

# **Public input on a connected networks approach for health information exchange in Minnesota**

## **SUMMARY ANALYSIS**

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## **Public input on a connected networks approach for health information exchange in Minnesota: summary analysis**

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## Introduction

The 2016 Minnesota Legislature directed the Minnesota Department of Health (MDH) to assess Minnesota's legal, financial, and regulatory framework for electronic health information exchange (HIE). As directed by the legislature, this Minnesota HIE study<sup>1</sup> also recommended modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable.

The study found that HIE is most often occurring in pockets (e.g., among large health care delivery systems) rather than more broadly, easily, and effectively between those health systems and other health providers who also need information for improved patient care and broader population health. Many of the networks are not efficiently connected to each other, which means that even basic HIE for the exchange of summary of care documents from a provider or hospital isn't consistently happening for every patient.

To address this gap, the study identified two key issues to address: 1) establishing trust and technical connections between providers across the care continuum; and 2) building upon existing HIE connections to facilitate exchange of more robust health information among all of a person's care providers. The most feasible means of achieving this robust HIE in the dynamic health technology environment is to move toward a connected networks approach. This means that networks are linked to one another creating more streamlined connections with reduced need for multiple, inefficient point-to-point connections between organizations and networks.

In 2018, MDH established the Minnesota e-Health HIE Task Force<sup>2</sup> (HIE Task Force) to develop implementation plans for a connected networks approach in Minnesota. The HIE Task Force was composed of 12 members representing many different types of health care stakeholders. The group met 11 times from May 2018 through May 2019 and used the following guiding principles in its work:

- Collaborate with and build upon complementary HIE efforts in the state and region;
- Begin with a manageable scope and remain incremental;
- Minimize duplication and the number of HIE connections when possible;
- Keep in mind the needs of the continuum of care and the multiple goals for HIE;
- Design for full participation of providers, health plans/payers, and government programs; and
- Consider the needs of Minnesota's entire health and health care community.

The HIE Task Force reviewed and discussed a number of key topic areas in the context of a connected networks approach. As an important first step, the HIE Task Force recommended, and the Advisory Committee endorsed, an implementation plan for use of the national eHealth Exchange network.<sup>3</sup> The eHealth Exchange<sup>4</sup> is a health information network which is active in

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<sup>1</sup> <https://www.health.state.mn.us/facilities/ehealth/hie/study/index.html>

<sup>2</sup> <https://www.health.state.mn.us/facilities/ehealth/hie/taskforce/index.html>

<sup>3</sup> <https://www.health.state.mn.us/facilities/ehealth/hie/taskforce/docs/hietf-implementationplan-8.16.2019.pdf>

<sup>4</sup> <https://ehealthexchange.org/>

all 50 states and is the principal network that connects federal agencies and non-federal organizations. The eHealth Exchange connection uses a query and response process whereby participating organizations can query other participating organizations and receive a patient's summary of care documents (i.e., consolidated clinical document or CCD), with appropriate authorization.

Use of the eHealth Exchange network in Minnesota will help support care transitions between organizations that use the Epic electronic health record (EHR) system, which are already participants with the eHealth Exchange, and those that do not. Organizations that are not connected to the eHealth Exchange can do so by participating with a Minnesota state-certified health information organization (HIO). By the end of 2019, it is expected that large health systems using the Epic EHR and providers participating with an HIO will be able to query for summary of care documents from another care provider using the eHealth Exchange network. As organizations increasingly participate with an HIO, this will help ensure that summary of care information moves with the patient to any provider that patient sees. However, it is limited to a query to – and response from – a single organization at a time. The responses may or may not be in a format that provides discrete data; could include multiple unconsolidated documents; and will include a limited set of data elements.

While using the eHealth Exchange network for exchange of summary of care documents is a good starting point and meets an important HIE need among Minnesota providers, it is not sufficient. Summary of care documents, as the name suggests, contain a summary of patient information and not necessarily all of the information a provider needs to address, manage and improve patient care. Further, those needs vary based on the provider's role and the situation at hand. Findings from the HIE Study and discussion by the HIE Task Force noted that much of the information they need is not included with the summary of care document; for example, notes, lab, radiology and pathology results, images, event alerts, among other types of information.

