# Electronic Medical Record Risk Assessment Checklist

| Contractual Details | | Yes | No | Comments/Actions |
|---|---|---|---|---|
| 1. | Is the EMR certified? | | | |
| *There are several certifying bodies that the Office of the National Coordinator (ONC) have authorized to certify products. To verify that an EMR is certified, go to their website at http://oncchpl.force.com/ehrcert.* | | | | |
| 2. | Understand clearly the costs associated with installation. | | | |
| *Have a realistic understanding about the number of licensed users needed and the costs to be incurred when users are added in the future.* | | | | |
| 3. | Does the contract define the costs of installation and how those are incurred? Is it an hourly rate or a flat fee? | | | |
| *When negotiating installation costs, be sure to include pricing for additional training if needed.* | | | | |
| 4. | Does the contract include options to upgrade and add modules? | | | |
| *Be aware of all system capabilities and modules available in the system prior to signing a contract. Consider staggered module implementation, but negotiate fees for future modules in the initial contract.* | | | | |
| 5. | Are updates and future enhancements included in the maintenance fees? | | | |
| *Find out if major upgrades, enhancements, and government mandated changes will be included in the maintenance and support fees.* | | | | |
| 6. | Does the practice have adequate contact information to escalate an issue in the event of an urgent matter? | | | |
| *Don't wait until you're in the midst of a system outage to discover you don't have contact information for anyone beyond the toll-free tech support line. Find out the name and number of high-level contacts and reserve the use of this information for true emergencies.* | | | | |
| 7. | Is license reassignment defined in the contract? | | | |
| *If the practice merges with, or sells to, another entity, are the licenses transferrable?* | | | | |

| Implementation and Training | | Yes | No | Comments/Actions |
|---|---|---|---|---|
| 8. | Did the practice receive adequate training at the time of implementation? | | | |
| *It is impossible for users to learn everything about the EMR at the time of initial training. A suggested strategy for training is to set up a series of training sessions. The initial session should be as basic as possible, teaching users only what they have to know to begin seeing patients while using the EMR. Subsequent sessions would occur soon after and would build on the users' basic proficiency to teach them additional features and capabilities.* | | | | |
| 9. | Are there designated trainers (at least 2) within the practice who have received extensive training and will continuously receive training from the EMR vendor? | | | |
| *Take ownership of your EMR. In order to minimize reliance upon the vendor, designate staff to be on-site trainers who are responsible for training new users and provide ongoing training for all staff. Many vendors offer specific training for these designated individuals, sometimes called 'train the trainer.'* | | | | |
| 10. | Is adequate training required and provided for new employees and providers? | | | |
| *Don't underestimate the value of new user training when staff or providers are added. Make sure adequate time is allotted for this. New users that are inadequately trained may make errors in the EMR that put patient care and your practice at risk.* | | | | |
| **Patient Satisfaction** | | **Yes** | **No** | **Comments/Actions** |
| 11. | Does the provider stay effectively engaged with the patient while using a computer? | | | |
| *If a computer is used by a provider in the exam room, is the computer positioned so that the provider is facing the patient? Providers must make a concerted effort to use their body language in a way that doesn't make the patient feel they're being ignored. Equally important is the provider's observance of the patient's body language during the encounter.* | | | | |
| 12. | Is the patient portal easy for the patient to use? | | | |
| *Consider using patient satisfaction surveys to determine patient opinions on ease of use.* | | | | |

| Documentation | | Yes | No | Comments/Actions |
|---|---|---|---|---|
| 13. | Is a unique record required for each individual patient? | | | |
| *With an EMR system in place, the days of family record charting are over. Each patient requires an individual record.* | | | | |
| 14. | Do signature procedures meet state, federal, and payer requirements? | | | |
| *Authentication of the medical record by the author is not only a "best practice," but is required by K.A.R. 100-24-1 as well as CMS and other third-party payers. Electronic signatures must also adhere to security standards of HIPAA.* | | | | |
| 15. | All chart documents that are signed by a provider are actually read by the provider. | | | |
| *The good faith assumption is that providers who electronically sign their documentation are attesting they have read and accept the documentation as it is written.* | | | | |
| 16. | Are chart notes temporally relevant? | | | |
| *For example, a copy-forward note that indicates the "patient is scheduled for hip replacement next month," that actually occurred 8 months ago, is temporally incorrect. This has the potential to mislead the next clinician relying on that information to make wrong clinical decisions.* | | | | |
| 17. | Are chart notes original? Do providers copy and paste portions of documentation from previous visits or other providers? | | | |
| *Using another provider's note content as your own causes an ethical issue in assuming credit for the intellectual work of another author. Periodic internal chart reviews along with written policies and procedures will help protect against inappropriate cloning and copy forward practices.* | | | | |
| 18. | Is each EMR entry time, date, and author-stamped in real time? | | | |
| *For example, if a nurse documents the patient's vitals in the record and the physician enters subsequent information pertaining to the exam, the appropriate author of each separate entry is evident. Users should never have the ability to alter these authentications.* | | | | |

