

EHR Selection Toolkit for Small Practices

A scored framework for comparing EHR systems against what a 1-5 provider practice actually needs

Most EHR demos are built to make every system look like a fit. This toolkit flips that: you define your must-haves first, price the full cost (not the headline number), and score vendors on a weighted grid you control. Bring filled-in scores to your final two demos instead of vibes.

Define your must-haves before you take a single demo

A sales engineer can demo around almost any gap if you let the conversation wander. Write down your non-negotiables first, then make each vendor prove them on your workflow with your example patient, not their canned script.

Mark each item below as Must-have, Nice-to-have, or Not needed. Anything you mark Must-have that a vendor cannot show live becomes a disqualifier, not a 'we have that on the roadmap.'

- Specialty workflow fit -- templates, order sets, and note types that match how you actually chart, not a generic primary-care build
- E-prescribing with EPCS (controlled substances) included and already enabled, not a paid add-on you discover later
- Lab and imaging interfaces to the specific labs and imaging centers you use today (Quest, LabCorp, local hospital, etc.)
- Patient portal for intake forms, messaging, results release, and online scheduling
- Telehealth that is built in or cleanly integrated, with no separate per-visit fee surprises
- Billing / practice-management integration so charges, claims, and eligibility flow without double entry
- Reporting you can run yourself (payer mix, A/R aging, no-show rate) without a paid analyst engagement

Have the vendor demo on YOUR top 3 visit types and YOUR most-used drugs and labs. If they reschedule to 'get the right specialist,' that is a signal.

The real cost picture (what the headline price hides)

Cloud EHR commonly runs \$300-\$700 per provider per month for an integrated EHR plus practice-management bundle. The sticker price is rarely the whole bill. Ask for an all-in monthly number in writing, then ask what is NOT included.

Budget the implementation cost and 1-2 months of reduced productivity. Most practices see throughput dip 20-40 percent in the first month as staff learn the system, then recover. That dip is a real revenue cost even though no invoice names it.

Cost line	Typical range	Often left out of the quote
Subscription	\$300-\$700 / provider / month	Per-user fees for non-provider staff

Cost line	Typical range	Often left out of the quote
Implementation / setup	\$1,000-\$10,000+ one-time	Custom template build, specialty content
Data migration from old system	\$2,000-\$15,000+	Discrete vs. PDF-only migration; how many fields actually move
Interface fees (modular setups)	~\$300 / month per interface	Lab, imaging, immunization registry, HIE connections
Training	Included or \$1,000-\$5,000	On-site hours, refresher sessions, new-hire training later
Patient portal / telehealth	Bundled or add-on	Per-message or per-visit charges

In modular (best-of-breed) setups, each interface commonly adds around \$300/month. Two or three interfaces can quietly add \$7,000-\$10,000 per year on top of the subscription.

Integrated PM+EHR vs. modular: pick on data flow, not branding

An integrated EHR plus practice-management system from one vendor means clinical notes, charge capture, claims, and eligibility share one database. Less double entry, fewer interface fees, one support number. The trade-off is you take whatever billing engine that vendor ships.

A modular setup lets you pair a clinical EHR you like with a separate billing/PM system you like, but you pay interface fees and own the finger-pointing when something breaks between them. For most 1-5 provider practices without dedicated IT, integrated wins on total cost and headache unless one module is genuinely a dealbreaker.

Factor	Integrated PM+EHR	Modular (best-of-breed)
Double data entry	Minimal	Common at the seams
Interface fees	Usually none internally	~\$300/mo per interface
Support when it breaks	One vendor	Vendors point at each other
Billing engine choice	Locked to vendor	Pick your own
Fit for no-IT practice	Strong	Weaker

Data ownership and exit terms (read this before you sign)

You will switch systems someday. The time to negotiate your exit is before you sign, when you still have leverage. Vendors who make leaving painful are counting on you not asking these questions up front.

- Confirm in the contract that your patient data is yours, not the vendor's
- Get the export format in writing -- a usable structured export (discrete data, C-CDA), not just a PDF dump of charts

- Ask the cost to export your full dataset at termination; some vendors charge thousands at the exit
- Check how long they retain your data after you leave and how you retrieve it
- Read the auto-renewal and notice-period terms -- a 90-day cancellation notice on an annual auto-renew can trap you for an extra year
- Get a signed Business Associate Agreement (BAA) -- non-negotiable for HIPAA

Ask the question plainly: 'If I leave in three years, exactly what do I get back, in what format, and what does it cost?' Vague answers are an answer.

Implementation and training realities

Plan for a 60-90 day implementation from contract to go-live for a small practice, longer if you are migrating years of charts. Name one internal person as the project lead. Without that, the build drifts and you go live on someone else's defaults.

Decide early how much chart history actually migrates. Discrete data migration (problems, meds, allergies as structured fields) costs more than a PDF-only migration where old charts become read-only documents. For many practices, migrating the active problem/med/allergy list discretely and PDF-ing the rest is the cost-sane middle.

- Block the go-live week: cut your schedule 30-50 percent for the first days, then ramp back up
- Train by role -- front desk, MA, provider, and biller each need a different path, not one generic webinar
- Build and test your top templates before go-live, not the week after
- Run a test claim end to end before you trust the billing flow with real money
- Schedule a refresher session 30 days post go-live, when real questions have surfaced

The weighted scoring framework

Score each finalist 1-5 on every criterion (5 = clearly demonstrated live, 1 = could not show it). Multiply by the weight, then total. Weights below are a sane default for a small practice -- adjust them to your reality, but set the weights BEFORE you see the demos so a slick presentation cannot move your priorities.

Suggested weights total 100. A criterion you marked Not needed earlier gets weight 0 and drops out.

Criterion	Suggested weight	Why it carries weight
Specialty workflow fit	20	Daily friction or daily speed -- this is what you live in
Total cost of ownership (all-in)	20	Subscription plus implementation, migration, interfaces, dip
Billing / PM integration	15	Drives whether you get paid cleanly
E-prescribing + EPCS	10	Table stakes; penalize if it is a paid afterthought

Criterion	Suggested weight	Why it carries weight
Lab / imaging interfaces	10	To the labs you actually use, live in the demo
Data ownership / exit terms	10	Your leverage to leave later
Implementation + support quality	10	Reference checks, not the sales rep's promises
Patient portal / telehealth	5	Patient-facing convenience and access

Total score is weight x your 1-5 rating, summed. The point is not a perfect number; it is forcing each vendor to earn its rating on your criteria instead of their script.

Your fill-in scoring table

Copy this for your top two finalists. Rate each 1-5, multiply by the weight from the section above, and total the weighted columns. Bring the filled grid to your final negotiation.

Criterion	Weight	Vendor A (1-5)	Vendor B (1-5)
Specialty workflow fit	20		
Total cost of ownership (all-in)	20		
Billing / PM integration	15		
E-prescribing + EPCS	10		
Lab / imaging interfaces	10		
Data ownership / exit terms	10		
Implementation + support quality	10		
Patient portal / telehealth	5		
Weighted total	100		

Before you sign: call two reference practices the vendor did NOT hand-pick, in your specialty and your size, and ask what surprised them in month one.

Compare EHR and healthcare-IT vendors that serve small practices in the GetPracticeHelp directory, and shortlist two to score with this grid.

This toolkit is general guidance, not legal, financial, or compliance advice. Pricing, features, and contract terms vary widely by vendor, specialty, and region; confirm every number and clause directly with vendors and your own advisors before signing. Dollar ranges are general market norms, not quotes.