MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

Minutes for the January 2016 Meeting

Date: Thursday, January 21st, 2016
1:00 pm – 3:00 pm

Location: 1st Floor Conference Rooms A, B, and C
Capitol View Building
201 Townsend
Lansing, Michigan 48933

Commissioners Present:

Patricia Rinvelt, Co-Chair
Rodney Davenport, Co-Chair
Karen Parker
Nick Smith
Orest Sowirka, D.O.
Rozelle Hegeman-Dingle, PharmD
Peter Schonfeld
Randall Ritter
Mark Notman, Ph.D.
Irita Matthews (Phone)
Robert Milewski (Phone)
Michael Chrissos, M.D (Phone)

Commissioners Absent:

Jill Castiglione, RPh

Staff:

Meghan Vanderstelt
Phillip Kurdunowicz
Kimberly Bachelder

Attendees:

Melissa Moorehead
Tim Antonelli
Ellen Ward
Bruce Maki
Nazy Kazerani
Jason Werner
Torey Schlaufman
Samantha Sherman
Bhanupriya Nalla
Trish O'Keefe
Umbrin Ateequi
Larry Wagenknecht
Rick Wilkening
Lynda McMillin
Laura Rappleye
Shelby Reed
Kristy Brown
Cindy Swihart
Mabel Leonard
James Bell III
Deb Eggleston
Angela Vanker
Julia Harshbarger
David Livesay
Sharon Kim
Andrew Kureeka
Paul Porras
Ryan Koolen
Doug Dietzman
Marcus Cheatham
Taylor Flynn
Rosalynn Beene-Harris

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, January 21st, 2016 at the Capitol View Building with 12 Commissioners present.

A. Welcome and Introductions

1. Chair Patricia Rinvelt called the meeting to order at 1:01 p.m.
2. 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. Commissioner Business

1. Chair Rinvelt asked the commissioners to review and consider approving the minutes from the November 2015 meeting.
    a. Commissioner Robert Milewski made a motion to approve the minutes, and Commissioner Peter Schonfeld seconded the motion.
    b. 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.
2. Chair Rinvelt noted that the HIT Commission needs to elect a new co-chair.
    a. Chair Rinvelt also noted that Commissioner Rodney Davenport had been identified as a potential candidate for this position.
    b. Commissioner Davenport confirmed his interest in serving as co-chair.
    c. Commissioner Schonfeld made a motion to nominate Commission Davenport to serve as co-chair for the HIT Commission.
    d. Commissioner Dr. Mark Notman seconded the motion.
    e. Chair Rinvelt asked if there was any objections to approving the nomination. Seeing none, she noted that Commissioner Davenport had been approved as the new co-chair for the HIT Commission at 1:07 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 presented the January 2015 Dashboard to the commissioners. She also noted that the MiHIN portion of the dashboard had been reconfigured to provide an overview of the status of different use cases.
3. Ms. Vanderstelt also presented the revised version of the 2015 HIT Commission Annual Report to the commission.
    a. Ms. Vanderstelt thanked the commissioners for their comments and noted that all of their edits had been integrated into the revised report.
    b. Ms. Vanderstelt asked the commissioners if they were ready to approve the report for distribution to the legislature.
        i. Co-Chair Rinvelt inquired about whether this report was the same as one that was sent by email before the meeting.
        ii. Ms. Vanderstelt confirmed that it was the same report.
        iii. Ms. Vanderstelt noted that the 2015 report has the same structure and domains as the 2014 report but includes updated content for 2015 and a forecast of activities for 2016.
        iv. Ms. Vanderstelt also drew attention to the inclusion of a list of previous HIT Commission resolutions in the 2015 report.
    c. Commissioner Dr. Orest Sowirka made a motion to approve the 2015 report.
        i. Multiple commissioners seconded that motion.

ii. Chair Rinvelt asked if there was any objections to approving the report. Seeing none, she noted that the 2015 Annual Report had been approved at 1:13 p.m.

d. Ms. Vanderstelt noted that the final report would be sent to the legislature.

