STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

HEALTH INFORMATION TECHNOLOGY COMMISSION

2024 PUBLIC MEETING NOTICE

The Health Information Technology Commission will meet in regular session for 2024 as listed below:

DATE	DAY	TIME	LOCATION
~~2/13/24~~	~~Tuesday~~	~~1:00 – 3:00PM~~	~~Conference Room 1K & 1L South Grand Building 333 South Grand Avenue Lansing, MI 48933~~
~~5/14/24~~	~~Tuesday~~	~~1:00 – 3:00PM~~	~~Conference Room 1K & 1L South Grand Building 333 South Grand Avenue Lansing, MI 48933~~
8/27/24	Tuesday	1:00 – 3:00PM	Conference Room 1K & 1L South Grand Building 333 South Grand Avenue Lansing, MI 48933
11/19/24	Tuesday	1:00 – 3:00PM	Conference Room 1K & 1L South Grand Building 333 South Grand Avenue Lansing, MI 48933

Materials needing to be displayed during public comment or any other feedback requiring commission attention can be emailed to MDHHS-HIT@michigan.gov prior to the meeting.

SEE NEXT PAGE FOR ADDITIONAL INFORMATION

VIRTUAL LOCATION

Meetings will be offered virtually, unless otherwise noted on the Health IT Commission web page.

DATE	ZOOM MEETING LINK	CALL-IN INFO
~~2/13/24~~	~~https://us06web.zoom.us/j/82164862495?pwd=MnnCRVvgt6yf5diXLDCrjQ0iPLM3nD.1~~	~~(216) 706-7005 or (866) 434-5269 Conference Code: 729478~~
~~5/14/24~~	~~https://us06web.zoom.us/j/81715579585?pwd=tRiWF0fTVl5qpXSNdDzSvNB9P1fxUb.1~~	~~(216) 706-7005 or (866) 434-5269 Conference Code: 729478~~
8/27/24	https://us06web.zoom.us/j/83315470217?pwd=BTVdlakLj6JFFmkUEOsc4NbzURBL2q.1	(216) 706-7005 or (866) 434-5269 Conference Code: 729478
11/19/24	https://us06web.zoom.us/j/81287793401?pwd=Eyf2tpky3Pi38wheKqWo7RwesNxMU0.1	(216) 706-7005 or (866) 434-5269 Conference Code: 729478

Full Zoom meeting invite information can be found below:

~~**Topic:** 2024 First Quarter Health IT Commission Meeting, **Time:** February 13, 2024, 01:00 PM Eastern Time (US & Canada)~~
Join from PC, Mac, Linux, iOS or Android:
~~https://us06web.zoom.us/j/82164862495?pwd=MnnCRVvgt6yf5diXLDCrjQ0iPLM3nD.1~~
~~**Or Telephone:** USA (216) 706-7005, USA (866) 434-5269 (US Toll Free), **Conference code:** 729478~~

~~**Topic:** 2024 Second Quarter Health IT Commission Meeting, **Time:** May 14, 2024, 01:00 PM Eastern Time (US & Canada)~~
~~**Join from PC, Mac, Linux, iOS or Android:**~~
~~https://us06web.zoom.us/j/81715579585?pwd=tRiWF0fTVl5qpXSNdDzSvNB9P1fxUb.1~~
~~**Or Telephone:** USA (216) 706-7005, USA (866) 434-5269 (US Toll Free), **Conference code:** 729478~~

Topic: 2024 Third Quarter Health IT Commission Meeting, **Time:** August 27, 2024, 01:00 PM Eastern Time (US & Canada)
Join from PC, Mac, Linux, iOS or Android:
https://us06web.zoom.us/j/83315470217?pwd=BTVdlakLj6JFFmkUEOsc4NbzURBL2q.1
Or Telephone: USA (216) 706-7005, USA (866) 434-5269 (US Toll Free), **Conference code:** 729478

Topic: 2024 Fourth Quarter Health IT Commission Meeting, **Time:** November 19, 2024, 01:00 PM Eastern Time (US & Canada)
Join from PC, Mac, Linux, iOS or Android:
https://us06web.zoom.us/j/81287793401?pwd=Eyf2tpky3Pi38wheKqWo7RwesNxMU0.1
Or Telephone: USA (216) 706-7005, USA (866) 434-5269 (US Toll Free), **Conference code:** 729478

**For those that wish to attend in person, all meetings will be held at:

Conference Room 1K & 1L
South Grand Building
333 South Grand Avenue
Lansing, MI 48933

The meeting site and parking are accessible. People with disabilities requiring additional accommodations to participate in the meeting should call 517-282-0888

Dated: February 01, 2024

Michigan Health Information Technology (HIT) Commission Meeting Agenda

Tuesday, August 27, 2024
1:00 – 3:00 p.m.
South Grand Building
333 S. Grand Avenue
Conference Rooms 1K & 1L
Lansing, MI 48909

Virtual Meeting
Zoom Conference Information:
Join from PC, Mac, Linux, iOS or Android:
Zoom Link
Or Telephone Dial:
(216) 706-7005 or (866) 434-5269
Conference Code: 729478

Item	Facilitator(s)	Time
1. **Commission Business** a. Quorum b. Welcome, Introductions, and Announcements c. Approve Meeting Minutes	HITC Chairs	1:00 pm - 1:10 pm
2. **HIT Roadmap** a. HIT Roadmap Tracker Highlights b. MI-POST Final Report c. MiHIN Board Update d. MiHIN FY24 Updates e. MI High-Speed Internet Update f. CIE Advisory Committee Update	a. MDHHS b. MI-POST Advisory Committee c. Commissioner Tyus d. MiHIN e. Commissioner Robinson f. Commissioner Ebersole-Wood, Commissioner Tyus	1:10 pm – 2:35 pm
3. **Open Discussion**	HITC Chairs	2:35 pm – 2:50 pm
4. **Public Comment**	HITC Chairs	2:50 pm – 3:00 pm
5. **Adjourn**		

Notes:
1. Handouts available for the public will be limited to the final agenda and annual public meeting notices. Please visit the MDHHS Health IT Commission web page for additional material (https://www.michigan.gov/mdhhs/doing-business/commissions-boards/hitcomm)
2. Updates on the Michigan Health IT Roadmap can be accessed from the MDHHS Health IT Commission web page (https://www.michigan.gov/mdhhs/doing-business/commissions-boards/hitcomm/hitcommdocs/strategic-planning)
3. Public comment for all items will be limited to three (3) minutes per item per speaker. This time may be adjusted dependent upon the number of speakers.
4. Subscribe to updates from the Michigan Health IT Commission, under "Doing Business with MDHHS"

Dated: August 2024

Next Tentative Meeting:
November 19, 2024

3. Public comment for all items will be limited to three (3) minutes per item per speaker. This time may be adjusted dependent upon the number of speakers.
4. Subscribe to updates from the Michigan Health IT Commission, under “Doing Business with MDHHS”

Dated: August 2024

Hit Commission Meeting Minutes

Date May 14th, 2024, 1:00 P.M. – 3:00 P.M.

Location South Grand Building, Conference Room 1K/1L, 333 S Grand Ave, Lansing, MI 48933

Commissioner Attendance

Name	*Representing*	*Attendance*
Alison Arnold	Schools of Medicine	Not Present
Marissa Ebersole-Wood **Co-Chair**	Health Plans or Other Payers	Present
Ninah Sasy	Department of Health and Human Services	Present
Walker Foland DO	Department of Technology, Mgmt., Budget	Present
Allison Brenner, PharmD	Pharmaceutical Industry	Present
Jeffrey Chin	Hospitals	Present
Jessica Robinson	Purchasers or Employers	Present
Janée Tyus (left 2:18)	Nonprofit Health Care Corporations	Present
Seat open. Vacated by Renée Smiddy, M.S.B.A. due to conflict of interest	Consumers	Not Present
Lee Marana	Health IT Field	Not Present
Hana Alawy	Pharmacists	Not Present
Michael Zaroukian, M.D., Ph,D. **Co-Chair**	Doctors of Medicine	Present

Michigan Department of Health and Human Services (MDHHS) Staff:
Natalie Holland, Elizabeth Hartig, Marcus Connolly, Tiffani Stanton, Justin Easter, Katherine Tucker, Ninah Sasy

Guests:
None

Minutes: The regular Health Information Technology Commission meeting was held in person on May 14, 2024, with ten (10) commissioners in attendance. Quorum was fulfilled.

