



# Steps to Group Purchasing of an Electronic Health Record System

LIFE **40**  
AFTER

National  
**Family Planning**  
& Reproductive Health Association



# Steps to Group Purchasing of an Electronic Health Record System

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**LIFE 40**  
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# Table of Contents

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<b>Introduction .....</b>	<b>1</b>
<b>About Indiana Family Health Council .....</b>	<b>2</b>
<b>Getting Started .....</b>	<b>2</b>
Working with Regional Extension Centers .....	3
Securing Buy-In from Sub-Recipient Agencies .....	3
<b>Selecting a Vendor .....</b>	<b>4</b>
Total Costs .....	4
Funding the Project .....	5
<b>EHR Template Development .....</b>	<b>5</b>
<b>Training and Go-Live Overview .....</b>	<b>7</b>
<b>Lessons Learned.....</b>	<b>8</b>
<b>Conclusion .....</b>	<b>9</b>
<b>Endnotes .....</b>	<b>9</b>
<b>Online Resources for EHR Acquisition .....</b>	<b>10</b>

# Introduction

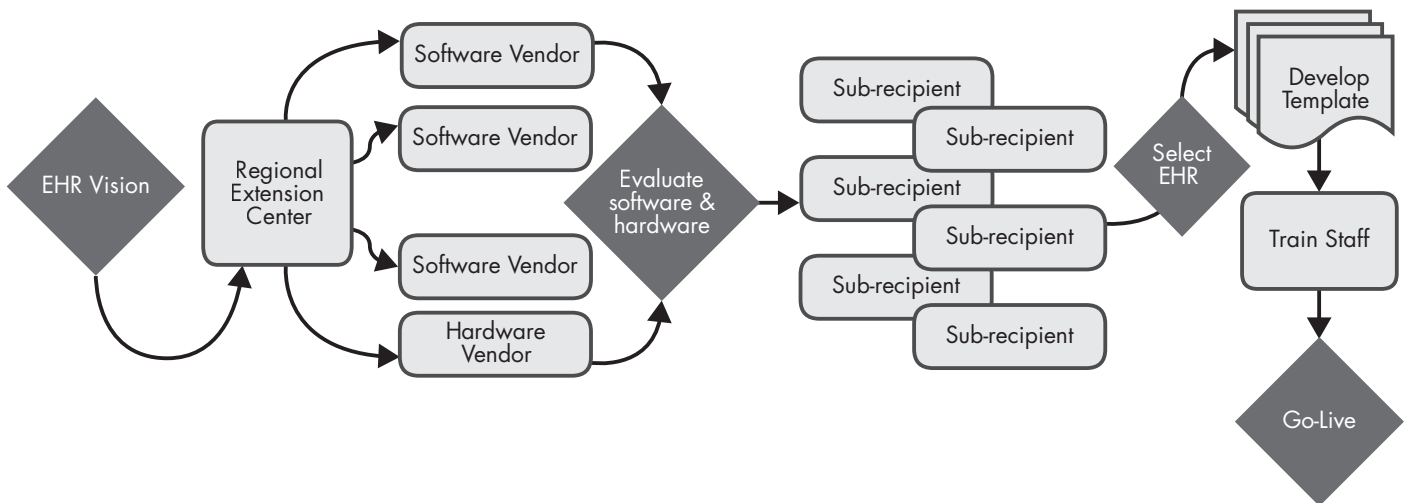
For publicly funded family planning programs, the move from paper to electronic health records (EHR) is a challenging prospect requiring investments of money, time, and expertise. After years of grappling with the costs and logistics of how to make the switch, the good news is that most family planning providers are poised to transition from paper to EHR.<sup>1</sup> Clinical, operational, and administrative efficiencies are just a few of the benefits of EHR. More than anything, EHR adoption improves the quality of care that publicly funded family planning health centers deliver to millions of people who depend on their services.

This case study snapshot can be used to inform your agency through a process of EHR purchasing and customization, using Indiana Family Health Council (IFHC) as a model. IFHC successfully implemented an EHR system for their sub-recipient agencies in 2011-2012. Its purchasing approach involved sub-recipient agencies joining together and buying as a group in order to secure savings. This case study snapshot documents every step

of the process from project planning to customization of the EHR templates, to guide your agency along the continuum of contemplation to action.

