



MiHIN – Business Operations Meeting Agenda



Meeting Date:	December 29, 2009	Teleconference #:	866-274-9016 Code: 241174, web conference invite sent separately
Place:	Web Conference and Holiday Inn Express location 2209 University park Drive, Okemos MI (Directions – I-96 at Exit #110/Mason Exit) Room: Coaches Room	Facilitator:	Shaun J. Grannis, MD MS FAAFP
Time:	3:00-4:30		

- Topic 0: Attendance, Approval of Meeting Minutes (5 minutes)
- Topic 1: Charter review and approval (15 minutes)
- Topic 2: HIE Service Priorities (30 minutes)
- Topic 3: Use Cases (30 minutes)
- Topic 4: Status of Other Workgroups (10 minutes)
- Topic 5: Public Comment

DISCUSSION	0. Attendance, Approval of Meeting Minutes (5 minutes)		
	<ul style="list-style-type: none"> Take attendance Approval of previous meeting's minutes 		
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE	
DISCUSSION	1. Charter review and approva [VOTE] (15 minutes)		
	<ul style="list-style-type: none"> Presentation by Co-Chairs 		
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE	
DISCUSSION	2. HIE Service Priorities [VOTE] (30 minutes)		
	<ul style="list-style-type: none"> Discussion facilitated by Shaun Grannis Vote on HIE Service Priority List 		

ACTION ITEMS / DECISIONS		PERSON RESPONSIBLE	DEADLINE
DISCUSSION	3. Use Cases (30 minutes)		
	<ul style="list-style-type: none"> • Presentation by Shaun Grannis 		
ACTION ITEMS / DECISION		PERSON RESPONSIBLE	DEADLINE
DISCUSSION	4. Status of Other Workgroups (10 minutes)		
	<ul style="list-style-type: none"> • Update by Rick Brady <ul style="list-style-type: none"> ○ Our Timeline ○ Other Workgroups ○ The overall plan 		
ACTION ITEMS		PERSON RESPONSIBLE	DEADLINE
DISCUSSION	5. Public Comment		
	<ul style="list-style-type: none"> • Open to public for any issue 		
ACTION ITEMS		PERSON RESPONSIBLE	DEADLINE



MiHIN – Business Operations Meeting Agenda



Meeting Date:	December 15, 2009	Teleconference #:	866-274-9016 Code: 241174, web conference invite sent seperately
Place:	Web Conference and MPHI, 2436 Woodlake Circle, STE 380, Okemos, MI 48864	Facilitator:	Shaun J. Grannis, MD MS FAAFP
Time:	1:30-4:30		

- Topic 0: Attendance, Approval of Meeting Minutes (5 minutes)
- Topic 1: Workgroup Goals (15 minutes)
- Topic 2: Meaningful Use, ONC HIE Services, and Priorities(60 minutes)
- BREAK – 15 minutes
- Topic 3: MiHIN Conceptual Architecture (30 minutes)
- Topic 4: Capacity for HIE in Michigan (30 minutes)
- Topic 5: Status of Other Workgroups (15 minutes)
- Topic 6: Public Comment

DISCUSSION	0. Attendance, Approval of Meeting Minutes (5 minutes)		
	<ul style="list-style-type: none"> • Take attendance – Done by Co-Chair Sue Moran • Voting Member Attendance: <ul style="list-style-type: none"> ○ Peter Ziemkowski-YES ○ Chrsitopher Beal -NO ○ Leland Babitch-YES ○ Bryan Dort-YES ○ Deana Simpson-YES ○ Sherri Stirn-NO ○ Bernard Han- YES ○ Gary Assarian-YES ○ Michael Bouthillier-NO ○ Betsy Pash-YES ○ Tim Pletcher-NO ○ Paul Edwards-YES ○ Scott Monteith-YES ○ Linda Young-YES ○ Rebecca Blake-NO ○ Mary Anne Ford-NO • Presented Rules of Engagement , no questions from attendees 		
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE	

