

# Wisconsin Security and Privacy Project

## *Implementation Plan Report*

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## Executive Summary

Governor Doyle created the eHealth Care Quality and Patient Safety Board (eHealth Board) by Executive Order 129 on November 2, 2005. Its purpose is to develop a strategic action plan for the statewide adoption and exchange of electronic health records in five years.

Health care spending represented a record 16 percent of the nation's Gross Domestic Product (GDP) in 2004.<sup>1</sup> The goal is to take advantage of health information technology to improve health care quality and safety while reducing overall costs in the system. This is a key component of Governor Doyle's Grow Wisconsin plan for economic development - making Wisconsin a great place to do business and enjoy good health.

In response to Executive Order 129, the Board worked intensively to develop the *Wisconsin eHealth Action Plan*, a road map for public-private partnerships to advance adoption of electronic health records and the exchange of health information in Wisconsin. On December 1, 2006, the *Wisconsin eHealth Action Plan* was delivered to the Governor. The *Action Plan* states: "No patient should ever be harmed by lack of information at the point of patient care. ... [This] is a plan to save lives, improve the health status of the people of Wisconsin and achieve a better return on the investment in health care. ... Wisconsin, and the nation, must achieve this vision."

The *Wisconsin eHealth Action Plan* addresses the following challenges:

- Ensuring health information is available at the point of care for all patients.
- Reducing medical errors and avoiding duplicative medical procedures.
- Improving coordination of care between hospitals, physicians and other health professionals.
- Furthering health care research.
- Providing consumers with their health information to encourage greater participation in their health care decisions.

The *Wisconsin eHealth Action Plan* balances privacy rights with providers' needs to share information for safe, effective treatment. A key concern identified in the Plan is the requirement to exchange health information electronically in a way that is secure and protects a patient's privacy. In March 2006, the Department of Health and Family Services (DHFS) applied for the Health Information Security and Privacy Collaboration (HISPC) contract on behalf of the eHealth Board. The resulting project is referred to as the Wisconsin Security and Privacy Project. Wisconsin was one of 34 states and territories awarded a contract to assess the security and privacy issues of health information exchange.

The Wisconsin Security and Privacy Project began in the fall of 2006, using the grant structure of four workgroups: Variations, Legal, Solutions, and Implementation. In forming the four workgroups required by this project, Wisconsin was fortunate to have 52 individuals who volunteered their time, representing advocates, clinics, consumers, law enforcement, health care organizations, health care providers, health care quality organizations, hospitals, industry, laboratories, pharmacies, professional associations, public health, research, schools, payers, and state government.

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<sup>1</sup> C. Smith, *et al.*, "National Health Expenditures in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs*, 25, No. 1 (2006): 186-196.

## Assessment of Variation

As required by the HISPC contract, the first group convened in this process was the Variations Workgroup. The Variations Workgroup was charged with reviewing 18 scenarios developed by RTI to identify current business practices related to health information exchange as well as the driver for each business practice. The Workgroup discussed variations in business practices between the responding stakeholders as well as which business practices posed barriers to health information exchange. For business practices which are considered barriers to exchange, the Workgroup discussed which barriers should remain as a privacy protection and which could be reduced or eliminated without removing necessary privacy protections. Staff assisted in the review of the business practices and the determination of which practices related to the domains in information exchange as identified by RTI.

The Legal Workgroup was then convened to identify the legal drivers of the business practices identified by the Variations Workgroup and evaluate potential legal barriers to health information exchange. The Legal Workgroup reviewed the 18 scenarios, and identified and cited the legal drivers for business practices as well as all legal barriers associated with the scenarios.

A summary of the barriers documented and analyzed by the Variations and Legal workgroups follows:

### 1. Barriers driven by Wisconsin law

Wisconsin statutory requirements relating to health information exchange (HIE) that are more restrictive than federal requirements cause barriers to the exchange of information.

Some of the most significant statutory barriers to HIE are the regulations associated with the treatment of sensitive information, defined as information pertaining to mental health, alcohol and other drug abuse and developmental disability. The requirements include:

- Consent for specific types of disclosures (payment and treatment)
- Verification of the requestor for this information
- Minimum necessary

HIV test results are also treated as sensitive information (Wisconsin Statutes section 252.15), except that they can be disclosed from provider to provider for treatment purposes.

Other barriers driven by Wisconsin law include:

- Documentation of all disclosures made with or without patient consent, including as defined in Wisconsin Statutes chapter 146 and section 51.30
- Requirements prohibiting re-disclosure of health information
- Consent requirements more stringent than federal requirements, such as for disclosure to the patient's family
- Required interface between state and federal law requirements

### 2. Barriers driven by state and federal law

Whenever state and federal law do not mirror one another, several barriers to the exchange of information are created. First, one must determine which law controls (state or federal), then once the controlling law is determined, one must understand the requirements of the controlling law. This

makes inter-state exchange of information increasingly difficult because other state laws must be understood in order to exchange.

Consent requirements, governed by state and federal law, present the greatest hurdles to health information exchange. The barriers are caused by:

- The process to obtain a consent, including determination of who is able to sign
- Validation of the statutorily required elements of the consent
- Analysis required of state and federal law to determine which law controls
- Variation in requirements between states

Although eliminating these consent requirements would reduce the barriers to exchange, federal law 42 CFR Part 2 requires patient consent to exchange alcohol and other drug abuse information for treatment purposes unless revision of that federal law occurs.

Other areas where state and federal law differ include:

- Minimum necessary
- Verification of requester
- Requirement to provide of Notice of Privacy Practices

### 3. **Barriers driven by federal law**

In some cases, federal law is more stringent than state law. In all of these cases, both the law and the varying interpretations of the law cause barriers to exchange. The federal requirements identified by the workgroups that pose barriers to exchange include:

- Verification of the individual requesting the information.
- Release of the “minimum necessary” health information for the purposes identified by the individual requesting the information.
- Implementation of business associate agreements to govern the exchange of information that meets the needs of both the covered entity and the vendor.
- The Federal Security Rule, which governs the technical security measures to guard against unauthorized access to electronic health information.
- The Federal Privacy Rule requirements, including patient rights.
- Regulation of the use of protected health information in situations where the use would not specifically be deemed a disclosure, such as when information is used to perform an internal business function.

### 4. **Barriers driven by policies and practices**

The Variations and Legal workgroups identified several barriers to HIE that are driven by organization-level business policies and practices. Most often, variations in policy and practice implementation create barriers to HIE.

Barriers driven by policies and practices include:

- Consent – varying interpretations of when consent is required for disclosure
- Method of requesting information – varying methods for making requests
- Method of disclosure – varying methods for disclosing information

- Method of retention
- Variability of implementation of the law
- Method for making or responding to a request, such as by phone, by fax, or in writing.
- Sophistication of the technology that an organization is willing to purchase to secure its patients' information.

The final barrier to exchange identified by the workgroups is technology. In general, current technology used in Wisconsin cannot limit access to relevant parts of the record or to specific records to comply with “minimum necessary” requirements. Furthermore, currently employed technology often cannot specify the type of access (read-only, edit/modify, delete) granted to the user. For those who do not have electronic medical records, the lack of technology creates a barrier to exchange. This will not be an easy barrier to overcome as technology systems are extremely expensive and many providers cannot afford the cost of technology. In addition, the costs related to the implementation of technology were also deemed a significant barrier to exchange.

## **Assessment of Solutions**

### ***Solutions Workgroup***

The Solutions Workgroup was charged with the analysis of identified barriers, balancing privacy protections against the need to know and developing solutions to improve the exchange of health information. The Solutions Workgroup included a mix of members from the previous workgroups, as well as new members who increased representation in advocacy and policy making, for a total of 35 members. Members represented clinics, hospitals, consumer organizations, law enforcement, health care quality organizations, industries, pharmacies, professional associations, providers, public health, research, state government, health information vendors and payers.

The Solutions Workgroup reviewed barriers to health information caused by variations in organization-level business practices and relevant state and federal laws as identified by the Legal and Variations workgroups. The Solutions Workgroup followed a complex, creative approach that included a series of small breakout groups and large group discussions to allow active participation from all members, the capture of varied viewpoints, and ultimately the creation of solutions that will improve HIE without compromising necessary patient privacy protections. Through this process, each barrier was analyzed to determine whether it should remain or be reduced or eliminated. Solutions were developed to reduce or eliminate barriers that the group decided should not remain, and finally grouped into broader solutions with a greater feasibility of implementation.

### ***Implementation Workgroup***

The Implementation Workgroup was charged with refining the solutions proposed by the Solutions Workgroup, then creating implementation plans for the refined solutions. The Implementation Workgroup comprised 33 members representing clinics, hospitals, consumer organizations, law enforcement, health care quality organizations, industries, pharmacies, professional associations, providers, public health, research, state government, health information vendors and payers.

The Implementation Workgroup used an interactive model similar to the Solutions Workgroup model. This included a preview of the proposed solution and a series of small breakout groups and large group discussions to further define the solution and develop implementation plans. Implementation plans included definition of the project structure, key activities required to complete implementation, identification of stakeholders, and development of a communications plan to ensure two-way communication with all affected stakeholder groups.

## **Summary**

An overview of the proposed solutions and implementation plans is provided below.

### **1. Verification of Patient**

Currently, health care providers do not use a uniform method to capture standardized criteria to identify a patient (patient identifiers).<sup>2,3</sup> Moreover, there is not a standard method to verify patient identifiers at the time of exchange.<sup>4</sup> This lack of standardization creates significant risks to accurate and timely patient care. Variation in practice also poses a number of challenges to exchanging information in a paper or electronic format. Moving into an electronic world where information is exchanged between electronic health care systems will require standardized collection of patient identifiers, verification of patient identifiers, and accurate matching of identifiers to patient information. Currently, national efforts are under way to develop a set of unique patient identifiers to alleviate these issues.

The solution proposed by the Solutions Workgroup addresses current issues with misidentification of patients while positioning Wisconsin to incorporate the national recommendations once they are completed.

The Solutions and Implementation workgroups proposed the development of a standard set of identifiers as well as a set of model policies and procedures to ensure appropriate capture and verification of those identifiers. The project team would maintain an understanding of national efforts to develop a national set of identifiers, and develop policies and procedures that will accommodate the national recommendations. This way Wisconsin's model policies and procedures can be easily revised to incorporate national standards once they are established.

### **2. Modification of Wisconsin Statutes chapter 146 to mirror HIPAA in specific areas**

Many of the barriers to health information exchange result from strict privacy protection requirements in the Wisconsin privacy laws. While some of the restrictions clearly interfere with or prohibit information exchange, others are so complex in their application that they result in wide variation in practices relating to disclosures. Additional barriers are created because HIPAA creates privacy protections in many of the same areas as Wisconsin Statutes section 146.81-146.84; thus application of these laws is complicated because it is difficult to determine which law applies.

Based on a review of the barriers to HIE created by the Wisconsin Statutes chapter 146, the Solutions Workgroup proposed revising this statute to mirror the language in HIPAA in the following areas:

1. Expanding disclosures to family (Wisconsin Statutes section 146.82, 146.83)
2. Expanding disclosures to law enforcement
3. Modifying re-disclosure restrictions (Wisconsin Statutes section 146.82(2)(b))
4. Modifying the requirements for documentation of disclosure (Wisconsin Statutes section 146.82(2)(d), 146.83(3))

The Solutions and Implementation workgroups determined that these additional restrictions did not significantly improve patient privacy; instead they added to the complexity of health information

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<sup>2</sup> Capture: The process of collecting patient identifiers from a patient.

<sup>3</sup> Patient Identifiers are information collected from a patient to assist in the identification of the patient (e.g., name, birth date, address, etc.)

<sup>4</sup> Verification: The process of confirming that patient identifiers are correct.



exchange, which can result in individuals not having the information required to diagnose, treat or care for patients. Implementation activities will include drafting new language, developing a communication and education plan, and seeking support of a wider group of stakeholders.

### **3. Modification of Wisconsin Statutes section 51.30 to allow the exchange of health information for treatment purposes**

Wisconsin Statutes section 51.30 provides additional protections for health information that contains information related to mental health, developmental disabilities, and alcohol and other drug abuse. These additional protections create barriers to the exchange of information, some of which are arguably necessary privacy protections, while others, it can be argued, deter the exchange of information that could lead to better care. Additional barriers are created because Wisconsin Statutes section 51.30 is more restrictive than HIPAA regarding the exchange of information protected by this law.

The Solutions Workgroup reviewed barriers associated with these restrictions and determined that Wisconsin Statutes section 51.30 should comport with HIPAA and be revised to allow exchange of information between providers for treatment purposes, without patient consent. While this would allow the exchange of information protected by this law, it would not affect the provider's inability to disclose treatment information without patient consent protected by 42 CFR Part 2, the federal statute protecting AODA information. Consent would still be required to exchange this information.

Although a substantial majority of the Workgroup believes strongly that necessary health information protected by Wisconsin Statutes section 51.30 should be shared between providers for treatment purposes without patient consent, this proposed change was not unanimously supported. Some Workgroup members and interested parties said that the extra protections afforded by Wisconsin Statutes section 51.30 are necessary for protecting mental health information and other health information that could result in stigma or otherwise negatively affect a patient's care if widely available.<sup>5</sup> However, many of these individuals recognized the need for providers who are providing care and treatment to access limited health care information without patient consent (e.g., medications, allergies, diagnoses, and other elements as may be deemed essential to patient care).

It should be noted that the majority of the members of the Implementation Workgroup further refined the solution and determined that the law should be revised to allow the exchange of information for treatment purposes, but did not determine what information should be exchanged freely without consent. The implementation plan includes further analysis of the specific elements that can be exchanged without patient consent for patients with protected health information; changing the law, if necessary, based on the decisions made about the elements to be exchanged; and implementing the change in law. Involving all stakeholders in the development of the proposed changes is essential in creating the solution, as the current language in Wis. Stat. 51.30 provides additional protections that are supported by advocates and lobbyists. If a compromise can be developed by all interested parties, legislation to increase the exchange of appropriate health information is possible.

### **4. Changes to HIPAA**

The Solutions Workgroup reviewed all of the barriers associated with the HIPAA Privacy Rule that were identified through the Variations and Legal workgroups' review of the 18 scenarios. Following discussions of the barriers, the Solutions Workgroup proposed changes to HIPAA in the following three areas:

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<sup>5</sup> More detailed feedback from the group of interested parties convened to discuss this issue can be found in Appendix 2.

- a. Remove the requirement for a business associate agreement, and instead develop a method to hold business associates accountable for adhering to state and federal privacy requirements.
- b. Remove the waiver process for research without patient consent, but maintain the Institutional Review Board (IRB) process requirements.
- c. Clarify the “minimum necessary” standard by revising the language in HIPAA and developing model policies and procedures to define and clarify the standard.

This proposed solution was not reviewed in detail by the Implementation Workgroup because it was determined that a plan to implement changes to federal law would most efficiently and effectively be created by individuals experienced with national legislative change.

## **Next Steps**

The eHealth Board extends its sincere appreciation to all of the volunteers who dedicated their time to the Security and Privacy Project. The information that has been collected through this process will be valuable as the eHealth Board begins the implementation phase in developing electronic systems and a means to exchange health information electronically.

The recommendations contained in the report represent possible solutions to the challenges identified through the analysis of the 18 scenarios. The recommendations are intended to inform policy discussions, but should not be construed as comprehensive or definitive legislative recommendations of the eHealth Board at this time. The eHealth Board will be using the Security and Privacy Project reports to assess where the proposed solutions fit within the eHealth Board’s scope of work for the coming years. Wisconsin is committed to developing the necessary policies and procedures to ensure the adoption of health information technology and exchange throughout Wisconsin in an effort to ensure quality of care and patient safety.

# Section 1 - Background

## 1.1 Purpose and scope

The Implementation Workgroup was the final step in a four-step process to develop solutions and implementation plans to facilitate the exchange of health information while maintaining privacy mechanisms that protect consumers.

As described in the *Analysis of Variations and Solutions Report*, the Variations and Legal workgroups identified barriers to health information exchange (HIE) through the analysis of business practices and legal barriers and drivers associated with the 18 scenarios created by RTI. Each barrier was reviewed by the Solutions Workgroup, who determined which barriers should remain and which should be reduced or eliminated. For those that should not remain, the Solutions Workgroup developed nine solutions to barriers to facilitate HIE.

In the final meeting, the nine solutions proposed by the Solutions Workgroup were grouped into the following four for easier implementation:

- Verification of patient (1)
- Modifications to the Wisconsin privacy law regulating general patient information (4)
- Modifications to the Wisconsin privacy law regulating mental health, alcohol and drug abuse and developmental disability information (1)
- Modification of the HIPAA privacy law (3)

A summary of the four proposed solutions developed by the Solutions Workgroup has been incorporated into this report in Section 2 – Summary of Interim Analysis of Solutions Report. The solutions, as proposed by the Solutions Workgroup and recorded in Section 2, were further refined by the Implementation Workgroup. The final proposed solutions, as well as the plans to implement them, are described in detail in Section 4 – State Level Implementation Plans and Section 5 – Multi-State Implementation Plans.

The solutions relating to modification of HIPAA were not developed by the Implementation Workgroup therefore only three of the solution groupings are described in detail in this report. The decision not to develop the HIPAA solutions at this time was a difficult one and was based on the assessment that the time constraints of the grant would not allow for full and adequate development of this solution. The Workgroup believed that the proposed changes to HIPAA are critical to achieving HIE and recommend further development of this solution requiring changes to federal law by individuals and stakeholders experienced with making national legislative changes.

## 1.2 Key assumptions and limitations

The work of this grant was completed in a very short timeframe by an extremely committed group of volunteers. RTI created scenarios which served as the starting point of discussions regarding identification of business practices in health information exchange and barriers to HIE. The scenarios elicited discussions that highlighted many of the barriers to the exchange of information, but given the time constraints, facilitators tried to stick as closely as possible to the issues relevant to the scenarios.

There were many areas that the workgroups would have liked to explore further; however, they focused instead on the areas felt to have the greatest impact on HIE.

Some of the areas the workgroups would like explored in the future include the treatment of minors and HIV test results (Wisconsin Statutes section 252.15) and other frequent health information exchanges such as for payment.

When discussing implementation of the three proposed solutions, significant consideration was given by the workgroups to liability issues that arise in information exchange. Current Wisconsin law provides both criminal and civil penalties for unauthorized exchange, and current privacy cases in Wisconsin underscore that liability in relation to health information exchange is a significant concern. Penalties and other consequences for unauthorized exposure in health information exchange was mentioned repeatedly in Workgroup discussions and led to the addition of a nurse risk manager to the Solutions and Implementation workgroups. However, without a full understanding of the future processes for health information exchange, it is difficult to predict the future liability issues. Prior to implementing these solutions, it is recommended that liability issues be explored in detail. In addition, this exploration will need to include potential liability that may occur that is not anticipated under current law.