Purchasing and implementing an EHR system is a complex process that requires an organized approach. The following diagram breaks down IFHC's process into a series of steps, and is described in detail in the case study snapshot.

**Diagram 1: Overview of IFHC's EHR Process**



# About Indiana Family Health Council

Indiana Family Health Council is the sole Title X grantee in Indiana. It has administered the Title X grant since 1976 and currently distributes Title X funds to 11 sub-recipient agencies, including stand-alone nonprofits and public agencies. The sub-recipient agencies include:

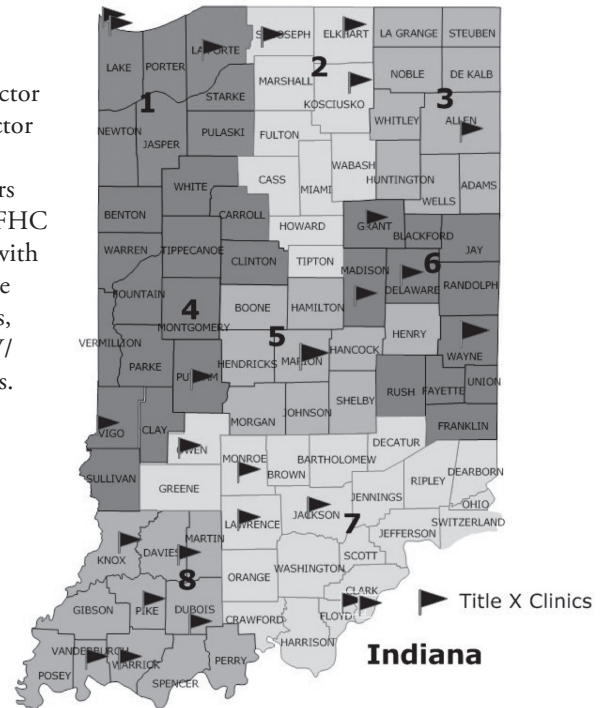
- 3 stand-alone health centers,
- 2 federally qualified health centers,
- 2 community action centers,
- 1 public hospital,
- 1 health department,
- 1 Planned Parenthood affiliate, and
- 1 school of nursing.

The sub-recipients operate 33 health centers and serve more than 45,000 clients annually, offering birth control, STD/HIV testing and counseling, STD treatment, cervical and breast cancer screenings, pregnancy testing, educational materials, and referrals to other health services. Seventy-nine percent of IFHC-supported clients have an annual income

at or below 100% of the federal poverty line, 8% are insured by Medicaid, and 2% are insured by private insurance.

IFHC's staff includes a President & CEO, an Executive Assistant, a Director of Finance, two accountants, a Director of Programs, a Director of Health Services, and three nurse practitioners (two full-time and one part-time). IFHC supports the sub-recipient network with technical assistance, quality assurance audits, annual clinic audits, trainings, and updates to family planning/HIV/STD protocols, among other services.

**Diagram 2: Indiana's Title X Health Centers**



## Getting Started

IFHC President & CEO, Gayla Winston, recognized that her family planning network faced a host of challenges related to changes in health care delivery brought about by the Affordable Care Act (ACA), particularly the EHR piece of the law.<sup>2</sup> Gayla wrestled with the prospect that some of the sub-recipients in the network would not survive even a few years if they did not adopt EHR.

Attending EHR sessions at NFPRHA's National Conference and regional meetings was enough to convince Gayla to move all sub-recipients toward concrete plans to acquire EHR. The diversity of sub-recipients within the IFHC network required different EHR solutions for different agencies. Those

sub-recipients that existed within large organizations such as hospitals, Planned Parenthood health centers, and community health centers, benefited from these affiliations as the larger organization was responsible for providing EHR solutions. The remaining sub-recipients faced steep costs without support from

a larger organization to acquire their own EHR system.

IFHC's first step was to establish an EHR project team that included representation from clinical and administrative staff, to ensure the project took into account their respective needs. The EHR project team included staff from both the sub-recipient agencies and IFHC. Participants included the directors from the participating sub-recipient agencies and, in addition to Gayla, IFHC's Director of Finance, Director of Health Services, and Clinical Program Consultant.

