NARA
The National Association of Rehabilitation Providers and Agencies

Together We Thrive
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Housekeeping Reminders

- All attendees are on mute
- **Handout** is available for everyone on the NARA website: Resources>Quick Links Page
- **Questions for Speakers:** submit them using the Q&A button on the attendee control panel
- **Technical Questions:** submit them using the Chat button on the attendee control panel
- **Recording:** will be available only for NARA Members on the Member Portal > Webinars on Monday, January 26, 2026

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Disclaimer

The information shared in today's presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), commercial payers, state and national associations, and continue to watch for new developments and information regarding the topics discussed today.

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Agenda

- Key Terms, Concepts, and Why They Matter
- Compliance, Policy, and Patient Care
- What to ask your vendors?
- Resources
- Questions & Answers

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HEALTHCARE SERVICES

Artificial Intelligence (AI): A Practical Overview

Key Terms, Concepts, and Why They Matter

Kathleen Dwyer, OTR/L, CHT, CHC, RAC-CT, CHPC
Senior VP of Compliance

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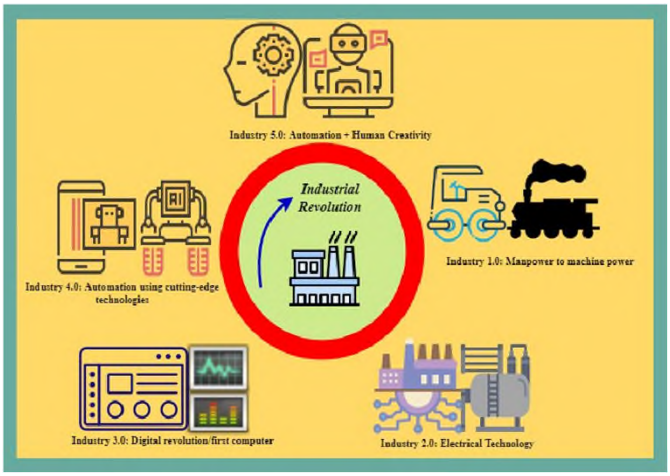
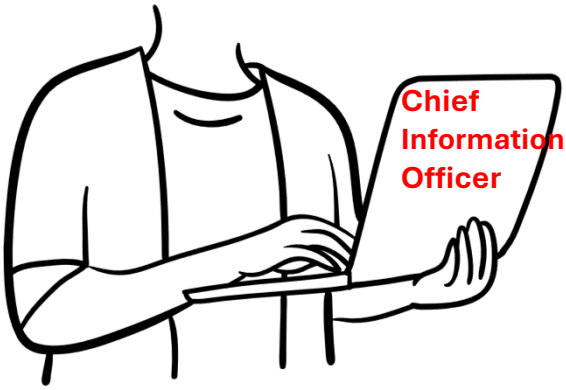
Industry: Mechanics to Intelligence



Humayun, Mamoona. (2021). Industrial Revolution 5.0 and the Role of Cutting Edge Technologies. International Journal of Advanced Computer Science and Applications. 12. 10.14569/IJACSA.2021.0121276.

What Is Artificial Intelligence?

- According to Merriman-Webster, the definition of AI is
  - *The capability of computer systems or algorithms to imitate intelligent human behavior*
  - 1955



"Artificial intelligence." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/artificial%20intelligence. Accessed 17 Jan. 2026.

Learning Objectives

- What is
  - Machine learning
  - Natural Language Processing
  - Large Language Models

"Artificial intelligence." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/artificial%20intelligence. Accessed 17 Jan. 2026.

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What is Machine Learning?

- Machine Learning (ML)
- *a computational method that is a subfield of artificial intelligence and that enables a computer to learn to perform tasks by analyzing a large dataset without being explicitly programmed*
- *1953*

"Artificial intelligence." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/artificial%20intelligence. Accessed 17 Jan. 2026.

