Meeting Summary
Health Information Exchange Task Force

Meeting Information

Date and Time: August 13, 2018, 9:00 a.m. – 12:00 p.m.
Location: Wilder Center, St. Paul
Participants: see list at end of summary

Objectives

▪ Discuss needs for connected networks to achieve robust and optimal HIE

Agenda Items

1. Welcome and introductions
2. Review meeting objectives, agenda and follow-up to July 12 meeting
3. Discuss needs and options for robust and optimal HIE
4. Public Input
5. Next steps

Notes and Discussion

Members and participants were introduced, and Minnesota e-Health Summit impressions were shared by the co-chairs.

The Task Force co-chairs reviewed the agenda and objectives, reviewed follow-up action from the last meeting and called the working portion of the meeting to order.

The co-chairs shared comments from the from August 10 e-Health Advisory Committee planning meeting.

The proposed Implementation Plan Subgroup was briefly described, estimated time commitment shared and a request for members was made. This HIE Task Force Subgroup would propose an implementation plan for 'HIE Task Force Recommendation 1: Enable Foundational HIE Using the eHealth Exchange'. Several members indicated a willingness to serve. MDH staff will follow up with those members. It is expected that the group will begin meeting in late September or early October.

The next portion of the meeting focused on needs and options for robust and optimal HIE.

Priorities and potential benefits of a connected networks approach

Task force members were asked to describe their organization's/category's information needs. There were two information uses illustrated by multiple task force members: 1) Information needed at the point of care for clinicians and care coordinators and 2) Information needed for broader cohort, attributed population or population data analytics.

The discussion started with a depiction of a clinician's "wish list" – excerpted here-

Notes
- Admission History
- Physical Exam
- Discharge Summary
- Consult Notes from specialists
- Operative/Procedure Notes
- ACOG (American College of Obstetrics & Gynecology) forms - tabulated information on a pregnant patient

Results
- Labs
- Radiology
- Pathology
- Sleep study
- Pulmonary Function Tests

Alerts
- Inpatient admission
- Inpatient discharge – needed by RNs (care coordinators) so they can call a patient at home within 2 days of discharge to assess readmission risk
- ER discharge
- Death alert
- Communicable disease
- Notice of available results (ex: pathology reports, CT scan/MRI images and reports)
- Urgent Care visits,
- Home Health nurse visits,
- Notice of Patient in Shelter

Images - prefer diagnostic quality
- Radiology (including X-rays, CT scans, MRIs, etc)
- EKG
- Colonoscopy? (waiting for our general surgeons' opinion on this one.)

Others to consider:
- Infectious disease reporting, monitoring reinfection rates
- Ordering / Registration capabilities
- Scheduling capabilities
- Charge Capture

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Multiple task force members highlighted the need for **alert notifications** for events such as hospital admission, hospital discharge and emergency department discharge. Some also expressed interest/need for alerts from non-clinic/acute care. Alert notifications are not currently provided by Epic's CareEverywhere or the eHealth Exchange options (alert notification is not a foundational query and response transaction).

Task force members who are clinicians indicated that information is most meaningful if it's available at the point of care in an easily digestible format (currently most clinical information is not consolidated from the receiving clinicians.) They also noted that social determinants of health information would be a valuable addition to provide a more complete **"patient story".**

Medication history and medication reconciliation among all sites/providers was also important. "…if we can error-proof one piece of data across the care continuum it is meds". Reconciliation can also be an issue as some meds can't be provided in long-term and post-acute care (LTPAC) so they need to be adjusted when a patient is admitted. In addition, having a good understanding of not only prescribed medications, but also which ones were actually filled (and eventually which ones were even taken) is needed. What is the source of truth?

Images are also an important tool at the point of care. Often an image report is sent, but this is not always the complete "story".

Having articulated some common themes for information needs, the discussion shifted to how a connected networks could help provide these needs. A connected networks approach could help improve care coordination by having a means to:

1) Get "all" the information in a usable format at the point of care –
   - ability to see information from all of providers that a person has seen.
   - a way of knowing what other providers the patient saw.
   - support integration of multiple documentation sources- e.g., nursing home & ambulatory her.
   - would support transitions of care – information is needed before the patient arrives, with high priorities of medication reconciliation and discharge summary, especially noted for long-term care and social services.
   - eliminate manual entry and re-entry of data.

2) Ensure/increase trust in the information – source and quality; be confident that one is getting the "whole story" not just a part of the story, or only from some organizations. Support "goal" of not collecting "all" the data at every provider location and/or sending data to multiple places.