1. **Commission Business**
   Presented by Michael Zaroukian
   a. Co-Chair Michael Zaroukian called the meeting to order at 12:57 P.M. Quorum was fulfilled.

b. Welcome, Introductions and announcements Co-Chair Michael Zaroukian
c. Approve Meeting Minutes
- Motion made by Commissioner W. Foland to approve minutes, seconded by Commissioner J. Chin. All in favor. Motion carries.

d. Nominate and approve Co-Chairs
- Chair Michael Zaroukian nominated Commissioner Marissa Ebersole-Wood for Co-Chair. Motion made by Chair Michael Zaroukian to approve Marissa Ebersole-Wood as Co-Chair, seconded by Commissioner J Tyus. All in favor. Motion carries.

e. Consumer Seat
- Seat open. Vacated by Renée Smiddy, M.S.B.A. due to conflict of interest

2. HIT Roadmap

a. HIT Roadmap – Tracker Highlights
Presented by Elizabeth Hartig
- Slides containing additional details can be found on the HITC website.
- Discussion within the room between the commissioners commenced throughout the presentation.

b. MiHIN Board Updates
Presented by Commissioner Janee Tyus
- Slides containing additional details can be found on the HITC website. Commissioner J. Tyus stated she believes she participated in two MiHIN Board meetings since the last HIT meeting and plans to attend an upcoming Strategic Planning Board meeting in person. Commissioner J. Tyus further stated she also attended a workshop in DC where she was able to speak on some of the things being done in Michigan and learn from others.

c. MiHIN use case dashboard and medication reconciliation project. Dr. Isabel Pacheco and Kim Balsinger spoke about the MiHIN strategic plan and goals. There was further discussion around medication management, patient medication list and how to access data. Dashboard first phase complete. Second phase of automation is delayed. Public facing dashboard still in the security phase. Next meeting the goal is to have a better update. Internal facing dashboard is producing data relevant to the CMS dashboard and a volume mechanism.

d. Jessica Robinson: Digital Inclusion Manager with the Michigan High Speed Internet Office addressed the Digital Divide via their Digital Equity Plan. Provided an overview of the office. The focus is on the community. Provide Universal Broadband to the community with 100% availability and reach 95% adoption of internet use. The goal is Digital Equity. Digital Divide is the issue. Digital Inclusion is the bridge.

e. CIE Advisory Committee *Presented by Commissioner Ebersole Wood.* The Commissioner provided updates related to the CIE advisory committee. The Commissioner stated Commissioner Tyus is also very engaged. The committee decided to break things up to make sure information is being delivered on a regular basis. Two subgroups developed. 1 group is focusing on social care data governance. 2nd group business case for the Community Based Organizations (CBO's). The first phase is March through July. Plan to provide update and documents at the August meeting. Group 1 looks at different components of community information exchange. Group 2 looks at onboarding community organizations, providing the right support, coordinating entities and how does healthcare support at the level of CBO's? There was also conversation around a barter group primarily around community engagement. CIE Professional Learning Community with Michigan 211 will host its first meeting May 16th at 2:00pm.

3. Discussion/Action

a. Commissioners discussed Artificial Intelligence (A.I.).
b. Open Space: Reflection from HIMSS.

4. Public Comment

a. Christina Dawkins from MDHHS suggests relevant labs and blood pressure measurements should also be included with patient medication list in relation to the case dashboard and medication reconciliation project.

5. Adjourn

Motion by Commissioner J. Tyus to adjourn the meeting, seconded by Commissioner W. Foland. The meeting adjourned at 3:01 P.M.

Next meeting scheduled for August 27, 2024

Michigan Health Information Technology Commission

August 27, 2024

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

Hybrid "Housekeeping" Guidelines

Access

- **This meeting is being recorded.**
- For members calling into the meeting and unable to use web-based meeting features, an open comment period will be offered at the end of the meeting.
- **If at any time you have accessibility or technical issues during the meeting,** please contact Easterj2@michigan.gov
- **Web cam video display is reserved for commissioners and presenters.**

Interacting

- **The group chat will be monitored and utilized throughout the meeting.** Any questions or comments raised in the group chat will be read aloud.
- Unless otherwise specified, **all attendees (besides the presenter) will be muted during a presentation.** This rule will reduce background noise or "feedback."
- **Please identify yourself by stating your name before you begin speaking.** This will assist us in keeping accurate meeting minutes.
- **Please be sure to mute yourself after you are done speaking**, this will reduce feedback during the meeting.

Public Participation

- Except for the public comment period, **public participants should remain muted unless invited to speak by the commission.**
- Per the Michigan Open Meetings Act, disclosing your identity in this meeting is not required.
- The public comment period will be accessible for multiple modalities at the end of the meeting.
- For those attending in person, please fill out a blue comment card and we will call on you during the public comment period.

Agenda

Item	Facilitator(s)	Time
1. **Commission Business** a. Quorum b. Welcome, Introductions, and Announcements c. Approve Meeting Minutes	HITC Chairs	1:00 pm - 1:10 pm
2. **HIT Roadmap** a. HIT Roadmap Tracker Highlights b. MI-POST Final Report c. MiHIN Board Update d. MiHIN FY24 Updates e. MI High-Speed Internet Update f. CIE Advisory Committee Update	a. MDHHS b. MI-POST Advisory Committee c. Commissioner Tyus d. MiHIN e. Commissioner Robinson f. Commissioner Ebersole-Wood, Commissioner Tyus	1:10 pm – 2:35 pm
3. **Open Discussion**	HITC Chairs	2:35 pm – 2:50 pm
4. **Public Comment**	HITC Chairs	2:50 pm – 3:00 pm
5. **Adjourn**		

1. Commission Businesses

A. Quorum
B. Welcome, Introductions, and Announcements
C. Approve Meeting Minutes

Led by: HITC Chairs

HIT Roadmap Initiatives

- Identify Champions and Empower Leaders
- Enhance Health Data Utility
- Address Michigan's Digital Divide
- Improve Onboarding and Technical Assistance
- Protect Public Health
- Adopt Standards for Social Care Data Fields

2023 Annual Report Recommendations

	Identify Champions and Empower Leaders	Enhance Health Data Utility	Address Michigan's Digital Divide	Improve Onboarding and Technical Assistance	Protect Public Health	Adopt Standards for Social Care Data Fields
Advance Social Care Data Standards and Governance	✓	✓				✓
Promote HIE and CIE Incentives		✓				
Strengthen Statewide HIE Accountability		✓			✓	
Expand Broadband Access	✓		✓		✓	✓
Support Technical Assistance and Training	✓	✓	✓	✓	✓	✓
Advocate for Patients and Consumers	✓	✓	✓	✓	✓	✓

Tracking progress:
1. Identify champions and empower leaders

INITIATIVE: Identify champions and empower leaders	Lead	Status				
		Plan	Build	Implement	Evaluate	Improve
1A: Drive implementation of roadmap	MDHHS					
1B: Refresh state health IT governance	MDHHS					

Michigan Physician Orders for Scope of Treatment (MI-POST)

Overview & Recommendations

MI-POST Advisory Committee

MDHHS
Michigan Department of Health & Human Services

Speakers

Rose Seavolt, BSN, CCP

Respecting Choices® Faculty Consultant, Next Steps™, and Advanced Steps Org Faculty

Choreographed Health Solutions

Amy Bailey, LMSW

Advance Care Planning Specialist

*My*Michigan Health

Crystal Young, MSN, RN

Quality, Safety, and Experience Program Director

Corewell Health

What is MI-POST?

The Michigan Physician Orders for Scope of Treatment (MI-POST) provides the following:

1	An optional, two-page medical order that directs care only when you are unable to tell medical staff your treatment decisions
2	Opportunity to choose cardiopulmonary resuscitation (CPR); decline CPR
3	Opportunity to share details on your treatment decisions about other medical interventions beyond CPR

MDHHS
Michigan Department of Health & Human Services

MI-POST General Rules:

1. Are for adults with advanced illness/frailty
2. Should use standard form
3. Should be retained in medical record
4. Should be used in acute care settings as a guide
5. Directs care provided by EMS
6. Can be accepted as verbal or telephone orders

MDHHS
Michigan Department of Health & Human Services

MI-POST Advisory Committee

- On Nov. 7, Public Act 154 of 2017 created the MI-POST

- MDHHS convened an Advisory Committee in 2022 to:
  - Revise and update the MI-POST form, Patient & Family Information sheets
  - Created MDHHS-endorsed educational materials for user groups
  - Develop a Frequently Asked Question (FAQ) document and established an MI-POST inbox to receive questions for response through the FAQ
  - Conduct educational outreach on the MI-POST form
  - MI-POST now available in Spanish, Arabic

MI-POST Advisory Committee Membership

- *MyMichigan Health*
- *Michigan Home Care and Hospital Association*
- *Honoring Healthcare Choices – Michigan*
- *Healthcare Association of Michigan*
- *Gogebic Medical Center*
- *Ascension*
- *Upper Peninsula Health System*
- *Munson Medical Center*
- *Corewell Health (formerly Beaumont, Spectrum)*
- *MiHIN*
- *Michigan Medical Directors Association*
- *Department of Licensing and Regulatory Affairs*
- *MDHHS*
- *MDHHS Bureau of Emergency Preparedness, EMS, and Systems of Care (BEPESOC)*
- *Choreographed Health Solutions, LLC*
- *Oakland County Medical Control Authority*
- *Covenant HealthCare*

Scenario 1: Edward

Scenario 1

Edward

Edward is a 78-year-old with congestive heart failure (CHF) who has been hospitalized 3 times over the past 6-months due to shortness of breath.

Edward's Primary Care Provider (Nurse Practitioner) indicates that his CHF has progressed and acknowledges that he does not want to endure repeated hospitalizations.

In partnership with his nurse practitioner, Edward completes the MI-POST form to indicate do-not-resuscitate and comfort-focused treatment. The diagnosis supporting the MI-POST is CHF.

