

CalRHT Technology Readiness Assessment

A streamlined, actionable assessment for rural providers of any size.

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“A healthier California where all receive equitable, affordable, and quality health care.”

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About this assessment

This tool combines lessons from established EHR readiness instruments with current considerations such as TEFCA-based interoperability, the rural cybersecurity threat landscape, broadband constraints, and lean rural staffing models. It is designed to take 30–60 minutes for a small team to complete, deliver immediately usable scores, and point clearly to next steps.

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How to Use This Assessment

This assessment is comprised of 30 core questions and 10 optional deep dive questions across six domains:

- Domain 1 – Leadership & Strategy
- Domain 2 – Workforce & Training
- Domain 3 – Workflow & Operations
- Domain 4 – Technology Infrastructure
- Domain 5 – Data, Privacy & Interoperability
- Domain 6 – Finance & Sustainability

Use the following guidance based on your organization size:

- Solo / very small (one to three providers): Complete the 30 core questions only.
- Small clinic (4–15 providers, single-site RHC, small FQHC): Complete the 30 core questions and consider 3–5 Deep Dive questions in your weakest domain.
- Multi-site / Critical Access Hospital / multi-program FQHC: Complete the 30 core questions and all 10 Deep Dive questions. Score by site if that's how decisions are made.

Who Completes the Assessment

Subrecipients of the California Rural Health Transformation (CalRHT) Electronic Health Records (EHR) Modernization Grant are required to complete this assessment.

Potential applicants may also complete this assessment if desired. Assemble a small team, typically three to six people that includes:

- A leader (executive director, medical director, owner, or board chair)
- A clinician (physician, NP, PA, etc.)
- An operations or front-desk lead who knows day-to-day workflow
- Whoever handles IT, billing, and compliance (these may be one person in a small rural organization)

For solo providers and very small organizations, one person may complete the assessment by obtaining input from one or two operational or IT experts within your organization.

Anticipated Effort

The total time to complete the assessment is as follows:

- Small Team completing 30 core questions: about 45 minutes.
- Solo provider completing 30 core questions: about 30 minutes.
- Optional Deep Dive: add 15 minutes.

Assessment Scoring Procedure

Each question has a rating scale of 1-5. The team or individual completing the assessment should read the scale descriptions and pick the one that most closely matches the current reality of the organization.

Honesty matters more than the number

It is much better to underestimate than overestimate. A score of 2 you can act on is more valuable than a 4 that papers over a real gap. If you sit between two levels, score the lower one and note why in the comments — that's the gap worth working on.

How Often to Repeat the Assessment

Complete the assessment at the following three milestones:

1. Prior to implementation launch, following signed grant agreement;
2. ~90 days before go-live as a final readiness check;
3. Annually after that, to keep ahead of evolving requirements (interoperability, security, payment models).

Organization Profile

Each applicant should complete the following profile.

Profile Item	Applicant Input
Organization name	_____
Site(s) being assessed	_____
Date completed	_____
Team members completing	_____
Organization type	☐ Hospital (rural) ☐ FQHC / FQHC Look-Alike ☐ Rural Health Clinic (RHC) ☐ Tribal Clinic or Native American Health Center ☐ Other Comprehensive Community Health Clinic ☐ Health Care District ☐ Skilled Nursing Facility or Long-Term Care Facility ☐ County-Operated Health or Behavioral Health Facility ☐ Other: _____
Provider headcount	FTE physicians: ____ APPs (NP/PA): ____ RNs: ____ CHWs / care managers: ____ Behavioral health: ____ Other clinical: ____
Annual patient volume (can be approximate)	Unique patients: _____ Visits: _____
Current EHR status	☐ Paper / no EHR ☐ Replacing existing EHR (current: _____)
Geography served	States: _____ Counties / regions: _____
Payer mix (approx %)	Medicaid: ____% Medicare: ____% Dual: ____% Commercial: ____% Uninsured / sliding scale: ____% Other: ____%

Profile Item	Applicant Input
Broadband (download / upload)	Approximate speeds at primary site: ____ / ____ Mbps Backup connection: ☐ Yes ☐ No
Required reporting	☐ UDS ☐ MIPS / Promoting Interoperability ☐ eCQM (CAH) ☐ State Medicaid quality program ☐ HRSA grant reporting ☐ Other: _____
Top 3 reasons for this assessment	1. _____ 2. _____ 3. _____

Domain 1 — Leadership & Strategy

The success of an EHR effort depends primarily on leadership clarity and follow-through rather than on the software itself. This domain assesses whether organizational leaders understand the commitment involved, have established a plan, and are visibly supporting it.

