September 10, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted electronically at: www.regulations.gov
Attention: CMS-1693-P

Centers for Medicare and Medicaid Services:

Thank you for the opportunity to provide a response to CMS-1693-P. The Minnesota e-Health Initiative is pleased to submit comments focused on two sections: 1) Proposed Advancing Care Information Performance Category and 2) Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare and Medicaid-Participating Providers and Suppliers. Our response reused and updated community input from CMS-1694-P response earlier this year.

We appreciate the work done to date by CMS to advance e-health to improve individual and population health. The Minnesota e-Health Initiative recognizes the value in advancing effective use and interoperability across the care continuum. 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.

Please contact Kari Guida, Senior Health Informatician, Office of Health Information Technology, Minnesota Department of Health at kari.guida@state.mn.use with any questions.

Sincerely,

Jennifer Fritz
Director, Office of Health Information Technology & e-Health
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 System

Minnesota e-Health Initiative Statewide Coordinated Response to 2019 IPPS Proposed Rule

Minnesota e-Health Initiative

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 stakeholder collaboration. More information on the Minnesota e-Health Initiative is at http://www.health.state.mn.us/e-health.

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 to 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 Bobbie McAdam, Vice President, Information Technology, Medica.

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 meetings, analyze and interpret data, and summarize findings that help support e-health policy development.

Statewide Coordinated Response Approach

This Minnesota e-Health statewide coordinated response to the request for public comment reused and updated community input from CMS-1694-P coordinated response earlier this year. This includes input from multiple stakeholders, including the Advisory Committee and workgroups. During the CMS-1694-P response, representatives from Minnesota health and health care providers and health care systems were encouraged to submit written comments and/or participate in one conference call hosted by MDH-OHIT. Comments were collected, summarized and reviewed.

Comments and Recommendations on the Proposed Changes to Medicare and Medicaid EHR Incentive Programs

Overall Comments

1. We applaud the effort to align the various federal programs. We strongly encourage ongoing resources for states and providers, and actions by federal programs and partners, to harmonize the federal programs' objectives, measures, and workflow implications for providers and states.
2. We encourage the measurement requirements to focus not only on effective sharing of health information, but also the effective use of the information by individuals, communities, and providers across the health care continuum.
3. We recommend that CMS clarify as soon as possible if PDMP could be a public health registry as now it is a measure under e-prescribing. This is important as states continue to implement many interventions and strategies in response to opioid misuse and overdose.

Specific Comments and Recommendations

Renaming Advancing Care Information Performance Category to Promoting Interoperability Performance Category

Comment

The new title is based on the assumption that providers have achieved optimal/effective/meaningful use of EHRs. This assumption is incorrect. All providers and states still struggle to achieve effective use. The opioid epidemic is one of many example of how effective use of EHRs has not been achieved.

Recommendation

We recommend a name more reflective of the current status and need such as "Advancing effective use and interoperability".

Certification Requirements Beginning in 2019

Comment

We agree with this proposed continuation of flexibility to use either 2014 or 2015 Edition in 2018. There is support for moving to the 2015 Edition but concern about the EHR vendor backlog and the 18+ months to implement EHR updates and versions. We are concerned that those providers not yet using or close to updating to 2015 Edition may not make the deadline.

Recommendation

We support a hardship option for providers, particularly independent, small, and rural providers, in queue for the 2015 Edition for 2019 and 2020.

Security Risk Analysis

Comment

The risk assessment is important but the action taken in response to the findings is very important. To truly see change, there needs to be focus on mitigation/addressing gaps and findings

Recommendation

We recommend looking at measures, tools, and resources focused on the outcomes/actions in response to the risk analysis.

E-Prescribing Measure

Comment

There is a lot of confusion on what can and cannot be e-prescribed and how to track e-prescribing.

Recommendation

We recommend CMS and partners provide clarity on the e-prescribing measure to assure providers understand what exactly is being measured such as non-controlled vs all prescriptions.

We support a measure for e-prescribing of all controlled substances going into effect by 2020 or later.

We recommend the federal government provide resources for prescribers to implement EPCS AND clinical decision support to improve/benefit all prescribing practices.

