

Digital Entry Is Not Clinical Completion

The Black Book Clinical Loop Closure Index 2026

A three-market research report on open clinical loops after health IT expansion
United States | Canada | United Kingdom



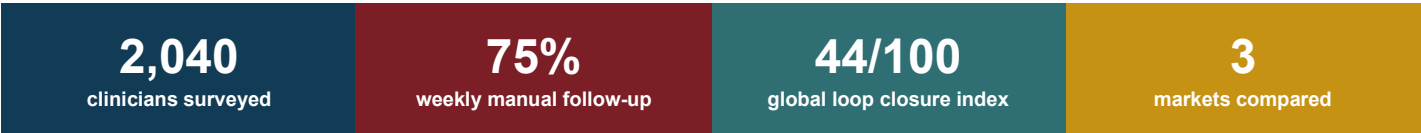
United States n=1,072 Payer authorization, RCM fragmentation, inbox growth and AI review burden	Canada n=471 Provincial interoperability, referral/waitlist visibility and cross-setting reconciliation	United Kingdom n=495 EPR expansion, discharge coordination, RTT/waiting-list and shared-care loops
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Executive summary

Digital healthcare has expanded rapidly across the United States, Canada and the United Kingdom. EHRs and EPRs are broadly embedded, AI pilots are multiplying, patient portals and digital access tools are more visible, and interoperability programs are advancing through federal, provincial and national initiatives. Yet clinicians continue to report that the work of completing care often remains manual after the digital event occurs.

Black Book Research Insights defines this as the clinical loop closure problem: the gap between a task being entered, routed, resulted, referred, authorized, messaged, discharged or algorithmically flagged and the point at which the task is visibly owned, completed and no longer requires side tracking by clinicians or staff.

Central thesis: digital entry is not clinical completion. The defining benchmark for the next phase of health IT is not whether a system is live, but whether the workflow closes without clinicians chasing it.



The three-market survey found that the same core pattern survives across different financing systems and vendor environments. The U.S. problem is heavily payer-centric. Canada shows a provincial and cross-system interoperability pattern. The U.K. shows an EPR, discharge, pathway and waiting-list closure pattern. The common issue is global: digital progress is not yet translating into reliable end-to-end workflow completion.

This Research Insights report consolidates the statistical release, the media release, the regional market framing and the source context into one report for healthcare executives, clinicians, informatics leaders, vendors, consultants, policy audiences and investors.

How to read this report

The first section establishes the respondent base and survey design. The second section reports global findings and introduces the Clinical Loop Closure Index. The market sections then examine how the open-loop problem differs in the United States, Canada and the United Kingdom. The final sections convert findings into a vendor-agnostic action framework and provide source notes, methodology and independence language.

Percentages are presented with rounded respondent counts. Multiple-response items can exceed 100%. Regional margins of error are wider than the full 2,040-respondent base. Subgroup analysis should be interpreted directionally where cell sizes are small.

SURVEY ARCHITECTURE

Research design and respondent profile

The survey measured whether digital workflows close the loop after work is started. Respondents were asked about orders, referrals, results, authorizations, messages, medications, discharge tasks, outside records, AI-generated tasks and escalation workflows. The emphasis was completion reliability, not simple technology adoption or satisfaction.

Table 1. Regional allocation of the 2,040-clinician survey base.

Market	Respondents	Share
United States	1,072	53%
Canada	471	23%
United Kingdom	495	24%
Total	2,040	100.0%

Table 2. Respondent allocation by clinician group and market.

Clinician group	United States	Canada	United Kingdom	Total	Share
Nurses charge nurses nurse managers care coordination nurses	269	151	138	558	27.4%
Physicians	219	99	92	410	20.1%
Nurse practitioners advanced practice clinicians	160	56	50	266	13.0%
Licensed pharmacy clinicians	79	34	35	148	7.3%
Licensed laboratory clinicians	71	40	40	151	7.4%
Licensed diagnostic imaging clinicians	70	36	24	130	6.4%
Rehabilitation therapists and allied health clinicians	41	27	32	100	4.9%
Registered dietitians nutrition clinicians	50	1	29	80	3.9%
Care management social work transition clinicians	65	4	24	93	4.6%
Clinical informatics quality safety clinicians	48	25	31	104	5.1%
Total	1,072	471	495	2,040	100.0%

The sample was intentionally multidisciplinary. A loop-closure study cannot be interpreted from physicians and nurses alone because many open-loop failures occur across pharmacy, laboratory, imaging, rehabilitation, nutrition, care management, social work, informatics, quality and clinical operations roles.

Organization context by market

Organization type was captured differently by market to reflect the way care is organized. In the United States, payer and revenue cycle workflows are more prominent. In Canada, regional and provincial structures shape data sharing and referrals. In the United Kingdom, NHS trust, ICS, EPR and pathway structures shape loop closure.

Organization-type results are reported by market among respondents providing organization context. The United States organization-type profile reflects 1,043 respondents with organization type recorded; Canada and the United Kingdom each reflect the full regional organization-type base reported in the tables.

Table 3A. United States organization profile.

