MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

2018 ANNUAL REPORT

GRETCHEN WHITMER, GOVERNOR | ROBERT GORDON, 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 three topics during 2018:

(1) Physical and Behavioral Health Integration

(2) Population Health Reporting

(3) Healthcare Transformation

The HIT Commission will continue to explore these issues during 2019. With regards to the Physical and Behavioral Health Integration activities, the Commission will continue to focus on the Section 298 Initiative, as well as work to define a concise definition of 'Care Coordination.' The HIT Commission will also focus on Opioid Crisis Remediation and Social Determinants of Health, including the Housing Initiative, all within the Population Health Reporting activities. Within the Healthcare Transformation activities, the Commission will work to collaborate with HIMSS, developing a high-level roadmap for the Commission, as well as continue the focus on the Integrated Service Delivery (ISD) model.

The HIT Commission did not approve any resolutions in 2018. Please see Appendix B for a list of past and present resolutions.

TABLE OF CONTENTS

Executive Summary 3

The HIT Commission 5

HIT Commission Meetings in 2018 6

HIT Commission Topics in 2018 7

Physical and Behavioral ahealth Integration 7

Population Health Reporting 9

Healthcare Transformation 14

Forecast of 2019 HIT Commission Topics 16

Appendix A: Public Act 137 of 2006 17

Appendix B: List of HIT Commission Resolutions 22

THE HIT COMMISSION

As of December 31, 2018

Heather Somand, PharmD was newly appointed to the HIT Commission and represents pharmacists for a term expiring August 3, 2022.

Jack Harris, representing the Department of Technology, Management, and Budget for a term expiring August 3, 2020, has replaced **Rodney Davenport**, State of Michigan CTO.

James VanderMey was newly appointed to the HIT Commission and represents the health information technology field for a term expiring on August 3, 2022.

Jonathan Kufahl was newly appointed to the HIT Commission and represents hospitals for a term expiring August 3, 2021.

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

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

Nicholas D'Isa was newly appointed to the HIT Commission as the representative of third-party payers for a term expiring August 3, 2022.

Norman Beauchamp, MD was appointed as the new representative of schools of medicine for a term that will expire August 3, 2021.

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

Pat Rinvelt of Ann Arbor 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.

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

Thomas Simmer, MD was appointed as the new representative of non-profit health care corporations and is acting Chair of the HIT commission for a term that will expire August 3, 2022.

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 2018

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 three times in 2018 with the meeting set for April unable to meet quorum and subsequently being cancelled.

Month	Meeting Topic	Attendance
February	The HIT Commission received an update on the physical health and behavioral health integration initiatives which included the Section 298 Initiative. The HIT Commission also explored the current statewide crisis in access to inpatient psychiatric services and learned about how technology could help improve transitions of care for individuals in psychiatric crisis. The HIT Commission also learned about inconsistencies between state and federal laws and regulations on confidentiality for behavioral health information and examined several ongoing projects that are focused on improving the sharing of behavioral health information.	10 out of 13 commissioners participated in the February meeting.
May	The HIT Commission explored the topic of the opioid crisis currently occurring in the State of Michigan and examined the response to this topic by the Michigan Department of Health and Human Services which includes prevention, early intervention and treatment. The HIT Commission also received information related to opioid data analytics updates through the Medicaid Innovation Accelerator Program (IAP). The HIT Commission also was provided a demonstration a new surveillance tool called the System for Opioid Overdose Surveillance (S.O.S.).	10 out of 13 commissioners participated in the May meeting.
November	With the addition of five new commissioners to the November meeting, the Policy Division coordinated with MiHIN and the Health Information Exchange (HIE) providers in the State of Michigan to provide an overview and update of the abilities and services provided by their systems. Several HIE providers presented at the meeting including Upper Peninsula Health Information Exchange, (UPHIE), Great Lakes Health Connect (GLHC), Northern Physician Organization (NPO) and Ingenium, as well as an overview of MiHIN Shared Services current and upcoming use cases.	10 out of 13 commissioners participated in the November meeting.

