

July 26, 2010

Honorable Members of the Subcommittee on Health for the Committee on Energy and Commerce in the United States House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515-6115  
C/o earley.green@mail.house.gov

Dear Honorable Members:

My name is Greg Starnes, and I am the Chief Executive Officer of Fayette County Hospital and Long Term Care in Vandalia, Illinois. I have been in health care administration my entire career of 34 years. I consider it an honor to provide this testimony to you for your perusal and consideration on the important matter of the Health Information Technology for Economic and Clinical Health Act (HITECH).

Fayette County Hospital and Long Term Care is a Critical Access Hospital with 25 acute beds and 85 long-term care beds. The hospital was constructed under the Hill-Burton Act in 1955 and was the first fully air conditioned hospital in the nation. The hospital design was an award-winner at the time. Since that time, the long-term care beds were added, and more recently the Imaging, Surgery and Emergency departments were expanded and improved. The facility serves a county of 21,000 people and resides in the county seat of Vandalia with a population of 7,000. The average household income is below the state average, the percentage of elderly in the population is higher than the state average, the unemployment rate is 10%, the number of Medicaid-eligible has increased in the last year, and the numbers of individuals who find themselves with no ability to pay for health care services have also risen. They represent the reality in today's rural health care environment in Illinois.

The challenges I have faced during the last 18 months have been the most difficult of my career. In early 2009 my hospital began to feel the effects of the changing economy. July of each year has typically been the month during which I have been able to provide merit pay increases for my dedicated employees. In May of 2009 I informed my employees that they would not be receiving any wage increases in July. The hospital finances did not improve in the ensuing months as a local employer with 140 employees relocated to Missouri. In early October, 2009, I conducted numerous meetings with all employees to inform them that I was reducing their work hours by 5 per 2-week pay period. That represented a 5% decrease in their wages. My managers and I accepted a 10% reduction in our salaries. I reduced vacation accruals and temporarily halted the employees' 401K match, and I eliminated several positions. We saved a great deal of money in the fourth quarter of 2009, yet we finished the year in the red with a net income of (\$74,000). January 1, I increased the managers' hours from 72 per pay period to 76, thereby increasing their salaries 5%. There have been no hours or wage increases since that time for anyone. My number of full-time-equivalent employees in September of 2009 was 225; my total now is 195. I represent only one example of many hospitals that

have faced those same challenges – hospitals that are within the top 3 employers in the communities we serve. We are not just about health care in our communities; we are also about jobs.

We are about jobs for nurses, nurse aides, physicians, lab and x-ray technicians, housekeepers, cooks, maintenance workers, therapists, and so on, and, of course, information technologists. In some of these job categories there are shortages of qualified personnel. In all these categories, these workers need the proper tools to do their jobs to the best of their abilities. CT scanners, MRI units, Operating Room equipment, ambulances, etc, are hugely expensive. Software, hardware, and training are extremely costly. To achieve the expectations of our patients, along with those of the governing authorities requires a great deal of money. Awareness of this among our Congress Men and Women is vital as we endeavor to improve health care in America.

There are 51 critical access hospitals and another 15 rural hospitals in Illinois out of 200 plus total hospitals. All are taking steps toward meeting meaningful use criteria. At least 10 of the critical access hospitals have less than 20 days cash on hand because of the impact of increased Medicaid and self-pay patients. A reasonable estimate would suggest that roughly half of the hospitals have inpatient health information systems, and 2/3 of them have Lab and Radiology systems. However, only 20 percent have physicians using Computerized Physician Order Entry. The new meaningful use rule will allow other practitioners to enter orders into the systems, and that will help, but it also places additional burden on the hospital staff.

Thank you for your support of changes in the final Meaningful Use Objectives. Some of them indeed lessen the burdens for Critical Access Hospitals to achieve those objectives. The loosening of the Computerized Physician Order Entry (CPOE) requirements as well as inclusion of critical access hospitals for Medicaid incentives represent a positive change from the original proposed guidelines. That said, the challenges our hospitals still face should not be underestimated. The capital necessary to procure the software and hardware is still less accessible in today's economy than it was 12 to 18 months ago. In my case the estimated cost for software and hardware necessary to achieve meaningful use criteria will likely be close to \$750,000. Training and process changes are likely to cost an additional \$50,000 to \$100,000. There will also be substantial costs associated with establishing the interfaces to enable all the hospitals' and other providers' systems to connect. These numbers are large for my hospital and for many other hospitals.

