Michigan Health Information Technology Commission

May 2020 Update

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

HIT Commission May 2020 Update
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Federal Update from HIMSS

State & Federal Response to COVID-19 and ONC & CMS Final Regulations

Jeff Coughlin, MPP
Senior Director, Government Relations
May 20, 2020

Congressional Action to COVID-19

COVID #1 - Coronavirus Preparedness and Response Supplemental Appropriations Act

- Signed into law March 6, 2020
- Provided $8.3 billion in emergency funding for federal agencies to respond to COVID-19 pandemic
- Granted HHS Secretary waiver authority over 1834(m) originating site restrictions on telehealth
  - Allowed rural AND urban sites, and beneficiary's home, to serve as eligible originating sites
  - Required providers to have a Medicare-established relationship with beneficiary in previous 3 years

COVID #2 - Families First Coronavirus Response Act

- Signed into law March 18, 2020
- Focused on paid leave, free coronavirus testing, protection for public health workers, and expanded benefits for children and families
- Modified "Qualified Provider" language for Medicare telehealth services to allow required preexisting relationship to be established outside the Medicare program

COVID #3 - Coronavirus Aid, Relief and Economic Security (CARES) Act

- Signed into law March 27, 2020
- Over $2 trillion relief package focused on healthcare delivery, state & local funding, business and non-profit relief, and overall economic stimulus.
- **Provides financial relief, advanced reimbursement payments, and expanded telehealth flexibility**

COVID #3.5/4 - Paycheck Protection Program and Health Care Enhancement Act

- Signed into law April 24, 2020
- $484 billion package for the Paycheck Protection Program and Emergency Economic Injury Disaster Loan program, Hospital and provider payments, and COVID-19 testing

COVID #5, 6 - ???

1. *$377 billion*
   Small businesses, including Paycheck Protection Program (which ran out on April 16th and was replenished with the latest relief bill)

2. *$500 billion*
   Big business and at-risk industries (airlines, cargo, national security)

3. *$500-600 billion*
   Direct aid to individuals and families

4. *$340 billion*
   State and local governments

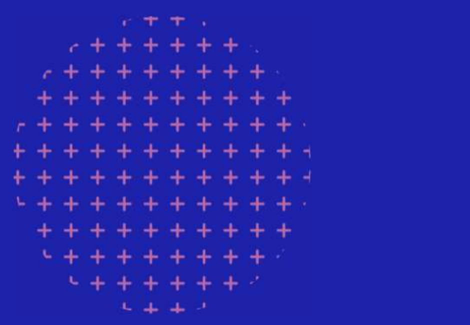
5. *$180 billion*
   Health and other public services

HIMSS

CARES Act - Key Healthcare, Health IT, and Funding Provisions

- **CDC Public Health Data Modernization -** Authorizes $500 million for public health data surveillance and infrastructure modernization efforts at the CDC, state, and local health departments
- **Public Health and Social Services Emergency Fund** – Provides $100 billion for our health system to prevent, prepare for, and respond to coronavirus, domestically or internationally
- **Coronavirus Relief Fund** - Provides $150 billion to States, Territories, and Tribal governments to use for expenditures incurred due to the public health emergency in the face of revenue declines
- **HRSA Grants -** Reauthorizes HRSA's grant programs that promote the use of telehealth, with at least 50% of the funds awarded for projects in rural areas
- **Medicare Telehealth Flexibilities -** Removes the requirement that a provider must have treated the patient in the past three years
- **Telehealth Distance Sites -** Allows Federally Qualified Health Centers and Rural Health Clinics to serve as a distant site for telehealth services during PHE
- **Federal Communications Commission** - Provides $200 million for the FCC to support the efforts of providers by providing telecommunications services, information services, and devices necessary to enable the provision of telehealth services

For additional takeaways, go to https://www.himss.org/news/cares-act-provisions-healthcare-and-health-it



Congress gave HHS all this new authority, but what does it all mean?

CMS Relaxes Requirements in Response to COVID-19 – Medicare Telehealth Changes

HHS Secretary Granted Waiver Authority over *all* 1834(m) restrictions. Starting on March 6, 2020 and lasting *for the duration of the public health emergency:*

- Geographic limitations are waived(urban and rural)
- Originating site restrictions are waived – any healthcare facility and patients home now eligible originating sites
- Providers can serve both new and established patients
- Added over 80 additional "telehealth services" that are eligible
- Audio-video requirements remain, but use of telephones that have both audio and video capabilities (e.g. smartphones) are allowed
- New billing rules pay telehealth services at same rate as in-person

Learn about other changes here: https://www.himss.org/news/telehealth-covid-19-spotlight and here: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Additional HHS Waivers and Flexibilities

- **HHS Office of Inspector General (OIG)**
  - Notified physicians that they will not be subject to administrative sanctions for reducing or waiving any cost sharing obligations federal health care program beneficiaries may owe for telehealth services furnished (Federal anti-kickback statutes)
    - Covers various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring
- **HHS Office of Civil Rights and HIPAA Requirements**
  - OCR will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that use platforms such as Skype and FaceTime for telehealth for the duration of the public health emergency
    - Must serve patients in good faith
- **In-State Telehealth Licensure Requirements**
  - In general, a provider must be licensed in the state where the patient is located at the time of treatment
    - CMS has waived this requirement for Medicare patients
    - States can request a Medicaid waiver from CMS

House of Representatives Passes $3 Trillion HEROES Act Relief Legislation on May 15th

- **Includes several healthcare-related provisions**
  - Serving as the starting point for House-Senate negotiations on the next relief package
- **Indian Health Service – $2.1 billion to address health care needs related to coronavirus for Native Americans, including**
  - $500 million to provide health care, including telehealth services
  - $140 million to expand broadband infrastructure and information technology for telehealth and EHRs
- **Health Resources and Services Administration**
  - $7.6 billion for Health Centers to expand the capacity to provide testing, triage, and care for COVID-19 and other health care services at approximately 1,000 existing health centers
- **Centers for Disease Control and Prevention**
  - $2.1 billion to support federal, state, and local public health agencies to prevent, prepare for, and respond to the coronavirus
- **National Institutes of Health**
  - $4.745 billion to expand COVID-19-related research on the NIH campus and at academic institutions
- **Public Health and Social Services Emergency Fund**
  - $100 billion in grants for hospital and health care providers to be reimbursed health care related expenses or lost revenue directly attributable to the public health emergency resulting from coronavirus
  - $75 billion for testing, contact tracing, and other activities necessary to effectively monitor and suppress COVID-19

State Level Activity in Response to COVID-19

Licensure Waivers for Telehealth

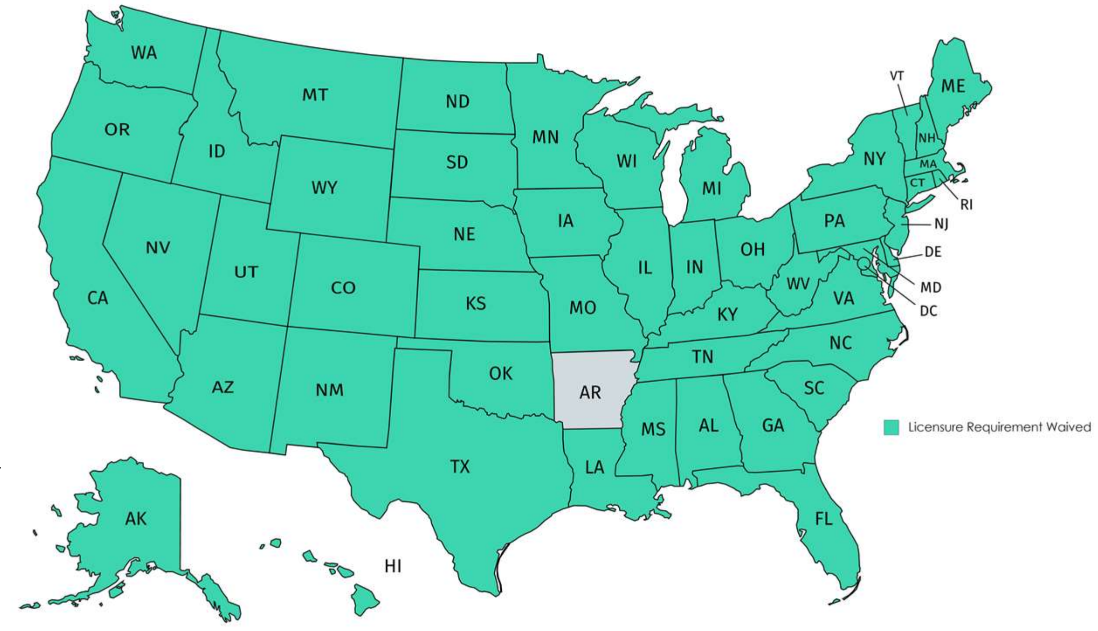
Before emergency declaration...

