Michigan Health Information Technology Commission
Approved Meeting Minutes

Date Tuesday, November 29, 2022, 1:00 p.m. – 3:00 p.m.

Location South Grand Room 1A, 333 S Grand Ave, Lansing, MI 48933

Commissioner Attendance

Name	*Representing*	*Attendance*
Norman Beauchamp, M.D.	Schools of Medicine	Not Present
Nicholas D'Isa	Health Plans or Other Payers	Not Present
Beth Nagel	Department of Health and Human Services	Not Present
Jack Harris	Department of Technology, Mgmt., Budget	Present
Allison Brenner, PharmD	Pharmaceutical Industry	Present
Heather M. Wilson. **Co-chair**	Hospitals	Present
Paul LaCasse, D.O.	Doctors of Osteopathic Med. and Surgery	Not Present
Camille Walker Banks	Purchasers or Employers	Not Present
Marissa Ebersole-Wood	Nonprofit Health Care Corporations	Present
Renée Smiddy, M.S.B.A.	Consumers	Present
Heather Somand, Pharm.D.	Pharmacists	Not Present
Jim VanderMey	Health IT Field	Present
Michael Zaroukian, M.D., Ph,D. **Co-chair**	Doctors of Medicine	Present

Michigan Department of Health and Human Services (MDHHS) Staff:
Molly Welch-Marahar, Kenny Wirth, Theresa Anderson, Ninah Sasy, Kate Tosto (virtual)

Guests:
Van Ly, Production Marketing Manager, MiHIN
Lisa Nicolaou, Cross Sector Data Sharing Program Director, MiHIN

Minutes: The regular Health Information Technology Commission meeting was held in-person on November 29 with eight (8) commissioners in attendance. Ninah Sasy attended meeting on Beth Nagel's behalf as the designee of the director of the department of health and human services.
Quorum was fulfilled.

1. **Commission Business**
Presented by Kenny Wirth and Heather Wilson
    A. Chair called the meeting to order at 1:02pm
    B. Hybrid meeting conduct & logistics
    C. Introductions of staff and Commissioners
    D. Amendments needed to be made to the 9/27/22 meeting minutes as follows: Page 7, typos HIMMS should read HIMSS. Motion to approve 9/27/22 meeting minutes with amendment by Jack Harris, seconded by Allison Brenner.

Roll call vote:

Brenner - yes
Wilson - yes
Harris - yes
Ebersole-Wood - yes
Zaroukian – yes
Sasy - yes
Smiddy – yes
VanderMey – yes

Motion carried.

E. Approval of 2023 Meeting Dates:
   i. February 21, June 27, September 26, November 28 all from 1-3 pm
   ii. Motion to approve by Zaroukian, seconded by Harris.

Roll call vote:

Brenner - yes
Wilson - yes
Harris -yes
Ebersole-Wood - yes
Zaroukian - yes
Sasy - yes
Smiddy - yes
VanderMey – yes

Motion carried.

2. Presentation and Q&A

Presented by Van Ly & Lisa Nicolaou of MiHIN
Michigan Health Information Network: Electronic Consent, Honoring Choices, Advance Directives

i. Introduction of MiHIN Honoring Choices Team: Lisa Nicolaou (Cross Sector Data Sharing Program Director), Lauren Fahlen (Project Manager), Monica Ward (Program Coordinator), and Van Ly (Production Marketing Manager)
ii. Technology is a Tool
   a. More powerful and easier to use than ever before (AI, advanced analytics, machine learning)

   b. At times there is a temptation to be able to implement technology because it is easier versus the slog of fixing older processes. However, it can sometimes complicate situations and increase expenses without impacting outcome
   c. Want to be good stewards of scarce resource dollars and implement tech well and conserve on human infrastructure that is also required. Important to look at reasoning for moving data, changing process, and how will it look different for the end user, what impact does it add for patients, and why are we collecting the data

iii. Current State
   a. Design, leverage, develop and deploy Honoring Choices services to make Medicaid patient choices available throughout the healthcare ecosystem
      i. Electronic consent for Behavioral Health including Specially Protected Information (SPI) and Substance Use Disorder (SUD) consent
      ii. Advance care planning document archival and retrieval
   b. Future Iterations may create additional modules
      i. Strategy must be guided by end user stakeholders

