Health Resources and Services Administration
Office of Rural Health Policy

National Advisory Committee on Rural Health and Human Services

Spring Meeting
Austin, Texas
April 9-11, 2024

Meeting Summary

The 94th meeting of the National Advisory Committee on Rural Health and Human Services (NACRHHS) was held April 9-11 in Austin, Texas. The meeting topics were Technology and Innovation and Rural Health Clinic Quality Measurement.

The committee members in attendance: April Anzaldua; Jeff Coyler, MD; Isabel Garcia-Vargas; Craig Glover, MBA, MA, FACHE; Clifford Hunter; Cara James, PhD; Michelle Mills; Kellie Phillips Asay; Matthew Probst, PA-C.

Present from the Department of Health and Human Services: Tom Morris, Executive Secretary, Office of Rural Health Policy (ORHP); Sahira Rafiullah, Senior Advisor, ORHP; Lindsey Nienstedt, Public Health Analyst, ORHP; Alixandra James and Oksanna Samey, Truman-Albright Fellows, ORHP; Keith Mueller, PhD, Director, Rural Policy Research Institute (RUPRI); Jocelyn Richgels, MPP, Director of National Policy Programs, RUPRI.

Additional attendees: Percy Devine, Administration for Community Living (ACL); Amanda Cash, ACL; Kevin Duval, ACL; Lisa Zingman, Administration for Children and Families (ACF); Ben Smith, Indian Health Service (IHS); Humberto Carvalho, Substance Abuse and Mental Health Services Administration (SAMHSA); Jalima Caulker, SAMHSA; Kellie Kubena, U.S. Department of Agriculture (USDA); Peter Kaboli, Veterans Administration (VA); Bon Ku, Advanced Research Projects Agency for Health (ARPA-H).

Tuesday, April 9

Cara James, Presiding Committee Member, convened the meeting.

WELCOME AND INTRODUCTIONS

Cara James, PhD
Presiding Committee Member

Cara James welcomed the committee and introduced the two meeting topics: innovation and technology in rural health and human services and expanding quality reporting and benchmarking in Rural Health Clinics (RHCs). She thanked Keith Mueller and his team at RUPRI for taking the lead on the technology and innovation topic and thanked the Texas State Office of Rural Health for identifying issues in RHC quality measurement.

WELCOME TO TEXAS RURAL HEALTH

John Henderson
President and CEO
Texas Organization of Rural & Community Hospitals (TORCH)

Albert Ruiz
State Office of Rural Health Coordinator
Texas State Office of Rural Health (SORH)

John Henderson congratulated the committee on its work and provided an overview of rural hospitals and RHCs in Texas. Texas has 254 counties and 158 rural hospitals, more than any other state in the country. Of those hospitals, 127 are trauma-designated, 89 are Critical Access Hospitals (CAHs), four are Rural Emergency Hospitals (REHs), and 63 have obstetrics units that deliver babies. There have been 27 rural hospital closures in the state since 2010, 26 of which closed between 2010 and 2020. There are 32 Texas counties with zero physicians.

Bowie, Texas was highlighted as an example of a community that lost its hospital. As a result of Bowie's hospital closure, more than 100 local jobs were lost, sales tax revenue dropped 38 percent, school enrollment went down, the town's housing market stagnated, and local infrastructure degraded.

John stated that TORCH believes technology, innovation, and primary care have an important role to play in solving the challenges Texas is facing in rural health care. He shared examples of resilience and community in rural Texas and expressed his belief that these qualities can help to produce solutions.

Albert Ruiz welcomed the committee to Texas. He shared that the Texas SORH had only four people on staff until 2019, when the office expanded to nine staff members, and stated that the expansion has allowed the SORH to be more productive.

RURAL HEALTH AND HUMAN SERVICES TECHNOLOGY INNOVATION

Keith Mueller, PhD
Director, RUPRI Center for Rural Health Policy Analysis
University of Iowa College of Public Health

Dan Shane, PhD
Associate Professor, Department of Health Management and Policy
Iowa College of Public Health

Keith Mueller introduced the topic of technology and innovation and asked the committee to consider three recurring themes throughout the meeting: 1) How technology can be used beyond a clinical setting to directly reach rural residents in their homes and communities; 2) How technology, including artificial intelligence (AI), can be used to relieve provider burden so that more time can be spent directly interacting with patients; and 3) How to support new startup efforts to encourage innovation in technology and connect these firms with rural providers and communities.

Dan Shane shared insights from conversations the RUPRI team has had with rural hospital administrators and professionals across the country, including professionals in the insurance and consulting industries. During these conversations, RUPRI asked hospital administrators and professionals about the biggest challenges facing rural health care, how technology and digital innovation could help to solve those

challenges, how to motivate engagement from innovators and funders, and how they foresee interactions between local stakeholders in the context of implementing new solutions.

Rural hospital administrators and professionals reportedly discussed the potential for technology to mitigate ongoing workforce challenges by reducing system resources dedicated to inefficiencies, expanding virtual access to specialty care, expanding access to laboratory and diagnostic services through virtual and mobile technology, and providing opportunities to increase the amount of time providers can spend with patients and decrease the amount of time spent in front of a computer. They reported positive experiences with telehealth, including tele-emergency care, but said they were not currently benefiting from ambient listening technology, AI medical scribes, Electronic Health Record (HER) extenders, and other technology meant to reduce provider workload.

Administrators and professionals also emphasized a need for collaboration and networks to more effectively diffuse technological innovations into rural communities, and stated concerns about inequities in broadband slowing the adoption of new technologies in some rural contexts. Licensing rules around who can perform which services and whether they need to physically be in the room to do so may also present complications going forward.

Generally, the rural administrators and professionals that RUPRI spoke with reported that rural patients were receptive to virtual care. Notably, they saw more potential for technology to be used in specialty care than in primary care, although primary care will be the most likely avenue for these technologies going forward. They also expressed concerns that new technologies could potentially cause rural health systems to lose out on key revenue generators, make the recruitment of specialty care physicians in rural areas more difficult, and weaken the connection between rural providers and their patients.

Q&A

Matthew Probst stated that he is excited about AI and believes that technology can be a valuable tool for rural providers, but that technology will not take the place of providers because AI does not have the generational wisdom and cultural equity that is needed to practice medicine in a rural community.

Kellie Phillips Asay asked about interoperability and continuity of care when using new technologies.

Dan Shane responded that partnerships and affiliation with larger systems will be necessary to provide continuity and bring digital platforms together.

Keith Mueller added that clinically integrated networks (CINs) can be useful in this way.

Kellie Phillips Asay noted that there is more than one health network in Texas, which might make continuity of care difficult across networks.

Peter Kaboli asked which technologies are already working well for the rural providers that RUPRI spoke with.

Dan Shane responded that tele-emergency departments (tele-EDs) and e-hospitalists have been successful in those rural communities and that administrators were interested in applying the same technology to other specialties or areas of care.

Michelle Mills asked whether there are certain certifications that the committee might turn its attention to in order to make it easier for rural communities to adopt these new technologies.

Dan Shane responded that the rural administrators he spoke with are frustrated about having a shortage of skilled and certified workers in their communities and are also frustrated with a lack of opportunities for local residents to get those certifications. He noted that there may be opportunities for rural health systems to partner with local education systems, such as community colleges, to offer certifications.

Michelle Mills said there is a resistance in primary care to do more virtual care because of lower reimbursement rates for virtual care.

Dan Shane responded that behavioral health is at the front lines of this issue and that reimbursement is a policy lever that can push rural care in one direction or another.

Keith Mueller added that this is part of a larger movement toward value-based payment models.

Isabel Garcia-Vargas said that the adjustment from in-person care to virtual care can be difficult for rural communities and that culturally some communities may not be ready.

Craig Glover asked the committee to consider which technologies can be implemented right now in rural areas with broadband gaps.

Dan Shane stated that there will need to be competition in the satellite internet service arena and said he would love to hear from others on the status of broadband improvement and the competitive satellite landscape.

Kellie Kubena said she sees an opportunity for health care organizations to use their influence to change local broadband regulations. Broadband is not regulated like power or water, meaning that broadband providers have first rights to a geographic area and no competition.

Dan Shane said this issue did not come up in conversation with administrators but that there is an opportunity for conversation.

Peter Kaboli stated that lower satellite has changed the internet service market in Alaska and made service more affordable.

Matthew Probst said education will be necessary to ensure technological literacy among health care workers and patients.

Cara James asked how providers are picking which technology to adopt and whether there are recommendations the committee might make about how to support adoption.

Peter Kaboli asked where and how value-based care works in rural.

Keith Mueller said RUPRI is aware of models that seem to be working in some places, such as a shared savings model.

Dan Shane said this depends on state policy. If there are incentives to reduce emergency department visits, AI-driven data will be helpful in identifying patients with chronic conditions so that providers can work on keeping them out of the emergency department via initiatives like the home health model.

Clifford Hunter stated that software companies have a financial incentive to not build connectivity with other EHR software providers and asked whether there is a way this could be fixed legislatively so that all

EHR providers can connect to other regional providers. He also asked how to reduce EHR costs for the best patient care.

Matthew Probst asked whether there is a legislative avenue to not only incentivize software companies to connect EHRs but to force connectivity.

Tom Morris said he believes bringing analysis to the human services world will flesh out this issue further.

