID.	Assumptions: 1) that consensus and agreement can be achieved among inter-hospital and intra-hospital work groups regarding minimum information necessary for marketing/quality control purposes; 2) that agreed-upon methodologies can be effectively and economically implemented to permit review of patient information in a secure environment and in a manner that enhances patient care and quality assurance.	Project Ownership: NJ Office of Information and Technology (create facility portal that is universally accessible by necessary facility staff; NJ Department of Health and Senior Services, NJ Board of Medical Examiners, NJ Hospital Association, patient's rights organizations regarding HIPAA such as NJDOBI and NJ Public Advocate and hospitals (acute and long-term care facilities such as Virtua, St. Barnabas, UMDNJ, Cooper CentraState).	1. Project Scope - establish technical parameters of secured web-based portal and use of PHI for quality assurance purposes. 2. Tasks Required - First Stage: establish stakeholders (physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, consumer groups, etc, legal analysts, information technology experts) to define minimum PHI necessary to assure quality of care and care oversight. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used to provide secure access to minimum PHI necessary for quality review. Third Stage: integrate established web-based portal methodology with electronic media recording and transmission platforms in a manner that safeguards the access and use of PHI. This stage is the key to establishing unified and consistent recordation and use protocols, as well as developing role-based authorization and access. Fourth Stage: explore utility of unique patient identifiers and NPI's to assure proper patient record is being accessed by a physician/institution that actually has a need to do so. Consensus in development and use of hardware (PC versus macro-platforms, cable/phone line encryption, network portals, etc) and software (method of interface between facility/provider and collection	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols and/or e-mail-based protocols, as well as content material that constitutes minimum information necessary to provide meaningful quality assurance audits; iv) establish test input, throughput and output exchanges of patient record/quality review at the institutional/provider level; v) create test exchange of information between inter hospital work groups (e.g., Quality Assurance and Emergency Department patient records); vi) review extent to which the test platform results in timely, accurate ands secure sharing on PHI relative to	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities and payors, as electronic systems are already in place in many NJ treatment centers. Quality Assurance access to facility mainframes or networks may be problematic -access protocols to be established. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care and reduction in treatment errors due to enhanced oversight; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware and software conventions, as well as universally accepted agreement of minimum necessary information.

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81	Interoperability	2 - IT provides hospital Marketing Department only names, addresses, telephone numbers and dates of service. Privacy and Security Officer meets with quality assurance personnel to determine the minimum amount of information necessary to meet the business purpose of analyzing patient encounters.	Technical barrier because of need for standard procedures and access by authorized personnel only.	3. Software needs to be developed that will be universal. This will provide access by authorized personnel only, and standardize procedures.	Based on role-level access, develop universal, standard software and procedures to permit exchange and use of patient information for marketing purposes. Utilize internet and intranet email exchange protocol through use of proprietary software, such as Secure Sockets Layer (A.K.A 128 SSL). This would serve the encryption function. Authentication can be achieved through password and NPI number as a user ID.	Assumptions: 1) that consensus and agreement can be achieved among inter-hospital and intra-hospital work groups regarding minimum information necessary for marketing/quality control purposes; 2) that agreed-upon methodologies can be effectively and economically implemented to permit review of patient information in a secure environment and in a manner that enhances patient care and quality assurance.	Project Ownership: NJ Office of Information and Technology (create facility portal that is universally accessible by necessary facility staff; NJ Department of Health and Senior Services, NJ Board of Medical Examiners, NJ Hospital Association, patient's rights organizations regarding HIPAA such as NJDOBI and NJ Public Advocate and hospitals (acute and long-term care facilities such as Virtua, St. Barnabas, UMDNJ, Cooper CentraState).	1. Project Scope - establish technical parameters of secured web-based portal and use of PHI for quality assurance purposes. 2. Tasks Required - First Stage: establish stakeholders (physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, consumer groups, etc, legal analysts, information technology experts) to define minimum PHI necessary to assure quality of care and care oversight. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used to provide secure access to minimum PHI necessary for quality review. Third Stage: integrate established web-based portal methodology with electronic media recording and transmission platforms in a manner that safeguards the access and use of PHI. This stage is the key to establishing unified and consistent recordation and use protocols, as well as developing role-based authorization and access. Fourth Stage: explore utility of unique patient identifiers and NPI's to assure proper patient record is being accessed by a physician/institution that actually has a need to do so. Consensus in development and use of hardware (PC versus macro-platforms, cable/phone line encryption, network portals, etc) and software (method of interface between facility/provider and collection	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols and/or e-mail-based protocols, as well as content material that constitutes minimum information necessary to provide meaningful quality assurance audits; iv) establish test input, throughput and output exchanges of patient record/quality review at the institutional/provider level; v) create test exchange of information between inter hospital work groups (e.g., Quality Assurance and Emergency Department patient records); vi) review extent to which the test platform results in timely, accurate ands secure sharing on PHI relative to	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities and payors, as electronic systems are already in place in many NJ treatment centers. Quality Assurance access to facility mainframes or networks may be problematic -access protocols to be established. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care and reduction in treatment errors due to enhanced oversight; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware and software conventions, as well as universally accepted agreement of minimum necessary information.

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87	Interoperability	1 - IT meets with Marketing to develop a query to extract aggregate information from patient records for birth outcomes. Query is tested on artificial data.	Technical barrier because of need for standard procedures and access by authorized personnel only.	3. Software needs to be developed that will be universal. This will provide access by authorized personnel only, and standardize procedures.	Based on role-level access, develop universal, standard software and procedures to permit exchange and use of patient information for marketing purposes. Utilize internet and intranet email exchange protocol through use of proprietary software, such as Secure Sockets Layer (A.K.A 128 SSL). This would serve the encryption function. Authentication can be achieved through password and NPI number as a user ID.	Assumptions: 1) that consensus and agreement can be achieved among inter-hospital and intra-hospital work groups regarding minimum information necessary for marketing/quality control purposes; 2) that agreed-upon methodologies can be effectively and economically implemented to permit review of patient information in a secure environment and in a manner that enhances patient care and quality assurance.	Project Ownership: NJ Office of Information and Technology (create facility portal that is universally accessible by necessary facility staff; NJ Department of Health and Senior Services, NJ Board of Medical Examiners, NJ Hospital Association, patient's rights organizations regarding HIPAA such as NJDOBI and NJ Public Advocate and hospitals (acute and long-term care facilities such as Virtua, St. Barnabas, UMDNJ, Cooper CentraState).	1. Project Scope - establish technical parameters of secured web-based portal and use of PHI for quality assurance purposes. 2. Tasks Required - First Stage: establish stakeholders (physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, consumer groups, etc, legal analysts, information technology experts) to define minimum PHI necessary to assure quality of care and care oversight. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used to provide secure access to minimum PHI necessary for quality review. Third Stage: integrate established web-based portal methodology with electronic media recording and transmission platforms in a manner that safeguards the access and use of PHI. This stage is the key to establishing unified and consistent recordation and use protocols, as well as developing role-based authorization and access. Fourth Stage: explore utility of unique patient identifiers and NPI's to assure proper patient record is being accessed by a physician/institution that actually has a need to do so. Consensus in development and use of hardware (PC versus macro-platforms, cable/phone line encryption, network portals, etc) and software (method of interface between facility/provider and collection	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols and/or e-mail-based protocols, as well as content material that constitutes minimum information necessary to provide meaningful quality assurance audits; iv) establish test input, throughput and output exchanges of patient record/quality review at the institutional/provider level; v) create test exchange of information between inter hospital work groups (e.g., Quality Assurance and Emergency Department patient records); vi) review extent to which the test platform results in timely, accurate ands secure sharing on PHI relative to	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities and payors, as electronic systems are already in place in many NJ treatment centers. Quality Assurance access to facility mainframes or networks may be problematic -access protocols to be established. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	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105	Interoperability	1 - If individual insurance policy, patient must sign an authorization which meets requirements of NJ Insurance Information Practices Act. If authorization of patient is submitted by provider, authorization must be in writing, signed and dated, and is effective for one year.	Need to have proper authorization.	1. Defining exact data elements that would be needed for examination would make authentication easier and show just the needed/requested information.	In consultation with NJ Dept of Banking and Insurance, NJ Dept of Health and Senior Services, payors such as State Farm, NJ Manufacturers, Cigna, Oxford, physicians and hospitals, a pilot test should be established to develop an electronic, uniform and standard generic form that can be used to extract minimum information necessary for payors and providers to determine status of patient authorizations. Emphasis to be placed on access controls.	Assumptions: 1) that consensus and agreement can be achieved among all stakeholders regarding minimum information necessary to determine if a patient authorization is valid and still in effect; 2) that agreed-upon methodologies can be effectively and economically implemented to permit review of patient authorizations in a manner that enhances patient privacy and care; 3) that access controls can be established and implemented.	Project Ownership: payors, NJ Board of Medical Examiners, NJ Hospital Association, patient's rights organizations regarding HIPAA such as NJDOBI and NJ Public Advocate and hospitals (acute and long-term care facilities such as Virtua, St. Barnabas, UMDNJ, Cooper CentraState).	1. Project Scope - establish technical parameters of secured web-based portal and use of PHI for determining status of patient authorizations. 2. Tasks Required - First Stage: establish stakeholders (physicians, acute, long-term, ambulatory facilities, lab clinics, diagnostics, consumer groups, etc, legal analysts, information technology experts) to define minimum PHI necessary to ascertain status of patient authorizations. Second Stage: develop stakeholder group that can address hardware and software recommendations (through reliance of existing IT expertise at NJ facilities) that can be used to assure role-based access and proper authorization. Third Stage: integrate established web-based portal methodology with electronic media recording and transmission platforms in a manner that safeguards the access and use of PHI/authorization information. This stage is the key to establishing unified and consistent recordation and use protocols, as well as developing role-based authorization and access. Fourth Stage: explore utility of unique patient identifiers, unique payor identifiers and NPI's to assure proper patient record is being accessed by a physician/institution that actually has a need to do so. Consensus in development and use of hardware (PC versus macro-platforms, cable/phone line encryption, network portals, etc) and software (method of interface between facility/provider and	1. Project timeline-12 months. Milestones: i) initial meeting of core group (steering committee) including project manager, technical/medical advisors and administrative staff to develop list of stakeholders based on expertise and availability; ii) call first meeting of stakeholders to establish roles/responsibilities; iii) research and deliberate on viable hardware and software, web protocols and/or e-mail-based protocols, as well as content material that constitutes minimum information necessary to provide meaningful authorization information; iv) establish test input, throughput and output exchanges of patient record/authorizations at the institutional/provider level; v) create test exchange of information between inter hospital work groups (e.g., Intensive Care Unit access to emergency dept/admission dept that has inform regarding patient authorization; vi) review extent to which the test platform results in timely,	Tracking and monitoring to be based on routine status meetings (weekly conference calls at a minimum, as established by steering committee). Progression to future stages to be premised on viable completion of prior stages.	Minimal impact on health care facilities and payors, as electronic systems are already in place in many NJ treatment centers. Authorization access to facility mainframes or networks may be problematic -access protocols to be established. However, the ultimate exchange protocol should end up being economical and provide an incentive for small institutions and health care providers to participate.	1. Feasibility Assessment: strongly feasible due to existing hardware and software technology. Voluntary participation may be problematic due to concerns about security and liability. Barriers include costs, fears of liability, consumers who decide to opt out if not mandatory, and variation in business agreements.	Single State	1: Importance - high due to potential for enhanced health care and reduction in treatment errors and inadvertent/erroneous exchange of PHI; Ease of Accomplishment - moderate, due to potential problems in achieving consensus on hardware and software conventions, as well as universally accepted agreement of minimum necessary information.