## Working with Regional Extension Centers

As the project group was forming, IFHC received a memo from the Office of Population Affairs advising Title X grantees to contact their Regional Extension Center (REC) for assistance with EHR adoption. Indiana Health Information Technology Extension Center (I-HITEC), the extension center in Indiana, was created to assist Indiana health care practices select, implement, and meaningfully use EHR. I-HITEC offered consulting and training services, including vendor selection and implementation assistance, meaningful use action plans, and go-live monitoring. IFHC contacted I-HITEC and arranged a meeting between a few members of the project team and I-HITEC staff. During the meeting, IFHC presented information about its sub-recipient agencies, the services they provide, and the patient population they serve.

RECs have a federal mandate to support providers' acquisition of EHR, especially safety-net providers that may lack resources to implement and maintain a system. Historically, however, family planning has fallen to the bottom of requests for technical assistance given that family planning agencies are typically small and have few sites. RECs prioritize their resources to agencies that have multiple sites covering wide geographic service areas to meet their grant

requirements for the number of practices they assist in EHR adoption. IFHC found a seat at the table by presenting a statewide network of health centers that would be part of the EHR project.

IFHC entered an agreement with I-HITEC to provide assistance in researching and recommending an EHR certified for meaningful use, negotiating discounts with vendors, and creating a project timeline with milestones for implementation. The total cost to IFHC for I-HITEC's services was \$3,750.

## Securing Buy-In from Sub-Recipient Agencies

Initially, the transition from paper to EHR was met with some resistance from the sub-recipient agencies. The sub-recipient directors understood the viability arguments for adopting EHR, and at least one sub-recipient agency had evaluated EHR systems at its own initiative; however, the cost of adopting EHR was a significant barrier. To assist sub-recipient agencies move beyond discussion and into action, IFHC pledged to pay for the EHR project, specifically the acquisition and implementation costs. Six sub-recipients, with a total of 13 health centers, chose to participate in the EHR project, whereas the remaining sub-recipients had previously established EHR systems.

Recognizing that EHR implementation would impact clinic systems and workflow, IFHC leadership promoted the operational and clinical benefits of EHR to get sub-recipient agency staff on board with the project. The following table highlights some benefits of EHR that IFHC found useful to promote when talking to staff at the sub-recipient agencies.

IFHC also needed to address the concerns of clinical and administrative staff about how the switch to EHR would impact the way they perform their jobs. Footing the bill for the EHR system and telling the sub-recipient agency staff – the ultimate users of the EHR – all the benefits of a new system was not enough to ensure buy-in. IFHC believed it was important that the clinical and administrative staff understood the impact these changes would have on their work. IFHC addressed the end-users' concerns by seeking and incorporating agency-specific clinical and administrative input in the selection and design of the EHR system.

**Table 1: EHR Benefits to Promote to Staff**

### EHR Benefits to Promote to Staff

- Immediate record access, regardless of service location
- Software prompts and reminders to enhance documentation, completeness, and quality
- Easier physician review of medical records for clinician collaborative practice agreement requirements
- Faster and more efficient billing submission and reimbursements
- Future mandate for government-provided health care reimbursement
- Potential increased income from meaningful use payments

# Selecting a Vendor

As described earlier, IHITEC managed the task of researching EHR systems and compiled recommendations that would be a good fit for the IFHC network. The technical expertise provided by IHITEC was critical to the success of the project. Most EHR systems for sexual and reproductive health are built for OB-GYN practices, not for specialized family planning providers. IFHC knew from the beginning that they would need to customize the templates in the EHR system they chose in order to meet the needs of the sub-recipient agencies. A preliminary needs assessment of the sub-recipient agencies was conducted to identify software priorities. The assessment revealed the top three priorities: ease of use, dependability, and cost-effectiveness.

In addition, they wanted the EHR software to facilitate collecting data for their grant requirements, and to facilitate timely and accurate reimbursement from Medicaid and private insurance.

