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Health Information Exchange

PRODUCT & SERVICE OFFERINGS



Health Information Exchange



The Next Generation of Health Information Exchange

The HIE Platform is a 3rd-generation, cloudbased, high-performance solution leveraging a series of custom-tailored AWS micro services and API gateway components that are natively built, tuned, and optimized using Amazon Web Services (AWS) cloud-native infrastructure high-volume message routing and clinical data exchange.

In addition, many organizations are struggling to prepare for the new federal and state interoperability regulations. The HIE Platform mitigates those issues by integrating with Active Care Relationship Service (ACRS), Health Directory (HD) and Intelligent Query Broker (IQB) as well as increasing flexibility and modularity for its users.

Benefits



Provides for wide scale monitoring and rapid response to COVID-19 in real-time



Empowering & friendly to HIE, state, & health plan activities at the local level



Honors the diverse jurisdictional needs at the state, county, & community levels



Supports CMS Conditions of Participation requirements for hospitals





Custom AWS Micro services and API gateway components optimized for high volume message routing



Modular, flexible, and highly scalable, and has plug-and-play architectural components that can be easily integrated with other industry standard solutions



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1. Core Infrastructure:

- a. Current version of ACRS on Neptune
 - i. Includes full batch load process that mirrors current batch load process in Michigan
 - 1. Files loaded through SFTP or File Uploader
 - ii. Real-time ACRS creation API
- b. Skinny version of HD on AWS, includes:
 - i. Delivery preferences file support
 - ii. Components required for facilitating message routing
 - iii. Components necessary to support routing by provider

2. Interface Layer

- a. Ability to receive messages (HL7 messages including ADTs, Lab, Rad, Trans, Path and C-CDAs) through the following mechanisms:
 - i. LLP over VPN - all
 - ii. REST API – ADTs, C-CDAs
 - iii. DSM – all
 - iv. SFTP – ADTs, C-CDAs, individual messages or batch files
- b. Ability to send messages through the following mechanisms:
 - i. LLP over VPN - all
 - ii. REST API – ADTs, C-CDAs
 - iii. DSM – all
 - iv. SFTP – ADTs, C-CDAs (finishing this sprint (7/15)), individual messages or batch files
- c. Ability to route messages based on:
 - i. Patient attribution in ACRS
 - ii. Provider listed in message
 - iii. ZIP code of patient in message
 - iv. On the roadmap is delivering messages by health plan associated with the patient in the message
- d. Combine ACRS and HD APIs into one call
- e. Ability to automatically pull CCD for patient from data lake and route based on inbound ADT
- f. Ability to receive Public Health Reporting message types (Immunizations, Disease Surveillance, Syndromic Surveillance, etc.) to appropriate registry
- i. Currently supports LLP over VPN and SFTP
- g. Supports capturing and utilizing opt-out status
- i. Flag stored in ACRS
- h. Specific customizations for WISHIN and GaHIN

3. ETL and Transformation layer

- a. Mapping tables (process mirrors current MiHIN mapping table functionality)
 - i. Supports normalization based on mapping tables (HIN defined values)
- b. Transform inbound ADTs in order to store in parquet data lake
- c. Introduction of Qvera allows for additional transformations

4. Storage layer

- a. Store messages in message specific parquet data lake
 - i. Individual data lakes per message type
 - ii. Can create customer specific data lakes

5. Reporting and analytics layer

- a. Operational reporting (akin to M3 reporting; built in Quicksight) for:
 - i. ACRS
 - 1. Number of relationships
 - 2. Total number of unique records
 - 3. Percentage of unique records
 - 4. Records with a common key
 - 5. Percentage of relationships with common key
 - 6. Total number of unique common keys in ACRS
 - ii. HD
 - 1. Hospital Count
 - 2. Pharmacy Count
 - 3. Managing Org Count
 - 4. Misc. Org Count
 - 5. Provider Count
 - 6. Affiliation Count
 - 7. Organization Count
 - 8. Practice Count

9. SNF Count

iii. Messages

- 1. Inbound totals with standard deviation
 - a. Broken down by sender
- 2. Outbound totals with standard deviation
 - a. Broken down by receiver
 - b. Conformance reporting
- i. Set up to mirror existing conformance reports for messages in Michigan but built in Quicksight
- c. Audit logging (based on latest audit logging functionality implemented in Michigan)
- i. Inbound and outbound logs
- ii. Logs for traffic through ACRS and HD
- iii. Logging for user activity within MIGateway

