

Minnesota e-Health Roadmap: Approach and Methods Report August 2016



This project is part of a State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and of Human Services in 2013 by the Center for Medicare & Medicaid Innovation (CMMI) to help implement the [Minnesota Accountable Health Model](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

Introduction

The Approach and Methods Report documents the development of the Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services (Roadmap). The [Roadmap](http://www.health.state.mn.us/e-health/roadmaps.html) (<http://www.health.state.mn.us/e-health/roadmaps.html>) provides use cases, a person-centered view, and recommendations and actions to support and accelerate the adoption and use of e-health in the four settings, referred to as priority settings.

Approach

The Roadmap process was structured with sequential steps that integrated the diverse issues of the priority settings. The steering team, with 19 individuals, and the workgroups, with over 50 subject matter experts from the priority settings, met over 40 times from January 2015 to June 2016. In addition, the Roadmap engaged 48 reviewers and a community of interest of over 900 people. The collaborative effort was led by the Minnesota Department of Health, Office of Health Information Technology, and Stratis Health.

Scope

The Roadmap is designed to identify recommendations and actions to advance e-health in the priority settings. The four priority settings are:

Behavioral Health: Providers and organizations that promote emotional health, prevent mental illness and substance use disorders, and treat and provide services for substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

Local Public Health: Community Health Boards whose responsibilities include preventing and controlling communicable disease, protecting from environmental health hazards, promoting healthy communities and healthy behaviors (including maternal and child health), preparing for and responding to public health emergencies, and assessing and sometimes addressing gaps in health services.

Long-Term and Post-Acute Care (LTPAC): A variety of providers and organizations with services including rehabilitation, medical management, skilled nursing services, and assistance with activities of daily living due physical and/or cognitive impairments. Common types of LTPAC providers include but are not limited to nursing facilities or skilled nursing facilities, home health agencies, hospice providers, inpatient rehabilitation facilities, long-term acute care hospitals, assisted living facilities, continuing care retirement communities, home and community-based services, and adult day service providers.

Social Services: Public, nonprofit or private agencies that help people meet social, economic, educational, and health needs that are fundamental to the well-being of individuals and families. Examples of social services agencies include but are not limited to providing housing, transportation, or nutritional services to individuals or families.

Assumptions

The Roadmap will:

- Build upon, support, and coordinate with the vision, goals, and work of the MN e-Health Initiative.
- Endeavor to be practical and pragmatic for all stakeholders.
- Focus on individual, population, and public health.
- Rely on a consensus-driven approach of stakeholders, facilitated by Stratis Health and the Minnesota Department of Health.
- Consider the perspective of multiple stakeholders, including the individual and community, while focusing on the priority settings.

Methods

Community Engagement

From December 2014 through February 2015, participants from across the care continuum, with special focus on the priority settings, were recruited for various levels of engagement. Communications were sent through Stratis Health and MDH channels to reach individuals representing a variety of perspectives and experiences, including consumers. The four opportunities for involvement were:

Community of Interest: Individuals interested in receiving periodic updates on the Roadmap process and related e-health activities (900 participants).

Reviewer/Subject Matter Experts: Individuals able to provide targeted feedback via email on materials and deliverables (48 participants).

Workgroup Member: Individuals able to provide insight and experience from the priority settings. The four workgroups, one for each priority setting, each were led by two co-chairs except social services, which only had one co-chair (52 participants).

Steering Team Member: Individuals able to provide leadership and guidance to the overall direction of the Roadmap and assure alignment between the priority settings. Two co-chairs led the steering team (19 participants).

The community engagement efforts were successful in engaging over 1,000 individuals through a variety of methods (Figure 1).

Figure 1. Community Engagement Milestones (as of July 31, 2015)

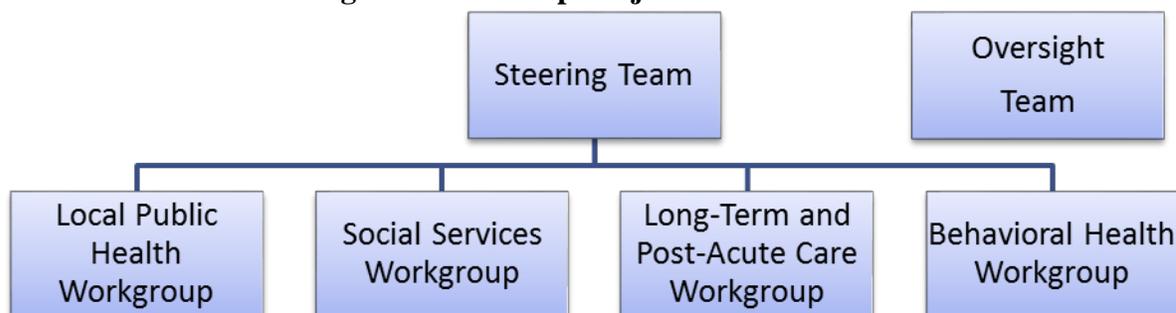
Engagement Opportunities	Focus/Description	Number of individuals engaged*	Number of Meetings	Estimated Hours Contributed**
Community of Interest	Receive periodic emails	+900	5 (communications)	NA
Reviewers/Subject Matter Experts	Provide targeted feedback on materials	48	5 (communications)	NA
Workgroups	Identify stories	52	38	1100
Steering Team	Provide overall direction and alignment	19	13	500

*Some individuals participated in multiple engagement opportunities.