Query of Prescription Drug Monitoring Program Measure

Comment

We support the use of medication and prescription information through the PDMP or other means but there are many concerns about the use of the PDMP and vendor monopoly due to proprietary interface. Some of these issues, as well as other ways to use e-health to prevent and respond to the opioid epidemic, were addressed in the Minnesota e-Health Advisory Committee's recommendation to Minnesota's Governor Mark Dayton. These recommendations are in Appendix A and should be reviewed.

Recommendation

We see a positive benefit to the PDMP as a public health registry and recommend that CMS clarify this as an alternative for states to pursue. Also, state if providers can get points for both the PDMP measure and public health registry when querying the PDMP.

We recommend that CMS and partners identify and implement strategies to assure affordable, effective and seamless use of PDMPs by prescribers and dispensers from the electronic health record, integrating into health information exchange services with full implementation of clinical guidelines and clinical decision support and access to other states' PDMPs information.

We recommend CMS and partners work to assure stakeholder input and oversight, representative governance, regulatory authority, and funding of the PDMPs to support alignment with state and federal requirements and standards, to improve data quality and usability, to support patient consent and privacy, and to meet workforce-training needs.

We recommend CMS and federal partners work to prevent/eliminate a monopolistic PDMP solution by requiring interfaces using standards such as NCPDP 2017, two-way interoperability with certified EHRs, and vendor competition to improve functionality and contain costs.

We recommend CMS and partners work to ensure that state and federal agencies, tribal governments, academia, local public health, payers, and other partners are able to appropriately access and analyze PDMP information for improved prevention, response, and care while safeguarding patient privacy. Transparent processes and principles should developed with input from stakeholders to guide access to the PDMP data. Potential data uses should include, but are not limited to:

1. Identify geographic areas and populations showing indicators of misuse and abuse to better target resources for prevention, response, and coordinated care, treatment, and services.
2. Ensure more timely and accurate responses to misuse and overdoses by leveraging other data sources such as overdose, toxicology, and drug seizure reports; medical examiner/coroner data; payer claims; poison control reports; and birth and death records.
3. Support the development and use of advanced clinical decision support and clinical guidelines to flag suspicious behavior and/or patterns and identify individuals at risk for opioid misuse at the point of care and beyond.
4. Identify critical needs for training and best practices for prescribers, dispensers and other providers such as emergency medical services and local public health.

Verify Opioid Treatment Agreement Measure

Comments

This is a very difficult, multi-step process that has conflicting data on its effectiveness. There may be technical solutions to support this but these are years away.

Recommendation

We recommend this measure not be included and instead allow providers to focus on implementing EPCS, understanding and using dosing/weaning recommendations , and expanding the use of telemedicine for those misusing opioids.

We also recommend reviewing the Minnesota e-Health Advisory Committee's recommendation on using e-health to prevent and respond to opioid misuse and overdose (Appendix A).

Support Electronic Referral Loops by Sending Health Information Measure

Comment

The proposed focus of the measure appears to be achieving interoperability through provider to provider exchange to reduce burden. However, we would caution that setting up or implying the setting up of point to point exchange may actually add burden. We see great benefit in the

sharing of information especially in the case of specialists returning information to the primacy providers.

Recommendation

We recommend CMS and federal partners take action to achieve interoperability between all providers in the care continuum, and review the full 2018 Minnesota HIE Study report (http://www.health.state.mn.us/e-health/hie/study/hie-study-report-2018.pdf) or fact sheet in Appendix B.

Removal of Request/Accept Summary of Care Measure and Clinical Information Reconciliation Measure

Comment

We support the removal of these measures to combine the two into the measure for receiving and incorporating health information.

Support Electronic Referral Loops by Receiving and Incorporating Health Information

Recommendation

We recommend that if Direct Secure Messaging is the preferred transport method, that HIE services for transforming the PDF into a clinical message be required to incorporate the health information. Alternative interoperability transport methods could also be encouraged.

Provider to Patient Access to Their Health Information Measure

Comment

There are a lot of questions and concerns around this measure including: making providers vulnerable, access to entire record, need for trust and technical agreements, and lack of streamlined process to accomplish this activity. There are a lot of legal aspects to be considered and addressed to assure alignment.

