Michigan Health Information Technology Commission
– An Advisory Commission to the Michigan Department of Community Health -

2012 Annual Report

Fulfilling Michigan Public Act 137-2006 "The HIT Commission shall annually report and make recommendations."

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Introduction & Overview

The Michigan Health Information Technology (HIT) Commission was created in May 2006 as an advisory commission to the Michigan Department of Community Health (MDCH) when the Michigan Legislature passed and the Governor signed Public Act (PA) 137-2006. The HIT Commission's purpose, membership, appointment process, frequency of meeting, scope of activities, and all other specifics are detailed in PA 137-2006. See appendix A for a copy of PA 137-2006.

As outlined in PA 137-2006, the purpose of the HIT Commission is to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in this state as well as advance the adoption of health information technologies throughout the state's health care system.

Since the passage of PA 137 in 2006, the American Recovery and Reinvestment Act (ARRA) of 2009 made an unprecedented investment in HIT across the nation. Michigan received approximately $250 million in HIT investment through the ARRA. The HIT Commission has become an integral part of monitoring the activity from the ARRA funding in Michigan and advising MDCH on action to ensure that the funding is being used most effectively and efficiently. Due to adherence to the Open Meetings Act, the HIT Commission has come to play a unique role in ensuring that all ARRA funded HIT programs in Michigan are operating transparently and in the best interest of the public. Much of the work of the HIT Commission in 2012 has focused on calling for information from and providing feedback to the ARRA HIT initiatives in Michigan.

The legislation creating the HIT Commission requires the distribution of an annual report to the Legislature detailing activities and providing recommendations for action. The report that follows fulfills this requirement.

HIT Commission 2012 Membership

The 13-member HIT Commission is appointed by the Governor as directed in the Public Act creating the HIT Commission. Commissioners serve four year terms or until a successor is appointed. Each Commissioner is appointed to represent a specific stakeholder group in one of the following groups:

1. The director of the department (of Community Health) or his or her designee
2. The director of the department of information technology or his or her designee

3. 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
4. One individual representing hospitals
5. One individual representing doctors of medicine
6. One individual representing doctors of osteopathic medicine and surgery
7. One individual representing purchasers or employers
8. One individual representing the pharmaceutical industry
9. One individual representing schools of medicine in Michigan
10. One individual representing the health information technology field
11. One individual representing pharmacists
12. One individual representing health plans or other third party payers
13. One individual representing consumers

In 2012, the following appointees served as members of the Michigan HIT Commission. Each individual is listed with their term expiration date and the representative stakeholder group.

Gregory Forzley, M.D., of Northville represents doctors of medicine for a term expiring August 3, 2015 and serves as the HIT Commission Chair.

Toshiki Masaki of Canton represents purchasers and employers for a term expiring August 3, 2013 and serves as the HIT Commission Vice-Chair.

James Haveman of Grand Rapids, Director of the Michigan Department of Community Health, is appointed for a term expiring August 3, 2016.

Nick Lyon of Marshall, Chief Deputy Director of the Michigan Department of Community Health, is appointed as the Director of Michigan Department of Community Health's designee as of December 20, 2013 with a term expiring August 3, 2016.

David Behen, of Ann Arbor, Designee of the Director of the Michigan Department of Technology Management and Budget, is appointed for a term expiring August 3, 2016.

Robert Milewski of Canton represents nonprofit health care corporations for a term expiring August 3, 2014.

Mark Notman, **Ph.D**., of East Lansing represents schools of medicine in Michigan for a term expiring August 3, 2013.

Thomas Lauzon of Shelby Township represents health plans or other third party payers for a term expiring August 3, 2014.

Dennis Swan of Okemos represents hospitals for a term expiring August 3, 2013.

Larry Wagenknecht, R. Ph., of Haslett represents pharmacists for a term expiring August 3, 2014.

Orest Sowirka, D.O. of Sterling Heights represents doctors of osteopathic medicine and surgery for a term expiring August 3, 2015.

Michael Gardner of Midland represents pharmaceutical manufacturers for a term expiring August 3, 2016.

Michael Chrissos of Ann Arbor represents consumers for a term expiring August 3, 2015.

Vacant- represents the health information technology field for a term expiring August 3, 2014.

HIT Commission Schedule of 2012 Meetings

In Public Act 137-06 it states that the HIT Commission must meet at least quarterly. All meetings are open to the public and adhere to the Michigan Open Meetings Act. All meeting dates, times, and locations are posted on the MDCH website (www.michigan.gov/mdch) along with meeting agendas, minutes and materials.

In 2012, the HIT Commission held five meetings. Below is the 2012 HIT Commission schedule of meetings that were held:

January 19, 2012

April 19, 2012

September 20, 2012

October 18, 2012

December 20, 2012

2012 Review of Activity

A brief overview of 2012 HIT Commission activities are listed within this section. The 2012 activities are outlined by the main initiatives and organizations that presented to the HIT Commission throughout the year and whose work provided the basis for much of the Commission's discussion and subsequent recommendations throughout the year.

2012 HIT Activities in Michigan

Michigan Health Information Network

MiHIN: Michigan Health Information Network Shared Services (MiHIN) is a public and private nonprofit collaboration serving as the State's strategic approach for enabling statewide data sharing of health information to improve the patient experience of care (including quality and satisfaction); improving the health of Michigan's population; and reducing the per capita cost of health care in the State.

During 2012, MiHIN has initiated a number of services and projects that are expanding Michigan's capabilities towards meeting Meaningful Use requirements for health information exchange. Collaborating in these efforts, are the State of Michigan's MDCH Data Hub and the seven sub-state HIEs qualifying organizations, as well as, one virtually qualified organization:

1. Great Lakes Health Information Exchange (GLHIE), based in East Lansing;
2. Ingenium, based in Bingham Farms;
3. Jackson Community Medical Records (JCMR), based in Jackson;
4. Michigan Health Connect (MHC), based in Grand Rapids;
5. Southeast Michigan Health Information Exchange (SEMHIE), based in Ann Arbor;
6. Southeast Michigan Beacon Community (SEMBC), based in Detroit;
7. Upper Peninsula Health Information Exchange (UPHIE), based in Marquette;
8. Carebridge

As a result of the combined efforts of MiHIN and the sub-state HIEs, health information exchange was broadly available in 2012 throughout Michigan.

