Welcome to the Healthy Start Virtual Grantees' Meeting

HEALTHY start TA & SUPPORT CENTER

NICHQ National Institute for Children's Health Quality

Meeting Logistics

Please note the following:

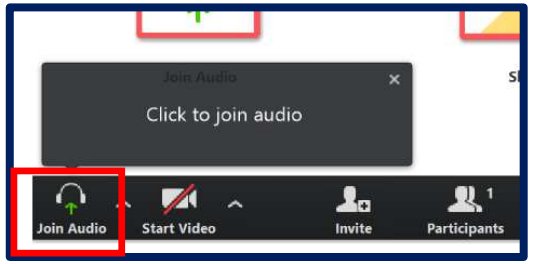
- This session is being recorded, and will be archived for future viewing.

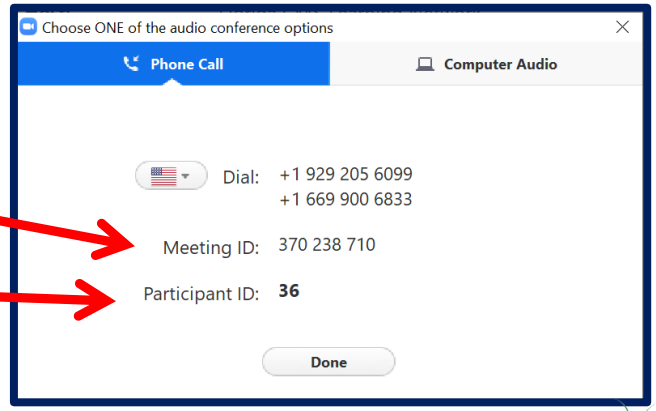
- All participants are muted upon entry and throughout the session.

- Members are encouraged to participate in the discussion by typing your comment/asking questions using the chat box.

Connecting to the Audio Conference

- Join Zoom Meeting by **clicking Zoom Webinar link** & launching the Zoom application
- An audio conference box will appear
  - If you do not see the box click the **'Join Audio' button**
- From the audio conference box: Select to **"Phone Call"** or **"Computer Audio"**
- If using the phone:
  - dial the number next to "Dial"
  - You will be prompted to enter the **"Webinar ID"**
  - Then you will be prompted to enter the **"Participant ID"**





