Michigan Health Information Technology Commission

May 28, 2019

The Michigan Health Information Technology 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

May 2019 Meeting Agenda

Item	Lead Presenter(s)
A. Welcome and Introductions	Chair
B. Commission Business a. Review of February 2019 Minutes	Chair
C. Health Information Technology (HIT)/Health Information Exchange (HIE) Update a. MDHHS Leadership Updates b. Update on Resolutions	Meghan Vanderstelt (MDHHS)
D. Healthcare Information and Management Systems Society (HIMSS) Update a. Interoperability Strategy b. Connecting Michigan for Health 2019 Proposals	TBD
E. Proposed HIT Commission HIT/HIE Strategy	Chair
F. MiHIN Shared Services: "Advancing Interoperability" *Presentation moved to September 2019 meeting*	TBD
G. HIT Commission Next Steps	Chair
H. Public Comment	
J. Adjourn	

Welcome and Introductions

Commission Business

HIT/HIE Update

Meghan Vanderstelt (MDHHS)

April 2019 HIT Commission Update

Governance Development and Execution of Relevant Agreements

- Data sharing legal agreements executed to date:
  - **163 total** Trusted Data Sharing Organizations
  - **656 total** Use Case Agreements/Exhibits
- Collective Medical Technologies has fully executed the Simple Data Sharing Organization Agreement (SDSOA), Master Use Case Agreement (MUCA), Active Care Relationship Service (ACRS) UCE, Admission Discharge, Transfer Notifications (ADT) UCE, Health Provider Directory (HPD) UCE, Common Key Service (CKS) UCE, and the Enhanced Care Collaboration Connectivity Pilot Activity Exhibit (PAE)
- Lake Huron PHO has fully executed the SDSOA, MUCA, ACRS UCE, ADT UCE and HPD UCE

Technology and Implementation Road Map Goals

- **93** Statewide Lab Result Senders in full production sending to MiHIN:
  - **173,675,104** labs sent to MiHIN total
  - **53,571,847** labs routed outbound from MiHIN since 3/27/2018 (first pilot go-live)
- **43** organizations in production for the QMI UC
  - **43** organizations sending all payer supplemental files under QMI
- **935** Admission Discharge Transfer senders in production
- **153** Admission Discharge Transfer receivers in production

MiHIN MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

April 2019 HIT Commission Update

QO & VQO Data Sharing

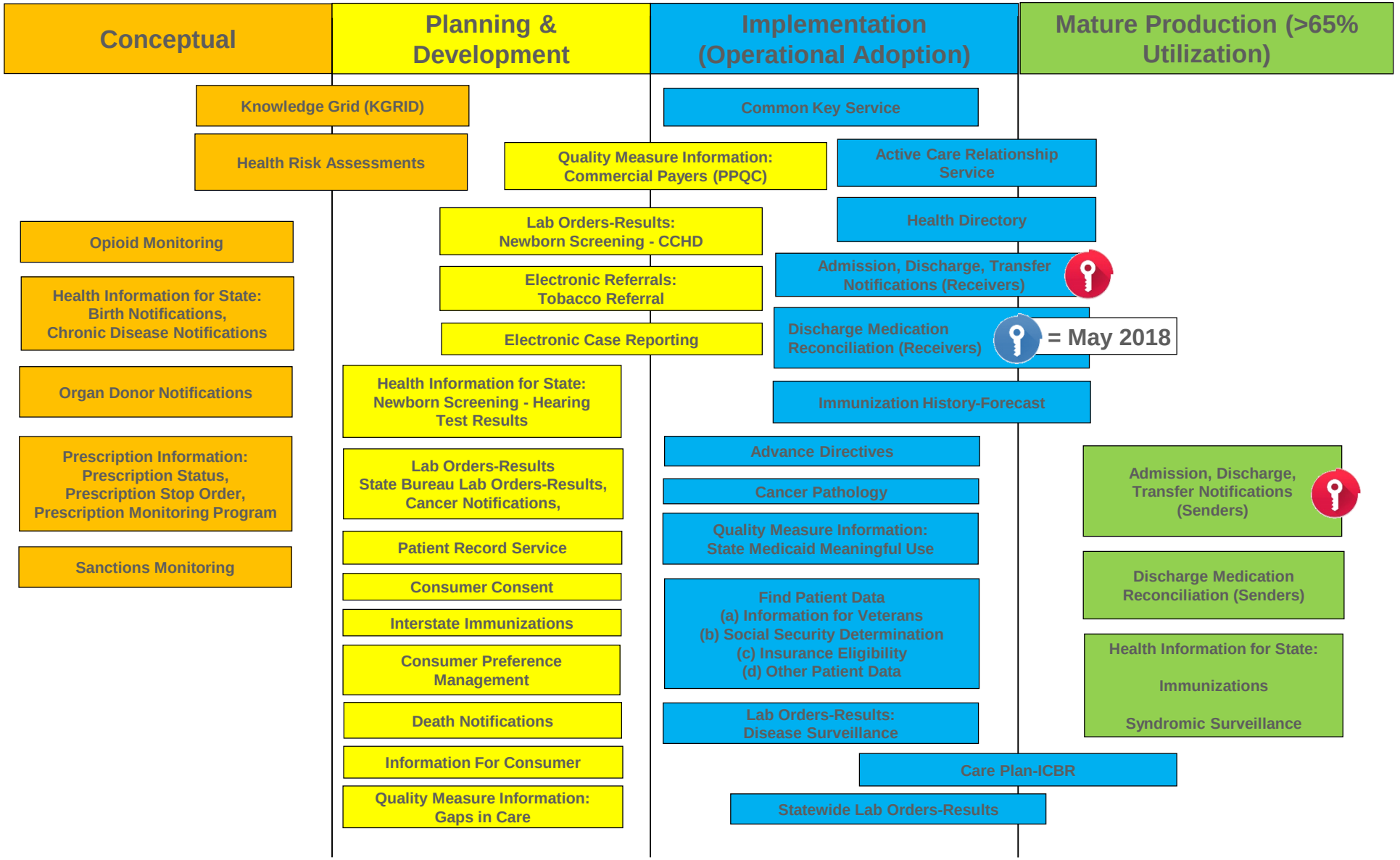
- More than **2.89 *billion*** messages received since production started May, 2012
  - Averaging **20.28 MLN+** messages/week
  - Averaging **14 MLN+ ADT** messages/week; **1.55 MLN+** public health messages/week
- Sent **876,896,206** ADTs outbound as of 5/1/2019
- Messages received from use cases in production:
  - **2,725,426 Reportable Lab results** sent to MiHIN
  - **44,923,818 Immunization History/Forecast** queries to MCIR
  - **47,952,547 Medication Reconciliations at Discharge** received from hospitals
  - **90,462 Care Plan/Integrated Care Bridge** Records sent from ACOs to PIHPs
- **33.8** MLN+ patient-provider relationships in Active Care Relationship Service (ACRS)
- **11.75+** MLN unique patients in ACRS
- **138,003** unique providers in statewide Health Directory
  - **41,964** total organizations
  - **447,552** unique affiliations between providers and entities in HD

MiHIN Shared Services Utilization

- **Common Key Service currently has 43 senders and 10 receivers**
- **241** Skilled Nursing Facilities (SNFs) sending ADTs – 57% of SNFs in Michigan
- 60 Home Health Agencies (HHAs) sending ADTs

MiHIN MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

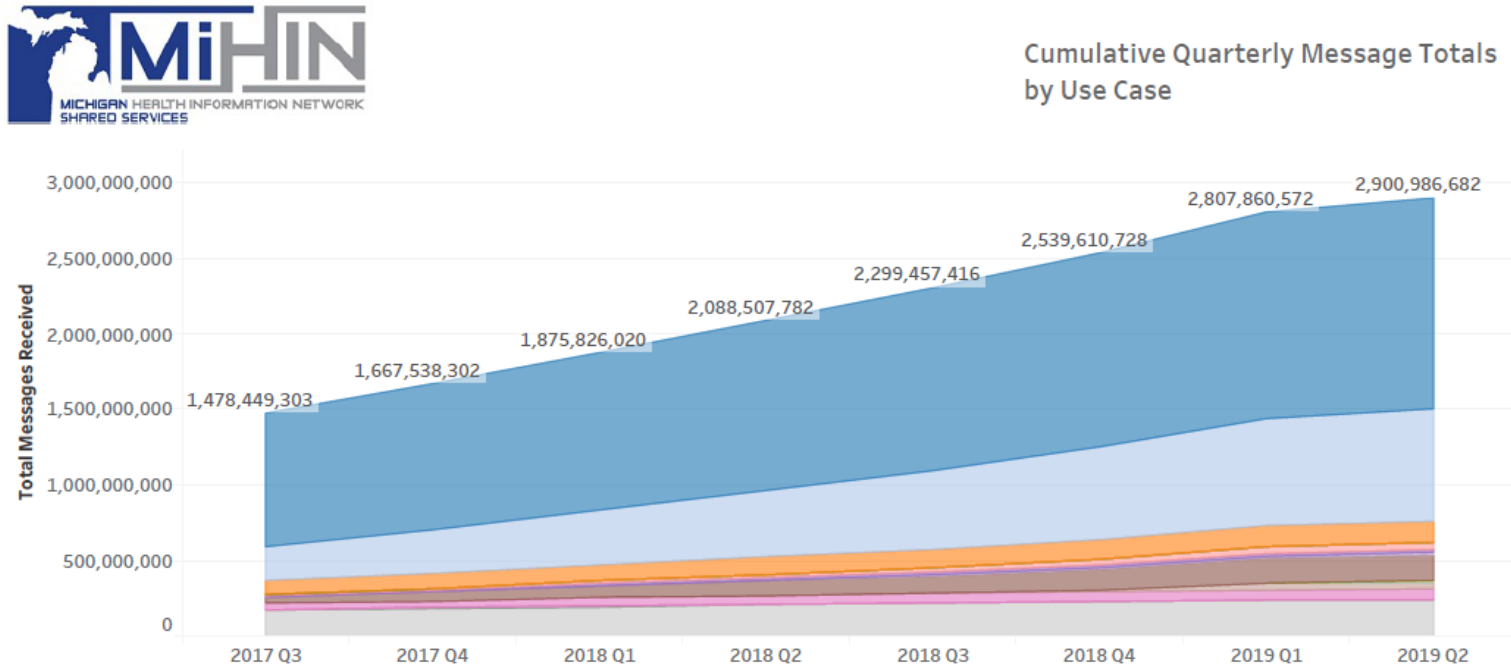
MiHIN Statewide Use Case and Scenario Status



