APPENDICES

APPENDIX 1

EXECUTIVE ORDER # 303

Relating to the Governor's WIRED for Health Board

WHEREAS, adoption and meaningful use of certified electronic health record systems, and a statewide health information exchange ("HIE") are critical components of a high performance health care system and would improve the quality and reduce the cost of health care in Wisconsin by:

1. Ensuring health information is available at the point of care for all patients; and
2. Reducing medical errors and avoiding duplicative medical procedures; and
3. Improving coordination of care between hospitals, physicians, and other health professionals; and
4. Enabling public health surveillance and improving population health over the lifespan; and
5. Furthering health care research; and
6. Providing consumers with their health information to encourage greater participation in their health care decisions; and

WHEREAS, on August 20, 2009, the Office of the National Coordinator for Health Information Technology issued its Funding Opportunity Announcement for the State HIE Cooperative Agreement Program under Section 3013 of the American Recovery and Reinvestment Act of 2009; and

WHEREAS, the federal government intends to financially support statewide initiatives aligned with federal efforts to achieve the goals of the Health Information Technology for Economic and Clinical Health ("HITECH") Act; and

WHEREAS, the Office of the National Coordinator will award $9.441 million to Wisconsin under a cooperative agreement for developing a statewide HIE; and

WHEREAS, the governance, policy, and technical infrastructure for an effective statewide HIE must be created to facilitate and expand the secure electronic movement and use of health information among organizations, according to nationally recognized standards; and

WHEREAS, the HITECH Act provides the State of Wisconsin the option of designating a not-for-profit entity (known as the State Designated Entity) to assume the aforementioned responsibilities;

NOW, THEREFORE, I, JIM DOYLE, Governor of the State of Wisconsin by the authority vested in me by the Constitution and the Laws of this State, and specifically by Wis. Stat. §14.019, do hereby:

1. Create a Board for the Wisconsin Relay of Electronic Data ("WIRED") for Health ("Board") organized under the Department of Health Services; and
2. Direct the Board to develop statewide HIE capacity and resolve issues related to HIE governance, finance, infrastructure, operations, and legal; and

3. Direct the Board to develop, no later than June 1, 2010, and implement Strategic and Operational Plans for statewide HIE, in accordance with the Office of the National Coordinator's State HIE Cooperative Agreement Program requirements, that will:

    a. Provide for oversight and accountability of HIE to protect the public interest, and develop and maintain a multi-stakeholder process to ensure HIE among providers is in compliance with applicable laws and policies; and

    b. Identify, secure, and provide for the management of financial resources needed to fund HIE, including public and private financing to build statewide HIE capacity and sustainability; and

    c. Provide for a secure, reliable statewide HIE technical infrastructure and services that leverage existing public and private health information technology assets; and

    d. Provide for business and technical operations activities needed to support providers' adoption and meaningful use of electronic health records; and

    e. Provide for the operation of a statewide HIE, and enable the efficient, appropriate, and secure flow of information to optimize decisions for health; and

    f. Create a common set of rules to enable inter-organizational and eventually interstate HIE while protecting consumer interests; and

4. Provide that up to fifteen (15) members of the Board shall be appointed by and serve without compensation at the pleasure of the Governor for an initial term of two years (except ex-officio positions); and

5. Provide that members of the Board shall represent both private and public stakeholders, including:

    a. A commercial health insurer or health plan; and

    b. A patient or consumer advocacy organization; and

    c. Hospitals or integrated delivery networks, representing both urban and rural hospitals or networks; and

    d. Physicians, preferably one from large group practice and one from solo or small group practice; and

    e. The business community; and

    f. Pharmacies; and

    g. Laboratories; and

    h. Higher education, from a health-services discipline; and

    i. Health information/quality organizations; and

    j. Public health (ex-officio position); and

    k. The State Medicaid program (ex-officio position); and

    l. The State Chief Information Officer (ex-officio position); and

6. Provide that the Officers (Chairperson, Vice Chairperson, Treasurer, and Secretary) of the Board shall be selected by the Board from among the Board's membership to serve for an initial term of one year; and

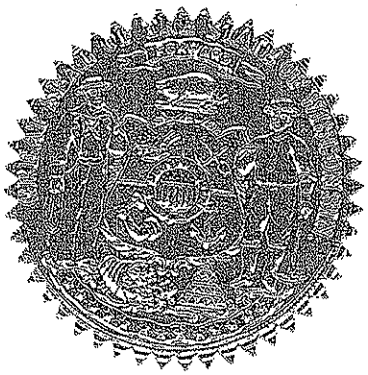
7. Provide that the Board may establish committees or workgroups as necessary to conduct its business; and

8. Provide that the Board may adopt policies and procedures to govern its proceedings and carry out its duties as specified in this Executive Order; and

9. Direct the Board to annually report to the Governor and the Secretary of the Department of Health Services on its activities and accomplishments, including HIE implementation progress and the impact of HIE on health care delivery in Wisconsin; and

10. Direct that the Board shall exist until such time as a qualified, not for profit corporation is designated by the Governor, or created and designated in statute specifically for the purpose of governing the implementation and operation of statewide HIE services; and

11. Rescind Executive Order 129 relating to the Governor's eHealth Care Quality and Patient Safety Board.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this first day of December, in the year two thousand nine.

JIM DOYLE
Governor

By the Governor:

DOUGLAS LA FOLLETTE
Secretary of State

APPENDIX 2

WIRED for Health Board
Communications, Education, and Marketing Committee Charter

Overall Committee Responsibilities:

- Provide support to the WIRED for Health Board of Directors
- Assist with the development of the Strategic and Operational Plans
- Assist with the creation of or the transition to the SDE
- Engage stakeholders in the WIRED for Health Program
- Lead workgroups associated with respective Committees

Co-Chairs:
Sue Gaard, Confident Conversations LLC
Terri Timmers, DHS

Project Staff:
Denise Webb, DHS

Responsibilities: This committee is responsible for researching, analyzing, and developing the strategic and operational plan content for HIT/HIE-related communications, education, and marketing.

Assignments:

1. Develop and document a communications, education, and marketing strategy to effectively communicate with and inform key health care stakeholders and the health community of the State's commitment to the advancement of the adoption and use of EHRs and HIE and the achievement of meaningful use in an open, consistent, and sustained manner.

2. Identify, implement, and/or support communication, education, and marketing activities and programs that will inform, educate, and engage health care stakeholders to support the adoption and use of EHRs and HIE and the achievement of meaningful use during both the planning and implementation phases of the WIRED for Health Project.

3. Initiate key messages directed at general and specific stakeholder groups regarding statewide HIE plans, progress, value, and overall strategy.

4. Engage key stakeholder organizations to help communicate important information to their members and constituents and assist with activities and programs.

5. Collaborate with the regional extension center, HIT/HIE professionals, employers, educators, and consumers in these efforts.

6. Propose, develop, and implement effective communication tools, such as web sites, email distribution lists, and newsletters.

7. Develop a detailed implementation work plan for communications, education, and marketing describing the tasks and sub-tasks along with resources, dependencies, and specific timeframes. Additionally, develop a staffing plan including a project manager and other key roles required to ensure successful implementation of the communications, education, and marketing work. Deliver the work plan and staffing plan to the Finance and Audit Committee for costing.

8. Identify opportunities to collaboratively work with other committees.

WIRED for Health Board
Finance and Audit Committee Charter

Overall Committee Responsibilities:

- Provide support to the WIRED for Health Board of Directors
- Assist with the development of the Strategic and Operational Plans
- Assist with the creation of or the transition to the SDE
- Engage stakeholders in the WIRED for Health Program
- Lead workgroups associated with respective Committees

Co-Chairs:
John Foley, Anthem Blue Cross Blue Shield
Jason Helgerson, DHS Medicaid Director

Project Staff:
Matt Schwei, DHS
Chris Van Houten, Deloitte Consulting

Responsibilities: This committee is responsible for researching, analyzing, and developing the Strategic and Operational Plan content for the Finance domain in accordance with the State HIE CAP requirements. The Finance domain encompasses the identification and management of financial resources necessary to fund health information exchange. This domain includes public and private financing for building HIE capacity and sustainability. This also includes but is not limited to pricing strategies, market research, public and private financing strategies, financial reporting, business planning, audits, and controls.

Assignments:

1. Define the value proposition by stakeholder type for each selected HIE service.

2. Develop cost estimates for implementation of the Strategic Plan for the time period covered by the Operational Plan, i.e., the costs associated with the operational work plans and staffing plans for each HIE domain, including Finance. Determine how costs will be allocated across the two grant award funding categories allotted for intra and interstate HIE implementation.

3. Develop a business plan with feasible public/private financing mechanisms to address short-term capital needs and long-term financing to support the development and ongoing sustainability of HIE infrastructure and services, by the

end of the project period of HIE governance and operations. Submit an annual report on sustainability to ONC. **(F.2)**

a. Develop options and make a recommendation for securing the upfront financial capital needed beyond the amount provided by the State HIE CAP to build the statewide HIE infrastructure and deliver services to support the business plan.

b. Recommend a viable strategy for long-term sustainable financing of ongoing statewide HIE services and operations.

4. Identify financial policies and oversight practices needed to monitor spending and provide appropriate financial controls relative to the implementation of the Strategic Plan (i.e., audit, etc.).

5. Obtain support and buy-in from stakeholders for financing strategies and sustainability models for HIE.

6. Develop a detailed implementation work plan for the Finance domain describing the tasks and sub-tasks that need to be completed to enable statewide HIE, along with resources, dependencies, and specific timeframes. The work plan shall also describe proposed resolution and mitigation methods for identified issues and risks within the work plan. Additionally, develop a staffing plan including a project manager and other key roles required to ensure successful implementation of the Finance work plan.
7. Identify opportunities to collaboratively work with other committees.

Governance Committee Charter
As Approved on 5/4/2010

Co-Chairs:
Karen Timberlake, Secretary, DHS
Craig Samitt, Dean Health Systems

Project Staff:
Faith Russell, DHS
Julie Bartels, WHIO

Responsibilities: This committee is responsible for researching, analyzing, and developing the Strategic and Operational Plan content for the Governance domain in accordance with the State HIE CAP requirements. The Governance domain addresses the functions of convening health care stakeholders to create trust and consensus on an approach for statewide HIE and to provide oversight and accountability of HIE to protect the public interest. One of the primary purposes of a governance entity is to develop and maintain a multi-stakeholder process to ensure HIE among providers is in compliance with applicable policies and laws.

Assignments:

#1 Vision, Mission, Strategic Goals and Objectives, Performance Measures (p. 51 FOA)

- Finalize the HIE vision, mission, strategic goals and objectives, and performance measures;
- Ensure that the vision, mission etc.:
    - reflect consensus among stakeholder groups;
    - accomplish statewide coverage for all providers to meet the meaningful use HIE requirements.
- Prepare the above for inclusion in the Strategic and Operational Plan (S/OP)
- Plan for and describe a transition process to the SDE which will support continued alignment with WIRED mission, goals and objectives (WIRED Board and SDE)

#2 WI HIE Governance Structure (G.3)

- Describe WI's choice of State HIE Governance Structure -- – to be included in the S/OP. Include the following:
    - Decision to work through a State Designated Entity (SDE) and process of arriving at that decision -- broad-based stakeholder support for SDE as governance structure;

    - Role of WIRED Board and transition to SDE;
    - Multi-disciplinary, multi-stakeholder nature WIRED Board and plans for SDE;
    - Focus on collaboration, transparency, buy-in, and trust (WIRED Board and to continue with SDE);
    - Statutory basis of SDE (if appropriate), including statutory requirements as to structure and function of SDE;
    - Decision-making authority the SDE will have;
    - Requirement for continued alignment with mission, goals and objectives and annual reporting to DHS Secretary. (State Legislation)
- Determine process for selecting a non-profit corporation to recommend to the WIRED Board as the SDE;
- Implement the process for selecting and recommending the SDE to the Board.

#3 Designation of State HIT Coordinator and Description of Role (G.1 and B.2)

- Identify, for inclusion in the S/OP, the designated state HIT Coordinator;
- Describe how the state HIT Coordinator will interact with federally funded state health programs and HIE activities in the state, including:

    - Describe the role of the HIT Coordinator, including the period after the SDE is in place
    - the Medicaid program;
    - Public Health programs;
    - Other federally funded health programs;
    - Other HIE activities within the state;

#4 Alignment of HIE S/OP with Medicaid and Public Health (B.2)

- Indicate how the state HIE plan aligns with the State Medicaid HIT Plan (SMHP);
- Confirm that State Medicaid Director approves Medicaid content in HIE S/OP;
- Describe how HIE S/OP aligns with and will leverage as appropriate public health's existing initiatives and future plans;
- Confirm that State Public Health Administrator approves content in HIE plan.

#5 Coordination with Other ARRA Programs (p. 52 FOA)

- Recommend a process to ensure coordination, integration, and alignment with other ARRA programs, including: REC, broadband, workforce development; SHARP Program, Beacon Communities, etc.

#6 Report to ONC on Statewide HIE alignment with other federal programs (O.2)

- Specify process for completing annual report to ONC on statewide alignment with other federal programs.

 # 7 Oversight and Accountability Mechanisms to Protect the Public Interest (G.4)

- Describe the oversight, accountability, and transparency mechanisms to be used by the WIRED Board during the planning process;
- Clarify that the SDE will also be required to put such mechanisms in place. (Question: however, we won't prescribe the mechanisms, will we?)

#8 Framework for Wisconsin to align with emerging nationwide HIE governance. **(G.5)**

- Recommend framework
- Describe for inclusion in HIE S/OP

#9 Implementation Plan for Governance Domain

Develop a detailed implementation work plan for the Governance domain. This implementation plan is to clearly delineate what must be done pre and post SDE transition and will include:

- Tasks and sub-tasks that need to be completed to enable statewide HIE,
- Resources, dependencies, and specific timeframes.
- Proposed resolution and mitigation methods for identified issues and risks within the work plan.
- Develop a staffing plan, including a project manager and other key roles required to ensure successful implementation of the Governance work plan.
- Deliver the work plan and staffing plan to the Finance and Audit Committee for costing.

#10 Evidence of Stakeholder Endorsement

Submit evidence of stakeholder endorsement of the Strategic and Operational Plans through voting of participants or through letters of endorsement and commitment to participate in or support the state-level HIE strategic and operational plans. **(P.1)**

#11 Identify Opportunities to Collaboratively Work with Other Committees

WIRED for Health Board
Legal and Policy Committee Charter

Overall Committee Responsibilities:

- Provide support to the WIRED for Health Board of Directors
- Assist with the development of the Strategic and Operational Plans
- Assist with the creation of or the transition to the SDE
- Engage stakeholders in the WIRED for Health Program
- Lead workgroups associated with respective Committees

Co-Chairs:
Jared Adair, WPS Health Insurance
Mark Kirschbaum, UW Health

Project Staff:
Alice Page, DHS
Matthew Stanford, WHA
Kelly Wilson, UW Health

Responsibilities: This committee is responsible for researching, analyzing, and developing the Strategic and Operational Plan content for the Legal and Policy domain in accordance with the State HIE CAP requirements. The mechanisms and structures in the Legal and Policy domain address barriers and enablers related to the electronic use and exchange of health information. These mechanisms and structures include but are not limited to: policy frameworks, privacy and security requirements for system development and use, data sharing agreements, laws, regulations, and multi-state policy harmonization activities. The primary purpose of the Legal and Policy domain is to create a common set of rules to enable inter-organizational and eventually interstate health information exchange while protecting consumer interests.

Assignments:

1. Outline a legal framework under which the state will facilitate health information exchange. Identify privacy and security issues related to HIE within the state and between states within the context of the HHS Privacy and Security Framework, and any related guidance. **(L.1)**

    a. Identify and analyze existing state privacy laws and determine whether new laws or revisions to existing laws are necessary.

1) Develop a plan to promulgate new laws or to make revisions to existing laws giving consideration to federal/state harmonization, including sequencing and a timeline.

b. Identify federal and state privacy and security policies and laws requiring harmonization that enable HIE services.
c. Develop a plan for federal/state harmonization and coordination activities for interstate HIE.

2. Develop a plan to establish a statewide policy framework that allows for incremental development of HIE policies over time. Inventory and evaluate existing policies and procedures required for HIE within the state and between states. **(L.2)**

   a. Identify gaps in existing policies and procedures.
   b. Develop a plan to fill those gaps, including sequencing and a timeline.

3. Inventory and evaluate existing trust agreements and other legal documents among parties to the HIE to enable the secure flow of information and minimize obstacles (i.e., business associate, data sharing, data use, and reciprocal services agreements).

   a. Identify gaps in existing trust agreements and other legal documents.
   b. Develop a plan to fill those gaps.

4. Develop a plan for addressing the oversight of and statewide compliance with federal and state policies and laws that protect health information and enable HIE. Describe and document the process of ensuring appropriate safeguards are in place, including a robust risk mitigation process, to assure the state adheres to legal and policy requirements. **(L.3)**

5. Develop a process for ensuring policies and legal agreements needed to guide prioritized technical services are implemented and evaluated as part of annual program evaluation. Submit an annual report to ONC. **(L.4)**

6. If health information will be exchanged with federal health care delivery organizations (i.e., VA, DoD, IHS), develop a plan for meeting federal requirements for the use and protection of health data.

7. If regional HIEs will be developed, develop a plan for certifying them.

8. Develop a detailed implementation work plan for the Legal and Policy domain describing the tasks and sub-tasks that need to be completed in order to enable statewide HIE, along with resources, dependencies, and specific timeframes. The work plan shall also describe proposed resolution and mitigation methods for identified issues and risks within the work plan. Additionally, develop a staffing plan including a project manager and other key roles required to ensure successful

implementation of the Legal and Policy work plan. Deliver the work plan and staffing plan to the Finance and Audit Committee for costing.

9. Identify opportunities to collaboratively work with other committees.

WIRED for Health Board
Standards and Architecture Committee Charter

Overall Committee Responsibilities:

- Provide support to the WIRED for Health Board of Directors
- Assist with the development of the Strategic and Operational Plans
- Assist with the creation of or the transition to the SDE
- Engage stakeholders in the WIRED for Health Program
- Lead workgroups associated with respective Committees

Co-Chairs:
Dave Lundal, SSM Healthcare Wisconsin
Kim Pemble, WHIE/NIMI

Project Staff:
Himanshu Arora, Deloitte Consulting
Harold Robinson, Deloitte Consulting

Responsibilities: This committee is responsible for researching, analyzing, and developing the Strategic and Operational Plan content for the Technical Infrastructure and the Business and Technical Operations domains in accordance with the State HIE CAP requirements. The Technical Infrastructure domain includes the architecture, hardware, software, applications, network configurations and other technological aspects that physically enable the technical services for HIE in a secure and appropriate manner. The activities in the Business and Technical Operations domain include but are not limited to procurement, identifying requirements, process design, functionality development, project management, help desk, systems maintenance, change control, program evaluation, and reporting. Some of these activities and processes are the responsibility of the entity or entities that are implementing the technical services needed for health information exchange; there may be different models for distributing operational responsibilities.

Ensure that products and processes are responsive to health care stakeholders and reflect the business and clinical requirements determined via the multi-stakeholder planning process.

Assignments:

1. Conclude the environmental scan of HIE readiness that was begun in Phase 1 of the State-Level HIE planning. This scan may include broad adoption of HIT but must include HIE adoption across health care providers within the state and potentially external to the state, as relevant. The environmental scan must include an

assessment of current HIE capacities that could be expanded or leveraged, HIT resources that could be used, the relevant collaborative opportunities that already exist, the human capital that is available and other information that indicates the readiness of HIE implementation statewide.

2. Identify and recommend services and strategies to facilitate and enhance patient care, disease surveillance, outbreak detection, trending, quality and cost measurement, public reporting, and health promotion and disease prevention efforts. For each of the following HIE services, determine Wisconsin's current status, requirements and needs as related to meaningful use, and qualitative benefits. Prioritize each service according to the state's needs.
   a. Electronic eligibility and claims transactions;
   b. Electronic prescribing and refill requests;
   c. Electronic clinical laboratory ordering and results delivery;
   d. Electronic public health reporting;
   e. Quality reporting;
   f. Prescription fill status and/or medication fill history; and
   g. Clinical summary exchange for care coordination and patient engagement.

3. Develop a comprehensive statewide technical architecture and phased implementation strategy for statewide HIT adoption and availability of HIE services and data access among healthcare providers, public health, and those offering services for patient engagement in support of the meaningful use requirements based on stakeholder input and consensus. **(T.2)**

   a. Develop a vendor-neutral HIE reference architecture.
   b. Document how health data will be protected.
   c. Document how the planned technical architecture leverages the appropriate HHS-adopted standards and certifications for health information exchange. **(T.4)**
   d. Document how the planned technical architecture for statewide HIE aligns with NHIN core services and specifications. This is required if the state plans to exchange information with federal health care providers including but not limited to VA, DoD, and IHS. **(T.5)**

4. Determine and document how existing regional, state, and federal public and private technical assets, resources, and initiatives can be leveraged to advance HIE, such as master patient indices, health information organizations (HIOs), Medicaid Management Information System (MMIS), and NHIN. **(T.1)**

   a. Collaborate with the regional extension center to promote standards-based exchange of health information as part of "meaningful use" requirements.

5. Develop a technical strategy for shared directories and technical services.

   a. Document how shared directories and technical services, as applicable for the state's approach for statewide HIE, will be created and used. Directories may

include but are not limited to: Providers (i.e., with practice location(s), specialties, health plan participation, disciplinary actions, etc.), Laboratory Service Providers, Radiology Service Providers, Health Plans (i.e., with contact and claim submission information, required laboratory or diagnostic imaging service providers, etc.). Shared technical services may include but are not limited to: Patient Matching, Provider Authentication, Consent Management, Secure Routing, and Advance Directives and Messaging. **(T.3)**

b. Coordinate and align efforts to meet Medicaid and public health requirements for HIE and meaningful use.
c. Document how the HIE services will meet the meaningful use HIE requirements.

6. Describe the technical solutions that will be used to develop HIE capacity within the state and particularly solutions that will enable the meaningful use criteria. Describe how the state will leverage current HIE capacities.

7. Describe whether and how the state will leverage state-level shared services and repositories including how existing HIOs and other data exchange mechanisms can leverage existing services and data repositories, both public and private. Shared services to consider include but are not limited to: Security Service, Patient Locator Service, Data/Document Locator Service, and Terminology Service.

8. Develop and describe an approach to provide technical assistance as needed to HIOs and others developing HIE capacity within the state. **(B.1)**

9. Develop and describe an approach for monitoring and remediating the actual performance of HIE throughout the state. **(B.3)**

10. Describe a plan for how the state will establish and maintain staff to effectively operate statewide technical services. **(B.4)**

11. Describe a plan for how the state will monitor and maintain a targeted degree of participation in HIE-enabled, state-level technical services. **(O.1)**

12. Develop a detailed implementation work plan for the Technical Infrastructure and the Business and Technical Operations domains describing the tasks and sub-tasks that need to be completed to enable a phased implementation of HIE services to reach all geographies and all providers across the state, along with resources, dependencies, and specific timeframes. The work plan shall also describe proposed resolution and mitigation methods for identified issues and risks within the work plan. Additionally, develop a staffing plan including a project manager and other key roles required to ensure successful implementation of the Technical Infrastructure and the Business and Technical Operations work plan. Deliver the work plan and staffing plan to the Finance and Audit Committee for costing.

13. Identify opportunities to collaboratively work with other committees.

APPENDIX 3

Wisconsin Relay of Electronic Data (WIRED) for Health Board Committee Members

Communications, Education, and Marketing

Co-Chair: Sue Gaard, Confident Conversations LLC
Co-Chair: Terri Timmers, State of Wisconsin, Public Health

Rich Albertoni, State of Wisconsin, Medicaid
James Angelici, Aurora Medical Center Kenosha
Ulrike Dieterle, UW Madison
Brenda Gonzalez, New Routes to Community Health
Mary Kay Grasmick, Wisconsin Hospital Association
Bill Jensen, Independent Care Health Plan
Greg Newman, Cardiac Science Corporation
Robert Peterson, ABC for Health, Inc.
Debra Rislow, Gunderson Lutheran Health Systems
Cindy Schlough, Wisconsin Collaborative for Healthcare Quality
Bill Sexton, Prairie du Chien Memorial Hospital
Linda Syth, Wisconsin Medical Society

Finance and Audit

Co-Chair: John Foley, Anthem Blue Cross Blue Shield
Co-Chair: Jason Helgerson, State of Wisconsin, Medicaid

Sandy Clark, UW Health
Kerra Guffey, Meriter Health Services
John Hartman, Wisconsin Medical Society
Jo Musser, Wisconsin Health Information Organization
Brian Potter, Wisconsin Hospital Association
Christopher Queram, Wisconsin Collaborative for Healthcare Quality
Debra Rislow, Gunderson Lutheran Health Systems
Greg Simmons, MetaStar, Inc.
Tim Size, Rural Wisconsin Health Cooperative

Governance

Co-Chair: Craig Samitt, MD, Dean Health Systems
Co-Chair: Karen Timberlake, State of Wisconsin

Stephen Brenton, Wisconsin Hospital Association
Cheryl DeMars, The Alliance
Seth Foldy, MD, State of Wisconsin, Public Health
Jeffrey Grossman, MD, UW Health
Albert Tzeel, MD, Humana Inc.

Legal and Policy

Jared Adair, WPS Health Insurance
Chris Ahmuty, Wisconsin ACLU
Kathleen Dallen, MD, Department of Defense
Nancy Davis, Ministry Health Care
Claudia Egan, von Briesen & Roper, S.C.
Denise Gomez, Meriter Health Services
Larry Hanrahan, State of Wisconsin
Catherine Hansen, St. Croix Regional Medical Center
Mark Kirschbaum, UW Health
Susan Turney, MD, Wisconsin Medical Society
John Whitcomb, MD, Aurora Health Care
Dan Zimmerman, State of Wisconsin, Mental Health and Substance Abuse

Standards and Architecture

Co-Chair: Dave Lundal, SSM Health Care
Co-Chair: Kim Pemble, WHIE/NIMI

Oskar Anderson, State of Wisconsin, CIO
Sandra Butschli, ACL Laboratories
Mariann Byers, WPS Health Insurance
Jean Doeringsfeld, State of Wisconsin, Medicaid
Jim Grant, State of Wisconsin, Public Health
Theresa Guilbert, MD, UW School of Medicine & Public Health
Scott Hansfield, MD, Fond du Lac Regional Clinic
Jay Klock, Gunderson Lutheran
Peter Nohelty, Hospital Sisters Health System
Timothy Patrick, UW Milwaukee - College of Health Sciences
Gary Plank, Marshfield Clinic
Will Weider, Ministry Health Care and Affinity Health System
Louis Wenzlow, Rural Wisconsin Health Cooperative

APPENDIX 4

JIM DOYLE
GOVERNOR
STATE OF WISCONSIN

October 16, 2009

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The official State of Wisconsin agency for the State Grants to Promote Health Information Technology Program, Section 3013 of the Public Health Services Act, is the Department of Health Services. Wisconsin's Health IT Coordinator is:

Denise B. Webb
eHealth Program Manger
Department of Health Services
Division of Public Health/Office of Health Informatics
1 West Wilson Street, Rm 250
Madison, WI 53703
(608) 267-6767 (W)
(608) 267-2832 (Fax)
denise.webb@wisconsin.gov

Sincerely,

Jim Doyle
Governor

P.O. BOX 7863, MADISON, WISCONSIN 53707-7863 • (608) 266-1212 • FAX: (608) 267-8983
WWW.WISGOV.STATE.WI.US

APPENDIX 5

Affinity
HEALTH SYSTEM, INC.

June 28, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

Affinity Health System, which represents a mission-driven, integrated health care system of clinics and hospitals, primary and specialty care physicians, home care and related services, located in Northeast Wisconsin, is pleased to submit to you a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Will Weider
CIO

THE ALLIANCE
Employers moving health care forward ™

August 20, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Alliance, a not for profit, employer owned and directed health care cooperative, is pleased to provide our endorsement of the Wisconsin HIT Strategic and Operational Plan. The Alliance is made up of 160 WI employers who provide health benefits for 83,000 employees and family members.

On behalf of The Alliance, I was privileged to be one of many volunteers who contributed to Wisconsin's efforts to develop the HIT Strategic and Operational Plan. The process to develop the plan was transparent, inclusive and thoughtful. As a result, I believe the plan we are submitting addresses the ONC's five Health Information Exchange domains while achieving the goals and operating principles set forth by the Wisconsin Relay for Electronic Data (WIRED) for Health Board. The Plan represents an important step toward improving health care delivery, performance measurement and ultimately, health outcomes in our State.

We look forward to continued participation in this important and collaborative effort.

Sincerely,

Cheryl A. DeMars

Cheryl A. DeMars
President and CEO

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Dean CLINIC
Partners who care

Craig E. Samitt, MD, MBA
President and Chief Executive Officer
1808 W. Beltline Highway | Madison, Wisconsin 53713

July 12, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

Dean Health System, which represents a 500+ physician multi-specialty group and a 250K+ member provider-sponsored health plan that collectively serve nearly 500,000 Wisconsin residents, is pleased to submit to you a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees (one on which I serve), are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Craig E. Samitt, MD, MBA
President and Chief Executive Officer

CES:ALM
\\DHS\DFS\GROUPS\ADMINISTRATION\DHS\MICKELSON_SAMITT\LETTERS, MEMOS\SOP LETTER OF SUPPORT 071210.DOC

(608) 250-1421 | Fax: (608) 280-4661 | craig.samitt@deancare.com

Humana Inc.
P.O. Box 1633
Waukesha, WI 53187-1633
262 951 2300 Tel

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

Humana Insurance Company in Wisconsin, which represents Managed Care Organizations/Payers in the state of Wisconsin, is pleased to submit to you this letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We here at Humana believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Albert Tzeel, MD, MHSA
National Medical Director, HumanaOne
Humana Insurance Company
Waukesha, WI

Drogsvold, Karen J - DHS

From: Larry Rambo [lrambo@humana.com]
Sent: Wednesday, August 25, 2010 10:53 AM
To: Webb, Denise B - DHS
Subject: Wired For Health SOP

This letter represents my strong endorsement of the Wired for Health Strategic and Operational Plan (SOP) which you are submitting to the Office of the National Coordinator. The process you have utilized has been inclusive of multiple stakeholders, and I have great confidence that this plan will be implemented effectively in the State of Wisconsin. I believe this plan is consistent with the stated goals of the program and will be executed in a way that becomes a model for the nation. I look forward to supporting this effort in any way appropriate as the program gets underway.

Larry Rambo
Senior Executive for Strategic Partnerships
lrambo@humana.com
(262) 951-2322
(262) 951-2321 (fax)

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Karl J. Ulrich, M.D., M.M.M.
President/CEO

Marshfield Clinic®

August 19, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

Marshfield Clinic, which represents one of the largest group practices of medicine in Wisconsin and the Midwest, is pleased to submit a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. Marshfield Clinic has a long history of electronic record development. With over 50 regional centers throughout central and northern Wisconsin utilizing a single electronic medical record we fully recognize the importance and critical role electronic health records play in providing optimal, highly effective and efficient care. The development of the State's plan is a significant accomplishment and we are pleased with the broad participation of stakeholders in this critical project. Great care was taken to be transparent and inclusive as the plan was developed by the State. Marshfield Clinic was directly involved with the WIRED Health Board. The collaborative process which developed this plan aligns with the goals agreed upon by the WIRED for Health Board and specific attention was paid to insure the ONC five Health of Information Exchange domains were incorporated and achieved within the state health information exchange.

Marshfield Clinic believes completion of the Plan as proposed is a critical and important step in improving the health outcomes in our State. We remain committed to participate in this important and collaborative effort and strongly encourage your support of our efforts.

Sincerely,

Karl J. Ulrich, M.D.

KARL J. ULRICH, MD, MMM
President/CEO

1000 North Oak Avenue Marshfield, WI 54449-5777 Fax 715-389-3414 **715-387-5253**

Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin

Department of Health Services

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY

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MADISON, WI 53701-0309

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FAX: 608-266-1096
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dhs.wisconsin.gov

July 29, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Wisconsin Medicaid Program is pleased to submit this letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community, including Medicaid.

We are particularly pleased that Wisconsin's health information technology stakeholders recognized the necessity of Medicaid participation in the development of the Plan and the connection to the State Medicaid HIT Plan. Our inclusion in the development of the Plan, our intent to be an organizational member of the exchange, and our legislatively mandated representation on the State Designated Entity board will help ensure that the Plan addresses the needs of the Wisconsin Medicaid Program including the infrastructure necessary for the successful implementation and operations of Wisconsin's Medicaid HIT Plan.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusionary manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors, including representatives from the Wisconsin Medicaid Program who served on the Board and each of the five committees. In carrying out their charge, the public and private sector volunteers committed significant amounts of time and resources to develop a Strategic and Operational Plan that helps meet the needs of Wisconsin's citizens, and it aligns with the goals agreed upon by the WIRED for Health Board. The Plan includes details that address the ONC's five domains included in the FOA and guidance provided in the Program Information Notice and an approach to achieve statewide health information exchange. This is a Plan that the Wisconsin Medicaid Program agrees with and supports.

We believe that the completion of the Plan represents an important step in improving care coordination for better health outcomes within our State through HIT and statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Jason A. Helgerson
Medicaid Director

Letter of Support for State HIE Plan August 19th, 2010

State HIE Plan

The implementation of a state HIE plan is essential for Wisconsin to have a healthy population, a healthy business community and a vibrant economy. All are now linked and inextricably linked.

The HIE opportunities that I see personally are worthy of enumerating in detail. The 60,000 foot view is abstract and difficult to articulate. As a practicing emergency physician in an innovative and maturing HIE market, Milwaukee, I have to offer my own experience as a testimony for why an HIE will be a benefit.

On a daily basis, consumers who have been elsewhere, come to emergency departments because their first interaction with health care didn't cure their problem. The consumer is confused and frustrated, in part because they haven't understood that health problems are not solved instantly and evolve over time, and some things just can't be fixed. A viral upper respiratory infection will just take a week to fix, and any number of visits to providers will not hasten its resolution. Our current health care system, without the efficient transferring of information between providers is a set up for duplication of services. It's just easier to do a chest xray again than it is to get a report by fax over the course of an hour and wonder what it might mean. In fact, in neither ED the patient visits for their cold was either chest xray necessary. A primary physician might have spoken to holistic methods to keep the person from getting a cold, like additional Vit D.

The net effect for practicing emergency physicians is that we order tests again and again, often without demonstrable benefit. When I see a women with vague abdominal pain who has had 13 CT scans in the prior 12 months at 5 health systems, I suspect a lack of coordination combined with mental illness has led to an almost complete lack of sensible coordination. On reviewing my own behavior, I can confidently predict that I can change $ 1000 worth of behavior in an 8 hour work shift, each and every day I work.

But not doing tests is only scratching the surface. The real savings from HIE comes at a much more profound level. The current fragmentation of medical care in America between various providers is to the breaking point. Virtually every patient over 65 has 5 to 6 distinct and separate prescribing providers. When those patients come to the ER, the patient can rarely provide for me a meaningful discussion on why they are taking any given medication, or who is in charge of changing them. The real benefit of an HIE becomes manifest with that insight. Patients need a person "in charge", a primary care provider who knows what they are about. Without an HIE, our primary care providers are blinded to all the other phsyicians their patients see. Thirty to forty percent of patients coming to EDs have problems that would be better served if the patient had access to a medical home that

coordinated their care. An HIE is the foundation of directing and supporting a primary care home.

The concepts involved in Wisconsin's emerging HIE plan that will bring consumer delight are myriad. Just start with the idea of a summary document that will always lets you know what your diagnosis is and what your medicines are for. Imagine having your medication list brought up to date every time you are "handed off" to another provider. That is a wonderful opportunity. We don't have that today. In Milwaukee we have a little taste of that with the Medicaid database open to emergency physicians. I use it every day. I can see precisely what meds my patients are on and can easily then avoid making mistakes. I see names of medications in print, and not have to depend on the patient trying to spell their medication name to me. This is really nice! An up to date medication list is foundational to good medical care. Right now we depend on each person's memory, spelling of non-English words, understanding of side effects.

Not only is it nice, it's safe! The number one cause of suicide death by teenagers in Wisconsin are prescription drugs. Emergency departments are often visited by those intentionaly seeking narcotics for use other than their personal pain. An HIE is the only technology available to us to identify this sort of abuse of our medical system. We are all struggling to find a means to stop that. EM physicians are leading initiatives with a variety of methods in Wisconsin to stop this sort of behavior. An HIE is at the foundation of that in every aspect.

And then there is privacy. An HIE is more private than what we have now. The very nature of computerized records is that we can see every person who has opened the record with an electronic fingerprint. Currently, we fax, mail, phone and write. Everyone can see those records, without much limit, without any real privacy and without any limits on who saw what when.. Not only will your records be more secure, but an HIE will also allow each of us to see our own records securely, with assured privacy to boot.

Please accept my endorsement of support for our HIE in Wisconsin. We have been leaders in innovation for others for years, it's time we innovate for ourselves and reap the benefit of our mid-Western good common sense.

John E Whitcomb, MD

Milwaukee County Health Care Partnership

Milwaukee County Medical Society

MINISTRY HEALTH CARE

Sponsored by Sisters of the Sorrowful Mother

June 28, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

Ministry Health Care, which represents a mission-driven, integrated health care system of clinics and hospitals, primary and specialty care physicians, home care and related services, located across Wisconsin and into Minnesota, is pleased to submit to you a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Will Weider
CIO

Information Technology Services
611 Saint Joseph Avenue, Marshfield, WI 54449-1898 715.387.7760 Fax 715.387.9826 ministryhealth.org

Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin

Department of Health Services

DIVISION OF PUBLIC HEALTH

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August 16, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Wisconsin Division of Public Health, on the behalf of state and local public health agencies, is pleased to submit this letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community, including ours.

We are particularly pleased that Wisconsin's health information exchange stakeholders have recognized the necessity of public health participation. Our inclusion in Plan development, our intent to be an organizational member of the exchange, and our legislatively mandated representation on the SDE board will help ensure that the Plan addresses the information needs of public health. Wisconsin's Strategic and Operational Plan includes four evolutionary phases and eight prioritized use cases for public health participation. The phases and use cases support public health requirements for mandatory case and electronic laboratory reporting, exchange of immunization data, syndromic surveillance, and the surveillance of communicable, chronic, injury, occupational, environmental, maternal, and child health conditions. The use cases also define bi-directional exchange wherein public health partners with clinical care to develop population health analyses to inform clinical care and foster quality improvement. This exchange will also creates a platform for clinical and public health comparative effectiveness research, contributing a key element for a 'rapid learning health system' for both individual and population health improvement.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors including representation from public health who serve on the Board and committees. In carrying out their charge, the public and private sector volunteers committed significant amounts of time and resources to develop a Strategic and Operational Plan that meets the needs of Wisconsin's citizens, and it aligns with the goals agreed upon by the WIRED for Health Board. It includes

details that address the ONC's five domains included in the FOA and guidance provided in the Program Information Notice and an approach to achieve statewide health information exchange. This is a Plan that the public heath community agrees with and supports.

We believe that the completion of the Plan represents an important step in improving care coordination and individual and population health outcomes within our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Seth Foldy, MD MPH
State Health Officer and Administrator, Division of Public Health

RWHC
Your partner. Your source.
880 Independence Lane
Sauk City, WI 53583

June 24, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Rural Wisconsin Health Cooperative (RWHC), a shared service and advocacy collaborative for rural health established in 1979, is pleased to submit to you a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Tim Size

Tim Size
Executive Director

UnitedHealthcare
A UnitedHealth Group Company

10701 W. Research Drive
Milwaukee, WI 53226

August 20, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Letter of Support for Wisconsin Statewide Health Information Network

Dear Dr. Blumenthal:

UnitedHealth Group has a long history of concrete commitments to modernizing healthcare using health information technology solutions to improve the quality and reduce the variability and the cost of care delivered to Americans. We have committed time, resources and funding to appropriate projects throughout the nation.

UnitedHealth Group has a strong history of engaging with market-based health information exchange collaboratives through UnitedHealthcare, our commercial insurance company. These engagements include existing health information exchange projects such as CareSpark (Southeastern Tennessee and Western Virginia), Indiana Health Information Exchange, CORHIO and others in development. Nationally, we are working on many levels to develop and implement standard data sets and interoperable information systems to speed adoption of health information exchange, as well as standard measures to objectively determine long term impact on quality and value. We use our experience thoughtfully to advance projects that have the possibility of improving and reducing the cost of care.

UnitedHealthcare recognizes that many different organizations around the country are applying for grants under HITECH. Operating in all 50 states, we have a keen interest in working collaboratively with new grantees, wherever they are located, to determine their specific needs and how we may be able to support those needs. To that end, we have participated actively in the Wisconsin Health Information Organization (WHIO) and the State of California's process to develop its plan for the development and implementation of statewide health information exchange in California, where we provide health insurance and related services for more than 1 million people.

Given our commitment to health care modernization efforts, including the widespread use of electronic health information to improve care and reduce its cost, we are pleased to offer this letter in support of the application of Wisconsin Statewide Health Information Network (WISHIN) for HITECH funding. We look forward to working with the State and healthcare community to support HIE adoption and implementation in WISHIN.

Sincerely,

Wendy Arnone
Chief Executive Officer
UnitedHealthcare of Wisconsin

UWHealth
University of Wisconsin
Medical Foundation

H4/863 Clinical Science Center
600 Highland Avenue, MC 8310
Madison, WI 53792

608.263.7013
608.265.0709 Fax
jeg@medicine.wisc.edu

June 28, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

On behalf of the University of Wisconsin School of Medicine and Public Health, I am pleased to submit to you a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens. I have been privileged to sit on the Board of Directors and the Governance Committee of WIRED.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Jeff Grossman

Jeffrey E. Grossman, M.D.
Senior Associate Dean for Clinical Affairs
President and CEO
University of Wisconsin Medical Foundation

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WCHQ
Wisconsin Collaborative *for* Healthcare Quality

July 15, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

On behalf of the Board and members of the Wisconsin Collaborative for Healthcare Quality (WCHQ), I am pleased to submit this letter of support endorsing the Wisconsin Health Information Technology (HIT) Strategic and Operational Plan.

Founded in 2003, WCHQ is a voluntary consortium of organizations working together to improve the quality and cost-effectiveness of health care for the people of Wisconsin. We pursue this aim through four inter-related core competencies – the development, prioritization, and implementation of performance measures; the collection, validation, and application of administrative and clinical data; public reporting of comparative performance information via our web site (www.wchq.org); and, the facilitation of collaborative learning sessions designed to share best practices for quality improvement, Of particular significance, WCHQ's method of performance measurement has generated an exceptionally high level of credibility among physicians in Wisconsin owing to our emphasis on the meticulous construction of a denominator that is representative of an entire *population* of patients irrespective of payment source. The resulting accuracy and actionability of our data has directly contributed to Wisconsin's national leadership in healthcare quality.

The development of this Strategic and Operational Plan is a significant accomplishment involving the active participation of a broad group of stakeholders representing Wisconsin's health care, business, insurance, and consumer communities. The process used to create the Plan was open, transparent, and inclusive; indeed, the Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed significant time and resources to ensure that the Plan strikes an appropriate balance between the requirements of the Cooperative Agreement of the Office of the National Coordinator (ONC) and the needs of Wisconsin's residents.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes provisions that fully address the ONC's five Health Information Exchange domains. We believe that the thoughtful and deliberate process has produced a Plan that represents an important step in improving the health of the residents of Wisconsin through statewide health information exchange. We look forward to continuing our active participation in this important and collaborative effort.

Sincerely,

Christopher Queram
President / CEO

7974 UW Health Court, P.O Box 628578, Middleton, WI 53562-8578
Phone 608-826-6841 Fax 608-833-1413

WISCONSIN HOSPITAL ASSOCIATION, INC.

July 9, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Wisconsin Hospital Association, which represents over 130 hospitals throughout Wisconsin, is pleased to submit to you a letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involves participants from a broad group of stakeholders representing Wisconsin's health community.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed many hours of time and significant resources to assist in the development of a Strategic and Operational Plan that sets forth a direction for an approach to achieve statewide health information exchange that is sustainable and can meet the needs of Wisconsin's citizens.

The result of this collaborative process is a plan for implementation of statewide health information exchange that aligns with the goals agreed upon by the WIRED for Health Board and addresses the ONC's five Health Information Exchange domains. Recognizing that the Plan must be flexible and be able to be modified as circumstances change and new information and ideas arise, we agree with and support the Plan's general approach to achieve sustainable statewide health information exchange.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Stephen F. Brenton
President
Wisconsin Hospital Association, Inc.

5510 Research Drive, Post Office Box 259038, Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org

Wisconsin Health Information Exchange

August 12, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Wisconsin Health Information Exchange (WHIE) and its parent organization, the National Institute for Medical Informatics (NIMI), are pleased to provide this letter of support endorsing the Wisconsin HIT Strategic and Operational Plan. The development of this Plan is a significant accomplishment that involved active participation from a broad group of stakeholders representing Wisconsin's health community.

WHIE supports several HIE use cases for clinical and/or public health disease surveillance in 24 Counties of Wisconsin. Active stakeholders include nine health systems (44 hospitals), four Federally Qualified Health Centers, Medicaid Managed Care Organizations, WI Department of Health Services Medicaid and Public Health, and City of Milwaukee Public Health.

Wisconsin's efforts to develop the Plan were conducted in an open, transparent, and inclusive manner. The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors. These volunteers committed time and resources to assist in the development of a Strategic and Operational Plan that meets the needs of Wisconsin's citizens. In this process, it has been my privilege to serve as co-chair to the Standards and Architecture Committee of the WIRED Board.

The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the ONC's five Health Information Exchange domains and an approach to achieve statewide health information exchange that we agree with and support.

We believe that the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Kim R. Pemble
Executive Director, WHIE
President, NIMI

1009 W. Glen Oaks Lane • Suite 101 • Mequon, WI 53092
Phone 262.240.0198 • Fax 262.240.0250
http://www.whie.org

Wisconsin Medical Society
Your Doctor. Your Health.

August 17, 2010

David Blumenthal MD, MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

The Wisconsin Medical Society (Society), which represents more than 12,000 physicians, submits this letter of support of the Wisconsin Health Information Technology Strategic and Operational Plan (Plan). The Society participated in the development of the Plan along with other stakeholders. The collaborative process was designed to achieve transparency, build consensus and trust, develop a shared vision and create a Plan that will enhance the delivery of health care for all Wisconsin citizens.

The Wisconsin Relay for Electronic Data (WIRED) for Health Board of Directors and its committees are comprised of a comprehensive cross-section of stakeholders from the public and private sectors, including physicians, hospitals, public health, patient representatives and others. These volunteers committed considerable time and resources to assist in the development of a Plan that meets the needs of the public and advances the goals of health information exchange. The result of this collaborative process is a Plan that aligns with the goals agreed upon by the WIRED for Health Board and includes details that address the Office of the National Coordinator's five health information exchange domains.

We believe the completion of the Plan through the WIRED for Health project's thoughtful and deliberate process represents an important step in improving health outcomes in our State through statewide health information exchange. We look forward to continued participation in this important and collaborative effort.

Sincerely,

Susan Turney

Susan Turney, MD, MS, FACP, FACMPE
Chief Executive Officer/EVP

Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org •

WPS

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION • 1717 W. BROADWAY • PO BOX 8190 • MADISON, WI 53708-8190 • (608) 221-4711

August 25, 2010

David Blumenthal, M.D., MPP
National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. Blumenthal:

Wisconsin Physicians Service Insurance Corporation (WPS), a founding member of the Wisconsin Health Information Organization (WHIO), a group of business, provider, and payer stakeholders, is pleased to submit this letter of endorsement of the Wisconsin HIT Strategic and Operational Plan. The Plan was developed using an inclusive process that involved a broad range of participants from all segments of the Wisconsin health community.

They put in hundreds of hours of time and significant resources to assist in the development of a Strategic and Operational Plan that, once rolled out, will result in statewide health information exchange that will be meaningful for Wisconsin citizens. I also believe that, as designed, it will be sustainable for the long run.

The Wisconsin HIT Strategic and Operational Plan aligns with the goals of the WIRED for Health Board and addresses the ONC's five Health Information Exchange domains. Recognizing that the Plan must be flexible and be able to be modified as circumstances change and new information and ideas arise, we agree with and support the Plan's general approach to achieve sustainable statewide health information exchange.

I believe health information exchange will lead to improving health outcomes in our state, and I look forward to continued participation in this important and collaborative effort.

Sincerely,

James R. Riordan

James R. Riordan
President and
Chief Executive Officer

JRR:dkl

APPENDIX 6

Appendix C

Participation

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1 HIE ONLINE SURVEY QUESTIONS

The following sections contain the questions from the online HIE survey related to respondent needs/concerns about participating in a SLHIE as well as the tabulated responses to the questions. Individuals/organizations were asked to identify the importance of the service being provided as well as who should provide the service.

Question 12 Organization's Interest in Establishing a State-Level HIE

Which statements best express your organization's interest in establishing a state-level HIE entity that would play a role in the secure exchange of patient data among health care organizations in Wisconsin? Check all that apply.

No SLHIE	*Wisconsin does not need a state-level HIE entity; the various communities should determine how to exchange patient data with other organizations on their own.*
Governance	*Wisconsin needs a state-level HIE entity that provides governance, support and oversight for HIE activities in Wisconsin.*
Tech Services	*Wisconsin needs a state-level HIE entity that provides some common technical and functional services to regional or local HIE entities.*
HIE Services	*Wisconsin needs a state-level HIE entity that provides HIE services directly to areas in Wisconsin where no regional or local HIE entity currently operates.*
Single SLHIE	*Wisconsin needs a single, state-level HIE entity that serves the HIE needs across Wisconsin; all existing regional or local HIE activities should be absorbed or managed by the state-level HIE entity.*
None	*None of these options express our perspective. Please elaborate.*

	1	2	3	4	Statewide	Multistate-National	None	Total
No SLHIE	1		1					2
Governance	4	7	11	12	8	5	1	48
Tech Services	8	3	10	8	5	6	0	40
HIE Services	3	5	4	5	4	2		23
Single SLHIE	5	5	5	12	1	5		33
Other	2	1	1	3	3	1	0	11
Total	**23**	**21**	**32**	**40**	**21**	**19**	**1**	**157**

Table 1. *Organization's Interest in Establishing a SLHIE by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Total
No SLHIE				1			1		2
Governance	9	3	3	16	3	3	5	1	43
Tech Services	4	5	2	8	2	4	5	1	31
HIE Services	5	1	4	5			1	2	18
Single SLHIE	7	2	1	12	2	4	5	1	34
Other	2			2	1		1		6
Total	**27**	**11**	**10**	**44**	**8**	**11**	**18**	**5**	**134**
# of Voters	14	9	5	29	5	9	17	2	90

Table 2*. Organization's Interest in Establishing a SLHIE by Stakeholder Type*

Summary Observations: Stakeholders selected all applicable statements. 90 respondents provided answers to this question. ~32% of respondents (out of the 134 total votes) indicated that the Wisconsin SLHIE should provide "governance, support, and oversight for HIE activities in Wisconsin."

Question 14 Organization's Internal Readiness

How would you describe your organization's internal readiness to participate in health information exchange in terms of its organizational capacity (i.e., having the ability to provide staff or procure the resources necessary to address the technical and process changes required to successfully participate in statewide health information exchange)?

No capacity	*No capacity to participate*
Min capacity	*Minimal capacity to participate*
Stretch capacity	*Participation would stretch our capacity (but would be able to achieve)*
Good capacity	*Participation would not be limited by our capacity*
Not sure / NA	*Not sure / not applicable*

	1	2	3	4	Statewide	Multistate-National	None	Total
Good Capacity	4	4	3	5	5	5		26
Stretch Capacity	6	4	11	9	2	4		36
Min Capacity	3	2	6	6	4	2		23
No Capacity			1	2				3
Not Sure / NA	2	2	2	5	3	1	1	16
Total	**15**	**12**	**23**	**27**	**14**	**12**	**1**	**104**

Table 3*. Organization's Internal Readiness (Capacity) by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Total
Good Capacity		2	2	7	2	2	2		17
Stretch Capacity		2	2	14	1	5	4	2	30
Min Capacity		5		7			5		17
No Capacity							3		3
Not Sure / NA	5		1	2	2	2	3		15
Total	**5**	**9**	**5**	**30**	**5**	**9**	**17**	**2**	**82**

Table 4*. Organization's Internal Readiness (Capacity) by Stakeholder Type*

Summary Observations: 82 respondents provided answers to this question. After removing the 15 respondents who indicated "Not sure/NA", ~45% of respondents indicated that participation in health information exchange would stretch their capacity.

Question 15 Organization's Capacity

Do you expect your organization's capacity to increase, decrease or stay the same in the next 12 months?

Decrease
Stay the same
Increase
Not sure / not applicable

	1	2	3	4	Statewide	Multistate-National	Total
Increase	5	5	9	8	5	7	39
No Change	9	6	10	13	7	4	49
Decrease		1	2	1			4
Not sure / NA	1		2	5	2	1	11
Total	**15**	**12**	**23**	**27**	**14**	**12**	103

***Table 5**. Organization's Capacity by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Total
Increase		1	3	8	3	4	5	2	26
No Change		8	1	17		4	10		40
Decrease				4					4
Not sure / NA	4		1	1	2	1	2		11
Total	**4**	**9**	**5**	**30**	**5**	**9**	**17**	**2**	**81**

***Table 6**. Organization's Capacity by Stakeholder Type*

Summary Observations: 81 respondents provided answers to the question. After removing the 11 respondents who indicated "Not sure/NA", ~94% of respondents indicated that their organization's capacity would increase or remain the same over the next 12 months.

Question 16 Organization's Internal Readiness

How would you characterize your organization's internal readiness to participate in a health information exchange in terms of its organizational capability (i.e., your organization's current level of functional readiness and staff expertise to successfully participate in statewide health information exchange)?

No Capability	*No internal capability to participate*
Min Capability	*Minimal internal capability to participate*
Stretch Capability	*Participation would stretch our capabilities (but would be able to achieve)*
Good Capability	*Participation would not be limited by our capabilities*
NA	*Not sure / not applicable*

	1	2	3	4	Statewide	Multistate-National	None	Total
Good Capability	6	5	6	7	5	6		35
Stretch Capability	5	2	8	8	2	2		27
Min Capability	1	2	5	5	4	3		20
No Capability	2	1	2	3				8
Not sure / NA	1	2	2	4	3	1	1	14
Total	**15**	**12**	**23**	**27**	**14**	**12**	**1**	**104**

***Table 7.** Organization's Internal Readiness (Capability) by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Total
Good Capability	1	2	2	12	2	3	2		24
Stretch Capability		2	2	12	1	3	3	2	25
Min Capability		5		4		2	5		16
No Capability							4		4
Not sure / NA	4		1	2	2	1	3		13
Total	**5**	**9**	**5**	**30**	**5**	**9**	**17**	**2**	**82**

***Table 8.** Organization's Internal Readiness (Capability) by Stakeholder Type*

Summary Observations: Of the 69 respondents who characterized their organization's internal readiness, ~71% of respondents indicated their organization could participate (good capacity or stretch

capacity) based on organizational capability. Of the 71%, ~51% of respondents indicated that participation would stretch their capabilities.

Question 17 Additional Comments on Organizational Readiness

Please provide any additional comments on organizational readiness.

Stakeholder Type	Additional Comments
Consumer	The organization would not be a participant in HIE as much as a monitor.
Consumer	Would help all in WI
Government	Realize the importance but short on resources.
Government	Functional readiness but no funding for additional staff time or EMR.
Government	Cost is a key factor.
Government	The organization is currently participating in an one-way exchange with two local hospitals and is interested in allowing physicians to have like access to the organization's electronic health record (EHR).
HIE/HIE Service Provider	As HIE, we have to have capacity and capability, and/or ability to scale as needed, to meet the opportunity and value of HIE activities for stakeholders and participants (e.g. providers, payers, public health, patients)
HIE/HIE Service Provider	The organization is a fully functional HIN/HIE throughout the country with strong roll out in Wisconsin and substantial growth with other organizations in 2009 in Wisconsin.
HIE/HIE Service Provider	We are highly motivated to participate, but have limited resources with strong database and interface background. So very limited capability compared to large healthcare organizations, but probably more capacity than any of the individual CAHs in Wisconsin.
Hospital/IDN	We have had an EHR for the past 11 years and by the end of this year will be paperless and by early next, will be meeting the Stage 7 criteria.
Hospital/IDN	Enterprise-wide EMR is currently in place.
Hospital/IDN	Will defer to another organization for further information.
Hospital/IDN	We are between level 3 and 4 of meaningful use
Hospital/IDN	We have a highly developed plan for regional medical information exchange. We are already doing a great deal of records exchange already with area providers and payers. I believe that the medical market in [region of] Wisconsin will likely have an exchange solution in place well before a state level effort could be architected, implemented or funded. I think that integrating into the existing plans and activities that have been ongoing for the last 3-5 years would be much more productive. We have a highly developed plan that I would be happy to share in how we expect to build and deliver an integrated approach to both our internal IT plans and external/community HIE. We are working closely with a vendor for our community HIE plans.
Hospital/IDN	The ability of any organization to have the resources to be able to dedicate to HIE initiatives may change depending on what the definition of "meaningful use" ultimately turns out to be if other projects need to be prioritized higher organizationally to meet competing requirements in the short term.
Hospital/IDN	There are vendor products available to us. We would strongly prefer to be able to utilize this software in any exchange - whether for population health or patient treatment purposes.
Hospital/IDN	Challenge will be in prioritizing HIE initiatives against new internal implementation and quality and efficiency process improvements that use technology.

Stakeholder Type	Additional Comments
Hospital/IDN	HIEs should not focus solely on connectivity within a state. Patients do not limit their health care to a single state so connectivity should not either
Hospital/IDN	We do not and likely would not independently possess data that would be detailed enough or timely enough to be meaningful in a SLHIE context.
Payer	Dental EHI has not evolved to the level of granularity and sophistication of medical or pharmacy data. There is little training available in dental informatics so it would take time to get up to speed even though our data is far more limited.
Payer	This could be supported locally or nationally.
Payer	We currently exchange health information with the state of Wisconsin weekly monthly, quarterly and annually as required by contract. Much of this is achieved by outsourcing the reporting and processing duties to a third party. It would seem that this will be the way requirements will be met in the future.
Provider	#s 15 and 17 are: Not Applicable because the emphasis is on Regional and not Statewide HIE.
Provider	Fully functional EHR for 15 years. Paperless records for 10 years. EHR used is Practice Partner. Electronic prescribing now included.
Provider	Electronic communication of EHR between private offices, though not critical in dentistry, would involve the various practice management software available to dentists being able to have a standard format of information that could be shared or imported into each offices programs. I feel you would find most offices willing to devote time and effort into that.
Provider	We are currently working on providing training/technical assistance and support to CHCs going through the EHR adoption process. Simultaneously, we are working with our Board to identify strategic goals and implementation steps for how we might facilitate more efficient and effective HIE among CHCs, with our state and federal partners/funders, etc.
Provider	We are actually part o fan organization's electronic health record and practice management system. Any involvement we would have with HIE would be contingent on the other organization's ability and willingness to participate.
Provider	IT expertise is a very limiting factor for most of us small, rural, community health centers.
Provider	We just started the process for EHR
Tribal	Organization has chosen an EMR solution and is implementing the patient management portion currently and will then move into the EMR implementation. We are engaged but have the same needs as many organizations as stated in the Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare and Medicaid Services (CMS) listening session to gain perspective needed to implement provisions in the new Health Information Technology (HITECH) Act set forth in the American on 6-24-09 The three items of need most noted in a national forum on 6-24-09 were: • Assistance with Work Flow so people understand how the system should work, what data is passed and what to do with it when you get it • Assistance on connectivity so sites could connect together and secured communication about patients could be exchanged. • Assistance on Interfaces so all vendors who provide Electronic Medical Record systems could be provided definition on what was to be exchanged and the method each should use for communication.

Table 9. *Additional Comments on Organizational Readiness*

Question 18 Priority of Participation

How would you characterize the priority your organization would place on participation in statewide HIE activities relative to other organizational priorities?

1 = Not on any list of organizational priorities
2 = Lowest level of priority
3 = An articulated priority, but not in our organization's five-year plan
4 = Part of our organization's five-year plan
5 = One of the top priorities for our organization in the next three years
6 = Not sure / not applicable

	1	2	3	4	Statewide	Multistate-National	None	Total
Top Priority	3	2	5	7	5	6		28
Five Year Plan	5	2	4	7	2	2		22
Articulated Priority	5	5	8	5	3	3		29
Lowest Level of Priority			3					3
Not a Priority		1	1	4			1	7
Not sure/not applicable	2	1	2	4	4	1		14
Total	**15**	**11**	**23**	**27**	**14**	**12**	**1**	**103**

Table 10. *Organization's Priority for Participation in statewide HIE by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Total
Top Priority		3	3	6	2	2	1		17
Five Year Plan		2	1	11	1	1	4		20
Articulated Priority		3	1	7		3	7	1	22
Lowest Level of Priority		1		1		1			3
Not a Priority	1			2			2	1	6
Not sure/not applicable	4			3	2	1	3		13
Total	**5**	**9**	**5**	**30**	**5**	**8**	**17**	**2**	**81**

Table 11*. Organization's Priority for Participation in statewide HIE by Stakeholder Type*

Summary Observations: 81 respondents provided answers to the question. After removing the respondents who indicated "Not sure/not applicable", ~54% of respondents indicated participation in statewide HIE as a top priority in the next three years or part of their organization's five year plan.

Question 19 Organization's Role in HIE

How would you characterize your organization's interest in playing the following health information exchange roles? Use the following scale to respond:

No interest
Little interest
Moderate interest
High interest
Not sure / not applicable

Participant in the state-level HIE entity governance or leadership

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	7	6	6	12	6	6		43
Moderate interest	4	5	7	5	5	2	1	29
Little interest	2		2	5	3	2		14
No interest	1		3	3		2		9
Not sure / NA	1		3	2				6
Total	**15**	**11**	**21**	**27**	**14**	**12**	**1**	**101**

***Table 12**. Participant in the state-level HIE entity Governance or Leadership by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest	2	3	3	13	2	3	6	1	33
Moderate interest	1	2	2	10	2	2	1	1	21
Little interest	1	2		2	1	1	4		11
No interest		1		2		1	4		8
Not sure / NA	1			3		1	1		6
Grand Total	5	8	5	30	5	8	16	2	79

***Table 13**. Participant in the state-level HIE entity Governance or Leadership by Stakeholder Type*

Summary Observations: 79 respondents provided answers to the question. Of the 73 respondents who indicated a level of interested (6 respondents indicated "Not sure/NA"), ~74% indicated their organization had a high or moderate interest in participating in the governance or leadership of the state-level HIE.

Participant in the state-level HIE entity technical workgroups

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	6	6	6	9	5	7		39
Moderate interest	4	3	7	8	5	4	1	32
Little interest	3	1	3	6	2	1		16
No interest	1	1	4	3	1			10
Not sure / NA	1		2	1	1			5
Total	**15**	**11**	**22**	**27**	**14**	**12**	**1**	**102**

***Table 14**. Participant in the state-level HIE Entity Technical Workshops by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest		3	3	13	2	3	2		26
Moderate interest	2	2	2	13	1	3	4	1	28
Little interest	1	3		3	1	1	4	1	14
No interest		1			1		5		7
Not sure / NA	2			1		1	1		5
Grand Total	5	9	5	30	5	8	16	2	80

***Table 15**. Participant in the state-level HIE Entity Technical Workshops by Stakeholder Type*

Summary Observations: 80 respondents provided answers to the question. Of the 75 respondents who indicated a level of interested (5 respondents indicated "Not sure/NA"), ~72% indicated their organization had a high or moderate interest in participating in the technical workshops of the state-level HIE.

Recipient of grants for pilots and implementation of health information exchange

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	6	3	12	12	4	7		44
Moderate interest	5	6	4	9	3	1		28
Little interest	3		2	2	4	3		14
No interest	1	1	2	3	1	1	1	10
Not sure / NA	0	1	1	1	2	0		5
Total	**15**	**11**	**21**	**27**	**14**	**12**	**1**	101

Table 16. *Recipient of Grants for Pilots and Implementation of Health Information Exchange by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest	1	3	4	15	2	2	4	1	32
Moderate interest		1		14	1	3	4	1	24
Little interest	1	2				2	5		10
No interest	1	2	1		2	1	1		8
Not sure / NA	2			1			2		5
Grand Total	5	8	5	30	5	8	16	2	79

Table 17. *Recipient of Grants for Pilots and Implementation of Health Information Exchange by Stakeholder Type*

Summary Observations: 79 respondents provided answers to the question. Of the 74 respondents who indicated a level of interested (5 respondents indicated "Not sure/NA"), ~76% indicated their organization had a high or moderate interest in receiving grants for pilots and implementation of HIE.

Data provider

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	8	8	9	8	5	6		44
Moderate interest	4	2	5	11	1	3		26
Little interest	1		1		1		1	4
No interest	1	1	4	5	3	2		16
Not sure / NA	1		2	3	4	1		11
Total	**15**	**11**	**21**	**27**	**14**	**12**	**1**	**101**

Table 18*. Data Provider by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest	1	2	4	16		5	5	1	34
Moderate interest		2		10	1	2	5	1	21
Little interest	1	1		1			1		4
No interest	1	2	1		3		4		11
Not sure / NA	2	1		3	1	1	1		9
Grand Total	5	8	5	30	5	8	16	2	79

Table 19. *Data Provider by Stakeholder Type*

Summary Observations: 79 respondents provided answers to the question. Of the 70 respondents who indicated a level of interested (9 respondents indicated "Not sure/NA"), ~79% indicated their organization had a high or moderate interest in providing data.

HIE data recipient

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	8	8	10	11	5	5		47
Moderate interest	5	2	5	10	2	3		27
Little interest	1		1					2
No interest	1	1	3	4	3	2	1	15
Not sure / NA			2	2	4	2		10
Total	**15**	**11**	**21**	**27**	**14**	**12**	**1**	**101**

***Table 20**. HIE Data Recipient by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest	2	4	3	16	2	5	5	1	38
Moderate interest		2		10		3	6	1	22
Little interest				1			1		2
No interest	2	2	1		2		3		10
Not sure / NA	1		1	3	1		1		7
Grand Total	5	8	5	30	5	8	16	2	79

***Table 21**. HIE Data Recipient by Stakeholder Type*

Summary Observations: 79 respondents provided answers to the question. Of the 72 respondents who indicated a level of interested (7 respondents indicated "Not sure/NA"), ~83% indicated their organization had a high or moderate interest in receiving HIE data.

A state-level HIE entity technology or service provider

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	3	3	2	5	4	7		24
Moderate interest			3	4	1	1		9
Little interest	6	2	3	3	2	1		17
No interest	3	5	9	10	3	2	1	33
Not sure / NA	3	1	4	4	4	1		17
Total	**15**	**11**	**21**	**26**	**14**	**12**	**1**	**100**

***Table 22**. State-Level HIE Entity Technology or Service Provider by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest	1	1	3	2	2	3	1	1	14
Moderate interest			1	6			2		9
Little interest		2	1	8			3		14
No interest	2	3		8	3	2	8	1	27
Not sure / NA	2	2		6		3	1		14
Grand Total	5	8	5	30	5	8	15	2	78

***Table 23.** State-Level HIE Entity Technology or Service Provider by Stakeholder Type*

Summary Observations: 78 respondents provided answers to the question. Of the 64 respondents who indicated a level of interested (14 respondents indicated "Not sure/NA"), ~36% indicated their organization had high or moderate interest in providing technology or service to the SLHIE.

A state-level HIE entity advocate

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	4	3	2	10	5	6		30
Moderate interest	4	5	8	8	3	1	1	30
Little interest	4	2	6	4	1	3		20
No interest	1		2	3	1	2		9
Not sure / NA	2	1	3	2	4			12
Total	**15**	**11**	**21**	**27**	**14**	**12**	**1**	**101**

Table 24 State-Level HIE Entity Advocate by MTA

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest	2	2	2	8	2	4	4		24
Moderate interest	1	1	2	11	2	1	4	1	23
Little interest		1	1	3		2	5	1	13
No interest		3		2	1		2		8
Not sure / NA	2	1		6		1	1		11
Grand Total	5	8	5	30	5	8	16	2	79

Table 25. *State-Level HIE Entity Advocate by Stakeholder Type*

Summary Observations: 79 respondents provided answers to the question. Of the 68 respondents who indicated a level of interested (11 respondents indicated "Not sure/NA"), ~69% indicated their organization had a high or moderate interest in serving as a state-level HIE advocate.

A state-level HIE entity financial supporter through dues, grants, transaction fees, etc.

	1	2	3	4	Statewide	Multistate-National	None	Total
High interest	1		1	1	2	2		7
Moderate interest	3	3		4		1		11
Little interest	4	4	5	8	3	1		25
No interest	4	2	11	5	2	4	1	29
Not sure / NA	3	2	4	9	7	4		29
Total	**15**	**11**	**21**	**27**	**14**	**12**	**1**	**101**

Table 26*. State-Level Entity Financial Supporter by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
High interest		1	1	1	1	1			5
Moderate interest	1		1	4		1	2	1	10
Little interest		1	2	11	1		4	1	20
No interest	1	3	1	5	2	3	7		22
Not sure / NA	3	3		9	1	3	3		22
Grand Total	5	8	5	30	5	8	16	2	79

Table 27. *State-Level Entity Financial Supporter by Stakeholder Type*

Summary Observations: 79 respondents provided answers to the question. Of the 57 respondents who indicated a level of interested (22 respondents indicated "Not sure/NA"), ~26% indicated their organization had high or moderate interest in financially supporting the state-level HIE entity.

Question 20 Additional Participation Comments

What would it take to enable your organization's participation in health information exchange either organizationally, technically or financially?

Stakeholder Type	Additional Comments

Stakeholder Type	Additional Comments
Consumer	The organization is interested in regulation, accountability and transparency in order to protect consumers. We would need greater access to technical and legal expertise.
Government	I need to clearly define the value the HIE will provide to the organization to justify the costs, both short term and long term.
Government	Money, plain and simple.
Government	Partially a matter of waiting for the environment to catch up with the need and interest (regulations, guidance, vendor ability) and partially receiving financial support for the process (piloting, implementation, continuance). Much desire not to reinvent the wheel (need for communication of what's out there), or be premature and having to changeover if not done compatibly with what others are doing.
HIE/HIE Service Provider	The organization is fully prepared to participate in Wisconsin's HIE in every aspect – organizationally, technically and financially.
HIE/HIE Service Provider	The organization offers a variety of HIN/HIE models to meet the community's needs. The organization is in no need of technology assistance from Wisconsin and has strong financial support from payers in the state.
HIE/HIE Service Provider	HIE data provider/recipient assumes presence of "up stream" HIE (e.g. state, NHIN) back to regional level. Financial supporter, to the extent that regional membership is used to support state level activities.
HIE/HIE Service Provider	We are positioned organizationally, but not clear at this stage what the technical and financial hurdles will be. We recommend planners carefully consider what levels of HIE are reasonably attainable so that small providers will not be defacto excluded from participating due to technical complexity and cost. We have little doubt that internal costs (in terms of staff time and system vendor's interface costs) to participate will be significant, which will stretch the resources of small hospitals.
Hospital/IDN	A single consolidated state run HIE to allow for the sharing of patient clinical data to provide the most appropriate non-duplicated care for patients at lowest possible cost and best outcome. Our organization fully supports a state run entity to allow sharing of information without competitive regional barriers.
Hospital/IDN	Financial incentives, vendor participation.
Hospital/IDN	Financial support for the additional required resources (people and equipment).
Hospital/IDN	Financially - I see us needing a dedicated technical person to work on this. We do not currently have this position.
Hospital/IDN	Financially as well as to identify with who we would exchange with.
Hospital/IDN	I think that getting the correct structure and role of the state in these HIE activities is critical in getting participation from HSHS and other healthcare providers. I believe that less is more in this case. I think the state should be an investor/collaborator in local/regional medical trading area HIE activities and these regional groups should directly interface into the national level HIE. I think that putting a State of WI level technology layer into this as well as a heavy governance layer would be viewed as counterproductive and financially or technically supporting this would be a hard sell.
Hospital/IDN	Integration of the solution with the vendor solution will be critical to the success of the organization's participation.
Hospital/IDN	Mostly financial
Hospital/IDN	Obviously cost will be a huge factor. Organization is very willing/able to proceed and is looking forward to a HIE system...
Hospital/IDN	Physical resources (people) to implement and support EHR to entities outside of our organization.

Stakeholder Type	Additional Comments
Hospital/IDN	Reform existing regulations related to privacy and release of information especially as it relates to Mental Health and AODA requirements.
Hospital/IDN	Reasonable value proposition; good leadership.
Hospital/IDN	Standards and Governance guidelines
Hospital/IDN	Substantial financial assistance
Hospital/IDN	To be determined once the details of participation are understood.
Hospital/IDN	We are currently working on connecting with another state for a record locator service as our first step.
Hospital/IDN	We are presently already participating in a HIE exchange.
Hospital/IDN	We are well positioned. At this time, we simply need all legal impediments cleared.
Hospital/IDN	We need to advance in capturing data in a format that could be exchanged. Not sure how the data would need to be configured and mapped.
Hospital/IDN	We need to replace our health information system, it is going to be very expensive and take a couple of years to accomplish that. Then we will be better ready to move ahead with HIE.
Hospital/IDN	We would need to see a much more clearly articulated objective in order to determine how or if we could participate or engage.
Other	Organization is interested and dependent on maintaining an existing.
Other	Financial support would have to be discussed once models were proposed. No interest in technical. We would be interested organizationally as indicated above.
Other	Not applicable
Payer	(We assume 'participation' is the missing word above): We would want an assurance that our investment in HIE would improve the quality, value and effectiveness of care for our members and providers.
Payer	A stronger business need or requirement for integrating dental data with medical.
Payer	Strategic alignment, having HIE be among organization's strategic objectives.
Payer	This is a value proposition exercise...if we can prove "return on investment" (investment = data, human resources or capital) and the fact that organization is living its mission by improving lives through more cost effective means, then we would be very interested.
Provider	A guarantee that knowledgeable professionals are in charge of the project. So often the State does not think a plan through and often excludes areas outside of Madison and Milwaukee.
Provider	Organization would first need the financial assistance to have an electronic medical records system.
Provider	I feel a provider be offered the opportunity to participate, though I do not personally feel it is a role for me. There are other colleagues I know who may be willing to do so.
Provider	Not applicable to our individual practice
Provider	Organizationally we would need staff development to allow for time for implementation. We would need help financially through grants to offset labor and organization costs as well as technical upgrades needed. Technically, our electronic system can handle any level of productivity needed.
Provider	Sentence incomplete - ?dropped word after "organization's in...".
Provider	The organization would like to be among those organizations eligible to serve on leadership boards or councils so that the needs of the children of Wisconsin are addressed.
Provider	We are currently focusing on strategies to assist remaining CHCs with the EHR adoption process. Support for technical assistance (vendor) in this area would be

Stakeholder Type	Additional Comments
	much appreciated. Funding for implementation would be also speed up the implementation process. We are simultaneously working with a committee of our Board to implement strategies that will help facilitate HIE among CHCs for quality improvement, easier reporting abilities, and replace outdated existing outdated patient registry systems. This may include a centralized data and reporting system for CHCs.
Provider	We need to implement EHR
Provider	We really don't know the answer to this question...unless it is "all of lots of the above". Organizationally, we would probably need additional manpower and expertise; technically we would definitely have to pay our current vendor for the technical expertise which I presume would be very expensive. Financially, the two above would cost a lot.
Provider	We would definitely need financial support and would also need the technical support.
Tribal	Grant subsidizing would be highly beneficial given the size of our organization. We utilize an E.H.R. developed by the Indian Health Service. Inclusion of IHS for technical aspects would be beneficial for us and other tribes. Recognition of tribe government to government will be important. Would definitely want some tribal representation at the board governance and technical workgroup levels.
Tribal	Implementation of EMR system; Defined operating rules in the exchange of data; Acceptable legal form; Value to citizens proposition; Infrastructure established and paid for by state.

***Table 28**. Additional Comments on Participation*

Question 22 Potential Challenges

Indicate your organization's level of concern regarding the following topics in the context of statewide health information exchange. Use the following scale to respond:

Not a concern
Minimal concern
Moderate concern
Major concern
Deal breaker (almost certain point of failure)
Not sure / not applicable

Privacy and Security

Ability of a state-level HIE entity to protect and secure personally identifiable health information from unauthorized access and use

	1	2	3	4	Statewide	Multistate-National	None	Total
Deal breaker	7	7	4	8	3	1		30
Major concern	5	3	12	14	7	9	1	51
Moderate concern	2		4		1	1		8
Minimum concern		1		2	1			4
No concern				1	1	1		3
Not sure / NA	1		1		1			3
Total	**15**	**11**	**21**	**25**	**14**	**12**	**1**	**99**

Table 29 *.Organization's Level of Concern for Privacy and Security by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Deal breaker	4	2		10	1	3	5	2	27
Major concern	10	5	4	15	1	4	7		46
Moderate concern		1	1	3	1		1		7
Minimum concern	1	1			1	1	1		5
No concern					1				1
Not sure / NA				1			1		2
Grand Total	**15**	**9**	**5**	**29**	**5**	**8**	**15**	**2**	**88**

Table 30*. Organization's Level of Concern for Privacy and Security by Stakeholder Type*

Summary Observations: 88 respondents provided answers to the question. Of the 86 respondents who indicated a level of interested (2 respondents indicated "Not sure/NA"), ~85% indicated privacy and security as a "deal breaker" or "major concern".

Sustainability

Ability of a state-level HIE entity to achieve long-term financial stability

	1	2	3	4	Statewide	Multistate-National	None	Total
Deal breaker	5	2	5	6	3	4		25
Major concern	6	6	9	15	7	7	1	51
Moderate concern	2	2	4	4	1			13
Minimum concern	1	1	1			1		4
No concern								0
Not sure / NA			1		3			4
Total	**14**	**11**	**20**	**25**	**14**	**12**	**1**	**97**

Table 31 *.Organization's Level of Concern for Sustainability by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Deal breaker	1	1	2	10		2	2		18
Major concern	10	6	3	9	5	5	8		46
Moderate concern	2	1		4			5	2	14
Minimum concern				2		1			3
No concern	1								1
Not sure / NA	1			3					4
Grand Total	**15**	**8**	**5**	**28**	**5**	**8**	**15**	**2**	**86**

Table 32. *Organization's Level of Concern for Sustainability by Stakeholder Type*

Summary Observations: 86 respondents provided answers to the question. Of the 82 respondents who indicated a level of interested (4 respondents indicated "Not sure/NA"), ~78% indicated sustainability as a "deal breaker" or "major concern".

Value Proposition

Ability of a state-level HIE entity participants and consumers to achieve a favorable level of clinical and financial benefits relative to the costs associated with the creation and maintenance of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Deal breaker	3	4	2	4	4	3		20
Major concern	7	5	8	12	5	6	1	44
Moderate concern	4	2	5	5	1	2		19
Minimum concern			2	2				4
No concern				1	1	1		3
Not sure / NA	1		2	1	3			7
Total	**15**	**11**	**19**	**25**	**14**	**12**	**1**	**97**

Table 33. *Organization's Level of Concern for Value Proposition by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Deal breaker		1	2	6		3	1		13
Major concern	7	2	3	12	2	5	5	1	37
Moderate concern	6	2		6	2		6	1	23
Minimum concern				2			2		4
No concern	2				1				3
Not sure / NA		3		2			1		6
Grand Total	**15**	**8**	**5**	**28**	**5**	**8**	**15**	**2**	**86**

Table 34. *Organization's Level of Concern for Value Proposition by Stakeholder Type*

Summary Observations: 86 respondents provided answers to the question. Of the 80 respondents who indicated a level of interested (6 respondents indicated "Not sure/NA"), ~63% indicated value proposition as a "deal breaker" or "major concern".

Health Reform

Impact of potential changes in health care reimbursement and regulation at the federal level on the value proposition of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Deal breaker	1	2	1	2		1		7
Major concern	6	2	5	14	4	4	1	36
Moderate concern	5	5	10	6	3	4		33
Minimum concern	2	2	3	1	2	1		11
No concern	1		1	2	3	2		9
Not sure / NA			1		2			3
Total	**15**	**11**	**21**	**25**	**14**	**12**	**1**	**99**

***Table 35**. Organization's Level of Concern for Health Reform by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Deal breaker				3		1	1	1	6
Major concern	8	4	2	11	1	1	10		37
Moderate concern	3	3	1	10	2	5		1	25
Minimum concern	2	1	2	2		1	3		11
No concern	1	1		1	2		1		6
Not sure / NA	1			2					3
Grand Total	**15**	**9**	**5**	**29**	**5**	**8**	**15**	**2**	**88**

***Table 36.** Organization's Level of Concern for Health Reform by Stakeholder Type*

Summary Observations: 88 respondents provided answers to the question. Of the 85 respondents who indicated a level of interested (3 respondents indicated "Not sure/NA"), ~51% indicated health reform as a "deal breaker" or "major concern".

