MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

Minutes for the August 2016 Meeting

Date: Thursday, August 18ᵗʰ, 2016
1:00 pm – 3:00 pm

Location: Conference Rooms L and K, First Floor
South Grand Building
333 South Grand Avenue
Lansing, Michigan 48933

Commissioners Present:

Patricia Rinvelt, Co-Chair
Mark Notman, Ph.D.
Rozelle Hegeman-Dingle, PharmD
Irita Matthews
Randall Ritter
Robert Milewski
Michael Chrissos, M.D
Jill Castiglione, RPh (Phone)
Peter Schonfeld (Phone)

Commissioners Absent:

Orest Sowirka, D.O.
Karen Parker
Nick Smith
Rodney Davenport, Co-Chair

Staff:

Meghan Vanderstelt
Kim Bachelder
Phil Kurdunowicz

Attendees:

Edward Worthington	Eric Roath	Eric Lin
James Nolan	Jessica Kauffmann	Spencer Herlong
Veronica M.	Rosalyn Beene-Harris	Jason Werner
Tina Scott	Dr. Tim Pletcher	Dr. Tom Stevenson
Kim Gaedeke	Lindsey Weeks	Angela Vanker
Keith Hoffman	Cindy Swihart	Dr. Gregory Forzley
Dr. Tim Pletcher	Linda McMillin	Jared Welehodsky

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, August 18ᵗʰ, 2016 at the South Grand Building with 9 Commissioners participating in person or by phone.

A. Welcome and Introductions
1. Co-Chair Patricia Rinvelt called the meeting to order at 1:01 p.m.
2. Co-Chair Rinvelt asked the other commissioners to introduce themselves and to share any updates since the last time that the commission convened. The other commissioners did not have any updates to share at this time.

B. Commission Business
1. Chair Rinvelt asked the commissioners to review and consider approving the minutes from the January 2016 meeting.
2. Multiple commissioners made a motion to approve the minutes, and multiple commissioners seconded the motion.
3. Chair Rinvelt asked if there was any objection to approving the minutes. Seeing none, she noted that the minutes had been approved at 1:06 p.m.

C. HIT/HIE Update
1. Co-Chair Rinvelt invited Ms. Meghan Vanderstelt from the Michigan Department of Health and Human Services (MDHHS) to provide an update on new developments in the health information technology (HIT) field since the last commission meeting. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Ms. Vanderstelt provided an overview of the HIT Commission Dashboard.
   a. Ms. Vanderstelt noted that the Michigan Health Information Network now has 67 trusted data sharing organizations within its network.
   b. Ms. Vanderstelt also noted that participation in the Medication Reconciliation Use Case continues to grow rapidly.
   c. Ms. Vanderstelt indicated that real-time Admission, Discharge, and Transfer messages for Medicaid participants began to flow into the MDHHS Data Warehouse in July. Ms. Vanderstelt explained that MDHHS will be using this information for care coordination and population health purposes.
   d. Ms. Vanderstelt highlighted new developments in the Cancer Pathology Use Case and noted that MDHHS is now ready to receive Cancer Pathology Messages.
   e. Ms. Vanderstelt also drew attention to the ongoing work of the Michigan Center for Effective Information Technology Adoption (M-CEITA) in assisting providers with participation and attestation for the Meaningful Use program.
      i. Ms. Vanderstelt mentioned that M-CEITA collects data on the barriers that delay or prevent providers from achieving meaningful use or cause them to be disqualified altogether.
      ii. She noted that M-CEITA shares monthly updates on these issues with MDHHS and that the updates could be shared with the HIT Commission.
   f. Ms. Vanderstelt noted that MDHHS had recently hosted the State Innovation Model (SIM) Summit on August 10th and 11th.
      i. Ms. Vanderstelt explained that the SIM Summit served as the kick-off for the implementation phase of the SIM model in Michigan.
      ii. Ms. Vanderstelt also noted that MDHHS provided key updates on Michigan's Patient-Centered Medical Home (PCMH) strategy, Accountable Systems of Care (ASC) strategy, and Community Health Innovation Region (CHIR) strategy during the summit.
      iii. Ms. Vanderstelt noted that the Division of Policy will share additional updates on the SIM at future HIT Commission meetings. Ms. Vanderstelt

stated that the Division of Policy will specifically highlight new developments in the Relationship Attribution Management Platform, which will play a key role in supporting health information sharing and advanced care coordination within the PCMH model and CHIR initiatives.