Recommendation

We recommend reviewing this measure to identify the value to providers and patients as well as ensuring the process is not burdensome to providers.

Public Health and Clinical Data Exchange

Comment

Comprehensive, bi-directional public health supports the health and wellness of the entire country. Without national consistency as supported by having required public health reporting, the ability to prevent and respond to epidemics will decrease while becoming less effective and efficient.

Recommendation

We see a positive benefit to the PDMP as a public health registry and recommend that CMS clarify this as an alternative for states to pursue. Also, state if providers can get points for both the PDMP measure and public health registry when querying the PDMP.

We recommend CMS and partners identify additional strategies and resources to create interoperability (bi-directionality) between providers and public health to improve provider and patient's ability to make well-informed decisions.

We do not support the removal of the public health measures in 2022. Public health and the public's health benefits from electronic reporting. Public health and its partners cannot afford to continue to collect information in many formats.

Support Electronic Referral Loops by Sending Health Information Across the Care Continuum & Support Electronic Referral Loops by Sending Health Information Across the Care Continuum

Comment

The summary of care record has too much information and not the right information.

Recommendation

We recommend more work to address the amount and type of information exchanged for these potential new measures.

We also recommend identifying strategies to engage all providers across the care continuum including behavioral health, dental health, local public health, long-term and post-acute care, and social services.

Finally, we encourage the option for providers to utilize the consolidation services of an entity to obtain more pertinent and useful summary of care information for their patients, and incorporate the information into their EHR and/or workflow.

RFI Promoting Interoperability and Electronic Health care Information Exchange

1. If CMS were to propose a new CoP/CfC/RfP standard to require electronic exchange of medically necessary information, would this help to reduce information blocking as defined in section 4004 of the 21st Century Cures Act?

    a. Until there is enforcement behind the policy to prevent information blocking, this strategy may not be helpful.

2. Should CMS propose new CoPs/CfCs/RfPs for hospitals and other participating providers and suppliers to ensure a patient's or resident's (or his or her caregiver's or representative's) right and ability to electronically access his or her health information without undue burden?

   a. There are a lot of questions and concerns around APIs including making providers vulnerable, access to entire record, need for trust and technical agreements, and lack of streamlined process to accomplish this activity. Also, is this policy being pushed with the hope that legal catches up?

3. Would existing portals or other electronic means currently in use by many hospitals satisfy such a requirement regarding patient/resident access as well as interoperability?

   a. Currently, patients are expected to manage multiple portals. A patient centered data home may be an option for individual/caregiver access to a consolidated and longitudinal health record. Querying for this may also ease the provider burden by not looking through so many documents received through a query and response only format.

4. Are new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information necessary to ensure patients/residents and their treating providers routinely receive relevant electronic health information from hospitals on a timely basis or will this be achieved in the next few years through existing Medicare and Medicaid policies, HIPAA, and implementation of relevant policies in the 21st Century Cures Act?

   a. Advancing electronic exchange of health information is important, however it would be helpful to focus beyond the sharing of information to the effective use of the information shared.

5. What would be a reasonable implementation timeframe for compliance with new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information if CMS were to propose and finalize such requirements?

   a. Similar to above comments regarding the use of 2015 CEHRT by 2019, it is suggested to allow exclusions for those providers still in the cue with vendors to implement compliance requirements.

6. Should these requirements have delayed implementation dates for specific participating providers and suppliers, or types of participating providers and suppliers (for example, participating providers and suppliers that are not eligible for the Medicare and Medicaid EHR Incentive Programs)?

   a. Providers that have not been eligible for EHR Incentive programs are not as ready to implement some of these requirements.

7. Do stakeholders believe that new or revised CMS CoPs/CfCs/RfPs for interoperability and electronic exchange of health information would help improve routine electronic transfer of health information as well as overall patient/resident care and safety?

a. Yes. As described in the Minnesota HIE Study (http://www.health.state.mn.us/e-health/hie/study/index.html) published in April 2018, exchanging health information for transitions of care is encouraged to improve patient care, reduce costs, and improve quality of care, including patient safety.

