NATIONAL RURAL HEALTH RESOURCE CENTER

NATIONAL RURAL HEALTH INFORMATION TECHNOLOGY (HIT) COALITION

Conference Call

October 22, 2013

Participants – Tommy Barnhart – Ten Mile Enterprises, Dennis Berens – Nebraska Times, Rob Boyle – Alabama State Office of Rural Health, Rebecca Davis–National Cooperative of Health Networks Association, Terry Hill – The National Rural Health Resource Center (The Center), Lisa Kilawee – Rural Health Services at Avera Health, Dr. Paul Kleeberg - Stratis Health, Mike McNeely – Federal Office of Rural Health Policy (ORHP), Jeff Mitchell – Attorney at Law, Tracy Morton – The Center, Neal Neuberger – HIMSS Institute for e-Health Policy and HealthTech Strategies, Anthony Oliver - ORHP, Mary Ring – Illinois Critical Access Hospital Network, Marty Rice - ORHP, Becky Sanders – Indiana Rural Health Association, Kate Stenehjem – The Center, Christina Thielst – Tower Consulting Group, Louis Wenzlow – Rural Wisconsin Health Care Cooperative, Joe Wivoda – The Center

1:00 PM - Welcome and Brief Introductions

National HIT Updates – Neal Neuberger

- National Health Information Technology (HIT) Week was held in Washington, DC in September with 300 groups participating including a policy summit and HIT showcases in the House and Senate.
- The Health Information Management Systems Society (HIMSS) opened an Innovations Center in Cleveland, OH that could serve as a venue for meetings and seminars.
- Secretary Sibelius announced a technology surge to improve the consumer experience on the healthcare.gov website. The chief technology officer will be one of the leads, including other public companies.
- Legislation was introduced September 12th that would build on previous efforts from the Department of Defense and the Department of Veterans Affairs. This would extend telehealth to other licensed practitioners across state lines. As long as practitioners were treating Medicare patients across lines, they would not have to be licensed in multiple states. This bill received a lot of support from both sides. There is very low fiscal impact anticipated.
- A new bill has been introduced to use telehealth for home-based kidney dialysis. This would be created through optional Medicaid authority and Medicare bundle payments and use of accountable care organizations (ACOs).
- HIT Now Coalition will introduce a bill to support a working group and the mobile guidance on mobile applications.

- There is still some unfinished regulatory business such as: including behavioral health in HIT incentives; accounting for home health care providers; what to do about big data; and, what to do about telehealth in the context of the HITECH Act.
- As a nation, we have surpassed the 1000 mark for small rural and critical access hospitals (CAHs) reaching meaningful use. Some Senators are calling for an extension of deadline for stage 2 of meaningful use (MU), supported by a number of stakeholder groups. It is very unlikely that there will be a delay because it would mean changing the timelines for stage 3 as well.
- As far as health information exchange is concerned (HIE), there are still some technical glitches that need to be sorted out. Many people are questioning why the experts were not brought in earlier. A basic, yet problematic question remains regarding what type of system needs to be created and utilized?
- The next announcement regarding stage 3 MU should be made on November 6th at the Office of the National Coordinator (ONC) HIT Policy Committee meeting. ONC's website has the stage 3 comments on there. A proposed rule will not be likely until sometime next year, possibly later in the year. The farther this proposed rule is pushed out, the more of a crunch will be created to meet the deadlines.

