TCCN EHR Best Practices Task Force Final Report and Recommendations

Introduction

Since October 2025, the Tennessee Charitable Care Network (TCCN) has convened the *Improving Cardiovascular Outcomes Through EHR Best Practices Task Force*. This group brought together representatives from four TCCN member clinics located in priority areas: Community Clinic of Shelbyville and Bedford County, Beersheba Springs Medical Clinic, Friends in Need Health Center, and Free Medical Clinic of Oak Ridge. In partnership with TCCN staff (Amanda Allen, Director of Impact and Sustainability, and Christi Granstaff, Executive Director), Task Force members collaborated with each other and worked closely with our EHR Consultant, Emilie Biniker, to strengthen their documentation and monitoring of cardiovascular risk factors, including hypertension, cholesterol, and social drivers of health (SDOH). This summary outlines how our objectives were carried out and highlights the resulting recommendations that TCCN will present to our broader membership and to our partners at the Tennessee Department of Health.

Key Deliverables

A. Documentation of Current EHR Practices

The initial phase of this project necessitated gaining a deeper understanding of how participating clinics currently gathered cardiovascular data, the measurements used, and how social drivers of health (SDOH) were documented in existing EHR systems. TCCN deployed a baseline survey to all four participating clinics, soliciting information around the areas of success, most pressing challenges, staff training and data-entry responsibilities, data review practices, reporting confidence, and specific questions around EHR use surrounding blood pressure, cholesterol/lipids, and SDOH. Following completion of the survey, one-on-one interviews were conducted with clinics to discuss their results and better understand their current EHR use cases and priorities.

The survey, completed by all four clinics in late 2025, identified that all participants in this project utilize athenahealth as their primary EHR. Across clinics, documentation practices varied depending on clinic resources and capacity. Blood pressure documentation was the strongest area of practice, with all clinics reporting that they consistently captured blood presure in structured, trackable fields at each visit. On the other hand, cholesterol/lipid documentation, SDOH screening, and patient demographic data collection had greater variability. Across the board, staff and volunteer onboarding and training were of great concern and were often informal. These findings informed the gap analysis we conducted to identify target areas for recommendations.

B. Identification of Gaps

Baseline survey responses were synthesized to identify gaps related to data entry, reporting, analysis, and decision-making. Key findings included:

- **EHR Functionality & Demographics:** Inconsistent protocols regarding staff responsibility for documenting demographic information and variations in documentation practices within the EHR.
- **Job Training & EHR Use:** Underutilization of available EHR training tools during staff onboarding and the absence of role-specific training guides.
- **Blood Pressure (BP):** Lack of standardized workflow protocols for documenting blood pressure measurements and reviewing blood pressure trends over time.
- **Cholesterol Management:**
    - Limited use of available EHR features, such as the Quality tab that provides health maintenance recommendations based on information entered in reportable fields.
    - Inconsistent documentation and absence of a standardized clinical workflow for ASCVD risk calculation and documentation used to guide statin therapy decisions in eligible patients according to clinical guidelines.
- **Social Drivers of Health (SDoH):** Inconsistent screening and documentation of SDoH measures, lack of standardized workflows, and documentation entered outside of reportable fields.
- **Quality Improvement (QI) & EHR Support:** Variability in staff understanding of reportable EHR fields and the importance of accurate and consistent documentation for quality reporting and improvement initiatives.

C. Development of Best Practices Policies and Templates

After identifying the most common areas of proposed intervention, TCCN staff partnered with our EHR consultant and Task Force members to develop sample policies and templates outlining recommended best practice data standards, workflows, and documentation approaches for cardiovascular disease management, including SDOH, in charitable care settings. Emphasis was placed on recommendations that can be implemented regardless of the specific EHR or plan utilized.

D. Training and Testing of Recommendations

Task Force members participated in training sessions and deployed short-term pilot projects of two recommendations. Two clinics implemented the recommended SDOH Screening Pilot, while two others implemented a Cholesterol Screening and Evaluation Pilot. Clinics were provided with a pilot implementation packet and staff training guide, as well as opportunities for group and one-on-one support as they launched their pilots. Pilot projects ran from February through April 2026, with all four clinics completing a pilot implementation. A post-pilot evaluation was conducted to gather feedback from clinics and determine whether implemented changes would continue after the conclusion of the project.

E. Peer Learning

The Task Force served as a community of practice to share lessons learned. Members met monthly over the project period to share lessons learned and engage in peer support over any implementation challenges. These gatherings fostered peer learning, knowledge exchange, and collaborative problem-solving throughout the pilot process. This opportunity for collaboration and support also informed the decision to assign two similarly situated clinics to each pilot, so that they would have a peer to communicate with as needed.

At the end of the project, we recorded a webinar outlining our findings and sharing the experiences of the Task Force members over the course of the year. This recording, along with the recommendations and templates, will be available to TCCN members online.

