

# MiHIN Stakeholder Engagement Workshop

Session 2: April 10, 2023



# Save the date for our next two workshops in the ACP series!

Workshop #2: April 10 from 2-4 p.m.

Workshop #3: May 10 from 3-5 p.m.



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- Convene to discuss Breakout Room Sessions

# Meet the Team



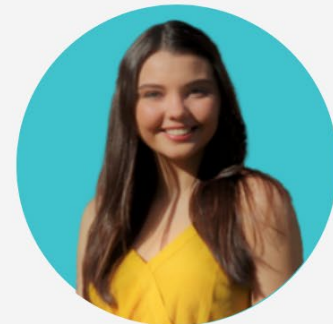
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Program Director**



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Honoring Choices**



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**Product Marketing  
Manager**



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**MCM Program  
Manager**

# Purpose of 2023 Convening:

- To level set on:
  - the current Michigan and National environment
  - the current national literature on ACP on outcomes
- To use facilitated discussion across broad stakeholder groups to come to recommendations on:
  - What success would look like in Michigan?
  - What metrics (shorter term and longer term) could be used to measure progress towards success?
  - What is available in the State of Michigan for ACP facilitator conversation training, leadership & collaboration, and individual conversations on ACP?
  - What information/ data/ documents must move between care environments to support serious illness care planning?
  - Are there policy barriers that create the need for technical workarounds?

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# Coming Up Next: Breakout Rooms

Everyone will automatically be assigned a breakout room

Each room will be facilitated by a MiHIN team member and will discuss the same topics

Breakout rooms will be recorded and have notes taken on the top 3 themes, to be discussed when we reconvene as a group

# Make the most of our breakout rooms!

Facilitators and Recorders Introduce yourselves; Participants, please drop your full name and organization into the breakout room chat

Dynamic conversation is CRITICAL to the success of this workshop

Please come off mute to engage in discussion - and remember to re-mute when you are not speaking

Join on camera if you are able.

We will be recording this breakout and taking notes that will be shared after

We will discuss each of our topics for 20 minutes and then summarize our top 3 themes to bring to the larger group



# What Data is being moved in Michigan?

- Document types:
  - ACP Documents (DPOAH/5 wishes/right for life/hospital specific docs); PA documents, OOH DNR, MI-POST
    - Barriers/people submitting now/storage locations/value/lift/frequency of change – create version control issues
- How to connect documents to patients if they're held in separate locations
- Is it appropriate to move documents between health systems?
- How is version control addressed in different settings & how does this affect providers' trust in documents available?
- What would allow ACP to hold more value & what is the value in documentation as it currently stands?
- How to document goals of care conversations vs. PA designation

# How are ACP Documents being used to aid in Care Coordination?

- Living wills are not honored in State of Michigan, only PA designation within these documents can be utilized, are the current tools being used part of the problem?
  - Should there be a simpler PA designation form instead of the current documents being used?
- PA designation: are patient advocates using these living wills as guides?

# Do different care location require different information?

- SNF, ED, inpatient, PCP, specialty care providers
  - Can calling EMS be overcome by using MI-POST document or OOH DNR?
    - Lift to do that to reach what percent of population?
    - How many times would this impact patients by flowing these documents through these different systems?
- Policy impacts around honoring document between points of care:
  - How to address policy barriers & work around them to honor patient's wishes?
  - Separate PA designation get around policy barriers & foster adoption of that part of ACP?
- Is there an added cost to payors and patients if we are resuscitating people against their own will?
  - Payment burden to patients/healthcare systems/EMS – appropriate use of healthcare resources?

# What Policy barriers influence the solution development?

- Next of kin laws
- Witnessing laws
- MI-POST rules/regulations
- SNF/EMS Regulations
- MI laws around ACP
  - Billing codes around ACP for reimbursement
  - Laws in different areas around reimbursement (i.e. rural health clinics requiring separate visits for ACP outside of wellness visits)
- Does term ACP confuse the issue?

# How does MiHIN fit in?

- Are we right body to do this?
  - What does MiHIN (HIE) do – is this a match for skillset/purpose of HIE
- Training, convening, conversations
  - Should we refer these to another organization?