      g. Ms. Vanderstelt also noted that the State of Michigan had recently applied for the Technical Assistance Program under the National Governors Association.

           i. Ms. Vanderstelt announced that Michigan had been officially been selected to participate in the program along with Illinois and Louisiana.

           ii. Ms. Vanderstelt explained that the technical assistance program specifically focuses on improving information sharing across health providers by creating a statewide framework for addressing privacy and consent issues.

           iii. Co-Chair Rinvelt inquired about the duration of funding for the program.

               a. Ms. Vanderstelt noted that the program will last for 10 months and that the main forms of support that NGA is providing are technical assistance and connections to federal partners.

               b. Commissioner Dr. Michael Chrissos asked if Michigan received any funding as part of the program, and Ms. Vanderstelt clarified that the program only provides technical assistance support.

               c. Commissioner Peter Schonfeld inquired about potential linkages between the Section 298 Initiative and the technical assistance program. Mr. Phil Kurdunowicz of MDHHS noted that the Department would be exploring opportunities to align the two different initiatives.

D. Update on the Prescription Drug and Opioid Abuse Task Force and MAPS Discussions

    1. Co-Chair Rinvelt invited Mr. Jared Welehodsky from MDHHS and Ms. Kim Gaedeke from the Department of Licensing and Regulatory Affairs (LARA) to provide an update on the Prescription Drug and Opioid Abuse Task Force and related discussions on the Michigan Automated Prescription System (MAPS). The PowerPoint slides for this presentation will be made available on the website after the meeting.

    2. Mr. Welehodsky presented some data on the rapid increase in hydrocodone and oxycodone prescriptions over the last two decades as well as the corresponding increase in deaths from prescription drug overdoses.

    3. Mr. Welehodsky also provided an update on the work of the task force as well as several State of Michigan Departments. He specifically highlighted the following updates:

        a. Creation of an ongoing Michigan Prescription Drug and Opioid Abuse Commission

        b. Introduction of legislation to expand the Good Samaritan Law

        c. Introduction of legislation to expand access to Naloxone

        d. Review of Benefits Monitoring Program

        e. Launch of RFI for strategies to reduce Neo-Natal Abstinence Syndrome

        f. Receipt of funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to reduce non-medical use of drugs among young adults

        g. Upgrading MAPS

        h. Receipt of new funding from the Department of Justice to focus on intelligence gathering, data analysis, enforcement, and prevention

        i. Establishment of new training on the use of Naloxone for state troopers

        j. Implementation of new pre-arrest diversion program for individuals with a substance use disorder

