



Washington State Health Care Authority
In collaboration with
OneHealthPort

Secure Exchange of Health Information
2010 Progress Report



As Required by Substitute Senate Bill 5501
Chapter 300, Laws of 2009

January 2011

Copies of this report will be available at: <http://www.hca.wa.gov>

(This page left intentionally blank.)



**Washington State
Health Care Authority**

**P.O. Box 42700 • Olympia, Washington 98504-2700
360-923-2828 • FAX 360-923-2606 • TTY 360-923-2701 • www.hca.wa.gov**

January 6, 2011

Thomas Hoemann
Secretary of the Senate
Washington State Senate
P.O. Box 40482
Olympia, WA 98504-0482

Barbara Baker
Chief Clerk of the House
House of Representatives
P.O. Box 40600
Olympia, WA 98504-0600

Dear Mr. Hoemann and Ms. Baker:

The Health Care Authority (HCA) is pleased to submit this progress report to the Legislature as directed by Substitute Senate Bill 5501 (SSB 5501), chapter 300, Laws of 2009, regarding the Secure Exchange of Health Information.

This report represents the joint work of the HCA and OneHealthPort over the past year. My staff and I, as well as the leadership team at OneHealthPort, will be glad to address any questions you may have concerning this report and plans for accomplishing the directives set forth in this legislation.

Sincerely,

Doug Porter
State Medicaid Director
Health Care Authority Administrator

cc: Senator Karen Keiser, Chair, Senate Health and Long-Term Care Committee
Senator Cheryl Pflug, Ranking Minority Member, Senate Health and Long-Term Care Committee
Representative Eileen Cody, Chair, House Health Care and Wellness Committee
Representative Doug Ericksen, Ranking Minority Member, House Health Care and Wellness Committee

Nick Lutes, Office of Financial Management
Jonathan Seib, Governor's Health Policy Office
Marty Lovinger, Governor's Health Policy Office
Edith Rice, Counsel, Senate Health and Long-Term Care Committee
Jim Morishima, Research Analyst, House Health Care and Wellness Committee
Erik Sund, Fiscal Analyst, Senate Ways & Means Committee
Tim Yowell, Senior Fiscal Analyst, Senate Ways & Means Committee
Dave Pringle, Counsel, House Ways and Means Committee
Erik Cornellier, Counsel, House Ways and Means Committee
Richard D. Rubin, President and CEO, OneHealthPort

Table of Contents

I.	Executive Summary	iv
II.	Introduction.....	1
III.	Organizing and Planning.....	2
IV.	Governance	3
A.	The Foundation for Health Care Quality	3
B.	The HIE Leadership Group.....	4
V.	Shared Services	5
A.	Business Case.....	5
B.	Community Stakeholder Requirements	6
C.	Key Policy Objectives.....	8
D.	Shared Service Components	8
VI.	Progress Toward Implementation	13
A.	HIE Strategic and Operational Plan.....	15
B.	Statewide HIE Secure Hub	15
C.	Privacy and Security	16
D.	Continued Stakeholder and Program Collaboration	17
VII.	Conclusion	19
	Appendix A: Substitute Senate Bill 5501	20
	Appendix B: Community Oversight Organization Board	26
	Appendix C: Health Information Exchange Leadership Group	27
	Appendix D: Presentation: HIE Hub Selection – Final Recommendation	28
	Appendix E: Health Information Technology Terms and Definitions	58

I. Executive Summary

In 2009, the Washington State Legislature passed Substitute Senate Bill 5501 (SSB 5501) which was enacted as chapter 300, Laws of 2009. The bill required the Health Care Authority (HCA) to designate one or more lead organizations to coordinate development of processes, guidelines, and standards for Health Information Exchange (HIE). SSB 5501 also directed the HCA and the designated lead organization to submit annual progress reports to the Legislature through 2012. This progress report is designed as a companion document to the first progress report dated December 1, 2009.

The American Recovery and Reinvestment Act (ARRA), signed by President Obama on February 17, 2009, also provided guidance and direction through the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) to improve the quality of care and establish a foundation for health care reform through the use of health information technology.

The HCA took advantage of the opportunities provided in this state and federal legislation to closely align and leverage these related efforts to establish a statewide coordinated activity to meet the requirements of both SSB 5501 and the HITECH Act. The HCA designated OneHealthPort (OHP) as the Lead Organization.

In the fall of 2009 OHP, with support from the HCA, conducted an extensive outreach effort to query interested stakeholders about requirements for governance and shared services. The collective input of the stakeholder community was that the ideal governance model would facilitate the participation of state government, enable broad-based community oversight, and support the efficient delivery and operation of shared HIE services. Essentially, a blended model appeared to be the most viable way to meet this broad spectrum of needs.

Based on this feedback, the HCA and OHP decided to continue with the basic lead organization model, but strengthen the private sector role in two distinct ways. First, in the spring of 2010 a Request for Proposal (RFP) was issued and the Foundation for Health Care Quality (Foundation) was selected to establish and support a qualified not-for-profit Community Oversight Organization. Second, OHP established the HIE Leadership Group as an advisory body to help guide its work on the business and technical aspects of implementing the statewide HIE.

The design of Washington State's HIE technical architecture for shared services was driven by three major considerations: previous lessons learned about the primacy of the business case, requirements gathered from community stakeholders, and alignment of key policy objectives embedded in federal and state legislation. The proposed shared HIE services for initial implementation of the statewide HIE will include a Hub to enable the secure exchange of transactions. The Provider Data Service directory currently being implemented under the directive of SSB 5346 (enacted as chapter 298, Laws of 2009) will be linked to the Hub to assist participating organizations to identify and locate their information exchange partners. Other areas of technology under consideration for the statewide HIE include a master patient index (MPI) and a record locator service (RLS).

On July 6, 2010, the HCA submitted [Washington State's Strategic and Operational Plan](#) to the Office of the National Coordinator for Health Information Technology (ONC). The plan was prepared over several months in a joint effort by OHP and the HCA with input from public and private stakeholders. The plan discusses the strategies and operational activities necessary to implement a sustainable statewide HIE. Over the past several months the HCA, OHP, and the ONC have been engaged in correspondence to clarify existing and provide additional information for the Strategic and Operational Plan. Additional rounds of information were provided in Addendums sent to the ONC on October 25, 2010, November 5, 2010, and December 8, 2010. The ONC approved the Strategic and Operational Plan on December 13, 2010.

Following submission of the Strategic and Operational Plan, the major focus of the statewide HIE project from July through October 2010 was the procurement of a secure Hub. OHP contracted with Deloitte to assist in preparing the RFP. The HIE Leadership Group and their Technical Advisory Group (TAG) provided advice throughout the selection process. The RFP was distributed through numerous local and national communication channels in August and all qualified vendors were encouraged to bid. In late October, Axway was declared the apparent successful vendor.

OneHealthPort will be working on a number of tasks in parallel to bring the Axway Hub service to market in early 2011 including negotiating a contract with Axway, working with the HIE Leadership Group on a pricing and policy model, submitting the pricing and policy model to the Community Oversight Organization for approval, continuing development of an optimal MPI/RLS solution for the community, and commencing marketing efforts to seek early adopters for the HIE Hub service.

In addition to the specific Hub related activities, OHP and the HCA will be working with TAGs, early adopters, and stakeholders to develop policies and practices that support evolution and sustainability of a statewide HIE. A key aspect of the policy work is privacy and security and will be framed by the following core principles: policies will fully comply with all applicable state and federal law, each party is responsible for actions within its perimeter, and participants exchanging information through the statewide HIE will be responsible for securing patient consent. A formal HIE Participant Agreement is currently in the editing process. A draft is scheduled for review at the December 17, 2010 TAG meeting. The final draft will be sent to the HIE Leadership Group and Community Oversight Organization in early 2011 for final review and approval.

In conjunction with this effort the HCA project team will continue collaborative work with other ARRA HITECH Act program areas across the state to align activities of the statewide HIE where they may add value and enable these other programs to meet their goals and requirements. The HCA will also continue efforts to efficiently and effectively engage stakeholders and communicate, facilitate, and coordinate activities in this broader unified effort. Additionally, the statewide HIE project will coordinate with Medicaid and public health to provide assistance, where appropriate, to support federal incentive programs sponsored by the Centers for Medicare & Medicaid Services that reward providers for adopting and using health information technology.

II. Introduction

In 2009, the Washington State Legislature passed Substitute Senate Bill 5501 (SSB 5501) enacted as chapter 300, Laws of 2009 (see Appendix A). The bill required the Health Care Authority (HCA) to designate one or more lead organizations to coordinate development of processes, guidelines, and standards for Health Information Exchange (HIE) to:

1. Improve patient access to and control of their own health care information and thereby enable their active participation in their own care.
2. Implement methods for the secure exchange of clinical data as a means to promote:
 - Continuity of care.
 - Quality of care.
 - Patient safety.
 - Efficiency in medical practices.

The American Recovery and Reinvestment Act (ARRA), signed by President Obama on February 17, 2009, also provided guidance and direction through the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) to improve the quality of care and establish a foundation for health care reform through the use of health information technology.¹

The HCA took advantage of the opportunities provided in this state and federal legislation to closely align and leverage these related efforts to:

1. Establish a statewide coordinated activity to meet the requirements of both SSB 5501 and the HITECH Act.
2. Designate OneHealthPort (OHP) as the Lead Organization for HIE in Washington State and, consistent with the lead organization model in SSB 5346 (enacted as chapter 298, Laws of 2009), not reimburse OHP for activities related to this lead role with any state funds.
3. Leverage the reach of the HITECH Act program areas, closely align statewide requirements, and apply for ARRA funding to enable full implementation of SSB 5501.
4. Create an efficient and effective stakeholder engagement structure and process to communicate, facilitate, and coordinate this broader unified effort.
5. Initiate planning for a statewide HIE framework that guides and supports governance, financial sustainability, technical infrastructure, business and technical operations, and policy development and implementation.

SSB 5501 directs the Lead Organization, with the HCA Administrator, to prepare a progress report for the Legislature by December 1. This progress report is designed as a companion document to the first progress report dated December 1, 2009. As such, this report will not repeat the background information on SSB 5501, HIE, the Lead Organizations, or the work accomplished in 2009. Some very limited information from the first report is repeated in this

¹The American Recovery and Reinvestment Act of 2009, Title XIII-Health Information Technology, Subtitle A-Promotion of Health Information Technology, Part 1-Improving Health Care Quality, Safety, and Efficiency, Title XXX-Health Information Technology and Quality, Section 3000
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf

document to assist the reader. This report will focus exclusively on the progress made implementing SSB 5501 from December 1, 2009, through mid-December 2010.

III. Organizing and Planning

The HCA and OHP identified several key considerations associated with the advancement of a statewide HIE that directly affect organization and planning activities:

- At the federal, state, and local level, in the public and private sectors, the goals are to make patient care safer, communities healthier, and the delivery of health services more efficient and effective.
- HIE, the ability to share information efficiently across organization and geographic boundaries, is a necessary but not sufficient condition to bring about the desired future state.
- The statewide HIE will support the shared health information needs of the key players who deliver, receive, and pay for health services and play the most prominent role in improvement efforts.

In this context the HCA and OHP made two important decisions that currently guide the federal grant program activities and shape the essential character of the Washington State HIE.

- **Leverage those who are already engaged and invested.** By its very nature, HIE is a collaborative activity. It bridges gaps across organizations, domains, and information silos. HIE also requires an initial investment on the part of all interested parties to participate. To exchange information electronically, participants must first have data in electronic form and an application to store and view the information. The Washington State HIE is optimized for the individuals and organizations that demonstrate by their actions an interest in connecting to others, sharing information, and improving patient care and community health.
- **Solve the business problem.** While HIE is both a business and a policy problem, many observers have commented that the failure to develop robust statewide HIEs in Washington State and elsewhere is at heart a business failure. Therefore, the priority of this effort is to design and implement a sustainable statewide HIE that meets the business and clinical needs of the parties. The focus on sustainability will not occur in a “policy vacuum.” The short-term approach is grounded in the achievement of long-term public policy goals, while the day-to-day decision making will be closely monitored and overseen to ensure the public interest is served.

Along these lines, in the fall of 2009 OHP, with support from the HCA, conducted an extensive outreach effort to query interested stakeholders about requirements for governance and shared services. Tapping into a large stakeholder community the HCA and OHP had worked with over the past several years in their respective health information technology (HIT) and HIE initiatives, feedback was solicited through in-person meetings, web casts, and online surveys to understand preferences for these key components of a statewide HIE.

