Electronic Health Record Implementation and Meaningful Use Adoption in Rural Hospitals and Physician Clinics

Executive Summary:

Introduction:

The American Recovery & Reinvestment Act (ARRA) of 2009 mandates adoption of Electronic Health Records (EHR) toward a goal of achieving Meaningful Use (MU) by the year 2014. Associated with this change in legislation are established timelines for implementation with financial incentives for qualifying healthcare providers. The goal of this legislation revolves around the implementation and use of technology to improve client care and increase patient safety. Rural healthcare providers and organizations possess unique challenges when compared to urban counterparts with the adoption of this mandatory legislation.

For rural entities to achieve compliance with this legislation, immediate consideration of amendments to the initial legislation is essential. It is imperative to develop a sense of urgency in the provision of assistance in rural areas lacking the ability to independently enact this legislative mandate.

Background:

In 2009, an era of health care reform evolved with the adoption of the Affordable Health Care for America Act, later referred to as the American Recovery & Reinvestment Act of 2009 (USDHHS, 2010). The goal of this federal legislation was "to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes. (H.R. 3962)." The HITECH Act, a portion of the ARRA bill was introduced by the Government as a response to incentivize the steadfast adoption of health information technology (HIT) by 2014 (Aldridge, 2011). The adoption of this legislation included a provision for the advancement of electronic health records (EHR) with a goal for entities urban and rural to achieve a state of meaningful use.

The Office of the National Coordinator for Health Information Technology (ONC), within the Department of Health and Human Services, was assigned the principal federal entity working to improve healthcare quality, safety, and efficiency through the promotion of health information technology and electronic health information exchange (KFMC, 2011). The Centers for Medicare & Medicaid (CMS) were charged with defining and disseminating information regarding requirements of this legislation. On a local level, Regional Extension Centers (REC) were selected and designated with local implementation tasks to assist facilities in the process of adopting EHR and achieving meaningful use. Financial incentives were set forth for qualifying providers. However, due to federal definitions set forth in the initial legislation, outlining those organizations qualifying to receive financial incentives to offset the cost of adoption to EHR; many rural providers were excluded from participation in these financial incentives. A primary care provider was defined as any medical doctor, doctor of osteopathy, advanced registered nurse

practitioner, nurse mid-wife, or physician assistant with prescriptive privileges in the locality where one actively practiced the following specialties: family medicine, internal medicine, pediatrics, obstetrics, gynecology, or geriatrics. Priority primary care providers function in the following settings:

- Individual and small group practices (ten or fewer professionals with prescriptive privileges primarily focused on primary care)
- Public and Critical Access Hospitals
- Community Health Centers and Rural Health Clinics
- Other settings that predominantly serve uninsured, underinsured, and medically underserved populations

(Aldridge, 2010)

Meaningful use, in its final definition included 15 core objectives and a menu set of 10 objectives of which the 5 must be chosen for eligible providers.
Three types of requirements for EHR meaningful use were established including the following:

- Use of certified EHR technology in a meaningful manner
- Use of certified EHR technology connected in a manner that provides for the electronic exchange of health information to improve the quality of care
- Submission of clinical quality measures and such other measures selected by the Secretary of Health & Human Services

(USDHHS, 2010)

The concept of adopting a certified EHR and evolving into a practice with meaningful use is multi-factorial. It is not confined to technology, but rather, about improving client care and measureable outcomes. Stage 1 involves the adoption of technology and initial health information exchange. Stage 2 enters into the realm of practice redesign, consumer engagement, and quantifiable outcomes. Subsequent stages, which are yet to be defined, challenge providers to transform care delivery in a meaningful way to measurably improve health outcomes. Together these programs build the foundation for every American to benefit from an EHR as a part of a modernized, interconnected and vastly improved system of care (Blumenthal, 2010) .

The evolution of adoption for rural providers has proved to be challenging. Recent research obtained post legislative mandate reports that rural hospitals have been slow in adopting electronic health record systems. In a recent survey American Hospital Association survey data suggests that the percentage of hospitals with basic standards of implementation in place to achieve the initial stage of meaningful use was at a 43% adoption rate in urban settings compared to a 14.9% adoption rate in their rural counterparts (DesRoches et al, 2012). Moreover, the authors indicated a concern that rates of adoption were increasing rapidly among large hospitals while small, rural non-teaching entities continue to fall behind. DesRoches et al (2012) believe that “federal policy makers need to redouble their efforts among hospitals that appear to be moving slowly or starting from a lower rate of adoption.” A proposed need may exist to design an ancillary policy for these slow to adopt minority of institutions to enable them to have resources beyond the regional extension centers to align a comparable field for achieving the same standards.

Obstacles to Implementation:

- Legislative gaps excluding segments of rural providers from participating in financial incentives due to improper verbiage defining client mix for eligibility
- Lacking technology including access to broadband networks to implement Health Information Technology (HIT) and EHR's
- Lacking informatics professionals adequately trained in rural areas to implement and sustain EHR systems
- Lacking local financial resources to finance start-up and maintenance fees associated with incorporating an EHR into clinical & hospital practice
- Inadequate timelines set forth by legislation to implement as outlined due to the above noted obstacles

Issue:

Achieving a viable EHR toward MU is impacted by disparities to rural versus urban entities. Issues involving legislative verbiage, lacking informatics resources and technology, funding sustainability issues, and inadequate implementation timelines will inhibit rural facilities from achieving the same success as their urban counterparts.

Recommendations:

1. NRHA supports revision of the current legislation to correct for disparities involving rural entities including exclusions in funding set forth by the initial legislation.

2. NRHA supports the development of integrative partnerships with informatics resources to align rural entities with technical resources to support adoption of EHR technology.

3. NRHA supports the extension of federal timelines to rural facilities and providers recognizing the challenges of noted legislative hindrances, inadequate funding sources, lacking technologic availability, and workforce deficits which make implementation delayed in rural populations.

Summary:

In an era of healthcare reform, advancing the quality and safety of client care are of utmost priority. Placing rural providers in optimum positions to successfully implement mandated legislation is a priority. The NRHA supports advocating for rural providers in the acquisition of resources which allow successful implementation of mandated legislation. Integral to this mission of the organization, policies must reflect that distinct differences exist between rural and urban entities. Recommendations of this policy reflect the need to expand provision of resources which allow rural providers the ability to comply and participate effectively toward the establishment of a viable EHR and achieve the ultimate goal of MU. It is felt the need for amendments in legislation to account for disparities are in need of immediate consideration and review.

References

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Authors: Rural Health Fellows: Michelle Reisinger, Deborah Herzberg

Approved January 2012