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Types of Machine Learning

SUPERVISED MACHINE LEARNING

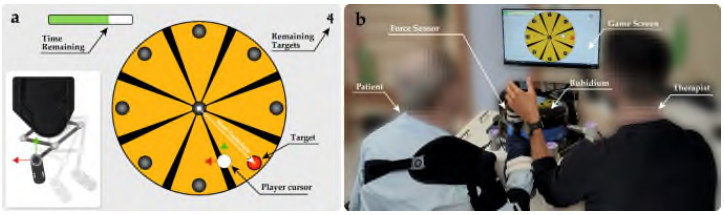
UNSUPERVISED MACHINE LEARNING

REINFORCEMENT MACHINE LEARNING

Gupta, V., Kariotis, S., Rajab, M.D. *et al.* Unsupervised machine learning to investigate trajectory patterns of COVID-19 symptoms and physical activity measured via the MyHeart Counts App and smart devices. *npj Digit. Med.* **6**, 239 (2023). https://doi.org/10.1038/s41746-023-00974-w

Robots in Therapy

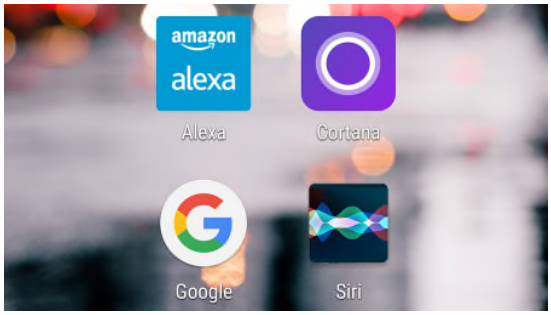
- According to the Journal of Neuro Engineering and Rehabilitation: January 2025
  - Robot-aided Rehabilitation with patients with neurological conditions
    - Learning how to deliver assistance based on therapist input
    - Robotic machine learning to adjust assistance levels during exercises
  - Robot-aided Rehab



Martínez-Pascual, D., Catalán, J.M., Lledó, L.D. *et al.* A deep learning model for assistive decision-making during robot-aided rehabilitation therapies based on therapists' demonstrations. *J NeuroEngineering Rehabil* 22, 18 (2025). https://doi.org/10.1186/s12984-024-01517-4

Natural Language Processing

Natural language processing (NLP) is a subfield of computer science and artificial intelligence (AI) that uses machine learning to enable computers to understand and communicate with human language.



https://www.ibm.com/think/topics/natural-language-processing

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Language Models & Large Language Models (LLMs)

- **Language Model:** *software that uses a language model to generate text (such as responses to queries or prompts)*
- **Large Language Model**: *a language model that utilizes deep methods on an extremely large data set as a basis for predicting and constructing natural-sounding text*

"Artificial intelligence." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/artificial%20intelligence. Accessed 17 Jan. 2026.

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Ambient Technology Example

LLM= The Brain

NLP- Understands Language

Machine Learning: Learns

AI in Healthcare: Compliance, Policy, and Patient Care

Presented by Amy McDermott, M.S., CCC-SLP, CHC, SHRM-CP
Senior Vice President of Compliance
EmpowerMe Wellness

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Pump Up The Jam

- **Low Volume: Scheduling, documentation support**
- **Medium Volume: Pattern recognition, care coordination**
- **High Volume: Clinical recommendations, patient care decisions**

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Core Principle

- Innovation without discernment isn't progress.
- In healthcare, AI should assist care – not accelerate risk.

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What Does Not Change

- Clinical accountability remains human
- Professional judgment cannot be delegated
- Licensed clinicians own outcomes

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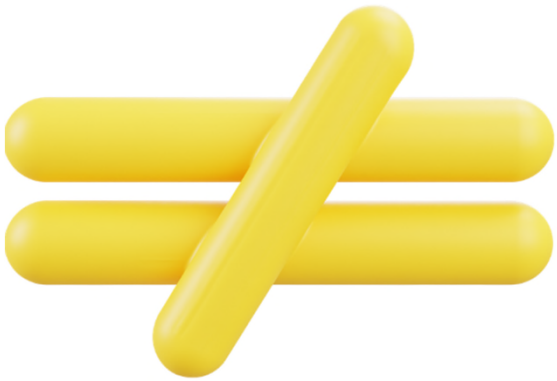
What DOES Change

- Documentation standards
- Workflow oversight
- Transparency requirements

Patient Transparency: Simple, Honest, Proportional

- Not a waiver.
- Not a liability shield.
- Not a reason to alarm patients.



The Pitfalls

1. **Using AI Just Because It Exists.**
2. **No Disclosure At All.**
3. **Treating AI Like Regular Software.**

Risk Assessment Framework

Top: Clinical recommendations, risk stratification, patient messaging

Middle: Documentation assistance, pattern recognition, care coordination

Bottom: Scheduling, workflow optimization, administrative support

From Philosophy to Practice: What does Monday morning look like?