6. MIGateway; includes:

- a. File Uploader
- b. Manage ACRS
- c. TOC Viewer

7. Core infrastructure components integrated with IQB functionality

- a. ACRS and HD support identifying relationships and endpoints
- b. Ability to query for patient information from MIGateway
- c. Ability to query internal data lakes for CCDs
 - i. Established a CCD data lake
 - ii. Established support of integration with Diameter application



Active Care Relationship Service®








The Active Care Relationship Service (ACRS®) connects patients' electronic health information with the providers delivering their care and the payers covering the cost. By making these connections in real time, ACRS helps strengthen and extend these important relationships, enhancing the continuity and quality of care delivery.

When doctors are well-informed about their patients, not only do patients feel more connected to their care team, but they have the assurance that they are getting the best personal care possible. Their providers know them... not just for one visit but for all previous visits and the visits they might make to other care facilities. ACRS helps make that happen.

Active Care Relationships can be created in several different ways:

- Velatura receives a batch file of all patients for whom a receiving provider or plan is attesting to have an active care relationship
- Relationships are captured in real-time based off of an organizations ADT feed
- Providers/care team members can add relationships through



Benefits

-  Improve care transitions and coordination
-  Speed results analysis and quality improvement
-  Standardize quality data sharing
-  Expand access to patient information
-  Gain insight with custom reporting

Additional information:

- Attribute ACRS – capture important attributes for a patient that adds valuable context and provides a map to where to go find more detailed information
- ACRS Choices – capture patient consent and important decisions a patient has made about who can see their health information and what they would like to share



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Common Key Services







Common Key Services

Common Key Service is an approach to improving patient matching across organizations through the addition of a unique coded “attribute” to a patient’s electronic health data. This attribute is not recognizable to humans and is stored in Velatura’s statewide master patient index (MPI). The information is then shared with all participating organizations to keep as an additional identifier for external data matching and exchange.



Common Key Service improves patient identification, safety, and care coordination. Organizations making use of Common Key can be assured that the patient information being referenced is accurate to the individual being treated, confirmed with a consistent and reliable method of matching patients to their specific electronic medical record.

Common Key Service is in use today, assuring that critical electronic patient data is accurate and available where and when it’s needed most – at the point of care.

Benefits

-  Strengthens patient matching among disparate systems
-  Ensures accuracy of message delivery for care coordination
-  Common keys can be leveraged in participating systems to improve data quality at the source
-  Allows for more accurate query and retrieve of pertinent information



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Health Directory



Health Directory is a comprehensive database containing contact information on a wide variety of health professionals from across the care continuum.

With Health Directory, health systems and providers can seamlessly and securely access, manage, and share cataloged data on how to reach professionals both inside and outside of their organizations to facilitate timely communications and enhance the quality of care delivery.

Health Directory's flexible design supports the complex network of affiliations and organizational relationships at play across our modern healthcare landscape. The service is highly scalable, and supports numerous health information use cases.

In addition, MiHIN provides the expertise needed to ensure that data is regularly updated and maintained for optimal accuracy. Health Directory is in use today, routing millions of transactions each day across Michigan, assuring that critical patient data is electronically available where and when it's needed most – at the point of care.

Benefits



Locate all endpoints where data is routed



Reference organization's current use case participation



Update provider data and practice locations in real time





Query and retrieve provider information using a variety of demographic attributes



Participate via user interface, FHIR API, standard REST API, or batch file process



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Intelligent Query Broker



Intelligent Query Broker

The Velatura Intelligent Query Broker (IQB) is a service that will allow healthcare providers actively caring for the patient to obtain their health information from multiple sources quickly and accurately, while reducing technical barriers between different facilities.

IQB allows providers to request documents for patients from Velatura or its connected facilities, including the eHealth Exchange, and greatly reduce the burden to obtain information from other organizations. IQB also allows organizations to request a single consolidated document with historical information for their patients contained in the Super C-CDA. Rather than receiving a document that requires a provider to sift through a large quantity of information, IQB provides a tailored result with the exact information the provider needs, and only that information, in the format they can use.

Benefits



Connects patients to providers



Allows organizations to retrieve documents from multiple sources, including the eHealth Exchange, through a single connection





Gives patients better ways to manage their own health



Addresses patient literacy and access without undue cost or technological burden on providers or patients



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MIGateway



MIGateway

MIGateway (Medical Information Gateway) is a single solution for seamlessly managing multiple health information reporting systems to streamline work flows, improve care coordination, and enhance the quality of electronic health data.

