

Meeting Summary

Health Information Exchange Task Force

Meeting Information

Date and Time: February 28, 2019, 9:00 a.m. – 12:00 p.m.

Location: Wellstone Center, St. Paul

Participants: see list at end of summary

Objectives

- Review incremental approach of framing governance of connected networks using a centralized patient directory or other patient matching service
- Reach consensus on strategies or options to ensure there is at least one HIE service provider (e.g., HIO) to fill connectivity gaps
- Reach consensus on strategies or options to address critical success factors, using a centralized patient directory as the use case/service, to help inform recommendations for the five-year interim plan for governance, financing and authority

Agenda Items

1. Welcome and introductions
2. Review meeting objectives and agenda
3. Review progress on HIE Task Force deliverables and Advisory Committee feedback
4. Public Input
5. Task Force action-Reach consensus on strategies or options to ensure sustainability for at least one HIE service provider (e.g., HIO)
6. Task Force input-patient matching perspectives
Task Force action- Reach consensus on strategies or options for financial commitment, alignment with other state and/or federal HIE activities and full participation
7. Next steps

Notes and Discussion

Advisory Committee comments

The committee was enthusiastic and endorsed the general direction and approach for the HIE Task Force work moving forward. The committee validated the four critical success factors and incremental approach to a design the governance framework for Minnesota Connected Networks.

Critical Success Factors

The Task Force returned to the critical success factor discussions.

Ensure sustainability for at least one HIE service provider (e.g. HIO)

At least one HIE service provider (e.g., HIO) is needed to fill HIE connectivity gaps (e.g., smaller, independent providers, LTPAC, BH, social services)

Common strategies (n=11)

- Require that an HIE service provider (e.g., HIO) be the vendor for the patient directory centralized service and require nodes and other stakeholders to pay to use the service
9 support, 3 do not support (*questions about still using the eHealth Exchange*)
- Require contributions from Connected Networks participants for use of patient directory and other services (e.g., nodes, the state, other stakeholders) to subsidize costs and support the safety-net HIE service provider (*more support for subsidizing costs rather than for transaction fees*)
9 support, 2 do not support
- State designates and possibly funds an HIE service provider (e.g., HIO)
10 support, 1 does not support (*concerns about funding*)
- Policy or recommendation to reduce the use of faxing and view-only access to health records (*not this strategy alone, but in conjunction with one or more other strategies; careful not to eliminate view-only until information is available via HIE to all providers*)
10 support, 1 does not support

Patient Matching Perspectives

Task Force members shared perspectives on the potential value of a centralized patient directory to address patient matching issue. The following questions were posed:

1. What pain points does your organization have with patient matching?

Task force members shared that patient safety is most important reason for enhanced and/or improved patient matching. From a patient perspective, anything we can do to improve the quality of care and patient safety is good. There may also be legal issues. For post-acute providers, nothing is going to happen without such a directory to help match patients moving among settings. Aside from patient care, a centralized patient directory with the right information may also address administrative burden and current problems with insurance matching, latest address changes of individuals, and HIE consent management.

2. What resources (FTEs, line-item costs, IT, etc.) does your organization dedicate to: developing and managing patient matching algorithms, managing issues related to mismatched records and legal and other costs associated with errant care?

One task force member shared that for longitudinal query patient matching they have almost 3 FTEs that deal with patient matching. It's 2 minutes effort at registration, but hours of work on the back end. Especially if you mismatch – it can be a big mess. Those health systems using multiple applications also have resource intense work process to correctly match the patient.

3. What does your organization/stakeholder group see as the benefit/value of a centralized patient directory or patient matching service to address patient matching issues?

For health plans, a significant pain point is with members not consistently being tracked through Medicaid and MNsure registration systems, among others. This service has the potential to resolve that. May also help with longitudinal claims across plans. Opportunity to clean up the data and keep it consistent. Opportunity to add in social determinants of health and connect community partners. Significant value add.

4. What concerns do you have about developing and using a shared patient directory in Minnesota?

Task force members emphasized that any patient directory or patient matching services should align, to the extent possible, with federal standards and with existing Epic functionality.

