APPENDIX A
STATE-LEVEL ACTIVITY CURRENTLY BEING PLANNED OR CONDUCTED AS A RESULT OF WORK ON THE PRIVACY AND SECURITY PROJECT

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security Project

State	Activity Reported by State Teams in Final Reports[a]
Alaska	As a result of the national Health Information Security and Privacy Collaboration (HISPC) conference, the Implementation Planning Work Group (IPWG) explored the current and proposed health information exchange (HIE) and electronic health record (EHR) projects pursued in other states to determine if their best practices could be applied in Alaska and incorporated into the Alaska implementation plans. Alaska plans on contacting Washington and Oregon and may contact other states often visited by Alaskans for health care purposes, including California and Minnesota. Given the high number of tourists that visit Alaska each year, it may also be beneficial to contact the cruise lines to determine their available health care systems.
Arkansas	The Arkansas HISPC is performing a thorough review of existing state laws in order to make all state mandates consistent with the Health Insurance Portability and Accountability Act (HIPAA). This work affects plans to amend statutes written in the permissive to mandate disclosure of protected health information (PHI) when doing so has been determined to be in the public interest; to edit state policies to mandate PHI disclosures when necessary; and to draft legislation to permit disclosure of PHI and to provide liability protection for the state, as well as for state personnel (beyond the protection afforded by sovereign immunity concepts), in its efforts to comply with HIPAA.
Arizona	Progress is being made toward the development of a state-level Master Provider Index. A 1-day education event was held on March 20, 2007, as a first step toward educating stakeholders and consumers about advances being made in the state in the health information technology (HIT) and health information exchange area. Approximately 400 people were in attendance. The decision has already been made to have a Consumer Task Force, a Technical Task Force, and a Legal Task Force. It is expected that the implementation plans from the Arizona HISPC project will drive some of the project work that each of these task forces will be doing.
California	California anticipates sharing information with Washington and Oregon as they proceed to establish the health information exchange organizational structure and begin the analysis and setting of privacy and security standards. In addition, California is actively participating in the State Alliance for E-Health Task Force on Health Information Protection. In this role, California will be sharing its HISPC findings with other states throughout the nation.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
	The state project team has closely coordinated its implementation activities with activities of the New York state team and has been in contact with and shared results with various other states teams, including those for the following states: ▪ Alaska ▪ Arizona ▪ Colorado ▪ Connecticut ▪ Florida ▪ Massachusetts ▪ Minnesota ▪ Mississippi ▪ New Hampshire ▪ New Jersey ▪ New York ▪ Ohio ▪ Oklahoma ▪ Utah ▪ Wisconsin ▪ Wyoming
Colorado	Colorado is pursuing a multifaceted initiative to implement a statewide federated interoperable HIE. This initiative has been named CORHIO. Efforts to establish CORHIO have progressed over the past 18 months with assistance from the HISPC project. The prototype for the CORHIO and Colorado's HIE network is a point-of-care clinical data exchange being developed by a Colorado consortium known as the Colorado Health Information Exchange project (COHIE), under a State and Regional Demonstration contract from the Agency for Healthcare Research and Quality (AHRQ).
Connecticut	Connecticut is reviewing HISPC reports from other states, which have shared their work with Connecticut, to determine best practices that can also be incorporated into Connecticut's implementation plan. eHealth Connecticut will seek an executive order from the Connecticut governor, the Honorable Jody Rell, to designate eHealth Connecticut as Connecticut's sole regional health information organization (RHIO). The Public Health Foundation of Connecticut, Inc., is prepared to continue its role to coordinate public- and private-sector collaboration efforts as part of the implementation plan. This will include efforts to facilitate state agency initiatives and partner with eHealth Connecticut. Early discussions are under way with Rhode Island and Massachusetts RHIO initiatives. Specific implementation planning for cross-state initiatives will require a joint planning initiative among the states considering information exchanges.
Florida	Florida is introducing and adopting legislation to create the Florida Health Information Network. In relation to health information sharing and exchange, Florida is developing definitions consistent with those that presently exist in statute for a paper and electronic environment. Florida invited participation of the National Conference of Commissioners on Uniform State Laws to serve as a resource for the national implementation of privacy and security solutions, including the development of a model state law for EHRs.

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Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
Iowa	A main success of the Iowa project has been bringing stakeholders and projects together that share a common goal of advancing HIT and electronic health information exchange efforts in the state. This project has helped foster greater awareness not only of HISPC goals but also of other Iowa HIT and electronic health information exchange initiatives, as well. Interaction with RTI International, the National Governors Association (NGA), the Office of the National Coordinator for Health Information Technology, and other HISPC states provided the state team with a much deeper understanding of goals and initiatives related to HIT and electronic health information exchange. Continued support from these organizations and sharing with other HISPC state contacts will add much value to the implementation efforts. Iowa is developing an audiovisual presentation of the findings from consumer focus groups to use in various settings; it will include a 10- to 20-minute DVD and associated PowerPoint presentation. Iowa plans to participate in a strategy session with the Iowa Governor's Office to determine its plans for ongoing involvement with HISPC implementation efforts. Iowa will formally assign an Iowa HISPC implementation oversight group. Iowa will pursue implementation funding. Iowa will continue to monitor key privacy and security national and state initiatives.
Illinois	The committee has adopted the goal of creating a supportive environment in Illinois for sharing electronic health information to ensure that every resident's complete and accurate medical history, including test results and medication information, is available to provide optimal care by the treating physician, improve the health care system, and improve the health of the population. Illinois will promote adoption of standards for personal health information. Illinois will monitor initiatives that are under consideration and could universally affect personal health information.
Indiana	Indiana is pursuing discussions with Centers for Medicare & Medicaid Services (CMS) about access to the claims data for standard health information exchange purposes (eg, to combine with other data sources for use at point of care for treatment of the patient). Because this type of use of claims data has not been contemplated in the past, progress has been slow to obtain such permission directly from CMS. Indiana has undertaken other activities, but they extend beyond the domain of privacy and security issues.