= requires Common Key Service

= Common Key Service target date

April 2019 HIT Commission Update



Period Total Use Case	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2
ADT ACRS Inbound	881,534,261	960,853,411	1,041,719,535	1,124,079,969	1,204,679,271	1,289,433,139	1,371,158,565	1,400,309,476
ADT ACRS Outbound	226,866,054	286,582,367	359,548,282	437,639,994	515,130,670	608,160,066	706,557,701	739,407,084
ADT Payer Outbound	92,677,662	99,948,847	107,518,331	115,934,871	123,000,105	129,121,859	135,226,576	137,489,122
Blood Lead		383	507	702	3,400	4,767	4,788	4,788
Cancer Notifications	258	3,331	6,987	11,026	11,028	11,028	11,035	11,035
Cancer Pathology	4,281	5,590	5,937	6,400	6,529	150,535	153,234	153,568
Consumer-Mediated Ex..						92	1,600	1,813
ICBR	29,116	33,210	60,862	69,122	74,761	80,248	88,840	90,462
Immunization History-F..	6,421,322	10,162,575	14,367,196	19,560,688	26,844,014	35,927,585	44,923,818	47,952,547
Medical Examiner Revie..							3,721	4,901
MedRec Inbound	10,181,393	11,934,601	13,654,492	15,577,895	18,645,509	20,057,951	21,702,432	22,245,719
MedRec Outbound	2,715,733	3,764,285	4,917,208	6,156,853	8,007,713	9,299,263	11,220,927	11,831,679
Statewide Labs	39,356,104	57,866,782	77,394,986	97,046,903	117,285,100	140,585,234	165,144,859	173,675,104
Statewide Labs Enhanc..							1,787	4,278
Statewide Labs-Outbou..			18,915	382,262	690,471	8,889,372	42,079,667	53,571,847
Submit Immunizations	38,364,508	45,054,244	54,938,214	59,033,806	61,867,407	65,915,679	67,871,445	68,489,337
Submit Newborn Scree..	7,258	16,416	24,423	29,390	32,968	35,906	38,251	39,158
Submit Reportable Labs	1,947,739	2,072,195	2,232,231	2,312,738	2,382,439	2,458,628	2,581,565	2,725,426
Submit Syndromic Surv..	178,343,614	189,240,065	199,417,914	210,665,163	220,796,031	229,479,468	238,122,638	241,295,601
Grand Total	1,478,449,303	1,667,538,302	1,875,826,020	2,088,507,782	2,299,457,416	2,539,610,728	2,806,886,341	2,899,291,953

Medicaid Promoting Interoperability Program

April 2019 Dashboard

	Reporting Status	Prior # of Incentives Paid (March)	Current # of Incentives Paid (April)	PY Goal: Number of Incentive Payments	PY Medicaid Incentive Funding Expended
Eligible Professionals (EPs)	MU 2016	2478	2479	2480	$22,690,796
	MU 2017	2432	2448	3500	$20,568,572
	MU 2018	34	273	2750	$2,317,667
Eligible Hospitals (EHs)	MU 2016	12	12	22	$2,093,294
	MU 2017	4	4	8	$757,670
	MU 2018	0	0	6	$0

Cumulative Incentives for EHR Incentive Program 2011 to Present		
	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	7346	$ 232,789,572
MU	10775	$ 176,479,065

Key: AIU= Adopt, Implement or Upgrade MU= Meaningful Use

Michigan Medicaid Program – April 2019

Michigan Medicaid PI Program

Supporting providers in Michigan with high volumes of Medicaid patients in achieving Meaningful Use.

Program Goals

- Assist 600 Specialists in their first year of Meaningful Use
- Assist 2350 Providers in any year of Meaningful Use

Ongoing Program Metrics

- 4344 Sign-ups for MU Support representing 2815 unique providers
- 2589 Total Meaningful Use Attestations to date
- 504 total Program Year 2018 attestations recorded to date with an additional approximately __ pending documentation.

Other program highlights:

M-CEITA received a message of gratitude from State of MI Medicaid PI Program management for the diligent work done in supporting the inaugural year of electronic Clinical Quality Measure reporting via MiHIN's CQMRR. M-CEITA staff were instrumental in identifying, troubleshooting, and resolving both CEHRT vendor and SOM system barriers preventing eligible providers from meeting the electronic submission requirement.

Program year 2019 client engagements continue with M-CEITA staff educating providers on Stage 3 objectives, encouraging early adoption of 2015 CEHRT, and identifying workflow and process improvements needed to successfully meet program requirements.. Early CEHRT reports indicate that there is much work to be done to ensure vendors are accurately capturing data in compliance with the CMS specifications for many of the new Stage 3 measures.

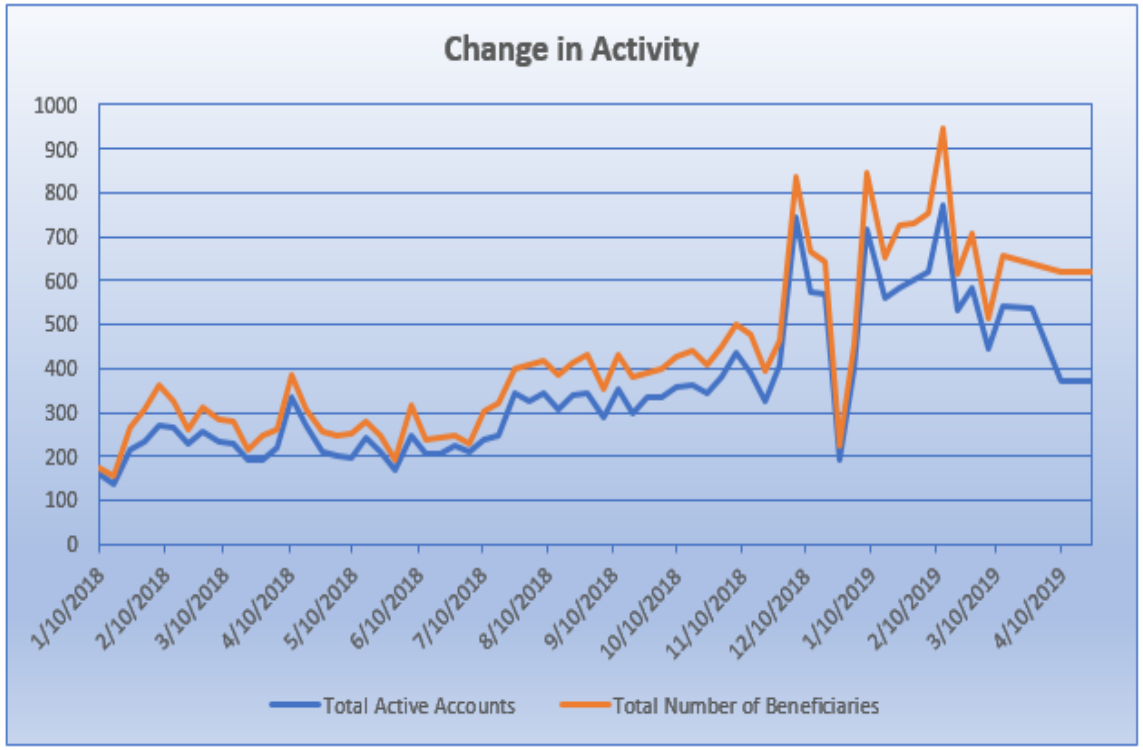
M-CEITA has begun development of educational webinar offerings with the aim of increasing knowledge of program relevant HIT topics and engaging providers in CEHRT driven quality improvement processes.

