

MINNESOTA OPERATIONAL PLAN FOR HEALTH INFORMATION EXCHANGE

*A Companion Document to the Minnesota Statewide Implementation Plan Released June 2008:
A Prescription for Meeting Minnesota's 2015 Interoperable Electronic Health Record Mandate*

-and-

Minnesota Strategic Plan for Health Information Exchange

July 2010



Minnesota e-Health Initiative Advisory Committee *and the*
Minnesota Department of Health

MINNESOTA OPERATIONAL PLAN FOR HEALTH INFORMATION EXCHANGE

Table of Contents

ACKNOWLEDGEMENTS	4
EXECUTIVE SUMMARY	7
STRATEGIC PLAN SUMMARY	8
PART 1:	
GOAL 1 - Enable interoperable health information exchange within Minnesota, across state borders and with the National Health Information Network (NHIN)	12
Governance Domain.....	12
Technical Infrastructure Domain.....	21
Legal and Policy Issues Domain.....	26
Finance Domain.....	28
Business and Technical Operations Domain.....	31
GOAL 2 - Ensure trust and support for a statewide approach to health information exchange	39
GOAL 3 - Create synergies and leverage resources available through all state and federal programs to support health information exchange and the effective use of HIT to improve health and health care	42
Goal 4: Improve coordination of care, quality of care, and health outcomes and decrease health care costs in Minnesota through health information exchange and meaningful use of electronic health records	47
PART 2: PROJECT RISK MANAGEMENT PLAN	50
PART 3: PROJECT SCHEDULE	52
PART 4: APPENDICES	72
Appendix A: 2010-2011 Health Information Exchange Workgroup Charge	
Appendix B: 2010-2011 Adoption and Meaningful Use Workgroup Charge	
Appendix C: 2010-2011 Standards and Interoperability Workgroup Charge	
Appendix D: 2010-2011 Privacy, Legal and Policy Issues Workgroup Charge	
Appendix E: 2010-2011 Communications and Outreach Workgroup Charge	
Appendix F: 2010-2011 Minnesota e-Health Communications Plan and Workplan	
Appendix G: 2010 Session Law Chapter 336	

- Appendix H: UM-HIE Proposal
- Appendix I: State Government Health Information Exchange Steering Committee Charge
- Appendix J: OHIT Public Health Collaboration Workgroup Charge
- Appendix K: Minnesota e-Health Connect Budget

ACKNOWLEDGEMENTS

The Minnesota Department of Health thanks the many members of the Minnesota e-Health Initiative for their ideas, their expertise and their time in developing the Operational Plan to accompany the Minnesota Strategic Plan for Health Information Exchange.

Minnesota e-Health Initiative Advisory Committee Members (2009 – 2010)

<p>Walter Cooney, JD Advisory Committee Co-Chair Executive Director Neighborhood Health Care Network Representing: Community Clinics and Federally Qualified Health Centers</p>	<p>Jennifer Lundblad, PhD Advisory Committee Co-Chair President and Chief Executive Officer Stratis Health Representing: Quality Improvement Organization</p>
<p>Alan Abramson, PhD Senior Vice President, IS&T and Chief Information Officer HealthPartners Representing: Health Plans</p>	<p>Barry Bershow, MD Medical Director, Quality & Informatics Fairview Health Services Representing: Expert in Clinical Guideline Development</p>
<p>Laurie Beyer-Kropuenske, JD Director, Information Policy Analysis Division Department of Administration Representing: Minnesota Department of Administration</p>	<p>RD Brown Consumer Advocate Representing: Consumers</p>
<p>Angie Franks Senior Vice President of Sales & Market Development Healthland Representing: Vendors of Health Information Technology</p>	<p>Tim Gallagher Vice President of Pharmacy Operations Astrup Drug, Inc. Representing: Pharmacists</p>
<p>Raymond Gensinger, Jr., MD Chief Medical Information Officer Fairview Health Services Representing: Professional with Expert Knowledge of Health Information Technology</p>	<p>John Gross Director, Health Care Policy Minnesota Department of Commerce Representing: Minnesota Department of Commerce</p>
<p>Maureen Ideker, RN SISU Medical Systems Representing: Small and Critical Access Hospitals</p>	<p>Julie Jacko, PhD Director, The Institute for Health Informatics University of Minnesota Representing: Academics and Clinical Research</p>
<p>Paul Kleeberg, MD Clinical Director Key Health Alliance Representing: Physicians</p>	<p>Marty LaVenture, PhD Director, Office of Health Information Technology Minnesota Department of Health Representing: Minnesota Department of Health</p>
<p>Bobbie McAdam Director, e-Business Medica Representing: Health Plans</p>	<p>Walter Menning Vice Chair, Information Services Mayo Clinic Representing: Health System Chief Information Officers</p>
<p>Charlie Montreuil Vice President, Enterprise Rewards and Corporate Human Resources Best Buy Representing: Health Care Purchasers and Employers</p>	<p>Brian Osberg Assistant Commissioner Minnesota Department of Human Services Representing: Minnesota Department of Human Services</p>
<p>David Osborne Director of Health Information Technology/ Privacy Officer Volunteers of America Representing: David Osborne</p>	<p>Joanne Sunquist, RN Chief Information Officer Hennepin County Medical Center Representing: Large Hospitals</p>

Mary Wellik Director Olmsted County Public Health Services Representing: Local Public Health	Bonnie Westra, RN, PhD Assistant Professor University of Minnesota, School of Nursing Representing: Nurses
Tamara Winden Health Informatics Specialist Allina Hospitals and Clinics Representing: Laboratories	Marty Witrak, PhD, RN Professor, Dean, School of Nursing College of St. Scholastica Representing: Academics and Research
John Whisney Director of Ridgeview Clinics Ridgeview Medical Center Representing: Clinic Managers	Cheryl Stephens Executive Director Community Health Information Collaborative Ex-Officio Exchange Liaison: CHIC
Michael Ubl Executive Director Minnesota Health Information Exchange Ex-Officio Exchange Liaison: MN HIE	

Minnesota e-Health Initiative Advisory Committee Designated Alternates

Megan Daman, RN, MA Nurse Manager University of Minnesota Medical Center Alternate Representing: Nurses	Becki Hennings Medical Laboratory Technician St. Michaels's Hospital Alternate Representing: Laboratories
John Hofflander Senior Vice President and Chief Information Officer PreferredOne Alternate Representing: Health Plans	Martha LaFave Health Fund Coordinator Internaitonal Union of Operating Engineers Local 49 Alternate Representing: Health Care Purchasers & Employers
Melinda Machones, MBA Health IT Consultant Alternate Representing: Professional with Expert Knowledge of Health Information Technology	Justin McMartin Government Coordinator LSS Systems Alternate Representing: Vendors of Health IT
Julie Ring Director Local Public Health Association of Minnesota Alternate Representing: Local Public Health	Phil Riveness Associate Administrator Noran Neurological Clinic Alternate Representing: Clinic Managers
Rebecca Schierman, MPH Manager, Quality Improvement Minnesota Medical Association Alternate Representing: Physicians	Peter Schuna Director of Strategic Initiatives Pathway Health Services Alternate Representing: Long Term Care
Mark Sonneborn Vice President, Information Services Minnesota Hospital Association Alternate Representing: Hospitals	Kenneth Zaiken, PMP Consumer Advocate Alternate Representing: Consumers

Minnesota e-Health Initiative Workgroup Leadership

<p>Health Information Exchange and Meaningful Use of Electronic Health Records Workgroup Co-chairs: Alan Abramson, PhD Paul Kleeberg, MD</p>	<p>Standards and Interoperability Workgroup Co-chairs: Bobbie McAdam Mike Ubl</p>
<p>Privacy and Security Workgroup Co-chairs: Laurie Beyer-Kropuenske, JD Darrell Shreve, PhD</p>	<p>Outreach and Communications Workgroup Co-chairs: Becky Schierman Mark Sonneborn Sue Severson</p>

Minnesota Department of Health Staff

Liz Cinqueonce	Mayumi Reuvers
Jennifer Fritz	Anne Schloegel
James Golden, PhD	Donna Watz, JD
Bob Johnson	Karen Welle
Martin LaVenture, PhD	Barb Wills
Priya Rajamani, MBBS, PhD	

EXECUTIVE SUMMARY

The Minnesota Strategic Plan for Health Information Exchange articulates the vision of the Minnesota e-Health Connect Program, health information exchange public good principles, strategic goals, objectives, strategies, and overall approach for achieving health information exchange statewide in Minnesota, across the continuum of care. The Minnesota Operational Plan for Health Information Exchange accompanies the Minnesota Strategic Plan for Health Information Exchange, and operationalizes how that plan will be implemented. The Minnesota Strategic and Operational Plans for Health Information Exchange engaged a broad base of stakeholders through: development and endorsement by Minnesota e-Health Workgroups and the Advisory Committee; a two-week public comment period for the Strategic Plan; and a four-week public comment period for the Operational Plan. The Minnesota Operational Plan for Health Information Exchange is a living document and will be modified as needed and will represent the voices of a broad spectrum of stakeholders. This Operational Plan was developed based on the following principles.

Principles for the Minnesota Operational Plan for Health Information Exchange

The Minnesota Operational Plan for Health Information Exchange will:

- Garner stakeholder support through the Minnesota e-Health Initiative and the Minnesota e-Health Advisory Committee infrastructure
- Ensure accountability and development of Minnesota health information exchange capacity over time by working with stakeholders to implement the Minnesota model of governance for health information exchange in Minnesota
- Build upon an existing statutory framework to enable health information exchange and establish a process for state certification of health information service providers
- Maximize the limited funding available to support health information exchange by minimizing duplication in costs associated with infrastructure development and building upon existing health information exchange services
- Move Minnesota toward universal interoperability among all providers

Ongoing Updates to Minnesota's Operational Plan for Health Information Exchange

Annual updates to Minnesota's Operational Plan for Health Information Exchange will provide Minnesota the opportunity to continually assess, plan, and implement the strategic approach for health information exchange. Updates to Minnesota's Operational Plan for Health Information Exchange will continue to engage broad-based stakeholder support and endorsement through the existing infrastructure of the Minnesota e-Health Initiative Advisory Committee and Policy Workgroups.

STRATEGIC PLAN SUMMARY

This *Minnesota Strategic Plan for Health Information Exchange*, through the *Minnesota e-Health Connect program*, builds upon the previous six-year effort of the *Minnesota e-Health Initiative*, whose vision has been to “*accelerate the adoption and effective use of health information technology to improve health care quality, increase patient safety, reduce health care costs and enable individuals and communities to make the best possible health decisions.*” Enabling the secure exchange of health information among health / health care stakeholders is essential to realizing the broad mission of the Minnesota e-Health Initiative.

To provide a brief overview, below are key excerpts of the Minnesota Strategic Plan for Health Information Exchange. The full plan may be located online at: www.health.state.mn.us/e-health/hitech/hitechmn.html.

2015 Interoperable Electronic Health Record Mandate in Minnesota and e-Health Standards Requirements

For the past six years, the Minnesota e-Health Initiative has laid the groundwork to enable statewide interoperability. As a result, Minnesota has a well-established infrastructure to assist in planning for statewide connectivity. Below are some of the recent activities that have and will continue to support planning efforts for statewide health information exchange.

In 2007, Minnesota enacted the first e-health mandate in the country which not only requires electronic health records but also emphasizes interoperability and the role of standards in making that happen. Minnesota statute, section 62J.495, states: “*By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. The commissioner shall include an update on standards development as part of an annual report to the legislature.*”

This mandate applies to all providers who deliver health services in the state of Minnesota and the facilities in which they practice to ensure that the benefits of e-health apply across the entire continuum of care. The statute also requires the Commissioner of Health, in consultation with the Minnesota e-Health Initiative Advisory Committee to monitor national activity related to health information technology and coordinate statewide input on policy development. The monitoring of proposed federal health information technology regulations and coordination of statewide response includes reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national Health Information Technology Standards Committee.

Minnesota e-Health standards are a requirement for electronic exchange of health information and achieving interoperability as required by the Minnesota 2015 mandate. Interoperability of EHR systems in Minnesota means the ability of two or more EHR systems or components of EHR systems to exchange information electronically, securely, accurately and verifiably, when and where needed. It is comprised of “technical,” “semantic” and “process” interoperability, and the

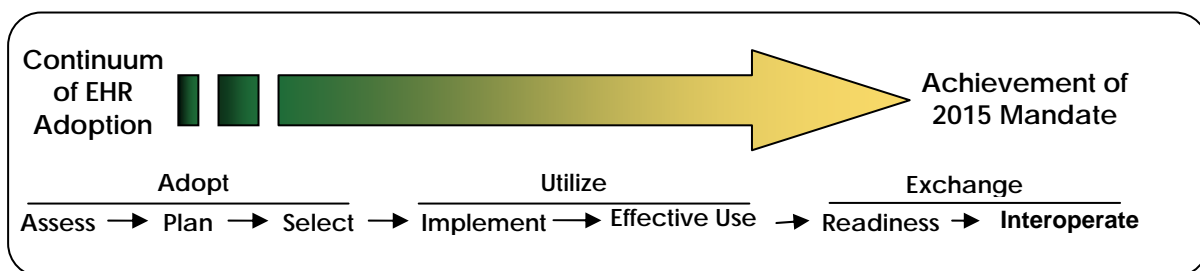
information exchanged includes transactions and standards as defined by the Minnesota Commissioner of Health.

Minnesota Model for Achieving Interoperability and Health Information Exchange

Much of the work of the Minnesota e-Health Initiative through 2008 focused on health information technology, particularly interoperable electronic health records adoption as it was the focus of the 2008 Plan, *Prescription for Meeting Minnesota’s 2015 Interoperable Electronic Health Record Mandate – A Statewide Implementation Plan*. In that plan, a model for the Minnesota health and health care community to meet Minnesota’s mandate for the adoption and use of interoperable electronic health records by 2015 was adopted (see Figure 1 below). The Minnesota model contains seven major steps in adopting, implementing and effectively using an interoperable EHR. The seven steps can, in turn, be grouped into three major categories:

- **Adopt**, which includes the sequential steps of assess, plan and select
- **Utilize**, which involves implementing an EHR product and learning how to use it effectively
- **Exchange**, which includes readiness to exchange electronically with other partners, and implementing regular, ongoing exchange between interoperable EHR systems

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



Since the Minnesota Model was adopted in 2008, the Minnesota e-Health Initiative has provided specific guidance to Minnesota providers working on adoption and utilization of EHRs. In 2009, the Minnesota e-Health Initiative turned its attention to addressing the third category on the Minnesota Model: Health Information Exchange. The full plan can be found at: www.health.state.mn.us/chealth.

THE MINNESOTA E-HEALTH CONNECT VISION

Through an integrated statewide approach, the Minnesota e-Health Connect Program will advance patient centered health information exchange that will:

- Provide Minnesotans with access to coordinated care each time they access the health care system, across the continuum of care
- Elevate the health of all Minnesotans by facilitating essential communications that support improvements in individual, community and public health
- Ensure that adequate protections are in place to maintain patient privacy, while enabling secure access to all of the information necessary to deliver the best possible care
- Empower Minnesotans with the information they need to work with their providers to achieve the best possible health outcomes
- Serve the citizens of Minnesota as a public good

HEALTH INFORMATION EXCHANGE PRINCIPLES: HEALTH INFORMATION EXCHANGE AS A PUBLIC GOOD

The following principles have guided Minnesota in establishing the vision for health information exchange:

- The improvement of health and health care for Minnesota citizens and communities is the central focus of statewide, interoperable health information exchange
- The need for secure exchange of health information is essential to transforming health care and improving the health of Minnesotans and must supersede technical, business, and bureaucratic barriers
- Health information exchange must provide functionality necessary to support meaningful use, and expand over time to provide for continuous improvement in quality and coordination of care
- The value of information increases with use, and the value of one set of information increases when linked with other information
- Consumption of HIE services by one health / health care stakeholder must not reduce availability for others, and no health / health care stakeholder can be effectively excluded from appropriately using interoperable HIE services

The Minnesota Strategic Plan for Health Information Exchange identifies four major goals with subsequent objectives and strategies to achieve those goals. All of the goals, objectives, and strategies can be found in Part 3 of the Minnesota Strategic Plan for Health Information Exchange. Table 1 below lists the four goals and the key objectives by the five critical domain areas identified by the Office of the National Coordinator.

Table 1. Minnesota Strategic Plan for Health Information Exchange Goals and Critical Domain Objectives

GOAL 1: Enable interoperable health information exchange within Minnesota, across state borders and with the Nationwide Health Information Network (NHIN).	
GOVERNANCE DOMAIN OBJECTIVE	Ensure an effective model for health information exchange governance and accountability.
TECHNICAL INFRASTRUCTURE DOMAIN OBJECTIVE	Expand technical infrastructure and services over time to facilitate the transactions necessary to support meaningful use, and support health information exchange across the continuum of care, including: <ul style="list-style-type: none"> ▪ Establishing a mechanism to promote utilization of nationally-recommended standards related to content exchange (vocabulary, messages, and documents), transport, privacy and security used for health information exchange ▪ Ensuring that standard operating procedures are in place that will assure role-based user authentication for both senders and receivers of electronic health information ▪ Certifying trust agreements between health information organizations and end users are in place, and addressing core content to ensure the health information accessed through health information exchange services are secure and confidential in compliance with federal and state privacy and security laws and best practices
LEGAL AND POLICY ISSUES DOMAIN OBJECTIVE	Ensure that a clear policy framework is established to enable health information exchange by providing requirements to ensure that information follows the patient and that patients' rights are protected.
FINANCE DOMAIN OBJECTIVE	Ensure the financial sustainability of health information exchange services beyond the Cooperative Agreement Program by: <ul style="list-style-type: none"> ▪ Ensuring state-certified HIOs maintain a business plan that clearly addresses financial sustainability beyond the cooperative agreement program ▪ Ensuring that a critical mass of Minnesota health / health care stakeholders are connected and utilizing HIE services ▪ Ensuring state-certified HIOs address specific barriers encountered by stakeholders related to technical, legal, financial, and/or organizational matters
BUSINESS AND TECHNICAL OPERATIONS DOMAIN OBJECTIVE	Oversee business and technical operations with clear articulation of: <ul style="list-style-type: none"> ▪ Responsibilities of the state and other health information exchange entities ▪ Approach to meet meaningful use requirements ▪ Efforts to coordinate and align efforts with Medicaid and public health requirements for HIE and meaningful use criteria ▪ Approach to leveraging existing HIE capability ▪ Plan for utilizing the Nationwide Health Information Network for information exchange between states with federal agencies
GOAL 2: Ensure trust and support for a statewide approach to health information exchange.	
GOAL 3: Create synergies and leverage resources available through all state and federal programs to support health information exchange and the effective use of HIT to improve health and health care.	
GOAL 4: Improve coordination of care, quality of care, and health outcomes and decrease health care costs in Minnesota through health information exchange and meaningful use of electronic health records.	

PART 1 OPERATIONAL PLAN TO ACHIEVE MINNESOTA GOALS FOR HEALTH INFORMATION EXCHANGE

GOAL 1: Enable interoperable health information exchange within Minnesota, across state borders and with the Nationwide Health Information Network (NHIN).

GOVERNANCE DOMAIN OBJECTIVE: Ensure an effective model for health information exchange governance and accountability.

The Minnesota Strategic Plan for Health Information Exchange (HIE) provided a significant amount of detail on Minnesota’s overall approach to governance of HIE, including the implementation of four primary strategies:

1. Multi-stakeholder approach to HIE policy development
2. HIE accountability, oversight and enforcement
3. Legal framework that includes criteria for governance within health information organizations
4. Mechanism for ongoing financing of HIE accountability, oversight and enforcement.

The following are the specific details on how the Minnesota Department of Health (MDH) and the Office of Health Information Technology (OHIT) will align operations to achieve Minnesota’s governance domain objective under Goal 1 utilizing these four strategies.

1. Multi-stakeholder approach to health information exchange policy development

The Minnesota Strategic Plan for Health Information Exchange outlined Minnesota’s intent to convene health / health care stakeholders through the existing e-Health Advisory Committee established under Minnesota Statutes, section 62J.495, to continue policy development across the five critical domains. In order to meet Minnesota’s goal to enable interoperable exchange within Minnesota, across state borders and with the Nationwide Health Information Network (NHIN), the workgroup structure outlined in Table 2 was adopted by the Minnesota e-Health Advisory Committee for 2010-2011.

Table 2. 2010-2011 Minnesota e-Health Initiative Advisory Committee and Workgroup Structure Interdependencies across the Five Domains of Health Information Exchange

Minnesota e-Health Initiative Committee, Workgroup (WG) or Subgroup (SG)	Governance	Finance	Technical Infrastructure	Business / Technical Operations	Legal / Policy
Advisory Committee ▪ HIE Review Panel	X	X	X	X	X
Health Information Exchange WG	X	X	X	X	X
Adoption & Meaningful Use WG ▪ Medicaid Advisory SG		X			
Standards and Interoperability WG ▪ Shared Services SG ▪ Security SG (as needed)			X		
Privacy, Legal & Policy WG					X
Communications and Outreach WG				X	

The Health Information Exchange Workgroup will serve as the lead workgroup in coordinating the development of statewide policy recommendations related to health information exchange into an integrated statewide approach across the five domains. In this capacity, the workgroup will serve to:

- Identify key issues that must be addressed to enable health information exchange
- Engage and rely on subject matter experts convened through the workgroups identified in Table 1, as necessary to address key issues identified
- Synthesize and incorporate input from each of the five workgroups into recommendations to the Minnesota e-Health Advisory Committee for inclusion in Minnesota's approach to HIE in Minnesota

See Appendix A for the 2010-2011 Health Information Exchange Workgroup charge. Appendices B-E also include the workgroup charges for the Adoption and Meaningful Use Workgroup, the Standards and Interoperability Workgroup, the Privacy, Legal and Policy Workgroup and the Communications and Outreach Workgroup.

Table 2 above identifies the cross-cutting issues and interdependencies between the 2010-2011 workgroups and a general framework for addressing policy matters across the five domains of health information exchange. Each of the workgroups will be composed of a diverse group of stakeholders to ensure the opportunity for public input on the specific topics to be addressed by each of the workgroups.

The Minnesota e-Health Communications Timeline provided in the 2010-2011 Minnesota e-Health Communication Plan in Appendix F outlines Minnesota's approach to broadly disseminate information regarding opportunities to participate in the 2010-2011 e-Health Initiative Workgroups and effectively engage stakeholders in discussions regarding health information exchange.

2. Health information exchange accountability, oversight and enforcement

The Minnesota Strategic Plan for Health Information Exchange outlined Minnesota's intent to use the Minnesota e-Health Advisory Committee recommendations on HIE which formed the basis for legislation passed in May 2010, granting the Commissioner of Health state oversight authority over entities engaged in health information exchange, and providing measures to ensure an open and transparent process as well as opportunities for public input from consumers and other stakeholders. See Appendix G to review a copy of Chapter 336 of the Laws of Minnesota 2010.

The Minnesota Department of Health Office of Health Information Technology will be responsible for working with the Commissioner to implement the new law. The new law also provided key definitions of entities participating in health information exchange activities, and outlines requirements for those providing health information exchange services. These service providers include:

Health data intermediary: an entity that provides the infrastructure to connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including pharmaceutical electronic data intermediaries as defined in 62J.495. This does not include health care providers engaged in direct health information exchange.

Health information organization: an organization that oversees, governs, and facilitates the exchange of health-related information among organizations according to nationally recognized standards.

agreements with other health information exchange service providers to ensure that information follows patients across the continuum of care.

Certified health data intermediaries are required to:

- Interoperate with at least one state-certified health information organization
- Provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization
- Have a record locator service as defined in Minnesota Statutes, section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions
- Hold reciprocal agreements with at least one state-certified health information organization to enable access to record locator services to find patient data, and for the transmission and receipt of meaningful use transactions consistent with the format and content required by national standards by Centers for Medicare and Medicaid Services

Certified health information organizations are required to:

- Be a legally established, nonprofit organization
- Have the appropriate and sufficient insurance, including liability insurance, for the operation of the health information organization to protect the interest of the public and participating entities
- Maintain strategic and operational plans that clearly address how the organization will expand technical capacity of the health information exchange organization to support providers in achieving meaningful use of electronic health records and providers across the continuum of care (e.g., public health, long-term care) over time. Annually submit strategic plans that address:
 - Increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability
 - Progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance
- Address the parameters to be used with participating entities and other health information organizations' participating entities and consumers
- Maintain a professional staff responsible to the board of directors with the capacity to ensure accountability to the organization's mission
- Be compliant with criteria established under the Electronic Healthcare Network Accreditation Commission (EHNAC) Health Information Exchange Accreditation Program (HIEAP) or equivalent criteria established by the Commissioner of Health
- Maintain a record locator service as defined in Minnesota Statutes section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions
- Demonstrate interoperability with all other state-certified health information organizations using nationally-recognized standards
- Demonstrate compliance with all privacy and security requirements required by state and federal law

- Use financial policies and procedures consistent with generally accepted accounting principles and have an independent audit of the organization’s financial books on an annual basis
- Meet the requirements established for connecting to the Nationwide Health Information Network (NHIN) with the federally-mandated timeline or within a timeframe established by the Commissioner of Health
- Develop and maintain a business plan that addresses:
 - Plans for ensuring the necessary capacity to support meaningful use transactions
 - An approach for attaining financial sustainability, including public and private financing strategies, and rate structures
 - Rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange
 - An explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing HIE services
- Annually submit a rate plan outlining fee structures for health information exchange services. The rate plan must:
 - Distribute costs equitably and among users of health information services
 - Provide predictable costs for participating entities
 - Cover all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers
 - Provide a predictable revenue stream for the health information organization and generate sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest
- Enter reciprocal agreements with all other state-certified health information organizations to enable access to record locator services to find patient data, and transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services

HIE Review Panel Established

The Commissioner of Health will appoint a five-member HIE Oversight Review Panel (“HIE Review Panel”), a sub-set of the Minnesota e-Health Advisory Committee, to participate in the hearings and the review process for applicants seeking Certificates of Authority to operate as HIE Service Providers in Minnesota. This HIE Review Panel will ensure consultation with appropriate stakeholders and coordination with the Minnesota e-Health Advisory Committee consistent with Minnesota Statutes section, 62J.498, subdivision 2(b) and section 62J.4982, subdivision 4.

The role of the HIE Review Panel will be to:

- Review applications from Health Information Organizations and Health Data Intermediaries and compile questions for applicants prior to public hearings
- Participate in Public Hearings and elect among themselves a lead panelist who will present questions to applicants at the hearings and coordinate review of public comments submitted following the hearing
- Provide to the Commissioner of Health written recommendations regarding certification of applicants to conduct HIE services in Minnesota and identify any related concerns
- Provide ongoing recommendations for improvement to the certification process
- Serve a term of no more than two years

The HIE Review Panel will include representation from the following 5 categories of stakeholders:

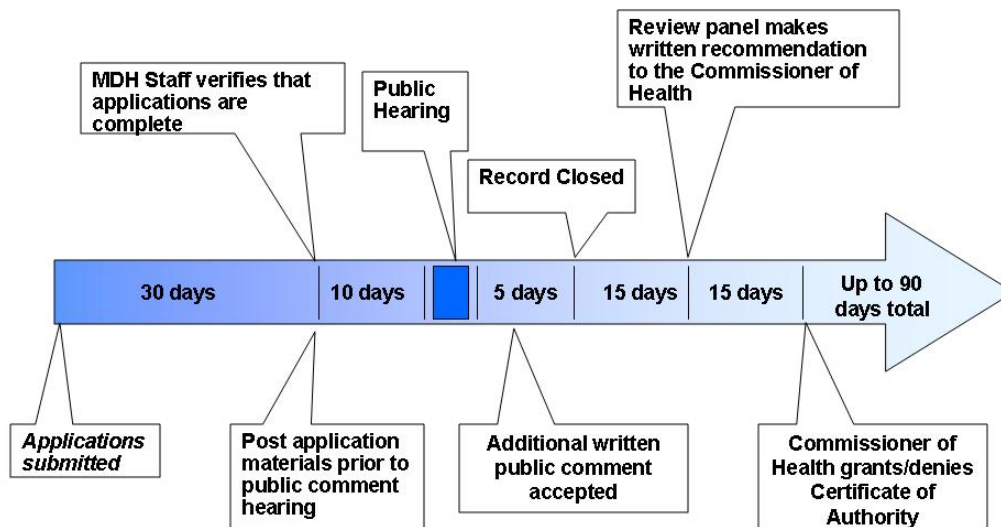
- Hospitals
- Physicians
- Other professionals eligible for incentives
- Other professionals in other settings not eligible for incentives
- Consumers

If an Advisory Committee member selected by the Commissioner of Health declines the appointment, the commissioner will select a designated alternate or a representative of the respective statewide association to serve on the panel. If the appointed member is unable to attend a meeting, a member of the appropriate statewide associations or a designated alternate may attend. Consistency and continuity of panel membership will be maintained to ensure stakeholders have the opportunity to participate in the review process; if a panel member is consistently unavailable to participate, the Commissioner of Health will appoint a different member of their respective category.

High-Level Timeline and Process for HIE Oversight

Minnesota Statutes, section 62J.498, subdivision 2, is specific with regard to how public hearings must be conducted and the timeline in which the Commissioner must respond to applications for certificates of authority submitted by health information exchange service providers. Figure 1 illustrates a high-level overview of the process and timeline that the commissioner and HIE Review Panel will use in meeting the requirements of this section.

Figure 2. Overview of Timeline and Process for HIE Oversight



The Project Schedule contained in Part Three of this Operational Plan provides specific detail on how MDH will move forward in notifying Minnesota stakeholders and health information exchange service providers of the new law, key activities related to start-up, and the first public hearings to consider applications for certificates of authority for health information organizations and health data intermediaries. The first hearings will be held in the fourth quarter of 2010 and HIE Service Providers who are currently operating or who have expressed an interest in operating in Minnesota will be sent information regarding the application process. Additional methods of public notices will be used to ensure that stakeholders and other interested entities are apprised of the application and hearing processes and the opportunities for public participation in the hearings.

Minnesota Statutes, section 62J.4981, outlines in detail the minimum criteria that an applicant must meet to obtain a certificate of authority to operate as an HIE service provider in Minnesota. The HIE Review Panel and the Commissioner will use the statutory requirements in the hearing and review process.

Authority to Enforce Minnesota Law

Minnesota Statutes, section 62J.4982, grants authority to the Minnesota Commissioner of Health to investigate any violation of statutes or rules applicable to an HIE service provider and to take administrative action in the event of a violation. The Commissioner has a range of options available in this process, including but not limited to: (1) arranging for a voluntary conference with alleged violators to discuss the facts about a suspected violation and find ways to correct or prevent it; (2) issuing orders to cause the entity to cease and desist from engaging in any act or practice in violation of the law; (3) issuing an administrative penalty; or (4) suspending or revoking a certificate of authority.

In addition, the Commissioner of Health will protect the public interest on matters pertaining to HIE by establishing a process for responding to public inquiries and complaints, monitoring HIE service providers to ensure compliance with state and federal law, and providing biennial reports on the status of HIE services in Minnesota, including recommendations on actions necessary to ensure that HIE services are adequate to meet the needs of Minnesota citizens and providers statewide.

Criteria for governance within health information organizations

The Minnesota Strategic Plan for Health Information Exchange called for measures within the statutory framework to ensure health information organization adherence to governance criteria, and provide processes for corrective action where necessary.

HIO Governance Criteria in the Law

Minnesota's law includes specific requirements for the governance of health information organizations that must be demonstrated in their application for a certificate of authority. These requirements include:

Minnesota Statutes, section 62J.498, subdivision 3. (5) the entity's board of directors is composed of members that broadly represent the health information organization's participating entities and consumers;(6) the entity maintains a professional staff responsible to the board of directors with the capacity to ensure accountability to the organization's mission;

Methods to demonstrate compliance will be developed and included in the application / certification process as specified in the Project Schedule contained in Part 3 of this Operational Plan. The Commissioner is allowed under Minnesota Statutes, section 62J.4982, to employ the use of various enforcement mechanisms, up to and including suspension and/or revocation of, a certificate of authority for any health information exchange service provider that fails to meet the statutory requirements. See Appendix G for Laws of Minnesota 2010 Chapter 336.

The HIE Review Panel will review criteria annually and report recommendations to the Minnesota e-Health Initiative Health Information Exchange Workgroup the Minnesota e-Health Initiative Advisory Committee.

Mechanism for the ongoing financing of health information exchange accountability, oversight and enforcement

The Minnesota Strategic Plan for Health Information Exchange called for a mechanism to provide for the ongoing financing of health information exchange accountability, oversight and enforcement to be established within the statutory framework. The new Minnesota law establishes application and certification fees under Minnesota Statutes, section 62J.498, to provide on-going financing of this aspect of governance. The new fees will become effective July 1, 2010, for health information exchange service providers. See Table 3 below.

Table 3: HIE Service Provider Application & Certification Fees

HIE Service Provider Type	One-Time Application Fee	Annual Certification Fee
HIO	\$10,500	\$14,000
HDI	\$7,000	\$7,000

Revenue Assumptions: In the first year of certification, an HIO and an HDI would pay both an application fee and a certification fee. Thereafter, these entities would just pay an annual certification fee. This fiscal analysis assumed that two health information organizations (HIO) and three health data intermediaries (HDI) will be granted certificates of authority in 2011, and that more HIO's and HDI's will be certified in subsequent years. This assumption would generate revenue as outlined in Table 4.

Table 4: Anticipated Revenue Based on Fees Established under Minnesota Statutes, section 62J.498

	Fee	HIE Service Providers	2011	HIE Service Providers	2012	HIE Service Providers	2013
HIO Application Fees	\$10,500	2	\$21,000	1	\$10,500	0	0
HDI Application Fees	\$7,000	3	\$21,000	2	\$14,000	2	\$14,000
HIO Annual Certification Fee	\$14,000	2	\$28,000	3	\$42,000	3	\$42,000
HDI Annual Certification Fee	\$7,000	3	\$21,000	5	\$35,000	7	\$49,000
TOTAL REVENUE			\$91,000		\$101,500		\$105,000

Expenditure Assumptions: MDH would require .75 FTE for SFY11, to start up oversight operations. Once routine operations have been established, .6 FTE would be required to perform on-going oversight functions.

Monetary penalties imposed for a violation of Minnesota Statutes, sections 62J.498-62J.4982, would be deposited into a revolving fund and used to cover any additional expenses associated with oversight in future years. These assumptions would require expenditures as outlined in Table 5.

Table 5: Anticipated Expenditures Associated with HIE Oversight Established under Minnesota Statutes, section 62J.498

EXPENDITURES	SFY09	SFY10	SFY11	SFY12	SFY13
Salaries	0	0	75	63	63
Other Operating Costs	0	0	9	15	15
Indirect Cost	0	0	20	19	19
TOTAL EXPENSES	0	0	104	97	97
TOTAL REVENUE	0	0	<91>	<102>	<105>
TOTAL	0	0	13	<5>	<8>

Long-Term Fiscal Considerations: In the event that modifications are necessary to ensure that fees established are sufficient to cover oversight expenses, the Minnesota Legislature would need to act to make any adjustments in the fees for application and/or certification of health information exchange service providers. Two long-term fiscal considerations have been identified that will need to be monitored to ensure this strategy is carried out successfully:

- If the estimate of health information organizations and health data intermediaries is too low, additional staff may need to be hired in the future

- If the estimate of health information organizations and health data intermediaries is too high, fees may need to be adjusted to cover the costs of oversight

Consistent with 62J.496, Subdivision 4 (b), the Commissioner will monitor the status of health information exchange in Minnesota, and include in the mandatory report to the Legislature in January 2011, recommendations on further action necessary to support health information exchange and related oversight activities, including any modifications necessary to ensure that fees established are sufficient to cover oversight expenses.

