



New Jersey
Innovation Institute



An NJIT Corporation

New Jersey Health Information Network

Common Key Service Implementation Guide

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Acronyms and Abbreviations Guide

ACRS	Active Care Relationship Service
ADT	Admission, Discharge, Transfer
API	Application Programming Interface
CKS	Common Key Service
CPT	Current Procedural Terminology code
ERR	Error
EVN	Event Type
FHIR	Fast Healthcare Interoperability Resources
HIN	Health Information Network
HL7	Health Level Seven
ISO	International Organization for Standardization
NJHIN	New Jersey Health Information Network Shared Services
MPI	Master Person Index
MSA	Message Acknowledgement
MSH	Message Header
NPI	National Provider Identifier
OBX	HL7 Observation Segment
OID	Object Identifier
PID	Patient Identification
PO	Participating Organization
QDSO	Qualified Data Sharing Organization
SFT	Software
SSN	Social Security Number
TDSO	Trusted Data Sharing Organization

TOC	Transition of Care
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Definitions

Active Care Relationship. (a) For health providers, a patient who has been seen by a provider within the past 24 months, or is considered part of the health provider's active patient population they are responsible for managing, unless notice of termination of that treatment relationship has been provided to HIN; (b) for payers, an eligible member of a health plan; (c) an active relationship between a patient and care manager or other person or organization for the purpose of treatment, payment or operations; or (d) a relationship with a health provider asserted by a consumer and approved by such health provider.

Active Care Relationship Service. The HIN Infrastructure Service that contains information on those TDSOs and health professionals who have an active care relationship with a patient.

Admission, Discharge, Transfer (ADT). An event that occurs when a patient is admitted to, discharged from or transferred from one care setting to another care setting or to the patient's home. For example, an ADT event occurs when a patient is discharged from a hospital and sent home. An ADT event also occurs when a patient arrives in care setting such as a health clinic or hospital.

ADT Message. A type of HL7 message generated by healthcare systems based upon ADT events; the HL7 ADT message type is used to send or receive patient demographic and/or healthcare encounter information, generated from source system(s). The HL7 ADT messages contain patient demographic, visit, insurance and diagnosis information.

ADT Notification. An electronic notification that a given patient has undergone an ADT event.

Applicable Laws and Standards. In addition to the definition set forth in the Data Sharing Agreement, the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute, section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2, and its implementing regulation, 42 CFR Part 2; the New Jersey Mental Health Code and the New Jersey Public Health Law.

Common Key Service. An Infrastructure Service that communicates with a Master Person Index (MPI) to match patients and to assign and retrieve HIN Common Keys that are linked to unique patients.

Data Sharing Agreement. Any data sharing organization agreement signed by both HIN and participating organization.

Electronic Address. A string that identifies the transport protocol and end point address for communicating electronically with a recipient. A recipient may be a person, organization or other entity that has designated the electronic address as the point at which it will receive electronic messages.

Electronic Medical Record or Electronic Health Record. A digital version of a patient's paper medical chart.

Exhibit. A use case exhibit or a pilot activity exhibit.

Health Level 7 (HL7). An interface standard and specifications for clinical and administrative healthcare data developed by the American National Standards Institute. HL7 provides a method for disparate systems to communicate clinical and administrative information in a normalized format with acknowledgement of receipt

Health Information. Any information, including genetic information, whether oral or recorded in any form or medium, that (a) is created or received by a health professional, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Information Network (HIN). An organization or group of organizations responsible for coordinating the exchange of protected health information (PHI) in a region, state, or nationally.

Health Professional or Health Provider. (a) Any individual licensed, registered, or certified under Federal or State laws or regulations to provide health care services; (b) any person holding a non-clinical position within or associated with an organization that provides healthcare or healthcare related services; and (c) people who contribute to the gathering, recording, processing, analysis or communication of Health Information.

HIN Infrastructure Service. Certain services that are shared by numerous use cases. HIN Infrastructure Services include, but are not limited to, ACRS, HPD, Statewide Consumer Directory (SCD), and the Medical Information Direct GATEway (MIDIGATE®).