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112	Interoperability	4 - If possible bioterrorism is suspected, governor's office will be briefed. Information will be provided about location of incidents and reasons why it appears to be bioterrorism.	This is a barrier because electronic transmission of health record will not provide all of the information needed. Epidemiologist's findings are relevant. Commission of DHSS has latitude to inform other state entities in cases of emergency.	1. A robust health data information exchange would allow DHSS to merge patient demographics and medical data with epidemiological exposure data.	A standard set of data elements needs to be established that constitute the reporting transaction that needs to be prepared and submitted by any reporting agency combined with the information linking demographics, medical data and epidemiology data. This standard set of data elements will become the baseline from which a standard electronic transaction can be defined for use. The standard set of data elements will become the baseline from which a web-enabled solution is developed to allow for the real time direct data test results by laboratories to the reporting State agency. Security of the web application is essential so that only authorized entities are permitted to record the results tests. The use of Logical Observation Identifier Names and Codes (LOINC) for the reporting of actual test results should be considered. It is expected the anticipated HIPAA electronic claim attachment rule will name this code set as part of the standard for communicating test results as part of a health care claim. It would seem logical to extend the use of this code set to other processes requiring the reporting of test results rather than attempting to establish a standard that uses a "proprietary" set of data elements to report test results. Without the establishment of a robust Health Information Exchange (HIE)	A single State agency should be made responsible for the collection of all patient, medical and epidemiology results. This entity will be responsible for the design, development, implementation and operation of a web based solution that can collect all pertinent information and inform the proper entities.	State of New Jersey Department of Health and Senior Services. DHSS is the agency that is responsible for the dissemination of bioterrorism information. State of New Jersey Department of Banking and Insurance. DOBI is required to adopt administrative rules for the implementation of the HIPAA Transaction and Codes Sets; the privacy and security of health care electronic networks and electronic health records. This work is done in consultation with DOHSS. Consequently, it is appropriate that DOBI act as the central coordinator for the development of a Health Information Exchange. The implementation of a Health Information Exchange will require the involvement of many state, local government agencies as well as private entities. Without the active participation of all, success is unlikely.	The scope of this project is to define, develop and implement a robust Health Information Exchange. A firm commitment from all stakeholders is necessary to create and operate this entity. The project must consider all business processes from the point that the information of the bioterrorism event is reported. Pertinent information is to be gathered to ensure that data included is standardized and available to all necessary entities. Major tasks are: Assemble Project Team Assess Legislative Limitations/Required Legislative Action Develop Project Plan Define Requirements for the storage of any PHI data Define standard data content reporting Define web pages (format and content) Define web access security requirements Prepare and Secure Approval of System Design Document Develop/Test Application Document Application Conduct User Training Implement Project Post Implementation Project Monitoring	A project schedule will be developed that will define all major units of work to be performed as part of this project.	The project manager, during the initial phase, will measure progress against the established project plan, tracking actual project schedule against proposed project schedule and actual resource utilization against projected project resource needs.	All stakeholders will need to develop a means to support electronic reporting and collection of data to the HIE.	The creation of a standard set of data elements to be reported by laboratories for all blood lead screening tests performed is feasible. Creation of both an electronic transaction for batch reporting as well as the development and deployment of a web based solution for laboratory reporting would give reporting laboratories the ability to select the method for submission of test results that they feel is most appropriate to their internal operations. Barriers to this solution could include the unwillingness to allow for the secure use of social security number to identify either the patient or the adult custodian of the patient based on confidentiality concerns or identity theft concerns. There is no other unique individual identifier that exists that could be used as an alternative to the social security number and there does not appear to be any interest at the national level to pursue the assignment and use of a unique patient identifier under HIPAA. Relying on use of non-unique secondary identifiers such as patient name, date of birth, gender and physical street address will have a significant adverse impact on the accuracy of reporting.	Single State	Project Importance: Very High. Ease of Accomplishment: From both a technical and a business process perspective this project is complex. Order to be Completed: There are several critical actions that need to be taken before significant effort can and should be invested in this project.