TECHNICAL INFRASTRUCTURE DOMAIN OBJECTIVE:

Expand technical infrastructure and services over time to facilitate the transactions necessary to support meaningful use, and support health information exchange across the continuum of care.

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota’s overall approach to technical infrastructure development necessary to enable statewide HIE, including the implementation of four primary strategies:

1. Ensure technical infrastructure is supported by Minnesota stakeholders and consistent with e-Health vision
2. Require all investments in HIE services to use nationally-recognized standards
3. Maximize funding available by leveraging current HIE mechanisms and building on existing infrastructure
4. Use an integrated approach to facilitate HIE across entities

The following are the specific details on how MDH and OHIT will align operations to achieve our technical infrastructure objective under Goal 1 utilizing these four strategies.

1. Ensure technical infrastructure is supported by Minnesota stakeholders and consistent with e-Health vision.

The Standards and Interoperability Workgroup will serve as the lead workgroup in coordinating the development of statewide policy recommendations related to health information standards and interoperability. In this capacity, the workgroup will serve to:

- Identify and recommend nationally-recognized standards, implementation specifications and certification criteria necessary to facilitate and expand the secure electronic movement and use of health information among organizations in Minnesota
- Review and comment on standards, implementation specifications and certification criteria related to the requirements of “meaningful use” and recommend resources and actions that will help increase implementation of these standards
- Review and comment on standards, technical infrastructure, or other technical requirements related to the implementation of statewide strategic and operational plans for health information exchange [Section 3013 of American Recovery and Reinvestment Act (ARRA)]

The Standards and Interoperability Workgroup will achieve the following deliverables in the 2010-2011 year.

- Provide review and feedback as necessary on HITECH activities including:
 - Identify, review and comment on proposed standards, implementation specifications and certification criteria for electronic exchange and use of health information (related to “meaningful use” requirements)
 - Coordinate specific meetings as needed to focus on security standards
 - Review and provide feedback on strategic and operational plans that support standards-based health information exchange as specified by Section 3013 of HITECH Act

- Convene a subgroup as needed to discuss and recommend an approach and technical details for creation and use of shared directories and related technical services, as applicable to the state’s approach for statewide HIE
- Identify implementation tools and resources promoted at the national level and disseminate tools, tips and templates to support statewide standards implementation
- Review plans of the regional extension centers to promote standards-based exchange of health information as part of “meaningful use” requirements and work collaboratively on resources and actions that will help increase implementation of these standards
- Update the tools and resources to support implementation of e-health standards including those that can help support achieving meaningful use
- Deliver a final draft of the 2011 update for Guide 2: Standards Recommended to Achieve Interoperability in Minnesota

The 2010-2011 Standards and Interoperability Workgroup will build upon the accomplishments of the previous three years’ work which is published in the 2010 edition of *Guide 2: Standards Recommended to Achieve Interoperability in Minnesota* at <http://www.health.state.mn.us/ehealth>. The workgroup will continue to look to key national standards activities for priorities, standards recommended, implementation specifications; certification criteria and timelines (See Appendix C for the 2010-2011 Standards and Interoperability Workgroup charge and process).

2. Require all investments in HIE services to use nationally-recognized standards.

Minnesota has a strong history of utilizing policy levers to require the use of nationally recognized standards, and providing consensus-based recommendations on implementation specifications, certification criteria and timelines consistent with the needs of the state’s health and health care community. Currently, Minnesota law includes requirements that health information organizations:

- Be compliant with criteria established under the Electronic Healthcare Network Accreditation Commission (EHNAC) Health Information Exchange Accreditation Program or equivalent criteria established by the Commissioner of Health
- Demonstrate interoperability with all other state-certified health information organizations using nationally-recognized standards
- Meet the requirements established for connecting to the Nationwide Health Information Network (NHIN) with the federally-mandated timeline or within a timeframe established by the Commissioner of Health
- Comply with specific national standards called out in law. The current recommendations on e-health standards are available in the 2010 edition of *Guide 2: Standards Recommended to Achieve Interoperability in Minnesota* and can be found at: <http://www.health.state.mn.us/ehealth>

The law also includes provisions for compliance and enforcement which allows the Commissioner of Health to set administrative procedures for a denial, suspension, or revocation of a certificate of authority; administer penalties and enforcement authority; or suspend or revoke certificates of authority.

In addition to the state oversight process, the Minnesota Department of Health will utilize the state contracting process to ensure that any sub-recipient of funds disbursed through this cooperative

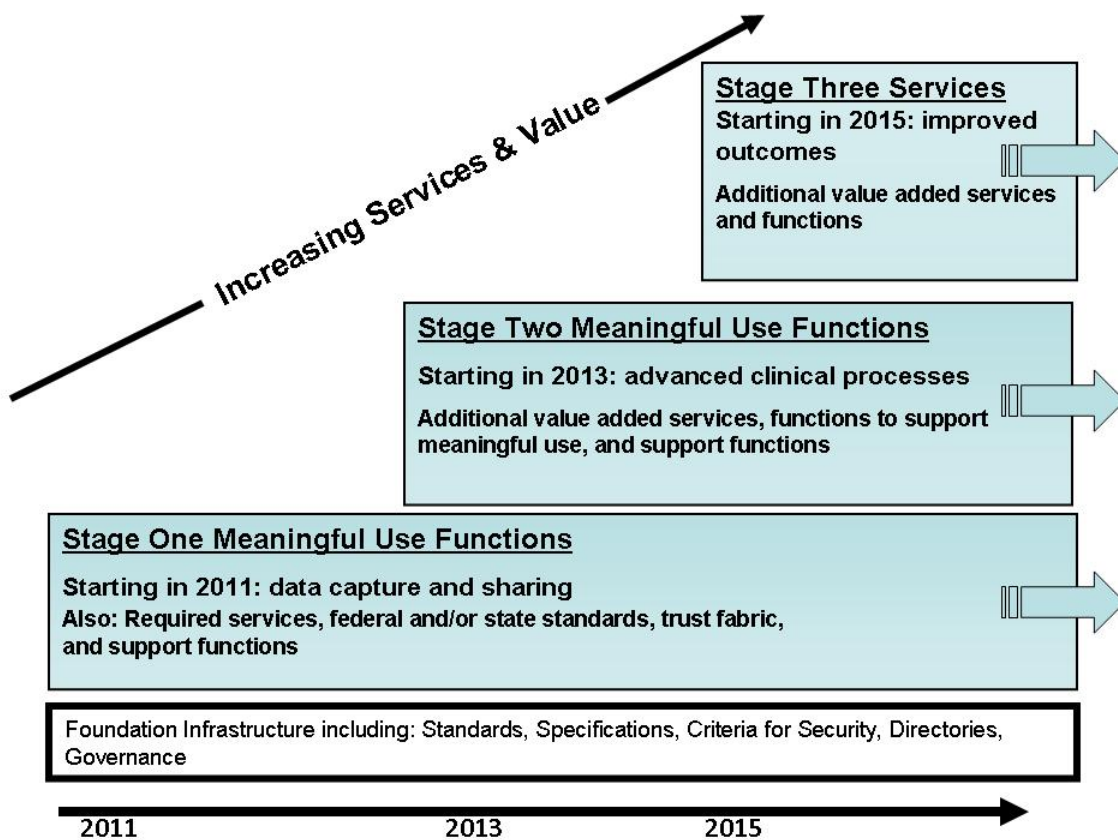
agreement for technical infrastructure development are bound by contract to adhere to national standards, including those established for NHIN. Please refer to details outlined in Strategy 3 below.

3. Maximize funding available by leveraging current HIE mechanisms and building on existing infrastructure.

Minnesota’s approach to health information exchange is to invest current and future federal and funding in existing infrastructure in Minnesota to capitalize on the momentum already established in Minnesota. The State Health Information Exchange Cooperative Agreement program (3013) provides states with some initial funding to expand health information exchange services, and this expansion in Minnesota will be established through a sub-recipient contract (details provided below). Recognizing the large investments needed by public and private stakeholders to ensure a fully statewide approach to health information exchange, future investments (private, state, and federal) will be needed. Minnesota will continue to encourage that future private, state, or federal investments are allocated so that they support existing infrastructure and resources.

Figure 3 below describes how services and value will increase over time as Meaningful Use Functions are expanded through Stage One, Stage Two and Stage Three and include additional value added services.

Figure 3. Expanding HIE Functions and Services over Time



Through the 3013 Cooperative Agreement Program, the Minnesota e-Health Connect Program will invest in the existing infrastructure to expand health information exchange capability statewide. The

following page describes the contractual details related to Minnesota's approach for technical infrastructure development.

Minnesota Approach for Technical Infrastructure Development Approved by ONC through the Notice of Award for the Statewide HIE Cooperative Agreement

The Minnesota Department of Health is authorized by the Office of the National Coordinator (ONC) to enter into a sole-source agreement with the following sub-recipient as approved and required by the notice of award for State HIE Cooperative Agreement number 90HT0011/01:

Subrecipient: Minnesota Health Information Exchange (MN HIE)

Contract Period: The contract will begin upon execution of a sole-source contract with the Minnesota Department of Health and will cover the duration of the State HIE Cooperative Agreement program. [Estimated Contract Period: May 2010 – February 2014]

Contract Terms:

- Funding will be made available in the following phases:
 - Phase I: Operational Planning
 - Phase II: Implementation of Functions & Services for Stage I Meaningful Use, Interstate Exchange
 - Phase III: Contract Updates to Address Stage II and Stage III Meaningful Use Requirements
- All funding is restricted until formal notice of approval is received from the HHS Office of the National Coordinator for the statement of work and budget justification for each phase of the contract.
- The sub-recipient will be required to comply with all requirements for sub-recipients as outlined in the Terms and Conditions of the Notice of Award, including all reporting requirements of the American Recovery and Reinvestment Act.

The Minnesota Department of Health is authorized by the Office of the National Coordinator to execute Phase I of the contract with MN HIE for operational planning activities, consistent with the budget justification as approved in conjunction with the Minnesota application for 3013 funds and outlined in Appendix H. Phase I of the contract will incorporate the following elements into the statement of work, requiring MN HIE to:

- Provide MDH with operational detail sufficient to identify the level of services and functions required to meet meaningful use requirements, including:
 - Scope, design, time and cost estimates for Stage 1 meaningful use categories
 - Timelines for infrastructure development
 - High-level communications and outreach plans
- Obtain estimates from vendors on costs associated with infrastructure development
- Identify specific deliverables for contracts and statements of work with vendors for infrastructure development
- Provide estimated timelines for compliance with state governance requirements
- Provide plans for meeting privacy and security requirements and standards in federal and state law
- Provide plans for reporting on performance indicators

The Minnesota Department of Health, in conjunction with the submission of this Operational Plan, will seek formal authorization by the Office of the National Coordinator to execute Phase II and III of the contract with MN HIE for implementation of functions and services for Stage I, II, and III Meaningful Use Requirements and Interstate Exchange.

4. Use an integrated approach to facilitate HIE across entities.

Minnesota's legal framework for health information exchange requires health information organizations to connect to and align with the Nationwide Health Information Network. In addition, conversations are being initiated with Indian Health Services, the Veterans Administration, and others to ensure coordination. Representatives from these organizations will also be recruited to participate on the Minnesota e-Health Initiative Policy Workgroups, particularly the Health Information Exchange Workgroup.

LEGAL AND POLICY ISSUES DOMAIN OBJECTIVE: Ensure that a clear policy framework is established to enable health information exchange by providing requirements to ensure that information follows the patient and that patients' rights are protected.

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota's overall approach to continued development in the legal and policy domain to enable statewide and interstate health information exchange, including the implementation of three primary strategies:

1. Build upon existing statutes and recommend further action necessary to enable HIE
2. Address key issues related to privacy, security, and management of patient consent
3. Work with states identified as high-priority by Minnesota stakeholders to enable HIE across state borders

The following are the specific details on how MDH and OHIT will align operations to achieve the legal and policy domain objective under Goal 1 utilizing these three strategies.

The Privacy, Legal and Policy Workgroup will serve as the lead workgroup in coordinating the development of policy recommendations related to e-health, including privacy, legal and policy matters necessary to enable statewide and interstate HIE. In this capacity, the workgroup will address the deliverables for each of these strategies as noted below:

1. Build upon existing statutes and recommend further action necessary to enable HIE.

The 2010-2011 Privacy, Legal and Policy Workgroup serves to:

- Monitor, assess and comment on policy and legal issues related to e-Health and health information exchange
- Review and comment on privacy and security-related policies and proposed federal regulations and guidance, and make recommendations on mechanisms to ensure compliance with state and federal requirements related to interstate and intrastate health information exchange
- Support providers and health care stakeholders in the implementation of privacy and security criteria necessary to qualify as a "meaningful user" of an Electronic Health Record (EHR) under the HITECH Act
- Ensure that the needs of consumers, providers, and health care stakeholders are fully considered in the development of the statutory framework for health information exchange and in the development of educational resources and tools

In this capacity, the Privacy, Legal and Policy Workgroup will:

- Provide review and feedback, including formal coordinated responses from Minnesota stakeholders and interested parties, as necessary on HITECH activities including: proposed federal rules and guidance pursuant to the HITECH Act related to privacy, legal and policy issues; legal and policy sections of updated strategic and operational plans that support health information exchange as specified by Section 3013 of HITECH Act, and privacy, legal and policy issues identified by Minnesota e-Health Advisory Committee and OHIT staff.

2. Address key issues related to privacy, security, and management of patient consent.

The 2010-2011 Privacy, Legal and Policy Issues Workgroup will continue to monitor, assess and plan modifications and new policies that will support the secure and private interstate and intrastate exchange of health information. The workgroup will conduct an environmental scan of laws in other states to assess Minnesota needs around patient consent and work with those states to ensure secure exchange of health information. The workgroup will also review and comment on legal and policy issues, including:

- Breach notification issues and requirements
- Management of consent and consumer preferences issues and establishment of dispute resolution process regarding differences among HIOs, HDIs and providers related to consumer preferences

3. Work with states identified as high-priority by Minnesota stakeholders to enable HIE across state borders.

The 2010 – 2011 Privacy, Legal and Policy Workgroup will analyze and provide recommendations regarding interstate HIE, including:

- Provide advice and comment on work conducted by a collaborative group of state HIE staff members from the upper Midwest border states and other states that are likely to be frequent trading partners of health information, to facilitate discussion of common challenges and solutions related to interstate health information exchange
- Review environmental scan of laws in those states and identify potential barriers to successful interstate HIE, including laws related to: patient consent requirements/options, sensitive services, processing paper transactions, release of lab results to providers other than the ordering provider, and authentication
- Discuss, analyze and comment on possible solutions, including: interstate compact agreements, DURSA/federal initiatives, and changes to Minnesota law

In addition to the Privacy, Legal and Policy Workgroup, six states intend to establish the Upper Midwest HIE (UM-HIE) Collaborative, to work together to create a regional vision for interstate health information exchange and pursue concrete solutions to barriers affecting HIE for treatment purposes between the UM-HIE states (Illinois, Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin). One purpose of this project is to build upon the work of the HISPC Intrastate/Interstate Consent Policy Options (IICPO) Collaborative to evaluate and pursue the development of template language for interstate agreements or other similar mechanisms that will enable interstate HIE despite differences in individual state consent laws. See Appendix H for the full proposal submitted to RTI International. In the event that the UM-HIE Collaborative does not receive additional support through RTI International, Minnesota will continue to pursue this initiative to the extent that existing resources allow.

FINANCE DOMAIN OBJECTIVE: Ensure the financial sustainability of health information exchange services beyond the Cooperative Agreement Program by:

- Ensuring state-certified HIOs maintain a business plan that clearly addresses financial sustainability beyond the cooperative agreement program
- Ensuring that a critical mass of Minnesota health / health care stakeholders are connected and utilizing HIE services
- Ensuring state-certified HIOs address specific barriers encountered by stakeholders related to technical, legal, financial, and/or organizational matters

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota's overall approach to financing of health information exchange, including the implementation of two primary strategies:

1. Development and Oversight of Financial Requirements for Health Information Organizations
2. Contingency Plans for Sustainable Health Information Exchange

The following are the specific details on how MDH and OHIT will align operations to achieve Minnesota's finance domain objective under Goal 1 utilizing these two strategies.

1. Development and Oversight of Financial Requirements for Health Information Organizations

The Minnesota Strategic Plan for Health Information Exchange outlined Minnesota's legal framework for health information exchange which requires health information service providers to maintain business plans that address financial sustainability and provide explanation on how their plans address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services. They must also submit their rate plans outlining fee structures for health information exchange services. The rate plan must:

- Distribute costs equitably among users of health information exchange services
- Provide predictable costs for health / health care providers
- Cover all costs associated with conducting the full range of meaningful use transactions
- Provide a predictable revenue stream for the health information exchange service provider to maintain operating costs and develop technical infrastructure

Through Minnesota's oversight process, the Department of Health will establish initial criteria in the summer of 2010 for assessing the financial sustainability of health information service provider business plans, and will also utilize the Health Information Exchange Workgroup and e-Health Advisory Committee to provide guidance on criteria over time.

2. Contingency Plans for Sustainable Health Information Exchange

Additionally, two of the required components that will be included in the application process for issuing certificates of authority are: contingency plans for sustainability if funding sources do not materialize and marketing mechanisms and plans to connect a critical mass of providers to HIE services.

Addressing Overall Financial Sustainability of Health Information Exchange in Minnesota

In addition to ensuring that health information organizations have a plan for sustainability beyond the cooperative agreement program, the Minnesota Strategic Plan for Health Information Exchange identifies long-term financial sustainability as a priority issue. The Health Information Exchange Workgroup will convene stakeholders in the fall of 2010 to coordinate the development of a long-term financial sustainability plan for the state. In this capacity, the workgroup will:

- Develop scope for financial sustainability plan
- Identify potential data sources and gather supporting data to help facilitate discussions
- Resolve discussion questions to identify and validate principles for financial sustainability
- Identify solutions for mitigating risks associated with potential issues / barriers related to financial sustainability
- Identify and discuss recommendations on HIE financing framework core components:
 - Sources of funds
 - Funders
 - Funding mechanisms
 - Recipients
 - Uses of funds
 - Revenue mechanisms
 - Revenue sources
- Discuss components for the HIE financial framework
- Review data submitted by HIOs on financial sustainability
- Develop projections and Minnesota plan for financial sustainability
- Monitor financial sustainability of existing HIOs, and recommend updates to criteria for HIOs regarding financial sustainability as needed

In order to adequately address statewide financial sustainability of health information exchange, a wide range of discussion questions need to be addressed. The following discussion topics will be used to assist in developing a long-term financial sustainability plan.

Funding /revenue / resources

- Given the finite amount of resources for HIE, how can we leverage resources and assets to ensure meaningful use and to assist in sustainability?
- To what extent will Medicare and Medicaid provide financing and/or participate in HIE?
- Should grants and/or state/federal funding be utilized for financial sustainability?
- What is the appropriate mix of funding sources?
- If grants and/or state/federal funding are used, how should health information exchange activities move beyond these additional funding sources in order to become independently sustainable?
- To what extent should only users of HIE services pay for them beyond initial development costs?
- How should payers (or other participating entities) be incorporated into the revenue model?
- To what extent should there be a financial reserve (e.g. for research and development)
- How can we learn from other HIEs and Minnesota's work with administrative transactions (e.g. models in place, interactions with payers, etc.)?
- Who are the consumers of the data (both short and long-term) as a means to understand potential longer-term investments?
- How can we quantify the value of data to arrive at appropriate pricing mechanisms?
- What sort of ongoing expenses are needed to support health information exchange?
- Are there relevant statistical models to demonstrate cost-benefit indicators and where the break even point (or critical mass point) is?

Business model philosophy

- How should scope of HIE be defined for determining long-term costs and potential funding and revenue sources for financial sustainability?
- Should financial sustainability be fully market-driven or utilize government involvement?
- How should the state use its purchasing power to enhance the demand for care coordination and information exchange?

Health information organizations (HIOs)

- We know there is an economy of scale, but what is the appropriate economy of scale for Minnesota?
- Is there an optimal size for HIOs?
- Is there an optimal number of HIOs?
- Should HIOs be allowed to engage in business value propositions unrelated to HIE as long as their core HIE functions and services remain intact?
- What services can be shared?

Stakeholder engagement

- How should stakeholders be engaged in financial sustainability planning?
- How can the state play a role in facilitating discussions to build collaboration and trust in the community and to share best practices?
- What are the right messages to engage stakeholders?
- How should the needs of interstate exchange be addressed?

Special considerations

- How can we include the broader continuum of care beyond meaningful use in a financially-sustainable model?
- Should HIE services be offered at a discount (e.g., to particular groups who have limited resources or for particular services in order to increase participation)?

For additional detail, please see the Health Information Exchange Workgroup charge in Appendix A.

BUSINESS AND TECHNICAL OPERATIONS DOMAIN OBJECTIVE:

Oversee business and technical operations with clear articulation of:

- Responsibilities of the state and other health information exchange entities
- Approach to meet meaningful use requirements
- Efforts to coordinate and align efforts with Medicaid and public health requirements for HIE and meaningful use criteria
- Approach to leveraging existing HIE capability
- Plan for utilizing the Nationwide Health Information Network for information exchange between states with federal agencies

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota’s overall approach to business and technical operations, including the implementation of three primary strategies:

1. Implement e-Health Advisory Committee recommendations on health information exchange enacted into law
2. Implement Outreach and Communications Plan
3. Identify barriers in accessing and effectively using HIE services

The following are the specific details on how MDH and OHIT will align operations to achieve Minnesota’s business and technical operations domain objective under Goal 1 utilizing these three strategies.

1. Implement e-Health Advisory Committee recommendations on health information exchange enacted into law

The Minnesota legal framework for health information exchange, established in the 2010 legislative session, was based on Advisory Committee recommendations related to health information exchange, including:

- Definitions
- Health information exchange activities
- Health information exchange requirements
- Certification criteria for HIOs
- Oversight of health information exchange

Recommendations for ongoing updates will be made, as necessary, to Minnesota’s legal framework for health information exchange through the existing policy governance infrastructure in place in Minnesota. The Health Information Exchange Workgroup serving as the lead in coordinating the development of statewide policy recommendations that will be presented to the Minnesota e-Health Initiative Advisory Committee for final approval prior to submission to the Commissioner of Health.

The Minnesota e-Health Initiative Advisory Committee provides policy recommendations to the Commissioner of Health on:

- Assessment of adoption and effective use of health information technology
- Recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for

clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data

- Recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care
- Recommendations on health information exchange oversight requirements

2. Implement Outreach and Communications Plan

The Minnesota e-Health Communications and Outreach workgroup has developed a Minnesota e-Health Initiative Communications Plan and Work Plan for 2010-2011. The plan is included in Appendix F and has received broad stakeholder support and endorsement by the Minnesota e-Health Initiative Advisory Committee. The goals of the communications plan are to:

- Successfully inform, encourage and support health and health care providers and health care organizations to adopt and use electronic health records and other health information technology
- Establish an effective statewide network of e-health communication channels that builds on existing relationships and creates new relationships with health and health care stakeholders, including provider associations, and recognize other collaborative opportunities to engage health and health care providers and organizations across Minnesota in e-Health activities and issues
- Coordinate and integrate communication efforts with other organizations including, but not limited to, provider associations, REACH (Minnesota's regional extension center), Minnesota health information exchange service providers, the Minnesota e-Health Connect program, and Minnesota Medicaid about e-Health activities and issues. Establish a fully integrated and seamless communication strategy between state, federal and locally-funded initiatives

To implement the Communication Plan, the Communication and Outreach Workgroup has established an initial six-month calendar which will be extended and updated quarterly. The calendar features main communication themes by month, key messages, resources to share, and potential services that may be offered. A consumer message has been identified specific to each of the themes and key milestones. These targeted communications on key themes and milestones will be complementary to the regular updates on broad state and national e-health activities. The full Communications Plan which includes the initial six month timeline can be found in Appendix F.

The 2010 – 2011 Minnesota e-Health Communications and Outreach Workgroup will:

- Advise on Minnesota e-Health Initiative communications activities, established in the Minnesota e-Health Communications Plan and Work Plan 2010-2011, to support health care providers and health care organizations in achieving meaningful use and meeting Minnesota mandates for e-prescribing by 2011 and interoperable EHRs by 2015
- Advise on the coordination of outreach and communication efforts statewide, including coordination with the HITECH/ARRA funded programs such as the Minnesota e-Health Connect, REACH Program, and Minnesota Department of Human Services (DHS)-Medicaid and others as appropriate

Specific deliverables to be met by this Workgroup during the 2010-2011 year includes:

- Identify and recommend opportunities for coordination with the REACH program, Minnesota health information organizations (HIOs) and health data intermediaries (HDIs), the Minnesota Department of Human Services (DHS)-Medicaid, and others as identified
- Evaluate the effectiveness of Minnesota e-Health messages and communication vehicles
- Review communications developed by other Minnesota e-Health Initiative workgroups
- Identify any gaps in outreach and communications and prioritize groups and messages
- Recommend activities to address outreach gaps that engage health care organizations, providers, and consumers to support the adoption and use of EHRs to achieve meaningful use and compliance with the 2011 and 2015 mandates
- Recommend consumer communications resources to list on the Minnesota e-Health website, incorporating the contributions of Minnesota e-Health workgroups

In addition to developing a Communications Plan, an initial Technical Assistance Plan has been developed to articulate the various audiences needing technical assistance, and the potential source of technical assistance. See Table 6 below. As part of the approved budget for the Cooperative Agreement program, MDH plans to utilize a portion of the funds during the first year to support outreach efforts, including the development and promotion of materials to support Health Information Exchange Service Providers, health care providers, and consumers in understanding key aspects to Minnesota's approach to health information exchange. This Technical Assistance Plan will be expanded in fall of 2010 to include specific plans to educate and connect Minnesota providers to HIE services.

Table 6. Minnesota e-Health Connect Technical Assistance Plan

	AUDIENCE		
Source	HIE Service Providers	Health Care Providers	Consumers
<i>MDH</i>			
<i>Office of Health Information Technology Staff</i>	Provide instructions for oversight process and answer questions as needed	Raise overall awareness of HIE plans in the state; describes how to get connected to certified HIE service providers; promote standards recommendations; raise awareness of tips, tools, resources.	Promote consumer materials about the personal benefits of health information exchange and how their personal health information will be protected; inform process for filing complaints; promote how consumers can be involved in providing public input to policy and oversight activities
<i>Oversight Review Panel</i>	Provide feedback regarding applications		
<i>Sub-recipient for technical infrastructure</i>	Outreach and connectivity to other service providers	Provide outreach for connectivity for HIE	Promote consumer materials about the personal benefits of health information exchange and how their personal health information will be protected
<i>Office of Rural Health and Primary Care</i>		Connect safety net providers to resources for adoption, meaningful use, and exchange	
<i>Certified Service Providers</i>	Outreach and connectivity to other service providers	Provide outreach for connectivity for HIE	Promote consumer materials about the personal benefits of health information exchange and how their personal health information will be protected
<i>Regional Extension Center – REACH Program</i>		Provide outreach on EHR adoption and meeting meaningful use requirements	
<i>Minnesota Medicaid</i>		Provide assistance on meeting Medicaid meaningful use requirements	
<i>Educational Programs</i>		Provide educational and training opportunities	

	AUDIENCE		
Source	HIE Service Providers	Health Care Providers	Consumers
<i>Minnesota e-Health Summit</i>	Provide learning opportunities regarding statewide view of health information exchange and showcases lessons learned along the continuum of adoption – use – and exchange of EHRs and the continuum of care beyond meaningful use	Provide learning opportunities regarding statewide view of health information exchange and showcases lessons learned along the continuum of adoption – use – and exchange of EHRs and the continuum of care beyond meaningful use	
<i>Health Care Providers</i>			Personal benefits of HIE and how personal health information will be protected
<i>Health Care Payers</i>			Personal benefits of HIE and how personal health information will be protected
<i>Community-based Organizations; local public health</i>		Identify priority needs for the collection and dissemination of population health information	What consumers should be expecting and demanding regarding HIE

3. Identify barriers in accessing and effectively using HIE services

The Adoption and Meaningful Use Workgroup serves as the lead workgroup in coordinating the development of policy recommendations related to resolving barriers to accessing and effectively using health information exchange services. In this capacity, the 2010-2011 Adoption and Meaningful Use Workgroup will serve to:

- Review and provide feedback as necessary on proposed state and federal definitions, criteria and/or proposed regulations regarding meaningful use pertaining to Medicare and/or Medicaid incentive payments under the American Reinvestment Act of 2009 (ARRA) to ensure that Minnesota providers seeking to obtain incentive payments are able to meet federal and state criteria
- Identify gaps, makes recommendations and provide guidance in Minnesota for meeting meaningful use requirements
- Identify gaps, make recommendations, and identify resources for how to support providers in other settings
- Review Minnesota progress in effective use of EHRs and make recommendations for supporting Minnesota providers, including identifying gaps and providing guidance to health / health care providers
- Provide recommendations and feedback to Minnesota Medicaid on the Medicaid HIT Plan and the Medicaid EHR Incentive Administration Plan

A core function of this workgroup will be to review information on assessment of the adoption, meaningful and effective use of electronic health records and health information exchange in Minnesota and across state borders, and actively seek to identify barriers encountered by health / health care stakeholders in accessing and effectively using HIE services. The following are some of the key methods for gathering information:

- Reports submitted by state certified HIOs regarding provider connectivity and identifying any known barriers
- Reports from REACH on provider experiences in accessing and effectively using HIE services, including barriers identified through REACH technical assistance efforts
- Assessment information gathered through Minnesota health reform initiatives (e.g., Minnesota Community Measurement HIT survey, American Hospital Association/Minnesota Hospital Association survey)
- Assessment information provided by statewide associations of health and health care professional organizations

The Adoption and Meaningful Use Workgroup will engage the Minnesota e-Health Advisory Committee and related workgroups and the MDH Office of Rural Health and Primary Care to develop solutions to address identified HIE barriers, which will be incorporated into the Minnesota Guide to Health Information Exchange planned to be released in June of 2011.

Operational Responsibilities

The Minnesota Department of Health, as the State Designated Entity, will coordinate all efforts associated with Minnesota's Strategic and Operational Plans for Health Information Exchange. See below for the key operational responsibilities of the Minnesota Department of Health, a contract for health information exchange services, the Minnesota e-Health Initiative Advisory Committee, and the Regional Extension Center.

Minnesota Department of Health, Office of Health Information Technology

- Convene stakeholders to create a comprehensive and unified vision for the use of electronic health records and health information exchange in Minnesota
- Coordinate and facilitate an integrated statewide approach to health information technology and health information exchange, and implement Minnesota's strategic and operational plan for health information exchange to expand the secure, electronic movement and use of health information among health / health care organizations according to nationally-recognized standards
- Oversee health information exchange governance structure and health information exchange oversight responsibilities, including developing a plan for health information exchange monitoring and remediation of the actual performance of health information exchange throughout the state (e.g., through Minnesota's legal framework process for filing complaints)
- Collaborate with other Federally-funded programs designed to promote the adoption and use of electronic health records and health information exchange (e.g., Regional Extension Centers, Medicare and Medicaid Incentive programs, the State Office of Rural Health and Primary Care)

- Coordinate across state government to maximize federal and state investments in health information technology and infrastructure development (e.g., the Department of Human Services, the Department of Corrections, and the Department of Administration)
- Provide technical assistance to health information exchange organizations and others developing health information exchange capacity in the state
- Facilitate the connection of Minnesota providers to a designated statewide health information organization and assist providers in obtaining technical assistance from the appropriate entities
- Provide referral to regional extension centers or others for technical assistance related to electronic health record adoption and implementation
- Leverage existing public health initiatives, (e.g., with Minnesota Electronic Disease Surveillance System modernization project, Minnesota Immunization Registry, Minnesota public health laboratory information system modernization, etc.)
- Support the goal of development and dissemination of meaningful population health reports to stakeholders and the public
- Support state and local public health in developing viable plans for interoperability and integration of public health information systems, and accomplishing requirements of state and federal laws related to health information exchange
- Develop and implement a robust communications and outreach plan that outlines Minnesota's strategy to effectively communicate with key stakeholders and the health community
- Manage relationship with the Office of the National Coordinator
- Manage contract for health information exchange services

Contract for health information exchange services

- Build technical infrastructure to enable health information exchange within Minnesota and nationwide
- Implement evaluation / data reporting requirements (submission of data for quarterly reports, assessment information, etc.)
- Provide necessary technical assistance to facilitate connection to a statewide HIO
- Comply with Minnesota's legal framework for health information exchange

Minnesota e-Health Advisory Committee

- Make policy recommendations related to e-health to the Commissioner of Health on overall direction of health information exchange activities in Minnesota, including governance, strategic and operational plans, and financial sustainability beyond the ARRA funding opportunity
- Oversee workgroup activities related to: standards and interoperability, privacy and security, outreach and education, health information exchange, meaningful use of electronic health records
- Make recommendations to the Department of Human Services regarding the development of the Medicaid HIT Plan and coordination with the e-health activities statewide.

Regional Extension Center (Key Health Alliance)

- Provide assistance to providers for implementation and meaningful use of EHRs
- Provide technical assistance services and support to priority primary care providers in Minnesota and North Dakota

- Lead and manage change, help providers utilize health information technology as a tool for improved quality and performance and provide actionable education
- Technical assistance and education will include provider readiness and leadership support, workflow redesign, EHR functionality, identifying and selecting a vendor, meaningful use, protecting privacy and security of patient information, developing vendor relationships, and preparing for and participating in health information exchange
- Coordinate closely with state agencies and other organizations leading related ARRA efforts

GOAL 2: Ensure trust and support for a statewide approach to health information exchange.

OBJECTIVE A: Engage stakeholders through an open and transparent governance structure

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota's overall approach to stakeholder engagement, including the following strategy: provide mechanisms for receiving public input on recommendations related to health information exchange.

1. Public input on recommendations related to health information exchange

All five of the e-Health Initiative workgroups are open to participation by the public. As the lead workgroup related to health information exchange, the Health Information Exchange Workgroup will facilitate developing recommendations related to health information exchange and present them for approval to the Minnesota e-Health Initiative Advisory Committee. Stakeholders are invited to participate across the spectrum of care based on their expertise and subject matter knowledge and/or interest. All meetings are open to the public and all participants are welcome. Minnesota e-Health Initiative Advisory Committee meetings where recommendations and any ongoing updates to Minnesota's Strategic and Operational Plans for Health Information Exchange are reviewed and action taken are also open to the public.

OBJECTIVE B: Accelerate the adoption and effective use of electronic health records and other health information technology as prerequisites to enabling health information exchange

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota's overall approach to adoption and effective use of electronic health records, including the following strategies:

- Identify funding opportunities to assist those not eligible for HITECH incentives
- Establish and disseminate methods of standardization of clinical operations necessary for HIE
- Coordinate with Regional Extension Center
- Coordinate with the MN Office of Rural Health and Primary Care

1. Identify funding opportunities to assist those not eligible for HITECH incentives

To achieve the broader e-health initiative vision, it is important that health / health care providers across the continuum of care have enough resources to enable adoption of HIT, effective use, and health information exchange. This strategy is an ongoing mechanism to ensure that maximum resources are obtained for settings not eligible for HITECH incentives. The Adoption and Meaningful Use Workgroup has included this as part of their charge for the 2010-2011 year.

2. Establish and disseminate methods of standardization of clinical operations necessary for HIE

Minnesota's legal framework for health information exchange includes a provision that requires the Commissioner of Health to develop recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences.

