NMA Statement to the Subcommittee on Government Management, Organization and Procurement

Committee on Oversight and Government Reform

U.S. House of Representatives

Statement

of the

National Medical Association

to the

Subcommittee on Government Management, Organization and Procurement

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RE: Vulnerable Populations/Vulnerable Physicians & Health Information Technology:

Are they at the Crossroads of a Healthcare Evolution or in Someone's Crosshairs During a Healthcare Revolution

Presented by Winston Price, MD, FAAP, FACPE

November 1, 2007

I want to thank you on behalf of the physicians in the National Medical Association (NMA), the Georgia Health Information Technology & Transparency Board and the millions of minority citizens impacted by the changing landscape as a result of HIT initiatives. I appreciate the opportunity to testify before you today regarding HIT as this technology has so much potential to improve healthcare and reduce health disparities yet like nuclear energy if not properly harnessed could bring devastating harm to many people in its path./ I would especially like to express our thanks to Representatives Henry Waxman (D-CA) & Edolphus Towns (D-NY) for their continued leadership on this issue.

I am Dr. Winston Price, a board certified pediatrician working in both NY and Georgia. I am a past president of the National Medical Association and current chair of the Georgia Health Information Technology & Transparency Board. Regarding Georgia I will reference factual information on current HIT initiatives and its demographic statistics but the recommendations and conclusions are in regards to the NMA and vulnerable populations in general. Mr. Chair, as you are aware, Health Information Technology holds the promise toward maximizing efficiency, reducing medical errors, facilitating consumer involvement in healthcare decisions and assuring adequate disaster readiness for all Americans. But for many physicians and for a significant number of US citizens the hope of participating in this rapid change in healthcare delivery will escape them due to a mal-distribution of fiscal, administrative and technical resources in America pertaining to HIT. In order to
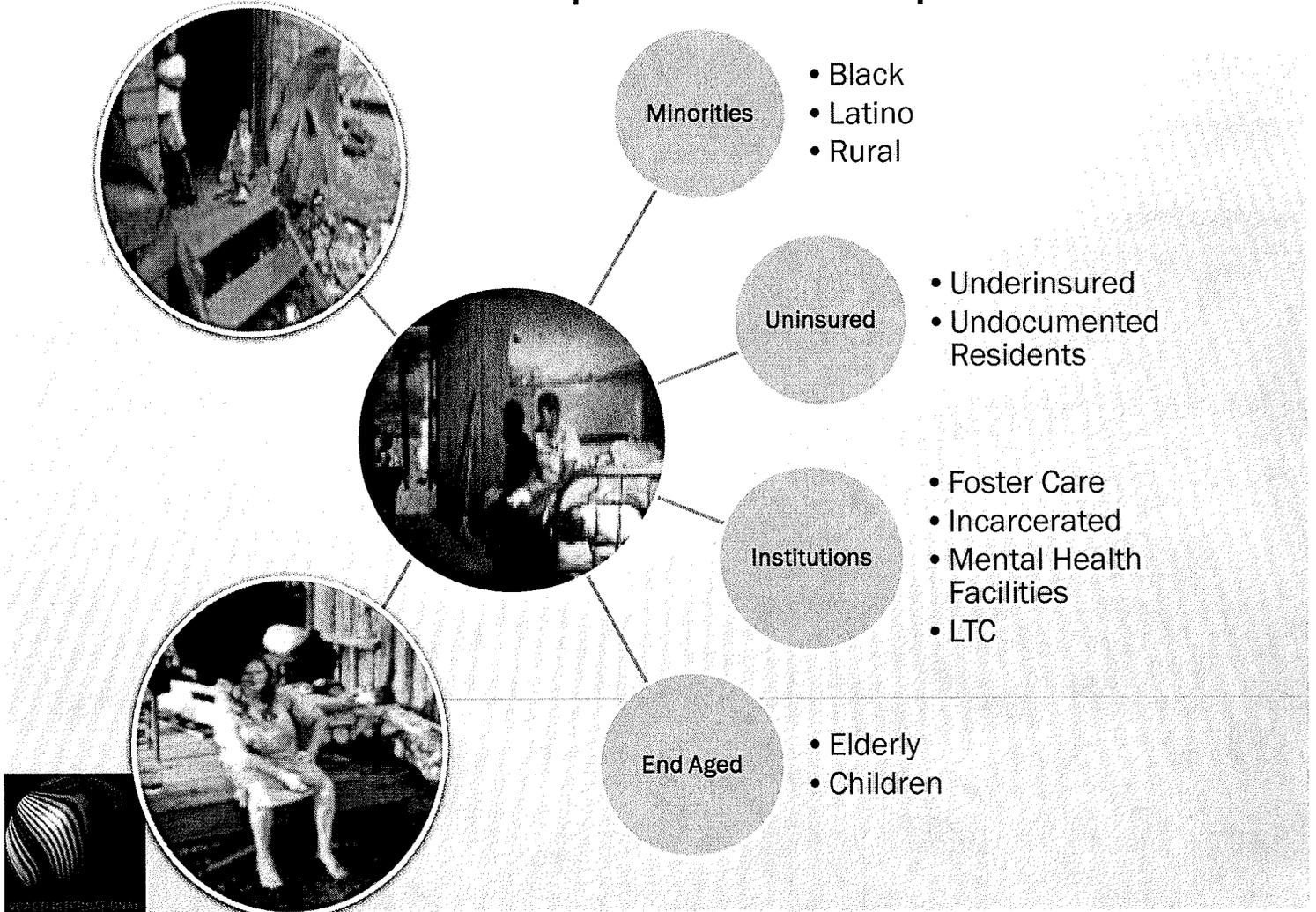
allow certain at risk communities to participate in the HIT evolution on par with more affluent areas of our nation there needs to be additional resources available to prevent the growing "digital divide" in HIT.

OVERVIEW

In order for HIT initiatives to serve as a key benefit for both the minority community and the healthcare professionals serving them they must assure that they can effectively accumulate data, share appropriate data and analyze that data. More importantly they must be able to create the protocols that determine what critical data must be assessed where none exists currently on the healthcare experience of Black consumers, Black health professionals and the healthcare industry in general for vulnerable populations. These key data points and their significance can impact on the critical indicators of health outcomes that potentially help better define the "Best Practices" toward improving the health of Black America. With the ability to obtain, analyze, share & coordinate this valuable information we can move ever closer toward understanding & eliminating the causes of health disparities.

The programs and strategies aimed at the elimination of health disparities must be soundly guided by real time evidence and this evidence must also include the intended population that it is trying to serve. A major deficiency in a vast portion of the currently available datasets used to create clinical guidelines and reimbursement methodologies is that it under-represents the Black population and other at risk communities in quantity and geographic mix. These datasets also poorly define many socioeconomic and lifestyle factors that affects the outcomes on health for these communities. As such we must take a *hard drive* at including the vulnerable, at-risk populations (VARP) in the HIT funding and implementation strategies. These VARP include, but are not limited to, minorities, the uninsured, the institutionalized, the rural communities, and the extreme aged (both young and old). The experience of minority physicians and other professionals caring for this population are largely under documented.

