Meeting Summary
Health Information Exchange Task Force

Meeting Information

Date and Time: March 21, 2019, 9:00 a.m. – 12:00 p.m.
Location: Wilder Center, St. Paul
Participants: see list at end of summary

Objectives

- Reach consensus on options for Minnesota Connected Networks governance model and authority to help inform preliminary recommendations for a five-year interim plan for governance, authority and financing
- Provide input on the implementation plan for enabling foundational HIE using the eHealth Exchange (Recommendation 1)

Agenda Items

1. Welcome and introductions
2. Review meeting objectives and agenda
3. Review progress on HIE Task Force deliverables, prior meeting and timeline
4. Public Input
5. Task Force action- Reach consensus on options for governance model
6. Task Force action- Reach consensus on options for source(s) of authority
7. Task force input- draft summary of HIE Task Force input
8. Task Force input- draft implementation plan for recommendation 1
9. Next steps

Notes and Discussion

Governance Model

The governance model discussion was introduced and tied to the critical success factor of alignment. The governing entity could be a central place for determining when/how to align with other state, federal and national HIE initiatives. The task force was introduced briefly to three governance model options including public-private (HIE Study recommendation), public only and the private entity option. Comparisons to five states were also presented to acknowledge there is not just one way. In particular, states with similar "network of networks" were highlighted.

There was discussion of what a private non-profit collaboration might look like. Michigan's decision-making entity has broad representation from HIEs and others; Michigan's use-case factory was used as an example.

A question was raised about who decides how much representation if using a private entity. It is anticipated that the governing entity would decide that (after the governance model is determined). Another task force member commented that absent some strong authority, a private entity may have difficulty enacting its

functions. In addition, the entity may gain some traction and capabilities, but the state could decide to go in a different direction.

In summary, while a public-private may move more slowly, it offers both the avenues for state funding and an equal voice on implementing and authority. One task force member commented that it's important that the public-private collaborative appears to have representation from all stakeholders which allows anyone to have governance say.

There was a request for more information on the private only option (e.g., Wisconsin).

Update: The State of Wisconsin decided to award a private entity (WISHIN) to govern their HIE. Members of the State participate on the WISHIN Board of Directors, and support the private entity through input, promoting the use of the HIE, and policy development to support the work of the HIE.

Governance Model Options
- Public-Private (highest level of support)
- Public only (support, but limited)
- Private only (falls short of threshold for Task Force support)

Source of Authority

The task force was introduced to the concept/need for a source/multiple sources of authority and why the authority may be needed for a connected networks approach. The reasons for why authority is needed varies (e.g., compliance, complaints, monitoring, and building trust). There may also be a need for multiple levels of authority. For example, there may be authority needed to get started with a governance model for a connected networks approach as well as authority from existing state laws (e.g., EHR mandate, HIE oversight, MHRA) which would need updates (e.g., allow for appropriate use by payers and MDH)

A brief overview of the current HIE governance authority held by the Commissioner of Health through the Minnesota e-Health Initiative, Interoperable EHR Mandate and HIE oversight were shared.

Some common options (authorities for different purposes) were highlighted:

- Option 1: State government grants the governing entity authority to make rules and set requirements
- Option 2: Governing entity depends on the state to exercise state government authority based on the entity's recommendations and requests
- Option 3: Governing entity derives its authority from agreements that entity has with participants in connected networks
- Option 4: Incorporate the governing entity into existing authorities (e.g., state quality reporting, public health reporting)

Task Force members asked what the difference would be between this authority and the authority of the Minnesota e-Health Advisory Committee (AC). The AC authority is close to option 2: Entity depends on state to exercise authority. Good parallel. AUC is an advisory body and, has statute that says the commissioner needs to consult with the AUC, also Option 2.

A task force member asked for an example of a functioning option 1. Some states (e.g., Michigan, New York, and Wisconsin) most resemble Option 1 where the governing entity is given the authority, but are not dependent on the state to do everything. MNSure may also be considered as an example. Option 1 would require legislative approval.

Clarification by Diane Rydrych, Director of Health Policy Division, MDH: in cases where there is a quasi-state governance, the legislature needs to give them authority

A member suggested Option 4 would require that the legislature give authority.

