



# Health Information Technology

## MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

2017 ANNUAL REPORT



Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR



## EXECUTIVE SUMMARY

The Michigan Legislature created the Michigan Health Information Technology (HIT) Commission for the following purpose:

“...to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in this state.”

Pursuant to Public Act 137 of 2006, the members of the HIT Commission have developed the following report to detail the Commission’s findings and recommendations for encouraging widespread adoption of health information technology and statewide health information exchange.

Michigan continues to make progress towards the development of an interoperable health care information infrastructure. Health care providers across the state have adopted and are using Electronic Health Records (EHR) to coordinate and improve the delivery of supports and services. The Michigan Department of Health and Human Services (MDHHS), the Michigan Health Information Network Shared Services (MiHIN), and other health care organizations have successfully established a shared infrastructure to support health information sharing across the Michigan health care system. Now that the technical infrastructure for health information sharing has been built, the HIT Commission has been exploring how the infrastructure can be leveraged to support statewide health care system transformation efforts. The HIT Commission focused its activities on four topics during 2017:

- (1) Public Health Reporting
- (2) Care Coordination
- (3) Physical and Behavioral Health integration
- (4) Practice Transformation and Quality Improvement

The HIT Commission will continue to explore these issues during 2018. The HIT Commission will also examine other topics during 2018 such as (1) consumer engagement and (2) cybersecurity.

The HIT Commission also approved three resolutions during 2017. The three resolutions are included below.

- **Resolved:** The Michigan Health Information Technology Commission endorses the proposed updates to the standard consent form that was established under Public Act 129 of 2014. The commission also encourages MDHHS to analyze the tools that the department has at its disposal (including but not limited to CareConnect360) to enhance the sharing of physical health and behavioral health information.
- **Resolved:** The HIT Commission recommends that the department develop a strategy for aligning different quality reporting and improvement efforts across the state. This strategy should be coordinated with the ongoing efforts of the Physician-Payer Quality Collaborative but should also encompass other initiatives across the state. The HIT Commission also encourages the department to include a representative from the commission as part of ongoing discussions about this strategy. Finally, the HIT Commission requests that the department provide an update on the aforementioned strategy at the first meeting in 2018.

- **Resolved:** The HIT Commission expresses its support for the statewide efforts to develop a standard framework for care coordination as summarized in the "Building Michigan's Care Coordination Infrastructure" report. The HIT Commission also expresses its support for the definition of "care coordination" from the report and encourages the department to review and consider this definition. Finally, the HIT Commission requests that the department provide an update to the HIT Commission at the first meeting in 2018 on whether the definition could be adopted as a statewide standard. The department should address the following issues as part of the update:
  - How does the definition from the report align with definitions for care coordination from other sources?
  - Which policies and programs would be impacted by the adoption of a standard definition?
  - What is the regulatory authority under which the department could adopt a standard definition?

## TABLE OF CONTENTS

<b>Executive Summary</b> .....	3
<b>The HIT Commission</b> .....	6
<b>HIT Commission Meetings in 2017</b> .....	7
<b>HIT Commission Topics in 2017</b> .....	8
Public Health Reporting.....	8
Care Coordination .....	9
Physical Health and Behavioral Health Integration.....	9
Quality Reporting and Quality Improvement.....	11
<b>Forecast of 2018 HIT Commission Topics</b> .....	13
<b>Appendix A: Public Act 137 of 2006</b> .....	14
<b>Appendix B: List of HIT Commission Resolutions</b> .....	19

## THE HIT COMMISSION

\*As of December 31, 2017\*

**Irita B. Matthews** of Grosse Pointe Park represents the health information technology field for a term expiring on August 3, 2018.

**Jill Castiglione** of Northville represents pharmacists for a term expiring August 3, 2018.

**Karen Parker** of Webberville represents the Michigan Department of Health and Human Services for a term expiring August 3, 2020.

Commissioner **Peter Schonfeld** served as the representative of hospitals until the expiration of his term on August 3, 2017. **Meredith Harper, MD** was appointed as the new representative of hospitals for a term that will expire on August 3, 2021.

**Michael Chrissos, M.D.** of Ann Arbor represents doctors of medicine for a term expiring August 3, 2019.

Commissioner **Mark Notman** served as the representative of schools of medicine until the expiration of his term on August 3, 2017. **Norman Beauchamp, MD** was appointed as the new representative of schools of medicine for a term that will expire August 3, 2021.

**Orest Sowirka, D.O.** of Sterling Heights represents doctors of osteopathic medicine and surgery for a term expiring August 3, 2019.

**Pat Rinvelt** of Ann Arbor is one of the two co-chairs for the commission and represents purchasers or employers for a term expiring August 3, 2021.

**Randall Ritter** of Grand Rapids represents consumers for a term expiring August 3, 2019.

**Rodney Davenport**, State of Michigan CTO, is one of the two co-chairs for the commission and represents the Department of Technology, Management, and Budget for a term expiring August 3, 2020.