4. Co-Chair Rinvelt asked about what opioid-related projects were being pursued by the State of Michigan besides changes to MAPS. Mr. Welehodsky noted that Michigan had just received federal grant funding to address the opioid epidemic.
5. Commissioner Dr. Chrissos inquired about the pilot that is being led by the Michigan State Police. Mr. Welehodsky noted that the Northern Michigan Regional Entity was also involved in these pilots and that he could follow-up with the commission with more information.
6. Commissioner Rozelle Hegeman-Dingle asked about whether the overhaul of MAPS would include linking MAPS to the Electronic Health Records (EHR) of providers.
    a. Ms. Gaedeke responded that LARA had discussed the possibility of direct connectivity to EHRs with the legislature but that the initial focus was replacing the IT system for MAPS.
    b. Ms. Gaedeke clarified that the initial $4.4 million would primarily be spent on upgrades and maintenance but also noted that LARA would take a look at other enhancements if funding was available.
    c. Ms. Gaedeke also noted that LARA is working with some vendors in Southeast Michigan to pilot potential connections between MAPS and EHRs.
7. Ms. Gaedeke also mentioned that LARA is working on enhancing the "delegate user" functionality to allow physicians to control access for clinic staff.
8. Commissioner Rinvelt noted that the legislature had been discussing the possibility of adding utilization of MAPS to physician licensure requirements. Ms. Gaedeke confirmed that legislation had been proposed to mandate use of MAPS by physicians and noted that pharmacists are already required to use MAPS.
9. Ms. Gaedeke noted that MAPS is just a repository of Schedule 2 through 5 drugs and that any prescriptions that fall outside of this schedule are not part of MAPS.
10. Ms. Gaedeke described current bandwidth problems that MAPS users are encountering and not that MAPS would be transitioning from server-based to cloud-based technology in order to address this issue.
11. Commissioner Dr. Chrissos inquired about what Ms. Gaedeke saw as the biggest hurdles for getting EHRs connected to MAPS.
    a. Ms. Gaedeke noted that education and outreach to clinicians is going to be the biggest hurdle and highlighted the challenge of encouraging clinicians to use MAPS as part of their clinical practice.
    b. Ms. Gaedeke noted that LARA had received feedback from the Michigan Pharmacist Association and Michigan State Medical Society on different types of automated reports that would be helpful to clinicians
12. Ms. Gaedeke highlighted some of the work that LARA had accomplished in terms of improving the quality, integrity, and accessibility of data within MAPS.
13. Ms. Gaedeke also described LARA's partnership with law enforcement, medical boards, and the Attorney General's office to define what constitutes legitimate overprescribing.
    a. Ms. Gaedeke noted that LARA would not pursue all prescribers and would concentrate enforcement efforts on top prescribers.
    b. Ms. Gaedeke also highlighted the role of the new Drug Monitoring Section within LARA on addressing drug diversion and over prescribing.
14. Ms. Gaedeke also mentioned that LARA is collaborating with insurance companies and the State Medicaid Agency to coordinate enforcement efforts to combat fraud.
15. Ms. Gaedeke noted that the State of Michigan had received one new grant from SAMHSA and two new grants from the Centers for Disease Control to support these efforts.

16. Commissioner Jill Castiglione asked about whether legislation had been introduced to require pharmacies to run MAPS.
    a. Ms. Gaedeke confirmed that the task force had discussed the possibility.
    b. Mr. Eric Roath of MPA noted that legislation had been introduced but that the focus was more on the prescriber end due to the need to prevent inappropriate prescriptions on the front end.
17. Ms. Vanderstelt asked about the possibility of pilots within MiHIN.
    a. Ms. Gaedeke noted that some initial discussions had taken place with MiHIN but that further discussions were on hold until the MAPS system is replaced.
    b. Ms. Gaedeke explained that the current IT vendor who is piloting the possibility of connecting EHRs to MAPS invested their own dollars into making the pilot happen.
18. Commissioner Hegeman-Dingle inquired about how LARA and the new commission would account for the needs of patients with chronic pain when redesign MAPS. Ms. Gaedeke noted that the issue would be addressed in upcoming commission discussions.
19. Co-Chair Rinvelt asked if the HIT Commission could receive an update on the roll-out of the new MAPS system next summer, and Ms. Gaedeke noted that it would be possible since LARA is aiming to roll out the new system next spring.