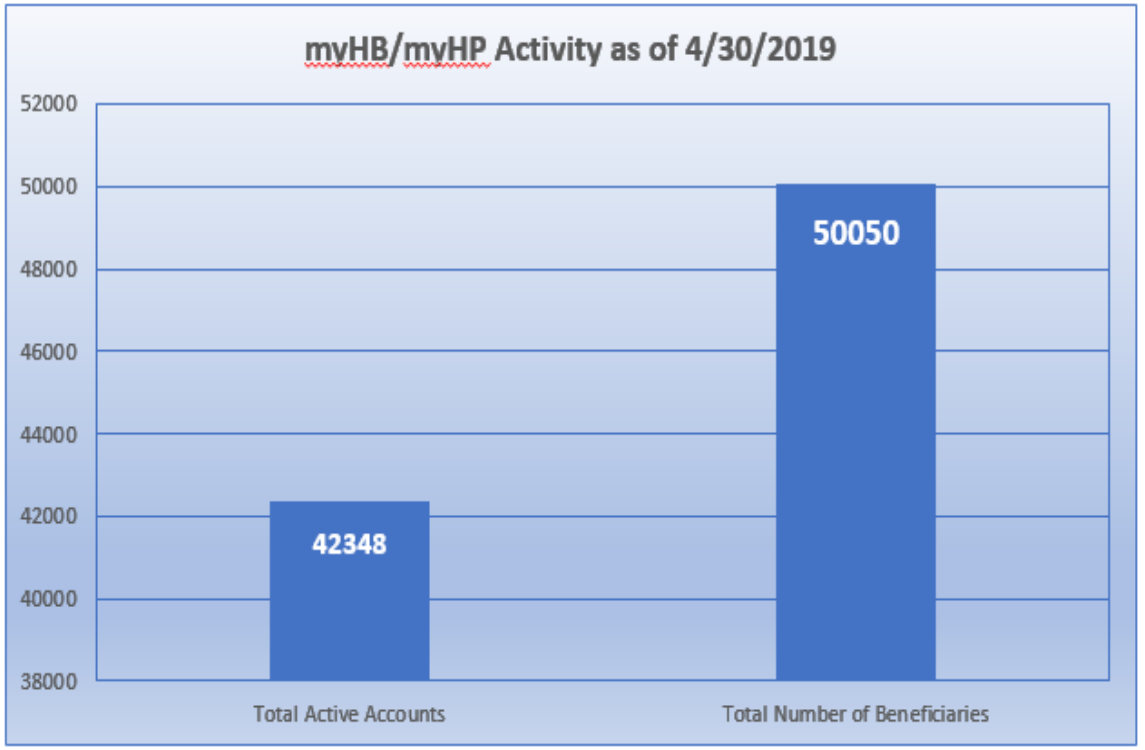
Project Contact

Project Lead: Amanda Chappel Amanda.Chappel@Altarum.org

Funder: CMS funding administered by the Michigan Department of Health & Human Services (MDHHS)

myHealthButton/myHealthPortal
April Dashboard





CONSUMER ENGAGEMENT DASHBOARD | April 2019

Outreach & Education

myHB | myHP Resources Page

The MichiganHealthIT website is now home to the myHealthButton/myHealthPortal resources page. Use this link to learn more about some of the outreach, marketing tools and other supporting documents for these applications.

www.MichiganHealthIT.org

HIMSS Update

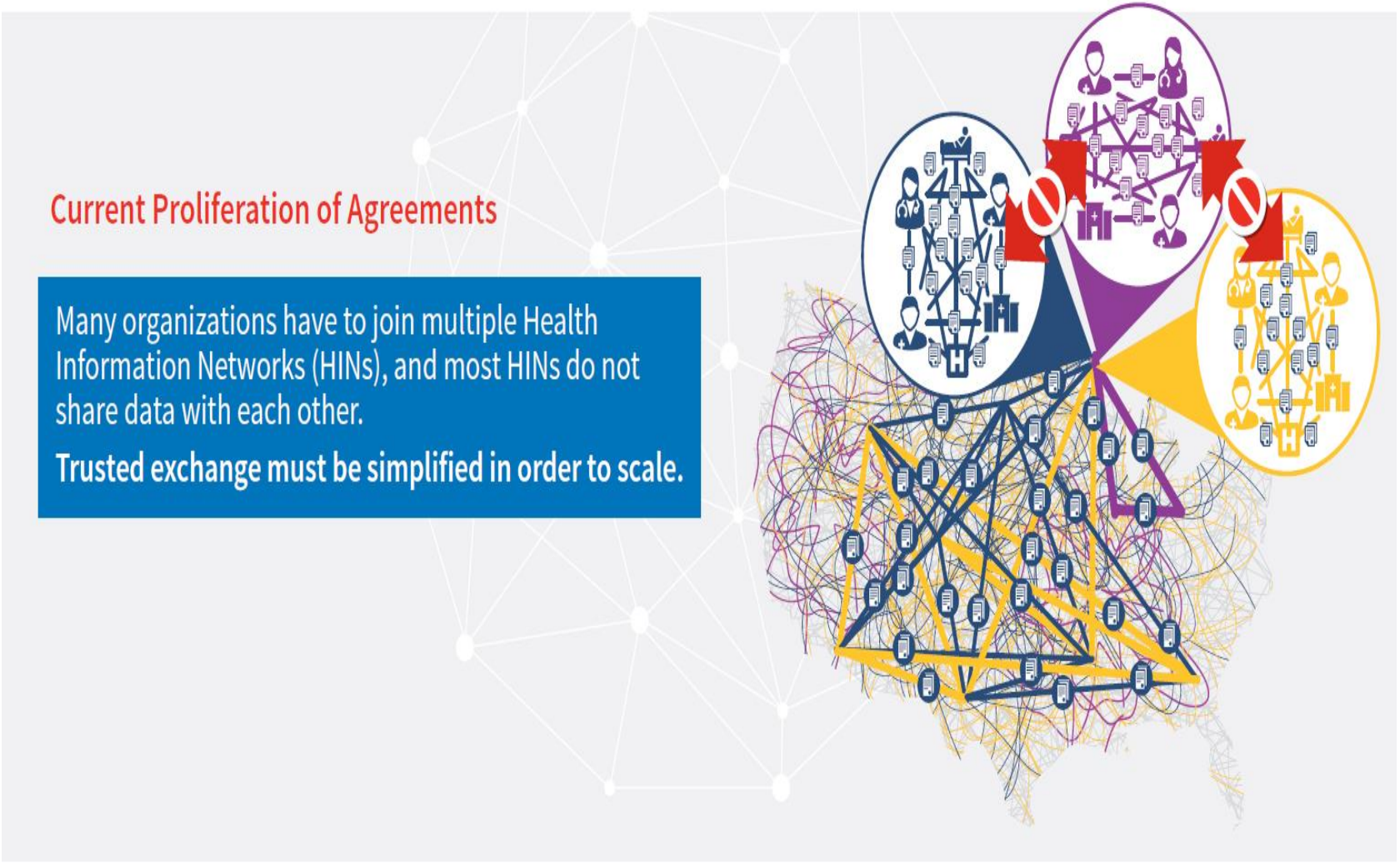
Trusted Exchange Framework and Common Agreement Draft 2

