

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

April 30, 2010

## HITECH Roundtable – Action Items

Action Item	Timeline	Person Responsible	Status	Notes
Forward information on HITECH training opportunities.	ASAP	Mr. Lyon	Ongoing	
Share a list of state contacts for the Medicaid HIT planning process.	ASAP	Ms. Garner	Ongoing	
Forward the names of contacts for organizations wishing to acquire the RPMS EHR to IHS.	ASAP	Participants	Ongoing	
Forward reports of problems with RPMS to IHS.	ASAP	Participants	Ongoing	
Look into the possibility of counting patients without third party payers toward the Medicaid incentive threshold.	ASAP	CMS	Ongoing	
Forward information on the purpose and function of the California REC.	ASAP	Ms. Pro	Ongoing	
Conduct another HITECH Roundtable in conjunction with the July TTAG meeting.	ASAP	CMS	Ongoing	
Develop solicitations concerning the EHR readiness assessments and training.	ASAP	CMS	Ongoing	

April 30, 2010

## HITECH Roundtable – Summary

Agenda Item	Discussion	Action
<b>Documents Received</b>	<ul style="list-style-type: none"> <li>HITECH Roundtable Briefing Book</li> <li>Slide Presentation – Jackie Garner</li> </ul>	
<b>Participants</b>	TTAG: W. Ron Allen James Crouch Valerie Davidson Jason Dollarhide Carolyn Finster Kathy Hughes Tracy Jones Jim Lamb Grace Manuel David Reede	

	<p>Anslem Roanhorse Carmelita Skeeter H. Sally Smith</p> <p>TTAG Technical Advisors: Myra Munson Kris Locke Carol Barbero</p> <p>Tribes and Tribal Organizations: Tiffany Elton Donna Keeler Alida Montiel John Olson Rosario Arreola Pro Bill Riley</p> <p>CMS: Jim Lyon Kitty Marx John Johns</p> <p>IHS: Elmer Brewster Stephanie Klepacki Lisa Tonrey</p> <p>NIHB: Tyra Baer Stacy Bohlen Robin Carufel</p> <p>Other: Chad Greeno, Cerner</p>	
<p><b>Call to Order</b></p>	<p>Following up on the previous day's Tribal Technical Advisory Group (TTAG), <b>Ms. Valerie Davidson</b>, Chair, TTAG and Executive Vice President and Senior Director, Legal and Intergovernmental Affairs, Alaska Native Tribal Health Consortium, reminded participants that subcommittees should submit their project proposals for end of year funds to <b>Ms. Tyra Baer</b>, CMS Staff Assistant, National Indian Health Board (NIHB), who will assemble the requests and forward them to TTAG Budget/Strategic Plan Subcommittee Chair <b>Mr. James Roberts</b>, Policy Analyst, Northwest Portland Area Indian Health Board. She also reminded participants that the next TTAG calls will take place on May 12 and June 9, and the next face-to-face meeting will take place on July 28-29.</p> <p><b>Mr. Jim Lyon</b>, Tribal Affairs Group (TAG), Office of External Affairs and Beneficiary Services (OEA), Centers for Medicare &amp; Medicaid Services (CMS), served as the meeting moderator.</p>	
<p><b>Welcome and Introductions</b></p>	<p><b>Mr. Lyon</b> welcomed the participants and stated that the purpose of the meeting was to provide an overview of the Health Information Technology for Economic and Clinical Health (HITECH) initiative and meaningful use. Additionally, it provided an opportunity to brainstorm on ways CMS can provide assistance to Indian Country.</p>	

	<p>Currently, the HITECH information CMS provides is based on draft regulations. Once the regulations are finalized, CMS will provide additional training. <b>Mr. Lyon</b> noted that there are many free training opportunities available from groups besides CMS. He committed to forwarding information on these sessions as they are posted.</p> <p><b>Mr. Lyon</b> took the opportunity to review several CMS information technology-related initiatives, including the nursing home quality, the hospital quality, physician quality, e-prescribing, and in-patient quality (HCAHPS) initiative. A common feature of CMS initiatives is the possibility of decreased Medicare reimbursements decreased as the result of non-participation,</p> <p><b>Mr. Lyon</b> thanked the presenters and others who helped put together the content of the meeting:</p> <ul style="list-style-type: none"> <li>• <b>Ms. Rosario Arreola Pro</b>, Health Systems Development Director, California Rural Indian Health Board (CRIHB);</li> <li>• <b>Mr. Bill Riley</b>, Director, Health Services, Jamestown S’Kallam Tribe;</li> <li>• <b>Ms. Tiffany Elton</b>, NCPS, Min-No-Aya-Win Center for American Indian Resources Pharmacy;</li> <li>• <b>John Olson</b>, Information Technology (IT) and Business Systems Analyst, Oneida Nation of Wisconsin;</li> <li>• <b>Donna Keeler</b>, Executive Director, South Dakota Urban Indian Health Clinic;</li> <li>• <b>Theresa Cullen</b> Chief Information Officer, Indian Health Service (IHS); and,</li> <li>• <b>Stephanie Klepacki</b>, IT Specialist, Policy &amp; Planning, Office of Information Technology (OIT), IHS.</li> </ul>	<p><b>Mr. Lyon</b> will forward information on HITECH training opportunities on an ongoing basis.</p>
<p><b>Overview of HITECH</b></p>	<p><b>Ms. Pro</b> provided an overview of the CMS Medicare/Medicaid electronic health record (EHR) incentive, with an emphasis on eligibility, payment methodology, and reporting methodology for tribal health programs and smaller providers. The overarching goal of the incentive program is to improve health outcomes.</p> <p>The incentive program starts as early as 2010, depending on each state’s readiness. Most participants will begin participating in the program in 2011. The Medicare and Medicaid programs have slightly different timelines.</p> <p>CMS has allocated \$35 billion dollars for this initiative. Maximum incentive payments are \$63,750 per eligible Medicaid provider and up to \$44,000 for eligible Medicare providers. Providers who are not currently Medicare or Medicaid providers are not eligible for the program.</p> <p>The Medicaid program is open to a larger number of provider types (including nurse practitioners and physicians assistants [PAs]) than the Medicare program. Indian health care providers have been advocating for both programs to allow a greater diversity of provider types to reflect the spectrum of care. <b>Mr. Riley</b> pointed out that some of the program requirements and restrictions are statutory. If the list of provider types is defined by statute, it will be very difficult to change it. <b>Mr. Jim Lamb</b>, Alaska Area Alternate and Director, Patient Financial Services, Alaska Native Medical Health Consortium</p>	

