
Health Information Technology Toolkit for Family Physicians

A Physician's Guide to Working with the Health Information Technology Regional Extension Centers in Indiana

Introduction to HITECH's Regional Extension Center Program

The American Reinvestment and Recovery Act of 2009 included provisions referred to as "HITECH" to both reward and support adoption and "Meaningful Use"¹ of health information technology (HIT). This Physicians' Guide focuses on the infrastructure created via the HITECH provisions to support health IT adoption.

HITECH provided a source of funding to create a system of Regional Extension Centers ("RECs") charged with helping priority primary care clinicians (PPCPs)² select, implement and use health IT. Inspired by the agricultural extension center model created to disseminate emerging knowledge to farmers and to provide local support to improve farming results, legislative framers envisioned a similar approach to deal with the challenges faced by small primary care organizations.

Through the REC model, HITECH has enabled creation of concentrated resources to help clinicians succeed in system selection and implementation, including system configuration and workflow and role redesign. Because the REC is expected to avoid conflicts of interest, exists to support providers on this journey, and receives federal funds only if it successfully attains specified milestones, it is highly incentivized to help providers succeed.

HITECH funding created a network of 62 RECs across the nation. Indiana has two organizations serving as RECs I-HITEC at Purdue and the Tri-State Regional Extension Center. Each REC is under contract with

¹ Meaningful Use refers to set of specific measures that document increasing use of EHR functionality as a tool to improve clinical care. HITECH provides for Meaningful Use requirements to ramp up over three stages. See the fact sheet entitled Summary of Meaningful Use Objectives for Eligible Professionals website for more information about Meaningful Use.

² PPCPs are primary care providers who have prescriptive privileges –in any of the following settings:

- Solo and small group practices (fewer than 10 PPCPs) providing primary care;
- Outpatient clinics affiliated with Public and Critical Access Hospitals;
- Community Health Centers and Rural Health Clinics and other settings predominantly serving the uninsured, underinsured and medically underserved

the federal government to support a specified number of PPCPs and this funding is released only after specific PPCP performance milestones are achieved.

HITECH's funding design places RECs under enormous pressure to move quickly and to establish a track record for attractive, marketable services. RECs are expected to have achieved substantial inroads in Electronic Health Record (EHR) adoption and use within their first two years of operation.

Regional Extension Center	Area Served
<i>Purdue (I-HITECH)</i>	<i>Northern Indiana and Most Southern Indiana Counties</i>
<i>Health Bridge (Tri State Regional Extension Center)</i>	<i>Southern Indiana Counties</i>
	<i>See map at http://www.switch.purdue.edu/</i>

RECs are paid only for accomplishing milestones. The three milestones that qualify a REC for payment are: 1) PPCP enrollment; 2) PPCP Go-Live status on a certified EHR, with e-prescribing and quality reporting; and 3) PPCP achieving Stage 1 Meaningful Use ("MU"). Since the REC is paid the full subsidy for services to a PPCP only if the PPCP achieves all three milestones during the period covered by federal subsidies, RECs need to enroll PPCPs up to their contracted quota quickly to assure PPCPs have the necessary time to complete implementation activities, learn to use the system and inculcate new processes required to meet MU.

REC Services

HITECH mandates that RECs provide specific services to help PPCPs:

- Assess health IT needs.
- Select EHRs best suited for them.
- Implement EHRs through individualized, on-site coaching, consultation, and troubleshooting.
- Redesign work processes, update roles and responsibilities, and implement rapid cycle activities to continuously improve performance and care quality.
- Report on meaningful use and access MU incentive payments.
- Assist providers in connecting to available health information exchange ("HIE") infrastructures to support exchange of information such as laboratory orders and results, medication prescriptions, patient summaries, etc.; and
- Implement best practices for privacy and security of personal health information.

RECs can also arrange for volume purchasing discounts and negotiating contract terms that assure PPCPs have choices among high value EHRs and vendor commitment to high service levels.

RECs are expected to be knowledgeable of their community and plugged into projects and programs that will help providers get connected for the electronic exchange of data, such as electronic prescriptions, lab orders and results reporting, care summaries, etc.

(RECs are not responsible for any costs associated with acquisition, installation, operation or maintenance of hardware or software. Their federal subsidy also does not address customization, interface development or intense support needs. These costs are the responsibility of the provider/practice/clinic.)