**Only includes hours of participants in meetings, does not include outside of meeting hours contributed

The Roadmap work was led by the steering team (Figure 2), who provided overall direction to the project and assured alignment between the workgroups and communication with all stakeholders. The workgroups focused on identifying stories that illustrate how an individual moves through the health and care systems, and how e-health can improve outcomes. Each workgroup and steering team met monthly or as needed, used a consensus-based approach, and were driven by charters (Appendix A). The charters clarified the role of the group and its members, identified the process, guiding principles, tasks and expectations, and project structures. In addition, MDH and Stratis Health staff met monthly as the oversight team to manage the project and contract deliverables.

Figure 2. Roadmap Project Structure



Develop Understanding and Common Terms

The steering team held discussions that developed an understanding of the project, e-health in Minnesota, and identified common terms. This was achieved through an iterative, consensus-based process. These terms align with the [Minnesota e-Health Glossary of Terms and Acronyms](http://www.health.state.mn.us/e-health/glossary.html) (<http://www.health.state.mn.us/e-health/glossary.html>) and led to the development and approval of:

- Charges for the steering team and workgroups (Appendix A)
- Roadmap Factsheet (August 2015) (Appendix B)
- Common Terms including:
 - E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT), including health information exchange (HIE), to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.
 - Implementation Guidance is guidance on what needs to be done by the community-at large to accelerate e-health.
 - Implementation Guide is how an individual health or care organization can implement an electronic health record or other health information technology.
 - Use Case is a tool used to identify interactions between entities and systems to achieve a goal for a particular scenario.

Identify and Prioritize Stories

The workgroups each identified person-centered stories that covered a wide range of provider/setting involvement, presenting issues, and individual need. The workgroups identified over 70 stories to potentially be developed into use cases. The stories were reviewed and synthesized across the workgroups, leading to 52 unique stories. To prioritize the stories, each workgroup identified criteria that they deemed important for their settings, and populations served. For example, the local public health workgroup identified the following criteria:

- State reportable communicable disease
- Primary care and local public health interaction/transitions
- Patient centered
- Health literacy
- Care coordination
- Community health
- Emergency preparedness
- Health education – understanding, engagement, empowerment – need to relay same message – consistency – need for standards
- Social determinants of health – many already being collected but need to have consistency in sharing
- Identify stories that are a stretch – need to identify stories that have gaps and needs – things we may not have the answers to right now
- Data analytics– how to use data to develop interventions before there is a crisis and to measure population and public health
- Patient empowerment/engagement

Each workgroup rated the stories it developed as a high, medium, or low. Ratings were assigned points (high = 3, medium = 2, low = 1). The scores for each story were averaged resulting in a composite score for the story. A ranking grid was created for the stories for each workgroup. The local public health ranking grid is illustrated below.

Figure 3. Local Public Health Ranking of Use Cases

Story Title	# Low Votes	# Medium Votes	# High Votes	Rank
Kari			7	3.00
Sam			7	3.00
TB		1	6	2.86
Community Health Board		1	5	2.83
Louise	1		6	2.71
Carson		3	3	2.43
Public Health/ Behavioral Health		4	3	2.43
Developmental & Social/ Emotional Screening		4	2	2.29
Emergency Preparedness	1	3	3	2.29
Home Visiting	1	4	2	2.14
Jail Population	2	4	1	1.86
Exchange of Info within PH Doc	6	6		1.14
Early Childhood Screening				Incorporated into another case.

The ranking grids from each workgroup were reviewed and the highest-ranking stories were identified. In each of the workgroup rankings, there was a clear distinction between the high-ranking stories and the remaining stories based upon the ranking score. This resulted in 19 high-ranking stories: 4 from social services and 5 each from behavioral health, local public health, and long-term and post-acute care.

The steering team reviewed and voted on all 19 high-ranking stories (Appendix C). This resulted in 11 priority stories. Upon reviewing the 11 stories, it was determined there was significant overlap and similarities between some of the stories and that the following 8 stories be converted into use cases and analyzed for the Roadmap:

Anderson Family has members with confirmed and suspected tuberculosis.

David has privacy concerns that inhibit full disclosure of health history between the Veterans Health Administration and other providers.

Grace has uncontrolled juvenile onset diabetes with poor health due to lack of care coordination.

Jasmine, a micro-preemie infant, has respiratory needs that require home care and equipment.

Kari is a teenager who needs support from and coordination between multiple health, school, and social services during her pregnancy.

Maria, with significant assistance from her daughter, is transitioning to an assisted living facility.

Mike is struggling to control his diabetes and depression and to find stable housing, healthy food options, and employment opportunities.

Sally, who has autism and lives in a group home, has recurring emergency department visits.

Develop and Analyze the Use Cases

These 8 stories were the Roadmap use cases. The workgroups and project staff used the [User Story Template](http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx) (http://wiki.siframework.org/file/detail/PHRIUserStoryTemplate121113.docx), developed by the Office of the National Coordinator, Standards and Interoperability (S&I) Framework, Public Health Reporting Initiative, to guide the development a story to a priority use case. Each priority use case had three components: summary, story, and future state. The use cases were analyzed using three strategies that identified e-health related challenges for care coordination and collecting, using and sharing information.

1. Actors and Workflow Maps identified the sequence of events, actors, and gaps for each use case. The workgroups used this tool to validate the use cases accurately captured the current state of each story.
2. Information Matrix, based on the [Interoperability Standards Advisory](https://www.healthit.gov/standards-advisory) (https://www.healthit.gov/standards-advisory) from the Office of Health National Coordinator for Health IT, identified the information elements needed for each use case by each priority setting. This led to the development of the Roadmap Core Information Elements found in the Roadmap appendix.
3. Gaps Analysis, based on the Minnesota HIE Framework to Support Accountable Health (Appendix D), identified and classified gaps. The analysis used the key elements of the HIE Framework: engage and activate individuals and caregivers; engage and activate all health providers; extend care coordination into the community; monitor cohorts and attributed populations; and manage population health. In addition, the overarching requirements were used, including transactions and standards; patient safety practices; privacy and security; total cost of care; and the learning health system.

