

Alabama Medicaid Agency

Request for Information

April 2, 2007

Contact:

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Title: Assessment of Alabama’s health information technology capacity to include two components: 1.) Health and human services agencies’ information systems and identification of data sharing needs to include an evaluation of each partner agency’s platform and 2.) data hub and data entry/retrieval tool.

RFI Issuance Timetable:

Date	Activity
April 2, 2007	Release Request for Information (RFI)
April 2-30, 2007	Question and answer period
April 30, 2007	Deadline for submission of information
May 1-31, 2007	Review of RFI responses (including on-site presentations if requested by the Alabama Medicaid Agency (ALMA))
May 10-30, 2007	Develop Request for Proposal (RFP) or Invitation to Bid (ITB) draft (and/or related approaches to secure sufficient services for timely and efficient implementation)
May 31, 2007	Issue RFP or ITB
June 29, 2007	RFP or ITB submission due date
July 2-September 13, 2007	Evaluate RFPs or ITBs
September 14, 2007	Notification of Award
June 16-August 15, 2008	System user testing and acceptance
August 18, 2008	System implementation
August 18-December 31, 2008	Final system evaluation

Synopsis:

The State of Alabama is seeking information for the utilization of health information technology (HIT) that includes a data hub/repository, a record locator service (RLS), and an interface to create interoperability among disparate public and private systems and applications. The State also seeks to develop a modified electronic health record (EHR) that will enhance physician care management.

In Alabama, the Alabama Medicaid Agency (ALMA) and other state health and human services (HHS) agencies are separate agencies that share data with the same limited approach in which healthcare is often delivered (e.g. fragmented, duplicated, and with insufficient information at the point of provider/patient decision). Shared patient/client information is not well-integrated electronically among the ALMA and Alabama’s other health and human services (HHS) agencies, although there are instances of joint project success such as that of the *Insure Alabama* partnership (<https://insurealabama.org>) between the ALMA, the Alabama Department of Public Health (ADPH), and Blue Cross and Blue Shield of Alabama (BCBS of AL) that

created a web-accessed joint application for SOBRA Medicaid, ALL Kids, Medicaid for Low Income Families (MLIF), and Alabama Child Caring Foundation. Typically, HHS agencies create programs and systems to serve their own specific organizational or accountability needs that are oftentimes duplicated among the agencies. This silo approach contributes to substantially higher costs and eligibility error rates, inappropriate billing, duplicated services, missed opportunities for efficiencies, and less than optimal service delivery approaches and outcomes.

One of the goals of *Together for Quality* is to develop a system of electronic communication [healthcare information exchange infrastructure] that allows all HHS agencies to share information about common recipients efficiently and effectively. This system, referred to as the Alabama Health Information System (ALAHIS), will also assist the ALMA and others to 1) improve the quality of care of patients by providing the tools that support the coordination of services and the communication of the patient health status across the patient's medical home and their specialty care providers, 2) enhance opportunities for continuous healthcare improvement and at the same time, reduce wasteful resources due to uncoordinated, duplicative, ineffective and unnecessary services, and 3) promote the adoption of evidence-based medical care and care-coordination programs through increasing the awareness and participation to available disease management protocols aimed at improving health outcomes and preventing further disease complications among patients.

Section 1-Request for Information:

The intent of this Request for Information (RFI) document is to solicit information from vendors and partners to the questions outlined in Section 4. *Together for Quality* Phase I: Planning and Development began on February 7, 2007 with the convening of the Stakeholder Council. Phase I will focus, in part, on the development of an architectural model and system design for statewide implementation of a clinical information-sharing system across all HHS agency systems and providers. The ALAHIS is planned for implementation between the ALMA and at least one other HHS state agency by October 2008, and provides the foundation for future connectivity and interoperability among all HHS agencies statewide.

This RFI requests technical and cost information from vendors interested in working with Alabama's *Together for Quality* stakeholders to develop the ALAHIS. The ALMA has put forth in this document as much detailed information as possible to provide potential responders with an overview of the *Together for Quality* project, including the ALAHIS. There is an opportunity for responders to ask questions during April 2007. All questions will be received via e-mail and all questions with responses will be posted on the Alabama Medicaid website

(www.medicaid.alabama.gov).