...49 states and D.C. required that providers delivering telehealth must be licensed in the state where the patient is located

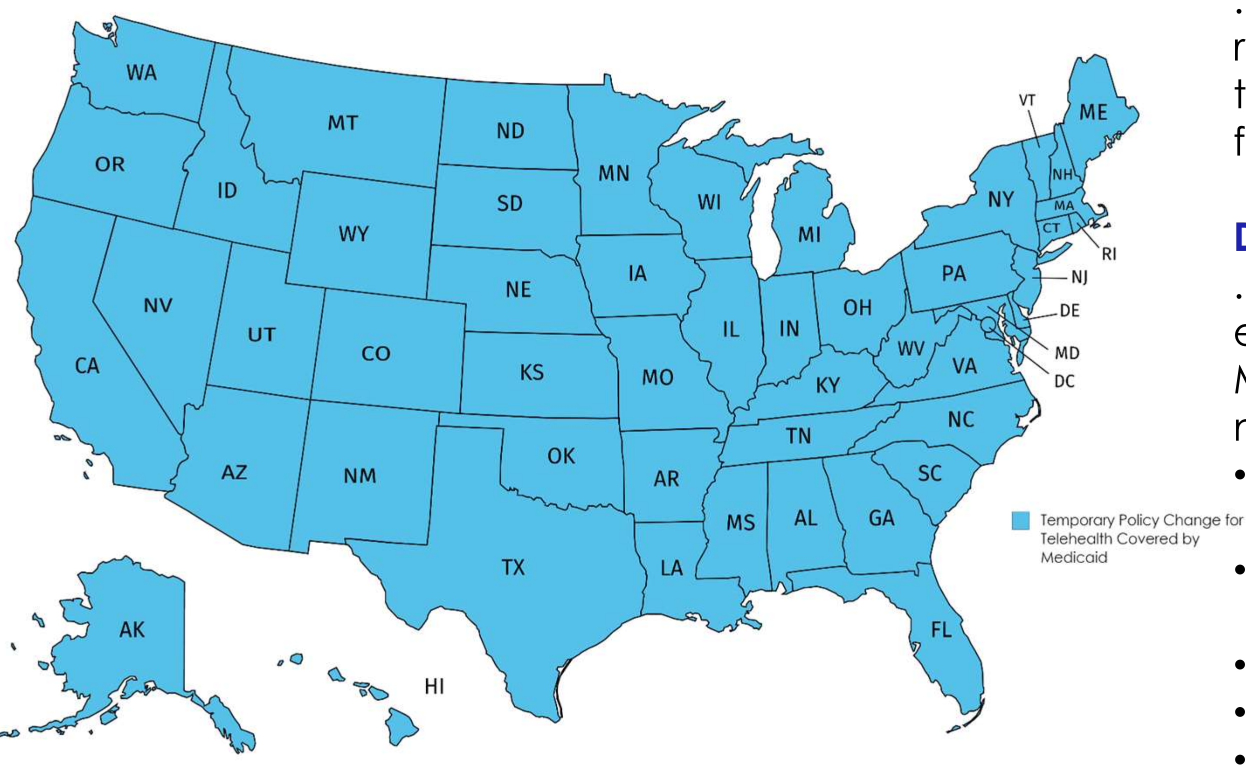
During declaration...

...49 states and D.C. (All except Arkansas) are temporarily waiving licensing requirements for telehealth, including one or more of the following:

- Providers can practice across state lines
- Process expedited to provide temporary licenses to qualified medical professionals



Medicaid Telehealth Policy Changes



Before the emergency declaration...
...all 50 states and D.C. provided reimbursement for some form of telehealth (i.e. live video) in Medicaid fee-for-service.

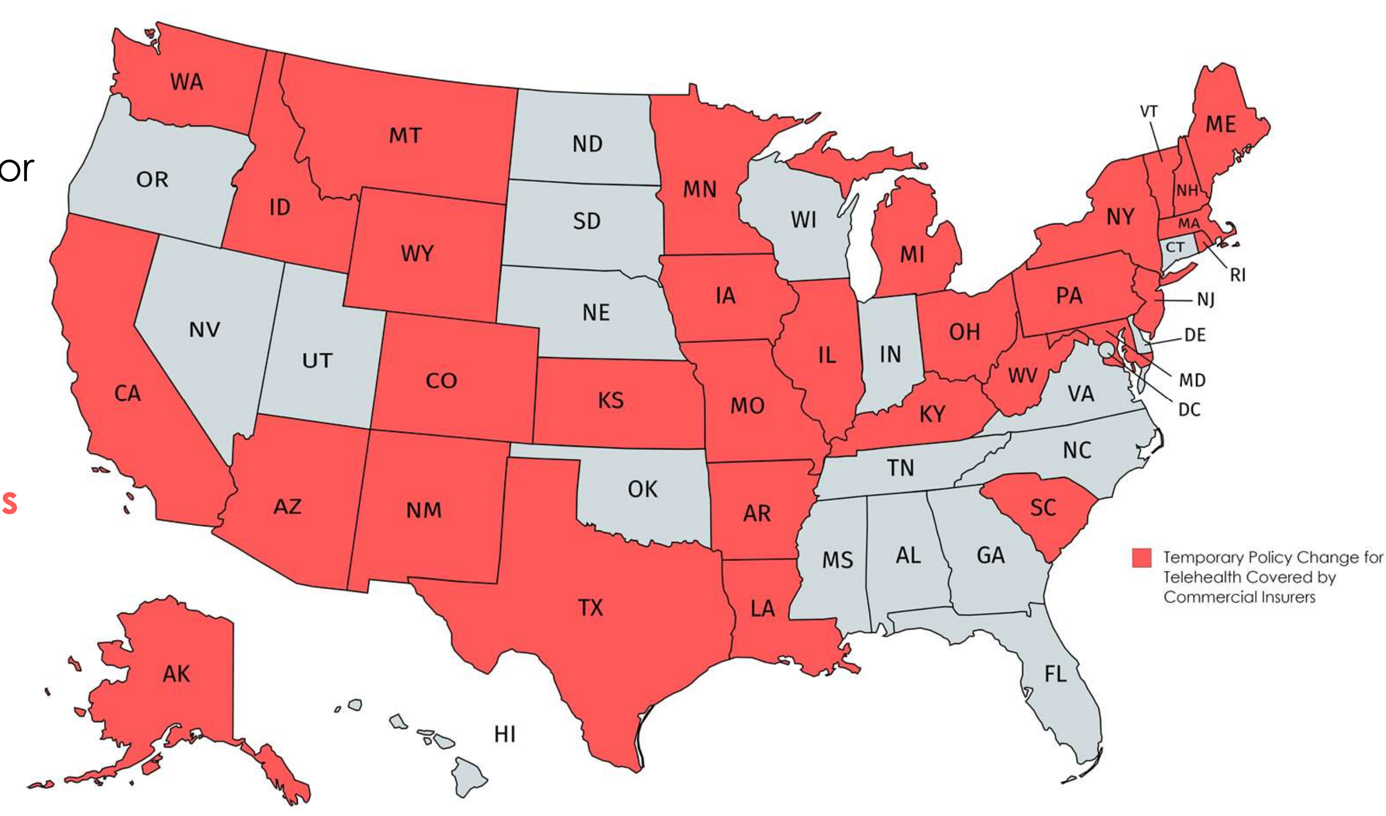
During the declaration...
... **All 50 states and D.C.** have temporarily expanded access to telehealth for Medicaid recipients. Includes one or more of the following changes:

- Patient can be at home (originating site)
- Payment parity between in-person and virtual
- Adding additional covered services
- Allowing for telephone without video
- Removing requirement of in-person initial appointment

Commercial Insurer Telehealth Policy Changes

Before declared emergency...
...40 states and D.C. govern commercial insurers. Other states can create guidances for telehealth services. Only six states allowed telehealth reimbursement to be equal to that of an in-person visit.

During declared emergency...
commercial insurers in **32 states** are increasing access to telehealth, on their own or through a government mandate.



HIMSS's ***Immediate State and Local Strategies for a Public Health Emergency***

- **Public health emergency preparedness and response plays an essential role in ensuring the health and strength of our communities during a pandemic**
- **Four Recommendations**
  - **Empower Electronic Case Reporting**
    - Leverage relief funding that supports eCR and that enables cross-jurisdiction sharing of notifiable condition reports as part of routine public health data submission and query
  - **Expand Telehealth Services**
    - All states should immediately scale-up telehealth services to reduce the number of individuals using healthcare facilities while at the same time preserving and improving health
  - **Strengthen Infrastructure**
    - Reinforce the data infrastructure by using current relief funding to prioritize syndromic surveillance, emergency and environmental data with clinical care documentation using standards-based platforms
  - **Utilize Health Data Sharing**
    - Leverage HIEs or cross-sector health data sharing platforms to collect data across sectors including electronic health record data, emergency room encounters, EMS data, or public health surveillance data

HIMSS COVID-19 Policy Resources

- CARES Act (PL 116-136) Health Provisions
- CARES Act- Support for Data Elemental to Health Campaign
- Telehealth in the COVID-19 Spotlight
- Remote Patient Monitoring: COVID-19 Applications and Policy Challenges
- States Tackling COVID-19 Using Information and Technology
- In Times of Crisis, HIEs are Front and Center
- Immediate State and Local Strategies for a Public Health Emergency

Final ONC and CMS Interoperability Regulations

Purpose of Interoperability Regulations

Increase Innovation and Competition
by giving patients and their health care providers safe and secure access to health information and to new tools, allowing for more choice in care and treatment

Reduce Burden and Advance Interoperability
through the use of United States Core Data for Interoperability (USCDI) standard, new API requirements, and EHI export capabilities for the purposes of switching health IT or to provide patients their electronic health information

Promote Patient Access
through a provision requiring that patients can electronically access *all* of their electronic health information (structured and/or unstructured) at no cost

