eHEALTHDC
A DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION PROGRAM

**Helping Healthcare Providers Adopt Digital Health Technologies and Achieve HIE Connectivity in the District**

DCPCA
DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION

# ARPA Home and Community Based Services (HCBS) Digital Health Technical Assistance (TA) Program

*Best Practices for Improving EHR Data Quality*

March 22, 2024

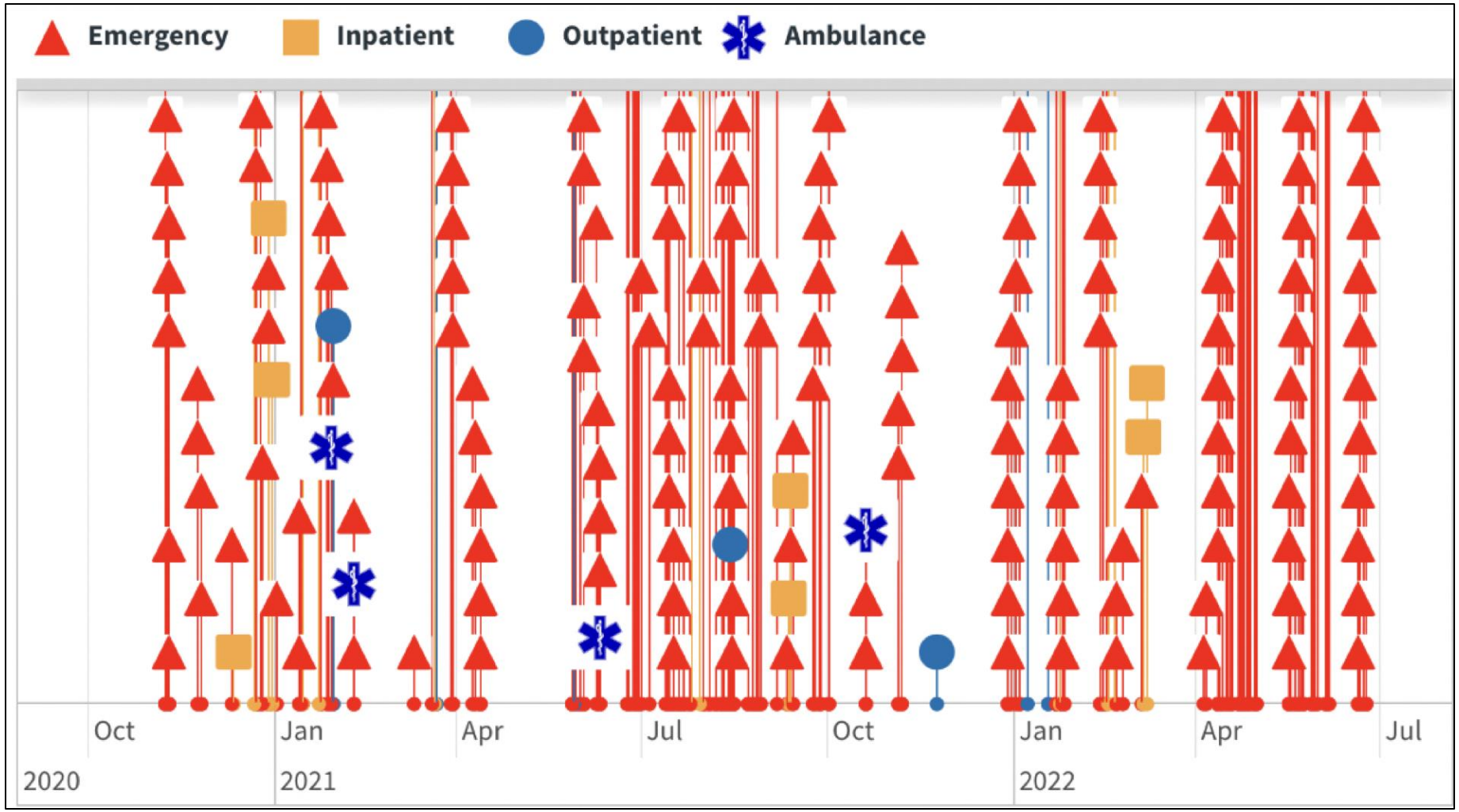
# How to Engage

- Use **Chat** to share questions and comments with the group

- Use **Raise Hand** function to be queued up for commenting / unmuting and share your comments with the group

# A Picture Is Worth A Thousand Words

## DC HIE Patient Snapshot



# Key Learning Objectives

1. Gain insights into the critical role that data quality plays in agency decision-making processes, provider service delivery, patient health outcomes, and overall organizational success

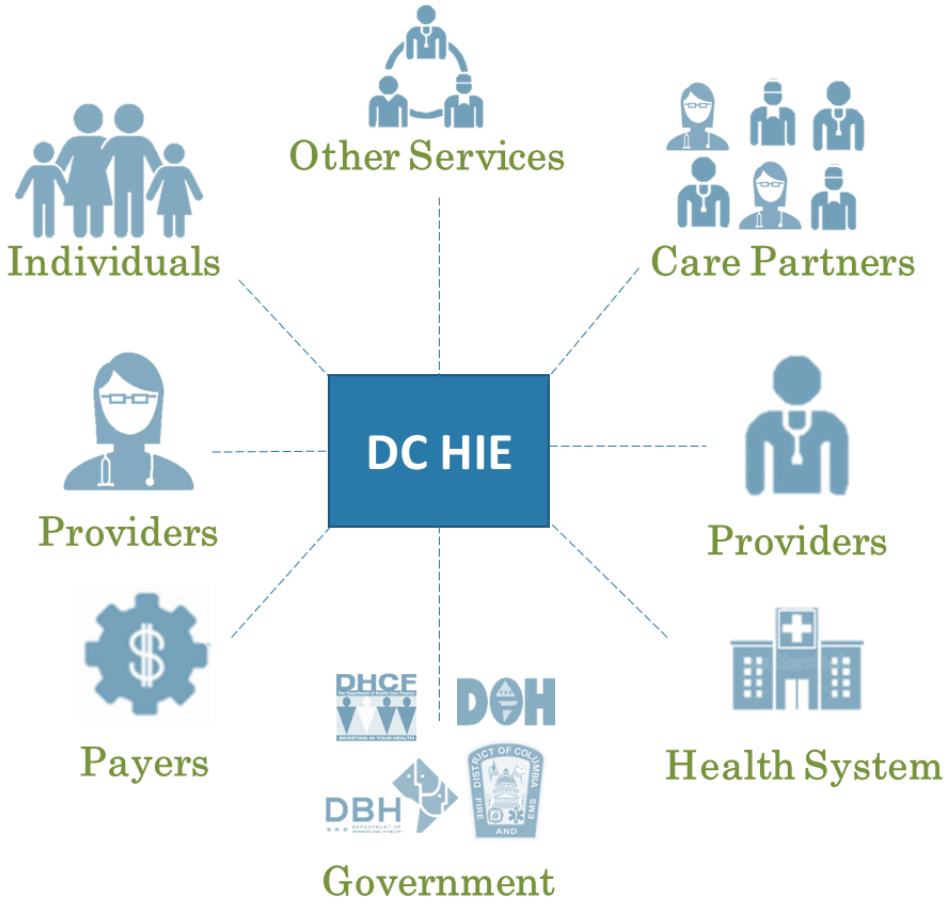
2. Acquire comprehensive knowledge about six dimensions of data quality and gain insights into practical strategies for improving data quality in your electronic health records (EHR) system

3. Enhance the value of the DC Health Information Exchange (HIE) for all stakeholders by implementing optimization techniques for Admission, Discharge, Transfer (ADT) and Continuity of Care Document (CCD) messages

4. Learn how to further elevate ADTs, CCDs, and overall EHR data by incorporating Social Determinants of Health (SDOH) information for a more holistic approach to care management and coordination

# Enable Information Sharing

- **Individuals** connected to multiple providers
- **Providers** connected to care partners and payers
- **Payers** connected to clinical information & services provided
- **Government** agencies connected to public health information



# Six Dimensions of Data Quality

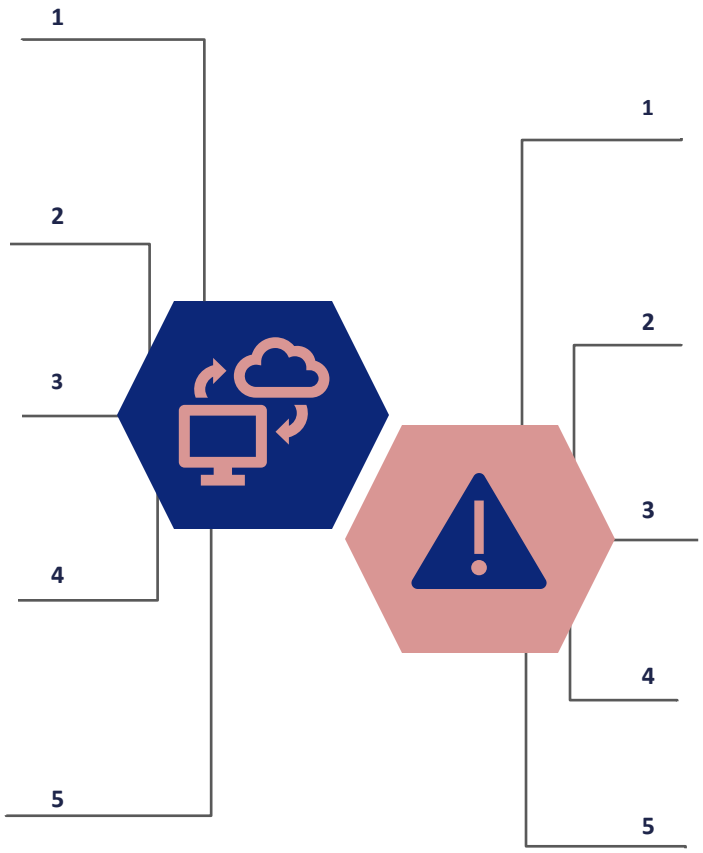
# ACCURACY

Records reflect the correct health status, medical history, and services provided

