

Asian & Pacific Islander American Health Forum and the Association of
Asian Pacific Community Health Organizations

Testimony before the Meaningful Use Workgroup, HIT Policy Committee

“Using HIT to Eliminate Disparities: A Focus on Solutions.”

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Introduction

This testimony is presented on behalf of the Asian & Pacific Islander American Health Forum (APIAHF) and the Association of Asian Pacific Community Health Organizations (AAPCHO). APIAHF is a national organization that strives to influence policy, mobilize communities and strengthens programs and organizations to improve the health and well-being of Asian Americans, Native Hawaiians and Pacific Islanders (AAs and NHPIs). AAPCHO is a national association representing community health organizations dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans & Native Hawaiians and other Pacific Islanders within the United States, its territories, and freely associated states, primarily through its member community health centers.

APIAHF and AAPCHO join in this testimony to ensure as the nation moves forward in implementing Health Information Technology that AAs and NHPIs are fully participating and realizing the benefits that HIT promises in improving the quality of care and eliminating health disparities. Some of the health conditions that disproportionately affect AAs and NHPIs are: cancer, diabetes, domestic violence, hepatitis B, HIV/AIDS, and obesity. AAs and NHPIs experience higher incidence and death rates for certain cancers including lung, breast, cervical, liver, and stomach, yet the 2001 and 2006 Health Care Quality Surveys revealed that Asian Americans were significantly less likely to receive preventive services such as cancer screenings and cholesterol checks, or counseling about smoking cessation, diet, weight, exercise, and mental health.¹ Less than half of Asian Americans with chronic conditions received the care they needed to manage their conditions.²

Language access is a huge issue for AAs and NHPIs. 36% of AAs and 14% of NHPIs are limited English proficient, compared to 9% of the general populations.³ Asian Americans reported greater communication difficulties during their health care visits.⁴ They were also “the least likely to feel that their doctor understands their background and values, to have confidence in their doctor, and to be as involved in decision-making as they would like to be.”⁵ HIT has the potential to facilitate communication, but also has the potential to exacerbate these barriers if language needs are not addressed.

What do you see as the greatest risks posed by the implementation of HIT in relationship to potentially increasing disparities in health processes and outcomes?

As with any quality improvement activity, there is a danger of exacerbating disparities if attention is not specifically paid to disparities.^{6,7} The recently released Institute of Medicine report on improving the Agency for Healthcare Research and Quality annual

¹ K. Collins, D. Hughes, M. Doty, B. Ives, J. Edwards, and K. Tenney, “Diverse Communities, Common Concerns,” 2002. A Beal, M. Doty, S. Hernandez, K. Shea, and K. Davis, “Closing the Divide: How Medical Homes Promote Equity in Health Care,” (New York: The Commonwealth Fund, June 2007).

² Beal et al, “Closing the Divide,” 2007.

³ 2006 American Community Survey.

⁴ Collins et al, “Diverse Communities, Common Concerns,” 2002.

⁵ Collins et al, “Diverse Communities, Common Concerns,” 2002.

⁶ Chin MH and Chien AT. Reducing racial and ethnic disparities in health care: An integral part of quality improvement scholarship. *Quality and Safety in Health Care.* (2006); 15(2):79-80.

⁷ Fiscella K, et al. Inequality in quality: Addressing socioeconomic, racial and ethnic disparities in health care. *Journal of the American Medical Association.* (2000); 283(19):2579-2584.

national quality and disparities reports emphasized the importance of integrating disparities reduction in any broader quality improvement activities.⁸

What are you, or others with whom you work, doing (or planning to do) to reduce the risk of exacerbating disparities as HIT is implemented across the county?

The National HIT Collaborative for the Underserved as well as many other minority health and advocacy organizations, are working to highlight the importance of disparities issues in the implementation of HIT.