Edward's decisions are now written in a portable medical order that serves to avoid unnecessary hospitalizations and aggressive medical interventions that he believes would only cause more pain and suffering.

Scenario 1: Edward's MI-POST in practice

Scenario 1

Edward

A few months after the execution of Edward's MI-POST with his attending health professional, his nurse practitioner, Edward is at home and experiences shortness of breath and must call emergency medical services.

Edward is nonresponsive.

EMS professionals are unable to determine and transfer Edward to an ED where he receives treatment that is not in-line with his wishes.

In practice, the Michigan MI-POST is not structured to support the realities of end-of-life care. In this scenario, EMS providers were unable to determine if his shortness of breath is connected to his diagnosis of CHF and defaulted to full treatment, including CPR.

The MI-POST Advisory Committee has identified several key recommendations to increase the efficacy and effectiveness of the MI-POST form.

Recommendations

Michigan should explore a Next of Kin Law as a policy tool to improve serious illness care.

- Less than 30% of US adults have completed a Patient Advocate Designation.
- A lack of a Next of Kin law places undue hardships on patients and their loved ones.

Allow electronic signatures for the MI-POST, the out-of-hospital DNR order, and the Durable Power of Attorney for Healthcare/Patient Advocate designation.

- CMS proposed e-signatures to improve the care and experiences for patients and providers.
- Allowing electronic signatures would support progress in the development of Advance Directive use cases to support health IT in the state, increasing the potential utility of a statewide repository for out of hospital DNR orders to be accessible by EMS and ED

Recommendations: Changes to the MI-POST form

Remove the 12-month expiration date of the MI-POST to align with the out of hospital DNR order.

- In no other instances do medical orders pertaining to advance care planning have expiration dates.
- The MI-POST has a 12-month expiration date, the out-of-hospital DNR order has no expiration. This inconsistency creates confusion among patients, health care professionals, LARA, and EMS, putting patients at risk for unwanted care.

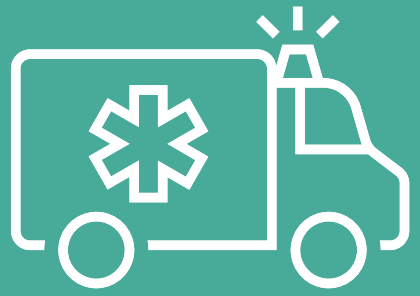
Remove the reaffirmation requirements of MI-POST to align with the Out-of-hospital DNR order.

- Given the care complexities of end-of-life care, this requirement places disproportionate burdens/expectations on healthcare providers and places patients at risk for receiving unwanted care when a provider is unable to meet reaffirmation requirements.

Recommendations: Changes to the MI-POST form

Remove ‘Diagnosis supporting MI-POST’ to improve effectiveness and reduce burdens on clinical teams.

- Currently, the MI-POST requires a diagnosis supporting the use of the MI-POST to be documented on the form.
- Given the care complexities of individuals with advanced frailty, this requirement places a disproportionate burden on healthcare providers to identify if an end-of-life care decision is connected to a diagnosis and places the patient at risk for receiving unwanted care.



Expand the MI-POST to direct care beyond EMS personnel.

- Currently, the MI-POST directs care provided by EMS.
- Given the care complexities that occur with advance frailty, including frequent changes in care setting and care teams, it is important that all clinical teams with a responsibility to honor a patient’s end of life care decisions are also directed by the MI-POST.

Recommendations: Changes to Out-of-hospital DNR order

Remove the witnessing requirements for an Out-of-hospital DNR order to align with the MI-POST.

- In no other circumstances does a medical order pertaining to advance care planning require witness signatures.
- The MI-POST does not require witnesses, while the out of hospital DNR does. This inconsistency creates confusion among patients, healthcare professionals, LARA, EMS personnel putting patients at risk for receiving unwanted care.

Allow Advance Practice Providers signing authority for an out of hospital DNR order to align with MI-POST.

- Advance Practice Providers, like Certified Nurse Practitioners or Physician Assistants, are licensed healthcare professionals responsible for the treatment of patients in most areas of medical care.
- End of life care should be no different.

	Durable Power of Attorney for Health Care	Out-of-Hospital DNR	MI-POST
Type of document?	Legal document.	Medical order.	Medical order.
Who can have the document?	Adults with Capacity.	Any Adult, regardless of health Parent on behalf of a minor with advanced illness.	Adult with advanced illness or frailty (12 months or less life expectancy).
Who completes the document?	Adults with Capacity.	Adult with capacity or patient representative*and a physician (cannot be NP or PA).	Adult with capacity or patient representative* and attending health professional (Physician, NP or PA).
What is communicated in the document?	Designates a patient advocate and any successor patient advocate(s); may include preferences for medical and/or mental health care.	Do Not Resuscitate (DNR) order for outside of the hospital, can be used as guidance in acute care.	Specific medical orders - may include: • Full Code with Full Treatment. • DNR with 3 Treatment Options including Comfort, Selective, or Full. • Additional orders.
Does it expire?	No.	No.	Yes, after 12 months (may be reaffirmed).
Must it be on special paper/color?	No. Copies: electronic, paper, and photo are acceptable.	No. Copies: electronic, paper, and photo are acceptable – individual county Medical Control Authority (MCA) may have specific requirements.	Yes, document must have pink border. Copies: electronic, paper, and photo are acceptable.
Witnessing requirements	2 adults, cannot be listed as patient advocate, family members, healthcare, or mental health facility employees where patient receives care, or employee of a life or health insurance provider, heir, or presumptive heir.	2 adults, if patient or patient advocate signs, at least one of whom is not a spouse, family member, or presumptive heir. If signed by patient's guardian, neither can be a spouse, family member, or presumptive heir.	Not required.
Is this actionable medical order by EMS?	No.	Yes.	Yes.

Appendix

Scenario 1: Edward

Scenario 1

Edward

Edward is a 78-year-old with congestive heart failure (CHF) who has been hospitalized 3 times over the past 6-months due to shortness of breath.

Edward is the primary caregiver of his wife, Betty, who has dementia and while hospitalized, Edward becomes frustrated being unable to attend to her needs.

Edward's Primary Care Provider (Nurse Practitioner) indicates that his CHF has progressed and acknowledges that he does not want to endure repeated hospitalizations.

Given this information, Edward's nurse practitioner talks with him about the MI-POST form. In partnership with his nurse practitioner, Edward completes the MI-POST form to indicate do-not-resuscitate and comfort-focused treatment. The diagnosis supporting the MI-POST is CHF.

Edward's decisions are now written in a portable medical order that serves to avoid unnecessary hospitalizations and aggressive medical interventions that he believes would only cause more pain and suffering.

Scenario 1: Edward's MI-POST in practice

Scenario 1

Edward

A few months after the execution of Edward's MI-POST with his attending health professional, his nurse practitioner, Edward is at home and experiences shortness of breath and must call emergency medical services.

EMS arrive at Edward's home; he is nonresponsive and unable to express his wishes. In line with MDHHS' recommendations, Edward's MI-POST is posted on his fridge, so EMS professionals view the MI-POST immediately upon entry to the home.

MI-POST professionals must review Edward's 'diagnosis supporting the MI-POST' and in real-time determine if Edward's shortness of breath that has advanced to unresponsiveness is connected to CHF. EMS professionals are unable to determine and transfer Edward to an ED where he receives treatment that is not in-line with his wishes.

In practice, the Michigan MI-POST is not structured to support the realities of end-of-life care. In this scenario, EMS providers were unable to determine if his shortness of breath is connected to his diagnosis of CHF and defaulted to full treatment, including CPR.

Tracking progress:
2. Enhance health data utility

INITIATIVE: Enhance health data utility	Lead	Status				
		Plan	Build	Implement	Evaluate	Improve
2A: Build on the success of health information exchange in Michigan	MDHHS/MiHIN			→		
2B: Promote standards and secure infrastructure	MDHHS/MiHIN			→		
2C: Build data exchange that is consumer-centric and mediated by each resident	MDHHS/MiHIN			→		

MiHIN Update

Health Information Technology Commission

2024 Q3 Meeting

08.27.2024

Kim Bachelder

Director, State Accounts

MiHIN

MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

FY24 MiHIN Projects

Supporting Initiative 2: Enhance Health Data Utility

- Emergency Medical Service Use Case
- Tobacco Free
- Integrated Care Bridge Record
- Medical Examiner

FY24 MiHIN Projects

Supporting Initiative 4: Improve Onboarding & Technical Assistance

MDHHS Dashboard

First Phase - *Complete*

- MiHIN utilizes an inventory of current use cases and the # of facilities signed on. The data is used to develop a baseline for use case prioritization.