Q1.1	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Leadership understanding of EHR purpose <i>Whether leadership views the EHR as a means to improve care rather than solely as a software purchase.</i>	Leadership sees the EHR mainly as a way to 'go paperless'; no quality or efficiency goals attached.	Some awareness that EHR can support clinical work, but no clear case for why or how.	Leadership can describe how EHR supports clinical efficiency; quality goals discussed but not documented.	Leadership broadly understands EHR as a tool for quality improvement and patient outcomes; goals documented.	Leadership clearly articulates how EHR enables specific care quality, access, and population health goals; this is referenced in board materials and staff communications.
Score (1–5):	_____				

Q1.2	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Physician / clinician champion <i>Whether a respected clinician is helping to lead the effort alongside administration.</i>	No clinician is involved in EHR planning or decision-making.	A clinician has been informally identified but is not actively engaged.	A clinician champion participates in meetings but is not driving decisions.	A clinician champion actively co-leads planning with administration.	A respected clinician champion leads planning, brings peers along, and is empowered to make decisions; supported by a small clinical-admin steering group.
Score (1–5):	_____				

Q1.3	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Written strategy and goals <i>Whether EHR-related goals are documented with measurable targets.</i>	No written EHR strategy exists.	Goals discussed verbally but not documented.	A draft strategy or goal list exists but is not measurable.	Written EHR strategy with at least some measurable targets (e.g., visit cycle time, quality measures).	EHR strategy is part of the organization's strategic plan with measurable targets, timelines, and named owners; reviewed at least annually.
Score (1–5):	_____				

Q1.4	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Change management capacity <i>Whether the organization has a demonstrated record of successfully managing change.</i>	Past changes have been chaotic or unsuccessful; staff turnover is high during transitions.	Changes happen reactively; communication is inconsistent.	Some change management practices exist (e.g., kickoff meetings, written updates) but are inconsistent.	Structured change approach used for most initiatives; staff feedback is collected.	Mature change management framework is consistently applied: clear sponsor, change owner, communications plan, training plan, and feedback loop.
Score (1–5):	_____				

Q1.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Board / governing body engagement <i>Note for very small organizations (solo, ≤3 providers): the governing body may consist of the owner or one or two advisors; apply the intent of the question accordingly.</i>	The board / owner has not discussed EHR.	EHR has been mentioned at one meeting but no decisions made.	Board / owner has approved a general direction but is not closely involved.	Board / owner reviews EHR progress periodically and has approved budget and scope.	Board / owner has formally approved EHR strategy, receives regular progress reports against metrics, and has an EHR subcommittee or designated lead.
Score (1–5):	_____				

Leadership & Strategy Score

Add the 5 question scores, then divide by 5	Total: _____ ÷ 5 = Section average: _____
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Comments / specific gaps to remember:

Domain 2 — Workforce & Training

Rural clinics typically operate with limited staff, so the success of an EHR transition depends heavily on having appropriately qualified personnel in the right roles and a realistic plan to prepare them. This domain assesses staffing, training, and accountability.

Q2.1	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Project lead and team <i>Who is responsible for managing the EHR project on a day-to-day basis.</i>	No project lead identified; the vendor is expected to drive the project.	A project lead exists in name only, with less than 25% of their time available.	A project lead is identified with partial time allocation (25–50%) and informal authority.	A project lead has substantial time (50–75%) and clear authority for decisions.	A dedicated project lead is fully allocated, has documented authority and accountability, and works with a cross-departmental team.
Score (1–5):	_____				

Q2.2	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Staff readiness and digital literacy <i>Whether current staff can use the tools the EHR will require.</i>	Many staff have limited digital literacy; basic computer use is a barrier.	Most staff can use computers but have not been assessed for EHR-specific skills.	Some staff are digitally proficient; gaps are known but no formal plan exists.	Skill gaps have been assessed and a training plan is being developed.	Skill gaps are formally assessed, addressed through targeted training, and re-evaluated regularly; new hires are screened for digital readiness.
Score (1–5):	_____				