(ANMHC), noted that including PAs would be beneficial to Indian Country as they are an integral part of the system of care. He also pointed out the important role of pharmacists and hoped that they could be added to the list.

**Ms. Lisa Tonrey**, Tucson Area, IHS, explained that PAs are not considered independent practitioners but nurses are. This may explain the way they are categorized. With regard to pharmacists, they have been identified as primary care providers in other contexts. She suggested that efforts be made to get these groups recognized under the program.

Providers do not need to use EHRs 100 percent of the time. At a minimum, providers must use EHRs for 50 percent of patient encounters. Providers who work at multiple sites must have a cumulative EHR use of at least 50 percent of encounters.

Under the Medicaid incentive program:

- Incentives will be paid by the states (states are not required to participate).
- The program will offer incentives to providers for a maximum of six consecutive years, starting as early as 2011 and ending as late as 2021. Providers must enter the program by 2016 to make full use of the incentives.
- The minimum patient threshold is 30 percent of patient volume per provider (pediatricians have a 20 percent threshold).
- Federally qualified health centers and rural health centers have a threshold of 30 percent needy individuals (including Medicaid, State Child Health Insurance Program, uncompensated care, sliding scale patients, and write-off patients).
- Incentives are up to \$21,000 the first year and up to \$8,500 per year thereafter.
- Allowable costs relate to the purchase, upgrade, implementation (e.g., revamp workflow, clinical decision support), maintenance, training, or staffing related to EHRs. Funding from federal or local governments (e.g., grants) cannot be counted in allowable costs.

Under the Medicare incentive program:

- Incentives will be paid directly by CMS.
- Incentives begin in 2011 and end in 2016.
- There is no patient threshold.
- Incentive payments are based on 75 percent of allowable eligible provider charges under Part B and fee-for-service claims up to the incentive limit.
- Total maximum incentive payments are \$44,000 per provider.
- Providers in a health professional shortage area qualify for an additional 10 percent incentive.
- Penalties for not having an EHR begin in 2015.

A single program data repository will be used to track providers by National Provider Identifiers. During the first year, there will be a 90-day window to achieve meaningful use; in subsequent years, the window will extend to a full year. Initial payments will be made once meaningful use has been achieved. Providers can reassign their incentives. Clinics can switch between the Medicare and the

Medicaid programs once. These switches must occur no later than 2014.

Reporting requirements fall into two categories: the ability to use the EHR in a meaningful way and the ability to report clinical measures. For those who already have EHRs, **Ms. Pro** encouraged the expansion of their use for things such as orders, e-prescribing, etc. She also encouraged providers to join the program as soon as possible to take maximum advantage of the incentives and allow more time to achieve proficiency in the use of EHRs. Additional actions include training staff on meaningful use and motivating them to make full use of the EHR.

**Ms. Davidson** asked how the reassignment provision would apply to temporary duty providers. She thought that her organization would not be able to count them in their statistics. **Ms. Pro** thought that this would be the case. **Mr. Lyon** added that the provider selects where his or her incentive is assigned.

**Ms. Carmelita Skeeter**, Executive Director, Indian Health Care Resources Center of Tulsa, noted that clinics that use PAs to treat most of their elderly patients and physicians to treat the rest would likely have to change the way patients are assigned to be able to access the incentives. **Ms. Klepacki** replied that PAs are only eligible under the Medicaid program. **Ms. Pro** observed that the incentive program might not be the best option depending on each provider's situation.

**Mr. Lamb** noted that it is important to know each facility's patient mix on a monthly basis. If the patient mix is less than the 30 percent Medicaid threshold, a provider will not be able to participate. Additionally, he stressed the importance of conducting more Medicaid outreach, which can help providers meet the threshold. This will be especially true in 2014, when Medicaid eligibility will expand.

**Ms. Carolyn Finster**, TTAG Secretary and Director, Pine Hill Health Center, asked if the 30 percent threshold is cumulative for the facility or if it applies to each eligible provider. She was concerned that this would affect the free choice of patients. **Ms. Klepacki** added that the patient volume requirements apply to the year prior to the reporting period. IHS is working on a Resource and Patient Management System (RPMS) report that will calculate patient volumes by type.