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Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
Kansas	On February 7, 2007, Governor Sebelius appointed a Health Information Exchange Commission. This group is designed to bring providers and stakeholders together to advance the use of information technology in health care. Two members of the HISPC steering committee have been named as chairs of this commission, and 2 other members have been appointed as members of the commission. This commission will continue the work of HISPC and other HIT and health information exchange state efforts. Participants in the HISPC project have presented at various professional meetings and academic programs and have solicited input regarding the solutions and implementation plan from participants. Kansas is pursuing a variety of funding opportunities to supplement funds allocated by the State of Kansas budget. Kansas will identify return on Investment (ROI) for HIT models for a variety of stakeholders' security. Kansas will identify comparable HIT efforts in Missouri and engage key Missouri stakeholders. Demonstration projects that cross state lines are in place and will be monitored to determine outcomes and, in particular, ROI. These projects include Healthe Mid America, KC CareLink, InfoLinks and Blue Cross Blue Shield (BC/BS) Immunization registry. Kansas will follow up with the State of Nebraska, contacted at the Regional and National HISPC meetings, to develop a strategic plan for coordinating health information exchange efforts. Kansas has established the Kansas and Missouri Immunizations Registry project, which builds on each state's registries.
Kentucky	January 18, 2007, during its regular meeting, the Kentucky e-Health Network Board approved a proposal to seat a permanent Privacy and Security Committee. A slate of candidates was appointed at the April 2007 e-Health Board meeting. Many volunteers who served on the steering committee and other work groups have agreed to serve on the Privacy and Security Committee to ensure continuity and implementation of the project's findings. Kentucky's forthcoming e-Health Action Plan, which will guide Kentucky's e-Health efforts over the next 5 years, has incorporated the work of this project into Kentucky's long-term planning for e-Health.
Louisiana	While developing the HISPC implementation plans, the project management team collaborated with the state Department of Health & Hospitals (DHH) in developing its 2007 legislative package, the Louisiana Health Information Exchange and the Louisiana Health Care Quality Forum Advisory Group, which are both in formative organizational stages. During the last phases of this project, the HIT subcommittee of the Louisiana Health Care Quality Forum Advisory Group was formed. Many members of this group were HISPC participants, and the subcommittee was viewed as an ideal structure to continue the work of HISPC.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
	Within the Office of the Secretary, DHH has hired an HIT Strategic Planner, who will coordinate DHH HIT and health information exchange efforts with external stakeholders and initiatives, such as the Louisiana Health Care Quality Forum and the Louisiana Health Information Exchange.
Massachusetts	Massachusetts is building a Consent Manager application and test in a health information exchange environment with several enterprises, through their subsidiary MA-SHARE.
	Massachusetts is beginning collaborative talks with Vermont and New Hampshire on health information exchange.
Maine	Maine has been working the past several years on implementing the capacity to facilitate timely exchange of patient clinical information through its state health information exchange project, HealthInfoNet. With HISPC support, Maine has continued planning and developing processes, including system governance, technical system requirements, and consumer engagement, while stressing stakeholder involvement. Maine has been closely working with stakeholders likely to be interested in or affected by an integrated statewide clinical information sharing infrastructure.
Michigan	The Michigan Department of Community Health (MDCH) is actively pursuing ways to fund the implementation of organized health information exchange networks and EHRs.
	MDCH was recently awarded a Medicaid Transformation Grant from the Department of Human Services to address provider and credentialing issues as they affect health information exchange.
Minnesota	The 2007 e-Health Summit, June 28, had privacy and security as one of its featured topics. Minnesota is incorporating identified principles into existing security activities and processes.
	Minnesota is identifying statewide, collaborative efforts to further refine and develop the principles.
	Minnesota is including the principles and their further development into recommendations issued by the Minnesota e-Health Advisory Committee.
	Minnesota is integrating the principles into grant programs and technical assistance activities at the Minnesota Department of Health.
Mississippi	March 7, 2007, Governor Haley Barbour signed an executive order creating the Health Information Infrastructure Task Force that will work to develop a HIT infrastructure and improve the quality and reduce the cost of health care in Mississippi. The 20-member task force convened in Jackson March 12–13, 2007, to begin the process of making detailed recommendations, searching for funding options, and setting dates for key milestones to achieve within the next 2 years.
North Carolina	North Carolina intends to participate in health information exchange opportunities such as RHIOs, community-based health information exchanges, the Nationwide Health Information Network, EHRs, and personal health records.
	North Carolina has also formed the North Carolina Consumer Advisory Council on Health Information to encourage consumer participation.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
New Hampshire	The project team will be integrating the HISPC reporting outcomes and implementation phase with the health information exchange priorities of the New Hampshire Citizens Health Initiative to implement several electronic health technology initiatives. The Citizens Initiative, at the direction of the governor's office, has requested that the New Hampshire Institute of Health Policy and Practice at the University of New Hampshire develop a statewide HIT and HIE strategic plan. New Hampshire will develop specific consumer education and marketing plans for the developing HIE pilot. New Hampshire will examine the creation of a unified consent form for statewide health information exchange, but also regional health information exchange, as well as adhere to national consent standards that are developed. A strategic planning work group convened May 23 to act as the initial IPWG. New Hampshire is open to the possibility of collaborations with Maine, Massachusetts, or Vermont entities pursuing similar goals. There are RHIOs in neighboring states.
New Jersey	New Jersey is interacting with New York State Department of Health to lay the foundation for discussions on creation of a metropolitan area Master Patient Index and to harmonize the public health electronic reporting registries that currently exist separately in New York and New Jersey so that each system registry will synchronize with and between the two states. New Jersey is working with New York State Medicaid Services and New Jersey Department of Human Services (NJDOHS) to share the benefits of a Medicaid Transformation Grant awarded to New Jersey to create one single EHR for Medicaid-covered children that will be interoperable across state lines. This grant has been awarded to NJDOHS to create EHRs, and NJDOHS has asked the New Jersey Department of Banking and Insurance (NJDOBI) to help with privacy, security, and composition of EHRs. New Jersey hopes to work with New York to share the benefits of these EHRs and other the opportunities that will likely emerge. New Jersey is working with New Jersey Hospital Association-Horizon BC/BS RHIO. This is a major effort funded by the Hospital Association and Horizon to develop a feasibility and business plan for a New Jersey RHIO. All the major stakeholders are involved; NJDOBI is a member of the steering committee and chairs the governance work group. NJDOBI is working on a joint project with Horizon and Our Lady of Lourdes Medical Center to create an interoperable EHR network between hospitals and providers in the Camden and Willingboro areas. These are 2 lower-income areas with many people who have chronic illnesses. New Jersey hopes to train and equip the NJDOBI Speakers Bureau in the benefits of EHRs, HIT, and National Provider Identifier implementation.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
	New Jersey has applied for an AHRQ Ambulatory Care Grant. This is a partnership project with the New Jersey Department of Health and Senior Services, NJDOBI, Clara Maas Medical Center, The Healthcare Quality Institute, and several others seeking to obtain federal funds to develop an electronic health care network for the ambulatory care of asthma patients, using an interoperable exchange of medical information between the hospital and providers.
	New Jersey actively supported the introduction of the New Jersey Assembly Bill 4044 for discussion. The bill could create a New Jersey Health Information Technology Commission and calls for the development of EHRs in this state. Coupled with the ongoing legislative hearings, major advances in New Jersey EHR and HIT apparently are on the threshold. Consequently, the various departments of state government are engaged in a significant analysis and drafting effort designed to create a self-sustaining interoperable EHR structure.
	New Jersey has assembled a dedicated and qualified group of highly professional individuals who are committed to the advancement in New Jersey of safe and secure EHR and HIT systems.
	New Jersey has established a cooperative working relationship with like-minded professionals from around the country.
	New Jersey has focused the attention of the New Jersey government, its people, the payers, and the business community in general on the value, efficiency, and cost savings that are achievable.
New Mexico	The project team recommends that primary responsibility for leadership and oversight with respect to implementation reside in the New Mexico Telehealth and Health Information Technology Commission (NMTHITC).[b] The purpose of the NMTHITC is to encourage a single, coordinated statewide effort to create a statewide telehealth and HIT system. New Mexico is currently working to determine which existing groups and initiatives are most appropriate to sponsor and lead new work.
New York	As part of the overall operating budget, the Deputy Commissioner in charge of the Office of Health Information Technology Transformation will have responsibility for money appropriated for the Health e-Links Program in the 2006 state budget (2006 N.Y. Laws, ch. 57, pt. G). A total of $1.5 million has been appropriated (half last year and half this year) "to enhance the adoption of an interoperable regional health information exchange and technology infrastructure that will improve quality, reduce the cost of health care, ensure patient privacy and security, enhance public health reporting including bioterrorism surveillance and facilitate health care research." A portion of the appropriations will be used to continue the work of the New York HISPC.
	The New York State Department of Health (NYSDOH) and the New Jersey Department of Banking and Insurance (NJDOBI) will be working together to explore the creation of a patient identification model in the metropolitan NYC area.
	NJDOBI was asked to participate with respect to privacy and security issues and invited NYSDOH to help create a single EHR for Medicaid-covered children that will be interoperable across state lines.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
	New York will pursue working with Massachusetts on a consent protocol based on the pilot being conducted in the North Adams Community.
	New York will pursue collaboration with the Massachusetts State Medicaid program to develop an interoperability platform for electronic prescribing.
Ohio	Ohio has begun advocating the establishment of a permanent state-level quasi-governmental organization to monitor consistent implementation of national standards and, where necessary, to develop state standards. The proposal is for the HISPC Governor's Steering Committee to serve in an interim capacity, determining specific responsibilities and functions of the state-level group and finalizing legal structure and membership of the ongoing group.
Oklahoma	The Oklahoma HISPC (OKHISPC) project established an effective collaboration among stakeholders, including tribal nations, which continues.
	Although Oklahoma is in the infancy stages of development of electronic health information exchange, there is certainly a synergy that has developed through this project, as well as collaboration between the private and public partners.
	The Oklahoma Insurance Commission has committed to continuing the efforts of the OKHISPC project under its own leadership, at the request of other state agencies.
	The OKHISPC project has built a solid foundation that will aid in the advancement of interoperable health information exchange in Oklahoma.
Oregon	Oregon HISPC has designed a consumer education tool and permission form for health information exchange that will be tested in both the metro area and a rural area. The goal is to use this education tool with the pilot HIE projects currently being developed in Oregon. The education tool has been designed with a "modular" concept to allow each HIE to include information that is specific to its project.
	Oregon will continue to work with stakeholders to design and implement a process for honoring individuals' wishes concerning participation in an HIE.
	A project that began in March 2007 entails creating a database that includes provider credentials, provider contact information, and related information to assist providers in validating or authenticating that a provider requesting patient health information is a valid entity or individual. The project has been funded by the Oregon Medical Association. Partnership with other major health care associations, providers, and health plans (including the State of Oregon) has been successful, and partner organizations have indicated a significant interest in participating in the development and population of the database. This effort exemplifies activity under way in Oregon to address challenges identified as part of the Oregon HISPC project.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
Puerto Rico	Puerto Rico proposes that a Health Information Exchange Committee be appointed before the end of the fiscal year, July 2007, and that it take up the task of allocating the work plans to subcommittees it will create. As proposed here, the Health Information Exchange Committee will consist of health care providers and professional associations, legal consultants from public and private health care providers, consumers, stakeholders affiliated with medical schools and licensing entities, and members of legislative organizations. Four subcommittees will be formed around each of the respective work plans: a legislative and regulatory subcommittee; a technological subcommittee; an administration, education, and public awareness subcommittee; and a Pilot Health Information Exchange Committee.
Rhode Island	The fundamental benefits and specific insights derived from Rhode Island's participation in the HISPC initiative have been used to refine guiding principles and to formulate and test the level of consensus on critical policies and supportive technical approaches for the emerging Rhode Island HIE system. As a state and a community of people striving for dramatic improvements in health care, Rhode Island has benefited greatly from this project and will continue to reap the benefits of participation as implementation proceeds.
Utah	Utah Department of Health (UDOH) executive director David Sundwall has created the Office of Public Health Informatics, a new unit with the Executive Director's Office. The UDOH Office of Public Health Informatics will support e-Health efforts at both the state and federal levels. The 2007 session of the Utah Legislature concluded in March, passing 2 relevant items: (1) a small, 1-time appropriation to the Utah Department of Health to promote use of electronic medical records by private providers; and (2) a bill that requires the Health Data Committee to begin planning a major health care cost-transparency project that will likely involve improved unique identification of electronic health care data.
Vermont	Governor Jim Douglas was recently appointed as co-chair of the NGA's State Alliance for eHealth initiative. The Vermont Health Information Technology Leaders are charged with developing the statewide HIT plan, including applicable standards, protocols, and pilot programs. The final Vermont Health Information Technology Plan, will be submitted by July 1, 2007. Work group members have identified key issues, developed a proposed outline for the final plan, and created a process for gathering input from diverse groups of Vermonters and reaching consensus.

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Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
Washington	A group of committed nongovernmental stakeholders is currently moving ahead with discussions on how they may provide bridge funding to maintain the momentum of HISPC. Based on discussions at the HISPC regional meeting, interest may exist in both Washington and Alaska to coordinate around disaster recovery and regional emergency support. Several discussions have been conducted between the Oregon and Washington HISPC teams, in addition to the discussions among all the Pacific Northwest state representatives at the HISPC regional meeting, and there is consensus that formal coordination would be highly desirable.
Wisconsin	The eHealth Board will be using the Security and Privacy project reports to assess where the proposed solutions fit within the eHealth Board's scope of work for the coming years as it articulates a path to improve the quality and reduce the cost of health care in Wisconsin through creation of a statewide health information infrastructure.
West Virginia	West Virginia will continue to closely monitor federal action on HIT legislation and related matters. The West Virginia Health Information Network (WVHIN) Board has demonstrated a strong commitment to the HISPC project and has indicated its desire to promote the work of the WVHISPC team once the RTI contract terminates. The WVHIN Board passed a resolution at its January 26, 2007, meeting, establishing an ad hoc committee tasked with the ongoing oversight of the West Virginia HISPC (WVHISPC) activities. The WVHISPC team, including members of the IPWG and Solutions Work Group (SWG), hold high-level policy or management positions in many of the private- and public-sector agencies and organizations that will be tasked with various implementation activities. The West Virginia Legislature has enacted 2 of WVHISPC's high-priority legislative proposals. These include House Bill 3184, a bill to amend an existing state statute by providing greater flexibility regarding the disclosure of confidential mental health information; and Senate Bill 1001, a bill to amend an existing state statute by adding a new section relating generally to the authorization of electronic prescribing. A process has been developed that will support the continuation of the efforts started by the WVHISPC work groups toward achieving West Virginia's long-term health information exchange objectives and the goal set forth by the U.S. Department of Health and Human Services to develop and implement a strategic plan to guide the nationwide implementation of HIT.
Wyoming	The project can take credit for catalyzing conversations among high-ranking policy makers, including Wyoming's congressional delegation, the governor's office, the Dean of the College of Health Sciences at the University of Wyoming, Wyoming State legislators, the Wyoming Healthcare Commission, and the Wyoming Health Information Organization.

