

Michigan Health Information Technology Commission Meeting Minutes

Date Tuesday, May 25th, 2021, 1:00 p.m. – 3:00 p.m.

Location Virtual Meeting

Commissioner Attendance

Name	Representing	Attendance
Norman Beauchamp, M.D.	Schools of Medicine	Present
Nicholas D’Isa, Chair	Health Plans or Other Payers	Present
Elizabeth Nagel	Department of Health and Human Services	Present
Jack Harris	Department of Technology, Mgmt., Budget	Present
Allison Brenner, PharmD	Pharmaceutical Industry	Present
Jonathon Kufahl, Co-chair	Hospitals	Present
Paul LaCasse, D.O.	Doctors of Osteopathic Med. and Surgery	Present
Pat Rinvelt	Purchasers or Employers	Present
Marissa Ebersole-Wood	Nonprofit Health Care Corporations	Present
Renée Smiddy, M.S.B.A.	Consumers	Present
Heather Somand, Pharm.D.	Pharmacists	Present
Jim VanderMey	Health IT Field	Present
Michael Zaroukian, M.D., Ph.D.	Doctors of Medicine	Present

Michigan Department of Health and Human Services (MDHHS) Staff:
Elizabeth Nagel, Brad Barron, Erin Mobley, Trevor Youngquist

Guests:

Registration is not required to attend Health IT Commission virtual public meetings. Due to open registration, we are currently not able to capture public attendance.

Minutes: The regular Health Information Technology Commission meeting was held virtually on May 25th, 2021 with eleven (12) commissioners in attendance.

1. Welcome and Introductions

Presented by Nicholas D’Isa

- i. Chair Nicholas D’Isa called the meeting to order at 1:00 p.m.

Commission Business

Presented by Erin Mobley

- i. Erin Mobley, MDHHS Technology Policy Specialist, Policy and Planning division, provided an update as to the new appointment of Elizabeth Nagel, representing the Michigan Department of Health and Human Services.

Review of the February 2021 Meeting Minutes

- i. Chair D’Isa presented a motion to approve the February 2021 meeting minutes.
 1. There were no objections from the commission and the motion passed unanimously.

2. MiHIN – SDoH Use Case/IR Update

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Presented by Michael Taylor and Adam Giroux, Michigan Health Information Network

- A. Example story: S lives in a food desert (no grocery in walking distance) and no car. So, most food is coming from fast food and convenience stores which are readily available to her. Transportation needs are not met. In an urgent care center, screening surveys will ask about these needs in her life - the focus of social determinants via MiHIN is to connect the community health worker who is an expert on social services and programs in the area. By coordinating, the community health worker (CHW) can refer them to different programs. Now S can have groceries delivered and get transportation to go to doctors' appointments.
- B. Social determinants of health means, things that influence a person's health that are outside of what constitutes traditional health care.
 - i. Pandemic has escalated an already growing need to address these topics.
- C. Working to Enhance -Social Determinants Use Case means screening data - build on the SIM system, while focusing on creating or establish a system that can notify people that need these services so they can be met.
 - i. Allows for creation of social care record, that has social intervention and social need history - to see if there are chronic needs/one time deal (kind of like a patient's medical record that stays with them)
 - ii. Begin with screening; there will be many screenings that do not indicate a need or diagnoses that do not have a relevant associated resolution. Need to maximize screening.
 - iii. SIM project had six domains of questions: food, housing, employment, utility assistance, health care finances, transportation. Recent additions: depression, anxiety, and stress. (these are crossover interplay between medical and other need areas)
 - 1. Questions are not standardized. Diff regions etc. use different screening tools.
 - 2. Want long term, to have questions be realized in a machine understanding way.
 - 3. Need the questions being asked to map to searchable domains, for those that need/want to look at this data -- standardize this in a productive way.
- D. Gravity Project: Problem today is that everything has been broken down into areas that need to be coded, into domains and then subdivided them into other categories and then are codifying them and releasing them one by one as finished. Are staying in close connection to this - but don't want to wait until the whole thing it is done to implement.
- E. SDoH Use Case, and what has changed:
 - i. Three added domains (depress/anxiety/stress). Making sure participants are providing information in a way that is useful without disenfranchising other established data takers.
 - ii. Options to make data available:

