

Wisconsin Security and Privacy Project

Interim Implementation Report

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Executive Summary

In November 2005, by Executive Order #129, Governor Doyle created the eHealth Care Quality and Patient Safety Board (eHealth Board). The goal of the eHealth Board is to have 100% adoption of electronic health records systems and the appropriate exchange of health information from these systems within five years. The eHealth Board was charged with developing a roadmap for achieving this goal.

The eHealth Board submitted the Wisconsin *eHealth Action Plan* to the Governor in December 2006. This 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.

A key concern identified within the *eHealth Action 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, 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.

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

Assessment of Variation

As required by the HISPC contract, the first group convened in this process was the Variations Workgroup, which was charged with assessing the variations in business-level policies and practices through the use of 18 prescribed scenarios. Through this assessment process, the Workgroup was to identify "barriers" created through these variations. A "barrier" was defined as any policy or practice that hinders the exchange of health information. Once a "barrier" was identified, it was analyzed to determine whether the barrier identified was a policy or practice that appropriately ensured privacy and security for a patient, or whether it created an unnecessary barrier to the exchange.

The Legal Workgroup was convened shortly after the Variations Workgroup, and evaluated potential legal issues in the exchange of information. The Legal Workgroup identified the legal drivers behind the policies and practices identified by the Variations Workgroup. A summary of the barriers documented and analyzed by these workgroups follows:

1. Barriers driven by Wisconsin state law

In some instances, Wisconsin state law is more restrictive than federal law. For general health information, the barriers identified are a result of the more restrictive Wisconsin state law, including:

- Documentation of health information that is disclosed with or without patient consent, and
- Limitations on re-disclosure of patient information to another provider when the information did not originate with the provider releasing the information.

In addition, Wisconsin state law is more restrictive for the exchange of “sensitive” health information, including information pertaining to mental health, developmental disabilities, and alcohol and other drug abuse. The Wisconsin requirements that were determined to impede the exchange of information include: obtaining consent for disclosing health information (for both payment and treatment information), verifying the individual requesting the information, and the additional documentation requirements when health information is released.

2. Barriers driven by state and federal law

There are a number of health information exchange processes that are governed by both state and federal law with the more restrictive legislation controlling the process. When state and federal law both apply, variation in interpretation and implementation of the law can and does occur. The mandate to obtain patient consent creates obstacles to information exchange, because the following are open to interpretation:

- The analysis to determine whether state or federal law controls the consent process.
- The process of obtaining a consent, including identifying who has the legal authority to sign the consent.
- The definition of the statutorily required elements that make up the consent.
- Variation between the states’ consent requirements.

3. Barriers driven by federal law

In the following instances, federal law is more stringent than state law:

- 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 provider and the vendor.
- The Federal Security Rule, which governs the technical security measures to guard against unauthorized access to electronic health information.
- 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

Organization-level business policies and practices can be more restrictive than both state and federal law, resulting in large variations in the way information is protected. The Variations and Legal workgroups identified the following policies and practices as barriers:

- Obtaining consent for information that may appear sensitive to the patient, but is not part of “sensitive” health information as defined by Wisconsin state law (e.g., HIV test results are

- protected by Wisconsin state law, but not all other health information about an HIV positive individual. Many providers allow special protection for these individuals).
- The method for making or responding to a request, such as by phone, fax, or in writing.
 - The sophistication of the technology that an organization is willing to purchase to secure their patients' information.

Assessment of Solutions

Solutions Workgroup

The Solutions Workgroup was charged with proposing solutions to the barriers identified by the Variations and Legal workgroups. The Solutions Workgroup included a mix of members from the previous workgroups, as well as new members, for a total of 34 members, representing clinics, corrections, health care quality organizations, industries, pharmacies, professional associations, providers, state government, and payers. At the beginning of each meeting, the Workgroup was provided with an overview of the barriers identified through the assessment of variations process, followed by small break-out session discussions. In these sessions, the members were asked to identify possible solutions, which were regrouped and packaged as the proposed solutions outlined below.

Implementation Workgroup

The Implementation Workgroup was comprised of 33 members representing clinics, corrections, health care quality organizations, industries, pharmacies, professional associations, providers, state government, and payers. The Workgroup was charged with creating implementation plans for the proposed solutions that were selected by the Solutions Workgroup.

The Implementation Workgroup followed a similar process to the one used by the Solutions Workgroup. At the beginning of each meeting, a summary of the proposed solution was reviewed followed by a large group discussion to refine the solution as needed. This was followed by small break-out session discussions, focused on defining the solution, defining a project structure, identifying the stakeholders, and developing a communications plan.

While there are many different aspects to the three implementation plans, there are a few common threads. In all three, the Workgroup recommended that the eHealth Board retain responsibility for the initiative, including oversight of major decisions and the appointment of a project director for oversight. Communication is critical to the success of each of these plans; therefore, the Workgroup recommended that a comprehensive communication plan be developed that would provide regular updates to the appropriate stakeholders. A carefully developed plan will should ensure participation and buy-in from all stakeholders; both those implementing and those impacted by the proposed change.

Summary

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

1. Verification of Patient

Currently, there are no standard methods for uniquely identifying a patient and matching his/her records in either a paper or electronic environment. This is already a complex issue in today's paper health care system, but this will become increasingly important in an electronic environment. The increased volume of information available through an electronic exchange will necessitate accuracy in providing the correct records for the correct patient.

Based on this premise, the Solutions Workgroup proposed that a standard set of criteria, elements, and/or parameters be developed at the national level and implemented in a consistent manner. Using

a standard process would not only improve the accuracy in identifying the correct patient and improve quality of care (through the right information being available at all points of care), but would also ease the administrative burden of resolving patient identification, and unintentional privacy violations related to personal health information.

The Implementation Workgroup recommended implementing model policies and procedures simultaneously with monitoring the national efforts. Components of the model policies should include clearly defined criteria for: identifying and verifying a patient; capturing, maintaining, and retaining the patient identifiers; and matching the patient identifier in both a paper and electronic environment.

The key components of the implementation plan for developing model policies and procedures are: creating a white paper; developing a plan for statewide adoption of these policies and procedures; developing an education plan and partnering with the appropriate stakeholder agencies to implement it; and building public awareness. Development of these policies will require broad stakeholder involvement to reach consensus and ensure distribution of the material once completed.

2. Modification of Wisconsin Statute 146 to mirror HIPAA

Wisconsin privacy laws are more restrictive than HIPAA in the following areas: documentation requirements, re-disclosure restrictions, limitation on disclosure to family, and limitation on disclosure to law enforcement. The Solutions Workgroup determined that these additional restrictions did not significantly improve patient privacy, and in some instances, decreased access to care. In addition, providers and health care organizations face the challenge of resolving differences between Wisconsin and HIPAA restrictions, which results in additional burden when attempting to comply with conflicting laws.

The Solutions Workgroup proposed that Wisconsin Statute 146 be modified to mirror the HIPAA requirements related to sharing health information with individuals involved in the care of a patient, re-disclosure of health information to providers without patient consent, and the documentation requirements. Currently, patient consent is required when disclosing information to family members and others involved in a patient's care, and when re-disclosing information received from one provider and sent to another. In both instances, changing the statute to mirror HIPAA would resolve the administrative burden of obtaining consent in these situations, as well as ensuring that health care information is available where needed. Lastly, the change to simplify documentation requirements would reduce the administrative burden, while retaining patients' rights to know who has accessed their records.

