MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

August 18, 2016

The Michigan Health Information Technology Commission is an advisory Commission to the Michigan Department of Health and Human Services and is subject to the Michigan open meetings act, 1976 PA 267, MCL 15.261 to 15.275

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

August 2018 Meeting

- Welcome and Introductions
- Commissioner Updates
- Review of the June Meeting Minutes
- Reappointments

HIT/HIE Updates

- HIT Commission Dashboard
- State Innovation Model Summit
- National Governors Association Initiative

2016 Goals – August HIT Commission Update

Governance Development and Execution of Relevant Agreements

- New Trusted Data Sharing Organizations (new total: **67**):
  - **McLaren Health Plan** – Qualified Data Sharing Organization Agreement
- New Use Case Agreements executed:
  - **OSF Healthcare System (St. Francis) –** Master Use Case Agreement (MUCA), Medication Reconciliation (MedRec) Use Case Exhibit (UCE)
  - **Mid Michigan Medical Center - Alpena –** Simple Data Sharing Organization Agreement, MUCA, Active Care Relationship Service (ACRS) UCE, Admission, Discharge, Transfer (ADT) UCE, Health Provider Directory (HPD) UCE
  - **Northern Physicians Organziation –** Quality Measure Information UCE
  - **Administrative Network Technology Solutions, Inc (ANTS) –** MUCA, ACRS UCE, ADT UCE, HPD UCE, MedRec UCE
  - **Northern Michigan Regional Entity (NMRE) –** MUCA, ACRS UCE, ADT UCE, HPD UCE

Technology and Implementation Road Map Goals

- **Transition to cloud successful - Now in production on Amazon Web Services**
- State of MI receiving ADTs for Medicaid patients from Henry Ford Health System
- Genesee Health System receiving ADTs via PatientPing
- **76 new** Skilled Nursing Facilities (SNFs) sending SNF ADTs via PatientPing and GLHC
- St. Francis Hospital sending MedRec Continuity of Care Documents directly to MiHIN
- Borgess Medical Center and the following St. John locations sending CCDs via Great Lakes Health Connect (GLHC):
  - St. John Providence Hospital
  - St. John Providence Park Hospital
  - St. John Hospital Medical Center
  - St. John River District Hospital
  - St. John Macomb Hospital
  - St. John Oakland Hospital

2016 Goals – August Update

QO & VQO Data Sharing

- More than **816 million** messages received since production started May 8, 2012
  - Have processed as many as **10.8 MLN+** total messages/week
  - Averaging **8.38 MLN+** messages/week
  - **7.7 MLN+ ADT** messages/week; **1.4 MLN+** public health messages/week
- Total 375 ADT senders, 76 receivers to date
  - Estimated **97%** of admissions statewide now being sent through MiHIN
- Sent **1.7 MLN+** ADTs out last week (65.95% match rate for "exact matches")
- Messages received from NEW use cases in production – more than:
  - **782,413 Immunization History/Forecast queries to MCIR**
  - **2,357,173 Medication Reconciliations at Discharge** received from hospitals
    - Approx. 100,000/week representing 67% of possible MedRecs
  - **4,461 Care Plan/Integrated Care Bridge Records** sent from ACOs to PIHPs

MiHIN Shared Services Utilization

- **10.1 MLN** patient-provider relationships in Active Care Relationship Service (ACRS)
- **6.18 MLN** unique patients in ACRS
- **491,815** unique providers in statewide Health Provider Directory
  - **56,612** unique organizations
- Jackson Community Medical Record now receiving A31 ADT messages with a common key and storing the key with patient identifiers
- Bronson Healthcare Group participating in Common Key Service pilot successfully completing testing scenarios
- Common Key Service pilot working as designed
- Physician Payer Quality Collaborative (PPQC) advancing Quality Measure Information Use Case
  - UPHIE, HVPA already participating
  - Category 3 QRDA files containing eCQMs received by MiHIN via "CQMRR" service and sent into State Data Warehouse (in full production)

MiHIN Statewide Use Case and Scenario Status

Conceptual

- Health Risk Assessments
- Health Information for State: Birth Notifications, Chronic Disease Notifications
- Organ Donor Notifications
- Prescription Information: Prescription Status, Prescription Stop Order, Prescription Monitoring Program
- Death Notifications

Planning & Development

- Patient Record Service
- Health Information For State: Newborn Screening - Hearing Test Results
- Common Key Service
- Lab Orders-Results
  State Bureau Lab Orders-Results, Cancer Pathology, Cancer Notifications-Registry, Statewide Lab Orders-Results
- Consumer Consent
- Consumer Preference Management
- Information for Consumer
- Clinical Quality Measures
- Lab Orders-Results: Newborn Screening - CCHD

Implementation (Operational Adoption)

- Advance Directives
- Care Plan-ICBR
- Immunization History-Forecast
- Single Sign-On
- Information for Veterans
- Social Security Determination
- Lab Orders-Results: Disease Surveillance
- Discharge Medication Reconciliation (Senders)
- Active Care Relationship Service
- Health Provider Directory
- Admission, Discharge, Transfer Notifications (Receivers)

Mature Production (>65% Utilization)

- Admission, Discharge, Transfer Notifications (Senders)
- Health Information For State:
  Immunizations
  Syndromic Surveillance

Project Updates

Admission, Discharge, and Transfer (ADT) Messages

Admission, Discharge, and Transfer (ADT) messages began flowing into the State of Michigan in July!

Real-time Admission, Discharge, and Transfer (ADT) messages for Medicaid beneficiaries began flowing into the MDHHS Data Warehouse in July. This completes phase one of the ADT projects. The MDHHS Data Hub Team can now begin scoping ADT Phase 2. Phase 2 work likely will include the infrastructure to get appropriate ADT information from the Data Warehouse to other MDHHS systems, such as CareConnect360 (CC360).

CC360 is the statewide care management tool used for sharing information on individuals who are eligible for both Medicaid and Medicare benefits. This will help reduce the time gap between when a person is admitted to or discharged from a hospital and when that information is available to care coordinators. Information is currently updated in CC360 using claims information, which is not real-time.

MDHHS will also develop analytical projects from this new data and has begun conducting meetings with the assigned analysts so that they can begin learning the data and understanding how the data can be used to benefit other MDHHS program areas.

Cancer Pathology

The State of Michigan is now ready to receive Cancer Pathology Messages.

In the fall of 2014, we had shared with the HIT Commission that Michigan lagged the nation in the implementation of the receipt of cancer pathology lab reports. To address this issue, funding was secured and planning began in February 2015 to remedy this situation.

Today, MDHHS is proud to share that the infrastructure project work has been completed, and the cancer program can now begin working with the national and state cancer laboratories to submit pathology information to MDHHS via the Michigan Health Information Exchange network.

MCSP MICHIGAN CANCER SURVEILLANCE PROGRAM

Participation Year (PY) Goals

August 2016 Dashboard

	Reporting Status	Prior # of Incentives Paid (June)	Current # of Incentives Paid (July)	PY Goal: Number of Incentive Payments	PY Medicaid Incentive Funding Expended
Eligible Professionals (EPs)	AIU 2014	1115	1115	1000	$ 23,375,015
	AIU 2015	908	924	500	$ 19,217,087
	MU 2014	1454	1454	1444	$ 12,883,183
	MU 2015	1563	1723	1702	$ 14,080,266
Eligible Hospitals (EHs)	AIU 2014	3	3	17	$ 2,421,405
	AIU 2015	1	1	5	$ 184,905
	MU 2014	64	64	44	$ 14,270,642
	MU 2015	15	15	28	$ 2,140,850

Cumulative Incentives for EHR Incentive Program 2011 to Present

	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	6010	$ 204,555,398
MU	5086	$ 120,417,462

Key: AIU= Adopt, Implement or Upgrade MU= Meaningful Use

Michigan Medicaid Program – August 2016

Michigan Medicaid MU Program
Supporting providers in Michigan with high volumes of Medicaid patients in achieving Meaningful Use.

Program Goals

- Assist 600 Specialists in their first year of Meaningful Use
- Assist 990 Providers in any year of Meaningful Use (6 possible years of participation)

Ongoing Program Metrics

- 2328 Sign-ups for MU Support representing 1992 unique providers
  - Primary Care Providers – 64% of active clients
  - Specialists Providers – 36% of active clients
- 590 Total Meaningful Use Attestations
  - 336 Providers have signed up for a subsequent year of support

Other program highlights:

- M-CEITA collects data on the barriers that delay or prevent participating providers from achieving meaningful use or cause them to be disqualified altogether. Monthly updates are shared with the Medicaid EHR Program Manager.

Project Contact

Project Lead: Judy Varela judith.varela@altarum.org
Funder: CMS funding administered by the Michigan Department of Health & Human Services (MDHHS)

Michigan Department of Health & Human Services

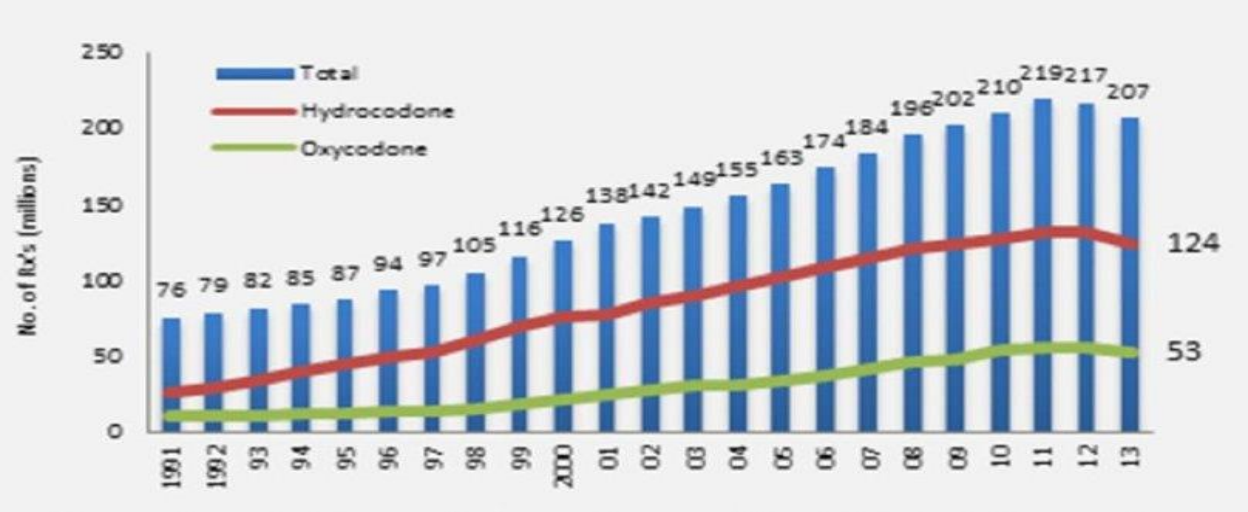
Michigan's Prescription Drug and Opioid Abuse Task Force

Jared Welehodsky
Policy, Planning, and Legislative Services Administration
August 18th, 2016

Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Impact of Opioid and Prescription Drug Abuse

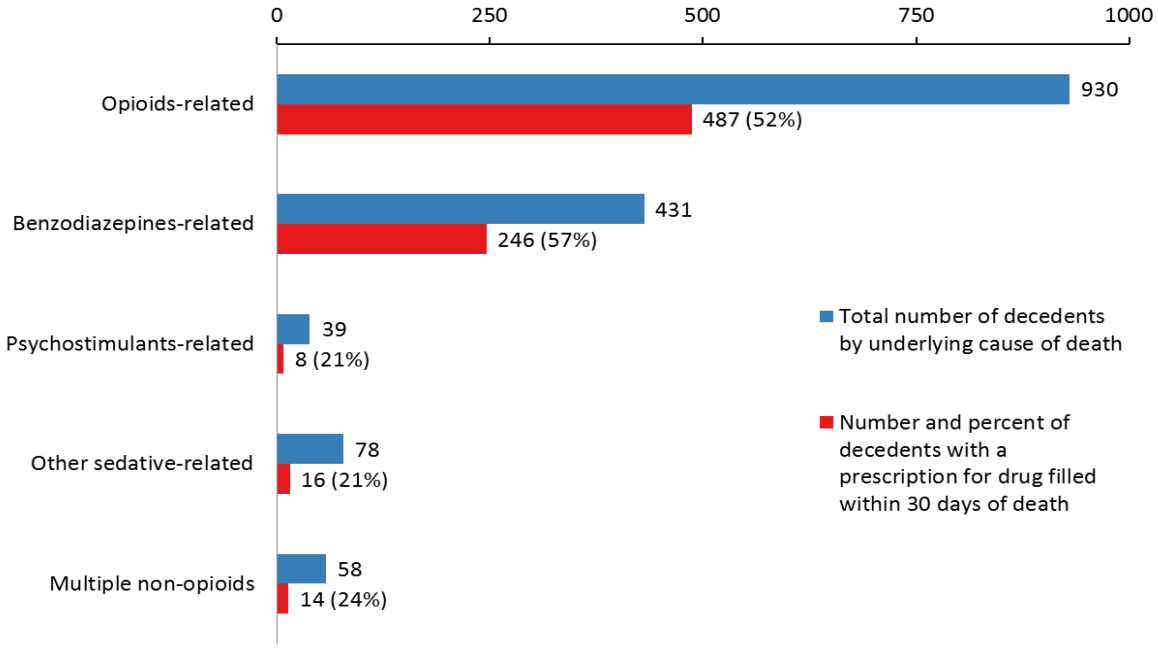
Hydrocodone and Oxycodone prescribing has increased nearly 300% nationwide since 1991



