

January 28, 2019

Office of the National Coordinator for Health Information Technology

U.S. Department of Health and Human Services

Submitted electronically at: <https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs>.

Attention: Public Comment on draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Office of the National Coordinator for Health IT:

Thank you for the opportunity to provide input on the draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. The Minnesota e-Health Initiative (Initiative) is pleased to submit comments as a public-private collaborative focused on advancing the adoption and use of electronic health records and other health information technology, including health information exchange. A legislatively authorized 25-member advisory committee guides the Initiative. Review Appendix A for list of advisory committee members. The Minnesota Department of Health, Office of Health Information Technology, coordinates activities of the Initiative.

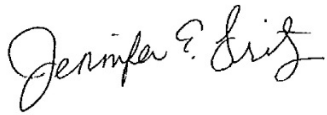
The advisory committee recognizes the need to reduce health care provider burden. We applaud your focus on 1) Clinical Documentation; 2) Health IT Usability and the User Experience; 3) EHR Reporting; and 4) Public Health Reporting. These areas are important areas, but the recommendations are lacking in sufficient detail to make and measure progress. Additional detail on prioritization, timelines, and accountability of the work is necessary. Without this information, HHS and partners cannot reduce provider burden. Therefore, we strongly recommend prioritizing a few recommendations and focus on fully implementing and measuring progress in those areas.

Based on the work and input of the Initiative, we recommend the following six recommendations for prioritization:

- Clinical Documentation, Strategy 1, Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.
- Clinical Documentation, Strategy 1, Recommendation 2: Leverage data already present in the EHR to reduce re-documentation in the clinical note.
- Clinical Documentation, Strategy 3, Recommendation 1: Evaluate and address the other process and clinical factors contributing to burden associated with prior authorization.
- Health IT Usability and the User Experience, Strategy 4, Recommendation 4: Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.
- Public Health Reporting, Strategy 1, Recommendation 1: Federal agencies, in partnership with states, should improve interoperability between health IT and PDMPs through the adoption of common industry standards consistent with ONC and CMS policies and the HIPAA Privacy and Security Rules.
- Public Health Reporting, Strategy 1, Recommendation 2: HHS should increase adoption of electronic prescribing of controlled substances with access to medication history to better inform appropriate prescribing of controlled substances.

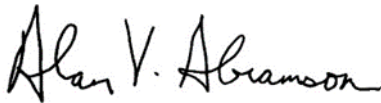
MINNESOTA E-HEALTH INITIATIVE COORDINATED RESPONSE TO DRAFT
STRATEGY ON REDUCING REGULATORY AND ADMINISTRATIVE BURDEN

Please consider the following comments and recommendations related to the draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs. They are developed from input from across Minnesota and from ongoing and previous work of the Initiative. Contact Kari Guida, Senior Health Informatician, Office of Health Information Technology, Minnesota Department of Health at kari.guida@state.mn.us with any questions.

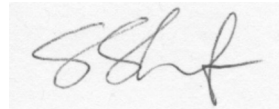


Sincerely,

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



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MINNESOTA E-HEALTH INITIATIVE COORDINATED RESPONSE TO DRAFT STRATEGY ON REDUCING REGULATORY AND ADMINISTRATIVE BURDEN

Clinical Documentation

Clinical Documentation Strategy	Recommendation	Minnesota Comments and Recommendations
<p>Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.</p>	<p>Recommendation 1: Continue to reduce overall regulatory burden around documentation of patient encounters.</p>	<p>We support this recommendation. Much of provider documentation is used to justify the level of service. This documentation impedes efficient storage and retrieval of patient information. In addition, statements in the documentation may be misleading/confusing to patients and their caregivers that can result in follow-up communication and/or using appointment time to address. Finally, some providers need scribes to assist with the documentation (billing and eQMs) to assure providing person-centered care. This has/can lead to providers feeling the need to see more patients to cover the cost of the scribe, which can be charged to the provider by the system.</p> <p>We would recommend strategies to support the EHR pulling forward all the previous notes about the presenting problem and allow the provider to document changes. This would assure the note is complete without having to repeat everything in the previous notes. A note with complete documentation is necessary to understand the patient status.</p> <p>We recommend that HHS identify and implement policy levers and strategies for other payers to reduce documentation to meet billing requirements.</p> <p>We recommend that HHS partner with current CMO groups and other clinical stakeholders to identify documentation requirements and workflow.</p> <p>Finally, some noted that although the CMS rules reducing the requirements for common “evaluation and management” physician services, seems like burden reduction, there is still documentation and at a potential lower reimbursement rate.</p>