iv. Value of Honoring Choices (HC)
   a. End user stakeholder/Patients/care teams are where the value is
   b. Create value by empowering Medicaid beneficiaries, reducing risk of unwanted healthcare spending, reutilizing and building on existing statewide infrastructure on AD and eConsent repositories

v. HC Work Timeline
   a. Increased emphasis as a result from COVID-19 on HC work
   b. In 2022 eCMS and AD were combined into HC work
   c. MiHIN started working with ADVault in 2022 for advanced care planning work
   d. In 2023, vendor agnostic approach, creating Application Programming Interface (API) for consent
   e. New work in 2023: Engaging stakeholders through stakeholder workshops to drive strategy going forward

vi. Electronic Consent Management Services (eCMS)
   a. eCMS captures, stores and is capable of sharing patient consent, and currently a digital version of the MDHHS 5515 form
   b. Allows MiHIN to share critically important clinical information protected by 42 CFR Part 2, such as opioid treatment information and medication history
   c. eCMS is interoperable and capable of sharing consent stored in the system with downstream EMR, EHR and consent vendors
   d. Currently piloting with 3 PIHPs, hoping for statewide in 2023

vii. MiHIN's Active Care Relationship Service (ACRS)
   a. Three types of ACRS
      i. Attribute ACRS – allow MiHIN to identify different types of data (SoD, chronic disease registry)

        ii. ACRS Linkages – Identifies various provider relationships with a single patient (PCP, specialists, part of care management team)
        iii. ACRS Choices – Identify if patient has provided choices on treatment preferences (AD, durable power of attorney, consent notification, etc)
    b. Ensures that only the active care relationships with patients are the only individuals or organizations that can view patient information following HIPPA

viii. eCMS Workflow for Pilot Sites
    a. Step 1 – patient is seen at clinic, receives education on consent release to MiHIN which creates ACRS relationship
    b. Step 2 – routes SPI-ADT information to providers in MiHIN and consented to receive information
    c. Step 3 – sharing consent information with MDHHS through the data hub, to pass information to CC360 to give access for 24 hours

ix. Advance Care Document Exchange Use Case
    a. Main objective is to include Advance Directive in all forms in MiHIN exchange, be able to query and retrieve documents across multiple repositories, link to ACRs, and provide participants with analytics on number of ADs stored for their ACRs population

x. AD Query & Retrieve
    a. Repository needed
    b. Contracted with ADVault, HITRUST certified
    c. Participants can manually upload or have an API automatically push ADs to the repository
    d. Developed vendor agnostic API, allows for query/retrieve ADs stored in commercial vendors, which can then be viewed/downloaded in MiHIN gateway portal
    e. Most important feature is the patient portal

Question (Smiddy): Does the patient have to give copies to health provider, or is there a connection with the State to do that through durable power of attorney

> Patient has the choice of where to have the AD shared. Shared with their lawyer and likely with their healthcare provider. MiHIN is saying to members (providers) that they can upload it to MiHIN, and it will be available to all the other MiHIN members. Healthcare providers can login to the gateway and search for the patient and their AD.

Question (Smiddy): What are the expirations/updates? As a patient how do we engage with this and how can it be easy to understand?

> Hopefully this will be covered in the stakeholder engagement work. Message to the patient comes from our provider users. If this is the statewide repository providers will use it to link up with other vendors

as the source for ADs, a central repository. Patient education will be important, but at the first step MiHIN is creating a repository.

Wilson: This is another point of patient education, clinicians will have to educate while trying to care for patients, which is not insignificant. Also, how will the process work around consents for research? Many patients are hesitant on participating in research based on historical injustices. It is difficult to get participation in research in clinical care, this may be compounded in research related to HIE.

Zaroukian: Hearing that the use case with a financial and health care trust with a lawyer, need to make sure that population is captured. Attorneys may be able to help by making sure what is being submitted is legal and valid. How can providers know they are looking at the latest, valid copy? Stakeholder groups should be helpful in identifying these areas to button up. Smiddy: Yes, when I try to pull my records with MiHIN I was unable to amend it without going back to a provider from six years ago. If I had more control to be able to upload my own records, it may work better.