Public Health Services – MiHIN has developed a robust state-wide infrastructure for the electronic submission of data across current information technology architectures (e.g. immunizations, reportable labs, disease surveillance) for compliance with *Meaningful Use* requirements. During 2012, there were a total of 522,670 public health messages that were transmitted across MiHIN's Health Information Services Cloud™ (HISC).

Health Provider Directory (HPD) Services – The HPD service was developed to foster the integration of a statewide health provider directory for assuring secure provider communication through the transmission of data. This service highlights the ability to query licensing status or other demographic information at the provider, care team, or organizational levels; provider submission of referrals through Direct secure messaging; and sub-state HIEs' submission of public health surveillance data for routing through MiHIN's Health Information Services Cloud™.
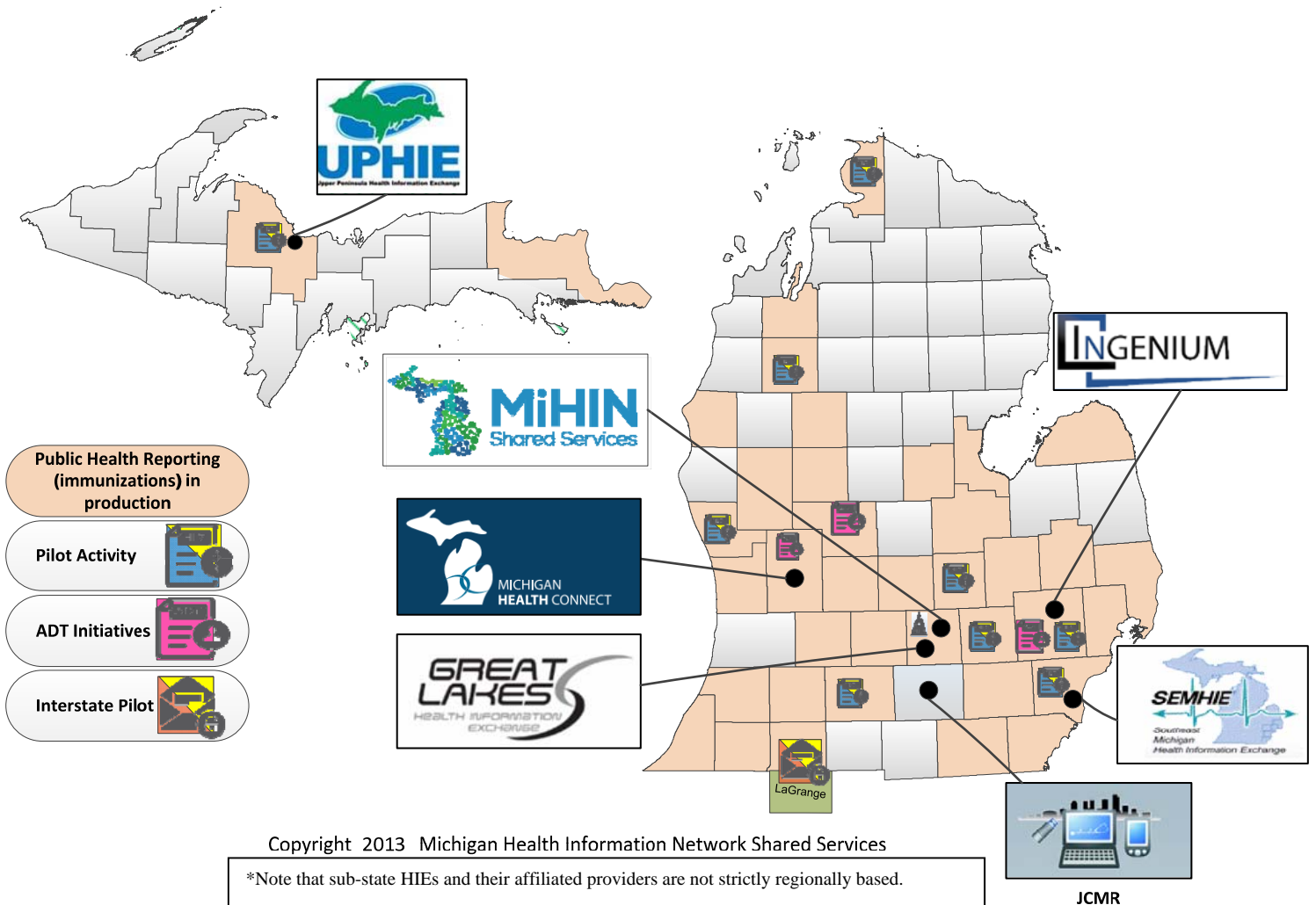
Transitions of Care Services – MiHIN's ability to connect providers through secure messaging for provider communication provides an environment for the implementation of the patient-centered medical home model. Although an initial focus was to explore the Admit, Discharge, Transfer (ADT) process, ADT is now in production and medication therapy management (MTM) pilots are being explored with retail pharmacies that focus on point-to-point (pharmacy-to-primary care physician) data flow for MTM. A major criterion for these stakeholders is to be able to demonstrate the capacity to participate in the notification services that identify clinicians interested in and authorized to receive MTM data. Pilot projects will focus on sharing data when there is a 'human-in-the-loop' to validate a current medication list and updating medication management plans as entered by a pharmacist. Furthermore, these pilots will explore expanding on data available from Surescripts (and similar vendors); by opening interesting silos of data that are verified by certified clinicians, and making data available to others in a patient's care team.