# Dimension #1: Accuracy Case Scenarios

## ACTION

1. **Incorrect** documentation of height, weight, body mass index
2. **Incorrect** documentation of allergies
3. **Incorrect** documentation of medication dosage
4. **Incorrect** documentation of symptoms (underrepresented/over exaggerated)
5. **Incorrect** documentation of diagnosis



## CONSEQUENCE

1. **Wrong** medication dosage administered, Inaccurate representation of trends in weight gain/loss
2. **Wrongly** prescribed a medication or provided a nutritional supplement that led to a reaction
3. **Improperly** controlled, drug-drug interactions, potential overdose
4. **Unnecessary** change or wrong medication prescribed
5. **Incorrect** medications prescribed and treatment plan

# TIPS & BEST PRACTICES FOR IMPROVING DATA ACCURACY

### Enter Accurate Data
Where possible, avoid using placeholder data such as entering all zeros for SSN or phone number

### Promote a Culture of Accuracy
Instill a culture where accuracy is prioritized in data entry. Recognize and reward staff for maintaining high standards of data accuracy and integrity

### Establish a Data Governance Team
Appoint a dedicated team or individual responsible for data quality and management (i.e., set standards, conduct audits, and be the go-to for any data-related issues)

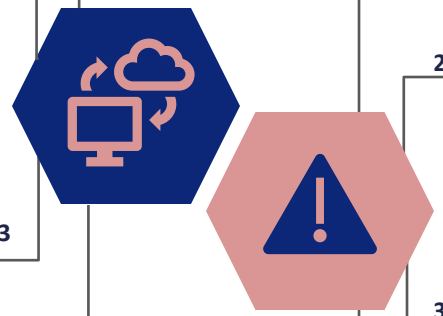
# COMPLETENESS

Records include all necessary data fields and narratives

# Dimension #2: Completeness Case Scenarios

## ACTION

1. **Lack** of documenting progression towards individual goals
2. **Incomplete** substance use history
3. **Missing** details in therapy session
4. **Neglect** to inform the agency of the need for rehabilitation services in the home setting



## CONSEQUENCE

1. **Repeating** tasks and prolonging achievement of higher-level independent living skills
2. **Incomplete** treatment planning
3. **Gaps** in understanding progress
4. **Inadequate** care planning resulting in missing services

# TIPS & BEST PRACTICES FOR IMPROVING DATA COMPLETENESS

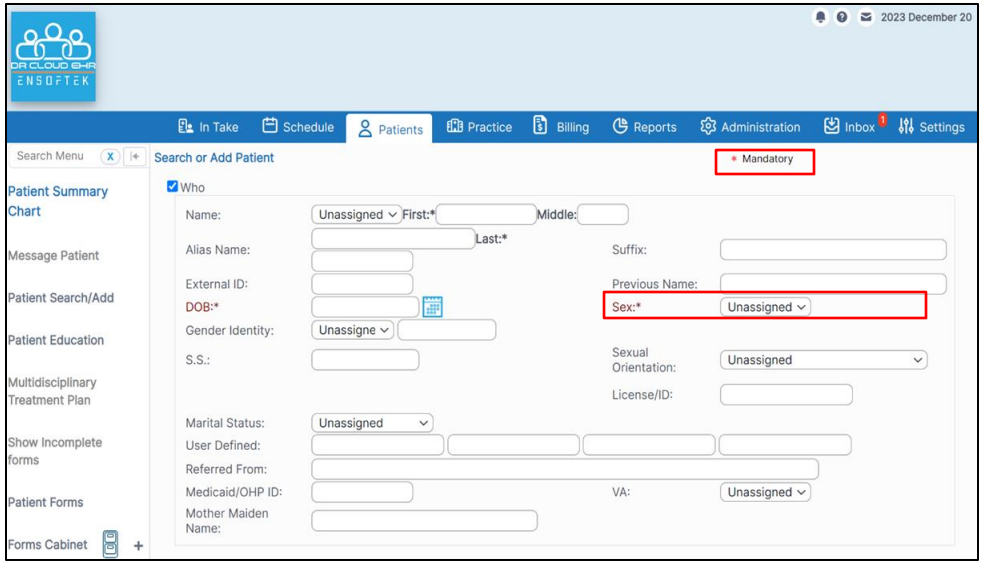
### Double Check Documentation
Ensure thorough documentation during treatment sessions

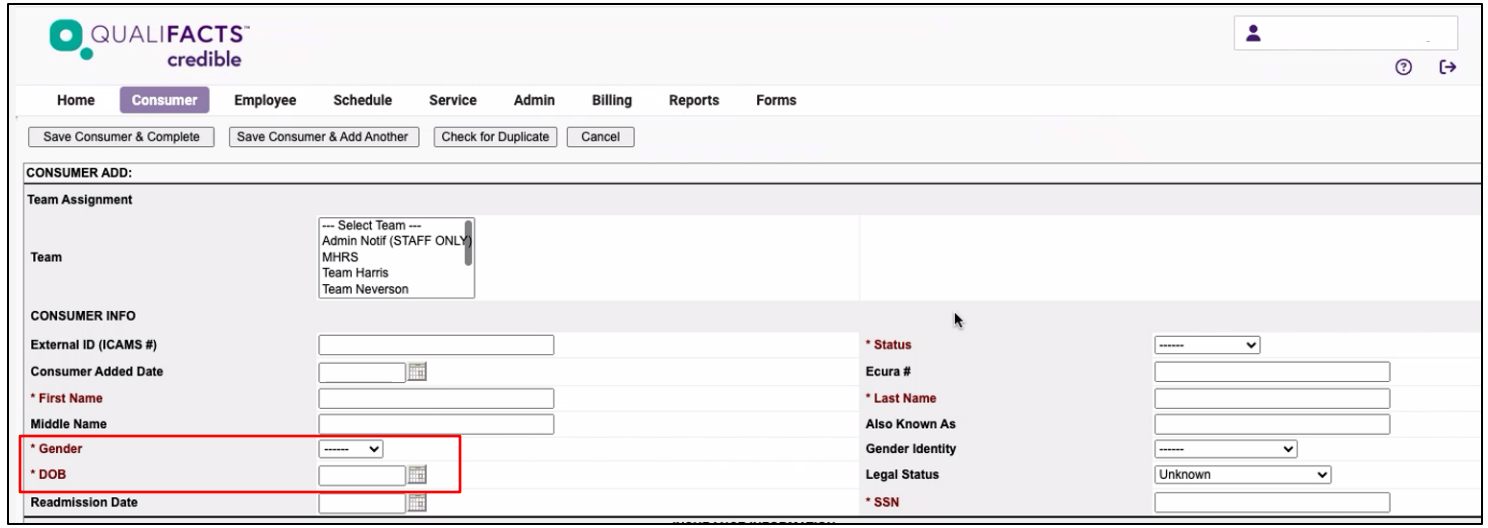
### Create Reports and Conduct Periodic Audits
Conduct regular audits of patient records and employee tasks to identify and rectify gaps in data completeness

