DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the National Coordinator
for Health Information Technology
Washington, D.C. 20201

Program Information Notice

DATE: February 8, 2012 Document Number: ONC-HIE-PIN-002

SUBJECT: Requirements and Recommendations for the State Health Information Exchange Cooperative Agreement Program

TO: State Health Information Exchange Cooperative Agreement Program Award Grantees

As stated in the State Health Information Exchange Cooperative Agreement Program Funding Opportunity Announcement (FOA), the Office of the National Coordinator for Health Information Technology (ONC) may offer program guidance to provide assistance and direction to states and State Designated Entities (SDEs) that receive awards under the program (Grantees). This Program Information Notice (PIN) provides direction on the timing, content and review process for annual updates to Grantee Strategic and Operational Plans (SOPs). This cover letter provides a summary of recommendations and requirements spelled out in the PIN. Detailed guidance follows in the body of the document.

The State Health Information Exchange Cooperative Agreement Program is at a critical stage. Grantees are intensely focused on ensuring that providers have affordable and usable options to meet the health information exchange (HIE) requirements of Stage 1 Meaningful Use. The requirements include e-prescribing, receiving electronic structured lab results from labs and sharing care summaries electronically with other providers to support patient transitions. These are the basic exchange building blocks that will support numerous care improvements for patients including better treatment and diagnosis, improved chronic care and reductions in medication errors and unnecessary repeat testing. At a minimum, they require the availability of ubiquitous directed exchange—information can be *sent* and *received* easily, securely and electronically—replacing fax, mail and phone.

While these requirements may seem straightforward, the effort required to make rapid progress is considerable. According to the 2010 American Hospital Association survey, fewer than one fifth of all hospitals (19 percent) have a mechanism to share electronic patient information with ambulatory providers outside their systems. Fortunately, the vast majority of pharmacies already participate in e-prescribing. Many providers already receive electronic results from labs and many partners within the healthcare system, including EHR vendors and hospital systems, are supporting the development of exchange capacity, sharing this burden.

Grantees have the opportunity to leverage and take advantage of these local and private sector investments while providing the gap-filling services, policy support and core infrastructure needed to ensure that every provider has affordable exchange options and to connect these diverse exchange networks—including state-supported networks—avoiding the perpetuation of "information silos".

When the conditions are right, we see adoption of health IT rapidly progressing in a steep curve. For instance, provider participation in e-prescribing almost doubled in the last year, increasing from 26 to 43

percent, according to SureScripts data. In 2012 we expect to see a similar progression for care summary and lab results exchange. The conditions are in place:

- These are foundational requirements for Meaningful Use and were established as programmatic expectations in the State HIE Program Information Notice (PIN) issued July 6th, 2010 (#ONC-HIE-PIN-001). Every Grantee has identified and is executing the most effective strategies and tactics to make rapid progress in their state and local environments.
- Every certified EHR can produce a care summary and incorporate a structured lab result.
- ONC, working with a community of on-the-ground implementers, has specified essential transport and content standards that support exchange of structured lab results and patient care summaries.[1]
- In addition, and importantly, payment reforms such as medical home efforts and accountable care organizations and new initiatives such as Partnership for Patients[2] are providing new incentives, business cases, and market conditions for health information exchange and care coordination.

Building on guidance outlined in the 2010 PIN, our 2012 goal is clear - ensuring that providers have options to meet the health information exchange (HIE) requirements of Stage 1 Meaningful Use - including for e-prescribing, receiving structured electronic lab results and sharing care summaries. This PIN offers guidance to support rapid progress towards this goal:

- **Phasing**: Many Grantees have phased approaches in their approved Strategic and Operational Plans with the first phase strongly focused on enabling Stage 1 Meaningful Use requirements. If we are to achieve our goal this year, we must rapidly demonstrate the success and impact of these initial efforts.