Best Practice Recommendations

- ***Standardized Clinical Data Documentation***
    - Ensure documentation occurs within a streamlined, standardized clinical workflow (e.g., intake, vital signs, provider visit, and checkout) and avoid duplicate or fragmented documentation.
    - Utilize standardized templates and clinical forms to promote consistency across clinical teams.
    - Ensure blood pressure measurements are documented in a discrete, reportable field within the EHR and that all BP readings obtained during patient encounters are consistently recorded.
    - Ensure lipid panel results are electronically imported into reportable fields within the EHR through an established laboratory interface whenever possible.
    - Ensure Social Drivers of Health (SDOH) screening results are documented in structured, reportable EHR fields to enable tracking, reporting, and referral follow-up.
    - Ensure ASCVD risk scores are calculated and documented in the EHR to guide statin therapy decisions in accordance with current clinical guidelines.
    - Ensure complete documentation of diagnoses in EHR Problem List based on clinical findings (such as diagnoses related to SDoH findings, cardiovascular risk factors, and blood pressure).
    - Use standardized ICD-10 diagnosis codes and CPT procedure codes to support accurate reporting and quality measurement.
    - Provide training to all appropriate clinical staff on how to review longitudinal patient data and utilize EHR reporting tools to identify trends in cardiovascular risk factors and outcomes.
- ***Policies, Protocols, and Standardized Clinical Workflows***
    - Implement formal policies and protocols that require the use of EHR software and complete documentation for all patient encounters.
    - Develop standardized onboarding protocols and workflow documentation, including quick-reference guides to support staff training.
    - Assess all individuals responsible for clinical documentation—including staff, volunteers, and trainees—and implement standardized training to ensure consistent documentation practices and understanding of data collection purposes.
    - Establish written policies and protocols that define standardized clinical workflows across care teams, including documentation expectations and role-specific responsibilities.
        - Set standard cadence for evaluating health maintenance and SDoH information (e.g. annual physical for all adults).

  - Ensure policies and protocols are readily accessible to all appropriate staff and incorporated into onboarding and ongoing training materials.
  - Implement standardized blood pressure measurement protocols consistent with clinical guidelines (e.g., appropriate cuff size, patient positioning, repeat measurement when readings are elevated).
  - Establish workflows for referral to community resources when SDoH needs are identified and track referral outcomes when possible.
- ***Demographic Data Collection***
  - Ensure demographic information is collected in standardized formats and documented in reportable EHR fields to enable disparity analysis.
  - Establish standardized processes for demographic data collection, such as assigning responsibility to front desk or intake staff and updating demographic information on a routine basis (e.g., annually).
  - Implement, when feasible, patient intake tools or electronic forms that allow patients to provide demographic information directly and integrate the information into the EHR when possible.
- ***Technology & EHR Utilization***
  - Assess potential device integrations (e.g., EKG, spirometry, continuous glucose monitors, or Bluetooth-enabled vital sign devices) to improve accuracy and reduce manual data entry.
  - Evaluate and implement available EHR add-on features that support documentation efficiency, such as patient intake tools, electronic forms, and connected vital sign devices.
  - Determine which EHR data fields are reportable and ensure required information for clinical care, quality reporting, and potential future grant reporting is captured within these fields.
  - Leverage clinical decision support tools within the EHR, including alerts, reminders, and required fields, to support guideline-based cardiovascular care.
  - Establish standards for identifying abnormal clinical results (e.g., customizable blood pressure ranges or lab-based thresholds) to ensure timely clinical review and follow-up.
- ***Engage Patient Support***
  - Provide patients with access to their health information through patient portals or similar tools to allow them to review, update, and confirm personal and social information, including SDoH data.
  - Utilize population-level reporting tools to identify care gaps and conduct patient outreach (e.g., notifying patients who are overdue for lipid screening).
  - Provide patients with access to educational materials, community resources, and referral services related to cardiovascular risk reduction and social needs.

- ***Staff Engagement***
    - Emphasize the *why* - Educate staff on the purpose and value of collecting clinical and social data to improve care quality, population health management, and grant reporting requirements.
    - Incorporate pre-visit planning, documentation preparation, and team huddles to review patient needs, clinical guidelines, and resource considerations for upcoming patient encounters.
    - Stay up-to-date on current clinical guidelines and discuss how recommendations apply to the clinic's patient population and available resources.
- ***Longitudinal Tracking & Quality Improvement***
    - Generate and review reports to monitor clinical trends in blood pressure control, cholesterol management, and social risk factors over time.
    - Conduct periodic audits of documentation completeness, timeliness, and data quality, and evaluate the use of EHR tools and workflow accelerators.
    - Provide feedback to clinical teams to support ongoing quality improvement and reinforce best practice documentation and care delivery.
    - Develop processes for identifying and closing care gaps (e.g., uncontrolled BP, overdue lipid testing, missing SDoH screenings).
    - Designate a clinic staff member or team responsible for overseeing data quality, reporting, and quality improvement initiatives related to cardiovascular care.