Finally, the proposed solutions were developed to improve the exchange of information in the current environment, which is heavily paper-based, and to lay the groundwork for the exchange of information in the electronic environment. However, it is impossible to reach the full benefits of HIE in an environment where some use paper records and others have electronic health records. We are far from a fully electronic environment. In order to create a fully electronic environment, financial assistance must be offered to providers who are struggling in the current health care climate. HIE will not work unless all providers use electronic systems.

## **Section 2 – Summary of Interim Analysis of Solutions Report**

The Solutions Workgroup reviewed each barrier to information exchange identified by the Variations and Legal workgroups and conducted a thorough analysis to determine which barriers were necessary for privacy protection and should therefore be retained as barriers, and which barriers should be eliminated or reduced. The Workgroup then created nine solutions to eliminate or modify barriers that impeded information exchange while still preserving the essential elements of patient privacy protection. Those nine solutions were grouped into four more manageable solution categories that are detailed in the Assessment of Variations and Analysis Solutions Report.

These solutions were later refined by the Implementation Workgroup. A detailed description of each of the final proposed solutions is included in Section 4, State Level Implementation Plans, of this report.

The solutions, as proposed by the Solutions Workgroup, are summarized below.

### **1. Verification of Patient**

Currently, providers do not use a uniform method to capture standardized criteria to identify a patient (patient identifiers).<sup>6,7</sup> Moreover, there is not a standard method to verify patient identifiers at the

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<sup>6</sup> Capture: The process of collecting patient identifiers from a patient.

<sup>7</sup> Patient Identifiers are information collected from a patient to assist in the identification of the patient (e.g., name, birth date, address, etc.)

time of exchange.<sup>8</sup> This lack of standardization in criteria and method creates significant risks to safe, accurate and timely patient care. Current significant variations in practice also pose a number of challenges to exchanging information in a paper or electronic format.

Moving into an electronic world, where information is exchanged between electronic health care information systems, will require standardized collection of patient identifiers, verification of patient identifiers, and accurate matching of identifiers to patient information. National efforts are underway to develop a set of unique patient identifiers to alleviate these issues.

The Solutions Workgroup proposed the development in Wisconsin of a standard set of identifiers to be used within Wisconsin and with other states, as well as a set of model policies and procedures to ensure appropriate capture and verification of those identifiers. The project team would use these standard identifiers while monitoring national efforts to develop a national set of identifiers. The team will develop policies and procedures that will accommodate integration of the national recommendations when available; in this way, the model policies and procedures could be easily revised to incorporate national standards once they are established.

The solution proposed by the Solutions Workgroup alleviates current issues with misidentification of patients while positioning Wisconsin to incorporate the national recommendations once they are completed.

Implementation of the policies and procedures would improve the accuracy in identifying the correct patient and improve patient safety and quality of care (through the right information being available at all points of care), as well as ease the administrative burden of resolving patient identification and unintentional privacy violations related to personal health information.

## **2. Modification of Wisconsin Statute chapter 146 to mirror HIPAA in specific areas**

Many of the barriers to health information exchange result from strict privacy protection requirements in the Wisconsin privacy laws. While some of the restrictions clearly interfere with or prohibit information exchange, others are so complex in their application that they result in wide variation in practices relating to disclosures. Additional barriers are created because HIPAA creates privacy protections in many of the same areas as Wisconsin Statutes section 146.81-146.84. This creates additional barriers because in order to exchange information within Wisconsin, one must first determine which law applies (HIPAA or Wisconsin privacy laws), then determine the statutory requirements for the exchange. In order for exchange to occur between an entity within Wisconsin and one outside the state, the entity outside Wisconsin must understand where Wisconsin privacy laws are more restrictive than HIPAA and must abide by restrictions created by the Wisconsin privacy laws if the more restrictive Wisconsin law applies.

Based on a review of the barriers to HIE created by Wisconsin Statute chapter 146, the Solutions Workgroup proposed revising this chapter of the statutes to mirror the language in HIPAA in the following areas:

1. Expanding disclosures to family (Wisconsin Statutes section 146.82, 146.83)
2. Expanding disclosures to law enforcement
3. Modifying re-disclosure restrictions (Wisconsin Statutes section 146.82(2)(b))
4. Modifying the documentation of disclosure requirements (Wisconsin Statutes section 146.82(2)(d), 146.83(3))

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<sup>8</sup> Verification: The process of confirming that patient identifiers are correct.

The Solutions Workgroup determined that these additional restrictions did not significantly improve patient privacy, and in some instances, decreased access to care and patient safety due to the additional statutory burdens required for exchange of patient information, particularly for treatment purposes.

### **3. Modification of Wisconsin Statute section 51.30 to allow the exchange of health information for treatment purposes**

Wisconsin Statutes section 51.30 provides additional protections for health information that contains information related to mental health, developmental disabilities, and alcohol and other drug abuse. These additional protections create barriers to the exchange of information, some of which are necessary privacy protections; others, it can be argued, deter the exchange of information that could lead to better and safer patient care. Additional barriers are created because Wisconsin Statutes section 51.30 is more restrictive than HIPAA and therefore controls the exchange of information protected by Wisconsin law.

The Solutions Workgroup reviewed the barriers associated with the more restrictive state privacy restrictions and determined that Wisconsin Statutes section 51.30 should comport with HIPAA, specifically for patient treatment purposes, and should be revised to allow exchange of information between providers for treatment purposes without patient consent. While this would allow the exchange of information currently protected by state law, it would not affect treatment information protected by 42 CFR Part 2, the federal statute protecting alcohol and drug abuse treatment information. Patient consent would still be required to exchange this information for treatment purposes unless revision of federal law could be accomplished.

Although a substantial majority of the Workgroup believes strongly that necessary health information protected by Wisconsin Statutes section 51.30 should be shared between providers for treatment purposes without patient consent, this proposed change was not unanimously supported. Some Workgroup members and interested parties said that the extra protections afforded by Wisconsin Statutes section 51.30 are necessary for protecting mental health information and other health information that could result in stigma or otherwise negatively affect a patient's care if widely available.<sup>9</sup> However, many of these individuals recognized the need for providers who are providing care and treatment to access limited health care information without patient consent (e.g., medications, allergies, diagnoses, and other elements as may be deemed essential to patient care).

It should be noted that although the Implementation Workgroup determined that the state law should be revised to allow the exchange of information between providers for treatment purposes, further exploration of the solution to determine the specific information that should be exchanged between providers for treatment purposes without patient consent is recommended.

### **4. Changes to HIPAA**

The Solutions Workgroup reviewed all of the barriers to information exchange associated with the HIPAA Privacy Rule that were identified through the Variations and Legal workgroups' review of the 18 scenarios. Following discussions of these barriers, the Workgroup proposed changes to HIPAA in the following three areas:

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<sup>9</sup> More detailed feedback from the group of interested parties convened to discuss this issue can be found in Appendix 2.

- a. Remove the requirement for a business associate agreement, and instead develop a method to hold business associates accountable for adhering to state and federal privacy requirements.
- b. Remove the waiver process for research without patient consent, but maintain the Institutional Review Board (IRB) process requirements.
- c. Clarify the “minimum necessary” standard through administrative code, FAQs or model policies and procedures.

This proposed solution regarding changes to HIPAA was not reviewed by the Implementation Workgroup because it was determined that a plan to implement changes to federal law would most efficiently and effectively be created by individuals experienced with national legislative change.

## Section 3 – Review of State Implementation Planning Process

### 3.1 State Implementation Planning Workgroup

The Implementation Workgroup was created to develop implementation plans for each of the proposed solutions developed by the Solutions Workgroup. The objectives of the Implementation Workgroup were to review the proposed solutions, refine them, and develop implementation plans for each. The Implementation Workgroup refined solutions and developed implementation plans with the overarching goal of interfacing patient privacy protections with widespread interoperability.

The charge of the Implementation Workgroup was to:

1. Evaluate the feasibility of the solutions developed by the Solutions Workgroup.
2. Develop implementation plans for the prioritized solutions that contain the following:
  - a. Clearly defined project scope
  - b. Tasks required to complete the implementation
  - c. Timeline with milestones
  - d. Tracking, measuring and monitoring process
  - e. Required resources and financial cost
  - f. Impact assessment and identification of barriers

Support to the Implementation Workgroup was provided by the Security and Privacy Team, which included staff from the Wisconsin Department of Health and Family Services and contractors who provided privacy and policy expertise, workgroup meeting planning and facilitation, and project management services. The Security and Privacy Team managed the process, identified key stakeholders for participation in the workgroups, documented the work of the Workgroup including business policies and practices and associated legal citations, and completed the required interim and final reports for the grant.

#### ***Membership***

The Implementation Workgroup consisted of 33 representatives from multiple stakeholder groups that will be affected by health information exchange (HIE). Every stakeholder group identified by RTI was represented in the Workgroup. In order to maintain continuity across the project, all Solutions Workgroup members were invited to participate in the Implementation Workgroup. Roughly two-thirds of the Implementation Workgroup consisted of individuals who previously served on the Solutions, Variations and/or Legal workgroups. The team also recognized that the skills required to create solutions differ from those required to figure out how to implement the solutions. Therefore individuals with additional skills, knowledge and experience were added to the Implementation Workgroup. An opportunity to serve was also extended to all members of the Consumer Interest Workgroup, a subgroup of Wisconsin's eHealth Board; individuals from that Workgroup also offered to participate in this phase of the project.



### ***Stakeholder Representation***

The Security and Privacy Team was overwhelmed by the response to the invitation to participate in the Implementation Workgroup. The membership fully represented the wide spectrum of RTI stakeholder groups who will be affected by HIE, and included an impressive array of knowledge and experience. Several Implementation Workgroup members are active participants in Wisconsin's eHealth Care Quality and Patient Safety Board (eHealth Board) and its workgroups, and will be instrumental in conveying the information to other members of the full eHealth Board moving forward.

The following stakeholder groups were represented on this Workgroup:

- Clinicians (primary care providers, specialty physicians, and nurses)
- Clinics, including community clinics with limited resources
- Consumer organizations (mental health, women's health, community advocates, and public health)
- Hospitals (state mental health, university and research facility, multi-facility affiliated health system)
- Physician groups – small (primary care)
- Physician groups – large (single and multi-specialty)
- Federal health facilities
- Home care and hospice
- Correctional facilities (Department of Corrections)
- Professional associations and societies representing hospitals, physicians, primary care physicians, long-term care, and mental health
- Laboratories
- Payers (both large national, and smaller occupation-based)
- State government
- Schools
- Public health agencies / research
- Public health agencies / local and state government
- Research
- Clinical information systems vendors
- Legal community
- Quality improvement organizations
- Medical and public health schools that undertake research

## **3.2 Implementation Workgroup Approach**

The Implementation Workgroup convened a series of four working sessions to evaluate three proposed solutions. (The Workgroup did not develop an implementation plan for the fourth proposed solution, "Changes to HIPAA," as it was decided given the time constraints of the grant it would be a more effective use of resources for that implementation plan to be developed by individuals with experience making changes to national legislation.) Discussion of each implementation plan spanned two meetings. This allowed staff to document outcomes from the initial discussion for use at the second meeting, for further discussion, review and finalization of the implementation plans.

Prior to each meeting, participants were given summary documents describing the proposed solution to be discussed. The documents summarized the barriers to information exchange identified by the Variations and Legal Workgroups, as well as the solution proposed by the Solutions Workgroup.

The Workgroup discussed each of the three proposed solutions as a large group and often made refinements to the solution. The additional expertise and diversity of viewpoints of the Implementation Workgroup helped to further refine the solutions. Once the solution was refined and Workgroup consensus achieved, the group determined the scope of the solution as well as major milestones required for its implementation.

Once the solution's scope and major implementation milestones were defined, the group divided into small groups to focus on specific components of the implementation plan. The small breakout session approach provided a setting conducive to individual participation not always possible in the larger group setting. Small breakout sessions enabled efficient use of meeting time, maximizing the work completed in the short timeframe available, as sections of the plan were built simultaneously by each smaller group. Finally, as each participant brought different skills and interests, this approach allowed each person to focus on his/her area of interest and to lend his/her expertise to the group. The small breakout groups then reported their ideas back to the larger group, which discussed these outcomes.

Breakout groups typically focused on:

- **Clear definition of the solution:** Building a roadmap or other specifics of the solution
- **Project structure:** Defining who should have overall responsibility, what the future project team should look like, how should project success be measured, etc.
- **Change management:** defining the stakeholder groups, how to engage them, how to communicate with them, etc.

The eHealth Board will use the recommendations and cost analysis as a starting point for incorporation into the implementation plans of Wisconsin's *eHealth Action Plan*.

### **3.3 Organization of the Interim Implementation Report**

The Implementation Workgroup created implementation plans for three of the four solutions that emerged from the Solutions Workgroup. These three implementation plans include:

- A. Amendments to Wisconsin Statute chapter 146
- B. Modification of Wisconsin Statutes section 51.30 in relation to provides access to information for treatment
- C. Standardization of process for verification of patient identity

The solution that proposes changes to HIPAA is not included in the Implementation Report. The Implementation Workgroup supports the HIPAA-related recommendations as essential to facilitating HIE; however, given the time constraints of the grant, the DHFS team determined that it was not the best use of resources for a state-level team to develop a plan to make changes to federal law. This plan should be developed by individuals with experience in changing federal law.

Solutions A and B, above, involving changes to Wisconsin Statutes chapter 146 and Wisconsin Statutes section 51.30, are presented as state-level solutions. Solution C, which ultimately advocates for a national approach to standardizing the patient verification process, is presented in Section 5 – Multi-State Implementation Plans.

### **3.4 Specific Planning Methods/Tools Used**

The Implementation Workgroup followed a process to develop implementation plans similar to the one used by the Solutions Workgroup to develop solutions. It used a combination of large group discussions and breakout sessions to refine solutions and develop implementation plans for each solution.

The beginning of each meeting was spent making sure all participants understood the proposed solution. Then the group discussed it. Utilizing its diverse representation, the large often refined the solution. Once the solution was agreed upon, the group went through an exercise to determine the key activities required to implement it and developed a corresponding timeline.

After determining key activities as a large group, the Workgroup would then divide into smaller teams to tackle the detailed work of building the implementation plans that are documented in this report. Groups were asked to answer more questions than they really could in the time allowed. This often led to frustration during breakout sessions, but ultimately to thoughtful and in-depth consideration of a majority of the questions. After the designated time for breakouts, the large group reconvened to hear a report back from each of the breakout groups. The groups were often surprised to discover the progress they had made in designing of an implementation plan. The Workgroup then discussed the results of the breakout groups and, in most cases, came to consensus on the plans.

Staff then documented the proposed implementation plans. The group was given time at the following meeting to offer suggestions.

## Section 4 – State-Level Implementation Plans

The Implementation Workgroup developed the following two plans to be implemented at the state level:

- Modify Wisconsin Statute chapter 146 to mirror HIPAA in specific areas.
- Modify Wisconsin Statutes section 51.30 to comport with HIPAA for treatment purposes.

Modifying Wisconsin Statutes section 146.81-.83 to mirror specific HIPAA components will help improve information exchange in Wisconsin and between states and ease administrative burdens currently impeding information exchange. Most importantly it will allow family and other caregivers assisting in the care and treatment of patients to have access to information that will support strong communication and improve patient care. The additional modifications will allow providers better information about their patients and reduce costly administrative time for documentation of all disclosures.

The proposed modification to Wisconsin Statutes section 51.30 will maintain strong patient privacy protection while providing the patient's physician with essential health care information needed in the care and treatment of the patient. When the purpose of the information exchange is treatment, this modification will enhance the rapid and efficient delivery of patient care information without the impediment of obtaining and verifying patient consent. It will ease barriers in the exchange of information, but will continue to maintain many privacy safeguards, stricter than HIPAA's, that were determined to be necessary protection for mental health, developmentally disabled and alcohol and drug abuse patients.

### 4.1 Statewide Strategy and Coordination

Wisconsin Governor Jim Doyle created the eHealth Care Quality and Patient Safety Board by Executive Order 129 on November 2, 2005. Its purpose is to develop a strategic action plan for the statewide adoption and exchange of electronic health records in five years, develop recommendations for a Wisconsin eHealth information infrastructure, and foster its implementation. The eHealth Board recruited a diverse group of volunteer stakeholders with a broad base of expertise who convened to assist in the development of the *eHealth Action Plan* through five workgroups: Patient Care, Information Exchange, Consumer Interests, Financing and Governance.

In November 2006 the workgroups submitted their reports; following Board approval, the eHealth Board submitted the *eHealth Action Plan* to the Governor on December 1, 2006. This five-year plan will guide state government's legislative and regulatory actions, encourage coordinated efforts in the private health care sector, further public and private partnerships for the development of a statewide eHealth information infrastructure, and maximize federal financial participation to support early adoption of the eHealth information infrastructure.

Wisconsin's Security and Privacy Project leverages the infrastructure that the eHealth Care Quality and Patient Safety Board is creating to support the privacy and security work. It will also build on the success of related initiatives in Wisconsin, such as the work of the HIPAA Collaborative of Wisconsin and the Wisconsin Health Information Management Association. The eHealth Board served as the Steering Committee for this project, which comprised four workgroups: Variations, Legal, Solutions and Implementation. Results of this project will provide guidance to the eHealth Board as it articulates a path to improve the quality and reduce the cost of health care in Wisconsin through creation of a statewide health information infrastructure.