Major Topics in the CMS Regulation

- **Changes to Conditions of Participation**
  - Medicare and Medicaid-participating hospitals required to send electronic notifications when a patient is admitted, discharged or transferred as part of their Conditions of Participation
- **Patient Access API**
  - Payers must share claims and other health information with patients in a safe, secure, understandable, user-friendly electronic format
  - Must make available adjudicated claims; encounters with capitated providers; and clinical data, including laboratory results
- **Payer-to-Payer Data Exchange**
  - At a patient's request, payers required to help coordinate care by exchanging the data elements specified in the data elements specified in USCDI v1 that ONC just finalized
  - Patients have up to five years after their coverage ends to submit a request to a payer to share their information
- **Provider Directory API**
  - Requiring payers to make standardized information about their provider networks available
  - At a minimum, these payers must make available provider names, addresses, phone numbers, and specialties
- **Public Reporting and Information Blocking**
  - Publicly report those providers that attested "no" to information blocking in Merit-based Incentive Payment System (MIPS)
  - Publicly report names and NPIs of those providers who do not have digital contact information included in the National Plan and Provider Enumeration System (NPPES) system

Major Topics in the ONC Regulation

- **Certification Program-Related Changes**
  - ONC sunsets the 2014 Edition and finalizes several changes to the 2015 Edition Cures Update, introducing some new certification criteria, revising existing certification criteria, and removing certification criteria
- **United States Core Data for Interoperability (USCDI v1) is adopted as a Standard in the ONC Cures Act Final Regulation**
- **Establishes specific API Conditions of Certification**
  - Focus on the practices developers of certified health IT should engage in, such as minimizing the "special effort" necessary to access, exchange, and use EHI via certified API technology
- **Definitions**
  - HIN/HIE Definition is merged
  - Data classes in USCDI v1 will define EHI during the initial 24-month period after implementation

Eight Exceptions for Reasonable and Necessary Activities

Exceptions for reasonable and necessary activities that do not constitute information blocking:

- ***Preventing harm***
  - Reasonable belief that the practice of not sharing EHI will directly and substantially reduce the likelihood of harm to a patient
- ***Privacy***
  - Practices that protect the privacy of EHI, based on sub-exceptions focused on scenarios that recognize existing privacy laws and privacy-protective practices
- ***Security***
  - The practice must be directly related to safeguarding the confidentiality, integrity, and availability of EHI
- ***Content and Manner***
  - Provides clarity and flexibility to actors on the required content (i.e., the scope of EHI) of an actor's response to a request to access, exchange, or use EHI, as well as the manner in which the actor may fulfill the request
- ***Fees***
  - Recover costs that reasonably incurred, in providing access, exchange, or use of EHI
- ***Infeasibility***
  - Declining to provide access, exchange, or use of EHI in a manner that is infeasible, and cannot fulfill the request due to events beyond the actor's control
- ***Licensing***
  - Licenses technologies that are necessary to enable EHI access on reasonable and non-discriminatory terms
- ***Health IT performance***
  - Health IT can be made temporarily unavailable in order to perform maintenance or improvements to the health IT, but for no longer than necessary

ONC and CMS Announce Enforcement Discretion for Interoperability Regulations

- **Period for enforcement discretion around implementation of the final interoperability regulations to provide all health system stakeholders with additional time to focus on addressing the COVID-19 Pandemic**
  - Agencies are allowing compliance flexibilities for many of the provisions
  - Regulations formally published May 1, 2020
- **Enforcement discretion covers certain parts of CMS Interoperability Regulation**
  - ADT Conditions of Participation extended by six months, to become effective May 3, 2021
  - Patient Access API and Provider Directory API policies to begin July 1, 2021
  - Other policies implemented and enforced on schedule
- **ONC effective date for many regulatory provisions comes 60 days later, or June 30, 2020**
  - Compliance occurs six months from its publication, or November 2, 2020
    - This date is when specific compliance requirements start for several Conditions of Certification, etc
  - ONC is instituting an additional three-month period of enforcement discretion, meaning that February 1, 2021, would be the earliest date for enforcement around many provisions

HHS OIG Issues Proposed Regulation for Information Blocking CMPs

- **Investigating and taking enforcement action against entities that engage in information blocking is consistent with OIG's history**
- **Actors are defined as health IT developers, HINs, and HIEs**
  - HHS has the authority to impose CMPs up to $1 million per violation on these actors
  - OIG's CMP authority does not extend to health care providers
    - OIG would refer provider to the appropriate agency for appropriate disincentives
- **OIG is proposing to use its discretion to choose which complaints to investigate and only select cases for investigation that are consistent with its enforcement priorities**
  - OIG's enforcement priorities will include conduct that resulted in, is causing, or had the potential to cause patient harm
  - OIG believes that it lacks the authority to pursue information blocking CMPs against actors who it concludes did not have the requisite intent
    - OIG is not planning to bring enforcement actions for innocent mistakes
- **Enforcement of the information blocking CMPs will not begin until this regulation is effective**
  - Effective date is 60 days from the date of final publication
  - Until that time, OIG plans to exercise enforcement discretion

ONC and CMS Interoperability Final Regulations

- Final ONC Interoperability Regulation: What You Need to Know
- Final CMS Interoperability Regulation: What You Need to Know
- CMS Interoperability Regulation: Conditions of Participation Fact Sheet
- ONC Interoperability Regulation: Provisions Related to Quality Program Reporting for Certified EHR Technology
- ONC and CMS Announce Enforcement Discretion for Interoperability Regulations
- HHS OIG Releases Proposed Regulation on Information Blocking Civil Money Penalties

Recently Submitted Public Comment Letters

- HIMSS and PCHAlliance Submit Letter in Support of FCC Actions to Address COVID-19
- HIMSS and PCHAlliance Comment on Federal Health IT Strategic Plan

Questions?

Thank You!

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Update on the Health IT Roadmap from the CedarBridge Group

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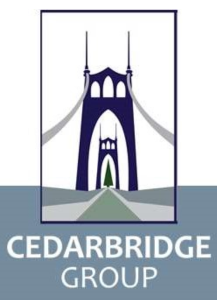
CedarBridge Group Overview



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CEDARBRIDGE GROUP

CORE COMPETENCIES

Communications
- Research and write topical white papers and case studies
- Support community engagement efforts using various media and modalities

Health IT Requirements & Evaluation
- Write functional and business requirements
- Develop health IT use cases
- Evaluate workflows and technology investments
- Author technical specifications

Operational Support
- Develop Medicaid IAPDs and SMHPs
- Manage technology audits
- Serve as systems integrator and validator
- Deliver business plans and technical assistance

Stakeholder Engagement
- Facilitate board and community engagements
- Conduct individual and focus group interviews
- Synthesize stakeholder feedback to inform strategy
- Curate best practices in public and private sector health IT governance

Strategic Planning
- Conduct environmental scans
- Provide strategy to advance telehealth
- Consult on quality measurement strategy
- Support procurement processes

Project Management
- Select and manage vendors
- Manage technology implementation

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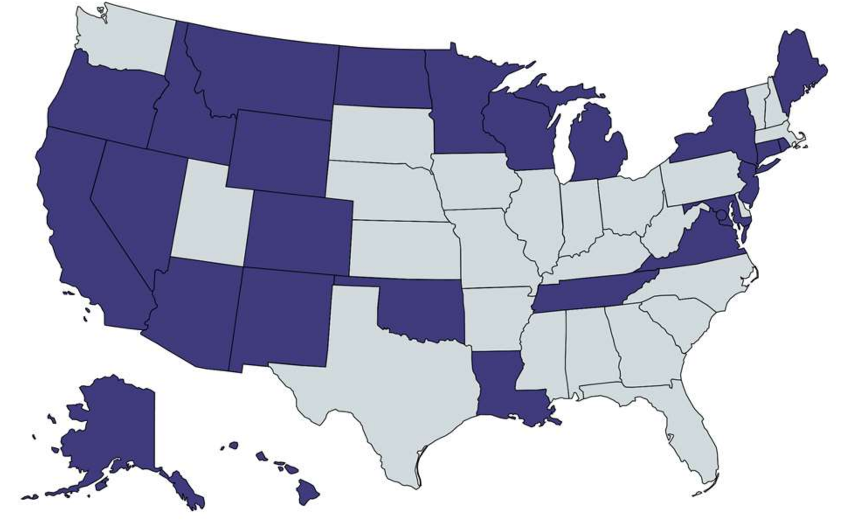
CedarBridge has provided consulting services to clients in 24 states…and counting

Examples of Our Work

Connecticut's Office of Health Strategy

- Planning for a statewide Electronic Clinical Quality Measures (eCQM) system
- Prioritizing Health Information Exchange (HIE) Use Cases
- Aligning goals for a new Immunization Information System (IIS)
- Conducting an Environmental Scan and developing a Recommendations Report



North Dakota Health Information Network (NDHIN)

- Conducting an Environmental Scan
- Developing a Business Plan

Office of the National Coordinator for Health IT:

- Supporting a national study on Patient Identification and Matching: Final Report
- Report on the Health IT Infrastructure to Support Accountable Care Arrangements
- Facilitating activities for the EHR|HIE Interoperability Workgroup's HIE Governance Grant from ONC: Best Practices & Standards Alignment Project Federated Provider Directories Pilots: Final Report

CedarBridge support for Intel Corporation Connected Care employee health benefit model

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CedarBridge Leadership Team

Carol Robinson, Founder and CEO

Don Ross, Project Director

Dawn Bonder, Managing Director

Project Management

Branden Pearson, Project Manager

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The CedarBridge Project Team **Consultants and Subject Matter Experts**

- **Terry Bequette**, Consultant

- **Pete Robinson**, Consultant

- **Sheetal Shah**, Consultant

- **Kate Kiefert,** Subject Matter Expert

- **Jamal Furqan**, Consultant

- **Vatsala Pathy**, Subject Matter Expert

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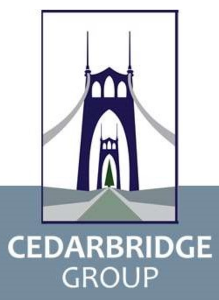
Overview of Project Charter



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Five-Year Health IT Roadmap Project Charter

Purpose

To develop an updated Five-Year Health Information Technology Roadmap by engaging stakeholders across the continuum of care to align under shared health IT priorities and leverage common efforts. The Roadmap will provide a framework for Michigan to implement and procure interoperable data sharing solutions with the purpose of expanding and improving the effectiveness of care coordination tools.