First, it is vital that there is targeted outreach, education and engagement of minority and safety net providers, especially through the regional extension centers. We commend the ONCHIT for prioritizing safety net hospitals, community clinics^{9,10} and small office practice^{11,12} providers for the technical assistance to be available from the regional extension centers.¹³ However, we urge that racial and ethnic minority physician practices which serve minority patients through Medicare and Medicaid also be explicitly prioritized.¹⁴ Many minority and other safety net providers do not have the office or organizational infrastructure to undertake HIT implementation without significant technical assistance.^{15,16}

Second, outreach, education and engagement of minority and underserved patients, health consumers and communities directly about the importance and imminent implementation of HIT is needed. HIT issues are extremely complex and there are always increased barriers to effective communication and public education based on literacy, Limited English Proficiency, general lack of access to government services and mistrust. For example, there is evidence that a digital divide persists among many racial and ethnic minority communities and access to and utilization of the internet cannot be assumed for minority and underserved populations, especially African Americans, Latinos, American Indians and those with Limited English Proficiency. However, there also is evidence that this digital divide may be closing, particularly for African Americans and Hispanics/Latinos, if wireless and mobile phone/device technologies are considered.¹⁷ Ethnic media also can be highly effective and cost-efficient partners in

⁸ Institute of Medicine. *Future Directions for the National Quality and Disparities Reports*. (2010).

⁹ Miller RH and West CE. The value of electronic health records in community health centers: Policy implications. *Health Affairs*. (2007); 26(1): 206-221.

¹⁰ Shields AE, et al. Adoption of health information technology in community health centers: Results of a national survey. *Health Affairs*. (2007); 26(5):1373-1383.

¹¹ Miller RH, et al. The value of electronic health records in solo or small group practices. *Health Affairs*. (2005); 24(5):1127-1137.

¹² Lee J, et al. The adoption gap: Health information technology in small physician practices. *Health Affairs*. (2005); 24(5):1364-1366. Miller RH and West CE. The value of electronic health records in community health centers: Policy implications. *Health Affairs*. (2007); 26(1): 206-221.

¹³ Grumbach K and Molds JW. Transforming primary care and community health: A health care cooperative extension service. *Journal of the American Medical Association*. (2009); 301(24):589-591.

¹⁴ Quality improvement in solo and small group practices: Strengthening the private practice safety-net. California Medical Association Foundation, (2008), accessed at:

<http://www.ethnicphysicians.org/projects/QISS%20Final%20Report%20020209.pdf>

¹⁵ Torda P, Han ES and Scholle SH. Easing the adoption and use of electronic health records in small practices. *Health Affairs*. 2010; 29(4):668-675.

¹⁶ Mostashari F, Kendall M and Tripathi M. A tale of two large community electronic health record extension projects. *Health Affairs*. (2009); 28(2):345-356.

¹⁷ Wireless internet access. Pew Research Center (2009), accessed at:

<http://www.pewinternet.org/~media/Files/Reports/2009/Wireless-Internet-Use.pdf>

public education, which can be delivered in multiple languages by trusted and credible sources.¹⁸

We are not aware of any specific plans or activities implemented by ONCHIT or HHS to conduct such public education activities. We respectfully request that such activities be conducted through existing, trusted networks among minority community-based grantees and contractors through HHS agencies such as the Office of Minority Health and the Bureau of Primary Health Care at the Health Resources and Services Administration. Specifically for our Asian American and Pacific Islander communities, we also encourage the ONCHIT to reach out and partner with the White House Initiative on Asian Americans and Pacific Islanders as the Initiative office conducts its own community outreach activities. The Initiative office can ensure effective dissemination to key community leaders and stakeholders.

Finally, it is crucial that the vendors and “suppliers” of health information technologies and services incorporate issues of disparities into their products and services. The most obvious example is the capacity to collect standardized, exchangeable data on race, ethnicity and language need. The Institute of Medicine Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement has provided detailed templates for how to categorize and code these data elements.¹⁹ Neither the ONCHIT nor CMS has explicitly adopted these IOM recommendations and we urge this Policy Committee to endorse them explicitly for adoption by ONCHIT and CMS.