D. Overview of the Prescription Drug and Opioid Abuse Taskforce Final Report and Recommendations

1. Co-Chair Rinvelt invited Mr. Jared Welehodsky from MDHHS to provide an overview of the Prescription Drug and Opioid Abuse Task Force report. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Mr. Welehodsky offered a quick introduction to opioids and emphasized that opioids were highly addictive.
    a. Mr. Welehodsky noted that the prescription of hydrocodone and oxycodone in the United States has skyrocketed by 300% since 1991. He emphasized that this increase in prescriptions far surpassed the growth and aging rate of the population.
    b. Mr. Welehodsky also drew attention to the elevated mortality rates for deaths from prescription drug overdoses. He accentuated the point that 52% of people who died from prescription drug abuse had a prescription filled within the last 30 days.
    c. Mr. Welehodsky also highlighted the surging rate of heroin use. He noted that many individuals have switched from prescription drugs to heroin because heroin is cheaper and more accessible than prescription drugs.
    d. Mr. Welehodsky also mentioned that other medications such as benzodiazepines and muscle relaxants were also increasingly being abused.
3. Mr. Welehodsky noted that Governor Snyder created a task force in June 2015 to develop strategies to address rising rates of prescription drug and opioid abuse.
    a. Mr. Welehodsky explained that the task force was composed of two committees.
        i. The Committee on Prevention, Treatment, and Outcomes was led by MDHHS Director Nick Lyon and focused on issues related to health care.
        ii. The Committee on Regulation, Enforcement, and Policy focused on issues related to law enforcement and was led by Attorney General Bill Schuette.
    b. Mr. Welehodsky noted that the task force had an ambitious timeline: he noted that the task force began its work in June 2015, finished its final report in September 2015, and published the report in October 2015.
    c. Mr. Welehodsky provided an overview of the 25 core recommendations and 7 contingent recommendations.
        i. Mr. Welehodsky noted that the recommendations were broken into five categories: (1) Prevention; (2) Treatment; (3) Regulation: (4) Policy and Outcomes; and (5) Enforcement.
        ii. Co-Chair Rinvelt inquired about what a “good faith exception” is. Mr. Larry Wagenknecht of the Michigan Pharmacists Association explained that good faith exceptions are provisions in law that allow pharmacists to refuse to dispense medications without being subject to criminal penalties and sanctions if the pharmacist is acting in good faith and has reasonable doubts about the use of the medication.
    d. Mr. Welehodsky noted that the State of Michigan is working to implement the recommendations from the report.
        i. Mr. Welehodsky indicated that 5 different agencies are involved in implementing the recommendations: (1) MDHHS; (2) Department of

Licensing and Regulatory Affairs, (3) Michigan State Police; (4) Attorney General; and (5) Department of Insurance and Financial Services.

ii. Mr. Welehodsky noted that one of the recommendations was related to the Beneficiary Monitoring Program.
    a. Mr. Welehodsky explained that the Beneficiary Monitoring Program focuses on reducing the inappropriate use of Medicaid services. He noted that the Department can restrict beneficiaries to one provider and one pharmacy if inappropriate use is identified.
    b. Mr. Welehodsky noted that the Beneficiary Monitoring Program uses the PROM application, which pulls data from the MDHHS CHAMPS system in order to identify inappropriate use.
    c. Mr. Welehodsky also outlined enrollment criteria for the program.
    d. Mr. Welehodsky noted that the task force had recommended that MDHHS reevaluate the enrollment parameters and evaluate the models that Tennessee and Washington are using.

iii. Mr. Welehodsky noted that the task force was also interested in expanding access to care through Medication-Assisted Treatment. He explained that MDHHS had enacted MSA Policy 15-56 in response, which expands access to Medication-Assisted Treatment through the Medicaid program.

iv. Mr. Welehodsky highlighted the task force's recommendation on Naloxone, which reduces the effect of opioids and can help prevent overdose deaths. He noted that the task force recommended changing state regulations to allow pharmacists to dispense medications like pseudoephedrine.

v. Mr. Welehodsky noted that the task force recommended that the Department of Licensing and Regulatory Affairs make substantial upgrades to MAPS, expand access to MAPS, and increase licensing sanctions.

vi. Mr. Welehodsky noted that the task force recommended increasing training for law enforcement and expanding access to drug treatment courts.