**Rozelle Hegeman-Dingle** of Rochester Hills represents pharmaceutical manufacturers for a term expiring August 3, 2020.

Commissioner **Robert Milewski** served as the representative of non-profit health care corporations until the expiration of his term on August 3, 2017.

**Thomas Simmer, MD.** Was appointed as the new representative of non-profit health care corporations for a term that will expire August 3, 2021.

Commissioner **Nick Smith** served as the representative of health plans until the expiration of his term on August 3, 2017. A new representative for health plans has not been appointed at this time.

## THE MISSION

The 13-member HIT

Commission is appointed by

the Governor as directed in

Public Act 137 of 2006. The

Commission's mission is to

facilitate and promote the

design, implementation,

operation, and maintenance of

an interoperable health care

information infrastructure in

Michigan.

The Michigan HIT Commission

is an advisory commission to

the Michigan Department of

Health and Human Services

and is subject to the Michigan

Open Meetings Act, 1976 PA

267, MCL 15.261 to 15.275

## HIT COMMISSION MEETINGS IN 2017

The members of the Health Information Technology Commission must meet on a quarterly basis in order to meet the legislative requirement that was set under Public Act 137. The Commission met four times in 2017 and held a meeting at least once each quarter.

Month	Meeting Topic	Attendance
February	The HIT Commission discussed several resolutions that stemmed from the October 2016 meeting. The HIT Commission also explored opportunities to leverage health information technology to support public health reporting. The HIT Commission also examined different ways that health information sharing through the statewide health information infrastructure can improve the coordination of care.	8 out of 13 commissioners participated in the February meeting.
May	The HIT Commission explored the topic of physical health and behavioral health integration. The HIT Commission examined the impact of federal and state privacy laws and regulations on the sharing of behavioral health information. The HIT Commission also received updates on several department initiatives on the integration of physical health and behavioral health services. The HIT Commission also convened a panel discussion on barriers to sharing behavioral health information.	8 out of 13 commissioners participated in the May meeting.
September	The HIT Commission explored the topic of quality reporting, quality improvement, and practice transformation. The HIT Commission received specific updates on the Medicare Access and CHIP Reauthorization Act (MACRA), MDHHS quality improvement strategy, and the Physician Payer Quality Collaborative (PPQC).	10 out of 13 commissioners participated in the September meeting.
November	The HIT Commission explored quality reporting and quality improvement, as well as care coordination. The HIT Commission received specific updates on the Coordinating the Coordinators Report, the Quality Measurement Information (QMI) use case, and the Physician Payer Quality Collaborative (PPQC).	7 out of 13 commissioners participated in the November meeting.

## HIT COMMISSION TOPICS IN 2017

The HIT Commission explored four main topics during the 2017 meetings. An overview of each topic and related HIT Commission discussions are included below.

- (1) Public health reporting
- (2) Care coordination
- (3) Physical health and behavioral health integration
- (4) Practice transformation and quality improvement

### Public Health Reporting

The HIT Commission explored the potential for health information technology to improve public health reporting during the February meeting. The HIT Commission invited the Michigan Health Information Network (MiHIN) to provide an overview of how the statewide infrastructure for health information exchange can support public health reporting. MiHIN is a network that provides a shared infrastructure for the sharing of health information across different parts of the health care system. Each organization that is connected to MiHIN can share health information with other organizations in the MiHIN network as well as with the State of Michigan.

MiHIN is currently implementing several specific “use cases” that would bolster public health reporting in the State of Michigan. A use case is “a unique instance of sharing a specific type of information regarding patients and their health. Each use case has a specific purpose, type of data exchanged, and rules for interactions between people and systems.”<sup>1</sup> Use cases improve the sharing of health information by defining a common set of rules for exchanging health information in a secure and reliable fashion. MiHIN has worked with the State of Michigan, health care providers, and payers to establish specific use cases for public health reporting, which include death notifications, immunization history forecast information, and newborn screening data.

The HIT Commission also learned about various state technology systems that support public health reporting in Michigan. The HIT Commission invited Altarum to provide an overview of these systems, which includes the Michigan Disease Surveillance System (MDSS) and Michigan Syndromic Surveillance System (MSSS).

- MDSS is a web-based reporting system that allows providers to submit communicable disease information in order to allow the state to conduct traditional disease surveillance and detect emergent infectious disease and biological terrorism.
- MSSS is an electronic reporting system that collects information on the chief complaints from patients during Emergency Department and Urgent Care visits. MSSS collects information from over 100 hospitals and urgent care clinics across the state and uses algorithms to detect spikes in certain syndromic categories (e.g. respiratory, constitutional, botulinic, gastrointestinal, hemorrhagic, neurological, heat, and rash, etc.). State and regional epidemiologists can access this information in order to investigate spikes in certain areas and determine whether an outbreak is occurring.