Key Players and Their Roles

In addition to the RECs, there are three additional categories of players involved. These are:

Service Partners:

Clinicians who enroll in REC programs will engage with a variety of different entities. Each of the RECs has established processes for accepting applications from interested consultants, vetting them for their HIT experience and track record. Once a consultant has been approved, he or she is recognized as a “Service Partner.” Before a Service Partner can provide HITECH-covered services, he or she must enter into an agreement that stipulates performance obligations under the REC programs and for what and how they will be paid through HITECH funds.

Service Partners include individuals and organizations with skill sets required to satisfy the REC services listed above. Experience includes expertise in practice assessment, vendor selection, hardware or software implementation, project management, workflow redesign and change management, etc. Some Service Partners may have all of these skills and some may specialize in a subset of them.

Most localities will have a variety of Service Partners from which to choose.

Vendors:

Vendors can be classified into two types – EHR Vendors and all other Vendors. EHR Vendors are companies that design and market EHRs³. Other vendors may sell and install hardware, provide connectivity, provide data migration services, etc. To participate in REC programs, EHR Vendors must be certified by the Office of the National Coordinator (“ONC”) as able to comply with the functional, privacy and security rules mandated under HITECH. This limitation is directly related to the HITECH requirement that providers must use certified systems to qualify for the HITECH incentive payments through Medicare and Medicaid. The current list of certified vendors can be viewed at <http://onc-chpl.force.com/ehrcert>. EHR Vendors may have relationships with hardware vendors to assure the selected hardware meets EHR specifications.

³ For purposes of this Guide, software vendors that offer information technology that provides a subset of EHR functionality are part of the EHR Vendor category. They are also subject to HITECH certification requirements.

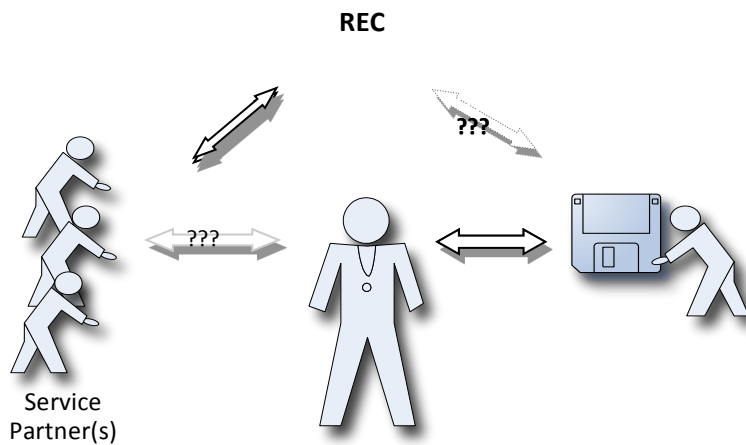
RECs are encouraged to arrange for group purchasing discounts and negotiate service level agreements with Vendors they deem to offer high value. Because the effort required to accomplish this is significant and negotiating leverage decreases as the number of Vendors increases, RECs will limit the number of EHR Vendors they pursue. RECs may not enter into any agreement with a Vendor that would create a conflict of interest and they may not limit providers to Vendors with whom they have contracts.

Relationships and Responsibilities

Getting to Meaningful Use is serious business and involves a lot of effort from many different players. In the sections above, the Guide described the various players: RECs, Service Partners and Vendors. The important work and multiple handoffs involved require clear roles and responsibilities and lots of coordination.

The diagram below is a simplified depiction of the relationships that will exist. The double-pointed arrows represent contractual relationships. The physician will have agreements:

- That specify roles and responsibilities with the REC
- With one or more Vendors (software, hardware, ongoing technical support)
- With one or more Service Partners, if the practice needs services that exceed subsidized REC services.



This agreement should specify what services will be received and the terms of payment by the practice/clinic/physician.

The REC will have an agreement with the Service Partner(s) involved and will be responsible for paying the Service Partner for services within the REC's scope (see discussion about costs for more information). The physician is financially responsible for Service Partner services outside the REC's scope (e.g., cost of interfaces, customization and associated installation and operation).

The physician (practice/clinic) will be directly responsible for paying the vendor(s) and will have a direct contract that governs the relationship. At minimum, there will be a contract with the EHR vendor. There may also be separate contracts with hardware vendors and organizations that provide ongoing technical support services that are not EHR-related. If the physician's chosen EHR vendor is one that has engaged in group purchasing and service level agreement negotiations with the REC, the terms of the agreement will be standardized and include special pricing defined during negotiations between the Vendor and REC. While the vendor agreement is specifically between the physician and the vendor, the REC's detailed involvement in establishing the terms of the agreement may position the REC to assist should problems arise.