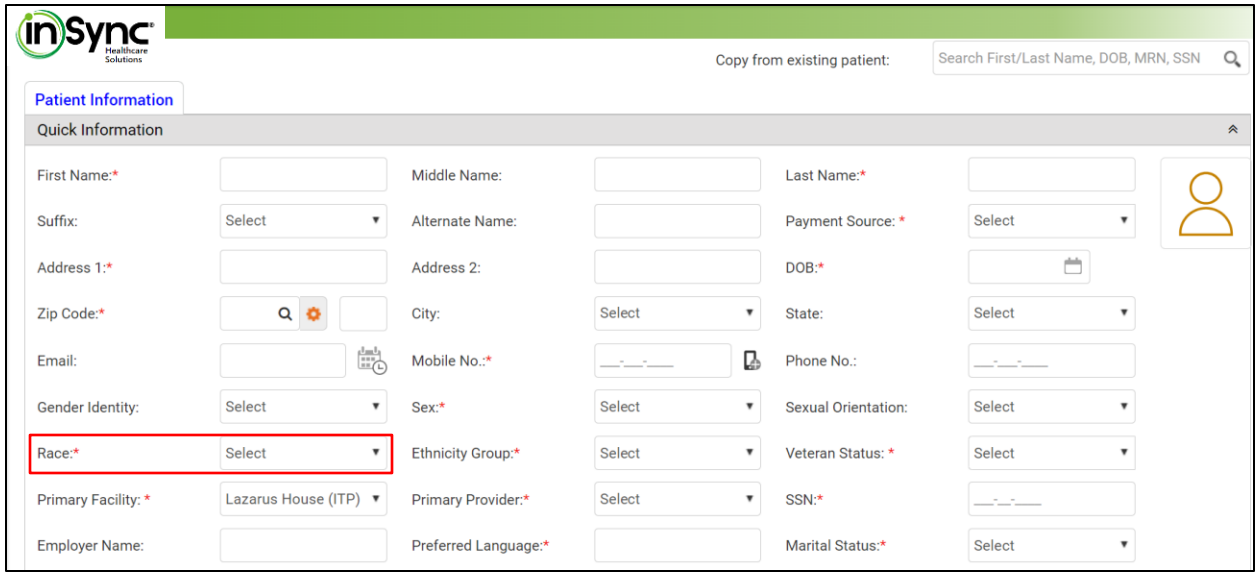
### Provide Ongoing Staff Training & Development
Ensure that everyone involved in data entry or processing is adequately trained and understand the importance of data accuracy and completeness

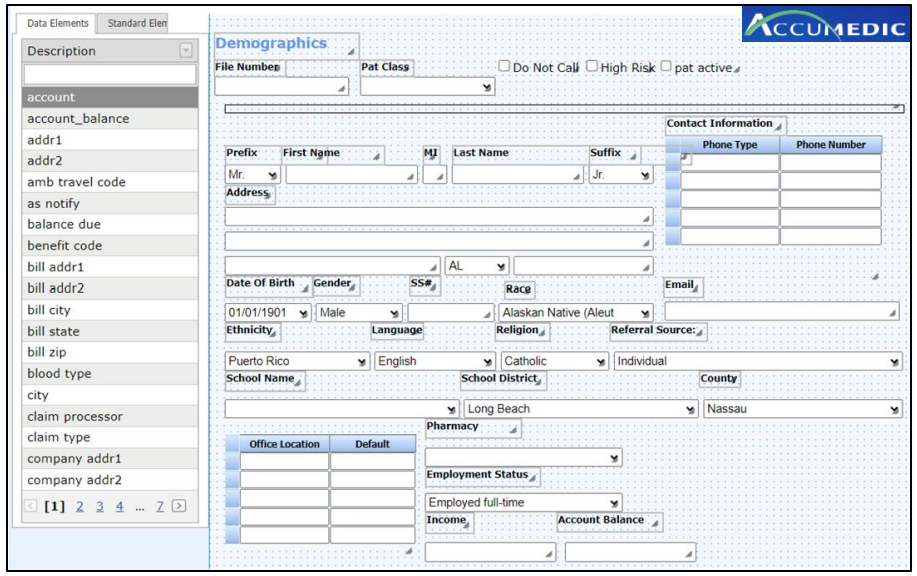
### Utilize EHR Templates and Form Builders
Implement mandatory fields in electronic forms for consistent and complete data capture

# Demographics & Mandatory Fields



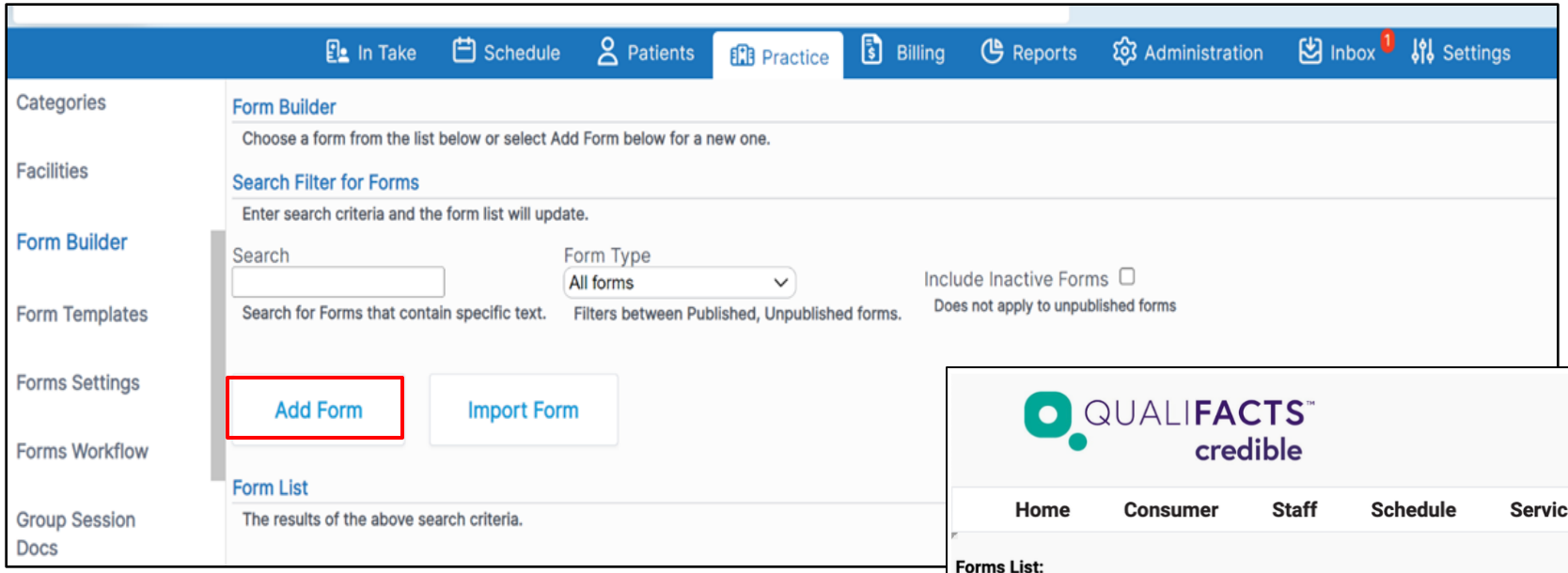



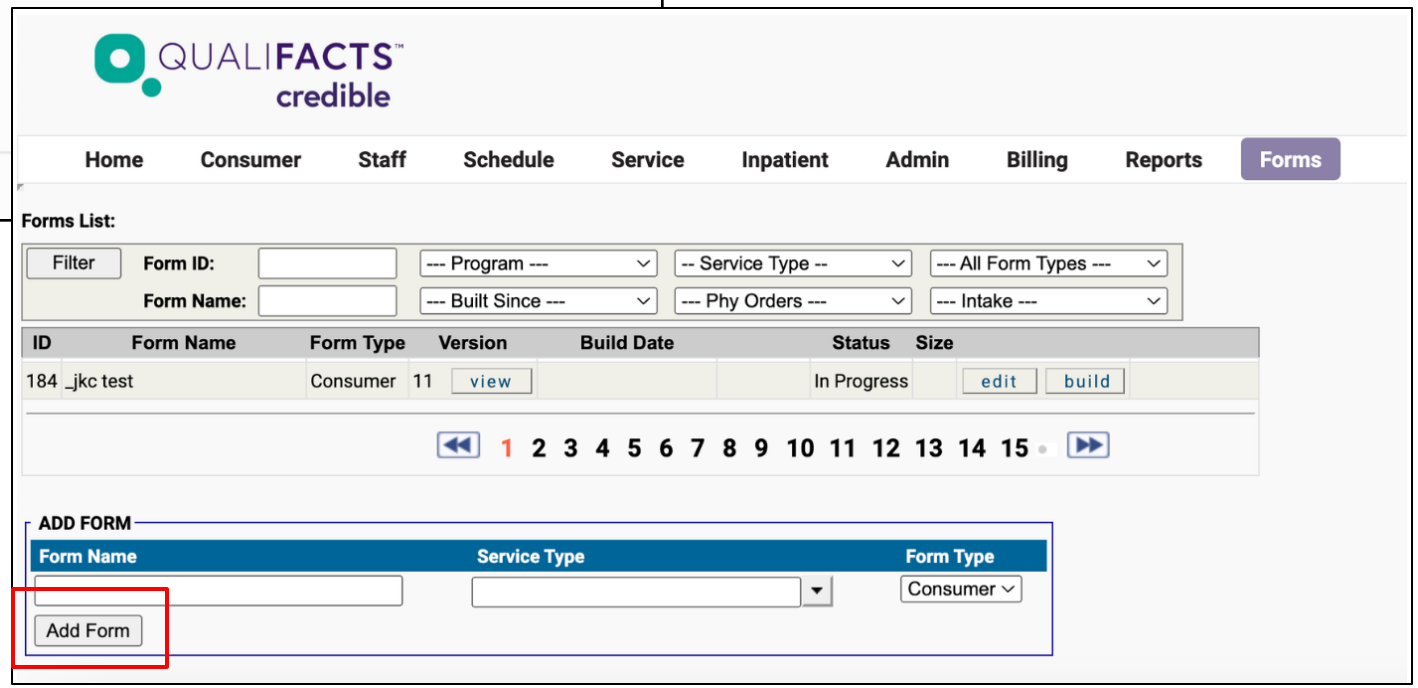



# Forms & Templates

- Form Builder is a user-friendly tool designed to effortlessly create clear and compact clinical forms.



