

The RURAL MONITOR

A Publication of the Rural Assistance Center

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Health Information Technology: A "HIT" in Rural Areas

by Hope Hanson

When Dr. John Dreyzehner was in medical school 18 years ago, he never used a computer—there were none around.

"In medical school, in terms of information technology, the best thing we had was a phone," Dreyzehner said. When he was an intern, there was a terminal he could use to check lab reports. He got his first desk computer in 1993, and initially used the Internet in 1995.

Today, Dreyzehner is chair of CareSpark, a collaborative health improvement project based in Kingsport, Tennessee, and director of the Cumberland Plateau Health District, based in Lebanon, Virginia. He is one of many professionals looking toward converting medical records and the business of health care from pencil and paper to personal computer. Health information technology (HIT) is an effort resonating with the highest levels of government and on the verge of opening a world of powerful possibilities in advancing health care, both urban and rural. The changes are looking to have positive ramifications for rural health care in spite of the challenges.

Why the Need?

Using technology in health care is becoming more important as medical findings and knowledge increase exponentially. Computer-aided treatment strategies help providers make decisions without having to memorize the newest research results or drug therapies available. This is especially



A nurse uses a Computer on Wheels (COW), a component of health care technology that helps prevent medication errors by verifying medication administration via bar code. Photo by James Watson, Mountain States Health Alliance.

useful for rural physicians, who are typically called upon to assess and treat a wide variety of afflictions with little time to study the latest research results on specific conditions. Also, with increasing life spans, Americans are requiring additional chronic care management. A much-needed aspect of HIT is keeping track of patients through electronic health records. Receiving care in multiple settings makes it difficult for providers to coordinate appropriate treatments without a single health record that each care facility can reference.

Even though HIT and health care are an ideal match, they haven't

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THE CARESPARK MODEL

Creating a rural HIT program is an intensive, time-consuming process but it can be done successfully. One model project is CareSpark (<http://www.carespark.com/>), serving a region that encompasses portions of five states.

The CareSpark planning process has been recognized nationally as a model for its broad-based coalition, multi-state region, long-range and comprehensive scope, and development of a sustainable financial model.

Project leaders say the first step to a successful start is to **bring everyone to the table**.

“CareSpark’s been very broad-based from the beginning,” said Executive Director Liesa Jenkins. “We’ve had public health, private health care providers, large and small hospitals, doctors offices, pharmacies, employers, health plans, and tech and community organizations. It’s had a wide scope from day one.”

The planning group includes nearly 100 representatives, many of whom work for competing businesses. About 700,000 patients are served by these competitors.

Another tip CareSpark offers is to **think of technology as a tool rather than a result**. They were careful to look at technology in terms of how it would help patients.

“CareSpark, in the beginning, got started when we said ‘how can we improve the health of people in our region?’ rather than ‘hey, what can we do with technology?’” said John Dreyzehner, chair of CareSpark’s board of directors.

“We understood that one of the biggest barriers to our ability to provide the best health care possible was lack of the best and most up-to-date information about the very patients for whom we were trying to provide that care,” Dreyzehner said.

Concerned about the significant health disparities in a region with high rates of diabetes, stroke, heart disease, asthma, lung disease, cancers and premature death for those under age 65, the group sought ways to coordinate care among multiple providers and to increase the use of evidence-based clinical guidelines and best practices.

To move forward, the group suggests **looking at other communities and organizations that share similar goals**. (Technology success stories can be found by visiting http://www.raconline.org/success/success_topic_details.php?topic=Technology, or by calling RAC’s information specialists at 800-270-1898).

CareSpark also says to **find funding help—it’s out there**. Some say the government is already spending too much on HIT, citing other American businesses, such as banks, that are making the electronic switch without the government’s help. Jenkins says that the government needn’t completely shoulder the responsibility.

“I don’t see it [implementing HIT] to be entirely government’s role. I actually think it’s more heavily in the private sector that we need to step up. It’s a shared responsibility for good health care decisions, and that information is shared—that responsibility is shared—among the patients, the providers and the people who are paying for health care,” Jenkins said. CareSpark was awarded a grant for seed funding by the Foundation for eHealth Initiatives (with funds provided by the U.S. Health Resources and Services Administration’s Office for the Advancement of Telehealth). These funds of \$100,000, awarded in July 2004, were matched by nearly \$500,000 from local organizations and their partners, allowing the

group to start planning in August 2004.

Yet Dreyzehner points out that in government’s role as a payer, it does have a reason to step up and share some of the costs associated with HIT.

“Medical care accounts for more than 15 percent of our gross domestic product, and yet, we are still doing things with pencil and paper. We continue to be a cottage industry. It’s in the government’s interest to help this process along. When you talk about health care and you talk about government funding, you have to understand that the government is already a huge piece of health care because it is a major payer of the bills. So when you have 15 percent of your budget tied up in an industry, it is a very wise investment to attempt to improve the efficiency of that industry and lower your costs and improve the product,” Dreyzehner said.

Jenkins says even if a HIT conversion project has funding, it’s wise to **take time to make purchases**, especially for the software products.