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116	Interoperability	1 - Hospital takes sample and transmits to Public Health Laboratory Services for Inborn Errors of Metabolism testing, along with information about the parent(s) and child.	Sample cannot be sent electronically.	1. Comprehensive database to receive results for sharing and reporting.	A standard set of data elements needs to be established that constitute the reporting transaction that needs to be prepared and submitted by any reporting agency combined with the information linking demographics, medical data and epidemiology data. This standard set of data elements will become the baseline from which a standard electronic transaction can be defined for use. The standard set of data elements will become the baseline from which a web-enabled solution is developed to allow for the real time direct data test results by laboratories to the reporting State agency. Security of the web application is essential so that only authorized entities are permitted to record the results tests. The use of Logical Observation Identifier Names and Codes (LOINC) for the reporting of actual test results should be considered. It is expected the anticipated HIPAA electronic claim attachment rule will name this code set as part of the standard for communicating test results as part of a health care claim. It would seem logical to extend the use of this code set to other processes requiring the reporting of test results rather than attempting to establish a standard that uses a "proprietary" set of data elements to report test results. Without the establishment of a robust Health Information Exchange (HIE)	A single State agency should be made responsible for the collection of all patient, medical and epidemiology results. This entity will be responsible for the design, development, implementation and operation of a web based solution that can collect all pertinent information and inform the proper entities.	State of New Jersey Department of Health and Senior Services. DHSS is the agency that is responsible for the dissemination of bioterrorism information. State of New Jersey Department of Banking and Insurance. DOBI is required to adopt administrative rules for the implementation of the HIPAA Transaction and Codes Sets; the privacy and security of health care electronic networks and electronic health records. This work is done in consultation with DOHSS. Consequently, it is appropriate that DOBI act as the central coordinator for the development of a Health Information Exchange. The implementation of a Health Information Exchange will require the involvement of many state, local government agencies as well as private entities. Without the active participation of all, success is unlikely.	The scope of this project is to define, develop and implement a robust Health Information Exchange. A firm commitment from all stakeholders is necessary to create and operate this entity. The project must consider all business processes from the point that the information of the bioterrorism event is reported. Pertinent information is to be gathered to ensure that data included is standardized and available to all necessary entities. Major tasks are: Assemble Project Team Assess Legislative Limitations/Required	A project schedule will be developed that will define all major units of work to be performed as part of this project.	The project manager, during the initial phase, will measure progress against the established project plan, tracking actual project schedule against proposed project schedule and actual resource utilization against projected project resource needs.	All stakeholders will need to develop a means to support electronic reporting and collection of data to the HIE.	The creation of a standard set of data elements to be reported by laboratories for all blood lead screening tests performed is feasible. Creation of both an electronic transaction for batch reporting as well as the development and deployment of a web based solution for laboratory reporting would give reporting laboratories the ability to select the method for submission of test results that they feel is most appropriate to their internal operations. Barriers to this solution could include the unwillingness to allow for the secure use of social security number to identify either the patient or the adult custodian of the patient based on confidentiality concerns or identity theft concerns. There is no other unique individual identifier that exists that could be used as an alternative to the social security number and there does not appear to be any interest at the national level to pursue the assignment and use of a unique patient identifier under HIPAA. Relying on use of non-unique secondary identifiers such as patient name, date of birth, gender and physical street address will have a significant adverse impact on the accuracy of reporting.	Single State	Project Importance: Very High. Ease of Accomplishment: From both a technical and a business process perspective this project is complex. Order to be Completed: There are several critical actions that need to be taken before significant effort can and should be invested in this project.
118	Interoperability	2 - Patient signs release in doctor's office to allow medical information to be shared with drug treatment clinic.	No common format for release form.	1. Enforce the state mandate as it offers greater protection to patients. Electronic exchange is ideal, and would streamline the process.										

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119	Interoperability	2 - Physician determines what information is relevant for treatment and faxes previous provider with description of emergency and request for information.	Administrative barrier because other provider may not respond or may have specific form required for request.	1. Require standardized request form that is to be used and accepted by all New Jersey entities that exchange private health information.	Implementation of standardized forms, both in paper and electronic version, and using email and internet capabilities to supplement existing fax/phone usage, will allow physician practices the capability to reduce barriers in current time delays in obtaining information from previous healthcare providers. Process would NOT replace options in place now (face to face, phone and fax communications), but would supplement and standardized multitude of forms now in use.	1) Electronic exchange of data would need to follow HIPAA regulations for encryption. 2) Identical form would need to be used in both electronic (PDF) and paper (fax) formats. 3) Form would need to have appropriate sections for certain health care provision with special regulations, such as mental health.	1) For standard form development, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide 'request for medical information form', to be used between medical providers, in both paper and electronic formats. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process, having covered entities use newer technologies in place of existing practices.
120	Interoperability	3 - If there is no previous relationship between the two hospitals, disclosing provider calls back hospital and asks to be connected to requesting physician to gain outside verification that physician is who he/she claims to be. If there is a previous relationship, check that fax number is correct. If disclosing provider is in another state, request may be ignored.	If requesting provider is not familiar or disclosing provider is short on staff, the process to verify identity is seen as too time-consuming.	1. Require standardized request form that is to be used and accepted by all New Jersey entities that exchange private health information.	Implementation of standardized forms, both in paper and electronic version, and using email and internet capabilities to supplement existing fax/phone usage, will allow physician practices the capability to reduce barriers in current time delays in obtaining information from previous healthcare providers. Process would NOT replace options in place now (face to face, phone and fax communications), but would supplement and standardized multitude of forms now in use.	1) Electronic exchange of data would need to follow HIPAA regulations for encryption. 2) Identical form would need to be used in both electronic (PDF) and paper (fax) formats. 3) Form would need to have appropriate sections for certain health care provision with special regulations, such as mental health.	1) For standard form development, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide 'request for medical information form', to be used between medical providers, in both paper and electronic formats. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process, having covered entities use newer technologies in place of existing practices.

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121	Interoperability	5 - Physician gives patient information for specialist to hand-carry if patient is competent. If not, patient information is faxed to specialist.	Technical barrier because of need to verify identity.	1. Utilize unique Patient Identification Number, photo ID or other form if valid ID. Can be placed on file and copied for visual recognition at subsequent visits.	Difficulty in patient identification process since there is not a statewide identification number or other identifier used by all providers. Current process is inefficient, and often leads to multiple, fragmented 'medical records' for patients, many times within a single provider information system. Processes to 'calculate' unique patient identifier are difficult to maintain over a lifetime, especially when an individual changes names (marriage, divorce, etc) multiple times.	1) Process would need to include identification for out of state resident patients, especially given New Jersey proximity to New York, Pennsylvania and Delaware. 2) Number would need to be included in all electronic and paper transaction forms, including billing.	1) For unique patient identifier, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide patient identification number. Card would be issued by Department of Health. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 1 year period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take two year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation, 1 year to allow preparation by existing vendors of electronic systems containing ePHI. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) All existing electronic systems would need to be modified or expanded to incorporate a statewide patient identification number	multi;	1) High 2) High due to need to add to existing systems.
129	Interoperability	3 - Releasing clinic in NJ will fax or mail to doctor if patient requests or give records to patient to hand carry.	No consistent understanding of what request form should contain. Verification procedures are often seen as too onerous.	2. Verification can be based on NPI and password access into RHIO, which act as security monitor.	Development of a RHIO would allow efficient patient more effective control over who could access their information, and reduce multiple forms now necessary between covered entities who exchange protected health information.	1) RHIO would utilize 'Pull' technology, where information would be available, with proper authorizations, and only on a needed basis. 2) Provider requesting information would need proper authorization credentials, and substantial fines/penalties could be levied against unauthorized individuals who attempt/succeed in accessing information under false pretenses.	1) For a RHIO, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide RHIO. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft process and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation for covered entities	Developed by project leader as part of project deliverables. Process would take two years total, 3 months for initial work, 3 months for comment period, 1 year for development and implementation, 6 months to allow preparation for use by covered entities. Costs would include appropriate reimbursement for staff hired or assigned to develop/maintain RHIO, participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Necessary education to ensure all involved in mental healthcare delivery process understand HIPAA regulations (what is allowed, what is not), proper use, and penalties for misuse, of system.	multi;	1) High 2) High due to need to development of statewide RHIO.

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103	State Law	3 - Specialty treatment facility will not release any information about substance abuse.	Belief that law inhibits released any information to a provider, shelter, or county program.	1. State mandate offering rules and regs regarding sharing of mental health and substance abuse and infectious disease information.										
104	State Law	4 - Patient must request information in writing from provider who treated her aunt. Provider needs to verify that patient is a blood relative and that information is being used for medical diagnosis.	State law restrictions. Physician may disclose information, but is not required to do so. Physician may feel it is too onerous.	1. Specific state and interstate mandates agreements should be put in place to release PHI as relates to risk stratification of patients. Standards to prove identity and relationship should be established.										
108	State Law	7 - Medical claims are submitted to patient auto insurance first and then to medical insurance company as secondary insurer.	State regulations must be followed. Policy is based on NJ no-fault, personal injury protection (PIP) auto coverage laws.	1. Payors need to know what they're paying for. Ensuring secure data transmission is key.	The NJ Department of Banking and Insurance should be required to maintain and publish a fee schedule of medical services covered under the Personal Injury Protection laws. The fee schedule should reflect the reasonable and prevailing rates, based on a market standard of provider charges, for these services. The Department will serve as an impartial third party in enforcing the fee schedule for providers and payers.	1)Greater transparency is needed to provide both payers and providers with complete information vis-à-vis services rendered and paid for. Facilitating greater transparency will reduce uncertainty and create greater efficiencies for both payers and providers. 2) The Department of Banking and Insurance is ready, willing and able to act as a third party regulator and enforcer over payers and providers to ensure compliance with the fee schedule. 3) There are mechanisms available to the Department that provides an accurate and independent assessment of the market value of the services in question.	The Office of Regulatory Affairs in the Department of Banking and Insurance should canvas affected constituencies including but not limited to the NJ Hospital Association, the Medical Society of NJ and the Insurance Association of NJ regarding the appropriate modality by which to implement an accurate fee schedule for services rendered pursuant to the Personal Injury Protection laws. That information should be utilized in developing a rule proposal that effectuates a market based fee schedule.	1)The promulgation of a rule governing the rendering of medical services under the Personal Injury Protection laws will foster complete transparency for payers and providers. In effectuating transparency the Department should be mindful of the economic realities impacting the availability of covered services. 2) The Department should engage affected constituencies in a pre-proposal setting to understand the intricacies of the services provided; the Department should then promulgate a rule pursuant to the rule making process.		1)The project should mirror the rule making timelines established by statute. The comment period associated with the rule proposal should be of an adequate duration to allow for a comprehensive economic analysis of the proposed fee schedule. 2) Costs would be commensurate with the normal rule making process, cost beyond that would be nominal. The Department would be expected to spend an adequate amount of human resources to effectuate a timely publication of the rule. The department should establish a working group composed of the affected constituencies and pertinent department staff whose charge is to track compliance and enforcement of the rule, and its impact on the availability of covered services. The group should also be empowered to suggest changes to the department in their administration of this particular rule.	Once implemented, the rule should foster enhanced transparency. Increased transparency should create greater predictability in projected costs and revenues for both payers and providers. That information should allow payers and providers greater certainty in planning and lead to novel efficiencies in rendering services to patients. A defined fee schedule could reduce the need for third party arbitration, translating into lower auto insurance rates for patients.	1)The rule making process and the available economic data should provide the necessary tools to develop a fee schedule. 2) Disagreements between payers and providers on the criteria by which the market standard is determined have traditionally disrupted efforts to promulgate mutually acceptable fee schedules.	Single	1)low 2) Difficult, considering the spectrum of stakeholders. 3) a. stakeholder canvassing b. rule proposal c. economic analysis d. comment review e. amendment f. adoption.

