

Health Information Technology Commission
Minutes

Date: Thursday April 21, 2011
1 – 4:00pm

Location: MDCH
1st floor Capital View Bldg
Conference Room B&C
201 Townsend Street
Lansing, Michigan 48913

Commissioners Present:

Greg Forzley, M.D. – Chair
R. Taylor Scott, D.O.
Olga Dazzo
Larry Wagenknecht, R.Ph.
Kimberly Ross – Jessup
Tom Lauzon
David Behen
Joseph Hohner
Toshiki Masaki – Vice Chair
Mark Notman

Commissioners Absent:

Robert Paul
Robin Cole
Dennis Swan

Staff:

Beth Nagel – MDCH

Guests:

Clayton Frick - Deloitte
Steve Werhle - Accenture
John Hazewinkel – MSU
Clare Tanner – MPHI
Rick Warren – Allegiance
Ed Dore – PAA
Rebecca Blake – MSMS
Jim Lee – MHA
David Durkee – MOA
Richard Weiner – Weiner & Assoc.
Sharon Leenhouts – Delta

Deb Mosher - CARHIO
Kimberly Lynch – M-CEITA
Carla Lough – SEMBCC
Carmen Redwine – DTMB
Mazhar Shaik – M-CEITA
Patrick O’Hare – Spectrum
MaryAnne Ford - CARHIO

Minutes: The regular monthly meeting of the Michigan Health Information Technology Commission was held on Thursday, April 21, 2011 at the Michigan Department of Community Health with ten Commissioners present including the Chair.

A. Welcome

B. Review and Approval of 3-17-11 meeting minutes

- Minutes of the 3-17-11 meeting were approved and will be posted to the HIT Commission website following this meeting.

C. Office of the National Coordinator for HIT Presentation on Activities, Trends and Vision

- Erica Galvez, project officer from the Office of the National Coordinator for HIT (ONC) presented ONC goals and principles, ONC perspective on statewide HIE, the cooperative agreement and trends from other states.
- Galvez drew a clear distinction that the State HIE Cooperative Agreement, which Michigan received, is a cooperative agreement and not a grant. This means that the federal government should be considered a partner with Michigan and should be included in decision-making. The ONC expects that states will need to make changes to their Strategic and Operational Plans and ONC wants to be a partner and resource.
- Galvez reported that ONC approves of Michigan's governance model and believes that Michigan's model will create trust. Galvez said that having difficult conversations is a way to build up the trust.
- Galvez characterized Michigan's technical model as being a "capacity builder" and an "orchestrator" while looking at four different models of statewide HIE. Galvez noted that the bulk of states also fit into this category.
- Galvez discussed Michigan's approach and said that ONC expects Michigan to follow national standards and leverage the changing HIE market to reach our goals.
- Galvez fielded questions and mentioned that other state approaches are varied – they range from not "building" any technology at all to building everything from the ground up.

D. Strategic Discussion on the MiHIN Shared Services

- Commissioner and MDCH Director Olga Dazzo moderated a conversation and stated that the goal is to drive toward full clarity of the vision and phasing of the MiHIN Shared Services. Director Dazzo said that since the last HIT Commission meeting she has investigated the MiHIN Shared Services approach. Dazzo has found that the vision for statewide HIE has not changed, but instead it has been phased.
- Beth Nagel presented information including the background on the State HIE Cooperative Agreement, where the funding is being directed, how the current costs were derived, a review of the MiHIN Shared Services Vision, the first phase of meeting that vision and an overview of how more information will be gathered.
- HIT Commissioners asked about the differences in the phasing technical approach and why the Master Patient Index technology was not included in the first phase. MiHIN Shared Services Board members answered that many

of the sub-state HIEs, statewide payers, and the state of Michigan are developing their own Master Patient Index functionality and that it makes more sense for those efforts to be leveraged at a later date. The Master Patient Index technology is not needed for the first phases of Meaningful Use criteria and most relevant use cases can be accomplished without the “query” functionality that is enabled by a Master Patient Index.

- Director Dazzo asked if the vision should be changed or if the MiHIN Shared Services should continue down the current path. Dazzo asked the HIT Commissioners and all HIT Commissioners present agreed that the vision is correct and that the MiHIN Shared Services should continue. Dazzo asked all audience members the same question, and no one in the audience voiced disagreement. Dazzo asked Erica Galvez from the ONC, and Galvez said that from the ONC perspective Michigan has the right vision and the right phasing. Galvez said that the ONC is happy that Michigan will be leveraging available assets as opposed to building complex functionality.
- Beth Nagel presented an overview of the history of sub-state HIEs in Michigan and the current status of the operational sub-state HIEs and those that are in implementation.
- The HIT Commission identified the need to continually monitor gaps in service areas and agreed that the sub-state HIEs should be asked to provide coverage area information on a regular basis.
- Rick Warren from Allegiance Health and a member of the MiHIN Shared Services said that he was leading the request for proposal committee and is expecting to release the RFP in May and anticipate a to be in place in August.

E. The Role of the HIT Commission

- Commissioner Greg Forzley, MD presented a section from the MiHIN Shared Services Strategic Plan that was submitted in April 2010. The section describes the HIT Commission’s roles as “monitoring” the MiHIN Shared Services. The MiHIN Shared Services role is to “facilitate” the MiHIN Shared Services.
- Forzley discussed that the statute creating the HIT Commission suggested a statewide role to HIT not just HIE. Forzley asked the Commissioners what topics the HIT Commission should focus on an ongoing basis.
- Commissioners said that monitoring for gaps in services is important as well as how HIT and HIE impact public health, quality and costs. Commissioners also said their role is to ensure that all initiatives are transparent and that the HIT Commission is a key to “checks and balances” of initiatives that have public funding. The Commission also noted that they are a link on creating a dialogue with stakeholders through the open meetings act.
- The HIT Commission requested that a strategic discussion on the HIT Commission’s role should be on the next agenda and the HIT Commission should be prepared to discuss their ideas on the HIT Commission’s future.

