

# MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

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January 21, 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

# January 2016 Meeting

- Welcome and Introductions
- Commissioner Updates
- Review of the September Meeting Minutes
- Co-Chair Nomination and Election

# HIT/HIE Updates

- HIT Commission Dashboard
- 2015 Annual Report
- Other Updates

# 2016 Goals – January HIT Commission Update



## Governance Development and Execution of Relevant Agreements

- New Trusted Data Sharing Organizations (total: 51):
  - **Southwest Michigan Behavioral Health (SWMBH) newest QO**
  - **All 10 of Michigan's Pre-paid Inpatient health Plans (PIHPs) now QOs**
- HIE-QO selected to pilot Exchange Consumer Consent Information Use Case
  - Pilot will result in development of Use Case Agreement and Use Case Implementation Guide
- Mid-state Health Network executed Use Case Agreements in the Active Care Relationship Service (ACRS)
- Henry Ford Health System entered pilot status for sending Medication Reconciliation at discharge

## Technology and Implementation Road Map Goals

- All 11 organizations participating in MiHealthLink successfully connected to the Common Gateway for exchanging care plans
- Common Key Service Workshop sessions:
  - Meeting #4 held December 15 in Lansing
  - Meeting #5 held December 22 virtually
  - 21 participants representing 14 organizations present
  - Completed timeline for CKS adoption over next 18 months to propose alignment with payer incentives
  - Next meeting January 28 in Lansing and will be combined with HIE-QO Day
- eCQM Affinity Group meetings with Office of the National Coordinator have identified numerous areas for improvement/cooperation with other states in reporting quality measures
- Payer-Provider Quality Collaborative working groups developing pilot Use Case for alignment of quality measure submissions

# 2016 Goals – January Update



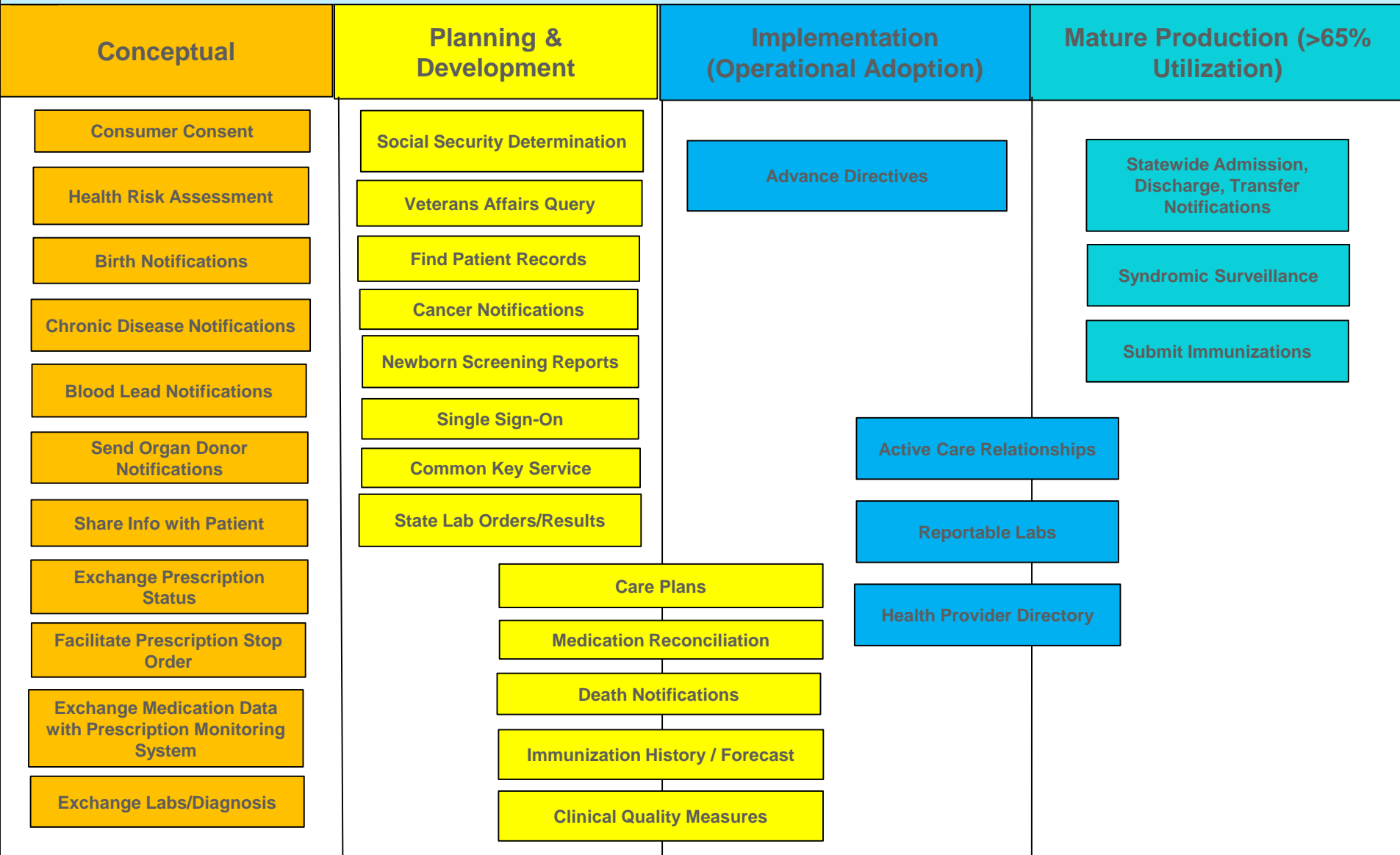
## QO & VQO Data Sharing

- More than **557 million** messages received since production started May 8, 2012
  - Have processed as many as **9.4 MLN+** total messages/week
  - Averaging **8.9 MLN+** messages/week
  - **8.1 MLN+ ADT** messages/week; **1.4 MLN+** public health messages/week
- Total 505 ADT senders, 61 receivers to date
  - Estimated **97%** of admissions statewide now being sent through MiHIN
- Sent **.988 MLN+** ADTs out last week (exact match rate approx. 60%)
- More than:
  - **845,000 Reportable Lab** messages received/sent to MDSS
  - **17.8 MLN Immunization** messages received/sent to MCIR
  - **82 MLN Syndromic Surveillance** messages received/sent to MSSS
  - **200 AVG** Care Plans/Integrated Care Bridge Records (ICBR) per week
- Presently processing approximately **332,000** Discharges per week (ADT A03)
  - **1.5+ MLN Medication Reconciliations at Discharge**/month *expected*

## MiHIN Shared Services Utilization

- **6.8 MLN** patient-provider relationships in Active Care Relationship Service (ACRS)
- **5.6 MLN** unique patients in ACRS;
- **479,157** unique providers in statewide Health Provider Directory; **54,718** unique organizations
- St. Francis Hospital completed DQA and entered production for Statewide ADT Service through MiHIN

# MiHIN Statewide Use Case Status <sup>6</sup>



## Project Accomplishments

### MILogin Accomplishments in 2015:

The new Single-Sign-On system and credential access management system, known as MILogin, completed the noncitizen facing infrastructure build in March 2015 and began the Medicaid application migrations (existing systems) and integrations (new systems), completing a total of 11 by year-end. Migrations are scheduled to be completed by September 2016.

New functionality was added in August 2015, multi-factor authentication (MFA) which distributes a one-time passcode enabling application users to connect successfully using a one-time passcode for identity authentication. Integrations included leveraging MILogin to allow Illinois providers to access the IL portion of the state’s Medicaid processing system (CHAMPS) for provider enrollment application (June 2015). In addition, MILogin and MIHIN established the necessary infrastructure to accomplish Federation (projected for 2016), the leveraging of a participating systems identity and credentialing when standards equal or exceed those of the participating organizations.

### MPI/PI Accomplishments in 2015:

The purpose of the Master Person Index (MPI)/Provider Index (PI) is to integrate/link data from multiple sources by creating a centralized index of Medicaid beneficiaries, providers, and other individuals for use by the Medicaid Enterprise. The Master Index Data Stewardship Portal (MIDSP) was successfully integrated with MILogin in December 2015. MIDSP will allow data owners and data stewards to access their data within the MPI/PI to identify and resolve data quality issues in their own systems.

The PI model was expanded to include Facilities, Organizations, and Agencies (FOAs) with existing data sources, allowing the project team to enable the system relationship functionality by linking providers to their work locations. This upgrade also allows the crosslinking of the MPI and PI databases. These integrations, coupled with system upgrades, improved the overall data quality and integrity of the MPI/PI system.

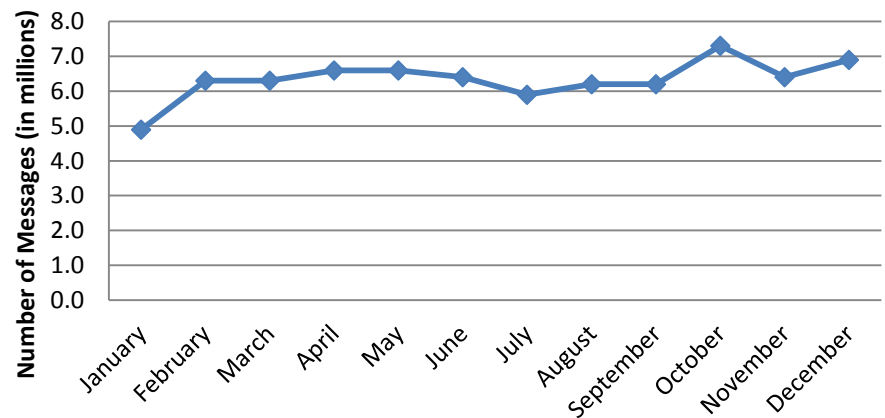
### Public Health Reporting Messages in 2015:

The advance directive project with the Peace of Mind (POM) registry went live in September 2015, enabling Medicaid beneficiaries to upload advance directives directly to the POM registry via the myHealthButton (mHB)/myHealthPortal (mHP).

In October 2015 the first provider organization moved into production for the MCIR Immunization Query History/Forecast use case. This was the Data Hub’s first bi-directional HIE message where providers submit a query from their EHR and receive patient immunization history and forecast information.

In November 2015, the first provider went into production with electronic reporting of Critical Congenital Heart Defect screening results (Pulse Ox) using an HL7 message format and the Michigan HIE network. The development of an electronic message that can transmit multiple-sequenced test results via the Michigan HIE platform from the hospital EHRs to MDHHS will eliminate the need for hospitals to data enter the information on the Newborn Screening’s web application, thus reducing significantly the data entry burden on hospital staffs and reduce the risk for data entry error.