The ALMA, the *Together for Quality* grantee, is releasing this RFI according to the schedule of activities herein. It is unclear at this time if a single Intent to Bid (ITB) or Request for Proposal (RFP) will be issued or if formal negotiations and scope of work development will be the next step after the RFI review along with an ITB or RFP. That decision will be made after information is received and reviewed by the ALMA and appropriate workgroups of the *Together for Quality* Stakeholder Council.

During Phase I, an assessment of Alabama's HHS agencies' electronic information systems, identification of data sharing needs and capabilities, and an evaluation of each HHS partner agency's platform will be conducted. After the evaluation has been completed and information needed to identify interoperability problems/solutions has been completed, a common identifier for Medicaid beneficiaries will be created which will assist with the development of an integrated view of patient information. Rather than invest in developing new integrated systems within each agency, *Together for Quality* will develop an overlay (interface) that will allow agencies to interact at appropriate security levels. This could also provide a common identifier for agency communication among disparate databases within their own organizations. An interface translates agency data elements into a format readable by other entities' systems creating a data system mapping that is transparent to the end user.

Also, a record locator service (RLS) will be developed which is necessary to assist in locating patient information dispersed among multiple entities or systems. Use of the RLS among multiple entities will support the integration of additional selected data into the abbreviated, claims-based electronic health record (EHR) and with applications that provide an electronic clinical support tool (ECST) to medical providers. The resulting interoperability will allow the ALMA and stakeholders to effectively and efficiently verify eligibility (limited to Medicaid during Phase 1 of the project), create efficiencies in the system, coordinate and improve services; and better manage the healthcare needs of Medicaid beneficiaries.

By April 30, 2007, ALMA is requesting information on the type of information or services your company can provide or develop, known sources of information, an estimate of the costs involved, implementation time, and method of data retrieval. You may use Section 4 or submit information in an alternative format if desired.

**Send information to:
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Section 2-Narrative:

Assessment

Through the use of information obtained by the eHealth Initiative Organizational Assessment Tool (OAT) and from worksheets contained within the State Level Health Information Exchange Initiative Development Workbook developed by the Foundation of Research and Education (FORE) of the American Health Information Medical Association (AHIMA), the ALMA will determine the status of development of health information technology (HIT) among state agencies and healthcare providers in Alabama. ALMA will also determine which health care delivery systems are actively pursuing solutions to address inter-system data sharing.

Additionally, during February and March 2007, the ALMA conducted a telephone survey of a sample of 180 randomly selected medical home provider practices in Alabama to ascertain who has adopted use of the BCBS of AL InfoSolutions program (a claims repository that provides physician access to their patients' data), whether they have also adopted some form of claims-based EHRs; and whether EHR use is widespread beyond practices owned by (or closely affiliated with) either hospital systems or large practices or practice groups in major population areas. Less than half (81) responded that they did use InfoSolutions in their practice; a majority of respondents who didn't use it, when asked for reasons most often replied that it was due to "their computer system" (lack of connectivity and/or user difficulties). Other results indicated that 40 offices used Alabama's IMMPrint system (Alabama's statewide immunization registry). EHR use was reported by 71 physician offices with 34 of those keying in the information from a written medical record. This survey demonstrates that the primary reasons for nonuse in Alabama are similar to one of the nationally stated reasons, e.g. lack of resources. Other trends that follow national perspectives which were found in Alabama include a lack of technical expertise to select, implement and maintain a system and lack of financial incentives.

Overview of Phase I

The ALMA, in collaboration with other organizations who have come together as the *Together for Quality* Stakeholder Council, now believes there is a window of opportunity during the duration of the *Together for Quality* project to bring together health care decision-makers to build a coordinated HIT infrastructure in Alabama.

The objective of Phase I is to lay the groundwork for the implementation of a statewide

clinical information-sharing network to begin in 2008. Phase I will be an intense, highly coordinated effort over the next twelve months to develop the governance model, implementation and long range funding plan, and architectural model and system design for the ALAHIS. The work under Phase I will focus on the following areas:

Healthcare Provider Engagement:

The *Together for Quality* Stakeholder Council includes a Clinical Workgroup with clinician and healthcare representatives to 1) determine the initial set of clinically-relevant information that is vital to patient care; 2) define the functional requirements of the user-interface as it relates to the care-provider and end-user cognitive workflow; 3) establish the initial priority of diseases to be focused; and 4) lay the foundation for Quality Improvement (QI) development, using the six Institute of Medicine (IOM) aims found in *The Quality Chasm (2001)* as a guide for the development of QI standards.