“Yes, it’s true that HIT funding, both public and private, could get tapped out, so there’s a window of opportunity for the earlier adopters. But on the other hand, waiting is an advantage because it gives you the chance to learn from others’ mistakes, and you could easily save money that way,” Jenkins said.

Finally, before spending any money, Jenkins says to be sure to **address your uniqueness**.

“Because of the composition of our area, and being in the corner of five states, we’ve had to take a regional approach. A lot of other organizations are taking a state approach, but we had to consider referrals patterns and where the patients travel for health care rather than state boundaries,” Jenkins said.

Human Services and HIT

by Hope Hanson

Just as health care practitioners have been moving toward a more holistic, “treating the whole person” philosophy in recent years, the medical community itself is moving toward a more integrative approach through HIT.

But to truly take a holistic approach, the medical community must find ways to integrate with human service functions. Dr. John Dreyzehner, who chairs CareSpark (see Page 2), says the current trend is for the medical community to find its own way through HIT and then to integrate with human services.

“There are a whole host of complex human factors that have an impact on a patient when he or she leaves the office. Can they afford their medications? Is the family set up to provide whatever nutritional needs they have? Can they heat their home? For some patients and some types of diagnoses, those things aren’t as important, but for some, they’re critical. I absolutely think that at some point, there will be a much more significant link between the health information sharing and referrals for human services and technology-leveraged care of the whole patient,” Dreyzehner said.

Much of what human service providers currently use IT (information technology) for is web-based learning, adaptive devices for the disabled, access to agency web sites and electronic resources for human service personnel. However, as HIT use increases, human services will integrate with the medical community.

One of the most useful applications of IT in human services is telehealth. Telehealth “is a broad set of applications using communications technologies to support long-distance clinical care, consumer and professional health-related education, public health,

health administration, research, and EHRs,” according to the Institute of Medicine. Telehealth services are able to bridge large distances between providers and patients in rural areas, improve coordination of care and collaboration among multiple service providers across wide areas, and enhance development of advocacy groups, peer groups and support groups across sparsely populated geographic areas while holding down costs.

One such rural telehealth project is the North Olympic Telehealth

Network based at Clallam County Hospital in rural Forks, Washington. It is deliberately integrating human services into its project scope.

“Our design was primarily for mental health services, but certainly other kinds of human services as well,” said Steve Ironhill, project director. “We have some real serious access issues in our rural area, primarily in psychiatry. One of the things that evolved out of our project is we have a regular psychiat-

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HIT and Immunizations

Michigan is one state making the most of information technology for the well-being of its children.

The state’s Department of Community Health aims to have 100 percent of the state’s children current on their immunizations and to make those children’s health records available at any time.

“In 1996, Michigan was rated last in the nation for complete immunization of children ages 19 to 35 months of age. We knew our children were immunized, because of low incidence of disease outbreaks, but all the immunization records were everywhere. Public health had a few, the private doctor had a few and the emergency room had a few more, but nothing was consolidated,” said Therese Hoyle, coordinator of the Michigan Childhood Immunization Registry (MCIR). “As a result, the Michigan Department of Community Health and the state legislators mandated that Michigan have an immunization registry [for children] by law.”

Hoyle said the public has been receptive to the project despite

security and privacy fears surrounding HIT.

“It’s been very successful because children receive 20 or more immunizations by the age of two. Parents like knowing they can get a copy from their health providers at any time, and it is complete. It saves time for the parents who need to have the records in hand for their children entering child care or school. Parents have the option also to opt out of the registry, but less than one percent have done that.”

MCIR is looking to use HIT to incorporate their records with health care providers outside of public entities.

“What we are working toward is a seamless integration, so that when doctors enter immunizations into a patient’s EHR, it sends the data to the registry. The other messaging component will happen when the provider looks up a patient’s record in their EHR. A message will be sent to the registry, and all the data from the registry on that patient is sent back to the EHR so that the provider can see the patient’s immunization history,” Hoyle said.



Rethinking Human Services

by Tom Corbett, Ph.D.

Rural Challenges in Meeting Human Needs

In prior columns, I argued that rural communities would benefit from integrated service systems. Why is that? Many of us assume that rural populations confront unique circumstances and challenges. For example, about 40 percent of rural counties have no form of public transportation. At the least, this raises the specter of social isolation for some of our more disadvantaged families.

But what do we really know about rural America? How much of our operating premise is evidence-based and how much of our so-called knowledge base is speculation or assumption? Let's pause for a moment and look more closely at rural communities and how they might differ from their urban counterparts.

The Department of Health and Human Services (HHS) alone administers some 225 programs, service systems and grants in rural areas. Not surprisingly, HHS takes an interest in rural areas and recognizes that what works in urban jurisdictions may not apply to non-urban communities. The Department created a task force that contracted with Mathematica Policy Research to examine rural non-rural differences. Below, I highlight a few of their findings.

Some 83 percent of the U.S. population is concentrated in 20 percent of the landmass. The remaining 49 million people are spread over the other 80 percent of the land. This unequal spatial distribution creates both problems and opportunities. In addition, it shapes the experiences and cultures of the people who live there.

It is not easy to establish a coherent profile of how low-income

rural families are doing. Employment, or unemployment, rates do not differ consistently in rural versus non-rural comparisons. Yet, rural households are more likely to be underemployed, seasonally employed or earn lower wages than their urban counterparts.

