

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

Digital Health Technical Assistance Program Learning Community



Hospitals

*EHR Workflows and Data Integration
Challenges*



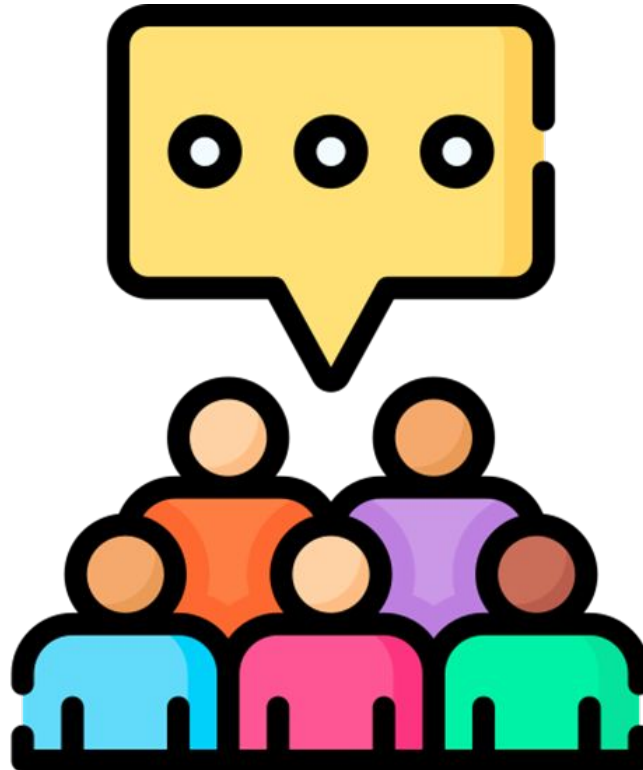


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The eHealthDC **EHR Data Quality Technical Assistance** learning communities are designed to promote knowledge sharing amongst participants and will require ongoing interaction and active participation among attendees.



- Use **Chat** to share questions and comments with the group
- Use **Raise Hand** function for questions or comments to share with the group
- **Cameras on** are encouraged for a more interactive and engaging experience





Our Vision: A future where high-quality data is captured, shared, and used to drive coordinated, efficient, whole-person care.

Our Mission: To deliver integrated, tailored EHR and HIE technical assistance that equips providers with the knowledge, skills and confidence to capture accurate, high-quality data, enable seamless and secure exchange, and use information to improve care delivery.



1

Identify common EHR workflow and data integration challenges that impact quality reporting and data exchange.

2

Recognize how inconsistent documentation and limited structured data capture affect data usability across systems.

3

Examine how EHR data is shared with the HIE and factors affecting missing or delayed data exchange.

4

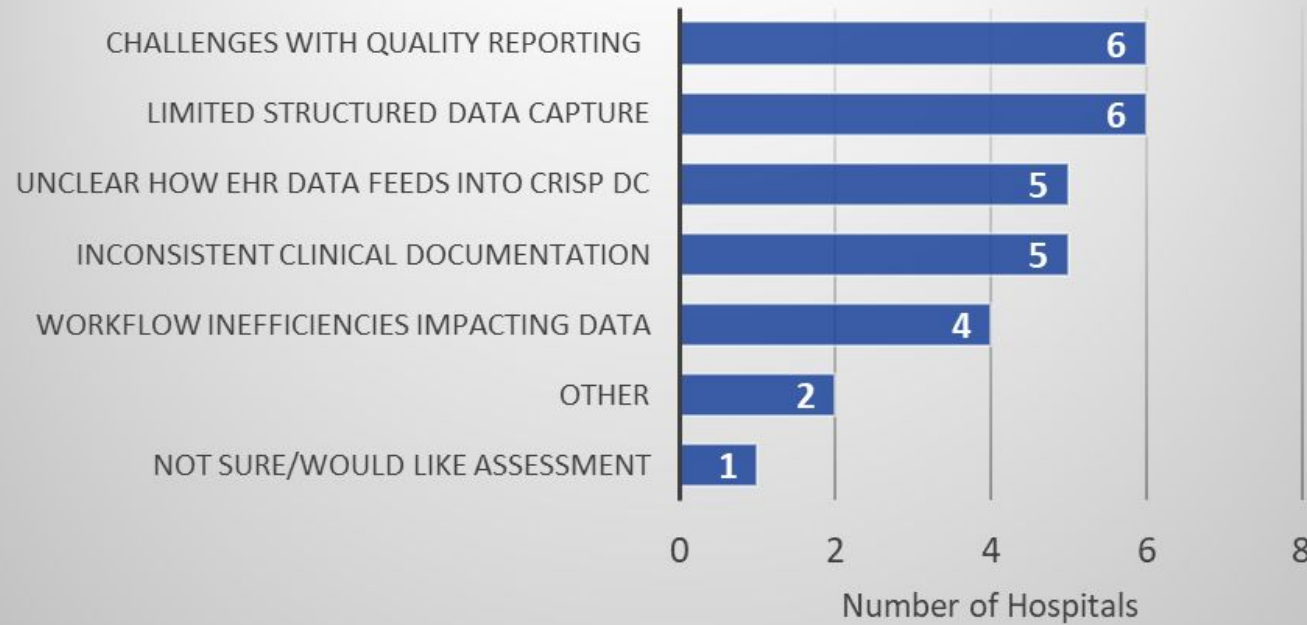
Apply best practices to improve documentation consistency, structured data capture, and reporting accuracy.