**Total Number of Health Messages per Month**





# Participation Year (PY) Goals

## January 2016 Dashboard

	Reporting Status	Prior # of Incentives Paid (November)	Current # of Incentives Paid (December)	PY Goal: Number of Incentive Payments	PY Medicaid Incentive Funding Expended
Eligible Professionals (EPs)	AIU 2014	1101	1102	1000	\$ 23,105,848
	AIU 2015	260	351	500	\$ 7,409,169
	MU 2014	1404	1427	1444	\$ 12,656,516
	MU 2015	170	193	1702	\$ 1,735,419
Eligible Hospitals (EHs)	AIU 2014	3	3	17	\$ 2,421,405
	AIU 2015	1	1	5	\$ 184,905
	MU 2014	61	61	44	\$ 13,684,481
	MU 2015	0	0	28	\$ -

### Cumulative Incentives for EHR Incentive Program 2011 to Present

	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	5429	\$ 192,258,729
MU	2521	\$ 103,754,870

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





## Michigan Medicaid MU Program

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

## Upcoming Presentations and Updates

### Program Goals

- Assist 600 Specialists in their first year of Meaningful Use
- Assist 990 Providers to subsequent years of Meaningful Use

### Ongoing Program Metrics

- 1200 unique participating providers
- 765 Primary Care Providers – 64% of clients
- 435 Specialists Providers – 36% of clients
- 213 Total Meaningful Use Attestations

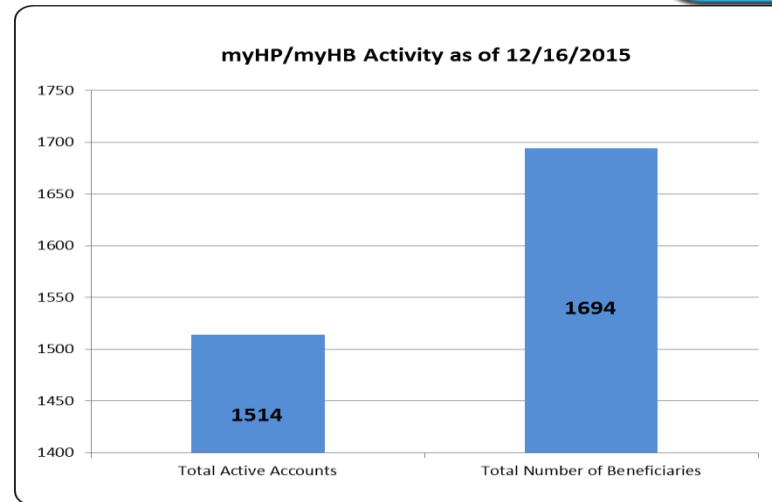
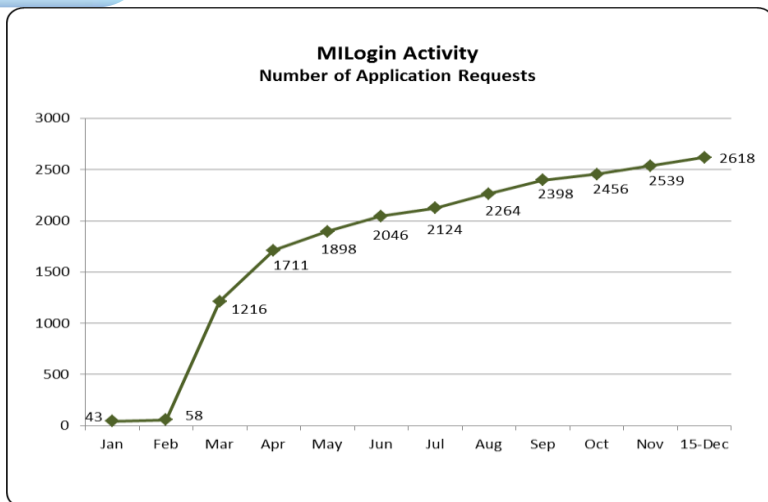
### Other program highlights:

- More than 450 people have attended the recent M-CEITA webinar series offering "Modified Stage 2 - Meaningful Use 2015-2017".
- Meaningful use assistance in 2016 for Specialist and Primary Care providers will align with Modified Stage 2 regardless of their year of program participation.

- February HIT Commission report will provide quarterly updates on full Health Innovations and Technical Assistance HIT/HIE project portfolio.



# myHealthButton/myHealthPortal Dashboard



## Updates:

### 6.1 Release (December 2015)

- ◇View Cost Share data
- ◇Upload and view Continuity of Care documents, including Results, Medications, and Immunizations
- ◇Notification of Redetermination Date
- ◇MDHHS-generated online alerts, notifications, and surveys

### Outreach Activities

- ◇Advertising efforts are now complete.
- ◇Brochures and flyers have been printed and will be distributed to appropriate parties in the near future.

## CONSUMER ENGAGEMENT INTEREST GROUP CALL

The Consumer Engagement Interest Group calls will continue in 2016 on a quarterly basis.

The MPHI Consumer Engagement team will start a monthly newsletter that will highlight the latest studies, news, products, and initiatives on consumer engagement from around the state and country.

**NEXT CALL:** TBD – February 2016

## MEDICAID HEALTH PLANS

Continuing to assist the MHPs with the HIT HIE rebid requirements as listed below:

- Must assist MDHHS in statewide efforts to target high-volume Medicaid providers eligible for EHR incentive payments
- Must promote EHR Incentive Programs as part of regular communications with providers.

## STAKEHOLDER COLLABORATION

### Michigan Health IT Site

We are reorganizing the MichiganHealthIT website so that it will continue to be an educational tool for providers & hospitals but also for Medicaid Health Plans, provider trade associations, and Medicaid patients and families.

I'm seeking information for:

**HEALTHCARE PROFESSIONALS**

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[MORE INFO](#)

**HOSPITALS**

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**PAYER & PROVIDER TRADE ASSOCIATIONS**

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[MORE INFO](#)

**PATIENTS & FAMILIES**

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[MORE INFO](#)



Michigan Department of Health & Human Services

# Michigan's Prescription Drug and Opioid Abuse Task Force

Jared Welehodsky  
Office of Health Policy and Innovation, MDHHS  
January 21<sup>st</sup>, 2016

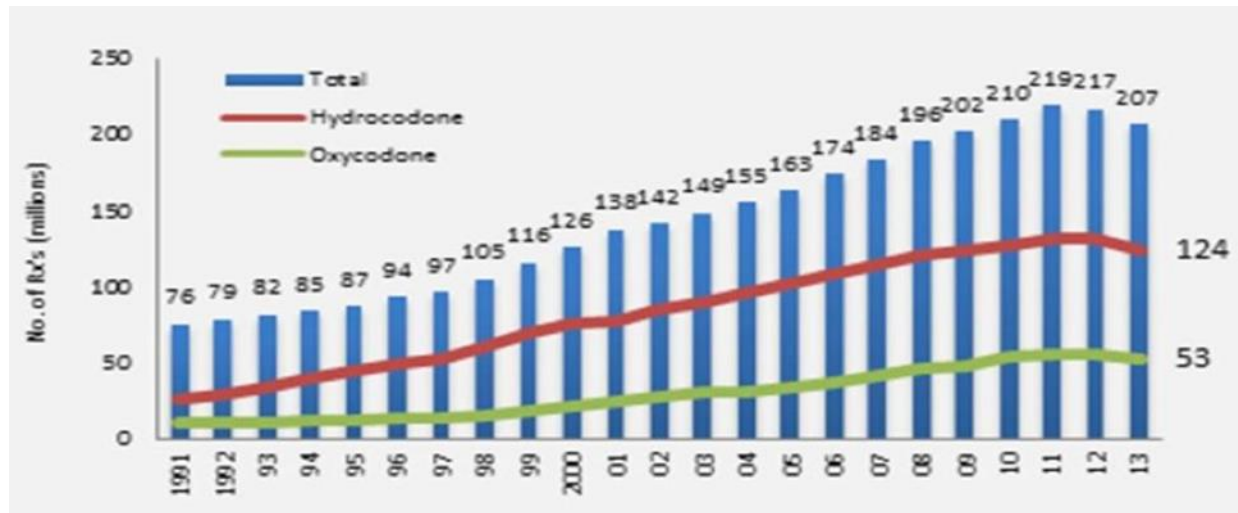
*Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.*

# Introduction to Opioids

- What are opioids?
  - Opioids are medications used to relieve pain.
  - Hydrocodone, Oxycodone, Morphine, and Codeine are all commonly used opioids.
  - Opioids are highly addictive.

# Increase in Prescription of Opioids

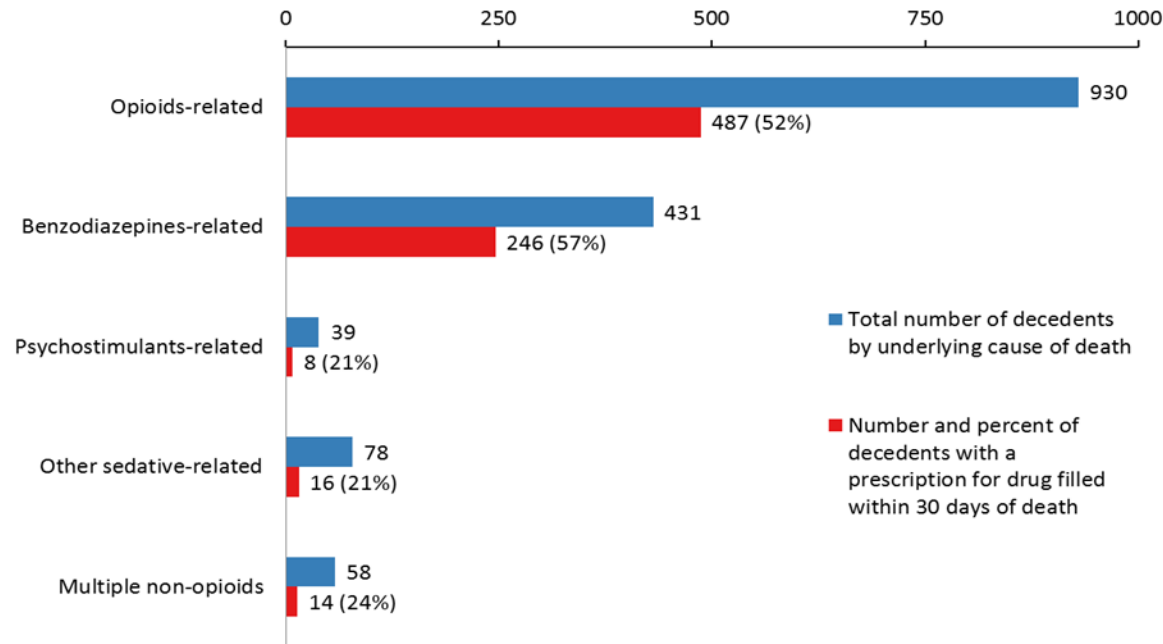
- Hydrocodone and Oxycodone prescribing has increased nearly 300% nationwide since 1991.