  Subsequent phases of grantees' work focus on value-added services and more sophisticated exchange infrastructure. These services are essential and will be in increasing demand due to new payment approaches. In this area, as in others, Grantees will need to be creative and resourceful in identifying the specific gaps they should fill and the services that will deliver business value, leveraging the assets, infrastructure and business motivation of the private sector. Grantees should consider a "building block" approach deploying modular services like provider directories, identity management and master patient indices that can support multiple phases of work.

- **Sustainability**: Rapid progress will require two types of sustainability steps from Grantees. Both should be addressed in sustainability plans.

  1. In coordination with state Medicaid and health reform efforts, Grantees should work to increase demand for information and the business case for exchange through leadership actions and the

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[1] Direct and SOAP for transport, consolidated Clinical Document Architecture (CDA) and Laboratory Results Interface specifications for care summary and lab exchange.

[2] http://www.healthcare.gov/compare/partnership-for-patients/index.html

use of policy and purchasing levers. This key policy leadership role was outlined in the 2010 PIN document:

A key role for states can be to provide leadership and direction to public and private stakeholders. States may also use policy and purchasing levers to extend and enhance existing HIE activities in the state so as to encourage key trading partners such as pharmacies and clinical laboratories to participate in electronic service delivery and to enable providers to meet Meaningful Use requirements.

2. Grantees should assure the business viability of any services they are directly providing, ensuring that the services deliver value, are in demand and are affordable (e.g., providers, payers or other stakeholders are willing and able to pay for them), fill gaps in the market and are easily adopted and used by providers.

- **Evaluation**: We are charting new waters. Incredible progress in health IT adoption and use has already been achieved in a short period. Our future progress and success rests on whether we can effectively learn from each other over the next two years. Openly and quickly sharing results will support ongoing progress, ensure we gain maximum value from limited resources and help us avoid repeating costly mistakes.

- **Tracking Program Progress:** We have set a clear goal for 2012: ensuring that providers have options to meet the Stage 1 Meaningful Use exchange requirements. But how will we know if we are on track to get there? Consistent with the 2010 PIN, we are asking Grantees to set goals and track progress for each of the three key core HIE program requirements—care summary exchange, lab exchange and e-prescribing—as well as for public health reporting.

If you have any questions or require further assistance, please do not hesitate to contact your State HIE Project Officer.

Sincerely,

Farzad Mostashari
National Coordinator for Health Information Technology

PURPOSE

This Program Information Notice (PIN) provides program guidance to all grantees under the State Health Information Exchange Cooperative Agreement Program (State HIE Program) on:

- What is required for Strategic and Operational Plans (SOP) updates
- Phasing of program activities
- The contents and information that will be required for sustainability and evaluation plans
- Requirements and measures for tracking program progress

ONC encourages grantees to coordinate all activities with their State Medicaid programs to ensure program alignment and rapid progress.

APPLICABILITY

This policy is applicable to all ONC State Health Information Exchange Cooperative Agreement Program Grantees (Grantees), whether the Grantee is a state government or a state designated entity. This PIN provides additional guidance to support the overall reporting requirements outlined in the Notice of Grant Award (NOA).

DISCUSSION

Grantees shall submit annual updates to their SOPs as required in the Funding Opportunity Announcement (FOA). This PIN provides a detailed explanation of the timing and contents of these SOP updates.

1. GENERAL REQUIREMENTS

1.1 Deadlines

Grantees shall submit SOP updates every year. Grantees whose SOPs were approved in 2010 will have 90 days from the release of this PIN to submit their SOP update. Grantees whose SOPs were approved in 2011 will have 120 days from the release of this PIN to submit their SOP update. The SOP update for 2013 will be due one year after the 2012 deadline. Only the "Tracking Program Progress" component of the SOP update will be required in 2014. This is due at the end of January, 2014.

Note: Grantees should disregard the annual SOP submission dates found in the NOA implementation requirements.

