



## **CAH News Update May 2010**

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### **ICAHN Expands IT Support Staff**

*Frank Penrose* has joined ICAHN as a contractor for IT services. Frank has worked in systems design, administration, and implementation for over 15 years. He provides consulting services for critical access hospitals in server, networking, and systems areas. Frank works with a variety of technology platforms including Microsoft Windows, VMWare vSphere, Red Hat/CentOS Linux, and storage area networks. Frank joins Todd Hart, Todd Cooper, and Jeff Perschall and can be reached through Todd Hart, [thart@icahn.org](mailto:thart@icahn.org)

### **EHR Incentive Program/Meaningful Use Update**

Officials at both the Centers for Medicare and Medicaid Services and the Office of the National Coordinator of Health IT continue their review of the approximate 2700 documents received in response to the publication of the proposed rule on meaningful use of electronic health records and the associated incentive payments. CMS is reviewing approximately 2000 of the documents and ONC the balance. ICAHN submitted comments on the proposed rule, which were distributed to all ICAHN members and are posted on the ICAHN Website.

Since the closing date for submission of comments on the proposed rule, national provider organizations, federal panels/committees, and members of congress all have expressed concern about the high level of expectations and the compressed timeframe to achieve the expectations. In mid-March, 249 members of the House of Representatives sent a letter to CMS expressing their (and their constituents) concerns with the proposed rule and its impact on hospitals ability to achieve meaningful use. An advisory group to the U.S. Department of Health and Human Services, the Health IT Policy Committee, recommended more flexibility and an incremental achievement of selected meaningful use requirements.

A group of 37 Democratic senators sent comments to HHS Secretary Kathleen Sebelius requesting deferment of certain timelines, making individual hospitals within a hospital system eligible for incentive payments, and making critical access hospitals eligible to participate in the

Medicaid incentive program. This request is similar to a letter sent earlier by a bipartisan group of 27 senators to Charlene Frizzera, acting administrator of CMS.

In early May 5, a coalition of 51 healthcare organizations – including the American Hospital Association, American Medical Association, and Federation of American Hospitals – recommended to the HHS secretary that more time and greater flexibility be allowed to achieve meaningful use. The key points addressed by the coalition included:

- greater flexibility in meeting meaningful use by allowing “....providers to implement a percentage or limited number of the meaningful use objectives and offer providers greater flexibility in choosing which requirements to implement.”
- more time to achieve meaningful use by extending “....the transition to meaningful use to 2017, consistent with the ARRA.”
- “....include representation from small physician practices in future meetings” of the Health IT Policy Advisory Committee
- create a feedback mechanism so “....physicians receive feedback on their performance so they know if they are meeting the criteria for the incentive payments”
- focus on clinical objectives and “....drop the two proposed objectives/measures related to administrative systems”
- develop a less restrictive definition of a hospital and “....define a hospital as a discrete facility of service, so that individual sites of hospitals are eligible to separately qualify for the incentives.”
- lessen the burden of reporting requirements and “.... only require reporting of HIT functionality measures that can be generated directly from EHRs, with no need for manual chart reviews. We also recommend that CMS postpone the requirement on submission of quality metrics until there is evidence that the means to capture the data from EHRs and submit the data to CMS is (sic) validated.”
- establish appeals processes for the Medicare program that mirror those required of state Medicaid programs, and processes to appeal incentive payment determinations, both amounts and provider eligibility to receive
- reduce from 10 years to five years the retention time for documentation of eligibility to receive incentive payments
- harmonize Medicare and Medicaid incentive program requirements
- allow critical access hospitals to participate in the Medicaid EHR incentive program

David Blumenthal, National Coordinator for Health IT, spoke at the recent American Hospital Association Conference and expressed “We are listening and anxious to make this work for you.” At the conference, executives of some of the most wired hospitals in the nation expressed their concerns about their ability to meet the meaningful use requirements in the first year of the program.

The most repeated estimate for the release by CMS of the interim final rule is “late spring.”

## **EHR Incentives Extended to Some Hospital-based Physicians**

Legislation has been signed by President Obama that changes the definition of a hospital-based physician contained in the HITECH Act. Originally, hospital-based physicians, including primary

care physicians working in ambulatory outpatient clinics, were excluded from the EHR incentive programs.

The Continuing Extension Act of 2010 (HR 4851) changed the description of a hospital-based setting from “inpatient or out-patient” to “inpatient or emergency room setting.” Physicians working in ambulatory settings such as provider-based rural health clinics now are eligible to participate in the incentive programs.

Many questions remain and more have been raised by the reference to “emergency room setting.” Hopefully, answers will be provided later this spring when the interim final rule on the EHR incentive program is to be released.

## **Medicaid Outpatient Cost-based Reimbursement Near Reality**

Illinois HB5765, which provides cost-based Medicaid reimbursement for outpatient services provided by critical access hospitals soon will be on its way to the governor for signature. The bill passed both chambers of the Illinois General Assembly on nearly unanimous, bipartisan votes. Funds to meet the obligation of the legislation still must be provided through the appropriation process, a hurdle to be faced once the bill is signed into law. The amount needed to fund the provisions of the bill represents just three-tenths of one percent of the total state expenditures for all Illinois hospitals.

