

Please note that these recommendations were made to the HIT Commission in December of 2007 and do not necessarily reflect the current views of MDCH, MDIT, MIHIN Resource Center, Legal Work Group or HIT Commission

Legislative Recommendations for Interoperable Health Information Exchange

Prepared by:

Michigan Health Information
Security and Privacy Collaborative (HISPC)
Legal Workgroup

Submitted to:

Michigan Health Information Technology Commission
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1. Background

Purpose and scope

The Legal Workgroup is part of two larger projects: the Health Information Privacy and Security Collaboration (HISPC) consisting of a multidisciplinary team of experts in privacy and security law and healthcare management addressing variations in state laws that affect privacy and security challenges to interoperable health information exchange; and the Michigan Health Information Network (MiHIN) Resource Center, which supports the State's role as convener and collaborator for HIE initiatives, including the development of Regional Health Information Organizations (RHIOs), along with inter-regional data exchange.

The Legal Workgroup consists of several dedicated volunteers from across the state. Many of these volunteers were originally part of the MiHIN Conduit to Care project, previously challenged to help answer legal questions arising from HIE development. The State of Michigan is extremely fortunate to have such a committed group. These diligent volunteers have been willing to travel, donate their time and perhaps, most importantly bring their expertise, professionalism and knowledge to this process. Without their dedication and commitment to the ongoing development of HIE in the state of Michigan, this project would not have been successful.

The participation of the Legal Workgroup in this process has given the State of Michigan an advantage in that critical stakeholders (and arguably leaders in the legal areas of HIE development) the ability to vet and collaborate on critical issues affecting HIE. The Legal Workgroup, under the guidance of Denise Chrysler and Margaret Marchak, held three meetings. Our final meeting was conducted in Brighton, where we were able to use a facilitator, provided to us through the HISPC project, to reach our final recommendations.

Legal Workgroup Process

The Legal Workgroup started with the MiHIN HIE Legislation Plan Matrix (Matrix)¹, developed utilizing the MiHIN *Conduit to Care* report². During the MiHIN project, the Legal Workgroup created the Overview of Michigan’s Legal Framework for Health Data Release/Sharing—eleven pages of citations to relevant Michigan statutes, court rules, administrative code rules, case law and Attorney General opinions relating to the privacy of health data.³ The Matrix distilled the most relevant statutes into categories based on subject matter most affecting HIE in Michigan. The Legal Workgroup’s primary goal was to review the Matrix and develop a “top ten” list of priorities to be addressed by the State in order to facilitate HIE.

Legal Workgroup Scope

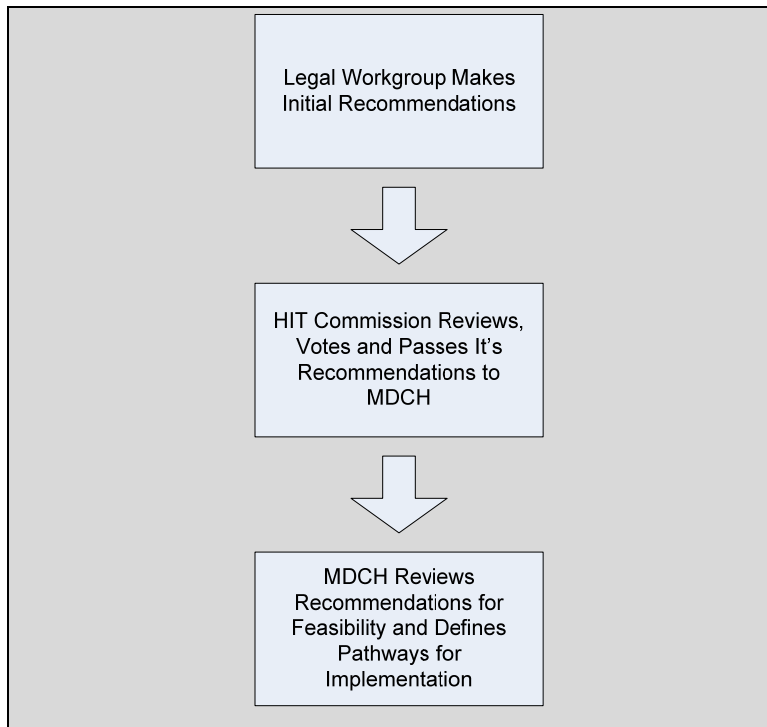
The scope of the Legal Workgroup was limited to: determining the areas of Michigan Statutes’ needing to be changed; creating an ordered short list of those priority areas of law based on the need for action; and drafting a subsequent position paper detailing those priorities and the reasoning behind them.