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# Contact us:



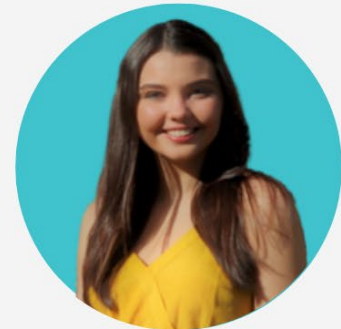
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**General question? Email [help@mihin.org](mailto:help@mihin.org)  
or call 844-454-2443 Ext 2 for ACP**



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# THANK YOU

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## LET'S CONNECT



[mihin.org](https://mihin.org)



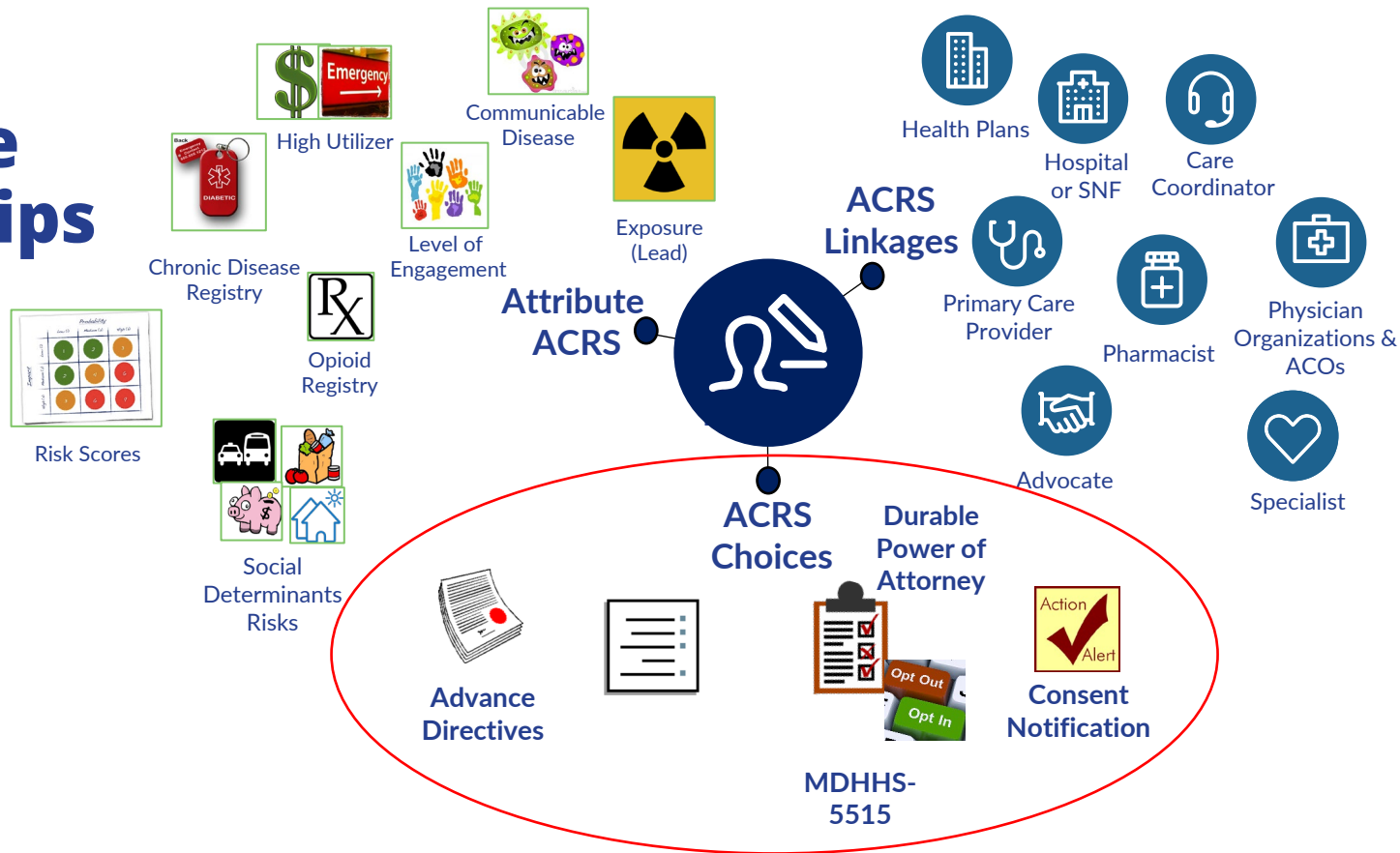
[@MiHIN](https://twitter.com/MiHIN)