Q2.3	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Training plan <i>How staff will be trained to use the system.</i>	Training plan does not exist; staff will rely on vendor training and on-the-job learning.	Vendor training is scheduled, but no internal training plan supplements it.	Initial training plan exists for go-live but no ongoing training.	Initial and refresher training planned; competency informally assessed.	Comprehensive training plan covers role-based initial training, super-users, refreshers, and new-hire onboarding; competency is formally verified before staff use the live system.
Score (1–5):	_____				

Q2.4	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Super-users / internal experts <i>Whether the organization has or plans to develop internal experts who can support their peers.</i>	No plan to develop super-users; staff will call the vendor for help.	Aware of the super-user concept but no individuals identified.	Super-users identified but not formally trained or given protected time.	Super-users selected, trained, and given some protected time to support peers.	A super-user program is in place with selection criteria, advanced training, protected time, regular meetings with leadership, and recognition.
Score (1–5):	_____				

Q2.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Workforce sustainability <i>Rural-specific consideration: turnover and small staff size mean that a single departure can severely disrupt the EHR effort. Assess the organization's depth of coverage for key roles.</i>	Loss of any one key person would stop the EHR effort. No cross-training.	Key roles are single points of failure; some informal knowledge sharing.	Some cross-training exists but documentation of procedures is thin.	Most key roles have a backup or documented procedure; cross-training is regular.	All EHR-critical roles have documented procedures, named backups, and active cross-training; key knowledge is not held by a single person.
Score (1–5):	_____				

Workforce & Training Score

Add the 5 question scores, then divide by 5	Total: _____ ÷ 5 = Section average: _____
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Comments / specific gaps to remember:

Domain 3 — Workflow & Operations

An EHR does not correct inefficient workflows; it reinforces them. Before selecting a system or going live, an organization should understand how care currently moves through the clinic, where it breaks down, and how the EHR will reshape it.

Q3.1	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Current-state workflow documentation <i>Whether the organization understands, step by step, how a patient currently moves through the clinic.</i>	No workflows are documented; each staff member follows their own approach.	Workflows exist informally in people's heads; written documentation is rare.	Some core workflows (e.g., check-in, visit) are documented but outdated.	Most core workflows are documented and reasonably current.	All major clinical and administrative workflows are documented, reviewed regularly, and used in training and improvement work.
Score (1–5):	_____				

Q3.2	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Future-state workflow design <i>Whether the organization has mapped how workflows will operate once the EHR is in place.</i>	No future-state workflow planning; issues are expected to be resolved at go-live.	General awareness that workflows will change but no specifics.	Some future-state workflows sketched for a few key processes.	Future-state workflows mapped for most major processes; staff have been consulted.	Future-state workflows are mapped end-to-end with input from frontline staff, validated against EHR capabilities, and used to drive build, training, and roll-out decisions.
Score (1–5):	_____				

Q3.3	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Policies, procedures, and standing orders <i>Whether standard operating rules are documented (e.g., documentation standards, downtime, corrections, controlled substances).</i>	Few written policies exist beyond what is legally required.	Basic HIPAA / safety policies exist but are not EHR-aware.	Most required policies exist; updates for EHR are planned but not done.	Required policies have been reviewed for EHR readiness; most updates complete.	All required policies (HIPAA, downtime, record correction, e-signature, access rights, e-prescribing, controlled substances, data retention) are EHR-aligned, reviewed annually, and staff are trained on them.
Score (1–5):	_____				

Q3.4	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Patient engagement and access <i>How do patients interact with the EHR (portal, messaging, online scheduling, telehealth).</i>	Electronic patient engagement has not been a priority / considered to date.	We have provided awareness that a portal exists but there is no plan for adoption, support for low-literacy / low-broadband patients.	Portal is turned on but limited formal effort associated with patient adoption.	Active plan for portal rollout has been executed including patient education, multilingual support, and alternate channels for patients without broadband.	Patient engagement is optimal per our plan and designed in (portal, messaging, telehealth, online forms), with adoption targets, support resources, accessibility considerations, and alternate paths for patients with limited connectivity.
Score (1–5):	_____				

Q3.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Quality measure capture and reporting <i>Whether operations can support federal, state, payer, or any other measures* the organization is required to report.</i>	Quality reporting is done manually, late, or not at all.	Required reports are produced but require extensive manual data pulling.	Some reports are EHR-driven but others are still manual; gaps in data integrity.	Most required quality reports run from EHR data with occasional manual cleanup.	All required quality reports run from EHR data on schedule; performance is reviewed regularly, and findings drive workflow changes.
Score (1–5):	_____				

*Quality measures may include [Health Center Program Uniform Data System](#) (UDS) for FQHCs, [Electronic Clinical Quality Measures](#) (eCQMs), [MIPS Promoting Interoperability](#), Medi-Cal quality reporting, Indian Health Services (IHS) [GPRA/GPRAMA](#) Reporting, or any other federal, state, payer, or any other measures the organization is required to report.