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Policy Language – Clinical Decision Support

"When AI-assisted tools are used to support clinical documentation or care coordination, the licensed clinician must review, edit as necessary, and authenticate all AI-generated content before it becomes part of the official medical record. AI-generated content that has not been reviewed and authenticated by a licensed clinician is not considered valid clinical documentation."

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Policy Language - Override Documentation

When a clinician overrides an AI recommendation or modifies AI-generated content, the clinical rationale must be documented in the patient record. This documentation serves to:

- Preserve clinical judgment
- Create an audit trail
- Protect against liability claims
- Identify patterns where AI tools may need recalibration

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Policy Language - Vendor Requirements

All contracts with AI vendors should include:

- Audit log access and retention periods
- Model transparency and update notification
- Data usage rights and training exclusions
- Incident response and liability protocols
- Compliance with applicable state regulations

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Consent vs. Notification Framework

Visual: Decision tree

Does AI influence clinical decisions or patient-facing communication?

NO → Notification sufficient

YES → Continue to next question

Is the influence automated or does it require clinician review?

Requires review → Notification sufficient

Automated → Explicit consent required

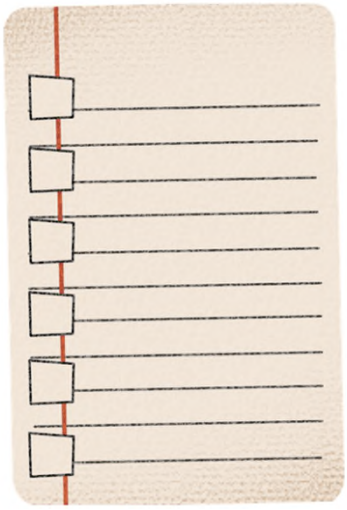
The Gray Zone

Examples Requiring Judgment:

- Fall risk scoring that triggers care plan changes
- Medication interaction alerts that delay treatment
- AI-generated patient education materials
- Automated appointment reminders with health information

Audit and Monitoring Requirements

- ❑ Documentation review rate (Are clinicians actually reviewing AI content?)
- ❑ Override patterns (What gets overridden and why?)
- ❑ Patient complaints related to AI
- ❑ Vendor model updates and notifications
- ❑ Training completion rates
- ❑ Policy compliance spot checks
- ❑ AI data handling compliance (Are staff using only approved tools? Any evidence of PHI entered into open systems?)



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Training Requirements

Clinical Staff:
- Critical evaluation of AI suggestions
- When and how to override
- Documentation requirements

Administrative Staff:
- What can/cannot be disclosed
- How to handle AI complaints
- Consent vs. notification protocols

Leadership:
- Metrics for mature vs. immature AI use
- How to evaluate vendor claims
- Risk escalation protocols

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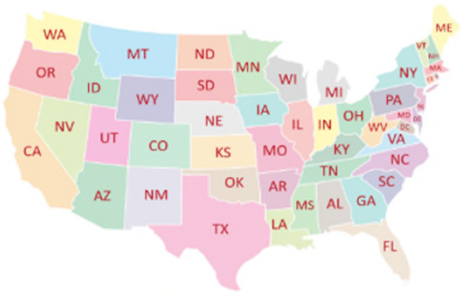
State Law Compliance Variations

California: AI disclosure requirements for diagnostic tools

Colorado: AI bias audit requirements

Illinois: Strict biometric data rules affecting AI training



What Gets WORSE With AI

New Risks AI Introduces:

- Documentation fraud becomes harder to detect
- Liability amplification through "the computer said so"
- Automation bias reduces clinical skepticism

Risk Assessment in Action

- **HIGH RISK - Requires comprehensive review:**
  - ✓ AI recommending treatment modifications
  - ✓ Patient-facing AI chatbots
  - ✓ AI-driven risk stratification affecting care access
  - ✓ Predictive algorithms for clinical outcomes
- **MEDIUM RISK - Requires compliance + clinical review:**
  - ✓ AI documentation assistance
  - ✓ Pattern recognition tools
  - ✓ Care coordination support
  - ✓ Clinical alert systems
- **LOW RISK - Standard approval process:**
  - ✓ Scheduling optimization
  - ✓ Administrative workflow tools
  - ✓ General health education content
  - ✓ Non-clinical patient communication

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The AI Risk & Bias Tool

1. **Influence on Care**
   - Administrative support
   - Clinical guidance
   - Patient-facing decisions
2. **Human Accountability**
   - Review required
   - Override authority
   - Documentation expectations
3. **Patient Transparency**
   - Notification vs. consent
   - Plain-language disclosure
   - Trust implications

Higher influence requires greater scrutiny.

