Meeting Summary
Health Information Exchange Task Force

Meeting Information

Date and Time: September 20, 2018, 9:00 a.m. – 12:00 p.m.
Location: Wilder Center, St. Paul
Participants: see list at end of summary

Objectives

- Review HIE Task Force progress on deliverables
- Review identified information needs from August 13 meeting
- Discuss options and considerations for HIE Services
- Introduce other state HIE governance models

Agenda Items

1. Welcome and introductions
2. Review meeting objectives and agenda
3. Review progress on HIE Task Force deliverables
4. Review information needs identified at August 13 meeting
5. Discuss options and considerations for HIE Services
6. Introduce other state HIE governance models
7. Public Input
8. Next steps

Notes and Discussion

Members and participants were introduced.

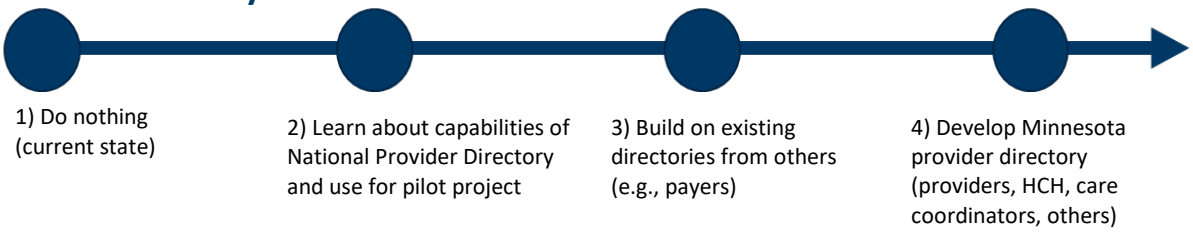
The Task Force co-chairs reviewed the agenda and objectives, reviewed follow-up action from the last meeting and called the working portion of the meeting to order.

After a brief discussion on the HIE Task Force deliverables, the co-chairs shared plans for the September 28 eHealth Advisory Committee meeting where 'HIE Task Force Recommendation 1: Enable Foundational HIE Using the eHealth Exchange' will be discussed. HIE Task Force members are encouraged to join the eHealth Advisory Committee meeting in person or by phone to add comments or stories to the discussion.

A summary of the information needs identified at August 13 meeting by HIE Task Force members was reviewed.

The next portion of the meeting focused on options and considerations for HIE Services.

Provider directory



Reactions and Discussion:

Overall initial reactions leaned toward a more "shared" or central provider directory, by building on national efforts already under way or current Minnesota directories. However, the details of how this might work and the infrastructure needed to stand-up and maintain could be significant. Task force members discussed how stakeholders have different approaches to provider directories (dependent on what their needs are).

Task force members agreed that more than just directory addresses are an issue, and that it is even more important to address how the directory is accessed and used, and the impact on workflow. One concern is that when there's a referral, often the recipient doesn't have an individual address for the sender, and can't respond to the sending provider. It is even more difficult to keep a provider directory of addresses updated, and this is needed in every provider directory used across the state.

Payer representatives and others commented on the complicated nature of payer provider directories and what they have or don't have. For example, the Department of Human Services has a fairly comprehensive directory of providers in the state, but have just the information needed to pay claims. If more than billing data is needed; it would need to be added.

There was strong agreement on understanding what's happening nationally before doing more.

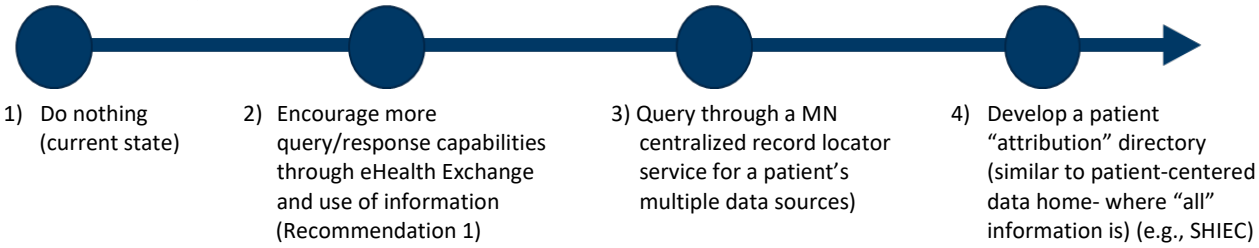
A centralized provider directory would also require rules of the road etc. In addition, the question was raised whether a centralized provider directory creates issues for payers? If DHS has their own, and CMS goes with a national directory, it seems that this could cause issues.

Preferential Vote:

Option 2: 5
Option 3: 4
Option 4: 2

Learn about National Provider Directory, consider building on existing provider directories. Group clarified that a common directory is not required for Recommendation 1.

Patient Query vs Patient Data Home



Reactions and Discussion:

There were questions about how these options compare to what Carequality is offering. Consensus was that Carequality is a part of a broader Option 2, especially as eHealth Exchange Participants expand to become Carequality implementers when possible.

Clarification on what the current SHIEC model may offer was also provided. At this time the SHIEC Patient-centered data home (PCDH) is like an alert system across the SHIEC members. It requires a patient attribution file by HIE/HIO and zip codes. So wherever a patient turns up, the other HIE/HIO participant will look up with the HIE who manages area within a patient's zip.

Some large health systems reported that providers are inundated with alerts and wanted them turned off. Conversation continued with the how EHRs provide alerts and that there needed to be a distinction between an EHR alert and an "event alert" of notification that was outside of the EHR. The importance and value of an event alert/notification is dependent on the patient condition and need for care coordination. Post-acute care coordination is very important because the patient may need home care or other assistance before a follow-up primary care provider visit. It is about "…getting the right alerts at the right time for the right reason" and is helpful for organizations participating in ACO/IHP arrangements and especially for organizations that do not have a hospital within their ACO or IHP network. Inpatient discharges were noted as of particular value.