Standard operating procedures may include:

- Procedures for responding to complaints
- Management of consumer preferences
- Expectations related to the implementation of standards
- Expected timeframes for delivery of clinical transactions
- Hours that services must be available to participating entities

3. Coordinate with Regional Extension Center and the Minnesota Office of Rural Health and Primary Care

Each of the e-Health Initiative Workgroups intend to provide feedback to REACH (Minnesota's Regional Extension Center), as well as other HITECH programs, throughout the 2010-2011 year. The Adoption and Meaningful Use Workgroup, however, has a specific deliverable around providing recommendations and guidance to the Regional Extension Center (REACH) regarding solutions to addressing barriers to HIT adoption and achievement of meaningful use. This will be an ongoing activity; however, there will be a heavier emphasis placed during the fall of 2010. In addition, quarterly updates will be provided at the Minnesota e-Health Initiative Advisory Committee as a way to coordinate efforts and encourage broad stakeholder support for REACH activities.

Minnesota's ORHPC and OHIT will regularly coordinate resources and outreach to ensure that Minnesota's safety net providers, including Critical Access Hospitals, Federally Qualified Health Centers, and Rural Health Clinics, are able to obtain resources to support EHR adoption and meaningful use through its Medicare Rural Hospital Flexibility Program (HRSA), Small Hospital Improvement Program (SHIP), Primary Care Office (PCO) program, the Minnesota EHR Loan Program and other state and federal programs.

OBJECTIVE C: Ensure that federal and state requirements and best practices to protect personal health information are utilized to maintain patient privacy and consumer confidence, while enabling secure access to all of the information necessary to deliver the best possible care.

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota's overall approach to protecting personal health information including the following strategy: work through the Minnesota Privacy, Legal and Policy Workgroup to:

- Review current laws related to health information exchange and identify potential updates; make recommendations needed to ensure that adequate privacy protections are in place.
- Monitor and respond to federal health information privacy and security activities, particularly those related to consumer preferences, and make recommendations to the Commissioner of

Health on how standard operating procedures for consumer preferences should be addressed when national standards become available

- Identify the best approach to ensure patient privacy protections are maintained while enabling health information exchange, including interstate exchange

1. Minnesota Privacy, Legal, and Policy Workgroup activities related to protecting personal health information

The Legal and Policy Issues Domain section of this Operational Plan includes a detailed description of the 2010-2011 Minnesota e-Health Privacy, Legal and Policy Workgroup charge and main deliverables, many of which are integrally related to protecting personal information. Particular attention will be placed in the area of interstate health information exchange with the analysis of barriers due to various patient consent requirements. The Minnesota e-Health Privacy, Legal and Policy Issues workgroup will be the primary group focused on addressing barriers to health information exchange while ensuring that personal health information is protected.

In addition to the Privacy, Legal, and Policy Workgroup, the proposed work of UM-HIE as described on page 26 and in Appendix H will look at interstate privacy issues.

OBJECTIVE D: Promote process interoperability to achieve data quality and integrity and encourage continuous data quality improvement
--

The Minnesota Strategic Plan for Health Information Exchange identified Minnesota’s overall approach to achieving data quality and data integrity through the following strategy: promote and disseminate recommendations and standard operating procedures to promote data uniformity and to promote timely, accurate, and completeness of data in all health / health care settings

1. Promote and disseminate recommendations and standard operating procedures

The Standards and Interoperability Workgroup acknowledges the importance of addressing “process” interoperability in the context of health information exchange. While much of the focus on interoperability to date has been on “technical” and “semantic” interoperability, the 2010-2011 Standards and Interoperability Workgroup plans to begin addressing process interoperability by identifying which guidelines need to be created and what process is optimal for developing those guidelines. It is likely that e-Health Connect program will not begin developing process interoperability guidelines until year two of the project.

GOAL 3: Create synergies and leverage resources available through all state and federal programs to support health information exchange and the effective use of HIT to improve health and health care.

OBJECTIVE A: Coordinate an integrated approach with Medicaid to enable health information exchange and support monitoring of provider participation in HIE as required for the administration of Medicaid meaningful use incentives

The Minnesota Strategic Plan for Health Information Exchange provided a significant amount of detail on Minnesota's overall integrated approach with Medicaid, including the following strategies:

1. Coordination within government
2. Coordination outside of government

1. Coordination within government

The Minnesota State Government Health Information Exchange Steering Committee coordinates activities between state government entities through representation from the State Government Health Information Technology Coordinator, the State Medicaid Director, the State Medicaid Health Information Technology Coordinator, and staff from the MDH Office of Health Information Technology. This group meets monthly and plans to continue doing so throughout the duration of HITECH funding. See Appendix I for a draft charter for the Minnesota State Government Health Information Exchange Steering Committee Charge.

2. Coordination outside of government

The Minnesota Medicaid program is closely connected to the Minnesota e-Health Initiative through representation on the Advisory Committee and involvement in the policy workgroups. The 2010-2011 Adoption and Meaningful Use Workgroup plans to solicit a smaller subgroup to assist in coordination with Medicaid. This Medicaid HIT Plan/EHR Incentives Subgroup will meet approximately bi-weekly over approximately five months to:

- Provide input and feedback on the State Medicaid HIT Plan (“as-is” landscape, “to-be” landscape, administration and oversight strategies, audit strategy, and roadmap)
- Provide feedback on the Medicaid EHR Incentive Administration Plan
- Review and provide feedback on CMS final regulations for EHR incentives

This group will report quarterly to the Minnesota e-Health Initiative Advisory Committee for additional broad-based stakeholder input and support.

OBJECTIVE B: Coordinate an integrated approach with state and local public health to enable information exchange

The Minnesota Strategic Plan for Health Information Exchange identified the need to develop an integrated approach with public health, including the following two strategies:

1. Identify a feasible approach for developing public health information system specifications to achieve meaningful use requirements between public health and the private health care setting
2. Identify opportunities to involve public health beyond meaningful use requirements

1. Identify a feasible approach for public health information systems to achieve meaningful use requirements between public health and the private health care setting.

The MDH OHIT plays a collaborative role with other state public health programs (e.g., immunization registry, disease reporting, lab). Recently, a Department-wide collaborative team was formed with broad representation across MDH. The Public Health Collaboration Team will convene monthly to:

- Understand the impact of State and Federal initiatives regarding the adoption and use of electronic health records including the electronic exchange of health information
- Identify actions that support effective coordination between MDH programs and MDH's OHIT
- Provide comments and feedback to OHIT on the public health implications of national proposals, including but not limited to those involving "meaningful use" incentives, HIT workforce development initiatives, and health informatics applied research
- Gather input from local health departments when appropriate

Key deliverables of this team include:

- Establish an internal gov-delivery e-mail list for public health persons interested in OHIT-related activities including public health informatics and e-health
- Advise on the development and update of the OHIT resource information and materials useful for public health, including tools, tips, templates and other information resources
- Schedule regular monthly updates and discuss OHIT programs and initiatives
- Identify and discuss opportunities for coordination within MDH and outside of MDH including coordination with Minnesota Medicaid, Key Health Alliance, and health information organizations (HIOs) in Minnesota

The OHIT Public Health Collaboration Team Charge is included in Appendix J.

In addition to the MDH Public Health Collaboration Team, MDH and local public health departments are developing a project plan to assist local public health interoperability with other local public health agencies, MDH, and health care providers. The project, when fully defined, will attempt to specify or coordinate the establishment of data standards, identify the needed architectural elements, and provide information upgrades to the local public health system. This project is aimed at meeting the requirement for the use of electronic health records by 2015 and will be carried out in collaboration with local health departments through the leadership of the Minnesota Local Public Health Association. OHIT will stay informed of this project and assist however possible.

2. Identify opportunities to involve public health beyond meaningful use requirements

The 2010-2011 Adoption and Meaningful Use Workgroup includes the spectrum of care beyond meaningful use. One of their deliverables for 2011 is to identify gaps, make recommendations, and

identify resources for how to support health / health care providers in other settings. Additionally, they plan to recommend strategies to expand on Minnesota's assessment activities beyond ambulatory care and hospitals by developing a standard set of questions that can be used in assessments conducted in other settings, such as public health. This standard set of questions can be promoted through various associations (e.g., the Local Public Health Association) to encourage assessments in other settings, such as public health.

OBJECTIVE C: Establish and coordinate common messages, training programs, and educational materials related to health information exchange through other programs funded by sections 3011, 3012, 3016, and 4201 of the HITECH Act

The Minnesota Strategic Plan for Health Information Exchange identified the need to coordinate efforts with other HITECH programs, including the following three strategies:

1. Utilize the Minnesota e-Health Advisory Committee as the primary coordination mechanism for HITECH programs.
2. Disseminate lessons learned from throughout Minnesota
3. Coordinate with ARRA-funded, workforce training opportunities, including

1. Utilize the Minnesota e-Health Advisory Committee

The quarterly Minnesota e-Health Initiative Advisory Committee meetings have a standing agenda item for updates from HITECH programs. In addition, each of the Policy Workgroups will be receiving updates and providing input/feedback to the various HITECH programs as appropriate. This strategy is viewed as an ongoing strategy through the duration of the HITECH funding.

2. Disseminate lessons learned

As the HITECH programs begin to evaluate their work and develop lessons learned, the Minnesota e-Health Initiative will disseminate findings through the existing communication infrastructure which includes a broad stakeholder-endorsed Communications Plan (see Appendix G) and additional dissemination through Minnesota associations. This strategy is viewed as an ongoing strategy through the duration of the HITECH funding.

3. Coordinate with ARRA-funded, workforce training opportunities

Each of the e-Health Initiative Workgroups intend to have standing agenda items on an ongoing basis to provide feedback to HITECH programs, which includes workforce programs in Minnesota through the University of Minnesota, College of St. Scholastica, and Normandale Community College. Each of the workgroups will provide feedback as necessary to these workforce groups. In addition, quarterly updates will be provided at the Minnesota e-Health Initiative Advisory Committee as a way to coordinate efforts and encourage broad stakeholder support for workforce education and training activities.

OBJECTIVE D: Ensure a coordinated approach with other state and federally-funded programs and federal care delivery systems.

The Minnesota Strategic Plan for Health Information Exchange identified the need to coordinate efforts with other HITECH programs, including the following two strategies:

1. Actively recruit representatives from state and federally-funded programs and federal care delivery organizations to participate in the Minnesota e-Health Initiative's policy development activities and articulate program needs related to HIE
2. Ensure that any sub-recipients of funds provided through the Section 3013 Cooperative Agreement Program clearly articulate their approach to ensure that HIE services are compatible with other federal programs and delivery systems

1. Representation from state and federally-funded programs and federal care delivery organizations

As mentioned in the section on technical infrastructure, MDH OHIT will engage representatives from state and federally-funded programs and federal care delivery organizations to participate in the 2010-2011 policy workgroups. The Health Information Exchange Workgroups will actively engage broader participation to include federal care delivery organizations and federally-funded programs; although participation is open in all of the workgroups. Table 7 below describes how the Minnesota e-Health Connect program will coordinate with state and federally-funded programs. Table 7 includes an initial list of programs which will be further developed as additional coordination opportunities arise.

Table 7. Coordination with Medicare and State and Federally-Funded, State Based Programs

	Communicate on a regular/ frequent basis	Communicate on a periodic basis	Recruit for participation in AC and Workgroups	Stay informed
Minnesota Department of Health Programs				
Epidemiology and Laboratory Capacity Cooperative Agreement Program			✓	✓
Assistance for Integrating the Long Term Care Population into State Grants to Promote HIT			✓	✓
HIV Care Grant Program Part B States/Territories Formula and Supplemental Awards (HRSA)			✓	✓
Maternal and Child Health State Systems Development Initiative Programs (HRSA)		✓	✓	✓
Minnesota Office of Rural Health and Primary Care (HRSA)	✓	✓	✓	
Office of Emergency Preparedness		✓	✓	✓
Minnesota Department of Human Services Programs				
Minnesota Medicaid	✓		✓	
State Mental Health Data Infrastructure Grants for Quality Improvement (SAMHSA)			✓	✓
Other Programs				
Emergency Medical Services for Children Program (HRSA)			✓	✓
Federal Health and Health Care Delivery Programs				
Veterans Administration	✓		✓	
Department of Defense	✓		✓	
Indian Health Services	✓		✓	
Other Federal ARRA Programs				
Regional Extension Center (Key Health Alliance)	✓		✓	
Research and Community Programs (SHARP – Mayo Clinic)	✓		✓	
Education and Training (UP-HI; Normandale Community College)	✓		✓	
EHR – Incentives Program	✓		✓	
Beacon Community Program (Mayo Clinic)	✓		✓	

2. Sub-recipient requirement

The sub-recipient will be required, through their contract with MDH, to ensure that HIE services are compatible with other federal programs and delivery systems.

GOAL 4: Improve coordination of care, quality of care, and health outcomes and decrease health care costs in Minnesota through health information exchange and meaningful use of electronic health records

OBJECTIVE A: Develop and implement an evaluation plan to monitor progress towards process and outcome-based indicators

The Minnesota Strategic Plan for Health Information Exchange identified the need to develop and implement an evaluation plan utilizing the following strategies:

1. Develop a Minnesota framework for evaluation
2. Identify available data sources, data collection methods and analysis plans for key indicators
3. Collect and analyze data and publish information to demonstrate linkages between investments in health information exchange, health care reform, and improved coordination of care, quality of care and health outcomes in Minnesota
4. Work collaboratively with other health care reform initiatives in Minnesota to demonstrate program effectiveness in the broader context of health reform

1. Develop a Minnesota framework for evaluation

The 2010-2011 e-Health Initiative Health Information Exchange Workgroup will be engaged, with additional input from the Adoption and Meaningful Use Workgroup, in developing a Minnesota framework for evaluation of Minnesota's health information exchange efforts. The framework will include key elements for approaching the overall evaluation, including process and outcome indicators.

2. Identify available data sources, data collection methods and analysis plans for key indicators

As part of the framework for evaluation of Minnesota's health information exchange efforts, available data sources, data collection methods and plans will be included and reviewed by the 2010-2011 Health Information Exchange and Adoption and Meaningful Use Workgroups. Additionally, the framework will be in alignment with federal plans for evaluation of state programs.

3. Collect and analyze data and publish information

MDH OHIT staff will work collaboratively with the respective sources of data to collect and analyze data, and publish information about Minnesota's health information exchange efforts. When available, this information will be published in an annual report to the Minnesota Legislature as well as required reports to the Office of the National Coordinator. The 2010 Health Information Exchange, Adoption and Meaningful Use, and Communications and Outreach Workgroups will be engaged in this activity.

4. Work collaboratively with other health care reform initiatives

MDH OHIT will work collaboratively with the MDH Health Economics Program which oversees Minnesota's health care payment reform activities. OHIT is currently seeking opportunities to work

collaboratively, particularly in the area of HIT assessment, and will continue to seek additional opportunities to assist in the evaluation of the impact of HIT/HIE in achieving MN health reform goals on an ongoing basis.

Key Performance Measures

The Minnesota e-Health Connect program anticipates using the following sources in Table 8 below to gather data necessary for reporting on the following anticipated performance measures.

Table 8. Performance Measures and their Potential Data Sources

PERFORMANCE MEASURE	DATA SOURCE
Governance Domain	
<ul style="list-style-type: none"> ▪ The proportion of the governing organization is represented by public stakeholders ▪ The proportion of the governing organization is represented by private sector stakeholders ▪ To what extent the governing organization represent government, public health, hospitals, employers, providers, payers and consumers ▪ To what extent the state Medicaid agency has a designated governance role in the organization ▪ To what extent the governing organization has adopted a strategic plan for statewide health information technology ▪ To what extent the governing organization has approved and started implementation of an operational plan for statewide health information technology ▪ To what extent the governing organization meetings are posted and open to the public ▪ To what extent the regional health information exchange initiatives have a designated governance role in the organization 	e-Health Advisory Committee documentation
Technical Infrastructure Domain	
<ul style="list-style-type: none"> ▪ To what extent the statewide technical architecture for health information exchange is developed and ready for implementation according to the health information exchange model chosen by the governance organization ▪ To what extent the statewide technical infrastructure integrates state-specific Medicaid management information systems ▪ To what extent the statewide technical infrastructure integrates regional health information exchange ▪ The proportion of healthcare providers in the state that are able to receive electronic health information using components of the statewide health information exchange technical infrastructure ▪ The proportion of healthcare providers in the state that are able to receive electronic health information using components of the statewide health information exchange technical infrastructure 	Sub-recipient documentation; ongoing HIT surveys
Finance Domain	
<ul style="list-style-type: none"> ▪ To what extent the organization has developed and implemented financial policies and procedures consistent with state and federal requirements ▪ To what extent the organization receives revenue from both public and private organizations 	Project documentation; sub-recipient documentation

PERFORMANCE MEASURE	DATA SOURCE
<ul style="list-style-type: none"> ▪ The proportion of the sources of funding to advance statewide health information exchange that are obtained from federal assistance, state assistance, other charitable contributions, and revenue from health information exchange services ▪ Of other charitable contributions listed above, the proportion of funding from health care providers, employers, health plans, and others ▪ To what extent the organization has developed a business plan that includes a financial sustainability plan ▪ To what extent the governance organization reviews the budget with the oversight board on a quarterly basis ▪ To what extent the recipient complies with the Single Audit Requirements of OMB ▪ To what extent there is a secure revenue stream to support sustainable business operations throughout and beyond the performance period 	
Business and Technical Operations Domain	
<ul style="list-style-type: none"> ▪ To what extent technical assistance is available to those developing health information exchange services ▪ To what extent the statewide governance organization is monitoring and planning for remediation of health information exchange as necessary throughout the state ▪ The percentage of healthcare providers that have access to broadband ▪ To what extent the statewide shared services or other statewide technical resources are developed and implemented to address business and technical operations 	Sub-recipient documentation; project documentation; ongoing HIT surveys; Greater Minnesota Telehealth/EHR Broadband Initiative
Legal and Policy Issues Domain	
<ul style="list-style-type: none"> ▪ To what extent the governance organization had developed and implemented privacy policies and procedures consistent with state and federal requirements ▪ The number of trust agreements that have been signed ▪ To what extent privacy policies, procedures and trust agreements incorporate provisions allowing for public health data use 	Project documentation; sub-recipient documentation
Additional Performance Measures	
<ul style="list-style-type: none"> ▪ Percent of providers participating in health information exchange services enabled by statewide directories or shared services ▪ Percent of pharmacies serving people within the state that are actively supporting electronic prescribing and refill requests ▪ Percent of clinical laboratories serving people within the state that are actively supporting electronic ordering and results reporting ▪ Electronic health record adoption rate by provider type and geographic region of the state ▪ Achievement of meaningful use – percentage of eligible providers achieving meaningful use ▪ Consumer support for health information exchange through measurement of opt-out rates for patient consent enabling health information exchange 	Sub-recipient documentation; ongoing HIT surveys

PART 2: PROJECT RISK MANAGEMENT PLAN

Table 9 below describes a preliminary assessment of risks to the overall success of the Minnesota e-Health Connect program. Resources to manage these risks will be provided by the Office of Health Information Technology with consultation by subject matter experts from other areas of state government, including MDH's Project Management office and the Minnesota Management and Budget. This preliminary project risk management plan will be updated on an ongoing basis as new risks and plans for addressing those risks are identified.

Table 9. Preliminary Project Risk Management Plan

Project Risk	Probability of Occurrence	Impact	Risk Mitigation Strategy
GOVERNANCE			
Oversight process is more administratively burdensome than predicted (e.g., related to enforcement, responding to consumer complaints)	Medium	Medium	Address through future legislation recommendations
Lack of consensus, agreement, buy-in among key stakeholders (e.g., value added services)	Low	High	Maintain transparency in all oversight activities, and provide opportunities for stakeholder input on future criteria for certification of HIE service providers.
TECHNICAL INFRASTRUCTURE			
Confusion over NHIN direct	High	Medium	Address in communication messages, as needed; develop outreach materials
NHIN specifications become available too late	Medium	Medium	Accept risk
Lack of standards related to content for shared directories	High	Medium	Convene a technical group to address initial content for shared directories; advocate that standards related to content for shared directories be developed at national level to assist with intrastate and interstate exchange
LEGAL / POLICY ISSUES			
Decreased consumer participation	Medium	High	Develop consumer outreach efforts
Difficulty in developing policies/processes to address consent issues during interstate exchange	Medium	Medium	Establish collaborative workgroup with border states to discuss possible solutions, such as interstate agreements

FINANCE			
Inadequate funding (providers, public health) to participate in HIE	High	High	Address in financial sustainability plan
Too many resources dedicated to MU stages 1-3, less resources on value added services resulting in lower demand for HIE	Medium	Medium	Address in financial sustainability plan
Decreased provider participation	Medium	High	Address in financial sustainability plan
Lack of sustainable financial resources	High	High	Address in financial sustainability plan
BUSINESS / TECHNICAL OPERATIONS			
Confusion over meaningful use rules resulting in decreased participation in HIE			Address in communication plan; work with REACH; develop outreach materials; seek stakeholder volunteers
Confusion over Minnesota mandates resulting in decreased participation in HIE			Address in communication plan; work with REACH; develop outreach materials; seek stakeholder volunteers
Inadequate staffing for coordination efforts, outreach efforts, communication efforts, etc.			Dedicated staffing on outreach and communications
Contracting process takes too long and HIE services are not available on time	Medium	High	Manage risk through project management and monitoring of contract process
Providers not meeting meaningful use requirements; therefore not achieving critical mass of provider participation	Medium	Low	Dedicated staffing on outreach and communications; work with REACH
Negative press due to unclear messages, potential consumer concerns, etc.	Medium	Medium	Develop communications materials
Lack of clear direction / communication from federal level	Medium	Low	Work with ONC Project Officer for bi-directional communication
Lack of available data for reporting			Contract process, legal framework

PART 3: PROJECT SCHEDULE

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)			
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER
STRATEGIC AND OPERATIONAL PLANS																	
<i>Strategic Plan – Establish and implement a strategic plan.</i>																	
Develop and approve a vision for health information exchange in Minnesota	✓								L		C	C	C	X	X		
Develop and approve public good principles for health information exchange in Minnesota	✓								L		C	C	C	X	X		
Develop and approve goals, objectives, and strategies for the strategic plan for each of the five domain areas	✓								L		C	C	C	X	X		
Draft strategic plan	✓										C	C	C		X		
Preliminary approval of the strategic plan by Advisory Committee	✓								L		C	C	C	X			
Two week public comment period for the strategic plan	✓		X												X		
Final approval of the strategic plan by the Advisory Committee with letters of support from members and approval by the Commissioner of Health and the Commissioner of Human Services	✓		X											X			
Submission of plan to ONC				X											X		
Approval of Plan by ONC				X													
Annual updates to the Strategic Plan reviewed and approved by ONC (as required)								X	L	C	C	C	C	X	X		
<i>Operational Plan – Establish and implement an operational plan.</i>																	
Draft operational plan	✓		X							C		C	C	C		X	
Preliminary approval of operational plan by Advisory Committee	✓		X											X			
Four week public comment period on the operational plan	✓		X												X		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Final approval of operational plan by the Advisory Committee			X												X			
Submission of plan to ONC				X												X		
Operational Plan approved by ONC				X														
Annual updates to the Operational Plan reviewed and approved by ONC (as required)								X	C	C	C	C	C	X	X	X		
GOVERNANCE DOMAIN																		
<i>Governance Structure – Establish a governance structure that achieves broad-based stakeholder collaboration with transparency, buy-in and trust.</i>																		
Review and approve possible governance models for health information exchange in Minnesota (differentiating different levels of governance - policy governance through the Advisory Committee, oversight governance through the oversight panel, internal HIO/HDI governance)	✓									L		C	C		X	X		
Develop and approve health information exchange governance recommendations following a 30 day public comment period including recommendations on: Definitions of health information exchange, health information organization, state certified health information organization, and state registered health data intermediary; Criteria for certified health information organizations and state registered health data intermediaries across the five domains; Recommendations for oversight of health information exchange.	✓									L		C	C		X	X		
Collaborative governance model endorsed by stakeholders	✓																	
Incorporate governance recommendations into a draft bill which was introduced to the Minnesota Legislature	✓															X		
Collaborative governance model approved by ONC	✓			X	X													
Policy structures (bylaws and charter or organizational equivalents) established and endorsed by stakeholders	✓			X	X											X		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Key stakeholder participants identified (including public stakeholders, private sector stakeholders, government, public health, hospitals, employers, providers, payers and consumers)	✓			X	X											X		
Stakeholder representatives committed to participate	✓			X	X											X		
Stakeholder conflict of interest issues managed	✓			X	X											X		
Role of Medicaid representative in HIE governance established and Medicaid agency has a designated governance role (in policy governance structure through the Advisory Committee)	✓			X	X											X		
Regional HIE initiative representative(s) have designated governance role (in policy governance as ex-officio members)	✓			X	X											X		
Government HIT Coordinator position established and filled and role established	✓															X		
Governance entity is holding regularly scheduled public meetings with active participation of key stakeholders	✓			X	X											X		
Oversight and Accountability - Establish oversight and accountability mechanisms to protect the public interest																		
Organization meetings posted and open to the public (ongoing)				X	X	X	X	X								X		
Account for the flexibility needed to align with emerging nationwide HIE governance				X	X	X	X	X								X		
Governance model aligned with NHIN governance (as applicable)				X	X	X	X	X								X		
State / SDE representatives in NHIN activities identified				X	X	X	X	X								X		
Oversight law goes into effect				X												X		
Education letter and notice sent to potential health information organization and health data intermediary applicants explaining new requirements				X												X		
Criteria for financial sustainability are developed				X	X									X	X			

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Certificate of authority application becomes available				X												X		
Second notice sent to potential HIO and HDI applicants				X												X		
Solicit applications and respond to questions on applications				X												X		
Applications due to MDH				X												X		
MDH/OHIT determines if applications submitted by 9/10/10 are complete; if so, MDH/OHIT posts the complete applications on its website for public review and comment. If application is incomplete, MDH/OHIT will notify the applicant of any further information required for the application to be processed and included in a future hearing					X											X		
First Public Hearing held; HIE review Panel will receive testimony and public comments on applications for Certificates of Authority					X									RP	X			RP
Additional public comments may be submitted in writing to the HIE Review Panel					X											X		
Record on first Public Hearing closes; HIE Review Panel begins deliberations on recommendations related to certification					X									RP	X			
HIE Review Panel sends Report and Recommendations to Commissioner of Health regarding issuance of Certificate of Authority for applicants who participated in the first Public Hearing					X									RP	X			
Target date for Commissioner of Health to issue or deny applicant(s)' Certificate(s) of Authority					X											X		
Final date for Commissioner of Health to issue or deny applicant(s)' Certificates of Authority					X											X		
Proposed future due dates for applications: September 1, 2010; November 1, 2010; February 1, 2011; May 2, 2011; August 1, 2011; November 1, 2011.					X	X	X	X								X		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Proposed future Public Hearing dates: December 15, 2010; March 15, 2011; June 15, 2011; September 15, 2011; December 15, 2011.					X	X	X	X								X		
Proposed final dates for Commissioner of Health to issue or deny applicant(s) Certificates of Authority: November 30, 2010; January 30, 2011; May 2, 2011; August 1, 2011; October 31, 2011; January 30; 2012.					X	X	X	X								X		
Annual certificate renewals and required reports for HIE service providers								X								X		
Review panel makes recommendations to MDH on how to do ongoing monitoring, how to respond to public complaints, and to identify areas needing input by the Advisory Committee					X	X	X	X							RP	X		
FINANCE DOMAIN																		
<i>Sustainability Plan – Develop a path to sustainability including a business plan with feasible public/private financing mechanisms for ongoing information exchange.</i>																		
Develop Minnesota Approach to HIE Financial Sustainability (including working definition, principles, issues/barriers, discussion questions, and overall approach)	✓			X	X				L						X	X		
Develop scope for financial sustainability (what is included, what is excluded)			X	X					L						X	X		
Identify potential data sources and gather supporting data to help facilitate discussions			X	X					L						X	X		
Identify and validate principles for financial sustainability and resolve discussion questions generated by sub-workgroup on financial sustainability				X					L						X	X		
Identify solutions for mitigating risks associated with potential issues / barriers related to financial sustainability				X	X				L	C					X	X		
Identify and discuss recommendations on HIE financing framework core components (e.g., sources of funds, funders, funding mechanisms, recipients, uses of funds, revenue mechanisms, revenue sources, etc.)				X	X				L						X	X		
Review data submitted by HIOs on financial sustainability				X	X				L							X		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Develop projections and Minnesota plan for financial sustainability				X	X				L	C						X		
Sustainability plan endorsed by stakeholders and approved by Advisory Committee					X									X				
Sustainability plan approved by ONC							X								X			
Sustainability plan reviewed and updated annually								X							X			
\$1 non-federal match for each \$10 of federal funds					X										X	X		
\$1 non-federal match for each \$7 of federal funds						X	X								X	X		
\$1 non-federal match for each \$3 of federal funds								X							X	X		
TECHNICAL INFRASTRUCTURE DOMAIN																		
<i>Technical Infrastructure – Develop or facilitate the creation of a statewide technical infrastructure that supports statewide HIE.</i>																		
Technical infrastructure plan established and approved by ONC				X					C			L		X	X	X		
Technical infrastructure plan endorsed by stakeholders	✓		X						C			L		X	X			
Technical infrastructure plan reviewed and updated annually						X		X	C			L			X			
Statewide technical infrastructure for supporting HIE services developed and ready for implementation (see additional detail below)				X	X												X	
Stage 1: e-Prescribing - e-prescribing services to support eligibility, formulary, medication history and electronic prescribing				X													X	
Stage 1: Patient Synchronization				X													X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Stage 1: Adding Pharmacy Network provider as data source - add pharmacy network provider as data source enabling medication reconciliation using that medication history as well as medication history already available				X													X	
Stage 1: Radiology History - provide view capability to aggregated radiology reports from participating diagnostic imaging providers					X												X	
Stage 1: Public Health Reporting: Syndromic Surveillance Data - provide capability to electronically report health related data for syndromic surveillance activities					X												X	
Stage 1: Public Health Reporting: Lab Results - provide capability for electronic submission of reportable lab results to appropriate agencies					X												X	
Stage 1: Procedure List - provide view capability to aggregated procedure list from participating providers					X												X	
Stage 1: Problem List - provide view capability to aggregated problem list from participating providers.					X												X	
Stage 1: Allergies and Adverse Reaction History - provide view capability to aggregated allergies and adverse reaction list from participating providers					X												X	
Stage 1: Populate Patient Community View with CCD information - provide capability to view data from appropriate CCD modules or text from CDA documents on individual sections (portlets) of the Patient Community View as well as within CCD itself (e.g., lab history, radiology history, immunizations, procedure and problem lists, allergies and adverse reactions) components from CCD to appropriate Portlets					X												X	
Stage 1: Discharge Summary - provide capability to exchange discharge summary between providers as well as view document on patient community view in section with CCDs					X												X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Stage 2: Document Push - ability to move data such as CCDs and other documents at request from one provider to another provider						X											X	
Stage 2: Lab Ordering and Results Delivery - provide direct access to participating labs to order labs and receive results						X											X	
Stage 2: Radiology Ordering and Results Delivery - provide direct access to participating radiology providers to place order and to PACS systems to view images and receive results						X											X	
Stage 2: State-wide Provider Directory - create and maintain statewide and regional provider directory that includes provider attributes, affiliations, capabilities						X											X	
Stage 2: Interoperable Transactions from EMR to MIIC (Immunization Registry) - ability to update immunizations in MN Immunization Registry from EHR							X										X	
Stage 2: Misc Diagnostic Test History - provide view capabilities to other diagnostic test results (e.g., EKG, Pulm Fx, Cardiac imaging, nuclear med, pathology, etc.), provide view capability to aggregated reports from participating diagnostic providers, creates portlet on patient community view as well as creating ability for standard messaging								X									X	
Stage 1: Quality Reporting - capability for providers to submit required clinical quality measures using EHR							X										X	
Stage 2: Patient Access to PHRs:HealthVault - Capability to transfer data to PHR via HealthVault								X									X	
Stage 2: Patient Access to PHRs: other Health Repositories - capability to transfer data to PHR via other data repositories								X									X	
Stage 2: Clinical Messaging - Ability for provider to send standard message (HL7, CCD, etc.) to another provider's secure inbox, provides exchange capabilities for less advanced providers								X									X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Stage 2: Text Documents - capability to exchange various text documents from EHR (case notes, op reports, etc.) between providers as well as document on patient community view in section with CCDs								X									X	
Stage 3: Experience of Care Reporting - capability for providers to submit patient access and experience reports using established quality measures								X									X	
Stage 2: Home Monitoring - capability to incorporate data uploaded from home monitoring devices								X									X	
Stage 2: Consumer Preferences - capability to manage consumer preferences including: the ability for consumer defined permissions re: access to information under what circumstances health information is made available to others by their health care providers; the ability for consumers to authorize the release of their health information; the ability to establish various types of consumer preferences including consents, advance directives and other types of data								X									X	
Stage 2: Specialty Reporting - capability for specialty providers to report to relevant external disease (cardiology, cancer, etc.) or device registries								X									X	
Stage 3: Medical Device Interoperability								X									X	
Stage 3: Additional Quality Reporting - capability for providers to submit additional quality reports (TBD)								X									X	
Stage 3: Trauma Registry - capability to submit and review data from MN Trauma Registry								X									X	
Advanced Directives - capability for providers to update and maintain a statewide repository of their patient's wishes for these end of life care decisions								X									X	
Multi-media support - capability to view radiology and other images								X									X	
Connectivity between sub-recipient and MDH lab					X												X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Stage 2: Interoperable transactions from EHR to MIIC immunization registry							X										X	
Statewide technical infrastructure integrates with state-specific Medicaid management information systems					X												X	
Statewide technical infrastructure integrates with regional HIEs [requirement for HIO reciprocal agreements and interoperability in proposed legislation]					X												X	
Subrecipient application to become a state authorized HIO					X												X	
Subrecipient receive EHNAC certification or as approved by the Commissioner					X												X	
Subrecipient connectivity to NHIN					X												X	
Subrecipient connectivity to Veterans Administration							X									X	X	
Subrecipient connectivity to Indian Health Service							X									X	X	
Interstate connectivity							X	X								X	X	
Shared Services – Develop or facilitate the creation and use of shared directories and technical services, as applicable for the state’s approach for statewide HIE.																		
Convene a subgroup as needed to discuss and recommend an approach and technical standards for creation and use of shared directories and related technical services, as applicable to the state’s approach for statewide HIE					X	X				C			L		X	X	X	
Shared services offerings determined, including providers attributes, affiliations, and capabilities				X						C			L		X	X	X	
Shared directories and technical services for care providers developed					X					C			L			X	X	
Shared directories and technical services for service providers (including laboratory and radiology service providers) developed					X					C			L			X	X	
Shared directories and technical services for health plans developed					X					C			L			X	X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Shared service providers identified					X				C			L				X	X	
Interoperability of shared services tested and confirmed								X	C			L				X	X	
Activities related to Standards and Interoperability																		
Provide review and feedback as necessary on HITECH activities including: proposed standards, implementation criteria for electronic exchange and use of health information (related to "meaningful use" requirements); security standards; strategic and operational plans that support standards-based health information exchange as specified by Section 3013 of HITECH Act				X	X	X	X		C	C		L			X	X		
Identify implementation tools and resources promoted at national level and disseminate to support statewide standards implementation				X	X	X	X		C			L			X	X		
Review plans of regional extension centers to promote standards-based exchange of health information as part of "meaningful use" requirements and work collaboratively on resources and actions that will help increase implementation of these standards				X	X	X	X		C	C		L			X	X		
Update the tools and resources to support implementation of e-health standards including those that can help support achieving meaningful use				X	X	X	X		C			L			X	X		
Deliver a final draft of updated Guide 2 (Standards Recommended for Use in Minnesota)				X				X	C			L			X	X		
Activities related to EHR Adoption and Meaningful Use																		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
State Medicaid HIT Plan/EHR Incentives Subgroup: Provide input and feedback on State Medicaid HIT Plan ("as-is" landscape, "to-be" landscape, administration and oversight activities, audit strategy, roadmap); provide feedback on Medicaid EHR Incentive Administration Plan; review and provide feedback on CMS final regulations for EHR incentives; analyze the implications of changes/updates to meaningful use guidelines and communicate those implications to stakeholders, providers, and the public				X	X				C	L						X		DHS
Coordinate communication efforts to: encourage all stakeholders and providers to understand state and federal mandates for HIT/EHR adoption; encourage all stakeholders and providers to understand and take advantage of resources made available through state and federal grants, low cost loans, and other sources of funding, technical assistance and training				X	X	X	X	X	C	L			C	X	X			DHS
Review and amend/update the state "meaningful use" adoption strategy. Review tactics that support the strategy and suggest changes/updates if strategic goals are not being reached				X	X				C	L				X	X			
Minnesota Community Survey Implementation		X	X			X	X	X								X		
American Hospital Association Survey/Minnesota Hospital Association Survey Implementation				X	X			X								X		
Review ongoing HIT assessments (e.g., Minnesota Community Measurement HIT survey, American Hospital Association/Minnesota Hospital Association Survey)					X	X		X	C	L				X	X			
Review reports from subrecipient on participating entities and corresponding transaction use				X	X	X	X	X							X	X		
Provide recommendations and guidance to the Regional Extension Center (REACH) and others regarding solutions to addressing barriers to HIT adoption and achievement of meaningful use							X	X	C	L				X	X			