Lisa Nicolaou: The issues being raised are the prime reason for the focus on stakeholder engagement. We have about a decade of national efforts, and we are starting to see metadata on how outcomes are progressing.

xi. Stakeholder Engagement FY2023
   a. A good time to look at where we are now, lessons learned from COIVD-19, the change in the healthcare ecosystem to make sure to drive at the right value
   b. How do we manage version control? How do we make sure the right information is getting to the provider at the right time? How do we measure effectiveness? What policy barriers are there to HC?
   c. In late spring MiHIN will hold a series of stakeholder engagement sessions

      Smiddy: Will issues of guardianship make this more difficult?

      Next slide addresses this, some policy barriers impacting the state brough up by stakeholders. Lack of surrogate law is one of them. We use technology as a band-aid to fix policy as it is now. MI-POST and teams who have to use this data, gaining that perspective is necessary
   d. Ask is for MDHHS to support MiHIN stakeholder engagement plan
      i. Logo, advertisement, promotion
      ii. White paper for future direction on data flow surrounding HC, eCMS, and advance care planning documents
      iii. Investigate how lack of surrogate law in the state impacts and drives tech solutions that are being developed currently

- Zaroukian: In addition to advertisement and promotion, participation by commissioners may also be helpful. Might be a good thing to add to the asks.
- VanderMey: Is there a recommendation for 2023 that we should be making around surrogate law?
- Smiddy: Some groups think it is too much of a heavy lift, but it might be a good recommendation
- Welch-Marahar: Do we know why it has failed before?
- Smiddy: Can find out specifics, but with the MI-POST law it was seen as too heavy of a lift to get a surrogate law through, to get coalition around it.
- Welch-Marahar: Why is there opposition to it at all? It seems like there are only reasons to recommend it from today. Who was against it?
- VanderMey: There are a number of concerns around data sharing with behavior health, substance abuse communities. Issues of privacy and personal autonomy, and data protection.
- Zaroukian: It's easy to ask patient while they are competent and able to speak for themselves, but when they have lost their autonomy, it is hard to get reasonable data on what they would prefer without a patient representative. Having clarity would help.
- VanderMey: A personal story related to my father, even though we knew what his wishes were we had to go to the hospital ethics committee and make a case for his desires in that context, but before the decision was made he passed away from a stroke. That is the kind of thing that requires a high level of advocacy and people having a very strong voice at a very difficult time.
- Anderson: Workflow pilot question timeline, has the pilot started and what is the timeline on that?
- Ly: Yes, it has started at the beginning of November. We have 3 PHIPs on the system, about 41 consents captured, and want to continue running the pilot for another month or so before adding more PHIPs.
- Anderson: What are you hoping to learn from the pilot?
- Ly: First, if it provided any value having electronic consent in statewide exchange. Also, if care coordination is of value to a patient with SUD treatment. The majority of feedback will come from provider users. Second, from a product perspective was the workflow simple, what inefficiencies are there from feedback.
- Welch-Marahar: Currently eCMS is used to replace sharing information via fax, etc. rather than sharing behavioral health information with new entities?

    Ly: Yes. The 5515 form is a pdf that typically has to get printed out and signed.
- VanderMey: What is the plan for sending this to other payer communities other than Medicaid?
- Ly: That would be a post-pilot goal, but the technology from a payer perspective is the same. Our goal is to make sure it's operational from a support/help desk perspective. An end goal of the pilot is to say we are

ready to onboard additional organizations, then it would be open for more than the Medicaid population.
- Zaroukian: In our roadmap initiatives we talk about the evaluation stage post-implementation. As a clinician, wondering if you build it will they come? As a Chief Medical Information Officer, I know how easy it has to be for people to use something especially to be done by a provider. In order to do our jobs as advisors, it may be helpful to have background information on how these things look and work and maybe make some comments to give it the best chance of working.
- Wilson: I agree. If it's 24 hours from the time the patient provides the consent, then it's going to MiHIN, then MDHHS in Optum and it give access in the next 24 hours.
- Anderson: Some of that may not be a limitation on MiHIN's capability but on CC360 on pulling data once every 24 hours. It might not be the instant ADT notification that folks are expecting now.
- Welch-Marahar: That 24-hour period is not the same time period to provider. What is that window of time for the provider?
- Ly: In eCMS it is all done in real time, all electronically captured and goes directly to the database. Notifications are sent out to participating providers that are able to then view documents.
- Zaroukian: How do they get the notification?
- Ly: Through direct message or through an interface. Whichever way the provider is currently receiving ADPs, will likely continue with that notification method.