In addition, while the scope of the Legal Workgroup meetings included determining “the what”, in regards to what areas of Michigan Law need action, the scope did not include determining “the how”, in regards to how the State should make the recommended changes. It was decided early on in the process that the Michigan Department of Community Health, through well-established processes would ideally be tasked with defining how the various recommendations would most effectively be implemented.

¹ See appendix

² Conduit to Care: Michigan’s eHealth Initiative, December 2006

³ Conduit to Care: Michigan’s eHealth Initiative, December 2006 , Appendix F, pp. 93-103



Legal Workgroup Matrix – Ranking Methodology

The MiHIN Plan for Michigan HIE Legislation is based on the previous work done by the HISPC Legal Workgroup in conjunction with the MiHIN project. In this second phase of the project, we asked that Legal Workgroup participants rank each of the subject matter areas based on the ranking methodology listed below. The Workgroup systematically worked through and ranked the subject matter areas based on the methodology, which encompassed three areas of measurement: impact, need for timely action and the ease of reaching consensus among stakeholders throughout the state.

In order to establish a level perspective, we asked that the Legal Workgroup participants accepted (for purposes of this ranking process only) the following assumptions:

- Full implementation of HIE is inevitable over time
- All clinical information will be available to clinicians at point of care.

- No secondary uses of the data will be permitted

Below are the detailed three areas of ranking measurements used by the Legal Workgroup (A- *Impact on HIE Development*, B- *Need for Timely Action*, and C- *Ease of Reaching Consensus*) used to rank each subject matter item listed on the Matrix. Throughout the process, the participants indicated the corresponding number (shown on the left of the items listed below) on the Matrix to indicate how they ranked each area. We then added A, B, and C, averaged them and this became the comprehensive score for each subject matter area.

A. Impact on HIE Development

The state of Michigan has targeted HIE Development as one of its goals in regards to improving healthcare. How will the implementation or lack thereof of the subject matter effect the progress of HIE development?

1. Insignificant- will have almost no impact on HIE development if implemented
2. Minor- will have some small effect on HIE development
3. Significant- will result in a tangible effect, albeit small in scale on HIE development
4. Serious- may have considerable effect on HIE development across the state
5. Critical- will have extensive and wide-ranging effect on HIE development across the state

B. Need for Timely Action

How does the subject matter fit in to Michigan's timeline for HIE implementation? Is the subject matter area one that requires immediate action? Or is it something that can wait a few years to be addressed? For example: electronic inter-HIE communication is likely not to occur for 3-5 years, so there is not a need for immediate action; conversely, the implementation of Electronic Medical Records (EMRs) is currently underway

for many HIEs, so action in regards to laws affecting EMRs would be needed immediately or soon.

1. No action needed
2. Action needed in 4-5 years
3. Action needed in 2-3 years
4. Action needed in 6 months to a year
5. Immediate action

C. Ease of Reaching Consensus

How difficult (or easy) will it be for the State to reach consensus among Michigan's stakeholders in order to implement HIE development (and remove existing barriers) as it relates to the subject matter?

1. Impossible- Consensus unlikely
2. Very Difficult
3. Difficult, but possible
4. Requires Discussion, but Consensus likely
5. No barriers – Consensus achieved

Summary of Legislative Recommendations

Main Findings

Recommendation #1 – Recognize federal Stark amendments through 2007 and update Michigan physician disciplinary law under MCL 333.16221.

