eHEALTHDC
A DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION PROGRAM

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

Digital Health Technical Assistance Program Learning Community

From Data Entry to Data Exchange: Best Practices in EHR Data Quality

March 25, 2026

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.

Introducing the eHealthDC Team

Together, we provide expertise in health information technology, quality improvement, and HIE innovation to strengthen digital health capacity, data sharing, and interoperability across District healthcare organizations.

New Digital Health TA Program Opportunity

Through this new Digital Health TA Program funded by DHCF, eHealthDC will provide free, tailored technical assistance to help improve EHR data quality, boost interoperability, and integrate CRISP DC HIE tools into daily workflows.

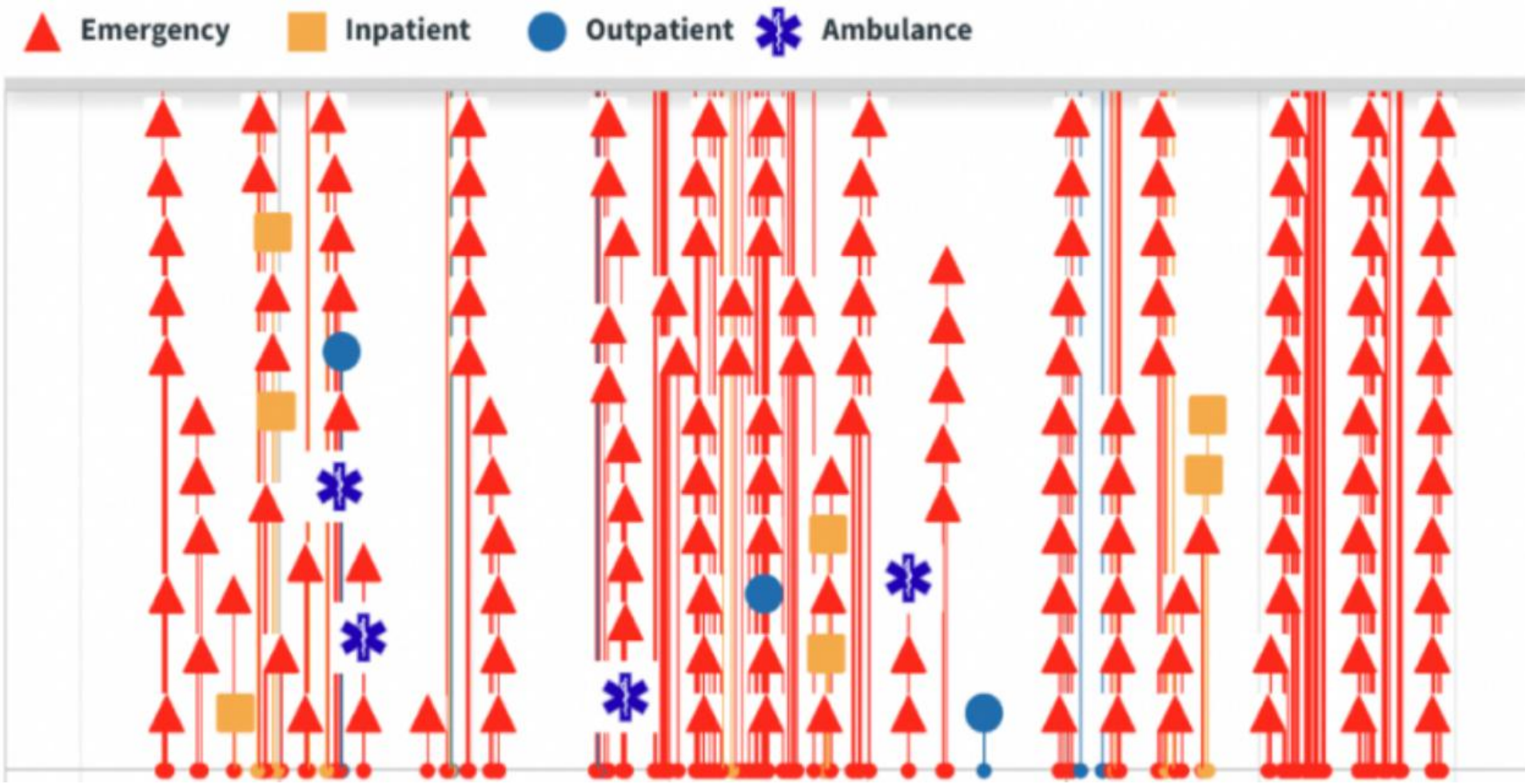
Fill out an Interest Form or reach out to contact@e-healthdc.org and we'll be in touch!