F. M-CEITA Advisory Structure and Reporting Relationship with the HIT Commission

- Commissioner Forzley presented a draft stakeholder input structure to the M-CEITA program for the HIT Commission's discussion and consideration.
- Forzley described that there are three stakeholder groups that need to provide input to the HIT Commission regarding M-CEITA's progress and challenges: the direct contractors of the program, statewide stakeholder groups and regional providers.
- Of these groups, the direct contractors already meet and would only need to report back to the HIT Commission on a regular basis. The statewide stakeholder concept came from a group that was previously meeting in a different form and the regional providers was part of a plan that has yet to be implemented.
- Forzley stated that a challenge was the staffing for these groups.
- Mazhar Shaik, the Executive Director of M-CEITA, said that there is no funding for staffing the committees. Commissioners questioned why M-CEITA could not provide the funding. Forzley mentioned that a third party has expressed interest in providing the staffing.
- **Commission Action:** Commissioner Joe Hohner moved and Commissioner Kim Ross-Jessup seconded that the HIT Commission approve the proposed stakeholder structure in concept and the HIT Commission should offer input on the details as they are developed. The motion carried with zero abstentions.

G. Commissioner Updates

- Commissioner Forzley announced that the HIT Commission will need to make some scheduling changes for the May, June and July meetings. The scheduled May 19 meeting conflicts with the Wiring Michigan Conference and there are significant conflicts for June and July. Forzley and Nagel will send out dates for the HIT Commission's consideration.
- Commissioner Larry Wagenknecht noted that the MiHIN Shared Services will have a website up by May 1 at www.mihin.org.
- Commissioner Taylor Scott reported that there would be a series of educational sessions at the upcoming Michigan Osteopathic Association's annual meeting focusing on Meaningful Use & Other CMS Incentive Programs, How to Adopt EHR Technology & Prosper Under Meaningful Use, Social Media in Medicine, and an overview of strategies to secure stimulus funds.
- Commissioner Forzley updated the HIT Commission on the MSMS HIT Symposium which will be held in June.

H. Public Input

- Clare Tanner from MPHI thanked the HIT Commission for their oversight and looks forward to working with the HIT Commission.

I. Adjourn

- Meeting Adjourned at 3:55pm



Michigan Health Information Technology Commission

April 21, 2011

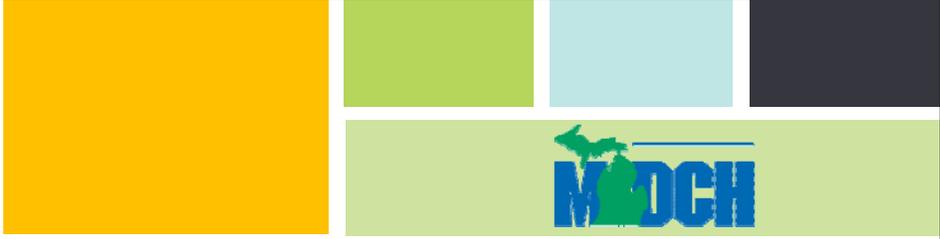
The Michigan Health IT Commission is an advisory Commission to the Michigan Department of Community Health and is subject to the Michigan open meetings act, 1976 PA 267, MCL 15.261 to 15.275

Agenda

- A. Welcome & Introductions**
- B. Review of 3-17-11 meeting minutes**
- C. Office of the National Coordinator for HIT
Presentation on Activities, Trends and Vision**
- D. Strategic Discussion on the MiHIN Shared Services**
- E. The Role of the HIT Commission**
- F. M-CEITA Advisory Structure & Reporting relationship
with HIT Commission**
- G. Commissioner Updates**
- H. Public Comment**
- I. Adjourn**

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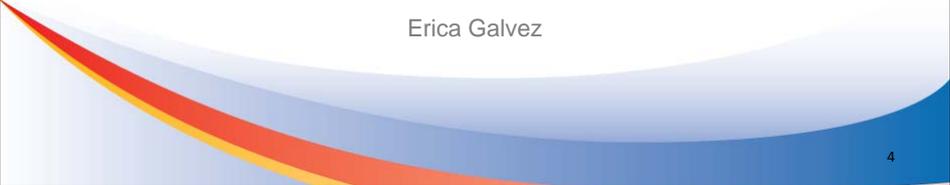




ONC Activities, Trends & Vision

Erica Galvez, ONC

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The Office of the National Coordinator for
Health Information Technology

**Office of the National Coordinator for
Health Information Technology**

**Michigan HIT Commission Meeting
April 21, 2011**

Erica Galvez

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State HIE Cooperative Agreement Program Overview



- Facilitates and expands the secure electronic movement and use of health information
 - Federal-State collaboration
- Prepares States to support their providers in achieving HIE MU goals, objectives and measures
 - Four year program, total funding available \$548 million
- 56 states/state designated entities and territories awarded in March 2010
- States need an ONC approved State Plan before Federal funding can be used for implementation
 - 48 plans approved to date

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State HIE Cooperative Agreement Program Principles



Ensure ALL eligible providers within every state have at least one option available to them to meet three meaningful use requirements.

- **E-prescribing**—the ability to generate and transmit permissible prescriptions electronically (eRx)
 - more than 40% are transmitted electronically using certified EHR technology
- **Receipt of structured lab results**—the ability to incorporate clinical lab test results into EHR as structured data
 - more than 40% of results ordered are incorporated in certified EHR technology as structured data
- **Sharing of patient care summaries across unaffiliated organizations**—the ability for every provider to provide a summary care record for each transition of care or referral
 - more than 50% of transitions of care include a summary of care record

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State HIE Cooperative Agreement

Program Goals



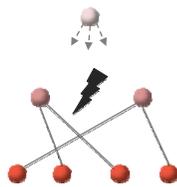
- Foster exchange networks
 - Build capacity of local and affinity models
 - Reduce cost and complexity, including through shared services
 - Policies that encourage exchange
- Monitor exchange and fill the gaps
 - Support the “little guy” – small providers, independent labs
 - Avoid closed networks
 - Consumer-mediated exchange
- Ensure exchange across networks
 - Every provider has at least one option for meeting health information exchange requirements of MU
 - Governance and trust
 - Common standards to connect the nodes

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Several Different Models Emerging