MIGateway will streamline workflows, improve efficiency in care coordination, and improve data quality while giving providers and managing organizations a single, consistent, interoperable solution for coordinating patient care.

With the use of MIGateway single-sign-on, users will also have access to the Longitudinal Record—a cloud-based longitudinal community health record that aims to reduce requests for medical records and improves overall workflow for all.

Benefits



Modules are accessible via web portal, iFrame, API or SSO



Significantly reduces burden necessary to access information



Allows existing applications to leverage shared services



Cost effective

Information available through MIGateway:

- Admission, discharge, and transfer (ADT) notifications
- Clinical care documents

Services accessible through MIGateway are:

- Ability to view, add, edit, and delete active care relationships
- Access to Diretto direct secure messaging inbox
- Single sign-on to the longitudinal record



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TOC Viewer

MIDIGATE (Demo 1.3.1) Home Care Coordination Directo Inbox Administrative Support Jason

ADT Filter Hide

Patient First Name Patient Last Name Patient Birth Date Sending Facility Health System

From Date To Date Sending Facility Type Sending Facility Name

Patient Class ADT Type ACRS File

Patient Chronic Conditions Sort Order Page Length ☒ Hide Reviewed ADTs ☐ Has Care Summary

None selected Message Date 25 results per page

Showing 1 to 18 of 18 entries Previous 1 Next






ADT	Patient Information	Actions
A03	<p>ALICE VARGAS born 05/10/1990 was Discharged to Von Voigtlander Women's Hospital - Michigan</p> <p>Medicine on 02/08/2021</p> <p>Diagnosis Type: F</p> <p>Diagnosis Coding Method: I10</p> <p>Diagnosis Code Identifier: F11.288</p> <p>Diagnosis Description: Opioid dependence with other opioid-induced disorder</p> <p>Chronic Conditions:</p> <p>Insurance Company Name:</p> <p>Patient Class: O</p> <p>Discharge Disposition:</p>	<div><input type="button" value="View"/> <input type="button" value="XML"/> <input type="button" value="PDF"/> <input type="button" value="Care Summary"/></div> <div><input type="button" value="View"/> <input type="button" value="HL7"/> <input type="button" value="ADT"/></div> <div><input type="button" value="View"/> <input type="button" value="VIPR"/></div>

TOC Viewer

The Transition of Care (ToC) Viewer provides Care Coordinators with the real-time access they need to valuable messages related to their patient population. Access to timely encounter notifications and test results not only reduces the lag time between transitions of care, it improves patient experience and outcomes.

Notifications that are sent through the statewide health information network when patients move to new care settings help improve care coordination for your patients. By providing notifications for all patients in an easily readable format, ToC Viewer establishes a clear picture about what occurred at each visit and the outcome of that visit.

Benefits

-  Improved coordination of care
-  Timely updates to patients health events
-  Decreased healthcare costs
-  Improved workflow efficiencies
-  Supports meaningful use reporting