There are many additional functionalities to address health disparities which HIT systems could facilitate. For example, all patient-facing materials, from health education materials to prescription medication instructions to hospital discharge instructions, could be made available at appropriate literacy levels and in translation according to identified patient language needs.

Finally, quality data can be stratified by race and ethnicity to identify potential health disparities. Targeted quality improvement interventions can then be implemented to reduce those disparities. There is an emerging body of evidence about effective interventions to reduce health disparities.^{20,21,22} While such evidence may not yet be robust enough to modify standard clinical guidances or create clinical decision supports for specific populations experiencing health disparities, the ability to aggregate and analyze a much higher volume of quality data through health information exchanges may lead to such evidence.²³

¹⁸ Bendixen and Associates. *Ethnic Media in America: The Giant Hidden in Plain Sight*. (2005) accessed at: <http://www.bendixenandassociates.com/studies/NCM%20Ethnic%20Media%20Final%20Report%202005.pdf>

¹⁹ Institute of Medicine. *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (2009).

²⁰ Chin MH, et al. Interventions to reduce racial and ethnic disparities in health care. *Medical Care Research and Review*. (2007); 64(5):7S-28S.

²¹ Chin MH, et al. Improving and sustaining diabetes care in community health centers with health disparities collaboratives. *Medical Care*. (2007); 45(12):1135-1143.

²² Landon BE, et al. Improving the management of chronic disease at community health centers. *New England Journal of Medicine*. (2007); 356(9):921-934.

²³ Fisher TL, et al. Cultural leverage: Interventions using culture to narrow racial disparities in health care. *Medical Care Research and Review*. (2007); 64(5):243S-282S.

What research is being done, or needs to be done, in this area to inform the HIT Policy Committee in trying to establish guidelines that will move providers to implement methods of using HIT to reduce disparities?

As often is unfortunately the case with minority health issues,²⁴ there are significant and urgent gaps in knowledge and experience in using HIT to reduce disparities. An informal effort to identify current examples among many of the leading health services researchers working on health disparities issues either all pointed to the same handful of examples (who are represented by the individuals testifying at this hearing) or described plans or intentions to implement HIT which would more directly address issues of disparities through collection and use of race, ethnicity and language need data; using data about patient language needs to schedule appointments with bilingual providers and/or health care interpreters; and providing patient education and other information in languages other than English.

From the perspective of the Asian American, Native Hawaiian and Pacific Islander communities, there are even greater gaps in research and knowledge. We urge this Policy Committee to continue to work to identify examples that are directly relevant to Asian Americans, Native Hawaiians and Pacific Islanders. For example, while language access issues are common to both Hispanic/Latinos and many Asian American ethnic groups, having HIT capacity to produce or translate document into Spanish but no other languages is simply not sufficient. In addition, the Institute of Medicine has recently reinforced the importance of collecting “granular ethnicity” data about Asian Americans, Native Hawaiians and Pacific Islanders, beyond the broad OMB categories of “Asian American” and “Native Hawaiian and Other Pacific Islander.”²⁵

With patient and family engagement in care at the forefront of our thinking about improving our Nation’s health, what particular strategies would you recommend to us as potential meaningful use requirements in 2013 and 2015 for the vulnerable populations we have asked you to address?

This Policy Committee already has identified many examples of how meaningful use of HIT might reduce health disparities. In its final proposed matrix for meaningful use issued last summer, which incorporated the quality improvement priorities of the National Priorities Partnership, this Policy Committee already identified the following Year Two and Year Three objectives and measures which might contribute to the identification and reduction of health disparities:

Engage patients and families

Year Two objectives

- Access for all patients to PHR populated in real time with patient health data
- Offer secure patient-provider messaging capability
- Provide access to patient-specific educational resources in common primary languages
- Record patient preferences (e.g., preferred communication media, advance directive, health care proxies, treatment options)
- Documentation of family medical history, in compliance with GINA

²⁴ Jacobs EA, et al. The need for more research on language barriers in health care: A proposed research agenda. *Milbank Quarterly*. 2006;84(1):111-133.

