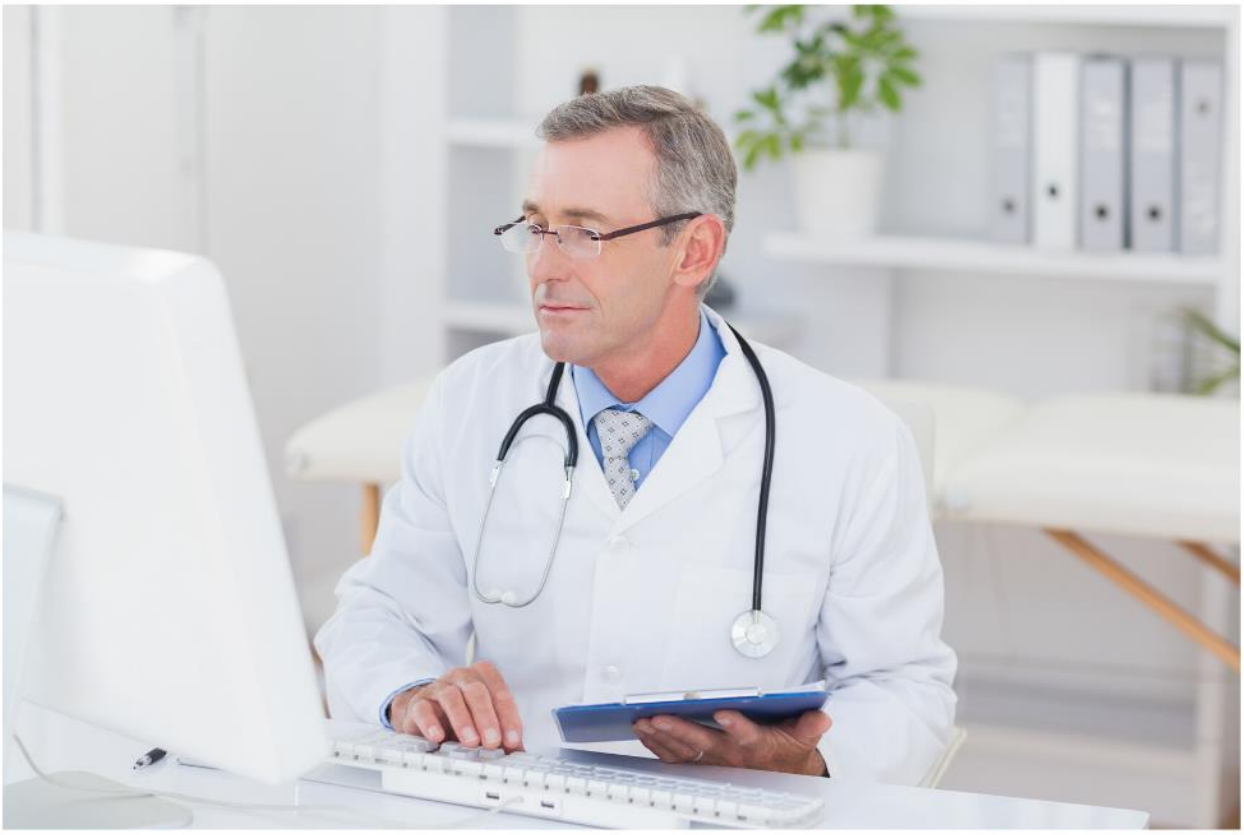
Closing or Moving Your Healthcare Practice



Jean L. Eaton,
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ATTENTION: All practice managers, healthcare providers, clinic managers of private healthcare practices. This resource guide has been created especially for you!

CLOSING OR MOVING YOUR HEALTHCARE PRACTICE

Closing or moving a healthcare provider practice takes co-ordination, patience, communication, and documentation. Once you have made the big decision about closing or moving and have a general idea about the next step for you, your practice, your employees, and your patient and business records you need to plan the continued administrative, technical, and physical safeguards of the patient health records.

Patients and clients have a unique trust with their healthcare provider. They trust that you will provide them continuing healthcare and continued access to their own health information that you have recorded. You are also expected to securely keep their personal health information and follow your professional college standards and health information privacy laws.