DISCUSSION	1. Workgroup Goals (15 minutes)		
	<ul style="list-style-type: none"> • Presentation by Co-Chairs, no questions 		
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE	
DISCUSSION	2. Meaningful Use, ONC HIE Services, and Priorities(60 minutes)		
	<ul style="list-style-type: none"> • Rick presented initial slides on project overview, Federal Grant requirements • Shaun Grannis presented subsequently • Bernie Han commented that we need to include a focus on preventing the duplication of services, such as duplicated lab tests at different health providers • Gary Assarian commented that there is a need for securing ePHI and ensuring information is only shared appropriately • Dan Boyle commented that BCBSM incentive programs in the PGIP program are driving the need for HIE in his area. • Scott Monteith commented that the workgroup needed listserv and threaded discussion capabilities. This comment was echoed by several, including co-chair Bob Brown. • Bob Brown questioned: Meaningful Use appears to need HIE. What happens if there is no HIE available for a provider? Will they get no meaningful use money? Answered by Shaun Grannis: Could use EMR to provide meaningful use measures, at least in 2011. • Leland Babitch commented that meaningful use requirements are soon, HIE capacity is obviously not there, therefore a reasonable person knows that meaningful use will not be solved by HIE in the near term. • Bob Brown questioned: There are seven ONC service priorities. Do we need to do them all? Answered by Shaun Grannis: ONC realized can't do all at once, they want a strategy to do them all eventually. • Dan Boyle commented that HIE will be a gradual process starting with lining up data silos.HIE will grow over time. Shaun Grannis agreed. • Bryan Dort commented that costs of quality reporting have shown that setting clinical priorities can be complex. • Bernie Han commented that there is a critical need for provider input to ensure validity. • Pete Ziemkowski commented that as a physician, he wants all the capabilities that we are prioritizing. • Hank Mayers commented that there was no explicit mention of security in the ONC's HIE service priorities. Shaun Grannis replied that security is both a large component of meaningful use and inherent in the ONC's services. HIE will play a critical role in security. 		
ACTION ITEMS / DECISIONS	PERSON RESPONSIBLE	DEADLINE	
<ul style="list-style-type: none"> • Listserv and threaded discussion capabilities 	Rick Brady	12/22/09	
DISCUSSION	BREAK – 15 minutes		
	<ul style="list-style-type: none"> • 		
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE	

DISCUSSION	3. MiHIN Conceptual Architecture, Constraints for Phase One (30 minutes)	
	<ul style="list-style-type: none"> • Presentation by Mike Gagnon, MiHIN Lead Technical Architect • Dan Boyle questioned: Who controls access to information. Mike Gagnon responded that this is an item for resolution by the Privacy and Security WG. • Scott Monteith commented that an architecture that forced structured documents for information exchange will have problems. There is a foundational need to be able to exchange data in unstructured formats. He also commented on the problems encountered when health information is serially encoded and decoded, introducing errors. • Bernie Han commented that the Business Operations workgroup should be sure to focus on process and requirements issues. • Gary Assarian commented that JVHL has capacity for lab information. This was noted by the MiHIN PCO for further investigation. • Dan Boyle commented that images are unstructured data. Experience has showed that exchange what data exist now, move towards structured data in the future. • Scott Monteith commented that exchanging information that providers have is critical for clinician buy in. • Paul Muneio asked how disclosure would be handled. Mike Gagnon responded that issue is on the issue list for Privacy and Security. 	
ACTION ITEMS / DECISION	PERSON RESPONSIBLE	DEADLINE
DISCUSSION	4. Capacity for HIE in Michigan (30 minutes)	
	<ul style="list-style-type: none"> • Presentation by Rick Brady • Leland Babitch asked if we could get the value propositions from Early Adopters in Michigan. Permission to share is being sought. The MiHIN PCO will also present candidate value propositions for the Use Cases chosen by the workgroup. • Dan Boyle commented that vendors can be a factor in slowing the growth of HIE. 	
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
<ul style="list-style-type: none"> • Permission for use of value propositions 	Rick Brady	12/22/09
DISCUSSION	5. Status of Other Workgroups (15 minutes)	
	<ul style="list-style-type: none"> • Estimated in person attendance for future meetings at 20 or less • Our near term agenda: HIE Service Priorities, Use Cases and Value Proposition • Other workgroups status will be summarized each meeting 	
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
DISCUSSION	6. Public Comment	
	<ul style="list-style-type: none"> • Dan Boyle commented that he felt the workgroup was a timely, worthy effort. Bryan Dort concurred. 	
ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE

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MiHIN Business Operations Work Group Charter

**DRAFT
December 2009**

Contents

Business Operations Work Group Mission..... 3

Business Operations Work Group 3

 Work Group Leadership 3

 Voting Work Group Members 3

Work Group Meetings Rules of Engagement..... 6

 Open Meetings 6

 Meeting Approach 6

 Decision Making..... 6

Goals and Deadlines 7

Business Operations Work Group Mission

Broad stakeholder involvement is critical to the success of the MiHIN. Toward that end, the initial Business Operations Work Group is tasked with providing input and approve plans for the development of HIE in the State of Michigan. The current strategy for HIE development in the State of Michigan is actualized through the MiHIN backbone.

Business Operations Work Group

The Business Operations Work Group was developed with an intent to provide broad stakeholder representation in the decision making for the MiHIN project as well as to align with ONC guidelines. The Work Group will be led by 2 co-chairs, 1 public, 1 private, who are appointed by the State of Michigan. Co-chairs of the Business Operations and Technical Work Groups as well as chairs of the Finance, Measurement and Privacy and Security Sub Groups will serve as members of Governance Work Group. Initial terms will run November 10, 2009 through April 15, 2010

Work Group Leadership

- Sue Moran: Co-Chair
- Bob Brown: Co-Chair

Roles and Responsibilities

- Work with project facilitators to lead the successful completion of WG deliverables as defined in the project plan within the specified timeframe
- Assign workgroup members to specific tasks/deliverables
- Assure balance of input from stakeholders to gather broad representation so that no one sector unduly influences the deliverables
- Appoint another representative from a similar stakeholder group (meeting minimum requirements) to fill a vacancy that occurs during the initial term
- Assure input from outside experts and advisors as needed to complete deliverables
- Serve as a full member of the WG

Voting Work Group Members

All interested stakeholders are invited to participate in Business Operations Work Group Meetings. However, only voting Work Group Members will be asked to develop consensus around key decision, voting if needed. Through a broad, open and transparent nomination and voting process that was begun at the MiHIN Kick-off meeting on November 10, 2009 and concluded November 24, 2009, the initial Business Operations Voting Work Group members through April 15, 2009:

Primary Care Physician.

Peter Ziemkowski, M.D. - Kalamazoo, MI
Christopher Beal, DO - St. Johns, MI

Chief Medical Information Officer

Leland Babitch, M.D., MBA - Detroit Medical Center

Hospital/Health System Representative

Bryan Dort - Alpena Regional Medical Center

Nursing

Deana Simpson, RN - Detroit Medical Center

Rural Health Centers

Sherry Stirn, BS, CPC, - Mecosta Health Services

University health researcher

Bernard Han - Center of WMU Health Information Technology Research and Services

Laboratory representative

Gary S. Assarian, D.O. – Henry Ford Health System

Pharmacy representative

Michael Bouthillier - Ferris State University

Public health representative

Betsy Pash - Michigan Department of Community Health

RHITEC representative

Tim Pletcher - Central Michigan University Research Corporation

Workforce development initiatives

Paul Edwards - Greater Flint Health Coalition's

Specialty physician representative with EHR experience

Scott Monteith, M.D. - Northern Lakes CMH/GTBM, PC

Home health representative

Linda Young - Borgess Visiting Nurse and Hospice Services

Provider Trade Association

Rebecca Blake - Michigan State Medical Society

Existing HIE Initiative

Mary Anne Ford - Capital Area RHIO

Roles and Responsibilities

- Provide broad stakeholder input in the successful completion of Work Group deliverables as defined in the project plan within the specified timeframe
- Represent other similar stakeholders across the State in the development of Work Group deliverables and serve as a conduit to these similar stakeholders

- Support guidance provided by the Office of the National Coordinator in developing the Strategic and Operational plans

Work Group Meetings Rules of Engagement

It is the intent of the State of Michigan to use an open and transparent process and to facilitate collaborative decision-making among broad stakeholders for key components of the MiHIN project. Toward this end, meetings will be conducted as follows:

Open Meetings

- All meetings conducted by the Work Groups will be open to all interested stakeholders
 - Voting Work Group Members as well as interested stakeholders will review and discuss items to be refined prior to vote.
 - A public comment period will be included at the end of each agenda and will be offered after each vote.
 - When possible, discussion of a decision and the vote on a decision will take place one meeting apart.
 - Agendas and documentation to be reviewed at each meeting will be posted to the MiHIN website and emailed to all workgroup members at least 2 days before each meeting
 - Approved meeting minutes will be posted within 1 week after each meeting.
 - All workgroups will begin meeting face-to-face and will decide on alternative options like web-conference and teleconference for subsequent meetings.