If the PPCP chooses an EHR Vendor that is appropriately certified but does not have a relationship with the REC, it is possible that the available Service Partners may not have deep expertise in that particular product. While the REC can still offer services, they may be limited. With no contractual relationship between REC and Vendor, the REC may have little influence on the Vendor if problems arise.

If the PPCP chooses a vendor that is not properly certified, he/she will not meet requirements for Meaningful use and the REC will not receive any subsidy for services to that PPCP. If the REC is willing to provide any assistance, the PPCP will be fully financially responsible for such services. All providers have to use a certified vendor to qualify for subsidized REC services, attain Meaningful Use and qualify for HITEC incentive funds.

Key Stages in the Process

- Physician expresses interest to REC.⁴
- Conversation held with REC to gather initial information and ascertain physician interest.
- Physician enrolls and executes an agreement to participate.
- A representative of the REC schedules a visit to conduct a readiness assessment (this representative can be a Service Partner).
- Based on the readiness assessment, the physician and REC representative develop a detailed project plan that specifies what will be done, when it will be done and whose responsibility it is to do it. (System selection can be part of this process.) Then, in keeping with the project plan, the REC and their representatives will help the physician with the various elements of successfully implementing an EHR:
 - Complete practice workflow and network design assessments, identify interface needs
 - Select Vendor (may influence Service Partner options) and execute agreements
 - Define project team members and roll-out sequence and timing

⁴ Providers can call or visit the RECs online to seek more information and express interest:

- All Indiana Counties – Purdue University I-HITEC, <http://www.switch.purdue.edu/>
 - Key Contact: Monica Arrowsmith, email: marrowsm@purdue.edu, phone: 765-496-6945
- Southern Indiana Counties – HealthBridge Tri-State REC, <http://www.tristaterec.org/>
 - Key Contact: David Groves, email: dgroves@healthbridge.org, phone: 513-247-6860

- Train people responsible for configuring the system
- Design future workflows and staffing
- Install hardware and software, configure and test EHR (done by the EHR vendor)
- Develop data migration plan
- Schedule Go-Live with patient appointment schedules adjusted accordingly
- Train on new workflow processes and EHR functionality
- Begin data loading for live use
- Go-live according to roll-out plan
- Refine clinical workflows to assure clinical performance, data capture and reporting as required for Meaningful Use.

Considerations for Enrolling for REC Services

Providers are under no obligation to sign up for REC services. Enrollment is not required to qualify for the HITECH incentives under Medicare and Medicaid (up to \$44,000 - \$63,750 per clinician, respectively). That said, there are many reasons a provider may benefit from these services. The discussion that follows explores many of the benefits and related considerations. For simplicity, references to the REC in the chart below include activities that may be carried out by LECs and Service Partners acting as REC agents.

Timing

What is your intention related to HITECH Medicare or Medicaid incentives? Physicians who want to qualify for one of these programs may find the REC is an excellent resource. But time is of the essence.

RECs are under strong incentives for rapid results as federal subsidies are time-limited. Additionally, each REC has a specific quota of PPCPs to bring to Meaningful Use, and, after that quota is met, federal subsidies are exhausted.

A timetable is presented to show key milestones for Eligible Professionals through 2012.^{5,6}

⁵ Eligible Providers who meet Stage 1 Meaningful Use requirements later than 2012 will forfeit eligibility for Medicare's maximum incentive payment. See <http://www.cms.gov/ehrincentiveprograms/> for more details on Incentive Payments

⁶ Sources: <http://www.cms.gov/EHRIncentivePrograms/Downloads/EHRIncentProgTimeline508V1.pdf>, <https://www.cms.gov/EHRIncentivePrograms>,