For example, during the initial phase of the project, the ALMA will assist in providing participating medical home providers the support necessary to access a claims-based EHR as well as access to a fully integrated ECST. Use of this enhanced ECST will empower physicians by giving them the clinically-relevant information and data necessary for patient management and monitoring as well as coordination of care for their patients. The project will also conduct statewide discussion forums with medical home providers to educate them on the disease and medication risk management information available through the ECST as well as how to access available services such as Medicaid's preferred drug list, generic and therapeutic options, pharmacy prior authorization requirements, and medication history. With better knowledge of the patient's clinical history at the point of service, healthcare providers will have the opportunity to improve the quality of care and provide targeted coordination of care to appropriate healthcare beneficiaries. For instance, healthcare providers caring for Medicaid beneficiaries can avail assistance from at least two ALMA case managers for high-risk recipients. Additionally, providers will be able to e-prescribe in an environment fostering quality and efficiency at a level not attainable in the current paper based environment. The project will pursue enhancements such as inclusion of diagnosis on e-prescriptions, something not currently available in Alabama.

Governance:

The Policy Workgroup of the *Together for Quality* Stakeholder Council will establish operating rules for the council and identify and recommend an appropriate governing body to assume responsibility for oversight, coordination, facilitation and management of the

implementation and operation of a statewide health information network (ALAHIN) after the completion of the *Together for Quality* grant period.

Consumer Engagement:

The *Together for Quality* Stakeholder Council includes a Privacy Workgroup with consumer advocacy representation to address issues of confidentiality, consent for access to patient-specific data, and patient access to their own personal health record through the ALAHIS. One goal of the *Together for Quality* project is to use quality improvement indicators to target disease management education and QI activities. Through this process, Medicaid recipients' use of services and chronic disease self-management could be improved as their confidence in the security and privacy of their personal health information is enhanced.

Technical Development:

The *Together for Quality* Stakeholder Council's Technical Workgroup will work with the Project Director and other ALMA staff to select an architectural design for the ALAHIS, develop a functional system design document, identify the ALAHIS clinical data elements and a phase-in plan for data transfers, identify and develop an interface relationship with data sources, and identify the resource commitment required of pilot phase data users and provider participants. In order to assure an appropriate foundation for the development of a statewide health information network after the *Together for Quality* project ends, this workgroup's effort will include the review and consideration of the results of comparable states' health information network initiatives (HINs) or regional health information organizations (RHIOs).

Funding and Business Plan Development:

The *Together for Quality* Stakeholder Council's Finance Workgroup will develop a business plan for long-term sustainability based upon the final architectural model. This workgroup will also review the financial models of comparable states for their health information exchange (HIE) systems.

ALAHIS Objectives

Responses should highlight your familiarity with HIT as well as any relevant experience with the establishment of an interconnected set of servers, software, networks and security mechanisms across disparate systems to supply providers, patients and facilities with the ability to create and manage this complex interconnectivity in Alabama. The ALAHIS should be designed for "routine" point-of-care access and, at least in its earliest iterations, is not intended to

be a primary source of information for emergency patient care. The system must have the capability to interface with well-known, commonly-used hospital and practice management and EHR systems for connectivity in the future.

An integrated information system of this kind will maximize the effectiveness of available technology to provide accurate and secure, clinical and administrative health care data to points of care in order to:

- Improve the quality of clinical care
- Identify potential threats to the public health
- Reduce duplication of services
- Improve clinical and administrative efficiency and effectiveness
- Allow connectivity to a regional and national network of interconnected healthcare data exchange
- Provide consumers with access to their personal healthcare information

An interconnected, secure data sharing network of healthcare providers, public health professionals, consumers, payers, and affiliated services would permit rapid access to patient-specific healthcare data at the point of care and across networks, hospital systems and state lines.

ALAHIS Principles

The following principles for the ALAHIS are being further developed and endorsed by stakeholders during March and April, 2007:

1. Patient privacy, system security and Health Insurance Portability and Accountability Act (HIPAA) compliance shall be the highest priorities in building and operating a statewide clinical information sharing system:
 - i. Individually identified data shall remain the property of the individual and shall not be disclosed or disseminated to others without that individual's express written consent.
 - ii. Any data accessed for the development of public health initiatives, clinical quality initiatives, and/or patient safety initiatives must be de-identified and remain under the control of the representative body.
2. Participation in the system shall be open to all individual health care providers and public health organizations that are involved in patient care and safety. Governance of the system shall be through an existing or new not-for-profit, organization that is based in Alabama, whose focus will be HIE and QI, and is representative of all stakeholders.
3. Participation in the system shall be voluntary and include the right of any individual or organization to withdraw at any time
4. System operations shall be designed in a format that is driven by end-user physician

value and shall be “hassle-neutral”.