[linkedin.com/company/mihin](https://linkedin.com/company/mihin)

# MiHIN's Active Care Relationships (ACRS)

- Submitted by MiHIN Participants
- Access to data based on use case



# Electronic Consent Management Service (eCMS) Workflow for Pilot Sites

STEP

1

*Patient provides consent at regional SUD clinic and includes MiHIN as a consented HIE in eCMS*



STEP

2

*MiHIN stores consent in statewide eCMS and checks consent before sending SPI-ADT to consented MiHIN participants*



SPI-ADT

MDHHS-5515  
Consent



MDHHS-5515  
Consent

STEP

3

*MiHIN sends consent to MDHSS and Optum (for CC360) for ACRS patients in real-time. Optum creates gives access in the SUD role in the next 24 hours.*



# Advance Directive Query & Retrieve Features

HITRUST Certified Advance Directive Repository

Provider-facing portal for manual submission of Advance Directives to MiHIN

Patients / family members can access/ share/ update documents through MyDirectives.com (app or website)

Advance Directive-related notifications through ACRS and MIGateway

Ability to query & retrieve documents from multiple vendors that store ACP documents through Advance Directive API





**Joanne Jarvi**

**Senior Director of Outreach  
and Market Communications**



# Michigan Health Information Network Shared Services (MiHIN)

MiHIN is Michigan's state-designated entity to continuously improve healthcare quality, efficiency, and patient safety by promoting secure, electronic exchange of health information.

MiHIN represents a growing network of public and private organizations working to overcome data sharing barriers, reduce costs, and ultimately advance the health of Michigan's population.



# Data for Good

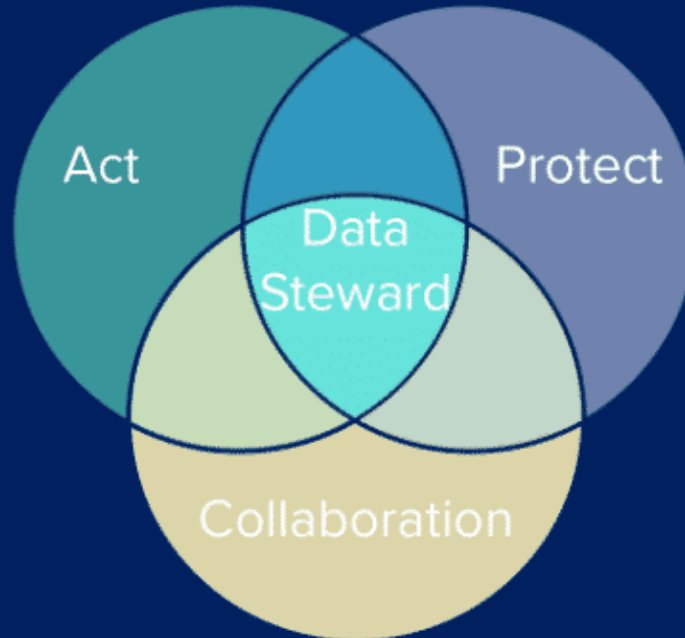
Technological Infrastructure +  
Human Infrastructure

Real impact will move at the  
speed of trust.

WHAT  
ARE WE TRYING TO  
COMMUNICATE  
AND WHY?

OR

WHAT DOES THIS DATA TELL US?



Communication,  
the *successful*  
conveying or sharing  
of ideas, is more  
critical than ever.

Every communication  
involves (at least) one  
sender, a message  
and a recipient.



# The Goals of Health Information Exchange

Reduced  
Inefficiencies



Improved  
healthcare access



Lower  
healthcare costs



Better quality of care  
and health outcomes



Personalized  
medicine for patients



# WITH/FOR WHOM?

To be able to exchange Health Information at **SCALE** (*the required size to solve a problem*)

*In 2023, WE WILL LIKELY HIT A CUMULATIVE TOTAL OF 10 BILLION MESSAGES*

Federal Gov't  
State Gov't  
Health Department  
Health Payers  
Health Systems  
PIHPs



Doctors  
Nurses  
Clinicians  
Care Managers  
Social Workers  
Dentists  
Pharmacists  
CARE SEEKERS!



