The Specialty-Fit EHR Checklist: What a Generic Demo Hides

Questions to confirm before you sign -- organized by where vendors gloss over the details

A polished demo runs on a clean sample chart in a generic specialty. Your day does not. This checklist is the set of specialty-specific features and contract questions to confirm in writing before you commit, so you find the gaps during evaluation instead of during go-live.

Clinical Workflow Fit

A demo moves fast because the rep already knows the template. Ask how many clicks a real note in your specialty takes, then count them yourself. If templates ship empty and your staff has to build every one, that is months of unbilled setup time.

- ☐ Confirm specialty templates ship pre-built for your specialty, not just a blank template engine you have to populate
- ☐ Count the clicks for one full, billable encounter note in your top 3 visit types -- ask the rep to do it live
- ☐ Confirm order sets exist for your common diagnoses (not a generic order entry screen)
- ☐ If dermatology: confirm body-map / image annotation and lesion tracking over time
- ☐ If behavioral health: confirm distinct note types (intake, therapy, med management) and time-based session documentation
- ☐ If pediatrics: confirm growth charts with percentile plotting and weight-based dosing
- ☐ If OB/GYN: confirm flow sheets that carry forward across prenatal visits
- ☐ Confirm how much template-building labor falls on your staff vs. comes pre-loaded

Documentation speed is the single biggest driver of daily satisfaction. Measure it, do not take the rep's word.

Prescribing and Controlled Substances

E-prescribing of regular meds is table stakes. The parts that trip up practices are controlled substances and state-mandated checks, which often cost extra or require separate enrollment.

- ☐ Confirm e-prescribing is included and certified (Surescripts)
- ☐ Confirm EPCS (electronic prescribing of controlled substances) is supported, and ask whether it is an add-on fee
- ☐ Confirm what identity-proofing and two-factor token process EPCS requires, and who pays for the tokens
- ☐ Confirm integration with your state's PDMP so controlled-substance lookups happen in-workflow, not in a separate website
- ☐ Ask whether PDMP checks are one-click or require manual re-entry of patient data
- ☐ If you prescribe controlled substances often, confirm EPCS works for every prescriber on day one, not after a multi-week enrollment

Interfaces: Labs, Imaging, Registries

Every interface to an outside system is a potential line item. Ask which are included, which carry a one-time build fee, and which carry a recurring per-interface monthly charge.

- ☐ Confirm bidirectional lab interfaces with the specific labs you use (Quest, LabCorp, hospital, in-house), not just 'lab interface capable'
- ☐ Get the per-interface build fee AND any recurring monthly fee in writing for each lab
- ☐ If imaging-heavy: confirm PACS / imaging integration and how results render in the chart
- ☐ If pediatrics or primary care: confirm bidirectional interface with your state immunization registry (IIS)
- ☐ Confirm HIE connectivity if you exchange records with a local hospital or referral network
- ☐ Ask how long each interface takes to build and go live -- weeks vs. months changes your timeline

Get interface fees itemized. 'Interfaces included' often means the capability, not the specific builds you need.

Billing, Coding, and Your Payer Mix

Whether billing is built in or bolted on changes both your cost and your claim flow. Map your actual payer mix before the demo so you can test the system against it, not a generic one.

- ☐ Confirm whether practice management / billing is native or a third-party module with its own interface fee
- ☐ Confirm claim scrubbing is built in and ask to see it catch a deliberately bad claim live
- ☐ Confirm the system handles your specialty's common CPT/modifier patterns (e.g. derm path, behavioral health time codes, surgical globals)
- ☐ Test it against your real payer mix -- if Medicaid-heavy, confirm your state Medicaid is supported and billed cleanly
- ☐ Confirm eligibility verification runs before the visit, not after the claim denies
- ☐ Ask for the clearinghouse used and whether it is included or a pass-through cost

Cost area	Often hidden	Ask for in writing
Billing/PM module	Separate interface fee if third-party	Native or modular? Monthly fee?
Per-interface charges	Recurring monthly per lab/registry	Itemized build + monthly cost
EPCS	Add-on plus token cost	Included? Per-prescriber fee?
Implementation	Quoted separately from license	Total one-time, with training hours

Regulatory and Quality Reporting for Your Payers

Quality reporting only matters in proportion to the payers who tie it to your money. If you are Medicare-heavy, MIPS support is not optional. If you are not, do not pay for reporting machinery you will never use.

- ☐ If Medicare-heavy: confirm the system supports MIPS reporting and is a certified reporting mechanism for the measures you report
- ☐ Confirm the specific quality measures relevant to your specialty are built in, not just 'MIPS capable'
- ☐ Confirm the EHR is ONC-certified (current edition) if you need certified-technology reporting

- [ ] Ask whether quality dashboards update in real time or only at reporting deadlines
- [ ] If you participate in an ACO or value-based contract, confirm the system can produce the reports that contract requires
- [ ] Confirm whether reporting/registry submission is included or an annual add-on

Match reporting features to your payer mix. Paying for MIPS tooling on a cash or commercial-heavy panel is wasted spend.

Patient-Facing Tools

Portal, telehealth, scheduling, and reminders are where patients judge you. Confirm each works the way your patients actually use it, and whether any are separate subscriptions.

- [ ] Confirm the patient portal handles what you need: results release, secure messaging, intake forms, bill pay
- [ ] Confirm telehealth is built in or integrated, and whether it carries a separate per-visit or monthly fee
- [ ] Confirm online self-scheduling respects your visit-type rules and provider templates
- [ ] Confirm automated appointment reminders (text/email/voice) and whether message volume is capped or metered
- [ ] Confirm intake/registration forms can be completed before the visit and flow into the chart, not re-keyed by staff
- [ ] If you serve non-English-speaking patients, confirm portal and reminder language support

Make the Vendor Prove It in YOUR Workflow

The standard demo is designed to hide friction. Take control: hand the rep your scenarios and make them perform the work in front of you. What they cannot show live, assume it does not exist yet.

- [ ] Give the rep 3 of your real (de-identified) visit scenarios and have them document each one start to finish, live
- [ ] Ask them to send an e-prescription and run a PDMP check during the demo
- [ ] Ask them to generate and scrub a claim for one of your common procedures
- [ ] Ask to speak with 2 reference practices in your exact specialty and similar size
- [ ] Get every 'yes, it does that' answer in writing, with which fees apply and when it goes live
- [ ] Confirm the total first-year cost: license, implementation, interfaces, training, and any per-provider or per-visit fees

If a feature can only be 'shown later' or 'on the roadmap,' price your decision as if it does not exist.

Compare specialty-fit EHR and healthcare-IT options in the GetPracticeHelp EHR directory before you book a single demo.