

HIT Policy Committee Hearing Testimony
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Small and Rural Hospitals and Practices Panel

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Opening Remarks

I want to thank the committee for your commitment to, and hard work on, this important issue, and for this opportunity to represent the views of small and rural hospitals that serve so many Medicare and Medicaid beneficiaries across the country. Currently, there are approximately 2,400 hospitals with fewer than 100 beds, most of which are in rural areas. The services offered by these hospitals are almost all primary care so this is the focus of my responses.

I am here to share my hospital's experience in implementing Health Information Technology (HIT) with the goal of developing an Electronic Health Record (EHR). Nemaha County Hospital is a 20-bed Critical Access Hospital (CAH) in Auburn, Nebraska. Auburn is a community of 3,500, and the hospital's primary service area is Nemaha County, which has a population of 7,500. We have five family practice physicians on our active medical staff, with specialty clinics provided by visiting physicians who travel to our community on a regular basis to meet the needs of our patients.

We began our EHR journey in September of 2003. We chose an integrated system, with software from a single vendor installed to meet all of our HIT requirements, with all data residing in a single database. We found this type of HIT system much easier to install and maintain than one made up of products from different vendors. It took considerable effort and resources, but we have achieved the goal. Today, we continue to improve our EHR by adding functionality through exploring participation in a Health Information Exchange (HIE) that would connect us to the Nationwide Health Information Network and refining our current system to continually improve the quality and safety of the care we provide to our patients. For three of the last four years, we have been on the "Most Wired" list of the American Hospital Association's Health Forum.

We were able to finance the implementation of our EHR because we were fortunate enough to accumulate some financial reserves over several years. We continue to finance part of the ongoing expenses associated with our EHR through the CAH program, and absorb the rest as operational expenses.

Responses to Questions

- 1. How will the proposed 2011 and 2013 meaningful-use objectives and measures help smaller practices or hospitals demonstrate that they are improving care?*

Small and rural hospitals are committed to continuously improving the quality of the care delivered to their patients, and we understand the role of the EHR in facilitating these quality gains. Despite the progress made at Nemaha County Hospital, some of the proposed requirements for meaningful use are beyond the capabilities of our current system.

We have focused our EHR installation on those functions that are most likely to improve care, including generating an accurate patient record, providing access to all of a patient's information in a single view, and supporting Computerized Physician Order Entry (CPOE) and clinical decisions. Such things as the electronic reporting of quality measures, patient access to their medical records and electronic submission of reportable lab results are beyond the scope of our HIT system. Adding these aspects of the 2011 objectives would take resources away from our care improvement goals, and be challenging to meet. These functions and the necessary supporting structures are not yet well-defined, and I doubt that our vendor would be able to incorporate them by 2011.

I am also concerned about the ability of other small and rural hospitals to meet the meaningful use criteria recommended by the HIT Policy Committee. It has taken us six years to achieve our current level of use. Many organizational factors, other than having the resources to purchase EHR technology, have contributed to our success.

Data show that small and rural hospitals have not been able to move as quickly as their larger, urban counterparts in implementing EHR systems. Taken together, the proposed 2011 and 2013 meaningful-use objectives describe a comprehensive EHR system that would be challenging for any hospital, especially a small or rural hospital, to meet.

In general, the objectives are aligned with specific types of functionality within an EHR system – whether a system can perform clinical decision support functions, provide clinical documentation, or exchange clinical data, for example. Many of the proposed measures, however, reflect quality and efficiency measures that may not be affected by implementation and use of an EHR system. For example, there is no body of evidence connecting the use of an EHR to improve clinical quality, with the 30-day readmission rate of an individual hospital.

The journey toward EHR system adoption is incremental and, although the path varies across institutions, certain system functions must be in place before other

functions can be successful. Nursing documentation and pharmacy functions, for example, must be in place before CPOE can be utilized. In recognition of this, meaningful-use objectives and measures should be defined in this same order, and by use of the system functions necessary to improve patient care. The system should be able to:

- put critical, accurate and current patient information at the fingertips of busy clinicians at the point of care and, over time, ensure that scientifically based clinical decision support is readily available to clinicians and patients to guide their diagnostic and treatment decisions.
- provide alerts or other signals that can help identify and prevent errors.

Eventually, EHRs should be able to routinely share summary data with patients, public health entities and other providers of care. However, hospitals will need a clearer picture of what type of information sharing will be considered meaningful, now and in the future, as more providers expand their capacity to share this data.