**Mr. James Crouch**, Executive Director, CRIHB, recommended using the TTAG to push for allowing a portion of IHS funds to be considered in the same manner as the sliding scale write-offs for Health Resources and Services Administration funded programs. While this might require some income documentation, it would solve the threshold problem. **Mr. Lamb** agreed, noting that ANMHC writes off 40 cents of every dollar for patients with no third party payer. Allowing this would make the threshold attainable for virtually all IHS providers.

**Mr. Riley** pointed out the importance of taking the Medicare Part B

	<p>billing requirements into account when selecting a program in which to participate (many tribal providers bill under Part A).</p> <p><b>Ms. Myra Munson</b>, TTAG Technical Advisor, Sonosky, Chambers, Sachse, Miller &amp; Munson, LLP, asked whether tribal self-determination funds are excluded from the cost basis for determination of the incentives. <b>Ms. Pro</b> agreed that it is important to clarify this as the law simply refers to “funding” in general.</p>	
<p><b>IHS HITECH Initiatives and Meaningful Use</b></p>	<p><b>Ms. Klepacki</b> presented an overview of HITECH meaningful use, including needed changes to the RPMS, major milestones, outreach efforts, area and site involvement, and next steps.</p> <p>To achieve meaningful use, as defined by Congress, EHR users must:</p> <ul style="list-style-type: none"> <li>• Use a certified EHR,</li> <li>• Be able to exchange information electronically, and</li> <li>• Submit reports that prove meaningful use – including performance measures – to CMS.</li> </ul> <p>Meaningful use, as outlined in the proposed rule, is an all or nothing proposition; providers must meet all criteria to qualify for incentives. Discussions are ongoing concerning the possibility of reducing the requirements during the first stage of implementation.</p> <p>Implementation of meaningful use will occur in three stages. The first stage, beginning in 2011, will be governed by the proposed rule that CMS published earlier this year and, once it is released, the final rule. It will focus on data capture and sharing. Additional rules will be issued prior to the start of Stages 2 (2013) and 3 (2015), with each rule becoming more comprehensive. The focus of Stage 2 will be advanced clinical processes. The final stage will emphasize improved outcomes.</p> <p><b>Ms. Klepacki</b> identified 21 changes that IHS must make to the current RPMS system to make it certifiable for meaningful use. These changes, which will be released as patches, extend beyond the graphical user interface (GUI) used by providers to the whole system and include functions such as patient registration, laboratory information, pharmacy, and clinical reporting. Changes highlighted by <b>Ms. Klepacki</b> were:</p> <ul style="list-style-type: none"> <li>• Enabling RPMS to do drug to formulary checks (this is also required for e-prescribing);</li> <li>• Requiring entry of “none” in problem, medication, or medication allergy lists;</li> <li>• Employing the Ensemble data base for e-prescribing;</li> <li>• Adding patient preferred language;</li> <li>• Enabling entry of underlying causes of death during a hospital stay (hospital only requirement.) <b>Ms. Finster</b> had concerns about whether and how facilities would enter cause of death data for tribal members who die outside of a facility’s jurisdiction, particularly when they die in a non-IHS facility. <b>Ms. Klepacki</b> replied that there has been much discussion concerning this matter. Based on IHS’ understanding of the rule, the facility in which a patient dies is responsible for reporting/recording the death.</li> </ul>	

- Enabling RPMS to calculate body mass index immediately upon entry of data;
- Incorporating lab test results into the EHR as structured data (50 percent requirement). This will be difficult to meet for facilities that use reference labs and do not have the bi-directional laboratory interface.
- Reporting quality measures to either CMS (Medicare) or states (Medicaid). IHS will incorporate these measures into the Clinical Reporting System;
- Sending patient reminders via patient-preferred method (i.e., Internet or non-Internet). RPMS needs to collect preferences, send the reminder, and document and report that reminder was sent;
- Tracking, recording, and reporting on alerts for five CDS rules (rules must be linked to quality measures and will vary based on provider type/specialty);
- Checking insurance eligibility electronically;
- Developing the ability to submit claims electronically;
- Enabling RPMS to record when and how patients access health information/records electronically (via Internet portal, CD, or USB drive);
- Revising the clinical summaries to include problem lists and procedures;
- Enable the exchange of continuity of care documents (CCD) with other, external, providers (need to generate a CCD and ensure that records are for the same patient);
- Revising the health summary to include the CCD for printing at time of referral or transfer;
- Reconciling medication lists with other providers;
- Developing interfaces for submitting immunization data to states with non-standard formats;
- Creating exports to report lab results to public health agencies.

Additional changes relate to security issues.

For most of the requirements associated with the above changes, **Ms. Klepacki** noted that there is an 80 percent performance threshold to qualify for meaningful use. All of the above changes should be in place by the end of the calendar year, with the majority in place by the end of October.

**Ms. Klepacki** addressed several of the major milestones in IHS' IT efforts. IHS is using American Recovery and Reinvestment Act (ARRA) funds to upgrade the Ensemble database at all RPMS sites. It is beginning work on the patient portal display for personal health records. IHS is pursuing modular certification for its EHR and is reviewing RPMS to identify gaps and required changes. IHS hopes that its EHR will be certified in October. With regard to testing of the master patient identifier, IHS is currently testing its patch and expects to deploy the fix beginning in September. IHS is also beta testing its Nationwide Health Information Network (NHIN) CCD.

IHS is in the process of writing a contract for the development of quality measures. However, the CMS has not yet released the final rule, which will include the measures that need to be addressed

within the EHR. The final rule will include specifications concerning the definition of the measures. This prevents IHS from working on either the measures or their specifications until CMS releases the final rule.