A Hard Drive for Special Needs Populations

Minorities
- Black
- Latino
- Rural

Uninsured
- Underinsured
- Undocumented Residents

Institutions
- Foster Care
- Incarcerated
- Mental Health Facilities
- LTC

End Aged
- Elderly
- Children

The predictive modeling schema that results from data-mining of experiential information is a growing area in many other industries and has helped to expedite many companies level of efficiency while reducing waste and errors. In order for America's HIT initiatives to fully benefit from this burgeoning and revolutionary aspect of data analysis, toward eliminating health disparities, it must develop and implement a sound HIT strategy for those communities and affected professionals specifically. In other words, it must use the right data to get the critical answers for at-risk communities to improve their outcomes as well. The HIT programs aimed at achieving that goal must also be appropriately funded and structured for long term success.

P4P Quality Initiatives May Worsen Health for At-Risk Populations

o   Pay-for-Performance (P4P) Task Force of the NMA
•   While many facets of determining the ROI that HIT could bring toward improving the state of health for Blacks center on cost reduction and increased efficiency much of the current debate and agendas focuses on the impact of P4P initiatives. These initiatives, while well intended under the guise of improving quality, aim to position themselves in such a way as to re-define methodologies for physician reimbursement. The importance to the NMA in this matter is to assure that P4P (or so-called "playing for dollars") does not worsen the status of health for Black America. The NMA Task Force on P4P has been creating greater awareness by educating our members, the healthcare regulators, the healthcare payors, the legislature and the community at large as to the potential negative aspects of P4P. The NMA White Paper on P4P addresses the potential bias, even if unintended, that many P4P schema place on minority physicians and those health professionals caring for these at-risk communities.

•   In any case, practice-based HIT is no longer just a strong recommendation because in this P4P scenario it becomes a key survival tool. It will be required and one of the driving factors will be the increasing presence of P4P payment schema. The NMA will need to be at the forefront of not only the P4P debate but supportive of the implementation of HIT for its member physicians. The reasons, as mentioned, are both qualitative toward improving outcomes and quantitative toward its economic impact on the cost of doing business and compensation. Consumer pressure will also be a driving force too as nearly three out of four Americans believe strongly that electronic medical records can make the difference between life and death in emergencies. Many HIT-related programs are being used to improve quality of care and reduce costs, with some states targeting specific aspects of care such as the overuse of emergency department services, reducing medication errors and assuring consumers have personalized health records (PHR) The later component of HIT assists consumers in having personal information to use with health transparency data to make informed decisions about selecting healthcare services. It also provides transportable health information as part of a sound disaster readiness program.

• As P4P becomes a more prevalent reality in the course of business for today's physician, he or she must face the daunting pressure to add health information technology (HIT) in the practice. These waves of change swell as a physician is challenged with declining revenue, increasing malpractice liabilities and a more demanding patient population. These changes are of particular concern to the physicians represented by the NMA and those caring for at-risk populations. It appears that P4P, as currently implemented, may further reduce the disproportionate reimbursements for NMA physicians due to a more economically-challenged and disease-intensive patient population. With their revenue streams already becoming more restrictive, our colleagues must also now bear the expense of integrating HIT solutions into their practice.

•   As consumers, physicians have already been challenged at home with trying to maintain secure computers, networking their households, and integrating internet-based communications into their lives. The challenge has been significant, enough so, that many still have not advanced beyond basic word-processing and email, even though those costs are moderate and with little risk. Now, they are expected to do the same with their offices at great cost and even greater risk with failure threatening their livelihood. Such hesitation among many of our physicians and local health systems is with merit. During previous years, the push for "technology" in physician's offices resulted in quickly out-dated hardware, incompatible systems, and programs ill-suited for practice management that drained more resources than "enhanced" physician practices anticipated. In fact, a 2005 study conducted by the Medical Group Management Association, found that little more than 10 percent of the nation's physicians had adopted electronic medical

technology. In larger hospitals, only about 35 percent of doctors have adopted the technology. Current movement forward in many sectors has remained slow and plodding because of, among other reasons, lack of technological standards, implementation costs, support resources and legal hurdles.

- Currently however, as a move to increase the adoption of HIT in physician practices, regulations have been relaxed to enable hospitals to donate technology to community physicians, and Congress passed legislation to make permanent a federal office that promotes health IT. Besides the qualitative reasons mentioned earlier for NMA members to begin adopting HIT, there are some economic reasons. First, government and industry feels this move is so important that they are willing to offer financial carrots. For the first time the Centers for Medicare & Medicaid Services (CMS) has announced grants providing states with $150 million in 2007 and 2008 to increase quality and efficiency of patient care through HIT. In addition, California has committed $240 million towards HIT and New York's commitment totaled $105 million in Phase 1 with an additional $350 million in Phase 3 of their initiative. Many other states have or are considering similar proposals. NMA is developing strategies to work with its members so that they to may benefit from such "largesse" during this window of opportunity.

- Although grants and government support along with the aura of improved quality of care are adequate reasons to move physician practices towards HIT-based solutions, the ultimate driving factor for many physicians still will be P4P or similar quality improvement program (QIP)activities. As noted in Healthcare Financial Management (Freeman, 2005) P4P programs are largely responsible for the success of the Nationwide Health Information Network (NHIN) and Regional Health Information Organizations (RHIO); two entities that are tasked by the federal government to oversee HIT. Many P4P programs require that physicians submit clinical data so it can be determined if they achieved the program's outcome targets. Some P4P programs also offer incentives when physicians use an EHR. Physicians who participate in a P4P program without an EHR must manually extract the required clinical data for reporting which is time consuming, staff intensive and costly. They also do not benefit from the automatically generated alerts and reminders, so called, decision support tools, that help them achieve their quality targets. P4P may well be the currently single biggest motivator driving physicians to adopting an EHR.

- This certainly impacts NMA physicians even more because more than half of the states were operating Medicaid pay-for-performance programs in the middle of 2006 and nearly all will have them within five years, according to a new study. This is a population that we disproportionately treat in our patient mix. Furthermore Brian Robinson, states in GovernmentHealthIT http://govhealthit.com/article98211-04-12-07-Web that more than 70 percent of the planned new programs will start within the next two years. Most of these will shift in emphasis from managed or primary care to environments that stress chronic-disease management. This will happen even while primary care remains the focus of most Medicaid pay-for-performance programs, the study states.

- Furthermore a study published by the Commonwealth Fund (by Kathryn Kuhmerker, a former director of Medicaid in New York state, and Thomas Hartman, vice president for health care quality improvement for IPRO, a health care quality assessment and improvement organization) state that HIT will be a focus for many of these programs. They added that several programs opted for a paying-for-participation approach rather than just for performance, in an effort to encourage providers to adopt electronic health records, electronic prescribing and other technologies. In addition, HIT "also has the potential to reduce data collection costs in [pay-for-performance]

programs, which should allow [pay-for-performance] programs to expand into less-traditional venues," they said.