Second Phase – *In Progress*

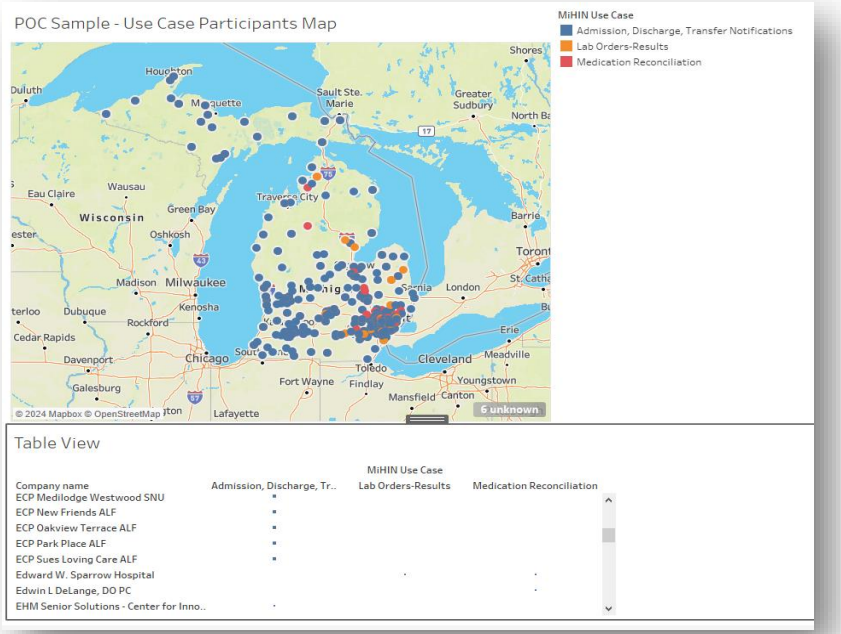
- Automation of the MDHHS version of the dashboard

Ongoing Maintenance and Enhancements

- Maintain data on current use cases and those in-pilot

Enable enhancements as needed

Public Facing Dashboard



FY24 MiHIN Projects

Supporting Initiative 5: Protect Public Health

- Maintenance of Public Health Reporting Use Cases
- MiGateway use for Public Health
  - Health Associated Infections
- Local Health Department Outreach

FY24 MiHIN Projects

Supporting Initiative 6: Adopt Standards for Social Care Data Fields

- Social Determinants of Health (SDOH) Screening Use Case
- Interoperable Referrals Use Case
- Community Information Exchange (CIE) Advisory Committee

THANK YOU

LET'S CONNECT

mihin.org

@MiHIN

linkedin.com/company/mihin

Tracking progress:
3. Address Michigan's digital divide

INITIATIVE: Addressing the digital divide	Lead	Status				
		Plan	Build	Implement	Evaluate	Improve
3A: Support digital connectivity efforts	MiHI/MDHHS		→			
3B: Pursue strategic partnerships that enable greater federal, state, and private investments in connectivity	MiHI/MDHHS		→			

Tracking progress:
4. Improve onboarding and technical assistance

INITIATIVE: Improving onboarding and technical assistance	Lead	Status				
		Plan	Build	Implement	Evaluate	Improve
4A: Sponsor onboarding at higher levels of statewide leadership	MDHHS		→			
4B: Support the continued implementation of telemedicine	MDHHS		→	→	→	

Tracking progress:
5. Protect public health

INITIATIVE: Protect public health	Lead	Status				
		Plan	Build	Implement	Evaluate	Improve
5A: Accurate and timely information in public health systems	MDHHS/MiHIN					
5B: Support quality improvement of resident care	MDHHS/MiHIN					
5C: Bolster public health preparedness systems	MDHHS					

Tracking progress: 6. Social care data

INITIATIVE: Social Care data	Lead	Status				
		Plan	Build	Implement	Evaluate	Improve
6A: Develop policies to accompany new standards that promote easy sharing of social care information	MDHHS		→			
6B: Support systems that promote better coordination and integration of services	MDHHS / MiHIN		→	→		

CIE Task Force Report

The CIE Task Force identified the following domains that support effective implementation of community information exchange:

- Capacities for Data Exchange
- Resource Directory Information Capacities
- Longitudinal Data Aggregation Capacities
- Legal and Ethical Framework
- Coordinating Entities Capacities
- Governance
- Sustainability

CIE Task Force Final Report

Health IT Commission - CIE Advisory Committee

The CIE Advisory Committee is tasked with developing a proposal for state-wide governance of CIE to establish baseline policy, standards, and core infrastructure, leveraging to the extent possible existing infrastructure in Michigan, in alignment with the recommendations of the CIE Task Force.

1. Develop strategies to facilitate adoption of national social care data interoperability standards for data exchange
2. **Establish statewide standards and protocols for CIE design and implementation, use cases, protocols for informed consent, and evaluation procedures to ensure equitable outcomes**
3. Recommend a baseline architecture for cross-sector identity matching (leveraging existing infrastructure)
4. **Propose mechanisms to enforce the rights of consumers and CIE participants, through formal representation of affected parties in governance processes, iterating on the established Consumers Bill of Rights**
5. **Identify any statutory and regulatory barriers to the implementation of CIE and, subsequently, establish a baseline policy framework for collection, exchange, and use of data in contexts not already governed by HIPAA, FERPA, or 42 CFR p2, along with a corresponding common structure for legal agreements**
6. Establishing minimum standards for Coordinating Entities
7. Provide guidance to the implementation of pilots in alignment with the CIE Task Force recommendations.
8. Provide learnings to ONC, FTC, and CMS to help guide development of national standards and policies

https://www.michigan.gov/mdhhs/doing-business/commissions-boards/hitcomm/hitcommlinks/committee-information

Social Care Data Governance Evolution: FY25 Priorities

Social Care Data Governance Workgroup developed initial governance recommendations by topic area:

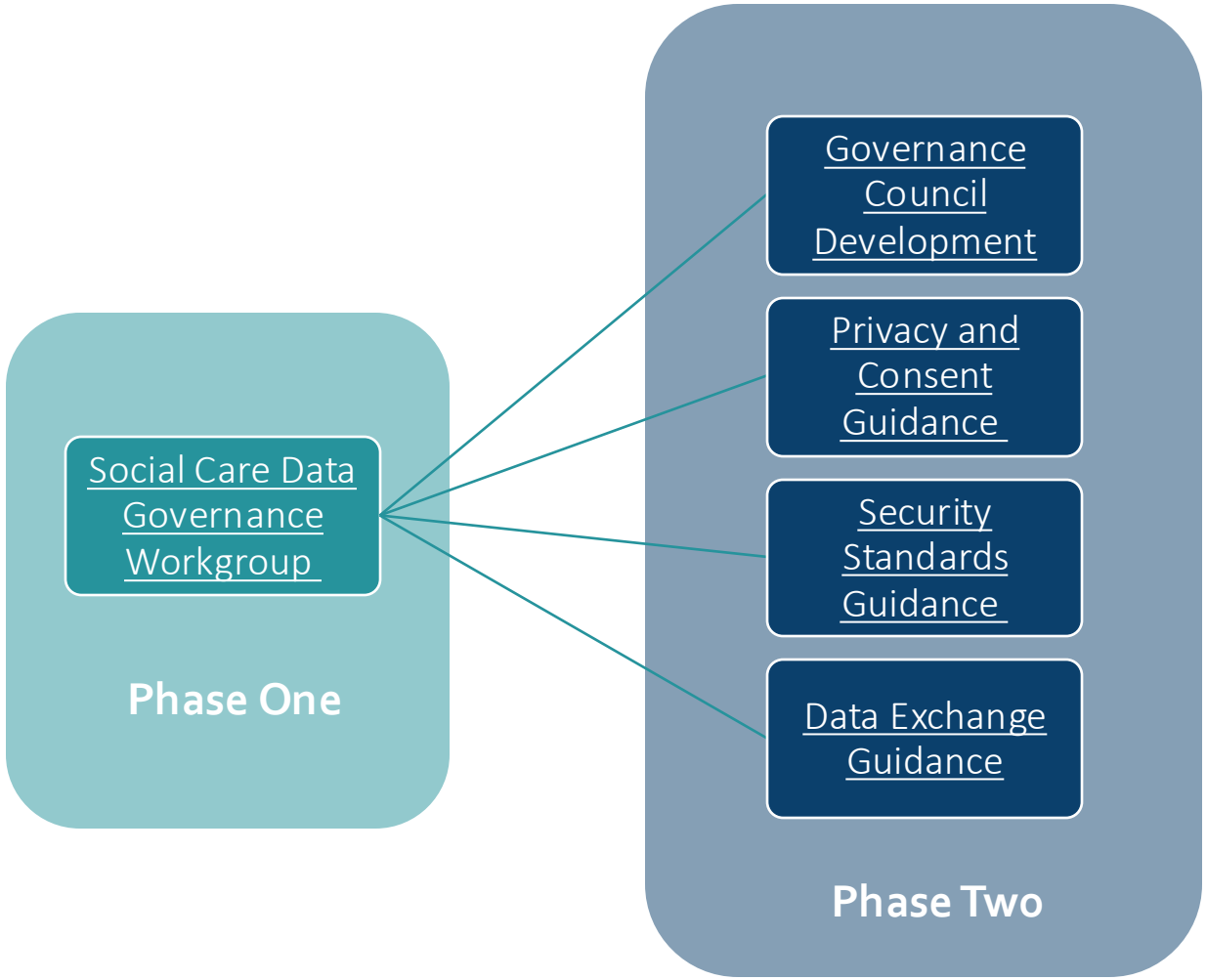
CIE Governance Council
Over the next two fiscal years, the Governance Council will establish itself and three subcommittees.