4. Commissioner Comments
    a. Co-Chair Rinvelt asked about whether the task force had a timeline for implementing the other recommendations, and Mr. Welehodsky noted that the task force was still in the process of implementing recommendations.
    b. Commissioner Dr. Orest inquired about how hospice care would be affected by monitoring programs, and Mr. Welehodsky noted that the task force was working on ensuring appropriate access to care while also preventing inappropriate use.
    c. Commissioner Peter Schonfeld asked about how the recommendations could be related to the work of the commission. Ms. Vanderstelt noted that the task force viewed data sharing as a way to improve prescription monitoring and that the next few presenters would highlight strategies for improving data sharing.
    d. Commissioner Dr. Michael Chrissos asked if the task force had recommended creating an interface between MAPS and HIE, and Ms. Vanderstelt noted that the task force had not made this recommendation but MiHIN was working on a proposal for this issue.
    e. Commissioner Dr. Notman inquired about the quality of the data that the State of Michigan has on this issue and asked about where gaps in data may exist.
        i. Mr. Welehodsky noted that there was room for improvement on this issue and mentioned the need for making data available on a real-time basis.

ii. Ms. Vanderstelt highlight the role that HIE could play in getting the data to the right places at the right time.

f. Commissioner Dr. Notman, Co-Chair Davenport, and Commissioner Dr. Sowirka asked for clarification on how the enrollment criteria for the Beneficiary Monitoring Program was derived.
   i. Ms. Torey Schlaufman of MDHHS noted that the BMP program has been around since 1979 and that the Department developed the criteria in consultation with the health plans.
   ii. Commissioner Dr. Notman inquired about why the task force recommended evaluating the Tennessee and Washington models, and Mr. Welehodsky noted that the National Governor's Association had reviewed multiple models around the country and had recommended those two models.

E. Overview of the Medication Reconciliation Initiative

1. Co-Chair Rinvelt invited Ms. Ellen Ward and Ms. Lynda McMillin from Blue Cross Blue Shield of Michigan (BCBSM) provide an overview of the BCBSM HIE Incentives and Exchange Medication Reconciliation Use Case Pilot. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Ms. Ward noted that BCBSM views information sharing as critical for improving the coordination of care and enhancing population health.
   a. Ms. Ward emphasized the importance of information sharing for building upon the team-based approach of Patient-Centered Medical Homes.
   b. Ms. Ward underscored the necessity of having a single access point for providers to share information as opposed to requiring providers to make multiple connections.
3. Ms. Ward noted that the incentive program started in 2015 with encouraging the use of Admit, Discharge, and Transfer (ADT) notifications.
   a. Ms. Ward indicated that providers had a strong interest in knowing if their patients were hospitalized.
   b. Ms. Ward also revealed that providers did not want to use a BCBSM-only solution and also did not want to create unique connections with individual hospitals.
   c. Ms. Ward demonstrated through one of her charts that every Physician Organization has patients who receive care from a wide variety of hospitals.
4. Ms. Ward provided some perspective on the trajectory for the BCBSM incentive program.
   a. Ms. Ward noted that BCBSM initially focused on incentivizing the use of ADT Notifications in 2014 and 2015.
   b. Ms. Ward mentioned that BCBSM collaborated with the Michigan Health and Hospital Association and MiHIN on operationalizing this use case and addressing data quality issues.
   c. Ms. Ward also indicated BCBSM has also been working with MiHIN on onboarding the remaining hospitals as well as skilled nursing facilities in Michigan.
   d. Ms. Ward noted that BCBSM had also been working on expanding incentives to include participation in medication reconciliation.
5. Ms. Ward outlined BCBSM's focus for incentives in 2016 and 2017:
   a. 2016: ADT Notifications, Medication Reconciliation, and Patient Matching
   b. 2017: Submission of Laboratory Values, Query, Electronic Quality Measures
6. Ms. Ward also indicated the BCBSM would continue to encourage new physician organizations and practices to get involved and promote the use of data in care processes.

a. Commissioner Schonfeld noted that a significant amount of work had been done around these issues and that data was now flowing. He also emphasized that more work needed to be done in terms of making data useful and actionable and leveraging the data to make improvements in patient care and physician practice.
b. Ms. Ward indicated that the Michigan Health and Hospital Association's CIO group is working on this issue.
c. Ms. McMillin provided an anecdote about how one physician had successfully leveraged ADTs to discover that one of her patients had been hospitalized and used that information to provide follow-up care.