---

<sup>1</sup> Michigan Health Information Network Shared Services. “What is a Use Case?” Retrieved from: <https://mihin.org/what-is-a-use-case/>



## Care Coordination

The HIT Commission explored ways that health information technology can enhance care coordination during the February and November meetings. The HIT Commission specifically examined the Coordinating the Care Coordinators initiative. The Michigan Primary Care Consortium (MPCC) and MiHIN jointly launched this initiative in order to establish a common statewide framework for improving care coordination through the use of health information technology. MPCC and MiHIN hosted a series of workshop meetings in 2017 as part of this effort. The workshop series culminated in the development of the “Building Michigan’s Care Coordination Infrastructure” report, which contains a series of recommendations for statewide action. The report’s recommendations focused on five key infrastructure elements, which include service delivery, regulations, reimbursement, technology, and workflow. The report also contains a draft definition for care coordination, which is included below:

*Care Coordination: 1. Monitoring a person’s goals, needs, and preferences. 2. Acting as the communication link between two or more participants concerned with a person’s health and wellness. 3. Organizing and facilitating care activities and promoting self-management by advocating for, empowering, and educating a person. 4. Ensuring safe, appropriate, non-duplicative, and effective integrated care.*

Based upon this discussion, the HIT Commission made the following recommendation to MDHHS:

*The HIT Commission expresses its support for the statewide efforts to develop a standard framework for care coordination as summarized in the "Building Michigan’s Care Coordination Infrastructure" report. The HIT Commission also expresses its support for the definition of "care coordination" from the report and encourages the department to review and consider this definition. Finally, the HIT Commission requests that the department provide an update to the HIT Commission at the first meeting in 2018 on whether the definition could be adopted as a statewide standard. The department should address the following issues as part of the update:*

- *How does the definition from the report align with definitions for care coordination from other sources?*
- *Which policies and programs would be impacted by the adoption of a standard definition?*
- *What is the regulatory authority under which the department could adopt a standard definition?*

## Physical Health and Behavioral Health Integration

The HIT Commission explored the challenges of integrating physical health and behavioral health services during the May 2017 meeting. The HIT Commission specifically examined barriers to the sharing of behavioral health information. The sharing of behavioral health information in Michigan is regulated under several different federal and state laws and regulations. The confidentiality requirements within these laws and regulations do not necessarily align with one another. The HIT Commission learned that the wide variability in confidentiality requirements between different laws and regulations leads to varying interpretations of these requirements by providers and payers, which causes confusion amongst providers and payers about when behavioral health information can be shared. The HIT Commission also learned about different laws that the Michigan legislature had passed in order to address this issue, which are described below:

- Public Act 129, which passed in 2014 and authorized the Michigan Department of Health and Human Services (MDHHS) to adopt a standard consent form for sharing behavioral health information. Prior to the law, providers often developed their own consent forms, which could differ significantly from one

practice to the next; now providers must accept and honor the standard form, creating a more streamlined process for information sharing.

- Public Act 559, which passed in 2016 and amended the Michigan Mental Health Code to enable the sharing of mental health records without patient consent for the purposes of payment, treatment, and coordination of care. The new law makes it easier for providers and health plans to share information and improve services to individuals with mental health needs.

The HIT Commission also explored the impact that barriers to the sharing of behavioral health information have on statewide efforts to integrate the delivery of physical health and behavioral health services. During the May meeting, MDHHS staff provided an overview of several statewide initiatives that focus on physical health-behavioral health integration. The HIT Commission specifically learned about the following initiatives:

- MI Health Link Demonstration
- Health Homes Initiatives
  - 2703 Health Homes
  - MI Care Team
- Shared Metrics
- Section 298 Initiative

The HIT Commission also investigated how the various initiatives were using health information technology and health information exchange to coordinate care more effectively for individuals with physical health and behavioral health needs. The HIT Commission discovered that all of the aforementioned initiatives were encountering barriers with sharing behavioral health information through the use of health information technology and health information exchange. One of the example of a barrier was ongoing challenges to accessing behavioral health information within CareConnect360. CareConnect360 is a web-based care management tool that was created by MDHHS to coordinate care and improve health outcomes for Michigan Medicaid beneficiaries. CareConnect360 makes integrated physical and behavioral health-related information available to health care providers and payers in order to promote greater coordination of care. However, specific confidentiality requirements have limited the ability of behavioral health information to be shared through CareConnect360.