Workflow & Operations Score

Add the 5 question scores, then divide by 5	Total: _____ ÷ 5 = Section average: _____
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Comments / specific gaps to remember:

Domain 4 — Technology Infrastructure

Infrastructure is often the decisive domain for rural organizations. Broadband gaps, aging hardware, and limited IT capacity can prevent an EHR from functioning. This domain assesses whether the organization's technical foundation can support a modern EHR, including 2026 cybersecurity expectations.

Q4.1	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Broadband / internet reliability <i>Rural-specific consideration: most cloud-based EHRs assume reliable broadband. Assess the connectivity the organization actually delivers, including during peak hours.</i>	Inconsistent broadband; outages or slowdowns happen weekly. No backup connection.	Generally functional but slow at peak times; no documented speed test or SLA.	Adequate broadband ($\geq 25/3$ Mbps) for current needs; no backup connection.	Solid broadband ($\geq 100/20$ Mbps) with documented performance; backup connection (cellular failover, second ISP) exists but untested.	Reliable broadband meeting or exceeding ONC / FCC* guidance for clinical use; documented uptime; tested failover, including backup and redundant capabilities (cellular, second ISP, or satellite); offline EHR workflow defined for outages.
Score (1–5):	_____				

* For further information on guidance from the Office of the National Coordinator for Health IT (ONC) and the Federal Communications Commission (FCC), please see the Alliance for Connected Care's [Broadband Access](#) page and the FCC's [Health Care Broadband](#) in America report.

Q4.2	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Devices and end-user hardware <i>Whether workstations, laptops, tablets, and exam-room devices are adequate and ready for use.</i>	Hardware is aging (>5 years), inconsistent, or insufficient for the number of users.	Some hardware is recent; many devices are aging or shared awkwardly.	Adequate devices in most areas; refresh plan being developed.	Modern devices in most areas with a documented refresh cycle.	All clinical and admin staff have appropriate, modern devices; documented refresh cycle in the budget; exam-room placement supports clinician–patient eye contact.
Score (1–5):	_____				

Q4.3	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Cybersecurity posture <i>In 2026, small rural providers are primary targets for ransomware and AI-enabled attacks. This area warrants particular attention.</i>	No formal cybersecurity program. Shared passwords, no MFA, no anti-virus monitoring, no risk assessment.	Basic protections (anti-virus, individual passwords) but no MFA, no documented risk assessment, no incident response plan.	MFA on most accounts; documented security policies; HIPAA Security Risk Assessment done but not regularly updated.	MFA universal; annual HIPAA Security Risk Assessment; documented incident response plan; staff phishing training; endpoint detection in place.	Cybersecurity follows a recognized framework (NIST CSF, HHS 405(d) HICP, or ASPR RISC 2.0); MFA universal; annual risk assessment; tested incident response and ransomware playbook; ongoing phishing training; vendor security reviews.
Score (1–5):	_____				

Q4.4	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Backup, disaster recovery, and business continuity <i>Whether the organization can continue to see patients if the EHR becomes unavailable or data is encrypted by ransomware.</i>	No documented backup or downtime procedure; loss of the system would halt operations.	Backups happen but have never been tested; no downtime procedure for clinical work.	Backups tested occasionally; rough downtime procedure exists on paper.	Backups tested regularly; downtime procedures documented and staff know them.	Documented backup strategy with offsite / immutable copies; tested restore at least annually; documented downtime procedures (paper forms, contact lists, manual workflows); tabletop exercises with staff.
Score (1–5):	_____				