HIN Services. The HIN infrastructure services and additional services and functionality provided by HIN allowing the participating organization to send, receive, find, or use information to or from HIN as further set forth in an exhibit.

Information Source. Any organization that provides information that is added to a HIN Infrastructure Service.

Master Use Case Agreement (MUCA). Legal document covering expected rules of engagement across all use cases. Trusted data sharing organizations sign master use case agreement one time, then sign use case exhibits for participation in specific use cases.

Message. A mechanism for exchanging message content between the participating organization to HIN services, including find and retrieve.

Message Content. Information which is sent, received, found or used by a participating organization to or from HIN Services, including, but not limited to, PHI, common keys, de-identified data, metadata, Digital Credentials, and data schema. Message Content includes the Message Content Header.

Message Header. The MSH segment present in every HL7 message type that defines the message's source, purpose, destination, and certain syntax specifics such as delimiters (separator characters) and character sets. It is always the first segment in the HL7 message, with the only exception being HL7 batch messages.

New Jersey Health Information Network Shared Services. The HIN for the State of New Jersey.

Person Record. Any record in a HIN Infrastructure Service that primarily relates to an individual person.

Provider Community. A healthcare provider with an active care relationship with the applicable patient.

REST. REST stands for Representational State Transfer. (It is sometimes spelled "ReST.") It relies on a stateless, client-server, cacheable communications protocol -- and in virtually all cases, the HTTP protocol is used.

Send / Receive / Find / Use. Means sending, receiving, finding, or using message content. Sending involves transport of message content. Receiving involves accepting and possibly consuming/storing message content. Finding means querying to locate message content. Using means any use of the message content other than sending, receiving and finding.

Source System. A computer system, such as an electronic health record system, at the participating organization, that sends, receives, finds or uses message content or notices.

Specifications. Specifications provide a standard set of service interfaces that enable the exchange of interoperable health information among the Health Information Exchanges.

Transitions of Care. The movement of a patient from one setting of care (e.g. hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, rehabilitation facility) to another and can include transfers within a healthcare organization.

Trusted Data Sharing Organization. An organization that has signed any form of agreement with HIN for data sharing.

Use Case. A specific scenario or group of scenarios for sharing patient health information.

Use Case Exhibit. The legal agreement attached as an exhibit to the Master Use Case Agreement that governs participation in any specific Use Case.

Use Case Implementation Guide. The document providing technical specifications related to Message Content and transport of Message Content between participating organizations, HIN, and other TDSOs. Use Case Implementation Guides are made available via URLs in exhibits.

Use Case Summary. The document providing the executive summary, business justification and value proposition of a use case. Use case summaries are provided by HIN upon request and are available via www.NJHIN.org.

1 Introduction

1.1 Purpose of Use Case

The Common Key Service use case provides a consistent and reliable way to match patients with their electronic health information across multiple organizations, applications, and services.

One of the most important goals of sharing patient information electronically is helping doctors build complete, current pictures of their patients using health information from multiple sources. These sources can include other doctors or specialists, hospitals, clinics, pharmacies, skilled nursing facilities and any other healthcare setting where care is provided. Enabling doctors to gather the details to build these complete patient pictures requires accurate “patient-matching” to make sure electronic health information from outside sources is linked to the correct patient.

These patient-matching challenges can cause higher healthcare costs and lower care quality in many ways. When a patient’s health information is shared among doctors who use different systems, a lot of effort is needed to find and evaluate variations and identify the correct patient in each health information system. Errors can and do occur, meaning the wrong information can be matched to a patient.

Patient-matching is very difficult due to the many ways patient information is stored in different computer systems and networks. For example, one hospital registration/admission system may show gender as “Male,” “Female,” and “Unknown,” while a primary care doctor’s office system may simply list “M,” “F,” and “U.” And while this simple difference can be quickly understood, the problem can be much more complex. A patient’s name may be entered as Maryann Anthony at the hospital, Marianne Anthony in her primary care physician’s system, and Mary Anthony in her specialist’s system.