This economic disadvantage in market earnings is offset, in part, by a lower cost of living in rural areas. Thus, official poverty calculations may overstate the problem. But the rural poverty that does exist tends to be more persistent—some 95 percent of so-called “persistent poverty” counties are rural, according to the Mathematica review of the literature.

There is evidence that rural areas, in general, disproportionately suffer from more social and individual challenges—the health status of rural residents is worse according to several indicators. This may not be surprising given the stresses in many remote communities, problems with access to health care and longer periods of being uninsured.

We often think of rural areas as being free of urban crime and drug problems. And sure enough, rural teachers report safer learning environments, and less student alcohol and drug use than urban teachers. But alcohol and drug use among rural youth has been approaching levels found among urban youth. We routinely see stories of meth labs being “busted” in small rural communities.

At the same time, we have seen a welfare miracle in rural communities. Since the Temporary Assistance to Needy Families program (TANF) replaced the Aid to Families with Dependent Children system in 1996, welfare caseloads have plummeted. Where caseloads exceeded five million families in the early 1990s, recent figures put the national

caseload at less than two million. Of course, poverty has not declined in a commensurate fashion. So, the participation rate, those on the program divided by those meeting the eligibility requirement, has fallen from about a high of 80 percent to about 48 percent today.

But the welfare miracle, falling caseloads, really has been a non-urban phenomenon. In Wisconsin, Milwaukee County now accounts for some 80 percent of all cash welfare cases. In pre-reform days, it accounted for about 40 percent. Many rural counties have virtually no cases. There are some rural states that could fit their entire TANF caseload in a modest-sized school auditorium.

Is this good or bad? Should we care? Access to TANF is not just about money for destitute families. It often is a gateway to help with jobs, child support, training, and a host of work supports. For many, it is a passport to a better life.

The problem is that we really don't know all that much about rural communities. Our data infrastructure is not robust and our attention span flows toward where the action is—the cities. Rural communities suffer from a form of neglect that is not always benign. Welfare reform, to take one example, has certainly lessened dependency in rural communities. But has it opened up opportunities to fully participate in mainstream America. This is just one of many questions about rural life about which we know precious little.

Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty where he served as Associate Director. He has worked on welfare reform issues at all levels of government and continues to work with a number of states on issues of program and systems integration.



Look What's Coming

by Wayne Myers, M.D.

Hospital Bills as Fantasy

Hospital managers don't seem a terribly imaginative lot but they get pretty creative in billing for patient care. Simply put, a hospital bill has little relation to the cost of the care that patient received. Rather, the amount charged is some multiple of the cost of care. The bill may be two times or three times or six times what the care actually cost. Picking a multiplier is where the fantasy comes in. In Kentucky the average multiplier is three with a range among 124 hospitals from 1.4 to 7. In Maine the median hospital is charging twice the cost of care.

The second fantasy is that inflated charges don't matter because almost nobody pays them. Insurance companies like charge inflation because it makes their services seem more attractive to prospective buyers, e.g., "Sign on with us and we'll get you a 60 percent discount." I remember a hospital system CEO musing that the insurance company negotiators really didn't seem to care what they actually paid for care as long as they were getting a big discount. In that particular setting 15 years ago, rural hospital charges were running about 30 percent below their urban equivalents. That real difference was not relevant in the eyes of the insurance contract negotiators. What they needed was a big discount, real or fantastic. So, with that sort of encouragement, we're now seeing several hundred percent charge inflation balanced by proportionate discounts.

Hospitals started inflating charges in the mid-1980s trying to make up for Medicare underpayments by overbilling other payers. The process accelerated in the early 1990s as increasingly powerful managed care

plans demanded large discounts regardless of costs or charges.

So what's the problem? I'd argue that there are four problems. First, what about the people getting hospital bills who have no insurance? We've heard various numbers on medical bills as factors in personal bankruptcy. That is a complex issue that I won't tackle here except to point out that hospital bills are a significant factor in many such tragedies. I was once at a town meeting in south central Kentucky. One of the town docs took advantage of the gathering to defend the local hospital: "They take care of anyone I send them regardless of ability to pay." But the local attorney/public defender took the floor to point out that the largest task he faced was defending against personal property seizure for hospital charges. Granted, most hospitals will negotiate some lower settlement with people who can't handle the full bill. How low will hospitals go in what percentage of cases? No data. What percent of people have the knowledge and skills to go through that process? No data.

The second problem relates to charity and indigent care. To the extent that the initial charges are grossly inflated, so are figures for charity, indigent care and bad debt. Anyone involved with hospital finance policy or the tax-free status of nonprofits should bear in mind that the cost to the hospital of the care given away is a fraction of the value assigned that care.

Third, this inflate-and-discount game makes it harder for hospitals to make their case for broad public support. Lay people, including legislators, may wonder whether any of these hospital numbers mean anything.

Finally, this charge inflation game contributes to our national confu-

sion about health care finance. If there is anything we don't need in this area it is augmented confusion.

If you'd like to look up cost-to-charge ratios of particular hospitals go to <http://www.hospitalvictims.com>. I believe the authors of this site wrongly conclude that hospitals are making lots of money in this inflate-and-discount game. The hospitals I know best are struggling to break even. But you'd never guess that from the size of the bills going out.

Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.



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Around the Country

by Hope Hanson

Dakota Network Enhances Access

A federal rural health grant is helping expand health information technology and bringing improved and more efficient health care to the rural Dakotas.

A \$540,000 U.S. Office of Rural Health Policy Network Development Grant “is making it possible for us to move ahead and centralize health care services across a wide expanse of rural America,” said Tom Olson, director of the Dakota Network of Community Health Centers.

The Dakota Network is a collaboration of nine health care organizations operating 31 of the region’s Community Health Centers (CHCs). The sites together employed 327 people and served 50,507 patients in 2005. The Dakota Network also received a \$202,720 grant from the U.S. Department of Agriculture Rural Utilities Service’s Distance Learning and Telemedicine Program.

The network plans to centralize practice management systems and eventually incorporate electronic health records.

“Today’s technology makes the business end of health care much more efficient. The CHCs can pool their data for federal reporting, saving the time, money and energy of individual efforts,” Olson said.

Although a few months away from completion, the Dakota Network already has interactive videoconferencing capabilities at 26 of the partner health care sites in North Dakota and South Dakota through its WAN (Wide Area Network). It is used for provider training and consultations, and was also integrated into managing this year’s mumps outbreak.

“We were able to videoconference with the state epidemiologist and infectious disease specialists at 24 of the sites to look at the current

outbreak patterns, high risk areas and MMR (vaccine) stockpile locations. And this happened simultaneously in real time across thousands of square miles,” Olson said.

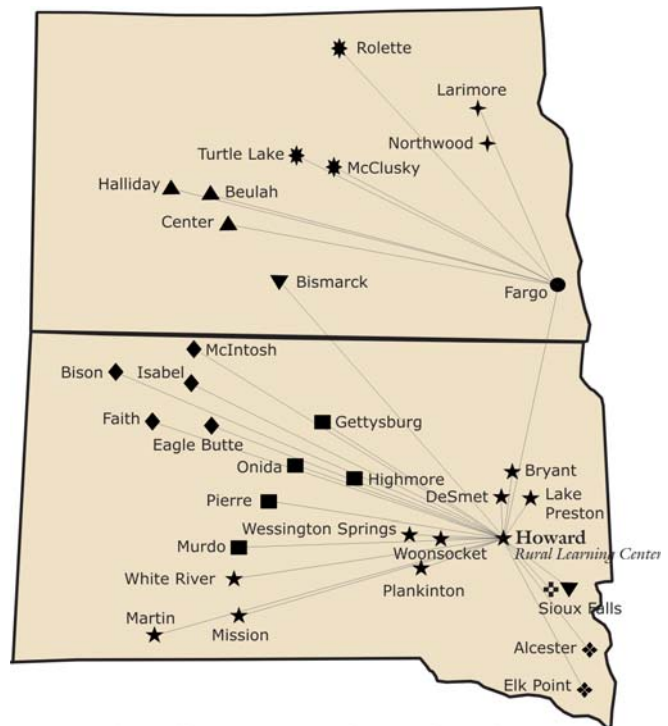
Olson says having this technology in place is improving health care, and as a result, quality of life.

“The providers now have the ability to talk face to face. It has really changed how they perceive their roles, and they don’t feel so isolated and burned out and alone,” Olson said. “The technology is really breathtaking, and it’s ideal for where you have these isolation problems.”

Olson said the project, even in its early stages, is saving lives.

“Many of these clinics, for example, don’t have a psychologist on staff. In years like this with the drought and low ag prices, you have what is known as prairie pride. People will not go to the mental health office for fear their neighbors will see their truck in the parking lot. But they’ll go to one of the CHC sites, and others will think they were just getting their blood pressure checked. Through interactive video, these people can do an interactive consult with a psychologist and they love it—they

Dakota Network of Community Health Centers



Community Health Center Partners (Proposed: 2006)

- Rural Health Care, Inc.
- ◆ Prairie Community Health, Inc.
- ▼ Community Health Care Association, Inc.
- Family Health Care Center, Inc.
- ★ Horizon Health Care, Inc.
- ◆ Sioux River Valley Community Health Center
- ◆ Union County Health Foundation, Inc.
- ▲ Coal Country Community Health, Inc.
- ★ Northland Community Health Centers, Inc.
- ✦ Valley Community Health Centers, Inc.

say they get a lot out of it and didn’t feel the stigma of being there. Having that option may have saved their lives,” Olson said.

He said technology looks to be the key in improving these rural health care options and lowering costs.

“It is definitely the wave of the future,” Olson said. “I just wish it weren’t so terribly expensive. But by collaboration and outside support, it makes it reachable.”

For more information about the Dakota Network, call Olson at (605) 332-7692, e-mail tmolson@dakotanetwork.org, or visit <http://www.dakotanetwork.org>.

Special Series: Technical Assistance Centers

*Editor's note: This is the fourth in a series of articles on rural health technical assistance resources around the country funded by the federal Office of Rural Health Policy (ORHP). The first article (see *The Rural Monitor*, Fall 2005) gave an overview of what is meant by technical assistance. For a complete list of technical assistance resources available through ORHP, see <http://ruralhealth.hrsa.gov/links/TACenters.asp>.*

National Rural Recruitment and Retention Network (3RNet)

Finding the right job in medicine can take months or years. With 3RNet, it can happen in weeks.