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Michigan Health IT Roadmap and Sustainability Plan

Identify and engage providers, payers, state agencies, social service organizations, employers, associations, labs, pharmacies, universities, and advocacy groups across Michigan in planning for and governance of health IT investments

ENGAGE & EDUCATE

DISCOVER

Collect input from stakeholders across domains through interviews, focus groups, roundtables, and electronic surveys on their current and desired future state for data services and electronic data exchange in Michigan

Seek stakeholder feedback on draft recommendations to confirm priorities and value propositions for health IT investments, policies, and governance of shared services across domains in Michigan

VALIDATE & FINALIZE

ANALYZE & SYNTHESIZE

Synthesize viewpoints on current state and desired future state for health IT investments, policies, and governance of data services and interoperable data exchange in Michigan

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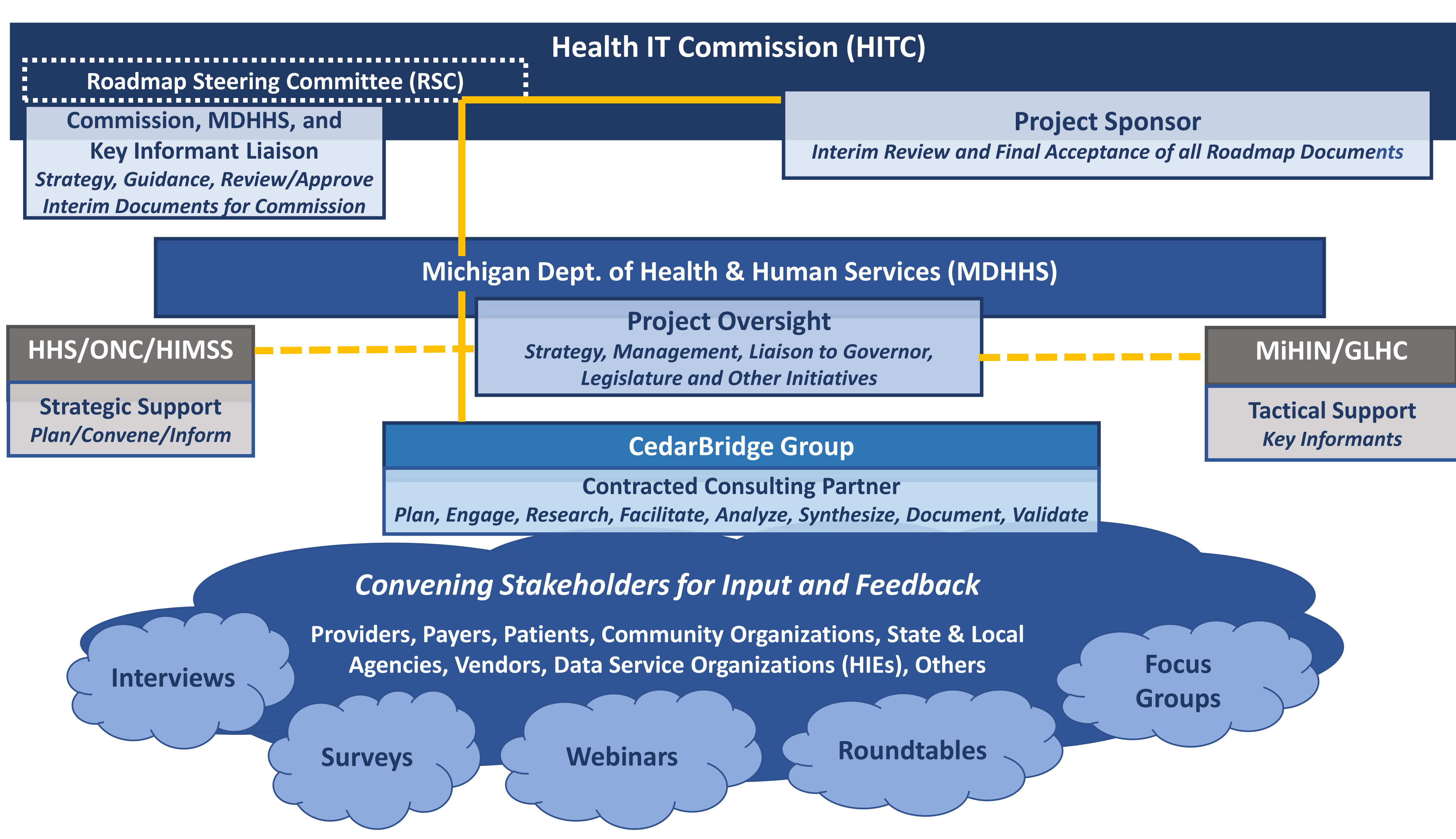

Health IT Commission (HITC)
Roadmap Steering Committee (RSC)
Commission, MDHHS, and
Key Informant Liaison
Strategy, Guidance, Review/Approve
Interim Documents for Commission
Project Sponsor
Interim Review and Final Acceptance of all Roadmap Documents
Michigan Dept. of Health & Human Services (MDHHS)
HHS/ONC/HIMSS
Strategic Support
Plan/Convene/Inform
Project Oversight
Strategy, Management, Liaison to Governor,
Legislature and Other Initiatives
MiHIN/GLHC
Tactical Support
Key Informants
CedarBridge Group
Contracted Consulting Partner
Plan, Engage, Research, Facilitate, Analyze, Synthesize, Document, Validate
Convening Stakeholders for Input and Feedback
Providers, Payers, Patients, Community Organizations, State & Local
Agencies, Vendors, Data Service Organizations (HIEs), Others
Interviews
Surveys
Webinars
Roundtables
Focus
Groups

Five-Year Health IT Roadmap Project Charter

Goals

1. Assess the "current state" of health IT initiatives in Michigan
2. Develop vision for the "desired future state" for health IT and HIE/CIE services by identifying policies, governance, operational and technical improvements, opportunities for creating efficiencies across entities, and developing innovative partnerships
3. Align the Roadmap with the Governor's 5-Year Priorities for MDHHS
4. Produce strategies to ensure all providers become connected to an HIE and encourage processes that ensure patient health data is readily available for providers at the point of care
5. Establish a framework for clear communication, governance and central planning for state agencies and statewide partners for expanding and utilizing HIE/CIEs
6. Lay the groundwork for maximizing local community utilization of, and benefit from, existing investments in the State of Michigan health IT infrastructure and HIE tools

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Five-Year Health IT Roadmap Project Charter

Scope

A Roadmap that is inclusive of all health IT stakeholders in Michigan

A project plan with oversight by the RSC

A *Stakeholder Outreach and Education Plan* to engage Michigan providers and other professionals, residents, and others through public communications

A *Statewide Environmental Scan* consisting of key informant interviews, focus groups or community roundtables, surveys, and review of relevant documentation to capture and compile feedback

A collection of key insights and draft recommendations, synthesized from the environmental scan process for prioritizing health IT use-cases, policies and governance, and technical approaches

Validation of stakeholder feedback through solicitation of public comment on draft recommendations, and development of the Michigan Five-Year Health IT Roadmap

Facilitation and support of the Health IT Commission, Roadmap Steering Committee, and MDHHS Roadmap Project

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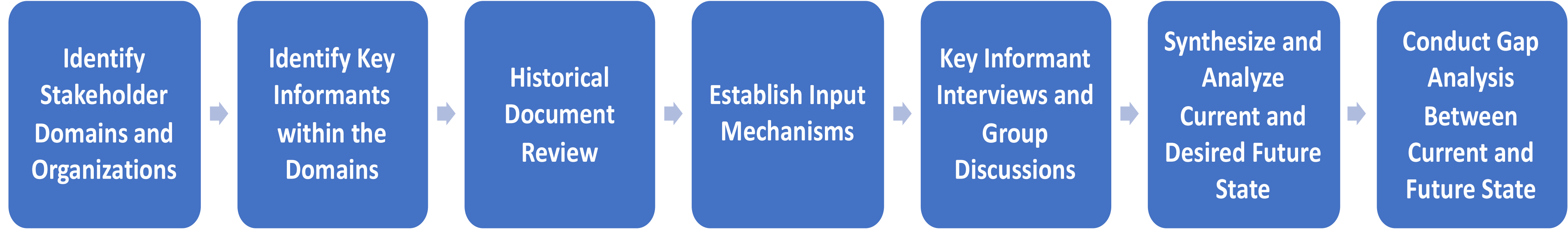
Environmental Scan Process



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Timeline

Final Roadmap and Sustainability Plan will be presented to the HIT Commission within 16 months of Project Kick-off

This timeline is conservative and may be compounded by COVID-19 pandemic challenges

* MDHHS website updates, social media postings, email blasts, and association newsletter blurbs will occur throughout the entire project timeline