Discipline may be imposed upon physicians who make referrals in violation of the Stark law unless a permitted exception exists as promulgated through 2002 according to MCL 333.16221(e)(iv)(B). The Stark regulations have been amended since 2002 and specifically, in 2006, the regulations were amended to permit donations of technology to physicians by certain entities, including hospitals⁴. As stated in MCL 333.16221(e)(iv)(B), MDCH is required to take make a decision as to “whether or not the revision pertains to referral by physicians for designated health services and continues to protect the public from inappropriate referrals by physicians. If the department decides that the revision does both of those things, the department may promulgate rules to incorporate the revision by reference.”⁵ If there are inconsistencies between federal and state physician referral laws that have not been reviewed by MDCH, such inconsistencies may have an unintended chilling effect on technology donations from hospitals to physicians, thereby acting as a barrier to the adoption of HIE.

All of the participants of the Legal Workgroup expressed a desire for Michigan to update its physician referral law to be consistent with the Stark Amendments. This recommendation was found to be significantly necessary. Several of Michigan’s health law attorneys have requested that MDCH recognize Stark II based on language in 333.16221:

If section 1877 of part D of title XVIII of the social security act, 42 USC 1395nn, or a regulation promulgated under that section is revised after June 3, 2002, the department shall officially take notice of the revision. Within 30 days after taking notice of the revision, the department shall decide whether or not the revision pertains to referral by physicians

⁴ 42 CFR 411.351, Stark exceptions

⁵ MCL 333.16221(e)(iv)(B)

for designated health services and continues to protect the public from inappropriate referrals by physicians. If the department decides that the revision does both of those things, the department may promulgate rules to incorporate the revision by reference. If the department does promulgate rules to incorporate the revision by reference, the department shall not make any changes to the revision. As used in this subparagraph, “designated health service” means that term as defined in section 1877 of part D of title XVII.⁶

In addition, the Legal Workgroup recommends that MDCH review federal Stark and Anti Kickback laws on a regular (annual) basis to ensure that Michigan’s physician referral law remains compatible with to federal law.

Finally, the Legal Workgroup recommends that when an interim period exists between federal amendment or enactment of updated or new Stark or Anti-Kickback laws and the time that MDCH has the opportunity to review and decide whether or not the revision pertains to referral by physicians for designated health services and continues to protect the public from inappropriate referrals by physicians recognized the updated federal law, the state would not take any disciplinary action against any physician who may be acting in contradiction to the Michigan physician referral law that is not harmonious with the new or updated federal law, but has not yet reviewed by MDCH. (It was also noted that an anticipatory change in federal law cannot be incorporated into Michigan statutes by reference.)

Recommendation #2 - Establish minimum administrative, technical and physical safeguards for privacy and security in HIE for participants.

Such standards do not currently exist in state law. While there are applicable standards under federal law (HIPAA⁷, FERPA⁸, etc).HIE entities may not be covered entities under HIPAA or may not fall into categories covered by other

⁶ MCL 333.16221(e)(iv)(B)

⁷ 45CFR Parts 160,162,164 HIPAA Security Standards; Final Rule

⁸ 20 U.S.C. § 1232g; 34 CFR Part 99, Family Educational Rights and Privacy Act

federal laws and standards. Stakeholders, including participants and consumers will expect minimum standards for privacy and security in order to build trust in HIE. All entities participating in an HIE should be held to, at a minimum, a nationally recognized privacy and security standards.

Recommendation #3 - Identify the types of individuals/entities to be granted access to the protected health information in HIEs:

As a trust building measure, the type of entities or individuals who may access the protected health information stored in the HIE, e.g., licensed or certified healthcare providers should be clearly established. The registered user or licensed provider should be held accountable for actions of those employees and staff granted access on their behalf. Further, access should be permitted to volunteers and other specifically designated individuals (as is allowed currently with paper-based health information) with a need for access, who may not ordinarily have access to data held by the HIE, in times of an emergency declared by state government.⁹

Recommendation #4 – Extend MCL 333.20201(2)(c) (Patients Rights and Responsibilities) to apply to all healthcare providers for the express purpose of treatment.

