June 14, 2019

Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St SW
Floor 7
Washington, DC 20201

Submitted electronically at: https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement

Attention: Minnesota e-Health Initiative Statewide Coordinated Response to the Trusted Exchange Framework and Common Agreement Draft 2

The Office of the National Coordinator for Health Information Technology:

Thank you for the opportunity to provide a response to the Trusted Exchange Framework and Common Agreement (TEFCA) Draft 2. The Minnesota e-Health Initiative is pleased to submit comments on the TEFCA Draft 2.

We appreciate the work done to date by ONC to advance e-health to improve individual and population health. The Minnesota e-Health Initiative applauds the ONC efforts to improve and increase access and interoperability to support patient care and population health.

Minnesota is supportive of this direction toward a "network of networks" as this approach aligns with and is complementary to the recently completed work of the Minnesota e-Health HIE Task Force (https://www.health.state.mn.us/facilities/ehealth/hie/taskforce/index.html) related materials available on webpage and Appendix C) on a connected networks approach. The HIE Task Force made recommendations for governance, authority and financing for a Minnesota connected networks approach.

The Minnesota e-Health HIE Task Force concluded its work on May 30, 2019. The recommendations of the HIE Task Force, which were endorsed by the Minnesota e-Health Advisory Committee (Advisory Committee) are anticipated to be released for public comment in early July. The input received will be reviewed by the Advisory Committee in fall 2019 to recommend the future direction and next steps.

The HIE Task Force was one of the primary recommendations of a Minnesota HIE Study. The study report is available here: http://www.health.state.mn.us/e-health/hie/study/index.html. This study identified three important uses for HIE that greatly and favorably impact individual and community health. First is "foundational" HIE, meaning that basic health information flows with the patient to any provider they see. Building upon the foundation, "robust" HIE involves using health information from all providers across the care continuum to manage patient care based on the patient's consolidated health picture and use analytics to support health outcomes. A third level of "optimal" HIE use allows communities to understand the health status of their population, better handle disease outbreaks, and manage emergency response.

By the end of 2019, it is expected that Minnesota's large health systems that use Epic, as well as other providers participating with a health information organization (HIO), will be able to exchange care summary documents using the national eHealth Exchange network. The Minnesota e-Health HIE Task Force recommended this important step and developed an implementation plan, endorsed by the Advisory Committee and being rolled out now.
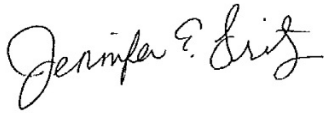
This move toward broader use of the national eHealth Exchange will help ensure that information moves with the patient (foundational HIE) to any provider that the patient sees. With foundational HIE, providers have ability to electronically share information outside their organization; providers can query and receive health information for consenting individuals. Building on the already existing, national eHealth Exchange network with the care summary use case was a key guiding principle for the task force because stakeholders have frequently emphasized the need to align Minnesota efforts with other HIE activities.

While the use of the eHealth Exchange meets an essential HIE need among Minnesota providers, more is required to meet the need for HIE to help manage patient care more proactively (robust HIE) and to support broader population and community health through connecting sets of information (optimal HIE). Further development of a connected networks approach may be the best option to advance robust and optimal HIE use and achieve goals for managing patient care and improving community health.
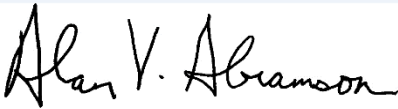
The Minnesota e-Health Initiative also recognizes the value and need for individuals to be at the center of their care, where providers have the ability to securely access and use health information from different sources. We support actions to assure there is a system where an individual's health information is not limited to what is stored in electronic health records, but includes information from many different sources and provides a longitudinal picture of their health.

Should you have questions you may contact Anne Schloegel, e-Health Program Lead, Office of Health Information Technology, Minnesota Department of Health, at anne.schloegel@state.mn.us.