HIT COMMISSION TOPICS IN 2018

The HIT Commission explored three main topics during the 2018 meetings. An overview of each topic and related HIT Commission discussions are included below.

(1) Physical Health and Behavioral Health Integration

(2) Population Health Reporting

(3) Healthcare Transformation

Physical Health and Behavioral Health Integration

The HIT Commission initially explored the challenges of integrating physical health and behavioral health services in 2017, and the HIT Commission revisited this issue during its February 2018 meeting. The HIT Commission also continue to investigate barriers related 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.

As part of the February meeting, the HIT Commission specifically examined two statewide initiatives and their implications for sharing behavioral health information.

- The Section 298 Initiative is a statewide effort to improve the integration of publicly-funded physical health and behavioral health services. The Michigan legislature directed MDHHS in 2017 to implement up to three pilots and a separate demonstration project to test the integration of services. During the February meeting, the HIT Commission explored the history behind the Section 298 Initiative and learned more about the specific models that are being tested across the state.

  The HIT Commission also examined the implications of the pilots and the demonstration project for sharing behavioral health information. The HIT Commission specifically discovered that providers and payers are still struggling with differences in interpretation of privacy requirements between HIPAA, the Michigan Mental Health Code, and 42 CFR Part 2. The HIT Commission also learned that the pilots and demonstration project offer opportunities to address these issues and improve the sharing of behavioral

health information by improving educational efforts for frontline staff, establishing appropriate legal agreements between providers and payers, and developing electronic consent management capacity.

- The Michigan Inpatient Psychiatric Admissions Discussion (MIPAD) was a statewide initiative that was launched by the department in order to investigate and address systemic barriers to inpatient care for individuals in psychiatric crisis. During the February meeting, the HIT Commission learned about some of the ongoing and persistent barriers to access, which includes a large decline in the number of available beds and a significant increase in demand for capacity for forensic examinations. The HIT Commission also learned about how these trends have led to significant rates of emergency department boarding, a long wait list for state hospital services, and high rates of denials at community hospitals.

  The HIT Commission also examined the department's efforts in partnership with the MIPAD workgroup to develop and implement a series of solutions to address this crisis. The HIT Commission also learned about parallel efforts by the department to enhance the sharing of behavioral health information in order to improve transitions of care for individuals in psychiatric crisis. These efforts include improving the electronic connectivity of state hospitals to other state agencies and health care providers and developing the capacity to send electronic notifications from inpatient psychiatric units to community partners when an individual is discharged after a psychiatric stay.

The HIT Commission also reviewed a series of recommendations for sharing behavioral health information that had emerged from the statewide discussions around the Section 298 Initiative and MIPAD Initiative. The HIT Commission discovered that the recommendations from these different initiatives shared a series of common themes, which are outlined below. The HIT Commission discussed these themes with MDHHS staff during the February meeting:

- Trust Themes – Develop and implement statewide policy in a manner that builds trust between consumers, providers, and payers around the sharing of behavioral health information.
    - Improve the accessibility of the standard consent form (MDHHS-5515) to consumers.
    - Encourage and support providers and payers in the implementation of Public Act 559.
    - Conduct education and outreach to consumers, providers, and payers on privacy laws and regulations.
    - Collaborate with the Consent Form Workgroup and other stakeholder groups on improving sharing behavioral health information.
- Technology Themes – Collaborate with providers, payers, and HIT-HIE partners to establish the technology infrastructure for sharing behavioral health information and coordinating care.
    - Integrate behavioral health information into CareConnect360.
    - Promote the sharing of Admit, Discharge, and Transfer notifications for inpatient psychiatric stays.
    - Develop the capacity to electronically manage consent across different health care organizations.

The HIT Commission will continue to investigate barriers to the sharing of behavioral health information in 2019 and advise department on developing a statewide approach to addressing these barriers.

Population Health Reporting

Also, in 2018 the HIT Commission explored ways in which data analytics can benefit population health reporting, making the data more consumable and useable to payers, providers and consumers, as was described during the May meeting. The HIT Commission specifically examined the use of HIT and data analytics through the Opioid IAP and the response by the State of Michigan, in the midst of the opioid crisis.