The HIT Commission concluded its May meeting by convening of subject matter experts to discuss the barriers to health information sharing. Panelists described (1) how their organizations have been working to improve the sharing of behavioral health information, (2) what progress has been made with sharing behavioral health information over the last few years, and (3) what some of the remaining barriers are to sharing behavioral health information on a statewide basis. Based upon this discussion, the HIT Commission made the following recommendation to MDHHS:

*The HIT Commission endorses the proposed updates to the standard consent form that was established under Public Act 129 of 2014. The commission also encourages MDHHS to analyze the tools that the department has at its disposal (including but not limited to CareConnect360) to enhance the sharing of physical health and behavioral health information.*

## Quality Reporting and Quality Improvement

The HIT Commission explored the topic of practice transformation and quality improvement during the September and November 2017 meetings. During the September meeting, the HIT Commission specifically examined different strategies that the federal and state governments are using to enhance the quality of service delivery. These initiatives are outlined below:

- The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 is a federal law that impacts Medicare reimbursement for physicians and other qualifying clinicians. The Centers for Medicare and Medicaid Services (CMS) The Quality Payment Program (QPP) under MACRA is part of a broader effort from CMS to shift away from pure fee-for-service compensation and transition towards paying for value and quality.
- MDHHS is also working on implementing a quality improvement strategy through its Medicaid program as part of achieving compliance with the new managed care rule. Under the new managed care rule, CMS is requiring states to develop one single quality strategy and is looking for consistency across all plans and programs.

The HIT Commission also investigated challenges that providers are encountering in participating in quality reporting and quality improvement programs. Physicians and other providers are frequently required to participate in multiple quality reporting and quality improvement programs as part of receiving reimbursement from different health care payers. The requirements for these different programs are also frequently not aligned, and providers therefore must commit resources and staff to preparing and submitting duplicative reports to payers. The Michigan State Medical Society (MSMS) conducted a survey as part of the State Innovation Model (SIM) initiative in order to assess the administrative and technological burdens that physicians confront in quality reporting. The survey demonstrated that many physicians cannot generate automatic reports from their Electronic Health Records and have a high-level of difficulty with meeting quality reporting requirements.

The HIT Commission also examined statewide efforts to streamline quality reporting for physicians and other clinicians. The HIT Commission specifically learned about the Physician Payer Quality Collaborative (PPQC), which is a joint initiative between MSMS and MiHIN to reduce the administrative burden of quality measurement and reporting. As part of the initiative, participating payers have agreed to align their incentive programs around a core set of 27 measures. Participating providers and payers also agree to use a common data file format for submitting information that will be used to calculate each provider's quality measure. Providers and payers can then electronically exchange this information through the Quality Measurement Information (QMI) use case through MiHIN. The goal of this framework is to allow physicians to "report once" and be able to submit the information for quality measures one time to one location for all payers and all patients.

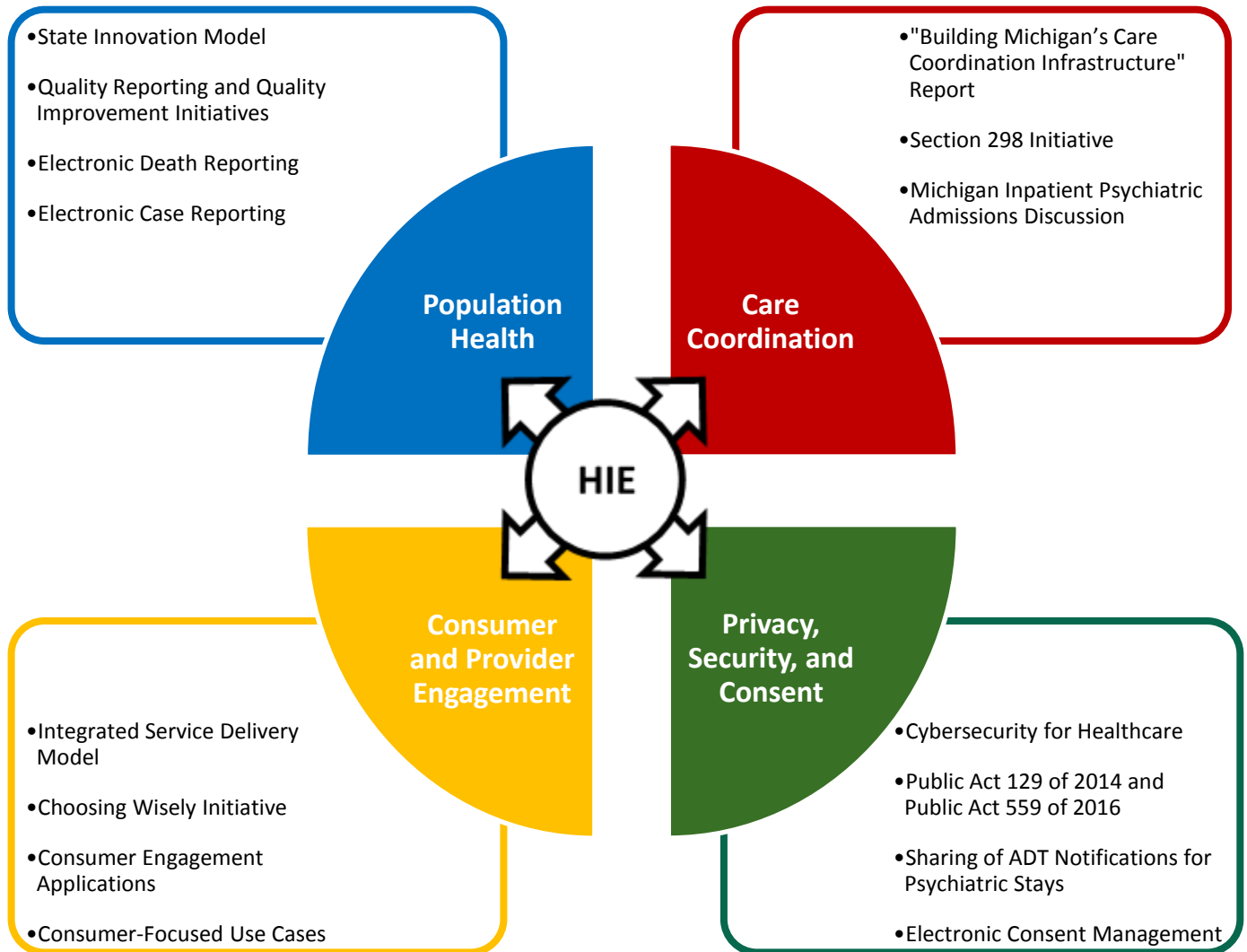
Finally, the HIT Commission explored the strategies that different payers are using to incentivize provider participation in the common quality reporting framework. For example, MDHHS is encouraging physician organizations to participate in the QMI use case through the Patient-Centered Medical Home (PCMH) Initiative: the PCMH initiative a statewide effort under the SIM initiative to transform primary care, which includes over 2,100 primary care providers statewide. Blue Cross Blue Shield of Michigan is also incentivizing provider participation in this use case through the Health Information Exchange incentives under its Physician Group Incentive Program. The HIT Commissioner learned during the November meeting that there is still a greater need for alignment amongst payers on quality reporting and quality improvement initiatives in order to enhance the quality of care and reduce the administrative burden on providers.