FEDERAL INVESTMENT AND POTENTIAL FOR TECHNOLOGY AND INNOVATION IN RURAL HEALTH – PART 1

Keith Muller, PhD
Director, RUPRI Center for Rural Health Policy Analysis
University of Iowa College of Public Health

Bon Ku, MD
Program Manager, Resilient Systems
Advanced Research Projects Agency for Health (ARPA-H)

Peter J. Kaboli, MD
Executive Director
VHA Office of Rural Health

Bon Ku introduced Platform Accelerating Rural Access to Distributed and Integrated Medical Care (PARADIGM), a five-year program that aims to make complex services, such as cancer screening, advanced imaging, and perinatal care, available to patients outside of a hospital setting. There is increased demand for distributed care from patients and clinicians, and the miniaturization of devices and improving battery and satellite technology have expanded the potential for care delivery in non-hospital settings.

PARADIGM has five technical areas: 1) Decentralizing hospital-level care; 2) building a care delivery platform; 3) creating a "plug and play," vendor-agnostic medical IoT* platform that connects medical devices and enables seamless data ingestion, normalization, and translation between common medical devices and EHRs; 4) ruggedizing, miniaturizing, and simplifying a CT scanner for use in a mobile unit; and 5) developing an easy-to-use, interactive, and intelligent task guidance system that uses AI learning to provide real-time support for health care workers performing tasks beyond their usual training. The task guidance system would allow a generalist to function as a specialist who can perform multiple services.

The program plans to conduct field demonstrations of the PARADIGM technology in rural communities, working with community organizations and existing local health care infrastructure to co-design the technology and evaluate its effectiveness. At the end of this process, the program hopes to have 2-3 years of testing and evaluation. The program is currently accepting proposals from potential demonstration sites. A strong proposal will include collaboration with a local community-based organization and local health care infrastructure.

Peter Kaboli provided an overview of rural veteran enrollment in the Veterans Administration (VA) healthcare system. There are 4.4 million rural veterans in the U.S., about 24% of the total veteran population. Not every person who has served in the military is eligible for VA healthcare. There are roughly 8-9 million veterans currently enrolled in the system, and another 3-5 million that could enroll

but have chosen not to. Rural veterans disproportionately enroll in the VA system: 61% of rural veterans are enrolled.

The VA Office of Rural Health (ORH) has a total annual budget of $331 million, distributed across 140 Veterans Affairs Medical Centers (VAMCs) and more than 1,000 clinics. There are 36 ORH initiatives at the national level in 2024. These include home-based primary care, working with pharmacists to deliver remote care, mobile prosthetic and orthotic care, local workforce training programs, transportation initiatives, a wide range of telemedicine services, and Clinical Resource Hubs, network hubs that provide core services and are now expanding in specialty services such as cardiology. Promising practices include advanced comprehensive diabetes care, and home-based cardiac rehabilitation via telephone or video.

Q&A

April Anzaldua asked what staffing will look like under the PARADIGM model.

Bon Ku responded that staffing will depend on the community. One community may identify a need for postpartum care, while another community may have different needs. Program leaders want to have as many clinical use cases as possible to run demonstrations on staffing levels, payments, reimbursements, and whether patients like the model.

April Anzaldua asked whether rural providers will be taken away from their hospitals to operate the PARADIGM technology and whether the model will be sustainable for rural communities.

Bon Ku responded that PARADIGM is meant to augment existing providers and that technicians, rather than physicians or nurses, will likely perform the services.

Tom Morris inquired about the timeline for PARADIGM demonstrations starting and how much funding will be given to sites that are chosen.

Bon Ku responded that proposals are coming in this spring and he anticipates that funding will start to be distributed in the fall. Funding will be awarded according to the merit of proposals rather than a specified amount per site.

Tom Morris asked if the funding will cover the full cost of developing the prototype.

Bon Ku responded that this will depend on the technical area. For sites that require a prototype, the funding will cover the cost of prototype development so that the provider or scientist can run demonstrations with the technology.

Matthew Probst noted that technology is getting smaller and more usable and asked whether PARADIGM program leaders are looking for major organizations or a mix of smaller and larger sites.

Bon Ku responded that they are looking for a mix of sizes. Smaller CAHs cannot respond to the request for proposals but can come in as subs. There is potential for entities to team up.

Kellie Phillips Asay asked how services will trickle down to rural communities, what the “hub” would look like for these sites, and whether transportation would be available for patients.

Bon Ku said the program is not prescriptive in what these details will look like and will depend on the specific use cases submitted by the proposers.

Kellie Kubena asked whether the PARADIGM team is exploring how to navigate local and state regulations as part of de-risking.

Bon Ku responded that there is extreme variation in regulations and this is why the program is asking proposers to choose which services they want to implement. PARADIGM's goal is not to change policy but by de-risking technology, technology could be used as a lever to change local regulations.

Cara James asked what the argument is to incentivize venture capital to invest in rural.

Bon Ku responded that while the immediate use case for these technologies is rural, they can also be used in non-rural settings, such as on space missions or in urban areas.

Tom Morris stated that if committee members like the PARADIGM model, there may be opportunities to make relevant recommendations concerning other aspects of HHS, such as reimbursement.

Ben Smith asked whether the committee might want to make a recommendation that would standardize the language around health extenders across states to make for easier conversations around Medicaid and Medicare reimbursements.

Peter Kaboli stated that the VA has had challenges with mobile units in the past.

CAPITAL INVESTMENT IN NEW TECHNOLOGIES IN RURAL HEALTH

Jeff Coyler, MD
Former Committee Chair

Jim Kerrigan
Vice President
Pharos Capital Group, LLC

Jeff Coyler stated that he wanted to share some ideas about technology and capital in rural areas. There are approximately 100 million people living in rural areas across the country, and the percentage of U.S. residents who are rural has decreased from 95% to 70-80%. However, rural communities have seen a recent upsurge since the COVID-19 pandemic. Today, rural populations tend to be aging but are increasing in diversity, especially in Hispanic communities. While people think of rural communities as reliant on agriculture and mining, in reality these industries account for less than 5% of rural employment. Rural residents are primarily employed in the service industry, mirroring their urban counterparts.

Telehealth first originated from an earthquake in Armenia in the late 1980s, when the Soviet Union partnered with NASA and John's Hopkins University to see patients in Armenia via a NASA Soviet satellite system. An estimated $5 million to $10 million was spent on these projects, which led to the telehealth systems we see today.

Telehealth today still presents some financial challenges: The technology is expensive, and billing issues present major policy problems. The COVID-19 pandemic expanded telehealth dramatically and demonstrated that it was possible to conduct much of telehealth with an iPhone. Now, telehealth has collapsed and financing, requirement, and payment systems are all having issues. There have been high adoption rates in some areas, including psychiatry, where the number of providers are extremely limited. Telehealth has also been used in some unique situations, such as for Ozempic prescriptions, where it is subsidized with something else. While some rural opportunities have been lost, he believes there are ways it can be used more integrally.

He provided examples of urban innovation, including electronic medical records, remote patient monitoring, radiology AI, and creative financing for large facilities. These high-risk new technologies are largely self-funded by inventors or developers, but can also receive funding from venture funds, private equity, health systems and universities, incubators, and state or federal funds.

Rural innovation, by contrast, is a large and overlooked market. There is a lower cost of entry in rural, and smaller investments can have bigger impacts. However, there are challenges with manpower, administration, and access in rural, and the market offers many small buyers rather than a few large buyers. HHS data is valuable but extremely difficult to access, and the sources of capital are different in rural technology. Government and businesses tend to focus on urban innovation.

He shared some ideas he has heard from other people to increase rural technology and capital, including: considering private technology and capital when dealing with any rural HHS issue; the government eliminating rural and urban silos and encouraging rural innovation across a wide range of programs; bringing rural opportunities to the attention of financial and technological investors; examining Medicare and Medicaid reimbursement rules for rural areas; emphasizing rural incentives, such as innovation prizes; HHS allowing access to "rural data sandboxes" where investors and inventors can access data, similar to "sandboxes" in Brazil; working with the U.S. Treasury, USDA, financial markets and agencies to encourage rural investment; encouraging AI development for rural innovations; encouraging rulemaking processes to minimize burdens on rural providers and patients; and reviewing and/or expanding reimbursements for rural providers and recognizing uniquely rural circumstances that are overlooked.

Jim Kerrigan introduced Pharos Capital Group, LLC, a healthcare-focused private equity firm, as a case study for incentivizing private investment in rural healthcare. He described Pharos as a tier above angel investors: if a company is somewhat or potentially profitable and has the ability to scale, Pharos will help them do that. He characterized Pharos as a firm that makes big investments in small companies, investing in innovation at an early stage.

Pharos was co-founded in 1997 by Kneeland Youngblood, MD, an emergency room physician who became familiar with private equity after spending time in philanthropy and politics. The firm was founded on the hope of finding effective health care solutions and scaling them to increase access to care. Dr. Youngblood brings his health care expertise to Pharos, while co-founder Bob Crants brings investment expertise. In 2013, following the Affordable Care Act, the firm pivoted to focus on value-based healthcare. Companies now must meet three required criteria for investment: improving outcomes, increasing access, and lowering costs. Pharos primarily makes intermediate-term investments, with roughly a five- to seven-year hold and fund life.

He provided an overview of the structure of Pharos Capital Group's funds and how that structure incentivizes Pharos to invest in health care businesses, and provided as an example one $545 million fund with 11 portfolio companies. Nine of those 11 companies were patient-facing; patient-facing companies tend to be most likely to improve outcomes, increase access, and lower costs. Of the 11 portfolio companies in the fund, four were behavioral, three were private practice management, and two were post-acute care businesses.