Electronic Health Record (EHR) Adoption and Utilization Rates

Impact of low EHR adoption and utilization rates in Wisconsin on the value proposition of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Deal breaker	1				2			3
Major concern	6	8	8	14	3	4	1	44
Moderate concern	6	2	8	8	3	5		32
Minimum concern	1	1	2	1	2	1		8
No concern			1	1	1	1		4
Not sure / NA	1		1	1	3	1		7
Total	**15**	**11**	**20**	**25**	**14**	**12**	**1**	**98**

***Table 37**. Organization's Level of Concern for EHR Adoption and Utilization Rates by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Deal breaker	1	1		1			1		4
Major concern	9	2	1	16	4	1	8	1	42
Moderate concern	2	3	4	9		2	5		25
Minimum concern	1	2				3	1	1	8
No concern	1			1	1				3
Not sure / NA	1			2		2			5
Grand Total	**15**	**8**	**5**	**29**	**5**	**8**	**15**	**2**	**87**

***Table 38.** Organization's Level of Concern for EHR Adoption and Utilization Rates by Stakeholder Type*

Summary Observations: 87 respondents provided answers to the question. Of the 82 respondents who indicated a level of interested (5 respondents indicated "Not sure/NA"), ~56% indicated EHR adoption and utilization rates as a "deal breaker" or "major concern".

Data Integrity

Legal liability and quality issues secondary to data loss, manipulation, compromise, etc

	1	2	3	4	Statewide	Multistate-National	None	Total
Deal breaker	4	6	5	5	2	2		**24**
Major concern	7	2	6	13	5	6	1	**40**
Moderate concern	3	3	5	5	3	3		**22**
Minimum concern			3	1	1			**5**
No concern				1	2	1		**4**
Not sure / NA	1		1		1			**3**
Total	15	11	20	25	14	12	1	**98**

***Table 39**. Organization's Level of Concern for Data Integrity by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Deal breaker	3	4		6	1	4	3	1	22
Major concern	11	3	2	16	1	3	6		42
Moderate concern	1		3	3	2	1	3	1	14
Minimum concern		1		2			2		5
No concern				1	1				2
Not sure / NA				1			1		2
Grand Total	**15**	**8**	**5**	**29**	**5**	**8**	**15**	**2**	**87**

***Table 40.** Organization's Level of Concern for Data Integrity by Stakeholder Type*

Summary Observations: 87 respondents provided answers to the question. Of the 85 respondents who indicated a level of interested (2 respondents indicated "Not sure/NA"), ~75% indicated data integrity as a "deal breaker" or "major concern".

Question 23 Top Two Challenges

Of those listed in the question above, what are the top two challenges for a state-level HIE entity?

	1	2	3	4	Statewide	Multistate-National	None	Total
Data Integrity	9	4	6	7	2	4	1	33
EHR Adoption and Utilization Rates	4	3	8	7	2	4		28
Privacy and Security	7	5	10	12	3	3		40
Sustainability	5	5	10	17	11	9	1	58
Value Proposition Reform	4	4	8	8	7	4	0	35
Other		1	1	1	2			5
Total	**29**	**22**	**43**	**52**	**27**	**24**	**2**	**199**

***Table 41**. Top Challenges for a state-level HIE Entity by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Other	Payer	Provider	Tribal	Grand Total
Value Proposition Reform	2	2	3	14	2	4		1	28
Sustainability	4	6	4	17	5	2	8		46
Privacy and Security	9	4	1	9	1	4	8	1	37
EHR Adoption and Utilization Rates	5	1		12	2	2	7	1	30
Data Integrity	10	2	2	4		4	8		30
Other	1	1		2			1	1	6
Grand Total	31	16	10	58	10	16	32	4	177

***Table 42.** Top Challenges for a state-level HIE Entity by Stakeholder Type*

Summary Observations: 177 answers were provided to the question. Respondents were able to select up to two challenges. The top two challenges were (1) sustainability and (2) privacy and security.

Question 35 Financial Considerations

Rate the following funding sources for their value in both start-up funding and ongoing funding. Use the following scale to respond:

*Should **not** be a source of funding*
*A **minimal** source of funding*
*A **secondary** source of funding*
*A **major** source of funding*
*The **sole** source of funding*

Start-up

Membership

An annual or monthly fee assessed to stakeholders or consumers – possibly prorated according to organizational size or role – charged to participants in the state-level HIE entity.

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	2	3	6	8	6	5	1	31
Minimal source	7	2	6	8	1	3	0	27
Secondary source	3	5	3	1	3	3	0	18
Major source	1	0	2	5	0	0	0	8
Sole source	0	0	1	0	0	0	0	1
Total	**13**	**10**	**18**	**22**	**10**	**11**	**1**	**85**

Table 43. *Start-up Funding: Membership Fee as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	4	1	10	3	5	2	1	27
Minimal source	1		2	9	2	4	1		19
Secondary source	1	1	2	5	1	3		1	14
Major source		1		4	1		2		8
Sole source		1							1
Total	**3**	**7**	**5**	**28**	**7**	**12**	**5**	**2**	**69**

Table 44. *Start-up Funding: Membership Fee as a Funding Source by Stakeholder Type*

Summary Observations: 69 respondents provided answers to the question. ~13% indicated membership fees should be a start-up source (sole or major) of funding.

Federal funding

Monies derived from federal taxes provided to the State government for support of a state-level HIE entity in the form of grants or outcomes-based

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	0	0	0	0	0	0	0	0
Minimal source	2	1	1	3	1	0	0	8
Secondary source	2	0	3	6	1	1	0	13
Major source	8	7	11	12	8	8	1	55
Sole source	1	2	3	2	1	2	0	11
Total	**13**	**10**	**18**	**23**	**11**	**11**	**1**	**87**

Table 45. *Start-up Funding: Federal Funding as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source									0
Minimal source	1			3		1			5
Secondary source	1	2		4	1	3			11
Major source	1	5	5	18	5	8	3	1	46
Sole source		1		3	1	1	2	1	9
Total	**3**	**8**	**5**	**28**	**7**	**13**	**5**	**2**	**71**

Table 46. *Start-up Funding: Federal Funding as a Funding Source by Stakeholder Type*

Summary Observations: 71 respondents provided answers to the question. ~77% indicated federal funding should be a start-up source (sole or major) of funding.

State funding

Monies derived from Wisconsin State taxes provided to the state-level HIE entity in the form of grants or outcomes-based performance incentives

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	0	1	0	0	1	1	0	3
Minimal source	1	2	1	4	1	2	1	12
Secondary source	5	2	9	7	0	3	0	26
Major source	7	5	5	10	8	4	0	39
Sole source	0	0	3	1	1	1	0	6
Total	**13**	**10**	**18**	**22**	**11**	**11**	**1**	**86**

Table 47. *Start-up Funding: State Funding as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		1					1	1	3
Minimal source	2			7		1			10
Secondary source			2	9	1	6	2		20
Major source	1	5	3	10	5	6	1	1	32
Sole source		1		2	1		1		5
Total	**3**	**7**	**5**	**28**	**7**	**13**	**5**	**2**	**70**

Table 48. *Start-up Funding: State Funding as a Funding Source by Stakeholder Type*

Summary Observations: 70 respondents provided answers to the question. ~53% indicated state funding should be a start-up source (sole or major) of funding.

Philanthropy

Gifts or grants from non-governmental sources in support of the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	1	1	5	4	2	2	0	15
Minimal source	7	4	6	9	6	4	0	36
Secondary source	3	1	5	8	1	2	0	20
Major source	2	4	1	1	1	2	1	12
Sole source	0	0	1	0	0	1	0	2
Total	**13**	**10**	**18**	**22**	**10**	**11**	**1**	**85**

Table 49. *Start-up Funding: Philanthropy as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		2	1	8	1	1	1		14
Minimal source	2	1	1	11	4	5	3		27
Secondary source		2	2	5	1	5	1	1	17
Major source	1	2		3	1	1		1	9
Sole source			1	1					2
Total	**3**	**7**	**5**	**28**	**7**	**12**	**5**	**2**	**69**

Table 50*. Start-up Funding: Philanthropy as a Funding Source by Stakeholder Type*

Summary Observations: 69 respondents provided answers to the question. ~16% indicated philanthropy should be a start-up source (sole or major) of funding.

Transaction Fee

Fee charged to any entity accessing data from the state-level HIE entity per clinical result delivered, per covered life or per month for use of software or data access

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	6	6	10	6	6	5	0	39
Minimal source	3	2	5	6	1	4	1	22
Secondary source	1	0	0	4	1	1	0	7
Major source	3	2	3	4	1	1	0	14
Sole source	0	0	0	1	0	0	0	1
Total	**13**	**10**	**18**	**21**	**9**	**11**	**1**	**83**

Table 51. *Start-up Funding: Transaction Fee as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		5	3	15	5	3	1	2	34
Minimal source	1		2	2	2	5	2		14
Secondary source	1			3		1	1		6
Major source		2		8		1	1		12
Sole source	1								1
Total	**3**	**7**	**5**	**28**	**7**	**10**	**5**	**2**	**67**

Table 52. *Start-up Funding: Transaction Fee as a Funding Source by Stakeholder Type*

Summary Observations: 67 respondents provided answers to the question. ~19% indicated transaction fees should be a start-up source (sole or major) of funding.

Fees from Payers

Per-member-per-month (PMPM) fee paid to the state-level HIE entity based upon overall revenues of insurers in support of the establishment and ongoing operations of a state-level HIE entity

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	3		11	4	1	1	1	22
Minimal source			1	2	2	4	2	1	12
Secondary source	2	2	4	5		3			16
Major source		1		9		4	2		16
Sole source		1							1
Total	**3**	**7**	**5**	**27**	**6**	**12**	**5**	**2**	**67**

Table 53. *Start-up Funding: Fees from Payers a Funding Source by Stakeholder Type*

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	4	5	7	3	2	1	1	23
Minimal source	3	1	4	5	0	2	0	15
Secondary source	4	3	3	6	4	3	0	23
Major source	2	1	3	7	3	3	0	19
Sole source	0	0	1	0	0	0	0	1
Total	**13**	**10**	**18**	**21**	**9**	**9**	**1**	**81**

Table 54. *Start-up Funding: Fees from Payers as a Funding Source by MTA*

Summary Observations: 67 respondents provided answers to the question. ~25% indicated fees from payers should be a start-up source (sole or major) of funding.

"Tax" on Health Insurance

Fee or assessment added to insurance premiums paid to insurers by individuals or sponsors of health insurance (employers or government) and used to support the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	5	7	13	14	7	8	1	55
Minimal source	5	2	2	3	1	2	0	15
Secondary source	2	1	2	1	1	0	0	7
Major source	1	0	1	4	1	0	0	7
Sole source	0	0	0	0	0	1	0	1
Total	**13**	**10**	**18**	**22**	**10**	**11**	**1**	**85**

Table 55. *Start-up Funding: "Tax" on Health Insurance as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	5	4	21	7	7	2	2	49
Minimal source				5		2	2		9
Secondary source	1		1	1		1			4
Major source	1	2		1		2	1		7
Sole source									0
Total	**3**	**7**	**5**	**28**	**7**	**12**	**5**	**2**	**69**

Table 56. *Start-up Funding: "Tax" on Health Insurance as a Funding Source by Stakeholder Type*

Summary Observations: 69 respondents provided answers to the question. ~10% indicated "tax" on health insurance should be a start-up source (sole or major) of funding.

"Tax" on Provider Services

Proportional fee paid to state-level HIE entity based upon overall dollars spent on health care services in support of the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	6	6	15	17	7	9	0	60
Minimal source	4	4	3	4	1	0	1	17
Secondary source	3	0	0	0	1	1	0	5
Major source	0	0	0	0	1	0	0	1
Sole source	0	0	0	1	0	1	0	2
Total	**13**	**10**	**18**	**22**	**10**	**11**	**1**	**85**

Table 57. *Start-up Funding: "Tax" on Provider Services as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		6	4	21	7	9	3	1	51
Minimal source	1	1	1	3		3	2	1	12
Secondary source	1			3					4
Major source				1					1
Sole source	1								1
Total	**3**	**7**	**5**	**28**	**7**	**12**	**5**	**2**	**69**

Table 58. *Start-up Funding: "Tax" on Provider Services as a Funding Source by Stakeholder Type*

Summary Observations: 69 respondents provided answers to the question. ~3% indicated "tax" on provider services should be a start-up source (sole or major) of funding.

Secondary uses of data

Fees charged to researchers or entities for the use of aggregated or de-identified data from the state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	3	3	10	7	6	3	1	33
Minimal source	4	1	3	10	2	4	0	24
Secondary source	5	5	3	2	0	3	0	18
Major source	1	1	2	2	1	0	0	7
Sole source	0	0	0	0	0	1	0	1
Total	**13**	**10**	**18**	**21**	**9**	**11**	**1**	**83**

Table 59. *Start-up Funding: Secondary Uses of Data as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	2	4	2	11	2	5	2		28
Minimal source		1	2	5	3	4	3		18
Secondary source			1	8	2	1		1	13
Major source	1	2		2		1		1	7
Sole source				1					1
Total	**3**	**7**	**5**	**27**	**7**	**11**	**5**	**2**	**67**

Table 60. *Start-up Funding: Secondary Uses of Data as a Funding Source by Stakeholder Type*

Summary Observations: 67 respondents provided answers to the question. ~12% indicated secondary uses of data should be a start-up source (sole or major) of funding.

Ongoing Costs

Membership Fees

An annual or monthly fee assessed to stakeholders or consumers – possibly prorated according to organizational size or role – charged to participants in the state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	1	2	3	6	4	4	1	21
Minimal source	4	2	3	9	1	1	0	20
Secondary source	4	5	2	2	5	3	0	21
Major source	1	0	3	4	1	2	0	11
Sole source	0	0	1	0	0	0	0	1
Total	**10**	**9**	**12**	**21**	**11**	**10**	**1**	**74**

Table 61. *Ongoing Funding: Membership Fees as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	3		8	2	2	2		18
Minimal source	1	1	1	7	1	4	1	1	17
Secondary source	1		4	4	2	3	1	1	16
Major source		2		5	1	1	1		10
Sole source		1							1
Total	**3**	**7**	**5**	**24**	**6**	**10**	**5**	**2**	**62**

Table 62. *Ongoing Funding: Membership Fees as a Funding Source by Stakeholder Type*

Summary Observations: 62 respondents provided answers to the question. ~18% indicated membership fees should be an ongoing source (sole or major) of funding.

Federal funding

Monies derived from federal taxes provided to the State government for support of a state-level HIE entity in the form of grants or outcomes-based performance incentives

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	0	0	0	1	1	0	0	2
Minimal source	1	0	2	4	3	5	0	15
Secondary source	3	1	3	6	4	2	0	19
Major source	6	7	7	9	2	3	1	35
Sole source	1	1	2	1	0	0	0	5
Total	**11**	**9**	**14**	**21**	**10**	**10**	**1**	**76**

Table 63. *Ongoing Funding: Federal Funding as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1			1					2
Minimal source		1	3	4		1	2		11
Secondary source	1	2	2	8	1	3	1		18
Major source	1	4		10	5	5	2	2	29
Sole source		1		3					4
Total	**3**	**8**	**5**	**26**	**6**	**9**	**5**	**2**	**64**

Table 64. *Ongoing Funding: Federal Funding as a Funding Source by Stakeholder Type*

Summary Observations: 64 respondents provided answers to the question. ~52% indicated federal funding should be an ongoing source (sole or major) of funding.

State Funding

Monies derived from Wisconsin State taxes provided to the state-level HIE entity in the form of grants or outcomes-based performance incentives

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	0	0	0	1	1	1	0	3
Minimal source	2	3	3	9	3	5	1	26
Secondary source	4	1	6	7	4	4	0	26
Major source	5	5	3	3	2	0	0	18
Sole source	0	0	2	1	0	0	0	3
Total	**11**	**9**	**14**	**21**	**10**	**10**	**1**	**76**

Table 65. *Ongoing Funding: State Funding as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		1		1			1		3
Minimal source	2	1	1	7	1	4	2	1	19
Secondary source	1	2	4	8	1	5	2		23
Major source		3		8	4			1	16
Sole source				2		1			3
Total	**3**	**7**	**5**	**26**	**6**	**10**	**5**	**2**	**64**

Table 66. *Ongoing Funding: State Funding as a Funding Source by Stakeholder Type*

Summary Observations: 64 respondents provided answers to the question. ~30% indicated state funding should be an ongoing source (sole or major) of funding.

Philanthropy

Gifts or grants from non-governmental sources in support of the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	0	1	5	6	4	4	0	20
Minimal source	5	3	3	9	4	2	0	26
Secondary source	3	1	4	5	2	3	0	18
Major source	2	3	0	0	0	0	1	6
Sole source	0	0	0	0	0	1	0	1
Total	**10**	**8**	**12**	**20**	**10**	**10**	**1**	**71**

Table 67. *Ongoing Funding: Philanthropy as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	4	1	8	2	1	2		19
Minimal source	1	1	2	11	1	4	2		22
Secondary source		2	1	2	2	4	1	1	13
Major source	1			2				1	4
Sole source			1						1
Total	**3**	**7**	**5**	**23**	**5**	**9**	**5**	**2**	**59**

Table 68*. Ongoing Funding: Philanthropy as a Funding Source by Stakeholder Type*

Summary Observations: 58 respondents provided answers to the question. ~8% indicated philanthropy should be an ongoing source (sole or major) of funding.

Transaction Fees

Fee charged to any entity accessing data from the state-level HIE entity per clinical result delivered, per covered life or per month for use of software or data access

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	4	3	5	3	3	1	0	19
Minimal source	3	2	3	2	1	2	1	14
Secondary source	0	2	2	7	3	2	0	16
Major source	3	2	3	8	4	6	0	26
Sole source	0	0	0	1	0	0	0	1
Total	**10**	**9**	**13**	**21**	**11**	**11**	**1**	**76**

Table 69. *Ongoing Funding: Transaction Fees as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		3		9	2	2	1		17
Minimal source	1	1	1	2	3	2	1		11
Secondary source	1			4	1	3	2	2	13
Major source		3	4	9	1	3	1		21
Sole source	1								1
Total	**3**	**7**	**5**	**24**	**7**	**10**	**5**	**2**	**63**

Table 70. *Ongoing Funding: Transaction Fees as a Funding Source by Stakeholder Type*

Summary Observations: 63 respondents provided answers to the question. ~35% indicated transaction fees should be an ongoing source (sole or major) of funding.

Fees from Payers

Per-member-per-month (PMPM) fee paid to the state-level HIE entity based upon overall revenues of insurers in support of the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	1	4	4	3	3	1	1	17
Minimal source	2	0	2	3	0	4	0	11
Secondary source	4	3	3	5	5	2	0	22
Major source	2	2	3	10	3	4	0	24
Sole source	0	0	1	0	0	0	0	1
Total	**9**	**9**	**13**	**21**	**11**	**11**	**1**	**75**

Table 71*. Ongoing Funding: Fees from Payers as a Funding Source by Stakeholder Type*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	2		8	3	1			15
Minimal source		1		3	4		1		9
Secondary source	2	1	2	4		6	2	1	18
Major source		2	3	8		3	2	1	19
Sole source		1							1
Total	**3**	**7**	**5**	**23**	**7**	**10**	**5**	**2**	**62**

Table 72. *Ongoing Funding: Fees from Payers as a Funding Source by MTA*

Summary Observations: 62 respondents provided answers to the question. ~32% indicated fees from payers should be an ongoing source (sole or major) of funding.

"Tax" on Health Insurance

Fee or assessment added to insurance premiums paid to insurers by individuals or sponsors of health insurance (employers or government) and used to support the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	2	6	9	12	8	7	1	45
Minimal source	6	3	2	3	1	2	0	17
Secondary source	1	0	1	1	1	1	0	5
Major source	1	0	1	5	1	0	0	8
Sole source	0	0	0	0	0	1	0	1
Total	**10**	**9**	**13**	**21**	**11**	**11**	**1**	**76**

Table 73. *Ongoing Funding: "Tax" on Health Insurance as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	1	5	3	16	6	7	1	1	40
Minimal source				4	1	1	3	1	10
Secondary source	1		1	3					5
Major source	1	2	1	1		2	1		8
Sole source									0
Total	**3**	**7**	**5**	**24**	**7**	**10**	**5**	**2**	**63**

Table 74. *Ongoing Funding: "Tax" on Health Insurance as a Funding Source by Stakeholder Type*

Summary Observations: 63 respondents provided answers to the question. ~13% indicated "tax" on health insurance should be an ongoing source (sole or major) of funding.

"Tax" on Provider Services

Proportional fee paid to state-level HIE entity based upon overall dollars spent on health care services in support of the establishment and ongoing operations of a state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	3	6	11	13	7	6	0	46
Minimal source	4	2	2	4	1	2	1	16
Secondary source	3	1	1	1	1	1	0	8
Major source	0	0	0	1	1	0	0	2
Sole source	0	0	0	1	0	1	0	2
Total	**10**	**9**	**14**	**20**	**10**	**10**	**1**	**74**

Table 75. *Ongoing Funding: "Tax" on Provider Services as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source		5	3	17	5	8	2	1	41
Minimal source	1	2		4	2	2	2		13
Secondary source	1		1	3				1	6
Major source			1	1					2
Sole source	1								2
Total	**3**	**7**	**5**	**25**	**7**	**10**	**4**	**2**	**64**

Table 76. *Ongoing Funding: "Tax" on Provider Services as a Funding Source by Stakeholder Type*

Summary Observations: 64 respondents provided answers to the question. ~6% indicated "tax" on provider services should be an ongoing source (sole or major) of funding.

Secondary Uses of Data

Fees charged to researchers or entities for the use of aggregated or de-identified data from the state-level HIE entity

	1	2	3	4	Statewide	Multistate-National	None	Total
Not a source	2	1	4	4	2	2	1	16
Minimal source	2	2	2	8	3	2	0	19
Secondary source	6	5	6	5	3	7	0	32
Major source	0	2	2	4	2	0	0	10
Sole source	0	0	0	0	0	0	0	0
Total	**10**	**10**	**14**	**21**	**10**	**11**	**1**	**77**

Table 77. *Ongoing Funding: Secondary Uses of Data as a Funding Source by MTA*

	Consumer	Government	HIE/HIE Service Provider	Hospital/IDN	Payer	Provider	Other	Tribal	Total
Not a source	2	1		5	1	3			12
Minimal source		2	2	5	1	2	3		15
Secondary source	1	1	3	11	5	2	2		26
Major source		3		2		2		2	9
Sole source									
Total	**3**	**7**	**5**	**23**	**7**	**9**	**5**	**2**	**62**

Table 78. *Ongoing Funding: Secondary Uses of Data as a Funding Source by Stakeholder Type*

Summary Observations: 62 respondents provided answers to the question. ~15% indicated secondary uses of data should be an ongoing source (sole or major) of funding.

2 SUMMIT HANDOUTS

What are the potential "deal breakers" for your organization's participation in a state-level HIE?

What are the potential deal breakers, landmines, or risks for your organization's participation in a state-level HIE?

Summit Location	Stakeholder Type	Answer
Sauk City	Hospital/IDN	If the information is not secure we are all at stake. How can we be assured the data will not be "hacked" into?
Appleton	Hospital/IDN	Lack of outcome/output; we need to focus on goal setting and accomplishing those goals
Sauk City	Hospital/IDN	Resources required to participate. We have already allocated all of our IT resources thru mid-2010, this would require stopping some those projects or adding un-budgeted resources; inaccurate or only very basic data elements would be of little value; For medication - add refill information for pharmacies to track prescription purchases to evaluate compliance.
Sauk City	Hospital/IDN	WI state 51:30; lack of "teamwork "by certain interest groups; our IS vendor lack of interoperable software; time commitment, monetary investment in resources; lack of physician involvement; assurance of privacy/ security standards
Milwaukee	Other	Increase the complexity and reporting to an organization and increasing an organization's overall cost. You must have an EMPI in order to do this work.
Sauk City	Hospital/IDN	Cost - cost – cost

Summit Location	Stakeholder Type	Answer
Sauk City	Hospital/IDN	Cost to institution, personnel required t o be involved, patient education, and physician involvement
Sauk City	Hospital/IDN	Costs; staffing resources; fairness relative to other organizations.
Milwaukee	Provider	Protection of privacy of PHI and payers shouldn't be excluded.
Sauk City	Hospital/IDN	Need to have accurate information, which would still rely on health care professional to verify patients; financing always an issue when small and rural hospitals; physician acceptance is very important and can make or break the deal.
Sauk City	Hospital/IDN	Money; physician buy-in an utilization of HIE.
Sauk City	Payer	In the event that health plans are linked to the HIE, it would be necessary to identify our members clinical information to effectively perform disease management, etc.
Appleton	Hospital/IDN	Concerns - which can be addressed: Cost/resources; security; representative - Delegate vs. provider; type / organization
Milwaukee	Other	Need consistency in legal framework, consent requirements, etc.
Milwaukee	Payer	Allowing patients to "opt-out" of the HIE. This could greatly decrease the usefulness of the system.
Milwaukee	Provider	I believe there remain legal/ regulatory barriers to the exchange of data and/or access to data relating to children in foster care. These barriers relate to privacy issues of biologic parents. Perhaps a new consent form that biologic parents could sign when children are placed into foster care - this electronic sharing consent form will need work at the legislative and executive level.
Sauk City	Government	Lack of privacy or security; not user friendly; difficulty in using or entering data; lack of appropriate timing; lack of funding
Milwaukee	Government	Funding! Overly focused on the EMR as the data collection point. Create a universal EMR built specifically for HIE.
Appleton	Government	force adoption of any specific vendor solution; too costly
Sauk City	Consumer	Sharing of sensitive patient data without patient consent
Sauk City	Hospital/IDN	Certify that data is clean and secure, not used for competition reasons. Consent of patients is consistently of governance and function, including burdens of paper processes currently required by state law.
Milwaukee	Consumer	Financial un-sustainability - how is it funded after ARRA?; Lack of interoperability with other states, failure to address market areas that cross state borders; there needs to be a clear legal mandate that personal health information is owned by the patient.
Sauk City	Provider	Privacy; Cost; less efficiency.
Appleton	Hospital/IDN	Lack of focus on patient; lack of equal treatment of all entities in state
Sauk City	Provider	Physicians trust that the record is accurate. How to get the HIE into the provider's workflow. How to educate patients to safely interact with their clinician with information. How complete will HIE be - will this be like a "sub-chart" - it would have office visit notes but not an important note from a telephone encounter.
Appleton	Hospital/IDN	Concern about "ownership" of HIE. If government owns it, it will always be at the mercy of the whim of government (see the pt. compensation fund debacle - government took money that was deposited by the physicians themselves … not even public money)

Summit Location	Stakeholder Type	Answer
Sauk City	Payer	Breach - incorrect information on a patient
Milwaukee	Hospital/IDN	Need an effective data exchange standards supported by the major vendors. Need a viable long term funding model.
Appleton	Provider	Too time intensive on smaller practices
Sauk City	Government	Legislation barring data sharing, data matching, or release of data; allowing a for-profit or private organization to control the HIE; not secure enough; once data is released, there is no possible remedy for getting it back or assuring privacy or confidentiality to people who have had their records accessed.
Appleton	Tribal	Easy and simple to use and does it help patient care and is it now an administrative burden; must be "patient centric"
Milwaukee	Hospital/IDN	Any standards that are inconsistent with federal, JCAHO and state requirements
Sauk City	Hospital/IDN	EMR vendors limitations; poor security.
Sauk City	HIE/HIE Initiative	HIE utility like a command/ control structure; failure to recognize and incorporate existing initiatives in governance/ operating models; lack of a role Board representation for WCHQ. Landmines - providing of services by the state. Risks - failure to recognize and incorporate existing initiatives.
Sauk City	Government	Staffing resources; lack of WI consensus on direction of state-level HIE; administrative workflow burden for health care providers, and adaption to change and technology by the patient/ consumer, individual health care workers and health care providers.
Sauk City	Payer	Based on what I heard at the meeting today, payers do not appear to have much involvement in HIE, which is disappointing. Both public and private payers could be major contributors and beneficiaries to HIE - if allowed.
Sauk City	Hospital/IDN	Need to capitalize on existing EHR and other IT investments or providers will not be able to participate. Need to assure all providers organizations are able to participate nit just large health systems. Need to assure access to qualified health IT expertise. Must maintain focus on creating electronic base first or there is no information to exchange.
Sauk City	Provider	LTC providers must be included as an active partner in the ARRA - fund planning and implementation at state/ and/or regional levels.
Sauk City	Hospital/IDN	This is really "an offer I can't refuse". Landmines: new HIS implementation will be very costly; small hospital implementation timelines are not the same as larger institutions; completely different capabilities of organizations to implement things like direct interface and physician practice
Sauk City	Government	Who will pay? It's a public good so all should contribute. How will the statewide WIHIE inventory quality of care?
Appleton	Hospital/IDN	A Board controlled by the state's largest provider systems.
Sauk City	Other	It is seen as a capture of any private interest group - e.g. payers, providers, and vendors.
Sauk City	HIE Initiative	Lack of resources for rural hospitals and clinics to be able to connect to a HIE network.
Sauk City	Provider	Data is very valuable to organizations, it is difficult to get payors and providers to share; contracting - I imagine that some types of

Summit Location	Stakeholder Type	Answer
		contracting among organizations will need to occur. This is a long process for some larger national organizations. Will there be incentives for all providers? How will they pay for participation and standardization? Time - will staff resources be allocated for organization involvement?
Appleton	Hospital/IDN	This must be easy to put in place and have a very focused value. Too large a scope will lead to failure and miss-trust; Must be insulated from political changes. Control of organization data, outputs must be transparent, and shared over all stakeholders
Appleton	Provider	Significant financial burden put on providers; difficult to manage consent process
Sauk City	Government	Profiteering from HIE by participants or interest groups. The HIE should be for the ultimate benefit of the public, not enrichment of a select group of individuals, groups, or entities.
Sauk City	Hospital/IDN	Money is of course a factor, we are small rural hospital; physician buy-in and the physicians need to be on board with the state's plan, and with our plan; assuming patient safety is ok, keeping the information secure and ensuring to the patient that their information is secure.
Sauk City	Hospital/IDN	Privacy/ security concerns; risk liability and the costs of lawsuits; mandatory disclosures, etc. Resources required for participation.
Marshfield	Hospital/IDN	Requirements to support multiple and/or non-standard interfaces; costs exceed the benefits; data is used for anti-competitive purposes
Marshfield	Hospital/IDN	Cost of entry too high; add complexity to providers; must work for large entities and small provider groups and critical access hospitals
Marshfield	Hospital/IDN	Unfunded mandates; legal liability

Table 79. *Dealbreakers, challenges, risks that may hinder stakeholder participation*

3 SUMMIT DISCUSSION: INFORMATION NEEDS

Information Needs - Attributes	Information Needs - Services
Accurate Audit capabilities Comprehensive/complete Confidential Current Equitable Scalable Standardized Timely User-friendly	Administrative data Advance directives Allergy and medication list Chronic disease management Cross-state exchange Demographics Diagnostic test results (lab, rad) Lab data exchange Patient identification Population health Public health case reporting Quality indicators and measures Quality reporting Real-time pharmacy State registries (immunization, etc.)

	Terminology standards Transitions in care (e.g., LTC, foster care)

***Table 80**. Information Needs from HIE Summit Meetings*

***Summary Observations:** Over the course of the five HIE Regional Summit Meetings, stakeholders identified key information needs based on characteristics of the need and services (patient care technical services and shared utility technical services).*

APPENDIX 7

Pharmacy and Lab HIE Capability Initial Data Collection Process

In accordance with the guidance provided by ONC through the Public Information Notice-001, the WIRED for Health Project set out with an agenda to collect baseline data for:

- Electronic exchange of prescriptions and refill requests
- Delivery of structured lab results

For both pharmacies and laboratories, we followed a similar process (detailed below) to collect and validate the required baseline data, as well as to guide the development of our strategy for addressing gaps that exist in the electronic exchange of such information in Wisconsin.

Step 1: We used existing information resources provided by licensing/credentialing and health system data sources to contact pharmacies and labs and collect raw baseline data:

- For e-Prescribing baseline data, we used two information resources to make contact with pharmacies operating in Wisconsin:
    - Data from the Wisconsin Department of Regulation and Licensing (DRL) on licensed pharmacies in the State
    - Data from a large integrated delivery network on pharmacies with which it currently electronically exchanges prescriptions
- For structured lab results baseline data, we used Clinical Laboratory Improvement Amendments (CLIA) contact data provided by the Wisconsin DHS Division of Quality Assurance (DQA). Upon establishing the baseline, we focused on laboratories that were identified as "Accredited" or "Compliant" by CLIA

For pharmacies, we undertook the additional step of matching and rationalizing the two lists to develop a single, comprehensive cross-matched and de-duplicated list of pharmacies operating in Wisconsin.

To the extent contact information was available or could be sourced, we developed a call list for both pharmacies and laboratories, so we could survey them to ask for basic information on current e-prescribing or electronic results delivery capabilities.

Step 2: We developed survey questionnaires (included in this Appendix) to be directed respectively at Managers/Owners of Labs and Pharmacies located in Wisconsin. Our primary goal in this step was to gather basic information about such electronic information exchange capabilities, as well as collect contact information so we could administer and collect more detailed surveys in the future. This information also served as the basis for us to identify potential strategies to address the gaps that currently exist in electronic exchange of such information throughout Wisconsin

Step 3: Next, we engaged the assistance of a Medicaid Call Center to help make calls to the laboratories and pharmacies, administer the short survey, and collect the required information to help develop baseline data for immediate use, as well as to inform future processes and decisions.

- We reached out to 812 pharmacies and were able to source information from 779 of those at a response rate of 96%. As we develop, refine, and finalize our strategy to address these gaps, we

will continue to reach out to the remaining 33 pharmacies and use such information to inform and affect the strategy we will pursue to close the gaps.

- We reached out to 767 laboratories and were able to source information from 694 of those at a response rate of 90%. Similar to the intent regarding pharmacies, as we develop, refine, and finalize our strategy to address these gaps, we will continue to reach out to the remaining 73 Accredited or Compliant laboratories and use such information to inform and affect the implementation of our strategy

Step 4: Upon completing the telephone surveys, we tabulated the baseline data and depicted the data for laboratories and pharmacies included at the end of this document. As we proceed with plans to refine the data, we fully intend to leverage the baseline data and measurements to assess progress as well as the effectiveness of the strategies we decide to implement to close any gaps.

At the conclusion of this initial data collection process to develop the baseline for electronic exchange of labs results and prescription data in Wisconsin, we now have a set of reusable assets, contact information for Labs and Pharmacies, as well as a repeatable process in place. This process will be leveraged as we develop, define, and implement our strategies (respectively for Labs and Pharmacies), as well as ongoing measurement of the effectiveness of our strategies and implementation approach to close the gaps.

WIRED for Health – ONC PIN Guidance – Pharmacy Survey

Opening

Hello:

My name is <***insert caller name here***> I'm calling on behalf of the Wisconsin Department of Health and State Health IT Coordinator, Denise Webb, and would like to speak with your Pharmacy manager to ask a few short questions about e-Prescribing. Your answers will be used to help establish a baseline indicating the percentage of pharmacies in Wisconsin engaging in e-prescribing.

When complete, this information will be aggregated and included in the Wisconsin HIT Strategic and Operational Plan for submittal to the Office of the National Coordinator at the end of August.

<***Repeat if/as needed when the Pharmacy Manager is on the phone***>

---

1. Detail contact information for the pharmacy (will not be shared outside of this Project)

a. Organization
b. Contact person
c. Title
d. Address, City, State, Zip
e. Phone
f. E-mail

2. Do you have an **electronic pharmacy system**? YES/NO

a. **If Yes**, what is the name of the Vendor?
b. **If No**, what are your plans to implement an electronic pharmacy system?
c. What is the timeline for your implementation?

3. Does your pharmacy use an **ePrescribing Intermediary or Network**? YES/NO

a. **If Yes**, what is the name of the Vendor?
b. **If No**, do you plan to in the next 12 months?
    i. **If Not, Why**?

Closing

Thank you for providing this information and I appreciate your time in responding to my questions. If you have any questions, please send them to ehealth@wisconsin.gov.

WIRED for Health – ONC PIN Guidance – Laboratory Survey

Opening

Hello:

My name is <***insert caller name here***> I'm calling on behalf of the Wisconsin Department of Health and State Health IT Coordinator, Denise Webb, and would like to speak with you Laboratory manager to ask a few short questions about electronic lab results delivery. Your answers will be used to help establish a baseline indicating the percentage of:

- Labs in Wisconsin with the ability to electronically deliver test results to providers.

When complete, this information will be aggregated and included in the Wisconsin Health IT Strategic and Operational Plan for submission to the Federal Office of the National Coordinator at the end of August.

<***Repeat if/as needed when the Laboratory Manager is on the phone***>

---

1. Detail contact information for the laboratory (will not be shared outside of this Project)

a. Organization
b. Contact person
c. Title
d. Address, City, State, Zip
e. Phone
f. Organizational E-mail Address
g. Contact Person's Email Address

2. Lab Services:

a. Do you provide lab services
   i. At onsite location
      YES/NO
   ii. At other locations within your parent organization
      YES/NO
   iii. Outside your parent organization (i.e., unaffiliated entities)
      YES/NO
b. Do you deliver results electronically to Providers' Electronic Health Record Systems? YES/NO
   i. If No
      1. Do you have any plans to do so in the next 12 months?
         YES/NO
      2. If no such plans for the next 12 months, please explain why?

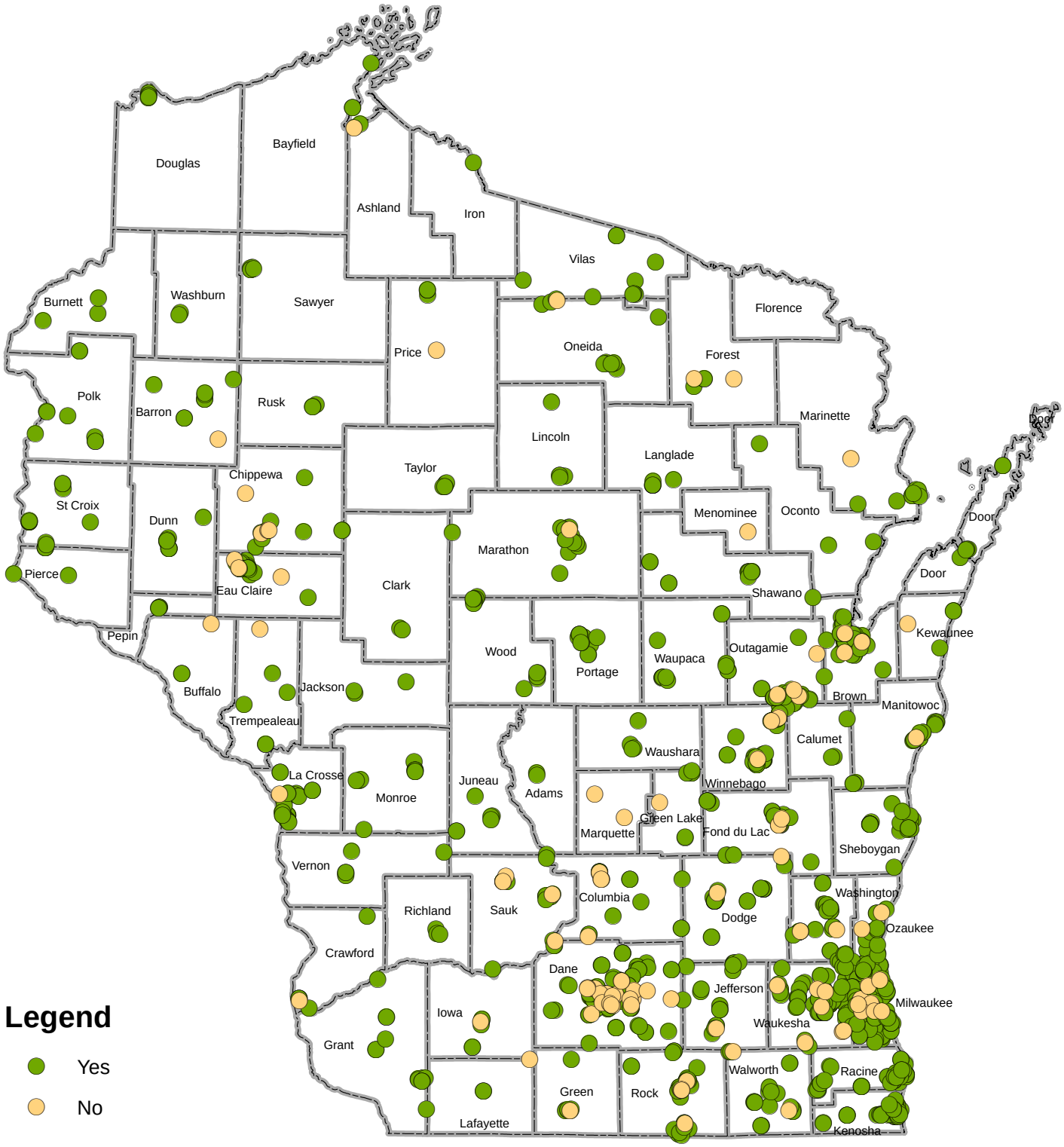
3. Do you provide a web portal for online lab results look up?
   YES/NO

Closing

Thank you for providing this information and I appreciate your time in responding to my questions. If you have any questions, please send them to ehealth@wisconsin.gov.

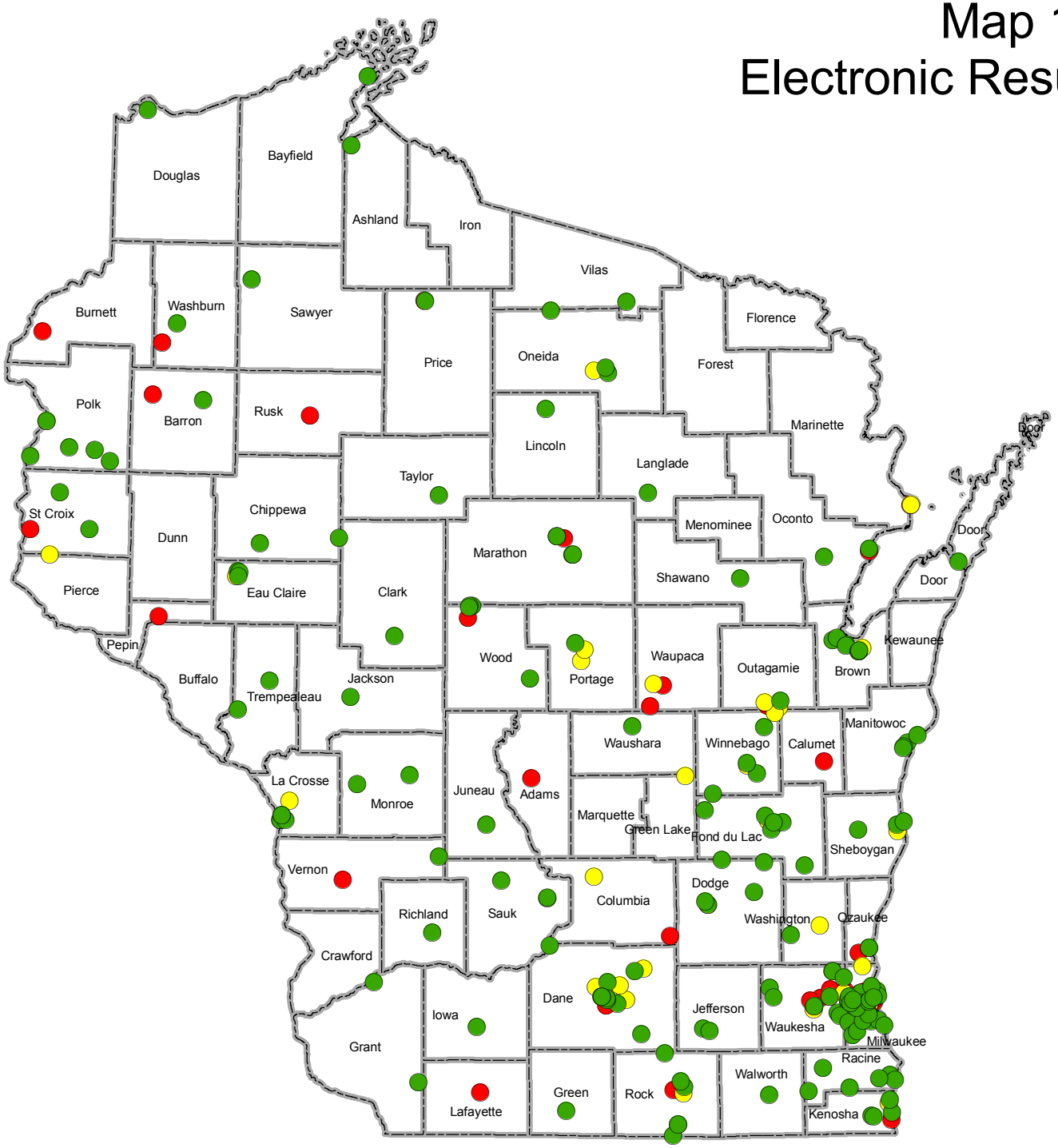
DRAFT

Locations of E-Prescribing Pharmacies



Last Updated on 8/25/2010

Map 1 - Electronic Results Delivery



Legend

- Yes
- Not Available
- No

Last Updated on 12/16/2010

APPENDIX 8

Wisconsin Division of Public Health
Public Health Meaningful Use Implementation Plan

As of August 24, 2010

1. Overview

Three of the 10 Meaningful Use (MU) menu set requirements specify electronic transmission of the following data to Public Health (PH): immunizations, laboratory results for reportable conditions, and syndromic surveillance. Eligible Providers/Hospitals (EP/Hospitals) must meet five of the menu set requirements, one of which must be a public health requirement. The measure for validation of Stage 1 public health meaningful use (PH MU) requires only that a single test be performed, and if successful, that transmission should continue if public health is ready to continue receipt. It is not necessary for the test to succeed in order to meet the Stage 1 PH MU requirement measure.

The Wisconsin Division of Public Health (DPH or "the Division") has systems that are technically well positioned to accept and continue receiving electronic submissions of immunization and laboratory data. The target systems are in place, administered by DPH, mature, already accept HL7 2.3.1, and can be readily upgraded to accept HL7 2.5.1 submissions (although a majority of immunization system data providers currently submit data in other formats). Existing funding for the upgrades appears to be sufficient. It is likely DPH will be ready to accept tests and subsequent transmissions by April 2011.

Syndromic surveillance data comes to DPH through an arrangement with the Wisconsin Health Information Exchange (WHIE) as part of the Emergency Department (ED) Linking project. DPH currently receives Admission, Discharge, and Transfer (ADT) data from 44 acute-care Wisconsin hospitals and associated clinics across 24 Wisconsin counties. At least some of these hospitals are providing data using HL7 2.3.1 or 2.5.1. The current arrangement for syndromic surveillance through WHIE is based on limited-term grants. The Division has not been made a decision regarding permanent, ongoing funding for this relationship.

Thus overall it appears that many EP/Hospitals will be able to point to existing data transmission relationships in one of the three PH MU menu set areas to fulfill the Stage 1 PH menu set requirement for the EHR Incentive Program in 2011 (Medicare) and 2012 (Medicaid and Medicare). Others may be providing data already but will need to make changes to meet standards, implementation specifications, and/or certification criteria detailed in the Office of the National Coordinator's (ONC) health information technology rule (45 CFR Part 170). Still others will be applying to submit data for the first time.

Although the systems are in place to accept Stage 1 PH MU, there may need to be adjustments to staffing and information processing capabilities to receive, process, and use data from a large number of EP/Hospitals that desire to test and then provide new data or data in a changed format. The additional work resulting from helping meet the demand for Stage 1 PH MU requirements may come at the expense of other current projects as well as day-to-day activities. It is also possible the volume of EP/Hospitals submissions could overwhelm the capacity to respond. Adding staff on a temporary or permanent basis may be necessary. Stage 2 and 3 MU requirements could exacerbate the situation.

The Division's current interpretation of the final rule puts the burden of electronic health record (EHR) technology certification on the EP/Hospitals and their system vendor(s). The Division does not need to validate if the sending EHR system or component is certified, nor do the public health systems that receive the data themselves need to be certified, only capable of accepting data per the applicable standards and implementation specifications. The final rule and standards are silent on the transmission method, other than it must be electronic, so that is not an issue either. The Division interprets this to mean that existing transmission-level practices (such as the use of Public Health Information Network Messaging System (PHIN-MS) may still be used. The public health systems will continue to accept transmissions in a variety of methods, i.e., batch, real-time, etc., but at the discretion of the Division.

2. Immunization Information System

2.1. Current State

The Wisconsin Immunization Registry (WIR), a web-based application used to record and track immunization information, is well positioned to meet the HL7 2.3.1 standard for MU. It can accept data in a variety of methods and formats ranging from a batch download of an ASCII file to real-time HL7 update. It is widely used and recognized.

2.2. Future State

To be able to meet both the standards specified for MU immunization data submission, WIR will need to be updated to handle HL7 version 2.5.1. The scope of the vendor modifications is currently under review. Additional processing capacity will also be required. Support will continue for all existing formats at least through 2011, including but not limited to HL7 2.3.1 and HL7 2.4.

2.3. Funding

The DPH Immunization Section submitted and is likely to receive an ARRA-funded CDC grant for Enhancing the Interoperability of Electronic Health Records and Immunization Information Systems. The final budget is not definite, but it appears the grant should be sufficient to cover the majority of the cost of WIR's HL7 2.5.1 upgrade and increased processing capacity. Additionally, the grant should cover some costs associated with establishing bi-directional interfaces with certain EHRs. The Immunization Program appears to be able to cover the remaining costs associated with upgrades required for MU.

2.4. Current Processing

- When a healthcare provider or EHR vendor makes an interface request, they are provided HL7 specifications which include transport options. It is possible requests will be limited to current or potential future MU standards and implementation specifications going forward.
- A conference call or live meeting discussion of the specifications, required fields and testing protocol is conducted.
- Test files are created by vendor/healthcare entity and passed to WIR staff and passed through processor to see if layout and data are appropriate.
- Once layout and data are deemed to be appropriate, access to the WIR test server is granted to appropriate provider/vendor personnel along with the web address and the key for data transport.
- Discussion occurs around data transport and appropriate configuration.
- Typically 2 weeks to 1 month of testing occurs.
- Once the healthcare provider/vendor is ready to go live, a production web address and key are provided. For the first 60 days, all data from this healthcare provider/vendor goes through a pre-processor to ensure data integrity and any issues seem are relayed back to the healthcare provider.

- After 60 days, the need for preprocessing is removed and the interface is deemed live.

3. Electronic Laboratory Reporting (ELR)

3.1. Current State

Electronic laboratory reporting of reportable conditions to the Wisconsin Electronic Disease Surveillance System (WEDSS), a web-based application used for communicable disease surveillance and case management, is managed through a contract with the Wisconsin State Laboratory of Hygiene (WSLH), and is well positioned to meet MU requirements. The WSLH accepts lab reports in a variety of formats now, converting to HL7 2.3.1 and adding LOINC and SNOMED codes as needed for transmission to the Wisconsin Electronic Diseases Surveillance System (WEDSS).

3.2. Future State

All components provided by WSLH and by the WEDSS vendor will need to be upgraded to be able to receive and process HL7 2.5.1 laboratory reports and meet the MU requirements. An upgrade to LOINC version 2.27 may also be required. The WSLH upgrade to HL7 2.5.1 will occur in early fall 2010. The upgrade of the WEDSS vendor components is under review. As with WIR, an increase in transaction volume will require additional processing capacity.

3.3. Funding

There is no specific funding allocated to upgrading WSLH and WEDSS components to meet MU requirements. Existing funding for WSLH will be redirected to underwrite the cost of the upgrade, if needed. The WEDSS vendor will make the upgrades to their components without charge as part of the original contractual agreement.

3.4. Processing

- WSLH and DPH prioritize laboratories to implement ELR based on relevant lab test volumes and technical readiness, and then contact the labs to determine interest and technical readiness.
- WSLH provides introductory and technical requirements packets.
- Laboratories provide registration form and letter of commitment.
- Laboratories acquire/install hardware, PHINMS, other software, licenses and certificates.
- WSLH conducts weekly conference calls with laboratory throughout implementation process.
- WSLH and laboratory create a customized spreadsheet of tests that may produce a reportable result and the applicable organisms.
- Laboratory extracts data from its laboratory system.
- Laboratory formats data into HL7 and sends test messages to WSLH.
- Messages are sent securely through PHINMS.

- WSLH verifies message content and format.
- WSLH assigned LOINC and SNOMED codes (this step should become less prominent as ONC-specified implementation specifications and vocabularies are used by data providers).
- WSLH standardizes the message as necessary.
- WSLH and DPH compare ELR reports with paper reports/provider reports.
- Laboratory is authorized to discontinue paper reporting.

4. Syndromic Surveillance

4.1. Current State

The Division currently receives its syndromic data through an arrangement the WHIE. The WHIE provides a PH view of ADT data from a variety of emergency departments, hospitals, and outpatient settings. Some proportion of providers currently use HL7 2.3.1 or 2.5.1 formats. Current delivery of data to public health is based on time-limited grants that fund contracts with WHIE.

WHIE PH data is exported to SAS, which is used to scan the Chief Complaint field for key words/combinations of words which are converted to syndromes. The syndromic data is made available through the DPH Analysis, Visualization, and Reporting (AVR) business intelligence platform. This data is used by the Bureau of Communicable Diseases and Emergency Response to create reports about the incidence and trends of symptoms and health care utilization areas of interest in detecting or managing communicable diseases. WHIE data is also exported for use in ESSENCE II by one major city health department in the state for similar purposes.

One of the largest health care systems in the state currently provides information both to DPH using WHIE and to CDC's BioSense application.

4.2. Future State

The Division could continue to have WHIE act as its agent for receipt of standards-compliant syndromic surveillance data from EP/Hospitals to fulfill their MU requirement option. Alternately, the Division could develop an alternate capacity to accept and process the data, possibly using the existing reporting structure maintained for ELR by the WSLH. In either case, the Division needs to identify an ongoing funding source. For this reason, if the Division needs to defer one of the three options available to EP/Hospitals for meeting the PH MU requirement, syndromic surveillance may be the one.

4.3. Proposed WHIE Processing

To establish, test, and implement new/additional operational data feeds that meet MU requirements for syndromic surveillance, the following are steps would need to be put in place:

- WHIE "Kick-Off" presentation and discussion establishing framework for potential project, scope, timing, benefits, etc. At this time, a project charter, key stakeholder list, and communication plan is established and agreed to.

- Review and execute Participation Agreement and Business Associate Agreement between WHIE and the participating health system, hospital, or clinic.
- Communicate exchange standards and requested data transactions and elements. For disease surveillance, this includes encounter specific:
  - Patient demographics (used for patient ID and establish minimal set of data for PH use (zip code, age, gender, etc.).
  - Registration data (e.g. reason for visit, chief complaint).
  - Discharge diagnosis (preferably top three diagnoses.)
  - For other data (e.g. lab, immunization), the data set is correspondingly expanded, associating back to the patient and encounter (this is optional at this time).
- Agreement on structure for providing the data and timing (e.g. real time, batch).
- Establish secure VPN tunnels to Test, Production, and Hot Site data centers from participant data center.
- Obtain sample transaction sets from the participating organization.
- WHIE technical team authors Receiver, Filer, and Parser related to these messages and conducts tests internally based on sample sets provided. WHIE works through questions on data with the data provider.
- Test internally and then with participant on validation of data feeds, data element treatment, data representation, etc., as well as uses of the data.
- Incorporate the new data feeds in WHIE Public Health data view, reporting views, and other views as appropriate per agreement with Participant.
- Final testing and sign off by participant on data feeds.
- Testing of new data feeds by data user (e.g. Public Health staff).
- Training as needed for new users and account management.
- Addition of data feed in production views.

A similar but abbreviated process would apply to EP/Hospitals that desire to change their current system used to send information to WHIE to match new ONC standards and implementation specifications.

4.4. Funding

No funding has been identified for either option described above. New funding would have to be found or existing funding redirected.

5. Timeline

DPH seeks to have the capability to receive electronic test submissions (and continued submissions if the tests are successful) of immunization data and laboratory data for reportable conditions by April 2011. A decision on whether DPH will be able to offer syndromic surveillance as a third PH MU option must await further identification of costs and possible options to fund these costs.

Preliminary milestones follow:

- Goals for system readiness set: September 15, 2010.
- System gap analysis complete: October 1, 2010.
- Work and cost estimates complete: October 22, 2010.
- Project plan complete: November 1, 2010.
- Hardware/Software modifications complete: February 28, 2011.
- DPH/Partner/Vendor MU testing complete: March 31, 2011.
- Ready to accept MU tests from EP/Hospitals: April 4, 2011.

6. High-Level Tasks

Roadmap to PH Meaningful Use	August 9, 2010	April 1, 2011
Planning and Analysis	August 9, 2010	November 1, 2010
High level assessment of current capacity	August 9, 2010	August 19, 2010
Designate PH MU Project Manager/Coordinator	September 3, 2010	September 3, 2010
Set goal for system readiness	September 15, 2010	September 15, 2010
Develop project plan for meeting PH MU goals	August 9, 2010	October 22, 2010
Identify likely EP/Hospitals submitters	TBD	TBD
Identify likely EP/Hospitals volume	TBD	TBD
Perform system gap analysis	TBD	TBD
System gap analysis complete	October 1, 2010	October 1, 2010
Develop work/cost estimates	August 9, 2010	August 9, 2010
Work/cost estimates complete	TBD	TBD
Project plan completed	November 1, 2010	November 1, 2010
Determine relationship with other actors	TBD	TBD
Identify additional Medicaid requirements	TBD	TBD
Identify changes to privacy/security rules	TBD	TBD
Monitor evolving syndromic surveillance requirements	TBD	TBD
Monitor modifications/clarifications to MU requirements	TBD	TBD
Identify funding	TBD	TBD
Plan for workflow/workforce changes	TBD	TBD
Identify need for additional training	TBD	TBD
Communications	August 9, 2010	February 15, 2011

Develop communications strategy and plan	August 9, 2010	August 9, 2010
Report on goals to _____	September 22, 2010	September 22, 2010
Notify Regional Extension Centers of goals	September 22, 2010	September 22, 2010
Notify EP/Hospitals of goals	October 1, 2010	October 1, 2010
Report on gap analysis to _____	October 8, 2010	October 8, 2010
Report final implementation plans	November 22, 2010	November 22, 2010
Finalize test communications plan	November 23, 2010	February 15, 2011
Report readiness status to _____	February 15, 2011	February 15, 2011
Plan for offering technical assistance	TBD	TBD
Implementation	August 9, 2010	April 1, 2011
HW/SW modifications	November 23, 2010	February 28, 2011
Develop process to validate provider claims	TBD	TBD
Test ability to receive MU submission	March 1, 2011	March 31, 2011
Initiate tests and submissions	April 1, 2011	April 1, 2011

APPENDIX 9

State of Wisconsin

Date of enactment: **May 11, 2010**
2009 Assembly Bill 779 Date of publication*: **May 25, 2010**

2009 WISCONSIN ACT 274

AN ACT ***to renumber and amend*** 153.85, 153.86 and 153.90; ***to amend*** 20.435 (1) (hg), 146.37 (1g), 153.01 (intro.), 153.01 (4j) (b), 153.01 (8m), 153.05 (1) (b), 153.05 (2m) (a), 153.05 (2m) (b), 153.05 (2r) (intro.), 153.05 (2s), 153.05 (3) (a), 153.05 (3) (b), 153.05 (3) (c), 153.05 (8) (a), 153.05 (8) (b), 153.05 (9) (a), 153.05 (9) (b), 153.05 (9) (c), 153.455 (4), 153.50 (3) (b) (intro.), 153.50 (3) (c), 153.50 (3) (d), 153.50 (3m), 153.50 (5) (a) 4. b., 153.50 (6) (a), 153.50 (6) (b), 153.50 (6) (c) (intro.), 153.55, 153.60 (1), 153.75 (2) (a), 153.75 (2) (c) and 895.043 (2); and ***to create*** subchapter I (title) of chapter 153 [precedes 153.01], subchapter II (title) of chapter 153 [precedes 153.80], 153.80, 153.81 and 153.82 of the statutes; **relating to:** designation of a corporation to receive funding for electronic health information exchange, creation of a corporation, and making an appropriation.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.435 (1) (hg) of the statutes is amended to read:

20.435 **(1)** (hg) *General program operations; health care information.* The amounts in the schedule to fund the activities of the department of health services under ch. 153 ~~and~~, to contract with the data organization under s. 153.05 (2r), and to make payments to a corporation under s. 153.81 to support health information exchange. The contract fees paid under s. 153.05 (6m) and assessments paid under s. 153.60 shall be credited to this appropriation account.

SECTION 2. 146.37 (1g) of the statutes, as affected by 2009 Wisconsin Act 113, is amended to read:

146.37 **(1g)** Except as provided in s. ~~153.85~~ 153.76, no person acting in good faith who participates in the review or evaluation of the services of health care providers or facilities or the charges for such services conducted in connection with any program organized and operated to help improve the quality of health care, to avoid improper utilization of the services of health care providers or facilities or to determine the reasonable charges for such services, or who participates in the obtaining of health care information under subch. I of ch. 153, is liable for any civil damages as a result of any act or omission by such person in the course of such review or evaluation. Acts and omissions to which this subsection applies include, but are not limited to, acts or omissions by peer review committees or hospital governing bodies in censuring, reprimanding, limiting or revoking hospital staff privileges or notifying the medical examining board or podiatry affiliated credentialing board under s. 50.36 or taking any other disciplinary action against a health care provider or facility and acts or omissions by a medical director in reviewing the performance of emergency medical technicians or ambulance service providers.

SECTION 3. Subchapter I (title) of chapter 153 [precedes 153.01] of the statutes is created to read:

CHAPTER 153

* Section 991.11, WISCONSIN STATUTES 2007−08 : Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

SUBCHAPTER I
INFORMATION COLLECTION AND DISSEMINATION

SECTION 4. 153.01 (intro.) of the statutes is amended to read:

153.01 Definitions. (intro.) In this ~~chapter~~ subchapter:

SECTION 5. 153.01 (4j) (b) of the statutes is amended to read:

153.01 **(4j)** (b) Receives oversight with respect to services performed by the entity under this ~~chapter~~ subchapter from the secretary of health services.

SECTION 6. 153.01 (8m) of the statutes is amended to read:

153.01 **(8m)** "Public health authority" means the department or a person acting under this ~~chapter~~ subchapter under a grant of authority from or contract with the department.

SECTION 7. 153.05 (1) (b) of the statutes is amended to read:

153.05 **(1)** (b) The entity under contract under sub. (2m) (a) shall collect from hospitals and ambulatory surgery centers the health care information required of hospitals and ambulatory surgery centers by the department under ch. 153, 2001 stats., and the rules promulgated under ch. 153, 2001 stats., including, by the date "that is 18 months after the date of the contract under sub. (2m) (a), outpatient hospital−based services. The entity shall analyze and disseminate that health care information, as adjusted for case mix and severity, in the manner required under this ~~chapter~~ subchapter, under ch. 153, 2001 stats., and under the rules promulgated under ch. 153, 2001 stats., and in language that is understandable to laypersons.

SECTION 8. 153.05 (2m) (a) of the statutes is amended to read:

153.05 **(2m)** (a) Notwithstanding s. 16.75 (1), (2), and (3m), by the 2nd month after July 26, 2003, the department of administration shall, from the appropriation under s. 20.505 (1) (im), contract with an entity to perform services under this ~~chapter~~ subchapter that are specified for the entity with respect to the collection, analysis, and dissemination of health care information of hospitals and ambulatory surgery centers. The department of administration may not, by this contract, require from the entity any collection, analysis, or dissemination of health care information of hospitals and ambulatory surgery centers that is in addition to that required under this ~~chapter~~ subchapter.

SECTION 9. 153.05 (2m) (b) of the statutes is amended to read:

153.05 **(2m)** (b) Biennially, the group specified under s. 153.01 (4j) (b) shall review the entity's performance, including the timeliness and quality of the reports generated by the entity. If the group is dissatisfied with the entity's performance, the group may recommend to the department of administration that that department use a competitive request−for−proposal process to solicit offers from other organizations for performance of the services. If no organization responds to the request for proposal, the department of health services shall perform the services specified for the entity with respect to the collection, analysis, and dissemination of health care information of hospitals and ambulatory surgery centers under this ~~chapter~~ subchapter.

SECTION 10. 153.05 (2r) (intro.) of the statutes is amended to read:

153.05 **(2r)** (intro.) Notwithstanding s. 16.75 (1), (2), and (3m), from the appropriation account under s. 20.515 (1) (ut) the department of employee trust funds may expend up to $150,000, and from the appropriation accounts under s. 20.435 (1) (hg) and (hi) the department of health services, in its capacity as a public health authority, may expend moneys, to contract with a data organization to perform services under this ~~chapter~~ subchapter that are specified for the data organization under sub. (1) (c) or, if s. 153.455 (4) applies, for the department of health services to perform or contract for the performance of these services. As a condition of the contract under this subsection, all of the following apply:

SECTION 11. 153.05 (2s) of the statutes is amended to read:

153.05 **(2s)** Annually, the department of health services and the department of employee trust funds shall jointly prepare and submit under s. 13.172 (3) to standing committees of the legislature with jurisdiction over health issues a report on the activities of the data organization under this ~~chapter~~ subchapter.

SECTION 12. 153.05 (3) (a) of the statutes is amended to read:

153.05 **(3)** (a) Upon request of the department for health care information relating to health care providers other than hospitals and ambulatory surgery centers and, if s. 153.455 (4) applies, for health care claims information as specified in sub. (1) (c), state agencies shall provide that information to the department for use in preparing reports under this ~~chapter~~ subchapter.

SECTION 13. 153.05 (3) (b) of the statutes is amended to read:

153.05 **(3)** (b) Upon request of the entity under contract under sub. (2m) (a) for health care information relating to hospitals and ambulatory surgery centers, state agencies shall provide that health care information to the entity for use in preparing reports under this ~~chapter~~ subchapter.

SECTION 14. 153.05 (3) (c) of the statutes is amended to read:

153.05 **(3)** (c) Upon request of the data organization under contract under sub. (2r) for health care claims information, insurers and administrators may provide the health care claims information to the data organization for use in preparing reports and developing and maintain-

ing a central data repository under this ~~chapter~~ subchapter, and, if s. 153.455 (4) applies, insurers and administrators may provide the health care claims information as requested by the department.

SECTION 15. 153.05 (8) (a) of the statutes is amended to read:

153.05 **(8)** (a) Unless sub. (13) applies, subject to s. 153.455, the department shall collect, analyze and disseminate, in language that is understandable to laypersons, claims information and other health care information, as adjusted for case mix and severity, under the provisions of this ~~chapter~~ subchapter, as determined by rules promulgated by the department, from health care providers, other than hospitals and ambulatory surgery centers, specified by rules promulgated by the department. Data from those health care providers may be obtained through sampling techniques in lieu of collection of data on all patient encounters and data collection procedures shall minimize unnecessary duplication and administrative burdens. If the department collects from health care plans data that is specific to health care providers other than hospitals and ambulatory surgery centers, the department shall attempt to avoid collecting the same data from those health care providers.

SECTION 16. 153.05 (8) (b) of the statutes is amended to read:

153.05 **(8)** (b) Unless sub. (13) applies, the entity under contract under sub. (2m) (a) shall collect, analyze, and disseminate, in language that is understandable to laypersons, claims information and other health care information, as adjusted for case mix and severity, under the provisions of this ~~chapter~~ subchapter, from hospitals and ambulatory surgery centers. Data from hospitals and ambulatory surgery centers may be obtained through sampling techniques in lieu of collection of data on all patient encounters, and data collection procedures shall minimize unnecessary duplication and administrative burdens.

SECTION 17. 153.05 (9) (a) of the statutes is amended to read:

153.05 **(9)** (a) Subject to s. 153.455, the department shall provide orientation and training to health care providers, other than hospitals and ambulatory surgery centers, who submit data under this ~~chapter~~ subchapter, to explain the process of data collection and analysis and the procedures for data verification, comment, interpretation, and release.

SECTION 18. 153.05 (9) (b) of the statutes is amended to read:

153.05 **(9)** (b) The entity under contract under sub. (2m) (a) shall provide orientation and training to hospitals and ambulatory surgery centers that submit data under this ~~chapter~~ subchapter, to explain the process of data collection and analysis and the procedures for data verification, comment, interpretation, and release.

SECTION 19. 153.05 (9) (c) of the statutes is amended to read:

153.05 **(9)** (c) Subject to s. 153.455 (1) to (3), the data organization under contract under sub. (2r) shall provide orientation and training to insurers and administrators that submit data under this ~~chapter~~ subchapter, to explain the process of data collection and analysis and the procedures for data verification, comment, interpretation, and release. If s. 153.455 (4) applies, the department may perform or contract for the performance of the duties specified for the data organization under this paragraph.

SECTION 20. 153.455 (4) of the statutes is amended to read:

153.455 **(4)** If the contract with the data organization is terminated under sub. (3) and no organization responds to the request for proposals or a successor contract cannot be achieved, the department, in its capacity as a public health authority, shall collect health care information, including as specified under s. HFS 120.14 (1), Wis. Adm. Code, in effect on April 13, 2006, and may request health care claims information, which may be voluntarily provided by insurers or administrators, under this ~~chapter~~ subchapter; shall analyze and disseminate, or contract for the performance of analysis and dissemination of, the health care information; and may analyze and disseminate, or may contract for the performance of analysis and dissemination of, the health care claims information.

SECTION 21. 153.50 (3) (b) (intro.) of the statutes is amended to read:

153.50 **(3)** (b) (intro.) Remove and destroy all of the following data elements on the uniform patient billing forms that are received by the department, the entity, or the data organization under the requirements of this ~~chapter~~ subchapter:

SECTION 22. 153.50 (3) (c) of the statutes is amended to read:

153.50 **(3)** (c) Develop, for use by purchasers of data under this ~~chapter~~ subchapter, a data use agreement that specifies data use restrictions, appropriate uses of data and penalties for misuse of data, and notify prospective and current purchasers of data of the appropriate uses.

SECTION 23. 153.50 (3) (d) of the statutes is amended to read:

153.50 **(3)** (d) Require that a purchaser of data under this ~~chapter~~ subchapter sign and have notarized the data use agreement of the department, the entity, or the data organization, as applicable.

SECTION 24. 153.50 (3m) of the statutes is amended to read:

153.50 **(3m)** PROVIDER, ADMINISTRATOR, OR INSURER MEASURES TO ENSURE PATIENT IDENTITY PROTECTION. A health care provider that is not a hospital or ambulatory surgery center or an insurer or an administrator shall, before submitting information required by the department, or by the data organization under contract under s.

153.05 (2r), under this ~~chapter~~ subchapter, convert to a payer category code as specified by the department or the data organization, as applicable, any names of an insured's payer or other insured's payer.

SECTION 25. 153.50 (5) (a) 4. b. of the statutes is amended to read:

153.50 **(5)** (a) 4. b. Any federal or state statutory requirement to uphold the patient confidentiality provisions of this ~~chapter~~ subchapter or patient confidentiality provisions that are more restrictive than those of this ~~chapter~~ subchapter; or, if the latter evidence is inapplicable, an agreement, in writing, to uphold the patient confidentiality provisions of this ~~chapter~~ subchapter.

SECTION 26. 153.50 (6) (a) of the statutes is amended to read:

153.50 **(6)** (a) The department or entity under contract under s. 153.05 (2m) (a) may not require a health care provider submitting health care information under this ~~chapter~~ subchapter to include the patient's name, street address or social security number.

SECTION 27. 153.50 (6) (b) of the statutes is amended to read:

153.50 **(6)** (b) The department may not require under this ~~chapter~~ subchapter a health care provider that is not a hospital or ambulatory surgery center to submit uniform patient billing forms.

SECTION 28. 153.50 (6) (c) (intro.) of the statutes is amended to read:

153.50 **(6)** (c) (intro.) A health care provider that is not a hospital or ambulatory surgery center may not submit any of the following to the department under the requirements of this ~~chapter~~ subchapter:

SECTION 29. 153.55 of the statutes is amended to read:

153.55 Protection of confidentiality. Data obtained under this ~~chapter~~ subchapter is not subject to inspection, copying or receipt under s. 19.35 (1).

SECTION 30. 153.60 (1) of the statutes is amended to read:

153.60 **(1)** The department shall, by the first October 1 after the commencement of each fiscal year, estimate the total amount of expenditures under this ~~chapter~~ subchapter for the department for that fiscal year for data collection, database development and maintenance, generation of data files and standard reports, orientation and training provided under s. 153.05 (9) (a) and contracting with the data organization under s. 153.05 (2r). The department shall assess the estimated total amount for that fiscal year, less the estimated total amount to be received for purposes of administration of this ~~chapter~~ subchapter under s. 20.435 (1) (hi) during the fiscal year and the unencumbered balance of the amount received for purposes of administration of this ~~chapter~~ subchapter under s. 20.435 (1) (hi) from the prior fiscal year, to health care providers, other than hospitals and ambulatory surgery centers, who are in a class of health care providers from whom the department collects data under this ~~chapter~~ subchapter in a manner specified by the department by rule. The department shall work together with the department of regulation and licensing to develop a mechanism for collecting assessments from health care providers other than hospitals and ambulatory surgery centers. No health care provider that is not a facility may be assessed under this subsection an amount that exceeds $75 per fiscal year. All payments of assessments shall be credited to the appropriation under s. 20.435 (1) (hg).

SECTION 31. 153.75 (2) (a) of the statutes is amended to read:

153.75 **(2)** (a) Exempting certain classes of health care providers that are not hospitals or ambulatory surgery centers from providing all or portions of the data required under this ~~chapter~~ subchapter.

SECTION 32. 153.75 (2) (c) of the statutes is amended to read:

153.75 **(2)** (c) Providing for the efficient collection, analysis and dissemination of health care information which the department may require under this ~~chapter~~ subchapter.

SECTION 33. Subchapter II (title) of chapter 153 [precedes 153.80] of the statutes is created to read:

CHAPTER 153

SUBCHAPTER II

ELECTRONIC HEALTH INFORMATION EXCHANGE

SECTION 34. 153.80 of the statutes is created to read:

153.80 Definitions. In this subchapter:

(1) "Department" means the department of health services.

(2) "Health care provider" has the meaning given in s. 146.81 (1) and includes an ambulatory surgery center, which has the meaning given for "ambulatory surgical center" under 42 CFR 416.2.

(3) "Secretary" means the secretary of health services.

(4) "State−designated entity" means a nonprofit corporation designated by the state as eligible to apply for and receive grants under 42 USC 300jj−33 from the secretary of the U.S. department of health and human services.

SECTION 35. 153.81 of the statutes is created to read:

153.81 Requirements for designation and funding. (1) The state may designate a nonprofit corporation that is incorporated under ch. 181 as the state−designated entity only if the secretary determines that all of the following conditions are satisfied:

(a) The articles of incorporation or bylaws of the corporation state that a purpose of the corporation is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information.

(b) The corporation annually evaluates, analyzes, and reports to the secretary on the progress toward imple-

menting statewide health information exchange and how the health information exchange efforts are enabling meaningful use of certified electronic health record technology, as defined in 42 USC 300jj and by the U.S. department of health and human services by regulation, by health care providers.

(c) The corporation complies with the requirements to be a qualified state−designated entity under 42 USC 300jj−33 (f) (2) to (5) and to receive a grant under 42 USC 300jj−33.

(d) The governing structure and bylaws of the corporation allow it to consult and consider recommendations from all of the persons specified under 42 USC 300jj−33 (g) (1) to (10) in carrying out statewide health information exchange.

(e) The board of directors of the corporation includes all of the following persons:

1. The state health officer, as defined under s. 250.01 (9), or his or her designee.

2. The person who is appointed by the secretary to be the director of the Medical Assistance program, or his or her designee.

3. One person who is specified by the governor, or his or her designee.

4. One or more persons who represent each of the following such that the representation of the public and private health sector is balanced in the board's representation:

a. Health care providers.

b. Health insurers or health plans.

c. Employers who purchase or self−insure employee health care.

d. Health care consumers or consumer advocates.

e. Higher education.

(f) The corporation agrees to fulfill all of the following purposes:

1. Building substantial health information exchange capacity statewide to support all of the following:

a. Health care providers' meaningful use of electronic health records.

b. Population health improvement.

c. Reporting of health care performance.

2. Developing policies and recommending legislation that advance efficient statewide and interstate health information exchange and that protect consumer privacy.

3. Developing or facilitating the creation of a statewide technical infrastructure that supports statewide health information exchange and enables interoperability among users of health information.

4. Coordinating between the Medical Assistance and public health programs to enable information exchange and promote meaningful use of electronic health records.

5. Providing oversight and accountability for health information exchange to protect the public interest.

6. Increasing public awareness of and support for statewide health information exchange and fostering agreement among health care providers and other users of health care information on an approach to statewide health information exchange.

7. Adopting standards for health information exchange in accordance with national standards, implementation protocols, and reporting requirements.

8. Prioritizing among health information exchange services according to the needs of the residents of this state.

9. Managing and sustaining funding necessary to develop and sustain statewide health information infrastructure and services.

10. Conducting or overseeing health information exchange business and technical operations, including providing technical assistance to health information organizations and other health information exchanges.

11. Developing or facilitating the creation and use of shared directories and technical services, as applicable to statewide health information exchange.

12. Creating a model, uniform statewide patient consent and authorization process to allow electronic access to, review of, or disclosure of a patient's identifiable health care information.

13. Certifying regional health information exchange networks, if any, and confirming that any regional health information exchange network meets the criteria to participate in and connect to the statewide health information exchange network.

14. Monitoring health information technology and health information exchange efforts nationally and facilitating alignment of statewide, interstate, and national health information exchange strategies.

15. Developing programs and initiatives to promote and advance health information exchange to improve the safety, quality, and efficiency of health care and to reduce waste due to redundancy and administrative costs.

(2) The department may make payments to a nonprofit corporation that is incorporated under ch. 181 to support health information exchange if the secretary determines that the conditions under sub. (1) are satisfied.

SECTION 36. 153.82 of the statutes is created to read:

153.82 Creation of corporation. (1) The secretary may organize and assist in maintaining a nonstock, nonprofit corporation under ch. 181 for all of the purposes specified under s. 153.81 (1) (f).

(2) If the secretary organizes a corporation under sub. (1), the secretary shall appoint all of the individuals specified under s. 153.81 (1) (e) 1. to 4. as initial directors of the board of the corporation.

(3) The assets and liabilities of the corporation under sub. (1) shall be separate from all other assets and liabilities of the state, of all political subdivisions of the state, and of the department. The state, any political subdivision of the state, and the department do not guarantee any obligation of or have any obligation to the corporation.

The state, any political subdivision of the state, and the department are not liable for any debt or liability of the corporation.

SECTION 37. 153.85 of the statutes is renumbered 153.76 and amended to read:

153.76 Civil liability. Except as provided in s. ~~153.86~~ 153.77, any person violating s. 153.50 or rules promulgated under s. 153.75 (1) (a) is liable to the patient for actual damages and costs, plus exemplary damages of up to $1,000 for a negligent violation and up to $5,000 for an intentional violation.

SECTION 38. 153.86 of the statutes is renumbered 153.77, and 153.77 (1) (intro.), as renumbered, is amended to read:

153.77 **(1)** (intro.) A health care provider that submits information to the department under this ~~chapter~~ subchapter is immune from civil liability for all of the following:

SECTION 39. 153.90 of the statutes is renumbered 153.78, and 153.78 (2), as renumbered, is amended to read:

153.78 **(2)** Any person who violates this ~~chapter~~ subchapter or any rule promulgated under the authority of this ~~chapter~~ subchapter, except ss. 153.45 (5), 153.50 and 153.75 (1) (a), as provided in s. ~~153.85~~ 153.76 and sub. (1), shall forfeit not more than $100 for each violation. Each day of violation constitutes a separate offense, except that no day in the period between the date on which a request for a hearing is filed under s. 227.44 and the date of the conclusion of all administrative and judicial proceedings arising out of a decision under this section constitutes a violation.

SECTION 40. 895.043 (2) of the statutes is amended to read:

895.043 **(2)** SCOPE. This section does not apply to awards of double damages or treble damages, or to the award of exemplary damages under ss. 46.90 (9) (a) and (b), 51.30 (9), 51.61 (7), 55.043 (9m) (a) and (b), 103.96 (2), 134.93 (5), 146.84 (1) (b) and (bm), ~~153.85~~ 153.76, 252.14 (4), 252.15 (8) (a), 610.70 (7) (b), 943.245 (2) and (3) and 943.51 (2) and (3).