8. Under new or revised CoPs/CfCs/RfPs, should non-electronic forms of sharing medically necessary information (for example, printed copies of patient/resident discharge/transfer summaries shared directly with the patient/resident or with the receiving provider or supplier, either directly transferred with the patient/resident or by mail or fax to the receiving provider or supplier) be permitted to continue if the receiving provider, supplier, or patient/resident cannot receive the information electronically?

   Providers commented on the burden of receiving multiple duplicative information from electronic and faxed sources for the same individual, suggesting the use of faxing be quickly discontinued as electronic exchange begins, or only fax if information is missing rather than sending both formats of information. Providers don't want duplicate information format but in many situations, the faxed information is better as the content is not great in the summary of care, as we stated above.

9. Are there any other operational or legal considerations (for example, HIPAA), obstacles, or barriers that hospitals and other providers and suppliers would face in implementing changes to meet new or revised interoperability and health information exchange requirements under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?

   a. No comment

10. What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future?

    a. Suggest allowing exceptions for providers who are in the queue with a vendor for implementing the requirements.

11. Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements?

    a. Yes.

12. Would extending such exceptions impact the effectiveness of these requirements?

    a. Yes. Consider organization exceptions for a limited term basis.

13. CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients.

    a. More information is needed to understand the nuances of the MyHealthEData. Identifying what specific capabilities would be required for the user would be helpful, so there is a base level of expected services. The discussion would benefit from playing out various scenarios or use cases particularly around mental health and substance abuse diagnoses.

14. We also welcome the public's ideas and innovative thoughts on addressing these barriers and ultimately removing or reducing them in an effective way, specifically through revisions to the current CMS CoPs, CfCs, and RfPs for hospitals and other participating providers and suppliers.

    a. Based on the Minnesota HIE Study, described above, MDH has convened an HIE Task Force to address these barriers and identify an implementation plan for transitions of care, event alerting, and a five year plan for governance, authority and financing. Updates of their work can be found at: http://www.health.state.mn.us/e-health/hie/taskforce/index.html

15. We would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well. (including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers)

    a. As an implementation plan for sharing and using information among all providers is identified, providers not eligible for EHR Incentive Programs, such as LTC, LPH, Behavioral Health, and Social Services, are requesting financial incentives to exchange information with those who are eligible. Although some states have used 90/10 funding for this purpose, providers are also looking for trust that the direction of what and how information is shared will not be changed again in the near future.

Appendix A: Opioids and e-Health Report: A Summary of the 2017 Minnesota e-Health Advisory Committee's Opioids and e-Health Recommendations

Opioids and e-Health Report

A SUMMARY OF THE 2017 MINNESOTA E-HEALTH ADVISORY COMMITTEE'S OPIOIDS AND E-HEALTH RECOMMENDATIONS

Introduction

In response to the opioid epidemic, Governor Dayton requested the Minnesota e-Health Advisory Committee provide a set of recommendations for using e-health to prevent and respond to opioid misuse and overdose. The advisory committee, with input from the Opioids and e-Health Steering Team and Minnesota Department of Health, Office of Health Information Technology (OHIT), developed seven recommendations. The advisory committee believes implementation of the recommendations can have a significant impact on mitigating the opioid epidemic. OHIT developed this report to summarize the approach, recommendations and next steps of the advisory committee's work on opioids and e-health.

Approach

The approach initially focused on the collection, use, and sharing of information necessary for the electronic prescribing of controlled substances (Figure 1) as requested by the advisory committee. With the request from Governor Dayton and input from the community, the scope was broadened to include additional uses of e-health to prevent and respond to opioid misuse and overdose. The following activities were critical to the development of the recommendations and building greater understanding of using e-health to prevent and respond to the opioid epidemic.

Minnesota Environmental Scan

Prescribers, payers, pharmacies and state agencies provided information and perspectives regarding the electronic health care information needed to address the opioid epidemic. The interviews focused on two areas including:

16. Whether and how such information is or could be exchanged via the types of data exchange subject to MN 62J.536 and 62J.495-4982; and
17. Any possible issues or constraints associated with the standard, electronic exchange or use of information needed to address the epidemic and how they might be addressed.