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Closing Framework

The organizations that get this right will pair:

- Innovation with discernment
- Power with responsibility
- Efficiency with patient benefit

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Engaging with AI / Tech Vendors

What OTs, PTs, and SLPs should ask before saying "yes!"

Jordan Bowman, M.A. CCC-SLP

NARA 2026

The Core Question

Was this technology designed for therapy in senior living and skilled nursing — or adapted later?

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Why This Matters Now

AI and automation are accelerating in rehab and senior living

Vendors often market to executives — not clinicians

The wrong technology increases burnout and risk

The right technology:

- Improves resident outcomes
- Reduces documentation burden
- Supports compliance and sustainability

Athelas
Powered by Commure

Clinical Fit + Workflow

Ask vendors:

- How does this support *my* discipline (SLP / OT / PT) specifically?
- Can you show a real therapy session workflow?
- How does goal tracking, progress notes, and outcomes reporting work?
- Does this support interdisciplinary coordination?

Red flag 🚩: Generic demos without therapy-specific examples

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Powered by Commure

Documentation + Burden

Ask vendors:

- How much documentation time does this realistically save per day?
- What parts of documentation are automated vs clinician-controlled?
- How does it support skilled justification and medical necessity?

Reality check ✅ : AI should assist — not replace — clinical judgment

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Compliance + Risk

Ask vendors:

- How does this support regulatory compliance in senior living?
- How is PHI protected? (HIPAA, audits, access controls)
- Can documentation be audited and defended?

Key insight 🛡️: Compliance risk ≠ just billing — it includes clinical documentation quality

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Powered by Commure

Interoperability + Integration

Ask vendors:

- Does this integrate with our EHR, scheduling, and billing systems?
- Is data shared automatically or manually?
- What standards are used (APIs, HL7, FHIR)?

Watch for 🚩: "We export spreadsheets" as a solution

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Resident + Family Engagement

Ask vendors:

- How does this EHR / RCM / scribe workflow affect the *resident experience* during therapy sessions?
- Does documentation happen **with** the resident — or pull the clinician away from them?

Remember 🧩**:** Therapy technology doesn't live in the background. It shapes attention, connection, communication — and quality of life.

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Outcomes + ROI

Ask vendors:

- What outcomes can we measure today?
- Can metrics be customized for therapy quality and efficiency?
- Do you have case studies in senior living rehab?

Important 📊 : ROI includes staff retention and reduced burnout

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"How do you ensure this platform/tech continues to evolve over the next 3–5 years?"

Follow-ups:

- "What specifically is on your product roadmap for the next 12–24 months?"
- "What signals tell you when the product needs to change?"
- "What's your operator to engineer ratio?"

What you're listening for

- Concrete roadmap themes (not feature lists)
- Clear ownership (named teams, not "we plan to")
- Evidence of iteration driven by customers, not hype

Red flag 🚩*:* "We're constantly innovating" with no specifics.

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CLINICIAN ROI RUBRIC (OT / PT / SLP)

Dimension	Low Benefit	Moderate Benefit	High AI ROI
Documentation Burden	Real-time only	End of day	Nights / weekends
Caseload Complexity	Low acuity	Mixed acuity	High cognitive & fall risk
Care Coordination	Minimal	Some IDT	Heavy IDT + nursing
Burnout Risk	Low	Moderate	High
Clinical Insight Access	Manual recall	Some dashboards	Needs trend-based insights

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OPERATOR ROI RUBRIC

Operator Priority	AI Contribution	ROI Signal
Falls Reduction	Predictive risk insights	Fewer incidents
Length of Stay	Faster functional gains	Improved LOS
Census Growth	Outcomes storytelling	Sales differentiation
Staff Retention	Less burnout	Lower turnover cost
Margin Protection	Automation & accuracy	Reduced leakage
Visibility	Real-time dashboards	Better decisions

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Key Questions to Ask RCM Vendors During Your Search

Technology & Automation	Transparency & Reporting	Revenue & Outcomes
What aspects of your RCM process are powered by AI or automation? How does your system handle claim scrubbing and error detection before submission? Do you integrate with my EHR, scheduling, or billing system natively—or via API? How frequently is your technology updated, and what's your process for continuous improvement?	What level of visibility do I have into my claims, denials, and collections? Can I access real-time dashboards for AR aging, payer trends, and collection rates? Do you provide custom reporting by payer, location, or provider? How do you measure and communicate performance metrics to clients?	What is your average improvement in AR days, denial rates, and collections across clients like ours? How long does it take to see measurable ROI? Do you have client case studies or references? How are incentives aligned—do you charge a flat rate, percentage of collections, or hybrid model?

