NEW YORK UNIVERSITY
HIPAA Information Security Policies, Specifications, and Definitions

Title: Policy 8. Contingency Plan
Effective Date: January 1, 2005
Amended: February 26, 2016
Issuing Authority: Executive Vice President for Health; Vice President, Information Technology and Chief Information Technology Officer
Responsible Officer: Executive Vice President for Health; Vice President, Information Technology and Chief Information Technology Officer

Policy

New York University strives to protect the confidentiality, integrity, and availability of EPHI by taking reasonable and appropriate steps to establish and implement documented emergency response procedures in order to prepare for and respond to emergencies and disasters that may damage or otherwise disable EPHI Systems and by taking reasonable and appropriate steps to ensure that critical data including applications, operating systems, database software, and other software supporting packages and tools will survive a disaster or other emergency. Who is affected by this policy is documented in HIPAA Policy 1 – Overview: Policies, Procedures, and Documentation.

Purpose of this Policy

In order to safeguard EPHI, New York University and the covered components must make efforts to plan for operational continuity in the event of emergency or disaster as required under the HIPAA Security Regulations. This policy reflects New York University’s commitment to comply with such regulations. Only with effective business resilience will the University be able to avoid situations that may lead to increased risks to EPHI.

Scope of this Policy

Affected by these policies are all covered components that may be designated by the University from time to time, including the NYU School of Medicine, NYU College of Dentistry, and the Student Health Center, and areas designated part of the health care component of the University from time to time but only to the extent that each component performs activities that would make such component a business associate of a component of the University that performs covered functions if the two components were separate legal entities (i.e., support components), including the Office of the Bursar, Controller’s Division, including Accounts Payable, NYU Information Technology (NYU IT), Office of Insurance and Risk Management, Internal Audit, Office of Compliance and Risk Management, Office of General Counsel, Office of Sponsored Programs, University Relations and Public Affairs, Public Safety, Treasury Applications, and University Development and Alumni Relations. The NYU School of Medicine follows HIPAA-related policies and procedures created specifically for its environment; School of Medicine compliance with HIPAA is coordinated through Langone Medical Center. These policies affect all NYU workforce members in covered components.

Operational Requirements

A. Through the combination of preventive and recovery controls and processes, New York University’s and each covered component’s disaster and emergency response procedures will seek to reduce to an acceptable level the risk to the confidentiality, integrity, and availability of EPHI Systems by developing a Contingency Plan (commonly called Business Continuity Plan).

B. The Contingency Plan shall include:
   1. A documented disaster and emergency recovery strategy that aligns with New York University’s operational objectives and priorities.
2. A documented Data Backup Plan that aligns with the disaster and emergency recovery strategy. New York University or the covered component, as appropriate, shall back up and store copies of EPHI, as set forth in its Data Backup Plan operational specification (see 8.A).

3. A documented Disaster Recovery Plan that aligns with the disaster and emergency recovery strategy. New York University or the covered component, as appropriate, shall implement a documented Disaster Recovery Plan to recover EPHI if impacted by a disaster or other emergency, as set forth in its Disaster Recovery Plan operational specification (see 8.B).

4. A documented Emergency Mode Operations Plan that aligns with the disaster and emergency recovery strategy. New York University or the covered component, as appropriate, shall implement a documented Emergency Mode Operations Plan to take reasonable steps to ensure the continuance of critical business processes that protect the security of EPHI during and immediately following a disaster or other emergency, as set forth in its Emergency Mode Operation Plan operational specification (see 8.C).

5. Testing, review, and revision of the Disaster Recovery Plan and Emergency Mode Operations Plan, as needed. New York University or the covered component, as appropriate, shall complete testing of its Disaster Recovery Plan and, if necessary, take reasonable steps to ensure that it is up-to-date and effective, as set forth in its Testing and Revision Procedure operational specification (see 8.D).

6. Review and revision of the criticality analysis of EPHI Systems, as needed, and how such EPHI Systems are vulnerable to loss or other damage in the event of a disaster or other emergency. New York University or the covered component, as appropriate, shall have a process to identify and define the criticality of applications and data on EPHI Systems, as set forth in its Application and Data Criticality Analysis specification (see 8.E).

7. An annual test of the Contingency Plan conducted by New York University and its covered components as set forth in its Testing and Revision Procedure operational specification (see 8.D) and retention of the documented results of the annual test.

C. New York University and each covered component shall provide periodic training about New York University’s and/or the covered component’s disaster and emergency response procedures to workforce members, as appropriate.