APPENDIX 10

Wisconsin Relay of Electronic Data (WIRED) for Health June 29, 2010

Request for Applications

The Wisconsin Department of Health Services and WIRED for Health Board seek a permanent, state-level, private-public, non-profit governing entity for statewide Health Information Exchange (HIE) that will effectively execute the State HIT Strategic and Operational Plan and fairly represent the needs of all consumers of health information.

Letters of intent to apply must be submitted and postmarked by July 19, 2010

Applications must be received by 4:30 pm CDT on August 24, 2010.

Wisconsin Department of Health Services
1 West Wilson Street, Room 250
Madison, Wisconsin 53703

PUBLIC NOTIFICATION

This announcement requests applications from qualified non-profit health information organizations to be considered for designation as the State Designated Entity (SDE) for state-level health information exchange governance and to receive grant funding through a contract with the Wisconsin Department of Health Services to implement the Wisconsin HIT Strategic and Operational Plan for statewide health information exchange. ***Applicants interested in responding to this announcement are required to submit a letter of intent to apply postmarked or emailed by July 19, 2010 before midnight CDT and a response to the RFA Questionnaire by 4:30 pm CDT on August 24, 2010.***

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Introduction

The Wisconsin Department of Health Services ("the Department") is designated to lead and coordinate implementation of the State's eHealth program to drive improvements in Wisconsin's health care quality, safety, transparency, efficiency, and cost effectiveness through statewide adoption and use of electronic health records (EHR) and health information exchange (HIE). A critical step towards achieving the state's eHealth goals is to select and designate a state-level entity, with broad stakeholder representation, that is organized to assume a distinct state-level HIE governance role and oversee the development and implementation of a statewide HIE business and technical infrastructure and services in Wisconsin.

This Request for Application (RFA) is put forth by the Wisconsin Relay of Electronic Data (WIRED) for Health Project, a private-public collaboration between the Department and a broad cross section of health care stakeholders planning for statewide HIE. The purpose of the RFA is to identify a private-public, non-profit entity to become the State Designated Entity (SDE) for Wisconsin to govern the implementation of a statewide health information network and HIE services. The WIRED for Health Project includes a Board of Directors and five committees that are responsible for establishing goals and objectives the SDE will implement. The five committees are: Governance; Finance and Audit; Standards and Architecture; Legal and Policy; and Communications, Education, and Marketing.

The WIRED for Health Board is requesting qualified applicants to provide comprehensive responses to a Questionnaire covering their company background and experience, implementation approach, and content knowledge and expertise related to the complexities of implementing a statewide health information network and services, including governance, privacy and security strategies to protect patient information, and a sustainable business model. The primary objective of HIE is to support and enable high quality, safe, and effective health care; and overall improvements in the Wisconsin population's health. The following principles are fundamental to the success of a statewide health information network in Wisconsin:

1. HIE is consumer-centric and consistently keeps at the forefront of decision-making the interests of the individuals whose personal health information is stored or exchanged.
2. The governance entity for the statewide health information network is transparent and inclusive, with a collaborative structure built on a private-public partnership to guide the planning, development, and implementation of HIE.
3. To the extent practical, HIE services support connectivity to the full range of stakeholders in the state health care community.
4. The HIE infrastructure and services have a business model that is sustainable and considers both who benefits from data sharing and who bears the cost.
5. The implementation of a statewide health information network and HIE services aligns with nationally recognized standards to ensure cost-effective implementation and interoperability within the State, with neighboring states, and with the Nationwide Health Information Network (NHIN).
6. The HIE service provider protects patient privacy and confidentiality and assures that both the storage and transmission of data are secure and consistent with HIPAA privacy and security requirements and provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act.
7. Data are appropriately accessible to properly authenticated individuals with the appropriate authorizations, and includes specific, formal penalties for inappropriate access and misuse of data.
8. The statewide health information network and HIE services help providers achieve CMS' ongoing meaningful use requirements.
9. The statewide health information network architecture is flexible and robust enough to eventually support approved secondary uses of the data for public health purposes, health services research, comparative effectiveness research, and quality and performance reporting, using identified, de-identified, or anonymized data as appropriate and as allowed by the consumer.

This RFA seeks qualified organizations that can govern and oversee the implementation of the statewide health information network and services. Although exchange-like entities exist and are likely to develop within communities or service areas to link entities within an integrated delivery network or link physicians to hospitals, the Office of the National Coordinator (ONC) for Health IT requires, as a condition of the State HIE Cooperative Agreement with the State, development of statewide and interstate interconnectivity to enable health information exchange across the state and the state borders. Responders to this RFA must demonstrate an understanding of the governance structure necessary to develop and maintain a state-level health information organization and a statewide HIE technical infrastructure and services capable of interstate and nationwide exchange and interoperability.

Background

In November 2005, Governor Jim Doyle created a multidisciplinary advisory board, the eHealth Care Quality and Patient Safety Board ("the eHealth Board") through Executive Order #129. The Governor appointed the Board members and designated the Department Cabinet Secretary to chair the Board in early 2006. He charged the eHealth Board with creating an Action Plan for Health Care Quality and Patient Safety ("eHealth Action Plan") to guide legislative and regulatory actions, encourage coordinated efforts in the private health care sector, further private and public partnerships for the development of a statewide health information infrastructure, and maximize federal financial participation to support the goal of the early adoption of an eHealth information infrastructure. The eHealth Board created five workgroups in 2006: Patient Care, Information Exchange, Consumer Interests, Governance, and Financing, to comprehensively review issues surrounding the creation of an eHealth information infrastructure in Wisconsin and develop guidance, strategies, and recommendations for creating this infrastructure to transform Wisconsin's health care delivery system and population health.

The workgroups were chaired by eHealth Board members and included volunteers from the private and public health care stakeholder community across Wisconsin. The result of their work was the eHealth Action Plan, which outlines high-level goals and strategies for statewide health information technology (HIT) adoption and HIE. The Plan also serves as a guide for the HIT and HIE planning and implementation activities.

As in many other states, there is a flurry of independent HIE-related initiatives being executed at local levels throughout Wisconsin. Exchange of health information in Wisconsin is currently fragmented with efforts primarily being coordinated within Integrated Delivery Networks (IDNs) and large hospital systems. A number of IDNs are exchanging health information regionally with a limited set of affiliated business partners, but are not exchanging information statewide or with unaffiliated health care providers. Despite a high EHR adoption rate in Wisconsin, barriers such as privacy and security concerns; outdated medical records laws; lack of perceived value to providers, payers, and the public; and resource and funding constraints have slowed progress towards achieving inter-organizational HIE connectivity and capacity.

In October 2009, the Department applied to participate in a State HIE Cooperative Agreement Program (CAP) under the American Recovery and Reinvestment Act (ARRA) of 2009. In February 2010, the Department was awarded $9.441 million through this program operated by the ONC of the U.S. Department of Health and Human Services (HHS). In December 2009, Governor Doyle signed Executive Order #303, creating the WIRED for Health Board, a private-public board charged with developing statewide HIE capacity and addressing HIE governance, finance, technical infrastructure, operations, and policy/legal needs. The Board is responsible for and is currently developing Wisconsin's Strategic and Operational Plan for statewide HIE, which must be submitted to the ONC by August 31, 2010 for review and approval. Governor Doyle appointed members to the WIRED for Health Board on February 23, 2010. The Board established committees in March made up of private and public sector volunteers to complete the planning for a statewide health information network and services.

Executive Order #303 directed that the WIRED for Health Board would exist until a qualified, non-profit corporation is designated by the Governor or created and designated in statute specifically for the purpose of governing the implementation and operation of statewide HIE services. On May 11, 2010, Governor Doyle signed into law 2009 Wisconsin Act 274, the WIRED for Health Act, which authorizes the Secretary of the Department of Health Services to create or designate a qualified organization for the

purposes stated in the Executive Order. The SDE will be able to receive a portion of the federal ARRA State HIE CAP funding as a sub-grantee through a contract with the Department to implement the Wisconsin HIT Strategic and Operational Plan. Selection of a corporation to serve as the SDE will occur through this RFA process. After selection, the Department will negotiate a formal contract with the SDE; and once the contract is executed, responsibilities of the existing WIRED for Health Board will be transitioned to the SDE's governing board of directors.

Health information technology can help improve health care quality, prevent medical errors, reduce health care costs, and improve population health by providing essential information at the time and place of care delivery and to public health. If we are to achieve a more efficient and effective health care delivery system, there are two principal tasks: assuring that relevant clinical data (and decision support) are available at the time and place of care and assuring that information developed in the course of real-world treatment contributes to our knowledge and further shapes the practice of medicine and public health. Further, there are two crucial precursors to effective HIE: widespread use of EHRs by providers and the ability to exchange health information securely and cost efficiently. While both EHR adoption and HIE capacity development are challenging projects conceptually, technologically, and economically, the development of secure information exchange poses special challenges in engaging all stakeholders in the effort to develop and establish a statewide health information network. Trusted HIE requires the involvement of multiple stakeholders and the consideration of a broad range of policies, principles, and designs.

The State's vision for HIE governance is to have a holistic, enterprise-wide view with a permanent multi-disciplinary, multi-stakeholder governing entity to efficiently and effectively manage a statewide HIE infrastructure and to leverage this infrastructure to improve health care outcomes and population health. The State's adoption of the national interoperability standards will include ongoing support of and coordination with the ONC's vision for the Nationwide Health Information Network. The State is also working in close coordination with the Medicaid and Medicare programs to ensure all activities are consistent with and enable the implementation of the Medicaid and Medicare HIT incentive payment programs and meaningful use of EHRs by providers. This shall be reflected in the governance structure, policy framework, HIE services, progress tracking, and outcomes. The State's WIRED for Health project to plan for the statewide health information network and HIE services is working collaboratively and jointly with the State Medicaid program while it develops a State Medicaid HIT Plan (SMHP) according to the guidelines provided by ARRA section 4201 and the Centers for Medicare and Medicaid Services (CMS). The SDE and its partners and subcontractors are expected to comply with the privacy and security provisions of the ARRA HITECH Act, the HIPAA Privacy Rule, the HIPAA Security Rule, Confidentiality of Alcohol and Other Drug Abuse (AODA) Patient Records Regulations, the HSS Privacy and Security Framework and the developing guidance and rules from the ONC and CMS while implementing Wisconsin's HIT Strategic and Operational Plan.

Links to the State HIE CAP Funding Opportunity Announcement (FOA) and the ARRA HITECH Act provisions and requirements can be found on the eHealth Web site at http://dhs.wisconsin.gov/ehealth. Appendix E includes the ARRA HITECH Act Section 3013 provisions and requirements which are applicable to the SDE. Any responder to this RFA should be familiar with the FOA and the ARRA HITECH Act, particularly Section 3013, provisions and requirements.

SDE Governance Entity Implementation

Interoperable HIE networks and services promise to transform the current health care system by giving providers access to the right information at the right time to reduce the overall costs of health care and ensure consumers have access to the highest quality, most efficient, and safest care. These networks and services will also improve the timeliness of information exchange between public health and clinical care and reduce the administrative costs of paper communication. Building successful HIE infrastructure and services requires considerable planning in order to implement a business model that creates incentives for use, and recognizes the need for those stakeholders that derive value and benefits by using the statewide health information network and services to fund the costs of HIE. The goal of HIE in

Wisconsin is to create an interconnected, consumer-driven electronic health care delivery system and to facilitate access to and retrieval of clinical data to enable safe, timely, efficient, effective, equitable, and patient-centered care.

A statewide and nationwide health information network will provide the capability to move health care information electronically across organizations and between disparate health care information systems. The private-public collaborative state-level HIE governing entity envisioned must ensure all major stakeholder groups are involved in the ongoing planning and implementation.

Both the State HIE CAP and 2009 Wisconsin Act 274 provide that the SDE is to be a non-profit organization that functions as a multi-stakeholder, private-public governance entity. The SDE will carry out the mission, goals, and objectives defined in the Wisconsin HIT Strategic and Operational Plan approved by the ONC. The Board of the SDE shall include both private and public sector members. Additionally, the State will support the work of the SDE in a variety of ways, including through efforts of the State Health IT Coordinator (see Appendix D for the Role of the State Health IT Coordinator) and by providing grant funding through the State HIE CAP.

The governance entity must build upon established relationships and stakeholders' HIT investments in Wisconsin, and leverage the work of existing multi-stakeholder health information organizations that are active and successful. Stakeholders indicated in statewide HIE regional summits last summer that they prefer a private-public, non-profit governance option over more direct state government governance. This preference reflects a perception that state government is limited in its ability to respond quickly and effectively, especially given economic constraints, and that state government typically does not provide the type of functions required of a governance entity for statewide HIE.

Distancing HIE development from direct government involvement is deliberate. A private-public governing entity will foster more robust private sector inputs and investment as part of a collaborative strategy that promotes flexibility and responsiveness. It will also stimulate negotiated approaches to HIE innovation across both private and public sectors in response to the rapidly evolving context for nationwide HIE Interoperability. Success of this model is highly dependent on an HIE governance entity achieving a level of operational maturity to facilitate HIE development to meet State HIE CAP and nationwide interoperability requirements.

The following table from the State HIE Toolkit, developed under the auspices of the State HIE Program sponsored by the ONC, sets forth the roles and organizational functions of the SDE. It is important to note that the SDE does not have to be the technical operator for the statewide health information network and HIE services, nor does the State expect it to be the technical operator. At a minimum, the SDE will be expected to manage procurements and contracts for the technical services and operations.

Overview of Key HIE Roles and Organizational Functions

State Government (executive, legislative, agencies) **HIE Coordinator**	**SDE Governance Entity** (Government-hosted, -sponsored, or authorized formal private-public organizational structure)		**SDE Governance Entity, its Subsidiary, and/or via Contracted HIE Operator**
Policy / Oversight / Accountability	**Convening/Consensus**	**Coordinating**	**Technical HIE Operations**
Set health policy goals (reform priorities) • HIE as part of policy agenda **Endorse statewide HIE plan** • Ensure adequate stakeholder input	**Organizational leadership & operations** • Trusted neutral venue for stakeholder participation • Establish trust among stakeholders	**Facilitate statewide HIE implementation** • Address barriers, mitigation • Lead HIE Plan development and/or implementation	**Own or manage contracts for hardware, software, & technical capacity to facilitate statewide HIE:** • Infrastructure

• Allocate resources **Statutory/regulatory/ mechanisms** • Agency support in HIE plan incentives for industry HIE participation • Align confidentiality protections • Authorize HIE governance model • Authorize state HIE funding mechanism **Direct State Agency HIE policy and program development/coordination** • Medicaid, public health, state employees HIE participation **Assess progress with statewide HIE development** • Monitoring and evaluation • Public reporting	• Support board, committee, other public/private stakeholder participation structures • Facilitate stakeholder consensus and buy in • Recruit HIE participants • Develop business plan and sustainable financing • Manage finances & business operations **Expertise, information, relationships** • Monitor & inform regarding HIE development (all levels) • Forge effective working relationships • Facilitate consumer input & public communications **Facilitate collaborative development of public policy options to advance HIE** • Inform agencies/policy-makers/stakeholders about needs and opportunities • Provide analysis / implications of policy options under consideration	**Facilitate state alignment with interstate, regional, and national HIE strategies** • Lead/participate in collaborative HIE development initiatives **Promote standards, consistent HIE policies, practices** • Diffuse prevailing national standards • Develop consensus for statewide data sharing • Monitor, enforce HIE policies **Contribute HIE perspectives and expertise to ongoing health care reform efforts** • Foster collaborative public/private approaches to harmonize health care quality improvement efforts	components (e.g., Master Patient Index, Record Locator Service, Interfaces, Data Repositories etc.), • Applications (e.g., Meaningful Use Reporting, Business and Clinical Decision Support, Clinical Systems, etc.), • Services (e.g., implementation guides / supports, standards, workflow optimization, coordination with REC)

Goals and High-Level Time Line for SDE

Wisconsin will establish a permanent, state-level, private-public, non-profit governing entity for statewide HIE that effectively executes the State HIT Strategic and Operational Plan and fairly represents the needs of all consumers of health information.

- By June 30, 2010 the Board will have established an open and transparent process for identification of qualified applicants and selection of the State Designated Entity.
- By October 1, 2010 the State will have selected the State Designated Entity.
- By February 1, 2011 the State Designated Entity will assume responsibility for execution of the Wisconsin HIT Strategic and Operational Plan.

Conditions and Minimum Requirements

This RFA outlines the conditions and minimum requirements below for non-profit organizations interested in developing a comprehensive response to organizing a permanent, state-level governance structure that is organizationally stable and financially sound to oversee the development, implementation, and

operation of an interoperable statewide health information network and HIE services. The SDE must comply with the legislative requirements of 2009 Wisconsin Act 274. The WIRED for Health Board is developing a Wisconsin HIT Strategic and Operational Plan including the Vision, Mission, and Guiding Principles that the selected applicant SDE must embrace and adopt. The SDE must implement the plans for the statewide health information network and HIE services in accordance with Wisconsin's HIT Strategic and Operational Plan as approved by the ONC. The SDE, as a federal HITECH Act sub-grantee, must also comply with the State HIE CAP FOA requirements and any additional requirements promulgated by the ONC through the CAP.

Once the SDE is selected, the Department and the organization will execute a contract to formally designate the SDE and sub-grant funding to the organization for implementing the Strategic and Operational Plan. Grant funding is released under the State HIE CAP when required milestones set by the ONC are reached by the State or the SDE. The Department's contract with the SDE will include a payment schedule based on the ONC-specified milestones and the ONC's State HIE CAP Notice of Grant Award terms and conditions. The State HIE CAP FOA and the Notice of Grant Award explain how the grant funding is allocated and may be used, and the requirements for matching funds, which can include in-kind contributions. The current Notice of Grant Award for planning can be found at http://dhs.wisconsin.gov/ehealth/WIREDforHealth/index.htm. The ONC will issue a new Notice of Grant Award to Wisconsin when the ONC receives and approves Wisconsin's Strategic and Operation Plan. ONC expects Wisconsin to submit its plan by August 31, 2010 and will take about 6 weeks to approve the plan and issue the new Notice of Grant award for implementation, around October 1, 2010. The State Health IT Coordinator is and will continue to be funded by the grant. All remaining implementation grant funding will be allocated to the SDE. Most of the other state costs incurred working on this grant project during the implementation phase will be funded by a state program revenue appropriation and will count towards the match requirements that begin October 1, 2010.

The State acknowledges that the HIT and HIE landscape at the federal and state level is evolving and some of the requirements of the ONC's State HIE CAP are not yet well defined. Therefore, while the SDE is expected to implement the HIT Strategic and Operational Plan developed by the WIRED for Health Board, it is a plan based on the requirements of the State HIE CAP as it exists today. The State understands and expects that the SDE's governing board of directors may need to adjust the plan, including the vision, mission, guiding principles, goals, and objectives; and timelines to meet environmental changes and evolving requirements, standards, and regulations. Changes to the plan and timelines will have to be coordinated with the Department and approved by the ONC under the terms and conditions of the State HIE CAP.

NOTE: Applicants may view the current draft of the Wisconsin HIT Strategic and Operational Plan on the WIRED for Health Microsoft SharePoint site. To sign up for access to the site, go to: http://wiredboard.wisconsin.gov/Reference/index.htm

Legislative Requirements of the SDE

2009 Wisconsin Act 274, Section 35, states that the Department may designate an organization as the State Designated Entity for governance of HIE and make payments to a non-profit corporation that is incorporated under Chapter 181 to support health information exchange if the secretary determines that the following conditions are satisfied:

1. The articles of incorporation or bylaws of the corporation state that a purpose of the corporation is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information.

2. The corporation annually evaluates, analyzes, and reports to the Secretary on the progress toward implementing statewide health information exchange and how the health information exchange efforts are enabling meaningful use of certified electronic health record technology, as defined in 42 USC 300jj and by the U.S. Department of Health and Human Services by regulation of health care providers.

3. The corporation complies with the requirements to be a qualified state-designated entity under 42 USC 300jj-33 (f) (2) to (5) and to receive a grant under 42 USC 300jj-33.

4. The governing structure and bylaws of the corporation allow it to consult and consider recommendations from all of the persons specified under 42 USC 300jj-33 (g) (1) to (10) in carrying out statewide health information exchange.

5. The board of directors of the corporation includes all of the following persons:
   a. The state health officer, as defined under s. 250.01 (9), or his or her designee.
   b. The person who is appointed by the Secretary to be the director of the Medical Assistance program, or his or her designee.
   c. One person who is specified by the Governor, or his or her designee.
   d. One or more persons who represent each of the following such that the representation of the public and private health sector is balanced in the board's representation:
      i. Health care providers.
      ii. Health insurers or health plans.
      iii. Employers who purchase or self-insure employee health care.
      iv. Health care consumers or consumer advocates.
      v. Higher education.

6. The corporation agrees to fulfill all of the following purposes:
   a. Building substantial health information exchange capacity statewide to support all of the following:
      i. Health care providers' meaningful use of electronic health records.
      ii. Population health improvement.
      iii. Reporting of health care performance.
   b. Developing policies and recommending legislation that advance efficient statewide and interstate health information exchange and that protect consumer privacy.
   c. Developing or facilitating the creation of a statewide technical infrastructure that supports statewide health information exchange and enables interoperability among users of health information.
   d. Coordinating between the Medical Assistance and public health programs to enable information exchange and promote meaningful use of electronic health records.
   e. Providing oversight and accountability for health information exchange to protect the public interest.
   f. Increasing public awareness of and support for statewide health information exchange and fostering agreement among health care providers and other users of health care information on an approach to statewide health information exchange.
   g. Adopting standards for health information exchange in accordance with national standards, implementation protocols, and reporting requirements.
   h. Prioritizing among health information exchange services according to the needs of the residents of this state.
   i. Managing and sustaining funding necessary to develop and sustain statewide health information infrastructure and services.
   j. Conducting or overseeing health information exchange business and technical operations, including providing technical assistance to health information organizations and other health information exchanges.

k. Developing or facilitating the creation and use of shared directories and technical services, as applicable to statewide health information exchange.
l. Creating a model, uniform statewide patient consent and authorization process to allow electronic access to, review of, or disclosure of a patient's identifiable health care information.
m. Certifying regional health information exchange networks, if any, and confirming that any regional health information exchange network meets the criteria to participate in and connect to the statewide health information exchange network.
n. Monitoring health information technology and health information exchange efforts nationally and facilitating alignment of statewide, interstate, and national health information exchange strategies.
o. Developing programs and initiatives to promote and advance health information exchange to improve the safety, quality, and efficiency of health care and to reduce waste due to redundancy and administrative costs.

ONC Reporting, Performance Measures, Project Management, and Evaluation Requirements

The ONC State HIE CAP has specific Reporting, Performance Measures, Project Management, and Evaluation requirements with which grantees (State Departments or State Designated Entities on behalf of State Departments) must comply to receive funding for HIE planning and implementation activities. These requirements are ongoing for the period of the cooperative agreement with the ONC and must be met as a condition of grant funding. Details on these requirements are included in Appendix C.

In Wisconsin, the Department of Health Services is the State HIE CAP grantee and the SDE will be a sub-grantee recipient under a contract with the Department. Both the Department and the SDE will be subject to the HIE CAP reporting requirements. However, as the principal grantee, the Department retains responsibility for submitting all required reports to the Federal government. The contract between the Department and the SDE will specify that the SDE must collect and submit all information needed for the federal reports to the Department as described in the State HIE CAP FOA, the Notice of Grant Award, and any supplemental program guidance ONC provides throughout the period of the cooperative agreement.

WIRED for Health Requirements

The SDE must:

1. Embrace and execute the Vision, Mission, and Guiding Principles put forth by the WIRED for Health Board.
2. Implement the Wisconsin HIT Strategic and Operational Plan submitted to and approved by the ONC.
3. Commit to the principles of collaboration, transparency, buy in and trust as a manner of conducting business and making business decisions.
4. Demonstrate the ability to perform or commitment to build performance capabilities to successfully execute stated requirements.

Letter of Intent to Apply

Applicants must submit a letter of intent to apply for this opportunity by July 19, 2010. The letter may not exceed five pages (11 point font or higher and 1-inch margins), and must be either postmarked by July 19, 2010 and mailed to:

Denise Webb, State Health IT Coordinator
1 West Wilson Street, Room 250
Madison, Wisconsin 53703

or signed and electronically scanned and e-mailed to ehealth@wi.gov.

Those organizations which do not submit a letter of intent to apply will not be considered eligible, and their applications will not be reviewed.

Questionnaire

To apply for consideration to be the Wisconsin SDE, applicants must address and provide a written response to all of the items in the RFA Questionnaire section below in a manner that provides sufficient detail to substantiate their responses. The applicants are at liberty to expand upon the information requested in the Questionnaire. Applications will be scored according to the rating parameters defined in the Review and Selection Process included in this RFA.

Joint applications are welcome. Organizations that individually submit a letter of intent to apply can subsequently join with other organizations and submit a joint application. Multiple organizations that wish to jointly form an organization that could be the SDE can submit a single, joint application. In such a case, a single response to each Questionnaire item on behalf of all the joint applicants is sufficient, except each organization included in the joint application should separately respond to the items marked with an asterisk.[1]

Company Overview

Please provide the following information regarding your organization or consortia of organizations.

1. Provide contact information for the principal individual(s) to be contacted regarding the information in this RFA.
2. Provide a brief background on your company including an overview of your company's core business.*
3. State how long your company has been in business.*
4. Provide information about your company's current financial status, including 2 years of recent audited financial statements or similar evidence of financial soundness.*
5. 2009 Wisconsin Act 274 authorizes the State to select a non-profit corporation organized under Chapter 181 of Wisconsin statutes as the SDE if the organization meets certain specified requirements (see list on pages 8-10 of this RFA). Discuss your organization's current status regarding satisfaction of the criteria in Section 35 of the Act, as well as any changes your organization would make to comply with requirements you do not currently satisfy.

[1] Companies that join together as a consortia to submit an application should address all items except items 2-4 with their collective partnership in mind.

6. Describe your organization's experience with the following:

   6.a Developing and successfully implementing a comprehensive business plan through the successive stages of the growth and maturation of an enterprise.

   6.b Establishing a business plan that successfully addresses sustainability dependent on providing value to a diverse group of interested stakeholders.

   6.c Developing, managing, and financing new initiatives, products, or services, including initial capitalization of those initiatives.

   6.d Managing annual operating and capital budgets, and implementing effective financial controls.

   6.e Managing procurements, contracting, and contract administration for business or technical services and operations.

   6.f Developing, implementing, and evaluating a continuous quality/process improvement plan.

   6.g Working with a multi-stakeholder board.

   6.h Advancing health care quality and cost-effective health care.

   6.i Developing and managing a public communications plan.

   6.j Working within the parameters of a Federal grant or program.

   6.k Working with physicians and physician organizations, hospitals and hospital systems, patients/consumers, commercial health insurers/health plans, Medicare, Medicaid, Department of Health Services, state and local Public Health, the Wisconsin HIT Extension Center, the Wisconsin Legislature and Governor, health care quality improvement and reporting organizations, and media organizations.

7. Identify any potential conflicts of interest your organization or board of directors would have if selected as the SDE and discuss how you would address the conflicts, including how your organization would make decisions and structure its business operations as the SDE so as to not give its pre-existing business operations undue advantage over other organizations who are similarly situated or potential competitors.[2]

8. Identify any questions, concerns, or reservations your organization or board of directors may have about meeting the requirements to serve as the SDE.

Implementation Approach

Please provide the following information regarding your organization's or consortia of organizations' implementation approach.

9. Describe the approach your organization would take to implement the Wisconsin HIT Strategic and Operational Plan (SOP), including how it would organize a private-public governing board and committees, and project team to address the five HIE domains (governance, finance, technical infrastructure, business and technical operations and legal/policy). Also discuss the core constituencies that are not well represented in your organization's current governance structure and how it would select/recruit any individuals needed to fill such a gap.

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[2] The response to this item should address anything in an applicant's current organizational structure, mission, and future plans that would present an impediment to its acting in the best interest of the new SDE organization in fulfilling the responsibilities outlined in the State HIE CAP FOA and 2009 Wisconsin Act 274.

10. In carrying out the SOP, the HITECH Act requires a qualified SDE to consult with and consider the recommendations of health care providers (including providers serving low-income and underserved populations), health plans, patient or consumer organizations that represent the population to be served, health information technology vendors, health care purchasers and employers, public health agencies, health professions schools, universities and colleges, clinical researchers, and other users of health information technology such as the support and clerical staff of providers and others involved in the care and care coordination of patients. Describe how your organization would ensure the principles of transparency and broad stakeholder participation in the implementation of the SOP are met. In particular, discuss your organization's approach for communicating with key stakeholders for whom access to health data is critical and obtaining their ongoing involvement and buy in.
11. Provide an overview, including CVs or resumes, of the individuals who would be likely most directly involved in this program/project implementation. For vacant positions and/or positions that would be filled through contracts, include a list of anticipated qualification requirements for each position.
12. Describe how your organization would monitor progress on the Goals and Objectives included in the SOP (see Appendix B), such as using performance measures and other means.
13. Describe how your organization would provide regular status report updates to the Department of Health Services, stakeholders, and the general public.
14. Describe how your organization would collaborate with and involve the State Health IT Coordinator and the State's eHealth program staff in the implementation of the SOP.
15. The statewide health information network will have thousands and possibly millions of users in the future. Describe your organization's experience with contractually managing data access and use.
16. If your organization expects to serve in the role of an HIE technical operator in addition to the state-level governance role, describe your organization's current capability to do so, or plans to develop that capability. Alternatively, if your organization envisions contracting with third parties to do the technical services/operations and knows of a specific technical implementation partner that it currently uses and would propose, list other similar projects in which the partner has been engaged.
17. Describe the processes and procedures your organization uses/follows or would use/follow to manage procurements, contracting, and contract administration for business or technical services and operations.
18. Describe how your organization would envision funding the capitalization and operation of a statewide health information network and services, with specific reference to what additional sources of funding, beyond ARRA grant funding, your organization would explore to assure that it is self sustaining.

Content Knowledge and Expertise

Please provide the following information regarding your organization's or consortia of organizations' content knowledge and expertise.

19. Describe steps your organization would take to ensure that implementation of HIE in Wisconsin incorporates the use of existing and evolving health care information technology standards and enables participation of independent electronic health record systems.
20. Describe how your organization has selected, managed and implemented information technology standards and architecture in your organization previously, and how your organization would go about doing so as part of your future HIE work.
21. Describe how your organization has previously addressed policies and procedures related to health information privacy, security, audits, access, authorization and authentication, and how you would go about doing so as part your future HIE work.
22. Describe the challenges your organization envisions facing with the currently proposed Meaningful Use rules specific to HIE and discuss how your organization would address these challenges.

23. Wisconsin communities and markets are served by an unusually diverse array of provider organizations ranging from very large and highly integrated to a variety of types of "independent" and smaller entities. Describe how this context would affect the design, funding, and operations of the HIE.
24. Describe the expertise of your organization at maintaining and using heath information for secondary use by public health, quality reporting and improvement, health services research or biomedical research.

Customer References

Please provide the contact information for 6 to 8 individual or organizational references we may contact. Include at least two public sector (i.e., federal, state, local government) references, two private sector references, and two health care references. Include the company names, addresses, phone numbers and contact person(s).

Additional Information

Please attach any additional critical information that supports your application to serve as the SDE that is not already addressed in this Questionnaire or any additional information about your company's products and services that you feel would be useful to the evaluation panel.

Questionnaire Response Format

The applicant must respond to all items in the Questionnaire section, including customer references and, optionally, any additional information. Responses shall adhere to the following guidelines:

1. Applicants are not limited to page counts and should thoroughly address each item in the Questionnaire section, while appropriately balancing length and content. The response to each item should be numbered and correspond to the number in the Questionnaire section.
2. Use an easily readable typeface such as Cambria, Arial, or CG Times and one inch margins. Text should be no less than 11 point font and tables and figures no less than 9 point font.
3. Deliver seven printed copies on 8½ by 11 paper and one electronic Microsoft Word copy on CD or USB flash drive to:

   Denise Webb, State Health IT Coordinator
   1 West Wilson Street, Room 250
   Madison, Wisconsin 53703

Responses should be organized, comprehensive, and address each item in the Questionnaire separately and completely. Vague responses will result in a reduced evaluation score.

Any questions about this RFA should be e-mailed to Denise Webb at ehealth@wi.gov. All questions and responses will be posted and made publicly available to all applicants on the Wired for Health SharePoint site.

Conformance to the RFA

The WIRED for Health Board has the authority to determine that an organization's application is not in conformance with the requirements of this RFA and request corrective action by the organization. Failure to take corrective action may result in termination of the applicant being considered under this RFA.

Deviations to the Provisions

Any deviations from the RFA instructions must be clearly delineated in the response, along with an explanation of why the instructions were not followed. The State reserves the right to determine the validity of the variation and failure to provide adequate justification may lead to rejection of the application.

WIRED for Health Board's Right to Use Information

The WIRED for Health Board may use any and all information provided in the responses to this RFA for any purposes the Board deems appropriate. This includes the use of information from applicants that are not selected to be the SDE.

Notification of Intent to Designate

In accordance with *Wisconsin Regulations and Statutes*, the State will designate an organization to become the State Designated Entity to govern the statewide health information network and HIE services. The Wisconsin Department of Health Services in accordance with 2009 Wisconsin Act 274, Section 35, 153.81 will determine final the designee.

Rules for Withdrawal

An applicant may request that his or her application be withdrawn by submitting a request in writing and stating the reason for withdrawal.

Evaluation and Selection Process

Applications that are complete and responsive to the RFA will be evaluated for merit by an appropriate panel of evaluators convened by the WIRED for Health Board using the review criteria and format included in Appendix A. A rating scale of Exceptional, Good, Acceptable, Poor, or Unacceptable will be applied to each numbered response. The points for each numbered response will be allocated proportionately to the ratings.

RFA Time Line

RFA released and distributed June 30, 2010

Wisconsin HIT Strategic and Operational Plan released of public comment July 16, 2010

Letters of intent to apply submitted and postmarked or emailed no later than midnight CDT July 19, 2010

Applications submitted no later than end of day (4:30 pm CDT) August 24, 2010

Wisconsin HIT Strategic and Operational Plan due to ONC August 31, 2010

Evaluation process completed by September 27, 2010

Notification to applicants of status by September 30, 2010

Appendix A – Evaluation Grid

	SDE Selection Criteria Score Card	Max Points	% of Max Points
Company Information		**410**	**51.90%**
1	Contact information	0	0.00%
2	Company background and core business	15	1.90%
3	Length of time in business	15	1.90%
4	Company's financial status with 2 years of financials	15	1.90%
5	2009 Wisconsin Act 274 Criteria	100	12.66%
6	Experience with:		0.00%
6a	Business Plan (BP)	15	1.90%
6b	BP on sustainability/value/many types of stakeholders	15	1.90%
6c	Developing, managing, financing new initiatives, products, services	15	1.90%
6d	Annual operating and capital budgets/ financial controls	15	1.90%
6e	Managing procurements, contracting, contract administration	15	1.90%
6f	Continuous quality/process improvement	15	1.90%
6g	Working with a multi-stakeholder board	15	1.90%
6h	Advancing health care quality and cost-effective health care	15	1.90%
6i	Developing/managing public communications plan	15	1.90%
6j	Working within parameters of Federal grant or program	15	1.90%
6k	Working with various health and health care stakeholders, government, media	15	1.90%
7	Conflicts of interest	100	12.66%
8	Questions/concerns/reservations	0	0.00%
Implementation Approach		**260**	**32.91%**
9	Approach to implementing SOP and organizational structure	100	12.66%
10	Transparency and broad stakeholder participation	25	3.16%
11	Overview of individuals/skill sets for SOP implementation	25	3.16%
12	Goals and Objectives/Performance Measures	25	3.16%
13	Status report for DHS/stakeholders/general public	15	1.90%
14	Involving the State HIT Coordinator/eHealth staff	15	1.90%
15	Management of large numbers of users	15	1.90%
16	Interest/ability to be HIE technical operator or third-party technical partner	0	0.00%

17	Managing procurement/contracting	15	1.90%
18	Vision for funding--capitalization and operation	25	3.16%
Content Knowledge		**120**	**15.19%**
19	Alignment with standards; participation of independent EHR systems	20	2.53%
20	Implementation of HIT standards and architecture	20	2.53%
21	Privacy, security, audits etc.	20	2.53%
22	Challenges with proposed Meaningful Use HIE criteria	20	2.53%
23	Impact of diverse WI provider environment on HIE design, funding, and operations	20	2.53%
24	Secondary use of health information	20	2.53%
TOTAL SCORE		**790**	**100%**

Appendix B – Description of Five HIE Domains and WIRED for Health Vision, Mission, Guiding Principles, and Goals and Objectives

Description of the Five HIE Domains

(from State HIE CAP Funding Opportunity Announcement)

Governance – This domain addresses the functions of convening health care stakeholders to create trust and consensus on an approach for statewide HIE and to provide oversight and accountability of HIE to protect the public interest. One of the primary purposes of a governance entity is to develop and maintain a multi-stakeholder process to ensure HIE among providers is in compliance with applicable policies and laws.

Finance – This domain encompasses the identification and management of financial resources necessary to fund health information exchange. This domain includes public and private financing for building HIE capacity and sustainability. This also includes but is not limited to pricing strategies, market research, public and private financing strategies, financial reporting, business planning, audits, and controls.

Legal/Policy – The mechanisms and structures in this domain address legal and policy barriers and enablers related to the electronic use and exchange of health information. These mechanisms and structures include but are not limited to: policy frameworks, privacy and security requirements for system development and use, data sharing agreements, laws, regulations, and multi-state policy harmonization activities. The primary purpose of the legal/policy domain is to create a common set of rules to enable inter-organizational and eventually interstate health information exchange while protecting consumer interests.

Technical Infrastructure – This domain includes the architecture, hardware, software, applications, network configurations and other technological aspects that physically enable the technical services for HIE in a secure and appropriate manner.

Business and Technical Operations – The activities in this domain include but are not limited to procurement, identifying requirements, process design, functionality development, project management, help desk, systems maintenance, change control, program evaluation, and reporting. Some of these activities and processes are the responsibility of the entity or entities that are implementing the technical services needed for health information exchange; there may be different models for distributing operational responsibilities.

Material from the Draft HIT Strategic and Operational Plan on Vision, Mission, Guiding Principles and Strategic Goals and Objectives

NOTE: Applicants may view the current draft of the Wisconsin Strategic and Operational Plan available on the WIRED for Health Microsoft SharePoint site. To sign up for access to the site, go to: http://wiredboard.wisconsin.gov/Reference/index.htm

Vision and Mission

The WIRED for Health **vision** is to promote and improve the health of individuals and communities in Wisconsin through the development of health information exchange that facilitates electronic sharing of the right health information at the right place and right time.

This vision recognizes the important role electronic health information exchange plays in enabling transformation in the health care delivery system and health care reform in Wisconsin. Adopting and using health information technology and sharing health information electronically is a necessary component—although not the only component—needed for this transformation to occur. Better information will help clinical care providers improve their practice of medicine and help improve the health individuals and communities in Wisconsin.

The WIRED for Health **mission** is to develop and sustain a trusted, secure statewide health information network and services that provide value to participants.

The WIRED for Health Board understands that stakeholder trust, data security, and services that provide value are the keys to sustainability.

Guiding Principles

The following overarching principles will serves as guideposts for the development of the statewide health information network and services.

Rome wasn't built in a day. We will use an incremental, voluntary, and collaborative approach to develop and maintain the statewide health information network and services that considers the relative benefit to and readiness of participants, beginning with meaningful use; and builds on existing health IT successes, standards, and investments.

Enabling and empowering. We will provide information and tools to the individuals responsible for making health decisions in a way that is easy to use and understand. The HIE solution will connect community resources to enable informed decision making and care coordination at the community level.

Strike the right balance. We will establish the right mix of services and functionality that benefits participants, encourages commitment to using the statewide health information network, and fosters cooperation among participants.

Enhancing delivery of care for improved quality. The statewide health information network will provide tools and information to improve the efficiency and effectiveness of care delivery, health promotion, and disease prevention while informing future policy and planning decisions and expenditures.

Stakeholders must see the value. We will align qualitative and quantitative benefits to provide value to the individual, health community, and population as a whole. We will present a value proposition that encourages stakeholders to voluntarily participate in and pay for the statewide health information network and services.

Transparency is critical for the advancement of HIE. We will establish trust among stakeholders by providing an environment where decisions about HIE are made openly and in full public view.

Balancing protection of health information with appropriate access. We will ensure the statewide health information network protects patient privacy by sharing electronic information on a "need-to-know" basis and in a way that is secure. We will foster trust among participants by establishing effective security safeguards and controls.

Strategic Goals and Objectives

A fundamental goal of the 2006 eHealth Action Plan was to establish an eHealth technology platform in Wisconsin. This goal had two components: 1) statewide adoption and use of electronic health record systems by all health care providers and 2) fostering the creation of regional health information exchanges while simultaneously developing statewide HIE services. Building on the strategic foundation established by the eHealth Action Plan, the WIRED for Health Board developed overarching HIT and HIE strategic goals; and high-level strategic goals, long-term and near-term goals and objectives for Governance, Legal and Policy, Finance and Audit, Standards and Architecture, and Communications, Education, and Marketing.

The WIRED for Health Board expects the corporation selected or created to serve as the State Designated Entity (SDE) to assume responsibility for implementing this Strategic and Operational Plan as a condition of its contract with the Department. The Board also expects the SDE to adopt these goals and objectives as the designated entity accountable for governing the statewide health information network and HIE services. The SDE will not be directly responsible for achieving the parts of the overarching goals related to EHR adoption but will be expected to support and foster attainment of these adoption goals for Wisconsin. Also, some of the near-term goals will have been accomplished prior to the completing the planning and receiving approval of the plan by the ONC.

Overarching HIT and HIE Goals

- By 2016, all ambulatory care providers and hospitals will have and use nationally certified EHR systems and HIE.
- By 2020, all health care consumers, providers, and public health agencies will have access to nationally certified EHR systems and HIE.
- By 2020, most patients, health care providers, and public health agencies will use electronic health records and information exchange to improve outcomes related to the effectiveness, quality, efficiency, and safety of health care and population health services.

Governance

High-Level Goals:

- Wisconsin will establish a permanent, state-level, public-private, not-for-profit governing entity for statewide HIE that effectively executes the State HIT Strategic and Operational Plans and fairly represents the needs of all consumers of health information.
- Wisconsin will establish a governance framework that is flexible and enduring, able to continuously improve and re-invent itself to meet changing environmental conditions.

Near-Term Goals and Objectives:

1. By June 30, 2010, the Board will establish an open and transparent process to identify qualified applicants and select the SDE.
    a. The Request for Application (RFA) will include the following selection criteria:
        i) All requirements specified by law.

ii) Commitment of the SDE Board of Directors (BoD) to embrace and execute the mission and goals of the WIRED for Health project.

iii) Commitment of the SDE BoD to the principles of collaboration, transparency, buy in, and trust as a manner of conducting business and making business decisions.

iv) Demonstrated ability to perform, or commitment to build performance capabilities to successfully execute, stated requirements.

b. The selection process will

i) Be well documented and easily understood by applicants and other participants,

ii) Be transparent and attract a broad group of applicants, and

iii) Invite broad stakeholder involvement.

2. By September 30, 2010 the State will select the SDE.

a. By September 24, 2010, the WIRED Governance Committee will recommend a SDE (one or more) for consideration to the WIRED for Health Board. The recommendation will include:

i. One or more organizations that successfully met the evaluation criteria and attained the highest number of points. Successful applicants must:

- Meet all/almost all of the requirements. If not all requirements are met, the applicant must agree to submit a plan of action to satisfy any outstanding requirements within a reasonable and acceptable time frame.
- Have generated broad public support during the selection process.

ii) A summary of each applicant SDE's profile with emphasis on what is already in place and what must be built/created/changed before transition of Governance authority can occur.

Long-Term Goals and Objectives:

1. By February 1, 2011, the SDE will assume responsibility for execution of the Strategic and Operational Plan.

a. By October 31, 2010, the State will execute a contract with the SDE. The contract will

i) Transfer responsibility and authority to the SDE for execution of the Strategic and Operational Plan of the WIRED for Health project,

ii) Document the transition process, including specific details about changes in structure or process identified through the selection and recommendation process and timing, and

iii) Establish the terms of the partnership between the SDE and the State of Wisconsin including the deliverables that must be met for transfer of funds.

(1) Identify State Health IT Coordinator role and authority in relation to business process and ongoing responsibilities of the SDE.

(2) Establish a tie between the State Medicaid HIT Plan and the SDE.

b. By February 1, 2011, the SDE will

i) Integrate the WIRED for Health's vision, mission, guiding principles, and goals into the SDE vision, mission, guiding principles, and goals;

ii) Fully understand and be committed to successful execution of the WIRED for Health Strategic and Operational Plan; and

iii) Establish a process for continued review and alignment of its vision, mission, guiding principles, and high-level goals as necessary to comply with the evolving requirements of the State HIE CAP.

2. By February 1, 2012, the SDE will satisfy the structural and functional transition requirements of the contract with the Department.
    a. The SDE will establish a process for continued review and alignment of its implementation plans with the State Medicaid HIT Plan.

Finance

High-Level Goal:

Develop a path to financial sustainability including a business plan with feasible public and private financing mechanisms for ongoing statewide health information exchange.

Near-Term Goals and Objectives:

1. Determine the short-term capital and operating fiscal needs for the statewide health information network and its core services.
    a. Identify services.
    b. Identify cost drivers.
    c. Achieve consensus with the Standards and Architecture Committee on capital and operating financing.
2. Prepare a short-term capital acquisition plan for statewide health information network and services.
    a. Identify sources of capital.
    b. Develop a strategy to acquire capital based on an implementation timeline.
3. Develop budget for ARRA State HIE CAP funding.
    a. Identify short-term costs.
    b. Develop plan to expedite spending of ARRA funds in the first 2 years of the State HIE CAP.
4. Based on recommended HIE services developed by the Standards and Architecture Committee, estimate the cost of implementation as well as ongoing operations for the statewide health information network and services.
    a. Develop individualized financing requirements for top-priority use cases and related services using financial model.

Long-Term Goals and Objectives:

1. Develop a comprehensive business plan to achieve long-term sustainability with public and private funding, once ARRA State HIE CAP funding is exhausted.
    a. Analyze the value propositions for each stakeholder group.
    b. Develop a balance for costs and benefits for each stakeholder group.
2. Identify key barriers to long term financial sustainability and recommend resolutions.
    a. Communicate with stakeholders to identify barriers to participation in the statewide health information network and services.
    b. Develop recommendations to overcome or mitigate the identified barriers.

3. Provide both contingency capital and operational financing plans if revenue sources do not materialize as originally predicted.
    a. Identify and prioritize sources of capital funding and operational revenues. Develop three financing scenarios based on differing amounts of capital.
    b. Determine which HIE services are non-essential.
    c. Work with Standards and Architecture Committee to prioritize HIE services. Prioritization will include current and future costs and revenues.
    d. Recommend adequate level of cash reserves to allow for growth as well as to withstand operational deficits and potential litigation risks.
4. Develop a consensus on stakeholder benefits and stakeholder investments required to both capitalize initial efforts and achieve long-term financial sustainability.
    a. Develop a benefits matrix to identify value add to each stakeholder.
    b. Committee members will communicate with their respective stakeholder communities to acquire buy in and commitment.
5. Develop and implement appropriate audits and controls focused on assuring equity and compliance among all stakeholders.

Legal and Policy

Near-Term Goals and Objectives:

1. Establish a policy framework that optimizes the electronic exchange of health information while protecting patient's privacy.
    a. Establish uniform privacy and security strategies, policies, and procedures for the statewide health information network and services that ensure health information is protected in accordance with Wisconsin law, HIPAA, and other federal laws and requirements (i.e., consent, authorization, authentication, access, audit, breach, etc.).
    b. Establish uniform business, technical, and operational policies, and procedures for the statewide health information that ensure health information is protected in accordance with Wisconsin law, HIPAA, and other federal laws and requirements.
    c. Develop a process for establishing strategies, policies, and procedures identified in Objectives a. and b. above incrementally over time.
    d. Consistent with the established legal and policy framework, establish a contractual model for governing participation in the statewide health information network and services in Wisconsin and in exchange with federal agencies.
    e. Establish oversight and accountability mechanisms that ensure compliance with the established legal and policy framework by the statewide health information network and participants.
    f. Develop a process to evaluate and update the legal and policy framework as part of an annual program evaluation and more often if necessary consistent with Objectives a. and b. above.
    g. Collaborate with neighboring states beginning with Minnesota to harmonize laws, regulations, policies, and practices in support of interstate HIE.
2. Establish a legal framework that enables the electronic exchange of health information while protecting patient's privacy.
    a. Recommend changes to Wisconsin health privacy laws and regulations where warranted.
    b. Advocate for the harmonization of existing federal and State laws to enable HIE services.

c. Consistent with the established legal and policy framework, establish a contractual model for governing participation in the statewide health information network and services in Wisconsin and in exchange with federal agencies.

d. Establish oversight and accountability mechanisms that ensure compliance with the established legal and policy framework by the statewide health information network and participants.

e. Develop a process to evaluate and update the legal and policy framework as part of an annual program evaluation and more often if necessary consistent with Objectives a. and b. above.

f. Collaborate with neighboring states beginning with Minnesota to harmonize laws, regulations, policies, and practices in support of interstate HIE.

Long-Term Goals and Objectives:

1. Evaluate and update the policy framework as part of annual program evaluation and more often if necessary to optimize the electronic exchange of health information while protecting patient's privacy.
   a. Position the statewide health information network for participation in the nationwide health information network.
2. Evaluate and update the legal framework as part of an annual program evaluation and more often if necessary to enable the electronic exchange of health information while protecting patient's privacy.
   a. Position the statewide health information network for participation in the nationwide health information network.

Standards and Architecture

High-Level Goal:

Develop a scalable, standards-based technical architecture for statewide HIE that supports interoperability and leverages existing investments in health IT to the extent possible.

Near-Term Goals and Objectives:

1. Deploy a standards-based architecture and core HIE services to be available to meet meaningful use requirements for eligible professionals and hospitals.
   a. Conduct a readiness assessment of providers and hospitals to determine status and ability to connect to the statewide health information network and services. Reference the data collected through other similar surveys to reduce response burden on providers and hospitals.
   b. By June 1, 2011, the statewide health information network and services will be available to support eligible health professionals and hospitals in meeting the Stage 1 meaningful use criteria for HIE.
   c. By January 1, 2013, the statewide health information network and services will be available to support eligible health professionals and hospitals in meeting the Stage 2 meaningful use criteria for HIE.
   d. By January 1, 2015, the statewide health information network and services will be available to support eligible health professionals and hospitals in meeting the Stage 3 meaningful use criteria for HIE.
2. Develop and implement a state-level business process for selecting and adopting standards.

   a. Review evolving national standards (e.g. NHIN Direct) and ensure planning incorporates standards that will enable interstate and national connectivity for Wisconsin's statewide health information network and services.

3. By 2016, data accepted from EHR systems statewide will be made available through HIE for measurement of health care quality, determinants of health, and trends and magnitude of health disparities in Wisconsin.
   a. Collaborate with the Wisconsin HIT Extension Center (WHITEC) to ensure providers' EHR rollout plans include standards-based connectivity in 2010 and going forward.
   b. Engage all health providers with EHR implementations.

Long-Term Goals and Objectives:

1. By 2020, the statewide health information network and services will reach all geographies and providers across the State and be able to continuously receive, access, and transmit health information among health systems.
   a. Determine HIE use cases to be implemented in priority order.
   b. Determine geographies and timeline to advance these implementations statewide.
   c. Define standards of timeliness for use cases and data elements.
   d. Align with and leverage the state broadband plan.
2. By 2016, the statewide health information network will facilitate unified electronic access to personal health information by patients and their appointed guardians via personal health record system(s). The statewide health information network will remain agnostic to PHR solutions and facilitate a standard feed for PHR implementations.
   a. Identify where this capability currently exists, differentiating from IDN-specific portal and HIE-served PHR.
   b. Assess and identify standards for content and communication and adopt these standards in the statewide architecture.

Communications, Education, and Marketing

High-Level Goal:

Inform and raise the awareness of consumers and the health community about the benefits of health information technology and health information exchange.

Near-Term Goals and Objectives:

1. Design a comprehensive HIE communication and educational program.
   a. Garner information that will be critical to message development through various methods, such as stakeholder meetings, town halls, surveys, and focus groups, within 90 days of the SDE assuming responsibilities.
   b. Develop and deploy messages to a broad spectrum of prioritized stakeholders through community partners within 6 months of receiving the results of the stakeholder input.

c. Develop measures to evaluate the success of the initial communications and education campaign within 6 months of receiving the results of the stakeholder input.

d. Develop and implement a continuous quality improvement plan after 6 months into the campaign.

e. Develop and deploy targeted messaging to enhance public transparency regarding uses of protected health information (PHI) maintained by HIEs in Wisconsin and individuals' rights related to uses of PHI by March 31, 2011.

2. Implement an ongoing marketing program within the SDE to solicit financial support and engage consumers and the health community in the adoption and use of HIE services.

   a. Once the Strategic and Operational Plan is approved by the ONC, immediately develop marketing strategies and tools to begin communicating the benefits to target stakeholders that are most likely to help capitalize the statewide health information network and services.

   b. Develop a marketing strategy and tools that target stakeholders who are most likely to contribute to the sustainability of the statewide health information network and services within 60 days of the SDE assuming responsibilities.

   c. By June 30, 2011, survey the consumer market to identify HIE services they are most likely to use and purchase.

Appendix C – State HIE CAP Reporting, Performance Measures, Project Management, and Evaluation Requirements

Recipients of State HIE grant funding will be required to report on specific reporting requirements and performance measurements, and ONC will make particular note of progress at the end of the first 2-year period.

Required Reporting and Performance Measures

Reporting and Performance Measures are required for grantees receiving funding for planning or implementation activities. Grantees must comply with the Reporting Requirements for planning and/or implementation activities. Once a grantee has entered into implementation activities, the Performance Measures become ongoing requirements as well.

The grantee must have and use methodologies, tools, and strategies to collect all data, including data needed for the reporting requirements and performance measures, for the project to satisfy the reporting requirements of the State ONC CAP and the Government Performance Reporting Act of 2003. Other performance measures specific to ARRA reporting are also required. ARRA reporting requirements are included in the Notice of Grant Award the State received. The performance measures will be used as part of the state and/or national program evaluation. As the program evolves, additional requirements may be provided by the ONC through program guidance.

Specific reporting requirements, performance and evaluation measures and methods to collect data and evaluate project performance will be provided at a later date by the ONC in program guidance and through technical assistance. These measures will include those related to the five HIE domains: governance, finance, technical infrastructure, business and technical operations, and legal/policy. The core set of reporting requirements and performance measures enables states to monitor their own progress, and when aggregated across recipients, provides ONC with a national view of progress across the program. The core set of reporting requirements and performance measures includes but is not limited to:

Reporting Requirements

- **Governance**
  - What proportion of the governing organization is represented by public stakeholders?
  - What proportion of the governing organization is represented by private sector stakeholders?
  - Does the governing organization represent government, public health, hospitals, employers, providers, payers and consumers?
  - Does the state Medicaid agency have a designated governance role in the organization?
  - Has the governing organization adopted a strategic plan for statewide HIT?
  - Has the governing organization approved and started implementation of an operational plan for statewide HIT?
  - Are governing organization meetings posted and open to the public?
  - Do regional HIE initiatives have a designated governance role in the organization?

- **Finance**
  - Has the organization developed and implemented financial policies and procedures consistent with state and federal requirements?
  - Does the organization receive revenue from both public and private organizations?
  - What proportion of the sources of funding to advance statewide HIE are obtained from federal assistance, state assistance, other charitable contributions, and revenue from HIE services?

- Of other charitable contributions listed above, what proportion of funding comes from health care providers, employers, health plans, and others (please specify)?
- Has the organization developed a business plan that includes a financial sustainability plan?
- Does the governance organization review the budget with the oversight board on a quarterly basis?
- Does the recipient comply with the Single Audit requirements of OMB?
- Is there a secure revenue stream to support sustainable business operations throughout and beyond the performance period?

- **Technical Infrastructure**
  - Is the statewide technical architecture for HIE developed and ready for implementation according to HIE model(s) chosen by the governance organization?
  - Does statewide technical infrastructure integrate state-specific Medicaid management information systems?
  - Does statewide technical infrastructure integrate regional HIE?
  - What proportion of health care providers in the state are able to send electronic health information using components of the statewide HIE Technical infrastructure?
  - What proportion of health care providers in the state are able to receive electronic health information using components of the statewide HIE Technical infrastructure?

- **Business and Technical Operations**
  - Is technical assistance available to those developing HIE services?
  - Is the statewide governance organization monitoring and planning for remediation of HIE as necessary throughout the state?
  - What percent of health care providers have access to broadband?
  - What statewide shared services or other statewide technical resources are developed and implemented to address business and technical operations?

- **Legal/Policy**
  - Has the governance organization developed and implemented privacy policies and procedures consistent with state and federal requirements?
  - How many trust agreements have been signed?
  - Do privacy policies, procedures and trust agreements incorporate provisions allowing for public health data use?

Performance Measures

The following measures are applicable to the implementation phase of the cooperative agreement. They are an initial set of measures intended to give a state specific and national perspective on the degree of provider participation in HIE enabled state level technical services and the degree to which pharmacies and clinical laboratories are active trading partners in HIE. E-prescribing and laboratory results reporting are two of the most common types of HIE within and across states.

- Percent of providers participating in HIE services enabled by statewide directories or shared services.[3]
- Percent of pharmacies serving people within the state that are actively supporting electronic prescribing and refill requests.
- Percent of clinical laboratories serving people within the state that are actively supporting electronic ordering and results reporting.

[3] ONC will negotiate with each state to determine best way to further specify this measure based on the statewide directories and shared services pursued within each state under this program.

Recipients will also be required to report on additional measures that will indicate the degree of provider participation in different types of HIE particularly those required for meaningful use.

Future areas for performance measures that will be specified in program guidance will include but ***are*** not limited to: providers' use of electronic prescribing, exchange of clinical summaries among treating providers, immunization, quality, and other public health reporting and eligibility checking.

Project Management

Grantees are required to have a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. Grantees have to specify who would have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports, and communications with other partners and ONC. The grantee must also monitor and track progress on the project's tasks and objectives.

Evaluation

Grantees are required to track and maintain project information expected to be required for the state to conduct a self-evaluation of the project and to inform a national program-level evaluation.

ARRA-Required Performance Measures

To assist in fulfilling the accountability objectives of the Recovery Act, as well as the Department's responsibilities under the Government Performance and Results Act of 1993 (GPRA), Public Law 103-62, applicants who receive funding under this program must provide data that measure the results of their work. Additionally, applicants must discuss their data collection methods in the application. The following are required measures for awards made under the Recovery Act:

Objective	**Performance Measures**	**Data the recipient provides for 3-month reporting period**	**Description** **(Plain language explanation of what exactly is being provided)**
Recovery Act: Preserving jobs	Number of jobs saved (by type) due to Recovery Act funding.	a) How many jobs were prevented from being eliminated with the Recovery Act funding during this reporting period? b) How many jobs that were eliminated within the last 12 months were reinstated with Recovery Act funding?	An unduplicated number of jobs that would have been eliminated if not for the Recovery Act funding during the three-month quarter. Report this data for each position only once during the project period. A job can include full time, part time, contractual, or other employment relationship.

Recovery Act: Creating jobs	Number of jobs created (by type) due to Recovery Act funding.	How many jobs were created with Recovery Act funding this reporting period?	An unduplicated number of jobs created due to Recovery Act funding during the three month quarter. Report this data for each position only once during the award. A job can include full time, part time, contractual, or other employment relationship.

Appendix D – Role of the State Health IT Coordinator

The State Health IT Coordinator is responsible for coordinating and working in close collaboration with the ONC, Wisconsin's State Designated Entity, the State's Medicaid Director, the State's Health Officer, other health leaders and stakeholders in the government and private health care sectors, and other states' Health IT Coordinators.

The State Health IT Coordinator must ensure state agencies and their partners in the statewide health information exchange initiative work cooperatively with their federal partners and other stakeholders to facilitate statewide health information exchange and to help move providers to meaningful use of electronic medical records systems.

The position of the State Health IT Coordinator resides in the Department of Health Services and is designated by the Governor's Office as the key liaison among government and private stakeholders in the statewide HIE efforts. Governor Doyle designated the State's eHealth Program Manager as the State HIT Coordinator on October 16, 2009. In fulfilling the role as the State HIT Coordinator, this person drives the coordination and integration of HIT/HIE-related projects funded under ARRA.

The State Health IT Coordinator:

1) Serves in a leadership role in fostering effective and efficient exchange of health information that leverages existing state and regional efforts based on U.S. DHHS-adopted standards and certification criteria;
2) Represents the State at HIT-related functions;
3) Maintains a library of HIT literature and be able to analyze and write about the health IT landscape and brief the Governor, Legislature, and other health entities;
4) Supports planning of HIE services within Wisconsin and across the State's borders, including the development and maintenance of the Wisconsin HIT strategic plan and an effective model for HIE governance and accountability;
5) Coordinates with Medicaid, state public health programs, other federally funded health programs, and other HIE activities in the state to enable and ensure an integrated, unified approach to HIE, the avoidance of duplication of efforts, and the monitoring of provider participation in HIE as required by the federal and state "meaningful use" requirements;
6) Coordinates with other ARRA-funded program—such as the Regional Extension Center, broadband, workforce development, the SHARP Program, Beacon Communities, as well as, other relevant federal initiatives, such as federal health care reform, as applicable to Wisconsin;
7) Will develop and chair a State of Wisconsin Interagency Health IT Council to provide input and resources to the SDE from state agencies such as the Department of Health Services, the Department of Corrections, the Department of Employee Trust Funds, and the Department of Veterans Affairs;
8) Will serve as a resource to the SDE governing board in the implementation of the statewide health information network and services, either as an appointed Board member, an ex-officio Board member, and/or through a close working relationship with the chief administrator of the SDE;
9) Will verify the SDE complies with the terms of any contract with the State pertaining to statewide HIE;
10) Ensures the annual report to the ONC on statewide HIE alignment with other federal programs is completed in a timely fashion;
11) Assists in increasing statewide consumer involvement in HIT/HIE development; and

12) Identifies and facilitates potential interstate partnerships pertaining to HIT/HIE.

Appendix E – Section 3013 of the ARRA HITECH Act

“SEC. 3013. STATE GRANTS TO PROMOTE HEALTH INFORMATION TECHNOLOGY.

‘‘(a) IN GENERAL.—The Secretary, acting through the National Coordinator, shall establish a program in accordance with this section to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.

‘‘(b) PLANNING GRANTS.—The Secretary may award a grant to a State or qualified State-designated entity (as described in subsection (f)) that submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may specify, for the purpose of planning activities described in subsection (d).

‘‘(c) IMPLEMENTATION GRANTS.—The Secretary may award a grant to a State or qualified State designated entity that—

‘‘(1) has submitted, and the Secretary has approved, a plan described in subsection (e) (regardless of whether such plan was prepared using amounts awarded under subsection (b); and

‘‘(2) submits an application at such time, in such manner, and containing such information as the Secretary may specify.

‘‘(d) USE OF FUNDS.—Amounts received under a grant under subsection (c) shall be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards through activities that include—

‘‘(1) enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information;

‘‘(2) identifying State or local resources available towards a nationwide effort to promote health information technology;

‘‘(3) complementing other Federal grants, programs, and efforts towards the promotion of health information technology;

‘‘(4) providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information;

‘‘(5) promoting effective strategies to adopt and utilize health information technology in medically underserved communities;

‘‘(6) assisting patients in utilizing health information technology;

‘‘(7) encouraging clinicians to work with Health Information Technology Regional Extension Centers as described in section 3012, to the extent they are available and valuable;

‘‘(8) supporting public health agencies’ authorized use of and access to electronic health information;

‘‘(9) promoting the use of electronic health records for quality improvement including through quality measures reporting; and

‘‘(10) such other activities as the Secretary may specify.

‘‘(e) PLAN.—

‘‘(1) IN GENERAL.—A plan described in this subsection is a plan that describes the activities to be carried out by a State or by the qualified State-designated entity within such State to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications.

‘‘(2) REQUIRED ELEMENTS.—A plan described in paragraph (1) shall—

‘‘(A) be pursued in the public interest;

‘‘(B) be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001;

''(C) include a description of the ways the State or qualified State-designated entity will carry out the activities described in subsection (b); and

''(D) contain such elements as the Secretary may require.

''(f) QUALIFIED STATE-DESIGNATED ENTITY.—For purposes of this section, to be a qualified State-designated entity, with respect to a State, an entity shall—

''(1) be designated by the State as eligible to receive awards under this section;

''(2) be a not-for-profit entity with broad stakeholder representation on its governing board;

''(3) demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information;

''(4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders; and

''(5) conform to such other requirements as the Secretary may establish.

''(g) REQUIRED CONSULTATION.—In carrying out activities described in subsections (b) and (c), a State or qualified State designated entity shall consult with and consider the recommendations of—

''(1) health care providers (including providers that provide services to low income and underserved populations);

''(2) health plans;

''(3) patient or consumer organizations that represent the population to be served;

''(4) health information technology vendors;

''(5) health care purchasers and employers;

''(6) public health agencies;

''(7) health professions schools, universities and colleges;

''(8) clinical researchers;

''(9) other users of health information technology such as the support and clerical staff of providers and others involved in the care and care coordination of patients; and

''(10) such other entities, as may be determined appropriate by the Secretary.

''(h) CONTINUOUS IMPROVEMENT.—The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants under this section, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will lead towards the greatest improvement in quality of care, decrease in costs, and the most effective authorized and secure electronic exchange of health information.

''(i) REQUIRED MATCH.—

''(1) IN GENERAL.—For a fiscal year (beginning with fiscal year 2011), the Secretary may not make a grant under this section to a State unless the State agrees to make available non-Federal contributions (which may include in-kind contributions) toward the costs of a grant awarded under subsection (c) in an amount equal to—

''(A) for fiscal year 2011, not less than $1 for each $10 of Federal funds provided under the grant;

''(B) for fiscal year 2012, not less than $1 for each $7 of Federal funds provided under the grant; and

''(C) for fiscal year 2013 and each subsequent fiscal year, not less than $1 for each $3 of Federal funds provided under the grant.

''(2) AUTHORITY TO REQUIRE STATE MATCH FOR FISCAL YEARS BEFORE FISCAL YEAR 2011.—For any fiscal year during the grant program under this section before fiscal year 2011, the Secretary may

determine the extent to which there shall be required a non-Federal contribution from a State receiving a grant under this section."

SDE RFA Amendment, 8/18/10

16. Describe your organization's plans for implementing the technical aspects of the statewide health information network and HIE services. This description should address the following questions:

    If your organization expects to serve in the role of an HIE technical operator, what is your organization's currently capability to do so, or plan to develop that capability.

    If your organization envisions contracting with third-party technical vendors to implement, host, and/or operate <u>any</u> or <u>all</u> of the technical services, what is your organization's planned approach for acquiring the technical vendors?

    If your organization intends to use an existing technical partner(s), identify the partner(s) and list similar projects in which the partner(s) has been engaged and whether or not this partner(s) was acquired through a competitive procurement process.

17. Describe the processes and procedures your organization would use/follow to manage any procurements, contracting, and contract administration envisioned to implement the strategic and operational plan.

19. Describe steps your organization would take to ensure that implementation of HIE in Wisconsin incorporates the use of existing standards and evolving health care information technology standards and enables participation independent of electronic health record systems.

Appendix A – Evaluation Grid

	SDE Selection Criteria Score Card	Max Points	% of Max Points
Company Information		**410**	**50.31%**
1	Contact information	0	0.00%
2	Company background and core business	15	1.84%
3	Length of time in business	15	1.84%
4	Company's financial status with 2 years of financials	15	1.84%
5	2009 Wisconsin Act 274 Criteria	100	12.27%
6	Experience with:		0.00%
6a	Business Plan (BP)	15	1.84%
6b	BP on sustainability/value/many types of stakeholders	15	1.84%
6c	Developing, managing, financing new initiatives, products, services	15	1.84%
6d	Annual operating and capital budgets/ financial controls	15	1.84%
6e	Managing procurements, contracting, contract administration	15	1.84%
6f	Continuous quality/process improvement	15	1.84%
6g	Working with a multi-stakeholder board	15	1.84%
6h	Advancing health care quality and cost-effective health care	15	1.84%
6i	Developing/managing public communications plan	15	1.84%
6j	Working within parameters of Federal grant or program	15	1.84%
6k	Working with various health and health care stakeholders, government, media	15	1.84%
7	Conflicts of interest	100	12.27%
8	Questions/concerns/reservations	0	0.00%
Implementation Approach		**285**	**34.97%**
9	Approach to implementing SOP and organizational structure	100	12.27%
10	Transparency and broad stakeholder participation	25	3.07%
11	Overview of individuals/skill sets for SOP implementation	25	3.07%
12	Goals and Objectives/Performance Measures	25	3.07%
13	Status report for DHS/stakeholders/general public	15	1.84%
14	Involving the State HIT Coordinator/eHealth staff	15	1.84%
15	Management of large numbers of users	15	1.84%

16	Interest/ability to be HIE technical operator and/or planned approach to acquire third-party technical vendors	25	3.07%
17	Managing procurement/contracting	15	1.84%
18	Vision for funding--capitalization and operation	25	3.07%
Content Knowledge		**120**	**14.72%**
19	Alignment with standards; participation independent of EHR systems	20	2.45%
20	Implementation of HIT standards and architecture	20	2.45%
21	Privacy, security, audits etc.	20	2.45%
22	Challenges with proposed Meaningful Use HIE criteria	20	2.45%
23	Impact of diverse WI provider environment on HIE design, funding, and operations	20	2.45%
24	Secondary use of health information	20	2.45%
TOTAL SCORE		**815**	**100%**

APPENDIX 11

Eligible Professional Incentives

Estimated Lost Medicare Incentives	2011	2012	2013	2014	2015	2016
Medicare incentive payment amount (YR1)	$ 18,000	$ 18,000	$ 15,000	$ 12,000	N/A	N/A
(YR2)		$ 12,000	$ 12,000	$ 12,000	$ 8,000	N/A
(YR3)			$ 8,000	$ 8,000	$ 8,000	$ 4,000
(YR4)				$ 4,000	$ 4,000	$ 4,000
(YR5)					$ 2,000	$ 2,000
New non-hospital based providers meeting MU req. (1)	6,000	2,500	1,000	500		
Potential Medicare MU incentive payments	$ 108,000,000	$ 117,000,000	$ 93,000,000	$ 62,000,000	$ 34,000,000	$ 11,000,000
% not meeting MU due solely to lack of SHIN (2)	0%	0%	18%	14%	10%	8%
Potential Medicare MU incentive payments lost	$ -	$ -	$ 16,740,000	$ 8,370,000	$ 3,443,000	$ 835,000

Estimated Lost Medicaid Incentives	2011	2012	2013	2014	2015	2016
Medicaid incentive payment amount (YR1) (3)	$ 21,250	$ 21,250	$ 21,250	$ 21,250	$ 21,250	$ 21,250
(YR2)		$ 8,500	$ 8,500	$ 8,500	$ 8,500	$ 8,500
(YR3)			$ 8,500	$ 8,500	$ 8,500	$ 8,500
(YR4)				$ 8,500	$ 8,500	$ 8,500
(YR5)					$ 8,500	$ 8,500
(YR6)						$ 8,500
New non-hospital based providers meeting MU req. (4)	300	200	55	50	45	40
Potential Medicaid MU incentive payments	$ 6,375,000	$ 6,800,000	$ 5,419,000	$ 5,780,000	$ 6,099,000	$ 6,375,000
% not meeting MU due solely to lack of SHIN (2)	0%	0%	18%	14%	10%	8%
Potential Medicaid MU incentive payments lost	$ -	$ -	$ 765,000	$ 637,000	$ 521,000	$ 420,000

Notes / Assumptions

1) Estimated number of non-hospital-based Medicare providers that would be eligible to receive Medicare meaningfully use incentive payments in any given year. This assumption is based on the number of non-hospital-based providers, the current and future EHR adoption rates, the prevalence of large group practices (Groups >100 physicians = 11,788; Groups 50-99 = 957; Groups 10-49 = 1,761; Groups <10 = 1,834) and their ability to implement HIT.
2) This is the percentage of non-hospital-based providers that will not meet meaningful use requirements due solely to the lack of a statewide health information exchange. This rate is zero in 2011 and 2012 because providers need to only perform a test of health information exchange rather than actively conduct exchange. This rate decreases over time due to independent or vendor solutions to achieve the meaningful use HIE requirement.
3) Incentive payment amounts are as listed in the HITECH Act. Medicaid incentive payments can extend beyond 2016. This estimate stops at 2016 because the great majority of Medicaid providers will have applied for the incentive program by 2016.
4) Estimated number of new non-hospital-based Medicaid providers that would be eligible to receive Medicaid meaningfully use incentive payments in any given year. This assumption is based on a 2010 DHS survey of eligible professionals and on an estimated number of Medicaid incentive-eligible non-hospital-based providers, current and future EHR adoption rates, and the prevalence of large group practices and their ability to implement HIT.

PPS Hospital Incentives

Estimated Lost Medicare Incentives	2011	2012	2013	2014	2015	2016
Medicare incentive payment amount (YR1) [1]	$ 17,187,000	$ 44,685,000	$ 34,373,000	$ 6,445,000	$ 4,297,000	N/A
(YR2)		$ 12,890,000	$ 33,514,000	$ 25,780,000	$ 4,297,000	$ 2,149,000
(YR3)			$ 8,594,000	$ 22,343,000	$ 17,187,000	$ 2,148,000
(YR4)				$ 4,297,000	$ 11,171,000	$ 8,593,250
New hospitals meeting MU req. [2]	10	26	20	5	5	
Potential Medicare MU incentive payments	$ 17,187,000	$ 57,575,000	$ 76,481,000	$ 58,865,000	$ 36,952,000	$ 12,890,000
Percent not meeting MU due solely to lack of SHIN [3]	0%	0%	25%	19%	14%	11%
Potential Medicare MU incentive payments lost	$ -	$ -	$ 19,120,000	$ 11,037,000	$ 5,196,000	$ 1,359,000

Estimated Lost Medicaid Incentives	2011	2012	2013	2014	2015	2016
Medicaid incentive payment amount (YR1) [4]	$ 2,782,000	$ 7,233,000	$ 5,564,000	$ 1,043,000	$ 695,000	N/A
(YR2)		$ 2,086,500	$ 5,424,750	$ 4,173,000	$ 695,000	$ 347,500
(YR3)			$ 1,391,000	$ 3,616,500	$ 2,782,000	$ 348,000
(YR4)				$ 695,500	$ 1,808,250	$ 1,391,000
New hospitals meeting MU req. [5]	7	18	14	3	3	
Potential Medicaid MU incentive payments	$ 2,782,000	$ 9,320,000	$ 12,380,000	$ 9,528,000	$ 5,980,000	$ 2,087,000
% not meeting MU due solely to lack of SHIN [3]	0%	0%	25%	19%	14%	11%
Potential Medicaid MU incentive payments lost	$ -	$ -	$ 3,095,000	$ 1,787,000	$ 841,000	$ 220,000

Notes / Assumptions

1) Incentive estimates are based on the aggregate Medicare incentive divided by the percentage of hospitals achieving meaningful use in a given year. Some totals represent a summations of hospital incentive of varying stages.
2) The estimated number of PPS hospitals that would be eligible to receive Medicare meaningfully use incentive payments in a given year. This assumption is based largely on the 2008 WHA hospital survey data. This estimate assumes all PPS hospitals achieve meaningful use by 2015.
3) This is the percentage of hospitals that will not meet meaningful use requirements due solely to the lack of a statewide health information exchange. This rate is zero in 2011 and 2012 because providers need to only perform a test of health information exchange rather than actively conduct exchange. This rate decreases over time due to independent or vendor solutions to achieve the meaningful use HIE requirement.
4) Incentive estimates are based on the aggregate Medicaid incentive divided by the percentage of hospitals achieving meaningful use in a given year. Some totals represent a summations of hospital incentive of varying stages.
5) The estimated number of PPS hospitals that would be eligible to receive Medicaid meaningfully use incentive payments in a given year. This assumption is based largely on the 2008 WHA hospital survey data. 2009 WHA finance survey data was used to estimate Medicaid eligibility. This estimate assumes all PPS hospitals achieve meaningful use by 2015.

Critical Access Hospital Incentives

Estimated Lost Medicare Incentives	2011	2012	2013	2014	2015	2016
Medicare incentive payment amount (1)	$ 1,125,000	$ 2,250,000	$ 3,375,000	$ 4,275,000	$ 2,250,000	N/A
		$ 1,125,000	$ 2,250,000	$ 3,375,000	$ 4,275,000	$ 2,250,000
			$ 1,125,000	$ 2,250,000	$ 3,375,000	$ 4,275,000
				$ 1,125,000	$ 2,250,000	$ 3,375,000
Percent hospitals meeting MU req. (2)	5	10	15	19	10	
Potential Medicare MU incentive payments	$ 1,125,000	$ 3,375,000	$ 6,750,000	$ 11,025,000	$ 12,150,000	$ 9,900,000
% not meeting MU due solely to lack of SHIN (3)	0%	0%	18%	14%	10%	8%
Potential Medicare MU incentive payments lost	$ -	$ -	$ 1,215,000	$ 1,488,000	$ 1,230,000	$ 752,000

Estimated Lost Medicaid Incentives	2011	2012	2013	2014	2015	2016
Medicaid incentive payment amounts (YR1) (4)	$ 507,000	$ 1,014,000	$ 1,521,000	$ 1,926,000	$ 1,014,000	N/A
(YR2)		$ 380,000	$ 761,000	$ 1,141,000	$ 963,000	$ 507,000
(YR3)			$ 254,000	$ 507,000	$ 761,000	$ 482,000
(YR4)				$ 127,000	$ 254,000	$ 380,250
New hospitals meeting MU req. (5)	2	5	7	9	5	
Potential Medicaid MU incentive payments	$ 507,000	$ 1,394,000	$ 2,536,000	$ 3,701,000	$ 2,992,000	$ 1,369,000
% not meeting MU due solely to lack of SHIN (3)	0%	0%	18%	14%	10%	8%
Potential Medicaid MU incentive payments lost	$ -	$ -	$ 456,000	$ 500,000	$ 303,000	$ 104,000

Notes / Assumptions

1) Medicare incentive estimates are based on an increase of allowable costs for EHR implementation. This increase is estimated to be approximately $900,000 per CAH and is paid out over a period of 4 years.
2) The estimated number of critical access hospitals that would be eligible to receive Medicare meaningfully use incentive payments in a given year. This assumption is based largely on the 2008 WHA hospital survey data. This estimate assumes all critical access hospitals achieve meaningful use by 2015.
3) This is the percentage of hospitals that will not meet meaningful use requirements due solely to the lack of a statewide health information exchange. This rate is zero in 2011 and 2012 because providers need to only perform a test of health information exchange rather than actively conduct exchange. This rate decreases over time due to independent or vendor solutions to achieve the meaningful use HIE requirement.
4) Incentive payment amounts are as listed in the HITECH Act. Medicaid incentive payments can extend beyond 2016. This estimate stops at 2016 because the great majority of Medicaid providers will have applied for the incentive program by 2016.
5) The estimated number of critical access hospitals that would be eligible to receive Medicaid meaningfully use incentive payments in a given year. This assumption is based largely on the 2008 WHA hospital survey data. 2009 WHA finance survey data was used to estimate Medicaid eligibility. This estimate assumes all critical access hospitals achieve meaningful use by 2015.

Meaningful Use Incentives Paid to Hospitals and Eligible Professionals

Non-hospital based eligible professionals	Medicare	Medicaid	Total incentives
Eligible professionals, estimated	10,000	690	
Cumulative individual incentive	$ 44,000	$ 63,750	
Lost MU incentives, potential maximum	$ 425,000,000	$ 36,800,000	$ 461,800,000
Lost MU incentives, adjusted for no SHIN	$ 29,400,000	$ 2,300,000	$ 31,700,000

Prospective Payment System (PPS) Hospitals	Medicare	Medicaid	Total incentives
Eligible hospitals, estimated	66	46	
Lost MU incentives, potential maximum	$ 283,581,000	$ 45,901,000	$ 329,482,000
Lost MU incentives, adjusted for no SHIN	$ 36,712,000	$ 5,943,000	$ 42,655,000

Critical Access Hospitals	Medicare	Medicaid	Total incentives
Eligible hospitals, estimated	59	27	
Lost MU incentives, potential maximum	$ 53,100,000	$ 14,953,000	$ 68,053,000
Lost MU incentives, adjusted for no SHIN	$ 4,685,000	$ 1,363,000	$ 6,048,000

Total MU Incentive Payments	Medicare	Medicaid	Total incentives
Lost MU incentives, potential maximum	$ 761,681,000	$ 97,654,000	$ 859,335,000
Lost MU incentives, adjusted for no SHIN	$ 70,797,000	$ 9,606,000	$ 80,403,000

Notes / Assumptions

1) Estimated number of non-hospital-based Medicare providers that would be eligible to receive Medicare meaningfully use incentive payments in any given year. This assumption is based on the number of non-hospital-based providers, the current and future EHR adoption rates, the prevalence of large group practices (Groups >100 physicians = 11,788; Groups 50-99 = 957; Groups 10-49 = 1,761; Groups <10 = 1,834) and their ability to implement HIT.
2) Incentive payment amounts are as listed in the HITECH Act.
3) Summation of potential Medicare and Medicaid incentives from 2011-2016. Medicaid incentive payments can extend beyond 2016. This estimate stops at 2016 because the great majority of Medicaid providers will have applied for the incentive program by 2016.
4) Summation of potential lost Medicare and Medicaid incentives (2011-2016) due solely to lack of SHIN.
5) Estimated eligible hospitals based on 2009 WHA Finance Survey data.
6) Summation of potential Medicare and Medicaid incentives from 2011-2016.
7) Summation of potential lost Medicare and Medicaid incentives (2011-2016) due solely to lack of SHIN.