## Description of a connected networks approach

A connected networks approach seeks to build upon existing HIE capabilities while also providing a governance process to evaluate and recommend new or expanded HIE services to meet evolving organizational, financial, and technical needs. A connected networks approach is intended to fill HIE gaps for Minnesota hospitals and health systems, primary care and specialty providers, social supports, and government agencies that need information for improved patient care and broader population health. This approach is intended to coordinate and align with national, federal and state HIE activities as well. The goals of this approach are to improve patient care experiences, increase organizational efficiency and effectiveness, improve the quality of data shared, and ultimately reduce costs and administrative burden.

**A connected networks approach would comply with all federal and Minnesota privacy and security requirements and best practices.**

A successful connected networks approach in Minnesota will require agreement on a governing process and the formation of a governing entity to address the need for authority, accountability and decision making. Agreement on, and implementation of, such a governing

process will ensure a coordinated and transparent review, evaluation and decision-making processes for existing and future HIE services. These processes will also support development of new services to address the information needs identified by the HIE Task Force. Governance for a connected networks approach in Minnesota will help ensure better coordination and alignment with other HIE activities, including:

- The eHealth Exchange, as noted above as a first step;
- Public health reporting to MDH;
- Minnesota Department of Human Services' Encounter Alerting Service (EAS); and
- The Trusted Exchange Framework and Common Agreement (TEFCA) and other federal recommendations.

A connected networks approach for Minnesota will require a flexible governance process with broad stakeholder representation. The request for public input<sup>5</sup> provided background information and a high-level description of the HIE Task Force recommendations to elicit support, ideas and suggestions from responders. Overall comments were requested, along with specific questions relating to the following topic areas:

- Governance needs and responsibilities
- Commitment by all stakeholders
- Need for a designated HIO to fill HIE gaps
- Importance of three centralized services/capabilities
- Financial commitment for initial governance and potential future needs
- Minnesota's oversight of HIE
- Proposed models for a connected networks approach

See Appendix A for a complete list of questions and information on the request for public input.

## Request for public input process

MDH thanks the [Minnesota e-Health Advisory Committee](#) and the [Health Information Exchange Task Force](#) for their work over the past twelve months. They volunteered over 330 hours of meeting time plus additional hours in preparation through conferences, conference calls with MDH staff and reading materials.

MDH, in collaboration with the Minnesota e-Health Advisory Committee and Health Information Exchange Task Force, invited public input on a connected networks approach for health information exchange (HIE) in Minnesota. The comment period was from July 17 – August 28, 2019. Invitations to provide input were distributed broadly and frequently during the comment period; a formal census or sampling effort was not used.

MDH appreciates the comments, input and perspectives were received from 32 organizations and/or individuals. Responses were submitted by a variety of organizations. The complete list of organizational responders is available in Appendix B.

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<sup>5</sup> <https://www.health.state.mn.us/facilities/ehealth/hie/taskforce/index.html>

## Themes

MDH staff conducted a review of the public comments and identified several themes as summarized below. A few example quotes from the responses are also included to better illustrate the themes. It should be noted that while the responses varied overall; there were similarities in perspectives/support depending on the organization or group responding (e.g., large health system, smaller health care organization, or actual provider of care).

### Theme 1: There was general support for a public-private HIE governance entity.

While there was general support for a public-private governance and governing entity, there were differing points of view regarding the form of governance that should be used as well as how the governance-related costs might be funded. For example, some responses noted a preference to utilize national governance mechanisms whenever possible. Some responses also noted a lack of willingness to pay for a Minnesota-specific governance entity. Those supporting a public-private governance indicated the need for broad representation and offered additional examples of who should be included.