²⁵ Institute of Medicine, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* (2009).

Year Two measures

- % of patients with full access to PHR populated in real time with EHR data
- % patients with access to secure patient messaging
- % of educational content in common primary languages
- % of all patients with preferences recorded
- % of transitions where summary care record is shared

Year Three objectives

- Patients have access to self- management tool
- Electronic reporting on experience of care

Improve care coordination

Year Two objectives

- Retrieve and act on electronic prescription fill data
- Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge)

Year Two measures

- Access to comprehensive patient data from all available sources

Ensure adequate privacy and security protections for personal health information

Year Two objectives

- Use summarized or de-identified data when reporting data for population health purposes (e.g., public health quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk

Year Two measures

- Provide summarized or de-identified data when reporting data for population health purposes (e.g., public health quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk

Year Three objectives

- Provide patients, on request, an accounting of treatment, payment, and health care operations disclosures
- Protect sensitive health information to minimize reluctance of patient to seek care because of privacy concerns

Year Three measures

- Provide patients, on request, with a timely accounting of disclosures for treatment, payment, and health care operations, in compliance with applicable law
- Incorporate and utilize technology to segment sensitive data

Each of these potential objectives and measures have language access and cultural competency components which in turn will determine whether achieving these objectives and measures as part of meaningful use of HIT adequately addresses disparities. For example, all patient-facing materials need to be at appropriate literacy levels, in the patient's language and culturally appropriate. It is not meaningful use of HIT to provide a patient who does not read English a visit summary or hospital discharge instructions in English. HIT systems can facilitate the use of pre-translated documents and templates

which are more comprehensible and therefore more effective in communications with patients.

HIT-enabled messaging and communications with health care providers in languages other than English may pose additional technology challenges. However, the widespread use of the internet in languages other than English reflects the technical capacity to have effective communications in languages other than English through internet interfaces. Similarly, mobile phone devices used globally are able to use languages other than English for texting and other mobile communications. Innovation and partnership with communities of color – and with technology vendors and service providers in nations of origin for global technologies and applications – are required. Again, for many Asian American and some Pacific Islander communities, it is important that such language capacities do not start and stop with Spanish. This Policy Committee should examine closely the need for language capacities in languages other than English and Spanish and ensure that meaningful use objectives and measures address the language needs of multiple communities.

While it is important to maintain privacy and security for health information data, it is vital that race, ethnicity and language data be included in all health information exchanges and quality improvement analyses. While some of this data can be considered more appropriately at an aggregated level such as through a regional or statewide health information exchange, such data should not be lost or de-identified.

Finally, we urge that this Policy Committee consider the adoption of the following additional objectives and measures to specifically address health disparities:

Specific Recommendations on Meaningful Use Care Goals, Objectives and Measures for Year Two and Year Three

Improve Quality, Safety, Efficiency and Reduce Health Disparities

We recommend changing the word in this first Goal from “Reduce” to “Eliminate”, and set this as a policy goal.

We applaud the Year One requirement that certified EHRs 1) support recording of primary (or preferred) language, race and ethnicity in **both** inpatient and ambulatory settings and 2) be able to stratify reports by primary (or preferred) language, race and ethnicity. We recommend that this Year One requirement be explicitly included in the Year Two and Year Three Objectives and Measures, together with increased requirements to provide the data to patient registries and health information exchanges and use the data to improve quality outcomes.

A Year Two Objective should be: “Use stratified race, ethnicity, language and other demographic data to identify disparities.”

A Year Two Measure should be: “Implementation of a quality improvement action plan to reduce an identified disparity in quality outcomes.”

A Year Three Measure should be: “Implementation of a quality improvement action plan to reduce at least three identified disparities in quality outcomes.”