Discussion around Option 3 – the participants are deriving the authority from the agreement, but how are they getting the authority to make the agreement? Once that initial authority or framework is set it should work, and use a set of established bylaws and procedures of a non-profit organization. Participants may include consumers of the data, but this is dependent on the charge from the governing body. It was noted that if participants included individuals as consumers, they would have to give consent. One member suggested that health systems may not be consumer of the information, but could contribute information only.

A discussion of where some states, for example New York, use a combination of option 1 and option 2. They spun off an entity to manage the networks. So, the authority of governance of operations is through option 1 and the authority of governance strategy is through option 2. It was suggested to add an option that is a combination of option 1 and option 2 similar to the New York model.

Governance source of authority options and support

Combination of Options 1 & 2 (highest level of support)
Option 1: State government grants authority (support)
Option 2: Entity depends on state to exercise authority (support, but limited)
Option 3: Entity derives authority from agreements (falls short of threshold for Task Force support)
Option 4: Incorporate into existing authorities (falls short of threshold for Task Force support)

Draft Summary of HIE Task Force input

A draft summary of HIE Task Force input was shared and discussed. A task force member started the discussion confirming no objections or red flags but wanted to call out that all the pieces be considered as a whole as they are contingent on the iterative process. It's a complete thing, not something that should be picked apart.

Another member asked that clarification and elevation of state government use cases and workflows be included. These use cases are anticipated to reduce some of the current burden on providers and potentially increased the value of a connected networks approach.

Large health system providers see themselves as primarily contributors. They are not seeing the value of consuming the data at this time. Most of the large health systems are already heavily investing in interoperability and are connected so the centralized services proposed aren't as valuable for them. For the large health systems, this seems to currently be working through the national exchanges. Adding use cases will bring a lot of value. There was acknowledgement that contributing to the services would be acceptable, and in time large health systems may choose to use those centralized services**.**

There was a recognition that there's need for all providers to have similar capabilities.

A smaller provider of care commented that our goal is to connect all patients and provide better care.

Other members acknowledged the large health system perspective that they have already invested a lot in doing this and why do they need to communally share for everyone else to catch up. The value is not an operational one for these participants at this point. Moving forward the value is systemic, with benefits for all stakeholders downstream.

The question from some members was whether having smaller providers connect to these centralized services will bring value to them. Will there be redundancies avoided by implementing each of the centralized services?

Another member noted that there are services you can't do without a patient directory. It's like a patient locator – if you're a small provider you need a service like this. Is this the role of the HIE/HIO? If we're trying to sell something, we need to prove value. So there is value to a patient directory for some, but not value for the large health systems. We're already using a patient matching process without a patient locator. It's not a matter of whether the technology exists. Exchange is not happening – that's the reason we're here.

Agree. It's very important to sustain it, so we need to sell it and have use cases that will sustain it over time. If there's no value for the organizations this will be very difficult.

The goal of the Task Force is to figure out how to move forward. We need to process this recent discussion – the summary is helping us revisit important elements.

Draft implementation plan for Recommendation 1

There was a brief discussion of draft implementation plan for Recommendation 1: Enable Foundational HIE Using the eHealth Exchange. There were questions about the timeline, outreach efforts and measurement.

The task force was asked if they were comfortable bringing this draft version to the Advisory Committee for consideration. All ten members present fully endorsed moving the implementation plan forward to the Advisory Committee.

Public Input

No one provided public input at this meeting.

Participants:

Timothy R. Getsay, Gillette Children's Specialty Healthcare (not in attendance)
George Klauser, Lutheran Social Service of Minnesota, *HIE Task Force Co-Chair*
Mike Lilly, Ridgeview Medical Center
Jonathon Moon, UCare
Steve Odd, Allina Health
Chad Peterson, The Koble Group (not in attendance)
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 (Sherry Hiller participating on her behalf)
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, April 18, 2019, 9:00 a.m. – 12:00 p.m., Wilder Center

Minnesota Department of Health
85 East 7th Place, Suite 220
PO Box 64882
St. Paul, MN 55164-0882
651-201-5979
mn.ehealth@state.mn.us
www.health.state.mn.us

4/11/2019

To obtain this information in a different format, call: 651-201-5979. Printed on recycled paper.