NATIONAL RURAL HEALTH INFORMATION TECHNOLOGY CONFERENCE CALL

THURSDAY, APRIL 8TH, 2010

11:00 A.M. – NOON (CENTRAL); 9:00 (PACIFIC); 10:00 (MOUNTAIN); NOON (EASTERN)

Purpose of the call is to discuss the sub-components of ARRA including HIT RECs, HIEs, Workforce Training Grants, and the CAH Supplement.

MINUTES

11:00am - Welcome/Purpose of Call – Terry Hill, Rural Health Resource Center
11:05am - Sub-components of ARRA: HIT RECs, HIEs, and CAH Supplement – Terry Hill, Rural Health Resource Center, will lead the discussion
What is the Coalition's Role with ONC?
11:30am - **University-based Workforce Training Grants** – William Hersh, M.D., Oregon Health & Science University
11:45am - **Health Care Broadband Plan Summary** – Kip Smith, Health Information Exchange of Montana, will lead the discussion
Noon - Adjourn

Participants
Brock Slabach, Louis Wenzlow, Terry Hill, Tracy Morton, Mary Devany, Kate Stenehjem, Kip Smith, Bill Hersh, Marty Witrak, Denny Berens, Gloria Vermie, Larry Allen, John Barnas, Alison Hughes, Lisa Kilawee, Chris Tilden, Kris Juliar, JoAnn Ort, Neal Neuberger, Don Asmonga, Debbie Robbins, Bill Jolley, Irene Alverez, Mike McNeely, Sally Buck, Chuck Lail, Kami Norland, Angie Emge, Christina Theist

Sub-components of ARRA: HIT RECs, HIEs, and CAH Supplement – Terry Hill, Rural Health Resource Center, will lead the discussion

Community College Consortia will be putting together HIT certificate programs. Concerns on whether or not this will prepare people to lead a rural HIT initiative in a hospital with only a 6-month certificate. $144M was awarded to 5 consortia. To supplement these awards, there are curriculum development centers.

Bill Hersh noted that the curriculum development centers are tasked with developing curricula in 23 topics to create curricula for the community colleges to use in the programs that they create. There is one university that will be the national training and dissemination center (house curricula, web site,

obtain feedback, and track use of curricula) this will be at Oregon Health & Science University. The only money that has not been awarded is the Beacon grants.

Terry Hill mentioned that there are 28 new HIT Regional Extension Centers (RECs) have been recently awarded to cover the entire United States for a total of 60 RECs.

Mike McNeely noted that there are some gaps for coverage for the RECs so some HIT RECs will have to cover additional areas. New Hampshire is one area that still needs to be covered. Potentially successful applicants may have been notified for the Beacon Grants. There were 15 slots and over 200 applicants for the Beacon grants.

CAH Supplement

There was a concern for the HIT RECs to provide meaningful TA to rural providers. A strong recommendation from a variety of organizations that we put a rural emphasis to designate a specific extension center to work with rural. Now it has been noted that they will do something for rural hospitals. The business model was focused on primary care clinics which was a real concern for the rural areas. We were hoping that there would be some $ designated for the rural hospitals. Now there has been $ designated for all rural hospitals under 50 beds. Outpatient services will be the emphasis, but it appears to be possible to provide TA on the outpatient side as well. Louis Wenzlow noted that there is a lot of concern with the focus on outpatient services. The primary way CAHs and rural hospitals can reach meaningful use is on the inpatient side. ONC has stated that RECs can help on the inpatient side if they want to but this has not been encouraged. There is a fear that many RECs will not do this b/c they have neither the processes nor expertise on the inpatient rural side.

Alison Hughes noted that the CAHs will not get the money directly, but the $12,000 will go to the RECs for TA.

Louis noted that the first installment of the REC payment is with the signing on of the CAHs/rural hospitals. Will the RECs direct the $ on the hospital side or the outpatient side? He stated that we need to focus on this issue.

Terry noted that the $ will not be automatically given to the RECs – the RECs have to apply for them. The RECs are under immense pressure to get things off of the ground soon. There are stringent guidelines and milestones and there are good business reasons for RECs to work with providers that are already further on the meaningful use process. As rural advocates we should encourage the RECs to work with the rural hospitals and to go after the money. Applications have to be in place by April 30th for the supplement.

Alison asked if states had to convince the CAHs to agree in writing to participate, as had been the case with the primary care physicians. Sally Buck noted that the RECs can apply w/out a letter of intent from the CAHs.

Terry offered some initial suggestions as to how can we might get the greatest value out of this TA money? RECs can contract with a experienced consultants, who might form cohorts of rural hospitals,

or with a network that is already doing this work. That would produce economies of scale and efficiencies. The entire REC approach is designed around primary care clinics, and we need to find ways to encourage them to work with the CAHs.

Mike McNeely stated that first, the $12,000 is in addition to the primary care providers at the hospital, second , RECs just have to cover a little of the outpatient side – ONC is on on-board w/ inpatient being covered – third , RECs can contract with each other for TA covering the rural hospitals.

Louis asked, what if a CAH does not have a primary care clinic – does that mean that CAHs that don't have outpatient services cannot be funded? Why are they requiring this?

Mike responded that it is a RURAL hospital program – not a CAH program.