This Practice Management Success Tip Will Help You

- ✓ Provide clarity about records management in your group or shared practice.
- ✓ Guide you to develop health records management plan when you close, move, or expand your healthcare practice.
- ✓ Contribute to the health information privacy compliance.

WHAT TO DO NEXT

- □ Download and review this document.
- □ Discuss with your team your exit strategy.
- □ Use the procedure and forms templates that you can use right away in your practice.
- □ Train your team.
- □ Monitor for success.

Examples That You Can Use

Watch the Practice Management Nuggets For Your Healthcare Practice - When You Close Your Healthcare Practice on YouTube: https://youtu.be/qGAg3zb5_v4

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This resource package is intended to help you along your journey by guiding you through a series of questions and providing resources to get you started.

It is expected that you will review and refine these documents to meet your needs.

This policy template is part of the Practice Management Success © series. July 2020.

This publication provides general guidance for healthcare practices in Alberta It is expected that you will review and refine these documents to meet your needs. For additional assistance, please contact INFORMATION MANAGERS LTD.

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CLOSING OR MOVING YOUR HEALTHCARE PRACTICE

Whether you are at the end of your career, or you are moving or leaving your current practice, **you have a number of responsibilities** when it comes to protecting the data you've collected from your patients. In the absence of a healthcare provider's regulatory college requirements, **these standards are reasonable best practices that other healthcare providers can adopt for their records management practices.**

The College of Physicians & Surgeons of Alberta (CPSA) has set standards of practice to ensure your patients' information remains safe and secure, and yet accessible to their new primary care provider and the patients themselves.

The following article provides the background and information necessary to comply with the rules set by the CPSA and the legislation in the Health Professions Act.

Background

The College of Physicians & Surgeons of Alberta (CPSA) provides **standards of practice** that detail the minimum standards of professional behaviour and good practice expected of Alberta physicians. These standards of practice are rules that are enforceable under the *Health Professions Act* and are referenced in the event of a complaint or disciplinary hearing.

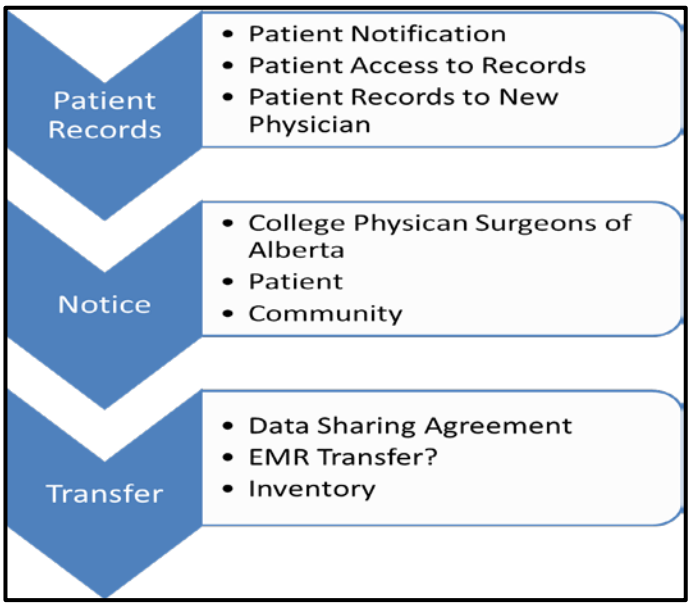
Physicians who close, leave, or move a medical practice must follow the steps laid out in Standard 22, which pertains to practice management, including the maintenance of patient records.

Physicians and other healthcare providers are considered custodians of patient records. According to the *Health Information Act Guidelines and Practices Manual*, "A 'custodian' is an organization or individual in the health system who receives and uses health information and is responsible for ensuring that it is protected, used and disclosed appropriately," (Alberta Health and Wellness, 2011*).