Michigan Health Information Technology Commission Meeting

May 28, 2019

HIMSS North America

Current Complexity



Graphic Courtesy of the Office of the National Coordinator for Health IT

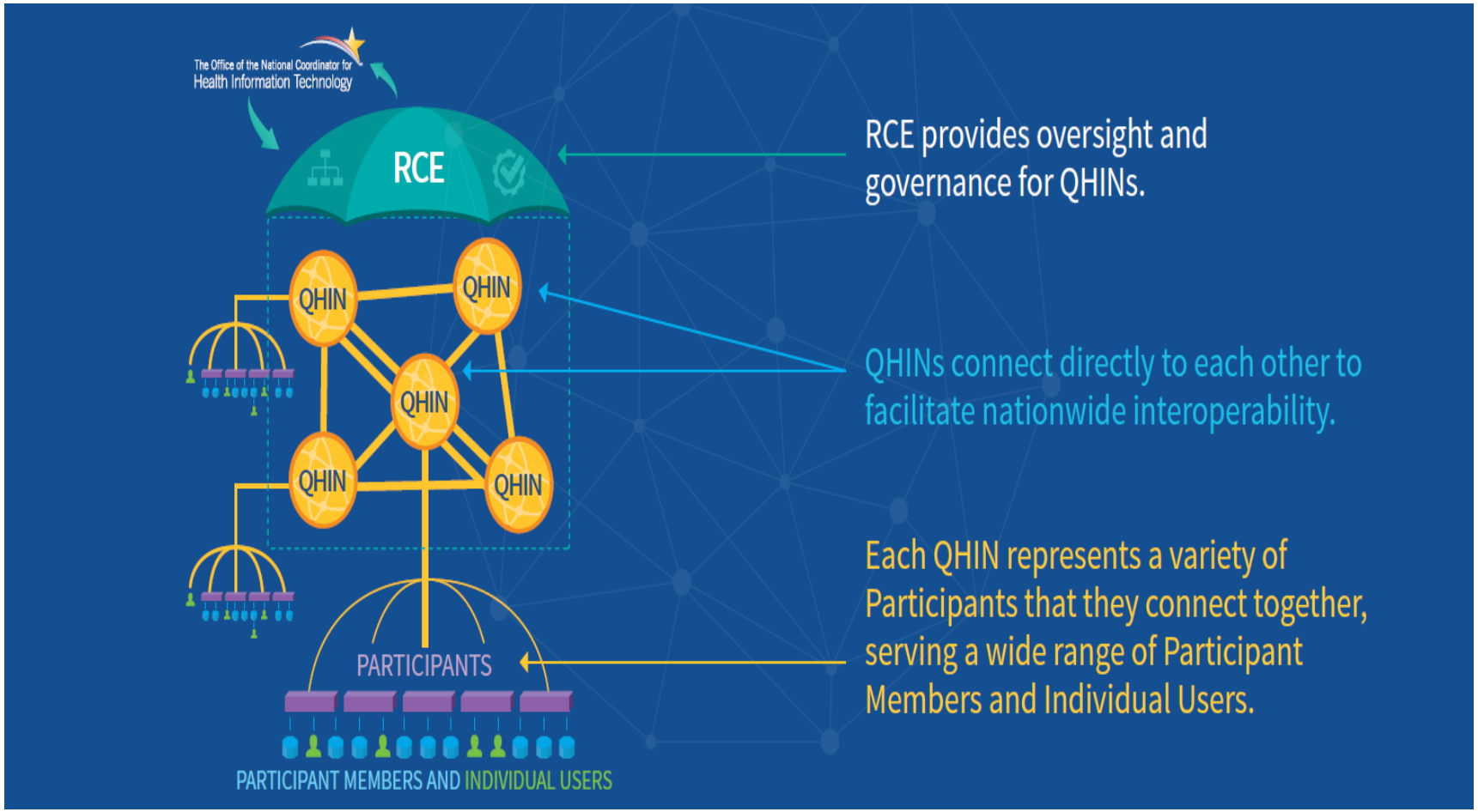
TEFCA Draft 2 Specifics

- Three Goals
  - Provide a single “on-ramp” to nationwide connectivity
  - Enable EHI to securely follow the patient when and where it is needed
  - Support nationwide scalability
- Exchange Modalities
  - Targeted Query, Broadcast Query, Message Delivery
- Exchange Purposes
  - Treatment, Quality Assessment, Public Health, Individual Access Services

Common Agreement Specifics

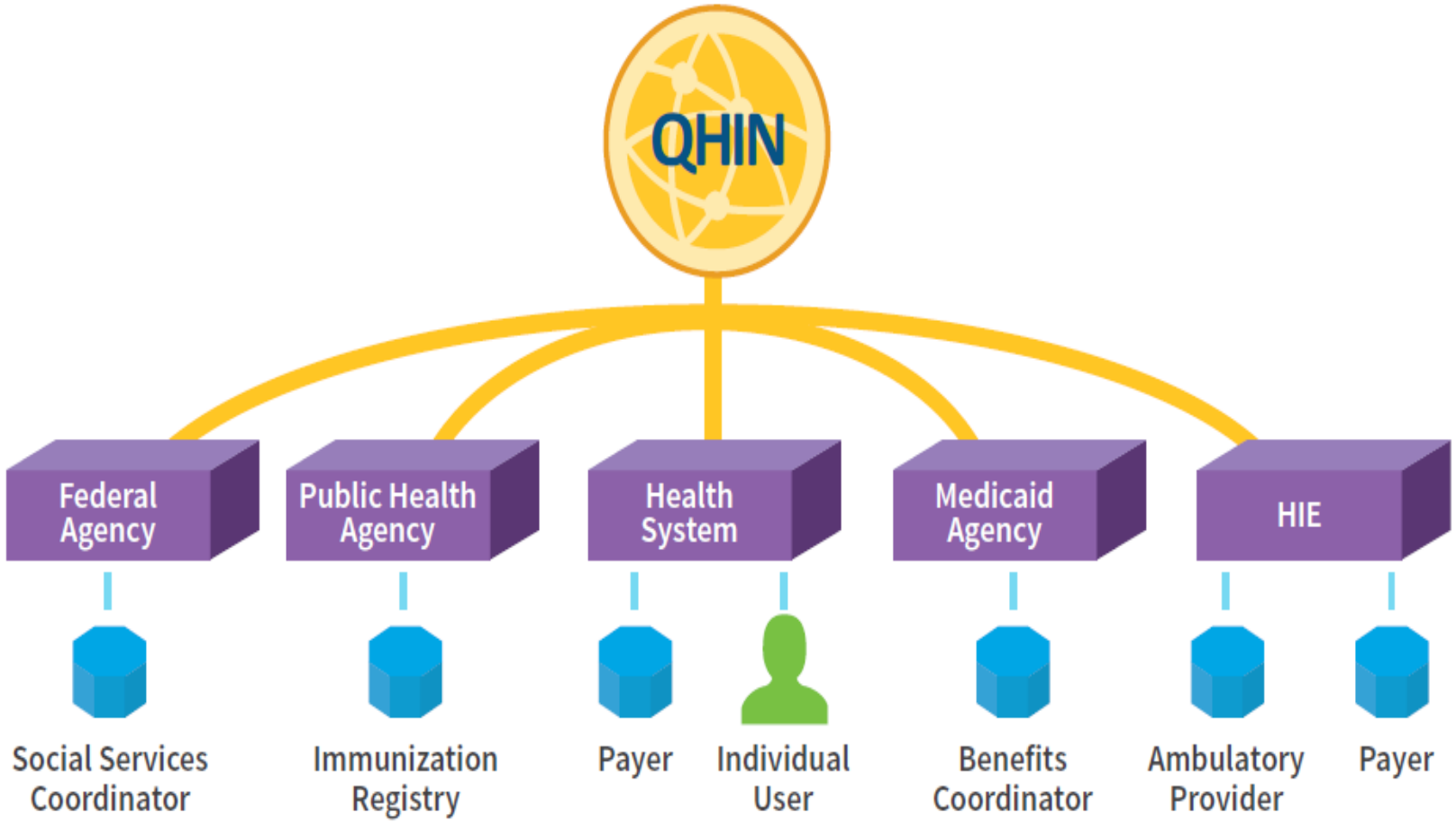
- Will provide governance necessary to scale functioning system of connected HINs and allow for evolution
- Three Parts
  - Minimum Required Terms and Conditions (MRTCs)
    - QHINs who agree to the CA would abide by
  - Additional Required Terms and Conditions (ARTCs)
    - Necessary for the day-to-day operation of an effective data sharing agreement
  - QHIN Technical Framework
    - Specifies functional and technical requirements for exchange among QHINs

How Will the Common Agreement Work?



Graphic Courtesy of the Office of the National Coordinator for Health IT

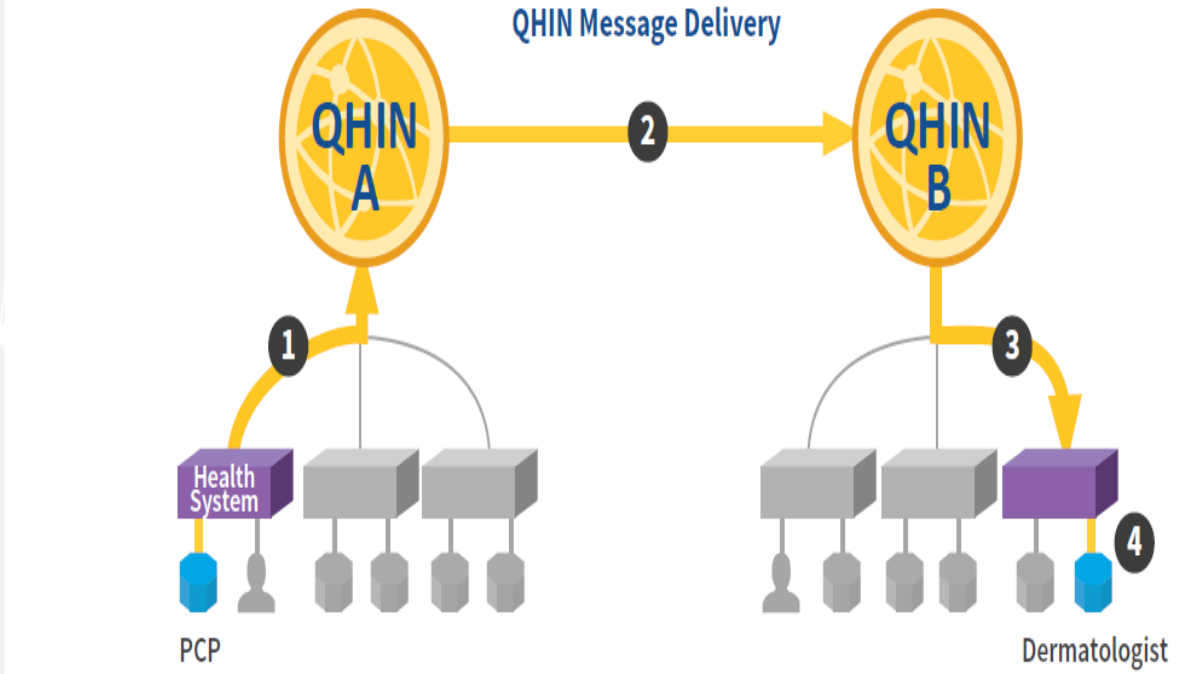
Sample QHIN



Graphic Courtesy of the Office of the National Coordinator for Health IT

Exchange Purpose Example

1. Primary Care Provider (PCP) (Participant Member) refers patient to Dermatologist, and sends care summary to QHIN A for Treatment
2. QHIN A initiates QHIN Message Delivery to send care summary to the appropriate QHIN B
3. QHIN B sends care summary to the appropriate Participant
4. Participant delivers care summary to the Dermatologist (Participant Member)