E. **Update on the Medication Reconciliation Use Cases**
    1. Co-Chair Rinvelt invited Dr. Tim Pletcher of MIHIN and Mr. Ed Worthington of Northern Physicians Organization (NPO) to provide and update on the medication reconciliation use cases. The PowerPoint slides for this presentation will be made available on the website after the meeting.
    2. Dr. Pletcher commented on the previous MAPS discussion and noted that MiHIN was interested in working with LARA to transition away from the use of a portal towards the use of health information exchange. He also stated that LARA is focused on just getting the system up and running at this point.
    3. Dr. Pletcher provided an overview of MiHIN's goals, which include improving the health care experience for consumers and providers, improving quality, decreasing cost, enabling statewide exchange of health information, and making data available at the point of care.
    4. Commissioner Robert Milewski inquired about whether MiHIN was exploring options for expanding nationwide.
        a. Dr. Pletcher confirmed that MiHIN is very active in many national standards groups and has also been assisting other states with setting up state-based HIEs.
        b. Dr. Pletcher noted that serving Michigan is still MiHIN's priority.
    5. Dr. Pletcher described MiHIN's position as a "network of networks" that connects multiple organizations across the Michigan health care ecosystem.
    6. Dr. Pletcher emphasized the role of MiHIN's robust legal framework and Use Case Factory in promoting the development and implementation of new use cases.
        a. Dr. Pletcher noted that MiHIN had posted a link on its webpage to submit new use case ideas in respond to a previous HIT Commission recommendation.
        b. Dr. Pletcher also emphasized the importance of incentives to promoting use case adoption and implementation.
        c. Dr. Pletcher described the different stages of use case implementation.
    7. Dr. Pletcher provided an overview of the Medication Management White Paper and highlighted the participation of a wide range of stakeholders in the drafting process. Dr. Pletcher noted that stakeholders rallied around three specific use case scenarios: (1)

Exchange medication reconciliation, (2) Exchange medication data with prescription drug monitoring programs, and (3) Exchange lab results/diagnosis.

8. Dr. Pletcher described the exchange medication reconciliation use case in greater detail.
   a. Dr. Pletcher highlighted the role that the Active Care Relationship Service (ACRS) plays in ensuring effective attribution of patients to providers.
   b. Dr. Pletcher also described the important connection between the ACRS use case and the State of Michigan's Master Person Index.
9. Dr. Pletcher provided an overview of the pilot for the Medication Reconciliation Use Case.
   a. Dr. Pletcher identified the health systems and physician organizations that had participated in the initial pilot.
   b. Dr. Pletcher also emphasized the importance of the financial incentives from Blue Cross Blue Shield of Michigan in encouraging participation.
   c. Dr. Pletcher also explained the process that MiHIN was using to conduct conformance testing for care summaries that were being sent through this use case and encourage adherence to applicable standards.
10. Dr. Chrissos inquired about how MiHIN and the participating qualified organizations ensured that the medication reconciliation information was accurate. Dr. Pletcher noted that Phase 1 of the use case only focuses on admission and discharge information and noted that Phase 2 would be practice focused.
11. Dr. Pletcher indicated that 60 hospitals were currently participating in the use case and that those hospitals represented 68% of discharges in Michigan. He also noted that the BCBSM incentives would drive participation into the high 90s.
12. Dr. Pletcher mentioned that the model under this use case could be expanded to include more general care summaries, which would be generated every time that a health care provider sees a patient and would be sent to all relevant providers.
13. Ms. Vanderstelt asked for clarification on which health care organizations are currently not submitting ACRS files. Dr. Pletcher noted that community-based groups such as Home Health providers and behavioral health settings were not participating yet.
14. Mr. Worthington provided an overview of NPO and highlighted NPO's role as a population health organization.
15. Mr. Worthington noted that NPO is currently receiving medication reconciliation information for all associated practices but is only sending information to 4 of them.
    a. Mr. Worthington described the work that NPO is conducting in order to effectively integrate medication reconciliation information into provider EHRs.
    b. Mr. Worthington walked through the different methods that NPO was using to integrate the medication reconciliation information into the four different EHRs.
    c. Mr. Worthington noted that 90% of the challenge was workflow related and noted the parallel with adoption and implementation of Admit, Discharge, and Transfer (ADT) Notifications: he noted that full implementation of ADT notifications into provider EHRs typically took a full year.
16. Co-Chair Rinvelt asked for more information on the pilot strategy for the medication reconciliation use case.
    a. Mr. Worthington explained that NPO was working with a few practices initially in order to explore how care managers want to view and use the data and that this functionality would eventually be rolled out system-wide.
    b. Mr. Worthington noted that NPO was working with four different types of practices of different sizes with different EHRs.
17. Co-Chair Rinvelt inquired about when the use case would move beyond the pilot stage.