Progress for electronic Health Information Exchange (HIE) – Progress was highlighted by the number of activities among MiHIN and the six sub-state HIEs: Michigan Health Connect (MHC), Upper Peninsula HIE (UPHIE), Ingenium, Jackson Community Medical Record (JCMR), and Southeast Michigan HIE (SEMHIE). All six sub-state HIEs, including GLHIE, JCMR, Ingenium, MHC, SEMHIE, and UPHIE, along with MDCH, entered into legal data sharing agreements with MiHIN to become Qualified Data Sharing Organizations.

MiHIN and Michigan Health Connect demonstrated the initial operational capability for immunization messages to flow from hospitals into the Michigan Department of Community Health via MCIR, the State's Immunization Registry System. Following the success, MHC, UPHIE, MiHIN, MDCH, and MCIR went into full production with immunization message reporting. By September 30, 2012, 522,670 public health messages were successfully transmitted from 39 counties through sub-states in production to MiHIN and MDCH into MCIR.

MiHIN in partnership with MHC and Ingenium, initiated several Transitions of Care (TOC) pilot projects transmitting Admit-Discharge-Transfer (ADT) messages .In addition, an interstate pilot project using Direct secure email to transport immunization messages from Indiana to MiHIN and MCIR was

successful.   Similar efforts were initiated with other states, including Florida.

Public Health Reporting (immunizations) in production

Pilot Activity

ADT Initiatives

Interstate Pilot

Copyright 2013 Michigan Health Information Network Shared Services

*Note that sub-state HIEs and their affiliated providers are not strictly regionally based.

During 2013, MiHIN expects to continue the initiatives that have been outlined in its charter:

What MiHIN Does for the State of Michigan/MDCH:

1. MiHIN provides the requisite shared infrastructure or "core services" that enable statewide sharing of health information.
2. MiHIN offers a robust legal framework to enable multi-stakeholder data sharing that crosses non-profit & for profit organizations, the State of Michigan, federal government, and interstate entities.
3. MiHIN helps minimize the external burden on providers and constituents imposed by state or federal regulations through the transparent adoption of standards and reusable approaches for data sharing.
4. MiHIN serves as a neutral convener of multiple stakeholders (health plans, hospitals, public health, physicians, pharmacists, corporations,

constituents, etc.) to address common data sharing issues and to recommend or develop cooperative approaches and solutions.
5. MiHIN acts as an accelerant to validate technological approaches and uncover unintended consequences of a given approach in an effort to foster more timely adoption, more successful implementations, at lower costs to operate.
6. MiHIN helps raise the awareness of important technology capabilities and the impact emerging technology, communication, and advanced forms of data sharing or access can have on improving health for Michigan's people.
7. MiHIN works to minimize the State of Michigan's financial burden by seeking external funding, leveraging existing capabilities across organizational silos, and creating an environment for multi-organization collaborative pooling of resources.

MiHIN has developed a suite of security vulnerability assessments and threat assessment services. Also, as a convener for topics related to health information sharing, MiHIN has helped pull together an initial white paper around recommendations for helping ensure the public's trust that their personal health information is protected. In addition, MiHIN has begun a public dialogue about the mechanisms to establish a robust statewide consent management infrastructure.

Medicaid EHR Incentives

The Electronic Health Record Incentive Program is focused on Medicare and Medicaid providers that adopt EHR technology and use the technology according to a specific set of criteria called Meaningful Use. The Medicare program is administered on a federal level, while States are charged with the administration of the Medicaid program. In Michigan, the Medicaid program is expected to result in more than $250 million in federal funding for HIT adoption over the next three years. The HIT Commission spent considerable time in 2012 exploring the EHR Incentive Program and providing feedback to MDCH on its administration and implementation.

The HIT Commission recognized that the Medicaid EHR program is focused on encouraging the adoption of EHRs in provider offices and hospitals throughout Michigan. The HIT Commission received regular updates on the number of professionals and hospitals registered for the program. As the EHR Incentive Program developed the HIT Commission received regular updates on the number of providers and hospitals that received incentive funding as well as the total amount of incentive funding expended within the program.

In 2012 the HIT Commission also explored outreach strategies, how to effectively go-live with Meaningful Use collection and provided recommendations on how to

further promote the EHR Incentive Program. The HIT Commission will continue to monitor and provide input to the program in 2013 as the program prepares to enter into Stage Two of Meaningful Use.

Southeast Michigan Beacon Community

The Southeast Michigan Beacon Community (SEMBC) is 1 of 17 communities in the United States established by The Office of the National Coordinator for Health Information Technology (ONC). SEMBC's mission is to use Health Information Technology (HIT) and Exchange (HIE) to enable patient-centered care and novel clinical intervention strategies that promote improved diabetes care and self-management. SEMBC initiatives are intended to encourage the meaningful use of electronic health record and other technology, deliver important information at the point of care through health information exchange, and ultimately, lower the cost of health care, increase quality, and improve health. SEMBC's activities set forth a scalable foundation for care and management of other disease types and populations in the future. SEMBC is governed by a multi-stakeholder board, including those who pay for care (MDCH has two seats on the Board, one ex-officio, and CMS has an ex-officio seat on the Board, among other payers), those who purchase care (e.g., autos, Chamber of Commerce), those who provide care (e.g., all major health systems, physician representation) and those who get care (e.g., consumer advocacy groups and Michigan's Peer Review Organization), among other organizations.

SEMBC is working with approximately 50 practices, including all Federally Qualified Health Centers and other free and private/hospital affiliated clinics, in Wayne County, Michigan which includes the City of Detroit and surrounding areas. Work includes workflow assessment and redesign, data assessment and targeted quality improvement, including both electronic and non-electronic clinical decision support deployment, assistance with meaningful use, connecting existing practice EHRs to health information exchange efforts (BeaconLink2Health) and other technology tools (including a consumer facing tool using cell phones), augmenting care support through a community health worker initiative, and other interventions. SEMBC also has an existing emergency department (ED) intervention in a number of health system locations connecting pre-diabetics and patients diagnosed with diabetes (through HbA1c screening at the ED) with regular care and other community resources.