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1. Augment established medical avenues to include this information.
2. MiGateway
- iii. Focus on Medicaid and genericize it so they can participate whether in Medicaid or not
- iv. Added gender, race and ethnicity
 1. For population health purposes so that can look at disparities of health in diff populations
- F. Inoperable referrals Use Case - how can we facilitate data sharing across medical and social sectors
 - i. Development of a Use case: focused on what are the core set of information that is most relevant to include when a referral is being made between the medical and social care sectors.
 1. Goal is to pay attention to (just like with SDoH) intervention/gravity standards, referrals are interventions. Want to align the standards between them.
 2. Review 360X standard - which has not been widely used
- G. Preliminary specification - next step is to finalize it and move it to production, then integrate and share this information with other things MiHIN offers - as an opportunity to establish for example with Active Care Relationship based on these referrals.
 - i. Also want to be able to report out on referral activity for social care needs and monitor when - statewide- there are opportunities and what has been done to get those needs met.
- H. Standards for Payload Data Requirements
 - i. Straightforward
 - ii. But accessible, not too much information etc. not too complex but enough that provides adequate value.
 - iii. Need a "sweet spot" of these.
- I. MiHIN Roadmap for SDoH Use Case; divided the work on SDoH domain into phases
 - i. Phase 1: building on the previous work from SIM, not dramatically changing but stabilizing for long term.
 - ii. Phase 2: More interesting things could implement with SDoH, like social care records - social intervention histories, bidirectional exchange of data etc. and population-based reporting aggregates and ability to see disparities
 1. Key features of screening:
 - a. identify social needs (with screening tools/referrals)
 - b. Track social needs over time (Social Care Record) chronic/one-time needs
 - c. Ability to provide more holistic treatment (MiGateway, ACRS/etc.)
 - d. Ability to assess needs beyond traditional medicine.

Questions:

Renee Smiddy: Do these screening questions result in an ICD-10 diagnosis?

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I'm thinking of the z-codes

Renee Smiddy: Is MiHIN offering guidance on standardizing gender, race and ethnicity categories?

Jim VanderMey: What community stakeholders are being engaged for early adoption? Community stakeholders for early adoption: Some Physician orgs already have advertised the availability to physician orgs at large but not campaigned to individual practices yet.

Renee Smiddy: Will these health screenings become a billable service? And if so, what would be the cost share be for patients? I'm aware of some health screenings that aren't 100% covered by payors (only because I personally receive the bills).

3. CedarBridge Group Presentation – Five-Year Health IT Roadmap

Presented by Don Ross, Senior Director and Carol Robinson, CEO, CedarBridge Group

- A. A years' worth of data collection, analysis, and compilation into a 78-page report for the environmental scan
 - a. Milestone in the five-year program
 - b. Key, wants to inform everyone and get on same page and describe next steps and complete roadmap
- B. Process: Developing statewide roadmap
 - a. Imperatives for roadmap planning:
 - i. Align with governors 5-year priorities for MDHSS which were set forth pandemic prior, and adjustments were made in recommendations due to this.
 - 1. Integrating data share to reduce social inequality
 - 2. Improve data to respond to lead exposure risk
 - 3. Develop tools to support agency in evidence-based decision making
 - b. Inclusive and transparent decision making - state and local
 - c. Oversight and accountability to protect public funded tech investments
 - d. Policies to prevent improper use of data collected, and engender public trust
- C. Environment Scan Focus
 - a. Current state of health IT initiatives
 - b. Desired future State priorities for these services
- D. Environmental Scan Activities
 - a. Deployed various modes of discovery, adapted due to pandemic, it was all virtual