That's what happened when Dr. Norman Petty looked at the National Rural Recruitment and Retention Network web site (<http://www.3rnet.org>) for a physician position in small-town America.

"3RNet had several fitting opportunities listed, so I was able to find one to suit me, then I was able to start interviewing," said Petty, who started his family practice position at Labette County Medical Center in Parsons, Kansas, just a few weeks after his initial Internet search. Petty was looking for a rural community where he, his wife and five children could settle near their native southern Missouri.

"I came down to look at the place, and things seemed to be right about what I was looking for," Petty said. "So we negotiated the job and I was here in no time."

Sending Doctors Where Needed

3RNet helped place 715 physicians and other health care professionals last year. In recent years, approxi-

mately 90 percent of placements have gone to underserved areas.

"3RNet started in 1995 as a result of many small rural communities being unable to effectively recruit health care professionals, especially physicians," said Tim Skinner, 3RNet executive director. "They didn't really have the resources—either financial or staffing resources—to recruit and do the marketing and to help candidates, so 3RNet was established and the web site developed."

3RNet is comprised of state organizations including state offices of rural health, area health education centers, cooperative agreement agencies and state primary care associations. Nearly half of its funding comes from its members, with the rest coming from a U.S. Health Resources and Services Administration contract. Each member pays dues of \$3,000 a year annually to pool resources and attract health care professionals.

"Our 44 members are all not-for-profit and state-based agencies. They're the ones involved in the direct recruiting, so 3RNet staff is supporting them and doing a fair amount of education and training," Skinner said. He said each state decides which agency or organization best represents the state as the 3RNet member.

"I am getting everything I need and more through 3RNet's services, and it is much more affordable than going out completely on your own," said Jennifer Forbes, director of physician recruitment and marketing at Labette County Medical Center, where she helped place Petty.

One of the main recruiting tools 3RNet offers is a versatile web site. Members maintain their own pages and tailor them to their needs.

"There's a great deal of diversity in rural America. What works for

rural Alaska doesn't necessarily work for rural Georgia, for example. So every state page on our web site is set up so that members can decide how their states are represented and which utilities they will use," Skinner said.

Members find the web site particularly useful in recruiting in this day and age.

"There are a lot of young doctors looking for opportunities and using the Internet to find jobs," Forbes said. "There are a lot of buzz words out there used in searching for medical jobs. With 3RNet, if someone's typing in a variety of search terms, we will come up. It's hard to know what kind of key words a physician will put into a search on the Internet. 3RNet has researched this and knows what kind of terms they'll be using."

The 3RNet web site also lists openings for nurse practitioners, physician's assistants, dentists, dental hygienists, pharmacists, and psychologists and social workers. Users can search for openings in their fields in all or selected states, or browse state recruitment pages.

Although states use 3RNet for recruiting, they are still free to go out on their own and do independent advertising and on-site enlistments. 3RNet can also help with that.

"We offer workshops and seminars regarding effective recruitment strategies, publications containing detailed training techniques regard-



Tim Skinner, executive director of 3RNet, says the organization's web site reflects the diversity of rural America.

ing recruitment, and presentations to conferences regarding workforce needs and demands,” Skinner said.

Another asset of 3RNet is helping physicians on J-1 visas who are just graduating from U.S. training programs and are seeking opportunities in appropriately designated communities.

“This is an ideal match because many physicians on J-1 visas have service obligations to work in some of the most underserved areas where there would simply be no doctors if they weren’t willing to go,” Skinner said. “Most states have a loan forgiveness program to add to the incentive.” Physicians with J-1 visas filled approximately 33 percent of 3RNet’s physician placements last year.

Besides recruitment activities, 3RNet helps out wherever needed.

“After Hurricanes Rita and Katrina, we changed the front page of the web site right away to reflect the tremendous and immediate medical needs in Texas, Louisiana and Mississippi. This way, physicians looking for jobs could go to those areas and make a difference right away,” Skinner said. “We also, through the 3RNet listserv, put out requests for people, equipment and assistance of any kind for those



Norman Petty, MD (left) found his job at the Labette County Medical Center ER after a search on the 3R Net web site. Also pictured: Tereasa DeMeritt, RN and Tim Breedlove, MD.

states. The three states got a great deal of response, and they got some help fairly early.”

He said the area is still struggling, and cites the long working hours for medical personnel that continue even a year afterward.

“They were so swamped, and still are. But it was nice to be able to instantly help them,” Skinner said.

For more information on 3RNet, write: National Rural Recruitment and Retention Network, 2004 King Street, La Crosse, WI 54601; phone (800) 787-2512; fax (608) 687-3993; visit <http://www.3rnet.org>; or e-mail info@3rnet.org.

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completely paired. At the end of the 1990s, most American industries were spending about \$8,000 per worker on technology. But the health care industry was investing only about \$1,000 per worker, according to the U.S. Department of Health and Human Services (HHS), and health care is still behind. Factors for the lag include concerns about record privacy and security, interoperability between the software choices of different providers and start-up costs.