1.2 Review Process

If updates to the SOP do not require approval of a new budget, do not propose a significant shift in strategy or in phasing and do not propose substantial new services, the Project Officer will review and give written approval for the SOP update.

If proposed changes to the SOP require approval of a new budget, propose a significant shift in strategy or in phasing or propose substantial new services, the Program Manager and/or Program Director will review and give written approval for the SOP update.

In cases where the state has re-written the SOP with a new overall approach and strategy, re-approval by the National Coordinator will be required.

During review of all SOP updates, Program staff may ask for revisions or adjustments to the SOP.

Until written approval of SOP updates is provided, the existing SOP will be in effect.

1.3 SOP Update Format

Grantees shall use the following format for SOP updates:

Section	**Submit in First SOP Update**	**Submit in Subsequent SOP Updates**
1. Changes in HIE Strategy	Complete and submit relevant sections of *Changes in HIE Strategy* (Appendix A)	Complete and submit relevant sections of *Changes in HIE Strategy* (Appendix A)
2. Sustainability Plan	Submit *Sustainability Plan* (see section 2 of this PIN for requirements)	Complete and submit "Sustainability" section in *Changes in HIE Strategy* in Appendix A
3. Program Evaluation	Submit *Program Evaluation Plan* (see section 4 of this PIN for requirements)	Submit *Annual Program Evaluation Results Report* (see section 4 of this PIN for requirements)
4. Privacy and Security Framework	Submit *Privacy and Security Framework* (additional program guidance will be provided)	Complete and submit "Privacy and Security Framework" section in *Changes in HIE Strategy* in Appendix A
5. Project Management Plan	Submit updated *Project Management Plan* for the upcoming year, including an updated staffing plan and an updated discussion of risks and mitigation strategies as outlined in PIN #ONC-HIE-PIN-001, released on July 6, 2010. The project management plan should include an update of major activities for the upcoming year including timelines and milestones.	
6. Tracking Program Progress	Complete and submit *Tracking Program Progress* for relevant year (Appendix C) Descriptions of measures and sources are in Appendix B This section shall be included in the first SOP update. For subsequent years, all Grantees shall submit this section of the SOP update in January of each year (e.g., January 2013, January 2014 etc)	

In addition to completing the above modules, grantees shall also submit a “track changes” version of their Strategic and Operational plans once any revisions and additions are approved by the Project Officer.

1.4 PHASING

Many Grantees have phased approaches in their approved SOPs with the first phase strongly focused on rapidly enabling Stage 1 Meaningful Use exchange requirements. Success in these initial phases will be critical, ensuring that every provider has options to share care summaries, receive electronic lab results and e-prescribe, providing critical implementation experience and allowing time to scope and develop policies and approaches to implement future phases.

In keeping with these objectives, Grantees will need to demonstrate the success of the current phase and submit plans for implementation of the next phase before transitioning from one phase to the other.

We recognize that many providers have existing exchange options that support them in meeting Meaningful Use exchange requirements. Therefore, success of the first phase can be demonstrated in two ways. The first focuses on adoption and use of services offered or enabled by Grantees while the second addresses use of exchange services by providers whether or not these services are provided by the Grantee.

Grantees *with phased approaches* shall meet one of two thresholds in order to move from Phase One to Phase Two of their SOPs:

1. The number of providers actively using services offered or enabled by the Grantee to support care summary or lab exchange is at least 30 percent of the Priority Primary Care Providers (PPCP) Regional Extension Center (REC) target (with a maximum of 1000). The actual providers served by the Grantee do not need to be those registered with the REC nor do they need to be primary care providers.
2. At least 50 percent of REC-registered providers who have reached “Milestone Two” (providers have registered with the REC <u>and</u> implemented an EHR) have an option they are actively using to share care summaries with other providers and receive electronic lab results. Grantees would need to work with the REC to collect this information.*

*As the number of providers who have reached Milestone Two increases over time, Grantees choosing this option should consult their Project Officer for an updated threshold number

See Appendix D for target values for the two thresholds for each state. Note that not every state has a phased approach in their approved Strategic and Operational Plan.