- Another example is the Silicon Valley Pay-for-Performance Consortium, a collaborative effort started by Cisco®, Intel Corporation and Oracle along with several large California physician organizations (IPOs) to accelerate the use of technology for quality health care.

- Through this consortium, after receiving NCQA PPC recognition, consortium members qualified to earn financial rewards for instituting new health information technology systems designed to improve the patient experience and outcomes. Utilizing nationally recognized quality of care standards helped ensure all seven POs were in alignment, and also helped them qualify for other Pay-for- Performance programs.

- NMA must not only work to make P4P an equitable and well-developed program that meets the needs of its members and patient population, it must also be at the forefront of educating and implementing health information technology among its physicians. Currently there is an inadequate environment willing to offset the costs, a burden that unduly falls on our members. The implementation of and effective reimbursement from P4P programs may however demand the presence of an EHR. Without such efforts to facilitate acquisition, implementation and maintenance of an EHR, not only could NMA physicians be at risk of reduction in reimbursements from P4P in of itself, but also by the mere fact of not having the tools in place to institute P4P. As time progresses HIT will also be used not only to measure "quantity of care" but also to define "quality" of care and thus slow adopters, the physicians in poor communities, may be further handicapped. He or she may neither have the "evidence" of the level of care that is being provided to their patients but may see their patient base eroded as consumers move increasingly to a data-driven and technology-based health delivery environment.

## AT-RISK POPULATIONS and HEALTH DISPARITIES

Even a cursory comparison of black and white populations shows that these groups bring substantially different health profiles to the clinical encounter. Significant racial disparities exist in health status, health system quality and access, healthcare utilization and patient compliance

Black Americans lead the nation in 12 of the top 15 leading causes of death, including heart disease, cancer, diabetes, and kidney disease. Racial disparities in health status persist across the entire human lifespan. At the start of life: Black infant mortality is two and a half times higher than that of white babies. And at the end of life: White men outlive black men by 7 years; and white women outlive black women by a half-decade.

When you quantify the human toll of health disparities, the results paint a clear and troubling picture. Depending on which causes of mortality you include in the equation, there are 85,000 to 130,000 excess deaths among blacks each year. The term "excess deaths" refers to the number of deaths that would not have occurred if blacks shared the same mortality rate as whites.

Although there has been an appreciable decline in infant mortality for both races, the racial gap remains striking, and the gap is actually widening. In fact, the racial gap in infant mortality was wider in 2000 than it was a half-century earlier in 1950.

Infant Mortality Rates, 1950-2000
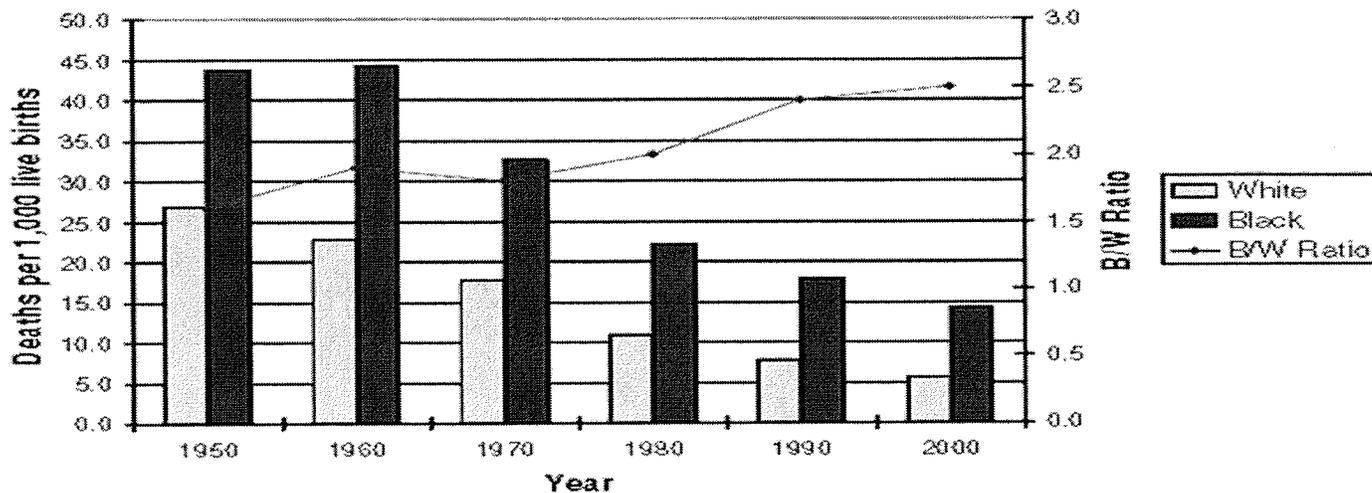
Williams, DR. 2003. Racial/Ethnic Disparities in Health.
http://www.macses.ucsf.edu/News/willams.pdf. Accessed March 29, 2006

When we look at mortality for "all causes," here again, we see the distinctive health status gap between whites and blacks. As with infant mortality disparities, we see the overall widening effect. And here again, the racial gap in overall mortality was higher in 2000 than it was in 1950.

Mortality Rates All Causes by Race, 1950c-2000
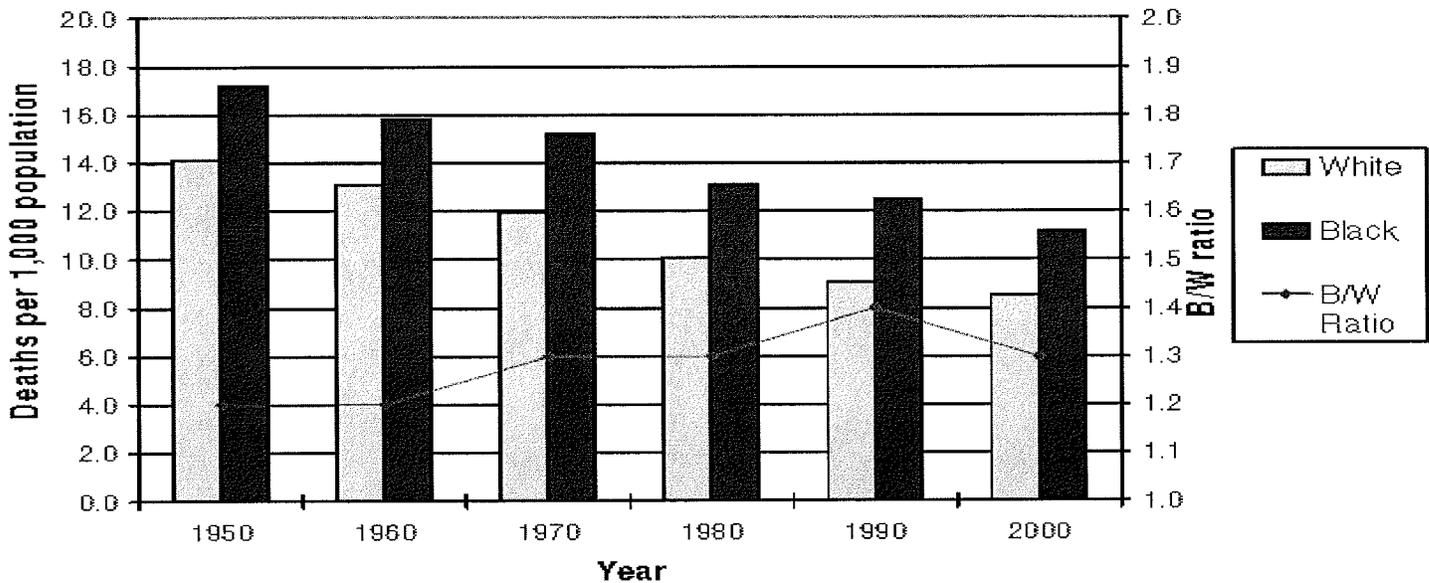
Williams, DR. 2003. Racial/Ethnic Disparities in Health.
http://www.macses.ucsf.edu/News/williams.pdf. Accessed March 29, 2006

