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August 20, 2019

Minnesota Department of Health  
Attn: Office of Health Information Technology  
P.O. Box 64882  
St. Paul, MN 55164-0882

Dear Minnesota eHealth Advisory Committee Members,

On behalf of the 32 member companies of the Electronic Health Record (EHR) Association, we are pleased to offer our comments to the Minnesota Department of Health on its Request for Input on a Connected Networks Approach.

The EHR Association is a trade organization that brings together companies that develop, market, and support electronic health records (EHRs), to collaborate on issues that impact their businesses and their collective customers—hospitals and providers that represent the majority of EHR users in the U.S. The Association speaks with a unified voice on health information and technology (IT) issues in a non-competitive, collegial effort to understand, educate, and collaborate with all stakeholders engaged with EHRs and other technologies.

EHRA members are strong proponents of health information exchange; our members have supported hundreds of thousands of providers in their effort to exchange electronic health information through the development of interoperability modules in their solutions and participation in industry frameworks such as the eHealth Exchange, CommonWell Health Alliance, and Carequality.

**Response to MDH’s Request for Input**

The EHR Association strongly agrees with MDH’s assessment of the numerous benefits of increased health information exchange and applauds MDH on its goal of promoting greater use of interoperability tools in the state—especially amongst stakeholders who may have traditionally been underserved by the health IT industry.

Health information exchange, especially across organizations using different technology suppliers’ software, has rapidly expanded within the last three years.

Millions of clinical documents containing discrete data are exchanged every day using the Consolidated Clinical Document Architecture (C-CDA) standard across state lines and across organizations using different health IT solutions. National private sector exchange collaboratives such as Carequality, CommonWell, and the eHealth Exchange have been instrumental in this expansion. They offer brokered and federated approaches with record location services built-in or made available through other parties. Through increased collaboration, common agreements, shared technical standards where needed, and synchronized governance, we have seen substantial uptake in national, cross-state, as well as local exchange of data.

Notably, these initiatives are networks of networks and build on the success that HIOs and other incumbents have already realized. Because of this, existing health information exchanges are able to connect without special effort and rapidly expand the number of organizations with which their participants can exchange health data. State health information exchanges such as CRISP (Maryland) and KHIN (Kansas), have already connected to each other using the Carequality framework. MiHIN (Michigan) is connected through CommonWell as well as a Carequality implementer. Single and multi-vendor networks have been able to connect within this network of networks. Further, because the eHealth Exchange is now a Carequality implementer, its members (such as WISHIN in Wisconsin) are able to connect to a network of networks and exchange with any other participant of any other Carequality implementer. These initiatives are now expanding to additional use cases such as scalable FHIR-based API access and event notifications.

Additionally, ONC is progressing the implementation of a trusted exchange framework under the 21<sup>st</sup> Century Cures Act. While the Cures Act allows for either development or support of such a national framework, we have urged ONC to follow Congress' intent and build on what has already been established. TEFCAs—the Trusted Exchange Framework and Common Agreement—has the opportunity to bolster and further accelerate the efforts referenced above if ONC pursues supporting existing trusted exchange frameworks (like Carequality, eHealth Exchange and CommonWell) through TEFCAs and its Recognized Coordinating Entity rather than developing a new, parallel framework.

EHR Association members understand that MDH has a requirement to ensure health information exchange happens and may establish network capabilities where there are gaps in infrastructure within the state to achieve that. Because of the proven success summarized above, the substantial progress being made, and relative low cost of leveraging existing frameworks, we recommend that MDH focus on working with these initiatives to build on existing capabilities. This will ensure not only intra-state health information exchange is enabled, but cross-state health information exchange to support regions where patients travel for their care, or patients who reside in other states for parts of the year, and opportunities to provide care via telehealth across jurisdictional boundaries.

In that context, we recommend MDH's approach be more collaborative with the aforementioned national initiatives to champion the needs of the state, and only establish state-specific infrastructure through a designated HIO where adopting a national approach is not feasible. Therefore, the EHR Association recommends the following steps:

1. Promote broad adoption of interoperable health IT amongst all providers and stakeholders identified as benefiting from improved health information exchange. This will ensure all parties are able to become participants in existing health information exchanges and exchange data with each other.
2. Incentivize connection of provider organizations and other stakeholders to the hundreds of thousands of clinicians already exchanging health information via existing networks and across networks within the Carequality framework. For example, an HIO could elect to become an eHealth Exchange participant and connect its members that way. Alternatively, if a provider organization is already connected to a Carequality implementer, it should not be required to establish a duplicative connection. For example, if a healthcare organization is connected to Carequality via the CommonWell Health Alliance, it should not also be required to connect via the eHealth Exchange. That organization would already have the capability to exchange with all entities connected to the eHealth Exchange.
3. Leverage and build on national initiatives, such as Carequality, CommonWell, the eHealth Exchange, and ONC's TEFCA efforts to meet the needs identified for the proposed designated HIO, rather than building a state-specific implementation.

The EHR Association applauds MDH's focus on improving interoperability in Minnesota, and we share its vision for the numerous improvements to healthcare increased health information exchange promises. As you continue to refine your approach, we are happy to be ongoing partners with MDH in determining the best path forward. Please contact Sarah Willis-Garcia, EHRA Program Manager, at [swillis@ehra.org](mailto:swillis@ehra.org) or 312-915-9518 with questions or for more information.

Sincerely,



Cherie Holmes-Henry  
Chair, EHR Association  
NextGen Healthcare



Hans J. Buitendijk  
Vice Chair, EHR Association  
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**About the EHR Association**

Established in 2004, the Electronic Health Record (EHR) Association is comprised of more than 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit [www.ehra.org](http://www.ehra.org).