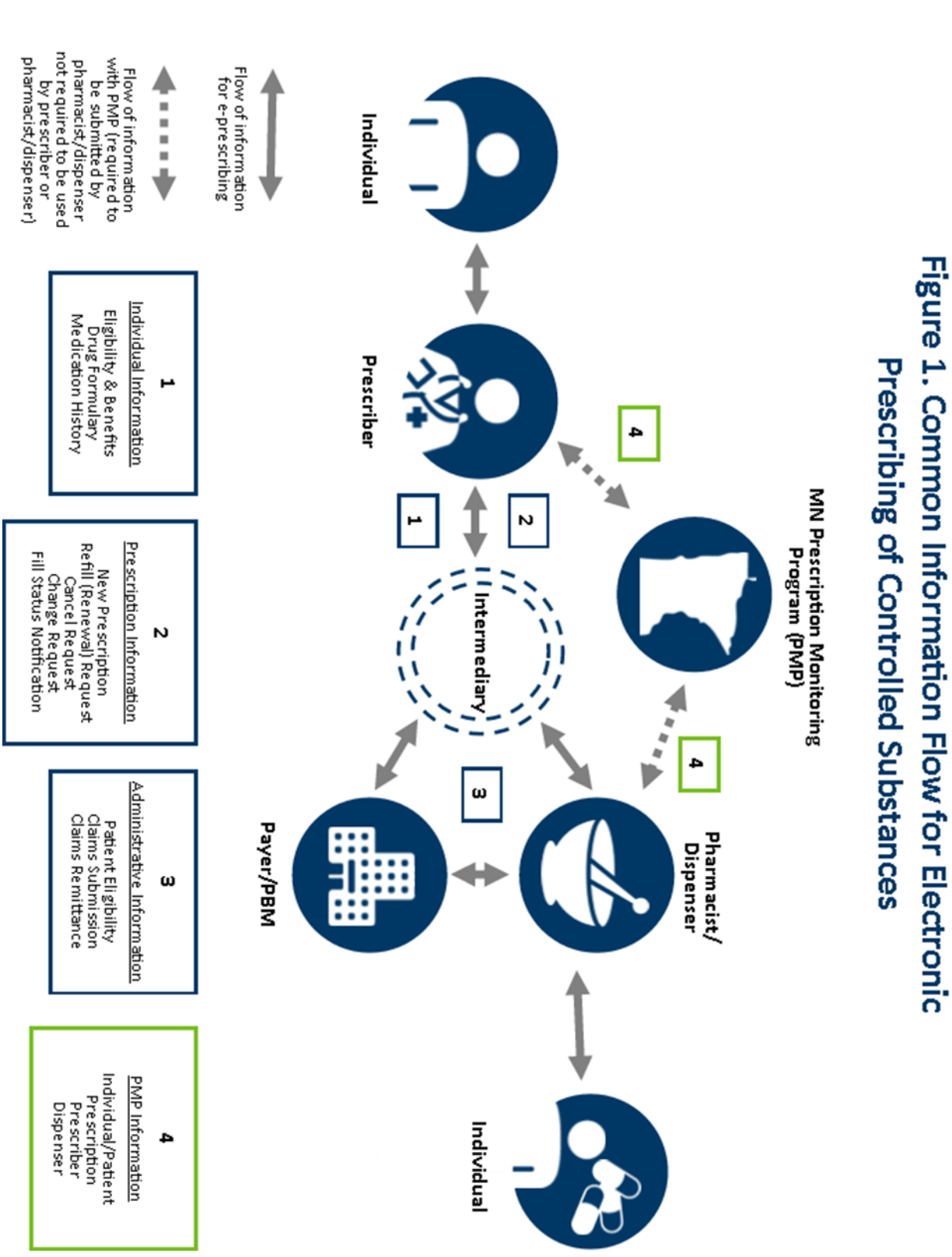


Figure 1. Common Information Flow for Electronic Prescribing of Controlled Substances
MN Prescription Monitoring Program (PMP)
Individual
Prescriber
Intermediary
Pharmacist/ Dispenser
Payer/PBM
Individual
1
2
3
4
Flow of information for e-prescribing
Flow of information with PMP (required to be submitted by pharmacist/dispenser not required to be used by prescriber or pharmacist/dispenser)
1 Individual Information
Eligibility & Benefits
Drug Formulary
Medication History
2 Prescription Information
New Prescription
Refill (Renewal) Request
Cancel Request
Change Request
Fill Status Notification
3 Administrative Information
Patient Eligibility
Claims Submission
Claims Remittance
4 PMP Information
Individual/Patient
Prescription
Prescriber
Dispenser