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

# Impact of Opioid Abuse

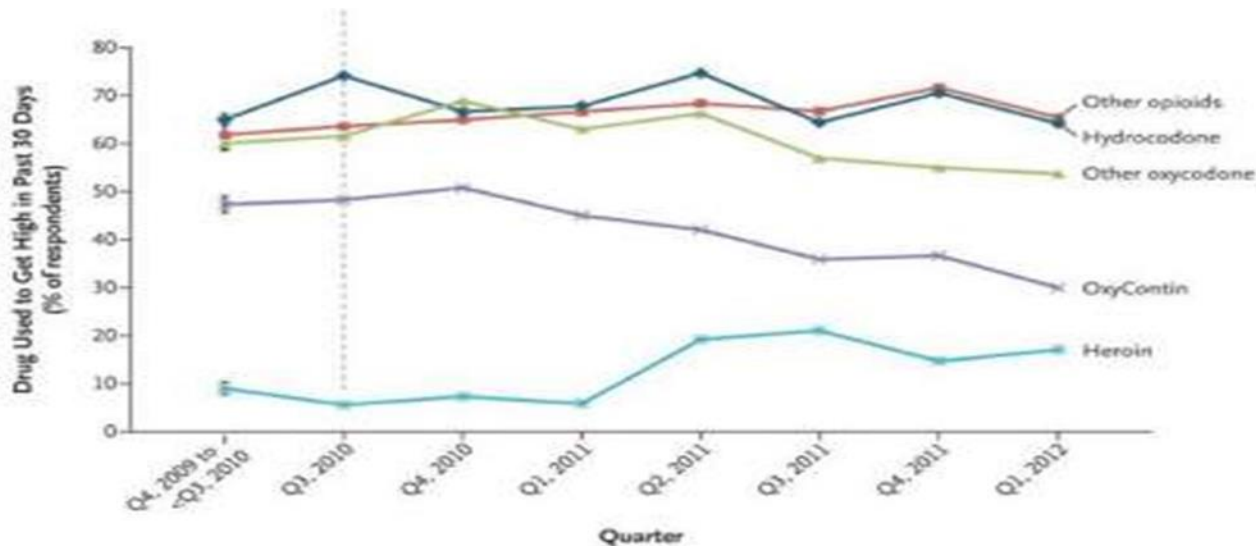
- Michigan overdose deaths from 2009 to 2012 in which a prescribed drug was mentioned as a cause of death



Source: [https://www.michigan.gov/documents/mdch/MAPS\\_Report\\_2014\\_-\\_FINAL\\_464112\\_7.pdf](https://www.michigan.gov/documents/mdch/MAPS_Report_2014_-_FINAL_464112_7.pdf)

# Heroin and Prescription Medications

- Prescription medicine are not the only opioids being abused.
  - Heroin is also an opioid and its usage has also increased.
  - Prescription opioid abusers often switch to heroin.

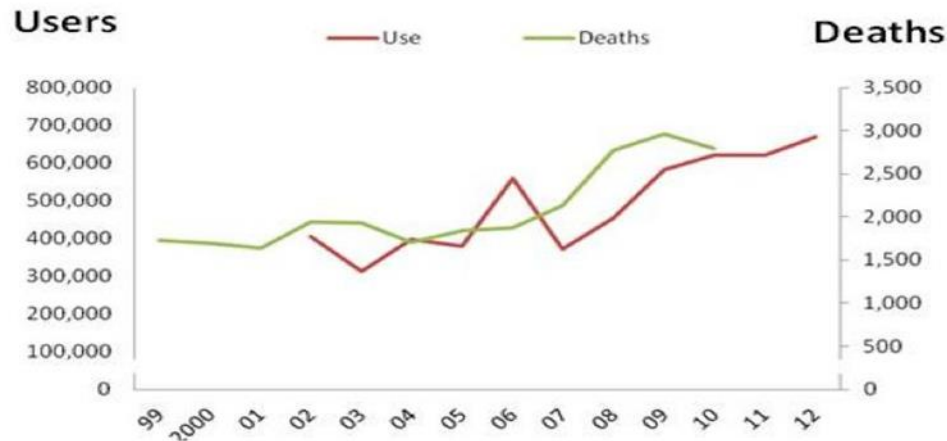


Source: <http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse>



# Increase in Heroin Use

- Heroin use increased nearly 100% from 2005 to 2012.
- Heroin deaths increased 50% from 2005 to 2010.



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

# Other Commonly Abused Prescription Medication

- Benzodiazepines
  - Xanax
  - Valium
- Muscle relaxers
  - Soma

# Michigan Prescription Drug and Opioid Abuse Task Force

- On June 18, 2015, Governor Rick Snyder appointed a task force to address prescription drug and opioid abuse.
- Governor Snyder appointed Lt. Governor Brian Calley to lead this effort.
- Lt. Governor Calley said “prescription drug and opioid addiction has quadrupled the number of unintentional drug deaths in our state since 1999 and we must come together to reverse this trend before more Michiganders are hurt.”

# Committee on Prevention, Treatment, and Outcomes

- MDHHS Director Nick Lyon was the chair of the committee.
- The following individuals served on the committee:
  - State Senator Jim Ananich
  - Dr. Steve Bell, Michigan Osteopathic Association
  - Matt Clay, Pokagon Band of Potawatomi
  - James Craig, Detroit Police Chief
  - State Representative Anthony Forlini
  - Sheriff Mike Lovelace, Marquette County
  - Conrad Mallett, Detroit Medical Center
  - Laurie Wesolowicz, Blue Cross Blue Shield of Michigan

# Committee on Regulation, Enforcement, and Policy

- Attorney General Bill Schuette was the chair of the committee.
- The following individuals served on the committee:
  - Col. Kriste Kibbey Etue, Director of Michigan State Police
  - Judge Linda Davis, Macomb County
  - Victor Fritz, Prosecutor Cass County
  - Bob Lathers, CEO Ionia CMH
  - State Representative Andy Schor
  - State Senator Tonya Schuitmaker
  - Larry Wagenknect, Michigan Pharmacists Association
  - Dr. R. Corey Waller, Spectrum Health
  - Mike Zimmer, Director, Department of Licensing and Regulatory Affairs

# Task Force Timeline

- The Task Force met weekly starting in June 2015.
- The Task Force finished their work in September 2015.
- On October 26, 2015, the Task Force released its final report.

# Governor Snyder's Response to the Task Force Report

- Governor Snyder said after the release of the report:

*“the impact of prescription drug and opioid abuse is being felt in every community across Michigan. It crosses all demographic, geographic, and political lines. This problem is something we must work together to address as soon as possible and I appreciate the dedication of Lt. Gov. Calley and the task force in working on this issue and presenting their findings in such a short time frame.”*

# Task Force Recommendations

- The Task Force report includes 25 primary recommendations and 7 contingent recommendations.
- The recommendations are grouped into the following categories:
  - Prevention
  - Treatment
  - Regulation
  - Policy and Outcomes
  - Enforcement



# Task Force Recommendations

- Prevention
  - Create additional training for prescribers
  - Increase prescription drop-off bins
  - Improve prescription monitoring program
- Treatment
  - Increase access to Naloxone
  - Increase access to care
  - Increase the number of addiction specialists
  - Require a bona-fide physician patient relationship
  - Develop best practices for reducing neo-natal abstinence syndrome

# Task Force Recommendations

- Regulation
  - Create a tiered licensing system
  - Good faith exemption for pharmacists
  - Review and endorse a best practices policy for hospitals and doctors
- Policy and Outcomes
  - Create ongoing Task Force
  - Create a State Dashboard to measure outcomes

# Task Force Recommendations

- Enforcement
  - Improve the MI Automated Prescription System (MAPS)
  - Increase access to MAPS
  - Increase sanctions

# Implementation

- State agencies that were impacted by the recommendations met to determine which agencies will take ownership of each recommendation.
- Implementation is an ongoing process led by Governor Snyder's Office.
- 5 different state agencies are responsible for the implementation of these recommendations:
  - Department of Health and Human Services
  - Department of Licensing and Regulatory Affairs
  - Michigan State Police
  - Attorney General
  - Department of Insurance and Financial Services

# MDHHS-Led Recommendations

# Benefits Monitoring Program

- The Task Force focused on a potential tool for reducing doctor and pharmacy shopping
  - Michigan's Medicaid program has a Benefits Monitoring Program that tracks misuse of medical services.
  - After reviewing the use of medical services, Medicaid can place a beneficiary in the Benefits Monitoring Program.
  - Once in the program, a beneficiary can be locked-in to one pharmacy and/or one provider.

# Benefits Monitoring Program

- The Benefits Monitoring Program uses the PROgram Monitoring (PROM) application as a tool to review utilization of medical benefits.
  - PROM application went live in April 2014.
  - PROM uses CHAMPS data to identify potentially inappropriate use.
  - Both Fee-For-Service Medicaid and Medicaid Health Plans have access to PROM.

# Benefits Monitoring Program

- Criteria for enrollment in the Benefits Monitoring Program:
  - Misuse of Emergency Department Services
  - Misuse of Prescription and Pharmacy Services (DEA Controlled Substances II-V)
  - Misuse of Physician Services
  - Fraud



# Benefits Monitoring Program

- Criteria for enrollment based on potential misuse:
  - 4 or more emergency department visits in LCFQ
  - 2 or more emergency department locations in LCFQ
  - 5 or more prescriptions for drugs subject to abuse in LCFQ
  - 4 or more pharmacies to fill drugs subject to abuse in LCFQ
  - 2 or more providers prescribing drugs subject to abuse in LCFQ
- Criteria for enrollment based on fraud include:
  - Forging prescriptions
  - Selling prescriptions purchased through Medicaid

# Recommendations about Benefits Monitoring Program

- Recommendations:
  - Review parameters to reduce doctor and pharmacy shopping
  - Examine Washington and Tennessee’s program
- Action Steps:
  - Medicaid is currently reviewing the Benefits Monitoring Program seeking to improve the program.