Based upon this discussion, the HIT Commission made the following recommendation. The HIT Commission will revisit this topic as its first meeting in 2018.

*The HIT Commission recommends that the department develop a strategy for aligning different quality reporting and improvement efforts across the state. This strategy should be coordinated with the ongoing efforts of the Physician-Payer Quality Collaborative but should also encompass other initiatives across the state. The HIT Commission also encourages the department to include a representative from the commission as part of ongoing discussions about this strategy. Finally, the HIT Commission requests that the department provide an update on the aforementioned strategy at the first meeting in 2018.*

## FORECAST OF 2018 HIT COMMISSION TOPICS

The HIT Commission will explore the following issues and initiatives during commission meetings in 2018.



## APPENDIX A: PUBLIC ACT 137 OF 2006

Act No. 137  
Public Acts of 2006  
Approved by the Governor  
May 10, 2006  
Filed with the Secretary of State  
May 12, 2006  
EFFECTIVE DATE: May 12, 2006

### STATE OF MICHIGAN 93RD LEGISLATURE REGULAR SESSION OF 2006

**Introduced by Reps. Newell, Farhat, Vander Veen, Meyer, Moore, Kooiman, Taub, Emmons, Kahn, Huizenga, Walker, Moolenaar, Casperson, David Law, Pearce, Jones, Steil, Wenke, Booher, Hansen, Stewart, Marleau, Caswell, Hildenbrand, Stakoe, Ward, Mortimer, Acciavatti, Ball, LaJoy, Nitz, Baxter, Proos, Caul, Green, Shaffer, Nofs, Sheen, Wojno and Accavitti**

## ENROLLED HOUSE BILL No. 5336

AN ACT to amend 1978 PA 368, entitled “An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to provide for the levy of taxes against certain health facilities or agencies; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates,” (MCL 333.1101 to 333.25211) by adding part 25.

*The People of the State of Michigan enact:*

#### PART 25. HEALTH INFORMATION TECHNOLOGY

Sec. 2501. As used in this part:

- (a) “Commission” means the health information technology commission created under section 2503.

(b) “Department” means the department of community health.

Sec. 2503. (1) The health information technology commission is created within the department to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in this state. The commission shall consist of 13 members appointed by the governor in accordance with subsection (2) as follows:

- (a) The director of the department or his or her designee.
- (b) The director of the department of information technology or his or her designee.
- (c) One individual representing a nonprofit health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1703.
- (d) One individual representing hospitals.
- (e) One individual representing doctors of medicine.
- (f) One individual representing doctors of osteopathic medicine and surgery.
- (g) One individual representing purchasers or employers.
- (h) One individual representing the pharmaceutical industry.
- (i) One individual representing schools of medicine in Michigan.
- (j) One individual representing the health information technology field.
- (k) One individual representing pharmacists.
- (l) One individual representing health plans or other third party payers.
- (m) One individual representing consumers.