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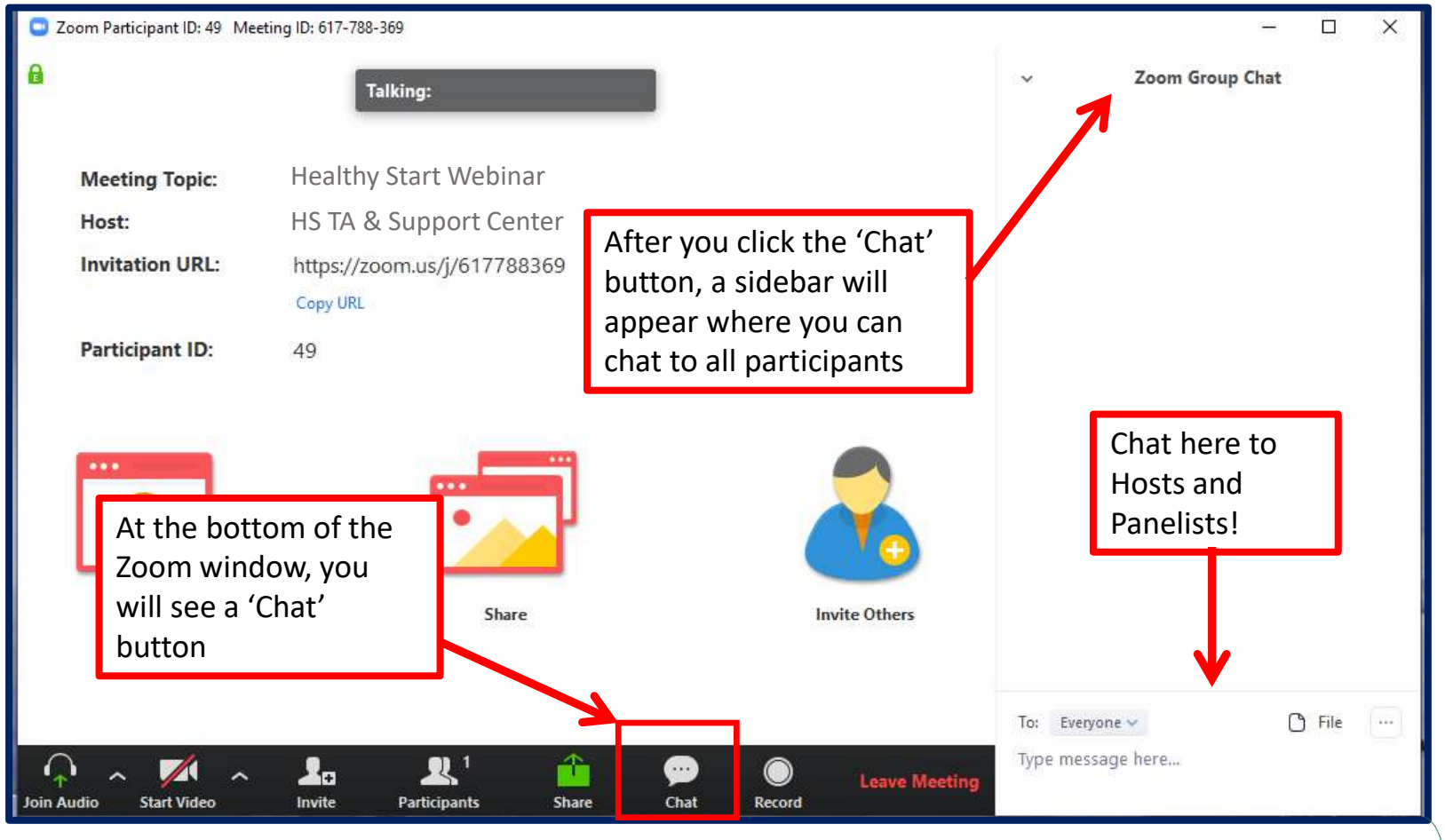
Ways to Participate: Chat



#HealthyStartStrong

- Spread the word about #HealthyStartStrong on social media
- Throughout the meeting, post about what you're learning/enjoying about the meeting
- Include the hashtag #HealthyStartStrong and be sure to tag @NICHQ

Healthy Start
Virtual Grantees' Meeting

Updates from HRSA's Federal Office of Rural Health Policy

William England, MS, PhD, JD
Kathryn T. Umali, MPH

June 25, 2020

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Agenda

Introductions	Vanessa Lee, MCHB, DHSPS
Updates from HRSA's Federal Office of Rural Health Policy	William English, MS, PhD, JD Kathryn T. Umali, MPH
Closing	Vanessa Lee, MCHB, DHSPS

William England, PhD

Kathryn T. Umali, MPH

HEALTHY start

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NICHQ National Institute for Children's Health Quality

HRSA
Health Resources & Services Administration

Office for the Advancement of Telehealth

Healthy Start National Grantee Meeting

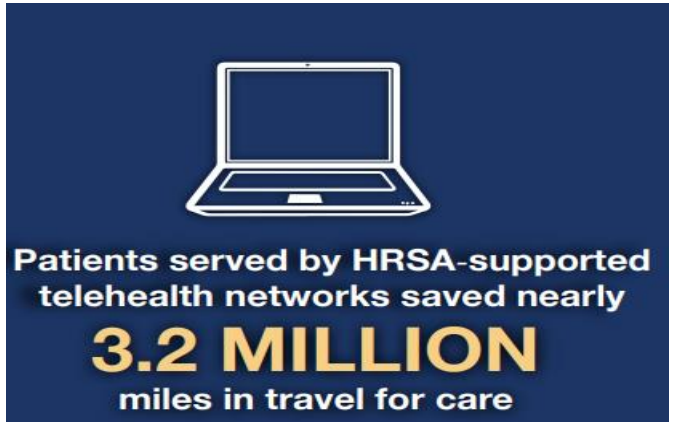
June 25, 2020

William England, PhD, JD
Director, Office for the Advancement of Telehealth
Federal Office of Rural Health Policy (FORHP)