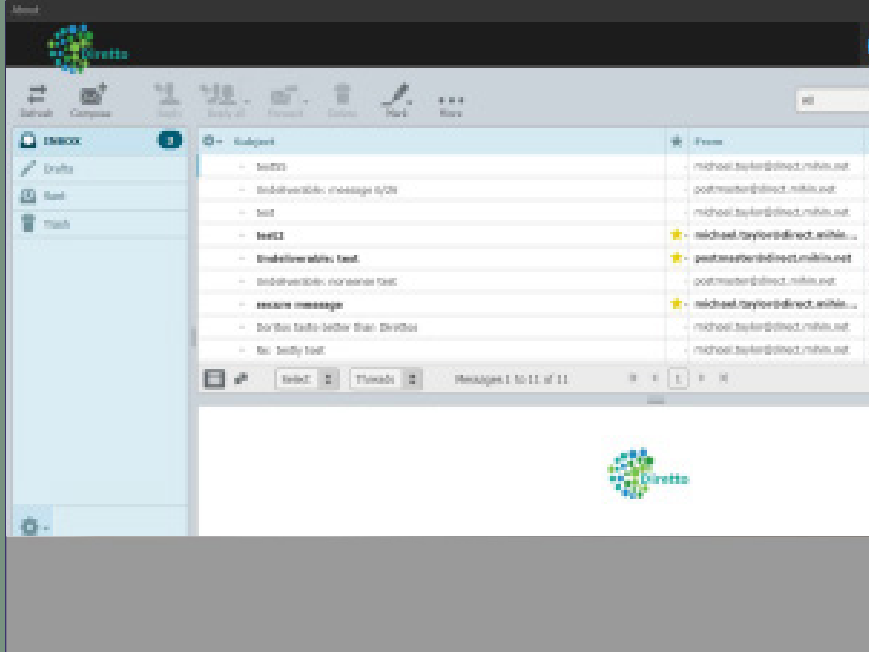


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Direct Secure Messaging



Diretto

Direct Secure Messaging is a commonly accepted national standard for securely sharing electronic communication of patient related data between healthcare providers. A key aspect is that many different and competing technology products can share patient data. Direct messages are shared via secure, closed-network electronic mail addresses provided by accredited Health Information Service Providers (HISPs).

As the largest HISP in Michigan, MiHIN manages Direct addresses across the state through their standalone secure messaging platform, called Diretto. With Diretto, anyone invested in patient care safely and securely send and receive patient health information to facilitate timely communications and enhance the quality of care delivery.

Diretto is in use today, routing hundreds of messages each day, assuring that critical patient data is electronically available where and when it's needed most – at the point of care.

Benefits



Securely send or receive messages containing PHI as either free text or an attachment



Applicable for use in formal use cases as well as out-of-band communications



Easily integrated into any workflow with minimal technical requirements



The largest network of accredited Direct addresses in Michigan



Affordable, accessible, and scalable health information interoperability

DirettoReg™

DirettoReg™-A free tool that reduces provider organization burden to communicate and register their selected types of endpoints, such as Direct Secure Messaging address, FHIR URL 4.0.1, Connect URL, etc. with the NPPEs.

In partnership with 3WON, MiHIN and Velatura are proud to improve interoperability across the US by offering such an important and timely tool for providers.



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CCD-A Normalization & Conformance



CCD-A Normalization & Conformance

A value added service that we are making available to our customers so that they can pull their conformance reports and fallout reports at any time in a self-service fashion.

Features

Ability to view ADT and CCD-A conformance reports and the ability to search for and download specific message examples.

Benefits



Enables organization to track data quality conformance scores





Ensures data is complete and actionable when it's received by the practitioners using the information

Reports available through MIGateway

- ADT Conformance Report for Hospitals
- ADT Conformance Overview for Hospital
- ADT Fallout Report
- MedRec (CCDA) Conformance Report for Hospitals
- MedRec (CCDA) Conformance Overview for Hospital
- MedRec Fallout Report



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Longitudinal Patient Record

1. Patient Banner

2. Patient Demographic Icon

3. Alerts Icon

4. Patient Information Tabs

5. Summary Snapshot

Longitudinal Patient Record

The Velatura Longitudinal Patient Record is patient-centric, real time, and statewide. The easy to navigate tool gives healthcare providers the essential clinical information they need. Information is available from over 200 healthcare organizations across the Midwest!

The Longitudinal Record helps bridge the gaps in data that may occur from one patient's visit to the next. Securely providing a comprehensive collection of clinical results and other relevant health information improves the quality, efficiency and cost of healthcare.

What information can you find?

- Admissions, Discharges, and Transfers
- Laboratory & Radiology Results
- Transcription Documents
- Diagnoses and Procedures
- Allergies and Alerts
- Patient Demographics and Insurance
- Advance Care Documents, Living Well, DPOA, POST, OB AGOG forms, etc.
- Telemedicine visit notes and summaries
- Patient Care Documents (Asthma, Diabetes, Cancer, Pain Management, Cardiovascular Action and Care Plans) Links to PACS Radiology images –This reduces CD distribution and delay



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Results Delivery



The coordination of laboratory, radiology and transcribed documents across organizations can be very challenging and can have a negative impact on healthcare costs as well as patient care. Results must be presented in a timely manner and in a usable, actionable format so recipients can deliver efficient and effective patient care.

An electronic exchange of results through an interconnected network of trusted data-sharing organizations (TSDOs) can help improve the quality, efficiency and cost of healthcare.

Results delivery includes the Statewide Lab Orders-Results scenario which helps participating organizations electronically send and receive lab results via the statewide health information network (HIN).