(2) Of the members appointed under subsection (1), there shall be representatives from both the public and private sectors. In order to be appointed to the commission, each individual shall have experience and expertise in at least 1 of the following areas and each of the following areas shall be represented on the commission:

- (a) Health information technology.
- (b) Administration of health systems.
- (c) Research of health information.
- (d) Health finance, reimbursement, and economics.

(e) Health plans and integrated delivery systems.

(f) Privacy of health care information.

(g) Medical records.

(h) Patient care.

(i) Data systems management.

(j) Mental health.

(3) A member of the commission shall serve for a term of 4 years or until a successor is appointed. Of the members first appointed after the effective date of the amendatory act that added this part, 3 shall be appointed for a term of 1 year, 3 shall be appointed for a term of 2 years, 3 shall be appointed for a term of 3 years, and 4 shall be appointed for a term of 4 years. If a vacancy occurs on the commission, the governor shall make an appointment for the unexpired term in the same manner as the original appointment. The governor may remove a member of the commission for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause.

(4) At the first meeting of the commission, a majority of the members shall elect from its members a chairperson and other officers as it considers necessary or appropriate. After the first meeting, the commission shall meet at least quarterly, or more frequently at the call of the chairperson or if requested by a majority of the members. A majority of the members of the commission appointed and serving constitute a quorum for the transaction of business at a meeting of the commission.

(5) Any business that the commission may perform shall be conducted at a public meeting held in compliance with the open meetings act, 1976 PA 267, MCL 15.261 to 15.275. The commission shall give public notice of the time, date, and place of the meeting in the manner required by the open meetings act, 1976 PA 267, MCL 15.261 to 15.275.

(6) The commission shall make available a writing prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function as the commission to the public in compliance with the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(7) The commission shall ensure adequate opportunity for the participation of health care professionals and outside advisors with expertise in health information privacy, health information security, health care quality and patient safety, data exchange, delivery of health care, development of health information technology standards, or development of new health information technology by appointing advisory committees, including, but not limited to, advisory committees to address the following:

(a) Interoperability, functionality, and connectivity, including, but not limited to, uniform technical standards, common policies, and common vocabulary and messaging standards.

(b) Security and reliability.



- (c) Certification process.
- (d) Electronic health records.
- (e) Consumer safety, privacy, and quality of care.

(8) Members of the commission shall serve without compensation.

Sec. 2505. (1) The commission shall do each of the following:

- (a) Develop and maintain a strategic plan in accordance with subsection (2) to guide the implementation of an interoperable health information technology system that will reduce medical errors, improve quality of care, and produce greater value for health care expenditures.
- (b) Identify critical technical, scientific, economic, and other critical issues affecting the public and private adoption of health information technology.
- (c) Provide recommendations on policies and measures necessary to achieve widespread adoption of health information technology.
- (d) Increase the public's understanding of health information technology.
- (e) Promote more efficient and effective communication among multiple health care providers, including, but not limited to, hospitals, physicians, payers, employers, pharmacies, laboratories, and any other health care entity.
- (f) Identify strategies to improve the ability to monitor community health status.
- (g) Develop or design any other initiatives in furtherance of the commission's purpose.
- (h) Annually, report and make recommendations to the chairpersons of the standing committees of the house of representatives and senate with jurisdiction over issues pertaining to community health and information technology, the house of representatives and senate appropriations subcommittees on community health and information technology, and the senate and house fiscal agencies.
- (i) Perform any and all other activities in furtherance of the above or as directed by the department or the department of information technology, or both.

(2) The strategic plan developed pursuant to subsection (1)(a) shall include, at a minimum, each of the following:

- (a) The development or adoption of health care information technology standards and strategies.
- (b) The ability to base medical decisions on the availability of information at the time and place of care.

- (c) The use of evidence-based medical care.
- (d) Measures to protect the privacy and security of personal health information.
- (e) Measures to prevent unauthorized access to health information.
- (f) Measures to ensure accurate patient identification.
- (g) Methods to facilitate secure patient access to health information.
- (h) Measures to reduce health care costs by addressing inefficiencies, redundancy in data capture and storage, medical errors, inappropriate care, incomplete information, and administrative, billing, and data collection costs.
- (i) Incorporating health information technology into the provision of care and the organization of the health care workplace.
- (j) The ability to identify priority areas in which health information technology can provide benefits to consumers and a recommended timeline for implementation.
- (k) Measurable outcomes.

Sec. 2507. The commission or a member of the commission shall not be personally liable for any action at law for damages sustained by a person because of an action performed or done by the commission or a member of the commission in the performance of their respective duties in the administration and implementation of this part.