7. Ms. McMillin provided an overview of the Exchange Medication Reconciliation Use Case.
    a. Ms. McMillin noted that this use case is initially focused on reconciling medications and reducing the risk of adverse drug events after a hospital discharge.
    b. Ms. McMillin also described the roles of physician organizations, hospitals, and MiHIN and illustrated the flow of information for this use case.
    c. Ms. McMillin noted that the following organizations are participating in the pilot of this use case: Beaumont Health System, Greater Macomb PHO, Detroit Medical Center, Medical Network One, Henry Ford Health System, Oakland Southfield Physicians, University of Michigan Health System, and United Physicians.
    d. Ms. McMillin emphasized the importance of the Active Care Relationship Service and Health Provider Directory for operationalizing this use case. Ms. McMillin noted that the Physician Organizations are migrating to ACRS 2.0 in February or March.
    e. Ms. McMillin also noted that BCBSM's experience with incentivizing ADTs notifications was valuable for understanding how to make this information useful and actionable as part of the care delivery process.
        i. Ms. McMillin indicated that part of this work involved reviewing the care summary for the Medication Reconciliation use case and refining the content to include the most important sections such as current medications, admission history, and medications at time of discharge.
        ii. Ms. McMillin recognized the role that MiHIN played in assisting hospitals with conformance reporting for case summaries. She noted that MiHIN's work helped hospitals with identifying the most important information in the case summary and refining the document to make it more actionable.
    f. Ms. McMillin also noted that different physician organizations have different workflows and levels of readiness. She highlighted the importance for the physician organization of determining who on the care team will receive alerts and how the care team will risk stratify the population.
    g. Ms. McMillin highlighted some of the successes and challenges of the use case pilot.
        i. Ms. McMillin noted that multiple health systems were sending messages through MiHIN that meet meaningful use and BCBSM requirements.
        ii. Ms. McMillin also emphasized the collaboration between health systems, provider organizations, data sharing organizations, and vendors on improving message content, delivery protocol, and workflow integration.
        iii. Ms. McMillin noted that stakeholders repeatedly emphasized the importance of ensuring that data is actionable and useable by physicians.
        iv. Ms. McMillin also indicated that providers were confronting challenges with variations in individual workflow and cost of participation.
        v. Ms. McMillin mentioned that providers have been focusing on improving the submission of Active Care Relationship Services files to MiHIN.

h. Ms. McMillin stated that the statewide data sharing infrastructure has reached a level of maturity where use case implementation is not wholly dependent on technology but rather delivery and workflow.
i. Ms. McMillin also emphasized that this use case helps set the foundation for other health care transformation initiatives such as the State Innovation Model (SIM). She also highlighted some particular ways that SIM can build upon the foundation of the use case pilot:
    i. Share lessons learned and best practices
    ii. Identify opportunities to reduce and eliminate barriers
    iii. Work together to stop data blocking and improve Electronic Health Record (EHR) functionality
    iv. Develop a common approach to care coordination and transitions of care

8. Commissioner Comments
    a. Commissioner Milewski commended Ms. Ward and Ms. McMillin on their presentation.
        i. Commissioner Milewski stated that "good IT is autocratic IT" and the challenge is keeping stakeholders at the table. He encouraged the presenters to ask for help from the Michigan Health and Hospital Association and MiHIN on this issue.
        ii. Commissioner Milewski inquired about the end date for the pilot. Ms. McMillin noted that the BCBSM is still receiving data from hospitals and preparing to present it to the physician organizations, but she also noted that the pilot is almost complete.
    b. Ms. Vanderstelt noted that MDHHS considered this pilot to be important in terms of the pre-implementation phase for SIM.
        i. Ms. Vanderstelt noted that this use case is important for building the functionality that will support implementation.
        ii. Ms. Vanderstelt also noted that this use case is written into the Medicaid Health Plan contracts and participation in this use case is required.