IV. Governance

Key governance findings from the stakeholder solicitation included a number of business requirements that were identified as being important for any HIE governance model. These findings could be summarized as follows:

- The ability to take business risk, deliver services, meet customer needs
- Be representative of multiple constituencies involved with HIE
- Be led by the private sector with public sector participation
- Be able to ramp up quickly in the initial phase and evolve as needed over time

The collective input of the stakeholder community was that the ideal governance model would facilitate the participation of state government, enable broad-based community oversight, and support the efficient delivery and operation of shared HIE services. Essentially, a blended model appeared to be the most viable way to meet this broad spectrum of needs.

Based on this feedback, the HCA and OHP decided to continue with the basic lead organization model, but strengthen the private sector role in two distinct ways. First, a Request for Proposal was issued for a qualified not-for-profit to serve as the Community Oversight Organization. The Foundation for Health Care Quality was selected to establish and support this oversight organization. Second, OHP established the HIE Leadership Group as an advisory body to help guide its work on the business and technical aspects of implementing the statewide HIE.

A. The Foundation for Health Care Quality

The Foundation is a well-established 501(c) (3) organization that has long focused on shared health information needs in the state and is governed by a diverse Board of public and private sector representatives. The Foundation participated in a competitive procurement process in spring 2010 to establish a Community Oversight Organization for the statewide HIE. On July 1, 2010, the Foundation contracted with OHP and the HCA to operate in this capacity. Under the Community Oversight Organization arrangement, the Foundation is charged with constituting a new operating Board to oversee the work of the Lead Organization.

It is important to distinguish that the Foundation is not a co-leader. Consistent with stakeholder preference for a private sector community oversight, the Foundation will review and act on specific elements of the Lead Organization's work. The role of the oversight organization is to help ensure the private Lead Organization is operating in the public interest and not ignoring or overwhelming the interests of other constituencies who may be less engaged in HIE work, but are still affected by it. Specifically, the Community Oversight Organization will review and act on the following:

- The pricing model developed by the Lead Organization for HIE shared services
- The privacy and security policies for the HIE
- Accessibility of the HIE

The HIE governance structure will take the form illustrated in Figure 1 below.

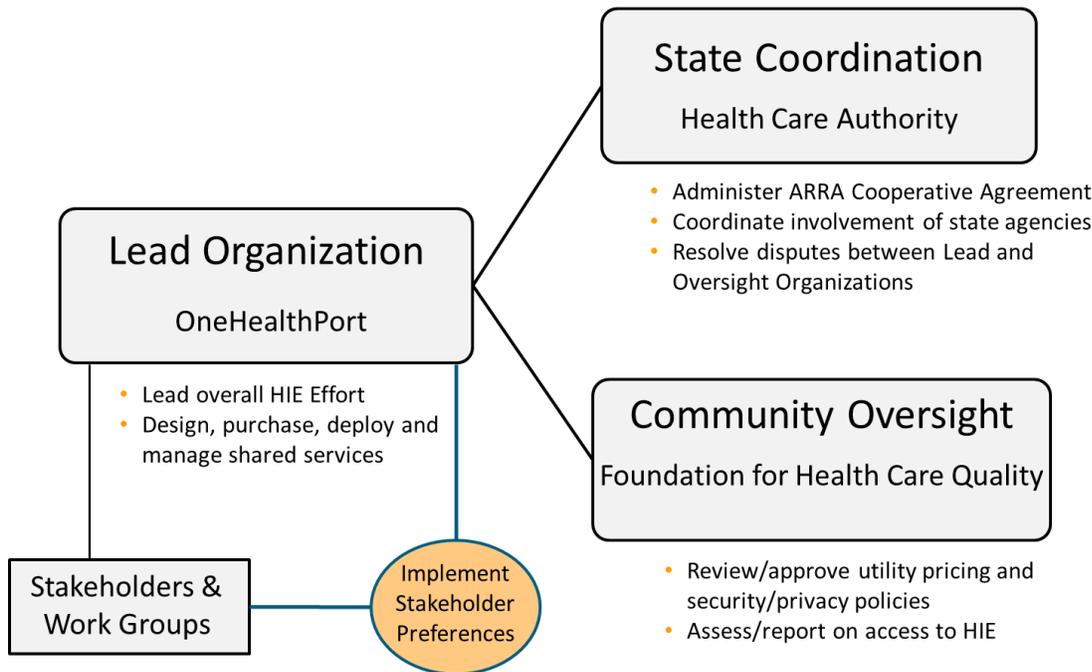


Figure 1: HIE Governance Model for Implementation Phase

The Foundation completed the constitution of the Community Oversight Organization Board in fall 2010. A list of the board members is presented in Appendix B. The Foundation scheduled the first meeting of the membership in November 2010 to review roles and responsibilities, and become oriented to the activities underway with the statewide HIE project.

B. The HIE Leadership Group

In addition to selecting the Foundation as the supporting entity for the Community Oversight Organization, OHP also constituted the HIE Leadership Group as an advisory body to help guide its work on the business and technical aspects of statewide HIE implementation. The HIE Leadership Group is comprised of senior executives from approximately 30 health care organizations that OHP has identified represents critical mass for HIE in Washington State. In addition, OHP has identified each of these organizations as being likely early adopters of the initial HIE service offering, the Hub. These organizations include hospitals, practices, health plans, public payers, public health, and ancillary care providers.

The senior executives invited to serve on the group are in most cases chief information officers (CIOs). They will have a major influence on their organizations' decision to participate in the HIE (see Appendix C for a complete listing of the HIE Leadership Group members). The HIE Leadership Group is tasked with guiding the development of technical and financial specifications. The purpose of organizing this group is to secure their support and encourage

ownership of the development of the statewide HIE. By doing so, the HCA and OneHealthPort hope to secure the critical mass necessary for a functioning and sustainable HIE in Washington State.

V. Shared Services

The Statewide HIE technical architecture will always be a work in progress. The health care system will evolve, business needs will shift, and technology will change. Particularly for a collaborative undertaking where change takes more time than in a typical private enterprise setting, it's important to avoid a sense of finding "the" solution, and remain willing, and even eager, to adapt and evolve. In this context, the architecture presented below should be considered the starting point and the initial phase.

The design of Washington State's HIE technical architecture was driven by three major considerations:

- Previous lessons learned about the primacy of the business case
- The requirements put forth by community stakeholders
- Alignment with key policy objectives embedded in federal and state legislation

The design exercise was essentially understanding, refining, blending, and applying these drivers.

A. *Business Case*

Several key stakeholders' comments included some variation of a common theme, "this has to make business sense for us or my organization won't play." Follow-up discussion almost always leads to the conclusion that the business case for broad-based HIE is neither black nor white; it's gray. Past experience, present realities, and deeply felt preferences around the HIE business case dictate the following requirements:

- **Leverage existing investments.** The HIE must add value to existing enterprise investments, not seek to replace these investments. Washington State has a number of local health information organizations and enterprises with HIT/HIE capabilities already in place. We see this as an advantage and an opportunity, not competition.
- **Scalability.** The market for clinical HIE is immature. There is great hope for the future, but the expectation should be conservative: volume will build slowly. The technical components must be able to start small and scale up to meet demand as industry interest and readiness expands.
- **Flexibility.** In Washington State, enterprises that are likely to participate in the statewide HIE have a wide range of capabilities, sophistication, and need. In the course of research on this topic, while there was not a health information organization (HIO) or enterprise that had fulfilled all of its HIE needs, it became clear that diverse participants will use different elements of the HIE in different ways and at a different pace. One size does not fit all.

- **Modest cost.** Even the most enthusiastic proponents of HIE will prioritize their enterprise infrastructure and applications higher than the statewide HIE. Budgets are tight and because of the “gray” business case, the “R” in return on investment is questionable; as such, the “I” needs to be of modest size.

The core requirement dictated by business case concerns can be summarized in three words: less is more.

B. Community Stakeholder Requirements

There are a limited number of options available to HIE designers. Depending on how terms are defined and capabilities lumped or split, there are typically nine major components that must be present over the long term for HIE to occur. Figure 2 below illustrates these core components:

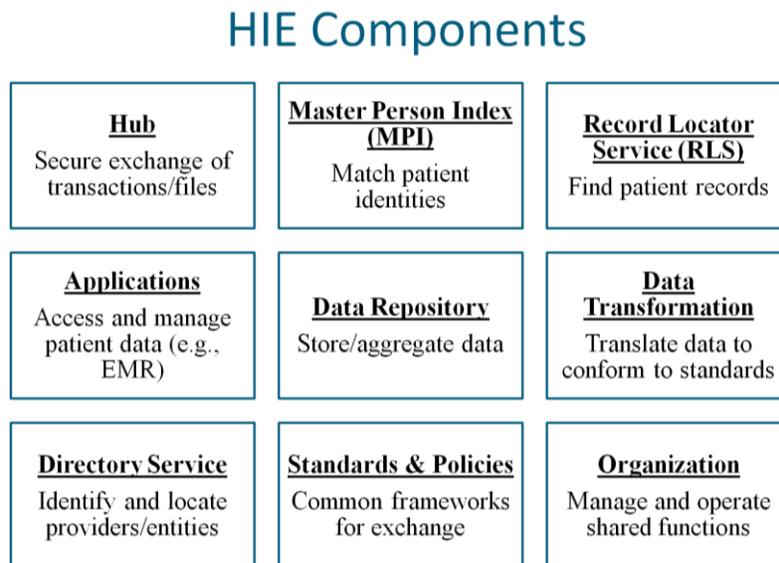


Figure 2: Core Components of HIE

High-level design questions revolve around phasing and whether to provide components centrally or on a distributed basis. In looking at the figure above, the last three boxes - directory service, standards & policies, and organization - must be central components of the HIE at initiation. It is hard to imagine operating an HIE without these core elements. The choices of centralization versus decentralization and phasing really relate to the other six elements.

OHP presented this choice to the community stakeholders in the context of “less is more,” and emphasized the need to pay for all shared capability. The stakeholders were not asked what they wanted. Rather, they were asked what they needed and what they were prepared to pay for and

use. To highlight the true nature of this choice, stakeholders were given a fixed sum of dollar bills and were required to spend the money on the components they most valued. Results of the exercise dictated a clear preference for a limited set of shared services that should be offered by the HIE, as opposed to those services likely to be offered in the market by other interested parties.

Shared services to be centralized in the HIE:

- Hub for secure exchange of Health Level Seven International (HL7) and Accredited Standards Committee (ASC) X12 health data transactions
- MPI to match patient identities
- RLS to find where patient data resides
- Provider Directory to identify and locate trading partners
- Standards and policies supporting the core components of HIE shown in Figure 2 to support trusted and efficient exchange
- Management organization to operate the HIE

Services to be offered in the marketplace by other parties:

- Data repository for storing patient information.
- Data transformation to edit and translate information will be offered both by the Hub and others in the marketplace.
- Applications for viewing, storing, and using information.

Figure 3 illustrates the Washington State “Thin-Layer” HIE:

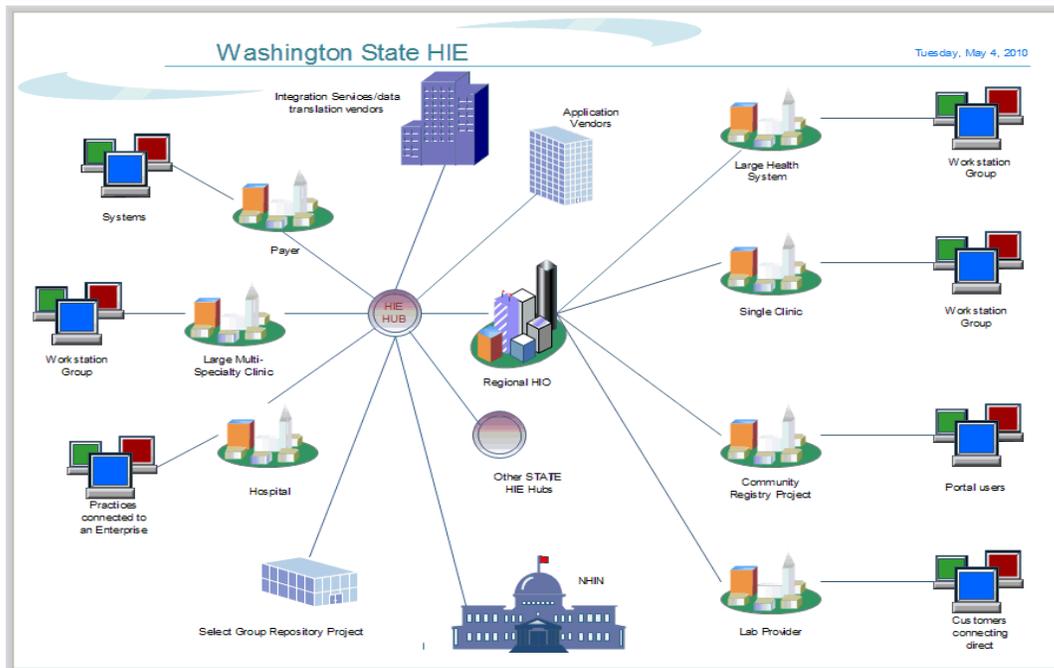


Figure 3: View of Washington State “Thin-layer” HIE

C. Key Policy Objectives

The importance of the business case and the emphasis on the business view by most in the private sector does not diminish the importance of the policy objectives. Blending the direction embedded in SSB 5501 and the requirements of the federal grant funding resulted in identification of the following key policy requirements for the technical architecture:

- **Improving performance.** Proliferating more boxes and wires is not the objective. Applying HIE to produce better results is the goal. The HIE must support better care management and coordination by increasing the availability of high value data for providers, patients, and payers.
- **Patients and providers.** The HCA has focused significant attention on patient-facing applications. The agency currently sponsors three pilots of patient-facing Health Record Banks. SSB 5501 directs the agency and Lead Organization to ensure the HIE serves both consumer- and industry-facing applications. While these applications are out of scope for the statewide HIE project, the HIE must be capable of supporting the exchange needs of patients and providers.
- **Meaningful Use.** The critical short-term focus of the ARRA HITECH Act state HIE grant program is to support the elements of Meaningful Use that require inter-enterprise exchange. The design must ensure deployment of at least basic capability by early 2011 to support Meaningful Use requirements.
- **Privacy and security.** The nature of the HIE thin-layer design (i.e., no applications and no data ownership) reduces some of the usual security and privacy concerns for the HIE. However, protecting privacy and security of patient data remains vitally important.
- **Standards based.** The march toward interoperability is predicated on broad-based adoption of national standards and movement away from proprietary approaches.

