Questions for health centers regarding electronic health records (EHRs)

1. Are there certain diagnoses that are considered more sensitive and therefore have automatic extra privacy measures in the EHR?
    a. What diagnoses?
    b. What are the extra privacy measures?
2. What information can you mark sensitive/change privacy for?
    a. Diagnoses
    b. Treatments
    c. Procedures
    d. An entire note
    e. A portion of a note
    f. Other:
3. Do you have the capability to limit certain information from appearing on:
    a. After visit summaries
    b. Billing
    c. Online patient portals
    d. Explanation of benefits
    e. Appointment reminders
    f. Release of Information
4. Can patients decide what aspects of their chart is shared with whom?
5. Does your system have “open notes”?
    a. If so, can patients/providers mark part or all of a note as private?
6. Can you set up a best practice alert based on age and gender to check if patient was screened for IPV?
7. In general, who can see details of a patient’s chart?
8. In general, who can enter information to a patient’s chart?
9. If staff other than a clinician providing direct care to a patient can enter information to charts, what types of information can non-clinical staff enter?
10. Does your EHR have the capability to trigger a “request/order” based on a diagnosis? For example, is it possible for the EHR to automatically notify a social worker/patient navigator when a patient has screened positive, so that they can come speak with patient after appointment?
11. Do non-clinical staff ever enter results of patient screens to a patient chart?
12. Do you have a “break the glass” function to restrict patient charts from certain staff members? If so, how does this work?
13. If certain diagnoses or procedures can be made private and not visible in billing, how does the clinic bill for those items? Are there any items that a clinic does not bill for because of issues around privacy?