F. Overview of the Medication Reconciliation White Paper and Related Use Cases

1. Co-Chair Rinvelt invited Mr. David Livesay of MiHIN and Mr. Wagenknecht to provide an introduction on the Medication Reconciliation White Paper and related use cases. The PowerPoint slides for this presentation will be available on the website after the meeting.
2. Mr. Wagenknecht noted that the Michigan health care community has been having a discussion about improving the sharing of medication information for the past 10 years.
    a. Mr. Wagenknecht also mentioned that he served on the Prescription Drug and Opioid Abuse Task Force and noted that the task force recognized that HIE would be one of the solutions for improving the sharing of medication information.
    b. Mr. Wagenknecht indicated that pharmacists migrated towards electronic sharing clinical information during the early 1980s. He also noted that a major issue emerged when physicians migrated to EHRs but pharmacists kept their own standards, which became a barrier to sharing information between the two groups.
    c. Mr. Wagenknecht also mentioned that he had previously served on the HIT Commission and participated in commission discussions on pharmacy issues.
    d. Mr. Wagenknecht also noted that pharmacists who are outside of clinical settings do not have access to patient data such as laboratory results and diagnoses. He

indicated that MiHIN had been exploring solutions for facilitating the sharing information across all members of the care team.

3. Mr. Wagenknecht introduced Mr. Livesay and indicated that Mr. Livesay would be providing an overview of the white paper.
4. Mr. Livesay acknowledged that there is a ton of energy around the medication management discussion in Michigan right now.
    a. Mr. Livesay noted that part of this interest stems from provider participation in the ADT use case: he revealed that providers who were receiving ADTs are also now interested in receiving medication information.
    b. Mr. Livesay indicated that MiHIN convened a wide array of stakeholders in a series of workshops in order to identify high value scenarios for data sharing.
        i. Mr. Livesay noted that workshop participants identified 80 possible use cases and that five priority use cases were eventually derived from that list.
            a. Exchange Lab Results and Diagnosis
            b. Exchange Medication Data with Prescription Monitoring Programs
            c. Exchange Prescription Status
            d. Facilitate Prescription Stop Order
            e. Exchange Medication Reconciliation
        ii. Mr. Livesay noted that the following three use cases were identified by stakeholders as the first priority out of the original five.
            a. Exchange Medication Reconciliation
            b. Exchange Medication Data with Prescription Monitoring Programs
            c. Exchange Lab Results and Diagnosis
5. Mr. Livesay also outlined the value proposition for the three priority use cases.
    a. Mr. Livesay indicated that the high level of interest in the Exchange Lab Results and Diagnosis use case was a surprise. He mentioned that several studies had demonstrated the positive impact that pharmacists can have when they can access diagnosis and laboratory information.
    b. Mr. Livesay noted that stakeholders saw value in the Exchange Medication Reconciliation use case due to the health and financial impacts of adverse drug events. Mr. Livesay provided the following estimates of the impact of poor information sharing:
        i. Annual cost of adverse drug events leading to morbidity and mortality in Michigan: $6.3 billion
        ii. Impact of poor communication of medical information at transition points:
            a. 50% of all medication errors
            b. 20% of all adverse drug events
            c. 66% of all medication errors resulting in death or major injury
    c. Mr. Livesay noted that stakeholders saw value in the Prescription Monitoring Program use case because physician organizations must expend significant amounts of time now to access data in MAPS. Mr. Livesay provided the following estimates of the lost productivity due to poor communication with MAPS.
        i. Clinicians and pharmacists in Michigan lose roughly 121,000 to 485,000 care hours per year accessing MAPS.
        ii. Clinicians and pharmacists in Michigan lose roughly $9,000,000 to $36,000,000 in time spent accessing MAPS per year.
        iii. Over a five year period, these ranges translate to roughly 600,000 to 2,400,000 lost care hours and $45,000,000 to $180,000,000 in time spent.