(c) A patient or resident is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the health facility or agency except as required because of a transfer to another health care facility, as required by law or third party payment contract, or as permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.¹⁰

Such uses and disclosures are permitted to health care facilities in MCL 333.20201(2)(c). Health care facilities are defined in the Public Health Code under 333.20201(2)(c) but do not include licensed professionals, including

⁹ See Appendix Recommendation 3.

¹⁰ MCL 333.20201(2)(c)

physicians, or other health care providers, such as home health agencies and hospice. All providers should be afforded protection to share information for treatment which is critical to HIE. Current uses/disclosures as set forth in HIPAA may be adopted or extend the uses and disclosures permitted in MCL 333.20201 to all health care providers, not just health facilities. Additional uses/disclosures may be contemplated at another time as policy develops.

Recommendation #5 – Establish Informed Opt-out as the method of consumer control of how their protected health information becomes part of the HIE:

Establish Informed opt-out (Opt out with the additional requirement of providing information regarding the impact and possible consequences of a patient opting out of participating in the HIE) to provide for consumer privacy while facilitating adoption of HIE. The precedence for this is the opt-out approach taken by MDCH for use with the Michigan Care Improvement Registry (MCIR). (While MCIR is a successful example of the opt-out process, it should be noted that MCIR, until recently has been limited to the immunization data of children¹¹. It should also be noted that historically there has been a very pervasive federal push for the collection and reporting of childhood immunization data.) In addition to the informed opt-out provision, in the case of an HIE, consumers should be counseled or appropriately educated on the potential risk they face by omitting health information from providers and the limitations to how their data will be used/disclosed. Under the opt-in approach, healthcare providers participating in the HIE would be required to obtain permission from patients before allowing their information to be available via the network. Without this permission, a patient's health information would not be accessible through the HIE.

This recommendation is coupled with Recommendation #6 to provide a complete continuum of consumer privacy protection.

¹¹ See Appendix: Recommendation 5.

Recommendation #6 – Provide sanctions for and enforcement over improper uses and/or disclosures of PHI in HIE.

There will be uses and disclosures that may not comport with the permitted uses and disclosures of PHI in HIE, some incidental and others may exceed this standard. An enforcement scheme by the State and resulting sanctions for such actions should be scaled to the severity of the breach/inappropriate use or disclosure. Different sanctions should be established for incidental, accidental, intentional and egregious actions.

Recommendation #7 – Clearly describe permissible uses and disclosures of special classes of PHI in HIE.

Michigan law provides special protection to certain types of health care information, e.g., certain reproductive health, HIV+ status, mental health and substance abuse treatment. Recommend that providers be permitted to access this information at the point of care to avoid adverse drug reactions and other quality of care issues. Exceptions to this would be for any federal protection, such as for 42 CFR Part 2 facility treatment¹².

Recommendation #8 – Consolidate Michigan laws affecting HIE to avoid inconsistency:

There should be centralization of the laws affecting health information and HIE for consistency. There are myriad laws currently in Michigan in the Public Health Code and elsewhere about uses and disclosures of PHI. These should be made centralized and consistent for all provider types as appropriate.

¹² See Appendix Recommendation#7.

Recommendation #9 – As part of HIE adoption guidance, uses and disclosures for HIE are permissible uses under HIT software licenses.

Some providers may experience conflict with software vendors that provide that their software be used for certain purposes that do not contemplate HIE. To permit those who wish to exchange electronic information in HIE, these software licenses may be a barrier by restricting use of the software. Such limitations, that have the effect of precluding HIE should be rendered unenforceable as against public policy for HIE purposes.