3. Updates

Presented by Policy, Planning, and Operational Support Administration

A. Health IT Roadmap Quarterly Report – presented by T. Anderson
   i. Updates on Health IT Roadmap work. Slides available on HIT Commission webpage.
   ii. Acronym list is available on the website
      1. Identifying champions and empowering leaders
      2. Enhance health data utility

- Zaroukian: Can you say more about the organizations?
- Anderson: This ties into protecting and modernizing public health which we'll come back to. There are about 300 systems within MDHHS, specifically for public health there are about 80. There is an assessment happening with each system to see where we can have better alignment. Hoping to have a report out by next quarter, we should have the catalog by the end of the year.
- Welch-Marahar: Not just with public health but this also encompasses work in child welfare and other systems. So a way to keep track of where we can create better integration with HIE as it's applicable.

- Zaroukian: My sense is that there is treasure in there that we are not leveraging as much as we could.
- Welch-Marahar: The Strategic Integration Administration has a great way of assessing the value of our systems from this matrix, to examine our systems and we could have them share that with you all.
- Wilson: I've been in a lot of conversations with our physician executives about screening. Screening is necessary but not sufficient. Like a patient with transportation issues, a screening also then needs documentation in the record. The way screening is picked up in the record, goes on the claim, and goes through HIE and other pathways.
- Zaroukian: A helpful example from Sparrow, we are tracking not only that collection of data but it did result in a referral to our navigation hub so we can also track "then what happened?"
- Brenner: Is there pushback from providers about doing some of this stuff because of lack of resources or having to stand up all these things?
- Wilson: There is a lot of push and pull there. Documentation of Social Determinants of Health by a provider could potentially have some impact on professional revenue, but there is also concern from patients on what will be done with their information. Some patients feel if they open up about these things, they get substandard care. I think our providers are motivated and want to capture SDOH but they struggle to know the most efficient way with the greatest impact.
- Zaroukian: We had that experience, we put out the screening and providers loved the idea, but struggle for time, but then don't know what to do with it once they have it. Once that was in place it started to take off so that is the important part. It reminds me of the definition of equality and everything you've said here is part of that. Is it patient-centered, effective, safe… can we do some anchoring on that for this initiative.
- Sasy: If they don't have the capacity or the resources it can't work. That is why the CIE taskforce work is so important, it looks at the policy and the funding. It is a more in-depth network of not only technology but making sure they are getting funding.
- Zaroukian: Without it everything hits the breaks.
- VanderMey: There was a research project funded by the Robert Wood Johnson Foundation in California that found when the CBOs were able to do part of the data collection process it helped provided better data.
- Welch-Marahar: To Ninah's point, that's what we're driving towards in CIE, but also the CHIRs do that pretty effectively.
- Anderson: They have that trust already developed which helps with the patient concern of what will be done with the data.
- Zaroukian: I'd love to see if anybody's done planning and implementation around this and if we could see it.
- VanderMey: UCSC was involved in that.
- Wirth: A question in the chat: What does "signed on" mean for MiHIN use cases?

- Anderson: If you have already signed your master use case agreement with MiHIN there are individual use cases, like your ACRS is your base and then you go to ADT then CCBA, so SDOH would be a separate use case. You're signing on to use that use case.
- Brenner: Is there work going on to understand non-utilizers? Are there certain workflows that don't allow for this use?
- Anderson: Find out where those gaps are, that's an excellent point. I think that inventory and assessment will be helpful. We know providers and facilities have been engaging in utilizing that information because they've been compensated for that through pay for performance or other payer incentives. That was the catalyst, but in this case, it's been more hospitals as passive senders of this data and not really ingesting the data or if they have the ability to do that.
- Wilson: Resources and value factor into those decisions.