*Only applies to HIPAA covered entities and business associates

Graphic Courtesy of the Office of the National Coordinator for Health IT

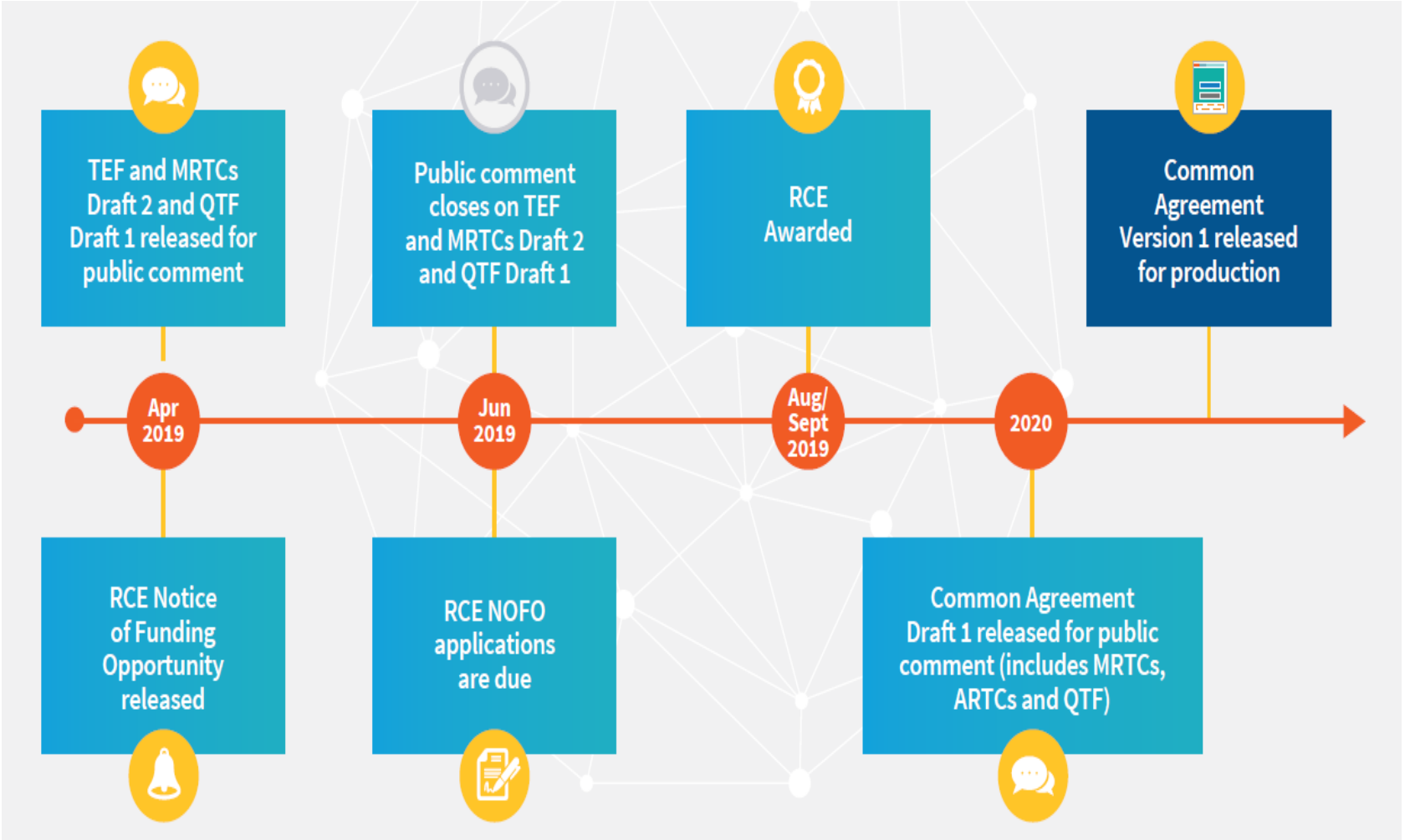
QHIN Designation Requirements

- An HIN must meet certain prerequisites, including:
  - Already operating a network that provides the ability to locate and transmit EHI between multiple persons or entities electronically, with existing persons or entities exchanging EHI in a live clinical environment
  - Providing the RCE with a written plan of how it will achieve all of the requirements of the Common Agreement within a specified time period

Allowable Fees

- QHINs must use reasonable and non-discriminatory criteria if it charges any fees to another QHIN
  - QHINs *may not* charge another QHIN any amount to exchange EHI for Individual Access Services
  - QHINs *may not* impose any other fee on the Use or further Disclosure of the EHI once it is accessed by another QHIN
- Any additional requirements around fees will be specified in the ARTCs

Implementation Timeline



Graphic Courtesy of the Office of the National Coordinator for Health IT

Intersection with ONC and CMS Interoperability Proposed Regulations

- ONC Regulation
  - RFI on requiring health IT developers to participate in TEFCA
  - Adherence to the Common Agreement as an Information Blocking Exception
- CMS Regulation
  - Payers required to participate in “Trust Networks”

Questions and Discussion

HIMSS PUBLIC POLICY

Michigan Health Information Technology Commission Meeting

HIMSS State Government Affairs Update

Valerie Rogers, MPH, Director, State Government Affairs HIMSS

May 28, 2019

HIMSS
transforming health through information and technology™

HIMSS Public Policy Efforts

- ***Ensure*** HIMSS is ***the trusted*** organization global government policy leaders involve as thought leaders, collaborators and conveners on ***all policy matters*** where health information and technology advance healthcare transformation --
- ***Leverage*** diverse member and organizational resources, and coalition-building capabilities to ***support*** government decision making
- ***Harness*** the value of health information & technology to:
  - Supporting Healthcare Transformation
  - Expanding Access to High Quality Healthcare
  - Increasing Economic Opportunity
  - Making Communities Healthier

HIMSS Strategic Advocacy Framework

Focus on the value of health information and technology through:

1. **Supporting Healthcare Transformation**
   - Ensuring interoperability across the spectrum of care
2. **Expanding Access to High Quality Care**
   - Particularly for underserved and remotely located patient populations
3. **Increasing Economic Opportunity**
   - Expanding health IT workforce
4. **Making Communities Healthier**
   - Public and population health

State Priorities in Health IT

- Health System Modernization
- Medicaid
- Telehealth and broadband
- SDoH
- Interoperability & health information exchange
- Cybersecurity
- Patient privacy
- Public health crises (e.g. natural disasters; opioid crisis, infectious disease) where health IT plays a valuable role
- Public-private partnerships
- Federal-state funding mechanisms
- New technologies: Blockchain in healthcare, etc.

CMS guidance for states in Combatting the Opioid Crisis and MMIS Modernization includes:

- Singles out telemedicine and prescription monitoring tools as useful in the effort to combat the opioid crisis
- Allows expanded use of Medicaid Information Technology Architecture (MITA), which gives a 90% match in federal funds for the development of a state-run HIT project, and 75% match to maintain these projects
- CMS issued a State Medicaid Director letter, *"Strategies to Address the Opioid Epidemic"* (SMD 17-003)7 on November 1, 2017, to describe state flexibility in addressing the opioid crisis via demonstration projects under section 1115 of the Social Security Act.
- The enhanced federal match for MITA and the HITECH Act applies to all states and territories irrespective of participation in a section 1115 demonstration project.