Looking toward the future, SEMBC's HIE and community level data repository efforts are being deployed through a multi-stakeholder effort. As efforts are deployed now and into the future, SEMBC aims to bring together the meaningful use of existing EHR technology and new care management tools at the point of care, along with relevant data through the HIE (augmenting existing data sources at the point of care.) SEMBC's work on the technical side is wrapped in a focus of clinical transformation and care integration toward care and health improvement. Making programs like Medicaid and Medicare (which constitutes a

large portion of the population SEMBC serves) work requires strong focus on care integration, managing medical costs and working closely with the provider which is what SEMBC is moving forward. SEMBC is driving this work through initiatives encouraging the adoption and use of EHR technology augmented through HIE.

HIT Workforce

Four Michigan community colleges received federal funding from ARRA to train HIT professionals to support the increasing demand for a knowledgeable HIT workforce. The four community colleges – Delta College, Lansing Community College, Macomb County Community College, and Wayne County Community College, are part of a larger consortium of Midwest community colleges.

The community colleges did not present before the HIT Commission in 2012, but provided regular monthly updates as part of the HIT Commission Dashboard. Macomb Community College will be concluding its grant funded training in December 2012, but will continue HIT workforce training through its Workforce and Continuing Education department in 2013.

The Michigan Center for Effective IT Adoption

The Michigan Center for Effective IT Adoption (M-CEITA) is a federally funded ARRA initiative to provide EHR implementation assistance to primary care providers across Michigan who serves underinsured or uninsured patients. The HIT Commission continues to be the primary focus of all stakeholder input to the M-CEITA program, per a revision to the M-CEITA input structure effective March 2011. Specifically, the HIT Commission is charged with supporting, promoting and advising M-CEITA on the direction and activity of the program, through regular review of financial and operational reports, and by serving as a liaison to other organizations that also promote HIT adoption.
In the last quarter of 2011, the Statewide Stakeholder Committee was replaced with a structured open comment opportunity at each HIT Commission, allowing public feedback directly to M-CEITA, mediated by the HIT Commission. In 2012, M-CEITA presented three times to the HIT Commission, each time with opportunity for public comment and discussion.

In the context of these presentations, as well as through the HIT Dashboard updates, M-CEITA has kept the HIT Commission informed of progress toward each of the programs key milestones: (1) Provider sign-up, (2) Provider go-live on an EHR, and (3) Provider attestation to Meaningful Use. M-CEITA achieved 100% of goal for Milestone 1 late in 2011, and continues to make progress on Milestones 2 and 3, with a current focus on Milestone 3 acceleration. To that end, M-CEITA partnered with Michigan Medicaid early in 2012 to set a state-wide Meaningful Use Acceleration Challenge goal of 7,000 providers paid through EHR incentive programs by the end of 2012.

M-CEITA also reported to the HIT Commission on their required subcontractor audit, second annual provider satisfaction survey, ongoing provider education and outreach activities, and sustainability planning.

MDCH Strategic Goals
2012 and 2013 Priorities

In April 2012, the MDCH Director, Olga Dazzo, presented the MDCH 2012 Strategic Plan. Director Dazzo provided information on MDCH goals related to health and wellness, access, healthcare reform and improved governance. Specifically, Dazzo noted the need to investigate the adoption rate of HIT and any barriers that are associated with adoption in Michigan. A copy of the MDCH 2012 Strategic Priorities is located in Appendix B.

 The HIT Commission discussed the need to understand MDCH's priorities so that as deliberations on all topics progress they can be cognizant of how various programs or policy recommendations may impact these goals. The HIT Commission also discussed the importance of investigating the barriers of HIT adoption and the role the HIT Commission can play in assisting with the identified barriers.

In December 2012, DCH Chief Deputy Director, Nick Lyon joined the HIT Commission as the Director's designee for the Department. Mr. Lyon presented on the DCH priorities and how they could be incorporated within HIT Commission goals for 2013. A copy of the MDCH 2013 Strategic Priorities is located in Appendix C.

HIT Commission Recommendations

Public Act 137-2006 that established the HIT Commission requires that the annual report include recommendations that are delivered to the Michigan Legislature. Throughout the HIT Commission's activities in 2012 the following recommendations emerged and have been reassigned for consideration by the Michigan Legislature. The HIT Commission is committed to working with MDCH and Michigan Legislature to assist in defining the specific details of these recommendations by participating in further dialog.

Add to the HIT Commission Membership

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.

Include HIT in the MI Public Health Code

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.

Address the Need for Consumer HIT Education

As HIT becomes more commonplace throughout Michigan's healthcare system, patients will likely have questions and concerns about the safety of using EHRs and HIE to capture and exchange health data. Currently the burden is on the healthcare facility or office to answer questions or provide education on the use of HIT and the benefits of HIE. Often this is accomplished through a Notice of Privacy Practices that meets specific legal requirements, but may not be easily understood by the general public especially those consumers with impairments or literacy challenges. To encourage consumer buy-in of HIT and HIE, the benefits and the risks of both must be presented clearly and in a straightforward manner.

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.

Forecast of 2013 Activity

In December of 2012 the HIT Commission participated in a planning meeting focused on the development and maintenance of a strategic plan to guide the implementation of an interoperable health information technology system in 2013. The following areas emerged as important topics for discussion and activity.

Develop and maintain a strategic plan to guide the implementation of an interoperable health information technology system

MiHIN and Qualified Organizations

The HIT Commission recognizes the effort put forth by MiHIN and the Qualified Organizations. A fundamental goal for the HIT Commission in 2013 is to continue to encourage and increase data exchange within the State. Therefore in 2013, the HIT Commission will continue to advise MiHIN and all HIE Stakeholders in Michigan on continuing statewide efforts towards interoperability and data exchange.

