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How-To

EHR Implementation Checklist

A phase-by-phase guide to implementing or migrating your EHR system without disrupting patient care

- ✔ Pre-implementation planning checklist (22 items)
- ✔ Vendor selection scoring matrix
- ✔ Data migration readiness assessment
- ✔ Go-live and post-go-live stabilization protocol

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Practice managers, hospital CIOs, clinic owners planning EHR implementation or migration

Phase 1: Pre-Implementation Planning (Weeks 1-8)

Governance & Stakeholders

- [ ] Appoint executive sponsor (C-suite champion with budget authority)
- [ ] Form implementation steering committee (clinical, IT, finance, operations)
- [ ] Hire or engage EHR implementation consultant (see Vetting Guide)
- [ ] Define project scope, timeline, and budget (use our Budget Worksheet)
- [ ] Establish change management plan and communication cadence

Current State Assessment

- [ ] Audit current EHR/EMR system capabilities and gaps
- [ ] Document all existing clinical workflows (by department/specialty)
- [ ] Inventory all system interfaces (lab, pharmacy, imaging, billing, clearinghouse)
- [ ] Catalog all custom reports and regulatory reporting requirements
- [ ] Assess data quality in legacy system (duplicates, missing fields, format issues)
- [ ] Inventory all hardware, network infrastructure, and devices

Requirements Gathering

- [ ] Define must-have vs. nice-to-have features by stakeholder group
- [ ] Document regulatory requirements (HIPAA, MIPS, state-specific mandates)
- [ ] Identify specialty-specific workflow needs
- [ ] Define integration requirements with existing systems
- [ ] Set measurable success criteria (adoption rates, efficiency metrics, compliance targets)

Critical

The pre-implementation phase is where 60% of projects succeed or fail. Rushing through discovery and requirements to "start building faster" is the most expensive mistake in EHR implementation. Budget 6-8 weeks minimum.

Vendor Selection Scoring Matrix

EHR Vendor Evaluation — Score Each Vendor on a 1-5 Scale

Evaluation Criteria	Weight	Vendor A	Vendor B	Vendor C
Clinical functionality fit (specialty match)	20%	___/5	___/5	___/5
Interoperability (HL7 FHIR, APIs, interfaces)	15%	___/5	___/5	___/5
Total cost of ownership (5-year)	15%	___/5	___/5	___/5
Data migration support and tools	10%	___/5	___/5	___/5
Training and onboarding resources	10%	___/5	___/5	___/5
Regulatory compliance (MIPS, Meaningful Use)	10%	___/5	___/5	___/5
Vendor financial stability and market share	5%	___/5	___/5	___/5
User interface / clinician satisfaction	5%	___/5	___/5	___/5
Mobile / remote access capabilities	5%	___/5	___/5	___/5
Customer support and SLA guarantees	5%	___/5	___/5	___/5
WEIGHTED TOTAL	**100%**	_____	_____	_____

Have at least 3 different stakeholder groups (clinical, IT, finance) complete this matrix independently, then compare scores. Consensus gaps reveal where you need deeper evaluation before committing.

Phase 2: Design & Build (Weeks 8-20)

Checklist continued

System Configuration

- [ ] Configure EHR settings to match documented workflows
- [ ] Build order sets, templates, and documentation templates
- [ ] Configure user roles, permissions, and access controls
- [ ] Set up clinical decision support rules and alerts
- [ ] Configure scheduling templates and appointment types
- [ ] Build billing/coding templates and charge capture workflows

Interface Development

- [ ] Build and test lab results interface (HL7/FHIR)
- [ ] Build and test pharmacy/e-prescribing interface (NCPDP/Surescripts)
- [ ] Build and test imaging/PACS interface (DICOM)
- [ ] Build and test billing/clearinghouse interface
- [ ] Build and test health information exchange (HIE) connections
- [ ] Validate all interfaces with end-to-end test transactions

Data Migration Preparation

- [ ] Complete legacy data extraction and inventory
- [ ] Execute data mapping between legacy and new system fields
- [ ] Clean and deduplicate patient records
- [ ] Run test migration on sample data set

- [ ] Validate migrated test data with clinical staff
- [ ] Plan migration timeline (parallel run vs. hard cutover)

Phase 3: Testing & Training (Weeks 16-24)

Testing Protocol

- [ ] Complete unit testing of all configured workflows
- [ ] Run integrated testing across all modules and interfaces
- [ ] Conduct user acceptance testing (UAT) with representative clinical staff
- [ ] Execute full data migration dry run
- [ ] Validate all regulatory reporting capabilities (MIPS, quality measures)
- [ ] Load test system at projected concurrent user volumes
- [ ] Document and resolve all testing defects before go-live