(continued)

Table A-1. State-level Activity Currently Being Planned or Conducted as a Result of Work on the Privacy and Security for Interoperable Health Information Exchange Project (continued)

State	Activity Reported by State Teams in Final Reports[a]
	The project has spurred an interest in EHRs among members of the press and has received a fair amount of coverage in both print and radio statewide.
	The HISPC project has brought Wyoming health care professionals together and provided them with the opportunity to express their concerns and visions regarding HIT and health information exchange in a collaborative fashion, with the probability that Wyoming's population will benefit from these discussions.
	The project has initiated discussions at regional and national levels, and Wyoming is pleased to be included in these discussions. As a result of the work, Wyoming is participating in various activities outside the state.
	Two members of the project staff attended a regional meeting on interstate health information exchange, which was held in Colorado.
	The Wyoming HISPC project director, Dr. Rex Gantenbein, was 1 of 3 state project directors invited by RTI to discuss the project at the American Health Information Community meeting in March 2007.
	Dr. Gantenbein participated in a CMS-sponsored Region VIII Health IT Roundtable in Salt Lake City in May, which was attended by several governors and state officials, CMS representatives, and others involved in HIT in the 6 Western states comprising the region.

[a]All activities listed were included by the state teams in their final reports.

[b]Formerly known as the New Mexico Telehealth Commission, the NMTHITC is created and operates under N.M. Stat. Ann. §§ 24-1G-1 *et seq.* (1978).

APPENDIX B
LIST OF STAKEHOLDER GROUPS

List of Stakeholder Groups[1]

Clinicians
Physician groups (primary and specialty care)
Federal health facilities (Department of Defense, Indian Health Service, Department of Veterans Affairs)
Hospital personnel/ER staff
Payers (including employers that sponsor group health plans)
Public health agencies
Community clinics and health centers
Laboratories
Pharmacies
Long-term care facilities/nursing homes
Homecare and hospice
Correctional facilities personnel
Professional associations and societies
Medical and public health schools that undertake research
Quality improvement organizations
Consumers/consumer organizations
State government (Medicaid, public health departments, etc)

[1] This is the stakeholder list described on page 49 of AHRQ-05-0115 request for proposal dated June 7, 2005.

APPENDIX C
PRIVACY AND SECURITY HEALTH INFORMATION EXCHANGE SCENARIOS GUIDE

Privacy and Security Health Information Exchange Scenarios Guide

The following 18 scenarios were developed by the American Health Information Management Association specifically for the privacy and security project to provide a standardized context for discussing organization-level business practices across all states and territories. The scenarios represent a wide range of purposes for the exchange of health information (eg, treatment, public health, biosurveillance, payment, research, and marketing) that take place within a broad array of organizations. The scenarios were not intended to cover the full range of conditions in which health information is exchanged but rather to ensure that we cover most of the areas in which we expect to find variation. The product of the "guided or focused" discussions is a database of organization-level business practices that forms the basis for the assessment of variation upon which all other work was based.

Key to the success of using the scenarios is bringing the appropriate stakeholders together to discuss the relevant scenarios. Figure C-1 shows a mapping of the relevant stakeholder organizations to the 18 scenarios. A shaded box containing an "X" provides a text description of the primary stakeholders identified in each scenario. These primary stakeholders are most likely to be knowledgeable about the business practices and policies that their specific organization engages in, given the situation presented in the scenario, and should be invited to discussions of those specific scenarios. A yellow box with no text indicates a secondary stakeholder group that could conceivably weigh in on the discussions generated by that scenario. For example, Scenario 1, Patient Care Scenario A, involves an exchange between the ER in Hospital A and an out-of-state hospital, Hospital B. Both the requesting and disclosing organizations are hospitals, regardless of the "actors" that may be representing those organizations in the work group meetings, which may include physicians, nurses, health information management professionals, and others. The organizations that are relevant for each scenario are also identified at the beginning of each scenario to facilitate the coordination of stakeholders for each work group.

Figure C-1. Scenario by Stakeholder Map

Scenarios	1. Clinicians	2. Physician groups	3. Federal health facilities	4. Hospitals	5. Payers	6. Public Health agencies	7. Community clinics and health centers	8. Laboratories	9. Pharmacies	10. Long-term care facilities and nursing homes	11. Homecare and hospice	12. Law enforcement/ correctional facilities	13. Professional associations and socieities	14. Medical and public health schools that undertake research	15. Quality improvement organizations	16. Consumers or consumer organizations	17. State government (Medicaid, public health departments)	18. Other, specify
1. Patient Care - Scenario A (Emergent Transfer)				X ER Staff (sending and receiving)														
2. Patient Care - Scenario B (Sub Abuse)	X Provider	X Primary Care Physician					^ Substance Abuse Treatment									X Client/Patient		
3. Patient Care - Scenario C (Access Security)	X Provider	X Psychiatrist		X Hospital Psych Unit						X Nursing Facility								X Transcription Service
4. Patient Care - Scenario D (HIV and Genetic)				X Mamography Dept.			X Outpatient Clinic											
5. Payment Scenario	X Provider	X Provider	X Provider	X Provider	X Health Plan		X Provider			X Provider	X Provider					X Patient		
6. RHIO Scenario	X Provider	X Provider	X Provider	X Provider			X Provider	X Provider	X Provider	X Provider	X Provider							
7. Research Final Scenario	X Provider	X Provider												^ IRB, Research Investigator		X Study Member		
8. Law Enforcement Final Scenario				X Provider								X Law Enforcement				X Patient Patient's family		
9. Pharmacy Benefit Final Scenario A							X Outpatient Clinic		^ Pharmacy Benefit Manager							X Patient		
10. Pharmacy Benefit Final Scenario B									^ Pharmacy Benefit Manager							X Employees		X Company
11. Operations and Marketing Final Scenario A				^ Tertiary Hospital Marketing Dept			X Critical access clinics (sending)											
12. Operations and Marketing Final Scenario B				^ Obstetrics department Marketing												X Patient		X Company
13. Bioterrorism Event Final Scenario	X Provider	X Provider		X Provider		X Public Health Staff						X Law Enforcement					X Emergency Gov't agencies	
14. Employment Information Final Scenario				X ER Staff												X Employees		X Company HR Dept
15. Public Health Final Scenario A	X Provider	X PCP				X Public Health Staff						X Law Enforcement				X Patient		
16. Public Health Final Scenario B	X Provider	X Physician				X Public Health Staff	X Specialty Care Center	X Lab Staff									X Public Health	
17. Public Health Final Scenario C	X Provider	X PCP		X Drug Treatment Center			^ Homeless shelter Community									X Patient Patient's family	X County Program	
18. Health Oversight Final Scenario						X Public Health Staff								X Faculty				

Health Information Exchange Scenarios

1. Patient Care Scenario A

The emergent transfer of health information between two hospitals that represent the 2 stakeholder organizations (ie, Hospital A and Hospital B) when the status of the patient is unsure. The actors are the staff involved in carrying out the request. The ER physician is requesting the information on behalf of Hospital A.

Stakeholder organizations and exchanges:

- Hospital emergency room in Hospital A is the organization requesting information.
- Hospital B is the organization releasing the information.

Patient X presents to emergency room of General Hospital in State A. She has been in a serious car accident. The patient is an 89-year-old widow who appears very confused. Law enforcement personnel in the emergency room investigating the accident indicate that the patient was driving. There are questions concerning her possible impairment due to medications. Her adult daughter informed the ER staff that her mother has recently undergone treatment at a hospital in a neighboring state and has a prescription for an antipsychotic drug. The emergency room physician determines there is a need to obtain information about Patient X's prior diagnosis and treatment during the previous inpatient stay.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Determining status of the patient and chain of responsibility.
2. Practice and policy for obtaining information sufficient for treatment.
3. Practice and policy for handling mental health information.
4. Practice and policy for securing the data exchange mechanism.
5. Practice and policy related to authentication of requesting facility by the releasing facility.
6. Practice and policy related to patient authorization for the release of information.

2. Patient Care Scenario B

The scenario involves the nonemergent transfer of records from a specialty substance treatment provider to a primary care facility for a referral to a specialist.

Stakeholder organizations and exchanges:

- Specialty substance abuse treatment facility (releasing sensitive clinical records)
- Primary care provider's organization (eg, doctor's office, community health center, public health agency) (requesting clinical records from the substance abuse facility, releasing information to specialist)

An inpatient specialty substance abuse treatment facility intends to refer client X to a primary care facility for a suspected medical problem. The 2 organizations do not have a previous relationship. The client has a long history of using various drugs and alcohol that is relevant for medical diagnosis. The primary care provider has requested that the substance abuse information be sent by the treatment facility. The primary care provider intends to refer the patient to a specialist and plans to send all of the patient's medical information, including the substance abuse information that was received from the substance abuse treatment facility, to the specialist.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. How does the releasing organization obtain authorization from the patient to allow release of medical records?
2. What is the process for handling substance abuse medical record data?
3. How does the releasing organization authenticate the health care provider requesting the information?
4. How is the data exchange secured?