When minorities do have healthcare coverage, there are still deep disparities in healthcare delivery which results in worse health and higher morbidity for minority patients. In March 2002, a 15-member committee from the Institute of Medicine (IOM) released its 600-page report titled, "Unequal Treatment." The committee's 18-month investigation found that racial disparity in healthcare was "remarkably consistent" across a 10-year corpus of literature. This pattern occurred in every investigated disease area, including cardiovascular disease, HIV, diabetes, and end stage renal disease. And the pattern persisted even after researchers took into account such factors as insurance, disease severity, and compliance with doctor's treatment plan. The IOM committee showed that these inequities result in significantly higher death rates for minority patients. Lastly, there are racial and ethnic disparities in healthcare utilization and medical compliance. Racial and ethnic minorities are more likely to avoid or delay seeking care. And they are less likely to comply with medical care.

These patterns also result in poorer health status, including greater mortality. Racial and ethnic disparities exist in:

> ➢ health status
> ➢ healthcare quality
> ➢ healthcare access (insurance)
> ➢ healthcare utilization & compliance

- We must also take into account physician practice patterns and patient perceptions of physician care.
- First, minority doctors are more likely to serve minority populations. This means that minority doctors are more likely to have the disparate population profile described earlier.
- Second, patients prefer physicians who share their racial or ethnic background.
- Patients tend to rate their physicians' communication style higher in race-concordant relationships.
- And minority patients report higher levels of healthcare satisfaction when receiving care from minority physicians.
- These patterns paint a clear picture about the uniquely beneficial clinical encounter between minority patients and providers.
- This is why the IOM committee that reported on health disparities in 2002, and the Sullivan Commission that examined healthcare diversity in 2004, both called for an <u>increase</u> in the proportion of minority healthcare providers.
- This all means that policy initiatives, like some P4P programs and ill-planned HIT mandates may threaten the viability of minority and rural providers. These measures are counterintuitive to improving minority health and must be approached with caution.
- And when you take these two scenarios together—poorer health status among minority patients, and the uniquely beneficial role of minority providers—you have a bigger picture that evokes a new set of questions:

  - How will Pay-for-Performance affect physician practice patterns as they relate to sicker minority groups?
  - Given the sicker caseload of minority doctors, how will Pay-for-Performance affect the viability of these physicians? And how will it affect the movement toward greater—not less—diversity in the healthcare workforce?
  - What are the implications of all of this for minority access and quality of care?
  - And ultimately, will Pay-for-Performance help or hurt the national effort to eradicate health disparities?
  - The data are not in, and ultimately the success or failure of Pay-for-Performance must be evidence-based.
  - But the concept's efficacy depends on the quality of the evidence by which performance benchmarks are determined.
  - If minority populations are not appropriately factored into the data collection and analyses processes, then the resultant standards will <u>not</u> reflect the actual clinical characteristics of minority patient populations.
  - And if physician practice patterns are not comprehensively factored into the equation, then the resultant standards pose potential danger to healthcare access and care for minority patients.

- The NMA is closely tracking this issue and it is our belief that any quality improvement/performance measurement system must be <u>patient-focused</u>.
- It must have <u>realistic performance standards</u> that reflect population profiles.
- And it must recognize <u>physician practice patterns</u> and the potential impact of policy on diversity and the viability of minority physicians.

POTENTIAL IMPACT OF P4P ON VULNERABLE POPULATIONS

- False quality measures could cause patients to go against their usual and customary choice of physician;

- Patients could face increased costs by potentially having to pay more to see their choice of physician;

- Physicians could be forced into more preventive care;

- Patients could be denied access to vital pharmaceuticals and other therapies on the basis of their assessed value to the P4P system;

- Physicians who serve sicker patients are less likely to report quality improvements that lead to increased rewards, and would therefore be less enthusiastic to work in underserved communities.

POTENTIAL IMPACT OF P4P ON MINORITY PHYSICIANS

- P4P will negatively impact the revenue stream of physicians that are already compensated the least for the populations they serve;

- Patients will get a false sense that they are getting poor quality care based on erroneous measures, thus undermining the doctor-patient relationship;

- P4P could have a deleterious effect on African American economics, given that Black physicians' economic well-being is a useful marker for economic solvency in the Black community;

- P4P could potentially lead to the practice of "cookbook" medicine, where compliance-driven physicians learn to 'check boxes' but jettison the 'art' of medicine;

- The physician/patient relationship could fall prey to the patients' geographic location and/or the patient pool of which they are a part.

NMA SOLUTIONS CONCERNS:

The 'evidence base' by which performance is measured should be compiled across diverse populations; Clinical data are probably more reliable predictors of quality improvement than are claims data; 'Bad' outcome does not equal 'bad' doctor and culturally competent providers should be included in the design and implementation of all P4P frameworks. Also P4P frameworks and the SGR cannot coexist [SGR, the Sustainable Growth Rate, is the current mechanism for reimbursement of physicians who serve the Medicare population]; Therefore, P4P reporting requirements should remain voluntary at this stage; Health information technology (HIT) is vital to the long-term viability of P4P – therefore, a financial commitment at the national level is *sine qua non to* insuring that solo and small-practice providers are able to install the necessary HIT infrastructure.

Mr. Chair, as a case in point, let me share with you one example of how funding at the federal level can miss maximizing adoption of HIT in vulnerable populations. The proposed legislation HR 3963 was introduces as part of the supplemental SCHIP funding. This bi-partisan bill shows the laudable efforts and sensitivity of the federal government to allocate funding for HIT programs but the structure of the bill recommends $225 million for quality improvement initiatives but only $5 million for demonstration projects, aimed at EHR pilots that would encourage the use of technology in the care of children. The problem that potentially exists in this bill is that many minority and rural physicians would not qualify or compete favorably for the larger granting offer. These physicians and their communities need HIT implementation, HIT training and HIT support funding to assist them in EHR, e–prescribing , health information exchange and transparency website adoption.

