Best Practices Checklist for Your EHR System
Optimal PA Utilization of Electronic Health Records

- There is someone in the organization with whom a PA can speak regarding questions or concerns about the design, implementation or functionality of the electronic health record (EHR) system.
- All professional services delivered by a PA are captured by the EHR.
- All professional services delivered by a PA can be tracked and attributed to the PA via the EHR, even when those services are billed under a physician’s name.
- A PA is able to obtain a report from the EHR system for all of the services he or she delivered.
- If a physician co-signature is required, the professional services a PA provided and documented will be attributed to the PA provider of service.
- The EHR system does not contain requirements that are more restrictive or prohibitive than federal or state law (e.g. co-signature requirements or limitations on writing orders/prescriptions) unless specified by practice or facility policy.
- If a PA practices in more than one specialty, the PA will have access to EHR functionality appropriate to his or her scope of practice, credentialing and privileges for each specialty.
- The requirement of a physician co-signature on one type of an order does not create an automatic requirement for a physician co-signature on other types of orders (e.g., a requirement for a physician co-signature on a controlled substances order does not necessitate a physician co-signature requirement on all medication orders).
- A PA can view changes, corrections, and/or addendums to the patient’s medical record made by him or her and other health professionals with access to the medical record.
- The EHR system can be modified based on feedback from PAs and other health professionals, to improve use, operability, and compliance.