Identify critical issues affecting adoption of HIT

Unique Identifiers/ Identity Management

In 2012, the HIT Commission learned that federal policymakers will not likely tackle a strategy for nationwide patient identification. HIT Commissioners noted that having each organization – hospital, payer, physician's office, sub-state HIE, state government – develop a system for uniquely identifying patients is redundant and inefficient. Moreover, having each state develop a strategy will also be redundant when the vision for health information exchange is nationwide. In the absence of federal policy, the HIT Commission plans to explore what, if any, action the state should employ to ensure patient safety and efficient use of HIT through the ability to uniquely identify a patient. The Michigan Department of Community Health in conjunction with The Department of Technology Management and Budget has formed an Enterprise Identity and Access Management workgroup that will help facilitate this issue within the State of Michigan systems.

MI Health Marketplace

With the national healthcare reform legislation – the Affordable Care Act – being implemented in Michigan, the HIT Commission plans to explore and gain a better understanding of the MI Health Marketplace – Michigan's Health Insurance Exchange initiative. The Commission specifically would like to evaluate upcoming plans and needs of the MI Health Marketplace and then determine if any of HIT or HIE efforts in Michigan can be leveraged to benefit this initiative and vice versa.

Provide recommendations on policies and measures necessary to achieve widespread adoption of health information technology

Consent Management

In 2008, the HIT Commission recommended that Michigan establish "Informed Opt-out" as the method of consumer control for protected health information in HIE. As HIE in Michigan continues to evolve and progress, the role of consent management becomes increasingly more important. The HIT Commission is expected to re-evaluate issues related to consent management and offer guidance on policy and implementation measures on an opt-out mode of consent management within the State.

Cyber Security

With the fast paced adoption of HIT by the health care industry, comes a rapid rise in the potential for public disclosures of breach notifications. The HIT Commission noted that this could create unintended distrust among the healthcare providers, consumers, and government. In 2013, the HIT Commission will explore the concept of cyber security to understand what policy recommendations may be necessary to assist Michigan in addressing privacy and security concerns.

Increase the public's understanding of HIT

Explore Consumer Focused HIT

Nationally, there is a clear trend of consumer focused HIT products which are often referred to as patient healthcare portals or Personal Health Records (PHR). The purpose of the technology is to provide a means for patients to access their electronic health data and to ultimately empower the patient consumer within their healthcare experience. In addition, the availability of patient portals is an crucial element within federal meaningful use requirements. In 2013, the HIT Commission will explore these initiatives to understand what policy recommendations may be necessary to assist MDCH in addressing consumer focused HIT efforts.

Appendix A: Public Act 137-2006

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.

(85)

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

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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: MDCH 2012 Strategic Priorities

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

2012 Strategic Priorities

1.   **Implement the Michigan 4 x 4 Wellness Plan**.

2.   **Implement the infant mortality plan**.

3. **Achieve person-centered care by integrating clinical, long term and support services.**
   - a. Implement person-centered medical home demonstration grant.
   - b. Implement Medicare/Medicaid dual eligible integration plan.
   - c. Integrate behavioral and physical health.
   - d. Continue to promote electronic health record adoption and MiHIN implementation.

4. **Implement federal health care reform law.**
   - a. Plan and implement expansion of Medicaid to 133% of FPL.
   - b. Evaluate Basic Health Plan Option.
   - c. Develop Medicaid offerings with LARA and new eligibility rules with DHS to implement through MiHealth Marketplace.
   - d. Implement 2013 and 2014 physician fee schedule increase to 100% of Medicare.
   - e. Explore option to provide health homes to Medicaid enrollees with chronic conditions.
   - f. Identify other health reform opportunities that meet Gov. Snyder's reform goals.

5. **Ensure access to excellent and compassionate behavioral and DD services.**
   - a. Evaluate continuum of behavioral health and DD services.
   - b. Evaluate psychiatric hospitals.
     - i. Conduct revenue cycle review.
     - ii. Conduct capital needs review.
     - iii. Evaluate quality measures and staffing levels.
   - c. Develop plan to reduce number of people with mental health and substance abuse in jails,use '08 Mental Health Workgroup Report as guide.
   - d. Implement autism coverage in Medicaid.
   - e. Bring efficiencies to mental health system administration.

6. **Continue to build community-based system of care for the aging population.**

7. **Prepare DCH infrastructure for massive change including 500,000 new Medicaid members effective 1/1/14.**

8. **Achieve service excellence in all customer points across DCH.**

9. **Aggressively pursue grant funding to support implementation of strategic priorities**

Appendix C: MDCH 2013 Strategic Priorities

DEPARTMENT OF COMMUNITY HEALTH
2013 STRATEGIC PRIORITIES

Michigan Department of Community Health

MDCH

Rick Snyder, Governor
James K. Haveman, Director

MISSION

MDCH will **protect, preserve, and promote** the health and safety of the people of Michigan with particular attention to providing for the needs of vulnerable and under-served populations.

VISION

Improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

STRATEGIC PRIORITIES

Improve Population Health

- Identify and target chronic care hot spots. (Public Health)
- Implement the Michigan Health and Wellness 4 x 4 Plan to reduce obesity and improve wellness using the MI Healthier Tomorrow campaign. (Public Health)
- Utilize Michigan's Infant Mortality Reduction Plan to address disparities and save babies. (Public Health)
- Identify and improve culturally-sensitive access to all services for persons with disabilities. (Behavioral Health & Developmental Disabilities)
- Establish a strategy for improving the continuum from preconception to early childhood. (Public Health)
- Enhance the safety planning and response to all hazards, public health and health care emergencies. (Public Health)
- Integrate services for physical health and mental health and increase coordination among care providers. (Behavioral Health & Developmental Disabilities)
- Enhance efforts to identify and improve early intervention mental health services for children and youth. (Behavioral Health & Developmental Disabilities)