Q4.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
IT support model <i>Note for very small organizations: IT support may be provided by a part-time contractor or the EHR vendor. This is acceptable, provided the arrangement is established and responsive.</i>	No dependable IT support; staff troubleshoot themselves or call vendors after problems become urgent.	Ad hoc support from a friend, family member, or unreliable contractor.	Contracted IT support (MSP or part-time staff) with informal expectations.	Contracted or in-house IT with documented SLA, regular check-ins, and a clear escalation path to the EHR vendor.	IT support is dependable, documented, and integrated with EHR vendor support; SLA monitored; security and patching cycles defined; IT advisor participates in EHR governance.
Score (1–5):	_____				

Technology Infrastructure Score

Add the 5 question scores, then divide by 5

Total: _____ ÷ 5 = Section average: _____

Comments / specific gaps to remember:

Domain 5 — Data, Privacy & Interoperability

The 2026 baseline is no longer whether an organization can share data, but whether it participates in TEFCA and FHIR-based exchange and is prepared for new HIPAA and CMS interoperability requirements. This domain addresses both current fundamentals and emerging expectations.

Q5.1	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
HIPAA Privacy & Security compliance <i>The foundation on which all other data practices depend.</i>	No current HIPAA risk analysis; policies are missing or outdated.	Some policies exist; staff training is irregular; no documented risk analysis in the past two years.	Most required HIPAA policies exist; staff training annual but informal; risk analysis dated.	HIPAA policies maintained; annual staff training documented; risk analysis updated annually.	Comprehensive HIPAA program: documented policies, annual risk analysis with remediation tracking, role-based access controls, audit logging reviewed, BAAs with all vendors, and breach response plan.
Score (1–5):	_____				

Q5.2	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Data quality and integrity <i>Whether the data in the current system is reliable enough to support decision-making.</i>	Data quality is not measured; known issues (duplicates, missing fields) are common.	Some awareness of data issues but no systematic cleanup or prevention.	Periodic manual cleanup; data standards informally understood.	Data standards documented; periodic data quality reviews; designated owner for data quality.	Documented data dictionary and standards; required-field rules enforced; routine data quality audits; trended over time; corrective actions taken.
Score (1–5):	_____				

Q5.3	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Interoperability — labs, e-prescribing, referrals <i>Whether the organization can exchange structured data with the partners it works with routinely.</i>	All exchange is by fax or paper; no electronic interfaces.	Some electronic interfaces (e.g., e-prescribing) but most exchange is manual.	Core interfaces (e-prescribing, lab results) in place but referrals and care summaries still manual.	Most routine exchange is electronic; some gaps with specific partners.	Electronic exchange is the default for labs, imaging, e-prescribing (including EPCS), referrals, immunization registry, and public health reporting; manual processes are the exception.
Score (1–5):	_____				

Q5.4	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
TEFCA / HIE / QHIN participation <i>In 2026, TEFCA is the national baseline. Assess whether the organization participates, plans to participate, or is considering participation.</i>	Not familiar with TEFCA or QHINs; not connected to any HIE.	Aware of TEFCA / HIE but no participation; no current plan.	Connected to a regional HIE or planning TEFCA participation through EHR vendor.	Actively participating in an HIE or QHIN through EHR vendor; clinicians use external records in care.	Connected via a QHIN under TEFCA (directly or via EHR vendor); clinicians routinely view and reconcile external records; participation is monitored for value (records pulled, care decisions changed).
Score (1–5):	_____				

Q5.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Reporting & analytics capability <i>Beyond required external reports, whether the organization can develop and answer its own analytic questions.</i>	No reporting capability beyond what the vendor produces; minimal analysis.	Vendor-supplied reports used; no ability to build custom reports.	Some custom reporting possible; analysis is mostly manual in Excel.	Custom reports run regularly; a designated person or team handles analysis.	Dashboards and ad hoc analysis available to managers and clinicians; data drives quality improvement; benchmarking against peer or state data is routine.
Score (1–5):	_____				

Data, Privacy, & Interoperability Score

Add the 5 question scores, then divide by 5	Total: _____ ÷ 5 = Section average: _____
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Comments / specific gaps to remember:

Domain 6 — Finance & Sustainability

Many EHR adoptions fail not because of the software but because the budget did not account for productivity loss, ongoing costs, or long-term maintenance. This domain assesses the financial realism of the organization's plan.