One of this fund's portfolio companies is FasPsych, a telepsychiatry staffing company for psychiatrists and psychiatric nurse practitioners. FasPsych primarily serves rural hospitals and mental health centers. The company provides night and weekend coverage, allowing rural hospitals and mental health centers to keep patients who they might otherwise have to discharge to an urban hospital with full-time psychiatrists on staff, and offers a variety of specialties that a hospital can choose from depending on its needs.

Another portfolio company within the fund is Beacon Specialized Living, an adult foster care service for people with traumatic brain injuries and intellectual and developmental disabilities. The program began with one psychiatrist visiting 17 houses throughout rural Michigan to see patients living in homes that he had purchased himself. The patients he served were primarily indigent and/or homeless, and had either traumatic brain injuries or intellectual or developmental disabilities. Pharos invested in the program in 2016 and expanded it from 17 houses to 220 houses in multiple states, housing over 1,000 people. Beacon provides wrap-around primary care services, vocational training, and medication management services, with the goal of increasing the overall health of the population it serves. Among patients that resided with Beacon for over 150 days, emergency room visits were reduced by 92%. Cost-wise, Beacon's home- and community-based setting was about 83% cheaper than the average per diem at inpatient facilities. By contracting with state-managed Medicaid and Medicare programs to bring value-based care to this population – thus reducing emergency department visits and overall costs to the system – the program has been profitable. Beacon Specialized Living ultimately sold to the Vistria Group, an impact-oriented private equity fund. Pharos has plans to invest in a respite day care company serving a similar population in Massachusetts and Connecticut.

This fund is part of the Small Business Investment Company (SBIC) program administered by the Small Business Administration (SBA). The SBIC program incentivizes investors to deploy capital into underserved communities. Pharos's partners in the fund are commercial banks who receive Community Reinvestment Act credit for their investments. The SBA then matches commercial banks' dollars one-for-one. More recently, the USDA has set up a similar Rural Business Investment Company (RBIC) program. The RBIC program was initially focused on agricultural lending, but the USDA and farm credit banks involved have shown an interest in investing in rural health care as well. Pharos has since raised the largest RBIC to-date and is excited about the opportunities for this type of fund. The USDA is now considering implementing the same matched funds leverage model for the RBIC program that the SBA has in place for the SBIC program.

He shared three rural examples of Pharos investments. The first example was Vantage Outsourcing, a company that gives rural hospitals the ability to perform cataract surgeries by having a traveling technician with cataract surgery equipment partner with an ophthalmologist from the region to perform a backlog of surgeries in a rural community. In this Vantage Outsourcing model, the rural hospital receives a facility fee and other revenue for providing the service while minimizing the patient's travel time. A similar model for colonoscopies will launch in Oklahoma in the fall, and Pharos hopes to explore other ways to leverage expensive equipment across multiple sites going forward. The second example was Renal Care 360, a tech-enabled practice management and population management company that extends the capability of nephrologists through chronic care management. Renal Care 360 partners with rural hospitals in Georgia to use hospitals' electronic medical record (EMR) data to earlier identify undiagnosed chronic kidney disease. The third example was Sanderling Home Dialysis, a company innovating in home-based dialysis and rural in-patient acute dialysis to bring down treatment costs.

Q&A

Peter Kaboli thanked the presenters and said he found the presentation interesting. He stated that he believes the incentives of rural health and human services providers and private equity firms are misaligned.

Jim Kerrigan responded that Peter's concerns are fair because the sickest rural patients are impossible to take care of in a profitable manner. This is why value-based care is important. However, to build value-based care requires scale, which is a challenge for rural. People who are best at creating outcomes and savings will be part of growing value-based care. If you are effectively managing kidney patients in a

rural market, payors will be eager to expand your reach to urban markets facing similar challenges as well. A holistic approach is needed.

Matthew Probst stated that rural and urban health care are interconnected and that an "urban and rural," not "urban or rural" approach should be taken by policymakers to put equal value on rural and urban lives.

Clifford Hunter asked how a company becomes involved with Pharos and what that process looks like.

Jim Kerrigan responded that Pharos often cold-calls physicians, entrepreneurs, and founders. Some innovators are approaching the end of their career and are looking for someone to be a steward of their brand. Others are at the beginning of their career and looking to expand their work.

April Anzaldua asked Jim Kerrigan what he would like to see the committee recommend.

Jim Kerrigan responded with several recommendations. 1) The implementation of rural waivers that would allow nurses and physicians to virtually oversee technicians in outpatient settings via telemedicine while they perform services such as dialysis and echocardiograms. 2) General support for the RBIC program. 3) The creation of a list of proven value-based care investors, possibly with some sort of accreditation, for entrepreneurs who are looking for funding.

Ben Smith asked what the committee should consider when it comes to mitigating or preventing unethical treatment practices such as patient brokering, unnecessary services, or overcharging. He said he believes that consideration is important.

Jim Kerrigan responded that a value-based care model disincentivizes overcharging or fraudulent claims.

Cara James thanked Jeff Coyler and Jim Kerrigan for their presentation and stated that people working in the health care space need to learn more about the finance world, how it works, and how to best make the case for investing in rural health. She said she was particularly glad to hear kidney disease discussed.

FEDERAL INVESTMENT AND POTENTIAL FOR TECHNOLOGY AND INNOVATION IN RURAL HUMAN SERVICES – PART II

Tom Morris
Director
Federal Office of Rural Health Policy

Kevin Duvall
Chief Technology Officer, Information Technology Specialist
Administration for Children and Families

Amanda Cash
Chief Data Officer
Administration for Community Living

Percy Devine
Regional Administrator, Region 8
Administration for Community Living

Tom Morris said he appreciated the opportunity to shift the discussion to human services and how the field relates to data, innovation, and technology. The dynamic in the human services world is different than in the health care world, since human services runs on a model of service provision without reimbursement. He argued that it is even more necessary to invest in innovation in human services than it is to invest in innovation in health care, as the human services sector is chronically underinvested-in and lacks the administrative resources to invest in technology, data and innovation on its own. Many HHS programs are based on categories such as income or age and therefore require patients to be re-qualified for each program. This is a data-intensive and time-intensive process for organizations that are often understaffed. He stated that he looked forward to a robust discussion and to incorporating human services into the committee's recommendations in a meaningful way.

Amanda Cash introduced ACL, the federal agency responsible for increasing access to community supports for older adults and people with disabilities. She provided an overview of three federal technology policy updates relevant to rural populations: 1) The Executive Order on Safe, Secure, and Trustworthy Development, and Use of Artificial Intelligence, published in October 2023, which directs HHS to examine the responsible use of AI for the healthcare sector. 2) A memorandum on AI published by the Office of Management Budget (OMB) providing further guidance for Executive Branch agencies, including HHS, to advance AI governance and innovation while managing risks from the use of AI, particularly those affecting the safety and rights of the public. HHS is currently formulating a plan for what that will look like. 3) HHS's data strategy, published last year, which outlines the department's priorities and initiatives to safety and effectively harness data to enhance the health and wellbeing of all Americans. The strategy has a focus of roughly five years with the intent to periodically review its content and ensure it is meeting HHS's evolving needs. The strategy has five goals: to cultivate data talent, foster data sharing, integrate administrative data into program operations, enable full-person care delivery by connecting human services data, and responsibly leveraging AI.

The human services sector is not as advanced as the health care sector when it comes to the availability and interoperability of the electronic exchange of data, particularly at the point of care. There is a need for more comprehensive data standards; freely available, standard taxonomies for human services provider information; better tools to manage consent, map household relationships, and perform matching and linkage; expanded provider onboarding; and aligned incentives and requirements to stimulate data flows. There is no EHR equivalent in human services and therefore there is a need to figure out how to better connect disparate systems. Improving interoperability would significantly enhance case management, coordinated care and service delivery, closed loop screening and referral with "warm handoffs" between providers, expedited enrollment into benefit and service programs, and would potentially enable more efficient and equitable program design and delivery. ACL believes these advances would improve participants' experiences and access to services.

A relevant ACL program is the Community Care Hubs initiative. This is a community-focused entity that organizes and supports a network of community-based organizations providing services to address health-related social needs. These hubs centralize administrative functions and operational infrastructure, including contracting with health care organizations; payment operations; management of referrals; service delivery fidelity and compliance; and technology, information security, data collection, and reporting. A Community Care Hub has trusted relationships with and understands the capacities of local community-based and healthcare organizations, and fosters cross-sector collaborations that practice community governance with authentic local voices. ACL recently funded the Center of Excellence to Align Health and Social Care, which directly aligns with the data strategy goal of enabling whole person care delivery through connecting health and human services. Many states are interested in establishing hubs, and ACL believes the model will see a lot of growth going forward.

Percy Devine shared some of the common rural challenges he has heard from people in the states he serves, which are primarily in the Mountain West and Midwest. These challenges include: social isolation and loneliness; strategies to connect families to the Internet; dementia; suicide prevention; hunger and food insecurity; building social support for families in rural settings; behavioral health; addiction, providing services close to home; transportation; and long-term services and supports.