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Key Questions to Ask RCM Vendors During Your Search

Compliance & Data Security	Team & Support	Implementation & Scalability
How do you ensure HIPAA compliance and patient data protection? Where is your data stored, and what encryption protocols do you use? How do you manage compliance with CMS, Medicare, and payer-specific regulations? Are there audit trails for all transactions and claim modifications?	What does your client support structure look like (dedicated rep, ticket system, chat)? How quickly do you respond to issues or claims inquiries? What level of training do you provide to our internal team? Do you partner with us strategically to identify revenue opportunities, or only manage billing tasks?	What is the average implementation timeline? How do you manage data migration and ensure no disruption to cash flow? How do you scale as our organization grows or adds service lines/sites? What does your onboarding and change management process look like?

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Thank You

Jordan Bowman, M.A. CCC-SLP
jordan.bowman@getathelas.com

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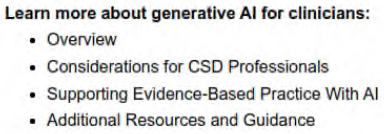
Resources

- https://www.whitehouse.gov/wp-content/uploads/2025/07/Americas-AI-Action-Plan.pdf

- https://www.**asha**.org/practice/generative-artificial-intelligence-for-clinicians

ASHA



Resources

AOTA: Artificial Intelligence and Occupational Therapy: From Emerging Occupation to Educational, Practice, and Policy Imperative - Vol. 79, Issue 6 – Nov/Dec – 2025

- https://www.research.aota.org/ajot/article-abstract/79/6/7906347100/28460

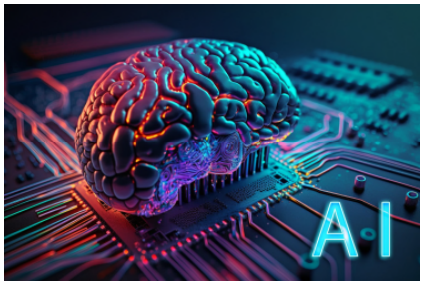
AOTA American Occupational Therapy Association

APTA: Digital Health Technologies, Digital Therapeutics, and Artificial Intelligence in Physical Therapist Practice

- https://www.apta.org/apta-and-you/leadership-and-governance/policies/digital-health-technologies-digital-therapeutics-and-artificial-intelligence-in-physical-therapist-practice

APTA American Physical Therapy Association

Resources



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Google AI Essentials Specialization

5 course series – for free

- https://www.coursera.org/specializations/ai-essentials-google

- Martínez-Pascual, D., Catalán, J.M., Lledó, L.D. *et al.* A deep learning model for assistive decision-making during robot-aided rehabilitation therapies based on therapists' demonstrations. *J NeuroEngineering Rehabil* 22, 18 (2025). https://doi.org/10.1186/s12984-024-01517-4

- https://www.ibm.com/think/topics/natural-language-processing

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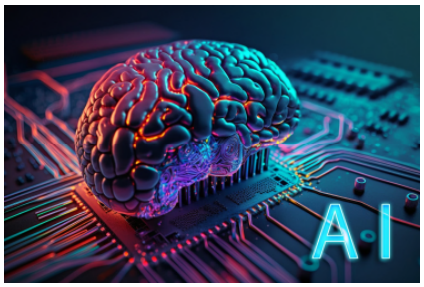

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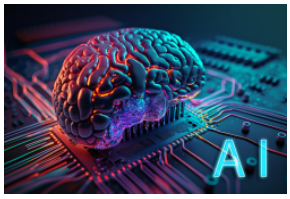
Gupta, V., Kariotis, S., Rajab, M.D. *et al.* Unsupervised machine learning to investigate trajectory patterns of COVID-19 symptoms and physical activity measured via the MyHeart Counts App and smart devices. *npj Digit. Med.* **6**, 239 (2023). https://doi.org/10.1038/s41746-023-00974-w

NARA Solution Partners



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- Athelas - Jordan.bowman@commure.com
  - Reseach: https://www.athelas.com/research-reports-and-guides?4348be99_page=1
- Innova Health – Zack Butterfield zack@innovahealth.com
- Limber Health / Net Health - https://www.limberhealth.com/for-providers/outcome
- One Step - https://onestep.co/product
- RESTORE Insights – Kerry@restoreskills.com https://restoreskills.com/
- Rehab Connect - https://www.z-pax.com/rehab-connect
- SaRA Health – steven@sarahealth.com www.sarahealth.com
- Via Cura - https://www.viacura.net/

EMPOWERME® WELLNESS

AI TOOL RISK & BIAS ASSESSMENT SCORECARD

Tool Name: _____
Vendor: _____
Evaluator: _____
Date: _____

ⓘ **Purpose**: This scorecard is a structured **risk-assessment and decision-support tool**. It does not replace clinical judgment, legal review, or ongoing monitoring. It is designed to surface risk, bias, and readiness issues **early and consistently**.