Sincerely,

Jennifer Fritz, MPH
Director, Office of Health Information Technology
Minnesota Department of Health

Alan Abramson, PhD
Advisory Committee Co-Chair
Minnesota e-Health Advisory Committee
Senior Vice President, IS&T and Chief Information Officer
HealthPartners Medical Group and Clinics

Sonja Short MD, FAAP, FACP
Advisory Committee Co-Chair
Minnesota e-Health Advisory Committee
Associate CMIO Ambulatory and Population Health
Fairview Health Services

Peter Schuna
HIE Task Force Co-Chair
Chief Executive Officer
Pathway Health Services

George Klauser
HIE Task Force Co-Chair
Executive Director Altair ACO
Lutheran Social Service of Minnesota

Minnesota e-Health Initiative Statewide Coordinated Response to the ONC Draft Trusted Exchange Framework

Minnesota e-Health Initiative and Advisory Committee

The Minnesota e-Health Initiative vision is that all communities and individuals benefit from and are empowered by information and technology which advances health equity and supports health and wellbeing.

For the past fourteen years the Minnesota e-Health Initiative, led by the Minnesota e-Health Initiative Advisory Committee and the Minnesota Department of Health's Office of Health Information Technology (MDH-OHIT), has encouraged and supported e-health across the continuum of care. As a result, Minnesota is a national leader in e-health implementation and collaboration.

Minnesota e-Health Advisory Committee

The Minnesota e-Health Advisory Committee is a 25-member legislatively authorized committee appointed by the Commissioner of Health to build consensus on important e-health issues and advise on policy and common action needed to advance the Minnesota e-Health vision. The Committee is comprised of a diverse set of key Minnesota stakeholders, including: consumers, providers, payers, public health professionals, vendors, experts in health information technology, and researchers, among others. The committee co-chairs are Alan Abramson, Senior Vice President, IS&T and Chief Information Officer, HealthPartners and Sonja Short, MD, Associate CMIO Ambulatory and Population Health, Fairview Health System.

Workgroups

Committee members participate in workgroups to address detailed topics such as privacy and security, health information exchange, and standards and interoperability. The workgroups are the primary vehicle for receiving public input and investigating specific e-health topics through discussion and consensus building. The workgroup co-chairs and participants contribute subject matter expertise in discussions, research, and analyses through hundreds of hours of volunteer time. MDH-OHIT staff facilitate, analyze and interpret data, and summarize findings that help support e-health policy development.

Appendix A

Minnesota e-Health Advisory Committee Members 2018-2019

Alan Abramson, PhD, *Advisory Committee Co-Chair*, Senior Vice President, IS&T and Chief Information Officer, HealthPartners Medical Group and Clinics
Representing: Health System CIOs

Sonja Short, MD, *Advisory Committee Co-Chair*, Associate CMIO, M Health Fairview
Representing: Physicians

Sunny Ainley, Associate Dean, Center for Applied Learning, Normandale Community College
Representing: HIT Education and Training

Constantin Aliferis, MD, MS, PhD, FACMI, Chief Research Informatics Officer, University of Minnesota Academic Health Center
Representing: Academics and Clinical Research

Karl Anderson, Global Digital Health Senior Manager, Medtronic
Representing: Vendors

Laurie Beyer-Kropuenske, JD, Director, Community Services Division
Representing: Minnesota Department of Administration

Jennifer Fritz, MPH, Director, Office of Health Information Technology
Representing: Minnesota Department of Health

Cathy Gagne, RN, BSN, PHN, St. Paul-Ramsey Department of Public Health
Representing: Local Public Health

Mark Jurkovich, DDS, MBA, Dentist, Gateway North Family Dental
Representing: Dentists

Jennifer Lundblad, PhD, President and Chief Executive Officer, Stratis Health
Representing: Quality Improvement

Bobbie McAdam, Vice President, Information Technology, Medica
Representing: Health Plans

Jeyn Monkman, MA, BSN, NE-BC, Institute of Clinical Systems Improvement
Representing: Clinical Guideline Development

Lisa Moon, PhD, RN, CEO Advocate Consulting
Representing: Nurses

Heather Petermann, Division Director, Health Care Research & Quality, Minnesota Department of Human Services
Representing: Minnesota Department of Human Services

James Roeder, Vice President of IT, Lakewood Health System
Representing: Small and Critical Access Hospitals

Peter Schuna, Chief Executive Officer, Pathway Health Services
Representing: Long Term Care
Co-Chair: Health Information Exchange Task Force

Jonathan Shoemaker, Chief Information Officer, Allina Health
Representing: Large Hospitals

Steve Simenson, BPharm, FAPhA, President and Managing Partner Goodrich Pharmacy
Representing: Pharmacists