3. Patient Care Scenario C

Stakeholder organizations and exchanges:

- Hospital psychiatric unit (sending) and the skilled nursing facility (receiving)
- Physician (sending) and the transcription service (receiving)
- Transcription service (sending) and the physician (receiving)
- Physician (sending) and the skilled nursing facility (receiving)

At 5:30 p.m., Dr. X, a psychiatrist, arrives at the skilled nursing facility to evaluate his patient, recently discharged from the hospital psychiatric unit to the skilled nursing facility. The hospital and skilled nursing facility are separate entities and do not share electronic record systems. At the time of the patient's transfer, the discharge summary and other pertinent records and forms were electronically transmitted to the skilled nursing home.

When Dr. X enters the facility, he seeks assistance locating his patient, gaining entrance to the locked psychiatric unit, and accessing the patient's electronic health record to review the discharge summary, I&O, MAR, and progress notes. Dr. X was able to enter the unit by showing a picture identification badge, but was not able to access the EHR. As it is Dr. X's first visit, he has no log-in or password to use their system.

Dr. X completes his visit and prepares to complete his documentation for the nursing home. Unable to access the skilled nursing facility EHR, Dr. X dictates his initial assessment via telephone to his outsourced, offshore transcription service. The assessment is transcribed and posted to a secure Web portal.

The next morning, from his home computer, Dr. X checks his e-mail and receives notification that the assessment is available. Dr. X logs into his office Web portal, reviews the assessment, and applies his electronic signature.

Later that day, Dr. X's office manager downloads this assessment from the Web portal, saves the document in the patient's record in his office, and forwards the now encrypted document to the long-term care facility via e-mail.

The skilled nursing facility notifies Dr. X's office that they are unable to open the encrypted document because they do not have the encryption key.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Agreements for data sharing—business associate agreements.
2. Setting out access and role management policies and practices for temporary or new access.
3. Determining appropriate access to mental health records.
4. Securing unstructured, possibly nonelectronic patient data.
5. Reliability of other entity security and privacy infrastructure.

4. Patient Care Scenario D

The nonemergent transfer of health information

Stakeholder organizations and exchanges:

- Hospital mammography department (requesting health information)
- Outpatient clinic (receiving request)

Patient X is HIV positive and is having a complete physical and an outpatient mammogram done in the Women's Imaging Center of General Hospital in State A. She had her last physical and mammogram in an outpatient clinic in a neighboring state. Her physician in State A is requesting a copy of her complete records and the radiologist at General Hospital would like to review the digital images of the mammogram performed at the outpatient clinic in State B for comparison purposes. She also is having a test for the *BrCa* gene and is requesting the genetic test results of her deceased aunt who had a history of breast cancer.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Authenticating entities and individuals.
2. Determining processes and laws for release of genetic and HIV information.

5. Payment Scenario

Stakeholder organizations and exchanges:

- Health care provider (hospital or clinic)
- Health plan (payer)
- Patients

X Health Payer (third party, disability insurance, employee assistance programs) provides health insurance coverage to many subscribers in the region the health care provider serves. As part of the insurance coverage, it is necessary for the health plan case managers to approve/authorize all inpatient encounters. This requires access to the patient health information (eg, emergency department records, clinic notes).

The health care provider has recently implemented an electronic health record (EHR) system. All patient information is now maintained in the EHR and is accessible to users who have been granted access through an approval process. Access to the EHR has been restricted to the health care provider's workforce members and medical staff members and their office staff.

X Health Payer is requesting access to the EHR for their accredited case management staff to approve/authorize inpatient encounters.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Get patient authorization to allow payer access.
2. Facility needs to determine the minimum necessary and limit to pertinent time frame.
3. If allowed, access and role management are issues.
4. Determine method for enabling secure remote access if allowed.

6. RHIO Scenario

Note: Each stakeholder should participate in this scenario keeping in mind the type of data their organization anticipates exchanging with a RHIO.

Stakeholder organizations and exchanges:

- Multiple provider organizations (providing data)
- Multiple RHIOs (receiving data)

The RHIO in your region wants to access patient identifiable data from all participating organizations (and their patients) to monitor the incidence and management of diabetic patients. The RHIO also intends to monitor participating providers to rank them for the provision of preventive services to their diabetic patients.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Decision to utilize medical record data to monitor disease management.
2. Authorization from patients to allow RHIO to monitor their PHI for disease management.
3. Determine mode of transferring information and type of information, ie, identifiable or de-identified information to the RHIO.

7. Research Data Use Scenario

Stakeholder organizations and exchanges:

- Health care consumer (taking part in the study)
- Health care provider (distributing meds and collecting clinical data)
- Research investigator (receiving and analyzing clinical data)
- Institutional Review Board (IRB) (receiving reports on data collection)

A research project on children younger than age 13 is being conducted in a double-blind study for a new drug for ADD/ADHD. The research is being sponsored by a major drug manufacturer conducting a double-blind study approved by the medical center's IRB, where the research investigators are located. The data being collected is all electronic, and all responses from the subjects are completed electronically on the same centralized and shared database file.

The principal investigator was asked by one of the investigators if they could use the raw data to extend the tracking of the patients over an additional 6 months or use the raw data collected for a white paper that is not part of the research protocols final document for his postdoctoral fellow program.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. IRB approval of any significant changes to the research protocol.
2. Research subjects have signed consents and authorization to participate in the research effort.

8. Scenario for Access by Law Enforcement

Stakeholder organizations and exchanges:

- Health care provider (providing health information)
- Law enforcement
- Patient
- Patient's family

An injured 19-year-old college student is brought to the ER following an automobile accident. It is standard to run blood-alcohol and drug screens. The police officer investigating the accident arrives in the ER, claiming that the patient may have caused the accident. The patient's parents arrive shortly afterward. The police officer requests a copy of the blood-alcohol test results, and the parents want to review the ER record and lab results to see if their child tested positive for drugs. These requests to print directly from the electronic health record are made to the ER staff.

The patient is covered under his parent's health and auto insurance policy.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. County contracts with emergency department to perform blood-alcohol test draws.
2. Printing of additional copies of medical record reports for parents, insurance companies, and police.
3. Asking patient if it is okay to talk to parents or give information to parents about their condition.
4. Communication with primary care provider.

9. Pharmacy Benefit Scenario A

Stakeholder organizations and exchanges:

- Pharmacy benefit manager (PBM) (requesting information)
- Outpatient clinic (receiving request)
- Patient X

The PBM has a mail order pharmacy for a hospital which is self-insured and also has a closed formulary. The PBM receives a prescription from Patient X, an employee of the hospital, for the antipsychotic medication Geodon. The PBM's preferred alternatives for antipsychotics are Risperidone (Risperdal), Quetiapine (Seroquel), and Aripiprazole (Abilify). Since Geodon is not on the preferred alternatives list, the PBM sends a request to the prescribing physician to complete a prior authorization in order to fill and pay for the Geodon prescription. The PBM is in a different state than the provider's outpatient clinic.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Patient authorization to share information with the PBM.
2. Agreements for data sharing—business associate agreements.
3. Health care provider must determine minimum necessary access to PHI.
4. If allowed, role and access management are issues.
5. Determine method for enabling secure remote access if allowed.

10. Pharmacy Benefit Scenario B

Stakeholder organizations and exchanges:

- Pharmacy benefit manager (PBM) (requesting information)
- Company A (providing claims information)
- Employees

A PBM (PBM1) has an agreement with Company A to review the companies' employees' prescription drug use and the associated costs of the drugs prescribed. The objective would be to see if PBM1 could save the company money on their prescription drug benefit. Company A is self-insured and as part of their current benefits package, they have the prescription drug claims submitted through their current PBM (PBM2). PBM1 has requested that Company A send their electronic claims to them to complete the review.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Business associate agreements and formal contracts exist between Company A and the PBMs.
2. The extent and amount of information shared between the various parties would be limited by the minimum necessary guidelines.

11. Health Care Operations and Marketing Scenario A

Note: This scenario could be modified to apply to any health care provider (physician group, home health care agency, etc) wishing to market services to a targeted subset of patients.

Stakeholder organizations and exchanges:

- Tertiary hospital (requesting study data)
- Critical access hospital (being asked to provide health information)

ABC Health Care is an integrated health delivery system composed of ten critical access hospitals and one large tertiary hospital, DEF Medical Center, which has served as the system's primary referral center. Recently, DEF Medical Center has expanded its rehab services and created a state-of-the-art, stand-alone rehab center. Six months into operation, ABC Health Care does not feel that the rehab center is being fully utilized and is questioning the lack of rehab referrals from the critical access hospitals.

ABC Health Care has requested that its critical access hospitals submit monthly reports containing patient identifiable data to the system six-sigma team to analyze patient encounters and trends for the following rehab diagnoses/procedures:

- Cerebrovascular accident (CVA)
- Hip fracture
- Total joint replacement

Additionally, ABC Health Care is requesting that this same information, along with individual patient demographic information, be provided to the system marketing department. The marketing department plans to distribute to these individuals a brochure highlighting the new rehab center and the enhanced services available.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Decision to conduct marketing using PHI with their consumers.
2. Authorization from consumer to allow IHDS to market to themselves.
3. Determine mode of transferring information and type of information, ie, identifiable or de-identified information to the marketing department.

12. Health Care Operations and Marketing Scenario B

Stakeholder organizations and exchanges:

- Health care provider (hospital obstetrics department sending data)
- Hospital marketing department (receiving data)
- Local company (purchasing data from marketing department)
- Patients/consumers

ABC hospital has approximately 3,600 births per year. The hospital marketing department is requesting identifiable data on all deliveries, including mother's demographic information and birth outcome (to ensure that contact is made only with those deliveries resulting in healthy live births).

The marketing department has explained that they will use the patient information for the following purposes:

1. To provide information on the hospital's new pediatric wing/services.
2. To solicit registration for the hospital's parenting classes.
3. To request donations for construction of the proposed neonatal intensive care unit.
4. To sell the data to a local diaper company to use in marketing diaper services directly to parents.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Requesting patient consent or permission to use and sell identifiable data for marketing purposes.
2. Decisions to conduct marketing using patient data.
3. Determining mode of transferring information and type of information, ie, identifiable or de-identified information to the marketing department.