This strategy to facilitate and provide economic support to small, rural and vulnerable physician groups is consistent with Goal 1 of CCHIT's strategic plan namely:

- **Goal 1: Inform Clinical Practice**

> Strategy 1. Incentivize EHR adoption
> Strategy 2. Reduce risk of EHR investment through standardization
> Strategy 3. Promote EHR diffusion in rural and underserved areas

We must therefore continue to be vigilant in breaking down the barriers to adoption of HIT which have been steady for the period from 2002-2006. These barriers according to the Medical Record Institute's (MRI) *Eighth Annual Survey of EHR Trends and Usage* in 2006 were as follows:

> **Lack of adequate funding or resources** **55.5%**

> **Lack of support by medical staff** **31.7%**

> **Inability to find an EHR solution or** **29.4%**
> **components at an affordable cost**

> **Difficulty in evaluating EHR solutions or** **23.6%**
> **components**

> **Unable to find an EHR solution that meets** **23.6%**
> **our application or technical requirements**

> **Difficulty in finding an EHR solution that is** **23.2%**
> **not fragmented among vendors or IT platforms**

> **Difficulty in creating a migration plan from** **22.9%**
> **paper to electronic health records**

> **Difficulty in building a strong business case (ROI)** **21.0%**

THE GEORGIA EXPERIENCE: ONE STATE ON THE MOVE

The goal of the Georgia Department of Community Health, under the leadership of Commissioner Rhonda Medows, is threefold.

1- To assure **Access** to affordable, quality health care in its communities.

2- To promote **Healthy** behaviors and improved health outcomes.

3- To assure **Responsible** health planning and use of health care resources.

Georgia's population in 2006 was 9,146,732 with 1,986,700 of those residents enrolled in Medicaid at a cost of $6,840,869,446 billion. The alarming reality in the state's demographics pattern is that 1,676,990 of those residents are identified as Poor i.e.-Below Federal Poverty Level (FPL) and the citizens categorized as Near-Poor i.e.-100-199% of the FPL consisted of another 1,640,766 people living in the state. The breakdown of the Georgia population for individuals living in poverty is summarized below and figure 1.

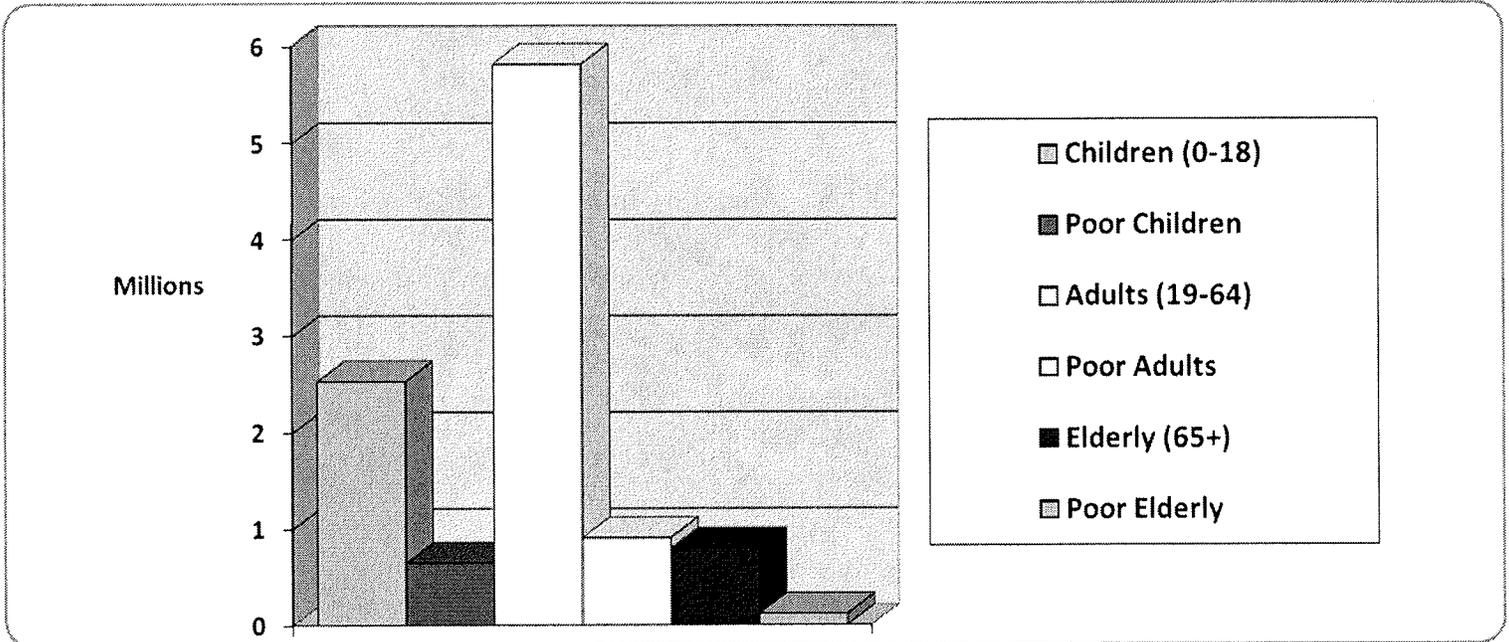| Children (0-18) | 2,530,127 | 28 % of total residents |
Poor Children	648,692	26 % of total children
Adults (19-64)	5,818,229	64 % of total residents
Poor Adults	910,359	16 % of total adults
Elderly (65+)	798,376	9 % of total residents
Poor Elderly	117,938	15 % of total elderly

Figure 3

Distribution by Race/Ethnicity
White   5,375,708 59 % of total residents
Black   2,679,383 29 % of total residents
Hispanic   759,498 8 % of total residents
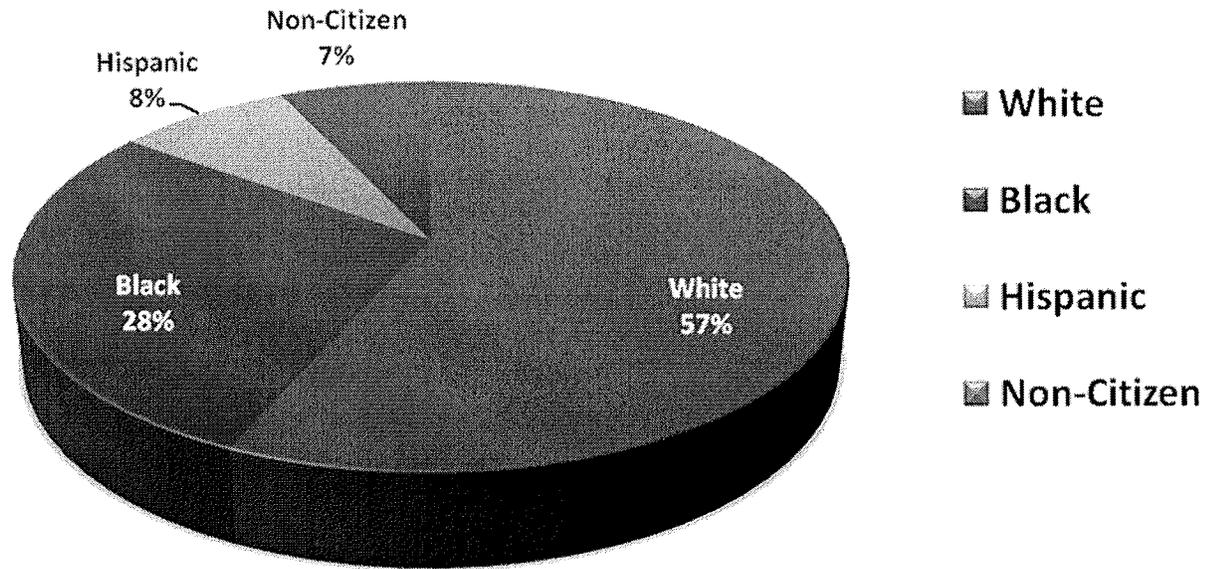Non-Citizen   664,618 7 % of total residents