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1. Electronic surveys: 10 surveys for various domains - common questions for all stakeholders and then some that were specific to certain stakeholders. 8 versions were 30+ and longer/half hour + freeform input boxes, and some briefer versions sent out later to increase response numbers: N = 200 stakeholders and orgs represented in the data.
 2. Virtual forums replaced what would be in person focus groups. Like a webinar format. 16 were held on 8 topics. (ex: delivering services and sharing data during pandemic, etc.). Focused on different regions like metro v. rural.
 - a. Large group and breakout discussion
 - b. Polling used in real time Q/A, and chat box input
 - c. >300 individuals attending across the state
 - b. Key informant interviews - provide data
 - i. Spend an hour with an org, and convened with more than 100 people - providers/social services/comm orgs/emergency medical services/hospitals/long term care/public health etc.
 - c. Additional outreach
 - i. Reached out to see if regularly meeting bodies would give them time and information/input on what people's experiences and preferences are around data sharing and data usage.
 - ii. Engagement of DHHS staff and leadership etc. - on pandemic demands and staffing etc.
- E. Data Analysis/synthesis
- a. HIE is used as a noun AND a verb in the report. (nHIE and HIE as the act of exchanging info)
- F. Findings Overview
- a. Tech capabilities vary widely based on the size/location/type of providers
 - b. Access to mobile devices and internet vary widely based on size/location/type of providers (the digital divide)
 - c. Amount of data exchanged and level of integration varies based on s/l/t of providers as well.
 - d. Hospitals and Health Systems Desires
 - i. Plan to standardize EHRs in future and may have been on different EHR's for a while. But desire to standardize to a single platform so they can share more easily.
 1. Including nationwide care aspects
 - ii. Expanding broadband across Mi, will help save lives and reduce disparities. Not having necessary info at provider fingertips results in lower care quality

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- iii. Statewide identity services managed as a public utility will lower admin costs for hospitals and improve the data quality across services (Single source of statewide identity management, as a desire)
- iv. electronic advances and real time death logging

G. Ambulatory providers Desires

- a. Whatever the amount of patient info they are able to access from other information, they often feel it's not as useful as they'd hoped. Some are not connected, and want data but those who are - feel they are buried in it and it's not as useful. Want more curated or integration that can be useful for use with a patient - "actionable" information for the moment that doesn't require so much filtering. And in one place, not having all these different portals and searching.
- b. Faxing is still a top way information is exchanged because of lack of electronic ability to send records etc.
- c. Need more clinical data at point of care
 - i. Emphasis lab results, radiology images not just reports, and care summaries from providers
- d. Better access to multiple systems like opioid surveillance and prescription monitoring and even better would be to connection one stop shop through MiHIN
- e. Sharing of records is not as much as they would like- some populations have more difficulty getting information on than others like VA and Dept of Corr. health records.
 - i. Need these for transitional care for when inmates are released, and if they are not connected with these services right away there is a lot of costs associated with high level of reoffending. Room to improve here.
- f. If policy makers might consider Incentive payments for HIE payments, and finding a good way to present ROI to providers in these contracts.
 - i. No legal resources to manage a bunch of data exchange agreements
 - ii. Many are receiving data but not integrating it into their systems. In this interim space.
- g. Most common barrier to participation is the cost, and the vendor modification required

H. Behavioral Health Providers Needs

- a. Need access to funding, grants/loans/incentive payments/quality payments/other (are earlier in the implementing these things and need more support)
- b. Access to more complete clinical information about individuals that INCLUDES social needs assessments
- c. Tech assistance and ongoing training
- d. Statewide contract management (for data? Exchange

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- e. In their words:
 - i. Privacy is a concern - extra cautions considering the nature of their work
 - ii. Knowledge of regulation and what constitutes compliance, and when they do not know the default is to not share. So, a statewide system may increase confidence as part of a system where it's clear what when and who they can share data with.
 - iii. Broadband
- I. Social Services Orgs Needs
 - a. More need for tech in technology onboarding and training support. This is because they weren't necessary. A part of the healthcare system or subsidized for that and are now becoming more integrated so a lot of learning is going on that needs this support. Steep learning curve.
 - b. Electronic consent management = priority of social service orgs, need to reduce legal and operational barriers to care and coordination and to support client choice with their personal data
 - i. MiBridges - experience a lot of needs related to connecting to health care providers and referring patients who have social barriers to health and wellness.
 - c. In their words: So many orgs are attempting to dev their own information exchange and there needs to be ONE verses ending up with organizations managing many.
- J. EMS Provider's Needs
 - a. Great need but in the same vein
 - b. Mobile access, go out on calls on the scene and are used to working with info collected from patient or who is there. Now they have devices where they can document and add to a system, but they do not have a way to access health information on the go - like history/prescripts/allergies etc.
 - c. Access to physician orders for life sustaining treatment (Mi-POST forms) and other advanced care plan docs. Thorough an online registry.
- K. Public health orgs/agencies Needs
 - a. Mostly share info through fax, and phone (greatest) only 16 percent is MiHIN and GLHC.
 - i. While it's true getting tech support and skill sets stakeholders need to document and collect info electronically/ bidirectional sharing - they are spending a lot of expense right now and time doing it manually so, it's not hard to show that this doesn't have to cost more they just need knowledgeable personnel. Etc. ---- training and things.
 - b. Health history information is high priorities
 - c. Pandemic highlighted need for tech training and assistance