5. Priorities for clinical data elements that will be made available through a statewide information sharing system will be determined by the Clinical Workgroup of the *Together for Quality* Stakeholder Council. Data element selection will be evidence based and outcomes focused.
6. System operations shall be funded in a manner that does not compromise the above principles in any way.

Section 3-Technical Vision and Criteria:

Technical Vision

From a technical perspective, the statewide clinical information sharing system should be primarily focused on the sharing of clinical information while recognizing the potential for such a system to eventually develop enhanced administrative and public health functionality. This Technical Vision fully supports the ALAHIS vision and principles stated above. To that end, the system must:

1. Provide “hassle-neutral” access to data that is clinically relevant, as determined by Alabama’s clinicians;
2. Provide point of service access and timely response;
3. Be compatible with existing and planned information systems;
4. Be consistent with national health IT direction and initiatives;
5. Be based upon and adhere to appropriate national and state data elements, coding transactions, and clinically-relevant terminology standards when such healthcare vocabularies and ontologies are available (e.g., ICD9CM, CPT, SNOMED, LOINC, RxNORM, etc);
6. Follow existing and developing national and state interconnectivity standards such as Health Level 7 (HL7) and other information and communication technology (ICT) industry standards (i.e., DICOM, among others);
7. Comply with federal and state privacy and security standards;
8. Guarantee accuracy, validity and timeliness of data across all participating sites’ standards, when such standards are available; and
9. Permit future expansion to eventually provide interconnectivity of all Alabama’s

healthcare delivery systems and provider sites.

System Criteria

The ALMA prepared a preliminary list of criteria for the statewide system for the Technical Workgroup, who reviewed and revised the criteria. The list of the adopted criteria follows:

Integration with existing and planned systems:

1. Interface with existing and planned information systems in order to extract claims and clinically-relevant data.
2. Work with system vendors to accommodate new versions of supported systems as they are developed.
3. Support national and state communication and messaging standards for the transfer of clinical data where they exist.
4. Provide the necessary conversions for data that does not conform to national and state standards.
5. Build on existing network and Internet capability.
6. Provide an easy-to-use, “hassle-neutral” front end that allows any clinician to access the system with minimal requirements. (For example: Internet connection, Web browser, Single-Sign on)
7. Provide well-documented interface specifications to vendors of existing systems to build access to the ALAHIS system into their proprietary front ends. (For example, the ability to receive current standards such as ASTM’s Continuity of Care Record (CCR), the joint ASTM/HL7 Continuity of Care Document (CCD), etc).
8. Work with vendors of existing front ends to guarantee that the interface to the ALAHIS system supports any existing or emerging data transfer and communication standards.
9. Support both the automatic and manual submission of data.

Performance:

1. The process of extracting information from existing information systems will not adversely impact the performance of those systems.
2. The process of requesting/importing data from the ALAHIS system will not adversely impact network performance at the point of service.

3. System will be capable of responding to queries at point of service within ALAHIS adopted standards for timeliness.
4. System will be capable of extracting data from existing information systems in a timely manner required to present clinical data in a meaningful manner.
5. If access to ALAHIS system is via Internet or WAN connection, sites will be responsible for their own Internet/WAN connection and for any impact that a slow or congested connection may have on the timely access to the ALAHIS system from their site.

Reliability/Compatibility:

1. The part of the system responsible for responding to point of service requests must be highly available (standards for downtime, ability to re-route requests to alternate systems, etc).
2. Any ALAHIS equipment located at central site(s) must meet reliability standards.
3. Any ALAHIS equipment located at remote sites must meet specified reliability standards even if high-availability is not necessary.
4. Any ALAHIS equipment and software located at remote sites must be simple, easy to support, and maintain.
5. If access to ALAHIS system is via an Internet or WAN connection, the reliability of the system at any point of service will be limited by the reliability of the Internet/WAN connection at that location.