APPENDIX 12

Meaningful Use Penalties

Percent of Providers Failing to Meet HIE Meaningful Use Requirement Solely Due to Lack of SHIN

Provider type	2015	2016	2017	2018	2019
Non-hospital based providers [1]	20%	18%	16%	15%	13%
PPS Hospitals [2]	20%	18%	16%	15%	13%
Critical Access Hospitals [2]	30%	27%	24%	22%	20%

Maximum Lost Medicare Revenues Due to Failure to Meet HIE Meaningful Use Requirement

Non-hospital based providers	2015	2016	2017	2018	2019
Penalty	1%	2%	3%	4%	5%
Expected Medicare Part B revenues	$ 3,395,000,000	$ 3,672,000,000	$ 3,972,000,000	$ 4,297,000,000	$ 4,648,000,000
Maximum lost Medicare revenue (est.)	$ 34,000,000	$ 73,400,000	$ 119,200,000	$ 171,900,000	$ 232,400,000
Medicare revenue lost due solely to lack of HIE (est.)	$ 6,800,000	$ 13,200,000	$ 19,300,000	$ 25,100,000	$ 30,500,000
Penalized Eligible Professionals (est.)	2,600	2,300	2,100	1,900	1,700
Lost revenue per penalized Eligible Professional (est.)	$ 2,600	$ 5,700	$ 9,200	$ 13,200	$ 17,900

Prospective Payment System (PPS) Hospitals	2015	2016	2017	2018	2019
Penalty	25%	50%	75%	75%	75%
Expected Medicare Part A revenues	$ 3,391,000,000	$ 3,574,000,000	$ 3,766,000,000	$ 3,969,000,000	$ 4,182,000,000
Expected PPS increase (avg.)	2.75%	2.75%	2.75%	2.75%	2.75%
Maximum lost Medicare revenue (est.)	$ 23,300,000	$ 49,100,000	$ 77,700,000	$ 81,900,000	$ 86,300,000
Medicare revenue lost due solely to lack of HIE (est.)	$ 4,700,000	$ 8,800,000	$ 12,600,000	$ 11,900,000	$ 11,300,000

Critical Access Hospitals	2015	2016	2017	2018	2019
Penalty	100.66%	100.33%	100.00%	100.00%	100.00%
Expected Medicare Part A revenues	$ 265,200,000	$ 279,500,000	$ 294,500,000	$ 310,400,000	$ 327,100,000
Maximum lost Medicare revenue (est.)	$ 900,000	$ 1,900,000	$ 2,900,000	$ 3,100,000	$ 3,300,000
Medicare revenue lost due solely to lack of HIE (est.)	$ 300,000	$ 500,000	$ 700,000	$ 700,000	$ 600,000

Total Lost Medicare Revenues	2015	2016	2017	2018	2019
Maximum lost Medicare revenue (est.)	$ 58,200,000	$ 124,400,000	$ 199,800,000	$ 256,900,000	$ 322,000,000
Medicare revenue lost due solely to lack of HIE (est.)	$ 11,800,000	$ 22,500,000	$ 32,600,000	$ 37,700,000	$ 42,400,000

Notes / Assumptions

1) These assumptions are largely based on the current rate of EHR adoption (66%), leaving only one-third of providers without an EHR. By 2015 is it assumed that all providers currently with EHRs will have an independent or vendor HIE solution (i.e.. Epic CareEverywhere). Of the non-adopters approximately 1/3 will never adopt EHRs. It is estimated that only 10% of those adopting EHRs by 2015 will not meet the meaningful use requirements solely because of lack of a statewide health information exchange. This rate decreases by 10% over time. The assumption being that providers will find alternative solutions to HIE to meet the meaningful use requirements.
2) These assumptions are largely based on the current rate of EHR adoption from the 2009 WHA Annual Survey. By 2015 is it assumed that hospitals currently with EHRs will have an independent or vendor HIE solution (i.e.. Epic CareEverywhere). This rate decreases by 10% over time because it is assumed that hospitals will find alternative HIE solutions to meet the meaningful use requirements.
3) This penalty is as described in the HITECH Act and amounts to a percent reduction in Medicare reimbursement rate that increase to a maximum of 5%.
4) Medicare Part B revenues (physician offices) were taken from the Dartmouth Atlas. These projections are based on 1996 through 2007 Wisconsin
5) This penalty is as described in the HITECH Act and amounts to a percent reduction in the market basket update applicable to the PPS hospital reimbursement rate
6) Medicare Part A revenues were taken from the Dartmouth Atlas. These projections are based on 1996 through 2007 Wisconsin Medicare Part A revenues. Ninety percent of total Medicare Part A revenues are attributed to PPS hospitals and 10% are attributed to critical access hospitals.
7) This is the expected market basket percent increase based on past performance and was provided by the Wisconsin Hospital Association.
8) This penalty is as described in the HITECH Act and amounts to a reduction in the CAH reasonable cost reimbursement rate (from the standard rate of 101%.

APPENDIX 13

Cost Estimates

	Short Term			Total 5 Year Outlook		Total 10 Year Outlook					
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	**Total**
SDE - OPERATIONAL COSTS											
SDE - FIXED											
WISHIN Staff [1]	$ 441,600	$ 585,575	$ 605,242	$ 625,605	$ 646,688	$ 666,089	$ 686,071	$ 706,653	$ 727,853	$ 749,689	6,441,064
Fringe Benefits [2]	$ 138,691	$ 183,582	$ 193,374	$ 203,827	$ 214,989	$ 266,435	$ 274,428	$ 282,661	$ 291,141	$ 299,875	2,349,005
Project Evaluation [3]		$ 85,000	$ 85,000								170,000
Total Annual Fixed Staffing Costs	**$ 580,291**	**$ 854,157**	**$ 883,616**	**$ 829,432**	**$ 861,677**	**$ 932,524**	**$ 960,500**	**$ 989,315**	**$ 1,018,994**	**$ 1,049,564**	**8,960,069**
SDE - Overhead											
Facilities, Equipment, Supplies and Travel [4]	$ 86,000	$ 90,300	$ 94,815	$ 99,556	$ 104,534	$ 109,760	$ 115,248	$ 121,011	$ 127,061	$ 133,414	1,081,699
Business and Legal Services	$ 106,000	$ 81,000	$ 66,000	$ 41,000	$ 41,000	$ 41,000	$ 41,000	$ 41,000	$ 41,000	$ 41,000	540,000
Total Annual SDE Overhead Costs	**$ 192,000**	**$ 171,300**	**$ 160,815**	**$ 140,556**	**$ 145,534**	**$ 150,760**	**$ 156,248**	**$ 162,011**	**$ 168,061**	**$ 174,414**	**1,621,699**
TECHNICAL OPERATOR - CAPITAL & OPERATIONAL COSTS											
Technical Operator - Capital & Operational Costs											
Hardware/Sys. Software/Hardware Install [5]	$ 50,000	$ 200,000	$ 110,000	$ 80,000	$ 100,000	$ 100,000	$ 75,000	$ 50,000	$ 100,000	$ 100,000	$ 965,000
Hardware Maintenance [6]		$ 5,000	$ 20,000	$ 11,000	$ 8,000	$ 10,000	$ 10,000	$ 7,500	$ 5,000	$ 10,000	$ 86,500
Core Application Software Licenses [7]	$ 40,000	$ 731,250	$ 689,361	$ 692,644	$ 695,959	$ 699,307	$ 702,689	$ 706,105	$ 709,555	$ 713,040	$ 6,379,910
Non-Core Software Licenses [8]	$ 75,000	$ 275,000	$ 375,000	$ 350,000	$ 325,000	$ 325,000	$ 325,000	$ 325,000	$ 325,000	$ 325,000	$ 3,025,000
Technical Operator - FTE Costs [9]	$ 1,273,578	$ 3,128,700	$ 2,038,800	$ 2,099,964	$ 2,162,963	$ 2,227,852	$ 2,294,687	$ 2,363,528	$ 2,434,434	$ 2,507,467	$ 22,531,972
Vendor Professional Services [10]	$ 166,400	$ 815,360	$ 815,360	$ 432,640	$ 133,120	$ 133,120	$ 133,120	$ 133,120	$ 133,120	$ 133,120	$ 3,028,480
Interfaces & Maintenance [11]	$ 25,000	$ 405,000	$ 881,000	$ 976,200	$ 795,240	$ 559,048	$ 511,810	$ 502,362	$ 500,472	$ 500,094	$ 5,656,226
Hosting & Support [12]	$ 150,000	$ 250,000	$ 257,500	$ 265,225	$ 273,182	$ 281,377	$ 289,819	$ 298,513	$ 307,468	$ 316,693	$ 2,689,777
Disaster Recovery (basic) [13]		$ 300,000	$ 309,000	$ 318,270	$ 327,818	$ 337,653	$ 347,782	$ 358,216	$ 368,962	$ 380,031	$ 3,047,732
Training [14]	$ 200,000	$ 500,000	$ 515,000	$ 530,450	$ 546,364	$ 562,754	$ 579,637	$ 597,026	$ 614,937	$ 633,385	$ 5,279,553
Insurance [15]	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 2,500,000
Total One-Time Costs	**$ 2,229,978**	**$ 6,860,310**	**$ 6,261,021**	**$ 6,006,393**	**$ 5,617,645**	**$ 5,486,111**	**$ 5,519,544**	**$ 5,591,370**	**$ 5,748,949**	**$ 5,868,829**	**$ 55,190,150**
Contingency											
Contingency [16]	$ 150,113	$ 394,288	$ 365,273	$ 348,819	$ 331,243	$ 328,470	$ 331,815	$ 337,135	$ 346,800	$ 354,640	$ 3,288,596
Total Annual Contingency Costs	**$ 150,113**	**$ 394,288**	**$ 365,273**	**$ 348,819**	**$ 331,243**	**$ 328,470**	**$ 331,815**	**$ 337,135**	**$ 346,800**	**$ 354,640**	**$ 3,288,596**
Total Annual HIE Costs	**$ 3,152,382**	**$ 8,280,055**	**$ 7,670,725**	**$ 7,325,199**	**$ 6,956,098**	**$ 6,897,865**	**$ 6,968,107**	**$ 7,079,830**	**$ 7,282,804**	**$ 7,447,448**	**$ 69,060,514**
Rolling Sum (Costs)	**$ 3,152,382**	**$ 11,432,437**	**$ 19,103,162**	**$ 26,428,361**	**$ 33,384,460**	**$ 40,282,325**	**$ 47,250,432**	**$ 54,330,262**	**$ 61,613,066**	**$ 69,060,514**	

Notes / Assumptions

1) Assumes WISHIN staff members will be the following: CEO, Executive Assistant, Project Director, Clinical/Outreach Manager, Communication Specialist, and other contracted services
2) SDE fringe benefit costs are based on actuals for Years 1-5; assumes 40 percent of staff costs for Years 6-10
3) Assumes ONC required project evaluation cost of 2 percent of total cooperative agreement amount
4) Costs associated with SDE facilities, equipment and supplies, phone and internet service, cell phones, computers, peripherals, and travel
5) Assumes an initial investment in Year 1 for start-up servers and hardware. Year 2 requires purchasing new hardware associated with SHIN development. Years 3 - 10 includes costs associated with new and replacement hardware
6) 10% of the costs associated from hardware/systems and software/hardware install from the previous year. Assumes materials and set-up costs for servers for hosting
7) Initial and on-going license costs for core software; Year 1 costs include the provider directory and Direct Hub with the full HIE solution costs reflected beginning in Year 2
8) Costs associated with non-core software licensing fees. Year 1 includes Certificate Authority and email. Year 2 and beyond assumes Certificate Authority, email, reporting, and analytics licensing.
9) Costs associated with on-going staff costs (i.e., Executive Director, Project Mgr, Tech Project Mgr, Help Desk, FTE benefits, and contractors to support implementation and field support)
10) Estimated costs associated with vendor resources required for implementation and support
11) Includes costs for building and testing interfaces. Assumes 6 to 8 interfaces the first year (IDN's, Pharmacy, Payer, and EHR). Assumes a passed roll-out of interfaces every year.
12) Costs associated with the set-up of hosting hardware. Hosting fees includes the cost for data storage. Assumes 3% increase after Year 3.
13) Assumes no disaster recovery costs are incurred in Year 1 due to support of Direct. In Year 2 costs are incurred to support cosre HIE services. Assumes 3% increase after Year 3.
14) Training costs associated with SDE staff (first year) and end user training. Assumes 20% per year based on initial training costs. Assumes 3% increase after Year 3.
15) An initial broker quote estimates there is likely to be a cap for Cyber insurance for Wisconsin.
16) Assumes 5% contingency to account for additional unforeseen costs

APPENDIX 14

Revenue Scenario - Primarily Funded by Private Sources

	Short Term			Total 5 Year Outlook		10 Year Outlook					
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	**Total**
Projected WI Population [1]	5,815,580	5,858,790	5,902,000	5,945,210	5,988,420	6,031,298	6,074,176	6,117,054	6,159,932	6,202,810	
Percent Insured [2]	94%	94%	94%	100%	100%	100%	100%	100%	100%	100%	
Projected Insured WI Population	5,466,645	5,507,263	5,547,880	5,945,210	5,988,420	6,031,298	6,074,176	6,117,054	6,159,932	6,202,810	
Public Funding Federal & State Sources											
ARRA Funding [3]	$ 2,200,000	$ 3,200,000	$ 3,200,000	$ 200,000							$ 8,800,000
HIT Regional Extension Center Program											$ -
CHIPRA Quality Demo Grant											$ -
CMS 90/10 [4]	$ 40,000	$ 90,000	$ 73,500	$ 69,045	$ 74,636	$ 76,275	$ 72,964	$ 69,703	$ 81,494	$ 83,339	$ 730,955
CMS 75/25 [5]	$ 174,458	$ 1,114,081	$ 1,009,718	$ 1,019,959	$ 998,874	$ 980,898	$ 992,187	$ 1,011,164	$ 1,032,303	$ 1,055,916	$ 9,389,560
State Appropriations - General Purpose Revenue (GPR)											$ -
Per Person - $0.25/year											$ -
Per Person - $0.50/year											$ -
Per Person - $1/year											$ -
Public Health											$ -
State Bonds											$ -
All Payer Assessment											$ -
Employee Trust Fund											$ -
Total State Sourced Revenue	**$ 2,414,458**	**$ 4,404,081**	**$ 4,283,218**	**$ 1,289,004**	**$ 1,073,511**	**$ 1,057,174**	**$ 1,065,151**	**$ 1,080,867**	**$ 1,113,797**	**$ 1,139,254**	**$ 18,920,515**
Private Sources											
Insurance Assessment [6]		$ 1,100,000	$ 1,100,000	$ 1,100,000	$ 1,100,000						$ 4,400,000
Payers/Employers [7]											$ -
$.75/Covered Life [8]		$ 2,250,000	$ 2,250,000	$ 2,250,000	$ 2,250,000						$ 9,000,000
$1/Covered Life [9]						$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 15,000,000
$1.50/Covered Life											$ -
Physicians [10]											$ -
Subscription Fees - $10/mo./physician		$ 300,000	$ 360,000								$ 660,000
Subscription Fees - $15/mo./physician [11]				$ 630,000	$ 720,000						$ 1,350,000
Subscription Fees - $25/mo./physician [12]						$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 1,500,000	$ 7,500,000
Subscription Fees - $30/mo./physician [13]											$ -
Hospitals [14]											$ -
Subscription Fees - $10/mo./physically available bed [15]		$ 360,000	$ 480,000	$ 720,000							$ 1,560,000
Subscription Fees - $15/mo./physically available bed [16]					$ 1,080,000	$ 1,260,000	$ 1,440,000				$ 3,780,000
Subscription Fees - $20/mo./physically available bed [17]								$ 1,920,000	$ 1,920,000	$ 1,920,000	$ 5,760,000
Laboratories											$ -
Pharmacies											$ -
Long Term Care/Skilled Nursing Facilities											$ -
Home Health/Home Health Monitoring											$ -
Philanthropy											$ -
Employer philanthropy programs											$ -
Grants [18]		$ 500,000	$ 500,000	$ 500,000	$ 500,000						$ 2,000,000
Foundations											$ -
Total Private Sourced Revenue	**$ -**	**$ 4,510,000**	**$ 4,690,000**	**$ 5,200,000**	**$ 5,650,000**	**$ 5,760,000**	**$ 5,940,000**	**$ 6,420,000**	**$ 6,420,000**	**$ 6,420,000**	**$ 51,010,000**
Total Annual Revenue	**$ 2,414,458**	**$ 8,914,081**	**$ 8,973,218**	**$ 6,489,004**	**$ 6,723,511**	**$ 6,817,174**	**$ 7,005,151**	**$ 7,500,867**	**$ 7,533,797**	**$ 7,559,254**	**$ 69,930,515**
Rolling Sum (Revenue)	**$ 2,414,458**	**$ 11,328,540**	**$ 20,301,758**	**$ 26,790,762**	**$ 33,514,273**	**$ 40,331,447**	**$ 47,336,597**	**$ 54,837,464**	**$ 62,371,261**	**$ 69,930,515**	

Notes / Assumptions

1) Wisconsin population is based on 2010, 2015, and 2020 projections (Wisconsin Department of Administration - Demographic Services Center).
2) Wisconsin health insurance coverage 2008 (source: Wisconsin Department of Health Services - Division of Public Health). Assumes same percent covered 2011 to 2013. Assumes 100% coverage due to health reform after 2014.
3) Wisconsin received $9.4 Million (ARRA Funding) from the ONC. In 2011, the remaining $8 Million will be spread out through early 2014.
4) It is assumed Medicaid will comprise of 20% of the users. Therefore CMS 90/10 is able to fund up to 20% of costs to build the SHIN. Sources for matching funds may need to come from other sources.
5) It is assumed Medicaid will comprise of 20% of the users. Therefore CMS 75/25 is able to fund up to 20% of costs to operate the SHIN. Sources for matching funds may need to come from other sources.
6) Assumes a 0.01% assessment on total WI insurance claims (i.e., HIRSP) with a sunset date of 2015. Assumes using an existing assessment mechanism in support of statewide HIE and may require a statutory change.
7) Assumes covered lives correspond with projected insured WI population.
8) It is assumed that not all payers will voluntarily participate in the first few years. Therefore, approximately half of the payers/employers are assumed to contribute $0.75 per covered life due to the value derived from the SHIN.
9) Assumes increased value due to more robust functionality and HIE services and higher levels of adoption. It is estimated that payers and employers representing half of the WI population will voluntarily contribute $1 per covered life, due to the value derived from the SHIN.
10) Assumes approximately 6,750 of the 13,500 physicians (source: WI Medical Society) in WI are not hospital based physicians.
11) Assumes only about 2,500 physicians will adopt in Years 2 & 3 at an introductory rate of $10 per physician per month.
12) Assumes adoption of the SHIN will grow to 3,000 in Year 4 and will continue to grow to 4,000 providers at $15 per physician per month.
13) Assumes adoption will cap at 5,000 providers at the beginning of Year 6 at $25 per month.
14) Assumes approximately 12,000 licensed beds in Wisconsin (source: Kaiser Family Foundation). Hospitals will only be charged based on physically available beds vs. licensed beds. By having a subscription fee based on the number of beds per hospital, this creates a tiered payment structure based on Hospital size.
15) It is assumed an introductory rate of $10 per physically available bed per hospital subscribing to the SHIN will be assessed. It is assumed a combined number of hospitals with a total of 3,000 physically available beds will adopt the SHIN in Year 2 and adoption will increase to a total of 6,000 physically available beds in Year 4.
16) A rate of $15 per physically available bed per hospital subscribing to the SHIN will be assessed. It is assumed a combined number of hospitals with a total of 6,000 physically available beds will participate in Year 5 and adoption will grow to 8,000 physically available beds by Year 7.
17) A rate of $20 per physically available bed per hospital subscribing to the SHIN will be assessed. It is assumed a combined number of hospitals with a total of 8,000 physically available beds will participate beginning in Year 8.
18) Assumes the SDE will pursue some grant funding to help support some of the HIE services.

APPENDIX 15

Use Case Workgroup Report

1. Use Case Selection and Categorization Process

The WIRED for Health Board's Standards and Architecture Committee established an ad-hoc Use Case Workgroup to select, categorize, and prioritize use cases of the HIE Services. The workgroup created a consolidated list of potential Use Cases from various sources, including NHIN Direct, industry best practices, and use cases used by other states. They reviewed and modified the initial list to ensure its completeness and to eliminate duplicates. Once they established the initial list, they then divided the use cases into the following functional categories:

1. Clinical summary for care coordination
2. Laboratory-related (including public health reporting)
3. E-prescribing
4. Quality
5. Public health and government reporting
6. Patient-related

The Workgroup placed initial emphasis on use cases that fell into the first four categories above to ensure proper alignment with ONC's prioritized services; however, all use cases were reviewed and completed.

During the process of completing the use cases, the workgroup modified the list of cases and changed the use case descriptions to be specific to Wisconsin's needs and specific health care environment. Where necessary, they added, combined, or split new use cases to ensure the most complete picture possible of the business process and benefits of each use case. This process produced a final list of 28 use cases that reflect Wisconsin's vision for HIE services.

One important point to note regarding Wisconsin's use cases is that many providers and Integrated Delivery Networks within Wisconsin have already implemented electronic eligibility and claims submission, and in some areas, electronic Explanation of Benefits (EOB) transactions as a result of the HIPPA rules related to eligibility and claims transactions. When the Workgroup created its use case list and prioritized the use cases, they determined that this existing work should be recognized, reused, and not replicated by the statewide health information network (SHIN); therefore, the workgroup did not develop use cases to address electronic eligibility and claims transactions.

2. Key Use Case Components

The Use Case Workgroup developed a template that collected key information for each case that facilitated the prioritization and planning efforts needed for the SHIN. The table below outlines the key information the Workgroup collected for each use case, along with the relative value of that information to the overall WIRED for Health Project.

Information Collected	Relative Value to WIRED for Health
Use Case Flow Diagram and Steps	The flow diagrams and steps provide a high-level description of the overall business process and the non-technical interactions between the statewide health information network and various stakeholder systems (e.g., provider EHR systems, laboratory LIS or HIS systems, and State/Government systems). The Workgroup used this information to ensure a clear understanding of the use case and to provide a basic understanding of its business complexity. They depicted hand offs between systems as well as points of entry into the process as part of the business flow and used this information to determine the technical services needed by the SHIN.
Meaningful Use Requirement Mapping	For each use case, the Workgroup determined which meaningful use requirement(s) could be satisfied by the use case. The Workgroup also noted where a meaningful use requirement may be enabled by a use case even if that case did not completely satisfy the requirement.
Benefits Summary by Stakeholder	For each stakeholder/actor in the use case, the Workgroup collected a high-level list of the potential benefits that could be achieved by that stakeholder if the use case was implemented. The benefits were categorized by 1) Quality, 2) Time/Cost, and 3) Other. The Workgroup collected this information to provide some guidance on the overall value of the case to the stakeholders and to aid in use case prioritization.
Potential Barriers, a Summary of Cost Drivers, and Assumptions	Each stakeholder could have barriers or costs that could drive their ability to leverage the functionality outlined in the use case. The Workgroup collected information about potential barriers and cost drivers in order to gain a more comprehensive understanding of what would be needed to fully implement the functionality in the use case. This information provided a broader view of the use case than would have been achieved by viewing the use case from a strictly HIE perspective. This insight was valuable in helping to understand the true value of the use case.
Technical Components/Services	The Workgroup documented technical components/services for each use case to understand which services were required or optional for each case. They used this information to inform the technical plan for implementing the SHIN.

Table 1: Use case components

During the completion of the use cases, the Use Case Workgroup established a broad definition for “provider” in order to be as inclusive as possible during the review. A

"provider" could be a hospital, an individual doctor, a case manager, or some other provider of health or human services.

3. Prioritization Process

a. Prioritization Process Summary

The Use Case Workgroup developed a prioritization methodology that used the key use case components noted in the previous section. The methodology focused on the following categories:

- Benefits
- Meaningful Use
- Complexity

For each use case, they calculated a separate score for each of the above categories and the sum of those scores determined the final priority ranking of the use case. The Standards and Architecture Committee decided to apply a discretionary measure to only one of the use cases (use case #35) to account for a uniqueness in the Wisconsin-specific HIE environment. The following diagram shows the overall prioritization methodology.

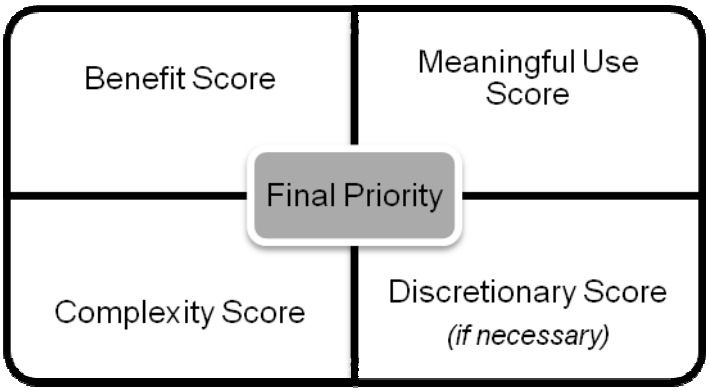

Figure 1: Overall prioritization methodology

The following diagram depicts the high-level process the Workgroup used to score each category. The Workgroup applied standardization to both the qualitative and quantitative information they captured. They also applied statistical methods to account for variations and to normalize the scores across all use cases. A description of the components for each category and a more detailed explanation of the statistical methods used to calculate the final score for each category is included in this report.

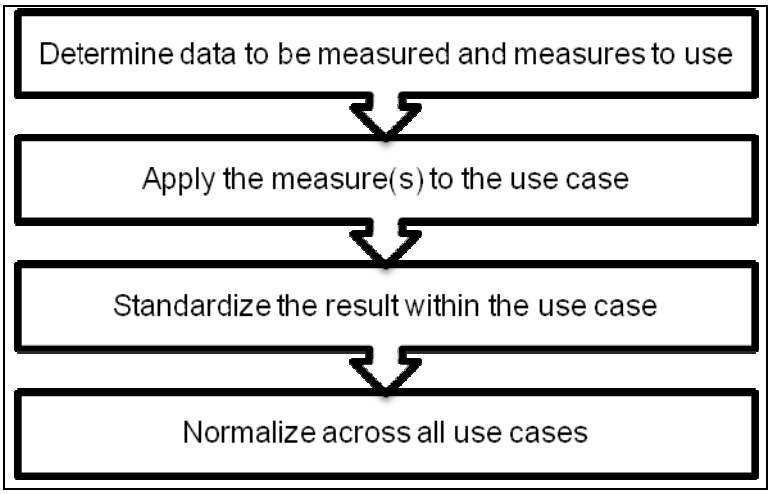

Figure 2: High-Level process for scoring of use case

The Workgroup totaled category scores to determine the priority rank of each use case and gave each category an equal weight. The Standards and Architecture Committee reviewed the resulting prioritized list to validate that the scores resulted in a list that was reasonable and expected. The Committee applied a discretionary score to only one use case (use case #35) to adjust its overall rank downward to account for mitigating factors specific to Wisconsin's HIE environment.

b. Category 1: Benefits

Each use case captures the benefits associated with each stakeholder directly impacted by it. The Workgroup generally understood that almost all use cases provide an overall benefit to the citizens of Wisconsin (i.e., patients) as a whole; however, the workgroup did not capture these benefits unless the use case specifically "touched" a patient as an actor in the use case.

The Workgroup segmented use case benefits into two categories: 1) those that improve quality and 2) those that generate cost savings and/or efficiencies. For the purposes of prioritization, the Workgroup determined that benefits in both categories should be weighted the same (e.g., a quality benefit would be just as important as a cost benefit).

The degree to which an individual benefit impacts a stakeholder can vary by many factors. Additionally, the particulars of the case itself can influence the degree to which a benefit can be achieved for the stakeholder. These factors made measuring benefits particularly challenging. The Workgroup relied on the expertise of the Standards and Architecture Committee members along with the Use Case Workgroup members to apply a measure to each benefit for each stakeholder in each use case. Although the benefit measure was broad, by applying the measure at the detail level, the Workgroup was able to get a fair

measure of the benefits that could be used to aide in the prioritization of the use case.

The table below outlines the possible measures that could be applied to the benefits.

Category	Measure
Quality	1 – Minimal Benefit
	2 – Moderate Benefit
	3 – Significant Benefit
	4 – Maximum Benefit
Cost/Time	1 – Minimal Benefit
	2 – Moderate Benefit
	3 – Significant Benefit
	4 – Maximum Benefit

Table 2: Measures applied to benefits

c. Category 2: Meaningful Use

For each use case, the Use Case Workgroup collected information on which of ONC's Meaningful Use requirement(s) are satisfied by the use case. The Workgroup also collected information on which use cases would enable the meaningful use requirement(s) even if it would not completely satisfy the requirement in and of itself. The Standards and Architecture Committee decided that use cases that enable meaningful use requirements should never outrank a use case that satisfies a meaningful use requirement, regardless of the number of meaningful requirements it enables.

Meaningful use requirements were counted only once per use case, meaning that if a requirement was satisfied by the use case, it was not also listed as enabling a use case.

d. Category 3: Complexity

The Use Case Workgroup created flow diagrams for each use case and captured the steps around how the use case would be completed. The Workgroup also collected information on which core technical services are required by the use case. The Workgroup documented interfaces and hand offs between systems, as well as optional transactions, assumptions, cost drivers, and potential barriers. Combined, this information takes into account the business, technical, political, and risk factors necessary to determining how complicated it may be to implement the use case.

To assign a measure to this complexity, the Workgroup once again leveraged the expertise of the Standards and Architecture Committee members and specific workgroup members. They asked each member to review the case and apply an overall complexity measure to the case after considering all of the information.

The less complex a use case, the higher its score. Below is the Workgroup's methodology for ranking use cases based on business complexity:

	Measure/Rank
Complexity	4 – Simple Complexity
	3 – Moderate Complexity
	2 – High Complexity
	1 – Maximum Complexity
Total Complexity Rank	Sum of all Measures

Table 3: Measures applied to complexity

e. Discretionary Measure (optional)

The Standards and Architecture committee reviewed the prioritized list of cases to validate they were reasonable and what was expected. During this review, the Committee applied a discretionary score to only one use case (use case #35 - Provider prescribes medication for patient) to bring it in line with expectations and make it consistent with the HIE environment in Wisconsin.

4. List of Prioritized Use Cases

During the prioritization process, the Use Case Workgroup classified two use cases as "core" use cases. These cases are integral to the success of the entire SHIN and are prerequisites to all other use cases. These cases (#38a and #38b) support the patient's ability to "opt out" and "opt back in" to having their health information/data exchanged via the SHIN. Because of their significance, the Workgroup ranked these use cases the highest of any cases and did not score them using the prioritization methodology.

The following table shows a prioritized list of all use cases, including the final score for each case. A detailed listing of each case, the individual categories scores along with supporting data for each of the scores, and the completed templates and flow diagrams for each use case are included in this report.

a. Core Use Cases

Case #	Description
38a	Patient Opts Out of having records shared in HIE (e.g., PHR or HIE Patient Web Portal)
38b	Patient decides to Opt back In to having information exchanged in the HIE (e.g., PHR)

Table 4: Core use cases

b. Prioritized Use Cases

Case #	Description	Total Score
25	Clinicians can send summaries to other providers and to patients	1.445
12	Provider send patient immunization data to public health	1.394
4	Hospital sends discharge information to referring provider	1.314
1	Provider refers patient to specialist (including care coordination document)	1.293
3	Specialist sends continuity of care document back to referring provider	1.262
33	Laboratory or reference lab send aggregate data to Public Health (batch)	1.244
2	Provider refers patient to hospital (including continuity of care record)	1.215
15	Laboratory (or reference laboratory) sends test results to Public Health	1.175
13	Provider or hospital submits quality data and/or measures to the CMS, the State, and/or health information organizations	1.134
11	Provider sends reminder for preventive or follow-up care to the patient/caregiver (via PHR)	1.061
32a	Provider sends reportable disease diagnosis data to public health	0.900
32b	Provider sends non-reportable, anonymized disease data to public health	0.898
39	Public Health sends feedback report to provider	0.889
16	Providers send chief complaint (non-reportable) data to public health for syndromic surveillance	0.886
5b	Provider receives lab results from laboratory or reference laboratory	0.784
37	Release of information (provider to provider)	0.682
36b	Laboratory receives lab results from another lab	0.629
30	Emergency Department link	0.580
5a	Provider orders patient lab tests from laboratory or reference laboratory	0.572
18	Pharmacist sends medication therapy management consult to provider	0.527
36a	Laboratory orders lab test from another lab	0.508
9	Provider sends a clinical summary of an office visit to the patient/caregiver (via PHR)	0.507
19	A patient-designated caregiver monitors and coordinates care across multiple domains	0.503
17	State public health agency reports public health data to Centers for Disease Control (CDC)	0.345
35	Provider prescribes medication for patient	0.182
31	Provide advance directives to requesting providers (via PHR)	0.098

Table 5: Prioritized use cases

5. Roadmap for Implementation

The list of prioritized use cases is a key input to the overall HIE implementation roadmap. The SDE should concentrate its initial efforts on implementing use cases with a total score of 1.0 or higher as these cases are the ones with the highest overall value to Wisconsin. Use cases with a total score less than 1.0 will be considered for subsequent phases unless additional information becomes available that would impact the roadmap.

The prioritized list of use cases is only one input into the implementation roadmap. The use cases provide the framework for the overall scope of work that must be completed. Other factors, including cost, time to implement, and capabilities of the technical solution vendor must also be considered. As with any project of this size, the final plan will balance scope with cost, time, and quality.

6. Next Steps for Use Cases

The information collected provides a solid foundational understanding of the HIE landscape in Wisconsin. As noted above, this information was used to prioritize the use cases and provide input into the implementation roadmap.

The continuously changing health care environment demands our implementation plan be flexible and responsive. As such, use cases will continue to be developed and expanded as Wisconsin's efforts toward achieving statewide HIE progress. The next steps include further detailed development of the existing use cases, collection of addition use case information, and another comprehensive review of the cases to ensure the list is complete. These steps will allow Wisconsin to refine and revise its plan while still making progress toward its goals.

Standards and Architecture
Use Case Prioritization

Core Use Cases

Case Number	Focus	Description	Benefits Score	Meaningful Use Score	Complexity Score	Discrepancy Score	Total Score
38a	Patient	Patient Opts Out of having records shared in HIE (e.g., PHR or HIE Patient Web Portal)					
38b	Patient	Patient decides to Opt back In to having information exchanged in the HIE (e.g., PHR)					

Additional Use Cases

Case Number	Focus	Description	Benefits Score	Meaningful Use Score	Complexity Score	Discrepancy Score	Total Score
25	Provider	Clinicians can send summaries to other providers and to patients	1.000	1.000	0.295		**1.445**
12	Public Health	Provider send patient immunization data to public health	0.082	0.968	1.000		**1.394**
4	Provider	Hospital sends discharge information to referring provider	0.390	0.968	0.799		**1.314**
1	Provider	Provider refers patient to specialist (including care coordination document)	0.477	0.968	0.713		**1.293**
3	Provider	Specialist sends continuity of care document back to referring provider	0.385	0.968	0.713		**1.262**
33	Public Health	Laboratory or reference lab send aggregate data to Public Health (batch)	0.136	0.968	0.770		**1.244**
2	Provider	Provider refers patient to hospital (including continuity of care record)	0.382	0.968	0.627		**1.215**
15	Lab	Laboratory (or reference laboratory) sends test results to Public Health	0.370	1.000	0.493		**1.175**

Case Number	Focus	Description	Benefits Score	Meaningful Use Score	Complexity Score	Discrepancy Score	Total Score
13	Other	Provider or hospital submits quality data and/or measures to the CMS, State, and/or other quality or health information organizations	0.197	0.935	0.610		**1.134**
11	Patient	Provider sends reminder for preventive or follow-up care to the patient/caregiver (via PHR)	0.261	0.935	0.426		**1.061**
32a	Public Health	Provider sends reportable disease diagnosis data to public health	0.160	0.032	0.885		**0.900**
32b	Public Health	Provider sends non-reportable, anonymized disease data to public health	0.150	0.032	0.885		**0.898**
39	Public Health	Public Health sends feedback report to provider	0.080	0.000	0.885		**0.889**
16	Public Health	Providers send chief complaint (non-reportable) data to public health for syndromic surveillance	0.000	0.032	0.885		**0.886**
5b	Lab	Provider receives lab results from laboratory or reference laboratory	0.516	0.032	0.590		**0.784**
37	Provider	Release of information (provider to provider)	0.414	0.032	0.541		**0.682**
36b	Lab	Laboratory receives lab results from another lab	0.216	0.032	0.590		**0.629**
30	Provider	Emergency Department link	0.184	0.097	0.541		**0.580**
5a	Lab	Provider orders patient lab tests from laboratory or reference laboratory	0.536	0.032	0.197		**0.572**
18	Provider	Pharmacist sends medication therapy management consult to provider	0.406	0.032	0.334		**0.527**
36a	Lab	Laboratory orders lab test from another lab	0.275	0.032	0.426		**0.508**
9	Patient	Provider sends a clinical summary of an office visit to the patient/caregiver (via PHR)	0.258	0.097	0.426		**0.507**

Case Number	Focus	Description	Benefits Score	Meaningful Use Score	Complexity Score	Discrepancy Score	Total Score
19	Provider	A patient-designated caregiver monitors and coordinates care across multiple domains	0.432	0.258	0.000		**0.503**
17	Public Health	State public health agency reports public health data to Centers for Disease Control (CDC)	0.077	0.032	0.334		**0.345**
35	Provider	Provider prescribes medication for patient	0.283	0.935	0.472	-0.903	**0.182**
31	Other	Provide advance directives to requesting providers (via PHR)	0.000	0.000	0.098		**0.098**

Use Case #1

Use Case #: 1

Title: Provider refers patient to specialist (including care coordination document)

Description:
1. Provider creates the HIE Referral Transaction Set, which includes: 1) Referral Request 2) CCD and 3)Attachments (optional).
2. Patient is referred to Specialist and makes appointment.
3a. A notification (optional) is created and sent to the Specialist's office.
3b. The Specialist receives the notification (optional).
4. The Specialist requests the Referral Transaction Set from the Exchange.
5. The Exchange sends the Transaction Set to the Specialists EHR.
6. The Specials reviews the Transaction Set and determines whether or not to incorporate it (in whole or in part) into their EHR.

General Use Case Information

Users: Provider, Specialist

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	Yes	---
24	Yes	---

Potential Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Specialist**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Reduced administrative cost	Standard data format allows for increased efficiency
		Reduced administrative cost
		Reduction in number of unnecessary diagnostic tests

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Use Case #1

Assumptions

Assumptions:
1) Provider and Specialist can connect to HIE
2) Data exchange integrated and executed in real-time
3) Provider and Specialist have certified EHR
4) Provider is able to select the data they want to send to the Specialist

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Notification service	Optional
Messaging (this is the service that exchanges the records)	Yes

Barriers

Barriers:
1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #2

Use Case #: 2

Title: Provider refers patient to hospital (including continuity of care record)

Description:
1. Provider creates the HIE Order Transaction Set, which includes 1) Test Required 2) Diagnosis and 3) CCD.
2. Patient makes the appointment for the test.
3. The appointment triggers the Hospital to request the order from the HIE.
4. The HIE retrieves the order from the Provider's EHR and forwards the record back to the Hospital.
5. The Hospital receives the order and determines whether or not to incorporate the data into its EHR.

General Use Case Information

Users: Provider, Hospital

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes
24	Yes	---

Potential Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Hospital**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
		Reduction in number of unnecessary diagnostic tests
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Standard data format allows for increased efficiency	Standard data format allows for increased efficiency
	Reduced administrative cost	Reduced administrative cost
		Reduction in number of unnecessary diagnostic tests

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Use Case #2

Assumptions

Assumptions:
1) Stakeholders can connect to HIE
2) Data exchange integrated and executed in real-time
3) Stakeholders have certified EHR

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes

Barriers

Barriers:
1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #3

Use Case #: 3

Title: Specialist sends Continuity of Care Document back to referring provider

Description: 1. Specialist creates the HIE Consultation Transaction Set, which includes: 1) Consultation Note 2) CCD and 3)Attachments (optional).
2a. A notification (optional) is created and sent to the Provider's office.
2b. The Provider receives the notification (optional).
3. The Provider requests the Consultation Transaction Set from the Exchange.
4. The Exchange sends the Transaction Set to the Provider's EHR.
5. The Provider reviews the Transaction Set and determines whether or not to incorporate it (in whole or in part) into their EHR.

General Use Case Information

Users: Specialist, Provider

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes
24	Yes	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Specialist**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Reduced administrative cost	Reduced administrative cost
	Standard data format allows for increased efficiency	
	Reduction in number of unnecessary diagnostic tests	

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Use Case #3

Assumptions

Assumptions:
1) Stakeholders can connect to HIE
2) Data exchange integrated and executed in real-time
3) Stakeholders have certified EHR

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Notification service	Optional

Barriers

Barriers:
1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #4

Use Case #: 4

Title: Hospital sends discharge information to referring provider

Description: 1. At the time of patient discharge, Hospital creates HIE Discharge Transaction Set, including the following: 1) discharge summary 2) CCD and 3) pertinent test results.
2. Hospital sends the Discharge Transaction to the referring provider through the Exchange
3a. A notification (optional) is created and sent to the Provider's office.
3b. The Provider receives the notification (optional).
3. The Provider requests the Discharge Transaction Set from the Exchange.
4. The Exchange sends the Discharge Transaction Set to the Provider's EHR.
5. The Provider reviews the Discharge Transaction Set and determines whether or not to incorporate it (in whole or in part) into their EHR.

General Use Case Information

Users: Hospital, Provider

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes
24	Yes	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Hospital**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Standard data format allows for increased efficiency	Standard data format allows for increased efficiency
	Reduced administrative cost	Reduced administrative cost
	Reduction in number of unnecessary diagnostic tests	

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Use Case #4

Assumptions

Assumptions:
1) Stakeholders can connect to HIE
2) Data exchange integrated and executed in real-time
3) Stakeholders have certified EHR

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Notification service	Optional

Barriers

Barriers:
1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #19

Use Case #: 19

Title: A patient-designated caregiver monitors and coordinates care across multiple domains

Description:
1) The caregiver (via the PHR) views the patient's CCRs, lab results, etc from all providers.
2) The caregiver monitors the data and exchanges messages with the various providers as needed to ensure care.
3) The caregiver requests additional data from one or more of the providers via the PHR.
4) The PHR sends the requests to the appropriate EHR(s) of the provider(s).
5) The provider(s) use their internal EHR(s) to send the requested data to the HIE
6) The HIE sends the response to the PHR.
7) The caregiver retrieves the information from the PHR.

General Use Case Information

Users: Caregiver/Patient, Providers

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
18	Yes	---
1	---	Yes
2	---	Yes
14	---	Yes
20	---	Yes
21	---	Yes
22	---	Yes
24	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Providers	**Caregiver/Patient**
Quality	Improved care coordination	Improved care coordination
	Patient/caregiver engagement helps ensure data accuracy	Patient/caregiver engagement helps ensure data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Extends health community access and clinical data	Extends health community access and clinical data
		Improved access to test results
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Reduced staff time spent on handling diagnostic results	
	Reduced administrative cost	
	Reduction in number of unnecessary diagnostic tests	
	Chronic Care cost reduction	
Other	Increased adoption of HIE	Increased adoption of HIE
	Optimize usage of HIE, EHR and PHR	Optimize usage of HIE, EHR and PHR

Use Case #19

Use Case #19

Summary of Cost Drivers

Cost Driver Summary:

Provider	Caregiver/Patient
1) Interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE	1) Connectivity to PHR

Assumptions

Assumptions:

Provider	Caregiver/Patient
1) Providers can connect to HIE 2) Data exchange integrated and executed in real-time 3) Providers have certified E.H.R. 4) At least one provider has a PHR for the caregiver/patient to access	1) Caregiver/Patient can connect to PHR 2) Caregiver/Patient has some level of knowledge on how to use a computer and internet

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Notification service	Optional
PHR	Yes

Barriers

Barriers:

Provider	Caregiver/Patient
1) EHR functionality may be limited (batch vs. real-time) 2) Availability of patient and/or provider records in the Exchange 3) Cost 4) Technical limitations of E.H.R. Systems 5) Data Fatigue (inability of a user to use the data provided) 6) Privacy or security policies or processes at stakeholder organization 7) Workflow processes at stakeholder organization	1) Limited technical knowledge to use PHR. 2) Limited ability to understand the information they see.

Issues & Follow-Up

Issues: None.

Use Case #25

Use Case #: 25

Title: Clinicians can send summaries to other providers and to patients

Description: 1. An originating provider (via an EHR) or patient (via a PHR) creates a HIE Patient Information REQUEST Transaction Set, including 1) Description of the Request 2) CCD and 3) Selected Attachments (optional and only for originating provider).
2. The REQUEST Transaction Set is sent to the Exchange.
3a. A notification (optional) is created and sent to the receiving Provider's office.
3b. The receiving provider receives the notification (optional).
3. The receiving Provider requests the REQUEST Transaction Set from the Exchange.
4. The Exchange sends the REQUEST Transaction Set to the receiving Provider's EHR.
5. The receiving Provider reviews the REQUEST Transaction Set and prepares an HIE Patient Information RESPONSE Transaction Set, including 1) Textual description of the response, 2) CCD and 3) Selected attachments (optional).
6. The provider sends the RESPONSE Transaction set to the Exchange.
7a. A notification (optional) is created and sent to the originating Provider's office or to the patient.
7b. The originating provider or patient receives the notification (optional).
8. The originating provider reviews the RESPONSE and determines whether or not to incorporate it (in whole or in p

General Use Case Information

Users: Originating Provider, Receiving Provider, Patient

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
18	---	Yes
22	---	Yes
24	Yes	---

Use Case #25

Benefits Summary by Stakeholder

Benefit	Measures		
	Originating Provider	Receiving Provider	Patient
Quality	Improved care coordination	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Extends health community access and clinical data exchange between HC Providers and Patients	Extends health community access and clinical data exchange between HC Providers and Patients	Extends health community access and clinical data exchange between HC Providers and Patients
	Improved access to test results	Improved access to test results	Improved access to test results
Time/Cost	Less time on individual encounter	Less time on individual encounter	Less time on individual encounter
	Reduced staff time spent on handling diagnostic results	Reduced staff time spent on handling diagnostic results	Reduction in number of unnecessary diagnostic tests
	Reduced administrative cost	Reduced administrative cost	
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests	
Other	Increased adoption of HIE	Increased adoption of HIE	Optimize usage of PHR
	Optimize usage of HIE, EHR and PHR	Optimize usage of HIE, EHR and PHR	

Summary of Cost Drivers

	Providers	Caregiver/Patient
Cost Driver Summary:	1) Interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE	1) Connectivity to PHR

Assumptions

	Providers	Caregiver/Patient
Assumptions:	1) Providers can connect to HIE 2) Data exchange integrated and executed in real-time 3) Providers have certified HER 4) At least one provider has a PHR for the caregiver/patient to access	1) Caregiver/Patient can connect to PHR 2) Caregiver/Patient has some level of knowledge on how to use a computer and internet

Use Case #25

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the	Yes
Notification service	Optional
PHR	Yes

Barriers

Barriers:

Provider	Caregiver/Patient
1) EHR functionality may be limited (batch vs. real-time) 2) Availability of patient and/or provider records in the Exchange 3) Cost 4) Technical limitations of E.H.R. Systems 5) Data Fatigue (inability of a user to use the data provided) 6) Privacy or security policies or processes at stakeholder organization 7) Workflow processes at stakeholder organization	1) Limited technical knowledge to use PHR. 2) Limited ability to understand the information they see.

Issues & Follow-Up

Issues: None.

Use Case #5a

Use Case #: 5a

Title: Provider orders patient lab tests from Laboratory or Reference Laboratory

Description:

1. Provider creates the Lab Order Transaction Set, which includes:
   1. Lab Order
   2. Test Information
   3. Diagnosis
   4. Patient Information
   5. Insurance Information
   6. Patient History (for pathology labs)
   7. "Copy To" information
2. Provider sends order to HIE.
3. Specimens are received at the Lab.
4. The lab requests any orders from the HIE.
5. The lab reviews the Transaction Set and determines whether or not to incorporate it (in whole or in part) into their LIS or HIS

General Use Case Information

Users: Provider, Lab

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
11	Yes	---
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Lab	**Provider**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Improved access to test results	Improved access to test results
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Higher productivity	Reduced staff time spent on handling lab orders/results
	Reduced administrative cost	Reduced administrative cost
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Increased adoption of HIE	
	Optimize usage of HIE and Labs	
Other	Increased adoption of HIE	Increased adoption of HIE
	Optimize usage of HIE and Labs	Optimize usage of HIE and Labs

Use Case #5a

Summary of Cost Drivers

	Providers	Lab
Cost Driver Summary:	1) E.H.R Interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE	1) Lab interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE 4) Workflow to match specimen to order (accession process)

Assumptions

Assumptions:
1) Provider and Lab connected to HIE
2) Data exchange integrated and executed in real-time
3) E.H.R must be able to route order to correct labs (may need to split order and send parts to multiple labs)

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Lab Vocabulary Service	Yes

Barriers

Barriers:
1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #5b

Use Case #: 5b

Title: Provider Receives Lab Results from Laboratory or Reference Laboratory

Description:

1. Lab creates the Lab Results Transaction Set in their LIS/HIS, which includes:
   1. Test Results
   2. Comments
   3. Normal Range (optional)
   4. Pathology Data (optional)
   5. Other Segments (optional)
   6. Performing Lab Information
   7. "Copy To" information
2. Lab sends Results transaction set to HIE.
3. The Provider's (and "copy to" provider's) E.H.R receives results and incorporates them into the record.

General Use Case Information

Users: Provider, Lab

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
11	Yes	---
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Lab	**Provider**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
		Reduction in number of unnecessary diagnostic tests
		Improved access to test results
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Higher productivity	Reduced staff time spent on handling lab orders/results
	Reduced administrative cost	Reduced administrative cost
	Increased adoption of HIE	Reduction in number of unnecessary diagnostic tests
	Optimize usage of HIE and Labs	
Other	Increased adoption of HIE	Increased adoption of HIE
	Optimize usage of HIE and Labs	Optimize usage of HIE and Labs

Use Case #5b

Summary of Cost Drivers

	Providers	Lab
Cost Driver Summary:	1) E.H.R Interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE	1) Lab interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE 4) Workflow to match specimen to order (accession process)

Assumptions

Assumptions:

1) Provider and Lab connected to HIE
2) Data exchange integrated and executed in real-time
3) E.H.R must be able to route order to correct labs (may need to split order and send parts to multiple labs)

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Lab Vocabulary Service	Yes

Barriers

Barriers:

1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #15

Use Case #: 15

Title: Laboratory (or Reference Laboratory) Sends Test results to Public Health

Description:

1. Lab creates the Public Health Lab Results Transaction Set in their LIS/HIS, which includes:
    1. Test Results
    2. Patient Demographic Data
    3. Comments
    4. Normal Range (optional)
    5. Pathology Data (optional)
    6. Other Segments (optional)
    7. Performing Lab Information
2. Lab sends Public Health Lab Results transaction set to HIE.
3. Public Health receives results and incorporates them into their records.

General Use Case Information

Users: Lab (LIS or HIS), Public Health Entity

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
26	Yes	---
27	Yes	---
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Lab	**Public Health Agency (PHA)**
Quality	Improved care coordination	Improved care coordination
	Provides critical electronic surveillance data to PHA	Provides critical electronic surveillance data to PHA
	Bridges some gaps in the prevention of major health risks	Patient satisfaction
		Bridges some gaps in the prevention of major health risks
		Improved population health
Time/Cost	Provides avenue for reporting of critical data	Reduces research time
	Reduced administrative cost	Enhances emergency response process
		Improves State agency preparedness

Use Case #15

Summary of Cost Drivers

Cost Driver Summary:

Lab	Public Health
1) Lab interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE 4) Workflow to match specimen to order (accession process) 5) LIS/HIS must be able to determine which labs to report to Public Health and which not to. May require manual intervention if LIS/HIS does not have this capability.	1) Interface to HIE 2) Technical and Business staff to support Interface(s) 3) Cost of HIE 4) Additional data requires more analysts to review/monitor

Assumptions

Assumptions:

1) Provider and Lab connected to HIE
2) Data exchange integrated and executed in real-time
3) LIS/HIS must be able to determine which labs to report to public health - or manual process will be needed.

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Lab Vocabulary Service	Yes

Barriers

Barriers:

1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization
8) Public Health funding is limited

Issues & Follow-Up

Issues: None.

Use Case #33

Use Case #: 33

Title: Lab or Reference Lab Send Aggregate Data to Public Health (Batch)

Description:
1) Lab (or Reference Lab) LIS/HIS creates Aggregated Results Transaction Set (batch process).
2) LIS/HIS sends transaction set to HIE.
3) HIE sends transaction to Public Health system(s).
4) Public Health receives transaction set and incorporates into records.

General Use Case Information

Users: Lab, Public Health

General Use Case Information

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
27	Yes	---
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Lab	**Public Health Agency (PHA)**
Quality	Provides critical electronic surveillance data to PH	Improved care coordination
	Bridges some gaps in the prevention of major health risks	Provides critical electronic surveillance data to PH
		Patient satisfaction
		Bridges some gaps in the prevention of major health
		Improved population health
Time/Cost	Provides avenue for reporting of critical data	Reduces research time
	Reduced administrative cost	Enhances emergency response process
		Improves State agency preparedness

Summary of Cost Drivers

	Lab	**Public Health**
Cost Driver Summary:	1) Lab interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE 4) LIS/HIS must be able to determine which labs to report to Public Health and which not to. LIS/HIS must be able to aggregate data into the appropriate transaction set. May require manual intervention.	1) Interface to HIE 2) Technical and Business staff to support Interface(s) 3) Cost of HIE 4) Additional data requires more analysts to review/monitor

Use Case #33

Assumptions

Assumptions:
1) Provider and Lab connected to HIE
2) Data exchange integrated and executed in real-time
3) LIS/HIS must be able to determine which labs to report to public health - or manual process will be needed.
4) LIS/HIS must be able to aggregate data.

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Lab Vocabulary Service	Yes

Barriers

Barriers:
1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization
8) Public Health funding is limited

Issues & Follow-Up

Issues: None.

Use Case #36a

Use Case #: 36a

Title: Laboratory orders lab test from another Lab

Description:

1. Originating Lab creates the Lab Order Transaction Set, which includes:
   1. Lab Order
   2. Test Information
   3. Diagnosis
   4. Patient Information
   5. Insurance Information
   6. Patient History (for pathology labs)
   7. "Copy To" information
2. Originating lab sends order to HIE.
3. Specimens are received at the Receiving Lab.
4. The Receiving lab requests any orders from the HIE.
5. The Receiving lab reviews the Transaction Set and determines whether or not to incorporate it (in whole or in part) into their LIS or HIS.

General Use Case Information

Users: Originating Lab, Receiving Lab

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**
	Both Labs
Quality	Improved care coordination
	Data accuracy
	Reduction in number of unnecessary diagnostic tests
	Improved access to test results
Time/Cost	Less time on individual encounter
	Higher productivity
	Reduced administrative cost
	Reduction in number of unnecessary diagnostic tests
	Increased adoption of HIE
	Optimize usage of HIE and Labs
Other	Increased adoption of HIE
	Optimize usage of HIE and Labs

Use Case #36a

Summary of Cost Drivers

	Lab
Cost Driver Summary:	1) Lab interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE 4) Workflow to match specimen to order (accession process)

Assumptions

Assumptions:
1) Both Labs connected to HIE
2) Data exchange integrated and executed in real-time

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Lab Vocabulary Service	Yes

Barriers

Barriers:
1) LIS/HIS, and EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization (The lab workflow to match the specimen to the order may be a barrier for some labs)

Issues & Follow-Up

Issues: None.

Use Case #36b

Use Case #: 36b

Title: Laboratory receives lab results from another lab

Description:

1. Receiving Lab creates the Lab Results Transaction Set in their LIS/HIS, which includes:
   1. Test Results
   2. Comments
   3. Normal Range (optional)
   4. Pathology Data (optional)
   5. Other Segments (optional)
   6. Performing Lab Information
   7. "Copy To" information
2. Receiving Lab sends Results transaction set to HIE.
3. The Originating Lab receives results and incorporates them into the record.

General Use Case Information

Users: Originating Lab, Receiving Lab

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**
	Both Labs
Quality	Improved care coordination
	Data accuracy
Time/Cost	Less time on individual encounter
	Higher productivity
	Reduced administrative cost
	Increased adoption of HIE
	Optimize usage of HIE and Labs
Other	Increased adoption of HIE
	Optimize usage of HIE and Labs

Summary of Cost Drivers

	Lab
Cost Driver Summary:	1) Lab interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE 4) Workflow to match specimen to order (ascession process)

Use Case #36b

Assumptions

Assumptions:
1) Provider and Lab connected to HIE
2) Data exchange integrated and executed in real-time

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
Lab Vocabulary Service	Yes

Barriers

Barriers:
1) LIS/HIS functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of LIS/HIS Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization (The lab workflow to match the specimen to the order may be a barrier for some labs)

Issues & Follow-Up

Issue: None.

Use Case #18

Use Case #: 18

Title: Pharmacist sends medication therapy management consult to provider

Description:
1. Pharmacist completes MTM encounter and creates care summary document\CCR from Pharmacy system.
2. Pharmacist sends clinical documents to the HIE.

3a. HIE sends notification to provider (optional).

3b. Provider receives notification (optional).

3. Provider initiates request to retrieve MTM encounter clinical documents.
4. Provider determines whether or not to incorporate documents into EHR.

General Use Case Information

Users: Pharmacy, Provider

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Pharmacist	**Provider**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary refill requests	
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Standard data format allows for increased efficiency	Standard data format allows for increased efficiency
	Reduced administrative cost	Reduced administrative cost
	cost containment	

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Assumptions

Assumptions:
1) Provider and Pharmacist can connect to HIE
2) Data exchange integrated and executed in real-time
3) Provider is able to select the data they want to send to the Pharmacy

Use Case #18

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Notification	Optional
Messaging	Yes

Barriers

Barriers:

1) Pharmacy and EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of Pharmacy or EHR Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization
8) Pharmacy system may need changes to support the creation of the transaction set
9) Internet connection of pharmacy

Issues & Follow-Up

Issues: None.

Use Case #35

Use Case #: 35

Title: Provider prescribes medication for patient

Description:
1. Provider completes encounter in EHR.
2. Provider accesses ePrescribe service and sends prescription.
3. The ePrescribe service processes the prescription and sends it to the pharmacist (note: may be faxed or electronic)
4. The ePrescribe services sends the data to the HIE.

General Use Case Information

Users: Provider, Pharmacy

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
5	Yes	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Pharmacist	**Provider**
Quality	Improved care coordination	Improved care coordination
	Data accuracy	Data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary refill requests	
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Standard data format allows for increased efficiency	Standard data format allows for increased efficiency
	Reduced administrative cost	Reduced administrative cost

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE
4) Cost of connecting to ePrescribe system

Assumptions

Assumptions:
1) Provider and ePrescribe systems can connect to HIE
2) Data exchange integrated and executed in real-time
3) Provider is able to select the data they want to send to the ePrescribe System

Use Case #35

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging	Yes

Barriers

Barriers:

1) Pharmacy, ePrescribe, and EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of Pharmacy, ePrescribe or EHR Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization
8) Pharmacy system may need changes to support the creation of the transaction set
9) Internet connection of pharmacy
10) Cost of the ePrescribe system

Issues & Follow-Up

Issues:

1) HIE is not an integral part of this use case

Use Case #13

Use Case #: 13

Title: Provider or hospital submits quality data and/or measures to the CMS, the State, and/or health information organizations

Description: Provider or hospital transmits clinical data to CMS, the State, and/or authorized health information organizations for the purpose of performing health care quality measurement and/or quality reporting.

1. Provider creates quality report from EHR system.
2. Provider's EHR sends quality report to the HIE.
3. HIE forwards Quality Report to appropriate receiving system at State or CMS.

General Use Case Information

Users: Hospital, CMS or other State Registry or Entity

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
13	Yes	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Hospital	**State\CMS**
Quality	Provides key Clinical Quality Measures (CQM) feedback to Hospital	Bridges some gaps in the prevention of major health risks or crisis
	Bridges some gaps in the prevention of major health risks or crisis	Improved population health
Time/Cost	Provides avenue for reporting of critical data	Reduces research time
	Quality feedback incorporated into workflows to	
	Facilitates the pay for performance aspects of health reform	

Summary of Cost Drivers

Cost Driver Summary: EHRs may not be able to extract data, therefore cost may be staff spent time on manually extracting information

Assumptions

Assumptions:

1) Defined quality measurement specifications to be reported are sent to hospitals.
2) CQM and other quality reports are reported on periodic basis.
3) CQM and other quality reports can be integrated into Hospital\EHR

Use Case #13

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Notification	Optional
Messaging	Yes

Barriers

Barriers:

1) Technical limitations of EHR. Systems
2) Privacy or security policies or processes at stakeholder organization
3) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: 1) EHR extraction of data

Use Case #12

Use Case #: 12

Title: Provider send patient immunization data to public health

Description: Provider EHRs would send immunization records to the HIE for transmittal to the appropriate registry:

1. Provider registers a patient's immunization information for sharing (make it or its source known)
2. Provider uses the HIE Service to locate a patient's immunization information
3. Provider retrieves a patient's immunization information
4. Provider recommend next immunizations
5. Provider submits a patient's immunization information to the exchange through the EHR

A provider may then request immunization data from the state registry via the HIE

1. Provider requests immunization data from the HIE
2. The HIE submits request to the State Registry and receives the data
3. The HIE forwards the data to the requesting provider
4. The requesting provider determines whether or not to add data to their EHR

General Use Case Information

Users: Provider, State or local Immunization Registry

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes
25	Yes	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Immunization Registry**
Quality	Bridges some gaps in the prevention of major health risks or crisis over time	Improved access to actual patient history
Time/Cost	Lower cost of registry and reporting compliance through reduced labor time to complete the reports and transmit them to the proper receiver	
	Lower cost of interfacing for digital reporting to the registries and quality organizations	
Other		Access to more info and data; increased surveillance for PH (awareness, programs, etc.)

Summary of Cost Drivers

Cost Driver Summary:

1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE
4) Cost of changes to the Immunization registry to exchange information

Use Case #12

Assumptions

Assumptions:
1. EHRs ability to transmit an Immunization transaction from the EHR or a portal for data entry.
2. Immunization Registry can receive, send and allows direct entry

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Interoperability and Data Standards	Yes
Directory - Provider	No
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Notification	No
Messaging	Yes

Barriers

Barriers:
1) Technical limitations of E.H.R. Systems
2) Privacy or security policies or processes at stakeholder organization
3) Workflow processes at stakeholder organization
4) Costs to changing the Immunization Registry

Issues & Follow-Up

Issues:
1) Notification of Immunization Updates to PCP

Use Case #16

Use Case #: 16

Title: Providers send chief complaint (non-reportable) data to public health for syndromic surveillance

Description: A provider or hospital sends (reports) anonymized chief complaint data, including a problem list, to state or local public health as part of a syndromic surveillance program.

1. Hospital EHR systems collect data on patient chief complaints as part of regular provision of care
2. The provider or hospital has made the determination that it is clinically and legally appropriate to send the chief complaint data to Public Health
3. Patient chief complaint data is communicated to Public Health agency on a pre-determined schedule (with capability for ad-hoc transmissions also)

General Use Case Information

Users: Provider (or Hospital), Public Health

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
27	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Public Health Agency**
Quality		Improved quality of data due to automation of reporting criteria and needs
Time/Cost	Reduced administrative costs	

Summary of Cost Drivers

Cost Driver Summary:

1) Interface between HIE and Provider/Hospital EHRs
2) Interface between HIE and Public Health Agencies
3) Data transformation (automation and personnel)

Assumptions

Assumptions: This use case does not cover the reporting of communicable diseases.

Technical Components / Services

Shared Utility Service	**Yes/No**
Patient Index	No
Patient Locator Service	Yes
Interoperability and Data Standards	Yes
Directory - Service	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Notification	Optional
Messaging	Yes

Use Case #16

Barriers

Barriers:

1) Technical limitations of E.H.R. Systems
2) Privacy or security policies or processes at stakeholder organization
3) Workflow processes at stakeholder organization
4) Availability of funding for Public Health

Issues & Follow-Up

Issues: None.

Use Case #17

Use Case #: 17

Title: State public health agency reports public health data to Centers for Disease Control (CDC)

Description: 1. State determines data set for identified conditions based on (Nationally Notifiable Disease Condition reports) to be reported to CDC
2. Authorized personnel use HIE functionality to send information to CDC

General Use Case Information

Users: State Public Health Agency, CDC

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
27	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Public Health Agency	**CDC**
Quality	Improved quality of data due to automation of reporting criteria and needs	
Time/Cost	Moving to standards for transport and format	Improved timeliness in getting this information from State agencies
		Moving to standards for transport and format

Summary of Cost Drivers

Cost Driver Summary: Interface between State HIE and CDC

Assumptions

Assumptions: None.

Technical Components / Services

Shared Utility Service	**Yes/No**
Patient Index	Yes
Patient Locator Service	Yes
Interoperability and Data Standards	Yes
Directory - Service	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Notification Service	Yes
Reporting Service	Yes
Messaging	Yes

Use Case #17

Barriers

Barriers: Cost of changes to Public Health Systems

Issues & Follow-Up

Issues: None.

Use Case #30

Use Case #: 30

Title: Emergency Department Linking

Description:
1. ED completes a request in their E.H.R for ED data from other providers.
2. ED E.H.R sends request to the HIE.
3. The HIE determines which providers have ED data for the requesting provider and sends them the request.
4. The providers receive the request, gather the data, and send it back to the HIE.
5. The HIE forwards the data back to the ED.
6. The ED reviews the data, determines if it should be included in it's EHR file, and treats the patient.

General Use Case Information

Users: Emergency Department, Other Providers

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes
23	---	Yes
24	---	Yes

Benefits Summary by Stakeholder

Benefit	Measures	
	Emergency Department	**Provider**
Quality	Improved care coordination	
	Data accuracy	
	Patient satisfaction	
Time/Cost	Less time on individual encounter	Reduced administrative cost
	Standard data format allows for increased efficiency	
	Reduced administrative cost	

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Assumptions

Assumptions:
1) ED and Providers can connect to HIE
2) Data exchange integrated and executed in real-time
3) Provider and ED have certified E.H.R.
4) Provider is able to select the data they want to send to the ED

Use Case #30

Technical Components / Services

Shared Utility Service	Yes/No
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Messaging (this is the service that exchanges the records)	Yes

Barriers

Barriers:

1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Privacy or security policies or processes at stakeholder organization
6) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #31

Use Case #: 31

Title: Provide Advance Directives to Requesting Providers (via PHR)

Description:
1. Provider determines need for Advance Directive Information.
2. Provider creates a request for AD information.
3. Provider sends the request to the HIE.
4. HIE receives request and determines which PHR systems have AD data on the patient.
5. HIE sends request to appropriate PHR systems.
6. PHR systems receive the request and send the data back to the HIE.
7. The HIE receives the data and forwards it to the requesting provider.
8. The provider receives the data, determines whether or not to incorporate it into their EHR, and treats the patient accordingly.

General Use Case Information

Users: Patient PHR system, Provider

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
none	---	---

Benefits Summary by Stakeholder

Benefit	Measures	
	Provider	**Patient PHR**
Quality	Improved care coordination	
	Data accuracy	
	Patient satisfaction	
	Patient safety	
Time/Cost	Less time on individual encounter	
	Standard data format allows for increased efficiency	
	Reduced administrative cost	

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Assumptions

Assumptions:
1) Stakeholders can connect to HIE
2) Data exchange integrated and executed in real-time
3) Providers have certified HER
4) Patient has completed advance directive in a PHR system that can connect to the HIE
5) Advance Directives can legally be shared across providers

Use Case #31

Technical Components / Services

Shared Utility Service	Yes/No
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Messaging (this is the service that exchanges the records)	Yes

Barriers

Barriers:

1) EHR and/or PHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. or P.H.R Systems
5) Privacy or security policies or processes at stakeholder organization
6) Workflow processes at stakeholder organization
7) Potential legal limitations on sharing Advance Directive data across providers

Issues & Follow-Up

Issues: Touch base with Legal to determine if Advance Directive information can be shared across providers.

Use Case #9

Use Case #: 9

Title: Provider sends a clinical summary of an office visit to the patient/caregiver (via PHR)

Description:
1) The provider sees the patient and creates a CCR in their E.H.R.
2) The provider sends the CCR to the HIE.
3) The HIE forwards the CCR to the patient's PHR system.
4) The Patient's PHR system receives the CCR and applies it to the patient's record.
5) The Patient's PHR notifies the patient that their record has been updated (optional)

General Use Case Information

Users: Caregiver/Patient, Providers

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
18	---	Yes
20	---	Yes
21	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Providers	**Caregiver/Patient**
Quality	Improved care coordination	Improved care coordination
	Patient/caregiver engagement helps ensure data accuracy	Patient/caregiver engagement helps ensure data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Extends health community access and clinical data exchange to HSP, Rehab and Patient	Extends health community access and clinical data exchange to Hospital,HSB and Rehab
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Reduced staff time spent on handling diagnostic results	Reduced staff time spent on handling diagnostic results
	Reduced administrative cost	Reduced administrative cost
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Chronic Care cost reduction	Chronic Care cost reduction
Other	Increased adoption of HIE	Increased adoption of HIE
	Optimize usage of HIE, EHR and PHR	Optimize usage of HIE, EHR and PHR

Use Case #9

Summary of Cost Drivers

	Provider	Caregiver/Patient
Cost Driver Summary:	1) Interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE	1) Connectivity to Patient Portal

Assumptions

	Provider	Caregiver/Patient
Assumptions:	1) The PHR is not part of the provider's HIE (i.e., the patient uses a PHR solution that is separate or different from the one provider by the Provider - if one is offered) 2) Providers can connect to HIE 3) Data exchange integrated and executed in real-time 4) Providers have certified E.H.R. 5) At least one provider has a PHR for the caregiver/patient to access	1) Caregiver/Patient can connect to Patient Portal 2) Caregiver/Patient has some level of knowledge on how to use a computer and internet

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
PHR	Yes

Barriers

	Provider	Caregiver/Patient
Barriers:	1) EHR functionality may be limited (batch vs. real-time) 2) Availability of patient and/or provider records in the Exchange 3) Cost 4) Technical limitations of E.H.R. Systems 5) Privacy or security policies or processes at stakeholder organization 6) Workflow processes at stakeholder organization	1) Limited technical knowledge to use Patient Portal. 2) Limited ability to understand the information they see.

Use Case #9

Issues & Follow-Up

Issues: None.

Use Case #11

Use Case #: 11

Title: Provider sends reminder for preventive or follow-up care to the patient/caregiver (via PHR)

Description:
1) The provider sees the patient and creates a follow up or preventative care transaction set in their E.H.R.
2) The provider sends the transaction to the HIE.
3) The HIE forwards the transaction to the patient's PHR system.
4) The Patient's PHR system receives the transaction and applies it to the patient's record.
5) The Patient's PHR notifies the patient that their record has been updated (optional)

General Use Case Information

Users: Caregiver/Patient, Providers

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
14	Yes	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Providers	**Caregiver/Patient**
Quality	Improved care coordination	Improved care coordination
	Patient/caregiver engagement helps ensure data accuracy	Patient/caregiver engagement helps ensure data accuracy
	Patient satisfaction	Patient satisfaction
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Extends health community access and clinical data exchange to HSP, Rehab and Patient	Extends health community access and clinical data exchange to Hospital,HSB and Rehab
Time/Cost	Less time on individual encounter	Less time on individual encounter
	Reduced staff time spent on handling diagnostic results	Reduced staff time spent on handling diagnostic results
	Reduced administrative cost	Reduced administrative cost
	Reduction in number of unnecessary diagnostic tests	Reduction in number of unnecessary diagnostic tests
	Chronic Care cost reduction	Chronic Care cost reduction
Other	Increased adoption of HIE	Increased adoption of HIE
	Optimize usage of HIE, EHR and PHR	Optimize usage of HIE, EHR and PHR

Use Case #11

Summary of Cost Drivers

	Provider	Caregiver/Patient
Cost Driver Summary:	1) Interface to HIE 2) Technical and Business staff to support interface(s) 3) Cost of HIE	1) Connectivity to PHR

Assumptions

	Provider	Caregiver/Patient
Assumptions:	1) The PHR is not part of the provider's HIE (i.e., the patient uses a PHR solution that is separate or different from the one provider by the Provider - if one is offered) 2) Providers can connect to HIE 3) Data exchange integrated and executed in real-time 4) Providers have certified E.H.R. 5) At least one provider has a PHR for the caregiver/patient to access	1) Caregiver/Patient can connect to PHR 2) Caregiver/Patient has some level of knowledge on how to use a computer and internet

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
PHR	Yes

Barriers

	Provider	Caregiver/Patient
Barriers:	1) EHR functionality may be limited (batch vs. real-time) 2) Availability of patient and/or provider records in the Exchange 3) Cost 4) Technical limitations of E.H.R. Systems 5) Privacy or security policies or processes at stakeholder organization 6) Workflow processes at stakeholder organization	1) Limited technical knowledge to use PHR. 2) Limited ability to understand the information they see.

Issues & Follow-Up

Issues: None.

Use Case #37

Use Case #: 37

Title: Release of Information (Provider to Provider)

Description:
1. New Provider requests ROI data
2. New Provider sends ROI transaction request to HIE.
3. HIE receives transactions request and forwards to appropriate previous provider.
4. Previous Provider receives request and send appropriate data back to the HIE.
5. The HIE forwards the data to the new provider.
6. The new provider reviews the data and determines whether or not to apply the data to their EHR.

General Use Case Information

Users: New Provider, Previous Provider

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
22	---	Yes

Potential Benefits Summary by Stakeholder

Benefit	**Measures**	
	New Provider	**Previous Provider**
Quality	Improved care coordination	
	Data accuracy	
	Patient satisfaction	
Time/Cost	Less time on individual encounter	Reduced administrative cost
	Standard data format allows for increased efficiency	
	Reduced administrative cost	

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Assumptions

Assumptions:
1) Stakeholders can connect to HIE
2) Data exchange integrated and executed in real-time
3) Stakeholders have certified EHR

Use Case #37

Technical Components / Services

Shared Utility Service	Yes/No/Optional
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes

Barriers

Barriers:

1) EHR functionality may be limited (batch vs. real-time)
2) Availability of patient and/or provider records in the Exchange
3) Cost
4) Technical limitations of E.H.R. Systems
5) Data Fatigue (inability of a user to use the data provided)
6) Privacy or security policies or processes at stakeholder organization
7) Workflow processes at stakeholder organization

Issues & Follow-Up

Issues: None.

Use Case #38a

Use Case #: 38a

Title: Patient Opts Out of having records shared in HIE (via PHR or HIE Patient Web Portal)

Description:
1. Patient completes Opt Out materials in PHR system
2. PHR system sends Opt Out notice to HIE.
3. HIE flags any of the patient's indexes/data as non-usable
4. HIE sends notice back to PHR indicated request was processed (optional)
5. PHR receives notice (optional)

General Use Case Information

Users: Patient

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
All	--	Yes

Potential Benefits Summary by Stakeholder

Benefit	**Measures**
	Patient
Quality	Patient satisfaction

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Assumptions

Assumptions:
1) Patient Ops Out via PHR
2) HIE has consent service module
3) HIE has a Patient Web Portal

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes
HIE Patient Web Portal	Yes
Consent Management Directory	Yes

Use Case #38a

Barriers

Barriers:

1) Ability to get PHR systems to participate
2) An HIE Patient Web Portal would be needed

Issues & Follow-Up

Issues: None.

Use Case #38b

Use Case #: 38b

Title: Patient decides to Opt back In to having information exchanged in the HIE (via PHR or HIE Patient Web Portal)

Description:
1. Patient completes Opt In materials in PHR system
2. PHR system sends Opt In notice to HIE.
3. HIE removes the "opt out" flag from the patients indexes/data
4. HIE sends notice to PHR indicating request was processed (optional)
5. PHR receives notice (optional)

General Use Case Information

Users: Patient

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
All	--	Yes

Potential Benefits Summary by Stakeholder

Benefit	**Measures**
	Patient
Quality	Patient satisfaction
	Improved care coordination
	Reduction in number of unnecessary diagnostic tests
	Less time on individual encounter
	Improved access to test results

Summary of Cost Drivers

Cost Driver Summary:
1) Interface to HIE
2) Technical and Business staff to support interface(s)
3) Cost of HIE

Assumptions

Assumptions:
1) Patient Ops Out via PHR
2) HIE has consent service module
3) HIE has a Patient Web Portal

Technical Components / Services

Shared Utility Service	**Yes/No/Optional**
Patient Index	Yes
Patient Locator Service	Yes
Terminology service	Yes
Directory - Provider	Yes
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Messaging (this is the service that exchanges the records)	Yes

Use Case #38b

HIE Patient Web Portal	Yes
Consent Management Directory	Yes

Barriers

Barriers:

1) Ability to get PHR systems to participate
2) An HIE Patient Web Portal would be needed

Issues & Follow-Up

Issues: None.

Use Case #32a

Use Case #: 32a

Title: Provider sends reportable disease diagnosis data to public health

Description: A provider or hospital sends reportable disease diagnosis data to state or local public health

1. Hospital EHR systems collect data on reportable disease, including a problem list, as part of regular provision of care
2. The provider or hospital has made the determination that it is a reportable disease based on Public Health guidelines/requirements
3. Reportable disease diagnosis data is communicated to Public Health agency via the HIE

General Use Case Information

Users: Provider, Public Health

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
27	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Public Health Agency**
Quality		Improved quality of data due to automation of reporting criteria and needs
Time/Cost	Reduced administrative costs	

Summary of Cost Drivers

Cost Driver Summary:

1) Interface between HIE and Provider/Hospital EHRs
2) Interface between HIE and Public Health Agencies
3) Data transformation (automation and personnel)

Assumptions

Assumptions: E.H.R. systems are able to distinguish reportable and non-reportable disease data.

Technical Components / Services

Shared Utility Service	**Yes/No**
Patient Index	No
Patient Locator Service	Yes
Interoperability and Data Standards	Yes
Directory - Service	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Messaging	Yes

Use Case #32a

Barriers

Barriers: 1) Availability of Funding for Public Health
2) System limitations on determining reportable vs. non-reportable -- may require system changes or manual process

Issues & Follow-Up

Issues: None.

Use Case #32b

Use Case #: 32b

Title: Provider sends non-reportable, anonymized disease data to public health

Description: A provider or hospital sends non-reportable, anonlymized, disease data (including a problem list) to state or local public health

1. Hospital EHR systems collect data on disease, including a problem list, as part of regular provision of care
2. The provider or hospital has made the determination that it is not a reportable disease based on Public Health guidelines/requirements
3. The provider's EHR system anonymizes the data and sends it to public health via the HIE.

General Use Case Information

Users: Provider, Public Health

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
27	---	Yes

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Public Health Agency**
Quality		Improved quality of data due to automation of reporting criteria and needs

Summary of Cost Drivers

Cost Driver Summary:

1) Interface between HIE and Provider/Hospital EHRs
2) Interface between HIE and Public Health Agencies
3) Data transformation (automation and personnel)
4) Provider's E.H.R. may need to be modified to send non-reportable data or a manual process may be needed

Assumptions

Assumptions:

1) E.H.R. systems are able to distinguish reportable and non-reportable disease data.
2) E.H.R. aggregates and anonymizes data before sending to HIE

Technical Components / Services

Shared Utility Service	**Yes/No**
Patient Index	No
Patient Locator Service	Yes
Interoperability and Data Standards	Yes
Directory - Service	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Messaging	Yes

Use Case #32b

Barriers

Barriers: 1) Availability of Funding for Public Health
2) System limitations on determining reportable vs. non-reportable -- may require system changes or manual process

Issues & Follow-Up

Issues: None.

