Rural hospital hinging future on federal incentive

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(AP) -- Electronic medical records are a life-or-death issue at Sac-Osage Hospital - not necessarily just for the patients, but for the hospital itself.

Facing a budget shortfall, the 47-bed hospital in rural western Missouri is borrowing nearly $1 million to pitch its paper medical charts and purchase a state-of-the-art electronic health records system. The hospital is hinging its survival on what it hopes will be a $3 million windfall of federal incentives for hospitals that go digital.

"If that doesn't happen, we're shutting it down," Sac-Osage CEO Jeff Speaks said. "We're rolling the dice."

It's the final gamble for a hospital that already has laid off staff, is operating on a $370,000 deficit and is warning of dozens of deaths if local voters on Tuesday don't also approve a property tax to keep its emergency room open and ambulances running.

The stimulus act signed by President Barack Obama directs $17 billion to doctors and hospitals, beginning in 2011, that make "meaningful use" of electronic medical records. In 2015, health care providers could face financial penalties if they haven't made the switch.

Electronic records are a key part of Obama's plan to remake the nation's health care system by expanding coverage and improving treatments for millions of Americans. Advocates say digitizing the nation's health care records will allow critical information to follow a patient through the

medical system, speeding through red tape and reducing the chance for errors.

But some paper-dependent hospitals are in a predicament. To qualify for the technology incentives, they must act soon to purchase the equipment and train their staff. Yet they won't know until later how the federal government defines the criteria to qualify.

Across the country, many small, rural hospitals have been hesitant to do away with their clipboards of handwritten nurses' notes and doctors' orders because of the budget-busting costs of electronic systems and a shortage of staff with the technical expertise to oversee them.

Hospitals with fewer than 100 beds and those in rural areas rank consistently lower than their larger and urban counterparts in their use of electronic records, according to quarterly reports of the Healthcare Information and Management Systems Society, or HIMSS. The lowest of all are in a central U.S. region comprised of Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota.

"The No. 1 barrier traditionally is the cost of the systems," said Rod Piechowski, senior associate director of policy for the American Hospital Association.

Sac-Osage is one of a couple thousand hospitals nationwide that still rely primarily on paper records. On a scale of 0-7, HIMSS rates Sac-Osage a mere .065, due partly to the fact that the hospital failed to note on a survey that it already uses electronic records in its laboratory, radiology and pharmacy units.

It's not uncommon, however, for patients at Sac-Osage Hospital to accumulate a 2-inch-thick binder of paper records during a weeklong stay.

When a patient arrives at the Sac-Osage emergency room, he or she signs a document consenting to treatment while a nurse starts jotting notes on a paper triage log. Then a nurse fills out a diagnostic form detailing the person's vital signs and symptoms and attaches it to a color-coded clipboard. There are 29 forms from which to choose, one for each type of problem ranging from chest pain to a skin rash to an apparent assault.

The nurse fills out more forms listing medications taken by the patient and verbal doctor's orders issued over the phone as the physician heads to the hospital. When the doctor arrives, he or she picks from among 52 specialized diagnostic forms stored on an emergency room shelf. If a patient needs an X-ray or CT scan, there are more forms to be filled out and delivered to the appropriate exam room.

But that's just the start of the paperwork.

If a patient needs to stay at the hospital, another consent form must be filled out. Then an inpatient nurse pulls out a 33-page packet of documents that becomes the basis for the patient's 17-tab, medical record binder. There are forms listing personal belongings, meals and bowel movements, and new forms daily for the nurses' observations and doctor's orders. One piece of paper allows nurses to make a hand-drawn, connect-the-dots graphic of a person's hourly body temperature.

When a patient leaves, the paper charts are placed alongside thousands of others for permanent keeping. The files have become so plentiful there now is an overflow closet.

On one recent day, patient Virginia "Ruth" Bishop, 85, had few complaints as she carried her paper doctor's order for a blood test from the hospitals' registration desk to the laboratory, where her information was re-entered into a separate computer system.

"Just so they get it right," Bishop quipped.

Most of the time they do. But Speaks estimates the staff catches an average of eight potential medication errors a month that he attributes largely to the imperfections of paperwork.

"We have several people, doctors included, who their handwriting is not the best," acknowledges Connie Chapman, the ward clerk for the inpatient care section.

Sac-Osage plans to begin its gradual electronic conversion this October. The paper charts will be replaced with computers, which will flag any unusual lab results or potential allergic reactions to medication. And patients will be tagged with bar codes that must be matched to similar coding on an electronic doctor's orders before any medications are given.

It's a big project for a hospital that averages five inpatients a day and has had trouble raising revenues. In April, local voters narrowly rejected a property tax levy for the hospital, which is the area's largest employer. Supporters are trying again in a special election Tuesday.

Even if the ballot measure passes, Speaks said, it will provide just enough money to sustain the hospital until 2011, when it hopes to begin reaping the enhanced Medicare and Medicaid payments available for hospitals that adopt electronic systems.

"We wouldn't have gone to an electronic health record at this point and time, because we just don't have the cash to do it," Speaks said. "We're taking a risk that we're going to be able to meet the criteria and get some of this stimulus money to help offset the cost."

The risk lies in the federal government's ultimate definition of what constitutes a "meaningful use" of electronic records.

The National Rural Health Association, which represents more than 2,000 hospitals and clinics, says the government's draft definition of "meaningful use" could be difficult for rural hospitals to obtain by 2011. The result could be a digital divide among hospitals, he said.

"It takes time to basically introduce this technology into a facility and culturally get it adapted and used," said Brock Slabach, the association's senior vice president. "You can't rush this."