2. What are the special considerations when applying meaningful use measures to the small provider organizations that you represent?

Smaller providers have fewer resources to acquire, implement and maintain EHR systems. In addition, they have fewer technical resources to manage the implementation process and, like all hospitals in these difficult economic times, small and rural hospitals have very limited access to capital.

Establishing realistic meaningful use criteria will allow small and rural hospitals to begin to do what I believe was the intent of Congress in passing the ARRA legislation: improve patient care. Setting the bar too high risks leaving many of these hospitals – and their patients and communities – behind.

Reporting requirements must be realistic. Scarce time, money and professional resources should focus on transforming the information flows and processes within the hospital. Requiring significant additional resources to demonstrate or prove meaningful use may divert these resources away from a hospital's primary mission of providing quality care.

The HIT vendors that market to and meet the needs of smaller hospitals are different from those that market to and meet the needs of large hospitals. Vendors design their products to meet CCHIT certification requirements, and making those requirements different from meaningful-use requirements would cause substantial delays in the products that are needed to achieve meaningful use.

3. *What other measures would you propose be considered to assess the meaningful use of EHRs by your type of providers and how would they align with the care goals and objectives the Policy Committee has recommended?*

Meaningful use measures should demonstrate, at least initially, the value of process change, and be:

- cost-effective to implement
- grounded in scientific evidence
- standardized
- tested and validated
- reliable
- easy to calculate
- appropriate for the evaluation of a single hospital, which, in the case of small and rural facilities, may have low patient volumes that can skew statistical outcomes

Given the limitations of the scientific evidence and the numerous factors that affect clinical outcomes (other than EHR use), process measures are currently most appropriate. Such a measure could be the percentage of patients for whom there is an EHR, since, in this case both the numerator and denominator exist (the number of unique patient records in the system, over the number of discharges or claims filed). Annual growth in this percentage would indicate an increasing reliance on, and use of, EHRs.

4. *What are the EHR adoption barriers for small provider organizations and what solutions would you recommend? What role should small provider organizations play in improving that adoption?*

The major barrier is cost, both initial and ongoing. The ARRA's incentives are paid *after* a hospital has become a meaningful user. However, the financial environment and a lack of available credit are impeding the achievement of meaningful use before penalties are applied. As a result, critical access and other small hospitals must find significant funding resources or face the Medicare penalties, regardless of whether they are already providing high-quality care. Capital must be made available to smaller organizations if their ability to provide care for their rural and underserved areas is not to be compromised by penalties. Since operating margins are already extremely small, further decreases in reimbursement could result in service reductions, or even hospital closings. I do not believe that this was the intent of Congress.

Another barrier is the availability of the technical resources needed to implement HIT. Smaller communities do not enjoy the large pool of technical expertise found in more urban areas. Talent is difficult to attract and retain, especially once a higher level of proficiency has been reached. It is therefore imperative

that scarce resources focus on implementing technology that supports the hospital mission of providing care. Meaningful-use measures that require system modification, additional analysis or other activities that extend beyond this basic mission would strain the hospital's ability to take care of people.

Also, the level of adoption recommended for meaningful use could itself be considered a barrier. The recommended 2011 requirements would mandate implementation of a *fully functioning* EHR. This is unattainable for most small hospitals by 2011, and, for many, it is unattainable for the foreseeable future. This is because all functions are required to be implemented at the same time. As mentioned above, HIT is typically rolled out in phases. An approach that recognizes hospitals for taking steps toward a fully functioning EHR would be a much more meaningful incentive.

Finally, it is important to recognize that HIT cannot be a one-size-fits-all proposition. The differences in meaningful-use requirements for hospitals and physician practices must be clearly defined, as each provides care in different ways, and each needs HIT systems that do different things

Thank you again for giving me the opportunity to share the views of smaller hospitals regarding the goals, objectives and measures for meaningful use. I understand the complexity surrounding this issue. I believe that, by defining realistic objectives and measures for meaningful use, EHRs can markedly improve the quality and safety of health care in this country, and they should be made available to as many health care providers as possible, along with the support needed to use it.

All health care providers want to improve patient care ... we strive every day to do just that. EHRs can be a critical tool as we build a better health care system, and we look forward to working with you to ensure that meaningful-use definitions move us toward that shared goal.