The analysis and discussion of the priority use cases identified two key themes: 1) person-centered view of e-health, and 2) collecting, sharing and using information. These themes were persistent throughout the project and incorporated into the recommendations and actions.

Synthesize Recommendations and Actions

The results of the three strategies were compiled and presented to the steering team and workgroups. The steering team and workgroups validated the results and identified additional themes. The project staff spent significant time synthesizing and categorizing recommendations and actions. In addition to the feedback from the participants, the reviewers and community of interest had opportunities to provide input. That input was continually provided to the steering team and workgroup members as the Roadmap continued to be refined.

The final product has 10 recommendations for providers within the priority settings. It also includes over 40 actions with resources and considerations that support the recommendations. There are an additional 35 actions for key partners such as professional organizations and state government.

Appendix

Appendix A: Steering Team and Workgroups Charges

Steering Team Charter

MN e-Health Roadmap
2015-2016

Charge

The purpose of steering team is to provide expert input and direction to support the development of the Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model (Minnesota e-Health Roadmap). The Minnesota e-Health Roadmap will be a path forward for using e-health to more effectively deliver high-quality, coordinated care and healthier communities. In addition, the steering team ensures that the needs of the consumers, providers and other health and health care stakeholders are fully considered.

Minnesota e-Health Roadmap Context

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT), including health information exchange, to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions. Minnesota has been a leader in e-health by leveraging a public-private collaborative, the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/about/home.html) (Initiative) (<http://www.health.state.mn.us/e-health/about/home.html>). Established in 2004, the Initiative was established to pursue strong policies and practices to accelerate e-health with a focus on achieving interoperability (the ability to share information seamlessly) across the continuum of care.

Minnesota enacted legislation in 2007 that requires all health and health care providers in the state to implement an interoperable EHR system by January 1, 2015 ([Minn. Stat. §62J.495](https://www.revisor.mn.gov/statutes/?id=62j.495)) (<https://www.revisor.mn.gov/statutes/?id=62j.495>). In order to help providers achieve the 2015 interoperable EHR mandate, the Initiative developed the Minnesota Model for Adopting Interoperable EHRs (Figure 1) in 2008 to outline seven practical steps leading up to and including EHR interoperability. This model groups each of the steps into three major categories that apply to all aspects of the Initiative’s work and policy development.

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



In recent years, federal funding has supported Minnesota’s e-health efforts and contributed to high rates of EHR adoption and growing rates of effective use and health information exchange (see the [Minnesota e-Health Profile](http://www.health.state.mn.us/e-health/assessment.html#brief) at <http://www.health.state.mn.us/e-health/assessment.html#brief>). However, e-health challenges and disparities still exist in settings

including behavioral health, local public health, long-term and post-acute care, and social services. The Minnesota Accountable Health Model, a State Innovation Model (SIM) testing grant awarded by the [Center for Medicare & Medicaid Innovation](http://innovations.cms.gov) (<http://innovations.cms.gov>), is supporting three programs to address some of the e-health challenges and disparities and focusing on using e-health to participate in accountable health. The three programs are: Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model Program; Minnesota Accountable Health Model e-Health Grant Program; and Privacy, Security and Consent Management for Electronic Health Information Exchange Grant Program.

Although each program has a specific focus, the work will be coordinated and directed by the Office of Health Information Technology at the Minnesota Department of Health (MDH). In December 2014, MDH and the Minnesota e-Health Initiative partnered with Stratis Health to develop MN e-Health Roadmap for the settings of behavioral health, local public health, long-term and post-acute care, and social services. The MN e-Health Roadmap will be action oriented and based on use cases, which describe how people, information and technology work to accomplish tasks. Concrete, achievable short and medium term steps and longer-term aspirational goals and recommended actions will be part of the MN e-Health Roadmap. The project will begin in January 2015 and end in the summer of 2016. For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

Process

The steering team, facilitated by Stratis Health and MDH and led by co-chairs, will meet monthly to build consensus and work collaboratively to meet the timelines of the project. The team is comprised of local, state and national representatives from each of the four settings of care in addition to local, state, and national partners and leaders. There is a workgroup for each setting of behavioral health, local public health, long-term and post-acute care, and social services. The workgroups will work together and with the steering team to assure coordination and alignment across all workgroups. In addition, subject matter experts will review and provide feedback on deliverables and materials. The steering team will build upon the vision, goals, and progress of the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) (<http://www.health.state.mn.us/e-health/abouthome.html>) and collaborate with the other health reform activities.

Key Tasks

- Provide overall direction to the workgroups for Roadmap development, including:
- Identify the audience, components, and use of the Roadmap.
- Discuss and reach consensus on Roadmap and workgroup issues.
- Review and provide guidance on stories and use cases (scenarios).
- Address and resolve disagreements between workgroups.
- Recommend actions and next steps.
- Define the course for the Roadmap.
- Assure coordination and collaboration between the workgroups.
- Provide leadership and give guidance when differences between workgroups emerge.
- Review and comment on Roadmap-related materials.
- Ensure communication material is clear and concise for the intended audiences.

- Participate in an e-health environmental scan.
- Coordinate with Minnesota e-Health Initiative, MDH, Minnesota e-health programs, and other partners.
- Coordinate with other parts of the care delivery system (Acute care, Primary Care, etc.)
- Make recommendations for activities partners may undertake, as appropriate.