Today, experts generally agree that HIT is the next level of progress in health care and human services. HIT is considered particularly useful for rural areas because it can or could “bridge distances by providing more immediate access to clinical knowledge, specialized expertise, and service not readily available in sparsely populated areas,” says a recent Institute of Medicine report titled *Quality Through Collaboration: The Future of Rural Health* (<http://darwin.nap.edu/books/0309094399/html/147.html>).

The importance of HIT, and electronic health records (EHRs) in particular, is gathering attention at the highest levels of government.

In April 2004, President Bush issued an executive order calling for Americans to be connected to an EHR within 10 years. The order soon followed with the creation of the federal Office of the National Coordinator for Health Information Technology (ONCHIT, <http://www.hhs.gov/healthit/>), under the direction of HHS Secretary Michael Leavitt. The office has three focus

areas that are aimed toward implementing wide-spread adoption of HIT: Regional Health Information Organizations (RHIOs); Nationwide Health Information Network (NHIN); and driving EHR adoption.

The National Advisory Committee on Rural Health and Human Services, an advisory group composed of rural experts, said in its 2006 annual report to Secretary Leavitt that HIT would be good for rural health care because it could “help disparate rural providers from across the spectrum of care better coordinate services for their patients,” and “help rural communities improve public health through disease surveillance and targeted health education.”

Until the government is ready to implement its Nationwide Health Information Network, most of health care is working statewide or regionally to implement their own networks (either health information exchange projects [HIEs] or RHIOs). These networks vary widely in approach but generally involve diverse stakeholders joining together to plan, finance and implement systems to share electronic health information. Successful collaborations can help resolve the complex technical, organizational, business, clinical and legal issues inherent in such networks.

Cost: The Biggest Rural Hurdle

The federal government is pitching in to support its electronic conversion order. In 2005, ONCHIT awarded more than \$36 million to public-private groups to accelerate the adoption of HIT and the secure portability of health data. That money was not targeted toward individual providers, but toward developing and evaluating prototypes. Some federal money is

available for purchasing components of HIT such as infrastructure and Internet connections (see “Focus on Funding,” Page 10), but it is usually in more limited amounts.

For providers, cost still remains the main issue, even though there are documented cost savings.

Studies in ambulatory care settings estimate that EHRs would save \$112 billion per year (7.5 percent of health care spending), including \$34 billion annually for in-office reduction and \$78 billion annually from interoperability of those EHRs, according to the Center for Information Technology Leadership. And ONCHIT estimates that the annual savings attributable to widespread EHR adoption are likely to lie between 7.5 percent and 30 percent of annual health care spending.

However, getting started is the barrier.

“A key corollary to use of IT (information technology) is money. It’s a very expensive endeavor and if you have lower revenues you have less ability to leverage the money that you need,” said Chantal Worzala, a senior assistant director of policy with the American Hospital Association (AHA) working with IT issues. “We surveyed hospitals on the significant barriers to adoption, and the number-one was initial cost, and we did see that rural hospitals were even more likely to cite that as a barrier.”

The AHA also asked members about their use of HIT and found widespread use at varying levels.

“Some hospitals are just getting started; some are already running sophisticated systems,” Worzala said. She said that although urban hospitals are more likely to be using HIT than rural entities, “there are significant leaders in the rural community. It’s not as if all the rural hospitals are behind. But you do see less use in the rural hospitals.”

As for Critical Access Hospitals (CAHs), the Medicare Rural Hospital Flexibility Program is watching the progress of the HIT mandates carefully, and recently issued a briefing titled “The Current Status of Health Information Technology Use in CAHs” (see <http://www.flexmonitoring.org>).

The executive summary states that the 333 CAH respondents “have relatively high use rates for many administrative and financial HIT applications, such as claims submission, billing, accounting, and patient registration,” but found “much lower use rates for a number of clinical applications, such as bar-coded patient identification bracelets and electronic medical records.” The summary said that “half of CAHs have a formal Information Technology plan, and three-quarters of CAH budgets include funding for purchasing IT. The vast majority of CAHs have high speed Internet access, and many CAHs are computerizing radiology, lab, and pharmacy functions. These results indicate that adoption of HIT is a priority for CAHs and suggest that Medicare cost-based reimbursement has permitted many CAHs to make some initial investments in HIT infrastructure. However, CAH use rates for several technologies are lower than the overall rates for hospitals reported by the American Hospital Association and others.”

Dreyzehner said that for rural providers, the decision to convert partially or completely to EHRs and HIT can be successful if they pool resources already in short supply.

“Everybody understands the health care system, and rural in particular, can’t have a bunch of islands and expect to serve patients in the best possible fashion. We have to be networked together in order to see our vision of health improvement realized,” Dreyzehner said. “I think we’re on the cusp of some great possibility.”

Focus on Funding

A guide to rural funding opportunities and how to access them

Finding the Funds for Rural HIT

If you're a hospital or clinic wanting to join the HIT parade, you might wonder where to start. The following is a condensed introduction to HIT funding sources and reference tools.

