

# Privacy and Security Solutions for Interoperable Health Information Exchange

*West Virginia's Interim Assessment of Solutions Report  
(Deliverable No. 3)*

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# **1. Background: Report Purpose, Scope, and Limitations**

## ***Purpose***

As specified by RTI in its paper specifying the format of the Solutions Work Group reports, the purpose of this report “...is to document privacy and security solutions identified by States aimed at addressing barriers to health information exchange that result from organization-level business practice, policies and laws and regulations that underlie them, and that were identified and documented by the Variations Workgroup (VWG).”

More specifically, as outlined in Section 3, this report reflects the activities of the West Virginia Solutions Work Group (SWG) and Implementation Planning Work Group (IPWG), as these groups grappled with the barriers identified by the Variations and Legal Work Groups and explored solutions that would eliminate or neutralize these barriers.

## ***Scope***

This interim report is essentially a review of a process that will continue over time. Thus, it is both a “look back” and a projection of future activity, or a “look forward.” We shall focus primarily upon the barriers noted in the final report of the Variations Work Group. We did, however, in discussing these barriers, identify other issues and business practices that were not explicitly covered by any of the scenarios and, in one case, is probably unique to West Virginia. We believe that all of these business practices are important and require exploration. Thus, an assessment of these business practices—specified in the Analysis of State Proposed Solutions section— will be part of our “look forward” activity.

## ***Limitations***

A primary limitation of this report, since it is a review of a “slice in time,” is that it incompletely profiles the proposed solutions. Because the joint work groups have identified further exploratory meetings and processes, this report can only note the activities completed thus far and point to the anticipated activities required to fully develop solutions and assess their feasibility.

A second limitation is that we confronted one of the risks specified in our proposal to RTI, a lack of participation by the full range of stakeholders. We had consistent, but limited participation throughout our work meetings, with a very strong contingent of consumers and representatives of consumer groups. As a mitigation tactic, we have scheduled specific meetings with key stakeholder groups, some of which have already occurred, some of which are part of our projected activity.

A final limitation is based in our proposed solution prioritization and implementation strategy for West Virginia, as we will note in Section 3. It is our hope that the Board of Directors of the West Virginia Health Information Network (WVHIN), profiled earlier in our final Variations report, will take the responsibility to prioritize the proposed

recommendations and monitor their implementation—taking whatever active role possible, subject to the limitations of staff resources and competing priorities, as West Virginia seeks to develop an interoperable network for the sharing of health care data.

At the time of submission of this interim report, we have not had the opportunity to present this role to the Board of WVHIN and, thus, have no way of knowing if this continuation strategy will take place. The primary staff resource to WVHIN, however, has been an active participant throughout the West Virginia HISPC process and a member of both the LWG and the SWG. For this reason, we believe that the WVHIN Board will take on this role and view our joint work groups as *ad hoc* committees working on their behalf.

## 2. Summary of the Interim Assessment of Variations Report

### *Main Findings of VWG*

The final report of the Variations Work Group (VWG) organized its responses by the scenarios that generated the business practices, with reference to the domains addressed. The report listed business practices under each set of scenarios and noted whether they represented barriers and whether the barriers were acceptable or not. All of the business practices noted in the VWG report were identified as “barriers” to the free flow of patient-specific healthcare information. In most cases, the “barriers” the VWG cited were deemed acceptable, reflecting public policy—primarily as encoded in HIPAA, and reflecting the public’s sense of confidentiality and privacy.

We have organized the summary of the VWG report in the following table, listing the categories the VWG used, a brief description of the business practice, and whether the VWG and Legal Work Group (LWG) determined the business practice to be acceptable or necessary or whether it exhibited unacceptable variation.

