The Rural HIT Coalition
1108 K Street, NW 2nd Floor
Washington, DC 20005
202-639-0550 (O)
202-639-0559 (F)

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David Blumenthal, M.D., M.P.P
National Coordinator
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Subject: Proposed Meaningful Use Matrix

Dear Dr. Blumenthal:

The National Rural Health Information (HIT) Coalition is pleased to have the opportunity to comment on the draft description for "Meaningful Use" of electronic health records as presented to the HIT Policy Committee on June 16th.

The National Rural HIT Coalition consists of rural and health information technology leaders from regional, state, national and federal organizations, working together to advance the implementation of health information technologies (HIT) across rural America. Below please find a subgroup listing of this coalition:

- American Health Quality Association
- Center for Healthcare Innovation, College of St. Scholastica
- College of St. Scholastica
- Illinois Critical Access Hospital Network (ICAHN)
- National Association of Rural Health Clinics
- National Association of Rural Mental Health
- National Center for Frontier Communities
- National Center for Rural Health Works
- National Cooperative of Health Networks Association
- National EMS Management Association
- National Organization of State Offices of Rural Health
- National Rural Health Association
- National Rural Health Resource Center
- National Rural Recruitment and Retention Network (3RNet)
- Rural Wisconsin Health Cooperative
- Stratis Health (Minnesota QIO)

Introduction

The National Rural HIT Coalition, or Coalition, is supportive of the HIT Policy Committee's ultimate vision, "in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities." Indeed, we strongly believe that HIT, if implemented with the significant upfront planning, workflow assessment, and change management that are required for success, will be a critical tool to help all providers achieve this vision over time.

As currently structured, however, the meaningful use draft definition threatens to undermine the ability of small and rural providers—those that are most in need of assistance (including rural acute care hospitals, critical access hospitals (CAH), rural health clinics (RHC), and other rural healthcare entities)—to participate in the promised healthcare transformation.

We strongly urge you to consider the following factors:

- The 2011 meaningful use draft requirements roughly correspond to reaching stage 4 of the 7 stage Healthcare Information Management Systems Society (HIMSS) Electronic Medical Record (EMR) Adoption model.[1]

- CAH's and rural acute care 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 CAH's and rural acute care 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.

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

- Rural clinics have an analogous HIT adoption disparity and related challenges

[1] The HIMSS EMR Adoption model is the healthcare industry's recognized source of hospital EMR adoption survey statistics. Each of the seven HIMSS hospital adoption stages, which represent a logical progression from basic foundational systems to a completely automated environment with advanced decision support, corresponds to various implementation milestones and challenges. The Rural HIT Coalition is not commenting on whether the HIMSS EMR model should be adopted as a federal standard. Rather, we are using the survey data reported in association with the model to demonstrate the EMR adoption disparity between the average rural hospital and the average general medical surgical hospital. Whatever meaningful use scale is eventually adopted, the disparity identified by the HIMSS EMR adoption statistics will remain in place and will need to be addressed.

If the above factors are granted, then average CAH's and rural acute care hospitals that begins 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.[2]

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 no incentive dollars to assist the process.

The draft definition claims to achieve 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.

Our analysis indicates that the draft definition only achieves this balance for providers that have already made significant strides in their EHR adoption efforts. If the Meaningful Use Matrix is aggressive yet achievable for hospitals that average 2.5 on the HIMSS adoption scale, we question the practicality of this also being achievable for a hospital that averages 1.2 or 0. Given that achievability is one of the tenants of the HIT Policy Committee, **we implore the Committee to reconsider a course of action that will result in the vast majority of the providers most in need of assistance being effectively excluded from receiving ARRA HIT incentive funds**.

