

# A Minnesota connected networks approach

## ADVISORY COMMITTEE DISCUSSION GUIDE AND REQUEST FOR INPUT

Draft for discussion, February 4, 2020

### Introduction

Secure, efficient, effective electronic health information exchange (HIE) is an important tool to improve individual and population health and reduce health care costs. While there have been considerable HIE advances in Minnesota, significant gaps remain across the health ecosystem<sup>1</sup> despite policy and funding efforts to encourage and require organizations to share information using HIE.

In recent years the Minnesota e-Health Advisory Committee (Advisory Committee), Minnesota Department of Health (MDH) and others have focused on paving a way forward. This way forward, a Minnesota connected networks approach (Minnesota approach) or “network of networks”, was developed with substantial community input through the Advisory Committee, a research study, an HIE Task Force, and a formal public input request. This approach is not necessarily a single connection or immediate new infrastructure, but rather a network of networks that would make use of existing HIE capabilities and resources to address and support HIE to fill the gaps and get health information to where it is needed statewide.

### Groundwork and planned strategies

To move a Minnesota approach forward, a two part strategy is planned. These strategies will help to coordinate and align with national, federal and state HIE efforts.

#### **Strategy 1: Build upon previous efforts and existing HIE capabilities to fill some HIE gaps right now**

An important first step is use of the eHealth Exchange<sup>2</sup> national network for exchange of care summary documents. Minnesota health systems using the Epic electronic health record (EHR) systems and Minnesota’s state-certified health information organizations (HIOs) are eHealth Exchange participants. Large health systems using the Epic EHR and providers participating with an HIO are able to query and receive summary of care documents using the eHealth Exchange<sup>3</sup>.

#### **Strategy 2: Create a new process for oversight, planning, decision-making, and accountability**

Developing an integrated, coordinated network of networks with the existing diverse collection of networks requires a new level of organization, structure, process, and accountability that is not currently in place. This coordination and structure is sometimes referred to as “governance” and is intended to be a pathway for longer-term improvements, new HIE services, or other changes needed to achieve more seamless statewide HIE.

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<sup>1</sup> Health ecosystem includes: individuals, their families and their environment; health care delivery systems of all sizes and types; health plans and payers; and policies, laws and other regulations

<sup>2</sup> <https://ehealthexchange.org/>

<sup>3</sup> [Implementation Plan for HIE Task Force Recommendation 1: Enable Foundational HIE using the eHealth Exchange, Version 1.2 \(PDF\)](#)

<https://www.health.state.mn.us/facilities/ehealth/hie/taskforce/docs/081619implementplan.pdf>

## Comparative analysis from other states

In recent years research of HIE governance examples from other states have been evaluated, shared with advisory groups and others to supplement the input from Minnesota stakeholders to ensure that other successful models, approaches and lessons learned are applied to a Minnesota approach.

While it is useful to consider other approaches there is almost never an easy way to just copy or insert what works in one state to another without at least some adjustment. Given the rapid evolution of HIE models, changing federal rules and regulations as well as continual finance and sustainability issues, no matter how successful a state's HIE landscape may appear, all states are struggling with one or more aspects.

## Lessons learned about successful HIE constructs (Vermont report)

Specifically, results from analysis done for the state of Vermont<sup>4</sup> (excerpted here) are included to help inform a Minnesota connected networks approach. Vermont commissioned an evaluation of the health information technology activities in nine states. The states were selected due to their varying economic and governance models and, because each state has unique characteristics, what may work in one state does not necessarily apply to another. However, the evaluation team was able to document specific lessons learned which may be directly applicable in any state.

The following list contains the lessons learned from these nine states.

- An economic model which includes a public/private partnership component supports an HIE that is more responsive to the needs of stakeholders and the marketplace.
- A governance model which includes a broad mix of accountability to public, private, and consumer stakeholders who clearly articulate a state-specific strategy and establish measurable and actionable program objectives is more successful in meeting the needs of the state.
- A use case approach focuses on high utility data exchange that can be optimized for interoperability, scalability, and rules for information sharing.
- Health information exchange has evolved as a network of networks which should be leveraged to provide efficient and non-redundant services.
- High degree of integration with state agencies (including Medicaid) is a critical success factor.

## Case study: Statewide Health Information Network of New York

The following is an example of one possible form of “governance” for one type of a network of networks, the Statewide Health Information Network for New York (SHIN-NY). The SHIN-NY is presented as a strawman in Figure 1, for illustrative purposes only, to help inform and assist in the governance discussion.

A "Network of Networks", The SHIN-NY connects regional HIE networks or Qualified Entities (QEs), which allow participating healthcare professionals, with patient consent, to quickly access electronic health information and securely exchange data statewide.