The Opioid IAP

As presented by Dave Schneider, one way to combat the opioid crisis in Michigan is to better understand the problem. The Michigan Department of Health and Human Services, Bureau of Medicaid Care Management and Quality Assurance is using data analytics to provide insight into the crisis. The Medicaid Innovation Accelerator Program (IAP), which is a collaborative between the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI) designed to build state capacity and support ongoing innovation in Medicaid. The Medicaid IAP provides targeted support to states' ongoing delivery system reform efforts across four priority program areas:

1. Reducing substance use disorders,
2. Improving care for Medicaid beneficiaries with complex care needs and high costs,
3. Promoting community integration through long-term services and supports, and
4. Supporting physical/mental health integration.

The IAP offered this opportunity for up to 12 states that are in the initial stages of examining their SUD data. There are three inter-related areas of focus for this cohort, including Opioid Use Disorder (OUD), Medication Assisted Treatment (MAT), and/or Neo-natal Abstinence Syndrome (NAS) and OUD care for pregnant women in the Medicaid program. Michigan has been given the choice to participate in any or all of these three areas.

Each area of focus will run sequentially beginning with Opioid Use Disorder. OUD runs from April through May 2018 and focuses on sizing and stratifying the magnitude of the opioid epidemic within the Medicaid population. Michigan would receive a data template, diagnosis and procedure codes for identifying OUD in Medicaid claims, and other technical assistance.

June through July 2018 will address Medication Assisted Treatment and will focus on assessing the availability and distribution of MAT treatment within the state's Medicaid program. Michigan would receive value sets to identify MAT utilization in Medicaid claims, table shells, a list of buprenorphine-waivered practitioners in the state and other technical assistance.

Lastly, August through September 2018 will represent NAS and OUD care for pregnant women. This area will focus on assessing the size and characteristics of NAS and opioid related maternity care in the state's Medicaid program. Michigan would receive tables, shells and value sets to identify NAS care to infants and OUD

maternity care to women. The aim is to help states understand where treatment occurs, what type of treatment, and the cost.

The Expression of Interest application requires that the State Medicaid Director acknowledges that the State of Michigan is seeking support and has a team that can, and will, have sufficient time and resources. This application also included a description of the state's planned goals and activities. The team identified to perform this initiative include:

- Medical Services Administration, including Office of Medical Affairs, Analytics and Long-Term Care Financing.
- Policy and Strategic Initiatives.
- Population Health Management, including Perinatal and Infant Health, Maternal Child Health Epidemiology.
- Behavioral Health and Developmental Disabilities, OROSC.
- Michigan State University, Institute for Health Policy.

Through participation in the Medicaid Innovation Accelerator Program Opioid Data Analytics Cohort, Michigan will enhance its ability to use existing data to focus and refine its efforts. Key objectives include:

- Using analytics to identify key linkage opportunities that may be missed, thereby improving access to needed prevention, early intervention or treatment;
- Increasing knowledge and understanding of the size, location, and demography of the populations most in need of the interventions planned;
- Increase treatment access through data driven decisions on service expansion; and
- Better evaluate the results of these efforts through solid data analytics.

Michigan chose to create 4 tables to identify their opioid use disorder cohort. The tables identified the following:

TABLE 1. Total Medicaid Beneficiaries Ages 12 and Over with Opioid Use Disorders

Table 1. Total Medicaid Beneficiaries Ages 12 and Over with Opioid Use Disorders

Categories		Total Beneficiaries	Beneficiaries without OUD		Beneficiaries with OUD		
Category	Sub Category	Total number of beneficiaries	Number without OUD	% without OUD	Number with OUD	% with OUD	Rate of OUD per 1000/Beneficiaries
Total	Total Ages 12 and over	1,814,271	1,762,997	97.17%	51,274	2.83%	28.3
Age Group	Children (12--17)	361,784	361,564	99.94%	220	0.06%	0.6
Age Group	Adults (18--45)	1,099,875	1,064,045	96.74%	35,830	3.26%	32.6
Age Group	Older adults (46--64)	411,684	396,157	96.23%	15,527	3.77%	37.7
Age Group	Elderly adults (65+)	12,477	12,472	99.96%	5	0.04%	0.4
Gender	Male	819,201	793,775	96.90%	25,426	3.10%	31.0
Gender	Female	995,070	969,222	97.40%	25,848	2.60%	26.0
Gender	Unknown						
Medicaid Product	Fee for Service	835,036	823,337	98.60%	11,699	1.40%	14.0
Medicaid Product	Managed Care	1,510,919	1,464,725	96.94%	46,194	3.06%	30.6
Medicaid Product	Other						
Basis of Eligibility	Disabled	201,912	191,424	94.81%	10,488	5.19%	51.9
Basis of Eligibility	Non-disabled	930,832	915,657	98.37%	15,175	1.63%	16.3
Basis of Eligibility	Newly Eligible	874,621	845,917	96.72%	28,704	3.28%	32.8
Basis of Eligibility	Other						

TABLE 2. Total Health Care Expenditures for Medicaid /CHIP Beneficiaries Ages 12 and Over With and Without OUD

Table 2. Total Health Care Expenditures for Medicaid /CHIP Beneficiaries Ages 12 and Over With and Without OUD							
Categories		Total Beneficiaries		Beneficiaries without OUD		Beneficiaries with OUD	
Demographic Category	Sub Category	Total expenditures	Per capita expenditures	Total expenditures	Per capita expenditures	Total expenditures	Per capita expenditures
Total	Total Ages 12 and over	$8,739,638,349	$4,817	$7,819,177,481	$4,435	$920,460,868	$17,952
Age Group	Children (12--17)	$750,199,740	$2,074	$745,969,742	$2,063	$4,229,998	$19,227
Age Group	Adults (18--45)	$4,272,165,261	$3,884	$3,759,887,790	$3,534	$512,277,471	$14,297
Age Group	Older adults (46--64)	$3,691,414,598	$8,967	$3,287,591,700	$8,299	$403,822,898	$26,008
Age Group	Elderly adults (65+)	$25,858,751	$2,073	$25,728,249	$2,063	$130,502	$26,100
Gender	Male	$3,899,997,469	$4,761	$3,459,328,675	$4,358	$440,668,794	$17,331
Gender	Female	$4,839,640,880	$4,864	$4,359,848,805	$4,498	$479,792,074	$18,562
Gender	Unknown						
Medicaid Product	Fee for Service	$1,183,861,462	$1,418	$1,082,261,196	$1,314	$101,600,266	$8,685
Medicaid Product	Managed Care	$7,555,776,887	$5,001	$6,736,916,284	$4,599	$818,860,603	$17,727
Medicaid Product	Other						
Basis of Eligibility	Disabled	$3,036,804,703	$15,040	$2,681,940,408	$14,010	$354,864,295	$33,835
Basis of Eligibility	Non-disabled	$2,586,795,839	$2,779	$2,401,761,400	$2,623	$185,034,438	$12,193
Basis of Eligibility	Newly Eligible	$3,116,037,808	$3,563	$2,735,475,672	$3,234	$380,562,136	$13,258
Basis of Eligibility	Other						

TABLE 3. Health Care Expenditures by Type for Medicaid Beneficiaries Ages 12 and Over with OUD