Timetable for REC subsidies and Medicare & Medical EHR Incentives

RECS accepting provider enrollment	Jan 3, 2011 Registration for Medicare EHR incentive program begins	Apr, 2011 Attestation for the Medicare EHR Incentive Program begins May 2011 Medicare payments scheduled to begin & Indiana Medicaid registration begins		Oct 1, 2011 Last day to begin 90-day reporting period for calendar year 2011 for the Medicare EHR Incentive Program. Later starts not eligible for incentives in 2011		Feb 29, 2012 Last day for eligible professionals to register and attest to receive an incentive payment for CY 2011		Maximum Medicare incentive payment amounts will be reduced for providers not meeting MU by Oct 1, 2012
Fall 2010	Jan – Mar 2011	Apr – Jun 2011	Jul – Sept 2011	Oct – Dec 2011	Jan – Mar 2012	Apr – Jun 2012	Jul – Sept 2012	Oct – Dec 2012
<p>RECs will receive highest federal subsidy payments for each milestone reached during their first two years of operation:</p> <ul style="list-style-type: none"> • Provider enrolling in program • EHR implemented • Meaningful Use achieved 								

* RECs are currently financed and will continue to be financed mostly by federal dollars for the next four years. After that, they will become responsible for the majority of their own funding.

CONSIDERATIONS: *Successful EHR implementation takes extensive involvement and preparation. Providers who desire to participate in the Medicare or Medicaid incentive programs are encouraged to get an early start*

Since the federal subsidy for REC services may be more limited in the future, practices/clinics that delay may have to pay more for REC help.

Service Partners and Vendors have finite capacity. Once capacity is filled, the best resources may no longer be available and waiting lists may result in delays that jeopardize meeting timelines for subsidies to the REC and incentive payments to clinicians.

Getting Started

Are the clinicians of your practice/clinic ready to engage and willing to provide the leadership necessary to make needed changes in the organization?

In addition to implementing a certified EHR, Stage 1 MU requires consistent collection and structured recording of specific clinical information. Most of this information now is collected episodically in primary care practices, but for MU, processes to collect and record the data may be more rigorous than current processes support. These data must be consistently collected, stored in a structured, retrievable

manner and incorporated in treatment decisions. While details about Meaningful Use are beyond the scope of this guide, physicians are encouraged to familiarize themselves on these requirements⁷ and ascertain willingness to make changes necessary to achieve them.

Physicians open to modifying workflow in ways that support efficient (and consistent) data capture and engagement of staff as part of the care team will have the advantage in implementing an EHR and achieving MU. But even highly motivated physicians will face substantial work on their part and the part of their staffs to make the necessary changes. Evidence indicates small practices tend not to have the internal resources to accomplish this work without expert assistance.

Enrolling in a REC is not required to qualify for Meaningful Use (MU). Physicians are free to work solely with an EHR vendor without REC involvement or may directly secure the assistance of any consultant they choose. RECs were created as an additional resource to help. They will not replace the need for vendor involvement and subsidized services may not be sufficient for the practice's specific needs, but they may offer valuable services that will make the process easier and less expensive. They also have a deep financial incentive to keep the practice on the right track.

Indiana RECs have a plethora information on their websites. If a physician thinks he/she wants to get started, he/she can check out the REC websites for more information. There is no penalty for the PPCP who enrolls and then elects to not follow through. To learn more, go to:

- All Indiana Counties – Purdue University I-HITEC, <http://www.switch.purdue.edu/>
- Southern Indiana Counties – HealthBridge Tri-State REC, <http://www.tristaterec.org/>

A first step following enrollment for REC services includes the practice's completion of a Practice Assessment. This document includes a lot of questions about the practice – things such as:

- Practice demographics – who you are, practice size (clinicians, staff, patients)
- Technology currently in use
- Perceptions about EHRs
- Roles and workflow
- Future plans

Once the practice/clinic has returned a completed Practice Assessment to the REC and determination is made that the provider is eligible for REC services, a REC representative will

To qualify for HITECH incentive payments, the provider must be using technology that is certified under federal rules. If the EHR or clinical module is not certified, the practice will not qualify and the REC will not be paid.

Meeting the federal certification requirements means required functions exist in the technology, including considerations for data security. There is no test for how usable the system is, so certification is necessary but insufficient basis for selection.

The list of products certified under federal rules is continually updated and can be viewed at <http://onc-chpl.force.com/ehrcert>.

⁷ Please review the Meaningful Use materials in our HIT Toolkit.

arrange a visit to work with the practice in development of a Practice Service Plan.

The REC Representative will review data from the Practice Assessment with the practice to clarify the practice's needs. With that information in hand, the REC Representative and provider will jointly review services needed. If the practice needs services for which it will be financially responsible, that determination should be made at this time and indicated on the Practice Service Plan. If the plan is acceptable, both the practice and REC sign the Practice Service Plan.