Elevator

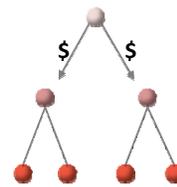


Rapid facilitation of directed exchange capabilities to support Stage 1 meaningful use

Preconditions:

- ✓ Little to no exchange activity
- ✓ Many providers and data trading partners that have limited HIT capabilities
- ✓ If HIE activity exists, no cross entity exchange

Capacity-builder

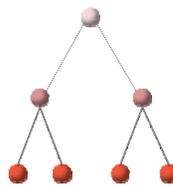


Bolstering of sub-state exchanges through financial and technical support, tied to performance goals

Preconditions:

- ✓ Sub-state nodes exist, but capacity needs to be built to meet Stage 1 MU
- ✓ Nodes are not connected
- ✓ No existing statewide exchange entity

Orchestrator

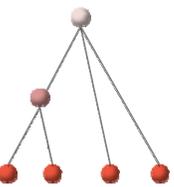


Thin-layer state-level network to connect existing sub-state exchanges

Preconditions:

- ✓ Operational sub-state nodes
- ✓ Nodes are not connected
- ✓ No existing statewide exchange entity
- ✓ Diverse local HIE approaches

Public Utility



Statewide HIE activities providing a wide spectrum of HIE services directly to end-users and to sub-state exchanges where they exist

Preconditions:

- ✓ Operational state-level entity
- ✓ Strong stakeholder buy-in
- ✓ State government authority/financial support
- ✓ Existing staff capacity

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ONC Principles and Expectations



| ONC Principle | HIE Core Expectation |
|---|---|
| <i>Be a worthy steward of the country's money and trust</i> | <ul style="list-style-type: none"> • Initiate transparent multi-stakeholder process • Align with Medicaid and other programs |
| <i>Eyes on the prize</i> | <ul style="list-style-type: none"> • Support providers in meeting meaningful use • Set and meet health goals through health information exchange |
| <i>Feet on the ground</i> | <ul style="list-style-type: none"> • Focus on gap-filling strategies • Take a phased and incremental approach • Monitor and track meaningful use capabilities • Adapt over time |
| <i>Foster innovation</i> | <ul style="list-style-type: none"> • Ensure consistency with national standards to lower cost and complexity of exchange, allow for new market entrants • Leverage the market and existing assets |
| <i>Support the little guy</i> | <ul style="list-style-type: none"> • REC for HIE: serving low capacity data suppliers and providers |
| <i>Patient at the center</i> | <ul style="list-style-type: none"> • Assure trusted information sharing |

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State HIE Program Key Requirements



1. Initiate transparent multi-stakeholder process.

Convene representative group of relevant stakeholders to:

- Set clear health and health care goals for state HIE efforts
- Assess how HIE link to and support care delivery and potentially payment reforms
- Analyze and understand the HIE currently taking place, and
- Address gaps in HIE to support achievement of HIE aspects of stage 1 Meaningful Use by eligible providers

2. Assure trusted information sharing.

Outline an approach that can assure trusted, secure and transparent information sharing to meet meaningful use requirements, clearly addressing the elements of the HHS HIT Privacy and Security Framework.

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State HIE Program Key Requirements



3. Monitor and track meaningful use HIE capabilities in state

- % health plans supporting electronic eligibility/claims transactions
- % pharmacies accepting electronic prescribing and refill requests
- % clinical laboratories sending results electronically
- % health departments electronically receiving immunizations, syndromic surveillance, and notifiable laboratory results

4. Set strategy to meet gaps in HIE capabilities for meaningful use.

- Policy, purchasing and regulatory actions
- Core services to reduce cost and complexity of exchange
- Targeted infrastructure for gap areas (e.g., shared services for small labs or pharmacies, rural providers)
- Need not directly provide any technology infrastructure or services

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State HIE Program Key Requirements



5. Ensure consistency with national standards. Ensure any HIE services funded through the State HIE Program are consistent with national standards and NHIN specifications.

6. Align with Medicaid and other programs. Coordinate with Medicaid and Public Health to establish an integrated approach.

- Ensure ability of State to participate in electronic public health reporting and quality reporting to Medicaid

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Strategic Discussion on the MiHIN Shared Services

Olga Dazzo



I. Status of the MiHIN Shared Services

State HIE Cooperative Agreement

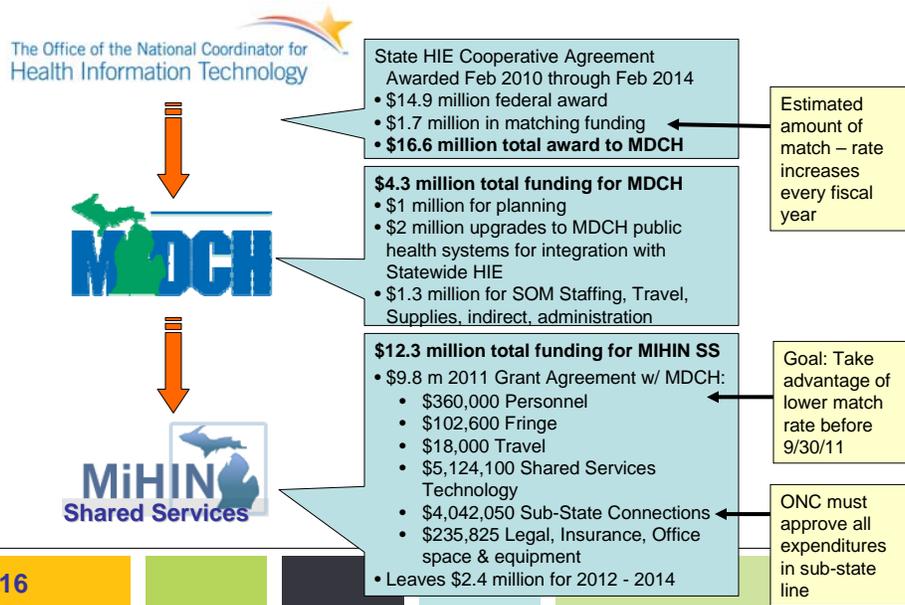
- ARRA program Issued by the Office of the National Coordinator for HIT (ONC)
- \$14.9 million over four years: 2010 – 2014
- Goal: interoperable statewide health information exchange
- Every state and territory received funding based on a formula

| Deliverables | Completion Date |
|---|-----------------|
| Convene Stakeholders for Planning Process | April 2010 |
| Approved Strategic & Operational Plans | December 2010 ✓ |
| Implement governance structure | December 2010 ✓ |
| All MI providers have at least one option for HIE | January 2012 ✓ |
| Operational statewide connectivity | January 2013 |
| Prepare for national connectivity | January 2014 |