Adam Stone, Chief Privacy Officer, Secure Digital Solutions
Representing: Expert in HIT

Meyrick Vaz, Vice President - Strategic Market Partnerships, UnitedHealthcare Office of the CIO
Representing: Health Plans

Donna Watz, JD, Deputy General Counsel, Minnesota Department of Commerce
Representing: Minnesota Department of Commerce

Ann Warner, Program Director, Data Governance and Analytical Education, M Health Fairview
Representing: Health Care Administrators

John Whitington, Chief Information Officer, South Country Health Alliance
Representing: Health Care Purchasers and Employers

Ken Zaiken, Consumer Advocate, AARP Minnesota
Representing: Consumers

Sandy Zutz-Wiczek, Chief Operating Officer, FirstLight Health System
Representing: Community Clinics and FQHCs

Designated Alternates

George Klauser, Executive Director, Altair-ACO, Lutheran Social Services
Alternate Representing: Social Services
Co-Chair: Health Information Exchange Task Force

Paul Kleeberg, MD, Medical Director, Aledade
Alternate Representing: Physicians

Charles Peterson, President and CEO, The Koble Group
Alternate Representing: Vendors

Mark Sonneborn, Vice President, Information Services, Minnesota Hospital Association
Alternate Representing: Hospitals

Susan Severson, CPEHR, CPHIT, Vice President, Health Information Technology, Stratis Health
Alternate Representing: Quality Improvement

Rochelle Olson, MPH, Systems Management Supervisor, Dakota County Public Health
Alternate Representing: Local Public Health

Appendix B
Minnesota e-Health HIE Task Force Members 2018-2019

Stephen W. Odd, RN, IS Program Manager Systems Integration, Allina Health
Representing: Minnesota Health Information Organization - A

Charles D. Peterson, President and CEO, The Koble Group
Representing: Minnesota Health Information Organization - B

Michael Lilly, Systems/Enterprise Integration Manager, Ridgeview Medical Center
Representing: Hospital, Health System, ACO or IHP-B (Small)

Jeffrey Stites, JD, MPA, Member Attorney, Context Law, LLC
Representing: Professional with Expert Knowledge of Legal Context & Patient Consent

Jackie Sias, Provider Informatics Lead, Care Delivery Payment Reform, Minnesota Department of Human Services
Representing: Minnesota Department of Human Services

Eleanor O. Vita, MD, Family Practice Physician, Chief Medical Information Officer, Mayo Clinic Health System, Owatonna
Representing: Practicing Clinician

Timothy R. Getsay, MA, Vice President, Performance and Information Management, Gillette Children's Specialty Hospital
Representing: Professional with Expert Knowledge of HIE

Deepti Pandita, MD, Staff Physician, Chief Health Information Officer, Division of General Internal Medicine, Department of Medicine, Hennepin County Medical Center
Representing: Chief Medical Information Officer

Paula Schreurs, MS, Application Manager, Sanford Health
Representing: Hospital, Health System, ACO or IHP-A (Large)

Peter B. Schuna, *HIE Task Force Co-Chair*, Chief Executive Officer, Pathway Health
Representing: Long-Term and Post-Acute Care

Jonathon W. Moon, Health Quality Analytics Manager, Health Care Economics, UCare
Representing: Health Plan, Payer or Health Care Purchaser

George Klauser, *HIE Task Force Co-Chair*, Executive Director Altair ACO, Lutheran Social Service of Minnesota
Representing: Individual with Expert Knowledge of Patient Advocacy

Appendix C

Summary of HIE Task Force preferences and preliminary recommendations for governance, authority and financing of a Minnesota connected networks approach

Note: This document was endorsed by the Minnesota e-Health Advisory Committee on April 22, 2019, as meeting requirements for HIE Task Force Deliverable 3.

I. Introduction and Purpose

This summary represents the Task Force preferences for a connected networks approach to health information exchange (HIE) and captures perspectives and preferences that evolved over the 12 months of the group's work. In some cases there may be more than one option or strategy recommended. The HIE Task Force (Task Force), using a set of agreed-upon guiding principles,[1] worked to develop a plan that would increase overall value for statewide HIE overall rather than for any single stakeholder.

This summary presents a set of options and preferences intended to be considered as a single package. If considered separately, they may not be fully representative of the Task Force's work or achieve the Task Force's overall charge.