To make the issue more confusing, Maryann’s address in one system may be her most recent, while another system still lists the address of her previous home. There may be another “Maryann Anthony” with the same birth date living in the same city or county. Newborn infants that aren’t named immediately may be entered into the birthing hospital’s system as simply “Baby Girl Anthony.” In a case like that, if there is a twin, Maryann’s lab results could be added to her twin sister Merry’s medical record instead of hers.

To clarify exactly how common this problem is, in Harris County, Texas in 2012 there were 2,488 real patients named Maria Garcia, 231 of which had the same birth date. In

fact, in just that county alone, there were 69,807 pairs of patients who shared both names and birth date.¹

The implications of an incorrect treatment as a result of these errors could cause serious adverse downstream effects for patients. Failures of care coordination cost \$35 billion² in annual healthcare waste and can cause complications, hospital readmissions, declines in functional status, and increased dependency (especially for the chronically ill for whom care coordination is essential). Average annual costs to correct mismatching errors range from \$500,000 to well over \$1 million on human resources alone.³

To streamline the exchange of health information, electronic healthcare systems require reliable patient-matching tools to ensure that the right information is attributed to the right patient every time. The Common Key Service (CKS) use case utilizes multiple methods to link health information to individuals, such as:

1. The CKS uses proven matching criteria to ensure that patient details (such as last name, date of birth, and phone number) positively and accurately identify the patient.
2. The CKS connects with a master person index (MPI) to manage information about patients and to eliminate duplicate entries with great accuracy.
3. This MPI uses an industry best-practice formula to determine that Maryann Anthony, Marianne Anthony, and Mary Anthony are in fact the same person based on her other details (such as last name, date of birth, and last four digits of her Social Security Number).
4. The CKS assigns a unique key that is stored and attached to the patient in the MPI and shared with all systems exchanging information about that patient. Each system can link their respective medical record number to the same common key and then include the common key when exchanging information about the patient.

Essentially, the CKS strengthens matching by providing a consistent and accurate detail (the individual patient's common key) that each system can rely on.

This reliable matching capability improves patient safety and data integrity in all use cases when information is shared about a specific patient. Over time, as CKS adoption grows throughout the state and more and more local systems link patients to a common key, it may no longer be necessary to include all of a patient's demographic information when exchanging their medical information. This would further improve the privacy and security of the information exchange as well by de-identifying the message.

¹ Susan D. Hall, "Which Maria Garcia? Bipartisan center seeks to improve patient data matching," *Fierce Healthcare* (June 27, 2012), accessed on July 28, 2016, <http://www.fiercehealthcare.com/it/which-maria-garcia-bipartisan-center-seeks-to-improve-patient-data-matching>

² "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012).

³ "Challenges and Strategies for Accurately Matching Patients to Their Health Data," (Bipartisan Policy Center, June 2012), http://bipartisanpolicy.org/wp-content/uploads/sites/default/files/BPC_HIT_Issue_Brief_on_Patient_Matching.pdf.

The CKS creates a patient list from various patient roster files or notification messages sent from participating organizations via a Trusted Data Sharing Organization (TDSO) to NJHIN. The CKS passes the patient list to the MPI which validates that the data is complete and properly formatted. The MPI uses the patient's demographic information to match the patient to existing entities in the MPI.

A successful integrated approach can improve efficiency and completeness of care coordination, safety of patients, quality of care, prevention of fraud, accuracy of information exchanged, and ease of participation by smaller organizations. It can help organizations prepare for future requirements, realize potential cost savings, improve data integrity, and drive standardization.

Over time, as CKS adoption grows throughout the state and more local systems link patients to a common key, it may no longer be necessary to include all of a patient's demographic information when exchanging medical information. Combining the common key with a second factor (such as birth date or last four digits of Social Security Number) can increase patient privacy by de-identifying messages while still reliably associating the information to the right patient whenever the information is exchanged.

1.2 Message Content

For this use case, Message Content means a unique patient identifier provided by NJHIN for use in system-to-system patient matching.