The HIA defines a custodian as "a healthcare provider who is designated in the regulations as a custodian, or who is within a class of healthcare providers that is designated in the regulation" (*HIA*, s.1,ix). This includes healthcare providers funded privately or through the Alberta Health Care Insurance Plan (AHCIP) (see HIA s2.2) See HIA s.1(1)(f)(ix) of the Act for a listing of each custodian. **In this document management tip, the terms "custodian," "physician" and "healthcare provider" are used interchangeably.**

*Websites for cited resources are identified in the bibliography

Closing or Moving a Healthcare provider Practice



Custodians who close or move their private primary care practice **are responsible for the secure storage and disposition of their individual patient records.** This rule applies whether the custodians manage the data storage themselves or share these responsibilities with other custodians or service providers. The *Health Information Act* (HIA) requires custodians to protect individually-identifying health information in their custody or control by making reasonable security arrangements to protect against its unauthorized access, collection, use, disclosure, or destruction.

Secure Storage And Disposition Of Patient Records

Custodians who close or move their private primary care practice **are responsible for the secure storage and disposition of their individual patient records.** This rule applies whether the custodians manage the data storage themselves or share these responsibilities with other custodians or service providers. The HIA requires custodians to protect individually-identifying health information in their custody or control by making reasonable security arrangements to protect against its unauthorized access, collection, use, disclosure, or destruction.

Patient Access

Under most privacy legislation, including Alberta's *Health Information Act***,** a **patient has the right to access their own records about themselves**. The information that a patient provides to the healthcare provider belongs to the patient. The healthcare provider is responsible to maintain the information on paper or in a computer and 'owns' the documents.

According to the *HIA* "An individual has a right of access to any record containing health information about the individual that is in the custody or under the control of a custodian" (section 7).

This means the information in a healthcare record belongs to (and must be provided to) the patient when it is requested. When you close your healthcare practice, you can anticipate many requests to access records. **Review, and revise if necessary, your written policies and procedures, to ensure that you have an efficient process that accurately documents these requests for access.**

When you close a practice, you must ensure that patient records are accessible to authorized individuals (like the patient him or herself, or a new custodian), while guaranteeing the continued safety of the information from reasonably-anticipated risks. In some cases, a healthcare provider may arrange to transfer patient records to another healthcare provider who will ensure their safekeeping and continue to provide patient access to them.

A custodian may contract a service provider or an information manager (as defined by the *HIA*) **to meet their record management obligations.** The *Health Information Act* also allows a healthcare provider (custodian) to make agreements with information managers to provide information technology and information management services described in s.66. Everything an information manager does on behalf of a custodian must comply with their agreement with the custodian as well as the *HIA*. Remember, **the custodian is ultimately responsible for anything an information manager does on his or her behalf.**

The custodian has the right to charge a fee for access requests as defined by the *Health Information Act*, s.67, and *Health Information Regulation*, sections 9–12. The basic fee of $25 may be applied or waived by the custodian. Additional fees may be charged for producing a copy of a record (for example, photocopies may cost $0.25 per page after the first 25 pages; producing a record from an electronic record may cost $10 per ¼ hour). See the *Health Information Regulation* schedule for more details.

Notify the CPSA

A physician must notify the College of Physicians & Surgeons before closing, leaving, or moving a medical practice in Alberta (CPSA, Standard 22, section 1). This notification must include the following:

- Information describing how the transfer of patient care will be managed
- Information about the location and disposition of patient records and how these records may be accessed
- A forwarding mailing address and contact information for the physician
- All unused triplicate prescription forms in the possession of the physician if he or she is closing a medical practice in Alberta

A physician must provide a minimum of 90 days notice to their patients of the medical practice closure or move, if there is NO expectation of offering ongoing care. This does not apply to a physician if the reason for leaving a medical practice is illness or other urgent circumstances (CPSA Standard 22, sections 5, 6). You must do everything you can to ensure the continuity of care for your patients.

Notify the Patient

A physician must provide a minimum of 45 days notice if you are relocating your practice and it is reasonable that you patients could continue to follow you to your new practice.

The leaving healthcare provider may wish to **notify patients individually by post, through a community newspaper, in person when the patient attends the clinic, or by any combination of these or other methods.** Personal letters to individuals and families demonstrate the healthcare provider's genuine concern for patients.

Posters in the clinic also advise patients and the general public about the upcoming changes.

Physicians who move must provide forwarding information to their old clinic, and their new location must be provided to any member of the public to asks for it (CPSA Standard 22, section 7).

