# Meeting Summary
## Health Information Exchange Task Force

## Meeting Information

**Date and Time:** October 16, 2018, 8:00 – 11:00 a.m.
**Location:** Wilder Center, St. Paul
**Participants:** see list at end of summary

## Objective

Continue discussion of HIE services toward robust and optimal HIE to help prepare for future decisions on governance, authority, and financing the connected networks.
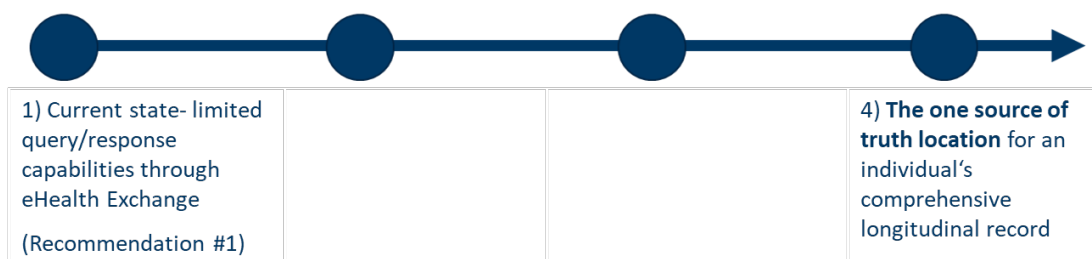
## Agenda Items

1. Welcome and introductions
2. Review progress on HIE Task Force deliverables
3. Recap of September 20 meeting discussion
4. Continue discussion of HIE services to get to robust/optimal HIE
5. Learn about the National Healthcare Directory and discuss
6. Public Input
7. Task Force Comments and Next steps

## Notes and Discussion

Members were introduced. The agenda and meeting objective were reviewed. George Klauser, Task Force co-chair, reviewed the September 20 meeting recap including task force preferences for HIE services and called the meeting to order.

The meeting then focused on HIE service options to move beyond foundational HIE.

### Concept of consolidated vs comprehensive longitudinal records



| 1) Current state- limited query/response capabilities through eHealth Exchange (Recommendation #1) | | | 4) **The one source of truth location** for an individual's comprehensive longitudinal record |
|---|---|---|---|

Discussion started with the value of having one location as the source of truth for a patient's health information. One source of truth is a complicated concept. It requires rules to determine what pieces of information are important, how they go together, and what gets removed. When there is a one source of truth location "system", there is a single point where the process

gets managed. Then the burden is not on every organization to manage the data, a situation which can increase inconsistencies and errors.

A member pointed out that Epic organizations are moving to consolidated/comprehensive records, so a separate comprehensive record would be duplication. Today, clinicians are distrustful about what information they pull in from other organizations. Epic-using organizations query for information and the multiple documents received are indexed so providers can look at what information they want and pull just that into the EHR. A comprehensive record might be too much information for the clinician to manage. Another member countered that without the comprehensive record, is there so much work to getting the information that HIE isn't used at all, or is it used much less?

An assumption was made that the comprehensive record is dynamic, not static, so it is continually updated. If the patient owns the record, and not the organization, there is value in terms of transparency, etc. It is aspirational, but aligned with national patient-centered goals.

Discrete vs. non-discrete data was also discussed. A comprehensive record would (eventually) have discrete data, so that data could be integrated and used. It was noted that states that have a single with one HIE (organization) house such a comprehensive records for individuals. They use or convert information into discrete data to increase the ability to use the information more effectively and efficiently. Source information may generate from multiple places, since each patient-provider visit is documented and updated at the time of the visit in that organization's EHR. The comprehensive record is able to combine information from multiple visits with multiple providers in multiple provider organizations across the continuum of care. A determination needs to be made as to where each individuals' comprehensive record would reside – possibly assigned to one of the nodes on the network.

It was noted that from both clinical and patient standpoints a consolidated record within a single organization's EHR does not provide all of the information needed.

One question raised was, if there is not a comprehensive record, could (non-Epic users) still query (possibly through a central locator), see a table of contents from all nodes, and still choose to get what we want?