## 4.2 Proposed Solution: Amend Wisconsin Statute Chapter 146

### 4.2.1 CONTEXT FOR PROPOSED SOLUTION

#### PROPOSED SOLUTION

Amend Wisconsin Statute Chapter 146 to mirror HIPAA in the following areas:

1. Expand disclosures to families and other individuals involved in the care or treatment of a patient (Wisconsin Statutes section 146.82,146.83)
2. Modify re-disclosure restrictions (Wisconsin Statutes section 146.82(2)(b))
3. Modify the requirements for documentation of disclosure (Wisconsin Statutes section 146.82(2)(d),146.83(3))

In 1980, Wisconsin Statutes section 146.81-.84 became law, designed to protect general patient health care information. The law was intended to balance the patient's right to have his/her health care information remain confidential with the need for disclosure without patient consent when societal "need to know" was greater than the patient's right to protection. HIPAA, the federal privacy law, which became effective in 2003, creates many of the same privacy protections at the national level that Wisconsin Statute chapter 146 affords Wisconsin citizens. Sometimes, however, the two sets of laws collide, creating barriers to health information exchange, notably:

- To exchange health information within Wisconsin, one must first determine which law applies (HIPAA or one of the Wisconsin privacy laws), then determine the statutory requirements of the exchange. For each disclosure, the analysis required to determine which law applies adds complexity and creates additional barriers to exchange.
- When Wisconsin law is more restrictive than HIPAA, the state law supersedes the national HIPAA standards for exchange. Consequently, when someone from outside the state attempts to exchange information with an entity in Wisconsin, he/she would have to follow the more restrictive Wisconsin regulations, and therefore, the exchange would be more difficult.

The changes proposed in this solution would standardize current practices and align Wisconsin law with HIPAA for the exchange of health information with families and others, for documentation of treatment disclosures, and for re-disclosure requirements. The Workgroup anticipates the changes outlined in this solution will:

- Pave the way for health information exchange within Wisconsin and between Wisconsin and other states by improving the consistency of practice among Wisconsin providers and reducing barriers to exchange.
- Improve physician relations with patients and their families by providing more reliable communication.
- Result in cost savings through reduction of the burden of requiring documentation for every disclosure. This could result in cost savings for providers, and, theoretically, for consumers as well.
- Provide physicians with more information and facilitate more informed treatment decisions by allowing for re-disclosure of health information without consent.

- Reduce duplication of services by allowing re-disclosure of health information. Providers could receive results of tests previously performed instead of duplicating the tests.

These solutions are driven by the universal goals of improving quality of care and patient safety.

## **4.2.2 PLANNING ASSUMPTIONS AND DECISIONS**

This implementation plan was created with the understanding that amending Wisconsin Statutes section 146.81-.83 was in line with the goals of Wisconsin's eHealth Initiative, to improve patient safety and health care communications through more efficient information exchange. Therefore, it is reasonable that the eHealth Board and its designated workgroups would have project oversight and overall responsibility for advancing the implementation of the proposed solutions. The proposed solutions fit within the Board's scope of work.

## **4.2.3 IMPLEMENTATION OWNERSHIP AND RESPONSIBILITIES**

The Implementation Workgroup recommends that the Wisconsin eHealth Board retain responsibility for amending Wisconsin Statutes section 146.81-.83 as outlined in this report. The Workgroup recommends that the eHealth Board designate staff, such as a project director, who has responsibility for designing and implementing the process to implement this change, meet the Board's needs for timely completion, and support the future project team with the level of expertise necessary to move this initiative forward. The Implementation Workgroup emphasizes the importance of engaging the future project team with content expertise (health information exchange and privacy) and an understanding of Wisconsin's legal requirements and provider policies in this arena to date.

Additionally, the Workgroup suggested the formation of an "oversight coalition" to engage the appropriate stakeholders and advise the future project team. This "oversight coalition" should include core team members from the following stakeholder groups: providers, consumers, patients, insurers, government, business, and labor. The coalition's charge should include the following:

- Identify champions in stakeholder groups not represented on the coalition.
- Solicit input from champions and other individuals.
- Identify lead authors/co-sponsors for the initiative.
- Provide oversight for the key activities of the future project team.
- Communicate project developments to champions as well as a wide audience.

When the eHealth Board reviews the recommendations resulting from the efforts of the Security and Privacy Project Implementation Workgroup, Board members are likely to consider its advice to create an "oversight coalition" composed of respected community leaders with expertise relating to health information disclosure and patient privacy, who can represent and communicate to a broad spectrum of individuals within their stakeholder groups. Since legislative change would need to occur in order to implement the proposed solution, this "oversight coalition" would have to include members with the political connections to facilitate legislative change, and a strong government leader to shepherd the proposed solution through the legislative process.

## 4.2.4 PROJECT SCOPE

This solution proposes changing Wisconsin Statute chapter 146 (and any affected administrative code) as follows:

| Area   | Current Law   | Proposed Change   |
|--|---|---|
| Documentation  | Wisconsin Statutes section 146.82(2)(d), 146.83(3) requires documentation of all disclosures (written, oral, etc.) with or without consent. Documentation becomes a legal part of the patient's record. | Rewrite to mirror 45 CFR 164.528 to require limited documentation of disclosures, enabling the patient to determine who has accessed his/her health information and when.   |
| Re-disclosure  | Wisconsin Statutes section 146.82(2)(b) requires that when information is disclosed without patient consent, the recipient must keep the information confidential and may not re-disclose it.           | Delete Wisconsin Statutes section 146.83(2)(b), and replace it with language that allows disclosure with patient consent or otherwise as allowed by law.  |
| Disclosure to individuals involved in the care or treatment of the patient | Wisconsin Statutes section 146.82 and 146.83 require patient consent to provide written or oral disclosure of health information to individuals involved in the care or treatment of the patient.       | Rewrite to allow oral disclosure to individuals involved in the care or treatment of the patient with patient agreement (not formal consent). Retain requirements for patient consent to disclose any copy of a patient's medical record. |

While the Implementation Workgroup does not believe there will be strong opposition to these proposed changes to Wisconsin Statutes chapter 146, the Workgroup encourages the future project team to develop a comprehensive communication and education plan to accompany these legal changes. A carefully crafted communications plan will ensure participation and buy-in from all relevant stakeholders: those who have a role in implementing the proposed changes as well as those who will be affected by the changes. Once the proposed legislation is codified, the future project team should partner with professional associations and others to hold training sessions to ensure adoption of updated policies and procedures at the organizational level.

## 4.2.5 TASKS REQUIRED

A key aspect of the proposed solution to change Wisconsin Statutes chapter 146 is the legislative process. An overview of this process is outlined in Appendix 1.

See Section 4.2.6 for a list of key tasks required to make the change.

## 4.2.6 PROJECT TIMELINE AND MILESTONES

The table below presents key activities and a proposed timeline to implement this solution.

Key assumptions:

1. This activity table is very high-level; there are many activities embedded in each line.
2. The process goes smoothly; all stakeholders and possible dissenters are brought on board early and support the statutory change.
3. While timelines are listed separately, some activities can occur concurrently, if there are sufficient staff resources for overlapping activities.

| Key Activities  | Duration                       |                                |
|---|--------------------------------|--------------------------------|
|   | Minimum                        | Maximum                        |
| <b><i>Part 1: Preparing for Legislative Change</i></b>  |                                |                                |
| Develop case for necessity of proposed changes: <ul style="list-style-type: none"> <li>▪ identify supporters and opposition</li> <li>▪ develop plans to address concerns</li> <li>▪ build support for proposed changes</li> </ul>   | 2 months                       | 4 months                       |
| Identify legislative sponsor(s), DHFS sponsor, and content expert(s)  | (concurrent with above period) | (concurrent with above period) |
| Hold listening sessions to discuss proposed changes ( <i>See Part 2</i> )   | See Part 2 timeline            | See Part 2 timeline            |
| Refine proposed changes to reflect stakeholder input ( <i>See Part 2</i> )  | See Part 2 timeline            | See Part 2 timeline            |
| Fine-tune specific legal changes identified (i.e., develop sample language)   | 1 week                         | 2 weeks                        |
| Ask legislative sponsor(s) to request that the Legislative Reference Bureau research and draft formal legal language.   | 4 weeks                        | 6 weeks                        |
| Review legislation as drafted by Legislative Reference Bureau   | 1 week                         | 2 weeks                        |
| Obtain fiscal note from the Department  | 2 weeks                        | 3 weeks                        |
| Monitor, manage, and nurture proposed changes through the legislative process: ( <i>See Part 3</i> ) <ul style="list-style-type: none"> <li>▪ identify who will appear in support of the change(s) at committee public hearings around the state</li> <li>▪ prepare talking points if asked to do so</li> </ul> | Section 3 timeline             | Section 3 timeline             |
| Determine who will interact with Governor’s staff; have these persons request that Governor sign the bill when it is sent to his desk by the Legislature.   | 1 week                         | 2 weeks                        |
|   |                                |                                |
| <b><i>Part 2: Building Stakeholder Involvement</i></b>  | 3 months total                 | 5 months total                 |
| Identify stakeholder groups that can provide input  |                                |                                |
| Identify areas where external input is most critical  |                                |                                |
| Align stakeholders with areas requiring input   |                                |                                |
| Invite input from a broad set of stakeholders   |                                |                                |
| Seek endorsements from involved stakeholder groups  |                                |                                |
|   |                                |                                |



| <b>Key Activities</b>   | <b>Duration</b> |                |
|---|-----------------|----------------|
|   | <b>Minimum</b>  | <b>Maximum</b> |
| <b><i>Part 3: Communicating the Proposed Solution</i></b>   | 3 months total  | 5 months total |
| Identify all stakeholder groups affected by the proposed changes  |                 |                |
| Determine communication needs of each group   |                 |                |
| Build communication plan for each stakeholder group   |                 |                |
| Develop communication pieces  |                 |                |
| Build Web site for project updates and all communication materials  |                 |                |
| Deliver communications throughout the legislative process   |                 |                |
|   |                 |                |
| <b><i>Part 4: Training and Education</i></b>  |                 |                |
| Determine how law changes will affect organizational policies and procedures  | 2 weeks         | 3 weeks        |
| Develop training materials to communicate law changes to providers  | 6 weeks         | 8 weeks        |
| Develop outreach materials to communicate law changes to consumers  | 3 weeks         | 4 weeks        |
| Build Web site with training materials for providers and with consumer information  | 6 weeks         | 8 weeks        |
|   |                 |                |
| <b><i>Part 5: Next Steps</i></b>  |                 |                |
| Develop administrative rules, if necessary ( <i>See Part 6</i> )  | 10 months       | 12 months      |
| Continue study of Wisconsin Statutes chapter 146 and its impacts on health information exchange   | Ongoing         | Ongoing        |
| Maintain Web site with training and educational materials   | Ongoing         | Ongoing        |
|   |                 |                |
| <b><i>Part 6: Administrative Rule Promulgation</i></b>  |                 |                |
| Brief Secretary's Office on need for rules or changes   | 1 day           | 1 week         |
| Submit Statement of Scope to Department Rules Manager   | 1 day           | 1 week         |
| Establish stakeholder advisory group and solicit input  | 1 month         | 2 months       |
| Complete draft rules, summary which includes the small business fiscal analysis, and fiscal estimates; submit to Department Rules Manager                                     | 3 months        | 4 months       |
| Periodically, brief the Secretary's Office on status of rulemaking – Clearinghouse review, Public Hearing dates and locations, Public Hearing Comments and Legislative Review | Ongoing         | Ongoing        |
| Complete the public hearing notice and submit to Department Rules Manager for approval  | 1 week          | 2 weeks        |
| Hold Public Hearings  | 2 months        | 3 months       |
| Submit legislative report to the Rules Manager  | 1 month         | 2 months       |
| Determine anticipated effective date of approved rules  | 2 months        | 2 months       |

With minimum staffing, the time frame to complete these tasks is, at a minimum, 2 years with administrative rule change, and 1 year without. At a maximum, these tasks could take 3 years with administrative rule change and 2 years without.

## 4.2.7 PROJECTED COST AND RESOURCES REQUIRED

The key assumptions in developing the costs and resources needed were:

- Staff resources would consist of a 0.5 to 1.0 full time employees.
- Contract staff may be necessary when specific expertise is needed. A flat contracting amount has been budgeted to cover these costs.
- Projected costs are provided for the optional third year. Identifying timelines within the legislative process is challenging, so a range of costs for this effort in the event that the project takes longer than anticipated.
- For each year of this project, a cost increase of 2.5% was included.

|                                | Category                       | Minimum           | Maximum           |
|--------------------------------|--------------------------------|-------------------|-------------------|
| <b>Year 1</b>                  | Direct Labor Salary and Fringe | \$ 55,244         | \$ 110,488        |
|                                | Other Expenses                 | \$ 47,270         | \$ 54,163         |
|                                | Contractual                    | \$ 70,000         | \$ 70,000         |
|                                | <b>Year 1 Subtotal</b>         | <b>\$ 172,514</b> | <b>\$ 234,651</b> |
| <b>Year 2</b>                  | Direct Labor Salary and Fringe | \$ 56,625         | \$ 113,250        |
|                                | Other Expenses                 | \$ 48,276         | \$ 55,342         |
|                                | Contractual                    | \$ 70,000         | \$ 70,000         |
|                                | <b>Year 2 Subtotal</b>         | <b>\$ 174,901</b> | <b>\$ 238,592</b> |
| <b>Year 3</b>                  | Direct Labor Salary and Fringe | \$ 58,041         | \$ 116,081        |
|                                | Other Expenses                 | \$ 56,738         | \$ 56,551         |
|                                | Contractual                    | \$ 70,000         | \$ 70,000         |
|                                | <b>Year 3 Subtotal</b>         | <b>\$ 184,779</b> | <b>\$ 242,632</b> |
| <b>Years 1 and 2 Total</b>     |                                | <b>\$ 347,415</b> | <b>\$ 473,243</b> |
| <b>Years 1 through 3 Total</b> |                                | <b>\$ 532,194</b> | <b>\$ 715,875</b> |

A more detailed budget for each year is included in Appendix 7.

## 4.2.8 MEANS FOR TRACKING, MEASURING, AND REPORTING PROGRESS

Regular communication is critical to successful project tracking and monitoring. To that end, the project director should provide progress reports to the following groups on a regular basis:

- Implementation “oversight coalition”
- External stakeholder groups
- Wisconsin’s eHealth Board

The project director should report to the oversight coalition, the eHealth Board, and selected stakeholder groups at key milestones identified in the timeline. (These milestones may be uniform or may vary based on each group’s role in the initiative.) Reports should highlight progress against the timeline, changes to the overall scope of the proposed law changes, additional barriers the initiative faces, and efforts to address barriers to date.

The project team should identify metrics to measure the effectiveness of the media campaign in persuading selected audiences that the proposed changes are for the betterment of health in Wisconsin. Hard and soft measures should be combined to gauge whether the initiative has secured bipartisan support. The project team should also monitor and report the time required to adopt and implement the proposed changes as a metric of success.

The project team should ensure that metrics are posted on the project Web site and updated periodically as fresh data becomes available.

#### **4.2.9 IMPACT ASSESSMENT ON ALL AFFECTED STAKEHOLDERS (INCLUDING SMALL AND RURAL PROVIDERS)**

The proposed changes to Wisconsin Statutes chapter 146 will affect many stakeholder groups in the health care system. This section identifies the groups that will be affected by the proposed changes, as well as how these stakeholders will be affected. The Workgroup understands that the identified stakeholder groups should serve only as a starting point for coalition building, and encourages expansion of the proposed list as necessary.

##### **Stakeholders Affected**

###### ***Consumers/Patients***

*Expand disclosures to individuals involved in care and treatment:* This proposed change will help to facilitate communications with many people who care for aging parents, children, and others ultimately improving both communication and patient care. However, in rare but real circumstances, it may also increase the likelihood that providers will inadvertently disclose information to inappropriate parties (such as abusive spouses, parents, or children) which may have a detrimental effect on patient care processes. The group noted the need for additional discussion and stakeholder input regarding this change, possibly to create an opt-out option or another solution to minimize inadvertent disclosures.

*Modify re-disclosure restrictions:* This change will allow providers to make more informed decisions through increasing their knowledge of the patient's medical history, resulting in improved patient care. This change also should improve efficiency by decreasing the number of duplicate tests and the time patients spend waiting for providers to receive information. Some Workgroup members asserted that this change would align current practice with consumer expectations that most health information (depending on type) is shared among providers for treatment purposes. If so, this proposed change would have a nominal impact on most consumers' perceptions about the protection of their health information, although those who currently receive special protections for some of their medical information may be concerned.

*Modify requirement to document disclosures:* The Workgroup speculates that requiring less documentation of disclosures may result in more time providing care to patients. The remaining requirements will continue to assure that a patient may determine when, and to whom, his/her record has been disclosed.

###### ***Providers***

*Expand disclosures to individuals involved in care and treatment:* This change would increase providers' ability to help caregivers coordinate patient care.

*Modify re-disclosure restrictions:* This change would enable providers to deliver better care through improved information and decreased delays in treatment. Although increased availability of information would likely increase the time it takes providers to review and prepare to see patients, this increase would likely be offset by efficiency gained through complete information.

*Modify requirement to document disclosure:* The Workgroup envisions that this change would decrease providers' costs and administrative burden over the long term, which could allow more time for patient care and lower costs.

### ***Individuals Involved in the Care or Treatment of a Patient***

*Expand disclosures to individuals involved in care and treatment:* In most cases, this change makes the law consistent with current practice, creating only a nominal impact on individuals involved in the care or treatment of a patient. In cases where providers comply strictly with Wisconsin's prohibition on sharing protected health information without patient consent, however, this change will lead to a decrease in frustration for concerned families and other caregivers and an increased ability to be informed caregivers.

### ***Payers***

*Modify re-disclosure restrictions:* This change would decrease costs related to duplicative services and provide increased information when review is required for payment of services. The Workgroup expressed concern that this change may increase payers' access to information on a patient's pre-existing conditions, by increasing the amount of information available for each patient.

### ***Public health***

*Expand disclosures to individuals involved in care and treatment:* This solution would allow health care providers to involve the patient's family and other caregivers in the public health treatment process. It would also increase providers' ability to help caregivers coordinate patient care. Due to the unique setting of caregiving within public health, consideration should be given to circumstances that may include other types of non-traditional caregivers such as translators and people who sign for the deaf and hearing impaired and nutritionists.

*Modify re-disclosure restrictions:* This change would enable public health providers to deliver better care through improved information and decreased delays in treatment. It would also allow greater access to necessary, comprehensive patient information for public health purposes.

*Modify requirement to document disclosure:* The Workgroup envisions that this change would decrease public health and provider costs and administrative burden over the long term, by decreasing of time-consuming documentations of disclosures.

### ***Professional associations***

Members of the professional associations can be expected to benefit from these proposed solutions, as providers, payers, consumers, etc. Because members of professional associations will benefit, these associations will play critical roles in the implementation of each proposed change to Wisconsin Statutes chapter 146 through targeted member education, development of best practices, FAQs, etc.