3) Support all providers with information needs for their settings (smaller providers, LTPAC, disability services).

4) Support care coordination between and among: payers, clinicians, home health, social services that do not currently have each other's information. Visible, chronological care coordination would be the best for the patient. Ability to better coordinate care for the patient, ability for care coordinators to share between themselves, or even to identify one care coordinator to avoid duplication

5) Reduce/eliminate the need for patient retelling their story …Several task force members noted a common breakdown in the current landscape is that the patient is too often the one trying to get information to move among providers in different systems or specialties/services.

6) Improve the value proposition of HIE for stakeholders; some low-hanging fruit might be:
   - discrete data to tell the story; not just a CCD;
   - agreement on what type of data that HIOs and "nodes" will have and on what data elements to share, as well as what standards to use for each (including social determinants of health);
   - quality reporting and/or public health reporting gateway.

7) Share a common understanding/interpretation of Minnesota Health Records Act (MHRA) –consent and HIPAA; ease administrative burden.

8) Consider the needs of payers and hybrids (payer/provider/case manager) e.g., DHS that is a large organization with multiple hats: provider of state services and payer.

9) Increase availability/capability for data that is searchable, for analytics use.

Ways to connect networks

What options for connected networks can you envision based on the current HIE landscape?

An overarching theme was that there is value in connecting beyond the current "clinically based" documents (CCDs) and establishing more connections to other providers/services without increasing point to point connections. Establishing single connections to state agencies (e.g., MDH for public health reporting and DHS) was a priority.

The concept of a "Patient Centered Data Home" was suggested; a model where there is one location or "home" for a consolidated, longitudinal record for every individual with information from all the patient's care providers. Using this model would allow for movement beyond eHealth Exchange model for query and exchange of CCDs and would allow an easier adoption of event alerting or other "push" transaction needs.

Another suggestion was a centralized record locator service for querying.

There was discussion of a shared or common agreement for consent, data sharing and protections/back-up if an HIO (or network) leaves the market.

HIE services each network will need to provide

Ideas for which HIE services are needed statewide for connected networks and which of those would drive interest, participation and investment

As noted in the first discussion topic, to summarize some of the top HIE services needed:

- Event Alerting- including notifications from non-traditional providers (not just hospitals)
- Access to individual data in emergencies
- Having data from all the individual's providers consolidated and longitudinal
- Medications- the most recent reconciled list available to all sites/providers
- Images- possibility of some type of appliance network for retrieving diagnostic images (potential to lower cost by reducing duplicate tests)
- Portal for payers – access to information for chart reviews that pre-dates patient start date with current health plan (currently getting information, but through many work-a-rounds and costs). In cases where there is no direct access to the patient EHR(s), choices are 1) physically go to a clinic and review chart or 2) have the chart(s) sent which is/are often incomplete.
- Service to support quality reporting or other reporting needs
- Patient- centered view "where is the patient in this discussion?" and patient access. What does the patient (and/or guardian) want? What is their value-add in a connected networks? What would patients like that flow of information to look like? Individuals may/do want more access/control of their information and where it goes.

Plans for HIE Task Force action

The HIOs would like to come to the table with some ideas for HIE services and governance, as well as how the first recommendation gets incorporated. The HIOs don't want to get too far ahead, but need to begin moving forward away from the current "business on hold" landscape. The task force members also want to hear about the impacts of connected networks on HIOs.

The task force members agreed that the next meeting should focus on a continued discussion of "core" or high-value HIE Services (e.g., event alerts) and begin the HIE governance conversation including a review of what other states are offering and how they are operating (e.g., consent management). The task force will use the HIE services discussion to get at the 'what', and how-design ideas, and HIE governance discussion to get at the process and 'who'.

Public Input

One member of the public provided input during the public input portion of the meeting.

- Reid Haase, Stratis Health

Participants:

Timothy R. Getsay, Gillette Children's Specialty Healthcare

George Klauser, Lutheran Social Service of Minnesota, *HIE Task Force Co-Chair*

Mike Lilly, Ridgeview Medical Center

Jonathon Moon, UCare

Steve Odd, Allina Health

Deepti Pandita, Hennepin County Medical Center

Chad Peterson, The Koble Group

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

MDH Staff: Jennifer Fritz, Melinda Hanson, Dave Haugen, Bob Johnson, Anne Schloegel, Sarah Shaw and Karen Soderberg

MMB Staff: Matt Kane (Management Analysis and Development)

Next HIE Task Force meeting

Thursday, September 20, 2018, 9:00 AM – 12:00 PM, Wilder Center

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