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Clinical Documentation

Clinical Documentation Strategy	Recommendation	Minnesota Comments and Recommendations
Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.	Recommendation 2: Leverage data already present in the EHR to reduce re-documentation in the clinical note.	<p>We support this recommendation.</p> <p>We would recommend strategies to support the EHR pulling forward all the previous notes about the presenting problem and allow the provider to document changes. This would assure the note is complete without having to repeat everything in the previous notes. A note with complete documentation is necessary to understand the patient status.</p> <p>We recommend that HHS identify and implement policy levers and strategies for other payers to reduce re-documentation.</p> <p>We recommend that HHS partner with current CMO groups and other clinical stakeholders to identify documentation requirements and workflow.</p>
Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.	Recommendation 3: Obtain ongoing stakeholder input about updates to documentation requirements.	We recommend including public health, research, CMO groups, and consumer perspectives on the representative task force to assure that the needed information is person-centered and available and useable to all across the care continuum.
Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.	Recommendation 4: Waive documentation requirements as may be necessary for purposes of testing or administering APMs.	We support this recommendation and recommend providing more information on the results of the pilot program to reduce medical review burden for certain APM participants.
Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.	Recommendation 1: Partner with clinical stakeholders to promote clinical documentation best practices.	We support this recommendation and recommend considering public health, CMO groups, research, and consumer perspectives when developing and promoting best practices as this may reduce follow-up and additional communication or documentation requests.

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<p>Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.</p>	<p>Recommendation 2: Advance best practices for reducing documentation burden through learning curricula included in CMS Technical Assistance and models.</p>	<p>We support providers having access to technical assistance and training. We are concerned about how to address the numerous EHRs in use and associated workflows.</p>
<p>Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.</p>	<p>Recommendation 1: Evaluate and address other process and clinical workflow factors contributing to burden associated with prior authorization.</p>	<p>We support this recommendation and suggest including language to assure adherence to nationally recognized standards such as NCPDP SCRIPT. Prior authorizations can be very challenging and time-consuming. Minnesota prescribers continually find that the prior authorization process is not using the most up-to-date information from payers nor is it real time. This is a barrier to patients getting their medication in a timely manner. The 2017 AMA Prior authorization Physician Survey (https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf) noted that 92% of physicians report care delays associated with prior authorizations.</p>
<p>Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.</p>	<p>Recommendation 2: Support automation of ordering and prior authorization processes for medical services and equipment through adoption of standardized templates, data elements, and real-time standards-based electronic transactions between providers, suppliers, and payers.</p>	<p>We support this recommendation. According to an article in Healthcare Finance (https://www.healthcarefinancenews.com/news/want-rid-healthcare-fax-machines-first-standardize-prior-authorization), \$6.84 per transaction could be saved using fully implemented electronic prior authorizations. There is an estimated 77 million manual prior authorizations each year.</p> <p>We also recommend consider the ordering of less “traditional” services and equipment such as those to address social determinant of health including but not limited to transportation, affordable food sources, shelter, and state and federal benefit programs.</p>