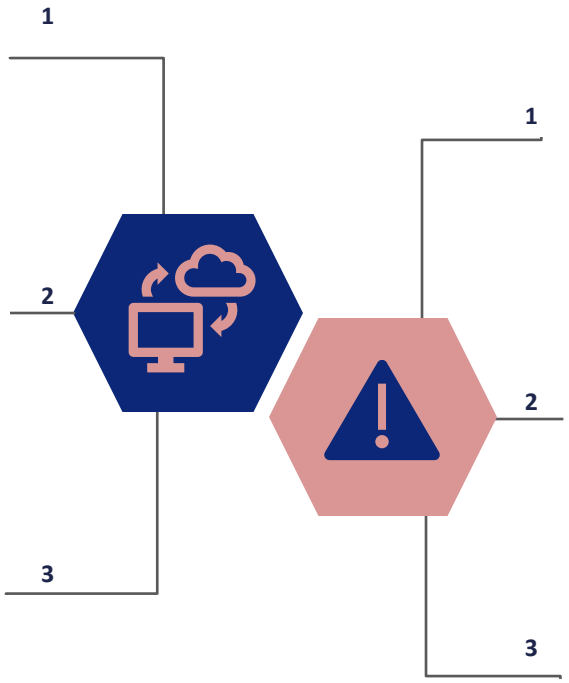
# CONSISTENCY

Records reflect appropriate use of tools and continuity of data across platforms

# Dimension #3: Consistency Case Scenarios

## ACTION

1. **Staff not** checking HIE for Encounter Notification Services (ENS) alerts
2. **Inconsistent** use of assessment tools
3. **Individual** neglected to inform the provider of a recent visit to the emergency room



## CONSEQUENCE

1. **Missed** individual's current Admission, Discharge, Transfer (ADT) state from other providers that could impact future care
2. **Incorrect** representation of individual's status
3. **Missed** medications and/or care plan changes and follow-up care

# TIPS & BEST PRACTICES FOR IMPROVING DATA CONSISTENCY

### Standardize Terminology and Assessments

Implement policies that encourage staff to use consistent assessment tools such as PHQ9 for Depression Screening, ASAM-American Society of Addiction Medicine, OASIS-Outcome Assessment and Information Set, Person Centered Questionnaire, Psychosocial Assessment, and other office form templates

### Utilize Structured Data Entry

Encourage the use of structured data entry formats in your EHR for any data fields that are not a unique identifier

### Develop and Utilize Workflow Documentation Tools

Leverage checklists, quick reference guides, and tip sheets, to promote consistent and timely data entry

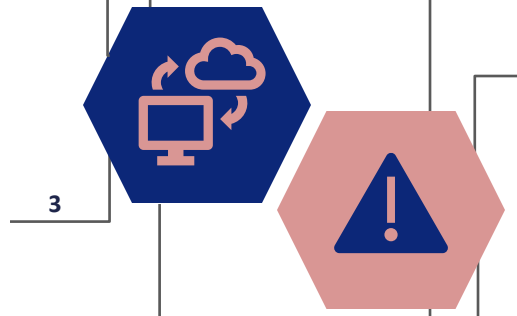
# TIMELINESS

Records reflect the most up-to-date changes and information

# Dimension #4: Timeliness Case Scenarios

## ACTION

1. **Delay** in transmitting the required information for the plan of care
2. **Delay** in entering a critical change in substance use pattern
3. **Late** documentation of a mood swing, affecting the treatment response
4. **Late** documentation of an achievement towards a goal



## CONSEQUENCE

1. **Outdated** information could compromise the individual's health, affect treatment outcomes and services provided
2. **Incorrect** treatment plan causes delay in recovery
3. **Treatment** not aligned with current mental state
4. **Prolongs** the individual's opportunity to work on higher-level independent living skills

# TIPS & BEST PRACTICES FOR IMPROVING DATA TIMELINESS

### Incorporate Review of HIE Encounter Notification Services (ENS) into Staff Workflow

Encourage timely locking of encounter notes to ensure HIE reflects the most up-to-date changes and information

### Document and Enforce Prompt Data Entry Policies

Encourage prompt data entry (24-48 hours is the suggested amount of time to complete documentation)

### Streamline Workflows

Aim to reduce documentation burden in your clinical workflow to enable more comprehensive and timely data capture

### Turn On Automated Alerts and Reminders

Set up automated alerts and reminders within EHR systems to notify staff about missing or incomplete data

# Notification Triggers In Credible

QUALIFACTS credible

Home | Consumer | Staff | Schedule | Service | Inpatient | Admin | Billing

**Daily Activities**

- Home Page
- Service Queue
- Staff Form Queue
- Dashboard
- Admin Time Queue
- Manage Teams
- Program Assignments
- Manage Resources
- Manage Foster Homes
- Bed Board Search
- Schedule Groups
- Notification Triggers

**Trigger List:**

Filter | -- Notification Triggers -- | -- Trigger

| | Trigger | Notification Title | | | |
|---|---|---|---|---|---|
| edit | Client Update | Upcoming Quarterly Review | | | |
| edit | Employee Add | Employee Added | | | |
| edit | Treatment Plan End Date | Consumer Plan of Care Notice Trigger | | | |
| edit | Treatment Plan End Date | Consumer Plan of Care Notice Trigger | | | |
| edit | Treatment Plan End Date | Consumer Plan of Care Notice Trigger | | | |
| edit | Treatment Plan End Date | Consumer Plan of Care Notice Trigger-ACT 4 | Client | N | delete |
| edit | Treatment Plan End Date | Consumer Plan of Care Notice Trigger-CSW | | | |
| edit | Authorization End | Expired Authorizations | | | |
| edit | Client Form Answer Selected | Consumer Referred to TIP | | | |
| edit | Client Form Answer Selected | Consumer Referred for Community Support at M | | | |
| edit | Client Form Answer Selected | Consumer Referred for Community Support at H | | | |
| edit | Client Form Answer Selected | Consumer Referred for Community Support at M | | | |
| edit | Client Form Answer Selected | Consumer Referred for Therapy at Minnesota | | | |
| edit | Client Form Answer Selected | Consumer Referred for Therapy at Hunt Place | | | |
| edit | Client Form Answer Selected | Consumer Referred for Therapy at MLK | | | |
| edit | Client Form Answer Selected | Client Referred to Outreach | | | |
| edit | Client Form Answer Selected | Consumer Referred for Day Treatment | | | |

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Add a New Trigger Entry

**To Do List**

| Summary | For | Begin Date |
|---|---|---|
| Consumer Plan of Care Notice Trigger-CSW | Consumer: Testing, John | 1/15/2024 |
| Consumer Plan of Care Notice Trigger-ACT 1 | Consumer: Testing, John | 1/15/2024 |
| Consumer Plan of Care Notice Trigger-ACT 2 | Consumer: Testing, John | 1/15/2024 |
| Consumer Plan of Care Notice Trigger-ACT 3 | Consumer: Testing, John | 1/15/2024 |
| Consumer Plan of Care Notice Trigger-ACT 4 | Consumer: Testing, John | 1/15/2024 |
| Consumer Plan of Care Notice Trigger-CSW | Consumer: Testing, John | 1/14/2024 |
| Consumer Plan of Care Notice Trigger-ACT 1 | Consumer: Testing, John | 1/14/2024 |
| Consumer Plan of Care Notice Trigger-ACT 2 | Consumer: Testing, John | 1/14/2024 |

All Current To Do List Items

**Trigger:** ---- SELECT ----

**Title:**

**Occur:** days to start occurence after trigger event

**Reminder:**

**Send Email:**

**Must Dismiss:**

**To Do List:**

Save | Cancel

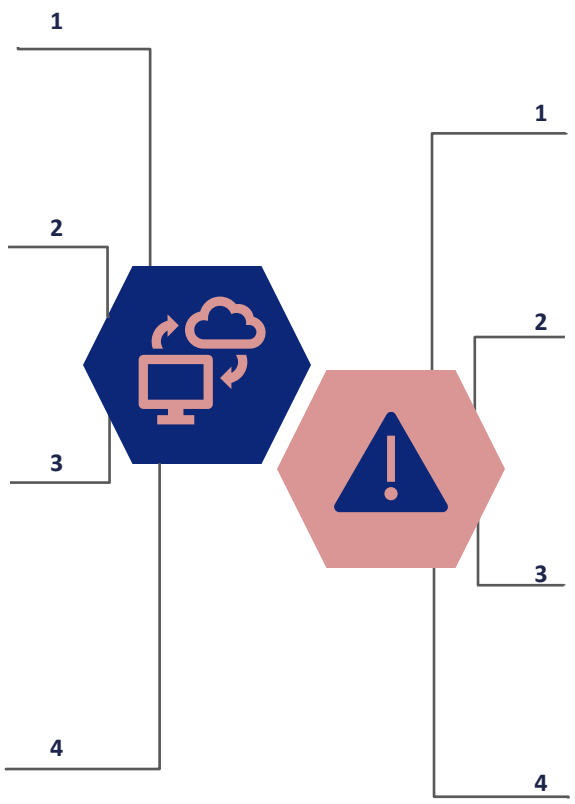
# VALIDITY

Records reflect the use of credible tools and sources of information

# Dimension #5: Validity Case Scenarios

## ACTION

1. **Reliance** on outdated substance use assessment tools
2. **Use** of unvalidated scales for symptom assessment
3. **Relying** on the individual or family member to provide information regarding medical appointments and treatments
4. **Use** of a method not stated in the Individual Service Plan (ISP) to measure progress towards goals can result in services being provided in an unsafe manner