a. Dr. Pletcher noted that the pilot would move beyond the pilot stage once 67% of hospitals are on board with the use case.
b. Dr. Pletcher noted that MiHIN would be able to open the use case to all HIEs now that the use case was getting close to critical mass.
c. Dr. Pletcher also noted that pilot groups were trying to figure out how to digest the information and leverage the information in order to support Patient-Centered Medical Home activities.
d. Mr. Worthington noted that NPO would be expanding the use case to most practices within 6 months as well as Community Mental Health agencies.
18. Commissioner Irita Matthews asked about how MiHIN and NPO were measuring success for the pilot.
a. Mr. Worthington noted that NPO was working on monitoring and evaluation for the pilot and noted that much of the emphasis would be measuring clinical effectiveness with the assistance of care managers.
b. Mr. Worthington also highlighted the role of Lean Process Improvement in improving the efficiency of clinical processes with new HIT capabilities.
19. Ms. Vanderstelt noted that NPO is operating within one of the regions for the State Innovation Model and that MDHHS was trying to learn lessons from NPO that could be used in other regions.

F. **Update on the Electronic Prescribing and Related Efforts to Improve Statewide Adoption and Use of Electronic Prescribing for Controlled Substances**
1. Co-Chair Rinvelt invited Ms. Lynda McMillin from BCBSM to provide update on efforts to improve the statewide adoption and use of electronic prescribing for controlled substances. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Ms. McMillin indicated that she would provide an overview of the role of prescription drug monitoring programs, highlight ways that technology could be used to support these programs, and describe BCBSM's strategy for supporting electronic prescribing.
3. Ms. McMillin shared some statistics that demonstrated the extent of the opioid epidemic: she noted that 15 million Americans abuse drugs regularly and 52 million Americans over the age of 12 have used prescription drugs non-medically.
4. Ms. McMillin emphasized the electronic prescribing could potentially hold some of the answers for mitigating the opioid crisis.
5. Ms. McMillin noted that the U.S. Drug Enforcement Agency authorized the use of electronic prescribing for controlled substances in 2010 and all states had also authorized electronic prescribing by 2015. Ms. McMillin noted that pharmacies have achieved rapid enablement but providers were still struggling with adoption.
6. Ms. McMillin provided an overview of Prescription Drug Monitoring Programs (PDMP).
a. Ms. McMillin noted that PDMPs act as a repository for controlled substances and that 49 states currently have operational PDMPs.
b. Ms. McMillin also mentioned that 22 states require access to PDMP before controlled substances can be prescribed.
c. Ms. McMillin noted that most states have not instituted penalties for providers who fail to check the PDMP before prescribing and have varying levels of enforcement.
    i. Ms. McMillin indicated that only 3 states crack down on providers who are not using the state PDMP.

        ii.   Ms. McMillin also noted that New York has a great program. She explained further that New York achieve a 20% decline in hydrocodone prescription, 5% decline in codeine prescriptions, and 10% decline in all opioid prescriptions after implementing the program.
    d.   Ms. McMillin also highlighted the role of InterConnect in enabling interoperability across state PDMPs and noted that Michigan is part of InterConnect.