Another question brought up is that there is still a need to store the comprehensive record somewhere, so even the Epic users can choose to render what they want into their own EHR. 'There are certain things I need to know about a patient, but I don't need everything.'

There was a comment that if the comprehensive record existed somewhere as the source of truth, you can manage data quality better. Many agreed that data quality is an issue with sharing and using HIE.

This is more than storing the comprehensive record locally and retrieving on demand, as there are other touchpoints for this data. The comprehensive record would potentially provide patients with a more complete health record. Sometimes we do not get much information from another provider in a current referral. The comprehensive record would give us complete information, and the patient would know we have it, or confirm the information. "I think the fundamental question is do I, as a clinician, want all of that information or does the patient want all of that information in one place? Should the patient have one source of truth?"
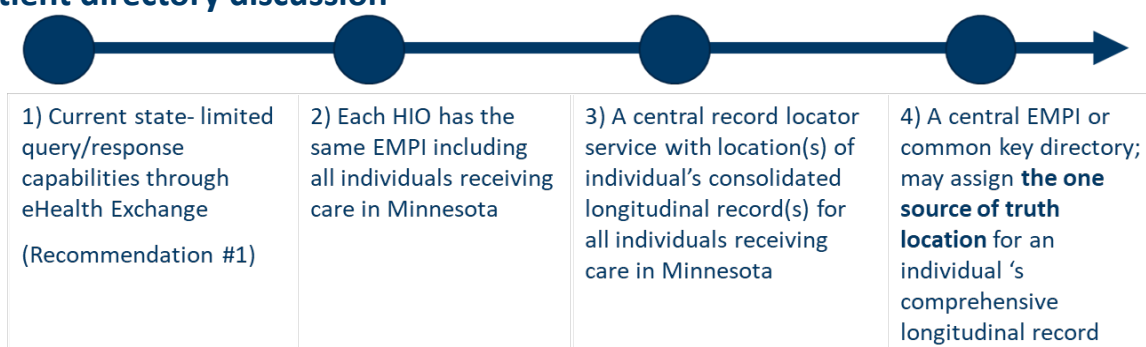
A comment was that one should not confuse what you see on the screen in an EHR with where it comes from. The data may be coming from many locations and it is really just about how it is

presented to you. Determining what you see is not technically relevant to where it is stored. The data quality from having it in one place is most important here.

**Preferential Vote:** Support for establishing goal for one source of truth location for an individual's comprehensive longitudinal record.

| Fist (No) | 0 |
|---|---|
| 1 (No, unless specific changes) | 3 |
| 2 (I'd rather not but can live with it) | 1 |
| 3 (OK, I can support the option) | 2 |
| 4 (I support the option) | 4 |
| 5 (I strongly support the option) | 0 |

## Patient directory discussion

| 1) Current state- limited query/response capabilities through eHealth Exchange (Recommendation #1) | 2) Each HIO has the same EMPI including all individuals receiving care in Minnesota | 3) A central record locator service with location(s) of individual's consolidated longitudinal record(s) for all individuals receiving care in Minnesota | 4) A central EMPI or common key directory; may assign **the one source of truth location** for an individual 's comprehensive longitudinal record |
|---|---|---|---|

There was discussion about three ways to use HIE: 1.) 'push' information to a specific location, 2.) 'pull' (query/response) information from a number of locations, and 3.) 'event alerting' (hospital or emergency room admittance or hospital discharge notice to a specific identified healthcare provider for a specific person when needed). We may be looking at multiple solutions to get to all three. There are also multiple transport methods that may be used (e.g., Direct, FHIR, API) – which will be considered during implementation discussions.

**Option 2 reactions:** For providers who are not HIO participants, option 2 is not supported; option needs to be broader than HIOs. The HIOs have suggested this option as a 'quick' win to get event alerts moving statewide in addition to CCD exchange through the eHealth Exchange. It could show results sooner while still moving toward the end goal.