Source: http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse

Impact of Opioid and Prescription Drug Abuse

2009-2012 Michigan overdose deaths in which a prescribed drug was mentioned as a cause of death

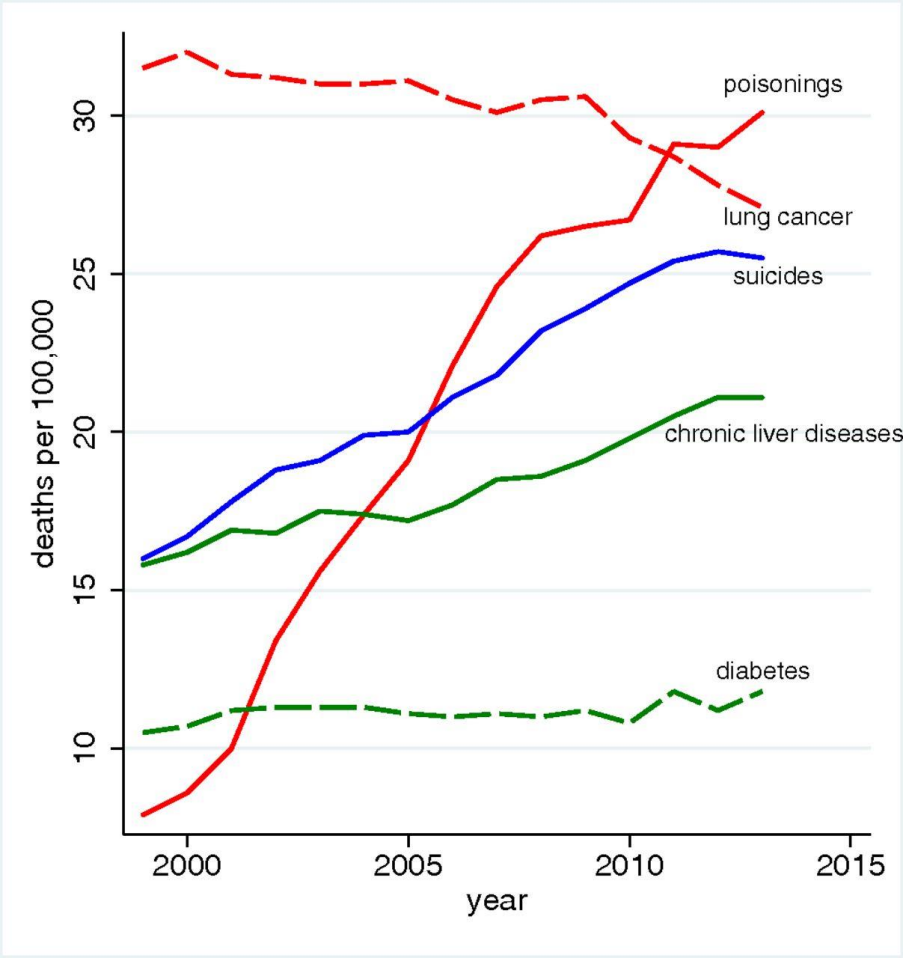


Source: https://www.michigan.gov/documents/mdch/MAPS_Report_2014_-_FINAL_464112_7.pdf

Impact of Opioid and Prescription Drug Abuse

National Data: Mortality by cause, white non-Hispanics ages 45–54.

Source: Anne Case, and Angus Deaton PNAS 2015;112:15078-15083



Update since January

- Developments from the Governors Office
- Developments from the Legislature
- Developments from MDHHS
- Developments from LARA
- Developments from MSP

MDHHS
Michigan Department of Health & Human Services

Developments from the Governor's Office

- On June 23, 2016, Governor Snyder signed Executive Order 2016-15, which created an ongoing Michigan Prescription Drug and Opioid Abuse Commission

- This Commission will be part of the Department of Licensing and Regulatory Affairs

- The Commission includes representation from across the health care and law enforcement community

MDHHS
Michigan Department of Health & Human Services

Developments from the Legislature

- Legislation introduced to expand the Good Samaritan Law

- Legislation introduced to expand access to Naloxone
  - Standing Order
  - Firefighters
  - Corrections officers
  - Schools

MDHHS
Michigan Department of Health & Human Services

Developments from MDHHS

- MDHHS is continuing its review of the Benefits Monitoring Program
- MDHHS recently announced a RFI for innovative strategies to reduce Neo-natal Abstinence Syndrome
- MDHHS received funding from SAMHSA to reduce non-medical use of prescription drugs among ages 12-25

MDHHS
Michigan Department of Health & Human Services

Developments from LARA

- The Department of Licensing and Regulatory Affairs (LARA) received funding for improving Michigan's Automated Prescription System (MAPS)
- MAPS is Michigan's prescription drug monitoring program.
- MAPS was a major discussion point for the Task Force
- 4 recommendations and 6 contingent recommendations of the Task Force involved MAPS

MDHHS Michigan Department of Health & Human Services

Developments from MSP

- The Michigan State Police received funding from the US Department of Justice to focus on intelligence gathering, data analysis, enforcement, and prevention
- The Michigan State Police will be training troopers in use of Naloxone
- Soon will be implementing a pre-arrest diversion program to assist addicts in getting treatment

Questions?

Jared Welehodsky

Policy, Planning, and Legislative Services Administration

WelehodskyJ@michigan.gov

MDHHS Michigan Department of Health & Human Services

Update on MAPS

Kim Gaedeke
Director
Bureau of Professional Licensing
Department of Licensing and Regulatory Affairs

Update on the Medication Use Case

HIT Commission

8-18-2016

Tim Pletcher
Executive Director
Michigan Health Information Network Shared Services
tim.pletcher@mihin.org

What we are doing at MiHIN

- Improving healthcare experience for consumers & providers
- Improving quality
- Decreasing cost
- Enabling statewide exchange of health information
- Making valuable data available at the point of care

For the people of Michigan

MiHIN Shared Services

Network of Networks:

Federal

CMS Centers for Medicare & Medicaid Services

Social Security Administration

carequality

the sequoia project

eHealth Exchange

commonwell HEALTH ALLIANCE

PriorityHealth

Meridian Health Plan

hap

MOLINA HEALTHCARE

FIDELIS SecureCare

PIHPs (10)

Aetna

AmeriHealth

Total Health Care

Upper Peninsula Health Plan

Blue Cross complete of Michigan

Health Plan QOs

Other Data Sharing Organizations

MHA Michigan Health & Hospital Association

MiHIN Statewide Shared Services

MDHHS Michigan Department of Health & Human Services

MCIR

Immunizations

MSSS

MI Syndromic Surveillance System

MDHHS Data Hub

MDSS

MI Disease Surveillance System

MyHealthPortal

MyHealthButton

State Labs

Data Warehouse

Chronic Diseases

Medicaid

NoMoreClipboard.com EASY. ACCURATE. SECURE

GIFT of LIFE MICHIGAN ORGAN AND TISSUE DONATION

MEDYEAR

Consumer QOs (more coming)

HIE

Qualified Organizations (QOs)

PCE PCE SYSTEMS

carebridge CONNECTING SYSTEMS OF CARE

Virtual QOs

Walgreens CVS

COSTCO WHOLESALE meijer

Walmart Save money. Live better. surescripts

Pharmacies (more coming)

HOSPITAL H

Providers & Health Systems

University of Michigan Health System

SPECTRUM HEALTH

ALTARUM INSTITUTE SYSTEMS RESEARCH FOR BETTER HEALTH

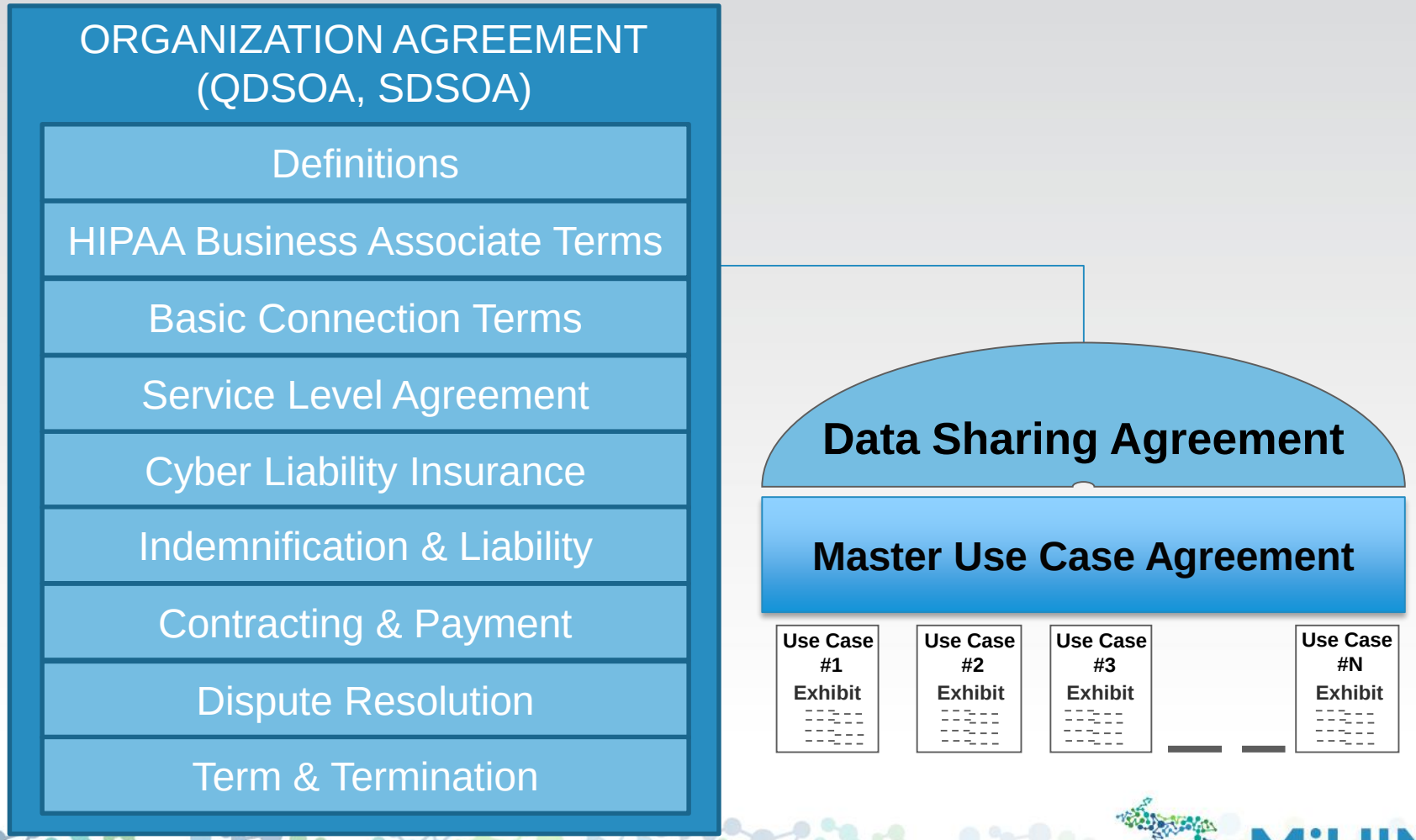
Beaumont Health

Sponsored Organizations

Single point of entry/exit for state

MiHIN Shared Services

Legal Infrastructure for Trusted Data Sharing Organizations (TDSOs)



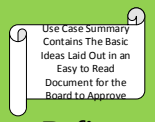
MiHIN Shared Services

Use Case Factory

Idea with Champion

Maintenance, Operations, & Continuous Improvement

Conceptual



Define Purpose

Evaluation

Idea with Sponsor

Design & Develop

Technical Planning

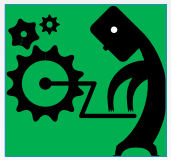
Pilot & Refine

MiHIN Board

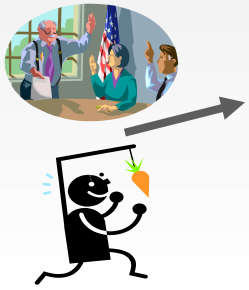
Implement

Production Status

Metrics



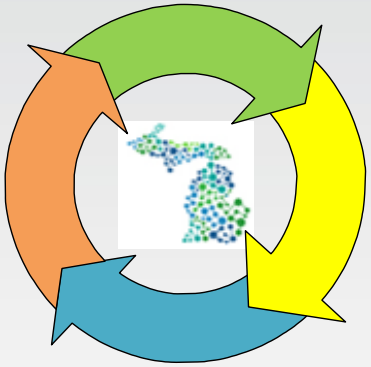
Successful Adoption



Mature Adoption

Critical Mass

Functional Data-Sharing Widget



Anyone can submit ideas for use cases: http://mihin.org/about-mihin/resources/use-case-submission-form/