6. Mr. Livesay outlined some of the opportunities that had been discussed in terms of electronic integration with MAPS.
    a. Push MAPS Use Case
    b. Pull MAPS Use Case
    c. MAPS Single Sign-On Use Case
7. Mr. Livesay outlined the concept behind the Exchange Lab Results and Diagnosis use case.
    a. Mr. Livesay explained that pharmacists see a medication come through and think it may be a mistake. He explained further that the pharmacists do not have the information to determine whether it was a mistake and must call the prescribing physician for clarification, which slows down the process.
    b. Mr. Livesay stated that pharmacists would benefit from having this information upfront and could reduce the number of phone calls, prior authorizations, duplicative therapies, and adverse drugs events with this information.
8. Mr. Livesay listed some of the technology, legal, and operational challenges that stakeholders identified for moving forward with these use cases. Mr. Livesay noted that MiHIN included a section in the white paper that specifically addressed technical and legal considerations, which are outlined below:
    a. Consent for Sharing Behavioral Health Records
    b. Data Sharing Agreements
    c. Data Standards
    d. Data Blocking
    e. Necessity of Shared Infrastructure
    f. Lack of Vendor Cooperation
    g. Limitations of EHR Functionality
9. Mr. Livesay concluded by noting some of the use cases (Medication Reconciliation) were moving forward while other use cases have momentum but are still being explored (Prescription Monitoring Program and Diagnosis/Lab Results).
10. Commissioner Comments
    a. Mr. Bruce Maki of the Michigan Center for Effective IT Adoption suggested that the State of Michigan could get physicians and vendors on board if MAPS were designated as a specialized registry. Mr. Maki noted that providers are scrambling to meet the public health reporting requirements under Meaningful Use and that reporting to a specialized registry would help address those requirements.
    b. Commissioner Schonfeld asked Mr. Wagenknecht about emerging care models where the pharmacist is part of the care team and inquired about whether we have examples of those models in Michigan.
        i. Mr. Wagenknecht noted that different health care organizations were moving in this direction and that BCBSM was offering incentives to organizations to integrate pharmacists into the care team.
        ii. Mr. Wagenknecht mentioned that pharmacists were historically employed by hospitals but also noted that physician organizations are starting to directly employ pharmacists as well.
        iii. Mr. Wagenknecht explained that pharmacists see an opportunity to help prevent hospital admissions, address chronic diseases, and coordinate care for individuals who use multiple medications.
    c. Commissioner Schonfeld asked follow-up questions about whether retail pharmacies or pharmacy managers are offering these services and how this relationship is affected by scope of practice regulations.

i. Mr. Wagenknecht noted that Michigan was lucky in terms of scope of practice because the Attorney General's Office issued an opinion that supports pharmacist participation in prescribing and care management if the pharmacist and physician have a delegation relationship in place.
ii. Mr. Wagenknecht noted that individual chains have been approaching health plans and health systems to provide support for certain activities.
iii. Mr. Wagenknecht noted that the current Fee-For-Service reimbursement system discourages collaboration because pharmacists are incentivized to dispense medications instead of participate in clinical activities.

d. Commissioner Milewski asked Mr. Wagenknecht where Michigan stands in terms of connectivity when compared to other states.
i. Mr. Wagenknecht indicated that Michigan was at approximately the same point as other states in terms of getting pharmacy data into the EHR. He noted that Michigan was ahead in terms of recognizing the potential role of pharmacists in coordinating care.
ii. Mr. Wagenknecht noted that Michigan was also ahead in terms of submitting vaccination information for public health reporting purposes.
iii. Mr. Wagenknecht stated that pharmacists who submit information to other providers should also have the ability to receive information as well.

e. Ms. McMillin noted that pharmacies are working with physician organizations on issues related to Healthcare Effectiveness Data and Information Set (HEDIS) measures and care management. She also echoed the statement that Michigan is making great strides in terms of addressing these issues.

G. HIT Commission Next Steps

1. Ms. Vanderstelt noted that the next HIT Commission meeting will be held in June.
   a. Ms. Vanderstelt explained that the next HIT Commission meeting would also be held in a separate location because MDHHS will be moving to a new building.
   b. Ms. Vanderstelt indicated that the June meeting will be held in Capitol Commons and that the HIT Office would be sending out an email with more instructions.
   c. Ms. Vanderstelt asked Mr. Livesay about how the June meeting date would coincide with Connecting Michigan for Health 2016. Mr. Livesay noted that Connecting Michigan is the week before the next meeting.
2. Ms. Vanderstelt noted that the HIT Office would be sending monthly email updates as well.
3. Co-Chair Rinvelt noted that she would be meeting with Ms. Vanderstelt and Co-Chair Davenport to plan the June meeting.

H. Public Comment

1. Chair Rinvelt invited the attendees to introduce themselves and offer public comment.
2. Meeting attendees introduced themselves but did not offer any comments.

I. **Adjourn**

1. Chair Rinvelt asked if there was a motion to adjourn the meeting.
2. Commission Dr. Notman made the motion, and Commissioner Hegeman-Dingle seconded the motion.
3. Chair Rinvelt asked if there was any objection to adjourning the meeting. Seeing none, she noted that the meeting was adjourned at 2:37 pm.