CONSIDERATIONS: *EHR implementation and workflow redesign are intense activities and it is important to be realistic about the time and resources required to do them right. Are there important considerations for timing for your practice/clinic (e.g., key persons on leave, access to capital, anticipated change in clinician panel)? In some circumstances, it may be possible to enroll now and delay implementation until later in 2011. Be sure to find out how any delay will affect your financial responsibility.*

The federal subsidies that reimburse REC services are tied to outcomes, not effort. The modest payments RECs receive cover specific services. Some of these services are measured in hours. Talk frankly with the REC representative to be clear about what will be provided at no cost to the practice and if, and under what circumstances, additional fees will apply.

EHR Selection

EHR selection is a daunting task and many physicians have been stymied at this stage. The REC concept designers appreciated this challenge when they encouraged the RECs to identify high value vendors and negotiate terms on behalf of the PPCPs they would serve.

As the physician contemplates EHR selection, here are a few tips to consider:

- Successful EHR implementation is 75 percent preparation and process and 25 percent technology. A lesser system well-implemented will get better results than a great system poorly-used. Bottom line – if there is commitment to implement the EHR well and skilled assistance to guide the process, most established, respected and certified EHR systems will likely serve the practice/clinic well. Most unhappy results are more the product of poor implementation than poor system selection.
- There is great value in community. Physicians have found it very helpful when other practices they know are using the same system. They can share learnings and discoveries that help flatten and soften the learning curve.
- Certain interfaces, like lab orders and results, offer incredible value to the practice. They improve efficiency, minimize the need for data entry and are a key element of MU. If your lab vendor has not already established an interface with an EHR in your area, developing an interface may not be a priority at any price.
- Physicians need support for MU work as it evolves. It is important to have *future* performance requirements clearly in mind –not to automate processes as they flow today.

- Is the Vendor product specifically listed as certified on <http://onc-chpl.force.com/ehrcert>? You will want to confirm this as the use of non-certified vendors will not meet qualifying requirements for Meaningful Use.
- KLAS (<http://www.klasresearch.com/>) collects customer ratings of EHR and other HIT systems. In exchange for sharing experience about technology you have used, KLAS will give you access to its accumulated performance data at no charge. Checking what it has to say can be very useful.

One REC responsibility is assisting the provider with EHR selection. Most RECs will be happy to arrange for demonstrations by their identified vendors for providers as part of their outreach activity. PPCPs who have enrolled in a REC will have additional access to coaching around EHR selection. If the REC-identified Vendor list is of interest, one helpful action can be to ask the REC to arrange a demonstration and access to current customers so you can ask questions of clinicians like you about their experience.

CONSIDERATIONS: *If the REC representative is a Service Partner, he or she could be more closely tied to a specific vendor. If there is any doubt, ask questions about potential bias or conflict of interest. If a provider has a specific EHR Vendor product in mind that is not on the identified Vendor list, ask about the level of experience available Service Partners have to support the implementation of that EHR. Be aware that federal subsidies to the REC are available only when the PPCP implements an EHR that is certified under federal certification requirements. If the EHR of interest is not on the list of certified products, the REC will not be paid. Any services the REC offers then will be the provider's full financial responsibility.*

EHR Pricing and Terms

EHR systems are complex. Software and hardware must be carefully selected and configured to work together seamlessly. Running these sophisticated new tools on mismatched hardware will likely generate more problems down the road and cost more in interruptions and service than may be saved by recycling older components. Practices/clinics should be prepared to purchase new hardware specifically designed to meet EHR Vendor specifications. In addition, hardware should be located in the clinical setting in ways that save time and improve capture of important clinical information as the patient moves through the visit. If the practice/clinic is not familiar with best practices and technology options, having a trusted guide can help identify valuable opportunity to redesign through location and selection of devices.

Vendor contracts address a host of complex terms and small practices have limited negotiating leverage. Unless the practice has taken time to read the contract carefully and is confident of the terms, there are legions of ways future costs are hidden – costs for services, for data retrieval, for upgrades and how licenses are defined, to name a few. Clarity around who owns the data and provisions for transferring data to other systems in the future is essential. Physicians are advised to do their homework and/or have a trusted, experienced guide to help them.

While there is no requirement to use an EHR on the RECs' list, there are good reasons to take advantage of REC negotiating leverage. If you decide to look into other products, learn about the terms

incorporated in the REC-negotiated Vendor packages and use those terms as a guide for exploring other EHR options.