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)			
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER
Evaluate Minnesota's impact of HIT/HIE on achieving Minnesota's health care reform goals								X	C	L				X	X		
Identify gaps, make recommendations, and identify resources for how to support health / health care providers in other settings							X		C	L				X	X		
Review Minnesota progress in effective use of EHRs and make recommendations for supporting Minnesota providers, including identifying gaps and providing guidance to health / health care providers					X	X	X		C	L				X	X		
Recommend strategies to expand on assessment activities, including: developing a standard set of questions that can be used in assessments conducted in other settings and promoting the standard set of questions with associations to encourage additional assessments							X	X	C	L				X	X		
BUSINESS AND TECHNICAL OPERATIONS DOMAIN																	
<i>Monitoring Capacity – Monitor and plan for remediation of the actual performance of HIE throughout the state.</i>																	
Project management protocols implemented and operational		X	X	X	X	X	X	X							X	X	SC
State or State Designated Entity is monitoring and reporting on all required program evaluation metrics		X	X	X	X	X	X	X							X	X	
Reporting requirements: ARRA reports due 10 days after each calendar quarter, submitted along with Financial Status Report SF-269		X	X	X	X	X	X	X							X	X	
Program progress reports due semi-annually				X	X	X	X	X							X	X	
Communication Plan																	
Communication plan implementation and ongoing updates as necessary			X	X	X	X	X	X	C	C	C	C	L		X	X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Communication plan implementation: leveraging meaningful use along the entire continuum of care; e-Health Summit promotion	✓		X													X		
Focused communication / education: Minnesota law on HIE oversight goes into effect in July (announce law, oversight process for HIE service providers established, etc.)				X												X		
Focused communication /education: Meaningful use rule released, announce standards final rule				X												X		
Focused communication / education: messages about 2011 e-prescribing mandate				X												X		
Focused communication / education: MN e-Health plans for 2010-2011 (announce workgroups for 2010-2011, how to participate in the MN e-Health Initiative)				X												X		
Focused communication / education: meaningful use incentives for hospitals					X											X		
Focused communication / education: announcements on health information exchange (how to get connected to a certified HIE service provider; announce HIE service provider complaint process)					X											X		
Identify and recommend opportunities for coordination with REACH program, MN HIOs and HDIs, the MN Dept of Human Services, and others as identified					X	X	X	X	C	C	C	C	L			X	X	
Monitor and provide feedback on Minnesota e-Health "key message" communication to Minnesota professional and trade associations to evaluate the effectiveness of messages and communication vehicles (quarterly)					X	X	X	X	C	C	C	C	L			X	X	
Review communications developed by other Minnesota e-Health Initiative Workgroups					X	X	X	X	C	C	C	C	L			X	X	
Identify any gaps in outreach and communications and prioritize groups and messages					X	X	X	X	C	C	C	C	L			X	X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)			
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER
Recommend activities to address outreach gaps that engage health care organizations, providers, and consumers to support the adoption and use of EHRs to achieve meaningful use and compliance with the 2011 and 2015 mandates					X	X	X	X	C	C	C	C	L		X	X	
Recommend consumer communications resources to list on the Minnesota e-Health website, incorporating contributions of the Minnesota e-Health workgroups					X	X	X	X	C	C	C	C	L		X	X	
Technical Assistance Plan																	
Technical assistance plan implementation and ongoing updates as necessary			X	X	X	X	X	X	L	C	C	C	C		X	X	
Develop a guide targeted to health/health care providers for health information exchange to develop solutions to address identified HIE barriers						X	X		L	C	C	C	C		X	X	
Project management/risk management																	
State Government Health Information Exchange Steering Committee meetings to provide project status updates				X	X	X	X	X							X	X	
Risk management plan and project plan updated on an ongoing basis			X	X	X										X	X	
LEGAL AND POLICY ISSUES DOMAIN																	
Statewide Policy Framework – Establish a statewide policy framework that allows incremental development of HIE policies over time.																	
Statewide Policy Framework endorsed by stakeholders	✓								C		L	C		X	X		
Statewide Policy Framework established and approved by ONC (Current legal framework pertaining to privacy & security, specific elements in HIE oversight language provides for automatic adjustments in HIE policies with the changing federal landscape and the evolution of HIE policy.)				X										X	X		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Needed modifications to state laws to enable and foster health information exchange within the state and interstate have been identified and, where possible, enacted				X	X			X	C		L	C			X	X		
Policies, procedures and trust agreements have been established to enable and foster health information exchange within the state and interstate and include provisions allowing for public health data use			X	X	X			X	C		L				X	X	X	
Provide review and feedback necessary on HITECH activities including: proposed federal rules and guidance pursuant to the HITECH Act related to privacy, legal and policy issues; legal and policy sections of updated strategic and operational plans that support health information exchange as specified by section 3013 of HITECH Act; privacy, legal and policy issues identified by the Minnesota e-Health Initiative Advisory committee and staff				X	X	X	X	X	C		L				X	X		
Develop annual report to be submitted to the Office of the National Coordinator on "Implementation and Evaluation of Policies and Legal Agreements related to HIEs" and identify any issues for further policy development				X	X	X			C		L				X	X		
Review and comment on policy issues, including: breach notification issues and requirements; management of consumer preferences issues and establishment of dispute resolution process regarding differences among HIOs, HDIs and providers related to consumer preferences				X	X	X			C		L				X	X		
COORDINATION WITH ARRA PROGRAMS																		
<i>Alignment with ARRA – Statewide HIE efforts are aligned with other federal programs.</i>																		
Ongoing coordination activities with other ARRA/HITECH programs		X	X	X	X	X	X	X	L	L	L	L	L	L	X	X	X	
COORDINATION WITH OTHER STATES																		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Planning with other state health information exchange organizations				X	X	X	X	X	C		L				X	X		
Plans for interstate connectivity				X	X	X	X	X	C		L				X	X		
Develop UM-HIE Coalition charter, project plan, timeline, and deliverables				X	X				C		L				X			
UM-HIE states identify mechanisms that will be used to gather stakeholder input on concerns/barriers and potential solutions to enable interstate HIE; UM-HIE states identify relevant statutes and regulations pertaining to consent laws and authority/enforcement mechanisms and liability for bad actors					X				C		L				X			
UM-HIE states work with stakeholder groups to gather input on potential assurances that could be incorporated into agreements with other states to address concerns; research potential mechanisms for establishing agreements to the states					X				C		L				X			
UM-HIE states work toward consensus on solutions to identified concerns/ barriers						X			C		L				X			
UM-HIE states gather feedback on proposed consensus solutions and potential mechanisms for establishing agreements between states						X			C		L				X			
UM-HIE states identify appropriate individuals to serve on drafting team to develop proposed language for state agreements						X			C		L				X			
Initial draft language is prepared for agreements between UM-HIE states; UM-HIE states gather feedback from stakeholders on draft language							X		C		L				X			
Final review and approval of language for agreements between UM-HIE states								X	C		L				X			

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)					
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER		
Provide advice and comment on work conducted by a collaborative group of state HIE staff members from the upper Midwest border states and other states that are likely to be frequent trading partners of health information to facilitate discussion of common challenges and solutions related to interstate health information exchange				X	X	X	X	X	C		L					X	X		
Review environmental scan of laws in those states and identify potential barriers to successful interstate HIE, including laws related to: patient consent requirements/options; sensitive services; processing paper transactions; release of lab results to providers other than the ordering provider; authentication				X	X	X	X	X	C		L					X	X		
Discuss and comment on possible solutions, including: interstate compact agreements; DURSA/federal initiatives; changes to Minnesota law				X	X	X	X	X	C		L					X	X		
OUTCOMES AND PERFORMANCE MEASURES																			
Review HIT/HIE assessments, key performance measures, and other data sources to identify issues and barriers regarding health information exchange				X	X				L	C					X	X			
Develop evaluation plan for HIE - including surveys to be use and timelines for receiving the data (e.g., Minnesota framework for evaluation; available data sources; data collection methods; analysis plans)				X	X				L	C					X	X			
Collect and analyze data and publish information about Minnesota's health information exchange efforts				X	X	X	X	X	L	C					X	X	X		
Work collaboratively with other health reform initiatives				X	X	X	X	X	C	C					X	X			
Develop annual report to legislature regarding status of health information exchange in Minnesota				X	X				C						X	X			
Monitor and maintain a targeted degree of participation in HIE enabled state level technical services																X	X		

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

Minnesota e-Health Connect Program Timeline

Milestone/Fulfillment Criteria	Status	Q1 (1/1-3/10)	Q2 (4/10-6/10)	Q3 (7/10-9/10)	Q4 (10/10-12/10)	Q5 (1/11-3/11)	Q6 (4/11-6/11)	Q7 and beyond	Lead (L) & Consulting (C) Workgroups					Advisory Committee (AC), MDH/OHIT Staff, Sub-Recipient and Other Roles (RP= Review Panel; DHS = Dept of Human Services, SC = State Government HIE Steering Committee, SP = HIE Service Providers)				
									EX	MU	L/P	S/I	O/E	AC	MDH/OHIT	SUB	OTHER	
Identify specific benchmarks that will be included in contracts with sub-recipients & outline technical assistance that will be available to the HIO to assist in reaching specified targets																X		
Initial performance measures (to be further developed upon development of evaluation plan and guidance from ONC)																		
Reporting elements for HIE to be collected from HIE Service Providers to include, but not limited to:																		SP
Percent of healthcare providers in the state are able to send electronic health information using components of the statewide HIE Technical infrastructure																X	X	SP
Percent of healthcare providers in the state are able to receive electronic health information using components of the statewide HIE Technical infrastructure																X	X	SP
Percent of pharmacies serving people within the state are actively supporting electronic prescribing and refill requests																X	X	SP
Percent of clinical laboratories serving people within the state that are actively supporting electronic ordering and results reporting																X	X	SP
Percent of healthcare providers in the state have access to broadband services																X		SP
Percentage of the state's providers have signed trust agreements																X	X	SP
Semi-annual progress reports submitted to ONC																X	X	
Program performance measurement results submitted																X	X	

*Project schedule to be updated on an ongoing basis as additional federal and state requirements are defined.

PART 4: APPENDICES

- Appendix A: 2010-2011 Health Information Exchange Workgroup Charge
- Appendix B: 2010-2011 Adoption and Meaningful Use Workgroup Charge
- Appendix C: 2010-2011 Standards and Interoperability Workgroup Charge
- Appendix D: 2010-2011 Privacy, Legal and Policy Workgroup Charge
- Appendix E: 2010-2011 Communications and Outreach Workgroup Charge
- Appendix F: Minnesota e-Health Communications Plan and Workplan for 2010-2011
- Appendix G: 2010 Session Law Chapter 336
- Appendix H: UM-HIE Proposal
- Appendix I: State Government Health Information Exchange Steering Committee Charge
- Appendix J: OHIT Public Health Collaboration Workgroup Charge
- Appendix K: Minnesota e-Health Connect Budget (to be added)

Workgroup Charge

- Serve as the lead workgroup in coordinating the development of statewide policy recommendations related to health information exchange into an integrated statewide approach across the five critical domains: governance, technical infrastructure, legal and policy issues, finance, and business and technical operations. In this capacity, the workgroup will serve to:
 - Identify key issues that must be addressed to enable health information exchange. Key priority issues to be addressed in 2010-2011 include: financial sustainability, evaluation of key performance measures, and guidance for providers regarding health information exchange
 - Engage and rely on subject matter experts convened through the other e-Health Initiative workgroups, as necessary, to address key issues identified
 - Synthesize and incorporate input from each of the workgroups into recommendations to the Minnesota e-Health Initiative Advisory Committee for inclusion in Minnesota’s approach to HIE, including any updates to Minnesota’s strategic and operational plans for health information exchange
 - Provide input on American Recovery and Reinvestment Act of 2009 (ARRA) implementation activities related to health information exchange
 - Coordinate HIE related activities of the e-Health Workgroups and Advisory Committee (See table 1)

Table 1. 2010-2011 Minnesota e-Health Initiative Advisory Committee & Workgroup Structure Interdependencies across the Five Domains of Health Information Exchange

Minnesota e-Health Initiative Committee, Workgroup (WG) or Subgroup	Governance	Finance	Technical Infrastructure	Business / Technical Operations	Legal / Policy
Advisory Committee ▪ HIE Review Panel	X	X	X	X	X
Health Information Exchange WG	X	X	X	X	X
Adoption & Meaningful Use WG ▪ Medicaid Advisory SG		X			
Standards and Interoperability WG ▪ Shared Services SG ▪ Security SG			X		
Privacy, Legal & Policy WG					X
Communications and Outreach WG				X	

Background

The American Recovery and Reinvestment Act of 2009 (ARRA) includes funds to states for aid in developing the health information exchange capacity needed to allow providers to meet meaningful use criteria. This assistance is provided through the State Health Information Exchange Cooperative Agreement Program, the overall purpose of which is to facilitate and expand the secure, electronic movement and use of health information among organizations according to nationally recognized standards. The cooperative agreements will focus on developing the statewide policy, governance, technical infrastructure, and business practices needed to support the delivery of HIE services. The resulting capabilities for healthcare-providing entities to exchange health information must meet the Medicaid and Medicare meaningful use requirements for health care providers to achieve financial incentives.

Work Group Deliverables and Timeline

- **September – December 2010**
 - Provide recommendations on a report on financial sustainability, including a business plan with feasible public and private financing mechanisms for ongoing information exchange.
 - Review HIT/HIE assessments, key performance measures, and other data sources to identify issues and barriers regarding health information exchange
 - Provide input to the evaluation plan for HIE (development of plan, reporting on indicators, etc.)

- Provide any necessary policy development recommendations related to health information exchange to the e-Health Initiative Advisory Committee.
- **December 2010**
 - Review and comment on annual report to legislature regarding status of health information exchange in Minnesota
- **December 2010 – February 2011**
 - Review and comment on annual report to the Office of the National Coordinator, including: statewide HIE alignment with other federal programs; sustainability; and implementation and evaluation of policies and legal agreements related to HIE
 - Review and comment on any updates to strategic and operational plans for health information exchange to be consistent with federal requirements.
- **March – May 2011**
 - Develop a guide targeted to health / health care providers for health information exchange to develop solutions to address identified HIE barriers
- **General Deliverables**
 - Provide quarterly updates to the Minnesota e-Health Advisory Committee
 - June 2011: Provide a status report issued at the Minnesota e-Health Summit
 - Identify opportunities in common with other committees, workgroups and organizations
 - Provide input on American Recovery and Reinvestment Act of 2009 (ARRA) implementation activities related to health information exchange.
 - Provide feedback to other HITECH programs in Minnesota (e.g., REACH, UPHI).

Approach for Coordination with other HITECH Programs

- Receive updates from Regional Extension Center (REACH), SHARP, BEACON, and workforce programs to gather practical advice and lessons learned that can better inform the community.

Cross-cutting Issues with other Workgroups

- Health information exchange technical architecture components (including exchange standards and directory services) with Standards and Interoperability Workgroup.
- Communication issues (e.g., key messages and communication resources) regarding health information exchange with Communications and Outreach Workgroup.
- Consent issues regarding interstate health information exchange with Privacy, Legal, and Policy Issues Workgroup.
- Considerations for health information exchange in other settings with Adoption and Meaningful Use Workgroup.

Workgroup Member Expectations

- Serve a one-year term: September 2010 – June 2011.
- Participate in meetings and/or conference calls approximately every 3-4 weeks or more frequently as needed during the term.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.
- Keep the statewide interests of the e-Health Initiative foremost in your decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Value in Participating

- Proactively help shape future policy directions that can have a major impact on your organization.
- Enable your organization to be more prepared to respond to the requirements of state and federal implementation plans as they are established.

Workgroup Leadership (TBD)

Approximately 20-25 stakeholders will be invited from across the spectrum of care based on expertise and subject matter knowledge to participate on the workgroup. Meetings are open to the public and all participants are welcome.

Workgroup Staff (TBD)

DHS Liaison (TBD)

For more information: www.health.state.mn.us/e-health or by e-mail: MN.eHealth@state.mn.us

Workgroup Charge

- Review and provide feedback as necessary on proposed state and federal definitions, criteria and/or proposed regulations regarding meaningful use pertaining to Medicare and/or Medicaid incentive payments under the American Reinvestment Act of 2009 (ARRA) to ensure that Minnesota providers seeking to obtain incentive payments are able to meet federal and state criteria.
- Conduct gap analysis, make recommendations, identify resources, and provide guidance in Minnesota for meeting meaningful use requirements
- Identify gaps, make recommendations, and identify resources for how to support providers in other settings
- Review Minnesota progress in effective use of EHRs and make recommendations for supporting Minnesota providers, including identifying gaps and providing guidance to health / health care providers
- Provide recommendations and feedback to Minnesota Medicaid on the Medicaid HIT Plan and the Medicaid EHR Incentive Administration Plan

Background

The American Recovery and Reinvestment Act of 2009 (ARRA) establishes Medicare and Medicaid incentives for hospitals and health care providers who can demonstrate they are meaningful users of electronic health records (EHRs). There are three core requirements for “meaningful use” identified in the new law:

1. Use of certified or qualified EHR technology
2. Electronic exchange of health information
3. Use of EHR in reporting on clinical and other quality measures

The ARRA requires the Office of the National Coordinator (ONC) and the Centers for Medicare and Medicaid Services (CMS) to develop rules, guidance and plans to promote the adoption and meaningful use of EHRs. Draft rules are expected to be published in late December 2009. The law gives states some flexibility in 2010 for determining the definition of meaningful use for the purpose of determining eligibility for Medicaid incentives. The Minnesota Departments of Health and Human Services will jointly implement the Medicaid incentives and define meaningful use to meet Minnesota and federal priorities. The definition of meaningful use is important because it will determine whether Minnesota providers are able to meet the necessary criteria to receive incentive funds.

Work Group Deliverables and Timeline

- June 2010 – December 2010 – Medicaid HIT Plan/EHR Incentives Subgroup (approximately bi-weekly meetings)
 - Provide input and feedback on State Medicaid HIT Plan (“as-is” landscape, “to-be” landscape, administration and oversight activities, audit strategy, roadmap)
 - Provide feedback on Medicaid EHR Incentive Administration Plan
 - Review and provide feedback on CMS final regulations for EHR Incentives
 - Analyze the implications of changes/updates to meaningful use guidelines and communicate those implications to stakeholders, providers, and the public
- June 2010 – June 2011
 - Work with the Communication and Outreach to coordinate and implement communication efforts to:
 - Encourage all stakeholders and providers to understand state and federal mandates for HIT / EHR adoption.
 - Encourage all stakeholders and providers to understand and take advantage of resources made available through state and federal grants, low cost loans, and other sources of funding, technical assistance and training.
- September – December 2010
 - Review and amend/update the State Meaningful Use adoption strategy. Review tactics that support the strategy and suggest changes/updates if strategic goals are not being reached.
 - Review ongoing HIT assessments (e.g., Minnesota Community Measurement HIT survey, American Hospital Association/Minnesota Hospital Association Survey)

- Provide recommendations and guidance to the Regional Extension Center (REACH) and others regarding solutions to addressing barriers to HIT adoption and achievement of meaningful use
- December 2010
 - Evaluate Minnesota's impact of HIT/HIE on achieving Minnesota's health care reform goals
 - Review and comment on annual report to legislature regarding status of HIT adoption and use in Minnesota
- January 2011 – March 2011
 - Conduct gap analysis, make recommendations, and identify resources for how to support health / health care providers in other settings
 - Review Minnesota progress in effective use of EHRs and make recommendations for supporting Minnesota providers, including identifying gaps and providing guidance to health / health care providers
- March 2011 – May 2011
 - Recommend strategies to expand on assessment activities, including: developing a standard set of questions that can be used in assessments conducted in other settings. Promote standard set of questions with associations to encourage assessments in other settings.
- General Deliverables
 - Quarterly: Progress updates to the Minnesota e-Health Advisory Committee
 - June 2011: Provide a status report issued at the Minnesota e-Health Summit
 - Provide input on American Recovery and Reinvestment Act of 2009 (ARRA) implementation activities related to meaningful use.
 - Provide feedback to other HITECH programs in Minnesota (e.g., REACH, UPHI).

Approach for Coordination with other HITECH Programs

- Receive updates from Regional Extension Center (REACH), SHARP, BEACON, and workforce programs to gather practical advice and lessons learned that can better inform the community and provide further guidance regarding adoption and meaningful use.

Cross-cutting Issues with other Workgroups

- Communication issues (e.g., key messages and communication resources) regarding HIT adoption and meaningful use with Communications and Outreach Workgroup
- Clinical quality standards and current state assessment with Standards and Interoperability Workgroup
- Considerations for health information exchange in other settings with Health Information Exchange Workgroup

Guiding Principles and Themes

- Focus guidance on the core ARRA requirements for providers needing to achieve meaningful use requirements for purposes of Medicare and Medicaid HIT incentive payments and then expand guidance to include all health care settings.
- Consider and expand upon the previous work completed and published in guides 1, 2, 3, and 4.
- Consider the broad view of issues that affect achieving meaningful use including technical, organizational, legal, community and telecommunications or related issues.
- Consider data collected at the provider level – a patient-centered approach.
- Ensure that deliverables are consistent with and support federal and state health care reform efforts

Workgroup Member Expectations

- Serve a one-year term: September 2010 – June 2011.
- Participate in meetings and/or conference calls approximately every 3-4 weeks or more frequently as needed during the term.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.
- Keep the statewide interests of the e-Health Initiative foremost in your decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Value in Participating

- Proactively help shape future policy directions that can have a major impact on your organization.

For more information: www.health.state.mn.us/e-health or by e-mail: MN.eHealth@state.mn.us

- Enable your organization to be more prepared to respond to the requirements of state and federal implementation plans as they are established.

Workgroup Leadership (TBD)

Approximately 20-25 stakeholders will be invited from across the spectrum of care based on expertise and subject matter knowledge to participate on the workgroup. Meetings are open to the public and all participants are welcome.

Workgroup Staff (TBD)

DHS Liaison (TBD)

Proposed Workgroup Charge

- Identify and recommend nationally recognized standards, implementation specifications and certification criteria necessary to facilitate and expand the secure electronic movement and use of health information among organizations in Minnesota
- Review and comment on standards, implementation specifications and certification criteria related to the requirements of “meaningful use” and recommend resources and actions that will help increase implementation of these standards.
- Review and comment on standards or other technical requirements related to the implementation of statewide strategic and operational plans for health information exchange [Section 3013 of American Recovery and Reinvestment Act (ARRA)].

Background

Standards related to “meaningful use” and health information exchange. The Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) aims to facilitate and expand the secure, electronic movement of health information among organizations through its State Health Information Exchange (HIE) Cooperative Agreement program (Section 3013). The standards based exchange of information is essential to achievement of “meaningful use” as identified in HITECH Act. One of the state responsibilities/requirements is to ensure compliance with relevant HHS adopted standards and all applicable policies for interoperability, privacy and security. Minnesota Department of Health has been designated as the entity to create and execute strategic and operational plans that advance standards-based health information exchange.

Minnesota e-Health Standards are a requirement for electronic exchange of health information and achieving interoperability as required by the Minnesota 2015 mandate. Interoperability of Electronic Health Records (EHR) systems in Minnesota means the ability of two or more EHR systems or components of EHR systems to exchange information electronically, securely, accurately and verifiably, when and where needed. It is comprised of “technical,” “semantic” and “process” interoperability, and the information exchanged includes transactions and standards as defined by the Minnesota Commissioner of Health. The Minnesota vision for exchange is to electronically move health information among disparate systems in order to improve health care quality, increase patient safety, reduce health care costs and improve public health, consistent with principles of health reform.

The 2010-2011 standards workgroup charge builds on the accomplishments of the previous three years’ work which is published in the 2010 edition of *Guide 2: Standards Recommended to Achieve Interoperability in Minnesota* at <http://www.health.state.mn.us/ehealth>. The workgroup will continue to look to key national standards activities for priorities, standards recommended, implementation specifications; certification criteria and timelines (*see Figure 1, page 3 for workgroup process*).

Workgroup Deliverables and Timeline

Deliverables Related to Standards:

- September 2010 – May 2011: Provide review and feedback as necessary on HITECH activities including:
 - Identify, review and comment on proposed standards, implementation specifications and certification criteria for electronic exchange and use of health information (related to “meaningful use” requirements)
 - Coordinate specific meetings as needed to focus on security standards
 - Review and provide feedback on strategic and operational plans that support standards-based health information exchange as specified by Section 3013 of HITECH Act.
- By December 2010: Convene a subgroup as needed to discuss and recommend an approach and technical standards for creation and use of shared directories and related technical services, as applicable to the state’s approach for statewide HIE.
- September 2010 – May 2011: Identify implementation tools and resources promoted at national level and disseminate tools, tips and templates to support statewide standards implementation.
- By May 2011: Review plans of the regional extension centers to promote standards-based exchange of health information as part of “meaningful use” requirements and work collaboratively on resources and actions that will help increase implementation of these standards.
- By May 2011: Update the tools and resources to support implementation of e-health standards including those that can help support achieving meaningful use.
- By May 2011: Deliver a final draft of the 2011 update for Guide 2 (Standards Recommended for Use in Minnesota).

General Deliverables:

- By December 2010: Review and comment on standards section of the 2011 MDH report to the Minnesota Legislature.
- September 2010 – May 2011: Provide quarterly updates to the Minnesota e-Health Advisory Committee
- June 2011: Provide a status report issued at Minnesota e-Health Summit.
- Identify opportunities in common with other committees, workgroups and organizations.

Approach for Coordination with other HITECH Programs

- Work collaboratively with regional extension center to promote standards-based exchange as part of “meaningful use” requirements and work together on resources and actions that will increase implementation of these standards.
- Receive updates from SHARP and BEACON project teams to gather practical advice and lessons learned than can better inform the community related to implementation of technical standards.
- Receive input from DHS/CMS to better understand the issues and needs related to standards.
- Promote standards materials to all HITECH funded projects in Minnesota

Cross-cutting Issues with other Workgroups

- Exchange standards and directory services with Health Information Exchange workgroup
- Clinical quality standards and current state assessment with Adoption and Meaningful Use workgroup
- Federal standards for health information privacy and security with Privacy, Legal & Policy workgroup
- Communications and outreach with Communications & Outreach workgroup

Guiding Principles and Themes

- Minnesota e-Health standards recommendations will be aligned with HITECH standards requirements from ONC
- Implementation tools, tips and resources are important to support statewide standards implementation
- The needs of Minnesota providers and industry readiness will be considered in recommendations
- Interoperability including process interoperability is a key element in success

Workgroup Member Expectations

- Serve a one-year term: September 2010 – June 2011.
- Participate in monthly workgroup meetings during the term and additional conference calls as needed.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.
- Keep the statewide interests of the e-Health Initiative foremost in decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Value in Participating

- Proactively help shape future policy directions that can have a major impact on your organization.
- Enable your organization to be more prepared to respond to the recommendations and requirements of standards and state and federal implementation plans as they are established.

Workgroup Leadership (TBD)

Co-Chairs:

Many members of the workgroup have expressed interest in continued participation. Additional members will be recruited across the spectrum of care based on expertise and subject matter knowledge. Meetings are open to the public and all participants are welcome.

Workgroup Staff

TBD

DHS Liaison

TBD



Appendix D. Privacy, Legal and Policy Workgroup Charge: 2010-2011

Proposed Workgroup Charge

- Monitor, assess and comment on policy and legal issues related to e-Health and health information exchange.
- Review and comment on privacy and security-related policies and proposed federal regulations and guidance, and make recommendations on mechanisms to ensure compliance with state and federal requirements related to interstate and intrastate health information exchange.
- Support providers and health care stakeholders in the implementation of privacy and security criteria necessary to qualify as a “meaningful user” of an Electronic Health Record (EHR) under the HITECH Act.
- Ensure that the needs of consumers, providers, and health care stakeholders are fully considered in the development of the statutory framework for health information exchange and in the development of educational resources and tools.

Background

Consumer acceptance and trust are the foundation for the successful development, implementation and use of EHRs and other Health Information Technologies (HIT). Privacy and security protections afforded to a patient’s health information are critical in earning that trust. Patients and consumers have a strong interest in how the privacy, confidentiality and integrity of their information will be addressed and integrated into the implementation and exchange of EHRs and other HIT.

The HITECH Act aims to facilitate and expand the secure electronic movement of health information among organizations through its State Health Information Exchange (HIE) Cooperative Agreement program (section 3013). The Minnesota Department of Health has been designated as the entity to create and execute strategic and operational plans that advance the private and secure interoperability of HIE in Minnesota. The Minnesota vision for exchange is to electronically move health information among disparate systems in order to improve health care quality, increase patient safety, reduce health care costs and improve public health, consistent with principles of health reform.

This year, the 2010-2011 Privacy, Legal and Policy Issues Work Group will build on the accomplishments of its predecessor, the Minnesota Privacy and Security Work Group (MPSP) by expanding its scope to include the analysis of legal and policy issues related to interstate health information exchange, in addition to monitoring privacy and security issues.

Workgroup Deliverables and Timeline

- September 2010 – May 2011: Provide review and feedback as necessary, including formal coordinated responses from Minnesota stakeholders and interested parties, on HITECH activities including:
 - Proposed federal rules and guidance pursuant to the HITECH Act related to privacy, legal and policy issues.
 - Legal and policy sections of updated strategic and operational plans that support health information exchange as specified by Section 3013 of HITECH Act.
 - Privacy, legal and policy issues identified by Minnesota e-Health Advisory Committee and staff.
- By December 2010: Analyze and provide comments or recommendations regarding interstate HIE, including:
 - Provide advice and comment on work conducted by a collaborative group of state HIE staff members from the upper Midwest border states and other states that are likely to be frequent trading partners of health information to facilitate discussion of common challenges and solutions related to interstate health information exchange.
 - Review environmental scan of laws in those states and identify potential barriers to successful interstate HIE, including laws related to:
 - Patient consent requirements/options
 - Sensitive services
 - Processing paper transactions
 - Release of lab results to providers other than the ordering provider
 - Authentication
 - Discuss, analyze, and comment on possible solutions, including:
 - Interstate compact agreements
 - DURSA/federal initiatives
 - Changes to Minnesota law

For more information: www.health.state.mn.us/e-health or by e-mail: MN.eHealth@state.mn.us

Last updated: June 25, 2010

- By February 2011: Provide consultation on the annual report to be submitted to the Office of the National Coordinator (ONC) on “Implementation and Evaluation of Policies and Legal Agreements related to HIEs” and identify any issues for further policy development.
- By April 2011: Review and comment on legal and policy issues, including;
 - Breach notification issues and requirements;
 - Management of consent and consumer preferences issues and establishment of dispute resolution process regarding differences among HIOs, HDIs and providers related to consumer preferences.; and

General Deliverables:

- September 2010-May 2011: Provide quarterly workgroup updates to the Minnesota e-Health Advisory Committee.
- December 2011: Review and comment on the privacy, legal and policy activities and deliverables in the MDH report to the Minnesota Legislature.
- June 2011: Provide a status report issued at Minnesota e-Health Summit.
- As needed, provide consultation and review of issues related to HIE and the need for standard language for agreements.
- Identify communication, education and collaboration opportunities to address common topics and issues with other committees, workgroups and organizations.

Approach for Coordination with other HITECH Programs

- Provide ongoing assistance to regional extension center and help Minnesota providers understand and achieve “meaningful use” with respect to privacy, legal and policy issues.
- Work collaboratively with Minnesota Medicaid and DHS to address mutual privacy, legal and policy issues.

Cross-cutting Issues with other Workgroups

- Federal standards for health information privacy and security with Standards Workgroup.
- Key messages about health information privacy and security with Communications and Outreach Workgroup.
- Collaboration with Health Information Exchange Workgroup to prepare report to Minnesota Legislature on HIE.

Guiding Principles and Themes

- Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use and disclosure of their individually identifiable health information.
- Individually identifiable health information should be collected, used and/or disclosed only to the extent necessary to accomplish a specified purpose, and should be protected with reasonable administrative, technical and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure.

Workgroup Member Expectations

- Serve a one-year term: September 2010 – June 2011.
- Participate in monthly workgroup meetings during the term and additional conference calls as needed.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.
- Keep the statewide interests of the e-Health Initiative foremost in decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Value in Participating

- Proactively help shape future policy directions that can have a major impact on your organization.
- Enable your organization to be more prepared to respond to the privacy and policy requirements of as they are established.

Workgroup Leadership

TBD

Workgroup Staff

Donna M. Watz
 Phone: (651) 201-3598
Donna.Watz@state.mn.us

Bob Johnson
 Phone: (651) 201-4856
Bob.B.Johnson@state.mn.us

DHS Liaison (TBD)

For more information: www.health.state.mn.us/e-health or by e-mail: MN.eHealth@state.mn.us

Last updated: June 25, 2010



Appendix E. DRAFT Communications and Outreach Workgroup Charge: 2010-2011

Proposed Workgroup Charge

- Advise on Minnesota e-Health Initiative communications activities, established in the Minnesota e-Health Communications Plan and Work Plan 2010-2011, to support health care providers and health care organizations in achieving meaningful use and meeting Minnesota mandates for e-prescribing by 2011 and interoperable EHRs by 2015.
- Advise on the coordination of outreach and communication efforts statewide, including coordination with the HITECH/ARRA funded programs such as the Minnesota e-Health Connect, REACH Program, and Minnesota Department of Human Services (DHS)-Medicaid and others as appropriate.