## **Stakeholder Involvement**

The Workgroup noted that any change to Wisconsin law will require a strong collaboration of supporters and emphasized the importance of engaging these stakeholder groups early and often. The following list presents examples of the types of groups that should be included in this effort:

### ***Consumers***

- AARP Wisconsin
- Coalition of Wisconsin Aging Groups (CWAG)
- Community advocates
- Great Lakes Inter-Tribal Council (GLITC)
- National Alliance for the Mentally Ill (NAMI) Wisconsin
- Survival Coalition of Wisconsin Disability Organizations
- Advocacy organizations representing:
  - Mental health
  - HIV/AIDS
  - Domestic violence
  - Alcohol and other drug abuse
  - Alzheimer's disease
  - Sexual assault
  - Minority health

### ***Providers***

- Community health centers
- Local health departments
- Providers (as defined by Wisconsin Statutes section 146.82)
- Schools (public, private, and parochial)
- WIC providers

### ***Insurers***

- Health Plans/HMOs
- Payer/provider Systems (Dean, Mercy Medical, WEA Trust, etc.)
- PIC Wisconsin
- Wisconsin Insurance Alliance

### ***Businesses***

- IT vendors
- National Federation of Individual Businesses (NFIB)
- Wisconsin Manufacturers and Commerce (WMC)

### ***Labor Organizations***

- AFL-CIO
- American Federation of State, County and Municipal Employees (AFSCME)
- Service Employees International Union (SEIU)
- Wisconsin Education Association Council (WEAC)

### ***Associations***

- HIPAA Collaborative of Wisconsin (HIPAA-COW)
- Wisconsin Counties Association (Human Services Component)
- Wisconsin Health Information Management Association (WHIMA)
- Wisconsin Hospital Association
- Wisconsin Medical Society
- Wisconsin Nurses Association
- Wisconsin Public Health Association (WPHA)

- Wisconsin School Nurses Association

### **Communication with Stakeholders**

The project team should work with the oversight coalition to develop a targeted communication plan in the initial phase of the efforts to change Wisconsin Statutes chapter 146 as outlined in this report. Such a plan should outline efforts to ensure appropriate stakeholder input and facilitate stakeholder buy-in. In addition, the project team should create and maintain a project Web site. This site should include scenarios that highlight, in an understandable way, how the changes in law will affect providers, consumers, and other stakeholders. It should also have a list of Frequently Asked Questions that is updated periodically.

Once the proposed legislation is drafted, the future project team should coordinate with the oversight coalition and the eHealth Board to begin an educational campaign. This campaign should communicate the proposed changes to relevant stakeholders and emphasize their importance to health information exchange and, ultimately, to better health care for Wisconsin. The educational campaign should consider multiple avenues of communication, including newsletters, talk radio, and television commercials.

### **4.2.10 FEASIBILITY ASSESSMENT**

The proposed changes to Wisconsin Statutes chapter 146 have been developed by a broad coalition of stakeholders, many of whom have successfully sought changes to Wisconsin Statutes chapter 146 in the past. Moreover, these changes would provide improvements in Wisconsin's ability to exchange health information electronically with minimal impact on the privacy and confidentiality of personal health information. Thus, the Workgroup is confident that the proposed changes are feasible.

### **4.2.11 POSSIBLE BARRIERS TO THE IMPLEMENTATION PLAN**

The Workgroup believes that, in most cases, the proposed changes to Wisconsin Statutes chapter 146 simply reflect current practice. They would remove administrative burdens and variations in practice that impede health information exchange while maintaining the basic privacy protections that HIPAA currently provides. Moreover, they offer promise as a means of improving the quality and safety of patient care across Wisconsin.

Nevertheless, changing the law is often a time-consuming and laborious process. This can be especially true in a legislature where the houses are controlled by different parties and legislators appear largely focused on other issues. Provider resistance to change, lack of familiarity with technology, or concerns about added training needs may present additional challenges to implementing this proposed solution. Consumer concern about the implications of these changes may also present obstacles.

None of these challenges is insurmountable. With a strong and representative coalition, the future project team and its partners can build the momentum necessary to spur legislator interest and support for these changes. Focused, honest communication efforts can alleviate consumer concerns, moderate provider resistance, and help consumers and providers adjust to change.

### **4.3 Proposed Solution: Allow Disclosure of Information Protected under Wisconsin Statute Section 51.30 from Provider to Provider for Treatment Purposes**

#### **PROPOSED SOLUTION**

Amend Wisconsin Statutes section 51.30 regulating mental health, alcohol and other drug abuse (AODA), and developmental disability health care information, to allow disclosure from provider to provider for treatment purposes without patient consent.

In the absence of a modification to 42 CFR Part 2, a barrier to health information exchange will remain: the applicable sections of this more stringent federal law will still control AODA patient information and an informed consent will still be required to exchange provider-to-provider for treatment purposes except in a medical emergency.

#### **4.3.1 CONTEXT FOR THE PROPOSED SOLUTION**

Wisconsin statutes governing disclosure of personal health information to providers for treatment purposes vary by the type of health information disclosed. General health information and HIV test results can be released to providers for treatment purposes without patient consent.<sup>10</sup> Information regarding mental health, alcohol and other drug abuse (AODA), and developmental disabilities can be released to providers for treatment purposes only with a patient's written informed consent except in a medical emergency, or for the following elements to health care providers within a related health care entity: patient's name, address, date of birth, name of mental health provider(s), date of service(s), diagnosis, medications, allergies and other relevant demographic information.<sup>11</sup>

Wisconsin statutes differ from federal HIPAA Privacy regulations, which allow release of mental health, AODA, and developmental disability health care information between providers for treatment purposes without patient consent.<sup>12</sup> Like current Wisconsin law, the federal law that controls AODA treatment records, 42 CFR Part 2, requires patient consent to disclose this information to a provider for treatment purposes.<sup>13</sup> In the absence of a modification to 42 CFR Part 2, a barrier to health information exchange will remain in Wisconsin and across the country: the applicable sections of this more stringent federal law will still control AODA patient information and an informed consent will still be required to exchange provider-to-provider for treatment purposes except in a medical emergency.

In the current environment, before mental health, AODA, and developmental disability health care information may be shared:

- There must be a determination of which privacy law applies (one of the state privacy laws, HIPAA, 42 CFR Part 2, etc.)
- Once the applicable law is determined, one must determine whether or not informed consent is required.

<sup>10</sup> Wisconsin Statutes section 146.82(2)(a)2.; Wisconsin Statutes section 252.15(5)(a)2

<sup>11</sup> Wisconsin Statutes section 51.30(4)(a)8

<sup>12</sup> 45 CFR 164.506

<sup>13</sup> 42 CFR Part 2

- If informed consent is required, the consent must contain elements mandated under the applicable privacy law.

The lack of uniformity between Wisconsin privacy laws and between state and federal regulations can impede the quality of care and hinder patient safety. In addition, this lack of uniformity increases the time, complexity, and cost required to exchange health information for treatment purposes in paper and electronic environments.

Moreover, the complexities in the statutory definitions of *registration* and *treatment* records make it difficult to determine when the protections of Wisconsin Statutes section 51.30 are applied. This means that some services related to mental health, AODA, and developmental disability do not receive the additional protections afforded by Wisconsin Statutes section 51.30. For example, a mental health service provided by a psychiatrist in an inpatient psychiatric facility is protected by Wisconsin Statutes section 51.30, but a similar note for a similar service prepared by a primary care provider in a general hospital is not.

Amending Wisconsin Statutes section 51.30 to allow disclosure from provider to provider for treatment purposes without patient consent would diminish many barriers to exchange and pave the way for wide-ranging exchange for treatment purposes. Ready access to necessary health information would lead to more informed health care decisions on the part of providers, improved patient care, and a reduction in preventable medical errors. Allowing disclosure of necessary health information would also reduce the administrative burden associated with exchange, simplifying exchanges between Wisconsin providers as well as between in-state and out-of-state providers.

Although a substantial majority of the Workgroup believes strongly that necessary health information protected by Wisconsin Statutes section 51.30 should be shared between providers for treatment purposes without patient consent, this proposed change was not unanimously supported. Some Workgroup members and interested parties said that the extra protections afforded by Wisconsin Statutes section 51.30 are necessary for protecting mental health information and other health information that could result in stigma or otherwise negatively affect a patient's care if widely available.<sup>14</sup> However, many of these individuals recognized the need for providers who are providing care and treatment to access limited health care information without patient consent (e.g., medications, allergies, diagnoses, and other elements as may be deemed essential to patient care). The majority of the Workgroup agreed that retaining existing protection for parts of the patient record, such as consultation notes containing highly personal patient information written by a psychiatrist, is necessary to retain patient trust.

Ultimately, a substantial majority of the Workgroup concurred that Wisconsin Statutes section 51.30 should be modified to allow some sharing of specific treatment information deemed essential to patient care without patient consent, but in the timeframe allotted to this project, was unable to finalize which specific elements should be exchanged more broadly without consent. Therefore, the implementation plan that follows outlines a broad-based approach to developing an agreed-upon set of elements that can be exchanged without consent for treatment purposes.

The Workgroup recommends that a similar project be undertaken at the federal level to examine the merits of changing 42 CFR Part 2 and to model the Wisconsin initiative to potentially remove the consent requirement to share specific, medically necessary AODA information.

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<sup>14</sup> More detailed feedback from the group of interested parties convened to discuss this issue can be found in Appendix 2.



## 4.3.2 PLANNING ASSUMPTIONS AND DECISIONS

This implementation plan assumes that, although the proposed solution to modify Wisconsin Statutes section 51.30 is articulated, the more specific proposal identifying elements to be exchanged without patient consent has not yet been fully developed. The first phase of the implementation plan involves convening a series of meetings with a broad base of relevant stakeholders to identify the set of elements that should be shared for treatment purposes without consent. The following phases will build consensus and support among all affected parties.

## 4.3.3 IMPLEMENTATION OWNERSHIP AND RESPONSIBILITIES

Wisconsin's eHealth Board should retain overall responsibility for determining what information should be shared from provider to provider for treatment purposes without consent. The eHealth Board should appoint a project director who has responsibility for designing and implementing the process to identify this information, meet the Board's needs for timely completion, and staff the project team with the level of expertise necessary to move this initiative forward. The Workgroup emphasizes the importance of a future project team with strong facilitation, communication, process management, and analytical skills as well as staff with content expertise (health information exchange and privacy) and an understanding of Wisconsin's activities in this arena to date.

The future project team should support a newly created volunteer workgroup (called the 51.30 Workgroup in this document) charged with identifying the information that should be shared among providers for treatment purposes without consent. This 51.30 Workgroup would propose a plan for Wisconsin Statutes section 51.30 information exchange to the eHealth Board for approval. The 51.30 Workgroup could be a subgroup of the eHealth Board's Consumer Interests Workgroup or a set of individuals appointed separately. In either case, the 51.30 Workgroup should comprise individuals representing the following stakeholder groups:<sup>15</sup>

- Patients who receive treatment for mental illness, developmental disabilities, and/or AODA issues.
- Advocates for individuals who receive treatment for mental illness, developmental disabilities and/or AODA issues, such as family or patient designees, advocacy organizations, patient safety advocates, and others.
- Providers who treat individuals with mental illness, developmental disabilities, and/or AODA issues, such as psychiatrists, case workers, hospital representatives, and health care system representatives.

The 51.30 Workgroup should receive regular, ongoing consultation from individuals with expertise in the areas of privacy and security law, health information management practice, and information technology throughout their deliberations. In addition, the Workgroup should work collaboratively with those individuals charged with operationalizing the charges they recommend.

To the extent possible, members of the 51.30 Workgroup should be respected leaders in their areas of expertise who can represent and communicate to a broad spectrum of individuals within their stakeholder groups.

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<sup>15</sup> Suggested starting points for the formation of this group are outlined under section 5.2.10 of this report.

### 4.3.4 PROJECT SCOPE

The Workgroup proposes a three-step approach to changing Wisconsin Statutes section 51.30 to allow disclosure of protected health information related to mental health treatment and developmental disability among providers for treatment purposes without patient consent. (Note: This proposed change will not affect treatment information governed by 42 CFR Part 2, which requires patient consent to disclose information related to AODA treatment.) Key components of this approach include:<sup>16</sup>

1. Clarifying the specific informational elements that should be exchanged without patient consent.
2. Changing law to reflect the recommendations of the 51.30 Workgroup as approved by the eHealth Board.
3. Implementing the amended statute.

The Workgroup encourages the project team to develop a comprehensive communications and education plan to accompany each stage of these efforts. Education materials and activities must be written clearly and must be accessible to Wisconsin consumers regardless of health literacy, reading skill, computer proficiency, or geographic location. Materials and activities must address the language, educational, and cultural needs of consumers of all backgrounds appropriately (be culturally competent) and be available in a timely manner.

### 4.3.5 TASKS REQUIRED

See section 4.3.6

### 4.3.6 PROJECT TIMELINE AND MILESTONES

Key Assumptions:

1. This activity table is very high-level; there are many activities embedded in each line.
2. The process goes smoothly; all stakeholders and possible dissenters are brought on board early and support the statutory change.
3. While timelines are listed separately, some activities can occur concurrently, if there are sufficient staff resources for overlapping activities.
4. Due the difficulty in convening mental health advocates and providers and the sensitive nature of this effort, additional time may be necessary for completing Part 1 of this plan.

| Key Activities  | Duration |           |
|---|----------|-----------|
|   | Minimum  | Maximum   |
| <b><i>Part 1: Defining Wisconsin Statutes Section 51.30 Solution</i></b>                              | 6 months | 12 months |
| Draft background paper outlining the case for considering changes to Wisconsin Statutes section 51.30 |          |           |
| Form project team (staff)   |          |           |
| Convene 51.30 Workgroup   |          |           |
| Formulate Workgroup charge  |          |           |

<sup>16</sup> A detailed timeline of project tasks is available in section 5.2.6 of this report.

| Key Activities  | Duration                       |                                |
|---|--------------------------------|--------------------------------|
|   | Minimum                        | Maximum                        |
| Clarify which information should be exchanged without patient consent   |                                |                                |
| Set Workgroup guidelines and ground rules to ensure all stakeholders are heard  |                                |                                |
| Formulate Workgroup value statements  |                                |                                |
| Develop proposal(s) outlining which information should be exchanged without consent   |                                |                                |
| Hold stakeholder listening sessions (vet proposals)   |                                |                                |
| Refine proposed solution based on listening session input   |                                |                                |
| Present proposal(s) to eHealth Board; adjust as appropriate   |                                |                                |
| <b>Part 2: Preparing for Legislative Change</b>   |                                |                                |
| Develop case for necessity of proposed changes: <ul style="list-style-type: none"> <li>▪ identify supporters and opposition</li> <li>▪ develop plans to address concerns</li> <li>▪ build support for proposed changes</li> </ul>   | 4 months                       | 8 months                       |
| Identify legislative sponsor(s), DHFS sponsor, and content expert(s)  | (concurrent with above period) | (concurrent with above period) |
| Hold listening sessions to discuss proposed changes ( <i>See Part 3</i> )   | See Part 3 timeline            | See Part 3 timeline            |
| Refine proposed changes to reflect stakeholder input ( <i>See Part 3</i> )  | See Part 3 timeline            | See Part 3 timeline            |
| Fine-tune specific legal changes identified (i.e., develop sample language)   | 1 week                         | 2 weeks                        |
| Ask legislative sponsor(s) to request that the Legislative Reference Bureau research and draft formal legal language.   | 4 weeks                        | 6 weeks                        |
| Review legislation as drafted by Legislative Reference Bureau   | 1 week                         | 2 weeks                        |
| Obtain fiscal note from the Department  | 2 weeks                        | 3 weeks                        |
| Monitor, manage, and nurture proposed changes through the legislative process: ( <i>See Part 4</i> ) <ul style="list-style-type: none"> <li>▪ identify who will appear in support of the change(s) at committee public hearings around the state</li> <li>▪ prepare talking points if asked to do so</li> </ul> | See Part 4 timeline            | See Part 4 timeline            |
| Determine who will interact with Governor's staff; have these persons request that Governor sign the bill when it is sent to his desk by the Legislature.   | 1 week                         | 2 weeks                        |
| <b>Part 3: Building Stakeholder Involvement</b>   |                                |                                |
| Identify stakeholder groups that can provide input  | 3 months total                 | 5 months total                 |
| Identify areas where external input is most critical  |                                |                                |
| Align stakeholders with areas requiring input   |                                |                                |
| Invite input from a broad set of stakeholders   |                                |                                |
| Seek endorsements from involved stakeholder groups  |                                |                                |

| <b>Key Activities</b>   | <b>Duration</b> |                |
|---|-----------------|----------------|
|   | <b>Minimum</b>  | <b>Maximum</b> |
| <b><i>Part 4: Communicating the Proposed Solution</i></b>   | 3 months total  | 5 months total |
| Identify all stakeholder groups affected by the proposed changes  |                 |                |
| Determine communication needs of each group   |                 |                |
| Build communication plan for each stakeholder group   |                 |                |
| Develop communication pieces  |                 |                |
| Build Web site for project updates and all communication materials  |                 |                |
| Deliver communications throughout the legislative process   |                 |                |
|   |                 |                |
| <b><i>Part 5: Training and Education</i></b>  |                 |                |
| Determine how law changes will affect organizational policies and procedures  | 2 weeks         | 3 weeks        |
| Develop training materials to communicate law changes to providers  | 6 weeks         | 8 weeks        |
| Develop outreach materials to communicate law changes to consumers  | 3 weeks         | 4 weeks        |
| Build Web site with training materials for providers and with consumer information  | 6 weeks         | 8 weeks        |
|   |                 |                |
| <b><i>Part 6: Next Steps</i></b>  |                 |                |
| Develop administrative rules, if necessary ( <i>See Part 7</i> )  | 10 months       | 12 months      |
| Continue study of Wisconsin Statutes section 51.30 and its impacts on health information exchange   | Ongoing         | Ongoing        |
| Maintain Web site with training and educational materials   | Ongoing         | Ongoing        |
|   |                 |                |
| <b><i>Part 7: Administrative Rule Promulgation</i></b>  |                 |                |
| Brief Secretary's Office on need for rules or changes   | 1 day           | 1 week         |
| Submit Statement of Scope to Department Rules Manager   | 1 day           | 1 week         |
| Establish stakeholder advisory group and solicit input  | 1 month         | 2 months       |
| Complete draft rules, summary which includes the small business fiscal analysis, and fiscal estimates; submit to Department Rules Manager                                     | 3 months        | 4 months       |
| Periodically, brief the Secretary's Office on status of rulemaking – Clearinghouse review, Public Hearing dates and locations, Public Hearing Comments and Legislative Review | Ongoing         | Ongoing        |
| Complete the public hearing notice and submit to Department Rules Manager for approval  | 1 week          | 2 weeks        |
| Hold Public Hearings  | 2 months        | 3 months       |
| Submit legislative report to the Rules Manager  | 1 month         | 2 months       |
| Determine anticipated effective date of approved rules  | 2 months        | 2 months       |

With minimum staffing, the time frame to complete these tasks is, at a minimum, 3 years with administrative rule change, and 2 year without. At a maximum, these tasks could take 4 years with administrative rule change and 3 years without.