1.3 Data Flow and Actors

1.3.1 Data Flow

When a patient's information is sent to NJHIN from a healthcare provider (such as a doctor, hospital, etc.), that patient record will be processed through the Common Key Service to facilitate better patient matching with existing records. One of three results are possible for each patient processed through the Common Key Service:

1. Match = "No"

If the patient is not found in the MPI, the MPI will invoke the CKS to assign the patient a common key. The patient and the assigned common key are added to and stored in the MPI.

2. Match = "Yes"

If a person is found in the MPI, it returns the common key that has been previously assigned to that patient by the CKS to ensure accurate mapping across systems.

3. Match = "Maybe"

If a potential match is identified but it cannot be determined with a high level of confidence whether the patient does or does not exist in the MPI (that is, the algorithm results in a score between predefined minimum "no match" and maximum "match")

score thresholds), a “possible duplicate” result is generated. A common key is not assigned until a definitive determination can be made to ensure the integrity and reliability of the common key.

The MPI then adds the common key or appropriate error message for each patient to the patient list and returns it to the CKS. The common keys are then passed back to the sender via the TDSO so that the common key(s) can be linked to the local identifier in their source system. The sender can subsequently add the common key to future messages for that patient, providing an additional attribution to help strengthen patient matching by the receiver of the message.

Receivers participating in the CKS may also link their local system identifier for that patient to the same common key and can now be much more certain to which patient the information in the message pertains.

Participating organizations may send patient list information to be assigned common keys via the following mechanisms:

1. *Active Care Relationship Service (ACRS) file:* An ACRS file format is sent to NJHIN to be assigned common keys. See the [ACRS file format](#) available on the NJHIN website for more information on this format.
2. *NJHIN Transition of Care Service:* NJHIN will build an ACRS 2.0 file per hospital system on a recurring basis from an Admission-Discharge-Transfer (ADT) notification feed received by NJHIN. The file will be populated with data from the A03 discharge notifications received by NJHIN. See the [ADT Notifications Implementation Guide](#) on the NJHIN website for details on the required A03 format.

Facilities may receive common keys via the following mechanisms:

1. *ACRS:* An ACRS 2.0 format file is returned with common keys filled in for the patient(s). The common key will be in the “common key” column, or empty if unable to assign
2. *HL7 v2.5.1:* An A31 ADT message is sent to the receiving system to alert the end system to common keys for the user, and to communicate changes to common keys

Facilities may query dynamically for common keys via the following mechanism:

3. *HL7 FHIR:* An organization can request the common key for a set of demographics using a RESTful FHIR-like query to the common key service.

1.3.2 Actors and Roles

- *Actor:* Hospital/Health System
 - *Role:* Sends ADT notifications to NJHIN and receives back an A31 message with the patient’s common key (if one is assigned); Stores common key in local system to be included in exchanged health care data for other NJHIN use cases.

- **Actor:** Provider/Physician Organization
 - **Role:** Sends ACRS files to NJHIN and receives them back with the patient's common key (if one is assigned); Stores common key in local system for use as an additional attribute for matching patients when receiving messages to NJHIN.
- **Actor:** TDSO
 - **Role:** Routes messages to and from NJHIN.
- **Actor:** NJHIN Shared Services
 - **Role:** Receives patient list information from sending systems; Invokes CKS on this data to assign common keys to patients.
- **Actor:** Master Person Index
 - **Role:** Maintains consistent, accurate and current demographic data on the patients seen and managed by the Hospital/Health System.