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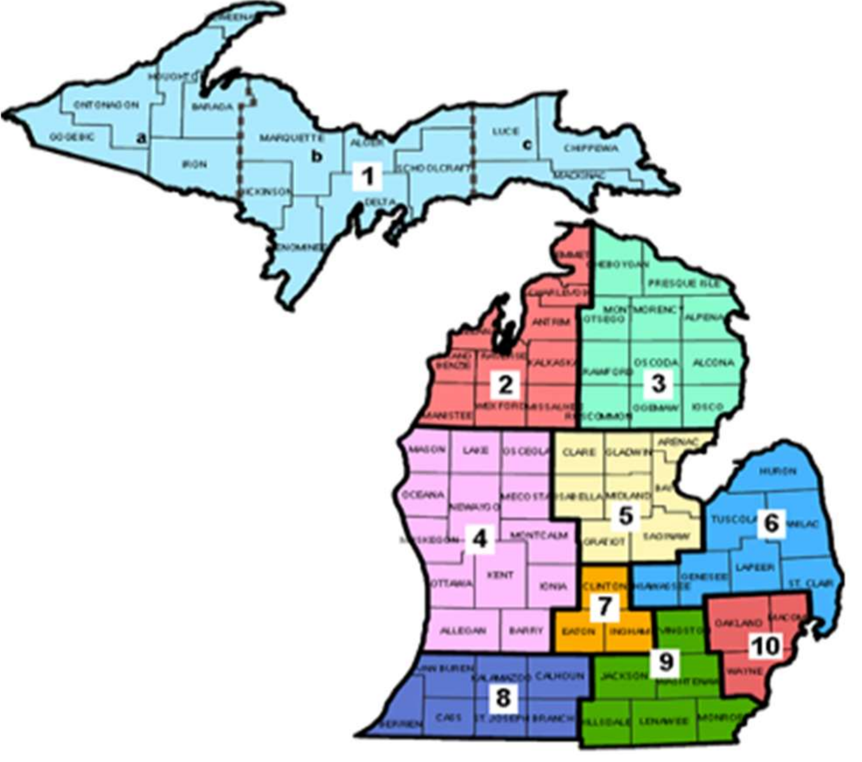
Stakeholder Outreach and Education Plan

- Stakeholder O&E Plan is designed to inform the Michigan healthcare community of the Michigan Five-Year Health IT Roadmap initiative
- CedarBridge, MDHHS, project sponsors and key informants will outline where stakeholders can find more information about the Roadmap and opportunities to participate in information sessions and webinars
- Collecting information from Michigan stakeholders on capacity for engagement activities
- Regional engagement strategies will group Michigan counties by the ten [State of Michigan Prosperity Regions].



Source: Michigan Regional Prosperity Initiative

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Stakeholder Domains

HIT Commission Stakeholders List

Accountable Care Organizations
Behavioral Health Providers
Clinically Integrated Networks
FQHC, PCMH, RHC, and PCPs

Dental Organizations
EMS
HIT Professional Societies
Research and Health Profession Schools

HIT/HIE Entities
HCBS Providers
Hospitals
LTC Providers

HIT Roadmap Stakeholder Domains

Behavioral Health
Community-Based Organizations
Health Information Exchanges
Health IT Professional Groups
Health IT Vendors
Hospitals and Health Systems
Justice System
Long Term Care Providers
Oral Health
Other Emergency Services
Other Non-Emergency Services
Payers
Pharmacies/Pharmacists
Primary Care
Quality Improvement Entities
Labs and Specialty Care
State Agencies
Public Health Experts

HIT Commission Stakeholders List

Area Agencies on Aging
Medical Supply Providers
Patient Advocacy Groups
Corrections
Public Safety Organizations

Pharmacists
Public Health Experts
Quality Improvement Entities
Hospice/Palliative Care

Safety Net Services
Specialists
Veterinary Care Providers

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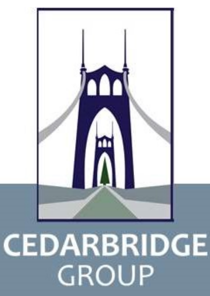
Roadmap Steering Committee Input

CedarBridge presented an overview of the project charter to the RSC on May 13th



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Initial Steering Committee Input on Roadmap Project Charter and Process

Recommended CedarBridge create a concise 1-page document on Roadmap development processes for RSC members to use and reference when speaking with stakeholders

- Aligns with CedarBridge Stakeholder Outreach & Education plans. 1-page document is being drafted for this purpose, and also MDHHS webpage and social media postings

Explain to stakeholders what the previous roadmap accomplished. What benefits we received and what benefits we expect to get from a new roadmap.

- Project Charter describes the previous *Conduent to Care Report from 2006 and outcomes.* CedarBridge will emphasis this in the new Roadmap and associated reports

Provide a clear proposal for how the Roadmap development process will proceed with the COVID-19 pandemic and in-person stakeholder engagement activities

- CedarBridge has created a proposal for stakeholder engagement with COVID-19 contingencies, and anticipates all engagements will be virtual until further notice by governing bodies

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Health Information Technology Commission Input

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Thank you!

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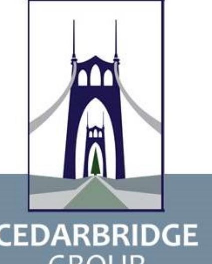

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HIE Update

Community Health Technology Network

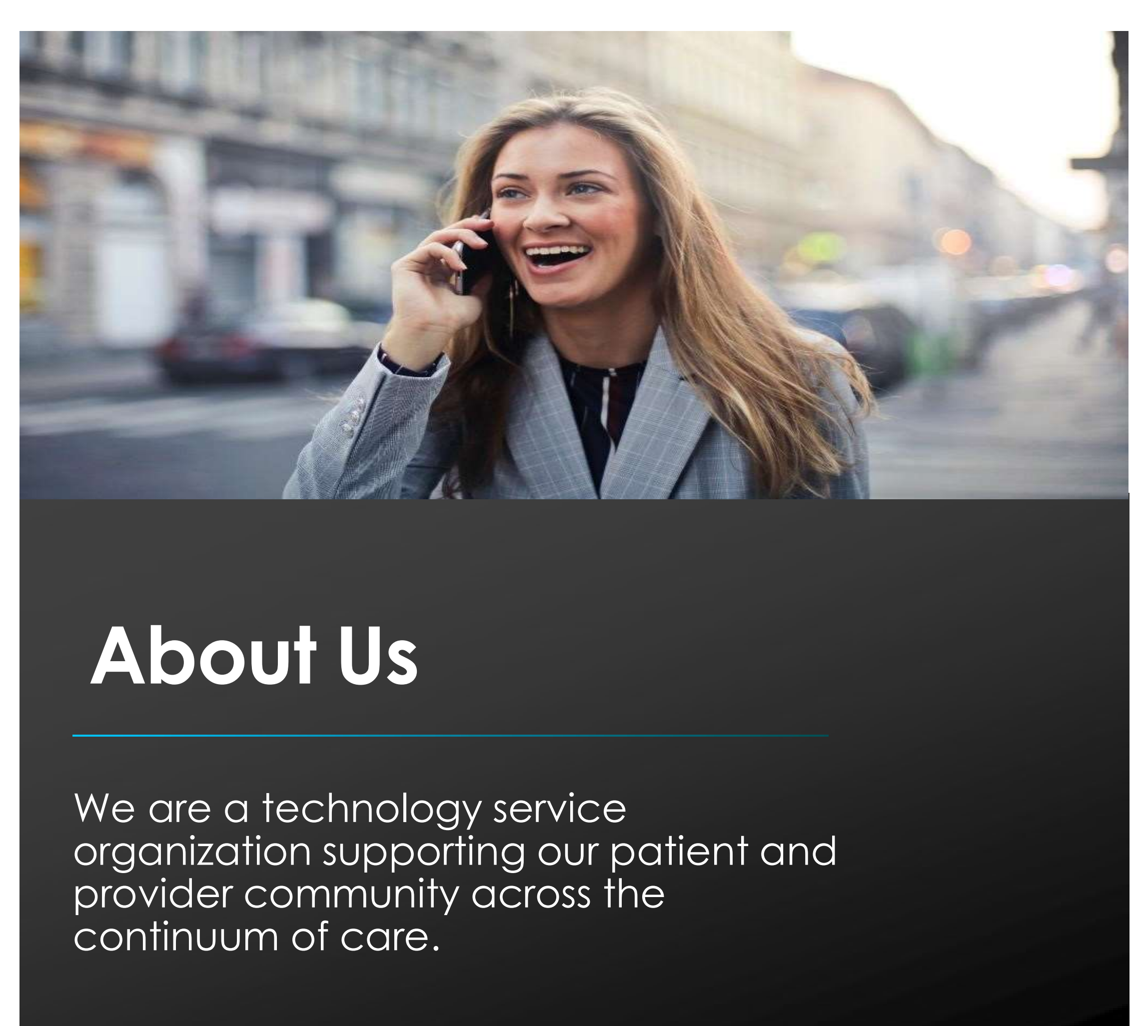
Formerly Jackson Community Medical Record (JCMR)

Agenda

1. Overview
2. Who we are
3. Collaboration
4. Services
5. Priorities
6. IT Barriers
7. Questions

Mission

To deliver state of
the art technology servic
es to our providers and
partners to aid
in improving the health
of the community.