Overview

One of the difficulties in finding funding for HIT is that health information technology is not just one thing. A HIT initiative or project might involve several actions and components including purchasing computers and other technology, acquiring a faster telecommunication service, and the hiring and training of IT (information technology) personnel, in addition to the initial and ongoing costs of developing a HIT plan.

To get started with HIT, it helps to get an idea of its many facets and possibilities. Key aspects of HIT include:

- **Computerized Physician Order Entry**
- **Electronic Medical/Health Records**
- **Electronic Prescribing**
- **Health Information Exchange**
- **Telemedicine**

For a comprehensive list and discussion of key HIT topics, see the Agency for Healthcare Research and Quality's **AHRQ National Resource Center for Health Information Technology** web site: <http://healthit.ahrq.gov/> (click on the "All Key Topics" link).

Most community HIT projects necessitate the making of a community HIT plan prior to the purchase of equipment or hiring of personnel. For help with developing a plan, the eHealth Initiative offers a **community toolkit**, available free to

registered users at <http://toolkit.ehealthinitiative.org/>. (Access to other parts of the web site requires an organizational membership fee.)

When drawing up a HIT action plan, it's best to get an idea of what HIT programs are available and currently active in your state. The Healthcare Information and Management Systems Society offers the **HIT Dashboard**, an interactive map that contains a state-by-state legend tracking various HIT activities, including current regional health information networks, private projects and state legislation. See <http://www.hitdashboard.com/MapPage.aspx>.

Finally, the Rural Health Resource Center is sponsoring **national conferences** for rural providers on the basics and benefits of adopting HIT practices. See <http://www.ruralcenter.org/events.shtml>.

General Federal Funding

For a discussion of rural-specific and general HIT funding programs in the federal government, see the chapter, "Health Information Technology in Rural Areas," in the *2006 Report to the Secretary* from the National Advisory Committee on Rural Health and Human Services: <http://ruralcommittee.hrsa.gov/nacpubs.htm>.

For a summary of federal HIT (not just HIT funding) activities, the Office of the National Coordinator for Health Information Technology (ONCHIT) offers a **Directory of Federal HIT Programs** at <http://www.hhs.gov/healthit/federalprojectlist.html#initiativestable>.

However, the Government Accountability Office has reported (see *Health Information Technology: HHS is Continuing Efforts to Define*

a National Strategy, accessible from: <http://www.gao.gov/highlights/d06346thigh.pdf>) that most federal HIT money has been targeted toward evaluating and developing HIT prototypes. Therefore, most providers will have to acquire HIT funding from a variety of sources, with the majority of the funds coming from local sources.

The following agencies provide funding for HIT that is not limited to development of HIT prototypes:

- **Office of Rural Health Policy (ORHP)** administers a number of grant programs for rural providers that have been utilized for HIT. Funds from the Small Rural Hospital Improvement Grant Program (SHIP) and the Rural Hospital Flexibility Grant Program have been used to purchase HIT infrastructure as well as improve hospital quality through HIT applications. Rural Health Network Development grants have been used to develop HIT infrastructure by providing funds for the purchase of hardware, software and technical assistance. See <http://ruralhealth.hrsa.gov/funding/GrantPrograms.htm>.

- **HRSA Telehealth** (formerly the Office for the Advancement of Telehealth) offers the Telehealth Network Grant Program, which provides funding for the improvement and establishment of sustainable telehealth programs in medically underserved areas including urban, rural and frontier communities. See <http://www.hrsa.gov/telehealth/>.

- **National Library of Medicine (NLM):** Integrated Advanced Information Management Systems (IAIMS) grants provide funding for integrated HIT systems; the Office for High Performance Computing and Communications offers a

number of grants to facilitate communication between networks. See <http://www.nlm.nih.gov/ep>.

Federal Funding for Specific Activities

Faster Internet Connections

The Rural Health Care Program of the Universal Service Fund makes discounts available to eligible rural health care providers for telecommunication services and monthly Internet service charges. <http://www.universalservice.org/rhc>.

Distance Learning and Telemedicine

In 2006, the USDA Rural Utilities Service (RUS) offered \$20 million in grants [the 2006 application deadline was June 12] to rural areas to encourage and improve telemedicine and distance learning services through the use of telecommunications, computer networks and advanced, related technologies. See <http://www.usda.gov/rus/telecom/dlt/dlt.htm>.

Information Management Systems

The National Library of Medicine (NLM) Extramural Programs (EP) Division provides grants and fellowships to organizations and individuals interested in applying

computers and telecommunication for improving storage, retrieval, access, and use of biomedical information. For an overview, see <http://www.nlm.nih.gov/ep>.

Additional Funding Sources

For a list of national, state and regional funding sources for HIT, see the RAC's **Funding by Topic: Health information technology** at http://www.raconline.org/funding/funding_topic_details.php?topic=Health%20information%20technology.

Additional Web Resources on HIT

- The eHealth Initiative's **State Legislation Tracking Center** service lists state-by-state information on bills that have been proposed, are pending or have passed that involve health information technology or health information exchange: <http://ccbh.ehealthinitiative.org/communities/community.aspx?Section=288>.
- The chapter, "Rural Health Care in the Digital Age" in the Institute of Medicine's 2005 **Quality Through Collaboration: The Future of Rural Health Care**

examines rural HIT activities. <http://www.iom.edu/?id=29734>.