Vision: Healthy Communities, Healthy People

Health Resources and Services Administration (HRSA)

Current Telehealth Activities



- **1,370 HRSA awards** last year included a telehealth component
- **50 states and 8 federal districts/territories have awards**
- Telehealth activities include
  - **Supporting distance learning**
  - **Workforce development**
  - **Telehealth delivery**
  - **Infrastructure development**
  - **Research**

OAT Programs (FY2020) - $29 M

Program	Awardees	Amount
Telehealth Network Grant Program	29	$8.7 M
Evidence-Based Telebehavioral Health Network Program	14	$4.7 M
Telehealth Resource Centers	14	$4.5 M
Licensure Portability Grant Program	2	$.50 M
Telehealth-Focused Rural Health Research Centers	2	$1.9 M
Telehealth Centers of Excellence	2	$6.0 M
Other		$2.7 M

The Coronavirus Aid, Relief, and Economic Security (CARES) Act PL 116-136 3/27/20 reauthorized Office for the Advancement of Telehealth programs.

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HRSA Funded Telehealth Resource Centers

TelehealthResourceCenters.org

TTAC TelehealthTechnology.org

Center for Connected Health Policy

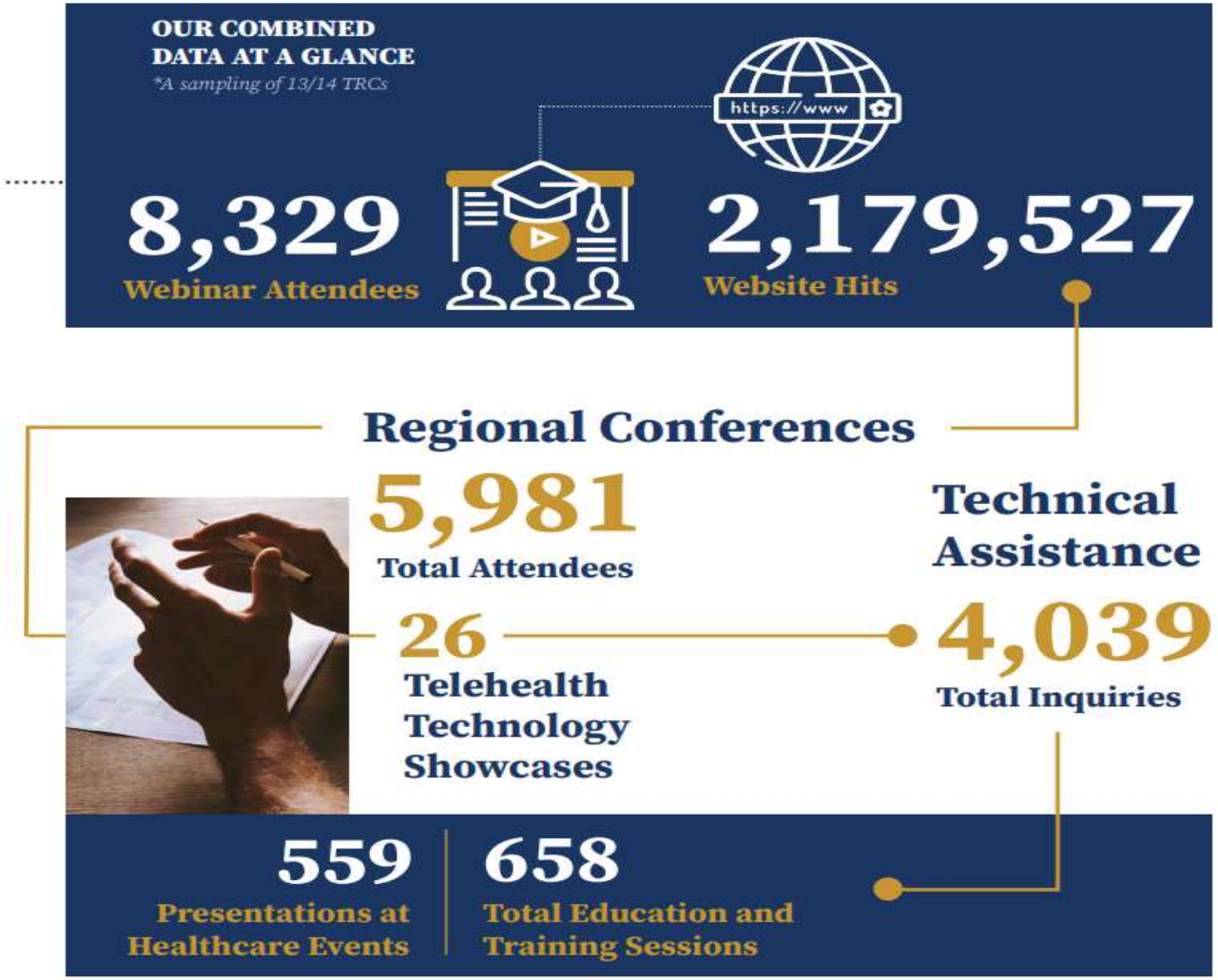
2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