Key Learning Objectives

1. Understand the relationship between EHR documentation and HIE data exchange
2. Recognize how poor data quality affects care coordination and outcomes
3. Define the six dimensions of data quality
4. Apply best practices to improve EHR and HIE data quality

A Picture Is Worth A Thousand Words

CRISP DC Patient Snapshot



Electronic Health Record (EHR) Overview

What is an EHR?

A digital system used to document, manage, and track patient care within an organization.

What Information Does an EHR Capture?

- Patient demographics
- Diagnoses and problem lists
- Medications and allergies
- Lab results and vital signs
- Visit documentation and care plans
- Billing and reporting

Why Does It Matter?

- Supports safe clinical decision making
- Promotes standardized documentation
- Enables accurate quality reporting and compliance
- Provides the foundation for information exchange

How EHR Data Flows?

1

Information is Captured

Information can be entered through:

- Free text documentation
- Structured data fields
- Drop-down selections
- Standardized forms and templates
- Clinical notes and narratives

2

Captured Data is Organized

Entries are organized, coded, and stored in categories such as:

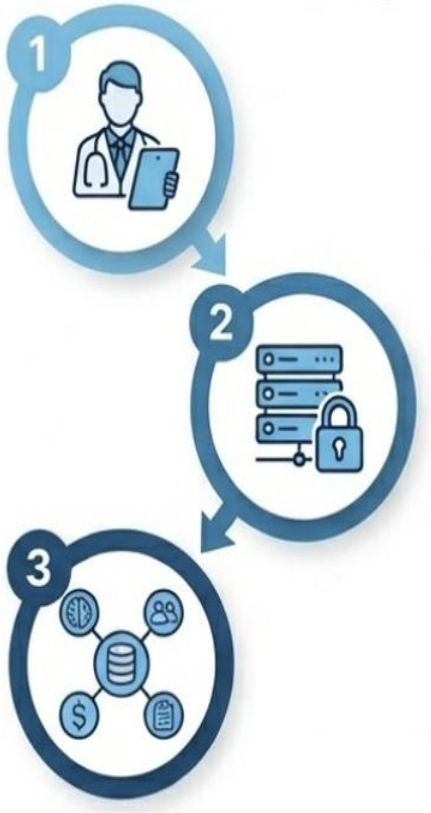
- Patient demographic
- Diagnoses, encounters and problem lists
- Medications
- Vital signs
- Laboratory results
- Progress notes

3

Organized Data Supports

Information supports activities like:

- Patient care and follow-up
- Billing and coding
- Quality reporting
- Data exchange with CRISP DC (HIE)



Understanding the Health Information Exchange (HIE)

What is a HIE?

A secure network that enables healthcare organizations to electronically share clinical information across care settings.

What Does the HIE Share?

- Admission, Discharge, Transfer (ADT) notifications
- Continuity of Care Documents (CCDs)
- Clinical encounter summaries
- Longitudinal patient history across organizations

Why Does It Matters?

- Improves care coordination across settings
- Reduces duplication of tests and services
- Decreases medication discrepancies and errors
- Supports population health management

Poll Question #1

Where do breakdowns in data exchange most often occur?