Recommendation #10 –Establish protections for HIE information from discovery:

All information available from the HIE is available from the original source and therefore, discovery of information in the HIE should be prohibited, similar to peer review protected information. All information related to legal action should be obtained from its original source. Entities hosting the HIE structure should audit use and disclosures of internal mechanisms to ensure proper use of HIE without fear of legal action.

Recommendation #11 - Provide exemptions from state taxes for HIE activities during the period covered by the planning and implementation grants: Financial viability of HIE entities is key to sustainability.

For a limited period of time, the state should ensure budget protection for HIE efforts through tax incentives. A lack of financial sustainability, which is often times related to weaknesses in the planning of governance and business structure, in conjunction with other issues, such as a lack of broad-based stakeholder and community buy-in, have been contributing factors of RHIO failure.^{13,14}

¹³ Healthcare Informatics, *From Struggles to Success: Part technology, part cooperation and part good old fashioned trial and error are what it takes to build—or break—a RHIO*, Hagland, Mark. Sept. 2007

¹⁴ Government Health IT, *Diagnosing a RHIO's Ills*. Pulley, John. August 2007

3. Legislative Recommendation Identification and Selection Process

Process Used to Develop Solutions

Michigan took a simple, straightforward approach to developing solutions. The process included the following steps:

1. **Identify a wish list of participants** – the Planning Team identified the list of proposed participants that would provide the greatest diversity, have the most experience, and are most likely to fully participate.
2. **Provide the HIE Legislation Plan** to the volunteers prior to the meetings, which distilled the most relevant statutes from the MiHIN Conduit to Care Report's into categories based on subject matter most affecting HIE in Michigan.
3. **Conduct Legal Workgroup Meetings** – The three meetings were conducted as a structured, combination conference call and live meeting. Each area of law was explained, the participants were given time to organize their thoughts, and then a group vote was taken on those issues where there appeared to be a great deal of discussion, or differing viewpoints, each participant was called on to vote on how critical they felt the issue was. Once every participant had an opportunity to comment, the voting score was tallied and the team moved on to the next issue.
4. **Legal Workgroup members were encouraged to continue consider possible issues**– The Legal Workgroup continue to provide insight and solution input after the meeting and requested that they meet on some sort of regular basis to review the recommendations and HIE development.

Description of Legal Workgroup

Participants Included representatives from:

- Michigan State University
- University of Michigan
- Henry Ford Health Systems
- Trinity Health Systems
- Michigan Department of Information Technology
- Michigan Department of Community Health
- Michigan ACLU
- Spectrum Hospitals
- CAHA
- Alliance for Health

- SEMHIE
- Miller, Canfield, Paddock and Stone, P.L.C.
- Hall, Render, Killian, Heath & Lyman, PLLC

4. Conclusion

To effectively accomplish the goal of integrating electronic HIE in Michigan, the Legal Workgroup has reviewed the current legislative scheme, focusing on the areas that impact or present a barrier to the electronic exchange of health information, drafting eleven recommendations that it found to be the most critical for HIE development. It should be noted that while all of the recommendations will facilitate the development of HIEs in Michigan, there is currently no legislation that prevents the formation of HIEs in the State.

The HISPC Legal Workgroup, active since the MiHIN *Conduit to Care* Project, found that possible issues with current legislation or a lack thereof fall mainly into two categories: areas of law that are antiquated, in that they were drafted at a time when the electronic exchange of health information had not yet been contemplated or, laws in need of updating to be consistent with federal legislation regarding privacy and security of medical information in the event national health information exchange is achieved.

The Legal Workgroup focused on the eleven recommendations to remove barriers from HIE development, while ensuring the protection of the privacy and security of electronic health information. A key consideration for the Legal Workgroup was to support interoperability both for intrastate and interstate HIE development by promoting the building of infrastructure that is flexible. In order to encourage participation in regional initiatives by potential HIE participants; the State of Michigan has worked to facilitate consensus of legal opinion state-wide.