- For a list of FAQs, regulations and funding for HIT, check out the Rural Assistance Center's **Health Information Technology** information guide at: http://www.raconline.org/info_guides/healthtech/. RAC also offers a **Telehealth** information guide at http://www.raconline.org/info_guides/telehealth/.

GENERAL FUNDING INFORMATION

For general information on all kinds of funding sources, see RAC's Funding Guide: <http://www.raconline.org/funding>.

You may also call the information specialists at the RAC, who can assist you in your search for information on HIT or other kinds of funding. Contact them at (800) 270-1898 or info@raconline.org. Please include the following information in your request: your name and organization; the type of project you are interested in funding; and the location for your project: city, county and state.

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ric consultation provided by the University of Washington. We're also able to have our practitioners provide medication monitoring and evaluations for more distant sites within our network."

The project uses live, interactive videoconferencing, and network sites can communicate with one another and any other site in the world that has compatible equipment.

Ironhill says other project perks include being able to interview job applicants from as far away as Alaska

without having to bring them in to the Olympic Peninsula, which is a rugged land mass surrounded by water on three sides and a roadless national park on the fourth. The project had also been able to save the costs in the foster care system by conducting meetings via satellite. He said relatives of a foster child in Forks were able to join a team meeting from a site near their home in Orlando, Florida.

Project plans also include adding teleradiology and telepharmacy

services, as well as electronic health record development. The network is the recipient of a U.S. Office of Rural Health Policy (ORHP) Rural Health Outreach Grant.

Even though human service organizations are taking a varied approach to HIT, most agree integration with health care services will come.

"Medical care is one aspect of human services. You can't separate them very well," Dreyzehner said. "We do, but we shouldn't."

State Resources

The Rural Assistance Center is pleased to announce the addition of **State Resources** to our web site.

State Resources have been developed in response to our users' needs. In providing information services over the past few years, we have noticed that people using our services are often looking for state-level contacts, resources or information that can help them maintain and improve services in their local communities. In the last few months, our information specialists have gathered information and resources to develop these state-specific resource pages for the RAC site. **State Resources** will allow RAC's web users to easily access information. Each state page will feature an overview of the state and its rural health and human services environment.

When users click on **State Resources**, they will see the main page containing a list of states.

As an example, the **State Resources** page for Minnesota (shown below) features:

- A statistical overview of the state
- Tools, including web sites with demographic and statistical information
- Documents and resources, including publications from various research centers, rural and public health agencies, and journals
- State-level contacts, organizations and groups involved in rural health
- Funding programs available in the state
- News and upcoming events of interest to rural health
- Examples of successful projects in the state that can serve as model projects in rural communities

The pages are designed to help rural communities find information and resources that can assist them in important activities such as locating and competing for funding opportunities, and networking within their state. RAC has worked with state-level partners, such as the State Offices of Rural Health, to develop these pages and will continue those relationships to ensure that the **State Resources** pages remain current and feature the best information available for each state.

We would appreciate your help in making your state page the best it can be for the communities in your state. If you see any changes or additional resources that would be useful to rural communities in your state, please contact us at 1-800-270-1898 or email your comments to info@raconline.org.

Written by Mary Reinertson-Sand, RAC Information Specialist.

Home > States

State Resources

Alabama	Louisiana
Alaska	Maine
Arizona	Maryland
Arkansas	Massachusetts
California	Michigan
Colorado	Minnesota
Connecticut	Mississippi
Delaware	Missouri
Florida	Montana
Georgia	Nebraska
Hawaii	Nevada
Idaho	New Hampshire
Illinois	New Jersey
Indiana	New Mexico
Iowa	New York
Kansas	North Carolina
Kentucky	North Dakota

States > Minnesota

Minnesota

On this page

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Maps	Success Stories	

Minnesota is called the land of 10,000 lakes and gets its name from the Dakota word minisota, meaning "water that reflects the sky." Minnesota covers 79,610 square miles, with a 2005 estimated population of 5,132,799 people - 1,412,006 living in rural Minnesota (USDA-ERS). Saint Paul, the state capital, is located in the southern region of the state. The largest cities are Minneapolis, Saint Paul, Bloomington, Duluth, and Rochester. According to the 2000 Census, 89.4% of the state's population is white, 3.5% is Black/African-American, 1.1% is American Indian, 2.9% is Asian, and 2.9% is of Hispanic/Latino origin.

There are 131 hospitals in Minnesota (Kaiser, 2004) with 80 currently identified by the Flex Monitoring Team as Critical Access Hospitals. There are 72 Rural Health Clinics in Minnesota, and 12 Federally Qualified Health Centers provide services at 67 sites in the state (Kaiser, 2004). Most Minnesotans have some form of health insurance coverage, although 9% of its residents lack any health insurance.

News

Aug 24, 2006 -- [NCTC Begins Work on New WorkForce Center](#)

Aug 21, 2006 -- [Small Pharmacies Struggle](#)

Aug 8, 2006 -- [Rural Health: Help Wanted](#)

Jul 27, 2006 -- [Health Department Makes Grants Available to Expand Use of Electronic Health Records in Rural and Underserved Areas](#)