**Ms. Finster** inquired whether IHS has a systematic process for deploying its EHR to tribal clinics. **Ms. Klepacki** replied affirmatively, noting that **Mr. David Taylor** leads the EHR Deployment Team.

IHS' Meaningful Use Team conducted 13 Web-based overview sessions and 10 provider and hospital training sessions. **Ms. Klepacki** is developing a new session on preparing for meaningful use, which will start on May 17. IHS might also develop a session on performance measures. OIT staff members participate in meetings such as this HITCH Roundtable to educate a wide range of groups about meaningful use.

The agency is also working with states to determine if they will participate in the incentive program and, if they do, whether they will add reporting requirements to those already specified.

OIT provides incentive payment calculators, a Web page, and a list serve to inform interested parties about issues related to meaningful use.

Next steps identified by **Ms. Klepacki** included understanding what is involved in achieving meaningful use, attending training sessions (many other groups offer complimentary sessions), assessing eligibility, beginning the process of obtaining the RPMS EHR (if not already using it), fully implementing an existing EHR, working with an Improving Patient Care (IPC) Team to reach the minimum thresholds, identify a Clinical Applications Coordinator within each organization, assessing current business practices, and identifying areas that need improvement.

OIT will fund 12 Meaningful Use Area Coordinator and seven IPC/Business Process Improvement Coordinator positions. These positions will initially be funded for two years starting in October. **Ms. Klepacki** did not know if these positions would continue beyond the first two years. **Ms. Davidson** was concerned that providers and facilities that wait until later to begin the adoption and implementation process would not have access to the support and guidance provided by these individuals if their positions are funded for only two years. She suggested that they be funded through 2020. **Ms. Klepacki** noted that those that begin the process late have to begin at a higher level of involvement; specifically, those that begin in 2015 must begin at Stage 3, while those that begin in 2014 can begin at Stage 1.

Regional Extension Centers (RECs) are tasked with helping providers and hospitals determine which EHR is best for their needs, install and implement EHR systems, and achieve meaningful use. However, RECs only receive the funds they have been awarded for facilities that achieve one of the steps in the process (Identification, installation, meaningful use).

**Ms. Klepacki** stated that NIHB received approximately \$15 million to serve as the REC supporting facilities and providers serving American Indian/Alaska Natives nationwide. **Ms. Stacy Bohlen**, Executive Director, NIHB, informed participants that **Ms. Jessica Burger**, NIHB's Director of Government Relations, leads this project and is working on the first draft of the plan to work with IHS and NIHB's project partners. She anticipates that the project will evolve as NIHB learns more about effective strategies for EHRs in Indian country. **Mr. Crouch** pointed out that TTAG advocacy was the reason IHS made and an Indian-specific REC award.

**Mr. Lyon** complimented IHS on its decision to include IPC teams in its outreach strategy.

**Mr. Crouch** commented that the IHS system needs to determine its appropriate relationship to those tribally operated health programs that have self-determined to be non-RPMS users. He expressed his complaint that IHS has allocated \$85 million to address technical issues related to making the RPMS system compliant with the meaningful use requirements but only provided \$3.5 million to non-RPMS users (and further limited that funding to improving interfaces with IHS). **Ms. Klepacki** promised to report his concerns to **Dr. Cullen**.

**Mr. Riley** noted that there is an interpretation that IHS Headquarters has some responsibility to do the work that will allow non RPMS-users to connect to the agency. Secondly, non-RPMS users face the same list of requirements that must be met. They must work with their respective vendors to ensure the changes are made. He felt that it would be very helpful to develop a list of non-RPMS users and the EHR systems they employ. This would allow one individual or group to work on developing solutions for the benefit of all tribes using the same system instead of duplicating each other's efforts.

**Ms. Davidson** felt that there are not enough resources available to help Indian Country prepare for the adoption and use of EHRs. The incentive programs assume that the tribal facilities are already using EHRs, which is not the case for many of them. Of the \$85 million of ARRA funds set aside for health information technology (HIT), which was not enough for IHS' needs, very little was given to self-governance tribes for EHR implementation. Instead, IHS funded routers and servers to facilitate communication with IHS. Indian Country is facing enormous requirements without much support from IHS – either in terms of funding or advocacy for support from Congress. Start-up costs are enormous, and the incentive payments do not offset them. Because resources and efforts are focused on RPMS, those users will probably meet the implementation requirements. She asked how IHS plans to ensure that all Indian facilities – whether run by IHS, tribes, or urban programs – have complete, manageable, workable products by the deadlines.

**Mr. Olson**, voicing a non-RPMS user's perspective, commented that these tribes do not get anything back for the money they allocate for IHS. He suggested that IHS allow tribes to keep these funds and use them for needed projects and activities. While **Mr. Crouch** was not in