Data Quality Gut Check

On a scale of 1–5, how much do you trust your EHR workflows and data integration to reliably support clinical data use across systems?

Please share any challenges or barriers related to EHR workflows or data integration. (Select all that apply)



Key Findings: Top 4 Challenges.

- 1 Challenges with quality reporting
- 2 Limited structured data capture
- 3 Unclear how EHR data feeds into CRISP DC
- 4 Inconsistent clinical documentation



- **CRISP DC provides health information technology solutions** that connect healthcare and community organizations to support timely, equitable, and patient-centered care.
- **CRISP DC is the Designated HIE for the District of Columbia** by the DC Department of Health Care Finance and the HIE Policy Board.
- **CRISP DC** has a robust team that is dedicated to serving District HIE users
- **CRISP DC is an affiliate to CRISP Shared Services (CSS)**, a vendor that provides our infrastructure and enables coordination with neighboring HIEs such as Maryland and Virginia.



App Engagement
58,000+
clicks/month in
the application

1,093 Participating Organizations
with over **17,000 Users**

Quality reporting is the process of submitting healthcare data such as patient outcomes and care measures to meet regulatory requirements and support reimbursement.



The Challenge

- Inconsistent EHR data capture
- Poor system interoperability
- Manual workarounds or entry



Consequences

- Inaccurate or incomplete reporting affecting compliance and reimbursement.
- Missing or delayed data impacting report accuracy and timeliness.
- Higher workload and increased documentation errors.



BEST PRACTICES FOR IMPROVING QUALITY REPORTING



- ✓ **Standardize data entry for key quality measures**
- ✓ **Regularly validate data for completeness and accuracy**
- ✓ **Align clinical workflows with reporting requirements**



Limited Structured Data Capture is when key clinical information is recorded in free-text instead of standardized, discrete fields, making it harder to search, share, and analyze.

UNSTRUCTURED DATA

VS

STRUCTURED DATA





The Challenge

- Key patient information is often documented in free-text or narrative form
- Important data elements are not consistently captured in discrete fields
- Some clinical details are not structured in a way that supports use across other systems



Consequences

- Key information can be harder to surface in the HIE
- Data may not be consistently reusable for patient follow up or reporting
- Limits how effectively EHR data can be leveraged across care settings



BEST PRACTICES FOR IMPROVING LIMITED DATA STRUCTURE



- ✓ **Prioritize structured fields for high-value data elements**
- ✓ **Train staff on when to use structured vs free-text fields**
- ✓ **Regularly review and optimize documentation workflows**



What would most strengthen structured data capture in your organization?

- A) Increased Use of Structured Fields:** Capturing key clinical information in standardized, reusable formats
- B) Better Staff Guidance:** Helping users understand when to use structured fields versus free-text documentation
- C) More Efficient Documentation Workflows:** Making structured documentation easier to complete during patient care
- D) Improved Data Usability:** Making patient data easier to search, report on, and share across systems

EHR → HIE Data refers to how EHR data is captured and transmitted to the HIE through elements such as ADTs (admission/discharge/transfer) messages and CCDs (Continuity of Care Documents).





