Minnesota e-Health Initiative Advisory Committee Meeting Summary

JANUARY 29, 2025

Objectives

- Review and discuss the advisory committee charge.
- Learn and discuss the Statewide Provider Directory Feasibility Study, including the advisory committee's potential role in supporting next steps.
- Provide an overview of key national and federal activities related to health information exchange.

Summary

A list of acronyms is included in Appendix A on page 11.

Meeting opening

Bilqis Amatus-Salaam shared that the January and March advisory committee meetings will be focused on learning opportunities, recognizing the desire from the advisory committee members to get caught up since the committee last met in 2021. The May advisory committee meeting will be in person (with a hybrid option) and focus on taking what has been learned to plan and prioritize advisory committee activities for the remainder of 2025-2026.

Co-chair introduction

The two co-chairs, selected by the commissioner of health, were announced: Bryan Jarabek and Lindsey Sand. Each had an opportunity to introduce themselves.

Bryan shared that he is CIO of MHealth Fairview and led the state CIO committee. He is excited to work with the committee, especially because of its great members. He is interested in interoperability (especially considering TEFCA) and social determinants of health (SDoH) and directories that help “front line” staff with their work.

Lindsey shared that she is VP at Vivie (formerly Knute Nelson and Walker Methodist), an organization often associated with senior care but also providing community-based services. She is a licensed nursing home administrator and has spent most of her career in senior care and community-based services. She said she is also interested in interoperability and including everyone in the dialogue. She noted that she will be asking questions herself and welcomes questions and learning.

November meeting summary

Members were asked to provide feedback on the November meeting summary. Members found the meeting summary to be helpful, especially the acronym list. The meeting summary included comments from the public and advisory committee members. It was noted that the public comments provided additional topics for future discussions and learning.

Review of the advisory committee charge

Bilqis Amatus-Salaam provided an overview of the charge, explaining its components and that it provides flexibility as the committee's priorities come into clearer focus and to allow for the committee to respond to requests from the commissioner, governor, and/or legislature.

Discussion

- Some members felt the charge was appropriately high level and appreciated the flexibility.
- One member asked if what is out of scope for the committee should be clearly defined. It was explained that the advisory committee could be asked to provide advice on any topic related to e-health.
- A few members had questions about the language in the charge, specifically:
  - The lack of privacy and security mentioned in the charge
    - It was noted that privacy and security is included in the "purpose" section
  - Clarification on the language "…implementing a statewide interoperable health information infrastructure." This is language was taken from the committee's enabling legislation; the committee will have the ability to interpret this as needed.
  - Insufficient person-centered or consumer-focused language. Members requested that the charge be edited to add a bullet to call out a commitment to supporting patient-centered care.

Action:

A motion to approve the charge was called with the edit related to patient-centered care. George Klauser moved; Lisa Moon seconded; the motion prevailed.

Statewide Provider Directory Feasibility Study

Presentation

Anne Schloegel, Minnesota Department of Health (MDH) staff, presented a slide deck describing the study, actions and progress to date, and planned next steps. The draft report is due June 2025. Information is available at https://www.health.state.mn.us/facilities/ehealth/pdstudy/index.html.

Anne shared that the legislature asked the MDH to assess the feasibility of creating a statewide shared provider directory. The study is connected to:

- The HIE Task Force recommendation for a provider directory as a potential "centralized service"
- The 2024-25 governor's budget proposal related to the federal No Suprises Act (Act), which protects consumers from surprise medical bills. The Act also created stringent requirements for health plans and health providers to maintain accurate, up-to-date consumer-facing provider directories.

The working definition of a statewide provider directory being used in the study is a centralized "platform" for provider data management that would serve as a single source of truth to support accurate provider information that would help health plans and providers streamline the complex data exchange processes to help improve efficiency, quality, and ease of use.

