

## COMMENTARY

## Your Second EHR: Is It Time for a Change?

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

With the promise of cash incentives through the American Recovery and Reinvestment Act of 2009 (ARRA), it is not surprising that many practices are finally making the jump into an electronic health record. Selecting and purchasing an EHR can be an overwhelming and expensive undertaking. Making the right choice of products the first time is critical, and no practice wants to have to do it twice.

In spite of this, many offices that chose to adopt an EHR in the past few years are now faced with a serious dilemma: Will their current software meet the demands of tomorrow's medicine? And (almost more important) will it qualify for the government financial incentives?

Electronic health records were around long before the ARRA legislation was ever conceived, and there are hundreds of products available that claim to be fully functional EHRs. Previously, the standard for determining the quality of an EHR was approval by the Certification Commission for Health Information Technology (CCHIT).

Most serious EHR vendors have pursued this designation in order to stand out among competing products. But to qualify for the financial incentives under the ARRA rules, an entirely different certification process has been proposed by the Department of Health and Human Services (HHS).

Many EHR vendors claim they will qualify under the new requirements, even though at the time of writing the certification process has not officially begun. Once it does, testing and approval will be fairly costly. This may prohibit smaller vendors from pursuing approval, and likely means that the next few years will see many companies going out of business or merging with larger entities. Practices already owning one of these products may find that the software is no longer supported or updated and will not meet criteria for the proposed incentives.

It may seem that upgrading to a new system is the only option, and many wonder when the best time is to switch.

Within the next few months, many EHR products will become officially certified under the new rules. Until that point, it probably would be unwise for any

practice that already has an EHR installed to make the switch to a new one.

An initial strategy for these practices would be to contact their EHR vendor to find out if the company plans on pursuing the new certification. If so, will the currently installed version of the software meet the meaningful use requirements, or will a costly upgrade be required to qualify? If updates need to be made to the existing software for certification, when are those changes expected? Will the software changes also require an investment in new computer hardware or network infrastructure?

Depending on the answers to these questions, the cost of staying with the existing EHR may be similar to investing in an entirely new one.

In the meantime, it is helpful to note that the final rule on the temporary certification program has addressed a few lingering concerns related to existing electronic record installations.

First, "grandfathering" of current EHR products will not be permitted, regardless of product age, unless these products submit to the new certification standards and are approved. Vendors cannot rely on previous standards such as CCHIT approval or the size of their user base to demonstrate usefulness or value.

Second, so-called "homebrew" EHRs – those developed by individual practices or hospital systems – also will not qualify for the incentives unless they undergo certification. These proprietary systems may be incredibly robust and represent a large financial and labor investment, so it will be up to the administrators to determine if it is worth pursuing certification to continue using them to achieve meaningful use.

Once any practice decides it is time to make a change to a different EHR, the process should be handled much like starting from scratch. Good practices include selecting a transition team, reevaluating office workflow, and creating buy-in from care providers and office staff.

One significant difference is considering a system that can accept data from your current EHR. Unfortunately, this may be challenging to find, because there has been little standardization in the industry up to this point. Previously scanned letters and re-

ports may be fairly easy to transfer, while demographic data and electronically generated notes may be impossible. Be sure to discuss this with the software vendor and consider the time investment required for the transition. If this all seems too overwhelming, consider hiring a consultant to help clarify the process and ask all the important questions to avoid a mistake.

Anyone who has ever purchased a personal computer is aware that technology changes rapidly and that the need to upgrade is inevitable. Purchasing a new electronic record, however, is not like upgrading a computer.

Aside from the huge cost difference, the potential labor and productivity loss can be staggering. The process of conversion to a different EHR may be more difficult and time consuming than the initial move from paper to electronic charts. Therefore, a tremendous amount of thought must be given before making any changes, as the costs of making the wrong decision may outweigh any promised financial incentives.



DR. SKOLNIK (left) is associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital and professor of family and community medicine at Temple University, Philadelphia. DR. NOTTE is in private practice in Chalfont, Pa. They are partners in EHR Practice Consultants, helping practices move to EHR systems. Contact them at [info@ehrpc.com](mailto:info@ehrpc.com).

## New Hospital Disaster and Evacuation Resources Available

BY JENNIFER FELSHER

Deciding whether and when to evacuate a hospital during an emergency situation can be a daunting decision, as can the decision about when it is safe to return after the event.

New resources from the Agency for Healthcare Research and Quality are now available that will help hospital administrators and facility planners make these critical decisions.

The Hospital Evacuation Decision Guide (found at [www.ahrq.gov/prep/hospevacguide](http://www.ahrq.gov/prep/hospevacguide)) walks users through the process of deciding when to evacuate, shelter in place, or defer and reassess as the situation evolves.

It distinguishes between "pre-event evacuations" – which are undertaken in advance of an impending disaster (such as a storm), when the hospital structure and surrounding en-

vironment are not yet significantly compromised – and "post-event evacuations," which are carried out after a disaster has damaged a hospital or the surrounding community.

The guidance draws on expert panel experiences, as well as lessons learned from past events including the Northridge, Calif., earthquake of 1994; the

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Three Mile Island nuclear reactor incident of 1979; and Hurricanes Katrina and Rita in 2005.

Included is a self-assessment work-

sheet to help hospitals consider the critical infrastructure issues that affect a decision to evacuate.

The companion piece, Hospital Assessment and Recovery Guide (found at [www.ahrq.gov/prep/hosp Recovery](http://www.ahrq.gov/prep/hosp Recovery)), helps hospital leaders and facility managers assess a facility's infrastructure after an emergency event so they can determine when it is safe to reoccupy the area.

Made up primarily of a 45-page checklist, the assessment and recovery guide covers 11 separate areas of hospital infrastructure components that should be evaluated before determining that it is safe to reoccupy a facility.

These two resources specifically address issues related to evacuation and reoccupation and are intended to supplement existing hospital emergency plans, which often do not include such decision-making guidance.

Both of these guides are available on the AHRQ's Web site at [www.ahrq.gov/prep](http://www.ahrq.gov/prep).