A. When data is sent from the organization's EHR

B. When the HIE receives and processes the data

C. When providers receive and act on notifications

D. All of the above

E. Unsure

The HIE Data Exchange Process

1 Organization Sends Data

EHR information is transmitted through standardized messages to share:

- ADT (Admission, Discharge, Transfer) alerts
- CCD (Continuity of Care Document) summaries
- Demographic entries and updates

2 HIE Receives and Routes Data

Shared data is securely processed to:

- Store encounter information
- Match patients across organizations
- Route updates to connect provider

3 Provider Accesses Shared Data

Connected care teams can:

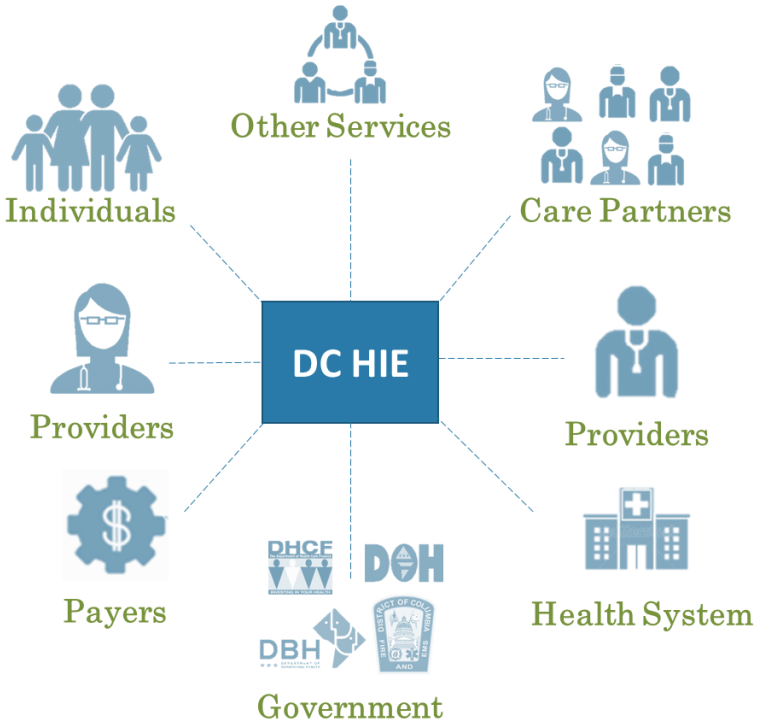
- Receive admission and discharge notifications
- View shared clinical summaries
- Support follow-up and care coordination

How EHR Data Quality Impacts the HIE

Who Depends on HIE Data?

Reliable HIE data supports:

- ☑ 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



Why Does This Matters?

Poor data quality can result in:

- ✖ Missed hospital follow-ups
- ✖ Incorrect treatment plans
- ✖ Billing and compliance risks
- ✖ Breakdowns in care coordination

Poll Question #2

How would you rate your familiarity with the Six Dimensions of Data Quality?

A. High = I'm very familiar

B. Moderate = I'm somewhat familiar

C. Low = I'm not familiar

Six Dimensions of Data Quality

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ACCURACY

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

Dimension #1: Accuracy Case Scenario

Action

Patient Jane Smith informed the MA of a new penicillin allergy. The MA writes it on a sticky note but forgets to update the chart. The chart still reflects "No Known Drug Allergies".

Consequences

The provider prescribes Amoxicillin, exposing the patient to a severe allergic reaction.

Key Takeaway: Always update patient records immediately to prevent life-threatening errors.

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

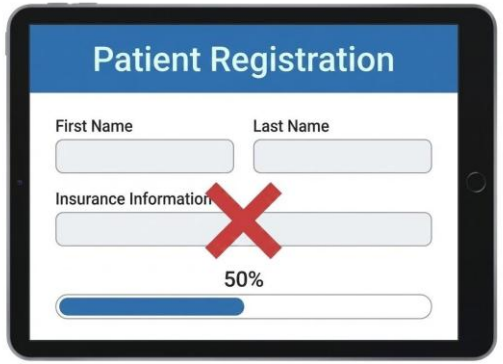
Appoint a dedicated team or individual responsible for data quality and management (i.e., set standards, conduct audits, and be the go-to for any data-related issues).