## CONSEQUENCE

1. **Incorrect** representation of individual's status
2. **Incorrect** representation of individual's status
3. **Incorrect** representation of individual's status
4. **Incorrect** representation of individual's status

# TIPS & BEST PRACTICES FOR IMPROVING DATA VALIDITY

### Encourage Individuals to Regularly Validate their Data

Educate and encourage individuals to provide accurate and detailed information during appointments, which can enhance the completeness and validity of their medical record

### Leverage the HIE

Check the HIE for updated provider visit summaries for the most up-to-date information regarding medical appointments and treatments

### Develop and Utilize Workflow Documentation Tools

Leverage checklists, quick reference guides, and tip sheets, to promote consistent and timely data entry

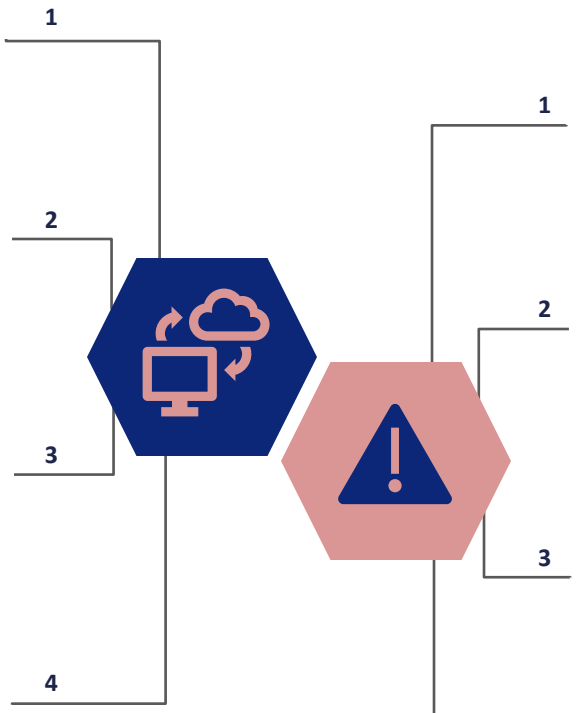
# RELIABILITY

Records reflect integrity, dependability, and consistency of data over time

# Dimension #6: Reliability Case Scenarios

## ACTION

1. **Inconsistent** tracking of an individual's recovery progress
2. **Variable** documentation of therapy outcomes across different sessions
3. **Inability** to consistently track health goals
4. **Variable** documentation of Individual Service Plan (ISP) outcomes across over time



## CONSEQUENCE

1. **Inability** to properly assess and plan further treatment
2. **Inability** to properly assess and plan further treatment
3. **Hinder** the assessment of interventions and progress towards goals
4. **Incorrect** representation of individual's status

# TIPS & BEST PRACTICES FOR IMPROVING DATA RELIABILITY

### Standardize Documentation Procedures
Implement and enforce Standard Operating Procedures (SOPs) related to data entry and validation

### Cross-Check Your Data
Encourage cross-verification of data by staff involved in patient care within your organization to help identify and rectify discrepancies

### Implement Data Quality Feedback Mechanisms
Create channels for staff to provide feedback on data entry challenges and regularly collect input from users to identify areas for improvement and address concerns

# Recap: Key EHR Data Quality Tips & Best Practices

## Establish a Data Governance Team
Appoint a dedicated team or individual responsible for data quality and management (i.e., set standards, conduct audits, and be the go-to for any data-related issues)

## Implement Data Quality Feedback Mechanisms
Create channels for staff to provide feedback on data entry challenges and regularly collect input from users to identify areas for improvement and address concerns


## Streamline Workflows
Aim to reduce documentation burden in your workflow to enable more comprehensive and timely data capture

## Create Reports and Conduct Periodic Audits
Conduct regular audits of records and employee tasks to identify and rectify gaps in data completeness

## Provide Ongoing Staff Training & Development
Ensure that everyone involved in data entry or processing is adequately trained and understand the importance of data accuracy and completeness

# PROMOTE MEANINGFUL DATA EXCHANGE

# Meaningful Data Exchange

- Admission, Discharge, Transfer Messages (ADT)
  - Deemed the "go-to data source for care coordination efforts across states" by the Office of the National Coordinator for Health IT (ONC)*
  - Communicates that an individual's "state" (admitted, discharged, or transferred) has changed
  - Communicates demographic information (i.e. name, insurance, next of kin, attending doctor, etc.) has been updated

- Continuity of Care Document (CCD)
  - A summary of an individual's encounter information in electronic form
  - It gives providers a standard way to share a comprehensive and concise view of an individual's history and current condition
  - A valuable tool to advance research and public health

*Source: https://www.healthit.gov/buzz-blog/state-hie/hie-bright-spots-adt-messages-support-care-coordination-part-ii
**Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3483927/

# Context Matters: Enhance ADTs & CCDs

## Good

Individual is associated with your organization in the HIE

## Better

Comprehensive encounter information (admit reason, services provided, etc.) is shared with the HIE

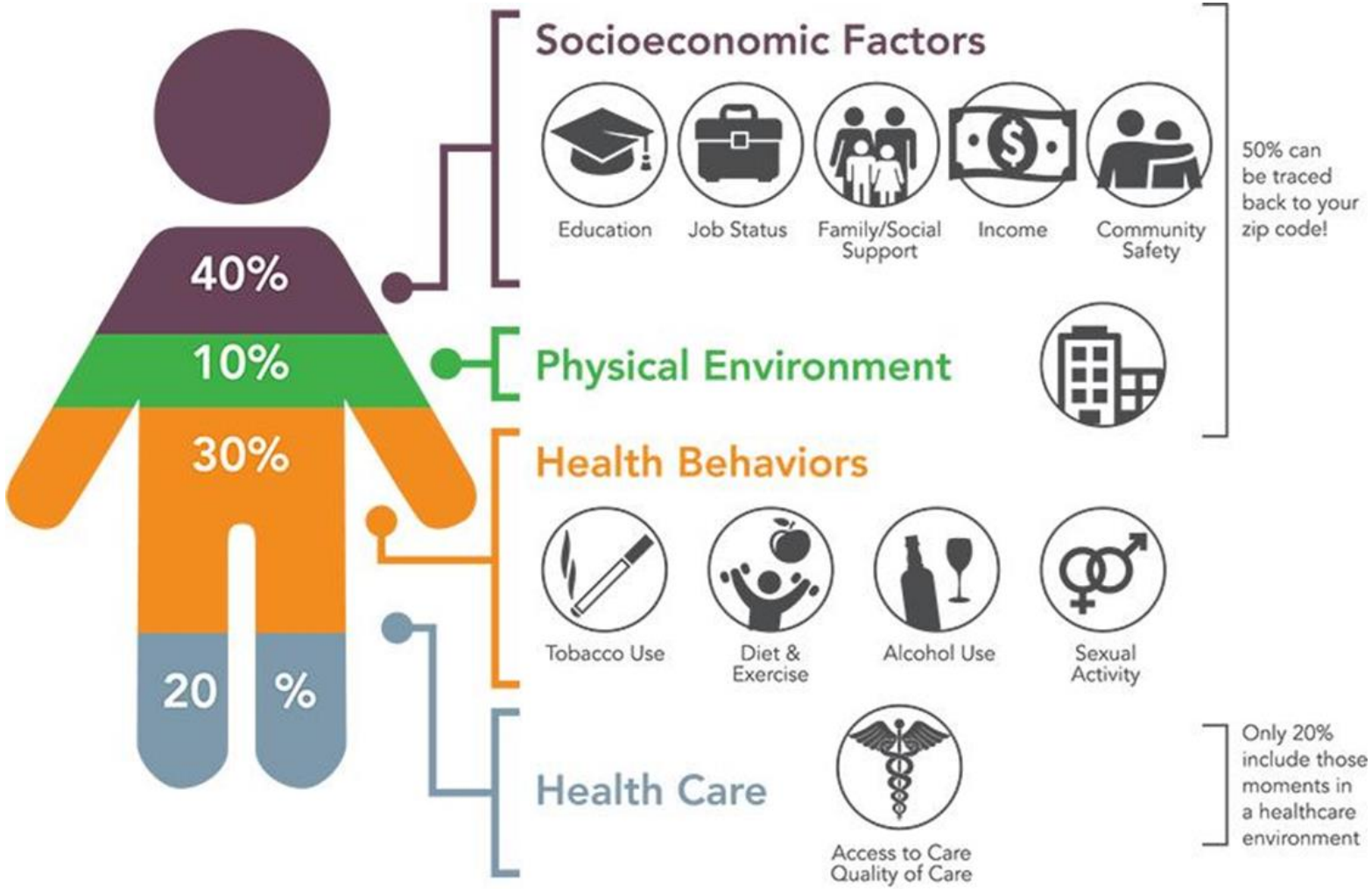
## Best

Additional context such as race, ethnicity, and other socioeconomic factors are shared with the HIE