The Challenge

- Unclear which EHR data elements are transmitted to the HIE
- Differences in interface configuration affect what is shared across systems
- Limited visibility into what data is successfully sent vs not transmitted



Consequences

- Missing or delayed data can impact clinical decision-making
- Less reliability in the completeness of HIE data
- Harder to identify or resolve data transmission issues



BEST PRACTICES FOR CLARITY ON HOW EHR DATA FEEDS TO THE HIE



- ✓ **Identify which data elements are shared with the HIE**
- ✓ **Use data quality insights to monitor data flow and troubleshoot missing or delayed data**
- ✓ **Collaborate with IT to understand interface configurations**

Data Category	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026
ADT						
ADDRESS	96.30%	96.44%	96.29%	96.52%	96.58%	96.58%
ADMIT REASON	64.10%	64.19%	64.31%	64.23%	64.33%	64.23%
DISCHARGE DISPOSITION	55.57%	54.23%	56.94%	53.92%	53.40%	54.04%
DISCHARGE LOCATION	1.22%	1.29%	1.25%	1.35%	1.25%	1.02%
DX CODE	38.94%	37.07%	38.98%	36.19%	37.73%	37.49%
DX DESC	35.86%	34.13%	35.11%	32.51%	34.85%	34.34%
ETHNICITY	59.93%	60.17%	60.19%	60.37%	60.81%	61.00%
LANGUAGE	63.00%	63.99%	63.13%	64.33%	64.60%	64.52%
NEXT OF KIN	57.63%	58.03%	57.97%	58.46%	58.59%	58.62%
PCP NPI	13.50%	13.57%	14.47%	13.48%	13.48%	13.74%
PHONE	72.48%	72.85%	73.85%	75.15%	75.32%	75.23%
RACE	95.77%	96.30%	96.21%	95.44%	96.25%	96.60%
CCD						
ALLERGY NAME	74.74%	73.87%	74.76%	75.20%	74.96%	74.47%
ALLERGY SECTION	98.85%	98.11%	99.34%	99.27%	99.33%	99.02%
IMMUNIZATION NAME	0.99%	0.08%	0.00%	0.00%	0.00%	0.00%
IMMUNIZATION SECTION	0.99%	0.08%	0.00%	0.00%	0.00%	0.00%
MEDICATION NAME	96.29%	96.59%	96.91%	96.68%	97.36%	67.03%
MEDICATION SECTION	96.29%	96.59%	96.91%	96.68%	97.36%	67.03%
MEDICATION SIG	27.24%	27.58%	27.97%	28.55%	28.70%	21.89%
PROBLEM SECTION	98.03%	98.44%	99.73%	99.22%	99.47%	68.83%
PROBLEMS NAME	98.03%	98.44%	99.73%	99.22%	99.47%	68.83%
VITAL SECTION	66.67%	66.67%	66.67%	66.67%	66.67%	43.54%
TIMELINESS						
ADMIT REASON TIMELINESS	75.68%	75.23%	75.81%	75.67%	76.03%	75.72%
ALLERGIES TIMELINESS	19.53%	16.55%	14.54%	18.51%	18.88%	18.34%
DIAGNOSIS TIMELINESS	29.52%	29.28%	31.97%	30.55%	30.23%	30.76%
DISCHARGE SUMMARY TIMELINESS	23.13%	21.06%	19.20%	22.10%	22.82%	21.58%
IMMUNIZATION TIMELINESS	0.24%	0.02%	0.00%	0.00%	0.00%	0.00%
MEDICATIONS TIMELINESS	18.93%	16.14%	13.97%	17.96%	18.46%	16.72%

ADT message communicates patient movement and status change (e.g., update demographics) within a healthcare facility.

CCD provides a snapshot in time of a patient's health information. CCD are organized into **standardized clinical sections**. Within each section are individual clinical statements e.g., (Allergy Name, Medication Name, Problem Name)

Timeliness measures the percentage of clinical data exchanged within 48 hours of an encounter

Completeness rates are used by organizations to identify trends over time, identify specific data elements to address that have dropped in completeness rates. Resolutions could require technical enhancements with the EHR vendor, or direct engagement to update documentation workflows.

