In 2010, Michigan applied for funding under the HITECH Act to build on preparatory work regarding the state-wide HIE. The State received approximately $14m through the ONCHIT State Funding in 2007 and 2008 proved sustainable. Over time, we can see the states’s strong track record and supportive legal framework in collecting public health-relevant data, the state decided to emphasize public health aspects in its Medicaid HIE implementation.

Because of Michigan’s departmental structure, State Medicaid officials were able to work with public health colleagues to apply for Federal incentive funding. As a result of the 2010 Federal EHR and HIE initiatives, and their interaction with existing initiatives at the state level, Michigan now has a dual governance structure. Stakeholders have access to not just one but two, areas of shared discretion at the state level: one through the Health IT Commission and another through the MiHIN Board of Directors.

In theory, these two organizations have distinct prerogatives. While the Health IT Commission is meant to provide high level governance regarding policy, the MiHIN board is supposed to manage day-to-day operations. However, these governance functions overlap, and MiHIN seems far from the subordinate body. From a review of the Health IT Commission minutes, the Commission spends more time monitoring a dashboard of state progress than it does formulating high level policy guidance. MiHIN, in turn, benefits from its direct connections with sub-state HIEs, which maintain control of much important health data.

This study uses a mixture of primary document analysis, a review of survey data and academic literature, and original interviews to analyze the collaborative governance models associated with HIE promotion. Primary documents pertaining to HIE promotion (relevant Federal and state laws, regulations, public statements during policy, strategic and operational plans, funding applications, meeting minutes, and presentations, n ~76) were assembled into a text corpus and subjected to content analysis. Documents were hand-coded to examine statements regarding collaborative governance, the costs and benefits of HIE, and the goals of HIE promotion.

At the state level, semi-structured interviews were conducted with 23 individuals in Michigan engaged in HIE, including those working with the Statewide HIE network (Michigan Health Information Network, or MiHIN), the Michigan Department of Community Health (MDCH), sub-state HIOs, and local public health officers. After an initial stratified sample across these groups, further interviews were selected via a snowball sampling method to the point of saturation.

From mid-2005 onwards, multiple regional HIOs existed in Michigan, incentivized by a mixture of Federal, state, and system initiatives. Over time, several of these HIOs have created functional sub-state exchanges, while others failed to last beyond the pilot stage. Of those identified in 2006 as existing HIOs, only those that received government funding in 2007 and 2008 proved sustainable. Over time, we can see the regional model of HIE replaced by a state-wide model. Great Lakes HIE and Michigan Health Connect (both merged in 2014) are the two largest HIEs, covering a large proportion of the state.

An examination of the governance structures of these sub-state HIOs showed that rather than being dominated by a particular kind of health organization, frequently one or more local dominant health providers or large employers. One common factor among sub-state HIEs is low representation of both the public (patients) and governments representing the public interest. With a few exceptions, local health departments do not participate in sub-state HIEs in Michigan.