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State HIE Cooperative Agreement Budget As approved on December 1, 2010



S&O Plan Budget by Funding Source

As approved on December 1, 2010

| Funding For MiHIN Shared Services Summary | | | | | | | |
|---|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | Totals |
| Federal | \$7,607,151 | \$4,379,419 | \$230,271 | \$161,500 | \$121,131 | \$0 | \$12,499,472 |
| Match | \$786,260 | \$336,388 | \$38,379 | \$80,750 | \$60,556 | \$0 | \$1,302,333 |
| Stakeholders | \$26,400 | \$52,800 | \$1,617,182 | \$1,635,945 | \$1,879,158 | \$1,935,641 | \$7,147,126 |
| | | | | | | | \$20,948,931 |

- **Assumptions:**

- June 1, 2010 start date, which was significantly delayed by Federal approval
- Most expenses would be encumbered in the first year of the program to take advantage of the lower matching funding rates (2011 – 10%, 2012 – 17% and 2013 – 33%)
- \$7.1 million in stakeholder contributions does not have a defined source
- Estimates based on the Vendor Technical Collaboration feedback – not gathered through RFI/RFP and not negotiated

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Key Points in MiHIN SS Phasing

- The MiHIN Shared Services Vision Has Not Changed
- The Role & Funding of Sub-state HIEs has not changed
- Costs and readiness of some technologies will improve
- Analysis Is Not Complete

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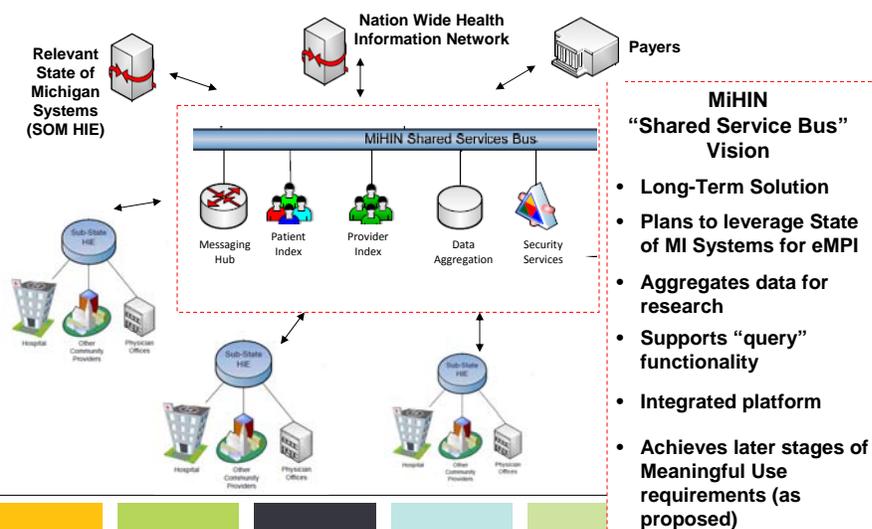
Factors that Influenced Phasing

- Medicaid EHR Program Funding
- Access to Other State HIE Plans
- Meaningful Use Criteria Stage 1 defined
- Sub-State HIE Evolution
- ONC Expectations Refined
- Stakeholder Contribution Assumption

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MiHIN Shared Services Vision



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Estimated Budget for “The Vision”

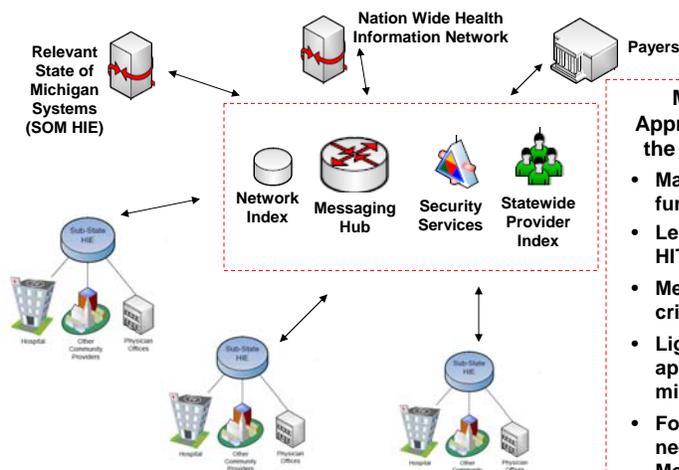
| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 | Total |
|-----------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|---------------------|
| Personnel & Benefits | \$159,019 | \$483,096 | \$709,026 | \$730,298 | \$965,305 | \$994,267 | \$4,041,011 |
| Equipment, Travel, Supplies | \$494,677 | \$336,995 | \$30,047 | \$27,220 | \$33,698 | \$30,881 | \$953,518 |
| Contractual | \$7,313,164 | \$3,052,116 | \$268,650 | \$242,250 | \$181,688 | - | \$11,057,868 |
| Other Expenses | \$452,950 | \$896,400 | \$878,109 | \$878,427 | \$880,155 | \$910,493 | \$4,896,534 |
| Total Expenses | \$8,419,810 | \$4,768,607 | \$1,885,832 | \$1,878,195 | \$2,060,846 | \$1,935,641 | \$20,948,931 |

- Same budget as appears in the S&O plans submitted April 2010
- Based on an estimate of costs provided through the Vendor Technical Collaboration Team facilitated by Planning consultants in March 2010
- Based on six sub-state HIEs connecting to the shared services bus
- Includes \$4 million for sub-state HIE connections
- Includes optimistic vendor discounts and contingency funds

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MiHIN Phase I To Accomplish Vision