MiHIN Shared Services

MiHIN Statewide Use Case and Scenario Status

Conceptual	Planning & Development	Implementation (Operational Adoption)	Mature Production (>65% Utilization)
Health Risk Assessments	Patient Record Service	Advance Directives	Admission, Discharge, Transfer Notifications (Senders)
Health Information for State: Birth Notifications, Chronic Disease Notifications	Health Information For State: Newborn Screening - Hearing Test Results	Care Plan-ICBR	Health Information For State: Immunizations Syndromic Surveillance
Organ Donor Notifications	Common Key Service	Immunization History-Forecast	
Prescription Information: Prescription Status, Prescription Stop Order, Prescription Monitoring Program	Lab Orders-Results State Bureau Lab Orders-Results, Cancer Pathology, Cancer Notifications-Registry, Statewide Lab Orders-Results	Single Sign-On	
Death Notifications	Consumer Consent	Information for Veterans	
	Consumer Preference Management	Social Security Determination	
	Information for Consumer	Lab Orders-Results: Disease Surveillance	
	Clinical Quality Measures	Discharge Medication Reconciliation (Senders)	
	Lab Orders-Results: Newborn Screening - CCHD	Active Care Relationship Service	
		Health Provider Directory	
		Admission, Discharge, Transfer Notifications (Receivers)	

Medication Management White Paper Background

- Over 60 participants from 24 organizations collaborated & identified high-value Medication Management Use Cases
- Medication management stakeholders discussed variety of Use Case data-sharing opportunities and considerations
- Initial brainstorming identified:
  - 11 Use Case opportunities and 80 possible scenarios
  - 10 considerations across all Use Cases
  - 11 broad benefits of Use Case adoption
  - 3 additional high-level considerations
  - 5 medication Use Case outliers
  - 5 priority Use Cases consolidated from 11 opportunities
- Stakeholders then determined 3 highest priority Use Cases

Top Priority Medication Management Use Cases

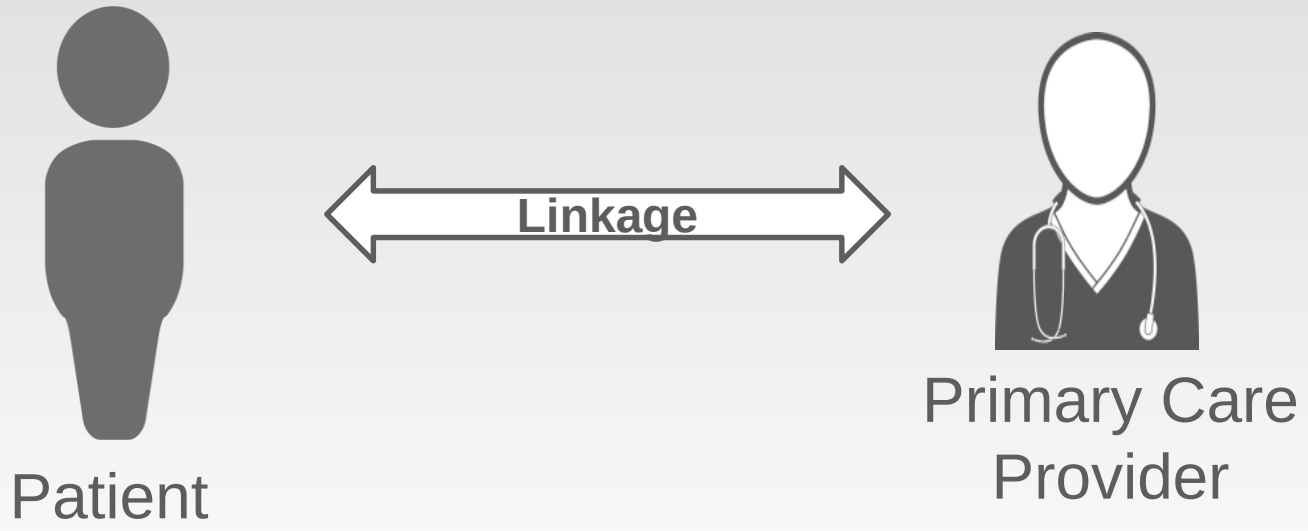
- **Exchange Medication Reconciliation**
  - Shares medication information at multiple points of care to help minimize Adverse Drug Events and decrease costs
- **Exchange Medication Data with Prescription Drug Monitoring Programs (PDMPs)**
  - Offers healthcare providers and pharmacists easier access to query PDMP information
  - Allows more accurate tracking of medication usage, timely alerts
- **Exchange Lab Results/Diagnosis**
  - Ensures better patient care coordination
  - Assists pharmacists and physicians in confirming correct medication and dosage

Exchange Medication Reconciliation

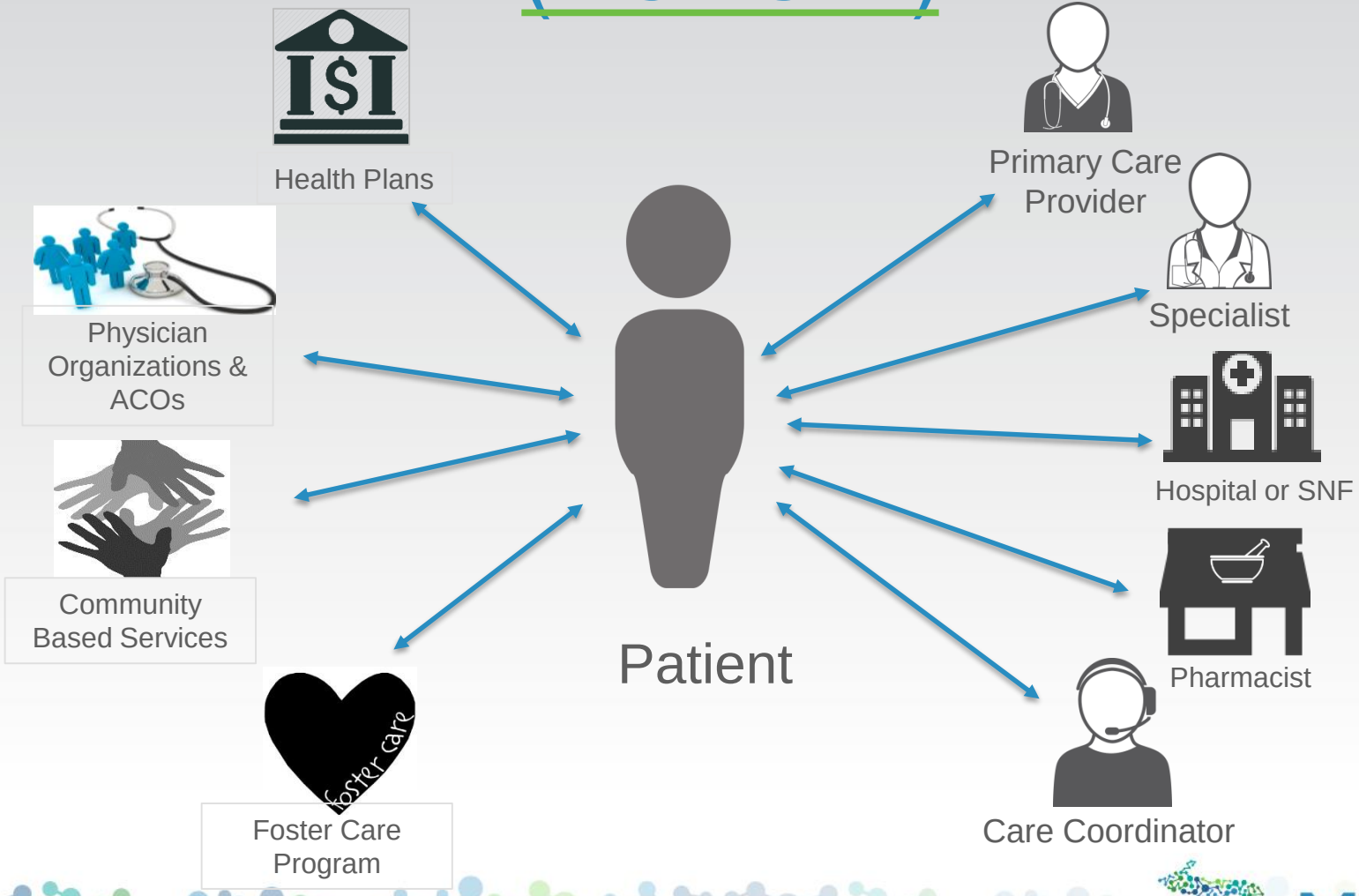
Description	A comprehensive evaluation of a patient's medication regimen any time there is a change in therapy in an effort to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions, as well as to observe compliance and adherence patterns.
Purpose	To share patient medication information at multiple points of care, including pharmacies, physician offices, hospitals, and transitional facilities such as outpatient tertiary and skilled nursing facilities. Statewide coordination in sharing patient medication information helps minimize Adverse Drug Events (ADEs) and maximize cost benefits. Additionally, this UC leverages the Michigan Health Information Network Shared Services (HIN) Active Care Relationship Service (ACRS) for notifying appropriate providers of changes to a patient's medication status.
Submission Mechanism	C-CDA files are sent via Direct Secure Messaging as email attachments (XDM.zip files). HISP must be EHNAC-DTTAAP accredited as of February 2015. Every email must adhere to the following specification: 1. There shall be only one C-CDA file attached per email.
Submission Frequency	Upon every discharge
Direct Message Address	For test messages with no PHI: medicationreconciliation-test@direct.mihin.org For pre-production certification: medicationreconciliation-foc@direct.mihin.org For production: medicationreconciliation@direct.mihin.org
Implementation Guide	

MiHIN Shared Services

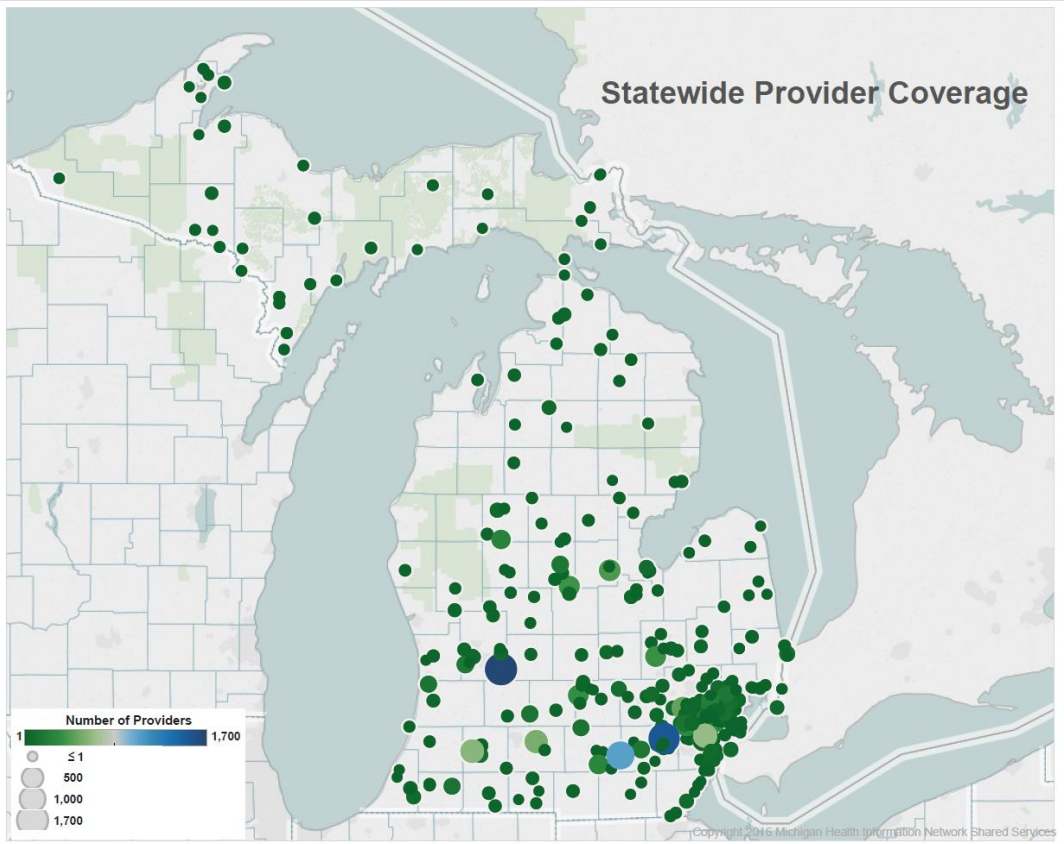
Active Care Relationships



Active Care Relationship Service™ (ACRS™)