### 4.3.7 PROJECTED COST AND RESOURCES REQUIRED

The collaborative, transparent process the Workgroup recommends to identify the information that should be shared among providers for treatment purposes without consent is likely to be time- and resource-intensive. Thus, the Workgroup emphasizes the importance of dedicated resources to:

- Reimburse 51.30 Workgroup members for travel and lodging
- Host meetings and listening sessions throughout Wisconsin
- Engage highly-skilled project staff dedicated to this initiative and the stakeholders involved

The key assumptions in developing the costs and resources needed were:

- Staff resources would consist of a 0.5 to 1.0 full time employees.
- Contract staff may be necessary when specific expertise is needed. A flat contracting amount has been budgeted to cover these costs.
- Projected costs are provided for the optional third year. Identifying timelines within the legislative process is challenging, so a range of costs for this effort in the event that the project takes longer than anticipated.
- For each year of this project, a cost increase of 2.5% was included.

|               | Category                       | Minimum           | Maximum           |
|---------------|--------------------------------|-------------------|-------------------|
| <b>Year 1</b> | Direct Labor Salary and Fringe | \$ 55,244         | \$ 110,488        |
|               | Other Expenses                 | \$ 53,270         | \$ 60,163         |
|               | Contractual                    | \$ 70,000         | \$ 70,000         |
|               | <b>Year 1 Subtotal</b>         | <b>\$ 178,514</b> | <b>\$ 240,651</b> |
| <b>Year 2</b> | Direct Labor Salary and Fringe | \$ 56,625         | \$ 113,250        |
|               | Other Expenses                 | \$ 54,601         | \$ 61,667         |
|               | Contractual                    | \$ 70,000         | \$ 70,000         |
|               | <b>Year 2 Subtotal</b>         | <b>\$ 181,226</b> | <b>\$ 244,917</b> |
| <b>Year 3</b> | Direct Labor Salary and Fringe | \$ 58,041         | \$ 116,081        |
|               | Other Expenses                 | \$ 65,794         | \$ 63,209         |
|               | Contractual                    | \$ 70,000         | \$ 70,000         |
|               | <b>Year 3 Subtotal</b>         | <b>\$ 193,835</b> | <b>\$ 249,290</b> |
| <b>Year 4</b> | Direct Labor Salary and Fringe | \$ 47,628         | \$ 118,983        |
|               | Other Expenses                 | \$ 79,282         | \$ 64,789         |
|               | Contractual                    | \$ 70,000         | \$ 70,000         |
|               | <b>Year 3 Subtotal</b>         | <b>\$ 196,910</b> | <b>\$ 253,772</b> |

**Years 1 through 3 Total** \$ 553,576 \$ 734,858  
**Years 1 through 4 Total** \$ 750,486 \$ 988,631

A more detailed breakdown of costs can be found in Appendix 8.

### 4.3.8 MEANS FOR TRACKING, MEASURING, AND REPORTING PROGRESS

Regular communication is critical to successful project tracking and monitoring. To that end, the Workgroup recommends that the future project team use creative means to disseminate information in a

timely and accessible manner. The Workgroup also recommends that the future project team provide the following groups with regular updates on this initiative on behalf of the 51.30 Workgroup:

- External stakeholder groups
- Wisconsin's eHealth Board and any appropriate advisory groups (e.g., Consumer Interests and Privacy Advisory Group)

On behalf of the 51.30 Workgroup, the project director should report progress to the eHealth Board and designated stakeholder groups at key milestones identified in the timeline (these milestones may be uniform or vary based on each group's role in the initiative). Reports should highlight progress against the timeline; changes to the overall scope of the proposed law changes; additional barriers the initiative faces; and efforts to address these additional barriers.

The future project team should identify metrics to measure the effectiveness of the media campaign in persuading selected audiences that the proposed changes will improve the health of Wisconsin residents. Quantitative and qualitative (or process and outcome) measures should be combined to gauge whether the initiative has secured bipartisan support. The future project team should monitor and report the time required to adopt and implement the proposed changes as compared to the established timeline as a metric of success.

The Workgroup recommends that the future project team develop a Web site, and ensure that information relating to this initiative (including metrics, milestones, and progress) are posted in a timely manner and updated frequently.

#### **4.3.9 ASSESSMENT OF IMPACT ON STAKEHOLDERS**

This section begins by identifying stakeholder groups that Workgroup members believe will be affected by this initiative as well as the ways they will be affected. It then notes specific organizations that should be invited to comment on the proposed changes. The Implementation Workgroup emphasizes that the identified stakeholder groups are the result of brainstorming and are intended to serve as a starting point for future coalition-building. The Workgroup encourages the future project team and participating stakeholders to expand the proposed list as they deem necessary.

##### **Stakeholders Affected**

###### ***Consumers***

Amending Wisconsin Statutes section 51.30 to allow disclosure from provider to provider for treatment purposes without patient consent will affect individuals and entities who are consumers or purchasers of health care services.

###### ***Patients***

Amending Wisconsin Statutes section 51.30 to allow disclosure from provider to provider for treatment purposes without patient consent will have a significant impact on patients with health information protected by this statute, and a limited impact on other patients. In many cases, more open exchange of patient information will lead to improved patient care, decreased medical errors, and higher quality services. In other cases, patients' concern over stigma and the lack of control over who accesses their health information could deter individuals from seeking needed care or motivate patients to withhold information relevant to their care. Initiating a transparent, collaborative process in developing the changes to Wisconsin Statutes section 51.30 will increase patient comfort with this proposed change.

### ***Providers***

Amending Wisconsin Statutes section 51.30 to allow disclosure from provider to provider for treatment without patient consent could dramatically improve the timeliness with which a provider can access patient information and the provider's knowledge of a patient's health care status, enabling providers to deliver better patient care with fewer medical errors. Because providers' access to information regarding mental health treatment will be increased, they will need to be more cognizant of the potential for stigma in the treatment they provide.

### ***Advocates***

Advocates are a trusted source of information for many patients and families. Thus, as this process goes forward, it will be important for advocates to increase their knowledge of the regulations governing disclosure of patient information as well as the risks and benefits of changing these regulations.

Advocates also represent a diverse mix (e.g., patients, families, etc.) with a variety of opinions. If all patients and families do not perceive the proposed legal changes in the same way, advocates will be challenged to represent the full range of opinions they hear from their members.

### ***Individuals Involved in the Care or Treatment of a Patient***

Providers would have increased access to a patient's health care information as a result of the proposed change. Therefore, caregivers would be required to retain and provide less information to ensure continuity of care. Presumably, caregivers could also provide better care if they need to spend less time keeping track of patient information.

### ***Payers***

Allowing providers increased access to patient health information could potentially lead to a decrease in patient service costs (e.g., for duplicative services) and improved care. Ultimately, this change could lead to cost efficiencies, and potentially cost reductions.

### ***Government***

A significant number of Wisconsin government agencies or government-related agencies provide services related to mental health, developmental disability, and AODA, including: the Department of Workforce Development (DWD); the Department of Regulation and Licensing; the Department of Public Instruction (DPI); the Department of Corrections (DOC); and the Department of Health and Family Services (DHFS). Each of these agencies may have to adjust policies and procedures governing disclosure of health information to reflect changes in the law.

### ***Professional Associations***

The Workgroup expects that professional associations will play critical roles in the implementation of any proposed changes through targeted member education, development of best practices, frequently asked questions, etc.

### **Stakeholder Involvement**

The Workgroup noted that any change to Wisconsin law will require a strong collaboration of supporters and emphasized the importance of stakeholder groups early and often. The list below presents examples of the types of groups that should be included in this effort. Groups that should be considered as a starting point for membership on the 51.30 Workgroup are marked with an asterisk (\*).<sup>17</sup>

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<sup>17</sup> The 51.30 Workgroup will be charged with identifying which information should be exchanged without patient consent.

### ***Consumers***

- AARP Wisconsin \*
- Arc-Wisconsin Disability Association (formerly the Wisconsin Association for Retarded Citizens) \*
- Coalition of Wisconsin Aging Groups (CWAG) \*
- Community Advocates
- Developmental Disability Council (DD Council) \*
- Disability Rights Wisconsin (DRW) \*
- Grassroots Empowerment Project \*
- Great Lakes Inter-Tribal Council (GLITC)
- Mental Health Association \*
- National Alliance for the Mentally Ill (NAMI) Wisconsin \*
- Survival Coalition of Wisconsin Disability Organizations
- Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA) \*
- Wisconsin Family Ties (WFT) \*
- Other advocacy organizations representing: \*
  - Mental health
  - HIV/AIDS
  - Domestic violence
  - Alcohol and other drug abuse
  - Alzheimer's disease
  - Sexual assault
  - Minority health

### ***Providers***

- Community health centers
- County mental health providers \*
- Hospital personnel \*
- Health information managers \*
- Local health departments
- Providers (as defined by Wisconsin Statutes section 146.82)
  - Family practitioners/primary care providers\*
  - Psychiatrists \*
  - Psychologists \*
  - Social workers \*
  - Nurses
  - Emergency medical personnel
- Schools (public, private, and parochial)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) providers

### ***Insurers***

- Health Plans/HMOs
- Payer/provider systems (Dean, Mercy Medical, WEA Trust, etc.)
- PIC Wisconsin
- Wisconsin Insurance Alliance

### ***Businesses***

- Information Technology (IT) vendors
- National Federation of Individual Businesses (NFIB)



- Wisconsin Manufacturers and Commerce (WMC)

#### ***Labor Organizations***

- AFL-CIO
- American Federation of State, County and Municipal Employees (AFSCME)
- Service Employees International Union (SEIU)
- Wisconsin Education Association Council (WEAC)

#### ***Associations***

- HIPAA Collaborative of Wisconsin (HIPAA-COW)
- Wisconsin Counties Association (Human Services Component)
- Wisconsin Health Information Management Association (WHIMA)
- Wisconsin Hospital Association (WHA)
- Wisconsin Medical Society (WMS)
- Wisconsin Nurses Association (WNS)
- Wisconsin Psychiatric Association
- Wisconsin Public Health Association (WPHA)
- Wisconsin School Nurses Association

### **Communication with Stakeholders**

The future project team should work with the 51.30 Workgroup to develop a targeted communication plan in the first phase of this initiative. Such a plan should outline efforts to ensure appropriate stakeholder input and build stakeholder support. In addition, the future project team should create and maintain a project Web site, updating it regularly. Materials presented on this Web site should be written in clear, understandable language and should include:

- Scenarios that demonstrate how the changes in law will affect providers, consumers, and other stakeholders
- A list of “frequently asked questions” that is updated as needed
- Reports relevant to the project
- A list of contact persons who are trained to answer questions about the project

Once the proposed legislation is drafted, the future project team should coordinate with the 51.30 Workgroup and the eHealth Board to design an educational campaign to gather legislative support. This educational campaign should communicate the proposed changes and emphasize their importance to health information exchange and, ultimately, to better health care for Wisconsin. The educational campaign should consider multiple avenues of communication, including newsletters, talk radio, and public service announcements.

### **4.3.10 FEASIBILITY ASSESSMENT**

In its assessment of the feasibility of amending Wisconsin Statutes section 51.30 to allow disclosure from provider to provider for treatment purposes without patient consent, the Workgroup explored a number of options for implementing this solution. These options fell into a continuum, from allowing exchange of limited elements between treating providers to allowing full disclosure of patient information between providers for treatment purposes without patient consent (per HIPAA).

The following section describes each option and summarizes the assessment completed by the Workgroup. The options are ordered from the most politically feasible to the least. In general, moving from Option One to Option Two, etc., increases the information available to providers and the quality of care, while it decreases patients' control of their own records. Option one, *maintain Wisconsin Statutes section 51.3 as written today*, was not discussed as an implementation option, but is documented in this report to demonstrate the risks and benefits of maintaining the status quo.

In addition to the options outlined below, the Workgroup discussed the possibility of amending Wisconsin Statutes section 51.30 to clarify which records the statute protects. Although this option was not discussed in enough detail to provide a thorough description or feasibility analysis, the Workgroup feels strongly that it should be considered by the 51.30 Workgroup and other decision-makers going forward.

***Option 1. Maintain Wisconsin Statutes section 51.30 as written today.***

**Description** This option requires informed consent to share mental health, developmental disability and AODA treatment information, except:

1. In case of medical emergency; and
2. When exchanging between providers within a related health care entity. In this case, the following is allowed to be exchanged without consent:
  - Name
  - Address
  - Birth date
  - Name of mental health provider(s)
  - Date of service(s)
  - Diagnosis
  - Medications
  - Allergies
  - Other relevant demographic information

**Risks** The risks of maintaining Wisconsin Statutes section 51.30 as written today include:

- Reduced patient safety and quality of care with lack of information sharing
- False sense of security that all mental health, developmental disability, and AODA records are protected when there is great variability in the protections employed
- Lack of compliance leading to practice variability
- More complexity associated with maintaining and exchanging information in an electronic medical record system; separating information that cannot be exchanged and applying “minimum necessary” is likely to result in increased costs that are not supported by health care organizations
- Higher costs of exchange
- Difficulty in exchanges with other states due to confusion over conflicting laws

**Benefits** The benefits of maintaining Wisconsin Statutes section 51.30 as written today include:

- No new legislation
- No change in policy or practice
- No additional work
- Protection of “sensitive” patient information (e.g., nominal likelihood it will be exchanged with the wrong party)
- Patient control of “sensitive” patient information through the requirement for patient consent prior to information sharing
- No additional controversy

**Option 2. *Remove reference to “in a related health care entity” in Wisconsin Statutes section 51.30(4)(b)8g to allow broader exchange of specific elements provider-to-provider for treatment purposes.***

**Description** This option would allow exchange among all health care providers for treatment purposes but would limit exchange to the specific elements currently allowed to be exchanged among treatment providers within a related health care entity without consent.<sup>18</sup>

AODA treatment information would continue to be governed by 42 CFR Part 2; this modification would make 42 CFR the more stringent law. As the more protective law, 42 CFR would control and patient consent would still be required to exchange AODA information except in a medical emergency.<sup>19</sup>

**Risks** Removing the reference to “in a related health care entity” in Wisconsin Statutes section 51.30 to allow providers to exchange a limited set of elements without consent would create the following risks:

- Reduced patient safety and quality of care with lack of information sharing
- Decreased patient control of protected health information (PHI)
- False sense of security that all current mental health, developmental disability, and AODA records are protected when there is great variability in the protections employed
- More complexity associated with maintaining and exchanging information in an electronic medical record system; separating information that cannot be exchanged and applying “minimum necessary” is likely to result in increased costs that are not supported by health care organizations
- Difficulty in exchanges with other states due to confusion over conflicting laws
- Difficult and time-consuming process to change law

**Benefits** Removing the reference to “in a related health care entity” in Wisconsin Statutes section 51.30 to allow providers to exchange a limited set of elements without consent would improve the ability to exchange information compared to what is allowed today. Specific benefits would include:

- Improved quality of care with availability of more information
- Decreased administrative burden from elimination of consent requirement for a specific set of elements

<sup>18</sup> As outlined in Wisconsin Statutes section 51.30(4)(b)8g.

<sup>19</sup> 42 CFR Part 2: No statutory authority for disclosure to providers except in a medical emergency.

- Improved ability to share information
- Better decision-making with availability of more information
- Reduced medication errors
- Improved ability to patients progress over time
- Decreased frustration for patients and family
- Improved coordination of care

**Comparison:**

**Option 1**

- Improved patient safety; however, barriers to exchange remain
- Decreased potential for patients to seek care for mental illness
- Increased potential for discrimination
- Potential decreased trust between patient and health care provider

**Option 3.** *Revise Wisconsin Statutes section 51.30 to mirror the language in Wisconsin Statutes section 146.82(2)(a)2, allowing the exchange of patient information between providers for treatment purposes without patient consent.*

**Description** This option would allow all patient information to be exchanged without consent between providers for treatment purposes as currently defined by Wisconsin Statutes chapter 146. If the modification is made to Wisconsin Statutes section 51.30, the “minimum necessary” standard relating to disclosure of patient information would still apply.<sup>20</sup>

AODA treatment information would continue to be governed by 42 CFR Part 2. Consent would still be required to exchange this information except in a medical emergency.

**Risks** Increasing the amount of information that can be exchanged without patient consent to the “minimum necessary” by changing Wisconsin Statutes section 51.30 to mirror Wisconsin Statutes section 146.82(2)(a)2 would create additional risks, including:

- Decreased patient control of protected health information (PHI)
- More complexity associated with maintaining and exchanging information in an electronic medical record system; separating information that cannot be exchanged and applying “minimum necessary” is likely to result in increased costs that are not supported by health care organizations
- Simpler to exchange with other states, but confusion over laws will remain
- Difficult and time-consuming process to change state law

**Benefits** Increasing the amount of information that can be exchanged between providers without patient consent to the “minimum necessary” by changing Wisconsin Statutes section 51.30 to mirror Wisconsin Statutes section 146.82(2)(a)2 would improve providers’ ability to exchange information and would create additional benefits, including:

- Improved quality of care with availability of more information
- Improved patient safety
- Better decision-making with availability of more information
- Improved ability to share information

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<sup>20</sup> HFS 92.03(n)

- Improved communication of patient conditions
- Improved compliance with law
- Improved patient understanding of privacy protections
- Better aligned patient/provider perceptions/expectations

**Comparison:  
Option 2**

- Improved patient safety
- Improved ability to share information
- Improved quality of care with availability of more information
- Better decision-making with availability of more information
- Reduced medication errors
- Improved ability to follow patient progress over time
- Decreased frustration for patients and family
- Improved coordination of care
- Decreased administrative burden associated with obtaining consent
- Decreased potential for patients to seek care for mental illness
- Increased potential for discrimination
- Potential decrease in trust between patient and health care provider

**Option 4. *Revise Wisconsin Statutes section 51.30 to comport with HIPAA regarding exchange between providers for treatment purposes.***

**Description** This option would allow all patient information to be exchanged between providers for treatment purposes without consent except for HIPAA-defined “psychotherapy notes,” which would still require patient consent.<sup>21</sup> The “minimum necessary” standard relating to disclosure of patient information would still apply.<sup>22</sup>

AODA treatment information would continue to be governed by 42 CFR Part 2. Consent would still be required to exchange this information except in a medical emergency.