Population by Race

Hispanic
8%

Non-Citizen
7%

Black
28%

White
57%

- White
- Black
- Hispanic
- Non-Citizen

Figure 4

Health Insurance Coverage of the Nonelderly, 2005-2006

Medicaid   1,109,064 Children 745,084 Adults   363,980

Uninsured 1,644,815 Children 313,465 Adults 1,331,350

MEDICAID ENROLLMENT
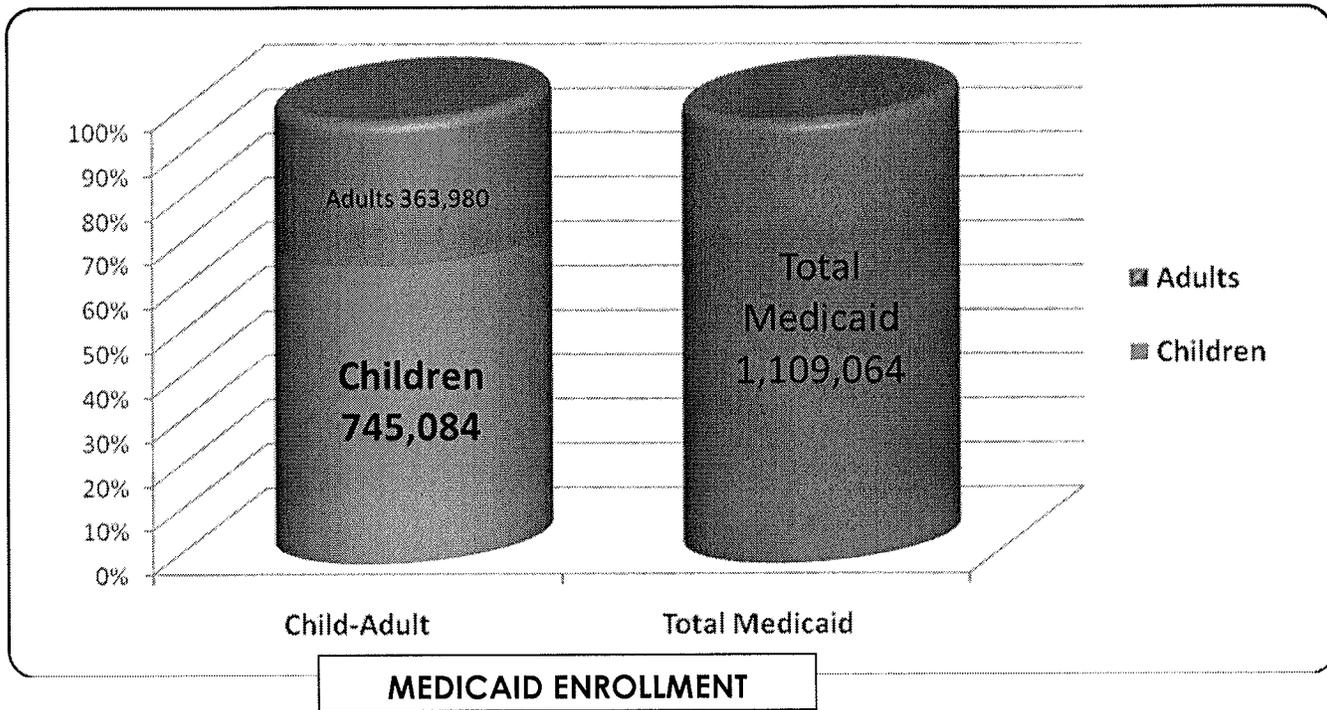
Figure 5

Poor: Below Federal Poverty Level (FPL) 572,812   35   % of uninsured

Near-Poor: 100-199% of the FPL 489,712   30   % of uninsured
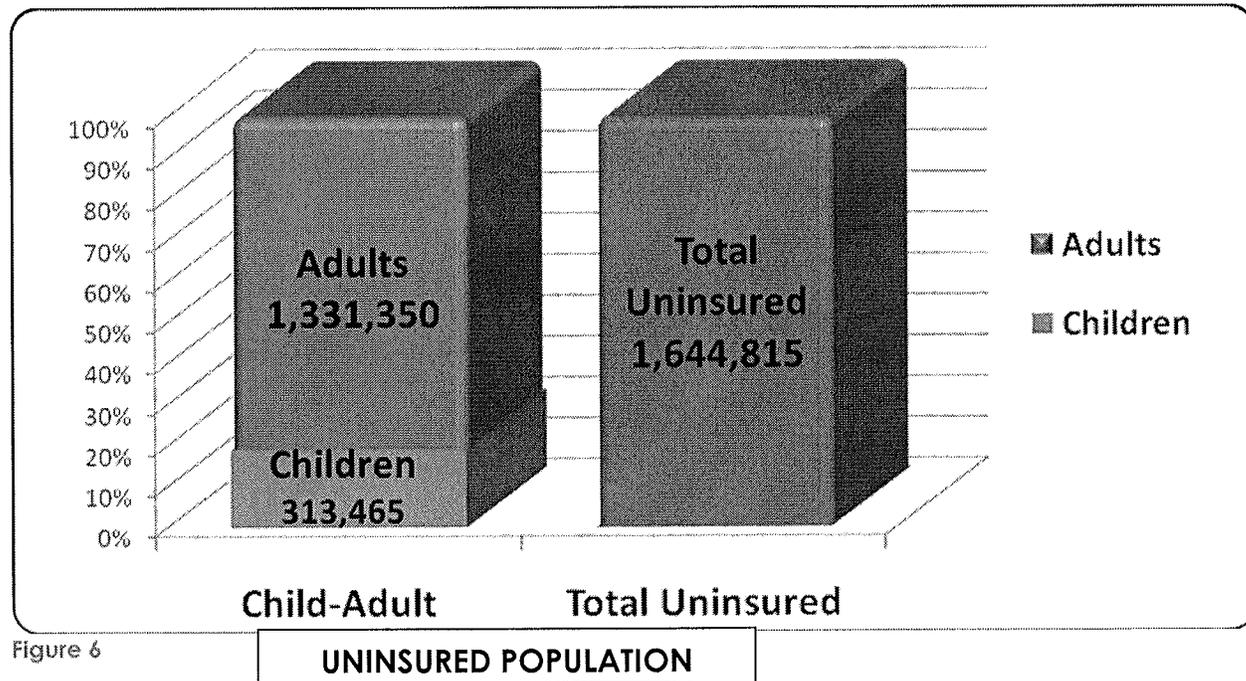

