Working With an REC

Chapter FastFACTS

1. **RECs help practices set goals, determine needed changes in office workflow, and select and implement EHR systems.**
2. **Federal funding covers 90% of an REC's fees.**
3. **The REC program has been extended through the end of 2014.**
4. **Some RECs are responsible for entire states, others for sections of states or particular metropolitan areas.**
5. **Practices can either choose a product from the REC's preferred list (if it has one) or make their own evaluation of other vendors and products.**

There's good news for primary care physicians: HITECH doesn't stop at funding EHR incentive payments and HIEs. It also allocates more than $600 million to organizations called Health IT Regional Extension Centers (RECs), specifically to help small primary care practices set EHR goals, select an EHR, implement needed changes in office workflow, and achieve meaningful use.

Whether you're just starting to look into EHRs or trying to figure out how to reach meaningful use with your existing EHR, check first with the REC in your area. (Visit *http://healthit.hhs.gov/programs/REC* for more information.) This chapter will explain RECs and factors to consider in working with them. For one example, see "Going Live: One Practice's REC Experience."

Reducing Your IT Spending

Because federal funding covers 90% of the cost of their services, RECs are a bargain for smaller practices, which are receiving subsidized services because they are generally less able than larger ones to afford their own IT people or to piggyback their EHR efforts with a hospital. For example, instead of spending $10,000 on vendor implementation services or a traditional IT consulting firm, a practice might pay only $1,000 out of pocket.

It's difficult to generalize about how much REC services will cost, because each one sets its own fee structure. A survey of 46 RECs was released last September by the eHealth Initiative, an independent not-for-profit group that promotes health IT. At that time many RECs were still in the planning stage—18 of the respondents hadn't yet signed up any physicians for their services. The survey showed a wide range of estimated fees. Only one REC expected to be charging practices more than $1,600 per year, and five thought their average fee would be between $100 and $400 per year.

Some aren't charging physicians anything. For example, in North Dakota, the state is picking up the rest of the tab. The REC serving New Hampshire, which has several sources of funding other than its HITECH grant, is absorbing the physicians' 10% as an "in-kind" donation. Read about one purchasing idea at "AMA Pilots EHR Service."

The bargain won't last forever. Originally the 90-10 arrangement was scheduled to run until 2012. At that point, practices using REC services would have seen their share of the cost jump to 90%. But, acknowledging that most physicians haven't even signed up for REC services, let alone achieved meaningful EHR use, HHS has extended the original arrangement to the end of 2014. HHS also allocated the program an additional $32 million to help the RECs sign up providers for their programs. Some have a form on their Websites that practices can fill out to sign up for services. While all RECs are required to give discounted services to small primary care practices, they're free to help all sizes and types of medical practices. They may charge "list price" to providers who fall outside their discount guidelines.

But even low-cost assistance is no bargain if the people helping you aren't competent. How do you know whether your REC

Going Live: One Practice's REC Experience

Even if your practice has some in-house IT expertise, working with an REC is invaluable, says Kallanna Manjunath, MD, a pediatrician with Whitney Young Health Center in Albany, N.Y. Its REC, the New York e-Health Collaborative, is helping the practice upgrade its EHR and overhaul its office procedures to achieve meaningful use. A local health plan is paying the REC fee. Dr. Manjunath says because the REC's consultants are very familiar with his practice's EHR software and have worked with practices of many sizes and types, they can identify specific areas for improvement much more quickly than the practice would be able to on its own.

Dr. Manjunath offers specific advice if your practice is considering an REC: Find out what level of training the REC is willing to commit to, how quickly it will be able to respond to calls for help once the system is live, and how much experience its personnel have with day-to-day medical practice. "[The REC consultants] have to understand the workflows in order to give meaningful advice," and academic training is no substitute for having worked in an office environment, he says.

Even with the REC's help, Whitney Young's staff is putting in plenty of time with its new system, Dr. Manjunath says. "It's not like buying Microsoft Office, installing it in the morning, and not seeing any changes to your practice flow," he says. "You have to take the time to become proficient. The more time you invest in workflows, templates, order sets, and training, the more benefit you'll get."

knows what it's doing? Where did they come from? There's no single answer. Currently 62 RECs are authorized. Some are responsible for entire states, others for sections of states or particular metropolitan areas. (A complete list of RECs is available at *http://healthit.hhs.gov/portal/server.pt?open= 512&mode=2&objID=3519*.) They've been allocated anywhere from $3.6 million (Alaska) to $44 million (Pennsylvania, in two separate grants) to help providers with needs analysis, system selection, contract negotiation, implementation, training, and achieving meaningful use. Collectively, their mandate is to help at least 100,000 physicians, and the federal grants average approximately $5,000 per physician.

Many, like those in Minnesota and Pennsylvania, are offshoots of their state's Medicare Quality Improvement Organization (QIO). Others, like the Massachusetts eHealth Collaborative and

the Colorado Regional Health Information Organization, are also the home of state or local health information exchanges. Some have helped physicians implement EHRs as part of the Medicare DOQ-IT program, an earlier federal initiative that ended in 2008. Some are based at universities; others are independent not-for-profit organizations. Some are staffing up to provide the necessary help, while others may use consultants as subcontractors.