3. Addressing the digital divide

- Smiddy: There's a federal program that offers discounts for libraries and schools for internet access and I was wondering would there be an interest from the state level to offer discounts to community organizations?
- Welch-Marahar: I just checked with Eric Frederic, the Chief Connectivity Officer and he said the map is live, and went live on the 18th. We can share the link with this group and any guidance he has about how we can be supportive.

4. Improving onboarding and technical assistance

- Smiddy: can we get an update on the post-COIVD-19 telehealth waiver?
- Welch-Marahar: Pretty much everything was preserved except for phone audio and there is some pushback on that.

5. Protect public health
6. Social care data standards

B. Community Information Exchange Task Force – M. Welch-Marahar
   i. M. Welch-Marahar: Has met 3 times, has adopted a charter available on CIE website. Charter outlines the goals of the group. Work has been done developing questions to answer through task force work:
      1. Given the diverse needs of diverse populations in our state (urban/rural/tribal), how can one strategy equitably serve all?
      2. How would individuals (help seekers) interface with CIE systems (to address their own needs, manage the use of their own data, etc.)?

3. Who will oversee the CIE and what is the right balance of roles and responsibilities between the State and regional and local entities?
4. What policies need to be in place to sustainably fund CIE operations and who should pay for what?
5. What does success look like and how would we measure it?

ii. Smiddy: It is a big group, so moving forward I hope we break up into smaller groups to tackle some of these questions.
iii. Ebersole-Wood: It's an aggressive target of what we want to go after and I think from a facilitation perspective it's been very interesting to see how the questions have percolated. I think getting a line on what to tackle is important. I've been impressed with the ability to facilitate that for our group and we are going to have to break up to get at those answers.
iv. Smiddy: Yeah, we really don't have much time.
v. Sasy: It's a complicated thing to think about, but you went way beyond that.
vi. Welch-Marahar: Yes, the goal for the next meeting is to break up into smaller groups and really start the business of who is going to do the work to get us to the answers to some of these questions.

C. 2022 HIT Commission Annual Report Recommendations for 2023 –Anderson

- Every year the HIT Commission submits an annual report to the Legislature. This will be the first since 2019 because the HIT Roadmap development has served as the annual report for the past couple of years. It summarizes what work has been done, but also makes recommendations to the legislature.
  i. Recommendation 1: Designate MiHIN as the SOM Health Data Utility
    a. Recognize MiHIN as a partner, not a vendor
    b. This will help secure maintenance and funding, clarify governance and roles
- Smiddy: Add that the entities providing the data have a voice and moving forward the concerns around fees of those facilities providing the data and then getting charged to have their data pushed back to them.
- Anderson: Providing clarity around how that is structured, in 2021 MiHIN implemented their tier three pricing and had a pick list. So that relationship when MDHHS formed MiHIN, it wasn't with the intent to carry them through the rest of their days. It's having transparency of how they are structured. Going back to how they are governed, we have the HIT Commission, MOAC, and the MiHIN board, all feeding into how they are moving forward.
- Smiddy: Does anybody sit on MOAC?
- Ninah: I'm a co-chair. But we haven't been partnering in terms of developing strategy going forward. This is a new role for us. I want to

clarify, is this a recommendation from the HIT Commission or from MDHHS?