Sample comments:

- “Minnesota is in a unique position to establish an evolved governance model aligned with a world of value-based care, health system consolidation, fewer EMR vendors, National Networks, and a push for APIs.”
- “(We) support the public-private connected networks approach, believing it to be the best way of structuring the governing entity, on the condition that the participants operate in good faith for all of Minnesota and not just their own self-interest or the interests of a select few.”

MDH sought to determine support for a governance process. Comments suggest that there is support for such a process in Minnesota to the extent that it aligns with existing mechanisms, represents a broad spectrum of stakeholders, and truly serves as a process to support decision making.

### Theme 2: A clear statement of the value of HIE services for stakeholders is needed.

Many responses noted the need for a clear statement of value for stakeholders and cautioned strongly against investing in additional HIE services without a strong value proposition. Several responses noted that one of the conditions to move forward may be that the value of any new/expanded HIE services must equal or exceed the actual cost of adding that service.

Sample comments:

- “...presumably the ‘economic savings’ and ‘better outcomes’ are the areas where value is increased by HIE. Commitment by appointees to achieving the most value should be a fiduciary responsibility.”

- “The cost of implementing information exchange in Minnesota should not exceed the cost containment savings realized from information exchange.”
- “There needs to be a clear statement of value to the different stakeholder types in order to ensure commitment and participation. Stakeholders will have different needs and value. For example, a payer will require different information sharing than a health care organization. In order for there to be value, participants must see an equal benefit for any cost.”

This theme is consistent with past work of MDH and the Minnesota e-Health Initiative, which identified that the value proposition for HIE services differs by organization (e.g., large health system, smaller health care organization, health plan/payer, actual provider of care). MDH recognizes the need to balance the priorities of multiple stakeholders as well as tie the “cost” of implementation to the value to individual and community health.

### Theme 3: Using and aligning with existing national networks for care summary exchange is strongly supported.

Many responses noted the need to move to implementation in a pragmatic/practical way. Furthermore, many responses also commented on the need to build on existing and/or future national or federal efforts whenever possible and not be restrictive (e.g., recommend only one methodology) in determining national options as long as information is shared appropriately among stakeholders.

Sample comments:

- “Because of the proven success of (the national networks), the substantial progress being made, and relative low cost of leveraging existing frameworks, we recommend that MDH focus on working with these initiatives to build on existing capabilities.”
- “It would be more cost-effective for the state to connect to Carequality implementing networks rather than build a new ‘networks of networks’ from scratch.”

The connected networks approach is intended to use and align with national networks. However, responses suggest that there are a range of assumptions about the current capabilities of national networks. Specifically, what information exchange they can and cannot support at this time.

### Theme 4: Some stakeholders indicated that there are HIE needs beyond the care summary document.

While nearly all responses stated the need to be practical about implementation, there were a number of organizations (types of organizations) who either believed that utilizing national networks would be “enough” for HIE versus those who wanted the state be more prepared for future HIE needs (e.g., value-based care environment).

Several responses elaborated on important information exchange needs such as:

- State public health reporting (e.g., immunization, case reporting);

- Alerts/notifications (e.g., ADTs from hospital/ED);
- Information not currently included on a care summary/ CCD (e.g., imaging, EKG, labs) – or "full" records;
- Use of information from the Prescription Monitoring Program

Responses indicated that there were differing opinions on whether the information currently available on a care summary document using a national network was adequate for patient care or if additional information would be helpful. Multiple organizations commented on the need for information that is not currently included on a care summary document or on the important value of other HIE services; e.g., notifications about hospital and ED admissions, radiology images, lab results, and others.

### Theme 5: There was mixed support for centralized HIE services.

There were varied and diverse opinions about the need for the three centralized services (e.g., provider/healthcare directory, patient directory, centralized routing) and/or priorities for one or more of those services. In general, the large health systems commented that all three centralized services may not be needed but that there was value in a provider/healthcare directory. Responses indicated potential support for only a provider/healthcare directory as a centralized service if it would serve as a single source of truth (as well as possibly including credentialing information and direct address information).