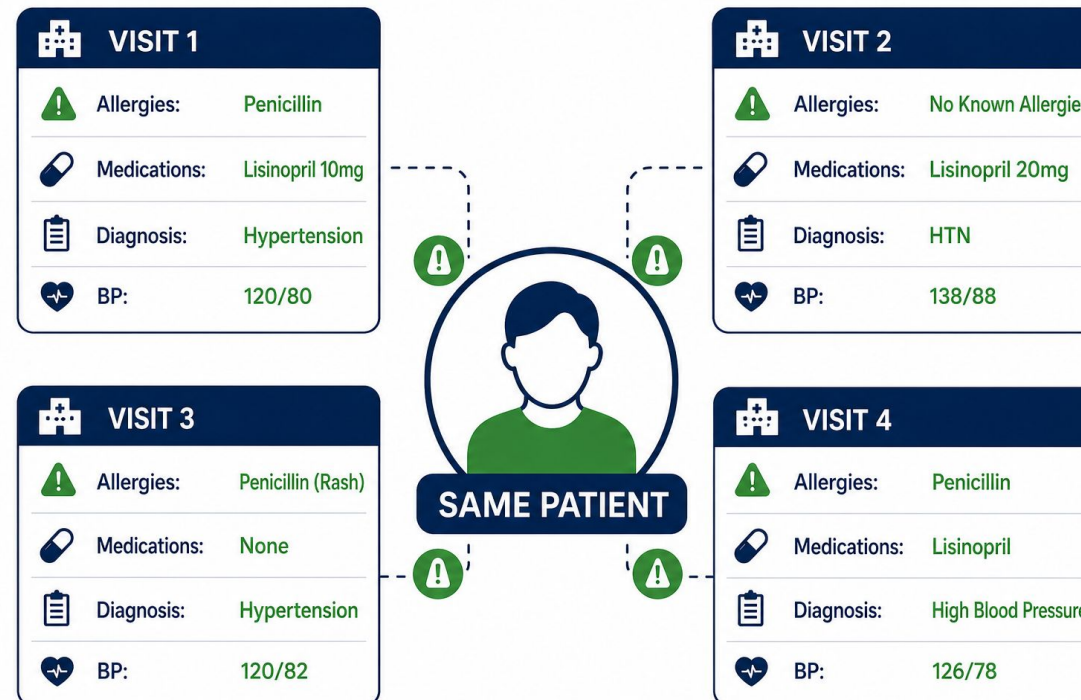
Peer Comparison enables organizations to compare their completeness rates to median completeness rates of similar organizations (e.g., Hospitals, SNFs, PCP)



What would most help your organization's EHR-HIE data exchange and reliability?

- A) Establishing proactive, routine data quality review processes to identify trends and address inconsistencies early
- B) Better understanding of interface workflows and system configurations
- C) Providing staff with guidance on where and how to improve data entry practices
- D) All of the above

Inconsistent clinical documentation refers to situations where the same patient's information is recorded differently across encounters or systems. This can include variations in terminology, missing details, duplicate records, or conflicting data





The Challenge

- Clinical documentation practices vary across settings
- Similar clinical concepts may be recorded using different terminology or levels of detail
- Documentation style is influenced by individual workflow preferences



Consequences

- Makes it harder to interpret and compare clinical information across encounters
- Increases effort to understand patient history
- Reduces consistency in downstream clinical and operational use



BEST PRACTICES FOR IMPROVING CLINICAL DOCUMENTATION



- ✓ **Standardize documentation workflows across departments**
- ✓ **Use consistent terminology and clinical definitions**
- ✓ **Provide ongoing training and feedback to clinicians**



What challenges impact consistent clinical documentation at your hospital?

- A) Inaccurate Clinical Coding and Capture:** Difficulty supporting correct assignment of diagnoses, procedures, and risk factors from documentation
- B) Documentation Variation Across Providers:** Inconsistent terminology and workflows between clinicians
- C) Incomplete or Inconsistent Patient Histories:** Clinical details missing or varying across encounters



Standardized Documentation Improves Data Quality

Consistent documentation and structured workflows help create more accurate, complete, and reliable clinical data

Structured Data Supports Reporting and Data Exchange

Using discrete fields instead of free-text improves reporting accuracy and allows data to be more effectively shared and reused across systems.

Understanding EHR-to-HIE Data Flow Is Important

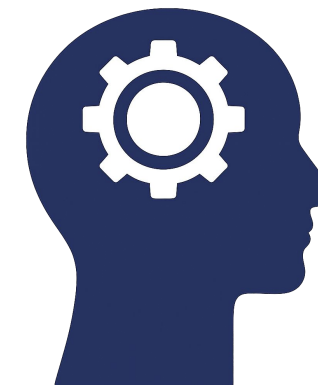
Knowing what data is transmitted to the HIE helps organizations identify missing information, troubleshoot delays, and improve confidence in shared data.

Ongoing Monitoring Helps Identify Data Gaps

Reviewing data quality trends and investigating inconsistencies can help organizations improve reliability and reduce reporting issues.

Workflow Variation Can Impact Clinical and Operational Use

Differences in documentation practices across providers and departments can affect reporting consistency, patient history review, and downstream data use.



Questions?
www.e-healthdc.org