D. HIPAA REGULATORY INFORMATION

CATEGORY: Administrative Safeguards
TYPE: Standard
HIPAA HEADING: Contingency Plan
REFERENCE: 45 CFR 164.308(a)(7)(i)
SECURITY REGULATION STANDARDS LANGUAGE: “Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information.”

Operational Specifications

8.A Data Backup Plan

1. Each covered component of New York University will take reasonable and appropriate steps to back up and store EPHI stored on EPHI Systems and to create exact and retrievable copies of EPHI.

2. Each covered component of New York University will create and implement a documented and detailed plan for creating and maintaining backup data from all electronic media associated with EPHI that:
   a. Defines who is responsible for taking reasonable steps to ensure the backup of EPHI.
   b. Defines a backup schedule.
   c. Specifies the EPHI Systems that are to be backed up.
   d. Defines where backup media is to be stored and New York University workforce members who may access the stored backup media.
   e. Defines where backup media is to be kept secure before it is moved to storage.
   f. Defines who may remove the backup media and transfer it to storage.
g. Defines restoration procedures to restore EPHI from backup media to the appropriate EPHI Systems.

3. Each covered component will implement a backup procedure that will
   a. generate up-to-date copies of EPHI that can be recovered in the event that EPHI Systems are damaged by or during a disaster or other emergency.
   b. complete periodic testing of its restoration procedures for EPHI Systems to confirm the effectiveness of those procedures and that the EPHI can be restored in the time set forth in the covered component’s Disaster Recovery Plan operational specification (see 8.B).
   c. document the retention period for backup media that contain backup copies of EPHI.
   d. store backup copies of EPHI, complete records of the backup copies, and document restoration procedures in a remote and secure location, within sufficient distance from the site.
   e. provide access to authorized workforce members for timely retrieval of the backup information stored at the remote location.
   f. provide physical, environmental, and technical security for the backup media stored at the remote location that will be consistent with the security provided to EPHI onsite.

4. HIPAA REGULATORY INFORMATION

   CATEGORY: Administrative Safeguards
   TYPE: REQUIRED Implementation Specification for Contingency Plan Standard
   HIPAA HEADING: Data Backup Plan
   REFERENCE: 45 CFR 164.308(a)(7)(ii)(A)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Establish and implement procedures to create and maintain retrievable exact copies of electronic protected health information.”

8.B Disaster Recovery Plan

1. Each covered component of New York University will take reasonable and appropriate steps to maintain a documented and detailed Disaster Recovery Plan to recover EPHI that is lost, damaged, or corrupted in the event of a disaster or other emergency.

2. The Disaster Recovery Plan will include:
   a. The conditions under which the Disaster Recovery Plan may be activated.
   b. New York University workforce members’ roles and responsibilities in executing the Disaster Recovery Plan.
   c. Recommended procedures that contain the actions to be taken to restore EPHI, and to return EPHI Systems to normal operations, within a defined timeframe.
   d. Documented order in which EPHI will be restored and the EPHI Systems will be returned to operation.
   e. Documented reporting and notification procedures to the covered component’s EPHI security officer or designated workforce members.
   f. In the event of a disaster or other emergency, procedures for permitting appropriate specified workforce members physical access to the covered component’s facilities, and to any backup media on which EPHI is stored whether onsite or offsite, in order to carry out the recovery plan.
   g. Procedures that specify how and when the plan will be tested and maintained.

3. Each covered component will provide periodic training and awareness on the Disaster Recovery Plan to New York University workforce members. The covered component’s EPHI security officer will determine the frequency of the training and awareness in accordance with New York University’s Security Training and Awareness policy (HIPAA Policy 6).
4. Each *covered component* will provide current copies of the Disaster Recovery Plan and training and awareness on that plan to the New York University EPHI Security Officer and to the appropriate New York University *workforce members* on a periodic basis, as well as keep copies of the plan off-site.

5. **HIPAA REGULATORY INFORMATION**

   **CATEGORY:** Administrative Safeguards  
   **TYPE:** REQUIRED Implementation Specification for Contingency Plan Standard  
   **HIPAA HEADING:** Disaster Recovery Plan  
   **REFERENCE:** 45 CFR 164.308(a)(7)(ii)(B)  
   **SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE:** “Establish (and implement as needed) procedures to restore any loss of data.”

**8.C Emergency Mode Operation Plan**

1. In an effort to enable continuation of critical operational procedures, New York University is committed to take reasonable and appropriate steps to ensure the confidentiality, integrity, and availability of EPHI by continuing operations and protecting EPHI during and immediately following an emergency.