Velatura offers three alternatives for Results Delivery:

1 Discrete delivery of information in your EMR

This method allows providers and medical staff to stay in the EMR when providing patient care.

2 Delivery into your network folder

From the network folder on your computer the documents can be delivered into a Fax Server, not the fax machine.

3 Delivery into the TOC viewer/Inbox

Provides Care Coordinators with real-time access they need to valuable messages related to their patient population

Benefits



Improving patient safety (by alerting clinicians to abnormal results in real-time)



Reduced Costs (by ensuring providers have access to results before ordering tests)



Improving care (by helping clinicians identify and target specific patients for follow-up care)



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Your state-wide reference for SDoH Screenings and Interventions



Social Determinants of Health screenings provide important information regarding conditions in which people live, learn, work and play. These factors impact health and involve the continuum of care and community. Knowing that your patient has identified needs and requested assistance is crucial for coordinating care.

The MIGateway Transition of Care (TOC) viewer can offer insight and information as to where screenings have been done and subsequent assistance rendered and/or in process. This is the first step. Over time, we will offer a Social Care Record, also accessed via MIGateway.

Participating Organizations (both healthcare providers and community resource agencies) who perform screenings and deliver services to support the SDoH needs will send that information to Velatura. We will share these data as permitted by the Active Care Relationship Service.

Benefits



Provides Social Determinants of Health screening information to Providers and Care Coordinators in simple, consistent format



Supports care and improved outcomes for neighbors, friends, family by identifying and addressing barriers.



Honors communities' diverse and unique relationships, services, and needs.



Real time, secure, user-friendly referral management tool (ReferralsPlus) available.



Supports state reporting and planning for resources.





Aligning to national initiatives supporting technology and code-based data submission



Empowers states and municipalities, health plans, and participating organizations with accurate actionable data



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Advanced Care Documents



Advanced Care Documents

Advance Care Documents are a patient's roadmap for future healthcare decisions. When treatment plans and patient wishes are followed by providers, the experience and outcomes of care improves. This is particularly true for those suffering from severe illness or who are nearing the end of their lives.

A persistent challenge in provider adherence to patient's health directives, is a lack of ready access to this information at the point-of care during times of crisis. The MiHIN Group is committed to helping people discuss, decide, and document their preferences for future healthcare. Those preferences are recorded in an advance directive (AD) and then electronically uploaded to the Virtual Integrated Patient Record (VIPR) for easy access by healthcare providers at the point-of-care.

Benefits



The Largest databases of Advance Directives and clinical care plans in the nation



Stored in the trusted and secure VIPR.



Information is readily available to a statewide network of hospitals, primary and specialty care providers and allied health organizations



Committed to helping people discuss, decide and determine their preferences for future healthcare



Educates the healthcare community to honor a person's AD to ensure that their wishes are respected



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Aware



Aware





Clinicians are frequently limited to the information contained within their own EMR to guide decisions on patient care. Yet increasingly care teams understand how important it is to collaborate with other stakeholders who may have valuable information to support clinical decisions. Unfortunately these stakeholders frequently lack a mechanism to share that information at the right time or within a care teams existing workflow.

The Aware product bridges that gap. Aware leverages MiHIN's core infrastructure (ACRS and HD) to provide care teams with information at the point of care. This product layers on top of existing EMRs in an unobtrusive panel which senses what patient and section of the chart a care team member is in, and surfaces information that can be customized to meet the needs of the care team.



The Aware product eliminates the need to search for information from disparate sources, allowing the care team to spend more time with the patient.

Examples might include surfacing quality measure gaps in care or indicating the presence of an Advanced Care Plan that can support care aligned with patient wishes. Identifying recent referrals outside of the healthcare system can also be valuable information to reduce workloads and better coordinate care for individuals.

Benefits

-  Eliminate duplicative testing, work and administrative burden on care team members
-  Increased collaborative view of where patient treatment and response is
-  Targeted information at the point of care without disrupting existing workflows
-  Customizable attributes allow information to be surfaced based on needs of care teams and populations



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Cancer Registry Updates



Cancer Registry Updates

The Cancer Registry record cases of cancer and other specified tumorous and precancerous diseases that occur in the state. The registry records information necessary and appropriate to conduct epidemiologic surveys of cancer and cancer-related diseases in the state. The Michigan Department of Community Health (MDCH) has used the registries to increase their understanding of statewide incidence rates and conclude possible trends which they now think may be related to inherited cancers. Cancer registries are essential for halting the burden of cancer.