**Table 1**  
**Summary of VWG Business Practices**

<b>Treatment (Scenarios 1-4)</b>		
Identifying and authenticating healthcare providers seeking access to healthcare records	Acceptable	
Ability to audit use and disclosure of healthcare records	Acceptable	
Control access by other healthcare providers and own staff	Acceptable	
Transmitting healthcare records and exchanging healthcare information between/among providers	Acceptable	
Physical safeguards of healthcare data	Acceptable	
Use of business associate agreements with third parties	Acceptable	
Patient authorization for release of sensitive information in non-treatment scenarios (HIV behavioral health John and Les, with regard to disclosure for treatment - (1) HIV – no legal requirement, but saw providers getting authorizations as a business practice. No real benefit to this. (2) mental health – state law only requires authorization for treatment where provider is a state hospital.	Acceptable	
Use of “minimum necessary” for treatment		Not necessary or required
Consent/authorization to release mental health information for treatment; which release without authorization is expressly forbidden for patients in state-operated mental health facilities.		Although required by state law, may not be “necessary” from a privacy standpoint; might be best to revert to

		HIPAA.
Limitations in exchange of records/info related to substance abuse.	Acceptable	Explore reversion to HIPAA for treatment.
Need for patient permission for treatment purposes of HIV data.		Not required; explore reversion to HIPAA for treatment.
<b>Payment (Scenario 5)</b>		
Patient and payer authentication; proper “match” of patient and of staff with “need to know.”	Acceptable	
Encryption of data for electronic transmission between provider and payer.	Acceptable	
“Read only” access to electronic health records	Acceptable	
“Minimum necessary” requirement for payment	Acceptable	
<b>RHIO (Scenario 6)</b>		
Business associate agreement with RHIO	Acceptable	
De-identified data or limited data sets for monitoring	Acceptable	
<b>Research (Scenario 7)</b>		
Use of Institutional Review Boards (IRBs)	Acceptable	
Securing patient consent	Acceptable	
<b>Law Enforcement (Scenario 8)</b>		
Identifying law enforcement end users	Necessary	Need for ongoing education for law enforcement and providers related to this scenario and all transfers of info to law enforcement.
Accessing, transmitting, securing, and auditing electronic health records to law enforcement.	Acceptable	Same as above
Policies related to release; viewed release under scenario as not permissible.	Acceptable	Same as above
Policies related to release; release of blood sample in scenario without patient authorization only possible if authorized by law.	Acceptable	Same as above
<b>Prescription Drug Use/Benefit (Scenarios 9 and 10)</b>		
Business associate agreement for PBMs	Necessary	
Need to authenticate multiple parties—patients, provider, payer staff.	Necessary	
Encryption of electronic data transmitted among PBMs, pharmacies, providers.	Necessary	
Need an inter-linked web of policies and procedures for	Acceptable	

release of information; use of de-identification where possible.		
Requirement in West Virginia law for “wet” signature		Significant and unnecessary barrier.
<b>Healthcare Operations/Marketing (Scenarios 11 and 12)</b>		
Need for stringent barriers to disclosure for marketing and for remuneration.	Necessary	May be a need to explore additional legislation.
<b>Public Health/Bioterrorism (Scenario 13)</b>		
Mandated reporting for specific diseases	Necessary	
Transmission of data to public health; electronic preferred.	Acceptable	
“Minimum necessary” required.	Acceptable	
Disclosure to law enforcement in terrorism attack	Acceptable	May require education, since current business practices may foreclose timely disclosure.
<b>Employee Health (Scenario 14)</b>		
Electronic transmission of health info to employer should require patient authorization.	Necessary	There is a key need for increased education and perhaps the development of protocols for such information exchange.
Only “minimum necessary” transmitted.	Necessary	Same as above
Use of data use agreements not relevant because of need for identifiable data.		Same as above
Policies and procedures for securing patient authorization	Necessary	Same as above
Transmission health information, including encryption	Necessary	Same as above
Verification of end user, auditing of process	Necessary	Same as above
<b>Public Health (Scenarios 15-17)</b>		
Identifying and authenticating patients may be more efficient electronically.	Acceptable	
Limiting access to such public health data	Necessary	
Transmission of electronic data to public health; encryption.	Necessary	
Reporting of communicable diseases and genetic disorders	Acceptable	
Patient authorization for substance abuse	Necessary	
Sharing of information for treatment; OK with HIPAA	Acceptable	
Consent and authorization for payment—Mental health	Acceptable	May explore legislative

		change.
<b>State Government Oversight (Scenario 18)</b>		
Requested disclosures not permitted under WV law.	Acceptable	
Use of de-identified data for oversight	Acceptable	