In particular, this document synthesizes the work of the Task Force to:

- identify preferred strategies to achieve effective, sustainable HIE in Minnesota; and,

- address needs for a five-year interim governance, authority, and financing to establish and expand a connected networks approach with a goal of future "optimal" HIE for all stakeholders.

This summary from the Task Force presents agreed upon principles and the beginnings of a governance process for a connected networks approach. It is not intended to be a detailed description of a connected networks model.

II. Working definitions

The Task Force used the following definitions to guide its work on multiple levels of HIE:

- **Foundational HIE –** With foundational HIE, providers have ability to electronically share information outside their organization; providers can query and receive health information for consenting individuals.

   Note: HIE Task Force Recommendation 1: Enable Foundational HIE Using the eHealth Exchange (CCDA transactions only) allows for foundational HIE.

- **Robust HIE** – Robust HIE includes event alerting for emergency department visits and hospital admission and discharges, closed-loop referrals, access to and sending of a patient's most recent

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[1] Guiding principles include: HIE Task Force is expected to collaborate with and build upon complementary HIE-related efforts in the state and region, including but not limited to: activities and evolution of HIOs and networks in Minnesota and nationally, implementation of the DHS EAS and cross-sector efforts to support stakeholders. Begin with a manageable scope and remain incremental. Prioritize actions that can be achieved in 2018 – 2019. Minimize duplication and number of HIE connections when possible. Keep in mind the needs of the continuum of care and the multiple goals for HIE (e.g., foundational, robust, optimal HIE as described in the HIE study report). Design for full participation of providers, payers, and government programs in the connected networks approach. Consider the needs of Minnesota's entire health and health care community.

consolidated and longitudinal records by providers and attributed population data for use in determining best practices, and identifying cohorts for better overall population management.

- **Optimal HIE –** Optimal HIE allows research into best practices, access to public health alerts for providers, community-based assessments of health for entire populations, and identification of important community health issues so that they can be addressed, including for example, opioid abuse and contagious illnesses before those illnesses become epidemics.

  Value propositions of levels of HIE above:

  Business case for HIE – Improved care coordination, improved patient satisfaction, and long-term lower costs from reductions in duplicate tests, faxing, manual exchange of data, and other improvements. The business case for HIE can be more easily demonstrated through **foundational** and **robust** HIE.

  Community value of HIE – Improved population health, improved community interventions, and lower community costs from improved overall community health. The community value of HIE can be demonstrated through **optimal** HIE.

- **Node** – A "node" refers to a health information organization (HIO), or a large health system already connected to the eHealth Exchange network and identified in the Task Force's Recommendation 1. Large health systems may choose to participate in a connected networks approach either as an independent node or through an HIO).

- **Centralized services** (examples of centralized services include the following**)**

  – **Patient directory or other patient matching tool/solution** – This may be a common key for patient matching between organizations. Each node will have a patient matching capability, but this would be enhanced with a central patient directory. There were other patient directory uses that could be considered through the governance process for a connected networks approach. This is not a repository of all the patient's information.

  – **Routing mechanism –** Minnesota's connected networks nodes (and eventually other stakeholders) could use this centralized service to help route health information more easily and efficiently to appropriate receiving organizations. Initial use cases may include MDH public health reporting.

  – **Healthcare (provider) directory** – This is a central directory to ensure that information is sent to the correct/appropriate provider using that provider's predetermined transport/ delivery method and workflow. This central directory may be used for referrals, transitions of care, and event alerting.

III. Task Force input for a five-year interim plan for governance, authority and financing of a Minnesota connected networks approach

For this work on a connected networks approach, Task Force members strove for consensus or general agreement on the options and strategies that received Task Force support and were recommended to the Minnesota e-Health Advisory Committee for consideration. However, Task Force members agreed at the start of their work to advance recommendations even if those recommendations fell short of support from all members, provided that a supermajority of at least nine of the 12 members found them acceptable. For this reason, the summary below indicates Task Force support for several options and strategies that nine or more Task Force members supported but that up to three members did not.

When voting on their preferences for strategies and options, Task Force members also indicated their level of acceptance or support using a four-point scale. The summary below uses the qualifiers "limited" or "weak" for cases when nine or more Task Force members considered the options and strategies as acceptable but some of those nine offered only weak support.