With the assistance of IFHC, I-HITEC prepared a request for proposal (RFP) to send to EHR vendors. The RFP gave vendors information about the IFHC network, workflow challenges, and requirements for EHR functionalities. I-HITEC reviewed the proposals and narrowed the field to three software vendors that met IFHC's minimum requirements. IFHC eliminated one vendor because

their charges were based on a percentage of collections and invited the other two vendors to meet with the EHR project team and demonstrate their product. The EHR demonstrations required 2-3 hours, and were attended by the sub-recipient directors and IFHC staff. The table below lists some questions IFHC asked when evaluating the software vendors.

## Total Costs

IFHC selected iSalus to be the EHR software vendor as their package included electronic medical records, scheduling, and billing. The EHR was a web-based system, which was a better option for

IFHC because web-based systems are less costly and less complex to implement than a client-server model. IFHC was aware that the start-up cost associated with EHR implementation was a significant barrier for its sub-recipients. This was true even though the fees associated with the project seemed modest compared to the estimates heard from the field. The iSalus software cost \$11,000 to set-up, and \$4,800 per full-time employee (FTE) per year for subscription costs. The yearly subscription fee totaled \$49,800 per year across the sub-recipient agencies. If funding permits, IFHC will cover each sub-recipient agency's yearly \$4,800 subscription fee per FTE to maintain their EHR.

IFHC selected iSalus' recommendation, Health Dynamix, as the hardware and networking vendor for their EHR system. The EHR software needed a secure and reliable hardware foundation with sufficient speed, bandwidth, and storage to run optimally. In order to determine the existing hardware's capacity to support the iSalus package, Health Dynamix surveyed the sub-recipient agencies to inventory hardware, wiring, connectivity, and the health center space. As is typical of many publicly funded programs, the sub-recipient's hardware varied from health center to health center, and equipment was at different stages of the life cycle. IFHC decided to purchase new hardware across the network in order to minimize problems and maintenance costs that happen with older computers, and so the iSalus software could run identically across the health centers. The total cost of hardware, connectivity, installation materials, and maintenance support was \$91,000. Each health center received new equipment including two tablets with docking stations, a desktop, a printer, and a scanner. The following diagram breaks down the EHR costs into hardware and software costs in the first year of the project.

**Table 2: Questions to Ask When Selecting a Vendor**

Questions to Ask When Selecting a Vendor
<ul style="list-style-type: none"><li>• Is the EHR system designed specifically for family planning?</li><li>• How many family planning agencies use the software? How may we contact them?</li><li>• What training and support does the company offer?</li><li>• Is the system web-based or a client-server model?</li><li>• Can data fields be customized?</li><li>• What are the functionalities?</li><li>• What types of reports can the system generate?</li><li>• Will the EHR system convert to ICD-10?</li><li>• How many years of EHR implementation experience does the company have?</li><li>• What are the acquisition, implementation, and maintenance costs? Other recurring and non-recurring costs?</li></ul>

**Table 3: IFHC’s EHR Costs**

Total Cost in the First Year	
<b>IT Contractor</b>	
• IHITEC .....	\$3,750
<b>Hardware – Health Dynamix</b>	
• Desktop .....	\$10,950
• Tablets, docking stations.....	\$48,813
• Routers.....	\$1,690
• Firewall.....	\$10,950
• Scanners .....	\$5,739
• Printers.....	\$4,141
• Hardware installation .....	\$8,402
<b>Software – iSalus</b>	
• Subscription .....	\$49,800
• Customization, training .....	\$11,000
<b>Total .....</b>	<b>\$155,235</b>

## Funding the Project

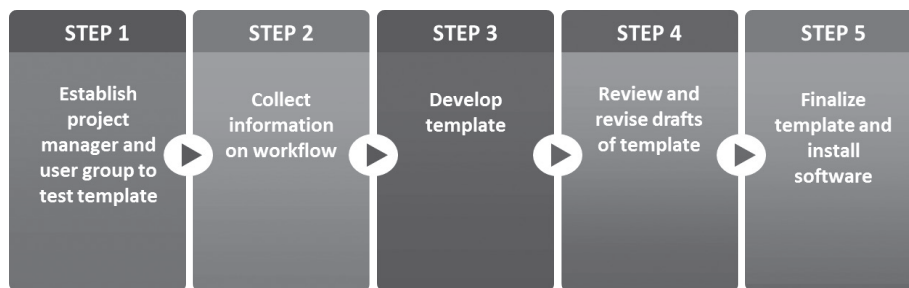
IFHC and the sub-recipients shared some of the costs associated with EHR implementation, although IFHC funded the majority of the project. The sub-recipients paid only the costs associated with internet services at their health centers and any additional IT staff time needed to support installation. Expenses associated with software development, the deployment of new hardware including set-up and customization, subscription, and training were assumed by IFHC.