Engage Patient and Families

We recommend that the text of this Goal be modified as follows (bold is new text suggested): “Provide patients and families with timely access to data, knowledge and tools **that are delivered in a linguistically and culturally appropriate manner** to make informed decisions and to manage their health.”

A Year Two Objective should be: “Ensure that all patient-specific information are provided in a linguistically and culturally appropriate manner.”

A Year Two Measure should be: “% of patient-specific information which are provided in a linguistically and culturally appropriate manner, based on patient demographic data.”

A Year Two Objective should be: “Ensure that all patient-specific education resources are provided in a linguistically and culturally appropriate manner.”

A Year Two Measure should be: “% of patient-specific education resources which are provided in a linguistically and culturally appropriate manner, based on patient demographic data.”

A Year Two Objective should be: “Offer secure patient-provider messaging capability in multiple languages to meet patient communication needs.”

A Year Two Measure should be: “% of patients offered secure patient-provider messaging capability in multiple languages to meet patient communication needs.”

A Year Three Measure should be: “% of patients using secure patient-provider messaging capability in multiple languages, which meet patient communication needs.”

A Year Three Objective should be: “Patients have access to linguistically and culturally appropriate self-management tools.”

A Year Three Measure should be: “% of patients who use linguistically and culturally appropriate self-management tools.”

A Year Three Objective should be: “Patients report on their experience of care electronically in a linguistically and culturally appropriate manner.”

A Year Three Measure should be: “% of patients who report on their experience of care electronically in a linguistically and culturally appropriate manner.”

Improve Care Coordination

A Year Two Objective should be: “Ensure that all electronic prescription fill data includes patient language needs.”

A Year Two Measure should be: “% of electronic prescriptions include patient language needs.”

A Year Two Objective should be: “Ensure that all electronic summary care records are provided in a linguistically and culturally appropriate manner.”

A Year Two Measure should be: “% of electronic summary care records which are provided in a linguistically and culturally appropriate manner, based on patient demographic data.”

Improve Population and Public Health

A Year Two Objective should be: “Capability to submit data stratified by primary language, race and ethnicity to immunization registries and syndromic surveillance systems, consistent with applicable laws.”

A Year Two Measure should be: “% of reports submitted to immunization registries and syndromic surveillance systems stratified by primary language, race and ethnicity.”

Ensure Adequate Privacy and Security Protections

A Year Two Objective should be: “Ensure that communications with consumers and patients regarding the privacy of their health information and, particularly, the choices and decisions they need to make regarding consents, directives and authorizations are done in a manner that is culturally appropriate and meets their linguistic and literacy needs.”

A Year Two Measure should be: “% of consents, directives and authorizations which are provided in a linguistically and culturally appropriate manner, based on patient demographic data.”

How can the meaningful use of HIT specifically reduce a health disparity?

There are at least three ways in which meaningful use of HIT could reduce health disparities. The first way that meaningful use could reduce health disparities is related to ensuring effective access to and communication with health care providers, and specifically, language access. There is evidence that ensuring language concordance, either with a bilingual provider or with a trained health care interpreter, improves processes of care, patient (and provider) satisfaction and proximate health outcomes.^{26,27,28,29} Given the proposed Year One requirement that hospitals and eligible

²⁶ Flores G. The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review* (2005); 62(3):255-299.

²⁷ Karliner LS, et al. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research* (2007); 42(2):727-754.

providers document the primary language of 80% their unique patients, hospitals and eligible providers will have robust data about the language needs of their patients.³⁰ However, if this data is not used to match those patient language needs with competent bilingual clinicians and/or trained health care interpreters, then there is no meaningful use of that important health information recorded in the EMR/HIT.

Similarly, if the language need data and the EMR/HIT is not use to produce written patient-facing materials such as clinical summaries, discharge instructions and patient education materials in the primary language of the patient, then all these materials will not be accessible to patients whose primary language is not English. The CMS/ONCHIT regulations require such patient-facing materials to be made available in a “human readable format”. The meaningful use regulations should explicitly require that such patient-facing materials generated from the EMR/HIT be understandable by the patient, i.e. in that patient’s primary language. The advantage and efficiency of having standardized translations of such patient-facing materials means that such provider-patient communication is optimized.