# Increase Access to Care

- One of the issues reviewed by the Task Force was a lack of access to care.
  - Increasing access to care focused on Medication Assisted Treatment (MAT).
  - MAT is essential for most patients who are addicted to opioids.
  - Therefore, the task force recommended increasing access to care for MAT.
- The Medical Services Administration at MDHHS released policy 15-56 that would allow fee-for-service Medicaid to reimburse for the office-based distribution of opioid treatment medication. This policy was effective 1/1/16.

# Increase Access to Naloxone

- Naloxone is a drug that reduces the affect of opioids.
  - Naloxone is a safe and life-saving drug
  - The Task Force felt that Naloxone should be as easy to obtain as possible
- Therefore, the Task Force recommend allowing pharmacists to dispense Naloxone to the public in similar fashion to how pseudoephedrine is currently dispensed.

# Recommendations led by other State Agencies

# Recommendations led by other State Agencies

- Department of Licensing and Regulatory Affairs
  - Improve/upgrade MAPS
  - Allow broader access to MAPS
  - Increase licensing sanctions
- Michigan State Policy
  - Increase law enforcement training for those suffering from addiction
- Attorney General
  - Expand access to drug treatment courts

# Questions?

Jared Welehodsky

Office of Health Policy and Innovation

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# BCBSM HIE Incentives and Exchange Medication Reconciliation Use Case Pilot

Health Information Technology Commission  
01/21/2016

Ellen Ward, Manager, Value Partnerships  
Lynda McMillin, Health Care Manager, Pharmacy Services  
Blue Cross Blue Shield of Michigan

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# Blue Cross and Statewide Health Information Exchange

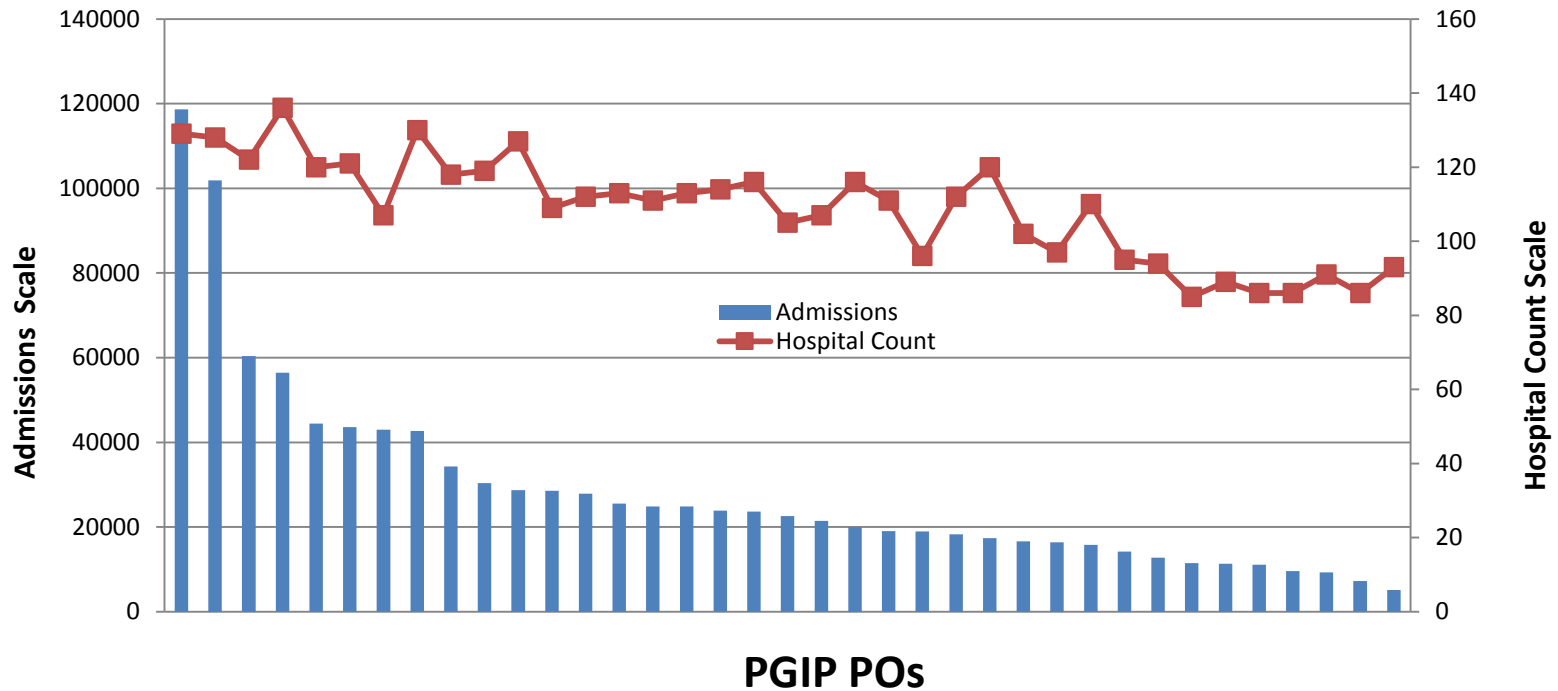
Why is it important?

- Information sharing is an integral capability for successful population management
  - Builds upon the team-based approach of the patient-centered medical home
  - Enables consistent and timely communication across care settings
  - Improves care coordination and transitions
- A single access point is needed to send and receive information across multiple participants
  - Patients often use hospitals not affiliated with their regular physician caregivers
  - Physicians are only aware of a portion of these admissions
  - Multiple connection points would not be feasible
- Enables BCBSM to obtain to meet the expectations of key customers



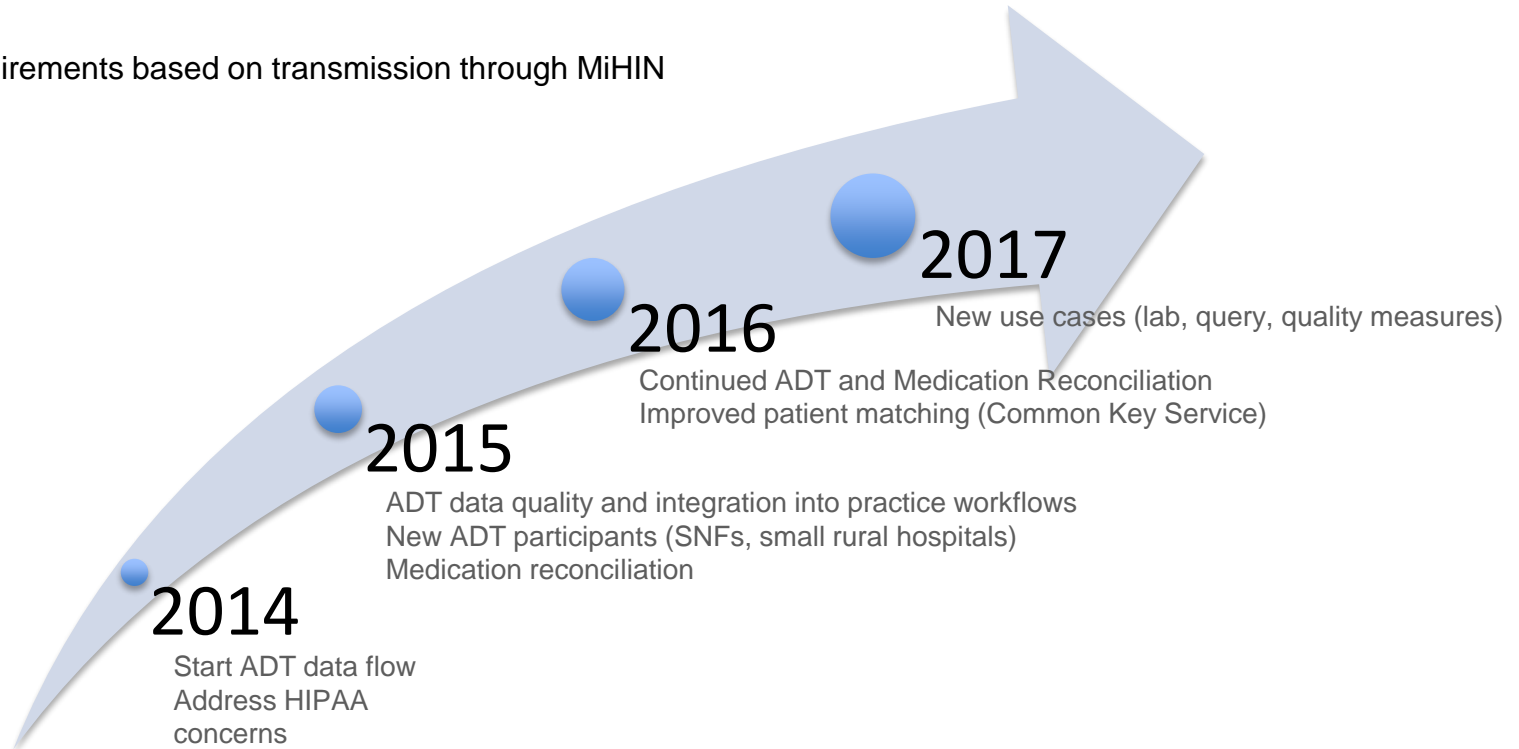
## Why We Need a Statewide HIE Service

Every PO has patients in numerous hospitals



# Blue Cross HIE Incentives

All requirements based on transmission through MiHIN



# Impact of Blue Cross Incentives – Plus a lot of hard work by MiHIN and hospitals

ADT data quality: April 2015 ADT data quality: December 2015

Fields populate	Fields mapped	Enhanced fields	Fields populate	Fields mapped	Enhanced fields
100.0%	100.0%	0.0%	100.0%	100.0%	100.0%
63.6%	53.8%	0.0%	100.0%	100.0%	66.7%
81.8%	53.8%	33.3%	100.0%	0.0%	33.3%
90.9%	61.5%	0.0%	72.7%	100.0%	66.7%
100.0%	38.5%	0.0%	100.0%	100.0%	66.7%
90.9%	92.3%	0.0%	100.0%	100.0%	100.0%
54.5%	15.4%	0.0%	90.9%	100.0%	100.0%
54.5%	15.4%	0.0%	100.0%	92.3%	66.7%
100.0%	0.0%	33.3%	100.0%	100.0%	66.7%
90.9%	61.5%	0.0%	100.0%	100.0%	100.0%
90.9%	76.9%	33.3%	100.0%	100.0%	100.0%
90.9%	23.1%	0.0%	100.0%	100.0%	100.0%
63.6%	69.2%	0.0%	100.0%	100.0%	66.7%
63.6%	92.3%	0.0%	100.0%	100.0%	100.0%
63.6%	0.0%	0.0%	100.0%	76.9%	66.7%
63.6%	38.5%	33.3%	72.7%	100.0%	66.7%
90.9%	92.3%	33.3%	63.6%	84.6%	66.7%
63.6%	53.8%	0.0%	100.0%	92.3%	100.0%
90.9%	92.3%	0.0%	100.0%	100.0%	33.3%
90.9%	38.5%	33.3%	100.0%	53.8%	33.3%
63.6%	38.5%	33.3%	100.0%	100.0%	66.7%
81.8%	23.1%	0.0%	100.0%	100.0%	66.7%
63.6%	53.8%	0.0%	63.6%	92.3%	0.0%
81.8%	69.2%	33.3%	72.7%	69.2%	66.7%
			90.9%	100.0%	33.3%
			100.0%	100.0%	66.7%