Q6.1	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Total Cost of Ownership (TCO) understanding <i>Whether the organization understands the full five-year cost of the EHR, not only the initial purchase price.</i>	Only the upfront license / subscription cost is known.	Upfront and basic ongoing costs known; implementation labor and productivity loss not estimated.	5-year TCO sketched out but with significant gaps (training, hardware refresh, interfaces).	5-year TCO documented covering licensing, implementation, training, hardware, interfaces, and support.	5-year TCO documented and stress-tested, including productivity loss, hardware refresh, ongoing training, optimization labor, interfaces, security tools, and a contingency reserve.
Score (1–5):	_____				

Q6.2	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Funding source and runway <i>Rural-specific consideration: HRSA, USDA, state Medicaid, philanthropy, and Promoting Interoperability incentives are common funding sources, but each carries specific requirements.</i>	No identified funding for EHR adoption.	General operating funds will be used; no dedicated budget.	Some funding identified (grant, capital reserve) covering most of upfront cost only.	Funding identified for upfront and first-year ongoing; sustainability plan being developed.	Funding covers upfront and at least 24 months of ongoing costs with a documented sustainability plan; grant / Promoting Interoperability / Medicaid funding sources tracked with reporting requirements.
Score (1–5):	_____				

Q6.3	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Productivity loss and revenue impact planning <i>Nearly every EHR implementation reduces provider productivity for three to six months. Assess whether the organization has planned for the resulting revenue impact.</i>	Productivity loss has not been considered.	Aware that productivity may dip but no plan or budget for it.	Productivity loss estimated; partial mitigation (reduced schedule, locum coverage) discussed.	Productivity loss estimated and budgeted; mitigation plan in place (reduced schedule at go-live, locum coverage, deferred non-urgent visits).	Productivity loss modeled by month and role; revenue impact reflected in cash-flow plan; reserve in place; recovery tracked weekly against plan.
Score (1–5):	_____				

Q6.4	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Billing and revenue cycle readiness <i>Whether billing operations can accommodate the new system, including 2026 coding and any value-based or care management billing.</i>	Billing is paper-based or manual; clearinghouse use is minimal.	Electronic billing happens but coding accuracy is inconsistent; denials not actively managed.	Electronic billing is routine; denial management is reactive.	Electronic billing with active denial management; coding audits performed periodically.	End-to-end revenue cycle is documented and metric-driven: eligibility checks, charge capture, claims, remits, denials, A/R aging; coding is audited; staff are trained on current CPT/HCPCS and value-based / care management codes where applicable.
Score (1–5):	_____				

Q6.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Long-term ownership and accountability <i>Who will be accountable for the EHR one, two, and five years after go-live.</i>	No long-term ownership defined; assumption is the vendor will handle everything.	Project team will dissolve at go-live; no permanent owner identified.	An informal owner is named but with no protected time or budget.	A permanent EHR / IT owner is named with some protected time and a small budget for optimization.	Permanent governance is in place: named EHR / informatics owner, protected time, optimization budget, user feedback channel, vendor management cadence, and annual roadmap reviewed by leadership.

Q6.5	1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized
Score (1–5):	_____				

Finance & Sustainability Score

Add the 5 question scores, then divide by 5	Total: _____ ÷ 5 = Section average: _____
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Comments / specific gaps to remember:

Optional Deep Dive (for larger or more complex organizations)

Multi-site organizations, Critical Access Hospitals, and larger FQHCs should complete these 10 additional questions using the same 1–5 scale. These questions are not included in the average scores above; they are diagnostic and intended to help the organization focus its efforts.

1-5 Scale				
1 — Not Ready	2 — Early	3 — Partial	4 — Mostly	5 — Optimized

#	Domain	Question
1	1 - Leadership & Strategy	Multi-site governance: How is EHR decision-making coordinated across sites or service lines?
	Score (1–5): ____	
2	1 - Leadership & Strategy	Equity and population health: Whether EHR efforts are explicitly tied to closing care gaps for the organization's specific patient populations.
	Score (1–5): ____	
3	2 - Workforce & Training	Clinical informatics role: Whether a dedicated clinical informatics function exists (MD/DO/RN informaticist) in addition to general IT.
	Score (1–5): ____	
4	3 - Workflow & Operations	Behavioral health / dental / pharmacy integration: How non-medical service lines are integrated into the workflow plan.
	Score (1–5): ____	
5	3 - Workflow & Operations	Telehealth integration: Whether the telehealth platform is integrated into the EHR workflow (scheduling, documentation, billing, e-prescribing).
	Score (1–5): ____	
	4 - Technology Infrastructure	Network segmentation and zero-trust posture: Beyond MFA, what controls limit lateral movement after a breach?