The Implementation Workgroup identified the following components required in the plan to change Wis. Stat. 146, including: preparation for a legislative change, expansion stakeholder involvement, development and implementation of a communication plan and educational effort, and any additional follow-up that may be necessary. While the proposed changes remove some of the administrative burdens and variations in practice that hinder exchange of information, changing law is a time-consuming process. Additionally, there may be resistance to this change, both by providers and consumers, because of concerns over the implications of such a change.

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

Wisconsin Statute 51.30 provides additional protections for health information that contains information related to mental health, developmental disabilities, and alcohol and other drug abuse. The Solutions Workgroup decided that this law should be modified to match HIPAA for treatment purposes, allowing for the exchange of all personal health information, except psycho-therapy notes

and AODA treatment information governed by 42 CFR Part 2. Initially, the Solutions Workgroup agreed that the “need to know,” in providing adequate and appropriate care, outweighed the potential for provider stigma to affect care. Upon further discussion within the Implementation Workgroup, the proposed solution has been broadened to consider a range of options, from not changing Wis. Stat. 51.30, to changing the language to mirror current HIPAA regulations. More discussion is required about what information would be exchanged for treatment purposes.

Key components of this implementation plan include identification 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

Finally, the Solutions Workgroup proposed to change the language of the HIPAA federal privacy rule to:

- 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. Develop model policies and procedures to clarify the “minimum necessary” standard.

The Solutions Workgroup did not advance this proposed solution to the Implementation Workgroup. The Solutions Workgroup members decided that to develop an implementation plan to propose modification of federal law was outside the scope of the Implementation Workgroup’s charge.

Next Steps

The eHealth Board extends its sincere appreciation to all of the volunteers that 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.

Due to the time constraints associated with the Security and Privacy Project, the eHealth Board would like to further evaluate the recommendations created through project in more detail. As a result, 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 Wisconsin Implementation Workgroup convened to develop implementations plans for select proposed solutions developed by the Solutions Workgroup to address security and privacy challenges to the implementation of health information exchange. The Implementation Workgroup included as broad a representation of the relevant stakeholder groups as possible.

The Solutions Workgroup developed four proposed solutions of which three were advanced to the Implementation Workgroup. These solutions incorporated many, but not all, of the barriers identified by the Variations and Legal workgroups. The proposed solutions that were not brought to the attention of the Implementation Workgroup were identified as legislation changes that need to occur at the national level; items deemed infeasible within the next two to five years; or were not considered by the Workgroup to result in sufficient impact on the health care system at this time. A summary of the proposed solutions developed by the Solutions Workgroup has been incorporated into this report in Section 2 – Summary of Interim Analysis of Solutions Report, on page 6.

1.2 Key assumptions and limitations

Throughout this project, there have been many practices and policies that have been identified as “barriers”; too many to address in such a short timeframe. Therefore, the Implementation Workgroup’s primary focus was to address the most burdensome barriers to exchanging health information by building upon the recommendations of the Solutions Workgroup. In addition, the Solutions Workgroup had the opportunity to identify any type of solution, both statutory and non-statutory, but chose to focus on those barriers that result from current law. Although this limited the types of solutions developed, the Implementation Workgroup will be advancing non-statutory solutions that were identified through this process to Wisconsin’s eHealth Board.

The Implementation Workgroup members agreed that they would move forward with the solutions as presented, but recognized that in some instances, the proposed solution could meet with opposition by special interest groups in the community, and their recommended solutions may require additional vetting. For example, due to the delicate nature of the solution related to “sensitive” health information, a special group of mental health advocates and providers was convened. This has helped the Implementation Workgroup as it discusses the next steps related to the proposed solution, but the Workgroup acknowledges that further discussions are needed.

Section 2 – Summary of Interim Analysis of Solutions Report

The Solutions Workgroup developed four proposed solutions, and of those selected three to advance to the Implementation Workgroup. The three proposed solutions incorporated many but not all of the barriers identified by the Variations and Legal workgroups. The proposed solutions follow:

1. Verification of Patient

Currently, there are no standard methods for uniquely identifying a patient and matching his/her records in either a paper or electronic environment. This is already a complex issue in today’s paper health care system, but this will become increasingly important in an electronic environment. The

increased volume of information available through an electronic exchange will necessitate accuracy in providing the correct records for the correct patient.

Based on this premise, the Solutions Workgroup proposed that a standard set of criteria, elements, and/or parameters be developed and employed in a consistent process at the national level. Using a standard process would not only improve the accuracy in identifying the correct patient and improve quality of care (through the right information being available at all points of care), but would also ease the administrative burden of resolving patient identification and unintentional privacy violations related to personal health information.

2. Modification of Wisconsin Statute 146 to mirror HIPAA

Wisconsin privacy laws are more restrictive than HIPAA in the following areas: documentation requirements, re-disclosure restrictions, limitation on disclosure to family, and limitation on disclosure to law enforcement. The Solutions Workgroup determined that these additional restrictions did not significantly improve patient privacy, and in some instances, decreased access to care due to the additional burdens that the patient faced. In addition, providers and health care organizations face the challenge of resolving differences between Wisconsin and HIPAA restrictions, and the administrative burden of implementing policies and procedures to incorporate the appropriate legislative burden (whether state or federal) when it applies.

The Solutions Workgroup proposed that Wisconsin Statute 146 be modified to mirror the HIPAA requirements related to sharing health information with individuals involved in the care of a patient, re-disclosure of health information to providers without patient consent, and the documentation requirements. Currently, patient consent is required when disclosing information to family members and others involved in a patient's care, and when re-disclosing information received from one provider to another. In both instances, changing the statute to mirror HIPAA would resolve the administrative burden of obtaining consent in these instances, as well as ensuring that health care information is available where needed. Lastly, the change to simplify documentation requirements would drastically reduce the administrative burden, while retaining patients' rights to know who has accessed their records.

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

Wisconsin Statute 51.30 provides additional protections for health information that contains information related to mental health, developmental disabilities, and alcohol and other drug abuse. The Solutions Workgroup recommends that this law be modified to match HIPAA for treatment purposes, allowing for the exchange of all personal health information, except psycho-therapy notes and AODA treatment information governed by 42 CFR Part 2. Initially, the Solutions Workgroup agreed that the "need to know," in providing adequate and appropriate care, outweighed the potential for provider stigma to affect care. Upon further discussion within the Implementation Workgroup, the proposed solution has been broadened to consider a range of options, from not changing Wis. Stat. 51.30 to changing the language to mirror current HIPAA regulations. More discussion is required about what information would be exchanged for treatment purposes.

4. Changes to HIPAA

Finally, the Solutions Workgroup proposed to change the language of the HIPAA federal privacy rule to:

- 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. Develop model policies and procedures to clarify the “minimum necessary” standard.

The Solutions Workgroup did not advance this proposed solution to the Implementation Workgroup because the members decided that developing an implementation plan to propose modification of federal law was outside the scope of the Implementation Workgroup’s charge.

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 goals of the Implementation Workgroup were to review the proposed solutions; revise the proposed solutions as appropriate; and, develop implementation plans for those solutions that would facilitate health information exchange, while maintaining privacy mechanisms that protect consumers.

The charge to this workgroup was to:

1. Evaluate the feasibility of 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

The Security and Privacy Team includes staff from the Wisconsin Department of Health and Family Services and contractors who provide policy expertise and project management services. The Security and Privacy Team is responsible for managing the process, identifying key stakeholders for participation in the workgroups, and documenting business policies and practices.