Meeting Approach

- Agenda items fall into three categories:
 - Review only – enable Work Group members to become familiar with information, to ask and/or respond to questions to guide the development of future deliverables
 - Review and refine – provides the opportunity for the Work Group members to review a draft, comment, question, and direct iterations by other Work Groups, as necessary, before approving the final deliverable at a subsequent meeting
 - Review and approve – aims for a decision (consensus or vote) on deliverables that either likely require minimal discussion or have already been reviewed and refined by the Work Group

Decision Making

When a vote is called, the following process will be followed:

- Only Voting Work Group Members are allowed to vote
- A quorum of Voting Work Group Members must be present in order to vote
- A majority vote rules

When possible, items that require a vote will be clearly noted on the agenda

Goals and Deadlines

1. Prioritize ONC HIE Services (December 29)
2. Select Use Cases for initial implementation (January 12)
3. Create Value Propositions for Use Cases Selected (January 26)
4. Provide Input and Approve Statewide Business Architecture (February 23)
5. Provide Input and Approve Statewide HIE Strategic Plan (March 9)
6. Provide Input and Approve Statewide HIT Coordination Plan (March 9)
7. Provide Input and Approve Statewide HIE Operational Plan (March 23)
8. Provide Input and Approve ARRA Reporting Measures (April 6)

PROSPECTIVE Priority	Service	Healthcare Outcomes Meaningfully Improved [Yes/No]	Healthcare Workflows Meaningfully Improved [Yes/No]	Magnitude [Most Population/Moderate Population/Some Population]	Current Michigan Capacity [Yes/No]	Support Meaningful Use in 2011 [Yes/No]	Financial Sustainability [Proven/Believed/Un known]	Alternative Solutions [Solution]	Incremental Health Improvement by Adding Statewide Capacity [Large/Moderate/Sm all]
1	Electronic clinical laboratory ordering and results delivery	Yes-history of labs, structured data for DSS	Yes-less cost to result, less time	Most Population	Yes-CARHIO, Michigan Health Connect	Yes	Proven	Proprietary through EMR vendor (multiple point to point interfaces)	Large
2	Electronic public health reporting	Yes-direct for children, indirect to general public in prevention	Yes-more efficient operations, no duplicate entry	Moderate Population: general public in prevention	Yes-MCIR, MDSS, MSSS	Yes	Unknown	Current proprietary methods (flat file, HL7/ADT feeds)	Small
3	Quality Reporting	Yes-through analytics, response to trends and best practice development (evidence based medicine)	Yes-standardize procedure reduces cost of compliance (operationally and implementation of ability to report)	Moderate Population: benefits are indirect.	No	Yes	Believed	Current proprietary methods (claims modifiers, entry via web portal)	Small
4	Clinical summary exchange for care coordination and patient engagement	Yes-better outcomes through shared data	Yes-fewer resources needed for data gathering.	Most Population	No	Yes	Unknown	None-early stages of CCD use of Certified EHRs.	Moderate
5	Electronic eligibility and claims transactions	No	Yes-less work to process claims, higher assurance of payment with eligibility checking	Most Population	No	Yes	Proven	BCBSM, Clearinghouses	Small
6	Electronic Prescribing and refill requests	Yes-accuracy of rX, ability to check for interactions	Yes	Most Population	No	Yes	Proven	Surescripts, DR. First, etc	Small
7	Prescription fill status and/or medication fill history	Yes-ensure meds are taken, drug interactions		Most Population		Yes	Proven	RXHUB	Small

A brief analysis of HIE service prioritization in Michigan

The purpose of the strawman prioritization is to stimulate discussion and provide reasoning for a possible prioritization of HIE Services. The priority list and analysis were informed through the work of the MiHIN PCO. The MiHIN PCO created two reports: the State of Michigan Systems Technical Analysis and Michigan Early Adopters Technical Analysis. Along with the analysis documents, a substantial body of knowledge was acquired, including interview results and technical surveys. The factors of analysis were evaluated to emphasize quickly achievable goals serving as many providers in Michigan regardless of their status of EHR adoption.