13. Bioterrorism Event

Stakeholder organizations and exchanges:

- Laboratory (collecting data)
- Health care provider (transmitting data to public health)
- Public health department (receiving data from provider, providing data to government agencies)
- Law enforcement (receiving data)
- Government agencies (receiving data)
- Patients

A provider sees a person who has anthrax, as determined through lab tests. The lab submits a report on this case to the local public health department and notifies their organizational patient safety officer. The public health department in the adjacent county has been contacted and has confirmed that it is also seeing anthrax cases, and therefore this could be a possible bioterrorism event. Further investigation confirms that this is a bioterrorism event, and the state declares an emergency. This then shifts responsibility to a designated state authority to oversee and coordinate a response, and involves alerting law enforcement, hospitals, hazmat teams, and other partners, as well as informing the regional media to alert the public to symptoms and seeking treatment if feeling affected. The state also notifies the federal government of the event, and some federal agencies may have direct involvement in the event. All parties may need to be notified of specific identifiable demographic and medical details of each case as it arises to identify the source of the anthrax, locate and prosecute the parties responsible for distributing the anthrax, and protect the public from further infection.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Providing patient-specific information related to specific symptoms to law enforcement, CDC, Homeland Security, and health department in a situation where a threat is being investigated.

14. Employee Health Information Scenario

Stakeholder organizations and exchanges:

- Hospital emergency room (releasing health information)
- Employer human resources department (requesting health information)
- Employee

An employee (of any company) presents in the local emergency department for treatment of a chronic condition that has worsened but is not work related. The employee's condition necessitates a 4-day leave from work for illness. The employer requires a "return to work" document for any illness requiring more than 2 days leave. The hospital emergency department has an EHR and their practice is to cut and paste patient information directly from the EHR and transmit the information via e-mail to the human resources department of the patient's employer.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Determining employee agreement to release information.
2. Determining what are the minimum necessary elements which can be legally transmitted.
3. Ensuring the data is secured as it is transmitted.

15. Public Health Scenario A—Active Carrier, Communicable Disease Notification

Stakeholder organizations and exchanges:

- Health care provider (primary care physician)
- Public health department
- Law enforcement
- Patient

A patient with active TB, still under treatment, has decided to move to a desert community that focuses on spiritual healing, without informing his physician. The TB is classified MDR (multidrug resistant). The patient purchases a bus ticket—the bus ride will take a total of 9 hours with 2 rest stops across several states. State A is made aware of the patient's intent 2 hours after the bus with the patient leaves. State A now needs to contact the bus company and other states with the relevant information.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Providing patient-specific information related to a specific communicable disease to law enforcement, non–health care entities, and health department in a situation where a threat is being responded to.
2. Ensuring the data is secured as it is transmitted.

16. Public Health Scenario B—Newborn Screening

Stakeholder organizations and exchanges:

- Health care provider (sending initial data to public health and lab, receiving data on follow up/eligibility)
- State laboratory (receiving data)
- State public health department (receiving data, sending data for program eligibility)

A newborn's screening test comes up positive for a state-mandated screening test and the state lab test results are made available to the child's physicians and specialty care centers specializing in the disorder via an Interactive Voice Response (IVR) system. The state lab also enters the information in its registry, and tracks the child over time through the child's physicians. The state public health department provides services for this disorder and notifies the physician that the child is eligible for those programs.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. Providing patient-specific information related to specific symptoms of a disease to a health department in a situation where a targeted disease is being investigated.

17. Public Health Scenario C—Homeless Shelters

Stakeholder organizations and exchanges:

- Primary care provider (sending) and hospital-affiliated drug treatment center (receiving)
- The hospital-affiliated drug treatment clinic (releasing) and the county program (requesting for purposes of reimbursement)
- The hospital-affiliated drug treatment clinic (releasing) and the shelter (requesting to verify the treatment)
- The family member (requesting) and the shelter

Stakeholder entities:

- Health care consumer/patient
- Primary care provider
- Hospital-affiliated drug treatment center
- Homeless shelter
- Patient relative/family member

A homeless man arrives at a county shelter and is found to be a drug addict and in need of medical care. The person does have a primary care provider, and he is sent there for medical care. Primary care provider refers patient to a hospital-affiliated drug treatment clinic for his addiction under a county program. The addiction center must report treatment information back to the county for program reimbursement, and back to the shelter to verify that the person is in treatment. Someone claiming to be a relation of the homeless man requests information from the homeless shelter on all the health services the man has received. The staff at the homeless shelter is working to connect the homeless man with his relative.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. The extent and amount of information shared between the various facilities would be limited by the minimum necessary guidelines.

18. Health Oversight: Legal Compliance/Government Accountability

Stakeholder organizations and exchanges:

- State university faculty (requesting health information)
- State public health agencies (asked to provide health information)

The governor's office has expressed concern about compliance with immunization and lead screening requirements among low-income children who do not receive consistent health care. The state agencies responsible for public health, child welfare and protective services, Medicaid services, and education are asked to share identifiable patient-level health care data on an ongoing basis to determine if the children are getting the health care they need. This is not part of a legislative mandate. The governor in this state and those in the surrounding states have discussed sharing this information to determine if patients migrate between states for these services. Because of the complexity of the task, the governor has asked each agency to provide these data to faculty at the state university medical campus who will design a system for integrating and analyzing the data. There is no existing contract with the state university for services of this nature.

Potential areas of discussion of BUSINESS PRACTICES based on this scenario:

1. What is the practice of the organization to provide appropriate information for health care oversight activities? These may include:
   - Determining minimum amount necessary.
   - How to release (electronically or paper—with existing claims data).

APPENDIX D
NINE DOMAINS OF PRIVACY AND SECURITY

Nine Domains of Privacy and Security

1. **Authentication:** User and entity authentication to verify that a person or entity seeking access to electronic personal health information is who they claim to be.

2. **Authorization and Access Control:** Information authorization and access controls to allow access only to people or software programs that have been granted access rights to electronic personal health information.

3. **Patient and Provider Identification:** Patient and provider identification to match identities across multiple information systems and locate electronic personal health information across enterprises.

4. **Transmission Security:** Information transmission security or exchange protocols (ie, encryption) for information that is being exchanged over an electronic communications network.

5. **Information Protection:** Information protections so that electronic personal health information cannot be improperly modified.

6. **Information Audits:** Information audits that record and monitor the activity of health information systems.

7. **Administrative Security:** Administrative or physical security safeguards required to implement a comprehensive security platform for health information technology.

8. **State Law:** State law restrictions about information types and classes and the solutions by which electronic personal health information can be viewed and exchanged.

9. **Policy:** Information use and disclosure policies that arise as health care entities share clinical health information electronically.

APPENDIX E
SCHEDULE AND PARTICIPATION AT REGIONAL MEETINGS

Table E-1. Schedule and Participation at Regional Meetings

Meeting	Date	Participants
Kansas City	10/25/2006	52
Minneapolis	10/27/2006	39
New Orleans	10/30/2006	54
Indianapolis	11/3/2006	54
Seattle	11/6/2006	42
Phoenix	11/8/2006	49
Salt Lake City	11/9/2006	40
Charlotte	11/13/2006	54
Newark	11/15/2006	48
Boston	11/17/2006	60

APPENDIX F
NATIONAL CONFERENCE AGENDA

National Conference Agenda

March 5–6, 2007

Current Landscape of Privacy and Security Issues That Impact Electronic Health Information Exchange

Monday, March 5

7:00 – 8:15	**Registration and Networking Breakfast**	Ballroom
8:15 – 9:00	**Welcome and Opening Remarks** Dr. Carolyn Clancy, Director Agency for Healthcare Research and Quality Dr. Robert Kolodner, Interim National Coordinator for Health Information Technology, Office of the National Coordinator for Health Information Technology	Ballroom
9:00 – 10:15	**Highlights of the Nationwide Summary of the Interim Assessment of Variation** Linda Dimitropoulos, PhD, RTI International	Ballroom
10:15 – 10:30	**BREAK**	Ballroom
10:30 – 11:45	**TRACK A: CONSENT ISSUES** **Session 1A: Framing the Issues** NY: What Is Legally Required, What Is Best, What Works? *Presenters: Jean Quarrier and Anna Colello* NH: Nature of Consent in New Hampshire *Presenter: Amy Philbrick Schwartz, MPH* *Associate Director & Clinical Assistant Professor* *New Hampshire Institute for Health Policy and Practice* **Moderator:** Joy Pritts, JD Health Policy Institute, Georgetown University	Potomac/ Bethesda
	TRACK B: DATA SECURITY AND QUALITY **Session 1B: The 4 A's** MN: Framework for Addressing the 4 A's *Presenter: James Golden, PhD* *Director, Division of Health Policy, Minnesota Department of Health* PR: Patient Identity Management *Presenter: Maria E. Vargas, HISPC Project Manager, CIRACET Corporation* **Moderator:** Walter Suarez, MD, MPH President and CEO, Institute for HIPAA/HIT Education and Research	Democracy/ Montgomery