This act is ordered to take immediate effect.

Clerk of the House of Representatives

Secretary of the Senate

Approved

Governor

## APPENDIX B: LIST OF HIT COMMISSION RESOLUTIONS

The following section outlines all resolutions that has been approved by the HIT Commission since 2008. This section also outlines whether the resolution has currently been implemented.

### 2008 Annual Report

Recommendation	Implemented
Recommendation #1 – Continue Funding for MiHIN - The HIT Commission recommends that Michigan continue to provide grant funding for the MiHIN program to support a statewide infrastructure to ensure statewide exchange of health information.	Yes
Recommendation #2 – Recognize the adopted definition of HIE – Recognize in all State of Michigan activities the HIT Commission adopted definition of Health Information Exchange (HIE).	No
Recommendation #3 - HIE Recognition in the Public Health Code - The Commission recommends that Michigan identify a place in the Public Health Code to Define HIE and serve as an expandable section for future HIE legislation.	No
Recommendation #4 – Adopt Informed Opt-Out - The HIT Commission recommends that Michigan establish “Informed Opt-out” as the method of consumer control for protected health information in an HIE.	Yes (Under the State HIE Cooperative Agreement Program)
Recommendation #5 –Adopt a Statewide Infrastructure for Communication between HIEs – The HIT Commission recommends that a statewide infrastructure be developed to ensure that there is communication between HIEs. The recommended infrastructure is called a Master Patient Index (MPI) and a Record Locator Service (RLS). The HIT Commission recommends that the State of Michigan develop and implement an MPI and RLS to facilitate the sharing of information statewide.	<u>Yes</u>

### 2009 Annual Report

Recommendation	Implemented
The HIT Commission recommended to MDCH that the overall goals of MiHIN should remain: 1.) Utilizing technology to improve healthcare outcomes and clinical workflow. This includes improving quality and safety, increasing fiscal responsibility, and increasing clinical and administrative efficiency; and 2.) Empower citizens with access to information about their own health.	<u>Yes</u>
The HIT Commission recommended to MDCH that a new MiHIN approach should centralize certain elements of HIE technology and administration at the statewide level in order to attain the optimal economy of scale and achieve the most efficient use of available resources.	<u>Yes</u>

## 2010 Annual Report

Recommendation	Implemented
<p>State of Michigan MiHIN Shared Services Strategic Plan – In lieu of a traditional 2010 Annual Report, the HIT Commission adopted the State of Michigan MiHIN Shared Services Strategic Plan that was submitted to answer the announcement of the Office of the National Coordinator (ONC) State Health Information Exchange Cooperative Agreement Program Award.</p>	<p><u>Yes</u></p>
<p>The HIT Commission recommended that a member from the MiHIN initiative should be added to the HIT Commission. This member would be responsible for considering the impact of proposed recommendations, policies, and program activities may have on the statewide exchange of health information.</p>	<p>No</p>

## 2011 Annual Report

Recommendation	Implemented
<p>The HIT Commission is upholding the recommendation from 2010 and adding an additional request for a member to be added to represent either the behavioral health or long term care fields. Currently, there are no members on the HIT Commission that solely represent either of these important areas of healthcare in Michigan. The HIT Commission recommends that membership be capped at 15 members, and therefore only two new members should be added to the existing 13 members.</p>	<p>No</p>
<p>The HIT Commission recommends that Michigan should continue to support the expansion of broadband to all areas of the state and that oversight is in place to ensure that it is affordable for clinician purchase.</p>	<p>No</p>
<p>The HIT Commission recommends that as updates are made to the Michigan Public Health Code, the use of HIT should be acknowledged and encouraged. The way that healthcare is organized and administered is changing through the use of technologies at the point of care, in the administration of care, and in payment. Michigan’s governing law should be altered to reflect these changes and pave the way for continued innovation in HIT.</p>	<p>No</p>
<p>The HIT Commission recommends that the need for consumer education about HIT be addressed through a consistent statewide campaign. Further, a resource should be identified to field questions and concerns from the public. The HIT Commission does not recommend whether this is a publicly or privately led initiative, only that the resources are clearly identified and available for consumers to provide privacy and security information.</p>	<p><u>Ongoing</u></p>

## 2012 Annual Report

Recommendation	Implemented
For the 2012 report, the HIT Commission is recommending a member to be added to represent the behavioral health, nursing field or long term care fields. Currently, there are no members on the HIT Commission that solely represent any of these important areas of healthcare in Michigan. The HIT Commission recommends that membership be capped at 15 members, and therefore only two new members should be added to the existing 13 members.	No
The HIT Commission recommends that as updates are made to the Michigan Public Health Code, the use of HIT and HIE should be acknowledged and encouraged. The way that healthcare is organized and administered is changing through the use of technologies at the point of care, in the administration of care, and the exchange of clinical data. Michigan’s governing law should be altered to reflect these changes and pave the way for continued innovation in HIT and HIE.	No
The HIT Commission recommends that the need for consumer education about HIT be addressed through a consistent statewide campaign. Further, a resource should be identified to field questions and concerns from the public. The HIT Commission does not recommend whether this is a publicly or privately led initiative, only that the resources are clearly identified and available for consumers.	<u>Ongoing</u>