Shared commitment and financial support

Financial commitment by all participants (nodes and other stakeholders) is needed to ensure long-term sustainability

Common strategies (n=10)

- Create incentives for participants to contribute data to and use centralized patient directory
9 support, 1 does not support
- Require participants to contribute data to and have the option to use centralized patient directory -
10 support
- Initial shared commitment for investment toward start-up implementation, with long term determination of support costs or fee for use of the centralized directory
10 weakly support, 1 abstain
- Payers initially fund with the requirement for full participation
10 strongly support (*with assumption that payers don't exclusively initially fund*).

Other comments:

We collectively have a shared goal around patient outcomes and reduced systemic costs. We don't do this because it's a benefit to the organization. So I support it. I wouldn't frame the cost value this way. We're all here for the greater good of Minnesota and need to frame it that way. RLS may add value. Having this as opt in/out so there is one source of truth on consent. If you have matching in one central place the opt-out could sit there.

Incentives are most appropriate for organizations that have a financial barrier to participate. There are barriers other than financial. If it's more painful to not participate than participate, that's an incentive.

Alignment

Alignment with other HIE activities (national, federal and state) is needed to achieve an efficient and effective network (e.g., minimize connections, reduce/eliminate duplicate services)

- Dependent on flexible governance process that can evolve to meet HIE needs

Discussion questions

- How can a governance structure be designed to ensure such alignment? Examples:
 - monitor and review HIE activities (federal, national, state) to inform alignment decisions
 - review Minnesota use cases and assess best alignment strategies
- What authority is needed to ensure this alignment?
- If we set up a centralized patient directory what are the alignment issues?

Comments:

It seems like the Minnesota e-Health Advisory Committee is the governing body to start. Maybe the nodes all come together to form an entity, all have a voice, maybe it's a state-appointed entity. Minnesota may benefit from a state-designated entity to participate with the national networks. Alignment with public health registries is also key.

Over the years, there's been a feeling that we've lacked governance, and our work here is an attempt to create that governance foundation. We're looking to this group to crystalize a recommendation to take to the AC. A lot of what we're proposing brings questions over time, and we would need a body to address them. Broad stakeholder group that is appointed by the Commissioner.

There needs to be a body with authority and rulemaking. It is less about what the group is comprised, although representation does matter as not every player within type of organization has the same perspective and interest.

This body needs to stay informed and established a continuous process improvement and needs a small group of experts to figure details out- similar to the Administrative Uniformity Committee or AUC- an eHealth UC. Technical side could be contracted out, but decision making should be with the entity. The operations could be part of a “use case factory” as a number of other states have in place.

Full Participation

Full participation is needed to achieve the most value for all

The Task Force supported the same strategies for full participation when applied to just a centralized patient directory including: Stand-up centralized services incrementally (e.g., patient directory, payer incentives, State government incentives/requirements, and payer requirements (least support).

Public Input

No one provide public input at this meeting.

Participants:

Timothy R. Getsay, Gillette Children’s Specialty Healthcare (not in attendance)
George Klausner, Lutheran Social Service of Minnesota, *HIE Task Force Co-Chair*
Mike Lilly, Ridgeview Medical Center
Jonathon Moon, UCare
Joshua Colbert for Steve Odd, Allina Health
Chad Peterson, The Koble Group
Heidi Twedt for Paula Schreurs, Sanford Health
Peter Schuna, Pathway Health, *HIE Task Force Co-Chair*
Jackie Sias, Minnesota Department of Human Services
Jeffrey Stites, Context Law
Eleanor O. Vita, Mayo Clinic
Deepti Pandita, Hennepin County Medical Center

MDH Staff: Jennifer Fritz, Melinda Hanson, Dave Haugen, and Anne Schloegel
MMB Staff: Matt Kane (Management Analysis and Development)

Next HIE Task Force meeting

Thursday, March 21, 2019, 9:00 a.m. – 12:00 p.m., Wilder Center

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3/6/2019

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