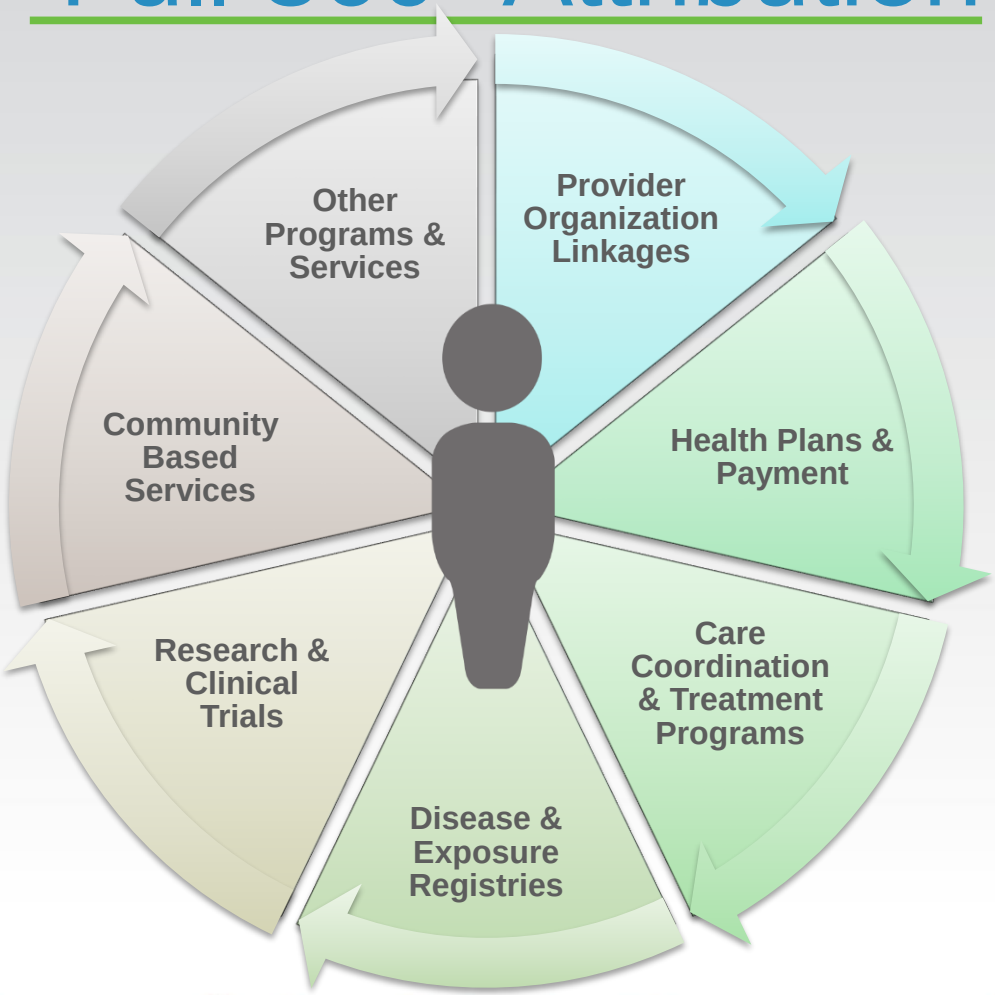


July 2016 ACRS Volumes



ACRS: 10,069,244
Providers: 11,717

MiHIN Plans Evolution Toward Full 360⁰ Attribution



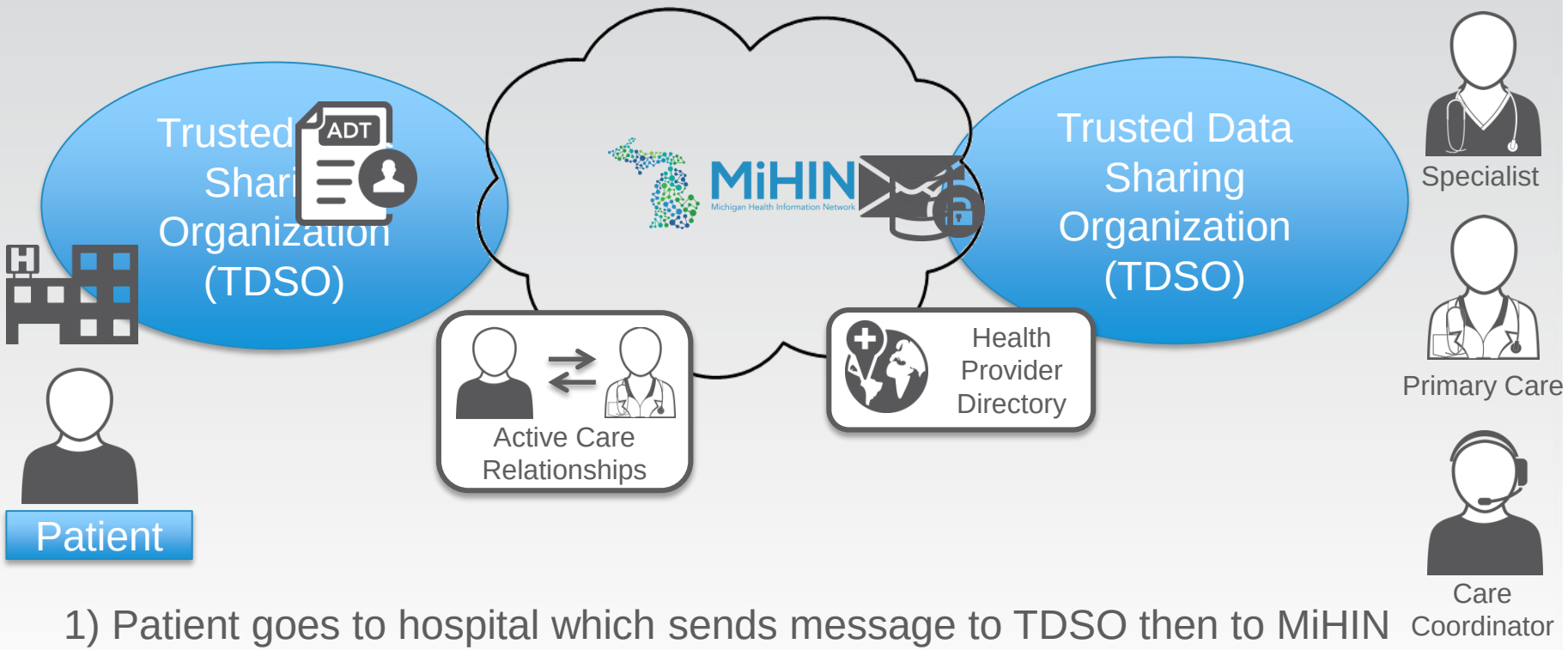
MiHIN Shared Services

Common Key ***Service*** (CKS)

- Provides consistent and reliable patient matching
  - Minimizes mismatches / finds right records
- Links individuals and their health information across multiple organizations, applications and services
- Improves patient safety through higher data integrity
- Reduces workflow significantly in care coordination
- Improves outcomes and reduces cost
- Enables mapping any HIT/HIE endpoint via CKS to State's Master Person Index (MPI)
- Runs as web service with rich FHIR API for easy integration
- Using 1.4.0 FHIR release (CQF on FHIR Ballot + Connectathon 12 in Montreal) using HAPI-FHIR 1.5-DEV Java Library

MiHIN Shared Services

Supports Seamless Exchange Alerting Disconnected Entities



1) Patient goes to hospital which sends message to TDSO then to MiHIN
2) MiHIN checks Active Care Relationship Service and identifies providers
3) MiHIN retrieves contact and delivery preference for each provider from HPD
4) Notifications routed to providers based on electronic addresses and preferences

Medication Reconciliation Pilot Group

Health Systems	Physician Organizations
Beaumont Health System	Greater Macomb PHO
Detroit Medical Center	Medical Network One
Henry Ford Health System	MiPCT
University of Michigan Health System	Northern Physician Organization
	Oakland Southfield Physicians
	United Physicians

- Defined required fields to make message actionable
- Defined Summary of Care document format and workflow
- Defined transport for sharing message
- Initiated onboarding activities
- Reviewed Exchange Medication Reconciliation Use Case Agreement
- Analyzing workflow and data alternatives to make data actionable

MIDIGATE® “Catcher” Modules

Doctor offices & Community Hospitals

immunizations@direct.mihin.org

Catcher Module

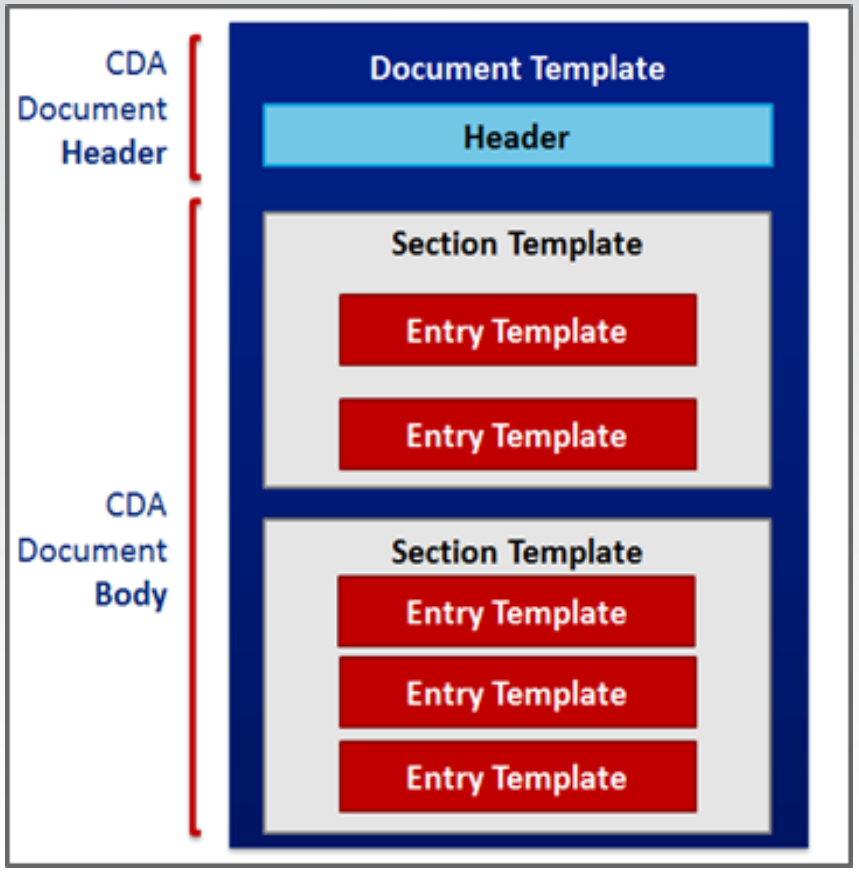
Base Gateway Service

Required Fields in Messages

1. **Patient Identifying/demographic Information – (Header Section of C-CDA)**
   a. Name
   b. Visit ID
   c. Institution Name/OID
   d. DOB
   e. Gender
   f. Social Security/last 4
   g. Address/Zip/Phone (primary)
   h. Care Team
      i. Attending provider name, NPI, phone

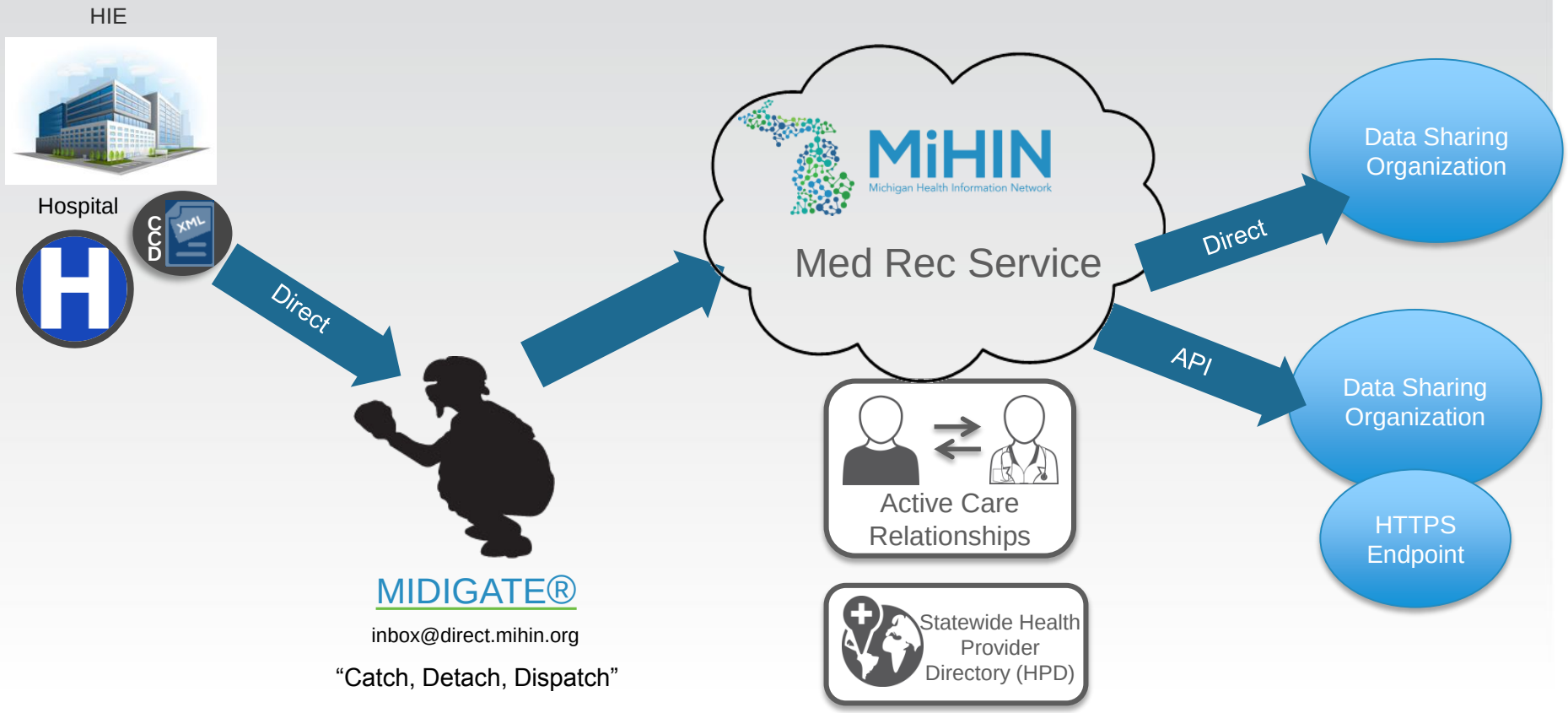
2. **Medication Section Information (3 sections) – each section should be a section template:**
   a. Current Medications (admission history)
   b. Prescriptions ordered during visit (optional)
   c. Medications at time of discharge
      i. Date (start/end) as applicable
      ii. Medication name (generic or brand)
      iii. RxNorm code from eRx system
      iv. Full sig (strength, frequency, dosage, route)

