

# e-Health Advisory Committee Meeting June 11, 2020

## MEETING SUMMARY

### Meeting attendance

#### Members in attendance (17 of 22)

Alan Abramson (Health System CIOs)	Lisa Moon (Nurses)
Sunny Ainley (Informatics Training/Education)	Heather Petermann (DHS)
Stacie Christensen (ADM)	James Roeder (Small Hospitals)
Jennifer Fritz (MDH)	Peter Schuna (Co-Chair/Long Term Care Providers)
Steve Johnson (Academics/Research)	Jonathan Shoemaker (Large Hospitals)
George Klauser (Social Services)	Sonja Short (Co-Chair/Physicians)
Pat Lang (Consumers)	Adam Stone (Experts in HIT)
Jennifer Lundblad (Quality Improvement)	Sandy Zutz-Wiczek (Community Clinics)
Bobbie McAdam (Health Plans)	

#### Alternates in attendance

James Dungan-Seaver (Experts in HIT)	Justin McMartin (Vendors)
Mark Jurkovich (Dentists)	Charles Peterson (Vendors)
Paul Kleeberg (Physicians)	

#### Absent

Karl Anderson (Vendors)	Steve Simenson (Pharmacists)
Cathy Gagne (Local Public Health Departments)	Meyrick Vaz (Health Plans)
Jeyn Monkman (Clinical Guideline Development)	

### Welcome and introductions

Karen Soderberg, MDH Staff, called the meeting to order at 11:05 a.m. Co-Chairs Sonja Short and Peter Schuna reviewed the actions from the committee's most recent meeting (February 10, 2020). See meeting slides for recap.

## Initiative Updates

### Advisory Committee appointments

Bob Johnson with MDH-CHIPT provided a brief update on open and upcoming committee vacancies, acknowledging and thanking Laurie Beyer-Kropuenske, who has left the committee due to taking a position at the University of Minnesota's Chief Data Practices Compliance Officer. Stacie Christensen will now represent the Minnesota Department of Administration on the Advisory Committee.

Seven committee members' terms will end on June 30, 2020; the Office of the Minnesota Secretary of State published those vacancies on April 1 and has been receiving applications. MDH expects to appoint those positions the second half of July.

Sonja Short's term as co-chair will be extended June 30, 2021.

### e-Health Initiative activities and plans for 2020-21

Karen Soderberg with MDH-CHIPT provided a brief update on current activities and a possible committee format for the coming e-Health year.

- Workgroup activity is currently suspended
- A coordinated response is underway for e-prescribing controlled substances
- The MN HIMSS and Minnesota e-Health Initiative Conference has been rescheduled for December 2 and a virtual option is being considered
- Staff are working on a legislative proposal for the connected networks approach

At this time, we expect to continue to convene the Advisory Committee for shorter, monthly, virtual meetings beginning in August or September. It is proposed that during even months the Committee will do deep dives into HIE and other topics, and will be open to any members and guest experts/stakeholders (workgroup style). During odd months the Advisory Committee will convene to take action and make recommendations. A summer planning meeting is not likely, but we could have an August meeting to discuss the legislative proposal. Existing and new workgroups may convene on an as-needed basis. Committee members and alternates will receive an email in July to provide input on this proposal.

### MDH and COVID-19 response

Jennifer Fritz and Anne Schloegel with MDH-CHIPT provided a brief update on e-health related MDH activities in response to the COVID-19 pandemic, including hospital and emergency department alerts for situational awareness/surveillance, and the \$200 million Health Care Response and Short Term Emergency grant funding for health care providers. See meeting slides for more information.

## Questions and discussion

### HIE-related discussion

Following the presentation on the expanded use case for the DHS Encounter Alerting Service (EAS) to send ADTs to MDH for COVID-19 surveillance, discussion centered on the need for a governance process to make decisions about such needs in the future. MDH and DHS engaged external stakeholders and the Minnesota Hospital Association, and had the authority to implement this use case. However, a governance process would have provided greater transparency, opportunity for more discussion, and formal consensus. Currently the EAS has an operations group but it is not a governance structure; rather, it is a group of users brought together for a particular service. How do we create/develop a process and convene appropriate stakeholders to consider and decide on matters like this? The appropriate stakeholders and subject matter experts need to be included to ensure we make consensus-driven decisions in support of our vision, and to build trust across all communities.