Use Case #39

Use Case #: 39

Title: Public Health sends feedback report to provider

Description: Public health sends a feedback report to provider(s). Feedback reports could include clinical care information, information on Public Health interventions, information on disease management, surveillance data, or information on patient care.

1. PH compiles feedback report data and determines which provider(s) should receive the report. May be a single provider, region, tribe, etc.
2. PH sends the feedback report to the HIE.
3. The HIE forwards the feedback report to the appropriate providers.

General Use Case Information

Users: Provider, Public Health

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
none	---	---

Benefits Summary by Stakeholder

Benefit	**Measures**	
	Provider	**Public Health Agency**
Quality	Improved care coordination	Assists Public Health in fulfilling their mission

Summary of Cost Drivers

Cost Driver Summary:

1) Interface between HIE and Provider/Hospital EHRs
2) Interface between HIE and Public Health Agencies
3) Data transformation (automation and personnel)
4) Provider's E.H.R. may need to be modified to receive feedback reports
5) Feedback reports will need to be defined and standardized

Assumptions

Assumptions: 1) Feedback reports can be defined and standardized so that provider EHRs can accept the varying types of feedback from Public Health

Use Case #39

Technical Components / Services

Shared Utility Service	Yes/No
Patient Index	No
Patient Locator Service	No
Interoperability and Data Standards	Yes
Directory - Service	Yes
Additional Services (Technical and shared utility)	**Yes/No**
Messaging	Yes

Barriers

Barriers: 1) Availability of Funding for Public Health
2) System limitations for provider E.H.Rs in accepting different types of feedback reports.

Issues & Follow-Up

Issues: Need standardized and defined feedback reports.

Use Case #: *Number assigned for Workgroup tracking from the List Appendix (Tab\Worksheet).*

Title: *Use Case or User Story Name\Label.*

Description: *Document one, two or more sentence description of the Use Case or User Story defining and providing the context, perspective and overview of the Use Case.*

General Use Case Information

Users: *List the primary Actors, Addresses, Sources and Destinations defined in the Use Case or User Story.*

Steps: *Document the Sequence of Events for the data exchange and transmitted data in the Use Case. Please note each case can and will vary and best practice examples are provided.*

1)
2)
3)
4) etc.

Meaningful Use Requirement		
Mapping#	**Satisfies MU Goal\Measure**	**Enables MU Goal\Measure**
XX	Yes	Yes
XX	Yes	Yes

Enter the Use Case Mapping# associated with the specific MU Objective. Specify if the MU Goals and Measures are satisfied and\or enabled. Reference: MU Mapping Appendix (Tab\Worksheet).

Benefits Summary by Stakeholder

Provide a summary of key the benefits and measures associated with the primary stakeholders or users\actors referenced in the Use Case.

Benefit	**Measures**	
	Stakeholder 1	**Stakeholder 2**
Quality		
Time/Cost		
Other		

Summary of Cost Drivers

List HIE infrastructure cost factors to be considered to achieve HIE integration and data

Cost Driver Summary:

Assumptions

List Key Assumptions associated with the Use Case.

Assumptions:

Technical Components / Services

Document which required HIE services and core infrascture components and any other technical services the Use Case covers.

Shared Utility Service	**Yes/No/Optional**
Patient Index	*Patient Index Manager which applies scientific algorithm to link or unlink demographic record to an existing enterprise record.*
Patient Locator Service	*Patient Record Locator and Search Services*
Interoperability and Data Standards Messaging Communication Security Transformation Terminology	*Data messaging, transport, communication protocol and security standards and integration \ infrastructure adaptor services, data transformation standards, terminology - data dictionary, codification and nomenclature standards.*
Directory - Provider	*Provider\Entity Index Manager to authenticate and authorize providers.*
Additional Services (Technical and shared utility)	**Yes/No/Optional**
Notification	*Send\Receive Alerts, SMS, email and other, secure and instant messaging services.*

Barriers

Document the barriers or obstalces associated with the deployment and execution of the Use

Barriers:

Issues & Follow-Up

Record all relevent issues, concerns and follow-up action items in this section.

1)

2)

Stage 1 Objectives		Stage 1 Measures	Mapping Number
Eligible Professionals	**Hospitals**		
Health Outcomes Policy Priority: Improving quality, safety, efficiency, and reducing health disparities			
Care Goals: (1) Provide access to comprehensive patient health data for patient's health care team; (2) Use evidence-based order sets and CPOE; (3) Apply clinical decision support at the point of care; (4) Generate lists of patients who need care and use them to reach out to patients; (5) Report information for quality improvement and public reporting			
Use CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders	1
		For eligible hospitals, CPOE is used for 10% of all orders	2
Implement drug-drug, drug-allergy, drug-formulary checks	Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality	3
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 CM or SNOMED CT	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 CM or SNOMED CT	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data	4
Generate and transmit permissible prescriptions electronically (eRx)		At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	5
Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data	6
Maintain active medication allergy list	Maintain active medication allergy list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data	7
Record demographics - preferred language - insurance type - gender - race - ethnicity - date of birth	Record demographics - preferred language - insurance type - gender - race - ethnicity - date of birth - date and cause of death in the event of mortality	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data	8
Record and chart changes in vital signs: - height - weight - blood pressure - Calculate and display: BMI - Plot and display growth charts for children 2-20 years, including BMI	Record and chart changes in vital signs: - height - weight - blood pressure - Calculate and display: BMI - Plot and display growth charts for children 2-20 years, including BMI	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20	9

Stage 1 Objectives		Stage 1 Measures	Mapping Number
Eligible Professionals	Hospitals		
Record smoking status for patients 13 years or older	Record smoking status for patients 13 years or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have "smoking status" recorded	10
Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests ordered where results are in a positive/negative format are incorporated in certified EHR technology as structured data	11
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with a specific condition	12
Record ambulatory quality measures to CMS or the States	Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule. For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule.	13
Send reminders to patients per patient preference for preventative/follow up care		Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over	14
Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3)	15
Check insurance eligibility electronically from public and private payers	Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital	16
Submit claims electronically to public and private payers	Submit claims electronically to public and private payers	At least 80% of all claims filed electronically by the EP or the eligible hospital	17

Stage 1 Objectives		Stage 1 Measures	Mapping Number
Eligible Professionals	**Hospitals**		
Health Outcomes Policy Priority: Engage patients and families in their health care			
Care Goals: (1) Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health; (2) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP; (3) Provide clinical summaries for patients for each office visit			
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours	18
	Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it	19
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being availabe to the EP		At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information	20
Provide clinical summaries for patients for each office visit		Clinical summaries are provided for at least 80% of all office visits	21
Health Outcomes Policy Priority: Improve care coordination			
Care Goals: (1) Exchange meaningful clinical information among professional health care team			
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care an patient authorized entities electronically	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care an patient authorized entities electronically	Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information	22
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	23
Provide summary care record for each transition of care and referral	Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transition of care and referrals	24

Stage 1 Objectives		Stage 1 Measures	Mapping Number
Eligible Professionals	**Hospitals**		
Health Outcomes Policy Priority: Improve population and public health			
Care Goals: (1) Communicate with public health agencies			
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries	25
	Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one tests of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)	26
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)	27
Health Outcomes Policy Priority: Ensure adequate privacy and security protections for personal health information			
Care Goals: (1) Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law; (2) Provide transparency of data sharing to patient			
Provide electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Provide electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or Review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary	28

APPENDIX 16

Appendix A

Private Health Organizations and State Government Assets

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Stakeholder Interviews

The table below is a list of all interviews conducted with state government and private health organizations.

Interview Date	Organization	Organization Interviewees	Project Interviewers
08/05/2009	Department of Health Services (DHS)	Bob Martin, DHS	Michael Kleinmann Susan Wood
08/06/2009	DHS – Public Health	Jim Grant	Susan Wood
08/10/2009	DHS – Public Health	Regional Directors Denise Webb	Susan Wood
08/11/2009	Health Insurance Risk Sharing Pool (HIRSP)	Amie Goldman	Susan Wood
08/12/2009	DHS	Bob Martin, DHS	Mike Connors Jennifer Ferrigan Susan Wood
08/12/2009	DHS – Division of Enterprise Services	Gina Frank, DES	Susan Wood
08/13/2009	Department of Children and Families (DCF)	Ron Hunt Maytee Aspuro	Susan Wood
08/13/2009	Department of Regulation and Licensing (DRL)	Diane Miller	Susan Wood
08/17/2009	Department of Administration (DOA)	Oskar Anderson, DOA Bob Martin, DHS	Jeff Bradfield Mike Connors
08/18/2009	Rural Wisconsin Health Cooperative (RWHC)	Louis Wenzel	Jennifer Ferrigan Rachel Frey
08/18/2009	DHS – Quality Assurance (Provider	Otis Woods	Susan Wood

Interview Date	Organization	Organization Interviewees	Project Interviewers
	regulation)	Jane Waeters	
08/19/2009	DHS – Disability Determination Bureau	Audrey Koehn, DDB	Mike Connors
08/19/2009	Wisconsin Health Information Exchange (WHIE)	Kim Pemble	Rachel Frey Michael Kleinmann
08/19/2009	Wisconsin Collaborative for Healthcare Quality	Chris Queram Kathy Werner	Jennifer Ferrigan Michael Kleinmann
08/20/2009	Wisconsin Health Information Organization (WHIO)	Julie Bartels	Jennifer Ferrigan Michael Kleinmann
08/20/2009	DHS – Health Care Access and Accountability	Jason Helgerson Jim Jones	Mike Connors Michael Kleinmann Susan Wood
08/26/2009	Department of Employee Trust Funds	Lisa Ellinger	Susan Wood
09/02/2009	Wisconsin Hospital Association (WHA)	Joe Kachelski	Michael Kleinmann

Table 1. Detailed information on stakeholder interviews.

Additional Private Health Organizations Assets Identified

Additional Private Health Organizations Assets Identified by WHIE
Principles of Operation
Security Incident Policy and Response Form
Test Plan Policy
Audit Policy
Information Systems Access Policy
CCT Policy (draft)
Implementation project plans and templates for interfaces
Help Desk Plan

Table 2. Additional documentation provided by WHIE.

Stakeholder Interview Template for State Assets

The following is the template used to capture and record notes with state government agencies and departments.

Wisconsin SLHIE Public Sector Organization Interviews Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	
Location	
Attendees	
Interviewer	

Meeting Notes

Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?

1. What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?

2. What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?

3. Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:

4. Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:

    a. Technical assets

    b. Functional assets

Individual Stakeholder Interview Summary Notes

Department of Health Services (DHS)

Wisconsin SLHIE Public Organization Interviews Department of Health Services Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	Multiple dates
Location	Room 672, 1 West Wilson St., Madison
Attendees	Gina Frank, Division Administrator, Division of Enterprise Services, DHS Bob Martin, CIO for DHS and Director of the Bureau of Information Services (BITS), Division of Enterprise Services, DHS Mary Ellen Havel-Lang, IT Specialist in BITS
Interviewer	Susan Wood & Gina Frank on 8/12/09 Michael Kleinmann & Susan Wood with Bob Martin on 8/5/09 Mike Connors, Jennifer Ferrigan & Susan Wood with Bob Martin on 8/12/09 Jennifer Ferrigan & Susan Wood with Bob's staff including Mary Ellen Havel-Lang to get started on the spread sheet describing DHS systems on 8/18/09

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

   Yes.

   The meetings with Division of Enterprise Services staff were focused on identifying the assets in the Department and in other state agencies that have potential value to statewide HIE.

   In the meeting with Gina, she indicated that the Department has just signed a contract with a vendor to help with strategic planning for MITA; they expect to see convergence between the deliverables on the Deloitte effort and this new contract. There is a new focus for the Department's IT Steering Committee which will now be focused on programmatic goals and issues rather than the technical focus it has had in the past.

   Bob provided contact information for people across the Divisions and in other agencies for team follow-up and facilitated a meeting with Oskar Anderson, State CIO.

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

   This will be evident in the information reported on the spread sheet.

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?**

NA

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   a. Name of the HIE initiative: see spread sheet

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

   a. Technical assets – Yes – see spread sheet completed by Bob Martin, CIO and Mary Ellen Havel-Lang of Bureau of Information Technology

   b. Functional assets – No

DHS – Division of Health Care Access and Accountability (DHCAA)

Wisconsin SLHIE Public Organization Interviews Department of Health Services Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 20, 2009
Location	DHS
Attendees	Jason Helgerson and Jim Jones
Interviewer	Mike Connors, Michael Kleinmann, and Susan Wood

Key stakeholders in HIE:
- Medicaid and Public Health

Potential assets to consider for HIE:
- Broadband access across state
- iC System to serve as central repository – consider other EDS states (Ohio)
- client index – consider MCI or Immunization Registry
- MITA assessment – use strategically

Potential funding:
- Discussed 90/10 HIE CMS funding-use through expedited process (planning, design, but not implementation). Use before January 2010 for meaningful-use, adoption, and providers. Build it from scratch governance with demands on governance.

Potential solutions:
- iC is the largest claim system – use iC and inter-op with physical transfer occurring between national HIT and MTAs

- Regional Extension Centers – HIT Adoption, assigned by CMS, cooperative agreement by region. Some regions may connect with other states.

- HRSP is quasi government organization. It went private from government. It is now non-profit and purchased own system. State participates and uses system.

Notes about national health care reform:
- National Health Care Reform is competing with citizen impact (health member index). Components of health care reform include: national exchange, gateway, get commercial insurance, 2013 (exchange up and running), which will be a portal for citizens.

- Role of Medicaid – public-private purchaser, state- couple of seats (provider, payer); the State is the largest payer.

Resources involved in HIE:
- State resources can be utilized. This includes use through technology and as a vendor.

Marketing aspect of HIE:

- Marketing aspect – It is difficult to reach the public. Consider security concerns and address potentially using biometric security

Considerations for health care reform:

- Improve outcomes by using program management based analytics results in chart based data. Derive payments based on value outcomes, which reward for better quality and outcomes. For example, 1% of salary on input care plan. This is a bonus to doctors. 50% of physicians, 50% of the time.
- Take into account that there is a small number of instances where individual access to data changes behaviors.

DHS – Division of Quality Assurance (DQA)

Wisconsin SLHIE Public Sector Organization Interviews DHS Division of Quality Assurance Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 18, 2009
Location	Room 1150, 1 West Wilson St, Madison
Attendees	Otis Woods, Administrator Jane Walters, Deputy
Interviewer	Susan Wood

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

Yes.

DQA is the survey and certification agency for Wisconsin, licensing and certifying health care providers for Medicare and Medicaid participation. This includes hospitals, nursing homes, facilities for the developmentally disabled, assisted living facilities, home health agencies, labs, ambulatory surgical centers, ESRDs

HIE is critical to the quality of care delivery system. Hospitals are on board, but nursing homes slower to adopt. Assisted living facilities are not in Medicare or Medicaid except for community waiver funding and are even more out of the loop. ASCs and ESRDs that are hospital-based are engaged in these efforts.

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

A huge gap is continuity of care on transfers from one setting to another. A short transfer summary would be wonderful. They are now engaged in a collaborative efforts on reducing injury and death from pressure ulcers and are creating a transfer summary to be used between nursing homes and hospitals to be used in all transfers.

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?**

Keep moving this initiative forward. Do not reinvent the wheel to do so, take advantage of existing resources. Keep the pressure on the nursing home industry to adopt EHRs.

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   Name of the HIE initiative: The national survey and certification office in CMS collects data on every nursing home and home health patient through their systems – required for use – Minimum Data Set (MDS) for NHs, and OASIS for HHAs. These are patient specific and include information

to measure outcomes. At this time the data comes to DHS and is stored on a server at 1 West Wilson but the plan is to send the info directly to CMS in the next year or two.

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

    a. Technical assets – They have the following systems (these are on the DHS spread sheet):

        i. Adult Programs Information System (APIS) – this is a data base of providers and their compliance history

        ii. Caregiver Regulation Information System – this is a registry of nurse aides who meet the training requirements and also includes complaint information about acts of patient abuse

        iii. Facility Licensing and Certification System –has now been replaced by ALICE – this is all licensed and federally certified health care providers. It is a web-based system that includes an interface to the Department of Regulation and Licensing to check on credentials

        iv. Plan review system – for engineers to track building and remodeling projects subject to plan review

    b. Functional assets - NO

DHS – Division of Public Health (DPH)

Wisconsin SLHIE Public/Private Sector Organization Interviews DPH Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 6, 2009
Location	Room 250, 1 West Wilson St., Madison
Attendees	Jim Grant, PHIN Manager, Division of Public Health, DHS
Interviewer	Susan Wood

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

   Yes.

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

   Surveillance data

   Information to manage population health improvement

   Critical to mission of public health

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?**

   Specific public health functions are defined in state law as government responsibilities

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   a. Name of the HIE initiative: see spread sheet

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

   a. Technical assets – Yes – see spread sheet and information below

   b. Functional assets – No

Important building blocks for PHIN (that might also become building blocks for statewide HIE):

1. WIR – the Wisconsin Immunization Registry. This has more than 6 million individuals, with a robust master person index. There is ongoing (two-way) health information exchange with Medicaid and with private providers. This is also their platform for the strategic stockpile and campaign response administration – both part of PH Preparedness program and will become the platform for a new child health profile that is under development. The system has two sides – one is not a protected health record under HIPAA (the immunization records) and the other is a protected medical record and will be the home for the child health record. EDS built this and does the maintenance. Jim is not sure about the master provider index functionality with WIR – check with the WIR staff.
2. WEDSS – Wisconsin Electronic Disease Surveillance System. This system will be statewide by the end of this year. It support communicable disease reporting and surveillance and case management, such as for cases of active TB.
3. Electronic lab reporting (ELR). The ELR Hub is run by the State Lab of Hygiene using an Atlas product. They have built a whole process for data exchange around this hub, and exchange data with private providers such as Marshfield, Aurora, and Gunderson Lutheran. DPH is now working with Minnesota public health officials to exchange data on behalf of the state's labs through each state's hubs. There will be 8 labs participating by the end of this summer. They map into national standards for the 25 notifiable conditions. Also thinking about adding pathology lab results.
4. AVR – a core component of PHIN, support analysis, visualization and reporting using SAS BI. There are several data sets that are linked to this utility, including newborn hearing screening, WEDSS reporting, Environmental Public Health Tracking Network.
5. Resource management - tracks information about ambulance runs, available hospital beds, patient tracking for mass casualties – used by paramedics and EMTs
6. WHIE – they are linked into WHIE – have the Amalga software on a computer in their office to receive data
7. Vital Records – putting in a new system, focus now is defining requirements, planning for a late spring 2010 pilot with first module

Other DPH systems include:

8. Maternal and child health applications.
    a. SPHERE data collection – information on audiometric screening is collected, this is linked to the Birth to 3 Program. Also linked to a birth defects registry.
    b. Casepoint application collects data from coroners about infant deaths
    c. Also other death reporting
9. WIC – Women, Infant and Children nutrition program – eligibility and benefits. The system is three years old, built by Cyber, and federally approved.
10. Cancer Reporting System
11. Health information reporting such as local public health department profiles, hospital data sets that come from WHA for analysis and reporting purposes
12. HIV tracking using a web-based system from CDC

Contact people on various systems:

<u>Communicable Disease and Preparedness</u> – Sandy Breitborde is the bureau director

WIR – Dan Hofensberger and Tom Maertz

WEDSS– Rick Hefferman

EMS – Brian Litza

State Lab – Sherry Gehl, Deputy Director

John Chapin IT director

Garrett Johnson

Vital Records – Denise Webb and John Kiesow

MCH – data integration Lorraine Lychinski

Public Health Regional Directors

Wisconsin SLHIE Public Organization Interviews Department of Health Services Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 10, 2009
Location	Room 250, 1 West Wilson St., Madison
Attendees	Division of Public Health Regional Directors: Terri Timmers, Rhinelander Mary Young, Madison Leiska Geise, Eau Claire Dennis Hybray, Green Bay Georgia Cameron and Robert Harris, Milwaukee
Interviewer	Denise Webb & Susan Wood

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

   Yes.

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

   Current systems create huge reporting burdens on local public health departments – they are all in separate silos – 7 - 9 different systems. Each has slightly different format (for instance, WIR, ROSIE – the WIC system, billing systems, local management systems)

   There have been many efforts over the past years to address this but so far not remedied the situation.

   Local and state public health departments are now engaged in developing community health improvement plans and pushing for outcome data to measure their impact. They need real time clinical information that can come from EHRs to complement long term measures that comes from mortality data. This data is also needed for research and assessing the effectiveness of various intervention strategies for public health concerns – examples: health disparities, birth outcomes.

   Another important area of interest is supporting local health departments and encouraging alignment with the goals set in the state health plan. Many in DPH are now engaged in developing the 2020 state health plan goals. Objectives for the state health plan need to be measurable and reflect important statewide priorities such as HIE.

   Discussed the importance of the meaningful use criteria to public health activities and priorities and how to make sure it is reflected in the 2020 plan – Lieske will raise the issue with the team organizing this work.

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else**

The Wisconsin Immunization Registry could play a vital role.

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   a. Name of the HIE initiative: No although there is considerable effort devoted to federal and state reporting, which could be streamlined through HIE. They would like to see consistent use of data from HIE in measuring health status including for local health improvement plans, the state 2020 plan and report cards on health status such as the County Health Profiles published by the UW School of Medicine and Public Health. The UW team now has a grant from RWJ to produce these report cards nationwide.

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

   a. Technical assets – Not for the regions

   b. Functional assets – No

Department of Children and Families (DCF)

Wisconsin SLHIE Public Sector Organization Interviews Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 13, 2009
Location	GEF 1 Office Building, Madison
Attendees	Ron Hunt, Administrator, Division of Enterprise Services, Wisconsin Department of Children and Families (DCF) Maytee Aspuro, CIO, DCF
Interviewer	Susan Wood

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

   Yes.

   Health information exchange supports their mission to promote the economic and social well-being of Wisconsin's children and families. The Department is committed to protecting children, strengthening families, and building communities.

   Programs administered include child care subsidies, W2 (TANF), child welfare, child support. Their work is carried out through county government. Population impact – child support about 1 million people. The others are smaller – with 9000 people in W2, about 8000 in foster care at any point in time and 32,500 receiving child care subsidies.

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

   Information about health insurance coverage is a critical requirement especially for the child support program.

   W2 program includes screening for barriers to employment that would benefit from statewide HIE.

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?**

   N/A

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   a. Name of the HIE initiative: see spread sheet for DCF

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

    a. Technical assets – see spreadsheet for DCF

    b. Functional assets – No

Department of Regulation and Licensing (DRL)

Wisconsin SLHIE Public Organization Interviews DRL Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 13, 2009
Location	8th floor, Department of Administration Building East Wilson St., Madison
Attendees	Diane Miller, IT Specialist, DOA, Former CIO of the WI Dept. of Regulation and Licensing
Interviewer	Susan Wood

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

   NA

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

   NA

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?**

   NA

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   Name of the HIE initiative: Yes - DHS has two interfaces that call for information from this system: One is for criminal background checks and the other for Medicaid.

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

   a. Technical assets – Yes – see spread sheet prepared by DRL staff (Jeff Runkel) and information below

   b. Functional assets – No

DRL maintains a web site supported by a data base to look up credential history including for health professionals. It includes information about these health professions: MD, DO, RN, LPN, and Advanced Medical Prescribers.

This is an Oracle data base maintained at DRL. The agency is just finishing a rewrite that will consolidate and streamline 9 stovepipe components into one normalized database. With this new system they will have a unique client ID tied to license number(s) for the individual.

The system does not store information about where the person works although this has been under discussion.

They provide information on physicians to the State Medical Society in the form of two lists. Providers can opt out of public disclosure, so they provide 15 data elements for the ones who have not opted out, and 10 data elements for those who have. This limited list does not provide name but does provide license number and city/state.

Cathy Pond is the Division Administrator responsible for credentialing and exams and the web site. Telephone: 266-0557

Health Insurance Risk Sharing Plan (HIRSP)

Wisconsin SLHIE Public/Private Sector Organization Interviews HIRSP Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 11, 2009
Location	33 E. Main St., Suite 250, Madison
Attendees	Amie Goldman, CEO, Health Insurance Risk Sharing Plan (HIRSP)
Interviewer	Susan Wood

Meeting Notes

1. **Is a state-level health information exchange initiative important to your organization? What do you see as a reasonable value proposition?**

   Yes

2. **What type of information does your organization have the greatest interest in exchanging or collecting? How critical is this information to your organization's mission/objectives?**

   They are supportive of EHRs and the transfer of electronic data. They have a large population served in rural areas and they pay on a fee for service basis. They want the tools to manage the health of their population. Biometric data is critical to their mission.

3. **What should be the role of the Wisconsin State government in a state-level HIE governance entity? Are there critical functions the Wisconsin State government must provide that no one else can provide?**

   Amie recommends some kind of public-private organization with a strong role for government to promote public accountability.

4. **Is your organization currently involved in any health information exchange initiatives with outside organizations? If so, please provide more information:**

   a. Name of the HIE initiative: They contract for claims administration and with a pharmacy benefit manager

5. **Does your organization have technical and/or functional assets that could be leveraged by a statewide HIE? If so, please provide more information about these assets:**

   a. Technical assets – No

   b. Functional assets – Yes. Governance structure offers an excellent option for HIE.

   Until 3 years ago HIRSP was part of state government, run in DHS. Legislation enacted about four years ago privatized HIRSP. It is now created as a quasi-public utility under chapter 149. The plan covers 16,600 people who cannot otherwise obtain health insurance. The plan is the 2nd largest insurer of individuals in Wisconsin with a $170 million budget for coverage

Role of state government in HIRSP.

Chapter 149 creates the authority. There are 13 quasi-public authorities created in state law including UW Hospital & WHEDA. When the law was written HIRSP was the only one of the 13 that did not provide their employees with access to state government benefits. The result was that they had to buy health insurance on the open market – a big problem. This was later remedied with clean-up legislation so they now are members of the state retirement system and can get state government benefits.

Original legislation created HIRSP as a public-private organization but this was not enacted because of concerns from advocates about accountability (vetoed by Governor). The second legislative effort creating the quasi-public utility was successful.

Implications of this structure:

Subject to open meeting and open records laws.

It is a "public body corporate"

Tax status: *not a not-for-profit*?. Tax status is defined under 501(c)(27)

Accountability measures include:

- Governor appoints board members, subject to confirmation by the Senate
- The Governor names the chair
- Also they are considered state public officials and so are subject to the Code of Ethics in Ch. 19
- In addition the Board has adopted a code of conduct to supplement the Code of Ethics in recognition that board members represent certain constituencies
- Strong consumer role with three seats plus a public member

Board structure

There is a 14 member board all appointed by the Governor. Thirteen are voting members, including one public member, four representing insurers, a representative of the State Medical Society, Pharmacy Society, and Wisconsin Hospital Association, one other health care provider, a small business representative, and three consumer representatives (two policy holders and a representative of a professional advocacy organization. The 14th non-voting member is the Commissioner of Insurance.

They serve staggered 3 years terms. The board works because of its responsibilities to the patients it serves and the personalities of the board members. The Governor appoints the Chair. The Board elects the other officers and hires the CEO. Board members are state officials. They are required to file statements of economic interests.

The board has created a consumer advisory committee that includes volunteers from the policy holder ranks.

Officers and committees:

There is a chair and vice-chair plus five committees. Board members serve on the committees. The committee structure:

- Executive
- Strategic Planning
- Finance and Audit
- Appeals
- Consumer
- *Staff*

Amie hires the staff. There are 3.5 positions – including CEO, Executive Assistant, Director of Operations, and a half time finance and accounting manager.

Contracts

Most of the business is carried out by contractors, including:

- WPS is the plan administrator
- Legal services through contract with local firm plus they can use the services of the Reference Bureau on some issues
- Actuarial services
- PBM (Medtrack)

Lessons learned in creating this structure

- Access to state employee benefits is very desirable
- Recommends not including legislators as designated board members
- Their authorizing legislation is good in that it gives the board the authority it needs to design plans and the authority to contract. However the threshold for procurement is set too low at $25,000. Amie recommends that it be higher and indexed to inflation.

Department of Administration (DOA)
Division of Enterprise Technology (DET)

Wisconsin SLHIE Public Organization Interviews Department of Health Services Meeting Notes	
Objective	To gather input from public sector organizations that may have assets that could be leveraged in a statewide Health Information Exchange.
Date	August 17, 2009
Location	DOA Building
Attendees	Oskar Anderson and Bob Martin
Interviewer	Jeff Bradfield and Mike Connors

The meeting kicked off with an explanation of the purpose of the HIE project to Mr. Anderson and Mr. Martin.

- Project structured in 2 phases; establishing the business architecture and then establishing the technical architecture.

DOA discussed potential assets to be used for HIE and other limitations:

- BadgerNet – Expanding state network capable of reaching rural areas within the state.
  Mr. Anderson mentioned that there is a grant pending with the Governor to expand BadgerNet to additional schools and libraries throughout the state. The deadline for the grant was last Friday.
- State Data Center (Femrite) – Full set of data center capabilities with the potential to host HIE related applications.
- DET does not have an enterprise architecture to use as a reference model or that could align with HIE.
- DET does not have a master list of all services provided to agencies at the data center.

DOA identified other potential resources within state government:

- Mr. Anderson suggested talking with Sheila Conroy who had worked on a privacy report for the Governor's office. The report was just finished on 8/10 and it identifies a list of privacy data within the state and its location. This could be a good source for the information areas that are required for an HIE. Bob Martin will send an email introducing Jeff and Mike.

Other considerations:

- Mr. Anderson stated that he felt that the state CIO should be represented in the governance model as the state CIO can represent all agencies, not just DHS. If the intent is to share data across agencies, then the state CIO should be at the table.

- Mr. Anderson mentioned that the HIE project may want to investigate the potential use of the GTech supported satellite network that the Department of Revenue uses for the State Lottery system. It has over 3600 locations throughout the state and is most effective in rural parts of Wisconsin.

State Government and Private Health Organizations Technical Assets

The following table provides details on the potential technical assets within each information type.

Information Type	Asset	Acronym	Owner
Administrative Claims	WHIO data mart	WHIO	WHIO
Admission, Registration & Billing	InsightCS	InsightCS	DHS
ADT/Order/Results/Care	HMS System	ITN	RWHC
Care Documentation	Progress Notes / Treatment Planning Sys	TxMS	DHS
	Wisconsin EHDI (Early Hearing Detection and Intervention) Tracking, Referral and Coordination	WE TRAC	DHS
	Wisconsin Health Information Exchange ED Syndromic Surveillance	WHIE	WHIE
Demographics	Donor Intent	Donor Intent	DHS
	Master Customer Index	MCI	DHS
	Vital Records	Vital Records	DHS
Disease Information	Cancer Screening and Tracking System	CaST	DHS
	Electronic Laboratory Reporting	ELR	DPH
	MCH Referral	MCHRef	DHS
	Wisconsin Cancer Reporting System	WCRS	DHS
	Wisconsin Electronic Disease Surveillance System	WEDSS	DHS
Eligibility Information	ACCESS	ACCESS	DHS
	CARES Mainframe	CARES	DHS
	Employer Verification of Health Insurance	EVHI	DHS
Encounters	DDES Encounter Reporting	DDES	DHS
Immunizations	Wisconsin Immunization Registry	WIR	DHS
Licensing Information	Adult Programs Information System	APIS	DHS
	Facility Licensing and Certification System	FL/CIS	DHS
Medication Information	AIDS/HIV Drug Assistance Program	ADAP	DHS
Multiple	ForwardHealth interChange	iC	DHS
Provider Information	Caregiver Regulation Information System	CRIS	DHS
	Emergency Medical Services	EMSS	DHS

Information Type	Asset	Acronym	Owner
	System (EMSS)		
Public Health Information	Wisconsin Public Health Information Network (WiPHIN)	WPHIN	DHS
Quality Data	Repository based data submission	RBS	WCHQ

Table 3. Potential state government and private health organizations technical assets sorted by information type.

APPENDIX 17

Wisconsin HIT/HIE Communication, Education, and Marketing Plan

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1. Communication, Education, and Marketing (CEM) Goals, Objectives, and Principles

A. CEM Goals and Objectives

High-Level Goal(s):
Inform and raise the awareness of consumers and the health community[1] about the benefits of health information technology and health information exchange.

Near-Term Goals and Objectives:

1. Design and implement a comprehensive HIE communication and educational program.

a. Begin gathering information that will be critical to message development through various methods, such as stakeholder meetings, town halls, surveys, and focus groups, within 90 days of the SDE assuming responsibilities.
b. Develop and deploy messages to a broad spectrum of prioritized stakeholders through community partners within 6 months of receiving the results of the stakeholder input.
c. Develop and deploy targeted messaging to enhance public transparency regarding uses of protected health information (PHI) maintained by HIEs in Wisconsin and individuals' rights related to uses of PHI.
d. Develop measures to evaluate the success of the initial communications and education campaign within 6 months of receiving the results of the stakeholder input.
e. Develop and implement a continuous quality improvement plan after 6 months into the campaign.

2. Develop and implement an ongoing marketing program within the SDE to solicit financial support and engage consumers and the health community in the adoption and use of HIE services.

a. Once the Strategic and Operational Plan is approved by the ONC, immediately develop marketing strategies and tools to begin communicating the benefits to target stakeholders that are most likely to help capitalize the statewide health information network and services.

[1] Health community is defined as any person or entity that provides, pays for, purchases or facilitates health care.

b. Develop a marketing strategy and tools that target stakeholders who are most likely to contribute to the sustainability of the statewide health information network and services within 60 days of the SDE assuming responsibilities.
c. Survey the consumer market to identify HIE services they are most likely to use and purchase.

B. CEM Principles

Wisconsin's communication, education, and marketing plan adopts a number of common principles to successfully accomplish its goals and objectives. These principles are described in the following table.

Table 1 – CEM Principles

PRINCIPLE	REASON
Communicate in plain language	Complex communication and the use of jargon can result in no message being heard, general confusion about the message, or a completely wrong interpretation of the message.
Deliver linguistically and culturally appropriate messaging	Information and messages that are professionally translated/interpreted into languages of commonly encountered cultural groups and checked for cultural appropriateness creates trust and promotes ownership by all communities.
Be credible	Without a credible communication approach or credible communicators, individuals will simply not believe in the end goal.
Involve critical and diverse constituencies	Promotes ownership among recipients so they feel they are a necessary part of the program.
Have communicators who are trusted and respected in their respective communities	If the recipients of the message do not trust or respect the communicators, the messages "fall on deaf ears."
Install visible management support	*Active* management commitment gives credibility to communication. Must be seen to demonstrate support.
Develop enhanced face-to-face communication	Audience is involved; communication is two-way and provides a feedback mechanism.

Avoid information overload	Too much information leads to confusion and irritation. Accurate and timely information is key.
Deliver consistent messages	Inconsistency in messages leads to loss of credibility and causes frustration and confusion. Consistency leads to predictability and understanding about what to expect.
Stick to the message and vary its delivery	People learn in different ways. Using multiple communication methods increases the likelihood of the message being understood by broader audiences.
Tailor communication to audience needs: Give information *audiences* want, not what *you* want to tell	Makes information "real" to the audience. The audience is more likely to listen if the information is provided in context to their current frame of reference.
Develop a centralized coordinated communication system	Ensures a consistent approach.
Manage expectations	Encourages audience to believe in what you to tell them.
Listen and act on feedback	Encourages support in the approach by being responsive to the needs of the audience. Ensures that the approach meets changing audience needs.
Adapt messages for various cultures	The use of trusted media sources (community/ethnic/news media) and messages provided in various languages ensures better chances of reaching specific populations.

2. Elements of Communication, Education, and Marketing

A. Stakeholder and Communication Partner Analysis

An effective plan for communications and education involves collaboration with key stakeholders and their respective partners. Wisconsin is unique in its capabilities to convene its diverse stakeholders and collectively develop a forum for consensus.

Targeted key messages about the benefits of health information technology and health information exchange will be developed in a consistent, standardized manner yet tailored for different audiences.

The following table illustrates the stakeholder types, specific groups within each stakeholder type, and their respective community partners/collaborators who may need to be engaged directly or indirectly throughout the project by the project team and on an ongoing basis by the State Designated Entity to provide and deliver credible messages to specific groups.

Table 2 – Stakeholder Matrix

Stakeholder Type	Specific groups within the stakeholder type needing targeted messaging	Community Partners/Collaborators--organizations or groups that could provide and deliver credible messaging to specific groups within the stakeholder type
Hospitals/Staff (including Critical Access Hospitals and Veterans Administration (VA) Hospitals)	**CEOs** **Hospital Direct Care Givers** **Hospital IT**	• **American Association of Family Practitioners (Wisconsin Chapter)** • **Media outlets** • **Rural Wisconsin Health Cooperative** • **Schools of Nursing** • **Veterans Administration** • **Wisconsin Dairyland Healthcare Information and Management Systems Society (HIMSS) Chapter** • **Wisconsin Health Information Management Association** • **Wisconsin Health Information Technology Extension Center (WHITEC)** • **Wisconsin Hospital Association** • **Wisconsin Medical Society** • **Wisconsin Nurses Association** • **Wisconsin Organization of Nurse Executives** • **Wisconsin Vocational/Technical Association**
Clinics/Staff	**Bilingual clinical/support staff**	• **American Association of Family Practitioners**

Stakeholder Type	Specific groups within the stakeholder type needing targeted messaging	Community Partners/Collaborators--organizations or groups that could provide and deliver credible messaging to specific groups within the stakeholder type
	Clinic Administrators Clinic IT Nurse practitioners Nurses Medical Interpreters Physician assistants Physicians Social Workers Ambulatory practices Correctional Facility Clinics Family Planning Clinics Federally Qualified Health Centers Free Clinics Rural Health Clinics Tribal Health Clinics University Clinics Veterans Administration Clinics	(Wisconsin Chapter) • Department of Veterans Affairs • Great Lakes Inter-Tribal Council • Media outlets • Office of Rural Health • Rural Wisconsin Health Cooperative • Schools of Nursing • Veterans Administration • WHITEC • Wisconsin Dairyland HIMSS Chapter • Wisconsin Department of Corrections • Wisconsin Health Information Management Association • Wisconsin Medical Group Management Association • Wisconsin Medical Society • Wisconsin Nurses Association • Wisconsin Primary Health Care Association • Wisconsin Vocational/Technical Association
Laboratory/ Pharmacy	Independent Labs Mail-order Pharmacies Pharmacists Pharmacy Benefit Networks Retail Pharmacies Wisconsin State Lab of Hygiene	• Media outlets • Pharmacy Society of Wisconsin • State of Wisconsin Lab Survey Agency • University of Wisconsin System (School of Pharmacy) • Wisconsin Lab Association
Other providers	Alcohol and Other Drug Abuse (AODA) providers Chiropractors Dentists Emergency Medical Technicians Mental Health Providers	• Media outlets • Wisconsin Chiropractic Association • Wisconsin Dental Association • Wisconsin EMS Association • Wisconsin Psychiatric Association • Wisconsin United for Mental Health • Wisconsin Mental Health Council • Wisconsin Department Health Services Divisions:

Stakeholder Type	Specific groups within the stakeholder type needing targeted messaging	Community Partners/Collaborators--organizations or groups that could provide and deliver credible messaging to specific groups within the stakeholder type
		o Public Health o Long Term Care o Mental Health and Substance Abuse
Public Health	Epidemiologists Local Health Officers and staff Schools of Public Health Tribal Health Departments	• Media outlets • UW Population Health Institute • Wisconsin Association of Local Health Departments and Boards • Wisconsin DHS Division of Public Health • Wisconsin Public Health Association
Home and Community-Based Care	Assisted Living Community-Based Residential Facilities Home Health Hospice K-12 Schools Nursing Homes Rehabilitation Centers	• Media outlets • Wisconsin Association of Homes and Services for the Aging • Wisconsin Board on Aging and Long Term Care • Wisconsin Department of Health Services Divisions: o Long Term Care o Mental Health and Substance Abuse o Public Health o Quality Assurance
Patients	All patients Patients with health care disparities Patients with Limited English Proficiency (LEP) Patients with physical or developmental disabilities Racial and ethnic minority populations Seniors Tribal Nations Veterans	• Advocacy Organizations (not an all inclusive list): o ABC for Health o Black Health Coalition of Wisconsin o Cancer Center o Coalition of Wisconsin Aging Groups o Disability Rights Organization o Disability Rights Wisconsin o Latino Health Council o Refugee Services o Retired Volunteer and Senior Program o United for Mental Health o United Refugee Services of Wisconsin o United Way of Wisconsin o Wisconsin AARP

Stakeholder Type	Specific groups within the stakeholder type needing targeted messaging	Community Partners/Collaborators--organizations or groups that could provide and deliver credible messaging to specific groups within the stakeholder type
		o Wisconsin Association of Mental Health o Wisconsin Literacy Inc. o Wisconsin Volunteer Referral Center • Disease-based organizations, such as: o American Cancer Society (Midwest Chapter) o Aids Resource Centers • Aging and Disability Resource Centers • HIPAA Collaborative of Wisconsin • Labor unions • Media outlets • Patient Ombudsman • Primary care physicians/clinicians • Tribal Health Directors • University of Wisconsin Extension • Veterans Administration • Wisconsin Department of Health Services (list of programs is not all inclusive) o Arthritis Program o Comprehensive Cancer Control Program o Diabetes Prevention and Control Program o Heart Disease and Stroke Prevention Program o Oral Health Program o Tobacco Control Program o Well Woman Program • Wisconsin Department of Veterans Administration • Wisconsin Library Association • Wisconsin Primary Health Care Association
Healthcare Payers/Health Plans	Abri Health Plan Anthem Blue Cross Blue Shield Arise Health Plan Children's Community Health Plan, Inc. Dean Health Plan	• Media outlets • Office of the Commissioner of Insurance • Wisconsin Association of Health Plans • Wisconsin Counties Association • Wisconsin Department of Health Services

Stakeholder Type	Specific groups within the stakeholder type needing targeted messaging	Community Partners/Collaborators--organizations or groups that could provide and deliver credible messaging to specific groups within the stakeholder type
	Family Care Organizations Family Care/Partnership Organizations Group Health Cooperative of Eau Claire Group Health Cooperative of South Central Wisconsin Health Insurance Risk Sharing Plan Humana, Inc. • iCare Managed Health Services Medicaid and Badger Care Plus MercyCare Health Plans Network Health Plan Physicians Plus Insurance Corporation Security Health Plan Third-Party Administrators for Self-Funded Plans United Healthcare of Wisconsin, Inc. Unity Health Plans Insurance Corporation Wisconsin Education Association Trust Wisconsin Physicians Service Insurance	
Health Care Purchasers	Employers (private and government) Individuals	• Employer coalitions, such as: o Business Health Care Group o The Alliance o Wisconsin Manufacturers and Commerce • Independent Insurance Agents of Wisconsin • Media outlets • Professional Insurance Agents of Wisconsin • Wisconsin Association of Health Underwriters • Wisconsin County Association
Health Care Quality Organizations (HIOs)	Metastar Thedacare Center for Healthcare Value Wisconsin Collaborative for Healthcare Quality Wisconsin Health Information Organization Wisconsin Hospital Association Wisconsin Medical Society	

Stakeholder Type	Specific groups within the stakeholder type needing targeted messaging	Community Partners/Collaborators--organizations or groups that could provide and deliver credible messaging to specific groups within the stakeholder type
Health IT Vendors/Regional Health Information Exchanges	Device vendors EMR vendors HIE vendors Wisconsin Health Information Exchange Lab vendors	• HIMSS
Education	Colleges/Universities Vocational Programs	• Medical College of Wisconsin • Midwest Community College Consortia • Population Health Institute • Department of Family Medicine • Population Health Sciences • University of Wisconsin • Wisconsin Area Health Education Center • Wisconsin Vocational/Technical Association
Taxpayer		• Legislators/Elected Officials • Media outlets • Wisconsin Association of Accountants • Wisconsin Department of Revenue • Wisconsin Institute of Certified Public Accountants • Wisconsin Taxpayers Alliance
General Public		• Faith-based organizations • Community Centers • Legislators/Elected officials • Libraries • Local Chambers of Commerce • Media Outlets • State and local government agencies
Government	Legislators/Elected Officials State and local government agencies Policymakers	• Governor's Office • Media outlets • State Health IT Coordinator • Wisconsin Legislative Council

B. Communications and Education Messaging

The Communications and Education matrices for WIRED for Health (Table 3) and the Medicaid HIT Incentive Program (Table 4) are work plans that detail the following for the planning and implementation phases of the state HIE and the Incentive Program:

- Communication and education needs/topics (i.e., messaging or education topic)
- Audiences (i.e., stakeholder types that may need to receive a targeted message or education—refer to the Stakeholder matrix, Table 2 for the specific groups within the stakeholder type and the community partners and collaborators that could provide and deliver the messages or education)
- Coordinator or Expert assigned to each topic (i.e. the person or persons who would serve a lead role or are a subject matter expert for this topic development)
- Medium and delivery methods (i.e., format, storage, and/or transmission tools that could be used to store and deliver information or data and channels or vehicles that could be used for disseminating the message or education)
- Resources needed (i.e. types of staff or skills needed to develop and manage content)
- Frequency (i.e., how often the message or education needs to be delivered)
- Timing (i.e., when the message or education needs to be delivered)
- Expected results (i.e., how we will know if the message or education delivered is successful)

Identifying these components will help ensure the right stakeholders get the right message, the right way, at the right time. The Wisconsin Medicaid Program is developing a State Medicaid HIT Plan in collaboration with the WIRED for Health planning effort. Much of the planning is being done jointly, such as in the area of communications and education, to share and coordinate resources where it makes sense and to ensure the promotion of HIT adoption and HIE among Medicaid providers aligns with the broader state plan for statewide HIE for all providers.

The initial set of message topics include:

1. General awareness of the WIRED for Health Initiative
2. HIT and HIE Terminology
3. WIRED for Health Act (State Designated Entity (SDE) Law)
4. SDE Request for Applications and Selection

5. Public comment period on Wisconsin's HIE Strategic and Operational Plan
6. HIE Procurement Process (RFI, RFB, RFP)
7. ONC Approval of Wisconsin's HIE Strategic and Operational Plan
8. Wisconsin's planned HIE architecture and services
9. Positive benefits and value of HIT and HIE
10. Process for governing data use and access ("Who decides how information will be used?")
11. Privacy protection and security of electronic personal health data/records held in an EHR and HIE, and patient rights
12. Consent model
13. Funding for statewide HIE infrastructure and services
14. Crisis and Incident Response
15. WIRED for Health Project Status—Planning Phase
16. WIRED for Health Project Status—Implementation Phase
17. Medicaid HIT Incentive Program

Prioritizing the audiences to receive communications and education will ensure stakeholder types and specific groups within each stakeholder type with an immediate need for information get the information first. Hospitals and health care professionals, such as physicians that are eligible for the Medicare and/or Medicaid HIT incentive payments, and patients have an immediate and on-going need to know what is happening with regard to HIE statewide. Other audiences will need to know only when information is relevant to them and their particular situation. A variety of strategies aimed at communicating information to and obtaining information from specific target populations will be developed to meaningfully involve them in the implementation of statewide HIE. Communications and educational materials developed and disseminated to the public by the Department and/or the SDE about HIT and HIE (e.g., the Statewide Health Information Network and HIE services), regardless of the medium, will comply with any applicable state and federal Limited English Proficiency and American Disability Act requirements.

The messages must be developed with input from the various committees and address all five HIE domains: governance, finance, policy and legal, technical infrastructure and services, and business and technical operations. How to deliver and channel the messages will vary depending on the target audience. For example, HIT and HIE education and information for patients could be managed at the clinics and hospitals, similar to the way information about HIPAA is managed. Media will also be helpful in communicating to various audiences at

proper times in the process. Answering the questions, what is the BENEFIT to ME and COST will be important for all audiences.

Table 3 – Communications and Education Matrix—WIRED for Health

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
General awareness of the WIRED for Health Initiative	• Hospitals/staff	Project Manager SDE Executive Director State Health IT Coordinator	• Talking points • WHA weekly newsletter • Direct emails • White Paper • Web postings • WHA, RWHC, DHS eHealth, and WIRED for Health Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board hospital members	• Bi-weekly update on WIRED for Health progress from Project Mgr • Communication specialist/Technical writer • Web administrator • LISTSERV administrator	Bi-weekly or as new updates or deadlines occur	May 2010 through end of project	• Hospital CEOs, CIO's, and direct care givers know the state-level, state-coordinated effort exists, what it is, and how this effort will help eligible hospitals achieve the meaningful use criteria related to HIE • Hospital CEO's, CIOs, and direct care givers know the vision, mission, and goals of WIRED for Health • Hospital CEOs, CIO's, and direct care givers know what is expected of them and know where to go to get additional information • Hospital CEOs, CIOs, and direct care givers are able to communicate with others about the WIRED for Health initiative • Regular progress updates and feedback loop established
General awareness of the WIRED for Health Initiative	• Clinics/staff	Project Manager SDE Executive Director State Health IT Coordinator	• Talking points • WMS Medigram • Direct emails • Web postings • CEO to CEO Report • WMS, DHS eHealth, WIRED for Health and other partners' Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • Field staff and agent education • WIRED for Health Board	• Bi-weekly update on WIRED for Health progress from Project Mgr • Communication specialist/Technical writer • Web administrator • LISTSERV administrator	Bi-weekly or as new updates or deadlines occur	May 2010 through end of project	• Clinicians know the state-level, state-coordinated effort exists, what it is, and how this effort will help eligible professionals achieve the meaningful use criteria related to HIE • Clinicians know the vision, mission, and goals of WIRED for Health • Clinicians know what is expected of them and where to go to get additional information • Clinicians are able to communicate with others about the WIRED for Health initiative • Regular progress updates and feedback loop established

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			physician members				
General awareness of the WIRED for Health Initiative	• Labs/Pharmacy • Other providers • Public Health • Home and Community-Based Care • Health care payers/health plans • Health Care Purchasers • Quality Health Information Organizations (HIOs) • Health IT Vendors/Regional HIEs • Education • Government	Project Manager SDE Executive Director State Health IT Coordinator	• Talking points • Articles • Direct emails • Web postings • DHS eHealth, WIRED for Health and other partners' Web sites[2] • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board members and committee co-chairs	• Bi-weekly update on WIRED for Health progress from Project Mgr • Communication specialist • Web administrator • LISTSERV administrator	Bi-weekly or as new updates or deadlines occur	May 2010 through end of project	• Stakeholders know the state-level, state-coordinated effort exists, what it is, and how this effort will help eligible professionals achieve the meaningful use criteria related to HIE • Stakeholders know the vision, mission, and goals of WIRED for Health • Stakeholders know what is expected of them and where to go to get additional information • Stakeholders are able to communicate with others about the WIRED for Health initiative • Regular progress updates and feedback loop established

[2] The plan is to have a primary Web site(s) serve as the source of information for certain message topics published on the Web and the other sites would have links on their sites to the source information to ensure consistent messaging. It is our expectation the SDE would maintain the source site for state-level HIE information, and WHITEC would be the source site for EHR adoption technical assistance information. We want to avoid duplicate, potentially inconsistent messaging on Wisconsin organization's Web sites.

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
General awareness of the WIRED for Health Initiative	• Patients • Taxpayers • General Public	Project Manager	• Talking points • Articles • Direct emails • Web postings • Go to editorial boards with a concise message regarding vision, mission, and goals • Develop letters to the editor to raise general awareness • DHS eHealth, WIRED for Health, and other partners' Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board members and committee co-chairs	• Bi-weekly update on WIRED for Health progress from Project Mgr • Communication specialist • Health literacy expert • Web administrator • LISTSERV administrator	As needed	May 2010 through end of project	• Taxpayers and the general public know what the WIRED for Health initiative is and why it matters • Taxpayers and the general public that want more information on the Wired for Health initiative know where to go to get the information • Regular progress updates and feedback loop established
HIT and HIE Terminology	• All • Media Outlets	Project Manager	• Glossary of terms and definitions (i.e., dictionary) • Wiki/Word on partners' Web sites • WIRED for Health SharePoint Site • Hand-held accessible	• Communication specialist/Technical writer • Web administrator	Update as needed once developed	Jul 2010 through end of project	• HIT and HIE terms are defined, understood, and used consistently, especially by the media outlets • Media coverage of HIT and HIE will reflect an understanding of the terminology and the benefits of adoption and use of the technology
WIRED for Health Act - (State Designated Entity (SDE) law)	• Not-for-profit HIOs • Health Community (i.e., providers, payers, purchasers,	Project Manager	• Press release • Talking points • FAQs • Articles • eHealth, Wired for Health Board and partners' Web sites • WIRED for Health	• Communication specialist • Web administrator	As needed	May – Dec 2010	• Individuals and organizations understand the purpose of the WIRED for Health Act and its relevance

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
	public health etc.) • General Public		SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board members and committee co-chairs				
SDE Request for Applications (RFA) and Selection	• Not-for-profit HIOs (during application process) • All (upon SDE selection)	WIRED for Health Governance Committee State Health IT Coordinator	• Public Notice—solicit letters of interest and add interested parties to distribution list for draft and final RFAs • Direct email message to known potential applicants • Talking points • Press release upon selecting the SDE • eHealth, Wired for Health Board, and partners' Web sites • State of Wisconsin's Public Notice Web site • WIRED for Health Board and committee members	• Communication specialist • Web administrator	As needed	Jun 2010 – Aug 2010	• Interested organizations that are potentially qualified get the message, submit a letter of interest, and apply for consideration • Organizations and individuals believe the process for selecting the SDE is transparent, open, and fair
Public comment period (July 16-31) on Wisconsin's HIE Strategic and Operational Plan	• General Public • Health Community (i.e., providers, payers, purchasers, public health etc.)	Project Manager	• DHS leaders meet in person with certain groups that may have concern about the plan, particularly the legal and policy aspects • Public Notice • WIRED for Health Board Press release • eHealth, Wired for Health Board, and partners' Web sites	• Communication specialist • Web administrator • LISTSERV administrator	One time messaging	June – July 2010	• Individuals and organizations get the message about the public comment period • Interested individuals and organizations review the plan and submit comments • Patient advocacy organizations and other entities that are particularly concerned about sharing health information get advance notice and information about the plan prior to it being released for public comment • Public comments are considered and the Strategic and Operational Plan is updated to reflect the input

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			• WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board and committee members • Post public notice at all (477) public libraries and the local health departments (LHDs) (provide talking points on WIRED for Health to library and LHDs so they can field questions)				
HIE Procurement Process (RFI, RFB, RFP)	• Health IT Vendors	SDE Executive Director	• Public notice • Articles/updates in Healthcare Informatics; Health Data Management; HIT/HIPAA Update News Service; HIMSS HIE Lights Newsletter; HIS Talk • Newspaper ad • Wisconsin VendorNet • DHS and SDE Web sites • HIT Trade organizations (e.g., HIMSS)	• Project manager • Contract administrator • Technical writer • Web administrator	As needed	Oct 2010	• Health IT vendors receive timely notification of procurement opportunities • Health IT vendors know the process for submitting bids and /or proposals and know where to go to get additional information • Health IT vendors believe the process is fair, open, and competitive
ONC Approval of Wisconsin's HIE Strategic and Operational Plan	• All stakeholders	State HIT Coordinator	• DHS, SDE, and partners' Web sites • Partner organizations' newsletters • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV	• Web administrator • LISTSERV administrator	One time messaging	Upon response from ONC	• Stakeholders get the message that the plan is approved and formal implementation is beginning

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
Wisconsin's planned HIE architecture and services	• Health IT Vendors • Health Community (i.e., providers, payers, purchasers, public health etc.)	Project Manger	• WIRED for Health SharePoint site • DHS, SDE, and WHITEC Web sites • Articles/updates in Healthcare Informatics; Health Data Management; HIT/HIPAA Update News Service; HIMSS HIE Lights Newsletter; HIS Talk • Blog updates • FAQs document • Compliance/technical specifications • HIMSS EHR Vendor Association • HIMSS HIE Liaison Roundtable	• Communication specialist • Technical writer • Web administrator • LISTSERV administrator	As needed	Aug 2010	• Informs health IT vendors about the WIRED and how they can participate. Directs them as to where to go to find more information. Provides vendors with a clear understanding of the requirements for their products to function properly in accordance with the WIRED for Health architecture and standards • Informs the health community, particularly hospitals and clinics on what services will be implemented and when, and expectations of the health community

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
Positive benefits and value of HIT and HIE	• Health community (i.e., providers, payers, purchasers, public health etc; tailored messages for each audience type) • Patients • General Public	Project Manager SDE Executive Director State HIT Coordinator	• For current WIRED for Health Board Members/ Committee co-chairs, talking points on benefits and value tailored by stakeholder type • Go to editorial boards with a concise message about the benefits and value of HIT and HIE • Develop letters to the editor to raise awareness of HIT and HIE benefits and value • Messages and articles through health trade associations (e.g., WHA newsletter and WMS Medigram) • Articles in journals and publications (e.g., Wisconsin Medical Journal) • Messages and newsletter articles through consumer/patient advocacy organizations like aging groups, health plans, and patients' physician/provider • Information sharing at meetings, events, and gatherings across the state, such as Rotary Clubs, etc. • Set up information booths in public places, such as shopping malls • Brochures for placement in clinics and ER waiting	• Public relations/ communications consultant for message development and testing • Communications specialist • Health literacy expert • Web administrator • LISTSERV administrator	Bi-weekly to monthly	June 2010 and ongoing	• Awareness raised on how HIT and HIE improves access to more timely health Information and provides opportunities to improve health decisions, safety, and outcomes • Stakeholders clearly understand, widely accept, and embrace the benefits and value of EHRs and HIE • Shared vision and goals for EHR adoption and use and HIE in Wisconsin • Physicians proactively communicate the value and benefits of HIT and HIE to their patients and to other physicians and clinicians not yet using HIT in their practices • Patients want and expect their providers to use an EHR system and electronic HIE to manage and coordinate their care • Awareness raised on how HIT and HIE will impact and enhance capabilities for research, population health, surveillance, and emergency preparedness

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			rooms • Webinars/ educational sessions • Townhall Meetings • Recorded presentations/ speeches on subject posted on Web • Elevator speech • DHS eHealth, WIRED for Health, SDE, and partners' Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board members and committee co-chairs • SDE Governing Board				

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
Process for governing data use and access ("Who decides how information will be used?")	• Patients • Health Community (i.e., providers, payers, purchasers, public health etc.) • General public	Governance Committee Legal/Policy Committee	• SDE policies and procedures • DHS eHealth, WIRED for Health, and other partners' Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV	• Communications specialist • Health literacy expert • Web administrator • LISTSERV administrator	As needed	March 2010 and ongoing	• Patients, health community, and general public know and understand how data use and access are governed by the SDE
Privacy protection and security of electronic personal health data/records held in an EHR or HIE, and patient rights	• General public • Patients • Health Community (i.e., providers, payers, purchasers, public health	Legal/Policy Committee	• Talking points and FAQs about what data is used and stored, how the data is used, and how the data is safeguarded/ protected • Standard language from Legal/Policy Committee for inclusion in Notices of Privacy Practice • Brochures for placement in clinic and ER waiting rooms	• Public relations/ communications consultant for message development and testing • Communications specialist • Health literacy expert • Web	Often	July 2010 and ongoing	• Patients and the general public understand that in many ways electronic records are more secure than paper records and access to electronic records is more easily tracked than with paper records • Patients understand how their electronic personal health information is secured and safeguarded • Patients, providers, and the general public accept and trust in HIT/HIE

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
	etc.)		• Focus Group Meetings • Town hall Meetings • Information pushed out through consolidated community partners' distribution list • DHS eHealth, WIRED for Health, SDE, and partners' Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • SDE Governing Board	administrator			
Consent Model	• Patients • Consumers/ Patient Advocacy groups • Health Community (i.e., providers, payers, purchasers, public health etc.)	Legal/Policy Committee	• Talking points and FAQs on what the consent model is, how it works, and patients' rights regarding consent • Brochures for placement in clinic and ER waiting rooms • Standard language from Legal/Policy Committee for inclusion in Notices of Privacy Practice • Focus Group Meetings • Town hall Meetings • Information pushed out through consolidated community partners' distribution list • DHS eHealth, SDE, and partners' Web sites • WIRED for Health SharePoint site	• Public relations / communications consultant for message development and testing • Communications specialist • Health literacy expert • Web administrator • LISTSERV administrator	Often in the next 12 months and then as needed	July 2010 and ongoing	• Patients understand the consent model and process for HIE and very few patients opt out

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			• DHS eHealth Updates LISTSERV • SDE Governing Board				
Funding for statewide HIE infrastructure and services	• All	Finance Committee	• Talking points • FAQs • Articles • Direct emails • Public forums/presentations • Web postings • DHS eHealth, WIRED for Health and other partners' Web sites[3] • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board members and committee co-chairs	• Communications specialist • Web administrator • LISTSERV administrator • Public presenters	At least twice a month	July 2010 and ongoing	• Stakeholders understand the value and costs of the HIE infrastructure and services and are willing to contribute to the cost of the services relative to the benefit they receive
Crisis and Incident Response	• General public	SDE Executive Director	• Press and media channels • SDE Governing Board	• Public relations / communications consultant for message development and testing • Communications specialist • Web administrator • LISTSERV	As often as needed	Messaging will be developed in advance of crises for high-risk, high-impact crises and messages will be delivered as soon as crisis/incident is known	• Impact of a crisis or incident, such as a PHI breach, is minimized and properly managed/controlled

[3] The plan is to have a primary Web site(s) serve as the source of information for certain message topics published on the Web and the other sites would have links on their sites to the source information to ensure consistent messaging. It is our expectation the SDE would maintain the source site for state-level HIE information, and WHITEC would be the source site for EHR adoption technical assistance information. We want to avoid duplicate, potentially inconsistent messaging on Wisconsin organization's Web sites.

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
				administrator			
WIRED for Health Project Status—Planning Phase	• WIRED for Health Board and committees • Key stakeholders • Project team	Project Manager and staff leads	• WIRED for Health SharePoint site • Weekly project management staff meetings • WIRED for Health bi-weekly meeting with DHS Secretary • WIRED for Health Board and committee meetings • DHS eHealth, WIRED for Health, SDE, and partners' Web sites • WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • WIRED for Health Board members and committee co-chairs • Project staff leads for each committee	• Project manager • Web administrator • LISTSERV administrator	At least weekly	Feb 2010 – Sep 2010	• Regular project statuses and functional feedback loop in place
WIRED for Health Project Status—Implementation Phase	• SDE Board and Committees • Key stakeholders • Project team	Project Manager and staff leads	• WIRED for Health SharePoint site • Weekly project management staff meetings • WIRED for Health bi-weekly meeting with DHS Secretary and SDE Executive Director • SDE Board and committee meetings • DHS eHealth, WIRED for Health, SDE, and partners' Web sites	• Project manager • Web administrator • LISTSERV administrator	At least weekly	Oct 2010 through end of project	• Regular project statuses and functional feedback loop in place

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator/ Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			• WIRED for Health SharePoint site • DHS eHealth Updates LISTSERV • SDE Board members and committee co-chairs • Project staff leads for each committee				

Table 4. Communications and Education Matrix—Medicaid HIT Incentive Program

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator / Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
Awareness: What is the Medicaid EHR Incentive Program? • Eligibility Requirements • Summary MU Rule • States Planning Effort-Project Update)	• Hospitals/staff (Medicaid Acute Care and Children's Hospitals)	Wisconsin Medicaid	• Information Pamphlet • Webcasts/Webinars • DHS Medicaid EHR Incentive Web site • ForwardHealth Portal Public Site • WHA and RWHC Web sites • Other Professional Organization Web sites, Newsletters, and Conferences • ForwardHealth Provider Portal-Secure Login (Portal Message) • ForwardHealth Update (Newsletter)	• Medicaid EHR Incentive Policy Expert • DHS Publication Staff • DHS Web administrator	As Needed	Starting September 2010	• Hospital CEOs, CIO's, Administrators, and direct care givers know about the Medicaid EHR Incentive Program and the actions they must take to meet both the eligibility requirements and the meaningful use criteria • Hospital CEOs, CIO's, Administrators, and direct care givers know what is expected of them and know where to go to get additional information • Hospital CEOs, CIOs, Administrators, and direct care givers are able to communicate with others about the Medicaid EHR Incentive Program • Regular progress updates and feedback loop established

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator / Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			• WHA weekly newsletter				
Awareness: What is the Medicaid EHR Incentive Program? • Eligibility Requirements • Summary MU Rule • States Planning Effort-Project Update)	• Clinics/staff (Medicaid Providers)	Wisconsin Medicaid	• Information Pamphlet • Webcasts/Webinars • DHS Medicaid EHR Incentive Web site • ForwardHealth Portal Public Site • WHITEC Web site, webinars, and marketing collateral) • Other Professional Organization Web sites, Newsletters, and Conferences • ForwardHealth Provider Portal-Secure Login (Portal Message) • ForwardHealth Update (Newsletter) • WMS Medigram • Wisconsin Medical Society 11th Annual Coding & Practice Management Symposium • Field staff and agent education	• Medicaid EHR Incentive Policy Expert • DHS Publication Staff • DHS Web administrator • Provider Field Rep (HP) • WHITEC Incentive Outreach Specialist	As Needed	Starting September 2010	• Clinicians and Administrative Staff know about the Medicaid EHR Incentive Program and the actions they must take to meet both the eligibility requirements and the meaningful use criteria • Clinicians and Administrative Staff know what is expected of them and where to go to get additional information • Clinicians and Administrative Staff are able to communicate with others about the Medicaid EHR Incentive Program • Regular progress updates and feedback loop established
Awareness: What is a certified EHR?	• Hospitals/staff (Medicaid Acute Care	Wisconsin Medicaid	• DHS Medicaid EHR Incentive Web site including a link to ONC Web site	• Medicaid EHR Incentive Policy Expert	As Needed	Starting September 2010	• Hospital staff and Clinic Staff understand what a certified EHR is and are able to easily find information on the vendors/products that have

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator / Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
• How do I know if I have a certified EHR?	and Children's Hospitals) • Clinics/staff (Medicaid Providers)		• ForwardHealth Portal Public Site including a link to ONC Web site • WHITEC webinars and education tools	• DHS Publication Staff • DHS Web administrator • Provider Field Rep (HP) • WHITEC Incentive Outreach Specialist			been certified by the ONC
Awareness/ Outreach &Training: Targeted Communication to those who indicated participation in 2010 • Registration Process • Eligibility Requirements (understand Patient Volume)	• Hospitals/staff (Medicaid Acute Care and Children's Hospitals) • Clinics/staff (Medicaid Providers)	Wisconsin Medicaid	• ForwardHealth Provider Portal-Secure Login (Portal Message) • WHITEC outreach activities • DHS Direct Contact, webinars, and onsite visits	• Medicaid EHR Incentive Policy Expert • Provider Field Rep (HP) • WHITEC Incentive Outreach Specialist	As Needed	Starting Fall 2010	• Hospital staff and Clinic Staff understand how to register for the Medicaid EHR Incentive Program • Hospital staff and Clinic Staff understand the eligibility requirements, and understand whether or not they will be able to meet them • Hospital staff and Clinic Staff know what is expected of them and where to go to get additional information • Relationship built with Wisconsin Medicaid staff providing the Hospital Staff/Clinic Staff with support system
Recruitment: DHS Identified Targeted Communication (based upon claims and encounter data) • Registration Process	• Hospitals/staff (Medicaid Acute Care and Children's Hospitals) • Clinics/staff (Medicaid Providers)	Wisconsin Medicaid	• ForwardHealth Provider Portal-Secure Login (Portal Message) • WHITEC outreach activities • DHS Direct Contact, webinars, and onsite visits	• Medicaid EHR Incentive Policy Expert • Provider Field Rep (HP) • WHITEC Incentive Outreach Specialist	As Needed	Starting Fall 2010	• Hospital staff and Clinic Staff are made aware of the program and their potential eligibility • Hospital staff and Clinic Staff understand how to register for the Medicaid EHR Incentive Program • Hospital staff and Clinic Staff understand the eligibility requirements, and understand whether or not they will be able to meet them • Hospital staff and Clinic Staff know what is expected of them and where to go to get

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator / Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
• Eligibility Requirements (understand Patient Volume)							additional information • Relationship built with Wisconsin Medicaid staff providing the Hospital Staff/Clinic Staff with support system
Outreach &Training: Process to apply and participate in the program • How to register • What information they will need to supply • Timeline of application • Appeals Process • Audit Plan	• Hospitals/staff (Medicaid Acute Care and Children's Hospitals) • Clinics/staff (Medicaid Providers)	Wisconsin Medicaid	• Information Pamphlet • Webcasts/Webinars • DHS Medicaid EHR Incentive Web site • ForwardHealth Portal Public Site • ForwardHealth Provider Portal-Secure Login (Portal Message) • ForwardHealth Update (Newsletter) • WHITEC Web site, webinars, and marketing collateral • Professional Organization Conferences • Provider Trainings	• Medicaid EHR Incentive Policy Expert • DHS Publication Staff • DHS Web administrator • Provider Field Rep (HP) • WHITEC Incentive Outreach Specialist	As Needed	Starting January 2010	• Hospital staff and Clinic Staff understand how to register for the Medicaid EHR Incentive Program • Hospital staff and Clinic Staff understand the eligibility requirements, and understand whether or not they will be able to meet them • Hospital staff and Clinic Staff know what is expected of them and where to go to get additional information
Outreach &Training: How to meet Medicaid Meaningful Use Requirements	• Hospitals/staff (Medicaid Acute Care and Children's Hospitals) • Clinics/staff (Medicaid Providers)	Wisconsin Medicaid	• Information Pamphlet • Webcasts/Webinars • DHS Medicaid EHR Incentive Web site • ForwardHealth Portal Public Site • ForwardHealth Provider Portal-Secure Login (Portal Message) • ForwardHealth Update (Newsletter) • WHITEC Web site,	• Medicaid EHR Incentive Policy Expert • DHS Publication Staff • DHS Web administrator • Provider Field Rep (HP) • WHITEC Incentive Outreach	As Needed	Starting January 2011	• Hospital staff and Clinic Staff know what is expected of them and where to go to get additional information

Communication Needs / Topics	Audience (Stakeholder Type)	Coordinator / Expert	Medium/Delivery Methods	Resources Needed	Frequency	Timing	Expected Result
			webinars, and marketing collateral • Professional Organization Conferences • Provider Trainings	Specialist			
Recruitment: Encourage EHR Adoption • Benefits of adoption • Discussion of how to overcome barriers to adoption (i.e. Financing Solutions)	• Hospitals/staff (Medicaid Acute Care and Children's Hospitals) • Clinics/staff (Medicaid Providers)	Wisconsin Medicaid	• WHITEC webinars and education tools • DHS Medicaid EHR Incentive Web site • ForwardHealth Portal Public Site • Other Professional Organization Web sites, Newsletters, and Conferences TBD—Currently doing research on EHR adoption which will provide guidance on effective methods of communication and information needed	• Medicaid EHR Incentive Policy Expert • WHITEC Outreach Specialist	TBD	TBD	• Hospital staff and Clinic Staff understand the value provided by EHR technology • Hospital staff and Clinic Staff have tools/solutions to the barriers they face when trying to adopt EHR technology
Targeted Communication: Coordination of Medicare/Medicaid Payments to Acute Care Hospitals	• Hospitals/staff (Medicaid Acute Care Hospitals)	Wisconsin Medicaid	• WHA weekly newsletter • DHS Medicaid EHR Incentive Web site • ForwardHealth Portal Public Site • ForwardHealth Provider Portal-Secure Login (Portal Message) • DHS Direct Contact – Provider Services Calls	• Medicaid EHR Incentive Policy Expert • DHS Publication Staff • DHS Web administrator • Provider Field Rep (HP)	As Needed	Starting January 2011	• Hospital staff knows what they need to submit to the State and what they need to submit to CMS in order to qualify for both Medicaid and Medicare EHR incentive payments • Hospital staff knows what is expected of them and where to go to get additional information

C. Branding and Message Mapping

Branding for the State Designated Entity and health information exchanges will be important. This branding needs to be integrated with all of the related HITECH programs.

Message mapping should be developed for each target group to assure the messages are focused and consistent, regardless of the channel used to provide the information. Message maps are sets of organized statements or messages that address certain topics or concerns. Each map identifies up to three unique messages that address a specific topic or issue. Each topic or issue may be addressed by several layered message maps.

Message maps should be developed as a specialized tool for communicating effectively in high-stress, high-concern, or emotionally charged situations. A message map provides multiple benefits. It provides a handy reference for spokespersons who must respond to questions on topics requiring timeliness and accuracy. Multiple spokespersons can work from the same message map to ensure the rapid dissemination of consistent and core messages across multiple communication outlets. Message maps provide a unifying framework for disseminating information on various issues.

When selecting communication and education strategies and channels, the communicator or educator should keep in mind that, according to marketing research, it takes one to three exposures to develop aided awareness, it takes 3 to 6 exposures to reach a level of unaided awareness, it takes 6 to 10 exposures to shape an attitude, and 10 exposures or more to motivate a behavior. Third Edition of *The Successful Marketing Plan* by Roman G. Hiebing and Scott W. Cooper

D. Feedback and Measuring Effectiveness

Feedback is key to ensuring the ongoing effectiveness of communications. In addition to determining whether people feel the communicators are doing a credible job, feedback will focus on finding the answers to a series of questions, for example, whether people:

- Understand the benefit of the health information exchange;
- Feel they have been involved in what is happening;

- Feel they have had a chance to voice their opinions;
- Feel their questions have been answered;
- Feel they have been appreciated for their participation

Some of the methods and options that may be used to measure effectiveness include:

- A basic competency tool for key stakeholders could be developed using web-based technology that would identify key HIT and HIE topics. The end-users of the competency tool will self assess skills and understanding of key HIT and HIE topics based on a competency range of 1 to 4, where 1 is no knowledge of a particular subject area and 4 is extensive knowledge and understanding of a subject area. The self-assessments would cross a variety of WIRED for Health technology issues and concerns. Once the baseline information is developed, again using web-based technology, specific web cast trainings to target specific areas or groups could be developed. By developing an initial baseline competency assessment with follow-up training, including pre- and post-testing, the WIRED for Health CEM Committee can address concerns related to building awareness and targeting key stakeholders of varying degrees of competency.

- Town hall meetings and focus groups may be used to develop and test targeted messages and to evaluate effectiveness.

- Surveys may be used to evaluate the effectives of messages to specific target groups.

By evaluating feedback on an ongoing basis, continuous quality improvement methods can be applied to the messages and the methods of delivery to assure effective communication, education, and marketing.

E. Marketing HIE Services

Understanding how the HIE technology works and the advantages and benefits to patients when used by physicians and health care organizations is critical to successfully marketing the HIE services to be delivered by the state-level health information network. This should include an educational segment on how the HIE works, specifically noting assurances that data integrity and security will be maintained throughout the exchange of information. Additionally, the marketing materials should include details regarding the type of data that can be exchanged and how the information made available through the HIE can be integrated into a physician's or health

care organization's electronic health record. There should be an emphasis on the value to the consumer of the HIE service.

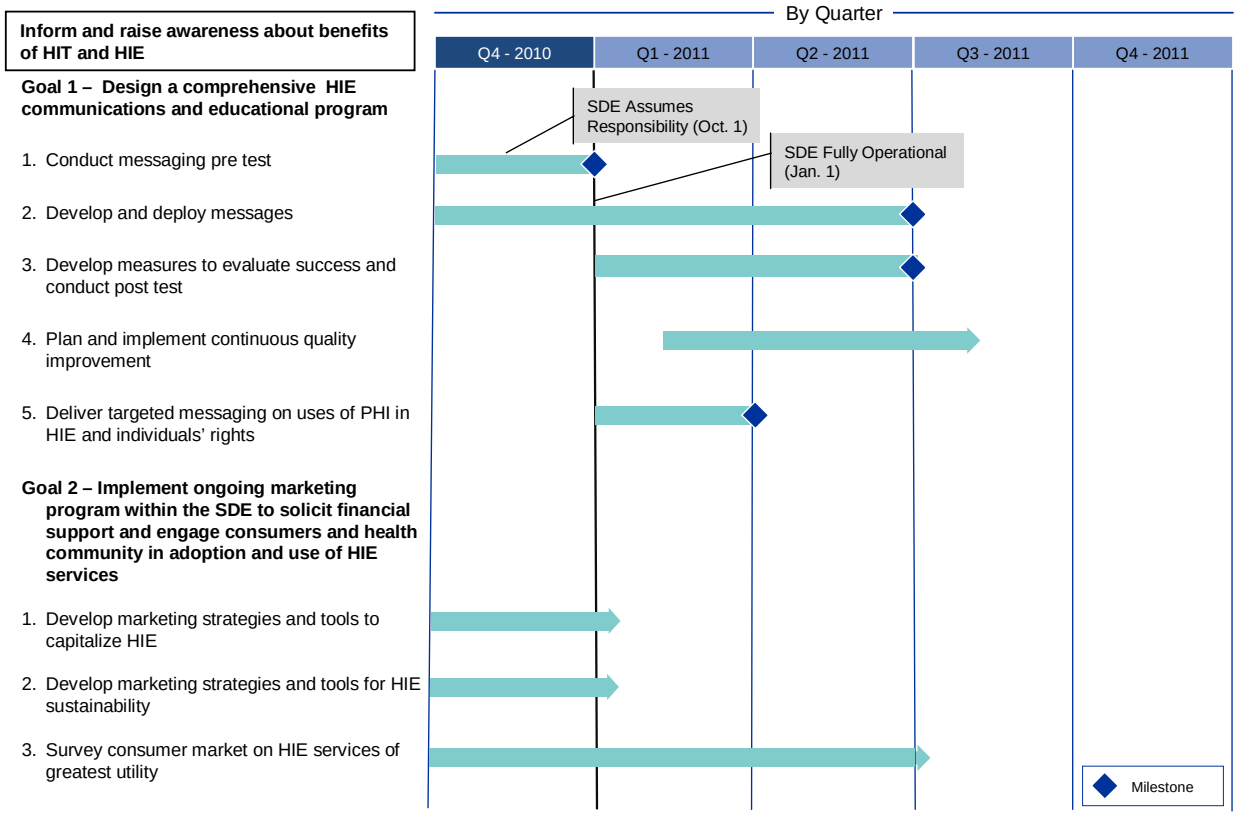
Elements of an effective marketing strategy should include:

- Defining sales goals and strategic objectives
- Conducting market research and performing an industry analysis (strengths, weaknesses, opportunities, and threats (SWOT))
- Performing a target audience analysis
- Defining strategies and tactics, including positioning, general strategies, and marketing mix (products, pricing, distribution, promotion)
- Developing projections
- Performing a budget and a financial analysis
- Developing performance measurements and performing an evaluation.

By collecting and evaluating metrics on the HIE services on an ongoing basis, improvements to the services can be identified and acted upon based on patient, provider, and/or healthcare system feedback and satisfaction, and the effectiveness and value of HIE can be continually communicated.

3. Communications, Education, and Marketing Timeline

The following calendar year timeline illustrates the sequencing of CEM goals and objectives and the estimated length of time required to implement the communications, education, and marketing strategy.



4. Crisis Communications

A. Purpose and Objectives

To mitigate the impact of a crisis or incident and serious negative repercussions for the organization, as well as, maintain a level of trust with the community, the SDE will need a Crisis Communication Plan. The purpose of a Crisis Communication Plan is to effectively manage communications through formal, clearly defined channels in order. The following is intended to serve as a crisis communications guide for the SDE to help manage communications around a crisis or incident.

The objectives of a Crisis Communication Plan are as follows:

- Prepare the SDE board and staff to effectively and nimbly manage crisis communications;
- Help the SDE board and staff respond in a unified, professional manner that reinforces leadership and creates loyalty;
- Strategically enhance the organization's brand/role, and the public's understanding of the value provided by health information exchange;
- Manage the distribution of critical, often sensitive information to the media, stakeholders, and public;
- Inform partner organizations of the SDE's position to help shape a consistent sector-wide response.

A crisis or incident is any situation that has the potential to threaten the integrity or reputation of the SDE, its board, and the widespread acceptance and trust in HIT and HIE. Usually, a crisis or incident is brought on by human error or a technology failure and is escalated by adverse or negative media attention. These situations can involve any kind of legal dispute, theft of data or a data breach, accidental release of personal health information to an unauthorized individual, etc. that could be attributed to HIT or HIE. It can also be a situation where the media or general public believes the SDE did not react to one of the above situations in the appropriate manner or not quickly enough. This definition is not all encompassing, but rather intended to describe types of situations when this plan would be activated. If handled correctly the damage can be minimized.

The tenets of a Crisis Communications Plan assume the best course of action in a crisis is tell it all, tell it fast, tell the truth, and tell it to the most important audience first.

When a situation arises that may be a crisis or an incident, the first action should be for the SDE President/CEO to contact the SDE Board of Directors. The second action should be to assemble a Crisis Communication Team.