The State Grant for Assistive Technology (AT) Program supports state efforts to improve the provision of assistive technology to individuals with disabilities of all ages through comprehensive, statewide programs that are consumer-responsive. The ACL funds 56 state and territory AT programs authorized under the 21st Century Assistive Technology Act. These AT programs use information, assistance and demonstrations to help people learn about AT that is available to assist them in carrying out functions with greater independence. In Oregon, there are more than 1,200 technology-related services available to seniors, including provided tablets, internet access, remote in-person training, connectivity for families and friends and medical teams, and robotic pets. In Iowa, Easter Seals taught the state's Area Agencies on Aging staff about AT kits that can help seniors who need assistance turning a doorknob, eating, or performing other tasks. In Rhode Island, digital training was provided to older adults in underserved areas at senior centers, libraries, and senior homes. In Connecticut, programing exists to bridge the digital divide by teaching older adults how to use smartphone features, social media, online shopping, and other types of technology, as well as new virtual senior centers. He also noted that the Broadband Equity Access and Deployment Program, a program administered by the National Telecommunications and Implementation Administration, currently has $42.5 billion to expand high speed internet access and is looking at funding plans, infrastructure deployment, and adopted programs in all states, including efforts targeting older adults.

In Colorado, the Supporting Older Adults through Relationships and Resources with Technology (SOARR) project is a community-based collaboration that is forming strategic partnerships and building relationships with statewide and local agencies to address gaps in technology accessibility. The program relies on feedback from community members to have a more meaningful impact on older adults across the state. A key component of the program is developing online teaching and support modules that are used by local community Tech Mentors to help elders in the community learn to use tablets, phones, computers, and other technology for telehealth visits, social connections, banking, shopping, and other activities. Collaborators include 20 regional and county aging service organizations, senior housing organizations, veteran volunteer organizations, and the University of Colorado Anschutz Multidisciplinary Center on Aging. An initial survey of over 1,700 older adults in Colorado, which yielded over 400 responses, found that many older people feel isolated but that technology offers them a solution, despite barriers that include access to devices, training, and connectivity. To address some of these challenges, the project hosts a website linking to accessibility features for phones, tablets and computers across a variety of common technologies and platforms. The project will focus next on adding community resources to support Tech Mentors.

In Virginia, technology is being used to address social isolation through the state's Social Health Connector program, which won ACL's Mental Health Innovation Challenge in 2020. The program uses a person-centered virtual assessment to generate a customized social health connection plan for people with disabilities, older adults, and family caregivers. This personalized plan uses AI and machine learning to offer insights into individualized risks and strengths, highlighting local recommended resources for users. The project was developed through a partnership between the Virginia Department for Aging and Rehabilitative Services, Virginia Commonwealth University, Virginia 2-1-1, and United Way Worldwide.

ACL's National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) is the federal government's primary disability research organization. Its mission is to generate new knowledge and to promote its effective use to improve the abilities of individuals with disabilities to

perform activities of their choice in the community, and to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. To achieve this, NIDILL funds research, demonstration, training, technical assistance and related activities to maximize the full inclusion and integration into society, employment, independent living, family support, and economic and social self-sufficiency of people with disabilities of all ages; promotes the transfer of, use and adoption of rehabilitation technology for people with disabilities in a timely manner; and ensures the widespread distribution, in usable formats, of practical scientific and technological information. The NIDILRR funded the Assistive Technology Network (ATNetwork), an online community of practice connecting people with disabilities and older adults, AT providers and social service case managers, and AT industry representatives. This benefits AT users in geographically isolated area, as well as those who are at risk for infectious disease and who wish to practice social distancing. The project is a partnership of the Georgia Institute of Technology and the Assistive Technology Industry Association, with collaboration from the AT Act Programs from Alaska, Georgia, Guam, Montana, and Texas, and the Association of Programs for Rural Independent Living.

Kevin Duvall introduced the Administration for Children and Families (ACF), which promotes the economic and social wellbeing of families, children, individuals and communities. It includes the Office of Child Care, Office of Child Support Services, Office of Family Assistance, and Office of Refugee Resettlement. Half of all rural areas are childcare deserts.

In considering technology, the ACF's primary concern is how technology can be used to improve efficiency, lower administrative burden, simplify forms, and make the system easier to navigate. Design is also critical to how the ACF communicates with rural communities. For example, if an application requires a lot of data to load, it won't work well on a cell phone in a rural area. The ACF is taking a different approach to technology, including through digital service function. This is designed to build capacity for better delivery of technology inclusive of rural environments: ensuring that technology is designed with users, not for users. Oftentimes rural context is not considered in the design of technology. The ACF is also taking a more hands-on approach to technology, looking at how people are using their systems every day. Enhancing capacity in cybersecurity should additionally be considered in rural contexts. The ACF has seen instances where a human services provider goes offline due to a cyberattack. Lastly, an interoperability request for information (RFI) is coming soon for human services with the goal of finding ways to use data standards more strategically to achieve better outcomes in the system. The building out of interoperability standards for human services is in early stages, but he is hopeful that AI will provide opportunities to build a more coherent ecosystem. Rural health and human services can be better served not through grandiose technology, but through better design and bringing users into the conversation.

Tom Morris invited Humberto Carvalho and Jalima Caulker, representing the Substance Abuse and Mental Health Services Administration (SAMHSA), to share their thoughts, noting that SAMHSA is at the intersection of health and human services.

Humberto Carvalho said SAMHSA is interested in promoting any type of program that will enhance patients' access to new technology, provide better interactions between patients and providers, and train providers. SAMHSA has created several programs, most of which are virtual, that provide training for rural providers.

Jalima Caulker added that SAMHSA and other human services agencies are exploring how technology, such as AI, can be used to connect providers and improve transition of care in rural communities as it relates to behavioral health and medical health. Transition of care between pediatric and adult providers is one example of an area where transitions could be improved to ensure "warm handoffs" and better serve rural communities.

Q&A

Michelle Mills asked whether funds could be pooled from every state to develop one national Community Care Hub rather than each state reinventing the wheel.

Kevin Duvall responded that the same four or five organizations have cornered the market on providing these systems and that there needs to be more diversity in delivery mechanisms. He also stated that he believes the more these projects are aggregated the more likely they are to fail, as 53% of IT projects fail in some way. He said the government needs to look at how it is incentivizing people to work in technology in a federal and state civil service capacity, as much of the issue stems from not getting the right people in the door.

Amanda Cash responded that while developing a national system is probably the right thing to do, she could not imagine an entity that would want to start and build a national system to take the burden off of states. There are too many legal issues to overcome from a federal perspective. This is why ACL has incentivized these networks at a local and state level. ACL is trying to figure out how to be more collaborative to reduce the burden on states and localities while building out the Community Care Hubs.

Cara James said that these silos occur in health and human services because Congress is also siloed through committees.

April Anzaldua stated that she sees Federally Qualified Health Centers (FQHCs) in her region of Texas easily connect and exchange EHRs with hospitals, but that communication between the medical and human services systems is more difficult. She asked whether there is a way the Community Cares Hubs can provide a centralized intake system that brings multiple programs together and allows them to refer back and forth through one system.

Kevin Duvall responded that health care standards are "patient"-centric, and that someone who is food-insecure may not have any illnesses and therefore don't qualify as a patient. ACF is trying to redefine and build off that standard to allow for a level of interoperability. The infrastructure for healthcare is about 10-15 years ahead of human services. Building the same capabilities on the human services side will require investment.

Matthew Probst asked whether the Community Care Hubs are physically located within communities, and stated that the New Mexico Hub and Spoke model uses schools and senior centers as hub sites to reach all generations within the community.

Amanda Cash responded that the Hubs are both virtual and physical. There are statewide networks and certain types of networks not limited by geographic areas.

CONNECTING INNOVATIVE TECHNOLOGY TO PATIENT SERVICES

Keith Mueller, PhD
Director, RUPRI Center for Rural Health Policy Analysis
University of Iowa College of Public Health

Carrie Nixon
Co-Founder and Managing Partner
Nixon Gwilt Law

Nirmal Kaur, MD
President and CEO
Syncoro Health

Dan Roline
Provider Market Leader
Mayo Clinic Platform

Keith Mueller stated that this session would feature the interface between technology and developments and rural health care organizations and providers, including in a context beyond the four calls of a clinic.

Carrie Nixon thanked the committee for the opportunity to speak. She described her law firm, Gwilt Nixon Law, as a firm that works extensively with health technology innovators. She stated that most of the innovators she works with have a real passion around addressing inequities in health care. Many are interested in working with rural communities, but don't know how to get connected to these communities.

She asked the committee to make seven recommendations. The first was to urge Congress to pass legislation making reimbursement permanent for all types of telehealth visits, including those by physical therapists, occupational therapists, and behavioral health therapists. She stated that requiring patients to go to a Rural Health Clinic (RHC) or FQHC to receive telehealth services from an urban center is an outdated and unnecessary measure and that making these telehealth interventions permanent is critical for improving access to care, including specialized care that is not easily accessed by rural populations. The second recommendation was to finalize and make permanent an allowance, implemented during the COVID-19 pandemic, that allows for "incident-to billing" for services performed by clinical staff under the virtual direct supervision of a billing practitioner via telehealth technology.

Many digital health companies working with Nixon Gwilt Law are eager to reduce health disparities in rural populations, particularly around morbidity/mortality rates and chronic disease management. Innovation in these spaces often involves remote monitoring or chronic disease care management programs. These types of programs can move the needle in improving patient outcomes and reducing cost of care. This year, remote monitoring services were bundled into Code G0511 for care management services, allowing FQHCs and RHCs to receive reimbursement for remote monitoring services. However, the reimbursement rate for remote monitoring services is lower than for typical Part B services. Remote monitoring is a business with thin margins. The reimbursement rate for remote monitoring should be increased, particularly in a rural context.

