

National Rural HIT Coalition

HIT and the American Recovery and Reinvestment Plan (Stimulus Package) Information

Identified Needs for Stimulus Package Language

- Ensure that all rural hospitals, including CAHs, are eligible for HIT incentives and that these incentives have achievable timeframes.
- Expand and continue HIT grant programs helping small rural providers at the front end and include EMS, small rural hospitals, CAHs, community mental health centers, CHCs, and rural health clinics.
- Account for the role of networks/consortia, which are critical HIT/EMR adoption drivers.
- Quality reporting and project evaluation are required to receive incentive payments.
- Utilize rural health technical assistance centers, funded by HRSA Office of Rural Health Policy, and rural HIT networks, including those funded through HRSA's CAH-HIT Program, to assist rural facilities with HIT implementation and evaluation.
- Ensure certification of EHR/HIT products.
- Ensure HIT vendor transparency and Federal standards development for HIT/EHR.
- Support development of health information exchanges and Nationwide Health Information Network (NHIN).
- Privacy and security are critical to ensuring public acceptance.
- HIT implementation should be grounded in quality improvement processes and results.
- Address current rural HIT workforce shortages and prepare for growing demand.
- Various organizations designated to assist (AHRQ, IHS, HRSA, USDA).

Economic Stimulus Conference Committee Legislative Points of Consideration

- A base amount of \$2 million per hospital plus additional incentive payments based on discharges to implement "Meaningful EMR" within 5 years. Current House language excludes Critical Access Hospitals (CAHs). Current Senate language includes CAHs, with potential \$2.5 million incentive payments over 4 years for those implementing by 2013.
- \$40,000-65,000 per practitioner per year to be "Meaningful EMR User". Excludes hospital-based practitioners in CAHs. SEC. 4311. INCENTIVES FOR ELIGIBLE PROFESSIONALS, HR 1
- Current language includes increased security and privacy requirements (particularly on disclosure) with state-level enforcement.
- States to receive money to provide loans so providers have resources to meet incentive deadlines.
- Draft language in Senate for uses 7 Point Adoption Scale for HIT, created by the Healthcare Information and Management Systems Society (HIMSS). Across the nation, CAHs average 1.3 on the 7 Point Adoption Scale while rural and urban general hospitals average 2.4.

Key Takeaways

- Legislation, as currently written in House version, is likely to significantly widen disparity in HIT adoption between rural and urban health care. Senate version will provide CAHs with incentives comparable to PPS hospitals.
- Current language does not support HIT infrastructure for all facilities, such as hospitals, clinics, EMS, mental health, long term care, community health centers, Veterans Affairs (VA), and their networks.
- The development of definitions and federal standards from this legislation, as well as related incentive requirements, could have substantial impact on rural adoption and utilization of HIT/EMR.
- To ensure the success of HIT implementation and utilization, various types of workers are required, including planners, implementers, clinicians, and educators.

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Resources

- Rural Health Resource Center <https://www.ruralcenter.org>
- Healthcare Information and Management Systems Society (HIMSS) <http://www.himss.org>
- College of Healthcare Information Management Executive (CHIME) <http://www.cio-chime.org>
- e-Health Initiative (e-HI) <http://www.ehealthinitiative.org>
- U.S. Government Accountability Office (GAO) <http://www.gao.gov>
- Rural Wisconsin Health Cooperative (RWHC) <http://www.rwhc.com>
- National Rural Health Association <http://www.ruralhealthweb.org>