**Risks** If Wisconsin Statutes section 51.30 is revised to comport with HIPAA regarding exchange between providers for treatment purposes, the “minimum necessary” standard relating to disclosure of patient information would still apply.<sup>23</sup> Additional risks would include:

- Decreased patient control of protected health information (PHI)
- Decreased potential for patients to seek care for mental illness
- Increased potential for discrimination
- Possibly provides too much information so providers have difficulty identifying the most important information in a timely manner, although this risk is mitigated by retention of the minimum necessary standard.
- Difficult and time-consuming process to change state law

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<sup>21</sup> 45 CFR 164.506(a) and (c)(2)

<sup>22</sup> HFS 92.03(n), Wis. Admin. Code

<sup>23</sup> HFS 92.03(n), Wis. Admin. Code

**Benefits**

Revising Wisconsin Statutes section 51.30 to comport with HIPAA allows a more open exchange than previous law. Minimum necessary in Wisconsin Statutes section 51.30 would still apply and limit free exchange of this information and a consent would still be required for 42 CFR Part 2. Benefits would include:

- Improved patient safety
- Improved ability to share information
- Improved quality of care with more information available
- Better decision making with more information available
- Reduced medication errors
- Improved ability to follow patient progress over time
- Decreased frustration of patients and family
- Improved coordination of care
- Decreased administrative burden of obtaining consent
- Improved compliance with law
- Improved patient understanding of privacy protections
- Better aligned patient/provider perceptions/expectations
- Simplified requirements for electronic medical records (EMRs)

**Comparison  
Option 3:**

- Improved patient safety
- Improved ability to share information
- Improved quality of care with more information available
- Better decision making with more information available
- Reduced medication errors
- Improved ability to follow patient progress over time
- Decreased frustration of patients and family
- Improved coordination of care
- Decreased administrative burden of obtaining consent
- Decreased potential for patients to seek care for mental illness
- Increased potential for discrimination
- Potential decreased trust between patient and health care provider

**4.3.11 POSSIBLE BARRIERS TO THE IMPLEMENTATION PLAN**

This proposed solution removes a perceived privacy protection provided by Wisconsin Statutes section 51.30. In 1977, mental health advocates and their supporters in Wisconsin fought to create the law—and have recently expressed support for the law as currently written. A recent change to Wisconsin Statutes section 51.30 expanded sharing of information between providers, allowing the exchange of specific elements between providers in a related health care entity. It expanded the ability to share information but stopped short of allowing providers to share all information or to share this limited information outside a related health care entity.

Engaging all appropriate stakeholders to develop proposed changes to the law will greatly improve the chances for a successful initiative. If consensus can be reached by all parties, the legislative changes necessary to implement the proposed solution may pass without difficulty.

## Section 5 – Multi-State Implementation Plans

The proposed solution to improve the verification of patient identity has two parts. While the first component is Wisconsin-specific, and does not depend on actions in other states, the second component clearly depends on national efforts and is specifically intended to further multi-state exchange.

### 5.1 Statewide Strategy and Coordination

As with the statewide implementation plans discussed above, Wisconsin's eHealth Board should oversee implementation of this recommendation. Verifying the identity of the patient is a necessary step in information exchange. Therefore, implementation of the plan to improve the verification of patient identity as outlined in this report should be a component of the eHealth Board's broader plan to achieve electronic exchange of information in the next five years.

### 5.2 Recommended Solution: Verification of Patient Identity

#### PROPOSED SOLUTION

The Workgroup advocates a two-part solution to improve the identification and verification of the patient:

1. Create model policies and procedures to ensure appropriate capture of patient identifiers, verification of patient identifiers, and match of patient identifiers with patient information in a health care system.
2. Adopt national standards for patient identification once defined and accepted.

#### 5.2.1 CONTEXT FOR PROPOSED SOLUTION

Currently, providers do not use a uniform method to capture standardized criteria to identify a patient (patient identifiers).<sup>24,25</sup> Moreover, there is no standard method to verify patient identifiers at the time of exchange.<sup>26</sup> This lack of standardization creates significant risks to accurate and timely patient care. Variation in practice also poses a number of challenges to exchanging information in a paper or electronic format:

- Criteria used to identify or verify patients in one provider practice might not be used or available in another practice;
- Accurate identification of a specific patient is difficult and complicated when sending and receiving information;
- Misidentification of patients could lead to medical errors such as the wrong treatment for the wrong patient, inaccurate records for an individual, and therefore, inaccurate continuity of care; and

<sup>24</sup> Capture: The process of collecting patient identifiers from a patient.

<sup>25</sup> Patient Identifiers are information collected from a patient to assist in the identification of the patient (e.g., name, birth date, address, etc.)

<sup>26</sup> Verification: The process of confirming that patient identifiers are correct.

- Misidentification of patients may create liability for inappropriate disclosure and inappropriate treatment.

Moving into an electronic world, where information is exchanged between electronic health care information systems, will require standardized collection of patient identifiers and verification of patient identifiers and accurate matching of identifiers to patient information.

## 5.2.2 PLANNING ASSUMPTIONS AND DECISIONS

A number of national organizations are convening experts and building coalitions to address issues surrounding verification of patient identity at the national level. The Confidentiality, Patient Safety, and Privacy Workgroup of the American Health Information Community (AHIC), for example, recently released recommendations regarding patient identity proofing, which they define as ‘the process of providing sufficient information to correctly and accurately establish and verify an identity to be used in an electronic environment.’<sup>27</sup> The Markle Foundation’s Connecting for Health Initiative devoted an entire policy guide of its Common Framework to ‘Correctly Matching Patients with Their Records.’<sup>28</sup> The second part of this proposed solution, the utilization of nationally established patient identification criteria (patient identifiers), requires ongoing monitoring of efforts like these to facilitate timely adoption of national patient identifiers when available.

Recognizing the importance of a well-researched nationwide approach to identification and verification of patient identity, the Implementation Workgroup chose to focus its efforts on a Wisconsin-specific approach that could be implemented simultaneously with the monitoring of national identifiers. The Workgroup recommends developing model policies and procedures to ensure appropriate capture and verification of patient identifiers and accurate patient identification within Wisconsin. These efforts for a Wisconsin-specific solution will alleviate existing patient identification challenges by streamlining and standardizing work processes in this area, laying the groundwork for successful electronic health information exchange and swift adoption of national standards once they become available.

The Workgroup identified several issues important to the process of patient identification and verification and relevant to the adoption of model policies but outside the scope of this implementation plan. The Workgroup recommends further consideration of the following questions as Wisconsin develops its model policies and procedures:

- Will the proposed model policies support the aggregation of data required to meet the state’s public health responsibilities?
- Should compliance with these model policies and procedures provide health care providers with legal protection in case of wrongful disclosure?
- Should compliance with these model policies and procedures be a prerequisite for participation in any state-supported health information exchanges?

The Workgroup also recommended revisiting Wisconsin statutes to ensure that these model policies and procedures do not conflict with existing law.

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<sup>27</sup> For additional information, see: [http://www.hhs.gov/healthit/ahic/materials/01\\_07/cps/draft\\_recs.doc](http://www.hhs.gov/healthit/ahic/materials/01_07/cps/draft_recs.doc)

<sup>28</sup> For additional information, see: <http://www.connectingforhealth.org/commonframework/#guide>



### 5.2.3 PROJECT OWNERSHIP AND RESPONSIBILITIES

The Wisconsin eHealth Board should have overall responsibility for this recommendation. This responsibility includes oversight of major decisions and guidance to ensure project success.

The eHealth Board or its delegated advisory groups should appoint a project director who is responsible for establishing the timeline, managing the project to the timeline, and staffing the future project team. The Implementation Workgroup recommends that the eHealth Board Chief of Staff or her appointee serve as the project director under the direction of the Board.

The project director should convene a workgroup of stakeholders in a transparent, collaborative process to develop the model policies and procedures. The Implementation Workgroup drafted the model policies and procedures as a starting point for this group (see Appendices 3 and 4).

To be widely adopted, model policies and procedures must be accurate, comprehensive, and appropriate to the current landscape. Thus, the project director and the staff should have a deep understanding of national efforts and a firm grasp of local sentiment in this arena. This should be continually communicated to the stakeholder workgroup charged with defining model policies and procedures.

### 5.2.4 PROJECT SCOPE

The Verification of Patient Identification project contains two parts that should happen concurrently, with a high level interaction between the two:

1. **Create model policies and procedures to ensure appropriate capture of patient identifiers, verification of patient identifiers, and match of patient identifiers with patient information in a health care system.**

Model policies and procedures should:

- a. Clearly define the criteria (identifiers) needed to identify an individual patient accurately.
- b. Outline clear policies and procedures to capture patient identifiers.
- c. Outline clear policies and procedures to maintain and retain patient identifiers.
- d. Outline clear policies and procedures to verify patient identifiers (confirm validity of existing identifiers).
- e. Outline clear policies and procedures to match patient identity to patient information in an electronic and/or paper system.

Adoption of these model policies and procedures should be strongly encouraged, but based on current knowledge, the Implementation Workgroup recommends that these policies not be mandated by law. Thus, the eHealth Board or its designees should:

- a. Issue a white paper describing the model policies and procedures and emphasizing their importance, particularly as they relate to patient safety and quality of care.
- b. Work with the Department of Health and Family Services (DHFS) to issue recommended guidance regarding the model policies and procedures that encourages their statewide adoption.
- c. Partner with professional associations and others to educate all stakeholders, state agencies, and affected organizations on the model policies and procedures.

- d. Build public awareness of the importance of adopting the policies and procedures.
- 2. Adopt national standards for patient identification once the standards have been defined and accepted.**

Wisconsin should move swiftly to adjust its model policies and procedures to reflect national standards when they are available.

### 5.2.5 TASKS REQUIRED

Tasks required to complete the project are outlined in the table in Section 5.2.6.

### 5.2.6 PROJECT TIMELINE AND MILESTONES

The following table is a proposed timeline for implementing this proposed solution.

| <b>Key Activities</b>   | <b>Minimum</b>         | <b>Maximum</b>         |
|---|------------------------|------------------------|
| <b><i>Part 1: Create model policy and procedure to facilitate collection and validation of patient identification</i></b> | <b><i>4 months</i></b> | <b><i>6 months</i></b> |
| Identify stakeholder groups that can provide input  |                        |                        |
| Create project structure/framework (governance structure, workgroups, project reporting, etc.)                            |                        |                        |
| Clarify definition and scope of key project terms (verification, etc.)  |                        |                        |
| Develop value statements to inform model policy development   |                        |                        |
| Agree on identifiers to be captured/validated/verified/matched  |                        |                        |
| Draft model for capture/validation/verified/matched   |                        |                        |
| Identify stakeholders who will be affected by the policies and procedures   |                        |                        |
| Hold listening sessions to validate identifiers and model policies and procedures   |                        |                        |
| Revise as appropriate   |                        |                        |
|   |                        |                        |
| <b><i>Part 2: Impact analysis on Electronic Systems</i></b>   | <b><i>4 months</i></b> | <b><i>6 months</i></b> |
| Identify key stakeholders who either use an EMR system, or are in the business of supporting EMR systems                  |                        |                        |
| Validate identifiers and model policies and procedures with technical stakeholder team                                    |                        |                        |
| Revise as appropriate   |                        |                        |
| Identify impact/risk new policies and procedures will have on current EMR systems in place                                |                        |                        |
| Identify impact/risk national standards may have on current and future EMR systems  |                        |                        |
| Develop plan to address impact/risks identified on EMR systems  |                        |                        |
|   |                        |                        |
| <b><i>Part 3: Facilitate adoption of policies and procedures</i></b>  | <b><i>4 months</i></b> | <b><i>8 months</i></b> |
| Develop a white paper outlining the policies and procedures   |                        |                        |
| Identify key stakeholders   |                        |                        |

| <b>Key Activities</b>  | <b>Minimum</b>         | <b>Maximum</b>         |
|--|------------------------|------------------------|
| Identify vehicles for education/communications   |                        |                        |
| Identify partner organizations to assist with for education/communications                                   |                        |                        |
| Develop incentives for adoption of policies and procedures   |                        |                        |
| Authorize DHFS to issue model policies   |                        |                        |
| Develop education pieces   |                        |                        |
| Refine key messages  |                        |                        |
| Deliver communications   |                        |                        |
|  |                        |                        |
| <b><i>Part 3: Monitor national efforts to develop standardized mechanism for verification of patient</i></b> | <b><i>Ongoing</i></b>  | <b><i>ongoing</i></b>  |
| Identify groups leading national effort  |                        |                        |
| Monitor activities   |                        |                        |
| Inform oversight committee of developments   |                        |                        |
| Adjust state efforts as appropriate  |                        |                        |
|  |                        |                        |
| <b><i>Part 4: Adopt national standard</i></b>  | <b><i>2 months</i></b> | <b><i>4 months</i></b> |
| Determine if changes need to be made to policies and procedures based on national standards                  |                        |                        |
| Communicate national parameters to be collected using state model policies and procedures                    |                        |                        |

With minimum staffing, the time frame to complete these tasks is, at a minimum 14 months. The budget associated with this plan only addresses the activities necessary to develop and implement model policy and procedures. It does not take into account of the cost to modify or develop new technology systems to incorporate standard patient identifiers. Depending on the impact and risk analysis, it may not be cost effective for current EMR systems to be modified to support the Wisconsin Model in the short term if the a National Standard is in the near future.

## **5.2.7 PROJECTED COST AND RESOURCES REQUIRED**

The key assumptions in developing the costs and resources needed were:

- Staff resources would consist of a 0.5 to 1.0 full time employees for the first year, and 0.25 to 0.5 FTE for the second year.
- Contract staff may be necessary when specific expertise is needed. A flat contracting amount has been budgeted to cover these costs.
- For each year of this project, a cost increase of 2.5% was included.

|                            | Category                       | Minimum           | Maximum           |
|----------------------------|--------------------------------|-------------------|-------------------|
| <b>Year 1</b>              | Direct Labor Salary and Fringe | \$ 55,244         | \$ 110,488        |
|                            | Other Expenses                 | \$ 47,270         | \$ 54,163         |
|                            | Contractual                    | \$ 70,000         | \$ 70,000         |
|                            | <b>Year 1 Subtotal</b>         | <b>\$ 172,514</b> | <b>\$ 234,651</b> |
| <b>Year 2</b>              | Direct Labor Salary and Fringe | \$ 28,313         | \$ 5,663          |
|                            | Other Expenses                 | \$ 40,371         | \$ 44,152         |
|                            | Contractual                    | \$ 70,000         | \$ 70,000         |
|                            | <b>Year 2 Subtotal</b>         | <b>\$ 138,684</b> | <b>\$ 119,815</b> |
| <b>Years 1 and 2 Total</b> |                                | <b>\$ 311,198</b> | <b>\$ 354,466</b> |

A more detailed breakdown of costs can be found in Appendix 9.

## 5.2.8 MEANS FOR TRACKING, MEASURING AND REPORTING PROGRESS

Regular communication is critical to successful project tracking and monitoring. To that end, the Workgroup recommends that the future project team provide the following groups with regular updates on this initiative:

- Wisconsin’s eHealth Board and designated advisory groups
- Stakeholder groups (partners)

The future project team should report to the eHealth Board, designated advisory groups, and selected stakeholder groups at key milestones identified in the timeline. (These milestones may be uniform or vary based on each group’s role in the initiative.) Reports should highlight progress against the timeline, changes to the overall scope of the proposed law changes, additional barriers the initiative faces, and efforts to address barriers identified to date.

The future project team should ensure that information on progress relating to the project is transparent and available to the public, and that metrics are posted on the project Web site and updated periodically as they are refreshed.

## 5.2.9 IMPACT ASSESSMENT ON ALL AFFECTED STAKEHOLDERS (INCLUDING SMALL AND RURAL PROVIDERS)

### Impact Assessment

The overall impact of this proposed solution is far-reaching. Benefits to Wisconsin’s health care system include:

- Improved patient care
- Improved communication between patients and providers
- Improved ability to exchange information
- Readily available, accurate, timely, and complete patient health information
- Reductions in medical errors and redundancy in services provided

- Reductions in inadvertent disclosures
- Improved data for public health and research

While the benefits of this solution are far-reaching, there are also potential costs and risks. These include:

- Additional costs to providers to implement the model policies and procedures
- Treatment not sought by a relatively small group of patients who use health care services with false identities
- Difficulty in adopting national standards if Wisconsin policies and procedures are too far in front of national standards.

### **Stakeholders Affected**

The Implementation Workgroup also assessed the impact of the proposed solution on several stakeholder groups. This section of the report identifies stakeholders and summarizes how the adoption of model policies and procedures will affect them.

#### ***Patients/consumers***

Ensuring accurate patient identification and facilitating accurate identity matching will increase the safety and quality of care. In addition, regular verification of patient identifiers will help empower patients to best manage their own care and understand the importance of identifying patients with accuracy prior to their receiving care. These efforts will make the health care industry's actions consistent with other industries efforts to verify identity prior to rendering services (airlines, banks, employers, service providers, etc.).

Furthermore, patients must understand how providing accurate and updated patient identifiers will significantly improve patient safety and quality of care. Patients need to be prepared to answer the questions so their provider has the information necessary for their treatment. Many forms of media should be used to communicate these messages to consumers.

#### ***Health care providers***

Improving the accuracy of patient data by ensuring that health care information is collected on the appropriate patient and stored as part of that patient's record empowers providers to provide better care. Much of the cost and administrative burden of adopting new policies and procedures is likely to fall on health care providers. Implementation of these model policies and procedures will be most successful when it is paired with ongoing quality and safety initiatives.

Health care providers differ widely in their complexity and available resources (e.g., urban vs. rural, large facility vs. solo practitioner, etc.). Wisconsin's model policies and procedures should account for this variation. Appropriately designed standards for collecting, verifying, and matching patient identifiers will ensure that providers have access to the same information on all patients.

#### ***Public health***

Improving the accuracy of patient identification will increase the ability to aggregate patient information and track individuals through episodes of care. This will enable public health professionals to better visualize best practices, advocate for excellence in patient care, and protect the health of the community.

#### ***Payers***

Improving the accuracy of patient identification will improve the accuracy of health care billing processes and minimize costs associated with the accurate identification of patients, recipients of services, and

health care services provided. Furthermore, improving the quality of care through better data capture may ultimately lead to lower costs of patient care, which may incrementally reduce rising health care expenses.