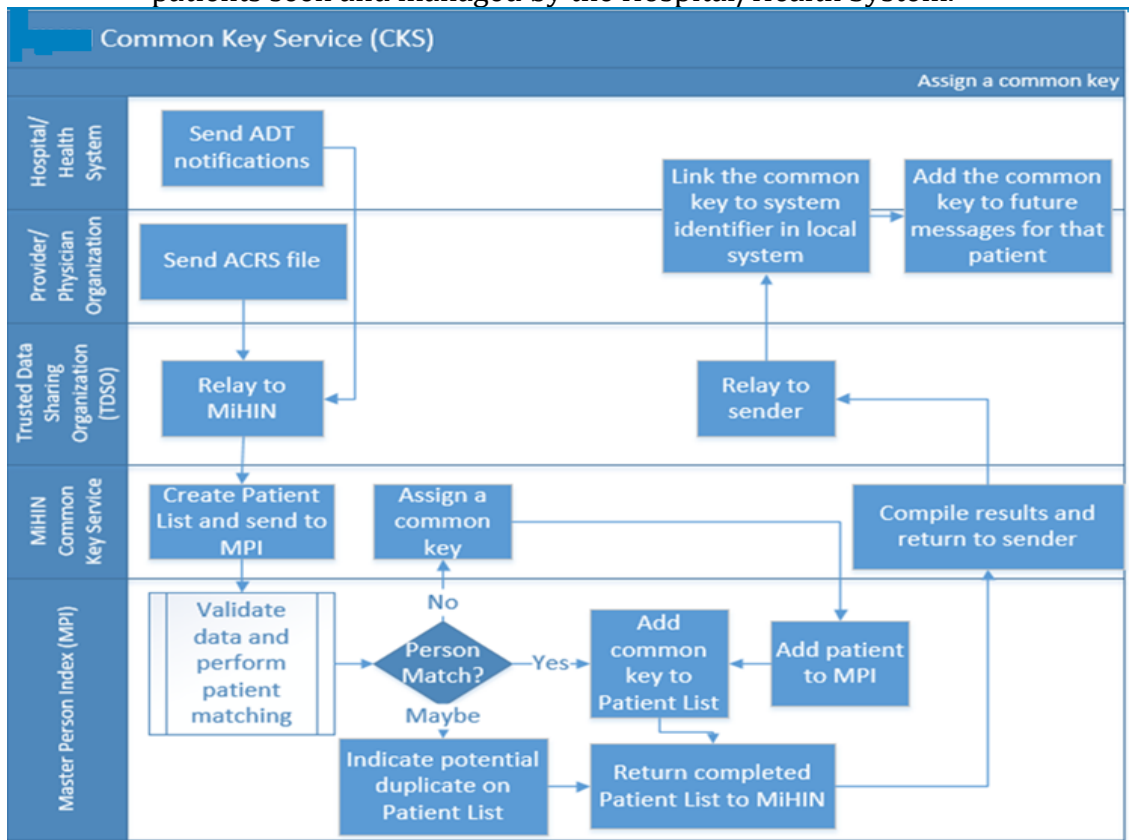


Figure 1. Common Key Service Use Case

For more information about this use case, refer to the documents that can be found online here:

- <https://NJII.com/NJHIN>

2 Standard Overview

2.1 Message Format

The current message formats supported by the IIS are HL7 v2.5.1 (preferred) and HL7 v2.3.1. Future versions of HL7 messages may be implemented and supported in the future, such as the Fast Healthcare Interoperability Resources (FHIR). For more information, refer to this website:

<http://www.hl7.org/implement/standards/fhir>

The health information network's (HIN's) role in the context of this implementation guide requires that HIN will at a minimum send the MSH (message header), EVN (event type), and PID (patient identification) segments with the associated demographics. The common key and local identifier(s) are located in PID-3 (section 4.2). For more information on MSH and EVN requirements, please see the NJHIN Admission-Discharge-Transfer Notifications Implementation Guide for HL7 Messages. All segments and fields will be present and populated according to the requirements of the NJHIN Common Key Service UCIG.

2.2 Message Example

An example A31 message conformant to this specification is below (minimum requirements):

```
MSH|^~\&|CKSOID|2.16.840.1.113883.3.1481|CKSListener|ReceiverOID|900402270  
90237-0900||ADT^A31|123456781919|P|2.5.1|||||
```

```
EVN|A31|90040227090237-0900|
```

```
PID|||10006579^^^1^MRN^1~afeuwdsvolwrdu6dufn3ivbn4ixnl7uptbyxur7^^^^C  
KS||CASTANEDA^MARCUS^H.||19721015|M|||62FOURTHCIRCLE^^WESTLAND^MI^  
48185|||||||3343|
```

* yellow highlight indicates common key

2.3 Common Key Change Events

Common keys may be updated from time to time as a result of ongoing de-duplication and data cleansing activities. Participating organizations (POs) and PO participants will subscribe to the CKS change ADT notification service to be aware of these changes. PO and PO participants will propagate changes to common keys throughout their health information systems within 14 calendar days of receipt of these updates. See section 4.2.1 for more details on common key de-duplication and data cleansing activities.