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115	State Law	9 - After 9/11 attack, hospitals were overwhelmed with requests about whether family members had been admitted. Some hospitals developed a web site where person's name could be typed in and their presence in the hospital could be verified. No list of patients was available on line.	Barrier because proper procedure and authority are not clear.	1. Development of state and interstate mandates/agreement for display of patient name, DOB, gender during catastrophic events at hospitals.	During a catastrophic event, like the aftermath of the 9/11 attack; there are multiple stakeholders who may request information from area hospitals to determine whether family members were admitted. These stakeholders may include public health authorities such as DHSS, state officials, media, law enforcement, Red Cross and other disaster relief agencies, next of kin, New Jersey hospitals and hospitals or authorities in other states if a national emergency is declared. Maintaining a directory of patients in a centralized website accessible to family members during a catastrophic event will effectively reduce the burden of requiring family members to go to individual hospitals to determine whether their loved ones are inpatients. As set forth in the attached, there is express authority under HIPAA and no express authority under state law (N.J.S.A. 28:13-17) to prohibit hospitals from developing patient directories consistent with the standards of 45 C.F.R. 164.510(a). However, there is no express authority or procedure to permit a third party (not designated as a relief agency) to receive patient information and to disclose it on its website to aid in reporting the location of patients after a catastrophic event. In order for hospitals to make patient directory information available in a website	Assumptions: 1)that the goal is to provide central access to limited patient directory information (meeting the standards of 45 C.F.R. 510(a) or more limited information) on a website during a catastrophic event to family members to reduce the burden of having to call individual hospitals to determine whether a family member was admitted; 2) access to patient directory information may need to be available in multiple states if a national emergency is declared; 3) HIPAA allows the maintenance of patient directory information (patient name, location and general condition) by hospitals, but does not specifically address a hospital's authority to provide this type of information in a central web-based data base; 4) NJ state law and the laws of other states would not prohibit the development of patient directories consistent with the standards of 45 C.F.R. 164.510(a).; 5) access to patient name, DOB and gender via input of patient name would allow non-family members (i.e. media, relief agencies) who otherwise may not have authority to access this information under normal circumstances; 6) express authority would need to be established in order for a hospital to disclose information to NJHA or another agency assisting in locating family members during an emergency. Decisions: 1) representatives from a cross-section of hospitals (large, small, community)	1) For a state solution, dependency exists on the team developing a process that includes clear authority to allow hospitals to provide patient information in a web database maintained by a hospital or a third party; 2) Team should also include legal SME, NJHA representatives involved in setting up the website after 9/11 (for process, lessons learned, challenges) to ensure development of state/interstate mandates/agreements are consistent with relevant law. The Team should also include consumers to ensure any concerns, privacy issues are addressed; 3) A team comprised of a cross-section of representatives from hospitals, NJHA, lawyers, and consumers to help ensure that the process for developing the website and its functionality meet the goal of the project to ensure rapid access to uniform information to locate family members in a hospital following a catastrophic event; 4) A team leader will need to be identified to facilitate team coordination and ensure work plan completion.	Scope: To develop a secure website (at least in NJ) that complies with patient privacy requirements and contains limited patient directory information accessible to family members by entering a patient's (first and last name) after a catastrophic event to reduce the burden of family members having to call individual hospitals to determine if a family member is an inpatient. The project must include a process to include patient directory information from other states in case a national emergency is declared. Tasks include: 1) Identify a team leader; 2) Identify members of the team taking into consideration the various stakeholders impacted by this business practice; 3) Evaluate the practice/procedure adopted in NJ after the 9/11 attack to make patient directory information available on a website and identify any barriers/lessons learned. Obtain information about how other states dealt with the same issue to identify best practices; 4) Draft a position paper on relevant HIPAA and other applicable state law. See NJHA position paper on "The Impact of the HIPAA Privacy Rule on Nihau's & Hospital's Emergency Response", dated August 25, 2004 and the NJHA "HIPAA Emergency Preparedness", both of which are instructive; 5) Develop a procedure to implement input/sharing by all hospitals at least in NJ to share patient directory information; 6) To the extent there is a need for a website with	Since process implemented in New Jersey to allow family members access to patient directory information via a website in 2001 after a catastrophic event (the 9/11 attack), can serve as a framework for implementing the business practice. Once consensus is reached in terms of the necessary authority required to permit an entity (other than a public health authority or a relief agency) to receive patient information then the following milestones could be met within the next 12-18 months: assemble hospital representatives, commissioner of health, community representatives, SME for planning team, legal adviser to assist in drafting state mandates/interstate agreements, choose group leader, develop timeline for work, research best practices and procedures implemented in other states and identify any barriers that could impact implementation of a website accessible in multiple states if a national emergency is declared, draft	The following steps can be developed to track project status, measure and report progress: (1) Team should develop a detailed project plan with deliverables and deadlines that is accessible to entire team to input status of assignments; (2) periodic conference calls convened by team leader for team discussion of progress, deliverables and co-dependencies; (3) Team members input status of tasks prior to conference calls with the team leader coordinating team sessions and updating the project plan; (4) team leader periodically reports to HISPC project team on status and progress, issues etc.; (5) final policy/procedure and template state mandate/interstate agreements provided to HISPC project team for implementation. Same process would apply if business practice is implemented in multiple states.	Once authority is identified and a procedure is developed for disclosure of patient directory information into a web database, the expectation is that all hospitals (statewide) would follow this procedure. Once the procedure is implemented by a majority, if not all, hospitals (small, rural, large and community hospitals), it may provide a uniform approach for family members to access patient directory information in one place and eliminate the need to access this information at each individual hospital. To the extent authority is identified and this procedure can be replicated in all states, then family members could access patient directory information in other states via a website in case of a national disaster/emergency. This will reduce the burden of family members having to contact individual hospitals in each state after an emergency, like Katrina, after which many New Orleans residents were displaced and relocated to other states.	Given the 2001 process to provide access to patient directory information on a website that took place after the 9/11 disaster, it is very feasible that a statewide procedure could be adopted. Possible barriers may include: failure to properly identify the authority to allow an agency not designated as a relief organization to maintain the website; inability of hospitals to update the website; rejection of the adopted procedure by the public unless individuals maintain the ability to opt out of including information in website directory; consistent and confirmed participation by stakeholders; failure for designated team members to complete tasks timely; failure of a majority of hospitals in NJ to adopt the policy; failure to reach interstate agreements or prohibition under applicable laws in other states to share patient directory information to respond after a national disaster.	Multistate as most catastrophic events have multistage implications.	1)This business practice is of medium/high importance as it will reduce the burden of family members having to approach individual hospitals in NJ to locate a loved one after a catastrophic event. 2) Accomplishment in New Jersey should not be too difficult as there is a process that was adopted after the 9/11 disaster that resulted in some hospitals disclosing patient directory information via a web database. Proper authority and procedure need to be documented to allow DHSS or hospitals to disclose patient directory information to non-relief agencies. May be more difficult to implement in other states if unwillingness or legal impediment for sharing patient directory information interstate or if interstate mandates/agreements cannot be reached. 3) Need to first establish authority for establishment of a website of patient directory information by disclosure of patient information by hospitals to