- MiHIN Phase 1 Approach for meeting the long-term vision**
- Maximizes federal funding
 - Leverages local HIT investments
 - Meets federal criteria
 - Light weight modular approach building minimum necessary
 - Focuses on services needed for 1st Stage of Meaningful Use and proposed Stage 2 (2013)

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Estimated Budget for “Phase I”

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 | Total |
|-----------------------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|
| Personnel & Benefits | \$159,019 | \$483,096 | \$709,026 | \$730,298 | \$965,305 | \$994,267 | \$4,041,011 |
| Equipment Travel & Supplies | \$440,677 | \$336,995 | \$30,047 | \$27,220 | \$33,698 | \$30,881 | \$899,518 |
| Contractual | \$3,000,000 | \$1,000,000 | | | | | \$4,000,000 |
| Other Expenses | \$270,000 | \$360,000 | \$360,000 | \$360,000 | \$360,000 | \$360,000 | \$2,070,000 |
| Expenses | \$3,869,696 | \$2,180,091 | \$1,099,073 | \$1,117,518 | \$1,359,003 | \$1,385,148 | \$11,010,529 |

- Uses the MiHIN Operational Plan as a base for costs
- Estimate of costs based on other state S&O plans that have included similar components – did not come from negotiated vendor prices
- Keeps the “Personnel & Benefits” the same
- Reduces the “Equipment” line by subtracting MPI and shared service bus equipment
- “Contractual” is reduced by less implementation staff necessary and less software costs.
- “Other Expenses” are less due to less software licensing costs and less hardware and maintenance costs.
- Budget estimate does not include Sub-state HIE funding (\$4 million)

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What is different between the Vision and Phase I?

- Phase 1 is a modular approach and the MiHIN Shared Services Bus is an integrated platform
- No Master Patient Index in phase 1
- No Record Locator Service and Data registry in Phase 1
- Plans to not need \$7.1 million in stakeholder investment in Phase 1
- The Phase 1 approach allows technologies to advance and evolve before significant investment and/or implementation.
- The Phase 1 approach would allow stakeholders to develop value propositions and use cases for greater centralized functionality before significant investment is required.

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What is the same between the Vision and Phase 1?

- Both utilize centralized services for messaging, provider index and security
- Both are federally approved approaches – most states with this approach are using similar phasing
- Both rely on a strong foundation of sub-state HIE initiatives that are connecting community providers and hospitals directly
- Both provide funding for sub-state HIEs that must be approved by the ONC before being dispersed
- Both rely on State of Michigan public health systems to interoperate for Meaningful Use requirements

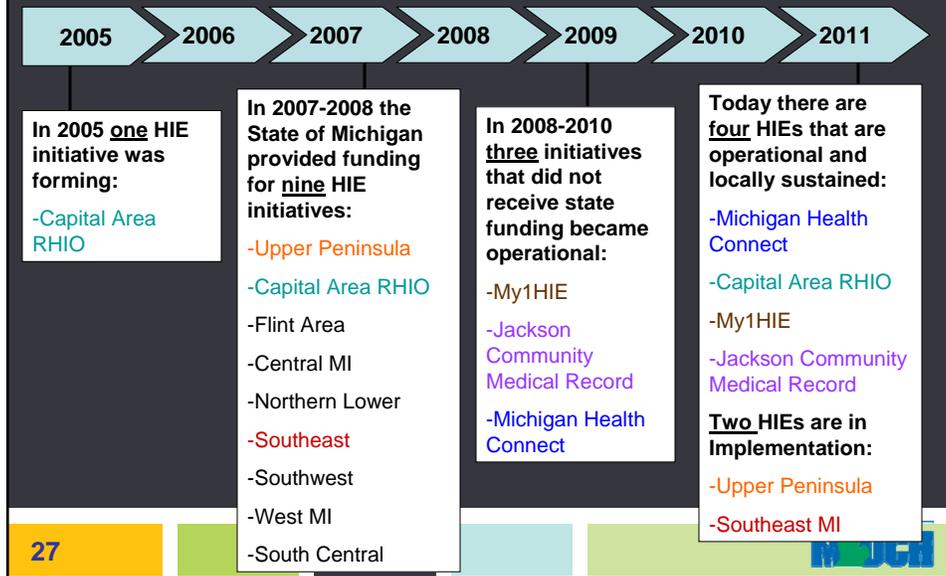
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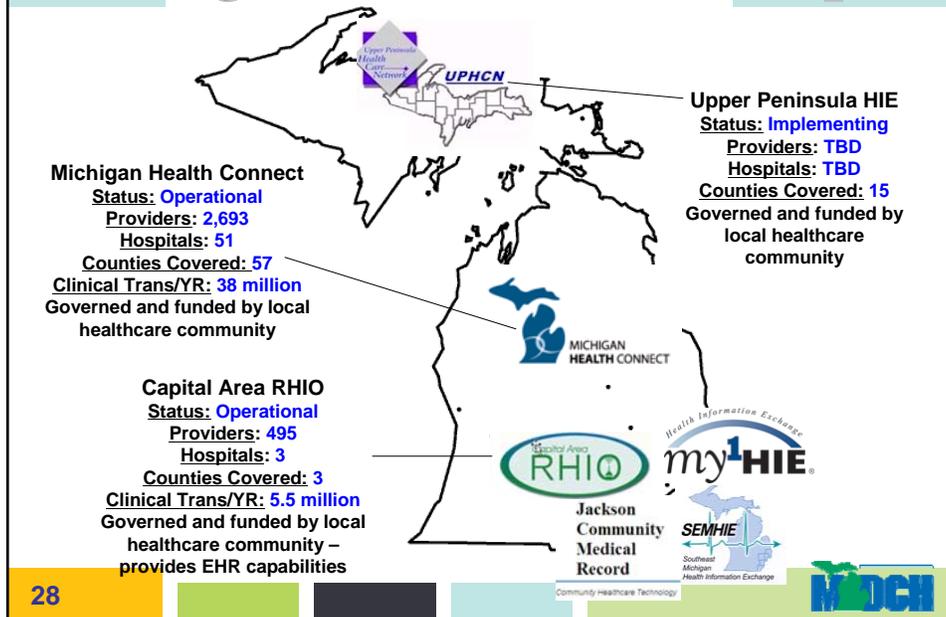
2. Status of Sub-State HIEs

