WIRED for Health

Wisconsin Health Information Technology Strategic & Operational Plan

Appendices

2011 SOP Update Submission
5/4/2012
Final

CONTENTS

Appendix 1: Executive Order 303

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 IDE 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:

I. Create a Board for the Wisconsin Relay of Electronic Data ("WIRED") for Health (' Board") organized under the Department C?f 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)i 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

   !. 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: Designation of the State Health IT Coordinator

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 3: Letter of Support

WISHIN

Wisconsin Statewide Health Information Network

PO Box 259038 Madison, WI 53725-9038

P 608-274-1820 F 608-274-8554 www.wishin.org

May 1, 2012

Dr. Farzad Mostashari
National Coordinator for Health Information Technology
US Department of Health & Human Services
200 Independence Avenue S.W.
Suite 729-D
Washington, D.C. 20201

Dear Dr. Mostashari:

It is with great pride that we, the members of the Wisconsin Statewide Health Information Network (WISHIN) Board of Directors, write this letter in support of Wisconsin's updated WIRED for Health Strategic & Operational Plan being submitted to your office.

As members of the WISHIN Board of Directors, we recognize the progress WISHIN has made over the past year in the development of a statewide health information network to improve the quality of health care in Wisconsin. The WISHIN Board of Directors and its committees are comprised of a comprehensive cross-section of volunteer stakeholders from the public and private sectors. These volunteers committed time and resources to assist WISHIN in the updated version 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 WISHIN Board of Directors, includes the details that address the ONC's five domains, and provides an approach to implement and sustain robust statewide health information exchange services that we agree with and support.

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

Sincerely,

Chris Queram, Board Chair
President/CEO
Wisconsin Collaborative for Health Care Quality

Dr. Farzad Mostashari
May 1, 2012
Page 2

Linda Syth, Board Vice Chair
ZOO
Wisconsin Medical Society

Lisa Ellinger, Board Secretary
Department Administrator
WI Dept. of Employee Trust Funds

Steve Brenton, Board Treasurer
President
Wisconsin Hospital Association

Henry Anderson, MD
Acting State Public Health Officer
State of Wisconsin

Patti Brennan, RN PhD FAAN
Chair, Industrial & Systems Engineering
University of Wisconsin – Madison

Jane Cooper
President/CEO
Patient Care

Brett Davis
Wisconsin Medicaid Director
Wisconsin Dept. of Health Services

John Foley
Vice President of Health Services
Anthem

Sheila Jenkins
CEO
Network Health Plan

Dianne Kiehl
Executive Director
Business Health Care Group

Ken Letkeman
Chief Information Officer
Marshfield Clinic

Chuck Nason
CEO
Worzalla Publishing

Craig Samitt
President/CEO
Dean Health System

Denise Webb
State Health IT Coordinator
Wisconsin Dept. of Health Services

Appendix 4: Public Health Meaningful Use Implementation Plan

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 (EPs/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, laboratory, and syndromic surveillance data. The target systems are mature and capable of accepting HL7 2.3.1/2.5.1 formatted data submissions. Thus overall it appears that many EPs/Hospitals will be able to rely on an existing data transmission relationships in one of the three PH MU menu set areas to fulfill their Stage 1 PH menu set requirement for the EHR Incentive Program in 2012 (both 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 (HIT) 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, the Division has limited capacity to accept new test submissions and ongoing receipt of reportable lab results and syndromic surveillance data. Therefore, many EPs/Hospitals may be claiming an exclusion for the PH MU requirement. Unless the Division is able to identify additional funding to increase its capacity, Stage 2 and 3 MU requirements could exacerbate the situation.

The Division's current interpretation of the final Electronic Health Record (EHR) Incentive Program rule puts the burden of EHR technology certification on the system vendors and verification by the EPs/Hospitals procuring and using the technology. The Division does not need to validate whether the EHR system or component producing the PH data for submission is certified. Further, the PH systems that receive the data do not need to be certified unless they are performing a meaningful use function on behalf of the EPs/Hospitals, such as lab translation services. The PH system only needs to be capable of accepting data in accordance with the applicable standards and implementation specifications. The final HIT rule and standards are silent on the transport protocol used to submit data to PH, other than it must be an electronic method (not fax or manual keying of data through a portal). The Division interprets this to mean that the Division and the EPs/Hospitals may continue to use existing transport protocols, such as the use of Public Health Information Network Messaging System (PHIN-MS). The Division's at its discretion will continue to support and accept transmissions through a variety of transport methods, i.e., batch, real-time, etc. The Division has plans underway to support the Direct secure messaging transport protocol in 2012.

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 currently accepting HL7 2.3.1/2.5.1 submissions for PH MU. It can also accept data using a variety of transmission methods/transport protocols and formats ranging from a

batch download of an ASCII file to real-time HL7 messages. The Registry is widely used and recognized.

2.2. Future State

WIR will be modified to accept immunization submissions via Direct secure messaging. The requirements definition phase will begin in the first quarter of 2012. The Division plans to do initial testing and pilot submissions by the end of the second quarter of 2012. The capability is expected to be complete before the end of 2012. Support will continue for all existing HL7 formats at least through 2012, including but not limited to HL7 2.3.1/2.4.1/2.5.1. WIR program and technical staff will continue to monitor the development of standards and work with WISHIN, ONC, and CDC to remain compliant.

2.3. Funding

The DPH Immunization Section received an ARRA-funded CDC grant for Enhancing the Interoperability of Electronic Health Records and Immunization Information Systems in 2011. The grant covered the cost of WIR's HL7 2.5.1 upgrade and increased processing capacity as well as funding bi-directional interfaces with targeted EHRs. The Section allocated some of the grant funding to enabling the WIR to support the Direct secure messaging transport protocol. The Division has not identified funding to support additional activity going forward, such as an interface with the Statewide Health Information Network.

2.4. 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 health care 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 and if required, up or down converts the data to the correct HL7 format and adds LOINC and SNOMED codes as needed for transmission to the Wisconsin Electronic Diseases Surveillance System (WEDSS).

3.2. Future State

The WSLH will continue to monitor the development of standards and work with WISHIN, ONC, and CDC to remain compliant. In addition, the WSLH will look for opportunities to pilot Direct as a means of transmitting and receiving reportable lab results and add submitters as resources permit. The WSLH may pursue obtaining ONC-ATCB certification of its ELR lab code translation and mapping software so it complies with the Stage 1 MU certification standards and requirements. This would enable hospitals currently submitting reportable lab results to ELR that require translation to attest to meeting the associated PH MU menu set requirement.

3.3. Funding

Upgrading processing capability to handle HL7 2.5.1 submissions was completed using existing funding. The Division has not identified funding to support additional activity going forward.

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 assigns 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 has an arrangement with the Wisconsin Health Information Exchange (WHIE) to serve as its intermediary for syndromic surveillance data collection. Presently WHIE collects Admission, Discharge, and Transfer (ADT) data from 51 acute-care Wisconsin hospitals and associated clinics across 24 Wisconsin counties. Some of these hospitals are sending the data from a certified EHR technology in the required PH MU HL7 format, either HL7 2.3.1 or 2.5.1. 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 and are able to provide data that meets the specifications outlined in the "PHIN Messaging Guide For Syndromic Surveillance: Emergency Department And Urgent Care Data." Funding to support the implementation of the current ADT interfaces with WHIE was provided through time-limited grants that funded contracts with WHIE. These grants are expired and are no longer available.

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 Division's 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 the WHIE and to CDC's BioSense application.

4.2. Future State

For the foreseeable future, DPH will continue to depend on WHIE for receipt of syndromic surveillance data. However, until the Division is able to identify a funding source to underwrite the cost of adding EP/Hospital submitters, the Division cannot expand its capacity and the scope of coverage. EPs/Hospitals could choose to fund the complete cost of the interface with WHIE.

4.3. Proposed WHIE Processing

To establish, test, and implement new/additional operational data feeds that meet PH MU requirements for syndromic surveillance, the following are the steps that 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 EPs/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

The Division needs to identify a stable and adequate funding model to support expanded coverage for syndromic surveillance data collection.

Appendix 5: 2009 Wisconsin Act 274

State of Wisconsin

2009 Assembly Bill 779

Date of enactment: **May 11, 2010**
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 6: Initial WIRED for Health Use Cases

The following tables show a prioritized list of all use cases considered as of November 2010 by the WIRED for Health Project, including the preliminary score for each case. During the prioritization process, 2 of 28 use cases were classified as "core." These use cases are integral to the overall operation of the statewide health information network and are prerequisites to all other use cases. These use cases (#38a and #38b) also support the patient's ability to "opt out" and "opt back in" to having their health data exchanged via the SHIN. Because of their significance, these use cases were ranked the highest of any use cases and were not scored using the prioritization methodology.

Core Use Cases

Case #	Description
38a	Patient Opts Out of having records shared in HIE (e.g., PHR or HIE Patient Web Portal) Note: WISHIN will establish process to be proposed, through WISHIN Policy Committee and consideration of HIPAA and State legislation, for patient consent and exchange participation
38b	Patient decides to Opt back In to having information exchanged in the HIE (e.g., PHR) (see previous Use Case Note.)

Preliminary 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

Case #	Description	Total Score
32b	Provider sends non-reportable, anonymized disease data to public health	0.898
39	Public health sends alert to provider (either general alert or patient-centered information on a particular patient)	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 Clinical summary 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

Appendix 7: Communications, Education, and Marketing Plan

This document provides an overview of WISHIN's 2011 Communication, Education, and Marketing (CEM) activities, which focused on two initial product offerings: WISHIN Direct and WISHIN Bridge. This document also provides background on partners and collaborators needed to implement the 2012 CEM plan, and outlines the 2012 CEM activities for WISHIN's robust, bi-directional HIE.

Stakeholder and Partner Communications

An effective plan for communications and education hinges on the 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 messages about the benefits of health information exchange (HIE) will continue to be developed and tailored for different audiences. Ongoing education on WISHIN Direct is planned, but the focus of WISHIN's CEM is on end-users of WISHIN's query-response services and consumer education on HIE.

The Communications Advisory Committee, a group of health care professionals with a marketing focus, was formed to provide recommendations related to increasing stakeholder awareness of and participation with WISHIN. In 2011, separate workgroups were formed that included members of the Communications Advisory Committee to focus on short-term projects. In 2012, WISHIN will continue to use workgroup to help meet CEM goals. The following table contains the members of the Communications Advisory Committee.

Committee Member	Organization
Pete Thompson (Committee Chair)	Dean Health Plan
Jane Cooper* (Committee Vice Chair)	Patient Care
Jason Acord	Wisconsin Chiropractic Association
Richard Ammon, Ph.D.	UW Milwaukee
Ken Carlson	Sauk Prairie Memorial Hospital
Mary Kay Grasmick	Wisconsin Hospital Association
Lisa Hildebrand	Wisconsin Medical Society
Beth Kaplan	Department of Health Services/Public Relations
Dianne Kiehl*	Business Healthcare Group
Jess King	WHITEC
Jason Klimowicz	Disability Rights Wisconsin
Laurie Kohel	UW Milwaukee
Chuck Nason*	Worzalla Publishing Company
Jesi Wang	WHITEC
* *Indicates WISHIN Board Member*	

The following table lists the stakeholder types, specific groups within each stakeholder type, and their respective community partners/collaborators who may need to be engaged directly or indirectly by WISHIN to provide and deliver credible messages to specific groups.

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 Caregivers • Hospital IT	• American Association of Family Practitioners (Wisconsin Chapter) • Media Outlets* • Rural Wisconsin Health Cooperative* • Schools of Nursing • Veterans Administration • 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

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
Clinics/Staff	• 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	• American Association of Family Practitioners (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 • Pharmacists • 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

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

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*:
		  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
	• 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
		  ▪ A focus for 2012 is to engage this market with WISHIN and educate them on WISHIN 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
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	

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 Care Payers/Health Plan	• Abri Health Plan • Anthem Blue Cross Blue Shield • Arise Health Plan • Children's Community Health Plan, Inc. • Dean Health Plan • Family Care Organizations • Family Care/Partnership Organizations • Group Health Care Cooperative of Eau Claire • Group Health Cooperative of South • Central Wisconsin • Health Insurance Risk Sharing Plan • Humana, Inc. • iCare • Managed Health Services • Medicaid and BadgerCare Plus • MercyCare Health Plans • Network Health Plan • Physicians Plus Insurance Corporation • Security Health Plan • Third-Party Administrators for Self-Funded Plan • United Healthcare of Wisconsin, Inc. • Unity Health Plans Insurance Corporation • Wisconsin Education Association Trust • Wisconsin Physicians Service Insurance	• Media Outlets • Office of the Commissioner of Insurance • Wisconsin Association of Health Plan • 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

Health Care Purchasers	Employers (private and government)
	Individuals
		• Employer conditions, such as:
		  ○ Business Health Care Group
		  ○ The Alliance
		  ○ 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)	Quality Care Organizations	• MetaStar • ThedaCare Center for Healthcare Value • Wisconsin Collaborative for Healthcare Quality • Wisconsin Health Information Organization • Wisconsin Hospital Association • Wisconsin Medical Society.
Health IT Vendors/Regional Health Information Exchanges	• Device Vendors • EMR Vendors • HIE Vendors • Wisconsin Health Information Exchange • Lab Vendors	HIMSS

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
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
Government	• Legislators/Elected Officials • State and Local Government Agencies • Policymakers	• Governor's Office • Media Outlets • State Health IT Coordinator • Wisconsin Legislative Council
* Key Influencers 2011 - 2012		

CEM Goals and Objectives

The high-level goals of the CEM are to inform and raise the awareness of consumers and health care community (physicians and other eligible medical providers, clinics, hospitals, etc.) about WISHIN, WISHIN services, and the benefits of HIE. This section describes the CEM activities conducted in 2011 and outlines the goals and objectives of the CEM for 2012.

2011 CEM Year-In-Review

In 2011, WISHIN's Marketing Advisory Committee and its workgroup revised the 2010 CEM plan and developed target market messages on WISHIN and WISHIN Direct. Focus for the year was on creating market awareness of WISHIN as an organization and launching WISHIN's initial product, WISHIN Direct. The following key CEM activities were completed in 2011:

- WISHIN implemented a corporate marketing and communications campaign, with a focus on "What is WISHIN?" and "What is WISHIN Direct?" Key messages for WISHIN Direct focused on how the product could help physicians and organizations achieve Stage 1 Meaningful Use requirements for HIE.
- WISHIN conducted key outreach for each of the ONC Program Information Notice (PIN) focus areas:

    1. Laboratory Results Delivery
    2. E-Prescribing
    3. Care Summary Exchange

    Outreach was conducted primarily via phone; however, electronic surveys were also developed. Data collected was used to track Wisconsin's "white space" in the PIN areas.

2012 Goals and Objectives

In 2012, WISHIN's CEM goals and objectives are:

1) Design and implement a comprehensive HIE communication and educational program.
2) Gather information for robust, bi-directional HIE that will be critical to message development through various methods, such as stakeholder and town hall meetings, surveys, and focus groups.
3) Develop and deploy messages to a broad spectrum of prioritized stakeholders through community partners.
4) Develop measures to evaluate the success of the initial robust, bi-directional HIE communications and education campaign in conjunction with Hiebing.

CEM Messaging

WISHIN messaging has been and will continue to be developed with input from the various WISHIN Advisory Committees and HIE stakeholders in the State. This allows WISHIN to ensure multi-stakeholder perspectives in development of marketing materials and outreach efforts. This section describes the messaging activities that occurred in 2011 and outlines the goals for messaging in 2012.

2011 CEM Messaging-in-Review

In 2011, the WISHIN Communications Advisory Committee prioritized the audiences to receive targeted communications and education to ensure stakeholder types (and specific groups within each stakeholder type) with an immediate need for information received it first.

The WISHIN Communications Advisory Committee identified that the highest priority group for WISHIN messaging and education would be hospitals and eligible professionals that are participating in the Medicare and Medicaid Meaningful Use HIE incentive programs payments. Other audiences, including patients and health care professionals not covered by the incentive programs, would be focused on when information becomes more relevant to them.

A variety of strategies aimed at communicating information to and obtaining information from specific target populations were developed. In addition to targeted messaging and outreach, WISHIN created two new communication vehicles including a new WISHIN website and a monthly e-Newsletter, WISHIN Connections.

WISHIN also collaborated with partners such as WHITEC and WMS to develop outreach and training materials where messages and markets fit and complemented the efforts of both organizations.

The following key messaging strategies were deployed by WISHIN in 2011:

- Launching various marketing and communication initiatives focused on introducing the health care community and stakeholders to WISHIN. Messages focused on WISHIN's purpose, mission, vision, and goals, along with important messages from WISHIN's founding organizations.
- Developing and conducting education initiatives focused on WISHIN Direct, including general use cases for the product and how the product could help eligible providers and hospitals achieve Meaningful Use and receive Meaningful Use incentive payments.
- Creation of a Value Proposition Work Group consisting of several industry leaders and representatives from Wisconsin HIE stakeholder organizations to help identify and prioritize use cases for WISHIN's robust, bi-directional HIE service offering. Value services identified by the work group were used in early 2012 as inputs into the Request for Proposal for WISHIN's robust, bi-directional HIE services as well as the evaluation criteria for vendor selection.

- Formation of marketing communications work groups around WISHIN's WISHIN Direct and WISHIN Bridge products. Marketing campaigns, messaging, and timelines were developed for both products.
- Development and delivery of two educational "town hall" type of meetings (in the Wisconsin Dells and Wausau) that provided education to the health care communities about WISHIN and WISHIN Direct. Sessions included a panel of presenters and were held in different population centers across the state.
- Development of deadline-driven promotional messages for WISHIN Direct that focused on the timeliest benefit of the product: its ability to help eligible professionals and hospitals meet Stage 1 Meaningful Use incentive program requirements for HIE. Target market mailings were developed and distributed to hospital and physician groups to support these promotions.
- Creation of trade show materials (including pre-show target mailings to registered participants) and capitalizing on trade show opportunities including the following events:
    - Wisconsin Hospital Association's Annual Meeting,
    - WHITEC's Health Care Quality Symposium
    - Anthem's Annual Physician meeting
    - Over 50 presentations and educational conference calls given to health care stakeholders in Wisconsin.

At the end of 2011, WISHIN's Marketing Advisory Committee and work groups developed and released an RFP to procure the assistance of a Marketing and Market Research firm to help with the planning and execution of two key marketing and communication efforts in 2012:

1) Consumer outreach and education on HIE and WISHIN.
2) The launch of WISHIN's robust, bi-directional HIE service offering.

2011 CEM Messaging-in-Review

In 2012, WISHIN will work with Hiebing, the selected market research and marketing services firm, to continue to define, develop, and implement the WISHIN CEM plan. The robust, bi-directional HIE technical vendor has not been identified, so WISHIN's product and service offering is not finalized; however, during the research, strategic planning, and professional and consumer outreach stages Hiebing and WISHIN will be addressing:

- Communication and education needs/topics.
- Audiences (i.e., stakeholder types that may need to receive a targeted message or education—refer to the Stakeholder matrix, Table 1 for the specific groups within the stakeholder type, community partners, and collaborators that could provide and deliver the messages or education).

- 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)
- 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. Planning and messaging will be developed with the assistance of Hiebing once the robust, bi-directional HIE technical vendor has been selected and the initial product/service offering is finalized. WISHIN and Hiebing will work with the Marketing Advisory Committee and other HIE stakeholders, and WISHIN's strategic partners to collaborate on areas of communications and education and to share and coordinate resources where it makes sense. Messages, stories and testimonials will be developed around:

- General awareness of the WISHIN
- Benefits of HIE (consumer/patient education component)
- Education on WISHIN's robust, bi-directional HIE products/services

WISHIN Direct Marketing

Background on Direct

Providers everywhere continue to use email, fax machines, and postal mail to communicate patient health information with their colleagues. These methods are appropriate for non-sensitive information, but have inherent disadvantages and security risks when used in a health care setting. The National Direct Project was launched in March of 2009 in response to the growing need for a single standard for exchanging health information electronically. The Office of the National Coordinator of Health Information Technology (ONC) set the stage for collaboration within the private sector to create a secure, simple, cost effective mechanism to send health information directly to a known, trusted recipient using the Internet.

WISHIN's initial product offering, WISHIN Direct, uses and complies with the standards and processes established by the National Direct Project. WISHIN Direct was implemented by WISHIN in August 2011 and offers providers a secure method for exchanging patient information with another provider. The WISHIN Direct product also helps hospitals and eligible professionals have the capability to meet Stage 1 Meaningful Use requirements for HIE.

WISHIN Direct

The following are key benefits of WISHIN Direct:

- It replaces less-secure communication methods, such as email, fax machines, and mail.
- It encrypts messages and securely routes them to the intended recipient, eliminating the risk of information being compromised during transmission.
- It helps providers in meeting Stage 1 Meaningful Use (MU) for electronic health information exchange when they use it to transport content exported from their EHR.
- It encourages the efficient exchange of health information that can lead to better care with less redundancy (for example, decreasing the number of duplicate tests and exams) as routine sharing summary of care records occurs.

WISHIN Direct Market Overview

Wisconsin is progressive in the adoption and use of health technologies that improve health care delivery, patient safety, and outcomes. As a result, opportunities exist for WISHIN to successfully launch HIE services in the state. Some of the market has used their electronic health record (EHR) or HIE vendors to meet the Stage 1 Meaningful Use HIE requirements. Those meeting the Meaningful Use HIE requirement with their EHR vendor have only solved HIE for the short term – subsequent stages of Meaningful Use will require that exchange occurs between providers on different EHR systems. WISHIN Direct allows customers the ability to securely exchange health information regardless of EHR system.

Market Segmentation

There is a potential for many stakeholders in Wisconsin to benefit from WISHIN Direct. Market segments for the product include physician/physician practices, independent hospitals, integrated delivery networks, laboratories, pharmacies and payer groups.

Physicians/physician practices and independent hospitals were the primary market segments targeted during the initial marketing push. Below are six market segments for WISHIN Direct:

- **Physicians/Physician Practices:** Approximately 13,500 physicians (source: WI Medical Society) are practicing in Wisconsin. WISHIN will offer services to physicians and physician practices that could help them realize efficiencies in their business and achieve Meaningful Use requirements for HIE.
  **Primary target for the initial Phase 1 launch*

- **Independent Hospitals:** Benefits of the HIE services to independent hospitals in Wisconsin would include the ability to communicate with physicians, labs, and other hospitals. Additionally, the ability to streamline reporting functions, gain administrative efficiencies, and exchange data electronically with outside entities make independent hospitals a key stakeholder. Wisconsin has approximately 130 acute care hospitals in the state.
  **Primary target for the initial Phase 1 launch*

- **Integrated Delivery Networks:** Integrated Delivery Networks (IDNs) in Wisconsin are widely known for their existing high level of EHR adoption. The ability to exchange data electronically with physicians, labs, and other hospitals not affiliated with their network is a need. Marketing to the IDNs will be customized to each entity and will revolve around the specific needs of the individual entities.
  **Secondary target for initial Phase 1 launch*

- **Laboratories:** During the "white space" analysis, DHS identified laboratories with capabilities to send results electronically and those that are currently not sending results electronically. The white space includes those reference laboratories not currently sending their results electronically outside the walls of their organization. This segment amounts to 41% (114 laboratories) in Wisconsin without the capability of sending results electronically. This segment also represents the potential target market for WISHIN Direct in the near-term; with more advanced bi-directional HIE service offerings to be provided over time.
  **Secondary target for Phase 1 launch. At this time laboratories have no financial incentive to participate in electronic health information exchange.*

- **Pharmacies:** Wisconsin currently has 41 pharmacies that cannot accept electronic prescriptions. This is a small group, but is still part of WISHIN's white space. Similar to the laboratory market segment, pharmacies also have no financial incentive to adopt electronic health information exchange. There will be limited marketing effort dedicated to reach this segment.
  **Secondary target for Phase 1 launch.*

- **Payers:** While payers are not a primary market segment for WISHIN Direct, payers in Wisconsin have approximately 5.4 million covered lives in the state. Payer organizations represent a market segment that could leverage and use the services provided by WISHIN. As potentially significant beneficiaries of HIE, participation by payers represents a key source for sustainability. Education about WISHIN Direct services is important to this group. Targeted communications and education for this group will become more important in robust, bi-directional HIE of WISHIN Direct.
  **Representatives from the Payer groups have been included in the marketing and the Value Proposition Work Group to provide insight on ways and timing to reach out to insurance companies.*

WISHIN Direct Key Messages

For WISHIN Direct, WISHIN focused outreach and education on two groups:

1. Physician/physician practice groups
2. Hospitals

Marketing messages and materials for each group were similar, focusing on the need to meet Stage 1 Meaningful Use requirements for HIE.

Physicians/Physicians Practices

Message: It's affordable for the practice

- Helps you easily meet HIE meaningful use
- Provides greater connectivity
- Allows you to make more informed decisions—with more information
- Smoothens transitions of care
- Will provide a single pipeline of secure health care information for all of Wisconsin (Eventually connects you to other states and nationally)

WISHIN Direct allows you to: Connect with the Statewide HIE to exchange health information and achieve meaningful use.

Independent Hospitals

- Connects hospitals to the Statewide HIE to achieve better patient care
- Provides stronger overall connectivity within Wisconsin
- WISHIN is the statewide health information network
- One solution connects you to WISHIN
- Smoothens transitions of care

Independent Delivery Networks

**Messaging for the IDN group will be customized to each organization*

- Connects users to the Statewide HIE to achieve better patient care
- Provides stronger overall connectivity within Wisconsin
- WISHIN is the statewide health information network and one solution connects you to the statewide network
- Helps improve quality of care
- Smoothens transitions of care reform

Laboratories

- Replaces faxing and migrates to electronic health information exchange
- Allows you to connect electronically with independent physicians
- Provides connectivity to Wisconsin Division of Public Health for reportable conditions
- Call WISHIN, create one interface, and save money.

Pharmacies

- Physicians will be required to send a certain percentage of prescriptions electronically to comply with meaningful use; to stay competitive you need to have an HIE solution
- WISHIN Direct provides your customers (physicians) easier access
- Helps you keep up with the competition/market place
- Connects you to the pipeline of health information exchange
- Helps you migrate to electronic prescriptions (e-prescribing)

WISHIN Direct Marketing Approach Recommendations

WISHIN took a multi-prong marketing and communication approach, using targeted messaging with each market segment. WISHIN staff work with stakeholders, using their channels to disseminate information in print, e-newsletter, meetings, education, or training sessions and vendor fairs.

WISHIN Direct Communications Considerations

WISHIN leverages the Wisconsin Hospital Association and Wisconsin State Medical Society marketing channels (print and electronic newsletters, websites, and meetings) to reach physicians, physician practices, clinics, hospitals, and independent delivery networks in the state.

WISHIN also works with WHITEC to jointly promote WISHIN Direct, educate consumers on HIE and EHRs, and other areas where collaboration and outreach align strategically.

- Wisconsin Hospital Association, *Valued Voice*
- Wisconsin Medical Society, *Medigram*
- Wisconsin Health Information Technology Extension Center (WHITEC), *Compass*
- Wisconsin Collaborative for Healthcare Quality, *News & Views*
- Rural Wisconsin Health Cooperative (RWHC), *Eye on News*
- *Wisconsin Health News*, a health industry independent e-daily

WISHIN Direct Pricing Summary

WISHIN Direct pricing was established based on the following principles:

1. Pricing reflects WISHIN's actual costs to provide the services
2. Discounted pricing encourages early adopters
3. Pricing varies according to the number of users and/or the size of the client
4. Pricing is compatible with "upgrade" pricing for optional value-added services offered in 2012 and beyond
5. Pricing is easy for clients to understand
6. Pricing allows for simple invoicing process

2011 WISHIN Direct Marketing Summary

- In 2011, pre-selling WISHIN Direct allowed potential customers to make informed decisions when selecting ways to achieve their HIE-related Meaningful Use requirements.
- WISHIN and WISHIN Direct education sessions that targeted hospital and clinic C-suite groups (CIO, CFO, and CEOs), along with physicians, and other health care providers, were held prior to the launch of WISHIN Direct. Education Sessions were strategically offered in different parts of the state for widespread messaging.

- Discounted pricing was promoted on the WISHIN web site and in all collateral materials.
- WISHIN Direct was marketed in a series of direct mail pieces to those physicians and hospitals trying to achieve Stage 1 Meaningful Use.
- Collateral material promoted an identifiable cost range for the product price point, which will allow the customers to identify and budget for the cost of the product in 2012.
- WISHIN marketing articulated the difference between just meeting year one HIE-related Meaningful Use requirements and finding a solution for ongoing requirements.
- For the roll out, a marketing tool kit for Stage 1 HIE Meaningful Use was created (logo, post card, press release, information on "how to sign up").
- Developed a leave behind "Sales Sheet" with pricing (August 2011),
- Developed and co-branded a brochure with WHITEC: "Steps to Connect, Adopt and Achieve Meaningful Use."
- Table-top posters were developed to promote WISHIN Direct at trade shows.
- WISHIN Direct talking points were defined and focused primarily on Stage 1 Meaningful Use.
- A list of frequently asked questions was developed for WISHIN Direct.
- WISHIN leveraged stakeholder communication channel opportunities.
- Positioned WISHIN's web site to sell to different WISHIN Direct markets. The web site acts as one of the primary sales tools.
- Educated stakeholders on market segment messaging (ongoing).
- Direct mail post cards were sent to both eligible professional and institutions (focusing on Phase 1 Meaningful Use).
- WISHIN Direct promotional messages were deadline-driven and focused on meeting Stage 1 HIE meaningful use requirements for both hospitals and eligible professionals.
- Educational sessions were held in different areas of Wisconsin: Wausau (8/10/11) and Wisconsin Dells (8/9/11).
- The benefits HIE were promoted in materials and on the web site. While selling WISHIN Direct, WISHIN positioned it as the initial service offering for our more robust HIE service offering(s) in 2012.

2012 WISHIN Direct Marketing Plan

In 2012, marketing for WISHIN Direct will continue in much the same way it did in 2011; however, some additional strategies will be employed:

1. WISHIN Direct will be included in the marketing plans for WISHIN's robust, bi-directional product/service offerings.
2. Because use of the product will be more established, WISHIN will incorporate success stories and testimonials into the marketing materials.

3. Education materials will be further developed, including the potential for web-based training material.

WISHIN will continue to proactively market WISHIN Direct at trade shows, speaking events, and include the product in demonstrations and presentations on HIE.

WISHIN Bridge Marketing

Background on WISHIN Bridge

As the state designated entity for governing HIE in Wisconsin, WISHIN pre-qualifies Health Information Service Provider (HISP) vendors operating in the state to ensure compliance with the national standards and to ensure connectivity between HISPs across the state and, eventually, with the Nationwide Health Information Network (NwHIN). HISP vendors meeting the WISHIN Bridge qualification criteria are branded as WISHIN Bridge HISPs.

WISHIN's vision is to establish a "network-of-networks" for statewide and interstate health information exchange. WISHIN Bridge helps WISHIN achieve this mission by assuring that health information exchange-related products offered in the state follow the National Direct Project standards.

Wisconsin does not mandate that vendors or vendor products used within in the state comply with standards or include connectivity to other products or networks; therefore there is no requirement for HISP vendors (the target market for WISHIN Bridge) to obtain WISHIN Bridge qualification. That said, there are several benefits for both HISP vendors and the providers choosing those vendors/products to obtain WISHIN Bridge qualification. These benefits are outlined in the sections below.

WISHIN Bridge development and marketing launched in October, 2011. WISHIN Bridge promotions were done via the WISHIN web site and via WISHIN's established vendor list service. A vendor education call was also hosted by WISHIN to answer questions regarding the product. Originally, 22 potential clients were highlighted as a target market for this product. As of the first quarter in 2012 three organizations signed up for WISHIN Bridge. WISHIN will add new organizations every six months.

WISHIN Bridge Market Overview

WISHIN Bridge Benefits for HISP Vendors

WISHIN Bridge HISPs are evaluated on an assessment of their services, standards, and compliance with the National Direct Project. By obtaining the WISHIN Bridge qualification (which requires connectivity to WISHIN's HISP) HISP vendors will increase their market exposure and the network coverage for their customers. WISHIN Bridge HISPs will have the opportunity to use WISHIN branding when selling their HISP services. "Branding" includes:

- WISHIN lists all WISHIN Bridge qualified HISPs on the WISHIN web site, including the logo of the HISP and a link to the HISP vendor's web site.

- WISHIN Bridge HISPs are allowed to use the WISHIN Bridge logo on their web site and in their marketing materials in order to promote their product.

WISHIN Bridge Benefits for Providers

When selecting vendors, products, and services for their practices, providers want to know that the products and vendors they choose meet standards and that the solution(s) they select will provide the ability to exchange health information with a broad number of providers. While WISHIN offers its own HISP solution (WISHIN Direct) that meets these standards and includes this connectivity, it is not reasonable for WISHIN to assume that every provider in Wisconsin will buy WISHIN Direct. As a result, it is important that WISHIN offer providers information to help ensure that they are fully informed about the vendors they are choosing.

WISHIN Bridge furthers WISHIN's mission and vision for expanding HIE capacity in the state through standards and connectivity with WISHIN but without requiring providers to purchase a WISHIN product. By selecting a HISP vendor and product that has been qualified by WISHIN as WISHIN Bridge, providers can be confident that the solution they choose meets national standards and offers them the broadest connectivity in the state. In short, WISHIN Bridge offers providers peace-of-mind and confidence in the solutions they choose – even when that solution is not offered directly by WISHIN.

WISHIN Bridge Pricing Summary

WISHIN Bridge costs HISP vendors $500.00 annually.

WISHIN Bridge Messaging for HISP Vendors

WISHIN Bridge Promotes Status

Obtaining WISHIN Bridge qualification gives your organization permission to use the WISHIN Bridge brand when promoting your HISP product. In addition, all WISHIN Bridge HISPs are represented on the WISHIN web site so that Wisconsin providers can select from qualified HISP vendors when choosing their solutions. You can elevate your HISP by getting qualified by Wisconsin's state-designated entity for health information exchange.