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134	State Law	4 - If law enforcement officer enters ED and requests urine drug screen (UDS) and blood alcohol, attending physician takes test materials from police kit and returns to officer after testing without looking at results. If physician wants UDS and blood alcohol for treatment will retest and record results in confidential patient record which does not go to officer.	Barrier because standard procedures must be followed.	1. To achieve standard procedures, education program regarding consent requirements and applicability of waivers should be a condition of retaining NPI in good standing. In this scenario, providing toxicology results to law enforcement would be considered legal. However, disclosure to the parents is not so clear, as this info (blood alcohol level) is potentially extraneous to the actual treatment that would ensue due to injuries sustained in the motor vehicle accident (absent any complications caused by intoxicants). This should be the subject of model laws and education.	1. Facilities must assure policies and procedures clearly lay out when and how ED staff can perform a UDS/BAT on an individual (the "Individual") brought to the ED and release the test results to a law enforcement official, when the law enforcement official is the one who requested the testing be performed and the results be released to him/her for law enforcement purposes, and such UDS/BAT is not otherwise necessary for treatment purposes with respect to such Individual. ED staff must be aware that before a UDS/BAT test can be performed in response to a request by a law enforcement official, the ED staff must either: (a) obtain consent from the Individual to perform any such test, or if the Individual is a minor, obtain consent from the parent; or (b) request that the law enforcement officer present a court order demonstrating his/her legal authority to compel the test to be conducted without the Individual's consent. [note: although New Jersey law permits minors (defined as individuals under the age of 18, See N.J.S.A. 9:17B-1.a) to independently consent (without a parent) to medical treatment under a certain circumstances (e.g., if married; pregnant; has been sexually assaulted; seeking treatment for drug or alcohol dependency; seeking treatment for a venereal disease; or	Assumptions: 1. that our goal is to create a standard policy and procedures (P/P) and "Consent" form, for use at least in the State of New Jersey, to facilitate uniform practice and understanding regarding the performance of UDS/BAT and release of test results for law enforcement purposes; 2. that representatives from other hospitals (and possibly from law enforcement) should participate in developing the standardized P/P and Consent that would be used in these circumstances (including determining whether such consent form should also be "HIPAA-compliant"); 3. that the planning should utilize an established understanding of governing laws in preparing the P/P and Consent, which will be provided in advance to the team by the HISPC implementation team; 4. that planning should incorporate education of all ED staff that may be the recipient of such request from a law enforcement official; 5. that this education should include written and oral training, with periodic follow-up; 6. that all ED staff and law enforcement are willing to embrace the standard P/P and use of the Consent.	Dependency exists on there being a uniform understanding between facility ED staff and law enforcement with regard to when and under what circumstances UDS/BAT can be performed on a patient for law enforcement purposes. Ideally, a Planning Team for this Solution should engage ED staff of several facilities and representatives of law enforcement to develop and implement a standard P/P and Consent form. This will assure or at least minimize a disconnect between law enforcement expectations and ED staff limits on performing non-routine procedures and tests on patients without valid consent or legal authorization. A Planning Team leader should facilitate team coordination and ensure work plan implementation/completion. Team must also include legal representation to assist with developing P/P and Consent that is consistent with relevant State law governing: patients right to consent; lawful search and seizures; duty to screen ED patients; minors etc.	1) To develop a standard P/P and Consent form for the hospital facility community to implement and use when ED staff is asked to perform a UDS/BAT on an Individual brought to the ED by a law enforcement official. The project must include education and implementation of a P/P and Consent that addresses and resolves open issues relating to whether ED staff can ever, under any circumstances: (a) perform a UDS/BAT without patient consent or a court order?; (b) perform a UDS/BAT on an Individual without "registering" him/her as a facility patient?; (c) release the UDS/BAT test result (even if solely for law enforcement purposes) to a law enforcement official without first obtaining a HIPAA-compliant written authorization from the Individual/patient; (d) perform a UDS/BAT on a minor without parental consent. The standard P/P and Consent must clearly address the manner in which each of these scenarios will be addressed. 2) Tasks include: 1. Identify P/P and Consent planning group leader; 2. Identify current hospital ED practices and issues; 3. Identify who (law enforcement vs. ED staff) will obtain necessary Consent from Individual prior to performing the UDS/BAT; 4. Obtain information and conclusions on understanding of relevant law governing or relevant to the "open issues"; 5. Discuss and determine appropriate and uniform P/P and Consent development	1) There must first be delivery of output on uniform understanding of relevant law on "open issues" before the Solution can be implemented. Law enforcement stake holders could delay consensus on developing a uniform P/P which facilities would likely otherwise agree upon. Over a 12-month period, it is expected that the following milestones could be met: (a) assemble appropriate ED or other facility staff representatives, law enforcement representative, and legal representative for the Planning Team; (b) develop a timeline for work and specific work assignments (within the Planning Team); (c) collect relevant data on current practices; (d) reach a consensus on relevant policy and procedural issues; (e) draft P/P document; (f) draft Consent document; (e) seek adoption of the P/P and Consent form by NJHA and State and local law enforcement agencies; (f) create steps for training and implementation. 2) Projected costs would	The following will be developed to facilitate project status tracking and completion: 1. Develop detailed project planning document, for entire team to utilize; 2. Periodic conf. calls pre-arranged for team discussion, planning and participation to occur; 3. Group Leader coordinates team sessions, as needed, and completes project plan to ensure milestones are achieved on a timely basis; 4. Group leader periodically reports (to post-HISPC project team) on status, progress, issues, etc.; 5. final policy and procedure documents provided to HISPC and disseminated.	Once developed, the standard P/P and Consent for ED staff performing UDS/BAT for law enforcement purposes will hopefully be adopted by the hospital and law enforcement community, and when adopted and implemented by a majority of the hospital and law enforcement community, this should promote uniformity with respect to this business practice.	1) The creation of a standard written P/P and Consent form for ED staff performing UDS/BAT for law enforcement purposes is very feasible; however, adoption of this standard procedure as a statewide standard will depend on their acceptability to/adoptability by the institutional community and law enforcement not represented on the Planning Team. 2) Barriers could include: 1. Failure of timely delivery of uniform understanding of relevant legal requirements (prior to work on this solution); 2. Challenges in identifying an appropriate Group Leader; 3. consistent and continued availability and participation of Planning Team members and identified stakeholders, impacting completion of work effort and timing; 4. Inability of group to reach consensus on standard approach to this Solution; 5. Inability to reach consensus on language of standard P/P and Consent form; 6. failure of non-participating facilities and law enforcement agencies to utilize the standard P/P and Consent developed.	??	1) Low. 2) To the extend that there are a lot of hospitals that perform UDS/BAT as a "courtesy" for law enforcement officials, there could be resistance from the law enforcement community if the implementation of the proposed P/P and Consent will force them to take additional steps, such as: obtain written consent from the Individual being tested; obtaining consent from the parent of a minor; obtaining a court order; or taking the Individual to another provider-type that will perform the UDS/BAT. If there is cooperation from law enforcement, then the Ease of Accomplishment of this Solution will be positively affected. 3) Cannot proceed until delivery of solutions relating to creation of standard, and uniform understanding of legal requirements regarding consent and lawful search and seizures.
68	Workflow: Role Based Access	4 - Provider's IT department gives each case manager a logon id and password to access the medical record on the web portal. Robustness of security varies between systems.	Need to maintain security of electronic system.	2. Limit access & screen access to only those cases that are be managed by the case workers. Policy and procedures need to be in place for access privileges.										
76	Workflow: Role Based Access	1 - Marketing/Quality Assurance each meet with IT develop a query to extract information from patient records for specific conditions. Queries are tested on artificial data.	Technical barrier because of need for standard procedures and access by authorized personnel only.	1. State mandated/approved algorithm for de-identification of data.										

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123	Workflow: Role Based Access	3 - If physician is part of network, need to show badge or sign in at desk to enter unit. If doctor is not part of network, nurse must confirm that appointment was made with physician; physician must sign in at desk.	Need for standard procedures for verifying identity of doctors.	1. This is an operational issue that each hospital/unit handles based on the level of physical security needed for that particular unit. Specifically, could include use of NPI ID card that contains an embedded bar code that, when swiped, describes key information regarding the provider for purposes of authentication. Could include taxonomy code, request for password or other unique info that appears on screen of reviewer.	Development of a physician ID card with NPI would allow efficient identification of providers, especially when physician does not normally participate in organizations health care delivery.	1) Process would need to include identification for out of state physicians, especially given New Jersey proximity to New York, Pennsylvania and Delaware. 2) Number would need to be included in all electronic and paper transaction forms, including billing.	1) For physician id card, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide physician id card. Card would be issued by Department of Health. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) six month period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take two year total, 3 months for initial work, 3 months for comment period, 1 year for modifications.implementation, 6 months to allow preparation by existing covered entities. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any physician provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other.	multi;	1) High 2) Medium due to setup time needed to implement statewide process.