Terry stated that he believed ONC really wants to get it right with rural and to work with us. Mat Kendel l indicated that he would like to have ongoing dialogues with our Coalition. They would like to know what they can do with the RECs to provide guidance and support to rural hospitals. Alison suggested that REC centers have a representative on this Coalition.

Terry noted that ONC is going to put a rural cohort together for the RECs. If we have a cohort of RECs, our Coalition might be in a position to advise them and help disseminate information

Additional Information on the CAH/Rural Hospital Supplement
ONC is driving the REC initiative. All 60 RECs have now been designated and every part of the country is now covered. For a list of the Regional Extension Centers, please visit http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&parentname=CommunityPage&parentid=3&mode=2&in_hi_userid=10741&cached=true

The RECs will support health care providers with direct, individualized and on-site technical assistance including:

- Selecting a certified electronic health record
- Achieving effective implementation
- Enhancing clinical and administrative workflows with electronic health records to improve quality and value of care
- Protecting the integrity, privacy and security of patients' health information

The RECs will focus their most intensive technical assistance on clinicians (physicians, physician assistants, and nurse practitioners) furnishing primary-care services, with a particular emphasis on individual and small group practices (fewer than 10 clinicians with prescriptive privileges). The goal of the REC program is to provide outreach and support services to at least 100,000 priority primary care providers within two years. This includes providing technical assistance in both rural and urban areas.

At the end of March, it was announced that RECs will also be able to provide technical assistance to rural hospitals and CAHs. ONC has stated that "CAHs and Rural Hospitals are vital components of the rural health care system in the United States. These hospitals are included on the priority list for the Regional Extension Centers (RECs)."

The REC will receive $12,000 supplemental funding per CAH or rural hospital they bring to meaningful use of electronic health records. The money will not go to the CAH or the rural hospital, but will go to the REC so that they are funded to provide technical assistance to these important facilities to assist them in achieving meaningful use of electronic health records. The hospitals that are included need to be 50 beds or less. Each REC has a designated geographic area they are covering. This can be a portion of a state, all of a state, portions of multiple states, or multiple states in their entirety. The CAHs and rural hospitals that can now be served by the RECs must be within geographical coverage area defined by the REC in its application. ONC recognizes the need for resources for outreach to CAHs and Rural Hospitals; therefore RECs can apply for this supplemental funding opportunity regardless of whether the REC mentioned specifically that it would be working with CAH and Rural Hospitals in its original application. ONC has supplied to each REC a list of CAHs and rural hospitals (50 beds or less) within its designated geographic area. It is up to the REC to enlist the CAH or rural hospital for technical assistance.

University-based Workforce Training Grants – Bill Hersh, M.D., Oregon Health & Science University, will lead the discussion

In addition to the community college consortia grants, then there are 9 universities that have been awarded the university-based training grants for a higher level. ONC has defined job roles. They will provide financial aid that they can award to students in the programs. Each will run their program differently. 80% of students have to be in a 'less than 1 year' training program. Other job roles are other IT types of things. It is described fairly well on the ONC web site. There will eventually be links from the ONC page to the different programs and how they are using the funding.

Marty Witrak noted that it really appears to be geared towards students that are already engaged in this type of work to get them out the door and working.

Bill stated that people that are already in programs are not eligible for funding so they all need to be new people. Marty clarified that there is a way to do add-on for a certificate.

Addition Information on the Workforce Training Grants
To learn more about the $144 Million in Recovery Act funds to institutions of higher education and research to address critical needs for the widespread adoption and meaningful use of HIT visit this site: http://www.hhs.gov/news/press/2010pres/04/20100402a.html

Health Care Broadband Plan Summary - Kip Smith, Health Information Exchange of Montana, will lead the discussion.

As part of ARRA, there was a focus on broadband and the status of the infrastructure and the needs for broadband. They released the national plan on March 16th. It is far-reaching and controversial. The chapter on health care is chapter 10 and the FCC included 11 recommendations and they went well beyond what was needed from FCC. Kate sent out a summary this morning – a 2-page recommendation. It is a nice summary that was encouraging because they went beyond infrastructure and discussed how the use of technology can (and should) be reimbursed and encouraged. Strong emphasis by FCC for a robust broadband infrastructure to support health care, education, etc … as the US trails other countries in terms of broadband access.

Louis – We are part of a pilot program. We liked that there is a provision to allow admin offices (networks); through the pilot program there is a revision of urban comparable rates which is better for rural providers; on page 200 there is one recommendation we are very concerned about:

"To protect against waste, fraud and abuse in the Rural Health Care Program, the FCC should require participating institutions to meet outcomes-based performance measures to qualify for Universal Service Fund (USF) subsidies, such as HHS's meaningful use criteria."

The American Hospital Association has estimated that up to 70% of critical access and rural hospitals are unlikely to meet the meaningful use standard due to the fact that they are at early stages of electronic health record adoption and cannot be expected to meet the standards as written in the timeframe currently proposed. The most disadvantaged rural hospitals will be the least likely to meet the meaningful use objectives as written. The above recommendation would then also remove existing funding for broadband for those unable to meet the requirements.

To remove this funding under the rationale of "waste, fraud, and abuse" would be unjust and would only further the digital divide between rural and other providers.

Chris Tilden noted the EMS should be part of the discussion on EHRs and HIT in general. They seem to have been left out of the national HIT initiative.

Terry – EMS has not been part of any of this discussion. Has the FCC considered them?

Adjournment The meeting was adjourned at approximately 12:10 pm, CST.