EHR REPORT

A Softer Look at EHR Hardware

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

When considering the transition to an EHR system, it is essential to think about more than just the software. The hardware can be just as important. All EHR vendors have minimum specifications required to ensure the proper functioning of their system, but most will allow individual practices to use existing computers or purchase new equipment on their own. When companies do suggest specific hardware, they often choose costly equipment that far exceeds the basic system requirements. Since this may not make sense for your practice and can far exceed your budget, it can be very helpful to think through the process ahead of time and truly assess your needs to maximize productivity and minimize price. Here are some issues to consider:

► **To PC or not to PC?** Regardless of your personal preference, the majority of EHRs run under the Windows operating system. If your office is already outfitted with Macs, you might need to replace them. You could also install Windows using software such as Boot Camp, a program that ships with new Intel-based Macs.

If your office is already established on PCs, you must determine if they meet the EHR's minimum specs. It won't take long to realize that running the software on a slow computer is frustrating, so consider the amount of RAM and processor speed in each unit.

Either way, be sure to find out exactly which version of Windows the software requires, as changing the operating system can be a very costly and time-consuming experience. For example, one well-known EHR product requires Windows XP Professional. XP Home Edition and other versions of Windows simply will not work. And, not surprisingly, many EHRs don't play well with Windows Vista.

► **Desktop, notebook, or tablet PC?** Initially, a lot of physicians wonder how an EHR will affect their documentation. Whether you currently dictate or handwrite your notes, installing an electronic system can dramatically change the way you practice. It is therefore very helpful to put some forethought into how you'll best be able to integrate computers into the office visit.

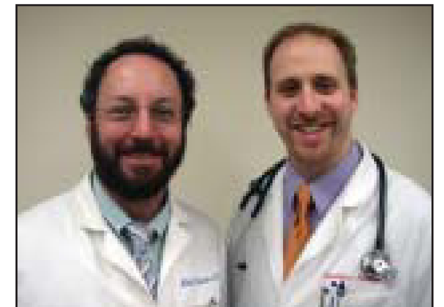
Some practices choose to install desktop computers in each exam room. In general, desktops are cheaper and more comfortable to navigate. On the downside, they cannot be easily moved to optimize patient interactions and take up a significant amount of space in the room. They also require power and network wiring.

As an alternative, consider wireless notebooks. They are mobile, flexible, and take up much less space, but they are typically more costly to purchase, can be quite heavy, and might be dropped and easily damaged. They may also have a small keyboard and a less-than-convenient pointing device.

For this reason, tablet PCs have become very popular in medicine. A tablet PC may or may not have a keyboard, but all are designed around a touch screen on which a digital pen serves as the mouse. While seemingly wonderful in concept, learning to use the pen to enter complicated information has a steep learning curve and can be extremely frustrating. Many EHR products address this issue by developing schemes to expedite the documentation process. Some involve a series of pull-down menus and check-offs, allowing the provider to quickly click through the available options and only "write" the rare additional information not already covered by the forms.

In the end, regardless of the type of PC you choose, expect it to take some time to get used to the new process of documentation. You may initially find yourself in the exam room with your face buried in the computer screen. Some get around this by documenting after they leave the room, a process that can become a significant time drain. Others choose to employ dictation software that allows them to speak directly into the EHR to generate a note. Although these programs are constantly improving, they still require training and may take a good deal of time to use accurately. No matter how you enter the information, practice makes perfect, and you'll find that documenting as you go becomes more efficient with time. Moving forward, the initial drawbacks of computerized documentation are quickly replaced with the advantages of legible, indexed notes and charts that are never lost.

► **Durability, price, and options.** Inevitably, every practice will need to purchase new computers. When making this decision, consider longevity as well as price. Extended warranties and service plans may be a high priority, but given the ever-dropping costs of computer hardware, some may decline to spend the money up front and risk the cost of replacement. Also, consider purchasing refurbished models. Major vendors such as Dell, HP, and Lenovo offer refurbished PCs for a fraction of the cost of new models. Often, these come with the same warranty and return policy. Be cautious about purchasing computers at retail or warehouse stores. These models may be attractively priced, but they are typically geared for home use and may not come with the proper version of Windows. Finally, inquire about getting additional batteries and an external battery charger if you opt for portable PCs. You will find that batteries die at the worst possible times, and it is convenient to have another battery freshly charged and ready to go.



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

Federal Requirements for EHR Adoption May Be Eased

BY JOYCE FRIEDEN

WASHINGTON — A Health and Human Services Department advisory committee is moving to make it easier for physicians to meet federal requirements for adopting electronic health records.

The Health IT Policy Committee has recommended that providers who adopt EHRs after 2011 or 2012—the first years that federal stimulus money for adoption will be available—have to meet only 2011-2012 requirements for "meaningful use" of EHRs in their first year of adoption. They will then need to meet additional requirements each year in order to continue getting the money, although they will receive less than they would have if they had adopted EHRs earlier.

"A rising tide floats all boats, but if you're not in the water, it just doesn't help," said Dr. Paul Tang, cochair of the committee's meaningful use working group. "So we're just trying to find a way to get people to deal with it, even if it's a little bit late."

Under the Recovery Act (formally known as the American Recovery and Reinvestment Act of 2009), $19 billion in stimulus money has been set aside to encourage adoption of health information technology, including EHRs. The money includes up to $44,000 in financial incentives for each physician who purchases a certified EHR system and who makes "meaningful use" of it.

To put the law into effect, the government has to define "meaningful use" and set standards for system certification and health information exchange. The HIT Policy Committee, chaired by Dr. David Blumenthal, national coordinator for health information technology at HHS, will make recommendations; the actual regulations will be written by staff members at the Centers for Medicare and Medicaid Services (CMS).

At a recent HIT Policy Committee meeting, committee member Gayle Harrell, former Florida state legislator and the wife of a retired ob.gyn., expressed concern that some of the meaningful use requirements were aimed more at primary care physicians and would not be appropriate for specialists. Dr. Tang agreed that the working group would try to make sure that specialists' needs were addressed when the recommendations were finalized, and noted that not all measures would apply to all specialties. The committee agreed to accept the meaningful use working group's recommendations.

Ms. Harrell also raised the question of whether specialists would now be liable for information presented in the EHR that falls outside of their purview. "Would an ophthalmologist have to verify whether or not I had a mammogram?" she asked.

Dr. Blumenthal said he didn't think the liability issue was within the committee's scope. "I think we have to stay focused on what we think appropriate good care should be, and we can't sort out the medical liability system here." Ms. Harrell agreed, but noted that "this presents a real fear out there for many people."

The standards and certification subcommittee also presented the following five recommendations to the committee:

► Focus certification on meaningful use.

► Leverage the certification process to improve progress on security, privacy, and interoperability.

► Improve the objectivity and transparency of the certification process.

► Expand certification to include a range of software sources, such as open-source and self-developed systems.

► Develop a short-term transition plan for certification.

Dr. Neil Calman, CEO of the Institute for Family Health, N.Y., said he was concerned that the last recommendation would send the wrong message to providers who were already certified by the Certification Commission for Health Information Technology, currently the government's only approved certifying body. "It basically makes it sound like CCHIT is temporary," he said.

But working group cochair Paul Egerman said that was not the message the group meant to convey. "That was not at all what was intended," he replied.

The committee agreed to adopt the working group's main recommendations but to let working group members rework some of the specifics. ■

Pages 60a—60d