WISHIN Bridge Gives your Customers Confidence

WISHIN Bridge qualification tells your customers and future customers that you have been qualified by Wisconsin's state designated entity for Health Information Exchange. This gives your customers confidence that they are choosing a vendor and a solution that meets the standards outlined by the National Direct Project and is going to provide them with the broadest network coverage possible.

2011 WISHIN Bridge Marketing Summary

- WISHIN Bridge promotional communications were sent to the WISHIN Vendor listserv to introduce the product, articulate standards of WISHIN HISPs and the benefits of being a WISHIN Bridge HISP
- WISHIN Bridge logo created
- Talking points developed
- Online sales materials developed
- Collateral information distributed in October 2011; the marketing efforts focused on the status of being a "WISHIN Bridge" HISP
- Updated WISHIN web site with WISHIN Bridge messaging
- WISHIN Bridge HISPs given the WISHIN Bridge logo

2012 WISHIN Bridge Marketing

Twice a year, WISHIN accepts applications from HISP vendors wanting to be WISHIN Bridge qualified. The marketing materials are updated only to the extent necessary to support the timing of the application process.

HIE Services

In 2012, planning and promotion of HIE services will be the primary focus for WISHIN and WISHIN's marketing efforts. This work can be broken down into three key focus areas:

1. Helping consumers understand HIE
2. Promoting the benefits of HIE to patients and potential HIE customers
3. Promoting WISHIN's robust, bi-directional products/services

These three focus areas are critical to successfully marketing the HIE services and ensuring the success of WISHIN.

WISHIN will work with Hiebing to define strategies and tactics, including positioning, general strategies, and marketing mix (products, pricing, and distribution, promotion) to help advance the three focus areas above. In addition, WISHIN and Hiebing will collect and evaluate metrics related to the effectiveness of the strategies and tactics employed so that improvements can be identified and acted upon quickly and the value of HIE can be continually communicated to the right people, at the right time, with the right message.

2012 HIE Product and Services Marketing

In 2012, WISHIN, with assistance from Hiebing, will work to complete the following marketing activities:

- Conduct health care consumer research
- Conduct health care provider research

- Develop a Health care Consumer (patient) Campaign that targets areas identified as needed in the consumer research
- Develop a press kit that addresses HIE and robust, bi-directional HIE products/services
- Write opinion editorials on HIE and WISHIN robust, bi-directional HIE products/services
- Develop and deploy social media activities that focus on consumers
- Continue to collaborate on HIE messaging with stakeholder organizations such as WHITEC, WHA, and WMS
- Develop a flash presentation for WISHIN products/services and HIE to be used on the WISHIN web site or in presentations
- Build out a health care consumer (patient) section of the WISHIN web site
- Brand the robust, bi-directional HIE products/services
- Develop an "elevator speech" for robust, bi-directional HIE products/services and HIE
- Develop a set of testimonials
- Develop patient education pieces on HIE (for distribution by providers to their patients)
- Hold educational sessions, webinars, and town hall types of meetings to "get the word out" on robust, bi-directional HIE products/services and HIE

2012 Crisis Communication

The WISHIN Crisis Communication Plan will be developed by September 2012. The plan will help mitigate the impact of a crisis and any serious negative repercussions for the organization as well as maintain a level of trust with the community. The purpose is to effectively manage communications through formal, clearly defined channels.

The objectives of WISHIN's Crisis Communication Plan are as follows:

- Prepare the WISHIN Board and staff to effectively and nimbly manage crisis communications
- Help the WISHIN Board and staff members respond to a crisis in a unified, professional manner that reinforces leadership and creates loyalty
- Manage the distribution of critical, often sensitive information to the media, stakeholders, and public
- Inform partner organizations of WISHIN'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 WISHIN, its board, and the widespread acceptance and trust of 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 HIE. It

can also be a situation where the media or general public believes the WISHIN did not react to one of the above situations in a timely and appropriate manner. 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 Crisis Communications Plan developed will:

- Identify crisis issues and events
- Include a briefing book with message maps for key communication trigger points
- Identify and provide training for a Crisis Communication Team
- Prepare pre-approved messages for the most likely crisis scenarios
- Include messages for all high-impact events, even if the likelihood of occurrence is low

Marketing Calendar

2012 CEM Activities	Timing
Market Research and Strategy	
Contract with an outside Market Research and Marketing Firm (Hiebing) to help WISHIN implement 2012 CEM objectives	March 27, 2012
Design a market research methodology and questionnaires with the market research firm	2nd quarter 2012
Conduct health care provider research – quantitative online survey of 200 health care professionals across the state (physicians, clinic, hospital and long term care administrators and pharmacists)	April - May
Conduct health care consumer research	April - May
Provide a consumer market assessment and analyze the data	May - June
Develop messaging strategies for the two research audiences	May - June
Potentially hold focus groups with stakeholders and potentially patient groups to refine messaging for WISHIN and robust, bi-directional HIE services	2nd and 3rd quarter
Update the WISHIN website to include robust, bi-directional HIE services and a patient education section that will incorporate testimonials	July-August
Brand Development	
Develop a brand for robust, bi-directional HIE services and a product name to replace "robust bidirectional HIE"	2nd quarter
Develop targeted messaging around WISHIN robust, bi-directional HIE services	July
Educate stakeholders on robust, bi-directional HIE services; provide them talking points and an "elevator speech"	July - August

2012 CEM Activities	Timing
Develop a set of testimonials from WISHIN's implementation programs to be used on the Web site and in collateral material development (print)	July 2012
Develop collateral materials to support robust, bi-directional HIE Services; a Tool Kit will include brochures, power points, and other support pieces	July
Develop a video version of the testimonials for the WISHIN website	July
Incorporate social media with robust, bi-directional HIE service promotion and patient education (with the assistance of the contracted firm) **Track hours on this part of the CEM to evaluate the "fit" of this medium and WISHIN*	August - September
Develop a trade show and event calendar for WISHIN to promote WISHIN, robust, bi-directional HIE services, and HIE	February
Develop a campaign ad to be used in trade shows (minimum) and potentially paid placements	July
Update WISHIN Direct marking collateral to include the additional service offerings	July - August
Public Relations	
Actively seek out speaking opportunities for WISHIN CEO and senior staff members, pitch putting WISHIN on the agenda health care industry meetings	Ongoing
Develop case studies on HIE (study examples)	October - December
Develop a press kit	July
Implement a Public Relations initiatives, focusing primarily on the robust, bi-directional HIE product launch	August - December
Craft Op Eds and Letters to the Editor	October - November
Design and post weekly on Google+ and/or Twitter	August - December
Develop provider-to-patient social media	July - September
Develop additional messaging that targets health care consumers, the "Patient Education Campaign"	Jun-July
Coordinate messaging with stakeholder organizations to educate patients on the importance of HIE; use a collaborative approach whenever possible with WHITEC and other groups	Ongoing
Hold "town hall" types of meetings in selected WI communities	June - December
Craft monthly e-Newsletter, WISHIN Connections **Changing from the 2011 "brief format" to something more substantive with contributors in 2012.*	Monthly or as needed
Expand communication and public relations efforts to include the secondary market groups	July - August
Incorporate robust, bi-directional HIE services into existing promotions	July

2012 CEM Activities	Timing
Develop a Crisis Communications Plan	September
Events	
Develop and promote 1-2 WISHIN educational events per quarter	Quarterly
Promote WISHIN educational events with e-invites, print mailing, and public relations; cross promote with stakeholder organizations.	Ongoing
Develop an Event calendar for WISHIN to capitalize on industry events	February
Continue to "build out" the WISHIN web site to include a patient focused section	June - July
Develop webinars or flash presentation(s) on WISHIN products for the website, highlight, them as a resource link in Connections (WISHIN's e-Newsletter), and promote them with a Constant Contact promotional email to WISHIN's eHealth listserv	2nd quarter

Appendix 8: HIE Development: 2010 WIRED for Health Archive

HIE Development
Environmental Scan for HIE Readiness and Adoption

The Environmental Scan provides an overview of HIE readiness and adoption in Wisconsin, as it relates to clinical providers, including pharmacies and labs; public health; and health plans. While overlaps exist among the HIE capabilities in these three categories, for the purposes of this scan, these categories will be discussed separately. The specific HIE capabilities identified in the following figure relate to various meaningful use objectives and are the focus of this planning effort. The initial step in understanding what HIE infrastructure and services Wisconsin needs to develop involves conducting a scan of the existing HIE capabilities and understanding the gaps.

The State of Wisconsin used a collaborative process to conduct the Environmental Scan to identify existing HIE capabilities and capacities. Inputs into this process included Wisconsin's eHealth Action Plan issued in 2006 and outputs generated by the SLHIE Planning and Design Project, which included input from over 1,000 stakeholders across Wisconsin.

A key input into the Environmental Scan included the output of five HIE regional summit meetings held throughout Wisconsin during the summer of 2009. These summit meetings provided stakeholders with an opportunity to express their opinions and make recommendations on statewide HIE governance, finance, and technical considerations. The Department of Health Services also invited stakeholders to share their opinions on statewide HIE through an online HIE Capabilities Survey, specifically related to readiness and participation.

Survey results from the HIE Capabilities Survey show that respondents are in support of a statewide HIE, but some may be lacking organizational capacity and resources to connect to a statewide health information network. There is currently a high degree of exchange within Wisconsin IDNs but only a minimal amount across unaffiliated providers. The high EHR adoption rate by Wisconsin providers is an enabling factor for HIE.

Clinical HIE Capabilities

The HIE Capabilities Survey recorded results from over 90 respondents across multiple stakeholder types—IDNs, hospitals, payers, consumers, independent physicians, and quality and health information organizations. The survey was available to the public. When stakeholders were asked to describe the statement that best represented their organization's interest in establishing a SLHIE, all but two respondents indicated that Wisconsin should provide a state-level governance structure and HIE services.

When asked to describe their internal readiness to participate in HIE based on organizational capacity, approximately 45 percent (45%) of respondents indicated that participation in health information exchange would stretch their organizational capacity. Organizational capacity was described as 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.

When asked to characterize the priority their organization would place on participation in statewide HIE activities, over 50 percent (50%) of stakeholders indicated participation in statewide HIE is a top priority in the next 3 years or part of their organization's 5-year plan.

Please refer to Appendix 6 for results from the HIE Capabilities Survey participation results.

Organizations have varying degrees of clinical HIE capabilities across the following objectives:

- Clinical summary exchange for care coordination
- Clinical summary exchange for patient engagement
- Electronic prescribing and refill requests
- Electronic clinical laboratory results delivery

The subsequent section discusses the baseline data and identifies gaps for each category.

Clinical Summary Exchange for Care Coordination

There are numerous examples of clinical summary exchanges for care coordination in Wisconsin. The Wisconsin Health Information Exchange (WHIE) is an example of a regional health information organization exchanging information across unaffiliated health systems. There are also other representative examples of clinical summary exchange for care coordination between unaffiliated health systems. This section provides three such examples: the Dane County Care Everywhere pilot, the Marshfield/Ministry exchange, and the Kiara Clinical Integration Network (KCIN). Numerous other examples can be found throughout the state.

While no exchange of full clinical summaries—defined here as a continuity of care document (CCD) consistent with the certification standard—currently exists, these examples do represent existing resources that could be leveraged in the statewide health information network. Based on the examples of clinical summary exchange between unaffiliated health systems included in this section, approximately 9,139 physicians in Wisconsin have the ability to exchange clinical summaries (although not full CCDs).[1] This number does not take into account physicians who may practice in more than one health system or hospital and are currently participating in more than one of the exchanges. The SDE should complete a more detailed analysis during the implementation phase of these and other clinical summary exchange examples.

Wisconsin Health Information Exchange (WHIE) (Intrastate)

[1]The number of physicians identified as having access to clinical summary exchange capabilities may be higher than actual depending on an unknown number of double counted physicians.

The Wisconsin Health Information Exchange (WHIE) is a regional health information organization based in southeastern Wisconsin. Emergency Department (ED) Linking was WHIE's first operational HIE project, funded by a Medicaid Transformation Grant and the five Milwaukee health systems. Current operations are supported by Medicaid, participating health systems, self-funded employers, and commercial and managed care payers.

The exchange receives and aggregates admission, transfer, and discharge (ADT) data real time from hospitals and associated clinics, including allergy history, primary care and case manager background and contact detail, chief complaint, discharge diagnosis, and other encounter specific data. Additionally, the exchange receives weekly data feeds from the Wisconsin Medicaid Program that include prescription fill data; medically relevant fee-for-service claims and HMO encounter data such as procedure and diagnosis detail; and physician, case manager, and pharmacy assignment data, if applicable, for all Medicaid beneficiaries statewide. The Medicaid pharmacy data has about a 1-week lag time and includes date of prescription, date of most recent dispensing, quantity, days' supply, number of refills, and prescriber's name. Much of the Medicaid medical claims and encounter data have an average lag time of about 90 days.

Currently, 44 hospitals, over 120 hospital/ambulatory clinic sites, and 1 FQHC across 24 counties contribute ADT data to the WHIE for both clinical care use and public health syndromic surveillance. WHIE recently implemented its first data feed from a Managed Care Organization (MCO), Independent Care (iCare), which is principally a Medicaid MCO. iCare provides the exchange data on case manager assignment, case manager contact details, and patient specific communications from case managers to providers in the ED and ambulatory settings, enhancing communication between providers and case managers.

The exchange presently has over 525 user accounts and provides clinicians at 10 hospital emergency departments and one federally qualified health center in Milwaukee county real-time access to a patient's historical encounter data stored in the exchange at the time of a patient's care. Clinicians are also able to post a "Clinician Communication" to the exchange about a patient under their care to alert other health care providers to issues that may affect care, such as the existence of a pain management contract. Based on current usage statistics, approximately 320 physicians have access to clinical summary information through the WHIE.

WHIE data suitable for syndromic surveillance and population health analysis is made available to the 16 local health departments serving Milwaukee and Waukesha counties, and to the state Division of Public Health. This data was used for real-time biosurveillance during the recent influenza H1N1 pandemic.

The economic and care impact of WHIE on Medicaid patients is the subject of an ongoing evaluation being conducted by the University of Wisconsin School of Nursing. Preliminary evaluation data from an evaluation being conducted by the Medical College of Wisconsin using physician surveys indicate that WHIE data influence care in 42 percent (42%) of emergency department cases. In about one half of these cases,

change included a reduction in prescribing, imaging, or laboratory testing.[2] Information from WHIE influenced a multi-million dollar impact decision over school closings during the influenza H1N1 pandemic.[3]

WHIE uses Microsoft Amalga Unified Intelligence System® for its exchange and can accept data in a variety of formats, including Health Level Seven (HL7), batch files, customized interfaces, and other current and evolving standards (e.g., HL7 2.x, HL7 3.x, Integrating the Healthcare Enterprise (IHE) Cross-Enterprise Document Sharing (XDS) XDS.b, Digital Imaging and Communications in Medicine (DICOM)). Both query response and central storage use cases are supported.

Depending on changes to data sharing agreements, the WHIE data could be shared for clinical quality improvement and for potential state-level core services such as a Master Person Index and Record Locator Service.

Epic Care Everywhere (Intrastate and Interstate)

One example of electronic health information exchange between unaffiliated health systems in Wisconsin (with potential for interstate expansion) is the Dane County Care Everywhere pilot. In Dane County, health exchange is occurring between health care organizations using Epic Care Everywhere. UW Health, Meriter Hospital, St. Mary's Hospital, Dean Clinic, and Group Health Cooperative South Central Wisconsin, representing a majority of providers in Dane County, exchanged full electronic health records (including patient allergies, medications, immunizations, history, problems, ante partum summary, labs, and results) in emergency departments and urgent care settings during the pilot. Providers surveyed believe this program has improved clinical decision-making and has reduced duplicative testing across EDs and urgent care settings. There are between 80 and 100 patient records exchanged daily between participating organizations. A challenge for the organizations that participated in the Dane County Care Everywhere pilot is current state legislation, which does not explicitly protect health care organizations when collecting prospective consent in an effort to provide better care for patients. This caused the participating organizations to design their workflows to require clinicians to obtain patient consent for HIE at every care encounter.

The pilot ended on July 31, 2010, and the participating organizations are now participating fully in the national Epic Care Everywhere network presently or plan to. Future roll-out strategies across the state are likely to vary by organization.

Through a survey of health system chief information officers (CIOs) across the state currently using or planning to use Epic Care Everywhere and consultation with Epic

[2] Data from J Rubin, MD in Pemble K. Impacting health and care in Wisconsin: the role of HIE. Dairyland HIMSS 10th Annual Spring Leadership and Legislative Conference, May 13, 2010. Delafield WI.

[3] Foldy SL. HIE-enabled Syndromic Surveillance of Pandemic (H1N1) Influenza 2009 and a High-Stakes Decision. Public Health Information Network Annual Meeting, Centers for Disease Control and Prevention, Atlanta, GA. Aug. 31, 2009.

Corporation, it is estimated that approximately 7,731 physicians are using or will have access to clinical summaries (CCDs) through Epic's Care Everywhere application. There may be some duplication in this count because some of the physicians are affiliated with more than on health system using Epic Care Everywhere.

Ministry/Marshfield Exchange (Intrastate)

Another example of electronic HIE among two unaffiliated systems is the Ministry/Marshfield exchange. Marshfield Clinic is a physician-owned and operated medical group comprised of approximately 750 multi-specialty physicians serving Northern Wisconsin. Ministry Health Care operates 11 hospitals in that service area. Seventy-five percent (75%) of all patients admitted to Ministry hospitals over the last five years have been treated by at least one Marshfield Clinic physician.

To provide the best possible care to the shared patient base, Ministry and Marshfield Clinic created a two-provider HIE where all key clinical information collected at Ministry hospitals is shared with the Marshfield Clinic HIE. This information includes clinical summaries, operative reports, discharge summaries, lab results, radiology interpretations, and all digital images.

To the extent that interoperability standards exist, the hospital information system (HIS) leverages these standards. For example, lab results are normalized using the Logical Observation Identifiers Names and Codes (LOINC) standard. The HIE is enabled by managing a common patient numbering system between Marshfield Clinic and the four Ministry HIS databases, which are separate systems from Marshfield Clinic's own EHR.

Combined, approximately 922 physicians have access to clinical summaries through the data exchange between Ministry and Marshfield Clinic.

Kiara Clinical Integration Network (KCIN)

The Kiara Clinical Integration Network allows electronic exchange between Hospital Sisters Health System **(**HSHS) owned and affiliated clinics in Wisconsin and Illinois using a provider portal. HSHS is a health care system that owns and operates 13 hospitals with both owned and affiliated clinics across northwestern and northeastern Wisconsin and Illinois. As a HIE, KCIN's primary objective is to facilitate the exchange of health care information across this system of organizations. KCIN is dedicated to enabling hospital and community partners with the ability to exchange health and other business information in a secure and efficient fashion for the purposes of maximizing excellence in patient care, excellence in care efficiency, and clinician experience excellence.

KCIN current existing capabilities include:

3) Medicity ProAccess Provider Portal eMPI and other associated technology solutions interface with all 13 HSHS hospitals' internal systems. All HSHS hospitals and HSHS owned and affiliated clinics in Wisconsin and Illinois are able to access and/or exchange records using this MPI.

4) Medicity EHR Gateway, Medicity/Novo EHR Grid Agent, and the Medicity/Novo Dropbox provide information access between owned and affiliated clinics and other community partners.

5) KCIN began rolling out two EHR systems (Allscripts Enterprise and EpicCare Ambulatory EHR systems) to community physicians across HSHS served geographies/communities.

The primary goal of these KCIN EHR offerings is to build large, single enterprise-level "virtual" EHRs that can group many smaller physician practices across geography (medical trading area) into a large single system. The intent is to allow more simplistic and efficient access to information within a single EHR and create a single point of integration from these numerous smaller physician practices into either local and/or state-level health care networks. KCIN presently serves approximately 100 physicians.

Community Health Information Collaborative (CHIC) (MN Intrastate and Interstate)

CHIC is a regional HIE in Duluth, Minnesota, a non-profit organization established in 1997. CHIC's mission is to provide regional access and use of health care information through collaboration and has applied for a Minnesota Certificate of Authority to operate as an HIE in Minnesota. CHIC's exchange, HIE-Bridge offers all information exchange capabilities included in the Meaningful Use Stage 1 criteria. HIE-Bridge currently has the capability to exchange key clinical information electronically. Stage 1 "Menu" criteria including ePrescribing and care summaries for referral are also currently available. The architecture of HIE-Bridge is a decentralized, "federated" model allowing each Participating Organization to keep its patients' information behind its respective firewalls. CHIC has a Medical Evidence and Gathering Analysis HIT (MEGAHIT) contract with the Social Security Administration Disability Determination contract to implement Continuity of Care Document (CCD) for exchange. Three of CHIC's participating hospitals will have that capability in early 2011 and others will participate at that level as they work to meet meaningful use deadlines within their respective organizations. HIE-Bridge Core Services consist of the following features and modules:

- Patient Lookup Service (RLS)
- Clinical Data Exchange using Continuity of Care Documents (CCD)
- MDH Immunization Registry (MIIC) Data
- Quality Reporting to CMS
- Public Health Syndromic Surveillance
- Personal Health Record (PHR) Support
- Federated Identity Management
- Role Based Access Controls (RBAC)
- ATNA Audit Logging Subsystem
- Patient Consent Management with Opt-in and Opt-out

Optional services may be selected for a subset of an organization's Participant Users based on their defined roles and responsibilities. These include:

- eScript ePrescribing from RelayHealth

- Lab Results from RelayHealth
- Medication History from SureScript

In addition, HIE-Bridge offers services through its technical partner, MEDNET, which are priced on a custom bid. Services include developing the CCD extract for exchange from existing EHRs, integrating HIE-Bridge within existing EHR systems, and connecting to federal agencies such as the Social Security Administration for disability determination and the Veterans Administration for their upcoming VLER project (Virtual Lifetime Electronic Record).

Essentia Health, an integrated health system serving patients in four states: Minnesota, Wisconsin, North Dakota, and Idaho has a hospital and clinics that are part of the St Mary's Duluth Clinic (SMDC) Health System covering the northwest portion of Wisconsin including Superior, Spooner, Hayward, and Ashland, approximately 66 physicians plus midlevel clinicians and nearly 52,000 unique patients. SMDC is a participating organization in CHIC and is using the Epic EHR and Epic Care Everywhere as well.

Clinical Information Exchange for Patient Engagement

To date, capability for clinical summary exchange for patient engagement exist, but this capability is primarily confined to individual IDNs.

Providers throughout the state are engaging their patients through various tools, including through patient-controlled personal health records. One example of a technology used by patients for clinical summary exchange is the Epic MyChart patient portal. MyChart allows patients to review their medications, immunizations, allergies, and medical history through a secure password-protected web portal. It also allows patients to request appointments, message their provider, and receive test results online. There are numerous other examples of patient engagement found throughout the state.

Electronic Prescribing and Refill Requests

Another area where clinical HIE capabilities already exist in Wisconsin is electronic prescribing and refill requests. Through a survey of all licensed pharmacies within Wisconsin, approximately eighty-eight percent (88%) (1,110 out of 1,264 total pharmacies) of pharmacies accept electronic prescribing and refill requests. According to the 2009 Surescripts' report, "W*isconsin Progress Report on E-Prescribing*," 17 percent (17%) of prescriptions are electronically routed in Wisconsin (up from only 1.94 percent (1.94%) of total prescriptions routed electronically in 2008).[4] For a map illustrating the geographic location of pharmacies and their current ability to accept electronic prescriptions and refill requests, please refer to Appendix 7.

Electronic Clinical Laboratory Ordering and Results Delivery

[4] http://surescripts.com/about-e-prescribing/progress-reports/state.aspx?state=wi

Through the Clinical Laboratory Improvement Amendments (CLIA), the Centers for Medicare and Medicaid Services (CMS) regulates all laboratory testing (except in research) performed on humans in the United States.[5] In Wisconsin, there are 3,489 CLIA-certified labs in Wisconsin. Major laboratory information systems in the state include the following:

- Aspyra CyberLAB
- Cerner PathNet®
- Epic Beaker (formerly known as EpicLab)
- HMS
- McKesson Horizon Lab
- MISYS/Sunquest LIS
- Orchard Harvest LIS
- SCC SoftLab

The WIRED for Health Project conducted a survey of all CLIA accredited and compliance reference labs (767) within the state to determine the baseline number of labs currently delivering results electronically. Survey results indicated that seventy-one percent (71%) (545 out of 767) of labs currently deliver results electronically. For a map illustrating the geographic location of laboratories and their current ability to deliver results electronically, please refer to Appendix 7.

Public Health HIE Capabilities

Public health has developed many different mechanisms over more than a century to collect information necessary to monitor public health and to trigger public health action. This information is often used to alert health care providers of time-sensitive opportunities to improve patient care (e.g., to alert clinicians of a disease outbreak requiring unique diagnostic or therapeutic considerations). The Department of Health's Division of Public Health (DPH) now seeks to improve information timeliness, completeness, and accuracy; and to reduce burdens on health care providers and other information sources, by moving from manual reporting to automatic data transmission from electronic health information systems. DPH also seeks to foster the electronic reuse of data (when appropriate) to improve the effectiveness and efficiency of public health and prevention programs. The division recently created the Office of Health Informatics in a reorganization that unites the State Health IT Coordinator; eHealth program staff; the vital records, population health, and healthcare information sections, the Public Health Information Network program; and the epidemiology coordinator into a single unit ready to share information and develop mutually interoperable systems in the new eHealth environment. The following sections provide details and baseline data about the primary public health capabilities related to immunizations, laboratory reporting, and syndromic surveillance.

Immunization Registry

[5] https://www.cms.gov/clia/

The Wisconsin Immunization Registry (WIR), sponsored jointly by Public Health and the State Medicaid Program, records and tracks immunizations given to Wisconsin children and adults, provides parents with access to their children's immunization records, provides a rich source of data for health care providers and health care organizations, and supports activities related to the Strategic National Stockpile.[6] There are over 1,600 immunization providers and about 2,650 schools with access to the registry who have reported over 50 million immunizations given to seven million de-duplicated clients (a population larger than the State of Wisconsin, including many residents of other states). In 2009, the registry performed 21 million information transactions. Legacy data from providers is typically received by ASCII batch files. New immunizations are received by manual entry (now only 15 percent (15%) of transactions); ASCII files (55 percent (55%) of transactions); HL7 2.3.1 batch files 2 percent (2%); HL7 2.4 batch files 37 percent (37%); HL7 real-time messages using the Public Health Information Network Messaging System (PHIN-MS) 3 percent (3%); and integrated URL encoding queries from inside EHR applications 3 percent (3%). Real-time HL7 transactions via web services with major EHR vendors are under development. The system currently exchanges ASCII or HL7 files with users of several large EHR systems including Cerner, Epic, GE Healthcare, McKesson, the Indian Health Services Resource and Patient Management System (RPMS), and the ROSIE system serving the WIC Supplemental Nutrition program. The WIR system is used by 16 states and U.S. territories, in addition to Wisconsin, where it was initially developed. As part of the Public Immunization Record Access feature, WIR allows parents and legal guardians to look up their child's immunization record in the WIR. This decreases the number of requests to providers for immunization records from their patients and provides parents with ready access to their children's immunization status. WIR also includes assessment reporting tools which help providers better understand immunization needs, rates of immunizations and missed vaccination opportunities. As part of future planning initiatives, DPH is looking to provide direct access to WIR within providers' electronic health record products. A new module of WIR now permits pediatric health providers to access a child's history of tests for lead poisoning.

One hundred percent (100%) of Wisconsin's local health departments and tribal health services currently have access to near-real-time immunization information from WIR (some view WIR data through RECIN, a regional registry in North Central Wisconsin). The receipt of such information from clinical providers is by a many-to-one exchange, with many immunization providers contributing information in one or more of the various modalities described above. Thus, all health departments are able to receive electronic records of immunization from providers, but all providers do not provide such records to the system. Nevertheless, 3,543 provider organizations representing over 30,000 WIR users do use the registry.

- Immunization data submission is considered fairly complete for childhood vaccinators, public health vaccinators, and vaccines administered in large group practices (which represent an unusually large proportion of clinicians in Wisconsin). Approximately 93.5 percent (93.5%) of Wisconsin children born since 1989 have at least two immunizations in the system.

[6] Centers for Disease Control and Prevention.

- A larger proportion of internists, OB/Gyns, and other adult care providers began submitting reports to WIR during the 2009-2010 influenza H1N1 pandemic.
- Improvement is needed in interstate vaccine record exchange to capture a higher proportion of vaccines administered to Wisconsin residents in Michigan, Minnesota, Iowa, and Illinois.

Electronic Lab Public Reporting

The Electronic Lab Reporting (ELR) system, operated by the Wisconsin State Lab of Hygiene (WSLH) on behalf of the DPH, provides results for Wisconsin patients tested for notifiable conditions by either public or private clinical laboratories. Current ELR functionality includes results transmission/delivery, results lists (historical), mandated public health disease/condition reporting, and voluntary public health reporting.

As of July 2010, 100 percent (100%) of local health departments, and the tribal health units that perform case management of communicable diseases in lieu of local health departments, are using the WEDSS. WEDSS receives electronic laboratory reporting through a hub operated by the WSLH. Nineteen major laboratories (including the WSLH) are reporting notifiable results via WEDSS. Over the next 2 years, HL7 reporting will be added from 8 to 10 other laboratories (including three major national labs), and bi-directional laboratory exchange with Minnesota for out-of-state residents. Laboratories that report small volumes of notifiable conditions will continue to use the Wisconsin Laboratory Reporting portal, a manual-entry web interface tailored to their local tests, until ELR exchange for such labs becomes practical. Nine labs are currently using the portal with more extensive training planned over the next 2 years.

Syndromic Surveillance

Currently State Public Health receives near real-time reports of hospital admissions from 44 hospitals and outpatient visits from over 120 ambulatory practice sites across 24 counties via the WHIE. Further expansion of data feeds to WHIE are in progress through funding provided by DPH. Data includes demographics and chief complaint. These represent major providers in every region of the state. An additional six hospitals from three health systems are in various stages of establishing participation with WHIE to further expand hospital and ED visit data volumes. Data includes demographics, date/time/facility of encounter and service type, chief complaint, allergies, primary care physician and for most sites diagnosis. Information from Milwaukee area sites are also received from WHIE by the City of Milwaukee Health Department and the Milwaukee-Waukesha Counties Public Health Emergency Preparedness Consortium of 17 local health departments. A separate project is creating real-time reporting of encounters, including demographics, symptoms, and laboratory results from 22 ambulatory family medicine clinics affiliated with the University of Wisconsin across Central and Southern Wisconsin. This project is scheduled to be operational on 11/30/10. Wisconsin and the City of Milwaukee also have access to syndromic reporting from CDC's BioSense application. The Madison-Dane County health department has online access to a syndromic surveillance system developed by the University of Wisconsin Division Of Emergency Medicine that tracks emergency department visits for influenza-like illness and gastrointestinal illness visits at one large emergency

department. It is otherwise unknown how many other local health departments enjoy local syndromic surveillance systems. Access to data in the possession of the Wisconsin Division of Public Health can be provided to 100 percent (100%) of local public health agencies on a role-based authorization basis through the Wisconsin Analysis, Visualization and Reporting application, but this has not yet been implemented.

Health Plan HIE Capabilities

For the purposes of electronic eligibility and claims transactions, all major health plans in the state can accept the 837 claims transactions and are progressing toward industry-wide acceptance of HIPAA 270/271 eligibility verification transactions. The HIPAA rule requires that "all private sector health plans (including managed care organizations and Employee Retirement Income Security Act (ERISA) plans but excluding certain small self-administered health plans) and government health plans (including Medicare, State Medicaid programs, the Military Health System for active duty and civilian personnel, the Veterans Health Administration, and Indian Health Service programs), all health care clearinghouses, and all health care providers that choose to submit or receive these transactions electronically are required to use these standards." Consistent with this requirement, 100 percent (100%) of health plans support electronic claims transactions and many fully support electronic eligibility transactions. The following section discusses the electronic eligibility and claims transactions in the public and private sector.

Government Health Plans and Electronic Eligibility and Claims Transactions

Health care providers across Wisconsin have multiple methods available to them to verify eligibility electronically for State-managed programs under the "ForwardHealth" umbrella including: Medicaid, Badger Care Plus (all plans), the Wisconsin Well Woman Program, the Wisconsin Chronic Disease Program, SeniorCare, Family Care, and several waiver programs. The following sections describe the State-managed mechanisms for electronic eligibility verification and claims submission.

ForwardHealth Eligibility Verification

ForwardHealth interChange is the State of Wisconsin's Medicaid Management Information System (MMIS), which supports real-time processing of Wisconsin ForwardHealth. ForwardHealth serves over 1.2 Million members and approximately 60,000 providers. To accommodate the significant differences in size, technical proficiency, and need of the providers, ForwardHealth offers multiple options for electronic eligibility verification for the various ForwardHealth programs including:

1) The direct exchange of HIPAA 270/271 transactions
2) The eligibility verification functionality on the ForwardHealth Portal
3) The Automated Voice Response (WiCall) system
4) The Pharmacy Point of Sale (POS)

The exchange of the 270/271 transaction is generally used by larger providers who need to verify the eligibility of a large number of members. The exchange of the

270/271 HIPAA transaction is available free of charge to providers who successfully complete HIPAA compliance testing to validate that they are able to securely transmit the transaction in the correct format. Alternatively, providers may choose to contract eligibility verification out to a verification service that can also be authorized to exchange transaction records. ForwardHealth processes an average of 1.2 million 270/271 transactions per month.