Table 3. Health Care Expenditures by Type for Medicaid Beneficiaries Ages 12 and Over with OUD							
Category	Sub Category	Total expenditures	Per capita expenditures	Total physical health expenditures	Per capita physical health expenditures	Total mental health expenditures	Per capita mental health expenditures
Total	Total Ages 12 and over	$920,460,868	$17,952	$740,636,781	$14,445	$90,992,831	$1,775
Age Group	Children (12--17)	$4,229,998	$19,227	$2,663,756	$12,108	$953,992	$4,336
Age Group	Adults (18--45)	$512,277,471	$14,297	$382,134,542	$10,665	$64,464,723	$1,799
Age Group	Older adults (46--64)	$403,822,898	$26,008	$355,708,360	$22,909	$25,573,737	$1,647
Age Group	Elderly adults (65+)	$130,502	$26,100	$130,123	$26,025	$379	$76
Gender	Male	$440,668,794	$17,331	$346,166,940	$13,615	$48,421,358	$1,904
Gender	Female	$479,792,074	$18,562	$394,469,840	$15,261	$42,571,473	$1,647
Gender	Unknown						
Medicaid Product	Fee for Service	$101,600,266	$8,685	$76,848,427	$6,569	$12,591,802	$1,076
Medicaid Product	Managed Care	$818,860,603	$17,727	$663,788,353	$14,370	$78,401,029	$1,697
Medicaid Product	Other						
Basis of Eligibility	Disabled	$354,864,295	$33,835	$310,602,109	$29,615	$30,403,766	$2,899
Basis of Eligibility	Non-disabled	$185,034,438	$12,193	$144,535,480	$9,525	$17,520,607	$1,155
Basis of Eligibility	Newly Eligible	$380,562,136	$13,258	$285,499,192	$9,946	$43,068,458	$1,500
Basis of Eligibility	Other						

TABLE 3. Continued

Table 3. Health Care Expenditures by Type for Medicaid Beneficiaries Ages 12 and Over with OUD

Category	Sub Category	Total non-OUD SUD expenditures	Per capita non-OUD SUD expenditures	Total OUD treatment medication expenditures	Per capita OUD treatment medication expenditures	Total OUD non-medication expenditures	Per capita OUD non-medication expenditures	Total OUD expenditures	Per capita OUD expenditures
Total	Total Ages 12 and over	$54,791,352	$1,069	$179,888,975	$3,508	$740,571,894	$14,443	$920,460,868	$17,952
Age Group	Children (12--17)	$3,966,000	$18,027	$325,647	$1,480	$3,904,350	$17,747	$4,229,998	$19,227
Age Group	Adults (18--45)	$29,280,553	$817	$93,776,094	$2,617	$418,501,376	$11,680	$512,277,471	$14,297
Age Group	Older adults (46--64)	$21,544,564	$1,388	$85,770,756	$5,524	$318,052,142	$20,484	$403,822,898	$26,008
Age Group	Elderly adults (65+)	$235	$47	$16,477	$3,295	$114,025	$22,805	$130,502	$26,100
Gender	Male	$35,738,751	$1,406	$83,482,682	$3,283	$357,186,112	$14,048	$440,668,794	$17,331
Gender	Female	$19,052,601	$737	$96,406,293	$3,730	$383,385,781	$14,832	$479,792,074	$18,562
Gender	Unknown								
Medicaid Product	Fee for Service	$10,536,387	$901	$56,208,551	$4,805	$45,391,714	$3,880	$101,600,266	$8,685
Medicaid Product	Managed Care	$44,254,965	$958	$123,680,423	$2,677	$695,180,179	$15,049	$818,860,603	$17,727
Medicaid Product	Other								
Basis of Eligibility	Disabled	$7,889,757	$752	$354,864,295	$33,835	$71,478,470	$6,815	$354,864,295	$33,835
Basis of Eligibility	Non-disabled	$12,850,465	$847	$185,034,438	$5,164	$36,808,621	$2,426	$185,034,438	$12,193
Basis of Eligibility	Newly Eligible	$34,051,130	$1,186	$380,562,136	$13,258	$71,601,884	$2,494	$380,562,136	$13,258
Basis of Eligibility	Other								

Table 4 is the top 100 most expensive beneficiaries with OUD. Michigan decided to look at top 1000 most expensive beneficiaries

TABLE 4: Top 100 Medicaid Beneficiaries Ages 12 and Over with OUD by Expenditure

Total Cost for Top 1000	$132,584,559
Total Inpatient for Top 1000	$75,574,343
Total Outpatient for Top 1000	$19,958,652
Total ED for Top 1000	$43,554,989
Total Pharmacy for Top 1000	$34,051,564

The four tables provided basic information, as well as raised several important questions, such as, “Who has an OUD but no opioid prescriptions and who has opioid prescriptions but no OUD?” Additional questions have been raised regarding predictive analytics and whether this data can support predictions surrounding the development of an OUD.