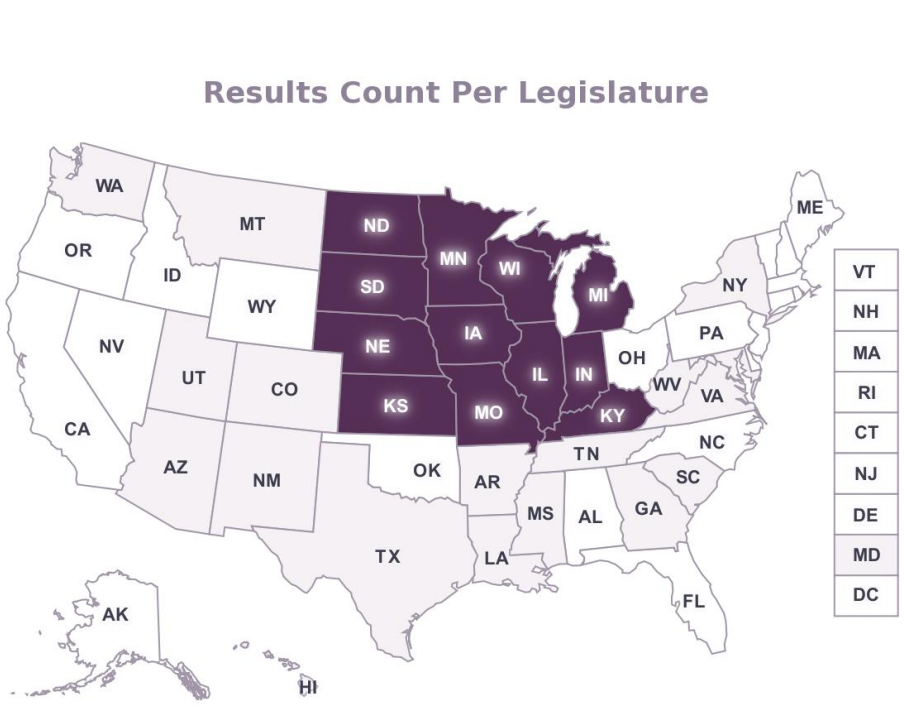
https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf

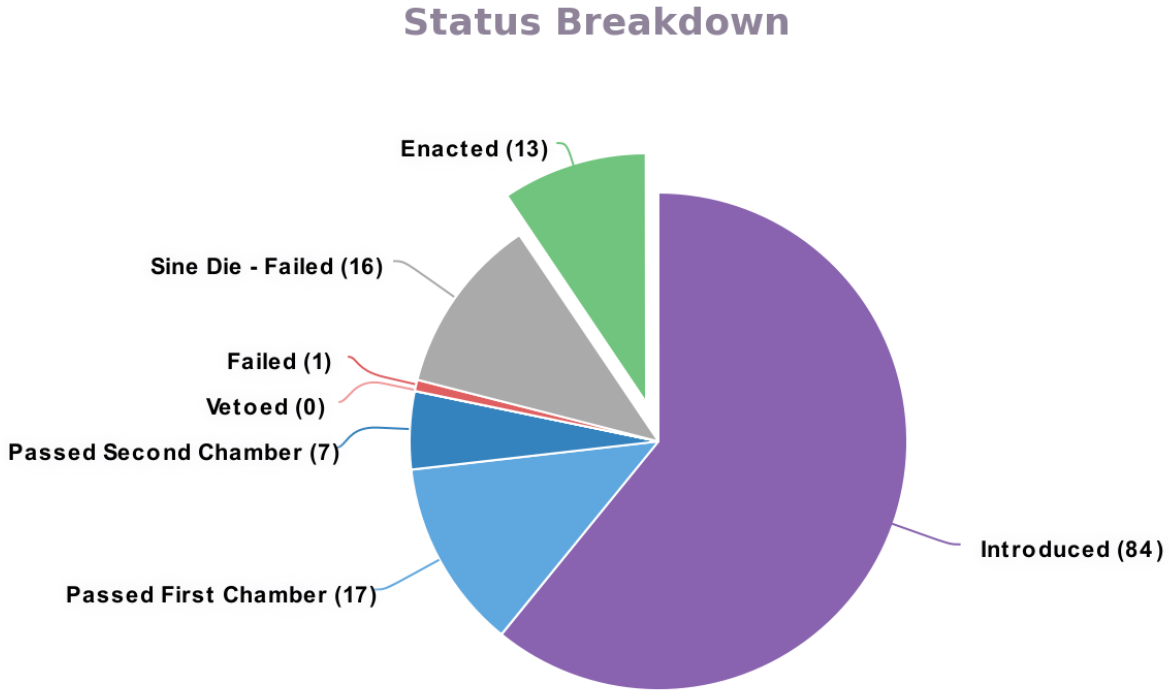
What is Telehealth and Why Should We Care?

EXPECTATIONS!!!

- A demand which is upon us today by federal and state leaders, and by the consumer is to have accessible more affordable care.
- It is estimated that 77% of Americans own smartphones and use their device for daily tasks
- Legislators are expecting solutions for reducing healthcare spend and improving patient outcomes
- Healthcare executives expect innovative thinking when developing programs which provide a service to the community

Telehealth/telemedicine Legislation: *ENACTED in Midwest*





13 bills enacted in Midwest relating to telehealth/telemedicine

Telehealth Program Challenges cont.

- Inadequate telehealth parity laws and reimbursement
- Differentiating telehealth regulations between governing bodies
- Integration between solution platforms
- Patient education
- Segmented systems creating workflow challenges
- Perception

REACH Health 2018 U.S. Telemedicine Industry Benchmark Survey

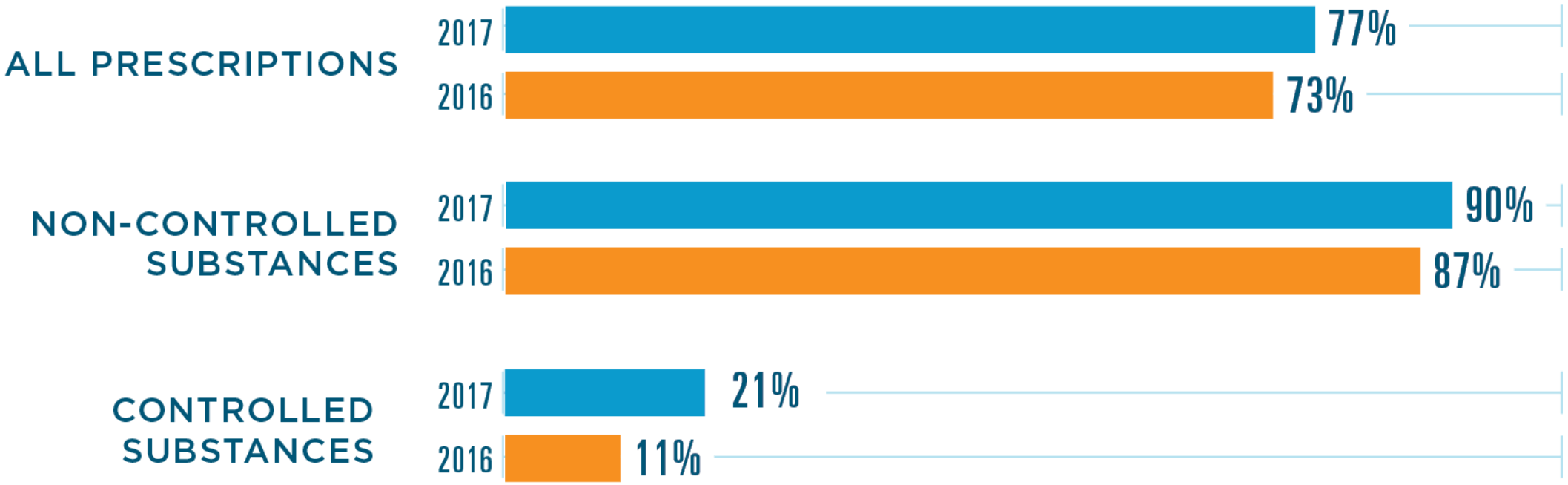
Looking Towards the Future

- Artificial Intelligence (AI)
- Chat bots
- Expanded remote patient monitoring capabilities
- Hospital at home
- Moving beyond the direct to consumer model
- Greater utilization of connected devices
- Deeper integration amongst delivery platforms
- Asynchronous telehealth communications
- 5G mobile cellular phone technologies
- Expanded broadband as commented by the FCC

CDC Opioid Grant Conditions Empower States Response to the Opioid Crisis

- The CDC and Department of Justice's Bureau of Justice Assistance have required membership in RxCheck, an open-source data-sharing hub, as a condition for the grants. The hub is intended to facilitate data-sharing between states at a lower price than private-sector competitors, PMP InterConnect and PMP Gateway, the federal government says.
- Federal officials say the private hubs charge too much to integrate PDMP checks into a clinician's EHR, considered critical to make the checks feasible. Appriss, the vendor that co-operates InterConnect and Gateway, says it charges $50 per subscriber per year for the integration service, with some discounts for states or health systems. It has to charge something to cover its costs, Appriss says.
- States had objected to the federal government's conditions because their language appeared to give the government rights to transfer PDMP data, but the federal government has said that's not its intention. A spokesperson for New Jersey's Department of Health said the state was "optimistic" about the grant after getting privacy assurances. Arizona, Louisiana and Ohio have also applied for the grants.