As a fourth recommendation, she stated that Centers for Medicare and Medicaid Services (CMS) should establish a designated benefits category for digital therapeutic interventions. These are clinically-evaluated software applications or platforms that deliver medical or therapy interventions directly to patients to assist with the treatment and management of a range of health conditions. Digital therapeutics can play a role in increasing therapeutic access for underserved rural populations and can serve as an alternative to pharmaceutical pain management, can treat conditions such as chronic obstructive pulmonary disease (COPD), and can provide cognitive behavioral therapy and monitoring. There is no existing dedicated benefits category for digital therapeutics, and the lack of certainty around coverage of these interventions discourages clinicians from providing them and disincentivizes companies to develop innovations in this field.

Fifth, she suggested that CMS and HHS consider creating a rural health innovation hub that connects FQHCs, RHCs, and CAHs with digital health innovators and incentivizes pilot programs between rural providers and digital health companies. This would bring new technology to rural providers while helping digital health companies hone their products to rural populations and demonstrate improved outcomes.

This innovation hub would include a mechanism to allow digital health companies to engage with multiple state Medicaid programs with as little friction as possible, as having to navigate differing state Medicaid programs creates barriers for innovators coming into rural communities.

She noted that none of these recommendations will be possible without adequate broadband access in rural communities, and said she would like to see a joint effort between HHS and the FCC to expand funding and make additional efforts for broadband advocacy in rural communities.

Lastly, she recommended that HHS consider expanding the mandate of regional telehealth resource centers to cover health technology in general and digital health specifically. Providing additional resources to rural providers helps to raise awareness of new innovations. She stated that digital health and healthcare technology provide tremendous opportunity for rural providers and their patients and urged HHS to do everything in its power to bring digital innovators and rural providers together.

Nirmal Kaur stated that she appreciated the opportunity to share the premise of Syncoro Health with the committee.

Patient access significantly affects patient outcomes. As a specialist, Dr. Kaur often hears from patients who say they have sacrificed their wages to make their appointment and won't be able to come back for another. She said she especially saw the impact of access on outcomes while building a tertiary care referral center for the care of complex Crohn's Disease and ulcerative colitis. Outcomes affect mortality, but less often discussed are non-fatal outcomes that result from suboptimal access, such as suffering, disability, and decreased work productivity.

At Henry Ford Health, Dr. Kaur led a team in creating the Virtual Care Clinical Network in rural Michigan. In this model, a patient visits a clinic, has their vital signs measured and physical tests performed, then sees a physician virtually. This model makes telemedicine accessible to patients without broadband access, allows the patient a degree of privacy they may not have in a home-based video visit, and allows for minimal disruption to the physician's day. Collaboration with existing local health care providers was key to implementing this model and minimizing local pushback. While the initial plan was to focus solely on gastrointestinal care, the program has grown to include 65 physicians in 24 specialties. The impact of the program has been significant: Among a sample of 2,000 patients with inflammatory bowel disease, hospitalizations and emergency department visits were reduced by two-thirds. Improvement in access also led to an improvement in parity.

The Virtual Care Clinical Network is driven by a model of collaborative care delivery. In this model, community physicians refer patients to specialists at a neighboring hospital. Community health care receives revenue from ancillary services, and the neighboring hospital gets the procedures and surgeries. Dr. Kaur launched Syncoro Health in 2023 to support the national application of collaborative care delivery. The company has recently partnered with an AI team specializing in intelligent task guidance to explore technology for cross-training radiology technicians. The implementation of the Virtual Care Clinical Network has demonstrated that each rural community is unique and that a one-size-fits-all approach does not work for this type of model.

Dan Roline thanked the committee for the opportunity to share some insights on strategic initiatives taking place through the Mayo Clinic Platform. He introduced himself as representing 35 health systems that are part of the Mayo Clinic Care Network, many of which are rural health systems. Mayo Clinic aims to cure disease, connect people, and transform health care, and uses the Mayo Clinic Platform as a tool to achieve these goals by connecting rural health care providers with the resources they need.

While hospitals and health systems often want to improve care locally, they often don't have the technology or bandwidth to do so. The Mayo Clinic Platform framework allows Mayo Clinic to assess and identify the best solutions, work with innovators to develop these solutions by providing them with use cases and sometimes deidentifying data to test the solutions, make technology deployment easier for providers, and eliminate any friction in the process. Recently, Mayo Clinic announced the Solutions Studio, a platform to work with and enable new solutions companies.

Health care providers are often skeptical and need trustworthy, timely solutions. It takes at least seven years to complete an FTA process, something that the Mayo Clinic and the NACRHHS can help to expedite. Technology and care standards are changing over time and providers must be enabled to have better rates of adoption and growth of new solutions. A more proactive approach focused on early disease detection is needed. He asked the committee to enable new solutions across a broad global framework and to push all of the health care world to be ready to adopt new solutions that make a difference for patients. He also asked the committee to recognize that there are evolving standards of care that require more technology and new ways of doing things, including tools such as telehealth, remote patient monitoring, and digital therapeutics. The accessibility and reimbursement of both clinical and administrative tools is an area to focus on.

Q&A

Cara James stated that she was interested in Syncoro Health's collaborative care delivery model and asked what the biggest challenges have been in getting people to play well together.

Nirmal Kaur responded that the biggest challenge has been convincing people to get to the root of why they work in health care. Initially, some local health care providers were skeptical of the model, and believed that it existed only for the financial benefit of Henry Ford Health. Gaining buy-in from local leadership sometimes required many meetings. The support and enthusiasm of local doctors was also important in convincing some hospital leaders to support the program. The customizable nature of the program was also helpful, as hospital leaders could pick and choose specialties based on what was already available locally.

Cara James asked Carrie Nixon for her top three recommendations for the committee.

Carrie Nixon responded that her top three recommendations would be 1) increasing reimbursement rates for remote patient monitoring, including remote physiological monitoring services and remote therapeutic monitoring services; 2) breaking down silos in CMS and HHS generally between people focusing on digital health care innovations and people immersed in rural health care; 3) the creation of a rural health innovation hub to connect innovators with rural providers and funding opportunities.

Clifford Hunter stated that there is a great deal of misinformation about AI and technology in rural spaces, as well as a fear that AI is going to replace workers. He asked how to get rural workers to understand that AI is a tool to help them, not to take their place.

Nirmal Kaur responded that bringing in people who already have personal experience with the technology may be helpful. As an example, she cited two medical assistants from rural Michigan who have been cross-trained in a number of different skills. She plans to bring those two medical assistants to training sessions to reassure other rural workers.

Kellie Phillips Asay stated that she is largely unfamiliar with digital therapeutics and asked what the process is for regulating this kind of technology.

Carrie Nixon responded that digital therapeutics is by definition software as a medical device. Sometimes a regulatory pathway is required by the Food and Drug Administration (FDA), but this is not always the case as some digital therapeutics have been deemed a low-enough risk to patient safety to be exempt from a typical regulatory process.

PHILANTHROPIC PERSPECTIVE ON TECHNOLOGY AND INNOVATION IN RURAL HEALTH

Kevin J. Lambing
Senior Program Officer, Health
T.L.L. Temple Foundation – Lufkin, Texas

Cindy Lucia
Senior Program Officer
Episcopal Health Foundation – Houston, Texas

Kevin Lambing thanked the committee on behalf of both presenters and said they planned to discuss philanthropy's role in introducing technology to rural communities.

Cindy Lucia stated that while there is geographic overlap between the areas served by the Episcopal Health Foundation and T.L.L. Temple Foundation, the two organizations have different philosophies. While the T.L.L. Temple Foundation gives to a variety of causes, the Episcopal Health Foundation focuses solely on health, with a specific focus on primary, preventative, and upstream health. FQHCs receive a bulk of the Episcopal Health Foundation's funding, which amounts to a total of about $35 million distributed annually. The foundation covers the cities of Houston, Austin, Fort Worth, and all of the rural counties in-between.

Recently, the foundation awarded a grant to five Local Mental Health Authorities (LMHAs) in Texas to fund research into a digital platform that could potentially address onboarding challenges and help with ongoing patient engagement. Initially, just one LMHA had approached Episcopal Health Foundation expressing an interest in an AI program that would help onboard patients, but saying they didn't have the time or resources to do their own research. The foundation then proposed that they collaborate with other LMHAs in Texas and awarded five LMHAs a single two-year grant to explore their options, figure out the needs of each individual organization, share information amongst each other, and pilot their work.

Kevin Lambing stated that foundations can play a role in building trust between partners, especially when it comes to introducing new innovations in rural communities where people may be wary of new technology and of the government. One tool that has worked well in rural East Texas is mobile coaches. The T.L.L. Temple Foundation has funded mobile coaches specializing in mammography, dentistry, and mobile health, including a school-based mobile program that treats students and faculty with a Family Nurse Practitioner (FNP) and behavioral health practitioner.

Cindy Lucia shared several examples of work Episcopal Health Foundation has funded in remote patient monitoring. Remote patient monitoring is a new concept to many of the rural clinics in Texas that Episcopal Health Foundation works with. While many people in rural Texas towns don't have cars and struggle with transportation, most have phones or access to a phone that can be used for remote monitoring. The foundation has provided operating and staff funding to these clinics to try different things, gather the data, and see what works best. As an example, one organization is currently implementing continuous glucose monitoring for diabetic patients. Having a foundation take on some of the risk of trying out new technologies, and provide funding for exploration and evaluation, gives rural clinics the impetus to move forward.

Kevin Lambing discussed the role that philanthropy can play in interagency work. As an example, he recently connected the VA and USDA for a partnership project with a Texas FQHC that the T.L.L. Temple Foundation has worked with. The foundation will also help to fund some of the infrastructure and equipment needed for the project.