Current State of Stage 2 Progress – Facilitated by Joe Wivoda

- On the inpatient side there are 21 complete electronic health record (EHR) vendors that are 2014 certified. There are some concerns about how vendors are interpreting certification. Currently, there are not a lot of people working on care transitions or referrals. A lot of CAHs feel that they will able to get by with sending a summary of care record to their primary tertiary referral source, which likely will not meet the requirement.
- Currently there is not a credible motion to add a year or delay stage 2. HIMSS recently disseminated a publication noting that 65% of hospitals have stage 2 certified software. Unfortunately, this is likely much lower for rural.
- There is a problem with the amount of vendors that are not certified yet because this delays implementation for the facilities. Many vendors are still struggling with 100s of job openings for implementation; roll out, as well as on the development side. Vendors will have a hard time delivering and, therefore, if facilities are not meeting the requirements for stage 2, it will not be the fault of the facility. The vendors need to be held accountable. Could there be an extension for the end of stage 2 to create more time, but not push back the start of stage 3? The Centers for Medicare and Medicaid Services (CMS) is aware there are a lot of issues and are currently looking at options. Changing the timeline would require new rule-making, but CMS may be able to do other things such as offering exceptions. It is vital that facilities keep a record of interactions with vendors about any communications and delivery dates by the vendors to show their due diligence. This could allow facilities to use an exception if one is created. Such an exception could not provide the facility with the incentive but could relieve the facility of the

penalty. However, the exceptions have not been clearly defined. Here is a presentation and a transcript on the exception rule.

- What is readiness in rural across the country?:
    - Many rural hospitals are having difficulty getting on the queue for vendor's 2014 certified platforms. Plus, once they implement the platform, there is still so much file-building on the new platform which is a lot of work.
    - In Wisconsin, at least five hospitals have gotten audit letters for MU 2012 stage 1 which is another resource expenditure. Minnesota and North Dakota have had a number of sites audited as well. A few have had some with follow up after the letters and thus far, no one has failed.
    - How involved are the audits?
        - CHIME has a PowerPoint presentation on surviving a MU audit.
        - The initial audit letter requests five categories of information.
        - After the initial audit is follow up. In the presentation referenced above, both CIOs discuss lots of back and forth with the auditors.
        - Biggest risk area is the security risk assessment. There is no trust if the security risk assessment was done before the end of the reporting period but also if the mitigation plan was completed before the end of the reporting period as security is an ongoing process. Could this plan introduce risk if you have items dated beyond the end of your reporting period?
    - There are concerns over transitions of care, quality measures, and the patient portal and how these will be achieved. The patient portal and summary of care document are standards and data elements that need to be built and collected very quickly to meet the requirements.
    - The group is concerned about zero denominators in small rural locations that a vendor may have just a few clinical quality measures (CQMs) to choose from on their platform. Clarification is sought. A vendor may have 16 of the 29 measures and not the others. If a facility has a zero in one area, but other CQMs have other numbers, the facility is required to report on. This is for 2014 quality measures and this is not stage dependent. Is there a minimum case number? Yes, if you have five or fewer discharges per quarters, it can be exempted for 2014 but you have to send aggregate sample sizes.
    - What are rural relevant quality measures? Marty Rice would like to include some rural specific measures into CMS incentive programs, including MU, with Hospital Compare. These could then be built into the certification process.
    - Strategy for many in rural is to get the technology pieces in place first. With the transitions of care measure in Wisconsin, there is a HIE component that could be a solution in the state. People are looking at that decision point and also at how to get the data in place and the standards built. This feels like the first step before moving on to engage partners. Many are focusing on the technology problem prior to focusing on the process problem. Many facilities do not understand

their referral network and have not yet engaged them to understand what their needs are.
    - How do we handle the transitions to long term care? Most facilities are simply wringing their hands on this.
- Patient divide: Patients find out a lot of information about their health care on the web and then present this information to their providers. There is not a lot of training out there for providers to adjust to this. Same thing could happen with the patient portals and the more educated patient who is going seek the web, and then their provider, to answer their health-related questions. There will be a large learning curve for families and the facilities will have to train their staff on how to engage patients, families and care givers with personal health records and digital health information.
- CCHIT's HIT Framework for ACOs. Joe thinks this is a really great resource. Almost a best practice even for HIT leaders. Includes tables, actions and pretty easy to read despite the length. Items on coordinating care, managing a cohort of patients, physician engagement. The group is to look at it and provide some feedback to Joe. Paul Kleeberg noted REACH is using it. This is a good thing for the Coalition to think about as it moves into the new world of accountable care and new payment mechanisms. The framework is a good framework for rural to consider going forward.

Follow-Up Activities

- Review CCHIT's HIT Framework for ACOs and provide feedback to Joe at jwidova@ruralcenter.org

Meeting Adjourned