Hospitals  
Clinics  
Practices  
CMHs  
Hospices  
FQHCs  
Pharmacies  
Physician Orgs  
Physician Hospital Orgs

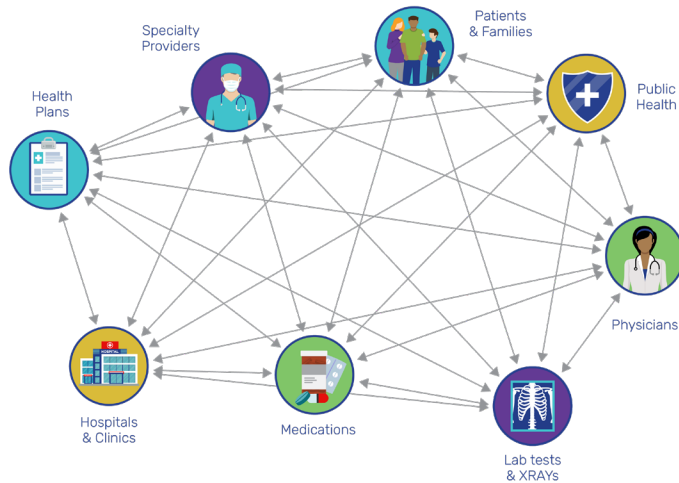
*A YEARLY AVERAGE OF ABOUT 7.5M Admit, Discharge, Transfer Notifications IN & 11.5M OUT*

*2 MILLION LABS FLOWING INBOUND TO MIHIN*

# Statewide Health Information Exchange Creates Efficiency

## BEFORE:

Duplication of effort, waste and expense



## NOW:

Connect once to access shared services



# What does an HIE Do?

- The goal of an HIE is to ensure the availability of data and information where and when it is needed to care for individuals and to inform decision making
  - Care coordination
  - Decisions about where to spend scarce resources
- Health Information Technology should be driven by clinical need
- What are clinicians telling us about the information / data they need to provide care?
  - What clinicians use this data
  - What decisions does this support?

# Michigan Landscape: Training and Education

- 1990 – 2000 National movement and conversation surrounding ACP conversations
  - Evolution of documents that would outline patient wishes gaining traction
  - ACP efforts promoted as a key driver for patient autonomy at end of life, save on unwanted care and lead to better outcomes of care and lower costs
- The Respecting Choices® model is a copyrighted systematic program licensed by Gundersen Health System
  - Initiated in 1991; Adopted through some health systems in Michigan and through Great Lakes Health Connect (GLHC)
- Extensive network of training and facilitation providers
  - Different models, different systems have invested in specific solutions
  - Does not have to be model specific training
  - No sources of free training

# MiHIN Involvement: Making Choices Michigan (MCM)

- MCM (MiHIN Strategic Business Unit):
  - Started in 2010 as community engagement model
    - Operated through Great Lakes Health Connect (GLHC) from 2017-2019
  - Adopted by MiHIN as a strategic business unit in **2020** following the merger with GLHC
    - Continues vendor specific model – Modeled on Respecting Choices
  - Promotes ACP conversations and process in healthcare and community
    - Leadership / Convening
    - Training
    - Individual engagement
  - 2020-2022:
    - Trained 66 people from 24 different organizations across the Midwest
    - Developed ACP Leaders/Coordinators group during COVID-19 pandemic
    - Maintained system of volunteers to conduct ACP Conversations within communities

# Michigan Landscape: Payment Support

- ACP efforts promoted as a key driver for patient autonomy at end of life, save on unwanted care and lead to better outcomes of care and lower costs
- ACP conversations financially supported through public and private payers
- ACP conversations not financially supported by Medicaid Health Plans despite payment support for conversations; engagement in ACP conversations estimates remain low at 7.5%
- ACP documents are not a required outcome in order to bill for conversations



# Michigan Landscape: Advance Care Documents

- Patient Advocate Designation (Durable power of Attorney for Healthcare)
  - Legal document
  - Identifies surrogate decision maker; intended to not just identify but provide contact information for
  - Requires patient signature in front of 2 witnesses
  - Patient advocate must sign acceptance to the role
  - Witnesses must sign
  - Treatment preferences (Optional Portion):
    - Variety of formats/ templates with varying content that can be filled in
    - Content of document may lack relevancy for clinicians to guide conversations as the individuals condition changes
- Out of Hospital Medical Orders:
  - Mi-POST (Physician Orders for Life Sustaining Treatment)
    - Directs CPR preferences and additional selected medical interventions
  - DNR Order:
    - Directs the withholding of CPR