Overview

Electronic Health Record

Improved clinical efficiencies and a robust end-to-end revenue cycle experience

Regulatory Quality Reporting

Guided support and regular performance monitoring

Health Information Exchange

Securely sharing data among separate Health care information systems

Areas we cover…

Hospitals: 12

Outpatient Offices: 379

Home Health & Hospice: 28

Health Department: 1

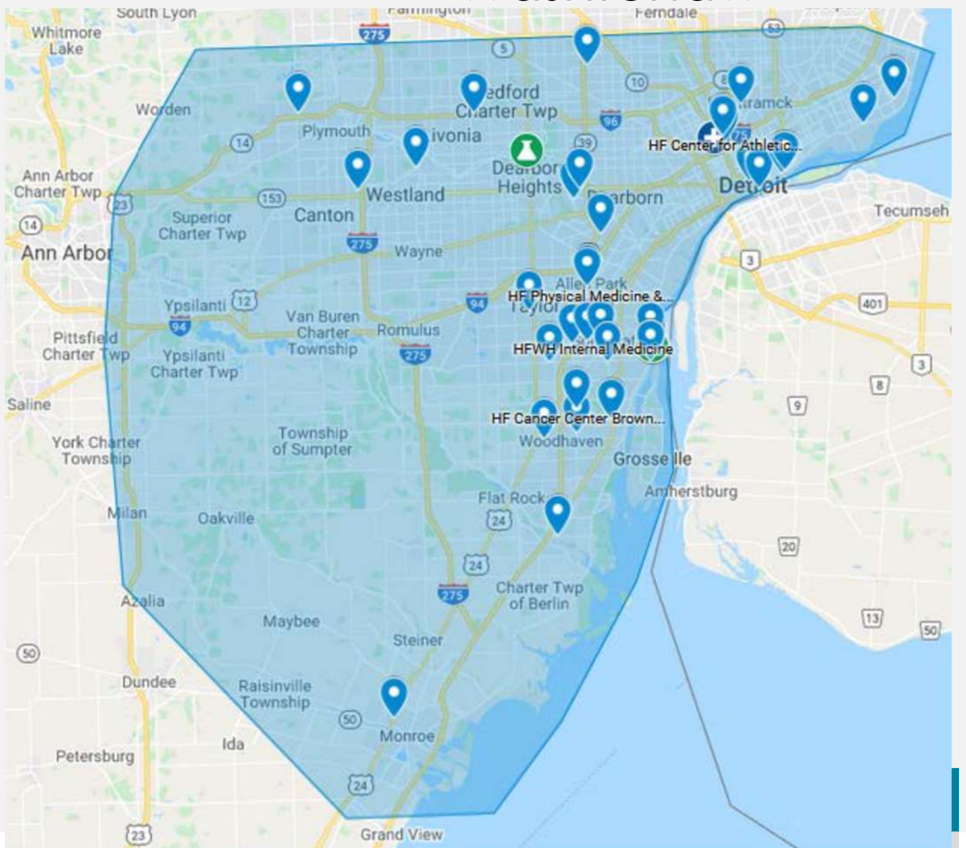
FQHC: 2

ACOs/CINs: 3

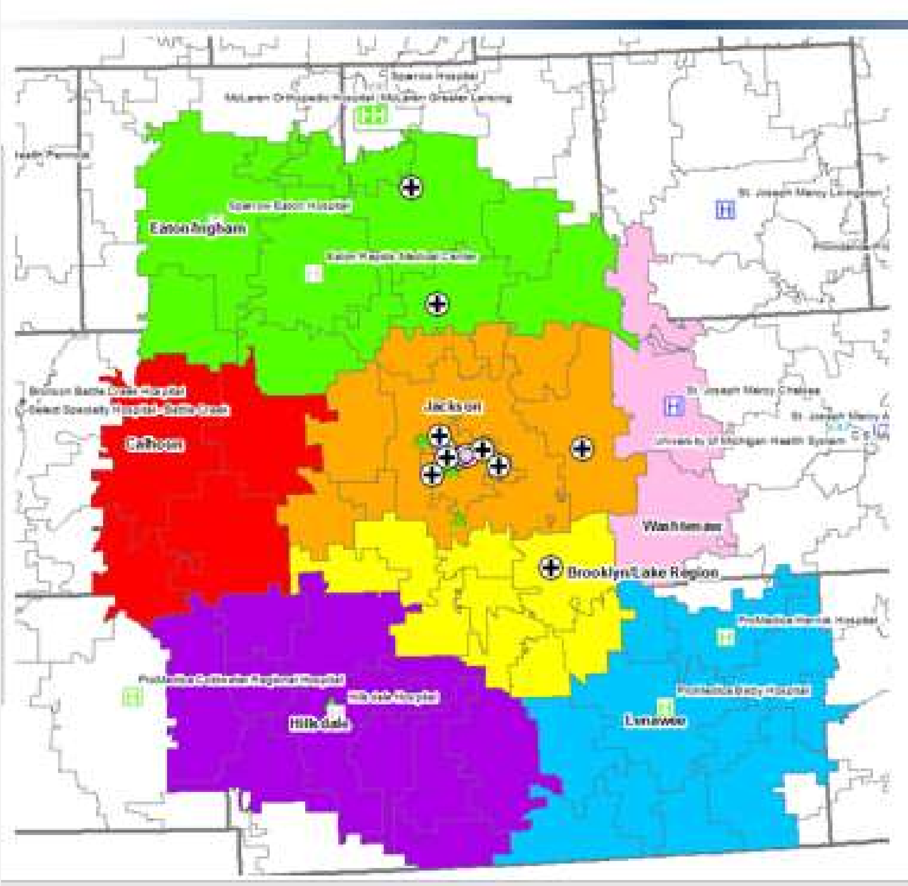
IT Landscape

North Market – 6 Counties

South Market – Wayne, Monroe, Eastern Washtenaw



IT Landscape



7 Micro-markets within the Central Market

Micro-market boundaries were determined by the following factors:

- **Drive time:** All zip codes that touch a 30 minute drive time included
- **Market Share:** Core of each micro-market made up of zip codes within a 20 minute drive time and not dominated by another hospital
- **Other:** Remaining zip codes grouped geographically based on similar:
  a) existing market share,
  b) location of competitors,
  c) drive time &
  d) payer mix

IT Collaborative Efforts

- Affirmant
- BCBS
- FQHC
- Hospitals
- Lifeways
- MiHIN
- PCMH Practices
- PGIP Practices
- POs
- 211/ United Way CIE
- Vendors

Interoperability

Exchanging data between external entities

Benefits include:

Patient data is available wherever they seek services

Decreased duplication of expensive testing

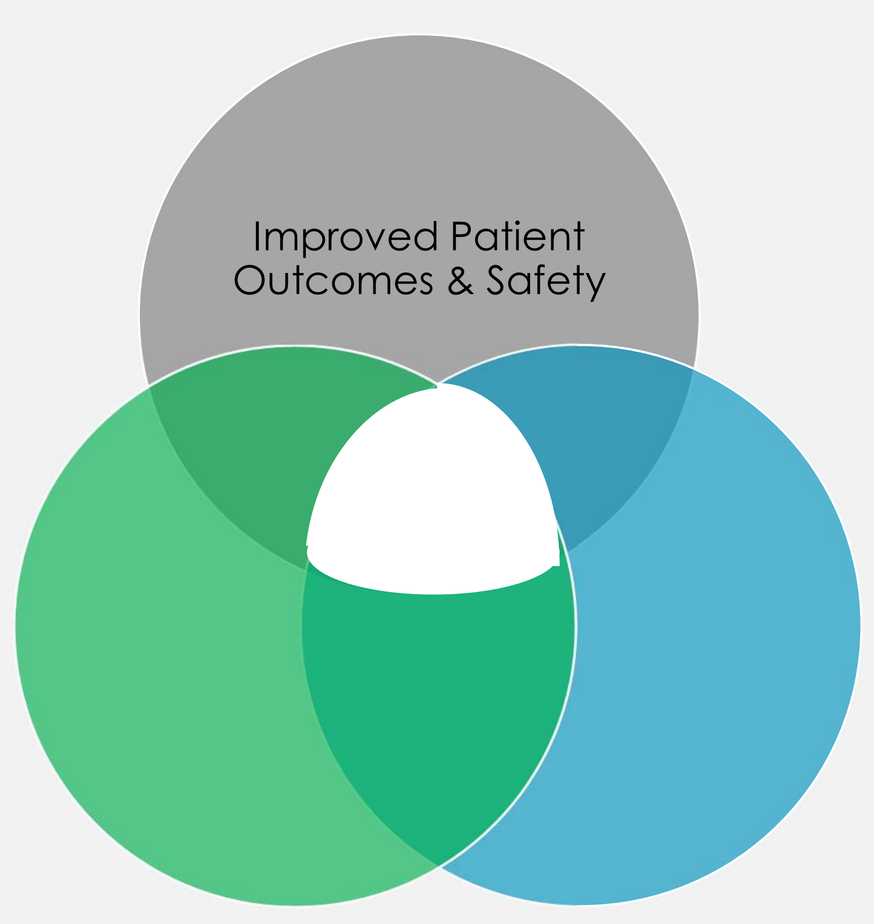
Improved conformance with payer quality indicators

Shared Use Case Priorities with MiHIN

- Conformance Task Force
- eConsent
- Death Notifications
- Health Provider Directory
- PPQC
- Super CCD - FHIR API options
- Utilizing Statewide Labs