Another critical factor to consider is the patient safety impact of setting phase requirements that will lead to rushed implementations. Any review of Agency for Healthcare Research and Quality (AHRQ) or other patient safety organization HIT research will find a stress on the importance of early planning, workflow assessment, and change management as part of successful HIT implementation. If reasonable time is not given for healthy implementation processes, providers are likely to experience increased medication errors, decreased patient satisfaction and safety, reduced efficiency, and a high percentage of implementation failures. All of these likely effects, which are obviously counterproductive to the goals of the American Recovery and Reinvestment Act (ARRA) and the Policy Committee, will disproportionately impact rural and underserved providers.

Two areas of particular concern are the 2011 requirement for Computerized Physician Order Entry (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-Medicate Administration Records or MAR's) 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.

Even as we stress the significant flaws of the draft Meaningful Use Matrix, **we want to make clear that we believe the ARRA HIT incentives, if properly structured, have the potential to profoundly increase rural provider HIT adoption and care quality**. We also believe that

[2] Anthony Trenkle, director of the Center for Medicare and Medicaid Service's (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.

rural providers should be required to stretch to receive their incentives, just as more advanced EHR providers will be required to stretch. But to avoid the consequences outlined above, we believe the rural provider stretch must be developed from the baseline of current rural provider average HIT adoption levels, rather than the significantly higher average adoption levels of large hospitals and systems.

We believe that a tremendous amount is at stake here for rural providers. **If the draft Meaningful Use Matrix is approved as written, early-stage adopters will be effectively excluded from incentives, and/or will be incentivized into implementing too quickly to achieve the goals of the Committee**. This will likely create a future provider landscape of HIT haves and have-nots with numerous negative impacts for most rural and underserved communities. If, instead, the Committee creates a second meaningful use phasing structure for early-stage adopters, then we will see a future in which all providers have made significant strides along the HIT adoption continuum. Early-stage providers that are currently largely paper-based will have implemented scores of systems to improve the safety and efficiency of their care, and will in 2015 stand positioned to participate in the healthcare reform HIT vision articulated by the Committee.

Recommendations:

1. In order to achieve the goals and the ultimate vision articulated in the Committee's report, we believe it will be necessary to create two distinctive phasing structures for meaningful use: one phasing structure for providers with mid-stage adoption levels, and another phasing structure for providers with early-stage adoption levels. The current draft Meaningful Use Matrix may be appropriate for the mid-stage adopters, but is clearly too advanced for early-stage adopters. Our preliminary estimate of appropriate meaningful use phasing for early-stage hospital adopters corresponds to the following HIMSS adoption level stages: reach roughly 2.0 in 2011; 3.0 in 2013; and then 4.0 in 2015. We believe this staging for early-stage adopters is as much of a stretch as the draft MU requirements are for mid-stage adopters. However, more work needs to be done to set appropriate meaningful use phases, both for inpatient (hospital) and outpatient (clinic) requirements, which will stretch the early-stage provider group.

2. Therefore, we recommend that a workgroup be convened to develop an early-stage adopter phasing model consistent with the goals of the Committee. This workgroup should include rural health, rural HIT, and patient safety representatives who are familiar with current rural HIT adoption levels and challenges. The workgroup should be tasked with developing a second early-stage adopter meaningful use matrix that is achievable, is consistent with the goals of the Committee, and which stretches early-stage providers.

3. We also recommend that time should be allotted for the development and presentation of an impact analysis of the likely effects of approving the draft Meaningful Use Matrix as written. We have generally identified likely impacts in this commentary. But given what is at stake, we believe that additional time should be granted to provide a more thorough, validated assessment of the impacts, specifically on rural providers and the sixty-two million Americans they serve.

Thank you for your consideration of our concerns. If you need additional information or have questions, please contact Alan Morgan at Morgan@nrharural.org or 202-639-0550. We look

forward to hearing from you on this matter, and we hope that we can work together to best realize the promise of HIT to improve the health of rural America.

Sincerely,

- American Health Quality Association
- Center for Healthcare Innovation, College of St. Scholastica
- College of St. Scholastica
- Illinois Critical Access Hospital Network (ICAHN)
- National Association of Rural Health Clinics
- National Association of Rural Mental Health
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