Key steps in preparing for a crisis or incident and being ready to respond include:

1. Identifying crises issues—developing a briefing book with message maps for key communication trigger points.
2. Developing a core Crisis Communications Plan.
3. Identifying and training a core Crises Communication Team.
4. Preparing canned messages for the most likely crisis scenarios. Messages should be created for all high-impact events, even if the likelihood of occurrence is low.
5. Identifying expert spokespersons for each identified crises issue and ensuring they are available to speak on demand in the event of said crisis.
6. Establishing a rigid escalation procedure—ensuring the appropriate individuals have approved the briefing materials and only the identified spokespersons will speak to the media using the approved briefing materials.

B. Identifying Crises Issues/Events

To more effectively plan for the response to a crisis or incident, it is valuable to identify high-risk areas that have the potential to create the need for a Crisis Communication Plan. Crises fall into two broad categories:

1. Overt acts and acts of omission.
2. Issues of competence or lack thereof in matters of public perception.

Some examples of potential crisis events are listed below:

1. Patient data is exposed due to a security breach
2. Incorrect diagnosis made due to incorrect data transfer. If the HIE transfers data incorrectly, either mis-population of a data element or the loss of critical information (i.e. allergy to drug)
3. System crash resulting in the system being unavailable for an extended period of time, limiting provider's ability to access information on their patients

Crises can stem from many root causes including but not limited to:

- Human error
- Clerical error
- Unauthorized procedures

- Inadequate supervision
- Inadequate quality control
- Misuse of confidential information
- Errors of judgment
- Miscommunications/misunderstandings (including due to language barriers)
- Accidents
- Adversarial stakeholders
- Contract breaches
- Inadequate standard operating procedures
- Denial of access to service or inappropriate provision of services due to language barrier
  - A specific clinical service
  - A prescription
  - Hospital admission
- Security breach

C. Developing a Crisis Communication Plan

While each crisis will have its own unique needs, all should rely on a core Crisis Communication Plan. The Crisis Communications Team will need a comprehensive plan to properly respond to crises issues. The plan establishes how the crisis management lead is appointed, the assignment of a spokesperson, the communications timeline, key messages, priority audiences, and preferred methods for distributing the messages. Responses to a crisis event must consider a wide range of consequences (e.g., legal, financial, public relations, effects on administration, and effects on operations).

Core Principles:

- Responses to a crisis or incident should be made within 24 hours, and every effort should be made to shorten the span of non-communication. It is imperative to provide timely and accurate information to mitigate rumors and maintain control over the messages.
- Talking points and key messages must go through an approval process dictated by escalation procedures (i.e. legal, compliance, and the director of communications) prior to distribution.

- Briefing materials (talking points and key messages) should be distributed to the SDE Board of Directors and partner organizations.
- Talking points, key messages, and briefing material templates should be prepared in advance of a potential, high-risk crisis for crises that have either a high likelihood of occurring or have a significant negative impact if the crisis occurs.
- All communications should be uniformly translated to the required languages and made accessible to the SDE Board of Directors and partner organizations.
- Develop a central communication hub, such as a Web site.

Important action steps:

1. Determining a crisis communications management lead person who is responsible for ensuring all tasks are completed (most likely the Director of Communications).
2. Determining the crisis communication spokesperson who will answer all media and other inquiries (most likely the SDE President/CEO).
3. Assessing the situation to determine the facts.
4. Determining the appropriate response/action.
5. Creating the plan of action for internal and external communications.
   a. Coordinate response with Department of Health Services Communications Director.
   b. Prioritize audiences to receive communications.
   c. Contact translator/interpreter as needed.
6. Developing factual, detailed messages that reflect the status of the crisis, the organization's response, and, if possible, proactive steps to resolve the situation. There should be canned messages prepared in advance on hand for high risk crises or incidents.
7. Preparing talking points and providing a script for the receptionist receiving incoming calls. These should be prepared in advance for high-risk crises or incidents and translated as needed.
8. Determining which mechanisms to use in disseminating messages, i.e. determine if a press conference, press release, and/or web updates are necessary.
9. Assessing what resources and solutions are necessary to manage and resolve the crisis.
10. Appointing staff to:
    – Serve as the official spokesperson and manage media;
    – Keep the chairs of the Board, the Secretary of DHS, and the Governor's office informed;
    – Contact partners, allies, members, etc. and assist with sector-wide talking points, if appropriate; and

– Record crisis details, actions taken, external responses, and resolution.

D. Creating a Crisis Communication Team

The Crisis Communication Team is essential to identify what actions should be taken. The core team should be comprised of the following staff: Public Relations Officer, Communications/Marketing Specialist, Legal Counsel, Compliance Officer, and SDE President/CEO. This core team should be trained on the content of the Crisis Communication Plan to provide them with the skills to facilitate the creation and dissemination of the organization's messages on the crisis or incident.

Each crisis or incident will also involve a subset of staff with subject matter expertise on the issue. It is important to engage them in the drafting of the talking points and factual, detailed messages that reflect the status of the crisis or incident. Also, the use of external resources may become important to obtain subject matter expertise on an issue or topic. For each identified crisis issue, there should be at least one subject matter expert identified to provide the Crisis Communication Team with a resource in the event of a crisis or incident.

E. Designating a Spokesperson

One individual should be designated as the primary spokesperson to represent the SDE. This individual will be responsible for making official statements and answering media questions throughout the crisis. A backup to the designated spokesperson should also be identified to fill the position in the event the primary spokesperson is unavailable.

In addition to the primary spokesperson and the backup spokesperson, individuals who will serve as technical experts or advisors should be designated. These resources might include a financial expert, a leader in the community including bilingual community leaders, clinician, public health official, security expert, interpreters as needed, etc.

It is important to establish in advance, the basic approach and core messages. It is also important to hold media training for any identified spokesperson, to prepare the individual on how to interact with the media.

While one individual should be designated as the primary spokesperson, it is important to plan for the larger effort needed to create and disseminate the core messages conveyed by the designated spokesperson. There should

be one designated crisis communication management lead, directing and coordinating all aspects of the organization's response including managing the messages and the media. They will work closely with the spokesperson to provide scheduling support and ensure the appropriate talking points have been developed. In some cases, particularly in the event of a "small crisis," the crisis communication management lead may act as the designated spokesperson. In others, the jobs may be divided to facilitate efficient handling of the situation. Most likely, but not necessarily, the two roles will be filled by the SDE's Director of Communications and the President/CEO, respectively.

APPENDIX 18

Key Analyses of Barriers, Resources and Opportunities for Overcoming Low Participation in Information Exchange

Existing Analysis of Privacy and Security Issues Related to HIE

Through the work of the eHealth Care Quality and Patient Safety Board (the "eHealth Board") created by Executive Order 129 on November 2, 2005, Wisconsin has undertaken significant analysis of privacy and security issues affecting in-state and out-of-state disclosures of electronic health information using a health information exchange.

During the past 5 years, Wisconsin has undertaken significant analysis of privacy and security issues affecting in-state and out-of-state disclosures of electronic health information using a health information exchange. The core of that analysis was undertaken by to related efforts: 1) The Consumer Interests Work Group of the eHealth Care Quality and Patient Safety Board (the "eHealth Board"), and 2) Wisconsin's participation in the Health Information Security and Privacy Collaboration (the "HISPC Project"). **The Legal and Policy Committee believes the information developed by these efforts remains an accurate analysis of privacy and security issues affecting in-state and out-of-state disclosures of electronic health information using a health information exchange.**

Consumer Interests Work Group

In 2006, the eHealth Board created the Consumer Interests Work Group consisting of a diverse group of stakeholders, and charged it with identifying HIE priorities from a consumer/patient perspective. The Consumer Interests Work Group had several charges, each of which is addressed in its Final Report[1]:

> **Charge 1:** *Understand consumer expectations regarding electronic health data exchange.*
> **Charge 2:** *Identify HIE and HIT outcomes that are highest priority from the consumer perspective.*
> **Charge 3:** *Define acceptable and unacceptable data use policies to maintain privacy and security, including agreements for patient consent and use of data.*
> **Charge 4:** *Make recommendations on whether health information with special protections will be included in electronic health data exchange.*
> **Charge 5:** *Define acceptable and unacceptable data use policies for oversight purposes, including public health and research.*
> **Charge 6:** *Define guidelines and examples that clarify how data sharing can balance the requirement to protect privacy and security with the need to share information to improve care.*
> **Charge 7:** *Identify options to help consumers manage their own health care, advocate for themselves, and support mutual accountability for health.*
> **Charge 8:** *Identify legal actions required for the priorities recommended by the clinical work team.*
> **Charge 9***: Fulfill responsibilities required by the state's contract with Research Triangle International (RTI) for the Health Information Security and Privacy Collaboration (HISPC).*

In November 2006, the Consumer Interests Work Group issued a Final Report of analysis and recommendations. In particular, the Final Report found that while Wisconsin privacy law is generally consistent with the Federal HIPAA privacy law's principle that sharing information for treatment purposes generally takes precedence over privacy, Wisconsin law does not follow this HIPAA principle for mental health and developmental disability:

> "Under Wisconsin law, sharing health information generally takes precedence over privacy when information is shared among health care providers for treatment purposes. In cases of treatment for mental health, developmental disability, and alcohol/other drug abuse, however, personal health information is

[1] http://ehealthboard.dhfs.wisconsin.gov/reports/ci-final-report.pdf

> generally shared only with explicit patient consent. Wisconsin's patient consent requirements for mental health and developmental disability are more stringent than federal HIPAA regulations." (Page 15)

The Final Report also contained several recommendations reflecting its efforts to balance the benefits of HIT/HIE with privacy concerns to achieve optimal patient care. Key recommendations included:

Rec. 3.1: Personal health information should be included in an exchange available to health care providers for treatment purposes; patients should not be able to opt-in to, or out of, this exchange.
Rec. 3.2: Data use policies should: (1) balance patients' right to privacy with providers' need to access health information to provide optimal care; and (2) differentiate among the areas delineated by HIPAA (treatment, health care operations, payment, research, and public health).
Rec. 4.1: The Wisconsin legislature should amend Wisconsin law governing disclosure of health information to providers to be consistent with HIPAA, which does not require patient consent to disclose information to providers about mental health and developmental disabilities for treatment purposes. This recommendation:

- Aims to improve providers' ability to give patients optimal care;
- Increases Wisconsin's potential to participate in multi-state exchanges for treatment; and
- Rests on the assumption that participating organizations have security measures that sufficiently protect all personal health information.

Rec. 4.2: The Wisconsin legislature should review Wisconsin Statutes protecting patient rights and revise them as necessary to ensure that any provider or entity that provides unfair or inappropriately discriminatory treatment is subject to severe penalties.
Rec. 4.3: The Wisconsin legislature should review Wisconsin Statutes protecting patient rights and revise them as necessary to ensure that any provider or entity that deliberately or inadvertently mishandles, inappropriately shares, or inappropriately distributes personal health information is subject to severe penalties. Penalties should reflect the egregiousness of the act.
Rec. 4.4: Health information exchanges must protect the integrity, security, privacy, and confidentiality of all personal health information and recognize that some types of information are especially sensitive. Thus, organizations participating in exchange should consider appropriate *additional* technical and/or procedural safeguards for more sensitive types of health information.
Rec. 5.1: Data use agreements and policies that support HIE should ensure that: (1) all reports and publicly available data sets resulting from provider-submitted identifiable data continue to include only de-identified data; and (2) strict controls continue to govern access to, and use of, reported data.
Rec. 7.1: Holders of personal health information should ensure that individuals are able to conveniently and affordably access their health information, including which entities have had access to this information.

<u>HISPC Project</u>

In 2006, the Wisconsin Department of Health Services (DHS) received funding from the Office of the National Coordinator at the Department of Health and Human Services (ONC) and the Agency for Healthcare Research and Quality (AHRQ) to participate in the HISPC Project. For Wisconsin, the HISPC Project was largely an offshoot of the eHealth Board's Action Plan, and it focused on identifying barriers to electronic health information exchanges and solutions to those barriers.

DHS convened four groups during the HISPC Project: Variations, Legal, Solutions, and Implementation. Each group produced an interim report; these reports were ultimately combined into the Assessment of Variation and Analysis of Solutions Report and the Implementation Plan Report.

The Legal Work Group created two summary documents that continue to guide analysis of Wisconsin and Federal privacy law relating to HIE: Wisconsin Security and Privacy Project – Legal Analysis Summaries[2] and the Wisconsin Security and Privacy Project – Legal Workgroup Analysis Grids[3]. Both analyze Wisconsin and Federal laws in the context of eighteen use cases relevant to HIE.

Building from Legal Workgroup Analysis Summaries and Analysis Grids, the Assessment of Variation and Analysis of Solutions Report[4] identified several "Barriers [to HIE] Driven by Wisconsin Law." Key barriers included:

1) *Consent requirements for mental health, alcohol and other drug abuse and developmental disability information*

   "Wisconsin Statutes section 51.30 requires patient consent to disclose information for treatment or payment purposes. Federal law allows these disclosures for treatment purposes without consent, which creates more of a state barrier to national exchange because Wisconsin has different regulations than federal law and other states. Furthermore, because, current technology in general cannot limit access to a portion of a medical record in most cases, this more stringent protection severely limits information exchange. Finally, the consent must meet the statutory requirements for a valid consent under Wisconsin law, which further increases the barrier because these elements differ from federal law and likely from required elements in other states." (Page 89)

2) *HIV Test Results*

   "Wisconsin law also treats HIV test results as "sensitive" information and provides more stringent privacy protection." (Page 89)

3) *Minimum necessary requirement for mental health, AODA and developmental disability*
   "State requirements relating to mental health, alcohol and other drug abuse and developmental disability allow only the "minimum necessary" information to be exchanged. Often technology cannot limit disclosures to the "minimum necessary," so processes that could be electronic need to be manual so that the information can be manually limited." (Page 90)

4) *Verification of the requester for mental health, AODA and developmental disability*

   "Wisconsin law mandates verification of the requester of health information related to mental health, alcohol and other drug abuse and developmental disability, but does not require verification for the disclosure of general health information. This process effectively blocks information exchange until this requirement has been met. The law does not indicate how the verification process should occur and therefore, verification practices vary. The requirement to verify the requester slows down the exchange of information, as does the wide variation in verification practices." (page 90)

5) *Re-disclosure requirements*

   "State law has specific requirements that prohibit re-disclosure of general health information released without patient consent." *Note – re-disclosure laws under s.146.82, Wis. Stats., were amended in 2007 Act 108.*

6) *Private pay patients opt out of research*

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[2] http://ehealthboard.dhfs.wisconsin.gov/security/legal/l-analysis2007-02-09.pdf
[3] http://ehealthboard.dhfs.wisconsin.gov/security/legal/l-results2007-02-12.pdf
[4] http://ehealthboard.dhfs.wisconsin.gov/security/variation-solutions2007.pdf

> "[C]urrent patient privacy statutes allow private-pay patients to opt out of research projects. This opt-out process may ultimately result in a barrier to information exchange for research purposes." (page 90)

New Analysis of Privacy and Security Issues Related to HIE

In addition to the existing analyses undertaken by the eHealth Board and HISPC Project, **the Legal and Policy Committee also identified the new HIPAA-related provisions in the American Recovery and Reinvestment Act of 2009 ("ARRA") and a new ONC white paper on consumer consent as highly relevant information affecting its consideration of HIE privacy and security issues.**

New HIPAA Provisions

The ARRA created new statutory law enhancing the privacy and security protections under HIPAA.

In March 2009, the American Health Information Management Association (AHIMA) created an "Analysis of Health Care Confidentiality, Privacy, and Security Provisions of The American Recovery and Reinvestment Act of 2009, Public Law 111-5"[5] that provides significant background on the privacy changes in ARRA affecting HIPAA. It identifies the following key provisions:

- "ARRA has several provisions that extend HIPAA privacy, security, and administrative requirements to business associates (BAs). In addition there are new provisions for HIPAA-covered entities and BAs, as well as provisions for those not considered HIPAA-covered.
- Breach requirements (identification and notification) are established both for HIPAA-covered entities and non-HIPAA-covered entities, essentially any organization holding personal health information.
- The Act calls for HHS regional office privacy advisors and an education initiative on the uses of health information.
- Restrictions are further established on the sales of health information.
- A new accounting requirement is established for disclosure related to treatment, payment, and operations.
- New access requirements are established for individuals related to healthcare information in electronic format.
- New conditions are instituted for marketing and fundraising functions.
- Personal health record information with non-HIPAA entities is now protected.
- Use of de-identified data and minimum necessary data will be addressed.
- Enforcement is improved and penalties are increased.
- The HHS Secretary and the Federal Trade Commission are required to provide a number of reports to Congress and guidance to the entities who are involved with healthcare data." (Page 2)

While many regulations implementing the privacy provisions in ARRA have been promulgated since the Act's passage, many regulations have yet to be developed.

ONC Whitepaper: Consumer Consent Options for Electronic Health Information Exchange

On March 23, 2010, the Office of the National Coordinator for Health IT released a white paper entitled Consumer Consent Options for Electronic Health Information Exchange: Policy Considerations and Analysis[6]. The white paper discusses in detail the "issues, nuanced considerations, and possible

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[5] http://www.ahima.org/dc/documents/AnalysisofARRAPrivacy-fin-3-2009a.pdf

[6] http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_911154_0_0_18/ChoiceModelFinal.pdf

tradeoffs associated with the various consent options to help facilitate informed decision making." (Page ES-1)

The ONC white paper explores five core consent options for electronic exchange, including the experiences of other states with the various options:

- No consent
- Opt-out
- Opt-out with exceptions
- Opt-in
- Opt-in with exceptions

According to the white paper, "Provider and patient participation in electronic exchange have been identified as key challenges – both patient and provider participation are desired to facilitate better care delivery and advance other societal goals (e.g. improved public health), as well as to ensure the viability and utility of the exchange. To enhance patient participation, numerous electronic exchanges have employed one or more of the following tactics:

- Active engagement of patients in the development of the exchange entity;
- Vigorous marketing of exchange efforts through effective channels;
- Initial and ongoing education (largely from providers) about the effort; and
- Adoption of an opt-out or no-consent model, in concert with tight restrictions on data access and / or use, including stringent penalties for misuse.

"In addition, these electronic exchanges have employed the following methods of ensuring adequate provider participation:

- Minimization of administrative burdens, sometimes coupled with financial or other incentives;
- Maximization of value (i.e., access to as much useful information as possible, as often as is needed); and
- Provision of key infrastructure and service components (e.g., a record locater service or consent management tool).
- Other issues of particular significance with regard to progress (or lack thereof) toward the greater proliferation of electronic exchange include:
- Numerous and sometimes inconsistent federal and state laws regarding patient consent generally, and disclosure of sensitive information specifically;
- Provider workflow challenges associated with obtaining and managing consent;
- The lack of (or difficulty in achieving) technical and procedural capacity to segment and manage data in the manners desired by various constituents;
- The concern that existing security and privacy provisions are inadequate; and
- The need to balance multiple and often conflicting stakeholder interests to ensure adequate participation." (page ES-2)

APPENDIX 19

SUMMARY – Key Differences Between State and Federal Privacy Law Regarding Disclosures for Purposes of Treatment, Payment, and Health Care Operations

	Wisconsin Law	**Federal Law**
General Health Information	**Generally same as Federal Law** Disclose without patient consent *Citation*: §§146.81 - .84, Wis. Stats.	Disclose without patient consent *Citation*: HIPAA. *Notes*: New provision in ARRA allows a patient to "opt out" of disclosures to a health plan for purposes of payment if the PHI pertains solely to a health care service paid by in full by the patient.
Mental Health and Developmental Disabilities Information	**Significantly more stringent than Federal Law** Patient consent generally required for treatment, payment, and operations purposes. However there are over 27 separate exceptions to confidentiality under the statute. *Citations*: §51.30, Wis. Stats.; HFS 92, Wis. Admin. Code *Notes*: The consent requirements under HFS 92 are generally incompatible with the operation of an eHIE. The consent must be in writing and contain the following information: • Name of the individual, agency, or organization to which the disclosure is to be made; • Name of the subject individual whose information is being disclosed; • The purpose or need for the disclosure; • The specific type of information to be disclosed; • The time period during which the consent is effective; • The date on which the consent is signed; • The signature of the person giving consent. HFS 92.03(1)(i) also requires a written statement to accompany all rereleases of such information.	Disclose without patient consent *Citation*: HIPAA. *Notes*: Federal law treats mental health and developmental disabilities information the same as general health information. New provision in ARRA allows a patient to "opt out" of disclosures to a health plan for purposes of payment if the PHI pertains solely to a health care service paid by in full by the patient.
Alcohol and Other Drug Abuse Information (AODA)	**Generally same as Federal Law** Patient consent generally required for treatment, payment, and operations purposes. *Citations*: §51.30, Wis. Stats.; HFS 92, Wis. Admin. Code *Notes*: Both state and federal law have consent and re-release provisions generally incompatible with an HIE.	Patient consent generally required for treatment, payment, and operations purposes. *Citation*: 42 CFR Part 2
HIV Test Results	**Somewhat more stringent than Federal Law** Generally, consent is not necessary for disclosures for treatment purposes, but is required for payment and operations purposes. [MS: This is still accurate after Act 209] *Citation*: §252.15, Wis. Stats.	Disclose without patient consent *Citation*: HIPAA.

APPENDIX 20

Consent Policy Framework Development Process

The Consumer Interactions Work Group of the Legal and Policy Committee met on Monday, April 26, 2010, from 10 AM until 12:10PM to discuss policy options regarding patient consent. Kathy Hansen, Nancy Davis, Dan Zimmerman, and Chris Ahmuty made up the Work Group with Alice Page, Kelly Wilson and Matthew Stanford facilitating the discussion as staff. Kathy Dallen is also a member of the Work Group but was unable to participate in the April 26 meeting.

By consensus, the "HIE-Level Opt-Out"[1] was identified as the strongly preferred consent policy option of the Work Group during the April 26 meeting. The Work Group recommended that option to the full Legal and Policy Committee. After discussion, the Legal and Policy Committee adopted the Work Group's recommendation during its April 28 meeting. All votes cast at the Legal and Policy Committee were in favor of the recommendation; however, one consumer representative abstained from voting pending the resolution of several issues raised in Section 9.2.2.1.

A full description and analysis of the two iterations of the HIE Level Opt Out option is provided in the "Consent Policy Options Matrix," herein referred to as the "Consent Matrix." The Consent Matrix can be found at the end of this appendix section.

The remainder of this document more fully explains the Consent Matrix, how the Consent Matrix was used by the Work Group, and the process by which the Work Group reached its consensus recommendation. This document also identifies recommendations related to "all or nothing consent" and "revocation of consent."

Background on the Consent Matrix

The Consent Matrix examined three scenarios:

1) Disclosure of health information (both general[2] and sensitive[3] information) for treatment, payment, and health care operations;
2) Disclosure of federal AODA information for treatment, payment, health care operations, and public health surveillance purposes; and
3) Disclosures for public health surveillance purposes (not including statutorily mandated reports, research purposes, or public health feedback/intervention purposes).

For each of the scenarios the Consent Matrix identified the full range of consent options theoretically compatible with HIE. For each consent option, the Consent Matrix describes:

1) The policy option (COLUMN 1);
2) An implementation framework (COLUMN 2);
3) A general description of any state law change necessary to implement the framework (COLUMN 3); and
4) The most notable aspects/considerations of the option (from patient, provider, and HIE perspectives) (COLUMN 4).

The Consent Matrix also makes three assumptions that underlie the analysis of the policy options. Those assumptions are:

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[1]

[2] Meaning "patient health care records defined under §146.81(4), Wis. Stats.

[3] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

1) The HIE architecture will require some information to be passed through a third party (i.e., the HIE uses either a central database architecture, or uses a record locator service through which all exchanged flows);
2) Chapter 51 information cannot be separated from general health care information for purposes of HIE; and
3) Existing exceptions to consent (including emergency exceptions) are maintained.

Agreement on the Consent Matrix as a fair and accurate consideration of all options

All members received an initial draft of the Consent Matrix three full days prior to the April 26 meeting. Roughly the first half of the April 26 meeting was spent reviewing a draft of the Consent Matrix and making revisions to achieve a goal of having a single document that fairly and accurately conveys all plausible options, necessary legal changes for each option and important considerations for each option. The Work Group believes the attached Consent Matrix meets that goal.

Process to reach the final recommendations of the Work Group

The remainder of the meeting was spent developing recommendations for:

1) Disclosure of health information (both general[4] and sensitive[5] information) for treatment, payment, and health care operations; and
2) Disclosure of federal AODA information for treatment, payment, health care operations, and public health surveillance purposes.

The Work Group did not consider recommendations regarding disclosures for public health surveillance purposes. The Work Group believed that recommendations regarding public health surveillance should be deferred for consideration with longer-term issues.

Least preferred options

The Work Group initially identified the least preferred consent policy options in the Consent Matrix. Based upon the considerations in "COLUMN 4 - The most notable aspects/considerations of the option," the Work Group identified the following Policy Options as the least preferred:

For disclosure of health information (both general[6] and sensitive[7] information) for treatment, payment, and health care operations -

1) Representational Opt In Consent
2) Provider-Level Opt In (plus modify DHS 92)
3) Provider-Level Opt In

For disclosure of federal AODA information for treatment, payment, health care operations, and public health surveillance purposes –

1) Disclosure of AODA information to HIE using Provider-Level Opt-In

Identification of top 3 preferred options

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[4] Meaning "patient health care records defined under §146.81(4), Wis. Stats.
[5] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.
[6] Meaning "patient health care records defined under §146.81(4), Wis. Stats.
[7] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

After identifying the least preferred consent policy options, the Work Group identified its top 3 consent policy options for disclosure of health information (both general and sensitive information) for treatment, payment, and health care operations. Rankings were made based upon the considerations in "COLUMN 4 - The most notable aspects/considerations of the option," of the Consent Matrix. For purposes of this exercise, the two "HIE Level Opt-Out" options were considered together as one option, and the two "Provider Level Opt-Out" options were considered together as one option – thus, only three consent options remained.

The provider representatives believed that the Work Group's top 3 consent options should be:

1) HIE Level Opt Out
2) Disclosure without consent
3) Provider Level Opt Out

The consumer representatives believed that the Work Group's top 3 consent options should be:

1) HIE Level Opt Out
2) Provider Level Opt out
3) Disclosure without consent (with the caveat that some consumers would not support this option)

"HIE Level Opt Out" identified as the consensus #1 preferred consent option

Because all representatives of the Work Group identified "HIE Level Opt Out" as the preferred consent option of the Work Group, the Work Group strongly recommends the "HIE Level Opt Out" options to the full Legal and Policy Committee as the preferred consent policy option. *The Work Group did not have time to fully consider whether the HIE Level Opt Out (Policy Option) was preferable to the HIE Level Opt Out (Full Statutory Option) or vice versa; the Legal and Policy Committee may choose to identify such a preference/recommendation at its April 28 meeting.*

<u>Other recommendations</u>

All or nothing consent

Given current technological considerations, the full work group strongly prefers limiting a person's consent option to either disclose all information or no information.

However, the consumer representatives suggested that this should be revisited if technology evolves so that granular consent is more feasible. Nonetheless, as noted in the Consent Matrix, there are also aspects other than technology that should also be considered if this issue is revisited in the future.

Revocation of opt out

The Work Group suggested that additional consideration should be given to limiting the right of an individual to revoke a decision to opt-out of disclosure. This would reduce the administrative cost of the HIE Level Opt Out option.

APPENDIX 21

Consent Policy Options Matrix

Analysis of Policy Options Regarding:

1) Disclosure of health information (both general[1] and sensitive[2] information) for treatment, payment, and health care operations

For purposes of this document, it is assumed that:

1) The HIE architecture will require some information to be passed through a third party (i.e., the HIE uses either a central database architecture, or uses a record locator service through which all exchanged flows);
2) Chapter 51 information cannot be separated from general health care information for purposes of HIE; and
3) Existing exceptions to consent (including emergency exceptions) are maintained.

The strongly preferred options of the Consumer Interests Work Group are shaded in GREEN.
Least favored options of the Consumer Interests Work Group are shaded in RED.

Those options most likely to encourage provider participation in HIE appear first.

COLUMN 1 **Policy Option**	**COLUMN 2** **Implementation framework**	**COLUMN 3A** **Law change necessary to implement (general health information)**	**COLUMN 3B** **Law change necessary to implement (sensitive information)**	**COLUMN 4** **Most notable aspects/considerations of the option**
Disclosure without consent	1) Provider provides notice of privacy practices; 2) Provider and HIE discloses without consent	None. Option: repeal 146.82 and rely on HIPAA.	1) Modify law to permit disclosure of "special" information for treatment, payment, and health care operations. May choose to limit to exchanges through a "certified" HIE (not preferred). Option: repeal 146.82 and 51.30 privacy provisions and rely on HIPAA.	1) Lowest cost to provider/HIE participants. No added administrative or IT costs. 2) Patients with mental health treatment records have <u>less</u> control of their participation in HIE than current <u>state</u> privacy law requires. Some believe that this will cause some individuals to not seek treatment. 3) Patients without mental health treatment records have same control of their participation in HIE as current state law. 4) Patients have <u>same</u> amount of control of their participation in HIE as current federal privacy law under <u>HIPAA</u>. 5) Improves patient care for all by

[1] Meaning "patient health care records defined under §146.81(4), Wis. Stats.

[2] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

				better enabling integration of mental health and other health care. 6) Recommendation of eHealth Board's Consumer Interests Workgroup.
HIE-Level Opt Out (Policy Option) **Strongly Preferred Option**	1) Provider provides notice of privacy practices (including option to contact HIE and prohibit HIE from disclosing information); 2) Provider discloses to HIE without consent; 3) HIE discloses unless individual contacts HIE and requests HIE not disclose.	None	1) Modify law to permit disclosure of "special" information (including the 51.30 treatment record) for treatment, payment, and health care operations. (Including modification of HFS92 regarding rerelease and minimum necessary) 2) No statutory requirement that an HIE offer an "opt out," but per the HIE's policy, the HIE will not further disclose information upon the patient's request. 3) May choose to limit to exchanges through a "certified" HIE (not preferred). Option: Make sharing mandatory?	1) Low cost to provider/HIE participants. Minor added administrative costs. No added IT costs. 2) Least state-wide cost to provide patient control of participation in HIE. Rather than requiring the modification of the hundreds of providers' individual EHR systems and policies, this requires only the yet-to-be built HIE system to build the capability to segregate or block the information of individuals who do not wish to have the HIE share their information. 3) Patients with mental health treatment records retain control of their participation in HIE. 4) Patients would have greater control of their participation in HIE than current federal privacy law under HIPAA. 5) Benefits to patients, because they would have one location to manage their consents. Also probably a quicker response. 6) Improves patient care for those by better enabling integration of mental health and other health care. 7) For general health care information, this option would be more stringent than current law and add barriers to exchange.
HIE-Level Opt Out (Full Statutory Option) **Strongly Preferred Option**	1) Provider provides notice of privacy practices (including option to contact HIE and prohibit HIE from disclosing information); 2) Provider discloses to HIE without consent;	None	1) Modify law to permit disclosure of "special" information (including the 51.30 treatment record) for treatment, payment, and health care operations to an HIE and from an HIE, but only	1) The key difference between this option and the above "HIE-Level Opt Out (Policy Option) is that under the "Policy Option" the amended law would simply allow disclosure of ch. 51 information without consent for treatment,

	3) HIE discloses unless individual contacts HIE and requests HIE not disclose.		if the HIE will honor an individual's request to not disclose information from the HIE (the "opt out"). 2) May choose to statutorily define the opt out process. Option: Make sharing with HIE mandatory.	payment, and operations, but the HIE would enact its own policy (over and above what would be required under law) that it would never disclose information from the HIE if a person contacted the HIE and "opted out." Under the "Full Statutory Option," the amended law would allow the provider to send ch.51 information without consent to the HIE contingent on the HIE will honoring an individual's request to "opt out" of further sharing from the HIE. 2) Low cost to provider/HIE participants. Minor added administrative costs. No added IT costs. 3) Least state-wide cost to provide patient control of participation in HIE. Rather than requiring the modification of the hundreds of providers' individual EHR systems and policies, this requires only the yet-to-be built HIE system to build the capability to segregate or block the information of individuals who do not wish to have the HIE share their information. 4) Patients with mental health treatment records retain control of their participation in HIE. 5) Patients would have greater control of their participation in HIE than current federal privacy law under HIPAA. 6) Improves patient care for those by better enabling integration of mental health and other health care. 7) Compared to the "HIE-Level Opt Out (Policy Option)," the "full statutory option" may provide less flexibility as new HIE initiatives and processes evolve over time. 8) For general health care information, this option would be more stringent than current law and

				add barriers to exchange.
Provider-Level Opt Out (Policy option)	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE unless individual contacts provider and requests the provider not disclose to HIE; 3) HIE discloses information it receives without consent.	None	1) Modify law to permit disclosure of "special" information (including 51.30 treatment record) for treatment, payment, and health care operations. 2) No statutory requirement that a provider offer an "opt out," but per contract (the "policy") between the provider and HIE, the provider would be required to honor a patient's request not to share information with the HIE. 3) May choose to limit to exchanges through a "certified" HIE (not preferred).	1) The HIE would not receive information from patients that choose to "opt out." 2) Higher cost to provider/HIE participants compared to earlier options. More significant added administrative costs. Significant IT costs. 3) Because all participating providers under this option would need to modify their EHR system to "turn off" the EHR's capability to send information to the HIE for patients that do not want to participate in the HIE, this option has a high cost to providers that is similar to the "opt in" option below. 4) Patients with mental health treatment records retain control of their participation in HIE. 5) Patients would have greater control of their participation in HIE than current federal privacy law under HIPAA. 6) Frequency of "opt out" then revocation of opt out then revocation of revocation becomes a concern. 7) For general health care information, this option would be more stringent than current law and add barriers to exchange.
Provider-Level Opt Out (full statutory option)	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE unless individual contacts provider and requests the provider not disclose to HIE; 3) HIE discloses information it receives without consent.	None	1) Modify law to permit disclosure of "special" information for treatment, payment, and health care operations to an HIE and from an HIE, but only if the provider will honor an individual's request to not disclose information to the HIE (the "opt out"). 2) May choose to statutorily	1) The HIE would not receive information from patients that choose to "opt out." 2) Higher cost to provider/HIE participants compared to earlier options. More significant added administrative costs. Significant IT costs. 3) Because all participating providers under this option would need to modify their EHR system to "turn off" the EHR's capability to

			define the opt out process.	send information to the HIE for patients that do not want to participate in the HIE, this option has a high cost to providers that is similar to the "opt in" option below. 4) Patients with mental health treatment records retain control of their participation in HIE. 5) Patients would have greater control of their participation in HIE than current federal privacy law under HIPAA. 6) For general health care information, this option would be more stringent than current law and add barriers to exchange.
Representational Opt In Consent **Among Least Preferred Options**	1) Receiving provider/participant required to receive consent before accessing information about the patient from the HIE and/or another provider.	To be discussed.	To be discussed.	1) Patients have greater control of their participation in HIE than state or federal privacy law requires. 2) Unclear burden on providers to receive and process the substituted consent. 3) Authentication may become easier.
Provider-Level Opt In (plus modify DHS 92) **Among Least Preferred Options**	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE only after receiving consent from individual to disclose to HIE and allow HIE to further disclose; 3) HIE discloses information it receives pursuant to consent. (Would business associate agreements be required?)	None	1) Modify "special" information consent requirements to allow disclosure to and from an HIE with minimal limitation and specificity. 2) Modify "special" information consent requirements to minimize # of times an individual must consent to disclosure to and from an HIE.	1) The HIE would not receive information unless individual provides written consent. 2) Higher cost to provider/HIE participants compared to earlier options. Significant added administrative costs. Significant IT costs. 3) Because all participating providers under this option would need to modify their EHR system to "turn off" the EHR's capability to send information to the HIE for patients that do not consent to participate in the HIE, this option has a high cost to providers. 4) High administrative cost to providers: Requires keeping track of millions (based on Wisconsin population) of consents and communicating consents to the HIE

				and possibly downstream providers/users. 5) Patients with mental health treatment records retain control of their participation in HIE. 6) Patients would have greater control of their participation in HIE than current federal privacy law under HIPAA. 7) Removes some barriers to HIE caused by the special consent requirements for ch. 51 information. 8) Would business associate agreements be required? If so, what are the HIPAA ramifications on the HIE and downstream HIE participants? 9) For general health care information, this option would be more stringent than current law and add barriers to exchange.
Provider-Level Opt In **Among Least Preferred Options**	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE only after receiving consent from individual to disclose to HIE and allow HIE to further disclose (may not be possible to do given consent specifications in 51.30 and HFS 92.03); 3) HIE discloses information it receives pursuant to consent. (Would business associate agreements be required?)	None	None	1) The HIE would not receive information unless individual provides written consent. 2) Higher cost to provider/HIE participants compared to earlier options. Significant added administrative costs. Significant IT costs. 3) Because all participating providers under this option would need to modify their EHR system to "turn off" the EHR's capability to send information to the HIE for patients that do not consent to participate in the HIE, this option has a high cost to providers. 4) High administrative cost to providers: Requires keeping track of millions of consents and communicating consents to the HIE and possibly downstream providers/users. 5) Patients with mental health treatment records retain control of

				their participation in HIE. 6) Patients would have greater control of their participation in HIE than current federal privacy law under HIPAA. 7) Would business associate agreements be required? If so, what are the HIPAA ramifications on the HIE and downstream HIE participants? 8) Not feasible under current law given HFS 92 9) For general health care information, this option would be more stringent than current law and add barriers to exchange.
Consideration of all or nothing issues (separate consideration)				
All or nothing consent **Given current technology, this is a strongly preferred recommendation**.	1) The consenting person would have two choices, either agree to have all clinical information shared with all HIE participants or have no clinical information shared with any HIE participants. 2) If a person choose to not share clinical information on the HIE, a "flag" would be placed on the person's HIE record indicating that the person has clinical information, but it is not available from the HIE.	None?	Would need to be addressed in whatever law change necessary to enact the chosen policy option.	1) Significantly less cost to the providers/participants and/or the HIE compared to the granular consent option. 2) Greatly simplifies operations of the HIE. 3) Patients feeling strongly about not sharing information with other providers/participants would have ability to not share. 4) Provider acceptance of the HIE would be greater if they were able to know whether a person has chosen to not share information.
Granular consent (not all or nothing)	The consenting person could choose to consent to share only some clinical information, but not all, and only with some HIE participants, but not all.	None?	Most likely, none.	1) Significantly increases the cost of the consent policy options for providers/participants and/or the HIE compared to the all or nothing consent option. 2) Unclear if granular consents are technologically practical using an EHR or HIE. 3) Provides patients greatest control over information. 4) Could reduce provider acceptance of the HIE (and hence HIE adoption rates) if providers were not confident that the

				information on the HIE may be incomplete. 5) Aspirational, but technology doesn't exist currently to do this easily.
Allow providers and/or the HIE to limit number of times you can revoke consent Needs further consideration.	1) To prevent a person from opting out then revoking that opt out, then opting out again from HIE, law or policy could allow a provider/participant and/or the HIE to "lock out" the person from exchange for a period of time (2 years for example) after the person chooses not to have their information shared on the HIE. 2) Once information is received it cannot be "returned".	None?	Would need to be addressed in whatever law change necessary to enact the chosen policy option.	
Pilot consent options? Not highly recommended by the Consumer Interests Work Group, but considered.	1) Sunset statutory changes after X years OR 2) Limit statutory changes to certain HIEs. Goal is to see if provider benefits and/or consumer concerns are realized			1) Might allow for the ability to see if provider benefits and/or consumer concerns are realized. 2) Would the pilot add cost? 3) Federal government is already requiring much review and oversight. 4) Concerns that providers might not be able to meet meaningful use. 5) Legislature less interested in doing short term pilot. 6) Already have "pilots:" Epic, WHIE, 2007 Act 108.

<u>Analysis of Policy Options Regarding:</u>

2) Disclosure of federal AODA information for treatment, payment, health care operations, and public health surveillance purposes

For purposes of this document, it is assumed that:

1) The HIE architecture will require some information to be passed through a third party (i.e., the HIE uses either a central database architecture, or uses a record locator service through which all exchanged flows);
2) Chapter 51 information cannot be separated from general health care information for purposes of HIE; and
3) Existing exceptions to consent (including emergency exceptions) are maintained.

Those options most likely to encourage provider participation in HIE appear first.

COLUMN 1 Policy Option	COLUMN 2 Implementation framework	COLUMN 3 Law change necessary to implement	COLUMN 4 Most notable aspects/considerations of the option
No disclosure of AODA information to HIE	No disclosure of AODA information to HIE	None	1) Lowest cost to provider/HIE participants.
Disclosure of Federal AODA information without consent (using existing emergency exceptions)	Not thoroughly discussed.	None	Not thoroughly discussed.
Disclosure of AODA information to HIE using Provider-Level Opt-In **Among Least Preferred Options**	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE only after receiving consent from individual to disclose to HIE and allow HIE to further disclose (may not be possible to do given consent specifications); 3) HIE discloses information it receives pursuant to consent. (Would business associate agreements be required?)	None	1) Highest cost to provider/HIE participants. Significant added administrative costs. Significant IT costs. 2) Maintains problems related to EHR and HIE integration of general health and mental health information in a summary record. 3) Additional analysis necessary to determine if inclusion segregation of AODA information is feasible. 4) Would business associate agreements be required? If so, what are the HIPAA ramifications on the HIE and downstream HIE participants?

Analysis of Policy Options Regarding:

3) Disclosures for public health surveillance purposes (not including statutorily mandated reports, research purposes, or public health feedback/intervention purposes)

For purposes of this document, it is assumed that:

1) The HIE architecture will require some information to be passed through a third party (i.e., the HIE uses either a central database architecture, or uses a record locator service through which all exchanged flows); and
2) Chapter 51 information cannot be separated from general health care information for purposes of HIE.

Those options most likely to encourage provider participation in HIE appear first.

The Consumer Interests Work Group reviewed the analysis below, but did not discuss it during its April 26 meeting.

COLUMN 1 Policy Option	COLUMN 2 Implementation framework	COLUMN 3 Law change necessary to implement	COLUMN 4 Most notable aspects/considerations of the option
No disclosure - HIE would not disclose any information to the HIE for public health surveillance. (STATUS QUO)	No provider disclosure of identifiable information to HIE for public health surveillance purposes.	None	1) No cost to provider or HIE. 2) HIE does not benefit public health surveillance.
No consent - Disclosure to HIE for public health surveillance without consent	1) Provider provides notice of privacy practices; 2) Provider and HIE discloses without consent.	1) Create law identifying HIE as a HIPAA "public health authority." This will permit covered entities to disclose information for public health surveillance purposes to HIE without HIPAA authorization. 2) Amend 146.82 and 51.30 if necessary to enable providers to disclose to HIE and HIE to public health for public health surveillance purposes.	1) Least cost to providers and HIE of remaining options to provide surveillance data to public health via HIE.
No consent - Disclosure of de-identified data to HIE for public health surveillance without consent.	1) Provider sends de-identified data to HIE for public health surveillance purposes. No consent necessary. 2) HIE sends de-identified data to public health for surveillance purposes. No consent necessary.	None	1) HIE would not collect identifiable information for public health surveillance purposes. 2) Provider could disclose de-identified information to HIE for public health surveillance purposes to extent consistent with state and federal law. 3) Some cost to provider to de-identify information prior to submission to the HIE.
HIE-Level Opt Out	1) Provider provides notice of privacy practices (including option to contact HIE and prohibit HIE from disclosing information); 2) Provider discloses to HIE without consent; 3) HIE discloses unless individual contacts HIE and requests HIE not disclose.	1) Create law identifying HIE as a HIPAA "public health authority." This will permit covered entities to disclose information for public health surveillance purposes to HIE without HIPAA authorization. 2) Amend 146.82 and 51.30 if necessary to enable providers to disclose to HIE and HIE to public health for public health surveillance purposes. May choose to specifically address opt-out procedures in the law change.	1) Patients have control of their participation in HIE. 2) The HIE would receive an individuals' information but could not use or disclose it for public health surveillance purposes if the individual choose to "opt out." 3) Least state-wide cost to provide patient control of participation in HIE. Rather than requiring the modification of the hundreds of providers' individual EHR systems and policies, this requires only the yet-to-be built

			HIE system to build the capability to segregate the information of individuals who do not wish to have the HIE share their information.
Provider-Level Opt Out	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE unless individual contacts provider and requests the provider not disclose to HIE; 3) HIE discloses information it receives without consent.	1) Create law identifying HIE as a HIPAA "public health authority." This will permit covered entities to disclose information for public health surveillance purposes to HIE without HIPAA authorization. 2) Amend 146.82 and 51.30 if necessary to enable providers to disclose to HIE and HIE to public health for public health surveillance purposes. May choose to specifically address opt-out procedures in the law change.	1) Patients have control of their participation in HIE. 2) The HIE would not receive information from patients that choose to "opt out." 3) Because all participating providers under this option would need to modify their EHR system to "turn off" the EHR's capability to send information to the HIE for patients that do not want to participate in the HIE, this option has a high cost to providers that is similar to the "opt in" option below.
Provider-Level Opt In	1) Provider provides notice of privacy practices; 2) Provider discloses to HIE only after receiving consent from individual to disclose to HIE and allow HIE to further disclose; 3) HIE discloses information it receives pursuant to consent. (Would business associate agreements be required?)	None	1) Patients have control of their participation in HIE. 2) The HIE would not receive the information unless individual provides written consent. 3) Because all participating providers under this option would need to modify their EHR system to "turn off" the EHR's capability to send information to the HIE for patients that do not consent to participate in the HIE, this option has a high cost to providers. 4) High administrative cost to providers: Requires keeping track of millions of consents and communicating consents to the HIE and possibly downstream public health users.

APPENDIX 22

Data Use Agreement Parameters[1]

The following provisions must be considered and included in the Data Use Agreement:

1. Introduction. A description of WIRED and its SDE, how it is organized and operated, and other information that is helpful in putting its Terms and Conditions into context.

    1.1. Nature of Organization. The legal structure within which the HIE is organized and its relationships to sponsors, founders, participants, users and others, such as public health, correctional institutions, and payers.

    1.2. Purposes. A statement of tax-exempt purposes for which WIRED is organized.

    1.3. Description of Services. The facilities, systems, and services that are subject to the Terms and Conditions, and that are available to Participants.

    1.4. Change or Termination of Services. The conditions under which WIRED or the SDE may have the right to change its services or cease providing services.

2. Definitions. The following are included for purposes of setting the data use parameters, and it may be necessary to add other terms.

"Authorized User" means an individual participant or an individual designated to use the SDE's Services on behalf of the Participant, including without limitation, an employee of the Participant and/or a credentialed member of the Participant's medical staff.

"Data Provider" means a participant that will provide information for use through the exchange; its definition assumes that some data users will not participate in the provision of data (which may or may not be the case, depending on the model).

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated there under at 45 CFR Parts 160 and 164 (and as amended under HITECH and its implementing regulations).

"Participant" means a party that is a Data Provider and/or a Data Recipient.

"Participant Type" means the category of Participants to which a particular Participant is assigned based upon that Participant's role in the health care system.

"Patient Data" means information provided by a Data Provider.

"Services" and "Systems" mean the SDE's information sharing and aggregation services and designated or provided software.

"Terms and Conditions" means the terms and conditions set forth in this document, as amended, repealed, and/or replaced from time to time.

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[1] This document uses the American Health Information Management Association (AHIMA) definition of a Federated Model with a Peer-to-Peer Network, as set forth at the following URL: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_032268.hcsp?dDocName=bok1_032268

"Data Recipient" means a Participant that uses the Services and Systems to obtain health information.

3. Terms and Conditions. The role of the Terms and Conditions, and how they are developed and administered. These terms are intended to be helpful in putting the other provisions into context.

   3.1. Generally. An overview of how the Terms and Conditions are developed and administered.

   3.2. Development and Dissemination; Amendments. How the SDE adopts the Terms and Conditions, makes changes, and informs Participants of those changes.

   3.3. Participant's Rights. How Participants will interface in making, approving or rejecting changes to the Terms and Conditions, leaving flexibility for adjustments without creating an administrative block that impedes the functioning of the exchange, with an ultimate right of termination upon any change.

4. Data Use Agreements. Who may be a Participant, and how Participant's will apply and register, assuming that "registering" is the method by which the SDE will monitor and control who uses the System and Services. If qualified through registration, Participants must enter into "Data Use Agreements" in order to assure that all parties will have substantially similar rights and obligations.

   4.1. Registration Required. The requirement that Participants register.

   4.2. Registration by Agreement. How Participants may enter into a written Data Use Agreement with the SDE.

      4.2.1 Participant Type. Whether to categorize Participants by their respective roles in the health care system (hospital, PBM, public health, researcher), for the purpose of determining rights and obligations that may vary in relation to the amounts and types of data provided or accessed.

      4.2.2 Review of Registration Forms. The SDE's right to review registration forms and decide whether or not to accept a Participant.

   4.3. Changes to Terms and Conditions. How Participants will be made aware of the changes to the Terms and Conditions, and will be obligated to comply (by an incorporation statement, for example).

   4.4. Termination Based on Objection to Change. How a Participant may avoid being bound to a Data Use Agreement if the Participant objects to a change.

   4.5. Participant's Other Rights to Terminate Data Use Agreement. How and under what circumstances a Participant may cease to be a Participant, generally (i.e., without cause, with notice, only at an anniversary, only for cause, any combination).

   4.6. Participant's Right to Terminate for Breach of Business Associate Agreement. A Participant's rights to terminate if the SDE fails to perform any obligations it may have as a business associate (as defined in HIPAA) of the Participant.

   4.7. SDE's Right to Terminate Data Use Agreements. How and under what circumstances the SDE may terminate a Participant's Data Use Agreement generally (i.e., without cause, with notice, only at an anniversary, only for cause, any combination).

4.8. Effect of Termination. The consequences of terminating a Data Use Agreement, including, for example, treatment of data furnished prior to termination, rights to access data for the period during which the agreement is in effect, access to data for defense of litigation purposes, purging of a Participant's data from the exchange, retaining "record locator" access if severable from any other data access, etc.

4.9. Survival of Provisions. The provisions of the Data Use Agreement that shall continue to bind the parties following termination.

5. Authorized Users. Terms that govern use of the SDE Services by the Participant's Authorized Users. Although one option is that "user agreements" will be required of every individual accessing the System or Services, it is easier administratively if Participants are responsible for designating the individuals within their organizations who would be Authorized Users.

5.1. Identification of Authorized Users. How the Participant will designate Authorized Users, including for any access control and audit purposes.

5.2. Certification of Authorized Users. How Participants will provide assurances that Authorized Users will be aware of and comply with the permitted uses and prohibited uses and disclosures of data, though training program participation, within a job role or as reasonable necessary to perform a function, through a written or other agreement to comply with terms and security measures, and acknowledgement of sanctions for violations.

5.3. Appropriate Safeguards. Describes the appropriate safeguards necessary to prevent the unauthorized use or disclosure of data, such as: access controls, authentication and authorization mechanisms, data retention and destruction requirements auditing user and system activity, and shielding from unauthorized access during data transmission and storage.

5.4. No Use by Other than Authorized Users. A requirement that the System and Services be accessed and used only by Authorized Users.

5.5. Responsibility for Conduct of Participant and Authorized Users. The Participant's responsibility and liability for the conduct of its Authorized Users, including any insurance mechanism, relating to other Participants or to the SDE.

5.6. Termination of Authorized Users. How the SDE will ensure that Participants perform their responsibility to control the acts and omissions of their Authorized Users, including ensuring Authorized Users comply with the Terms and Conditions.

6. Data Recipient's Right to Use Services.

6.1. Grant of Rights. The nature of the Participant's right to use the System and Services, including a license to access the System and Services, subject to limitations including compliance with the Terms and Conditions.

6.2. Permitted Uses. The permitted uses of the SDE's System and Services, which could be any legally permitted use, a narrower range, such as limiting use to locating and retrieving only certain data sets (for example, anonymized data), or specific uses based on a Participant Type (for example, aggregating data for chronic disease management studies or measuring provider compliance for pay-for-performance reporting).

6.3. Prohibited Uses. The prohibited uses of the System and Services, such as no services to third parties, no services prohibited by local laws, and no use of the Services to

aggregate data without the express written consent of the Participants and Authorized Users being compared.

7. Data Provider's Obligations.

7.1. Grant of Rights. The nature of the Participant's right to use the System and Services, including a license to access the System and Services, subject to limitations including compliance with the Terms and Conditions.

7.2. Provision of Data. Terms that apply to the Data Provider's delivery of data, such as format and standards, and the general obligation to deliver the data.

7.3. Measures to Assure Accuracy of Data. The Data Provider's obligations to provide accurate, complete, and timely information, preferably to specific standards.

7.4. License. The Data Provider's agreement that the data it provides will be available for use by grant of a license for the SDE and therefore all Participants and Authorized Users, to have such access and use.

7.5. Limitations on Use of Patient Data. Limitations the SDE will impose upon the uses of information provided by Data Providers, including uses prohibited by the policies and procedures, laws, rules and regulations, and other prohibitions the SDE determines are appropriate (such as the performance of comparative studies) being careful to ensure meeting any NHIN or other chosen requirements.

8. Software and/or Hardware Provided by SDE. (If the SDE does not provide software and/or hardware to Participants, this section would be omitted.)

8.1. Description. A description of any software and/or hardware that the SDE will provide to Participants.

8.2. Grant of License. A description of the Participant's right to use the Software and/or Hardware.

8.3. Copying. Restrictions upon the Participant's right to copy software provided by the SDE, such as a prohibition on copies or limited copies for back-up purposes.

8.4. Modifications. Restrictions on modifying, reverse engineering, decompiling, copying, modifying, or combining any Software.

8.5. Third-Party Software, Hardware and/or Services. How the SDE and Participants will address requirements imposed by third-party software, hardware, and/or service vendors.

9. Protected Health Information. Provisions addressing compliance with applicable laws addressing the confidentiality, security, and use of patient health information.

9.1. Compliance. Provisions requiring compliance with patient information privacy, security and use laws imposed at the state and/or local level and/or other requirements that the SDE otherwise determines are appropriate.

9.2. Business Associate Agreement. Provisions requiring the SDE to be a HIPAA business associate of the Participant, including permitted uses and disclosures, appropriate safeguards, reports to Participants of contract violations, binding subcontractors, all patient rights (including accounting), and actions at termination (such as destruction or return of data).

9.3. Reporting of Breaches. Provisions requiring Participants and the SDE to report breaches to one another when sufficiently serious.

10. Other Obligations of Participants. Additional terms governing the conduct of Participants.

10.1. Compliance with Laws and Regulations. The Participant's obligations to comply with applicable laws and regulations, generally.

10.2. System Security. The Participant's obligations to implement reasonable and appropriate measure determined by the SDE to maintain the security of the SDE System and to notify the SDE of breaches in security.

10.3. Software and/or Hardware Provided by Participant. Provision requiring the Participant to obtain and maintain all hardware and software required to use the SDE's System and Services that are not to be provided by the SDE.

10.4. Viruses and Other Threats. Requirements determined by the SDE that Participants take appropriate measures to prevent damage to the SDE's System.

10.5. Training. A description of the training, if any, that the SDE will require the Participant to provide to its personnel.

11. SDE Operations and Responsibilities. Provisions describing the role and responsibilities of the SDE.

11.1. Compliance. The SDE's obligations to require that all Participants agree to be bound by the SDE Terms and Conditions.

11.2. Training. The SDE's obligations to provide training for Participants and/or their Authorized Users.

11.3. Telephone and/or E-Mail Support. The SDE's obligations to provide support (telephone, email, help desk or otherwise) for the Participant's use of the SDE's System and/or Services.

11.4. Audits and Reports. Audits the SDE is to perform and reports it is to provide such as usage reports, reports to public agencies, and audit trails.

11.5. Management Committee. Any role Participants would have in governance or decision-making by the SDE.

11.5.1 Composition. The composition of a body in which Participants would be involved (either as members of the non-stock entity or through a governance body).

11.5.2 Meetings and Responsibilities of Management Committee. The responsibilities of such a body and how often it would meet.

11.5.3 Management Committee Bylaws. How this body would be organized and governed.

12. Fees and Charges. Terms regarding amounts, if any, that the Participant will be required to pay to the SDE in order to use the Services.

12.1. Agreed-Upon Fees. Provision for a Participant's written agreement to take precedence over general Terms and Conditions.

12.2. Service Fees. The SDE's fees for Participants, if any, either by a posted or legally mandated fee or in the Data Use Agreement.

12.3. Changes to Fee Schedule. Provisions allowing the SDE to change its Fee Schedule at any time or only at a specified period of notice or at a specific date, such as an anniversary.

12.4. Miscellaneous Charges. Provisions addressing the SDE's ability to charge for additional services.

12.5. Payment. How and when payment is due and payable.

12.6. Late Charges. Whether the SDE would impose late charges on delinquent Service Fees and Miscellaneous Charges.

12.7. Suspension of Service. Whether the SDE would be permitted to suspend services until the Participant pays amounts that are due.

12.8. Taxes. The party responsible for payment of taxes arising out of the use of the SDE's System and/or Services.

12.9. Other Charges and Expenses. The extent to which Participants and/or the SDE are responsible to pay for other expenses relating to their respective roles.

13. Proprietary Information. Provisions concerning the parties' respective obligations to preserve the confidentiality of others' proprietary information (i.e., other than health information).

13.1. Scope. The scope of the proprietary information, such as trade secrets, business plans, et al, and any exceptions, such as information that is already in the public domain.

13.2. Non-Disclosure. Obligations of non-disclosure.

13.3. Remedies. Equitable remedies for breach.

13.4. Notices. Permitted disclosures, such as pursuant to a court order, with a caveat of furnishing of notice to the party whose information is disclosed.

14. Disclaimers, Exclusions of Warranties, Limitations of Liability and Indemnifications. Terms directed to avoiding inappropriate legal claims between the parties.

14.1. Carrier Lines. The parties' respective responsibilities with respect to the use of carrier, e.g., telephone lines.

14.2. No Warranties. The extent to which the SDE disclaims warranties it might otherwise be assumed to be making to Participants, such as provision of Services and Systems "as is", to limit the SDE's liability to the Participants and to third parties.

14.3. Other Participants. The extent to which the SDE is responsible for uses of information and/or the Network by others, to limit the SDE's liability.

14.4. Participant's Actions. The extent to which the Participant assumes responsibility for its own actions or those of its Authorized Users.

14.5. Unauthorized Access; Lost or Corrupt Data. The extent to which the parties are responsible for others' access to information , or for misconduct related to the use and/or

disclosure of that data, or for the accuracy or completeness of that data; where generally Participants would retain liability for the accuracy and provision of the data and the SDE would retain liability only for the functioning of the Services and/or System under its control, and all other liability would be disclaimed.

14.6. Inaccurate Data. The extent to which the parties are responsible for inaccurate data and the caveat that all information would be subject to change (such as though patient requests, changes in health conditions, and the passage of time).

14.7. Patient Care. The parties' responsibilities with respect to patient outcomes, for example, where Participants and Authorized Users are solely liable for all clinical outcomes, no matter the data provided through participation, and a waiver of all claims between Participants and Authorized Users relating to the contributed data.

14.8. Limitation of Liability. The extent to which the parties' potential legal liabilities to each other are limited, such as to am amount of fees paid in a time period.

15. Insurance and Indemnification.

15.1. Insurance. Whether and to what extent the parties are to be required to carry insurance.

15.2. Indemnification. Whether and to what extent the parties would agree to indemnify each other for losses sustained as a result of their relationships or conduct, where the options may include: the parties (the SDE and the Participant) indemnify one another for losses caused by claims by third parties; the parties indemnify each other and the Participants indemnify one another; the agreement does not specify and the doctrines of equitable indemnity, comparative negligence et al apply; only certain losses, such as arising from breaches of confidentiality or security, give rise to an indemnification obligation; or a Data Provider indemnifies the SDE for the provision of inaccurate data.

16. General Provisions. General provisions appropriate to a contract such as assignment, entire agreement, no third party beneficiary, choice of law, and dispute resolution.

APPENDIX 23

Legal and Policy Issues List for Data Use Agreements

The L/P Committee recommends that the State Designated Entity (SDE) create a Data Use Agreement and require that all Participants in Health Information Exchange (HIE) (through the HIE system established by the SDE) enter into such agreement.

The agreement should at a minimum include provisions addressing the following:

1. The role of the Data Use Agreement and how its terms and conditions are developed and administered, including:

    1.1. Whether and how the SDE adopts the Terms and Conditions, makes changes, and informs Participants of those changes.

2. Whether and how Participants will be involved in making, approving or rejecting changes to the agreement, leaving flexibility for adjustments without creating an administrative block that impedes the functioning of the exchange, with an ultimate right of Participants to terminate upon any change to the Data Use Agreement.

3. Who may be a Participant and who decides – if the SDE or a Committee or other group designated by the SDE or otherwise, through what process? If not the SDE, who and how?

Potential Participants besides providers will have different roles in the health care system (insurers, PBMs, researchers) and each type of participant must be addressed as to whether and to what extent data will be received from and available to a participant. Much of this also will be dependent on how data can be sorted and redacted and other issues of how technology may be able to support (or not) additional granularity of HIE options by purpose and participant.

    2.2. Will there be appeal rights if someone is denied a request to participate in the SDE?

4. Whether and how a Participant may avoid being bound to a Data Use Agreement if the Participant objects to a change.

5. How and under what circumstances a Participant may cease to be a Participant, generally (i.e., without cause, with notice, only at an anniversary, only for cause, any combination).

6. How and under what circumstances the SDE may terminate a Participant.

7. What are the consequences of terminating a Data Use Agreement, including, for example, treatment of data furnished prior to termination, rights to access data for the period during which the agreement is in effect, access to data for defense of litigation purposes, purging of a Participant's data from the exchange, retaining "record locator" access if severable from any other data access, etc.

8. How the Participant will designate and monitor Authorized Users, including:

    8.1. How will Participants provide assurances that Authorized Users will be aware of and comply with the permitted uses and prohibited uses and disclosures of data, though training program participation, within a job role or as reasonable necessary to perform a function, through a written or other agreement to comply with terms and security measures, and acknowledgement of sanctions for violations.

    8.2. What safeguards are necessary and appropriate to prevent the unauthorized use or disclosure of data, such as: access controls, authentication and authorization

mechanisms, data retention and destruction requirements auditing user and system activity, and shielding from unauthorized access during data transmission and storage.

8.3. What is the Participant's responsibility and liability for the conduct of its Authorized Users, including any insurance mechanism, relating to other Participants or to the SDE.

8.4. How will the SDE will ensure that Participants perform their responsibility to control the acts and omissions of their Authorized Users, including ensuring Authorized Users comply with the Terms and Conditions. Will there be an audit of Participant's, either by the SDE, or self-audits that must be submitted periodically to the SDE, or both or other.

8.5. What are the permitted uses of the SDE's System and Services; this could be any legally permitted use or some a narrower range, such as locating and retrieving only certain data sets (for example, anonymized data) or uses based on a Participant Type (for example, aggregating data for chronic disease management studies or measuring provider compliance for pay-for-performance reporting).

8.6. What uses are prohibited; for example, no use of the Services to aggregate data without the express written consent of the Participants whose data is aggregated? Can the SDE sell data?

9. What is the Data Provider's obligations to provide accurate, complete, and timely information, including what standards can be set to measure and ensure such accuracy.

10. How will the SDE participate in enforcement of and compliance with applicable laws addressing the confidentiality, security, and use of patient health information, such as:

10.1. Provisions requiring compliance with patient information privacy, security and use laws imposed at the state and/or local level and/or other requirements that the SDE otherwise determines are appropriate.

10.2. Provisions requiring the SDE to be a HIPAA business associate of the Participant, including permitted uses and disclosures, appropriate safeguards, reports to Participants of contract violations, binding subcontractors, all patient rights (including accounting), and actions at termination (such as destruction or return of data).

10.3. Provisions requiring Participants and the SDE to report breaches to one another when sufficiently serious.

11. What reasonable and appropriate security measures must a Participant implement (i.e., encryption) and who will determine these measure and require updates and upgrades—the SDE.

12. What hardware and software will the Participant be required to purchase and use.

13. Audits the SDE is to perform and reports it is to provide such as usage reports, reports to public agencies, and audit trails.

14. What role will Participants w have in governance or decision-making by the SDE.

15. What amounts, if any, will a Participant will be required to pay (to the SDE or for equipment or software) in order to use the Services and on what terms.

16. Protection of a participant's or the SDE's proprietary information, such as trade secrets, business plans, et al., and any exceptions, such as information that is already in the public domain.

17. The extent to which the SDE disclaims warranties it might otherwise be assumed to be making to Participants, such as provision of Services and Systems “as is”, to limit the SDE’s liability to the Participants and to third parties.

18. The extent to which the SDE is responsible for uses of information and/or the Network by others, to limit the SDE’s liability.

19. The extent to which the Participant assumes responsibility for its own actions or those of its Authorized Users.

20. The extent to which the parties are responsible for others’ access to information , or for misconduct related to the use and/or disclosure of that data, or for the accuracy or completeness of that data; where generally Participants would retain liability for the accuracy and provision of the data and the SDE would retain liability only for the functioning of the Services and/or System under its control, and all other liability would be disclaimed.

21. The extent to which the parties are responsible for inaccurate data and the caveat that all information would be subject to change (such as though patient requests, changes in health conditions, and the passage of time).

22. The parties’ responsibilities with respect to patient outcomes, for example, where Participants and Authorized Users are solely liable for all clinical outcomes, no matter the data provided through participation, and a waiver of all claims between Participants and Authorized Users relating to the contributed data.

23. The extent to which the parties’ potential legal liabilities to each other are limited, such as to am amount of fees paid in a time period.

24. Whether and to what extent the parties are to be required to carry insurance (and is it available).

25. Whether and to what extent the parties would agree to indemnify each other for losses sustained as a result of their relationships or conduct, where the options may include: the parties (the SDE and the Participant) indemnify one another for losses caused by claims by third parties; the parties indemnify each other and the Participants indemnify one another; the agreement does not specify and the doctrines of equitable indemnity, comparative negligence et al apply; only certain losses, such as arising from breaches of confidentiality or security, give rise to an indemnification obligation; or a Data Provider indemnifies the SDE for the provision of inaccurate data.

26. Whether a participant must use informal dispute resolution such as arbitration.

APPENDIX 24

Issues/Decision Paper

DRAFT v8

WIRED for Health
Legal & Policy Committee

Public Health Participation in State-wide Health Information Exchange

July 9, 2010

Public Health Workgroup
Lawrence Hanrahan PhD MS

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Decision Needed for Public Health

The legal and policy framework must be developed and decided upon for public health agencies participation in state-wide health information exchange.

Issue

The Field of Public Health

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals." (1920, C.E.A. Winslow) “It is concerned with threats to the overall health of a community based on population health analysis.” The population in question can be as small as a handful of people (e.g. a food borne outbreak at a company picnic) or as large as all the inhabitants of several continents (for instance, the global HIV pandemic). Important public health fields include communicable disease, environmental and occupational health, chronic disease, maternal and child health, and injury prevention.

In Wisconsin, the Division of Public Health (DPH) is responsible for environmental and public health regulation, and for providing public health services. The Division includes programs that address environmental and occupational health, family and community health, emergency medical services and injury prevention, chronic disease prevention and health promotion, and communicable diseases. It is also responsible for issuing birth, death, marriage and divorce certificates as well as collecting statistics related to the health of Wisconsin's population.

Public health practice is highly dependent upon health information systems. Epidemiologic investigation and public health surveillance are its key methods of using health data to understand disease causation, monitor population health, provide services, implement, and evaluate public health interventions. “Epidemiology is the study of the distribution and determinants of health events in specified populations, and the application of this study to the control of health problems.” Public Health Surveillance “is the ongoing, systematic collection, analysis, and interpretation of health event data (e.g., agent/hazard, risk factor, exposure, disease) essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control.”

Thus the focus of public health is to prevent disease and injury through the epidemiologic discovery of causes, and the ongoing surveillance of disease cases (e.g. infectious, injury, chronic conditions) to assess trends and intervention effectiveness. Through public health’s processing of health information, interventions can be developed such as the promotion of healthy behaviors and the creation of health supporting environments. In many cases treating a disease may be vital to preventing it in others, such as during an outbreak of an infectious disease. Hand washing, vaccination programs and restaurant inspections are other examples of public health interventions to prevent disease. Many local public health interventions involve the delivery of clinical services to prevent disease.

Accordingly the State Health Information Exchange (HIE) Funding Opportunity Announcement recognizes public health agencies as organizations that must participate in the exchange. Furthermore, Stage 1 Electronic Medical Record (EMR) ‘meaningful use’ criteria include HIE with public health, such as electronic submission of reportable lab results, submission of electronic data to immunization registries, and submission of electronic syndromic surveillance data (e.g. real-time monitoring of influenza like illness). Stages 2 and 3 will also include public health exchange criteria for clinical and population health improvement.

Public Health Statutes

As Wisconsin plans and implements the State HIE it must be mindful of existing public health law and support statutory intent. To carry out the mission of public health, Wisconsin has a number of statutes governing health information collection and use (see appendix for a complete listing of all statutes and administrative codes that govern Wisconsin's public health system). Statutes governing surveillance and epidemiologic investigation include:

- The Department may investigate the cause and circumstances of any special or unusual disease or mortality and may do any act necessary for the investigation (Wis. Stat. § 250.04(1));

- The Department shall establish and maintain surveillance activities sufficient to detect any occurrence of acute, communicable or chronic diseases and threat of occupational or environmental hazards, injuries or changes in the health of mothers and children. (§250.04(3)(a), Wis. Stats.).

- The Department shall analyze occurrences, trends and patterns of acute, communicable or chronic diseases, maternal and child health, injuries and occupational and environmental hazards and distribute information based on the analyses (Wis. Stat. § 250.04(3)(a)) and analysis of these events (Wis. Stat. § 250.04(3)(b)(1));

- The Department shall operate a Public Health Data System (Wis. Stat. § 250.04(3)(b)(2));

- The Department may conduct investigations, studies, experiments and research pertaining to any public health problems which are a cause or potential cause of morbidity or mortality (Wis. Stat. § 250.04(3)(b)(3));

- Individual questionnaires or surveys shall be treated as confidential patient health care records under §146.81 to 146.835, but the information in those questionnaires and surveys may be released in statistical summaries (Wis. Stat. § 250.04(3)(b)(3));

A number of statutes govern the mandatory reporting of diseases to protect public health (e.g., communicable and chronic disease reporting, immunization registry) (Wis. Stat. § 252 and § 255, DHS Ch. 145). See appendix for detailed listing. In addition, all deaths and births must be reported to the Department of Health Services, Division of Public Health / Vital Records (Wis. Stat. § 69), and the Department is directed to "…study especially the vital statistics of the state and use the analysis of the vital statistics for health planning (Wis. Stats.§250.04(1)).

Finally, the Department possesses all powers necessary to fulfill the duties prescribed in the statutes (Wis. Stat. § 250.04(2)(a).

A Vision for Public Health Participation in Health Information Exchange

Some of Wisconsin's electronic public health information systems have been around for over 50 years. Starting with vital records in the late 1950's, information from the paper copies of births and deaths have been abstracted and stored in machine readable form. Over the decades these data have been used to understand the ebb and flow of public health problems, such as the much greater risk of infant mortality experienced by African Americans, the decrease over time in the incidence of cardiovascular disease mortality, the growing lung cancer mortality risk among women, and the increased suicide and injury risk among Wisconsin's returning Vietnam veterans.

Because electronic medical records are a relatively recent development, and because they are not yet universally adopted, over the years public health out of necessity has had to develop its own information systems to carry out its public health mandates that depend upon health information. In addition to birth and death reporting, other important public health electronic information systems include cancer reporting, communicable disease reporting (Wisconsin Electronic Disease Surveillance System – WEDSS), electronic laboratory results reporting, childhood

lead poisoning reporting, Environmental Public Health Tracking Network (EPHTN), Wisconsin Immunization Registry (WIR), birth defects reporting, Women, Infants, and Children (WIC) program, Maternal and Child Health SPHERE – Secure Public Health Electronic Record Environment, YRBS – Youth Risk Behavior Surveillance and BRFSS – the Behavioral Risk Factor Surveillance System (anonymous telephone surveys of disease and behaviors), Family Health Survey (anonymous telephone survey), violent death reporting system, audiometric screening of newborns, metabolic disease screening of newborns, Health Alert Network, Wisconsin Emergency Assistance Volunteer Registry (WEAVR), chronic disease and risk factor surveillance programs and systems – including asthma, diabetes, cardiovascular disease and stroke, oral health, tobacco, obesity and physical activity, and inpatient and outpatient hospital discharge and emergency room reporting (now maintained by the Wisconsin Hospital Association). Wisconsin's Public Health Information Network (PHIN) directly supports some of these systems and provides a secure web platform for integrated surveillance reporting for all programs through its Analysis, Visualization, and Reporting (AVR) services.

While creating these systems was necessary, their development and maintenance has been costly. And it has resulted in the unintended consequence of creating 'data silos'. Data reporters must send information out in differing formats and communication mechanisms to each program, and there is poor integration across these systems. In some instances local public health departments must re-key in the same client information because systems cannot communicate with each other.

But the universal adoption of electronic medical records (EMR) and statewide health information exchange creates the opportunity for streamlined public health data acquisition, surveillance, reporting, improved reporting timeliness and completeness, and improved data quality. Possibly except for SPHERE and WIC, the EMR contains the majority if not all of the data elements used in the public health information systems listed above. And in some instances it may contain far more and a much higher quality of information than what is available in the current system (e.g. BRFSS / chronic disease surveillance contains self-reports of disease and risk factors. In contrast the EMR contains diagnoses and measurements e.g. blood pressure, cholesterol level, A1c level, etc.). And using the EMR and statewide HIE as the source for public health information systems may also greatly decrease the reporting burdens of data submitters.

But it still will take many years for EMRs to be adopted universally. So once again out of necessity public health will need to maintain and support its own systems. However public health must be fully engaged in the statewide HIE so it can transition to data acquisition from the EMR / statewide HIE. In this way, the EMR / statewide HIE may become the principal source for public health information systems.

The statewide HIE also sets the stage for public health to take on new roles that can improve health care quality and the science base for public health practice and interventions. In addition to being a data consumer, public health can be a value added data provider – sending analyzed or processed information back into the clinical care system. For example, public health could provide clinical decision support by giving views of population health information to health care practitioners for quality benchmarking and comparative effectiveness decision support. It could provide alerts warning about and displaying the spread and course of disease outbreaks. It could describe the geographic patterns of antibiotic and antiviral resistance or show the demographic and geographic completeness of screening activities. It could provide rich local public health data on chronic diseases and behavioral risk factors to better plan community and health care interventions, and better assess their effectiveness.

Committee Impacts and Dependencies

The envisioned public health role impacts the architecture and governance committees and potentially finance. The principal motivation for HIE is patient care and this drives its design. Simply stated this means having all of the patient's clinical health information available to the health care provider during the episode of care, regardless of where the information is located. HIE thus supports the 1 patient, 1 physician interaction to improve care. But for public health, the patient is the population. And while public health also provides individual clinical services, public health also requires case reporting and surveillance of multiple disease events: data must be exchanged in a way that allows for the aggregation and statistical analysis of diseases and risk factors. Thus statewide HIE must also be designed to monitor and maintain the population's health.

Constraints and Assumptions

Completeness of EHR adoption and HIE participation is a principal constraint for Public Health participation. In the early stages of EMR adoption and HIE participation, public health data acquisition will be incomplete. This means existing public health data systems will need to be available and maintained. Even with a critical mass of adoption, existing public health information systems may still need to exist to support very late adopters. The public health role assumes that statewide HIE supports the monitoring and treatment of its "patient" as well, i.e. the population, in addition to the 1-patient 1-physician episode of care.

Approaches

The approaches described below represent the distillation of ideas that the Wisconsin Division of Public Health has developed with partners, over the last five years to describe the evolution of public health participation in health information exchange. Our partners have included faculty and staff from the University of Wisconsin (UW) Department of Family Medicine, UW Department of Pediatrics, UW Hospitals and Clinics, UW School of Medicine and Public Health – Office of Continuing Professional Development, Wisconsin Health Information Exchange, Wisconsin State Laboratory of Hygiene, the Wisconsin Primary Health Care Association, Medical College of Wisconsin, local public health departments, CDC, and the Public Health Informatics Institute. Conceptual development was funded in part by grants from the Robert Wood Johnson Foundation (Information Links and Common Ground programs). Finally, two grant applications (NIH GO, ONC ARRA HITECH Beacon Community) were developed to elaborate upon and demonstrate the techniques.

The evolutionary stages listed below are not 'either – or' options. Rather they represent stages in the evolution of public health participation in the exchange. They range from relatively simple to increasingly complex interactions with clinical care. Accordingly it may be easier for the statewide HIE to implement them in a timed sequence rather than attempting to do them all at once. The first two represent one-way flows of clinical data to public health to accomplish mandated public health case reporting and surveillance functions. The last two evolutionary levels describe bi-directional data flows between public health and clinical care to improve health care quality and the evidence base for public health interventions. All of the evolutions support the meaningful use criteria for EMR adoption, that is, the reporting of public health information to improve population health, and the exchange of clinical information with public health to improve health care quality and effectiveness of public health interventions. Finally there is a discussion on public health information needs when it provides clinical services.

Evolution 1 - Advance and simplify electronic reporting of existing mandated case reports and disease reports (e.g. communicable disease reporting, electronic laboratory result reporting, and immunization registry data exchange)

Mandatory Case reports (e.g. infectious diseases -such as tuberculosis- that must be reported to public health) are sent to HIE and exchanged with public health. Data contains personal identifiers for Public Health case contact, management, and follow-back, partner notification, etc – as specified by statute / administrative law for each condition. In addition, electronic data exchange is established with the Wisconsin Immunization Registry (WIR).

Pros

- Supports stage 1 meaningful use (electronic laboratory results reporting, immunization registry reporting). Approach provides opportunity to create automated case reporting (i.e. filter / decision rule triggers case report), eliminating provider staff reporting burden. Providers and public health need only deal with one entity, the exchange. This potentially reduces data exchange costs and complexity for both data providers and recipients. Experience in other states show that automated electronic medical record systems can also markedly improve the speed of case notification and case reporting completeness. For example pilot study in Massachusetts found a 39% and 53% increase in reporting for two conditions with automated EMR case transmission. In Indiana, automated electronic laboratory reporting to an HIE identified 4.4 times as many cases as traditional spontaneous, paper-based methods and identified those cases 7.9 days earlier than spontaneous reporting.

Cons

- Case reporting may be incomplete and surveillance results may not be representative at early stages of HIE when there are fewer exchange participants (i.e. results will need to be interpreted cautiously in the beginning when there are fewer data submitters).
- Public health will need to support legacy systems until the critical mass of case reporters interface with the HIE. Thus public health may need to allow for an alternative case reporting mechanism for quite some time, or until all case report submitters are using EMRs and are a part of the HIE.

Legal / Policy

- Wisconsin statutes and administrative rule language governing mandatory case reporting is general enough to also support reporting through HIE without any change.
- Surveillance mandate is provided (Wis. Stats. §250.04(3)(a)), as is the analysis of surveillance data (Wis. Stats. §250.04(3)(b)(1)), and the operation of a public health data system (Wis. Stats. §250.04(3)(b)2)).
- Case reporting is permitted without prior patient consent (HIPAA and Wis. Stats.).

Evolution 2- Surveillance Using De-Identified Data

Report all data within existing public health surveillance authority under 250.04(3)(a). Establish surveillance for chronic disease, injury, occupational and environmental health, maternal and child health, etc. Based on the continuity of care record (CCR), exchange a HIPAA Limited Data Set as stipulated under the Privacy Rule. All Protected Health Information is deleted, except dates of service, and census bloc group code of geography. Encrypted accession numbers are created for patient, primary care provider, clinic / hospital, and health care system (for follow back if a critical event is detected or suspected and more information is needed). However individual records cannot be published / viewed by public health. Only aggregated statistical surveillance summaries, shaded maps, etc. are generated from the information. All public health data displays and publications cannot identify individual patients, primary care providers, clinics / hospitals, or health care delivery systems. For a very small subset of cases that are time sensitive, provide (near) real time data exchange (e.g. to monitor the spread of an outbreak. Ideally, as bandwidth increases, most time sensitive data will be available in near real time for public health monitoring).

Pros

- Supports stage 1 meaningful use (syndromic surveillance). Revolutionizes public health surveillance capability for non-reportable conditions, such as asthma, diabetes, cardiovascular disease, stroke, falls among the elderly, etc. Exchange creates a single mechanism to support multiple surveillance programs, thus eliminating potential for data silos, differing program reporting mechanisms, multiple provider reporting burdens, etc. Public health can carry out a vast surveillance mandate without building and financing separate systems for each monitored condition. Exchange is configured to ensure and protect privacy of patients, providers, clinics / hospitals, and health care systems.

Cons

- Surveillance results may not be representative at early stages of HIE when there are fewer exchange participants (i.e. results will need to be interpreted cautiously in the beginning when there are fewer data submitters).