5. APPENDIX

Additional Citations and Reference Material per Recommendation

Recommendation 1

42 USC 1395nn Stark Law
42 CFR 411.351, Stark exceptions

Recommendation 2

45 CFR Parts 160,162,164 HIPAA Security Standards; Final Rule 20
U.S.C. § 1232g; 34 CFR Part 99, Family Educational Rights and Privacy
Act

Recommendation 3

MRAA, MCL 333.26261 et seq.
MCL 333.20175 (facility records)
MCL 333.16648 (dental records)
MCL 333.16213 (practitioner records)
MCL 333.17752 (prescription drug records)
MCL 550.1406; 550.1604 (confidentiality obligations)

**Potential (health provider) participants in HIE based on licensure
or certification under state law, or certification to participate in
Medicaid or Medicare**

1. Public Health Code - Licensed Health Facilities or Agencies

“Health facility or agency” means:

- (a) An ambulance operation, aircraft transport operation, non-transport, pre-hospital life support operation, or medical first response service.
- (b) A clinical laboratory.
- (c) A county medical care facility.
- (d) A freestanding surgical outpatient facility.
- (e) A health maintenance organization.
- (f) A home for the aged.

- (g) A hospital.
- (h) A nursing home.
- (i) A hospice.
- (j) A hospice residence.

MCL 333.20106.

Except for HMOs and homes for the aged, each of these requires a license from the Michigan Department of Community Health. Homes for the Aged are licensed and regulated by the Department of Human Services. MCL 445.2011. HMOs are regulated by the Department of Labor and Economic Growth under Chapter 35 of the Insurance Code, and must have a certificate of authority to operate. MCL 500.3505.

Under Part 209 of the Public Health Code, EMS related operations include licensure of individuals, including licensure as a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic. MCL 333.20950.

2. Public Health Code – Licensed Substance Abuse Services

A substance abuse treatment or prevention license is required for any organization offering, or purporting to offer, substance abuse treatment, rehabilitation, or prevention under Part 62 of the Public Health Code, MCL 333.6201 *et seq.*

3. Public Health Code – Licensed Health Professionals

Under Article 15 of the Public Health Code, a “health occupation” means a health related vocation, calling, occupation, or employment performed by an individual whether or not the individual is licensed or registered under this article. MCL 333.16105(1). A “health profession” means a vocation, calling, occupation, or employment performed by an individual acting pursuant to a license or registration issued under Article 15 of the Public Health Code. MCL 333.16105(2). Under Article 15, a license or registration is required for the following health professions:

Chiropractor	Part 164
Acupuncturist	Part 165
Dentist, dental assistant, or dental hygienist	Part 166
Audiologist	Part 168
Marriage and family therapy.	Part 169
Medicine and physician's assistant	Part 170
Registered nurse, licensed practical nurse, or trained attendant	Part 172

Nursing home administrator	Part 173
Optometry	Part 174
Osteopathic medicine and surgery and physician's assistant	Part 175
Pharmacy	Part 177
Physical therapy	Part 178
Athletic trainer	Part 179
Podiatric medicine and physician's assistant	Part 180
Counseling	Part 181
Psychologist	Part 182
Certified occupational therapist or certified occupational therapist assistant	Part 183
Dietitian or nutritionist	Part 183A
Sanitarian	Part 184
Respiratory therapist	Part 187
Veterinary medicine or veterinary technician	Part 188

4. Mental Health Code – Licensed hospitals and programs

A psychiatric hospital, psychiatric unit, or psychiatric partial hospitalization program must be licensed under the Mental Health Code, MCL 330.1001 *et seq.* State psychiatric hospital and centers are not licensed. All are Medicaid/Medicare certified, with the exception of the Center for Forensic Psychiatry. All are JCAHO-accredited, with the exception of Mt. Pleasant.

A Community Mental Health Service Program must be certified by Michigan Department of Community Health in order to receive state funding. MCL 330.1232, MCL 330.1232a.

5. Adult Foster Care Licensing Act

Adult foster care facilities must be licensed by the Department of Human Services. These include AFC family homes, small group homes, large group homes, congregate facilities, and camps.