Background

The Minnesota Department of Health and the Minnesota e-Health Advisory Committee have been working to carry out significant legislation enacted in Minnesota in 2007 and 2008. This includes mandates that all health care providers have interoperable EHRs by 2015 (MS s 62J.495), and that all health care providers, dispensers and payers establish and use an e-prescribing system by January 1, 2011 (MS s 62J.497). In June of 2008, the Minnesota e-Health Initiative and the Minnesota e-Health Advisory Committee issued: *A Prescription for Meeting Minnesota's 2015 Interoperable Electronic Health Record Mandate: A Statewide Implementation Plan*. In 2009, companion guides to the statewide plan were updated or added including: *A Practical Guide to Electronic Prescribing*, *Standards Recommended to Achieve Interoperability in Minnesota*, and *A Practical Guide to Effective Use of EHR Systems*.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), part of the American Recovery and Reinvestment Act of 2009 (ARRA), requires the Office of the National Coordinator (ONC) and federal Department of Health and Human Services (HHS) to develop rules, guidance and plans to promote adoption and meaningful use of health information technology (HIT). The Act also establishes incentives for hospitals and health care providers through Medicare and Medicaid for meaningful use of electronic health records (EHRs).

The 2010-2011 outreach and communications workgroup charge builds on the accomplishments of previous years' work which is published in the updated *Minnesota e-Health Communications Plan and Work Plan 2010-2011* at <http://www.health.state.mn.us/ehealth>. The workgroup will continue to look to key national and Minnesota communications activities for priorities, additional resources and coordination opportunities.

Workgroup Deliverables and Timeline

Deliverables Related to Outreach and Communications

September 2010 – May 2011:

- Identify and recommend opportunities for coordination with the REACH program, Minnesota health information organizations (HIOs) and health data intermediaries (HDI), the Minnesota Department of Human Services (DHS)-Medicaid, and others as identified.
- Evaluate the effectiveness of Minnesota e-Health messages and communication vehicles.
- Review communications developed by other Minnesota e-Health Initiative workgroups.
- Identify any gaps in outreach and communications and prioritize groups and messages.
- Recommend activities to address outreach gaps that engage health care organizations, providers, and consumers to support the adoption and use of EHRs to achieve meaningful use and compliance with the 2011 and 2015 mandates.
- Recommend consumer communications resources to list on the Minnesota e-Health website, incorporating the contributions of Minnesota e-Health workgroups.

General Deliverables:

- June 2011: Provide a status report issued at Minnesota e-Health Summit.
- September 2010 – May 2011: Provide quarterly updates to the Minnesota e-Health Advisory Committee
- Identify opportunities in common with other committees, workgroups and organizations.
- By December 2010: Review and comment on appropriate section of the 2011 MDH report to the Minnesota legislature.

For more information: www.health.state.mn.us/e-health or by e-mail: MN.eHealth@state.mn.us

Approach for Coordination with other HITECH Programs

- Work collaboratively with regional extension center to promote REACH program to achieve “meaningful use” requirements and work together on resources and actions that will increase provider adoption of EHRs.
- Work collaboratively with Minnesota Medicaid and DHS to coordinate communications to Minnesota Medicaid providers.
- Coordinate with Minnesota e-Health Connect Program and monitor communications from Minnesota health information organizations (HIOs) and health data intermediaries (HDIs).
- Receive updates from SHARP and Beacon project teams to gather practical advice and lessons learned and develop communications to inform community and state about these projects.

Cross-cutting Issues with other Workgroups

- Key messages and/or fact sheets from Health Information Exchange workgroup
- Key messages and/or fact sheets from Adoption and Meaningful Use workgroup.
- Key messages and/or fact sheets from Privacy, Legal and Policy workgroup

Guiding Principles and Themes

- Minnesota e-Health communications will be aligned with national e-Health priorities when appropriate.
- Resources for EHR implementation (e.g. tools, tips and resource links are important to support statewide EHR adoption and achieving of meaningful use for Minnesota providers across the entire continuum of care.
- The needs of Minnesota health and health care providers will be paramount.

Workgroup Member Expectations

- Serve a one-year term: September 2010 – June 2011.
- Participate in meetings and/or conference calls quarterly or more frequently as needed during the term.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.
- Keep the statewide interests of the e-Health Initiative foremost in your decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Value in Participating

- Proactively help shape future policy directions that can have a major impact on your organization.
- Enable your organization to be more prepared to respond to the requirements of state and federal implementation plans as they are established.

Workgroup Leadership (TBD)

Many members of the workgroup have expressed interest in continued participation. Additional members will be recruited across the spectrum of expertise and subject matter knowledge. Meetings are open to the public and all participants are welcome.

Workgroup Staff (TBD)

DHS Liaison (TBD)

Appendix F



Minnesota e-Health Initiative Communications Plan and Work Plan for 2010-2011

May 2010



Office of Health Information Technology
P.O. Box 64882
St. Paul, MN, 55164-0882
651-201-5979 www.health.state.mn.us/e-health

Acknowledgements

Outreach and Communications Workgroup Participants

Rebecca Schierman, Minnesota Medical Association, Workgroup Co-Chair. **Susan Severson**, Stratis Health, Workgroup Co-Chair. **Mark Sonneborn**, Minnesota Hospital Association, Workgroup Co-Chair. **Alain Ainsworth**, Phenomenal Networks. **Virginia Barzan**, Minnesota Academy of Family Physicians. **Nancy Bauer**, Twin Cities Medical Societies. **Pam Bednar**, VisionShare. **Jeneva Bellefeuille**, Minnesota Directors of Nursing Administration-LTC. **Todd Bergstrom**, Care Providers of Minnesota. **Barry Bershow**, Fairview Health Services. **Gary Braley**, Braley Consulting Services. **RD Brown**. **Kristi Calvert**, **Melyx Corporation**. **Shawn Carlson**, Merck. **Victoria Champeau**, Midwest Independent Practice Association, **Kathryn Clements**, Clements Health Consulting. **Walter Cooney**, Neighborhood Health Care Network. **Tim Gallagher**, Astrup Drug, Inc., **Kathy Hansen**, **American Society for Clinical Laboratory Science-Minnesota**. **Bob Hussey**, **Martha Lafave**, IUOE #49. **Rose Lindquist**, Minnesota Home Care Association. **Justin McMartin**, LSS Data Systems. **Shirley Eichenwald Maki**, College of St. Scholastica. **Martin LaVenture**, Minnesota Department of Health. **Walter Menning**, Mayo Health System. **Lori Meyer**, Aging Services of Minnesota. **Gwen Mielke**, Midwest Independent Practice Association. **Bob Paulsen**, Minnesota Department of Human Services. **Junelle Peterson**, American Society for Clinical Pathology – Minnesota. **Colleen Sauter**, 7 Medical. **Peter Schuna**, Pathway Health Services. **Eileen Smith**, Minnesota Council of Health Plans. **Scott Smith**, Minnesota Medical Association **Bill Sonterre**, Valor Solutions. **Susan Spell**, Arcadia Solutions. **Tami Stanger**, Clinical Laboratory Managers Association - Minnesota. **Trisha Stark**, Minnesota Psychological Association. **Jim Trevis**, Institute for Clinical Systems Integration. **Lori Trygg**, MMIC Group. **Deneace Tucek**, Minnesota Medical Group Management Association. **Linda Vuketich**, Minnesota Psychiatric Society. **Karen Welle**, Minnesota Department of Health. **Mary Wellik**, Director, Olmsted County Public Health Services. **Tamara Winden**, Allina. **Colleen Winters**, Minnesota Medical Association. **Matthew Woods**, Minnesota Department of Human Services. **Robert Zarracina**, Xylo Technologies. **Kathy Zwieg**, Oral Health America.

Minnesota e-Health Initiative Advisory Committee Members

Jennifer Lundblad, PhD, Advisory Committee Co-Chair; President and CEO, Stratis Health. **Walter Cooney, JD**, Advisory Committee Co-Chair; Executive Director, Neighborhood Health Care Network. **Alan Abramson, PhD**, Senior Vice President, IS&T and Chief Information Officer, Health Partners. **Barry Bershow, MD**, Medical Director, Quality & Informatics, Fairview Health Services. **Laurie Beyer-Kropuenske, JD**, Director, Information Policy Analysis Division, Department of Administration. **RD Brown**, Consumer Advocate. **Angie Franks**, Senior Vice President of Sales & Market Development, Healthland. **Tim Gallagher**, VP Pharmacy Operations, Astrup Drug, Inc. **Raymond Gensinger, Jr., MD**, Chief Medical Information Officer, Fairview Health Services. **John Gross** Director, Health Care Policy, Minnesota Department of Commerce. **Maureen Ideker**, Associate Administrator, Care Management, Rice Memorial Hospital. **Julie Jacko, PhD**, Director, The Institute for Health Informatics, University of Minnesota. **Paul Kleeberg, MD**, Medical Director, Clinical Decision Support, HealthEast Care System. **Martin LaVenture, PhD**, Director, Center for Health Informatics, Minnesota Department of Health. **Bobbie McAdam**, Director, e-Business, Medica. **Walter Menning**, Vice Chair, Information Services, Mayo Health System. **Charlie Montreuil**, Vice President, Enterprise Rewards and Corporate Human Resources, Best Buy. **Brian Osberg**, Assistant Commissioner, Minnesota Department of Human Services. **David Osborne**, Director of Health Information Technology/ Privacy Officer, Volunteers of America. **Cheryl M. Stephens, MBA, PhD**, Executive Director, Community Health Information Collaborative. **Joanne Sunquist**, Chief Information Officer, Hennepin County Medical Center. **Michael Ubl**, Executive Director, Minnesota Health Information Exchange. **Mary Wellik**, Director, Olmsted County Public Health Services. **Bonnie Westra, RN, PhD**, Assistant Professor, University of Minnesota, School of Nursing. **John Whisney**, Director of Ridgeview Clinics, Ridgeview Medical Center. **Tamara Winden**, Healthcare Informatics Consultant, Healthia Consulting. **Marty Witrak, PhD, RN**, Professor, Dean, School of Nursing, College of St. Scholastica. **Michael Ubl**, Executive Director, Minnesota Health Information Exchange

Minnesota e-Health Initiative Workgroups

Exchange and Meaningful Use, Co-Chairs: Alan Abramson, Paul Kleeberg

Standards Workgroup, Co-Chairs: Bobbie McAdam, Mike Ubl.

Privacy and Security Workgroup, Co-Chairs: Laurie Beyer-Kropuenske, Darrell Sherve

University of Minnesota, School of Nursing

Nursing Informatics students Karen Auel and Molly Hagen and Bonnie Westra, RN, PhD, Assistant Professor

Minnesota Department of Health (MDH) Staff

Elizabeth Cinqueonce, James Golden, Robert B. Johnson, Martin LaVenture, Jennifer Fritz, Sripriya Rajamani, Mayumi Reuvers, Anne Schloegel, Donna Watz. Karen Welle, and Barb Willis.

Minnesota e-Health Initiative Communications Plan and Work Plan for 2010-2011

Table of Contents

A. Minnesota e-Health Communications Plan

I. Introduction	4
II. Special Considerations	6
III. Principles	7
IV. Purpose	7
V. Goals	8
VI. Key Objectives	8
VII. Evaluation Questions	9

B. Minnesota e-Health Communications Work Plan for 2010-2011

Objective 1: Inform stakeholders about national and state e-Health Activities.....	10
Objective 2: Inform eligible health care providers and hospitals of opportunities to access Medicare and Medicaid incentive payments for being meaningful users of electronic health records.....	11
Objective 3: Encourage and support health care providers to achieve e-prescribing by 2011 and interoperable EHRs by 2015.....	12
Objective 4: Inform consumers about the benefits of electronic health records and health information exchange as well as protections in place to ensure the privacy and security of health information	13
Objective 5: Gather and communicate opportunities to the current and future health care workforce about existing health informatics education and training resources	13

Tables and Figures

Figure 1: Minnesota Model for Adopting Interoperable Electronic Health Records.....	4
Table 1: Minnesota e-Health Communications Timeline and Examples of Key Messages	15
Table 2: Minnesota e-Health Communication Vehicles	16
Table 3: Minnesota Associations and Organizations for Key Message Distribution	17
Table 4: Selected List of Minnesota e-Health Fact Sheets and Other Resources.....	19
Table 5: Examples of Sources for e-Health Activities Monitoring.....	22
Figure 2: Approach for Monitoring and Sharing e-Health Information	23
Table 6: Providers Impacted by the 2015 Interoperable EHR Mandate	24
Table 7: Health Information Technology and Health Informatics Education and Training	25

Appendices

Appendix A: Glossary of e-Health Terminology and Acronyms	27
Appendix B: 2009-2010 Minnesota e-Health Advisory Committee Charge	30
Appendix C: 2009-2010 Minnesota e-Health Outreach and Communications Workgroup Charge	33
Appendix D: 2009-2010 Minnesota e-Health Workgroup Charges	35

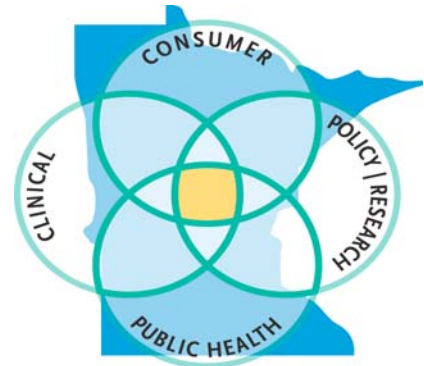
Minnesota e-Health Initiative Communications Plan

I. Introduction

This communications plan is under the direction of the Minnesota e-Health Initiative, the primary mechanism for the health and health care community to gather and coordinate health information technology-related activities in Minnesota. This public-private collaboration reflects the health community's strong commitment to pursue e-health goals in a coordinated, systematic, thoughtful and focused way.

The vision of the Minnesota e-Health Initiative is to "... accelerate the adoption and use of health information technology to improve health care quality, increase patient safety, reduce health care costs and improve public health."

Established in 2004, the Initiative encompasses four overlapping domains: clinical, consumer, policy/research and public health. The area of overlap relies on exchange of information, a major contribution of e-health.

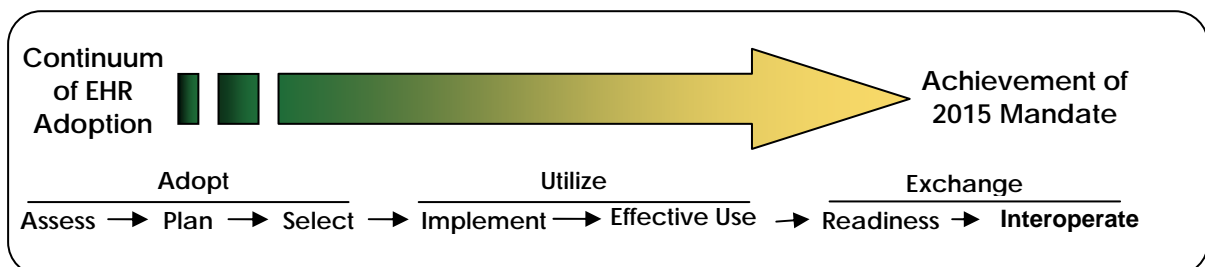


The Initiative is guided by a public-private advisory committee representing consumers, the health care delivery community, purchasers, public health, government and others. Dozens of other volunteers serve on workgroups.

Much of the work of the Minnesota e-Health Initiative through 2008 focused on health information technology, particularly interoperable electronic health records adoption as it was the focus of the 2008 Plan, *Prescription for Meeting Minnesota's 2015 Interoperable Electronic Health Record Mandate – A Statewide Implementation Plan.* In that plan, a model for the Minnesota health and health care community to meet Minnesota's mandate for the adoption and use of interoperable electronic health records by 2015 was adopted (see figure X below). The Minnesota model contains seven major steps in adopting, implementing and effectively using an interoperable EHR. The seven steps can, in turn, be grouped into three major categories:

- **Adopt**, which includes the sequential steps of assess, plan and select
- **Utilize**, which involves implementing an EHR product and learning how to use it effectively
- **Exchange**, including readiness to exchange electronically with other partners, and implementing regular, ongoing exchange between interoperable EHR systems.

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



Since the Minnesota Model was adopted in 2008, the Minnesota e-Health Initiative has provided specific guidance to Minnesota providers working on adoption and utilization of EHRs. In 2009, the Minnesota e-Health Initiative turned its attention to addressing the third category on the

Revised: May 26, 2010

Minnesota Model: Health Information Exchange. The full plan can be found at: www.health.state.mn.us/ehealth.

Meaningful Use

In order to access federal incentives, providers and hospitals will need to demonstrate “meaningful use” of an EHR system. Congress established three measures of meaningful use in legislation: the use of nationally certified EHR systems that include e-prescribing, the submission of clinical quality measures, and the electronic exchange of health information. Further definition and guidance was released in a proposed rule by the federal Department of Health and Human Services on January 13, 2010. The Centers for Medicare & Medicaid Services (CMS) proposed a phased, incremental approach of adoption of certified EHR technology across three stages. CMS describes these stages as reflecting reasonable criteria based on currently available technology and provider practice experience that build over time to a more robust definition of “meaningful use,” consistent with anticipated development of technology and health IT infrastructure. The proposed rule only specifies objectives and measures Stage 1. CMS plans to establish Stage 2 and Stage 3 criteria through future rulemaking processes. CMS describes each Stage as follows:

- Stage 1 meaningful use criteria focus on:
 - 1) Capturing health information in a coded format,
 - 2) Using the information to track key clinical conditions;
 - 3) Communicating captured information for care coordination purposes; and
 - 4) reporting of clinical quality measures and public health information.

- Stage 2 criteria will likely expand upon Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement, research, and bi-directional communication with public health agencies. For Stage 2, CMS may also consider applying the criteria more broadly to both the inpatient and outpatient hospital settings. CMS expects to propose Stage 2 criteria by the end of 2011.

- Stage 3 criteria will likely focus on achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self-management tools, access to comprehensive patient data and improving population health outcomes. CMS expects to propose Stage 3 criteria by the end of 2013.

Minnesota Medicaid

While the Centers for Medicare and Medicaid Services will determine the requirements for Medicare incentives, the federal law gives states some leeway for determining the definition of “meaningful use” for Medicaid incentives. In Minnesota, the Department of Health and the Department of Human Services are working closely with the Minnesota e-Health Initiative to respond to the proposed federal rule, and to explore options for tailoring the requirements to meet the needs of Minnesota Medicaid. The proposed definition of *meaningful use* is important because it will be a key measure that determines provider eligibility to receive incentive funds and will have an impact on Minnesota providers and hospitals. As a part of the broader e-health efforts, the Minnesota e-Health Initiative views the definition of *meaningful use* as part of our framework of effective use of electronic health records. This approach recognizes that the real value in EHR systems comes from using them effectively to support efficient workflows and effective clinical decisions, which have a positive and lasting effect on the health of individuals and populations.

Minnesota's Health Reform Initiative

In May 2008 Governor Pawlenty signed significant health care reform legislation into law. The reforms include recommendations from the Governor's Health Care Transformation Task Force and the Legislature's Health Care Access Commission. This comprehensive health care reform package will make significant progress toward achieving quality, affordable, accessible health care for all Minnesotans.

The reform package includes:

Statewide Health Improvement Program (SHIP)

SHIP will improve health and reduce demands on the health care system by decreasing the percentage of Minnesotans who are obese or overweight or use tobacco.

Health care homes

Minnesotans with complex or chronic conditions will receive coordinated care through health care homes. This new approach to primary care promotes coordinated care from a team of health care providers focusing on common goals.

Payment reform, quality measurement and cost/quality transparency

These parts of the health reform bill are aimed at making sure the right financial incentives are in place to encourage changes in health care that reduce cost and improve quality. Reforms include the development of [health care quality measures](#), a [provider peer grouping system](#) and [baskets of care](#).

Insurance coverage and affordability

The bill makes it easier for people to get information about state health care programs, promotes the use of Section 125 plans for employees to buy health insurance with pre-tax money, and requires reports to the Legislature on subsidies for employer-based health insurance coverage and value-based benefit sets.

Other activities

The bill establishes a Health Care Reform Review Council, requires several studies and reports to the Legislature, and establishes a mechanism for projecting health care costs and measuring savings.

II. Special Considerations

Successful communication strategies for health information technology and health information exchange messages require understanding both the overall environment and identified target audiences. There are some special considerations noted here:

- Engaging health and health care stakeholders from across the continuum of care can be challenging.
- Health care providers in rural and smaller practices, long term care, home health and safety net clinics, typically face greater challenges in the adoption of electronic health records and health information technology.
- Including population health and stakeholders from public health organizations is critical to achieving all the benefits of health information technology.

- Electronic health record, health information exchange (HIE) and other e-health related topics can be difficult to communicate to health and health care stakeholders and consumers that are inundated with messages and information.
- Some Minnesota residents cross the state line to receive medical and public health services or live in areas that serve residents of other states. This phenomenon affects all parts of the state and both rural and urban communities.

III. Communication Principles

The Minnesota e-Health initiative communications plan is guided by several key principles. The principles are that Communications efforts must:

- Engage health and health care stakeholders from across the continuum of care.
- Create synergies by coordinating with organizations working toward similar goals.
- Use surveys, audience feedback, or other tools wherever possible to ascertain effectiveness of messages, and communication vehicles.
- Capitalize on specific opportunities to capture interest, such as conferences, passage of significant legislation, or other news events or news coverage.
- Maintain integrity and credibility by providing timely, accurate, and complete information to the public and other stakeholders on an ongoing basis and when responding to public questions or concerns.

IV. Purpose

This communications plan will directly support activities related to the Minnesota e-Health Initiative and to the extent possible support other associated e-health related programs. The programs include, but are not limited to:

This plan directly supports communications for these activities:

- The Minnesota e-Health Advisory Committee including communication tasks identified in the Committee Charge (see Appendix B)
- Minnesota e-Health Advisory Committee workgroups; 2009-2010 workgroups include standards, exchange and meaningful use, privacy and security and outreach and communications and workgroups in subsequent years. (see Appendices C and D)
- Minnesota e-Health Connect Program for health information exchange.
- Minnesota health and health care providers and hospitals working to achieve meaningful use.

This plan leverages resources to coordinate communications efforts with at least the following programs.

- Minnesota's regional extension center (Key Health Alliance)
- Minnesota health information exchange service providers [e.g. health information organizations (HIOs) and health data intermediaries (HDIs)]
- Minnesota Medicaid program
- Other federal HITECH programs as they are funded such as the Beacon Community Program to promote health information technology infrastructure and exchange capabilities.
- Minnesota Health Reform efforts
- Other e-health federal, state and local activities as appropriate

V. Goals

This plan has three main communications goals that are intended to help assure that health information flows seamlessly between health and health care providers to improve care and help ensure that the workforce has the knowledge and skills needed to implement, use and manage electronic health records and other health information technology.

The goals of this communications plan are:

- Successfully inform, encourage and support health and health care providers and health care organizations to adopt and use electronic health records and other health information technology.
- Establish an effective statewide network of e-health communications channels that builds on existing relationships and creates new relationships with health and health care stakeholders, including provider associations, and recognize other collaborative opportunities to engage health and health care providers and organizations across Minnesota in e-Health activities and issues.
- Coordinate and integrate communication efforts with other organizations including, but not limited to, provider associations, Minnesota's regional extension center, Minnesota health information exchange service providers, and Minnesota Medicaid about e-Health activities and issues. Establish a fully integrated and seamless communication strategy between state, federal and locally funded initiatives

VI. Key Objectives

This communications plan seeks to increase awareness of health information technology and health information exchange opportunities for health and health care stakeholders and consumers and to encourage and support the entire continuum of health care providers through the following objectives:

1. Inform stakeholders about national and state e-Health activities.
2. Inform eligible health care providers and hospitals of opportunities to access Medicare and Medicaid incentive payments for being meaningful users of electronic health records and provide information on resources and technical assistance (e.g. regional extension center).
3. Encourage and support health and health care stakeholders to achieve e-Health goals, including compliance with Minnesota mandates for e-prescribing by 2011 and for interoperable EHRs by 2015 and provide information on resources and technical assistance.
4. Inform consumers about the benefits of electronic health records and health information exchange as well as protections in place to ensure the privacy and security of health information.
5. Gather and communicate opportunities to the current and future health care workforce about existing health informatics education and training resources.

VII. Evaluation Questions

To determine success of any communications initiative, it is essential to revisit and review communication objectives periodically. Several key questions, when evaluated, can help measure effectiveness. They include:

- ✓ Are stakeholders responding favorably to communication efforts?
- ✓ Has the Minnesota e-Health Initiative expanded its network of involved partners and stakeholders?
- ✓ Have key messages resonated with their respective stakeholder groups?
- ✓ Have action steps to date achieved desired outcomes?

Minnesota e-Health Communications Work Plan for 2010-2011

To achieve the overall goals of this communications plan the Minnesota e-Health Initiative must convey a sense of urgency and optimism through well-planned strategies and action steps that support the adoption and effective use of interoperable electronic health records (EHRs) to improve the health and health care of all Minnesotans and allow Minnesota's eligible providers to access incentives for the meaningful use of EHRs.

The 2010-2011 Communications Work Plan details specific implementation objectives and tactics from the overarching communications plan. This includes developing communications for cross-cutting issues identified by the 2009-2010 Minnesota e-Health Initiative workgroup activities listed here:

Exchange and Meaningful Use Workgroup:

Criteria for State certification of health information exchange service providers
Coordinated responses to CMS proposed regulations
Assist Minnesota Medicaid with incentive program

Standards and Interoperability Workgroup:

Updated standards for health information exchange (HIE)

Privacy and Security Workgroup:

Consumer preferences
Interstate privacy & security issues
Coordinated responses to federal rules

Objectives, Strategies and Action Steps

Objective 1: Inform stakeholders about national and state e-Health activities

Target Audience: All interested Minnesota health and health care stakeholders and consumers

Key Focus:

- National, state and local e-Health news and its implications for Minnesota stakeholders.
- Announcements and opportunities to engage with Minnesota e-Health Initiative activities.

Strategies for Objective 1:

Set priorities for communications that send unified messages to support statewide goals.

Action Steps for Objective 1:

- Monitor national, state and regional publications including, but not limited to, those in Table 5. See Figure 2 for process outline.
- Synthesize information to specifically address implications for Minnesota stakeholders, focus on brevity in written materials with links to further content and organize information so stakeholders can easily find what is pertinent to them.

- Develop a schedule of key messages for stakeholders to use in their communications strategies. (See Table 1)
- Draw on associations and others to redistribute information. (See Table 3)
- Develop and update useful educational and communications materials to inform all stakeholders through one or more of the vehicles listed in Table 2.
- Develop an active feedback framework to determine whether communications are being used and meeting the objectives.

Objective 2: Inform eligible health care providers and hospitals of opportunities to access Medicare and Medicaid incentive payments for being meaningful users of electronic health records.

Target Audience: Eligible Health Care Providers and Hospitals

Eligible Providers must meet meaningful use criteria and may participate in only one incentive program: Medicare or Medicaid.

Medicare Incentives

- Physicians
- Dentists
- Podiatrists
- Optometrists
- Chiropractors

Medicaid Incentives

(certain patient volumes required)

- Physicians
- Dentists
- Certified Nurse Midwives
- Nurse Practitioners
- Physician Assistants practicing in Federally Qualified Health Centers or Rural Health Clinics

Most hospitals are eligible for both Medicaid and Medicare incentives if they are meaningful users of an EHR.

Key Focus:

- Centers for Medicare & Medicaid Services (CMS) incentives for meaningful use of electronic health records (EHRs)
- REACH program and other technical assistance opportunities available for health care providers to adopt and effectively use EHRs.
- Health Information exchange options, opportunities and requirements

Strategies for Objective 2:

- Coordinate and integrate communications with REACH program, health information exchange service providers [health information organizations (HIOs) and health data intermediaries (HDIs)], Minnesota Medicaid and others as appropriate.
- Establish new and reinforce existing relationships with provider associations and recognize other collaborative opportunities necessary to inform their membership on this issue.
- Connect providers to technical assistance opportunities such as web-based toolkits and through coordination with the REACH program.
- Assist providers in understanding the costs and benefits of health information exchange.

- Explain role of HIT and HIE in Minnesota's health reform efforts, and how effective use of HIT (including exchange) can assist them in meeting state health reform requirements such as health care homes and administrative simplification.
- Coordinate with State Health Information Exchange activities (Minnesota e-Health Connect)

Action Steps for Objective 2:

- Meet with lead representatives from MDH, Minnesota Medicaid and regional extension center to identify and coordinate communications related activities.
- Inform providers on availability and requirements for federal incentives and penalties to increase health care community awareness and mitigate misinformation.
- Provide links to technical assistance opportunities such as web-based toolkits and through coordination with the REACH program.
- Develop and update useful educational and communications materials to inform all stakeholders through one or more of the vehicles in Table 2.

Objective 3: Encourage and support all health and health care stakeholders affected by the state requirements to achieve e-Health goals, including compliance with Minnesota mandates for e-prescribing by 2011 and for interoperable EHRs by 2015.

Target Audience: All health and health care stakeholders affected by the state requirements for EHRs and other related HIT (see Table 6)

Key Focus:

- Tools and resources for adoption and effective use, of interoperable electronic health records (EHRs) by 2015 and e-prescribing by 2011
- Tools and resources for understanding options for health information exchange.

Strategies for Objective 3:

- Establish new and reinforce existing relationships with provider associations and recognize other collaborative opportunities necessary to promote and implement the communications plan.
- Inform providers of the 2015 Minnesota mandate for interoperable electronic health records; encourage them to use Recovery Act opportunities to achieve compliance with the mandate.
- Coordinate with State Health Information Exchange activities (Minnesota e-Health Connect) and other federal programs as appropriate.
- Review data on barriers and needs to identify opportunities for assistance

Action Steps for Objective 3:

- Meet with association representatives to understand the needs and identify opportunities for shared action including common key messages, shared publications and useful communication vehicles.
- Maintain Minnesota e-Health Initiative Outreach and Communications workgroup via e-mail for ongoing feedback.
- Communicate survey results on EHR and e-prescribing adoption and use in Minnesota.

Objective 4: Inform consumers about the benefits of electronic health records and health information exchange as well as protections in place to ensure the privacy and security of health information.

Target Audience: Consumers – the general public

Key Focus:

- Value of health information technology and health information exchange (HIE)
- Privacy and security protections for sensitive health information
- Patient rights and preferences and participation issues, such as consent
- Options and opportunities for receiving your health and health care information electronically

Strategies for Objective 4:

- Coordinate and integrate communications with consumers using consumer groups, stakeholder channels and other methods and opportunities as appropriate.
- Encourage and support health care providers in communicating e-health information to patients
- Consider representatives from national and state consumer advocate organizations in the communications implementation.

Action Steps for Objective 4:

- Develop or update fact sheets for privacy and security issues starting with issues identified by the Privacy and Security workgroup.
- Identify and share current communications tools and practices used by providers and others leaders to promote consumer education and engagement.
- Update the consumer pages and improve the links for the Minnesota e-Health web pages and promote links, access and use.

Objective 5:

Gather and communicate opportunities to the current and future health care workforce about existing health informatics education and training resources.

Target Audience: Health and Health Care Workforce

Key Focus:

- Opportunities for education and training to support the electronic health records and other health information technology.

Strategies for Objective 5:

- Communicate workforce development opportunities
- Coordinate with the University of Minnesota School of Nursing Informatics students to maintain list of educational opportunities on Minnesota e-Health Initiative web site. (See Table 7)
- Coordinate with the federally funded training and academic programs funded in Minnesota and nationally.

Action Steps for Objective 5:

- Develop and update communications materials to inform all stakeholders about educational opportunities for health information technology.
- Identify training resources available through Recovery Act funding and publish on the Minnesota e-Health Initiative web site.
- Publish and promote the materials on MDH web site. Add health care workforce page.
- Reach out to/coordinate with the Health Education and Industry Partnership (HEIP)
- Add county workforce centers/agencies to stakeholder distribution.