COMPLETENESS

Records include all necessary data fields and narratives

Dimension #2: Completeness Case Scenarios

Action



William Brown was recently seen for a virtual visit. The registration staff did not complete the full registration process and bypassed putting his insurance information.

Consequences

The visit was not properly billed because insurance information is missing, resulting in delayed or denied reimbursement, and the patient possibly receiving a bill.

Key Takeaway: Always complete the full registration process to avoid billing errors, denied reimbursements, and unexpected patient bills.

TIPS & BEST PRACTICES FOR IMPROVING DATA COMPLETENESS

Double Check Documentation
Ensure thorough data entry is captured during all visits.

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.

CONSISTENCY

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

Dimension #3: Consistency Case Scenarios

Action

ABC Health does not have a standardized process for documenting vitals. Tammy, an MA on the Green Team, records blood pressure in the structured vital signs fields using the intake template, while April, an MA on the Blue Team, documents vitals in free-text notes.

Consequences

Without a standardized process for documenting vitals, staff record them differently across teams, resulting in inconsistent data that cannot be reliably included in reporting.

Key Takeaway: Always ensure vital signs are documented using standardized fields across all teams to maintain consistent, reliable data for accurate reporting.

TIPS & BEST PRACTICES FOR IMPROVING DATA CONSISTENCY

Develop and Utilize Workflow Documentation Tools

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

Standardized Assessments Tools

Implement standardized forms or templates for assessments so all staff document patient information the same way.

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.

TIMELINESS

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

Dimension #4: Timeliness Case Scenario

Action

Maria had a medical visit last week. The provider has not yet completed or signed the encounter note, leaving the visit open in the EHR beyond the required sign off time frame.

Consequences

The incomplete note delays billing and places the organization at risk for non-compliance with documentation and audit requirements.

Key Takeaway: Always ensure encounter notes are completed within the required time frame to prevent billing delays and maintain compliance.

TIPS & BEST PRACTICES FOR IMPROVING DATA TIMELINESS

Implement Timely Documentation Workflow

Establish clear documentation deadlines and workflows to ensure patient information is entered and finalized promptly.

Leverage EHR Task Reminders

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

Prioritize Time-Sensitive Information

Escalate urgent clinical updates quickly so care teams can respond without delay.

VALIDITY

Records reflect the use of credible tools and sources of information

Dimension #5: Validity Case Scenarios

Action

James is screened for depression. Instead of using the full PHQ-9, the staff member asks a few questions and then enters a PHQ-9 score into the EHR based on their own judgement.

Consequences

The score entered in the system is not a valid PHQ-9 result because the official assessment and scoring method were not used leading to inaccurate depression screening data and incorrect clinical decision.

Key Takeaway: Always use the approved clinical assessment tool and scoring method when documenting screening results to ensure the data entered in the EHR is valid.

TIPS & BEST PRACTICES FOR IMPROVING DATA VALIDITY

Promote Patient Portal Use

Encourage patients to use the portal to review and update their information, helping ensure data remains accurate and valid.

Implement Data Validation Rules

Leverage EHR validation rules to flag incorrect formats, missing required fields, or values outside expected clinical ranges.

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RELIABILITY

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

Dimension #6: Reliability Case Scenario

Action

After knee surgery, David Thompson attends several follow-up visits to monitor his recovery. Different providers document his pain level and mobility progress in different ways, and sometimes the information is not recorded at all.

Consequences

Because the patient's recovery data is not captured consistently over time, the care team cannot reliably track progress or determine whether treatment adjustments are needed.

Key Takeaway: Always ensure patient progress is documented consistently and completely at every visit to enable reliable tracking and informed treatment decisions.