While the targets are short of our goal—that EVERY eligible provider has options to meet Meaningful Use exchange requirements—they demonstrate that adoption and use of exchange services to meet Meaningful Use has reached a critical tipping point.

Grantees with more than two phases of work should consult with their Project Officers to determine success metrics and milestones that must be met for Phases Two and Three before proceeding to the next phase.

Information outlining plans for the next phase and demonstration of success with the current phase can be submitted separately at any time or as part of the annual SOP updates. The Project Officer shall provide written approval prior to the Grantee's transition from one phase to another.

To assure steady progress and provide the time and resources needed to plan and effectively implement the next phase, we would not expect a rigid stop and start of phases. For instance, planning for Phase Two can occur in Phase One. Planning activities might include work planning, developing policy requirements, issuing RFPs and potentially pilot testing approaches that will be deployed in the next phase. Grantees should discuss specifics with their Project Officers.

2. SUSTAINABILITY

Grantees are expected to create the "conditions" for the sustainability of information exchange in the state and also outline viable business plans for the sustainability of services they are directly providing or funding. As stated in PIN #ONC-HIE-PIN-001, released on July 6, 2010, "the primary focus of sustainability should be on sustaining information sharing efforts, and not necessarily the persistence of government-sponsored health information exchange entities".

As stated in the previous PIN released on July 6, 2010 (#ONC-HIE-PIN-001):

> *ONC is concerned that HIE sustainability models that rely on mandated provider or hospital participation in specific HIE services offered by the state or SDE might inappropriately limit provider choices in the full array of information exchange alternatives, thereby threatening the ability of providers to achieve Meaningful Use, particularly where state-designated services are still limited or nonfunctional.*

Grantees shall submit a sustainability plan as part of their first SOP update addressing these two distinct components:

Conditions for sustainability of health information exchange: The Grantee shall submit a strategy and coordination plan to create the business drivers for safe and secure health information exchange to support care transformation and provider achievement of Meaningful Use. The strategy and coordination plan may include use of policy levers, payment reforms and purchaser requirements. Examples include:

a. Create demand for exchange through policy and purchasing levers. For example:
   i. Medicaid uses reimbursement levers to encourage participating providers to electronically share visit summaries with primary care providers and patients.
   ii. State encourages private plans to give preference to labs sending electronic lab results in a structured format in their lab networks.
   iii. State includes health information exchange requirements in its state employee insurance plan contracts.

b. Advance care transformation models and payment reform initiatives that increase demand for exchange, and deliberately incorporate health IT adoption and health information exchange requirements into these efforts.

    i. Accountable Care/Shared Savings Initiatives
    ii. Health homes
    iii. Pay for performance
    iv. Integrated care for dual eligibles

c. Foster systemic changes to support health information exchange
    i. Engage consumers to request their own electronic health information, demand HIT-enabled care and expect that providers will make their transitions safe and effective.
    ii. Increase provider engagement and adoption.

(1) **Business sustainability of services directly offered or enabled**: The grantee shall also submit a thorough and thoughtful business plan for the sustainability of any services directly offered or funded by the Grantee. The starting place for this plan is not, "how do I generate enough income to maintain my organization at the current level of operation", but rather "which services will fill market gaps, and offer valuable, affordable exchange options that will be widely adopted and used." This plan should:

a. Offer a clear description of services offered and fees for those services to different participants
    i. Describe how these fees were set, including adoption assumptions
    ii. Include data on the current adoption and use

b. Provide evidence that there is demand for the services from participants
    i. Describe who will be adopting services and to perform what exchange tasks
    ii. Describe how services will provide value in a competitive market

c. Describe ongoing public or private contributions to support exchange services

As a condition of the grant, ONC expects that all grantees will meet the Meaningful Use exchange needs of eligible providers, including those serving Medicaid patients and rural and underserved communities. We recognize that there is a potential tension between offering services that are self-sustaining and serving communities and providers with the fewest resources. One way Grantees can resolve this tension is by offering affordable and easy-to-adopt exchange options.