D. Shared Service Components

Each of the proposed shared HIE services, prioritized by the stakeholder requirements, is described in more detail below.

Secure Hub

The purpose of the Hub is to support and enable secure exchange of HL7, ASC X12, and other similar health data transactions in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA). OHP had extensive discussions with stakeholders about specific use cases for the Hub. In the aggregate, these use cases encompass key priorities for the ARRA HITECH Act and SSB 5501 to support the achievement of Meaningful Use for interested providers.

The following list provides the data exchange priorities identified in the use cases:

- Admission, discharge, transfer, and patient demographic details from hospitals to health plans

- Admission, discharge, transfer, and patient demographic details from hospitals to primary care/consulting physicians
- Eligibility, benefits, and claim status checking
- Medication histories in emergency departments and hospitals
- Lab results delivered to physicians and clinics (and reportable conditions to public health agencies)
- Medication histories and drug formularies to e-prescribing applications used by physicians
- Clinical messaging service to provider portals
- Emergency department hospital discharge summaries to physicians and clinics
- Chart summaries to emergency departments and hospitals
- Chart summaries to physicians and clinics
- Radiology reports to emergency departments and hospitals
- Radiology reports to physicians and clinics
- Reporting to registries
 - Immunization reporting to state registry
 - Biosurveillance tracking via a regional registry
 - Electronic submission of notifiable conditions to public health agencies
- Matching patient records – master patient index
- Matching provider records – provider directory
- Finding patient records – record locator service
- Chart summaries and results reporting to patient health records

The high level use cases suggest the following basic business requirements for the Hub service:

- Enterprise business-to-business (B2B) gateway solution
 - Secure messaging
 - Compliance with HIPAA, the Code of Federal Regulations (CFR)– 21 CFR Part 11, and the Healthcare Information Technology Standards Panel (HITSP)
 - Highly scalable to very large enterprises
 - Push and pull options
 - Batch and real-time transactions
 - Web services and the full gamut of B2B gateway standards and protocols
 - Proven technology supporting large volumes in health care industry today
- Governance for secure messaging
 - Intelligent content-based routing out-of-the-box
 - Support for Electronic Data Interchange (EDI), Extensible Markup Language (XML), HL7, Continuity of Care Document (CCD), and any document format

- Automated routing for simple administration of HIE
- Security with flexibility
 - Encryption with Federal Information Processing Standards (FIPS) 140-2 libraries (HITECH Act requirement)
 - Certificate management
 - Secure transport over [Transport Layer Security](#) (TLS)/Secure Sockets Layer (SSL) & Secure Shell (SSH)
 - Support for Lightweight Directory Access Protocol (LDAP)
- Management tools
 - Tracking and visibility of messages - auditing of all transactions
 - Activity monitoring and reporting tools
 - Easy integration options for monitoring, reporting, and alerting
 - Automated HIE provisioning tools – trading partner setup
 - Billing/reporting trading partner transactions

OHP assessed the Hub business requirements and debated the buy/build decision. In consultation with stakeholders, OHP decided to pursue a buy strategy to acquire the Hub capability. This decision was guided by the following considerations:

- **Risk.** The risk of a build was seen as greater than a buy.
- **Experience.** There are a number of mature commercial Hub solutions that appear to meet the requirements. The version 1.0 of a Hub we would build will be competing with second, third, and fourth generation offerings from experienced vendors.
- **Time to market.** The Hub plays a critical role in supporting the inter-enterprise exchange requirements for Meaningful Use. An experienced vendor can deploy the Hub service more rapidly than we could deploy a newly built offering.
- **Operating cost.** If we build it we have to operate it, and we do not believe we can rapidly achieve the same level of economy or skill as experienced vendors.

Master Patient Index (MPI)

It is clear that the vast majority of potential HIE participants believe an MPI is important. The core MPI capability is central to most visions of HIE – comprehensive information about the patient where and when it’s needed. To fulfill this vision, the ability to match patients (i.e., distinguish between patients with similar names) is essential. However, unlike the Hub conversation, which proceeds easily from service concept to detailed specifications to product purchase, the MPI is a more nuanced and complex service. The MPI design is complicated by the following considerations:

- **Cost.** The MPI is expensive technology to purchase and can also be expensive to operate.
- **Need.** While everyone believes they will need it “someday,” it is not clear how many organizations are prepared today to take advantage of a community MPI. The early phase of information exchange may well be “pushing” known patient data, rather than

searching for unknown patients. For example, most stakeholders do not believe the MPI is required to support their initial Meaningful Use requirements.

- **Policy.** A significant level of community consensus is required before the MPI goes operational. Policies and conventions related to MPI use, liability, and privacy will all have to be developed.
- **Model.** There are a variety of ways to deploy an MPI – federated, centralized, and leveraging an existing MPI implementation, to name a few. Or, to take a different approach, a state could issue its own unique patient identifier, changing the way the MPI functions. While the correct choice is not obvious, the cost, policy, and operational implications of this decision are profound.
- **Interactions with enterprise MPIs.** Many large enterprises already have an MPI to help reconcile patient identities across their own disparate systems. It is not clear how best to integrate and interoperate enterprise MPIs and the community MPI.

In light of these considerations, OHP and its stakeholders will conduct a more detailed assessment before finalizing the design of the MPI and its role in the overall architecture. This assessment should be complete by early 2011. At that time, design decisions will be made and the appropriate next steps related to the MPI will be taken.

Record Locator Service (RLS)

Much of what was said above about the MPI applies to the RLS. In some respects, the record locator involves fewer operational choices and alternatives. However, the RLS imposes additional costs and potentially burdensome requirements for participating enterprises. It also raises some significant privacy concerns. Once again, the assumption is that the RLS is a necessary component to meet the long-term objectives of patient-centered health information exchange. It is the sequencing of the Hub, MPI, and RLS that needs to be resolved. As such, at the conclusion of the MPI assessment, a similar assessment process will be undertaken in regard to the RLS.

Provider Directory

In addition to its work supporting HIE, OHP is the Lead Organization for the state's administrative simplification legislation, SSB 5346. One key requirement of SSB 5346 is the development and deployment of a uniform electronic solution for collecting the provider data required to support credentialing and privileging. All hospitals, health plans, public payers, and licensed practitioners will be required to use the system. OHP is tasked with developing, deploying, and operating what is now called the Provider Data Service. OHP is well into the process. A vendor, Medversant, has been selected, contracts are being executed with hospitals and plans, and the system went live in November of 2010.

Ultimately, this Provider Data Service will become a very comprehensive and rich provider directory that includes all licensed practitioners. It will be used and financially supported by all hospitals, health plans, and public payers. OHP will be repurposing the Provider Data Service created under SSB 5346 to serve as the statewide HIE provider directory. The directory will be

linked to the Hub to assist participating organizations to identify and locate their information exchange partners.

The provider directory will also assist organizations engaged in quality measurement activities. As quality measurement organizations attempt to aggregate data from multiple sources, they encounter a variety of issues related to attribution and identifiers. OHP has used some prior directory service offerings to assist local organizations involved in quality measurement, and anticipate ongoing use of the provider directory in this manner.

Standards, Conventions, and Policies

As indicated above, the Hub will transact HL7, ASC X12, and other standard data sets. The Washington State HIE is firmly committed to the use of national standards where available. OHP's role will be to adapt the "optional" elements of national standards for the preferred local implementation and has significant experience in forging consensus on the use of national standards for local e-commerce.

Currently, OHP operates a process designed to develop consensus best practices that has proven itself over the last seven years. This process has forged agreement on common policies, processes, and local implementations of national standards. Included in this extensive body of work are:

- Local implementation guides for ASC X12 transaction sets.
- Privacy and security policies and information sharing agreements adopted and used by over 35,000 health care organizations and 85,000 individuals within those organizations today.
- Best practices for workflow innovation and information processing.

OHP will employ these same skills and experience to develop and maintain the policies, standards, and conventions required to support the technical architecture. This process will parallel the rollout of services. For example, policies to support the Hub will have first priority. It is assumed the following policies, standards, and conventions will be required to support the first phase of service deployment related to the Hub:

- Information sharing agreement
- Privacy and security policy related to identity management and authentication
- Naming conventions
- Adoption of standards

Meaningful Use

The Washington State HIE is not offering applications of any type. Therefore, we cannot assist providers who do not otherwise acquire EHR and PHR capability. However, for those who do acquire clinical applications, the HIE can potentially assist providers to meet the Meaningful Use requirements that involve information exchange outside the enterprise. As of today, that could include the following provider requirements and similar ones for hospitals:

- Report clinical quality measures to CMS or the states (can be manually submitted in 2011, and must be electronically submitted in 2012).
- Send reminders to patients for preventive and follow-up care for at least 20 percent of patients age 65 and older or 5 years of age or younger.
- Generate and transmit permissible prescriptions electronically for more than 40 percent of prescriptions.
- Provide patients with, upon request (and within 3 business days), clinical summaries for each office visit for more than 50 percent of patient office visits or an electronic copy of hospital discharge instructions for more than 50 percent of all patients discharged.
- Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) within 3 business days for at least 50 percent of patients requesting electronic copies.
- Demonstrate the capability to electronically exchange key clinical information among providers and patient-authorized entities by performing at least one test of transmission.
- Demonstrate the capability to incorporate clinical laboratory test results into electronic health records as structured data for more than 40 percent of clinical laboratory test results received from laboratories.
- Demonstrate the capability to perform medication reconciliation between care settings for more than 50 percent of transitions of care.
- Provide summary of care record for patients referred or transitioned to another provider or setting for more than 50 percent of patient transitions or referrals.
- Provide patients with electronic access to their health information (including lab results, problem list, medication lists, and allergies) for more than 10 percent of patients within 4 days of the information being updated in the electronic health record.
- Demonstrate the capability to provide electronic submission of reportable lab results to public health agencies and follow-up submission where it can be received, by performing at least one test of transmission.
- Demonstrate the capability to submit electronic data to immunization registries and actual submission where required and accepted, by performing at least one test of transmission to immunization registries.
- Demonstrate the capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice, by performing at least one test of transmission to public health agencies.