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)

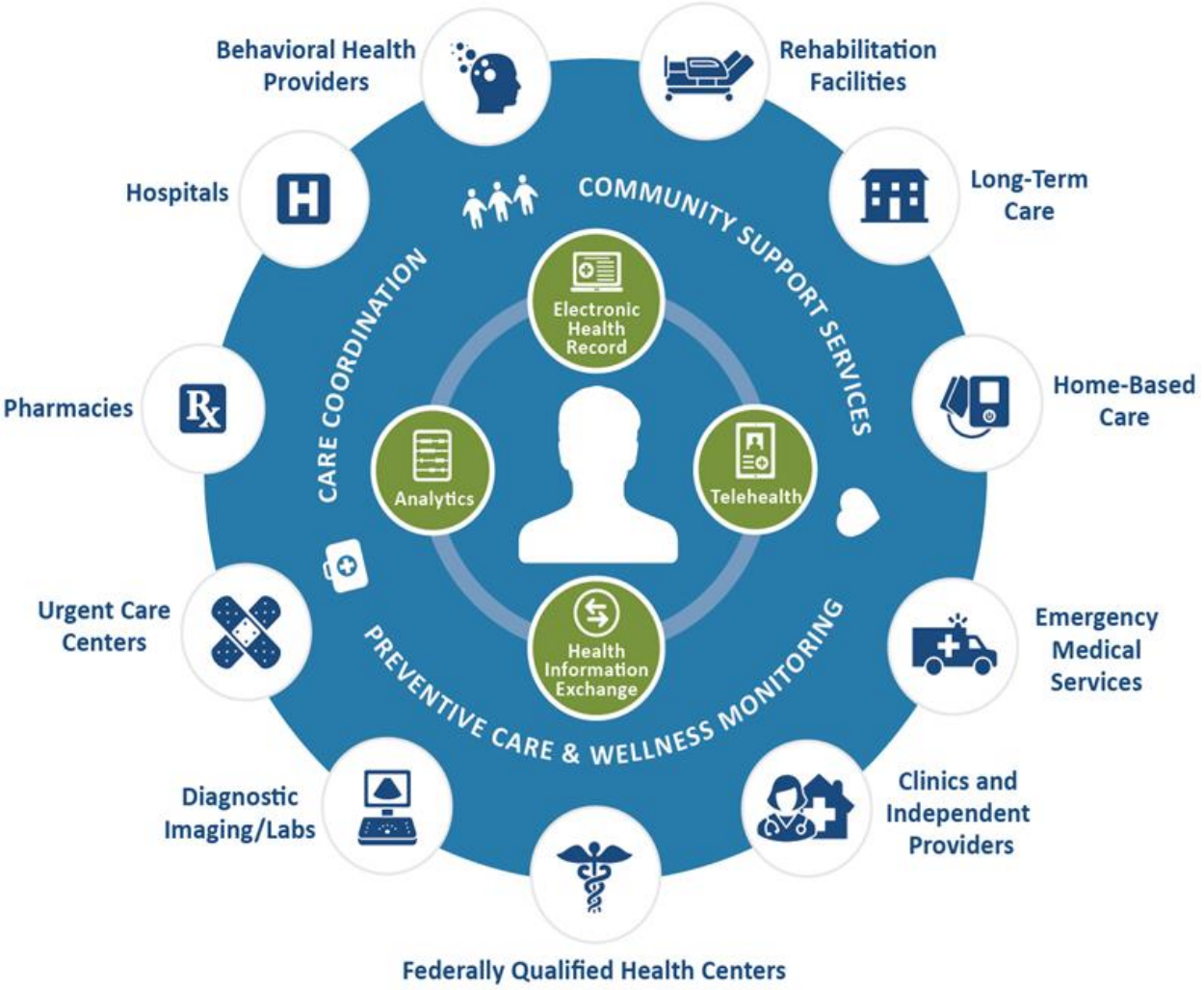
Implement Data Quality Feedback Mechanisms
Create channels for staff to provide feedback on data entry challenges and regularly collect input from users to identify areas for improvement and address concerns