The ability to rapidly repurpose the EAS infrastructure already in place will create opportunities for more communities to use the EAS for the care coordination. This expanded participation also creates additional value to the current Integrated Health Partnership (Medicaid ACO) users and other EAS users.

MDH provided funding provided for hospitals to connect to either Ai (the EAS vendor) or Koble-MN (a state-certified HIE). A question was raised why these were the only options. Because of the rapid implementation, the decision was made to optimize HIE connections already in place with EAS participants and between Ai and Koble-MN.

The discussion then focused on what may be needed and next steps to stand up an HIE governance structure. In light of the current environment and increased need for information to address multiple issues (e.g., COVID-19, racial inequities) It was suggested that we move forward in a proactive way, with an understanding that maybe not as much authority is needed, with efforts to get started with a more focused approach and smaller scope.

There was agreement on the need to ensure that we have an “infrastructure” to enable quick decisions and action when faced with an emergency situation. Setting up a governance structure, gathering stakeholders to discuss needs and solutions, make decisions (including provenance, stewardship, security, and others), and getting the process underway does not require authority. It does require some coordination, but mostly will rely on both the public and private sector willing to make an effort. Building trust through this process (as well as prior efforts such as the EAS) is very important. “Governance is the glue that holds the trust fabric together”. A formal action was not taken on this topic, but there was verbal agreement/commitment to start to operationalize a governance structure and begin discussion of need for shared or centralized services.

## COVID response

The group discussed what is being done now to meet the challenges of the pandemic. HealthPartners ramped up testing rapidly, going from about 500 tests per day to 1200-1500 tests per day, including implementing drive-through testing capacity using Wi-Fi connection extenders outside of buildings. When MDH recommended that individuals involved in protests or clean-up activities get tested, they completed over 5,000 tests in two days for people involved in those large gatherings. The lab staff have been working all night. The call centers are jammed with companies asking to test employees before they can return to work. What are we doing to capture the information about these activities to help manage the pandemic? We do not have an adequate structure or governance to capture and report, monitor and measure across the state. If we have a second surge in the fall, we need to be better positioned to respond.

The surge in telehealth use was discussed, including the need to understand how different cultures respond to this type of care delivery. One member has observed a potential unintended consequence in the Somali immigrant community due to a reluctance to engage with telehealth care and/or participate with COVID testing. Similar issues may exist with other communities. There is a need to address this potential cause of disparities to understand the root of the issue(s) and develop solutions. MDH has a team with the COVID incident command system that may be able to help collaborate on this issue.

Concern was raised about how the ADTs allowed for appropriate protection of information for mental health conditions. Ai has established special handling for 42 CRF, part 2 providers, allowing them to participate with EAS care coordination and maintain protection of that information.

## Racism and public safety

A question was raised about having a conversation centered on racism, health equity, and the intersection between health and public safety, including behavioral health, social services, etc. What can we do to address the critical need for quick and well-coordinated care at the point of incident? How can our committee direct our efforts to address the health disparities and discrimination that our non-White communities face?

A committee member sent a follow-up email with some thoughts on addressing much needed change by leveraging our e-Health work, such as:

- If we can change and improve our infrastructure and systems by always addressing the needs of our minority and at-risk populations, then we are supporting change as it moves up the hierarchy of change.
- Focus (and actually prioritize) on social determinants of health and the systems, infrastructure, supports, etc. that are needed to improve these areas as it relates to our technology/systems/data/exchange, etc.
- Proactively (overtly? formally?) place a lens of DEI (diversity, equity and inclusion) when working on these activities – to influence what we do and how we do it.
- Change involves education and meaningful conversations – what can we do there that can be infused into our current work?

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- Where are the biases within healthcare? Within overall wellness? What do we know about this? How could we try to address these in our overall work, activities, and recommendations?

CHIPT staff are aggregating these conversations to incorporate in the Initiative's work for 2020-21. Committee members and any interested parties are welcome to direct comments and ideas to [mn.ehealth@state.mn.us](mailto:mn.ehealth@state.mn.us).

Meeting adjourned at 12:54 p.m.

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