ABCDs

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A focus on health is the key to a successful health information technology plan

Build on the successes of others and generalize. Build an argument beginning with the state of health and clear objectives and argue back to the infrastructure a state needs to support this infrastructure:

1. Characterize the state of health for specific conditions
2. Document all of the efforts the community is taking to improve the status of these conditions
3. Document the provider base and the degree of HIT adoption broadly (i.e. How many have billing systems, how many have internet, how many have eRx, how many have EMR).
4. Discuss how other private sector provisions and state provisions are going to impact this effort (these include workforce, broadband, health plan incentives, provider investments, ARRA-funded regional extension centers, health care technology and policy research, and integration with Medicare and Medicaid programs.)
5. State's role in the 3013 application would be to summarize this and then demonstrate how 3013 would connect things together to create a meaningful improvement in care. This approach would have to also describe how state coordinates this with regional extension centers, work force development, and meaningful use, of course.

Focusing on a few issues that would demonstrate the range of what a state can do to improve quality in a way that tests specific health information technology capabilities. One could build on the "ABCs" of New York City[1] with some modifications:

- **A**dherence (to drugs used to treat the following)
- **B**lood pressure monitoring and control
- **C**holesterol levels and treatment
- **D**iabetes
- **S**moking

Focusing on only a few items tests the ranges of capabilities of technology but also summarizes the effort in a brief statement understandable to the public. "Missouri is using taxpayer funds to improve both its measurement and improvement of our state's ABCDs." It also avoids the fuzzy thinking, privacy risks, and adverse political ramifications of "all payer claims database" initiatives.

[1] York City's "ABCs" program define "A" as daily aspirin, "B" as blood pressure measurement, "C" as cholesterol laboratory values, and "s" as smoking cessation.

Using and extending the ABCDs

Each of the elements provides the basis for a state-wide report card. Highly focused attention on these efforts will lead to broader integrated HIT frameworks. Adherence will require access and use of a medication history, blood pressure will require fairly uniform measurements of a physiologic measure, cholesterol will require lab integration, diabetes will require care coordination and outcomes metrics, and smoking will require behavior-change programs. From these instances, one can extend the same approaches and technologies over time to encompass a broader set of issues.

If the technologies are implemented correctly, the marginal cost of extending these measurements to other measurements should be minimal at the infrastructure level. Examples include:

- **A**dherence – medication reconciliation, integration with over-the counter meds (e.g., aspirin) from personal health records, polypharmacy, controlled substances (separate database would not longer be necessary)
- **B**lood pressure – weight (obesity, congestive heart failure management), height (needed for drug dosing), and integration with home technologies (blood glucose monitoring).
- **C**holesterol – any labs (along the lines of the Memphis work)
- **D**iabetes – same care coordination tools can be used for more extensive transitions in care (e.g., nursing home care, ambulatory follow-up) and for medical home pilots.
- **S**moking – other behavioral risk assessments and interventions