7. Ms. McMillin described New York's iSTOP program in further detail, which is an internet system for tracking overprescribing in order to combat rising rates off drug abuse.
   a. Ms. McMillin noted that New York implemented a requirement to check the registry before prescribing with corresponding civil and criminal penalties in March 2016.
   b. Ms. McMillin also indicated Maine implemented a similar requirement that goes into effect on July 1st of 2017. Ms. McMillin noted that Maine also implemented requirements for Continuing Medical Education on addiction as well as limits on duration and dosages that can be prescribed.

8. Ms. McMillin noted that provider adoption of electronic prescribing for controlled substances has stagnated despite most providers now having EHRs.
   a. Ms. McMillin indicated that many providers are now focused on using quality improvement to optimize the use of technology and address gaps in care.
   b. Ms. McMillin provided data on current nationwide adoption trends.
      i. Ms. McMillin noted that most states (except for New York) have a 10% adoption for prescribers in contracts to a 90% adoption rate for pharmacies.
      ii. Ms. McMillin also mentioned that certified electronic prescribing software is now offered by a wide variety of vendors.
      iii. Co-Chair Rinvelt asked about the disparity between provider and pharmacy adoption rates.
         a. Ms. McMillin explained that many providers do not know how to implement this technology or think that electronic prescribing of controlled substances is still illegal. Ms. McMillin highlighted the potential for provider education to address this issue.
         b. Commissioner Milewski noted that physicians were told for years that they must write controlled substance prescriptions by hand.
         c. Ms. McMillin highlighted the role of BCBSM incentives in inspiring pharmacy adoption of electronic prescribing.

9. Ms. McMillin provided an overview of the BCBSM's 2016 Electronic Prescribing of Controlled Substances initiative.
   a. Ms. McMillin indicated that BCBSM viewed this initiative as part of the organization's social mission and that the goal of the initiative was to raise electronic prescribing by providers to 25% over three years.
   b. Ms. McMillin also explained that BCBSM would initially focus on providers who prescribe 25 or more controlled substances per quarter per physician.
   c. Ms. McMillin also noted that BCBSM would update the Patient-Centered Medical Home (PCMH) model to include an EPCS component.
      i. Ms. McMillin emphasized the importance of having the MAPS replacement complete in time in order to allow PCMHs to meet this requirement.
      ii. Ms. McMillin also noted that BCBSM is working on developing criteria for PCMHs that are treating patients who require chronic pain management.
   d. Ms. McMillin also noted that BCBSM has been sending out quarterly reports to physician organizations that list top prescribers within practices.