IFHC was able to provide this financial assistance using under-spending from its Title X grant. IFHC’s agreement with their sub-recipient agencies stipulates that Title X funds not used within a designated timeframe will be refunded to IFHC. The money returned to IFHC was nearly \$200,000 and a request for purchase was submitted to and approved by Office of Population Affairs to allow the use of these funds for the EHR project.

# EHR Template Development

Once the EHR hardware and software were selected and purchased, the next step was to develop the family planning templates. For IFHC, template development was a five-step process as illustrated in the following table.

**Diagram 3: EHR Template Development**



## Step 1: Establish Project Manager

IFHC’s success in implementing the EHR system relied heavily on having a project lead to manage the day-to-day coordination with iSalus and Health

Dynamix and to keep the staff and sub-recipients up-to-date on the progress of the project. The Clinical Program Consultant was a natural fit for this position. Her background as a Women’s Health Nurse Practitioner gave her the

ability to evaluate the EHR from a user perspective and identify functionality needs for clinicians that an IT expert may not recognize. Since the clinical and administrative staff would be deeply involved in EHR implementation at the health center, each sub-recipient identified one clinical and one administrative representative to be part of the template development process. Including sub-recipient staff not only established participant ownership over the change process, but it ensured the EHR was designed from a user perspective, not an IT perspective.

## Step 2: Collect Information

The next step was to gather information from the sub-recipients about their client visit forms, such as initial and annual forms. Each sub-recipient submitted their forms and the Director of Health



Services and the project manager created a universal form. The project manager held a conference call with the sub-recipients to obtain feedback and then made revisions to the form.

### Step 3: Develop Template

The finalized client visit form was sent to iSalus for development into a template. It took three months to develop templates that suited clinical care needs and FPAR data needs. To keep the lines of communication open through the process, the Director of Health Services and the project manager held weekly meetings with iSalus.

### Step 4: Revise Template

The first round of the family planning templates were developed for presentation to the sub-recipient agencies. The project manager scheduled a webinar that allowed the sub-recipients to see the screens as the iSalus developer walked through the template. During the demonstration, the sub-recipient agencies identified areas for improvement about the flow of the templates related to entering clinical notes. The iSalus developer used the feedback to revise the template. The project manager scheduled a second webinar with iSalus and the sub-recipient staff to review the new templates and a second round of input was collected.

### Step 5: Finalize Template and Install Software

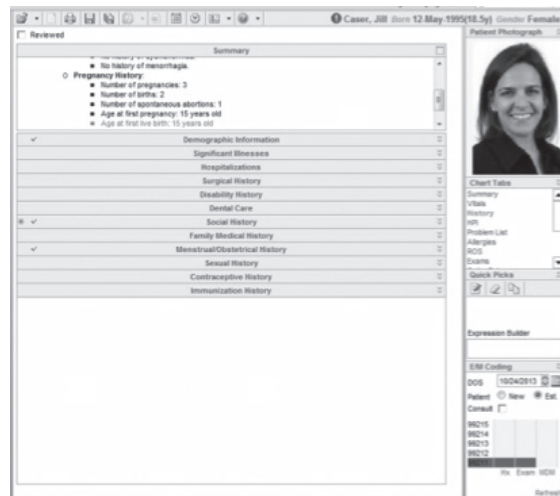
A second round of revision was made to the templates and the templates were finalized. The following diagram shows the family planning templates which were designed and set up in order of patient encounter.

Once the software was finalized, Health Dynamix, the hardware company identified through iSalus, managed the software installation on the desktops and tablets and coordinated with the sub-recipients directly to install the computers, tablets, scanners, and printers.