Other responses were either neutral on centralized services and/or expressed different opinions about which service was most important and thus supported one or more centralized services to varying degrees. Each of the three centralized services was identified as the most important in one or more responses.

#### Sample comments:

- “Overall, we do not support the centralized services model, but it is important to look at each service individually as there is some merit in one of the services.”
- “...does not support a state patient directory as this will not address current matching issues and will only add additional complexity and expense.”
- “HIE services are a key component that Minnesota needs to progress in our ability to bring more providers into ACO/APM models and target and support patients with complex care needs and multiple chronic conditions.”
- “Given the Minnesota Health Records Act, consideration of a statewide opt-out service, that could evolve into a “patient preference” service with more granular consent options.”

Responses suggest that the development of centralized or shared services may be premature at this time. While value was noted for a provider/healthcare directory, there are many aspects of establishing such a service that may impact the ability to implement just this one service. Further, responses pointed out that these centralized services, in and of themselves, may help support but may not entirely solve the problems these services are intended to address.

## Theme 6: The State should play several important roles.

Most, if not all responses pointed to an important role for the state as a convener, facilitator, and potential funder of key HIE activities (governance, HIE services). There was strong support for the state and the Minnesota e-Health Advisory Committee to serve in those capacities.

Sample comments:

- “From a state government perspective, we see MDH in its joint work with the eHealth Advisory Committee as necessary to take the next steps to recommend the structure of an HIE governing body... Our hope is that this can be a priority for the MDH Commissioner as well as the Governor, elevating the support, commitment, and transparency necessary to lead to success.”
- “State government can provide funding and facilitation, much the way MDH staffs the Minnesota e-Health Advisory Committee. This is important (and thankless) work that is critical for public-private partnerships to be successful long-term.”
- “OHIT to take a more active role to oversee, coordinate, encourage participation and steward the policies, laws etc.”
- “In order to successfully implement a public-private consortium, the state will need to promote and facilitate the implementation of this type of enterprise as well as help organize future meetings between all parties.”

## Theme 7: There is a need to support organizations with greater resource needs and/or serving populations at higher risk.

Many responses emphasized the need to better support provider organizations with less robust EHRs, those with greater resource needs, or those serving populations at higher risk. Many acknowledged that a designated HIO might be one way to help support those organizations, with an assumption that the costs for connecting to that HIO would be minimal.

Sample comments:

- “We request the state help mitigate these costs, especially for safety-net providers.”
- “Without new funding (or a mandate) HIE connectivity will not be extended to longterm services and supports, post-acute care/SNF, behavioral health, dental, public health, public health reporting to MDH.”
- “Though we recognize the positive impact HIE technology would have on their ability to provide care in a more comprehensive and coordinated way, we do not have the resources required to implement HIE technology. We support the concept of the designated HIO that will ensure that all organization have an opportunity to benefit from and contribute to a robust network of health information.”

MDH recognizes that there is a need to support organizations that have fewer financial and technical resources and that the concept of a “designated” HIO to fill HIE gaps, as described in

this request for public input, was perhaps not clear. A “designated” HIO to fill HIE gaps was intended to refer to the concept of ensuring that there would be at least one HIO available for organizations to participate with in order to connect with current and future networks. MDH recognizes that future discussions should clarify what a “designated HIO” and any proposed services would entail.

## Theme 8: There was lack of agreement on how to fund a connected networks approach.

Responses acknowledged a need to fund the upfront and ongoing costs for HIE services in a connected networks approach and many remarked that the state should pay these costs, at least initially. Others indicated that those that benefit from the HIE service(s) should pay.

Sample comments:

- “The best principle around which to structure financial support for an HIE is proportionality: stakeholders should support the system to the extent they benefit from it...under the ideal model, HIEs would allow participants to contribute data free of charge and require any organization pulling or retrieving data to pay corresponding fees.”
- “...would encourage the State to fund the initial cost until such a time as the financial benefit of information exchange becomes a reality.”