3. TRACKING PROGRESS

Demonstrating progress and the tangible results of Grantee implementation efforts is critical for encouraging participation in HIE, maintaining provider/user buy-in and trust and establishing the long-term sustainability of health information exchange. Both local and national stakeholders are looking to understand how HIE Cooperative Agreement funds are enabling health information exchange and supporting providers in achieving Meaningful Use.

Consistent with and building on the PIN released on July 6, 2010 (#ONC-HIE-PIN-001), Grantees shall monitor and track key Meaningful Use HIE capabilities in the state. This PIN provides further clarity on measures, which include:

1. % pharmacies participating in e-prescribing

2. % clinical laboratories sending lab results electronically and in structured format
3. % providers and hospitals sharing patient care summaries electronically
4. % state health departments electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results. These data will need to be collected at the state or sub-state level, depending on the approach to public health reporting in the state.

Grantees shall report on progress and set annual targets for these key measures in their first SOP update due in 2012 and then separately in January 2013 and January 2014.

Appendix C provides a format for states to use in reporting progress and setting targets for these key measures while Appendix B outlines measure definitions and data sources.

As outlined in Appendix B, ONC will provide state-level data showing annual progress for areas 1 and 3 above. Grantees will need to collect data to show annual progress for areas 2 and 4.

4. PROGRAM EVALUATION

As required by section 3013 of the HITECH Act, ONC will conduct a national program evaluation and will provide documented lessons learned, technical assistance and program guidance based on the results.

As stated in the FOA, Grantees must comply with the requirements of and cooperate with ONC in completing the national evaluation. In addition, Grantees must conduct an annual state-level program evaluation. The grantee's evaluation plan shall be included in the first SOP update. The plan should be no more than 3,000 words. Revisions to the evaluation plan and annual evaluation results shall be reported in subsequent SOP updates. The FOA requires Grantees to use at least two percent of their funds for state-level program evaluations. ONC will make the national evaluation results available to Grantees to support rapid learning and encourages Grantees to quickly and openly share their own evaluation results.

State's program evaluations should:

1. Describe the approaches and strategies used to facilitate and expand health information exchange in the program priority areas and other areas as appropriate for the state's strategy. Program priority areas that must be included are:

    a. Laboratories participating in delivering electronic structured lab results
    b. Pharmacies participating in e-prescribing
    c. Providers exchanging patient summary of care records

2. Identify and understand conditions that support and hinder implementation of those strategies (e.g. how did your governance model or engagement with stakeholders support your strategy to increase lab exchange activity in your state?)

3. Analyze HIE performance in each of the key program priority areas (e.g., where did your state/territory begin at the start of the program and how have you progressed?) Grantees with operational health information exchange underway are encouraged to assess participant adoption and use (e.g. measure provider adoption) and analyze its impact (e.g. assess impact on care transitions, patient safety, duplicate lab test ordering, etc.)

4. Assess how the key approaches and strategies contributed to progress in these areas, including lessons learned.

The following elements are required for the *evaluation plan* that shall be submitted to ONC in the first annual SOP update:

- Aims of the evaluation (as noted above), including key evaluation questions that the Grantee seeks to address.
- Evaluation framework to assess the aims (e.g., context, process, outcomes)
- Evaluation methods including:
    - **Study Design:** describe the study design, which should include both qualitative and quantitative components. For quantitative analysis, the use of comparison or control groups or designs that assess change over time (pre-post) is suggested to enhance the validity of the findings.
    - **Study population:** describe the population to be included in the evaluation (e.g. providers, pharmacies, laboratories, etc.) Specify inclusion and exclusion criteria as appropriate, and the recruitment strategy.
    - **Data sources and data collection methods:** describe the data collection approach to answer key evaluation questions, which may include implementing surveys, analysis of existing survey data, focus groups, interviews and audit log data from HIE vendors.
    - **Data analysis**: describe the analytic methods that will be used including sample size.
- The following elements are required for the *annual evaluation results reports* that shall be submitted to ONC in the 2013 SOP update and 30 days after the end of the Program:
    - Updates or changes to evaluation plan (if any).
    - Progress on the evaluation (e.g. describe data collection efforts underway) and any issues encountered while conducting the evaluation.
    - Results and interpretation of those results. Findings can be summarized as briefs (3-5 pages) or peer-reviewed publications on key topics.
    - Implications of the evaluation findings for program implementation and strategy.

APPENDIX A - Changes to HIE Strategy

Domain/Sections	Short Description of Approved Portion of SOP that Grantee is Proposing to Change (include page numbers)	Proposed Changes	Reason for the Proposed Changes	Budget Implications of Proposed Changes
Include in First and Subsequent SOP Updates				
Overall HIE Strategy including Phasing				
Governance				
Technology				
Financial				
Business Operations				
Legal/Policy				
Strategies for e-Prescribing				
Strategies for Structured Lab Results Exchange				
Strategies for Care Summary Exchange				
The Core Documents Are Required As Part Of First SOP Update. Changes Should be Indicated in Subsequent SOP Update				
Sustainability				
Privacy and Security Framework				
Evaluation Plan				

APPENDIX B

Measure Definitions and Sources to be used in completing *Tracking Program Progress* (Appendix C)

PIN Priority	Numerator	Denominator	Source
1. % of pharmacies participating in e-prescribing	Number of pharmacies that sent or received any electronic new prescription, refill request, or refill response messages in December of the former year via Surescripts network	Total number of licensed pharmacies operating in the state (per NCPDP)	Surescripts/NCPDP data ***ONC will provide data to Grantees***
2. % of labs sending electronic lab results to providers in a structured format[3]	Number of hospital and independent clinical laboratories that send electronic lab results to ambulatory care providers in a structured format	Total number of hospital and independent clinical laboratories that respond to census	*Numerator: data collected through Grantee's lab census (a sample instrument will be provided following the release of this PIN)* *Denominator: Census should target all labs in "hospital" and "independent" lab categories, including LabCorp and Quest, in CLIA OSCAR database (http://wwwn.cdc.gov/clia/oscar.aspx)* ***Grantee assesses. ONC will provide a sample instrument.***

[3] **Structured format:** Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text).

PIN Priority	Numerator	Denominator	Source
3. % of labs sending electronic lab results to providers using LOINC	Number of hospital and independent clinical laboratories that send electronic lab results to ambulatory care providers using LOINC	Total number of hospital and independent clinical laboratories that respond to survey	*Numerator: data collected through Grantee's lab census* *Denominator: Census should target all labs in "hospital" and "independent" lab categories, including LabCorp and Quest, in CLIA OSCAR database (http://wwwn.cdc.gov/clia/oscar.aspx)* ***Grantee assesses. ONC will provide a sample instrument.***
4. % of hospitals sharing electronic care summaries with (a) unaffiliated hospitals and (b) unaffiliated providers	Number of non-federal acute care hospitals sharing electronic clinical care summaries with the following entities as reported in the AHA HIT Supplement survey: a. Hospitals outside their system b. Ambulatory care providers outside their system	Total number of non-federal acute care hospitals responding to AHA HIT supplement survey	AHA HIT supplement survey ***ONC will provide data to Grantees annually. Grantees may expect an annual release in December or January.***