The ForwardHealth Portal contains an eligibility verification function that allows a provider to look up individual members and verify their eligibility in any of the ForwardHealth programs. This functionality is typically used by small-to-medium size providers who are able to do individual member look-ups. Providers must enter specific identifying criteria (as defined by CMS) before they can obtain member-specific benefit information. As with the 270/271 transaction exchange, the ForwardHealth Portal is free of charge to providers. All that is needed is an internet connection.

The WiCall system is available toll-free to providers wishing to obtain eligibility verification information over the phone. WiCall conducts 32,000 eligibility verifications every month.

ForwardHealth Pharmacy providers have the ability to verify eligibility automatically at the time they submit their POS claims transactions. The ForwardHealth system checks 1.1 million eligibility verifications every month. The ForwardHealth POS system checks eligibility automatically as part of the claims adjudication response and notifies the pharmacy if any eligibility issues are discovered. This functionality, although only available to ForwardHealth Pharmacy providers, supports over 2.5 million pharmacy transactions per month.

ForwardHealth Electronic Claims Submission

As with eligibility verification, ForwardHealth offers several mechanisms by which providers can submit claims electronically for any of the ForwardHealth programs, including:

1) Direct exchange of HIPAA 837 claims transactions
2) The claims direct data entry (DDE) functionality on the ForwardHealth Portal
3) The Pharmacy Point of Sale (POS)

Similar to the 270/271 transaction exchange, the exchange of the HIPAA 837 transactions is available to providers who complete HIPAA compliance testing with the State. While ForwardHealth offers this service for free, many providers contract out to a billing service to conduct this exchange on their behalf.

For providers who do not want to contract with a billing service but are also not able to modify their internal systems or conduct the required testing, ForwardHealth offers a free software package called Provider Electronic Solution (PES), which can exchange the transaction electronically with ForwardHealth. Providers are able to enter claims information into PES and then upload the information directly to ForwardHealth.

Providers wanting to submit their claims in real-time or who are in need of a more interactive method of submitting claims can do so through the ForwardHealth Portal claims DDE functionality. Each of the various claims forms (UB04, 5010, and Dental) are available for providers to complete and submit (note: the pharmacy claim DDE functionality is currently under development). The ForwardHealth claims engine processes the claim near real-time (every 15 minutes) and sends the response back to the provider from the claims engine. During data entry of the claim, the provider is given immediate feedback on any potential errors and is able to make corrections prior to submitting the claim. It is important to note that this functionality only processes the claim through the ForwardHealth claims engine and does not provide immediate feedback on responses from the financial cycle.

As noted earlier, the Pharmacy POS system provides ForwardHealth Pharmacy providers with the ability to submit pharmacy claims real-time to the ForwardHealth system. The system supports over 2.5 million POS transactions per month.

Commercial Health Plans and Electronic Eligibility and Claims Transactions

Most insurers receive greater than 70 percent (70%) of claims electronically, though, depending on a health plan's service area and provider relationships, the percentage can be as high as 95 percent (95%). The highest percentage of electronic claims is submitted by pharmacies, nursing homes, and hospitals. Ancillary providers (e.g., PTs, acupuncturists, and out-of-state providers) submit the majority of paper claims. The marketplace currently addresses the need for commercial payers to exchange information electronically. Most payers are already using third party clearinghouses to exchange data.

The highest percentage of electronic claims is submitted by pharmacies, nursing homes, and hospitals. The marketplace currently addresses the need for commercial payers to exchange information electronically. Most payers are already using third party clearinghouses to exchange data.

Supporting Stage 1 Meaningful Use HIE Requirements: Gap Analysis and Strategies

The Wired for Health Project completed a preliminary baseline measurement of HIE capabilities of health care providers to exchange care summaries, of pharmacies to electronically receive prescriptions and refill requests from providers, and of labs to electronically deliver results to providers. Wisconsin has gaps in all three areas. The process used to complete the initial pharmacy and lab data collection, the call scripts, and the survey questions are included in Appendix 7. To assess the feasibility of strategic options to close the pharmacy and lab gaps, we need to complete initial data collection and validation, including reconciling duplicate records and additional outreach to non-responders; and conduct data analysis. We also have to identify and collect additional information about providers, pharmacies, and labs to assess the magnitude and impact of the gaps on eligible professionals and hospitals applying for incentive payments.

The State and the SDE are identifying the providers, pharmacies, and reference labs in the "white space" by collaborating with private sector partners to obtain information about providers that are unable to e-prescribe because their local pharmacies cannot receive electronic prescriptions, that are unable to receive structured lab results electronically because their servicing labs do not deliver results electronically, or that are unable to exchange a clinical summary or CCD with other providers because they are either not part of one of the existing HIE networks described in Section 4.1.1.1 or the network does not yet have this capability. We will also coordinate with the Medicare and Medicaid programs to obtain National Level Registry (NLR) information about providers applying for the EHR Incentive Program that practice in counties with an identified gap. Collectively, the Department of Health Services and the SDE and its partners will conduct outreach to the physicians and hospitals, the pharmacies, and the reference labs identified in the "white space." We will implement feasible strategies to fill gaps so providers will have at least on option for meeting Stage 1 HIE meaningful use requirements. The approach for identifying the "white space" and strategies for clinical summary exchange, electronic prescribing, and lab results delivery are outlined in the section below and in Section 11 where additional technical detail is provided.

Clinical Summary Exchange – As previously noted, no full clinical summary exchange consistent with the CCD certification standard is currently taking place except within the Epic Care Everywhere network. The long-term emphasis of Wisconsin's SOP is focused on establishing a fully robust bidirectional exchange infrastructure (push – pull) and policy framework that enables the exchange of CCDs as described in Sections 7 and 9. However, Wisconsin recognizes this capability will not be operationally achievable in the near term to meet the ONC's CAP requirements for Stage 1 meaningful use and will pursue an interim, near-term technical strategy as described in Section 11 to incrementally achieve its long-term goals.

Electronic Prescribing – Wisconsin has a very high rate of adoption by pharmacies to receive prescriptions electronically. Of the twelve percent (12%) that currently cannot accept electronic prescriptions from a provider's EHR, a portion of these pharmacies are retail or inpatient pharmacies internal to a health system. These health systems already have plans in place to close this gap so their hospital and/or clinic physicians will be eligible for meaningful use. The remaining pharmacies are independent retail pharmacies and define the "white space" for pharmacies. The following strategies will be pursued to address the independent pharmacies currently not accepting electronic prescribing and refill requests:

1) Assess the volume of Medicaid claims coming from pharmacies that do not accept electronic prescriptions and if significant, consider policy levers the State Medicaid Program has to increase adoption, such as HIT incentives; or technical services the State Medicaid Program could provide.
2) Assess feasibility of using state licensure vehicles to set requirements for e-prescribing. Coordinate with WI Department of Regulation and Licensing (DRL) on possible regulatory or policy options. The 2009 Wisconsin Act 362, enacted in May 2010, requires the Pharmacy Examining Board to implement a prescription drug monitoring program and requires pharmacists or practitioners to generate a record documenting each dispensing of certain prescription drugs and deliver

the record through a secure electronic format to the Pharmacy Examining Board. The transmission of these records could potentially be done through the SHIN and may encourage pharmacies to adopt HIT. The Board is permitted to specify penalties for failure to comply. This presents an opportunity for collaboration and may prevent duplication of effort in both infrastructure creation and reporting requirements.

3) Evaluate opportunities to leverage prevalent vendor(s) in the state such as Surescripts to provide connectivity and services to pharmacies that do not currently support e-prescribing at a reduced cost based on a negotiated rate.

Laboratories – Just over half of the labs surveyed have the capability to deliver results electronically. We still need to determine if these labs can deliver structured results, assess the level of transaction volume processed by these labs, and determine geographic coverage. Knowing this information will help determine which strategy is most feasible and best suited to help close the gap. Our primary focus will be on the reference laboratories that are unable to deliver electronic lab results presently to external (not part of the legal entity that owns the lab) providers' EHR's and to public health for reportable conditions. These labs define the "white space" for labs. The following strategies will be pursued:

1) Assess the volume of Medicaid claims coming from labs that are unable to deliver electronic results to providers and if significant, consider policy and HMO contract levers the State Medicaid Program has to increase adoption, such as HIT incentives; or technical services the State Medicaid Program could provide. Wisconsin law does not regulate labs; however, the Medicaid Program does certify labs that want to submit claims to receive Medicaid reimbursement. The State Medicaid Program requires labs to be CLIA certified. The Medicaid Program does not contract with labs.
2) Provide reference lab technical assistance through the SDE's HIE technical operator to implement the Direct project's transport standards and service specifications to push structured lab results to known, trusted health care providers and public health for reportable results using existing health information sharing laws and policies.
3) Providing eligible professionals and hospitals access to a state-level Direct hub with authentication and directory services via a Health Information Service Provider.
4) Negotiate with labs and existing HIEs in Wisconsin or outside of Wisconsin, such as the WHIE, Minnesota HIE (MNHIE), and the CHIC, etc., on providing a structured interface to providers through an HIE network. Eventually this use case will be supported by the SHIN.

Public Health – Three of the 10 meaningful use menu set requirements specify electronic transmission of the following data to public health: immunizations, laboratory results for reportable conditions, and syndromic surveillance. Eligible providers and hospitals must meet five of the menu set requirements, one of which must be a public health requirement.

DPH 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 currently comes to DPH through an arrangement with the WHIE from 44 acute-care Wisconsin hospitals and associated clinics as discussed previously in earlier sections. At least some of these hospitals and clinics 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.

For further details on the Public Health Meaningful Use Implementation Plan, see Appendix 8.

Strategic Framework

The WIRED for Health Board developed a strategic framework that included two interdependent components. The first component consisted of the vision, mission, and guiding principles for statewide health information exchange. The second component included the goals, objectives, and performance measures.

The result was a shared vision that reflected the WIRED for Health Board's collective aspirations for HIE and its impact on stakeholders. The mission translated the vision into a "purpose statement" which captured the importance of statewide HIE to Wisconsin and the health community. The guiding principles developed by the Board articulated the philosophies and core beliefs about health information exchange, which guided goal-setting activities.

Once the Board established the foundation for the strategic framework, the committees identified detailed near and long-term goals and objectives as well as performance measures. Combined, the goals and objectives provided the committees with the strategic direction required to develop the proposed performance measures designed to gauge success. The SDE will be responsible for leveraging this strategic framework in implementing the overall Strategic and Operational Plan. The following section describes the various components of the strategic framework.

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 of individuals and communities in Wisconsin.

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

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

Guiding Principles

Wisconsin adopted the following overarching principles that will serve 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 HIE 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 HIE 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.

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 each of its committees.

While the WIRED for Health Board developed HIT Strategic and Operational Plan for Wisconsin, including the vision, mission, and goals, it will be a nonprofit corporation selected or created to serve as the State Designated Entity (SDE) that will oversee the implementation of the Plan. Once the Plan is approved by the ONC, the goals and objectives under the Plan will serve as the starting point for the implementation period. However, with an eye toward continuous improvement in realizing effective and secure HIE across health care providers, the SDE will also engage in continuous review and updating of the entire Plan, including the goals and objectives. During the term of the State HIE CAP, reassessments and updates to the Plan are required annually in collaboration with ONC.

The SDE will not be directly responsible for achieving the parts of the overarching goals related to EHR adoption. However, it will be the SDE's role to support and foster attainment of these goals for Wisconsin. The SDE is also not responsible for setting standards for providers' EHR systems. Some of the near-term goals will have been accomplished prior to completing the planning and receiving approval of the plan by the ONC.

Overarching 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, non-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:

     All requirements specified by law.

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

     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.

     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.
     - **iii)** Invite broad stakeholder involvement.
2) By September 30, 2010, the State will select the SDE.
   - **a)** By September 24, 2010, an Evaluation Team selected by the WIRED for Health Board will make a recommendation to the Board on the organization to serve as the SDE. The recommendation will include:
     - **i)** The organization that successfully met the evaluation criteria and was rated as the best applicant by the Evaluation Team. The successful applicant 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.

A summary of the applicant's profile with emphasis on what is already in place and what must be built/created/changed before transition of Governance authority can occur.

For details on the selection process, refer to Section 4.1.1.2, "Selection of the SDE."

Long-Term Goals and Objectives:

1) By February 1, 2011, the SDE will assume responsibility for implementation of the Strategic and Operational Plan.
   - **a)** By December 30, 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 requirements.
     - **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 vision, mission, guiding principles, and goals in the Strategic and Operational Plan into the SDE vision, mission, guiding principles, and goals.
     - **ii)** Fully understand and be committed to successful implementation of the Strategic and Operational Plan.
     - **iii)** Establish a focus on continuous improvement in realizing effective and secure HIE across health care providers by implementing a process for continuous 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 continuous 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 domain on capital and operating financing.
2) Prepare a short-term capital acquisition plan for statewide health information network and HIE 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 in the Standards and Architecture domain, estimate the cost of implementation as well as ongoing operations for the statewide health information network and HIE 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 HIE services.
   b) Develop recommendations to overcome or mitigate the identified barriers.
3) Provide contingency 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 domain 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) Communicate with 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.

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:

The timelines and goals presented below may be met at an earlier date, but the goals are intended to serve as a starting point.

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 HIE services. Reference the data collected through other similar surveys to reduce response burden on providers and hospitals.

   b) By July 1, 2011, the near-term technical infrastructure will be available to support eligible health professionals and hospitals in meeting the Stage 1 meaningful use criteria for HIE through the Direct gateway.

   c) By October 1, 2012, the statewide health information network and HIE services will be available for bi-directional exchange to help 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 HIE services will be available to help 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 and initiatives (e.g., NHIN Exchange, NHIN Direct) and ensure planning incorporates standards that will enable interstate

and national connectivity for Wisconsin's statewide health information network and HIE services.

3) By 2016, data accepted by the statewide health information network from EHR systems statewide will be anonymized and made available to authorized entities 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 encourage providers to include standards-based connectivity to the statewide health information network in their EHR roll-out plans.

   b) Encourage all health care providers with EHR implementations to connect to the statewide health information network and provide data.

   c) Will work with experts in the field of anonymization.

Long-Term Goals and Objectives:

1) By 2020, the statewide health information network and HIE 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 personal health record (PHR) solutions and facilitate a standard feed for PHR implementations.

   e) Identify where this capability currently exists, differentiating from IDN-specific portal and HIE-served PHR.

   f) Assess and identify standards for content and communication and adopt these standards in the statewide architecture.

Legal and Policy

Near-Term Goals and Objectives:

1) Establish a policy framework that optimizes the electronic exchange of health information while protecting patient privacy.

   a) Establish uniform privacy and security strategies, policies, and procedures for the statewide health information network and HIE 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 network and HIE services 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 HIE 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 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 HIE 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 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 privacy.

   a) Position the statewide health information network for participation in the nationwide health information network.

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 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.

   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 HIE 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.

Performance Measures

The WIRED for Health Board intends that, over time, the state-level governance entity for statewide HIE will identify measures and analyze the impact HIE has on the health care process and its intermediate and longer-term impacts on health care quality and efficiency. Designing effective ways to capture and report on these measures will be an ongoing governance responsibility.

The WIRED for Health Board identified a number of preliminary, high-level performance measures that will evolve over time as additional guidance becomes available from the ONC and others, such as the State-Level HIE Leadership Forum and the National Opinion Research Center, and as the SDE begins implementation of the Strategic and Operational Plan. The State Health IT Coordinator will assist the SDE in the continuing evaluation of effective performance measures for statewide HIE.

The preliminary measures identified by the WIRED for Health Board are as follows:

Overarching HIT and HIE Measurement Areas:

- The percentage of health care providers participating in HIE services enabled by the statewide HIE technical infrastructure and core services.
  - The percentage of health care providers in the state that are able to send electronic health information using components of the statewide HIE technical infrastructure and core services (e.g., Patient Index, Directory Services, Patient Information Locator Service, and Consent).
  - The percentage of health care providers in the state that are able to receive electronic health information using components of the statewide HIE technical infrastructure and core services (e.g., Patient Index, Directory Services, Patient Information Locator Service, and Consent).
- The percentage of pharmacies serving people within the state that are able to connect to the statewide health information network to actively support electronic prescribing and refill requests.
- The percentage of clinical laboratories (including for example reference laboratories and the State Laboratory of Hygiene (SLOH)) serving people within the state that are able to connect to the statewide health information network to actively support electronic ordering and results reporting. This includes the ability to respond to queries for results outside of the order/result reporting flow such as the case for newborn screening where access to such data may be useful outside of the "standard" pediatric provider.

Governance

- The state-level governing entity's board composition has broad and balanced public and private stakeholder representation, i.e., Medicaid, public health, hospitals, providers, commercial payers, employers, and consumers.

- There is evidence the state-level governing entity is conducting transparent business operations. For example, the governance entity:
  - Publicly posts its meetings and meetings are open to the public;
  - Has processes to regularly inform the public on progress and performance of the statewide HIE initiative (listservs, media presence, etc.);
  - Makes its policies and procedures available on a public Web site or SharePoint site; and
  - Has a working methodology for regular self-monitoring, evaluation and reporting.

Finance

- A working business plan exists, including a plan to acquire capital funding for implementation and a financial sustainability plan that will support business operations throughout the State HIE CAP performance period and beyond.
- The implementation of financial policies and procedures is consistent with state and federal requirements, including Single Audit requirements of the Office of Management and Budget.

Standards and Architecture

- The ratio of number of encounters in the state and the percentage reported to public health for disease surveillance meets or exceeds a yet to be specified percentage.
- The ratio of eligible providers sharing information through electronic HIE and "known" to the Directory Services and those with an EHR meets or exceeds a yet to be specified percentage.
- The ratio of lab results reported directly to EHRs and total number of lab results in comparison to the ratio prior to HIE, recognizing that there is a high uptake of electronic lab reporting in Wisconsin already.

Legal and Policy

- The percentage of patients who opt in/opt out of the HIE (depending on consent model adopted).
- The percentage of participants who are in compliance with their data sharing agreements.

Communications, Education, and Marketing

- The percentage of stakeholders by stakeholder type that know the state-level, state-coordinated HIE effort exists, what it is, and how this effort will help eligible professionals and hospitals achieve the meaningful use criteria related to HIE.
- The percentage of stakeholders by stakeholder type that have raised awareness on how HIT and HIE improves access to more timely health Information and provides opportunities to improve health decisions, safety, and outcomes.
- The percentage of consumers that have raised awareness on how their electronic personal health information is used, secured, and safeguarded by the statewide health information network.

Appendix 9: Interstate Exchange Workgroup Deliverable

ACKNOWLEDGEMENTS

The completion of this document was made possible through the generous contributions of members of the WISHIN Interstate Exchange Workgroup.

Workgroup Members
Cathy Hansen
Kathy Johnson
Daniel Barr
Kathy Callan
Nancy Davis
Dan Peterson
Laurie Schimek
Karl Stebbins

SCOPE OF INTERSTATE EXCHANGE WORKGROUP

The primary goal of this Workgroup is to explore issues unique to interstate health information exchange by WISHIN and Wisconsin providers, and to provide recommendations to mitigate risks to WISHIN and Wisconsin providers unique to interstate exchange.

The primary deliverable for this Workgroup is the development of an Interstate HIE Plan that:

- Discusses what Wisconsin border states are doing with regard to HIE and to ensure that what is implemented in Wisconsin will mesh.
- Documents the extent to which data is currently being shared across state borders and the workflows/policies that support such data sharing.
- Identifies key areas that might be a concern, such as how other states are dealing with patient consent, or if other states have restrictions/policies regarding with who they will connect.
- Includes interstate exchange risks that the Workgroup identifies as unique to Wisconsin.
- Outlines any potential issues and then include further analysis around the level of risk and any recommendations for how/what WISHIN and Wisconsin should do to mitigate those risks.

The plan's focus should be on things that could impact WISHIN's ability to connect to the HIE in other states or things that could impact our border state providers.

UPPER MIDWEST HEALTH INFORMATION EXCHANGE CONSORTIUM (UM-HIE) PARTICIPATION

The Upper Midwest Health Information Exchange Consortium (UM-HIE) was originally comprised of representatives from six states: Illinois, Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin.

After several week s of participation, representatives from Iowa determined they would be unable to complete the scope of work due to resource issues and discontinued participation in the Consortium. Representatives from Illinois participated in Phase I of the project, but will not participate in Phase II

of the project. It should also be noted that Michigan and Ohio are not represented in the UM-HIE Consortium.

Upper Midwest Health Information Exchange Common Consent Form

Members of the WISHIN Interstate Exchange Workgroup collaborated with UM-HIE to evaluate and provide recommendations for a Common Consent Form. Informal feedback was solicited from stakeholders in Wisconsin, including providers and Health Information Management (HIM) professionals, and was submitted to UM-HIE for review and editing. The WISHIN Interstate Workgroup expressed that the Common Consent Form is a plausible option for health care providers that do not have a pre-established consent form; however, there should be no mandate for the use of the UM-HIE Common Consent Form.

Upper Midwest Health Information Exchange Common Consent Form Pilot Project

St. Croix Regional Medical Center, located in St. Croix Falls, Wisconsin, is in the planning phases for a pilot project of the UM-HIE Common Consent form using WISHIN Direct for secure exchange. St. Croix has identified four facilities in Minnesota that they commonly exchange information with and these facilities have been targeted for participation in the pilot project. Wisconsin's State HIT Coordinator is collaborating with the Minnesota's State HIT Coordinator to facilitate this pilot project. WISHIN will leverage lessons learned and best practices from this pilot project in future demonstration projects.

Midwest HIT Coordinators & SDE Executive Directors Conference Call

Wisconsin's State HIT Coordinator, Denise Webb, and WISHIN's CEO, Joe Kachelski, participate in a monthly conference call with State HIT Coordinators and SDE Executive Directors from other states. This group is convened by Illinois and includes participants from Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Missouri, Ohio, and Wisconsin. The purpose of these conference calls is to provide multi-state communication on states' Strategic and Operational Plan (SOP) implementation activities and allow for collaboration on areas that enhance or impact interstate exchange. The calls provide a forum to launch interstate HIE initiatives in support of states' SOPs.

Policy Statement on Interstate Access

A representative from Illinois drafted a "Policy Statement on Interstate Access" document that was presented for analysis and feedback from the WISHIN Interstate Exchange workgroup. The workgroup is in support of a reciprocal state exchange agreement and provided suggestions for improvement, including a stronger supporting statement about the benefits of secure electronic exchange of health information across state borders to patients and providers.

Discussion of Current Practices for Exchanging Health Information

Currently, patient health information is being exchanged within provider networks, regionally, statewide, and nationally. At a minimum, healthcare organizations must comply with HIPAA law and state-specific statutes related to the exchange of patient health information. Health care organizations have developed internal policies and workflows to comply with these regulations. Providers are using postal mail, fax, email, and electronic health information exchanges to transmit patient health information.

Since states have varying statutes that govern the exchange of health information, some of which are more restrictive than Wisconsin state statutes, it is not uncommon for organizations in Wisconsin (especially those on state borders) to have a patient complete an Authorization to Release Information Form prior to establishing a need for the exchange of health information with the border state. This pre-signing of the Authorization to Release Information form allows health information to be readily exchanged once a need is established.

Discussion of Current Plans For Statewide Health Information Exchanges

Several states, including Wisconsin, are pursuing HIPAA Harmonization legislation to allow for electronic health information to be exchanged more readily. While many experts agree that HIPAA Harmonization would reduce barriers to the exchange of health information, states are developing Health Information Exchanges (HIE) that are compliant with current state laws since there is no guaranteed timeline for the passage of such legislation. For this reason, it is necessary for WISHIN to be aware of state laws that impose additional complexity around the exchange of health information.

The Health Information Security and Privacy Collaboration (HISPC) was established by the United States Department of Health and Human Services (HHS) in June 2006. HISPC compiled comprehensive reports that summarize state-specific laws related to the exchange of health information. The Workgroup utilized HISPC reports in their analysis of state-specific laws that may affect interstate exchange.

Illinois Statewide Health Information Exchange

The Illinois Office of Health Information Technology (OHIT) and the Illinois Health Information Exchange Authority are responsible for implementing the statewide Illinois Health Information Exchange (ILHIE).

Illinois State Laws

Illinois has state laws that provide heightened privacy protection for certain types of health information outlined in the "Mental Health and Developmental Disabilities Confidentiality Act." Illinois, by statute, imposes specific patient consent requirements with respect to the disclosure of health information relating to alcoholism and drug abuse treatment, mental health and developmental disability services, testing for and treatment of HIV/AIDS/sexually-transmissible diseases, genetic information testing, treatment of child abuse or neglect, and treatment of sexual assault and abuse.

Illinois Consent Management Approach

In Illinois, most statutes require consent to be written but do not require witnesses or other procedures. Illinois has adopted the federal consent requirements for the release of alcohol and substance abuse treatment information (42 CFR Part 2, Section 2.3.1).

The Phase II (robust) HIE Request for Proposal (RFP issues by OHIT specifies the vendor must supply a robust patient consent management system that enable appropriate filers to patient-specific clinical data based on specialized considerations and/or patient consent.

Illinois Permissible and Non-Permissible Records

Illinois OHIT intends to filter patient-specific sensitive information from the exchange in compliance with existing Illinois state laws.

Iowa Statewide Health Information Exchange

Iowa e-Health, formed by the Iowa Department of Public Health, is responsible for the implementation of the Iowa Health Information Network (IHIN).

Iowa State Laws

Healthcare providers exchanging Protected Health Information (PHI) through IHIN must comply with the policies, procedures, and regulations established by HIPAA.

Iowa Consent Management Approach

Iowa has selected an "opt-out" strategy for consent management. This means, patient health information will be available automatically, unless the patient formally requests that health information not be exchanged.

Iowa Permissible and Non-Permissible Records

The IHIN is not a central depository for health information. The HIE facilitates the exchange of information between EHR systems. The HIE will not store data, except for the information necessary to identify a patient and locate a patient's records.

Image transfers are an option for IHIN; however, this type of service will not be offered initially because of the internet bandwidth required to transfer these files.

Michigan Statewide Health Information Exchange

The Michigan Department of Community Health (MDCH) and the Michigan Department of Information Technology (MDIT) are responsible for the Michigan Health Information Network (MiHIN).

Michigan State Laws

Healthcare providers exchanging Protected Health Information (PHI) through MiHIN must comply with the policies, procedures, and regulations established by HIPAA.

Michigan Consent Management Approach

At this point in time, a statewide approach to consent management has not been developed. Consent is delegated to individuals HIEs and/or trading partners.

Michigan Permissible and Non-Permissible Records

Representatives from MiHIN continue to research and address inconsistent state laws addressing the disclosure of "sensitive" patient information. Based on findings, MiHIN may filter mental health and substance abuse records from the exchange.

Minnesota Statewide Health Information Exchange

The Minnesota Department of Health coordinates the Minnesota e-Health initiative. The e-Health organization is responsible for the implementation of a statewide HIE.

Minnesota State Laws

Minnesota passed legislation in 2007 as part of the Minnesota Health Records Act (Minnesota Statutes sections 144.291-144.298) that established an Opt-Out requirement for including patient information in a Record Locator Service (RLS) in Minnesota. Record Locator Service is defined under this Act as "an electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and group purchasers." (Minn. Stat. section 144.291).

In addition, Minnesota state law requires that a provider obtain the patient's written consent for all releases of patient information; including for treatment, payment, and operations. Patient consent is required each time the provider seeks to access or query the RLS or records through the RLS, expect for emergent situations. Representation of consent (which can occur when the requesting Provider tells the releasing Provider that the patient has given the requesting Provider written consent to obtain his/her patient records from the releasing Provider) is permitted if both Providers are located in Minnesota.

Minnesota Consent Management Approach

Minnesota has a hybrid approach to consent management. For purposes of populating a Record Locator Service (RLS), Minnesota is an Opt-Out state, and by statute requires the operator of the RLS to provide an opportunity for a patient to have his/her patient identifying information excluded from the RLS either through his/her Provider or directly through the RLS. As per Minnesota State Law, the Minnesota e-Health will implement an Opt-Out model to manage consent Minnesota is developing a shared service for consent management; however, requirements and specifications have not been finalized.

Minnesota Permissible and Non-Permissible Records

Minnesota has adopted a market-based approach with state government oversight, which means that there will be multiple health information exchange options in Minnesota as long as they meet certain minimum requirements. Different State-Certified HIE Service Providers will provide health information exchange services for different types of information; therefore, Minnesota is not limiting the types of information allowed for health information exchange, as long as it complies with state and federal law.

Ohio Statewide Health Information Exchange

The Ohio Health Information Partnership ("OHIP") is the state-designated entity responsible for the creation of a statewide HIE. Ohio has been identified as a state that has stringent state laws regarding the confidentiality of health records.

Ohio State Laws

OHIP published the following information in marketing literature for providers with an interest in participating in the statewide HIE, CliniSync:

"A written request signed by the patient, personal representative or authorized person is required for a provider to release medical records Ohio Rev. Code §3701.74. Healthcare providers can be sued and found liable for the unauthorized, unprivileged disclosure to a third party of medical information that a physician learns within a physician patient relationship Biddle v. Warren General Hospital, et al. (1999) 86 Ohio St. 3d 395."

Ohio Consent Management Approach

CliniSync's Privacy and Policy Committee has recommended that, for purposes of HIE, patients be given the choice to opt-in to allow their treating physicians to electronically query their health records from previous treatment episodes. The Committee also recommended that participating entities, such as hospitals and physicians practices, use a standardized CliniSync Consent form to permit them to access a patient's records through CliniSync, which will reassure patients they are in control of who has access to their medical records. This does not mean, nor does the Committee recommend, that a separate patient consent is required for every instance of disclosure of patient information among the patient's treating providers during the course of treatment or for other permitted purposes.

Consent is required on time before a treating physician can query a patient's information on CliniSync. Every entity participating in CliniSync must either obtain a signed HIE Consent form from the patient prior to viewing the patient's medical records or verify that one is on file in the HIE.

Ohio Permissible and Non-Permissible Records

In a September 2011 document, the CliniSync Privacy and Policy Committee published the following information:

"The Code of Federal Regulations (42 CFR Part 2) sets forth limitations on the release of alcohol and drug related health records maintained in connection with any federally assisted alcohol and drug abuse program. This includes the requirement for patient consent for disclosure to include the name/title of the individual-organization to whom/which disclosure is to be made. The Substance Abuse and Mental Health Services Administration (SAMHSA), under HHS, has interpreted this provision as requiring that a patient's consent for inclusion of these records on an HIE list the names of each person or organization to whom disclosures are authorized, as well as the purposes for the disclosure. A similar requirement is included in the Ohio Administrative Code section applicable to release of information by agencies certified to provide mental health services by the Ohio Department of Mental Health (OAC 5122-27-08).

At this point, there is uncertainty as to whether CliniSync will be capable of permitting a selective/granular exchange of records among specific participants in order to comply with the regulatory limitations outlined above. Therefore, the Privacy and Policy Committee has recommended that alcohol, drug, and mental health records not be included in the HIE until further relevant technical, legal and policy considerations are considered. This will take place in the fourth phase of policy development."

Discussion of Health Information Exchange Risks

The following tables list risks identified for interstate exchange of health information in order of importance. Many of the risks identified for the exchange of electronic health information are risks identified in current practices for health information exchange. The risks listed in the table below will be prioritized and assessed as part of the second deliverable for the Interstate Exchange Workgroup.

Health Information Exchange Risks: Policy Risks

The following table displays identified policy risks, a description of the risk, and a mitigation strategy.

Priority	Identified Risk	Description	Mitigation Strategy
1	**State Statutes for Consent**	Numerous states, including Iowa, Illinois, Minnesota, Ohio, and Wisconsin, have consent laws that are more restrictive than HIPAA.	Wisconsin will pursue HIPAA Harmonization. If legislation is not passed, Wisconsin will procure a robust consent management module and develop policies and procedures in compliance with existing state and federal statutes.
2	**Exchange of Sensitive Health Information**	Numerous states, including Wisconsin, Minnesota, Illinois, Michigan, and Ohio, have provisions around the transfer of sensitive health information, such as: Behavioral Health Records, HIV, Alcohol & Other Drug Abuse, Sexually Transmitted Diseases, and Genetics Testing.	Wisconsin will pursue HIPAA Harmonization. If legislation is not passed, Wisconsin will seek to implement technology that filters sensitive patient information.
3	**Reciprocal Agreements between States**	Providers (on the border) that see patients from other states would need to sign up for HIE services in multiple states unless coherent reciprocal agreements exist between states.	Wisconsin should support the proposed "Policy Statement Interstate Access" document discussed during the Upper Midwest Stakeholders meeting.

Health Information Exchange Risks: Technical Risks

The following table displays identified technical risks, a description of the risk, and a mitigation strategy.

Priority	Identified Risk	Description	Mitigation Strategy
1	**Technology Standards**	Standards, such as HL7 and IHE, do not provide enough rigor in message formats to guarantee that data conforms for interstate exchange. This means a Continuity of Care Record (CCR) or Continuity of Care Document (CCD) may not be cross-border compatible.	WISHIN should be cognizant of emerging standards approved by ONC and should create interface control protocols consistent with these standards.
2	**Authentication**	Interstate exchange will require authentication from the Provider that is making the query to receive patient health information. Without a common standard for secure token passing, as well as trusted identity, this is a large risk for the exchange. These types of conflicts are what sophisticated hackers will use to penetrate the system.	WISHIN should discuss the possibility of creating an interstate exchange identity management system in collaboration with other states.
3	**Patient Identification**	States may use different probabilistic matching algorithms to identify patients using demographic data. This could be an issue unless some Protected Health Information (PHI) is used to identify patients. The sharing of PHI for this purpose may violate consent laws in other states.	WISHIN should leverage lessons learned from existing state programs to understand patient (customer) identification mechanisms currently implemented in the state. Additionally, WISHIN should be cognizant of consent laws in other states when designing its Patient Identification system.