A question was raised whether any of the options, or potentially other options, may address "batch queries"- queries on multiple individuals at one time - a noted health plan need.

It was suggested that Options 3 and 4 are complements to Option 2 with Carequality.

Task force members recommended an Option 5 that is a combination of options 2 and 3. A continued challenge for both HIOs and larger health systems is that health systems want to use their EHR capabilities and house their own data to keep workflows simple for their providers. A '0' preference was added as 'undecided' or needs more discussion vote.

Preferential Vote: not conclusive

Closed fist (0): 4
Option 3: 2
Option 4: 1
Option 5 (combined options 2&3): 4

Routing Options

1) Do nothing (current state)

2) Pilot routing with a few provider connections through an HIO.

3) Have a few entities route for state/national connections (could be NODES on connected networks)

4) Create a centralized routing mechanism for state/national connections (could be one HIO)

Reactions and Discussion:
Initial reactions were around whether any options raised consent issues. Yes, possibly, depending on routing options considered; would be part of the governance considerations.

The overall consensus was that simpler is better, but often that is reframed from a "what does the vendor recommend?"

Chad Peterson presented on behalf of the HIOs. They have discussed ways to simplify things between HIOs and avoid confusion in the market. Directory routing may not involve creating another entity; it could be HIOs and partners working together to create one connection or single gateway. This could be the pipe for all stakeholders, including for national initiatives. With respect to HIO sustainability, HIOs could consider what services are managed now, and potentially split up services between HIOs and consolidate how the services are delivered. Conceptually a distributed set of services could still have one connection with consolidated and coordinated HIO services.

From a sustainability perspective, HIOs could potentially create demand if they develop services that support the business case. A market-based structure based on federal standards and using shared services may support the need for connected networks. It was suggested that payers would value connection to such a connected networks as a node and may be willing to bear some financial burden. Preference would be to simplify our purchasing and contracting and access any shared services through a connection/contract with one HIO, not four.

Preferential Vote: Create centralized routing mechanism for state/national connections (could be one HIO)

Fist (0): 2
Option 4: 9

Consent

1) Do nothing (current state)

2) Agree to a common understanding, interpretation, and implementation of MHRA consent requirements

3) Consent managed at each connected network NODE for their attributed population

4) Establish a "central" consent management infrastructure (works for single state HIE, but not a connected networks)

Reactions and Discussion:
Task Force members noted the biggest "pain point" is #2 (Minnesota Health Records Act- MHRA) and lack of alignment with the Health Insurance Portability and Accountability Act (HIPAA). Consent is individual to each patient and organization so agreement on a common interpretation

is crucial. Others noted that health care organizations don't apply consent and HIE requirements in a consistent or standard way and that even within organizations there is confusion.

A common understanding is needed, including ensuring vendors are understanding, and then a check/audit downstream to be sure the consent is appropriately maintained.

One issue is that individuals/patients can change their mind at any time and with different providers. So what is the source of truth and how to manage the changes?

All HIO participants could use a common agreement/form to help standardize; any organization needs to have the opt-out clause. However, since HIE goes beyond our borders, there are implications on how to manage consent in Minnesota, with our border states and for participating in national initiatives.

Adding to the complexity, we're getting consent for so many things. Our form is nearly 2 pages of fine print and I'm not sure what value that has for the patient. And the release of information is a third thing. Social services has had release of information problems.

Co-Chairs recommended vote on 2 to 4 and that the task force consider a separate recommendation to change MHRA.

Preferential Vote:

Option 2: 10
Option 3: 1

Task Force agreed that a common understanding of MHRA, statewide consent and consent management would be helpful. More information on of the MHRA, HIE Study recommendations and legislative activity is needed**.**

Governance

A brief introduction to governance and some considerations were presented.

Governance is about bringing entities together for the oversight and development of policies, standards and services. It is a set of mechanisms and processes that can be used to achieve shared objectives; it's about making meaningful, trusted, and respected decisions. Governance is not necessarily a single organization, entity or new structure tasked with 'governing' nor limited to 'Government' actions, rules and regulations.

Highlights from an environmental scan of HIE in 12 other states (not all states) found that most, if not all, states are still trying to 'figure out' HIE; there is no one way to do this. Most states are still at foundational HIE, a few are at robust HIE, but none are yet to optimal HIE. Participation is still mostly hospitals and clinics only. Three states have higher participation and robust HIE. There are multiple governance models in use (e.g., private sector, public utility, government and hybrid) and several states are currently shifting from one model to another.

Some considerations for a connected networks approach may include:

- Requirements and expectations (i.e., rules of the road) of nodes on connected networks (e.g., HIOs, health systems, any others such as MDH, etc.)
- Legal agreement for participation as nodes on connected networks
- Definition of permitted purposes for disclosure and use of the information

- Membership/representation of governance structure
- Policies and procedures
- Minimum initial data set/use cases and decision making process for expanding the minimum data set/use cases/future HIE services (think "eUC")
- Finance mechanism and costs for participation/access to common services
- Who provides connected networks implementation oversight? If one or more organization(s) oversee this work, who provides oversight over organization(s)?
- Conflict resolution – case of "bad actor" and/or inability to reach agreement among parties.
- It was suggested to add 'What if someone leaves the market?'

Public Input

There was no public input given during the meeting.

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
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
Deepti Pandita, Hennepin County Medical Center (not in attendance)

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

Next HIE Task Force meeting

Tuesday, October 16, 2018, 8:00 – 11:00 AM, Wilder Center

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