- Subcommittee recommendations align with peer states and anticipated CIE certification priorities

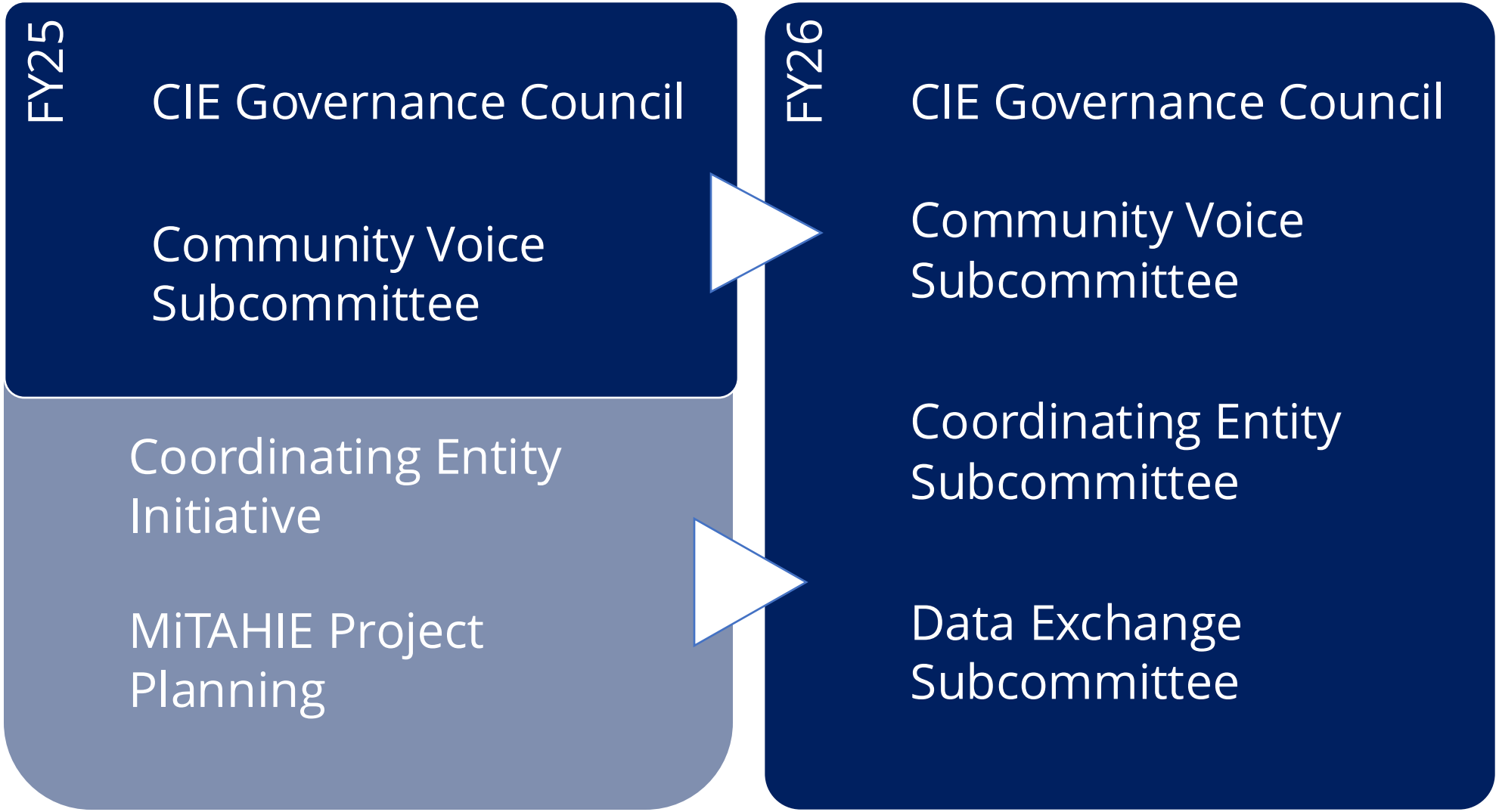
Privacy and Consent Guidance
Initial guidance will be co-designed with local/regional leaders to move toward a standardized consent process.

Security Standards Guidance
Initial guidance will be complemented by DTMB resources and capacity building.

Data Exchange Guidance
Initial regulatory landscape assessment will be continued through the MiTAHIE Planning Project.



Proposed Governance Structure



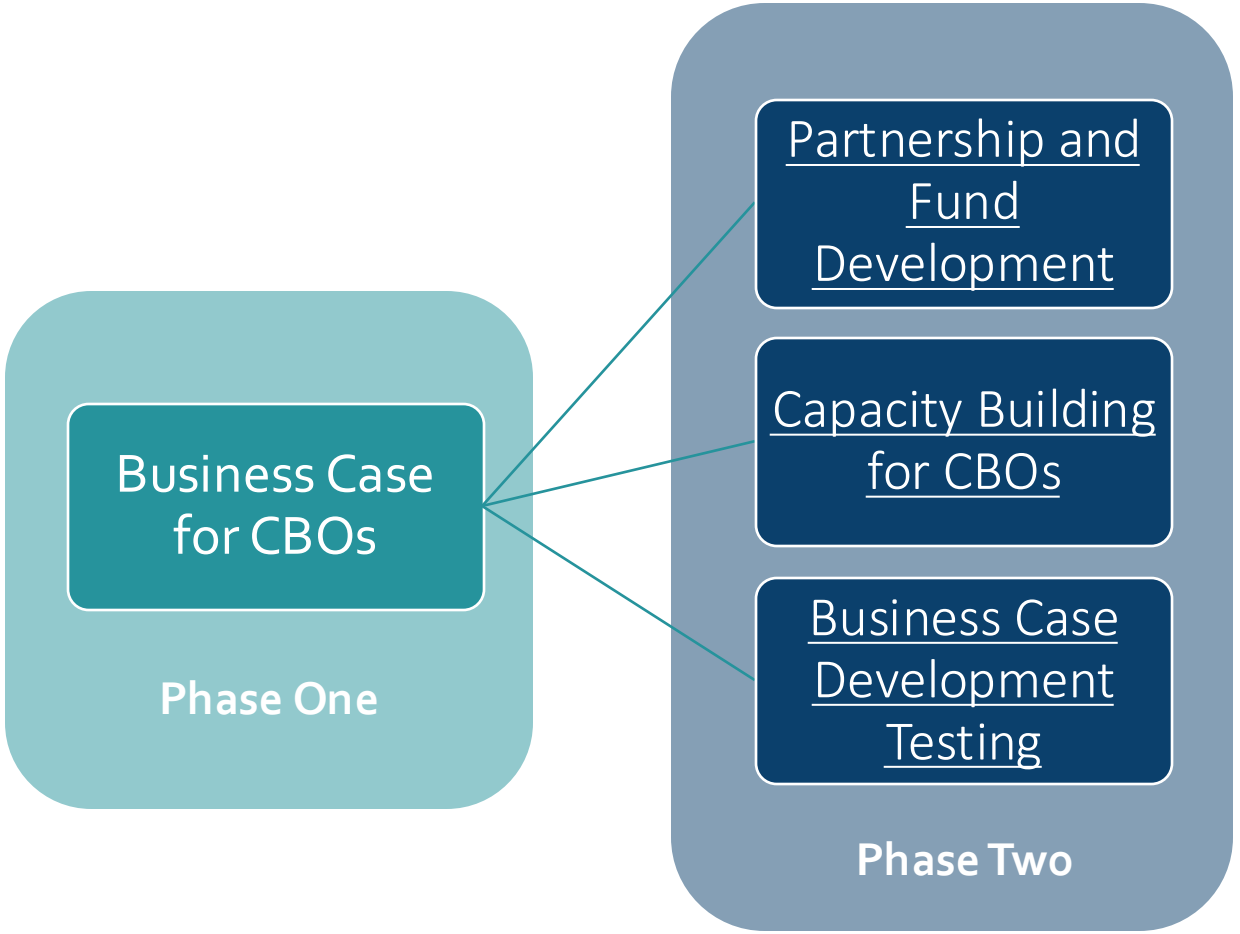
Business Case for CBOs Evolution: FY25 Priorities

The Business Case for CBO Workgroup focused discussions on sustainable business models that decentered healthcare needs:

Partnership and Fund Development
The Business Case template surfaced the need for clear value propositions and returns on investment (both quantitative and qualitative).

Capacity Building for CBOs
The social service sector has been under-resourced for far too long. Building capacity for CIE in meaningful ways requires a deep understanding of the social service sector itself.

Business Case Development Testing
The workgroup developed a co-design process that integrates the business case template with data process flow and user stories.



Additional Initiatives Evolution: FY25 Priorities

CIE Professional Learning Community

Phase One

- Launched May 2024
- Monthly peer-to-peer learning space
- Total attendees to date: 40+
- Co-design CIE Micro-toolkit

Phase Two

- Invite CIE PLC members into CIE AC community engagement work
- Cont. co-design CIE Micro-toolkit
- Elevate learnings of on-the-ground CIE partnerships

Coordinating Entity Working Group

Phase One

- Seven session series (May 2024 – June 2025)
- Begin to develop shared definition of coordinating entity or hub

Phase Two

- Finalize coordinating entity endorsement program (levels, types)
- Finalize recommendations for state-level monitoring, data analysis

New Initiatives in FY25: Michigan Technical Assistance for Health Information Exchange (Planning APD)

Overview

- MDHHS received approval from CMS for a one-year planning period to develop statewide structured technical assistance and training for health and social care providers to better serve Medicaid beneficiaries.
- All project activities will: 1) strengthen data collection and conformance standards, including race and ethnicity data collection practices that align with new federal standards; and 2) expand IT infrastructure and data exchange capacities.