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125	Workflow: Role Based Access	6 - If physician will continually visit, medical director of facility meets with him/her to establish a business agreement covering the access physician will have to facility medical records. Physician must supply multiple credentialing documents. After agreement is place, facility staff know physician by hospital gown with name tag when he/she checks in with nurse on unit.	Vetting of physicians to assure appropriate care of patients. Need for business agreements including privacy policies and procedures.	1. This is an operational issue that each hospital/unit handles based on the level of physical security needed for that particular unit - in this case, a psych unit where security should be higher. Solution could include use of NPI ID card that contains an embedded bar code that, when swiped, describes key information regarding the provider for purposes of authentication. Could include taxonomy code, request for password or other unique info that appears on screen of reviewer. The Hardware system that processes the NPI number could then access a centralized database (RHIO or other patient-physician centric system) that matches the patient to the provider as the primary care health giver. A match would then result in an immediate release of the patient's admission records while the physician was at the facility.	Development of a physician ID card with NPI would allow efficient identification of providers, especially when physician does not normally participate in organizations health care delivery.	1) Process would need to include identification for out of state physicians, especially given New Jersey proximity to New York, Pennsylvania and Delaware. 2) Number would need to be included in all electronic and paper transaction forms, including billing.	1) For physician id card, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide physician id card. Card would be issued by Department of Health. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) six month period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take two year total, 3 months for initial work, 3 months for comment period, 1 year for modifications.implementation, 6 months to allow preparation by existing covered entities. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any physician provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other.	multi;	1) High 2) Medium due to setup time needed to implement statewide process.
31	Workflow: Security/Privacy Standard	7 - If information is not needed immediately, ED physician contacts medical records department at other hospital. Will be asked name, department, and license number by staff. Sometimes sending hospital will require a form verifying identity to be completed, signed, and faxed. Information will be received by fax hours later.	Barrier because of need for procedures to verify identity and maintain security of fax.	1. Web portal with integrated authentication mechanisms using a single sign on approach to automatic sending requests (which can then dump to fax) and then be sent back (converted from fax to .pdf) to web portal.				Define Encryption Requirements for the storage of any PHI data						

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33	Workflow: Security/Privacy Standard	7 - If information is not needed immediately, ED physician contacts medical records department at other hospital. Will be asked name, department, and license number by staff. Sometimes sending hospital will require a form verifying identity to be completed, signed, and faxed. Information will be received by fax hours later.	Barrier because of need for procedures to verify identity and maintain security of fax.	3. *****Web portal with fax/in out capabilities would speed process and have inbuilt authentication.				Define primary and secondary match processes						
35	Workflow: Security/Privacy Standard	7 - If information is not needed immediately, ED physician contacts medical records department at other hospital. Will be asked name, department, and license number by staff. Sometimes sending hospital will require a form verifying identity to be completed, signed, and faxed. Information will be received by fax hours later.	Barrier because of need for procedures to verify identity and maintain security of fax.	5. Procedures need to be developed to address the identity and security level of the faxed information. This needs to be followed with policy & procedure documents. Suggest including Medical Records Association input, with development of procedures.				Develop/Test Application						
36	Workflow: Security/Privacy Standard	2 - Physician determines what information is relevant for treatment and faxes previous provider with description of emergency and request for information.	Administrative barrier because other provider may not respond or may have specific form required for request.	1. *****Faxes have security liabilities with drawn out verification that is not always carried out. Use of a web portal with fax in/out capability will facilitate such a communication.	May need to adopt law in NJ that expressly requires providers to freely share PHI with other providers unless an exception exists. Alternatively, include a policy verifying that one provider's reliance on another provider's authorization as valid will be deemed a compliant practice under HIPAA and NJ law. In addition, a policy verifying that treating providers do not need to limit PHI to the minimum necessary will help ensure that information is efficiently shared.	1. Providers usually prefer to use their own authorization form to ensure it meets HIPAA requirements for valid authorizations and has been vetted by legal counsel. 2. Providers are risk-averse following the adoption of HIPAA privacy rules and, as a result, are reluctant to rely solely on the request for info from another provider.	The New Jersey DHSS, DOBI or Board of Medical Examiners may head project team dedicated to developing standard p/p related to use of sharing PHI among treating providers. Participants should include representation from hospitals, physicians, medical records staff and emergency department nurses and physicians.	Document Application						

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39	Workflow: Security/Privacy Standard	4 - If requesting provider is known, releasing entity checks fax number. If requesting provider is not known, then staff person calls and verifies identity.	Barrier due to need for verification procedures.	1. *****Web portal with fax in/out. The portal could get fax verification signal using current fax communications standards.				Post Implementation Project Monitoring						
40	Workflow: Security/Privacy Standard	4 - If requesting provider is known, releasing entity checks fax number. If requesting provider is not known, then staff person calls and verifies identity.	Barrier due to need for verification procedures.	2. ******Creating standards related to fax communications as well as creating standard Business Associate Agreements. Also, educating stakeholders on HIPAA's TPO (Treatment, Payment and Health Care Operations) clause for disclosures.										
41	Workflow: Security/Privacy Standard	4 - If requesting provider is known, releasing entity checks fax number. If requesting provider is not known, then staff person calls and verifies identity.	Barrier due to need for verification procedures.	3. Procedures need to be developed to address the identity and security level of the faxed information. This needs to be followed with policy & procedure documents.										
43	Workflow: Security/Privacy Standard	8 - When physician uses EMR for referrals, sends request for patient referral to referral department, which creates an electronic referral and sends to specialist through secure web portal. If specialist is not in EMR network, referral department will print out copy of electronic version and fax to specialist. After faxing, perhaps weeks or months later, physician will receive letter that patient was seen by specialist and description of the assessment and treatment plan.	Technical barrier due to need for security policies and procedures for web portal.	2. Minimum encryption and authentication standards need to be developed for all web portals related to medical information.										

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44	Workflow: Security/Privacy Standard	8 - When physician uses EMR for referrals, sends request for patient referral to referral department, which creates an electronic referral and sends to specialist through secure web portal. If specialist is not in EMR network, referral department will print out copy of electronic version and fax to specialist. After faxing, perhaps weeks or months later, physician will receive letter that patient was seen by specialist and description of the assessment and treatment plan.	Technical barrier due to need for security policies and procedures for web portal.	3. Procedures need to be developed to address the identity and security level of the faxed information. This needs to be followed with policy & procedure documents.										
45	Workflow: Security/Privacy Standard	2 - If physician is part of LTC facility's network, patient discharge summary (includes final diagnosis, medications w/ dosage and instructions), lab tests, etc. can be accessed through web portal, using password, and can be downloaded from web portal. If doctor is out of network, little or no data will be shared.	Technical barrier due to need for security policies and procedures for web portal. May be problem with consistent identifiers for patients.	1. If physician/provider is patient's PCP but out of network then state mandate should be made for PCP to view information on web portal through web sign up procedure.										
46	Workflow: Security/Privacy Standard	2 - If physician is part of LTC facility's network, patient discharge summary (includes final diagnosis, medications w/ dosage and instructions), lab tests, etc. can be accessed through web portal, using password, and can be downloaded from web portal. If doctor is out of network, little or no data will be shared.	Technical barrier due to need for security policies and procedures for web portal. May be problem with consistent identifiers for patients.	2. Minimum encryption and authentication standards need to be developed for all web portals related to medical information.										