Responses suggested that opinions on how to fund HIE will vary by organization size and type, and several indicated strong support for state funding. A strong value proposition is needed to engage funding from non-state organizations.

## Theme 9: Modify Minnesota requirements to align with national efforts.

Responses to modify Minnesota HIE oversight requirement were received from both EHR/HIE vendors and other organizations. Minnesota requirements for HIE oversight were put in place before there were all the certification requirements –and or volunteer programs- at the federal and national level (e.g., Health IT Certification Criteria [2015 Edition] of EHRs through the Office of the National Coordinator for HIT EHNAC accreditation) that could potentially replace the certification process for health data intermediaries.

While not included as a question in the request for input, there were multiple suggestions to align the Minnesota Health Records Act (MHRA) with federal HIPAA requirements.

## Conclusion

MDH appreciates the comments, input and perspectives were received from organizations and individuals. These comments and input will be used to help inform next steps on a connected networks approach. The themes were shared with the Minnesota e-Health Initiative Advisory Committee as they continue to advance e-health policies and efforts in the state.

## Appendix A: Public Input Topic Areas and Questions

A complete copy of the request for public input is available here:

<https://www.health.state.mn.us/facilities/ehealth/hie/taskforce/docs/publicinputrequest.pdf>

The specific questions for which MDH was seeking comment are listed below. Responders could choose to address any or all of these questions. Additional comments were also encouraged.

### **Governance needs and responsibilities**

1. To what extent do you support the proposal for a public-private governing entity for a connected networks approach, including the plan for representation from a broad set of stakeholders?
2. What is needed from state government to make this work? And from private industry?
3. What thoughts do you have on stakeholder representatives to include within a proposed governing entity, as noted in the list above? Who is missing?

### **Commitment by all stakeholders helps achieve the most value**

4. What approaches or actions would you suggest be used to ensure commitment by all stakeholders to share information in a common and coordinated way?
5. What priority use cases would your organization support? For example, what are your greatest needs for exchanging health information?

### **Need for a *designated* HIO**

6. To what extent do you support this concept of a designated HIO to fill HIE connectivity gaps and why?

### **Importance of three centralized services/capabilities**

7. Describe if and how, if at all, any of these centralized services would help your organization provide better patient care, improve operational efficiencies and/or provide value. What other centralized services would help your organization?
8. Which centralized services or capabilities, if any, would be a priority for your organization to use?

### **Financial commitment for initial governance and potential future needs**

9. Thinking specifically about the financial support needed for implementation and ongoing sustainability of a connected networks, what principles would you suggest for the governing entity to consider in allocating responsibility to different stakeholders?
10. Please share comments you might have about the three types of financing needs for a connected networks approach identified above.

### **Minnesota's oversight of HIE**

11. What changes to Minnesota's HIE oversight law do you recommend in order to move the state toward a connected networks approach?

### **Proposed models for a connected networks approach**

12. Describe how you think these models in Appendix C align with the HIE Task Force's guiding principles (page 8) and the expectations presented in this document? How do you see your organization fitting in to one or more of these models?

## Appendix B: Responders

- Allina Health
- Audacious Inquiry
- Care Providers of Minnesota
- Center for Diagnostic Imaging
- CentraCare
- Collective Medical
- Dalan, Dan
- Datuit, LLC
- EHR Association- HIMSS
- Epic
- Fairview Health Services
- FirstLight Health System
- HealthPartners Radiology
- Hennepin Healthcare
- Hickory Tech
- KobleMinnesota
- Lakewood Health System
- Mayo Clinic
- MedKaz
- Minnesota Association of Community Health Centers
- Minnesota Chapter of the American College of Physicians
- Minnesota Council of Health Plans
- Minnesota Dental Association
- Minnesota Home Care Association
- Minnesota Rural Health Cooperative
- NXC Imaging/Medicom
- OCHIN
- Olmsted County Public Health
- PrimeWest Health
- Public Consulting Group
- Stratis Health