Priority	Identified Risk	Description	Mitigation Strategy
4	**Provider Directories**	States will construct provider directories in different manners, such as centralized lookup repositories for provider data. Technology must be developed to share provider information across state lines and map information to the agreed format.	WISHIN should closely monitor progress made by the Standards & Interoperability (S&I) Framework Provider Directory workgroup and leverage best practices and standards to the extent practicable.
5	**Quality Measures**	Different quality measures, (i.e., the detail of information exchanged, service level agreements like transmission time, and atomicity of data exchanged) will be used by states to evaluate quality. The underlying data may not be compatible which could lead to different results, especially in the consolidated repository.	WISHIN should stay abreast of developments from the ONC related to data standardization.
6	**Technology Limitations**	Due to internet bandwidth limitations, several statewide HIEs have documented concerns about the exchange of images. Healthcare organizations may be required to enforce additional policies around the exchange of this information.	Edge servers should be used by WISHIN participants to introduce local caching to reduce download and bandwidth issues from the central server.

Appendix 10: Liability Issues Workgroup Deliverable

MEMORANDUM

TO: **WISHIN POLICY COMMITTEE**

FROM: **WISHIN POLICY COMMITTEE LIABILITY ISSUES WORKGROUP**[7]

DATE: **August 10, 2011**

RE: **Liability Concerns and Recommended Mitigation**

The Liability Issues Workgroup (Workgroup) met on Thursday, July 14, 2011, at the Wisconsin Medical Society. It identified a number of liability concerns relevant to WISHIN and its participants, as well as to others who might be impacted. It also agreed upon recommendations for WISHIN to explore to address those liability concerns. Those concerns and recommendations are detailed in this memorandum. Evaluating the liability concerns of WISHIN and its participants will be an ongoing responsibility for WISHIN as it develops and expands its business plan, products and services.

A. <u>Liability Concerns</u>

1. Negligence
    a. Inappropriate disclosure of patient data (due to theft or accident)
    b. Errors and omissions in data entry
    c. Professional liability could flow from exchange of inaccurate, incomplete or untimely information
        i. Wrong patient data exchanged due to similar name or demographic information
        ii. Human error in data processing
    d. Duty to review/Failure of data users to utilize available data
        i. "There are no widely recognized standards for reasonable physician behavior in seeking or reviewing electronically available data, or for the extent to which that data should inform his/her clinical decisions."[8]
        ii. Unable to check HIE for pertinent clinical information when doing so may not be feasible or possible (unable to connect)

---

[7] List of Workgroup members and their affiliations is attached.

[8] *Liability Coverage for Regional Health Information Organizations—Lessons from the AHRQ-Funded State and Regional Demonstration Projects in Health Information Technology and Other Community Efforts (AHRQ Report) June 2009, Page 12; HIE Liability and Insurance article/post, August 10, 2010, viewed at:* http://www.legalhie.com/lawsuits/prescription-label-dumpster-de-je-vu/

e. Improper transmission of health information
    i. Information sent to wrong provider
    ii. Information sent without necessary consent
f. Technology malfunction resulting in erroneous data
g. Mismanagement: Hiring unskilled/untrained staff, failure to supervise, failure to have or implement proper policies
h. Identity theft (statutes may create separate cause of action besides negligence)

2. Vicarious liability (WISHIN for its participants and vice versa)
3. Products liability (IT Vendors/Providers)
4. Contractual
    a. Master data sharing agreements (MDSAs)
        i. "tremendous variability in the MDSA terms"[9]
    b. Business Associate Agreements
    c. Contracts with data providers
    d. Contracts with data users
    e. Contracts with technology providers

B. <u>Potential Damages</u>

1. Violation of patient privacy (remedies under HIPAA, state law, common law violation of privacy)
2. Negative health outcomes (remedies for malpractice, other negligence)
3. Breach of contract

C. <u>Factors Impacting Liability (and also insurance premiums)</u>

1. Data ownership – What amount and type of data will WISHIN centrally store (PHI)? The more data resides at WISHIN, the higher the liability concern. Likewise, the more clinical data, the higher the concern as compared to administrative data.[10]
2. Technical architecture: Use of a federated (decentralized) architecture associated with less risk.[11]
3. Data security: Where stored, how many people have access, firewalls, encryption and intrusion detection.[12]
4. Extent of services provided: The more services, the higher the exposure.[13]
5. Number of exchange partners and volume of transactions[14]

---

[9] *AHRQ Report*, page 7

[10] AHRQ Report, page 17

[11] Id.

[12] Id.

[13] Id.

6. State and Federal laws[15]
    a. Sovereign Immunity for HIE and participants
        i. Pros[16]
            1. Increased stakeholder participation
                a. Participating organizations would want liability protection, not just central organization, or else there would be concern that they are bearing the liability burden (deep pockets).
            2. Decreased start-up costs
            3. Long-term stability
        ii. Cons [17]
            1. HIE may not be sufficiently rigorous in establishing privacy and security controls.
            2. Unintentionally reduce sense of accountability. [18]
                a. Does answering to the public provide that accountability?
            3. Immunity for entity governing/facilitating exchange only (not for its participants) may decrease stakeholder buy-in as potential participants would interpret the immunity for the entity governing/facilitating exchange to mean that participants would be more likely targeted in lawsuits.[19]
        iii. Examples
            1. Delaware—As a RHIO, Delaware Health Information Network (DHIN) granted sovereign immunity, exempting DHIN and its member organizations from liability under State constitution. RHIO will not be held liable except in cases of bad faith or malicious conduct. Statute was largely created for the purpose of addressing physicians' liability concerns. [20]
                a. Stakeholders spent over a year discussing alternatives and building consensus; trial lawyers lobbied in opposition. [21]

---

[14] Id.

[15] *AHRQ Report*, pages 19-21

[16] AHRQ Report, page 20 and 27

[17] Id.

[18] A*HRQ Report*, page 20

[19] *AHRQ Report*, pages 20 and 27.

[20] *AHRQ Report*, pages 19- 20

[21] Id.

b. Statute has a provision that provides immunity to health care providers who rely in good faith upon information accessed through HIE.[22]
c. To further ease physicians' concerns about liability, DHIN statute states that providers of inaccurate data will be held responsible only if they violate specific rules in their contracts.[23]
d. Some questioned whether sovereign immunity would unintentionally reduce sense of accountability.[24]
    i. DHIN would have to answer to public, which may provide another mechanism for accountability.
e. May be more difficult for larger states to pursue Delaware model because of the effort required to come to a consensus.[25]

iv. Florida—Electronic Health Record Exchange Act: Provides immunity from liability for a health care provider releasing an identifiable health record in reliance on the information provided to the health care provider on a properly completed Agency authorization form.
v. North Dakota—Governor signed HIE legislation that included immunity provision on April 25, 2011
    1. New code provision— Immunity for reliance on data from the health information exchange. A health care provider that relies in good faith upon any information provided through the health information exchange in the treatment of a patient is immune from criminal or civil liability arising from any damages caused by that good-faith reliance. The immunity granted under this section does not apply to acts or omissions constituting gross negligence or reckless, wanton, or intentional misconduct.
vi. Nevada—On June 13, 2011 Governor signed HIE legislation that included immunity from liability to health care providers for certain acts in connection with EHR and the statewide HIE and to governing entity of HIE, the administrator of the system and HIEs for information which they include or cause to be included in statewide HIE in certain circumstances.
    1. NV SB 43—Section 9—Immunity for Health Care Providers

[22] *AHRQ Report*, page 20

[23] Id.

[24] Id.

[25] Id.

A health care provider who with reasonable care relies upon an apparently genuine electronic health record accessed through the statewide health information exchange system to make a decision concerning the provision of health care to a patient is immune from civil or criminal liability for the decision if:

1. The electronic health record is inaccurate;
2. The inaccuracy was not caused by the health care provider;
3. The inaccuracy resulted in an inappropriate health care decision; and
4. The health care decision was appropriate based upon the information contained in the inaccurate electronic health record.

2. NV SB43—Section 9.5—Immunity for HIE—Governing Entity, Administrator and HIEs

The governing entity established or contracted with pursuant to section 6 of this act, a public or private entity with whom the governing entity contracts to administer the statewide health information system pursuant to section 6 of this act, and any health information exchange with which the governing entity contracts pursuant to section 6 of this act that with reasonable care includes or causes to be included in the statewide health information exchange system apparently genuine health-related information that was provided to the governing entity, administrator or health information exchange, as applicable, is immune from civil and criminal liability for including the information in the statewide health information exchange system if reliance on that information by a health care provider results in an undesirable or adverse outcome if:

1. The information in the statewide health information exchange system mirrors the information that was provided to the governing entity, administrator or health information exchange;
2. The health care provider was informed of known risks associated with the quality and accuracy of information included in the statewide health information exchange system;
3. Any inaccuracy in the information included in the statewide health information exchange system was not caused by the governing entity, administrator or the health information exchange; and
4. The information in the statewide health information exchange system:
   (a) Was incomplete, if applicable, because a health care provider elected not to participate in the system; or
   (b) Was not available, if applicable, because of operational issues with the system, which may include, without limitation, maintenance or inoperability of the system.

b. Other immunities or limitations on liability.

c. Continued monitoring by HIE—"HealthBridge recently hired a full-time employee to regularly monitor State and Federal laws and regulations for affects on the RHIO's liability and operations. Variation in the state interpretation of Federal regulations such as HIPAA, and the impact of other relevant State laws and regulation necessitate this kind of vigilance."[26]
d. Accreditation
    i. Would establishing accreditation provide a level of credibility that would make it easier to acquire appropriate coverage/keep costs of coverage and premiums down? [27]
    ii. Accreditation may also negatively impact HIEs (i.e., increased burden on entities operating and/or governing exchange).[28]

D. Options to Address Potential Liability

"The distribution of liability is typically a collective decision and can be a lengthy process requiring considerable negotiation to ensure the agreement of all parties in the sharing of liability."[29]

1. Insurance –HIE
    a. Risk Assessments vary; little or no precedent to evaluate risk based upon functionality or technical architecture
    b. High degree of uncertainty with regard to what constitutes adequate coverage
    c. Insurance policy options for HIEs/RHIOs, while growing, remain limited
    d. Wide variability in liability practices across HIEs
    e. Premiums vary greatly depending on technology, type of data exchanged, and extent of services offered
    f. Revenues limited (mostly grant monies)
    g. Accreditation (e.g., EHNAC) can help with premium cost
        i. May create other issues for HIE
    h. Coverages that other organizations have obtained include:
        i. Directors & Officers (D&O)
        ii. Errors & Omissions (E&O)
        iii. Employment Practices Liability
        iv. Technology Errors & Omissions
        v. General liability
        vi. Cyberliability
        vii. Product liability (for IT vendors)

[26] *AHRQ Report*, page 19

[27] AHRQ Report, page 20

[28] Id.

[29] *AHRQ Report*, page 7

viii. Professional liability (malpractice)
ix. Umbrella

2. Insurance—Participant (health care providers)
    a. Current coverages
    b. Additional coverages as a result of HIE participation
        i. Added cost of participation (in addition to subscription fees) for health care providers –if the cost and liabilities are too high or complex the incentive to participate will decline.
3. Insurance—Participant (non health care provider—IT vendors, partnering/Qualified Organizations [data sources and data users], state agencies)
    a. AHRQ Report noted that one factor that strongly influenced the amount of liability assigned to IT vendors was the negotiating power of the RHIO. Type of coverage in their liability insurance that the IT vendors were asked to carry varied, but typically total liability coverage ranged from $1-$3 million.
4. Statutory Immunity/Protections (absolute immunity, damages caps) – only protect from state law claims if under Wisconsin statute
    a. Examples
        i. Delaware (described earlier)
        ii. CORHIO MDSA included language acknowledging special characteristics of governmental hospitals
        iii. North Dakota (described earlier)
        iv. Nevada (described earlier)
        v. Florida –Liability protections tied to use of standardized forms
5. Raising the level of fault required to bring suit on a claim related to HIE participation.
6. Contractual indemnification – how to apportion liability among stakeholders (data providers, data users, WISHIN, technology providers, etc.)[30]

E. <u>Potential Recommendations</u>

The Liability Issues Workgroup recommends that WISHIN:

1. Pursue HIPAA harmonization legislation to eliminate risks and operational challenges arising from Wisconsin's more restrictive privacy laws.
2. Pursue legislation providing immunity to participants in HIE in Wisconsin and WISHIN itself. The Nevada and other models should be consulted to determine what best works for Wisconsin. The liability issues workgroup recognized that its group represents mostly providers, and that there are other advocacy groups (e.g., trial lawyers) who will oppose immunity, but this workgroup recommends that WISHIN pursue immunity to the extent

[30] *AHRQ Report* noted that negotiating indemnification language has been challenging for RHIOs, and also that there are sustainability concerns with RHIOs given financial support currently mostly grants. See pages 13-14.

possible under Wisconsin law, recognizing that there will remain exposure to liability at the federal level regardless (HIPAA, HITECH, etc.)

3. Engage lobbyist(s) to pursue (1) and (2).
4. Consult with an insurance broker to obtain appropriate coverage.
    a. Plan ahead with insurance application process. Don't underestimate resources required.
5. Build consensus among partners on liability distribution. The subgroup did not believe providers would be willing to participate if they perceive that they will be exposed to increased liability, at least until the value proposition of WISHIN products becomes more clear and the value of participation is perceived to outweigh the risks associated with such participation.
6. Secure appropriate resources to track and address these issues, and to keep abreast of the developing liability landscape of similar activities across the country.
7. Evaluate the liability concerns of WISHIN and its participants on an ongoing basis and make adjustments to WISHIN's strategy for managing such risk as needed.
    a. This will be critical, as at each stage of product development, the risk analysis may change.
8. Make risk evaluation management for itself and its participants an ongoing activity and priority.

This memorandum constitutes the completion of all deliverables currently requested of the Workgroup in the Committee Workplan. The Workgroup shall reconvene as needed based on future requests for the Workgroup's input, feedback or recommendations.

Appendix 11: Sample WISHIN Direct Participation Agreement

PART 1: IDENTITY VERIFICATION FORM

IVF #: **(pre-populated with auto numbering)** **Preferred Direct Address:** **(pre-populated by web form)**
Date: **(pre-populated with auto date)**

First Name: **(pre-populated by web form)** **Last Name:** **(pre-populated by web form)**
Lic/Cert Type: **(pre-populated by web form)** **Lic/Cert #:** **(pre-populated by web form)**
Practice Name: **(pre-populated by web form)** **Email:** **(pre-populated by web form)**
Address: **(Address 1: pre-populated by web form)**
(Address 2: pre-populated by web form)
(City, State, Zip: pre-populated by web form)

PARTICIPANT ORGANIZATION AUTHORIZATION	
PRINTED NAME OF ORGANIZATION'S SIGNING AUTHORITY	SIGNATURE OF ORGANIZATION'S SIGNING AUTHORITY

INSTRUCTIONS FOR NOTARY

FOR THE PURPOSES OF THIS DOCUMENT, PERSONAL ACQUAINTANCE WITH THE INDIVIDUAL IS INSUFFICIENT. YOU MUST:

1. Review a current government-issued ID containing the individual's name and photograph.
2. Record the serial number and type of government-issued ID presented by the applicant. You should also record in your "notary's journal" the ID serial number of the identification that was presented to you.

The undersigned applicant warrants, represents, and attests that all facts and information provided are accurate, current, complete and not misleading and that he or she:

1. is authorized to receive, and has applied for, a digital certificate to be issued by Certificate Authority;
2. has read and accepts the personal identifying information to be contained in the certificate;
3. is who he or she represents himself or herself to be; and agrees to comply with the responsibilities associated with being a Participant, including the terms and conditions found in this WISHIN Direct Secure Messaging Participant Agreement.

The applicant agrees to accurately represent him or herself in all communications using the digital certificate.

TO BE COMPLETED BY PARTICIPANT IN THE PRESENCE OF THE NOTARY

Signed By: _____
(Sign Only in the Presence of Notary)

Printed Name: _____
First Name, Middle Initial, Last Name

TO BE COMPLETED BY THE NOTARY

Acknowledgement

State of:_____ County of: _____

The foregoing instrument was acknowledged before me this_____ day of_____ ,_____ , by the signer and subject of the above form, who personally appeared before me and signed or attested the same in my presence, and presented the following government-issued photo ID card as proof of his/her identity:

_____	_____	_____	_____
Exact Name Listed on Photo ID	Serial Number of Photo ID	Expiration	ID Type

Notary Public:_____

Residing in: _____

My Commission Expires: _____

Street Address of Branch or Office

Name of Organization Employing Notary

PART 2: PARTICIPANT and ORDER INFORMATION

PARTICIPANT INFORMATION

Date: **(pre-populated by web form)**

Preferred Direct Address: **(pre-populated by web form)**

First Name: **(pre-populated by web form)**

Last Name: **(pre-populated by web form)**

Lic/Cert Type: **(pre-populated by web form)**

Lic/Cert #: **(pre-populated by web form)**

Practice Name: **(pre-populated by web form)**

Address: **(pre-populated by web form)**

Email: **(pre-populated by web form)**

Telephone: **(pre-populated by web form)**

Website: **(pre-populated by web form)**

ORDER INFORMATION

Description of Services
(pre-populated by web form)

SKU

PART 3: FEES and TERMS

WISHIN Direct fees are as follows:

Individual WISHIN Direct addresses:

- $300/year per person; however, if you sign up before January 2012, you pay $200/person for the first year.
- This service is designed to support unlimited professional email usage but excludes machine generated messaging.

Organizations that have six or more participants with individual WISHIN Direct addresses:

- $240/year per person; however, if all participants sign up before January 2012, each participant pays $160 for the first year.
- This service is designed to support unlimited professional email usage but excludes machine generated messaging.

Machine WISHIN Direct addresses:

- $1,500/year per machine. If you sign up before January 2012, you pay $1,040/machine for the first year.
- This service is designed to support machine generated Direct messages.

Payment is required at enrollment and Net 30 days from invoice date.

Participant hereby authorizes WISHIN to provide the services as described above and warrants and represent that Participant has the requisite authority to legally bind and approve payment of forthcoming invoices. Via written notice to WISHIN, Participant may cancel services for any reason within 30 days of invoice date, resulting in a refund of service fees. Written notice must be sent to:

WISHIN
Attn: WISHIN Direct
PO Box 259038
Madison, WI 53725-9038

PART 4: NETWORK OPERATIONS, POLICIES, and TECHNICAL REQUIREMENTS

Participant must provide its own web browser and workstations, desktops, laptops or other hardware, software, and applications as necessary to access the internet. The minimum technical requirements are:

Internet Explorer versions 6 through 9
FireFox versions 2 and higher
Opera versions 9 and higher
Safari versions 3 and higher

Google Chrome (any version)

WISHIN Direct does not impose an internet connection speed requirement; however, transferring any large files via a slow (dial-up) connection may not be workable. A broadband connection is recommended.

Integration of WISHIN Direct into an existing software package, such as an electronic medical record, may necessitate additional requirements.

PART 5: WISHIN DIRECT SECURE MESSAGING PARTICPANT AGREEMENT

Participant Legal Name: **(First Name and Last Name: pre-populated by web form)**

This WISHIN Direct Secure Messaging Participant Agreement, which includes the above Parts 1-4, this Part 5 and the following Parts 6-7 (this "Agreement"), is an agreement between the Participant set forth above and the Wisconsin Statewide Health Information Network, Inc. ("WISHIN"), a nonstock, not-for-profit corporation administrating Wisconsin's statewide health information exchange.

This Agreement is made effective as of (**pre-populated by web form)** (the "Effective Date").

RECITALS

A. Participant furnishes, or may furnish, healthcare or healthcare related services to individuals in Wisconsin.

B. WISHIN furnishes health information exchange related services and products, directly and through its certified vendors, to subscribing participants.

C. Participant desires to access and use the WISHIN products and services set forth below, and WISHIN agrees to furnish such services under the terms of this Agreement, including the WISHIN General Terms and Conditions of Participation, set forth in Part 6 and incorporated herein by reference and as amended from time to time, (the "Terms and Conditions").

D. Capitalized terms used but not defined in the body of this Agreement shall have the meanings given to them in the Terms and Conditions.

In consideration of the Recitals and the mutual agreements that follow, the parties agree as follow:

AGREEMENTS

1. Services and Support. WISHIN shall furnish the following to Participant:
   (a) Access to Direct Secure Messaging; provided, however, that WISHIN shall not be responsible for or verify the accuracy of any messages or whether any participant is authorized to send, receive, use, or disclose particular information and/or Health Data;
   (b) Documentation on how to access and use the Direct Secure Messaging available to Participant online.
   (c) Telephone support during business hours to answer reasonable questions regarding how to use the Direct Secure messaging.
   (d) All licenses necessary for Participant to access the Direct Secure Messaging.
   (e) Any other custom, professional, or technical services as agreed in a writing signed by the parties from time to time.
   (f) Create and maintain for six (6) years an audit trail of Participant's (including each Participant Authorized User) transactions.

2. Permitted Purposes for this Direct Secure Messaging Service. Participant agrees to use Direct Secure Messaging to send Health Data to, or use Health Data received from other participants only in strict compliance with HIPAA and all other Applicable Law and for only the following (the "Permitted Purposes"):
   (a) Participant's or another health care provider's Treatment (as that term is defined in the HIPAA Regulations) of the individual who is the subject of the PHI sent or received by Participant or a Participant Authorized User.
   (b) Participant's or another Covered Entity's Health Care Operations (as that term is defined in the HIPAA Regulations); provided, however, that in the case of Participant's disclosure of PHI to another Covered Entity: (i) Participant and the other Covered Entity each had or shall have a Treatment relationship with the Individual

who is the subject of the PHI; (ii) the disclosure is for a purpose permitted by the HIPAA Regulations; and (iii) Participant shall disclose or request and use only the Minimum Necessary (as that term is defined in the HIPAA Regulations) PHI.

(c) Public health activities, as permitted by Applicable Law.

(d) Reporting on clinical quality and other measures to demonstrate "meaningful use," as specified in regulations promulgated by the Department of Health and Human Services, or other payer incentive or accreditation programs, to the extent permitted by Applicable Law.

(e) Each disclosure and each receipt of Health Data by Participant through Direct Secure Messaging shall constitute a certification by Participant that Participant is complying with this Section 2.

3. Responsibilities of Participant. Participant shall:

(a) Comply, and have each Participant Authorized User comply, with this Agreement;

(b) Comply with Network Operating Policies and Technical Requirements in Part 4;Register with WISHIN as a participant in Direct Secure Messaging;

(c) Provide a completed and notarized Identity Verification Form (Part 1);

(d) Provide its own web browser and the workstations, desktops, laptops or other hardware, software, and applications as necessary to access the internet, the minimum technical requirements are set forth in Part 4;

(e) Verify each Participant Authorized User;

(f) Update its information with WISHIN as necessary and required;

(g) Permit its registration information to be audited for consistency with other information sources; and

(h) Be solely responsible for its use, nonuse and interpretation of any Health Data it receives, and the accuracy of any Health Data it sends, using Direct Secure Messaging.

4. Term and Termination. This Agreement shall commence on the Effective Date, continue for a term of one year, and automatically renew for additional one-year terms, unless earlier terminated as set forth in this Agreement (including Section 14 of the Terms and Conditions). Either of Participant or WISHIN may choose to not renew this Agreement upon written notice to the other party at least 30 days prior to any renewal date.

5. Fees. As consideration for the Services, Participant shall pay to WISHIN the fees set forth in Part 3, in accordance with the Terms and Conditions.

6. Miscellaneous. Each party represents and warrants that the individual executing this Agreement has read and understood its terms and is duly authorized to execute and deliver this Agreement.

Accepted by PARTICIPANT:	Accepted by WISHIN:
By:_____	By:_____
Print Name:_____	Print Name:_____
Title:_____	Title:_____
Date:_____	Date:_____
Address for Notices: _____	Address for Notices: _____
_____	_____
_____	_____
_____	_____

PART 6: WISHIN GENERAL TERMS and CONDITIONS of PARTICIPATION ("Terms and Conditions")

1. Definitions.

For the purposes of the Agreement and these Terms and Conditions, capitalized terms shall have the meanings set forth below:

"Agreement" means the WISHIN Direct Secure Messaging Participant Agreement entered into by and between WISHIN and Participant, including Parts 1-7.

"Applicable Law" means the applicable statutes, rules, and regulations of Wisconsin, as well as all applicable federal statutes, rules, and regulations such as HIPAA.

"Common Network Resource" means software, utilities, and automated tools made available for use in connection with the Network and which have been designated as a "Common Network Resource" by WISHIN.

"Covered Entity" shall have the meaning set forth in the HIPAA Regulations.

"Direct Secure Messaging" means the service through which Participant's System may be accessed and used by Participant Authorized Users to send Health Data and related information regarding an Individual to, or receive such data from, Participants and Wisconsin's public health agency.

"Discloser" means Participant, a Participant Authorized User or WISHIN that discloses Proprietary Information to a Receiving Party.

"Dispute" means any controversy, dispute, or disagreement arising out of or relating to this Agreement.

"Health Data" means that information which is requested, disclosed, stored on, made available on, or sent through the Network, including, but not limited to, Participant directory information, patient directory information, PHI, individually identifiable health information, de-identified data (as defined in the HIPAA Regulations), Limited Data Sets as defined in the HIPAA Regulations, pseudonymized data, metadata, and schema.

"HHS Secretary" means the Secretary of the United States Department of Health and Human Services or a designee.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended and as implemented by the HIPAA Regulations.

"HIPAA Regulations" means the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160, 162 and 164) promulgated by the U.S. Department of Health and Human Services.

"Network" means Wisconsin's statewide health information network operated by WISHIN that allows for the sharing of Health Data and information between users of Direct Secure Messaging.

"Network Operating Policies and Technical Requirements" means WISHIN's Network Operating Policies and Technical Requirements set forth in this Agreement and at www.wishin.org and as amended from time to time by WISHIN.

"Notice" means a written communication, unless otherwise specified in this Agreement, sent to the appropriate party's representative at the address listed in this Agreement, in compliance with Section 20 of these Terms and Conditions.

"ONC Contract" means the terms and conditions that WISHIN is subject to as a result of its subaward under a federal grant from the Office of the National Coordinator for Health Information Technology to govern Health Information Exchange ("HIE") and to provide state-level HIE services to assist medical professionals and hospitals in the achievement of meaningful use of electronic health records.

"Participant" means the other party (other than WISHIN) to this Agreement that (i) meets the requirements for participation in the Network as contained in the applicable Network Operating Policies and Technical Requirements, and (ii) is accepted by WISHIN for participation.

"Participant Authorized User" means Participant's employees, contractors, and agents authorized by Participant to use the Network.

"Permitted Purposes" means the reasons for which Participant and Participant's Authorized Users may legitimately exchange or use Health Data through the Network as defined in Section 2 of the Agreement.

"Proprietary Information" means proprietary or confidential materials or information of a Discloser in any medium or format that a Discloser labels as such or that is commonly understood to be proprietary information. Proprietary Information includes, but is not limited to (i) the Discloser's designs, drawings, procedures, trade secrets, processes, specifications, source code, system architecture, processes and security measures, research and development, including, but not limited to, research protocols and findings, passwords and identifiers, new products, and marketing plans; (ii) proprietary financial and business information of a Discloser; and (iii) information or reports provided by a Discloser to a Receiving Party pursuant to this Agreement. Notwithstanding any label to the contrary, Proprietary Information does not include Health Data or any information which is or becomes known publicly through no fault of a Receiving Party; is learned of by a Receiving Party from a third party entitled to disclose it is already

known to a Receiving Party before receipt from a Discloser as documented by Receiving Party's written records; or, is independently developed by Receiving Party without reference to, reliance on or use of Discloser's Proprietary Information. Health Data is excluded from the definition of Proprietary Information because other provisions of the Agreement address the appropriate protections for Health Data.

"Protected Health Information" or "PHI" shall have the meaning set forth in the HIPAA Regulations.

"Psychotherapy Notes" shall have the meaning set forth in the HIPAA Regulations.

"Qualified Service Organization" or "QSO" shall have the meaning set forth at 42 CFR § 2.11.

"Receiving Party" means Participant, a Participant Authorized User or WISHIN that receives Proprietary Information from a Discloser.

"Recipient" means a person or organization that receives Health Data through the Network for a Permitted Purpose. Recipients may include, but are not limited to, Participants, and Participant Authorized Users.

"System" means software, portal, platform, or other electronic medium used by Participant to send, receive, disclose or use Health Data, whether Participant's use is through ownership, lease, license, or otherwise.

"WISHIN" means the Wisconsin Statewide Health Information Network, Inc., the entity which has been charged by the State of Wisconsin with administering, directly or through contractors, the Network.

2. Subcontractors. WISHIN may delegate its responsibilities to one or more subcontractors; provided, however, that each subcontractor shall agree that: (i) only specifically authorized representatives of subcontractor shall be granted access to the Network in connection with subcontractor's responsibilities, (ii) subcontractor shall comply with the security and confidentiality provisions of this Agreement and (iii) subcontractor shall comply with all Applicable Law.

3. Use of Health Data and Network.

a. Agreement. Participant's use of Health Data and the Network shall be governed by this Agreement, as well as all Applicable Law.

b. Permitted Future Uses (Re-Disclosure). Subject to any rights or obligations at Termination, Recipients may retain, use and re-disclose Health Data received in response to a request facilitated by WISHIN in accordance with all Applicable Law and the Recipient's policies and procedures.

c. Access of Health Data by WISHIN. WISHIN shall only access Health Data for the express purpose of connecting the Participants, facilitating the delivery of the Health Data on behalf of such Participants, and otherwise fulfilling its obligations under the Agreement. WISHIN does not claim any ownership in any of the content, including any text, data, information, images, sound, video or other material, that Participant may send, store or receive via the Network.

d. Impermissible Purposes. Participant shall not use the Network or permit any Participant Authorized User to use the Network to conduct any business or activity, or solicit the performance of any activity, which is prohibited by or would violate any Applicable Law or legal obligation, or for purposes that may create civil or criminal liability, including but not limited to: (i) uses which are defamatory, deceptive, obscene, or otherwise inappropriate; (ii) uses that violate or infringe upon the rights of any other person, such as unauthorized distribution of copyrighted material; (iii) "spamming," sending unsolicited bulk e-mail or other messages on the Network or sending unsolicited advertising or similar conduct; (iv) threats to or harassment of another; (v) knowingly sending any virus, worm, or other harmful component; (vi) attempt to gain unauthorized access to WISHIN's or any Participant's computer system and (vii) impersonating another person or other misrepresentation of source.

e. Other Prohibited Purposes. WISHIN, Participants or Participant Authorized User may not access or use the Health Data or any Proprietary Information of another party to compare patient volumes, practice patterns, or make any other comparison.

4. Reports and Evaluations. WISHIN is required under the ONC Contract to arrange for certain reports and evaluations of the Network, and Participant shall permit WISHIN to generate such reports and provide such information for such evaluation, as required under any other federal grant or contract awarded to WISHIN, or to the Wisconsin Department of Health. Any Health Data in such reports shall be deidentified, as defined in the HIPAA Regulations.

5. Requests by WISHIN. WISHIN may request information from Participant related to potential breach, security or technical issues, and Participant shall not unreasonably refuse to provide information for such purposes. Notwithstanding the preceding sentence, in no case shall Participant be required to disclose PHI to WISHIN in violation of Applicable Law. Any information, other than Health Data, provided by Participant to WISHIN shall be treated as Proprietary Information as set forth in these Terms and Conditions, unless agreed otherwise.

6. Requirements for Participants.

a. Compliance. All use of and interactions with the Network by Participant and Participant Authorized Users shall comply with this Agreement, including all applicable Network Operating Policies and Technical Requirements, these General Terms and Conditions and all Applicable

Law. Nothing in this Agreement shall require a disclosure that is contrary to Applicable Law. Participant and Participant Authorized Users shall be solely responsible for their use of the Network and maintaining patient medical records, as applicable, in accordance with Applicable Law.

b. Confidentiality. Participant agrees to comply with all Applicable Law governing confidentiality, privacy, disclosure and sharing of PHI and other data in its use of Direct Secure Messaging. This includes, but is not limited to, Wisconsin privacy laws, HIPAA, the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the Gramm-Leach-Bliley Act of 1999.

c. Cooperation by Participants in Network Evaluations. Participant shall cooperate in studies conducted from time to time by WISHIN or its agent related to various issues surrounding the Network, including, but not limited to, the project evaluation required under the ONC Contract and the efficacy and usefulness of the Network. Such cooperation shall include, but not be limited to, participation in interviews, the completion of surveys, and the submission of other written or oral evaluations.

7. Security.

a. Safeguards. Each of WISHIN and Participant shall be responsible for maintaining a secure environment that supports access to, use of, and the continued development of the Network, and shall use appropriate safeguards to prevent use or disclosure of Health Data by such party other than as permitted by this Agreement. Participants shall also be required to comply with any applicable Network Operating Policies and Technical Requirements that may define expectations for Participants with respect to enterprise security.

b. Malicious Software. Participant and WISHIN shall use commercially reasonable efforts to ensure that the information and Health Data being transmitted and any method of transmitting such information and Health Data shall not introduce any viruses, worms, unauthorized cookies, Trojans, malicious software, "malware," or other program, routine, subroutine, or data designed to disrupt the proper operation of a System, the Network or any part thereof, or any hardware or software used by Participant or WISHIN in connection therewith, or which, upon the occurrence of a certain event, the passage of time, or the taking of or failure to take any action, shall cause a System or the Network or any part thereof or any hardware, software or data used by Participant or WISHIN in connection therewith, to be improperly accessed, destroyed, damaged, or otherwise made inoperable.

