



Health Information Technology: Using IT To Improve Care

Finance Committee

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Testimony of Marty Fattig, CEO, Nemaha County Hospital, Auburn, Nebraska

My name is Marty Fattig, and I am the Chief Executive Officer of Nemaha County Hospital, a 20 bed critical access hospital in Auburn, Nebraska. Auburn is located in southeastern Nebraska approximately 65 miles south of Omaha and 65 miles southeast of Lincoln. Nemaha County has a population of 7,500 people and is considered to be our primary service area.

In addition to my work as a critical access hospital CEO, I also serve as an appointed member of the Meaningful Use Work Group of the Health Information Technology Policy Committee (HITPC). The HITPC was created by the American Recovery and Reinvestment Act to advise the National Coordinator for Health Information Technology, currently Dr. Farzad Mostashari, with respect to the implementation of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information. I am proud to represent small and rural hospitals on this work group.

I want to thank Chairman Baucus and other members of the Committee for holding this hearing and inviting me to testify. This is a critical time in health care, not only with respect to the adoption of electronic health records (EHRs), but also as we pursue the improvement of care coordination, patient engagement, and quality improvement, while at the same time finding new ways to control health care costs. I will focus my remarks on the unique challenges faced by rural hospitals and providers as they transition to using health information technology (HIT), with a focus on the meaningful use program. After speaking to my own experience, I will outline the unique factors I see affecting rural hospitals. **I would like to say at the outset that I believe policymakers will need to make changes to the meaningful use program to ensure small and rural hospitals are not left behind as we make the transition to Stage 2 of meaningful use.**

The Nemaha County Hospital's Experience with EHRs and Meaningful Use

I came to the meaningful use program with a better background for adoption of EHRs than most rural hospital CEOs. My background is in laboratory medicine and one of the positions that I held was laboratory information systems manager. It was while working with this system that I saw the value of having clinical data in an electronic format. When I came to Nemaha County Hospital in 2002, the financial computer system that we had needed to be replaced. I took this as an opportunity to install an integrated

system with applications for every department in the hospital, including an electronic health record. We went live with everything but the EHR in September of 2003 and with the EHR in January of 2004. We immediately realized improvements in the quality and safety of the care we were able to provide to our patients because the system could check for such things as adverse reactions between prescribed medication and through the use of the medication verification system. We have continued to add modules to improve our system since that time and today we have a paperless medical record.

We have been recognized as one of the “Most Wired” hospitals in America seven of the last eight years. We were first recognized in the “Most Improved” category, then as “Most Wired Small and Rural, and for the last four years we have been recognized in the group of hospitals of all sizes. We are also one of fifteen “site visit” hospitals for our HIT vendor, which means that they bring potential customers to our hospital to show them how their software works in the live environment.

Even with an above average vendor relationship and being recognized nationally as an early adopter, implementing the Stage 1 meaningful use requirements was more difficult than we anticipated. And, given the way that the Centers for Medicare and Medicaid Services calculates payments for critical access hospitals as only for a limited set of capital expenditures, our incentive payments have been very small, and did not cover the bulk of our expenses.

Looking forward to Stage 2, our hospital expects to be prepared to attest in mid to late 2014. I recently checked the ONC website and fortunately, our vendor is one of only six listed that is certified for the “2014 Edition” to support Stage 2. We will be required to purchase some new software and incorporate it into our workflow. We are concerned about the functionality and security of the patient portal as well as the interface with our state department of public health to report the required public health measures.

The Digital Divide in EHR Adoption

As I look beyond my own experience to that of my rural colleagues, I see strong commitment to providing the highest quality care to their communities, including the use of EHRs. Progress is being made in adoption of EHRs in rural areas, but the digital divide between urban and rural hospitals persists.

All of the critical access hospitals in Nebraska have had a computer system in place for some time to complete their financial requirements, but very few had an EHR before 2009. Some are now discovering that the EHR provided by their current vendor will not meet their needs so they must change vendors. This delays their journey toward meaningful use while also consuming considerable resources. Another group of thirty-three hospitals in our state all use the same vendor and they are extremely concerned that that vendor will not be certified for Stage 2 by the time the hospitals need to be utilizing the system.

According to data from a recent article in *Health Affairs*, co-authored by academics, Dr. Mostashari and others from ONC, and a team from the American Hospital Association (AHA), “large urban hospitals continue to outpace rural and nonteaching hospitals in adopting EHR systems,” with 44 percent of all hospitals -- but only one-third of rural hospitals -- having “at least a basic” EHR.