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Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.	Recommendation 3: Incentivize adoption of technology which can generate and exchange standardized data supporting documentation needs for ordering and prior authorization processes.	We support this recommendation but want to assure sufficient resources are provided for developing and supporting training and implementation plans. This can avoid the unintended consequences technology adoption without the necessary training and planning.
Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.	Recommendation 4: Work with payers and other intermediary entities to support pilots for standardized electronic ordering of services.	We support this recommendation and encourage that the pilots include/consider large systems, small systems, independent/small providers, and dental and mental health providers. We also note it is important for payers and other intermediaries provide accurate and real time information to providers.
Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.	Recommendation 5: Coordinate efforts to advance new standard approaches supporting prior authorization.	We support this recommendation but also recommend focus on improving/leveraging X12EDI while looking at new approaches to supporting prior authorization. According to an article in Healthcare Finance (https://www.healthcarefinancenews.com/news/want-rid-healthcare-fax-machines-first-standardize-prior-authorization), \$6.84 per transaction could be saved using fully implemented electronic prior authorizations. There is an estimated 77 million manual prior authorizations each year.

Additional Comments relating to Clinical Documentation:

We recommend that any providers in a shared risk program with a payer should be exempt from prior authorizations for medications as those providers are at risk for excessive high-cost medication use.

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Health IT Usability and the User Experience		
Health IT Usability and the User Experience Strategy	Recommendation	Minnesota Comments and Recommendations
<p>Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.</p>	<p>Recommendation 1: Better align EHR system design with real-world clinical workflow.</p>	<p>We support this recommendation but have three identified challenges. First, often the individual purchasing the EHR is not the individual who will use it unless it is a small practice. Second, individuals in small practices each work in very different environments (mental vs. dental) therefore each have different requirements and workflows which do not translate well from one to another. Third, individuals in small practices do not have the time to participate in many user centered design sessions.</p> <p>We also recommend studies/research or funding studies/research to better understand the usability needs and opportunities and how to address these across the care continuum. This should include using the data within the EHRs to improve the experience.</p> <p>We recommend collaborating with CMO groups and other clinical stakeholders to better align EHR system design with real-world clinical workflow.</p>
<p>Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.</p>	<p>Recommendation 2: Improve clinical decision support usability.</p>	<p>We support this recommendation and recommend focusing on the ability of EHR to pull data already inputted and providing documentation/reason for the “decision” so providers do not feel like they are working with a black box/do not have the information to understand the decision.</p> <p>We recommend HHS fund/support a task force to focus on improving 3-5 CDS – either proven effective or proven painful. It is not enough to say here is a document – HSS must lead the way in the work.</p> <p>We recommend partnering with CMO groups and other clinical stakeholders to improve clinical decision support usability.</p>
<p>Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.</p>	<p>Recommendation 3: Improve clinical documentation functionality.</p>	<p>We support this recommendation and recommend focusing on the ability of EHR to pull data already inputted and providing documentation/reason for the “decision” so providers do not feel like they are working with a black box/do not have the information to understand the decision.</p>

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Health IT Usability and the User Experience		
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		We recommend partnering with CMO groups and other clinical stakeholders to improve clinical documentation functionality.
Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.	Recommendation 4: Improve presentation of clinical data within EHRs.	<p>We support this recommendation and recommend assessing if natural language processing could be a tool to convert free text into discrete data elements to support a more complete presentation of data to the user.</p> <p>We recommend assuring the presentation of data is useful to individual and caregivers not just the provider.</p> <p>We recommend partnering with CMO groups and other clinical stakeholders to improve the presentation of clinical data within EHRs.</p>
Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.	Recommendation 1: Harmonize user actions for basic clinical operations across EHRs.	We support this recommendation but recognize that harmonization can stifle innovation. Therefore we recommend focusing on harmonizing key basic structural elements and then allow for innovation. Harmonization of interfaces, log-ons, and orders can reduce provider burden.
Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.	Recommendation 2: Promote and improve user interface design standards specific to health care delivery.	We support this recommendation but identified a significant barrier. Many providers' contracts have gag clauses that prevent sharing how a particular EHR is designed. Gag clauses significantly impact patient safety and innovation and serve only to protect vendors and their product. For any progress in this area, HHS needs to identify and implement policy levers or strategies that remove the incentive to not share.
Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.	Recommendation 3: Improve internal consistency within health IT products.	We support this recommendation but see the same barrier as identified for recommendation #2. Many providers' contracts have gag clauses that prevent sharing how a particular EHR is designed. Gag clauses significantly impact patient safety and innovation and serve only to protect vendors in their product. For any progress in this area, HHS

