REGIONAL EXTENSION CENTERS

Where are they and where are they going?

By David Hartzband, D.Sc.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 authorized a Health Information Technology Extension Program, comprising a national Health Information Technology Research Center (HITRC) along with Regional Extension Centers (RECs) under the jurisdiction of the Office of the National Coordinator (ONC) for Health IT. The RECs are intended to support provider adoption and meaningful use of electronic health records (EHRs).

Regional Extension Centers are loosely patterned after the Department of Agriculture's Cooperative Extension Service Program, an educational program designed to facilitate access to research-based information to help the farm community improve its agricultural capabilities. As explained by a farmer in Athens County, Ohio, "The extension agents were people who had farmed the land right here and could tell from looking at the dirt and the streams what the problems might be and what to do about fixing them."

The ONC's REC program, however, differs from the agriculture program in both structure and emphasis. Regional Extension Centers are not-for-profit entities chartered by law to:

- Provide education, outreach and technical assistance to help providers in a specific geographic service area select, successfully implement, and meaningfully use certified EHRs, and
- Support provider efforts to achieve, through appropriate available infrastructures, exchange of health information in compliance with applicable statutory and regulatory requirements, and patient preferences.[1]

A total of 62 RECs have been funded to date. Most cover a single state, while several cover multiple states, and five states (California, Texas, New York, Pennsylvania, and Illinois) support multiple, non-overlapping RECs in specific regions. Several are associated with universities or academic medical centers. While all have a common mandate, they each have different models for staffing and community relationships.

There is no comprehensive evaluation of the REC program, but some information is available to understand the effectiveness of RECs in meeting their mandate of supporting all providers – especially small practices, those that may lack resources to implement and maintain EHRs, and safety net providers – to become meaningful users of HIT and qualify for Medicare and Medicaid incentive payments.[2]

Findings from the "2010-11 Readiness for Meaningful Use of HIT and Patient Centered Medical Home Recognition Survey," released in November by the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, indicate that 48 percent of health centers are currently involved with a Regional Extension Center while 16 percent are in discussions with a REC.[3]

The recent eHealth Initiative (eHI) 2011 Survey of Regional Extension Centers focuses on the operations, marketing and sustainability of the operational RECs. With respect to their role in facilitating the selection of appropriate HIT, the survey found that approximately two-thirds of 39 responding RECs had used an RFP process to define a list of recommended or preferred EHRs.[4] Most of the RECs planned to select five or more recommended vendors, giving providers a broad choice of vendors but requiring that a recommended vendor product be adopted.

For the group that did not use an RFP, 42% indicated they would support only providers who adopted a product certified by one of ONC's Authorized Testing and Certification Bodies (ACTBs), while 35% reported they would offer services to those providers who had not already selected an EHR, but would require them to use an ACTB-certified product.[5] Six RECs, or 19% of 31 responding to the question, reported that 50% or more of the community health center providers in the service area had signed agreements with the REC. Another 11, or 35%, reported that between 20% and 49% health centers had signed agreements.[6]

A key evaluative measure to help understand the effectiveness of the RECs is the number of providers who have qualified for meaningful use incentive payments. With no direct data yet publically available, this requires some "reading between the lines."

The Centers for Medicare and Medicaid Services (CMS) has published data indicating that over 114,000 eligible professionals, eligible hospitals, and critical access hospitals had registered in the Medicare and Medicaid EHR Incentive Programs through September 2011.[7] Further, the states with the highest level of incentive payments to Medicare and Medicaid providers through October 2011 are Texas and Louisiana, with total payments of $75,000,001, followed by Oklahoma, Ohio, Kentucky and Michigan, with payments of $ 50,000,001 - $75,000,000.[8]

Other data show that large provider entities outrank smaller ones in qualifying for and receiving payments. An August 2011 report on HIT trends by Circle Square, Inc. shows that 76% of practices with more than 25 physicians have already adopted EHRs, a baseline requirement for incentive payment, as compared with 51% of practices with 3 to 5 physicians, and 42% of two-physician practices.[9]

Summarizing their recent survey, the College of Healthcare Information Management Executives (CHIME), which represents members at hospitals nationwide, reports that in September 2011, just under 25% of community hospitals had qualified for incentive payments in this fiscal year as compared with 33% of hospital/clinic model practices, and 32% of academic medical centers.[10] While the contribution of Regional Extension Centers isn't easily quantifiable, it seems that larger providers, rather than the smaller ones the RECS are intended to assist, still dominate the field of those who have received payment.