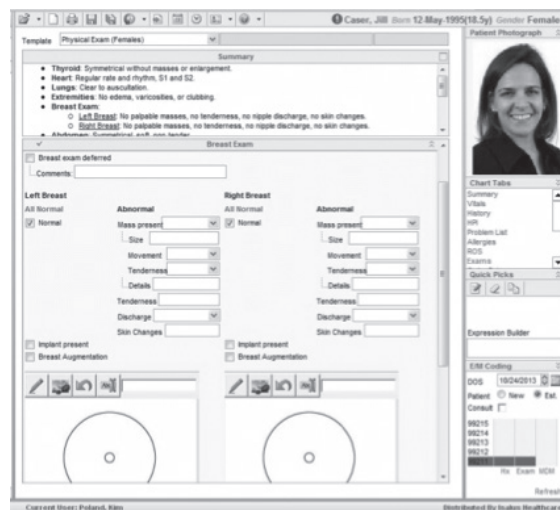
## Diagram 4: Family Planning Templates



Patient Timeline



Patient History Intake Form



Female Exam

Source: Family Planning Template, iSalus Health Care<sup>3</sup>

# Training and Go-Live Overview

Once the EHR system was customized and installed, the next step was to plan the EHR trainings for sub-recipient staff. During EHR roll-out, productivity dips largely due to the learning curve experienced by staff with the new software. In order to minimize health center disruption, IFHC dedicated three days of training when iSalus software experts trained super-users from each agency, who would in turn train their staff. The following table provides a checklist for planning training on a new EHR system. The trainings were held at the IFHC office in Indianapolis, and each day focused on a different module:

- Day 1 - device setup, EHR dashboard, communication, client scheduling, and help menu
- Day 2 - billing dashboard, receipts analysis, account inquiry, claim filing, statements, payment posting, balancing, reports, and administrator functions
- Day 3 - electronic medical record

Go-live refers to the first day the system will be used at the health centers. IFHC expected the go-live day to slow down health center operations and decrease patient load as staff got accustomed to the EHR system. IFHC planned an aggressive roll-out schedule, with one agency going live at a time, over the period of one month. On the go-live date, the sub-recipient health center had an IFHC clinical program consultant and iSalus implementation specialist on location to provide support and technical assistance. The following tables provide a training planning checklist and a go-live planning checklist.

**Table 4: Planning Checklist for EHR Training**

Planning Checklist for EHR Training
<ul style="list-style-type: none"><li>• Identify trainer</li><li>• Set date(s) for the training sessions</li><li>• Outline the topics to be covered with the trainer, including hands-on, task-oriented sessions tailored to staff responsibilities</li><li>• Identify trainee group</li><li>• Assess trainee group's knowledge of coding, billing, and claims filing</li><li>• Develop the agenda, including plenty of breaks, and distribute to trainee group</li><li>• Prepare training handouts and manuals</li><li>• Set up appropriate training space and A/V requirements</li><li>• Place lunch orders for training days</li><li>• Develop evaluation form</li><li>• Schedule staff on-the-job learning time to practice the system</li></ul>

Source: EHR Training Tips, Iowa Foundation for Medical Care<sup>4</sup>

**Table 5: Go-Live Planning Checklist**

Go-Live Planning Checklist
<ul style="list-style-type: none"><li>• Set date(s) with health center and vendor for go-live launch</li><li>• Test systems<ul style="list-style-type: none"><li>◦ Network connectivity</li><li>◦ Hardware – computers, tablets, printers, scanners, servers, etc.</li><li>◦ Software – screens, templates, reports, etc.</li><li>◦ Interfaces – lab, billing, etc.</li><li>◦ System backups</li></ul></li><li>• Check that workflow and process improvements are in place</li><li>• Develop go-live day schedule and review with staff</li><li>• Develop escalation procedure to follow in event of problem</li><li>• Develop downtime procedures and have paper copies of all forms available in the event of system failure</li><li>• Review EHR policies and procedures</li><li>• Perform a system walk through with staff of patient visit beginning to end</li><li>• Adjust staff schedules to have a lighter patient load than normal</li><li>• Schedule a mid-day check-in and end-of-shift debrief to address any issues</li><li>• Post signs and notify patients of go-live date to request patience for delays</li></ul>

Source: EHR Implementation Go-Live Planning Checklist, National Learning Consortium<sup>5</sup>

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# Lessons Learned

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An EHR project is a major undertaking, with project timelines that can take 12-18 months from vendor selection until implementation is complete. There is no such thing as too much planning when it comes to EHR implementation. Many lessons and advice emerged from IFHC's experience that can inform your agency's EHR strategy.