Other projects that have received T.L.L. Temple Foundation funding include three residency programs in the last three years, which give preference to Texans in an effort to grow the number of rural providers in East Texas, and a new simulation lab created in partnership with the Sam Houston State University School of Osteopathic Medicine and St. Luke's Hospital in Lufkin, Texas. This lab will give rural residents, medical students and staff training opportunities in complex procedures that they might not encounter often in a small rural hospital.

Cindy Lucia stated that foundations have the power to convene people and organizations and to incentivize collaboration. As an example, the Episcopal Health Foundation has conducted three five-year cohort initiatives where eight to twelve FQHCs or communities in the region learn about and work together to evaluate a new process. Foundations can offer a unique type of flexibility as a partner, as they don't require the same protocol as government funding sources and do not need to make a profit.

Q&A

Craig Glover stated that his experience with foundations has been very structured and asked how other foundations can function in a way that is more open and organic.

Cindy Lucia responded that the Episcopal Health Foundation and T.L.L. Temple Foundation are also both very structured and have strict guidelines, but that personal relationships are important. A program officer can help an applicant to design their application or give them insight into where else they might seek funding.

Peter Kaboli asked how the two foundations encourage and support sustainability after a grant has ended. He stated that the VA has seen some initiatives end after grant money runs out, which can make the effort ultimately more harmful than beneficial.

Kevin Lambing responded that the T.L.L. Temple Foundation was a responsive grantmaker until 2016, when it wrote its first strategic plan. In 2021, the foundation rewrote its strategic plan. Sustainability is now built into the grant application, and all health applicants are asked whether they have read the strategic plan to see if their grant idea is a good fit.

Kellie Kubena asked what philanthropy's role is in reducing policy barriers to health care access.

Kevin Lambing responded that as a family foundation, the T.L.L. Temple Foundation is allowed to perform advocacy work but cannot lobby. The foundation has done advocacy work around various issues, including issues related to Medicaid expansion.

Cindy Lucia responded that the Episcopal Health Foundation engages in advocacy on several different levels. Policy is critical. The foundation feels that teaching advocacy and self-reliance is important to community development. It also works extensively with Managed Care Organizations (MCOs).

Cara James stated that a recent webinar clarified what 501c3s and foundations can do. Private foundations cannot lobby, but they can engage in education. Public charities and community foundations can support lobbying. She has seen more foundations moving into the policy space.

Cindy Lucia stated that she has learned not to work with a community unless local leaders, such as commissioners and judges, support health.

Cara James asked how HHS can encourage and foster more public-private partnerships.

Cindy Lucia responded that she appreciates the HHS seminar on public-private partnerships and that exposure to other rural organizations and foundations is helpful. She said she would like the opportunity to build longer relationships with federal agencies and more time to learn about specific federal initiatives or ideas, since learning about many at once can be overwhelming.

Kevin Lambing stated the importance of ongoing communication between public and private entities.

Cindy Lucia stated that foundations can afford organizations the chance to "fail gloriously" as they give them the freedom to try new things.

WRAP-UP AND PLAN FOR DAY TWO

Cara James thanked the day's presenters, Keith Mueller, and the team at RUPRI for cultivating a rich conversation around innovation and for providing good starting points for recommendations. She asked the committee to consider how it can support innovation and build a greater understanding of the role capital investment can play in rural communities and where connections can occur. She thanked the team at FORHP for putting together the background paper.

Sahira Rafiullah provided an overview of Wednesday's itinerary.

PUBLIC COMMENT

There was no public comment.

The meeting adjourned for the day.

Wednesday, April 10

Cara James welcomed the committee back and introduced the second topic of the meeting, rural health quality measurement. The RHC designation was created under Medicare to increase access to care in rural communities. As the health care system has begun moving toward quality reporting, benchmarking, and value-based care efforts, rural clinics find themselves in a unique position. Unlike other primary care clinics, RHCs are not required to report quality data to HHS, due in part to concerns about administrative burden. However, as health care moves toward value-based care, RHCs and other health stakeholders are recognizing the value of quality reporting. In Texas, there is an innovative effort underway to support RHC quality reporting.

RURAL HEALTH CLINIC QUALITY MEASUREMENT IN TEXAS

Lindsay Nienstedt
Public Health Analyst
Federal Office of Rural Health Policy

Albert Ruiz
SORH Coordinator
Texas State Office of Rural Health

Kelsey Beggs
Clinical Administrator
Sudan Medical Clinic

Quang Ngo
President, Texas Organization of Rural & Community Hospitals (TORCH) Foundation

Lindsay Nienstedt provided the committee with a brief history of the RHC program and explained how it relates to current quality issues. The program was established in 1977 through the Rural Health Clinic Services Act; before that point, reimbursement rates were often insufficient for rural clinics. The RHC program aimed to increase utilization of nurse practitioners (NPs) and physician assistants (PAs) by establishing an enhanced Medicaid/Medicare reimbursement rate for rural clinics. RHC statute has not been updated since the program was established in 1977, leading to current issues with quality.

To be certified as an RHC, a clinic must have a quality assessment and improvement plan. This means each clinic must conduct annual program evaluation examining the appropriate utilization of clinic services and whether established clinic policies were followed. This requirement may be met by having a quality assessment and performance improvement program in place.

An RHC must be located in a non-urbanized area and must be designated as a Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or government-designated shortage area. They must post their operation days and hours, employ at least one NP or PA, and must have an NP, PA, or certified nurse midwife (CNM) working at least 50% of the time during operational hours. There are two types of RHCs: independent RHCs and provider-based RHCs. In Texas, the majority of RHCs are provider-based; many are owned by hospitals. Independent RHCs are office-based and can be nonprofit, for-profit, or publicly owned.

RHCs are reimbursed by an All Inclusive Rate (AIR) rather than through a traditional fee-for-service model. This means that an RHC will receive one payment for all qualified services in a visit. That rate is currently set at $139 per visit. Certain services, including chronic care management, are billed differently.

Over the last decade, many health care facilities have started taking part in value-based care and quality reporting programs. Due to the quality improvement plan written into their participation and due to concerns about administrative burdens, RHCs have been exempt from the Merit-based Incentive Payment System (MIPS) and other CMS Innovation Center alternative payment models that require quality reporting. However, RHCs have demonstrated interest in quality reporting. RHC participation in the Shared Savings Program has increased, with 2,500 RHCs participating as of January 2024. Still, RHCs face challenges including a lack of standardized quality improvement measures, difficulty extracting information from EHRs, limited staff time, reporting burdens, and the costs associated with retrieving quality data.

Albert Ruiz provided an overview of the RHC landscape in Texas. There are 354 RHCs throughout the state, and they are often the main point of primary care in their communities. These clinics often face challenges around workforce and turnover. One of the biggest concerns for RHCs is the lack of standardized quality reporting. There is no incentive for RHCs to report quality, and due to workforce challenges they often do not.

The Texas RHC program is modeled after the Medicare Rural Hospital Flexibility Program (Flex program). The Flex program grants CAHs funds to report quality and focus on finance and operations. The Texas program similarly focuses on finance, operations, and quality for RHCs, and uses a graphical user interface (GUI) format to make data easily accessible. Prior to the Texas RHC program, there was no

set way for the SORH to contact all of the state's RHCs due to the clinics' high staff turnover rates. The SORH often received calls from clinics asking how to become an RHC, as there was no centralized way for the SORH to relay information about the process. The dispersion of federal funds during the COVID-19 pandemic created more confusion throughout the state without a mechanism in place to deliver information in a streamlined way.

A needs analysis of 112 Texas RHCs conducted in 2019 focused on compliance, finance and operations, quality, technology and data, market and strategy, and education/training. The needs analysis found that some clinics were not using EMRs or were otherwise lacking modern technology; that some clinics needed more effective marketing strategies to make community members better aware of their services; and that a robust education and training platform was needed. To address these needs, the Texas SORH, Texas Association of Rural Health Clinics (TARHC) and Texas Organization of Rural and Community Hospitals (TORCH) created an online toolkit for RHCs that includes information about rules and regulations, including CMS manuals and policies; training and funding resources; a knowledge library with research, case studies, innovation models and best practices; documents such as directories and maps; tools including templates, checklists, and step-by-step instructions; and finance and operations resources pertaining to data and technology, marketing, quality and compliance, and coding and billing. A document with step-by-step instructions on how to become an RHC has been particularly useful. Additionally, RHC listening sessions have given clinics the opportunity to get to know representatives from federal and state agencies and other partner organizations. A yearly data analytics cohort of 25 RHCs – more than 100 participating RHCs in total since 2019 – meets to discuss program goals and objectives, including technical assistance opportunities, value-based care, training and education, and services delivery. A grant secured by TORCH allowed 22 Texas RHCs, including the Sudan Medical Clinic, to address another common challenge: a lack of funding for capital improvements, such as roof replacement or HVAC system upgrades.

Prior to 2019, there were 305 RHCs in Texas. Today, there are 354 RHCs. This jump indicates that Texas is closing health care delivery gaps. He stated that Texas was able to make a significant impact only when it focused on targeting RHCs specifically.

Kelsey Beggs introduced herself as the Clinic Administrator of Sudan Medical Clinic (SMC). The clinic has two locations: one in Sudan, Texas, and one in Muleshoe, Texas, roughly 15 miles away. SMC is an independent RHC. Sudan has a population of 958, with the closest hospital 20 minutes away in either direction. The town does not have a grocery store and is considered a food desert. Muleshoe has a population of 5,000. The median age in the area is 35.