Table 1: Minnesota e-Health Communications Timeline and Examples of Key Messages

Month	Themes/Key Milestones	Key Messages	Resources to Share	Services
May	<ul style="list-style-type: none"> Leveraging meaningful use along the entire continuum of care e-Health Summit Promotion 	<ul style="list-style-type: none"> Register for the MN e-Health Summit David Blumenthal, National Coordinator confirmed as keynote speaker The past five Summits have sold out Announce completion of strategic and operational plans for HIE 	<ul style="list-style-type: none"> Brochure Online Registration Press release 	
	<ul style="list-style-type: none"> Consumer Message 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	
June	<ul style="list-style-type: none"> Minnesota law goes into effect (in July) 	<ul style="list-style-type: none"> New Legislation on HIE oversight in MN Oversight process for HIE service providers Is established All Minnesota health care organizations should sign with a certified HIO A complaint process mechanism is in place for Consumers 	<ul style="list-style-type: none"> Fact Sheet on HIE Oversight MPSP Consumer Information 	<ul style="list-style-type: none"> Technical assistance on oversight process (MDH)
	<ul style="list-style-type: none"> Consumer Message 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none">
July	<ul style="list-style-type: none"> Meaningful use rule released Standards Final Rule 	<ul style="list-style-type: none"> Criteria to meet meaningful use in order to obtain incentives have been finalized All Minnesota health care organizations should use the standards proposed by ONC when applicable Regional Extension Center resources are available to help with implementation 	<ul style="list-style-type: none"> Final Rule Document Fact Sheet on MU MN Effective Use Guide Updated Standards Guide 	<ul style="list-style-type: none"> REACH Educational Programs
	<ul style="list-style-type: none"> Consumer Message 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none">
August	<ul style="list-style-type: none"> E-Prescribing 	<ul style="list-style-type: none"> Prepare for compliance with Minnesota e-Prescribing mandate in effect in 2011 	<ul style="list-style-type: none"> E-Prescribing Guidance Document 	
	<ul style="list-style-type: none"> Consumer Message 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	
September	<ul style="list-style-type: none"> MN e-Health plans for 2010-2011 	<ul style="list-style-type: none"> Announce workgroups for 2010-2011 Participate in the Initiative and MN e-Health policy development through workgroups 	<ul style="list-style-type: none"> Updates to e-Health Website 	
	<ul style="list-style-type: none"> Consumer Message 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	
October	<ul style="list-style-type: none"> Health information exchange Meaningful use incentives for hospitals begin 	<ul style="list-style-type: none"> How to begin receiving payments How to get connected to a certified HIE service provider Announce HIE service provider complaint process 	<ul style="list-style-type: none"> Fact Sheet on MU Announcement of certified HIE service providers 	
	<ul style="list-style-type: none"> Consumer Message 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> 	

Table 2: Minnesota e-Health Communication Vehicles

Primary Communication Vehicles for Which e-Health is the Main Focus						
Vehicle	Responsible	Audience Reached	Content	Frequency	Format	Size
Minnesota e-Health News Update	MDH MN e-Health	Consumers, Advisory Committee, Workgroups, Policy Makers	Update on state and national e-health activity.	Weekly	Self-subscribing E-mail	3000+
Minnesota e-Health Fact Sheets and FAQs	MDH MN e-Health	Consumers, Advisory Committee, Workgroups, Policy Makers, Associations	Facts and Guidance on e-health topics.	As needed	Email and Web	3000+
Recovery Act Update Calls	MDH MN e-Health	Consumers, Advisory Committee, Workgroups, Policy Makers	New information released on HITECH implementation	Monthly	In-person/ Phone	~60-120
Public Meetings	MDH MN e-Health	Consumers, Advisory Committee, Workgroups, Policy Makers, Associations	Update on state and national e-health activity. Information on what groups/individuals should be doing.	Twice/year	In-Person/ Phone	~100-300
Minnesota e-Health Website	MDH MN e-Health	Consumers, Advisory Committee, Workgroups, Policy Makers	Repository of all information Resources	Continuous	Web	Undefined
Education & Outreach Presentations	Organizer	Associations, Providers	Specified to stakeholder needs/request.	Upon Request	In-Person	~25-50
Advisory Committee Meetings	MDH MN e-Health	Advisory Committee, Workgroups, Policy Makers	Policy review and recommendations	Quarterly	In-Person/ Phone	~25-75
Minnesota Privacy and Security Program Update	MDH MN e-Health	Providers, CIOs, CISOs, Privacy Officers, Attorneys, Consumers	Privacy and security updates, news, resources	As Needed	Email	~90
Public Health Informatics Update	MDH MN e-Health	Public Health Professionals	Public health informatics topics, news, and resources	Semi-Monthly	Email	~40
Standards Update	MDH MN e-Health	Standards workgroup members	Standards topics, news, and resources	As Needed	Email	~30
e-Health Summit	MDH MN e-Health	Providers of health and health care, public health and other health care settings	Adoption, Use and Exchange of EHRs	Annual	In-Person	~450
MN e-Health Grants Program	MDH ORHPC	e-Health Grant Recipients	Updates and Sharing Lessons Learned	Quarterly	Phone	~20
Supportive Communication Vehicles which Contribute to e-Health						
MN Rural Health Conference	MDH ORHPC	Providers of health and healthcare, public health, and other settings	Tools to respond to rural and safety net provider issues.	Annual	In-Person	~350
Minnesota Rural Health and Primary Care News Update	MDH ORHPC	Consumers, Workgroups, Policy Makers	Update on MN and national rural and safety net provider issues.	Monthly	Self-subscribing E-mail	1800+
Minnesota Office Rural Health and Primary Care Quarterly	MDH ORHPC	Consumers, Workgroups, Policy Makers	Newsletter on MN and national rural and safety net provider issues.	Quarterly	Self-subscribing E-mail	1800+

Table 3: Minnesota Associations and Organizations for Key Message Distribution

Stakeholders	Associations and Organizations
Chief Information Officers, Health Managers & Technical Experts	Minnesota Chapter of Health Information & Management Systems Society (MN HIMSS)
	Minnesota Health Information & Management Association (MHIMA)
Chiropractors	Minnesota Chiropractic Association
Chronic Disease	ALS Association
	American Diabetes Association- Minnesota
	Cancer Society
	Heart Association
	Lupus Foundation of Minnesota
	Muscular Dystrophy
	National Multiple Sclerosis Society-Minnesota Chapter
Clinics (e.g. Primary Care Clinics, Community Clinics, Specialty Clinics)	Midwest Independent Practice Association
	Minnesota Association of Community Health Centers (MNACHC)
	Minnesota Healthcare Network
	Minnesota Medical Group Management Association (MMGMA)
Dentists	Minnesota Dental Association
	Oral Health America
Health Plans/ Group Purchasers	Buyers Health Care Action Group
	Minnesota Department of Human Services
	Minnesota Council of Health Plans (MCHP)
Hospitals	Minnesota Hospital Association (MHA)
Laboratories	American Society for Clinical Laboratory Science (ASCLS)-Minnesota
	American Society for Clinical Pathologists (ASCP)
	Clinical Laboratory Managers Association - Minnesota
	Minnesota Department of Health, Minnesota Laboratory System
Long Term Care, Home Care and Hospice	Aging Services of Minnesota
	Care Providers of Minnesota
	Hospice Minnesota
	Minnesota Home Care Association (MHCA)
	Volunteers of America
Mental Health Programs	Minnesota Association of Community Mental Health Programs (MACMHP)
Mental Health Providers	Minnesota Psychiatric Society
	Minnesota Psychological Association
Nurses	Minnesota Nurses Association
	Minnesota Directors of Nursing Administration-LTC (MN-DONA)
	Minnesota Organization of Leaders in Nursing (MOLN)

Revised: May 26, 2010

Page 17 of 27

Table 3: Minnesota Associations and Organizations for Key Message Distribution (continued)

Stakeholders	Associations & Organizations
Optometrists	Minnesota Optometric Association
Pharmacists	Minnesota Pharmacists Association (MPhA)
	Minnesota Society of Health-System Pharmacists
Physicians	Minnesota Academy of Family Physicians
	Minnesota Academy of Ophthalmology
	Minnesota Medical Association
	Twin Cities Medical Societies
	Minnesota Medical Directors Association (geriatric medicine/LTC)
Public Health Agencies	Local Public Health Association (LPHA)
	Minnesota Department of Health
Public Health Professionals	Minnesota Public Health Association (MPHA)
	MN Dietetic Association
Quality Improvement Organizations	Institute for Clinical Systems Improvement
	Minnesota Community Measurement
	Stratis Health
Rural Health	Medi-Sota
	Minnesota Department of Health, Office of Rural Health and Primary Care
	Minnesota Rural Health Association
	National Rural Health Resource Center
Seniors / Retired Citizens	American Association for Retired Persons (AARP)
Seniors in long term care	Elder Care Rights Alliance
	Hospice Minnesota
	Minnesota Association of Area Agencies on Aging
	Senior Community Services

Table 4: Examples of Minnesota e-Health Fact Sheets and Other Resources

Topic Area	Fact Sheet Title	Brief Description	Audience	Publication Date
	Existing			
General	Minnesota e-Health Initiative	Overview of vision and activities of the Minnesota e-Health Initiative.	Consumers, Providers, Public Health	September 2008
ARRA	Recovery Act Incentives FAQ	Answers to general questions about the American Recovery and Reinvestment Act	Providers	June 2009
	Hospital Medicare Payment Incentives under the HITECH Act	Hospital eligibility requirements and formulas for calculating potential incentive payment amounts for Medicare program.	Hospitals	April 2009
	Physician Medicare Payment Incentives under the HITECH Act	Provider eligibility requirements and formulas for calculating potential incentive payment amounts for Medicare program.	Physicians	April 2009
	DHS Medicaid Incentive Program under HITECH Act	Hospital and provider eligibility requirements and potential incentive payment amounts for Minnesota Medicaid program.	Eligible providers	March 2009
e-prescribing	Minnesota's e-Prescribing Mandate	Overview of e-prescribing benefits, stakeholders affected transaction standards, and links to resources.	Providers, Pharmacies, Group Purchasers	October 2008
	The 2011 e-Prescribing Mandate	Guidance on the e-prescribing mandate including considerations of Recovery Act requirements and potential incentives.	Providers, Pharmacies, Group Purchasers	December 2009
Grants and Loans	e-Health Grants 2006-2007	Critical lessons learned from 11 collaboratives that received \$1.3 million in matching grants for EHR or health information exchange projects in 2006-2007.	Providers	March 2008
	e-Health Grants 2008	Critical lessons learned from 16 organizations that received \$3.5 million in matching grants for EHR or health information exchange projects in 2008-2009.	Providers	November 2009

Table 4: Examples of Minnesota e-Health Fact Sheets and Other Resources (continued)

MN Law	Minnesota Health Information Exchange Fact Sheet	Information on new law regarding health information exchange (HIE) in Minnesota	Legal/Policy	June 2010
	Minnesota e-Health HITECH Policy Bill	Information on law enacted to advance and update e-Health activities in Minnesota	Legal/Policy	April 2009
	Minnesota Health Records Act	Proposed Legislation	Providers, Privacy Officers, Consumers	June 2007
Privacy	Federal Trade Commission Health Breach Notification Rule	Summary of national breach rule including background, definitions and rules.	Providers, Privacy Officers, Consumers	November 2009
	Standard Consent Form to Release Health Information	Background information and answers to common questions about Minnesota's standard consent form to release health information	Providers, Privacy Officers, Consumers	May 2008
Consumer	Personal Health Records in Minnesota	Overview of personal health records (PHRs) including definitions, background on use, and consumer benefits.	Consumers	June 2007

Table 4: Selected List of Minnesota e-Health Fact Sheets and Other Resources (continued)

Topic Area	Resource Title	Brief Description	Audience	Publication Date
	Existing			
EHR Adoption	A Prescription for Meeting Minnesota's 2015 Interoperable Electronic Health Record Mandate <i>Statewide Implementation Plan and Guide 1: Addressing Common Barriers to EHR Adoption</i>	The Plan includes information to: <ul style="list-style-type: none"> ▪ accelerate the adoption and effective use of interoperable electronic health records (EHRs) ▪ identify a model for achieving the 2015 interoperable EHR mandate. ▪ provide practical guidance to providers and provider organizations on how to overcome barriers and accelerate progress in adopting interoperable EHRs. ▪ provide links to tested planning and implementation tools. 		June 2008
Effective Use of EHRs	Guide 4: A Practical Guide to Effective Use of EHR Systems	This Guide is intended to assist organizations to maximize the value of their EHR investment, increase patient safety and improve quality of care. The guide includes experiences, lessons, tips, templates and resources from providers and academic and industry literature.		June 2009
e-Prescribing	Guide 3: A Practical Guide to Electronic Prescribing	This Guide is intended to support to achieve the quality and safety benefits of e-prescribing, to become eligible for federal incentives, and to support implementation of and compliance with Minnesota law. Includes “Strategies for Success..” for each of three groups: prescribing providers, pharmacists and pharmacies, and payers or pharmacy benefit managers		June 2009
Standards	Guide 2: Standards Recommended to Achieve Interoperability in Minnesota	This Guide introduces the Minnesota e-Health Initiative's: <ul style="list-style-type: none"> ▪ Approach to electronic health information exchange ▪ Framework for interoperability ▪ Recommended e-health standards and their role in interoperability ▪ Key actions and resources for using standards and helping achieve interoperability 		June 2009

Table 5: Examples of Sources for e-Health Activities Monitoring

Federal Government

Agency for Healthcare Research and Quality (AHRQ)	http://healthit.ahrq.gov/
Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/
Centers for Medicare & Medicaid Services	http://www.cms.hhs.gov/
Department of Health and Human Services	http://www.hhs.gov/
Health Resources and Services Administration	http://ruralhealth.hrsa.gov/
National Institute of Standards and Technology (NIST)	http://www.nist.gov/index.html
National Library of Medicine	http://www.nlm.nih.gov/
Office of the National Coordinator for Health Information Technology (ONC)	http://healthit.hhs.gov/

National Organizations

American Health Information Management Association (AHIMA)	http://www.ahima.org/
American Hospital Association (AHA)	http://www.aha.org/
American Medical Association (AMA)	http://www.ama-assn.org/
Certification Commission for Health Information Technology (CCHIT)	http://www.cchit.org/
eHealth Initiative (eHI)	http://www.ehealthinitiative.org/
Health Information Management and Systems Society (HIMSS)	http://www.himss-mn.org/
HL7	http://www.hl7.com/
Public Health Informatics Institute	http://www.phii.org/
SNOMED	http://www.cap.org/apps/cap.portal? nfpb=true& pageLabel=snomed_page
State Alliance for E-Health	http://www.nga.org/

Minnesota

Community Health Information Collaborative (CHIC)	http://www.medinfosystems.org/mission.html
Health Information and Management Systems Society (HIMSS)- Minnesota	http://www.himss-mn.org/
Local Public Health Association	http://www.lpha-mn.org/
MDH- Office of Rural Health & Primary Care (ORHPC)	http://www.health.state.mn.us/divs/orhpc/
Minnesota Department of Health (MDH)- Health Reform	http://www.health.state.mn.us/healthreform/
Minnesota Department of Human Services (DHS)	http://www.dhs.state.mn.us/
Minnesota Health Information Exchange (MN HIE)	http://www.mnhie.org/
Minnesota Hospital Association (MHA)	http://www.mnhospitals.org/
Minnesota Medical Association (MMA)	http://www.mmaonline.net/
Minnesota Nurses Association (MNA)	http://www.mnnurses.org/
Minnesota Public Health Association (MPHA)	http://www.mpha.net/

Figure 2: Approach for Monitoring and Sharing e-Health Information

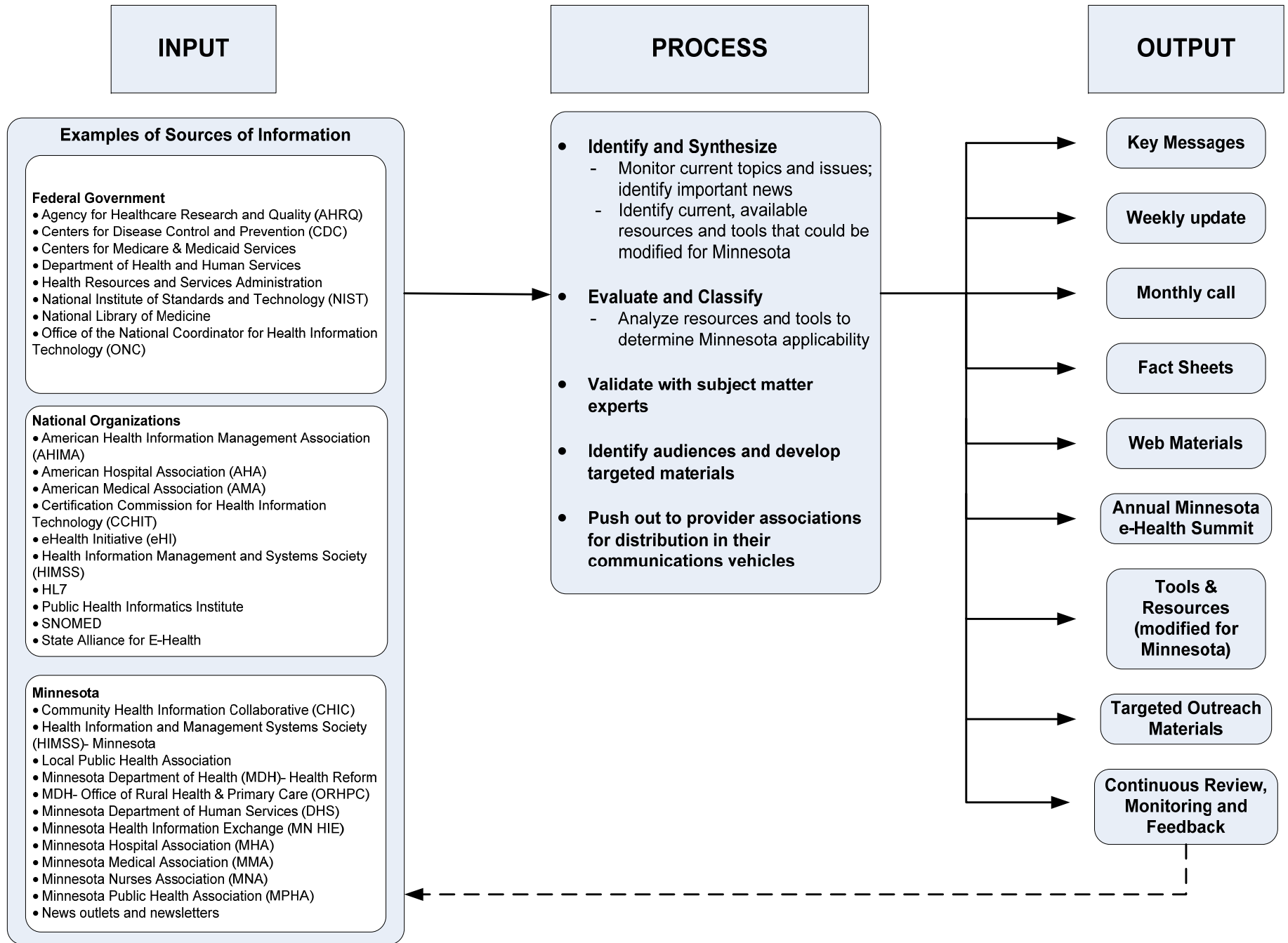


Table 6: Providers Impacted by the 2015 Interoperable EHR Mandate

Example Provider/Care Delivery Setting	Example Provider/Care Delivery Setting
Primary Care Settings	Radiology
Family Practice	Radiation Oncology
Pediatrics and pediatric subspecialties	Diagnostic Centers
Retail-based clinics	Urgent Care Centers
OB-Gyn	
Community Clinics/FOHCs	Ambulatory Surgical Centers
Jail Health/Correctional Facilities	
School-based Clinics	Long Term Care Facilities
Migrant Health	Assisted Living
	Skilled Nursing Facilities
Examples of specialty care clinics, including but not limited to:	
Allergy and Asthma	Home Health Agencies
Bariatrics	Hospital/Health System based
Cardiology	Independent
Cosmetic/Plastic/Reconstructive	
Dermatology	Hospice
Gastroenterology	Hospital/Health System based
Infectious Disease	Independent
Internal Medicine	
Neurology	Local Public Health Departments
Oncology	Services to at-risk populations (i.e. TB, STD, WIC)
Ophthalmology	Population-based screening & other services
Podiatry	Surveillance
Urology	
Family Planning	Habilitation
Genetic Services	Occupational therapy
Anesthesia	Physical therapy
Cardiac	Recreational therapy
Head and Neck	
Neurology	Dental
Occupational Medicine	General practice
Osteopathic Clinics	Oral Surgery
Sports Medicine	
Pain Management	Mental /Behavioral Health
Sleep Disorders	Mental Health Centers
	Group/private practice
Hospitals	
In-patient	Chiropractic Clinics
Outpatient	
Emergency Departments	Complementary Medicine/Care
Pharmacies	State Agencies
Community	Minnesota Department of Health
Hospital-based	Minnesota Department of Human Services
	Minnesota Department of Corrections
Laboratories	
Clinic-based	
Hospital-based	
Independent	

Table 7: Health Information Technology and Health Informatics Education and Training

The following tables and accompanying Minnesota e-Health website tool is the result of a collaborative effort between the Minnesota Department of Health and University of Minnesota School of Nursing Informatics Students. Students completed an inventory of current health information technology/informatics education, training and informational resources that could increase workforce informatics competencies and meet HITECH role definitions. The Minnesota e-Health website will host an online search tool that links these HITECH roles links to programs, courses, seminars/conferences and resources for each role.

Twelve roles, highlighted in the following two tables, have been identified by the Office of the National Coordinator for Health IT and are supported by two Recovery Act grants for Community College and University based programs that will increase workforce training opportunities to support the meaningful use of electronic health records. Descriptions and prerequisites are provided below.

University based Education and Training	Health IT Workforce Roles	Description
	Clinician/Public Health Leader	Individuals in this role will be able to lead the successful deployment and use of health IT to achieve transformational improvement in the quality, safety, outcomes, and thus in the value. Will require at least one year of study leading to a university-issued certificate or master's degree in health informatics or health IT, as a complement to the individuals' prior clinical or public health academic training. <i>Prerequisites: Masters degree or higher in a clinical or public health field or enrollment in an advanced degree program.</i>
	Health Information Management and Exchange Specialist	Individuals in these roles support the collection, management, retrieval, exchange, and/or analysis of information in electronic form, graduates of this training would typically not enter directly into leadership or management roles. <i>Prerequisites: Health care or information sciences background may be helpful for training in this role.</i>
	Health Information Privacy and Security Specialist	Individuals in this role would be qualified to serve as institutional/organizational information privacy or security officers. <i>Prerequisites: Training appropriate to this role would require either specialization within baccalaureate-level studies or post-baccalaureate-level training.</i>
	Research and Development Scientist	These individuals will support efforts to create innovative models and solutions that advance the capacities of health IT and conduct studies on the effectiveness of health IT and its effect on health care quality. <i>Prerequisites: Training appropriate to this role will require a doctoral degree in informatics or related fields for individuals not holding an advanced degree in one of the health professions, or a master's degree for doctorally prepared individuals.</i>
	Programmers and Software Engineer	These individuals will be the architects and developers of advanced health IT solutions. These individuals will be cross-trained in IT and health domains. <i>Prerequisites: Training appropriate to this role would require specialization within baccalaureate-level studies or post-baccalaureate-level training. Advanced training in a health-related topic area is also appropriate for individuals with information technology backgrounds.</i>
	Health IT Sub-specialist	Individuals in these roles combine health care or public health generalist knowledge, knowledge of IT, and disciplines that inform health IT policy or technology. They could be employed in research and development settings, and could serve as teachers. Training appropriate to this type of role would require successful completion of at least a master's degree in an appropriate discipline other than health informatics, but with a course of study that closely aligns with health IT. <i>Prerequisites: Include a minimum of baccalaureate preparation in a health care related field.</i>

Table 7: Health Information Technology and Health Informatics Education and Training (continued)

	Health IT Workforce Roles	Description
Community College based Education and Training	Practice workflow and information management redesign specialists	Individuals in this role assist in reorganizing the work of a provider to take full advantage of the features of health IT in pursuit of meaningful use of health IT to improve healthcare. <i>Prerequisites: Individuals in this role may have a background in health care or in information technology, but are not licensed clinical professionals.</i>
	Clinician/practitioner consultants	This role is similar to the “redesign specialist” role listed above but includes the background and experience of a licensed clinical and professional or public health professional. <i>Prerequisites: Include experience as a licensed clinical or public health professional.</i>
	Implementation support specialists	Workers in this role provide on-site user support for the period of time before and during implementation of health IT systems in clinical and public health settings. <i>Prerequisites: Individuals in this role may have background in health and/or information technology.</i>
	Implementation managers	Workers in this role provide on-site management of mobile adoption support teams for the period of time before and during implementation of health IT systems in clinical and public health settings. <i>Prerequisites: Individuals in this role may have experience in health and/or information technology environments or managerial background.</i>
	Technical/software support staff	Workers in this role maintain systems in clinical and public health settings, including patching and upgrading of software. <i>Prerequisites: Individuals in this role may have backgrounds in information technology or information management.</i>
	Trainers	Workers in this role design and deliver training programs to employees in clinical and public health settings. <i>Prerequisites: Individuals in this role may have experience as a health professional or in information management.</i>

For More Information

For more information, contact Bob Johnson by phone at (651)201- 4856 or Bob.B.Johnson@state.mn.us. This communications plan, as well as other Minnesota e-Health Initiative publications, can be found on our website at: www.health.state.mn.us/e-health

Subscribe to get Minnesota e-Health e-mail updates by clicking on the red envelope marked subscribe in the center of the Minnesota e-Health Initiative Homepage at: www.health.state.mn.us/e-health.



Office of Health Information Technology
P.O. Box 64882
85 East Seventh Place, Suite 200
St. Paul, MN. 55164-0882
612-201-5979
www.health.state.mn.us/ehealth

Minnesota Session Laws

Search

Key: (1) ~~language to be deleted~~ (2) new language

2010, Regular Session

This document represents the act as presented to the governor. The version passed by the legislature is the final engrossment. It does not represent the official 2010 session law, which will be available here summer 2010.

CHAPTER 336--S.F.No. 2974

An act

relating to health; amending provisions for electronic health record technology; providing for administrative penalties; defining significant disruption to normal operations; appropriating money; amending Minnesota Statutes 2009 Supplement, sections 62J.495, subdivisions 1a, 3, by adding a subdivision; 62J.497, subdivisions 4, 5; proposing coding for new law in Minnesota Statutes, chapter 62J.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** (a) "Certified electronic health record technology" means an electronic health record that is certified pursuant to section 3001(c)(5) of the HITECH Act to meet the standards and implementation specifications adopted under section 3004 as applicable.

(b) "Commissioner" means the commissioner of health.

(c) "Pharmaceutical electronic data intermediary" means any entity that provides the infrastructure to connect computer systems or other electronic devices utilized by prescribing practitioners with those used by pharmacies, health plans, third-party administrators, and pharmacy benefit managers in order to facilitate the secure transmission of electronic prescriptions, refill authorization requests, communications, and other prescription-related information between such entities.

(d) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act in division A, title XIII and division B, title IV of the American Recovery and Reinvestment Act of 2009, including federal regulations adopted under that act.

(e) "Interoperable electronic health record" means an electronic health record that securely exchanges health information with another electronic health record system that meets requirements specified in subdivision 3, and national requirements for certification under the HITECH Act.

(f) "Qualified electronic health record" means an electronic record of health-related information on an individual that includes patient demographic and clinical health information and has the capacity to:

(1) provide clinical decision support;

- (2) support physician order entry;
- (3) capture and query information relevant to health care quality; and
- (4) exchange electronic health information with, and integrate such information from, other sources.

Sec. 2. Minnesota Statutes 2009 Supplement, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** To meet the requirements of subdivision 1, hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(a) The electronic health record must be a qualified electronic health record.

(b) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers ~~only~~ if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(c) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(d) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(e) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a state-certified health data intermediary as defined in section 62J.498.

~~(f)~~ (f) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 3. Minnesota Statutes 2009 Supplement, section 62J.495, is amended by adding a subdivision to read:

Subd. 6. **State agency information system.** Development of state agency information systems necessary to implement this section is subject to the authority of the Office of Enterprise Technology in chapter 16E, including, but not limited to:

(1) evaluation and approval of the system as specified in section 16E.03, subdivisions 3 and 4;

(2) review of the system to ensure compliance with security policies, guidelines, and standards as specified in section 16E.03, subdivision 7; and

(3) assurance that the system complies with accessibility standards developed under section 16E.03, subdivision 9.

Sec. 4. Minnesota Statutes 2009 Supplement, section 62J.497, subdivision 4, is amended to read:

Subd. 4. **Development and use of uniform formulary exception form.** (a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity

Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.

(b) No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. ~~Facsimile shall not be considered secure electronic transmissions.~~

Sec. 5. Minnesota Statutes 2009 Supplement, section 62J.497, subdivision 5, is amended to read:

Subd. 5. Electronic drug prior authorization standardization and transmission.

(a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, ~~2011~~ 2015, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

Sec. 6. [62J.498] HEALTH INFORMATION EXCHANGE.

Subdivision 1. Definitions. The following definitions apply to sections 62J.498 to 62J.4982:

(a) "Clinical transaction" means any meaningful use transaction that is not covered by section 62J.536.

(b) "Commissioner" means the commissioner of health.

(c) "Direct health information exchange" means the electronic transmission of health-related information through a direct connection between the electronic health record systems of health care providers without the use of a health data intermediary.

(d) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(e) "Health data intermediary" means an entity that provides the infrastructure to connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators, or pharmacy benefit managers to facilitate the secure transmission of health information, including pharmaceutical electronic data intermediaries as defined in section 62J.495. This does not include health care providers engaged in direct health information exchange.

(f) "Health information exchange" means the electronic transmission of

health-related information between organizations according to nationally recognized standards.

(g) "Health information exchange service provider" means a health data intermediary or health information organization that has been issued a certificate of authority by the commissioner under section 62J.4981.

(h) "Health information organization" means an organization that oversees, governs, and facilitates the exchange of health-related information among organizations according to nationally recognized standards.

(i) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.

(j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors of the health information organization.

(k) "Meaningful use" means use of certified electronic health record technology that includes e-prescribing, and is connected in a manner that provides for the electronic exchange of health information and used for the submission of clinical quality measures as established by the Center for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(l) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.

(m) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization or health data intermediary has contracts or other agreements for the provision of health information exchange service providers:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

(n) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to

allow for the pass-through of meaningful use transactions.

(o) "State-certified health data intermediary" means a health data intermediary that:

(1) provides a subset of the meaningful use transaction capabilities necessary for hospitals and providers to achieve meaningful use of electronic health records;

(2) is not exclusively engaged in the exchange of meaningful use transactions covered by section 62J.536; and

(3) has been issued a certificate of authority to operate in Minnesota.

(p) "State-certified health information organization" means a nonprofit health information organization that provides transaction capabilities necessary to fully support clinical transactions required for meaningful use of electronic health records that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. Health information exchange oversight. (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from health data intermediaries and health information organizations for certificates of authority to operate in Minnesota;

(2) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

(3) respond to public complaints related to health information exchange services;

(4) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

(5) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences;

(6) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) hold public hearings that provide an adequate opportunity for participating entities and consumers to provide feedback and recommendations on the application under consideration. The commissioner shall make all portions of the application classified as public data available to the public at least ten days in advance of the hearing. The applicant shall participate in the hearing by presenting an overview of their application and responding to questions from interested parties;

(2) make available all feedback and recommendations gathered at the hearing available to the public prior to issuing a certificate of authority; and

(3) consult with hospitals, physicians, and other professionals eligible to receive meaningful use incentive payments or subject to penalties as established in the HITECH Act, and their respective statewide associations, prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 7. ~~62J.4981~~ CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. Authority to require organizations to apply. The commissioner shall require an entity providing health information exchange services to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information organization whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

Subd. 2. Certificate of authority for health data intermediaries. (a) A health data intermediary that provides health information exchange services for the transmission of one or more clinical transactions necessary for hospitals, providers, or eligible professionals to achieve meaningful use must be registered with the state and comply with requirements established in this section.

(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

- (1) interoperate with at least one state-certified health information organization;
- (2) provide an option for Minnesota entities to connect to their services through at least one state-certified health information organization;
- (3) have a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions; and
- (4) hold reciprocal agreements with at least one state-certified health information organization to enable access to record locator services to find patient data, and for the transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid

Services. Reciprocal agreements must meet the requirements established in subdivision 5.

Subd. 3. Certificate of authority for health information organizations.

(a) A health information organization that provides all electronic capabilities for the transmission of clinical transactions necessary for meaningful use of electronic health records must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, a nonprofit corporation organized to do so may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established, nonprofit organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans clearly address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time;

(4) the entity addresses the parameters to be used with participating entities and other health information organizations for meaningful use transactions, compliance with Minnesota law, and interstate health information exchange in trust agreements;

(5) the entity's board of directors is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with criteria established under the Health Information Exchange Accreditation Program of the Electronic Healthcare Network Accreditation Commission (EHNAC) or equivalent criteria established by the commissioner;

(8) the entity maintains a record locator service as defined in section 144.291, subdivision 2, paragraph (i), that is compliant with the requirements of section 144.293, subdivision 8, when conducting meaningful use transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

- (1) meet the requirements established for connecting to the Nationwide Health Information Network (NHIN) within the federally mandated timeline or within a time frame established by the commissioner and published in the State Register. If the state timeline for implementation varies from the federal timeline, the State Register notice shall include an explanation for the variation;
- (2) annually submit strategic and operational plans for review by the commissioner that address:
 - (i) increasing adoption rates to include a sufficient number of participating entities to achieve financial sustainability; and
 - (ii) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;
- (3) develop and maintain a business plan that addresses:
 - (i) plans for ensuring the necessary capacity to support meaningful use transactions;
 - (ii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;
 - (iii) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and
 - (iv) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;
- (4) annually submit a rate plan to the commissioner outlining fee structures for health information exchange services for approval by the commissioner. The commissioner shall approve the rate plan if it:
 - (i) distributes costs equitably among users of health information services;
 - (ii) provides predictable costs for participating entities;
 - (iii) covers all costs associated with conducting the full range of meaningful use clinical transactions, including access to health information retrieved through other state-certified health information exchange service providers; and
 - (iv) provides for a predictable revenue stream for the health information organization and generates sufficient resources to maintain operating costs and develop technical infrastructure necessary to serve the public interest;
- (5) enter into reciprocal agreements with all other state-certified health information organizations to enable access to record locator services to find patient data, and transmission and receipt of meaningful use transactions consistent with the format and content required by national standards established by Centers for Medicare and Medicaid Services. Reciprocal agreements must meet the requirements in subdivision 5; and
- (6) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. Application for certificate of authority for health information exchange service providers. (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following:

- (1) a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;
- (2) a list of the names, addresses, and official positions of the following:

- (i) all members of the board of directors, and the principal officers and, if applicable, shareholders of the applicant organization; and
- (ii) all members of the board of directors, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;
- (3) the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;
- (4) a copy of each standard agreement or contract intended to bind the participating entities and the health information organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;
- (5) a copy of each contract intended to bind major participating entities and the health information organization. Contract information filed with the commissioner under this section shall be nonpublic as defined in section 13.02, subdivision 9;
- (6) a statement generally describing the health information organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;
- (7) financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent certified financial statement;
- (8) strategic and operational plans that specifically address how the organization will expand technical capacity of the health information organization to support providers in achieving meaningful use of electronic health records over time, a description of the proposed method of marketing the services, a schedule of proposed charges, and a financial plan that includes a three-year projection of the expenses and income and other sources of future capital;
- (9) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;
- (10) a description of the complaint procedures to be used as required under this section;
- (11) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;
- (12) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;
- (13) a copy of the conflict of interest policy that applies to all members of the board of directors and the principal officers of the health information organization; and
- (14) other information as the commissioner may reasonably require to be provided.
- (b) Within 30 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.
- (c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the

commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 for health data intermediaries or subdivision 3 for health information organizations. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.
(d) Upon being granted a certificate of authority to operate as a health information organization, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. Reciprocal agreements between health information exchange entities.

(a) Reciprocal agreements between two health information organizations or between a health information organization and a health data intermediary must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of transactions necessary to achieve meaningful use;

(2) does not charge a fee for the exchange of meaningful use transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization or health data intermediary either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization or state-certified health data intermediary from entering into contractual agreements for the provision of value-added services beyond meaningful use.

(e) The commissioner of human services or health, when providing access to data or services through a certified health information organization, must offer the same data or services directly through any certified health information organization at the same pricing, if the health information organization pays for all connection costs to the state data or service. For all external connectivity to the respective agencies through existing or future information exchange implementations, the respective agency shall establish the required connectivity methods as well as protocol standards to be utilized.

Subd. 6. State participation in health information exchange. A state agency that connects to a health information exchange service provider for the purpose of exchanging meaningful use transactions must ensure that the contracted health information exchange service provider has reciprocal agreements in place as required by this section. The reciprocal agreements must provide equal access to information supplied by the agency as necessary for meaningful use by the participating entities of the other health information service providers.

Sec. 8. [62J.4982] ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. Penalties and enforcement. (a) The commissioner may, for any violation of statute or rule applicable to a health information exchange service provider,

levy an administrative penalty in an amount up to \$25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

- (1) the number of participating entities affected by the violation;
 - (2) the effect of the violation on participating entities' access to health information exchange services;
 - (3) if only one participating entity is affected, the effect of the violation on the patients of that entity;
 - (4) whether the violation is an isolated incident or part of a pattern of violations;
 - (5) the economic benefits derived by the health information organization or a health data intermediary by virtue of the violation;
 - (6) whether the violation hindered or facilitated an individual's ability to obtain health care;
 - (7) whether the violation was intentional;
 - (8) whether the violation was beyond the direct control of the health information exchange service provider;
 - (9) any history of prior compliance with the provisions of this section, including violations;
 - (10) whether and to what extent the health information exchange service provider attempted to correct previous violations;
 - (11) how the health information exchange service provider responded to technical assistance from the commissioner provided in the context of a compliance effort; and
 - (12) the financial condition of the health information exchange service provider including, but not limited to, whether the health information exchange service provider had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information exchange service provider to continue to deliver health information exchange services.
- The commissioner shall give reasonable notice in writing to the health information exchange service provider of the intent to levy the penalty and the reasons for them. A health information exchange service provider may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.
- (b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information exchange service provider and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.
- (c) The commissioner may issue an order directing a health information exchange service provider or a representative of a health information exchange service provider to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information exchange service provider may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. Suspension or revocation of certificates of authority. (a) The commissioner may suspend or revoke a certificate of authority issued to a health data intermediary or health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information exchange service provider is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information exchange service provider is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information exchange service provider is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information exchange service provider has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information exchange service provider, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information exchange service provider would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information exchange service provider has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information exchange service provider is suspended, the health information exchange service provider shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information exchange service provider is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the

greatest practical opportunity to access continuing health information exchange services.

Subd. 3. Denial, suspension, and revocation; administrative procedures. (a)

When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information exchange service provider in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information exchange service provider may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information exchange service provider to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information exchange service provider.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information exchange service provider written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

- (1) a reference to the statutory basis for the penalty;
- (2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;
- (3) the nature and amount of the proposed penalty;
- (4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;
- (5) instructions for responding to the notice, including a statement of the health information exchange service provider's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and
- (6) the address to which the contested case proceeding request must be sent.

Subd. 4. Coordination. (a) The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information exchange service providers when implementing sections 62J.498 to 62J.4982.