A. Governance model

The Task Force noted that a governance model/process is necessary to ensure an open, transparent, aligned process for HIE policy, using stakeholder input. The Task Force recommends that the governing entity of a connected networks approach include representation from participants (e.g., health care providers, payers, state government, and other stakeholders similar to those represented on the Task Force). The Task Force also recommends that the governing entity represents the participants of the connected networks and has the authority to require financial commitment of connected networks participants. The Task Force considered the following governance models and their potential strengths and weaknesses. Below are the options reviewed, listed in order of Task Force support:

- Public-Private (highest level of support)
- Public only (support but limited)
- Private only (fell short of threshold for Task Force support)

B. Governance source(s) of authority

The Task Force noted the need for one or more sources of authority to ensure appropriate compliance for a connected networks approach. It also considered potential strengths and weaknesses of different sources of authority. Below are options listed in order of Task Force support:

- Combination of Options 1 and 2 -- the state government grants authority to the governing entity for some circumstances and for others that entity depends on the state to exercise state authority based on its recommendations and requests (highest level of support)
- Option 1: State government grants authority (support)
- Option 2: Entity depends on state to exercise authority (support but limited)
- Option 3: Entity derives authority from agreements (fell short of threshold for Task Force support)
- Option 4: Incorporate into existing authorities (fell short of threshold for Task Force support)

C. Essential elements of governance

The Task Force identified essential elements of governance for a connected networks approach. The Task Force considered the elements key to the effective and efficient governance process for a connected networks approach. The Task Force grouped theses essential elements, listed below, into five broader categories, divided between "strategic" and "operational" considerations.

1. **Strategic governance**

   - ***Determining Governance*** – Composition of a governance body include determining roles and responsibilities for nodes, state government, payers, and others; decision making

processes; patient and participant representation; oversight for fees and costs; conflict resolution; role of HIOs and HDIs; complaint processes. Key stakeholders to be represented through the governance body include health providers, payers, and other stakeholders similar to those that participated in the Task Force.

- *Formalized Participant Agreement* – Policies and procedures include consent policy, rules and requirements; consent across states, national efforts and populations; rules of the road; reporting and auditing; data protection; accountability; risk and audit; ensuring legal and regulatory compliance.

- *Ensure Sustainability* – Responsibility for funding, revenue and sustainability; encouraging/incentivizing participation; determining optimal participation; enabling and ensuring full adoption.

2. **Operational Governance**

- *Data Standards and Usage* -- Permitted purposes; access policy; responsibility for assessing data quality and completeness; data stewardship; data standards, uniformity and normalization; discrete data to get to optimal HIE; trust framework.

- *Defined Services* -- Define minimum functionality; service definition and data; roadmap for workflow and priority use cases; implementation of shared services; decisions about national connectedness; business continuity; ensure redundancy of critical components; ensure functionality of network; assessing and integrating new technology.

D. Participation and Services/Capabilities

The Task Force agreed that participation and services are necessary to ensure that Minnesota meets needs for foundational, robust and eventually optimal HIE. The Task Force also recognized that stakeholders and end users of the services/capabilities are at varying stages in their need for the services/capabilities and that they vary in the benefits they might derive from the services/capabilities. As a result, the need or value of the services/capabilities may vary by stakeholders over time.

1. **Expectations of Nodes** (expected to be developed/adopted/implemented as needed within the next one-three years)

- State-certification or other process may be required.

- Data is normalized, aggregated, and may be stored at the node. The node is the primary place that an individual's information may be queried from (for a visit) and kept. For the interim, more than one node may have information on a patient depending on how many providers an individual visits.

- Information is shared based on rules of the connected networks. All nodes will participate with centralized service(s). Participation is defined as contributing data to the centralized service(s), or contributing data to and using the centralized service(s).

- Nodes participate in development and agreement/consensus on standards. An HIE governance model/process is needed that will include a uniformity process with representation of node organizations to harmonize, align, and develop standards as needed to achieve full agreement.

- All nodes maintain and update consent management of an individual's HIE consent, as defined by the governance process. (This service could be provided through a centralized patient directory, as another use case suggestion).