Hospital Systems

December 2015 snapshot shows one health system by individual hospitals, resulting in additional rows



# BCBSM Hospital Incentives: 2016 - 2018

- Hospitals will participate in at least one new HIE use case through the MiHIN statewide service each year.
- These new use cases will be in addition to the ADT and Medication Reconciliation use cases already in place.
  - Hospitals must also maintain compliance with data quality standards for implemented use cases
- Hospitals will be allowed to choose which new use case they complete each year from the following options:

2016	2017 (proposed)	2018 (proposed)
<ul style="list-style-type: none"> <li>• Common Key Service (pilot participation)</li> <li>• Submit Lab Values*</li> <li>• Query (response)**</li> </ul>	<ul style="list-style-type: none"> <li>• Common Key Service (implement)</li> <li>• Submit Lab Values</li> <li>• Query (response or initiate)</li> <li>• Transmit quality measures or data sets</li> </ul>	<ul style="list-style-type: none"> <li>• Common Key Service (implement)</li> <li>• Submit Lab Values</li> <li>• Query (response or initiate)</li> <li>• Transmit quality measures or data sets</li> <li>• Care plan exchange</li> </ul>

\* An extension of the existing Disease Surveillance System for reporting outbreaks of communicable diseases

\*\* Implement the ability to respond to a query for patient information through the statewide service

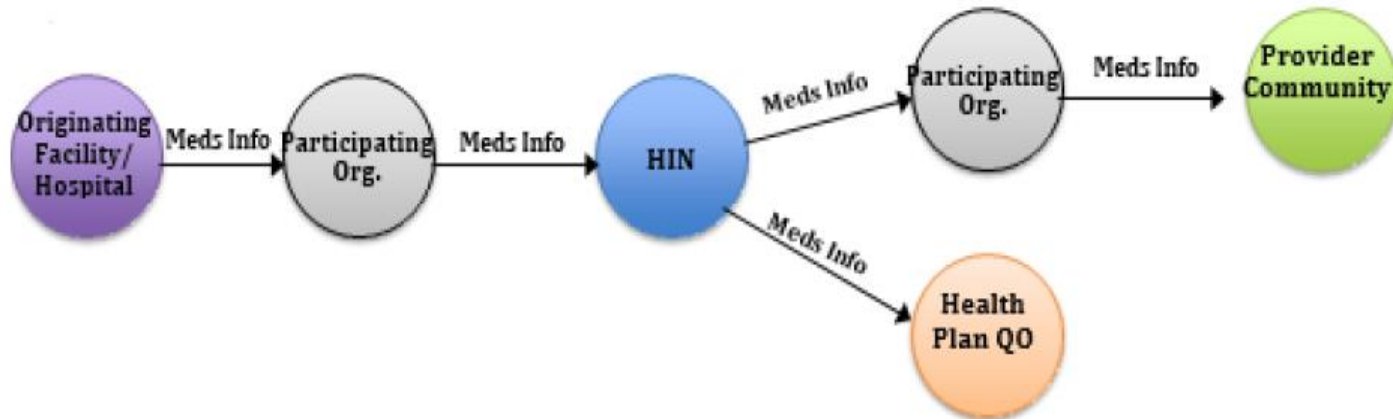
# BCBSM Physician Incentives: 2016 - 2017

- Increase PO participation
  - New POs and new practices
- Increase integration of data into care processes
  - Help POs use the data effectively
- Support adoption of additional use cases:
  - Medication Reconciliation
  - Common Key
- Support ability to implement ACRS 2.0

# Exchange Medication Reconciliation

## Use Case Pilot

# Exchange Medication Reconciliation Use Case





# Exchange Medication Reconciliation: Use Case Pilot

## Purpose

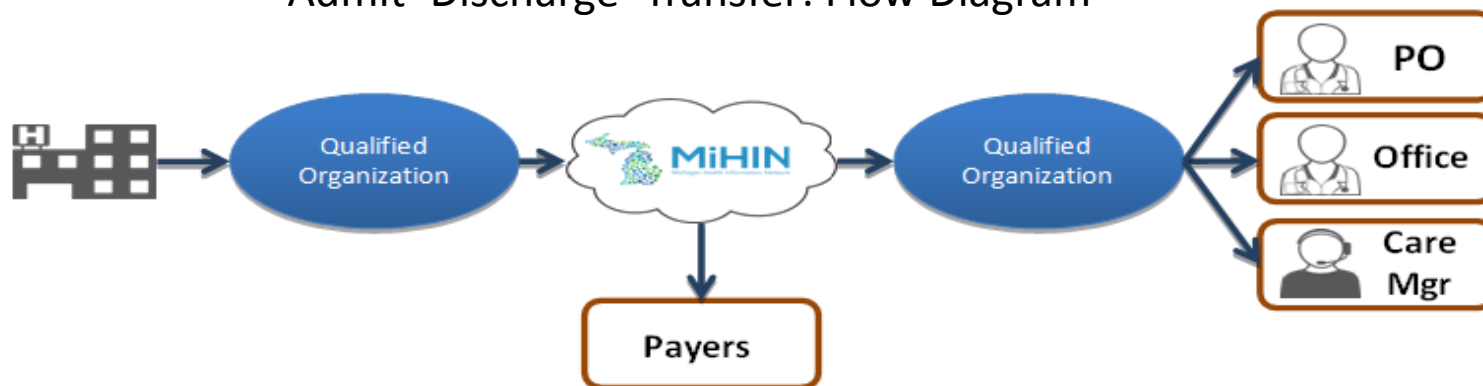
- Share patient medication information across multiple points of care
  - Physician offices (current pilot)
  - Hospitals
  - Transitional facilities (outpatient tertiary and skilled nursing facilities, pharmacies)
- Coordinate patient medication to minimize adverse drug events (ADEs) and maximize cost benefits
  - Leverage MiHIN's – Shared Services Active Care Relationship Service (ACRS) to notify appropriate provider of changes to a patient's medication status

# Exchange Medication Reconciliation: Use Case Pilot

## Leveraging ADT for Medication Reconciliation/Transition of Care Events

*Exchange medication reconciliation leverages ADT notifications and risk assessments to identify patients in need of advanced medication reconciliation services by pharmacists.*

Admit–Discharge–Transfer: Flow Diagram



# Exchange Medication Reconciliation: Use Case Pilot

## Participant Roles

### Hospitals (senders)

- Capture and document medication reconciliation at admission
- Capture and document medication reconciliation at discharge
- Upon discharge send Summary of Care (CCDA) with medication information through MiHIN to care team
  - Meets facility requirements for Meaningful Use

### Providers (recipients)

- Patient's care team receives medication information and integrates into transition of care workflow

# Exchange Medication Reconciliation: Use Case Pilot

## Participants

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

# Exchange Medication Reconciliation: Use Case Pilot

## ACRS and Health Provider Directory

- Patient matching is an important component for timely data sharing. Pilot participants will use ACRS 2.0 to improve match rates.
  - Additional patient information will minimize false positives and non-match rates

### ACRS™ - Version 2.0

#### Patient Information Information

Source Patient ID  
 First Name  
 Last Name  
 Middle Initial  
 Suffix  
 Date of Birth  
 Gender  
 SSN – last 4  
 Address  
 City, State, Zip  
 Home &  
 Mobile Phone

#### Physician

NPI  
 First Name  
 Last Name  
 Practice ID (OID)  
 Practice Name  
 Physician Organization ID (OID)  
 Physician Organization Name  
 Physician DIRECT Address  
 DIRECT Preferences



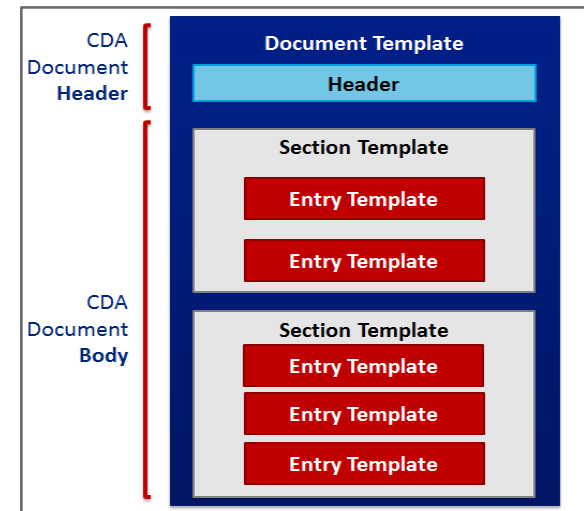
## Exchange Medication Reconciliation: Use Case Pilot Lessons Learned from ADT

- Collaboration and transparency with all partners – what is possible and what is not possible
- Leveraging data sharing organizations' expertise
- How much information is too much information
  - Care Summary Documents exported from an EHR and sent directly to practitioner can be overwhelming

# Exchange Medication Reconciliation: Use Case Pilot

## Drilling it Down

- Patient identifying/demographic information
- Medication Section Information (3 sections)
  - Current medications (admission history)/ at admission / reconciliation
  - Prescriptions ordered during visit (optional)
  - Medications at time of discharge
- Other information
  - Admitting diagnosis
  - Active allergies and adverse reactions
  - Visit diagnosis/working diagnosis (on file)
  - Active problems
  - Discharge disposition – home, SNF, etc (if available)
  - Chief complaint (if available)