(b) By January 1, 2011, the commissioner shall report to the governor and the chairs of the senate and house of representatives committees having jurisdiction over health information policy issues on the status of health information exchange in Minnesota, and provide recommendations on further action necessary to facilitate the secure electronic movement of health information among health providers that will enable Minnesota providers and hospitals to meet meaningful use exchange requirements.

Subd. 5. Fees and monetary penalties. (a) The commissioner shall assess fees on every health information exchange service provider subject to sections 62J.4981 and 62J.4982 as follows:

- (1) filing an application for certificate of authority to operate as a health information organization, \$10,500;
- (2) filing an application for certificate of authority to operate as a health data intermediary, \$7,000;
- (3) annual health information organization certificate fee, \$14,000;
- (4) annual health data intermediary certificate fee, \$7,000; and

(5) fees for other filings, as specified by rule.

(b) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 9. FEDERAL FUNDING.

To the extent that the commissioner of health applies for additional federal funding to support the commissioner's responsibilities of developing and maintaining state-level health information exchange under section 3013 of the HITECH Act, the commissioner of health shall ensure that applications are made through an open process that provides health information exchange service providers equal opportunity to receive funding.

Sec. 10. NONSUBMISSION OF HEALTH CARE CLAIM BY CLEARINGHOUSE; SIGNIFICANT DISRUPTION.

A situation shall be considered a significant disruption to normal operations that materially affects the provider's or facility's ability to conduct business in a normal manner and to submit claims on a timely basis under Minnesota Statutes, section 62Q.75, if:

(1) a clearinghouse loses, or otherwise does not submit, a health care claim as required by Minnesota Statutes, section 62J.536; and

(2) the provider or facility can substantiate that it submitted a complete claim to the clearinghouse within provisions stated in contract or six months of the date of service, whichever is less.

This section expires January 1, 2012.

Sec. 11. APPROPRIATION; HEALTH INFORMATION EXCHANGE OVERSIGHT.

\$104,000 in fiscal year 2011 is appropriated from the state government special revenue fund to the commissioner of health for the duties required under Minnesota Statutes, sections 62J.498 to 62J.4982. Base funding shall be \$97,000 in fiscal year 2012 and \$97,000 in fiscal year 2013.



**Upper Midwest HIE Collaborative
State Health Policy Consortium Support Services Request Proposal**

Submitted behalf of Illinois, Iowa, Minnesota, North Dakota, South Dakota & Wisconsin

A. Summary

Six states intend to establish the Upper Midwest HIE (UM-HIE) Collaborative, to work together to create a regional vision for interstate health information exchange (HIE) and pursue concrete solutions to barriers affecting HIE for treatment purposes between the UM-HIE states. One purpose of this project is to build upon the work of the HISPC Intrastate/Interstate Consent Policy Options (IICPO) Collaborative to evaluate and pursue the development of template language for interstate agreements or other similar mechanisms that will enable interstate HIE despite differences in individual state consent laws.

Since there are different political environments in each state, UM-HIE Collaborative will seek to understand the assurances necessary to address concerns of policymakers in the UM-HIE states. By understanding the differences, UM-HIE Collaborative will create an environment where it is possible to modify legal frameworks or enter into agreements to enable HIE across borders (e.g., identifying what enforcement mechanisms are needed for providers who act negligently regarding a patient's privacy rights). Subject matter experts will be engaged to facilitate the establishment of a charter for the UM-HIE Collaborative, and assist with analysis of issues and current policy to develop recommendations, and to negotiate and finalize language that could be included in an interstate agreement. A complete list of state responsibilities is contained in section G.

At the conclusion of this project, UM-HIE Collaborative findings on the viable uses of interstate agreements or other mechanisms, template language and educational materials will be available to other states and/or regions seeking to enable interstate HIE.

B. Introduction/Understanding of the Problem

This proposal is being submitted by State of Minnesota on behalf of the states of Illinois, Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin. (Please see letters of support from State Government HIT Coordinators contained in Appendix A.) The state entities involved in the proposal submission include:

Illinois Office of the Governor, Office of Health Information Technology

Iowa Department of Public Health, Office of Health Information Technology

Minnesota Department of Health, Office of Health Information Technology

North Dakota Information Technology Department

South Dakota Department of Health

Wisconsin Department of Health Services

Health information privacy, confidentiality and security issues are historically complicated. As each of the UM-HIE states moves forward with its Strategic and Operational Plans for health information exchange, it is critical for the state to address how electronic health records will be exchanged with other states, and in particular with its border states. The Minnesota's Health Records Act, requiring consent each time there is a release of patient records (even for treatment purposes), has made the exchange of health records across state lines difficult for some of Minnesota's border states. As e-health activity is building across the country, there is an increased urgency to develop the necessary strategies and tools to collaboratively respond to barriers affecting health information exchange, especially with border-states that are frequent trading partners.

State Experience Working on Interstate Solutions to Policy Issues, Privacy & Security Challenges

The six states who will be members of the UM-HIE Collaborative have all been involved in work focused on the development of interstate solutions to policy issues, and in particular, privacy and security challenges to interoperable HIE. The information set forth below provides a brief summary of the work performed by the UM-HIE states on these topics.

Illinois: The State of Illinois participated in one of the seven HISPC Collaboration projects, the "Intrastate and Interstate Consent Policy Options", together with California, North Carolina and Ohio.

The Final Report from that project is available at:

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1280&PageID=16054&mode=2&cached=false>

Following from participation in that HISPC project, patient consent forms were created for use within Illinois. Those forms and a report from Illinois' involvement in the project are available at:

<http://www.idph.state.il.us/hispc2/index.htm>.

Iowa: Since its inception in 2006, Iowa has participated in HISPC, a multi-state, collaborative project to address the privacy and security challenges presented by electronic health information exchange. With multi-stakeholder collaboration, the project resulted in multiple deliverables including: 1) assessment of privacy and security barriers; 2) urban and rural consumer focus groups; 3) proposed privacy and security solutions; 4) patient consent framework for treatment scenarios; 5) continuity of care document exchange pilot; 6) legal and legislative recommendations; and 7) model inter-organizational data sharing agreements which resulted in a pilot flat file exchange of immunization records between Iowa and South Dakota.

Participation in HISPC has provided an opportunity for Iowa to review and understand inter-state and intra-state privacy and security challenges. HISPC provides the foundation for development of a 2009 Privacy and Security report of the Iowa legislature, ongoing Iowa e-Health workgroup discussions, and Iowa's statewide HIE privacy and security policies. The Iowa e-Health privacy and security policies will address intra-state and inter-state sharing of electronic health information.

Minnesota: From 2005 to 2009, the Minnesota Department of Health participated in all phases of the HISPC project, which completed a comprehensive review of laws and practices to identify those that impeded the electronic exchange of health data and determined how Minnesota law aligned with federal statutes such as HIPAA. The project identified the most significant privacy and security issues and gaps facing organizations in implementing the electronic exchange of health information and developed solutions to address these gaps. In the final phase of HISPC, Minnesota worked with 11 other states on the Interstate Disclosure and Patient Consent Requirements Collaborative. The final report in March, 2009, provided a uniform set of templates, discussion about proposed analytical methods and recommendations related to consent for disclosure of protected health information in various states to help advance interstate HIE.

This work resulted in the 2007 re-codification and update of the Minnesota Health Records Act to support secure and confidential electronic exchange of health information. Before the re-codification, Minnesota health care providers were required to obtain and submit a signed paper consent form to another health care provider prior to exchanging health information even for treatment. The new law provides a mechanism that allows consent to be exchanged electronically and eliminates the need for a paper based system. It also updated the assignment of liability associated with inappropriate requests or disclosures of health information.

North Dakota: North Dakota has participated in the National Governors' Association (NGA) State Health Alliance 40 Health E-Health Privacy and Security Task Force and various other NGA committees which identified "consent" laws and making "opt-in" and "opt-out" policies work in an electronic environment as a significant challenge.

South Dakota: South Dakota previously participated in the HISPC Inter-Organizational Agreements (IAO) Collaborative. The goal of this Collaborative was to create model data sharing agreements among the six states and one territory who participated. The model data sharing agreement was designed to share immunization data across state/territory lines and the focus was creating a document that encompassed varying state laws and policies. The final outcome was the model agreement which all 7 participating states signed. They were further endorsed by the American Immunization Registry Association for use nationally. The second deliverable from this work was an actual pilot data exchange among the registries to. Two individual pilots were performed as part of this second deliverable.

South Dakota's participation in the HISPC IOA Collaborative provided much groundwork for exchanging public health data across state lines. This work can be expanded upon to include other more sensitive health care data. These model data sharing agreements served as a basis for addressing the varying privacy, security, and consent laws of the states participating. Much work was done in cross-walking the various statutes and laws from the participating states. This work could also serve as a template for other states to analyze varying state laws.

Wisconsin: Wisconsin participated in all phases of HISPC's Interstate Disclosure and Patient Consent Requirements Collaborative. The Collaborative assembled and analyzed detailed requirements stipulated in state laws, regulations, and rules pertaining to consent for the disclosure of protected health information across a range of specific interstate HIE scenarios and offered several options for incrementally moving forward with HIE across state boundaries.

One of the final outputs of this project was the enactment of 2007 Wisconsin Act 108. The enactment of this law was a result of extensive dialogue and collaboration with a wide range of stakeholders. This Act better aligned Wisconsin laws with the federal HIPAA privacy laws. Changes were made to Wisconsin's Mental Health, Developmental Disabilities and AODA statutes and Patient General Health Care Records to address certain barriers to health information exchange in the statutes.

Building on Work Completed by Previous Interstate Exchange Initiatives Funded by ONC

There have been many privacy and security-related accomplishments that will facilitate planning and successful implementation of concrete privacy and security solutions for the UM-HIE states. Achievements and assets include: 1) the U.S. Department of Health and Human Services privacy and security framework; ONC's Data Use and Reciprocal Support Agreement (DURSA) developed as a trust agreement for the Nationwide Health Information Network (NHIN); 2) privacy and security policies established in other states; 3) national HISPC reports with recommendations for privacy and security policies; and 4) HISPC demonstration projects. Other state-level and federal health IT initiatives (e.g., Healthcare Information Technology Standards Panel, National Health Information Network, Healthcare Information Management Systems Society, and American Health Information Management Association)

also provide a solid foundation for planning and implementation of health IT in Iowa. The participating states agree that leveraging smart practices and lessons learned is a critical success factor for the UM-HIE initiative. In particular, UM-HIE will use work that began through HISPC, NHIN, and other state HIE initiatives to develop model language for interstate agreements.

C. Justification

Advancing the Ability of UM-HIE States to Exchange Health Information with One Another

The project will foster effective communications between border states that have the need for frequent exchange of health information across state lines. The project will clarify the needs of the various states to create an environment for law or policy changes or for interstate agreements allowing for interstate HIE, even if under certain defined circumstances, (e.g., the establishment of sanctions or consumer dispute resolution processes in the event that a patient's health information is exchanged without the consent required by the applicable state law). The project will result in template language for interstate agreements or legislation allowing for interstate exchange.

Additionally, the project will help establish an on-going regional collaborative that will have a charter and a process established for discussion of future issues related to interstate HIE.

Potential for Other States to use Methods and Knowledge from UM-HIE Collaborative Project

The establishment of UM-HIE Collaborative will provide a more formal structure for publishing the results of the regional collaborative, including any model language, agreements or forms developed by UM-HIE Collaborative with the assistance of the subject matter expert. The problems facing the upper Midwest states are not unique or different from other regions; therefore, the results of UM-HIE Collaborative's work will benefit to other states where consent laws are not identical to each other.

Alignment with Existing Office of the National Coordinator Programs Goals and Needs

The formation of the UM-HIE Collaborative and the proposed project schedule outlined in section E aligns directly with the goals of the HITECH programs being implemented by the Office of the National Coordinator (ONC) and the Centers for Medicare and Medicaid Services (CMS).

Dr. Blumenthal expressed the national vision in November 2009, indicating a key premise that, "information should follow the patient, and artificial obstacles – technical, business related, bureaucratic – should not get in the way." In order to fulfill this vision, and enable information to follow the patient "seamlessly and effortlessly to every nook and cranny of our health system, when and where it is needed," it is essential that we seek out specific solutions to the differences in state laws that result in electronic HIE being halted at the borders.

Recognizing that enabling interstate HIE is a difficult task, and will require adjustments on the part of each state to fully accomplish interoperability, the formation of the UM-HIE Collaborative enables the upper Midwest states to take an incremental approach to identify and overcome barriers to interstate exchange over time. This is consistent with how ONC and CMS have set out to incrementally advance transformative change by urging health care providers toward full meaningful use of electronic health records over time. It is also consistent with how ONC is developing the Nationwide Health Information Exchange (NHIN). NHIN is being developed to provide an infrastructure for secure, interoperable, nationwide HIE. To date, connection to NHIN has been limited to select organizations (e.g., Department of Defense, Social Security Administration, Veteran's Affairs); however by developing and making available clear technical specifications, ONC is preparing states to connect to NHIN as they are able in the future.

By engaging the State Government Health IT Coordinators of each of the UM-HIE Collaborative States, the work of the collaborative can be incorporated into coordination activities with the various HITECH programs funded in each state (e.g., regional extension centers, state health information organizations, and workforce development programs). As solutions are identified to enable interstate HIE, the other HITECH Programs can be partners in educating and informing health care providers and other stakeholders about their options for engaging in interstate HIE.

D. Desired Outcomes

National efforts to move forward on HISPC projects have been somewhat hampered by limited funding, multiple tiers of accountability, and the difficulty of multiple states with varied self-interests attempting to address a complex issue. However, the UM-HIE project will seek to leverage work completed through HISPC and transition to pursue concrete solutions to barriers affecting HIE for treatment purposes between the UM-HIE states. UM-HIE states seek to expedite discussion of localized issues and reconcile differences between consent laws through targeted regional collaboration with border-states, focusing on ways to reconcile differences between consent laws. UM-HIE states have noted that a critical component of any progress in this area is to create a mechanism, such as the UM-HIE Collaborative, to develop the necessary relationships with agency or department staff from the UM-HIE states that oversee the privacy and security of health information. The establishment of a structured forum and process to facilitate the discussion of issues of regional importance will not only address the immediate concerns of interstate HIE, but will also provide the tools necessary for decisions to be made in the years ahead.

The Support Services offered through the State Health Policy Consortium are needed by the UM-HIE states to provide the structured communications, meetings and subject matter experts for the establishment of the UM-HIE Collaborative. The Support Services will also help the UM-HIE Collaborative set and accomplish goals related to privacy and security issues involving HIE between the states. This includes the effective use of a subject matter expert to guide the UM-HIE Collaborative in defining what can be accomplished through the regional collaborative effort and to provide practical advice and services in producing the agreements or model language needed to allow interstate HIE to take place between the constituent states.

Specific outcomes sought by the UM-HIE states include the following:

Outcome 1: Establishment of UM-HIE Collaborative

Enlist the services of a subject matter expert (SME) to facilitate in-person meetings, webinars and teleconferences with UM-HIE state representatives to develop and finalize a charter for the UM-HIE Collaborative. The SME will assist the UM-HIE Collaborative to refine specific goals, priorities and timelines related to actions needed to overcome barriers to interstate HIE. An expert's review of the charter of UM-HIE Collaborative and preliminary documents related to its work will be critical to the success of the regional collaborative. The SME will provide written reports of the decisions made at the meetings.

Outcome 2: Analysis of Current Law

Using exchange scenarios relating to meaningful use, enlist the services of SME(s) to identify, obtain and compile key information from each UM-HIE state [either from an examination of previous HISPC reports or a survey prepared by the SME] regarding current law related to key topics identified by UM-HIE Collaborative in its initial meetings This includes but is not limited to answers to the following questions:

- a. Under what circumstances are providers in each state allowed to assert or signify that appropriate consent has been obtained from the patient, in order to authorize the provider to access health information through electronic HIE?
- b. In the event that there is a dispute about whether consent was given, what laws exist to establish the liability of providers, including liability on providers who act negligently or willfully in representing that consent to release the health records was obtained?
- c. What enforcement mechanisms exist in each state to take action against a “bad actor” (i.e. actions against the provider’s license, administrative penalties, other sanctions, or a private cause of action)?
- d. What types of health record information present a specific problem for interstate HIE, such as sensitive services or behavioral health records, and are there any specific tools that will assist the constituent states in dealing with these barriers?

Outcome 3: Identify Possible Mechanisms and Common Language to Enable Interstate HIE

Enlist the services of SME(s) to research and present possible solutions or mechanisms for UM-HIE states to pursue to address issues such as consent and “bad actor” liability. The SME would present recommended options in a formalized way to the group of states (via telephone conference or in-person meeting) and provide detailed sample language, if applicable, for options including but not limited to:

- Model language for state laws to enable interstate health information exchange
- Template language for an interstate agreement or compact
- Sample language to be incorporated into the consent forms used in the states

The SME would also assist the UM-HIE states to reach a consensus on which mechanism best meets the goal of facilitating interstate health information exchange and identify next steps.

Outcome 4: Identify Electronic Method for Implementation of Preferred Mechanisms

In order to ensure that UM-HIE states are able to share information electronically, without the need to send signed consent forms via e-mail or fax, the collaborative will work with SME(s) to explore and identify the best electronic method for implementation.

E. Project Schedule and Table of Milestones

MONTH	MILESTONE	TOOLS/OUTCOMES
July - Sept	Confirmation of Project Details	<ul style="list-style-type: none"> With RTI, finalize MOU, detailed workplan and other necessary management documents.
September	First Meeting (In-person, facilitated by SME)	<ul style="list-style-type: none"> Finalize UM-HIE Coalition Charter Review final project plan and timeline Identify state deliverables for next meeting
October	Interim Work	<ul style="list-style-type: none"> States identify mechanisms that will be used to gather stakeholder input on concerns/barriers and potential solutions to enable interstate HIE. States work with SME to identify relevant statutes and regulations pertaining to consent laws and authority/enforcement mechanisms and liability for bad actors. SME captures incorporates discussion from first meeting and produces the final project plan & timeline. SME synthesizes information from participating states and prepares overview for discussion at November meeting.
October	Bi-monthly Status Meeting with RTI Project Manager	
November	Second Meeting: Environmental Scan & Issue Identification (Webinar / Interactive Conference Call)	<ul style="list-style-type: none"> Overview of State Consent Laws Overview of State Authority/Enforcement Mechanisms and Liability for “Bad Actors” Overview of primary issues of concern identified by stakeholders in participating states Identify state deliverables for next meeting
December	Interim Work	<ul style="list-style-type: none"> States work with stakeholder groups to gather input on potential assurances that could be incorporated into agreements with other states to address concerns & prepares summary for third meeting. SME researches and prepares presentation on potential mechanisms for establishing agreements to the states for discussion at third meeting.
December	Bi-monthly Status Meeting with RTI Project Manager	
January	Third Meeting (Webinar / Interactive Conference Call)	<ul style="list-style-type: none"> Overview of potential solutions identified through discussions with state stakeholders. SME facilitated discussion to work toward consensus on solutions to identified concerns/barriers. SME presents overview of potential mechanisms for establishing agreements between states Identify state deliverables for next meeting.
February	Interim Work	<ul style="list-style-type: none"> SME provides report to states that includes proposed consensus solutions to identified concerns/barriers and potential mechanisms for establishing agreements between the states States gather stakeholder feedback on proposed consensus solutions & potential mechanisms for establishing agreements between states. States identify appropriate individuals to serve on drafting team to develop proposed language for state agreements
February	Bi-monthly Status Meeting with RTI Project Manager	

March	Fourth Meeting (In-person, facilitated by SME, includes representatives from states serving on drafting team)	<ul style="list-style-type: none"> ▪ Final discussion on proposed consensus solutions. Review and incorporate changes based on feedback from stakeholders. ▪ Overview of feedback on potential mechanisms for establishing agreements between states. ▪ SME facilitates discussion on mechanisms to establish agreements to begin working toward consensus on appropriate approach(es). ▪ Identify state deliverables for next meeting.
April	Interim Work	<ul style="list-style-type: none"> ▪ SME prepares initial draft language for agreements between states and works with the State drafting team to prepare proposed language for discussion at fifth meeting. ▪ SME prepares a report based on discussion of mechanisms to establish agreements between the states and drafts proposed recommendations for discussion at fifth meeting. ▪ States gather feedback from stakeholders on draft language for agreements between the states.
April	Bi-monthly Status Meeting with RTI Project Manager	
May	Fifth Meeting (Webinar / Interactive Conference Call)	<ul style="list-style-type: none"> ▪ Review and feedback on draft language for agreements between states. ▪ Review and discussion on recommendations for mechanisms to establish agreements between UM-HIE states. ▪ Identify state deliverables for next meeting.
June	Interim Work	<ul style="list-style-type: none"> ▪ SME incorporates final feedback on draft language for agreements between states for review and approval at sixth meeting. ▪ States provide input to communications SME to develop key messages and materials to promote the agreements in the states. ▪ States identify appropriate mechanisms in their states to distribute messages to stakeholders in their communities.
June	Bi-monthly Status Meeting with RTI Project Manager	
July	Sixth Meeting (Webinar / Interactive Conference Call)	<ul style="list-style-type: none"> ▪ Final review and approval of language for agreements between states. ▪ Final review and approval of recommendations on mechanisms to establish agreements between UM-HIE states. ▪ Review and provide feedback on draft communications materials to promote agreements. ▪ Discuss future plans for the UM-HIE Collaborative and next steps.
August	Follow-up Items to Complete Project	<ul style="list-style-type: none"> ▪ Communications SME incorporates feedback and works with states to finalize communications materials. ▪ SME works with states to finalize report that includes language for agreements and final recommendations on mechanisms to establish agreements from UM-HIE states. ▪ States incorporate use of communications materials into state HIE communications plans.
August	Bi-monthly Status Meeting with RTI Project Manager – Project Wrap-up	

E. Personnel

The following individuals from each of the UM-HIE states will be primarily responsible for the work in their designated state. Resumes and a brief overview of roles and relevant experience of key personnel are included in Appendix B.

Illinois	Mark Chudzinski	General Counsel Office of Health Information Technology
Iowa	Tracy Donner	Iowa e-Health Project Manager Iowa Department of Public Health
Minnesota	Donna Watz	Director of Privacy, Security and HIE Oversight Minnesota Department of Health, Office of Health IT
North Dakota	Michael J. Mullen	Assistant Attorney General North Dakota Attorney General's Office
South Dakota	Kevin DeWald	State HIT Coordinator South Dakota Department of Health
Wisconsin	Kathy Johnson	Privacy and Compliance Officer Wisconsin Department of Health Services

F. Roles and Responsibilities

Minnesota:

- Act as the lead state in submission of the UM-HIE Collaborative project proposal and in working with RTI on all necessary activities to coordinate implementation of the UM-HIE Collaborative project.

All UM-HIE States:

- Participating in UM-HIE meetings, providing on-going input, and presenting information relevant to their state as necessary to achieve project objectives.
- Assisting the SME(s) with identifying the appropriate sections of state law relevant to the project scope, and relevant state contacts that can provide further information and resources on subject matter.
- Reviewing analysis provided by SME(s) and providing regular input on the development of project deliverables.
- Identifying appropriate individuals to serve on the Upper Midwest HIE Collaborative Advisory Group.
- Working with stakeholders and policy makers in their state to identify key issues that must be addressed in an interstate agreement or other solution mechanism to enable HIE.
- Conducting an analysis of the state's legal framework to identify how existing laws and regulations speak to issues raised by UM-HIE states.
- Identifying gaps that may need to be addressed in order to facilitate the adoption of an interstate agreement or other solution mechanism.
- Participating in discussions with UM-HIE states and SME(s) to reach consensus on essential elements to include in the interstate agreement or other solution mechanism.
- Identifying appropriate legal and policy staff to serve on the Upper Midwest HIE Collaborative drafting team.
- Participating in the development of educational materials to be utilized by UM-HIE states in educating policy makers and other stakeholders about the interstate agreement or other solution mechanism.
- Pursuing appropriate authorizations to advance state legislation, if needed, to give effect to the interstate agreement or other solution mechanism approved by the Upper Midwest HIE Collaborative.

G. Specific Resources Requested

Support Service	Detail	Support Requested	Explanation
RTI Subject Matter Experts	AHIMA Foundation and/or Brown University	~240-300 Hours	Acting as primary facilitator over the course of the project, working with coalition states to keep the project on schedule and the development of consensus recommendations for pursuing interstate agreements to enable HIE.
RTI Subject Matter Experts	Walter R. McDonald & Associates and/or Baker, Donelson, Bearman, Caldwell & Berkowitz, PC	~120-160 Hours	Provide overview of possible legal mechanisms to establish agreements between states to enable HIE, including but not limited to interstate compacts. Assist with the drafting of language for agreements between states to enable HIE.
State Level Subject Matter Experts	TBD	~120 Hours	Assistance with analysis of state laws, mechanisms for state agreements and drafting agreement language.
Teleconferences	Approx. 10-15 Attendees per Tele-conference for regular meetings, likely fewer participants for calls between meetings.	Approx. 10-15 Hours	Teleconferences will be the primary vehicle for meetings between coalition members (Meetings 2,3,5, and 6 on project schedule). Teleconferences may also be held between meetings as necessary to clarify state responsibilities and/or prepare for presentations at scheduled meetings.
Web Conferences	Approx. 15 Attendees per Conference	Approx. 4-5 Hours	To provide a mechanism for information to be presented visually during meetings held via teleconference. (Meetings 2,3,5, and 6 on project schedule)
In Person (travel)	Approx. 10-12 attendees would participate in Meeting 1, including State Government HIT Coordinators & designated lead staff. Approx. 15-19 attendees would participate in Meeting 4, including State Government HIT Coordinators, designated lead staff, and designated staff on drafting team.	Travel will be provided for two in-person meetings over the course of the 12-month project.	Meeting 1: Initial meeting to provide an opportunity for coalition members to get to know one another and finalize the coalition charter, project schedule and table of milestones, and identify state deliverables for interim and goals for future meetings. Meeting 4: Mid-term meeting to allow face-to-face discussion on proposed consensus solutions, to receive education on potential mechanisms to establishing agreements between states, and work toward consensus on the best mechanisms to move forward.

State Government Health Information Exchange Steering Committee Proposed Scope and Membership

PROPOSED SCOPE

Provide **coordination of state government agencies** in using policy levers and government authority to promote health information exchange, including:

- Analysis of state purchasing power to facilitate health information exchange (a requirement of Minnesota's 3013 Cooperative Agreement)
- Coordination between Minnesota's Strategic Plan for Health Information Exchange and the State Medicaid HIT Plan (SMHP)

Provide **state government oversight of 3013 technical infrastructure** components of the Minnesota HIE Technical Infrastructure Project, including:

- Ongoing review and of the HIE Technical Infrastructure Project Plan (registered with the Minnesota Department of health and the Minnesota Office of Enterprise Technology) and status reports, including: assessment of project scope, project risks, and development of necessary plans to ensure successful completion of Minnesota's Health Information Exchange Technical Infrastructure Project
- Evaluation of deliverables and contract language for Minnesota's contract to provide technical infrastructure as part of Minnesota's Operational Plan for Health Information Exchange
- An approach for monitoring and plan for remediation of the actual performance of HIE throughout the state (a requirement of Minnesota's 3013 Cooperative Agreement)

PROPOSED MEMBERSHIP

Minnesota Department of Human Services

Brian Osberg, State Medicaid Director
Bob Paulsen, State Medicaid HIT Coordinator
Tom Baden, Enterprise Architecture Lead

Minnesota Department of Health

Jim Golden, State Government HIT Coordinator
Liz Cinqueonce, Deputy Director, Office of Health Information Technology
TBD, Office of Rural Health and Primary Care
TBD, Information Systems and Technology Management

Minnesota Management and Budget

Nathan Moracco, Employee Management Division Director

Minnesota Department of Corrections

TBD



Appendix J. OHIT's Public Health Collaboration Team 2010-2011 Charge

Purpose - Charge

- **To understand the public health aspects of State and Federal initiatives regarding the adoption and use of electronic health records including the electronic exchange of health information.** This includes but is not limited to State initiatives: (MN e-Health Initiative, MN-e-Health Advisory Committee) and Federal ARRA funded projects including: MN-e-Health Connect, REACH, SHARP, UP-HI, BEACON and other programs.
- **To identify actions that support effective coordination between MDH programs and MDH's Office of Health Information Technology (OHIT)** including but not limited to MN e-Health Connect, and MN e-Health Initiative programs. This includes assuring information is available from OHIT that is needed for MDH program applications for funding.
- **To provide comments and feedback to the OHIT on the public health implications of national proposals,** including but not limited to those involving Meaningful Use incentives, HIT workforce development initiatives, and health informatics applied research.

Background

The MDH Office of Health Information Technology (OHIT)

On September 21, 2009, the Commissioner of Health announced the establishment of the Minnesota Office of Health Information Technology (OHIT) to coordinate and facilitate an integrated statewide approach to health information technology and health information exchange.

The American Recovery and Reinvestment Act (ARRA) included significant federal funding to advance the health care delivery system's use of electronic health records and facilitate health information exchange statewide. Electronic health records and other health information technologies are powerful tools that can be used to improve health care quality, increase patient safety, reduce health care costs and improve public health.

The OHIT is intended to ensure that the various programs created by the Recovery Act are coordinated and non-duplicative to maximize the benefit of these dollars in achieving a transformed health care system in Minnesota.

The OHIT's responsibilities are to:

- Collaborate with health care providers and other stakeholders to ensure Minnesota's health care community can take full advantage of Federal funding and Meaningful Use incentive programs;
- Convene stakeholders to create a comprehensive and unified vision for the use of electronic health records and health information exchange in Minnesota;
- Advocate for the needs of Minnesota's health care community with Federal policy makers (e.g., The Office of the National Coordinator for HIT and the Centers for Medicare and Medicaid Services);
- Develop and implement Minnesota's strategic and operational plan for health information exchange to expand the secure, electronic movement and use of health information among health care organizations according to nationally recognized standards;
- Collaborate with other Federally-funded programs designed to promote the adoption and use of electronic health records (e.g., Regional Extension Centers and Medicare and Medicaid Incentive programs);
- Coordinate across state government to maximize federal and state investments in health information technology and infrastructure development. Carrying out the e-health responsibilities assign to the Department of Health under M.S. § 62J.495 - .497.

Team Tasks and Deliverables through June 2011

- May 2010: Establish an internal gov-delivery e-mail list for public health persons interested in OHIT related activities including public health informatics and e-health.
- September 2010: Advise on the development and update of the OHIT resource information and materials useful for public health including tools, tips, templates and other information resources.
- Ongoing: Schedule regular monthly updates and discuss OHIT programs and initiatives
- Ongoing: Identify and discuss opportunities for coordination within MDH and outside of MDH including coordination with Minnesota Medicaid, Key Health Alliance, and health information organizations (HIOs) in Minnesota.

Participant Expectations

- Participate in a meeting approximately monthly and join additional conference calls if needed.
- Bring the perspective of the MDH program you represent to all discussions and decisions.
- Keep the statewide interests of the e-Health Initiative foremost in your decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.

Value in Participating

- Stay abreast of projects underway in the Office of Health Information Technology and proactively shape future policy directions that can have a major impact on your program.
- Enable your program to be more prepared to respond to the requirements of state and federal implementation plans as they are established.
- Help improve coordination and reduce duplication of effort related to state public health programs.

Leadership

Co-Leads:

- Marty LaVenture, Director, Office of Health Information technology
– MDH 651 201-5950 martin.laventure@state.mn.us
- Priya Rajamani, Senior Health Informatician - Office of Health Information Technology
MDH 651-201-4119 priya.rajamani@state.mn.us

Participants:

We hope to meet with a group of approximately 10-15 participants from MDH that meet regularly. We hope to have a primary and designated backup person identified for each division. Meetings are open to any MDH staff who is interested in attending.