Federal funding for RECs runs out after four years (2013), at which point the RECs are expected to be self-sustaining. Yet as with Health Information Exchanges, it appears that sustainability is a real issue for RECs, and fee schedules for REC services reflect their challenge in remaining viable. As reported by eHi, 67% of the 21 reporting RECs indicate they charge a[11] flat-fee while 16% said they charge either a per-hour fee or use a subscription model with tiered services.

So what does all this mean for health centers? Is aligning with a Regional Extension Center as a resource for EHR selection and meaningful use qualification a "no-brainer' for community health centers with limited resources?

As previously noted, RECs typically elect to support a small number of EHRs, or in some cases a single recommended EHR. We know that health centers have unique functional requirements for EHRs, and HIT in general, and therefore the adoption of an EHR, even if it has already been selected by the REC, needs to be vetted very carefully. Health centers should conduct careful and informed due diligence to be sure the REC supported product meets the center's needs.

Further, to date, community health centers report varied experience with RECs. Of those health centers responding to the recent HIT readiness survey, 40% were receiving some form of technical assistance from Regional Extension Centers.[12] Responding to the question, "How helpful is this REC collaboration in advancing your efforts to achieve Medically Underserved (MU) status?" – one half of those engaged with RECs reported that the REC was either "helpful" (23.7%) or "very helpful" (25.2%). Over a quarter reported that their REC participation was "not helpful yet, but potentially helpful" (26.7%[13]). With little data to go on, it is unclear that RECs can help expedite and smooth the path to MU qualification. That being said, RECs can be a resource for both EHR selection and meaningful use qualification.

The purpose of RECs is to help provide assistance to a broad range of providers and help level the playing field toward EHR adoption and meaningful use. Primary care associations and/or health center controlled networks are also a significant resource.

RECs will have to develop sustainable models in order to remain relevant once federal funds run out. The fee-for-service model intended by some RECs to achieve sustainability will add a cost burden for health centers and other providers. This necessitates new models focused on collaboration and partnerships with vendors and with state agencies and entities that can provide both support and expertise.

While it appears that RECs may need to mature further, foster tighter relationships in order to support providers locally and make available IT people who can "look at the dirt," they are one resource that can assist health centers in making their way down the MU path.

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1. *eHealth Initiative, 2011 eHI Survey of Regional Extension Centers, http://www.ehealthinitiative.org/, p.3*
2. *The Office of the National Coordinator for Health information Technology, "Get the Facts About Regional Extension Centers," http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=1835*
3. *Cunningham, M., Lara, A., and Shin P. "Results from the 2010-11 Readiness for Meaningful Use of HIT and Patient Centered Medical Home Recognition Survey," Geiger Gibson/RCHN CHF Research Collaborative Policy Research Brief No. 27, November, 2011, p. 48*
4. *eHealth Initiative, 2011 eHI Survey of Regional Extension Centers, http://www.ehealthinitiative.org/, p.10*
5. *Ibid*
6. *eHealth Initiative, 2011 eHI Survey of Regional Extension Centers, http://www.ehealthinitiative.org/, p.9*
7. *State Breakdown of Registration by Medicaid and Medicare Providers through September 2011., https://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp#TopOfPage*
8. *"State Breakdown of Payments to Medicare and Medicaid Providers through October 6, 2011", https://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp#TopOfPage*
9. *HIT Trends, August 2011 http://www.circlesquareinc.com/home.html, p.3*
10. *"Quarter of CHIME Healthcare CIOs Report Their Organizations Have Qualified for Stimulus Funding" http://www.cio-chime.org/advocacy/CHIME_MU4_Survey_Report.pdf, p.5*
11. *eHealth Initiative, 2011 eHI Survey of Regional Extension Centers, http://www.ehealthinitiative.org/, p.14*
12. *Cunningham, p. 56*
13. *Cunningham, p. 48.*