There will be many assertions from EHR Vendors. It is likely many will claim they cost less than products on the REC Vendor lists. Be mindful. Acquisition price is an incomplete (and often misleading) indicator of a system’s full cost. Vendor agreements can be quite biased and very complex. Individuals can find they have little leverage when things don’t go as they expect. If the practice has not had deep experience in reviewing vendor contracts, having an unbiased guide is very important.

Some things the RECs’ group purchasing agreements are hashing out and will specify clearly include:

EHR Software	The cost related to the EHR product, licenses and hosting fees (if applicable)
Bundled Modules	The specific additional modules and their cost to support all necessary functions to achieve MU. These may include other modules of this Vendor or other companies – such as practice management system, immunization registry, clinical decision support, e-prescribing software, patient portals, etc.
Updates	Provisions for updating the EHR as MU Stage 2 and 3 requirements are identified
Implementation Support and Training Services	Vendor services necessary to include up front planning, system configuration, installation, testing, project management and go-live support
Training Services	Scope and cost of training services (including costs of travel, if any)
Annual Support & Maintenance	Costs of components of annual support based on specified levels of service
Data Conversion	Specifics and cost of support for converting existing paper or electronic data to the EHR
Data Ownership	Who owns the data? In what form and how will the provider get the data if he/she should decide to change to a different EHR in the future? What data elements will be available in human-readable format upon termination of contract, i.e., medications, problem lists, labs, etc?
Data Recovery Services	Vendor services for backing up data off site and data recovery. How often will this process be tested?
Hardware	Specifications for the hardware needed by the EHR. Some RECs are also negotiating hardware prices as a “bundle” to the EHR.
Interfaces	Requirement for EHR vendor to receive lab results from any lab vendor using the ELINCS standard. Don’t assume that the lab will pay for the interface.
System Security	Specifications for meeting HIPAA privacy and security standards

CONSIDERATIONS: *The best time to think ahead is before the Practice Service Plan is finalized. It is important to consider the movement of the patient through the visit to determine where data can be most easily collected and recorded. The technology to support point- of-care recording has made great strides and continues to improve. Tools to help with data entry – such as tablet and stylus, Dragon and interfaces from diagnostic equipment direct to the EHR – exist and can be great time savers. Ask about them. Ask for demonstrations if their use is unfamiliar.*

If the practice is interested in an EHR vendor on the REC’s identified vendor list, talk with the REC representative about the contract terms and clarify any issues of concern. Understanding how they can help in the event of future problems may also bring comfort.

If the vendor under consideration is not on the REC’s identified vendor list, ask whether and how the REC might help should there be future disputes. And confirm that the specific product under consideration is certified under federal rules⁸. Every vendor assigns a name for its product and a way of denoting specific versions of the product. The listing of ONC-certified vendors is VERY specific. Even if a vendor is listed on the ONC-certified products list, a provider should verify that the specific version under consideration is listed. Previously cited, that link is [HTTP://ONC-CHPL.FORCE.COM/EHRCERT](http://onc-chpl.force.com/ehrcert).

Once at this site, selecting “Search Ambulatory Products” lets the visitor browse all products to see who is listed, to search for a specific product or search for specific criteria a product meets. If “Browse” is selected, an extended, real-time list of all certified products – both complete EHR and EHR modules appear. Its contents are identified below.

Certifying ATCB	ONC Certification #	Vendor	Product	Product Version #	Product Classification	Additional Software	Additional Software
<i>Who certified it?</i>	<i>The number assigned this product upon receipt of ONC certification</i>	<i>The vendor associated with the product</i>	<i>Product name and link to view certified MU features</i>	<i>Specific version of vendor’s product that is ONC certified</i>	<i>Complete EHR or a limited-purpose module</i>	<i>The additional software the EHR relied upon to meet certification requirements</i>	<i>Add to Cart link</i>

The link activated by clicking on the product name reveals a page listing all MU requirements and checks which of these requirements this product has been certified as meeting. A practice should carefully review this list to confirm whether the product is certified for the particular Stage 1 criteria the practice has chosen to meet and report and to note whether additional software would be required for that product.

This site also allows the user to select EHR modules that offer limited functionality – e.g., support reporting for specific clinical measures, track educational materials, etc.

⁸ There are several certifying bodies. Regardless of the vendor’s claims, certification for purposes of the HITECH incentives specifically refers to products certified under federal rules set forth by ONC. Providers can verify certification status by checking at <http://onc-chpl.force.com/ehrcert>.