# Exchange Medication Reconciliation: Use Case Pilot

## Hospital On-boarding

Template ID	Title	Conformance Report Column
1.3.6.1.4.1.19376.1.5.3.1.3.1	Reason For Referral	**SUSPECTED INTERNAL OID - does not begin with root template OID 2.16.940.
1.3.6.1.4.1.19376.1.5.3.1.3.5	Hospital Course	**SUSPECTED INTERNAL OID - does not begin with root template OID 2.16.940.
2.16.840.1.113883.10.20.1.10	Plan of Care	
2.16.840.1.113883.10.20.1.12	Procedures from 05/14/2015 to 08/14/2015	
2.16.840.1.113883.10.20.1.15	Social History	
2.16.840.1.113883.10.20.1.3	Encounter Details	
2.16.840.1.113883.10.20.1.9	Insurance	
2.16.840.1.113883.10.20.22.2.1	Medications	Admission Medications Component Present (Title^TemplateID^Content) Discharge Medications Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.1.1	Medications	Admission Medications Component Present (Title^TemplateID^Content) Discharge Medications Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.10	Plan of Care	
2.16.840.1.113883.10.20.22.2.11.1	Hospital Discharge Medications	Discharge Medications Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.12	Reason for Visit	
2.16.840.1.113883.10.20.22.2.14	Functional Status	
2.16.840.1.113883.10.20.22.2.17	Social History	
2.16.840.1.113883.10.20.22.2.18	Payers	
2.16.840.1.113883.10.20.22.2.2	Immunizations	
2.16.840.1.113883.10.20.22.2.2.1	Immunizations	
2.16.840.1.113883.10.20.22.2.20	Resolved Problems	
2.16.840.1.113883.10.20.22.2.21.1	Advance Directives	
2.16.840.1.113883.10.20.22.2.22.1	Encounters	
2.16.840.1.113883.10.20.22.2.24	Hospital Discharge Diagnosis	Visit Diagnosis Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.3	Results	
2.16.840.1.113883.10.20.22.2.3.1	Results	
2.16.840.1.113883.10.20.22.2.38	Medications Administered	Admission Medications Component Present (Title^TemplateID^Content) Discharge Medications Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.4	Vital Signs	
2.16.840.1.113883.10.20.22.2.4.1	Vital Signs	
2.16.840.1.113883.10.20.22.2.41	Discharge Instructions	
2.16.840.1.113883.10.20.22.2.43	Admitting Diagnoses	Visit Diagnosis Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.45	Instructions	
2.16.840.1.113883.10.20.22.2.5	Problem List	Active Problems Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.5.1	Problems	Active Problems Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.6.1	Allergies	Allergy Component Present (Title^TemplateID^Content)
2.16.840.1.113883.10.20.22.2.7.1	Procedures	
2.16.840.1.113883.10.20.22.2.8	Assessments	
2.16.840.1.113883.10.20.22.2.9	Assessment and Plan	

Summary of Care Document transmitted from participating hospitals

MiHIN validates conformance to specifications for relevant sections (yellow highlights)





# Exchange Medication Reconciliation: Use Case Pilot

## Engaging and Enhancing the Transition of Care Process

- Hospital discharge to home or other transitional facility (SNF/LTC)
  - Notification of ADT sent to providers/health plans participating in use case
  - Notification of post discharge medication and other information sent to providers/health plans participating in use case
- Use case participation enables timely, high-value reconciliation services to better support the patient and primary care provider during the transition process

# Exchange Medication Reconciliation: Use Case Pilot

## Physician Organization Readiness and Workflow

- Physician organization's have different processes
- The role of data sharing organizations is critical to participants workflow
- Engaging the care team
- Evaluating patient risk

# Exchange Medication Reconciliation: Use Case Pilot

## Successes and Challenges

### Successes:

- Health systems (facilities) currently sending care summary documents to MiHIN based on Meaningful Use Stage 2 and BCBSM incentive requirements
  - Most facilities have successfully transmitted test messages from their production environment
- MiHIN is successfully capturing messages and identifying conformance to specification requirements
- Data sharing organizations are fully engaged and developing protocols for transmitting messages routed to them based on ACRS matching
- Health systems, provider organizations, data sharing organizations and vendors are working collaboratively on message content, delivery protocol and workflow integration

### Challenges

- Workflow (change is difficult)
- Cost
- Practices' ability to generate ACRS and transmit to physician organizations

# Exchange Medication Reconciliation: Use Case Pilot

## Benefits

- The Michigan state-wide data sharing infrastructure has reached a level of maturity where use case implementation is not dependent mainly upon the technology, but rather the delivery and workflow
- The use case furthers the goals outlined in Michigan's Blueprint for Health Innovation by collaborating with the State of Michigan and the State Innovation Model to support efforts for electronic data sharing opportunities
- Participation in the use case builds collaboration between providers and the entire care team



# Exchange Medication Reconciliation: Use Case Pilot

## Collaboration with Michigan's Blueprint for Health and SIM

- Share lessons learned and best practices
- Identify opportunities to reduce and eliminate barriers
- Work together to ensure data blocking isn't an issue and EMR capability and functionality is explored to bring clinical information directly to the providers EMR workflow
- Join forces to present a common approach to care coordination and transitions of care, creating a theme that will unite the provider community

# THANK YOU!

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# Overview of Medication Management Initiatives in Michigan

Presentation to HIT Commission – January 21, 2016

**David Livesay**

Director, Marketing and Communications

**Larry Wagenknecht**

Chairman, MiHIN Board of Directors

Chief Executive Officer, Michigan Pharmacists Association



# 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





# Initial Eleven Use Case Opportunities

1. Alert care team of any medication alterations
2. Integrate existing workflows with Michigan Automated Prescription System (MAPS)
3. Share lab results and diagnosis with pharmacist
4. Confirm patient is receiving mailed prescriptions
5. Monitor if and when prescription has been filled
6. Medication reconciliation at various points of care
7. Establish process to request and execute “stop order”
8. Improve communication between provider and pharmacist to reduce interference, time delays
9. Record use of Patient Assistance Programs
10. Track/monitor medications not requiring prescriptions (over the counters, herbals, and vitamin supplements)
11. Track/monitor prescriptions paid for with cash



# First Cut: Five priority Use Cases

Use Case	Benefits	Challenges	Comments
Exchange Lab Results & Diagnosis	<ul style="list-style-type: none"> <li>Improving awareness, clinical decision making, and real-time results delivery</li> <li>Reducing costs</li> </ul>	<ul style="list-style-type: none"> <li>Preventing information overload and irrelevant data sharing</li> <li>Regulating privacy &amp; security</li> <li>Encouraging submissions</li> </ul>	<ul style="list-style-type: none"> <li>Include vitals</li> <li>Providers' preferences</li> <li>Include everyone in query (not just care team)</li> </ul>
Exchange Medication Data with Prescription Monitoring Programs	<ul style="list-style-type: none"> <li>Increasing ease of use, awareness, and safety</li> <li>Decreasing substance abuse</li> </ul>	<ul style="list-style-type: none"> <li>Regulating break the glass</li> <li>Minimizing alert fatigue</li> <li>Considering patient consent</li> <li>Ensuring data accuracy</li> </ul>	<ul style="list-style-type: none"> <li>MAPS is in LARA</li> <li>Only dispensers should update</li> <li>Focus on interoperability</li> <li>MAPS expansion to all drugs</li> </ul>
Exchange Prescription Status	<ul style="list-style-type: none"> <li>Increased ease of use, patient safety, and efficiency</li> </ul>	<ul style="list-style-type: none"> <li>Regulating pharmacy capability</li> <li>Minimizing workflow interruptions</li> <li>Achieving adoption rates</li> </ul>	<ul style="list-style-type: none"> <li>Requires testing/validation among stakeholders</li> <li>Data must be current/ near-real-time</li> </ul>
Facilitate Prescription Stop Order	<ul style="list-style-type: none"> <li>Increased ease of use, functionality, and safety</li> </ul>	<ul style="list-style-type: none"> <li>Developing proper workflow to avoid operational complexity</li> <li>Creating standards</li> </ul>	<ul style="list-style-type: none"> <li>Determine a clear way to send request for stop order</li> </ul>
Exchange Medication Reconciliation	<ul style="list-style-type: none"> <li>Increased consistency, awareness, patient safety, transition of care</li> </ul>	<ul style="list-style-type: none"> <li>Determining standards of use and source of truth</li> <li>Establishing coordination</li> <li>Anticipating provider pushback</li> </ul>	<ul style="list-style-type: none"> <li>Obtain/share pharmacy data in all settings</li> <li>Consider third party repository</li> <li>May disclose protected class medications</li> </ul>



# 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

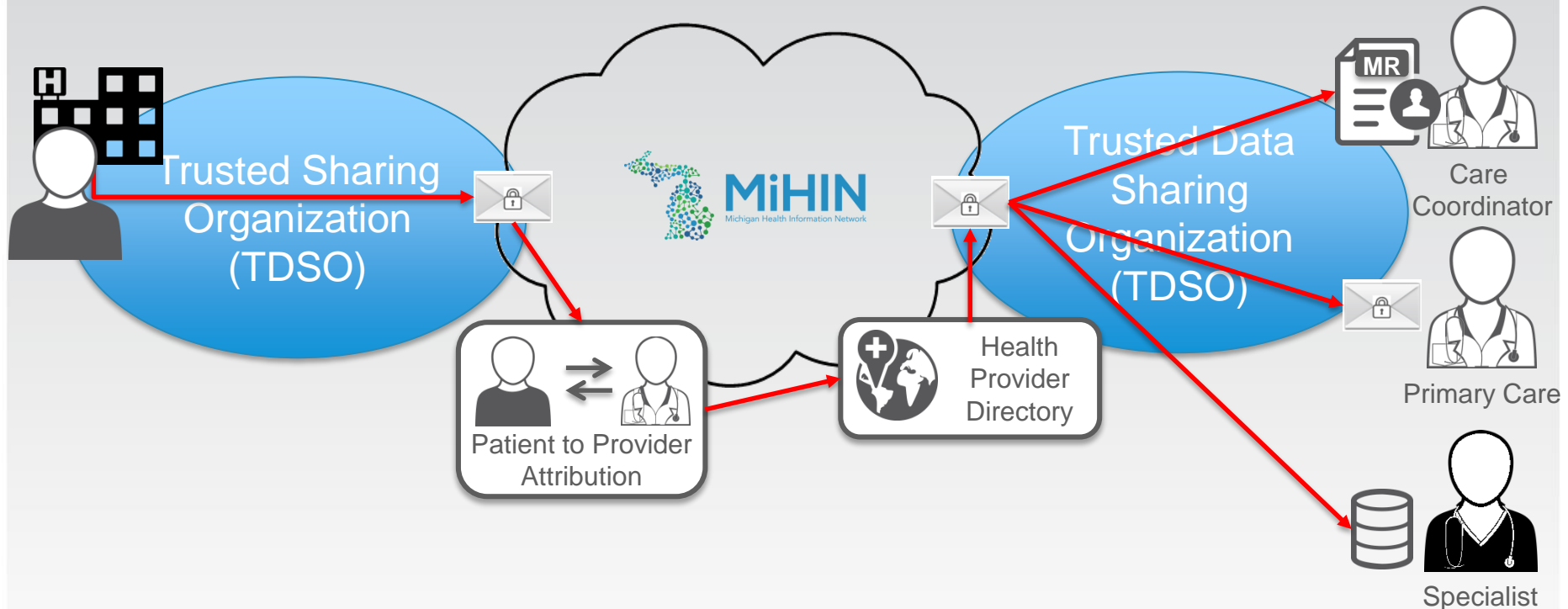


# Medication Reconciliation Value Proposition

- Annual cost of adverse drug events leading to morbidity and mortality in Michigan is \$6.3 billion
- Poor communication of medical information at transition points is responsible for:
  - 50% of all medication errors
  - 20% of all adverse drug events
  - 66% of all medication errors resulting in death or major injury