Membership

The Implementation Workgroup consists of 33 representatives across multiple stakeholder groups who will be impacted 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 and roughly two thirds of the members of the Implementation Workgroup served previously on the Solutions, Variations, and/or Legal workgroups. To round out the Workgroup, individuals with additional skills, knowledge, and experience were invited to participate in the Implementation Workgroup as the skills required to create solutions can differ from those required to figure out how to implement the proposed solutions.

Stakeholder Representation

Implementation Workgroup members represented the wide spectrum of stakeholder groups who will be impacted by HIE, and the knowledge and experience of the group was unparalleled. Several of the 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 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 in Health, community advocates, and public health)
- Hospitals (State with 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
- Homecare 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
- 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 the Workgroup decided it was beyond the charge of this group to develop a plan to change federal law. Discussion of each implementation plan spanned two meetings. This allowed staff to document outcomes from the initial discussion 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 at the meeting. The documents summarized the barriers to information exchange identified by the Variations and Legal Workgroups, as well as the solution as proposed by the Solutions Workgroup.

The Workgroup discussed the three proposed solutions as a large group and were provided an opportunity to further refine the solution if necessary. Once consensus was achieved for each proposed solution, the Workgroup determined the scope of the proposed solution as well as major milestones required for implementation.

With the scope and major milestones defined, the group divided into small groups to focus on specific components of the implementation plan. The small break-out session approach provided a setting conducive to individual participation not always possible in the larger group setting. Small break-out 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 came with a different skill set and interest, this approach allowed each participant to focus on his/her area of interest and to lend his/her expertise to the group. The small break-out groups then reported their ideas back to the larger group, and the outcomes were discussed in the larger group.

Break-out 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 to them, etc.

Due to time constraints, the project timeline and cost analysis will be completed by the Security and Privacy Project Team with input from relevant stakeholders following the submission of the Interim Implementation Report. Members of the Workgroup did not feel they had the expertise or the time to complete this part of the plan adequately. The eHealth Board will use the recommendations from this report and the subsequent project timeline and cost analysis from the Security and Privacy Project Team as a starting point for incorporation into the framework already developed in 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 came out of the Solutions Workgroup. Those three implementation plans follow:

- a. Amendments to Wisconsin Statute 146
- b. Modification of Wisconsin Statute 51.30 in relation to access to providers 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. While the Implementation Workgroup supports the recommendations as essential to facilitating HIE, the Implementation Workgroup felt that developing a plan to change federal law was outside the scope of its charge.

Solutions a and b, above, involving changes to Wisconsin Statutes 146 and 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 the multi-state approach section.

3.4 Specific Planning Methods/Tools Used

The Implementation Workgroup followed a process in developing the implementation plans similar to that used by the Solutions Workgroup to develop its proposed solutions. The Implementation Workgroup used a combination of large group discussions and break-out sessions to arrive at refined proposals for solutions and implementation plans for each solution addressed.

At the beginning of each meeting, the proposed solutions were reviewed to make sure all participants understood them, followed by a large group discussion. By drawing upon the diverse representation of the Workgroup, the proposed solution was often refined as a large group. The Workgroup then went through an exercise to determine the key activities required to implement the solution and developed a corresponding timeline.

The Workgroup then divided into smaller teams to tackle the detailed work of building the implementation plans documented in this report. The smaller groups were asked to answer more questions than they really could in the time provided. This often led to frustration during small break-out sessions, but ultimately led to thoughtful and in-depth consideration of a majority of the questions. After the designated time for break-outs, the large group reconvened to hear a report back from each of the break-out groups. The groups were often surprised to discover the progress they had made on the design of an implementation plan. Together, the group discussed the results of the break-out sessions and in most cases, came to consensus on the plans.

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

Due to time constraints, the project timeline and cost analysis will be completed by the Security and Privacy Project Team with input from relevant stakeholders following the submission of the Interim Implementation Report.

Section 4 – State-Level Implementation Plans

The Implementation Workgroup developed two plans to be implemented at the state level. The two plans are to modify:

- a. Wisconsin Statute 146 to mirror HIPAA for treatment purposes.
- b. Wisconsin Statute 51.30 in relation to access for treatment.

Proposed solution a will help Wisconsin exchange information between states by rewriting state privacy laws to mirror HIPAA. Proposed solution b will ease some of the barriers to exchanging information, but will maintain some privacy safeguards that are stricter than HIPAA. Additionally, solution b will provide necessary protection for mental health, developmentally disabled, and alcohol and other drug abuse patients.

4.1 Statewide Strategy and Coordination

Wisconsin Governor Doyle created the eHealth Care Quality and Patient Safety Board by Executive Order in November 2005. The eHealth Board is charged with developing and implementing the Wisconsin eHealth Action Plan for Health Care Quality and Patient Safety (*eHealth Action Plan*), Wisconsin's five-year action plan for the adoption and exchange of interoperable electronic health records. To develop the *eHealth Action Plan*, the eHealth Board convened a diverse group of volunteer stakeholders with a broad base of expertise. These volunteers helped guide the development of the *eHealth Action Plan* through participation in the eHealth Board's workgroups: Patient Care, Information Exchange, Consumer Interests, Governance, and Financing. The eHealth Board submitted the Wisconsin *eHealth Action Plan* to Governor Doyle in December 2006, and will be focusing its efforts on implementing the plan in the coming year.

The Department of Health and Family Services (DHFS) applied for the Health Information Security and Privacy Collaborative, referred to as the Wisconsin Security and Privacy Project, on behalf of the eHealth Board. Due to the extensive analysis required for this project, the eHealth Board decided to delay refinement of some of its recommendations until the Security and Privacy Project's completion. There is overlap between the issues addressed in the *eHealth Action Plan* and the issues addressed by the Wisconsin Security and Privacy Project. Moreover, there is common ground in many of the recommendations coming out of both the eHealth Board and the Privacy and Security Project efforts. The eHealth Board will have responsibility for the evaluation and implementation of the proposed Security and Privacy Project solutions in Wisconsin, using the eHealth Board workgroup structure as put forth in the *eHealth Action Plan* as a starting point, with consideration of additional workgroups as necessary and providing a statewide entity to coordinate multiple efforts, ensuring an efficient and informed process.

4.2 Recommended Solution: Amend Wisconsin Statute 146

4.2.1 CONTEXT FOR PROPOSED SOLUTION

PROPOSED SOLUTION

Amend Wisconsin Statute 146 as follows:

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

Following the enactment of a provision for protection of “sensitive” health care information in 1977, the Wisconsin Legislature passed Wisconsin Statutes 146.81-.84 to protect general patient health care information in 1980. 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 the societal “need to know” was greater than the patient’s right to protection. The Federal Privacy law, HIPAA, which became effective in 2003, creates many of the same privacy protections at the national level that Wisconsin Statute 146 affords Wisconsin citizens. Sometimes, however, compliance with two sets of laws creates 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 whether state or federal law governs the information disclosure process adds complexity.
- 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 both 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 modification of re-disclosure requirements. The Workgroup anticipates the changes outlined in this solution will:

- Improve the consistency of practice among Wisconsin providers, paving the way for health information exchange within Wisconsin and between Wisconsin and other states.
- 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 as well as decreasing duplication of services. This could result in cost savings for providers, and theoretically, could eventually result in some cost savings for consumers.
- Provide physicians with more information and facilitate more informed treatment decisions by allowing for re-disclosure of health information without consent. The documentation burden would also be reduced with this change

4.2.2 PLANNING ASSUMPTIONS AND DECISIONS

This implementation plan was created with the understanding that amending Wisconsin Statute 146.81-.83 was in line with the goals of Wisconsin’s eHealth Board, 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 would have overall responsibility for advancing the implementation of the solutions, as it fits within the Board’s scope of work .