UNINSURED POPULATION
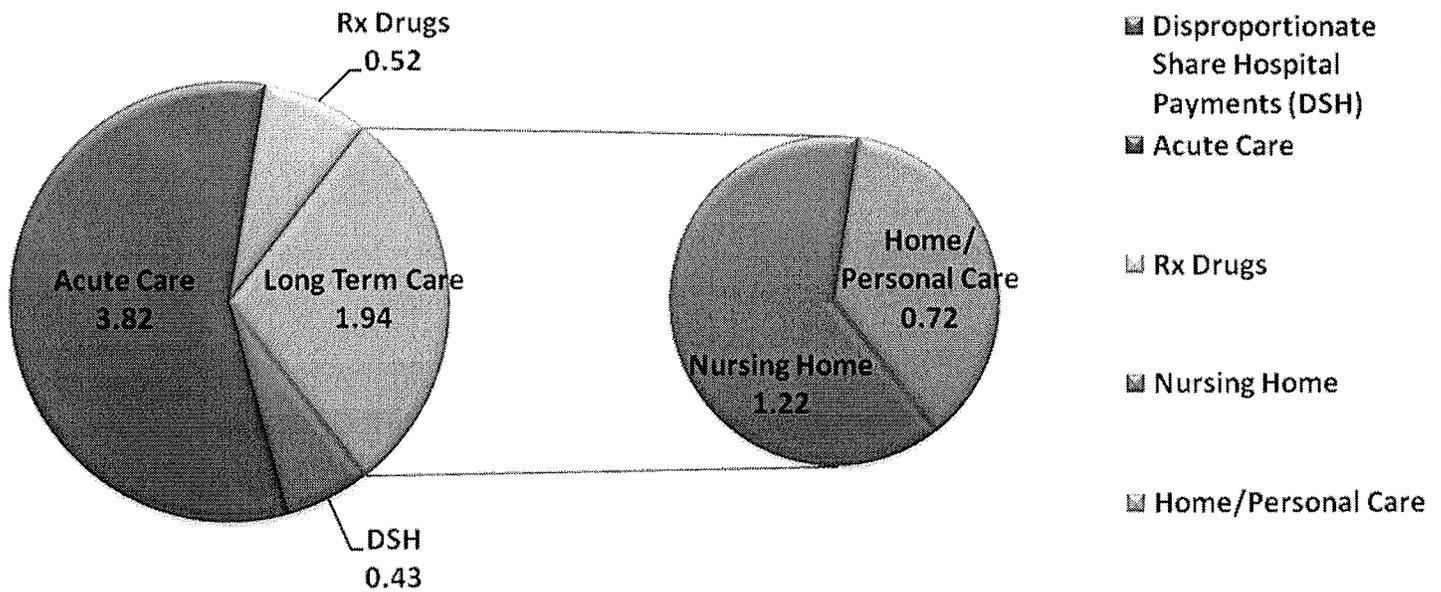
Figure 6

MEDICAID EXPENDITURE COST (Billions)

Figure 7

Medicaid Expenditures
Total Medicaid Spending, FY2006 $6,840,869,446 Billion Including DSH

Disproportionate Share Hospital Payments (DSH) accounted for $424,627,514 million or 6.2 % of total spending;
Acute Care costs were $4,343,902,324 billion or 63.5 % of total spending of which
Rx Drugs costs carved some $522,087,319 million or 12.0 % of the acute care spending.

In the current graying of America Georgia has its share of responsibilities and therefore liabilities which incurred for Long Term Care (LTC)expenditures a staggering $2,072,339,608 billion which represented a full 30.3 % of total spending. The bulk of this expense was spread across nursing home care totaling some $1,223,538,302 billion or 59.0 % of LTC spending and another $718,957,094 million for home/personal care which made up 34.7 % of LTC spending. (Fig. 7, 8)
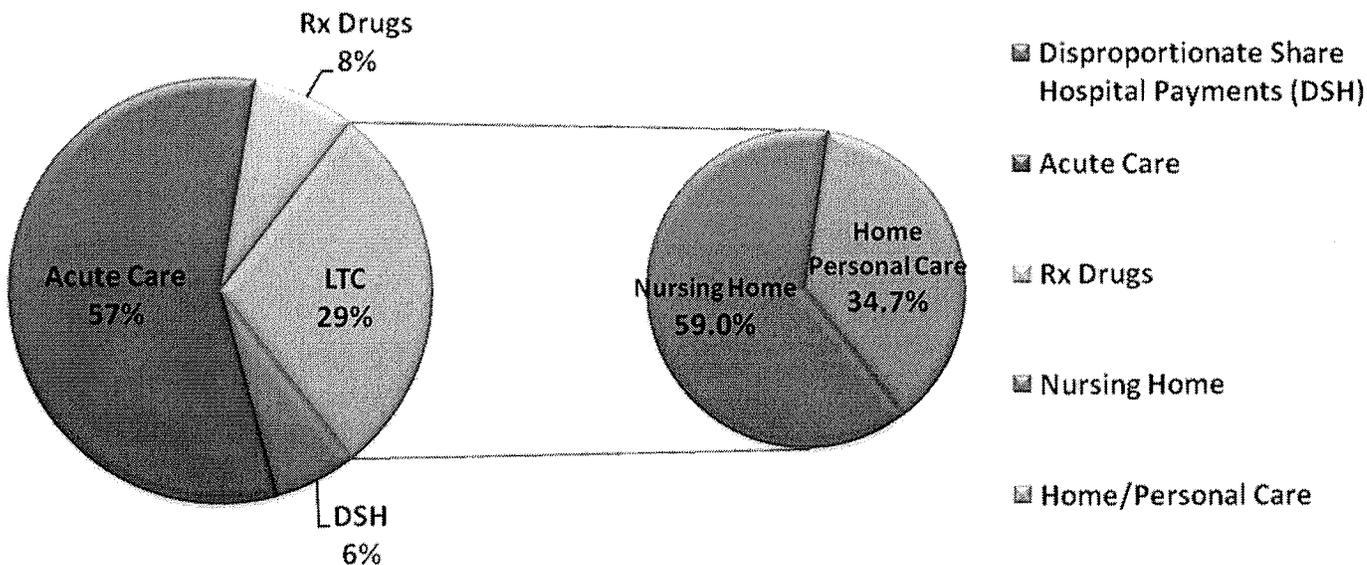
MEDICAID EXPENDITURE DISTRIBUTION

Figure 8

- Georgia is one of the many states that make up the so called "stroke belt" in the Southeast, and as such it experiences some of the Nation's worse indicators of poor health outcomes. These fall into the categories of disproportionate incidence of obesity, diabetes, hypertension, CVD, infant mortality, cancer and HIV /AIDS. Minority, indigent, rural and uninsured populations tend to compose a large segment of those affected by these maladies. A significant proportion of these conditions and chronic diseases could be avoided, eliminated or better managed with improved preventive health screening, more effective disease management and more efficient use of resources to help in consumer education which facilitates them making better informed health decisions. So Georgia has a lot to gain in terms of improving efficiency, reducing medical errors and giving consumers better access to healthcare information to assist in those informed medical decisions.