1. **Other Information (Body Template/s of C-CDA)**
   a. Admitting diagnosis
   b. Active allergies and adverse reactions
   c. Visit diagnosis/working diagnosis (on file)
   d. Active problems
   e. Discharge disposition – home, SNF, etc. (if available)
   f. Chief complaint (if available)



MiHIN Shared Services

Medication Reconciliation



Medication Reconciliation Current Status

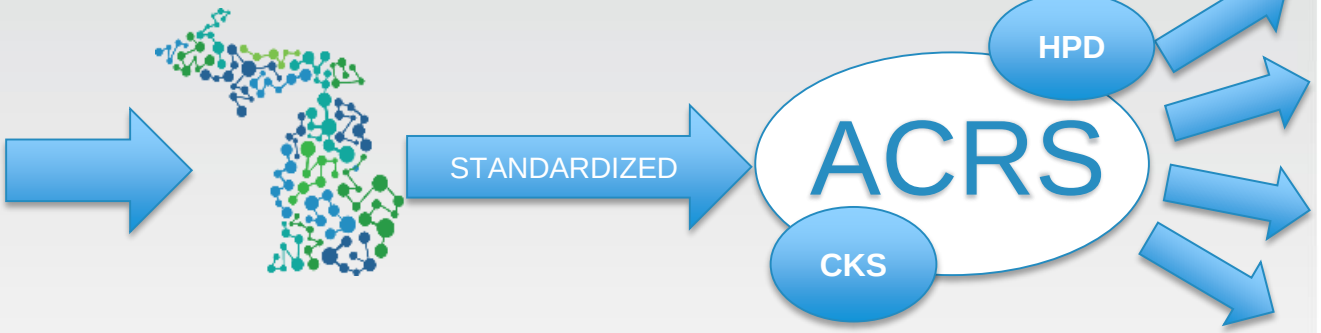
- 60+ of the largest hospitals within largest health systems responsible for 68% of all discharges across Michigan
- 150k+ messages per week following inpatient discharge and emergency room visits
- BCBSM hospital P4P incentive in 2015 & 2016

A Simplified Model for **Send**

- ADT or Regular ACRS
- Care Summary & Results
- Cat1 Quality Measure

Primary Care Provider

Community Based Services



ONC THINGS TO DO

SEND

RECEIVE

FIND

USE

THANK YOU!

Follow Up Questions:

Tim Pletcher

Executive Director

Michigan Health Information Network Shared Services

tim.pletcher@mihin.org

Phone: 989.621.7221

Initial Med Rec Results

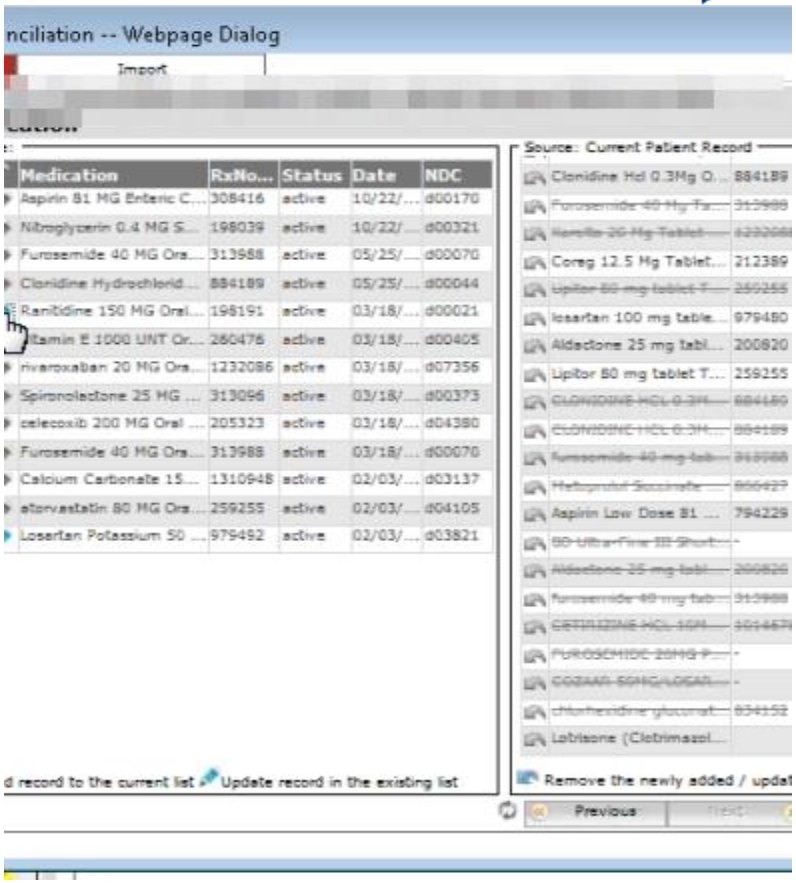
Northern Physicians Organization
Presented by Ed Worthington
eworthington@npoinc.org

How it is being tested by NPO

- We are currently testing Med Rec in four practices (all on different EMRs).
- We receive the documents from MiHIN (via a web service), perform some matching validation, and then send them via DirectTrust to the practices' EMRs.
- We also store the documents to use in our analytics – we are currently testing the analytics portion in a separate small project.

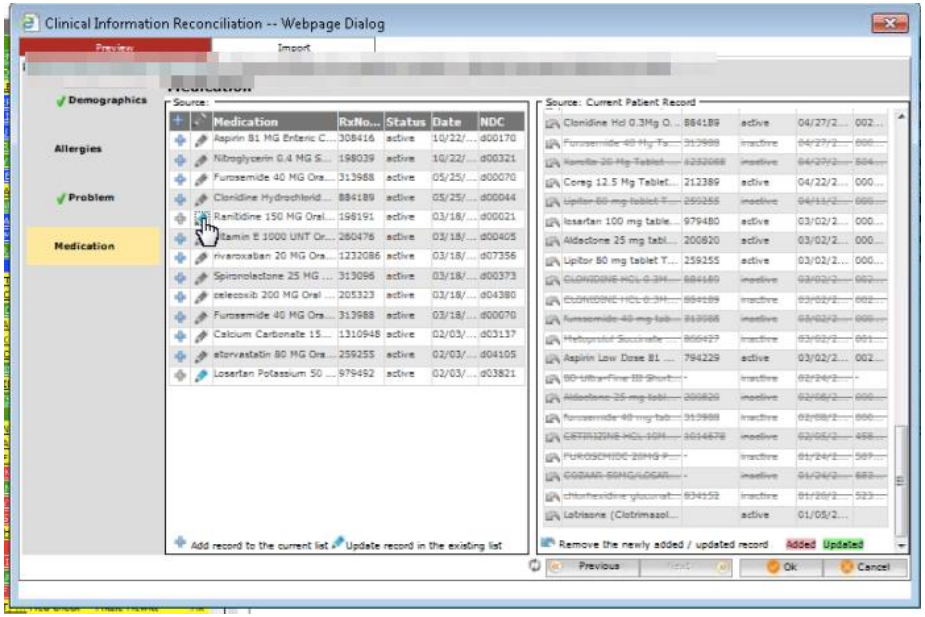
iPatientCare

- This EMR allows the CCDA to be saved as a document (in its entirety).
- It allows for discrete medication import/update.
- Users can select an individual medication and update the corresponding record in their EMR.

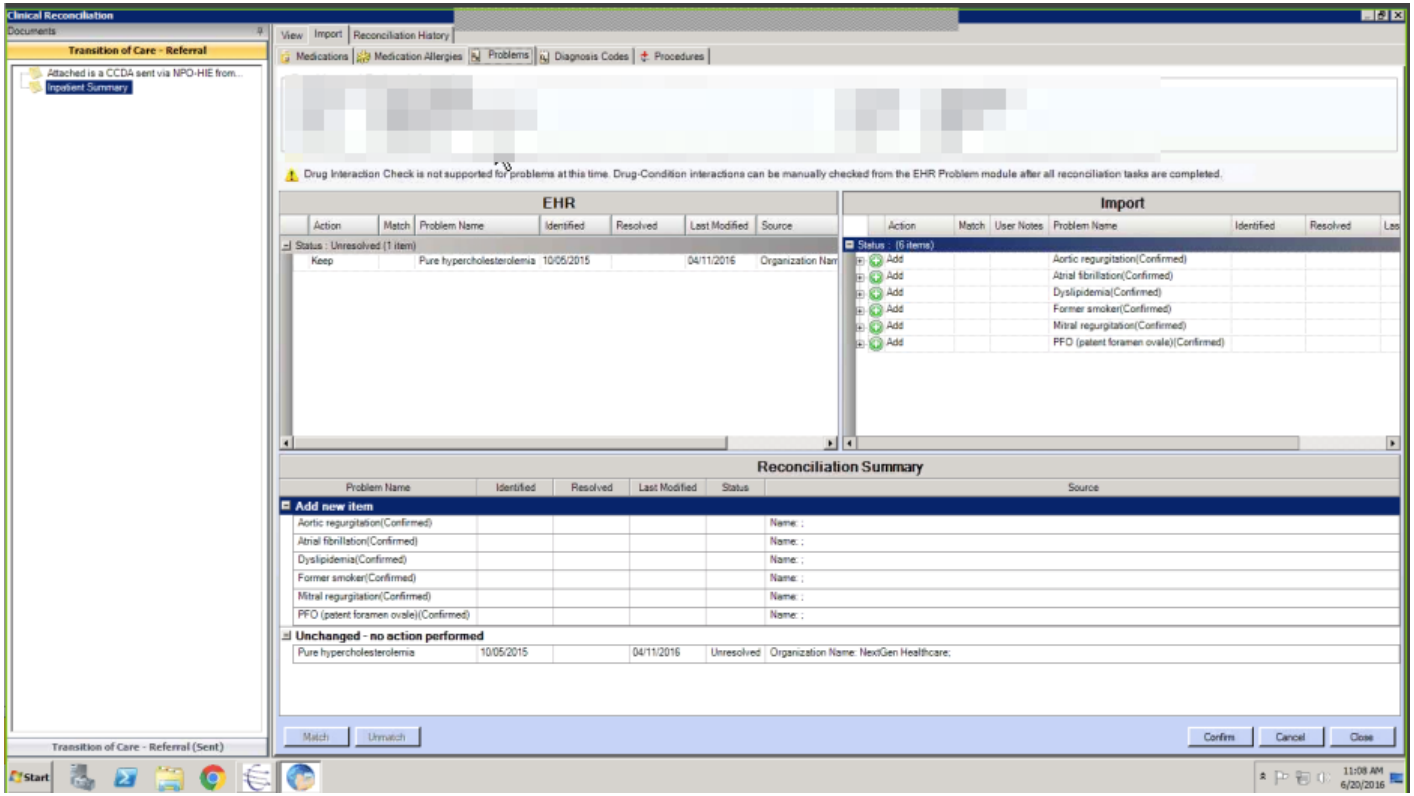


iPatientCare (cont)

- The user can go through the demographics, allergies, problems, and medications and perform discrete reconciliation.
- This can be done during the import process.
- The message lands in their EMR's Direct inbox.