| | | | | |
|---|---|---|---|---|
| 19. | Are chart notes entered timely? | | | |
| *Timeliness of chart entries is as important as it was in the paper world, and now with EMR it's permanently documented. Dates and times are automatically captured creating an audit trail.* | | | | |
| 20. | Do chart notes include thoughtful analysis of patient's current diagnosis, status, and treatment? | | | |
| *Medical records preserve all information vital to a patient's health and appropriate treatment. Records should show the patient's progress, both positive and negative, during the course of treatment.* | | | | |
| 21. | All services charted were actually performed. | | | |
| *Checks and balances should be in place to verify that all services documented were actually performed.* | | | | |
| 22. | Negative and positive findings in the Review of Systems (ROS) are marked appropriately. | | | |
| *Marking all checkboxes on a template can lead to "note bloat" and may not be medically necessary for the patient's presenting problem at that encounter. Only appropriate positive and negative responses should be marked.* | | | | |
| 23. | Pertinent ancillary reports are reviewed and referenced by the provider. | | | |
| *Just as with a paper record, all ancillary reports ordered by the provider should be reviewed by that provider. Any notes or addendums related to those ancillary results must be electronically signed.* | | | | |
| 24. | Addendums are associated with the appropriate visit. | | | |
| *Addendums must be dated and signed the day they are created, but must reference and tie to the associated date of service. When a record is printed, any associated addendums should automatically print as part of that encounter.* | | | | |

| | | | | |
|---|---|---|---|---|
| 25. | The E&M code selection is driven by medical necessity rather than by the EMR. | | | |
| *EMRs do not have the cognitive ability to determine the correct level of service based on the documentation of the note. Deferring the code selection to the provider based on medical necessity is a Best Practice.* | | | | |
| 26. | Pop-ups/alerts are used appropriately, but not excessively. | | | |
| *Best Practice is to have providers agree on what alerts are useful to the practice. Standardization will help avoid "pop-up fatigue."* | | | | |
| 27. | The printed version of the medical record is complete. | | | |
| *Test the system to see exactly what prints when records are reproduced for the purpose of fulfilling medical records requests. Understand your system's print ability. Addendums and amendments to records should be tied to the original note they reference and should print accordingly.* | | | | |
| 28. | The EMR alerts the provider to incomplete records. | | | |
| *Sometimes, records are incomplete due to pending test results or lab work. The system should alert the provider once tasks tied to the visit are complete and the note is ready to be signed.* | | | | |
| 29. | The provider is prompted to read and sign off on completed tests. | | | |
| *All tests ordered by a provider should be reviewed and electronically signed by that provider.* | | | | |
| 30. | Limit the number of authorized personnel who can create forms and/or templates. | | | |
| *Standardization is the key to accuracy and efficiency. When too many people are given the ability to create and implement forms and/or templates the potential for inconsistencies or redundancies may result. Designate one or two people and establish a process for forms to be reviewed before implementation.* | | | | |
| 31. | Internal coding/billing audits are performed at least once per year. | | | |
| *Your compliance plan should include a plan for regular chart audits. Regular chart audits can identify system errors before they become a significant risk.* | | | | |

| Privacy and Security | | Yes | No | Comments/Actions |
|---|---|---|---|---|
| 32. | Does each employee have a unique login and password they are prohibited from sharing? | | | |
| *Adhering strictly to the use of unique logins ensures consistency and accuracy of EMR authentication for all entries.* | | | | |
| 33. | Are employees asked to lock their screens when they step away from their work area? | | | |
| *Computers that are left idle are at risk for misuse by others. A best practice is to set computers to automatically lock when left idle.* | | | | |
| 34. | Is all online communication with patients done through an encrypted patient portal? | | | |
| *Any electronic communication with a patient must be handled through encryption software.* | | | | |
| 35. | Are all electronic devices (smart phones and laptops) password protected? | | | |
| *Mobile devices are highly susceptible to fraudulent activity. Using password protection and setting the auto-lock timer can minimize risk.* | | | | |
| 36. | Are procedures in place to continue operations in the event of a server malfunction? | | | |
| *Technology cannot be 100% reliable. Workable solutions to sustain key operational processes should be developed before they are needed.* | | | | |
| 37. | Can lost electronic devices be remotely erased/cleared? | | | |
| *Establish the ability to remotely erase all information from a device that is lost.* | | | | |