E-PRESCRIBING



*Calculations do not account for unfilled prescriptions

States with enacted EPCS legislation

As of 2015, all 50 states plus the District of Columbia have **approved EPCS for all schedules**

States with Enacted Legislation				
State	**Effective Date**	**Additional Info**	**Prescriber EPCS Enablement***	**Pharmacy EPCS Enablement***
Minnesota	01/01/2011	Requires e-prescribing for all medications, including controlled substances, but there are no specific penalties for non-compliance.	31.1%	96.3%
New York	03/27/2016	The I-STOP mandate requires all prescriptions, including controlled substances, to be electronically prescribed.	76.3%	98.2%
Maine	07/01/2017	Requires e-prescribing for all controlled substances containing opiates. It also has provisions that limit the durations and quantities of opioid prescriptions. The mandate allows prescribers to apply for waivers. There are specific penalties for not adhering to the law ($250/violation up to $5,000/calendar year).	64.3%	99.3%
Connecticut	01/01/2018	Requires e-prescribing for all controlled substances. This bill allows for exceptions and waivers, but does not include any specific penalties.	57.4%	99.2%
Arizona	01/01/19 & 07/01/19	Requires EPCS for Schedule II opioids on a staggered implementation basis, i.e., the mandate is effective in counties with populations of >150,000 on 01/01/19 and on 07/01/19 in counties of <150,000. There are exceptions, but no waivers or penalties are included in the law.	27.6%	98.0%
New Jersey	05/01/19	Requires EHR vendors operating in NJ to adopt EPCS for Schedule II controlled substances no later than one year after the effective date of the bill.	13.4%	97.7%

* as of September 2018
National Prescriber EPCS Enablement is at 29.3%
National Pharmacy EPCS Enablement is at 95.1%

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States with Enacted Legislation				
State	**Effective Date**	**Additional Info**	**Prescriber EPCS Enablement***	**Pharmacy EPCS Enablement***
Pennsylvania	10/24/2019	Requires prescribing for all controlled substances. The bill includes multiple exceptions, the possibility of exemptions (waivers) and specific dollar penalties for noncompliance. Department of Health & Human Services implementing regulations will be forthcoming.	21.5%	96.9%
Iowa	01/01/2020	Requires e-prescribing for all prescriptions, including controlled substances. The law includes the possibility of waivers and exceptions and specific penalties for noncompliance.	13.1%	97.8%
Massachusetts	01/01/2020	Requires e-prescriptions for Schedules II through VI. (Massachusetts statute states that Schedule VI drugs consist of all prescription drugs that are not included in Schedules II-V, which effectively means that e-prescribing will be required for all prescriptions.) The law includes the possibility of waivers and exceptions, but there is no mention of specific penalties.	15.1%	97.4%
North Carolina	01/01/2020	Requires e-prescribing for "targeted" controlled substances, which means Schedule II and III opioids. It does not mention waivers or specific penalties.	37.6%	97.0%
Oklahoma	01/01/2020	Requires e-prescribing for all controlled substances. The law includes the possibility of waivers and exceptions, but there is no mention of specific penalties. In addition, on 06/17/2018, the Oklahoma Board of Pharmacy adopted a regulation stating that "Any pharmacy that dispenses controlled dangerous substances shall have computer software that supports EPCS by January 1, 2019."	14.9%	98.9%

* as of September 2018
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States with Enacted Legislation				
State	**Effective Date**	**Additional Info**	**Prescriber EPCS Enablement***	**Pharmacy EPCS Enablement***
Rhode Island	01/01/2020	Requires e-prescribing for all controlled substances "no sooner than January 1, 2020," pursuant to regulations adopted by the RI Department of Health.	29.7%	100%
Virginia	07/01/2020	Requires e-prescribing for all prescriptions containing opiates and prohibits pharmacists from dispensing opiate prescriptions unless they are electronic. The law does not mention waivers or exceptions, but the VA E-Prescribing Work Group has recommended that exceptions be adopted and that the pharmacist mandate be modified. These recommended changes are due to be considered during the 2019 VA legislative session.	13.9%	96.7%
Tennessee	07/01/2020	Requires e-prescribing for all Schedule II Controlled Substances. The law includes the possibility of waivers and exceptions. There is the potential for specific penalties for noncompliance with the law, i.e., a civil penalty of $1,000 for each violation. Prescribers who issue 50 or fewer prescriptions for Schedule II controlled substances per year are exempt from the law's requirements.	20.8%	96.5%
California	01/01/2022	Requires that health care practitioners authorized to issue prescriptions have the capability of transmitting prescriptions electronically, as well as requires that pharmacies have the capability to receive prescriptions electronically, by 01/1/2022. On and after 01/01/2022, all prescriptions must then be transmitted electronically. The law includes exceptions, and it states that the failure to meet the requirements of the law shall result in a referral to the appropriate state professional licensing board solely for administrative sanctions as deemed appropriate by that board.	26.3%	93.5%

* as of September 2018
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National Pharmacy EPCS Enablement is at 95.1%

States with EPCS Legislation Introduced

Industry stakeholders expected to pursue additional legislation in another 5-10 states in 2019

States with Legislation Introduced				
State	**Proposed Effective Date**	**Additional Info**	**Prescriber EPCS Enablement***	**Pharmacy EPCS Enablement***
Michigan	01/01/2020	SB 802 will require e-prescribing for opioids and benzodiazepines, both for prescribers and pharmacies. The bill does not mention exceptions, but it does allow for waivers and includes specific penalties.	28.5%	98.0%
Illinois	01/01/2022	SB 2058 will mandate e-prescribing for all drugs, including controlled substances, and medical devices. There is no mention of exceptions, waivers, or specific penalties, but the bill does require the Department of Health & Human Services to adopt rules governing the use of electronically transmitted prescription orders.	20.2%	95.1%

* as of September 2018
National Prescriber EPCS Enablement is at 29.3%
National Pharmacy EPCS Enablement is at 95.1%

Social Determinants of Health and Information Technology

- **MA H 2002 -** An Act advancing innovations in digital health technology to improve patient outcomes and the quality of health care delivered in the commonwealth by developing a plan to complete the implementation of electronic health records systems by all providers in the commonwealth; and advance the commonwealth's economic competitiveness by supporting the digital health industry, including the digital health industry's role in improving the quality of health care delivery and patient outcomes
- **NC SB 549** – Establishes a pilot project is to establish a trauma-informed integrated health foster care model to facilitate partnerships between county departments of social services and local management entities/managed care organizations (LME/MCOs) regarding children placed in foster care
- **CA AB 887** - Establishes an Office of Health Equity, reporting to the CA Surgeon General and advises and assists other state departments in their mission to increase the general well-being of all Californians, and advises the Governor on a comprehensive approach to addressing health risks and challenges as effectively and early as possible.

7 Factors Influencing States' Health IT Planning Efforts

1. Health reform and achieving the **Triple/Quadruple Aim**
2. Increased emphasis on **consumer engagement** in their health
3. Need for integration of **health related social needs**
4. Need for **common, coordinated, tools** and services
5. Focus on **broad interoperability** and **information sharing**
6. The need to **reduce gaps and overlaps** in statewide health information tools
   services.
7. s that reflect real world situation and are **<u>implementable</u>**

How Do We Begin to Get There?

Improving Healthcare and Public Health with out of the box thinking while focusing on the Triple Aim…

1. Improving the patient experience
2. Reducing the per capita costs of health care
3. Improving the health of populations overall

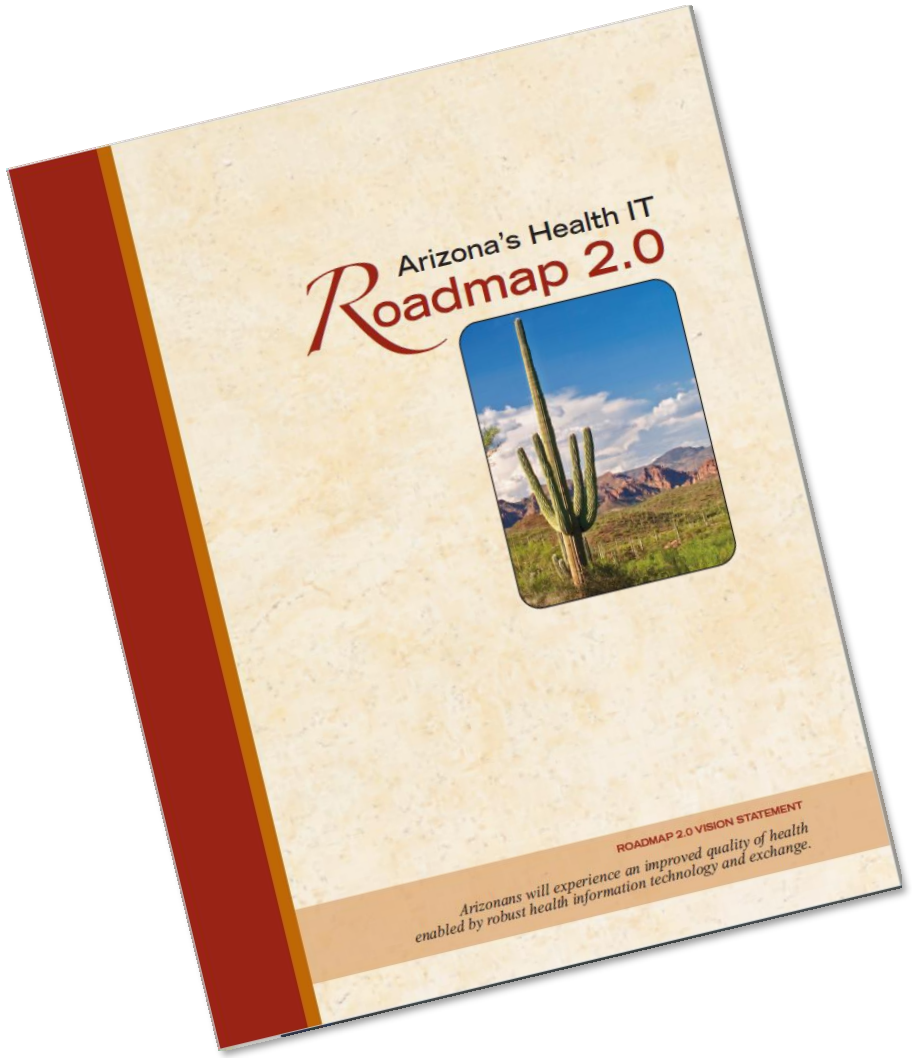
2019 Connecting Michigan for Health Conference Explores Trends in Statewide Health IT Roadmaps