Transform the System of Care

- Establish a fund to provide innovative approaches to improve the health of Michigan citizens. (Policy & Planning)
- Implement regionalization plan for health care services and programs. (Policy & Planning)
- Enhance technical support and identify additional federal opportunities for Federally Qualified Health Centers (FQHC's). (Policy & Planning)
- Support the person centered medical homes model and preserve the safety net. (Medical Services)
- Establish and support policies for a full continuum of services for Long-term Care. (Office of Services to the Aging)
- Improve access to federal benefits and local services for Veterans. (Behavioral Health & Developmental Disabilities)
- Develop opportunities for persons with mental illness and substance abuse issues to receive early intervention services to prevent incarceration. (Behavioral Health & Developmental Disabilities)
- Champion expanding the Health Care Workforce and promoting the positive benefits of health care in stabilizing healthier communities. (Policy & Planning)

Reform the Health Care System

- Create an integrated multidisciplinary delivery system with a focus on person-centered models of care. (Policy & Planning)
- Improve fraud identification and prevention to reduce waste and increase accountability. (Office of Health Services Inspector General)
- Focus on quality and outcomes for fee for service and managed care rather than quantity. (Medical Services)
- Streamline the payment and reimbursement process for providers. (Medical Services)
- Develop a standardized method to provide services consistently through the state to improve the quality of care. (Medical Services)

Transform the Department of Community Health

- Reinvent MDCH by creating an organizational structure that is effective, efficient, interactive, customer focused, and value driven. (Chief Deputy Director)
- Create and support a culture in which employees feel engaged and take ownership of our mission. (Policy & Planning)
- Establish standards and procedures to enhance customer experience. (Chief Deputy Director)
- Provide and promote leadership development opportunities to all employees. (Policy & Planning)
- Ensure IT systems are unified, usable and meet future business needs. (Chief Deputy Director)

www.michigan.gov/mdch

Revised 3/7/13

Appendix D: 2012 MI HIT Dashboard-Date December 20, 2012

| **Michigan Health Information Network (MiHIN)**	Last Updated12/20/2012 - monthly	
Milestone	**Status**	**Notes**
Governance	**Green**	The MiHIN Operations Advisory Committee (MOAC) continues work on the reccomendations for the addition for new QO's. The first Virtual QO has been created. Beacon is making progress toward becoming a QO.
Technology and Implementation	**Green**	MiHIN Public health continues, ADT now in production, DIRECT gateway for public health in production, HPD soft launch under way. New PIT projects started related
Integration with State of Michigan HIE (SOMHIE)	**Green**	MiHIN in everyday production with MDCH Data Hub
Connect Sub-State HIEs to MiHIN Shared Services	**Green**	MHC & UPHIE are now both live, VPNs in place and inititial operational capability for GLHIE, Ingenium (My1HIE), and JCMR
Follow up MU Reporting for public health in production using the Michigan HIE model in full production.	**Green**	MHC & UPHIE live, DIRECT to MCIR gateway service production ready
Statewide HIE Available to Every MI Provider	**Green**	Milestone complete
Planning for Second Phase of Technology	**Green**	Planning underway for role out of expanded ADT service, staging of LOINC/SNOMED shared service, evaluation of Consent Management Service Underway
Financial Sustainability Identified & Implemented	**Green**	Version 2.0 of the MiHIN business plan targeted for Feb 2013 release

| **Qualified Organizations-QO's**	Last Updated 10/18/12 (3rd Qtr 2012) - quarterly					
Measure	**Previous**	**Current**	**Goal**	**Status**	**Notes**	**Trend**
# of MI providers utilizing sub-state HIEs services	5918	6277	10000	**Green**	Measures 6 sub-state HIEs operating in MI: Working on new goals	⬆ Chart
# of reference and hospital laboratories connected (providing data) to a sub-state HIE	53	55	60	**Green**	Measures 6 sub-state HIEs operating in MI: Working on new goals	⬆ Chart
# of providers meeting HIE specific MU criteria by utilizing sub-state HIE capabilities.	2479	2629	4832	**Green**	Structured Lab Results: 1117 CCDs: 1512	⬆ Chart
# of hospitals/health systems meeting HIE specific MU by utilizing sub-state HIE capabilities:	59	61	60	**Green**	Structured Lab Results: 48 CCDs: 13	⬆ Chart

of MI Providers Utilizing Sub-state HIE Services

of hospital laboratories connected (providing data) to a sub-state HIE

of providers meeting HIE specific MU criteria by utilizing sub-state HIE capabilities
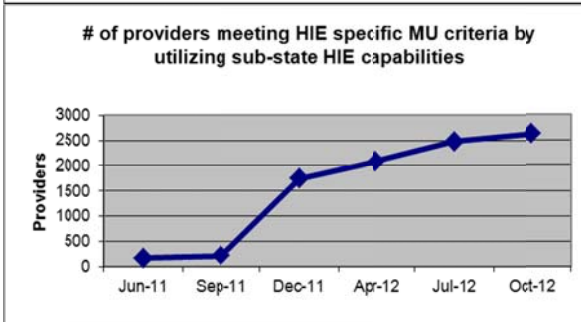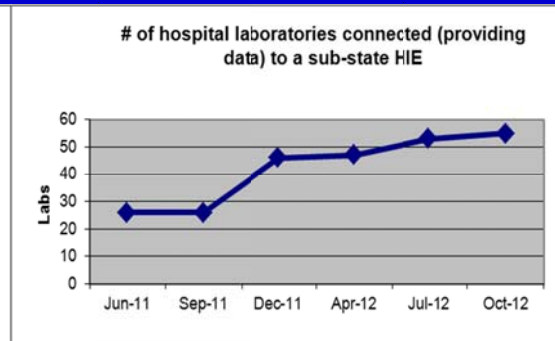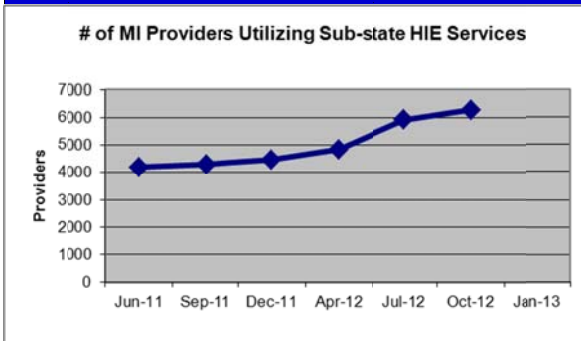
| Medicaid EHR Incentive Program	Updated 12/20/2012 - monthly					
Measure	Previous	Current	Goal	Status	Notes	Trend
# of Eligible Professionals receiving Medicaid Incentives	1,637	1,915	4,787	Green	Goal has been updated	Chart
# of Eligible Hospitals receiving Medicaid Incentives	80	85	130	Green	Goal remains unchanged	Chart
Amount of Federal Medicaid Incentive Funding Expended	$101,788,311	$118,936,027	$250 million	Green	Goal has been updated	Chart