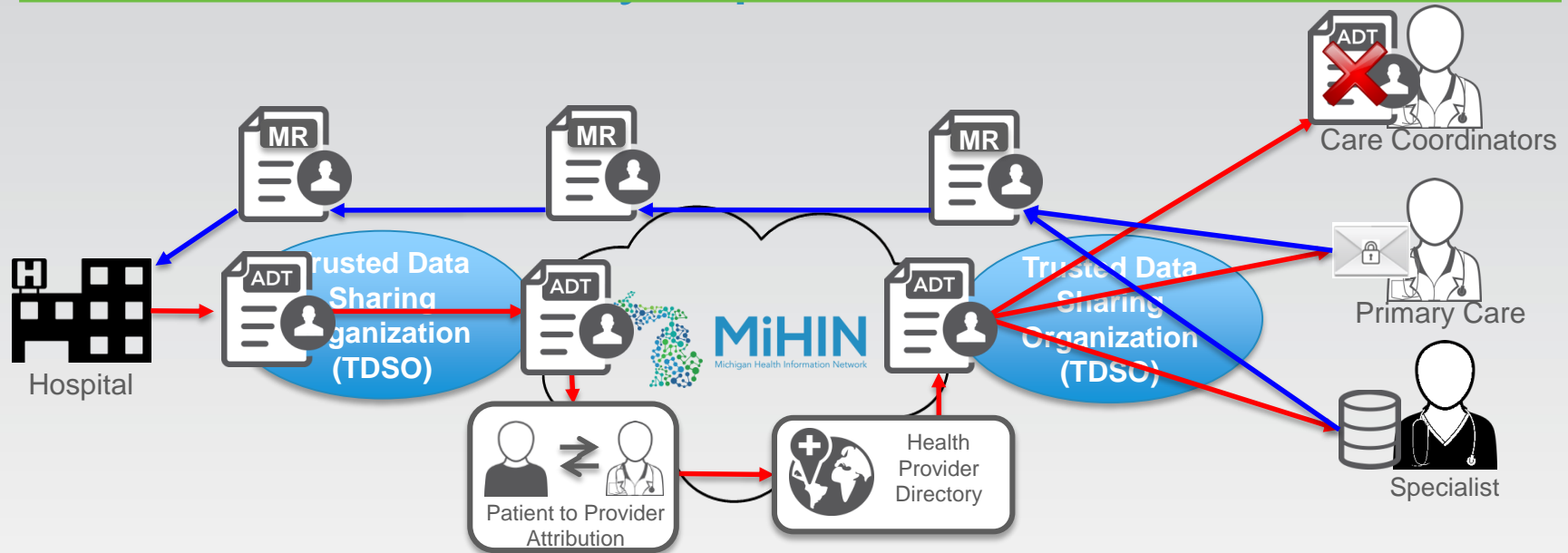


# Medication Reconciliation Use Case: Discharge Medication Reconciliation Scenario



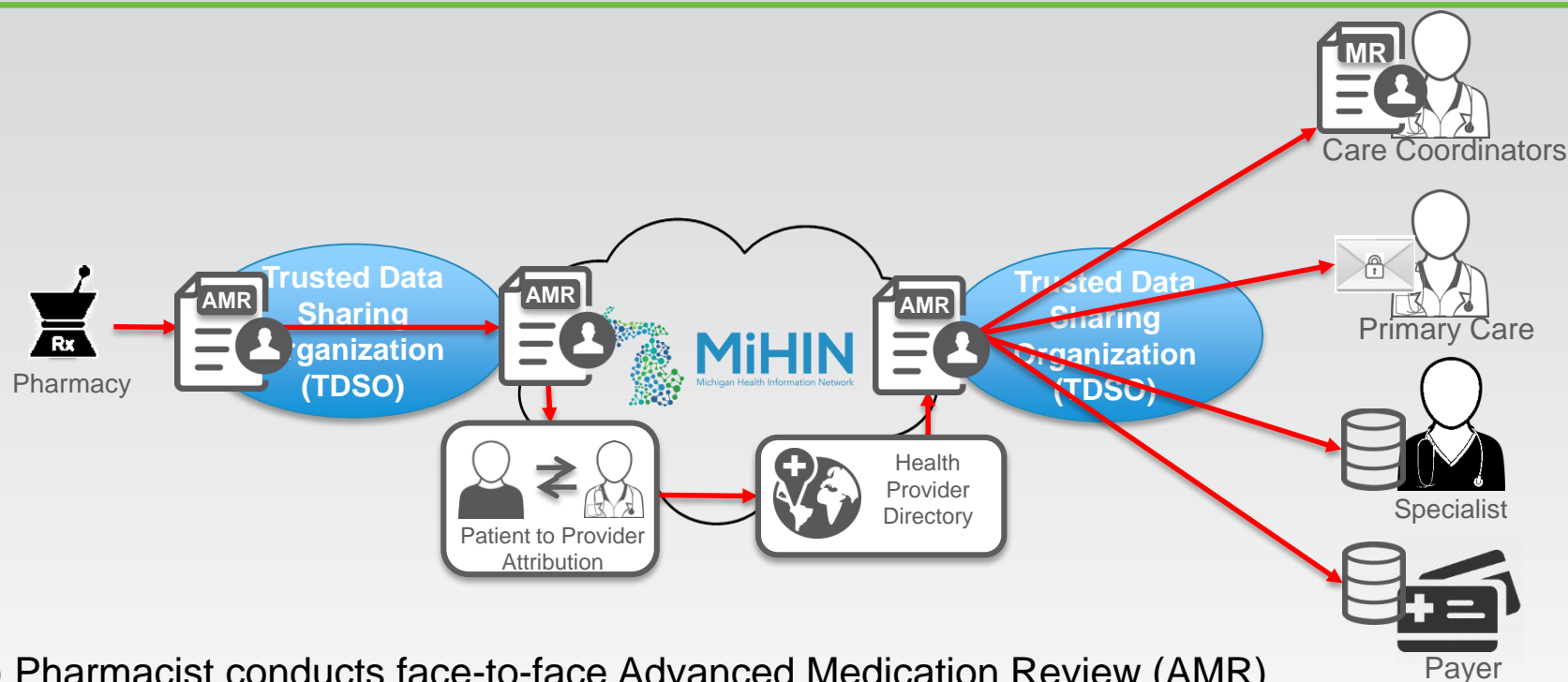
- 1) Patient discharged, hospital sends message to TDSO / MiHIN
- 2) MiHIN checks patient-provider attribution and identifies providers
- 3) MiHIN retrieves contact and delivery preference for each provider from HPD
- 4) Medication reconciliation routed to providers based on contact info, preferences

# Medication Reconciliation Use Case: Medication History Upon Admission Scenario



- 1) Patient admitted, hospital sends message to TDSO / MiHIN
- 2) MiHIN checks patient-provider attribution & delivers based on provider's preference
- 3) Provider receives admission notification and identifies medication history for patient
- 4) Medication history sent back to admitting hospital to support care within the hospital

# Medication Reconciliation Use Case: Advanced Medication Reconciliation Scenario



- 1) Pharmacist conducts face-to-face Advanced Medication Review (AMR)
- 2) Pharmacy sends AMR to TDSO / MiHIN
- 3) MiHIN checks patient-provider attribution and identifies providers
- 4) MiHIN retrieves contact and delivery preference for each provider from HPD
- 5) AMR routed to providers and payers based on contact info, preferences

# Integration with MAPS Value Proposition

- Clinicians and pharmacists in Michigan **lose roughly 121,000-485,000 care hours per year** accessing MAPS
- Clinicians and pharmacists in Michigan **lose roughly \$9,000,000-\$36,000,000 in time spent** accessing MAPS per year
- **Over a five year period**, these ranges translate to **roughly 600,000-2,400,000 lost care hours and \$45,000,000-\$180,000,000 in time spent**