Proposed Solutions

- Create and adopt standards to guide the exchange of social care data, including legal and use case framework; statewide guidance for all data sectors; and standardized social care data fields
- Develop and deploy Regional Extension Centers to assist SNFs, FQHCs, RHCs, local government, community-based organizations, and others by providing technical assistance and training in the standards and exchange of health-related social needs (HRSN) data

New Initiatives in FY25: Community Engagement

- Moving to action
  - Shared messaging
  - Community dialogues
  - In-person events

4. Discussion/Action Items

Led by: HITC Chairs

5. Public Comment

Led by: HITC Chairs

MEDICATION MANAGEMENT INTEROPERABILITY IN MICHIGAN

SUMMARY OF FINDINGS

Published August 2024 by the

Michigan Health Information Network Shared Services

Contents

Abstract

Michigan Health Information Network Shared Services (MiHIN)—as the state-designated entity for health information exchange and a lead entity in Michigan's five-year Health Information Technology (HIT) Plan — is taking the lead in understanding the current obstacles impeding the sharing of an accurate list of patients' medications between care providers, and comprehensive, timely medication reconciliation. This report details what MiHIN learned over the past year while exploring the potential for health information exchange (HIE) to enable medication interoperability processes for all providers and patients throughout Michigan.[1]

Following several months of assessment and planning, MiHIN hosted a three-part workshop series. Between January and April 2024, a diverse and changing array of stakeholders were engaged three times to produce a landscape analysis of the major challenges impeding timely medication reconciliation today and identify the priority needs of Michigan healthcare professionals for more timely and accessible medication information. This workshop series provided a platform for the community, health consultants, pharmacists, providers, and leaders from hospital systems, skilled nursing facilities, the payer community, and others to share their professional perspectives on capturing, accessing, and utilizing patient medication information.

This document contains the following:

- A statement outlining MiHIN's role in the State of Michigan
- Necessary context around medication reconciliation, its purpose, and challenges that impede it
- An outline of the MiHIN workshop series' goals and a related list of participating organizations
- A compilation of the key workshop series takeaways
- A list of identified potential solutions that could facilitate medication reconciliation
- MiHIN's hope is that the Michigan Department of Health and Human Services (MDHHS) and the HIT Commission utilize these findings and consider support for the potential solutions in their ongoing efforts to improve Michigan's Health Information Technology landscape.

Author Attributes

The primary authors of this document include the following professionals:

Name	Organization	Title
Isabell Pacheco, DSc, FACHE	MiHIN	Chief Administrative Officer
Shelby Denhof, PMASI	MiHIN	Business Development Specialist
Allen Flynn, PhD, PharmD	University of Michigan	Director of the Master of Health Informatics Degree Program, School of Information

[1] *Michigan Department of Health and Human Services. (2022, June). Michigan Health IT Roadmap "Bridge to Better Health" Report. Health Information Technology Commission. https://www.michigan.gov/mdhhs/doing-business/commissions-boards/hitcomm*

James Stevenson, PharmD	University of Michigan	Former Chief Pharmacy Officer, University of Michigan Health System; Professor Emeritus, University of Michigan School of Pharmacy
Eric Roath, PharmD, MBA	Michigan Pharmacists Assocation	Director of Governmental Affairs

This document conveys many important ideas shared by workshop series participants. See Appendix A for a complete list of participants in the workshop series.

Overview of the Michigan Health Information Network Shared Services (MiHIN)

MiHIN is Michigan's non-profit, statewide entity that legally, technically, and securely provides critical and comprehensive patient information to its network of care providers. This network comprises doctors, clinics, federally qualified health centers, hospitals, pharmacies, health insurance providers, public health, and more. MiHIN serves its network of participants by providing an interoperable digital fabric designed to facilitate statewide connectivity between all the entities responsible for the health and wellness of their patients, clients, and members.

In short, MiHIN builds the technical and legal infrastructure—a critical foundation needed for a Health Data Utility— that ensures the availability of data and information where and when needed to improve care coordination and inform clinical decision-making at the patient and population levels.
MiHIN's stakeholders find value in the meaningful exchange of health data at every level of the healthcare ecosystem. This is because clinical needs drive MiHIN's developed technology. To understand the landscape around particular health topics, MiHIN convenes relevant stakeholders to share their perspectives. MiHIN uses community and clinical insights to shape future technologies that will meet care team needs and allow equitable, high-quality care to flourish.

Alignment

Increasing Interoperability for better medication management— and especially to facilitate accurate and timely medication reconciliation— directly supports the Michigan Health IT Roadmap. Under the umbrella of enhancing health data utility, initiative 2C-2 states, "Prioritize use cases that protect patient safety (advance directives, timely medication information, ID management)." [2] MiHIN presented a summary of its medication management interoperability findings, challenges, potential solutions to the Michigan Health Information IT Commission on May 14th, 2024.

There is a clear and longstanding consensus among healthcare organizations and regulatory bodies regarding the importance of effective medication reconciliation in promoting patient safety and quality of care. The following organizations have issued policy statements calling for improvements in medication reconciliation: the American Medical Association, the American College of Emergency Physicians, the Institute for Healthcare Improvement, the American Society for Health-System

[2] *Michigan Department of Health and Human Services. (2022). CY2022 Bridge to Better Health Report. Retrieved from https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Doing-Business-with-MDHHS/Boards-and-Commissions/Health-Information-Technology-Commission/CY2022-Bridge-to-Better-Health-Report_Adopted_Final-Aug22.pdf?rev=4dd6bf50a4d24d71a049c15f7032b524*

Pharmacists, the Centers for Medicare and Medicaid Services, the Joint Commission, the World Health Organization, the Agency for Healthcare Research and Quality, and others.

Medication Reconciliation: Context

Definition

One of the most challenging aspects of ensuring safety while improving health outcomes with medications is ensuring that accurate information about a patient's medication use is available across the healthcare continuum. Maintaining an accurate and up-to-date list of the medications every patient actually uses is essential to providing optimal care, as medication regimen changes occur regularly. So that care plans are properly informed, the medication reconciliation process has been developed to identify the most accurate list of medications each patient takes at a given moment in time.

Medication reconciliation involves listing, validating, evaluating, and documenting a comprehensive list of medications a patient currently takes, including prescribed and over-the-counter (OTC) medications, nutritional supplements, and other remedies.

Purpose

Medication reconciliation surfaces and clarifies each person's full spectrum of medication use for the purpose of providing the critical information needed to avoid common medication errors, especially duplicative drug therapies, incorrect dosages, drug interactions, and failure to restart intended medication therapies after procedures or hospitalizations.

Improved medication reconciliation can enhance care quality and reduce healthcare costs:

- A 2023 study, approximately 94% of patients had at least one medication history error identified and resolved by pharmacy staff; approximately 1 in 4 of the reported errors could have resulted in serious of life-threatening patient harm.[3]
- A study to minimize medication history errors in high-risk patients demonstrated 7.4 history errors on average per patient.[4]
- A 2021 study shows that 16% of hospital readmissions within 30 days of discharge are medication-related, of which 40% are potentially preventable.[5]
- Systematic reviews indicate that by minimizing discrepancies in medication records and ensuring accurate medication lists, healthcare providers can decrease the likelihood of adverse events and subsequent healthcare utilization, resulting in cost savings.[6]

[3] Tu, T., Stephens, S., Bajorek, S., Leang, D., Nguyen, D., & Shane, R. (2023). Preventing medication history errors in high-risk patients: Impact of California Senate Bill 1254. American journal of health-system pharmacy : AJHP: official journal of the American Society of Health-System Pharmacists, 80(9), e104–e110. https://doi.org/10.1093/ajhp/zxad038

[4] Pevnick, J. M., Nguyen, C., Jackevicius, C. A., Palmer, K. A., Shane, R., Cook-Wiens, G., Rogatko, A., Bear, M., Rosen, O., Seki, D., Doyle, B., Desai, A., & Bell, D. S. (2018). Improving admission medication reconciliation with pharmacists or pharmacy technicians in the emergency department: a randomised controlled trial. BMJ quality & safety, 27(7), 512–520. https://doi.org/10.1136/bmjqs-2017-006761

[5] Uitvlugt, E. B., Janssen, M. J. A., Siegert, C. E. H., Kneepkens, E. L., van den Bemt, B. J. F., van den Bemt, P. M. L. A., & Karapinar-Çarkit, F. (2021). Medication-Related Hospital Readmissions Within 30 Days of Discharge: Prevalence, Preventability, Type of Medication Errors and Risk Factors. Frontiers in pharmacology, 12, 567424. https://doi.org/10.3389/fphar.2021.567424

[6] Mueller, S. K., Sponsler, K. C., Kripalani, S., et al. (2012). Impact of medication reconciliation and review on clinical outcomes. Annals of Pharmacotherapy, 46(12), 1746-1755.