2. **Importance of three centralized services/capabilities**

The Task Force has noted, and the Minnesota e-Health Advisory Committee has also acknowledged, the importance of three centralized services/capabilities:

   – Patient directory/other patient matching service

   – Routing mechanism

   – Healthcare (provider) directory

The Minnesota e-Health Advisory Committee also noted that a patient directory alone may not have enough value and encouraged incremental implementation of all three centralized services during or within a similar timeframe.

E. Critical success factors for a Minnesota connected networks approach.

In order to meet the needs of a connected networks approach, the Task Force and Minnesota e-Health Advisory Committee corroborated that the following four critical success factors be addressed as part of the governance, authority and financing discussions.

- Full participation is needed to achieve the most value for all. (A commitment from large health systems, which are key data contributors, is essential.)

- At least one HIE service provider (e.g., HIO) is needed to fill HIE connectivity gaps for stakeholders such as smaller, independent providers, long-term and post-acute care providers, behavioral health providers, and social services organizations. (There is a need to ensure sustainability for a "safety-net" HIE provider).

- Financial commitment by all participants (e.g., nodes and other stakeholders) is needed to ensure long-term sustainability.

- Alignment with other HIE activities (national, federal, state) is needed to achieve an efficient and effective network, one that uses a flexible governance process that can evolve to meet HIE needs.

The Task Force discussed each success factor separately, identified common strategies to help achieve them and indicated support for one or more of those strategies.

1. **Full participation is needed to achieve the most value for all**

The concept of full participation means that all stakeholders of a connected networks approach (e.g., providers, payers, state government, and others) contribute and use information to ensure that information is available to those for whom it is essential for patient care. Below are suggested Task Force strategies for "full participation" listed in order of Task Force support:

    • State government incentives (highest level of support);

    • Stand-up centralized services incrementally (high level of support);

    • Payer incentives (support);

    • State government requirements (support but limited); and

- Payer requirements (fell short of threshold for Task Force support).

2. **At least one HIE service provider (e.g., HIO) is needed to fill HIE connectivity gaps**

As noted in the discussion of centralized or shared services above, stakeholders have varying capabilities and resources available for implementing and benefitting most effectively from HIE. In particular, smaller independent providers, providers of long-term care and post-acute care and behavioral health, and others may be lagging in their adoption and use of HIE. It may also be prohibitively expensive and burdensome for them to implement and use HIE on an individual or small-scale basis.

At least one HIE service provider is anticipated to provide a "safety net" for HIE connections for those who may have significant challenges implementing HIE otherwise. The service provider could also be available to anyone else, regardless of their capabilities. Below are suggested Task Force strategies for ensuring that there is at least one HIE service provider for anyone needing those services, listed in order of Task Force support:

- Establish policies or recommendations to reduce the use of faxing and view-only access to health records – not this alone but in conjunction with one or more other strategies – instituted carefully so as not to eliminate view-only access until information is available via HIE to all providers (highest level of support);

- State designates and possibly funds an HIE service provider (e.g., HIO) (support);

- Require contributions from nodes, the state and other stakeholders that participate in a connected networks approach to help subsidize costs and support at least one HIE service provider; (support); and

- Require that an HIE service provider (e.g., HIO) be the vendor for a centralized patient directory service and require nodes and other stakeholders to pay for use of the service (support but somewhat limited).

3. **Financial commitment is needed from nodes, the state and all other stakeholders that participate in a connected networks approach to ensure long-term sustainability**
Participants are broadly defined here as nodes, payers, state government and others that may contribute to or use the connected networks. The financial commitment would be determined by the connected networks governance process and the governing entity. The Task Force recommends that the governing entity represents the participants of the connected networks and has authority to require financial commitment of said participants. Below are suggested strategies for ensuring financial commitment by all participants listed in order of Task Force support:

- Require participants to contribute data to a centralized patient directory and provide them with the option to use that directory (highest level of support);

- Payers initially fund with the requirement for full participation but with the assumption that the costs for initial funding do not fall exclusively on payers (high level of support);

- Create incentives for participants to contribute data to and use centralized patient directory (support); and

- Initial shared commitment for investment toward start-up implementation, with long term determination of support costs or fees for use of centralized directory (support but very weak).

4. **A connected networks approach in Minnesota needs to align with other national, federal and state HIE activities in order to be efficient and effective, and it should depend on a flexible governance process that can meet evolving HIE needs.**

   Stakeholders emphasized the need to monitor and align with other HIE activities and build this critical success factor into a governance process for a connected networks approach.