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52	Workflow: Security/Privacy Standard	7 - When physician uses EMR but facility does not, he/she comes with lap top and enters practice notes, physicians orders, and assessments into EMR and provides nursing home with hard copy for its records.	Need for policies and procedures to protect exchange and physical access to records.	1. Treat the printed documentation equivalent to a handwritten note. Physician's laptop should be secure enough to not to have others access this info.										
53	Workflow: Security/Privacy Standard	7 - When physician uses EMR but facility does not, he/she comes with lap top and enters practice notes, physicians orders, and assessments into EMR and provides nursing home with hard copy for its records.	Need for policies and procedures to protect exchange and physical access to records.	2. Minimum encryption and authentication standards need to be developed for all web portals related to medical information. Also, the NPI must be mandated for all providers to utilize for identification purposes, not just HIPAA covered providers.										
54	Workflow: Security/Privacy Standard	7 - When physician uses EMR but facility does not, he/she comes with lap top and enters practice notes, physicians orders, and assessments into EMR and provides nursing home with hard copy for its records.	Need for policies and procedures to protect exchange and physical access to records.	3. Procedures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedure documents, which will provide technical & physical safeguards.										
55	Workflow: Security/Privacy Standard	8 - Physician use of EMR eliminates the need for dictation. Patient assessment is entered directly into EMR at time of visit and no separate dictation is done. When system is down, doctors wait until system returns and then enter notes into each electronic record.	Need to maintain policies and procedures for security of system.	1. Paper notes made by providers may be made until official documentation is entered into the EMR. Paper notes then must be disposed of as the EMR record becomes the official record. Paper records should be destroyed (shredded). Scanning paper is a duplication of effort.										

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57	Workflow: Security/Privacy Standard	8 - Physician use of EMR eliminates the need for dictation. Patient assessment is entered directly into EMR at time of visit and no separate dictation is done. When system is down, doctors wait until system returns and then enter notes into each electronic record.	Need to maintain policies and procedures for security of system.	3. Procedures need to be developed to address the identify and security of the information. This needs to be followed with policy & procedure documents, which will provide technical & physical safeguards.										
61	Workflow: Security/Privacy Standard	13 - Only physicians at particular level within health care system, for example attending level, can access secure web portal from home. Doctors must go through a lengthy orientation and configure their computers properly before installing system software.	Technical barrier due to need to maintain security of electronic system.	1. All providers must be provided with remote EMR software and a software mechanism that provides level of PC maintenance (anti-virus,anti-worm,anti-spam) consistent with facility standards. Stratification of information access and strong auditing measures will ensure proper access to all providers who need access.										
63	Workflow: Security/Privacy Standard	13 - Only physicians at particular level within health care system, for example attending level, can access secure web portal from home. Doctors must go through a lengthy orientation and configure their computers properly before installing system software.	Technical barrier due to need to maintain security of electronic system.	3. Procedures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedure documents, in compliance with HIPPA.										

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66	Workflow: Security/Privacy Standard	3 - Process to provide case managers with access to medical information varies: Usually provider faxes information from medical record (with telephone contact to insure that information is going to the correct place), but some providers can give authorized access to medical record on a secure web portal, through encrypted email or sending a tape with patient records.	Hospitals appear to provide access to their electronic records mainly for members of their networks. Issues include the need for business associate agreements with many types of payers, the need to maintain security for users from many organizations, and	2. Procedures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedure documents, in compliance with HIPPA.										
70	Workflow: Security/Privacy Standard	1 - If doctor uses an electronic prescribing system, the doctor can use PDA to submit a request for a drug which is not on formulary. If not electronic, PBM sends an authorization form to prescribing physician by email or fax. Doctor completes form and faxes back to PBM.	Technical barrier - security policies should be in place and implemented.	2. Procedures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedure documents, compliant with HIPPA rules.										
71	Workflow: Security/Privacy Standard	2 - Electronic system: Doctor uses wireless PDA to submit prescription. The information is encrypted at the PDA level (VPN or SSL 128-bit encryption) and sent to a server in the doctor's office, which transmits it to the PBM securely. If not electronic, doctor will give form to patient or designate someone in the office staff (some doctors do it themselves) to fax it to pharmacy.	Technical barrier - security policies should be in place and implemented.	1. Provider either uses electronic prescribing or a fax-based method. If using fax, patient must authorize the transaction via a form with scripts attached.										

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72	Workflow: Security/Privacy Standard	2 - Electronic system: Doctor uses wireless PDA to submit prescription. The information is encrypted at the PDA level (VPN or SSL 128-bit encryption) and sent to a server in the doctor's office, which transmits it to the PBM securely. If not electronic, doctor will give form to patient or designate someone in the office staff (some doctors do it themselves) to fax it to pharmacy.	Technical barrier - security policies should be in place and implemented.	2. Procedures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedure documents, compliant with HIPPA rules.										
73	Workflow: Security/Privacy Standard	3 - If the PBM has electronic communication with customers, information can be encrypted using VPN or SSL 128-bit encryption and sent by email, CD-ROM, or secure FTP. The encryption key will be sent in a separate email. If there is no electronic communication, information is transmitted to group plan administrator by FedEx or certified mail or hand delivered.	Technical barrier because encryption and proper procedures must be in place.	1. PBMs should send encryption keys/authentication mechanism (username and password) via standard mail. Email can be intercepted or misrouted. Patient can then receive the information and then log on in a secure manner.										
74	Workflow: Security/Privacy Standard	3 - If the PBM has electronic communication with customers, information can be encrypted using VPN or SSL 128-bit encryption and sent by email, CD-ROM, or secure FTP. The encryption key will be sent in a separate email. If there is no electronic communication, information is transmitted to group plan administrator by FedEx or certified mail or hand delivered.	Technical barrier because encryption and proper procedures must be in place.	2. A minimum acceptable encryption mechanism for data in transport needs to be defined. 128 Secure Sockets Layer (SSL) encryption seems like a reasonable solution for data in transport.										

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75	Workflow: Security/Privacy Standard	3 - If the PBM has electronic communication with customers, information can be encrypted using VPN or SSL 128-bit encryption and sent by email, CD-ROM, or secure FTP. The encryption key will be sent in a separate email. If there is no electronic communication, information is transmitted to group plan administrator by FedEx or certified mail or hand delivered.	Technical barrier because encryption and proper procedures must be in place.	3. Security measures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedures.										
82	Workflow: Security/Privacy Standard	3 - Information is transmitted between the hospital IT group and other departments by encrypted email or placed into shared network files	Technical barrier because of need for standard procedures and access by authorized personnel only.	1. Since clinical info may not necessarily be shared with IT depts., standard encryption/user authentication rules should apply here. Usage of de-identified patient data is preferred in these scenarios.										
83	Workflow: Security/Privacy Standard	3 - Information is transmitted between the hospital IT group and other departments by encrypted email or placed into shared network files	Technical barrier because of need for standard procedures and access by authorized personnel only.	2. A minimum encryption method for PHI in E-mail should be created. Again 128 SSL seems to be the reasonable solution. Also, may want to look at some of the audit requirements "SOX" places on financial firms related to e-mail. This could be beneficial as well.										
84	Workflow: Security/Privacy Standard	3 - Information is transmitted between the hospital IT group and other departments by encrypted email or placed into shared network files	Technical barrier because of need for standard procedures and access by authorized personnel only.	3. Software needs to be developed that will be universal. This will provide access by authorized personnel only, and standardize procedures.										

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92	Workflow: Security/Privacy Standard	3 - Information is transmitted between the hospital IT group and other departments by encrypted email or placed into shared network files.	Technical barrier because of need for standard procedures and access by authorized personnel only.	2. A minimum encryption method for PHI in E-mail should be created. Secure Sockets Layer (128 SSL) seems to be the reasonable solution. Also, prudent to consider the audit requirements that "SOX" (Sarnes-Oxley Act of 2002) places on financial firms related to e-mail. This could be beneficial as well.										
93	Workflow: Security/Privacy Standard	3 - Information is transmitted between the hospital IT group and other departments by encrypted email or placed into shared network files.	Technical barrier because of need for standard procedures and access by authorized personnel only.	3. HIPAA Security rules need to be incorporated into policy & procedures. IT needs to follow those protocols.										
94	Workflow: Security/Privacy Standard	1 - Provider sends specimen to lab for testing; additional cases might go to state lab.	Technical barrier due to need for secure transmission.	1. State specifications on minimum security requirements for data reporting to state. Would be better solved if state conceives and implements true health data information exchanges.										
96	Workflow: Security/Privacy Standard	1 - Provider sends specimen to lab for testing; additional cases might go to state lab.	Technical barrier due to need for secure transmission.	3. Procedures need to be developed to address the identity and security of the information. This needs to be followed with policy & procedure documents.										
97	Workflow: Security/Privacy Standard	4 - Attending physician records information in medical record and contacts other clinicians treating child.	Barrier is need to verify identity of other clinicians/health facilities.	1. Web portal to share information with access given to different providers utilizing NPI. A Health Data Information Exchange with all providers having compatible EMR connectivity is the optimum setup for this scenario.										