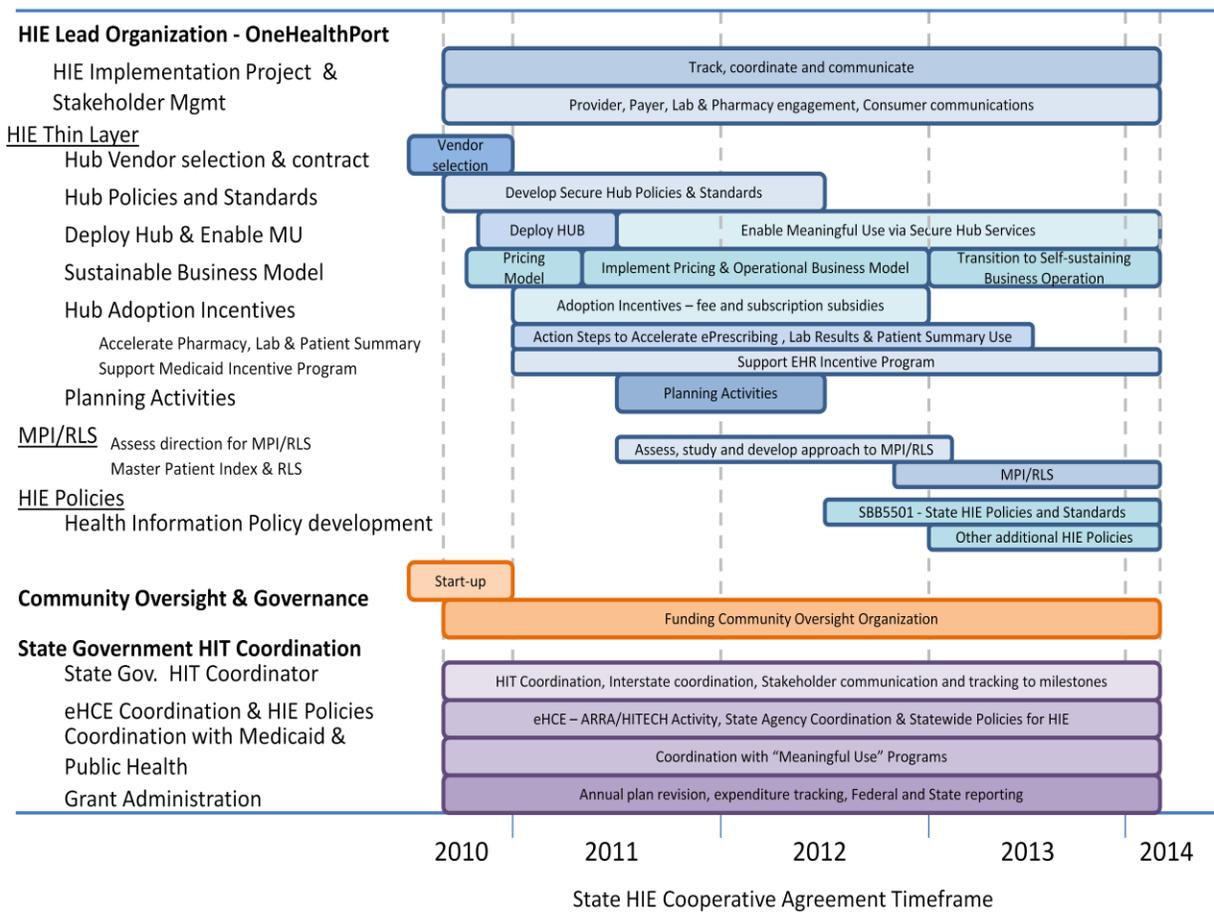
VI. Progress Toward Implementation

On February 8, 2010, the HCA was awarded a grant in the amount of \$11.3 million through the State Health Information Exchange Cooperative Agreement Program sponsored by the Office of the National Coordinator for Health Information Technology in response to the application submitted on October 16, 2009. An initial amount of \$1 million was made available in March

2010 for planning to support the activities described above and the development and submission of an HIE Strategic and Operational Plan.

The partnership between the HCA and OHP has achieved significant milestones during this first year of the project and these accomplishments have set the groundwork for the next phase of the work. The project timeline depicted in Figure 4 provides a high-level view of key activities scheduled through 2014.

Statewide HIE Implementation Timeline



State HIE Implementation Timeline REVISION_v3_8Oct10_AW

Figure 4: Statewide HIE Implementation Timeline

Specific tasks and activities for 2011 are highlighted below and are instrumental to the fulfillment of the requirements of SSB 5501, the federal grant, and implementation of the statewide HIE.

A. HIE Strategic and Operational Plan

On July 6, 2010, the HCA submitted [Washington State's Strategic and Operational Plan](#) to the ONC. The plan was prepared over several months in a joint effort by OHP and the HCA with input from public and private stakeholders. The plan discusses the strategies and operational activities necessary to implement a sustainable statewide HIE. Approval of the plan by the ONC was required before the statewide HIE could expend HITECH Act funds on technology solutions. OHP and the HCA communicated and worked with the ONC during the remainder of 2010 and received approval for the plan in December.

In a letter to the Health Care Authority dated September 23, 2010, the ONC detailed their response to the Strategic and Operational Plan. In general, the response from the ONC was positive toward the proposed approach. The letter sought clarification and more detail on a few items, particularly as to how the proposed approach supports the ONC's primary objective of helping providers to attain Meaningful Use of certified EHRs in 2011. The HCA and OHP prepared responses to the ONC in an Addendum dated October 25, 2010.

On November 1, 2010, the ONC made an additional request for data representing Washington State's position and efforts with respect to health information exchange and technology capabilities in several key areas of interest:

- E-prescribing
- Receipt of structured lab results
- Sharing patient care summaries across affiliated organizations
- Percent of health plans supporting electronic eligibility and claims transactions
- Percent of pharmacies accepting electronic prescribing and refill requests
- Percent of clinical laboratories sending results electronically
- Percent of health departments electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results

This information was provided in an Addendum sent to the ONC on November 5, 2010, with clarifying information sent in a final Addendum dated December 8, 2010. The ONC approved the Strategic and Operational Plan on December 13, 2010.

B. Statewide HIE Secure Hub

Following collection of stakeholder requirements described previously, the major focus of the statewide HIE project from July through October 2010 was the procurement of a Secure Hub. OHP contracted with Deloitte to assist in preparing the RFP. The HIE Leadership Group and its Technical Advisory Group (TAG) provided advice throughout the selection process. The RFP was distributed through numerous local and national communication channels in August and all qualified vendors were encouraged to bid.

Over 35 companies expressed initial interest. Twelve companies submitted bids and of those, five were qualified. The five companies were ultimately winnowed down to two semi-finalists, Axway and Medicity. In late October, Axway was declared the apparent successful vendor.

Appendix D is the HIE Leadership Group presentation that summarizes the RFP process and the rationale for its conclusions.

OneHealthPort will be working on a number of tasks in parallel to bring the Axway Hub service to market in early 2011:

- Negotiate a contract with Axway
- Work with the HIE Leadership Group on a pricing and policy model
- Submit the pricing and policy model to the Community Oversight Organization for approval
- Continue development of an optimal MPI/RLS solution for the community
- Commence marketing efforts and seek early adopters for the HIE Hub service

In addition to the specific Hub related activities, OHP and the HCA will be working with TAGs, early adopters, and stakeholders to develop policies and practices that support evolution and sustainability of a statewide HIE. A key aspect of the policy work is privacy and security.

C. Privacy and Security

The statewide HIE privacy and security framework is embedded in the overarching contractual framework for participation in the statewide HIE. The framework follows core principles:

- The policies will fully comply with all applicable Washington state and federal law.
- Each party is responsible for actions within their perimeter.
- In the thin-layer HIE, patient consent will be secured by the responsible trading partner(s) who touches the patient, as is true today with other similar exchanges of health care information.

Parties interested in utilizing the HIE will execute a Participation Agreement and, by doing so, will agree to the Participation Agreement Terms and Conditions, the HIE User Policy, the HIE Security Policy, and the Glossary, which will collectively establish the general terms applicable to all participants in the HIE, regardless of which HIE service(s) they select.

Each participant will also execute an HIE Services Election Form identifying the HIE service(s) they choose to use (they may make additions or deletions to the HIE services they use by executing a new HIE Service Election Form at any time in the future). By selecting an HIE Service on the HIE Election Form, participants are also agreeing to HIE Policies/Terms of Use applicable to that service.

From a process perspective, this framework is currently in the editing process. A complete draft was distributed to the HIE Leadership Group Policy TAG for review. The Policy TAG will suggest any changes and make recommendations back to the HIE Leadership Group. The final privacy and security model approved by the Leadership Group will be formally submitted to the Foundation for Health Care Quality by OneHealthPort in early 2011.

The Foundation, as the Community Oversight Organization, has final approval of the privacy and security policies embedded in the framework (the Foundation does not have approval rights

over the non-privacy/security related contractual terms). If the Foundation and OneHealthPort cannot reconcile any differences in the policies, the HCA will make the final determination.

This process allows OneHealthPort as the Lead Organization to rapidly develop the contract model, gain buy-off from a critical mass of the organizations that will be asked to execute the agreement, and seek final and timely approval from the broader constituencies, including consumers that will be affected by the terms contained in the agreement.

D. Continued Stakeholder and Program Collaboration

In conjunction with this effort the HCA project team will continue collaborative work with other ARRA HITECH Act program areas across the state to align activities of the statewide HIE where they may add value and enable these other programs to meet their goals and requirements. The HCA will also continue efforts to efficiently and effectively engage stakeholders and communicate, facilitate, and coordinate activities in this broader unified effort. Additionally, the statewide HIE project will coordinate with Medicaid and public health to provide assistance, where appropriate, to support federal incentive programs sponsored by the Centers for Medicare & Medicaid Services that reward providers for adopting and using health information technology.

eHealth Collaborative Enterprise

The Washington State eHealth Collaborative Enterprise (eHCE) Project Team is a public-private partnership that coordinates the activities of multiple organizations engaged in work related to SSB 5501 and ARRA HITECH Act. The eHCE Team is comprised of the HCA ARRA HITECH Act project management staff and consultants, state agency representatives, and principals from the state Medicaid office, Department of Health, Department of Information Services, and Department of Labor and Industries.

The eHCE also includes designated Lead Organization principals for each respective ARRA HITECH Act and ARRA Broadband program in Washington State. In addition to OHP, these Lead Organizations include Qualis Health's Washington and Idaho Regional Extension Center (WIREC) as the Regional Extension Center (REC), Bellevue College for Work Force Training and Development, Inland Northwest Health Services (INHS) for the Beacon Community of the Inland Northwest, and the Washington Telehealth Consortium (WTC) for Telemedicine/Telehealth and Broadband. The HIE Oversight and Governance entity, the Foundation for Health Care Quality, is also represented at the eHCE meetings.

On a bi-weekly basis, the eHCE convenes a meeting where ARRA HITECH Act and ARRA Broadband program lead organizations and designated state agencies share status updates, communicate issues, seek resolution, and identify ways to leverage activities and resources across programs to expedite Meaningful Use implementation and support. On a periodic basis, the eHCE also benefits from the ONC's participation. The project officer assigned to our state routinely conferences in to meetings and provides guidance or clarification when needed.

The project team aggregates and communicates information about overall progress of Washington State ARRA HITECH Act and Broadband activities to:

- The ONC in regular reports.
- The public, legislators, health industry stakeholders, and agency staff in informational forums, regular stakeholder meetings, a bi-monthly newsletter, and a specific eHCE and ARRA HITECH Act web page and electronic mailing list (listserv).

This investment of time and resources has paid off in a number of ways:

- The Telemedicine/Telehealth and Broadband lead organization and constituency are working closely with OHP to determine how each group can leverage the other's capability rather than replicating it.
- ARRA HITECH Act programs cross-populate each other's advisory boards and have representation in their respective advisory bodies. WIREC Project Director, Peggy Evans, is a member of the Beacon Community Stakeholder Group along with Richard Onizuka, State Health IT Coordinator, and Rick Rubin, President and CEO of OHP. Patricia Dombrowski from Bellevue College; Jac Davies, Program Director of the Beacon Community of the Inland Northwest; Jeff Mero of the Telemedicine/Telehealth/Broadband Project; and Rick Rubin all sit on the Joint eHCE/WIREC Advisory Council, co-chaired by Richard Onizuka and Peggy Evans. Jac Davies also sits on the OneHealthPort Governing Board.

Medicaid

The eHCE Project Team is currently working closely with Medicaid in the planning and development of their State Medicaid Health Information Technology Plan (SMHP) and the Implementation-Advanced Planning Document (I-APD) for implementation and administration of the Electronic Health Record (EHR) Incentive Program. Work to date has centered around four key areas: current assessment of the HIT landscape in Washington State, development of an envisioned future state, a Roadmap for State Medicaid HIT activities, and deployment and data analysis of an HIT Adoption and Meaningful Use Readiness online survey.

The HIE Project joined forces with Medicaid in summer 2010 to begin planning for Medicaid's participation in the statewide HIE, the HIE's support in helping providers achieve Meaningful Use, and the statewide HIE's support of Medicaid's efforts to prepare the SMHP. Medicaid formed an HIT Advisory Group that includes the State HIT Coordinator, the HIE Lead Organization, and WIREC. This group provides information to Medicaid for consideration in the planning and implementation of the EHR Incentive Program as well as the integration and coordination of HIE efforts with the SMHP.