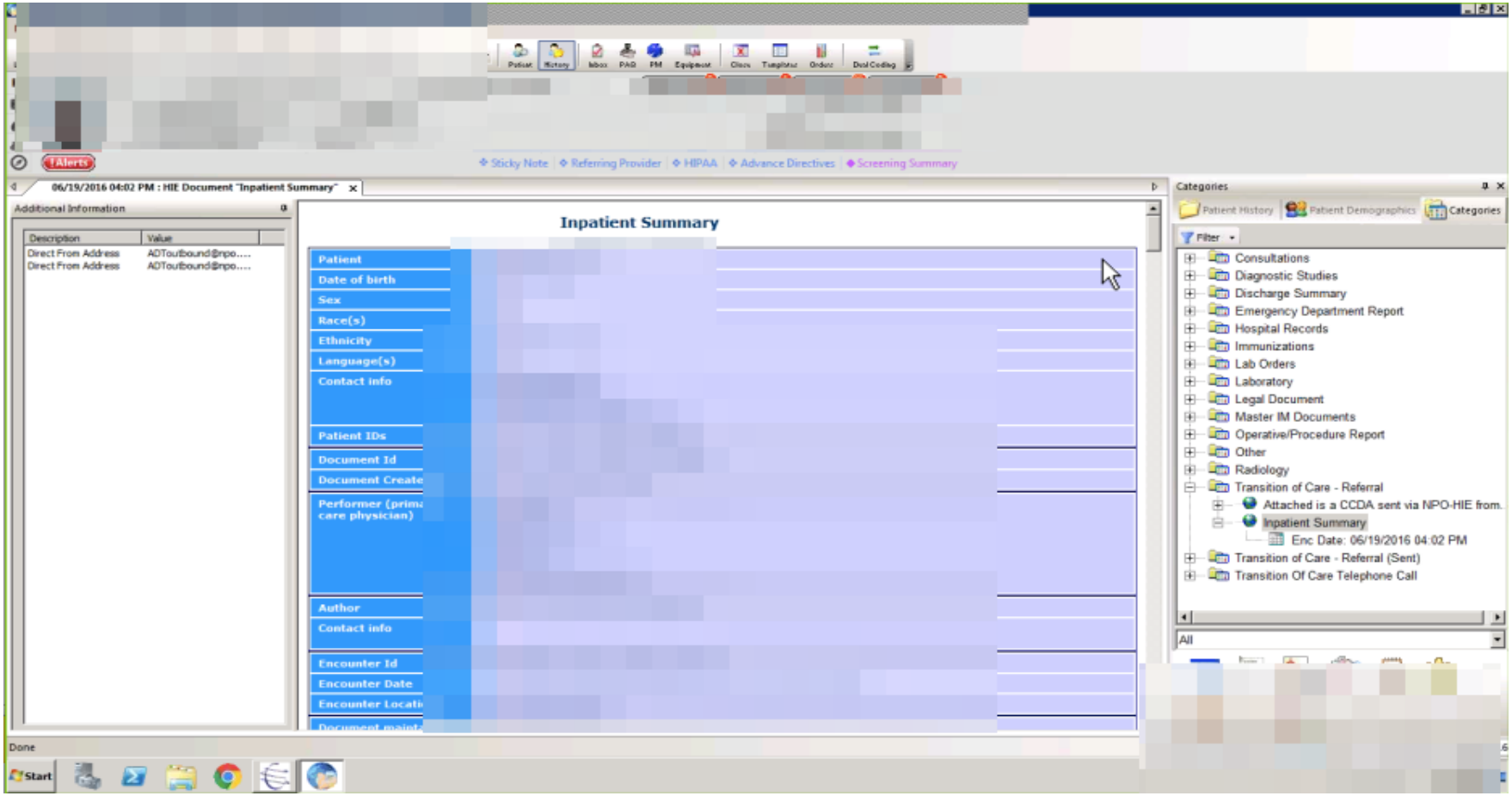


NextGen



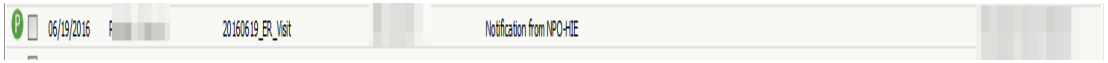
- Messages come in the provider's inbox.
- Discrete import possible for medications, allergies, problem list, diagnosis codes, and procedures.
- The CCDA can be stored in the patient documents.

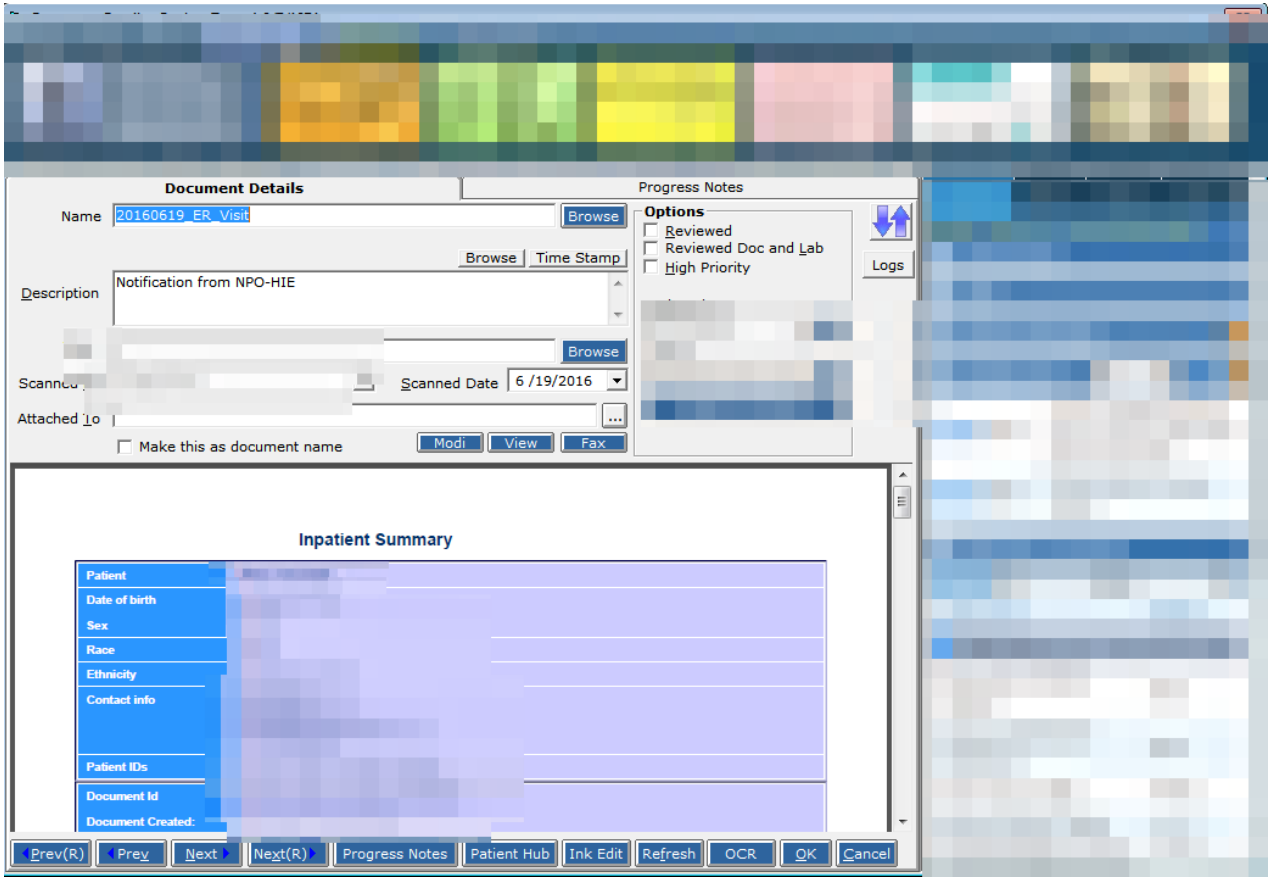
NextGen (cont)



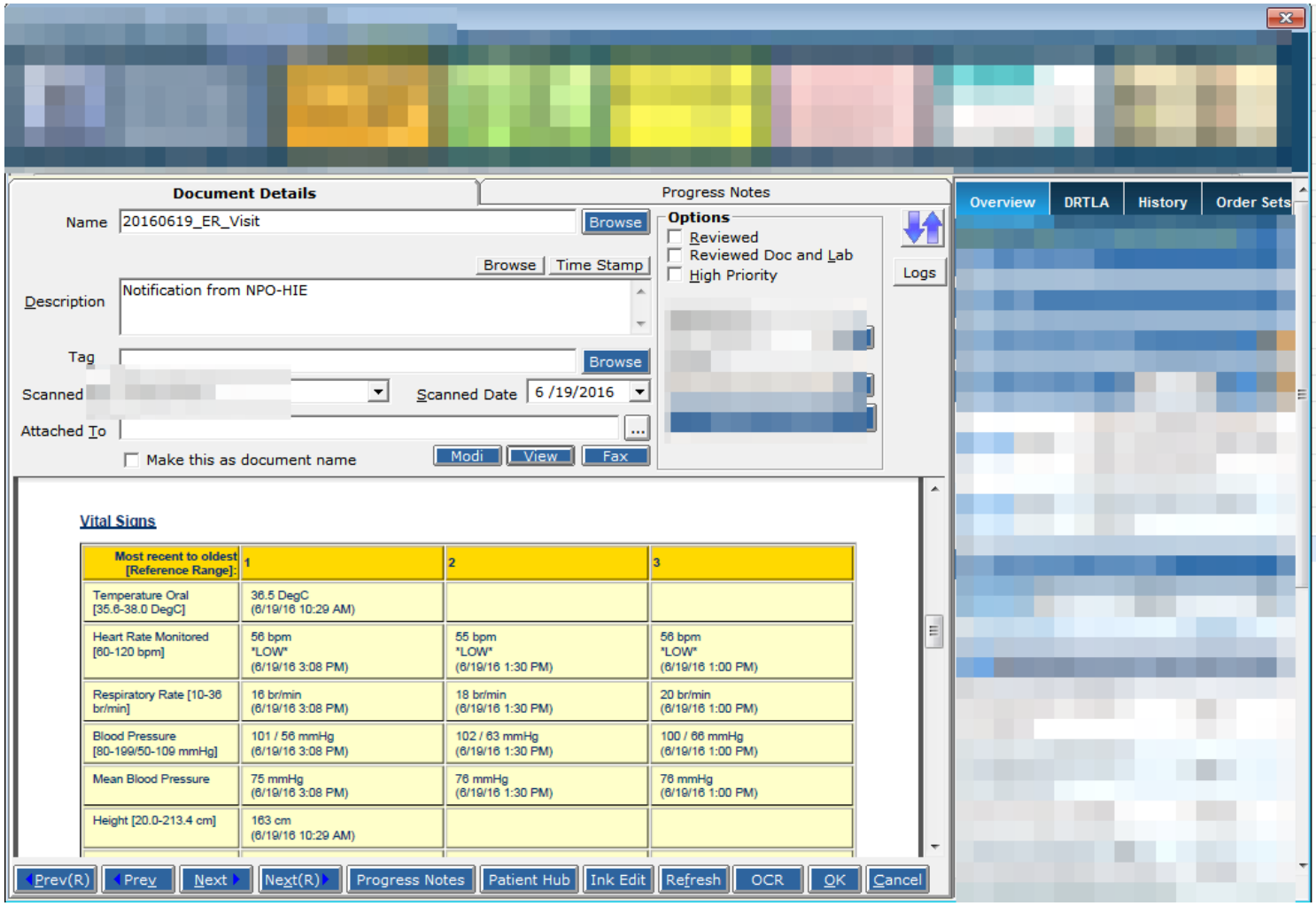
eClinicalWorks

- Messages come in the provider's inbox.
- Discrete import possible for medications, allergies, problem list.
- Document can be stored in the patient documents.

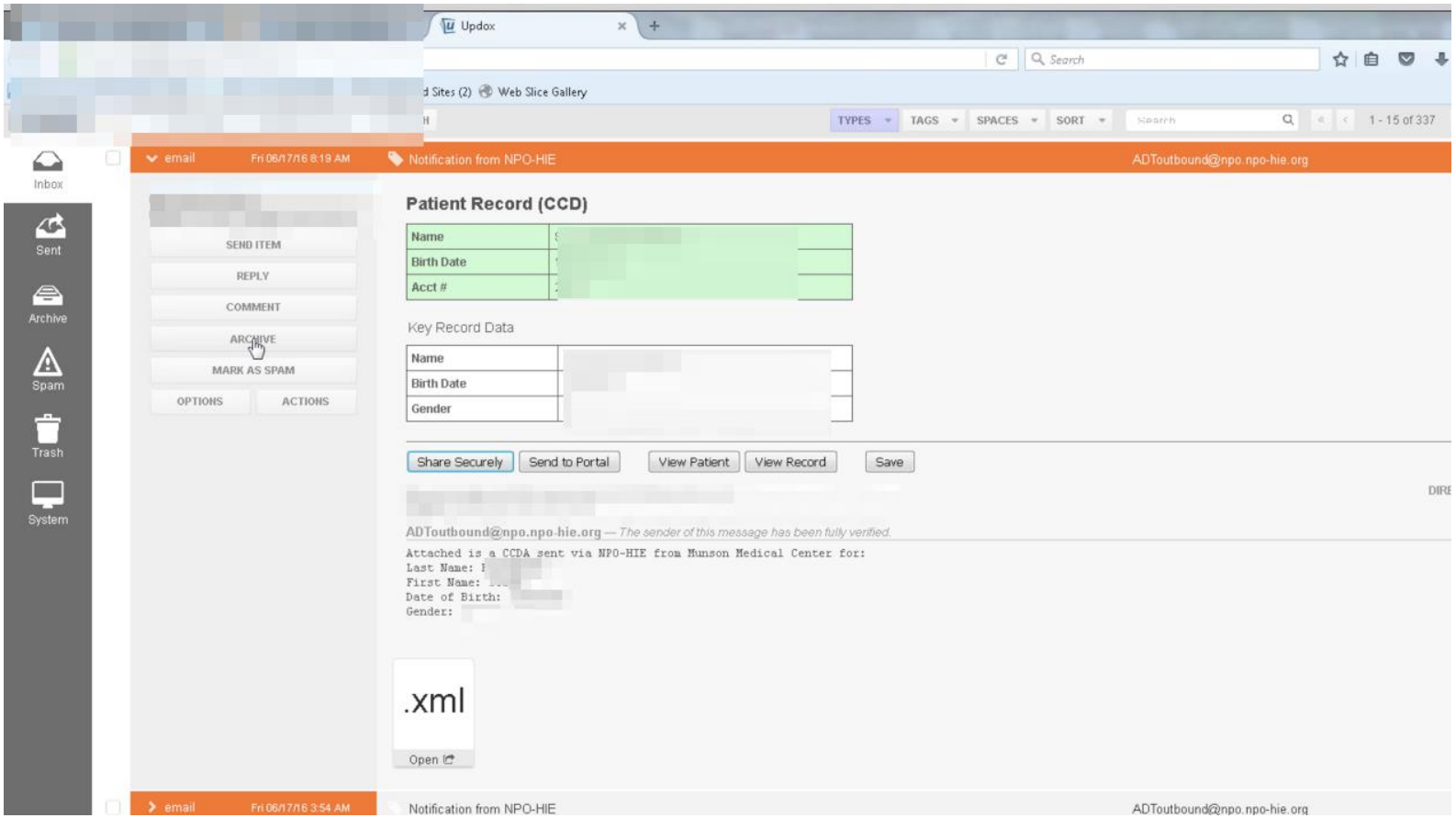




eClinicalWorks (cont)



Amazing Charts



Immediate Advantages

- It helps to promote PCMH by more readily keeping primary care givers/providers informed about transitions throughout the health care system.
- It can reduce manual entry – thus creating fewer opportunities for errors.
- Hospitals can more easily accommodate heterogeneous ambulatory environments with this use case.
- Practices like receiving the documents earlier, and they like easily viewing ER labs.