3 Onboarding Process

3.1 Initial Onboarding

- For organizations to share data with HIN under this use case, the organization undergoes two onboarding processes simultaneously. The two onboarding processes are legal onboarding and technical connectivity onboarding. These may occur in parallel – i.e. the organization can review and complete legal agreements with HIN while simultaneously establishing and testing technical connectivity. To initiate these two parallel onboarding processes, notify HIN via <https://NJIL.com/NJHIN> .

3.1.1 Initial Legal Process

The first time an organization undergoes the legal onboarding process with HIN, the organization negotiates and enters into a master organization agreement and master use case agreement which then allows the organization to enter into one or more use cases via use case exhibits.

Once an organization has entered into a master organization agreement, the organization can enter into an unlimited number of use cases with HIN. All of HIN’s use cases are available at:

- <https://NJIL.com/NJHIN>

3.1.2 Initial Technical Connectivity Process

It is assumed that the participating organization has onboarded to ACRS and ADT notification Use Cases.

4 PID (Patient Identification) Segment Fields

4.1 PID-2 (Patient ID)

The historical intent of this field is to contain an identifier for the patient at an institution or facility other than the institution or facility at which the event occurred. Previous to HL7 Version 2.3.1, it was referred to as “external ID.” It is recommended that identifiers for the patient be sent in occurrences of PID-3-patient identifier list rather than in fields PID-2-patient ID, PID-4-alternate patient ID-PID, or PID-19-SSN-patient, all of which were deprecated as of HL7 Version 2.3.1.

The data type of PID-2-patient ID is CX, whose components are as follows.

Cmp	DT	Usage	TBL#	Element Name	Comments
1	ST	R		ID	The full, unique identifier value for the patient.
2	ST	X		Check Digit	



Cmp	DT	Usage	TBL#	Element Name	Comments
3	ID	X		Code Identifying the Check Digit Scheme Employed	
4	HD	RE	0063	Assigning Authority	The system, organization, agency or department that created this patient identifier.
5	IS	RE	0203	Identifier Type Code	What kind of identifier this is: local, facility, state or national, Social Security, Medicare, etc.
6	HD	RE		Assigning Facility	The place or location where the identifier was first assigned to the patient.

4.2 PID-3 (Patient Identifier List)

This field, which allows for up to 99 occurrences, contains at least the identifier for the patient at the institution or facility at which the event occurred. The common key will be placed in PID-3 as one of these occurrences, in combination with the original patientID from the ACRS 2.0 file. It is recommended that any other identifiers for the patient be sent in additional occurrences of PID-3-patient identifier list.

The data type of PID-3-patient identifier list is CX, whose components are as follows.

Cmp	DT	Usage	TBL#	Element Name	Comments
1	ST	R		ID	The full, unique identifier value for the patient.
2	ST	X		Check Digit	Restatement of the check digit portion, if any, of the ID number in component 1.
3	ID	X		Code Identifying the Check Digit Scheme Employed	
4	HD	RE	0063	Assigning Authority	The system, organization, agency or department that created this patient identifier.
5	IS	RE	0203	Identifier Type Code	What kind of identifier this is: local, facility, state or national, CKS, Medicare, etc.
6	HD	RE		Assigning Facility	The place or location where the identifier was first assigned to the patient.

Note the identifier type for component 5 when the identifier is a common key will be "CKS." Because the common key identifier is alphanumeric, the <check digit> and <code identifying check digit scheme> components may be left blank.

- Example PID-3: agsehodt6wzrdzey5uabkxib7ug37hccd6w4m5e7^^^CKS

Example PID-3 showing an imaginary source identifier from the original system, with the common key:

- 10006579^^^1^MRN^1
~agsehodt6wzrdzey5uabkxib7ug37hccd6w4m5e7^^^CKS

NOTE: If there is no common key available, no A31 message will be sent. Any A31 sent will have a common key in PID-3.