- Anderson: In past annual reports MDHHS makes the recommendation to the legislature through the annual report through the HIT Commission. It's also a recommendation for ourselves. The HIT Commission is saying this is what we think should happen with MDHHS, this is our advice to them. But it is submitted to legislature and through that changes can be made.
- Zaroukian: For clarity, my understanding is the Commission advises the Department, the Department takes the advice and does with it what it will and then interacts with the legislature around that. So this represents a recommendation from us to the department.
- VanderMey: But by statute we provide the report to the legislature.
- Zaroukian: It's a report that we have autonomy in generating, yes?
- Welch-Marahar: Yes, this is a report by the HIT Commission to MDHHS who submits it to the legislature.
- Zaroukian: But may not modify it?
- VanderMey: I think it's been interpreted differently over time.
- Anderson: Going over past recommendations, there are some that have been recommended multiple years and never been adopted. MiHIN is considered the state designated Health Information Exchange, so the distinction is in recognizing that that is a partnership and not a vender relationship.
- VanderMey: When the policy was put in place in 2006 our HIEs were not a term at the time. There was a discussion that regional HIEs were the outcome of. MiHIN is not just a partner, but it is a coordinating mechanism for data sharing in the state.
- Anderson: and the conduit to care report was MiHIN's strategy created with the State.
- Zaroukian: Not to parse words, they're either a vendor or a partner, or a vendor/partner. Every good vendor ought to be a partner. We're talking about enhancing the partner nature of our vendor relationship?
- Anderson: But it is interesting how the HIT Commission and MOAC govern. Funding is also a big piece. Rarely does a vendor allow a customer to have that much say in how they are governed. That infrastructure that is already existing, how is that maintained and how are they operating with that? This underlies all the following recommendations and the Roadmap itself because this is part of enhancing data utility. How are we using our funds through APD, through grants to follow that Roadmap.
- Smiddy: I want MiHIN in this partnership to be viewed as a value from the provider and not an unfunded mandate. If we start issuing rules requiring certain data collection, I think we'll lose good will that we've built up over the years.
- VanderMey: I've asked that question very specifically to some of my friends in the West CHIR hospital community because it's been so tied to

the BlueCross P4P programs that it's viewed as tightly integrated in that space and funded in the at space as opposed to it being a public utility.
- Anderson: Especially when it goes back to the conformance task force. The state hasn't had a voice on that task force, it's been built around the hospital P4P by BlueCross, to their credit they've been the ones funding that and getting participation. Now it's going back to the ambulatory providers and BlueCross has stepped up again with the vendor initiative with the independents and smaller POs.
- Sasy: So, these are recommendations that we [the Commission] are bringing forward, these are not MDHHS's recommendations
- Welch-Marahar: These are recommendations that we developed either from the Roadmap or in talking with stakeholders and are bringing to the HIT Commission to finesse, accept, reject, amend as needed.
- Sasy: So, the HIT Commission has the right to decide if these are not recommendations they want to move forward with?
- VanderMey: These will require a motion to move forward?
- Wirth: That'll be in February. We'll do a roll call vote on that.
- Zaroukian: My only other question on this is the word "the."
- Anderson: So, it's not exclusive, that's a great point. In talking with other stakeholders, it is not exclusive. So, we'd still be working with regional HIEs. Investments the state has made in MiHIN as a Health Data Utility are what we're trying to leverage and recognize.
- VanderMey: I like the definite article with "the" because, from a technology standpoint, duplicative activity is reduction of investment and efficiency.
- Anderson: Maybe that is where having the distinction and definition between health data utility, health information exchange is good.
- Zaroukian: It's missing an adjective.
- Wilson: So, we're saying this is "the designated" …
- Zaroukian: "MiHIN is the State's designated…" not the sole designated one.
- Welch-Marahar: I don't think there is any other entity that does what MiHIN does.
- Anderson: In the report, which fleshes it out more, there are references to other states that have a designated health data utility. It has more context. It's like looking at it like a water or power company. We've already paid for the pipes, now we want to maintain them and optimize the usage.
- Brenner: Today is to just review the recommendations to formally vote on in February.

  i. Recommendation 2: Increase Diversity of HIT Commission

     1. Expand from 13 to 15, include representation from LTC and Behavioral Health

- Welch-Marahar: Update to 16 to include an additional seat for community-based organizations.