Expectations

- Serve an 18 month term: Winter 2015 – Summer 2016
- Participate in monthly workgroup meetings
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.
- Keep the statewide interests of the Minnesota e-Health Initiative and the Minnesota Accountable Health Model foremost in decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.
- Advocate for the Roadmap and e-health within your organization and setting.
- Report out on three achievements and three challenges/barriers at each monthly meeting.

Milestones (Note: milestone dates may change to reflect the Development Plan)

- February 2015: Minnesota e-Health Roadmap Kick-Off Meeting
- March 2015: First workgroup meeting
- April 2015: Initial Roadmap framework completed
- May 2015: Stories identified, coordinated and developed
- June 2015: Environmental scan completed and priority use cases selected
- October 2015: 1st draft of Minnesota e-Health Roadmap
- January 2016: 2nd draft of Minnesota e-Health Roadmap
- March 2016: 3rd draft of Minnesota e-Health Roadmap
- April – June 2016: Disseminate the Minnesota e-Health Roadmap

Guiding Principles

- Seek first to understand (ask and listen).
- Make expectations explicit (tell).
- Think about the part and the whole.
- Be accountable and responsible to the whole team.
- Present problems in a way that promotes mutual discussion and resolution.
- Consensus is defined as agreeing to support decision.
- Treat each other with dignity and respect.
- Trust each other and the process.

Steering Team Membership

Co-Chair: Randy Farrow, Mankato Clinic

Co-Chair: Cally Vinz, Institute for Clinical Systems Improvement

Co-Chair (past): Carol Berg, UCare

Members:

Wendy Bauman, Dakota County Public Health
Todd Bergstrom, Care Providers of Minnesota
Jennifer Blanchard, Minnesota Department of Human Services
Kris Dudziak, HealthPartners
Dan Edelstein, Allina Health and HealthPartners
Cathy Gagne, St. Paul Ramsey County Public Health
Tim Gothmann, Jewish Family Service of St. Paul
Cindy Grolla, Northfield Hospital
George Klauser, Lutheran Social Service
Kevin Larsen, Office of the National Coordinator of Health IT
Martin LaVenture, Minnesota Department of Health
Jennifer Lundblad, Stratis Health
Deanna Mills, Community University Health Care Center
Krista O'Connor, Minnesota Department of Human Services
Peter Schuna, Pathway Health
Annie Schwain, Voda Counseling
Darrell Shreve, LeadingAge Minnesota (past)
Trisha Stark, Minnesota Psychological Association
Catherine VonRueden, Essentia

Workgroup Staff

Kari Guida
MDH Office of Health Information Technology
kari.guida@state.mn.us

Brad Sparish
Stratis Health
BSPARISH@stratishealth.org

Meetings are not open to the public.

Behavioral Health Workgroup Charter

MN e-Health Roadmap
2015-2016

Charge

The purpose of this workgroup is to provide expert input to support the development of the Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model (Minnesota e-Health Roadmap) for Behavioral Health. The Minnesota e-Health Roadmap will be a path forward for using e-health to more effectively deliver high-quality, coordinated care and healthier communities. In addition, the workgroup ensures that the needs of the consumers, providers and other health and health care stakeholders are fully considered.

Minnesota e-Health Roadmap Context

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT), including health information exchange, to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions. Minnesota has been a leader in e-health by leveraging a public-private collaborative, the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/about/home.html) (Initiative) (<http://www.health.state.mn.us/e-health/about/home.html>). Established in 2004, the Initiative was established to pursue strong policies and practices to accelerate e-health with a focus on achieving interoperability (the ability to share information seamlessly) across the continuum of care.

Minnesota enacted legislation in 2007 that requires all health and health care providers in the state to implement an interoperable EHR system by January 1, 2015 ([Minn. Stat. §62J.495](https://www.revisor.mn.gov/statutes/?id=62j.495)) (<https://www.revisor.mn.gov/statutes/?id=62j.495>). In order to help providers achieve the 2015 interoperable EHR mandate, the Initiative developed the Minnesota Model for Adopting Interoperable EHRs (Figure 1) in 2008 to outline seven practical steps leading up to and including EHR interoperability. This model groups each of the steps into three major categories that apply to all aspects of the Initiative’s work and policy development.

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



In recent years, federal funding has supported Minnesota’s e-health efforts and contributed to high rates of EHR adoption and growing rates of effective use and health information exchange (see the [Minnesota e-Health Profile](http://www.health.state.mn.us/e-health/assessment.html#brief) at <http://www.health.state.mn.us/e-health/assessment.html#brief>). However, e-health challenges and disparities still exist in settings including behavioral health, local public health, long-term and post-acute care, and social services. The Minnesota Accountable Health Model, a State Innovation Model (SIM) testing

grant awarded by the [Center for Medicare & Medicaid Innovation](http://innovations.cms.gov) (<http://innovations.cms.gov>), is supporting three programs to address some of the e-health challenges and disparities and focusing on using e-health to participate in accountable health. The three programs are: Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model Program; Minnesota Accountable Health Model e-Health Grant Program; and Privacy, Security and Consent Management for Electronic Health Information Exchange Grant Program.

Although each program has a specific focus, the work will be coordinated and directed by the Office of Health Information Technology at the Minnesota Department of Health (MDH). In December 2014, MDH and the Minnesota e-Health Initiative partnered with Stratis Health to develop MN e-Health Roadmap for the settings of behavioral health, local public health, long-term and post-acute care, and social services. The MN e-Health Roadmap will be action oriented and based on use cases, which describe how people, information and technology work to accomplish tasks. Concrete, achievable short and medium term steps and longer-term aspirational goals and recommended actions will be part of the MN e-Health Roadmap. The project will begin in January 2015 and end in the summer of 2016. For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

Process

The workgroup, facilitated by Stratis Health and led by co-chairs, will meet monthly to build consensus and work collaboratively to meet the timelines of the project. There is a workgroup for each setting of behavioral health, local public health, long-term and post-acute care, and social services. The workgroups will work together and with the Minnesota e-Health Roadmap Steering Team to assure coordination and alignment across all workgroups. In addition, subject matter experts will review and provide feedback on deliverables and materials. The workgroup will build upon the vision, goals, and progress of the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/abouthome.html) (<http://www.health.state.mn.us/e-health/abouthome.html>) and collaborate with the other health reform activities.