### **Stakeholder Involvement**

The Workgroup believes that patients and providers will be significantly benefited by the adoption of model policies and procedures to standardize patient identification. To this end, providers and consumers should be invited to participate in working sessions to help draft the model policies and procedures. A media campaign should be developed to communicate to these stakeholder groups early and often through the life of the project.

### **Communication with Stakeholders**

If the model policies and procedures are not adopted, they will have no impact and there will be no resulting improvement in patient safety and quality of care. The future project team should develop a communications plan to communicate the model policies and procedures to providers, patients, payers, public health and the health care IT community. The communication plan should clearly state not only the policies and procedures, but also the benefits to each stakeholder. In addition to targeted communications, a Web site should be created and maintained by the future project team. This Web site should include scenarios that demonstrate how the model policies and procedures will be applied (i.e., how and when information should be collected and/or verified and what information will be requested). The Web site should also have a list of Frequently Asked Questions that are updated periodically.

## **5.2.10 FEASIBILITY ASSESSMENT**

The Workgroup believes that developing Wisconsin-specific model policies and procedures is feasible. However, targeted outreach and education will be critical to ensure that these policies and procedures are adopted uniformly throughout the state.

The second part of the project, the adoption of national standards for patient identification, relies on development of standards at the national level. Assuming these standards are developed, Wisconsin should be well prepared to adopt them. There is a risk in moving forward ahead of national standards that the policies and procedures will not conform to the standards; however, with careful monitoring of national developments this risk will be mitigated.

## **5.2.11 POSSIBLE BARRIERS TO THE IMPLEMENTATION PLAN**

Developing statewide model policies and procedures may not be easy. It will require a collaborative, broad-based process that brings stakeholders with various viewpoints (e.g., experts in health information technology, health information management, providers, payers, consumers, vendors) to consensus. There is the risk that Wisconsin policies and procedures will not be compatible with eventual national standards. A targeted effort to vet and finalize these proposals with an eye toward activities at the national level will be important to the success of this plan.

Once model policies and procedures are finalized, they will need to be adopted. This process will require significant outreach and education to ensure broad understanding of the benefits of verifying patient identity as well as principles of the model policies and procedures (e.g., when to use these policies and

what information to request). With strong leadership, targeted communication efforts, and an appropriate media campaign, the Workgroup expects that most providers and consumers will align in support of these model policies.

The second part of the project, the adoption of national standards for patient identification, relies on development of national standards. If standards are not set at the national level, the full potential of the proposed solution will not be reached. However, Wisconsin will still reap substantial benefits from developing a state model and implementing a standard approach to obtaining and verifying patient information.

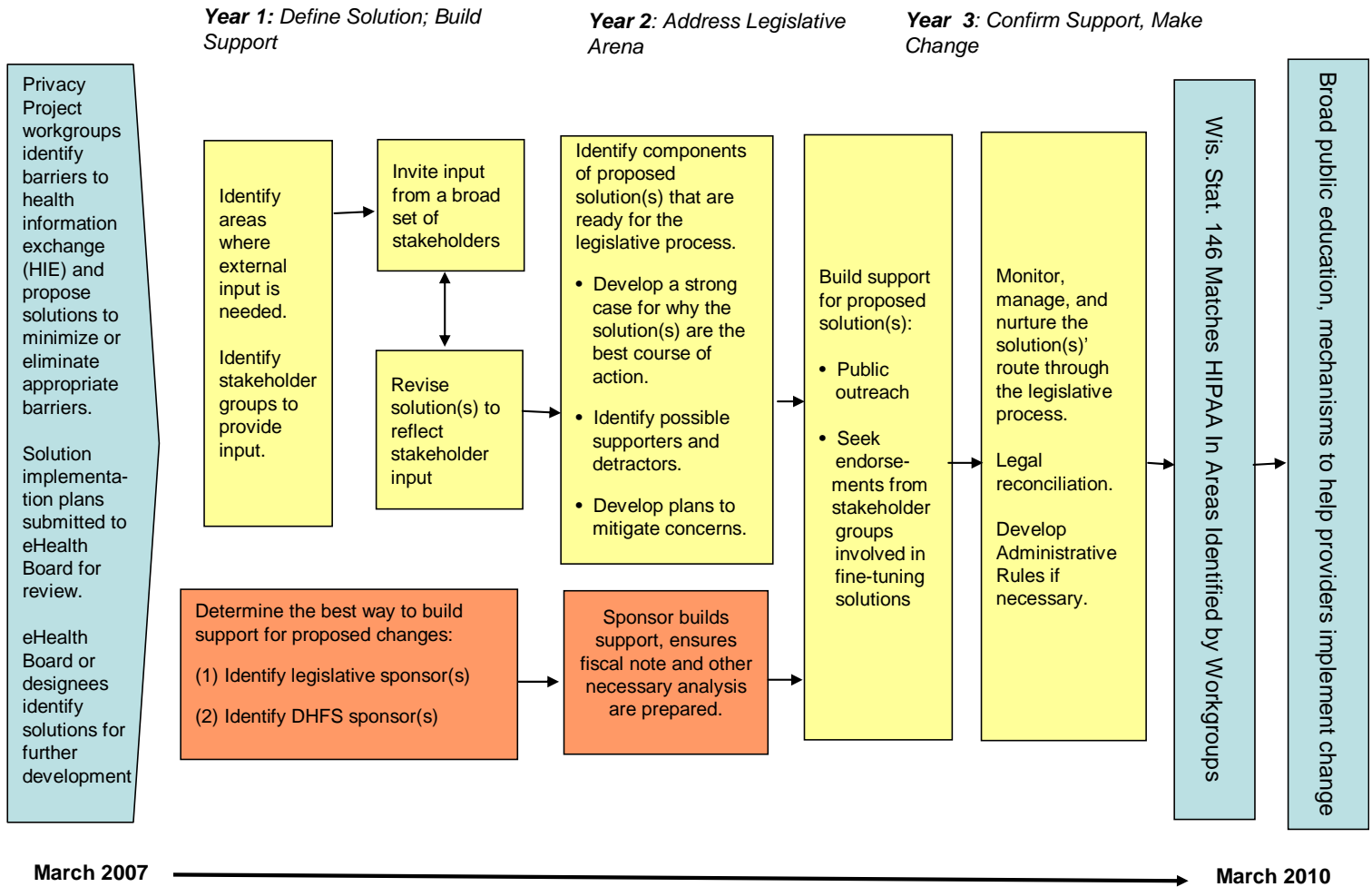
Finally, as with all of the changes to the way information is exchanged, current liability laws must be closely examined to ensure that the laws protect patients and physicians within the new framework. Simplifying the exchange of information makes information more available to physicians. This may result in additional liability exposure for physicians when they have more information yet might not have the time to review every piece of information available. Liability issues are not insurmountable. Laws simply need to be reviewed and refined in the context of the new reality of information exchange.

## **Appendices**



## Appendix 1: Sample Timeline and Milestones to Change Wisconsin Law

### Sample Timeline and Milestones to Change Wisconsin Law



**Appendix 2: Summary of Mental Health Advocates  
Concerns Regarding Proposed Changes to Wisconsin  
Statutes Section 51.30**

**Security and Privacy Project**  
*Mental Health Advocates Meeting*

High-level summary of main points - January 25, 2007

**Concerns about the proposed solution for Wisconsin Statutes section 51.30**

- Quality of care may actually be compromised, not improved, because patients may withhold information knowing that it is available to all providers involved in their care or may avoid treatment knowing this information will be recorded in their electronic medical record.
- The proposed solution increases access to information without establishing controls or penalties to make people accountable for inappropriate uses of information.
- In order to maintain the integrity of the mental health record, mental health providers need to feel comfortable including information in their notes. The group was concerned that the proposed changes to Wisconsin Statutes section 51.30 to broaden provider access to this information would not provide mental health caregivers with the assurances they need to create and maintain a complete record.
- Language and terminology used by mental health providers may not be understood or may be misinterpreted in a primary care environment, potentially resulting in decreased quality of care.
- Providers generally maintain their notes within electronic records rather than keeping two versions, which opens the door for this information to be available where it is not necessarily appropriate.
- Mental health patients continue to suffer the negative effects of stigma. In an ideal world, stigma would not affect the health decision-making process.
- Increased concern over non-health-related uses of information contained within an individual's medical record. The current trend is for employers to require the release of an individual's health record to insurers and payers as a condition of employment.
- One of the foundations of the mental health system in recovery is consumer empowerment. Informed consent for release of information is a key component of empowerment.

**Overarching themes (beyond proposed solution)**

- Education and documentation standards are needed throughout all organizations.
- While appropriate education and professionalism are certainly not the full solution, they are clearly important elements in this issue.
- The problem with sharing mental health information across providers is the unintended consequences that could negatively affect a patient and his/her care. These include valid medical complaints being discounted once the provider becomes aware of the consumer's mental illness, or a patient's unwillingness to seek treatment or bring forward sensitive information as part of his/her treatment because of the increased access to that information by other providers.
- Mental health and substance abuse records should be treated in the same manner, preferably with more rather than fewer restrictions for use.

## Alternate solutions

The group did not support the proposed solution to revise Wisconsin law to mirror HIPAA. The general consensus was that more information is not always better as noted in the concerns above. The group did discuss the following alternatives:

- Develop “minimum necessary” standards and apply them consistently and uniformly across all exchanges of health information (similar to HFS 92.03(n), Wis. Admin. Code, which states whenever information from treatment records is disclosed, that information shall be limited to include only the information needed to fulfill the request).
- Change HIPAA to mirror 42 CFR Part 2 for mental health information so they are consistent with those for substance abuse information.
- Change HIPAA to establish consistency across the nation with the most restrictive state law codified at the federal level.
- Expand Wisconsin Statutes section 51.30(4)(b)8g to allow out-of-network exchange of all of the elements currently included in that section (an individual’s name, address, date of birth, name of the individuals’ mental health treatment providers, the date of mental health services provided, medications, allergies, diagnosis, and other relevant demographic information necessary for the treatment of the individual).

While all of these alternative solutions were discussed, the group clearly favored changes that maintained a certain level of protections for the client. Therefore, the last bulleted item was found to be less desirable.

### **Appendix 3: Suggested parameters for Verification of Patient Identity Proposed Solution**

The Workgroup suggested that the individuals developing the model policies and procedures consider the identifiers below as a starting point in their decision-making, with an understanding that the more identifiers collected, the higher degree of validity of an accurate match:

- Patient's full name
- Gender
- Date of birth
- Address
- Zip code
- Phone number
- Last four digits of Social Security Number (SSN)

## **Appendix 4: Model Policy and Procedure Outlines for Verification of Patient Identity Proposed Solution**

The Workgroup brainstormed the following structural elements as a starting point for future efforts in this area:

### **A. Model policy and procedure for verification prior to release of PHI**

#### ***Policy:***

Requests for patient information should include the appropriate quantity and accuracy of patient identifiers to assure an accurate match to the requested patient information. Similarly, a provider requesting patient information should give as many identifiers from the list of patient identifiers as possible to assure accuracy in the match.

#### ***Procedure:***

1. When receiving a request for information, obtain as many identifiers from the list of patient identifiers as possible relating to the patient.
2. If you do not have enough identifiers to uniquely identify the patient, do not release the information.

### **B. Model policy and procedure for capture and verification of patient identifiers at the point of care**

#### ***Policy:***

Attempts should be made to capture and/or validate as many of the patient identifiers as possible during a patient contact to assure the correct patient is matched to the correct information.

#### ***Procedure:***

##### *For new patients:*

1. Collect the patient identifiers from the patient.
2. Use appropriate resources to obtain patient identification information.
3. Validate the patient identifiers against some type of accepted identification (e.g., driver's license) when possible.

##### *For established patients:*

1. Verify patient identifiers from the patient.
2. Update patient identifiers if the patient's identifiers have changed, as appropriate.
3. Validate patient identifiers on a periodic basis.

##### *Care contact*

1. Obtain patient identifiers.
2. To extent possible, verify that the patient presenting for care matches the patient who is supposed to receive care.
3. Provide care.

**C. Model policy and procedure for capture and verification of patient identifiers under circumstances not addressed in A and B above (e.g., phone call, appointment confirmation, and patient query).**

***Policy:***

Attempts should be made to capture and/or verify as many of the patient identifiers as possible.

***Procedure:***

*For new patients:*

1. Collect the patient identifiers from the patient.
2. Use appropriate resources to obtain patient identification information.
3. Validate the patient identifiers against some type of accepted identification (e.g., driver's license) when possible.

*For established patients:*

1. Verify patient identifiers from the patient,
2. Update patient identifiers if the patient's identifiers have changed, as appropriate.
3. Validate patient identifiers on a periodic basis.

## **Appendix 5: Implementation Strategies for Verification of Patient Identity Proposed Solution**

The Workgroup suggested that the individuals developing the model policies and procedures consider the following additional issues in their discussion of implementation:

1. Develop a guidance document at the Department of Health and Family Services and distribute as a patient safety effort.
2. Add date of birth to the requirements for consent.
3. Include a statement on reminder notices that demographic information needs to be updated.
4. Develop patient identification cards with identifying information as well as current medications.

## **Appendix 6: Consumer Interest Workgroup Recommendations**

The Consumer Interests Workgroup of the eHealth Board is charged with oversight of Wisconsin's Security and Privacy Project on behalf of the Board. To that end, the Consumer Interests Workgroup met to review and discuss the Interim Implementation report on February 27, 2007. Consumer Interests Workgroup recommendations are listed below:

1. Strengthen the case to change Wisconsin Statute section 51.30 in the final report to RTI and the eHealth Board.
2. In conjunction with the process to determine specific changes to Wisconsin Statutes section 51.30 that will allow disclosure from provider to provider for treatment purposes without consent, consideration should be given to the following:
  - a. Changing section Wisconsin Statutes section 252.15 (governing release of HIV test results).
  - b. Changing Wisconsin Statutes section 51.30 to allow disclosure for payment purposes, as well as treatment purposes, without consent.
  - c. Changing related statutes governing disclosure of a minor's health information.
3. The project team driving this process should ensure significant lead time is allowed to convene the workgroup(s) charged with formulating final recommendations re: Wisconsin Statutes section 51.30.

At its final meeting on March 7, 2007, the Implementation Workgroup agreed to incorporate two of the Consumer Interests Workgroup's recommendations into the Final Implementation Report:

1. Strengthen the case to change Wisconsin Statutes section 51.30; and
2. Suggest consideration be given to changing Wisconsin Statutes section 252.15 going forward.

The Implementation Workgroup recommended that the Consumer Interests Workgroup's remaining recommendations be included in the report as an appendix and be considered by the eHealth Board along with the Final Implementation Report.



**Appendix 7: Cost Proposal: Amend Wisconsin Statute Chapter 146**

**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Amend Wisconsin Statute Chapter 146  
Cost Proposal Summary**

| <b>Direct Labor Salary and Fringe</b> |              |                  |              |                  |
|---------------------------------------|--------------|------------------|--------------|------------------|
| <b>Titles</b>                         | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
| Policy or Research Analyst            | 0.5          | 22,114           | 1.0          | 44,227           |
| <b>Staff Total</b>                    | <b>0.5</b>   | <b>\$ 22,114</b> | <b>1.0</b>   | <b>\$ 44,227</b> |

|                                |  |                  |  |                  |
|--------------------------------|--|------------------|--|------------------|
| Fringe 0.4422 of Salary        |  | 9,779            |  | 19,557           |
| Indirect 0.056 of Salary       |  | 1,238            |  | 2,477            |
| <b>Salary and Fringe Total</b> |  | <b>\$ 33,130</b> |  | <b>\$ 66,261</b> |

| <b>Other Expenses</b>         |  |     |                   |                   |
|-------------------------------|--|-----|-------------------|-------------------|
|                               | Agency Privacy consultant  | 0.1 | 20,800            | 20,800            |
| Rent                          | Per FTE at \$2624 per FTE annually   |     | 1,312             | 5,248             |
| Network                       | Per FTE at \$1740 per FTE annually   |     | 870               | 1,740             |
| Phone                         | Per FTE at \$475 per FTE annually  |     | 238               | 475               |
| Internal Services             | Per FTE at \$3300 per FTE annually   |     | 1,650             | 3,300             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years |     | 3,200             | 3,200             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    |     | 200               | 400               |
| Travel                        | 2 positions to travel  |     | 7,000             | 7,000             |
| Meetings and conference Calls | \$1000 per month for 1 year  |     | 12,000            | 12,000            |
|                               | <b>Subtotal</b>  |     | <b>\$ 47,270</b>  | <b>\$ 54,163</b>  |
|                               | <b>DHFS Total</b>  |     | <b>\$ 102,513</b> | <b>\$ 164,651</b> |

| <b>Contractual</b>                                     |                       |                   |                   |
|--|-----------------------|-------------------|-------------------|
| Possibility for contract staff to work on this project |                       | 70,000            | 70,000            |
|  | <b>Contract Total</b> | <b>\$ 70,000</b>  | <b>\$ 70,000</b>  |
|  | <b>Year 1 Total</b>   | <b>\$ 172,513</b> | <b>\$ 234,651</b> |

**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Amend Wisconsin Statute Chapter 146  
Cost Proposal Summary**

**Year 2**

**Direct Labor Salary and Fringe**

| <b>Titles</b>              | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
|----------------------------|--------------|------------------|--------------|------------------|
| Policy or Research Analyst | 0.5          | 22,666           | 1.0          | 45,333           |
| <b>Staff Total</b>         | <b>0.5</b>   | <b>\$ 22,666</b> | <b>1.0</b>   | <b>\$ 45,333</b> |

|                                |  |                  |  |                  |
|--------------------------------|--|------------------|--|------------------|
| Fringe 0.4422 of Salary        |  | 10,023           |  | 20,046           |
| Indirect 0.056 of Salary       |  | 1,269            |  | 2,539            |
| <b>Salary and Fringe Total</b> |  | <b>\$ 33,959</b> |  | <b>\$ 67,917</b> |