Legal / Policy

- Surveillance mandate is provided (Wis. Stats. §250.04(3)(a)), as is the analysis of surveillance data (Wis. Stats. §250.04(3)(b)(1)), and the operation of a public health data system (Wis. Stats. §250.04(3)(b)2)).
- Surveillance is permitted without prior patient consent (HIPAA and Wis. Stats.)

Evolution 3 – Public Health Alerting and Surveillance Feedback to Clinical Care

Public Health provides alerts to the EMR. In addition, surveillance analytics are developed to provide feedback to clinical care for decision support and health care optimization. Public health acquires other available community level data to link to EMR data (e.g., fresh fruits and vegetable consumption, education, poverty, alcohol, cigarette, fast food consumption etc. - at census block group). These data, plus HIE information, are used to create prediction models for feedback to health care. Working in collaboration with the best minds in health services research and medical quality analytics, public health creates surveillance tables, charts, and maps (aggregate data / mathematical relationships – predicting health outcome, disease risk, quality, etc at the patient, health care provider / system, and community levels). Public Health surveillance reporting preserves confidentiality of patient, primary care provider, clinic, hospital, and health care system (exchange with public health contains encrypted accession numbers for these factors – as in Evolution 2 above). It is not possible for public health to view accession data elements or to create patient data line listings. Line listings of data cannot be downloaded by public health. Public health provides feedback analytics to HIE health care participant. HIE health care participant can see feedback results for their own patients, primary care providers, clinics or hospitals, and health system as a whole (i.e. HIE participant is able to decode their own accession numbers). Individual health care HIE participants can benchmark their performance to peers and the rest of the state. Permitted system use is only for health care quality improvement. Information cannot be used for marketing, business competition, etc (see Figure 1 below).

Pros

- Approach provides predictive models and insight into the determinants of health care quality. This platform directs actions to be taken to improve health care. The HIE participant clinicians see individualized results that provide actionable intelligence to benchmark performance and to begin planning process improvement or comparative effectiveness trials.

Cons

- Must conform to capabilities of HIE architecture. Must ensure that role based access, encrypted accession numbers for patient, primary care provider, clinic / hospital, heath care system are integrated into HIE architecture.

Legal / Policy

- Surveillance mandate is provided (Wis. Stats. §250.04(3)(a)), as is the analysis of surveillance data (Wis. Stats. §250.04(3)(b)(1)), and the operation of a public health data system (Wis. Stats. §250.04(3)(b)2)).
- Surveillance is permitted without prior patient consent (HIPAA and Wis. Stats.)
- WI statutes provide public health with the authority to conduct investigations, studies, experiments and research pertaining to any public health problems which are a cause or potential cause of morbidity or mortality (Wis. Stats.§250.04(3)(b)(3)).

Evolution 4 – HIE Supports Research to Improve Clinical and Public Health Services

Here, HIE exchange with public health is designed to facilitate participation in care by public health (i.e. interventions), and to conduct clinical, multi-center comparative effectiveness research trials. High risk / eligible patients are segmented into treatment (new method of care) and controls (usual method of care) based on predictive analytics (Evolution 3- Public health alerting and surveillance feedback to health care) and other information. For example, patients that are predicted to be poorly controlled asthmatics or diabetics are randomized into treatment and control groups. Treatments may be differing methods that clinicians use to engage these patients in their care. Or it may involve public health interventions (for example, home visitation by a local public health nurse to educate asthmatics on medication use, allergen trigger avoidance, environmental assessment, etc.). Performance is monitored through subsequent cycles of data exchange with HIE. That is,

status (new treatment approach vs usual care), and performance results (e.g. asthma inhaler use / Emergency Room avoidance, blood sugar / A1c control) are exchanged with public health through HIE. Public Health performs multi-center analysis of results & status and reports findings to participants. Here again Public Health is blinded to the health care participants but can analyze the data and provide individualized results back to clinician participants (see Figure 1 below).

Pros

- Approach systematically develops evidence base for improving clinical care and public health interventions. Care is customized to the needs of differing patient population segments. Approach tightly integrates the processes of clinical care with public health to improve performance in both domains. HIE allows for multiple center participation, increasing study sample size and ability to discover meaningful results. Approach provides for a Continuing Medical Education (CME) platform. CME is accomplished through Practice Improvement Modules (PIMs). PIMs are designed to study the sources of clinical performance variation and suggest interventions. Interventions are run, results calculated, and findings shared to improve performance system-wide. Thus Evolution 4 effectively automates the PIM work flow.
- Option creates a compelling 'value proposition' for HIE: Wisconsin can become a statewide digital laboratory or a 'rapid-learning health system' to quickly advance the U.S. evidence base for clinical care. Rapid learning could fill major knowledge gaps about the benefits and risks of drugs and procedures, geographic variations, environmental health influences, the health of special populations, personalized medicine, and public health intervention effectiveness. If Wisconsin designs its HIE to support this capability, it will be come a magnet for biomedical research, creating jobs and economic growth that will strengthen the state's economy and strengthen the capabilities of its health care sector.

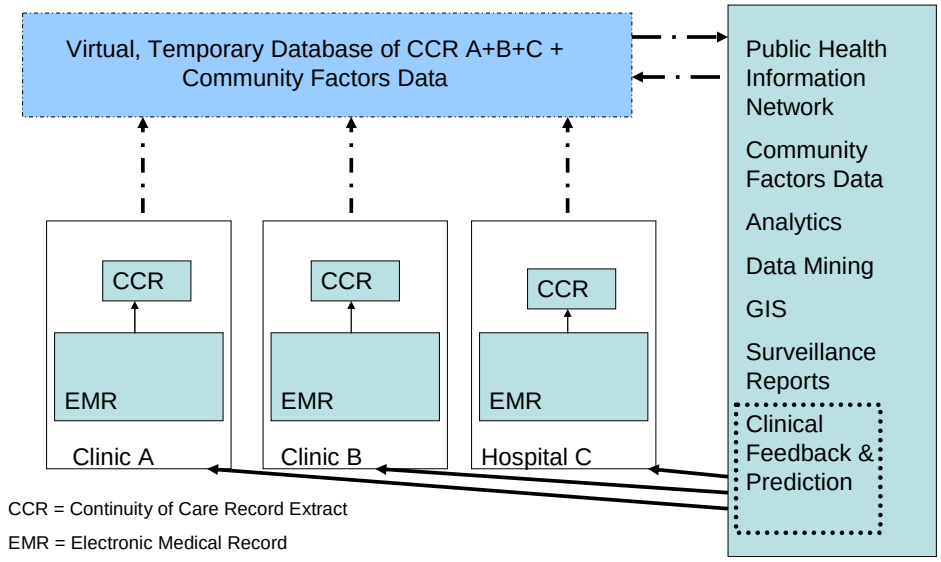
Cons

- Option needs to conform to capabilities of HIE architecture. Must ensure that role based access, encrypted accession numbers for patient, primary care provider, clinic / hospital, heath care system are integrated into HIE architecture.

Legal / Policy

- WI statutes provide public health with the authority to conduct investigations, studies, experiments and research pertaining to any public health problems which are a cause or potential cause of morbidity or mortality (Wis. Stats.§250.04(3)(b)(3)).
- Surveillance mandate is provided (Wis. Stats. §250.04(3)(a)), as is the analysis of surveillance data (Wis. Stats. §250.04(3)(b)(1)), and the operation of a public health data system (Wis. Stats. §250.04(3)(b)2)).
- Surveillance is permitted without prior patient consent (HIPAA and Wis. Stats.)
- Comparative effectiveness / intervention research will require IRB review.
- Should consider creating a single, statewide IRB that can serve the HIE and speed up IRB review and eliminate multiple IRB protocol assessments for a single, HIE wide activity involving many unaffiliated health care provider participants. If multi-center studies must go through each participant's IRB, this will markedly slow the implementation of investigations and it will make Wisconsin less competitive as a digital rapid-learning health system.

Figure 1. Conceptual Model of Grid / Federated Data Exchange between Clinical and Public Health



This is the conceptual diagram for a federated or grid enabled, bi-directional data exchange between clinical and public health (i.e. Evolution 3 & 4 discussed above).

Dashed lines and boxes indicate transient data feeds to create temporary databases and clinical feedback reports, both of which are never permanently stored centrally at public health.

By using a grid computing or a federated data model approach, there is no central, permanent database. Each participating facility keeps its health information at its own data center, where it belongs.

Each clinic and hospital's Electronic Medical Record (EMR) extracts a data subset, the Continuity of Care Record (CCR). This CCR extract is stored on a separate edge server at each facility, which is also connected to the secure grid. The grid queries each CCR to create a virtual, temporary database of all facility data combined. The grid also queries the community factors databases stored on the Public Health Information Network (PHIN). The virtual, temporary database of combined CCRs and community factors is analyzed by PHIN – creating maps, data mining and multivariate prediction models, outbreak alerts, situational awareness, analyzing the results of comparative effectiveness trials, etc.

Aggregate data surveillance summaries are stored on the secure PHIN for consumption by state and local public health, and clinical care. Public health surveillance reports preserve anonymity of patient, primary care provider, clinic, hospital, and integrated health care system (i.e. public health does not have role based access to these factors). They display only the mathematical relationships between risk factors and health outcomes based on the population as a whole.

Clinical feedback and prediction reports are created by PHIN analytics and transmitted to each clinic and hospital, along with each of their own accession numbers (patient, primary care provider, clinic / hospital). Recipients can decode accession numbers and link analysis and predictions back to patients, primary care provider, clinic / hospital, etc. PHIN does not keep any permanent record of facility feedback reports: data are temporarily held in memory for analysis and report transmission, and then they are deleted. And the virtual database dissolves away after reporting terminates. Public health does not have role based access to the facility feedback reports.

Assumption: HIE supports Public Health Clinical Services

Thus far we have largely centered the discussion on data exchange with public health for case reporting, surveillance, epidemiologic investigation, and health care quality improvement, and research. But we have not discussed the clinical public health role. Examples include –

Clinical services such as immunizations, measurement of height, weight, and blood pressure, pregnancy testing, physical assessment, preventive counseling, vision and hearing screening, referrals to other community resources and care coordination.
Perinatal Services - for pregnant women, postpartum women and their newborns. It can include nursing home visits for mothers and infants. Case management services are provided by public health nurses for women at risk for poor birth outcomes
Chronic Disease Prevention Services – for example screening children at WIC clinics for overweight / obesity; and health education and guidance to individual children and families served through public health programs;
Communicable disease control – Nursing follow-up with TB positive test patients to ensure compliance with medication treatment; Sexually Transmitted Infections / HIV / AIDS testing, counseling and partner services.

Thus public health is producing actions and data of great interest to health care providers who will want to know if patients received immunizations, mammograms, lab tests, examinations, and prescriptions (e.g., perinatal care, TB medications) in public health settings. With health care reform, interaction between public health and similar agencies is likely to grow as Local Health Departments assume roles within Accountable Care Organizations and as they provide community-based support to health care teams in Medical Homes. Thus one problem the Wisconsin plan must solve is how rendered public health clinical services become part of the exchange. If this is not addressed, information exchange will be incomplete, patients will suffer discontinuities in care, possible dangerous drug interactions and other problems, and the HIE promise for population health will be severely undercut.

At stage 1 meaningful use, public health's participation in EMR meaningful use centers on receipt of data from clinical care (case reporting, immunization data exchange, surveillance). Meaningful use at stages 2 and 3, although yet to be fully defined, do include the concept of bi-directional data exchange with public health and the improvement of health care quality and population health.

However provisions have not been made for incentives to support clinical public health activities (and indeed there are no incentives funding for the listed stage 1 public health meaningful use roles).

So how will Public Health Clinical Services participate in the HIE and efficiently communicate with clinical care, to fully document interactions with patients in public health settings and to improve health outcomes? With the reality of extremely limited public health funding, how will public health purchase, install, support and maintain a certified EHR so that it may participate? Several ideas come to mind:

One option could be the universal adoption of the 'free' VA EMR. This is attractive because the software is free. However this is a partial solution because substantial resources would still be needed for hardware, software, and staff to support an EMR installation environment for every public health agency. Thus significant costs will still accrue to public health departments.

A second option might be the 'adoption' of local health agencies by the dominant health care providers within the local public health jurisdiction. The public health agency would be given an EMR 'seat' at the clinic system within their jurisdiction (for example, Gunderson might support LaCrosse public health & the surrounding counties, Aurora – Milwaukee and surround, UW – Madison Dane county, Marshfield – northern counties, etc.). An example of this is approach is perhaps illustrated by the UW's support of Access Community Health. Though not a local public health department, Access is an independent Federally Qualified Health Care Center (FQHC) / safety net provider which uses the UW Epic EMR to provide care. There are of course technical issues to deal with (e.g. creating a public health instance at the clinic). And there are costs associated with providing the hosting environment for public health. But what funding local public health departments do have for health IT could be allocated to support their adoption by clinical care, and perhaps a discounted costing fee could be negotiated with vendors to support public health agency adoption and HIE participation. However another problem with this

solution is that the EMR of course will not support all of the many different public health functions. Thus it may add complexity without fixing the core problem of interoperable and interacting systems for the understaffed public health workforce.

A third option would specify that local and state public health departments upgrade all their current systems to enable bidirectional interoperability with exchanges and with certified EMRs. This has the advantage of preserving current public health information systems functionality and user acceptance but the disadvantage of considerable redundancy of effort, complexity and cost of ongoing maintenance, and a lost opportunity to engineer truly integrated systems for the most common public health functions. And again there are insufficient resources to fund the redesign and upgrade.

A fourth option is to develop, in collaboration with other states and with vendors interested in this space, requirements and core code for an open source public-health oriented EMR. We have proposed this with the Wisconsin's Secure Public Health Electronic Record Environment (Maternal and Child Health) system which provides both clinical and outcome documentation for several public health areas of practice in Wisconsin. Unfortunately, funding for both the technical and human aspects of this task is currently lacking. However, other states are known to be facing the identical problem.

A fifth option is to explore what vendors are preparing to upgrade public health documentation systems for interoperability with Meaningful Use functions in a certifiable manner and to provide sufficient technical and financial support to enable local and state health departments to migrate to these.

Regardless of the most practical option, ensuring such a migration to bidirectional interoperability between clinical and public health is an important need if the WIRED for Health 2020 goals will be met. Accordingly, the WIRED Legal and Policy Committee should recommend actions to ensure clinical public health participation in the HIE.

Considerations and Suggestions

To support surveillance, public health alerting, epidemiologic investigation, and clinical and public health improvement, State-wide HIE should consider a phased approach to implementing evolutionary stages 1 through 4 – over time.

A statewide IRB should be considered to support HIE based research involving multiple performance sites. This IRB would govern the protection of patients for all clinical biomedical and public health research trials conducted through Wisconsin's Health Information Exchange. Currently most multi-center investigations require each institution's IRB to review the protocol – this can add many months if not years to the start-up time. The motivation is that by creating one IRB, we can speed the deployment of biomedical research (clinical trials – drug, device, etc., clinical comparative effectiveness, public health interventions, etc.) across Wisconsin's HIE – and more rapidly improve health care quality and population health.

If we can accomplish this, Wisconsin could become a 'Digital Framingham' – attracting biomedical research dollars to create jobs, grow Wisconsin's economy, strengthen the state's biomedical research and health care industries, and strengthen public health. This in turn creates a compelling value proposition for Wisconsin's HIE. But we are in competition with every other state because each one is also creating a statewide HIE. The state that first realizes the potential for HIE based health R&D and streamlines operations to support it – will be in a much better position to attract biomedical research investments nationwide.

Finally, one very serious challenge for HIE implementation is the integration of public health clinical services. Without substantial federal investment in the redesign of public health information systems, Wisconsin's public health departments will be unable to fully participate in the exchange, and participation will be piecemeal at best. Therefore creative policies must be developed to ensure that public health can fully participate in the exchange.

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Appendices

(From Wisconsin eHealth Care Quality and Patient Safety Board Consumer Interests Workgroup. Final Report November 29, 2006)

Mandatory and Discretionary Reporting Requirements – Public Health

While the lists below provide many examples of mandatory and discretionary reporting requirements in Wisconsin, they are not an exhaustive list of these requirements.

Public Health Mandatory Reporting

Under Wisconsin law, providers must report the events, diseases, and situations listed below to the Wisconsin Department of Health and Family Services:

1. Deaths: Unusual circumstances, homicides, suicides, following an abortion, caused by poisoning, following accidents, no physician in attendance prior to 30 days, physician refuses to sign death certificate, when physician unavailable to sign death certificate (§979.01, Wis. Stats.)

2. Deaths due to suicide, seclusion/restraint use or psychotropic medications in mental health programs, nursing homes, and community based residential facilities. (§51.64, 50.04(2t), 50.035(5), Wis. Stats)

3. Births: Birth and Developmental Abnormalities (§253.12, Wis. Stats.)

4. Induced Abortions (§69.186, Wis. Stats.)

5. Non-spousal Artificial Insemination: Husband's consent (§891.40, Wis. Stats.)

6. Lead Poisoning: Requires reporting of diagnosis of lead poisoning or lead exposure, including any lead screening, regardless of result (§254.13(1), Wis. Stats)

7. Communicable Diseases: *Category I:* Anthrax, Botulism, Botulism, infant, Cholera, Diphtheria, Food-borne or water borne outbreaks, Haemophilus influenzae invasive disease, Hantavirus infection, Hepatitis, viral type A, Hepatitis E, Measles, Meningococcal disease, Pertussis, Plague, Poliomyelitis, Rabies (Human), Ricin toxin, Rubella (congenital syndrome), Smallpox, Tuberculosis, Yellow Fever

   Category II: Amebiasis, Arboviral infection (encephalitis/meningitis), Babesiosis, Brucellosis, Campylobacteriosis (campylobacter infection, Cat scratch disease, Cryptosporiasis, Cyclosporiasis, erlichiosis, Encephalitis, viral (other than arbooviral, E-coli and other enterohemorragic E-coli, Giardiasis, Hemolytic uremic syndrome, Hepatits, viral types B, C, D, non-A, non-B (acute), Histoplasmosis, Kawasaki disease, Legionnaires' disease. Leprosy, Leptospirosis, Listeriosis, Lyme disease, Malaria, Meningitis, viral, Meningitis, bacterial, Mumps, Nontuberculous myobacterial disease, Psittacosis, Q fever, Reye's syndrome, Rheumatic fever, Rocky mountain spotted fever, Salmonellosis, Sexually transmitted diseases, Shigellosis, Streptococcal disease, streptococcus pneumoniae invasive disease, Tetanus, Toxic shock syndrome, Toxic substance related disease, Toxoplasmosis, Trichinosis, Tularemia, Typhoid fever, Typhus fever, Varicella, Yersiniosis, suspected outbreaks of other acute or occupationally related diseases

   Category III: Acquired immune deficiency syndrome (AIDS), Human Immunodeficiency virus (HIV) infection, CD4+T-lymphocyte count

8. Sexually Transmitted Diseases (see number 6 above)

9. Child Abuse (§48.981, Wis. Stats.)

10. Cancer (§255.04, Wis. Stats.)

11. Infant Drug or Alcohol Screens (§146.0255, Wis. Stats.)

12. Crime injuries, Gunshot wounds, Burns (§146.995, 146.995(2)(a)3, Wis. Stats.)

13. Caregiver abuse (§146.40(4r), Wis. Stats)

14. Certain limited situations of abuse, neglect, financial exploitation and self-neglect of adults at risk (§46.90, 55.043, Wis. Stats.)

15. Caregiver Misconduct (HFS ch. 13, Wis. Admin. Code)

Public Health Discretionary Reporting

Under Wisconsin law, providers may choose to report the following events, diseases, and situations, to the Wisconsin Department of Health and Family Services:

1. Unsafe Drivers (§146.82(3)(a), Wis. Stats.)

2. Abuse, Neglect, Financial Exploitation and Self-Neglect of Most Adults at Risk (§46.90 and 55.043, Wis. Stats.)

Public Health Surveillance Authority

Under Wisconsin law, designated public health entities:

1. May investigate the cause and circumstances of any special or unusual disease or mortality (§250.04(1), Wis. Stats.)

2. Shall establish Surveillance Systems to detect any occurrence of acute, communicable or chronic diseases and threat of occupational or environmental hazards, injuries or changes in the health of mothers and children. (§250.04(3)(a), Wis. Stats.)

3. Shall analyze occurrences, trends and patterns of acute, communicable or chronic diseases, maternal and child health, injuries and occupational and environmental hazards and distribute information based on the analyses. (§250.04(3)(b)(1), Wis. Stats.).

4. Shall operate a Public Health Data System (§250.04(3)2), Wis. Stats.)

5. Conduct investigations, studies, experiments and research pertaining to any public health problems which are a cause or potential cause of morbidity or mortality. Individual questionnaires or surveys shall be treated as confidential patient health care records under §146.81 to 146.835, but the information in those questionnaires and surveys may be released in statistical summaries. (§250.04(3)(b)(3), Wis. Stats.)

6. Use hospital emergency room and inpatient health care records, abstracts of these records and information the state or federal government collects to correlate exposure to certain occupational and high risk environments with resulting acute or chronic health problems. (§250.04(3)(b)(4), Wis. Stats.)

STATE ADMINISTRATIVE RULES IMPORTANT FOR PUBLIC HEALTH

The State Administrative Code can be found on the Internet at
http://www.legis.state.wi.us/rsb/code/index.html

DEPARTMENT OF HEALH SERVICES
Health
Chapter

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HFS 111 Licensing of emergency medical technicians--intermediate and approval of emergency medical technician--intermediate operational plans
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HFS 196.03 Definitions.
HFS196.04 Permits.
HFS 196.05 Inspections.
HFS 196.06 Enforcement.
HFS 196.07 Adoption of Wisconsin Food Code
Appendix - Wisconsin Food Code (The Wisconsin Food Code is available on the Internet at: http://www.legis.state.wi.us/rsb/code/hfs/hfs196_app.pdf)

HFS 197 Bed and breakfast establishments
HFS 197.01 Authority and purpose.
HFS 197.02 Scope.
HFS 197.03 Definitions.
HFS 197.04 Permits.
HFS 197.05 Water supply and waste disposal.
HFS 197.06 Toilet, hand washing and bathing facilities.
HFS 197.07 Furnishings, equipment and utensils.
HFS 197.08 Food.
HFS 197.09 Building safety.
HFS 197.10 Maintenance.
HFS 197.11 Enforcement.

HFS 198 Vending of food
HFS 198.01 Authority and purpose.
HFS 198.02 Scope.
HFS 198.03 Definitions.
HFS 198.04 Permit to operate.
HFS 198.05 Approval of vending machines and related equipment.
HFS 198.06 Vending machine location.
HFS 198.07 Inspection of vending machines and commissaries.
HFS 198.08 Foods.
HFS 198.09 Food protection.
HFS 198.10 Equipment maintenance and sanitizing.
HFS 198.11 Water supply.
HFS 198.12 Waste disposal.
HFS 198.13 Delivery of foods.
HFS 198.14 Personnel.
HFS 198.15 Enforcement.

Appendix**: Disclosure of Health Information in Wisconsin - public health**

		Information to state and local public health department for surveillance and epidemiology purposes	
		Regulation Influences (State/Fed)	**For Reporting, Epidemiology, Surveillance, Etc. (If Public Health Department is providing treatment, refer to "A. Treatment")**
Type of health information	**General Information**	§146.82 (2)(a) 5, Wis. Stats.; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA	For required reporting disclose without patient consent. For disclosure of information beyond required reporting – disclose without patient consent to legally authorized state agency.
	Mental Health	§51.30(4)(b) 1, Wis. Stats.; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA	For required reporting disclose without patient consent. For exchange of information beyond required reporting, disclose without patient consent to agency designated by DHFS with written documentation of authority for access per statute or authority of DHFS. Any other information, disclose with patient consent only.
	Alcohol/Drug Abuse Treatment	§51.30(4)(b)1, Wis. Stats.; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA 42 CFR 2.53	For required reporting disclose without patient consent. For exchange of information beyond required reporting - disclose without patient consent to agency designated by DHFS with written documentation of authority for access per statute or authority of DHFS. Any other information – disclose with patient consent only. If disclosure does not identify the patient as receiving alcohol and/or drug abuse, the communicable disease information may be reported to the appropriate state agency. Also, in the event that a public health investigation may be deemed a health oversight agency activity, limited information with documented assurance regarding patient privacy may be accessible.
	Developmental Disabilities	§51.30(4)(b)1, Wis. Stats.; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA	For required reporting disclose without patient consent. For exchange of information beyond required reporting - disclose without patient consent to agency designated by DHFS with written documentation of authority for access per statute or authority of DHFS. Any other information – disclose with patient consent only.
	Communicable Disease See Appendix A	Various Wisconsin Reporting Statutes (see Appendix A); §146.82(2)(a)5., Wis. Stats.; §51.30(4)(b)1., Wis. Stats.; §252.15(5)(a)6, Wis. Stats.; HIPAA	Disclose without patient consent for legally required reporting. [146. 51.30. 252.15]. For additional access: For 146: disclose without patient consent to legally authorized state agency [146.82(2) (a) 5.]. For 51.30: disclose without patient consent to agency designated by DHFS with written documentation of authority for access per statute or authority of DHFS. For 252.15: disclose without patient consent to the state epidemiologist or designee for the purpose of providing epidemiologic surveillance or investigation or control of communicable disease.
	HIV Test Results	§252.15(5)(a)6, Wis. Stats.; HIPAA	Disclose without patient consent to the state epidemiologist or designee for the purpose of providing epidemiologic surveillance or investigation or control of communicable disease.
	Genetic Testing	§146.82(2)(a)5, Wis. Stats; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA	Disclose without patient consent for legally required reporting. For additional exchange of information – see "General Information, Mental Health, Alcohol/Drug Abuse and Developmental Disability" categories. No specific state or federal law protection. Federal law pending.
	Adoption	Various Wisconsin Reporting Statutes (see Appendix A); HIPAA	Disclose without patient consent for legally required reporting. For additional exchange of information – see "General Information, Mental Health, Alcohol/Drug Abuse and Developmental Disability" categories.
	Sexual Assault	§146.82(2)(a)5, Wis. Stats.; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA*	Disclose without patient consent for legally required reporting. For additional exchange of information – see "General Information, Mental Health, Alcohol/Drug Abuse and Developmental Disability" categories.
	Domestic Violence	§146.82(2(a)5, Wis. Stats.; Various Wisconsin Reporting Statutes (see Appendix A); HIPAA*	Disclose without patient consent for legally required reporting. For additional exchange of information – see "General Information, Mental Health, Alcohol/Drug Abuse and Developmental Disability" categories.

* Separate Statutes regulate the disclosure of information in a record created and held by a domestic violence or sexual assault service agency.

Appendix: **Disclosure of Health Information in Wisconsin - research**

		Information to external or internal researchers	
		Regulation Influences (State/Fed)	**For Research**
Type of health information	**General Information**	§146.82(2)(a)6, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and privacy assurances from the researcher.
	Mental Health	§51.30(4)(b)3, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following - Waiver received from the Institutional Review Board (IRB) or Privacy Board, approval by DHFS and assurances from the researcher relating to patient privacy.
	Alcohol/Drug Abuse Treatment	§51.30(4)(b)3, Wis. Stats.; HIPAA 164.512(i); 42 CFR 2.52	Disclose without patient consent upon documentation of the following - Waiver received from the Institutional Review Board (IRB) or Privacy Board, approval by DHFS and assurances from the researcher relating to protocols, patient privacy, 3 person independent review and no redisclosure of identifying information (other than to program).
	Developmental Disabilities	§51.30(4)(b)3, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following - Waiver received from the Institutional Review Board (IRB) or Privacy Board, approval by DHFS and assurances from the researcher relating to patient privacy.
	Communicable Disease *	§146.82(2)(a)6, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and privacy assurances from the researcher.
	HIV Test Results	§252.15(5)(a)10, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and written privacy assurances from the researcher.
	Genetic Testing	§146.82(2)(a)6, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and privacy assurances from the researcher. No specific state or federal protection. Federal law pending.
	Adoption	§146.82(2)(a)6, Wis. Stats.; HIPAA 164.512(i)	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and privacy assurances from the researcher. May need further research on pre-adoption records.
	Sexual Assault	§146.82(2)(a)6, Wis. Stats.; HIPAA 164.512(i) *	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and privacy assurances from the researcher.
	Domestic Violence	§146.82(2)(a)6, Wis. Stats.; HIPAA 164.512(i) *	Disclose without patient consent upon documentation of the following – Waiver received from the Institutional Review Board (IRB) or Privacy Board and affiliation between the researcher and the healthcare provider (affiliation not defined) and privacy assurances from the researcher.

* Separate Statutes regulate the disclosure of information in a record created and held by a domestic violence or sexual assault service agency.

APPENDIX 25

ID		Task Name	Duration	Start	Finish
1		**General Implementation Activities**	**913 days**	**Wed 8/11/10**	**Fri 2/7/14**
2		**Administrative activities (ongoing)**	**898 days**	**Wed 9/1/10**	**Fri 2/7/14**
3		Update to Project Plan	898 days	Wed 9/1/10	Fri 2/7/14
4		Report bi-weekly status	809 days	Wed 9/1/10	Mon 10/7/13
5		Provide support to Board and Committee meetings	898 days	Wed 9/1/10	Fri 2/7/14
6		**Attend annual meetings**	**2 days**	**Tue 12/14/10**	**Wed 12/15/10**
7		National HITECH Meeting	2 days	Tue 12/14/10	Wed 12/15/10
8		**Annual updates to ONC**	**652 days**	**Thu 3/31/11**	**Mon 9/30/13**
9		**Annual Update Strategic and Operational Plan**	**521 days**	**Fri 9/30/11**	**Mon 9/30/13**
10		**Annual Update in 2011**	**0 days**	**Fri 9/30/11**	**Fri 9/30/11**
11		**Update the Strategic and Operational Plan**	**0 days**	**Fri 9/30/11**	**Fri 9/30/11**
12		Report performance measures to ONC	0 days	Fri 9/30/11	Fri 9/30/11
13		Submit update to the ONC	0 days	Fri 9/30/11	Fri 9/30/11
14		**Annual Update in 2012**	**0 days**	**Fri 9/28/12**	**Fri 9/28/12**
15		**Update the Strategic and Operational Plan**	**0 days**	**Fri 9/28/12**	**Fri 9/28/12**
16		Report performance measures to ONC	0 days	Fri 9/28/12	Fri 9/28/12
17		Submit update to the ONC	0 days	Fri 9/28/12	Fri 9/28/12
18		**Annual Update in 2013**	**0 days**	**Mon 9/30/13**	**Mon 9/30/13**
19		Update the Strategic and Operational Plan	0 days	Mon 9/30/13	Mon 9/30/13
20		Submit update to the ONC	0 days	Mon 9/30/13	Mon 9/30/13
21		**Annual OMB Circular Updates**	**541 days**	**Thu 3/31/11**	**Thu 4/25/13**
22		**2011 ONC Reports**	**20 days**	**Thu 3/31/11**	**Wed 4/27/11**
23		Update OMB Circular A-122 for SDEs	20 days	Thu 3/31/11	Wed 4/27/11
24		**2012 ONC Reports**	**20 days**	**Fri 3/30/12**	**Thu 4/26/12**
25		Update OMB Circular A-122 for SDEs	20 days	Fri 3/30/12	Thu 4/26/12
26		**2013 ONC Reports**	**20 days**	**Fri 3/29/13**	**Thu 4/25/13**
27		Update OMB Circular A-122 for SDEs	20 days	Fri 3/29/13	Thu 4/25/13
28		Conduct Evaluation Activities with NORC (ongoing)	810 days	Mon 1/3/11	Fri 2/7/14
29		**Additional HIT Program Coordination Activities (ongoing)**	**913 days**	**Wed 8/11/10**	**Fri 2/7/14**
30		**Coordinate with state and federally funded programs**	**810 days**	**Mon 1/3/11**	**Fri 2/7/14**
31		Coordinate with Medicaid	810 days	Mon 1/3/11	Fri 2/7/14
32		Coordinate with Medicare	810 days	Mon 1/3/11	Fri 2/7/14
33		Coordinate with state public health programs	810 days	Mon 1/3/11	Fri 2/7/14
34		Coordinate with other federally funded health programs	810 days	Mon 1/3/11	Fri 2/7/14
35		Coordinate with the SDE	810 days	Mon 1/3/11	Fri 2/7/14
36		Coordinate with other HIE initiatives in the state	810 days	Mon 1/3/11	Fri 2/7/14
37		Assess opportunities to partner with WHITEC	810 days	Mon 1/3/11	Fri 2/7/14
38		**Create a State of Wisconsin Interagency Health IT Council to provide input and resources to the SDE**	**810 days**	**Mon 1/3/11**	**Fri 2/7/14**
39		Develop State of Wisconsin Interagency Health IT Council	100 days	Mon 1/3/11	Fri 5/20/11
40		Chair the Health IT Council	710 days	Mon 5/23/11	Fri 2/7/14
41		Participate in the Health IT Council	810 days	Mon 1/3/11	Fri 2/7/14
42		Foster cross-program coordination among ARRA-funded programs in the State	810 days	Mon 1/3/11	Fri 2/7/14
43		**Identify and facilitate potential interstate partnerships pertaining to HIT/HIE**	**810 days**	**Wed 8/11/10**	**Tue 9/17/13**

Project: WIRED Implementation Plan
Date: Tue 8/24/10

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID	Task Name	Duration	Start	Finish
44	Identify partnerships with border states, to help ensure that interstate and nationwide HIE interoperability and connectivity goals are achieved	810 days	Wed 8/11/10	Tue 9/17/13
45	Work with state health policy makers on strategies to achieve statewide HIE goals	810 days	Mon 1/3/11	Fri 2/7/14
46	Periodically brief the Governor, the DHS Secretary, the Legislature, and other health entities on the health IT landscape in the State	810 days	Mon 1/3/11	Fri 2/7/14
47	Verify SDE compliance with the terms of any contract with DHS pertaining to statewide HIE	810 days	Mon 1/3/11	Fri 2/7/14
48	Work to ensure the meaningful use HIE requirements related to public health will be satisfied	810 days	Mon 1/3/11	Fri 2/7/14
49	**Discuss with Board the role of Committees and Workgroups during the Transition Period to the SDE**	**22 days**	**Fri 8/20/10**	**Mon 9/20/10**
50	**Draft recommendation for role, tasks, and members**	**20 days**	**Fri 8/20/10**	**Thu 9/16/10**
51	Governance	20 days	Fri 8/20/10	Thu 9/16/10
52	Finance	20 days	Fri 8/20/10	Thu 9/16/10
53	Standards and Architecture	20 days	Fri 8/20/10	Thu 9/16/10
54	Legal and Policy	20 days	Fri 8/20/10	Thu 9/16/10
55	Communications, Education, and Marketing	20 days	Fri 8/20/10	Thu 9/16/10
56	Present Committee and Workgroup recommendation to the Board	1 day	Fri 9/17/10	Fri 9/17/10
57	**Form Committees and Workgroups (e.g. Directories, Operations, etc.)**	**1 day**	**Mon 9/20/10**	**Mon 9/20/10**
58	Form Directory Implementation Workgroup	1 day	Mon 9/20/10	Mon 9/20/10
59	**Governance**	**976 days**	**Fri 5/14/10**	**Fri 2/7/14**
60	**Create SDE Selection Process**	**30 days**	**Fri 5/14/10**	**Fri 6/25/10**
61	Draft SDE Selection Process including timeline and resource needs	14 days	Fri 5/14/10	Wed 6/2/10
62	Finalize and Recommend SDE Selection Process Flow to the WIRED for Health Board	0 days	Thu 6/17/10	Thu 6/17/10
63	Review and Approve SDE Selection Process	0 days	Fri 6/25/10	Fri 6/25/10
64	**Invite Broad List of SDE Applicants**	**5 days**	**Fri 6/4/10**	**Thu 6/10/10**
65	Applicant Solicitation	5 days	Fri 6/4/10	Thu 6/10/10
66	**Create SDE Request for Application**	**30 days**	**Fri 5/14/10**	**Fri 6/25/10**
67	Draft Request for Application (RFA) including Introduction and Background, Minimum Qualifications, Questionnaire and Scoring Grid	20 days	Fri 5/14/10	Thu 6/10/10
68	Distribute Draft RFA to Interested Parties for Comment	5 days	Fri 6/11/10	Thu 6/17/10
69	Review Comments and make final changes to RFA for Board Review/Approval	1 day	Tue 6/22/10	Tue 6/22/10
70	Review/Approve RFA for Distribution	0 days	Fri 6/25/10	Fri 6/25/10
71	**Use Transparent Process to Publish RFA**	**32 days**	**Mon 6/28/10**	**Wed 8/11/10**
72	Post approved RFA with process instructions and timeline to SharePoint	0 days	Wed 8/11/10	Wed 8/11/10
73	Email RFA with process instructions and timeline to all Interested Parties	0 days	Mon 6/28/10	Mon 6/28/10
74	**Establish Multi-Stakeholder RFA Evaluation Team**	**16 days**	**Thu 6/3/10**	**Fri 6/25/10**
75	Identify RFA Evaluation Team and Process	10 days	Thu 6/3/10	Wed 6/16/10
76	Finalize RFA Evaluation Team and Process	0 days	Fri 6/25/10	Fri 6/25/10
77	**Implement SDE Selection Process**	**49 days**	**Mon 7/19/10**	**Thu 9/23/10**
78	Prepare Instructions for Evaluation Team	14 days	Mon 7/19/10	Thu 8/5/10
79	Meet with Evaluation Team to review instructions and address questions	0 days	Mon 8/16/10	Mon 8/16/10
80	Collect Completed Applications	0 days	Tue 8/24/10	Tue 8/24/10
81	Notify applicants of time set reserved for interviews	0 days	Wed 8/25/10	Wed 8/25/10
82	Distribute copies of all completed applications with instructions to review team members	0 days	Wed 8/25/10	Wed 8/25/10
83	Have conference call with Evaluation Team to address any questions	0 days	Thu 8/26/10	Thu 8/26/10
84	Review applications and complete evaluation spreadsheet	8 days	Thu 8/26/10	Mon 9/6/10
85	Compile Evaluation Team member responses/recommendation and share with Evaluation Team	2 days	Wed 9/8/10	Thu 9/9/10
86	Meet to Identify Applicants for further consideration based on established criteria and Evaluation Team responses	0 days	Tue 9/14/10	Tue 9/14/10

Project: WIRED Implementation Plan
Date: Tue 8/24/10

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID	Task Name	Duration	Start	Finish
87	Schedule Interviews. Send notice of rejection to those applicants not selected as finalists	2 days	Wed 9/15/10	Thu 9/16/10
88	Hold face-to-face interviews with qualified candidates and follow-up discussion/decision by Evaluation Team	2 days	Mon 9/20/10	Tue 9/21/10
89	Make recommendation on SDE to WIRED for Health BOD	1 day	Thu 9/23/10	Thu 9/23/10
90	**Select SDE**	**4 days**	**Fri 9/24/10**	**Thu 9/30/10**
91	Recommend SDE to DHS	0 days	Fri 9/24/10	Fri 9/24/10
92	Certify and Announce SDE Selection	0 days	Thu 9/30/10	Thu 9/30/10
93	Notify applicants of selection/rejection	0 days	Thu 9/30/10	Thu 9/30/10
94	**Prepare for Transition to SDE Governance**	**65 days**	**Fri 10/1/10**	**Thu 12/30/10**
95	Implement any action required for SDE to fully comply with the terms of the RFA	65 days	Fri 10/1/10	Thu 12/30/10
96	Agree on a plan to transfer responsibility and authority to the SDE for execution of the plan of the WIRED for Health Initiative	21 days	Fri 10/1/10	Fri 10/29/10
97	**Negotiate contract between the State and the SDE based on the HIE CAP**	**42 days**	**Fri 10/1/10**	**Mon 11/29/10**
98	Includes deliverables	42 days	Fri 10/1/10	Mon 11/29/10
99	Includes financial terms of engagement	42 days	Fri 10/1/10	Mon 11/29/10
100	Includes requirement for conflict of interest policies	42 days	Fri 10/1/10	Mon 11/29/10
101	Includes commitment to principles of collaboration, transparency, buy-in and trust as a manner of conducting business and making business dec	42 days	Fri 10/1/10	Mon 11/29/10
102	Determine SDE Board/Committee/Workgroup structure and membership	42 days	Fri 10/1/10	Mon 11/29/10
103	Recruit and/or reassign staff for SDE	1 day	Fri 10/1/10	Fri 10/1/10
104	Prepare initial operating policies and procedures for SDE, with emphasis on transparency, accountability, and stakeholder involvement as provided u	1 day	Fri 10/1/10	Fri 10/1/10
105	**Engage in SDE Governance of Implementation Phase**	**913 days**	**Wed 8/11/10**	**Fri 2/7/14**
106	**Officially transfer governance responsibility to SDE**	**125 days**	**Wed 8/11/10**	**Tue 2/1/11**
107	**Identify and assign resources**	**125 days**	**Wed 8/11/10**	**Tue 2/1/11**
108	Transfer work from State	1 day	Wed 8/11/10	Wed 8/11/10
109	**Transfer work from WIRED for Health Board**	**1 day**	**Tue 2/1/11**	**Tue 2/1/11**
110	**Transfer work from Committees and Workgroups**	**1 day**	**Tue 2/1/11**	**Tue 2/1/11**
111	Governance	1 day	Tue 2/1/11	Tue 2/1/11
112	Finance	1 day	Tue 2/1/11	Tue 2/1/11
113	Standards and Architecture	1 day	Tue 2/1/11	Tue 2/1/11
114	Legal and Policy	1 day	Tue 2/1/11	Tue 2/1/11
115	**Communications, Education, and Marketing**	**1 day**	**Tue 2/1/11**	**Tue 2/1/11**
116	Review and update CEM work plan and integrate current ongoing communications activities	1 day	Tue 2/1/11	Tue 2/1/11
117	Lead implementation of the Strategic and Operational Plan (SOP) with continued multi-stakeholder participation	789 days	Tue 2/1/11	Fri 2/7/14
118	Convene regular meetings of the SDE BOD and associated committees and workgroups	789 days	Tue 2/1/11	Fri 2/7/14
119	Engage in regular communication with DHS, ONC, and CMS on the HIE CAP and the SOP	789 days	Tue 2/1/11	Fri 2/7/14
120	Comply with all required reports under the HIE CAP, Act 274, and related State Contracts	789 days	Tue 2/1/11	Fri 2/7/14
121	Ensure state alignment with interstate, regional, and national HIE strategies by participating in collaborative HIE development initiatives	789 days	Tue 2/1/11	Fri 2/7/14
122	Plan and implement an HIE communication and education program	789 days	Tue 2/1/11	Fri 2/7/14
123	Establish a process for continued linking of WIRED for Health initiative and the Medicaid HIT Plan	42 days	Fri 10/1/10	Mon 11/29/10
124	**Promote intrastate coordination of HIE development initiatives**	**789 days**	**Tue 2/1/11**	**Fri 2/7/14**
125	**Review neighboring states' strategic and operational plans**	**789 days**	**Tue 2/1/11**	**Fri 2/7/14**
126	Identify interdependencies and priority areas for the development of strategies to achieve interstate exchange	789 days	Tue 2/1/11	Fri 2/7/14
127	Meet with applicable states' health IT coordinators and SDEs to develop the strategies	789 days	Tue 2/1/11	Fri 2/7/14
128	Promote HIE policies and practices consistent with developing nationwide governance models	789 days	Tue 2/1/11	Fri 2/7/14
129	Promote transparency, buy-in and trust through statewide HIE implementation	789 days	Tue 2/1/11	Fri 2/7/14

Project: WIRED Implementation Plan
Date: Tue 8/24/10

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID	Task Name	Duration	Start	Finish
130	Encourage and participate in public/private collaboration on methods to harmonize HIE and other health care quality improvement efforts	789 days	Tue 2/1/11	Fri 2/7/14
131	Coordinate with WHITEC to ensure that providers participating in WHITEC's education and technical services are aware of the statewide health infor	789 days	Tue 2/1/11	Fri 2/7/14
132	Address barriers to statewide HIE and prepare mitigation strategies	789 days	Tue 2/1/11	Fri 2/7/14
133	Implement process for regular review and adjustment of goals, objectives, performance measures, policies and procedures, and implementation plans	789 days	Tue 2/1/11	Fri 2/7/14
134	**Legal and Policy**	**892 days**	**Mon 8/2/10**	**Tue 12/31/13**
135	Explore and address issues identified in the Legal and Policy section of the Plan	109 days	Mon 8/2/10	Thu 12/30/10
136	**Legislation**	**885 days**	**Wed 8/11/10**	**Tue 12/31/13**
137	**Finalize preliminary list of HIE-related issues to be addressed in legislation**	**65 days**	**Fri 10/1/10**	**Thu 12/30/10**
138	Privacy and security	65 days	Fri 10/1/10	Thu 12/30/10
139	HIE-related liability	65 days	Fri 10/1/10	Thu 12/30/10
140	Data use modifications	65 days	Fri 10/1/10	Thu 12/30/10
141	Complete informal first draft of proposed HIE-related legislation	65 days	Fri 10/1/10	Thu 12/30/10
142	Seek input from relevant stakeholders on and make changes to informal first draft of proposed HIE-related legislation. (Dependent on final determina	86 days	Wed 12/1/10	Wed 3/30/11
143	Identify legislative strategy (including communications) for passing HIE-related legislation	63 days	Mon 1/3/11	Wed 3/30/11
144	Begin process to formally draft and introduce proposed HIE-related legislation	63 days	Mon 1/3/11	Wed 3/30/11
145	Pass HIE-related legislation. (Likely dependent on timing of biennial budget)	65 days	Wed 6/1/11	Tue 8/30/11
146	**Participation/Data Use Agreements (DUAs)**	**885 days**	**Wed 8/11/10**	**Tue 12/31/13**
147	Finalize preliminary list of issues to be addressed in DUAs	65 days	Fri 10/1/10	Thu 12/30/10
148	Complete preliminary resolution of how DUA will address the preliminary list of DUA issues	63 days	Mon 1/3/11	Wed 3/30/11
149	Complete initial draft of standardized DUAs (dependent on formal drafting of HIE-related legislation and final determination of initial architecture	45 days	Fri 4/1/11	Thu 6/2/11
150	Finalize standardized DUAs (dependent on final passage of HIE-related legislation)	65 days	Wed 6/1/11	Tue 8/30/11
151	Annually, or as needed, review and refresh DUAs as the environment changes. Ongoing.	638 days	Wed 8/11/10	Fri 1/18/13
152	**Internal Policy Development**	**782 days**	**Mon 1/3/11**	**Tue 12/31/13**
153	Identify at a high-level the core security, privacy, operational, and accountability policies of the SHIN, including processes to update such pc	63 days	Mon 1/3/11	Wed 3/30/11
154	Complete initial draft of core security, privacy, operational, and accountability policies of the SHIN, including processes to update such polic	45 days	Fri 4/1/11	Thu 6/2/11
155	Seek input from relevant stakeholders on and make changes to first draft of core security, privacy, operational, and accountability policies c	45 days	Fri 4/1/11	Thu 6/2/11
156	Finalize core security, privacy, operational, and accountability policies of the SHIN, including processes to update such policies. Summer 2	65 days	Wed 6/1/11	Tue 8/30/11
157	Annually, or as needed, review and refresh policies as the environment changes. Ongoing.	610 days	Wed 8/31/11	Tue 12/31/13
158	**Technical Infrastructure**	**910 days?**	**Mon 8/9/10**	**Sat 2/1/14**
159	**Supporting Stage 1 Meaningful Use HIE Requirements for Lab and Pharmacy**	**43 days**	**Mon 9/13/10**	**Wed 11/10/10**
160	**Complete initial telephone pharmacy and lab data collection**	**15 days**	**Thu 9/16/10**	**Wed 10/6/10**
161	Do additional outreach to non-responders	15 days	Thu 9/16/10	Wed 10/6/10
162	**Perform data validation and finalize baseline measures of HIE capability**	**5 days**	**Mon 9/13/10**	**Fri 9/17/10**
163	Reconcile duplicate records	5 days	Mon 9/13/10	Fri 9/17/10
164	Establish method for ongoing measurement of progress to close gaps	5 days	Mon 9/13/10	Fri 9/17/10
165	**Identify and collect additional information need to assess magnitude and impact of gap on providers, pharmacies, and labs**	**10 days**	**Mon 9/13/10**	**Fri 9/24/10**
166	Conduct more in-depth electronic survey with pharmacies and labs	3 days	Mon 9/13/10	Wed 9/15/10
167	Collect data from WHITEC and other partners	10 days	Mon 9/13/10	Fri 9/24/10
168	Collect data from Medicare and Medicaid through the National Level Registry	6 days	Mon 9/13/10	Mon 9/20/10
169	Analyze data and assess magnitude and impact of gap on eligible professionals and hospitals by county	5 days	Thu 10/7/10	Wed 10/13/10
170	**Analyze feasibility of strategy options specified in the plan to close gap and select options for implementation**	**10 days**	**Thu 10/14/10**	**Wed 10/27/10**
171	Analyze Medicaid data and coordinate with State Medicaid Program	10 days	Thu 10/14/10	Wed 10/27/10
172	Coordinate and collaborate with WI DRL	10 days	Thu 10/14/10	Wed 10/27/10

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ID		Task Name	Duration	Start	Finish
173		Coordinate and collaborate with local WI and neighboring HIEs	10 days	Thu 10/14/10	Wed 10/27/10
174		Develop work plan, timeline, and budget for selected options	10 days	Thu 10/28/10	Wed 11/10/10
175		Identify potential barriers and risks and risk mitigation approaches	10 days	Thu 10/28/10	Wed 11/10/10
176		Identify technical support and coordination from ONC to support selected options	10 days	Thu 10/28/10	Wed 11/10/10
177		**Complete Environmental Scan of Existing Assets**	**40 days**	**Wed 8/18/10**	**Tue 10/12/10**
178		Evaluate existing HIE assets	30 days	Wed 9/1/10	Tue 10/12/10
179		Evaluate existing assets for directories	30 days	Wed 9/1/10	Tue 10/12/10
180		Evaluate existing health care quality and health information organization assets	15 days	Wed 8/18/10	Tue 9/7/10
181		Evaluate Medicaid assets	15 days	Wed 8/18/10	Tue 9/7/10
182		Evaluate public health assets	15 days	Wed 8/18/10	Tue 9/7/10
183		**Review the proposed architecture in the Strategic and Operational Plan**	**30 days**	**Wed 9/1/10**	**Tue 10/12/10**
184		Reference Architecture	30 days	Wed 9/1/10	Tue 10/12/10
185		Security Architecture	30 days	Wed 9/1/10	Tue 10/12/10
186		**Review the use case prioritization in the Strategic and Operational Plan**	**30 days**	**Wed 9/1/10**	**Tue 10/12/10**
187		Update based on meaningful use requirements	30 days	Wed 9/1/10	Tue 10/12/10
188		Prioritize use cases based on stakeholder input	30 days	Wed 9/1/10	Tue 10/12/10
189		**Make Recommendation on Existing Assets for Final Infrastructure**	**15 days**	**Wed 10/13/10**	**Tue 11/2/10**
190		Select existing assets for directories	15 days	Wed 10/13/10	Tue 11/2/10
191		Select existing health care quality and health information organization assets	15 days	Wed 10/13/10	Tue 11/2/10
192		Select Medicaid assets	15 days	Wed 10/13/10	Tue 11/2/10
193		Select public health assets	15 days	Wed 10/13/10	Tue 11/2/10
194		**Organize and Complete Vendor (Fair) Demonstration**	**72 days**	**Wed 8/11/10**	**Thu 11/18/10**
195		Prepare Notice	10 days	Wed 8/11/10	Tue 8/24/10
196		Prepare Scenarios	10 days	Wed 8/11/10	Tue 8/24/10
197		Submit Scenarios	30 days	Wed 8/11/10	Tue 9/21/10
198		Develop Criteria	10 days	Mon 9/6/10	Fri 9/17/10
199		Draft Plan and Schedule	10 days	Mon 9/13/10	Fri 9/24/10
200		Implement Plan	48 days	Mon 9/13/10	Wed 11/17/10
201		Complete Demonstrations	1 day	Thu 11/18/10	Thu 11/18/10
202		**Define and Complete RFP Process**	**56 days**	**Mon 10/4/10**	**Mon 12/20/10**
203		RFP Planning	56 days	Mon 10/4/10	Mon 12/20/10
204		Draft RFP	56 days	Mon 10/4/10	Mon 12/20/10
205		Release RFP	56 days	Mon 10/4/10	Mon 12/20/10
206		Close RFP	56 days	Mon 10/4/10	Mon 12/20/10
207		Vendor Selection	56 days	Mon 10/4/10	Mon 12/20/10
208		**Select hosting environment (through vendor or procurement)**	**30 days**	**Mon 1/3/11**	**Fri 2/11/11**
209		Set-up hosting services for the SHIN	30 days	Mon 1/3/11	Fri 2/11/11
210		Establish operational performance monitoring requirements	30 days	Mon 1/3/11	Fri 2/11/11
211		**Set-up core infrastructure**	**100 days**	**Mon 2/14/11**	**Fri 7/1/11**
212		Use existing assets	100 days	Mon 2/14/11	Fri 7/1/11
213		Set-up core infrastructure	100 days	Mon 2/14/11	Fri 7/1/11
214		**Survey consumers about HIE services they are most likely to use and purchase**	**480 days**	**Mon 4/2/12**	**Sat 2/1/14**
215		Develop survey	44 days	Mon 4/2/12	Fri 6/1/12

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Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID	Task Name	Duration	Start	Finish
216	Deploy survey	66 days	Fri 6/1/12	Sat 9/1/12
217	Analyze results of survey	20 days	Mon 9/3/12	Mon 10/1/12
218	Develop and market the identified services	350 days	Mon 10/1/12	Sat 2/1/14
219	**Public Health Specific Tasks**	**332 days?**	**Mon 8/9/10**	**Tue 11/15/11**
220	Roadmap to PH Meaningful Use	170 days	Mon 8/9/10	Fri 4/1/11
221	**Planning and Analysis**	**61 days?**	**Mon 8/9/10**	**Mon 11/1/10**
222	High level assessment of current capacity	9 days	Mon 8/9/10	Thu 8/19/10
223	Designate PH MU Project Manager/Coordinator	1 day	Fri 9/3/10	Fri 9/3/10
224	Set goal for system readiness	1 day	Wed 9/15/10	Wed 9/15/10
225	**Develop project plan for meeting PH MU goals**	**40 days?**	**Mon 8/9/10**	**Fri 10/1/10**
226	Identify likely EP/H submitters	1 day?	Wed 8/11/10	Wed 8/11/10
227	Identify likely EP/H volume	1 day?	Wed 8/11/10	Wed 8/11/10
228	Perform system gap analysis	1 day?	Wed 8/11/10	Wed 8/11/10
229	System gap analysis complete	1 day	Fri 10/1/10	Fri 10/1/10
230	Develop work/cost estimates	1 day	Mon 8/9/10	Mon 8/9/10
231	Work/cost estimates complete	1 day?	Wed 8/11/10	Wed 8/11/10
232	Project plan completed	1 day	Mon 11/1/10	Mon 11/1/10
233	Determine relationship with other actors	1 day?	Wed 8/11/10	Wed 8/11/10
234	Identify additional Medicaid requirements	1 day?	Wed 8/11/10	Wed 8/11/10
235	Identify changes to privacy/security rules	1 day?	Wed 8/11/10	Wed 8/11/10
236	Monitor evolving syndromic surveillance requirements	1 day?	Wed 8/11/10	Wed 8/11/10
237	Monitor modifications/clarifications to MU requirements	1 day?	Wed 8/11/10	Wed 8/11/10
238	Identify funding	1 day?	Wed 8/11/10	Wed 8/11/10
239	Plan for workflow/workforce changes	1 day?	Wed 8/11/10	Wed 8/11/10
240	Identify need for additional training	1 day?	Wed 8/11/10	Wed 8/11/10
241	**Communications**	**332 days?**	**Mon 8/9/10**	**Tue 11/15/11**
242	Develop communications strategy and plan	1 day	Mon 8/9/10	Mon 8/9/10
243	Report on goals to _____	1 day	Wed 9/22/10	Wed 9/22/10
244	Notify Regional Extension Centers of goals	1 day	Wed 9/22/10	Wed 9/22/10
245	Notify EP/H of goals	1 day	Fri 10/1/10	Fri 10/1/10
246	Report on gap analysis to _____	1 day	Fri 10/8/10	Fri 10/8/10
247	Report final implementation plans	1 day	Mon 11/22/10	Mon 11/22/10
248	Finalize test communications plan	256 days	Tue 11/23/10	Tue 11/15/11
249	Report readiness status to _____	1 day	Tue 11/15/11	Tue 11/15/11
250	Plan for offering technical assistance	1 day?	Wed 8/11/10	Wed 8/11/10
251	**Implementation**	**168 days?**	**Wed 8/11/10**	**Fri 4/1/11**
252	HW/SW modifications	70 days	Tue 11/23/10	Mon 2/28/11
253	Develop process to validate provider claims	1 day?	Wed 8/11/10	Wed 8/11/10
254	Test ability to receive MU submission	23 days	Tue 3/1/11	Thu 3/31/11
255	Initiate tests and submissions	1 day	Fri 4/1/11	Fri 4/1/11
256	**Business and Technical Operations**	**1006 days**	**Thu 4/1/10**	**Fri 2/7/14**
257	**Develop a process for on-going decisions on HIE Exchange Standards**	**55 days**	**Mon 9/27/10**	**Fri 12/10/10**
258	Define governance structure for connect exchange standards and interoperability	55 days	Mon 9/27/10	Fri 12/10/10

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Split		Summary		External Milestone	
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ID	Task Name	Duration	Start	Finish
259	Review approach for implementing NHIN standards that will enable integration and interoperability	55 days	Mon 9/27/10	Fri 12/10/10
260	Check that standards are compatible with ONC's EHR certification rule	55 days	Mon 9/27/10	Fri 12/10/10
261	**Maintain communications with key stakeholders and the general public on the WIRED for Health project**	**1002 days**	**Thu 4/1/10**	**Sat 2/1/14**
262	Maintain content of eHealth Initiative, WIRED from Health Board, and SharePoint Sites	980 days	Mon 5/3/10	Sat 2/1/14
263	Develop and publish messages to the eHealth listserv as needed	980 days	Mon 5/3/10	Sat 2/1/14
264	Develop and disseminate press releases as needed	1002 days	Thu 4/1/10	Sat 2/1/14
265	Develop and maintain SDE Web site and content	784 days	Tue 2/1/11	Sat 2/1/14
266	**Design and implement a comprehensive HIE communication and educational program**	**954 days**	**Mon 6/14/10**	**Fri 2/7/14**
267	**Develop plan for information gathering and a gap analysis on stakeholder understanding of key HIT and HIE topics**	**54 days**	**Tue 3/1/11**	**Sun 5/15/11**
268	Implement plan to gather data	44 days	Tue 3/1/11	Sat 4/30/11
269	Analyze data gathered	10 days	Mon 5/2/11	Sun 5/15/11
270	**Develop and deploy messages and educational materials on HIE to priority stakeholders**	**175 days**	**Fri 11/12/10**	**Fri 7/15/11**
271	Identify priority stakeholders	12 days	Mon 5/16/11	Wed 6/1/11
272	Develop messages and educational materials (build on existing materials)	44 days	Mon 5/16/11	Fri 7/15/11
273	Test messages/educational materials and modify	22 days	Wed 6/15/11	Fri 7/15/11
274	Identify partner organizations and deploy messages/educational material to stakeholders	1 day	Fri 11/12/10	Mon 11/15/10
275	**Evaluate the success of initial communications/educational materials**	**954 days**	**Mon 6/14/10**	**Fri 2/7/14**
276	Develop measures and methods to collect evaluation data	1 day	Mon 6/14/10	Tue 6/15/10
277	Measure results of initial communications/educational materials	1 day	Wed 7/14/10	Thu 7/15/10
278	Revise messages/educational material, and redeploy and test	670 days	Fri 7/15/11	Fri 2/7/14
279	Develop and implement a Continuous Quality Improvement (CQI) process	593 days	Tue 11/1/11	Fri 2/7/14
280	**Develop and deploy messages about protected health information maintained by HIEs and an individual's rights**	**632 days**	**Thu 9/1/11**	**Sat 2/1/14**
281	Develop messages (build on existing materials)	87 days	Thu 9/1/11	Sat 12/31/11
282	Test messages and modify	44 days	Tue 11/1/11	Sat 12/31/11
283	Deploy messages and use CQI to assure effectiveness	545 days	Mon 1/2/12	Sat 2/1/14
284	Establish a crisis communication plan and protocols	87 days	Wed 8/11/10	Thu 12/9/10
285	**Finance**	**865 days**	**Mon 9/20/10**	**Fri 1/10/14**
286	**Finance Sustainability Planning Meetings**	**98 days**	**Mon 9/20/10**	**Wed 2/2/11**
287	September Sustainability Planning Meeting	1 day	Mon 9/20/10	Mon 9/20/10
288	October Sustainability Planning Meeting	1 day	Wed 10/20/10	Wed 10/20/10
289	November Sustainability Planning Meeting	1 day	Wed 11/10/10	Wed 11/10/10
290	December Sustainability Planning Meeting	1 day	Wed 12/8/10	Wed 12/8/10
291	January Sustainability Planning Meeting	1 day	Wed 1/19/11	Wed 1/19/11
292	February Sustainability Planning Meeting	1 day	Wed 2/2/11	Wed 2/2/11
293	**Develop Finance Sustainability Plan**	**104 days**	**Mon 9/20/10**	**Thu 2/10/11**
294	**Meeting with the Finance Committee**	**10 days**	**Mon 9/20/10**	**Fri 10/1/10**
295	Plan Committee Involvement Through Sustainability Plan	5 days	Wed 9/22/10	Tue 9/28/10
296	Validate Implementation Tasks	10 days	Mon 9/20/10	Fri 10/1/10
297	**Key Financial Sustainability Review Dates**	**93 days**	**Mon 9/20/10**	**Wed 1/26/11**
298	September Sustainability Review Date	1 day	Mon 9/20/10	Mon 9/20/10
299	October Sustainability Review Date	1 day	Wed 10/20/10	Wed 10/20/10
300	November Sustainability Review Date	1 day	Wed 11/10/10	Wed 11/10/10
301	December Sustainability Review Date	1 day	Wed 12/8/10	Wed 12/8/10

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ID	Task Name	Duration	Start	Finish
302	January Sustainability Review Date	1 day	Wed 1/26/11	Wed 1/26/11
303	**Finance Sustainability Plan Document Write-Up**	**93 days**	**Mon 9/27/10**	**Wed 2/2/11**
304	Write Draft Finance Sustainability Plan	80 days	Mon 9/27/10	Fri 1/14/11
305	Submit Finance Sustainability Plan for Review	4 days	Mon 1/17/11	Thu 1/20/11
306	Refine Sustainability Plan Based on First Review Comments	3 days	Fri 1/21/11	Tue 1/25/11
307	Refine Sustainability Plan Based on Second Review Comments	3 days	Wed 1/26/11	Fri 1/28/11
308	Refine Sustainability Plan Based on Third Review Comments	3 days	Mon 1/31/11	Wed 2/2/11
309	Complete Financial Sustainability Plan Document	5 days	Thu 2/3/11	Wed 2/9/11
310	**Components of Financial Sustainability Plan**	**104 days**	**Mon 9/20/10**	**Thu 2/10/11**
311	**Benefits Analysis**	**100 days**	**Mon 9/20/10**	**Fri 2/4/11**
312	**Revisit Existing Benefits Analysis**	**95 days**	**Mon 9/20/10**	**Fri 1/28/11**
313	Re-Evaluate Benefits Analysis Approach	15 days	Mon 9/20/10	Fri 10/8/10
314	Develop Benefits Analysis Approach	10 days	Mon 10/11/10	Fri 10/22/10
315	Conduct Benefits Analysis	65 days	Mon 10/25/10	Fri 1/21/11
316	Determine the tangible and intangible benefits of the planned HIE services	5 days	Mon 1/24/11	Fri 1/28/11
317	**Benefits Analysis Write-up**	**60 days**	**Mon 11/15/10**	**Fri 2/4/11**
318	Begin Writing Benefits Portion of the Sustainability Plan	50 days	Mon 11/15/10	Fri 1/21/11
319	Incorporate Benefits Analysis Data	5 days	Mon 1/31/11	Fri 2/4/11
320	Review with SDE	1 day	Fri 2/4/11	Fri 2/4/11
321	Benefit Analysis Complete	0 days	Fri 2/4/11	Fri 2/4/11
322	**Cost Analysis**	**90 days**	**Mon 10/4/10**	**Fri 2/4/11**
323	Costs Estimates from Potential Technical Operator Submitted	1 day	Wed 11/17/10	Wed 11/17/10
324	Review Technical Operator Proposed Costs	12 days	Thu 11/18/10	Fri 12/3/10
325	Use Estimates to Create Revised Cost Estimate Diagrams	5 days	Mon 12/6/10	Fri 12/10/10
326	**Cost Estimate Write-up**	**90 days**	**Mon 10/4/10**	**Fri 2/4/11**
327	Begin Writing Cost Estimate Portion of the Sustainability Plan	20 days	Mon 10/4/10	Fri 10/29/10
328	Incorporate Cost Data Received Potential Technical Operators	4 days	Mon 12/6/10	Thu 12/9/10
329	Cost Analysis Draft Complete	1 day	Fri 12/10/10	Fri 12/10/10
330	Review Work Completed with New SDE	1 day	Mon 1/10/11	Mon 1/10/11
331	Review Draft with SDE	1 day	Thu 2/3/11	Thu 2/3/11
332	Obtain Sign-Off for Cost Estimate Write-Up	1 day	Fri 2/4/11	Fri 2/4/11
333	**Revenue Analysis**	**104 days**	**Mon 9/20/10**	**Thu 2/10/11**
334	**Stakeholder Assessment**	**86 days**	**Mon 9/20/10**	**Mon 1/17/11**
335	**Stakeholder Assessment Preparation**	**17 days**	**Mon 9/20/10**	**Tue 10/12/10**
336	Make A List of Target Stakeholder Contacts	5 days	Mon 9/20/10	Fri 9/24/10
337	Develop Materials for Stakeholder Analysis	5 days	Mon 9/27/10	Fri 10/1/10
338	Send Out Stakeholder Analysis Communication	3 days	Mon 10/4/10	Wed 10/6/10
339	Set-Up Interview Times	4 days	Thu 10/7/10	Tue 10/12/10
340	**Speak with Various Stakeholder Groups About Revenue Feasibility**	**54 days**	**Wed 11/3/10**	**Mon 1/17/11**
341	Compile Results of Stakeholder Assessment	54 days	Wed 11/3/10	Mon 1/17/11
342	Collect and Compile Data from Stakeholder Assessment	3 days	Wed 11/3/10	Fri 11/5/10
343	Analyze data and make projections about the target market	3 days	Mon 1/3/11	Wed 1/5/11
344	Document a Draft of the Data Results for the Sustainability Plan	5 days	Thu 1/6/11	Wed 1/12/11

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345	Review the Stakeholder Assessment with SDE	3 days	Thu 1/13/11	Mon 1/17/11
346	**Revisit Existing Revenue Analysis**	**55 days**	**Mon 11/15/10**	**Mon 1/31/11**
347	Evaluate Finance SOP Revenue Approach with Stakeholder Assessment	45 days	Mon 11/15/10	Fri 1/14/11
348	Re-Develop Finance Approach	10 days	Mon 1/17/11	Fri 1/28/11
349	Review Approach with SDE	10 days	Mon 1/17/11	Fri 1/28/11
350	Obtain Approach Approval	0 days	Mon 1/31/11	Mon 1/31/11
351	**Revenue Write-up for Sustainability Plan**	**83 days**	**Mon 10/18/10**	**Wed 2/9/11**
352	Begin Writing Finance Portion of the Sustainability Plan	30 days	Mon 10/18/10	Fri 11/26/10
353	Incorporate Results of Stakeholder Analysis	5 days	Thu 1/6/11	Wed 1/12/11
354	Finance Approach Complete	5 days	Thu 1/13/11	Wed 1/19/11
355	Review with SDE	11 days	Thu 1/20/11	Thu 2/3/11
356	Obtain Sign-Off for the Revenue Write-Up	0 days	Thu 2/3/11	Thu 2/3/11
357	Format Sustainability Plan Before Submitting to SDE	4 days	Fri 2/4/11	Wed 2/9/11
358	Submit Sustainability Plan to ONC	0 days	Thu 2/10/11	Thu 2/10/11
359	**Finance Tasks Beyond the Sustainability Plan Feb 2011 to Dec 2013**	**750 days**	**Mon 2/28/11**	**Fri 1/10/14**
360	**SDE Finance Status Meetings 2011**	**186 days**	**Wed 3/23/11**	**Wed 12/7/11**
361	schedule finance status meetings 2011	1 day	Wed 3/23/11	Wed 3/23/11
362	schedule finance status meetings 2011	1 day	Wed 4/20/11	Wed 4/20/11
363	schedule finance status meetings 2011	1 day	Wed 5/18/11	Wed 5/18/11
364	schedule finance status meetings 2011	1 day	Wed 6/15/11	Wed 6/15/11
365	schedule finance status meetings 2011	1 day	Wed 7/13/11	Wed 7/13/11
366	schedule finance status meetings 2011	1 day	Wed 8/17/11	Wed 8/17/11
367	schedule finance status meetings 2011	1 day	Wed 9/14/11	Wed 9/14/11
368	schedule finance status meetings 2011	1 day	Wed 10/12/11	Wed 10/12/11
369	schedule finance status meetings 2011	1 day	Wed 11/9/11	Wed 11/9/11
370	schedule finance status meetings 2011	1 day	Wed 12/7/11	Wed 12/7/11
371	**SDE Finance Status Meetings 2012**	**231 days**	**Wed 1/18/12**	**Wed 12/5/12**
372	schedule finance status meetings 2012	1 day	Wed 1/18/12	Wed 1/18/12
373	schedule finance status meetings 2012	1 day	Wed 2/15/12	Wed 2/15/12
374	schedule finance status meetings 2012	1 day	Wed 3/14/12	Wed 3/14/12
375	schedule finance status meetings 2012	1 day	Wed 4/18/12	Wed 4/18/12
376	schedule finance status meetings 2012	1 day	Wed 5/16/12	Wed 5/16/12
377	schedule finance status meetings 2012	1 day	Wed 6/13/12	Wed 6/13/12
378	schedule finance status meetings 2012	1 day	Wed 7/18/12	Wed 7/18/12
379	schedule finance status meetings 2012	1 day	Wed 8/15/12	Wed 8/15/12
380	schedule finance status meetings 2012	1 day	Wed 9/12/12	Wed 9/12/12
381	schedule finance status meetings 2012	1 day	Wed 10/17/12	Wed 10/17/12
382	schedule finance status meetings 2012	1 day	Wed 11/14/12	Wed 11/14/12
383	schedule finance status meetings 2012	1 day	Wed 12/5/12	Wed 12/5/12
384	**SDE Finance Status Meetings 2013**	**231 days**	**Wed 1/16/13**	**Wed 12/4/13**
385	schedule finance status meetings 2013	1 day	Wed 1/16/13	Wed 1/16/13
386	schedule finance status meetings 2013	1 day	Wed 2/13/13	Wed 2/13/13
387	schedule finance status meetings 2013	1 day	Wed 3/13/13	Wed 3/13/13

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Split		Summary		External Milestone	
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ID	Task Name	Duration	Start	Finish
388	schedule finance status meetings 2013	1 day	Wed 4/17/13	Wed 4/17/13
389	schedule finance status meetings 2013	1 day	Wed 5/15/13	Wed 5/15/13
390	schedule finance status meetings 2013	1 day	Wed 6/19/13	Wed 6/19/13
391	schedule finance status meetings 2013	1 day	Wed 7/17/13	Wed 7/17/13
392	schedule finance status meetings 2013	1 day	Wed 8/14/13	Wed 8/14/13
393	schedule finance status meetings 2013	1 day	Wed 9/18/13	Wed 9/18/13
394	schedule finance status meetings 2013	1 day	Wed 10/16/13	Wed 10/16/13
395	schedule finance status meetings 2013	1 day	Wed 11/13/13	Wed 11/13/13
396	schedule finance status meetings 2013	1 day	Wed 12/4/13	Wed 12/4/13
397	**Stakeholder Marketing Campaign**	**135 days**	**Mon 3/28/11**	**Fri 9/30/11**
398	Develop Stakeholder Marketing strategies, tools, and materials	20 days	Mon 3/28/11	Fri 4/22/11
399	Develop an advertising and promotion plan	85 days	Mon 6/6/11	Fri 9/30/11
400	Implement the advertising and promotion plan	85 days	Mon 6/6/11	Fri 9/30/11
401	Conduct Stakeholder Marketing Activities	85 days	Mon 6/6/11	Fri 9/30/11
402	Conduct Stakeholder Meetings	85 days	Mon 6/6/11	Fri 9/30/11
403	**Develop and market the identified services**	**30 days**	**Mon 4/25/11**	**Fri 6/3/11**
404	Physician Groups	30 days	Mon 4/25/11	Fri 6/3/11
405	Hospital Groups	30 days	Mon 4/25/11	Fri 6/3/11
406	Payer/Employer Groups	30 days	Mon 4/25/11	Fri 6/3/11
407	Patients	30 days	Mon 4/25/11	Fri 6/3/11
408	**Stakeholder Financing Process**	**30 days**	**Mon 5/2/11**	**Fri 6/10/11**
409	Develop a Subscription Process for HIE Stakeholders to Participate	21 days	Mon 5/2/11	Mon 5/30/11
410	Subscription Process Communication Plan	20 days	Mon 5/2/11	Fri 5/27/11
411	Develop Communication Plan for Stakeholders	10 days	Mon 5/2/11	Fri 5/13/11
412	Distribute a Communications to Stakeholders	10 days	Mon 5/16/11	Fri 5/27/11
413	Open Subscription Process to Stakeholders	10 days	Mon 5/30/11	Fri 6/10/11
414	**Financial Model Roll-Outs**	**289 days**	**Tue 3/1/11**	**Fri 4/6/12**
415	Implement Financial Mechanism by Stakeholder Type	60 days	Mon 1/16/12	Fri 4/6/12
416	**Philanthropy**	**30 days**	**Mon 3/7/11**	**Fri 4/15/11**
417	Identify Philanthropy Opportunities	15 days	Mon 3/7/11	Fri 3/25/11
418	Identify Philanthropy Application Process	5 days	Mon 3/28/11	Fri 4/1/11
419	Apply for Funding	10 days	Mon 4/4/11	Fri 4/15/11
420	**Pursuit of Grant Funding**	**75 days**	**Tue 3/1/11**	**Mon 6/13/11**
421	Evaluate Potential SHIN Grant Options	20 days	Tue 3/1/11	Mon 3/28/11
422	Choose Grant Options to Pursue	20 days	Tue 3/29/11	Mon 4/25/11
423	Begin Grant Application Processes	25 days	Tue 4/26/11	Mon 5/30/11
424	Submit Grant Applications	10 days	Tue 5/31/11	Mon 6/13/11
425	**Manage Budget**	**750 days**	**Mon 2/28/11**	**Fri 1/10/14**
426	Develop Process for Tracking Cost and Revenue	20 days	Mon 2/28/11	Fri 3/25/11
427	**Manage Costs**	**727 days**	**Thu 3/31/11**	**Fri 1/10/14**
428	**2011 Cost Reports**	**202 days**	**Thu 3/31/11**	**Fri 1/6/12**
429	Cost Report 1st Quarter	5 days	Thu 3/31/11	Wed 4/6/11
430	Cost Report 2nd Quarter	5 days	Thu 6/30/11	Wed 7/6/11

Project: WIRED Implementation Plan
Date: Tue 8/24/10

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID	Task Name	Duration	Start	Finish
431	Cost Report 3rd Quarter	5 days	Fri 9/30/11	Thu 10/6/11
432	Cost Report 4th Quarter	5 days	Mon 1/2/12	Fri 1/6/12
433	**2012 Cost Reports**	**202 days**	**Fri 3/30/12**	**Mon 1/7/13**
434	Cost Report 1st Quarter	5 days	Fri 3/30/12	Thu 4/5/12
435	Cost Report 2nd Quarter	5 days	Fri 6/29/12	Thu 7/5/12
436	Cost Report 3rd Quarter	5 days	Fri 9/28/12	Thu 10/4/12
437	Cost Report 4th Quarter	5 days	Tue 1/1/13	Mon 1/7/13
438	**2013 Cost Reports**	**206 days**	**Fri 3/29/13**	**Fri 1/10/14**
439	Cost Report 1st Quarter	5 days	Fri 3/29/13	Thu 4/4/13
440	Cost Report 2nd Quarter	5 days	Fri 6/28/13	Thu 7/4/13
441	Cost Report 3rd Quarter	5 days	Mon 9/30/13	Fri 10/4/13
442	Cost Report 4th Quarter	5 days	Mon 1/6/14	Fri 1/10/14
443	**Manage Revenue**	**727 days**	**Thu 3/31/11**	**Fri 1/10/14**
444	**2011 Revenue Reports**	**202 days**	**Thu 3/31/11**	**Fri 1/6/12**
445	Revenue Report 1st Quarter	5 days	Thu 3/31/11	Wed 4/6/11
446	Revenue Report 2nd Quarter	5 days	Thu 6/30/11	Wed 7/6/11
447	Revenue Report 3rd Quarter	5 days	Fri 9/30/11	Thu 10/6/11
448	Revenue Report 4th Quarter	5 days	Mon 1/2/12	Fri 1/6/12
449	**2012 Revenue Reports**	**202 days**	**Fri 3/30/12**	**Mon 1/7/13**
450	Revenue Report 1st Quarter	5 days	Fri 3/30/12	Thu 4/5/12
451	Revenue Report 2nd Quarter	5 days	Fri 6/29/12	Thu 7/5/12
452	Revenue Report 3rd Quarter	5 days	Fri 9/28/12	Thu 10/4/12
453	Revenue Report 4th Quarter	5 days	Tue 1/1/13	Mon 1/7/13
454	**2013 Revenue Reports**	**206 days**	**Fri 3/29/13**	**Fri 1/10/14**
455	Revenue Report 1st Quarter	5 days	Fri 3/29/13	Thu 4/4/13
456	Revenue Report 2nd Quarter	5 days	Fri 6/28/13	Thu 7/4/13
457	Revenue Report 3rd Quarter	5 days	Mon 9/30/13	Fri 10/4/13
458	Revenue Report 4th Quarter	5 days	Mon 1/6/14	Fri 1/10/14
459	**Track Risks and Issues**	**610 days**	**Mon 3/7/11**	**Fri 7/5/13**
460	Develop Process for Tracking Risk and Issues	15 days	Mon 3/7/11	Fri 3/25/11
461	**Risks Reporting**	**527 days**	**Thu 6/30/11**	**Fri 7/5/13**
462	Risk Reporting 2011 (As Needed)	10 days	Thu 6/30/11	Wed 7/13/11
463	Risk Reporting 2012 (As Needed)	10 days	Mon 6/25/12	Fri 7/6/12
464	Risk Reporting 2013 (As Needed)	10 days	Mon 6/24/13	Fri 7/5/13
465	**Issues Reporting**	**527 days**	**Thu 6/30/11**	**Fri 7/5/13**
466	Issues Reporting 2011 (As Needed)	10 days	Thu 6/30/11	Wed 7/13/11
467	Issues Reporting 2012 (As Needed)	10 days	Mon 6/25/12	Fri 7/6/12
468	Issues Reporting 2013 (As Needed)	10 days	Mon 6/24/13	Fri 7/5/13
469	**Track Metrics / Performance**	**705 days**	**Mon 5/2/11**	**Fri 1/10/14**
470	**Metric Reporting**	**705 days**	**Mon 5/2/11**	**Fri 1/10/14**
471	Identify Metrics Variables to Track	15 days	Mon 5/2/11	Fri 5/20/11
472	Develop Tools to Track Metrics	15 days	Mon 5/23/11	Fri 6/10/11
473	**Marketing Metrics**	**683 days**	**Wed 6/1/11**	**Fri 1/10/14**

Project: WIRED Implementation Plan
Date: Tue 8/24/10

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

ID		Task Name	Duration	Start	Finish
474		Develop marketing performance measures	50 days	Wed 6/1/11	Tue 8/9/11
475		Measures and evaluate performance	683 days	Wed 6/1/11	Fri 1/10/14
476		**Metrics/Performance Reporting**	**527 days**	**Thu 6/30/11**	**Fri 7/5/13**
477		Metrics Reporting 2011 (As Needed)	10 days	Thu 6/30/11	Wed 7/13/11
478		Metrics Reporting 2012 (As Needed)	10 days	Mon 6/25/12	Fri 7/6/12
479		Metrics Reporting 2013 (As Needed)	10 days	Mon 6/24/13	Fri 7/5/13

Project: WIRED Implementation Plan
Date: Tue 8/24/10

Task		Milestone		External Tasks	
Split		Summary		External Milestone	
Progress		Project Summary		Deadline	

APPENDIX 26

WIRED for Health

Strategic and Operational Risk Management Strategy

Version 1.0
August 17, 2010

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Introduction

Risk management is a systematic approach to identifying and addressing potential negative outcomes before they happen and setting up procedures that will avoid them, minimize their impact, or help cope with their impact. A risk is an uncertain event or condition that, if it occurs, has a negative effect on the project objective.[1] Risks have two key elements: 1. The probability of a specific risk occurring, 2. The impact on the project if the risk occurs.