Training Program

- [ ] Identify and train super-users (2-3 per department/location)
- [ ] Deliver role-based end-user training (clinical, front desk, billing, admin)
- [ ] Provide hands-on practice in training/sandbox environment
- [ ] Create quick-reference guides and workflow tip sheets per role
- [ ] Schedule training refreshers for 2 weeks and 6 weeks post-go-live
- [ ] Establish help desk / support escalation path for go-live

Training Benchmark

Industry best practice allocates 15-25% of total project budget to training. A 4-hour training session is not enough — plan for 8-16 hours of role-specific training per user, spread across multiple sessions with practice time between.

Phase 4: Go-Live (Week 24-26)

Go-Live Readiness Checklist

- [ ] All testing defects resolved or documented with workarounds
- [ ] Final data migration completed and validated
- [ ] All interfaces live and verified with real data
- [ ] Help desk staffed and escalation procedures published
- [ ] On-site support team scheduled (consultant + super-users + vendor)
- [ ] Downtime procedures printed and distributed (paper-based fallback)
- [ ] Communication sent to all staff with go-live date, support contacts, and schedule
- [ ] Patient communication prepared (portal access changes, check-in process changes)

Go-Live Day Protocol

- [ ] Verify all systems operational at start of business
- [ ] Station support staff at every clinical area ("elbow support")
- [ ] Monitor system performance and interface queues hourly
- [ ] Track and triage all reported issues in real-time
- [ ] Conduct end-of-day debrief with support team
- [ ] Send daily status update to steering committee

> **Go-Live Day Staffing Rule**
>
> For every 10 end-users, have 1 on-site support person (super-user or consultant) available for the first 3 days. Under-staffing go-live support is the most common cause of post-launch chaos.

Phase 5: Post-Go-Live Stabilization (Weeks 26-38)

First 30 Days

- [ ] Maintain on-site support staff for first 5-10 business days
- [ ] Hold daily issue triage meetings (first 2 weeks)
- [ ] Monitor adoption metrics: login rates, documentation completion, order entry
- [ ] Track patient safety events related to new system
- [ ] Identify top 10 workflow friction points and prioritize fixes
- [ ] Conduct "lessons learned" session at day 30

Days 30-90

- [ ] Transition from daily to weekly issue reviews
- [ ] Deploy first round of workflow optimizations based on feedback
- [ ] Deliver training refresher sessions (target low-adoption users)
- [ ] Validate regulatory reporting accuracy (first quarterly submission)
- [ ] Audit user access controls and deactivate unnecessary accounts
- [ ] Begin decommissioning legacy system (maintain read-only access for 12 months)

Key Metrics to Track

Metric	Target	How to Measure
User adoption rate	>90% at 30 days	Active logins / total licensed users
Documentation completion	>95% at 60 days	Notes finalized same-day vs. delinquent
Patient throughput		Encounters/day vs. baseline

Metric	Target	How to Measure
	Return to pre-go-live levels by day 14	
Interface error rate	<1% of transactions	Interface queue monitoring
Help desk tickets	Declining trend week-over-week	Ticket volume and resolution time
Clinician satisfaction	>3.5/5 at 90 days	Survey at 30, 60, 90 days

Common Pitfalls & How to Avoid Them

Two-column layout: Pitfall -> Prevention

Pitfall	Prevention
Scope creep during build phase	Define change order process and budget cap in SOW; steering committee approves all changes
Insufficient training time	Budget 15-25% of project for training; plan 8-16 hours per user minimum
Data migration failures	Require pre-migration audit; run full dry run; validate with clinical staff
Provider resistance / low adoption	Include providers in design phase; appoint physician champion; address "what's in it for me"
Go-live staffing shortfall	1 support person per 10 users for first 3 days; on-call support for 2 weeks
Interface failures at go-live	Test all interfaces with live data in staging; have manual fallback procedures
Underestimating total cost	Use our Budget Worksheet; add 30% contingency; get fixed-fee milestones
Losing legacy data access	Maintain read-only legacy access for 12 months post-migration

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1. **Printability matters.** Practice managers print these for steering committee meetings. Avoid large solid color areas on interior pages (waste ink). Reserve full-bleed backgrounds for cover and back cover only. 2. **Tables are the star.** These guides live or die on their reference tables. Make tables scannable, well-spaced, and easy to read at 100% zoom on screen AND when printed on letter pa

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