The study has included an environmental scan:

- Reviewed responses to CMS October 2023 request for information (RFI) on a national directory of health care providers and services
- Tracking a CMS provider directory pilot in Oklahoma for that state's Qualified Health Plans
- Reviewed, interviewed or in the process of, other states' efforts past and current (New York, California, Washington, Michigan, Oregon, Rhode Island)

MDH conducted a public request for information (RFI) in fall of 2024. Responses were received from 25 organizations including: health systems/providers (7), health plans (8), associations (1), local government (3) and vendors (6). Themes from these responses include:

- Health plans and health systems maintain multiple provider directories for specific purposes (e.g., credentialing, consumer-facing)
- Data accuracy was greatest burden for most respondents
    - Keeping directories current and accurate is time and resource intensive for both providers and health plans due to:
        - Lack of alignment in state and federal directory requirements
        - Lack of coordination among health plans and within individual plans
        - Differing health plan directory requirements (data items, transport)
        - Changes to data elements may require reconfiguring entire system
        - Respondents expressed both benefits to a shared provider directory and drawbacks/challenges

- Benefits of statewide provider directory
  - Save time and resources as single “source of truth” could make updating and sharing easier for both health systems and health plans (especially smaller clinics/independent providers)
  - Support health plans receipt of race, ethnicity and language information
  - Help identify and fill network adequacy gaps
  - Improved standardization
- Drawbacks and challenges
  - Achieving full participation/buy-in/support
  - Could be just another place with conflicting information
  - Potential to be one more database to maintain if not everyone on board
  - Complexity of provider networks makes “single source of truth” unattainable
  - Costs may be significant (stand-up and maintenance)
  - Governance concerns

Next steps for the study include further interviews with states and vendors. Advisory committee members were encouraged to express interest to MDH or co-chairs if want to assist with the study.

Discussion

Committee members raised key questions and considerations, particularly about who a provider is, which sectors are involved, and potential use cases.

- Long-term care, post-acute care, and community-based services were not explicitly mentioned in the study.
- The definition of "provider" is complex, particularly in post-acute care, where a provider is a facility rather than an individual.
  - Anne responded that the definition of “provider” varies and that provider directories could focus on individual providers or facilities. She noted that skilled nursing facilities (SNFs) and other providers are often included in broader directories, and future efforts could expand the definition of "provider" to reflect a broader continuum.
- It is important to determine whether the directory would be consumer-facing or serve another function.
- What is the primary use case for the directory—whether it would focus on care coordination, credentialing verification, or other purposes? Defining use cases is crucial.

    - The legislative request did not specify a use case; MDH has identified potential use cases to include in the findings.
- Further comments regarding use cases:
    - New York's provider directory helps patients find covered health care services but has inaccuracies, such as outdated provider information. They asked whether other use cases were being considered.
    - Provider directories also help patients choose doctors, though provider organizations often direct patients to their own websites as the best "source of truth."
    - Some HIEs use their provider directory to understand 'all the relationships' a patient has to coordinate care and register the electronic endpoints for providers.

Overview of Trusted Exchange and Common Agreement (TEFCA)

Presentation

Advisory committee member Lisa Moon presented on the Trusted Exchange Framework and Common Agreement (TEFCA) explaining what it is, its requirements, and how it is organized and being implemented.

TEFCA aims to establish a universal policy and technical floor for nationwide health data interoperability by simplifying connectivity for healthcare organizations, payers, and public health authorities to exchange information. The goals of TEFCA are to:

- Provide a single "on-ramp" to nationwide connectivity
- Enable Electronic Health Information (EHI) to securely follow the patient when and where it is needed
- Support nationwide scalability

Use cases are called Exchange Purposes, which identify the reason for which information can be requested or shared through TEFCA. Authorized Exchange Purposes include:

- Treatment
- Payment
- Health Care Operations
- Government Benefits Determination
- Individual Access Services

The Qualified Health Information Network (QHIN) structure is a logical one, but organizations will need to decide where they participate in the structure – as QHINs, participants, or sub-participants. Each level of participation will have cost and other trade-offs associated with it. A discussion ensued regarding QHIN membership and access to QHINs.

Discussion

Discussion centered around QHIN participation in Minnesota, potential challenges related to QHINs and use cases/functionality.