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<sup>4</sup> [Vermont Evaluation of Health Information Exchange Activities, November 2017](https://legislature.vermont.gov/assets/Legislative-Reports/VT-Evaluation-of-HIT-Activities-FinalReport-Secretary-Signature.pdf)

(<https://legislature.vermont.gov/assets/Legislative-Reports/VT-Evaluation-of-HIT-Activities-FinalReport-Secretary-Signature.pdf>); the states included were Delaware, Colorado, Maine, Maryland, Michigan, Nebraska, Oklahoma, Oregon, and Utah.

Each regional network enrolls participants within their community, including those from hospitals, clinics, FQHCs, home care agencies, payers, and ambulatory practices, among others, so they can access and exchange electronic health information with participants in their region. They are required to offer free basic services (e.g., clinical event notifications (alerts), patient record lookup, and secure messaging to their participants).

Figure 1. Statewide Health Information Network of New York (SHIN-NY)

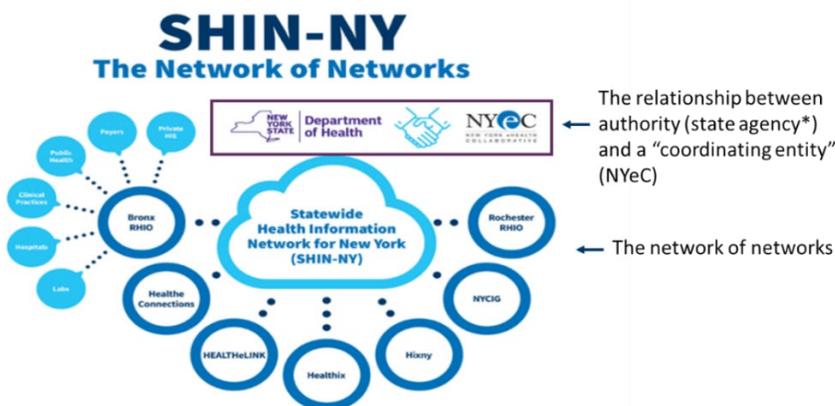


Figure 2 illustrates the New York model, whereby with the State Department of Health (which includes the state Medicaid program) has the authority and works in partnership with the New York eHealth Collaborative. The SHIN-NY is overseen by the New York State Department of Health and governed by privacy and security policies and standards.

The New York eHealth Collaborative is a non-profit organization which, on behalf of New York State, leads the advancement of the Statewide Health Information Network for New York (SHIN-NY), a network connecting healthcare professionals statewide as described above.

Figure 2. Statewide Health Information Network of New York (SHIN-NY)<sup>5</sup>



A significant part of the SHIN-NY is the Statewide Collaborative Process. As health information technology grows, new policy must be written, and new standards set. An essential task of NYeC is to develop common policies, procedures, and technical approaches through an open and transparent process—the Statewide Collaborative Process—to support New York’s expanding health information infrastructure. These will ensure the highest quality of service, interoperability, and full patient privacy, security, and safety.

<sup>5</sup> <https://www.nyehealth.org/shin-ny/what-is-the-shin-ny/>

## Possible Legislative Proposal for 2021 Session

Developing and implementing governance needed to support and foster a connected networks approach will require changes in existing state law and possible new state law(s). MDH is planning a possible legislative proposal that would propose these changes to existing law and/or possible new laws, to potentially be introduced in the 2021 legislative session. The MDH legislative proposal process requires that a draft proposal concept must be ready by approximately mid-summer 2020.

This document focuses on key concepts for authority – why it is needed, what it will be intended to address, issues and options for consideration, and other information. The concepts and examples are presented to help foster discussion. Future Advisory Committee meetings will focus on the funding and law modifications needed for a legislative proposal.

### Key concepts

The proposed foundation of the “Minnesota Connected Networks” includes the concepts of an authority entity, a coordinating entity and a partnership between these entities. These concepts are briefly described here:

- Authority entity: organization(s) that has responsibility to direct activities (in the SHIN-NY example the New York Department of Health oversees the SHIN-NY).
- Coordinating entity: organization that implements and/or manages the connected networks with shared or delegated authority from authority entity. In a number of states this is usually a private nonprofit organization (in SHIN-NY example the New York eHealth Collaborative has this role).
- Partnership between authority entity and a coordinating entity (e.g., a public-private arrangement).