Michigan was asked to participate in the ‘all state’ calls throughout the summer and provide information as to where this data is moving Michigan forward. It is intended that this IAP will result in a richer understanding of the various characteristics of the Opioid Crisis here in Michigan and the development of a data sets, along with appropriate analytics, to support the application of resources in ways that will improve prevention, early intervention and treatment. MDHHS will use such data sets and analytics to objectively determine the outcomes of those efforts.

UPDATE: Michigan did complete the IAP project, participating in the second (MAT) and third (NAS) components of the project. Although MDHHS was able to learn more about their Opioid Use Disorder (OUD) data, the speed at which the IAP progressed, did not allow for the ‘deep dive’ MDHHS had hoped for. To remedy this issue. MDHHS has continued to meet with the IAP workgroup and has expanded membership with the goal of performing more analysis on the MME and MEDD tables. MDHHS is also working to establish data use guidelines

and appropriate priorities through this group as well. MDHHS continues to make progress and has built a foundation for continued efforts.

Michigan Department of Health and Human Services Public Health Response to the Opioid Crisis

Jared Welehodsky, MDHHS Policy and Strategic Initiatives Section, provided an update on MDHHS' efforts to address the opioid crisis. Jared discussed key points to measure success, updates on legislation, and new grant funding received by MDHHS to address the opioid epidemic. Jared then answered questions from Commission members.

Jared explained to the Commission that the State of Michigan has used a three-layered approach with the first layer being Prevention, with an emphasis on promoting awareness, reducing supply and demand and improving IT analytics and surveillance. The second layer is Early Intervention with the goal of identifying co-occurring conditions, as well as the risk of addiction and overdose. Finally, the third-layer is Treatment, in which an increase of treatment and emergency services are provided.

The Prevention layer has been addressed in several ways. In addition to providing information within the school curriculum, Michigan has also launched a statewide public awareness campaign in 2017 and will run until 2019. The campaign provides information related to treatment resources medication-assisted treatment centers, including a treatment services locator, and provides guidance on the proper disposal of opioids and other medications. The campaign can be viewed at the following address, michigan.gov/stopoverdoses, and has currently had over 100,000 page-views to date.

Early Intervention is a critical layer of the plan and is supported by care coordination, collaboration and continuity of care through programs such as Michigan Medicaid and the Healthy Michigan Plan, both of which have provided nearly $100 million in substance use disorder services in 2016, half of which was directly related to opioid abuse expenses. Medicaid services also provide additional support to those suffering from substance use disorder through residential and outpatient services, withdrawal management and medication assisted treatment plans and services.

Early intervention will also be addressed with the Opioid Health Home, of which a pilot program will soon be created in Northern Lower Michigan. This program provides better care management and care coordination with multiple chronic conditions, is eligible for 90/10 federal funding and will include those Medicaid beneficiaries with an opioid use disorder, in additional to another chronic condition.

Supporting the Treatment layer, Michigan has implemented legislation in the form of the Naloxone Standing Order Report. This report provides valuable information and a view into the number of opioids prescribed in Michigan. The report highlights statistics such as, the number of pharmacies with controlled substance licenses in Michigan, the number of pharmacies with naloxone standing orders and the total number naloxone orders filled by Michigan physicians.

The Michigan Department of Health and Human Services (MDHHS) was awarded a two-year State Targeted Response to the Opioid Crisis (STR) Grant from SAMHSA in April 2017 for $16,372,680 per year. This grant can be used for interventions related to prevention, treatment and recovery and will specifically support improvements made to Michigan's Prescription Drug Monitoring Program (MAPS) and enhance opioid prescribing practices for common surgical procedures through training for medical and dental practitioners called MI Open II.