PIN Priority	Numerator	Denominator	Source
5. % of ambulatory providers electronically sharing care summaries with other providers	Number of ambulatory care, office-based physicians who share electronic clinical summaries or summary of care records with other providers	Total number of ambulatory care, office-based physicians who responded to the survey	National Ambulatory Medical Care Survey (NAMCS) Electronic Medical Records (EMR) Supplement (also known as National Electronic Health Records Survey) ***ONC will provide data to Grantees annually. Grantees may expect an annual release in December or January.***
6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources in HL7 2.5.1 format with LOINC and SNOMED.	1= Yes 0= No (or %)		Grantee assesses

PIN Priority	Numerator	Denominator	Source
7. Immunization registries receiving electronic immunization data produced by EHRs in HL7 2.3.1 or 2.5.1 formats using CVX codes.	1= Yes 0= No (or %)		Grantee assesses
8. Public Health agencies receiving electronic syndromic surveillance data from hospitals produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide)	1= Yes 0= No (or %)		Grantee assesses

PIN Priority	Numerator	Denominator	Source
9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1 formats.	1= Yes 0= No (or %)		

APPENDIX C

See Appendix B for measure definitions and sources

Tracking Program Progress

	Report in first SOP update		Report January, 2013		Report January, 2014	
Program Priority	Status as of December, 2011	Target for December, 2012	Status as of December, 2012	Target for December, 2013	Status as of December, 2013	Target for end of grant period
1. % of pharmacies participating in e-prescribing						
2. % of labs sending electronic lab results to providers in a structured format[4]						
3. % of labs sending electronic lab results to providers using LOINC						
4. % of hospitals sharing electronic care summaries with unaffiliated hospitals and providers						

[4] **Structured format:** Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text).

	Report in first SOP update		Report January, 2013		Report January, 2014	
Program Priority	**Status as of December, 2011**	**Target for December, 2012**	**Status as of December, 2012**	**Target for December, 2013**	**Status as of December, 2013**	**Target for end of grant period**
5. % of ambulatory providers electronically sharing care summaries with other providers						
6. Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC and SNOMED. **Yes/no or %**						
7. Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code. **Yes/no or %**						

	Report in first SOP update		Report January, 2013		Report January, 2014	
Program Priority	**Status as of December, 2011**	**Target for December, 2012**	**Status as of December, 2012**	**Target for December, 2013**	**Status as of December, 2013**	**Target for end of grant period**
8. Public Health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide). **Yes/no or %**						
9. Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1. **Yes/no or %**						

APPENDIX D- Threshold Levels to Demonstrate Phase One Success

State*	30%of REC Target (max of 1000)	50%of REC Providers at Milestone 2**
Alaska	300	90
Alabama	391	343
Arkansas	384	258
Arizona	587	295
California	1000	1682
Colorado	689	730
Connecticut	392	249
District of Columbia	300	234
Delaware	300	430
Florida	1000	905
Georgia	1000	1049
Hawaii	300	51
Iowa	360	156
Illinois	836	468
Indiana	660	616
Kansas	360	248
Kentucky	300	152
Louisiana	313	112
Massachusetts	746	786
Maryland	300	231
Maine	300	143
Michigan	1000	680
Missouri	350	334
Mississippi	300	345
North Carolina	1000	835
Nebraska	339	143
New Hampshire	300	400
New Jersey	1000	1155
New Mexico	311	213
New York	1000	2173
Ohio	1000	1851
Oklahoma	300	258
Oregon	802	715
Pennsylvania	1000	1152
Puerto Rico	1000	213
Rhode Island	300	242
South Carolina	300	314
South Dakota	321	53
Tennessee	403	590
Texas	1000	664
Virginia	686	694
Vermont	330	278
Wisconsin	488	472
West Virginia	300	223
States in Mult-State RECs		
Idaho	130	146
Minnesota	962	949
Montana	197	102
Nevada	200	197
North Dakota	118	117
Utah	239	234
Washington	581	652
Wyoming	103	54

*Territories: Please consult your Project Officer for thresholds for American Samoa, Commonwealth of the Northern Mariana Island, Guam, and the Virgin Islands.

**Please confirm current threshold with your Project Officer at time of submission