- *Intended to change as the individuals condition changes*  
- *Advisory only in hospital*

# MiHIN Involvement: ACP Document Exchange Use Case

- **Vision driven by HIT Commission:**
  - Statewide and vendor neutral ACP Repository
  - Obtain ACP documents regardless of what vendor is used and be able to make available to care providers as required
- **Query / retrieve and display ACP Documents:**
  - Currently available to connect through ADVault
  - Organizations can upload documents through MIGateway (one at a time) even if their organization does not have capacity organizationally from their system
- **Multiple repositories where ACP documents are stored:**
  - EMR, Commercially available vaults ( examples: ADVault, Vynca, Vital Decisions)
  - Varying ways in which treatment preferences are documented (paper or electronic document, video or voice recording)
  - No requirements for commercial vendor repositories to connect to MiHIN's Use case
  - Vendors may not be organizationally or technically capable of connecting (example: HiTrust Certification)

# MiHIN Advance Care Document: Data

## Total Advance Directives

- 606
- 70% are Durable power of Attorney
- 30% are DNR, POLST, Medical Power of Attorney, Living wills

## Annual Michigan Queries

- ~12,000

# National Trends

1

Serious discussions about validity of current processes and tools which outline serious illness conversations

2

Most important to understand Patient Advocate Designation and contact information

3

Additional focus by clinicians to understand what is meaningful / valuable to a person with serious illness

- Creates a starting point for meaningful conversation & care planning

4

Recognizing inclusion criteria for inclusion in palliative or hospice care earlier in illness progression.

5

Opportunity costs being questioned

# Data to Drive Decision Making

“Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations” (CMS)



<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement#:~:text=Quality%20improvement%20is%20the%20framework,%2C%20healthcare%20systems%2C%20and%20organizations.>

# ACP Quality Improvement

- **Plan:**
  - The theories on which ACP as a concept were formed were solid
  - A national movement
- **Do:**
  - 20 years' worth of ACP processes, documents and conversations which have been invested in; normalized and incentivized
- **Study:**
  - 20 years' worth of data on ACP processes
  - Many high-quality studies to draw on
  - Systematic literature reviews
  - Randomized control studies
- **Act:**
  - What do we as a state plan to do with this information
  - How should processes, documents, conversations and information movement be changed to support serious illness conversations

# National Literature

- Research and outcomes data bringing current approaches into question
- Large studies, systematic literature reviews, randomized control studies (High quality body of evidence)
  - ACP fails to improve end-of-life care
  - No association of ACP with subsequent health care use, including emergency department visits, hospitalizations, and critical care
  - Could not identify meaningful differences in health care use, patient quality of life, or goal-concordant care between those randomly assigned to receive either ACP or usual care

Creating a focus on serious illness conversations and training of clinicians to initiate these conversations earlier in the disease progression







# National Literature

“The whole notion of advance care planning ignores the reality that we can't anticipate our future ability to adjust and accept constraints on our life that at an earlier stage of life would have seemed unacceptable,”

Diane E. Meier, MD, FACP, a palliative care physician at Icahn School of Medicine at Mount Sinai in New York City

*JAMA. 2021 October 26; 326(16): 1575–1576.  
doi:10.1001/jama.2021.16430.*

# National Literature

“The focus of advance care planning should be on preparing both the patient and the surrogate for medical decision making by focusing on what quality of life means to the patient”

Rebecca Sudore, MD, Geriatrician at the University of California, San Francisco,

<https://acpinternist.org/archives/2022/05/rethinking-advance-care-planning.htm#:~:text=Once%20a%20surrogate%20is%20chosen,to%20the%20patient%2C%20she%20said.>





# National Literature

“The inability of ACP to achieve its desired outcomes represents the gap between hypothetical scenarios and the decision-making process in clinical practice settings.”

*Morrison RS, Meier DE, Arnold RM. What's Wrong With Advance Care Planning?. JAMA. 2021;326(16):1575-1576. doi:10.1001/jama.2021.16430*

# National Literature

“Scenarios and situations in clinical practice settings rarely reflect these conditions. Treatment choices near the end of life are not simple, consistent, logical, linear, or predictable but are complex, uncertain, emotionally laden, and fluid.”

*Morrison RS, Meier DE, Arnold RM. What's Wrong With Advance Care Planning?. JAMA. 2021;326(16):1575-1576. doi:10.1001/jama.2021.16430*