- To that end, on October 17, 2006, Governor Sonny Perdue issued an executive order creating the Health Information Technology and Transparency (HITT) Advisory Board. The Board advises DCH on the best practices for encouraging the use of electronic health records and establishing a statewide strategy to enable health information to be readily available and transparent. DCH goals for HIT in Georgia are to enable the understandable, universal, timely and secure communication of health information across the public and private sectors for the benefit of today's health care consumer. Better coordinated care means:

- Improve health care quality and safety
- Increase clinical and administrative efficiency
- Improve detection of natural and man-made population threats

- Enable research
- Provide cost savings

The two initiatives of the HIT Board are outlined below:
Health Information Technology & Transparency Advisory Board

Health Information Exchange

Goal:

- Facilitate the implementation of health information exchange statewide

Deliverable(s):

1. Create a state matching fund pilot program to promote health information exchange: Plan for 2-3 pilot sites.

   o   a. Matching grant funding to support partnerships between groups of providers and/or payors, local communities – both public and private sector entities

2. Serve as a source of state and federal regulatory information regarding health information exchange, privacy and security issues, etc

Resources:

1. HITT Advisory Council – HIE Committee

2. DCH Designated Staff (IT Division)

3. Dedicated Project Manager

4. Ad hoc members as requested

Health Care Transparency Web Site

Goal:
- Develop a consumer focused Web site that provides to consumers health care quality and cost information.

Deliverables:

1. Develop and implement the transparency Web site

   a. Obtain consumer input, (direct input, focus groups, etc). Create a site that is consumer focused and consumer friendly

   b. Base the Web site info on current and accurate data that is kept updated on a timely basis:

   c. Data sources: Data maintained by DCH, other state agencies, and stakeholder organizations, as well as data information provided by health care providers and insurers

   d. Build/buy the web platform needed to support the Web site

   e. Procure the Web site creation, programming, and maintenance services needed: (RFI for information, RFP for procurement)

Resources

1. HITT Advisory Council – Transparency Committee

2. DCH Designated Staff (Health Planning Unit with IT support)

3. Dedicated Project Manager

4. Ad hoc members as requested

Since the HITT Board's inception they have initiated a $1 Million demonstration pilot project for the State of Georgia, funded by the state budget, as part of the Health Information Exchange initiative. They also recently were awarded a $3.9 Million grant from CMS for the development of its Health Care Transparency Web Site initiative for the state of Georgia.

In addition Georgia operates The **Georgia Health Partnership** (GHP) which is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other providers easy, secure and efficient access to health care information. The new system began operating April 1, 2003 for the Medicaid and PeachCare for Kids programs. This portal allows Medicaid health care providers to electronically submit claims to the MMIS System. The Georgia Health Partnership has improved turn-around times for claims, eligibility verification, and enrollment requests for Medicaid. The MMIS system also interfaces with the Georgia Department of Human Resources by sharing data collected for the Georgia Registry for Immunization Transactions and Services (GRITS). With adequate federal support this invaluable system can be expanded to serve a larger population in Georgia as well as enhanced to provide even more functionality.

The goals of the portal site are simple:

- Increase access to health care information for members
- Reduce paperwork and increase efficiency for providers and administrators
- Improve services for people served by Medicaid and the state's health plans

This electronic environment will allow administrators to easily manage data and improve turnaround times for claims payments, eligibility verifications and enrollment requests. The new system will improve the department's ability to develop disease management programs, identify emerging trends, and determine policies about treatment and prescription coverage.

The **DCH Initiatives** for HITT over the next two years are outlined below and they are laudable goals but they must be supported by a significant federal fiscal commitment to assure its timely success for what has been described to you as a very vulnerable community:

FY 2007	FY 2008
• **Medicaid Transformation**	• **Medicaid Transformation** • **Financial Integrity**
• **Integrity of our Programs & Safety Net**	• **Health Improvement** • **Solutions for the Uninsured**
• **Consumerism**	• **Medicaid Program Integrity** • **Workforce Development**
• **Health Improvement & Resolving Disparities**	• **PeachCare for Kids™ Program Stability**

	• SHBP Evolution
• **Uninsured: Community Solutions**	• **Consumer Service and Communication**
	• **Health Care Consumerism**

Overview

President George W. Bush launched an initiative in 2004 to reform health care through the improved adoption of health information technology and empowerment of consumers through information. In support of President Bush's initiative, Governor Sonny Perdue issued two Executive Orders relating to Health Information Technology and Transparency (HITT):

1. Signed in October 2006, the first created the HITT Advisory Board to facilitate and encourage the use of electronic health records and to establish a statewide health information exchange strategy and to promote marketplace transparency
2. The second, signed in February 2007, encouraged marketplace transparency by providing cost and quality data to consumers, and application of industry best practices that facilitate the use of electronic health records

The Board members, which are representative of various heaviders and businesses, will advise the Georgia Department of Community Health (DCH) in applying industry best practices for facilitating and encouraging the use of electronic health records and establishing a statewide strategy that will enable health information to be available across the full continuum of care.

The Vision

Health information technology promises to help transform health care in Georgia by lowering costs, reducing medical errors and improving quality of care. Georgia providers will have access to the clinical information they need to make informed decisions about patient care when and where they need it. Georgia citizens will have access to the information they need to make decisions about their own care based on cost and quality.

The Process

The HITT Advisory Board is working to develop a strategy to enable health information technology to be available across the full continuum of care. The strategy encompasses encouraging the development of interoperable and secure health information across different provider and payer groups.

The HITT Advisory Board and DCH worked together to develop evaluation criteria used to determine pilots eligible for funding through the Georgia Health Information Exchange (HIE) Pilot Program. Providers, payers or local health communities may submit pilot proposals. Potential pilots would include the use of:

* **Electronic health records** to improve the safety and quality of health care and reduce the costs
* **e-prescribing** to reduce medication errors and the cost of medication by helping to ensure formularies are used as prescribing decisions are made
* **Health information exchange** to provide clinical information when and where it is needed for health care decisions

Applicants must submit a mandatory Letter of Intent to apply by August 31, 2007. Completed applications must be delivered to DCH by 4:00 PM., EST on or before September 28, 2007.

For more information about the Georgia Health Information Exchange Pilot Program, visit www.dch.georgia.gov.