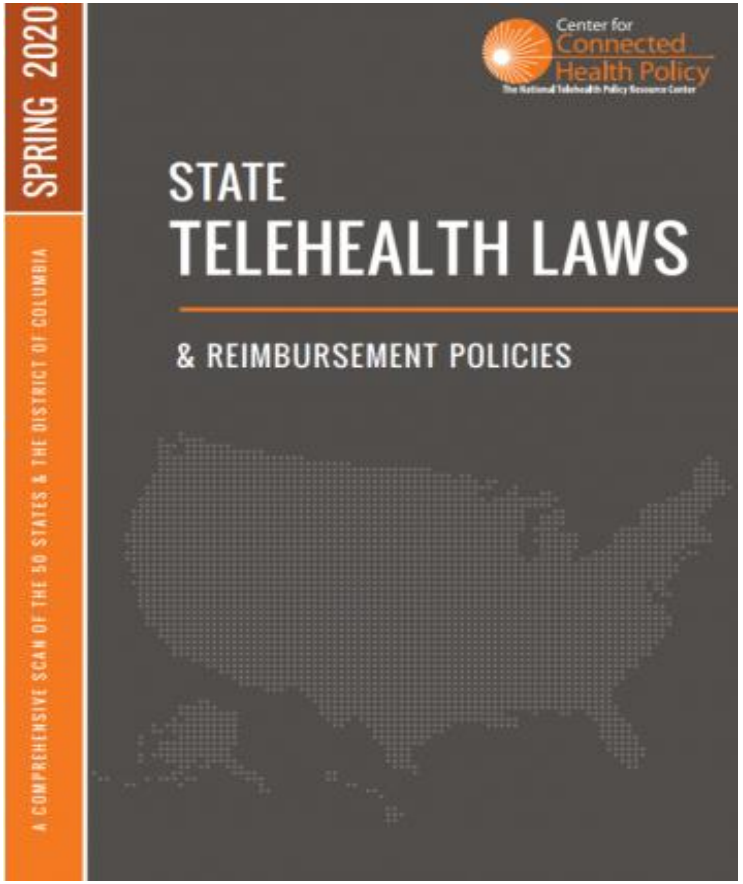
TRC's have a mission to serve as a focal point for advancing the effective use of telehealth and support access to telehealth services in rural and underserved communities.