See the template forms and posters here that you can use to notify the patient. Template Forms

Ownership of Records

Clinical office records are considered the property of the healthcare provider who produced them.

Ownership of records produced in the course of group practice may require special consideration.

According to CPSA Standard 21, section 17, physicians in a group medical practice must determine custodianship arrangements of patient records within that medical practice so that:

> (a) if a physician leaves the medical practice, custodianship of patient records will be clear to all parties and to the patients of the departing and remaining physicians, and
>
> (b) the departing physician and his or her patients have reasonable access to the relevant patient records.

Ideally, healthcare providers in a group practice will have documented their agreement or expectations about records management when the practice was first formed. Refer now to these agreements, or to Data Sharing Agreement Outline for Physician Group Practices (INFORMATION MANAGERS, 2009).

Information Sharing Agreement

Are you part of a group practice? **If you didn't create an information sharing agreement when you opened your practice, we recommend you do this now.** See the **Top 3 Agreements Your Healthcare Practice MUST Have (and Why).**

The following issues should be discussed, and decisions should be documented in writing:

- Will the remaining healthcare providers of the clinic accept the ongoing management of the records?
- If a patient has not been seen recently and individual authorization has not yet been acquired will the records be transferred to the remaining healthcare provider (or, if the practice has been sold, to the purchasing healthcare provider) as an information manager? Will this information manager provide secure custody, as well as transfer or destroy these records when appropriate?
- If the exiting healthcare provider has authorized the transfer of patient records to the remaining healthcare providers, how will the exiting healthcare provider have reasonable access to the relevant patient records, if required?
- If the patient records are maintained in a shared database, as often happens in a group practice using electronic medical records (EMRs), how will the exiting healthcare provider have access to them? In what media (hard copy, electronic)? At what cost? Who will assume this cost, the departing physician, patients, or remaining healthcare providers? **These decisions must be included in an exit agreement and/or purchasing agreement.** We recommend that you include your EMR vendor in this discussion to ensure the best choices for your system.

For example, one or more of the following options are possible:

- During the daily use of the EMR, the most responsible (or primary) physician will be identified in each patient's record using a specified data field. For example, the scheduled healthcare provider / billing provider / chart note author or default physician data field.
- Healthcare providers leaving the clinic who may have authored patient records maintained by the clinic either on paper or electronically may request access to either paper or electronic copies of the patient records.

- Paper records will be provided in hard copy, photocopy, or may be scanned to pdf format.
- Electronic patient records may be transferred by the clinic to secured encrypted mobile media (e.g., DVD).
- The group practice will authorize the EMR vendor to create a copy, extract, or transfer those patient records belonging to the custodian for the purpose of transferring them to the sole care and custody of the exiting healthcare provider. The cost will be determined by the EMR vendor and paid in advance by the exiting healthcare provider.

Practice Management Success Bonus Tips

- ✓ Don't assume that the remaining healthcare providers will accept your patient records. Discuss this with your team.
- ✓ If you are a healthcare provider of a practice that is accepting new providers, you are not required to accept the new healthcare provider's previous patient records. Discuss this with your new team.
- ✓ Patients may authorize that their records in the custody of the current custodian (originating clinic) be disclosed to the exiting healthcare provider (*HIA*, section 34.1) or any other healthcare provider as authorized by the patient. A consent form authorized by the patient is required. See Patient Record Transfer Authorization Form in this guide.

Inventory Of Patient Records

Whether you plan to move, archive, or transfer the patient files to another custodian, you need to know what patient records you currently have. **Prepare an inventory or list of all patient records that you have created and maintained during your practice.** This often can be generated from existing data sources such as your billing or EMR system's central patient index.

The inventory should include, at minimum, the following information:

- Patient's first and last name
- Unique Identifier or Chart Number
- Date of birth
- First and last visit date
- Healthcare provider's name

See the Procedure Inventory Of Patient Records in this guide.

Document, Document, Document!

The *HIA* requires custodians to record the **collection, use, access, disclosure, or destruction** of health information. Before you move, close, or expand your healthcare practice, ensure that you have reviewed and documented the following processes in your policies and procedures.