Key Tasks

- Review and comment on Roadmap-related materials;
- Identify the audience, components, and use of the Roadmap;
- Select stories and develop use cases (scenarios) for implementing e-health;
- Participate in an e-health environmental scan; and
- Coordinate and align with the Roadmap workgroups and steering team, Minnesota e-Health Initiative, MDH, Minnesota e-health programs, and other partners.
- Escalate issues resulting from differences between the workgroups to the Steering for guidance, coordination and resolution.

Expectations

- Serve an 18-month term: Winter 2015 – Summer 2016.
- Participate in monthly workgroup meetings.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.

- Keep the statewide interests of the Minnesota e-Health Initiative and the Minnesota Accountable Health Model foremost in decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.
- Advocate for the Roadmap and e-health within your organization and setting.

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Co-Chair: Annie Schwain, Voda Counseling

Co-Chair: Trisha Stark, Minnesota Psychological Association

Members:

Matthew Chiodo, Fraser Institute

Gregory Clancy, Allina Health/Health Catalyst

Alisa Cohen, Therapeutic Services Agency, Inc.

James Dungan-Seaver, Hamm Clinic

Ann Eiden, Nystrom & Associates

Scott Gerdes, Zumbro Valley Health Center

Mark Alan Gustafson

Nancy Houlton, UCare

Eric Larsson, Lovaas Institute Midwest

Ellen Luepker

Gwen Pekuri, South Central Human Relations Center

Shauna Reitmeier, Northwestern Mental Health Center

Mark Schneiderhan, University of Minnesota, College of Pharmacy

Lisa Squire

Grace Tangjerd Schmitt, Guild Incorporated
Khaonou Vang, RESOURCE, Inc.
Steven Vincent, Minnesota Psychological Assn.
Linda Vukelich, Minnesota Psychiatric Society
Claire Wilson, Minnesota Association of Community Mental Health Programs

Meetings are not open to the public.

Workgroup Coordinator

Amy Heikkinen

Stratis Health

aheikkinen@stratishealth.org

Local Public Health Workgroup Charter

MN e-Health Roadmap
2015-2016

Charge

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Although each program has a specific focus, the work will be coordinated and directed by the Office of Health Information Technology at the Minnesota Department of Health (MDH). In December 2014, MDH and the Minnesota e-Health Initiative partnered with Stratis Health to develop MN e-Health Roadmap for the settings of behavioral health, local public health, long-term and post-acute care, and social services. The MN e-Health Roadmap will be action oriented and based on use cases, which describe how people, information and technology work to accomplish tasks. Concrete, achievable short and medium term steps and longer-term aspirational goals and recommended actions will be part of the MN e-Health Roadmap. The project will begin in January 2015 and end in the summer of 2016. For more information on the SIM grant, the Minnesota Accountable Health Model and other health reform activities visit [State Innovation Model Grant](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

Process

The workgroup, facilitated by Stratis Health and led by co-chairs, will meet monthly to build consensus and work collaboratively to meet the timelines of the project. There is a workgroup for each setting of behavioral health, local public health, long-term and post-acute care, and social services. The workgroups will work together and with the Minnesota e-Health Roadmap Steering Team to assure coordination and alignment across all workgroups. In addition, subject matter experts will review and provide feedback on deliverables and materials. The workgroup will build upon the vision, goals, and progress of the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/about/home.html) (<http://www.health.state.mn.us/e-health/about/home.html>) and collaborate with the other health reform activities.

Key Tasks

- Review and comment on Roadmap-related materials;
- Identify the audience, components, and use of the Roadmap;
- Select stories and develop use cases (scenarios) for implementing e-health;
- Participate in an e-health environmental scan; and
- Coordinate and align with the Roadmap workgroups and steering team, Minnesota e-Health Initiative, MDH, Minnesota e-health programs, and other partners.
- Escalate issues resulting from differences between the workgroups to the Steering for guidance, coordination and resolution.

Expectations

- Serve an 18-month term: Winter 2015 – Summer 2016.
- Participate in monthly workgroup meetings.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.

- Keep the statewide interests of the Minnesota e-Health Initiative and the Minnesota Accountable Health Model foremost in decisions and recommendations.
- Review meeting materials ahead of time and be prepared to contribute clear and focused ideas for discussion.
- Advocate for the Roadmap and e-health within your organization and setting.

Milestones (Note: milestone dates may change to reflect the Development Plan)

- February 2015: Minnesota e-Health Roadmap Kick-Off Meeting
- March 2015: First workgroup meeting
- April 2015: Initial Roadmap framework completed
- May 2015: Stories identified
- June 2015: Environmental scan completed and priority use cases selected
- October 2015: 1st draft of Minnesota e-Health Roadmap
- January 2016: 2nd draft of Minnesota e-Health Roadmap
- March 2016: 3rd draft of Minnesota e-Health Roadmap
- April – June 2016: Disseminate the Minnesota e-Health Roadmap

Guiding Principles

- Seek first to understand (ask and listen).
- Make expectations explicit (tell).
- Think about the part and the whole.
- Be accountable and responsible to the whole team.
- Present problems in a way that promotes mutual discussion and resolution.
- Treat each other with dignity and respect.
- Trust each other and the process.