In addition, if the language need data is not a required component of health information exchange, then effective care coordination is compromised. For example, if electronic prescribing is successfully completed without using the EMR/HIT to specifically alert the pharmacist that the patient has a language need, then the opportunities for the pharmacist to be prepared to provide medication counseling, or basic drug information, or even the prescription bottle/container label in the patient’s primary language are all missed and less likely to be done when the patient arrives to pick up the medication. Without the actual use – in this case, the exchange – of the vital health information such as the patient’s language need, then there is no meaningful use of the HIT. Finally, if the patient’s language need is not considered in analyses of process and health outcomes data (through stratification) for quality improvement, then disparities by language need will not be identified or addressed through interventions. The Standards for Multicultural Health Care recently issued by the National Committee for Quality Assurance specifically require such stratification in quality improvement activities.³¹

The second way that meaningful use could reduce health disparities is using HIT to support medical homes for minority and underserved populations.³²

And finally, a third way that meaningful use could reduce health disparities is to support disease registries and other targeted activities to identify and reduce specific disparities. The experience of community health centers participating in the national and regional collaboratives to reduce health disparities in diabetes care demonstrated statistically

²⁸ Green AR, et al. Interpreter services, language concordance, and health care quality: Experiences of Asian Americans with limited English proficiency. *Journal of General Internal Medicine* (2005); 20(11):1050-1056.

²⁹ Ngo-Metzger Q, et al. Providing high-quality care for limited English proficient patients: The importance of language concordance and interpreter use. *Journal of General Internal Medicine* (2007); 22(Suppl 2):324-330.

³⁰ A recent study reports that this 80% benchmark is achievable by primary care, medical specialty and surgical specialty physician practices which have implemented EMRs. Hogan SO and Kissam SM. Measuring meaningful use. *Health Affairs* (2010); 29(4):601-606.

³¹ National Committee for Quality Assurance. *Standards and Guidelines for Distinction in Multicultural Health Care* (2010), accessed at: <http://www.ncqa.org/tabid/1157/Default.aspx>

³² Beal AC, et al. *Closing the divide: How medical homes promote health equity in health care*, The Commonwealth Fund (2007).

significant quality improvements.^{16,17} There is a growing body of evidence to support specific interventions to reduce health disparities.¹⁵

What specific HIT applications have been used to address health literacy (panel 1), culture (panel 2), or access (panel 3)?

The Association of Asian Pacific Community Health Organizations (AAPCHO) is collaborating with member organizations AlohaCare and three Hawaii Federally Qualified Community Health Centers in a HRSA-funded grant to evaluate the impact of tracking enabling services, such as in-language health education, case-management, and financial eligibility assistance, on improving access and health outcomes for underserved populations, specifically Asian Americans, Native Hawaiians and other Pacific Islanders. The project involves collecting enabling services measures into an electronic health information exchange (HIE), developing reporting and decision-making tools to inform providers of patient needs to improve patient-centered care, evaluating the implementation of enabling services measures and reporting tools into the HIE system, and assessing the impact of enabling services on specific quality measures in the targeted population (diabetes HbA1c outcomes, emergency room utilization and hospitalization rates). The goal is to demonstrate how the addition of such enabling services data can make quality improvement initiatives more appropriate in the low income, limited English, low health literacy, and racial/ethnic medically underserved populations served by CHCs.

AlohaCare, in partnership with Hawaii's Community Health Centers, has launched several other innovative initiatives that draw on health information technology to improve our ability to meet the disparate needs of our members. One such initiative developed to improve our ability to identify patients' health care needs, implement effective interventions and better coordinate care with network providers, AlohaCare has developed an innovative health information technology solution called the Mercury Care Management System, currently in its second year of implementation.