Special thanks are directed to Randy Dauby, CEO at Hamilton Memorial Hospital and to Hervey Davis, CEO at Franklin Hospital for their extraordinary diligence in pursuing this legislation and rallying the supportive efforts of all ICAHN members. Also appreciated are the assistance and support provided by Howard Peters and staff at the Illinois Hospital Association.

## **DEA Rule on e-Prescribing Effective June 1**

The Drug Enforcement Agency’s long-awaited interim final rule that allows electronic prescription of controlled substances was published March 31. It becomes effective June 1, barring any complications from the 60-day comment period and the required congressional review and approval.

The proposed rulemaking appeared in June 2008 and caused great concern due to complex processes for authentication of prescribers. Many of the issues have been addressed although two-factor authentication is still required in the new interim final rule.

Provider organizations expect significant increases in the number of electronic prescriptions. Surescripts reported that the number of prescriptions submitted electronically had increased from an estimated 68 million in 2008 to 191 million in 2009. Because many providers did not want to use both electronic and paper systems, the new DEA rule is expected to result in even greater increases in electronic prescribing in the future.

Electronic prescribing is credited with improved patient safety and with cost savings. Although the controlled substances rule eliminates one of the most prominent barriers, the eHealth

Initiative, a national organization that seeks healthcare improvement through the use of information technology, identifies several lingering issues that must be eliminated to enable full adoption of electronic prescribing and include:

- financial burdens
- workflow modification
- connectivity issues
- ability of electronic systems to readily reconcile medication histories from multiple sources

## **EHR User Groups to Form**

At the recommendation of participants on the monthly meaningful use conference calls, user groups will be formed for each of the primary vendor sources of EHRs used by our critical access hospitals to share and compare information about use of the systems. The first sessions are scheduled in mid-June and will be conducted by video. Subsequent sessions may continue by video or by teleconference, whichever a group's participants prefer. To date, individuals from 16 hospitals have indicated interest in participating; please contact Mary Ring at [mring@icahn.org](mailto:mring@icahn.org) if you would like to be added to the registration list. The sessions are scheduled as follows:

<b>Tuesday, June 15</b>	10:00 AM to Noon	CPSI
	1:00 PM to 3:00 PM	MEDITECH
<b>Wednesday, June 16</b>	10:00 AM to Noon	Healthland
	1:00 PM to 3:00 PM	HMS

Information on video host sites and Springfield location will be distributed prior to the sessions. If there is interest in adding additional user groups, such as ambulatory EHRs, please forward your requests to Mary Ring.

## **Stroke Management Training Scheduled July 9, 2010**

The ICAHN Stroke Initiative will present the first Webinar in a series of accredited education programs on stroke management. On **Friday, July 9<sup>th</sup>, 2010**, Dr. Michael Schneck, Loyola University Chicago, will present a program titled *Acute Stroke Science: The Foundation for Quality Stroke Care in the Critical Access Hospital Setting*. CME/CE credits will be available.

Registration information will be distributed soon.

Contact ICAHN's Stroke Initiative consultant Peggy Jones at [pjones@icahn.org](mailto:pjones@icahn.org) if you have stroke-related information needs.

## **Illinois Receives HITECH Act Funds for EHR Selection and Implementation Assistance**

The HITECH Act, created as part of the American Recovery and Reinvestment Act, authorizes a Health Information Technology Extension Program that will establish HIT Regional Extension Centers or RECs. The RECs will offer technical assistance and guidance to support and accelerate primary care providers' efforts to select and implement electronic health records and to become meaningful users of the technology. The funds may not be used to assist with inpatient technology selection.

Sixty RECs were funded nationwide and two of those will serve Illinois providers. Northern Illinois University and its partners – Metropolitan Chicago Healthcare Council, Quality Quest for Health of Illinois, and Southern Illinois Healthcare Foundation – received a grant of \$7.546 million to assist providers outside the city of Chicago. Northwestern University and its partners received a grant of \$7.649 million to assist providers in the city.

NIU solicited proposals from potential technical assistance providers and ICAHN applied for consideration. No decisions have been reported to date.

Keep in mind ICAHN staff will provide assistance to the critical access hospitals and their employed physicians in the selection and implementation of EHRs. REC funding would help support the provision of technical assistance to community-based physicians in the critical access hospital communities.

NIU applied to the U.S. Department of Health and Human Services for supplemental funds to support technical assistance for physicians employed by rural hospitals, both CAH and others. No funding decisions have been announced. ICAHN staff are participating in a nationwide CAH effort to seek HHS/ONC approval to use the supplemental funds to assist rural hospitals, especially CAHs, select and implement inpatient EHRs. Verbal agreement has been confirmed by ONC staff and we are hopeful written clarification will be available soon.