Funding from the STR grant will increase access to treatment services by expanding the availability and use of Medication Assisted Treatment, including Michigan Opioid Collaborative, as well as, provide a new model for prisoner re-entry population with co-occurring Opioid Use and Mental Health Disorders. The grant will also

increase tribal interventions within the many tribal communities in Michigan and provide naloxone directly to the Michigan State Police, decreasing the number of opioid related overdose deaths.

System for Opioid Overdose Surveillance (S.O.S.)

Dr. Mahshid Abir, working in conjunction with the University of Michigan Acute Care Research Unit and the Injury Center has created an opioid surveillance system, known as the System for Opioid Overdose Surveillance (S.O.S.), that aims to combat some of the hindrances noted in the current way in which opioid overdoses and deaths are surveilled.

Some of the roadblocks that have made it difficult to accurately surveil opioid overdose include information from emergency departments and medical examiners lacking centralization, as well as overdose information that is not timely or necessarily accurate. Through a partnership with MDILog, Great Lakes Health Connect (GLHC) and using data obtained through the MI-EMSIS database, this project, federally funded by the High Intensity Drug Trafficking Area (HIDTA), Dr. Abir was able to create a surveillance system that has proven to be scalable, using the minimum number of datasets available to obtain the most relevant data, maximize limited resources by identifying 'hotspots' of fatal and non-fatal overdoses, as well as provide more timely and accurate data that is not over- or under-counted.

Washtenaw County was used as a pilot area to combine EMS data, emergency department (ED) data and additional data gained from the Washtenaw County medical examiner which was standardized and matched through GLHC prior to being inputted into S.O.S. Using geo-coding, the EMS data provided the data points related to Naloxone deployments transported to Michigan Medicine. The emergency department information provided the points necessary to map the Michigan Medicine opioid overdoses and the medical examiner information provided data points representing the opioid related deaths in Washtenaw County. The culmination of this information provides a map of Washtenaw County in which 'hotspots' can be identified and the linkage of the three data sets eliminates the over counting of EMS and fatal ED visits.

The capabilities of the S.O.S. provides information on suspected fatal overdoses every 24 hours and provides confirmation of these fatal overdoses after toxicology results become available. S.O.S. also provides information on non-fatal overdoses, with updates every 24 hours from the ED and updates 3 times weekly from EMS. This system provides granular, identifiable opioid overdose data to key stakeholders, providing the necessary securities needed for protected health information (PHI) using password protected access. This system is also available to the public at a county level, allowing transparency into the current state of opioid use and deaths in Michigan.

Healthcare Transformation

2018 brought several new appointees to the Health Information Technology Commission. In an effort to introduce the new Commissioners to health information technology and the role that the HIT Commission plays in this space, the Policy Division invited the health information exchange (HIE) entities engaged within the State of Michigan to present information and updates as to what their HIE has to offer, including the process by which they became an HIE and their future endeavors. The HIEs that presented were Upper Peninsula Health Information Exchange (UPHIE), Great Lakes Health Connect (GLHC), Northern Physician Organization (NPO) and Ingenium.