8. Breach Notification. Each party shall report to the other any serious breach of confidentiality or security with respect to Health Data of which it becomes aware. This Section shall not be deemed to supersede or relieve a party's obligations (if any) under relevant security incident, breach notification or confidentiality provisions of Part 7 and Applicable Law,

9. Disclaimers.

a. Accuracy of Patient Record Matching. Participant acknowledges that there could be errors or mismatches when matching patient identities between disparate data sources, but WISHIN shall take commercially reasonable measures to help ensure accurate patient matching occurs, if WISHIN is involved in matching for the particular service to which Participant is subscribed. Participant is solely responsible for ensuring that any PHI obtained through the Network relates to a particular individual as intended by Participant and for the immediate destruction of any PHI obtained inadvertently.

b. Accuracy of Health Data. Nothing in these Terms and Conditions shall be deemed to impose responsibility or liability on Participant or WISHIN related to the clinical accuracy, content or completeness of any Health Data provided pursuant to these Terms and Conditions.

c. Reliance on a System. Participant may not rely upon the availability of a particular Participant's Health Data. Participant is responsible for developing and maintaining backup procedures to be used in the event of a failure or unavailability of the Network, and is responsible for implementing any such backup procedures, as determined necessary by Participant.

d. Incomplete Medical Record. Each Participant acknowledges that Health Data may not include the Individual's full and complete medical record or history.

e. Carrier Lines. Participant acknowledges that the exchange of Health Data through the Network may be provided over various facilities and communications lines, and information shall be transmitted over local Network and Internet backbone carrier lines and through routers, switches, and other devices (collectively, "carrier lines") owned, maintained, and serviced by third-party carriers, utilities, and Internet service providers, all of which may be beyond Participant's or WISHIN's control. Provided Participant and WISHIN use security measures, no less stringent than those in these Terms and Conditions, Participants and WISHIN shall assume no liability for or relating to the integrity, privacy, security, confidentiality, or use of any information transmitted over such carrier lines, or any delay, failure, interruption, interception, loss, transmission, or corruption of Health Data or other information attributable to transmission over such carrier lines.

10. Proprietary Information. Each Receiving Party shall hold Proprietary Information in confidence and agrees that it shall not, during the term or after the termination of this Agreement, redisclose to any person or entity, nor use for its own business or benefit, any information obtained by it in connection with this Agreement, unless such use or redisclosure is permitted by the terms of these Terms and Conditions. Proprietary Information may be redisclosed

under operation of law, provided that the Receiving Party immediately notifies the Discloser of the existence, terms and circumstances surrounding such operation of law to allow the Discloser its rights to object to such disclosure. If after Discloser's objection, the Receiving Party is still required by law to redisclose Discloser's Proprietary Information, it shall do so only to the minimum extent necessary to comply with the operation of the law and shall request that the Proprietary Information be treated as such.

11. Business Associate Provisions. In the event that Participant is a Covered Entity, WISHIN and each of its subcontractors furnishing services to Participant shall be a Business Associate of Participant and, along with Participant, shall be subject to the terms and conditions of Part 7.

12. Qualified Service Organization Provisions. This Section shall apply in the event that: (i) Participant is, has a program subject to, or transmits Health Data from or other data about clients in a program subject to 42 CFR Part 2; and (ii) the particular service to which Participant is subscribed makes WISHIN a Qualified Service Organization or QSO of Participant for the purpose of providing such services.

a. Limits on Use and Disclosure.

i. The QSO acknowledges that in receiving, storing, processing, or otherwise using any information from the Part 2 program about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

ii. The QSO undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to Part 2 program clients otherwise than as expressly provided for in 42 CFR Part 2, and the QSO shall notify the appropriate Participant.

Any subcontractors or agents of the QSO may only access information from a Part 2 program if the subcontractor or agent has entered into an agreement with the QSO and has agreed to the same obligations stated in this Section 12, including but not limited to being bound by 42 CFR Part 2.

13. Limitation of Liability. Neither party will be liable to the other for indirect, special, incidental, exemplary or consequential (including but not limited to loss of profit or goodwill) damages of any kind in connection with or arising out of the furnishing, performance or use of network or other deliverables provided or services performed under this agreement, whether alleged as arising under a breach of contract, tort or other legal theory, even if party has been advised of the possibility of such damages. In addition, neither party will be liable for any damages caused by delay in delivery or furnishing services, other deliverables or other services performed under this agreement. Each party's liability under this agreement for any direct damages of any kind will not exceed an amount equal to the fees paid or payable by participant to WISHIN under this agreement in the preceding twelve (12) months.

14. Termination. In the event that: (a) Participant is fails to make any undisputed payment due to WISHIN hereunder within ten (10) days after written notice of non-payment is received from WISHIN to Participant; or (b) an involuntary petition in bankruptcy is filed against Participant or WISHIN and is not dismissed within ninety (90) days; or (c) Participant or WISHIN files a voluntary petition in bankruptcy or seeks other relief under the Federal bankruptcy laws; or (d) a receiver is appointed for Participant and such appointment is not removed or discharged within ninety (90) days; then, all amounts payable hereunder shall become immediately due and payable and this Agreement shall terminate.

In the event that either party materially defaults in the performance of any of its obligations under this Agreement and does not substantially cure such default within thirty (30) days after being given written notice specifying the default, the non-defaulting party may, by giving written notice to the defaulting party, terminate this Agreement as of a date specified in such notice of termination.

Either party shall have the right to terminate this Agreement upon ninety (90) days' written notice to the other. Participant shall pay WISHIN any amounts due and owing up to and until the time of termination.

15. Warranty. WISHIN represents and warrants to Participant that: (i) WISHIN has the authority to enter into this Agreement; (ii) WISHIN will perform the Services required under the Agreement in a professional and workmanlike manner. WISHIN's exclusive obligation, and Participant's exclusive remedy, in the event of a breach of the warranties in this Agreement will be for WISHIN to re-perform the applicable services not in compliance with the warranty, provided WISHIN receives written notice from Participant of such breach within thirty (30) calendar days after such services were originally performed.

Other than as expressly set forth in this section 15, WISHIN makes no express or implied warranties to participant regarding the network, the direct secure messaging services, the health data made available through the network and direct secure messaging or any other deliverables provided hereunder or otherwise regarding this agreement. Any implied warranty of merchantability or fitness for a particular purpose are expressly disclaimed. Wishin does not warrant that the network, the direct secure messaging services and the other deliverables will operate error free, that they will operate uninterrupted, that they will operate in combination with other software not licensed or sub-licensed by WISHIN or that all defects are correctable. The foregoing warranties are exclusive and in lieu of all other warranties, express, implied or statutory, including, but not limited to, any warranties of quiet enjoyment, accuracy of

the data and non-infringement. Wishin does not warrant third party software, products or equipment, but will take commercially reasonable steps to permit participant to receive the benefits of any warranties that may be offered by third parties.

The health data made available through the network is provided "as is" and "as available." Each of participant and WISHIN disclaims any and all liability for erroneous transmissions and loss of service resulting from communication failures by telecommunication service providers, or other third parties or due to hardware or software failures.

16. Insurance. WISHIN shall secure and maintain sufficient insurance coverage in an amount not less than $2,000,000, in effect through the performance of its obligations under this Agreement and following termination of this Agreement arising from its obligations under this Agreement. Upon request, WISHIN shall provide Participant with certificates of insurance evidencing the required insurance coverage.

17. Indemnification. Each party shall indemnify and hold the other harmless for any losses, claims, damages, awards, penalties, or injuries incurred by any third party, including reasonable attorney's fees, which arise from any alleged breach of such indemnifying party's representations and warranties made under this Agreement, provided that the indemnifying party is promptly notified of any such claims. The indemnifying party shall have the sole right to defend such claims at its own expense. The other party shall provide, at the indemnifying party's expense, such assistance in investigating and defending such claims as the indemnifying party may reasonably request. This indemnity shall survive the termination of this Agreement.

18. General Fee Terms for Services. Any fees payable for each service offered are set forth in this Agreement and may be amended from time to time. Unless expressly modified the following terms shall apply to Participant's payment of fees.

a. Taxes. All fees and other charges for a particular service shall be exclusive of all federal, state, municipal, or other government excise, sales, use occupational, or like taxes now in force or enacted in the future, and Participant shall pay any tax (excluding taxes on WISHIN's net income) that WISHIN may be required to collect or pay now or at any time in the future and that are imposed upon the sale or delivery of items or services provided pursuant to these Terms and Conditions.

b. Third-Party Fees and Charges. Participant shall be solely responsible for any other charges or expenses Participant may incur to access or use the service.

c. Failure to Pay Fees.

i. Interest on Late Payments. Fees not paid for the service by the due date set in the Agreement(s) executed by Participant shall bear interest at the rate of 1.5% per month or the highest legal rate of interest, whichever is lower. The accrual of such interest shall not affect the rights and remedies of WISHIN under these Terms and Conditions.

ii. Suspension of Service. In the event fees are not paid by 30 days following the due date (or, in the event Participant disputes any portion of the fees due), WISHIN may suspend Participant's access to a service on 30 days' prior notice. WISHIN may charge a reasonable renewal fee to cover its costs and overhead associated with restoring a suspended service after suspension due to non-payment.

iii. Collection. In the event that payment due to WISHIN is collected at law or through an attorney-at-law, or under advice therefrom, or through a collection agency, Participant shall pay all costs of collection, including without limitation all court costs and reasonable attorneys' fees.

19. Dispute Resolution. In the event that any matter or disagreement shall arise in connection with this Agreement, such disagreement shall be promptly settled by binding arbitration in the City of Madison, Wisconsin, in accordance with the rules then existing of the American Health Lawyers Association.

20. Notices. All notices to be made under this Agreement shall be given in writing to the appropriate party's representative at the address listed in the signature blocks of Part 5 of this Agreement in which the Participant subscribes to an Network service and shall be deemed given: (i) upon delivery, if personally delivered; (ii) upon the date indicated on the return receipt, when sent by U.S. Postal Service Certified Mail, return receipt requested; or (iii) if by nationally recognized overnight courier service that has the capability to track the notice, upon receipt. A party may change its address for receiving notices by written notice to the other party.

21. Governing Law; Venue. The laws of the State of Wisconsin shall govern this Agreement. The venue of any action will be Dane County, Wisconsin.

22. Changes to Applicable Law. Any new legislation or amendments to government regulations or administrative rules that become effective after the Effective Date of this Agreement shall be mutually agreed to by WISHIN and the Participant as to the applicability of the change to this Agreement. Upon mutual agreement of the parties, a written amendment will subsequently be made to this Agreement to incorporate the requisite change(s).

23. Assignment. Participant may not assign this Agreement, in any respect, without the prior written

consent of WISHIN, which consent shall not be unreasonably withheld.

24. Severability. If any term or condition of this Agreement shall to any extent be held invalid or unenforceable by a court of competent jurisdiction, the remainder of this Agreement shall not be affected and each term and condition shall be valid and enforceable to the fullest extent permitted by law.

25. Force Majeure. A party shall not be deemed in violation of any provision of this Agreement if it is prevented from performing any of its obligations by reason of: (i) severe weather or storms; (ii) earthquakes or other disruptive natural occurrences; (iii) strikes or other labor unrest; (iv) power failures; (v) nuclear or other civil or military emergencies; (vi) terrorist attacks; (vii) acts of legislative, judicial, executive, or administrative authorities; or (viii) any other circumstances that are not within its reasonable control. This Section shall not apply to obligations imposed under Applicable Law.

26. Waiver. Failure or delay by either party to enforce compliance with any term or condition of this Agreement shall not constitute a waiver of such term or condition.

27. Entire Agreement. The Agreement and its Exhibits constitute the entire agreement between the parties with regard to the subject matter of the Agreement and supersede all previous communications, whether oral or written, between the parties with respect to such subject matter.

28. Amendments Required by Law. WISHIN may amend or restate this Agreement at any time upon at least thirty (30) days prior written notice to Participant if WISHIN determines that such amendment is required to comply with Applicable Law. Such amendments shall become effective as of the dates and times described in WISHIN's notice thereof, subject to Participant's right to terminate the Agreement by written notice to WISHIN prior to the effective date specified by WISHIN.

29. Other Amendments. Except as set forth in Section 28 and for changes to any fees charged by WISHIN and changes to Network Operating Policies and Technical Requirements, this Agreement may be amended only by an instrument in writing signed by the party against whom the change, waiver, modification, extension, or discharge is sought, unless otherwise indicated in this Agreement.

30. Relationship of the Parties. The parties are independent contracting entities. Nothing in this Agreement shall be construed to create a partnership, agency relationship, or joint venture among the parties. No party hereto shall have any authority to bind or make commitments on behalf of one another, nor shall any such party hold itself out as having such authority.

31. Licenses. WISHIN or its subcontractor shall issue Direct accounts/addresses and digital certificates to the Participant for use of Direct Secure Messaging.

32. Survival. The terms and conditions contained in this Agreement that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration, or termination of this Agreement.

33. Counterparts. This Agreement may be may be executed in two or more counterparts, each of which shall constitute an original, but all of which together shall constitute one and the same agreement.

PART 7: BUSINESS ASSOCIATE PROVISIONS

This Section applies if Participant is a "covered entity" under HIPAA. In that event, WISHIN and any WISHIN subcontractor shall be a "Business Associate" of Participant for purposes of HIPAA and this Section.

1. Definitions. The following terms used in this Exhibit are defined as follows:

a. "**Breach**" shall have the same meaning as the term "breach" in 45 C.F.R. § 164.402.
b. "**Breach Notification Rule**" means 45 C.F.R. Part 164, Subpart D.
c. "**Electronic Protected Health Information**" or "**EPHI**" has the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.
d. "**Electronic Transactions Rule**" means the final regulations issued by HHS concerning standard transactions and code sets under 45 C.F.R. Parts 160 and 162.
e. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended and as implemented by the Department of Health and Human Services regulations, including the Privacy Rule, the Security Rule and the Breach Notification Rule.
f. "**HHS**" means the United States Department of Health and Human Services.
g. "**Individual**" shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
h. "**Privacy Rule**" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E.
i. "**Protected Health Information**" or "**PHI**" shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103. PHI includes EPHI.

j. "**Required By Law**" shall have the same meaning as the term "required by law" in 45 C.F.R. §164.103.
k. "**Secretary**" shall mean the Secretary of HHS or his designee.
l. "**Security Incident**" has the same meaning as the term "security incident" in 45 C.F.R. § 164.304.
m. "**Security Rule**" means the Security Standards and Implementation Specifications at 45 C.F.R. Part 160 and 164, Subpart C.
n. "**Transaction**" shall have the same meaning as the term "transaction" in 45 C.F.R. § 160.103.
o. "**Unsecured Protected Health Information**" has the same meaning given to the term "unsecured protected health information" in 45 C.F.R. § 164.402.

Capitalized terms used, but not otherwise defined, in this Section shall have the same meaning as those terms in the Privacy Rule, the Security Rule or the Breach Notification Rule.

2. **Business Associate Compliance with HIPAA.** Business Associate shall comply with all provisions of HIPAA that are applicable to business associates including, if Business Associate creates, receives, maintains or transmits EPHI on behalf of Participant, the Security Rule. Except as permitted by HIPAA or a valid authorization obtained from an individual in accordance with 45 C.F.R. 164.508, Business Associate shall not directly or indirectly receive remuneration in exchange for the PHI of the individual.

3. **Permitted Uses and Disclosures of PHI.**

a. **Services for Participant.** Business Associate may use and disclose PHI received from, or created or received on behalf of, Participant only as permitted or required by any agreement for services between Business Associate and Participant, this Exhibit, as permitted by law, or as otherwise authorized in writing by Participant.

b. **Business Associate's Operations.** Business Associate may use and disclose PHI for proper management and administration of Business Associate's business and to carry out its legal responsibilities. Business Associate only may use or disclose PHI pursuant to this paragraph if: (i) such use or disclosure is required by law; or (ii) Business Associate receives reasonable written assurance from any person or organization to whom Business Associate will disclose PHI that the person or organization will hold such PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization and the person or organization will notify Business Associate of any breach of confidentiality related to the PHI.

c. **Data Aggregation.** Business Associate may use or disclose PHI to provide data aggregation services relating to the health care operations of Participant.

d. **Minimum Necessary.** In its performance of the functions, activities, services, and operations specified above, Business Associate will make reasonable efforts to use, disclose, and request only the minimum amount of Participant's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate nor Participant is required to limit its use, disclosure or request to the minimum necessary. To the extent it uses, discloses, and requests PHI in a manner that involves Business Associate, Participant will make reasonable efforts to use, disclose, and request only the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request to the extent it is required to do so under HIPAA. The phrase "minimum necessary" shall be interpreted in accordance with the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), passed as part of the American Recovery and Reinvestment Act of 2009, and HHS guidance.

4. **Unauthorized Uses and Disclosures of PHI.** Business Associate shall not (and shall ensure that its officers, directors, agents and employees do not) use or disclose PHI in any manner other than as permitted or required by any agreement for services between Business Associate and Participant, this Exhibit, or as Required by Law. This Exhibit does not authorize Business Associate to use or disclose Participant's Protected Health Information in a manner that would violate the Privacy Rule if done by Participant.

5. **Safeguards Against Misuse of Information.** Business Associate will develop and use appropriate administrative, technical and physical safeguards to prevent the improper use or disclosure of PHI. Such safeguards shall include, but not be limited to, developing, documenting and keeping current policies and procedures and training personnel regarding the proper use and disclosure of PHI. If Business Associate creates, receives, maintains or transmits EPHI on behalf of Participant, Business Associate shall implement safeguards that reasonably and appropriately protect the

confidentiality, integrity, and availability of Participant's EPHI as required by the Security Rule. Such safeguards shall include, but not be limited to, developing, implementing and maintaining adequate: administrative safeguards to manage the selection, development, implementation, and maintenance of security measures to protect EPHI; physical safeguards to protect Participant's EPHI from natural and environmental hazards, and unauthorized intrusion; and technical safeguards for its use that protect EPHI and control access to such information.

6. **Disclosures To Third Parties.** Prior to disclosing PHI to an agent or subcontractor of Business Associate, Business Associate shall obtain written assurance from such party that it agrees to be bound by the same restrictions and conditions that apply to Business Associate with respect to PHI. Business Associate shall provide Participant with copies of such written assurance upon request.

7. **Reporting of Any Breach, Improper Use or Disclosure, and Security Incidents.**

   a. **Breach.** Business Associate shall notify Participant without unreasonable delay (and in no case later than 60 days after discovery of a Breach) of any Breach of Unsecured Protected Health Information. The notice shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. Business Associate shall provide Participant with any other available information that Participant is required to include in notification to the individual under 45 C.F.R. § 164.404(c) at the time Business Associate provides notification of any Breach or promptly thereafter as information becomes available.

   b. **Security Incidents.** Business Associate will report to Participant any Security Incident of which Business Associate becomes aware.

   c. **Other Improper Uses and Disclosures.** Business Associate shall report to Participant any use or disclosure of Participant's PHI that is not provided for by this Exhibit of which Business Associate becomes aware.

8. **Access to PHI.** If PHI is in a Designated Records Set, Business Associate agrees to make available PHI in accordance with 45 C.F.R. § 164.524.

9. **Amendments to PHI.** If PHI is in a Designated Records Set, Business Associate agrees to make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526.

10. **Accounting of Disclosures.** Business Associate agrees to make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

11. **Availability of Books and Records.** Business Associate will make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Participant available to the Secretary of the United States Department of Health and Human Services for purposes of determining Participant's compliance with the Privacy Rule.

12. **Return or Destruction of PHI.** Upon termination of the Agreement, Business Associate shall cease all use and disclosures of Participant's PHI except as directed by Participant. In addition, Business Associate will, if feasible, return or destroy all PHI of Participant, including all PHI Business Associate has disclosed to its employees, subcontractors and/or agents. Destruction shall include destruction of all copies including backup tapes and other electronic backup medium. If such return or destruction is not feasible, Business Associate will extend the protections of this Exhibit to the information and limit further uses and disclosures to those purposes that make return or destruction of the information infeasible.

13. **Breach of Agreement/Termination of Agreements.** In the event either party (the "**Non-breaching Party**") has evidence that the other party, or the other party's agent or subcontractor (the "**Breaching Party**"), has committed a material breach of this Exhibit or violation of HIPAA, the Non-breaching Party shall have the right to: (i) provide the Breaching Party with an appropriate period to cure the breach or end the violation; (ii) terminate this Exhibit and any other agreement between the parties if the Breaching Party does not cure the breach or end the violation within the time specified by the Non-breaching Party; or (iii) if termination is not feasible, report the problem to the Secretary of the HHS. The Non-breaching Party may exercise its right to terminate this Exhibit and any other agreement between the parties by providing written notice of termination stating the breach of the Agreement that provides the basis for

termination. No waiver of any breach of any provision of this Exhibit shall constitute a waiver of any prior, concurrent or subsequent breach.

14. **Enactments and Amendments to HIPAA.** If there are amendments to HIPAA, or if there are any changes in the manner in which HIPAA is interpreted by the agencies or courts, the parties shall take those actions necessary to comply with the current state of the law, including by amending this Exhibit.

15. **Interpretation.** Any ambiguity in this Exhibit shall be resolved to permit compliance with HIPAA.

16. **No Third-Party Beneficiaries.** There are no third-party beneficiaries to these Business Associate provisions.

Appendix 12: Key Analyses of Barriers, Resources and Opportunities for Overcoming Low Participation in Information Exchange

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[31]:

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:

[31] http://ehealthboard.dhfs.wisconsin.gov/reports/ci-final-report.pdf

> "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 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.

HISPC Project

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[32] and the Wisconsin Security and Privacy Project – Legal Workgroup Analysis Grids[33]. 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[34] 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

[32] http://ehealthboard.dhfs.wisconsin.gov/security/legal/l-analysis2007-02-09.pdf

[33] http://ehealthboard.dhfs.wisconsin.gov/security/legal/l-results2007-02-12.pdf

[34] http://ehealthboard.dhfs.wisconsin.gov/security/variation-solutions2007.pdf

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*
"[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"[35] 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)

[35] http://www.ahima.org/dc/documents/AnalysisofARRAPrivacy-fin-3-2009a.pdf

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[36]. The white paper discusses in detail the "issues, nuanced considerations, and possible 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;

[36] http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_911154_0_0_18/ChoiceModelFinal.pdf

- 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 13: 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

	Wisconsin Law	Federal Law
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 14: Consent Policy Framework Development Process

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" 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[37] and sensitive[38] 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).

[37] Meaning "patient health care records defined under §146.81(4), Wis. Stats.

[38] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

The Consent Matrix also makes three assumptions that underlie the analysis of the policy options. Those assumptions are:

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[39] and sensitive[40] 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[41] and sensitive[42] 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

[39] Meaning "patient health care records defined under §146.81(4), Wis. Stats.

[40] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

[41] Meaning "patient health care records defined under §146.81(4), Wis. Stats.

[42] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

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

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.*

Other recommendations

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 15: Consent Policy Options Matrix

Analysis of Policy Options Regarding:

1) Disclosure of health information (both general[43] and sensitive[44] 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 less control of their participation in HIE than current state 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 same amount of control of their participation in HIE as

[43] Meaning "patient health care records defined under §146.81(4), Wis. Stats.

[44] Including mental health and state AODA "treatment records" governed by §51.30, Wis. Stats., and HIV test results governed by §252.15, Wis. Stats.

				current federal privacy law under HIPAA. 5) Improves patient care for all by 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**	1) Provider provides notice of privacy practices (including option to contact HIE	None	1) Modify law to permit disclosure of "special" information	1) The key difference between this option and the above "HIE-Level Opt Out (Policy Option) is that

Option	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.		(including the 51.30 treatment record) for treatment, payment, and health care operations to an HIE and from an HIE, but only 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.	under the "Policy Option" the amended law would simply allow disclosure of ch. 51 information without consent for treatment, 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	None	1) Modify law to permit disclosure of "special" information for treatment, payment, and health care	1) The HIE would not receive information from patients that choose to "opt out." 2) Higher cost to provider/HIE participants compared to earlier

	the provider not disclose to HIE; 3) HIE discloses information it receives without consent.		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 define the opt out process.	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) 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	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	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

	be required?)		times an individual must consent to disclosure to and from an 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.	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

	(Would business associate agreements be required?)			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	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.

	HIE.			
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			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

	concerns are realized			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.

Analysis of Policy Options Regarding:

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	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	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

	individual contacts HIE and requests HIE not disclose.	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.	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 16: Legal and Policy Issues List for Data Agreements

Data Use Agreement Parameters[45]

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.

---

[45] 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 an 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 17: Legal & Policy: 2010 WIRED for Health Archive

Legal and Policy

The WIRED for Health Board established a legal and policy framework and plans that when implemented will optimize and enable the electronic exchange of health information while protecting patient privacy, and position Wisconsin to participate in HIE with neighboring states and eventually nationwide HIE. Two principal areas are addressed in this section: security and privacy mechanisms; and mechanisms for participation, oversight, and accountability.

The differences between existing Wisconsin and Federal laws and the problems those differences create for HIE were previously identified and documented by HISPC workgroups of the eHealth Board. Wisconsin statutes and regulations, including those governing privacy, consent, liability, contracts, and data breaches, among others, will need to be assessed and updated as part of implementation to achieve the legal and policy goals. Harmonization with federal laws will be required, and the laws of neighboring states will need to be identified and analyzed to enable interstate collaboration. Data use agreements are recommended and will be developed to contractually govern participation in the SHIN and provide mechanisms for oversight and accountability. Privacy and security strategies, policies, and procedures will be developed incrementally over time along with business, technical, and operational policies and procedures.

Privacy and Security Strategy

Analysis of Privacy and Security Issues Related to HIE

Wisconsin has undertaken significant analysis of privacy and security issues affecting in-state and out-of-state disclosures of electronic health information using health information exchange. Much of this analysis was originally undertaken as part of Wisconsin's participation in the HISPC Project, the work of the eHealth Board, and a Section 51.30 (Mental Health/Substance Abuse) Work Group specially convened by the DHS in 2007. Additional analysis of the recent HITECH Act and the ONC's Consumer Consent Options for Electronic Health Information Exchange white paper (the "ONC Consumer Consent White Paper")[46] has added to Wisconsin's consideration of privacy and security issues.

Through the Legal and Policy Committee of the WIRED for Health Board, Wisconsin undertook an extensive review of the above analyses and is using those analyses to help guide its privacy and security implementation for the SHIN and information exchange throughout Wisconsin. Key issues considered in that review include:

1) Consent requirements for general health care records

[46] http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_11673_911197_0_0_18/ChoiceModelFinal032610.pdf

Pursuant to Sections 146.81 and 146.82 of the Wisconsin Statutes, general health care records must remain confidential. However, such records may be shared without patient consent for purposes of treatment, payment, and healthcare operations, or if one of over 20 statutory exceptions to confidentiality applies.

2) Consent requirements for mental health, alcohol and other drug abuse, and developmental disability records

- **a)** Pursuant to Section 51.30 of the Wisconsin Statutes, certain records created in the course of providing services to individuals for mental illness, developmental disabilities, alcoholism, or drug dependence ("mental health treatment records") are held to more stringent confidentiality standards than general health care records under Sections 146.81 and 146.82 of the Wisconsin Statutes and HIPAA. While there are over 27 exceptions to confidentiality under Section 51.30, this section generally prohibits the disclosure of mental health treatment records for treatment, payment, and health care operations purposes without written patient consent.[47] The disparate laws governing disclosures of general health care records and mental health treatment records for treatment, payment, and health care operations purposes continue to be identified by many as an impediment to the integration of physical health care and mental health care, and widespread provider participation in cost-effective health information exchange.

3) HIV test results

- **a)** Wisconsin law treats HIV test results as "sensitive" information and provides more stringent privacy protection than is provided under Sections 146.81 and 146.82 of the Wisconsin Statutes.

4) Minimum necessary requirement for mental health, alcohol and other drug abuse (AODA), and developmental disability

- **a)** 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.

5) Balancing patient right to privacy with providers' need to access health information to provide optimal and cost-effective care

6) New HITECH security and privacy requirements

[47] Two notable exceptions allow for certain disclosures without consent in certain emergency situations (§ 51.30(4)(b)8., Wis. Stats.) and, as agreed to by the 2007 § 51.30 Work Group and enacted by 2007 Act 108, disclosures without consent of certain limited types of information if necessary for the current treatment of the individual (§ 51.30(4)(b)8g., Wis. Stats.).

a) HITECH added significant new security and privacy requirements to Federal HIPAA law, including substantially increased penalties for HIPAA violations, new federal enforcement mechanisms, new breach identification and notification requirements, and new accounting requirements.

7) ONC recommendations to enhance patient and provider participation in health information exchange

a) ONC's Consumer Consent White Paper included several key recommendations for states as they develop infrastructure to encourage statewide health information exchange. Those recommendations included:

Adopt an opt-out or no-consent model, in concert with tight restrictions on data access and/or use, including stringent penalties for misuse.

i) Address the lack of or difficulty in achieving technical and procedural capacity of health information networks to segment and manage data in the manners desired by various constituents.

ii) Actively engage patients in the development of the infrastructure to enable statewide health information exchange.

iii) Minimize administrative burdens, and as appropriate, encourage participation with financial or other incentives.

Development and implementation of a centrally managed opt-out consent model for health information exchange

Description of centrally managed opt-out consent model

Wisconsin is considering using a centrally managed opt-out consent model for the exchange of health information using the SHIN that is based on a concept similar to the Wisconsin and Federal telemarketing "do not call" registries. Due to the establishment of the Wisconsin and Federal telemarketing "do not call" registries, consumers are now able to contact a single authority if they do not wish to receive telemarketing calls, rather than having to contact each telemarketer they encounter. Similarly, under the envisioned centrally managed opt-out consent model, if a Wisconsin patient does not wish to have the patient's caregivers exchange information with each other using the SHIN, then the patient will only need to contact the operator of the SHIN (or its agent) rather than each of the patient's caregivers in order to effectuate that wish.

Thus, for the SHIN, a central organization (likely the technical operator of the SHIN) would manage all patient requests to "opt out" of the SHIN instead of the individual provider centrally blocking the movement of patient information between the patient's caregivers. Such an arrangement would remove the burden from providers and patients to individually manage consents for each exchange of health information over the SHIN. This arrangement has the potential also to be extended to other health information exchange networks in Wisconsin.

Preferred option for consent model

Depending on the final architecture of the SHIN, a centrally managed opt-out consent model for the SHIN would have benefits for both patients, providers, and the SHIN. Such a model would:

1) Allow a patient to choose not to participate in the SHIN.
2) Like the "No Call List," make it easier for patients to manage their participation in health information exchange through the SHIN.
3) Have substantially lower IT and operational costs than an opt-in consent model.
4) Have substantially lower IT and operational costs than opt-out consent models that require providers to solely manage consents for each exchange of health information over the SHIN.

When joined with the right HIE architectural infrastructure, security measures, and implementation process, the centrally managed opt-out consent model has initially received support from both provider and patient representatives.

At the present time, the final technical infrastructure for the SHIN has not been determined. Wisconsin, with input from stakeholders, will continue to evaluate the feasibility of the centrally managed opt-out consent model as the final architecture for the SHIN becomes clearer.

Wisconsin, with input from stakeholders, will also continue to evaluate the feasibility of the centrally managed opt-out consent model as a statewide solution for health information exchange through systems other than the SHIN. Preliminary analysis and discussions with stakeholders suggest that the centrally managed opt-out consent model could be a viable solution not just for the SHIN but for other health information exchange systems throughout Wisconsin.

Development of implementation framework for consent model

Wisconsin tasked the Legal and Policy Committee of the WIRED for Health Board, a committee composed of diverse stakeholder interests including patient and consumer representatives, with undertaking a deliberative process to develop a consent policy for the SHIN that optimizes the electronic exchange of health information while protecting the patient from inappropriate use of the patient's health information. While much of the focus was on developing a policy for the SHIN, it was recognized that any law changes needed to implement such policy could also apply to existing and future health information exchange systems in Wisconsin. Thus, consideration was also given to how the SHIN consent model could be extended to other health information exchange systems in Wisconsin. A description of the process used to develop a consent policy for the SHIN is contained in Appendix 20.

Implementation of consent model

Wisconsin has outlined the following high-level framework for implementing a centrally managed opt-out consent policy that would be compatible with initial projections of the SHIN architecture:

1) Participants in the SHIN would be required to add a provision to their HIPAA-mandated notice of privacy practices document that must be provided to the providers' patients and explains in easy to understand terms:
   a) That the entity participates in the SHIN.
   b) The benefits of electronic health information exchange, including that participation in the SHIN will allow other health care providers that treat the patient to have more complete information about the patient's past care.
   c) If the patient does not wish to participate in an exchange between providers using the SHIN, the SHIN will block sharing of clinical information about the patient between providers using the SHIN upon the patient's request to the SHIN.
   d) Instructions on how the patient can contact the SHIN to make such a request.
2) Participants in the SHIN would be permitted to disclose information to the SHIN without patient consent.
3) However, the SHIN would not be permitted to disclose clinical information about a patient or identify to providers the other providers that have clinical information about the patient if the patient requested the SHIN operator block sharing of the patient's clinical information between providers using the SHIN.

Thus, if a patient requests such an "opt out," clinical information may be disclosed from a provider to the SHIN and reside at the SHIN, but that clinical information would be securely "trapped" within the SHIN and not further shared with other providers. Pursuant to the "opt-out," the SHIN would not be permitted to share that clinical information with other providers or identify to providers what other providers have clinical information about the patient. However, in order to engender provider trust with the reliability of the information on SHIN, the SHIN would be permitted to disclose to providers a simple indication that the patient has chosen to "opt out" of exchanges using the SHIN.

Subject to possible yet-to-be-finalized administrative limitations, a patient would also have an option to choose to revoke their decision to "opt out" of participation in the SHIN.

Notable aspects of consent model

Wisconsin has identified several distinguishing aspects of a centrally managed opt-out consent model that suggest that it could be a viable consent solution for the SHIN and health information exchange in general:

1) Patients will have control of their participation in electronic health information exchange.
2) The model will require the least statewide cost to provide patient control of participation in the SHIN. Rather than requiring the modification of hundreds of providers' individual EHR systems and policies, this requires only the yet-to-be built SHIN to build the capability to segregate or block the information of individuals who do not wish to have the SHIN share their information. Providers' cost to

implement the policy would be minor administrative costs associated with informing patients of their ability to contact the SHIN to "opt out." Similar cost savings may be available to other health information exchange systems that use a centrally managed opt-out consent model, if such systems' architectures are compatible with the model.