Engaging Partners and Collecting Input during the Minnesota e-Health Summit

During the 2017 Minnesota e-Health Summit's, 'Leveraging e-Health to Prevent and Respond to Opioid Misuse and Overdose' session approximately 30 participants from across the care continuum shared feedback on:

- Preferred/recommended data sources;
- How information can best be provided/communicated via standard, electronic health business transactions and electronic health records;
- How electronic health data can be leveraged to help address the opioid epidemic;
- Key obstacles/challenges to providing/communicating the needed information; and
- Changes/solutions needed to address the challenges/obstacles.

Nationwide Scan of Strategies Implemented by States to Address Opioid Epidemic

The scan obtained information about other states' legislative and policy strategies for addressing the epidemic. Key words used in the review included: "opioids," "EPCS" (electronic prescribing of controlled substances), "prescription monitoring program/prescription drug monitoring program," (PMP/PDMP) "medical cannabis," and "individual/patient education."

Opioids and e-Health Steering Team

The Opioids and e-Health Steering Team provided input to the Advisory Committee on recommendations and strategies for using e-health to prevent and respond to opioid misuse and overdose. The participants of the Steering Team included experts in prescribing and dispensing controlled substances, e-prescribing controlled substances, and the Minnesota Prescription Monitoring Program. The Steering Team met twice and shared their perspectives and experiences during numerous advisory committee and public meetings.

Recommendations

The advisory committee believes implementation of the following recommendations can have a significant impact on mitigating the opioid epidemic.

The advisory committee recommends that:

1. By July 2018, the Minnesota Legislature should provide resources to fully implement and ensure compliance with Minnesota Statutes Section 62J.497 including a focus on increasing the rate of e-prescribing of controlled substances from approximately 20 percent (Surescripts 2016 National Progress Report) to over 80 percent by 2020. Implementation of this recommendation should occur with input from the Minnesota e-Health Advisory Committee to:
    a. Provide or ensure statewide education and technical assistance on electronic prescribing (e-prescribing) of controlled substances.

b. Support full-implementation of all e-prescribing related transactions in the nationally recognized National Council for Prescription Drug Programs Standards (NCPDP), including electronic prior authorization and Formulary and Benefits.
c. Provide grants to increase the rate of e-prescribing of controlled substances. Grantees include, but are not limited to, prescribers that serve rural or underserved populations; prescribers that have small, independent practices; and other providers needing support such as dentists.
d. Support the use of evidence-based clinical guidelines and clinical decision support.
e. Monitor the status of e-prescribing, specifically for controlled substances, and assess the barriers to e-prescribing of controlled substances.
f. Develop and implement policy options including rulemaking and enforcement for non-compliance of e-prescribing as needed, if goals are not met.

2. By January 2019, the Minnesota Board of Pharmacy, with input from the Minnesota e-Health Advisory Committee, health and health care provider associations, and other stakeholders, should develop requirements and an implementation plan to improve the Prescription Monitoring Program (PMP). The requirements and implementation plan should include use cases and policies for the required use of the PMP. The implementation plan should:
    a. Address affordable, effective and seamless use of the PMP by prescribers and dispensers through the EHR, other HIT, and integration into Minnesota's HIE and include full implementation of clinical guidelines and clinical decision support and access to other states' PMP information.
    b. Improve stakeholder input and oversight, representative governance, regulatory authority, and funding of the PMP to support alignment with state and federal requirements and standards, improve data quality and usability, support patient consent and privacy, and meet workforce-training needs.