# of Eligible Professionals receiving Medicaid Incentives
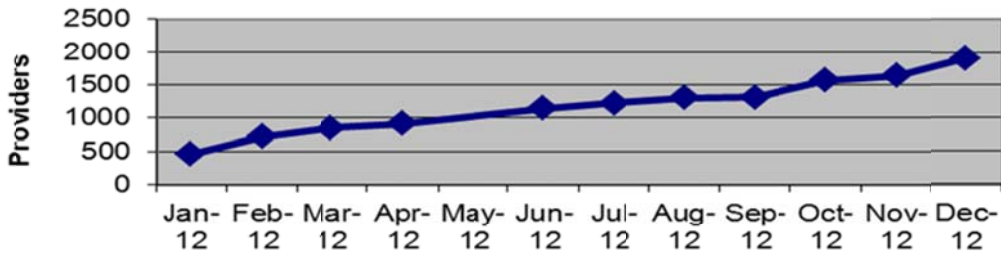
# of Eligible Hospitals receiving Medicaid Incentives
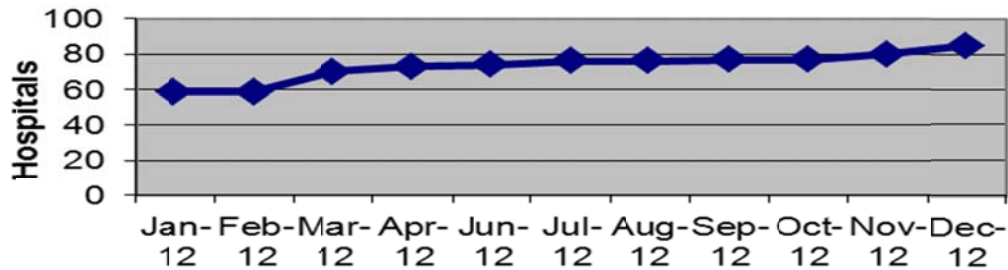
Amount of Federal Medicaid Incentive Funding Expended
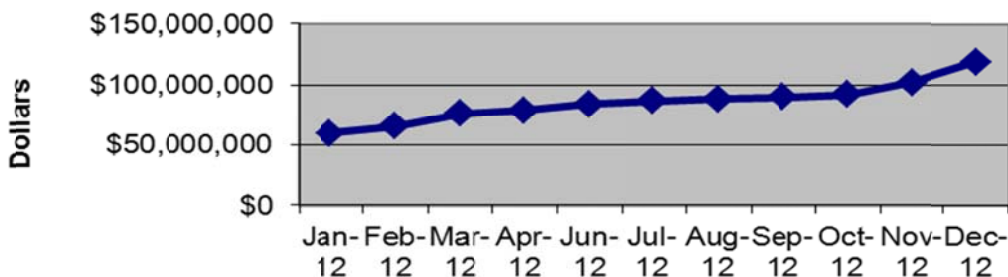
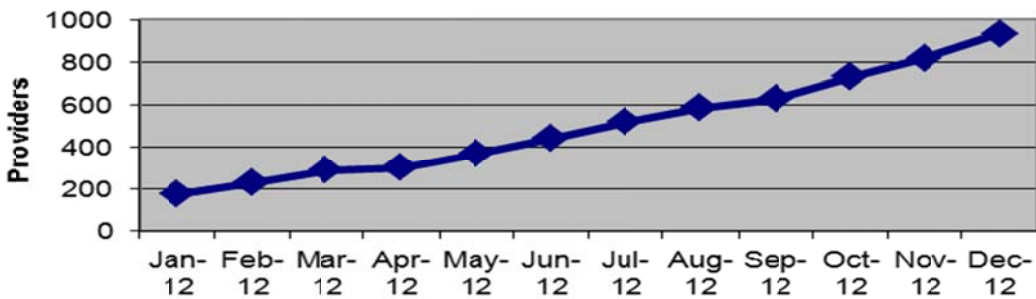| Michigan Center for Effective IT Adoption (M-CEITA)	Updated 12/20/2012 - monthly					Trend
Measure	Previous	Current	Goal	Status	Notes	
# of Providers Signed Up to Use M-CEITA Services	4,258	4,285	3,724	Green	M-CEITA has exceeded our goal to reach 3,724 providers by 12.31.2011. This represents full enrollment for M-CEITA subsidized services	⬆ Chart
# of Providers Go-Live on EHRs	2,730	2,811	3,724	Green	M-CEITA exceeded our previous goal to reach 1,700 M2s by 12.31.2011. New goal reflects the total goal for end of program in 2014.	⬆ Chart
# of Providers Reaching Meaningful Use	818	935	1,676	Yellow	Working with ONC, M-CEITA has set a goal of 45% to M3 by 12/31/2012.	Chart