**“Effective” Practices**

We would argue that “effective practices” are those wherein all parties understand the parameters of the transactions and share mutual perceptions about the ends and means of the transactions. If that definition is granted, then all of the practices labeled “Acceptable” or “Necessary” but without any comment in the last column represent “effective” practices. In these cases, **even though there is a “barrier” to the free flow of patient information**, all the parties either understand the reason for these barriers, or accept the procedures for sharing such information, or both. In such cases, there is no **unexpected** impediment to information transfer; rather, clear procedures govern the transfer and all parties “build in” the time and effort required to effect such transfers. Under those conditions, these transfers are “effective.” One of the primary benefits of HIPAA has been to create mutual expectations related to such healthcare information transfers and such transfers are largely “ineffective” when there is widespread confusion about how to implement or comply with HIPAA, or when other state laws conflict with HIPAA.

**Lessons Learned**

In the “Summary of Critical Observations and Key Issues” section of the VWG final report, five issues were cited; we have bolded those sections specifying concrete suggestions:

- “In order to achieve the goal of improving the overall quality of health care, an EHR system must maximize the ability of health care providers to share information for treatment purposes. ...**West Virginia policymakers should consider the express adoption of the national HIPAA standard as it applies to all patients... ...[E]xisting West Virginia laws governing the health information of state mental health patients, mental health patients generally, and HIV-infected patients should be clarified** to ensure that such health information can be readily disclosed for treatment purposes without first seeking patient consent or authorization.”
- “...**Existing (West Virginia) law should be modified to allow e-prescribing in some regulated form...**”
- “...[T]he business practices described in this report still vary considerably from stakeholder to stakeholder. **The WVHIN must take a leadership role in developing and implementing standardized business practices for stakeholders to utilize upon joining the statewide, interoperable EHR network...**”
- “...**West Virginia (should) closely follow the national standard established by HIPAA, which allows health information be disclosed for payment purposes without prior patient authorization or consent. Current West Virginia laws governing state**

**mental health patients, and mental health patients generally, need clarification on this issue. ...[Because patient privacy concerns can be met by the HIPAA “minimum necessary” requirement], the EHR network must include the technical capacity of electronically segregating the “minimum necessary” records needed for payment purposes.”**

- “A statewide, interoperable EHR network will accumulate vast amounts of data...  
...**West Virginia policymakers must ensure that the statewide network properly balances public access to such data with patient privacy...** [T]echnologies for de-identifying data stored in digital format can be legitimately used by researchers and public health advocates...”

### **3. Review of State Solution Identification and Selection Process**

#### ***West Virginia State Solutions Work Group (SWG)—Charge and Stakeholder Representation***

The Charter for the SWG, complete with its starting members (others were added as the work groups did their work), is included as Appendix A. WVMI, with assistance from the Health Care Authority, recruited members from the following stakeholder groups:

- West Virginia University Hospital System, both executives and privacy officers
- WV State Medicaid Agency (Privacy Officer)
- Major health insurance company
- AARP
- Commissioner of Behavioral Health and Health Facilities
- Behavioral health providers and members of trade association
- League of Women Voters
- Public Employee Insurance Agency
- Private practice lawyer
- WV Board of Pharmacy
- Union representation (United Mine Workers)
- WV Executive Branch Director of Information Security
- Physician (WVU Hospital System)
- Large hospital researcher (SWG Chair)
- Senior Assistant Attorney General
- WV Health Care Authority.

#### ***Methodology—Overall Approach and Process***

Early in our efforts, late October 2006—before the Variations Work Group finished its work—the WVMI staff resources for the SWG and the IPWG convened a meeting of the two people who had accepted the role of work group chairs. The intent of the meeting was to develop a timeline and process for how our two work groups would operate. WVMI had already signaled in its RFP response that there was some overlap between these two work groups and that we would create a small joint sub-group to provide some momentum to the IPWG, as solutions began to take shape, enabling it to meet the highly compressed time frames of this project.

An unexpected, but solidly consensual, outcome of that meeting was the decision on the part of the two work group chairs to merge the work groups and treat the solution search and implementation planning as a single process. The chair people believed that discussions generating solutions would lead immediately to proposed implementation plans, particularly as we attempted to prioritize solutions, and that it would be more efficient and productive to permit such discussions to reach their integral conclusions.

