MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

Minutes for the September 2015 Meeting

Date: Thursday, September 17th, 2015
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, Chair
Rodney Davenport
Robert Milewski
Orest Sowirka, D.O. (Phone)
Mark Notman, Ph.D.
Irita Matthews
Rozelle Hegeman-Dingle, PharmD (Phone)
Nick Smith
Karen Parker
Jill Castiglione, RPh (Phone)
Peter Schonfeld
Ritter, Randall

Commissioners Absent:

Michael Chrissos, M.D

Staff:

Meghan Vanderstelt
Phillip Kurdunowicz
Kimberly Bachelder

Attendees:

Philip Viges
Kristy Brown
Bruce Maki
Debra M. Miros
Spencer Herling
Cindy Swihart
Sharice George
Tom Korff
Traci Wightman
Cynthia Green Edwards
Brody McClellan
George Bosnjak
Shelley Mannino Marosi
James Bell III
Jeff Livesay
David Durkee
Erin Sarzynski
Jason Werner
Joel Wallace
Umbrin Attequi
Angela Vanker
Ryan Koolen
James Noland
Anya Day
Rick Wilkening

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, September 17th, 2015 at the Capitol View Building with 12 Commissioners present.

A. Welcome and Introductions

1. Chair Patricia Rinvelt called the meeting to order at 1:02 p.m.
2. Chair Rinvelt noted that the Governor had made several appointments and re-appointments to the Health Information Technology Commission ("HIT Commission" or "Commission"):
    a. Commissioner Randall Ritter (Appointed to represent the General Public)
    b. Commissioner Dr. Michael Chrissos (Re-appointed to represent Doctors of Medicine)
    c. Commissioner Dr. Orest Sowirka (Re-appointed to represent Osteopathic Doctors of Medicine)

B. Commissioner Updates

1. Chair Rinvelt asked the other commissioners if they had any updates to share since the last time that the commission convened.
2. The other commissioners did not have any updates to share at this time.

C. **Review and Approval of the 8/20/2015 Meeting Minutes**

1. Chair Rinvelt asked the commissioners to review and consider approving the minutes from the August 2015 meeting.
2. Commissioner Robert Milewski made a motion to approve the minutes, and Commissioner Matthew 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.

D. HIT/HIE Update

1. Chair Rinvelt invited Ms. 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 reminded the Commissioners that Dr. Greg Forzley, the former co-chair of the Commission, had finished his term last month and that the Commission is in need of a new co-chair.
    a. Ms. Vanderstelt noted that the Commission would consider nominations for a new co-chair at the next meeting.
    b. Ms. Vanderstelt also suggested that Commissioners contact Chair Rinvelt if they have questions about the co-chair position.
3. Ms. Vanderstelt provided an overview of statewide policy initiatives as context for today's meeting on the importance of statewide Health Information Exchange infrastructure for supporting health care transformation efforts.
    a. Ms. Vanderstelt provided a re-cap of last month's discussion regarding the Peace of Mind Registry.
        i. Ms. Vanderstelt noted that the successful implementation of the registry on a statewide basis will be reliant on the use of foundational infrastructure.
        ii. Ms. Vanderstelt emphasized that all of the initiatives that she would mentioned today would leverage this foundational infrastructure.
    b. Ms. Vanderstelt identified the other following initiatives that would use this foundational infrastructure:
        i. Blueprint for Health Innovation
        ii. Request for Proposals for Comprehensive Health Plan Contracts for Michigan's Medicaid Health Plans
        iii. MI Health Link Demonstration

c. Ms. Vanderstelt noted that these initiatives share common themes of integration, person-centered focus, care coordination, population health management, and payment reform.
d. Ms. Vanderstelt also highlighted that these initiatives have the following common barriers that need to be overcome:
    i. Identifying a consumer throughout the healthcare system.
    ii. Identifying who should be kept informed regarding the consumers episode of care.
    iii. Inserting the consumer's point of view regarding provider relationships and access to health data.
e. Ms. Vanderstelt asked the Commission to consider taking the following actions:
    i. Support the utilization of the Active Care Relationship Service (ACRS) and Common Key statewide service as a means to achieve MDHHS policy goals
    ii. Encourage Michigan healthcare stakeholders to adopt Active Care Relationship Service (ACRS), Common Key statewide service, and utilize the Statewide Health Provider Directory (HPD).