SMC was established in 2006. Prior to 2006, there was no medical care in Sudan. An additional clinic in Muleshoe was established in 2018. In 2020, SMC joined an Accountable Care Organization (ACO) decided to become an RHC. It was part of the inaugural class of the Rural Health Physicians Transition Project (RHPTP) in 2021. Both clinics were re-accredited as RHCs in 2023, and received patient-centered medical home (PCMH) certification. That same year, SMC joined the Rural Advantage ACO and entered value-based care agreements with WellMed and Superior HealthPlan, two Medicare Advantage programs local to Texas.

SMC credits RHPTP for building the clinic's understanding of value-based care by providing education on value-based care models and helping SMC to figure out some of the processes and financials of value-based care. Through this experience, SMC learned that it would need to track quality measures and patient visits, as well as learning tips on tracking and clinic processes. Joining an ACO in 2020 and again in 2024 helped SMC to start tracking its data and helped SMC to identify populations to focus on. The ACO also provides a possible form of extra revenue for CMS measures yet, although SMC has not seen any shared savings yet, and has provided coding training and other education for staff. Gaining a PCMH

certification has allowed SMC to expand its population focus and continues to provide education on quality care for all. Entering into Medicare Advantage contracts with WellMed and Superior HealthPlan has guaranteed an extra revenue stream for metrics met, provided SMC staff with continued education in topics such as transitional care management and medication adherence, and further identified a population focus.

SMC has created several templates to reduce provider burden. The clinic requests that all patients come in every three to six months and has everyone come in within six months of December 31 to re-capture codes from previous diagnoses. Patient education is key but is a time-consuming process, as patients must be educated on when to go to the emergency room and when to call their SMC provider. Staff education is also time-consuming and has also been a challenge at times. SMC has built a value-based care team to manage this population and is in the process of creating a chronic care management team.

Some of the most significant challenges SMC has faced in adopting a value-based care model include the lack of financial incentive for value-based care for small clinics; a lack of hospital support as an independent clinic, which can make it difficult to keep up; a relatively small local Medicare population; a lack of data, as RHCs are not currently required to provide it; and the learning curve that comes with value-based care. Trying to communicate with other health systems that do not provide value-based care can be difficult. Gaining buy-in from patients, staff, and some community and health care partners has been a challenge at times. At the same time, there is a sense that people want value-based care, SMC has been able to track data internally, and patient care and communication has improved. SMC has been able to implement smoother and better processes, and staff are encouraged to provide feedback on these processes. Overall, she believes that value-based care is doable in an RHC with some changes to the current structure of clinic processes, and that balance for value-based care is needed to help clinics have financial gain with the extra time and effort put in.

Quang Ngo stated that he planned to share some observations. He thanked people such as Kelsey Beggs who are working on the front lines of health care and thanked everyone working in the federal government who has created programs and resources to support rural health.

Rural health organizations are foundations of rural economies, and RHCs are vital primary care access points. However, there is significant underperformance and variation among RHCs, and many are at existential risk. Evidence points to a new imperative that is based on value, outcomes, and patient experience, and that rewards prevention and efficiency. Achieving high-value health in the future demands a value-creation focus and value-driven capabilities.

Texas has seen a number of rural hospital closures. The number of RHCs has increased in Texas, from 305 in 2019 to 354 in 2023. Of these clinics, 62% (219 clinic) are provider-based, and 38% (135) are independent. Physician practice acquisition and physician employment accelerated between 2019 nand 2022, with 50% of practices now owned by hospitals, health systems, or corporations.

He shared several lessons learned from TORCH's work with rural hospital and clinics in Texas. These lessons included: the importance of collaborating and aligning strategic partnerships and missions, which is critical to building trust networks and optimizing value; the importance of primary care in rural, though there is still work needed to align policies, processes, providers, and payments; the ability of telehealth and an omnichannel model to improve access and choice; the impact of economic, health and social inequities; and that persistent, compounding challenges remain, including inflationary pressures, workforce challenges, and rising costs. The path forward will depend on the leadership, people, and culture of rural organizations, an understanding of context through data, investment in data insight and subsequent action, a focus on efficiency and operational excellence to minimize variations, building strategic agility, the strengthening of core revenue-cycle functions, and building systems of care and trust.

He asked the committee to prioritize RHCs in its recommendations. This would include the creation of an auxiliary funding and technical assistance program for RHCs, modeled after the Flex program, with finance and operations, quality, and value-based care readiness and participation as its core objectives. This program would allow for capacity building through technical assistance and enabling performance improvement and quality improvement through analytics. He additionally asked the committee to improve payment parity and operational flexibilities by reducing the amount and type of services that are bundled, tying data reporting to billing and attribution, and simplifying facility requirements and administrative burden.

Q&A

Ben Smith stated that there are at least three federally-recognized tribes in Texas and asked whether there has been interaction with the tribal health system regarding this work.

Quang Ngo responded that there was not.

Kellie Kubena asked about working with rural development and cooperative extension offices in Texas.

Albert Ruiz responded that relationships are important in rural areas to sustain efforts and that the SORH is focused on bringing everyone together, including rural development officials.

Kelsey Beggs responded that Texas is the only state where RHCs fall under the state Department of Agriculture, which can make it difficult for connections to be made.

RHC QUALITY SUBCOMMITTEE SITE VISIT
Ascension Texas
Burnet, TX

Denise Watson
Program Director – Rural Market, Ascension Texas

Subcommittee Members: Albert Ruiz, Ali James, Craig Glover, Darci Graves, Kellie Phillips-Asay, Kelsey Beggs, Lindsey Nienstedt, Matthew Probst, Quang Ngo, Sahi Rafiullah, Scott Miller, Trenton Engeldow

The RHC Quality Subcommittee departed for the Ascension Texas facility in the town of Burnet, Texas.

The subcommittee returned to the Hyatt House Austin/Downtown in Austin, Texas.

TECHNOLOGY AND INNOVATION SUBCOMMITTEE DISCUSSION

Subcommittee Members: Adam Persiani, April Anzaldua, Ben Smith, Bon Ku, Cara James, Cindy Lucia, Clifford Hunter, Dan Shane, Humberto Carvalho, Isabel Garcia-Vargas, Jalima Caulker, Jeff Colyer, Jim Kerrigan, Jocelyn Richgels, Keith Mueller, Kellie Kubena, Kevin Duvall, Lisa Zingman, Michelle Mills, Oksanna Samey, Percy Devine, Peter Kaboli, Sarah Hepper, Tom Morris

The Technology and Innovation Subcommittee remained in the meeting room for its discussion.

DEBRIEFS ON SUBCOMMITTEE VISITS

Cara James welcomed committee members back and invited Keith Mueller and Matthew Probst, heads of the Technology and Innovation Subcommittee and the RHC Quality Subcommittee respectively, to share summaries of their subcommittee site visit and discussion.

Keith Mueller characterized the Technology and Innovation Subcommittee discussion as ranging from a general discussion of how to define technology to a conversation about technology in a rural environment. The central question of the discussion was: What do we need to accomplish in rural health and human services and what role does technology have to play in doing that? This includes technology that is in use already and the question of how to utilize that technology going forward, as well as the "moonshot" approach of PARADIGM and how new and future technology might be implemented in a rural context. Other discussion takeaways included:

- Broadband access as a public health emergency, as it is a prerequisite to virtually any technological progress.
- Cybersecurity is important to consider, both at an individual level (i.e. ensuring that ambient technology used in chronic care management is secure) and at an organizational and community level.
- There is a gap in communication between tech developers and rural organizations. How do we make innovators aware of what is needed and make organizations aware of what is out there?
- Questions remain around the relationship between technology and workforce challenges. There are technological innovations that could help address workforce needs, but to implement these innovations requires trained workers. How do we find these people and train them in a rural environment?
- There was discussion around investments in technology itself, as well as what to do with that technology. This includes government programs, public-private sector collaborations, and how to generate local investment in the long term.
- Discussion about payment policies and language is needed.
- The subcommittee discussed the role of both government and philanthropy in funding and enabling technology in rural health.

Matthew Probst stated that the RHC Quality Subcommittee site visit provided an interesting perspective on the issue of clinical quality measures. Ascension Seton Burnet Health Center is a primary care clinic affiliated with the Ascension health care system. The clinic's association with a hospital and larger system gives the clinic an advantage over independent clinics in some ways. The clinic has been able to reach community members through various outreach efforts outside the clinic walls, such as setting up pop-ups for immunization at rodeos and at a parade. Having home-grown employees who care for their community has been an important factor in the quality of care at Ascension Seton Burnet Health Center. He discussed the balance between these non-tangible, "feel-good" aspects of the Burnet clinic's work, and capturing that quality of care through data. The conversation during the site visit included discussion of how to set up payment structures in the way that makes the most sense.

Lindsey Nienstedt added that RHCs are unable to be paid for Annual Wellness Visits as multiple visits in one day, an issue that has been brought up before in comments and rulemaking. RHCs do not receive an add-on payment from CMS for conducting the Social Determinants of Health (SDOH) Needs Risk Assessment during the Annual Wellness Visit.

Craig Glover stated that FQHCs experience similar challenges. He reported that Burnet clinic leaders said they were happy to report metrics, but they want to report things that are already in their system

rather than having to come up with additional metrics. He shared that in his experience, challenges also arise when multiple different entities ask for the same data, such as data around A1C, but ask for different numbers or metrics. This creates additional work because it requires providers to run reports with different parameters to get the correct data. He stated that this should be standardized if clinics are expected to share quality metrics.