	TRACK C: LEGAL AND REGULATORY ISSUES **Session 1C: State Laws: Finding Them and Interpreting Them** FL: Scattered State Law: A Three-Year Plan for Consolidating Statutes *Presenters: Lisa Rawlins, BS, Bureau Chief, and Carolyn Turner, MS, Government Analyst, FL Agency for Health Care Administration* LA: Establishing a Health Information Committee Under the Louisiana State Law Institute *Presenter: Tony Keck, Tulane University* **Moderator:** Mike Hubbard, JD Womble, Carlyle, Sandridge & Rice	Chevy Chase/ Rockville
	TRACK D: INTERPRETING AND APPLYING HIPAA **Session 1D: Variations in "Minimum Necessary" Interpretation** WI: Defining and Applying the Minimum Necessary Standard *Presenter: Stacia Jankowski, Program and Policy Analyst* CT: Leveraging the Interconnecting Healthcare Enterprise Patient Care Coordination Profiles *Presenter: Lori Reed-Fourquet, MSCS, CT HISPI Project Manager* **Moderator:** W. Braithwaite, MD, PhD Health Information Policy Consulting	Montrose/ Kenwood
12:00 – 1:00	**LUNCH**	Ballroom
1:00 – 2:15	**Session 2A: State Consent Laws** WI: States Requiring Consent for Treatment *Presenter: Stacia Jankowski, Program and Policy Analyst* MN: Liability Issues Specifically Related to State Consent Laws *Presenter: James Golden, PhD, Director, Division of Health Policy, Minnesota Department of Health* **Moderator:** Joy Pritts, JD Health Policy Institute, Georgetown University	Potomac/ Bethesda
	Session 2B: Access and Auditing Access CT: Standard Methods and Semantics *Presenter: John Lynch, MPH, CT HISPI Associate Project Director* VT: Access Control Issues and Solutions *Presenters: Greg Farnum, Vermont Information Technology Leaders, and Keith Boone, GE Healthcare* **Moderator:** Chris Apgar, CISSP Apgar & Associates	Democracy/ Montgomery

	Session 2C: State Laws That Are Outdated or Nonexistent NM: Promulgation of New Laws to Protect Privacy and Security of Patient Data in Electronic Form *Presenters: Randy McDonald, JD, and Miller Stratvert, PA, Chair, New Mexico Legal and Implementation Plan Work Groups* AR: Developing a Single Set of Rules Governing PHI Exchange *Presenter: Kevin Ryan, JD, MA, Associate Director, Arkansas Center for Health Improvement* **Moderator:** Mike Hubbard, JD Womble, Carlyle, Sandridge & Rice	Chevy Chase/ Rockville
	Session 2D: Fear of Liability OK: Policies That Are More Restrictive Than State Law or HIPAA Requires *Presenter: Robn Mitchell, MPH, HIPAA Privacy Officer, OK State Department of Health* WY: Fear of Liability and Litigation for Wrongful Disclosure *Presenter: Ryan Sandefer, MA, University of Wyoming, Center for Rural Health Research & Education* **Moderator:** W. Braithwaite, MD, PhD Health Information Policy Consulting	Montrose/ Kenwood
2:15 – 2:30	**BREAK**	Ballroom
2:30 – 3:45	**Session 3A: Special Protections and Public Health** IN: Drug and Alcohol, Mental Health, and Communicable Disease Data *Presenter: Viki Prescott, JD, Regenstrief Institute* ME: Dissemination of Data to Public Health Authorities *Presenter: Jonathan Harvell, Vice President, Information Technology and Administration, Maine Health Information Center* **Moderator:** Joy Pritts, JD Health Policy Institute, Georgetown University	Potomac/ Bethesda
	Session 3B: Trust in Security UT: Intra-agency Sharing *Presenter: Lois Haggard, PhD, Director, Office of Public Health, Utah Department of Health* CA: Adoption of Common Privacy and Security Standards *Presenter: Bobbie Holm, Chief, Policy Management Branch, California Office of HIPAA Implementation* **Moderator:** John Christiansen, JD Christiansen IT Law	Chevy Chase/ Rockville

	Session 3C: Intersection Between State Laws and Federal Regulations NC: Clinical Laboratory Improvement Amendments (CLIA), 42 C.F.R. § 493.2: Issue and Proposed Solutions *Presenter: Don Horton, JD, Labcorp* WV: Framing the Issue: Amendment to State Medicaid Plan *Presenter: Les DelPizzo, MA, MSW, COO Quality Insights of Delaware* **Moderator:** Patricia MacTaggart, MBA Health Management Associates	Democracy/ Montgomery
	Session 3D: HIPAA for HIEs and Non-Covered Entities OR: Entities Handling PHI That Are Not Covered by HIPAA *Presenter: Jody Pettit, MD, Office for Oregon Health Policy & Research* CO: HIPAA as Applied to the RHIO Concept *Presenter: Lynn Dierker, RN, Colorado Health Institute* **Moderator:** W. Braithwaite, MD, PhD Health Information Policy Consulting	Montrose/ Kenwood
3:45 – 4:00	**BREAK**	Ballroom
4:00 – 5:00	**Summary Reports for Day 1** Track A : Joy Pritts, JD, Institute for Health Policy, Georgetown University Track B : John Christiansen, JD, Christiansen IT Law Track C : Mike Hubbard, JD, Womble, Carlyle, Sandridge & Rice Track D : W. Braithwaite, MD, PhD, Health Information Policy Consulting	Ballroom
5:00 – 5:30	**Day 1 Closing Remarks** Susan Christensen, Senior Advisor, Agency for Healthcare Research and Quality Jodi Daniel, Director, Office of Policy and Research, Office of the National Coordinator for Health Information Technology	Ballroom

Future Directions: Privacy and Security Solutions

Tuesday, March 6

7:00 – 8:15	Networking Continental Breakfast	Ballroom
8:15 – 8:30	**Preview of Day 2 Activities** Linda Dimitropoulos, PhD RTI International	Ballroom
8:30 – 9:45	**TRACK A**: **REDUCING MISTRUST THROUGH EDUCATION AND OUTREACH**	Potomac/ Bethesda
	Session 4A: Educating Consumers About Risks and Rewards AK: Public Awareness of Risks Associated With Paper Charts and Benefits of Technology *Presenters: Rebecca Madison, Director, Alaska Chartlink, and Tom Nighswander, MD, ATAC/Alaska Native Tribal Health Consortium* CA: Reducing Mistrust and Confusion Among Patients *Presenters: Kathleen Delaney-Greenbaum, CalOHI, and Kier Wallis, CalRHIO* **Discussant:** Deven McGraw, JD National Partnership for Women & Families **Moderator/Discussant:** Joy Pritts, JD, Health Policy Institute, Georgetown University	
	TRACK B: MOVING FORWARD IN STATES AT DIFFERENT POINTS IN THE PROCESS	Chevy Chase/ Rockville
	Session 4B: Key Issues in States Planning the Move From Paper to Electronic HIE MS: Comfort in Paper: Bringing Stakeholders to the Table to Discuss Private and Secure Electronic Health Information Exchange *Presenter: Mary Helen Conner, BSN, MPH, CHES Information and Quality Healthcare* WY: Establishing the Wyoming HIE Policy Center *Presenter: Rex Gantenbein, Director, Center for Rural Health Research and Education* **Discussant:** Dennis Berens Director, Nebraska Office of Rural Health **Moderator/Discussant:** Vicki Y. Estrin, Vanderbilt Center for Better Health	

Future Directions: Privacy and Security Solutions

Tuesday, March 6

	TRACK C: GOVERNANCE AND LEADERSHIP FOR PRIVACY AND SECURITY SOLUTIONS	Montrose/ Kenwood
	Session 4C: Governance CA: Establishing a Statewide Privacy and Security Advisory Board (CA) *Presenters: Bobbie Holm, CalOHI, and Lori Hack, CalRHIO* WA: Governance Structure for Washington State Privacy and Security Solutions *Presenter: Greg Baumgardner, MS, Qualis Health* **Discussant:** David Sharp, PhD Maryland Healthcare Commission **Moderator:** John Christiansen, JD Christiansen IT Law	
	TRACK D: STATE LEGISLATION AND BUSINESS POLICIES	Ballroom
	Session 4D: Model Laws and Policies FL: Creating an Emergency Care Model Law for Interstate Health Information Exchange *Presenters: Christopher Sullivan, PhD, Technical Coordinator, and Carolyn Turner, MS, Government Analyst, FL AHCA* KS: Moving Toward a Consistent and Comprehensive Statewide Interpretation of HIPAA *Presenter: Jeff Ellis, JD, Attorney, Lathrop and Gage* **Discussant:** W. Grant Callow, National Conference of Commissioners on Uniform State Laws **Moderator:** Mike Hubbard, JD Womble, Carlyle, Sandridge & Rice	
9:45 – 10:00	**BREAK**	
10:00 – 11:15	**Session 5A: HIPAA Education: Why the Confusion and What Can We Do About It?** NJ: Perspectives From New Jersey *Presenter: William O'Byrne, Department of Banking and Insurance* Perspectives From Multiple States *Presenter: Susan Miller, JD* **Discussants:** Walter Suarez, MD, MPH Institute for HIPAA/HIT Education and Research Vicki Y. Estrin Vanderbilt Center for Better Health **Moderator:** W. Braithwaite, MD, PhD Health Information Policy Consulting	Potomac/ Bethesda

Future Directions: Privacy and Security Solutions

Tuesday, March 6

	Session 5B: Next Steps in States With Established Electronic HIEs	Chevy Chase/ Rockville
	MA: Next Steps for MA-HISPC *Presenter: Diane Stone* IN: Next Steps for Indiana *Presenter: Viki Prescott, JD, Regenstrief Institute* **Moderator/Discussant:** Mark Frisse, MD Vanderbilt Center for Better Health	
	Session 5C: Implementation	Montrose/ Kenwood
	RI: Managing Incremental Implementation Across Organizations *Presenter: Amy Zimmerman, MPH, Director, RI Health Information Exchange Project, and Laura Ripp, RPM Incorporated* UT: The Short-Term and Long-Term Models *Presenter: Francesca Garcia Lanier, MA, Coordinator/Project Manager, Utah Department of Health* **Discussant:** Susan Manning, JD RHIA Privacy Consultant **Moderator:** Ryan Bosch, MD FACP George Washington University	
	Session 5D: Model Forms and Business Agreements	Ballroom
	AZ: Interstate Memoranda of Understanding *Presenter: Kristen B. Rosati, JD, Coppersmith, Gordon, Schermer & Brockelman PLC* CT: Establishing Uniform HIE-wide Exchange Policies *Presenter: John Lynch, MPH, CT HISPI Associate Project Director* **Discussant:** Susan Brown Iowa Foundation for Medical Care **Moderator:** John Christiansen, JD Christiansen IT Law	
11:15 – 11:30	**BREAK**	
11:30 – 12:15	**Summary Reports on Tracks A, B, C, D** W. Braithwaite, MD, PhD, Health Information Policy Consulting Vicki Y. Estrin, Vanderbilt Center for Better Health Mark Frisse, MD, Vanderbilt Center for Better Health John Christiansen, JD, Christiansen IT Law Mike Hubbard, JD, Womble, Carlyle, Sandridge & Rice	Ballroom
12:15 – 12:30	**Final Comments**	Ballroom