QHIN participation:

- Chad Peterson reported that Koble intends to join the e-Health Exchange QHIN (planning to go live by the end of June) and will revise its agreements to reflect its participation in the QHIN.
- A question was raised about whether a provider on e-Health Exchange is automatically a participant with the e-Health Exchange QHIN, and whether providers can participate in more than one QHIN.
  - Lisa responded that it is still too early to have definitive answers.
  - Chad pointed out that all Minnesota hospitals are connected to Koble for public health reporting, making them part of e-Health Exchange
- Most of the large systems are using Epic as their QHIN. Is there a way to collect information on how non-Epic organizations can connect, or not, and when?
  - A list of health systems pledging to join a QHIN via Epic was shared in the chat to provide additional context, Leading Health Systems Pledge to Join TEFCA | Epic
  - A member noted that pledging, being connected, and live is not the same as actually using the network for exchanging patient information.
- MDH is interested in participating in TEFCA but needs to understand the legal framework.

Challenges:

- Concerns were raised about access for smaller providers, especially smaller clinics, as large health systems using Epic are leveraging Epic as their QHIN. Some FQHCs are on EPIC OCHIN, but for several clinics it is cost prohibitive to join an HIE.
- A suggestion was made to conduct a statewide survey to identify providers lacking readily available connections and compare these findings with known QHIN availability timelines.
- It was pointed out that becoming a QHIN requires significant effort, which explains why there are currently so few.
- A question was asked regarding the Minnesota Health Records Act and if it impacts the ability to participate in QHINs. Lisa Moon shared that there is an open comment period right now on computable consent, The Sequoia Project.

Use cases/functionality:

- Lisa noted that the primary QHIN use case at this time is treatment, while quality-related use cases may evolve later.

- A member shared that a QHIN at a recent conference mentioned obtaining Data Aggregator (DAV) certification for HEDIS use, suggesting that similar certifications across QHINs could simplify HEDIS reporting.
- The most prevalent form of communication remains "push," though "query" capabilities are expected to grow with increased FHIR adoption.

Next steps and closing remarks

The co-chairs summarized the meeting and invited members to volunteer the following, as interested:

- Suggestions for additional learning topics for advisory committee meetings.
- Further engage with the Statewide Provider Directory Feasibility Study.
- Further discussion and planning relating to TEFCA participation.

Members can provide feedback and suggestions via the post-meeting survey form, or by contacting MDH staff or the co-chairs.

The March and May committee meetings will be scheduled soon.

Comments submitted by survey form

Meeting attendees (including the public) were invited to submit comments using a web-based form. These comments were received within 2 weeks of the meeting date:

- Interested in learning from the committee their viewpoints, experience, and hopes for electronic data exchange with public health, TEFCA, and what are the opportunities for reduction of burden/increasing joy in practice in the context of Data Modernization.
- Great presentation from Anne Schloegel. Are you also looking at possible vendor solution viewpoints (e.g., CAQH) where many providers are going for credentialing and have perhaps a centralized source of truth for providers and groups. They wouldn't have the external component for consumer directory facing but there are perhaps some key vendor solutions that could centralize provide directory data and work to improve quality and consistency.
- Question if Provider Directory could help Public Health electronically collaborate with our clients' medical providers.
- Great information, was set up well to ensure time for questions and comments. Ongoing help with acronym clarity and summary of topics may be needed as feedback is needed by MDH. Thank you for the great organization of this.
- The meeting was very informative and easy to follow for someone who is not involved or does not know much about the meeting. Many great questions were asked and I look forward to seeing this come to life soon!