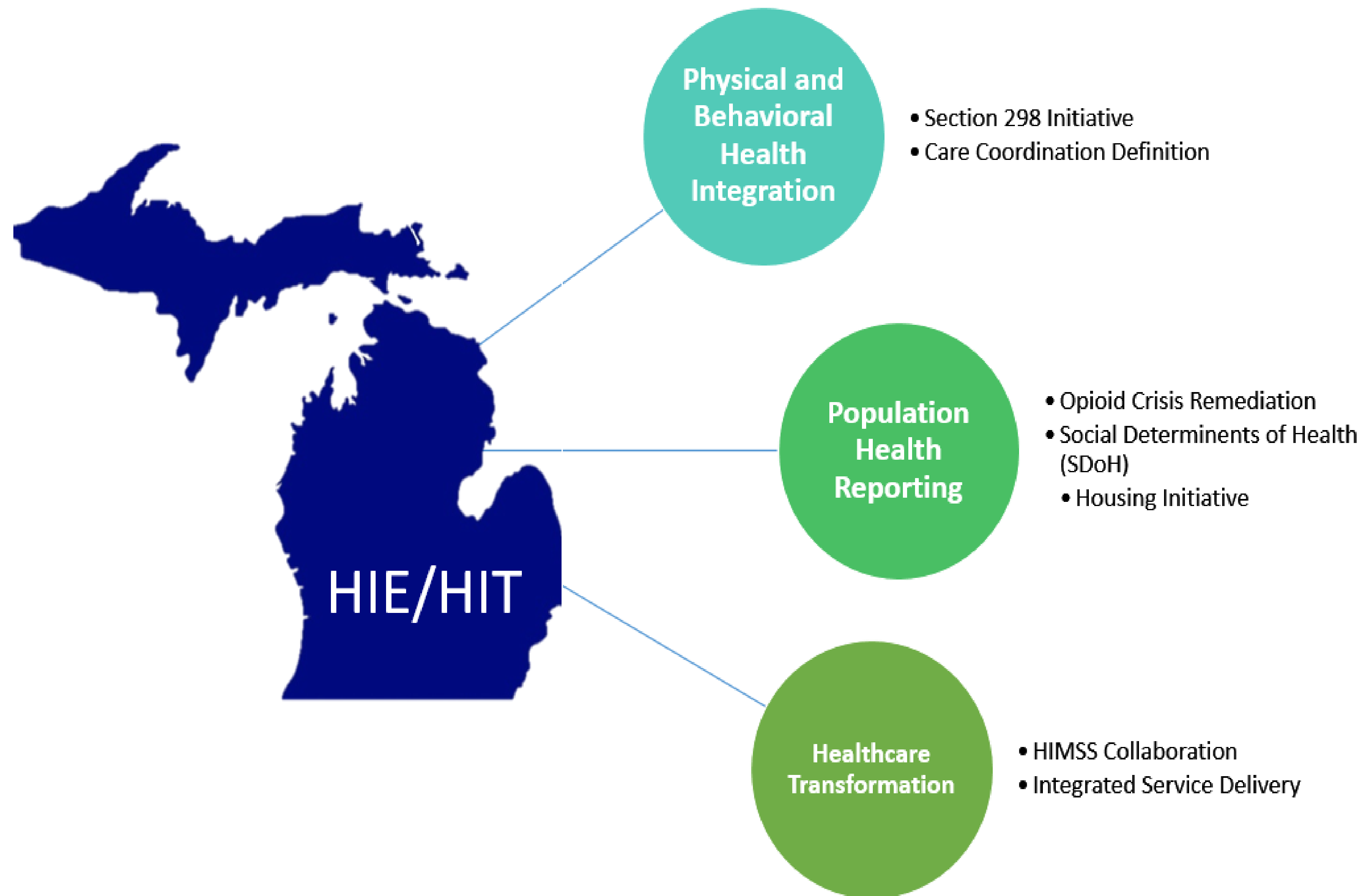
The HIT Commission also invited the Michigan Health Information Network (MiHIN) to provide an overview of how the statewide infrastructure for health information exchange can support public health reporting. MiHIN is a network that provides a shared infrastructure for the sharing of health information 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."[1] 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.

[1] Michigan Health Information Network Shared Services. "What is a Use Case?" Retrieved from: https://mihin.org/what-is-a-use-case/

FORECAST OF 2019 HIT COMMISSION TOPICS

The HIT Commission will explore the following issues and initiatives during commission meetings in 2019



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.	Yes

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.	Yes
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.	Yes

2010 Annual Report

Recommendation	Implemented
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.	Yes
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.	No

2011 Annual Report

Recommendation	Implemented
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.	No
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.	No
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.	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 to provide privacy and security information.	Ongoing

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.	Ongoing

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.	Yes
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.	Yes
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.	Yes

2014 Annual Report

Recommendation	Implemented
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 PA 129 of 2014.	Yes

2015 Annual Report

Recommendation	Implemented
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.	Ongoing

2016 Annual Report

Recommendation	Implemented
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.	Ongoing (SB-0802 of 2018 did not pass)
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.	Ongoing

2017 Annual Report/2018 Updates

Recommendation	Implemented
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.	In Process
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?	In Process
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.	In Process