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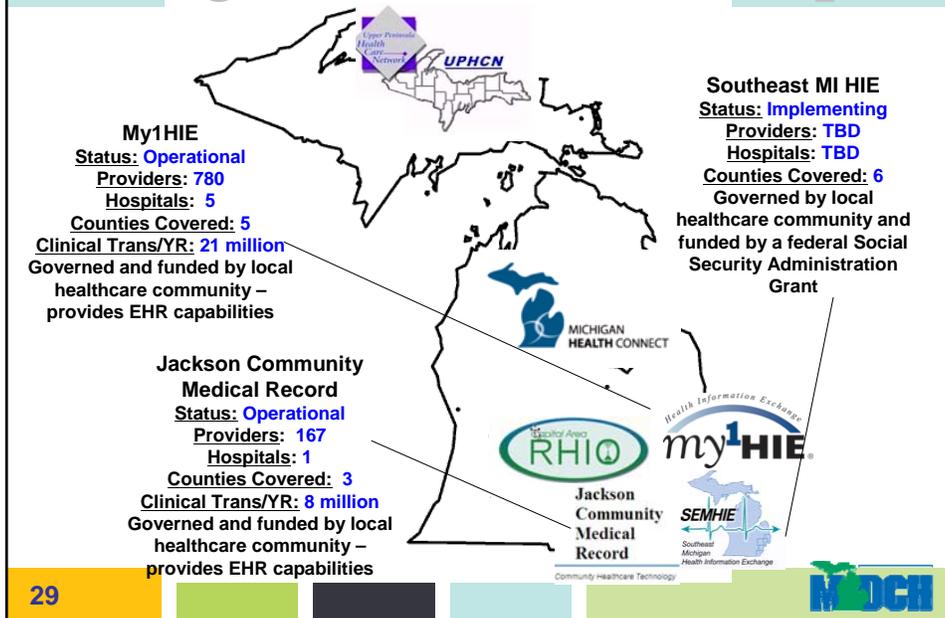
Sub-state HIE Maturation & Rationalization



Michigan's Local HIE Landscape



Michigan's Local HIE Landscape



Functionality Table for Sub-state HIEs

| | Jackson Community Medical Record | Capital Area RHD | Michigan Health Connect | my1HIE |
|---|---|---|--|---|
| HIE Vendor Solutions in Michigan | | | | |
| What vendor(s) are you using to ensure that you will be able to support meaningful use in 2011? | Integrated Healthcare Solutions | Axolotl | The Medicity HIE solution platform - specifically their Novo Grid clinical messaging capabilities | Covisint, or First, WellCentive and DocSite. |
| Sub-State HIE Capabilities for Delivery of Structured Lab Results | | | | |
| Are you currently able to deliver structured lab results directly to provider EHRs, as opposed to through an internet portal? | Yes | Yes | Yes. | Yes |
| How do you provide the delivery of structured lab results directly to provider EHRs? | EHR interface and secure messaging based on customer use case | For Elysium EHR - through clinical messaging. For all other EHRs, through EHR interface via Axolotl's Interoperability-Hub. | We currently use standard HL7 transactions sent through a secure encrypted agent-based messaging architecture. We can deliver results discretely if the EHR vendor can handle it or as text-based reports. | Either from the lab to the EHR via Covisint HUB or the My1HIE data warehouse. Secure messaging via LLP over a site-to-site vpn or secure web services are used to transport messages. The capability also exists to push messages that are then received by a small agent that resides at the physicians office, the HL7 messages are then consumed by the EHR. |
| What standards and specifications are you currently using? | HL7/IHE, LOINC in near term | LOINC, HL7 - IHE in future phases. | HL7, LOINC, SNOMED, CCR/CCD, XML | HL7, IHE, LOINC, SNOMED |
| Scope of Technology Implementation for Exchange of Patient Care Summaries | | | | |
| Are you currently able to exchange patient care summaries across unaffiliated providers/organizations? | Yes | Yes | Yes | Yes |
| Do you provide an EHR option to your providers? | Yes - comprehensive | Yes - modular | No - no market demand, utilizing M-CBITA | Yes - modular and comprehensive |



Next Steps

- **MiHIN Shared Services is preparing an RFP to be issued in the early summer, which will provide:**
 - More accurate cost comparison and analysis among potential vendors for full vision and phase 1
 - Findings from RFP will further educate the precise direction
- **Funding for Sub-state HIEs will be submitted to the ONC for approval:**
 - Sub-state HIEs must submit: a description that includes amount of funding, scope of work, products used, timelines and milestones.
 - MiHIN Shared Services must submit: a plan for accountability and quarterly progress reports

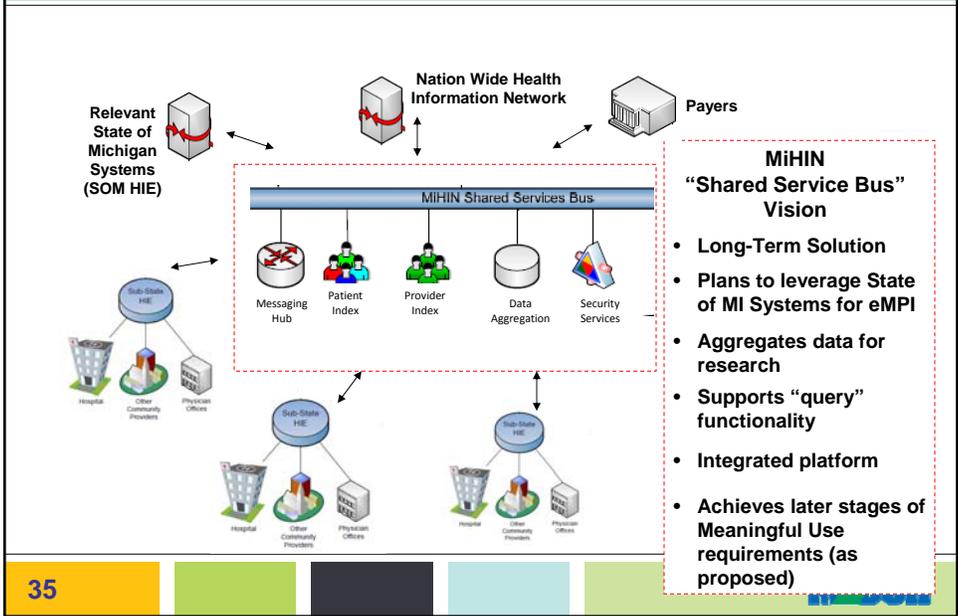
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4. Future