In discussions with the eHCE and HIE project teams, Medicaid has indicated that it intends to connect to the HIE in its capacity as a payer. It is the intent of Medicaid to use the HIE as its Hub and direct trading partners who want access to Medicaid data to do so through the statewide HIE Hub. Medicaid and the HIE agreed that Medicaid would pay for such services using the standard fee schedule.

VII. Conclusion

The HCA, OHP, and all the participating stakeholders are committed to advancing HIE in Washington State. The progress to date and activities underway describe a practical vision that is well-positioned to be achievable in our state. Although the plans are evolving, the project has amassed key leaders, established a proven process, organized critical mass in the market, and developed a sustainable HIE design to support improvement of patient and population health. The HCA and OHP look forward to working constructively and in partnership with the stakeholder community over the next several years to implement the statewide HIE.

Appendix A: Substitute Senate Bill 5501

CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 5501

Chapter 300, Laws of 2009

61st Legislature
2009 Regular Session

HEALTH INFORMATION--PATIENT ACCESS--STANDARDS DEVELOPMENT

EFFECTIVE DATE: 07/26/09

Passed by the Senate April 20, 2009
YEAS 45 NAYS 0

BRAD OWEN

President of the Senate

Passed by the House April 14, 2009
YEAS 96 NAYS 0

FRANK CHOPP

Speaker of the House of Representatives

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5501** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

Approved April 30, 2009, 11:13 a.m.

FILED

May 1, 2009

CHRISTINE GREGOIRE

Governor of the State of Washington

Secretary of State
State of Washington

SUBSTITUTE SENATE BILL 5501

AS AMENDED BY THE HOUSE

Passed Legislature - 2009 Regular Session

State of Washington 61st Legislature 2009 Regular Session

By Senate Ways & Means (originally sponsored by Senators Keiser,
Pflug, Franklin, Parlette, Murray, and Kohl-Welles)

READ FIRST TIME 03/02/09.

1 AN ACT Relating to the secure exchange of health information;
2 adding new sections to chapter 41.05 RCW; and creating a new section.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. Sec. 1. The legislature finds that:

5 (1) The inability to securely share critical health information
6 between practitioners inhibits the delivery of safe, efficient care, as
7 evidenced by:

8 (a) Adverse drug events that result in an average of seven hundred
9 seventy thousand injuries and deaths each year; and

10 (b) Duplicative services that add to costs and jeopardize patient
11 well-being;

12 (2) Consumers are unable to act as fully informed participants in
13 their care unless they have ready access to their own health
14 information;

15 (3) The blue ribbon commission on health care costs and access
16 found that the development of a system to provide electronic access to
17 patient information anywhere in the state was a key to improving health
18 care; and

1 (4) In 2005, the legislature established a health information
2 infrastructure advisory board to develop a strategy for the adoption
3 and use of health information technologies that are consistent with
4 emerging national standards and promote interoperability of health
5 information systems.

6 NEW SECTION. Sec. 2. A new section is added to chapter 41.05 RCW
7 to read as follows:

8 The definitions in this section apply throughout sections 3 through
9 5 of this act unless the context clearly requires otherwise.

10 (1) "Administrator" means the administrator of the state health
11 care authority under this chapter.

12 (2) "Exchange" means the methods or medium by which health care
13 information may be electronically and securely exchanged among
14 authorized providers, payors, and patients within Washington state.

15 (3) "Health care provider" or "provider" has the same meaning as in
16 RCW 48.43.005.

17 (4) "Health data provider" means an organization that is a primary
18 source for health-related data for Washington residents, including but
19 not limited to:

20 (a) The children's health immunizations linkages and development
21 profile immunization registry provided by the department of health
22 pursuant to chapter 43.70 RCW;

23 (b) Commercial laboratories providing medical laboratory testing
24 results;

25 (c) Prescription drugs clearinghouses, such as the national patient
26 health information network; and

27 (d) Diagnostic imaging centers.

28 (5) "Lead organization" means a private sector organization or
29 organizations designated by the administrator to lead development of
30 processes, guidelines, and standards under this act.

31 (6) "Payor" means public purchasers, as defined in this section,
32 carriers licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.62
33 RCW, and the Washington state health insurance pool established in
34 chapter 48.41 RCW.

35 (7) "Public purchaser" means the department of social and health
36 services, the department of labor and industries, and the health care
37 authority.

1 (8) "Secretary" means the secretary of the department of health.

2 NEW SECTION. Sec. 3. A new section is added to chapter 41.05 RCW
3 to read as follows:

4 (1) By August 1, 2009, the administrator shall designate one or
5 more lead organizations to coordinate development of processes,
6 guidelines, and standards to:

7 (a) Improve patient access to and control of their own health care
8 information and thereby enable their active participation in their own
9 care; and

10 (b) Implement methods for the secure exchange of clinical data as
11 a means to promote:

12 (i) Continuity of care;

13 (ii) Quality of care;

14 (iii) Patient safety; and

15 (iv) Efficiency in medical practices.

16 (2) The lead organization designated by the administrator under
17 this section shall:

18 (a) Be representative of health care privacy advocates, providers,
19 and payors across the state;

20 (b) Have expertise and knowledge in the major disciplines related
21 to the secure exchange of health data;

22 (c) Be able to support the costs of its work without recourse to
23 state funding. The administrator and the lead organization are
24 authorized and encouraged to seek federal funds, including funds from
25 the federal American recovery and reinvestment act, as well as solicit,
26 receive, contract for, collect, and hold grants, donations, and gifts
27 to support the implementation of this section and section 4 of this
28 act;

29 (d) In collaboration with the administrator, identify and convene
30 work groups, as needed, to accomplish the goals of this section and
31 section 4 of this act;

32 (e) Conduct outreach and communication efforts to maximize the
33 adoption of the guidelines, standards, and processes developed by the
34 lead organization;

35 (f) Submit regular updates to the administrator on the progress
36 implementing the requirements of this section and section 4 of this
37 act; and

1 (g) With the administrator, report to the legislature December 1,
2 2009, and on December 1st of each year through December 1, 2012, on
3 progress made, the time necessary for completing tasks, and
4 identification of future tasks that should be prioritized for the next
5 improvement cycle.

6 (3) Within available funds as specified in subsection (2)(c) of
7 this section, the administrator shall:

8 (a) Participate in and review the work and progress of the lead
9 organization, including the establishment and operation of work groups
10 for this section and section 4 of this act; and

11 (b) Consult with the office of the attorney general to determine
12 whether:

13 (i) An antitrust safe harbor is necessary to enable licensed
14 carriers and providers to develop common rules and standards; and, if
15 necessary, take steps, such as implementing rules or requesting
16 legislation, to establish a safe harbor; and

17 (ii) Legislation is needed to limit provider liability if their
18 health records are missing health information despite their
19 participation in the exchange of health information.

20 (4) The lead organization or organizations shall take steps to
21 minimize the costs that implementation of the processes, guidelines,
22 and standards may have on participating entities, including providers.

23 NEW SECTION. Sec. 4. A new section is added to chapter 41.05 RCW
24 to read as follows:

25 By December 1, 2011, the lead organization shall, consistent with
26 the federal health insurance portability and accountability act,
27 develop processes, guidelines, and standards that address:

28 (1) Identification and prioritization of high value health data
29 from health data providers. High value health data include:

30 (a) Prescriptions;

31 (b) Immunization records;

32 (c) Laboratory results;

33 (d) Allergies; and

34 (e) Diagnostic imaging;

35 (2) Processes to request, submit, and receive data;

36 (3) Data security, including:

37 (a) Storage, access, encryption, and password protection;

- 1 (b) Secure methods for accepting and responding to requests for
2 data;
- 3 (c) Handling unauthorized access to or disclosure of individually
4 identifiable patient health information, including penalties for
5 unauthorized disclosure; and
- 6 (d) Authentication of individuals, including patients and
7 providers, when requesting access to health information, and
8 maintenance of a permanent audit trail of such requests, including:
- 9 (i) Identification of the party making the request;
10 (ii) The data elements reported; and
11 (iii) Transaction dates;
- 12 (4) Materials written in plain language that explain the exchange
13 of health information and how patients can effectively manage such
14 information, including the use of online tools for that purpose;
- 15 (5) Materials for health care providers that explain the exchange
16 of health information and the secure management of such information.

17 NEW SECTION. Sec. 5. A new section is added to chapter 41.05 RCW
18 to read as follows:

19 If any provision in sections 2 through 4 of this act conflicts with
20 existing or new federal requirements, the administrator shall recommend
21 modifications, as needed, to assure compliance with the aims of
22 sections 2 through 4 of this act and federal requirements.

Passed by the Senate April 20, 2009.

Passed by the House April 14, 2009.

Approved by the Governor April 30, 2009.

Filed in Office of Secretary of State May 1, 2009.

Appendix B: Community Oversight Organization Board



Community Oversight Organization Board as of November 9, 2010

<p>Board Chair</p> <p>Gretchen Murphy, M.Ed., RHIA, FAHIMA Dir, Health Informatics & Health Information MgtProg. School of Public Health University of Washington</p> <p><i>Position #3 expires: November 2012.</i> Appointed for an initial 2-year term; eligible for two additional 3-year terms upon expiration of initial term.</p>	<p><u>Representing HIE Users: (four positions)</u></p> <p>Dave Roach, BSEE, CPHIMS, CCE VP, Information Systems / CIO Kadlec Health System</p> <p><i>Position #4 expires: November 2012.</i> Appointed for an initial 2-year term; eligible for two additional 3-year terms upon expiration of initial term.</p>
<p><u>Representing HIE Consumers: (one position)</u></p> <p>Rudy Vasquez Multicultural Services Director Sea Mar Community Health Centers</p> <p><i>Position #1 expires: November 2011.</i> Appointed for an initial 1-year term; eligible for two additional 3-year terms upon expiration of initial term.</p>	<p>Margaret J. Lane mLane and Company 1143 16th Ave E</p> <p><i>Position #2 expires: November 2011.</i> Appointed for an initial 1-year term; eligible for two additional 3-year terms upon expiration of initial term.</p>
<p><u>Representing the Public Sector (one position):</u></p> <p>Bryant Thomas Karras MD Public Health Informatics Officer, Sr. Epi, State of Washington, DOH, Public Health Lab</p> <p><i>Position #7 expires: November 2013.</i></p>	<p>Marc Pierson, MD Regional VP, Clinical Information & Special Projects</p> <p><i>Position #6 expires: November 2013.</i></p>
	<p>Michael J. Tronolone, MD, MMM Medical Director The Polyclinic</p> <p><i>Position #5 expires: November 2013.</i></p>

Appendix C: Health Information Exchange Leadership Group

Washington State HIE Leadership Group

Name	Organization
Hospitals	
1. Jody Albright	Overlake
2. Paul Anderson	Providence
3. Florence Chang	MultiCare
4. David Chou	University of Washington
5. Drex Deford	Children's
6. Fred Galusha	INHS
7. Mary Kasal	Franciscan Health Services
8. Petra Knowles	Southwest Washington
9. Tom Martin	Evergreen
10. Janice Newell	Swedish
11. Marc Pierson	St Joseph's (PeaceHealth)
12. Dave Roach	Kadlec
Practices	
13. Bill Gotthold	Wenatchee Valley Clinic
14. Becky Hood	Everett Clinic
15. Roy LaCroix	PTSO
16. Hamilton Licht	Yakima County Medical Society/Connected
17. Rick MacCornack	Community
18. Bill Poppy	NPN
	Virginia Mason
Health Plans	
19. Vaughn Holbrook	Regence
20. Gwen O'Keefe	Group Health
21. Greg Palmberg	First Choice
22. Dave Young	Premera
Public Agencies	
23. Rich Barnhill	Madigan
24. Rich Campbell	Medicaid
25. Bryant Karras	Public Health Laboratories
26. Paul Nichols	VA Seattle
27. Christy Ridout	Dept Labor and Industries
28. Frank Westrum	Dept of Health
Ancillary Providers	
29. Jon Copeland	Inland Imaging
30. Sonny Varadan	PAML

**Appendix D: HIE Leadership Group Presentation: HIE Hub Selection –
Final Recommendation**



OneHealthPort
HIE Hub Selection –
Final Recommendation

**Presented to the HIE Leadership Group
November 2, 2010**

Executive Summary

Axway is the recommended HIE Hub solution for the Washington State HIE

- OHP conducted a comprehensive RFP process to identify the preferred vendor to provide the HIE Hub services under the stakeholder approved Thin-Layer model
- Five HIE vendors (AT&T, Axolotl, Axway, Medicity, Microsoft) qualified to undergo a structured evaluation and due diligence process
- OHP is recommending Axway as the preferred HIE Hub solution because the Axway solution is best aligned with the Thin-Layer model as demonstrated by achieving superior results across the following key categories of criteria:
 - Vendor Experience and Viability
 - Secure Hub
 - Implementation & Support
 - Optional HIE Services
 - Cost
- The recommended Axway solution also aligns best with ONC priorities – support of Meaningful Use by all types of provider organizations in 2011
 - ONC is the key funder of the Hub purchase

Background – How We got Here

The statewide HIE is guided by multiple drivers...