As the practice identifies the complete EHRs (and/or modules) it intends to use, it can click “add to cart” for each of the chosen products. Adding to cart triggers a mechanism that sums the meaningful use criteria met by the products in the cart. If the sum of met criteria is less than 100%, the website enables the practice to search for additional EHR products that address the unmet criteria.

In the planning stage, this tool located at <http://onc-chpl.force.com/ehrcert> provides useful information for reviewing potential EHR products. Once the final choices of EHR vendors are made, this site enables the practice to add the specific EHR products selected to the cart and, if the selected products equal 100%, the site will provide the practice the specific CMS EHR Certification ID required to attest for payment of Medicare or Medicaid EHR incentive funds.

Implementation Support

Getting a good start is critically important. As previously stated, successful outcomes depend more heavily on effective implementation than on selecting the “right” EHR. The better prepared the practice is before go-live, the more rapidly clinicians and staff will adapt to the new system and processes, the quicker productivity will get back to desired levels and the happier everyone will be.

RECs’ coaching, project management and support can be a great resource to keep the practice moving on the right track. But the federal subsidy is limited to high level and time-limited services. REC services do not cover customized solutions, interface development, or additional support required due to lack of internal project management capacity or lack of practice follow through.

Be prepared to work intensely with the Vendor and REC in getting everyone and everything set for this event. Skimping on preparation will cause significant pain at Go-Live and will lengthen the time productivity is impaired. Talk with the Vendor and REC about expectations and set the practice/clinic up for a winning start.

Service Providers are all different and some may be a better fit for a practice/clinic than others. Talk with the REC representative about any concerns for meeting practice needs.

Implementation will involve close collaboration and cooperation between the practice, the EHR Vendor (and any other vendors of hardware or associated bundled services) and the REC. It is very important that responsibilities are clear and each one delivers on their commitments.

CONSIDERATIONS: *Thoroughly discuss and understand roles and expectations during development of the Practice Service Plan. Identify any additional services the practice may need and the practice’s financial responsibility for them before signing off on the plan. It is far better to anticipate needs in advance and proceed with knowledge than end up with ugly surprises.*

Be clear about responsibilities. The best way to avoid problems with so many players involved is being clear about who is responsible for what and staying attentive and involved through each step of the process. If you have a problem, work to resolve it immediately so its impact is minor.

Success is important and the buck stops with the REC. Each has an escalation process to resolve problems. They also plan to obtain feedback from providers about Service Partners and post results on their websites.

Workflow Redesign

Achieving MU requires acquiring, recording, sharing and acting on data in ways that have not been possible without the use of technology. But the technology is only a tool. Getting to MU will require changes in roles and the way work is performed.

Providers/practices/clinics have to be open to changing how work is done and are encouraged to look carefully at MU requirements and existing challenges to meeting them consistently.

Changing how one works is no small task. It requires openness, intention to achieve better results, and willingness to create and use feedback to improve.

Providers must be willing to do things differently. A provider/practice/clinic embarking on this journey only because of HITECH incentive payments may find the effort required is not worth the money. In such cases, the REC may not be the program for you.

RECs have access to a large compendium of tools and best practices that are being compiled to assist in their work. Some best practices may seem foreign and not relevant to the practice. When the REC's suggested approach requires change, ask questions to understand why this is recommended. Often the limitations in today's processes are not apparent until viewed against requirements for different outcomes. HITECH and healthcare reform legislation are moving the U.S. healthcare system to meet critical challenges that the status quo cannot support. Understanding what the new process is designed to accomplish will help the practice adapt it appropriately.

Considerations: *If the Service Partner assigned to your practice by the REC has recommendations that fail to address practice concerns, talk with the REC. The practice may need a Service Partner more attuned to the practice's specific needs or the practice may need more help in redesign. A conversation with the REC may help sort this out.*

Exchanging data electronically

RECs are working in collaboration with organizations building health information exchange (HIE) services to enable transfer of data between different providers. Clinicians whose systems are ready to connect to these external sources of data, e.g., lab and x-ray results, will have a significant financial and time advantage. REC's in Indiana are also able to assist practices with electronic prescribing.

Think about sources of data you need. For example, where do you get your lab results? Can the results of your diagnostic equipment be uploaded into your EHR, e.g., spirometry? To whom do you send clinical information?