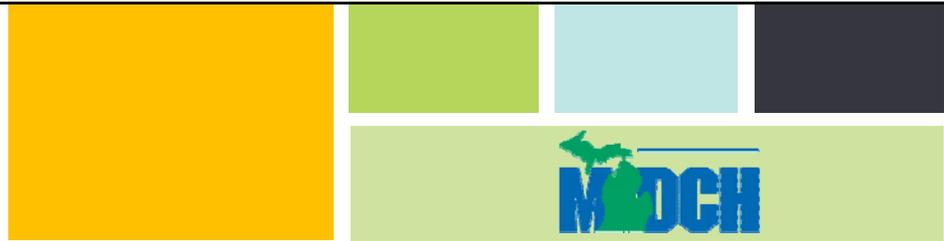
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MiHIN Shared Services Vision



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5. Conclusion



Role of the HIT Commission

**Greg Forzley,
Larry Wagenknecht**

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HIT Commission & MiHIN SS

- Roles & Responsibilities as delineated in the MiHIN Strategic Plan submitted April 2010

| HIT Commission | MiHIN Shared Services Governance Board |
|---|--|
| <ul style="list-style-type: none"> • Setting consensus-based goals, objectives, and performance measures to achieve statewide coverage for all providers that relate to FOA requirements for HIE services • Overseeing diverse ongoing health information exchange activities to ensure compliant HIE practices, meeting targets for interoperability, and demonstrating health care improvements. • Navigating emerging opportunities and requirements to align state efforts with the NHIN, including standards and emerging governance. • Monitoring the implementation of statewide HIE technical infrastructure according to the agreed upon respective roles and responsibilities of local, regional and state level stakeholders, vendors and state government | <ul style="list-style-type: none"> • Facilitating State Strategic and Operational Plan implementation • Ensuring the coordination, integration and alignment of efforts with Medicaid and Public Health programs through efforts of HIT coordinators. • Facilitating the implementation of statewide HIE technical infrastructure according to the agreed upon respective roles and responsibilities of local, regional and state level stakeholders, vendors and state government. • Developing public and/or private financing strategies and ensuring a sustainable business model is developed that supports and incorporates different types of HIE across the state. • Supporting business and technical operations as appropriate. |

3 Figure 4. Role Delineation for the Coordinated Governance Structure

HIT Commission & MiHIN SS

- Roles & Responsibilities as delineated in the MiHIN Strategic Plan submitted April 2010

There are four major advantages of the coordinated governance structure. The structure leverages the success of the existing HIT Commission. It enables a broad, statewide view combined with a focus on the connection of sub-state HIEs. Keeping the two separate yet highly collaborative entities promotes efficient and effective decision making toward achieving the goals of statewide HIE while promoting broad stakeholder representation in accordance with the State HIE Cooperative Agreement requirements. The legislative oversight of the HIT Commission combined with the state representation on the MiHIN Shared Services Governance Board provide checks and balances by two branches of state government to the new, emerging statewide HIE.

HIT Commission & MiHIN SS

- Roles & Responsibilities as delineated in the MiHIN Strategic Plan submitted April 2010

As an advisory Commission to the Michigan Department of Community Health, the HIT Commission recommends policy and action to MDCH and provides recommendations to the Michigan Legislature annually, at minimum. The HIT Commission is made up of 13 members that are appointed by the Governor to represent stakeholders as specified in the legislation that created the Commission.

The MiHIN Shared Services Governance Board will have decision making authority over the business and technical operations of the MiHIN Shared Services. The MiHIN Shared Services Governance Board will be established through articles of incorporation and bylaws that will guide the specifics of voting, financing and membership terms. The MiHIN Shared Services Governance Board will include a maximum of 13 board members.



M-CEITA Stakeholder Advisory Structure & Reporting Relationship to the HIT Commission

Greg Forzley

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Review

- On March 1, 2011 ONC issued a letter to Altarum stating:

“ONC is directing Altarum to consolidate stakeholder advisory activities under the Health Information Technology Commission”

- ONC wanted to address transparent collaboration and resolve conflicts of interest

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Review

- **At the March HIT Commission meeting**
 - Discussed the need to revise the stakeholder input structure
 - Ensure consistency in stakeholder input
 - Address ONC concerns
- **Between the March & April meetings**
 - Sub-group formed Greg Forzley, Mark Notman, Taylor Scott
 - Formed a draft charter and structure

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M-CEITA Mission & Vision

- By the following Mission and Vision the Michigan HIT Commission will evaluate all proposed policies, issues and performance:
 - Mission: M-CEITA's mission is to partner with Michigan's healthcare providers to accelerate the selection, adoption and meaningful use of health information technology (HIT) to improve the quality and efficiency of care delivered in our state.
 - Vision: M-CEITA's vision is to serve as a trusted agent on behalf of primary care providers. By 2012, the expectation is to assist over 4,000 of those provides, benefitting their patients and the community at large. Further, M-CEITA or its successor organization will remain a provider resource for years to come through dedication to program sustainability and proven value.