## Promote staff buy-in

Even if all agree that change will result in overall improvements, there will be resistance. Sub-recipient agency staff recognized EHR was necessary to both provide better services and keep their health center doors open, but many were concerned about the operational inefficiencies during roll-out and the time it would take before clinicians could see their full client load. IFHC promoted the operational, administrative, and clinical benefits of EHR to keep staff encouraged especially during the learning curve. Making sure staff understands the motives for change and keeping them engaged in the planning, set-up, and implementation is vital to success.

## Take into account staff needs

Given that clinical and administrative staff will be using the system daily, it is critical that the template development takes into account their needs. Having staff participate in the design and revision of the EHR template ensured the EHR was set up to follow the order of a patient encounter. Staff input established ownership over the change and ensured their functionality needs were included.

## Get a detailed contract

Have a detailed contract with the vendor with timelines for each deliverable. IFHC was told sliding fee-scale schedule would be one of the functionalities in their EHR system, however it was not included initially, and it was not until a year after implementation when the sliding fee-scale functionality was complete and available to IFHC. The importance of a contract that establishes the deliverables and costs cannot be underestimated.

## Centralize technical assistance

Identify a project lead to champion the EHR implementation. Having a central point of contact to manage the day-to-day coordination and to keep others up-to-date eases the anxiety that comes with EHR implementation. When IFHC sub-recipients had an issue with the software, they directed their questions and concerns to the project manager, who in turn, communicated the issues to the iSalus representative. Centralizing technical assistance system ensured that changes at one agency were extended to all of the agencies. It also made iSalus more accountable because they had one point of contact versus multiple contacts across the sub-recipient agencies.

## Train staff on billing and coding

Identify staff's knowledge base on coding, billing, and claims filing before planning the EHR training, and provide additional training to fill in the gaps. Following the go-live launch, it was discovered that more time should have been allotted for billing and coding training for the sub-recipient staff, because much post-implementation time was spent on supporting the staff in these areas.

## Test equipment

Be sure to test equipment, data lines, and internet connectivity prior to implementation. Following the go-live launch, the battery life of the tablets was discovered to be insufficient to get through the health center workday, and therefore new, extended life batteries for the tablets had to be purchased. Sub-recipient staff also identified the speed of scanners to be an important consideration for hardware. Digitizing paper-based medical records is a time-consuming process, and having a high-speed scanner better meets the demands of a busy health center.

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# Conclusion

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Many publicly funded family planning agencies have been putting off EHR implementation. Now, however, impending changes in health care delivery will reward agencies that implement EHR, while agencies that fail to act will be penalized. EHR adoption is a large undertaking, but learning and researching the process is a first, important step. IFHC's experience outlined in this case study snapshot breaks down the EHR adoption process into manageable steps and decisions, with insights that may be useful to other agencies implementing EHR.

## Endnotes

- 1 Jennifer Frost, Jenna Jerman and Adam Sonfield, *Health Information Technology and Publicly Funded Family Planning Agencies: Readiness, Use and Challenges*, New York: Guttmacher Institute, 2012, accessed November 1, 2013, <http://www.guttmacher.org/pubs/Health-IT.pdf>.
- 2 Health Information Technology for Economic and Clinical Health Act (HITECH Act), Pub. L. No. 111-5, 123 Stat. 226 (2009).
- 3 "Office EMR Template Library," iSalus Healthcare, accessed November 1, 2013, <http://www.isalushealthcare.com/Doctors/Customization.aspx>.
- 4 Iowa Foundation for Medical Care, *Not 10, But 11 EHR Training Tips*, accessed November 1, 2013, [http://mhcc.dhmh.maryland.gov/hit/ehrVendors/Documents/www.internetifmc.com\\_/provider/documents/11\\_ehr\\_training\\_tips.pdf](http://mhcc.dhmh.maryland.gov/hit/ehrVendors/Documents/www.internetifmc.com_/provider/documents/11_ehr_training_tips.pdf).
- 5 "EHR Implementation Go-Live Planning Checklist," National Learning Consortium, accessed November 1, 2013, <http://www.healthit.gov/providers-professionals/ehr-implementation-go-live-planning-checklist>.