Challenges

- A lot of work will need to be undertaken to really integrate this into practice workflow.
  - Buy-in may take a while as practices navigate their current process (with faxed documents) and this process.
- Process re-design will be 90% of the work going forward.
- EMRs are somewhat variable on how well they integrate with DirectTrust (and CCDAs overall).

HIT Commission Update on Electronic Prescribing (eRx) and Efforts to Improve State-wide Adoption and Use of Electronic Prescribing Controlled (EPCS) Substance

August 18, 2016

Lynda McMillin
Manager, BCBSM Pharmacy Services

AGENDA

- Challenges - (the problem)
- EPCS and the Role of PDMP (Prescription Drug Monitoring Programs)
- Using Healthcare Technology to Help Solve the Opioid Abuse Crisis
- Current State of EPCS
- Blue Cross Blue Shield EPCS Initiatives and Update
- Recent Regulations that Continue the Promotion of eRx

Challenges facing e Prescribing – The Problem

- More than 15 million people in the U.S. abuse prescription drugs regularly
- 52 million Americans over the age of 12 have used prescription drugs non-medically in their lifetime
- Prescription painkiller abuse is a national "crisis" US Centers for Disease Control

Each day, 44 people in the United States die from an overdose of a prescription painkiller.

It takes just one prescription to become addicted

Challenges facing e Prescribing

- Electronic prescribing is one VERY important technology that may prove invaluable to help mitigate the opioid crisis

- The U.S. Drug Enforcement Administration (DEA) authorized the use of e-prescribing of controlled substances (EPCS) in 2010.
  - State level legalization in all 50 states and the District of Columbia was achieved in 2015, putting protocols in place to allow EPCS for all schedules (II-V)

- Pharmacies rapid enablement of EPCS (82.4% nationally) is in stark contrast to the disproportionately low rate of EPCS adoption by physicians at just 7.1%

EPCS and the Role of Prescription Drug Monitoring Programs (PDMPs)

- 49 states currently participate in drug information exchange through PDMP's encouraging prescribers to check the PDM registry before prescribing controlled substances
- 22 states, nearly half of the states with PDMP programs, require providers to access the state PDMP before prescribing painkillers (states have varying levels of rules, enforcement criteria and penalties.)
  - 1 year after NY implemented requirements to check the online registry, the number of prescriptions for all opioids decreased by 10%. The largest decreases were in hydrocodon (⬇20%) and codeine 5(⬇33%)
- 3 states have proposed legislation to require the state to make access available to prescriber systems (EHRs)
- InterConnect is the PMP program that enables interoperability and interstate data sharing among state PDMPs that participate in the program. The program was launched in 2011 by the National Association of Boards of Pharmacy (NAPD).
  - 35 states have issued letter of memorandum to participate and 30 are currently live.

EPCS and the Role of Prescription Drug Monitoring Programs

Blue Cross Blue Shield Blue Care Network of Michigan

Legislative Regulation Driving Change:

- New York's Prescription Monitoring Program – ISTOP
  - ISTOP = Internet System for Tracking Overprescribing
  - Goal: Combating the rising rates of prescription drug abuse.
  - Details of the ISTOP law:
    - Mandatory Physician Monitoring Program Queries – effective date 2013
      - Medical providers must query the state PMP system and review a patients recent medication history prior to writing any prescriptions for Schedule II-V controlled substances.
    - Mandatory E-Prescribing by March 27, 2016 (all prescriptions)
    - Non compliance carries severe penalties including:
      - Civil and or Criminal charges
- Maine – 2nd state to mandate EPCS and the third to require eRx
  - New Statute: "An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program"
  - Effective date: July 1, 2017
  - Other provisions
    - Limits on duration and doses of opioid prescriptions
    - Required CME on addiction

Using Healthcare Technology to Address the Opioid Abuse Crisis

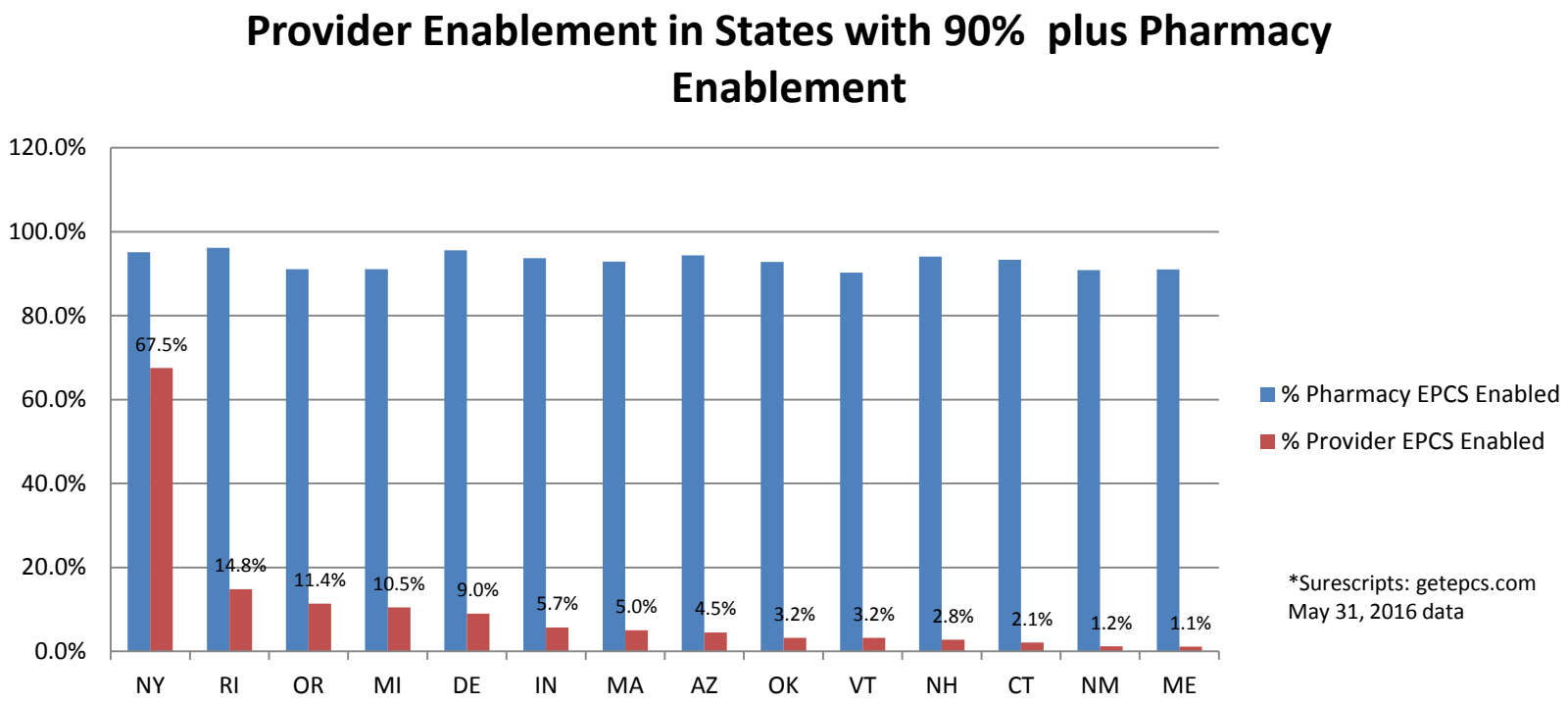
Blue Cross Blue Shield Blue Care Network of Michigan

- Electronic Health Record Technology (EHR) is integrated into most provider workflows and are now the **primary method** of writing prescriptions including printed and electronically transmitted.

- Optimization of existing EHR's has replaced New adoption as there is more focus on:
  - Quality improvement
  - Resolving gaps-in-care
  - Increasing practice efficiency
  - Standardizing treatment protocol

State of EPCS

Pharmacy and Provider Adoption

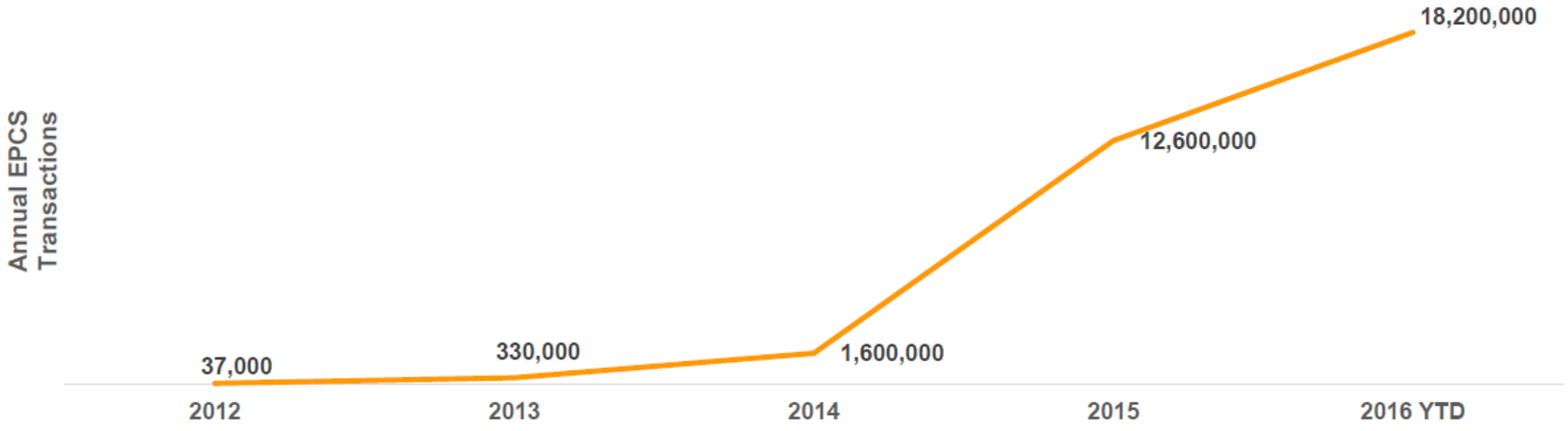


Blue Cross Blue Shield Blue Care Network of Michigan

Software Readiness and Adoption Trends

- Pharmacy and prescriber software are available
  - 64 pharmacies and pharmacy vendors are certified
  - 100+ prescriber vendors are certified

12.6 Million EPCS transactions were sent across the Surescripts network in 2015. Over **18.2 Million** have already been sent through June 2016.



Current State of EPCS

Blue Cross Blue Shield Blue Care Network of Michigan

Status of EPCS Adoption – June 2016[1]

Pharmacy Adoption

- Nationally 96% of all pharmacies received an e-prescription in the last 30 days
- Nationally **86% of all pharmacies received an EPCS** in the last 30 days
- 96% EPCS adoption in New York, 90% EPCS adoption in Texas

Prescriber Adoption

- Nationally 61% of all prescribers sent an e-prescription in the last 30 days
- Nationally **11% of all prescribers are enabled[2] to send EPCS**
- 68% EPCS adoption in New York, 9% EPCS adoption in Texas

1. Please note that adoption stats for all states are available on the More Details page of getEPCS.com.
2. "Enabled" means a prescriber has software that is capable of sending EPCS, but practice level setup may not be complete.

BCBSM Initiatives and Updates

BCBSM – EPCS 2016 Initiative

- Initiative Goal
  - Increase electronic prescribing of controlled substances in order to improve patient safety and health outcomes.
    - Participation is a commitment to the long term health and wellness of Michigan residents
- Initiative Objective
  - Increase the average percentage of electronically prescribed controlled substances to 25% over three years (by 2018)
- Initiative Focus
  - Work with providers (PCP and SCP) that prescribe 25 or more new controlled (schedule II-V) prescriptions per quarter per physician with an opportunity for improvement

BCBSM Initiatives and Updates

BCBSM – PCMH 2017 Initiative

- Updates to PCMH Model for 2017 are proposed to include several new EPCS capabilities for the prescribing and management of controlled substance prescriptions

- New PCHM capabilities propose to require providers to adopt the following workflow practices:
  - Adopt and utilize certified e Prescribing System - in use for all prescribing providers (implemented)
  - Utilize the e Prescribing system to prescribe controlled substance prescriptions
  - Utilize MAPs reporting prior to prescribing controlled substance drugs
  - Ensure criteria is in place that identifies and engages patients with chronic conditions that may require on-going pain management

Blue Cross Blue Shield Blue Care Network of Michigan

Sample eRx Opportunity Report (quarterly)

Total DEA prescribed

Total (all) prescribed.