Integrity:

1. Data sources must demonstrate ability to assure accuracy of data within acceptable standards.
2. ALAHIS will attempt to identify and flag errors and inaccuracies in data from the data sources.
3. ALAHIS will guard against inaccuracies that may result from building a statewide system, e.g. duplicate patients, conflicting test results, identifying providers, etc.
4. A solid methodology for identifying unique patients across networks and provider sites will be identified and adopted.

Privacy and Security:

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All HIPAA and Alabama state requirements will be met regarding patient authorization, data privacy, and security. Site specific security requirements will be met. Strong user authentication standards will be developed, maintained, and clearly stated for all participants. Authorization standards for accessing data will be developed, maintained, and clearly stated for all participants. ALAHIS must have robust auditing capability and provide for the maintenance of logs containing the ID of users' access to clinical data.

Cost:

1. Upfront/initial cost for ALAHIS must be identified and affordable.
2. Ongoing/monthly costs for ALAHIS must be identified and affordable.
3. Add-on costs related to customized requests must be identified and managed by the ALAHIS.
4. Programming costs for building interfaces may be negotiated as one or more ALAHIS contracts.

Design Discussions (Key Success Factors)

Architecture:

At the outset of Phase I, the Technical Workgroup will review potential architectural models for the system, including those submitted in response to this RFI. After adopting the technical criteria, each model will be re-evaluated to determine its ability to support the criteria. Architectural drawings will be posted on the ALMA web site (www.medicaid.alabama.gov) at the time of the release of an ITB or RFP on May 31, 2007. It is recognized that other models may also successfully meet the Technical Criteria.

Patient Identification:

Frequently referred to as “master patient index”, the MPI is a mechanism to identify each patient in a system and is one of the key components required to ensure accuracy of data mapping. This is essential so that data from different sources can be mapped reliably to the appropriate patient. Assessments conducted early in the *Together for Quality* project will help to identify partners that have either developed or are in the process of developing an identifier algorithm or are using an MPI. The ALAHIS must have such a mechanism that functions on a statewide level and does not require participating organizations to change or replace their internal MPI or identifier algorithms. Some provider sites may be using a billing ID number as an identifier for their patients and have no MPI link at this time. The ALMA recognizes that a

significant amount of procedural work will be needed for the statewide MPI implementation, and hence is also interested in a workflow component to the MPI which helps in manually resolving “close” matches across systems.

Patient Privacy and Confidentiality

No information is more sensitive than the information resulting from a clinical encounter between patient and provider. This fact has been reinforced by regulations established as a result of federal legislation including HIPAA. The ALAHIS must employ state-of-the-art tools and techniques to protect patients’ rights to privacy and confidentiality in accordance with federal and state guidelines. Mechanisms should be included to acquire and manage patient consent for use and release of protected information as well as tracking and reporting all access to protected information. It is likely that the final architecture of some of the data is a distributed model, meaning that the information is pulled from the source system in real-time to show to the stakeholder. However, due to the nature of the data in this solution as well as healthcare system accountability it is important that a complete audit trail be maintained not only of the data resident in the system but also all real-time transactions.

Source of Data

Providers need to be assured of the validity of the data used for clinical decision support. One key to building and maintaining confidence in data depends on knowing the source of the data. Sources of data include: BCBS of AL and the ALMA claims data, the state immunization registry, pharmacy and non-pharmacy claims, and laboratory results.

ALAHIS must have the ability to link data to its originating source at the data element level regardless of whether it is clinical data or demographic data.

Minimum Data Content and Standards

The Clinical Workgroup is responsible for defining a minimum data set that would be most likely to add value, reduce errors, and minimize costs at the point-of-care (this is data comprising the claims-based EHR). The Clinical Workgroup is currently reviewing, for adoption, nationally-recognized standards such as the ASTM Continuity of Care Record (CCR) and the HL7 Continuity of Care Document (CCD) to identify and prioritize clinically-relevant data elements needed in the first phase of the project. The ALAHIS project will use the above national consensus standards and data elements, including its supporting healthcare terminologies and ontologies, in order to enhance semantic interoperability among participating EHR systems. The following are to be included, but not limited to, in the first phase:

1. Patient identification information, including emergency patient information.
2. Information regarding the patient's health status, including:
 - Diagnoses
 - Allergies
 - Medications prescribed and filled
 - Laboratory results
 - Immunizations
 - Non-pharmacy services
 - Procedures (e.g. CPT codes)
 - Number of physicians seen by specialty during specified intervals to identify patients associated with higher risk and/or need/use of case management
3. Formulary management information:
 - Prior authorization requirements
 - Preferred drug lists
 - Generic and therapeutic alternatives

Section 4-Your Response:

Your response should indicate if you would be willing to provide a face-to-face presentation if requested by the ALMA (see schedule).