M-CEITA: # of Providers Signed Up to Use M-CEITA Services
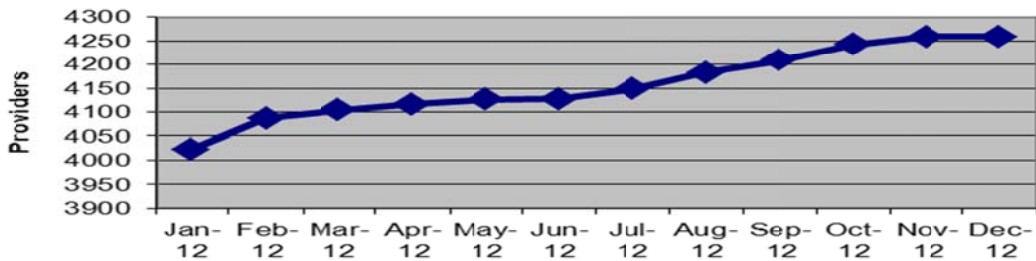
M-CEITA: # of Providers Go-Live on EHRs
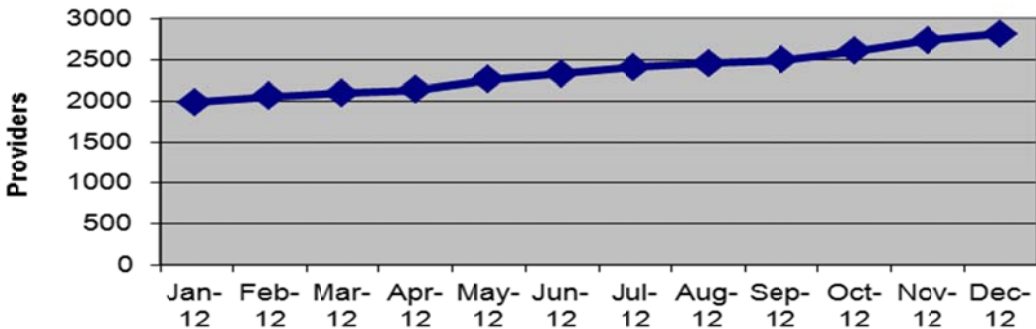
M-CEITA: # of Providers Reaching Meaningful Use

Beacon Community Collaborative		Updated 12/20/2012 - monthly		
Milestone		**Status**	**Notes**	**Trend**
Clinical Transformation		**Green**	Activities include: 47 practice sites (36 min required), 121 PCPs, 22,590 diabetic patients (4000 min required), 181,141 total patients affiliated with Beacon practices for CT intervention engaged to date. Patient health navigators for patient engagement (over 2,450 patients referred to date). Measures tracked for PHN program (e.g., med adherence, patient attitude toward disease, etc) showing positive results. ED intervention launched at three hospitals; over 10,000 patients tested for A1C levels, 30% pre-diabetic and diabetic. Fourth hospital ED intervention launched late November 2012. Intervention practices are working to provide quarterly data on high impact diabetes measures. Interim results suggest at least 4% improvement (goal is 5% before end of 1 year measurement period) across the high impact measures for the first quarter of the measurement period.	⬆
Information Technology and Exchange		**yellow**	Activities include: HIE architecture implementation work for eMPI, CDR and Community View complete. Data flowing into eMPI and CDR, and has been moved into production. EHR integration in process and EHR Pilot Integration will be complete by year's end. Currently, there are 12 executed HIE Participation Agreements, including one health system and affiliates, 23 additional practice sites/71 physicians which includes all FQHCs in Wayne County; Privacy and Security finalized Policies & Procedures. Active discussion with multiple additional participants and EHR vendors.	➡
Evaluation & Measurement		**Green**	Activities include: reporting health system, payer and provider submitted data quarterly, analyzing provider and patient surveys, developing supplemental provider qualitative evaluation tools.	⬆
Communications & Outreach		**Green**	1) Developing a public-facing website and collateral materials to support BeaconLink2Health 2) Ongoing support for txt4health: partner-supported marketing activities, community outreach, and visibility at targeted events. (1,825 enrollments toward 3,000-5,000 program end goal) 3) Communications development activities to support the newly-launched ED initiative; video and press release complete.4) 2012 SEMBC Annual Report in process; will be complete by year end.	⬆
Scalability, Sustainability and Research		**Green**	Activities include: background research and preparation of sustainability and business plan. Executive Board serving as committee of the whole for review. Targeted completion of plan January 2013. Continuing to identify and pursue funding opportunities.	⬆

Midwest Community College HIT Consortium			Updated 12/20/2012- monthly			
Measure	**Previous**	**Current**	**Goal**	**Status**	**Notes**	**Trend**
Lansing Community College students enrolled	235	242	200	**Green**	158 have completed the program (goal is 200), 50 are currently being trained.	⬆
Lansing Community College students placed in related jobs or current job expanded	13	14		**Green**	Voluntary reporting from students of new positions in Health IT gained after training completion.	
Macomb Community College students enrolled	453	453	300	**Green**	Students enrolled are total students for the program to date. 377 graduates.	⬆
Macomb Community College students placed in related jobs or current job expanded	82	89		**Green**	Voluntary reporting from students	
Delta College students enrolled	242	242	300	**Green**	Students enrolled are total students for the program to date. 134 graduates. Revised completion goal - 188	⬆
Delta College students placed in related jobs or current job expanded	4	10		**Green**	Voluntary reporting from students	
Wayne Community College students enrolled	333	333	300	**Green**	156 Successfully Completed the program. Revised Completion Goal - 167 No Update for December	⬆
Wayne Community College students placed in related jobs or current job expanded	21	25		**Green**	Voluntary reporting from students	

KEY:	Green: Progress Being Made, On Target, No Significant Barriers
	Yellow: Moderate Progress, Behind Target, Barriers With Mitigation Strategy Identified & Implementing Corrective Action Successfully
	Red: No Progress, Significantly Behind Target, Barriers Without Mitigation Strategy, Unsuccessful Corrective Action