4.2.3 IMPLEMENTATION OWNERSHIP AND RESPONSIBILITIES

The Implementation Workgroup recommends that the Wisconsin’s eHealth Board retain responsibility for amending Wis. Stat. 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 staff the future project team with the level of expertise necessary to move this initiative forward. The 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 group’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.

The Implementation Workgroup recommends that, upon review by the eHealth Board of the recommendations resulting from the efforts of the Security and Privacy Project Implementation Workgroup, the eHealth Board consider the advice given to create an “oversight coalition” comprised 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 group. With the understanding that legislative change would need to occur in order to implement the proposed solution, composition of an “oversight coalition” would have to include members who have the political connections to facilitate legislative change; and, would include a strong government leader to shepherd the proposed solution through the legislative process.

4.2.4 PROJECT SCOPE

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

| Area | Current Law | Proposed Change |
|---------------|---|--|
| Documentation | Wis. Stat. 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. | Wis. Stat. 146.528 will require limited documentation of disclosures to enable the patient to determine who has accessed their health information and when. |
| Re-disclosure | Wis. Stat. 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. | When a provider receives health information, the provider may release the received information with patient consent or under a statutory exception as indicated in Wis. Stat. 51.30/Administrative Code HFS 92.03(h)(1). |
| Disclosure to | Wis. Stats. 146.82 and 146.83 | Allow oral disclosure to individuals |

| | | |
|--|---|---|
| individuals involved in the care or treatment of the patient | require patient consent to provide written or oral disclosures of health information to individuals involved in the care or treatment of the patient. | 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. |
|--|---|---|

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 impacted by the changes. Once the proposed legislation is codified, the future project team should partner with professional associations and others to launch trainings 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 Wis. Stat. 146 is the legislative process. An overview of this process is outlined in Appendix 1. The list below outlines key activities required to amend Wis. Stat. 146 as described in this report. Each section should be completed in parallel.

Section 1: Preparing for Legislative Change

- Identify legislative sponsor(s), DHFS sponsor, and content expert(s)
- Develop case for necessity of proposed changes
- Hold listening sessions to discuss proposed changes
- Refine proposed changes to reflect stakeholder input
- Fine tune specific legal changes identified (i.e., develop sample language)
- Request and review legislative draft
- Obtain fiscal note
- Identify supporters and opposition
- Develop plans to address concerns
- Build support for proposed changes
- Monitor, manage, and nurture proposed changes through the legislative process

Section 2: Building Stakeholder Involvement

- 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

Section 3: Communicating the Proposed Solution

- Identify all stakeholder groups impacted by the proposed changes
- Determine communication needs of each group
- Build communications plan for each impacted stakeholder
- Develop communications pieces
- Build Web site for project updates and all communication materials
- Deliver communications throughout the legislative process

Section 4: Training and Education

Determine how law changes will impact organizational policies and procedures
Develop training materials to communicate law changes to providers
Develop outreach materials to communicate changes to consumers
Build Web site with training materials and consumer information

Section 5: Next Steps

Complete the legal reconciliation process
Develop administrative rules if necessary
Continue study of Wis. Stat. 146 and its impacts on health information exchange
Maintain Web site with training and educational materials

4.2.6 PROJECT TIMELINE AND MILESTONES

In the previous section a number of key activities were identified for implementing the proposed solution. In the final report, a project timeline will be included.

4.2.7 PROJECTED COST AND RESOURCES REQUIRED

Due to time constraints, the project timeline and cost analysis will be completed by the Security and Privacy Project Team with input from relevant stakeholders following the submission of the Interim Implementation Report.

4.2.8 MEANS FOR TRACKING, MEASURING, AND REPORTING PROGRESS

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 future project team 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 vary based on each group’s role in the initiative). Regular communication is critical to successful project tracking and monitoring, so 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 purpose of the proposed changes is to improve the health of Wisconsin residents. Hard and soft 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.

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

The proposed changes to Wisconsin Statute 146 will impact many stakeholder groups in the health care system. In the following section, groups impacted by the proposed changes are identified as well as how the stakeholders will be impacted. The Workgroup understands that the identified stakeholder groups should serve as a starting point for coalition building, and encourages expansion of the proposed list as necessary.

Impacted Stakeholders

Consumers/Patients

Expand disclosures to individuals involved in care and treatment: This proposed change will help to facilitate communications with a majority of individuals who care for aging parents, children, and others, which will ultimately improve communication and improve patient care for some Wisconsin residents. The risk associated with this change is that in some circumstances, this increased ease of access may increase the likelihood that providers will inadvertently disclose information to inappropriate parties (abusive spouses, parents, or children, etc.), which may have a detrimental effect on the patient's care and progress. The Workgroup noted the need for additional discussion and stakeholder input regarding this change, potentially to create an opt-out option or another proposed solution to minimize inadvertent disclosures.

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

Documentation of 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 their record has been disclosed.

Providers

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

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

Modify documentation of disclosure requirement: Long-term, the Workgroup envisions that this change will decrease providers' costs and administrative burden, which could allow more time for patient care services and lower costs.

Individuals Involved in the Care or Treatment of A Patient

Expand disclosures to individuals involved in care and treatment: In cases where providers comply strictly with Wisconsin’s prohibition on sharing protected health information without patient consent, this change will lead to:

- A decrease in frustration for concerned families and other caregivers, and
- Increased ability to be informed caregivers.

Payers

Modify re-disclosure restrictions: This change will decrease payment for duplicative services and provide increased information when payment for services require review. By increasing the amount of information available for each patient, the Workgroup expressed concern that this change may increase payers’ access to information on a patient’s pre-existing conditions.

Public health

Expand disclosures to individuals involved in care and treatment: Health care providers in local health departments in most cases use a broad definition of family. Thus, expanding the language would be acceptable and fit the context of care given increasing diversity of family constellations. However, consideration should be given to unique circumstances that include but are not limited to: translators, people who sign for the deaf and hearing impaired. Additionally, it needs to be determined if nutritionists should be added to the list of health care providers in Wis. Stat. 146.82. In recent years they were included, but then were “sunsetting” as health care providers. Adding this language would assure that public health nutritionists are formally considered part of the public health team, and like public health nurses, they focus on the health of individuals, families, and communities.

Modify re-disclosure restrictions: Adapting state law to conform to HIPAA re-disclosure is good common sense. The Wisconsin Department of Health and Family Services and the Wisconsin Department of Public Instruction must assure that changes in law governing patient health care records be formally and regularly communicated to local health departments and schools, respectively, as they are not set up like hospitals and health care clinics in terms of hierarchy and bureaucracy when it comes to health information management.

Modify documentation of disclosure requirement: Adapting the documentation to conform to HIPAA is good common sense.