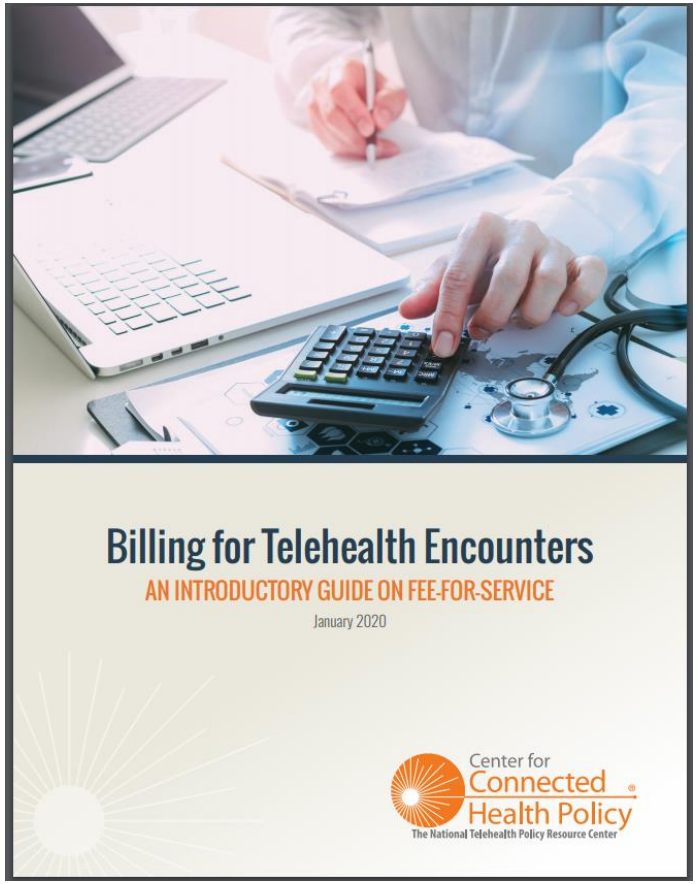
2019 TRC Year in Review

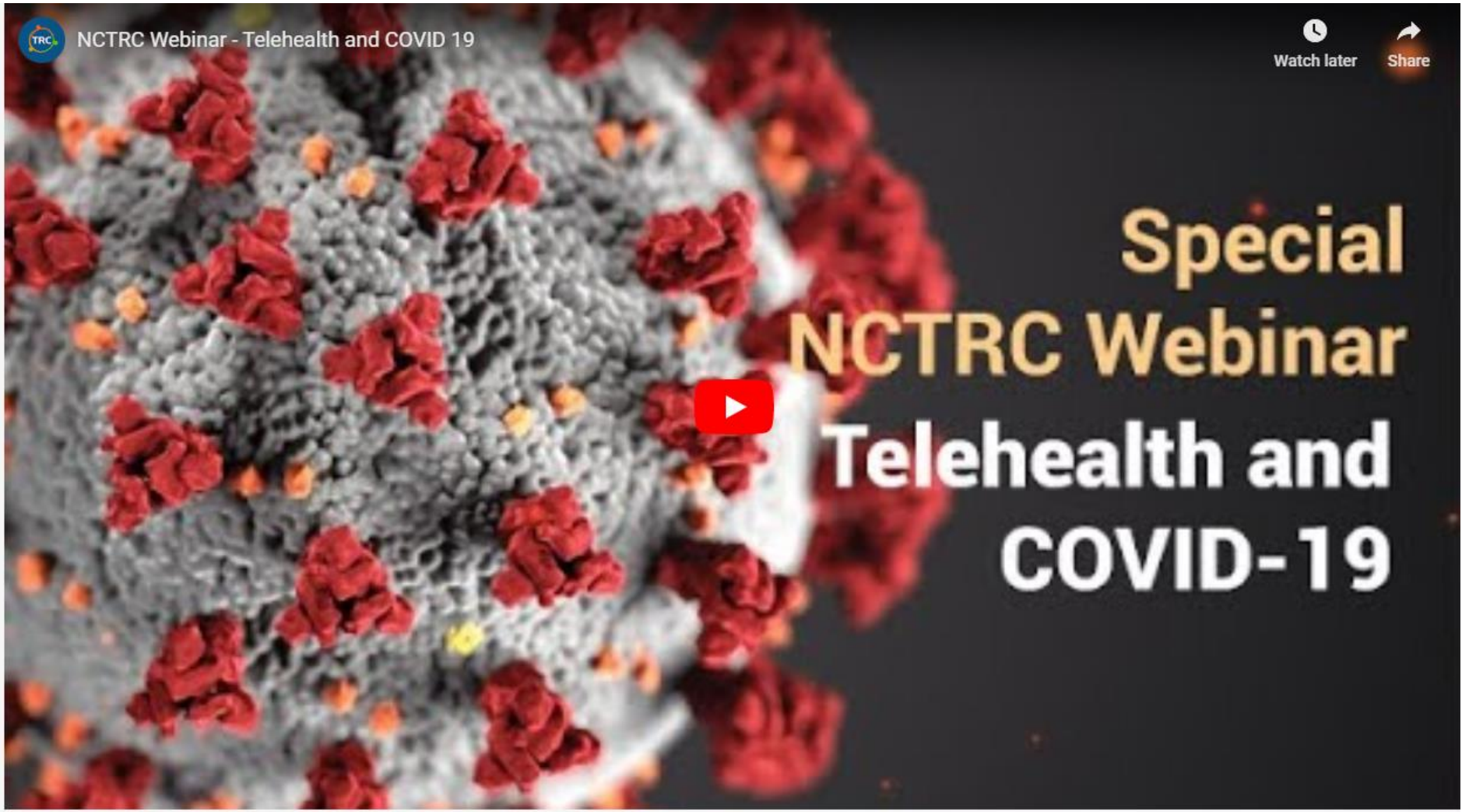


<- Inquiries increased almost 1000% with pandemic

Telehealth Policy Resources







DOWNLOAD THE POWERPOINT

UPDATED POLICY SLIDES - 3/24/2020

Health Resources & Services Administration

TELEHEALTH POLICY CHANGES DUE TO COVID-19

MEDICARE ISSUE	CHANGE
Geographic Limit	Waived
Site limitation	Waived
Distant Provider List	Added FQHC/RHC
Services Eligible	Added additional 80 codes
Visit limits	Waived certain limits
Modality	Unchanged, still Live Video
Supervision requirements	Relaxed some
Licensing	Relaxed payment rules
Tech-Enabled/Comm-Based (not considered telehealth, but uses telehealth technology)	More codes eligible for phone & allowed PTs/OTs/SLPs & other use

MEDICAID ISSUE	CHANGE
Modality	Allowing Plain Old Telephone
Location	Allowing home as site
Consent	Relaxed requirements to allow oral consent over phone
Services	Expanded types of services eligible
Providers	Allowed new provider types such as allied health professionals
Licensing	Waived some requirements in state based Practice Acts

DEA – Allow teleprescribing without in-person visit.
HIPAA –Good faith effort for PHI by televideo (OCR Notice of Enforcement Discretion)

Private payer orders range from telehealth coverage to explicit mandates.

If you're having a **medical emergency**, call 911. If you aren't sure, read when to seek emergency care.

TELEHEALTH.HHS.GOV

For patients For providers

Telehealth: Health care from the safety of our homes.

During the COVID-19 Public Health Emergency, we don't have to choose between medical care and social distancing. When patients can get health care through telehealth — and doctors can provide it — we protect ourselves and our communities.

Learn more about telehealth

For patients

Find out what telehealth is, what you'll need (not much!), and what to expect from a visit. You can also check out our tips on finding telehealth options.

- Understanding telehealth >
- Telehealth during COVID-19 >
- Finding telehealth options >

See more on the patients page >

For providers

Get information to help you integrate telehealth, get up to speed on recent COVID-19 related policies, and learn what patients will need to use telehealth.