	<p>complete agreement with Mr. Olson, he did point out that the \$4 million HIT line item in the FY 2011 IHS budget is specifically for updating the RPMS system.</p> <p><b>Ms. Kris Locke</b>, TTAG Technical Advisor, asked which four health boards are supporting NIHB on the \$15 million REC grant and how the money will be used to help the various health boards. <b>Ms. Bohlen</b> stated they were the United South and Eastern Tribes, CRIHB, Alaska, and Northwest Portland. The funds will be implemented in the way in which the consortium partners design the program. <b>Mr. Crouch</b> pointed out that providers could be either self-governance or non-self-governance (how tribes get money from IHS) and they could also be RPMS users or non-RPMS users (how they handle information). NIHB and its partners will serve everyone equally.</p> <p><b>Mr. Elmer Brewster</b>, Health Science Administrator, IHS, suggested that the REC set up a site where tribes can report data on the systems they are using to form a baseline on which advocacy could be based.</p> <p><b>Ms. Alida Montiel</b>, Health Systems Analyst, Inter Tribal Council of Arizona, asked whether tribes must have their own EHRs or if they can work under a larger umbrella. She also asked if facilities that serve both Medicare and Medicaid patients had to choose between the two incentive programs. <b>Ms. Klepacki</b> replied that they must make a choice.</p>	
<p><b>CMSO and State Perspective</b></p>	<p><b>Ms. Jackie Garner</b>, Consortium Administrator, Center for Medicaid, CHIP, and Survey &amp; Certification, CMS, focused her remarks on the non-technical aspects of the Medicaid HIT provisions and their implementation. She reported that CMS is still in the process of developing the final HITECH rule and expects to issue it in May or June.</p> <p>CMS issued its first State Medicaid Director letter, which addressed Section 4201 of Medicaid Incentive Program, on September 1, 2009. The agency is working on updated guidance that will provide greater specifics</p> <p>On January 13, CMS issued the proposed rule on the Medicare and Medicaid EHR incentive programs. The agency works closely with the Office of the National Coordinator (ONC) that CMS and ONC grants and rules do not conflict or contradict each other.</p> <p>CMS provides technical assistance and holds ongoing discussions with states concerning the submission of their Plans to Plan, which are very general outlines of how each state intends to proceed with Medicaid HIT planning and development work. To date, 47 or 48 states have submitted their initial plans and requests for funding. CMS expects the final states that have not submitted their Plan to Plan documents to do so soon. CMS stressed the need to include the tribes, tribal organizations, and IHS in the planning process. Most states are now beginning to work on the actual state Medicaid HIT plans.</p>	

**Ms. Garner** promised to share a list of the state representatives who are the leaders or points of contacts for each of the state planning processes.

As part of the Plan to Plan process, CMS encouraged states to cast a broad net for stakeholders. The state plans will need input from other government entities, private organizations, the health community, etc. In some cases, states are looking at ways to share information within their respective regions. **Ms. Garner** encouraged the participants to begin reaching out to and working with the states. CMS will provide support for these discussions in much the same way it does for tribal/state consultation. She indicated that CMS is working on a web portal that will contain all of the state Plan to Plans.

CMS is encouraging states to create leadership teams, to look outside of government ranks for ideas and leadership, and to think far into the future. The agency encourages the planners to think about the long-term goals of HIT. Several states are well into this process and serve as models and resources for the other states. **Ms. Garner** stressed that CMS expects tribes and tribal organizations to be involved in this process.

Many states are on the third or fourth generation of their Medicaid Management Information System (MMIS), which is a claims processing system. CMS is working to move states toward a Medicaid Information Technology Architecture (MITA) format, which allows states to reach out beyond Medicaid and link with other organizations within the state, such as public health. MITA, which is a form of MMIS system, helps states access data that is essential for making program decisions. Currently 18 states are converting their MMIS systems. This is part of CMS' broader effort to help states expand the use of their claims systems to fit into the greater HIT environment. Although states receive a 90 percent match on their claims systems, some are having difficulty funding their portion of the costs.

**Ms. Pro** asked if the lack of a HIT governance entity would affect the ability of states to participate in the incentive program. **Ms. Garner** indicated that it would.

**Mr. Brewster** asked about the source of funding within states for the 10 percent match on the MMIS funds. He asked if there was anyway to plug into the program at a national level (IHS serving as an umbrella structure) to benefit tribes. **Ms. Garner** stated that CMS has strict rules about where the funding comes from within states. States need to show that they are committed to their systems. She did not think that it would be possible for IHS to plug into the match.

**Mr. Crouch** asked if IHS and CMS meet regularly to discuss the data architecture. He observed that much of the research being done by the TTAG Data Subcommittee could be automated. **Ms. Garner** replied that there are executive level meetings of the various HHS components to discuss this topic. With regard to data, CMS has made significant investments in improving data collection and analysis. She