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

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

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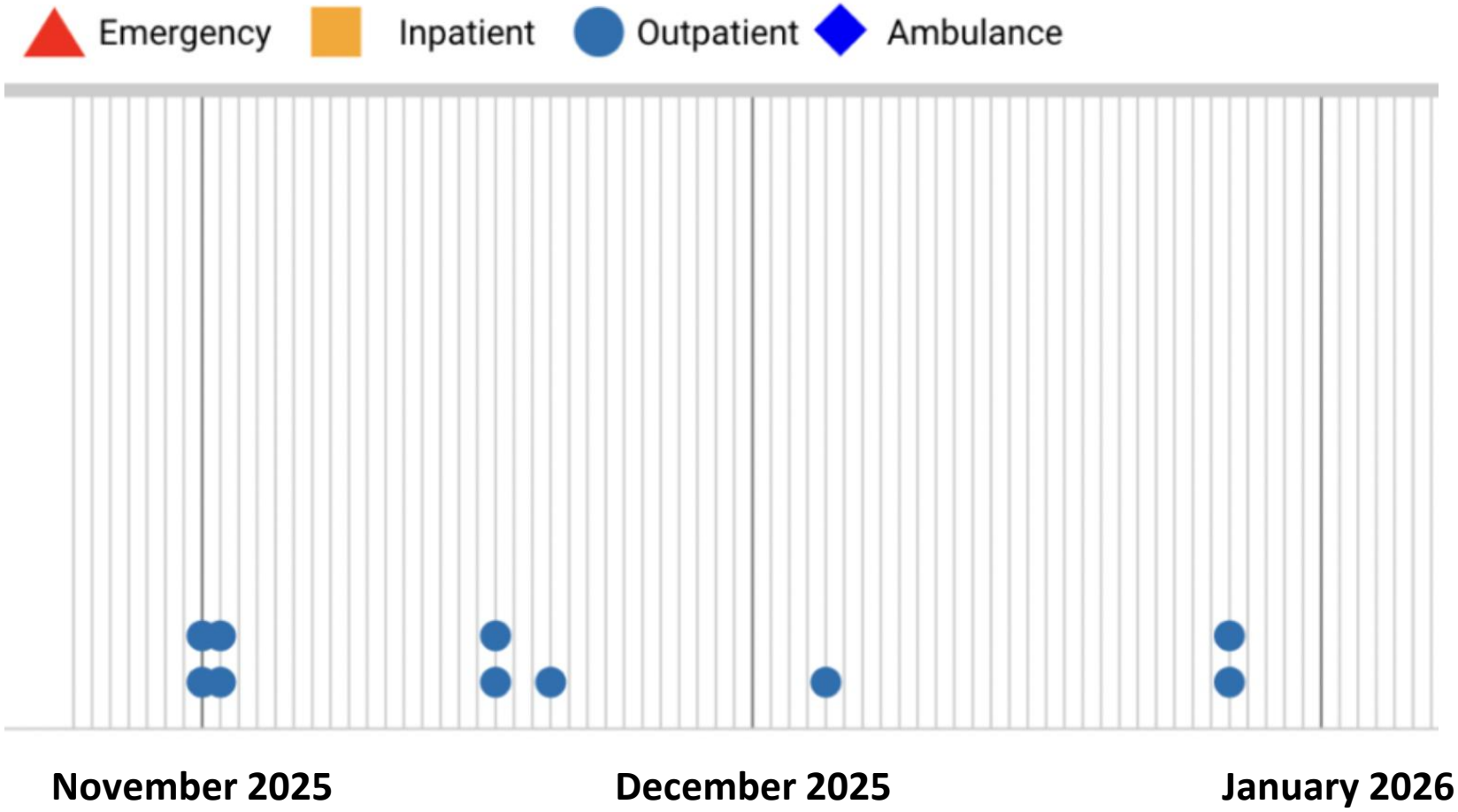

If you have any additional questions please email: contact@e-healthdc.org