10. Ms. McMillin also highlighted new electronic prescribing requirements under the Merit-Based Incentive Payment System (MIPS).
    a. Ms. McMillin explained further that MIPS will mandate electronic prescribing by all providers with no exclusions or hardship exemptions.
    b. Ms. McMillin also highlighted the three new Medicare Access and CHIP Reauthorization Act (MACRA) requirements for use of certified HIT: (1) change prescription, (2) cancel prescription, and (3) fill status.
11. Ms. McMillin concluded her presentation by re-emphasizing the benefits of electronic prescribing and highlighting the role of HIT in enabling effective prescribing of controlled substances. She also stated the BCBSM will remain committed to continuing to educate and incentive providers to adopt and utilize electronic prescribing.
12. Commissioner Milewski posed a question to the other physicians in the room in regards to whether payer incentives or legislation are more appropriate for encouraging adoption of electronic prescribing. Commissioner Milewski also asked about whether the HIT Commission should play a role in addressing this issue.
    a. Dr. Tom Stevenson of MiHIN noted that the HIT Commission could play a role in making recommendations to MDHHS on potential legislation, but he also noted that a legislative mandate would likely include a hard time limit which could be onerous for physician practices that are struggling with steep barriers to adoption. Dr. Stevenson also noted that initiatives could also be part of the solution.
    b. Dr. Gregory Forzley noted that both methods could be used and that implementing a mandate could eliminate fraud for prescription of controlled substances.
    c. Ms. McMillin noted that EHR vendors will be required to certify to standards which will make provider adoption much easier. She also emphasized the potential for MiHIN to support providers in overcoming barriers to adoption.
    d. Commissioner Milewski questioned whether the HIT Commission should recommend potential legislation or just continue to track this issue. He also questioned whether incentives would be sufficient in isolation to encourage adoption when providers face significant technological barriers.
    e. Commissioner Dr. Chrissos suggested that the Opioid commission may be the best venue to address this issue and wondered what the interface between the HIT Commission and the new commission.
    f. Ms. Vanderstelt noted that the Opioid commission is still being established and that the HIT Commission could potentially direct this issue to the new commission.
    g. Dr. Pletcher encouraged the HIT Commission to not wait for the annual report and to make a formal recommendation to the new commission.
    h. Ms. Vanderstelt noted that she could facilitate contact between the commissions.
13. Co-Chair Rinvelt asked whether one of the HIT Commissioners would like to make a motion to adopt a resolution that addresses the aforementioned issues.
    a. Commissioner Milewski made the following motion, which was seconded by Commissioner Hegeman-Dingle:
       Resolved: The Michigan Health Information Technology Commission recommends a proposal for legislation to be enacted that addresses statewide adoption and use of Electronic Prescribing Controlled Substance (EPCS). The proposed legislation should be modeled after New York and Maine, who have enacted legislation to address the rising rates of prescription drug abuse by strengthening the controlled substance prescription monitoring program through mandatory electronic prescribing efforts.

b. Co-Chair Rinvelt asked whether the commissioners supported the resolution, and the commissioners responded in the affirmative. Seeing no opposition, Co-Chair Rinvelt confirmed that the resolution had been adopted at 3:09 p.m.

c. Commissioner Chrissos made the following motion, which was seconded by Commissioner Milewski:
Resolved: The Michigan Health Information Technology Commission recommends that the Michigan Prescription Drug and Opioid Abuse Commission and the Michigan HIT Commission establish a relationship that promotes coordination and collaboration in addressing and implementing the recommendations outlined in the Michigan Prescription Drug and Opioid Abuse Task Force's Report of Findings and Recommendations for Action.

d. Co-Chair Rinvelt asked whether the commissioners supported the resolution, and the commissioners responded in the affirmative. Seeing no opposition, Co-Chair Rinvelt confirmed that the resolution had been adopted at 3:09 p.m.

G. HIT Commission Next Steps
1. Ms. Vanderstelt noted that the next meeting for the HIT Commission would be held on October 20th in the Grand Conference Room.
2. Ms. Vanderstelt also noted that the Division of Policy would start to work on drafting the 2016 Annual Report.
   a. Ms. Vanderstelt explained that the Division of Policy would be aiming to share an outline of the report with the commission by the October meeting.
   b. Ms. Vanderstelt explained further that the Division of Policy would build upon the outline and send a draft report by email to the commission by late 2016 with the goal of finalizing the report by February 2017.

H. Public Comment
1. Co-Chair Rinvelt invited the attendees to introduce themselves and offer public comment.
2. Ms. Cindy Swihart of Altarum noted the difficulty that providers had experienced with implementing electronic prescribing for controlled substances, and Ms. Angela Vanker of Altarum seconded that comment.
3. Mr. Rick Wilkening of MiHIN thanked Lynda for all of her hard work on making the pilot successful.
4. Mr. Keith Hoffman of Aetna complimented the commission on a great meeting and emphasized the importance of the MAPS discussion.

I. Adjourn
1. Co-Chair Rinvelt asked if there was a motion to adjourn the meeting.
2. Multiple commissioners supported a motion to adjourn the meeting, and multiple commissioners seconded the motion.
3. Co-Chair Rinvelt asked if there was any objection to adjourning the meeting. Seeing none, she noted that the meeting was adjourned at 3:17 pm.