*"Good, better, best, don't let it rest until the good is better and the better is best!"*

# Social Determinants of Health (SDOH) Integration

# SDOH




Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

# SDOH Z-Codes

## COMMON CATEGORIES:

**Z55** - Problems related to education and literacy

**Z56** - Problems related to employment and unemployment

**Z57**- Occupational exposure to risk factors

**Z58**- Problems related to physical environment

**Z59**- Problems related to housing and economic circumstances

**Z60**- Problems related to social environment

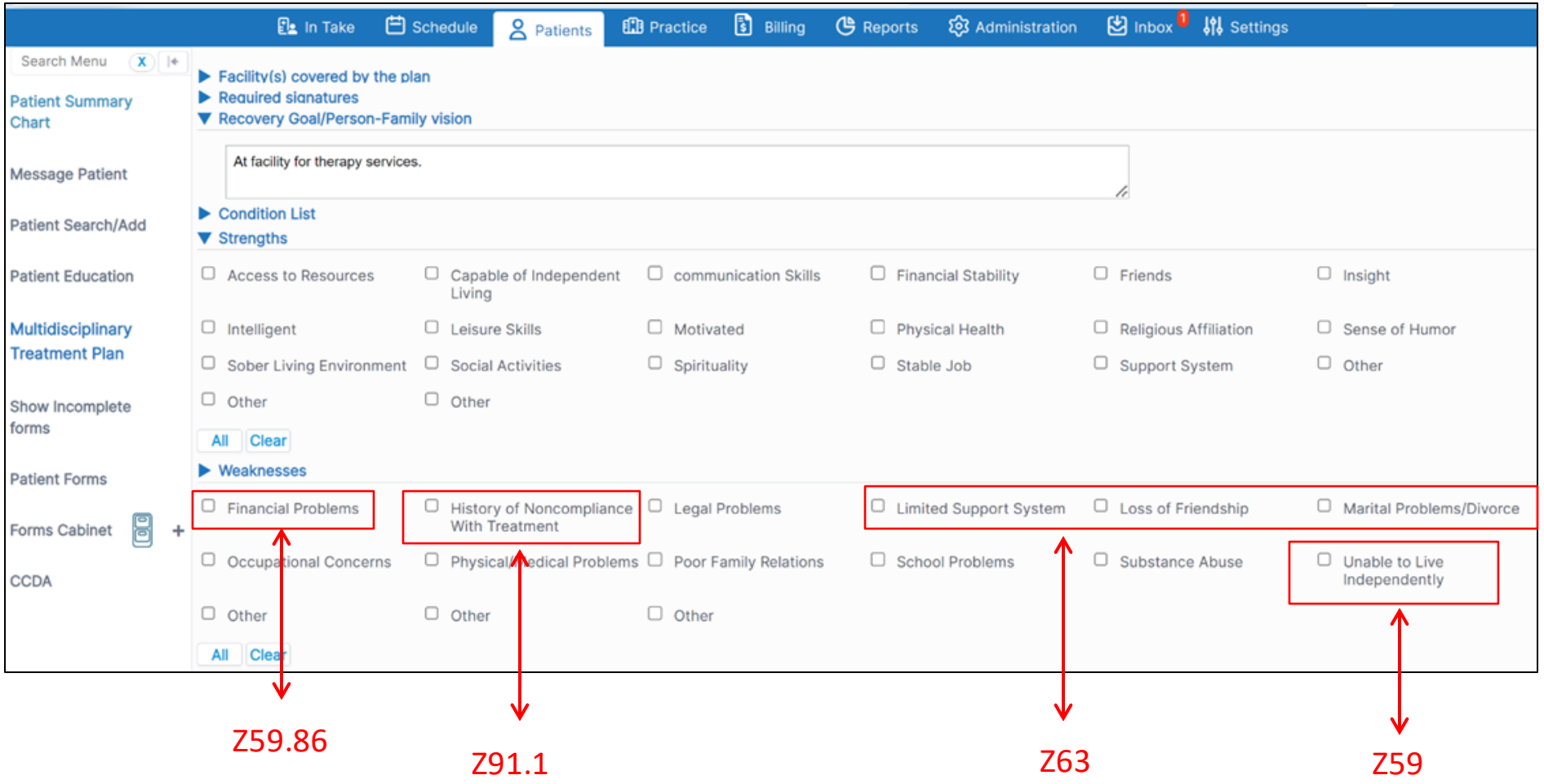
**Z62**- Problems related to upbringing

**Z63**- Other problems related to primary support group, including family circumstances

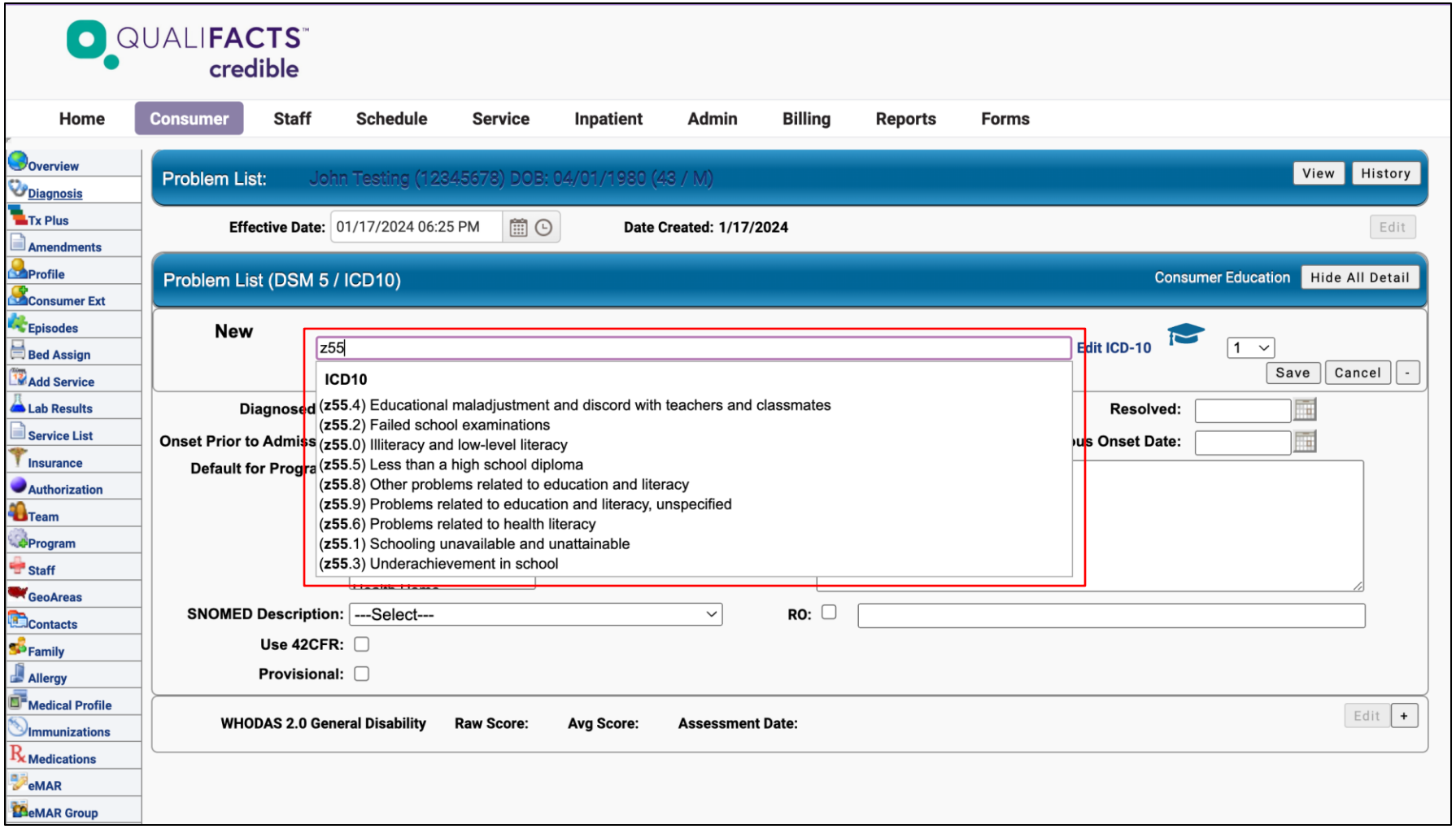
**Z64**- Problems related to certain psychosocial circumstances