This scorecard supports responsible innovation that improves care while protecting patients, care providers, and the organization.

When to use:

- Prior to AI vendor contracting
- During procurement evaluations
- Annually for existing tools
- After material model or scope changes

How Scoring Works (Read First)

This scorecard evaluates AI risk across **five independent domains.** Scores are not combined into a single total.

Each section answers a distinct question:

- **Clinical Risk**: What could go wrong clinically, and how quickly?
- **Bias & Equity Risk**: Could the tool introduce or amplify inequities?
- **Regulatory & Compliance:** Are minimum legal and contractual safeguards met?
- **Operational Readiness**: Can the organization support this tool today?
- **Vendor Red Flags**: Are there trust, governance, or credibility concerns?

A **low score in one domain does not offset a high score in another**. Final recommendations must reflect the **highest area of risk**, not an average.

For scoring consistency, all **High-Risk** responses are capped at **3 points**. Scores indicate **severity tiers**, not statistical precision.

Each section uses its **own scale**, based on the number of risk factors assessed. Section scores are interpreted **independently**.

Interpretation: This scorecard does not make the decision for you. It structures disciplined decision-making. A high-risk score does not automatically mean “no,” but it ***does*** require proportionate safeguards before proceeding. Scores reflect risk exposure, not likelihood of harm.

Not intended to be legal or clinical advice. January 2026

EMPOWERME® WELLNESS

🎯 INTENDED USE & CONTEXT

1. What problem is this tool intended to solve?

_____

_____

_____

2. Is this tool replacing or supplementing an existing process?

☐ Replace (AI output substitutes for a human task)
☐ Supplement (AI informs but does not replace a human task)
☐ New capability

3. Who is the intended user?

☐ Licensed clinician
☐ Non-clinical staff
☐ Patient
☐ Caregiver
☐ Multiple (specify): _____

4. Is use of this tool optional or required?

☐ Optional
☐ Required

Note: *This assessment applies only to the intended use described above. Any expansion of scope requires re-evaluation.*

🩺 SECTION 1: CLINICAL RISK ASSESSMENT

Purpose: Evaluates the potential for patient harm if the AI tool performs incorrectly, is over-relied upon, or operates outside appropriate clinical oversight.

5. What does this AI tool do?

☐ Administrative support only (scheduling, workflow) LOW RISK (1) 🟢
☐ Documentation assistance (suggests language, summarizes) LOW RISK (1) 🟢
☐ Clinical decision support (flags risks, suggests options) MEDIUM RISK (2) 🟡
☐ Direct patient interaction (chatbots, messaging) HIGH RISK (3) 🔴
☐ Diagnostic or treatment recommendations (proposes a specific diagnosis or treatment) HIGH RISK (3) 🔴

6. Who makes the final decision?

☐ Licensed clinician reviews and approves all AI outputs LOW RISK (1) 🟢
☐ AI makes recommendations; clinician can override MEDIUM RISK (2) 🟡
☐ AI makes automated decisions in some circumstances HIGH RISK (3) 🔴
☐ AI makes fully automated decisions HIGH RISK (3) 🔴

7. What happens if the AI is wrong?

☐ Minimal impact (administrative inefficiency) LOW RISK (1) 🟢
☐ Delayed care or inconvenience MEDIUM RISK (2) 🟡
☐ Potential for clinical harm HIGH RISK (3) 🔴
☐ Serious patient safety risk HIGH RISK (3) 🔴

8. How quickly could harm occur if the AI behaves incorrectly?

☐ Slowly, detectable over time LOW RISK (1) 🟢
☐ Moderately fast, detectable with monitoring MEDIUM RISK (2) 🟡
☐ Rapid, before intervention is possible HIGH RISK (3) 🔴

📊 **CLINICAL RISK SCORE:**

- For each question, record the highest-risk response selected.
- Add the scores from Questions 5–8.