3) Patients will have greater control of their participation in health information exchange than is required under the federal HIPAA privacy regulations and Wisconsin laws governing general health care information.
4) Patients are benefited by having a single entity manage their participation in health information exchange.
5) Having a shared and consistent consent policy for general health care information and mental health care information can enable the integration of mental health and other health care and result in better care.
6) Because this framework is compatible with federal law, federal care delivery organizations can easily participate in the Wisconsin SHIN.

A notable limitation of the centrally managed opt-out consent model is that it is generally incompatible with truly peer-to-peer electronic exchange networks that do not route clinical information through any central hub or server capable of blocking the transmission of information from one provider to another.

Law changes necessary to implement consent model

Changes to Wisconsin law governing mental health treatment records, AODA treatment records, and HIV test results would be required.

Pursuant to federal HIPAA regulations and Wisconsin's general health care information privacy law, § 146.82, Wis. Stats., consent would not be needed from a patient to allow a health care provider to exchange "general" health care information with other providers using the SDE's health information exchange infrastructure. Thus, for general health care information, the proposed centrally managed opt-out consent policy for the SHIN would be a more stringent and onerous disclosure standard than what existing law requires.

However, even for purposes of treatment, payment, and health care operations, disclosure of mental health and state AODA treatment records governed by § 51.30, Wis. Stats. and HIV test results governed by § 252.15, Wis. Stats. ("Special Health Care Information"), in most cases, requires the informed consent of the patient under current Wisconsin law (though disclosures of HIV test results for treatment is permitted). Thus, for Special Health Care Information, the proposed centrally managed opt-out consent policy for the SHIN is incompatible with existing Wisconsin law.

Thus, as one part of the comprehensive update of medical record policies and laws described in Section 9.2.2, we recommend the SDE consider developing and pursuing enactment of amendments to Wisconsin laws governing Special Health Care Information that would be compatible with a centrally managed opt-out consent model for the SHIN, assuming such policy is compatible with the SHIN architectural

infrastructure. Appendix 21 describes two separate options for making statutory changes that would be compatible with the centrally managed opt-out consent policy: a "HIE-level opt-out policy option" and a "HIE-level opt-out full statutory option."

The Legal and Policy Committee is further recommending that the legislation be broad enough to allow for incremental development of the SHIN, existing regional health information exchange networks, and other potential health information exchange networks that may develop in Wisconsin. New legislation or rules should not be required each time a health information exchange networks wishes to expand the type of clinical information shared.

As noted in Appendix 20, the centrally managed opt-out model received broad support from both provider representatives and consumer representatives on the WIRED for Health Board's Legal and Policy Committee. Wisconsin intends to build on that initial support by actively seeking support from key mental health and HIV/AIDS stakeholders. Thus, Wisconsin believes that the law changes proposed will have broad support and have a high likelihood of being enacted in mid to late 2011.

Additional security and privacy related policies

All or nothing participation policy

Under existing technology it is not practical to implement a policy that would allow an individual to choose to share some types of clinical information but not other types of information through a health information exchange system or to choose to share information only with particular providers. Furthermore, widespread provider participation and use of a SHIN will be unlikely if providers cannot trust that the health information exchange system is providing complete and accurate information relevant to the provider's care of the patient. Thus, Wisconsin will pursue the implementation of an "all or nothing" participation policy in which a patient and provider will have two options: opt out of all exchange of clinical information between all providers using the SHIN, or fully participate in the SHIN without limitation. However, Wisconsin will routinely monitor the evolution of exchange technology, and will consider revisions to the all or nothing participation policy to the extent granular consents become a practical option.

Exclude federal AODA information

Federal regulations under 42 Code of Federal Regulations (CFR) Part 2 requires patient consent for certain disclosures of alcohol and other drug abuse information for treatment, payment, and health care operations purposes. Because of these consent rules, providers that have such information, as well as the SHIN, would have to incur significantly higher IT and administrative costs in order to share such information using the SHIN. To minimize barriers to participation, Wisconsin will pursue the implementation of a policy that will dictate that the SHIN not request or receive federal AODA information or any other information that is not permitted to be disclosed without specific prior patient consent. While the inclusion of such information in the SHIN or any other Wisconsin health information exchange system would be beneficial to improve the overall care provided to individuals receiving AODA services, the burdens imposed by 42 CFR Part 2 would make the exchange of such information prohibitively expensive and thereby add barriers to provider participation. Wisconsin will monitor Federal efforts to modify 42 CFR Part 2 to make it more consistent with federal goals to enable widespread health information exchange.

Strong security is a top priority

Widespread participation in health information exchange systems by providers and patients will not occur unless they know that information on the health information exchange system is secure. Thus, the SHIN's health information exchange infrastructure must have strong security mechanisms to protect against inappropriate use of patient information. At a minimum, the SHIN's exchange infrastructure will follow the HIPAA security standards for electronic transactions. Furthermore, the SHIN operator will be required to identify and follow any additional established security best practices for health information exchange.

Wisconsin will also pursue new state statutory security requirements for other health information exchange systems as part of its efforts to update its medical record policies and laws. Through a combination of security and privacy measure updates to Wisconsin statutes, Wisconsin will work to (1) strengthen mechanisms to prevent patient information from being inappropriately used and (2) facilitate improvements in patient care and reductions in patients' cost of care by encouraging health care providers to securely share patient information between patients' caregivers. The Federal HIPAA regulation's security requirements will be the guide for Wisconsin as it considers new statutory security requirements for health information exchange systems.

Breach notification considerations

Pursuant to the HITECH Act, health care providers, health information exchanges, and other users of patient information are required to meet stringent new notification requirements if the provider or health information exchange does not use certain security standards and a breach of patient health information occurs. It will be a high priority for the SDE to investigate all options to implement those security standards for the Wisconsin SHIN.

Significant issues related to the privacy and security framework to be resolved during implementation

In order to implement Wisconsin's security and privacy framework for statewide health information exchange and the SHIN, Wisconsin has identified several issues that will be resolved during implementation. The WIRED for Health Project intends and will expect the SDE to involve key stakeholders as it resolves these issues. For example:

- All plans for the security framework of the SHIN, including the contractual enforcement of the SHIN's security framework, should be completed prior to any legislative votes on health information exchange-related legislation amending Wisconsin's consent laws
- A specific process for requesting an "opt out" from the SHIN shall be determined. While the WIRED for Health Board recommends that the patient be responsible for requesting an "opt out," the process must be easy to understand and easy to access and complete for the patient
- Identify specific language that should be communicated to inform patients about the SHIN and the process for requesting an opt-out from the SHIN. Determine whether such language should be a statutory requirement or a contractual requirement. Determine whether different language would be needed for other health information exchange networks
- A specific process for implementing a requested "opt out" from the SHIN shall be determined
- For purposes of implementing a patient's request to opt out of sharing using the SHIN, develop mechanisms to match the identify of a patient who chooses to opt out from the SHIN with the patient's records
- Develop a procedure to revoke an opt out and determine whether there should be limitations on the ability of a patient to repeatedly revoke an opt out
- Develop a procedure for patient surrogates to request or revoke an opt out on behalf of a patient
- Determine how the SHIN will authenticate a request to opt out of participation or a request to revoke an opt out
- Determine what, if any, circumstances may permit a caregiver or other person to override a patient's choice to opt out of sharing information using the SHIN. For example, should medical urgency be a reason to override a patient's decision to opt out?
- Develop a process for patients and providers to request and receive an accounting of disclosures made from the SHIN
- Determine timeframes for the SHIN to respond to requests: to opt out, to revoke an opt out, or to provide an accounting of disclosures
- Under current laws governing Sensitive Health Care Information, there are several circumstances in which consent is not necessary for disclosure. Wisconsin will need to determine whether all of these exceptions should apply if a patient chooses to opt out

- Determine a realistic time frame for enacting legislation necessary to implement the privacy and security framework. The Wisconsin legislature has adjourned for 2010 and will not be in session again until January 2011, after the election of a new governor
- Determine the effects of the final meaningful use rule issued in July 2010 on the outlined privacy and security framework

Interstate Collaboration

Wisconsin has a critical need to electronically exchange health information for the care and treatment of patients with four neighboring states—Minnesota, Iowa, Illinois, and Michigan. There are existing medical trading areas involving Wisconsin and each of these states in which the exchange of health information for clinical purposes is occurring without regard to state boundaries. However, interstate electronic HIE is currently impeded because of differences in privacy and security requirements between states.

As a first step, Wisconsin intends to identify and analyze possible policy approaches to address barriers to and enable opportunities for interstate HIE. Consideration will be given to a variety of issues, including, but not limited to, purposes of exchange, consent, privacy and security, liability, and the development and use of uniform agreements. The identification and examination of solutions involving legislation, contracts, policies, and practices to advance and support interstate HIE will follow.

Wisconsin and Minnesota have agreed to begin their efforts to advance interstate HIE with each other. Wisconsin plans to work with the Minnesota Office of Health Information Technology to advance interstate HIE through a series of teleconferences and meetings. It is expected that other border states will be included in these efforts in the future.

Wisconsin and Minnesota were both members of the Health Information Security and Privacy Collaboration's (HISPC) Interstate Disclosure and Patient Consent Requirements Collaborative. The Collaborative assembled and analyzed detailed requirements stipulated in state laws, regulations, and rules pertaining to consent for the disclosure of protected health information across a range of specific interstate HIE scenarios and offered several options for incrementally moving forward with HIE across state boundaries. Its report provides a comparative analysis of privacy laws as well as a basic understanding of the types of conflicts that must be resolved. This information can be leveraged in Wisconsin's work with Minnesota as well as with other neighboring states to plan, design, and implement feasible and practical approaches to interstate HIE.

Wisconsin along with Minnesota, Iowa, North Dakota, South Dakota, and Illinois applied as a consortium for a new opportunity to receive support services through RTI International via the State Health Policy Consortium (SHPC) Project to advance interstate HIE, which is funded by the ONC. Minnesota served as the facilitator for a coordinated submission on behalf of the participating states. On June 9, 2010, Minnesota submitted the Upper Midwest HIE Consortium's request to RTI for the first cycle of support services awards.

Our proposal for the SHPC Project is separate and distinct from, yet congruous with, our State HIE CAP work to advance and support interstate HIE. The request seeks support services to: (1) formally establish the Upper Midwest HIE (UM-HIE) Consortium, (2) analyze current law from each state through either an examination of previous HISPC reports or a survey prepared by a subject matter expert, (3) identify possible mechanisms and common language to enable interstate HIE, and (4) identify an electronic mechanism for implementation of the preferred mechanism to enable interstate HIE. We received notification on July 27, 2010 from RTI that our consortium was selected to receive support services for the SHPC Project in the first cycle.

Participation, Oversight, and Accountability Mechanisms

Background on Data Use Agreement

Under the WIRED for Health Act, the State of Wisconsin will designate a nonprofit corporation (the "SDE") to receive and administer federal funds to implement the SHIN and HIE services. In accordance with the direction set by the WIRED for Health Board, the SDE will establish the legal and policy structure relating to the SHIN. The structure will consist primarily of a contractual model. The structure will address the core legal and policy issues of privacy and security; auditing, accountability and enforcement; and liability and indemnification. This structure will be critical to facilitating trust among SHIN participants.

Data Use Agreement

Qualified participants will be entities that will access the SHIN by entering into and complying with a data use agreement with the SDE. The SDE will set the qualification criteria, including the types of participants (e.g., providers, payers, researchers, public health, regional health organizations). The terms of the data use agreement may vary, based on these different types of participants. In addition, participants' access may vary based on whether the participant contributes data to the SHIN, receives data from the SHIN, or both. Unique participants, such as correctional institutions or public health, may require specialized access and/or terms and conditions. In all these instances, Wisconsin will establish the primary trust relationships necessary to create the framework for the SHIN through the data use agreement. An initial draft of the data use agreement parameters and components is included in Appendix 22.

Individual authorized users of the SHIN will need to be affiliated with a qualified participant in order to access the SHIN. Participants will use various methods of forming trust relationships with such individuals, such as employment or by contract.

Notwithstanding the use and terms of the data use agreement, the SDE must evaluate and propose necessary revisions to state law to ensure the agreement is appropriate, effective, and enforceable. The WIRED for Health Board intends that the combination of state law and entry into the data use agreement will facilitate exchange, promote accountability, engage appropriate oversight, create accountability and a mechanism for enforcement of rights and obligations of the various constituents, and provide remedies for violations of law or contract. Remedies are closely related to

oversight and accountability, and enforcement is as important as establishing the protections.

Adaptability of Terms and Conditions

The SDE will determine and finalize the terms and conditions of the data use agreement. These terms and conditions will be based on the actions, assumptions, and guidance of the WIRED for Health Board, as evidenced by the SDE's organization, operations, and infrastructure. The terms and conditions will comply with all applicable laws, rules, and regulations. In addition, the SDE will revise the data use agreement as necessary to ensure necessary alignment with the NHIN. Most importantly, the SDE will create the mechanism to set, review, and revise the data use agreement in reaction to future changes in technology, law, and policy.

Legal and Policy Issues

Many legal and policy issues will need to be resolved in order to draft an effective and accepted data use agreement. The WIRED for Health Board, including the Legal and Policy Committee, and later the SDE itself, will work to create short- and long-term project plans that address these issues. A detailed list of these legal and policy concerns is set forth in Appendix 23. The primary concerns are as follows:

Privacy and Security

A re-examination of the legal remedies available to address specific privacy violations, such as unauthorized access or unauthorized disclosure, is warranted. Existing law may not provide reasonable and necessary protection of the privacy and security of information. Even if existing law is adequate, the SDE must establish policies and procedures to provide assurances that the SHIN is used only for permitted uses and disclosures.

Existing Wisconsin and Federal HIPAA law provides legal remedies for privacy violations, such as unauthorized access or unauthorized disclosure. The availability of these remedies may be dictated by the type of record that is accessed or disclosed. For example, stricter access limitations apply to mental health treatment records. Remedies include civil actions for violations, damages, injunctive relief, monetary penalties, imprisonment, and discipline of certain public employees.

Wisconsin has adopted a data security breach law that requires notice to individuals of any unauthorized disclosure of their personal information. However, health care providers, health information exchanges, and other entities subject to federal data security regulations under HIPAA must follow more rigorous federal breach notification and mitigation requirements, and thus are exempt from the state law. Other Wisconsin and Federal laws relating to identity theft and the unauthorized use of an individual's personal identifying information or documents also exist. Their applicability to unauthorized access or disclosure of health information requires further examination.

Under existing Federal law, covered entities (e.g., health care providers and many SHIN participants) and their business associates (e.g., the SDE) are governed by HIPAA. In addition, other federal laws, such as laws governing AODA records may apply. Under the recent HITECH Act, federal law imposes notification and mitigation obligations for the breach of unsecured protected health information, unless such information has been rendered "unusable, unreadable, or indecipherable." It may be valuable to participants and the SDE if the SHIN only uses and exchanges this "secured" protected health information.

Participants will need to continue to comply with existing laws. In addition, any participants that are not otherwise governed by such laws will be required to comply by contract.

Authorized users may only request information through the SHIN for permitted purposes established by law and SDE policies.

Liability and Indemnification

The SHIN must operate in a manner that ensures adequate remedies are available to the SDE, its participants and authorized users and individuals whose data may be used or disclosed. However, it must also appropriately limit liability to ensure participation in the SHIN and its continued existence. A re-examination of the legal remedies available to address liability and rights of indemnification is warranted.

In general, the SHIN will function within the existing state law and common law indemnification principle that each actor is responsible for its own acts and omissions. Thus, the SDE would be responsible only for the "exchange activities" it undertakes, and not for the accuracy or efficacy of the data furnished by the participants. For example, the SDE would be responsible for failing to exclude from disclosures data of an individual who "opts out" of the exchange. A participant would be responsible for including erroneous data in a record. Participants would be required to obtain any required consents or authorizations relating to the disclosure of data, and would be liable for any failure to do so.

This responsibility, however, must be tempered with sufficient protections and immunities to encourage and enable the use of the SHIN. Those protections will be accomplished by law and by contract under the data use agreement.

To ensure the sustainability and widespread use of statewide health information network, issues pertaining to liability indemnification must be considered. This may include legislation to ensure that limitations on liability apply as a matter of law (rather than mere contract); that an appropriate remedy is provided if the SDE fails to observe an opt-out of any individual from participation in the SHIN; and that participants and the SDE itself are protected from "bad acts" by participants.

The data use agreement must conform to any such laws, and may provide additional contractual limitations on liability and indemnification obligations. This may include the manner in which participants interact with one another to resolve disputes, including issues of responsibility when costs are incurred.

Finally, the SDE must be aware of changes in liability standards, as the increasing access to information creates new and changing legal concerns. For example, trial attorneys are beginning to pursue negligence claims based on a physician's failure to make a SHIN inquiry or a physician's delay in signing an order, which delays entry of that order into the medical record.

SHIN Model

The contractual model for SHIN participation described in this section was developed concurrently with the Standards and Architecture Committee. Therefore, the parameters of the data use agreement and the legal and policy issues to be addressed are difficult to settle. However, it is fair to assume that the SHIN will involve use of an interactive system that will assist participants in locating and sharing patient demographic and clinical data held by multiple health care organizations with disparate health information computer applications.

Because the architecture and data sharing of this network may be through any number of models, the model that is chosen will impact the analysis and recommendations regarding data use parameters, enforcement of legal and contractual rights and obligations, and appropriate legal protections. In general, the more data that is contained in a central repository, the greater the need for the SDE to ensure individuals' rights are protected and to secure access to the SHIN and its data.

Appendix 18: Implementation Plan

The following is the detailed implementation plan for the WIRED for Health project. The plan includes tasks completion percentages to date (see" % Complete" column) as of March 2012. Items in red denote milestone tasks.

% Complete	Task Name	Duration	Start	Finish
37%	**Ongoing Activities**	**1021 days**	**2/1/11**	**12/30/14**
27%	**Budgets**	**522.5 days**	**11/30/11**	**11/29/13**
100%	Submit updated budget to DHS for review	0.75 days	11/30/11	12/13/11
0%	Submit updated budget to DHS for review	1 day	9/4/12	11/30/12
0%	Submit updated budget to DHS for review	1 day	9/3/13	11/29/13
20%	**Work Plan Updates**	**566.5 days**	**9/30/11**	**12/2/13**
100%	Submit updated detailed project/work plan to DHS for review by 9/30	0.5 days	9/30/11	9/30/11
0%	Submit updated detailed project/work plan to DHS for review by 9/28	1 day	9/28/12	12/3/12
0%	Submit updated detailed project/work plan to DHS for review by 9/30	1 day	9/30/13	12/2/13
42%	**Federal Reporting & Data Requests**	**924 days**	**6/16/11**	**12/30/14**
100%	Submit data requested by DHS for ARRA 1512	1 day	6/16/11	6/16/11
100%	Submit data requested by DHS for ARRA 1512	0.5 days	9/15/11	9/15/11
100%	Submit data requested by DHS for Federal FSR Annual Report	11.5 days	10/12/11	12/15/11
100%	Submit data requested by DHS for ARRA 1512	1 day	12/15/11	12/21/11
0%	**ARRA 1512**	**459 days**	**4/10/12**	**1/10/14**
0%	2012 Q1 ARRA 1512	1 day	4/10/12	4/10/12
0%	2012 Q2 ARRA 1512	1 day	7/10/12	7/10/12
0%	2012 Q3 ARRA 1512	1 day	10/10/12	10/10/12
0%	2012 Q4 ARRA 1512	1 day	1/10/13	3/29/13
0%	2013 Q1 ARRA 1512	1 day	4/10/13	6/4/13
0%	2013 Q2 ARRA 1512	1 day	7/10/13	7/19/13
0%	2013 Q3 ARRA 1512	1 day	10/10/13	10/10/13
0%	2013 Q4 ARRA 1512	1 day	1/10/14	1/10/14
0%	**Annual Fed Financial Report SF-425**	**523 days**	**12/28/12**	**12/30/14**
0%	2012 FFY (Oct 1 2011 thru Sept 30 2012)	1 day	12/28/12	12/28/12
0%	2013 FFY (Oct 1 2012 thru Sept 30 2013)	1 day	12/30/13	12/30/13
0%	2014 FFY (Oct 1 2013 thru Sept 30 2014)	1 day	12/30/14	12/30/14

0%	**Quarterly FFR Cash Transaction Report**	**459 days**	**4/30/12**	**1/30/14**
0%	2012 Q1	1 day	4/30/12	4/30/12
0%	2012 Q2	1 day	7/30/12	7/30/12
0%	2012 Q3	1 day	10/30/12	10/30/12
0%	2012 Q4	1 day	1/30/13	1/30/13
0%	2013 Q1	1 day	4/30/13	4/30/13
0%	2013 Q2	1 day	7/30/13	7/30/13
0%	2013 Q3	1 day	10/30/13	10/30/13
0%	2013 Q4	1 day	1/30/14	1/30/14
22%	**Progress & Projection Reporting**	**741 days**	**3/31/11**	**1/30/14**
100%	Submit Progress Report to DHS and ONC (initial perf. Measures; no guidance received)	1 day	7/29/11	7/29/11
100%	Submit Progress Report to DHS and ONC (through September 2011)	1 day	10/31/11	10/31/11
100%	Submit Progress Report to DHS and ONC (for all of 2011)	1 day	1/27/12	1/30/12
14%	**Quarterly Projection Reports**	**642 days**	**3/31/11**	**9/13/13**
100%	2012 Q2 (April 01 through June 30)	1 day	3/31/11	3/31/11
0%	2012 Q3 (July 01 through Sept 30)	1 day	6/15/11	6/15/11
0%	2012 Q4 (Oct 01 through Dec 30)	1 day	9/14/12	9/14/12
0%	2013 Q1 (Jan 01 through March 30)	1 day	12/14/12	12/14/12
0%	2013 Q2 (April 01 through June 30)	1 day	3/15/13	3/15/13
0%	2013 Q3 (July 01 through Sept 30)	1 day	6/14/13	6/14/13
0%	2013 Q4 (Oct 01 through Dec 30)	1 day	9/13/13	9/13/13
0%	**Progress Reports**	**459 days**	**4/30/12**	**1/30/14**
0%	2012 Q1 Progress Report - Quarter (for PIN areas only - 2012 Q1)	1 day	4/30/12	5/1/12
0%	2012 Bi-Annual Progress Report (for PIN areas Q2 and for FOA areas Q1 & Q2)	1 day	7/30/12	7/30/12
0%	2012 Q3 Progress Report - Quarter (for PIN areas only - 2012 Q3)	1 day	10/30/12	10/30/12
0%	2012 Bi-Annual Progress Report (for PIN areas Q4 and for FOA areas Q3 & Q4)	1 day	1/30/13	4/5/13
0%	2013 Q1 Progress Report - Quarter (for PIN areas only - 2013 Q1)	1 day	4/30/13	4/30/13
0%	2013 Bi-Annual Progress Report (for PIN areas Q2 and for FOA areas Q1 & Q2)	1 day	7/30/13	7/30/13
0%	2013 Q3 Progress Report - Quarter (for PIN areas only - 2013 Q3)	1 day	9/30/13	9/30/13
0%	2013 Bi-Annual Progress Report (for PIN areas Q4 and for FOA areas Q3 & Q4)	1 day	1/30/14	1/30/14

37%	**Submit updated SOP to DHS for review**	**708 days**	**8/22/11**	**5/7/14**
84%	**Update the Strategic and Operational Plan in 2011 (includes Sustainability Plan)**	**187 days**	**8/22/11**	**5/8/12**
100%	Begin review of Plan and annual updates	14.5 days	9/1/11	9/21/11
82%	**Revise Sustainability Plan (Financial Section of SOP)**	**187 days**	**8/22/11**	**5/8/12**
100%	Gather feedback from Value Proposition Workgroup	73 days	8/22/11	11/30/11
83%	Update the Plan	75 days	1/2/12	4/13/12
0%	Submit SOP to Board and DHS	8 days	4/16/12	4/25/12
0%	Receive Board approval of Plan	1 day	4/26/12	4/26/12
0%	Receive DHS approval of Plan	1 day	4/26/12	4/26/12
0%	Modify plan as necessary	5 days	4/27/12	5/3/12
0%	Submit updated plan to ONC	1 day	5/8/12	5/8/12
0%	**Update the Strategic and Operational Plan in 2012**	**132 days**	**11/5/12**	**5/8/13**
0%	Begin review of Plan and annual updates	105 days	11/5/12	3/29/13
0%	Submit SOP to Board and DHS	20 days	4/1/13	4/26/13
0%	Receive Board approval of Plan	1 day	4/29/13	4/29/13
0%	Receive DHS approval of Plan	2 days	4/29/13	4/30/13
0%	Modify plan as necessary	5 days	5/1/13	5/7/13
0%	Submit updated plan to ONC	0 days	5/8/13	5/8/13
0%	**Update the Strategic and Operational Plan in 2013**	**133 days**	**11/4/13**	**5/7/14**
0%	Begin review of Plan and annual updates	64 days	11/4/13	1/30/14
0%	Submit SOP to Board and DHS	20 days	4/1/14	4/28/14
0%	Receive Board approval of Plan	1 day	4/29/14	4/29/14
0%	Receive DHS approval of Plan	1 day	4/29/14	4/29/14
0%	Modify plan as necessary	5 days	4/30/14	5/6/14
0%	Submit updated plan to ONC	1 day	5/7/14	5/7/14
37%	**Submit monthly activity and expense report**	**833 days**	**2/1/11**	**4/10/14**
100%	**2011 Activity**	**258.83 days**	**2/1/11**	**1/27/12**
100%	Monthly Activity and Expense Report for January Activity	8 days	2/1/11	2/10/11
100%	Monthly Activity and Expense Report for February Activity	8 days	3/1/11	3/10/11
100%	Monthly Activity and Expense Report for March Activity	6 days	4/1/11	4/8/11
100%	Monthly Activity and Expense Report for April Activity	7 days	5/2/11	5/10/11
100%	Monthly Activity and Expense Report for May Activity	8 days	6/1/11	6/10/11
100%	Monthly Activity and Expense Report for June Activity	6 days	7/1/11	7/8/11
100%	Monthly Activity and Expense Report for July Activity	8 days	8/1/11	8/10/11
100%	Monthly Activity and Expense Report for August Activity	7 days	9/1/11	9/9/11
100%	Monthly Activity and Expense Report for September Activity	6 days	10/3/11	10/10/11
100%	Monthly Activity and Expense Report for October Activity	8 days	12/28/11	1/18/12
100%	Monthly Activity and Expense Report for November Activity	7 days	1/18/12	1/27/12
100%	Monthly Activity and Expense Report for December Activity	7 days	1/2/12	1/10/12

18%	**2012 Activity**	**294.33 days**	**12/1/11**	**1/17/13**
100%	Monthly Activity and Expense Report for January Activity	8 days	2/1/12	2/10/12
100%	Monthly Activity and Expense Report for February Activity	7 days	3/1/12	3/9/12
0%	Monthly Activity and Expense Report for March Activity	7 days	4/2/12	4/10/12
0%	Monthly Activity and Expense Report for April Activity	8 days	5/1/12	5/10/12
0%	Monthly Activity and Expense Report for May Activity	6 days	6/1/12	6/8/12
0%	Monthly Activity and Expense Report for June Activity	7 days	7/2/12	7/11/12
0%	Monthly Activity and Expense Report for July Activity	8 days	8/1/12	8/10/12
0%	Monthly Activity and Expense Report for August Activity	7 days	12/1/11	12/12/11
0%	Monthly Activity and Expense Report for September Activity	8 days	12/10/12	12/20/12
0%	Monthly Activity and Expense Report for October Activity	6 days	12/20/12	12/31/12
0%	Monthly Activity and Expense Report for November Activity	6 days	12/31/12	1/17/13
0%	Monthly Activity and Expense Report for December Activity	6 days	1/27/12	2/16/12
0%	**2013 Activity**	**272.67 days**	**1/2/13**	**1/17/14**
0%	Monthly Activity and Expense Report for January Activity	6 days	2/1/13	2/8/13
0%	Monthly Activity and Expense Report for February Activity	6 days	3/1/13	3/8/13
0%	Monthly Activity and Expense Report for March Activity	8 days	4/1/13	4/10/13
0%	Monthly Activity and Expense Report for April Activity	8 days	5/1/13	5/10/13
0%	Monthly Activity and Expense Report for May Activity	6 days	6/3/13	6/10/13
0%	Monthly Activity and Expense Report for June Activity	8 days	7/1/13	7/10/13
0%	Monthly Activity and Expense Report for July Activity	7 days	8/1/13	8/9/13
0%	Monthly Activity and Expense Report for August Activity	7 days	12/9/13	12/19/13
0%	Monthly Activity and Expense Report for September Activity	8 days	12/19/13	12/31/13
0%	Monthly Activity and Expense Report for October Activity	6 days	12/31/13	1/8/14
0%	Monthly Activity and Expense Report for November Activity	7 days	1/8/14	1/17/14
0%	Monthly Activity and Expense Report for December Activity	7 days	1/2/13	1/10/13
0%	**2014 Activity**	**49 days**	**2/3/14**	**4/10/14**
0%	Monthly Activity and Expense Report for January Activity	6 days	2/3/14	2/10/14
0%	Monthly Activity and Expense Report for February Activity	6 days	3/3/14	3/10/14
0%	Monthly Activity and Expense Report for March Activity	8 days	4/1/14	4/10/14
100%	**WISHIN Start Up Activities**	**107 days**	**1/3/11**	**5/31/11**
100%	**Staffing Plan**	**85 days**	**1/3/11**	**4/29/11**
100%	Staffing Plan Approval from DHS	15 days	1/3/11	1/21/11
100%	Staff positions filled	44 days	3/1/11	4/29/11
100%	Tracking/documentation methodology for cost sharing and matching contributions	31 days	1/3/11	2/14/11
100%	**Procurement policies and procedures**	**55 days**	**1/3/11**	**3/18/11**
100%	Submit to DHS	41 days	1/3/11	2/28/11
100%	Approval/disapprove	14 days	3/1/11	3/18/11

100%	**Establish Advisory Committees**	**29 days**	**4/21/11**	**5/31/11**
100%	**Policy Advisory Committee**	**6 days**	**4/21/11**	**4/28/11**
100%	Finalize Policy Advisory Committee Charter	1 day	4/21/11	4/21/11
100%	Complete detailed work plan with deliverables and due dates	1 wk	4/22/11	4/28/11
100%	**Technical Advisory Committee**	**11 days**	**4/28/11**	**5/12/11**
100%	Finalize Technical Advisory Committee Charter	1 day	4/28/11	4/28/11
100%	Complete detailed work plan with deliverables and due dates	2 wks	4/29/11	5/12/11
100%	**Communications Advisory Committee**	**27 days**	**4/25/11**	**5/31/11**
100%	Finalize Communications Advisory Committee Charter	1 day	4/25/11	4/25/11
100%	Complete detailed work plan with deliverables and due dates	2 wks	5/18/11	5/31/11
100%	**Develop Initial Strategy for 2011, 2012, and Beyond**	**7 days**	**4/12/11**	**4/20/11**
100%	Attend Direct Boot Camp	3 days	4/12/11	4/14/11
100%	Debrief on Boot Camp and Review Options for business models/strategy	1 day	4/19/11	4/19/11
100%	Identify any deviations from SOP & SOW	1 day	4/19/11	4/19/11
100%	Identify key services for 2011, 2012, and Beyond	1 day	4/20/11	4/20/11
100%	**Financial Sustainability Plan**	**26 days**	**4/4/11**	**5/9/11**
100%	**Review and Approval of Deloitte Sustainability Plan Deliverable**	**26 days**	**4/4/11**	**5/9/11**
100%	Obtain Sustainability Plan from Deloitte	1 day	4/4/11	4/4/11
100%	Review and Comment on Sustainability Plan	2 wks	4/5/11	4/18/11
100%	Deloitte to Revise the Sustainability Plan	2 wks	4/19/11	5/2/11
100%	Obtain, Review, and Approve Deloitte Revised Sustainability Plan	1 wk	5/3/11	5/9/11
100%	Transition from WIRED to WISHIN complete	1 day	1/27/12	1/27/12
100%	**WISHIN 2011**	**260 days?**	**1/3/11**	**12/30/11**
100%	**2011 Policy Advisory Committee**	**184 days?**	**3/1/11**	**11/11/11**
100%	**Policy Advisory Committee - Liability Issues Wkgp**	**56 days**	**6/1/11**	**8/17/11**
100%	Begin Identification of Liability Concerns	45 days	6/1/11	8/2/11
100%	Draft a summary of Liability Concerns	5 days	8/3/11	8/9/11
100%	Identify Solutions to Liability Concerns	6 days	8/10/11	8/17/11
100%	Recommend solutions to Liability Concerns	1 day	10/19/11	10/19/11
100%	**Consent Management - Framework Component Development**	**152 days**	**3/1/11**	**9/28/11**
100%	Analyze options for patient consent management model	106 days	3/1/11	7/26/11
100%	Brief Board	1 day	7/27/11	7/27/11
100%	Receive Board approval on approach	1 day	7/27/11	7/27/11
100%	Review Consent Management Options Summary with Technical Committee	1 day	8/22/11	8/22/11
100%	Work with Workgroup to gather consent management options	23 days	8/22/11	9/21/11
100%	Brief Policy and Technical Committees	1 day	9/21/11	9/21/11
100%	Brief Board	1 day	9/28/11	9/28/11
100%	Consent Management Plan/Approach is Approved	1 day	9/29/11	9/29/11