6. Health Care Providers that are not licensed or certified under state law, but may be certified by Medicaid or Medicare

e.g. Durable medical goods suppliers 42 CFR Part 424
Home health agencies 42 CFR Part 484

Recommendation 4

MCL 333.20201(2)(c)

Recommendation 5

MRAA, MCL 333.26261 et seq.
MCL 722.30 (parents' right to information) MCL 333.2834 (fetal death)
MCL 333.2835; 333.2837 (abortion reporting)
MCL 333.9132 (minor capacity to consent)
MCL 722.623 (child abuse)
MCL 333.2640 (provision of medical records)
MCL 3330.1748a (mental health)
MCL 350.1723 (obligation to report)
MCL 330.1707 (Mental health services)
MCL 333.5127 (HIV, STD)
MCL 333.6121 (substance abuse)
MCL 333.5114; 333.16267 (test results)
MCL 333.5114a (partner notification)
MCL 333.5131 (confidentiality)
MCL 500.3407b (non-discrimination based on testing)
MCL 333.17020 (informed consent)
MCL 550.1401(3)(e) (nondisclosure of genetic test results)
MCL 330.1748 (confidentiality)
MCL 333.6521 (confidentiality)
MCL 333.1946 (duty to warn)
MCL 333.6112; 333.6113 (disclosures of substance abuse records)

Public Act 91 of 2006 requires that all immunization providers report childhood immunizations (those administered to persons born 1/1/1994 to present) to the MCIR. As of June 5, 2006 the reporting of adult immunizations to MCIR is highly encouraged.

The goal for the Registry is to improve the overall health of the citizens of Michigan by insuring widespread utilization of immunizations to target vaccine preventable illnesses, including:

Pertussis (whooping cough)
Polio
Measles (rubeola or hard measles)
Mumps
Rubella (German measles)
Haemophilus Influenzae Type B (Hib)
Hepatitis B
Tetanus (lockjaw)
Diphtheria
Chickenpox (Varicella)
Influenza
Pneumococcal disease

Recommendation 7

MCL333.17015 (informed Consent for abortion)

Recommendation 8

MCL 333.17015 (informed consent for abortion)
MCL 333.2834 (fetal death)
MCL 333.2835; 333.2837 (abortion reporting)
MCL 333.9132 (minor capacity to consent)
MCL 722.623 (child abuse)
MCL 333.2640 (provision of medical records)
MCL 330.1748a (mental health)
MCL 350.1723 (obligation to report)
MCL 330.1707 (mental health services)
MCL 333.5127 (HIV, STD)
MCL 333.6121 (substance abuse)
MCL 333.5114; 333.16267 (test results)
MCL 333.5114a (partner notification)
MCL 333.5131 (confidentiality)
MCL 500.3407b (non-discrimination based on testing)
MCL 333.17020 (informed consent)
MCL 333.17520 (informed consent)
MCL 550.1401(3)(e) (nondisclosure of genetic test results)
MCL 330.1748 (confidentiality)
MCL 333.6521 (confidentiality)
MCL 33.1946 (duty to warn)
MCL 333.6111 (records of substance abuse treatment)
MCL 333.6112; 333.6113 (disclosures of substance abuse records)

Recommendation 10

MCR 2.314; 2.506 (court rules on subpoenas, discovery)
MCL 331.531 Michigan peer review laws
Public Health Code (e.g. records retention under MCL 333.16213;
333.20175)
MCL 333.17753 (prescription processing)
R.338.471a et seq. (Board of Pharmacy rules)
MCL 450.831 et seq. (Uniform Electronic Transactions Act)
FRCP 16, 26, 33,34,37,45
Medicare EDI Enrollment
FRE 1002

Recommendation 11

Relevant State Law and Legislative Proposals

H.R. 2991 (revenue generation)

Vermont H.229

Illinois H.1254

Maryland H.879

Florida H.1121

Indiana S.551

Texas H.1006