Professional associations

It is anticipated that members of the professional associations will benefit from these proposed solutions and that their professional associations will play critical roles in the implementation of each proposed change to Wis. Stat. 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. Each of these

stakeholder groups was identified because they have a strong interest in these arenas, or may have responsibility for education of their representative populations. 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 Wis. Stats. 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 future project team should work with the “oversight coalition” to develop a targeted communication plan in the initial phase of the efforts to change Wis. Stat. 146 as outlined in this report. Such a plan should outline efforts to ensure appropriate stakeholder input and facilitate stakeholder buy-in. One option for effective communication would be to create and maintain a centralized project Web site. This Web site could include scenarios that highlight the way changes in the law would impact providers, consumers, and other stakeholders.

Once the proposed legislation is drafted, the future project team should coordinate with the Oversight Committee and the eHealth Board to begin an educational campaign, which should communicate the proposed changes to relevant stakeholders and emphasize their importance to health information exchange and, ultimately, to better health care for the state of 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 Wis. Stat. 146 have been developed by a broad coalition of stakeholders, many of whom have successfully sought changes to Wis. Stat. 146 in the past. Moreover, these changes provide improvements in Wisconsin’s ability to exchange health information electronically with minimal impacts on the privacy and confidentiality of personal health information. Thus, the Workgroup is confident that the proposed changes are feasible, although there are many challenges to overcome in the process.

4.2.11 POSSIBLE BARRIERS TO THE IMPLEMENTATION PLAN

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

However, changing 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 legislative priorities are 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. Likewise, consumer concern about the implications of these changes may present obstacles.

None of these challenges are 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 and moderate provider resistance to change.

4.3 Recommended Solution: Allow Disclosure from Provider-to-Provider for Treatment Purposes

PROPOSED SOLUTION

Amend Wisconsin Statute 51.30 to allow disclosure from provider-to-provider for treatment purposes without patient consent.

This proposed change would not impact treatment information relating to alcohol and other drug abuse treatment between providers for treatment purposes without patient consent, as governed by 42 CFR Part 2. The federal law protection would be more protective and preempt a less protective state statute.

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.¹ Information regarding mental health, alcohol and other drug abuse (AODA), and developmental disabilities, referred to as “sensitive information,” can only be released for treatment purposes with a patient’s written informed consent. Patient consent is not required for sensitive information in a medical emergency or when disclosing 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 to health care providers within a related health care entity.²

By requiring patient consent to release information relating to mental health and developmental disabilities, Wisconsin statutes differ from federal HIPAA regulations, which allow release of information between providers for treatment purposes without patient consent.³ Like Wisconsin law, the federal law that controls AODA treatment records, 42 CFR Part 2, requires patient consent to provide this information to a provider for treatment purposes.⁴ Both state and federal laws create a barrier to health information exchange between providers by requiring patient consent. Even with modification of state law relating to the requirement for consent, the federal law barrier will not be eliminated by the implementation of this proposed solution. The applicable sections of the more stringent federal law will still control state AODA patient information and an informed consent will still be required to exchange AODA information unless a modification to the federal requirement for consent is proposed.

¹ Wis. Stat. 146.82(2)(a)2.; Wis. Stat. 252.15(5)(a)2

² Wis. Stat. 51.30(4)(a)8

³ 45 CFR 164.506

⁴ 42 CFR Part 2

Not only do the consent requirements create a barrier to exchange, but the lack of uniformity between Wisconsin state and federal regulations also impose barriers. These barriers exist in both paper and electronic environments. Before treatment 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 an informed consent is required.
- If an informed consent is required, the consent must contain elements mandated under the applicable privacy law.

The state law, as written, protects some patient information; Wisconsin Statute 51.30 protects records based on the statutory definitions of “registration” and “treatment” records, which are further defined by the services provided and where they are maintained. So, a mental health service provided by a psychiatrist in an inpatient psychiatric facility would be protected, but a similar note for a similar service prepared by a primary care provider in a general hospital would not receive the additional protection provided by Wis. Stat. 51.30.

Allowing providers to exchange information for treatment purposes would lead to more informed health care decisions on the part of the provider, would eliminate the potential for errors or adverse results in the provision of patient care and some of the administrative burden required to obtain a patient consent for this information. Removing the consent requirements would simplify exchanges between providers. It may also simplify exchanges between states that do not have consent requirements. These changes would lead to improvements in patient care, decreases in preventable medical errors, decreases in costs for providers and patients, and improvements in providers’ ability to share patient information between states.

At the same time, our Workgroup heard from several people who have conditions that are protected by more stringent privacy laws such as Wis. Stat. 51.30. Many people believe the extra protections are necessary for medical information that could lead to the patient being treated differently if the information were more widely available. The Workgroup supports the concept that patient therapy notes containing highly personal patient information written by a psychiatrist should not be shared without patient consent. The individuals supporting stringent privacy protection did, however, support the need for a provider to have limited treatment information without patient consent, such as medications, allergies and diagnoses and other elements as may be deemed essential to patient care. More detailed feedback from these individuals can be found in Appendix 2.

While the Workgroup believes strongly that information should be shared between providers for treatment purposes without patient consent, the Workgroup supports added protection for some elements of the elements of the patient record. These elements should remain under patient control and not be shared without patient consent. Some common ground between free exchange of sensitive information for treatment purposes and the way the law is written today needs to be reached, and appears attainable based on early discussions with some of the impacted stakeholders.

Agreeing that there should be modification to Wis. Stat. 51.30 and agreeing that some sharing of specific treatment information should be allowed without consent, the Workgroup found it difficult to determine what elements should be designated to be shared. The Workgroup does not feel that sufficient stakeholders were present or that the timeline for the grant was sufficient to reach consensus on the elements that should be exchanged between providers for treatment purposes.

Therefore, the proposed solution is that the law should be changed to allow exchange from provider-to-provider for treatment purposes. The implementation plan outlines a detailed approach for developing an agreed upon set of elements that can be exchanged without consent, as well as the steps for changing and implementing the new law. The Workgroup suggest that a similar project be undertaken at the federal level to examine the merits of 42 CFR Part 2 and to model the Wisconsin initiative to potentially remove the consent requirement to share specifically medically necessary AODA information.

4.3.2 PLANNING ASSUMPTIONS AND DECISIONS

This implementation plan assumes that although the proposed solution to modify Wis. Stat. 51.30 is articulated, the more specific proposed solution incorporating the specific elements to be exchanged has not yet been fully designed. The first phase of the implementation is to conduct a series of meetings with the relevant stakeholders to identify the set of elements that can be shared for treatment purposes without consent.

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 engaging 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 to be 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" will propose a plan for Wis. Stat. 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 separately appointed set of individuals. In either case, the "51.30 workgroup" should be comprised of individuals representing the following stakeholder groups:⁵

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

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

⁵ 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 Statute 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.⁶ Key components of this approach include:⁷

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 easily understandable and accessible for Wisconsin consumers regardless of health literacy, reading skill, computer proficiency, or geographic location. Materials and activities must appropriately address the language, educational, and cultural needs of consumers of all backgrounds (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 Activity | Target Date |
|---|-------------|
| Draft background paper outlining the case for considering changes to s. 51.30 | |
| Form project team (staff) | |
| Convene “51.30 workgroup” | |
| Formulate workgroup charge | |
| 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 | |

⁶ This proposed change will not impact treatment information governed by 42 CFR Part 2, which requires patient consent to disclose information related to AODA treatment.