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M-CEITA Principles

- As the M-CEITA program carries out its mission, it will remain fully dedicated to adhering to the following principles:
 1. **Transparency.** M-CEITA operations will meet the objectives of the HIT Extension Program in a transparent, objective and efficient manner. M-CEITA will proactively engage a diverse set of stakeholders supportive of its core mission and will make information and opportunities for participation public.
 2. **Objectivity.** M-CEITA will provide unbiased advice on the systems and services best suited to enable providers to become meaningful users of EHRs. M-CEITA will avoid actual or apparent conflicts of interest, to act solely in the best interests of the providers we serve.
 3. **End Use Service Orientation.** M-CEITA will assist Michigan's diverse primary care provider population to make informed HIT-related decisions by exploring options based on their wide-ranging individual needs and preferences, using a "high-touch" approach to achieving results.
 4. **Innovation.** M-CEITA will serve as Michigan's central entity for evidence-based HIT knowledge transfer as it builds on the experience of state and national experts.
 5. **Collaboration.** M-CEITA will coordinate its activities with State of Michigan health information exchange initiatives, HIT workforce development and educational programs, HIT research and development efforts, and other relevant initiatives as appropriate.
 6. **Accountability.** M-CEITA will meet the intent of present and future federal guidelines and legislation, beginning with the HIT Extension Program and its goal of assisting providers to become meaningful users of certified EHRs, to ultimately improve the quality of health care delivery.

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Responsibilities

- HIT Commission Responsibilities:
 - Support, promote and advise on the direction and activity of the program.
 - Review financial and operational documents and reports to advise on program direction for meeting the M-CEITA goals.
 - Serve as a liaison function to other organizations that also promote the adoption of HIT
 - Advise on courses of action to expand and extend the M-CEITA program to result in a sustainable program of assistance for Michigan providers in HIT adoption
 - Consider input from committees, stakeholder groups and the general public in making recommendations and advise to M-CEITA.
 - Escalate issues, points of interest or inquiries to the Office of the National Coordinator through the Michigan Department of Community Health, as necessary.

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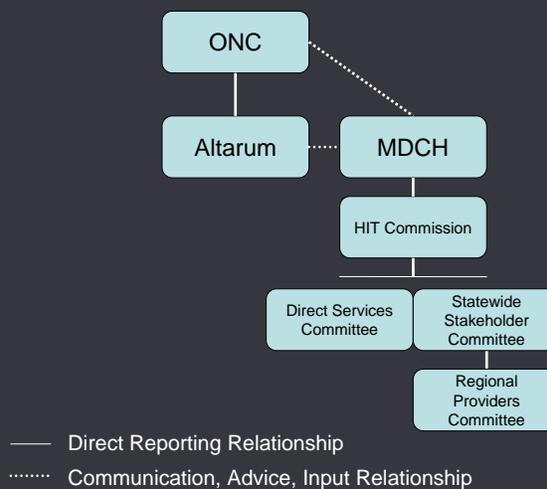


Responsibilities

- **Altarum Responsibilities:**

- Provide the HIT Commission and relevant committees with access to Operational Documents to allow the Committee to provide functional advice. Operational Documents will include the operational plan, as well as any other documents that the Executive Committee deems relevant or as reasonably requested in writing by the Chair of the Committee.
- Provide the HIT Commission and relevant committees with access to financial reports to allow the Commission and committees to provide functional advice. Financial documents will include (i) a monthly milestone target to actual report, (ii) a quarterly ARRA grant and other third party funding commitment and expenditure report, and (iii) a quarterly match report, as well as any other documents that Altarum deems relevant or as reasonably requested in writing by the Chair of the Commission and agreed to by the Managing Director.
- Support the Chair of the Commission and relevant committees in conducting the roles and responsibilities of the Commission and relevant committees' activities, including developing standing and timely agenda items.

Draft Stakeholder Input Structure



Direct Services Committee

- The Direct Services committee will be made up of organizations that are contractors and sub-contractors to Altarum tasked with performing M-CEITA services. **This committee is responsible for reporting overall program progress against the stated M-CEITA goals.**
 - Members: Altarum, MPRO, MPHI, UPHCN and relevant sub-contractors
 - Deliverables: Consistent reporting to HIT Commission on program progress and challenges in a format that is approved by the HIT Commission.

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Statewide Stakeholder Committee

- The statewide stakeholder committee will be made up of the associations that represent the stakeholders that are impacted by the services of M-CEITA. **This committee will formulate recommendations to the HIT Commission based on the feedback from their respective stakeholders.**
 - Members: MSMS, MHA, MOA, ACOG- MI, AAP – MI, MAFP, MPCA, and others
 - Deliverables: Updates to the HIT Commission based on stakeholder feedback.

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Regional Provider Committee

- The regional providers committees are essential component of reflecting the unique opportunities and challenges in local healthcare markets as they relate to M-CEITA services. The regional providers committees will report back to the HIT Commission through the Statewide Stakeholder Committee with insights, progress, and challenges based on the M-CEITA services being offered in their respective communities.
 - Members: Members recruited locally.
 - Deliverables: Provide regionalized feedback and input to the HIT Commission.

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Next Steps

- Refine reporting structure
- Identify Resources for Staffing

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G. Commissioner Updates

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Wiring For Michigan Conference

- May 18 -19 (preconference workshops on May 17)
- Ypsilanti at the Ann Arbor Marriott Ypsilanti at Eagle Crest Hotel
- HIT Commission Leadership and Innovation Awards reception is at 4:30pm on May 18

- More info at:

<http://ihcs.msu.edu/HIT/wiring2011.php>



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Scheduling Next Meeting

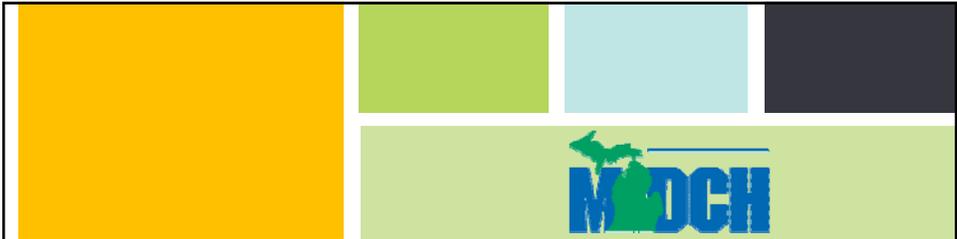
- **Current Schedule**
 - May 19, 2011 (Conflicts with Wiring MI Conf.)
 - June 16, 2011 (Several Commissioner Conflicts)
 - July 21, 2011
- **Proposed Schedule**
 - May – Reschedule as needed
 - June 23, 2011 (June-July Meeting)
 - August 18, 2011 (Regularly Scheduled)

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H. Public Comment

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I. Adjourn

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