### Role of a Coordinating Entity

A Minnesota coordinating entity would provide for implementation and oversight of the “Minnesota Connected Networks” which may include, but is not limited to, the following example responsibilities:

- Develop and implement draft minimum functionality (defined HIE services), reporting outcomes, and performance measures for all HIE service requirements.
- Revise and administer a participation agreement and trust framework (e.g., if eHealth Exchange DURSA needs to be modified for other transactions or additional requirements).
- Manage and enforce requirements for participants (e.g., what entities are required to participate; how requirements are met).
- Develop and implement a statewide collaborative decision-making process that includes input and representation from a broad stakeholder group to:
  - Align current national, federal and state HIE activities (existing federal programs, incentives, requirements, future federal interoperability and data access regulations, etc., DHS encounter alerting service (EAS), MDH interoperability, and others).
  - Identify, evaluate and prioritize use cases.
  - Facilitate plan for phased implementation of priority use cases.
  - Expand information sharing across the health ecosystem (fill gaps, address disparities between “haves” and “have-nots”).
  - Identify and develop plans for technical infrastructure to promote efficiency (e.g., develop shared services such as a centralized provider directory or consent management system).

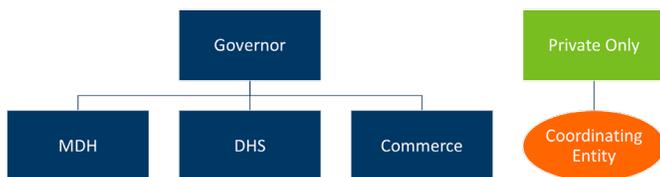
- Identify and recommend (or require) best practices (e.g., common process for capture, maintenance and update of an individual’s HIE consent).

## Authority Models

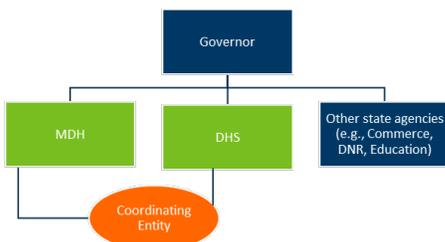
Having laid out the concepts and potential coordinating entity role, the primary focus is now directed at where the authority should be vested (where/who) and will be a major discussion topic at the Minnesota e-Health Advisory Committee meeting on February 10.

Three types of authority models are identified here on a continuum from a more hand-off approach, to models for authority at a state agency or governor level:

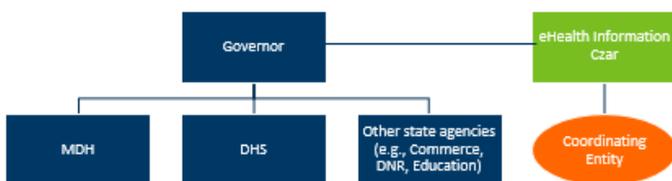
- **Private-only:** a private organization(s) with no state government representation



- **State agency(ies):** single state agency or shared across agencies (e.g., MDH, DHS, Commerce, new agency, shared authority MDH and DHS, or other)



- **Governor:** a subcabinet or executive-level “office” reporting directly to Governor



There are strengths, limitations and consideration for each type of model. For example:

- A private-only model would allow affected stakeholders to be key drivers of policy, but there could be limits on authority and enforcement without government involvement.
- State agencies have established processes in place for activities and authority (e.g., rulemaking) and may have access to federal and state funding. However, an agency’s focus may be limited and may lack influence over other agencies, and any shared accountability could be challenging.
- A Governor-level model may potentially have authority over other state agencies and could coordinate across multiple agencies. However, establishing such an “office” could be time-consuming and subject to revision with administration changes.

The Advisory Committee has provided direction and support to this approach. The MDH's Center for Health Information Policy and Transformation (CHIPT) has also engaged a small group of HIE experts to provide expertise and guidance on HIE strategy over the past two years. This group was recently asked about these models and shared the following additional thoughts:

- Most other states have models that incorporate advisory boards with state agencies represented; state agencies have a major role in influencing but are not usually running the HIE.
- The private sector is in a better position for implementation of technical infrastructure.
- Partnership between MDH and DHS is important; inclusion of other state agencies (e.g., Commerce or Administration) is also worth considering.
- Urgency; this problem needs fixing now – the time required to move forward with any of these examples should be a key consideration.
- Uncertainty of pending federal and national activities requires continuous monitoring.

## Discussion for February 10 Advisory Committee meeting

Your help is needed to ensure this legislative proposal solves the problems and can be supported by a broad stakeholder group. CHIPT staff seek input from the Advisory Committee on these concepts and, in particular, the authority models.

Please be prepared for this discussion by reviewing this document in advance of the Advisory Committee meeting. The following questions may be helpful to consider:

- Thoughts on working assumptions of authority entity, coordinating entity and partnership between entities.
- Thoughts on the authority models and examples
  - Strengths and limitations
  - Desirability and feasibility
  - Other