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98	Workflow: Security/Privacy Standard	4 - Attending physician records information in medical record and contacts other clinicians treating child.	Barrier is need to verify identity of other clinicians/health facilities.	2. A standardized secure web portal solution would probably work best here. A unique identifier such as the NPI could be utilized to determine authorization/Authentication.										
101	Workflow: Security/Privacy Standard	9 - Principal investigator at state university completes human subject research applications for data analysis project to all appropriate Institutional Review Boards, including state departments where data will come from. In NJ, the Department of Health and Senior Services and divisions of the Department of Human Services have separate IRBs.	Barrier to assure that subjects of research are protected appropriately.	1. Strict web portal for IRB info gathering and dissemination would speed process.										
110	Workflow: Security/Privacy Standard	2 - Lab informs state or local health officials; often report directly to NJDHSS. Information transmitted by phone or fax with information about patient.	Barrier because informants were not clear about applicable state law and procedures to protect PHI from unauthorized disclosure.	1. Electronic exchange would reduce human error.										
111	Workflow: Security/Privacy Standard	3 - State epidemiologist begins investigation. Each incident is investigated to determine whether these are isolated incidents or possible bioterrorism. If bioterrorism is suspected, investigators look for sentinel event. Data is gathered from patient and other related individuals and from health providers by phone or in person. Local health departments may be briefed to be on the lookout for incidents.	Information is gathered manually; may go into a state registry data base as appropriate, but is not done electronically from the field.	1. Using computer methods from the field would increase security and reliability of information.										

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126	Workflow: Security/Privacy Standard	11 - Fax machine for receiving discharge summary for patient returning from hospital is located in separate social service office isolated from other home areas. Hospital calls ahead to verify fax number and social service staff awaits receipt of information.	Need for procedures to safeguard exchange of information and assure it is not viewed by unauthorized personnel.	1. Establish secure, encrypted email to transmit sensitive documents. Computers and email are becoming more ubiquitous for all levels of office-based healthcare providers.	Implementation of standardized forms, both in paper and electronic version, and using email and internet capabilities to supplement existing fax/phone usage, will allow physician practices the capability to reduce barriers in current time delays in obtaining information from previous healthcare providers. Process would NOT replace options in place now (face to face, phone and fax communications), but would supplement and standardized multitude of forms now in use.	1) Electronic exchange of data would need to follow HIPAA regulations for encryption. 2) Identical form would need to be used in both electronic (PDF) and paper (fax) formats. 3) Form would need to have appropriate sections for certain health care provision with special regulations, such as mental health.	1) For standard form development, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide 'discharge summary form', to be used between medical providers, in both paper and electronic formats. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process, having covered entities use newer technologies in place of existing practices.
148	Workflow: Security/Privacy Standard	2 - Attending physician writes script or note clearing employee to return to work. Information provided may include diagnosis, but usually only certifies that employee is able to return to work. If there was communicable disease, physician may need to certify that employee is free of communicable disease if employee does direct patient care.	Barrier because employers are not sure how to determine whether information comes from a valid health provider.	2. To verify authenticity of note, an encrypted portal system can be implemented to permit the employer to confirm that the employee did in fact have an office visit or was admitted on the dates referenced in the note. PHI need not be exchanged, but only whether the employee was where he/she said on the dates of disability/injury/illness.										

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149	Workflow: Security/Privacy Standard	5 - A person at employer is authorized to receive and process information about employee's ability to return to work. In small employer, may be the owner or in larger firms, an HR person. Most firms report storing these records in a separate locked file cabinet, and some keep cabinet in a locked room.	Need for standard policies and procedures.	1. Although the data relating to a patient's admission and treatment record are PHI in the hands of the facility, they are not in the hands of the employer. That said, it is prudent for the employer to nonetheless employ appropriate measures to protect and safeguard the privacy and security of employment information (that is not PHI), for good business practice/liability reasons.	HIPAA regulations already address this.									
122a				Additional suggestions to item above:	Development of a RHIO would allow efficient storage, transmission and availability of critical patient information. This is especially important in mental health issues, since laws regarding information are more stringent than for other patient information.	1) RHIO would utilize 'Pull' technology, where information would be available, with proper authorizations, and only on a needed basis. 2) Provider requesting information would need proper authorization credentials, and substantial fines/penalties could be levied against unauthorized individuals who attempt/succeed in accessing information under false pretenses.	1) For a RHIO, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide RHIO. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft process and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation for covered entities	Developed by project leader as part of project deliverables. Process would take two years total, 3 months for initial work, 3 months for comment period, 1 year for development and implementation, 6 months to allow preparation for use by covered entities. Costs would include appropriate reimbursement for staff hired or assigned to develop/maintain RHIO, participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Necessary education to ensure all involved in mental healthcare delivery process understand HIPAA regulations (what is allowed, what is not), proper use, and penalties for misuse, of system.	multi;	1) High 2) High due to need to development of statewide RHIO.

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124a				Additional suggestions to item above:	Development of a RHIO would allow efficient patient more effective control over who could access their information, and reduce multiple forms now necessary between covered entities who exchange protected health information.	1) RHIO would utilize 'Pull' technology, where information would be available, with proper authorizations, and only on a needed basis. 2) Provider requesting information would need proper authorization credentials, and substantial fines/penalties could be levied against unauthorized individuals who attempt/succeed in accessing information under false pretenses.	1) For a RHIO, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide RHIO. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft process and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation for covered entities	Developed by project leader as part of project deliverables. Process would take two years total, 3 months for initial work, 3 months for comment period, 1 year for development and implementation, 6 months to allow preparation for use by covered entities. Costs would include appropriate reimbursement for staff hired or assigned to develop/maintain RHIO, participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Necessary education to ensure all involved in mental healthcare delivery process understand HIPAA regulations (what is allowed, what is not), proper use, and penalties for misuse, of system.	multi;	1) High 2) High due to need to development of statewide RHIO.
127a				Additional suggestions to item 127:	Implementation of electronic transmission of consent using portal, email and internet capabilities to supplement existing fax/phone usage, will allow physician practices the capability to reduce barriers in current time delays in obtaining information from previous healthcare providers. Process would NOT replace options in place now (face to face, phone and fax communications), but would supplement and standardized multitude of forms now in use.	1) Electronic exchange of data would need to follow HIPAA regulations for encryption. 2) Identical form would need to be used in both electronic (PDF) and paper (fax) formats. 3) Form would need to have appropriate sections for certain health care provision with special regulations, such as mental health.	1) For standard form development, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide 'consent form', to be used between medical providers, in both paper and electronic formats. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process, having covered entities use newer technologies in place of existing practices.

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134a				Additional suggestions to item 134:	Development of education process by Department of Health regarding UDS. Education would be mandatory for all covered entities and related organizations (such as law enforcement) that are affected by HIPAA consent standards.	1) Department of Health would have authority to provide education to organizations currently not defined as covered entities.	1) Task force selection of state health officials, law enforcement, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to agree to consent process and develop education materials.	1) Development of statewide UDS process, including electronic tutorials on state website. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations including 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process.
144a				Additional suggestions to item 144:	Implementation of standardized forms (permitted to start/return to work), both in paper and electronic version, and using email and internet capabilities to supplement existing fax/phone usage, will allow providers the ability to send minimum information to employer. Process would NOT replace options in place now (face to face, phone and fax communications), but would supplement and standardized multitude of forms now in use.	1) Electronic exchange of data would need to follow HIPAA regulations for encryption. 2) Identical form would need to be used in both electronic (PDF) and paper (fax) formats.	1) For standard form development, task force selection of state health officials, physicians, Health Information Management (Medical Records), hospitals, mental health professionals and other key stakeholders would be selected to make recommendation for standard.	1) Development of statewide 'ready for/return to work form', to be used between medical providers, in both paper and electronic formats. 2a) Selection of planning committee with project manager 2b) Approval of project scope and timeline 2c) PM develops charter and base plan to be approved by committee 2d) Working committee defines draft form and instruction use 2e) 90 day 'comment period' for all organizations defined as 'covered entities' by HIPAA law 2f) Modifications as necessary 2g) 180 day period for preparation allowed for covered entities	Developed by project leader as part of project deliverables. Process would take one year total, 3 months for initial work, 3 months for comment period, 6 months for modifications.implementation. Costs would include appropriate reimbursement for staff hired or assigned to participate in project, meeting costs including conference calls, legal assistance, technology fees.	Regularly scheduled project meetings, reporting progress by workgroup members against the project plan. Allow for complaint process to Department of Health for violations. Audits to be performed by Department of Health to ensure compliance.	Appropriate representation of stakeholders in design/implementation process and during the comment period will ensure all affected parties have necessary input.	1) Any provider currently defined as a 'covered entity' under HIPAA law must follow HIPPA guidelines for electronic transmission of information, via ePHR, email, fax, phone or other. 2) Inability to monitor enforcement	multi;	1) High 2) Medium due to existing practices, adhering to new mandatory process, having covered entities use newer technologies in place of existing practices.