The Mercury system systematically mines data, including member demographic information (race/ethnicity, age, gender, language, & education), health risk assessment data, administrative (claims) data, including diagnoses and prescription drugs, and lab results. The system categorizes members for specific interventions which include member education to improve compliance with age- and condition-specific preventive screening and diagnostic services and identification of members for case management services. For example, Mercury identifies EPSDT-age members who may not have received age-appropriate well-child visits or women of appropriate age categories without evidence of pap and mammogram screenings, or diabetic members without recent claims history of HbA1c labs and other tests. Mercury prompts the mailing of in-language educational materials and letters or telephonic member outreach to remind members of appropriate preventive health screenings in the absence of claims data for such services. Utilizing a set of "triggers" based on a member's response to a health screening survey or claims data, members with potential complex conditions are prioritized for care management assessment.

The next developmental step for Mercury is the creation of the "Individual Care Management" (ICM) module which will serve as the repository of member care plans and consolidate other member health management information in one application. The

care plans will be based on and ensure the consistent application of best clinical practices and protocols.

Please share any relevant evidence on your topic.

Please see attached summaries of findings from the above discussed research.

See citations above.

ATTACHMENT

Pacific Innovation Collaborative (PIC) Pacific Health Technology Innovation Project. AAPCHO began its Pacific Innovation Collaborative project in 2007 with nine health centers, two Medicaid managed care health plans in Hawaii and Washington states, and PTSO of Washington. Funded by HRSA OHIT, the project established a clinical data repository shared by all partners. The goals of this project are to align the participants' quality improvement efforts with the development of performance-based measurement as outlined by the federal Centers for Medicare & Medicaid Services. This project includes key demographic data including race and ethnicity and clinical performance measurements including rates of uncontrolled diabetes, childhood immunizations, well child visits, emergency room utilization, access to primary care, and early notification of pregnancy to health care plans. Overall, the health information exchange provides a reliable source of data from which to make performance-based measurements in order to evaluate quality improvement efforts within the current project and contribute to better health outcomes and reduced disparities for underserved patients. Quality improvement data from this project indicate that PIC Network members involved in the proposed project have improved in performance measures from 2007 to 2008 (See **Table 1** below). We have submitted a grant to HRSA OHIT to expand on our existing PIC collaborative to integrate culturally and linguistically appropriate enabling services measures into our PIC electronic data warehouse to better assess their impact on the clinical outcome measures shared in our data repository.

Table 1. Pacific Innovation Collaborative Quality Improvement Data from 2007-2008*

MEASURE	2007			2008		
	Num	Den	%	Num	Den	%
1. Patients with either Type 1 or Type 2 Diabetes whose HBA1c is > 9	115	349	32.95%	100	317	31.55%
2. Patients < 7 yo who had a primary care visit within the last 12 months	1640	1935	84.75%	2797	3052	91.64%
3. Patients seen in ER with low complexity problems	1633	6969	23.43%	1165	8131	14.33%
4a. Patients with well child visits in first 15 months	575	727	79.09%	607	758	80.08%
4b. Patients with well child visits at 3-6 years	639	1247	51.24%	685	1192	57.47%
4c. Patients with well child visits at 12-21 years	540	1912	28.24%	638	2150	29.67%

*Data from sample of PIC CHCs

The **Enabling Services Accountability Project** involves collaboration between the Association of Asian Pacific Community Health Organizations (AAPCHO) and four of its member clinics. The purpose of the project is to build on AAPCHO's enabling services data collection model to improve Electronic Medical Record (EMR) data collection on enabling services and to describe the impact of the services on health care access and outcomes. Enabling services are supportive services, including interpretation, eligibility assistance and health education, provided to health center patients that promote, support, and assist in the delivery of health care and facilitate access to quality patient care. The services are essential for reducing health disparities and improving health outcomes, especially for medically underserved AAPIs that are economically disadvantaged and Limited English Proficient (LEP). Overall, the project aims to facilitate electronic data collection, reports, and analyses of enabling services, and use the information to demonstrate the important role that enabling services plays in increasing access and quality of health care for medically underserved communities of color, and provide compelling data to adequately compensate health centers for delivering these services.