This meeting established the following process:

- **A set of meetings to review the VWG report, identify barriers, discuss solutions, and begin implementation planning.** These meetings would extend over November, 2006, (two meetings before Thanksgiving) and continue into early December, 2006. Members would have option of attending by phone, if necessary. All meeting materials would be shared with all members by email.
- **A set of two and possibly three public meetings to solicit responses to proposed solutions.** We made a commitment to explore the use of the state videoconferencing network for at least one of these meetings. These meetings, at least two of them, were targeted for the month of December, 2006, before Christmas; we would target the third meeting, if needed, for early January, 2007.

As we began our joint work group meetings, we found that we were continually picking up new members. Because of the activity of the VWG and LWG and because of the opportunities WVMI had to publicize the HISPC project, we continued to “accrete” members as we progressed through these meetings. We started this meeting process with a cadre of three or four AARP members, when we had anticipated only one. We will highlight below key additions to the joint work group, as they occurred.

### **Recap of joint work group meetings**

#### *Joint Work Group Meeting 1—November 3, 2007*

Goal: Review of VWG Draft Final Report to identify barriers requiring solutions.

Outcomes:

- Identification of key barriers.
- Decision to have sub-group review all cited VWG business practices to determine if any needed further escalation to “key barrier” status.
- Decision that first public meeting needed to include a significant amount of education about health information technology (HIT) and electronic medical records (EMRs), since most of the general public had little knowledge of benefits and risks of such technology.

#### *Joint Work Group Meeting 2—November 20*

Goal: Ratify and begin generating solutions for key barriers identified in Meeting 1; begin filling out table on next pages.

Outcomes:

- Ratified table of issues, next pages, and began discussions of solutions.
- Set December 7 as date for public meeting, with an educational agenda.
- **Introduction of new member, representative from Social Security Administration, which uses an electronic system to receive and send cases for review.**

## Business Practices That Create Friction in the Interoperability of Health Care Information Transmission

### Identified by Variations Work Group Report

Business Practice	Type	Possible Solutions	How Implement?
Limit sharing information for treatment purposes to only “minimum necessary.”	Misunderstanding of law (HIPAA)		
Limit imposed by WV law involving sharing of info in state-operated behavioral health facilities: all sharing, even for treatment and payment, has to be authorized by patient.	Inconsistency between state law and federal standard (HIPAA); requires more rigorous practice than federal standard.		
Limit sharing for treatment purposes for HIV patients without authorization of patient.	Misunderstanding or misapplication of both State and Federal law.		
Various practices related to sharing information with law enforcement in compliance with HIPAA and other laws.	Misapplication of HIPAA requirements.		

Business Practice	Type	Possible Solutions	How Implement?
WV law forbids anything except “wet” physician signature and use of third-party between physician and pharmacy; eliminates e-prescribing.	State law more rigorous than any federal law and most other states.		
Sharing of information related to bioterrorism event with law enforcement officials; practice questioned.	Misinterpretation of state and federal laws.		
Sharing of health information with employers; variety of concerns, e.g., “minimum necessary” and need for authorization by patient. (If release authorized, HIPAA puts no limits on what can be shared.)	Need for state legislation or regulation more rigorous than HIPAA? <b>Key issue for public discussion.</b>		
Reporting requirements for rare genetic disorders, especially involving out-of-state labs.	Misinterpretation or misunderstanding of state law.		
Use of PHI in monitoring public program performance related to legislatively mandated screening programs.	If not authorized by law, may represent gap in both state and federal law, where oversight agency requires identifiable data.		

*Joint Work Group Meeting 3—December 7, 2006*

Goal: Continued discussion of key barriers and potential solutions.

Outcomes:

- Request for staff to convene sub-meetings with behavioral health advocates and providers to more fully discuss issues related to specific key barriers.
- Request for staff to convene sub-meetings with HIV advocates and public health officials to more fully discuss issues related to specific key barriers.
- Decision to schedule another meeting in early January to complete discussions of key barriers.

*Public Meeting 1—December 7, 2006*

This meeting was held in a large conference room on the campus of Charleston Area Medical Center (CAMC), a large integrated healthcare delivery system.