100%	**2011 Rapid Deployment Workgroup**	**130 days?**	**5/16/11**	**11/11/11**
100%	**Participation Agreements - WISHIN Bridge**	**130 days?**	**5/16/11**	**11/11/11**
100%	Review example agreements	5 days	5/16/11	5/20/11
100%	Get Workgroup Comments on Samples	15 days	5/23/11	6/10/11
100%	Draft WISHIN-specific Agreement	5 days	6/13/11	6/17/11
100%	Review with full committee	1 day	6/20/11	6/20/11
100%	Finalize with WISHIN counsel	105 days	6/20/11	11/11/11
100%	Develop Provider Directory Specifications	8 days?	9/22/11	10/3/11
100%	WISHIN Bridge Participation Agreement Complete	1 day	11/11/11	11/11/11
100%	**Participation Agreements - WISHIN Direct**	**68 days**	**5/16/11**	**8/17/11**
100%	Review example agreements	5 days	5/16/11	5/20/11
100%	Get workgroup Comments on Samples	15 days	5/23/11	6/10/11
100%	Draft WISHIN-specific Agreement	5 days	6/13/11	6/17/11
100%	Review with full committee	1 day	6/20/11	6/20/11
100%	Finalize with WISHIN counsel	40 days	6/20/11	8/12/11
100%	Get final agreement from Ability and WHIE	3 days	8/15/11	8/17/11
100%	WISHIN Direct Participation Agreement Complete	1 day	8/18/11	8/18/11
100%	**WISHIN Bridge Policy**	**101 days**	**5/16/11**	**10/3/11**
100%	Review example WISHIN Bridge Criteria	5 days	5/16/11	5/20/11
100%	Get Workgroup Comments on Samples	15 days	5/23/11	6/10/11
100%	Incorporate Workgroup Comments	5 days	6/13/11	6/17/11
100%	Review with full committee	1 day	6/20/11	6/20/11
100%	Finalize Qualification process and policy	75 days	6/21/11	10/3/11
100%	WISHIN Bridge Materials are Complete	1 day	10/4/11	10/4/11
100%	**2011 Technical Advisory Committee**	**154 days**	**3/1/11**	**9/30/11**
100%	**Develop a process for on-going decisions on HIE Exchange Standards**	**154 days**	**3/1/11**	**9/30/11**
100%	Define governance structure for Connect exchange standards and interoperability	154 days	3/1/11	9/30/11
100%	Review approach for implementing NwHIN standards	154 days	3/1/11	9/30/11
100%	Check that standards are compatible with ONC's EHR Qualification rule	154 days	3/1/11	9/30/11
100%	Develop standards roadmap	154 days	3/1/11	9/30/11
100%	**2011 Communications Advisory Committee**	**120 days**	**5/2/11**	**10/14/11**
100%	**Expand WISHIN Website**	**30 days**	**5/2/11**	**6/10/11**
100%	Define WISHIN Website specifications	15 days	5/2/11	5/20/11
100%	Procure Web development service	15 days	5/23/11	6/10/11
100%	WISHIN Website Developed and Operational	3 wks	6/13/11	7/1/11

100%	**Marketing and Communications for WISHIN Bridge**	**120 days**	**5/2/11**	**10/14/11**
100%	**Develop Marketing and Communications Plan to cover WISHIN Bridge**	**63 days**	**5/2/11**	**7/27/11**
100%	**Gather informaton on the market**	**30 days**	**5/2/11**	**6/10/11**
100%	Implement plan to gather data	2 wks	5/2/11	5/13/11
100%	Analyze data gathered	10 days	5/16/11	5/27/11
100%	Define the WISHIN Bridge Market for Phase I	10 days	5/30/11	6/10/11
100%	**Develop Communications Strategy for WISHIN Bridge**	**10 days**	**6/13/11**	**6/24/11**
100%	Identify and prioritize stakeholders	2 wks	6/13/11	6/24/11
100%	Identify communications and methods for Phase I; leverage CEM (Appendix 17 in SOP)	2 wks	6/13/11	6/24/11
100%	**Finalize the Marketing and Communication Plan for WISHIN Bridge**	**26 days**	**6/22/11**	**7/27/11**
100%	Draft the Marketing & Communications Plan for WISHIN Bridge	2 wks	6/22/11	7/5/11
100%	Present the Marketing & Communications Plan for WISHIN Bridge to the Board for Input	1 day	7/27/11	7/27/11
100%	2011 Marketing & Communications Plan for WISHIN Bridge Finalized	1 day	7/27/11	7/27/11
100%	**Develop and Deploy messages and educational materials for WISHIN Bridge**	**30 days**	**6/3/11**	**7/14/11**
100%	Develop messages and educational materials for WISHIN Bridge	30 days	6/3/11	7/14/11
100%	Deploy messages/educational material for WISHIN Bridge	1 day	10/14/11	10/14/11
100%	**Marketing and Communications for WISHIN Direct**	**89 days**	**5/2/11**	**9/1/11**
100%	**Develop Marketing and Communications Plan for WISHIN Direct**	**64 days**	**5/2/11**	**7/28/11**
100%	**Gather information on the market**	**30 days**	**5/2/11**	**6/10/11**
100%	Implement plan to gather data	6 wks	5/2/11	6/10/11
100%	Collect data on White Space	1 day	5/30/11	5/30/11
100%	Analyze data gathered	5 days	5/31/11	6/6/11
100%	Define the WISHIN Direct Market for Phase I	5 days	5/31/11	6/6/11
100%	**Develop Communications Strategy for WISHIN Direct**	**5 days**	**6/7/11**	**6/13/11**
100%	Identify priority stakeholders	1 wk	6/7/11	6/13/11
100%	Identify communications and methods for Phase I; leverage CEM (Appendix 17 in SOP)	1 wk	6/7/11	6/13/11
100%	**Finalize the Marketing and Communications Plan for WISHIN Direct**	**38 days**	**6/7/11**	**7/28/11**
100%	Draft the Marketing & Communications Plan for WISHIN Direct	2 wks	6/7/11	6/20/11
100%	Present the Marketing & Communications Plan for WISHIN Direct to the Board	1 day	7/27/11	7/27/11
100%	Incorporate Board input	1 day	7/28/11	7/28/11
100%	2011 Marketing & Communications Plan for WISHIN Direct Complete	1 day	7/29/11	7/29/11
100%	**Develop and deploy messages and educational materials for WISHIN Direct**	**24 days**	**8/1/11**	**9/1/11**
100%	Develop messages and educational materials	24 days	8/1/11	9/1/11
100%	Deploy Initial Messages/Educational Material for WISHIN Direct	19 days	8/8/11	9/1/11

100%	**2011 White Space**	**260 days**	**1/3/11**	**12/30/11**
100%	**Validate White Space Data and finalize baseline measures of HIE capability**	**90 days**	**5/23/11**	**9/23/11**
100%	**Collect additional information needed to assess white space**	**90 days**	**5/23/11**	**9/23/11**
100%	Identify issues with the data	1 wk	5/23/11	5/27/11
100%	**Outreach to labs, pharmacies, and physicians to refine data**	**85 days**	**5/30/11**	**9/23/11**
100%	Interview pharmacies to refine data, identify barriers, benefits, and potential incentives	20 days	5/30/11	6/24/11
100%	Interview labs to refine data, identify barriers, benefits, and potential incentives	15 days	6/6/11	6/24/11
100%	Work with WMS to refine data	40 days	8/1/11	9/23/11
100%	Determine baseline White Space for all PIN priority areas	1 day	9/26/11	9/26/11
100%	**Performance Measure Reporting (per 2010 SOP 4.2.4)**	**64 days**	**5/2/11**	**7/28/11**
100%	Begin to develop process for tracking, monitoring, and reporting on performance measures	64 days	5/2/11	7/28/11
100%	Select additional measures to supplement initial set of measures specified by ONC	42 days	6/1/11	7/28/11
100%	Process for tracking, monitoring, and reporting on performance measures implemented.	20 days	7/1/11	7/28/11
100%	**Identify and Implement Strategies to Address the White Space**	**260 days**	**1/3/11**	**12/30/11**
100%	**Pharmacies**	**174 days**	**1/3/11**	**9/1/11**
100%	Determine approaches to receive a 50% reduction in gap	1 wk	1/3/11	1/7/11
100%	Create a plan to reduce Pharmacy White Space by 50%	1 wk	1/10/11	1/14/11
100%	**Implement Plan**	**109 days**	**4/4/11**	**9/1/11**
100%	Conduct Round 1 Outreach to Pharmacies	109 days	4/4/11	9/1/11
100%	Complete 2011 ending measurement of eRx White Space	1 day	12/30/11	12/30/11
100%	**Laboratories**	**66 days**	**6/1/11**	**8/31/11**
100%	Determine approaches to receive a 50% reduction in gap	1 wk	7/5/11	7/11/11
100%	Create a plan to reduce Lab White Space by 50%	1 wk	7/12/11	7/18/11
100%	**Implement Plan**	**66 days**	**6/1/11**	**8/31/11**
100%	Conduct round 2 of outreach to laboratories	66 days	6/1/11	8/31/11
100%	Complete 2011 ending measurement of laboratory White Space	1 day	12/30/11	12/30/11
100%	**Clinical Summary Exchange (Physician White Space)**	**148 days**	**6/1/11**	**12/23/11**
100%	Refine the data	83 days	6/1/11	9/23/11
100%	Create a plan to reduce White Space	18.4 wks	8/11/11	12/16/11
100%	**Implement Plan**	**56 days**	**10/7/11**	**12/23/11**
100%	Conduct the Survey (email via WMS)	41 days	10/7/11	12/2/11
100%	Complete secondary outreach measures (mail, phone, fax)	39 days	11/1/11	12/23/11
100%	Complete 2011 ending measurement of Care Summary White Space	1 day	12/30/11	12/30/11

100%	**WISHIN 2011 Operations**	**128 days**	**4/21/11**	**10/17/11**
100%	**Establish Operations for WISHIN Bridge**	**121 days**	**5/2/11**	**10/17/11**
100%	**Develop WISHIN Bridge Standards & Processes**	**120 days**	**5/2/11**	**10/14/11**
100%	Obtain samples from other States	1 wk	5/2/11	5/6/11
100%	Write Draft	4 wks	5/9/11	6/3/11
100%	Obtain input from Technical Advisory Committee	1 day	6/20/11	6/20/11
100%	Obtain input from policy Advisory Committee	1 day	6/15/11	6/15/11
100%	Incorporate input into standards and process document	1 wk	6/21/11	6/27/11
100%	Develop HISP application materials	70 days	6/28/11	10/3/11
100%	Release Marketing Materials for WISHIN Bridge	1 day	10/14/11	10/14/11
100%	Go-Live with WISHIN Bridge	1 day	10/17/11	10/17/11
100%	**Establish Operations for WISHIN Direct**	**92 days**	**4/21/11**	**8/26/11**
100%	**Develop RFP for HISP services**	**32 days**	**4/21/11**	**6/3/11**
100%	Obtain samples from other States	1 wk	4/21/11	4/27/11
100%	Write baseline draft	2 wks	4/28/11	5/11/11
100%	Obtain input from Technical Advisory Committee	1 day	5/17/11	5/17/11
100%	Obtain input from Policy Advisory Committee	1 day	5/20/11	5/20/11
100%	Obtain input on RFP from ONC	1 wk	5/30/11	6/3/11
100%	Identify potential vendors	2.5 wks	5/12/11	5/30/11
100%	Finalize the RFP	1 wk	5/12/11	5/23/11
100%	**Release RFP, Review Responses, and Award**	**44 days**	**6/1/11**	**8/1/11**
100%	Release RFP to vendor community	**0 days**	**6/1/11**	**6/1/11**
100%	Receive Vendor Responses	20 days	6/1/11	6/28/11
100%	Review RFP Responses	1 wk	6/29/11	7/5/11
100%	Award the Contract	3.8 wks	7/4/11	8/1/11
100%	**Stand Up HISP Services**	**19 days**	**8/1/11**	**8/26/11**
100%	Develop Plan with Vendor for Standing up Services	1 wk	8/2/11	8/8/11
100%	Begin Stand Up of Direct	14 days	8/1/11	8/18/11
100%	Announce WISHIN is Operational	1 day	8/26/11	8/26/11
100%	WISHIN Direct Operational	1 day	8/26/11	8/26/11
39%	**WISHIN Direct Pilots**	**181 days**	**11/7/11**	**7/16/12**
100%	Newborn Screening Laboratory Results Delivery	83 days	11/7/11	2/29/12
23%	Exchange between a clinic and a long term care facility (WWMA)	60 days	3/21/12	6/12/12
47%	Use of Direct to send immunization data to the Wisconsin Immunization Registry (Boscobel)	60 days	3/1/12	5/23/12
0%	Exchange between a clinic and a long term care facility (SFCC)	60 days	4/23/12	7/13/12
0%	Use of Direct between a Rural Hospital and a Community Clinic	60 days	4/23/12	7/13/12
0%	WISHIN Direct Pilots Complete	1 day	7/16/12	7/16/12

76%	**Procurement and Planning for HIE**	**376 days**	**1/3/11**	**6/11/12**
100%	**Organize and Complete Vendor (Fair) Demonstration**	**209 days**	**1/3/11**	**10/20/11**
100%	Prepare Notice	2 days	7/18/11	7/19/11
100%	Submit Scenarios	5 days	1/3/11	1/7/11
100%	Draft Plan and Schedule	10 days	7/25/11	8/5/11
100%	Implement Plan	47 days	8/8/11	10/11/11
100%	Complete Demonstrations	2 days	10/12/11	10/13/11
100%	Compile Results	5 days	10/14/11	10/20/11
100%	Vendor Fair Complete	1 day	10/21/11	10/21/11
100%	**Define and Complete RFP and Vendor Selection Process**	**120 days**	**10/24/11**	**4/6/12**
100%	RFP Planning	15 days	10/24/11	11/11/11
100%	**Draft RFP**	**7 days**	**12/1/11**	**12/9/11**
100%	Preliminary Draft of RFP to Technical Committee	1 day	12/1/11	12/1/11
100%	Preliminary Draft of RFP to Policy Committee	1 day	12/1/11	12/1/11
100%	Obtain HIE Operations Policy Cross-Collaboration Workgroup Recommendations	5 days	12/2/11	12/8/11
100%	Complete RFP	1 day	12/9/11	12/9/11
100%	Distribute courtesy copies to Committees and Board	1 day	12/1/11	12/1/11
100%	Board Approval of RFP	1 day	12/12/11	12/12/11
100%	Submit RFP to DHS for Approval	1 day	12/13/11	12/13/11
100%	Submit RFP to ONC for Approval	1 day	12/22/11	12/22/11
100%	ONC Review Period	11 days	12/23/11	1/6/12
100%	Incorporate ONC Feedback	2 days	1/6/12	1/9/12
100%	Release RFP	2 days	1/9/12	1/10/12
100%	Close RFP	25 days	1/16/12	2/17/12
100%	Evaluate Vendor Proposals	29 days	2/20/12	3/29/12
100%	Oral Demonstrations for Vendor Short List	5 days	4/2/12	4/6/12
100%	Final Vendor Evaluation	5 days	4/2/12	4/6/12
100%	Announce Vendor Notice of Intent to Award	1 day	4/9/12	4/9/12
14%	**Define and Negotiate Vendor Contract**	**53 days**	**3/29/12**	**6/11/12**
0%	Conduct Vendor Contract Negotiations	15 days	4/10/12	4/30/12
43%	Develop Draft Vendor Contract	23 days	3/29/12	4/30/12
0%	Send Draft Contract to ONC and DHS for Approval	30 days	5/1/12	6/11/12
0%	Receive Board Approval of Vendor Contract	1 day	6/6/12	6/6/12
0%	Execute Vendor Contract	0 days	6/11/12	6/11/12

8%	**WISHIN HIE Planning and Policy Development**	**298 days?**	**10/26/11**	**12/14/12**
0%	**Laboratory and Clinic Surveys**	**120 days**	**2/28/12**	**8/13/12**
0%	Contract with UWSC	4 days	2/28/12	3/2/12
0%	Survey's developed (clinic and lab)	30 days	3/5/12	4/13/12
0%	Mail Surveys & Collect Results	54 days	4/16/12	6/28/12
0%	Final survey results delivered from UWSC	1 day	6/29/12	6/29/12
0%	**2012 Laboratory Work Group**	**31 days**	**7/2/12**	**8/13/12**
0%	Review results of Laboratory and Clinic Surveys	30 days	7/2/12	8/10/12
0%	Recommend approach to minimize laboratory white space and provide services to labs	1 day	8/13/12	8/13/12
10%	**WISHIN Communications Advisory Committee and Work Groups**	**298 days**	**10/26/11**	**12/14/12**
0%	**Crisis Communications**	**87 days**	**6/21/12**	**10/19/12**
0%	Establish a crisis communication plan and protocols	87 days	6/21/12	10/19/12
12%	**Marketing and Communications for WISHIN HIE Services**	**298 days**	**10/26/11**	**12/14/12**
35%	**Develop Marketing and Communications Plan for WISHIN HIE Services**	**192 days**	**10/26/11**	**7/19/12**
100%	Develop and Release Marketing RFP	49 days	11/1/11	1/6/12
14%	**Gather information on the market**	**179 days**	**10/26/11**	**7/2/12**
23%	Implement plan to gather data	14.2 wks	10/26/11	4/30/12
0%	Gather data	5 wks	5/1/12	6/4/12
0%	Analyze data gathered	2 wks	6/5/12	6/18/12
0%	Define the market for provider-centered, bi-directional exchange services	2 wks	6/19/12	7/2/12
0%	**Develop Communications Strategy**	**10 days**	**7/3/12**	**7/16/12**
0%	Identify priority stakeholders	2 wks	7/3/12	7/16/12
0%	Identify communications and methods; leverage CEM (Appendix 17 in 2010 SOP)	2 wks	7/3/12	7/16/12
0%	**Finalize the Marketing and Communications Plan**	**3 days**	**7/17/12**	**7/19/12**
0%	Draft the Marketing & Communications Plan	1 day	7/17/12	7/17/12
0%	Present the Marketing & Communications Plan to the Board for Approval	1 day	7/18/12	7/18/12
0%	Incorporate Board input	1 day	7/19/12	7/19/12
0%	Marketing & Communications Plan Approved	1 day	7/20/12	7/20/12
0%	**Stakeholder Marketing Campaign 2012+**	**105 days**	**7/23/12**	**12/14/12**
0%	**WISHIN Stakeholder Marketing**	**105 days**	**7/23/12**	**12/14/12**
0%	Develop Stakeholder Marketing Materials	20 days	7/23/12	8/17/12
0%	Stakeholder Marketing Activities	85 days	8/20/12	12/14/12
0%	**Develop and market the services**	**60 days**	**8/20/12**	**11/9/12**
0%	Physician Groups	60 days	8/20/12	11/9/12
0%	Hospital Groups	60 days	8/20/12	11/9/12
0%	Payer/Employer Groups	60 days	8/20/12	11/9/12
0%	Patients	60 days	8/20/12	11/9/12
0%	Deploy Initial Messages/Educational Material for HIE services	1 day	11/12/12	11/12/12

0%	**WISHIN Clinical Data Work Group**	**21 days**	**4/2/12**	**4/30/12**
0%	Define Minimum Data Set	21 days	4/2/12	4/30/12
0%	**WISHIN Pilot Communities Work Group**	**26 days?**	**4/30/12**	**6/4/12**
0%	Identify characteristics for pilot communities	26 days?	4/30/12	6/4/12
0%	**WISHIN Policy Work Group**	**51 days**	**4/11/12**	**6/20/12**
0%	Policies around basic HIE participant requirements	14 days	4/11/12	4/30/12
0%	Policies related to disclosure of information	9 days	4/18/12	4/30/12
0%	Policies related to consumers/patients	14 days	5/1/12	5/18/12
0%	Policies related to system security	14 days	5/18/12	6/6/12
0%	Policies related to HIPAA security	14 days	6/1/12	6/20/12
0%	**Stand Up HIE Services**	**90 days**	**6/12/12**	**10/15/12**
0%	Infrastructure and Configuration Activities	90 days	6/12/12	10/15/12
0%	Stand up technical infrastructure	90 days	6/12/12	10/15/12
0%	Configure HIE	90 days	6/12/12	10/15/12
0%	**Incorporate Consent Management Model into Infrastructure**	**61 days**	**6/12/12**	**9/4/12**
0%	Determine best implementation approach based on Wisconsin law and vendor capabilities	30 days	6/12/12	7/23/12
0%	Adjust participation agreements and policy mechanisms as needed	15 days	7/24/12	8/13/12
0%	Develop participant materials or option sheets to assist with roll out	15 days	8/14/12	9/3/12
0%	Consent Management Model Incorporated into Infrastructure	1 day	9/4/12	9/4/12
0%	**Migrate WISHIN Direct into WISHIN HIE Offering**	**45 days**	**5/1/12**	**7/2/12**
0%	Determine approach for integrating WISHIN Direct into new infrastructure	20 days	5/1/12	5/28/12
0%	Integrate WISHIN Direct Messaging into new services (branding, config, etc)	20 days	5/29/12	6/25/12
0%	Test integration to ensure continuity of WISHIN Direct service	5 days	6/26/12	7/2/12
0%	WISHIN Direct fully migrated	1 day	7/3/12	7/3/12
0%	**HIE Services - Segment 1 Rollout**	**144 days**	**4/2/12**	**10/18/12**
0%	**Community Pilot 1**	**144 days**	**4/2/12**	**10/18/12**
0%	Engage participants	60 days	4/2/12	6/22/12
0%	**Define Community Pilot scope of work**	**31 days**	**6/12/12**	**7/24/12**
0%	ID use cases	30 days	6/12/12	7/23/12
0%	ID interfaces	30 days	6/12/12	7/23/12
0%	ID EHR integration needs (if any)	30 days	6/12/12	7/23/12
0%	Scope Defined	1 day	7/24/12	7/24/12
0%	**Configure, Test and Train**	**61 days**	**7/25/12**	**10/17/12**
0%	Conduct Integration activities (interface testing,etc)	60 days	7/25/12	10/16/12
0%	Training (longitudinal patient record, plus any EHR integration)	10 days	10/3/12	10/16/12
0%	Configuration, Testing, and Training Complete	1 day	10/17/12	10/17/12
0%	**Launch**	**1 day**	**10/18/12**	**10/18/12**
0%	Pilot 1 Go-Live	1 day	10/18/12	10/18/12

0%	**Community Pilot 2**	**144 days**	**4/2/12**	**10/18/12**
0%	Engage participants	60 days	4/2/12	6/22/12
0%	**Define Community Pilot scope of work**	**31 days**	**6/12/12**	**7/24/12**
0%	ID use cases	30 days	6/12/12	7/23/12
0%	ID interfaces	30 days	6/12/12	7/23/12
0%	ID EHR integration needs (if any)	30 days	6/12/12	7/23/12
0%	Scope Defined	1 day	7/24/12	7/24/12
0%	**Configure, Test and Train**	**61 days**	**7/25/12**	**10/17/12**
0%	Conduct Integration activities (interface testing,etc)	60 days	7/25/12	10/16/12
0%	Training (longitudinal patient record, plus any EHR integration)	10 days	10/3/12	10/16/12
0%	Configuration, Testing, and Training Complete	1 day	10/17/12	10/17/12
0%	**Launch**	**1 day**	**10/18/12**	**10/18/12**
0%	Pilot 2 Go-Live	1 day	10/18/12	10/18/12
0%	**Integrate SureScripts**	**144 days**	**4/2/12**	**10/18/12**
0%	Engage SureScripts	60 days	4/2/12	6/22/12
0%	**Define scope of work**	**31 days**	**6/12/12**	**7/24/12**
0%	ID interfaces	30 days	6/12/12	7/23/12
0%	Scope Defined	1 day	7/24/12	7/24/12
0%	**Integration**	**61 days**	**7/25/12**	**10/17/12**
0%	Conduct Integration activities (interface testing,etc)	60 days	7/25/12	10/16/12
0%	Integration Complete	1 day	10/17/12	10/17/12
0%	**Launch**	**1 day**	**10/18/12**	**10/18/12**
0%	SureScripts available to Pilot Participants	1 day	10/18/12	10/18/12
0%	HIE Services - Segment 1 Complete	1 day	10/19/12	10/19/12
0%	**HIE Services - Segment 2 Rollout**	**153 days**	**10/22/12**	**5/22/13**
0%	**NwHIN - SSA**	**153 days**	**10/22/12**	**5/22/13**
0%	Engage participants	60 days	10/22/12	1/11/13
0%	**Define NwHIN - SSA scope of work**	**31 days**	**1/14/13**	**2/25/13**
0%	ID interfaces	30 days	1/14/13	2/22/13
0%	ID EHR integration needs (if any)	30 days	1/14/13	2/22/13
0%	Scope Defined	1 day	2/25/13	2/25/13
0%	**Configure, Test and Train**	**61 days**	**2/26/13**	**5/21/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	2/26/13	5/20/13
0%	Training (longitudinal patient record, plus any EHR integration)	10 days	5/7/13	5/20/13
0%	Configuration, Testing, and Training Complete	1 day	5/21/13	5/21/13
0%	**Launch**	**1 day**	**5/22/13**	**5/22/13**
0%	NwHIN- SSA Go-Live	1 day	5/22/13	5/22/13

0%	**Immunization Registry as part of the Community Health Record**	**153 days**	**10/22/12**	**5/22/13**
0%	Engage participants	60 days	10/22/12	1/11/13
0%	**Define Immunization Registry scope of work**	**31 days**	**1/14/13**	**2/25/13**
0%	ID interfaces	30 days	1/14/13	2/22/13
0%	Scope Defined	1 day	2/25/13	2/25/13
0%	**Configure, Test and Train**	**61 days**	**2/26/13**	**5/21/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	2/26/13	5/20/13
0%	Training (community health record)	10 days	5/7/13	5/20/13
0%	Configuration, Testing, and Training Complete	1 day	5/21/13	5/21/13
0%	**Launch**	**1 day**	**5/22/13**	**5/22/13**
0%	Immunization Registry Go-Live	1 day	5/22/13	5/22/13
0%	**Image Viewing**	**153 days**	**10/22/12**	**5/22/13**
0%	Engage participants	60 days	10/22/12	1/11/13
0%	**Define Image Viewing scope of work**	**31 days**	**1/14/13**	**2/25/13**
0%	ID interfaces	30 days	1/14/13	2/22/13
0%	Scope Defined	1 day	2/25/13	2/25/13
0%	**Configure, Test and Train**	**61 days**	**2/26/13**	**5/21/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	2/26/13	5/20/13
0%	Training (community health record)	10 days	5/7/13	5/20/13
0%	Configuration, Testing, and Training Complete	1 day	5/21/13	5/21/13
0%	**Launch**	**1 day**	**5/22/13**	**5/22/13**
0%	Image Viewing Go-Live	1 day	5/22/13	5/22/13
0%	**Electronic Lab Reporting (ELR)**	**153 days**	**10/22/12**	**5/22/13**
0%	Engage participants	60 days	10/22/12	1/11/13
0%	**Define ELR scope of work**	**31 days**	**1/14/13**	**2/25/13**
0%	ID interfaces	30 days	1/14/13	2/22/13
0%	Scope Defined	1 day	2/25/13	2/25/13
0%	**Configure, Test and Train**	**61 days**	**2/26/13**	**5/21/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	2/26/13	5/20/13
0%	Training (community health record)	10 days	5/7/13	5/20/13
0%	Configuration, Testing, and Training Complete	1 day	5/21/13	5/21/13
0%	**Launch**	**1 day**	**5/22/13**	**5/22/13**
0%	ELR Go-Live	1 day	5/22/13	5/22/13

0%	**Nursing Home Transitions of Care (form)**	**153 days**	**10/22/12**	**5/22/13**
0%	Engage participants	60 days	10/22/12	1/11/13
0%	**Define scope of work**	**31 days**	**1/14/13**	**2/25/13**
0%	ID use cases	30 days	1/14/13	2/22/13
0%	ID interfaces	30 days	1/14/13	2/22/13
0%	Scope Defined	1 day	2/25/13	2/25/13
0%	**Configure, Test and Train**	**61 days**	**2/26/13**	**5/21/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	2/26/13	5/20/13
0%	Training (community health record, transition of care form)	10 days	5/7/13	5/20/13
0%	Configuration, Testing, and Training Complete	1 day	5/21/13	5/21/13
0%	**Launch**	**1 day**	**5/22/13**	**5/22/13**
0%	NH transition of care form Go-Live	1 day	5/22/13	5/22/13
0%	**Expand Segment 1 Services to additional customers and/or use cases**	**153 days**	**10/22/12**	**5/22/13**
0%	Engage participants	60 days	10/22/12	1/11/13
0%	**Define scope of work**	**31 days**	**1/14/13**	**2/25/13**
0%	ID use cases	30 days	1/14/13	2/22/13
0%	ID interfaces	30 days	1/14/13	2/22/13
0%	ID EHR integration needs (if any)	30 days	1/14/13	2/22/13
0%	Scope Defined	1 day	2/25/13	2/25/13
0%	**Configure, Test and Train**	**61 days**	**2/26/13**	**5/21/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	2/26/13	5/20/13
0%	Training (longitudinal patient record, plus any EHR integration)	10 days	5/7/13	5/20/13
0%	Configuration, Testing, and Training Complete	1 day	5/21/13	5/21/13
0%	**Launch**	**1 day**	**5/22/13**	**5/22/13**
0%	Segment 1 Expansion Go-Live	1 day	5/22/13	5/22/13
0%	HIE Services - Segment 2 Complete	1 day	5/23/13	5/23/13
0%	**HIE Services - Segment 3 Rollout**	**153 days?**	**5/24/13**	**12/24/13**
0%	**NwHIN - Connection to other States**	**153 days**	**5/24/13**	**12/24/13**
0%	Engage participants	60 days	5/24/13	8/15/13
0%	**Define NwHIN - Other States scope of work**	**31 days**	**8/16/13**	**9/27/13**
0%	ID interfaces	30 days	8/16/13	9/26/13
0%	Scope Defined	1 day	9/27/13	9/27/13
0%	**Configure, Test and Train**	**61 days**	**9/30/13**	**12/23/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	9/30/13	12/20/13
0%	Training (longitudinal patient record)	10 days	12/9/13	12/20/13
0%	Configuration, Testing, and Training Complete	1 day	12/23/13	12/23/13
0%	**Launch**	**1 day**	**12/24/13**	**12/24/13**
0%	NwHIN- Other States Go-Live	1 day	12/24/13	12/24/13

0%	**Backbone - ESB Service**	**153 days**	**5/24/13**	**12/24/13**
0%	Engage participants	60 days	5/24/13	8/15/13
0%	**Define Image Viewing scope of work**	**31 days**	**8/16/13**	**9/27/13**
0%	ID interfaces	30 days	8/16/13	9/26/13
0%	Scope Defined	1 day	9/27/13	9/27/13
0%	**Configure, Test and Train**	**61 days**	**9/30/13**	**12/23/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	9/30/13	12/20/13
0%	Training (community health record)	10 days	12/9/13	12/20/13
0%	Configuration, Testing, and Training Complete	1 day	12/23/13	12/23/13
0%	**Launch**	**1 day**	**12/24/13**	**12/24/13**
0%	Backbone/ESB Go-Live	1 day	12/24/13	12/24/13
0%	**Quality Organization Connections**	**153 days**	**5/24/13**	**12/24/13**
0%	Engage participants	60 days	5/24/13	8/15/13
0%	**Define scope of work**	**31 days**	**8/16/13**	**9/27/13**
0%	ID interfaces	30 days	8/16/13	9/26/13
0%	Scope Defined	1 day	9/27/13	9/27/13
0%	**Configure, Test and Train**	**61 days**	**9/30/13**	**12/23/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	9/30/13	12/20/13
0%	Training (as appropriate)	10 days	12/9/13	12/20/13
0%	Configuration, Testing, and Training Complete	1 day	12/23/13	12/23/13
0%	**Launch**	**1 day**	**12/24/13**	**12/24/13**
0%	Connection to Quality Orgs Go-Live	1 day	12/24/13	12/24/13
0%	**Nursing Home Transitions of Care via CCD push**	**153 days**	**5/24/13**	**12/24/13**
0%	Engage participants	60 days	5/24/13	8/15/13
0%	**Define scope of work**	**31 days**	**8/16/13**	**9/27/13**
0%	ID use cases	30 days	8/16/13	9/26/13
0%	ID interfaces	30 days	8/16/13	9/26/13
0%	Scope Defined	1 day	9/27/13	9/27/13
0%	**Configure, Test and Train**	**61 days**	**9/30/13**	**12/23/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	9/30/13	12/20/13
0%	Training (community health record, transition of care form)	10 days	12/9/13	12/20/13
0%	Configuration, Testing, and Training Complete	1 day	12/23/13	12/23/13
0%	**Launch**	**1 day**	**12/24/13**	**12/24/13**
0%	NH transition of care CCD push Go-Live	1 day	12/24/13	12/24/13