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		needs to identify and implement policy levers or strategies that remove the incentive to not share.
Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.	Recommendation 4: Promote proper integration of the physical environment with EHR use.	We support this recommendation but echo previous concerns about workflow varying so greatly between providers. Steps need to be taken to assure that these variations are taken into consideration.
Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.	Recommendation 1: Standardize medication information within health IT.	We support this recommendation and recommend considering the workflow processes and use of nationally recognized standards relating to prior authorizations, use of the PDMP/PMP, and patient access to their medication information.
Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.	Recommendation 2: Standardize order entry content within health IT.	We support this recommendation but recommend steps be taken to prevent stifling innovation.
Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.	Recommendation 3: Standardize results display conventions within health IT.	We support this recommendation but recommend steps be taken to prevent stifling innovation.
Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency,	Recommendation 1: Increase end user engagement and training.	We support this recommendation. It is ideal for large practices but less so for small practices. For a small practice (and even a large), the product should be intuitive and make the provider want to use it/see the advantage of it. If this happen use and engagement will follow.

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Health IT Usability and the User Experience		
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satisfaction, and lowered burden.		
Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.	Recommendation 2: Promote understanding of budget requirements for success.	We support this recommendation but recognize there may be different models for different providers.
Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.	Recommendation 3: Optimize system log-on for end users to reduce burden.	We support this recommendation and recommend assuring that when the provider transitions to a different machine, they start where they left off at. Research (https://www.sciencedirect.com/science/article/pii/S1386505617300394) has found that single sign on has benefits beyond just information security but also in time savings and cost.
Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.	Recommendation 4: Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.	We support this recommendation for not just payment, administrative, and clinical information to reduce burden but also to assure that the patient and their caregivers have access to their information.

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EHR Reporting		
EHR Reporting Strategy	Recommendation	Minnesota Comments and Recommendations
Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	Recommendation 1: Simplify the scoring model for the Promoting Interoperability performance category.	<p>We support this recommendation.</p> <p>We recommend working with other national such as JCAHO and other state such as state quality measurement groups and/or develop a workgroup to identify and make recommendations to simply the scoring model for the PI performance category.</p>
Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	Recommendation 2: Incentivize innovative uses of health IT and interoperability that reduce reporting burdens and provide greater value to physicians.	<p>We support this recommendation.</p> <p>We recommend working with other national groups such as the Joint Commission and other state groups such as state quality measurement groups</p>
Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	Recommendation 3: Reduce burden of health IT measurement by continuing to improve current health IT measures and developing new health IT measures that focus on interoperability, relevance of measure to clinical practice and patient improvement, and electronic data collection that aligns with clinical workflow.	<p>We support this recommendation and recommend special focus on/awareness of small practices and primary care providers.</p> <p>We recommend working with other national groups such as the Joint Commission and other state groups such as state quality measurement groups and/or develop a workgroup to review best practices and identify and make recommendations to improve and create new health IT measures.</p>

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Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	Recommendation 4: To the extent permitted by law, continue to provide states with federal Medicaid funding for health IT systems and to promote interoperability among Medicaid health care providers.	<p>We support this recommendation. There is great variability in interoperability across states – this is creating a health disparity for populations who live in states with limited interoperability.</p> <p>We also encourage looking beyond just human services and health departments but consider education, public safety, and corrections to support both providers and care teams, public and community health, research and policy, and individuals and their caregivers.</p>
Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.	Recommendation 5: Revise program feedback reports to better support clinician needs and improve care.	We support this recommendation and recommend that the feedback be more timely to support clinical needs and improve care.
Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.	Recommendation 1: Recognize industry-approved best practices for data mapping to improve data accuracy and reduce administrative and financial burdens associated with health IT reporting.	We support this recommendation but recognize that policy levers may be needed for EHR vendor adoption.