#	Domain	Question
6	Score (1–5): ____	
7	4 - Technology Infrastructure	Medical device security: Whether connected medical devices (point-of-care lab, imaging, RPM, infusion) are inventoried and patched.
	Score (1–5): ____	
8	5 - Data, Privacy & Interoperability	USCDI / FHIR API readiness: Whether the EHR can expose USCDI data via FHIR APIs for patient access and partner use.
	Score (1–5): ____	
9	5 - Data, Privacy & Interoperability	Population health / risk stratification: Whether the organization can stratify panels by risk, social drivers, or chronic condition.
	Score (1–5): ____	
10	6 - Finance & Sustainability	Value-based care contracts: Whether EHR capabilities are aligned with the data and quality requirements of the organization's VBC / ACO / Medicaid contracts.
	Score (1–5): ____	

Summary scoring

Record all six domain averages below and compute the overall average. Then review the interpretation guide on the following pages.

Domain	Sum of 5 scores	÷ 5 = Avg.	Readiness stage
1 - Leadership & Strategy	___ / 25	___	___
2 - Workforce & Training	___ / 25	___	___
3 - Workflow & Operations	___ / 25	___	___
4 - Technology Infrastructure	___ / 25	___	___
5 - Data, Privacy & Interoperability	___ / 25	___	___
6 - Finance & Sustainability	___ / 25	___	___
Overall	Sum of 6 averages: ___	÷ 6 = ___	___

Interpreting your scores

Score Range	Readiness Stage	What it means and what to do next
1.0 – 2.0	Foundational	Significant work is needed before selecting or replacing an EHR. Use the next three to six months to establish the fundamentals: designate a clinician champion, document current workflows, complete a HIPAA Security Risk Assessment, and identify a funding source. Engage a Regional Extension Center, the state Primary Care Association, or a technical assistance partner. Do not begin vendor evaluation at this stage.
2.1 – 3.0	Developing	The organization is building momentum, but the foundation remains uneven. Preliminary vendor research and reference calls may begin; however, contract signing should be deferred until the two weakest domains have been strengthened. Plan for six to nine months of preparation conducted in parallel with selection.

3.1 – 4.0	Operational	The organization is largely ready. It may begin formal vendor selection or, if implementation is under way, focus on the specific questions scored at or below 3. Most clinics that succeed begin from this range.
4.1 – 5.0	Optimized	The organization is ahead of most rural peers. This assessment should be repeated annually to keep pace with evolving requirements (TEFCA, security, value-based care). The organization may also consider mentoring peer organizations through its state PCA, REC, or rural network.

Do not rely on the average alone

The most informative figure is the lowest domain average, not the overall average. An organization with a 4.0 overall average but a 1.5 in Technology Infrastructure should not purchase an EHR until that score improves. Strong domains cannot compensate for a weak foundation.

Developing your action plan

For each domain scoring below 4.0, complete the grid below. Rather than addressing all gaps simultaneously, select the two or three actions per domain that will have the greatest impact.

Domain & Gap	Specific Action	Owner	Target Date

Common high-impact actions by domain

For organizations that are uncertain where to begin, the following actions most often produce meaningful improvement for rural organizations:

Domain	Recommended Actions
1 - Leadership & Strategy	Designate a clinician champion (with protected time), document EHR goals with measurable targets, and add EHR progress as a standing board or leadership agenda item.
2 - Workforce & Training	Identify and protect time for two to three super-users; develop a role-based training plan with a competency check before go-live; and cross-train at least one backup for every EHR-critical role.
3 - Workflow & Operations	Document the organization's five most critical current workflows as one-page maps; involve frontline staff; and design future-state workflows before configuration rather than after.
4 - Technology Infrastructure	Confirm broadband and arrange a backup connection (cellular or second ISP); enable MFA universally; complete or refresh the organization's HIPAA Security Risk Assessment; and test a restore from backup.
5 - Data, Privacy & Interoperability	Confirm the EHR vendor's QHIN / TEFCA participation status; enable e-prescribing (including EPCS), lab interfaces, and immunization registry feeds; and designate a data quality owner.
6 - Finance & Sustainability	Model the five-year TCO, including productivity loss; identify funding to cover 24 months of operations rather than only go-live; and designate a permanent post-go-live EHR owner with protected time and budget.