    The Governor and Legislature should appropriate funds for the development and implementation of the requirements and implementation plan to improve the PMP.

3. By July 2018, the Minnesota Legislature should amend Minnesota Statutes, Section 152.126 to expand the permitted uses of Prescription Monitoring Program data. The updated language should ensure that state and federal agencies, tribal governments, academia, local public health, payers, and other partners are able to appropriately access and analyze information for improved prevention, response, and care while safeguarding patient privacy in accordance with state and federal law. Transparent processes and principles developed by the Board of Pharmacy with input from the Minnesota e-Health Advisory Committee and other stakeholders should guide access to

the Prescription Monitoring Program data. Potential data uses should include, but are not limited to:

a. Identify geographic areas and populations showing indicators of misuse and abuse to better target resources for prevention, response, and coordinated care, treatment, and services.
b. Ensure more timely and accurate responses to misuse and overdoses by leveraging other data sources such as overdose, toxicology, and drug seizure reports; medical examiner/coroner data; payer claims; poison control reports; and birth and death records.
c. Support the development and use of advanced clinical decision support and clinical guidelines to flag suspicious behavior and/or patterns and identify individuals at risk for opioid misuse at the point of care and beyond.
d. Identify critical needs for training and best practices for prescribers, dispensers and other providers such as emergency medical services and local public health.

The Governor and Legislature should appropriate funds to support the expanded uses of the Prescription Monitoring Programs data, and develop and implement the transparent processes and principles to guide access to data.

4. State agencies and associations should, by September 2018, review, update, and provide education on e-health and opioids policies and guidelines to ensure dispensers, prescribers, payers, and other providers, including the care team, have appropriate and timely access to health information, can subsequently share information, and understand their scope of action related to the information. Use cases should include, but are not limited to, instances when prescribing and dispensing practices are outside nationally recognized clinical guidelines, such as those published by the Centers for Disease Control and Prevention and the U.S. Food and Drug Administration, and individuals are at-risk for misuse and abuse.

5. The Governor, by July 2018, should ensure access and coverage for all Minnesotans and providers, and provide resources for grants and technical assistance, to expand access to services and care enabled by telehealth, telemedicine and other forms of virtual technology to fill access gaps in opioid tapering and withdrawal, chemical dependency, mental health, and alternative pain treatment and services.

6. The Governor should support state agencies and stakeholders in participating in statewide coordinated HIE services. The support should be consistent with the findings of Minnesota Health Information Exchange Study, which will be submitted to the Legislature in February of 2018, align with input from the Minnesota e-Health Advisory

Committee, ensure providers and public health have access to information to support individual and community health services, and support:

a. Alerts for emergency services, urgent care, and other medical visits relating to substance misuse and overdose.
b. Referrals to substance abuse treatment and community services.
c. Access to patient health history including medication lists.

7. The Minnesota Department of Health, by December 2018, should submit to the Governor and the Legislature an update to their informatics profile that assesses the gaps in current information and information systems used to prevent and respond to substance misuse and overdose and identify resources needed to fill those gaps. The Governor and Legislature should appropriate funds to ensure those needs are met.

The advisory committee also recognized that mitigating the opioid epidemic goes beyond e-health. There is a need for better access to and coverage for health services, specifically opioid tapering and withdrawal, chemical dependency, mental health and alternative pain treatment and services. Therefore, they also recommend the Governor work to ensure all Minnesotans have access to the treatment and services needed to achieve health and wellbeing.

Next Steps

The advisory committee and its stakeholders will continue to prioritize work to mitigate the opioid epidemic. In the coming months, it will move forward with the findings of the legislatively mandated study on HIE, which improves the seamless flow of information to prescribers and dispensers. It will continue to monitor and provide input into state and national activities regarding e-prescribing of controlled substances, Prescription Monitoring Program, and related issues.