E. Update on MDHHS Infrastructure for Identity Management and Attribution

1. Chair Rinvelt invited Ms. Cynthia Green-Edwards of MDHHS to provide an update on the infrastructure that MDHHS is building to support identity management and attribution on a statewide basis. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Ms. Green-Edwards explained that the Governor's "River of Opportunity" framework for improving the delivery of services and supports is reliant upon the capability of ensuring that the right information is available for the right person at the right time at the right place.
    a. Ms. Green-Edwards noted that information technology can facilitate this goal and promote the delivery of services in a way that is more person-centered, less fragmented, and more effectively coordinated.
    b. Ms. Green-Edwards indicated that leveraging the statewide infrastructure can help improve integration but also noted that there is work that needs to be done in terms of improving the accuracy and quality of data.
3. Ms. Green-Edwards highlighted some initiatives that are currently using the statewide infrastructure.
    a. Ms. Green-Edwards noted that Medicaid beneficiaries can use the myHealthButton or myHealthPortal applications to (1) access data within the State of Michigan or (2) upload Advance Directives through these applications and have them sent through the Data Hub and Michigan Health Information Network (MiHIN) to the Peace of Mind Registry. She also noted that physicians will eventually be able to query for this advance directives.
    b. Ms. Green-Edwards also noted that the Admit, Discharge, and Transfer Notification use case leverages the statewide infrastructure.
4. Ms. Green-Edwards noted that the Data Hub is focused on the person and not the program. She expanded on this concept by noting that the State of Michigan wants to ensure that the information is available where it is needed regardless of what Department is responsible for the particular program.
    a. Ms. Green-Edwards emphasized that the goal of the Data Hub is to promote interoperability across systems.

    b. Ms. Green-Edwards highlighted the importance of understanding identities of different users across systems and ensuring that only authorized users can access appropriate information.
5. Ms. Green-Edwards provided an overview of some of the key pieces of infrastructure:
    a. Michigan Identify, Access, and Credential System
    b. Master Person Index and the Provider Index
        i. Ms. Green-Edwards mentioned that different data sources have different identifiers for the same individual and noted the importance of being able to link these identifiers across data sources.
        ii. Ms. Green-Edwards emphasized that MDHHS does not share the master identifier and that the Department can make the linkage between different data sources based on identifiers without sharing identities.
    c. Common Key Service, Active Care Relationship Service, and the Health Provider Directory
        i. Ms. Edwards noted that these three services were developed and are being supported by MiHIN.
        ii. Chair Rinvelt asked about the meaning of the acronym TDSO, and Ms. Green-Edwards clarified that TDSO is a Trusted Data Sharing Organization within the MiHIN network. Ms. Green-Edwards also noted that TDSOs can access shared infrastructure once they connect to the "trust framework".
        iii. Ms. Green-Edwards noted that information and identifiers are not shared across the board as part of the Common Key Service. She explained further that the Common Key Service is used to match providers in the Health Provider Directory and to link to the State of Michigan's Master Person Index and Provider Index via the Active Care Relationship Service.
    d. CareConnect360
        i. Ms. Green-Edwards explained that CareConnect360 providers a "360 degree" view of the services that the individual is receiving.
        ii. Ms. Green-Edwards noted that the CareConnect360 is being leveraged by care coordinators as part of the MI Health Link demonstration.
        iii. Ms. Green-Edwards emphasized the importance of the Common Key Service and Active Care Relationship Service to operationalizing CareConnect360.
6. Ms. Green-Edwards noted some of the benefits of the Master Person Index and Provider Index such as providing a 360-degree view of the services that the individual is receiving, reducing duplicate records, and improving data quality.
    a. Commissioner Peter Schonfeld inquired about the source of the information for the Master Person Index and Provider Index.
    b. Ms. Green-Edwards noted that MDHHS began linking records in the Data Warehouse in 2001 and continued to expand the Master Person Index and Provider Index over time by adding more data sets.
    c. Ms. Green-Edwards also highlighted the importance of using this process to rectify mistakes in data sets in source systems.
    d. Ms. Green-Edwards also noted the potential opportunity for updating the Master Person Index and Provider Index based on dynamic data from the Active Care Relationship Service.
7. Ms. Green-Edwards also provided an overview of MiLogin and noted that MiLogin supports identity management and proofing.

a. Chair Rinvelt asked about whether MiLogin is live, and Ms. Green-Edwards confirmed that MiLogin is live but that more systems are being integrated into it.
b. Ms. Green-Edwards highlighted the value of MiLogin in allowing customers to have one set of credentials across state systems and reducing the number of passwords.
c. Ms. Green-Edwards also emphasized the potential to use federated identity management to allow organizations to log into state systems by using their organization's credentials as long as the organization is a trusted entity.