Appendix A — Rural-focused resources

The following organizations regularly publish current, no-cost tools and technical assistance specifically for rural and underserved providers:

Resource	What it offers
HealthIT.gov — Health IT in Health Care Settings	Federal hub for EHR adoption guides for small, rural, and CAH settings.
Rural Health Information Hub (RHIhub)	Authoritative collection of toolkits including Telehealth & Health IT and Cybersecurity overviews tailored to rural providers.
National Rural Health Resource Center	Free toolkits including the Population Health Readiness Assessment and small-rural-hospital technical assistance.
Stratis Health Health IT Toolkit	Free toolkit for Critical Access Hospitals and rural clinics covering planning, implementation, and optimization.
Regional Extension Centers (RECs) and state Primary Care Associations (PCAs)	Direct technical assistance, often at no cost; PCAs are the right entry point for FQHCs and RHCs.
HHS 405(d) — Health Industry Cybersecurity Practices (HICP)	Cybersecurity best practices scaled for small, medium, and large healthcare organizations.
ASPR RISC 2.0 Toolkit (2026 update)	Risk assessment and cybersecurity module specifically for healthcare and public health organizations.
ONC TEFCA resources and QHIN list	Current list of QHINs and guidance for connecting through an EHR vendor or HIE.
CMS Promoting Interoperability and MIPS Quick Start Guides	Annual reporting requirements for CAHs and eligible clinicians.
HRSA Bureau of Primary Health Care UDS resources	Required reporting guidance for FQHCs.

Appendix B — Glossary

- **California Rural Health Transformation Program (CalRHT):** Statewide initiative designed to improve access, quality, workforce capacity, technology, and sustainability of rural health care delivery.
- **Critical Access Hospital (CRA):** A small rural hospital designated by CMS with cost-based Medicare reimbursement.
- **Community Health Worker (CHW):** A frontline public health worker who supports patients in navigating care and addressing social needs.
- **Electronic Clinical Quality Measure (eCQM):** Quality measures reported electronically; required for CAHs under Promoting Interoperability.
- **Electronic Health Record (EHR) / Electronic Medical Record (EMR):** Terms used interchangeably in this document, though EHR typically implies broader interoperability.
- **Electronic Prescribing of Controlled Substances (EPCS):** Required in most states; needs specific identity-proofing and software.
- **Fast Healthcare Interoperability Resources (FHIR):** The modern standard for sharing health data via APIs; underpins USCDI and TEFCA exchange.
- **Federally Qualified Health Center (FQHC):** Community-based provider with HRSA designation and enhanced reimbursement.
- **Health Information Exchange (HIE):** Organization or technology arrangement supporting electronic exchange of health information.
- **Health Insurance Portability and Accountability Act (HIPAA):** Federal privacy and security baseline for protected health information.
- **Multi-Factor Authentication (MFA):** Requiring a second factor (phone, token) beyond a password; now the de facto baseline.
- **Merit-based Incentive Payment System (MIPS):** CMS quality reporting program with a Promoting Interoperability category that affects Medicare payment.
- **Managed Service Provider (MSP):** An outsourced IT support firm — a common model for small rural clinics.
- **Qualified Health Information Network (QHIN):** The top-level participants in TEFCA; smaller organizations typically connect through their EHR vendor or HIE.

- **Regional Extension Center (REC):** ONC-supported organizations offering technical assistance for health IT adoption.
- **Rural Health Clinic (RHC):** A Medicare-designated clinic in a non-urbanized area with enhanced reimbursement.
- **Remote Patient Monitoring (RPM):** Using connected devices to capture patient data between visits.
- **Total Cost of Ownership (TCO):** The full 5-year cost of an EHR including license, implementation, training, hardware, support, and productivity impact.
- **Trusted Exchange Framework and Common Agreement (TEFCA):** The U.S. national framework, in production since 2024, that connects health information networks into a 'network of networks' through QHINs.
- **Uniform Data System (UDS):** HRSA's annual reporting system for FQHCs.
- **U.S. Core Data for Interoperability (USCDI):** The federally defined minimum set of data elements every certified EHR must support.