## **FCC Makes Health Care Broadband Recommendations**

Congress directed the Federal Communications Commission to prepare a *National Broadband Plan*, which was released in August 2009 (<http://fcc.gov>). The plan expresses a “detailed strategy” to maximize the use of broadband to improve nearly every facet of American life, including health care delivery.

Dozens of recommendations were offered and six long-term goals were crafted to provide guidance over the next decade. Of particular interest to the health care community is Goal 4:

Every American community should have affordable access to at least one gigabit per second broadband service to anchor institutions such as schools, hospitals, and government buildings.

A 25-page Chapter 10 is devoted to health care-related recommendations. Eleven recommendations are grouped into four categories:

- 1) create appropriate incentives for e-care utilization

- 2) modernize regulations to enable health IT adoption
- 3) unlock the value of data
- 4) ensure sufficient connectivity for health care delivery locations

It is evident the FCC made recommendations for action by other federal agencies as well as the for-profit and non-profit private sectors. The report has generated robust discussions among many stakeholders.

The report suggests problems exist with the current structure of the FCC's Rural Health Care Program, which subsidizes telecommunications charges for public and non-profit rural health care providers and facilities to eliminate rural/urban price differences. The FCC reports that less than 25 percent of the nearly 11,000 eligible institutions participate in the program and in 2009, 82 percent of the funds were used to support connections speeds of 4 mbps or less. To overcome these shortcomings, the FCC developed a Rural Health Care Pilot Program; Northern Illinois University received one of the Pilot Program grants.

Using information and best practices identified from the Pilot Program grantees, the FCC now recommends several activities to enhance rural broadband access.

Recommendation 10.7: The FCC should establish a Health Care Broadband Infrastructure Fund to subsidize network deployment to health care delivery locations where existing networks are insufficient.

Recommendation 10.8: The FCC should authorize participation in the Health Care Broadband Funds by long-term care facilities, off-site administrative offices, data centers and other similar locations. Congress should consider providing support for for-profit institutions that serve particularly vulnerable populations.

Another recommendation could complicate access by health care providers to the broadband support funds:

Recommendation 10.9: 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 USF (Universal Service Fund) subsidies, such as HHS's meaningful use criteria.

The report does not document any fraud and abuse occurring to date and reports that less than one-quarter of eligible providers currently access the available subsidies. Linking meaningful use of electronic health records by rural health providers to future access to subsidized broadband connectivity does will further complicate provider efforts to improve their connectivity. This recommendation requires on-going monitoring and possibly public advocacy in the future.

## **Section 340B Drug Pricing Program Update**

Eligible critical access hospitals now may receive significant discounts on outpatient drugs purchased through the Section 340B Drug Pricing Program. Changes to the program were recently enacted by the Patient Protection and Affordable Care Act.

A complimentary Web conference to explain the new 340B Program will be conducted by Foley and Lardner's Critical Access Hospital and Rural Provider Team on **Tuesday, June 15<sup>th</sup> at 10:00 AM**. Pre-registration is required: contact Melissa Roth at [mroth@foley.com](mailto:mroth@foley.com) or 312-832-5786.

## **Take 2 to Save 2 Initiative**

Take 2 to Save 2 is a new initiative from the American Stroke Association and Power to End Stroke. The initiative asks that people take two minutes to learn life saving information and to share it with others. Learn the warning signs, risk factors and how to prevent stroke by visiting [www.powertoendstroke.org/take2](http://www.powertoendstroke.org/take2). Then, spread the word by sending special health messages to people you care about.

## **Rural Health Care Ethics Guide Available**

A new resource is available - the *Handbook for Rural Health Care Ethics*, which uses a case-based approach to analyzing, solving and anticipating health care ethics dilemmas. The handbook was authored by physicians, nurses, health care ethicists, and hospital administrators with scholarship or expertise in rural ethics, and was funded by a grant from the National Institutes of Health National Library of Medicine. Access the handbook at <http://dms.dartmouth.edu/cfm/resources/ethics/>

## **ICAHN Web Site Adds Job Openings Postings**

ICAHN has added a new feature – postings of jobs openings of all categories at critical access hospitals. Hospitals interested in posting a position are to contact Matt Comerford at the ICAHN office (815-875-2999 or [mcomerford@icahn.org](mailto:mcomerford@icahn.org)). Please provide a short paragraph describing the available position as well as a link to your hospital's Web site. Look at the ICAHN Web site at [www.icahn.org](http://www.icahn.org).

## **ICAHN Staff**

Curt Zimmerman, Director of Business Services; Matt Comerford, Operations Coordinator; Todd Cooper, IT Coordinator; Don Evans, Education Coordinator; Holly Hammerich, Office Assistant; Todd Hart, Director of IT Services; Carrie Galbraith, Physician Recruitment Services; Frank Penrose, IT Consultant; Jeff Perschall, IT Consultant; Mary Ring, PHIN Grant Project Director; Pat Schou, Executive Director; Bill Spitler, Special Projects Consultant