This Risk Management Strategy (RMS) has been developed for the WIRED for Health Project. The RMS will ensure that potential issues are addressed at the earliest possible point and that explicit action plans, both preventive and contingent, are developed to reduce the probability of a risk occurring.

Purpose

Experience tells us that projects conducted without a dynamic risk management component are often late, over budget, or ineffective, particularly if the project is large, complex, critical and incorporating major change. Without formal risk management, project managers find themselves reacting to negative events and issues, rather than anticipating those events and managing in ways to decrease the likelihood that they will occur.

To be successful, risk management must be an ongoing dynamic process that is conducted through the life of the project. It begins with identifying risks and developing plans to manage those risks. It continues with regular risk monitoring, continued identification of new risks, and timely implementation of mitigation plans if an identified risk occurs.

In summary, a formal risk management process helps increase the likelihood of project's success by:

- Proactively identifying and assessing critical risks.
- Understanding the underlying causes, assumptions, and impacts of the risks.
- Addressing risks with targeted mitigation actions.
- Focusing efforts toward the areas of the most concern.
- Demonstrating that the probability or impact of the risk has been reduced to an acceptable level.
- Developing contingency plans for risks that cannot be alleviated.

Objectives

The objectives of this risk management strategy are to:

- Identify consistent processes and tools for the Risk Management process to be considered as the WIRED for Health Project enters implementation.
- Identify common roles and responsibilities in the risk management process.
- Identify a basis for risk ranking that matches the potential risk tolerance of the project stakeholders.
- Identify a communication approach for the dissemination of risk information.

[1] Risk definition is adapted from *A Guide to the Project Management Body of Knowledge*, 2000 Edition.

Key Principles

The following set of guidelines is provided to govern risk management processes:

- Risk is managed as part of a formal and continuous process throughout the project lifecycle.
- Risk management is a top-down, pro-active approach to managing risk.
- Major risks are escalated for communication, monitoring, and mitigation.
- Formal checkpoints and reviews identify when risks become issues and trigger actions.
- Risk management must be simple but effective.
- Focus is placed on risks that impact the critical success of the project.
- Contingency plans will be developed for critical, untreatable risks (see Appendix D).
- Assumptions, dependencies, and linkages behind every risk will be identified.
- Risk remaining after implementation of risk mitigation plan (i.e., residual risk) may be great enough to justify becoming a risk item.
- Some risk mitigations and contingencies expand the scope of the project. Scope changes resulting from risks should be managed using the Scope Change procedures.

Roles and Responsibilities

The following table outlines the key roles in Risk Management and the responsibilities associated with each.

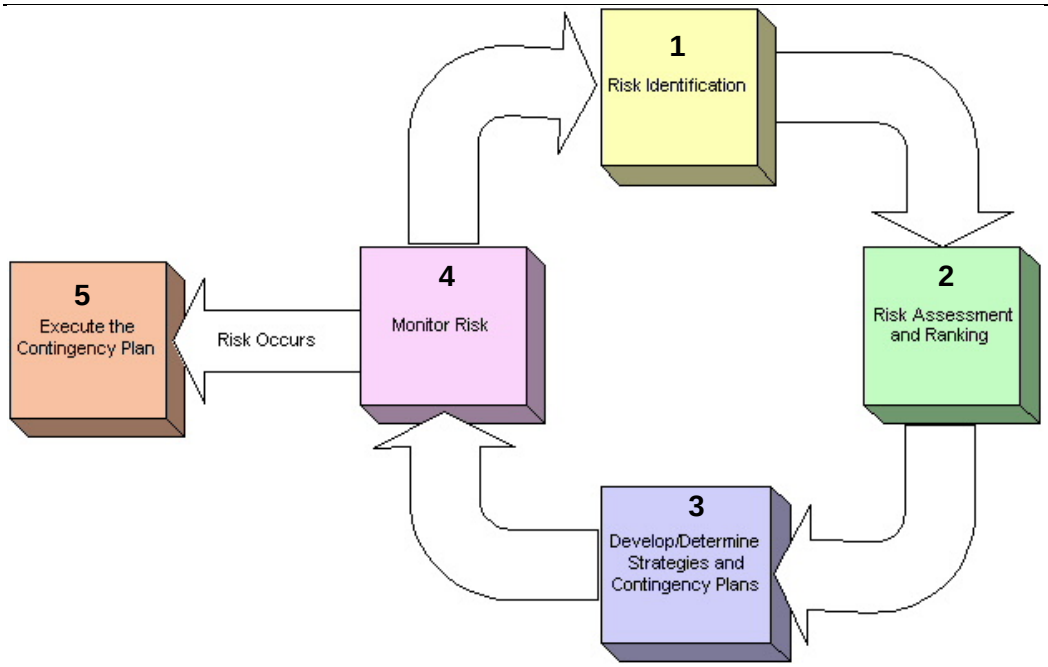
Role	Responsibility
Project Management Team	Identify risks. Review appropriateness of risk entries. Assess risks. Assign a risk owner. Update the risk information with all appropriate information. Monitor risk. Verify risk action is complete. Regularly review risk description, strategy, and plans.
Project Manager	Identify risks. The Project Manager has authority for authorizing risk mitigation and contingency plans. Review and approve proposed risk management plan. Evaluate cost justification for the proposed risk mitigation plan. Determine disposition of risk mitigation plan. Approve or disapprove risk mitigation plan. If approved, assign the proposed implementation of the risk mitigation plan. If disapproved, provide justification for disapproval.

Role	Responsibility
Risk Owner	Identify risks. Determine need for an issue, assumption, action item, or decision. Determine trigger events for contingency and mitigation actions Implement risk mitigation plans. Monitor risk triggers and implement contingency plans.
Risk Manager(s)	Identify risks. Monitor risks at a high level, ensuring the appropriate plans and responsibilities for monitoring risks are carried out.
Team Members	Identify risk. Send risk information to Risk Manager or complete Risk Identification form.

Risk Management Process

The following high-level steps are included in the risk management process. A summary of the steps and the various components of each are provided in this section.

0. Preparation and Planning
1. Identify the Risks
2. Assess and rank/prioritize the Risks
3. Develop/Determine Mitigation Strategies and/or Contingency Plans
4. Monitor/Review the Risks
5. Execute Contingency Plans as appropriate



0 – Preparation and Planning

Before the risk management process can begin, the following must be completed:

1. Risk Management Team: A risk management team should be established for the ongoing management of risk throughout the project's life cycle. The team will be responsible for identifying new risks, assessing risks, assigning/taking responsibility for risk mitigation strategies and/or contingency planning, monitoring risks, and invoking mitigation and contingency plans as appropriate.

2. Risk Tolerance: The overall "risk tolerance" for the project must be assessed. Determining the risk tolerance is critical to effective risk management because it allows the team to focus its attention on only those risks that have a high "pain" level for the project. If the Project Team is risk adverse the number or risks that get contingency plans or mitigation strategies will increase. The project's risk tolerance should be assessed several times throughout the course of the project because the potential for, and severity of, the pain gets more intense as the project progresses – because the further you go into a project, the more you have to lose if something goes wrong.

   The Risk Tolerance matrix for the project is shown in Appendix A.

3. Risk Monitoring and Ongoing Management: Determine the schedule for ongoing risk management meetings. Doing this up front will ensure that risk is continually managed and monitored throughout the life of the project.

   The Risk Management Communication and Monitoring strategy for the project is listed later in this document.

1 – Identify the Risks

Risk identification is an ongoing process throughout the life of the project. New risks will be identified as the project progresses. Risks should be identified and evaluated via day-to-day project management activities including regular risk reviews performed by the Project Management Team (PMT).

The first step of risk identification is to gather a risk management team and begin identifying risks to the project. For each risk identified, the following suggested information should be collected to ensure that the risk can be properly analyzed in the Risk Analysis step (step 2):

- Risk Number: Unique number assigned to the risk. The risk number increments by one for each subsequent risk identified.
- Date Identified: Date on which the risk is identified.
- Identified By: Individual or group who identified the risk.
- Risk Description: Information on the risk, its nature, etc.
- Phase: A risk may affect one or more phases of the project and should indicate the impacted phase.
- Risk Category: Risk categories are high-level classifications that can be directly related to the success of the project. The grouping of the risks into the risk categories is critical for determining the drivers of each risk. Risk categories also ensure that common mitigation strategies should be applied across the project phases. Suggested Risk Categories include Political, Leadership, Project Management, Resources (non-people), People, Technology, External Stakeholder Impact, and Transition to Operations. The SDE should develop a comprehensive list of risk categories with detailed description for each.

2 – Assess the Risks

The first step in assessing risk is to take each identified risk and agree on a probability (or likelihood) of the risk occurring during the project. Following are potential risk probability rankings:

Probability	Description
.1	Rare: 0 – 10% chance of occurrence.
.3	Unlikely: 11 – 25% chance of occurrence
.4	Moderate: 26 – 49% chance of occurrence
.6	Likely: 51 – 65% chance of occurrence
.7	Probable: 66- 75% chance of occurrence
.9	Almost Certain- 76 – 99% of occurrence

Some specific points to note about the probability rankings:

- There is no probability of zero (0); zero indicates that there is no chance of the risk occurring, which means that there is no risk.
- There is no probability of one (1); one indicates that the event has occurred, which makes it an issue, not a risk.
- There is no probability of ".5"; a .5 (or 50%) probability does not allow project management to be deterministic about the risk or about how to effectively manage that risk. To be effective, risk management requires a deterministic approach.

The second step in assessing risk is to identify the possible impact on the project if the specific risk occurs. It is important that everyone assessing risks have a common definition and understanding

of "impact." The following potential risk impact categories should be considered in assessing the impact of each risk. To ensure a common understanding of the different impact categories, an example and common analogy is included for each description.

Impact	Description	Example	Analogies
1	Negligible: Insignificant impact during the life cycle of the project. The consequences are dealt with by routine operations. Risks will have almost no impact if realized.	**Risk:** The development team is not located at the client site. **Implementation Impact:** May result in communication issues throughout the development and testing phases. **Operations Impact:** none	▪ Turbulence ▪ Delay on a direct flight ▪ Sitting next to <u>your</u> screaming 2-year old
2	Low: Minor impact to the implementation project. The consequences would threaten the efficiency or effectiveness of some aspects of the project. Management intervention is likely.	**Risk:** Project standards (communication, technical documentation, etc.) are not accessible and/or communicated to staff. **Implementation Impact:** May result in rework of communications plan to adhere to standards. **Operations Impact:** Stakeholders do not receive consistent responses from the implementation team.	▪ Lost Luggage ▪ Sitting next to <u>someone else's</u> screaming 2-year old
3	Medium: Average impact on the Implementation project. The consequences would not threaten the implementation of the SHIN but would mean that the scope would be subject to significant review and possible amendment. Senior Management intervention is required.	**Risk:** Requirements Sessions are not scheduled in a logical sequence. **Implementation Impact:** May result in incomplete requirements being collected and inadequate or incorrect system design. **Operations Impact:** The SHIN does not properly handle all the business needs. Users may need to perform specific business functions outside of the SHIN until the functionality is added to the system.	▪ Missed Connection ▪ Flying with a sinus infection
4	Very High: Major impact on the implementation project. The consequences would threaten the	**Risk:** Project workplan is not current. **Implementation Impact:**	▪ Emergency Landing ▪ Diversion

	implementation of the SHIN and would require management intervention at the highest level.	May result in the Project Management Team being unable to use the plan to monitor progress of the project. **Operations Impact:** The SHIN does not get implemented on time or within budget.	
5	Extreme: Tremendous impact on the implementation project. The consequences may halt the implementation of the SHIN.	**Risk:** Federal and State money to fund the project is unavailable. **Implementation Impact:** Implementation is postponed or cancelled. **Operations Impact:** The project is postponed or cancelled.	▪ Crash

Once each risk has been given a probability (P) and impact (I) category, the risk should be "normalized" (N) so that unlike risks can be ranked/prioritized (for example, normalizing risk allows you to compare schedule risks against budget risks). Normalization should be conducted using the following formula:

$$N = P*I$$

Normalized risks can then be assigned a ranking/priority according to the risk tolerance thresholds of the project. These thresholds should be determined by management and used by the risk management team to determine which risks need mitigation strategies or contingency plans. This allows the team to focus its attention on the severe and high/major priority risks. See Appendix A for the Risk Tolerance Matrix for the project. The suggested risk ranking/priority categories for the project include:

- Severe
- Major
- Significant
- Moderate
- Low

Additional information should be collected for each risk where appropriate, including:

- Date Updated: Date on which the risk information was last updated.
- Internal / External: Indicator of whether the risk is due to or controllable by entities internal or external to the project.
- Status: Indicator of where the issue is in its stages of resolution (such as OPEN, CLOSED, CANCELLED, etc.).
- Mitigation Plan: Brief description of the strategy for mitigating the risk.
- Contingency Plan – Yes/No indicator of whether a plan has been constructed to handle this risk.

Finally, each risk should be assigned an owner and a due date. The owner should be responsible for the day-to-day monitoring of the risk and ensuring that mitigation and contingency plans are created when necessary. They are also responsible for ensuring that "triggers" are identified in both the budget and workplan that will help determine if the risk assessment (probability or impact) needs to be modified. The due date determines when the mitigation or contingency plan must be complete to ensure those plans can be executed if/when needed.

3 – Develop/Determine Mitigation Plans and Contingency Plans

Mitigation is the process of lessening the probability or the impact of a specific risk. The Risk Mitigation Strategy includes information on how the risk should be addressed by project management in terms of resources, time, and tasks. At a minimum, those risks that are identified, through the risk assessment process, as having a *Severe* and *Major* ranking should have mitigation plans associated with them. In addition, Risk Contingency Plans should be developed for risks with a *Severe* ranking. See Appendix D for some sample Contingency Plans.

- Depending on the ranking/priority of the risk, the following actions should be taken:

  Severe Risks: Prepare a Risk Contingency Plan. This includes the steps to be taken in the event the risk occurs as well as "triggers" in the project that will allow the project team to know that the Contingency Plan needs to be executed. The Contingency Plan is also sometimes referred to as the "Back-up" plan or the "Back-out" plan. The Contingency Plan attempts to reduce the impact of the risk on the project once the risk has occurred.

  Severe and *Major* Risks: Prepare a Risk Mitigation Plan. This includes key steps to be taken in order to reduce the probability or the impact of the specific risk. Project "triggers" are identified in the Risk Mitigation Plan to allow for proper monitoring of the risks. The plan should strive to reduce the ranking/priority of each risk to an acceptable level.

  Significant, Moderate, and *Low* Risks: Monitor risks to help ensure the probability or impact of the risk is modified as necessary throughout the life of the project.

4 – Monitor/Review the Risks

Risk management review activities should be conducted to help ensure risks are being correctly identified, appropriately assessed, and managed. This includes:

- Day-to-day risk review by risk owner.
- Weekly risk review by the project management team at regularly scheduled weekly meetings.
- Quarterly risk review with the Board or project advisory team. This should include a formal review of the risk management plan.

5 – Execute Contingency Plans (as appropriate)

If a risk is realized (i.e., it occurs), the contingency plan for that risk must be executed.

Risk Management Communication and Monitoring Strategy

All risks ranked 4 or higher (severe) should be reviewed in detail on a monthly basis during regular status meeting. A full listing of risks should be reviewed by the SDE at every project status meeting. In addition, on a quarterly basis, the SDE should review the risk assessments and assigned rankings.

In addition, the SDE should consider including a "Risk Status" section in the status reports distributed for the Board. The Risk Status section will include:

- A summary of any new risk(s) identified during the reporting period.
- A summary of any risks prevented/avoided during the reporting period.
- A summary of any risks requiring mitigation during the reporting period.
- A summary of any risks where contingency plans were executed during the reporting period.

Risk identification and monitoring should be a standing agenda item for the project team meetings.

In addition, risk management meetings should be held on a regular basis to continuously assess new risks and re-evaluate existing risks.

Risk owners should monitor risks on a frequent or daily basis.

Planning for Operational Risk Management

Six months prior to go-live, the Risk Management Team should begin identifying potential risks to operations. These risks should be identified, assessed, and monitored in accordance with this strategy. This would allow the team to focus only on implementation risks and also allow adequate planning for potential operational risks.

Summary

The project management team should take a sensible approach to managing risk by implementing a Risk Management Strategy. The likelihood of the project's success will be increased significantly by following a well-defined strategy that identifies, assesses and mitigates and monitors risks. Project success will be increased by:

- Encouraging proactive project management activities rather than reactive project management activities.
- Implementing steps to reduce or control risks.
- Planning contingencies to alleviate the consequences of risks.

Risk management is a dynamic and continuous process that will occur throughout the life of the project. As a result, project management should continuously identify, assess, prioritize, mitigate and monitor risks as defined in this strategy.

Appendix A: Risk Tolerance Matrix

		Probability					
		0.1 Rare	**0.3 Unlikely**	**0.4 Moderate**	**0.6 Likely**	**0.7 Probable**	**0.9 Almost Certain**
Impact	**1 Negligible**	0.1 Low	0.3 Low	0.4 Low	0.6 Low	0.7 Low	0.9 Low
	2 Low	0.2 Low	0.6 Low	0.8 Low	1.2 Moderate	1.4 Moderate	1.8 Moderate
	3 Medium	0.3 Low	0.9 Low	1.2 Moderate	1.8 Moderate	2.1 Significant	2.7 Significant
	4 Very High	0.4 Low	1.2 Moderate	1.6 Moderate	2.4 Significant	2.8 Significant	3.6 Major
	5 Extreme	0.5 Low	1.5 Moderate	2.0 Significant	3.0 Major	3.5 Major	4.5 Severe

Normalized Risk Score	**Rank**
<1	Low
1.0-1.9	Moderate
2.0-2.9	Significant
3.0-3.9	Major
4+	Severe

Appendix B: Terms and Definitions

Term	Definition
Risk	A risk is an uncertain event or condition that, if it occurs, has a negative effect on the project objective.
Risk Management	Systematically thinking about potential negative outcomes before they happen and setting up procedures that will avoid them, minimize their impact, or help you cope with their impact
Mitigation Plan	An action taken to reduce or eliminate the probability and impact of an identified risk before it occurs.
Contingency Plan	The action(s) to be taken if a previously identified risk event should occur.
Residual Risk	Risk remaining after a risk mitigation action has been implemented.
Risk Management Log	A centralized repository for documenting and tracking project risks.

APPENDIX 27

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
1	**Strategic Plan**		**Combined with Operational Plan**		
2	The strategic planning process includes the development of the initial Strategic Plan and ongoing updates. There are distinct and/or concurrent planning activities for each domain that need to be coordinated and planned. The Strategic Plan may address the evolution of capabilities supporting HIE, as well as progress in the five domains of HIE activity, the role of partners and stakeholders, and high-level project descriptions for planning, implementation, and evaluation.	FOA			
3	**Operational Plan**		**Combined with Strategic Plan**		
4	Prior to entering into funded implementation activities, a state must submit and receive approval of the Operational Plan. The Operational Plan shall include details on how the Strategic Plan will be carried forward and executed to enable statewide HIE.	FOA			
5	**General Components**				
6	**Environmental Scan**		**4.1 Environmental Scan for HIE Readiness and Adoption**		
7	Environmental scan of HIE readiness	FOA	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
8	Broad adoption of HIT	FOA	3.1 Ambulatory Care Providers and Hospitals	Y	
9	HIE adoption across health care providers within the state	FOA	4.1.1 Clinical HIE Capabilities	Y	
10	HIE adoption across health care providers potentially external to the state	FOA	4.1 Environmental Scan for HIE Readiness and Adoption 4.1.1.1 Clinical Summary Exchange for Care Coordination	Y	
11	Overview of the penetration of electronic lab delivery	ONC PIN	4.1.1.4 Electronic Clinical Laboratory Ordering and Results Delivery Appendix 7 - Pharmacy and Lab HIE Capability Data Collection Process	Y	
12	Overview of the penetration of e-prescribing networks	ONC PIN	4.1.1.3 Electronic Prescribing and Refill Requests Appendix 7 - Pharmacy and Lab HIE Capability Data Collection Process	Y	
13	Overview of the penetration of other existing HIE solutions	ONC PIN	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
14	Assessment of current HIE capacities that could be expanded or leveraged	FOA	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
15	HIT resources that could be used	FOA	3.3.2 HIT Workforce	Y	
16	Relevant collaborative opportunities that already exist	FOA	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
17	Human capital that is available	FOA	3.3.1 Wisconsin HIT Extension Center (WHITEC) 3.3.2 HIT Workforce	Y	
18	Other information that indicates the readiness of HIE implementation statewide	FOA	4.1.1 Clinical HIE Capabilities 4.1.2 Public Health HIE Capabilities 4.1.3 Health Plan HIE Capabilities	Y	
19	Measures to determine health information exchange taking place with data trading partners	ONC PIN	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
20	% pharmacies accepting electronic prescribing and refill requests	ONC PIN		Y	Pharmacy survey
21	% clinical laboratories sending results electronically	ONC PIN		Y	Lab survey
22	% health plans supporting electronic eligibility and claims transactions	ONC PIN		Y	
23	% health departments receiving immunizations, syndromic surveillance, and notifiable laboratory results	ONC PIN		Y	
24	**HIE Development and Adoption**		**4.2 Strategic Framework**		
25	Vision, goals, objectives and strategies associated with HIE capacity development and use among all health care providers in the state	FOA	4.2.1 Vision and Mission 4.2.2 Guiding Principles 4.2.3 Goals and Objectives	Y	
26	Meeting HIE meaningful use criteria to be established by the Secretary through the rulemaking process.	FOA	4.3 Technical Infrastructure and Services	Y	
27	Shall describe how [the states and SDEs] will invest federal dollars associated matching funds to enable providers to have at least one option for each of these Stage 1 meaningful use requirements in 2011:	ONC PIN		Y	
28	e-Prescribing	ONC PIN		Y	
29	Receipt of structured lab results	ONC PIN		Y	
30	Sharing patient care summaries across unaffiliated organizations	ONC PIN		Y	
31	Should describe a strategy and plan to address the other required information sharing capabilities, including:	ONC PIN		Y	

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
32	Building capacity of public health systems to accept electronic reporting of immunizations, notifiable diseases, and syndromic surveillance reporting from providers	ONC PIN		Y	
33	Enabling electronic meaningful use and clinical quality reporting to Medicaid and Medicare	ONC PIN		Y	
34	Continuous improvement in realizing appropriate and secure HIE across health care providers for care coordination and improvements to quality and efficiency of health care	FOA	4.1.1 Clinical HIE Capabilities 7.2.7.3 Alignment with Quality Measurement, Reporting, and Improvement Activities	Y	
35	HIE between health care providers, public health, and those offering services for patient engagement and data access	FOA	4.1.1 Clinical HIE Capabilities 4.1.2 Public Health HIE Capabilities 7.2.7.2 Alignment with Public Health	Y	
36	**HIT Adoption**		**3.0 HIT Adoption**		
37	Other HITECH ACT programs or state funded initiatives to advance HIT adoption in a state	FOA		Y	
38	While many states have already addressed HIT adoption in their existing Health IT State Plans, it is not a requirement	FOA		Y	
39	The inclusion of Health IT adoption in the Strategic Plan is valuable and provides for a more comprehensive approach for planning how to achieve connectivity across the state	FOA		Y	
40	**Medicaid Coordination**		**2.2.2 Coordination with Medicaid**		
41	Describe the interdependencies and integration of efforts between the state's Medicaid HIT Plan and the statewide HIE development efforts	FOA	2.2.2.1 Medicaid Participation in the WIRED for Health Project 2.2.2.2 Project Management Coordination	Y	
42	The state's HIE related requirements for meaningful use to be established by the Secretary through the rulemaking process and the mechanisms in which the state will measure provider participation in HIE	FOA	NA	NA	The State is not requiring additional state-specific MU criteria
43	Describe coordination with Medicaid, including the following required activities:	ONC PIN		Y	
44	Governance structure shall provide representation of the SMP	ONC PIN	2.2.2.1 Medicaid Participation in the WIRED for Health Project	Y	
45	Coordinate provider outreach and communications with the SMP	ONC PIN	3.3.1 Wisconsin HIT Extension Center (WHITEC) 8.7 Communications, Education, and Marketing Strategy Appendix 17 - Communications, Education, and Marketing Plan	Y	
46	Identify common business or health care outcome priorities	ONC PIN	2.2.2.1 Medicaid Participation in the WIRED for Health Project	Y	
47	Leverage, participate in, and support all Beacon Communities, RECs, and ONC funded workforce projects, in collaboration with the SMP	ONC PIN	3.1 Ambulatory Care Providers and Hospitals	Y	
48	Align efforts with the state Medicaid agency to meet Medicaid requirements for meaningful use	ONC PIN	2.2.2 Medicaid Participation in the WIRED for Health Project	Y	
49	Describe coordination with Medicaid, including the following **encouraged activities:**	ONC PIN		Y	
50	Obtain a letter of support from the Medicaid Director. If a letter of support is not provided, ONC will inquire as to why one was not provided and the lack of a letter may impact the approval of a state plan, depending on circumstances.	ONC PIN	2.3 Stakeholder Endorsement of the Plan	Y	
51	Conduct joint needs assessments.	ONC PIN	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
52	Conduct joint environmental scans.	ONC PIN	4.1 Environmental Scan for HIE Readiness and Adoption	Y	
53	Leverage existing Medicaid IT infrastructure when developing the health information exchange technical architecture.	ONC PIN	7.2.7.1 Alignment with Medicaid	Y	
54	Determine whether to integrate systems to accomplish objectives such as making Medicaid claims and encounters available to the health information exchange and information from non-Medicaid providers available to the Medicaid program.	ONC PIN	7.2.7.1 Alignment with Medicaid	Y	
55	Determine which specific shared services and technical services will be offered or used by Medicaid.	ONC PIN	7.2.7.1.1 Medicaid as a provider of statewide HIE services 7.2.7.1.2 Medicaid as a consumer of statewide HIE services	Y	
56	Determine which operational responsibilities the Medicaid program will have, if any.	ONC PIN	2.2.2.1 Medicaid Participation in the WIRED for Health Project	Y	
57	Use Medicaid HIT incentives to encourage provider participation in the health information exchange.	ONC PIN	3.3.3 Medicaid EHR Incentive Program 3.3.4 EHR Tax Credit 4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
58	Collaborate during the creation of payment incentives, including Pay for Performance under Medicaid, to encourage participation by additional provider types (e.g. pharmacies, providers ineligible for incentives).	ONC PIN	3.3.3 Medicaid EHR Incentive Program 3.3.4 EHR Tax Credit 4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
59	**Coordination of Medicare and Federally Funded, State Based Programs**		**2.2.3 Coordination of Medicare and Federally Funded, State Based Programs**		

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
60	Describe the coordination activities with Medicare and relevant federally-funded, state programs (see program guidance)	FOA	2.2.3 Coordination of Medicare and Federally Funded, State Based Programs	Y	Identified programs all reside within DHS
61	Coordination with Epidemiology and Laboratory Capacity Cooperative Agreement Program (CDC)	FOA		Y	
62	Coordination with Assistance for Integrating the Long-Term Care Population into State Grants to Promote Health IT	FOA		Y	
63	Coordination with Implementation (CMS/ASPE)	FOA		Y	
64	Coordination with HIV Care Grant Program Part B States/Territories Formula and Supplemental Awards/AIDS Drug Assistance Program Formula and Supplemental Awards (HRSA)	FOA		Y	
65	Coordination with Maternal and Child Health State Systems Development Initiative programs (HRSA)	FOA		Y	
66	Coordination with State Offices of Rural Health Policy (HRSA)	FOA		Y	
67	Coordination with State Offices of Primary Care (HRSA)	FOA		Y	
68	Coordination with State Mental Health Data Infrastructure Grants for Quality Improvement (SAMHSA)	FOA		Y	
69	Coordination with State Medicaid/CHIP Programs	FOA		Y	
70	Coordination with IHS and tribal activity	FOA		Y	
71	Coordination with Emergency Medical Services for Children Program (HRSA)	FOA		Y	
72	**Participation with federal care delivery organizations (encouraged but not required)**		**2.2.4 Coordination with Federal Care Delivery Organizations**		
73	Should include a description of the extent to which the various federal care delivery organizations will be participating in state activities related to HIE.	FOA	2.2.4 Coordination with Federal Care Delivery Organizations	Y	
74	Participation of VA	FOA		Y	
75	Participation of DoD	FOA		Y	
76	Participation of IHS	FOA		Y	
77	**Coordination with other ARRA programs**		**3.0 HIT Adoption**		
78	Coordination mechanisms with other relevant ARRA programs	FOA	3.0 HIT Adoption	Y	
79	Coordination with Regional Centers	FOA	3.3.1 Wisconsin HIT Extension Center (WHITEC)	Y	
80	Coordination with workforce development initiatives	FOA	3.3.2 HIT Workforce	Y	
81	Coordination with broadband mapping and access	FOA	7.2.8 Broadband Mapping and Access	Y	
82	Describe specific points of coordination and interdependencies with other relevant ARRA programs	FOA	3.0 HIT Adoption	Y	
83	Regional Centers	FOA	3.3.1 Wisconsin HIT Extension Center (WHITEC)	Y	
84	Workforce development initiatives	FOA	3.3.2 HIT Workforce	Y	
85	Broadband mapping and access	FOA	7.2.8 Broadband Mapping and Access	Y	
86	**Coordinate with Other States**		**2.2.5 Coordination with Other States**		
87	In order to share lessons learned and encourage scalable solutions between states, the Operational Plan shall describe multi-state coordination activities including the sharing of plans between states.	FOA		Y	
88	**Domain Requirements**				
89	**Governance**		**5.0 Governance**		
90	**Collaborative Governance Model**	FOA	5.1 Establishing a State-Level Governance Entity	Y	
91	Describe the multi-disciplinary, multi-stakeholder governance entity	FOA	5.1.1 Role of the SDE	Y	Act 274
92	Description of the membership	FOA	5.1.1 Role of the SDE	Y	Act 274
93	Description of decision-making authority	FOA	5.3 Decision Making Authority	Y	
94	Description of governance model	FOA	5.1.1 Role of the SDE	Y	Act 274
95	States are encouraged to consider how their state governance models will align with emerging nationwide HIE governance	FOA	5.5 Alignment with Nationwide HIE Governance	Y	
96	**State Government HIT Coordinator**	FOA	2.2.1 Role of the State HIT Coordinator	Y	
97	Strategic Plan shall identify the state Government HIT Coordinator	FOA		Y	
98	Describe how the state coordinator will interact with the federally funded state health programs	FOA		Y	
99	Describe how the state coordinator will interact with the HIE activities within the state	FOA		Y	
100	**Accountability and Transparency**	FOA	5.4 Oversight, Accountability, and Transparency	Y	

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
101	To ensure that HIE is pursued in the public's interest, the Strategic Plan shall address how the state is going to address HIE accountability and transparency.	FOA		Y	
102	Governance entity is holding regularly scheduled public meetings with active participation of key stakeholders	Toolkit Checklist		Y	
103	Track progress of meaningful use by documenting how the HIE efforts within the state are enabling meaningful use	Toolkit Checklist	5.4.3 ARRA Reporting and Evaluation Requirements	Y	
104	**Governance and Policy Structures**	FOA	5.0 Governance	Y	
105	Describe the ongoing development of the governance and policy structures	FOA	5.1 Establishing a State-Level Governance Entity 5.1.2 Selection of the SDE 9.3 Mechanisms to Refresh Legal and Policy Framework	Y	
106	Policy structures (bylaws and charter or organizational equivalents) established and endorsed by stakeholders	Toolkit Checklist	2.3 Stakeholder Endorsement of the Plan Appendix 5 - Letters of Support	Y	
107	**Medicaid Specific Tasks**	FOA			
108	What governance structure should be in place by 2014 in order to achieve your goals and objectives	FOA	5.1 Establishing a State-Level Governance Entity	Y	
109	What is missing today that needs to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies	FOA	NA	NA	Addressed in SMHP
110	**Finance**		**6.0 Finance**		
111	**Sustainability**	FOA	6.0 Finance	Y	
112	Ensure the financial sustainability of the project beyond the ARRA funding	FOA	6.2 Approach to Financial Sustainability	Y	
113	Business plan that enables for the financial sustainability, by the end of the project period of HIE governance and operations	FOA	6.2.1 Sustainability Success Factors	Y	
114	Shall describe initial thoughts for sustaining HIE activities during and after the cooperative agreement period	ONC PIN		Y	
115	Consider how to achieve sustainability based on the model being pursued and to incorporate any work that has been done to test the market acceptance of revenue models	ONC PIN		NA	To be included in Sustainability Plan
116	SDE as a Facilitator of Services:				
117	Shall describe preliminary plans for how sustainability of the HIE market in the state may be enhanced by state or SDE actions including any state policy or regulation	ONC PIN	6.5 SHIN Capital and Operational Revenue Sources	Y	
118	Address specific plans for sustainability of any directories or authentication services offered at the state level by the grantee during the course of the four-year program	ONC PIN	NA	NA	To be included in Sustainability Plan
119	SDE Directly Offering Services:				
120	Shall provide preliminary but realistic ideas on who will pay for the services and under what mechanisms (e.g., per transaction fees, subscription models, payers receiving a percentage allocation based on their covered base)	ONC PIN	6.5.1 Revenue Sources	Y	
121	Should consider how program sustainability can be supported by state policy or regulation including payment reforms to incentivize demand for information sharing or contracting requirements to ensure participation of key partners such as labs and pharmacies	ONC PIN	4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
122	**Cost Estimates and Staffing Plans**	Toolkit Checklist	**6.3 SHIN Capital and Operational Cost Estimates**	Y	
123	Provide a detailed cost estimate for the implementation of the Strategic Plan for the time period covered by the Operational Plan	FOA	6.3.1 Cost Estimate Data	Y	
124	Include a detailed schedule describing the tasks and sub-tasks that need to be completed in order to enable statewide HIE	FOA	10.0 Implementation Plan Appendix 27 - Implementation Plan	Y	
125	Include with resources	FOA		Y	
126	Include with dependencies	FOA		Y	
127	Include with specific timeframes	FOA		Y	
128	Recipients shall provide staffing plans including project managers and other key roles required to ensure the project's success	FOA	8.2 Staffing Plan	Y	
129	**Controls and Reporting**	FOA	**6.7 Transition to SDE and Controls and Reporting**	Y	
130	Describe activities to implement financial policies, procedures and controls to maintain compliance with generally accepted accounting principles (GAAP) and all relevant OMB circulars	FOA	6.7.2 Controls and Reporting 6.7.3 Audit Requirements	Y	

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
131	The organization will serve as a single point of contact to submit progress and spending reports periodically to ONC	FOA	6.7.2 Controls and Reporting	Y	
132	**Technical Infrastructure**		**7.0 Technical Infrastructure and Services**		
133	**Interoperability**	FOA	7.2 Reference Architecture	Y	
134	Indicate whether the HIE services will include participation in the NHIN	FOA	7.2.2.1 Architecture Description	Y	
135	Appropriate HHS adopted standards and certifications for health information exchange	FOA	7.2.4 Standards, Interoperability, and Certifications	Y	
136	Especially planning and accounting for meaningful use criteria to be established by the Secretary through the rulemaking process	FOA		Y	
137	**Technical Architecture/Approach (encouraged but not required)**	FOA	7.2 Reference Architecture	Y	
138	Because the state or SDE may or may not implement HIE, the Strategic Plan may include an outline of the data and technical architectures	FOA	7.2.1 Architecture Overview	Y	
139	Describe the approach to be used: Including the HIE services to be offered as appropriate for the state's HIE capacity development	FOA	7.2.2.1 Architecture Description	Y	
140	Describe how the technical architecture will accommodate the requirements to ensure statewide availability of HIE among healthcare providers, public health and those offering service for patient engagement and data access.	FOA	7.2.2.1 Architecture Description	Y	
141	Availability among healthcare providers	FOA		Y	
142	Availability among public health	FOA		Y	
143	Availability among those offering service for patient engagement and data access	FOA		Y	
144	Describe the technical approach taken to facilitate data exchange services within the state based on the model being pursued:	ONC PIN	7.2.2 Architectural Model and Data Flows	Y	
145	States and SDEs Facilitating Services:	ONC PIN		Y	
146	Shall describe the approach of obtaining statewide coverage of HIE services to meet meaningful use requirements and also the processes or mechanisms by which the state or SDE will ensure that the HIE services comply with national standards.	ONC PIN		Y	
147	States and SDEs Directly Offering Services:	ONC PIN		Y	
148	Shall provide either the detailed specifications or describe the process by which the detailed specifications will be developed (including shared directories or provider authentication services)	ONC PIN		Y	
149	For those plans that don't have a detailed architecture, the updated Notice of Award for implementation will have a requirement to provide the detailed plans at a later date.	ONC PIN		Y	
150	Include plans for the protection of health data	FOA	7.2.3 Authentication and Security 7.2.4 Standards, Interoperability, and Certifications	Y	
151	Reflect the business and clinical requirements determined via the multi-stakeholder planning process	FOA	7.2.1 Architecture Overview	Y	
152	If a state plans to exchange information with federal health care providers their plans must specify how the architecture will align with NHIN core services and specifications	FOA	7.2.4 Standards, Interoperability, and Certifications	Y	
153	Exchange with VA	FOA		Y	
154	Exchange with DoD	FOA		Y	
155	Exchange with IHS	FOA		Y	
156	**Standards and Certification**	FOA	7.2.4 Standards, Interoperability, and Certifications	Y	
157	Describe efforts to become consistent with HHS adopted interoperability standards and any certification requirements, for projects that are just starting	FOA		Y	
158	Should specify an explicit mechanism that ensures adoption and use of standards adopted or approved by the Department of Health and Human Services (HHS) as well as the appropriate engagement with ONC in the ongoing development and use of the NHIN specifications and national standards to support meaningful use	ONC PIN		Y	
159	Should explain how the states will encourage any vendors or service providers to follow national standards, address system modularity, data portability, re-use of interfaces, and vendor transition provisions	ONC PIN		Y	
160	**Technology Deployment**	FOA	7.3 Technology Deployment	Y	

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
161	Describe the technical solutions that will be used to develop HIE capacity within the state and particularly the solutions that will enable meaningful use criteria established by the Secretary for 2011, and indicate efforts for nationwide health information exchange	FOA	4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
162	Shall describe how they will invest federal dollars and associated matching funds to enable eligible providers to have at least one option for each of these Stage 1 meaningful use requirements in 2011	ONC PIN	4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
163	Outline a clear and viable strategy to ensure that all eligible providers in the state have at least one viable option in 2011;	ONC PIN	4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
164	Include a project timeline that clearly illustrates when tasks and milestones will be completed;	ONC PIN	10.1 Project Work Plan Appendix 25 - Implementation Plan	Y	
165	Provide an estimate of all the funding required, including all federal funding and state funding, used to enable stage one meaningful use requirements;	ONC PIN	6.5.1.1 Revenue Sources – Capitalization and Implementation	Y	
166	Indicate the role both in funding and coordination of the state Medicaid agency in achieving the state strategy;	ONC PIN	6.5 SHIN Capital and Operational Revenue Sources	Y	
167	Identify potential barriers and risks including approaches to mitigate them; and,	ONC PIN	10.2 Risks and Mitigation Strategies	Y	
168	Identify desired technical support and coordination from ONC to support the state strategy	ONC PIN		Y	Multiple needs were identified across all of the domains throughout the SOP
169	If a state plans to participate in the Nationwide Health Information Network (NHIN), their plans must specify how they will be complaint with HHS adopted standards and implementation specifications	FOA	7.2.4 Standards, Interoperability, and Certifications 7.2.5 Alignment with NHIN	Y	
170	**Medicaid Specific Tasks - Standards and Architecture**	FOA	7.2.7.1 Alignment with Medicaid	Y	
171	How the Medicaid Agency will support integration of clinical and administrative data	FOA		Y	
172	How the Medicaid Agency will promote the use of data and technical standards to enhance data consistency and data sharing through common data-access mechanisms	FOA		Y	
173	How the State and other Stakeholders have leveraged MMIS and other HIT technologies to support EHR adoption the exchange of health information, continuity of care and personal health records to promote quality health outcomes	FOA		Y	
174	Provide a description of data-sharing components of HIT solutions	FOA		Y	
175	How the Medicaid Agency will adopt national data standards for health and data exchange and open standards for technical solutions as they become available	FOA		Y	
176	How the Medicaid Agency will promote secure data exchange, where permissible under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA and other requirements included in the Recovery Act	FOA		Y	
177	What will your system architecture look like by 2014 to support achieving the 2014 goals and objectives? Web portals? Enterprise Service Bus? How will providers interface with your HIT/HIE program? With other medical professionals? With their patients?	FOA		Y	
178	**Business and Technical Operations**		**8.0 Implementation and Operations**		
179	**Implementation**	FOA	8.0 Implementation and Operations	Y	
180	Address how the state plans will develop HIE capacity	FOA	8.3 Technical Assistance	Y	
181	Project management protocols implemented and operational	Toolkit Checklist	8.4 Project Management	Y	
182	Shall explain their project management approach including the project plan tasks that are managed by vendors in order for ONC to judge the comprehensiveness and the feasibility of the plans	ONC PIN		Y	
183	Should also describe the change management and issue escalation processes that will be used to keep projects on schedule and within budget	ONC PIN		Y	
184	Monitoring Capacity – Monitor and plan for remediation of the actual performance of HIE throughout the state.	Toolkit Checklist	8.6 Monitoring Performance	Y	
185	State or State Designated Entity is monitoring and reporting on all required program evaluation metrics	Toolkit Checklist		Y	
186	Include a strategy that specifies how the state intends to meet meaningful use HIE requirements established by the Secretary	FOA	4.1.4 Supporting Stage 1 MU HIE Requirements	Y	
187	Leverage existing state and regional HIE capacity	FOA	4.1 Environmental Scan 7.2.7 Integration of Existing Assets and Initiatives	Y	

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
188	Leverage statewide shared services and directories	FOA	7.2.6 State-Level Shared Services and Directories	Y	
189	Describe the incremental approach for HIE services to reach all geographies and providers across the state	FOA	7.3 Technology Deployment	Y	
190	Monitor and maintain a targeted degree of participation in HIE-enabled state-level technical services.	FOA	8.6 Monitoring Performance	Y	From Governance/Board
191	XX% of healthcare providers in the state are able to send electronic health information using components of the statewide HIE Technical infrastructure	Toolkit Checklist		Y	From Governance/Board
192	XX% of healthcare providers in the state are able to receive electronic health information using components of the statewide HIE Technical infrastructure	Toolkit Checklist		Y	From Governance/Board
193	XX% of pharmacies serving people within the state are actively supporting electronic prescribing and refill requests	Toolkit Checklist		Y	From Governance/Board
194	XX% of clinical laboratories serving people within the state that are actively supporting electronic ordering and results reporting	Toolkit Checklist		Y	From Governance/Board
195	Trust agreements covering XX% of the state's providers have been signed	Toolkit Checklist		Y	From Governance/Board
196	Semi-annual progress reports submitted	Toolkit Checklist		Y	From Governance/Board
197	Program performance measurement results submitted	Toolkit Checklist		Y	From Governance/Board
198	Statutory requirements for HIE as defined in the HITECH Act achieved	Toolkit Checklist		Y	From Governance/Board
199	Identify if and when the state HIE infrastructure will participate in the NHIN.	FOA	7.2.5 Alignment with NHIN	Y	
200	**Current HIE Capacities**	FOA	4.1.1 Clinical HIE Capabilities	Y	
201	Describe how the state will leverage current HIE capacities, if applicable, such as current operational health information organizations (HIOs), including those providing services to areas in multiple states	FOA	4.1.1 Clinical HIE Capabilities	Y	
202	Leverage public help desk/call center contracts and services between the State HIE Program, Medicaid and the REC.	ONC PIN	NA	NA	This is an implementation activity to be determined by the SDE
203	**State-Level Shared Services and Repositories**	FOA	7.2.6 State-Level Shared Services and Directories	Y	
204	Address whether the state will leverage state-level shared services and repositories including how HIOs and other data exchange mechanisms can leverage existing services and data repositories, both public or private	FOA	7.2.6 State-Level Shared Services and Directories	Y	
205	Shared services for states. These technical services may be developed over time and according to standards and certification criteria adopted by HHS in effort to develop capacity for nationwide HIE.	FOA	7.2.6 State-Level Shared Services and Directories	Y	
206	Consider Security Service	FOA		Y	
207	Consider Patient Locator Service	FOA		Y	
208	Consider Data/Document Locator Service	FOA		Y	
209	Consider Terminology Service	FOA		Y	
210	**Standard operating procedures for HIE (encouraged but not required)**	FOA	8.1 Standard Operating Procedures and Participation Process	Y	
211	Explanation of how standard operating procedures and processes for HIE services will be developed and implemented	FOA	8.1 Standard Operating Procedures and Participation Process	Y	
212	Collaborate with the Medicaid program and the ONC-supported RECs to provide technical assistance to providers outside of the federal grant for RECs' scopes of work.	ONC PIN	3.3.1 Wisconsin HIT Extension Center (WHITEC)	Y	
213	**Medicaid Specific Tasks - CEM**	FOA			
214	Define the specific goals and objectives expected to achieve for EHR adoption and meaningful use (e.g., 100% of all Medicaid-participating acute care and children's hospitals, primary care physicians and nurse practitioners will meet the Meaningful Use criteria as currently proposed)	FOA	8.7 Communications, Education, and Marketing Strategy Appendix 17 - Communications, Education, and Marketing Plan	Y	
215	How will we support providers in achieving Meaningful Use	FOA	8.7 Communications, Education, and Marketing Strategy Appendix 17 - Communications, Education, and Marketing Plan	Y	
216	**Legal and Policy**		**9.0 Legal and Policy**		
217	**Privacy and Security**	FOA	9.1 Privacy and Security Strategy	Y	
218	Shall develop and fully describe their privacy and security framework including the specific policies, accountability strategies, architectures and technology choices to protect information.	ONC PIN	9.2 Framework for HIE Policies and Procedures	Y	Adresses strategy for security architectures and technology choices to protect information; specific technology choices will be made during implementation.

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
219	Shall contain a description of the analysis of relevant federal and state laws as related to HIE and the plans for addressing any issues that have been identified	ONC PIN	9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.1.2 Key Differences between Wisconsin and Federal Law Appendix 19 - SUMMARY – Key Differences Between State and Federal Privacy Law Regarding Disclosures for Purposes of Treatment, Payment, and Health Care Operations	Y	
220	Address privacy and security issues related to health information exchange within the state	FOA	9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.2.2 Security and Privacy Mechanisms	Y	
221	Address privacy and security issues related to health information exchange between states	FOA	9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.2.2 Security and Privacy Mechanisms	Y	
222	Conduct joint assessment and alignment of privacy policies at the statewide level and in the Medicaid program.	ONC PIN	9.2.1 Developing the Legal and Policy Framework	Y	
223	Give special attention to federal and state laws and regulations and adherence to the privacy principles articulated in the HHS Privacy and Security Framework, and any related guidance	FOA	9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.2.1 Developing the Legal and Policy Framework 9.2.2 Security and Privacy Mechanisms Appendix 20 - Consent Policy Framework Development Process	Y	
224	Must address all the principles outlined in the HHS HIT Privacy and Security Framework, including: - Disclosure Limitation - Individual Access - Correction - Openness and Transparency - Individual Choice - Collection and Use - Data Quality and Integrity - Safeguards - Accountability	ONC PIN	9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.2.1 Developing the Legal and Policy Framework 9.2.2 Security and Privacy Mechanisms 7.2.3 Authentication and Security	Y	
225	Shall describe the process the [state or SDE] will use to fully develop a [a privacy and security] framework in the absence an existing framework	ONC PIN	9.2.1 Developing the Legal and Policy Framework	Y	
226	**State Laws**	FOA	9.2.2.4 Interstate Collaboration	Y	
227	Address any plans to analyze and/or modify state laws, as well as communications and negotiations with other states to enable exchange	FOA	9.2.1 Developing the Legal and Policy Framework 9.2.2.4 Interstate Collaboration	Y	
228	**Policies and Procedures**	FOA	9.2 Framework for HIE Policies and Procedures	Y	
229	Address the development of policies and procedures necessary to enable and foster information exchange within the state and interstate	FOA	9.2.1 Developing the Legal and Policy Framework	Y	
230	**Trust Agreements**	FOA	9.2.3 Participation, Oversight, and Accountability Mechanisms	Y	
231	Discuss the use of existing or the development of new trust agreements among parties to the information exchange that enable the secure flow of information	FOA	9.2.3.1 Background on Data Use Agreement 9.2.3.2 Data Use Agreement Appendix 22 - Data Use Agreement Parameters Appendix 23 - Legal and Policy Issues List for Data Agreements	Y	
232	Examine data sharing agreements	FOA		Y	
233	Examine data use agreements	FOA		Y	
234	Examine reciprocal support agreements	FOA		Y	
235	Policies, procedures and trust agreements have been established to enable and foster health information exchange within the state and interstate and include provisions allowing for public health data use	Toolkit Checklist	9.2.2.4 Interstate Collaboration 9.4 Public Health	Y	
236	Trust agreements covering XX% of the state's providers have been signed	Toolkit Checklist		Y	
237	**Oversight of Information Exchange and Enforcement**	FOA	9.2.3.3 Oversight and Accountability Background	Y	
238	Address how the state will address issues of noncompliance with federal and state laws and policies applicable to HIE	FOA		Y	
239	**Establish Requirements**	FOA	**9.2.3.3 Oversight and Accountability Background**	Y	
240	Describe how statewide health information exchange will comply with all applicable federal and state legal and policy requirements	FOA		Y	
241	Developing, evolving, and implementing the policy requirements to enable appropriate and secure health information exchange through the mechanisms of exchange consistent with the state Strategic Plan	FOA		Y	

ID	ONC Requirement	Source	S&O Plan Reference	Addressed? (Y, N, NA)	Comments
242	Should specify the interdependence with the governance and oversight mechanisms to ensure compliance with these policies	FOA		Y	
243	Should describe the methods used to ensure privacy and security programs are accomplished in a transparent fashion	ONC PIN		Y	
244	**Privacy and Security Harmonization**	FOA	**9.1.1 Analysis of Privacy and Security Issues Related to HIE**	Y	
245	Describe plans for privacy and security harmonization and compliance statewide and also coordination activities to establish consistency on an interstate basis	FOA		Y	
246	**Federal Requirements**	FOA	**7.2.3 Authentication and Security**	Y	
247	To the extent that states anticipate exchanging health information with federal care delivery organizations, such as the VA, DoD, Indian Health Service, etc. the Operational Plan must consider the various federal requirements for the utilization and protection of health data will be accomplished.	FOA		Y	
248	**Medicaid Specific Tasks**	FOA			
249	How the Medicaid Agency will promote secure data exchange, where permissible under the Health Insurance Portability and Accountability Act (HIPAA)	FOA	9.1 Privacy and Security Strategy	Y	
250	What interoperability arrangements and other agreements should be in place	FOA	9.2.3.1 Background on Data Use Agreement 9.2.3.2 Data Use Agreement	Y	
251	**Other**				
252	**Project Schedule (Implementation Work Plan)**		**10.0 Implementation Plan**		
253	Include a project schedule describing the tasks and sub-tasks that need to be completed in order to enable the statewide HIE	FOA	10.0 Implementation Plan Appendix 25 - Implementation Plan	Y	
254	Shall include a robust project management plan with specific timelines, milestones, resources and interdependencies for all the activities in the state's HIE project	ONC PIN	Appendix 25 - Implementation Plan	Y	
255	**Implementation Description**		**10.0 Implementation Plan**		
256	Identify issues, risks, and interdependencies within the overall project	FOA	10.2 Risks and Mitigation Strategies	Y	
257	The implementation description shall specify proposed resolution and mitigation methods for identified issues and risks within the overall project	FOA	10.2 Risks and Mitigation Strategies	Y	
258	Shall identify known and potential risks and describe their risk mitigation strategies	ONC PIN	10.2 Risks and Mitigation Strategies	Y	
259	Risks should be prioritized using risk severity and probability. Examples of risks that may be included are: changes in the HIE marketplace, evolving EHR and HIE standards, lack of participation of large stakeholders including Medicaid, breach of personal health information	ONC PIN	10.2 Risks and Mitigation Strategies Appendix 26 - Risk Management Strategy	Y	

APPENDIX 28

Glossary of Health IT-Related Terms

Access Control: The prevention of unauthorized use of a resource, such as health information, including the prevention of use of a resource in an unauthorized manner.

Accountability: Makes sure that the actions of a person or agency may be traced to that individual or agency.

Accountable Care Organization (ACO): A local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.

Agency for Healthcare Research and Quality (AHRQ): A federal agency within the United States Department of Health and Human Services charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans.

American Recovery and Reinvestment Act of 2009 (ARRA): A $787.2 billion stimulus measure, signed by President Obama on February 17, 2009, that provides aid to states and cities, funding for transportation and infrastructure projects, expansion of the Medicaid program to cover more unemployed workers, health IT funding, and personal and business tax breaks, among other provisions designed to "stimulate" the economy.

Anonymized: Personal information, which has been processed to make it impossible to know whose information it is.

Audit trail: A chronological sequence of audit records, each of which contains evidence directly pertaining to and resulting from the execution of a process or system function.

Authentication: Verifying the identity of a user, process, or device, before allowing access to resources in an information system.

Brand: A brand is the identity of a specific product, service, or business. A brand can take many forms, including a name, sign, symbol, color combination or slogan. The word brand began simply as a way to tell one person's cattle from another by means of a hot iron stamp. A legally protected brand name is called a trademark. The word brand has continued to evolve to encompass identity - in effect the personality of a product, company or service.

Clinical Document Architecture (CDA): The HL7 Clinical Document Architecture (CDA) is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Certification Commission for Health IT (CCHIT): A recognized certification body (RCB) for electronic health records and their networks. It is an independent, voluntary, private-sector initiative, established by the American Health Information Management Association (AHIMA), the Health care Information and Management Systems Society (HIMSS), and The National Alliance for Health Information Technology.

Certificate Authority (CA): A trusted third party that associates a public key with proof of identity by producing a digitally signed certificate. A CA provides to users a digital certificate that links the public key with some assertion about the user, such as identity, credit payment card number etc. Certification authorities may offer other services such as time-stamping, key management services, and certificate

revocation services. It can also be defined as an independent trusted source that attests to some factual element of information for the purposes of certifying information in the electronic environment.

Clinical Decision Support System (CDSS): Computer tools or applications designed to assist physicians in making clinical decisions by providing evidence-based knowledge in the context of patient-specific data. Examples include drug interaction alerts at the time medication is prescribed and reminders for specific guideline-based interventions during the care of patients with chronic disease.

Community Health Centers (CHC): Health centers spread across the United States that provides comprehensive primary care to 20 million Americans with limited financial resources. CHCs focus on meeting the basic health care needs of their respective communities, providing treatment regardless of an individual's income or insurance coverage.

Computerized Physician Order Entry (CPOE): A process of electronic entry of medical practitioner instructions for the treatment of patients under his or her care. These orders are communicated over a computer network to the medical staff or to the departments responsible for fulfilling the order. Additionally defined as a computer application that allows a clinician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests) to be entered electronically instead of being recorded on order sheets or prescription pads. The computer compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the clinician about potential problems. http://en.wikipedia.org/wiki/Computerized_physician_order_entry

Confidentiality: Obligation of a person or agency that receives information about an individual, as part of providing a service to that individual, to protect that information from intentional or unintentional unauthorized disclosure to unauthorized persons or for unauthorized uses. Confidentiality also includes respecting the privacy interest of the individuals who are associated with that information.

Consolidated Health Informatics (CHI) Initiative: One of the 24 Presidential eGovernment initiatives with the goal of adopting vocabulary and messaging standards to facilitate communication of clinical information across the federal health enterprise. CHI now falls under FHA.

Continuity of Care Document (CCD): A patient summary that contains a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's health care, covering one or more health care encounters. It provides a means for one health care practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care.

Continuity of Care Record (CCR): A way to create flexible documents that contain the most relevant and timely core health information about a patient, and to send these electronically from one caregiver to another. It contains various sections such as patient demographics, insurance information, diagnosis and problem list, medications, allergies, and care plan and represent a "snapshot" of a patient's health data.

Control Objectives for Information and related Technology (COBIT): A set of best practices for information technology management created by the Information Systems Audit and Control Association (ISACA), and the IT Governance Institute (ITGI) in 1996. COBIT provides a set of generally accepted measures, indicators, processes and best practices to assist in maximizing the benefits derived through the use of information technology and developing appropriate IT governance and control in a company.

Current Procedural Terminology (CPT): Code set that is maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set accurately describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml

CVX (CDC maintained HL7 standard list of immunizations): Proposed vocabulary standard for submission to Immunization Registries.

Data Use Agreement: An agreement between a health provider, agency, or organization and a designated receiver of information to allow for the use of limited health information for the purpose of research, public health, or health care operations. The agreement assures that the information will be used only for specific purposes.

Decision-Support System (DSS): Computer tools or applications to assist clinicians in clinical decisions by providing evidence-based knowledge in the context of patient specific data. Examples include drug interaction alerts at the time medication is prescribed and reminders for specific guideline-based interventions during the care of patients with chronic disease. Information should be presented in a patient-centric view of individual care and also in a population or aggregate view to support population management and quality improvement. http://en.wikipedia.org/wiki/Decision_support_system
Decryption: The process used to "unscramble" information so that a "scrambled" or jumbled message becomes understandable.

De-identified Health Information: Name, address, and other personal information are removed when sharing health information so that it cannot be used to determine who a person is.

Digital Certificate: A certificate identifying a public key to its subscriber, corresponding to a private key held by that subscriber. It is a unique code that typically is used to allow the authenticity and integrity of communication can be verified. Like a driver's license, it proves electronically that the person is who s/he says they are.

Digital Imaging and Communications in Medicine (DICOM): A standard for handling, storing, printing, and transmitting information in medical imaging. It includes a file format definition and a network communications protocol. http://medical.nema.org/

Digital Signature: Uniquely identifies one person electronically and is used like a written signature. For example, a doctor or nurse may use a digital signature at the end of an e-mail to a patient just as s/he would sign a letter.

Direct Data Entry (DDE): Direct Data Entry is a method for providers to key and submit claims directly to ForwardHealth via the ForwardHealth Provider Portal.

Disclosure: The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

eHealth: A relatively recent term for health care practice which is supported by electronic processes and communication.

Electronic Health Record (EHR): As defined in the ARRA, an Electronic Health Record (EHR) means an electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical histories and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to health care quality; and to exchange electronic health information with, and integrate such information from other sources.

Electronic Prescribing (eRx): The transmission, using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network. ePrescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

Eligible Hospital: Per Title 18 of the Social Security Act as amended by Title IV in Division B of ARRA, an 1886(d) inpatient acute care hospital paid under the Medicare inpatient prospective payment system (IPPS) or an 1814(l) Critical Access Hospital (CAHs).

Eligible Professional: For purposes of the Medicare incentive, an eligible professional is defined in Social Security Act Section 1848(o), as added by ARRA, as a physician as defined in Social Security Act 1861(r). The definition at1861(r) includes doctors of medicine, doctors of osteopathy, doctors of dental surgery or of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

Enterprise Architecture: A strategic resource that aligns business and technology, leverages shared assets, builds internal and external partnerships, and optimizes the value of information technology services.

Federal Health Architecture (FHA): A collaborative body composed of several federal departments and agencies, including the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), the Department of Veterans Affairs (VA), the Environmental Protection Agency (EPA), the United States Department of Agriculture (USDA), the Department of Defense (DoD), and the Department of Energy (DOE). FHA provides a framework for linking health business processes to technology solutions and standards and for demonstrating how these solutions achieve improved health performance outcomes.

Federally Qualified Health Center (FQHC): Safety-net providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. FQHCs provide their services to all people regardless of ability to pay, and charge for services on a community board approved sliding-fee scale that is based on patients' family income and size. FQHCs are funded by the federal government under Section 330 of the Public Health Service Act.

Funding Opportunity Announcement (FOA): A funding opportunity announcement is a notice in Grants.gov of a federal grant funding opportunity.

Health Care Effectiveness Data and Information Set (HEDIS): A widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.

Health Care Information and Management Systems Society (HIMSS): A health care industry membership organization focused on the optimal use of health information technology and management systems.

Health Information Exchange (HIE): As defined by the Office of the National Coordinator and the National Alliance for Health Information Technology (NAHIT), Health Information Exchange refers to the electronic movement of health-related information among organizations according to nationally recognized standards. *For the purposes of the State HIE Cooperative Agreement Program, organization is synonymous with health care providers, public health agencies, payers, and entities offering patient engagement services (such as Personal Health Records).*

Health Information Network (HIN): The physical infrastructure and services operated and/or overseen by a Health Information Organization (e.g., the State Designated Entity) to enable health information exchange between organizations that are participants in the HIO.

Health Information Organization (HIO): An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Health Insurance Portability and Accountability Act (HIPAA): Enacted by Congress in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their

jobs. Title II of HIPAA, known as the administrative simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The AS provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange.

Health Information Security and Privacy Collaboration (HISPC): Partnership consisting of a multi-disciplinary team of experts and the National Governor's Association (NGA). The HISPC works with approximately 40 states or territorial governments to assess and develop plans to address variations in organization-level business policies and state laws that affect privacy and security practices which may pose challenges to interoperable health information exchange. RTI International, a private, nonprofit corporation, is overseeing HISPC and was selected as the HHS contract recipient.

Health Information Technology (HIT): As defined in the ARRA, Health Information Technology means hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.

Health Information Technology for Economic and Clinical Health (HITECH) Act: Collectively refers to the health information technology provisions included at Title XIII of Division A and Title IV of Division B of the ARRA.

Health Information Technology Standards Panel (HITSP): A multi-stakeholder coordinating body designed to provide the process within which stakeholders identify, select, and harmonize standards for communicating and encouraging broad deployment and exchange of health care information throughout the health care spectrum. The Panel's processes are business process and use-case driven, with decision-making based on the needs of all NHIN stakeholders. The Panel's activities are led by the American National Standards Institute (ANSI), a not-for-profit organization that has been coordinating the U.S. voluntary standardization system since 1918.

Health Information Trust Alliance (HITRUST): Established the Common Security Framework (CSF), a certifiable framework that can be used by any and all organizations that create, access, store or exchange personal health and financial information.

Hospital-Based Professional: SSA 1848(o)(1)(C)(ii), as added by ARRA, defines a 'hospital-based professional' for purposes of clause (i) of SSA 1848(o)(1)(C). A hospital-based professional is an otherwise eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her covered professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible physician shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the priority primary care provider and any other provider. SSA 1848(o)(1)(C)(i) that no Medicare incentive payments for meaningful use of certified EHR technology may be made to hospital-based eligible professionals.

Identity Access Management (IAM): Involves people, processes, and products to identify and manage the data used in an information system to authenticate users and grant or deny access rights to data and system resources. The goal of IAM is to provide appropriate access to enterprise resources.

Incident Response Plan: An organized approach to addressing and managing the aftermath of a security or privacy breach or attack (also known as an incident). The goal is to handle the situation in a way that limits damage and reduces recovery time and costs. An incident response plan includes a policy that defines, in specific terms, what constitutes an incident and provides a step-by-step process that should be followed when an incident occurs

Individual primary-care physician practice: For purposes of this Funding Opportunity Announcement, ”individual primary-care physician practice” is defined as a a practice in which only one primary-care physician furnishes professional services. The practice may include one or more nurse practitioners and/or physician assistants in lieu of or in addition to registered and licensed vocational nurses, medical assistants, and office administrative staff.

Informatics: Health informatics, Healthcare informatics or medical informatics is the intersection of information science, computer science, and healthcare. It deals with the resources, devices, and methods required to optimize the acquisition, storage, retrieval, and use of information in health and biomedicine. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems. It is applied to the areas of nursing, clinical care, dentistry, pharmacy, public health and (bio)medical research.

Informed Consent: Informed consent is the process by which permission is granted by an authorized person that allows the provider, agency, or organization to release information about a person. The authorized person may be the subject of the information or they may be a designated representative such as a parent or guardian. Law, policy and procedures, and business agreements guide the use of consent. Informed consent requires three elements: the provision of sufficient information to the authorized person; the comprehension of that information by the authorized person, and capacity by the authorized person to give informed consent,

Integrated Delivery Network (IDN): A network of facilities and providers working together to offer a continuum of care to a specific market or geographic area. IDNs include many types of associations across the continuum of care and one network may include a short- and long-term hospital, Health Maintenance Organization, Primary Health Organization, Preferred Provider Organization, Home Health agency, and hospice services.

Integrated Healthcare Enterprise (IHE) A standard protocol adopted by RSNA and HIMSS for use in sharing Electronic Healthcare Records between multiple providers and selected organizations. IHE is currently the primary source of interoperability protocols identified for EMR/EMR certification by CCHIT.

Integrity: Data or information that has not been changed or destroyed in an unauthorized or unintentional way.

International Organization for Standardization (ISO): An international-standard-setting body composed of representatives from various national standards organizations. The organization disseminates worldwide proprietary industrial and commercial standards.

Interoperability: The ability of systems or components to exchange health information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed.

Limited Data Set: Health information that does not contain identifiers. It is protected but may be used for certain purposes without the owner’s consent.

LISTSERV: Electronic mailing list software application, consisting of a set of email addresses for a group in which the sender can send one email and it will reach a variety of people.

Log In, Logging Into: The action a person must take to confirm his or her identity before being allowed to use a computer system.

Logical Observation Identifiers Names and Codes (LOINC): Proposed vocabulary standard for Lab Testing Orders and Results.

Managed Care Organization (MCO): A classification of organizations with different business models that provide managed care. Some organizations are made up of physicians, while others can include combinations of physicians, hospitals, and other providers.

Master Patient Index (MPI): An electronic index that enables lookup of patient data distributed across multiple systems, to provide an aggregated view of patient's EHR (also referred to as a Master Person Index).

Meaningful Use (MU): Under the HITECH Act, an eligible professional or hospital is considered a "meaningful EHR user" if they use certified EHR technology in a manner consistent with criteria to be established by the Secretary through the rulemaking process, including but not limited to e-prescribing through an EHR, and the electronic exchange of information for the purposes of quality improvement, such as care coordination. In addition, eligible professionals and hospitals must submit clinical quality and other measures to HHS.

Medicaid Information Technology Architecture (MITA): An IT initiative intended to stimulate an integrated business and IT transformation affecting the Medicaid enterprise in all States. The MITA initiative's intention is to improve Medicaid program administration by establishing national guidelines for technologies and processes.

Medical Trading Area (MTA): The natural market within which most referrals, hospitalizations, and other flows of both patients and patient information typically occur. Another term for this is a medical referral area.

National Information Exchange Model (NIEM): An information exchange framework that represents a collaborative partnership of agencies and organizations across all levels of government (federal, state, tribal, and local) and with private industry. NIEM is designed to facilitate the creation of automated enterprise-wide information exchanges, which can be uniformly developed, centrally maintained, quickly identified and discovered, and efficiently reused.

National Institute of Standards and Technology (NIST): The non-regulatory federal agency within the United States Department of Commerce whose mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology. NIST oversees the NIST Laboratories, the Baldrige National Quality Program, the Hollings Manufacturing Extension Partnership, and the Technology Innovation Program.

National Provider Identifier (NPI): A system for classifying all providers of health care services, supplies, and equipment covered under HIPAA.

Nationwide Health Information Network (NHIN): A collection of standards, protocols, legal agreements, specifications, and services that enables the secure exchange of health information over the Internet.

Non-eligible Hospital: Per Title 18 of the Social Security Act as amended by Title IV in Division B of ARRA, any hospital ***other than*** an acute-care hospital under 1886(d) or Critical Access Hospital under 1814(l). (Per SSA 1886(d), examples include Long-term Care Hospitals, Inpatient Rehabilitation Hospitals, Inpatient Psychiatric Hospitals, non-IPPS Cancer Centers and Children's Hospitals.)

Non-Repudiation: The process of confirming proof of information delivery to the sender and proof of sender identity to the recipient.

Notice of Privacy Practices or Privacy Notice: Health Insurance Portability and Accountability Act (HIPAA) requires that all covered health plans, health care clearinghouses, or health care providers give patients a document that explains their privacy practices and how information about the patients' medical records may be shared. See also Health Insurance Portability and Accountability Act

Office of the National Coordinator (ONC) for Health IT: Serves as principal advisor to the Secretary of HHS on the development, application, and use of health information technology; coordinates HHS's health information technology policies and programs internally and with other relevant executive branch agencies; develops, maintains, and directs the implementation of HHS' strategic plan to guide the

nationwide implementation of interoperable health information technology in both the public and private health care sectors, to the extent permitted by law; and provides comments and advice at the request of OMB regarding specific Federal health information technology programs. ONC was established within the Office of the Secretary of HHS in 2004 by Executive Order 13335.

Opt-in/Opt-out: Opt-in is intended as a proxy for gaining affirmative consent prior to the collection or use of information, while opt-out is a proxy for collecting information without gaining prior consent.

Patient Centered Medical Home (PCMH): An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal Providers, and when appropriate, the patient's family.

Personal Health Record (PHR): A PHR is defined by ARRA as "an electronic record of [individually identifiable] information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual."

Primary-Care Physician: For purposes of this Funding Opportunity Announcement, "Primary-Care Physician" is defined as a licensed doctor of medicine or osteopathy practicing family practice, obstetrics and gynecology, general internal or pediatric medicine regardless of whether the physician is board certified in any of these specialties.

Privacy: (1) The prevention of unauthorized access and manipulation of data. (2) The right of individuals to control or influence what information related to them may be collected and stored and by whom and to whom that information may be disclosed.

Privacy Incident: A situation in which there is knowledge or reasonable belief that there has been unauthorized or inappropriate collection, use, access, disclosure, transfer, modification and/or exposure of sensitive health information.

Private Key: The private or secret key of a key pair, which must be kept confidential and is used to decrypt messages encrypted with the public key, or to digitally sign messages, which can then be validated with the public key.

Provider Electronic Solutions (PES): Provider Electronic Solutions Software supports the processing of claims transactions. This software has most claim types used in the NH Title XIX program including Dental, CMS-1500, Inpatient, Nursing Home, and Outpatient, and includes Recipient Eligibility and Claims Status Inquiry functions.

Public Health Information Network (PHIN): A national initiative led by the Centers for Disease Control and Prevention (CDC) to implement a single information network that will integrate, functionally and organizationally, public health partners across the nation. PHIN establishes technical and data standards and work specifications, and provides a process for developing and implementing specifications and standards.

Public Key: In an asymmetric cryptography scheme, the key that may be widely published to enable the operation of the scheme. Typically, a public key can be used to encrypt, but not decrypt, or to validate a signature, but not to sign.

Public Key Infrastructure (PKI): Supporting infrastructure, including non-technical aspects, for the management of public keys.

Record Locator Service (RLS): An information service that locates patient records across systems that subscribe to the service.

Regional Extension Center (REC): As set out in the ARRA, Regional Extension Centers will be created by ONC to provide technical assistance and disseminate best practices and other information learned

from the Health Information Technology Research Center to aid health care providers with the adoption of health information technology.

Regional Health Information Organization (RHIO): A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Rural Health Clinic: For purposes of the State HIE Cooperative Agreement Program, "rural health clinic" is defined as a clinic providing primarily outpatient care certified to receive special Medicare and Medicaid reimbursement. RHCs provide increased access to primary care in underserved rural areas using both physicians and other clinical professionals such as nurse practitioners, physician assistants, and certified nurse midwives to provide services.

RxNorm: Proposed vocabulary standard nomenclature for clinical drugs (Medication List) and drug delivery devices, is produced by the National Library of Medicine (NLM).

Security: Safeguarding information against unauthorized disclosure; or, the result of any system of administrative policies and procedures for identifying, controlling, and protecting from unauthorized disclosure, information the protection of which is authorized by Executive Order or statute.

Security Incident: Any real or potential attempt (successful or unsuccessful) to access and/or adversely affect data, systems, services or networks in the following context: data availability, disclosure of proprietary information, illegal access, misuse or escalation of authorized access.

Service Oriented Architecture (SOA): An application architecture comprising components, whose interface descriptions can be published, discovered and invoked. Components are said to be loosely coupled in that they have no knowledge of each other except for their respective interfaces and communicate with each other through messages.

Shared Directory: A service that enables the searching and matching of data to facilitate the routing of information to providers, patients and locations.

Small-group primary-care physician practice: For purposes of this Funding Opportunity Announcement, "small-group primary-care physician practice" is defined as aa group practice site that includes 10 or fewer licensed doctors of medicine or osteopathy routinely furnish professional services, and where the majority of physicians practicing at least 2 days per week at the site practice family, general internal, or pediatric medicine. The practice may include nurse practitioners and/or physician assistants (regardless of their practice specialties) in addition to registered and licensed vocational nurses, medical assistants, and office administrative staff.
Note: a practice otherwise meeting the definition of individual or small-group physician practice, above, may participate in shared-services and/or group purchasing agreements, and/or reciprocal agreements for patient coverage, with other physician practices without affecting their status as individual or small-group practices for purposes of the Regional Centers.

Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT): Proposed vocabulary standard for comprehensive clinical terminology covering diseases, clinical findings, procedures and clinical terms.

State Designated Entity (SDE):

- The entity that is designated by the State as eligible to receive awards;
- The entity is a not-for-profit entity with broad stakeholder representation on its governing board;
- The entity demonstrates that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information; and

- The entity adopts nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders. http://dhs.wisconsin.gov/ehealth/FederalFAQ/StateHITGrant.htm

Unique Ingredient Identifiers (UNII): Proposed vocabulary standard and Structured Product Labeling for medication allergy lists.

Unified Code for Unit of Measure (UCUM): Proposed vocabulary standard for Units of Measure, (vital signs).

Wisconsin Health Information Technology Extension Center (WHITEC): Wisconsin's Regional Extension Center.

Wisconsin Relay of Electronic Data (WIRED) for Health: Wisconsin's project for statewide HIE is titled Wisconsin Relay of Electronic Data for Health or WIRED for Health. The goal of the WIRED for Health project is to build substantial health information exchange capacity statewide to support providers' meaningful use of electronic health records and enable efficient, appropriate, and secure flow of information to optimize decisions for health. The approach is to plan, develop, and implement interoperable, standards-based, secure electronic exchange of patient and health data.

APPENDIX 29

Consolidated Near-Term Timeline

	Responsible Party	2011												Ongoing Activity?
		JAN '11	FEB '11	MAR '11	APR '11	MAY '11	JUN '11	JUL '11	AUG '11	SEPT '11	OCT '11	NOV '11	DEC '11	
Electronic Prescribing and Refill Requests														
Step 1: Identify pharmacies that do not accept electronic prescriptions and refill requests	WISHIN													
A) Identify pharmacies that are not internal hospital pharmacies	WISHIN													
B) Identify acceptable distance between pharmacies based on county or address	WISHIN													
Step 2: Determine approaches to receive a 50% reduction in gap	WISHIN													
A) Assess the volume of Medicaid claims	WISHIN, DHS													
i) Reconcile pharmacy data with Medicaid data	WISHIN													
ii) Explore and evaluate Medicaid policy levers	WISHIN, DHS													
1) Meet with Medicaid	WISHIN, DHS													
2) Identify potential policy levers	WISHIN, DHS													
B) Assess feasibility of using state licensure vehicles to set requirements for e-prescribing	WISHIN, DHS, DRL													
i) Meet with DRL	WISHIN													
ii) Identify potential policy levers	WISHIN, DHS, DRL													
Step 3: Conduct outreach to pharmacies through the State HIT Coordinator, WISHIN, HISP, and WHITEC	WISHIN													Annual
A) Interview pharmacies to identify barriers, benefits, and potential incentives	WISHIN													
B) Encourage adoption among pharmacies	WISHIN													
C) Match providers with pharmacies capable of sending electronic prescriptions and refill requests	WISHIN, WHITEC													
Step 4: Track and monitor pharmacies in the state	WISHIN													Annual
A) Report updated number of pharmacies annually	WISHIN													

Consolidated Near-Term Timeline

	Responsible Party	2011												Ongoing Activity?
		JAN '11	FEB '11	MAR '11	APR '11	MAY '11	JUN '11	JUL '11	AUG '11	SEPT '11	OCT '11	NOV '11	DEC '11	
Laboratories														
Step 1: Conduct outreach to identify reference laboratories not delivering structured lab results electronically using the LOINC standard	WISHIN, WHITEC, WHIE, DHS													
A) Identify barriers for participation	WISHIN, WHITEC, WHIE, DHS													
B) Identify incentives for participation	WISHIN, WHITEC, WHIE, DHS													
Step 2: Help eligible providers identify local laboratories with electronic messaging capabilities	WHITEC, WISHIN													
Step 3: Provide subsidized technical assistance to implement the Direct project's transport standards and service specifications to electronically push lab results	WHIE													Annual
A) Assess current state of laboratories in need of assistance to electronically deliver lab results through Direct	WISHIN													
i) Prioritize areas of "white space" with existing gap	WISHIN, WHIE													
1) Critical access hospitals	WISHIN, WHIE													
2) Other areas	WISHIN, WHIE													
B) Provide subsidized technical assistance to help labs electronically deliver lab results through Direct	WHIE													
Step 4: Provide laboratories access to a state-level Direct gateway	WHIE													
A) Develop near-term infrastructure	WHIE													
i) Provider directory	WMS, WHIE													
ii) Certificate authority	WMS, WHIE													
Step 5: Monitoring and tracking progress toward the goal of electronically delivering structured lab results	WISHIN													Yes
A) Implement ongoing monitoring mechanisms to track progress	WISHIN													
B) Report updated number of pharmacies annually	WISHIN, WHIE, WHITEC													Yes

Consolidated Near-Term Timeline

	Responsible Party	2011												Ongoing Activity?
		JAN '11	FEB '11	MAR '11	APR '11	MAY '11	JUN '11	JUL '11	AUG '11	SEPT '11	OCT '11	NOV '11	DEC '11	
Clinical Summary Exchange														
Step 1: Identify the physicians by name in the "white space"	WISHIN, DHS													
A) Reach out to organizations with existing exchange activities	WISHIN, DHS													
i) Health care organizations (hospitals and/or clinics) participating in WHIE	WISHIN, DHS													
ii) Health care organizations (hospitals and/or clinics) using Epic in the state	WISHIN, DHS													
iii) The Marshfield/Ministry network	WISHIN, DHS													
iv) The KCIN network	WISHIN, DHS													
v) Wisconsin healthcare organizations participating in CHIC	WISHIN, DHS													
B) Match them against the list WMS will provide from their provider directory	WISHIN, DHS													
C) Populate WMS' directory with EHR and HIE adoption information	WISHIN, DHS													
D) Produce a list of physicians to target for technical assistance outreach for EHR and HIE adoption	WISHIN, DHS													
E) Maintain the central data source for EHR and HIE adoption by physicians	WMS													Yes
i) Provide data source for EHR and HIE adoption by Wisconsin hospitals	WHA													Yes
ii) Track and report the adoption rates using these sources of data	WISHIN													Yes
iii) Work with the HIE networks operating in Wisconsin to annually report on participants	WISHIN													Yes
Step 2: Provide technical assistance to implement the Direct project's transport standards and service specifications	WHIE													
A) Assess the current state of providers wanting to exchange clinical care summaries through DIRECT	WISHIN													
i) Prioritize areas of "white space" with existing gap	WISHIN, WHIE													
1) Rural areas	WISHIN, WHIE													
2) Other areas	WISHIN, WHIE													
B) Provide subsidized technical assistance to help unaffiliated organizations for exchange through DIRECT	WHIE													
Step 3: Provide eligible professionals and hospitals access to a state-level Direct gateway	WHIE													
A) Develop near-term infrastructure	WHIE													
i) Provider directory	WMS, WHIE													
ii) Certificate authority	WMS, WHIE													
Step 4: Support existing EHR connectivity among unaffiliated hospitals and health systems	WISHIN, WHIE													
A) Examine existing EHR connectivity in the state among unaffiliated hospitals and health systems	WISHIN, WHIE													
B) Work with EHR vendors in the state to support the CCD standard	WISHIN													

Consolidated Near-Term Timeline

	Responsible Party	2011												Ongoing Activity?
		JAN '11	FEB '11	MAR '11	APR '11	MAY '11	JUN '11	JUL '11	AUG '11	SEPT '11	OCT '11	NOV '11	DEC '11	
Clinical Summary Exchange (continued)														
Step 5: Monitoring and tracking progress toward the goal of exchanging clinical care summaries	WISHIN													Yes
A) Implement ongoing monitoring mechanisms to track progress	WISHIN													
B) Report updated number of pharmacies annually	WISHIN, WHIE, WHITEC													Yes