APPENDIX G
A MODEL FOR ASSESSING AND CATEGORIZING THE STAGE OF DEVELOPMENT OF HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE ACROSS HISPC-PARTICIPATING STATES

Table G-1. State Health Information Exchange (HIE) Profiles

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Alaska	Yes	One starting in 2007	Completed	Lead entity identified; board established; committees established State gov. role: active participant	No	No	Yes	AK-RHIO or Alaska ChartLink, a project under the Alaska TeleHealth Advisory Council (state gov. body)	No	already in place ■ Recommend legislation to authorize entity
Arizona	Yes	SAHIE—Southern AZ Health Info Exchange	Completed	Lead organization identified; board established; committees established Roadmap completed State gov. role: lead facilitator	Starting roadmap implementa-tion	No	Yes	Arizona Health-e Connections ■ Nonprofit ■ Created by executive order and legislation	http://www.azhec.org/	■ Lead entity already in place ■ Recommend legislation to address privacy and security issues
Arkansas	Yes	A few local and regional HIE efforts currently underway	Arkansas Telehealth Alliance currently examining HIE options	No	No	No	No	No Arkansas Telehealth Alliance formed by state	No	■ Lead entity not identified ■ No legislative recomm. done
California	Yes	Several regional HIEs, including OCPRHIO, Mendocino HIE, Santa Cruz RHIO	Completed	Lead entity identified; board established; committees established Strategic plan completed State gov. role: active participant	Vendor selection completed	No	Yes	CalRHIO ■ Nonprofit ■ Not created by legislation or executive order	http://www.calrhio.org/	■ Lead entity already in place ■ Recommend legislation to establish several privacy and security committees

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Colorado	Yes	Several regional HIEs: InfoLinks, CO Quality Health Network, Integrated Physic. Network, Health Track, Northern CO Health Alliance, CO Health Info Exchange	Foundational planning completed	Currently in the process of incorporating organization	No	No	Yes	COHIE or CORHIO ■ Independ. statewide public/priv. coalit. ■ Not yet formal entity ■ Hosted by the CO Health Institute	http://www.corhio.org/	■ Lead entity already in place
Connecti-cut	Yes	Connecticut Health Info Network (CHIN)	Foundational planning completed	Lead entity identified; board established Strategic plan to be developed State gov. role: active participant	No	No	Yes	eHealth Connecticut ■ Nonprofit ■ Not created by legislation or executive order	http://www.ehealthconnecticut.org/	■ Lead entity already in place ■ Recommend legislation to authorize roles of statewide HIE org.
Florida	Yes	Several other regional HIEs, including three RHIOs (Big Bend RHIO, Palm Beach Comm. Health Care Alliance, and Tampa Bay RHIO)	Completed	Lead organization identified; board established; committees established Detailed project plan and roadmap completed State gov. role: lead facilitator	Early steps being taken Legislation establishing FHIN corporation, project budget introduced	No	Yes	FHIN, Florida Health Information Network ■ Created under the Governor HII Adv. Council ■ Not an independ. entity	http://ahca.myflorida.com/dhit/index.shtml	■ Lead entity already in place ■ Legislation to establish FHIN corp. introduced

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Illinois	Yes	Some regional HIEs including the IL Health Information Network (ILHIN), the Northern IL Physicians for Connectivity, Kane Comm. Health Access Integ. Network (KCHAIN)	IL Electronic Health Records Task Force recommended in December 2006 to establish a nonprofit entity, the ILHIN	Discussions on the IL EHR TF recommenda-tions currently underway	No	No	No	No IL Electronic Health Records Task Force (formed by state) recommended in December 2006 to establish the ILHIN	http://www.idph.state.il.us/ehrtf/ehrtf_home.htm	■ Recommend to create the ILHIN—Illinois Health Information Network
Indiana	Yes	Yes, including MichIana Health Information Network, Bloomington eHealth Collaborative, and Fort Wayne health information network	Completed	Completed	Completed	Operating HIE in central Indiana, with eventual statewide implement. State gov. role: active participant	Yes	IN Health Information Exchange ■ Nonprofit ■ Not created by legislation or executive order	http://www.ihie.org/	■ Lead entity already in place ■ No Legislat. recomm.
Iowa	Yes	IA HIT Initiative	Formed steering committee Currently developing plan State gov. role: active participant	No	No	No	No	No The IA Medical Society, in partnership with the IA Foundation for Medical Care started the IA Health Inform. Technology Initiative	http://www.iowamedical.org/HIT/index.htm	■ Recommend to create the IA-RHIO

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Kansas	Yes	Some regional HIEs including InfoLinks, KS Public Health eXchange Health-e Mid-America, Central Plains Regional HC Foundation, Comm. Health Record Pilot in Wichita	Formed steering committee Developed a roadmap identifying foundational, organizational, environmental actions	No	No	No	No	No KS Health Care Cost Containment Commission oversees development of a plan for KS	No Roadmap report at http://www.governor.ks.gov/ltgov/healthcare/items/roadmap.pdf	■ Monitor developm. of state RHIEs ■ No legislat. on forming statewide HIE
Kentucky	Yes	HealthBridge (Northern KY), Louisville Health Information Exchange (LouHIE), Northeast Kentucky RHIO	Completed	Lead organization identified; board established; committees formed The State e-Health Action Plan was released April 2007 State gov. role: colead facilitator	No	No	Yes	Kentucky e-Health Network ■ Created by state legisl. ■ Board appointed ■ Not a separate entity	http://www.ehealth.ky.gov/	■ Entity already created by state law
Louisiana	Yes	Several regional HIEs including Bayou Tech Community Health Net, Catahoula Consortium on HIE, LA Rural Health Information Tech Partnership, Partnership for Access to Healthcare	The LaHIE Project (funded by ONC) completed its assessment and developed a roadmap Recently, LA is undertaking a Healthcare Redesign Project, of which Health IT is a central component	Currently aligning the LaHIE project with the Healthcare Redesign Project State gov. role: lead facilitator	No	No	Yes	Louisiana Health Information Exchange (LaHIE) ■ An ONC-funded project Governor's "Louisiana Healthcare Redesign Project" underway	http://www.dhh.louisiana.gov/offices/?ID=288	■ Recommend to establish the LA Health Info Tech and Exchange Organization.

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Maine	Yes	Health IT and EHR integration projects underway at 2 largest provider systems in state	Completed	Lead organization identified; board established; committees established Strategic plan completed State gov. role: active participant	Vendor selection completed	No	Yes	Maine HealthInfoNet ■ Nonprofit ■ Not created by legislation or executive order	http://www.hinfonet.org/	■ Entity already in place ■ Legislation being considered to provide funding support for implement.
Massachu-setts	Yes	Some regional HIE initiatives including MA-Share, NEHEN, RxGateway, Clinical Data Exchange Gateway, MA e-Health Collaborative	Completed	Lead organizations identified; boards established; committees established Strategic plan completed State gov. role: active participant	Participated in the implementa-tion of NHIN pilots Implementing local HIE pilots in 3 communities	No	Yes	MA-SHARE ■ Nonprofit Mass eHealth Collaborative ■ Nonprofit	MA-SHARE http://www.mahealthdata.org/ma-share/mission.html MAeHC http://www.maehc.org/communities.html	■ Entities already in place

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/ Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Michigan	Yes	Several regional HIEs including Capital Area RHIO, Greater Flint Health Coalition, Holland Regional Effort, Michigan Health Infrastructure, Michigan Health Info. Alliance, Michigan Upper Peninsula Health IT Network, Southeast Michigan HIE, Thumb Rural Health Network	In December 2006, completed the MiHIN Conduit to Care strategic planning report identifying mission, goals, principles, and short-term/long-term next steps for the statewide HIE initiative	State legislature passed a law in 2006 to create the Health Information Technology Commission, and appropriated $9.5 million to support regional HIE projects RFPs are issued for $5.0 million regional HIE projects State gov. role: lead facilitator	No	No	No	Michigan Health Information Network—MiHIN ■ Governm. convened ■ Not a separate entity	http://www.michigan.gov/mihin	■ Legislation passed in 2007 to create HIT Commission
Minnesota	Yes	Several regional HIEs including Comm. Health Info. Collab, MN Rural Health Coop., MN Wilderness health care coalition, MN HIPAA Collaborative, Winona Health Community Record Exchange	Completed	Lead organizations identified; boards established; committees established Strategic plan completed State gov. role: lead facilitator	No	No	Yes	MN eHealth Initiative ■ Public/ private Collab. ■ Created by Legis. MN Health Care Connections ■ Nonprofit	http://www.health.state.mn.us/e-health/index.html	■ Landmark legislation requiring adoption of EHR by all health care organizations by 2015 being considered ■ Several legislative amendments addressing privacy issues

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Mississippi	Yes	MS is a member of the Gulf Coast Health Info. Technology Task Force, a collaborative group involving TX, LA, AL, and MS to develop a plan for a technology infrastructure in the region	In March 2007, the governor issued an executive order creating the MS Health Information Infrastructure Task Force, charged with developing an overall strategy for the statewide adoption and use of HIT and HIE State gov. role: lead convener	No	No	No	No	Health Information Infrastructure Task Force	http://www.governorbarbour.com/proclamations/Executive%20Order%20Home%20Page/EO-HealthInfrastructure.htm	■ Governor issued executive order creating first Health Info Infrast. Task Force

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/ Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
New Hampshire	Yes	Some regional HIE initiatives: Capital Regional Health Care's Centricity EMR project, Electronic Comm. Across Provider Settings, NH TeleHealth Planning Group, and the North Country Health Consortium	NH Citizens Health Initiative convened in 2006 the second "NH Connect for Health" summits A roadmap is being developed under the auspices of UNH and NH Citizens Health Initiative, to define strategy for governance, sustainability, clinical use, technical approach, and privacy/ security State gov. role: active participant	No	No	No	No	No NH Interconnectiv-ity Project, created by NH Citizens Health Initiative and the Univ. of New Hampshire is facilitating the initial planning phases of the statewide HIE	No	No