0%	**EHR Lite for Physicians**	**103 days?**	**5/24/13**	**10/15/13**
0%	Engage participants	60 days	5/24/13	8/15/13
0%	**Define scope of work**	**31 days**	**8/16/13**	**9/27/13**
0%	ID use cases	30 days	8/16/13	9/26/13
0%	ID interfaces	30 days	8/16/13	9/26/13
0%	Scope Defined	1 day	9/27/13	9/27/13
0%	**Configure, Test and Train**	**11 days?**	**9/30/13**	**10/14/13**
0%	Configure physician-specific parameters	1 day?	9/30/13	9/30/13
0%	Training on EHR lite	10 days	9/30/13	10/11/13
0%	Configuration, Testing, and Training Complete	1 day	10/14/13	10/14/13
0%	**Launch**	**1 day**	**10/15/13**	**10/15/13**
0%	EHR Lite for Physicians Go-Live	1 day	10/15/13	10/15/13
0%	**Expand Segment 1 & 2 Services to additional customers and/or use cases**	**153 days**	**5/24/13**	**12/24/13**
0%	Engage participants	60 days	5/24/13	8/15/13
0%	**Define scope of work**	**31 days**	**8/16/13**	**9/27/13**
0%	ID use cases	30 days	8/16/13	9/26/13
0%	ID interfaces	30 days	8/16/13	9/26/13
0%	ID EHR integration needs (if any)	30 days	8/16/13	9/26/13
0%	Scope Defined	1 day	9/27/13	9/27/13
0%	**Configure, Test and Train**	**61 days**	**9/30/13**	**12/23/13**
0%	Conduct Integration activities (interface testing,etc)	60 days	9/30/13	12/20/13
0%	Training (longitudinal patient record, plus any EHR integration)	10 days	12/9/13	12/20/13
0%	Configuration, Testing, and Training Complete	1 day	12/23/13	12/23/13
0%	**Launch**	**1 day**	**12/24/13**	**12/24/13**
0%	Segment 1 & 2 Expansion Go-Live	1 day	12/24/13	12/24/13
0%	HIE Services - Segment 3 Complete	1 day	12/25/13	12/25/13

Appendix 19: Compliance Matrix

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
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		Y
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		Y
5	**General Components**			
6	**Environmental Scan**			
7	Environmental scan of HIE readiness	FOA	Appendix 8: HIE Development: 2010 WIRED for Health Archive	Y
8	Broad adoption of HIT	FOA	4.1 Ambulatory Care Providers and Hospitals	Y
9	HIE adoption across health care providers within the state	FOA	4.1 Ambulatory Care Providers and Hospitals	Y
10	HIE adoption across health care providers potentially external to the state	FOA	4.1 Ambulatory Care Providers and Hospitals	Y
11	Overview of the penetration of electronic lab delivery	ONC-HIE-PIN-001	3.3.2 Laboratories	Y
12	Overview of the penetration of e-prescribing networks	ONC-HIE-PIN-001	3.3.1 Pharmacies	Y
13	Overview of the penetration of other existing HIE solutions	ONC-HIE-PIN-001	Table 3.3.3 HIE Statewide Activities	Y
14	Assessment of current HIE capacities that could be expanded or leveraged	FOA	8.2.7 Integration of Existing HIE Networks, Assets, and Initiatives	Y
15	HIT resources that could be used	FOA	4.3.2 HIT Workforce	Y
16	Relevant collaborative opportunities that already exist	FOA	2.2 HIT Program Coordination	Y
17	Human capital that is available	FOA	4.3.2 HIT Workforce	Y
18	Other information that indicates the readiness of HIE implementation statewide	FOA	4 HIT Adoption	Y
19	Measures to determine health information exchange taking place with data trading partners	ONC-HIE-PIN-001	3.3 ONC PIN Requirements - Wisconsin's White Space	Y
20	% pharmacies accepting electronic prescribing and refill requests	ONC-HIE-PIN-001	3.3 ONC PIN Requirements - Wisconsin's White Space	Y
21	% clinical laboratories sending results electronically	ONC-HIE-PIN-001	3.3 ONC PIN Requirements - Wisconsin's White Space	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
22	% health plans supporting electronic eligibility and claims transactions	ONC-HIE-PIN-001	3.3 ONC PIN Requirements - Wisconsin's White Space	Y
23	% health departments receiving immunizations, syndromic surveillance, and notifiable laboratory results	ONC-HIE-PIN-001	3.3 ONC PIN Requirements - Wisconsin's White Space	Y
24	**HIE Development and Adoption**			
25	Vision, goals, objectives and strategies associated with HIE capacity development and use among all health care providers in the state	FOA	6.1 WISHIN's Mission, Vision, and Goals 6.1.1 WISHIN's Mission 6.1.2 WISHIN's Vision 6.1.3 WISHIN's Goals	Y
26	Meeting HIE meaningful use criteria to be established by the Secretary through the rulemaking process.	FOA	8 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-HIE-PIN-001	8 Technical Infrastructure and Services	Y
28	e-Prescribing	ONC-HIE-PIN-001	9 Technical Infrastructure and Services	Y
29	Receipt of structured lab results	ONC-HIE-PIN-001	10 Technical Infrastructure and Services	Y
30	Sharing patient care summaries across unaffiliated organizations	ONC-HIE-PIN-001	11 Technical Infrastructure and Services	Y
31	Should describe a strategy and plan to address the other required information sharing capabilities, including:	ONC-HIE-PIN-001	12 Technical Infrastructure and Services	Y
32	Building capacity of public health systems to accept electronic reporting of immunizations, notifiable diseases, and syndromic surveillance reporting from providers	ONC-HIE-PIN-001	13 Technical Infrastructure and Services	Y
33	Enabling electronic meaningful use and clinical quality reporting to Medicaid and Medicare	ONC-HIE-PIN-001	14 Technical Infrastructure and Services	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	8.2.7 Integration of Existing HIE Networks, Assets, and Initiatives	Y
35	HIE between health care providers, public health, and those offering services for patient engagement and data access	FOA	4.2 Local Public Health and Tribal Health Department Providers	Y
36	Changes in HIE Strategy	ONC-HIE-PIN-002	Foreword	Y
37	**HIT Adoption**		**4 HIT Adoption**	
38	Other HITECH ACT programs or state funded initiatives to advance HIT adoption in a state	FOA	4 HIT Adoption	Y
39	While many states have already addressed HIT adoption in their existing Health IT State Plans, it is not a requirement	FOA	5 HIT Adoption	Y
40	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	FOA	6 HIT Adoption	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
	state			
41	**Medicaid Coordination**			
42	Describe the interdependencies and integration of efforts between the state's Medicaid HIT Plan and the statewide HIE development efforts	FOA	2.2.2 Coordination with Medicaid 2.2.2.1 Medicaid Participation in the WIRED for Health Project 2.2.2.2 Project Management Coordination	Y
43	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
44	Describe coordination with Medicaid, including the following required activities:	ONC-HIE-PIN-001		Y
45	Governance structure shall provide representation of the SMP	ONC-HIE-PIN-001	6.2 WISHIN Board of Directors	Y
46	Coordinate provider outreach and communications with the SMP	ONC-HIE-PIN-001	4.3.1 Wisconsin HIT Extension Center (WHITEC) 5.1.1 Marketing and Outreach for WISHIN Direct 9.7 Communications, Education, and Marketing Strategy	Y
47	Identify common business or health care outcome priorities	ONC-HIE-PIN-001	2.2.2.1 Medicaid Participation in the WIRED for Health Project	Y
48	Leverage, participate in, and support all Beacon Communities, RECs, and ONC funded workforce projects, in collaboration with the SMP	ONC-HIE-PIN-001	3.1 Ambulatory Care Providers and Hospitals	Y
49	Align efforts with the state Medicaid agency to meet Medicaid requirements for meaningful use	ONC-HIE-PIN-001	2.2.2.1 Medicaid Participation in the WIRED for Health Project	Y
50	Describe coordination with Medicaid, including the following **encouraged activities:**	ONC-HIE-PIN-001		Y
51	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-HIE-PIN-001	Appendix 3: Letters of Support	Y
52	Conduct joint needs assessments.	ONC-HIE-PIN-001	2.2.2 Coordination with Medicaid	Y
53	Conduct joint environmental scans.	ONC-HIE-PIN-001	2.2.2 Coordination with Medicaid	Y
54	Leverage existing Medicaid IT infrastructure when developing the health information exchange technical architecture.	ONC-HIE-PIN-001	2.2 HIT Program Coordination 2.2.2 Coordination with Medicaid	Y
55	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-HIE-PIN-001	2.2.2 Coordination with Medicaid	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
56	Determine which specific shared services and technical services will be offered or used by Medicaid.	ONC-HIE-PIN-001	2.2.2 Coordination with Medicaid	Y
57	Determine which operational responsibilities the Medicaid program will have, if any.	ONC-HIE-PIN-001	2.2.2 Coordination with Medicaid	Y
58	Use Medicaid HIT incentives to encourage provider participation in the health information exchange.	ONC-HIE-PIN-001	4.3.3 Medicaid EHR Incentive Programs 4.3.4 EHR Tax Credit	Y
59	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-HIE-PIN-001	3.1 Implementing Direct to Support Stage 1 Meaningful Use 4.3.3 Medicaid EHR Incentive Programs 4.3.4 EHR Tax Credit	Y
60	**Coordination of Medicare and Federally Funded, State Based Programs**			
61	Describe the coordination activities with Medicare and relevant federally-funded, state programs (see program guidance)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
62	Coordination with Epidemiology and Laboratory Capacity Cooperative Agreement Program (CDC)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
63	Coordination with Assistance for Integrating the Long-Term Care Population into State Grants to Promote Health IT	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
64	Coordination with Implementation (CMS/ASPE)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
65	Coordination with HIV Care Grant Program Part B States/Territories Formula and Supplemental Awards/AIDS Drug Assistance Program Formula and Supplemental Awards (HRSA)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
66	Coordination with Maternal and Child Health State Systems Development Initiative programs (HRSA)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
67	Coordination with State Offices of Rural Health Policy (HRSA)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
68	Coordination with State Offices of Primary Care (HRSA)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
69	Coordination with State Mental Health Data Infrastructure Grants for Quality Improvement (SAMHSA)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
70	Coordination with State Medicaid/CHIP Programs	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
71	Coordination with IHS and tribal activity	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
72	Coordination with Emergency Medical Services for Children Program (HRSA)	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
73	**Participation with federal care delivery organizations (encouraged but not required)**			

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
74	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	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
75	Participation of VA	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
76	Participation of DoD	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
77	Participation of IHS	FOA	2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
78	**Coordination with other ARRA programs**			
79	Coordination mechanisms with other relevant ARRA programs	FOA	2.2 HIT Program Coordination 2.2.2 Coordination with Medicaid 2.2.3 Coordination with Medicare and Federally Funded, State-Based Programs	Y
80	Coordination with Regional Centers	FOA	4.3.1 Wisconsin HIT Extension Center (WHITEC)	Y
81	Coordination with workforce development initiatives	FOA	4.3.2 HIT Workforce	Y
82	Coordination with broadband mapping and access	FOA	8.2.8 Broadband Mapping and Access Initiative	Y
83	Describe specific points of coordination and interdependencies with other relevant ARRA programs	FOA	2.2 HIT Program Coordination 4.3 Resources for HIT Adoption	Y
84	Regional Centers	FOA	4.3.1 Wisconsin HIT Extension Center (WHITEC)	Y
85	Workforce development initiatives	FOA	4.3.2 HIT Workforce	Y
86	Broadband mapping and access	FOA	8.2.8 Broadband Mapping and Access Initiative	Y
87	**Coordinate with Other States**		**2.2.5 Coordination with Other States**	
88	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	2.2.5 Coordination with Other States	Y
89	**Domain Requirements**			
90	**Governance**			
91	**Collaborative Governance Model**	FOA	6 Governance	Y
92	Describe the multi-disciplinary, multi-stakeholder governance entity	FOA	6 Governance	Y
93	Description of the membership	FOA	6.2 WISHIN Board of Directors	Y
94	Description of decision-making authority	FOA	6 Governance	Y
95	Description of governance model	FOA	6 Governance	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
96	States are encouraged to consider how their state governance models will align with emerging nationwide HIE governance	FOA	6.5 Alignment with Nationwide HIE Governance	Y
97	**State Government HIT Coordinator**	FOA	2.2.1 Role of the State HIT Coordinator	Y
98	Strategic Plan shall identify the state Government HIT Coordinator	FOA	2.2.1 Role of the State HIT Coordinator	Y
99	Describe how the state coordinator will interact with the federally funded state health programs	FOA	2.2.1 Role of the State HIT Coordinator	Y
100	Describe how the state coordinator will interact with the HIE activities within the state	FOA	2.2.1 Role of the State HIT Coordinator	Y
101	**Accountability and Transparency**	FOA	6.5 Oversight, Accountability, and Transparency	Y
102	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	6.5 Oversight, Accountability, and Transparency	Y
103	Governance entity is holding regularly scheduled public meetings with active participation of key stakeholders	Toolkit Checklist	6.5 Oversight, Accountability, and Transparency	Y
104	Track progress of meaningful use by documenting how the HIE efforts within the state are enabling meaningful use	Toolkit Checklist	6.5 Oversight, Accountability, and Transparency	Y
105	**Governance and Policy Structures**	FOA	6 Governance	Y
106	Describe the ongoing development of the governance and policy structures	FOA	6 Governance 10.5 Mechanisms to Refresh Legal and Policy Framework	Y
107	Policy structures (bylaws and charter or organizational equivalents) established and endorsed by stakeholders	Toolkit Checklist	Appendix 3: Letters of Support	Y
108	**Medicaid Specific Tasks**	FOA		
109	What governance structure should be in place by 2014 in order to achieve your goals and objectives	FOA	6.3 Role of State Government	Y
110	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
111	**Finance**			
112	**Sustainability**	FOA	7 Sustainability Plan	Y
113	Ensure the financial sustainability of the project beyond the ARRA funding	FOA	7 Sustainability Plan	Y
114	Business plan that enables for the financial sustainability, by the end of the project period of HIE governance and operations	FOA	7 Sustainability Plan	Y
115	Shall describe initial thoughts for sustaining HIE activities during and after the cooperative agreement period	ONC-HIE-PIN-001	7 Sustainability Plan	Y
116	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-HIE-PIN-001	7 Sustainability Plan	NA
117	SDE as a Facilitator of Services:			

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
118	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-HIE-PIN-001	7 Sustainability Plan	Y
119	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-HIE-PIN-001	NA	NA
120	SDE Directly Offering Services:			
121	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-HIE-PIN-001	7 Sustainability Plan	Y
122	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-HIE-PIN-001	7 Sustainability Plan	Y
123	Sustainability Plan	ONC-HIE-PIN-002	7 Sustainability Plan	Y
124	**Cost Estimates and Staffing Plans**	Toolkit Checklist	7.3.3 Staffing 9.2 Staffing Plan	Y
125	Provide a detailed cost estimate for the implementation of the Strategic Plan for the time period covered by the Operational Plan	FOA	7 Sustainability Plan	Y
126	Include a detailed schedule describing the tasks and sub-tasks that need to be completed in order to enable statewide HIE	FOA	8.1 HIE Services 9 Implementation and Operations	Y
127	Include with resources	FOA	9 Implementation and Operations	Y
128	Include with dependencies	FOA	9 Implementation and Operations	Y
129	Include with specific timeframes	FOA	9 Implementation and Operations	Y
130	Recipients shall provide staffing plans including project managers and other key roles required to ensure the project's success	FOA	9.2 Staffing Plan	Y
131	**Controls and Reporting**	FOA	**6.7 Transition to SDE and Controls and Reporting**	Y
132	Describe activities to implement financial policies, procedures and controls to maintain compliance with generally accepted accounting principles (GAAP) and all relevant OMB circulars	FOA	6.4.2 ARRA Reporting and Evaluation Requirements 9.1.1 Process 9.1.2 Audit	Y
133	The organization will serve as a single point of contact to submit progress and spending reports periodically to ONC	FOA	9.1.1 Process	Y
134	**Technical Infrastructure**			
135	**Interoperability**	FOA	8.2.4 Standards, Interoperability, and Certifications	Y
136	Indicate whether the HIE services will include participation in the NHIN	FOA	8.2.1 Architecture Overview 8.2.5 Alignment with NwHIN	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
137	Appropriate HHS adopted standards and certifications for health information exchange	FOA	8.2.4 Standards, Interoperability, and Certifications	Y
138	Especially planning and accounting for meaningful use criteria to be established by the Secretary through the rulemaking process	FOA	8.2.4 Standards, Interoperability, and Certifications	Y
139	**Technical Architecture/Approach (encouraged but not required)**	FOA	8.2 Reference Architecture	Y
140	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	8.2.1 Architecture Overview	Y
141	Describe the approach to be used: Including the HIE services to be offered as appropriate for the state's HIE capacity development	FOA	8.2.1 Architecture Overview	Y
142	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	8.2.1 Architecture Overview	Y
143	Availability among healthcare providers	FOA	8.2.1 Architecture Overview	Y
144	Availability among public health	FOA	8.2.1 Architecture Overview	Y
145	Availability among those offering service for patient engagement and data access	FOA	8.2.1 Architecture Overview	Y
146	Describe the technical approach taken to facilitate data exchange services within the state based on the model being pursued:	ONC-HIE-PIN-001	8.2.2 Architecture Model and Data Flows	Y
147	States and SDEs Facilitating Services:	ONC-HIE-PIN-001	8.1 HIE Services	Y
148	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-HIE-PIN-001	8.1 HIE Services	Y
149	States and SDEs Directly Offering Services:	ONC-HIE-PIN-001	8.1 HIE Services	Y
150	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-HIE-PIN-001	8.1 HIE Services	Y
151	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-HIE-PIN-001	8.1 HIE Services	Y
152	Include plans for the protection of health data	FOA	8.2.3 Authentication and Security 8.2.4 Standards, Interoperability, and Certifications	Y
153	Reflect the business and clinical requirements determined via the multi-stakeholder planning process	FOA	8.2.1 Architecture Overview	Y
154	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	8.2.4 Standards, Interoperability, and Certifications	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
155	Exchange with VA	FOA	8.2.4 Standarsd, Interoperability, and Certifications	Y
156	Exchange with DoD	FOA	8.2.4 Standarsd, Interoperability, and Certifications	Y
157	Exchange with IHS	FOA	8.2.4 Standarsd, Interoperability, and Certifications	Y
158	HIE Architectural Model	ONC-HIE-PIN-003	Foreword 8.2.2 Architectural Model and Data Flows	Y
159	**Standards and Certification**	FOA	8.2.4 Standards, Interoperability, and Certifications	Y
160	Describe efforts to become consistent with HHS adopted interoperability standards and any certification requirements, for projects that are just starting	FOA	8.2.4 Standards, Interoperabilty, and Certifications	Y
161	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-HIE-PIN-001	8.2.4 Standards, Interoperabilty, and Certifications	Y
162	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-HIE-PIN-001	8.2.4 Standards, Interoperabilty, and Certifications	Y
163	**Technology Deployment**	FOA	8.1.1 Roadmap for Implementation	Y
164	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	3.1 Implementing Direct to Support Stage 1 Meaningful Use	Y
165	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-HIE-PIN-001	3.1 Implementing Direct to Support Stage 1 Meaningful Use	Y
166	Outline a clear and viable strategy to ensure that all eligible providers in the state have at least one viable option in 2011;	ONC-HIE-PIN-001	3.1 Implementing Direct to Support Stage 1 Meaningful Use	Y
167	Include a project timeline that clearly illustrates when tasks and milestones will be completed;	ONC-HIE-PIN-001	11 Implementation Plan 11. 1 Project Work Plan Appendix 18: Implementation Plan	Y
168	Provide an estimate of all the funding required, including all federal funding and state funding, used to enable stage one meaningful use requirements;	ONC-HIE-PIN-001	7 Sustainability Plan	Y
169	Indicate the role both in funding and coordination of the state Medicaid agency in achieving the state strategy;	ONC-HIE-PIN-001	2.2.2 Coordination with Medicaid	Y
170	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	8.2.4 Standards, Interoperability, and Certifications 8.2.5 Alignment with NHIN	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
171	**Medicaid Specific Tasks - Standards and Architecture**	FOA	2.2.2 Coordination with Medicaid	Y
172	How the Medicaid Agency will support integration of clinical and administrative data	FOA	2.2.2 Coordination with Medicaid	Y
173	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	2.2.2 Coordination with Medicaid	Y
174	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	2.2.2 Coordination with Medicaid	Y
175	Provide a description of data-sharing components of HIT solutions	FOA	2.2.2 Coordination with Medicaid	Y
176	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	2.2.2 Coordination with Medicaid	Y
177	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	2.2.2 Coordination with Medicaid	Y
178	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	2.2.2 Coordination with Medicaid	Y
179	**Business and Technical Operations**			
180	**Implementation**	FOA	9 Implementation and Operations	Y
181	Address how the state plans will develop HIE capacity	FOA	9.3 Technical Assistance	Y
182	Project management protocols implemented and operational	Toolkit Checklist	9.4 Project Management	Y
183	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-HIE-PIN-001	9.4 Project Management	Y
184	Should also describe the change management and issue escalation processes that will be used to keep projects on schedule and within budget	ONC-HIE-PIN-001	9.4 Project Management	Y
185	Monitoring Capacity – Monitor and plan for remediation of the actual performance of HIE throughout the state.	Toolkit Checklist	9.6 Monitoring Performance 12 WISHIN Evaluation Plan	Y
186	State or State Designated Entity is monitoring and reporting on all required program evaluation metrics	Toolkit Checklist	9.6 Monitoring Performance 12 WISHIN Evaluation Plan	Y
187	Include a strategy that specifies how the state intends to meet meaningful use HIE requirements established by the Secretary	FOA	3.1 Implementing Direct to Support Stage 1 Meaningful Use	Y
188	Leverage existing state and regional HIE capacity	FOA	8.2.7 Integration of Existing HIE Networks, Assets, and Initiatives	Y
189	Leverage statewide shared services and directories	FOA	8.2.6 State-Level Shared Services and Directories	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
190	Describe the incremental approach for HIE services to reach all geographies and providers across the state	FOA	8.3 Technology Deployment	Y
191	Monitor and maintain a targeted degree of participation in HIE-enabled state-level technical services.	FOA	9.6 Monitoring Performance	Y
192	XX% of healthcare providers in the state are able to send electronic health information using components of the statewide HIE Technical infrastructure	Toolkit Checklist	9.6 Monitoring Performance	Y
193	XX% of healthcare providers in the state are able to receive electronic health information using components of the statewide HIE Technical infrastructure	Toolkit Checklist	9.6 Monitoring Performance	Y
194	XX% of pharmacies serving people within the state are actively supporting electronic prescribing and refill requests	Toolkit Checklist	9.6 Monitoring Performance	Y
195	XX% of clinical laboratories serving people within the state that are actively supporting electronic ordering and results reporting	Toolkit Checklist	9.6 Monitoring Performance	Y
196	Trust agreements covering XX% of the state's providers have been signed	Toolkit Checklist	9.6 Monitoring Performance	Y
197	Semi-annual progress reports submitted	Toolkit Checklist	9.6 Monitoring Performance	Y
198	Program performance measurement results submitted	Toolkit Checklist	9.6 Monitoring Performance	Y
199	Statutory requirements for HIE as defined in the HITECH Act achieved	Toolkit Checklist	9.6 Monitoring Performance	Y
200	Identify if and when the state HIE infrastructure will participate in the NHIN.	FOA	8.2.5 Alignment with NwHIN	Y
201	**Current HIE Capacities**	FOA	Appendix 8: HIE Development: 2010 WIRED for Health Archive	Y
202	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	Appendix 8: HIE Development: 2010 WIRED for Health Archive	Y
203	Leverage public help desk/call center contracts and services between the State HIE Program, Medicaid and the REC.	ONC-HIE-PIN-001	NA	NA
204	**State-Level Shared Services and Repositories**	FOA	8.2.6 State-Level Shared Services and Directories	Y
205	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	8.2.6 State-Level Shared Services and Directories	Y
206	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	8.2.6 State-Level Shared Services and Directories	Y
207	Consider Security Service	FOA	8.2.6 State-Level Shared Services and Directories	Y
208	Consider Patient Locator Service	FOA	8.2.6 State-Level Shared Services and Directories	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
209	Consider Data/Document Locator Service	FOA	8.2.6 State-Level Shared Services and Directories	Y
210	Consider Terminology Service	FOA	8.2.6 State-Level Shared Services and Directories	Y
211	**Standard operating procedures for HIE (encouraged but not required)**	FOA	9.1 Standard Operating Procedures and Participation Process	Y
212	Explanation of how standard operating procedures and processes for HIE services will be developed and implemented	FOA	9.1.1 Process	Y
213	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-HIE-PIN-001	4.3.1 Wisconsin HIT Extension Center (WHITEC)	Y
214	**Medicaid Specific Tasks - CEM**	FOA	8.7 Communications, Education, and Marketing Strategy Appendix 17 - Communications, Education, and Marketing Plan	
215	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
216	How will we support providers in achieving Meaningful Use	FOA	9.7 Communications, Education, and Marketing Strategy Appendix 7: Communications, Education, and Marketing Plan	Y
217	**Legal and Policy**			
218	**Privacy and Security**	FOA	10.2 Legal and Policy Framework	Y
219	Shall develop and fully describe their privacy and security framework including the specific policies, accountability strategies, architectures and technology choices to protect information.	ONC-HIE-PIN-001	10.2 Legal and Policy Framework	Y
220	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-HIE-PIN-001	Appendix 10: Liability Issues Workgroup Deliverable Appendix 12: Key Analyses of Barriers, Resources and Opportunities for Overcoming Low Participation in Information Exchange 9.1.2 Key Differences between Wisconsin and Federal Law Appendix 13: Key Differences Between State and Federal Privacy Law Regarding Disclosures for Purposes of Treatment, Payment, and Health Care Operations	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
221	Address privacy and security issues related to health information exchange within the state	FOA	10.1 Privacy and Security Strategy 10.1.1 Analysis of Privacy and Security Issues Related to HIE	Y
222	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
223	Conduct joint assessment and alignment of privacy policies at the statewide level and in the Medicaid program.	ONC-HIE-PIN-001	9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.2.2 Security and Privacy Mechanisms	Y
224	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	Appendix 10: Liability Issues Workgroup Deliverable Appendix 12: Key Analyses of Barriers, Resources and Opportunities for Overcoming Low Participation in Information Exchange 9.1.2 Key Differences between Wisconsin and Federal Law Appendix 13: Key Differences Between State and Federal Privacy Law Regarding Disclosures for Purposes of Treatment, Payment, and Health Care Operations	Y
225	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-HIE-PIN-001	6.4 Oversight, Accountability, and Transparency 8.2.3 Authentication and Security 9.1.1 Analysis of Privacy and Security Issues Related to HIE 9.2.2 Security and Privacy Mechanisms	Y
226	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-HIE-PIN-001	10.2.1 Developing the Legal and Policy Framework	Y
227	Guiding Statewide Privacy and Security Frameworks	ONC-HIE-PIN-003	10.2.1 Developing the Legal and Policy Framework	Y
228	**State Laws**	FOA	10.3.2 Interstate Exchange Appendix 9: Interstate Exchange Workgroup Deliverable	Y
229	Address any plans to analyze and/or modify state laws, as well as communications and negotiations with other states to enable exchange	FOA	10.3.2 Interstate Exchange Appendix 9: Interstate Exchange Workgroup Deliverable	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
230	**Policies and Procedures**	FOA	9.1 Standard Operating Procedures and Participation Process	Y
231	Address the development of policies and procedures necessary to enable and foster information exchange within the state and interstate	FOA	10.2.1 Developing the Legal and Policy Framework	Y
232	**Trust Agreements**	FOA	6.4 Oversight, Accountability, and Transparency	Y
233	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	Appendix 16: Legal and Policy Issues List for Data Agreements	Y
234	Examine data sharing agreements	FOA	Appendix 16: Legal and Policy Issues List for Data Agreements	Y
235	Examine data use agreements	FOA	Appendix 16: Legal and Policy Issues List for Data Agreements	Y
236	Examine reciprocal support agreements	FOA	Appendix 16: Legal and Policy Issues List for Data Agreements	Y
237	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	10.3.2 Interstate Exchange	Y
238	Trust agreements covering XX% of the state's providers have been signed	Toolkit Checklist	10.3.2 Interstate Exchange	Y
239	**Oversight of Information Exchange and Enforcement**	FOA	6.5 Oversight, Accountability, and Transparency	Y
240	Address how the state will address issues of noncompliance with federal and state laws and policies applicable to HIE	FOA	6.5 Oversight, Accountability, and Transparency	Y
241	**Establish Requirements**	FOA	6.5 Oversight, Accountability, and Transparency	Y
242	Describe how statewide health information exchange will comply with all applicable federal and state legal and policy requirements	FOA	6.5 Oversight, Accountability, and Transparency	Y
243	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	6.5 Oversight, Accountability, and Transparency	Y
244	Should specify the interdependence with the governance and oversight mechanisms to ensure compliance with these policies	FOA	6.5 Oversight, Accountability, and Transparency	Y
245	Should describe the methods used to ensure privacy and security programs are accomplished in a transparent fashion	ONC-HIE-PIN-001	6.5 Oversight, Accountability, and Transparency	Y
246	**Privacy and Security Harmonization**	FOA	10.1.1 Analysis of Privacy and Security Issues Related to HIE	Y
247	Describe plans for privacy and security harmonization and compliance statewide and also coordination activities to establish consistency on an interstate basis	FOA	10 Legal and Policy	Y
248	Privacy and Security Framework	ONC-HIE-PIN-	Foreword	Y

ID	ONC Requirement	Source	Strategic & Operational Plan Reference	Addressed? (Y, N, NA)
		002		
249	**Federal Requirements**	FOA	8.2.3 Authentication and Security	Y
250	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	8.2.3 Authentication and Security	Y
251	**Medicaid Specific Tasks**	FOA	10.1 Privacy and Security Strategy	
252	How the Medicaid Agency will promote secure data exchange, where permissible under the Health Insurance Portability and Accountability Act (HIPAA)	FOA	10.1 Privacy and Security Strategy	Y
253	What interoperability arrangements and other agreements should be in place	FOA	Appendix 16: Legal and Policy Issues List for Data Agreements	Y
254	**Other**			
255	**Project Schedule (Implementation Work Plan)**			
256	Include a project schedule describing the tasks and sub-tasks that need to be completed in order to enable the statewide HIE	FOA	11 Implementation Plan Appendix 18: Implementation Plan	Y
257	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-HIE-PIN-001	Appendix 18: Implementation Plan	Y
258	Project Management Plan	ONC-HIE-PIN-002	11 Implementation Plan Appendix 18: Implementation Plan	Y
259	**Implementation Description**			
260	Identify issues, risks, and interdependencies within the overall project	FOA	9 Implementation and Operations	Y
261	The implementation description shall specify proposed resolution and mitigation methods for identified issues and risks within the overall project	FOA	9 Implementation and Operations	Y
262	Shall identify known and potential risks and describe their risk mitigation strategies	ONC-HIE-PIN-001	9 Implementation and Operations	Y
263	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-HIE-PIN-001	9 Implementation and Operations	Y
264	Program Evaluation	ONC-HIE-PIN-002	12 WISHIN Evaluation Plan	Y
265	Tracking Program Progress	ONC-HIE-PIN-002	Foreword	Y

Appendix 20: Glossary of Health-IT Related Terms

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 Service Provider (HISP): Health information service provider organizations (HISPs) provide the framework for secure exchange of clinical messages over the internet between disparate electronic health record systems. The HISP enables users to easily send information through Direct protocols, while structuring an interface to verify Direct addresses of users and organizations. Additionally, the HISP ensures that clinical messages are sent and received in an accurate and usable manner at both ends of the exchange.

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 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 21: Tracking Program Progress Measure Definitions

Program Information Notice, ONC-HIE-PIN-002, issued on February 8, 2012, and contains measure definitions to complete the Tracking Program Progress section. These measure definitions will be used to complete annual SOP updates.

PIN Priority	Numerator	Denominator	Source
1. % of pharmacies participating in e-prescribing	Number of pharmacies that sent or received any electronic new prescription, refill request, or refill response messages in December of the former year via Surescripts network	Total number of licensed pharmacies operating in the state (per NCPDP)	Surescripts/NCPDP data ***ONC will provide data to Grantees***
2. % of labs sending electronic lab results to providers in a structured format	Number of hospital and independent clinical laboratories that send electronic lab results to ambulatory care providers in a structured format	Total number of hospital and independent clinical laboratories that respond to census	*Numerator: data collected through Grantee's lab census (a sample instrument will be provided following the release of this PIN)* *Denominator: Census should target all labs in "hospital" and "independent" lab categories, including LabCorp and Quest, in CLIA OSCAR database (http://wwwn.cdc.gov/clia/oscar.aspx)* ***Grantee assesses. ONC will provide a sample instrument.***

PIN Priority	Numerator	Denominator	Source
3. % of labs sending electronic lab results to providers using LOINC	Number of hospital and independent clinical laboratories that send electronic lab results to ambulatory care providers using LOINC	Total number of hospital and independent clinical laboratories that respond to survey	*Numerator: data collected through Grantee's lab census* *Denominator: Census should target all labs in "hospital" and "independent" lab categories, including LabCorp and Quest, in CLIA OSCAR database (http://wwwn.cdc.gov/clia/oscar.aspx)* ***Grantee assesses. ONC will provide a sample instrument.***
4. % of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	Number of non-federal acute care hospitals sharing electronic clinical care summaries with the following entities as reported in the AHA HIT Supplement survey: a. Hospitals outside their system b. Ambulatory care providers outside their system	Total number of non-federal acute care hospitals responding to AHA HIT supplement survey	AHA HIT supplement survey ***ONC will provide data to Grantees annually. Grantees may expect an annual release in December or January.***

PIN Priority	Numerator	Denominator	Source
5. % of ambulatory providers electronically sharing care summaries with other providers	Number of ambulatory care, office-based physicians who share electronic clinical summaries or summary of care records with other providers	Total number of ambulatory care, office-based physicians who responded to the survey	National Ambulatory Medical Care Survey (NAMCS) Electronic Medical Records (EMR) Supplemental (also known as National Electronic Health Records Survey) ***ONC will provide data to Grantees annually. Grantees may expect an annual release in December or January.***
6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC and SNOMED. Yes/no or %	1 = Yes 0 = No (or %)		Grantee assesses
7. Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code. Yes/no or %	1 = Yes 0 = No (or %)		Grantee assesses

PIN Priority	Numerator	Denominator	Source
8. Public Health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formation (using CDC reference guide). Yes/no or %	1 = Yes 0 = No (or %)		Grantee assesses
9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1. Yes/no or %	1 = Yes 0 = No (or %)		