**Ms. Garner** will share a list of state contacts for the Medicaid HIT planning process.

	<p>predicted that there would be opportunities for discussing ideas such as this in the near future.</p> <p><b>Mr. Crouch</b> asked if CMS would require more uniformity in the MMIS between states, and require more patient specific data from the Medicare managed care entities concerning what they are doing per capitated amount. <b>Ms. Garner</b> did not have the information that he requested.</p>	
<p><b>Discussion</b></p>	<p><b>Mr. Lamb</b> indicated that ANMHC, after a careful selection process, selected Cerner to provide its EHR. He introduced <b>Mr. Chad Greeno</b>, Managing Director, Health Care Reform Group, Cerner. Mr. Greeno's responsibilities include educating Cerner staff and the firm's client base about the effects of health care reform policies and requirements contained in the ARRA and the Patient Protection and Affordable Care Act (PPACA) and supporting the development of strategies to address them. Cerner is one of the largest HIT vendors worldwide.</p> <p><b>Mr. Lyon</b> stated that the purpose of this session was to brainstorm about the areas in which TTAG should focus its efforts in the coming months, areas in which the participating organizations might require assistance, and resources that are available to help with the adoption and implementation of EHRs.</p> <p>Many of the Indian programs are in rural areas and have connectivity problems as a result. Although IHS and CMS are working with the Federal Communications Commission to improve connectivity, some tribes will still have problems in this area.</p> <p>CSM is looking for a contractor to identify facilities that do not use RPMS and to provide training. <b>Mr. Lyon</b> hoped that this session would identify areas of interest for the training that could be incorporated into CMS' solicitation.</p> <p><b>Ms. Finster</b> asked if there are any requirements for non-RPMS users to upload data – specifically the Government Performance and Results Act (GPRA) data – to IHS so that their data can be included along with that of RPMS users. She also inquired whether there are commercial companies that provide interfaces to RPMS. <b>Ms. Klepacki</b> noted that CMS sent out a tribal letter concerning grants to establish an RPMS interface from non-RPMS sites. <b>Mr. Crouch</b> added that the letter was sent out on April 2 and reissued on April 16 with an extension of the due date until May 15. The grants will be funded out of the \$3.5 million in ARRA funds. He had concerns about the lateness of the notice, the quick turnaround time for requests, the funding restrictions not being developed in consultation with tribes and tribal organizations, and the low amount of funding available. <b>Mr. Olson</b> pointed out that non-RPMS users want to report GPRA data but cannot because IHS has not provided specifications. Based on the discussion and general confusion over the goals of the interfaces, <b>Mr. Lyon</b> suggested that that CMS add Ms. Finster's question to its action list.</p> <p><b>Mr. Lamb</b> suggested that the group consider some of the pitfalls that</p>	

organizations need to be aware of as they move toward EHRs. He suggested that computerized provider order entry significantly changes the way providers practice and that provider willingness to use EHRs is one of the biggest hurdles to adoption.

**Ms. Finster** noted that under the pilot project at Zuni Hospital, getting all of the staff, such as nurses, to buy into the EHR has been a challenge. Not all staff members are comfortable with a keyboard, and errors can be made in data entry. The overriding question is whether changing the way a clinic or provider practices medicine is worth the incentive dollars.

**Mr. Crouch** wondered if there is an operating unit that is so small that adoption of an EHR is not efficient. Implementation is expensive because the number of encounters that can be conducted in a day during the initial period of use is reduced due to the extra time needed to work with the EHR, reducing income until providers become more familiar and comfortable with using the EHR. The question is not so much related to the financial aspects of adoption; it should be about the value of the improvement in quality and knowledge about clinic operations.

**Mr. Lyon** pointed out the need to have adequate IT and clinical applications staff as well as staff and provider buy-in in order to successfully implement EHRs. **Ms. Finster** emphasized the need for training, especially in rural areas, to help ease adoption. **Mr. Lamb** added that it is important to manage expectations of the facility staff by informing them about what will happen, when it will happen, and the inevitability of the change. **Mr. Greeno** noted that change management is always challenging. It is important to explain why things – such as entering data in a particular way for reporting purposes – need to be done in order to achieve buy-in.

**Ms. Keeler** noted that urban programs need to prove that they are providing excellent care in order to receive their funding, and the GPRA measures are how they do this. Her program developed a team to help staff acclimate to its new EHR system. She recommended involving staff in the process from the earliest stages. She also suggested participating in the IPC program, as it will help engage staff in change.

**Ms. H. Sally Smith**, Alaska Area Representative, NIHB and Chairman, Bristol Bay Area Health Corporation, described the process the Bristol Bay Area Health Corporation used to adopt EHRs at the Kanakanak Hospital. They worked hard to educate the board of directors, hired appropriate staff, established a budget, and began implementation. Over a relatively short time, providers – including those who come from ANMHC – began to accept the EHR. She noted the importance of having the complete support of the board of directors in promoting acceptance of the EHR and of having individuals within the organization who are excited about using the tool. **Mr. Greeno** reiterated the important role internal evangelists play in helping other members of the staff accept the EHR.

**Mr. Brewster** pointed out that there are various degrees of

implementation within the 638 program and that these institutions have very different needs.

**Mr. Crouch** suggested that service provider applications might be a cost effective approach for small systems. This would effectively be a commercialization of the RPMS system through the use of an off-the-shelf product with external support for software updates or query support. He also addressed staffing issues by anticipating that “provider flight” (providers changing practices to avoid the use of EHRs) will end as use of EHRs becomes almost universal. On the other hand, individuals with experience in managing EHRs will potentially find employment in practices that can offer higher pay and benefits than Indian facilities. **Mr. Greeno** noted that the RECs were envisioned as providing services to organizations that cannot afford the services of a specialty contractor as they make decisions concerning the selection and adoption of EHRs.

**Ms. Tracy Jones**, Director, Business Office, Chickasaw Nation Health System, noted that her organization has been using the RPMS EHR for four years for outpatients and will begin using it for inpatients later this year. While most providers were able to transition to the EHR, some had more difficulty doing so and others were never able to make the transition. It is important to find a balance between the quality of care and the quantity of data providers are asked to report. She was concerned that ever increasing reporting requirements would eventually reduce the number of patients providers are able to see.