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# Online Resources for EHR Acquisition

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This is a compiled list of toolkits, websites, issue briefs, and webinars that focus on various EHR purchasing and implementation issues. Family planning administrators and clinicians alike will find useful information in the resources. Visit [www.LA40resources.org](http://www.LA40resources.org) under the “Case Studies” tab for a list of links to the following resources:

1. **Health IT Glossary** - The Office of the National Coordinator for Health Information Technology provides a glossary of acronyms and terms commonly used in health information technology.
2. **Embarking on an Electronic Health Record System: From Thought to Action** – A webinar produced by the Family Planning National Training Center for Management and Systems Improvement that outlines step-by-step how to implement EHR.
3. **Regional Extensions Centers** - Regional Extensions Centers have a mandate to support providers’ acquisition of EHR, especially safety net providers that may lack resources to implement and maintain a system. Learn more about working with RECs at [HealthIT.gov](http://HealthIT.gov) and search for RECs by zip code.
4. **Assembling the Right EHR Project Team** - The Washington and Idaho Regional Extension Center offers tips for how to assemble the right EHR project team, including team member roles and estimates of time involvement.
5. **Certification Commission for Health Information Technology** – A nonprofit organization that inspects health IT products functionality, interoperability, and security.
6. **Request for Proposal Template for HIT** – The Office of National Coordinator for Health Information Technology developed a request for proposal template to assist providers through the vendor selection process.
7. **Workflow Analysis: EHR Deployment Techniques** - The California HealthCare Foundation published an issue brief that describes the stages of workflow analysis, process mapping, and process redesign.
8. **EMR Funding Options** - Healthcare Information and Management Systems Society developed a guide of funding options available for providers seeking to purchase an EHR system.
9. **EHR Demonstration Scenario, Evaluation, and Vendor Questions** – A toolkit produced by the Office of National Coordinator for Health Information Technology that can help providers understand vendor capabilities and ask the right questions during the selection process.
10. **Patient Encounter Data Entry** - The Indiana Family Health Council uses this data entry form for the patient history, services provided, counseling provided, and contraceptive method.
11. **EHR Implementation Checklist** – A checklist from the Illinois Foundation for Quality Healthcare that can be used to help your agency think about the steps needed to implement EHR.
12. **Hardware Survey** - The Indiana Family Health Council has a survey form to assess a health center’s existing hardware and IT infrastructure.
13. **Training Strategies: EHR Deployment Techniques** - The California HealthCare Foundation published an issue brief that describes three approaches to EHR training with insights that may be useful to other health centers planning trainings for staff.
14. **EMR Cheat Sheet** - The Indiana Family Health Council has an iSalus EMR in-house cheat sheet to help staff use the EHR system.
15. **Go-Live Planning Checklist** - Health Information Technology Research Center (HITRC) produced a planning checklist to help your agency think about the steps needed to plan the go-live event.
16. **Getting Meaningful Use Dollars for Your Program** - The Family Planning National Training Center for Management and Systems Improvement produced a webinar on the criteria and benefits around Medicaid Meaningful Use in the context of Title X family planning programs.
17. **Health IT Toolbox** - Health Resources and Services Administration produced videos about a range of health IT issues for safety net providers.

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# About NFPRHA

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The National Family Planning & Reproductive Health Association (NFPRHA) represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured.

NFPRHA serves its members by providing advocacy, education, and training to those in the family planning and reproductive health care fields.

For more than 40 years, NFPRHA members have shared a commitment to providing high-quality, federally funded family planning and sexual health care making them a critical component of the nation's public health safety net. Every day NFPRHA members help people act responsibly, stay healthy, and plan for strong families. For more information, visit [www.nationalfamilyplanning.org](http://www.nationalfamilyplanning.org).