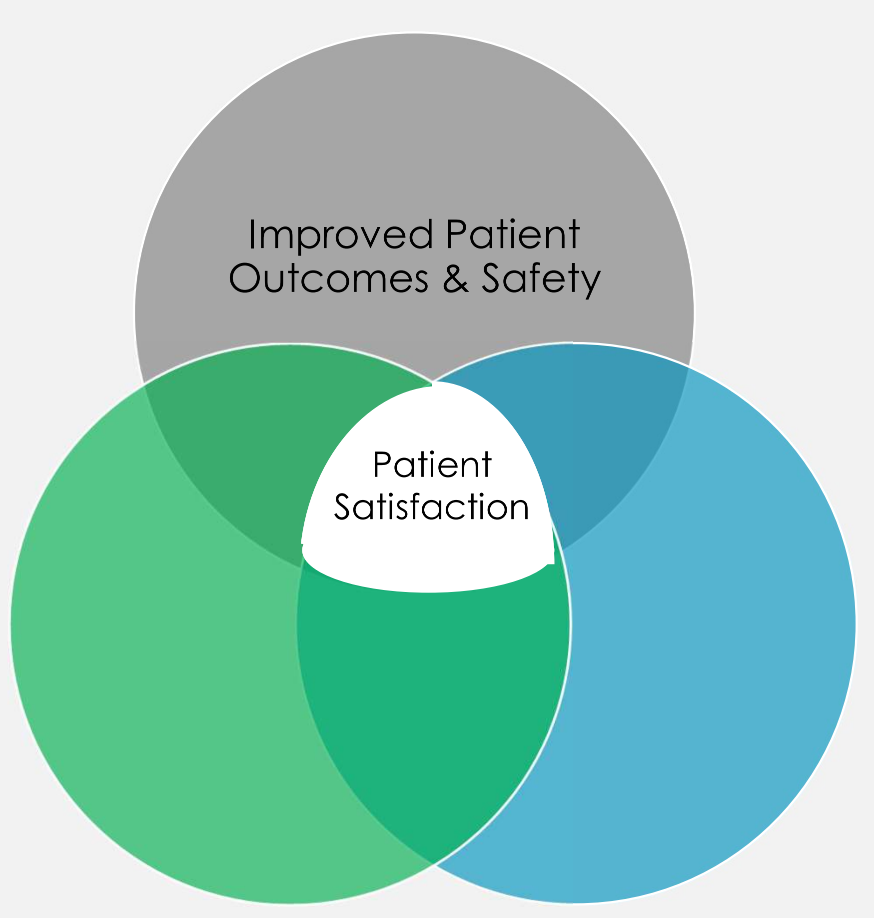
Improving Patient Outcomes & Safety

1. Collaboration with CIN and community on optimization opportunities impacting quality performance and cost/utilization
2. Development of centralized, payer-neutral quality measure “Guidebook,” satisfying requirements across programs, reporting methodologies, and technologies



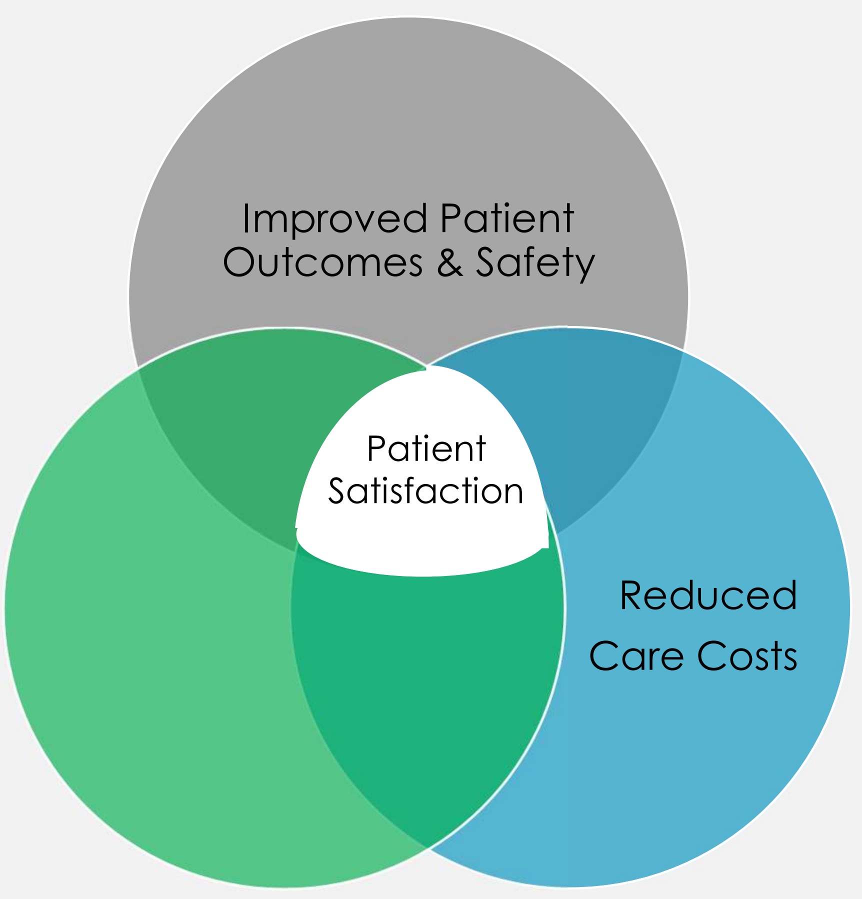
Enhancing Patient Experience

1. SDoH screening tool and workflow development across community agencies
2. Telehealth and Video Conferencing Solutions



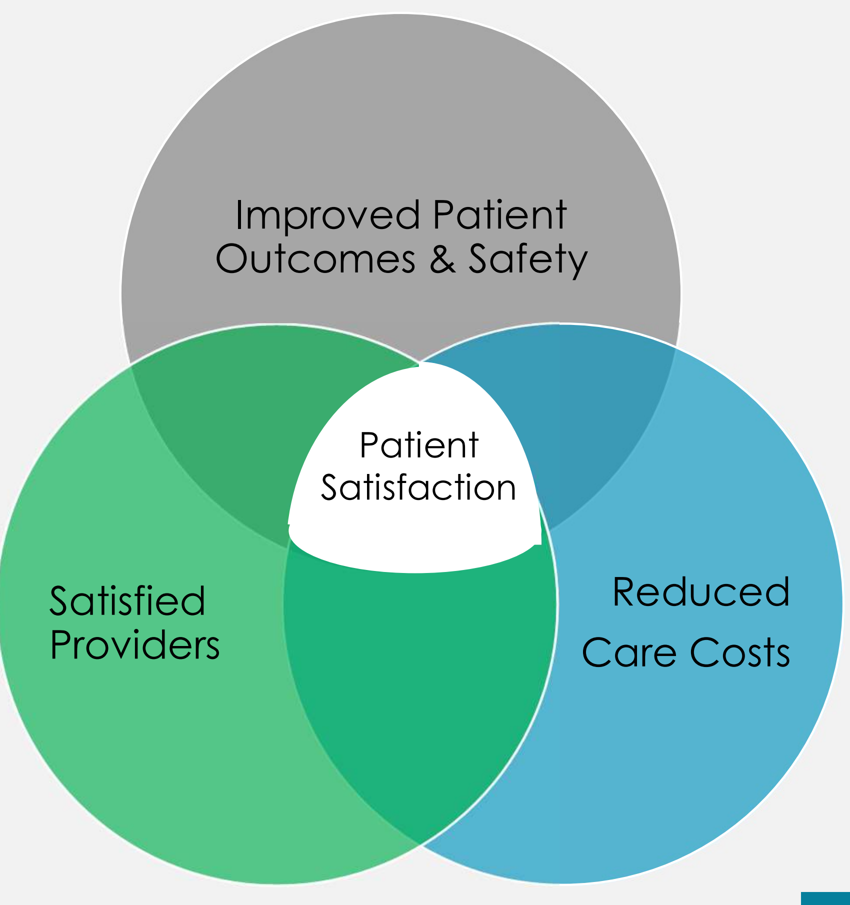
Reducing Overall Cost

1. Technology solutions to support integration
2. Payer contract support
3. Creation of front-end gaps in care platform using longitudinal data across organizations



Improving Physician Experience

1. Improved performance in risk contracts
2. Hospital Utilization: Development of IP/ED Follow-Up process
3. On-site support of program attestations
4. Quality measure validation (across various technologies), continual assessment of incoming functionality
5. Regular monitoring of employed and private practice performance against respective quality reporting programs
6. Develop integrated performance improvement and population health platforms



Barriers to Interoperability

CURES ACT

a) Vendor implications
b) Development connection pricing
c) Access to data
d) Ability to consume data
e) Ability to incorporate data into workflow

IT Barriers faced in light of COVID-19

Issues

1. CCDs data is not consumable by many EHRs
2. Costly interfaces, and there is a lot of maintenance with this option
3. Many EHRs have the ability to allow FHIR access, but many do not have the ability to consume the data retrieved in a meaningful way
4. Variations of structure of data by each vendor and thus the data itself is a barrier
5. Public health couldn't receive data due to no connections
6. Infrastructure issues – fiber optic lines / high speed internet connections caused delay in patient care

Successes

1. Services were able to be provided in several different locations
2. We were able to utilize current infrastructure for statewide labs

HITC Questions

1. How can MiHIN support CURES ACT Interoperability?
2. What strategies will be used to engage vendors?

Michigan Health Information Network (MiHIN)

MiHIN Strategic Direction

- Refine Use Case Factory to organize statewide efforts to address shared challenges
  - Proposal submitted to MI Health Endowment Fund to convene Behavioral Health/Telehealth workshop in 2021 to ensure telehealth and eConsent can be maximized to meet behavioral health service delivery and information sharing needs
- Expand Active Care Relationships to identify care team members
  - 29,524,667 total relationships between an individual and a member of their care team
  - 8,748,618 unique individuals with common keys that enhance patient matching
- Expand the health information "floor" to increase access to information
  - ADT event notification: 988 senders and 205 receivers
  - Statewide information viewer or MIDIGATE: 82 individual users along with the Jackson Collaborative Network and Care Convene users accessing the View Care Team module through an API.
  - Care summaries: 96 senders and 82 receivers (14 more are on deck via onboarding)