**Ms. Montiel** asked whether organizations that are in the process of selecting between RPMS and a commercial package should wait until IHS has completed the upgrades to the RPMS package. **Ms. Pro** thought that there is a transition that needs to occur for current RPMS users to move into the revised, meaningful use compliant package. **Ms. Klepacki** stated there is a difference between the RPMS “roll and scroll” and the EHR GUI. Sites need to have the EHR GUI to qualify for meaningful use. There is an implementation process that is time-consuming. Well-timed training is essential to easing the process of adoption. She asked groups wishing to move to the RPMS EHR to send her their names and she would forward the information to the appropriate people within IHS. She also asked participants to send any reports of problems with service issues to her.

**Ms. Klepacki** described some of the general training available from IHS concerning HIT as well as more educational offerings related to RPMS. **Mr. Crouch** pointed out that many of the implementation and training processes under discussion are standard for both RPMS and commercial EHR systems.

**Ms. Klepacki** noted that installation of an EHR system often requires the upgrade, replacement, or new purchase of hardware.

**Ms. Tonrey** made some programmatic observations. In the case of *locum tenes* doctors, many of who either do not know how to use a particular EHR system or are not granted access. Because some facilities use these doctors to provide a significant portion of care,

Participants will forward the names of contacts for organizations wishing to acquire the RPMS EHR to **Ms. Klepacki**.

Participants will forward reports of problems with RPMS to **Ms. Klepacki**.

facilities must take their effect on meaningful use into account when writing their contracts. She also pointed out that nurses and other medical support staff need to receive training because they are responsible for data entry. This means that doctors are not the only ones who receive training.

**Mr. Lamb** noted that reporting seems to be a major theme and a significant obstacle to meaningful use. With regard to physician quality measures, he noted that IHS is ahead of much of the private sector in collecting these measures. Many of these measures cannot be gleaned from claims data. This data serves both to show how well each facility is doing in providing excellent care and to provide valuable information to patients.

**Ms. Finster** pointed out that new electronic systems in rural areas are dependent on the local infrastructure. Generators may keep the power on, but telephone lines might not be available for some time after a storm or other event. Back-up plans are essential. She hoped that policymakers would take this into account.

**Ms. Jones** noted that her organization tends to use agency nurses for inpatient services. They are concerned that these nurses will have problems learning the EHR system and that quality issues will result.

**Mr. Lamb** stated that the discussion underscored the importance of providing continual, just-in-time training. Organizations need to have staff that can work with new people immediately (not wait for a class). **Mr. Olson** added that staff positions established to implement the EHR will never go away. EHRs require continuous improvement and staff to execute those improvements and train users. It is essential that EHR adoption not be viewed as an IT project; staff members at all levels need to understand the importance of the EHR beyond the IT implications.

**Mr. Robin Carufel**, Consultant, NIHB, reported his experience with an organization that used a combination of RPMS and an off-the-shelf EHR product. They had one very resistant physician who was eventually convinced to move to the EHR after a chart review showed the EHR as a better way of capturing information. He also reported problems with the knowledge vacuum created by retirements at IHS. He suggested that IHS create a list of “best of the best” vendors to help smaller tribal groups that do not have the resources to conduct extensive research. **Mr. Lyon** pointed out that certification serves to identify a smaller list of vendors (approximately 30 to 50 vendors) that are qualified to install an EHR system.

With regard to the continuous nature of the EHR process, **Mr. Lyon** noted that CMS and ONC are developing a pediatric EHR. This will be particularly valuable to IHS and Indian health programs, which have many pediatric patients. **Ms. Munson** asked if the pediatric EHR tracks the Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. The EPSDT requirements are very important indicators for state Medicaid programs. She felt that not tracking this would be a missed opportunity. The EHR would need to allow enough flexibility to handle the differing periodicity of the various states’ EPSDT

requirements.

**Mr. Riley** stated that it is important to manage tribes' expectations of the incentive programs. First, they need to determine, on a provider-by-provider basis, whether they can achieve the thresholds required to participate in the programs. EHRs also offer opportunities for young people to launch careers within Indian health care. **Mr.**

**Greeno** pointed out that the ONC has provided funding to colleges and universities to train up to 50,000 professionals in HIT development, implementation, and support. **Mr. Carufel** suggested that the tribal colleges could be used as a training ground for these professions.

**Mr. Greeno** suggested that the TTAG use the National Rural Health Association, which works with small hospitals that face similar resource challenges, including connectivity issues, as another resource.

**Ms. Elton** observed that all facilities will face similar challenges in rolling out an EHR regardless of its source (RPMS or commercial). She pointed out that ongoing training is essential to stay abreast of software updates. She suggested that CMS or IHS create a checklist or flowchart for use by organizations just starting the process of acquiring an EHR.

**Ms. Davidson** stated that it is important to make sure that all facilities and providers in Indian Country are aware of and preparing for the EHR requirements and deadlines (specifically the 2015 milestone when the reimbursement penalties begin) and to ensure that Congressional leaders are aware of the challenges Indian Country is facing. She felt the need for a separate line appropriation in the IHS budget for assisting self-governance and urban Indian centers deploy EHRs and meet the meaningful use criteria. **Mr. Crouch** agreed and suggested meeting with IHS to ensure that the budget support language directs that funds under such a line item be available to all parts of the system. He encouraged all groups in Indian Country to advocate for this.

**Mr. Lamb** indicated that it would be helpful if each Indian site could undergo an assessment of EHR readiness. He hoped that this could be done under the NIHB REC contract. **Mr. Lyon** stated that there is an assessment associated with RPMS. He felt that this would be appropriate for non-RPMS sites.