⁷ A detailed timeline of project tasks is available in section 5.2.6 of this report

| Key Activity | Target Date |
|---|--------------------|
| Hold stakeholder listening sessions (vet proposals) | |
| Refine proposed solution based on listening session input | |
| Present proposal(s) to eHealth Board, adjust as appropriate | |
| Build support for proposed legal change(s) | |
| Communicate proposed legal change(s) to stakeholder groups | |
| Identify legislative sponsor(s), DHFS sponsor(s), and content expert(s) | |
| Fine tune case for legislative change | |
| Identify supporters and opposition | |
| Partner with supporters to further legislation | |
| Develop plans to mitigate opposition | |
| Legislative Changes | |
| Monitor, manage, and nurture proposed solution through the legislative process | |
| Complete legal reconciliation | |
| Develop Administrative Rules if necessary | |
| Confirm Support, Implement Change | |
| Conduct study to determine changes to policies and procedures/training requirements | |
| Conduct training sessions | |
| Deliver on-line training | |

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

Due to time constraints, the project timeline and cost analysis will be completed by the Security and Privacy Project Team with input from relevant stakeholders following the submission of the Interim Implementation Report.

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 utilize 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)

The project director should report to the eHealth Board and stakeholder groups at key milestones identified in the timeline on behalf of the “51.30 workgroup” (these milestones may be uniform or vary based on each group’s role in the initiative). Regular communication is critical to successful project tracking and monitoring, so 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 are to improve the health of Wisconsin residents. Hard and soft 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 should ensure that information relating to this initiative including metrics, milestones, and progress are posted in a timely manner and updated frequently.

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

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 impacted. It then notes specific organizations that should be invited to weigh in on the proposed changes. The Workgroup emphasizes that the identified stakeholder groups are a result of brainstorming and are intended to serve as a starting point for identification of stakeholders for coalition building. The Workgroup encourages the future project team and identified stakeholders to expand the proposed list as they deem necessary.

Impacted Stakeholders

Consumers

Amending Wisconsin Statute 51.30 to allow disclosure from provider-to-provider for treatment purposes without patient consent will impact individuals who are consumers of health care services or purchasers.

Patients

Amending Wisconsin Statute 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. However, patients' concern over stigma associated with some of these conditions, and the lack of control over who would have access to this information, could create a situation where patient care may be negatively impacted. Increased access to sensitive health information may deter patients from seeking needed care resulting in untreated illness, or may motivate patients to withhold relevant information to his/her care. Initiating a transparent, collaborative process in developing the changes to Wis. Stat. 51.30 will increase patient comfort with this proposed change.

Providers

Amending Wisconsin Statute 51.30 to allow disclosure from provider-to-provider for treatment without patient consent could improve the:

- Timeliness in which a provider can access patient information (particularly when in an electronic environment), and
- Provider's knowledge of a patient's health care status, enabling providers to deliver better patient care with fewer medical errors.

By increasing providers' access to information regarding mental health treatment, providers will need to be more cognizant of the potential for stigma in the treatment they provide.

Advocates

Advocates are a trusted source for 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 of individuals (e.g., patients, families, etc.) with a variety of opinions. If all patients and families do not perceive any 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

This change will likely impact individuals involved in the care or treatment of a patient. by limiting the information the caregiver is required to retain to assist in providing better care, as the provider will have increased access to the patient's health care information..

Payers

By allowing providers increased access to patient health information, this change could potentially lead to a decrease in patient service costs (e.g., for duplicative services), and improved care. Ultimately, this 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 anticipates 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 engaging 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 (*).⁸

Consumers

- AARP Wisconsin *
- Arc-Wisconsin Disability Association (formerly the Wisconsin Association for Retarded Citizens) *
- 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
- Developmental Disability Council (DD Council) *
- Disability Rights Wisconsin (DRW) *
- 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
 - Sexual assault
 - Minority health

Providers

- Community health centers
- Local health departments
- Providers (as defined by Wis. Stat. 146.82)
 - Family Practitioners/Primary Care Providers*

⁸ The “51.30 workgroup” will be charged with identifying which information should be exchanged without patient consent.

- Psychiatrists *
- Psychologists *
- Case Workers *
- Nurses
- Emergency medical personnel
- Schools (public, private, and parochial)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) providers
- Hospital personnel *
- Health Information Managers *

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 (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 initial phase of this initiative. Such a plan should outline efforts to ensure appropriate stakeholder input and facilitate stakeholder buy-in. In addition, the future project team should create and maintain a centralized project web site is updated regularly. This web site should include scenarios that highlight, in an easy to relate to way, how the changes in law will impact providers, consumers, and other stakeholders. It should also have a list of Frequently Asked Questions that is updated periodically and relevant reports and contact persons.

Once the proposed legislation is drafted, the future project team should coordinate with the “51.30 workgroup” and the eHealth Board to launch a legislative road-show. This educational campaign should communicate the proposed changes and emphasize their importance to health information exchange and, ultimately, to better health care for the state of Wisconsin. The road-show should consider multiple avenues of communication, including newsletters, talk radio, and television commercials.

4.3.10 FEASIBILITY ASSESSMENT

The Workgroup discussed several potential solutions that fit into a continuum from allowing exchange of limited treatment elements between treating providers to allowing full disclosure of all patient information between providers for treatment without patient consent (as allowable by HIPAA today). Each proposed solution was evaluated based on risks, benefits and feasibility.

The following section defines each proposed solution discussed and summarizes the assessment completed by the Workgroup. Maintain s. 51.30 as written today was not a proposed solution discussed as the group, but rather is documented to demonstrate the risks and benefits of maintaining the status quo. The Workgroup believes there should be change made to s. 51.30. The proposed solutions are ordered from the most politically feasible to the least. With each progressive proposed solution, information available to providers and quality of care increases, while patient control of their own records decreases.

Option 1. Maintain Wis. Stat. 51.30 as written today

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

1. In case of medical emergency
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
 - Birthdate
 - Name of mental health provider(s)
 - Date of service(s)
 - Diagnosis
 - Medications
 - Allergies
 - Other relevant demographic information

Risks The risks of maintaining Wis. Stat. 51.30 as written today include:

- Lack of compliance leading to practice variability
- Decreased patient safety with lack of information sharing
- False security that your current records are protected when there is great variability in the protections employed
- More complexity associated with maintaining in electronic medical record system as this would generally result in increased costs that are not supported by health care organizations to separate information that cannot be exchanged and in applying minimum necessary
- Higher costs of exchange

- Difficulty in exchanges with other states – confusion over laws

Benefits

The benefits of not making changes to Wis. Stat. 51.30 include:

- No additional controversy
- No change
- No additional work
- No new legislation
- Better protection of “sensitive” patient information – decreased likelihood it will be exchanged with the wrong party

Option 2. Remove reference to “in a related health care entity” in Wis. Stat. 51.30(4)(b)8g

Definition

This would allow exchange among all health care providers for treatment purposes but would limit the exchange to the specific elements currently allowed to be exchanged among treatment providers within a related health care entity, without consent (see 51.30(4)(b)8g).

AODA treatment information would continue to be governed by 42 CFR Part 2⁹ since this modification would make 42 CFR the more stringent law, the more protective federal law would control and patient consent would still be required to exchange AODA information except in a medical emergency.