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
New Jersey	Yes	Yes	The NJHA convened an EHR/EMR task force that recommended an extensive business plan/ feasibility study In December 2006 NJHA and BCBS commissioned a more comprehensive feasibility study and plan State gov. role: colead facilitator	No	No	No	No	No NJ Hospital Association (NJHA) commissioned a RHIO feasibility study	HISPC website: http://www.state.nj.us/dobi/njhispc.html	■ Legislation already in place authorizing the Dept of Banking/ Insurance to promulgate rules to adopt EHRs in state

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
New Mexico	Yes	Yes—Taos, NM	NMHIC is a statewide public and private collaboration supported by the Lovelace Clinic Foundation to develop a statewide HIE	Lead organization identified; board established; committees formed State gap analysis and implementation plan completed State gov. role: active participant	Three major network elements in place: a patient index or medical record locator, an infrast. for transmitting HI, and a mechanism to exchange clinical messages electronically and securely 10 particip. organizations signed in Electronic referral process underway	No	Yes	New Mexico Health Information Collaborative ■ Nonprofit	http://www.lcfresearch.org/nmhic-hie	Solicited financial support from state legislature

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
New York	Yes	Several regional HIEs including Taconic IPA, New York City Primary Care Information Project, Federal-State Health Reform Partnership (F-SHRP), New York e-Health Collaborative (NYeC), New York State Health Information Technology Evaluation Collaborative (HITEC)	HIT Stakeholders Group Planning Committee convened by NY Dept. of Health to develop recommenda-tions on mission, goals, and structure	NY eHealth Collaborative formed in November 2006 Next step: develop a roadmap and strategic plan State gov. role: active participant and funder	No	No	No	No NY State Dept of Health administers the HEAL NY grant funding for HIT/HIE ($52 million) NY e-Health Collaborative ■ Nonprofit ■ Created in November 2006	NY Dept of Health http://www.health.state.ny.us/technology/ NY eHealth Collaborative http://www.uhfnyc.org/pubs-stories3220/pubs-stories_list.htm?attrib_id=14783	■ The HEAL NY program provided $52 million to support HIT/HIE
North Carolina	Yes	Several regional HIEs including Western NC Health Network; NC Healthcare Quality Initiative (NCHQI); NC Emergency Department Database, Emergency Surveillance System, and Disease Event Tracking and Epidemiologic Collection Tool; NC NHIN prototype pilot projects	Several regional HIT/HIE projects or topic-specific project with statewide scope No efforts to establish a statewide HIE are currently underway	Lead organization identified; Board established; Committees formed The State gap analysis and implementation plan to be developed State gov. role: active participant	No	No	Yes	NCHICA serves as statewide facilitator ■ Nonprofit	http://www.nchica.org/	■ No

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Ohio	Yes	Health Policy Institute of Ohio, The Center for Healthy Communities (CHC) in Dayton, HealthBridge in Cincinnati, The Comm. Health Alliance of Northwest OH-Toledo, NEORHIO, The Appalachian Regional Informatics Consortium (ARIC)	Health Policy Institute of Ohio developed a roadmap for state HIT/HIE adoption	Statewide roadmap was issued December 2006 State gov. role: active participant	No	No	No	No Health Policy Institute of Ohio has served as facilitator	http://www.healthpolicyohio.org/publications/HITRoadmap.html	■ General support to be pursued in 2007 from state legislature
Oklahoma	Yes	The Health Improvement Collaboration in Cherokee County	No central coordinated effort to develop a statewide HIE HISPC seen as an initial step towards moving in such direction State gov. role: lead facilitator	No	No	No	No	No	No	■ Recommend that legislation create the Office of Health Information Technology

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Oregon	Yes	Oregon Health Information Infrastructure Project, Our Community Health Information Network (OCHIN), South Coast Ruralhealth Integrated Provider Team (SCRIPT)	A high-level report describing options for action towards HIE was released in November 2006 by the OR Business Council Council has commissioned a comprehen. study on business case, finance, and mobilization for a state HIE demonstration project	No	No	No	No	No Oregon Health Care Quality Corp. is facilitating initial planning process	http://www.q-corp.org/q-corp/default.asp?id=13	■ No
Puerto Rico	Yes	PR Dept. of Health and major local hospitals	The PR Dept. of Health is implementing the PR Integrated Health System (statewide Master Patient Index) PR Healthcare Information Network (PRHIN) Unsure about status	No	No	No	No	No The PR Dept. of Health is implementing an integrated hospital information system and EHR across its hospital facilities and medical centers	PR HISPC http://www.salud.gov.pr/HISPC/Pages/default.aspx PR Integrated Health System http://www.ciracet.com/recentprojects-06-1.htm	No

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Rhode Island	Yes	RI is 1 of 6 states to be awarded a "State and Regional Demonstrations of Health IT" grant to support the development of a statewide HIE; the State General Assembly also approved $20 million revenue bond to support HIE infrastructure expansion	Completed	Lead organization identified; board established; committees formed State strategic plan and roadmap completed State gov. role: colead facilitator	Initial implementation of key infrastructure components underway	No	Yes	RI HIE ■ A Project of the RI Quality Institute	http://www.riqi.org/matriarch/MultiPiecePage.asp_Q_PageID_E_25_A_PageName_E_StrategicInitTTCHealthInfoExch	No
Utah	Yes	Statewide effort	Completed	Lead organization identified; board established; committees formed State strategic plan and roadmap completed State gov. role: active participant	Early piloting and implementation of clinical HIE underway	Operating statewide network for administrative HIEs	Yes	UHIN—Utah Health Information Network ■ Nonprofit	http://www.uhin.com/	No

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Vermont	Yes	Several regional and local HIE efforts	VITL had completed a preliminary VT Health Info. Technology Plan for the implement. of a statewide HIE effort Final plan is due to state legislature by July 1, 2007	Lead entity identified; board established; committees formed State strategic plan/roadmap completed State gov. role: active participant	No	No	Yes	Vermont Health Information Tech Leaders ■ Nonprofit ■ Not created by state law	http://www.vitl.net/	No
Washing-ton State	Yes	Several regional HIE efforts	State HCA and Health Info. Infrast. Advisory Board completed the "Washington Health Info. Infrastructure Roadmap for State Action" report in December 2006	Recommenda-tion to establish board to oversee initiative, provide funding, and move to implement statewide initiative	No	No	No	Washington State Health Care Authority and Health Information Infrastructure Advisory Board ■ State Agency ■ Advisory Board	http://www.hca.wa.gov/hit/	Yes
West Virginia	Yes	West Virginia eHealth Initiative—NHIN prototype participant; Boone County Community Care Network	Roadmap completed and approved by board in September 2006 http://www.statejournal.com/story.cfm?func=viewstory&storyid=14552	Lead entity identified; board established; state strategic plan and roadmap completed State gov. role: active participant	No	No	Yes	West Virginia Health Information Network ■ Established by law ■ Under state's Health Care Authority	http://www.wvhin.org/home.aspx	No

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Table G-1. State Health Information Exchange (HIE) Profiles (continued)

State	Single-Entity HIT Efforts	Local/Regional HIE Initiatives	Statewide HIE: Early Planning	Statewide HIE: Establish Foundation Components	Statewide HIE: Early Implement.	Statewide HIE: Functional, Operating Implement.	State-wide Org.	Statewide Organization Name, Origin	Statewide HIE Website	HISPC Project Recommended Solutions Related to Statewide HIE
Wisconsin	Yes	Several regional HIEs	WI eHealth Care Quality and Safety Board delivered in December 2006 the *eHealth Action Plan*, providing a roadmap for statewide HIE implement	Lead organization identified; board established; committees formed State strategic plan and roadmap completed State gov. role: colead facilitator	No	No	Yes	WI eHealth Care Quality and Safety Board ■ Executive Order ■ Not an independent entity	http://ehealthboard.dhfs.wisconsin.gov/	No
Wyoming	Yes	Some regional HIEs including Laramie		Lead organization identified; board established; currently working on an assessment of HIT adoption in the state State gov. role: active participant	No	No	Yes	WyHIO – Wyoming Health Information Organization ■ Nonprofit	http://www.wyhio.org/	Yes

APPENDIX H
GLOSSARY OF ACRONYMS

Glossary of Acronyms

AHIC	American Health Information Community
AHIMA	American Health Information Management Association
AHRQ	Agency for Healthcare Research and Quality
AT	assessment tool
AVAS	Assessment of Variation and Analysis of Solutions
BAA	Business Associate Agreement
CBPM	Community-Based Participatory Model
CCHIT	Certification Commission for Health Information Technology
CEU	continuing education unit
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
DHS	designated health services
ED	Department of Education
EHR	electronic health record
FERPA	Family Education Rights and Privacy Act
HIE	health information exchange
HIPAA	Health Insurance Portability and Accountability Act
HISPC	Health Information Security and Privacy Collaboration
HIT	health information technology
HITSP	Health Information Technology Standards Panel
IPWG	Implementation Plan Work Group
IT	information technology
LOUHIE	Louisville Health Information Exchange
LWG	Legal Work Group
MOU	memorandum of understanding
MPI	Master Patient Index
NCCUSL	National Conference of Commissioners on Uniform State Laws
NCVHS	National Committee for Vital Health Statistics
NGA	National Governors Association
NHIN	Nationwide Health Information Network
NPI	National Provider Identifier
NPP	notice of privacy practices
NRC	National Resource Center
OCR	Office for Civil Rights
OIG	Office of the Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
PKI	public key infrastructure

RFP	Request for Proposals
RHIO	regional health information organization
RLS	record locator service
SC	steering committee
SNO	Sub Network Organization
SWG	Solutions Work Group
TAP	Technical Advisory Panel
TPO	treatment, payment, and health care operations
UCC	Uniform Commercial Code
USC	United States Code
VWG	Variations Work Group