## 2013 Annual Report

Recommendation	Implemented
The HIT Commission recommends partnering with the Michigan Healthcare Cybersecurity Council (MiHCC), a task force formed as an action from the Governor Snyder’s Cyber Security Advisory Council, to review and potentially adopt cyber security recommendations in the Cyber Security White Paper.	<u>Yes</u>
The HIT Commission recommends that the CIO Forum, Diversion Council, and MiHIN collaborate on producing a common form. This initiative will continue into 2014 activities, in which the HIT Commission will review the final product for formal recommendation to the Department of Community Health.	<u>Yes</u>
The Michigan Health Information Technology Commission strongly encourages MiHIN (the Michigan Health Information Network) to complete the development of Qualified Data Sharing Organization criteria, to publicize and make known those criteria, and to encourage the appropriate organizations to participate in facilitating the exchange of health information throughout the State of Michigan.	<u>Yes</u>

## 2014 Annual Report

Recommendation	Implemented
<p>In 2013, the HIT Commission recommended that the CIO Forum, Diversion Council, and MiHIN collaborate on producing a common form. The HIT Commission recommends the Department of Community Health adopt the work produced by the aforementioned collaboration and use in response to <a href="#">PA 129 of 2014</a>.</p>	<p><a href="#">Yes</a></p>

## 2015 Annual Report

Recommendation	Implemented
<p>The HIT Commission supports the utilization of the Active Care Relationship Service and Common Key statewide service as a means to achieve the policy goals of the Department. The HIT Commission also encourages Michigan healthcare stakeholders to participate in the following use cases: Active Care Relationship Service, Common Key Statewide Service, and Statewide Health Provider Directory. The HIT Commission recommends that the aforementioned use cases should be implemented in a manner that promotes usability and addresses workflow issues for providers. The HIT Commission also encourages stakeholders to work together to achieve consensus and resolve barriers that are related to implementation of the aforementioned use cases.</p>	<p>Ongoing</p>

## 2016 Annual Report

Recommendation	Implemented
<p>The Michigan Health Information Technology Commission recommends a proposal for legislation to be enacted that addresses statewide adoption and use of Electronic Prescribing Controlled Substance (EPCS). The proposed legislation should be modeled after New York and Maine, who have enacted legislation to address the rising rates of prescription drug abuse by strengthening the controlled substance prescription monitoring program through mandatory electronic prescribing efforts.</p>	<p><a href="#">Ongoing</a></p>
<p>The Michigan Health Information Technology Commission recommends that the Michigan Prescription Drug and Opioid Abuse Commission and the Michigan HIT Commission establish a relationship that promotes coordination and collaboration in addressing and implementing the recommendations outlined in the Michigan Prescription Drug and Opioid Abuse Task Force's Report of Findings and Recommendations for Action.</p>	<p>Ongoing</p>

## 2017 Annual Report

Recommendation	Implemented
<p>The HIT Commission endorses the proposed updates to the standard consent form that was established under Public Act 129 of 2014. The commission also encourages MDHHS to analyze the tools that the department has at its disposal (including but not limited to CareConnect360) to enhance the sharing of physical health and behavioral health information.</p>	<p>In Process</p>
<p>The HIT Commission expresses its support for the statewide efforts to develop a standard framework for care coordination as summarized in the "Building Michigan's Care Coordination Infrastructure" report. The HIT Commission also expresses its support for the definition of "care coordination" from the report and encourages the department to review and consider this definition. Finally, the HIT Commission requests that the department provide an update to the HIT Commission at the first meeting in 2018 on whether the definition could be adopted as a statewide standard. The department should address the following issues as part of the update:</p> <ul style="list-style-type: none"> <li>• How does the definition from the report align with definitions for care coordination from other sources?</li> <li>• Which policies and programs would be impacted by the adoption of a standard definition?</li> <li>• What is the regulatory authority under which the department could adopt a standard definition?</li> </ul>	<p>No</p>
<p>The HIT Commission recommends that the department develop a strategy for aligning different quality reporting and improvement efforts across the state. This strategy should be coordinated with the ongoing efforts of the Physician-Payer Quality Collaborative but should also encompass other initiatives across the state. The HIT Commission also encourages the department to include a representative from the commission as part of ongoing discussions about this strategy. Finally, the HIT Commission requests that the department provide an update on the aforementioned strategy at the first meeting in 2018.</p>	<p>No</p>