Please review and comment on the priorities and analysis, adjusting the priorities to reflect your beliefs.

Number 7: *Prescription fill status and/or medication fill history:* While required for meaningful use, there is widespread capability present for this, both as a stand-alone applications and through EHRs. Created State level capacity through the MiHIN would create redundant solutions to a priority that is currently met.

Number 6: *Electronic Prescribing and refill requests:* same reasoning as for Number 7.

Number 5: *Electronic eligibility and claims transactions:* There is capacity in Michigan already: web-DENIS (web-based eligibility checking through BCBSM) and CHAMPS (web-based Medicaid eligibility checking through the State of Michigan). With limited funds, it is better to add functionality that currently doesn't exist.

Number 4: *Clinical summary exchange for care coordination and patient engagement:* The clinical documents envisioned here are structured documents (such as the HITSP C32, a type of CCD electronic document) for use not only by physicians but also to be used by computer applications in clinical decision support systems. While there isn't much capacity for this in the State, and there would be clinical and process benefits, it has no readily apparent sustainability factor. In addition, the point raised by Dr. Monteith, that clinical documents are generally scanned images of paper documents (unstructured) and that we need to transition to structured data in an incremental fashion, suggests we should place less priority on this and more on other HIE services that have consensus on current value.

Number 3: *Quality Reporting:* Required for meaningful use. Current methods (claims modifiers, proprietary extracts or software reports) are not scalable or very efficient. We need a way to capture this, in the case of the Medicaid incentives, perhaps sooner than later, to allow efficient incentive operations.

Number 2: *Electronic public health reporting:* like all of these priorities, this supports a meaningful use requirement. Michigan has a strong public health program now: MCIR (Michigan Care Improvement Registry: focusing on immunization histories), MDSS (Michigan Disease Surveillance System: focusing on reportable conditions from lab results), MSSS (Michigan Syndromic Surveillance System: focusing on encounter admission data to find potential outbreaks). Using Grant funds to transition proprietary exchange formats to standards based exchanges builds on systems that are widely seen as useful. The

foundational capacity in Michigan has been built, there are clear standards in the area, and we can adopt best practices from places that have already built this functionality. The technical framework developed for PH use cases may potentially be leveraged for additional use cases.

Number 1: *Electronic clinical laboratory ordering and results delivery:* There is a financial case for electronic laboratory results delivery: the replacement of paper results in lower costs.. There is widespread capacity that can be leveraged, but there is also a substantial proportion of smaller practices that can be helped by electronic labs. It would be possible to leave the current networks in place and have the MiHIN capacity serve to connect the various lab results networks to each other and allow providers with no access to electronic labs connect to the networks in place. This would also enable State wide reporting on such things as referrals, useful for those providers that refer to referral hospitals such as DeVoss Childrens or University of Michigan. While the initial focus is likely to be just results, we plan for reducing duplicate labs by storing lab results in a clinical repository at some point. By reducing duplicate labs, we enable labs to service the 1.1 million uninsured in Michigan, who are apparently going to be insured shortly, without having to spend money to expand capacity.

The top two priorities are quick wins based on activities that are in large part currently occurring. Additional capacity enables use for smaller practices that the market hasn't moved to service.