Goal: Increased public awareness of benefits/risks of health information technology.

Outcomes:

- Presentation, included as Appendix B.
- **Recruitment of two (2) new members to the work group, Executive Director of West Virginians for Affordable Health Care, and an attorney representing WV Legal Aide. Both organizations are a key consumer-based advocacy groups.**

*“Public” Meeting 2—December 13, 2006*

This meeting was held at a conference room on the campus of West Virginia University Hospital, Morgantown, WV. WVMH asked WVU Hospital staff to recruit members of various patient/disease advocacy groups. Because of nature of the family illnesses involved, primarily cancer, all parties decided that this meeting would not be advertised to the general public and would only be open to patients and their families from such groups associated with WVU Hospital. Thus, this meeting was smaller in number, but very intense, since all of those attending had multiple physicians—many scattered across the country—and a very clear awareness of the benefits of health information sharing. This meeting was essentially a focus group of people very involved in the healthcare system.

Goals:

- Increased public awareness of benefits/risks of health information technology.
- Get specific and targeted feedback from group heavily involved in healthcare system.

Outcomes:

- Ratified benefits of interoperable sharing of healthcare data among large group of physicians and facilities.
- Expressed deep concern about privacy and security of healthcare data.

*Telephonic Meeting, VWG Behavioral Health Sub-group—December 21, 2006*

Following up on request from joint work group, IPWG staff resource requested that the Commissioner, Behavioral Health and Health Facilities, convene a phone meeting. The Commissioner was able to assemble a highly representative group, involving state governmental staff, private and publicly-funded providers, and advocates.

Goal: Address various behavioral health key barriers, especially the legislative requirement that patients of state-operated facilities must authorize release of any data, including for payment.

Outcomes:

- Recognition that issues are multi-faceted and not amenable to quick solution.
- Commitment to continue discussion through future phone or in-person meetings.

*Telephone and Email Discussions, Acting Commissioner, WV Bureau of Public Health—December 18-22*

Goal: Get consultation related to state public health reporting, including registries, out-of-state labs, and HIV business practice.

Outcomes:

- Recognition that many public health registries operate under legal/regulatory infrastructure more restrictive than HIPAA.
- Commitment to further discuss, as part of solution development.

*Joint Work Group Meeting 4—January 4, 2007*

Goals:

- Receive updates from other meetings.
- Complete discussion of key barriers, generating “first cut” solutions.
- Request staff to follow up with public health and to ask Acting Commissioner to assist in setting up meeting with HIV advocate community.
- Raised the following issues that will require further exploration:
  - Role of Freedom of Information Act (FOIA) requests in health information sharing; state has access to considerable health related data, including medical records.
  - Role of professional ethics in creating business practices that impede data sharing, particularly in behavioral health.
  - The impact of the new Medicaid State Plan Amendment, creating member contracts and requiring compliance with contract to access enhanced benefits; will require increased review of medical records.
- Established process to review interim final report.

### ***Process to Prioritize and Gauge Feasibility of Proposed Solutions***

The joint work groups will rank or prioritize the proposed solutions, as part of the implementation planning process. All of the proposed solutions have been judged as feasible, or they would not be listed. Relative feasibility will be a major factor in determining priority, especially for any solutions involving legislative action. The first preference will be always to assist the Governor in developing legislation that will come from his Office, since such legislation will have the highest probability of passage.

It is the intent in West Virginia to persuade the Board of Directors of the West Virginia Health Information Network (WVHIN) to accept the role of shepherding and monitoring the progress of proposed solutions. WVHIN is in the process of hiring full-time staff and, thus, will have a modicum of resources to undertake such a role. Moreover, since it has the mission of developing an interoperable, statewide, health information sharing network, resolution of these key barriers fits integrally into that mission.

In the best circumstances, the joint VWG and IPWG could act as an *ad hoc* committee of the WVHIN Board, chartered to assist its staff in prioritizing, implementing, and monitoring activity related to these key barriers. This will be the proposal we shall make to the WVHIN Board of Directors as the HISPC project winds down.