All reports of cancer diagnoses are required by a facility that either diagnoses or treats a cancer patient. All healthcare facilities such as hospitals, laboratories, physician offices, dentists who have obtained knowledge of a positive case of cancer, is mandated to report the case to the Michigan Department of Health and Human Services (MDHHS). The Michigan Cancer Registry receives these reports and compiles the data into a statewide registry.

Benefits



Helps identify possible trends in cancer diagnoses based on demographic characteristics, such as age, race, and sex.



Helps aid in the planning of public health efforts to hopefully prevent new cases of cancer and help better treat existing cancer cases.



Helps identify high risk behaviors and environmental risk factors so proper preventive measures can be put in place to help reduce the number of positive cancer cases.





Reporting information to the cancer registry also helps when planning patient follow up. It can serve as a reminder to both health care professionals and patients to keep regularly scheduled exams



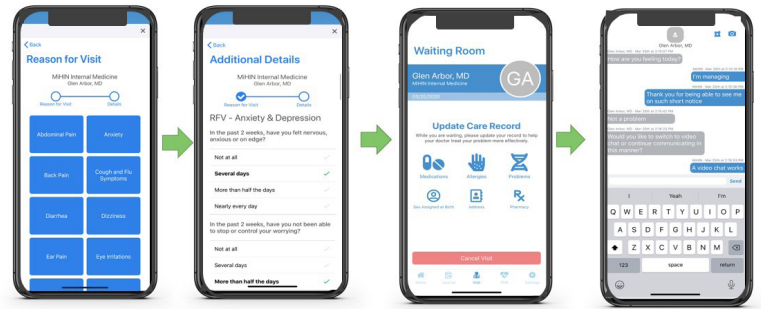
Helps those involved in cancer case studies to better understand the disease and use resources and technology to better aid in prevention and treatment.



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Care Convene







Care Convene



Care Convene is a HIPAA compliant telehealth platform that allows for greater patient access to quality care. Extending the reach of the care team beyond the traditional brick and mortar practice, Care Convene increases patient retention and satisfaction and helps providers work more efficiently.

Care Convene offers both virtual visit chats (like texting) and video visit options. Providers set up a “clinic” within Care Convene and invite patients to join through a basic invite link. Providers can assign patient assessments that communicate directly back to the provider, empowering patients to proactively manage their own health and enabling providers to monitor important changes.

Benefits

-  connects patients to providers
-  allows care teams to consult virtually
-  gives patients better ways to manage their own health
-  addresses patient literacy and access without undue cost or technological burden on providers or patients



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Death Notifications



Death Notifications

Deaths are an unfortunate reality in the world of healthcare. When a patient or physician passes away, it is critical to quickly notify multiple healthcare organizations (physician offices, pharmacies, health plans, public agencies, etc.) to help reduce waste and prevent fraud. For example, medical supply companies often continue shipping expensive and non-returnable supplies for weeks or months before learning a person is deceased. Those shipments result in hard-dollar waste in the millions of dollars. This waste is all preventable.



For many years, delayed death notifications have financially impacted healthcare facilities and government departments. There have also been accounts of people using these delays for fraudulent insurance claims or other criminal activities.

The Fact of Death Notifications use case helps participating organizations receive notifications of deaths in a timely and accurate fashion. Electronic death notifications help improve awareness of the event, avoid unnecessary and wasteful spending, preclude falsified insurance claims, and stop dispensation of prescribed medications.

The Fact of Death use case also can help inform care teams of a death if the person is involved in a study and can notify care teams of fact of death so they can help identify intervention opportunities for suspected fraud and substance abuse. It can also improve home health, rehabilitation, and hospice organizations' ability to reallocate resources and scheduling availability and enable better synchronization between state and local vital records registries.



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eConsent

The eConsent product provides a standard method to manage consent forms used to capture a consumer's preference to share or withhold Specially Protected Information (SPI) in a health information exchange (HIE) environment. This includes electronically storing, updating, finding, revoking, or deleting a consent preference related to SPI when expired.

These consent preferences can be used by the Health Information Network electronically, as well as by the providers themselves should they need to verify consent exists to send a message manually.