Specifically, this RFI seeks the information listed in this section. Please respond to these topics in numerical order:

1. Conceptual technical architecture alternatives.
2. Comments and discussion on technical feasibility and alternatives.
3. List of major architectural components.
4. Approximate cost information (i.e. software, hardware, implementation cost and resources, on-going and maintenance costs and other relevant cost estimates, etc.) for alternatives including areas where lower cost alternatives (ex. open source software, commodity hardware, etc.) might be used to reduce the overall system cost and what sorts of impacts this might have on system performance, reliability, and maintenance cost.
5. Information about various telecommunications and networking technologies that could be used for this type of system and what capacity, if any, would be required for the different elements (contributing data sources, data consumers, system servers).
6. Schedule for implementation and related cost estimates including statewide development costs.
7. Explicitly define how the solution utilizes acceptable health IT standards to enable inter

and intra-system communication and semantic interoperability.

8. Any ideas and suggestions that provide alternative approaches to designing, developing, acquiring, operating, and maintaining this type of system or components including the following:

- Disease and medication risk management
- Patient risk scoring solutions and predictive modeling
- Emergency response technology
- Geo-mapping solutions for risk scoring or disease surveillance
- Peer to peer comparative clinical support data
- E-Prescribing
- Pharmacy electronic prior authorization exchange
- High Risk Case Management
- Record Locator Service
- User Authentication
- Security and Firewall

RFI Questions/Requirements:

General:

1. Briefly describe your company, your products and services, history, and other information you deem relevant.
2. Describe the capabilities of your staff and company in supporting an ALAHIS system. Describe your process for project management and identify your usual level of on-site involvement.
3. Provide a recent annual report. Include separate statements for the portion of your company serving the healthcare market. If your company is a subsidiary of another company, please provide the parent company financials. Include financial information for each vendor partner included in your proposed product.

Partners:

1. Name and describe all existing and potential future relationships with partners who may provide products and services that meet the ALAHIS requirements.
2. Differentiate between the role of your organization and those of your partners. What are the responsibilities associated with each partner by product and/or service?
3. Please describe any interfaces that you have already built with specific health care information systems vendors.

References:

1. Describe your experience managing HIT projects.
2. Provide references to three operational HIT systems including contact names and telephone numbers.
3. Describe current/recent HIT projects that are similar in concept to the ALAHIS and identify current status including implementation dates. Please provide a sample design document developed for one of your projects.
4. List participant entities in these projects and describe the geographic area involved.
5. Describe the applications supported/installed and planned.
6. What economic justification data was shown to participants and were you involved in developing that data?
7. What level of application integration was necessary at each site?
8. Describe any other HIT projects undertaken in Alabama within the past two years.
9. Provide information on security and user authentication procedures.

ALAHIS Architecture and System Design:

Please describe in detail, including a network diagram, the architecture of the solution you would like to propose for the ALAHIS and how it/you would meet the system criteria outlined herein. Discuss the capability for the solution to be constructed in phases and identify the type of software/equipment that would typically be deployed. Identify currently available software applications or equipment vs. that to be developed.

Procedural Items

Please respond to the above questions referencing topics in bullet format. Questions and responses should be in Microsoft Word format and emailed to carroll.nason@medicaid.alabama.gov according to the schedule of dates on page 2.