## 4. Analysis of State Proposed Solutions

### *Introduction*

Our workflow was generated by key barriers identified by the VWG and LWG, linked to specific scenarios and domains. The joint SWG and IPWG then took these key barriers and began a reiterative process of generating possible solutions. In many cases, the appropriate stakeholders were not present to reach a conclusion; in such cases, the joint work group charged the staff with creating sub-groups to further explore issues and develop proposed solutions. In all cases, these sub-groups will refer the solutions back to the joint work group for ratification and review. Thus, the current process is fluid and quite dynamic.

Given the large contingent of consistent consumer representation in the joint work groups and the strong message we got from the two public meetings, it was clear that public perceptions of **privacy and security** were critical to implementing a statewide, interoperable health information network. For that reason, we spent a significant time in many of our joint work groups rigorously exploring the many ways that personal health information could “leak” out of the healthcare system. By doing so, we uncovered a number of situations that were not explicitly covered by any scenario, although they clearly related to all of the domains, and that were not explicitly addressed by the VWG. We will highlight these issues in the table below.

### *Presentation of Solutions*

We have structured the table below to capture all of the requested information in a single format. While somewhat complex, the table enables a reviewer to get a clear view of how all of the elements—key issues, proposed solutions, scenarios, domains, stakeholders, and solution type—are linked.

**Table 4.1**

**Key Barriers and Proposed Solutions  
Including Scenarios, Domains, Stakeholders, and Solution Category**

<b>Key Barrier</b>	<b>Scenario(s)</b>	<b>Domain(s)</b>	<b>Solution(s)</b>	<b>Stakeholders</b>	<b>Solution Category</b>
Limit sharing information for <b>treatment</b> purposes to only “minimum necessary”	1. Patient Care, A-D	Primarily 9, although holds even in paper-based system	<p>Targeted educational programs and training for health care professionals in all provider types.</p> <p>Targeted educational programs and training for key support staff, e.g., office managers, medical records.</p> <p>Negotiate with HIT vendors with largest “footprint” in WV to include appropriate HIPAA procedures related to sharing for treatment as part of implementation training of their customers.</p>	<p>All healthcare profession (through professional societies); all institutional providers.</p> <p>Professional/technical associations related to office managers, medical records staff.</p> <p>HIT vendors</p>	<p>Federal laws/regulation</p> <p>Federal laws/regulation</p> <p>Federal laws/regulation</p>
Limit imposed by WV law involving sharing of personal info of patients in state-operated facilities; all sharing, even for treatment	1. Patient Care, B and C	8 and 9; holds even in paper-based system	Explore change in WV law; determine reasons for existing restrictions.	State-operated facilities.	State laws/regulation

<b>Key Barrier</b>	<b>Scenario(s)</b>	<b>Domain(s)</b>	<b>Solution(s)</b>	<b>Stakeholders</b>	<b>Solution Category</b>
and payment, has to be authorized by patient.			Continue work with behavioral health sub-group to fully explore this and other issues; generate issues and solutions.	Behavioral health providers, consumers, advocates, state government.	State laws/regulation
Limit sharing for treatment purposes for HIV patients to only patient-authorized exchange.	1. Patient Care, D	8 and 9; holds even in paper-based system.	Review all state restrictions with Bureau of Public Health; convene consumer/advocacy group to discuss issues. Based on above, develop and deliver targeted education/training to healthcare professionals and institutional provider staff. Note: this barrier is a result of business practices and not law.	HIV patients, families, advocates.  All healthcare providers.	State law/regulations Federal law/regulations
Various practices related to sharing information with law enforcement (and corrections) staff in compliance with HIPAA and other laws.	8. Law enforcement	May impact all 9 domains.	Targeted training/educational program for law enforcement and public officials (including judges) to clarify HIPAA requirements. Development of consistent protocols for local, county,	All healthcare providers, law enforcement, state government, various public officials.  Same as above; WVHIN Board of	Federal law/regulations  Federal law/regulations