The same study found that while 42 percent of all hospitals could meet a proxy for Stage 1 meaningful use, only 5 percent could meet a proxy for Stage 2, with larger and urban hospitals ahead of their smaller and rural counterparts. The study concludes that policymakers should “*focus on hospitals that are still trailing behind, especially small and rural institutions. This will be especially important as stage 2 meaningful-use criteria become the rule, and positive incentives are replaced by penalties.... As the penalty phase draws nearer, efforts to assist these hospitals will become even more important because the decrease in their revenue could further exacerbate barriers to their adoption of EHR systems.*”

(DesRoches, et. al., *Health Affairs* 32:8; available at <http://content.healthaffairs.org/content/early/2013/06/27/hlthaff.2013.0323>)

The Challenge for Rural Hospitals

Feedback from my rural hospital colleagues confirms the academic studies. They are committed to adopting EHRs and using them to improve care. They are making considerable progress, but still have some distance to travel. Most rural hospitals have yet to meet the exceedingly complex requirements for Stage 1 of meaningful use. And they worry that time is running out, as the positive incentives quickly turn to penalties.

On the Medicare incentive side, CAHs must have met meaningful use in FY 2012 to receive the full four years of payment. This is one year sooner than PPS hospitals. We know from the earlier data that the majority of CAHs did not meet this deadline and will not benefit fully from the program. Hospitals paid under the inpatient prospective payment system must meet the meaningful use requirements by July 1, 2014 to avoid significant financial penalties. For critical access hospitals, the last possible date to avoid penalties is September 30, 2015.

Some hospitals may meet the eligibility requirements for an incentive payment under the Medicaid program, as well. Under the Medicaid program, hospitals do not have to meet the meaningful use criteria in their first year of participation; but they do need to make a demonstrated financial commitment to adopt, implement, or upgrade an EHR. Thus, the Medicaid program provides at least some much needed up-front capital to those who are eligible. In general, however, rural areas have fewer patients covered by Medicaid, and may therefore be less likely to meet the eligibility requirement. Our hospital did meet the Medicaid eligibility requirements but only will receive a relatively small payment compared to costs due to our low Medicaid volume.

Two defining attributes of rural hospitals make implementation of electronic health records (EHRs) more challenging for them than for other types of hospitals: smaller size and volume, and geographic isolation. These factors lead to challenges such as:

- **Financial constraints.** Lower patient volume at small and rural hospitals complicates long-range financial forecasting and contingency planning, limits the ability to maintain adequate cash flow, and constrains capacity to commit to large, long-term capital projects like adoption of EHRs. Implementing EHRs also increases operating costs for maintenance, IT personnel, training, etc.
- **Workforce issues.** Rural hospitals have a difficult time attracting and retaining highly skilled personnel, including both clinical informaticists and technical IT staff. Many of them are actually losing their health IT-skilled personnel to vendors, who can afford to pay double, or even triple, the salary that small and rural hospitals can. In addition, in a small hospital, the skill set for hospital IT staff is often bigger – they must do all tasks, not specialize in hardware, software, networking, or security.
- **Vendor readiness.** Given their size and geographic location, there are a limited number of vendors that work with small and rural hospitals. Rural hospitals often find it more difficult to get timely attention from vendors. For instance, our vendor has over 600 hospitals that all need to have software upgrades in order to meet the Stage 2 objectives. This is an extremely difficult task even if there are no problems. If bugs are discovered the task becomes impossible. We purchased a piece of software from our vendor in May that we will need for Stage 2 and were told that it would be nine months before they could complete the install because they are so busy. Because the overall cost of IT projects is lower than at larger hospitals, small or rural hospitals can be less appealing to some health IT vendors, who are focusing first on larger and more established hospital projects. In addition, hospitals already working with a vendor have limited negotiating power given the federal mandate to buy a certified EHR.

I believe that changes to federal policies and continued technical assistance are needed to support adoption of EHRs in all communities across the country and ensure that we narrow the digital divide between rural and urban areas. The complexity of meaningful use and the aggressive timelines for the program pose a real challenge for small and rural providers that limit their ability to benefit from the program. During the development of the Stage 2 rules, I raised concerns over the unique challenges facing rural hospitals with the meaningful use work group of the HITPC. I am, however, the only voice for rural health care providers on that group. While my fellow committee members are clearly motivated to create positive change, I am concerned that the unique circumstances of rural providers are not being adequately considered in the policy making process as well in the regulations.

The Office of the National Coordinator for Health Information Technology (ONC) has given important technical assistance to rural providers through the Regional Extension Centers and other programs. However, the support for rural hospitals, as opposed to primary care physicians, was quite limited, at \$18,000 per facility. While very helpful,

this kind of technical assistance cannot address all of the challenges rural hospitals face, such as financing, workforce, and vendor readiness issues.

The 2014 Time Crunch

The continued aggressive timelines for meaningful use could, unfortunately, increase the digital divide. The rules are very complex. However, they boil down to a regulatory requirement that all health care providers -- hospitals and physicians -- install or upgrade to the "2014 Edition" certified EHR, regardless of where they are in meeting meaningful use. This means that vendors will need to support over 500,000 physicians and hospitals in a single year. For hospitals and physicians, many will be upgrading systems that they just installed this year. As I talk with my small and rural hospital colleagues, they have significant concerns about whether the vendor community has the ability to support all of those upgrades in such a short period of time, and are mindful that they are often at the end of the vendor queue due to their smaller revenue streams and remote locations.