Outcome I: Develop stakeholder consensus and capacity to maintain a broad base of support for <i>Together for Quality</i> implementation to assure long term sustainability.			
OBJECTIVES, TASKS AND ACTIVITIES	FY 2007	FY 2008	RESPONSIBLE PERSON(S)
1. Identify champions and key stakeholders for Stakeholder Council; establish membership, form workgroups	February – March, 2007		ALMA Sponsor Team (AST), & Project Director (PD)
a. Develop operating rules	3/8/07		Steering Committee (SC) All Workgroups (WGs), AST & PD
b. Elect Co-chairs	3/8/07		All WGs and SC
c. Create Workgroup Charters and Workplan	February-March, 2007		All WGs and SC, Sponsor Team, AST & PD
d. Develop consensus, generate vision, mission, and value statements, create an initial framework for the Alabama Roadmap	3/8/07-3/9/07		All WGs, eHI Consultants, AST & PD
e. Reach consensus on initial governance, technical, privacy, and security policies.	March-June 2007		All WGs and SC, AST & PD
f. Sample survey of AL health information technology use using eHI Organization Assessment Tool (OAT)	March 2007		Technical WG, AST & PD
g. Conduct market characteristic assessment using AHIMA FORE worksheet	March 2007		Technical WG; AST & PD
h. Develop RFI	February-April 2007		Project Director, Finance, Technical, and Clinical WGs
i. Complete appropriate business associate agreements and other required legal documents among partners	May 2007		Privacy WG; AST & PD
j. Research governance models and lessons learned; reach consensus on a sustainable governance model for long term sustainability, prepare task list for model implementation, and implement prior to October 2008 along with related legal policies.		January 2008	AST & PD, SC, Policy assisted by all other Workgroups as needed for research
Outcome II: A data-driven outcomes focused quality improvement pilot will be in place with documentation of selected measure improvement of at least 4 percentage points from the baseline by August 2008			
1. Provide overview for Stakeholder Council of a general understanding of TFQ, Pt 1 st Profiling, InfoSolutions, and ePrescribing capabilities.	3/8/07		AST & PD
2. Sample survey of medical home providers to	3/8/07		AST; staff of Pt 1 st

determine value and use of current electronic access to existing data; inform Stakeholder Council Clinical Workgroup of results.			and Communications & Education
3. The initial claims-based, electronic health record (EHR) database for use by medical home providers in will be populated by June 2007.	June 07		AST & PD, Partners, Technical WG
4. Medicaid non-pharmacy claims data and laboratory results will be added to the database.	March-April 2007		AST & PD and Technical WG
5. Explore feasibility of expanding database by importing additional lab data from hospitals' labs	June 07		AST & PD and Technical WG
6. The ALMA quality improvement organizational structure will be in place by February 2007 and high risk case management protocols developed by May 2007 for implementation by July 2007	2/07-7/07		AST & PD, ALMA Medical Director
7. Evidence based quality measures will be selected by May 2007	5/07		Clinical WG, AST & PD
8. Baseline data determined	6/07		Clinical WG, AST & PD
9. Algorithms and tools will be created by July 2007	7/07		Clinical WG, AST & PD
10. QI process initiated and results reviewed.	7/07		Clinical WG, AST & PD
11. A 30% ECST saturation of the ALMA medical home providers will be obtained by June 2007	6/07		Clinical WG, AST & PD, assisted by the SC, other WGs & other provider stakeholders
12. Enhance, test ECST	9/07		Clinical WG, AST & PD
13. Develop promotional and distribution plan for ECST	9/07		Clinical WG, AST & PD assisted by the SC and Policy WG
14. Conduct statewide discussion forums with medical home providers	10/07		Clinical WG, AST & PD
15. Distribute the ECST to selected sample of medical home providers and assure connectivity.	10/07		Clinical & Technical WGs, AST & PD
16. Provide onsite technical assistance and education and support for ECST medical home providers	Ongoing		Clinical & Technical WGs, AST & PD
17. Obtain 50% ECST saturation of medical home providers by end of Grant Year two		9/08	Clinical & Technical WG, AST & PD
Outcome III: A statewide, shared interoperable health information system will be in place and successfully utilized by the ALMA and at least one other HHS agency by October 2008.			
1. A statewide, central, shared interoperable information system will be in place by March 2008.		3/08	Technical and other WGs as needed; AST & PD
2. Identify participating HHS agency	<June, 2007		AST & PD
a. Establish parameters for agency choice	3/8/07		Privacy WG; AST