Workgroup Membership

Co-Chair: Wendy Bauman, Dakota County Public Health

Co-Chair: Cathy Gagne, St. Paul Ramsey County Public Health

Members:

Sue Ellen Bell, Minnesota State University- Mankato

Bill Brand, Public Health Institute

Phyllis Brashler, Minnesota Department of Health

Melanie Countryman, Dakota County Public Health

Sue Grafstrom, LifeCare Medical Center

Daniel Jensen, Olmstead County Public Health Services

Susan Strohschein, Retired

Jessica Tarnowski, Minnesota Department of Health

Diane Thorson, Otter Tail County Public Health

Meetings are not open to the public.

Workgroup Coordinator

Amy Heikkinen

Stratis Health

aheikkinen@stratishealth.org

Long-Term and Post-Acute Care Workgroup Charter

MN e-Health Roadmap
2015-2016

Charge

The purpose of this workgroup is to provide expert input to support the development of the Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model (Minnesota e-Health Roadmap) for Long-Term and Post-Acute Care. The Minnesota e-Health Roadmap will be a path forward for using e-health to more effectively deliver high-quality, coordinated care and healthier communities. In addition, the workgroup ensures that the needs of the consumers, providers and other health and health care stakeholders are fully considered.

Minnesota e-Health Roadmap Context

E-health is the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT), including health information exchange, to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions. Minnesota has been a leader in e-health by leveraging a public-private collaborative, the [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health/about/home.html) (Initiative) (<http://www.health.state.mn.us/e-health/about/home.html>). Established in 2004, the Initiative was established to pursue strong policies and practices to accelerate e-health with a focus on achieving interoperability (the ability to share information seamlessly) across the continuum of care.

Minnesota enacted legislation in 2007 that requires all health and health care providers in the state to implement an interoperable EHR system by January 1, 2015 ([Minn. Stat. §62J.495](https://www.revisor.mn.gov/statutes/?id=62j.495)) (<https://www.revisor.mn.gov/statutes/?id=62j.495>). In order to help providers achieve the 2015 interoperable EHR mandate, the Initiative developed the Minnesota Model for Adopting Interoperable EHRs (Figure 1) in 2008 to outline seven practical steps leading up to and including EHR interoperability. This model groups each of the steps into three major categories that apply to all aspects of the Initiative’s work and policy development.

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



In recent years, federal funding has supported Minnesota’s e-health efforts and contributed to high rates of EHR adoption and growing rates of effective use and health information exchange (see the [Minnesota e-Health Profile](http://www.health.state.mn.us/e-health/assessment.html#brief) at <http://www.health.state.mn.us/e-health/assessment.html#brief>). However, e-health challenges and disparities still exist in settings including behavioral health, local public health, long-term and post-acute care, and social services. The Minnesota Accountable Health Model, a State Innovation Model (SIM) testing grant awarded by the [Center for Medicare & Medicaid Innovation](http://innovations.cms.gov) (<http://innovations.cms.gov>),

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Key Tasks

- Review and comment on Roadmap-related materials;
- Identify the audience, components, and use of the Roadmap;
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- Escalate issues resulting from differences between the workgroups to the Steering for guidance, coordination and resolution.

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- Participate in monthly workgroup meetings.
- Bring the perspective of the stakeholder group you represent to all discussions and decisions.

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Workgroup Membership

Co-Chair: Todd Bergstrom, Care Providers of Minnesota

Co-Chair: Kris Dudziak, HealthPartners

Co-Chair (past): Darrell Shreve, LeadingAge Minnesota

Members:

Mary Chapa, Ebenezer, a part of Fairview Health System

Lisa Fowler, Bayada Pediatrics

Abdi Galgalo Gonjobe, Metro Health Care Services, LLC

Jennie Harvell, US Department of Health and Human Services/ Office of the Assistant Secretary for Planning and Education

Deborah Kaspar, Perham Living

Janel Peterson, Evangelical Lutheran Good Samaritan Society

Sarah Shaw, Minnesota Department of Health

Bonnie Westra, University of Minnesota

Meetings are not open to the public.

Workgroup Coordinator

Amy Heikkinen

Stratis Health

aheikkinen@stratishealth.org

Social Services Workgroup Charter

MN e-Health Roadmap
2015-2016

Charge

The purpose of this workgroup is to provide expert input to support the development of the Minnesota e-Health Roadmap to Advance the Minnesota Accountable Health Model (Minnesota e-Health Roadmap) for Social Services. The Minnesota e-Health Roadmap will be a path forward for using e-health to more effectively deliver high-quality, coordinated care and healthier communities. In addition, the workgroup ensures that the needs of the consumers, providers and other health and health care stakeholders are fully considered.

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Workgroup Membership

Co-Chair: Tim Gothmann, Jewish Family Service of St. Paul

Co-Chair: George Klauser, Lutheran Social Service

Members:

Stephanie Abel, Hennepin County Human Services and Public Health Department

Karen Crabtree, Essentia Health St. Mary's

Elizabeth Dodge, Chisago County Health and Human Services

Scott Fridley, Volunteers of America

Melinda Hanson, Minnesota Department of Health

Joel Kalle, Minnesota Cameroon Community

Jody Lien, Otter Tail County Human Services

Kate Onyeneho, Center for Africans Now in America

Eric Ratzmann, Minnesota Association of County Social Service Administration

Isaak Rooble, Somali Resources Aid Associates

Mary Jo Schifsky, Store to Door

Cheryl Shanks, Camilia Rose Care Center, LLC

Deb Taylor, Senior Community Services

Meetings are not open to the public.