Disclosure and Transfer Requests

'Disclosure' is defined by the *HIA* as an event **when a custodian provides health information to another custodian or to other entities.** It is also considered to be disclosure when you transfer the care of patients and their records to another physician. Review (and revise if necessary) your written policies and procedures to ensure you have an efficient

process that accurately documents the disclosure request. **A disclosure log or notation should be maintained, and copies of the authorized signed release forms should be included in each patient file.** Disclosure notations must include the following information:

- Who the disclosure was sent to
- Date and purpose of the disclosure
- Description of the information disclosed

If a patient asks a physician to transfer his or her patient records to a new doctor, the fee schedule under the *HIA* does not apply. The transfer of records to a new service provider is governed by fee guidelines established by the Alberta Medical Association. In Alberta, a physician may not charge another healthcare provider for the exchange of limited patient information such as a copy of a discharge summary.

If you **transfer all patient records** to the care of another healthcare provider, you must create an **inventory of all records transferred**, and ensure that you keep a permanent copy of this inventory for safe-keeping. Provide the inventory list to the accepting healthcare provider. The accepting healthcare provider should provide an acknowledgement of receipt of all the patient records.

Records Retention

The College of Physicians & Surgeons Retention Schedule states that chart destruction may occur ten years after the end of the year in which the last visit was recorded, and, for minors, at the end of the tenth year following the last date of service or until two years past the patient's age of majority – whichever is longer (CPSA Standard 21, section 9).

Determine which, if any, records have met the minimum records retention policy and can be securely destroyed. Ensure that you have documented which records have been destroyed, the method of destruction, and the date and signature of the person responsible for the destruction.

See the template Procedure Archive Destruction Log in this guide.

Note: It may seem easier to keep records forever rather than destroy them after the retention periods and legislative requirements are met. However, remember that you may be required to produce or provide access to patient records for as long you continue to have custody of them.

If you transfer all the patient records to another custodian and the health information is subsequently migrated to another platform (for example, a different electronic medical record (EMR) the data migration specifically triggers a requirement under the HIA to complete a privacy impact assessment and submit it to the Office of the Information Privacy Commissioner in Alberta for review and comment.

See the template Procedure Data Quality Assurance including the Data Migration and Functionality Testing, Data Migration Planning, and the Data Migration QA Worksheets.

Information Manager

If a physician closing his or her medical practice **is unable to provide ongoing management of patient medical records**, either personally or through a colleague, **they should be put into commercial storage** for custody, transfer as necessary, and destruction when appropriate. The above steps to create an inventory of patient records also apply in this instance.

A physician who engages the service of an information manager, as defined under the HIA, to manage the electronic health records under the custody or control of that physician must first enter into a written agreement with the information manager.

The agreement between the physician and the information manager must comply with the requirements of an information manager agreement as specified under section 7.2 of the Health Information Regulation.

The information manager may use or disclose information for the purposes authorized by the agreement and must comply with the *Health Information Act* and regulations, and the agreements entered into with the physician. The physician continues to be responsible for the compliance with the HIA and regulations, including protecting the records.

See the **Top 3 Agreements Your Healthcare Practice MUST Have (and Why).**

Whatever reason you have for deciding to close or move your business, follow these steps to ensure that you meet your commitments to your patients, employees, colleagues, regulatory professional college, and legislation. The reasonable safeguards that you implement for the continued access, use, and disclosure of patient records is one key component of your exit strategy.

In the next section, you will find the forms and procedure templates to assist you when you close or move your practice.

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TEMPLATES FORMS

Sample Letter to Patients – Physician's Notice of Absence or Closing of Practice

Objective: To notify the patient that the physician giving the notice will be leaving the practice and to enable the patient to make alternate arrangements.

Instructions: Copy and paste appropriate wording to your clinic letterhead. Keep a listing of patients whom you have notified.

Physician's Notice of Absence or Closing of Practice

Dear _____
(name of patient or guardian/parent of a minor patient)

This is to advise that I will be leaving my practice commencing _____ and
(date)

I will not be available to provide care for my regular patients after that date.