**Z65**- Problems related to other psychosocial circumstances

# Capturing SDOH Z Codes



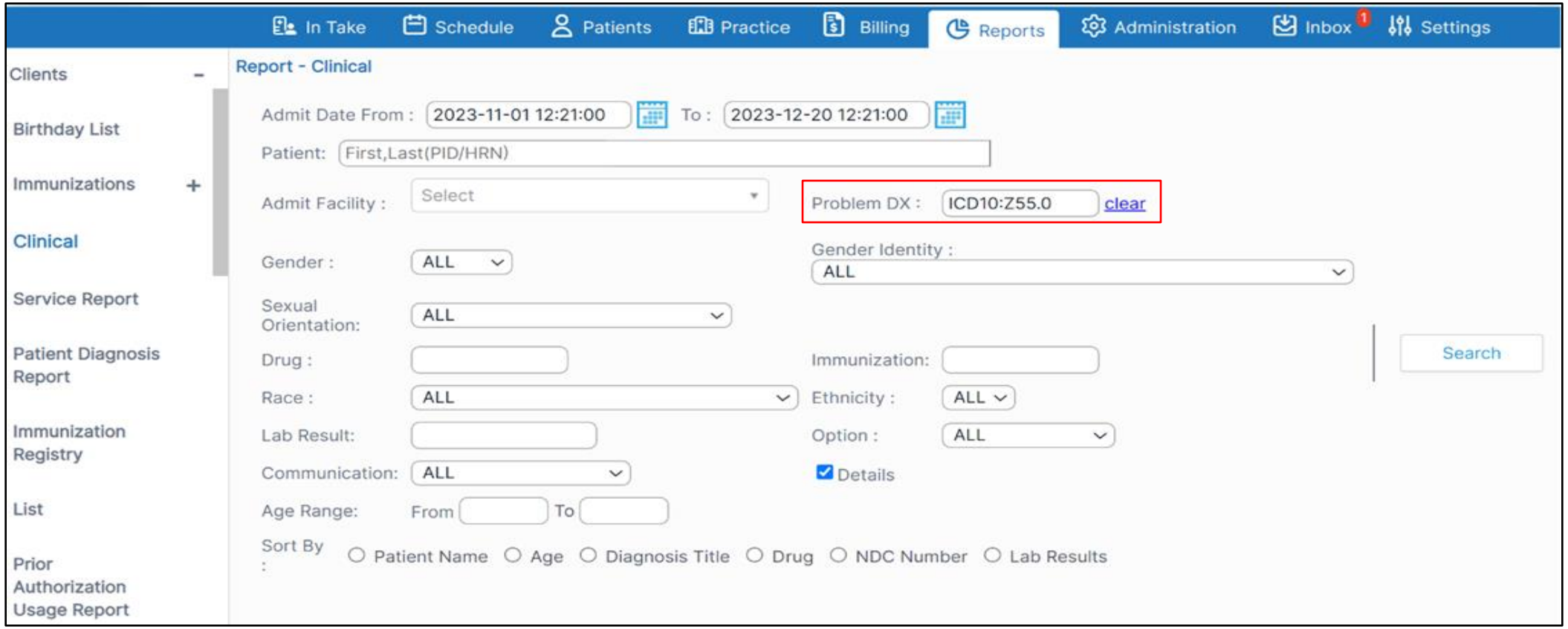
# Capturing SDOH Z Codes



# Run SDOH Reports

## Run Clinical DX report

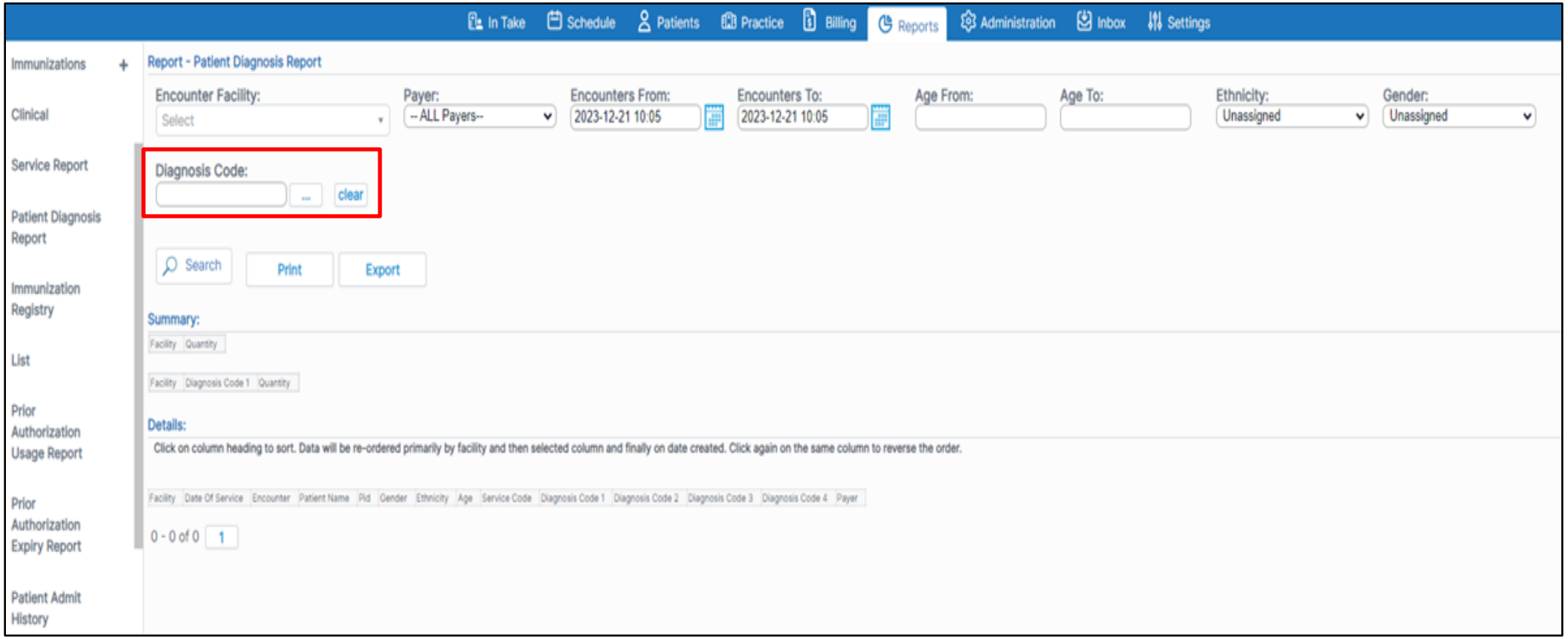
Reports > Clinical > enter search criteria