MiHIN Business Operations Workgroup

Clinical Use Case Overview

December 29, 2009



Objectives

- Two chief objectives of the business operations workgroup are to prioritize:
 - ~~○ **ONC HIE services**~~
 - Specific use cases to be supported within priority HIE services
- With outcomes including:
 - ~~○ **List of priority statewide HIE services**~~
 - List of priority use cases
 - List of other clinical priorities for future consideration (parking lot)



Overview: What We'll Cover

- Mapping Use Cases to HIE services
- Overview of formal use cases:
 - What is a use case?
 - Why is a use case helpful?
 - What is an example of a Use-Case?
- What are next steps?
 - Straw man list of use cases
 - Discussion
 - Vote



Mapping Use Cases to HIE services

- **Electronic eligibility and claims transactions**
 - Verify social security administration disability claims
 - Leverage claims data for quality improvement/reporting process
 - Leverage claims data for prescription fill status
- **Electronic prescribing and refill requests**
 - Verify formulary compliance (cost reduction)
 - Assess potential for adverse drug events (Improving patient safety)
 - Generate and transmit permissible prescriptions electronically
- **Electronic clinical laboratory ordering and results delivery**
 - Incorporate lab test results into EHR (improved timeliness and workflow efficiency)
 - Leverage HIE framework to reduce complexity of delivering clinical results



Mapping Use Cases to HIE services

- **Electronic public health reporting**
 - Receive histories and recommendations from immunization registries using EHR's and MCIR
 - Deliver newborn screening results to public health and clinicians via results delivery
 - Automatically transmit reportable condition data to the Michigan Disease Surveillance System from laboratory systems and EHR systems
 - Deliver public health decision support or public-health alerts directly to physicians and other care providers' EHR
 - Provide electronic syndromic surveillance data to the Michigan Syndromic Surveillance System according to applicable laws



Mapping Use Cases to HIE services

- **Quality reporting**
 - Support process for reporting meaningful use metrics to HHS
 - Aggregate clinical and claims data across separate data sources to document compliance with existing treatment and quality reporting processes
- **Prescription fill status and or medication fill history**
 - Support integration of medication data from various sources including local inpatient settings, large vendors such as Surescripts and Medicaid claims
 - Deliver integrated Rx data at transitions of care



Mapping Use Cases to HIE services

- **Clinical summary exchange for care coordination and patient engagement**
 - Exchange key patient level clinical information among providers of care (e.g., problems, medications, allergies, test results) in various care contexts
 - Produce and share electronic summary care record for every transition in care (place of service, consults, discharge)
 - Provide patients with access to electronic clinical information (including lab results, problem list, medications list, allergies) per patient preference
 - Support quality reporting: summary data contributes to generating quality measures, etc.



What is a Use Case?

- A use case describes relationships between users and systems by detailing the user intention and system response for each step in a particular interaction
- A use case describes what the system will do (rather than how it is done) at a high-level, focused on users
- A use case can be written in both an informal (high-level) and formal (detailed) styles
- A use case can aid in capturing system requirements



Example of an Informal (high-level) Use Case

Name: Order and Receive clinical results

1. Physician places order for clinical test using an EHR.
2. EHR transmits request to clinical service provider (e.g., microbiology lab).
3. Clinical service provider performs requested test.
4. Laboratory information system (LIS) transmits culture report to results delivery service.
5. Results delivery service verifies ordering physician and maps to appropriate electronic destination.
6. Result electronically delivered to ordering physician's EHR.
7. Physician authenticates to their EHR and retrieves electronic result.



Components of a formal (high-level) Use Case

Name: Order and Receive clinical results

1. **Description** (high-level overview)
2. **Scope** (e.g., what processes/components are to be described)
3. **Actors/Stakeholders** involved (e.g., physician, EHR, LIS, results delivery service)
4. **Pre-conditions** (requirements that must be in place before the start of the use case.)
5. **Post-conditions** (results or the output from the use case, e.g., electronic result transmitted to EHR)
6. **Details of Use Case Scenarios**



Prioritizing Use cases



Factors Informing Prioritization (review)

As we evaluate potential use cases, potential factors that can inform prioritization include:

- Potential to improve health outcomes
- Potential to improve workflow (does it address current “pain points”, is there a clear value proposition?)
- Existing evidence?
 - Cost Reduction?
 - Improved Outcomes?
- Magnitude of impact (many or few affected?)
- Does current capacity exist to support process?
- Support Incremental Growth of HIE in Michigan?
- Support Meaningful Use?
- Sustainable?



For Next Meeting

- Review/refine factors that inform prioritization of use cases
- Solicit missing use cases
- Engage in vigorous electronic debate
- Prepare short list to vote upon



MiHIN Business Operations Workgroup: Clinical Use Case Overview

Discussion / Questions