8. HIT Commission Discussion
    a. Commissioner Nick Smith asked about whether external systems would be able to leverage the work that is happening with the MPI.
        i. Ms. Green-Edwards provided examples of how the Master Person Index and Provider Index help link records and allow the provider to query for data from the Data Warehouse:
            a. Michigan Care Improvement Registry and information on immunizations, lead results, and well-child visits
            b. Women Infant and Child program and homeless data
        ii. Ms. Vanderstelt also noted that the Master Person Index makes linkages with external systems.
        iii. Mr. Jeff Livesay of MiHIN noted that the Common Key Service is an outward-facing Application Programming Interface for the Master Person Index.
        iv. Ms. Green-Edwards noted that analyzing identifiers across programs helps drive improvements in the linkage rules and may lead to discovery of new data sets.
        v. Commissioner Smith inquired about how an organization can leverage and connect to the Master Person Index.
            a. Ms. Green-Edwards noted that an organization only needs to make one connection to MiHIN, which would connect to the State of Michigan and link to the Master Person Index.
            b. Ms. Green-Edwards noted that the State of Michigan has been matching identities since 2001 and that Medicaid contributes to the Health Provide Directory and Active Care Relationship Service.
    b. Commissioner Ritter asked about whether the myHealthButton and myHealthPortal applications are restricted to certain parts of the consumer population and whether these applications can be expanded to other groups.
        i. Ms. Green-Edwards noted that these applications were originally built for Medicaid beneficiaries but could be expanded to other groups.
        ii. Ms. Green-Edwards also mentioned that the State of Michigan has been talking with the Centers for Medicare and Medicaid Services about allowing providers to get Meaningful Use credit if their patients access the myHealthButton or myHealthPortal applications.
    c. Commissioner Smith asked for further clarification about what Ms. Green-Edwards meant by "…we need everyone to participate." Ms. Green Edwards clarified that she was referring to stakeholders getting used to using CareConnect360 and participating in health information exchange by leveraging the Health Provider Directory and Active Care Relationship Service.
9. Public Comment

a. Mr. George Bosnjak from Great Lakes Health Connect asked about how many individuals are currently listed in the Master Person Index, and Ms. Green-Edwards noted that 16,000,000 individuals are currently included in the Master Person Index.

F. Update on MiHIN Infrastructure Use Cases

1. Chair Rinvelt invited Dr. Tim Pletcher of MiHIN to provide an update on the infrastructure use cases that support identity management and attribution. The PowerPoint slides for this presentation will be made available on the website after the meeting.
2. Dr. Pletcher provided an overview of the history of statewide coordination on health information exchange in Michigan. Dr. Pletcher highlighted the importance of the Conduit to Care report and MiHIN Shared Services plan in setting the framework for health information exchange.
3. Dr. Pletcher reviewed the "Phase One" Statewide Use Cases, which are in full production.
    a. Public Health Reporting: Dr. Pletcher highlighted the importance of this use case to supporting Meaningful Use reporting.
    b. Health Provider Directory: Dr. Pletcher noted the importance of developing a system for how providers could be contacted electronically.
    c. Push Alerts and Notification
4. Dr. Pletcher introduced the "Phase Two" use cases, which are not in full production.
    a. Dr. Pletcher specifically highlighted the potential for the Pull/Query Care Summaries use case.
    b. Dr. Pletcher noted that this use case could be used to exchange information with the federal government and national groups.
    c. Dr. Pletcher also highlighted the potential workflow efficiencies that could be achieved by organizations who electronically exchange information with the Social Security Administration. Dr. Pletcher explained further that this particular scenario allows organizations to reduce the time for requesting medical information from 2.5 years to 2.5 weeks.
        i. Chair Rinvelt asked for clarification if this capacity is currently in place but not being used, and Dr. Pletcher confirmed this statement.
        ii. Commissioner Irita Matthews inquired about what the cost of implementation would be, and Dr. Pletcher noted that the cost would be negligible with the potential for a subsidy from the Social Security Administration of $15 per completed transaction.
    d. Dr. Pletcher provided some perspective on the vision for statewide health information exchange under the original grant from the Office of the National Coordinator for Health Information Technology.
        i. Dr. Pletcher noted that the State of Michigan was responsible for coordinating data sharing within the State while MiHIN was responsible for coordinating data sharing outside of the State.
        ii. Dr. Pletcher also referenced the point of MiHIN being a "Network of Networks" that allow a single point of entry into the state.
        iii. Dr. Pletcher provided an overview of the governance structure of MiHIN.
            a. Dr. Pletcher noted that the Commission provides external transparency while the MiHIN board ensures internal accountability.
            b. Dr. Pletcher also emphasized the role of the MiHIN Operations Advisory Committee and related working groups to driving consensus and collaboration on MiHIN initiatives.