Lynn Belgea, Legal Unit
Chris Brueske, Public Health Laboratory
Richard Danila, Infectious Disease Epidemiology,
Prevention & Control
Maggie Diebel, Community & Family Health
Mark Doerr, Office of Emergency Preparedness
Arden Fritz, Legal Unit
Kari Guida, Community & Family Health
Leyla Kokmen, Communications
Pati Maier, Health Promotion & Chronic Disease
Jim Mack, Legal Unit

Judy Marchetti, Office of Emergency Preparedness
Emily Peterson, Infectious Disease Epidemiology, Prevention
& Control
Susan Ross, Health Promotion & Chronic Disease
Asa Schmit, Infectious Disease Epidemiology, Prevention &
Control
Al Tsai, Health Promotion & Chronic Disease
Julia Wooldridge, Environmental Health
Matthew Zerby, Public Health Laboratory

Appendix K
Minnesota 3013
Budget Justification and Narrative

Object Class Category	FTE	Year 1 - Jan 1, 2010 -Dec 31, 2010			Year 2 - Jan. 1, 2011 - Dec. 31, 2011			Year 3 - Jan. 1, 2012 -Dec. 31, 2012			Year 4 - Jan. 1, 2013 -Dec. 31, 2013			Combined Totals Years 1-4		
		Federal Funds	Non-Federal Cash	Non-Federal In Kind	Federal Funds	Non-Federal Cash	Non-Federal In Kind Match 1/10	Federal Funds	Non-Federal Cash	Non-Federal In-Kind Match 1/7	Federal Funds	Non-Federal Cash	Non-Federal In-Kind Match 1/3	TOTAL FEDERAL	Total Non-Federal Cash	Total Non-Federal In Kind
1. Personnel		332,324		151,778	343,955		157,090	355,994		162,589	368,453		168,279	1,400,726		639,737
State HIT Coordinator, James Golden	0.5	49,296			51,021			52,807			54,655			207,780		0
Director, Office of HIT, Martin LaVenture	0.5			53,987			55,876			57,832			59,856			227,550
Deputy Director, Office of HIT, Elizabeth Cinqueonce	0.8			58,928			60,991			63,125			65,335			248,379
Privacy & Security Coordinator, Mick Hawton	1.0	53,221			55,084			57,012			59,007			224,323		0
Senior Informatics Specialist, Priya Rajamani	1.0	47,597		20,399	49,262		21,112	50,987		21,851	52,771		22,616	200,617		85,979
Evaluation & Coordination Project Lead, Jennifer Ellsworth	1.0	65,686			67,985			70,364			72,827			276,863		0
Management Analyst III, TBD	0.2	9,956			10,304			10,665			11,038			41,962		0
Education and Outreach Coord, TBD	1.0	52,550			54,389			56,293			58,263			221,495		0
HIT Planning Specialist, TBD	1.0	43,085		18,465	44,593		19,111	46,154		19,780	47,769		20,472	181,601		77,829
Admin. Support, Mayumi Reuvers	0.3	10,934			11,316			11,713			12,122			46,085		0
2. Fringe Benefits @ 30.6% of Salary		101,691		46,444	105,250		48,070	108,934		49,752	112,747		51,493	428,622		195,759
3. Equipment		0			0			0			0			0		0
4. Supplies		10,960			5,840			3,819			3,688			24,306		0
5. Travel		13,500			11,500			11,500			11,500			48,000		0
In-state travel		4,000			4,000			4,000			4,000			16,000		0
Out-of-state travel		9,500			7,500			7,500			7,500			32,000		0
6. Contractual		2,820,000		0	2,810,000		250,000	810,000		100,000	790,000		265,000	7,230,000	0	615,000
Grant to MN HIE		2,500,000		0	2,500,000		250,000	810,000		100,000	790,000		265,000	6,600,000		365,000
Contract for outreach/enrollment (TBD)		320,000			310,000			0			0			630,000		0
7. Other		0		0	0		0	0		0	0		0	0		0
Total Direct Costs		3,278,475		198,222	3,276,546		455,160	1,290,246		312,341	1,286,388		484,773	9,131,655		1,450,496
Indirect Costs @ 23.9%		121,525			123,454			120,754			124,612			795,244		0
TOTAL COSTS		3,400,000		198,222	3,400,000		455,160	1,411,000		312,341	1,411,000		484,773	9,622,000		1,450,496

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

Category	Justification	Federal Funds	Non-Federal Cash	Non-Federal In-Kind
Personnel	State Designated HIT Coordinator. Assumes salary of 0.5 FTE full time position (Dr. James Golden) for the 48 month grant period. Salary is based on current salary range for this classification. Responsible for overall all direction and coordination of state government participation in HIE. This position will provide leadership and oversight of the cooperative agreement and liaison with key stakeholders, other agencies and the Minnesota legislature. Dr. Golden is responsible for direction of the MDH Division of Health Policy, the division responsible for leading the implementation of the Minnesota health care reform efforts. Serving in these dual roles will enable Dr. Golden to ensure consistency between the cooperative agreement program and the overall goals of the state for health care reform.	2010: \$49,296 2011: \$51,021 2012: \$52,807 2013: \$54,655		
	Director, Office of Health Information Technology. Assumes in kind services of the Director of Health Information Technology, Dr. Martin LaVenture, at 0.5 FTE throughout the course of the cooperative agreement. The in-kind estimate is based on current salary. As director of the OHIT, Dr. LaVenture provides leadership for the Minnesota e-Health Initiative, the public-private collaborative that will serve as the forum for the development of consensus among Minnesota stakeholders. Dr. LaVenture provides expertise in health informatics and standards for health information exchange that are critical for the success of the cooperative agreement.			State: 2010: \$53,987 2011: \$55,876 2012: \$57,832 2013: \$59,856
	Deputy Director, Minnesota Office of Health Information Technology. Assumes in kind services of the deputy director of the Office of Health Information Technology, Elizabeth Cinqueonce, at 0.8 FTE throughout the course of the cooperative agreement. The in-kind estimate is based on current salary. The deputy director will oversee operations related to the cooperative agreement and ensure compliance with reporting requirements. Additionally, the deputy director will play a leadership role in policy development and the promotion of consensus among stakeholders. She will provide support to the State Designated HIT Coordinator to ensure synchronization of state government HIT initiatives and efforts to advance legislation necessary to enable statewide HIE. The deputy director will be a liaison to the Office of the National Coordinator in managing the cooperative agreement, and will play a lead role in contract development for sub-recipients.			State: 2010: \$58,928 2011: \$60,991 2012: \$63,125 2013: \$65,335

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

	<p>Privacy and Security Coordinator. Assumes the salary of 1.0 FTE (Michael Hawton) for the 48 month period of the cooperative agreement. The salary is estimated based on the mid-range of the project consultant classification. Salary is typical for this level of qualifications and responsibility in the proposed service area. This position is primarily responsible for the coordination of privacy and security policy development, as well as education and coordination across stakeholders, and will play a key role in working with border states to address privacy and security issues necessary to enable interstate HIE.</p>	<p>2010: \$53,221 2011: \$55,084 2012: \$57,012 2013: \$59,007</p>		
	<p>Senior Informatics Specialist for Standards and Interoperability. Assumes 1.0 FTE (Dr. Priya Rajamani), funded 70% by the cooperative agreement and 30% by state funds offered in-kind. The salary is based on the mid-high range for a research scientist III, and assumes a PhD in health informatics and a masters in public health. Dr. Rajamani will provide direction and oversight of the informatics activities relating to standards and interoperability specifications.</p> <p>Responsibilities include the identification, assessment and coordination of standards related activity including leadership for the Minnesota e-Health Initiative Standards Workgroup. has been actively involved in various informatics projects such as creation of informatics profile for the agency, design of public health informatics profile tool-kit, business process methodologies by Common Ground grant of RWJF and mentoring of informatics projects by graduate students from UMN.</p>	<p>2010: \$47,597 2011: \$49,262 2012: \$50,987 2013: \$52,771</p>		<p>State: 2010: \$20,399 2011: \$21,112 2012: \$21,851 2013: \$22,616</p>
	<p>Evaluation and Coordination Project Lead. Assumes 1.0 FTE (Jennifer Ellsworth) for the 48 month cooperative agreement period. The salary is based on the mid-high range of the research scientist III class, and assumes a masters degree in public health or a related field.</p> <p>This position is intended to provide project management for the cooperative agreement, and will play a critical role in developing and implementing mechanisms to gather assessment data and evaluate progress toward program goals. Essential functions will include the preparation and review of reports and papers that demonstrate progress toward project goals, and identify areas of concern that may need to be addressed through further planning. This position will also be responsible for maintaining compliance with federal and state reporting requirements and working with contracted entities to ensure timely submission of all required information for reporting purposes.</p>	<p>2010: \$65,686 2011: \$67,985 2012: \$70,364 2013: \$72,827</p>		

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

	<p>Management Analyst III. Assumes 0.2 FTE (Vacant). The salary assumes mid-range for a management analyst III, to provide administrative and fiscal support for the accounting and management of the cooperative agreement including funds distributed to sub-recipients. This position will assist with the development of reports to meet the needs of MDH financial management for agency and Recovery Act reporting requirements.</p>	<p>2010: \$9,956 2011: \$10,304 2012: \$10,665 2013: \$11,038</p>		
	<p>Education and Outreach Coordinator. Assumes 1.0 FTE (TBD) for the 48 month cooperative agreement period, at the mid-range of the health educator III classification. Job requirements include: knowledge of principles of public health, health education, health promotion, and risk reduction, as well as health education theory and practice. The individual holding this position will play a key role in developing a strategy for planning, developing and implementing a coordinated education effort to providers and hospitals to promote connection to HIE. The person who holds this position will be responsible for designing and evaluating educational materials for hospital and clinic administrators, providers, and consumers regarding HIE and the privacy and security mechanisms that are in place to safeguard patient information. The education and outreach coordinator will play work to develop and maintain working relationships with a variety of organizations in the Minnesota health care community, and to assist them in connecting their members with Regional Extension Centers and the state designated HIO. This position will play a critical role in helping providers recognize the value of HIE and the role it can play in improving patient care.</p>	<p>2010: \$52,550 2011: \$54,389 2012: \$56,293 2013: \$58,263</p>		
	<p>HIT Planning Specialist. Assumes 1.0 FTE (TBD) for the 48 month cooperative agreement period. The salary is based on the mid-range for a planner principle state classification, and assumes a masters degree.</p> <p>Job requirements include: Strong knowledge of State and federal HIT/EHR program policies and related regulations and HIT/EHR activities conducted by other agencies sufficient to evaluate and interpret impact. The individual hired for this position must have the ability to: review and evaluate complex technical reports and technology documents, identify and evaluate and summarize information/data, develop policy and program management recommendations and to conceptualize alternative solutions to complex issues and convey them to diverse audiences. Further, they will play a key role in writing, editing, and organizing technical, policy and other EHT/HIT related material from diverse sources to prepare comprehensive reports and plans, and will be</p>	<p>2010: \$43,085 2011: \$44,593 2012: \$46,154 2013: \$47,769</p>		<p>State: 2010: \$18,465 2011: \$19,111 2012: \$19,780 2013: \$20,472</p>

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

	<p>prepared to make effective oral and written presentations to advance HIE in Minnesota.</p> <p>This position is responsible for obtaining and analyzing assessment and evaluation data, to inform on-going HIT/EHR plans by OHIT in consultation OHIT staff, the advisory committee, stakeholders, and others to achieve program goals. Further, they are charged with engaging key MDH staff, the state government agencies, and the regional extension centers in planning and implementing a coordinated approach to assist providers and hospitals in connecting to exchange organizations and integrating health information exchange into their workflow processes.</p> <p>The individual responsible for this coordination will have a thorough understanding of national health data standards required to achieve technical, semantic and process interoperability and will provide leadership in the development of a framework for assessment in Minnesota to measure HIE among the stakeholders necessary to facilitate meaningful use.</p>													
	<p>Administrative Support Staff. Assumes 0.3 FTE (Mayumi Reuvers) for the 48 month cooperative agreement period. The salary is based on the mid-range for an office administrative specialist senior. This position will provide administrative support to program staff for the project related activities including scheduling, maintaining program files, and other administrative tasks as assigned.</p>	<p>2010: \$10,934 2011: \$11,316 2012: \$11,713 2013: \$12,122</p>												
<p>Fringe</p>	<p>Calculated at 30.6 percent of all salaries and includes health insurance, life insurance, retirement, FICA, SUTA.</p> <table border="1" data-bbox="373 1146 1444 1325"> <tr> <td>FICA</td> <td>6.2%</td> </tr> <tr> <td>Medicare</td> <td>1.45%</td> </tr> <tr> <td>Retirement</td> <td>4.5%</td> </tr> <tr> <td>Insurance</td> <td>18.45%</td> </tr> <tr> <td>AVERAGE</td> <td>30.6%</td> </tr> </table>	FICA	6.2%	Medicare	1.45%	Retirement	4.5%	Insurance	18.45%	AVERAGE	30.6%	<p>2010: \$101,691 2011: \$105,250 2012: \$108,934 2013: \$112,747</p>		<p>State: 2010: \$46,444 2011: \$48,070 2012: \$49,752 2013: \$51,493</p>
FICA	6.2%													
Medicare	1.45%													
Retirement	4.5%													
Insurance	18.45%													
AVERAGE	30.6%													

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

Travel	Out of State Travel. Includes the two required trips to Washington DC and two required trips to Chicago for the State Government HIT Coordinator and one additional staff member as required by the cooperative agreement. Additional funding is included in the for travel to border states to engage in discussions necessary to overcome barriers to interstate HIE. Amount includes air fare and ground transportation, food and lodging and registration fees.					2010: \$9,500 2011: \$7,500 2012: \$7,500 2013: \$7,500			
	Location		Multipliers	Price	Total	Years			
Washington DC	Airfare	2 Attendees	\$450/ea.	\$900	2010 2011 2012 2013				
	Hotel	2 Attendees x 2 Night Stay	\$290/night	\$1,160	2010 2011 2012 2013				
	Ground Transport	2 Attendees	\$150/ea.	\$300	2010 2011 2012 2013				
	Per Diem	2 Days/2 Attendees	\$35/ea.	\$140	2010 2011 2012 2013				
Chicago	Airfare	2 Attendees	\$450/ea.	\$900	2010 2011 2012 2013				
	Hotel	2 Attendees x 2 Night Stay	\$275/night	\$1,100	2010 2011 2012 2013				
	Ground Transport	2 Attendees	\$150/ea.	\$300	2010 2011 2012 2013				
	Per Diem	2 Days/2 Attendees	\$35/ea.	\$140	2010 2011 2012 2013				
Wisconsin	Mileage	2 Trips @ 698.18 miles RT + travel	\$.55	\$768	2010				

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

		while in WI																																													
	Hotel	3 Attendees x 2 Night Stay x 2 trips	\$280/night	\$3360	2010																																										
	Per Diem	3 Attendees x 2 days x 2 trips	\$31/ea.	\$372	2010																																										
Iowa	Mileage	1098 Miles	\$.55	\$604	2011																																										
	Hotel	3 Attendees x 2 Nights	\$280/night	\$1680	2011																																										
	Per Diem	3 Attendees x 2 days	\$31/ea.	\$186	2011																																										
North Dakota	Airfare	2 Attendees	\$675	\$1350	2012																																										
	Hotel	2 Attendees x 2 Nights	\$256.50/night	\$1026	2012																																										
	Per Diem	2 Attendees x 2 days	\$31/ea.	\$124	2012																																										
South Dakota	Airfare	2 Attendees	\$675	\$1350	2013																																										
	Hotel	2 Attendees x 2 Nights	\$256.50/night	\$1026	2013																																										
	Per Diem	2 Attendees x 2 days	\$31/ea.	\$124	2013																																										
<p>In-State Travel . Mileage is calculated at \$.55 per mile which is the current state reimbursement rate. In-state travel includes travel for project staff to attend meetings and for other work related to grant activities (approximately 4575 miles for Greater Minnesota and 316 miles for Twin Cities metro area). Includes 5 overnight stays, two days each, at \$131 per diem for lodging and food.</p> <table border="1"> <thead> <tr> <th>Location</th> <th>Expense</th> <th>Quantity</th> <th>Rate</th> <th>Total</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td rowspan="4">Greater MN</td> <td rowspan="4">Mileage</td> <td rowspan="4">4575</td> <td rowspan="4">\$.55</td> <td rowspan="4">\$2,516.00</td> <td>2010</td> </tr> <tr> <td>2011</td> </tr> <tr> <td>2012</td> </tr> <tr> <td>2013</td> </tr> <tr> <td rowspan="4"></td> <td rowspan="4">Per Diem</td> <td rowspan="4">10</td> <td rowspan="4">\$131</td> <td rowspan="4">\$1,310.00</td> <td>2010</td> </tr> <tr> <td>2011</td> </tr> <tr> <td>2012</td> </tr> <tr> <td>2013</td> </tr> <tr> <td rowspan="4">Twin Cities Metro</td> <td rowspan="4">Mileage</td> <td rowspan="4">316</td> <td rowspan="4">\$.55</td> <td rowspan="4">\$174.00</td> <td>2010</td> </tr> <tr> <td>2011</td> </tr> <tr> <td>2012</td> </tr> <tr> <td>2013</td> </tr> <tr> <td>Total</td> <td></td> <td></td> <td></td> <td>\$4000</td> <td></td> </tr> </tbody> </table>						Location	Expense	Quantity	Rate	Total	Year	Greater MN	Mileage	4575	\$.55	\$2,516.00	2010	2011	2012	2013		Per Diem	10	\$131	\$1,310.00	2010	2011	2012	2013	Twin Cities Metro	Mileage	316	\$.55	\$174.00	2010	2011	2012	2013	Total				\$4000		<p>2010: \$4,000 2011: \$4,000 2012: \$4,000 2013: \$4,000</p>		
Location	Expense	Quantity	Rate	Total	Year																																										
Greater MN	Mileage	4575	\$.55	\$2,516.00	2010																																										
					2011																																										
					2012																																										
					2013																																										
	Per Diem	10	\$131	\$1,310.00	2010																																										
					2011																																										
					2012																																										
					2013																																										
Twin Cities Metro	Mileage	316	\$.55	\$174.00	2010																																										
					2011																																										
					2012																																										
					2013																																										
Total				\$4000																																											

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

Equipment	None																																	
Supplies	<p>This includes new computer workstations (in 2010) 3 FTE's. Also includes funds for the printing/publication of promotional and educational materials for providers and consumers regarding health information exchange, privacy and security issues, etc. and general office supplies.</p> <table border="1" data-bbox="373 399 1360 1032"> <tr> <td align="center" colspan="2">2010</td> </tr> <tr> <td>New Work Stations, Computers, Installation Costs, 3 @\$1,200</td> <td align="right">\$3,600</td> </tr> <tr> <td>General office supplies</td> <td align="right">\$3,610</td> </tr> <tr> <td>Printing. Consumer and hospital/provider brochures, 5,000 @ \$.75</td> <td align="right">\$3,750</td> </tr> <tr> <td>Total</td> <td align="right">\$10,960</td> </tr> <tr> <td align="center" colspan="2">2011</td> </tr> <tr> <td>General Office</td> <td align="right">\$3,590</td> </tr> <tr> <td>Printing. Consumer and hospital/provider brochures, 3,000 @ \$.75</td> <td align="right">\$2,250</td> </tr> <tr> <td>Total</td> <td align="right">\$5,840</td> </tr> <tr> <td align="center" colspan="2">2012</td> </tr> <tr> <td>General office supplies</td> <td align="right">\$3,819</td> </tr> <tr> <td>Total</td> <td align="right">\$3,819</td> </tr> <tr> <td align="center" colspan="2">2013</td> </tr> <tr> <td>General office supplies</td> <td align="right">\$3,688</td> </tr> <tr> <td>Total</td> <td align="right">\$3,688</td> </tr> </table>	2010		New Work Stations, Computers, Installation Costs, 3 @\$1,200	\$3,600	General office supplies	\$3,610	Printing. Consumer and hospital/provider brochures, 5,000 @ \$.75	\$3,750	Total	\$10,960	2011		General Office	\$3,590	Printing. Consumer and hospital/provider brochures, 3,000 @ \$.75	\$2,250	Total	\$5,840	2012		General office supplies	\$3,819	Total	\$3,819	2013		General office supplies	\$3,688	Total	\$3,688	<p>2010: \$10,960 2011: \$5,840 2012: \$3,819 2013: \$3,688</p>		
2010																																		
New Work Stations, Computers, Installation Costs, 3 @\$1,200	\$3,600																																	
General office supplies	\$3,610																																	
Printing. Consumer and hospital/provider brochures, 5,000 @ \$.75	\$3,750																																	
Total	\$10,960																																	
2011																																		
General Office	\$3,590																																	
Printing. Consumer and hospital/provider brochures, 3,000 @ \$.75	\$2,250																																	
Total	\$5,840																																	
2012																																		
General office supplies	\$3,819																																	
Total	\$3,819																																	
2013																																		
General office supplies	\$3,688																																	
Total	\$3,688																																	

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

Contracts	<p>Grant to MN HIE. Represents a contract to be developed with the Minnesota Health Information Exchange (MN HIE) for the development of the infrastructure necessary to support statewide HIE necessary to enable meaningful use. This includes development required across the five domains outlined in the funding opportunity announcement. The funding provided through the grant will support technical infrastructure development, business and technical operations, legal costs, and funding to off-set initial costs of connection for Minnesota health care providers during 2010 and 2011. \$50,000 will be built into the contract each year for the purpose of evaluation. The majority of the funding will be provided during the first two years of the project during which time, MN HIE will be expected to connect a critical mass of providers and the subscription agreements necessary to sustain the on-going operations and future development of HIE services necessary to support meaningful use requirements. MN HIE will be required to provide matching funds necessary to access funding available through the cooperative agreement program.</p>	<p>2010: \$2,500,000 2011: \$2,500,000 2012: \$810,000 2013: \$790,000</p>		<p>Private: 2010: \$0 2011: \$250,000 2012: \$100,000 2013: \$265,000</p>																				
	<p>Grant/Contract for Outreach/Enrollment (TBD). Priority will be given to assist the most providers as possible to obtain funds for meaningful use. Also providers in areas serving the underserved will be considered a priority. Coordination with the regional extension center will be used to serve areas.</p> <table border="1" data-bbox="373 824 1444 1153"> <thead> <tr> <th>Category</th> <th>Description</th> <th>2010</th> <th>2011</th> </tr> </thead> <tbody> <tr> <td>Personnel</td> <td>Outreach and enrollment coordinators (5) @ \$46,000)</td> <td>\$230,000</td> <td>\$230,000</td> </tr> <tr> <td>Fringe</td> <td>Calculated at 30.6 percent of salaries and includes health insurance, life insurance, retirement, FICA, SUTA.</td> <td>\$70,380</td> <td>\$70,380</td> </tr> <tr> <td>In-state travel</td> <td>Mileage, 4,000 miles @ \$.55 + 20 nights lodging/food at \$131 per diem</td> <td>\$3,222</td> <td>\$3,222</td> </tr> <tr> <td>Supplies</td> <td>Communications, Web, printing, postage</td> <td>\$9,868</td> <td>\$6,398</td> </tr> </tbody> </table>	Category	Description	2010	2011	Personnel	Outreach and enrollment coordinators (5) @ \$46,000)	\$230,000	\$230,000	Fringe	Calculated at 30.6 percent of salaries and includes health insurance, life insurance, retirement, FICA, SUTA.	\$70,380	\$70,380	In-state travel	Mileage, 4,000 miles @ \$.55 + 20 nights lodging/food at \$131 per diem	\$3,222	\$3,222	Supplies	Communications, Web, printing, postage	\$9,868	\$6,398	<p>2010: \$320,000 2011: \$310,000</p>		
Category	Description	2010	2011																					
Personnel	Outreach and enrollment coordinators (5) @ \$46,000)	\$230,000	\$230,000																					
Fringe	Calculated at 30.6 percent of salaries and includes health insurance, life insurance, retirement, FICA, SUTA.	\$70,380	\$70,380																					
In-state travel	Mileage, 4,000 miles @ \$.55 + 20 nights lodging/food at \$131 per diem	\$3,222	\$3,222																					
Supplies	Communications, Web, printing, postage	\$9,868	\$6,398																					
Other	None																							

**Budget Justification Narrative
Minnesota 3013 Cooperative Agreement**

Indirect Costs	Calculated at approved rate at 23.9 percent (for contracts above \$25,000, in-direct has been charged for only the first \$25,000).	2010: \$121,525 2011: \$123,454 2012: \$120,754 2013: \$124,612		
Total Grant Budget		2010: \$3,400,000 2011: \$3,400,000 2012: \$1,411,000 2013: \$1,411,000		State & Private Match: 2011: \$198,222 2011: \$455,160 2012: \$312,341 2013: \$484,773

Appendix K

2010					
Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In Kind	Total	Justification
Personnel	\$252,750		\$252,750	\$505,500	Project Manager 2.25 FTEs @ \$156,000 (50% Federal; 50% Non-Federal In Kind) Operations Director 1FTEs @ \$156,000 (50% Federal; 50% Non-Federal Cash)
Fringe Benefits	\$84,250		\$84,250	\$168,500	Benefits @ 34% of salaries (50% Federal; 50% Non-Federal In Kind): Federal taxes 30%, MN taxes 25%, FICA 10%, Medicare 2%, WC and Unemployment 6%, Medical Ins 20%, Dental Ins 5%, Life Ins 2%
Travel			\$9,350		In-state travel for marketing and implementation activities. Estimate 17,000 miles @ \$0.55 per mile (Non-Federal In Kind)
Equipment	\$180,000			\$180,000	Hardware and software. Four Federated Identity Management Servers and Software for 4 collaborating groups of clinics (Federal)
Supplies			\$37,000	\$37,000	Supplies , \$1,800 (\$150/month) Printing , \$24,000 (\$2,000/month) Postage , \$11,200 (\$933/month)
Contractual	\$1,983,000		\$1,262,200	\$3,245,200	New Development \$893,000 (Federal: \$593,000 Non-Federal In Kind \$300,000) Maintenance on New Development \$178,600 (Non-Federal In Kind) On Boarding of Providers and Small Health Plans \$1,785,600 (Federal: \$1,360,000 Non-Federal In Kind \$425,600) Maintenance On Boarding \$313,000 (Non-Federal In Kind) Legal Work on New Development , \$75,000 (Federal \$30,000 Non-Federal In Kind \$45,000)
Other		\$3,660,000		\$3,660,000	Capitol Investment by 6 Founding Members (\$500,000 per organization) Subscription Fees Estimated Subscription Fees from providers (1000 @ \$55/month) = \$660,000
Totals	\$2,500,000	\$3,660,000	\$1,645,550	\$7,796,200	

Appendix K

2011					
Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In Kind	Total	Justification
Personnel	\$234,000		\$234,000	\$468,000	Project Manager 2 FTEs @ \$156,000 (50 % Federal; 50% Non-Federal In Kind) Operations Director 1 FTE @ \$156,000 50 % Federal; 50% Non-Federal In Kind)
Fringe Benefits	\$78,000		\$78,000	\$156,000	Benefits @ 34% of salaries (50 % Federal; 50% Non-Federal In Kind) Federal taxes 30%, MN taxes 25%, FICA 10%, Medicare 2%, WC and Unemployment 6%, Medical Ins 20%, Life Ins 2%
Travel			\$11,000	\$11,000	In-state Travel for marketing and implementation activities. Estimate 20,000 miles @\$0.55 per mile (Non-Federal In Kind)
Equipment	\$180,000			\$180,000	Hardware and Software Four Federated Identity Management Servers and Software for 4 collaborating groups of clinics (Federal)
Supplies			\$40,000	\$40,000	Supplies , \$2,400 (\$200/month) Printing , \$26,000 (\$2,167/month) Postage , \$11,620 (\$967/month) (Non Federal In Kind)
Contractual	\$2,008,000		\$615,600	\$2,623,600	New Development \$525,000 (Federal) Maintenance on New Development \$283,600 (Non-Federal In Kind) On Boarding of Providers and Data Sources \$1,425,000 (Federal: \$1,423,000; Non-Federal In Kind \$2,000) Maintenance On Boarding \$330,000 (Non-Federal In Kind) Legal Work on New Development \$60,000 (Federal)
Other		\$4,320,000		\$4,320,000	Capitol Investment by 6 Founding Members (\$500,000 per organization = \$3,000,000) Subscription Fees Estimated Subscription Fees from providers (2000 @\$55/month) = \$1,320,000
Total	\$2,500,000	\$4,320,000	\$978,600	\$7,798,600	

Appendix K

2012					
Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In Kind	Total	Justification
Personnel	\$234,000		\$234,000	\$468,000	Project Manager 2 FTE @ \$156,000 (50 % Federal; 50% Non-Federal In Kind) Operations Director 1 FTE @ \$156,000 (50 % Federal; 50% Non-Federal In Kind)
Fringe Benefits	\$78,000		\$78,000	\$156,000	Benefits @ 34% of salaries (50 % Federal; 50% Non-Federal In Kind) Federal taxes 30%, MN taxes 25%, FICA 10%, Medicare 2%, WC and Unemployment 6%, Medical Ins 20%, Dental Ins 5%, Life Ins 2%
Travel			\$13,200	\$13,200	In-state travel for marketing and implementation activities. Estimate 24,000 miles @\$0.55 per mile (Non-Federal In Kind)
Equipment	\$90,000			\$90,000	Hardware and Software Two Federated Identity Management Servers and Software for 2 collaborating groups of clinics (Federal)
Supplies			\$42,000	\$42,000	Supplies \$2,400 (\$200/month) Printing, \$26,000 (\$2,167/month) Postage \$13,620 (\$1135/month) (Non Federal In Kind)
Contractual	\$408,000		\$1,680,000	\$2,088,000	New Development \$275,000 (Federal: \$125,500; Non-federal in Kind \$125,500) Maintenance on New Development \$338,600 (Non-Federal In Kind) On Boarding of Providers and Data Sources \$772,000 (Federal: \$252,500; Non-Federal In Kind \$519,500) Maintenance On Boarding \$666,400 (Non-Federal In Kind) Legal Work on New Development \$60,000 (Federal \$30,000; Non-Federal In Kind \$30,000)
Other		\$5,406,000		\$5,406,000	Estimated Subscriber Fees from Health Plan Founding Members with Additional Health Plan subscriber \$3,426,000 Providers: Estimated Subscription Fees from Providers (3000 @55/mo) \$1,980,000
Total	\$810,000	\$5,406,000	\$2,047,200	\$8,263,200	

Appendix K

2013					
Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In Kind	Total	Justification
Personnel	\$145,125		\$145,125	\$290,250	Project Manager .85 FTE @ \$132,600 (50% Federal; 50% Non-Federal In Kind) Operations Director 1FTE @ \$156,000 (50 % Federal; 50% Non-Federal In Kind)
Fringe Benefits	\$48,375		\$48,375	\$96,750	Benefits @ 34% of salary (50 % Federal; 50% Non-Federal In Kind) Federal taxes 30%, MN taxes 25%, FICA 10%, Medicare 2%, WC and Unemployment 6%, Medical Ins 20%, Dental Ins 5%, Life Ins 2%
Travel			\$15,400	\$15,400	Travel In-state travel for marketing and implementation activities. Estimate 28,000 miles @\$0.55 per mile (Non-Federal In Kind)
Equipment	\$0			\$0	
Supplies			\$45,000	\$45,000	Supplies , \$3,000 (\$20/month) Printing , \$27,500(\$2,292/month) Postage, \$14,500 (\$\$1,208/month) (Non Federal In Kind)
Contractual	\$596,500		\$1,116,300	\$1,712,800	New Development \$175,000 (Federal) Maintenance on New Development \$373,600 (Non-Federal In Kind) On Boarding of Providers and Data Sources \$382,000 (Federal) Maintenance On Boarding \$743,300 (Non-Federal In Kind) Legal Work on New Development \$40,000 (Federal)
Other		\$5,782,000		\$5,782,000	Estimated Subscriber Fees from Health Plan Founding Members with Additional Health Plan subscriber \$3,426,000 Estimated Subscription Fees from Providers (4500) \$2,970,000
Total	\$790,000	\$5,782,000	\$1,370,200	\$7,942,200	

Appendix K
MN HIE Four Year Plan 2010 - 2013

MN HIE Release	Target Delivery Date	Initiative	Description	Meaningful Use Requirement (Y/N)	Year Required for Meaningful Use	Meaningful Use Cross-Reference Descriptor	MN Related Requirements	Covisint Infrastructure Costs	Comments	Covisint Infrastructure Totals	Annual Maintenance	Maintenance Totals				Legal Costs	MN HIE staff costs
												2010	2011	2012	2013		
2.5	Jan-10	ONC-MU	Patient access to PHRs	Y	2013	Populate PHRs		\$50K		\$50,000	\$10,000					\$15,000	\$50,000
3	Apr-10	e-Rx	e-Prescribing services to support eligibility, formulary, med. History and scripts	Y	2011	Prescribing	January 1, 2011 mandate	\$50K/ SSO w/Context New	Assumes 3 vendors	\$150,000	\$30,000						
3	Apr-10	e-Rx	Patient synchronization connectivity to the e-prescription software, uses industry standard HL7 transactions from the Provider's EMR or PMS	Y	2011	Prescribing		\$5K/Practice	Covered in On-Boarding Assumes 200 new connections								
3	Apr-10	JCAHO	Medication Reconciliation using medication history available from SureScripts	Y	2011	Prescribing		\$44K/Source	Assumes one Data Source (SureScripts)	\$44,000	\$8,800						
3	Apr-10	ONC-MU	Extending the data displayed and exchanged in both the CCD and PHR to include Immunizations and Lab Results.	Y	2013	Health Summaries for Continuity of Care Populate PHRs		\$25K		\$25,000	\$5,000						
3	Apr-10	CCHIT	Participation in the SSA pilot with connectivity to the NHIN	Y	2015	Access Comprehensive data from all available sources		\$0									
3	Apr-10	ONC-MU	Ability to update Immunizations directly from EMR	Y	2011			\$25K	Uses interoperable transaction	\$25,000	\$5,000					\$30,000	\$312,000
4	Oct-10	ONC-MU	Radiology Reports from participating diagnostic imaging providers - view capability	Y	2013			\$50K portlet		\$50,000	\$10,000						
4	Oct-10		Access to Radiology Reports from participating diagnostic imaging labs.	Y	2013			\$44K/Center	Covered in On-boarding Assumes 6 Radiology Providers								
4	Oct-10	ONC-MU	Lab results delivery to meet the remaining for 2011's Meaningful Use requirements.	Y	2011	Lab Results Delivery		\$44K/Lab	Covered in On-Boarding Assumes 13 labs								
4	Oct-10	ONC-MU	Claim Status to meet the remaining for 2011's Meaningful Use requirements.	Y	2011	Claims and Eligibility Checking		\$84K/ 6 Plans \$50K Portlet		\$134,000	\$26,800						

Appendix K
MN HIE Four Year Plan 2010 - 2013

MN HIE Release	Target Delivery Date	Initiative	Description	Meaningful Use Requirement (Y/N)	Year Required for Meaningful Use	Meaningful Use Cross-Reference Descriptor	MN Related Requirements	Covisint Infrastructure Costs	Comments	Covisint Infrastructure Totals	Annual Maintenance	Maintenance Totals				Legal Costs	MN HIE staff costs
												2010	2011	2012	2013		
4	Oct-10	ONC-MU	Public Health Surveillance service that includes filtering and de-identification of lab results to be sent to the public health department manage or gain early detection of flu outbreaks and other public health issues	Y	2013	Registry reporting and reporting to public health		\$100K		\$100,000	\$20,000						
4	Oct-10	ONC-MU	Capability for Providers (both hospital and office) to report to Minnesota's Health Department or other such entities, also a Meaningful Use requirement for 2013, is also planned for this release	Y	2013	Registry reporting and reporting to public health		\$100K		\$100,000	\$20,000						
4	Oct-10	ONC-MU	Advanced Directives application that allows providers to update and maintain a state-wide repository of their patient's wishes for these end-of life care decisions.	Y	2011			\$25K		\$25,000	\$5,000						
4	Oct-10	ONC-MU	Extending the data displayed and exchanged in both the CCD and PHR to include Radiology Reports and Advanced Directives.	Y	2013	Health Summaries for Continuity of Care Populate PHRs		\$20K/Clinical Data Type	Assumes 2 Clinical Data Types	\$40,000	\$8,000						
4	Oct-10	ARRA	Offer Single Sign On capabilities to 3 CCHIT certified EMR products.	Y	2011	Providers must have an EMR		\$50K/ SSO w/Context New	Assume 3 EMR vendors	\$150,000	\$30,000					\$30,000	\$312,000
2010										\$893,000	\$178,600	\$178,600	\$0	\$0	\$0	\$75,000	\$674,000
5	Oct-10	ONC-MU	Access to participating PACS systems to view images and place orders.	Y	2013	Electronic Ordering		\$50K/ SSO w/Context New	Assumes 3 Radiology Providers (for ordering)	\$150,000	\$30,000						
5	Apr-11	ONC-MU	Capability to receive and forward orders via EDI from an EMR to the appropriate participating Lab or Imaging Center	Y	2013	Electronic Ordering		\$5K/Practice	Covered in On-Boarding Assumes 100 practices								

Appendix K
MN HIE Four Year Plan 2010 - 2013

MN HIE Release	Target Delivery Date	Initiative	Description	Meaningful Use Requirement (Y/N)	Year Required for Meaningful Use	Meaningful Use Cross-Reference Descriptor	MN Related Requirements	Covisint Infrastructure Costs	Comments	Covisint Infrastructure Totals	Annual Maintenance	Maintenance Totals				Legal Costs	MN HIE staff costs
												2010	2011	2012	2013		
5	Apr-11	ONC-MU	Providers will be granted access to the Collaborative Tools set which will allow Providers from both hospitals and offices to securely communicate with each other regarding a patient's health information via the secure messaging (email-like) capability.	Y	2013	Substantially steps up exchange between providers		\$25K		\$25,000	\$5,000						
5	Apr-11		Decision Support software provides non-hospital providers with knowledge and patient-specific filtered information that is presented at appropriate times to improve patient care for acute conditions.	Y	2013			\$50K		\$50,000	\$10,000						
5	Apr-11	ONC-MU	Clinical Research --- This includes the capability to support local (ex. U. of Minnesota) and national clinical research studies. The initiative would allow individuals with PHRs associated with MN HIE to receive research data	Y	2013	Populate PHRs with invitations to participate (not clinical data)		\$100K		\$100,000	\$20,000				\$30,000	\$312,000	
6	Oct-11	ONC-MU	Home Monitoring	Y	2013	Home Monitoring		\$75K		\$75,000	\$15,000						
6	Oct-11	ONC-MU	Case Management/Case Notes	Y	2013	Health Summaries for Continuity of Care		\$75K		\$75,000	\$15,000						
6	Oct-11	ONC-MU	Discharge Summary	Y	2013	Health Summaries for Continuity of Care		\$25K		\$25,000	\$5,000						
6	Oct-11	ONC-MU	Narratives/notes	Y	2013	Health Summaries for Continuity of Care		\$25K		\$25,000	\$5,000				\$30,000	\$312,000	
2011										\$525,000	\$105,000		\$283,600	\$0	\$0	\$60,000	\$624,000
7	Apr-12	ONC-MU	Establish access to other exchanges (comprehensive data from all available sources).	Y	2015	Access Comprehensive data from all available sources		\$50K		\$50,000	\$10,000						
7	Apr-12		Third Party Reporting through one or more 3rd party reporting services.	Y	2013	Registry reporting and reporting to public health		\$75K		\$75,000	\$15,000						