Risks

Removing the reference to “in a related health care entity” in Wis. Stat. 51.30 to allow providers to exchange a limited set of elements without consent creates the following risks:

- Decreased control of PHI
- Improved patient safety from Option 1, but barriers to exchange remain
- False security that your current records are protected when there is great variability in the protections employed
- More complexity associated with maintaining in electronic medical record system as this would generally result in increased costs that are not supported by health care organizations to separate information that cannot be exchanged and in applying minimum necessary
- Difficult to exchange with other states – confusion over laws
- Decreased potential for patients to seek care for mental illness vs. Option 1
- Increased potential for discrimination vs. Option 1
- Potential decreased trust between patient and health care provider vs. Option 1
- Difficulty in changing law

Benefits

Allowing providers to exchange a specific set of elements for treatment purposes, without patient consent, improves the ability to exchange information over what is allowed today. Specific benefits include:

- Decreased administrative burden of obtaining consent
- Improved ability to share information
- Better decision making with more information

⁹ 42 CFR Part 2: No statutory authority for disclosure to providers except in a medical emergency.

- Improved quality of care with more information
- Reduced medication errors
- Improved the ability to trend patients
- Decreased frustration of patients and family
- Improved coordination of care

Option 3. *Revise Wis. Stat. 51.30 to mirror the language in Wis. Stat. 146.82(2)(a)2*

Definition This would allow all patient information to be exchanged between providers for treatment purposes as currently defined by Wis. Stat. 146, without consent. If the modification is made to Wis. Stat. 51.30 the minimum necessary standard relating to disclosure of patient information would still apply.¹⁰

AODA treatment information would continue to be governed by 42 CFR Part 2. Consent would still be required to exchange 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 Wis. Stat. 51.30 to mirror HIPAA creates additional risks. These include:

- Decreased control of PHI
- More complexity associated with maintaining in electronic medical record system as this would generally result in increased costs that are not supported by health care organizations to separate information that cannot be exchanged and in applying minimum necessary
- Simpler to exchange with other states, but confusion over laws will remain
- Decreased potential for patients to seek care for mental illness vs. Option 2
- Increased potential for discrimination vs. Option 2
- Potential decrease in trust between patient and health care provider vs. Option 2
- Difficulty in changing state law

Benefits Increasing the amount of information that can be exchanged without patient consent to the minimum necessary by changing Wis. Stat. 51.30 to mirror HIPAA improves the ability of providers to exchange information. This creates additional benefits over Option 2 including:

- Improved patient safety vs. Option 2
- Improved compliance with law
- Improved patient understanding of privacy protections
- Better aligned patient/provider perceptions/expectations
- Decreased administrative burden of obtaining consent vs. Option 2
- Improved ability to share information vs. Option 2
- Improved quality of care with more information vs. Option 2
- Better decision making vs. Option 2 with more information
- Reduced medication errors vs. Option 2
- Improved ability to trend patients vs. Option 2
- Decreased frustration of patients and family vs. Option 2

¹⁰ HFS 92.03(n)

- Improved coordination of care vs. Option 2

Option 4. *Revise Wis. Stat. 51.30 to mirror the language in HIPAA*

Definition Would allow all patient information to be exchanged, between providers for treatment purposes without consent.¹¹

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

Risks Revising Wis. Stat. 51.30 to mirror HIPAA removes the minimum necessary requirement and therefore increases the risks over allowing providers to exchange the minimum necessary without patient consent.

- Decreased control of PHI
- Decreased potential for patients to seek care for mental illness vs. Option 3
- Increased potential for discrimination vs. Option 3
- Potential decreased trust between patient and health care provider vs. Option 3
- Difficulty in changing state law
- Possibly provides too much information so providers can't see the important information

Benefits Removing the minimum necessary requirement and allowing providers to exchange all information covered by Wis. Stat. 51.30 for treatment purposes without patient consent allows for the simplest exchange of information evaluated by the Workgroup. Benefits to this include:

- Improved patient safety vs. Option 3
- Improved compliance with law
- Improved patient understanding of privacy protections
- Better aligned patient/provider perceptions/expectations
- Decreased administrative burden of obtaining consent vs. Option 3
- Improved ability to share information vs. Option 3
- Improved quality of care with more information vs. Option 3
- Better decision making vs. Option 3 with more information
- Reduced medication errors vs. Option 3
- Improved ability to trend patients vs. Option 3
- Decreased frustration of patients and family vs. Option 3
- Improved coordination of care vs. Option 3
- Simplified requirements of EMR vs. all proposed solutions
- Minimum necessary requirement removed

4.3.11 POSSIBLE BARRIERS TO THE IMPLEMENTATION PLAN

This proposed solution removes a perceived privacy protection provided by Wis. Stat. 51.30. Lobbying groups in Wisconsin fought to create the law—and have expressed support for the law as currently written. A recent change to Wis. Stat. 51.30 expanded sharing of information between providers,

¹¹ 45 CFR 164.506(a) and (c)(2)

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 outside of a related health care entity.

Involving all necessary stakeholders in the development of the proposed changes to the law will greatly improve the chances of success for this initiative. If an agreed upon compromise solution can be developed by all parties, legislation to implement the proposed solution may be achievable.

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. Thus, this implementation plan is under the category of ‘multi-state implementation plans.’

5.1 Statewide Strategy and Coordination

As with the state-wide implementation plans discussed above, Wisconsin’s eHealth Board should oversee this recommendation. Verifying the identity of the patient is a necessary step in information exchange. Therefore, the implementation of the plan 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 nationally defined standards for patient identification once available.

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).^{12,13} Moreover, there is not a standard method to verify patient identifiers at the time of exchange.¹⁴ This lack of standardization creates significant risks to accurate and timely patient care.

¹² Capture: The process of collecting patient identifiers from a patient.

¹³ Patient Identifiers are information collected from a patient to assist in the identification of the patient (e.g., name, birth date, address, etc.)

¹⁴ Verification: The process of confirming that patient identifiers are correct.

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 utilized or available in another practice;
- Accurate identification of a specific patient information 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 inappropriate continuity of care; and
- Misidentification of patients may create liability for inappropriate disclosure.

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.

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.’¹⁵ The Markle Foundation’s Connecting for Health Initiative devoted an entire policy guide of its Common Framework to ‘Correctly Matching Patients with Their Records.’¹⁶ 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 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 available.

The Workgroup identified a number of areas 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?

¹⁵ For additional information, see: http://www.hhs.gov/healthit/ahic/materials/01_07/cps/draft_recs.doc

¹⁶ For additional information, see: <http://www.connectingforhealth.org/commonframework/#guide>

- Should compliance with these model policies and procedures be a pre-requisite 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.

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 ensuring that the project is on track to successfully meet milestones.

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 workgroup recommends that the eHealth Chief of Staff or her appointee serve as the project director under the direction of the eHealth Board.

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. Strong partnerships with diverse stakeholders (e.g., consumers, providers, vendors, etc.) will be important when defining and disseminating model policies and procedures.

5.2.4 PROJECT SCOPE

The Verification of Patient Identification project contains two parts that should happen concurrently, constantly informing each other:

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 criteria (identifiers) needed to accurately identify an individual patient
- 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 Care Quality and Patient Board or its designees should:

- a. Issue a white paper describing the model policies and procedures and emphasizing their importance, particularly as this relates 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 statewide adoption of these model policies and procedures.
- c. Partner with professional associations and others to educate all stakeholders, state agencies, and impacted organizations on the model policies and procedures.
- d. Build public awareness of the importance of adopting the policies and procedures.

2. Adopt nationally defined standards for patient identification once available.

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

5.2.5 TASKS REQUIRED

See section 5.2.6.