e. Dr. Pletcher provided an overview of the MiHIN legal framework for statewide health information exchange.
    i. Dr. Pletcher noted that there are two levels of legal infrastructure:
        a. Organization Agreement (QDSOA): Dr. Pletcher compared this document to a "Master Agreement" between organizations.
        b. Data Sharing Agreement (DSA): Dr. Pletcher noted that these documents functioned like "Statements of Work" and that they are primarily focused on specific scenarios for data sharing.
    ii. Dr. Pletcher highlighted the importance of these documents in establishing the "Chain of Trust"
    iii. Dr. Pletcher outlined the following functions of MiHIN as the "Curator" of the Statewide Health Information Exchange Ecosystem:
        a. Manage the statewide legal trust fabric
        b. Maintain the master data for the Active Care Relationship Service, Health Provider Directory, and Statewide Consumer Directory
        c. Convene groups to identify data sharing barriers, reduce provider burdens, engage consumers, and enable population health
f. Dr. Pletcher also walked through the conceptual framework of the Use Case Factory.
    i. Dr. Pletcher identified the three phases of a use case in the Use Case Factory process as (1) Planning and Development; (2) Implementation; and (3) Statewide Adoption.
    ii. Dr. Pletcher also highlighted the role of three documents in the Use Case Factory process:
        a. Use Case Summary (Basic Summary)
        b. Use Case Agreement (Legal Agreement)
        c. Use Case Implementation Guide (Technical Standards)
    iii. Dr. Pletcher also emphasized the role of "personas" and "storyboards" to develop realistic scenarios and eventual use cases.
    iv. Dr. Pletcher underscored the importance of different mechanisms in accelerating the developing and adoption of use cases:
        a. Financial Incentives and Disincentives
        b. Clinical Endorsement and Evidence
        c. Policy and Regulatory Levers
    v. Dr. Pletcher noted the shift of the health care system from an ecosystem with a scarcity of data towards an ecosystem with an abundance of data.
        a. Dr. Pletcher explained further that stakeholders in an ecosystem with an abundance of data must increasingly focus on the quality of data as well as strategies for effective use and referenced the Admit-Discharge-Transfer (ADT) Notification use case as an example of this effort.
        b. Commissioner Schonfeld asked Dr. Pletcher if he thought the ADT use case is a successful example of this effort, and Dr. Pletcher confirmed that he did believe it is a successful example.
        c. Commissioner Schonfeld referenced to the wide disparity in the number of entities who are receiving data versus the number of entities who are sending data. He also referenced the lack of usability of current ADT data.

d. Dr. Pletcher noted that the Medicare incentives currently support making this data available but do not reimburse doctors for coordinating care based on this data.
e. Commissioner Schonfeld noted that the current structure of ADTs does not fit into provider workflows, which does not help.
f. Dr. Pletcher highlighted the importance of education to helping providers successfully integrate ADTs into their workflow.
g. Commissioner Bob Milewski emphasized the importance of ADTs for tackling readmissions
h. Commissioner Schonfeld expressed concerns about organizations checking the box about using ADTs without really using them.
i. Dr. Pletcher mentioned that ADTs are a success because they got people started on the journey towards other use cases such as Medication Reconciliation.
j. Ms. Green-Edwards provided CareConnect360 as an example of when organizations do not know exactly how to use new technology as first but can eventually integrate it into their workflow.
k. Commissioner Schonfeld acknowledged that Ms. Green-Edwards had a good point and mentioned that the health plans are trying to do care coordination.
l. Dr. Pletcher noted that providers are shifting from "…we don't know what we want, but we want it all" to "…we don't want all of this…"
m. Commissioner Schonfeld agreed that there is currently a "data flow" for ADT notifications but that the use case is not fully functioning at this point. He emphasized the need to leverage the data flow to support better patient care.