National Trends

Performing medication reconciliation effectively is very difficult and time-consuming because of the fragmented U.S. healthcare system. Sources of information about patient medication use exist in many places, including e-prescribing systems, clinic and hospital EHRs, physician office records, and pharmacies. Unfortunately, none of these sources are consistently complete or accurate. Instead, each source generally has limited information about patient medication use. Patients often see many different providers, but each provider may only have records of what they prescribe. Further, patients often obtain medications from multiple pharmacies, but most pharmacies only have records of the prescriptions they receive and drug products they subsequently dispense.

Another challenge is that patients can be unreliable reporters of their own medication use due to cognitive impairment, the complexity of their drug regimens, or medication name confusion. Moreover, the use of OTC medications and supplements is often missed during medication reconciliation, especially when too little time is spent in direct dialog with patients or their home caregivers. Besides OTCs, sometimes low-cost prescription medications may also not be identified and listed during medication reconciliation if patients pay in cash and insurance claims are not generated. Additionally, Federally Qualified Health Centers and Veterans Affairs utilize systems that don't interact with common e-prescribing systems.

HIE and Medication Reconciliation

Currently, Nebraska may make the best use an HIE on a statewide basis to improve safety and medication use outcomes via medication reconciliation. The Nebraska Prescription Drug Monitoring Program (PDMP) operates under the authority of Nebraska Revised Statutes §§ 71-2454 through 71-2455.[7] Uniquely, Nebraska's PDMP collects all prescription drug product dispensation data from every Nebraska pharmacy, not just the dispensation of controlled substances. Jointly administered by the Nebraska Department of Health and Human Services (DHHS) and CyncHealth (Nebraska's Health Data Utility), the Nebraska PDMP offers a medication query functionality accessible to all prescribers and dispensers in the state without cost to providers.[8]

On May 8th, 2024, MiHIN staff interviewed Craig Reha, PharmD, BCPS at Nebraska Medicine, to learn more about Nebraska's comprehensive dispensed medication information. According to Reha, most Nebraska pharmacists and other providers access the PDMP portal through CyncHealth. He noted that compiling medication dispensation information does make medication reconciliation easier. Currently, the Nebraska PDMP includes the medication dispensed, the date of dispensing, and the quantity dispensed. Nebraska is working to improve the quality of the medication dispensation data coming from its pharmacies so that all records will also include the instructions for use associated with each prescription.

[7] Nebraska Legislature. (n.d.). Nebraska Revised Statute 71-2454. Retrieved from https://nebraskalegislature.gov/laws/statutes.php?statute=71-2454

[8] Nebraska Department of Health and Human Services. (n.d.). PDMP Submitter User Guide [PDF file]. Retrieved from https://dhhs.ne.gov/DOP%20document%20library/PDMP-Submitter-User-Guide.pdf

In summary, what makes Nebraska unique is that the state passed legislation to collect all dispensation data for all medications from pharmacies throughout the state, and Nebraska is utilizing its HIE to make this dispensation record for each patient accessible to care team members and facilitates the process of accessing an accurate medication list.

Here in Michigan, MiHIN is strategically positioned with its technical and legal infrastructure to support the collection of medication prescription and dispensation data, and the additional provider information needs are identified in MiHIN's medication reconciliation workshop series (see below).

Workshop Series Overview

Goals and Objectives

Over the course of four months—and in partnership with the University of Michigan and Michigan Pharmacists Association-- MiHIN convened a wide and diverse range of stakeholders across Michigan in a series of three six-hour workshops to understand the current, complicated landscape of medication reconciliation and work to develop possible solutions. The objectives of these workshops were the following:

- Summarize the current obstacles to compiling, accessing, and sharing information detailing patient medication use
- Identify possible tools and solutions to make the medication reconciliation process more complete, efficient, timely, and effective for all providers and the patients they serve

Workshop Dates and Locations

- January 24th, 2024 | Lansing, Michigan
- February 22nd, 2024 | Detroit, Michigan
- April 18th, 2024 | Lansing, Michigan

Participating Organizations

60 individual professionals participated in the workshop series. Excluding MiHIN staff, 18 professionals attended at least two of the three workshops. Participants provided insight from the following sectors and organizations. See Appendix A for a complete list of participants.

- Michigan Pharmacists Association
- MDHHS
- Community Pharmacists
- Health-System Pharmacists
- Consultant Pharmacists
- Pharmaceutical Manufacturers
- Physican Organizations
- Health Information Technology Commission
- Commercial Health Plans
- Health Information Networks
- Technology Vendors
- Skilled Nursing Facilities
- Emergency Services
- Hospital Systems
- Healthcare Providers

Key Workshop Takeaways

Major Challenges

Through this workshop series, pharmacists, physician organizations, payers, technology vendors, and others across Michigan's healthcare ecosystem identified common themes related to medication reconciliation challenges.

Michigan stakeholders confirm that medication reconciliation is currently not as efficient, comprehensive, or effective as it could be at preventing errors due to many obstacles, including:

- **There is no single source of truth for medication use information.** Rather, as noted above, information about a patient's medication use is fragmented and exists in many places.
- **Medication use changes are frequent and many**. Maintaining an accurate, up-to-date list of each patient's medications requires the ability to keep up with new prescription and dispensation transactions every day.
- **Medication reconciliation is complex and time-consuming,** yet in some cases, providers and pharmacists are not financially incentivized to prioritize this process, and in other cases, providers are unaware of billing codes that could be documented to compensate them for time spent doing this process.
- **No one person or entity is responsible for medication reconciliation.** Rather, all providers are expected to do medication reconciliation in the absence of sufficient information. A lack of clearly defined roles can cause overlaps or gaps within a patient's care team.
- **The results of performing medication reconciliation are not accessible to all care team members.**
  - For example, individual hospitals may incorporate medication reconciliation into workflows to improve safety and reduce readmissions, but the results of the process are accessible only to hospital staff.
  - Pharmacists increasingly provide insured outpatients with Medication Therapy Management (MTM) services that incorporate the medication reconciliation process, but the results and recommendations from pharmacists are not shared in a seamless, accessible manner. This frequently results in the products of these services never being integrated by the patient’s primary care team.
- The results of performing medication reconciliation often include questions needing to be answered and issues needing to be addressed.
  - Because medication reconciliation can and does surface potential problems with medication use, workshop participants emphasized that the results of medication reconciliation are often interim results that come with a list of pending questions and issues still to be sorted out and finally resolved.

Key Needs

In addition to the clear challenges above, there was also consensus from stakeholders working with patients around some shared needs:

- Providers need an **accessible platform for care team members to view prescribed and dispensed medications from myriad sources.** Such a platform would enable providers to establish more comprehensive patient medication lists. This platform should be well integrated within the workflow of various healthcare practitioners to facilitate the use of the information.
- **Pharmacists need access to patient medical records.** Very few community pharmacists can access institutional EHRs or patient longitudinal medical records. As a result, community pharmacists practice without access to essential information on diagnoses and indications for medication use, relevant lab results, treatment goals, etc. Pharmacists communicated that accessing relevant information in each patient's healthcare record would help them provide the best possible care.
- **Bi-directional electronic communication** between providers, pharmacists, and payers is needed to streamline care delivery, medication prescription review, and medication dispensing.
- Healthcare professionals are seeking **financial incentives** to help prioritize this time-consuming task. If financial incentives already exist, **further dissemination**, **communication, and education around current billing codes for this work** is needed.

Ranking of Potential Solutions

During the third workshop in the series, MiHIN staff presented the participants with six potential solutions brought forth from the earlier two workshops. The goal of the third workshop was for participants to rank the possible solutions from highest value to lowest value. After reviewing and discussing the six potential solutions as a group, participants engaged in two rounds of individual voting, ranking the potential solutions by importance and perceived feasibility.

Potential Solutions in Brief

#1 Highest Priority	A platform for viewing all known dispensations of prescription drug products from community pharmacies
#2 Priority	A platform for viewing all electronic prescriptions for prescription drug products
#3 Priority	A log of recent medication reconciliation procedures done with direct patient (or caregiver/family) involvement
#4 Priority	A log of the most recent medication-related treatment plans produced by care providers, including pharmacists, nurses, and providers
#5 Priority	A solution that shares relevant lab results with community pharmacists
#6 Lowest Priority	A solution that links current payer formulary, related drug product coverage, and copay information to current patient-level prescription drug insurance plan identifiers

Highest Priority Solution: The Med Rx Hub

The 'Med Rx Hub' is an informal shorthand name given to the two highest-ranked potential solutions for increasing the interoperability of medication information to facilitate medication reconciliation Conceptually, the Med Rx Hub is a platform that acts as a "single source of truth" where authorized care team members can view all prescribed and dispensed medications from myriad sources in Michigan for any given patient. Using the Med Rx Hub, more highly accurate and comprehensive lists of medications actually being used by patients can be established. MiHIN is uniquely positioned with the infrastructure and network needed to support the creation of the Med Rx Hub.