Total Clinical Risk Points: ____ /12

- **4 points** = Low Risk 🟢
- **5–8 points** = Medium Risk 🟡
- **9–12 points** = High Risk 🔴

⚖️ SECTION 2: BIAS & EQUITY ASSESSMENT

Purpose: Assesses whether the AI tool may introduce, amplify, or obscure bias or disparate impact across patient populations, including through opaque training data or non-representative datasets.

9. What data was used to train this AI model?

☐ Vendor provides complete transparency on training data LOW RISK (1) 🟢
☐ Vendor provides partial information on training data MEDIUM RISK (2) 🟡
☐ Vendor claims proprietary/confidential training data and provides only high-level detail HIGH RISK (3) 🔴
☐ Vendor cannot or will not disclose training data HIGH RISK (3) 🔴

10. Does the training data composition reflect your patient population?

☐ Yes, vendor confirms demographic match LOW RISK (1) 🟢

☐ Partially - some demographic gaps MEDIUM RISK (2) 🟡

☐ Unknown - vendor has not provided this information — HIGH RISK (3) 🔴

☐ No - significant demographic mismatches exist — HIGH RISK (3) 🔴

⚠️ *Unknown or non-representative training data increases the likelihood of structural bias and requires follow-up.*

11. Has the tool's performance been tested for bias across demographic groups (by the vendor or a third party)?

☐ Yes, vendor provides bias audit results LOW RISK (1) 🟢

☐ Yes, but only for some demographic factors MEDIUM RISK (2) 🟡

☐ Vendor claims testing but provides no documentation HIGH RISK (3) 🔴

☐ No bias testing has been conducted HIGH RISK (3) 🔴

12. Which populations might be disadvantaged by this tool?

Check all that apply:

☐ Racial/ethnic minorities

☐ Non-English speakers

☐ Elderly patients

☐ Patients with disabilities

☐ Rural populations

☐ Low-income populations

☐ LGBTQ+ patients

☐ Other: _____

☐ Unknown - insufficient data to assess

⚠️ *Each selection adds +1 point. Selecting "Unknown" adds +1 point and requires follow-up even if no specific population is identified.*

13. Are AI outputs meaningfully explainable to clinicians?

☐ Yes - clear explanation of how conclusions are reached LOW RISK (1) 🟢

☐ Partially - limited transparency MEDIUM RISK (2) 🟡

☐ Limited - "black box" HIGH RISK (3) 🔴

☐ No - fully opaque decision-making HIGH RISK (3) 🔴

🔢 **Bias Risk Scoring**

Total points from Questions (Q9, 10, 11, and 13): _____ / 12

Additional points (Q12) (populations identified): + _____

Total Bias Risk Points: _____ / 12+

Bias Risk Level:

- **4–6 points = Low Bias Risk** 🟢
- **7–9 points = Medium Bias Risk** 🟡
- **10–12+ points = High Bias Risk** 🔴

Note: Scores above 12 are possible when multiple populations are identified in Question 12.

🚩 **Mandatory Bias Escalation Rules**

Escalation is required if **any** apply:

- Bias Risk = High (10+ points)
- Any High-Risk score in Q9–11 or Q13 **and** any population identified
- AI affects access, prioritization, eligibility, or clinical decisions
- Training data or bias testing is unknown or undisclosed

🛠️ **MITIGATION & MONITORING**

(Required if Question 12 identifies any population)

Population(s) at risk: _____

Nature of potential disadvantage: _____

Planned safeguards: (e.g., clinician override, human review, translation services, enhanced monitoring)

_____

⚠️ *Bias risk must be reassessed as use cases or populations change.*

📜 **SECTION 3: REGULATORY & COMPLIANCE ASSESSMENT**

Purpose: Confirms whether the vendor and tool meet minimum legal, contractual, privacy, and disclosure requirements applicable to healthcare AI use.

14. Does the vendor meet required contract standards?

Mark Y (yes), N (no), or U (unknown) for each:

_____ Provides audit logs with retention guarantees*
_____ Commits to notifying us of model updates
_____ Specifies data usage rights and training exclusions*
_____ Has incident response and liability protocols
_____ Complies with state-specific AI regulations where we operate
_____ Provides PHI protection documentation
_____ Offers override capability for all AI recommendations*

Compliance Score: _____ / 7 requirements met

⚠️ *All "U" (unknown) responses represent unresolved compliance risks.*

* Core requirements — absence may preclude approval regardless of total score.