g. Dr. Pletcher provided an overview of the workflow process for the Statewide ADT Use Case and highlighted the essential role of the Active Care Relationship Service and Health Provider Directory for enabling this use case.
    i. Dr. Pletcher stated that MiHIN is in the raw data business and emphasized that the local Qualified Organizations are responsible for taking the raw data and tailoring it to meet the needs of providers.
    ii. Dr. Pletcher drew attention to the potential for the infrastructure use cases under the ADT use case to be re-used for other use cases such as Medication Reconciliation and Care Plans.
h. Dr. Pletcher highlighted the linkages between the Health Provider Directory, Active Care Relationship Service, and Common Key Service.
    i. Dr. Pletcher noted that the Common Key Service is built upon a patient matching algorithm and adds an identifier that raises the confidence that organizations can have in patient matching across data sets.
    ii. Dr. Pletcher noted the importance of the Active Care Relationship Service for "crowd-sourcing" data for the Common Key Service.
i. Dr. Pletcher introduced another initiative related to the alignment of quality measure reporting across providers and payers.
    i. Dr. Pletcher demonstrated through the use of a venn diagram that the Michigan physicians currently have to report five sets of quality measures with a grand total of 400 to 500 measures and noted that only 9 measures are commonly shared between those five quality measure sets.

ii. Dr. Pletcher mentioned the interest of the physician community in increasing coordination on quality measures and streamlining the electronic submission of Clinical Quality Measures.
iii. Dr. Pletcher highlighted the potential for MiHIN's MIDIGATE technology for helping physicians submit Clinical Quality Measures once and then having those quality measures be reported to multiple organizations.

j. Dr. Pletcher outlined some health information exchange topics that MiHIN is planning to attempt to address in 2016 and 2017.
    i. Medication Management
    ii. Coordinating Care Coordination
    iii. Quality Reporting
    iv. Consent Management
    v. Statewide Consumer Services
        a. State Health Risk Assessment (Healthy Michigan)
        b. Peace of Mind Registry
k. Dr. Pletcher also mentioned that MiHIN is working with a variety of organizations on a national level such as:
    i. The Sequoia Project
        a. Carequality
        b. eHealth Exchange
    ii. CommonWell Health Alliance
    iii. NATE
    iv. WEDI
l. Commissioner Schonfeld noted that progress on simplifying quality data collection will be greatly appreciated.
m. Commissioner Schonfeld also inquired about the letter from Great Lakes Health Connect stating that they would not be submitting certain types of data to MiHIN.
    i. Dr. Pletcher explained that Great Lakes Health Connect did not believe that they were in the position to share data about providers with MiHIN for inclusion in the Health Provider Directory. Dr. Pletcher noted that this issue could prevent MiHIN from running reports to indicate that these patients should be attributed to these providers for federal reporting purposes.
    ii. Commissioner Schonfeld encouraged the involved parties to resolve this issue to ensure that the Health Provider Directory is fully accurate.

G. HIT Commission Next Steps

1. Chair Rinvelt asked the Commission to consider the following resolution for approval:

RESOLVED: The HIT Commission supports the utilization of the Active Care Relationship Service and Common Key statewide service as a means to achieve the policy goals of the Department. The HIT Commission also encourages Michigan healthcare stakeholders to participate in the following use cases: Active Care Relationship Service, Common Key statewide service, and Statewide Health Provider Directory. The HIT Commission recommends that the aforementioned use cases should be implemented in a manner that promotes usability and addresses workflow issues for providers. The HIT Commission also encourages stakeholders to work together to achieve consensus and resolve barriers that are related to implementation of the aforementioned use cases. Multiple Commissioners voiced their approval for the recommendations.

a. Commissioner Matthews made a motion to approve this resolution, and Chair Rinvelt seconded the motion.
b. Commissioner Rinvelt asked if there were any objections to this resolution. Seeing none, the motion was carried unanimously at 2:56 p.m.

2. Ms. Vanderstelt asked the commissioners to send information on their fourth quarter availability to the HIT Office.

H. Public Comment

1. Chair Rinvelt opened the meeting to public comment and invited attendees to introduce themselves.
2. All attendees at the meeting took the opportunity to introduce themselves.

I. **Adjourn**

1. Chair Rinvelt adjourned the meeting at 2:59 pm.