Workgroup Coordinator

Alyssa Meller

National Rural Health Resource Center

ameller@ruralcenter.org

Appendix B: Minnesota e-Health Roadmap Factsheet

Minnesota e-Health Roadmap Factsheet

Introduction and Purpose

The purpose of the Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services (Roadmap) is to provide recommendations and actions to support and accelerate the adoption and use of e-health. The Roadmap will emphasize the future state of using e-health in these priority settings to improve health outcomes. In addition, it will:

- Enhance a provider's ability to give better care through improved communication between providers, including primary care and hospitals, and with individuals and their families.
- Support individuals' access to their health information and engagement in their care and health.
- Make recommendations to the Minnesota e-Health Initiative on key information and functionality needs for electronic health records (EHR) and health information exchange (HIE).
- Provide recommendations on policies and actions to support e-health across the care continuum to state and federal policymakers, agencies, and organizations.
- Identify evaluation and applied research opportunities to advance e-health.

The Roadmap is primarily for use by providers and organizations that represent the priority settings of behavioral health, local public health, long-term and post-acute care, and social services. Others who might want to use the Roadmap are:

- Professional and trade associations that can help disseminate and implement the recommendations.
- Other health and care providers and organizations, including EHR and HIE vendors, impacted by the recommendations.
- Policymakers and leaders interested in e-health and its contribution to health transformation and high-quality, coordinated care.
- Persons interested in how e-health is impacting health and care of individuals and communities.

Approach

The Roadmap project, occurring January 2015 – June 2016, is a collaborative effort led by the Minnesota Department of Health (MDH), Office of Health Information Technology, and Stratis Health. A consensus-based approach is used to create the Roadmap through stakeholder engagement, including:

- A **Steering Team** that provides overall guidance to the Roadmap, assuring alignment between the workgroups and other e-health and health reform activities, and communication with all stakeholders.
- **Workgroups** for each priority setting that provide expert input to support the Roadmap development and ensure all stakeholder needs are fully considered.



August 2015

- **Reviewer/Subject Matter Experts** that review and provide feedback on key materials.
- **A Community of Interest** that receives periodic communications on the Roadmap and related e-health activities.

The Roadmap has three phases: plan, develop, and educate. These three phases will support and accelerate the adoption and use of e-health but will not include implementation guides or detailed directions for individual providers and organizations to implement an EHR or HIE.

This project is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and of Human Services in 2013 by the Center for Medicare & Medicaid Innovation (CMMI) to help implement the [Minnesota Accountable Health Model](http://www.mn.gov/sim) (<http://www.mn.gov/sim>).

Connection to State and National Activities

The [Minnesota e-Health Initiative](http://www.health.state.mn.us/e-health) (www.health.state.mn.us/e-health) (Initiative) is a public-private collaborative whose vision is to accelerate the adoption and use of health information technology. E-health is the adoption and effective use of EHR systems and other health information technology, including HIE, to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions. To achieve the vision, the Initiative developed the Minnesota Model for Adopting Interoperable Electronic Health Records (Figure 1).

Figure 1. Minnesota Model for Adopting Interoperable Electronic Health Records



The Initiative and state and federal funds have supported Minnesota’s e-health efforts and contributed to high rates of EHR adoption and growing rates of effective use and HIE. However, e-health challenges and disparities still exist, including in the priority settings. The Roadmap will begin to address these challenges and disparities through supporting and aligning with the Initiative’s vision, purpose, and activities and federal activities such as the [Medicare and Medicaid EHR Incentive Program](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html), referred to as “meaningful use”, (<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>).

For more information on the roadmaps or to sign up for the community of interest, visit [Minnesota e-Health Roadmaps](http://www.health.state.mn.us/e-health/roadmaps) (www.health.state.mn.us/e-health/roadmaps).



August 2015

Appendix C: Priority Stories and Review Criteria

E-Health Roadmap
Scoring of Use Case Stories
as of 7/13/2015

Story Title	Setting Author	Votes	Work Group Score	Setting						Age	Family/Community	Location	Payer	Privacy/Consent	Social Determinant	Technology	Timeline
				BH	LPH	LTPAC	SS	Acute Care	Primary Care								
Grace	BH	17	300	X	X			X	X	14	Family	small town		X	pediatric	FERPA, paper records HIE consultation summary, referral management	multiple events
David	BH	17	255	X				X	X	50	Individual		out of pocket	X	race, vet	fax orders, care coordination docs	multiple events
Jasmine	LTPAC	13	300			X		X		new born	family				pediatric	med list exchanged, discharge doc exchanged, keyHIE transform tool	multiple events
Mary	LTPAC	11	300			X		X	X	87	Mother-daughter		switches insurance frequently, on restricted provider list		elderly, vulnerable adult	Direct - Epic, tele-health	single event
Joe	BH	10	250	X	X	X	X	X	X	78	Individual-neighbor	Rural		X	elderly, vulnerable adult		single event
Mike	SS	7	288				X	X		52		urban	CADI Waiver		limited income, disabled		multiple events
Blanche	LTPAC	7	250			X	X	X	X	87	Mother-daughter		Medicare	X	elderly	medical records transferred	multiple events
Kari	LPH	7	300	X				X	X	15	mother-child			X	adolescent	PHR	single event
TB	LPH	7	285	X				X	X	40s, 20s teens	Family involvement	Border location	none		Nationality, adolescent	HIO	multiple events