4.2.1 Special Handling of PID-3 (When Just the CKS Identifier Is Present)

If CKS is the only identifier to appear in the PID-3 field of the A31 update to the receivers' CKS listening system, that is an indication that the receiving system should delete the common key anywhere it is stored in their system as it is now invalid.

For example, if two patients, ABC and DEF, who were assigned two different common keys were later to be found to be the same person, then those patients would be manually merged in the state MPI and a new common key would be assigned to the new merged record. Note this does not mean you must merge in your local system, however the obsolete common keys for those two old separate records must now be removed in your source system.

NJHIN would send out two A31 messages - one for patient ABC and one for DEF. Each PID-3 field in the A31 would have no local identifier and would only include the common key to be unmapped where it may be stored by the sender. For example, if PID-3 only contained "agsehodt6wzrdzey5uabkxib7ug37hccd6w4m5e7^^^^CKS" and no other identifiers, this common key should be unmapped/deleted anywhere that is stored in the receiver's system, regardless of the other associated demographics in the PID segment. A similar A31 would be sent out for the obsolete common key that was assigned to patient DEF.

If the common key is no longer or not present in your system, you can ignore the A31 message.

The same mechanism will be used for splits, overlays, and other types of items that will result in old keys being removed and new ones assigned (as referenced in section 2.3). The goal is to prevent the propagation of known bad keys stored by systems if identified in the rare event a split/merge/overlay occurs. These A31 messages do not indicate you must do any merge, split, or other record level action on your part. *The only requirement is to remove the provided bad/obsolete key from the system, when CKS is the only provided identifier in PID-3.*

To re-assign or discover new keys for records that no longer have a common key, a CKS query could be performed to discover a new common key for each patient in question if desired.

4.3 PID-4 (Alternate Patient ID)

The historical intent of this field is to contain one or more identifiers for the patient other than the principal patient identifier carried in PID-3. It is recommended that identifiers for the patient be sent in occurrences of PID-3-patient identifier list rather than in fields PID-2-patient ID, PID-4-alternate patient ID-PID, or PID-19-SSN-patient, all of which were deprecated as of HL7 Version 2.3.1.

The data type of PID-4-alternate patient ID-PID is CX, whose components are as follows.

Cmp	DT	Usage	TBL#	Element Name	Comments
1	ST	R		ID	The full, unique identifier value for the patient.
2	ST	X		Check Digit	
3	ID	X		Code Identifying the Check Digit Scheme Employed	
4	HD	RE	0063	Assigning Authority	The system, organization, agency or department that created this patient identifier.
5	IS	RE	0203	Identifier Type Code	What kind of identifier this is: local, facility, state or national, Social Security, Medicare, etc.
6	HD	RE		Assigning Facility	The place or location where the identifier was first assigned to the patient.



5 Troubleshooting

5.1 Production Support

	Severity Levels			
	1	2	3	4
Description	Critical Impact/ System Down: Business critical software is down or critical interface has failed. The issue is impacting all production systems, causing all participating organizations' or other organizations' ability to function to be unusable.	Significant Business Impact: Software component severely restricted. Entire organization is unable to continue business functions, causing all communications and transfer of messages to be halted.	Partial Failure or Downtime: Program is useable and less significant features unavailable. The service is online, though may not working as intended or may not currently working as intended or may not currently be accessible, though other systems are currently available.	Minimal Business: A non-critical software component is malfunctioning, causing minimal impact, or a test system is down.
Example	All messages to and from NJHIN are unable to be sent and received, let alone tracked	NJHIN cannot communication (send or receive) messages between single or multiple participating organizations, but can still successfully communicate with other organizations.	Messages are lost in transit; messages can be received but not transmitted.	Additional feature requested.
Primary Initiation Method	Phone: (517) 336-1430	Phone: (517) 336-1430	Web form at http://NJHIN.org/requesthelp	Web form at http://NJHIN.org/requesthelp
Secondary Initiation Method	Web form at http://NJHIN.org/requesthelp	Web form at http://NJHIN.org/requesthelp	Email to help@NJHIN.org	Email to help@NJHIN.org
Tertiary Initiation Method	Email to help@NJHIN.org	Email to help@NJHIN.org	N/A	N/A
Initial Response	Within 2 hours	Within 2 hours	1 business day	1 business day
Resolution Goal	24 hours	24 hours	3 business days	7 business days