Benefits



42 CFR Part 2 facilities can now participate in sending messages that contain SPI like ADTs which helps Part 2 hospitals comply with CMS Conditions of Participation



Consumers have a standard, statewide solution for managing SPI consent



Providers with consent on file can now receive messages from MiHIN that contain SPI



Providers have ability to access consent forms from across the state that they are listed on, easing the burden of re-obtaining consent to share at each facility



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Electronic Case Reporting (eCR)



Electronic Case Reporting (eCR)

The Electronic Case Reporting (eCR) use case allows healthcare providers to send case reports regarding a patient's infectious disease status to a public health agency. Having an interoperable electronic case reporting (eCR) capability between healthcare providers and public health reporting agencies allows for reduced costs for stakeholders, increased accuracy and effectiveness, and speed of reporting cases of infectious diseases.

eCR allows lays the foundation for two-way data exchange so clinicians are better able to collaborate with public health officials during outbreaks, while staying better informed. State public health reporting data is also used to support national and international disease surveillance efforts.

Healthcare providers are required to alert public health agencies of reportable conditions; however, several limitations exist to record/report in a timely manner.

Benefits



Outbreaks can be managed



More routine trends can be investigated and managed



The public can be protected from infection



Treatment and education can be provided to impacted populations and providers



Preventive measures can be enacted



Long-term success efforts can be measured



Research into causes and cures can be more exact



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Immunization Query



Immunization Query

Immunization Query allows healthcare providers the ability to look at MCIR information directly from their electronic medical/health record (EMR) system.

This connection eliminates the need to navigate to the MCIR website separately and log in, therefore more quickly informing the provider of critical immunization information.

Benefits



Allows vaccine administering providers to receive a real-time response of whether a vaccine record exists at MCIR for any given patient. This helps to reduce duplicate immunizations, and also provides a more complete immunization record for a patient.



A patient that may have just moved to a new location within Michigan may not have up to date immunization records, and by querying MCIR, the provider office is able to see all vaccine history of that patient in real-time.



Providers are able to know if their administered vaccines made it all the way to MCIR or not because they receive a real-time acknowledgment. Childhood vaccines administered in the State of Michigan are required to be entered into MCIR within 72 hours of administration. If an office has the bi-directional immunization query interface, the provider's office will know right away if there was an error. If the 72 hour window is missed, the provider may be out of compliance.



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Immunization Submissions



Immunization Submissions

Complete immunization histories for children and adults in Michigan are sent to the Michigan Care Improvement Registry (MCIR). Providers are required by state law to report childhood immunizations within 72 hours of administration.

The reporting of adult immunizations is also highly encouraged. Health care organizations, schools, and the general public benefit from the consolidations of immunization information. MCIR provides health care providers with up-to-date patient immunization history, which can help reduce vaccine-preventable diseases and over-vaccination. MCIR also assists in pandemic flu preparedness based on vaccines and medication information in the registry.

Benefits



Immunization records from all providers within the State are in a centralized record.



Sending immunization records electronically helps prevent vaccine-preventable diseases, and repeatable vaccines because all vaccine records are in a central repository.



Reduces the burden on medical staff that formerly were required to manually enter vaccines in MCIR. This reduces the opportunity for clerical error, and ensures immunizations get to MCIR in a timely fashion.



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InterOp Station



InterOp Station

The InterOp Station is a streamlined solution to enable Payers in meeting the 21st Century Cures Act goals of enabling member access to a consolidated view of their health and plan information in applications of member choice through FHIR® APIs.

As a scalable, cloud-native FHIR API platform, the InterOp Station, which includes the Patient Access, Provider Directory, and Payer-to-Payer APIs, adheres to federally required FHIR® 4.0.1 standards and reflects industry best practices such as the CARIN Alliance Blue Button and Da Vinci implementation guides to provide an efficient framework to support compliance with the federally mandated timelines.

Benefits

Module Framework:

- “Plug and play” platform that complies with requirements and standards
- Build to augment existing services while addressing gaps in others

Reuse of Investments:

- Leverage existing state investments in HIE to provide a streamlined compliance strategy for Medicaid

Promote Collaboration and Buy-In:

- Align with federal priorities to invest in solutions that serve multiple healthcare stakeholders
- Promote buy-in and collaboration through our InterOperability Land

Streamline Efforts and Vendor Management:

- Aggregated across state subsystems and vendors – especially in a highly modularized MMIS environment
- Provide funding strategies and APD development

Highway to Interoperability:

- “On-ramp” to future interoperability strategies and initiatives (quality reporting, SDoH, TPL)
- Low-cost/low-effort scalability through AWS SAM framework



For more information please contact help@mihin.org

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Lab to C-CDA Conversion








Lab to C-CDA Conversion

Lab to C-CDA Conversion grants a patient's care team the ability to receive laboratory results in a single Continuity of Care Document (CCD). Using MiHIN's Common Key Service, laboratory results will be aggregated into a single CCD and routed to organizations with an active care relationship to the patient.



