

HIT Standards Committee

Remarks from: Kim Davis-Allen, Director, Transformation Initiatives Division, Alabama Medicaid Agency

BACKGROUND:

The Alabama Medicaid Agency received a Medicaid Transformation Grant in 2006 in the amount of \$7.6 million dollars. With these monies, we began our Together For Quality Project which is comprised of three components: a chronic care management program; cross-Agency interoperability and an electronic health record. The health record, known as QTool, is a web-based tool that is overlaid with clinical alerts for certain diseases. The system is populated with both payor claims data and physician entered information. There is an e-Prescribing component based on Alabama's Preferred Drug List, prior authorization requirements and has systematic edits alerting physicians on quantity, refill and drug-drug interactions. The system also has push-pull capability with existing EMR systems so that the physician's day-to-day clinical system is augmented with additional information. The system is designed to give providers a level of information not currently available to them. It allows a provider to view a more complete picture of the patients' overall health status; use, and abuse, of the healthcare system; and past referral patterns. By combining both the Medicaid claims information and Blue Cross of Alabama claims information, patients moving in and out of payor systems are still represented.

The State is in the process of planning the transition of the current technical infrastructure and end-use application to the next level in the building a statewide health information exchange. The Medicaid Agency has been named as the State Designated Entity and as such, in a unique position to leverage the ONC vision for health information exchange and the CMS vision of providers adopting and meaningfully using health information technology.

ORAL REMARKS:

1. What is your role in supporting meaningful use (MU) and quality reporting?

As the State Medicaid Agency our role is to implement the payment incentive program and based on our previous experience we have a different perspective than most. Through the work made possible through the Medicaid Transformation Grant process, the Alabama Medicaid Agency has worked for the last two years trying to get providers to adopt electronic health records as well as the State's responsibilities in implementing such a program. Let me explain, though we have built a system that is web based - thereby not requiring any special equipment, and we combine payor information, and we have the ability to push that information into existing systems, and did I mention it is all provided at no-

cost to the provider - provider adoption has been minimal. The sad truth is only when we started tying an upfront payment to the use of the system, did we have more than a handful of providers actually using the system. Now we are at the crossroads where novelty becomes standard.

Before I talk more about the how of what we are going to do, I want to make the point, that States are not opposed to the health information technology vision. Standardization is not necessarily evil, it is a good thing that supports and allows innovation, but with standardization there is a need to have states at the table establishing the standards - not commenting on the standards, not responding to the standards, not just implementing the standards. Buy-in is easier and avoiding mistakes is definitely easier when you have state government at the design - not "adjusting" the design or adjusting to the design.

As the Agency designated to actually implement the incentive payment program, we realize that our work will begin with education. We must first help providers and our patients understand the why of health information technology. It is our responsibility to set the vision and outline the goals of what our State will realize through adoption and utilization of health information technology. We are approaching our responsibility seamlessly in coordinating the work of establishing a statewide information exchange as the primary mechanism by which providers can achieve meaningful use. We are educating our providers about the advantages that HIT will offer in terms of clinical decision support and patient knowledge. We are educating our patients that their participation in such an exchange will allow them to be treated appropriately regardless of the where, when and why of needing services. We are educating our public that health information technology will allow us to get a handle of out-of-control healthcare costs while actually increasing access and quality. Education is critical to our success.

The problem is that providers cannot get past the process of how all this will be done before they can begin to realize the value. The questions surrounding the meaning, timing and impact of meaningful use are foremost in provider minds. With so much still undecided, it is difficult to respond especially when so much of the undecided can make or break a provider's participation.

For a successful program we will have to appreciate what it really is that we are asking of the "eligible" provider. The transition to any form of electronic health care records is tremendous. The reality is that many providers do not think that the value of HIT will ever outweigh true cost of HIT. At this point, providers are confused in thinking that the "incentive payment" is actually the money to buy a system. Many understand that the incentive payment does not even begin to cover the cost of acquisition, implementation, training much less loss of productivity in daily operations. Many of our traditional Medicaid providers have not been trained to use

technology in documenting care for patients – they prefer the human approach – the human touch. So even if they understand the why – it is our responsibility to help them translate the why into practice. It will be necessary for the State to develop a comprehensive training program that accounts for the provider’s unique needs and can be tailored for that provider to achieve meaningful use. The support services through the Regional Extension Centers will be pivotal in helping providers overcome the hurdles that will be present. It will be necessary for all involved parties to work together to avoid duplication, confusion and non-achievement. But will it be enough. Are we equipped to provide the types of services that providers really need to make it all come together at the end of the day. In order for providers to participate, the “system” must also undergo some significant changes.

To begin the process of program implementation, the State will have to define program parameters that are transparent, accessible, understandable and straightforward. It is our intent that as many providers as possible will be able to participate in this program as quickly as possible. We are not rushing to be the first to have a system implemented; rather we intend to work thoughtfully so that our program meets provider expectations. Program design will start with a thorough understanding of the regulations. But there are critical decisions to be made that effect program parameters so where to start. We must not set ourselves up to fail and have to ask ourselves are the timeframes and expectations realistic. Much like the reality check with the eligible provider, is it realistic for states to have systems and processes implemented at a time when states are already struggling. The balance of setting the bar to low and setting it too high is totally understood by states. However, consideration must be given to state budget issues and even more importantly, state staff competency. HIT is new and much like providers who have not been educated and trained, the learning curve for states is fairly steep.

A new era for many states will be the consistent reporting of quality measures. What are we going to do with all this new information? How are we going to translate that data into public policy? How are we going to use that information to improve patient care? Don’t get me wrong, Alabama, along with many other states, are thrilled to have this information, we just need to be sure that we are not collecting data for data’s sake.

2. What resources, experience, expertise and innovative solutions do you have that could support both the public and private sectors?

There is not a “magic bullet” that states can use in helping providers achieve meaningful use. It will be critical that providers are involved in the decision making process and enter the playing field with a understanding of what it all means – of what is all expected. It is the State’s responsibility to give providers that knowledge.

The achievement of meaningful use will take State competency, State thoughtfulness in planning and execution, State willingness to be flexible and creative and finally a belief on the part of the State that the “why” of health information technology is the right thing to do. The right thing to do for the State, the provider, nationally, but most important it is the right thing to do for the patient. But it will also take a reality check to what can truly be achieved and what it will really all mean.