A list of common questions regarding the Common Key Service use case can be found at:

- <https://NJII.com/NJHIN>

common-key-service

If you have questions, please contact the NJHIN Help Desk:

- www.NJII.com/requesthelp
- HOURS TBD
- Days TBD

6 Legal Advisory Language

This reminder applies to all use cases covering the exchange of electronic health information:

The Data Sharing Agreement (DSA) establishes the legal framework under which participating organizations can exchange messages through the HIN Platform, and sets forth the following approved reasons for which messages may be exchanged:

- a. By health care providers for Treatment, Payment and/or Health Care Operations consistent with the requirements set forth in HIPAA
- b. Public health activities and reporting as permitted by HIPAA and other Applicable Laws and Standards
- c. To facilitate the implementation of “Meaningful Use” criteria as specified in the American Recovery and Reinvestment Act of 2009 and as permitted by HIPAA
- d. Uses and disclosures pursuant to an Authorization provided by the individual who is the subject of the Message or such individual’s personal representative in accordance with HIPAA
- e. By Data Sharing Organizations for any and all purposes, including but not limited to pilot programs and testing, provided that such purposes are consistent with Applicable Laws and Standards
- f. For any additional purposes as specified in any use case, provided that such purposes are consistent with Applicable Laws and Standards

Under the DSA, “**Applicable Laws and Standards**” means all applicable federal, state, and local laws, statutes, acts, ordinances, rules, codes, standards, regulations and judicial or administrative decisions promulgated by any governmental or self-regulatory agency, including the State of New Jersey, the New Jersey Health IT Program, or the New Jersey Hospital Association, as any of the foregoing may be amended, modified, codified, reenacted, promulgated or published, in whole or in part, and in effect from time to time. “Applicable Laws and Standards” includes but is not limited to HIPAA; the federal Confidentiality of Alcohol and Drug Abuse Patient Records statute, section 543 of the Public Health Service Act, 42 U.S.C. 290dd-2, and its implementing regulation, 42 CFR Part 2; the New Jersey Mental Health Code; and the New Jersey Public Health Laws.

It is each participating organization’s obligation and responsibility to ensure that it is aware of Applicable Laws and Standards as they pertain to the content of each message sent, and that its delivery of each message complies with the Applicable Laws and Standards. This means, for example, that if a use case is directed to the exchange of physical health information that may be exchanged without patient authorization under HIPAA, the participating organization must not deliver any message containing health information for which an express patient authorization or consent is required (e.g., mental or behavioral health information).



Disclaimer: The information contained in this implementation guide was current as of the date of the latest revision in the Document History in this guide. However, Medicare and Medicaid policies are subject to change and do so frequently. HL7 versions and formatting are also subject to updates. Therefore, links to any source documents have been provided within this guide for reference. HIN applies its best efforts to keep all information in this guide up-to-date. It is ultimately the responsibility of the participating organization and sending facilities to be knowledgeable of changes outside of HIN's control.

Appendix A: Data Definition Tables

The following tables are defined for use in fields, components and subcomponents of data types ID, IS and CE whose values are derived from HL7-defined tables or user-defined tables published by HL7 and NJHIN. Each table below describes the value source for the table and the data elements to which the table applies, and lists values that will be recognized by conformant sending and receiving applications.

Table 0361: Application

This table provides NJHIN-defined values to be sent in component 1 of fields *MSH-3-sending application* and *MSH-5-receiving application*.

Value	Comment
CKS Application Specific OID	To be used in MSH-3
CKS Listener	To be used in MSH-5 by all organizations receiving from NJHIN

Table 0362: Facility

This table provides values to be sent in component 1 of fields *MSH-4-sending facility* and *MSH-6-receiving facility*.

Value	Comment
Receivers OID	To be used in MSH-6 by all organizations received by NJHIN.
NJHIN OID	To be used in MSH-4