# Run SDOH Reports

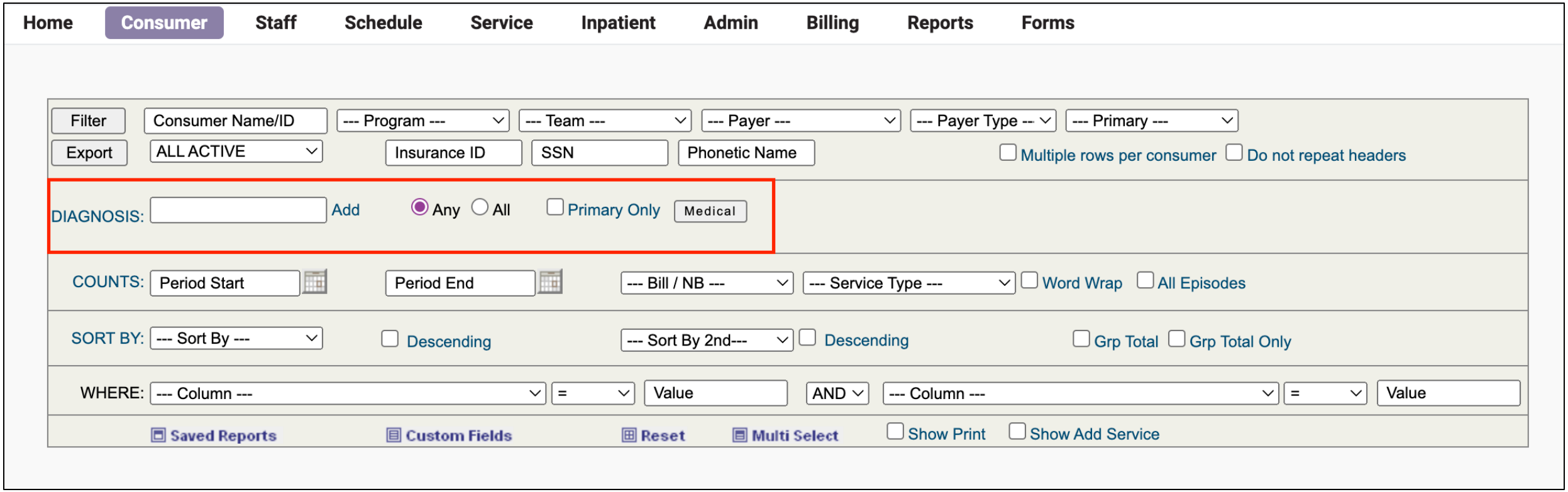
## Run Patient DX Report

Reports > Patient Diagnosis Report> enter range criteria> print or export

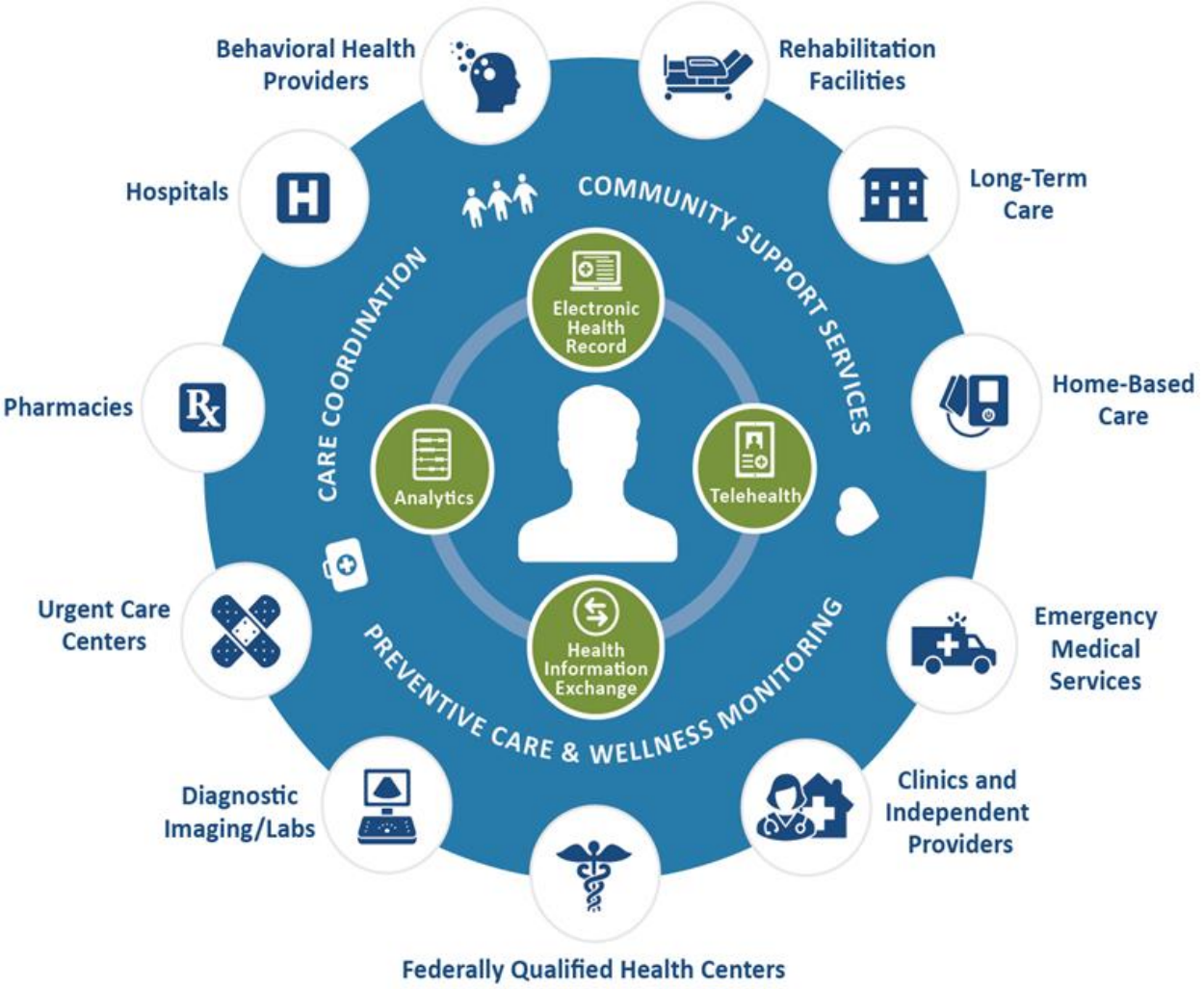


# Run SDOH Reports

## Credible Advanced Search



# Recap: Importance of EHR Data Quality

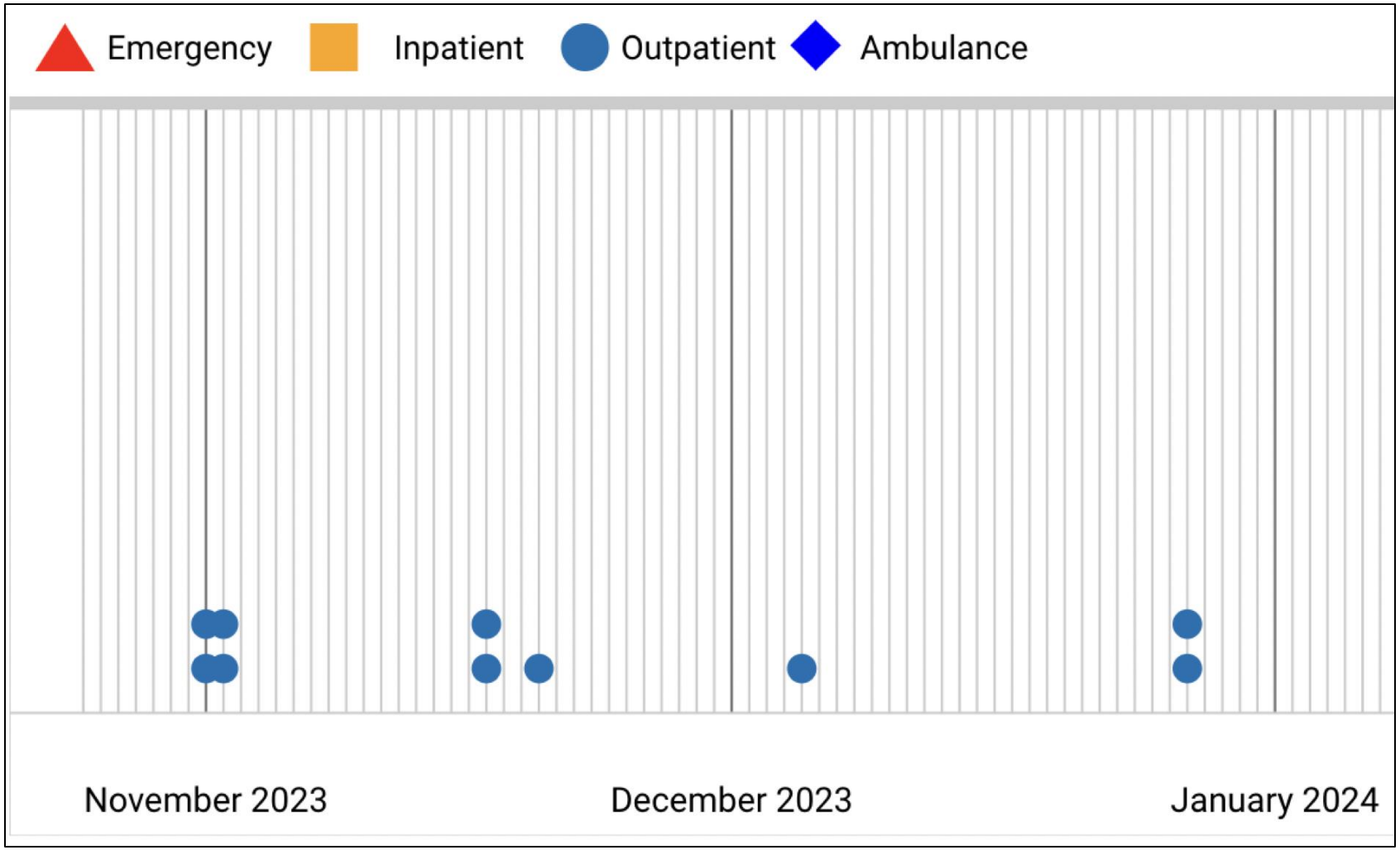



*Source: 2022 State Medicaid Health IT Plan (SMHP) Update: Creating a Digital Health Roadmap for the District*

- **Improved Data Quality:**
  - ✓ ensures that decisions are based on accurate, reliable, and relevant information
  - ✓ leads to increased efficiency and productivity
  - ✓ helps maintain compliance
  - ✓ leads to improved service delivery
  - ✓ improves understanding of population health trends
  - ✓ enables precise billing, reducing errors and rejected claims

# A Picture Is Worth A Thousand Words

## DC HIE Patient Snapshot



# Questions?

# Upcoming eHealthDC Trainings

| Training | Date | Training Type |
|---|---|---|
| Best Practices for Improving EHR Data Quality | Tuesday, February 27, 2024 | EHR |
| eHealth DC Learning Community | Thursday, February 29, 2024 | EHR |
| Care Coordination | Tuesday, March 12, 2024 | EHR |
| Security and Privacy | Friday, March 15, 2024 | EHR |
| Best Practices for Improving HER Data Quality | Friday, March 22, 2024 | EHR |

| Training | Date | Training Type |
|---|---|---|
| Social Needs Screening Tool | Wednesday, February 28, 2024 | HIE |
| Advance Care Planning | Tuesday, March 5, 2024 | HIE |
| Consent Tool | Thursday, March 7, 2024 | HIE |
| I'm Connected to the HIE, Now What? | Wednesday, March 13, 2024 | HIE |
| PopHealth/Analytics | Tuesday, March 19, 2024 | HIE |