E-Health Roadmap
Scoring of Use Case Stories
as of 7/13/2015

Story Title	Setting Author	Votes	Work Group Score	Setting							Age	Family/Community	Location	Payer	Privacy/Consent	Social Deter	Technology	Timeline	
				BH	LPH	ITPAC	SS	Acute Care	Primary Care	Other									
Louise	LPH	7	2.71		x	x	x	x	x	x	Pharmacist, care coordinator	79	Family involvement	Rural	Medicare, Waiverd services		elderly disabled person (autistic), non-verbal; low income	Secure email, PHR, Tele-health	multiple events
Sally	SS	3	3.00				x	x	x	x	pharmacist, Ambulance/EMS		group home, individual				low income	Telemedicine	multiple events
Sam	LPH	6	3.00		x					x			Family support				adolescent		single event
Mary III	BH	6	2.67		x					x	sleep clinic, rheumatologist, pharmacy		Mother-children		Medicaid				single event
Dan	SS	5	3.00				x			x	Vocational Services Employer;		individual	Urban (assumed)			low income	ACO, Shared Bridge system	single event
Mary II	SS	5	3.00			x	x	x		x	dietician, Mayo specialist, PCA/Home health		individual	Urban	medical assistance		Low income	electronic referral, 485 billing	multiple events
Henry	ITPAC	5	3.00			x	x	x		x	housekeeping help		father-daughters extended family (nephews)	Urban	Medicare			patient portal	multiple events
Jenny Community Health Board	ITPAC LPH	4	2.75			x				x	Pharmacy		individual	Urban				elderly	multiple events
Jean	BH	0	2.63		x								individual	Rural	Grant funding		low income	direct email	single event

Appendix D: Minnesota HIE Framework to Support Accountable Health

Minnesota HIE Framework to Support Accountable Health ^{1,2}

Key Element	Key Premise (<i>Desired Outcomes</i>)	Key HIE Functions and Capabilities to Achieve Desired Outcomes	Overarching Requirements
A. Engage and Activate Individuals and Caregivers	Individuals who have access to their health information are more engaged, more responsible for their health and have better health outcomes.	<ul style="list-style-type: none"> a) Patients have access to bi-directional communication with providers. b) Individuals have access to their personal health information that is understandable, in a useable form and actionable. c) Individuals and patients have access to information about their providers and health care services d) Individuals have access to tools to actively monitor and care for themselves and are able to share health activity monitoring information with providers. e) Individuals have easy access to chronic disease management tools f) Individuals have easy access to disease specific and preventative education materials 	<p>F. Transactions and Standards Recommended transactions and national standards are supported</p> <p>G. Patient Safety Practices HIE and e-health protocols and procedures are supportive and enhance patient safety</p> <p>H. Privacy and Security Protect all health information; any data sharing includes patient permissions (shared with whom and for what purpose).</p> <p>I. Total Cost of Care (TCOC) HIE and e-health protocols and procedures support TCOC model (clinical decision support, program evaluation etc.)</p> <p>J. Administrative Simplification Providers, patients and individuals can easily access information for appointment, insurance eligibility and benefits among other needs</p> <p>K. Learning Health System moving toward an "ecosystem where all stakeholders can securely, effectively and efficiently contribute, share and analyze data and create new knowledge that can be consumed by a wide variety of electronic health information systems to support effective decision-making leading to improved health outcomes (Collect, Share, Use)"³</p>
B. Engage and Activate all Health Providers	Providers who are engaged, with access to all necessary information at the point of care, help contribute to better health outcomes for patients.	<ul style="list-style-type: none"> a) Providers have access to bi-directional communication with patients. b) Providers have ability to communicate/share information within their own organization c) Providers have the ability to communicate/share information outside their organization d) Providers have access to user friendly, timely clinical decision support (CDS) e) Providers have access to public health alerts f) Providers have access to comprehensive patient medication histories 	
C. Extend Care Coordination into the Community	Individuals are healthier when health care and related services are coordinated across providers.	<ul style="list-style-type: none"> a) Providers have closed loop referral capability b) Individuals and providers have access to identified social & community supports (for referral) that address social as well as medical needs c) Providers have the information needed for care coordination in standard and/or shared terminologies where possible d) Providers participate in care teams e) Providers have access to bi-directional care coordination support services to/from MDH f) Providers have access to information on targeted patients (e.g., cohorts) for follow-up/support g) Individuals and patients have access to financial information needed for care management h) Care coordinators have access to shared care management plans 	
D. Monitor Cohorts and Attributed Populations	Cohorts and attributed populations have better health and financial outcomes when program decisions are made using information generated with enhanced data analytics.	<ul style="list-style-type: none"> a) Access to information to identify and monitor cohorts; share trends with care coordinators b) Access to financial risk sharing models use predictive analytics c) Access to shared care management plan and transparency of data analyzed d) Ability to normalize and integrate data, including social determinants of health e) Ability to provide care coordinators and providers performance reports f) Access to information that allows for participation in reimbursement systems for other than fee for service (ACO, value-based payment) g) Access to and ability to use repository and data warehouse 	
E. Manage Population Health	Health policy, emergency preparedness, and public program decisions are improved when based on accurate & timely population health information.	<ul style="list-style-type: none"> a) Access to information for health assessment of entire population b) Ability to evaluate effectiveness of public health programs c) Ability to report measures to external designated entities d) Ability to report adverse events to Patient Safety Organization e) Access to emergency preparedness monitoring and assessment information f) Access to information needed to react to emergency disasters and outbreaks more quickly g) Access to and ability to share research protocol information h) Access to and ability to share comparative effectiveness research i) Access to and ability to share population health analysis 	

¹ Adapted from COHIT's A Health IT Framework for Accountable Care http://www.healthit.gov/FACAS/sites/default/files/a_health_it_framework_for_accountable_care_0.pdf

² Adapted from: Stratis Health's An Actionable Model for Health Reform-Preparing for the future of health care <https://www.stratishealth.org/pubs/qualitvupdate/13/reform.html>

³ Source: Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap January 2015