15. Vendor documentation provided:

☐ Peer-reviewed validation studies
☐ Internal validation data
☐ FDA clearance or approval (if applicable)
☐ Third-party bias audits
☐ Security/privacy certifications (SOC 2, HIPAA, etc.)
☐ Other
☐ None of the above

Documentation Quality:

- 4-5 items checked = Strong 🟢
- 2-3 items checked = Adequate 🟡
- 0-1 items checked = Insufficient 🔴

16. State law considerations: Do we operate in states with specific AI requirements?

☐ California
☐ Colorado
☐ Illinois
☐ Not applicable
☐ Other states: _____

Has vendor confirmed compliance with applicable state laws?

☐ Yes, with documentation
☐ Vendor claims compliance but provides no proof
☐ Vendor unaware of state-specific requirements
☐ Not applicable

⚠️ *Unverified claims or vendor ignorance of state requirements is a compliance risk.*

🛠 SECTION 4: OPERATIONAL READINESS

Purpose: Determines whether the organization has the policies, training, monitoring, and accountability structures necessary to deploy this AI tool safely today.

17. Do we have the infrastructure to use this tool responsibly?

☐ Staff trained to critically evaluate AI outputs
☐ Defined criteria for mandatory review
☐ Documented override and escalation process
☐ Training addresses automation bias (risk of over-reliance on AI outputs)
☐ Clear accountability for errors
☐ Audit process established
☐ Policy language updated
☐ Patient disclosure language prepared
☐ Incident response plan
☐ Defined criteria for suspension or de-implementation

Operational Readiness: _____ /10 requirements met

⚠️ *Fewer than 6 requirements met → implementation should be delayed.*

🚩 SECTION 5: VENDOR RED FLAGS

Purpose: Identifies credibility, governance, or representation concerns that undermine trust in the vendor or materially increase implementation risk.

Check any that apply:

☐ Vendor claims AI "eliminates the need for clinical review"
☐ Vendor cannot explain how AI works
☐ Vendor dismisses bias concerns
☐ Vendor refuses to commit to contractual requirements
☐ Vendor makes outcome guarantees ("will reduce falls by 40%")
☐ Vendor has no healthcare regulatory experience
☐ Vendor updates models without notification
☐ Vendor lacks clear liability/insurance coverage
☐ Marketing materials contradict technical documentation
☐ Uses proprietary performance metrics that cannot be independently validated

Red Flag Count: _____ flags identified

⚠️ One = scrutiny. Three+ = strong basis to decline.

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🧠 FINAL RISK ASSESSMENT

Clinical Risk: ☐ **Low** ☐ **Medium** ☐ **High**
Bias Risk: ☐ **Low** ☐ **Medium** ☐ **High**
Compliance Requirements Met: _____ / 7
Operational Readiness: _____ / 10
# of Red Flags Identified: _____

✅ RECOMMENDATION

Approval reflects risk acceptance with safeguards, not endorsement of accuracy.

☐ **APPROVE** - Low risk across all domains
☐ **APPROVE WITH CONDITIONS** – Risk identified but controllable prior to go live.

Conditions:

- Condition 1: _____
- Condition 2: _____
- Condition 3: _____

☐ **PILOT PROGRAM** – Real-world performance, bias behavior, or clinician interaction cannot be reliably predicted. (Pilot use is a risk-control strategy, not provisional approval.)

If selecting pilot, the following must be defined before proceeding:
☐ Define pilot duration and sample size
☐ Establish success/failure criteria before pilot begins
☐ Require interim review at ☐ 30 days ☐ 60 days ☐ 90 days
☐ Specify data collection and monitoring plan

☐ **DELAY** – Operational readiness insufficient. Reassess in ____ months.
☐ **DECLINE** - Risk too high or vendor unable to meet minimum requirements.

REQUIRED APPROVALS
☐ Compliance Officer
☐ Clinical Leadership
☐ Legal
☐ IT/Security
☐ Privacy Officer

Evaluator Signature: _____
Date: _____

POST-IMPLEMENTATION MONITORING
(For approved tools only)

Frequency of performance review: ☐ Monthly ☐ Quarterly ☐ Annually

Override rate monitoring threshold: ____%
(If override rate exceeds this threshold, trigger re-assessment)

Other triggers for re-assessment:

_____

_____

_____

DOCUMENTATION: Keep completed scorecards in vendor files.

END OF SCORECARD

Framework developed by Amy McDermott | 2026
Shared freely for learning and adaptation

Not intended to be legal or clinical advice.