EXPERT OPINION

A Softer Look at EHR Hardware

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

When you consider the transition to an EHR system, think about more than software. The hardware can be just as important. All EHR vendors have minimum specifications 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 vendors do suggest hardware, they often choose costly equipment that far exceeds the basic system requirements. This may not make sense for your practice and can far exceed your budget, so think through the process ahead of time and 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, most EHRs run under Windows. If your office is already outfitted with Macs, you might need to replace them, or you could 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. Running the software on a slow computer is frustrating, so consider the amount of RAM and processor speed in each unit.

Also, find out exactly which version of Windows the software requires, as changing the operating system can be costly and time consuming. 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?** Many physicians wonder how an EHR will affect their documentation. Whether you currently dictate or handwrite your notes, installing an EHR system can dramatically change the way you practice.

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.

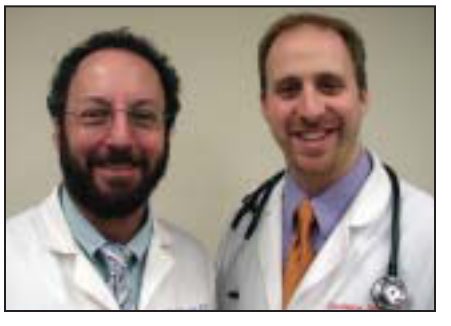
Or consider wireless notebooks. They are mobile and flexible, and take up much less space, but most are more costly to purchase, can be quite heavy, and might easily be dropped and damaged. They may also have a small keyboard and a less-than-convenient pointing device.

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.

Expect it to take some time to get used to the new process of documentation, regardless of the type of PC you choose.

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. 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. ■



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Feds Recommend 'Preliminary Certification' for EHRs

BY JOYCE FRIEDEN

WASHINGTON — Electronic health records systems should be precertified to comply with Recovery Act requirements even before the government issues its final certification rules, a federal advisory panel recommends.

Because the final rules may not go into effect until next year, "the suggestion is to establish something called preliminary certification based on the assumption that vendors would be willing to take a reasonable risk that what has been proposed in the regulatory process is probably pretty close to what is going to come out the other side," Paul Egerman, cochair of the certification/adoption workgroup of the Health and Human Services Department's Health Information Technology (HIT) Policy Committee, said at a meeting of the committee.

That way, vendors could start certifying based on the proposed criteria, "and when the regulatory process is completed, hopefully there's only a very small adjustment that we can tack on" before the software becomes HHS-certified, he added.

Whether and when HHS will adopt its committee's recommendation is uncertain at this point, according to Dr. David Blumenthal, the committee's chair and national HIT coordinator at HHS.

"We'll have to do this in a deliberate way that includes public comment and takes the necessary steps within the department and in the federal government generally," he said during a conference call. "I think the rule-making process we have to go through will make it very difficult to react in that time frame."

Despite Dr. Blumenthal's cautious response, the Certification Commission for Health Information Technology (CCHIT)—currently the only federally approved certification body for EHR—is moving ahead. During a Sept. 3 conference call, CCHIT officials announced that they were going to publish criteria at the end of September for EHR vendors to meet in order to "precertify" one or more components of their EHR systems. The organization planned to begin accepting precertification applications on Oct. 7. Once certification requirements, slated for spring publication, are final, CCHIT will revise its criteria accordingly and perform any additional testing needed to make sure the precertified systems conform to the final regulations.

Under the Recovery Act, formally known as the American Recovery and Reinvestment Act, $19 billion has been set aside to encourage HIT adoption, including electronic health records. The money includes up to $44,000 in financial incentives for each physician who purchases a certified EHR system and makes "meaningful use" of it by 2011; physicians who adopt EHRs later will also get an incentive, but the amount will diminish gradually over several years and disappear completely after 2014. Providers who have not adopted EHRs by 2015 will see reductions in their Medicare reimbursement.

Right now, only CCHIT can certify an EHR; certification/adoption workgroup members emphasized the need for more than one certifying organization and recommended that any certifying groups be distinct from those that set the certification criteria.

To help physicians and hospitals get ready to implement EHRs, the Obama administration is making $598 million in Recovery Act funds available now to establish 70 HIT "extension centers" that will provide hospitals and clinicians with hands-on technical assistance in the selection, acquisition, implementation, and meaningful use of certified EHRs. The extension center grants will be awarded on a rolling basis, with the first being issued in fiscal year 2010, which began on Oct. 1.

Another $564 million is also being made available in fiscal 2010 to states and state-designated groups to implement health information exchange.

HHS also will provide assistance to health care providers through the HIT Research Center, which will disseminate relevant information on effective practices and help the extension centers collaborate with one another and share best practices on EHR use.

In other business at the meeting, the committee also refined its proposed definition of certification. The new definition reads, "HHS certification means that a system is able to support the achievement of privacy and interoperability, and that the system is able to support the achievement of the meaningful use results that the government expects."

The workgroup on the definition of meaningful use outlined its plans, which included a meeting to address gaps in meaningful use criteria. Specifically, the group planned to meet in October to hear from specialist physicians about how to make the criteria relevant to them.

They also wanted to address the needs of smaller practices and hospitals, and of safety net providers.

Committee member Gayle Harrell of Stuart, Fla., a former member of the Florida state legislature and the wife of a retired ob.gyn., said she was happy to hear that the workgroup was focusing on specialists.

"I'm delighted that you're going to be meeting with the specialties and understanding the impact of meaningful use criteria on them," she said.

The committee also discussed barriers to widespread EHR adoption. Committee member Judith Faulkner of Epic Systems Corp. in Verona, Wis., said cost was not the biggest issue for many of the providers with whom she had spoken. "It doesn't matter what the incentive money is," she said.

Ms. Harrell agreed, noting, "The real barrier is legal concerns. Our customers are not jumping on [EHRs] because lawyers and their other advisers are much more [concerned] about legal issues, and I don't think the money matters as much." ■