

Rural Wisconsin Health Cooperative Recommendations for HIT Stimulus Package

RE: Our smallest rural hospitals are struggling to implement HIT systems, including EMRs (Electronic Medical Records), which have shown the potential to enhance care quality. These hospitals provide a critical service for rural and underserved communities and should not be left behind in the ongoing HIT revolution.

Policy Recommendations for Promoting HIT in Small Rural Hospitals:

1. Continue and expand existing programs that increase the use of quality focused HIT in small hospitals and hospital networks.
 - a. HRSA's Critical Access Hospital Health Information Technology Network (CAHHITN) Program supports the development of critical access hospital (CAH) networks that collaboratively implement EMRs. This program should be continued and expanded to allow existing networks to add new hospitals and provide additional services. HIT networks (INHS, SISU) have demonstrated the capacity to effectively implement and support EMRs in our smallest rural hospitals.
 - b. FCC's Rural Healthcare Pilot Program provides telecommunications and wide area network (WAN) equipment and expertise to networks of hospitals and other healthcare providers, so they can exchange data, engage in telemedicine, and share HIT related systems and infrastructure. This program should be continued/expanded so that participants who have implemented their projects can add facilities and expand their networks.
 - c. USDA's Distance Learning and Telemedicine (DLT) Grant and Loan Programs provide funding for telemedicine applications and until recently for hospital EMR implementation. The DLT EMR program was just discontinued, but it is a great way to fund individual hospital efforts in this area and should be reinstated. The drawback for participants is that the DLT Program employs very restrictive lending practices (participants need to have the same amount of money in the bank in order to get the loan), so that currently only hospitals that don't need the loan qualify for it. This should be remedied.
2. Implement small hospital HIT incentives through CMS, so CAHs using HIT are reimbursed at a higher rate. The proposed Stark Health IT Bill included incentive language exclusively for PPS hospitals. But as is demonstrated in the Wisconsin Office of Rural Health and RWHC Report, "The Density of HIT Adoption in Wisconsin Rural Hospitals," (<http://www.rwhc.com/Papers/Density.pdf>), it is our smallest CAHs that are in greatest need of this type of incentive and should not be excluded. CAHs are reimbursed at cost plus 1% and incentives should be over and above that amount.

3. Question the assumption that Open Source EMRs are the right answer for our smallest hospitals. There are good reasons to believe that OpenVista is not the optimal EMR product for small rural facilities (<http://www.worh.org/ruraltech/>). Fund Open Source pilot programs and case studies to ascertain its effectiveness in the small hospital setting.
4. Develop new programs that explore the benefits of HIT in small hospital settings and identify rurally relevant HIT implementation strategies. Most HIT research occurs in large teaching hospital settings, so there is very little data that informs policy makers and helps small hospitals make good HIT decisions.
5. Continue to fund standards development work and leverage CCHIT to lead the HIT vendor community (both small and large hospital-focused) to build toward established and emerging standards.

By pursuing the above recommendations, Congress will be supporting President-Elect Obama's goal of both stimulating the economy (through job-creation, and investment in US technology and telecommunications companies) and building an HIT infrastructure that will prepare us for the future of healthcare without excluding our smallest hospitals.