Community Requirements

- Leverage existing investments – Hubs, applications, repositories and related capabilities
- The business case is “gray,” keep the costs down – “don’t make us pay for things twice”
- Use the same infrastructure for admin and clinical
- The HIE doesn’t have to do it all – many services are better provided by enterprises and vendors in the community
- Retain flexibility – let different organizations implement in their own way, at their own pace
- The Thin-Layer model – Hub first, MPI/RLS to follow

ONC

- It’s all about Meaningful Use (MU)
- Initially, it is all about 3 MU requirements – Erx, Lab, CCD
- The HIE needs to offer all interested providers at least one path to address inter-enterprise MU requirements
- MU overall – get to market early in 2011, make it work for little guys and big guys alike, emphasis on transaction exchange in key areas
- It’s also all about standards – move health industry to robust use of standards
- Stick to the basics, don’t get too ambitious too quickly

SSB 5501

- Accelerate secure exchange of high value data sets
- Private sector leadership, public sector and community oversight
- No state money, pursue federal funds
- Benefit from the leadership, expertise, resources and flexibility of private sector, but...
- Make sure the process stands up to public sector scrutiny – transparent, inclusive, objective
- Operate like a private sector organization, but do it in the public interest

Scoring Team, Advisor and Observer Participants

Strong support for the scoring team from the community

Observers

Linda Lekness	Foundation for Healthcare Quality
Terry Rogers	Foundation for Healthcare Quality
Bryant Karras	Dept of Health/HIE Leadership
Vadim Plitman	Group Health
Aliyah Quraish	Group Health
Roy LaCroix	PTSO/HIE Leadership
Cole Hanford	Inland Imaging
Jon Copeland	Inland Imaging/HIE Leadership
Kazi Hague	Inland Imaging
Matt Simpson	Inland Imaging
John Peterson	Regence Blue Shield
Michael Sponholtz	Virginia Mason Medical Center
Steve Tsukuno	Virginia Mason Medical Center
Karen Hartman Voss	INHS
John Gepford	Overlake Medical Center
Dave Roach	Kadlec Medical Center/HIE Leadership
Robert Taylor	Kadlec Medical Center
Greg King	Evergreen Healthcare
Ray Jensen	Multicare
Cheryl Moeller	Overlake
Chuck Hitchings	L&I
Christy Rideout	L&I/HIE Leadership
Jenny Regalado	WA ST DIS
Ryan McNeilly	OneHealthPort
Rick Rubin	OneHealthPort

Scoring Team

- Sue Merk, OneHealthPort
- Chris Davis, Deloitte
- Ernie Hood, Independent Consultant
- Bryan Nordstrom, Deloitte
- Russ Sarbora, Independent Consultant

Advisors

Michael Davisson	Dept of Health
Brian O'Keefe	Overlake Hospital Medical Center
Jamie Trigg	Evergreen Healthcare
Mike Birmingham	LNI
Phillip Lowe	DOH
Rhonda May	Multicare Medical Center
Howard Thomas	Thomas Consulting

HCA Observers

Kelly Llewellyn
Anne Wahrmund
Dwayne Eriksen
Juan Alaniz
Annette Burgin

Selection Scope and Approach

HIE HUB Selection Process Objectives & Scope

Objectives

- Develop an RFP that clearly delineates the requirements for the Statewide HIE Secure HUB
- Conduct an objective, transparent, and thorough selection process
- Determine the recommended vendor to provide the technology for the Statewide HIE Secure HUB

Scope for the Selection



** Message transformation – ability to map message content and protocols from one format to another (e.g. HL7 to XML, batch to real-time, etc.), added to scope based on assessment of market readiness and nature of vendor offerings*

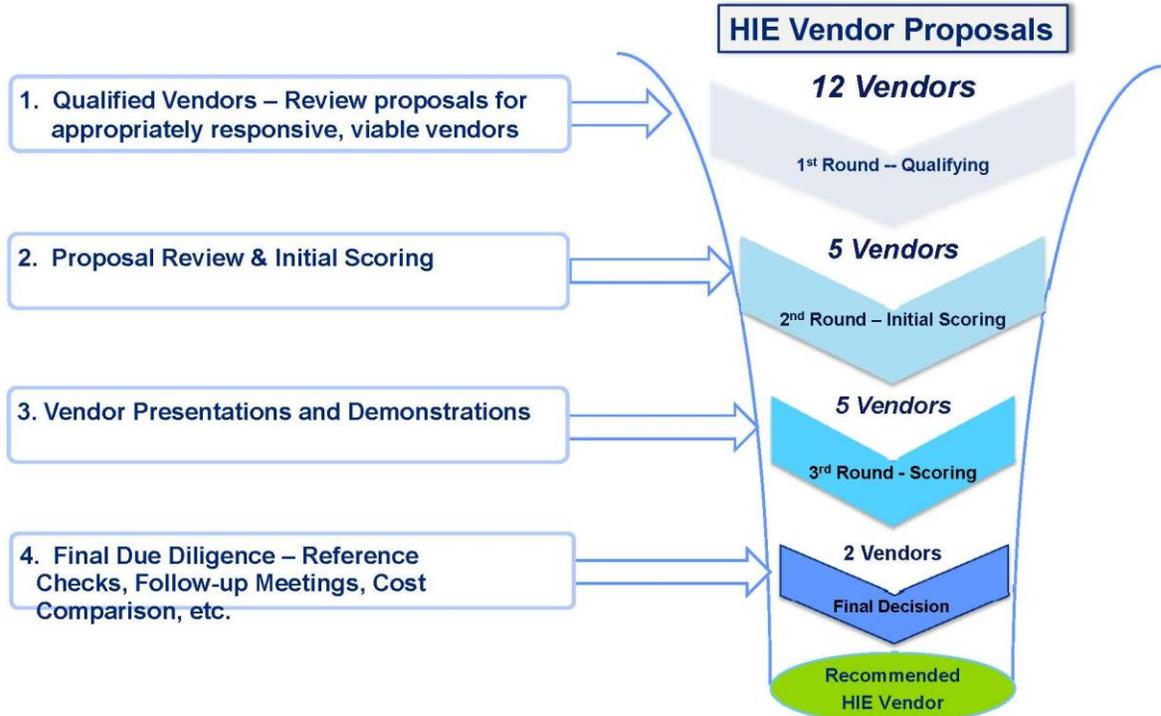
Potential Future Scope



These capabilities are included in the RFP for the purpose of exploring overall vendor capabilities, but will not be purchased as a result of this process

HIE Vendor Selection Approach

A multi-step process was used to narrow the field to a preferred vendor



Selection Activities by Round

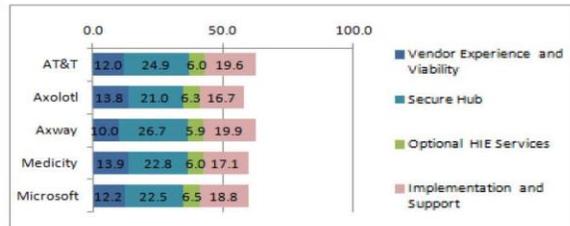
Selection Round	Activities			
	Scoring Team	Advisors	Observers	Leadership
1 st Round - Qualification	<ul style="list-style-type: none"> Evaluated 12 vendor proposals against qualification criteria Determined list of 5 qualifying vendors 	<ul style="list-style-type: none"> Reviewed and validated the rationale for qualifying and disqualified vendors 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A
2 nd Round – Initial Scoring	<ul style="list-style-type: none"> Reviewed and scored written proposals from 5 vendors Determined that all vendors should be invited to demonstrations 	<ul style="list-style-type: none"> No vendors were eliminated during this round, so Advisors did not review scoring 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A
3 rd Round – Presentations/ Demonstrations	<ul style="list-style-type: none"> Actively participated in all vendor demonstrations Scored all vendor demonstrations Utilized vendor scoring and differentiators identified in 2nd and 3rd rounds to determine recommended vendor finalists 	<ul style="list-style-type: none"> Attended all demonstrations Participated in debrief session following each demo Reviewed, validated rationale for finalist vendors 	<ul style="list-style-type: none"> Attended some demos 	<ul style="list-style-type: none"> Attended some demos
Final Due Diligence	<ul style="list-style-type: none"> Performed reference checks Conducted on-site meetings with vendor finalists Determined recommended vendor using scores, risk analysis, cost comparison, and key differentiators 	<ul style="list-style-type: none"> Performed reference checks Conducted on-site meetings with vendor finalists 	<ul style="list-style-type: none"> Attended some reference check calls and on-site meetings 	<ul style="list-style-type: none"> Attended some reference check calls and on-site meetings
Final HIE Vendor Recommendation	<ul style="list-style-type: none"> Recommended the preferred HIE vendor to Advisors and HIE Leadership 	<ul style="list-style-type: none"> Reviewed, provided input on Scoring Team recommendation 	<ul style="list-style-type: none"> Notification of recommended vendor 	<ul style="list-style-type: none"> Validated recommended vendor

Scoring Summary

Scoring Summary

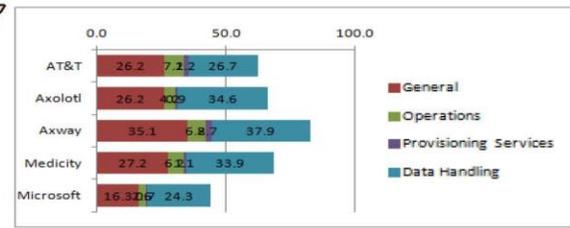
Written Proposal Scoring

Evaluation Criteria		AT&T	Axolotl	Axway	Medicity	Microsoft
Vendor Viability and Partnership	20%	12.0	13.8	10.0	13.9	12.2
Secure Hub	40%	24.9	21.0	26.7	22.8	22.5
Optional HIE Services	10%	6.0	6.3	5.9	6.0	6.5
Implementation and Support	30%	19.6	16.7	19.9	17.1	18.8
Weighted Total (out of 100)		62.5	57.8	62.5	59.8	60.0
Ranking		2	3	1	4	3



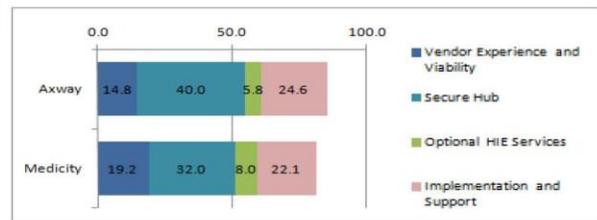
Demonstration Scoring

Evaluation Criteria		AT&T	Axolotl	Axway	Medicity	Microsoft
Secure Hub	Count					
General	15	26.2	26.2	35.1	27.2	16.3
Operations	3	7.1	4.2	6.8	6.2	2.6
Provisioning Services	1	2.2	0.9	2.7	1.1	0.7
Data Handling	17	26.7	34.6	37.9	33.9	24.3
Total (out of 100)		62.2	65.9	82.5	68.4	43.9
Ranking		4	3	1	2	5



On-Site Meeting Scoring

Evaluation Criteria		Axway	Medicity
Vendor Experience and Viability	Weight*		
Vendor Experience and Viability	20%	14.8	19.2
Secure Hub	40%	40.0	32.0
Optional HIE Services	10%	5.8	8.0
Implementation and Support	30%	24.6	22.1
Weighted Total (out of 100)		85.2	81.3
Ranking		1	2

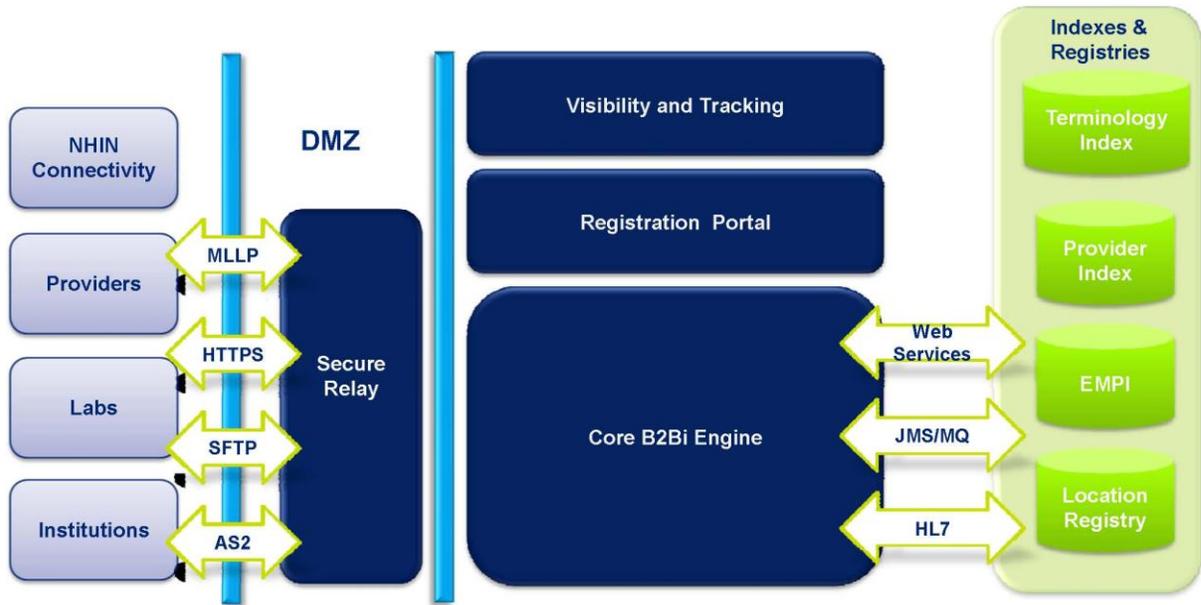


Who is Axway?