     2. Have CIE Task Force become a sub-committee of the HIT Commission in Q4 CY23

- Smiddy: would that go through an application process like this Committee?
- Anderson: Right now, the HIT Commission has the power to create that themselves without going through legislature. The items on expanding the committee and representation would have to go through an amendment.
  - ii. Recommendation 3: Catalog and leverage all payor incentives and requirements around interoperability and HIE for healthcare providers and CBOs
  - iii. Recommendation 4: Improve data quality in the HIE
    1. Within the state systems, REaL, SOGIE data, and increased engagement with MOAC and the Conformance Task Force
- VanderMey: For language to be consistent, you should probably say health data utility here
  - iv. Recommendation 5: Actively promote MIHI office efforts
    1. ROBIN, BEAD, and affordable connectivity program
- Smiddy: With all these programs, with my understanding, don't actively engage health care providers?
- Anderson: The affordable connectivity program, that is something providers and facility can help promote through SDOH screening and learning where people are at with connectivity, where they live, what they can afford. It provides $100 toward a device and $30 a month for assistance. For BEAD or ROBIN internet providers have to sign on and participate with the affordable connectivity program
- Welch-Marahar: MIHI is an office of 5 right now, so we could really lean in to help them get the message where it's needed so we can promote things like telemedicine and broadband access. The goal here is to be as active a participant as we can to get information to communities who need it. And with the SDOH lens, there's funding only not spent on infrastructure to go toward education to patients.
- Zaroukian: Consideration to adding that to a question in SDOH because they don't ask about their connectivity.
- Smiddy: I liked the last recommendation about the digital divide.
- Anderson: So, connect it back to that?
  - v. Recommendation 6: Strategically leverage state funding opportunities to support onboarding and technical assistance
    1. Utilizing BEAD funding for technical assistance related to telemedicine and virtual care, making use of CDC funding to public health administration for technical assistance and training for providers that have been left behind, leveraging the rebid of managed care organization contracts to include more incentives for HIE and usage of health data utility
- Welch-Marahar: We have so much money coming into our state for things that are tangential to public health, how do we leverage this funding to

make investments in this infrastructure that we know will help health outcomes

- Ebersole-Wood: Are there things you need to be able to actively manage the roadmap and all the pieces that need to come together? How do we coordinate and make sure you have the program staff to make sure you can keep all of these balls in the air?
- Welch-Marahar: We did put it in our legislative ask list. This work can be as big as we can make it. Right now, the Department owns CIE. What can we influence to make other pieces happen? We do have more staff coming on, and on our wish list was to have a team devoted to this work.
- Anderson: In our review of past plans and recommendations there always seems to be a designated HIE team that would oversee that work. It's just understanding what we have the capacity to do or just making sure everyone is rowing in the same direction and providing that oversight and input where we can.
- VanderMey: One thing I see missing is developing a template for what the technical baseline would be for those marginalized providers so you can say this is what "good" looks like. Otherwise, it is left to a dozen agencies to figure it out.
- Anderson: And it was easier before with EHR incentives because we had that template. Are we looking at creating that ourselves? If we have that standard, are we using a carrot or a stick. If we're leveraging our rebid, then it could be a carrot. A lot of unknowns with that.
- VanderMey: And recognizing that the access to the technology that's enabled by the funding may not be enough for a left behind provider to actually know what they should do, and you're then forcing that provider to be the technical expert on how to figure out connectivity in the building, create wireless infrastructure, make sure its secure. We've been supporting a local CBO and the absence of sophistication, like they were asking about what type of laptop they should be getting. They just didn't know and they're providing services to underserved patients.
- Anderson: And to Ninah's point earlier, it's their capacity and if they're strapped with staff to begin with, what are they going to do with this information? How are they going to deal with it, and do they have the capacity to take on more services as they exist now.
- VanderMey: Often times we're finding the office administrator, or the receptionist is the one that gets tasked with during that work.
- Sasy: Molly mentioned our wish list of things we sent to the legislature, these are things we are needing supported otherwise they get left on the shelf. And a correction, Molly is now the co-chair of MOAC, she will be officially the chair in January.
- Welch-Marahar: This is the first draft. It will be sent out for Commissioner comments and suggestions, hopefully provided within the next month to provide to MDHHS prior to sending to the legislature. They are not written in stone, but things we pulled from our Roadmap, or from stakeholders. Hopefully they can help establish our next steps in the near-term goals

between now and 2024.

4. Public Comment

- Dan Boyle
- Jim Camp, Altarum
- Helen Hill, HIMSS and MiHIN

Wilson & Zaroukian recognize Jim VanderMey for his work on the Commission and thank him for his service. This will be his last HIT Commission meeting.

5. Adjourn

Ebersole-Wood makes motion to adjourn, Zaroukian seconds, motion approved unanimously.

Next meeting scheduled for February 21, 2023.