EMR data on enabling services from the four health centers participating in the project demonstrated that health center ES users had better immunization rates and better outcomes for diabetes compared to those health center patients that did not use ES. ⁱ (Figures 1 and 2) Although enabling services used by these health centers varied by individual health center, as an aggregate, the most common were financial counseling/eligibility assistance and interpretation. A separate study looked at one category of enabling services – health education, and found that average HbA1c level significantly improved for active health education users than non-active users one year after baseline, indicating that utilization of enabling services is associated with improved diabetes outcomes. ⁱⁱ (Figure 3).

Figure 1: Impact of Enabling Service Utilization on HbA1c

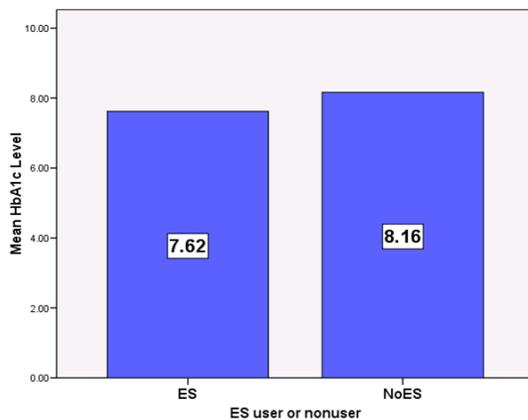
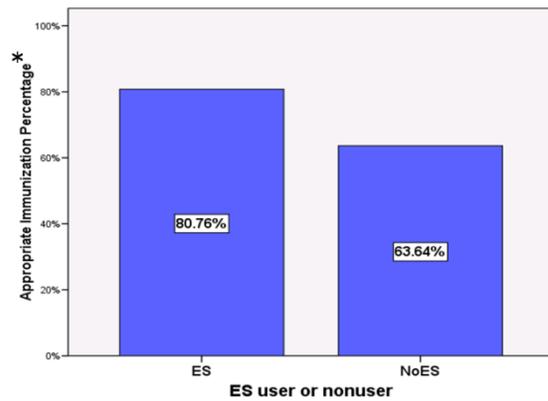
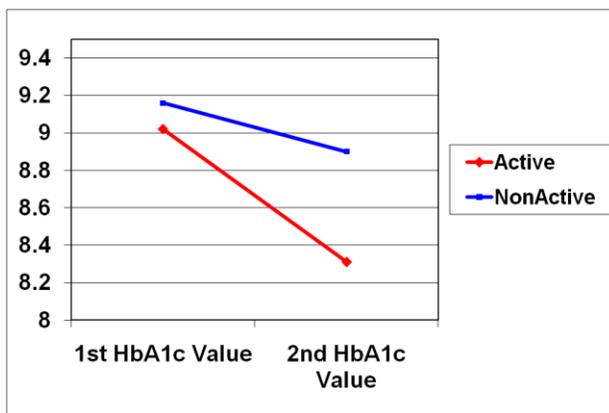


Figure 2: Impact of Enabling Service Utilization on Immunization



* Percentage of children by 2 years of age with appropriate immunizations (4XDTP/DTaP, 3xIPV, 1xMMR, 3xHib, 3xHepB)

Figure 3: Mean HbA1c Values by Active and Non-Active Enabling Service Users



ⁱ Association of Asian Pacific Community Health Organizations. Fact Sheet: Impact of Enabling Services Utilization on Health Outcomes. 2009. <http://enablingservices.aapcho.org/>

ⁱⁱ Association of Asian Pacific Community Health Organizations. Fact Sheet: Evaluation of Culturally Appropriate Community Health Education on Diabetes Outcomes. 2008. <http://enablingservices.aapcho.org/>