With this stakeholder feedback, MiHIN aims to create a Med Rx Hub for all Michigan providers connected to the MiHIN network. This service will maintain a running list of all known electronic medication prescriptions and all known community pharmacy instances of dispensed drug products to patients. Relying on e-prescribing data alone is flawed because some prescriptions that are written are never filled. The consensus from the workshop that the best source of information on dispensed prescriptions would need to come from the dispensing pharmacies. The Med Rx Hub will require broad submission of electronic prescription data from provider EHRs and pharmacy dispensation records from pharmacies. This platform would be viewable by MiHIN network participants.

Benefits

Having a centralized service such as the Med Rx Hub that collects and presents information about all prescribed and dispensed medications for patients from nearly every provider offers several benefits:

- **More Highly Comprehensive Medical Histories:** It would provide a nearly complete overview of a patient's medication regimen, helping healthcare providers make more informed decisions and avoid potential drug interactions or duplications.
- **Improved Coordination of Care:** Different healthcare providers often prescribe medications independently, leading to fragmented care. A centralized service could facilitate better coordination among providers by ensuring they have access to the same medication information.
- **Enhanced Patient Safety:** By reducing the risk of medication errors and adverse drug reactions through better oversight, such a service could improve patient safety and outcomes.
- **Increased Efficiency in Healthcare Delivery:** Streamlining medication management can save patients and healthcare providers time, leading to more efficient healthcare delivery and reduced costs. Having a nearly complete list will greatly improve the efficiency of the medication reconciliation process and make it more likely that healthcare practitioners will complete it.
- **More Data for Research and Analysis:** Aggregated medication data could be anonymized and used for research purposes, such as studying medication adherence patterns or evaluating the effectiveness of specific treatments.

Identified Dependencies and Considerations

Workshop participants identified the following topics are items to consider when designing the Med Rx Hub Use Case:

- It will be a challenge to connect all relevant entities. As examples, Federally Qualified Health Centers and Veterans Affairs utilize systems that generally don't interact with other e-prescription management systems.
- This solution will not capture over-the-counter medications or medications obtained through patient assistance programs unless there is a mechanism for providers to manually enter these to the Med Rx Hub.
- MiHIN's Med Rx Hub should display the dispensation timeframe.
- It would be advantageous for MiHIN's Med Rx Hub to display the last time a medication was confirmed by a patient or provider
- Switches (entities that route claims from the pharmacy to the plan/payer) may be a strong source of information.
- This use case will be of most use to providers and pharmacists if medications include directions such as use, quantity, days supply, refills, prescriber, fill data, and picked up data, including prescriptions delivered to the home.

Initial Steps for the Med Rx Hub

If MiHIN is able to secure funding to pursue an initial medication management interoperability solution along the lines of the Med Rx Hub, the initial steps towards realizing it include the following:

- Design, pilot, and implement a Med Rx Hub Use Case that supports receiving prescription and dispensation data from providers and pharmacies
- Design a solution for stakeholders to view patient prescription and dispensation data from the Med Rx Hub Use Case
- Enact outreach, communication, and education to providers and pharmacies broadly on connection to MiHIN via the Med Rx Hub Use Case

Additional Opportunities for Medication Management Interoperability

During the third and final workshop, participants indicated that the following services would enhance the baseline information access provided by Med Rx Hub. MiHIN aims to explore these opportunities further, but only after the initial Med Rx Hub Use Case and viewable platform are created and in use.

- **Patient-Confirmed Medications Service—**For the purpose of sharing the results of medication reconciliation with all of a patient's care team members, this service logs the facts and results of the following provider activities: medication history taking, Comprehensive Medication Reviews (CMRs), Medication Therapy Management (MTM) sessions, or other medication reconciliation procedures completed with direct patient or caregiver involvement (up to 5 most recent).

- **Provider Medication Therapy Plan Service**—This service documents the most recent medication-related treatment plans or plan updates produced by care providers, including pharmacists, nurses, and physicians (up to 5 most recent), to share care plans involving medication therapies with all care team members for a patient.
- **Share Relevant Labs Service**—To protect patients from harm and optimize the benefits of high-risk medications, this service leverages FDA-mandated Risk Evaluation and Mitigation Strategies (REMS) to define required lab results that must be checked and monitored for all drug products subject to REMS. The defined lab results are then consistently shared with community pharmacists and others so that they may better serve Michigan patients.
- **Enhanced Medication Formulary Service**—To help prescribers make prescribing decisions informed by patient insurance coverage and anticipated out-of-pocket costs, this service links current payer formulary, related drug product coverage, and copay information to current patient-level prescription drug insurance plan identifiers.

Medication reconciliation is a complex, multi-faceted challenge. Some combination of the items above may be needed to support and facilitate it.

Next Steps

MiHIN is eager to work alongside MDHHS and the Michigan Health IT Commission to create interoperability solutions that further the state's Health IT Roadmap goal of prioritizing use cases that enable timely medication information delivery to protect patient safety. MiHIN is excited at the opportunity of further partnership with MDHHS and the Michigan Health IT Commission to be one of the first states in the county working on statewide medication management interoperability solutions.
To further these initiatives, MiHIN is seeking funding sources and potential partners to develop a proof of concept.

Conclusion

MiHIN's stakeholder convenings provide insight and advice from professionals across the healthcare ecosystem. Stakeholders who participate in MiHIN workshops and other events share their perspectives and information needs, ultimately guiding technology solutions that improve health outcomes, increase efficiencies, and decrease healthcare costs. In this case, 60 professionals representing 37 diverse organizations attended one or more of the three medication reconciliation workshops in this series hosted by MiHIN during Winter – Spring 2024. This document outlines several solutions and describes one high-priority solution for improving the medication reconciliation process and making patient medication information more widely and easily accessible to Michigan's healthcare professionals.

MiHIN requests that MDHHS and the HIT Commission consider these findings in their mission to advance Michigan's Health IT landscape. MiHIN's initiative aligns directly with the state's goal of enhancing community health and wellness by providing vital resources and support to Michigan residents. We request funding support to amplify our efforts and ensure a broader, more impactful reach across the state.

Appendix A: List of Workshop Participants

Individual	Organization Name	Job Title
Paul Dobry	Ascension	Clinical Pharmacist
John Hillary	Avocare	Chief Financial Officer
Natalie Garcia-Foster	Avocare	Chief Operating Officer
Rp Garcia	Avocare	
Jacob Cooper	Bamboo Health	Senior Director, State Account Management
Jennifer Spear	Bamboo Health	Senior Channel Manager, External Affairs
Brad Whittle	BCBSM	Manager, HIE
Heather Stamat	BCBSM	Medical Director, Clinical Partnerships
Betty Chaffee	BetterMyMeds	Owner
Alyse Esquivel	Corewell Health	Medication History Technician
Ashley Blanchette	Corewell Health	Medication History Supervisor
Todd Raehtz	Indispensable Health	Pharmacist, CEO
Daniel Lane	Henry Ford Health System	Pharmacist
Julie A Lowry	JCMR doing business as CHTN and Henry Ford Health System	HIE Manager
Haley Winans	LARA - MI Automated Prescription System	Specialist
Kareen Knappins	McKenzie Health	RN Educator/Clinical IT Specialist
Andrea Phillips	McLaren	Care Coordination Director
Molly Welch Marahar	MDHHS	State Administrative Manager
Brian Brazda	Medical Advantage	SVP of Sales
Shelly Straw	Medical Advantage (PMC)	Practice Consultant
Andrew Kurecka	Medical Network One	Director of Innovation
Erica Ross	Medical Network One	Care Management Strategist

Mark Lazar	Medical Network One	Care Management Strategist
Ian Nagy	Meijer	Manager, Third Party Government Programs
Doug Miller	Wayne State University College of Pharmacy	Professor Emeritus
Cynthia Ochs	Michigan Medical Directors Association (MiMDA)	Physician, Medical Director for LTC/SNF
Eric Roath	Michigan Pharmacists Association	Director of Government Affairs
Dara Barrera	Michigan State Medical Society	Director, Health Quality, Equity and Technology
Helen Hill	MiHIN Board	Chairperson
Cheryl Huckins	MiMDA	President
Kimberley Diener	Munson Healthcare	Clinical Pharmacist
Sara Posey	Munson Healthcare	Systems Architect
Chelsie Methner	Northern Michigan Care Partners	PHO Sr System Analyst
Annaliese Brindley	Oakland Southfield Physicians	Director of Clinical Programs
Allison Brenner	Pfizer	Clinical Pharmacist
Mike Brenner	Pfizer	Medical Outcomes and Analytics
Hamad Husainy	PointClickCare	Chief Medical Officer
Pooja Babbrah	Point-of-Care Partners	Pharmacy and PBM Practice Lead
Loraine Stewart	Professional Medical Corporation	Practice Consultant
David Bach	Retired	Retired
Larry Wagenknecht	Retired	MiHIN Chairman of the Board
Jennifer Tucker	Shiawassee Health & Wellness	Behavioral Health Data Analyst
Grant Brown	Southwest Michigan Behavioral Health	Pharmacist & Advisor
Amy Ellis	Spartan Nash	Director of Pharmacy
Lisa Bade	Spartan Nash	Pharmacy Clinical Care Coordinator
Amy Pouillon	Spectrum Health	Clinical Specialist - Informatics
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