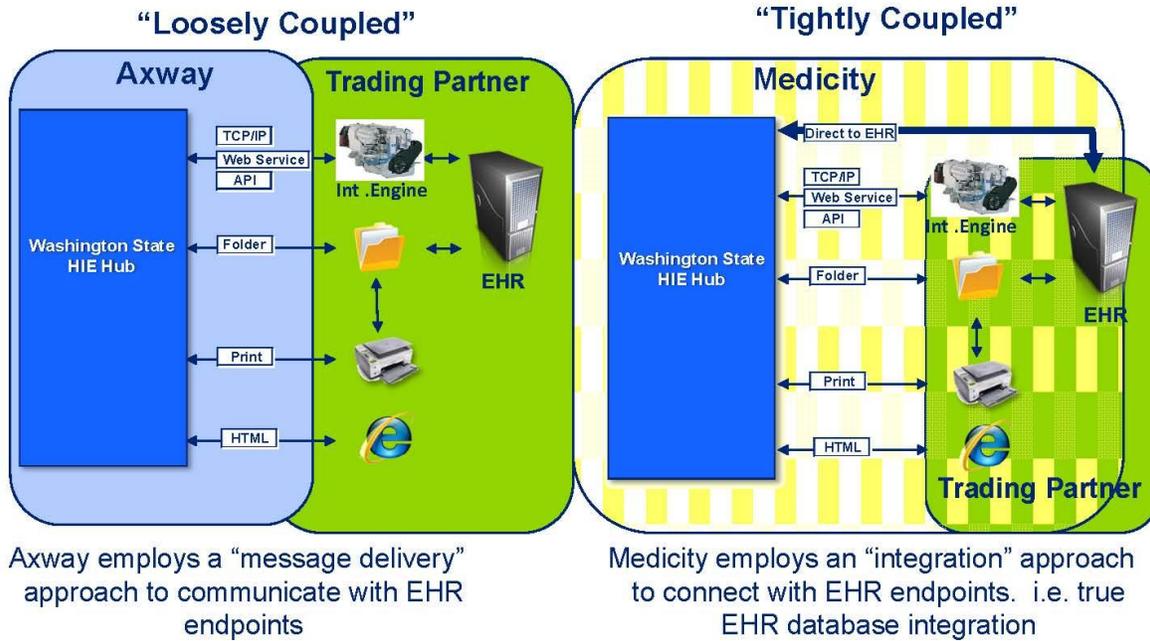
Axway is the Business Interaction Networks company. We are the only provider in the market today to manage, run, secure, and monitor all your business interactions — emails, files, messages, services, events, and processes.

Axway HIE Architecture



The Two Finalists Have Significantly Different Installation and Implementation “Models”

The differences have significant implications for the HIE operating model as total vendor costs



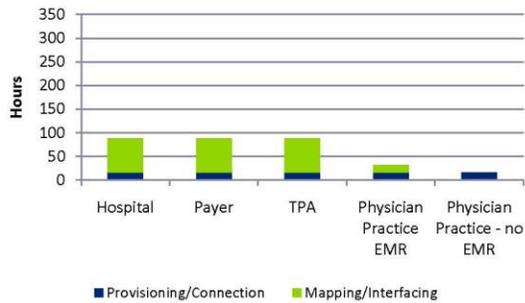
Deployment Differences

Speed to market and implementation costs are driven by deployment model

Axway	Medicity
<ul style="list-style-type: none"> ➤ Heavily invested in Standards in multiple verticals <ul style="list-style-type: none"> • Leverage lessons and tools from other verticals 	<ul style="list-style-type: none"> ➤ Healthcare market exclusive focus <ul style="list-style-type: none"> • Enterprise and local HIE and RHIOs historically
<ul style="list-style-type: none"> ➤ Communication layer hands messages to diverse systems with minimally “invasive” connection = “loosely coupled” model ➤ Mapping and translation abstracted in the “HUB” to allow one-time mapping to standard for each trading partner ➤ Any vendor can do integration – not an Axway service 	<ul style="list-style-type: none"> ➤ Integration into systems = “tightly coupled” model ➤ Start with templates but heavily customize
<ul style="list-style-type: none"> ➤ Trading partner, vendors or HIE Operator can provide mapping services. 	<ul style="list-style-type: none"> ➤ Medicity manages most integration – starting to train consultants to allow options

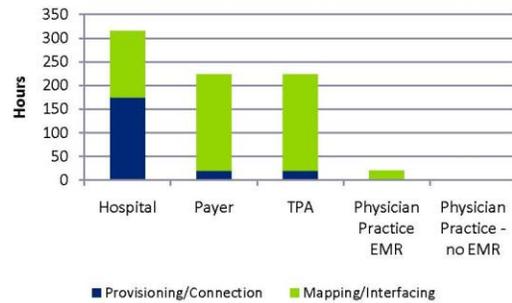
Implementation Effort Comparison

Axway - Estimated Trading Partner Implementation Time



Trading Partner, OHP, Axway, or 3rd party can perform this work

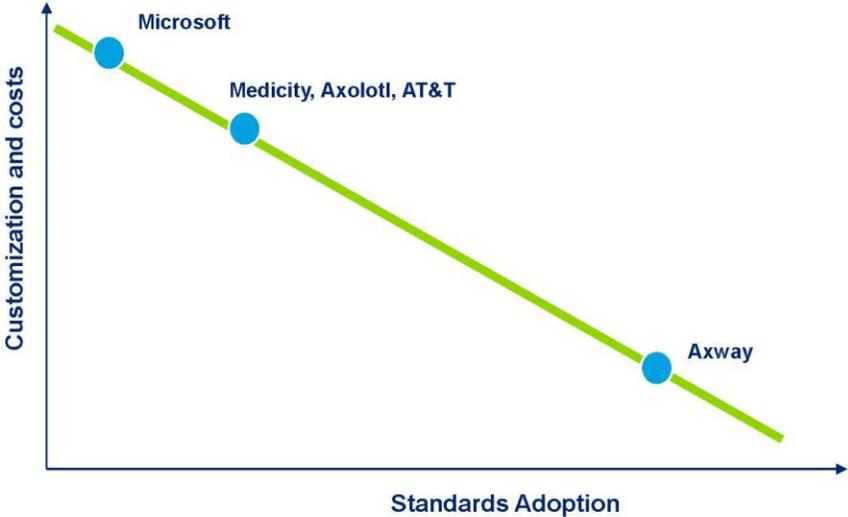
Medicity - Estimated Trading Partner Implementation Time



Medicity, 3rd Party Integrator (or in some cases OHP) can perform this work

HIE Standards Maturity Curve

Customization drives cost and maintains complexity – Standards reduce variation and enable trading at lower costs



Selected Customers by Industry

Blend shared information exchange expertise with healthcare knowledge

The image displays a grid of 10 industry categories, each containing a collection of customer logos. The categories are:

- Healthcare & Life Sciences** (highlighted with a red dashed border): Includes logos for STANFORD, AstraZeneca, CHILDREN'S HOSPITAL, PREMERA, MCKESSON, Mount Sinai, Pfizer, Cleveland Clinic, Allstate, AmersourceBergen, MERCK, celestio, CUB, RITE AID, MEMORIAL SLOAN KETTERING CANCER CENTER, esk, medco, Insurers Administrative Corporation, and Independence Holding Group.
- Financial Services**: Includes logos for CHUBB, PRUDENTIAL, MetLife, Mutual of Omaha, SOCIETE GENERALE, Standard Chartered, Aetna, HSBC, NASDAQ, WACHOVIA, Banco Pastor, Northern Trust, BNP PARIBAS, CITI, JPMORGAN CHASE & CO, MasterCard, FannieMae, ING, LBBW, STANDARD LIFE, and AXA.
- Manufacturing & Energy**: Includes logos for Westinghouse, OPEC, ADI, Eneco, PHILIPS, THALES, EADS, AMD, Enel, Raytheon, JOHN DEERE, SECO, and DELL.
- Logistics & Transportation**: Includes logos for Hactl, International, W.W. HALLMARK, YRC, DB, SCHENKER, Dagang-Net, POST, DTTN, DHL, Posteitaliane, LA POSTE, LOOMIS, UNITED STATES AIR MAIL SERVICE, SNCF, and APL.
- Retail & Consumer**: Includes logos for NIKE, DELHAIZE GROUP, KRAFT, Nestle, MERCADONA, ACE Hardware, Sears, Tetra Pak, Electrolux, groupe carrefour, MARKS & SPENCER, H-E-B, LVMH, P&G, Casino, COSTCO, CONAD, SFD, and thoc.
- Services & Telecom**: Includes logos for BT, SFR, nielsen, National Instruments, SFR, T-Mobile, IBM, symantec, Telewest, Verizon, 3E, Digi, Systems, ACCOR, Alcatel, Cellcom, eby, LAWS ON, ittel, ORACLE, TIME WARNER, and Seagate.
- Automotive**: Includes logos for GM, BOSCH, LEAR, BMW Group, PEUGEOT, Valeo, DAIMLER, Continental, GOOD YEAR, MICHELIN, VOLVO, RENAULT, and TOYOTA.
- Government**: Includes logos for USDA, Marines, 厚生労働省 (Ministry of Health, Labour and Welfare), Bundesagentur für Arbeit, emea, MINISTÈRE DU BUDGET DES COMPTES PUBLICS ET DE LA FONCTION PUBLIQUE, CDC, FDA, DISA, and ELINT.