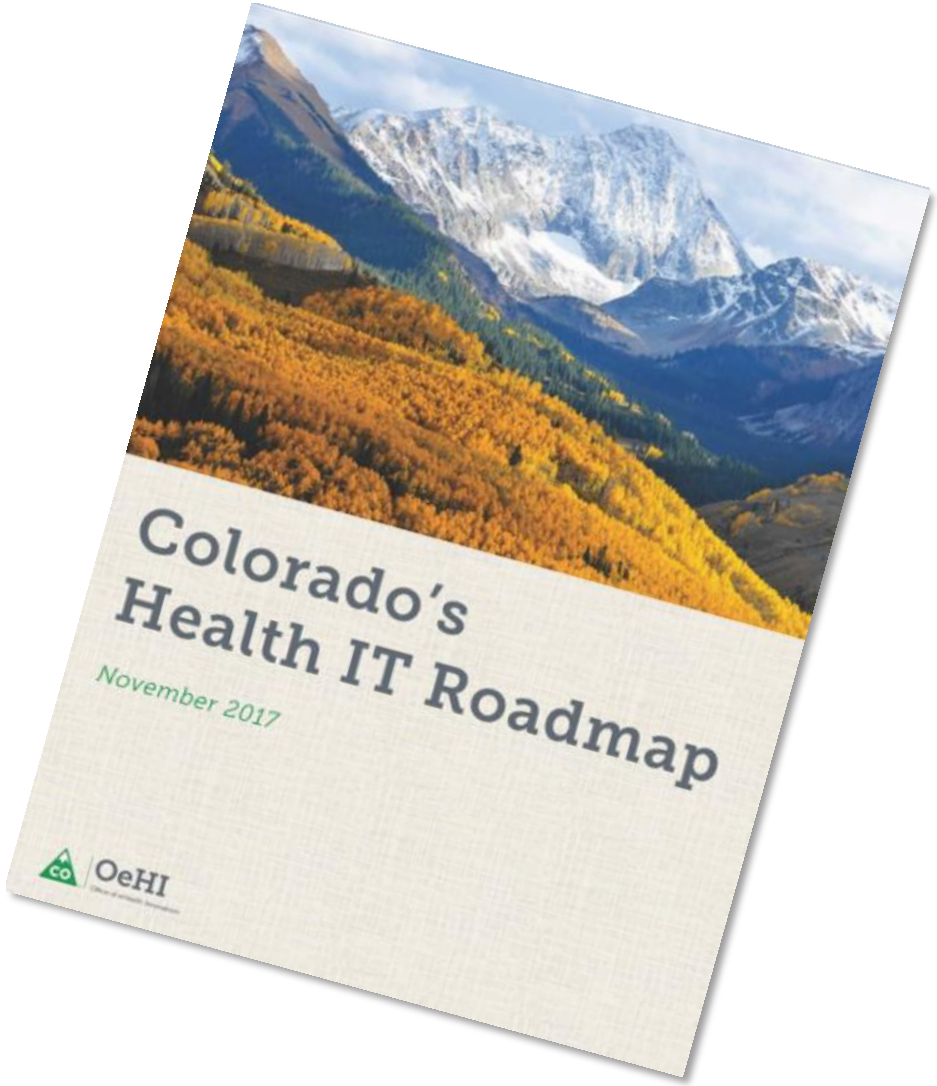
From		*To*
Focus on Technology	→	*Support of Common Capabilities*
Focus on Medical Needs	→	*Focus on Healthier Residents*
Focus on Provider	→	*Focus on Needs of Whole Person*

Attributes of a Successful Statewide Health IT Roadmap

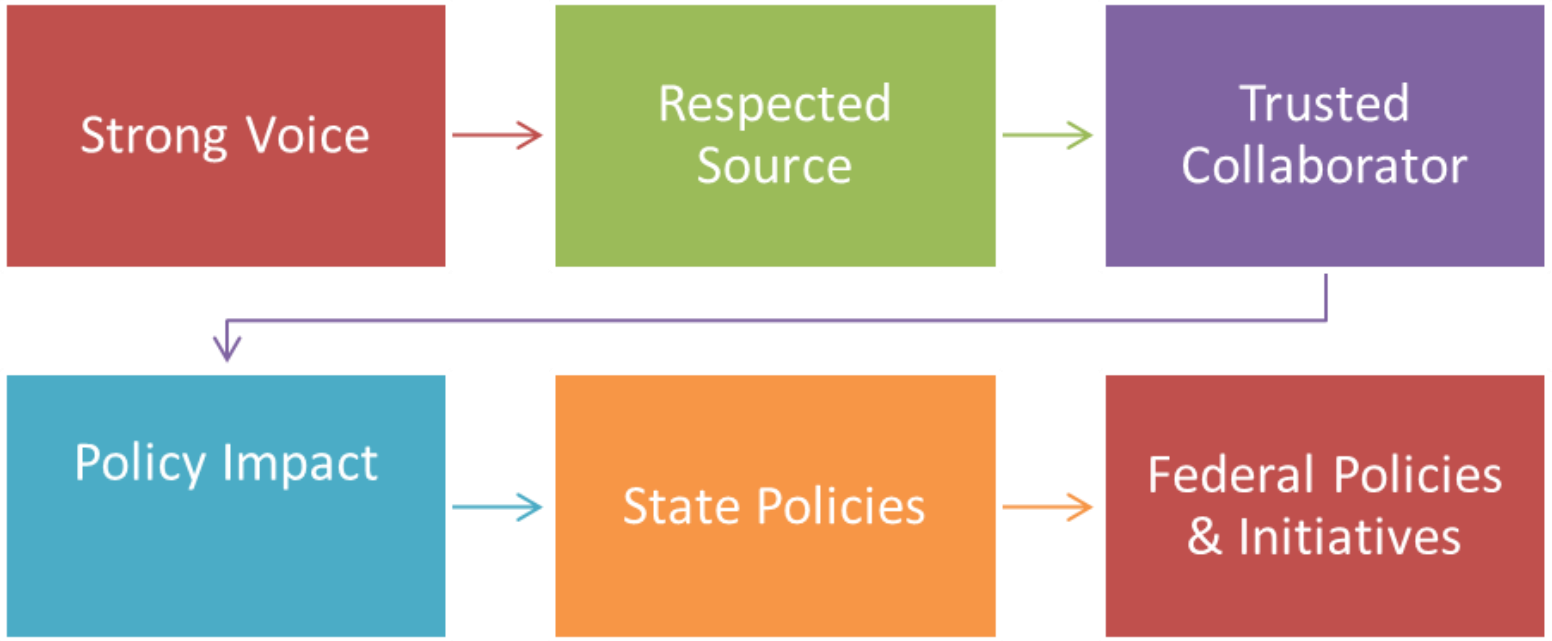
A successful Statewide Health IT Roadmap is *actionable* and *sets the stage* for successfully achieving the future vision.

- There is a broad sense of **ownership** of Roadmap
- There is an **agreed upon path** (the initiatives) that will be taken to make the vision a reality
- There is **agreement and collaboration** among wide cross-section of stakeholders to implement the plan
- It's something you – and others – can **believe in**


Arizona's Health IT
Roadmap 2.0
ROADMAP 2.0 VISION STATEMENT
Arizonans will experience an improved quality of health enabled by robust health information technology and exchange.


Colorado's
Health IT Roadmap
November 2017
OeHI

Build meaningful & sustainable partnerships



CONNECTING MICHIGAN FOR HEALTH 2019

Options for collaboration between HITC members, HIMSS staff, ONC and other speakers include:

- **Monday, June 3rd**
  - **Legal Summit** – Jeff Coughlin will be speaking on the legal ramifications of interoperability - 9:30am - 11am
  - Dinner with HIMSS, federal, state and local speakers

- **Tuesday, June 4th**
  - Join Jeff Coughlin and Valerie Rogers at 12 noon to continue discussion on Federal & State Health IT Policy Solutions to Connect Michigan's Spectrum of Care
  - Connecting Michigan debrief 1-2pm
  - Reception at Connecting Michigan at 5 pm

Join us for stakeholder discussions throughout conference!

Questions? Contact us!

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Proposed HIT Commission HIT/HIE Strategy

Thomas Simmer, M.D., Co-Chair

HIT Commission Next Steps

Public Comment

Adjourn

Next Tentative Meeting for 2019:
Tuesday, September 24, 2019, 1:00 p.m. – 3:00 p.m.
MDHHS South Grand building, Grand Conference Room