Rural Wisconsin Health Cooperative

06/17/09

Rural Wisconsin Health Cooperative (RWHC) comments regarding the preliminary definition of "Meaningful Use" as presented to the HIT Policy Committee on June 16, 2009.

[RWHC is a cooperative of 35 rural hospitals (including 28 Critical Access Hospitals) that promotes regional collaboration for health and health care services on behalf of rural communities.]

As an organization with significant experience in rural electronic health record (EHR) implementation, we believe that the meaningful use definition, as drafted, will make it impossible for the average small rural hospital, including critical access hospitals (CAHs), to meet the meaningful use standard.

The result will be that the vast majority of an entire sector of providers will be excluded from receiving ARRA HIT incentive funds and, consequently, will lack the tools required to engage the challenges of healthcare reform.

In the HIT Policy Committee Meaningful Use Workgroup Presentation, the three part phasing (2011, 2013, 2015) of meaningful EHR use is characterized as a balance between on the one hand: (1) currently available EHR capabilities, (2) the time needed to implement, and (3) the implementation challenges associated with small practices (and presumably small hospitals?); and on the other hand: (1) the urgent need for health reform, and (2) the desire to substantively improve health outcomes.

According to the HIT Policy Committee presentation, the proposed Meaningful Use Matrix achieves this balance by providing escalating capabilities that will meet the need of reform and yet be feasible and achievable for providers to attain.

We disagree with this assessment. Please consider the following factors:

- The 2011 meaningful use draft requirements roughly correspond to reaching stage 4 of the 7 stage HIMSS EMR Adoption model.

- CAHs and rural hospitals average 1.2 on HIMSS EMR Adoption Scale, whereas general medical surgical hospitals average 2.5

- A "reasonable" time required for any hospital to implement from stage 1 to stage 4 (considering what is required for appropriate vendor selection, workflow assessment, education, and implementation) is 3-5 years.

- Many CAHs and rural hospitals will be required to essentially start from scratch after determining that their existing vendors will not position them to become meaningful users; and this will add to the "reasonable" time required.

Contact: Louis Wenzlow, RWHC Director of Health Information Technology, lwenzlow@rwhc.com

- Many CAHs and rural hospitals will need to address critical network infrastructure and HIT staff expertise challenges that will also add to the "reasonable" time required.

If the above factors are granted, then average CAHs and rural hospitals that begin their implementation process now will not be able to achieve the 2011 requirements until 2013 or later and as a result will receive no reimbursement.[1] They will next be faced with the daunting challenge of reaching roughly stage 5.5 on the HIMSS adoption scale in literally no time and with little to no incentive dollars to assist the process.

One question is at the core of our concerns: If the Meaningful Use Matrix is aggressive yet achievable for hospitals that average 2.5 on the HIMSS adoption scale, how can it also be achievable for a hospital that averages 1.2 or 0? Given that achievability is one of the tenants of the HIT Policy Committee, we believe that the Committee needs to adjust the definition for hospitals currently lower on the scale.

We believe it would be reasonable to move CAHs and small rural hospitals to above stage 2 in 2011; then above stage 3 in 2013; and then to roughly stage 4 in 2015. While it is outside the scope of the word allotment to go into the requirements point by point, we would like to call attention to our own meaningful use recommendations, which identify an attainable (yet still aggressive) rural-focused phase-in of meaningful use: http://www.rwhc.com/Meaningful.pdf.

Relating to the Meaningful Use Matrix requirements for 2011, two areas of particular concern are the requirement for CPOE and patient portals, both of which are advanced applications that are traditionally (and for good reason) implemented as capstone applications after dozens of other applications (such as the ancillary systems that feed the data repository, physician EMR portals, and e-MARs) are implemented. To rush these in as part of the 2011 phase, even if achievable, which we dispute, would likely lead to a high risk of implementation failure, as well as an increase in the errors the legislation is designed to prevent.

The ARRA HIT incentives, if properly structured, have the potential to profoundly increase all provider HIT adoption and care quality. But by setting the bar at a place within reach of the average large facility yet out of reach of the average small facility, HHS will effectively exclude the providers that serve predominantly rural areas. This will have a severely negative impact on rural providers, as well as on the rural communities and the 62 million rural residents that rely on them for healthcare. Please reconsider this course of action.

---

[1] Anthony Trenkle, director of the CMS' office of e-Health Standards and Services, said the requirements will not be "tiered" based on when the provider adopts an EHR after 2011. Instead, whatever meaningful use standards are applicable for the year the provider applies for an EHR subsidy are the standards that provider must meet, regardless of whether it is the provider's first year of EHR implementation.