Michigan Stakeholder Interoperability Progress

	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2
ADT ACRS Inbound	1,370,061,454	1,453,843,034	1,538,635,437	1,625,190,628	1,714,307,778	1,730,336,978
ADT ACRS Outbound	706,217,029	801,805,901	909,893,588	1,029,241,997	1,150,324,059	1,173,742,804
ADT Payer Outbound	135,226,576	141,755,294	148,362,481	155,166,052	161,630,384	162,818,946
Blood Lead	4,788	4,788	4,788	4,788	4,788	4,788
Cancer Notifications	11,035	11,035	11,035	13,008	13,010	13,170
Cancer Pathology	153,234	153,982	155,119	155,883	157,200	157,243
Consumer-Mediated Exchange	1,600	2,272	3,191	3,668	4,068	4,132
ICBR	88,840	94,587	98,627	101,858	106,626	108,149
Immunization History-Forecast	44,923,818	53,135,957	61,298,136	69,987,660	77,381,007	78,943,423
MedRec Inbound	21,702,432	23,366,706	24,886,336	26,298,134	27,772,433	27,969,166
MedRec Outbound	11,220,927	12,973,765	14,954,785	16,891,349	18,638,942	18,893,996
Query Patient Record History	3,721	11,656	31,119	57,239	86,237	97,489
Statewide Labs	165,144,859	189,096,066	211,107,300	233,957,324	255,383,432	260,333,557
Statewide Labs-Outbound	42,079,667	75,614,913	85,264,880	90,065,891	94,277,368	97,003,699
Submit Immunizations	67,871,445	69,754,562	72,933,995	78,194,219	81,583,417	81,815,959
Submit Newborn Screening	38,251	40,850	43,505	45,958	48,259	49,052
Submit Reportable Labs	2,581,565	2,824,727	3,007,076	3,176,434	3,398,827	3,542,909
Submit Syndromic Surveillance	238,122,638	247,547,161	257,287,621	266,263,633	276,044,759	277,900,970
Grand Total	2,805,453,879	3,072,037,256	3,327,979,019	3,594,815,723	3,861,162,594	3,913,736,430

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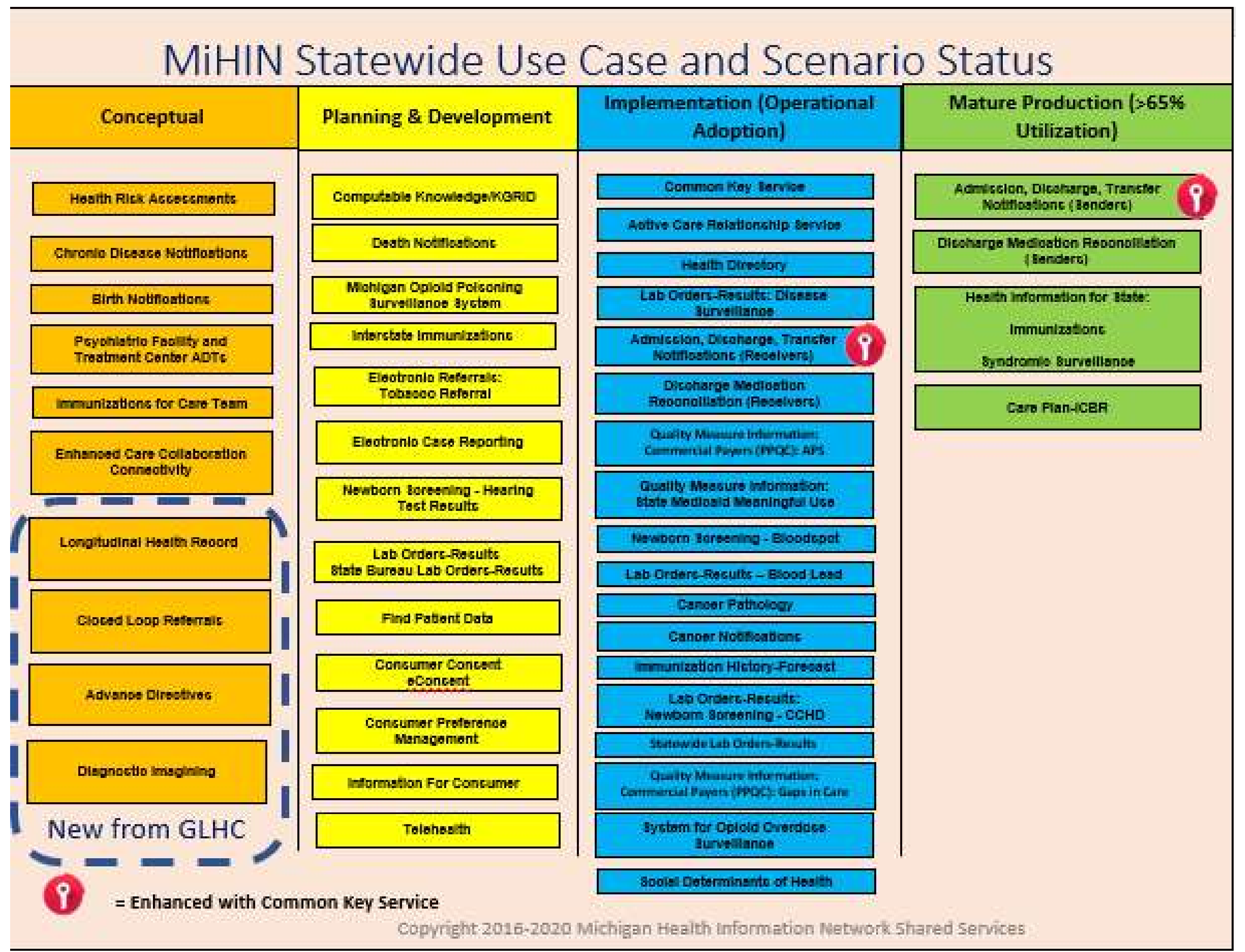

MiHIN Statewide Use Case and Scenario Status
Conceptual
Planning & Development
Implementation (Operational Adoption)
Mature Production (>65% Utilization)
Health Risk Assessments
Chronic Disease Notifications
Birth Notifications
Psychiatric Facility and Treatment Center ADTs
Immunizations for Care Team
Enhanced Care Collaboration Connectivity
Longitudinal Health Record
Closed Loop Referrals
Advance Directives
Diagnostic Imaging
New from GLHC
Computable Knowledge/KGRID
Death Notifications
Michigan Opioid Poisoning Surveillance System
Interstate Immunizations
Electronic Referrals: Tobacco Referral
Electronic Case Reporting
Newborn Screening - Hearing Test Results
Lab Orders-Results State Bureau Lab Orders-Results
Find Patient Data
Consumer Consent eConsent
Consumer Preference Management
Information For Consumer
Telehealth
Common Key Service
Active Care Relationship Service
Health Directory
Lab Orders-Results: Disease Surveillance
Admission, Discharge, Transfer Notifications (Receivers)
Discharge Medication Reconciliation (Receivers)
Quality Measure Information: Commercial Payers (PPQC): APS
Quality Measure Information: State Medicaid Meaningful Use
Newborn Screening - Bloodspot
Lab Orders-Results – Blood Lead
Cancer Pathology
Cancer Notifications
Immunization History-Forecast
Lab Orders-Results: Newborn Screening - CCHD
Statewide Lab Orders-Results
Quality Measure Information: Commercial Payers (PPQC): Gaps in Care
System for Opioid Overdose Surveillance
Social Determinants of Health
Admission, Discharge, Transfer Notifications (Senders)
Discharge Medication Reconciliation (Senders)
Health Information for State:
Immunizations
Syndromic Surveillance
Care Plan-ICBR
= Enhanced with Common Key Service
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Michigan Stakeholder Engagement Snapshot

COVID ACRS Attribute

- ACRS files are sent daily at 8:30am via SFTP with COVID-19 lab results, timestamps, and laboratory submitter for any matching patient
- A total of 97,233 COVID results were delivered from 15 distinct lab submitters to 196 distinct receivers via ACRS as of 5/4

Michigan Stakeholder Engagement Snapshot

SDOH Workshop Update

- Overall goals of the workshop series are to foster collaboration among multi-sector Michigan stakeholders, understand current environment, priorities, and concerns, and to identify preferred technologies for normalizing and categorizing SDoH data in order to promotes collection, use and exchange across organizations.
  1. Workshop 1 occurred 3/31 at 10am featuring a kickoff conversation with ~80 stakeholders representing ~41 distinct organizations and 11 organization types. Participants provided feedback on SDoH domains being screened for and current and planned uses for SDoH data.
  2. Workshop 2 will occur 5/26 at 10 am featuring: "Defining Common Domains and Sending/Receiving SDoH Screening Data."
  3. Workshop 3 will occur on 6/23 at 10 am and feature" "Sending/Receiving SDOH Screening Data Part II and Introduction to SDOH Diagnosis and Treatment Data"

Rescheduled Meeting:
Thursday, June 25, 2020
1:00 p.m. – 3:00 p.m.
Will Be Held Virtually

Please check the HIT Commission web page as the meeting approaches for information on accessing the virtual meeting