



Improving the Quality of Care through Health Information Technology The Role of the State Chronic Disease Prevention Programs

Introduction: Beginning in November 2010, a Community of Practice (CoP) consisting of NACDD members met monthly to learn more about the role of the states in improving health care quality, specifically exploring how health information technology can play a role in these efforts. The following document summarizes their discussions, and provides links to resources and tools they found or created. This document was updated in August 2011.

Members: The CoP members were mainly drawn from the CVH Council, representing each of its committees. The CDC Division for Heart Disease and Stroke Prevention was also represented.

Janice Gray	AK	Barb Pryor	OH
Melody Gwilliam	WV	Stan Shanedling	MN
Daniel Kim	VA	Lynette Shaw	IL
Patricia McManus	AR	Ann Lutz	CDC
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Definitions: Health Information Technology (HIT) is a new field so it's important for state chronic disease program staff to know and understand some of the common terminology:

- **Health Information Technology (HIT)** - makes it possible for health care providers to better manage patient care through secure use and sharing of health information. Health IT includes the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information.
- **Meaningful Use** - describes the use of health information technology (HIT) that leads to improvements in healthcare and furthers the goals of information exchange among health care professionals.
- **Patient-Centered Medical Home** - the patient's personal, comprehensive, long-term relationship with a primary care physician and a philosophy of care focused on preventing illness and helping patients take an active role in promoting their own good health.

Guest Expert – The CoP invited Bill Brand, MPH, CPHIE, Director of Programs, Public Health Informatics Institute, to their May 2011 meeting. After a lively discussion, Bill made these recommendations:

- Get involved with what's going on in your state around HIT; learn about the Health Information Exchanges, the Regional Extension Centers and the HIT Coordinator who is responsible for setting policies around HIT. Stay connected. *(Find the link to your state HIT plan here: <http://statehieresources.org/state-plans/>. This should take you to the organization in your state that is funded to create the Health Information Exchange. From there, you can get on the mailing list and join a workgroup.)*

- Try to join a federal health advisory workgroup. *(These can be found here: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_federal_advisory_committees_%28facas%29/1149. At present there are no openings.)*
- When proposed rules for Meaningful Use and other HIT-related regulations are released, generate a volume of comments from NACDD, states, and local health departments to push for a role for public health. *(News, events and resources are on this page: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_news%2C_events_resources/1320. Calls for comments should appear here when available.)*
- Partner with Medicaid programs and others in your state collecting quality measures, including payers. They have experience with much of this and are already involved. Use the power of PH as a neutral convener. *(State HIT contacts are here: <http://statehierresources.org/contacts/>. These are the folks setting up Health Information Exchanges in each state.)*
- Look at your state data sharing laws so you know which data you will be able to access once it's available, and which you won't. *(Each state will need to find these but you can get some general information and ask for assistance from the Public Health Law Network: <http://www.publichealthlawnetwork.org/about-the-network/health-information-data-sharing-2/>.)*
- One goal for electronic health records is to establish decision supports using expert rules or guidelines, to trigger alerts or reminders. Public health now has the opportunity to be part of the design of these systems – which guidelines are being used, when they are used, etc. Decisions are being made by payers, including Medicaid, by clinics, and other health systems and they move into Meaningful Use.
- The PH Informatics conference in late August, sponsored by CDC should have a chronic disease presence. *(Information and registration: <http://www.cdc.gov/phiconference/index.html>.)*

Information Gathering: CoP members learned more about several considerations that impact on electronic health records:

- **Meaningful Use** - members reviewed several resources describing Meaningful Use:
 - [Overview](#)
 - [FAQ](#)
 - [Fact Sheet for Physicians](#)
 - [Explanation](#)
 - What is "[Meaningful Use](#)"
 - What are the [Criteria for Meaningful Use](#)
 - [How do I Meet Meaningful Use Requirements](#)
 - What are the requirements for [Stage 1 of Meaningful Use \(2011 and 2012\)](#)
 - What are "[Clinical Quality Measures](#)"
 - What can I Learn from [Meaningful Use Objectives Specification Sheets](#)
 - [Downloads, related links](#)
- **Patient-Centered Medical Home** - the patient's personal, comprehensive, long-term relationship with a primary care physician and a philosophy of care focused on preventing illness and helping patients take an active role in promoting their own good health.
 - [Overview](#) from the Prevention Institute
 - [State Initiatives](#)
 - [Definition and Characteristics](#) from Ohio
 - [State of the Science](#) from the federal Agency for Healthcare Research and Quality
 - [Activity in Alaska](#)
- **Health Information Technology (HIT):**

- Office of the National Coordinator for HIT - http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204
- [Beacon Community Program](#) - The Beacon Community Cooperative Agreement Program provides funding to 17 selected communities throughout the United States that have already made inroads in the development of secure, private, and accurate systems of electronic health record (EHR) adoption and health information exchange. The Beacon Program will support these communities to build and strengthen their health information technology (health IT) infrastructure and exchange capabilities to improve care coordination, increase the quality of care, and slow the growth of health care spending.
- Public Health Informatics Institute - <http://www.phii.org/>
- **Additional Resources** – The Group looked at several other resources that may be of interest to states.
 - From CMS – [Health Homes for Medicaid Enrollees](#)
 - [iHealthBeat - Reporting Technology's Impact on Health Care](#) – a service of the California Health Care Foundation.
 - [How Medical Homes Can Advance Health Equity](#)

Networking and Sharing: Each participant shared information about work currently going on in his/her state:

- **Arkansas:** Electronic health records (EHRs) are a specific requirement for physician practices and clinics that want to take part in the collaborative training the state CD programs offer. Learn more about the collaborative here: <http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx>
HITArkansas, a division of the Arkansas Foundation for Medical Care (AFMC), is the federally designated Health Information Technology Regional Extension Center (HITREC) for the state of Arkansas. HITArkansas is part of a new effort by the federal government to increase the use of health information technology nationwide by offering guidance, technical assistance and financial incentives to health care providers who want to make the transition to electronic health records. www.hitarkansas.com
- **Alaska:** has state statute on use of electronic health records (EHR) and has developed “E-Health Network.” There are two state-sponsored vendors which makes it easier for providers to find software and preferred pricing. The network has a website with a regular newsletter to keep providers informed. <http://www.ak-ehealth.com/>
- **Illinois:** is looking at the medical home program although this is not in HDSP; the chronic disease programs are just starting to get connected and are looking at data they collected. They put out quarterly educational materials to providers which chronic disease programs might find useful. Some IL hospitals moving to EHR but not many; not many CHC’s have started this technology either.
- **Kansas:** The HDSP and DPCP programs work together on a quality of care program with 90 clinics, 20 of which collect hypertension and cholesterol information. They use the CDEMS software and have about 12,000 patients registered. They are adapting the software to include measurements for blood pressure, cholesterol, BMI, waist circumference. They will measure, collect the data and produce reports that show the percent changed. The state programs provide funding to clinics that participate and fund a contractor for technical support. You can find a report about the program [here](#).
- **Kentucky:** The CVH Program joined the Diabetes Program to conduct an annual refresher learning session on the Chronic Care model as well as informal sharing by learning teams.