Keith Mueller asked about clinics needing separate submission systems for billing and quality.

Kelsey Beggs responded that the current system is confusing, which makes things more difficult for SMC, as data is not always accepted due to either CMS or clearinghouse issues.

Keith Mueller asked about measures that SMC needs to report for its ACO, but that cannot be included in the data system for AIR. He asked whether the clinic needs separate systems for each of these data sets.

Kelsey Beggs confirmed this.

Matthew Probst stated that more organizational structure is needed.

Isabel Garcia-Vargas stated that the discussion reminded her of her mother and grandmother, who were reluctant to make multiple visits to their rural health clinic because they believed the clinic just wanted their payment.

Peter Kaboli shared that in his experience with small clinics within the VA system, the individual data of small clinics is only meaningful when it is aggregated. For RHCs, which are not part of large integrated clinic networks, collecting data is not worth it.

Michelle Mills stated that in Colorado, by 2025 all clinics that accept Medicaid patients must collect data. Many of these clinics do not have the systems, money, or staffing to do this. She shared that she is afraid for a lot of these clinics.

Matthew Probst responded that in Colorado, Medicaid is paying for the data collection. He suggested that quality measures should include factors such as high school graduation rates.

Clifford Hunter said he liked the idea of using Application Programing Interfaces (APIs). The issue is cybersecurity and the risk of data leaks.

Craig Glover stated that even if you have an API, there is a lot of work that needs to be done to meet that API. Some data items may be proprietary.

Kelsey Beggs responded to Peter’s comment and stated that while her clinic has small numbers, each of the people served is worth collecting data on to improve quality.

Peter Kaboli responded that he agrees with Kelsey, but would hate to see clinics be penalized for having small numbers.

Kelsey Beggs responded that the reason SMC is concerned is because data collection is required but no one is paying for it.

Tom Morris stated that one consideration would be to pull back and focus on potential ways for states and the federal government to not be so hard on RHCs.

Cara James stated that agencies cannot lobby in Congress, but that there is a process to provide feedback. She asked whether there might be an opportunity for a "Flex lite" program, and whether there is a way for the committee to make a recommendation directed to Congress.

Ben Smith shared that IHS has run into funding challenges; since the agency is on a single-year appropriation, it is severely impacted by any lapse in funding. Tribal health programs are required to report on health status. While this requirement is mandatory, it was contingent on providing the programs with the funds to do this reporting. He asked whether this might open the door for some wiggle room for a waiver to prevent harm down the road.

Percy Devine asked who owns proprietary data and noted that he has observed that states have the ability to choose their own vendor.

Cara James responded that some vendors are now trying to put into contracts that they own the data. If this goes unnoticed and is not adjusted in contracts, it could lead to trouble. She thanked the day's presenters and stated that the committee had seen detailed, specific examples of where there is room for improvement and how the committee might help.

PUBLIC COMMENT

There were no requests for comment submitted.

Cara James invited anyone in the room to make a public comment.

Nirmal Kaur expressed her appreciation of the API idea. She suggested that action items and automation for said action items could be built on top of measurement programs.

The meeting adjourned for the day.

Thursday, April 11

TECHNOLOGY AND INNOVATION RECOMMENDATIONS DISCUSSION

Cara James welcomed the committee back for its final day and provided an overview of the morning's agenda.

Keith Mueller summarized his working outline of the committee brief on technology and innovation. He shared an overview of recurring themes throughout the technology discussion, which included:

- Sustaining new models of delivery in rural communities that benefit rural residents, including meeting the needs of residents outside of organizations' campuses
- How to define technology, and the multiple categories within the technology "bucket": 1) technologies that are already familiar to rural providers, i.e. telehealth; 2) information technology; 3) technologies that are newer to the HHS world, i.e. miniaturized equipment that expands the possibilities of care outside of clinic walls
- Existing technologies that might be assistive to rural service delivery
- Meeting the needs of rural organizations through the use of new technology

Overarching points of the discussion included the critical role of broadband, bidirectional awareness between innovators (and investors) and rural end-users, and cybersecurity, and specific needs outlined

included the need to address workforce questions and challenges, investments to initiate and implement new technology, technology to generate efficiencies in service delivery, the alignment of payment policies, and mechanisms with HHS and other agencies supporting local organizations struggling with knowledge and investment gaps.

The outline included the following recommendations:

- On the issue of broadband:
  - Elevate attention to the urgency of the broadband issue by declaring a public health emergency or taking comparable steps.
  - Give attention to both potential access (putting infrastructure in place) and real access (making the service affordable and reliable).
- On bidirectional awareness between innovators and rural end-users:
  - Use the power of convening for a national discussion and dialogue supported by HHS.
  - Encourage state and sub-state regional convening sponsored by others.
- On investments to initiate and implement new technology:
  - Make direct community provider engagement in PARADIGM demonstrations a prerequisite for funding.
  - Continue existing support across federal agencies.
  - Interaction of local providers and private projects
- On technology to generate efficiencies in service delivery:
  - HHS should invest in creating common intake forms and require programs to use them.
  - Reduce administrative burden to meet reporting requirements.

Other considerations included creating a focus for rural innovation within HHS, which would involve CMS/CMMI, HRSA, and others.

Lisa Zingman stated that she would like to see interoperability work to share across data systems for human services programs added to the outline.

Cara James added that data sharing capability, and ensuring that rules governing privacy, such as the Health Insurance Portability and Accountability Act (HIPAA) and Federal Information Security Modernization Act (FISMA), allow for the spreading of data, was also not included in the outline.

Kellie Phillips-Asay suggested that the U.S. Playbook to Address Social Determinants of Health published last fall, which includes data about data and interoperability, could be useful.

Ben Smith advocated for the inclusion of tribes when reaching out to states or other organizations, and reminded the committee that HHS recently updated its tribal consultation policy.

April Anzaldua stated that she agreed with Lisa's recommendation and mentioned incorporating care.

Michelle Mills asked to add support for analytics programs and health exchanges in the context of interoperability to the outline.

Percy Devine asked whether "Human Services" should be added to the title of the outline.

Cara James asked whether the committee should mention support for post-implementation evaluation of how these issues are impacting rural communities, beneficiaries, and providers.

Lisa Zingman asked whether tele-human services should be mentioned.

Matthew Probst stated that the downturn in telehealth usage could correlate with inequity in payment and reimbursement, and asked whether the committee should mention equity in payment for telehealth services. He speculated that the downturn could have been provider-driven, rather than what patients wanted.

Cara James thanked Keith for a job well done capturing a wide-ranging conversation.

Keith Mueller invited committee members to email him with any additional thoughts.

RHC QUALITY IMPROVEMENT RECOMMENDATIONS DISCUSSION

Matthew Probst stated that HHS has a goal of moving as many clinicians as possible into alternative payment models (APMs). RHCs, for both intentional and unintentional reasons, are left out of required Medicare quality reporting. Because of current policy, RHCs are in a less advantageous position to take part in value-based models and APMs, undermining HHS's goal. Most other Medicare provider types are required to report quality, with the exception of CAHs and FQHCs.

Other challenges include:

- The fact that ICD and CPT coding systems disconnect if quality data is included, resulting in duplicative submission systems for billing and quality
- The inability for RHCs and FQHCs be paid for an Annual Wellness Visit as a multiple visit in one day, which results in patients needing to come back. The SDOH is optional, and RHCs do not receive an add-on incentive payment from CMS for conducting the SDOH during AWV.
- A lack of formal federal support to voluntarily report Medicare incentive payments
- Administrative burden on RHCs to report data
- Varying data reporting separate and apart from Medicare that measures the same condition in different ways

He shared two possible recommendations for the committee:

1) Add RHCs to the Flex program. This would provide a way for states to help their RHCs. This is currently included in a proposal bill that would reauthorize the Flex program.
2) HHS should conduct studies that analyze the policy implications of prohibitions against billing for multiple visits in one day, specifically as it relates to Annual Wellness Visits, for RHCs and FQHCs. These studies should account for beneficiary time and co-pay burdens while accounting for program integrity concerns about non-value driven billing concerns.

Tom Morris provided context on the study recommendation. This is a complex issue and there is a need to unpack the issue in a way that addresses valid concerns. Rather than try to fix a number of very technical issues, it is better to study the issue more broadly through the lens of a beneficiary and give CMS a chance to explain its concerns. After further study, the committee can revisit the issue from a more informed perspective.

Matthew Probst shared that in his personal experience both over-coding and under-coding can be an issue and expressed his support for the study recommendation.

Craig Glover mentioned his recollection that clinic leaders asked for site neutrality for payment during the site visit and discussed how some MCOs in the area do not follow the payment structure, leading to the clinic receiving lower rates.

Tom Morris responded that the committee will make a note of that issue and add it to the study.

Michelle Mills asked that funding be included in the recommendation that RHCs are added to the Flex program. She also stated that she did not see anything in the recommendations about supporting the passage of telehealth to occur so that FQHCs and RHCs can continue to utilize it, and that she didn't see anything about standardized QI measures.

Matthew Probst noted that these points could be emphasized more in the outline.

Craig Glover suggested adding under the challenges category that different entities asking for different data requires clinics to run multiple reports.

Lisa Zingman noted that AI was not mentioned in the Technology and Innovation outline and suggested adding it.

DISCUSSION OF FUTURE MEETING TOPICS

The committee discussed potential topics for the next NACRHHS meeting, which will take place September 4-6, 2024.

PUBLIC COMMENT

There was no public comment.

The meeting adjourned.