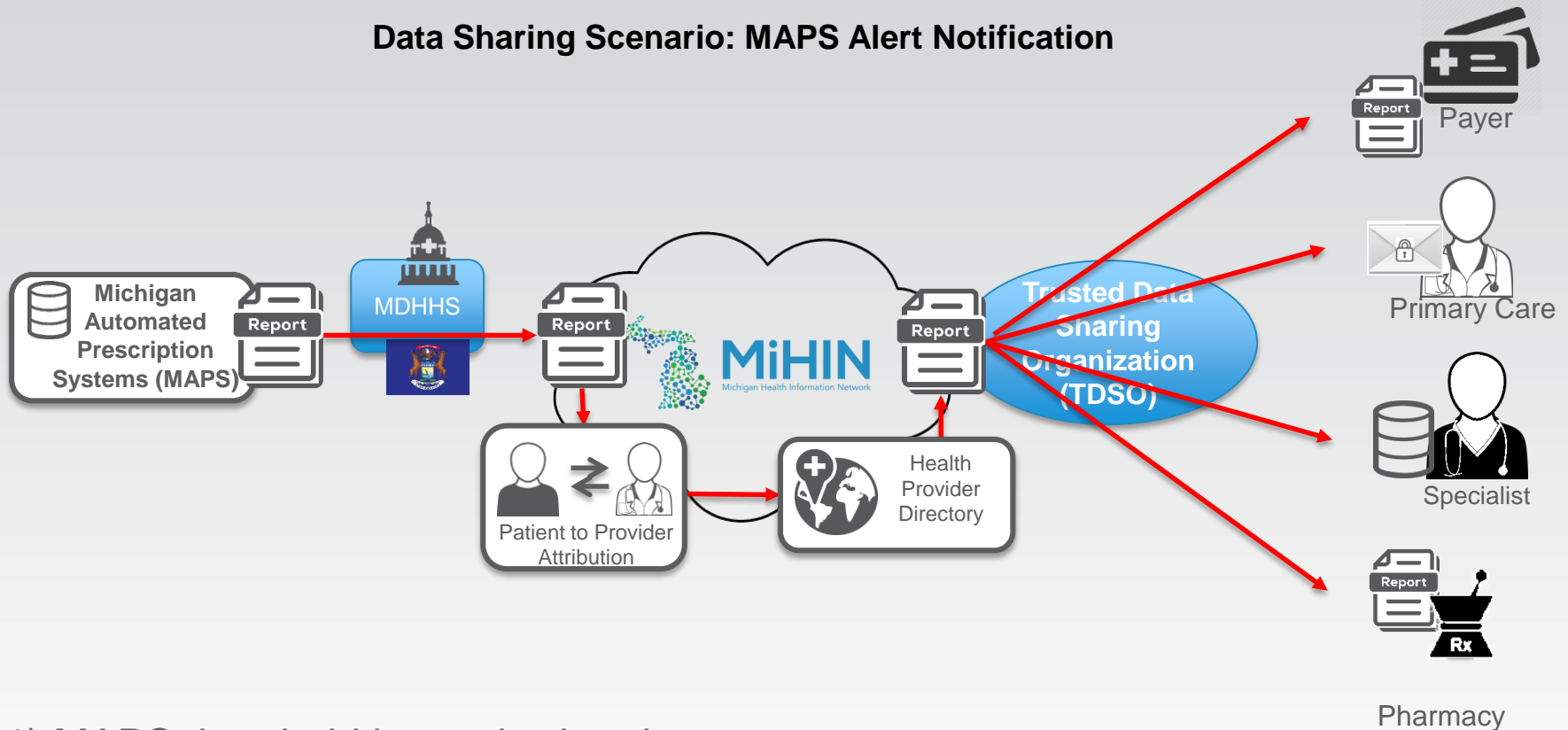
# MAPS Opportunities Identified

- **Push MAPS Use Case:** Reduces provider burdens and might also reduce the stress on MAPS by generating a “report” that gets sent out to licensed providers with a declared “Active Care Relationship” with the patient
- **Pull MAPS Use Case:** Instead of each doctor or pharmacist interrupting their workflow to log on to the portal, ideally MAPS would support a standard data interchange capability to be queried electronically
- **MAPS Single Sign-On Use Case:** Stop-gap opportunity identified to implement single sign-on capabilities for providers to access MAPS from their native EHR applications



# Push: MAPS Data exchange

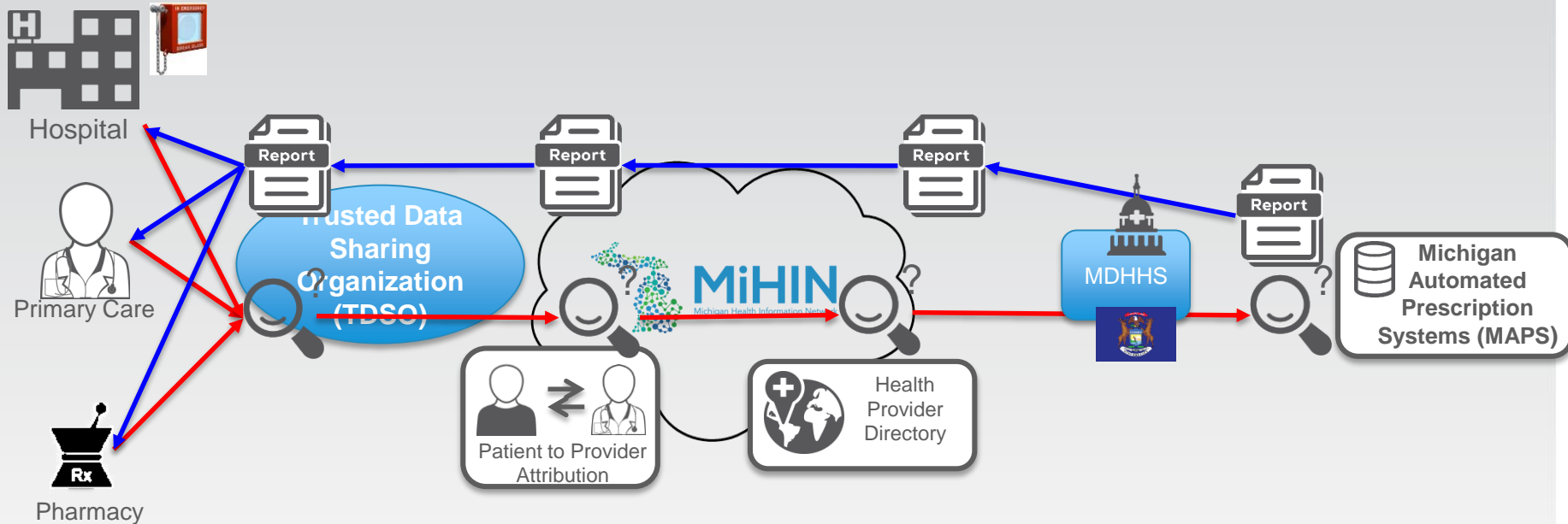
## Data Sharing Scenario: MAPS Alert Notification



- 1) MAPS threshold is reached and generates a report
- 2) MAPS report is routed to MIHIN via MDHHS Data Hub
- 3) MiHIN checks patient-provider attribution & delivers based on provider's preference
- 4) Notification is sent to care team members

# Pull: Electronic Query to MAPS

## Data Sharing Scenario: Request



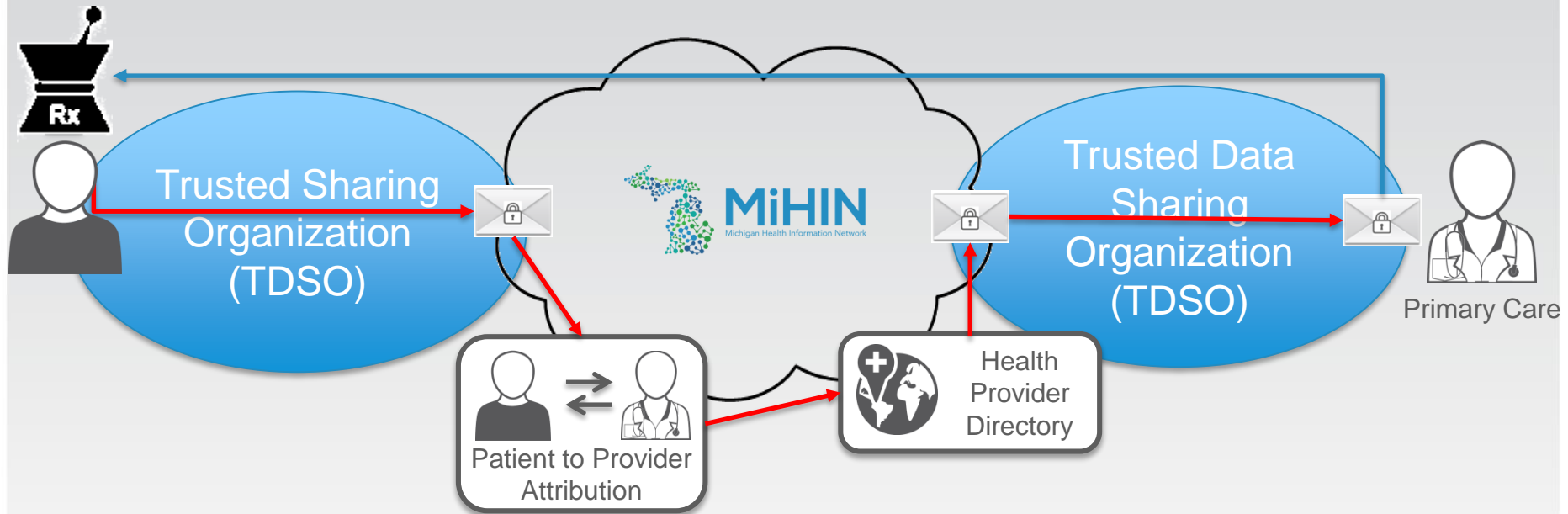
- 1) Care team member requests MAPS report from MiHIN via TDSO
- 2) MiHIN routes request to MAPS via MDHHS Data Hub
- 3) MAPS report is routed back to requestor

# Exchanging Lab Results/Diagnosis Value Proposition

- Helps providers/pharmacists determine appropriate medication dosing (e.g. using serum creatinine levels, international normalized ratio (INR), hepatic function, renal function, drugs with narrow therapeutic indices, etc.)
- Allows pharmacists to more accurately make medication recommendations to patients and providers
- Enables better visibility for health providers and pharmacists
- Helps develop new workflows to support additional communication opportunities
- Saves time for pharmacists in gathering information
- Facilitates prior authorization requests
- Reduces duplicate therapies and adverse drug events
- Optimizes medication efficacy and usage



# Exchange Lab Results/Diagnosis Use Case



- 1) Patient visits pharmacy with new prescription or refill request
- 2) Pharmacy requests lab results/diagnosis through MiHIN
- 3) MiHIN verifies patient-provider relationship, routes request to provider
- 4) Provider routes lab results/diagnosis back through MiHIN to pharmacist

# Technical and Legal Considerations

- Stakeholders held focus group sessions to discuss legal and technical considerations around prioritized Use Cases
  - Technical Considerations
    - Vendor readiness
    - System constraints
    - Data standards
  - Legal Considerations
    - Patient consent and authorization
    - Implications of HIPAA and 42 CFR part II
    - Policy considerations at state and federal levels
    - Other legal considerations



# Conclusions

- Changes needed to bolster and improve medication management efforts in Michigan
- Working through Michigan's network of networks, stakeholders and Michigan's community of Trusted Data Sharing Organizations have begun or will begin:
  - Developing priority Medication Management Use Cases
    - Medication Reconciliation already in advanced pilot status
  - Tracking results of Use Case implementation
  - Leveraging Use Cases to share data and ensure better medication management results



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# HIT Commission Next Steps

- Meeting Schedule for early 2016:
  - January 2016 – Meet as Scheduled
  - February 2016 – Cancelled
  - March 2016 – Cancelled
  - April 2016 – Cancelled
  - May 2016 – Cancelled
  - June 2016 – Meet as Scheduled

# Public Comment

# Adjourn