This 2014 time crunch also raises concerns about patient safety. We implement EHRs to improve the quality and safety of health care. Patient safety is the first item on the agenda of every board meeting at our hospital so you can see we are very concerned about this issue. In fact, one of the main reasons we installed our EHR when we did was to improve patient safety. And it has done just that. Our closed loop medication administration system has all but eliminated medication errors in our hospital. However, these systems, especially when they are upgraded under severe time constraints, can, and unfortunately do, introduce risk when things go wrong. We installed a software upgrade some time ago and all of the allergies listed in the patient record disappeared. We were able to catch this problem before patients were harmed, and restored the allergies to the record, but this is the kind of thing that can happen.

Finally, hospitals must incorporate the adoption of EHRs in with all of the other regulatory requirements and strategic decisions they face. Adoption of EHRs is not the only mandate from HHS. The most challenging competing priority is the transition to ICD-10 by October 1, 2014. However, hospitals must also manage the other changes to payment and delivery systems created by the Affordable Care Act, such as value-based purchasing, medical homes, and accountable care organizations.

I believe that the Administration could, and should, take steps to provide more flexibility in the transition to Stage 2 and address the challenges faced by small and rural hospitals. If done correctly, the changes could alleviate the time crunch, but still keep the program moving forward.

- One important step would be to allow providers that are at Stage 1 to continue to use their existing certified EHR – the 2011 Edition – if they want to, rather than taking a mandatory upgrade to the 2014 Edition. Those just entering program at Stage 1 should also be able to choose either the 2011 or 2014 Edition.

- HHS could also allow more flexibility in the Stage 2 requirements, which set a very high bar and adopt an “all or nothing” approach, where failure to meet one part of an objective, or missing a threshold by only a small amount means a provider does not meet meaningful use, and will, starting with 2014, be subject to future payment penalties.
- Finally, HHS could extend the length of each stage of meaningful use to be 3 years for all providers. The current two-year cycle is simply too short for vendors to develop safe, useable products that providers can then deploy in safe, efficient ways that really help them better coordinate care, engage patients, and control health care costs. The cultural changes that are needed to fully realize the promise of EHRs requires more time than the current year-over-year changes in meaningful use allow.

The Interoperability Challenge

The establishment of an efficient and reliable mechanism for health information exchange is, to my thinking, the key to future progress. It is also critical to success at Stage 2, since many of the objectives, such as those for public health and transitions of care, assume a level of interoperability and information exchange infrastructure that is still maturing in some areas, and not yet available in others. Holding providers accountable to share information when the infrastructure to exchange is immature essentially puts the cart before the horse.

However, once we have mechanisms in place to share data electronically as easily as we can make a phone call, other incentives will lead providers to share data to support clinical care. For example, the Medicare payment penalties for high readmission rates provide an incentive for hospitals to share data and better coordinate care with physicians and nursing homes after a patient leaves the hospital.

In Nebraska we have one health information exchange (HIE) and it is working quite well. Various hospitals and physicians are signing up to use it. It is my belief that they are somewhat ahead of most state HIEs, but I still have some concerns. I don't think they will be at a point where they can connect with the state to report the public health measures at the time hospitals are required to do so, meaning that we will have to pay our vendor to develop an interface with the state to meet the meaningful use Stage 2 requirements. Additionally, I am worried about the financial sustainability of the HIE. When the grant money is exhausted I am not sure they can remain financially viable through subscription fees alone.

To make all of this work, we need an infrastructure for health information exchange based on national standards that require all HIEs to communicate with each other and that include such things as provider directories and support for providers to learn how to use the standards to share data. Efforts so far are encouraging, but they are not at the level we need. I would like to see policymakers re-double efforts in this area, starting

with a clear strategic plan that lays out a realistic timeline and accounts for the resources and supports needed by providers to be part of exchanges.

It is my belief that we need to reassess the program in light the reasons that the Congress chose to support the adoption of electronic health records. The first goal was to ensure that all healthcare providers could implement an electronic health record in their facility. The second goal was to have all of the individual electronic records be able to communicate with each other so that healthcare providers could view all of the patient's information in one place. The last goal was to build on the system put in place over time, to make it more and more robust. We are making progress on the first two goals, but have yet to fully achieve them. It is my opinion that we are trying to make the system more robust before the first two steps are anywhere near complete. To address the needs of all communities, we should re-focus our efforts on achieving widespread adoption and efficient information exchange. Rural hospitals need to share patient data in a timely manner because so many of our patients are transferred on to a higher level of care. We also need to be able to receive accurate, timely patient data when these same patients return to our facility for follow-up care. Widespread adoption and efficient information exchange will allow us to do this, which will exponentially improve the quality of care we are able to provide.

Thank you again for the opportunity to participate in today's hearing. I look forward to working with the Committee and all who are committed to the shared goal of widespread adoption of EHRs so that all Americans can benefit from the quality, safety, and efficiency gains they allow, whether they live in the largest city or the smallest rural community. Together we can achieve the triple aim of better health, better health care and lower costs for all Americans.