Lab to C-CDA Conversion provides greater access to a patient's health information, as well as allows an organization the option of receiving a CCD rather than individual HL7 messages. A comprehensive CCD will allow for a broader overview of a patient's laboratory orders and results, and thus better care coordination and outcomes.

Lab to C-CDA Conversion is still in development, and not currently in use. However, once available it will be a part of the Statewide Lab Orders Results scenario which helps participating organizations electronically send and receive lab results via the statewide health information network (HIN)

Benefits

-  Securely receive laboratory orders and results as a CCD
-  Improved care coordination and patient safety
-  Easily integrated into existing Statewide Lab Orders Results scenario
-  Statewide network of participating organizations
-  Affordable, accessible, and scalable health information interoperability



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Newborn Screening



Newborn Screening

Before leaving the hospital or birthing center, a newborn child will have a series of screening tests implemented. These tests will check if the child has any inherited disorders by pricking their heel, perform a hearing test that checks the child's response to sound, and measure the level of oxygen in the newborn's blood with a skin test which expresses whether or not they have a congenital heart defect.

Without the newborn screening, serious medical conditions that are not apparent at birth could very easily go unnoticed, possibly resulting in lifelong health complications or death.

Goals and Benefits of Newborn Screening:



Provide and ensure follow-up care for infants with positive screening results



Monitor health of infants long-term, to ensure positive future health



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Quality Measure Information

Quality Measure Information

Closing gaps in care continues to be a critical component of the transition to value based care. But unfortunately, the administrative burden that comes with the variety of reporting requirements and technical standards does not seem to be getting any easier. Whether you are a provider or health plan, MiHIN has developed solutions to help so more energy can be spent on ensuring patients get the care they need.

Quality Measure Information

Michigan's Physician-Payer Quality Collaborative (PPQC) is a multi-stakeholder group co-hosted by MiHIN and the Michigan State Medical Society (MSMS). The group works to standardize and streamline the exchange of supplemental clinical data, and bridge gaps in care between providers and health plans.




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The PPQC has successfully implemented a data flow that has exchanged hundreds of millions of records to date. State and federal organizations including CMS and NCQA have endorsed PPQC and the emphasis on collaboration and standardization.

Helping Providers with eMeasure Reporting

The Clinical Quality Measure Reporting & Repository Service® (CQMRR®) allows providers across Michigan to submit their electronic clinical quality measure (eCQM) results to a centralized portal with easy drag & drop functionality. The QRDA formatted files are validated to ensure compliance with state and federal requirements, and a full-service help desk is available to assist with any issues. Once validated, files can be delivered to reporting programs such as Michigan Medicaid Promoting Interoperability (formerly Meaningful Use), MIPS, or CPC+.

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Reportable Labs



Reportable Labs

Electronic Laboratory Reporting (ELR) is the automated communication of necessary laboratory reports from laboratories to the public health department. Previously, these reports are received by public health agencies via fax, mail, or phone, and then manually entered into electronic disease surveillance systems.

ELR allows for automation of these manual processes, saving time, money, and other resources. Once the lab results are received, they are processed and distributed to the local or state health department, or sometimes, the Centers for Disease Control (CDC).

Benefits



Improved timeliness of reports



Reduction of manual errors



More complete reports



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Syndromic Surveillance



Syndromic Surveillance

Syndromic Surveillance is a systematic assembly that continuously analyzes and interprets health-related data which is used for organizing, applying and evaluating public health practice, in emergency room patients. This can be very beneficial for detecting and responding to unusual outbreaks resulting from a variety of health threats and emergencies.

Institutions like Centers for Disease Control and Prevention (CDC) and World Health Organizations (WHO), have now created databases that are able to track and monitor emerging outbreaks of illnesses due to the assistance of syndromic surveillance. Currently, only hospitals and urgent care sites are able to attest for this measure.

Benefits



Receiving notification of an illness in a timely fashion can allow for early public health intervention to reduce the overall impact and risk to the general population.



Outbreaks can be better managed and pinpointed to a general location.



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