2. Each *covered component* of New York University will implement a documented and detailed Emergency Mode Operation Plan designed to allow the continuation of critical operations processes, while permitting necessary access to and use of EPHI, during and immediately following an emergency.

3. The Emergency Mode Operation Plan will:
   a. Define and categorize reasonably foreseeable emergencies that could have an impact on the confidentiality, integrity, and availability of EPHI Systems.
   b. Include a procedure that specifies how the *covered component* will react to emergencies that impact the confidentiality, integrity, and availability of EPHI.
   c. Include a procedure for the *covered component* to follow during and immediately following an emergency that outlines how the *covered component* will maintain security processes and controls to ensure the confidentiality, integrity, and availability of EPHI.
   d. Include a procedure authorizing New York University *workforce members* to enter New York University and any offsite location where backup storage media are stored to maintain the security processes and controls that protect the confidentiality, integrity, and availability of EPHI while the *covered component* is functioning in emergency mode.
   e. Identify and document processes and controls that protect the confidentiality, integrity, and availability of EPHI while New York University is functioning in emergency mode.

4. **HIPAA REGULATORY INFORMATION**

   **CATEGORY:** Administrative Safeguards  
   **TYPE:** REQUIRED Implementation Specification for Contingency Plan Standard  
   **HIPAA HEADING:** Emergency Mode Operation Plan  
   **REFERENCE:** 45 CFR 164.308(a)(7)(ii)(C)  
   **SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE:** “Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of electronic protected health information while operating in emergency mode.”

**8.D Testing and Revision Procedure**

1. New York University and each *covered component* of New York University will take reasonable and appropriate steps to perform testing of its Contingency Plan to assess its sufficiency and determine whether it is accurate and up-to-date, and by making necessary revisions on a periodic basis.
2. New York University’s EPHI Security Officer will receive the documented testing results. The EPHI security officer of the covered component will review and recommend revisions, as necessary, to the Contingency Plan to address any issues identified in the testing of the disaster recovery.

3. New York University and each covered component will use a change control process to modify its Disaster Recovery Plan to make it sufficient and keep it accurate and up-to-date. Events that result in a revision of the plan will include:
   a. Disaster recovery role and responsibility changes, including changes to contact information.
   b. Changes to New York University’s and/or each covered component’s physical or technical infrastructure.
   c. Changes in threats to EPHI Systems.
   d. Results of testing that indicate that the plan needs to be modified to ensure that it is sufficient, accurate, and up-to-date.

4. HIPAA REGULATORY INFORMATION
   CATEGORY: Administrative Safeguards
   TYPE: ADDRESSABLE Implementation Specification for Contingency Plan Standard
   HIPAA HEADING: Testing and Revision Procedure
   REFERENCE: 45 CFR 164.308(a)(7)(ii)(D)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Implement procedures for periodic testing and revision of contingency plans.”

8.E Applications and Data Criticality Analysis

1. Each covered component will analyze and document the criticality of EPHI and EPHI Systems. The purpose of this criticality analysis is to document the impact to its services, processes, and operating objectives if a disaster or other emergency causes EPHI Systems to become unavailable for a documented amount of time. The criticality analysis will serve as the basis for the prioritization of EPHI and EPHI Systems.

2. REGULATORY INFORMATION
   CATEGORY: Administrative Safeguards
   TYPE: ADDRESSABLE Implementation Specification for Contingency Plan Standard
   HIPAA HEADING: Applications and Data Criticality Analysis
   REFERENCE: 45 CFR 164.308(a)(7)(ii)(E)
   SECURITY REGULATION IMPLEMENTATION SPECIFICATION LANGUAGE: “Assess the relative criticality of specific applications and data in support of other contingency plan components.”

Policy Definitions

Access
Availability
Backup
Business associate
Confidentiality
Covered component
Disaster
Electronic Protected Health Information (or EPHI)
Emergency
EPHI systems
HIPAA Security Regulations
Integrity
Restoration
Risk
Threat
Workforce member

Related HIPAA Documents

HIPAA Policy 1 – Overview: Policies, Procedures, and Documentation
HIPAA Operational Specification 2.A – Risk Analysis
HIPAA Policy 6 – Security Training and Awareness
HIPAA Operational Specification 14.D - Data Backup and Storage
HIPAA Policy 15 – Access Control

HIPAA Privacy Regulations covered component’s Minimum Necessary Policy