5.2.6 PROJECT TIMELINE AND MILESTONES

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

| Key Activities | Target Date |
|--|-------------|
| <i>Create model policy and procedure to facilitate collection and validation of patient identification</i> | |
| Clarify definition and scope of key project terms (verification, etc.) | |
| Develop values statements to inform model policy development | |
| Agree on identifiers to be captured/validated/verified/matched | |
| Draft model for capture/validation/verified/matched | |
| Hold listening sessions to validate identifiers and model policies and procedures | |
| Revise as appropriate | |
| <i>Facilitate adoption of policies and procedures</i> | |
| Develop a white paper outlining the policies and procedures | |
| Identify key stakeholders | |
| 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 | |
| <i>Monitor national efforts to develop standardized mechanism for verification of patient</i> | |
| Identify groups leading national effort | |
| Monitor activities | |
| Inform oversight committee of developments | |
| Adjust state efforts as appropriate | |
| <i>Adopt national standard</i> | |
| Determine if changes need to be made to policies and procedures based on national standards | |

| Key Activities | Target Date |
|---|-------------|
| Communicate national parameters to be collected using state model policies and procedures | |

Key activities are identified above for implementing the proposed solution. In the final report, a project timeline will be included.

5.2.7 PROJECTED COST AND RESOURCES REQUIRED

Due to time constraints, the project timeline and cost analysis will be completed by the Security and Privacy Project Team with input from relevant stakeholders following the submission of the Interim Implementation Report.

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 and progress relating to the project is transparent, 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.

Impacted Stakeholders

The Implementation Workgroup also assessed the impact of the proposed solution on several stakeholder groups. The next section of this report identified impacted stakeholder and summarizes how the adoption of model policies and procedures will impact 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 matching patients to their identity prior to receiving care. These efforts will make the health care industry's actions consistent with other industry's 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 within the correct patient's record empowers providers to provide better quality 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 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, enabling 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 nationally rising health care expenses.

Stakeholder Involvement

The Workgroup believes that patients and providers will be significantly impacted by the adoption of model policies and procedures and resulting benefits will be readily identifiable. 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 change in patient safety and quality improvement. 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. In addition to targeted communications, a centralized web site should be created and maintained by the future project team. This website 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 the national standards for patient identification, relies on development of a standard at the national level. Assuming this standard is developed, Wisconsin will be well prepared to adopt it.

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 view points (e.g., experts in health information technology, health information management, providers, payers, consumers, vendors etc.) to consensus. A targeted effort to vet and finalize these proposals with an eye towards activities at the national level be important to the success of this effort.

Once model policies and procedures are finalized, they will need to be adopted. This process will require significant empowerment of those distributing the model and 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 requested). With strong leadership, targeted communications efforts, and an appropriate media campaign, the Workgroup anticipates that most providers and consumers will align in support of these model policies.

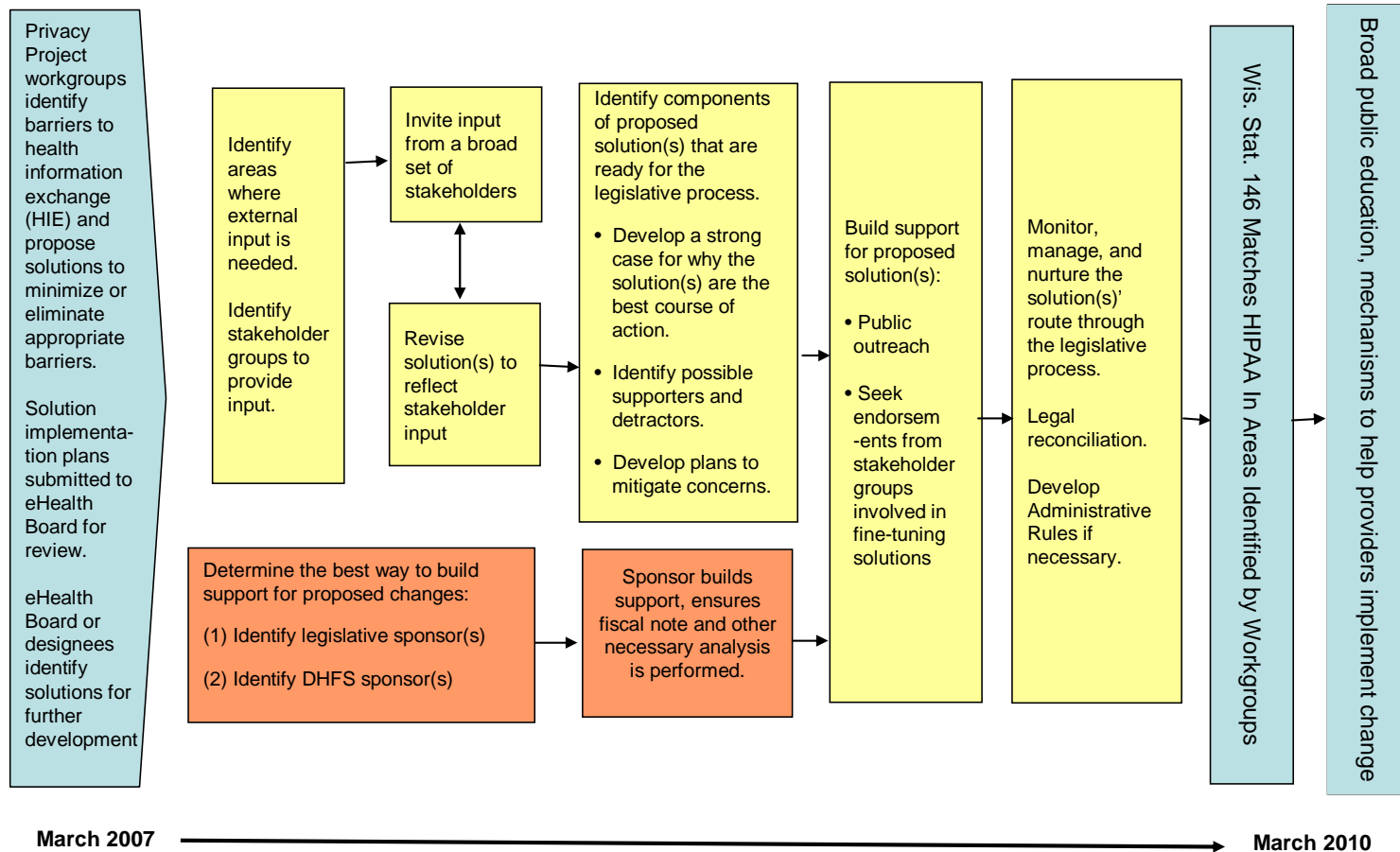
The second part of the project, the adoption of the national standards for patient identification, relies on development of a national standard. If standards are not set at the national level, the full potential of the proposed solution will not be reached. However, Wisconsin will still reap substantial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

Appendices

Appendix 1: Sample Timeline and Milestones to Change Wisconsin Law

Sample Timeline and Milestones to Change Wisconsin Law

Yr. 1: Define Solution; Build Support Yr. 2: The Legislative Arena Yr. 3: Confirm Support, Make Change



**Appendix 2: Summary of Mental Health Advocates
Concerns Regarding Proposed Changes to Wis. Stat. 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 Wis. Stat. 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 Wis. Stat. 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 impact 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 impact 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 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), 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 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 alternate 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:

- The 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. Utilize appropriate resources to obtain patient identification information
3. Validate the patient identifiers against some type of accepted identification (drivers 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, patient query, etc.).

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. Utilize appropriate resources to obtain patient identification information
3. Validate the patient identifiers against some type of accepted identification (drivers 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 public health 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

**Wisconsin
Security and Privacy Project**

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