**Option 3 reactions:** Would a central record locator service duplicate the eHealth Exchange? There is value from the effectiveness and efficiency in how HIE shared services are set up. For example, some organizations may query and receive nothing back; need to ensure the design works. The eHealth Exchange currently offers only CCD exchange. This query option could support more transactions. Providers not using the eHealth Exchange need this information too.

**Option 4 reactions:** Many agreed with the need for a directory, but there were concerns about having to tie it, at this point, to the goal of a comprehensive longitudinal record. Task force members asked about the directory's purpose – would it scrub for patient identifiers and return results to node participants, etc.? Using this as a centralized EMPI would be helpful for improving patient matching. It was also encouraged to incorporate an EMPI with the Medicaid population, with potential federal match dollars (75%) for future sustainability.

After discussion of options 2, 3, and 4, the group decided to make two changes.

1) For option 3, the central record locator service would include a central consent management so that event alerting could also be part of the design capabilities. It was noted that consents are obtained and managed at provider organizations. However, the current consent for HIE is received by and currently managed at each of the HIOs, so it is known whether information can be shared or not. Since Option 2 is set up through the HIOs, it already has the HIE consent identified for sharing event alerts.

2) For option 4, remove in the design section 'to use to query for comprehensive longitudinal records, and' so this option can be used without reference to the comprehensive record.

**Preferential Vote:** Three separate votes indicating support for options 2, 3, and 4

|  | Option 2 | Option 3 | Option 4 |
|---|---|---|---|
| Fist (No) | 3 | 0 | 0 |
| 1 (No, unless specific changes) | 3 | 2 | 0 |
| 2 (I'd rather not but can live with it) | 0 | 1 | 0 |
| 3 (OK, I can support the option) | 1 | 3 | 1 |
| 4 (I support the option) | 3 | 4 | 9 |
| 5 (I strongly support the option) | 0 | 0 | 0 |

The group attempted to vote for a favorite option, however noted it is difficult as these are not mutually exclusive options.

## National Healthcare Directory (provider directory)

As requested at the last meeting, MDH staff followed up on the National Healthcare Directory (provider directory) and the potential for pilots. The Office of the National Coordinator (ONC) reported a number of reasons why pilots are not being offered. However, after two years of work with many stakeholders, the standards and implementation guide for the healthcare directory was validated by the HL7 group. This is available for states to use when setting up a central provider directory

In discussing the value of a provider directory, comments included:

- there is no good source for all provider information;
- record cleanup is a nightmare and no organization has solved it;
- most organizations have difficulty getting addresses, even Direct,
- it is a challenge to maintain addresses;
- could help with many things, including attributed information (FHIR capabilities).

However, it was also noted that it will take a lot of work to get a central provider directory to reconcile with our directories at the participating organizations.

**Use cases: What would drive this? The highest priorities.**

Use cases from the ONC healthcare directory information were shared and members highlighted which use cases they saw as a high value. The first use case identified was referrals and transitions of care, especially in the context of provider and patient; using a provider directory for transitions of care is a great opportunity to optimize workflows.

Endpoint discovery (e.g., EHR endpoint, direct address, quality reporting, credentialing were considered priorities by number of task force members.

One member mentioned that WISHIN (Wisconsin Statewide Health Information Network) has a front-facing provider directory for consumers that has been well received.

From a health plan perspective, all the use cases seemed important. Most agreed that to prioritize the use cases, it's a matter of your organizations' worst pain points.

**Preferential Vote:** support a provider (healthcare) directory as a shared HIE service

| | |
|---|---|
| Fist (No) | 0 |
| 1 (No, unless specific changes) | 0 |
| 2 (I'd rather not but can live with it) | 0 |
| 3 (OK, I can support the option) | 0 |
| 4 (I support the option) | 1 |
| 5 (I strongly support the option) | 9 |

## Public Input

No public was given during the 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
Paula Schreurs, Sanford Health
Peter Schuna, Pathway Health, *HIE Task Force Co-Chair* (not in attendance)
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

Tuesday, November 20, 2018, 9:00 a.m. – 12:00 p.m., Wilder Center