Appendix B: Health Information Exchange (HIE) Study Fact Sheet (April 2018)

Health Information Exchange (HIE) Study

APRIL 2018

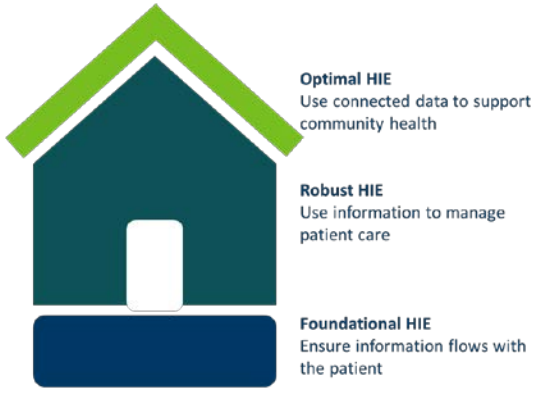
HIE study conducted in response to opportunities to improve health care system in Minnesota

The 2016 Minnesota Legislature directed MDH to assess Minnesota's legal, financial, and regulatory framework for HIE, including the requirements in Minnesota Statutes, Sections 144.291 to 144.298 (the Minnesota Health Records Act), and to recommend modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable. The report is available at: http://www.health.state.mn.us/e-health/hie/study/index.html

Health information exchange presents opportunities to improve individual and community health

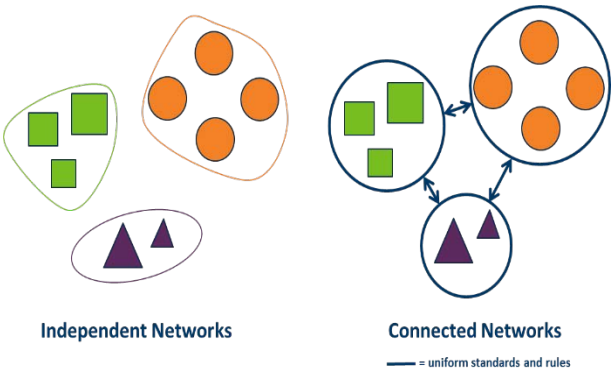
Health Information Exchange (HIE) is the electronic flow of health information between a patient's health care providers. Statewide HIE is critical for providing safe, efficient, effective, coordinated patient care.

Minnesota has made progress on HIE, but it is not yet occurring equitably or robustly across the state. This means that access to health care information for many Minnesotans continues to be inefficient and fragmented when they visit multiple providers or health systems. To have effective HIE, every health organization needs to participate, so that every person's information is more easily available when and where it is needed to better serve them.



This assessment identified three important uses for HIE that can greatly and favorably impact individual and community health. Minnesota needs to establish foundational HIE across all providers in the state to ensure that a person's entire care team is connected for transitions of care, referrals and ongoing coordination with a person's care team.

In Minnesota, quite a lot of HIE is happening, within individual health systems and health information networks. However, many of the networks are not efficiently connected to each other, which means that even foundational HIE is not consistently happening for every patient. Achieving higher levels of HIE will require moving toward a concept of "connected HIE networks," which means that each of these networks has a connection to each other network



and all can exchange clinical information with each other using uniform standards and rules. Any organization that participates with any of those networks is then securely connected to all of the organizations participating in any of the networks.

Recommendations to develop connected networks model

The primary recommendation, based on this study's findings, is to move Minnesota in the direction of a connected networks model that will provide essential HIE services accessible to all stakeholders statewide, and to align with and build upon national initiatives. To achieve this, the assessment, with endorsement from the Minnesota e-Health Advisory Committee, recommends:

1. The Minnesota Legislature should modify the Minnesota Health Records Act to align with HIPAA for disclosure purposes only while maintaining key provisions to ensure patient control of information and to support HIE.
2. MDH should establish a HIE task force of the e-Health Advisory Committee to develop strategic and implementation plans (including rules of the road) for the connected networks model by focusing on actions and policies to: expand exchange of clinical information to support care transitions between organizations that use Epic and those that do not; expand event alerting (for admission, discharge, and transfer) to support effective care coordination; and identify, prioritize and scope needs for ongoing connected networks and HIE services with the goal of optimal HIE.
3. The MN Legislature should act on the recommendations of the e-Health Initiative's HIE task force, which are expected to include: updating Minnesota's Health Information Exchange Oversight law to support the coordinated networks concept; and appropriating funds to help providers connect to HIE services and develop ongoing coordinated HIE services.