I have made arrangements for care to be provided by:

Dr. _____ , at _____
(new provider name) *(address)*

_____
(telephone)

If you are in agreement with transferring your care to _____, please indicate this by signing this letter and returning it to me. If you wish to have a different provider look after your care, please note this and make certain that the physician has agreed to accept you as a patient. By indicating your choice, I will accept this as your authorization to make copies of the relevant records in your file and forward them to the provider you have indicated, and to advise that provider on any matter regarding your care that may be necessary.

If you have any questions, please do not hesitate to call my office at _____.
(telephone)

With many thanks for your understanding and assistance in making these arrangements.

_____
(name of provider)

_____
(signature of provider)

Patient Record Transfer Authorization Form

Objective: To collect the patients' authorization to transfer their patient record to a new custodian.

Instructions: Copy and paste appropriate wording to your clinic letterhead. Keep the signed, completed forms in the patients' health record.

For Patient:

By signing this document, I _____
(full name, date of birth)

hereby authorize to transfer any information from my files currently managed by

Dr. _____ to:
(current provider name)

Dr. _____ , _____
(new provider name) *(address)*

and to discuss with Dr. _____ any matter concerning my condition for the purpose of taking over my care.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release.

I understand that I make revoke my consent at any time, by providing a signed, written statement to that effect.

Date: _____ Valid Until: _____

Signature: _____ Print Name: _____

Moving / Closing Poster for Clinic

(to be displayed in waiting room, exam room, etc.)

Objective: Notification to patients when they present at the originating clinic. A physician practicing in the location where another physician had previously practiced must provide information to any member of the public about the new location of the physician who has moved. (CPSA Standard 22, sections 7)

Instructions: Copy and paste appropriate wording to your clinic letterhead. Modify the wording as required.

This is to advise that I will be leaving my practice commencing _____
(date)

and will not be available to provide care for my regular patients after that date.

I have made arrangements for care to be provided by:

Dr. _____, at _____ ,
(new provider name) *(address)*

_____ .
(telephone)

If you wish, you may contact me at my new location _____, or
(new clinic name / address)

by phone at _____ .
(telephone)

You may also view the Clinic Website for additional information _____
(website address)

Access To Patient Records

You may request to have your patient records transferred to Dr. _____ .
(new provider name)

Please request a form from the receptionist to authorize the transfer of the records.

If you wish to have your records transferred to another physician, please advise the receptionist. You will be given a form to bring to the physician of your choice. Make certain that the custodian has agreed to accept you as a patient. By indicating your choice, I will accept this as your authorization to make copies of the relevant records in your file and forward them to the provider you have indicated, and to advise that provider on any matter regarding your care that may be necessary.

If you have any questions, please do not hesitate to call my office at _____.
(telephone)

TEMPLATE PROCEDURES

Procedure: Inventory of Patient Records

Objective: To securely maintain the privacy and confidentiality of patient records.

Instructions:

1. Create an inventory record keeping form in paper or electronic format.
2. Include the data fields listed below.
3. Securely maintain this inventory as part of your business records.
4. The inventory is confidential and must be maintained with appropriate privacy and security safeguards including encryption and restricted access to authorized custodians.

Whether you plan to move, archive, or transfer the patient files to another custodian, you need to know what patient records you currently have. **Therefore, prepare an inventory or listing of all patient records that you have initiated during your practice.** This inventory can often be generated from existing data sources like your billing or EMR system's central patient index. Remember to include patient records that may have been previously archived or moved to off-site storage.

If records do not have a patient demographic sheet at the front of the chart, record the patient information in a separate document (sample below). To make retrieval of this information easier, try using a spreadsheet or print patient labels and affix to create an inventory master list.

Data elements in the inventory listing should include the following. You may modify the list to best fit your unique practice requirements.