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- d. Analytic solutions/aggregate data about populations are also high priority -
 - e. System integration needs, need to integrate that data that does come to them through the e- systems so it can be actionable at the point of care
- L. Long Term and Post-Acute Care Needs
 - a. Severely challenged by covid19 - adapted by modifying patient contact protocol and video visits etc. other devices - wireless nurse buttons and other items - were able to invest in means to reduce face to face and close contact.
 - b. Want creation of statewide directives
 - c. Access to veteran health records
 - d. More clinical information about patients especially on intake like medical diagnosis and medication - include it in ADT messages, trauma etc.
 - e. Improving data quality
- M. Consumers Needs
 - a. Ability to access OWN health information - fed reg has new requirements
 - b. Perception about the ability of doctor etc. to access my information, and if they have what they need to provide well for me
 - c. Ability to provide consent etc. via eConsent
 - d. 50% report having to hand carry records to referrals
 - i. Unhappy about lack of control over their health information
 - e. 86% (up from pandemic) report having an electronic health service encounter in the last year
- N. ACROSS ALL DOMAINS priorities - nonspecific to any particular group
 - a. Wide variation in the approach to handling health information
 - i. Unsure of specific requirements for disclosure and redisclosure etc. HIPPA - not necessarily high confidence with the instruction in place right now
 - b. Barriers to share behavioral health information via e health means
 - i. Data is not easily in sync or is configured correctly for a particular provider, difficulty with consent and sharing sensitive information - clients do not understand consent forms, consumer education is necessary
 - c. Do you collect SDoH data
 - i. 61 percent do not (of who was engaged)
 - ii. Report need for standard assessment tools. Would like them accessed when another org has collected it, would like the state to standardize it, would like to reduce redundant assessments due to inability to access these past interviews, race etc. data has increased but is not standardized
 - d. Barriers to community wide info change
 - i. Cost - do not know where they will find the money to collect/document

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- ii. Negotiating data sharing agreements
 - iii. Making sure accurate consent forms are in place
 - e. Cybersecurity and privacy protection
 - i. More than a third have taken steps to improve these measures handling public health records
 - 1. Firewalls, security to buildings, requiring ID by staff, random surveillance, dual factor auth, reviewing policies and protocol, doing risk assessment etc.
 - f. Funding consideration
 - i. Sustainability plan will be in roadmap
 - g. Workforce consideration
 - i. Smaller stakeholders do not have the tech training and support capacity for their staff due to turnover etc. May want to think about this as a lifelong program and not just one that comes at the time of implementation - as imperative part of plan
- O. Desired future state
 - a. Big pic: engagement/discovery phase of roadmap - stakeholders shared their ideas for the standards: desire more leadership, more community collab and the setting of policies etc.
 - i. Need for an entity of authority to set the course, the broader course - a single voice to get things going across the board. Get everyone on the same page.
 - ii. Urgency around this, and setting those standards - need meaningful participation
 - b. Key themes/Needs:
 - i. Relevant/easy to access clinical information - at point of care across ALL domains
 - ii. Accurate and timely info in public health services
 - iii. Inclusive process/supportive frameworks to make decisions and engagement by Mi top executives
 - c. Address the digital divide in Michigan
 - d. Statewide shared services - want to link together, things like public identity management - statewide master person index, statewide consent management services, statewide advance care plan registry to help with end-of-life treatment in event of EMS.
 - e. Funding and technical assistance.
- P. Recommendations:
 - 1. Identify champions, empower leaders within MDHSS (staff)
 - a. Agency difficulty with understaffing etc.
 - b. Find right leadership and sr. management for these projects
 - c. Action Step: Have a small team convened to review existing legislature