At this time my hospital needs to purchase a new CT scanner for a minimum of \$350,000, because the one currently in use is 8 years old and is increasingly unreliable. We also need to buy a digital mammography unit for approximately \$350,000, so that women in the community can take advantage of up-to-date technology and so the unit can work with an Electronic Health Record System (EHR). There are numerous other needs as well that are very expensive to purchase. Again, I represent merely one example of hospitals that face like challenges already and that now face the acquisition and

implementation of EHR systems. I believe there may be rural hospitals that will not meet the imposed timeline under HITECH.

Assistance for hospitals is available from Regional Extension Centers (RECs) recently established by the Office of the National Coordinator. These RECs are to provide EHR consulting to hospitals but will not include a separate specific focus on the special needs of our rural facilities. Funding for RECs to assist small rural hospital has been increased, but I fear those funds may be under-utilized without a more specific focus.

Therefore, I recommend a change in priority and focus for the REC model by reprogramming a portion of the funding to serve critical access hospitals. Specifically, I support the idea of directing those funds through organizations like the Illinois Critical Access Hospital Network (ICAHN) or the Illinois Hospital Association's (IHA) Small and Rural Hospital section. Many other states have similar organizations that are designed specifically to assist their member hospitals. If a portion of the funds were simply redirected, there should be no additional cost to the overall REC initiative. In some state associations like IHA there may already be some IT consulting services available that could be increased without adding a large number of new IT staff.

Qualified health IT professionals are in high demand, and the supply is currently a problem, so increased need for them in order for hospitals to achieve the IT requirements for Electronic Health Record systems may present real time and cost concerns. It is indeed fortunate that there are efforts underway to boost the health IT workforce through funding for community colleges. However, the boost might not materialize in time for hospitals to realize the currently structured incentives for meaningful use. Failure on the part of some hospitals to arrive at meaningful use capabilities could jeopardize patient safety.

A recent national survey of critical access hospitals conducted by the National Rural Health Association (NRHA) to measure the hospitals' ability to achieve the original proposed meaningful use estimates that only 30 percent of CAHs nationwide would qualify for stage 1 incentives. This survey was completed prior to the revised meaningful use rule, which may render closer to 50 percent of CAHs able to meet the stage 1 incentives.

Ultimately, the most critical benefit to all hospitals and providers achieving Electronic Health Record system functionality is the overall impact to and improvement of patient safety. Without the ability to provide an Electronic Health Record for every patient, medial and medication errors, compromised patient safety, reduced efficiency, decreased patient satisfaction, and a potentially high percentage of implementation failures may become more prevalent. That would work directly against the intentions and goals of the entire initiative and could create a disproportionate sets of issues for rural providers and patients.

To help minimize the burdens rural hospitals, I suggest:

- Provide a broader payment window for hospitals unable to qualify for Stage 1 Incentive payments due to a lack of capital and the barriers faced by rural hospitals and critical access hospitals.
- Reprogram currently available funding for RECs to hospital associations already established to assist their member hospitals. Or a national rural REC office could be created to provide consultation to individual rural hospitals and to current RECs to offer rural insight in their outreach.

Please know that Fayette County Hospital and Long Term Care, along with virtually every rural hospital and provider across the U.S., truly wants to offer patients the benefits of a fully functional Electronic Health Record system. We understand the advantages it can have in reducing overall costs, duplication, and errors while also improving accountability and patient safety. Without a definition of meaningful use that recognizes the unique nature of rural hospitals and providers, however, there is concern that the benefits we pursue may not be realized by rural patients.

Thank you for this opportunity to offer my testimony. I will be happy to answer any questions you might have about any statement contained in this document. I look forward to working with you to ensure that all hospitals and providers, urban and rural, realize the benefits of Electronic Health Record Systems.

Respectfully,

Gregory D. Starnes, MBA  
Chief Executive Officer