Cost Summary

Vendor Cost Comparison Assumptions

Overall Assumptions & Caveats

- HIE Hub Solution Only (no MPI, RLS, etc.)
- Vendor-hosted
- Costs compared over a 5-year period
- Includes all vendor costs
 - Implementation, software licenses/subscription fees, training
 - Maintenance, hosting, support

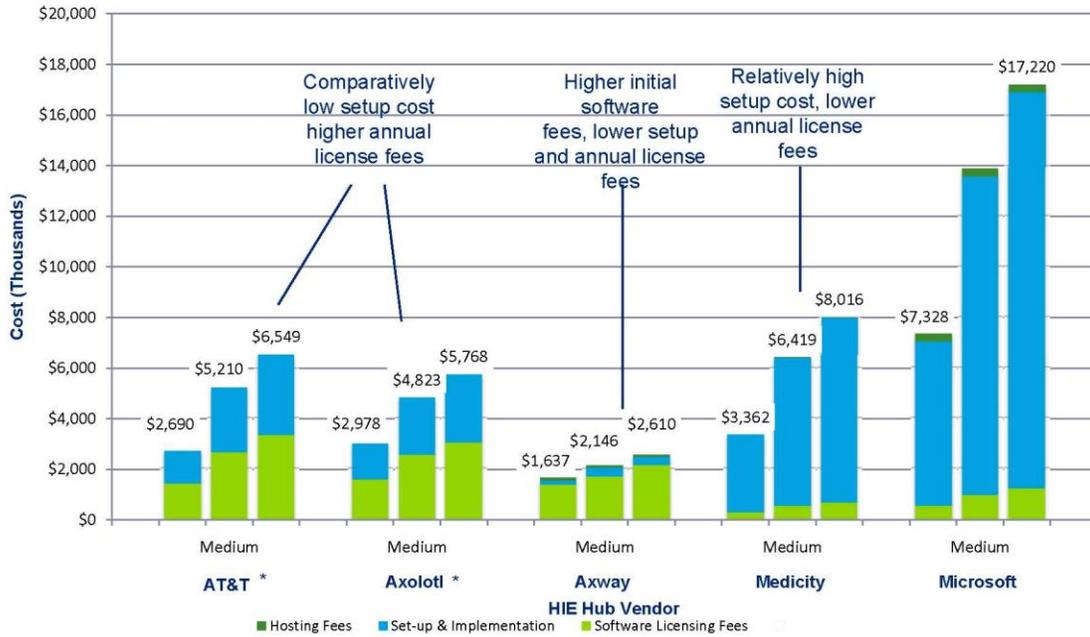
Volume Assumptions

Three cost scenarios were developed based on low, medium, and high rates of Trading Partner adoption

Trading Partner Type	Year 1			Year 2*			Year 3*			Year 4*			Year 5*		
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H
Hospital/IDN/Large Physician Practice (100 beds)	10	20	25	20	40	50	22	44	55	25	49	62	27	54	68
Health Plan/Agency	2	3	4	2	3	4	2	4	5	3	5	7	3	6	8
TPA	0	0	0	1	1	2	1	2	3	2	3	4	2	4	5
Physician Practice (3 MDs with EMR)	200	400	500	400	800	1,000	600	1,200	1,500	650	1,300	1,625	700	1,400	1,750
Physician Practice (3 MDs no EMR)	50	100	125	100	200	250	150	300	375	175	350	438	200	400	500
Total Trading Partners	262	523	654	523	1,044	1,306	775	1,550	1,938	855	1,707	2,136	932	1,864	2,331

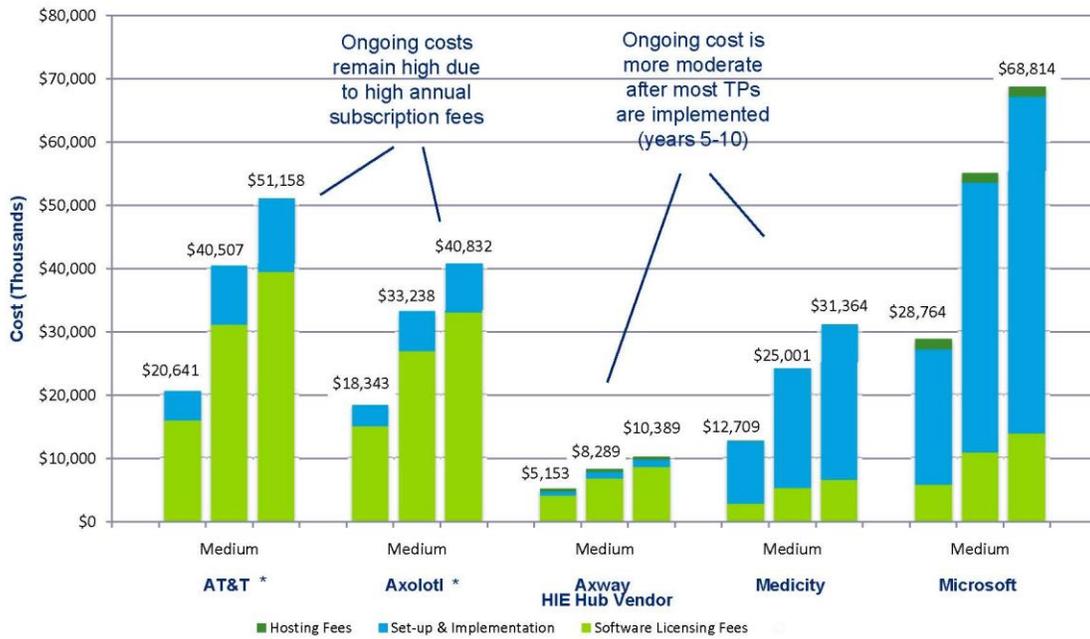
*Reflects the cumulative number of trading partners

Total Year 1 Cost Comparison



*AT&T and Axolotl do not charge hosting fees

Total 5-Year Cost Comparison



*AT&T and Axolotl do not charge hosting fees

Axway's Costs Are Lowest

"Medium" cost estimate shown

	Axway		Medicity	
	Year 1 Cost	5 Year Cost	Year 1 Cost	5 Year Cost
Software/Licensing Fees	\$1,720,807	\$6,801,935	\$496,512	\$5,137,824
Implementation & Training	\$938,740	\$2,199,820	\$5,892,460	\$19,713,500
Hosting	\$111,000	\$555,000	\$30,000	\$150,000
Discounts	(\$624,082)	(\$1,267,929)	\$0	\$0
Total	\$2,146,465	\$8,288,826	\$6,418,972	\$25,001,324

Vendor Finalist Comparison

Vendor Finalist Differentiators

	Axway	Medicity
Positives	<ul style="list-style-type: none"> ✓ Strong trading partner self-registration and provisioning tools ✓ Strongest options for trading partner self-provided and/or vendor provided configuration ✓ Very powerful and comprehensive core hub capabilities, including message routing, mapping, transformation, and protocol translations, including ability for use by trading partners ✓ Strong and easy to use message tracking, monitoring, reporting, auditing capabilities ✓ Ability to inspect/use message content for routing, splitting, etc. ✓ Campaign tools for trading partner recruiting, tracking, set-up ✓ Rapid implementation approach, speed and ease of rapidly adding large numbers of Trading Partners ✓ Proven scalability to millions of transactions and thousands of Trading Partners ✓ Extensive experience with x12 transactions ✓ Significantly lower cost 	<ul style="list-style-type: none"> ✓ Good track record with provider directory/index products & services ✓ Are providing MPI and RLS licensing as part of their quoted solution (However, usage-based charges and implementation fees would apply) ✓ Extensive current customer base, big pipeline, and strong recent sales track record
Negative	<ul style="list-style-type: none"> ✗ Less experience with EMRs ✗ Limited existing experience with MPI and RLS (partnering with Initiate & NextGate) 	<ul style="list-style-type: none"> ✗ Significant customer backlog - potential resource constraints ✗ Higher Cost ✗ Longer Implementation Timeline ✗ Gaps with various integration toolsets ✗ Very limited tools for campaigns

Reference Checks – Who Did We Talk To

Axway	Medicity
<ul style="list-style-type: none"> ➤ Astra Zeneca Pharmaceuticals • World wide organization • Axway customer since 2000 • Services: Full suite of tools WA St is considering • Used for: All internal and external file and transaction traffic including SAP, FDA, DEA, supply chain and research 	<ul style="list-style-type: none"> ➤ Mississippi Coastal Health Information Exchange • Eleven hospitals and 60 docs • Medicity customer since 2008 • Services: ProAccess (browser-based EHR-Lite) and Med History now, more later • Rolling out over 5 years – out of money – hoping to be picked up by Mississippi State HIE when funded by ONC
<ul style="list-style-type: none"> ➤ United Health Group • National Health Plan • Axway customer since 2007 • Services: Gateway, secure relay, Sentinel, Connectors, Passport. Do not use data transformation features of the HUB. • Used for: Secure file transport and tracking inside and outside the organization • Size: 7,000 trading partners trading 30-35,000 files/day 	<ul style="list-style-type: none"> ➤ Daughters of Charity • Six hospitals in California • Medicity customer since 2002 • Services : ProAccess for years, now starting to roll out Novo Grid to connect to EMRs
<ul style="list-style-type: none"> ➤ Catholic Health West • 43 Hospital health system • Axway customer since 2009 • Services: Same suite WA ST is considering • Used for: Still rolling out. Plan to deploy in 100 hospitals using over 150 different file formats. Using to standardize file handling with all trading partners and internal systems. 	<ul style="list-style-type: none"> ➤ El Camino Hospital • 2 hospital group in California • Medicity customer since 2002 • Services: ProAccess, Grid, Virtual Care Teams, Orders, EMPI

Reference Checks – Key Feedback

Two strong vendors respected by their customers

	Axway	Medicity
Positive	<ul style="list-style-type: none"> ✓ Very focused on understanding underlying business issues and figuring out how to apply technology ✓ Fast and reliable transaction tracking ✓ “They are one of our best vendors to work with” ✓ Scalability and performance is proven with large numbers of transactions. (UHG does 30k transactions/day) ✓ Good user group forum to exchange ideas with other customers ✓ Good visibility into product roadmap and planning ✓ Good continuity of resources from support “we have been working with the same team throughout the relationship” 	<ul style="list-style-type: none"> ✓ “They have always been there for us” ✓ “Feels like a true partnership not a typical vendor relationship” ✓ People at the top of Medicity really “get it” ✓ Deep knowledge of the utilization of health data and able to assist with clinical quality reporting not just data transport issues
Negative	<ul style="list-style-type: none"> ✗ Custom enhancements need to be carefully managed. <ul style="list-style-type: none"> • Engineering can be slow to respond to enhancement requests • Documentation is sometimes lacking • Additional testing is necessary when applying patches 	<ul style="list-style-type: none"> ✗ “Development not as quick as I’d like in their support of Apple products (Safari browser)” ✗ “Sometimes Medicity will listen to suggestions and act on them, sometimes they’ll listen and ignore”
Overall	<p>Customer references for both vendors were very positive. Various issues that were brought up were minor in nature and there were no major concerns for either vendor.</p>	

Summary of Key Risks

Axway	Medicity
<ul style="list-style-type: none"> ✘ No live customer experience exchanging communications with RLS, MPI vendors ✘ Impact of potential IPO is unknown (Sopra may divest Axway) 	<ul style="list-style-type: none"> ✘ Impact of major organizational growth – can the executive leadership make the next growth leap ✘ Concern over target for acquisition by larger entity ✘ Potential challenges to provide sufficient implementation resources/support (due to large project backlog). ✘ Concern for average timeline to implement individual trading partners and the need to be able to on-board many orgs to meet Meaningful Use requirements

Final Recommendation - Why Axway?

Our vendor selection process concluded that Axway best delivers on the functional and technical requirements and that Axway meets these important criteria for a quality long-term strategic partner

Fit	Control	Sustainability
<ul style="list-style-type: none">▪ Very powerful and comprehensive core hub capabilities▪ Strong partner self-registration and provisioning tools▪ Ability to extend self-management capabilities to trading partners▪ Rapid implementation approach▪ Consistent with ONC priorities▪ Proven scalability to millions of transactions and thousands of Trading Partners▪ Gartner places Axway #1 in the "Leaders" quadrant for Managed File Transfer (2009)	<ul style="list-style-type: none">▪ Empowers Washington State HIE to tightly manage operations▪ Greater role for Washington State HIE to manage the risks of the implementation▪ Very flexible toolbox to build additional capabilities	<ul style="list-style-type: none">▪ Low ongoing cost▪ Business is diversified across multiple products and industries▪ Openness of Axway solution allows flexibility to adapt to future requirements▪ Low cost of HUB proposal provides option to invest in future functionality (e.g., MPI/RLS)▪ Proven Hub-to-Hub interconnectivity

Next Steps

Parallel processes over the next 90 + days

- OHP seeks ratification of Axway selection from HIE Leadership Group
- OHP begins contract negotiation with Axway
- HCA and OHP seek ONC final approval of Washington State HIE Plans
- OHP determines operational roles for OHP and contractors
- OHP proposes initial pricing model for review by HIE Leadership Group and OHP Board, then seeks formal approval by Oversight Organization – FHCQ
- OHP proposes initial policies for review by HIE Leadership Group/TAG and OHP Board, then seeks formal approval by Oversight Organization – FHCQ
- OHP prepares “Go To Market” communications and marketing plan
- OHP seeks early adopters

Appendix E: Health Information Technology Terms and Definitions

Electronic Health Record (EHR) – A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting.

Health Information Exchange (HIE) – The electronic information system of connectivity among health care providers and health care systems that complies with safety, security access, and quality standards; is interoperable; and allows unified access to all available information for a given patient regardless of location of the patient or the information.

Health Information Technology (HIT) – The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Interoperability – The ability of disparate health information systems to work together within and across organizational boundaries and readily exchange health information in standard formats with standard representation so that information can be moved from one system to another without loss of detail or meaning.

Sources: The American Recovery and Reinvestment Act of 2009, Title XIII-Health Information Technology, Subtitle A-Promotion of Health Information Technology, Part 1-Improving Health Care Quality, Safety, and Efficiency, Title XXX-Health Information Technology and Quality, Section 3000

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf;

Dictionary of Healthcare Information Technology Terms, Acronyms and Organizations, Healthcare Information and Management Systems Society (HIMSS).