Attendance

Members Present

Bryan Jarabek, MD, PhD, Chief Medical Informatics Officer, M Health Fairview
Co-chair, Representing: Large Hospitals

Lindsey Sand, LHSE, NHA, Vice President of Population Health, Vivie
Co-chair, Representing: Health Care Administrators

Najma Abdullahi, Executive Board of Directors-Member, UMN Community-University Health Care Center
Representing: Consumer Members

Stacie Christensen, Deputy Commissioner and General Counsel
Representing: Department of Administration

Brittney Dahlin, MS, RHIA, CPHQ, Chief Operating Officer, Director of Quality Improvement, Minnesota Association of Community Health Centers
Representing: Community Clinics/Fed Qual. Health Centers

Greg Hanley, MBA, FACHE, CPHQ, Vice President, Health Services Quality and Operations, UCare
Representing: Health Plans

Matt Hoenck, Director of IT & Analytics, South Country Health Alliance
Representing: Health Plans

Nila Hines, Chief Data and Analytics Officer
Representing: Minnesota Department of Health

Steve Johnson, PhD, Associate Director, CTSI Health Informatics Program, University of Minnesota
Representing: HIT Training and Education

George Klauser, Executive Director – Community Services-ACO/Healthcare Consultant, Lutheran Social Services of Minnesota
Representing: Social Services

Lisa Klotzbach, MA, BA, PHN, Public Health Supervisor – Informatics, Dakota County Public Health
Representing: Local Public Health

Sarah Manney, DO, FAAP, Chief Medical Information Officer, Essentia Health
Representing: Physicians

Genevieve Melton-Meaux, MD, PhD, Senior Associate Dean, Health Informatics and Data Science, University of Minnesota
Representing: Academics and Clinical Research

Lisa Moon, PhD, RN, LHIT, LNC, CEO, Principal Consultant, Advocate Consulting, LLC
Representing: Experts in Health IT

Bradford Newton, Chief Information Officer, North Memorial Health
Representing: Health System CIOs

Charles Peterson, Chief Executive Officer, The Koble Group
Representing: Health IT Vendors

Peter Schuna, Chief Executive Officer, Pathway Health Services
Representing: Long Term and Post-Acute Care

Ashley Setala, Director of Regulation & Policy Strategy
Representing: Department of Commerce

Tarek Tomes, Commissioner
Representing: MNIT

Mary Winter, Senior EDI Analyst, PrimeWest Health
Representing: Health Care Purchasers and Employers

Members Absent

Kim Heckmann, MSN, FNP-C, SCRN, PHN, Primary Care NP Residency Program Director and APRN Educator, VA Medical Center
Representing: Nurses

Mark Jurkovich, DDS, MBA, MHI, Director of Data Infrastructure, Health Care Systems Research Network
Representing: Dentistry

Jane Pederson, MD, MS, Chief Medical Quality Officer, Stratis Health
Representing: Experts in Quality Improvement

Mathew Spaan, Manager, Care Delivery and Payment Reform
Representing: Department of Human Services

Alternates Present

Alexandra De Kesel Lofthus, Associate Director, State Strategy, Unite Us
Representing: Consumer Members

Alicia Jackson, MS, CPPM, Healthcare Analyst Principal, Blue Cross Blue Shield of Minnesota
Representing: Health Plans

Adam Stone, Vice President Services Delivery, Chief Privacy Officer, Secure Digital Solutions, Inc.
Representing: Experts in Health IT

Laura Unverzagt, MBA, Vice Chair-Information Technology, Mayo Clinic
Representing: Health System CIOs

Alternates Absent

Roxanee Pierre, MD, MHA, Medical Director/ Administrator, Eden Pathways Homecare Agency
Representing: Physicians

Tamara Winden, PhD, MBA, FHIMSS, FAMIA, Founder Principal Consultant, Winden Consulting, LLC
Representing: Academics and Clinical Research

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4/3/25

To obtain this information in a different format, call: 651-201-5979.

Appendix A

Acronyms

CAQH:	The Council for Affordable Quality Healthcare
CMS:	Centers for Medicare and Medicaid Services
DAV:	Data aggregator validation
FQHC:	Federally Qualified Health Center
HEDIS:	Healthcare Effectiveness Data and Information Set, performance measures for health care
HIE:	Health information exchange
QHIN:	Qualified Health Information Network, large health information networks that support connectivity through TEFCA
TEFCA:	Trusted Exchange Framework and Common Agreement, https://rce.sequoiaproject.org/tefca/