<b>Key Barrier</b>	<b>Scenario(s)</b>	<b>Domain(s)</b>	<b>Solution(s)</b>	<b>Stakeholders</b>	<b>Solution Category</b>
			and state law enforcement staff for the acquisition, maintenance, security, and exchange of individual health information.	Directors	
WV law forbids anything except “wet” signature; forbids use of third party between physician and pharmacy.	9. Pharmacy Benefit, A and B	May impact all 9 domains; clearly 8.	Work with Governor’s Office and WVHIN Board to draft and pass legislation	Physicians, pharmacies, most healthcare providers	State law/regulations
Sharing of health information with employers. Variety of concerns, e.g., “minimum necessary,” need for authorization by patient/employee; if authorized, HIPAA puts no limited on what can be shared. This issue represents one of the most compelling for consumers and elicits the strongest negative reactions.	14. Employer	May impact all 9 domains; operative even in paper-based system.	Explore need for additional state law to clarify what can be requested and uses of such information; must take into account various legitimate reasons employer needs healthcare information to manage benefits and monitor use of benefits—FLMA, workman’s comp. Will involve intensive work with a number of stakeholders.	All employers and employees	State law/regulation
Release of information for payment purposes in WV related to mental health and substance abuse requires	5. Payment	8, in particular; may involve all	Continue work with behavioral health sub-group to fully explore this and other issues; generate issues	Behavioral health providers, consumers, advocates, state government.	State law/regulation

Key Barrier	Scenario(s)	Domain(s)	Solution(s)	Stakeholders	Solution Category
patient authorization. (More general than previous barrier that applied only to patients in state-operated facilities.)		others.	and solutions. <b>May involve code of ethics for psychiatrists.</b>		
Reporting requirements for rare genetic disorders, other disease registries and public health reporting requirements. Registries often cross state lines and may involve cooperative agreements.	15. Public Health, A-C.	8, since public health laws relating to registries often more restrictive than HIPAA	Creation of sub-group involving Acting Commissioner, Bureau of Public Health, to clarify issues and explore solutions.	Researchers, all healthcare providers, public health authorities.	Organization business practices, especially as related to cooperative agreements. State law/regulations Interstate health information exchanges.
Use of PHI in monitoring public program performance.	18. Health Oversight	9	Explore the development of protocols covering most common types of such use. Explore impact of FOIA requests, since state government stores large amounts of data, including patient records. (Variability created by different judges using different balancing criteria to release.) Explore impact of PHI leaving HIPAA compliant	State government, consumers  State government, consumers  State government, consumers	Organization business practices  Organization business practices  Organization business practices

Key Barrier	Scenario(s)	Domain(s)	Solution(s)	Stakeholders	Solution Category
			agencies of state government to other state and federal agencies or branches of government not covered by HIPAA.		
Variance in security-related business practices from one stakeholder to another.	All	7	None proposed at this time; will be education-based.	All healthcare providers.	Federal law/regulation
<p><i>I see the discussion of the oversight below, but am not sure this is a privacy or security issue or a barrier to interoperability. This potential barrier is unique to WV and not identified by the VWG.</i></p> <p>West Virginia has secured an amendment to its State Medicaid Plan that includes a member contract, requiring Medicaid clients to comply with a number of health related items. Only through such compliance will clients be eligible for an expanded benefit that includes many of the “optional” benefits now</p>	Could be considered part of 18. Health Oversight	9	None proposed at this time.	State government, Medicaid beneficiaries, “medical home” provider, unknown other oversight staff	Unknown

Key Barrier	Scenario(s)	Domain(s)	Solution(s)	Stakeholders	Solution Category
<p>available to all Medicaid beneficiaries.</p> <p><b>Operation of this amendment will require ongoing review of Medicaid members' health records by their "medical home" provider. Oversight of this process will require monitoring of this process and access to these health records by people who are not the "medical home" provider.</b></p>					

### ***Status of Solutions***

All of the proposed solutions, with one exception, are only at the earliest phase of development. The exception is the development of a state law to enable e-prescribing. Based on an increasing public awareness of the need to rectify this situation in West Virginia, a public awareness that the HISPC project can claim to have substantially impacted, the Governor's Office is preparing a legislative remedy for the next legislative session. It is highly likely that this proposed law will pass, thus removing a substantial impediment to the interoperable sharing of healthcare information in West Virginia.

### ***Barriers to Solutions***

Barriers to solutions will be fully examined as part of the solution prioritization process and as we begin the implementation planning process.