Appendix I

**RFI-Together for Quality
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			& PD
b. Recommend agency	<June, 2007		Stakeholder Council
3. Release Request for Information (RFI)	4/2/07		AST & PD
4. Respond to questions with at least weekly post of all Q & A's on the ALMA website	April 2007		AST & PD; all WGs as needed
5. Review RFI responses	May 2007		AST & PD; Technical, Clinical, Finance WGs
6. Prepare and initiate RFP or ITB process	June 2007		AST & PD; Technical, Clinical, Finance WGs
7. Establish the ALAHIS operating environment <ul style="list-style-type: none"> a. Design communication linkages between the participating partners b. Implement communication linkages between the participating partners c. Develop common identifier algorithm and create Master Patient Index for all patients/clients served by partners d. Establish representative data validation and integrity enhancement processing e. Populate database to support transactions among partners f. Implement transaction mapping to support care management and related services among partners. 		3/08	AST & PD; Technical, Clinical, Finance WGs
8. Pilot ALAHIS utilization by the ALMA and one other HHS agency by May 2008		5/08	AST & PD assisted by the partner HHS agency staff; all WGs as needed
9. Develop a process, in partnership with Federally Qualified Health Centers, Rural Health Clinics and hospital emergency rooms to create health records for uninsured individuals.		3/08	Clinical and Technical WGs; AST & PD assisted by APHCA and ALAHA
10. Identify opportunities for data sharing improvement and interventions by March 2008		3/08	Clinical and Technical WGs; AST & PD
11. Evaluate interoperability and user acceptance by August 2008.		8/08	Clinical and Technical WGs; AST & PD
12. Develop web portal access for the public, providers and agencies to establish an emergency/disaster response for privately and securely exchanging healthcare and demographic data to assure that appropriate health and human services are provided/received as needed.		8/08	Technical WG; Governor's Task Force for Strengthening Alabama's Families, AST & PD
13. Opportunities for improvement and intervention	Ongoing		AST & PD; WGs

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will be identified			as needed
14. Interventions implemented by end of August 2008 as needed		8/08	AST & PD; WGs as needed
15. Develop the project evaluation plan before the end of June 2008, submit quarterly reports, and finalize final evaluation report for timely submission to CMS by December 2008		12/08	Project Director & AST; Together for Quality Evaluation Team

Use Case:**ALAHIS and End-user Functional Requirements and Information Needs**

This narrative provides an example to more clearly define the functional requirements and informational needs identified by the Clinical Workgroup and are based on the assumption that ALAHIS is fully implemented and all objectives, tasks and activities have been completed.

Storyboard:

Jane Doe is a 30 y/o patient presenting to Dr. Smith's primary care office for a slight fever and uncontrolled wheezing. Upon registering the patient into the clinic's EMR system, the clerk notes her insurance provider and that she has a history of chronic asthma and notifies Nurse Nightingale.

Upon accessing patient's record in the EMR system, Nurse Nightingale identifies several alerts; no pap smear in the past year and no flu shot. Nurse Nightingale confirms that Ms. Doe has not had a flu shot or Pap smear. She enters her chief complaint and vital signs into the EMR. The EMR automatically displays the guidelines for asthma and indicates the assessments due or needed. It also displays Ms. Doe's medication profile which lists all medications prescribed and filled. Nurse Nightingale then downloads the most current performance profile for Dr. Smith's review.

Dr. Smith notes that he is performing above his peers on most indicators including asthma. Dr. Smith is also able to see that Jane Doe is on all medications recommended by the current guidelines. Dr. Smith evaluates Jane Doe and enters the clinical history and findings into the EMR system and then goes on to enter orders for several medical interventions. While in the office, Jane Doe receives a nebulizer treatment as well as a single dose of oral prednisone. Also, oxygen saturation testing is performed using a pulse oximeter; pulmonary function is checked using a peak flow meter; and a complete blood count (CBC) and chest x-ray (CXR) are taken to rule out pneumonia.

Upon accessing the patient's record, Dr. Smith notes that Jane Doe has been previously seen by an allergist and another primary physician during the past two months. He also notes that she was seen in the emergency room two days before. While performing a medication reconciliation process, he also finds that Jane Doe has been refilling her asthma preventive medication on a regular basis.

Noting an improvement of Jane Doe's symptoms after the medications and an unremarkable CBC and CXR, Dr. Smith writes prescriptions using the online ePrescribing function. Although the tool provides the option to print the prescription, Dr. Smith transmits the prescription electronically to the pharmacy.

Appendix II

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Jane Doe is sent home on several prescriptions, which include albuterol MDI, prednisone tablets, and a refill of her montelukast tablets. She also receives the flu vaccine before she goes home. She is advised to return to the clinic if she gets worse or does not feel better in the next 3 days and a visit is scheduled for her annual pap smear and for follow-up. Jane Doe goes straight to a local pharmacy, where her prescriptions are waiting for her. Her symptoms are better within 3 days.