"Some RECs are poised to do good work and some aren't," Dr. Waldren says. Certain RECs launched Websites and began signing up practices for their services shortly after the contracts were awarded. Others took several months to develop an online presence, and even now don't keep their information updated.

The Regional Extension Assistance Center for Health Information Technology (REACH), the REC for both Minnesota and North Dakota, is among the experienced ones. One of its collaborating organizations, Stratis Health, is the QIO for Minnesota and was involved in DOQ-IT. However, Dr. Kleeberg, its clinical director, says even RECs that do not have the same strong foundation are worth a look, especially considering the federal subsidy. "Because we're not competitive with each other, we're very willing to share tools and knowledge and experience," he says. "Those that weren't fully prepared to start with, are rapidly ramping up."

What to Expect From Your REC

Dr. Kleeberg says half his organization's work occurs before a practice has even selected a vendor: assessing readiness, clarifying values, setting goals, documenting office workflows, and identifying ways the clinic would like to see the EHR improve their practice. The REC consultant's job is to show the way and work with your own IT staff if you have one (see "Growing the Health IT Workforce") rather than doing all the work. For example, he or she might analyze how the work flows for one task, then project how that workflow may change with an EHR. The practice's staff does the same analysis on its other tasks.

The REC should offer a full spectrum of aid through the achievement of meaningful use. Most practices need more help with EHR implementation than they can get from their software vendor. "There's a tendency to think that your vendor will do

AMA Pilots EHR Service

The American Medical Association (AMA) is piloting a service in Michigan, called "AMAgine," that offers three different meaningful use-certified EHRs—Nextgen Ambulatory EHR, Quest Diagnostics Care360, and Ingenix Caretracker—via the Internet.

The service piggybacks on a portal developed by the Michigan State Medical Society (MSMS) for its members. A basic membership ($149 a year for AMA members) gives users the premium version of the Epocrates online drug database, the clinical decision support tool Harrison's Practice, the Isabel diagnosis checklist, patient education materials, safety updates and alerts, access to *JAMA*, AMA's Archives Journals, AMA Morning Rounds, and HIPAA-compliant secure e-mail.

For additional fees, subscribers can get an EHR readiness assessment and product recommendations, and can purchase their EHR through AMAgine if they choose one of the products it offers. It may not be any cheaper than if you purchased directly from a vendor, but the AMA connection potentially gives you more clout, says Virginia Gibson, director of subsidiary services for the MSMS and manager of the AMAgine pilot. "If you're a small practice, you're just a small voice; but if you go through the portal, you'll have the AMA backing you when you talk to the vendors."

If you're from Michigan, or merely curious, visit *getstarted.amaexchange*.org to learn more.

everything, but they don't—they sell software," says Mr. Tripathi of the Massachusetts e-Health Collaborative (MaEHC), which due to a complex series of events is the REC for New Hampshire rather than Massachusetts. Mr. Tripathi says his organization can provide "end to end" support—from help with accomplishing meaningful use if a practice already has an EHR, to overall project management services for practices that are starting from scratch. Dr. Kleeberg says the same is true for his organization. In Minnesota, which has one of the highest rates of physician EHR use in the country, most of the REC's work focuses on helping practices optimize their use of existing EHRs in order to achieve meaningful use.

RECs vary in how they approach the heart of the process—vendor selection, contract negotiation, and purchase. The e-Health Initiative survey showed that 28 RECs were planning to have a preferred vendor list, using criteria such as total cost

Growing the Health IT Workforce

In at least one respect, HITECH seems likely to outdo itself as an economic stimulus measure by creating more jobs than there are qualified people to fill them. The Bureau of Labor Statistics projects much higher than average growth for health IT and medical records jobs—and that's based on the market in 2008, before the ARRA pumped billions of extra dollars into the field.

The HITECH legislation includes an effort that should eventually make it easier to find qualified IT help by creating or expanding existing health IT education and training programs. For details, go to *healthit.hhs.gov*.

Source: ONCHIT. healthit.hhs.gov.

of ownership over three years, the vendor's willingness to guarantee the ability to achieve meaningful use, and the availability of local support. Appearing on a "preferred" list doesn't necessarily mean the vendor offers better pricing—just that the REC has vetted the product. It may also mean that the REC has staff or contractors who are familiar with that product; some RECs charge more for their services if a practice chooses a product that's not on their list. Practices don't have to choose a vendor on the REC's preferred list; but if they don't, they have to make their own evaluation of other vendors and products.

Not all RECs have preferred vendor lists. For example, Dr Kleeberg says his organization doesn't, because most of the clinics in its market already have a short list of products they're interested in, and consequently the REC did not believe making its own list would be worthwhile. However, it will provide practices with guidance to determine which products are certified and assist them in finding the product that meets their specific needs. "Then we help them with the vendor contract to make sure both sides are getting a fair deal," he says. "You don't want an adversarial relationship with your vendor."