- Getting started with telehealth >
- Policy changes during COVID-19 >
- Planning your telehealth workflow >

See more on the providers page >

Contact Information

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Rural Maternity and Obstetrics Management Strategies (RMOMS) Program

Kathryn Umali

Director, Community-Based Division (CBD)

HRSA/FORHP

HRSA
Health Resources & Services Administration

Access to Obstetrics Services

POLICY BRIEF
April 2017

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

State Variability in Access to Hospital-Based Obstetric Services in Rural U.S. Counties

Peiyin Hung, MSPH
Katy Kozhimannil, PhD
Michelle Casey, MS
Carrie Henning-Smith, PhD

Key Findings

Between 2004 and 2014:

- County-level access to hospital obstetric (OB) services varied considerably across states.
- More than two-thirds of rural counties in Florida (78%), Nevada (69%), and South Dakota (66%) had no in-county hospital OB services.
- Rural counties in South Carolina (25%), Washington (22%), and North Dakota (21%) experienced the greatest decline in hospital OB services.
- North Dakota (15%), Florida (17%), and Virginia (21%) had the lowest percentage of rural counties with continual hospital OB services owing to loss of hospital OB units in rural noncore areas of North Dakota and Virginia, and in micropolitan areas of Florida.

rhrc.umn.edu

Purpose

The purpose of this policy brief is to describe state variations in 1) the availability of hospital-based obstetric services, and 2) the scope of obstetric unit and hospital closures resulting in the loss of obstetric services in rural U.S. counties from 2004 to 2014.

Background

The availability of hospital-based obstetric services in rural areas is a policy issue of long-standing concern to rural community members, clinicians, and policymakers. Previous studies have documented the loss of obstetric services in rural areas of individual states, including Alabama, Florida, and Missouri, and raised concerns about the potential impact of greater distances to travel for obstetric services on maternal and infant outcomes.[1–3] This study uses national data to examine the availability of obstetric services in all U.S. states with rural counties. This is the second in a series of two policy briefs examining the closure of hospital obstetric services in rural areas; a companion policy brief takes a national perspective, whereas this brief documents state-level variability in access to hospital-based obstetric services in rural counties from 2004-2014.

Approach

We identified the obstetric service status of each hospital in each year using hospital-reported data on the number of births, provision of obstetric services, level of maternity care, and number of obstetric beds from the 2003-2014 American Hospital Association annual surveys, and data on hospital provision of obstetric services from the Centers for Medicare & Medicaid Services Provider of Services File. We used data from 2003-2014 to identify closures between 2004-2014; the additional year of data (2003-2004) was necessary to identify loss of obstetric services in 2004.

We categorized counties into three groups: 1) no obstetric services since 2004, 2) continual obstetric services since 2004, and 3) full closure of obstetric services from 2004-2014. Counties that had multiple hospitals providing obstetric services but only experienced closure of obstetric services in some of the hospitals were categorized as having continual obstetric services – accounting for 59 counties over the study period. A hospital's county was categorized into micropolitan (counties with a population of 10,000 – 49,999) and rural noncore areas (counties with less than 10,000 residents or other rural

Between 2004 and 2014:

- The percent of rural counties with hospital-based obstetrics services declined from 55% to 46%.
- 179 rural counties (9% of all rural counties) lost access to in-county hospital obstetric services.
- Women living in rural noncore counties (areas with less than 10,000 residents) were disproportionately affected by the loss of hospital obstetric services.
- Only 30% of rural noncore counties had continuous hospital obstetric services compared to 78% of micropolitan counties.

HRSA
Health Resources & Services Administration

Rural Maternity and Obstetrics Management Strategies (RMOMS) Program

Purpose & Focus Areas

- Improve the ***access to and continuity of maternal and obstetrics care in rural communities*** through testing models that focus on:

  1) Rural Hospital Obstetric Service Aggregation

  2) Network Approach to Coordinating a Continuum of Care

  3) Leveraging Telehealth and Specialty Care

  4) Financial Sustainability

Investment

- Program Start Date: September 1, 2019
- 4-Year Award
  1 Planning Year (up to $600k)
  3 Implementation Years (up to $800k)

Awards

- **TX-RMOMS Comprehensive Maternal Care Network**
  Bexar County Hospital District (Texas)
- **Bootheel Perinatal Network Project**
  Saint Francis Medical Center (Missouri)
- **Rural OB Access and Maternal Services (ROAMS) Network**
  Taos Health Systems, Inc. (New Mexico)

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Questions?

Kathryn Umali

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Up Next

Day 2 Wrap-up