Interfaces can be very expensive. You'll want to avoid creating custom interfaces whenever possible. Take advantage of work being done to simplify and lower the cost of data exchange. Your REC will be informed about activities underway in your area. Ask questions.

Privacy and Security

HITECH significantly tightened HIPAA privacy and security requirements and penalties for failure to meet them.

Patients want to know their data is secure. Ask questions of your REC about the new requirements and how it can help you meet them.

Fees

For purposes of this Guide, there are three general categories of fees:

1. Vendor costs (software, hardware, connectivity, licenses, etc.)
2. REC services – Core Services subsidized through the HITECH program
3. Non-core services

Vendors:

Practices are directly responsible for all Vendor fees.

Depending on the practice and its choices, one or more vendors will provide and install the software, hardware, connectivity and associated training. These fees and their terms will be spelled out in agreements between the practice and the vendor(s). RECs can provide information to PPCPs who qualify for Medicaid EHR Incentive funds to reimburse a portion of the costs associated with acquisition, implementation and upgrade of their EHRs.

REC Core Services:

Fees can fluctuate depending on REC and practice size, but average around \$1,000 for eligible primary care practices. A call to the REC will quickly determine the cost of core services All Indiana Counties

- Most Indiana Counties- Purdue University I-HITEC, phone: 765-496-6945
- Southern Indiana Counties – HealthBridge Tri-State REC, phone: 513-469-722 (select option 3)

How RECs are funded:

HITECH provides four years of federal subsidy to the RECs to help PPCPs implement EHRs and achieve MU. Initially, HITECH subsidies contribute 90% of approved, budgeted REC costs and the RECs have to supply the 10% match. After 2014, no further subsidy has been planned.

The subsidy is structured as a per PPCP amount up to a specified quota of PPCPs. (REC subsidies differ.)

Subsidies are earned only as milestones are met. (For example, if the PPCP total subsidy is \$3,000 the REC will receive \$1,000 each time a PPCP enrolls in the program, implements a certified EHR and achieves MU.) The REC must cover all of its costs, the cost of the LECs and fees to Service Partners out of this subsidy and match.

RECs must generate their own revenue to cover services beyond the core set of services, costs associated with PPCPs beyond the quota and for providers who do not meet the definition of PPCPs.

Non-Core Services:

RECs are not funded to develop interfaces, install hardware or software, provide customized designs, detailed project management or intensive handholding. The practice is free to pay for any additional services it desires, purchasing them either from the Service Partner or another consultant.

CONSIDERATIONS: RECs may only pay consultants to work with PPCPs if the consultant has been recognized as an approved Service Partner and has entered into a contract with a REC. A provider/practice should not enter into any agreement expecting REC-funded service with a consultant without confirming the consultant is a contracted Service Partner. A call to the REC or check on their website should confirm status in case of questions.

The Service Partner who completed the Practice Service Plan and the Service Partner who carries out the plan may not be from the same entity. If either the practice or the Service Partner suggests modifications to the Practice Service Plan that results in additional services, additional fees may be incurred. To avoid surprises, ask questions – stay engaged and informed. Additional services may be exactly what are needed, but additional costs should not be a surprise. If the practice has questions about proposed costs or unexpected fees, talk with the Service Partner. If reasonable accommodation is not possible, escalate to the REC.

RECs are organizers

They are connected to events and resources in the local community. Health information exchange connections were mentioned above.

Another important connection is with local community colleges educating an information technology-savvy workforce.

Does the practice/clinic have open positions that need to be filled and want to increase the HIT skills in your practice/clinic? Talk with your REC about interns who may be available through the new workforce development programs. New graduates are emerging from six-month programs and looking for opportunity to advance the use of HIT in settings of all types. These programs may also be a great fit for your existing staff members who wish to grow in their ability to support the practice/clinic. The REC can tell you more.

Sharing Learning

Being part of a movement can be exciting. Connecting with peers on the same journey can make the process less scary and provide opportunity for sharing practical tips and great discoveries. RECs should be able to facilitate providers collaborative learning.

Being siloed is no fun. With the increasing use of hospitalists and lost camaraderie of the physicians' lounge, many primary care physicians find their ability to interact informally with their peers about clinical matters more limited than they would like. The REC programs create a new venue for exchange of ideas among clinicians and staff from many settings. Physicians are encouraged to ask the REC about

how it can help connect them to others for sharing experiences and ideas during this important journey.