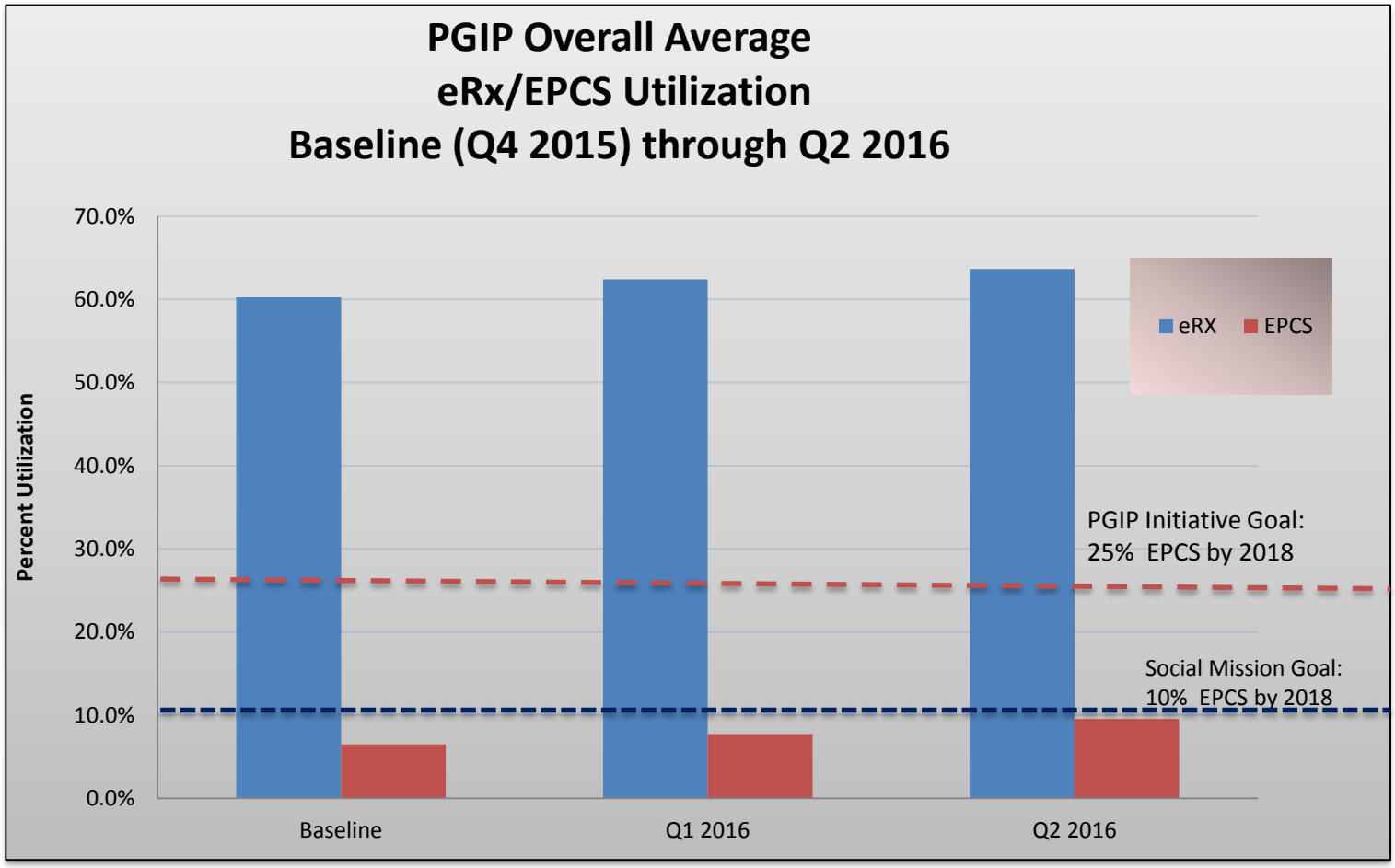
% eRX

% EPCS

Physician Organization
2016 Electronic Prescribing Controlled Substance (EPCS) Opportunity Report

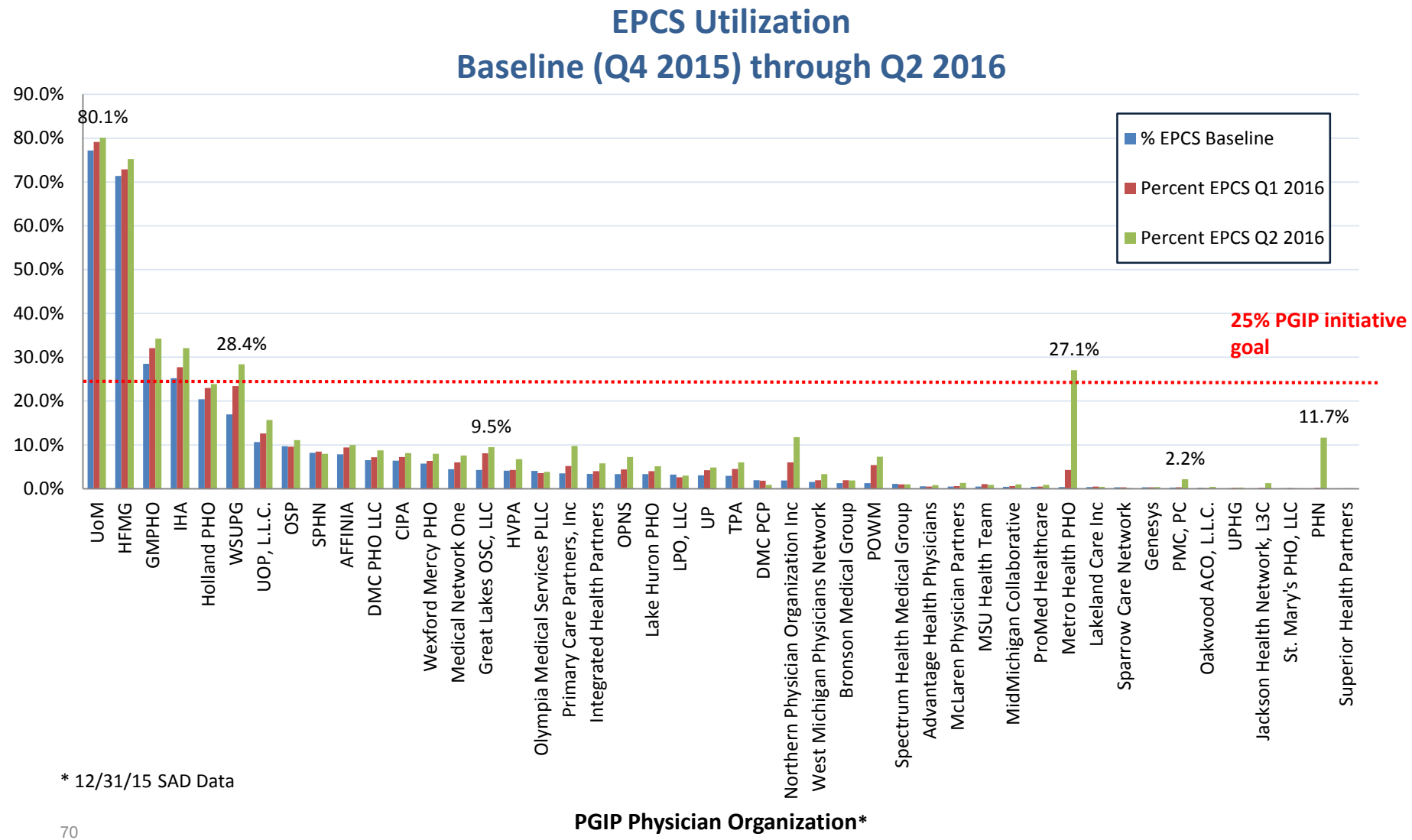
PU Name	Physician First Name	Physician Last Name	Primary Specialty	eRX platform	Retail Written	Retail Telephone	Retail Fax	Retail EPCS	Retail Electronic Total	Retail DEA (Schedule II-V) Total	Retail Total	Retail EPCS - Percent	Electronic Retail - Percent	Home Delivery Mail	Home Delivery Fax	Home Delivery Phone	Home Delivery EPCS	Home Delivery Electronic Total	Home Delivery DEA Total	Home Delivery Total	Home Delivery EPCS - Percent	Home Delivery Electronic Percent Total	Total Electronic Total Schedule II-V (DEA Class)	Total EPCS	Total Claims	Electronic Total - Percent	EPCS Total Percent is your	provider/physician currently utilizing EPCS	EPCS vendor and version
Practice Unit			Internal Medicine	SureRx	453	87	18	0	85	76	643	0%	13%	20	3	0	0	52	1	75	0%	69%	137	77	0	718	19%	0%	No	No
Practice Unit			Family Medicine	SureRx	300	54	104	0	807	215	1,265	0%	64%	11	24	0	0	136	2	171	0%	80%	943	217	0	1,436	66%	0%	No	No
Practice Unit			Family Medicine	SureRx	311	66	96	0	977	259	1,450	0%	67%	18	26	0	0	135	6	179	0%	75%	1,112	265	0	1,629	68%	0%	No	No
Practice Unit			Internal Medicine	SureRx	431	71	78	0	449	351	1,029	0%	44%	14	69	3	0	138	6	224	0%	62%	587	357	0	1,253	47%	0%	No	No
Practice Unit			Family Medicine	Allscripts	159	77	43	0	620	181	899	0%	69%	14	33	3	0	83	8	133	0%	62%	703	189	0	1,032	68%	0%	No	No
Practice Unit			Family Medicine	Allscripts	74	67	18	1	244	92	403	1%	61%	12	43	3	0	47	11	105	0%	45%	291	103	1	508	57%	1%	No	No
Practice Unit			Family Medicine	SureRx	438	36	1	0	487	345	963	0%	51%	29	3	1	0	64	9	97	0%	66%	551	354	0	1,060	52%	0%	No	No
Practice Unit			Family Medicine	SureRx	405	14	3	1	216	336	638	0%	34%	3	0	0	0	22	0	25	0%	88%	238	336	1	663	36%	0%	No	No
Practice Unit			Family Medicine	SureRx	360	70	6	0	543	345	979	0%	55%	7	1	0	0	42	7	50	0%	84%	585	352	0	1,029	57%	0%	No	No

PGIP EPCS Initiative and Social Mission Goals



BCBSM Initiatives and Updates

2016 EPCS PGIP Initiative Progress:



* 12/31/15 SAD Data

ePrescribing and MACRA

- The Medicare Access and CHIP reauthorization Act of 2015 (MACRA) which creates **MIPS (Merit-based Incentive Payment System) includes:**
  - Require eRx to be mandatory for all providers.
  - EHRs will certify to new NCPDP SCRIPTS standard v10.6 – this segment will standardize dosing instructions (Sig) for most prescriptions that are submitted electronically
  - In addition to existing eRx MU criteria – 2015 MACRA criteria include three new eRx transactions (increasing patient safety and adding more robust clinical decision making value) and are:
    - **Change Prescription**. This transaction is sent by the pharmacy to the prescriber when the pharmacy requests approval to switch from a drug originally prescribed to something different
    - **Cancel Prescription**. This transaction is used by the prescriber to cancel an existing prescription
    - **Fill Status.** This transaction is sent to the prescriber from the pharmacy and indicates the fill status of the prescription (dispenses, partially dispenses or not dispenses).

Conclusion

- E Prescribing Benefits
  - E Rx helps keep patients focused – a 2012 Surescripts study shows 10% better adherence when prescriptions are e Prescribed
  - E Rx provides additional capabilities to aid in combating the current surge of opiate additions and deaths (EPCS)
- Encouraging inclusion of PDMP programs has shown effective in states mandated to utilize such programs (NY decrease in opiate prescriptions by 10% after 1st year)
- EHR optimization that leverages full EPCS capabilities into workflows will improve patient safety and help reverse the current crisis related to opiate abuse including:
  - decrease in overdose deaths
  - elimination of stolen/forged prescription blanks
  - reduction in patients who “doctor shop”
  - Identification and shut-down of “pill mills”
- New Script standards for e Prescribing will increase patient safety, making e Rx an even better clinical decision making value.
- BCBSM is committed to educating providers and encouraging the continued use and optimization of current e Prescribing and EPCS

Blue Cross Blue Shield Blue Care Network of Michigan

e-Prescribing – The Infrastructure is Solid…

80%

Providers e-Prescribing today

700

e-Prescribing vendors (EHR's) Enabled for eRx

100%

Nearly all Retail Pharmacies

…For MACRA/MIPS, EPCS and Electronic Prior Authorization (ePA)…

Contact: Lynda McMillin
lmcmillin@bcbsm.com

HIT Commission Next Steps

- Planning for the October Meeting
- HIT Commission Annual Report

Public Comment

Adjourn