**Other Expenses**

|                               |  |     |                   |                   |
|-------------------------------|--|-----|-------------------|-------------------|
|                               | Agency Privacy consultant  | 0.1 | 21,320            | 21,320            |
| Rent                          | Per FTE at \$2624 per FTE annually   |     | 1,345             | 5,379             |
| Network                       | Per FTE at \$1740 per FTE annually   |     | 892               | 1,784             |
| Phone                         | Per FTE at \$475 per FTE annually  |     | 243               | 487               |
| Internal Services             | Per FTE at \$3300 per FTE annually   |     | 1,691             | 3,383             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years |     | 3,280             | 3,280             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    |     | 205               | 410               |
| Travel                        | 2 positions to travel  |     | 7,000             | 7,000             |
| Meetings and conference Calls | \$1000 per month for 1 year  |     | 12,300            | 12,300            |
|                               | <b>Subtotal</b>  |     | <b>\$ 48,276</b>  | <b>\$ 55,342</b>  |
|                               | <b>DHFS Total</b>  |     | <b>\$ 104,901</b> | <b>\$ 168,592</b> |

**Contractual**

|  |                       |        |                   |                   |
|--|-----------------------|--------|-------------------|-------------------|
| Possibility for contract staff to work on this project |                       | 70,000 |                   | 70,000            |
|  | <b>Contract Total</b> |        | <b>\$ 70,000</b>  | <b>\$ 70,000</b>  |
|  | <b>Year 2 Total</b>   |        | <b>\$ 174,901</b> | <b>\$ 238,592</b> |

**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Amend Wisconsin Statute Chapter 146  
Cost Proposal Summary**

**Year 3 (possible)**

**Direct Labor Salary and Fringe**

| <b>Titles</b>              | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
|----------------------------|--------------|------------------|--------------|------------------|
| Policy or Research Analyst | 0.5          | 23,233           | 1.0          | 46,466           |
| <i>Staff Total</i>         | <i>0.5</i>   | <i>\$ 23,233</i> | <i>1.0</i>   | <i>\$ 46,466</i> |

|                                |  |                  |  |                  |
|--------------------------------|--|------------------|--|------------------|
| Fringe 0.4422 of Salary        |  | 10,274           |  | 20,547           |
| Indirect 0.056 of Salary       |  | 1,301            |  | 2,602            |
| <i>Salary and Fringe Total</i> |  | <i>\$ 34,808</i> |  | <i>\$ 69,615</i> |

**Other Expenses**

|                               |  |     |                   |  |                   |
|-------------------------------|--|-----|-------------------|--|-------------------|
|                               | Agency Privacy consultant  | 0.1 | 25,691            |  | 21,853            |
| Rent                          | Per FTE at \$2624 per FTE annually   |     | 1,620             |  | 5,514             |
| Network                       | Per FTE at \$1740 per FTE annually   |     | 1,075             |  | 1,828             |
| Phone                         | Per FTE at \$475 per FTE annually  |     | 293               |  | 499               |
| Internal Services             | Per FTE at \$3300 per FTE annually   |     | 2,038             |  | 3,467             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years |     | 3,952             |  | 3,362             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    |     | 247               |  | 420               |
| Travel                        | 2 positions to travel  |     | 7,000             |  | 7,000             |
| Meetings and conference Calls | \$1000 per month for 1 year  |     | 14,822            |  | 12,608            |
|                               | <i>Subtotal</i>  |     | <i>\$ 56,738</i>  |  | <i>\$ 56,551</i>  |
|                               | <b>DHFS Total</b>  |     | <b>\$ 114,779</b> |  | <b>\$ 172,632</b> |

**Contractual**

|  |                       |                   |  |                   |
|--|-----------------------|-------------------|--|-------------------|
| Possibility for contract staff to work on this project |                       | 70,000            |  | 70,000            |
|  | <i>Contract Total</i> | <i>\$ 70,000</i>  |  | <i>\$ 70,000</i>  |
|  | <b>Year 3 Total</b>   | <b>\$ 184,779</b> |  | <b>\$ 242,632</b> |

**Appendix 8: Cost Proposal: Allow Disclosure of Information Protected under Wisconsin Statute section 51.30 from Provider to Provider for Treatment Purposes**

**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Allow Disclosure of Information Protected under Wisconsin Statute section 51.30 from Provider to Provider for Treatment Purposes  
Cost Proposal Summary**

| <b>Direct Labor Salary and Fringe</b> |              |                  |              |                  |
|---------------------------------------|--------------|------------------|--------------|------------------|
| <b>Titles</b>                         | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
| Policy or Research Analyst            | 0.5          | 22,114           | 1.0          | 44,227           |
| <b>Staff Total</b>                    | <b>0.5</b>   | <b>\$ 22,114</b> | <b>1.0</b>   | <b>\$ 44,227</b> |

|                                |                  |  |                  |
|--------------------------------|------------------|--|------------------|
| Fringe 0.4422 of Salary        | 9,779            |  | 19,557           |
| Indirect 0.056 of Salary       | 1,238            |  | 2,477            |
| <b>Salary and Fringe Total</b> | <b>\$ 33,130</b> |  | <b>\$ 66,261</b> |

| <b>Other Expenses</b>         |  |     |                   |                   |
|-------------------------------|--|-----|-------------------|-------------------|
|                               | Agency Privacy consultant  | 0.1 | 20,800            | 20,800            |
| Rent                          | Per FTE at \$2624 per FTE annually   |     | 1,312             | 5,248             |
| Network                       | Per FTE at \$1740 per FTE annually   |     | 870               | 1,740             |
| Phone                         | Per FTE at \$475 per FTE annually  |     | 238               | 475               |
| Internal Services             | Per FTE at \$3300 per FTE annually   |     | 1,650             | 3,300             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years |     | 3,200             | 3,200             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    |     | 200               | 400               |
| Travel                        | 2 positions to travel  |     | 7,000             | 7,000             |
| Meetings and conference Calls | \$1500 per month for 1 year  |     | 18,000            | 18,000            |
|                               | <b>Subtotal</b>  |     | <b>\$ 53,270</b>  | <b>\$ 60,163</b>  |
|                               | <b>DHFS Total</b>  |     | <b>\$ 108,513</b> | <b>\$ 170,651</b> |

| <b>Contractual</b>                                     |                       |                   |  |                   |
|--|-----------------------|-------------------|--|-------------------|
| Possibility for contract staff to work on this project |                       | 70,000            |  | 70,000            |
|  | <b>Contract Total</b> | <b>\$ 70,000</b>  |  | <b>\$ 70,000</b>  |
|  | <b>Year 1 Total</b>   | <b>\$ 178,513</b> |  | <b>\$ 240,651</b> |

**Wisconsin Health Information Security and Privacy Collaboration**  
**Proposed Solution: Allow Disclosure of Information Protected under Wisconsin Statute section**  
**51.30 from Provider to Provider for Treatment Purposes**  
**Cost Proposal Summary**

**Year 2**

**Direct Labor Salary and Fringe**

| <b>Titles</b>              | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
|----------------------------|--------------|------------------|--------------|------------------|
| Policy or Research Analyst | 0.5          | 22,666           | 1.0          | 45,333           |
| <b>Staff Total</b>         | <b>0.5</b>   | <b>\$ 22,666</b> | <b>1.0</b>   | <b>\$ 45,333</b> |

|                                |                  |  |                  |
|--------------------------------|------------------|--|------------------|
| Fringe 0.4422 of Salary        | 10,023           |  | 20,046           |
| Indirect 0.056 of Salary       | 1,269            |  | 2,539            |
| <b>Salary and Fringe Total</b> | <b>\$ 33,959</b> |  | <b>\$ 67,917</b> |

**Other Expenses**

|                               |  |                   |                   |
|-------------------------------|--|-------------------|-------------------|
| Agency Privacy consultant     | 0.1  | 21,320            | 21,320            |
| Rent                          | Per FTE at \$2624 per FTE annually   | 1,345             | 5,379             |
| Network                       | Per FTE at \$1740 per FTE annually   | 892               | 1,784             |
| Phone                         | Per FTE at \$475 per FTE annually  | 243               | 487               |
| Internal Services             | Per FTE at \$3300 per FTE annually   | 1,691             | 3,383             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years | 3,280             | 3,280             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    | 205               | 410               |
| Travel                        | 2 positions to travel  | 7,175             | 7,175             |
| Meetings and conference Calls | \$1000 per month for 1 year  | 18,450            | 18,450            |
| <b>Subtotal</b>               |  | <b>\$ 54,601</b>  | <b>\$ 61,667</b>  |
| <b>DHFS Total</b>             |  | <b>\$ 111,226</b> | <b>\$ 174,917</b> |

**Contractual**

|  |                   |  |                   |
|--|-------------------|--|-------------------|
| Possibility for contract staff to work on this project | 70,000            |  | 70,000            |
| <b>Contract Total</b>                                  | <b>\$ 70,000</b>  |  | <b>\$ 70,000</b>  |
| <b>Year 2 Total</b>                                    | <b>\$ 181,226</b> |  | <b>\$ 244,917</b> |

**Wisconsin Health Information Security and Privacy Collaboration**  
**Proposed Solution: Allow Disclosure of Information Protected under Wisconsin Statute section**  
**51.30 from Provider to Provider for Treatment Purposes**  
**Cost Proposal Summary**

**Year 3**

**Direct Labor Salary and Fringe**

| <b>Titles</b>              | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
|----------------------------|--------------|------------------|--------------|------------------|
| Policy or Research Analyst | 0.5          | 23,233           | 1.0          | 46,466           |
| <b>Staff Total</b>         | <b>0.5</b>   | <b>\$ 23,233</b> | <b>1.0</b>   | <b>\$ 46,466</b> |

|                                |                  |  |                  |
|--------------------------------|------------------|--|------------------|
| Fringe 0.4422 of Salary        | 10,274           |  | 20,547           |
| Indirect 0.056 of Salary       | 1,301            |  | 2,602            |
| <b>Salary and Fringe Total</b> | <b>\$ 34,808</b> |  | <b>\$ 69,615</b> |

**Other Expenses**

|                               |  |                   |                   |
|-------------------------------|--|-------------------|-------------------|
| Agency Privacy consultant     | 0.1  | 25,691            | 21,853            |
| Rent                          | Per FTE at \$2624 per FTE annually   | 1,620             | 5,514             |
| Network                       | Per FTE at \$1740 per FTE annually   | 1,075             | 1,828             |
| Phone                         | Per FTE at \$475 per FTE annually  | 293               | 499               |
| Internal Services             | Per FTE at \$3300 per FTE annually   | 2,038             | 3,467             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years | 3,952             | 3,362             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    | 247               | 420               |
| Travel                        | 2 positions to travel  | 8,646             | 7,354             |
| Meetings and conference Calls | \$1000 per month for 1 year  | 22,232            | 18,911            |
| <b>Subtotal</b>               |  | <b>\$ 65,794</b>  | <b>\$ 63,209</b>  |
| <b>DHFS Total</b>             |  | <b>\$ 123,835</b> | <b>\$ 179,290</b> |

**Contractual**

|  |                   |  |                   |
|--|-------------------|--|-------------------|
| Possibility for contract staff to work on this project | 70,000            |  | 70,000            |
| <b>Contract Total</b>                                  | <b>\$ 70,000</b>  |  | <b>\$ 70,000</b>  |
| <b>Year 3 Total</b>                                    | <b>\$ 193,835</b> |  | <b>\$ 249,290</b> |

**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Allow Disclosure of Information Protected under Wisconsin Statute section  
51.30 from Provider to Provider for Treatment Purposes  
Cost Proposal Summary**

**Year 4**

**Direct Labor Salary and Fringe**

| <b>Titles</b>              | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
|----------------------------|--------------|------------------|--------------|------------------|
| Policy or Research Analyst | 0.5          | 23,814           | 1.0          | 47,628           |
| <b>Staff Total</b>         | <b>0.5</b>   | <b>\$ 23,814</b> | <b>1.0</b>   | <b>\$ 47,628</b> |

|                                |  |                  |  |                  |
|--------------------------------|--|------------------|--|------------------|
| Fringe 0.4422 of Salary        |  | 10,530           |  | 21,061           |
| Indirect 0.056 of Salary       |  | 1,334            |  | 2,667            |
| <b>Salary and Fringe Total</b> |  | <b>\$ 23,814</b> |  | <b>\$ 71,356</b> |

**Other Expenses**

|                               |  |     |                   |  |                   |
|-------------------------------|--|-----|-------------------|--|-------------------|
|                               | Agency Privacy consultant  | 0.1 | 30,957            |  | 22,399            |
| Rent                          | Per FTE at \$2624 per FTE annually   |     | 1,953             |  | 5,652             |
| Network                       | Per FTE at \$1740 per FTE annually   |     | 1,295             |  | 1,874             |
| Phone                         | Per FTE at \$475 per FTE annually  |     | 353               |  | 512               |
| Internal Services             | Per FTE at \$3300 per FTE annually   |     | 2,456             |  | 3,554             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years |     | 4,763             |  | 3,446             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    |     | 298               |  | 431               |
| Travel                        | 2 positions to travel  |     | 10,418            |  | 7,538             |
| Meetings and conference Calls | \$1000 per month for 1 year  |     | 26,790            |  | 19,384            |
|                               | <b>Subtotal</b>  |     | <b>\$ 79,282</b>  |  | <b>\$ 64,789</b>  |
|                               | <b>DHFS Total</b>  |     | <b>\$ 126,910</b> |  | <b>\$ 183,772</b> |

**Contractual**

|  |                       |                   |  |                   |
|--|-----------------------|-------------------|--|-------------------|
| Possibility for contract staff to work on this project |                       | 70,000            |  | 70,000            |
|  | <b>Contract Total</b> | <b>\$ 70,000</b>  |  | <b>\$ 70,000</b>  |
|  | <b>Year 3 Total</b>   | <b>\$ 196,910</b> |  | <b>\$ 253,772</b> |

**Appendix 9: Cost Proposal: Verification of Patient Identity**

**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Verification of Patient Identity  
Cost Proposal Summary**

| <b>Direct Labor Salary and Fringe</b> |              |                  |              |                  |
|---------------------------------------|--------------|------------------|--------------|------------------|
| <b>Title</b>                          | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>    |
| Policy or Research Analyst            | 0.5          | 22,114           | 1.0          | 44,227           |
| <b>Staff Total</b>                    | <b>0.5</b>   | <b>\$ 22,114</b> | <b>1.0</b>   | <b>\$ 44,227</b> |

|                                |                  |  |                  |
|--------------------------------|------------------|--|------------------|
| Fringe 0.4422 of Salary        | 9,779            |  | 19,557           |
| Indirect 0.056 of Salary       | 1,238            |  | 2,477            |
| <b>Salary and Fringe Total</b> | <b>\$ 33,130</b> |  | <b>\$ 66,261</b> |

| <b>Other Expenses</b>         |  |     |                   |                   |
|-------------------------------|--|-----|-------------------|-------------------|
|                               | Agency Privacy consultant  | 0.1 | 20,800            | 20,800            |
| Rent                          | Per FTE at \$2624 per FTE annually   |     | 1,312             | 5,248             |
| Network                       | Per FTE at \$1740 per FTE annually   |     | 870               | 1,740             |
| Phone                         | Per FTE at \$475 per FTE annually  |     | 238               | 475               |
| Internal Services             | Per FTE at \$3300 per FTE annually   |     | 1,650             | 3,300             |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years |     | 3,200             | 3,200             |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    |     | 200               | 400               |
| Travel                        | 2 positions to travel  |     | 7,000             | 7,000             |
| Meetings and conference Calls | \$1000 per month for 1 year  |     | 12,000            | 12,000            |
|                               | <b>Subtotal</b>  |     | <b>\$ 47,270</b>  | <b>\$ 54,163</b>  |
|                               | <b>DHFS Total</b>  |     | <b>\$ 102,513</b> | <b>\$ 164,651</b> |

| <b>Contractual</b>                                     |                       |                   |                   |
|--|-----------------------|-------------------|-------------------|
| Possibility for contract staff to work on this project |                       | 70,000            | 70,000            |
|  | <b>Contract Total</b> | <b>\$ 70,000</b>  | <b>\$ 70,000</b>  |
|  | <b>Year 1 Total</b>   | <b>\$ 172,513</b> | <b>\$ 234,651</b> |



**Wisconsin Health Information Security and Privacy Collaboration  
Proposed Solution: Verification of Patient Identity  
Cost Proposal Summary**

**Year 2**

**Direct Labor Salary and Fringe**

| <b>Titles</b>              | <b>FTE %</b> | <b>Amount</b>    | <b>FTE %</b> | <b>Amount</b>   |
|----------------------------|--------------|------------------|--------------|-----------------|
| Policy or Research Analyst | 0.25         | 11,333           | 0.1          | 2,267           |
| <b>Staff Total</b>         | <b>0.25</b>  | <b>\$ 11,333</b> | <b>0.1</b>   | <b>\$ 2,267</b> |

|                                |                  |  |                 |
|--------------------------------|------------------|--|-----------------|
| Fringe 0.4422 of Salary        | 5,012            |  | 1,002           |
| Indirect 0.056 of Salary       | 635              |  | 127             |
| <b>Salary and Fringe Total</b> | <b>\$ 16,979</b> |  | <b>\$ 3,396</b> |

**Other Expenses**

|                               |  |                  |  |                  |
|-------------------------------|--|------------------|--|------------------|
| Rent                          | Per FTE at \$2624 per FTE annually   | 672              |  | 5,379            |
| Network                       | Per FTE at \$1740 per FTE annually   | 446              |  | 89               |
| Phone                         | Per FTE at \$475 per FTE annually  | 122              |  | 24               |
| Internal Services             | Per FTE at \$3300 per FTE annually   | 846              |  | 169              |
| Printing                      | \$8 per copy for printed material, estimate up to 400 copies of the materials may be needed over the course of 2 years | 3,280            |  | 3,280            |
| Training                      | Per position at \$200 per position annually (assuming 2 possible positions assigned to this aspect)                    | 205              |  | 410              |
| Travel                        | 1 positions to travel  | 2,500            |  | 2,500            |
| Meetings and conference Calls | \$1000 per month for 1 year  | 12,300           |  | 12,300           |
| Incentives for Adoption       | \$20,000 total with development of a policy for distributing to follow   | 20,000           |  | 20,000           |
|                               | <b>Subtotal</b>  | <b>\$ 40,371</b> |  | <b>\$ 44,152</b> |
|                               | <b>DHFS Total</b>  | <b>\$ 68,683</b> |  | <b>\$ 49,814</b> |

**Contractual**

|  |                       |                   |                   |
|--|-----------------------|-------------------|-------------------|
| Possibility for contract staff to work on this project | 70,000                |                   | 70,000            |
|  | <b>Contract Total</b> | <b>\$ 70,000</b>  | <b>\$ 70,000</b>  |
|  | <b>Year 2 Total</b>   | <b>\$ 138,683</b> | <b>\$ 119,814</b> |

**Wisconsin  
Security and Privacy Project**

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**Wisconsin  
Security and Privacy Project Team**

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