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EHR Reporting		
EHR Reporting Strategy	Recommendation	Minnesota Comments and Recommendations
Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.	Recommendation 2: Adopt additional data standards to makes access to data, extraction of data from health IT systems, integration of data across multiple health IT systems, and analysis of data easier and less costly for physicians and hospitals.	We support this recommendation but recognize that policy levers may be needed for EHR vendor adoption.
Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.	Recommendation 3: Implement an open API approach to HHS electronic administrative systems to promote integration with existing health IT products.	We support this recommendation.
Strategy 3: Improving the value and usability of electronic clinical quality measures while decreasing health care provider burden	Recommendation 1: Consider the feasibility of adopting a first-year test reporting approach for newly developed electronic clinical quality measures.	We support this recommendation but it may require financial support/incentives for piloting.

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EHR Reporting		
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Strategy 3: Improving the value and usability of electronic clinical quality measures while decreasing health care provider burden	Recommendation 2: Continue to evaluate the current landscape and future directions of electronic quality measurement and provide a roadmap toward increased electronic reporting through the eCQM Strategy Project.	We support this recommendation but see capturing the needed quality measurement information the barrier to improving the value and usability of eCQMs.
Strategy 3: Improving the value and usability of electronic clinical quality measures while decreasing health care provider burden	Recommendation 3: Explore alternate, less burdensome approaches to electronic quality measurement through pilot programs and reporting program incentives.	We support this recommendation.

Public Health Reporting		
Public Health Reporting Strategy	Recommendation	Minnesota Comments and Recommendations
Strategy 1: Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health	Recommendation 1: Federal agencies, in partnership with states, should improve interoperability between health IT and PDMPs through the adoption of common industry standards consistent with ONC	<p>We support this recommendation but have many concerns with PDMPs.</p> <p>We recommend providing resources, specifically funding, to prescribers to cover the cost of PMP integration.</p> <p>In 2017, Governor Mark Dayton requested recommendations on how e-health can be a tool to prevent and respond to opioid overdose and deaths. The Minnesota e-Health Initiative responded with seven recommendations. The complete recommendations are in</p>

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IT into health care provider workflow.	and CMS policies and the HIPAA Privacy and Security Rules, to improve timely access to medication histories in PDMPs. States should also leverage funding sources, including but not limited to 100 percent federal Medicaid financing under the SUPPORT for Patients and Communities Act, to facilitate EHR integration with PDMPs using existing standards.	<p>Appendix B. The two relating to PDMPs/PMPs are highlighted below. Although Minnesota specific, these should be considered as part of the recommendation as many issues and needs are universal.</p> <ol style="list-style-type: none"> 1. Partners should work to develop requirements and an implementation plan to improve the Prescription Monitoring Program. The requirements and implementation plan should include use cases and policies for the required use of the Prescription Monitoring Program. The implementation plan should: <ol style="list-style-type: none"> a. Address affordable, effective and seamless use of the Prescription Monitoring Program by prescribers and dispensers through the electronic health record, other health information technology, and integration into Minnesota’s health information exchange services, and include full implementation of clinical guidelines and clinical decision support and access to other states’ Prescription Monitoring Program information. b. Improve stakeholder input and oversight, representative governance, regulatory authority, and funding of the Prescription Monitoring Program 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 2. Ensure that state and federal agencies, tribal governments, academia, local public health, payers, and other partners are able to appropriately access and analyze PDMP/PMP 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:

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Public Health Reporting		
Public Health Reporting Strategy	Recommendation	Minnesota Comments and Recommendations
		<ul style="list-style-type: none"> 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.
<p>Strategy 1: Increase adoption of electronic prescribing of controlled substances and retrieval of medication history from state PDMP through improved integration of health IT into health care provider workflow.</p>	<p>Recommendation 2: HHS should increase adoption of electronic prescribing of controlled substances with access to medication history to better inform appropriate prescribing of controlled substances.</p>	<p>We support this recommendation but there are barriers to adoption of EPCS that need to be addressed.</p> <p>We recommend providing resources, including funding, for small, independent, and rural providers for EPCS.</p> <p>In 2017, Governor Mark Dayton requested recommendations on how e-health can be a tool to prevent and respond to opioid overdose and deaths. The Minnesota e-Health Initiative responded with seven recommendations. The complete recommendations are in Appendix B. The recommendation relating to EPCS is highlighted below. Although Minnesota specific, it should be considered as part of the recommendation as many issues and needs are universal.</p> <p>Fully implement EPCS by:</p> <ul style="list-style-type: none"> ▪ Providing or ensuring statewide education and technical assistance on e-prescribing of controlled substances.

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		<ul style="list-style-type: none"> ▪ Supporting full-implementation of all electronic prescribing related transactions in the nationally recognized National Council for Prescription Drug Programs Standards, including electronic prior authorization and Formulary and Benefits. ▪ Providing 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. ▪ Supporting the use of evidence-based clinical guidelines and clinical decision support. ▪ Monitoring the status of e-prescribing, specifically for controlled substances, and assess the barriers to e-prescribing of controlled substances. ▪ Developing and implementing policy options including rulemaking and enforcement for noncompliance of e-prescribing as needed, if goals are not met.
<p>Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.</p>	<p>Recommendation 1: HHS should convene key stakeholders, including state public health departments and community health centers, to inventory reporting requirements from federally funded public health programs that rely on EHR data. Based on that inventory, relevant federal agencies should work together to identify common data reported to relevant state health departments and federal program-specific reporting platforms.</p>	<p>We support this recommendation.</p> <p>We recommend including ASTHO, NACCHO, and counties as key stakeholders for inventory of reporting requirements.</p>

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Public Health Reporting

Public Health Reporting Strategy	Recommendation	Minnesota Comments and Recommendations
<p>Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.</p>	<p>Recommendation 2: HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards.</p>	<p>We support this recommendation.</p> <p>We recommend including ASTHO, NACCHO, and counties as key stakeholders for harmonization of reporting requirements.</p>
<p>Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.</p>	<p>Recommendation 3: HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care.</p>	<p>We support this recommendation.</p>

Appendices

Appendix A: Minnesota e-Health Advisory Committee 2018-2019

Members

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, Fairview Health Systems
Representing: Physicians

Sunny Ainley, Associate Dean, Center for Applied Learning, Normandale Community College
Representing: HIT Education and Training
Co-Chair: e-Health Workforce Workgroup

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

Laurie Beyer-Kropuenske, JD, Acting Assistant Commissioner
Representing: Minnesota Department of Administration

Jennifer Fritz, MPH, Director, Office of Health IT, Minnesota Department of Health
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

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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 Workgroup

Jonathan Shoemaker, SVP and Chief Information and Improvement 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: Vendors

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

Ann Warner, Manager, Data Engineering, HealthEast
Representing: Health Care Administrators

John Whittington, South Country Health Alliance
Representing: Health Care Purchasers and Employers
Co-Chair: e-Health Workforce Workgroup

Ken Zaiken, Consumer Advocate
Representing: Consumers
Co-Chair: Consumer Engagement Workgroup

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

Designated Alternates

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

Nancy Garrett, PhD, Chief Analytics Officer and Senior Vice President for Information
Technology, Hennepin County Medical Center
Alternate Representing: Large Hospitals

Oyin Hansmeyer, HIT Consultant
Alternate Representing: Experts in Health IT

Elisha Harris, RN, Registered Nurse, United Hospital
Alternate Representing: Nurses

George Klauser, Executive Director, Altair-ACO, Lutheran Social Services
Alternate Representing: Social Services

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

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: Opioid and e-Health Report: 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:

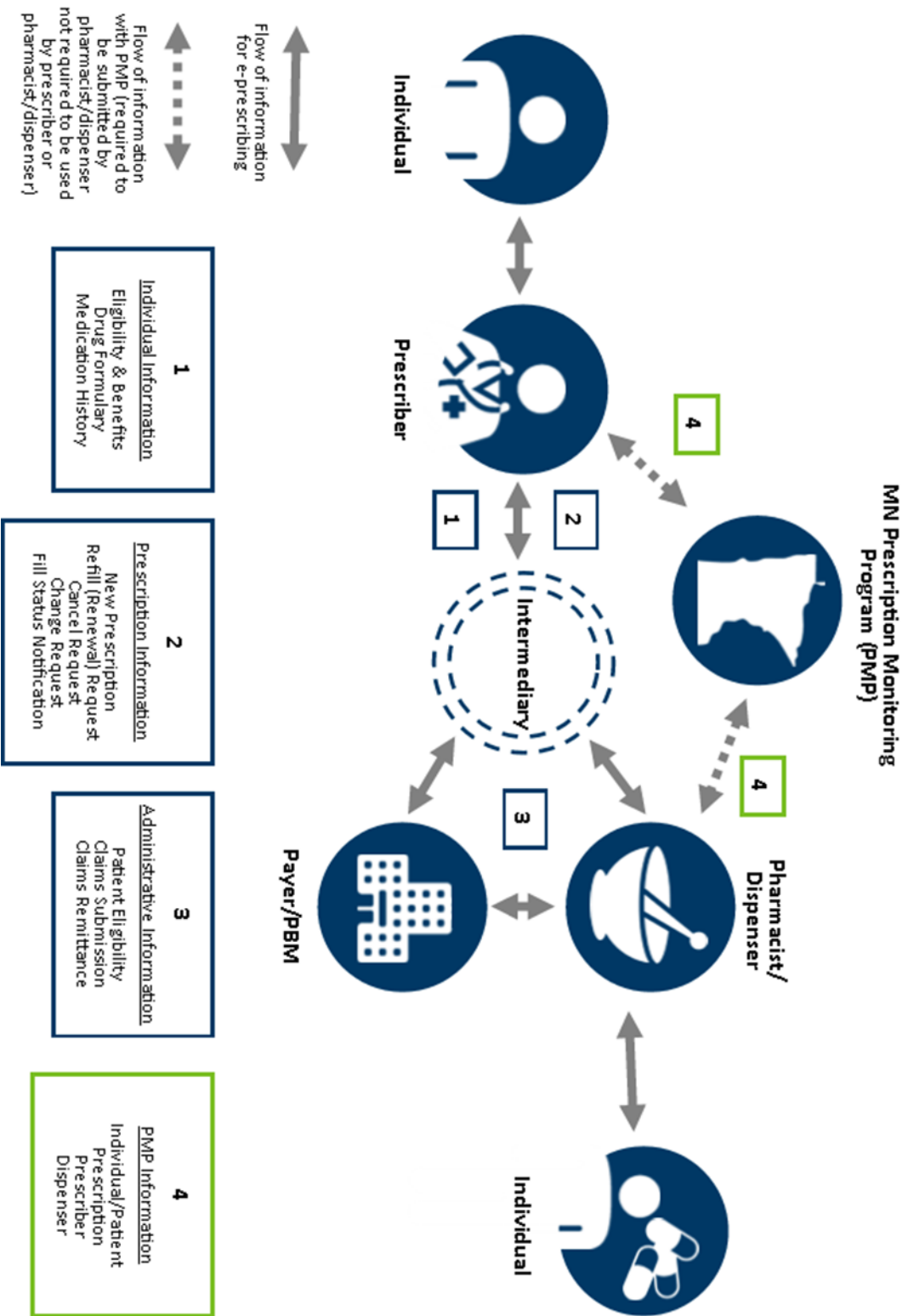
1. Whether and how such information is or could be exchanged via the types of data exchange subject to MN 62J.536 and 62J.495-4982; and
2. Any possible issues or constraints associated with the standard, electronic exchange or use of information needed to address the epidemic and how they might be addressed.

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.

Figure 1. Common Information Flow for Electronic Prescribing of Controlled Substances



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

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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.