- Last Name
- First Name
- Other Name
- Date of Birth (spell month)
- File / Chart number
- First visit date
- Last visit date
- Primary physician
- Initials of Staff
- Location of file

Procedure: Archive and Destruction Log

Start Date:
Revision Date:
Approved By:
Date:

Purpose:	Record patient records which have been purged and destroyed
Scope:	All original patient records
Prerequisites:	Must meet retention requirements
Materials Needed:	Outdated, inactive patient records
Performed by:	
Start:	

1. Identify patient records that are eligible to be purged and destroyed.
    a. Retention Schedule: College of Physicians and Surgeons Retention Schedule. Chart destruction 10 years after the end of the year in which the last visit was recorded and at the end of the 20th year following birth for records of minors who are no longer patients whichever comes later.
    b. If purging records in 2009,
        i. Last visit must be 1999 or earlier and
        ii. Patient's date of birth must be 1989 or earlier

If records have patient demographic sheet at the front of the chart,

2. Scan patient record to ensure that each page in the record belongs to the same patient.
3. Ensure patient demographic sheet has (at minimum) the following:
    a. First and last name (circle in felt marker)
    b. Date of birth (circle in felt marker)
4. Remove patient demographic sheet
5. In addition, record (in felt marker at bottom of page):
    c. The first and last visit date
    d. The primary physician
    e. Date purged, initials of staff, and how record was destroyed (this could be pre-printed on computer generated labels for consistency and efficiency)
6. Maintain patient demographic sheets, in alphabetical order by last name, in binder (location details)
7. Look up patients and append a note in the central patient index and add date of destruction.
    f. Consider – if patient was not previously in central patient index, should it be entered at this time?

If records do not have patient demographic sheet at the front of the chart, record the patient information in a separate document (sample attached). To make retrieval of information easier, this could be entered into an excel spreadsheet.

Last Name	First Name	Other Name	Date of Birth (spell month)	First visit date	Last visit date	Primary physician	Date purged	Initials of Staff	How destroyed

Procedure: Data Quality Assurance

Start Date:
Revision Date :
Approved By:
Date:

Use when moving health information data between electronic medical record (EMR) systems or similar data migration.

Data Migration and Functionality Testing

Do not rely on your vendor to test your data quality. You must undertake a comprehensive quality assurance before and after data migration. Here are some tips:

1. Create Test Patients in the live database.
2. Train using these test patients.
3. Reserve some test patients only for testing by authorized users so that you can create specific test scenarios.
4. Capture Screen Prints of how the test patient windows appear. Remember to take screen prints of pop-up dialogue boxes, user preferences, pick lists, audit trails, security settings, user groups, etc.
    a. To create screen prints, use 'PRT SCR" button on the keyboard, usually above the Delete key.
    b. Paste this image into a word document or use Notepad, Paint or similar application.
    c. Insert instructions, comments, and dates to provide a narrative about the image.
    d. Save the new document to your testing files.
    e. Print the document and maintain as part of your test scenarios
5. Create test scenarios that capture the routine day to day functions of your office – for each user type. This also can become your training manual.
    a. Remember to include any special enhancements, functionality requests, modifications, or work around that you may have developed or asked your vendor to develop on your behalf. Often these get 'lost' between one version to the next.
6. Print a sample of each report / clinic notes / prescriptions / appointment slips etc. that you use in your clinic (using test patients)

Immediately before the migration:

7. Capture screen prints of the current week using real data for each provider for each date.
8. Print a representative sampling (a select few of real patient records) of each report / clinic notes / prescriptions / appointment slips.

Immediately after the migration and before users are permitted to enter new 'real' data:

9. Re-create steps #7 and #8 and carefully compare your results.
10. Also test each functionality that was identified by your vendor as part of the release notes. Use the release notes and your comments as part of the test scenario for next version.

11. Re-create steps in #5 and document your results and comments. Keep as part of the test scenario for next version.

Data Migration Planning

Consider the following EMR Data requirements when changing EMR vendors (now or in the future)

Standard	**Vendor Provides**	**Custodian Provides**	**Comments**
EMR Data			
Orderly transition to the new system that considers data transfer and hardware and software changes?			
If you are transferring data from your old EMR to the new one, how will you ensure data integrity and prevent data loss?			
If you run your old system in parallel with your new EMR during a transition period, how will you ensure health information is accurate and complete when it is available from two source systems?			
Do you have a fallback plan in case you discover data integrity or data loss issues in your new EMR?			
What is your quality assurance plan to verify data transfer?			
Once your old system is decommissioned, how will you ensure that data from your old EMR is still available in some form if needed for continuity of care, to respond to access requests under HIA, or other legally required disclosures?			
Do you have a plan to securely dispose of data storage media from your old system (and vendor) once it is no longer in use?			
Have you planned staff training on the new system's privacy and security features?			
Record data losses.			