- **Minnesota:** The state has a legislative mandate that all hospitals and clinics be using electronic health records by 2014. The chronic disease unit is providing technical assistance to hospitals and clinics; most are using EPIC software. Once they have 100% compliance, they will add the registry function of the software to track key indicators. The HDSP program is also using its optional funding in the second year of a project with a major health plan in the state – working to improve quality and prevent a second cardiac event, and therefore prevent costly readmissions to the hospital. A key attribute of the project is helping patients adhere to medication and to recommended lifestyle changes. Electronic health records are a major component of the project, connecting cardiologists to primary care providers and even to other ancillary providers where possible, such as pharmacists or social workers. They have had positive initial findings, and hope to spread the program via the Council of Health Plans.
- **Missouri:** The HDSP Program partners with the Diabetes program and Primary Care Association to sponsor learning sessions, professional education and continuing medical education courses on primary and secondary prevention of heart disease and stroke.
- **Nebraska:** The Registry Partnership has implemented a chronic disease registry in fifteen rural health clinics since 2007.
- **New York:** State Primary Care Association (CHCANYS) will identify Community Health Centers to work on hypertension control using the collaborative model. Physician adherence is just one of the issues that CHC's will be asked to address. They are currently refining the process and CHC's are being asked to select three domains of the Chronic Care Model (CCM) to address. They are also working to tighten the data gathering process. Currently they are working with 5 CHC's in a total of 20 locations. They just received their second monthly report which includes the number of patients in the population of focus (patients with hypertension, age 18 and over), percentage of patients with 2 readings on 2 separate occasions in 6 months, percentage of patients with self-management goal, percentage of patients with blood pressure under control. There are also optional measures; and each CHC chooses one. For example, the number of providers that use the JNC classifications or the percentage of patients with follow-up on self management.
- **Ohio:** They are conducting a pilot project on patient centered medical home; this is being done at a higher level than HDSP. Another group, the Ohio Information Partnership has set the standard for vendor certification which was released in September 2010 with 5 preferred vendors; most are smaller systems. Providers receive incentives if they use one of the preferred vendors. Ohio has initiated a Community College consortium and money is allocated for training to install and provide technical assistance. Ohio has also completed a project with physicians and African American men. The men were interviewed to learn their beliefs on how to manage their hypertension; providers were also interviewed for their perceptions. The report on this project is published on the OH website. They are now expanding the project to include cholesterol and aspirin therapy. The Ohio Health Care Quality Consortium has slowed down due to new administration change.
<http://www.hccqc.ohio.gov/Pages/MedicalHomesTaskForce.aspx>
<http://www.ohionline.org/Pages/Home.aspx>
<http://www.odh.ohio.gov/odhPrograms/hprp/cardio/prioritypopulations.aspx>
- **Oklahoma:** In 2008, they began working with Primary Care Centers, providing bridging software to help Centers connect their existing electronic medical records system to CDEMS, avoiding double data entry, to allow for the collection of data in a format compatible with other CHC's. Laboratory interface was included. The Centers were very receptive and were eager to receive the technical assistance from the WVU Office of Health Services Research which we provided for them. This project was funded via optional funding which is no longer available so they only received data from

the clinics once. Oklahoma DHSP program along with the State QIO provided training on the Chronic Care model to 15 private primary care practices.

- **Rhode Island:** Cardiovascular Chronic Care Collaborative - The purpose is to improve management of high blood pressure and cholesterol in FQHCs. A quality improvement team works with CHCs to promote the adoption and use of practice guidelines.
- **Virginia:** 1.) Contracted with Community Care Network (data management firm) for development of a “smart form” to determine if patients are being treated to guidelines for blood pressure, cholesterol, diabetes and tobacco use. 2.) Working on blood pressure measurement standardization, working to get providers to adhere to guidelines. They have not been successful with physicians but have had the curriculum included at two technical schools who train technicians to take BP. 3.) Hired an HIT analyst for the CD programs who will help in the “smart form” development and use.
- **Washington:** The State Patient-Centered Medical Home Collaborative – The State chronic disease programs, the WA Chapter of the AAFP, and the Primary Care Association have engaged 33 practices in a two year collaborative that ends September 2011. Outcomes include improvements in control of high blood pressure, cholesterol, A1c and smoking cessation counseling. Washington State is also taking lessons learned from this collaborative and beginning another project in a community health system to improve compliance with the JNC7 guidelines.
- **West Virginia:** piloting use of a patient electronic registry in three primary care centers, to learn about management of blood pressure and cholesterol – whether patients are being correctly diagnosed and treated. This project is in its early stages, recruiting clinics. They will partner with the WV Office of Health Services, who will gather the data from the clinics. Once a baseline is established, the HDSP program will provide training to all clinics, using a curriculum based on one used in VA.