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- i. Pros/Cons of what's in place/ any suggested amendments
 - ii. Changes to advisory rules, duties, and related to other leadership orgs.
- 2. Address the Digital Divide
 - a. Did a lot of investigation, looked to other states, considered things like FCC upgrade rural health care program etc. To make internet access more affordable.
 - b. Consider partnering with dept. Of ed/ align with other orgs or elected officials to work on strategies to address the gaps
 - c. Make it a Health-Related Priority -- essentially.
 - i. There is some work going on, but it needs to be stepped up
- 3. Increase availability and accuracy of timely information
 - a. Public Gateway that supports bidirectional exchange of all major public health data systems
 - i. Need to develop frameworks that allow this -
 - ii. Creating a timeline
 - iii. Extensive training
 - iv. Monitoring and support and integrate - within the public health divisions because they get significant funding
- 4. Onboarding and tech assistance program
 - a. To supp orgs that are not part of the high-tech act incentive programs
 - b. Action Step: develop program and perhaps asking health endowment fund to facilitate some planning activities
 - i. Cost benefit for programs etc.
 - ii. Create a plan for working with budget concerns and incentive
- 5. Adopt standards for SDoH
 - a. Charter a work group to assess the work being done by the Gravity Project - and SIREN
 - b. Do so in a way that meets needs of all domains
- 6. Statewide Identity Linking and Authorization Services (SILAS)

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- a. A system that includes health directory, master person index, care team mapping, verify identify of users etc., honoring choices services (consent, power atty forms, public utility offering of these kinds of things for ppl).
- b. Action Steps:
 - i. Have a SILA committee
 - 1. Do cost benefit for economic and potential data quality improvement
 - 2. Collab with stakeholders
 - 3. Dev a phased implementation strategy etc.
- 7. Stakeholder feedback opportunities
 - a. Will be Online June/July 2021
 - b. Post of the environmental scan findings and draft of roadmap recommendations - Public Comment
 - c. Additional review cycle
 - d. Close out activities for a final report to MDHSS for Mi Health Endowment fund in Jan 2022

Commissioner Comments:

-Is there any dev./thought put into turnover of work force, stimulus for getting people on board? What about financial gain provider might have for reduction in turn over as staff across country would be familiar with a unified process. (a financial offset)?

-Ms. Robinson: Aligning financial responsibility to where value is created in health context information is the most important

-Love idea of utility of identification - want to get across it is a safe place to have/do this and in current political climate may be a big lift --- but really appreciate it

Questions:

-How was CedarBridge chose to work with MDHSS and health endowment fund and HITC?

-Erin Mobley: Wrote them into the grant with the fund, were not required to do a bidding process and chose them based on recommendations from other areas within this health information tech community and with some individuals who had previously worked with them and vetted them highly - because they were written in no bidding was required.

-Is this a 5-year roadmap?

-Ms. R: Did put it on a 5-year timeline, as a practical amount of time. CMS requirements for Medicaid generally ask for 5 years, and so felt it was a good alignment, but also for other reasons don't know how the future will be.

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-Is there a recommendation in the roadmap with starting points and things to build off, and what has priority?

-Want feedback on recommendations, to see what is needed and fill out anything that is not explicit enough and see how stakeholders and commissioners see the priorities. That is what CB would like to hear. What has been done so far is preliminary to the final roadmap report, a lot can happen in 5 years.

Mike Zaroukian- Roadmap committee person

-Commends CB for their comprehensive perspective

-Adds is struck by hopefully leaving no one behind in the next five years at the very least. The areas of difficulty are in more specially curated arenas. But help in this area will be important over the 5 years.

-Ms. R: issues of data quality are increasing because more data is being exchanged each year, CMS is even encouraging thinking these things through at the statewide level because of this. MI is far ahead in having the right sort of systems in place to move forward, smaller lift here even as a larger state. And that is inspiring.

-Faster things move increases the risk that smaller and private stakeholders do get left behind. As info exchange and networks of integrated health systems advance. Some are concerned they won't even be able to practice in the future without being able to catch up with technology.

Public Questions:

-Michigan Resident: Are vaccine passports coming to mi, and what violation of privacy law do they see regarding this, and as keeping records of vaccines.

-What contracts does MI have regarding health data centralization software, vaccine passports etc. or do they have any interest in these kinds of things.

-Nick D: OSHA is promulgating these rules, which would be the proper forum for that discussion

-CedarBridge Group has no financial interest and has done no work with vaccine passports

-Erin Mobley can reach out to MDHSS legal etc. to get more information for this resident about this.

-Another Michigan Resident asking about HIPPA and electronic app things - on the last minutes. She is saying they are trying to adapt a new policy about HIPPA for residents.

Adjourn

- i. Chair D'Isa made a motion to adjourn the meeting. The motion was approved unanimously, and the meeting ended at 3:00 p.m.