These business continuity planning and testing scenarios must be documented and maintained throughout the duration of your healthcare office and for as long as patient's healthcare records are maintained. Long after the current EMR and employees are gone, the custodian (physician) may be required to access the patient record *as it was at the time it was created*. This may require a user's knowledge of the EMR system at the time it was in use. These documents and testing scenarios will be valuable to document the collection, use, and access of health information.

See Data Migration QA Worksheet

Data Migration QA Worksheets

Data Migration Quality Assurance Worksheet Instruction / Introductions

This workbook is provided by Information Managers to assist its clients in managing the accuracy and completeness of their data migration projects.

Introduction / Instructions
Data Inventory Extract Sample
Patient Record Review Sample
System Review Sample

The purposes of the worksheet are to:

Document the quality assurance initiative to ensure that data migration is accurate and effective for the end user
Ensure accuracy of patient information
Comment on the effectiveness for the end user - data appears in a format acceptable to the user
Create a system for continued, routine, quality assurance after EMR updates, restoration, etc.

Instructions - Data Inventory Extract Sample

To be completed by technical support, provided to Custodian / physician
Sample metrics are provided here for illustration; customize as appropriate

Instructions - Patient Record Review Sample

1. Select a sample of source records - perhaps a random sampling or one day's clinic list.
2. Write your observations and comments on review worksheet. Be as specific as you need to be so that you can re-create the same view later.
3. Compare patient records from the originating source to test EMR database. Write your observations.
4. Compare the same patient record to the next test EMR database and/or EMR production (live) database. Write your observations.
5. Aim to develop a representative sampling of all patient types and record types. Modify / add to the review items as needed.
6. There is value to document unique or important key EMR functionality and record keeping practices.

General

- Records reviews should be done by a variety of EMR users. Each user will identify key points that may not be recognized by other users.
- Pictures - or print outs - are worth 1000 Words! Where it makes sense to do so, print a sample of the data.
- Screen prints are very useful - Select (at the same time) 2 computer keys - CTRL + PRT SCR. This will take a picture of the image currently on your screen - perhaps the way a scheduled appointment appears or how a prescription is displayed.
- Paste the screen print into Word (open a word document, select PASTE or CTRL+ V)
- Print the screen print and Review worksheet and put into a common QA Binder.
- Re-use the Review Worksheet when the next series of data is available.

- Keep your worksheets and screen prints. This becomes important evidence of your due diligence.
- The review worksheets in addition to new more recent patient records reviews build to develop a robust Quality Assurance program for your EMR for years to come.

Procedure: Quality Assurance Document Imaging (Scan) to EMR

Start Date:
Revision Date:
Approved By:
Date:

Purpose: Prior to implementing a 'scan and shred' practice implement a quality assurance routine to ensure accuracy of scanned documents. This is a simple process that is done monthly.

Instructions:

1. Randomly select 10-20 documents that have been scanned and are waiting for shredding.
2. Look up each document in the EMR and note if the image is clear and indexed to the correct patient and visit.
3. Note the identity of the employee that did the scanning (to ensure you have a good sampling of all employees over time) and date the scan was completed.
4. If there are no errors, repeat the QA monthly OR
5. Record any errors and corrective actions. If errors are noted, repeat the QA more frequently (weekly) until an acceptable accuracy rate is achieved.

QA Scan and Shred Program Implemented (Date):

Date:

QA Performed by:

Date Scanned	Initials of Entry Author	Image Clarity	Indexed to Correct Patient	Indexed to Correct Visit Date	Comments / Errors / Corrective Action

Reviewer's Overall Comments:

Next Scheduled Review: _____

Reviewer's Signature: _____

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ABOUT JEAN L. EATON



When we know better, we can do better…

Jean Eaton is constructively obsessive about privacy and confidentiality in the healthcare sector – and I think you should be too!

I assist healthcare providers, clinic managers, practice managers, privacy officers, and independent healthcare practice owners with practical privacy awareness training and tools that are easy to implement, consistent content, cost-effective, and meaningful to your day-to-day business.

If you would like to discuss how I can help your practice, just send me an email. I am here to help you.

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