**Ms. Kathy Hughes**, Vice Chairwoman, Sovereign Nation of Oneida, noted that IHS is supposed to represent all tribes, not just those with RPMS. She felt that IHS is putting much effort into making RPMS certifiable, but that it is not putting much effort at all into helping non-RPMS groups.

**Mr. Olson** suggested that IHS could serve as the conduit by which tribes connect to other tribes and to the states, instead of the various state health information exchanges, in instances where tribal members seek care away from home (e.g., traveling to a powwow).

**Ms. Klepacki** indicated that this might not be possible due to the way

	<p>the state exchanges are being set up. IHS is in the process of determining each state’s requirement for health information exchange. The easiest approach is to go through the NHIN. However, if each state decides to use its own exchange, it might be necessary to create individual state interfaces. There is a multitude of other exchanges that still need to be developed. She suggested that the NHIN would be the best way to transmit patient summary data. <b>Mr. Crouch</b> pointed out that this would not transmit the full patient record that would be needed to ensure the highest level of care. <b>Ms. Klepacki</b> indicated that IHS would likely connect to states through the NHIN; otherwise, separate interfaces will have to be developed.</p> <p><b>Mr. Crouch</b> noted that there are multiple layers of issues related to EHRs – some are related to ARRA, others to PPACA, and others to states. <b>Mr. Lamb</b> expressed his opinion that it is not yet time to build the exchanges. There is no funding yet and they are still in the planning stages. Whatever system is developed must be agile and be able to talk to the various exchanges.</p> <p><b>Mr. Greeno</b> described that Cerner’s approach to this issue. He noted that there are many overlaps in the data. Cerner will offer a single connection; pull out all of the data for all of the various reporting requirements; and, subsequently, route data through the appropriate, approved connections. Cerner is not counting on NHIN. The firm is looking at various approaches for point-to-point data exchange. <b>Ms. Klepacki</b> noted that IHS is required to use the NHIN.</p> <p><b>Mr. Lyon</b> pointed out the opportunities offered by end of year funding and suggested the TTAG might request these funds to conduct readiness assessments for non-RPMS clinics.</p> <p><b>Ms. Pro</b> announced that CRIHB will host the fourth Annual Tribal Health Connection Conference in Sacramento, Calif. She invited all participants, especially those with EHRs.</p>	
<p><b>Summary and Next Steps</b></p>	<p><b>Mr. Lyon</b> addressed the need to identify next steps including:</p> <ul style="list-style-type: none"> <li>• A breakout session on HITECH issues at the NIH CMS Day,</li> <li>• A HITECH training session for organizations that do not use the RPMS system, and,</li> <li>• Assessments of non-RPMS organizations’ readiness to move toward and EHR system.</li> </ul> <p><b>Ms. Kitty Marx</b>, Director, TAG, OEA, CMS, asked participants for their feedback on what they would like to see CMS do to support HITECH beyond serving as a liaison with the various state Medicaid agencies.</p> <p><b>Mr. Riley</b> hoped that CMS would track how many tribes qualify for the incentives, especially among the self-governance tribes. He was concerned that the law was not written in a way that actually supports the tribes’ efforts to adopt EHRs.</p> <p><b>Mr. Lamb</b> indicated that CMS could change the language to give the tribal providers credit for the patients they serve who have no payer source. This would help these providers qualify for the Medicaid incentives. Secondly, CMS could provide in-kind technical assistance to NIH as it sets up the REC. CMS could also provide funding for</p>	<p>CMS will look into the possibility of counting patients with out third party payers toward the Medicaid incentive threshold.</p>

	<p>assessments to draw attention to this issue at the various facilities. <b>Mr. Crouch</b> added that facilities would be willing to document income for clients who are IHS-dependent or medically indigent. <b>Ms. Marx</b> indicated that CMS would look into this and determine how the agency is addressing this issue.</p> <p><b>Mr. Lyons</b> asked if participants would like to have another meeting on this topic at a future date, possibly in conjunction with a TTAG face-to-face meeting. <b>Mr. Lamb</b> expressed a desire to hear from NIHB about the progress it has made in setting up the REC as part of the July TTAG meeting. He would also like to hear more about the purpose and functions of the REC. <b>Ms. Pro</b> volunteered to forward information on the California REC model to participants. <b>Mr. Crouch</b> requested that <b>Ms. Klepacki</b> bring <b>Dr. Cullen</b> to the next meeting. He also stated that the data symposium on July 29 would provide an opportunity to learn more about the role of data in advancing Indian health and as a tool for advocating for Indian health issues.</p> <p><b>Mr. Lyon</b> agreed to hold a similar session in conjunction with the next TTAG meeting. He also indicated that the HITECH work group would schedule several calls before the next meeting. He asked participants to send comments and suggestions to him. Finally, he indicated that CMS would work on developing solicitations for assessments and training.</p> <p><b>Mr. Jason Dollarhide</b>, Chair, National Congress of American Indians and Second Chief, Peoria Tribe, indicated that he would like to see more collaboration between IHS and the tribes so that tribes can become advocates to the Congress for additional funding for IHS.</p>	<p><b>Ms. Pro</b> will forward information on the purpose and function of the California REC.</p> <p>CMS will conduct another HITECH Roundtable in conjunction with the July TTAG meeting.</p> <p>CMS will develop solicitations concerning the EHR readiness assessments and training.</p>
<b>Adjourn</b>	<p>With no more business to discuss, <b>Ms. Finster</b> made a motion for unanimous consent to adjourn. With no objections voiced, the motion carried and the TTAG adjourned.</p>	