United States organization type	n	Share
IDN health-system hospital	369	35.4%
Community hospital	209	20.0%
Academic medical center	122	11.7%
Ambulatory physician group	188	18.0%
Rural critical access organization	71	6.8%
Post-acute rehab behavioral health	62	5.9%
Children's pediatric organization	22	2.1%
Total	1,043	100.0%

Table 3B. Canada organization profile.

Canada organization type	n	Share
Provincial regional health authority hospital	215	45.6%
Community hospital	85	18.0%
Academic teaching hospital	41	8.7%
Ambulatory community clinic	54	11.5%
Rural remote organization	29	6.2%
Post-acute rehab behavioral health	32	6.8%
Children's pediatric organization	15	3.2%
Total	471	100.0%

Table 3C. United Kingdom organization profile.

United Kingdom organization type	n	Share
NHS acute trust	303	61.2%
Teaching tertiary trust	94	19.0%
Community mental health trust	14	2.8%
GP primary care ambulatory organization	45	9.1%
Rural coastal smaller trust	19	3.8%
ICS community post-acute transition setting	13	2.6%
Children's specialist trust	7	1.4%
Total	495	100.0%

GLOBAL FINDINGS

Health IT expansion without loop closure

Across the full 2,040-clinician base, the survey found substantial evidence of progress without complete repair. Clinicians did not describe a world lacking digital systems. They described digital systems that often document or route a task, but still leave completion dependent on manual verification, ownership clarification, side lists, phone calls, portals, screenshots, escalation relationships and staff memory.

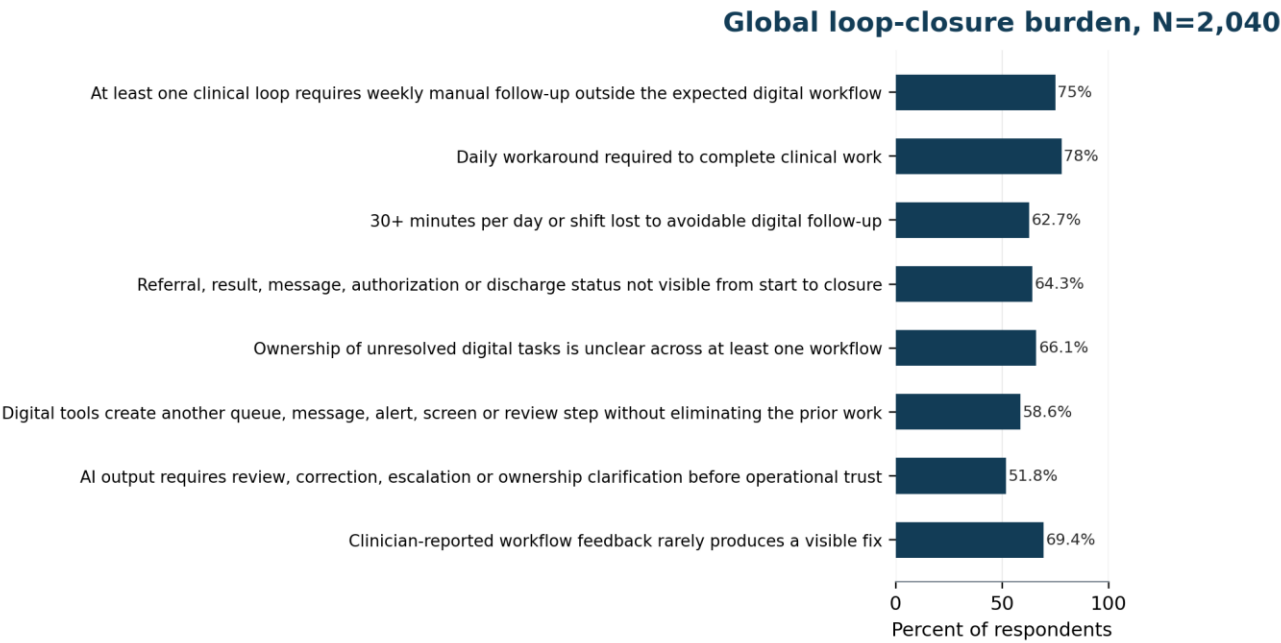


Figure 1. Global loop-closure burden across the 2,040-clinician three-market survey.

Table 4. Global summary findings across 2,040 clinician respondents.

Global finding	%	Estimated n
At least one clinical loop requires weekly manual follow-up outside the expected digital workflow	75%	1,530
Daily workaround required to complete clinical work	78%	1,591
30+ minutes per day or shift lost to avoidable digital follow-up	62.7%	1,279
Referral, result, message, authorization or discharge status not visible from start to closure	64.3%	1,312
Ownership of unresolved digital tasks is unclear across at least one workflow	66.1%	1,348
Digital tools create another queue, message, alert, screen or review step without eliminating the prior work	58.6%	1,195
AI output requires review, correction, escalation or ownership clarification before operational trust	51.8%	1,057
Clinician-reported workflow feedback rarely produces a visible fix	69.4%	1,416

Interpretation: the global issue is not a lack of digital activity. It is the persistence of unresolved work after the digital activity occurs.

The specific loops clinicians still chase

The most visible open loops are those that cross clinical, administrative, payer, scheduling, patient-response or post-acute boundaries. These are the workflows least likely to be solved by one module or one department because they require ownership across clinical operations, revenue cycle, access, informatics, care management and external partners.

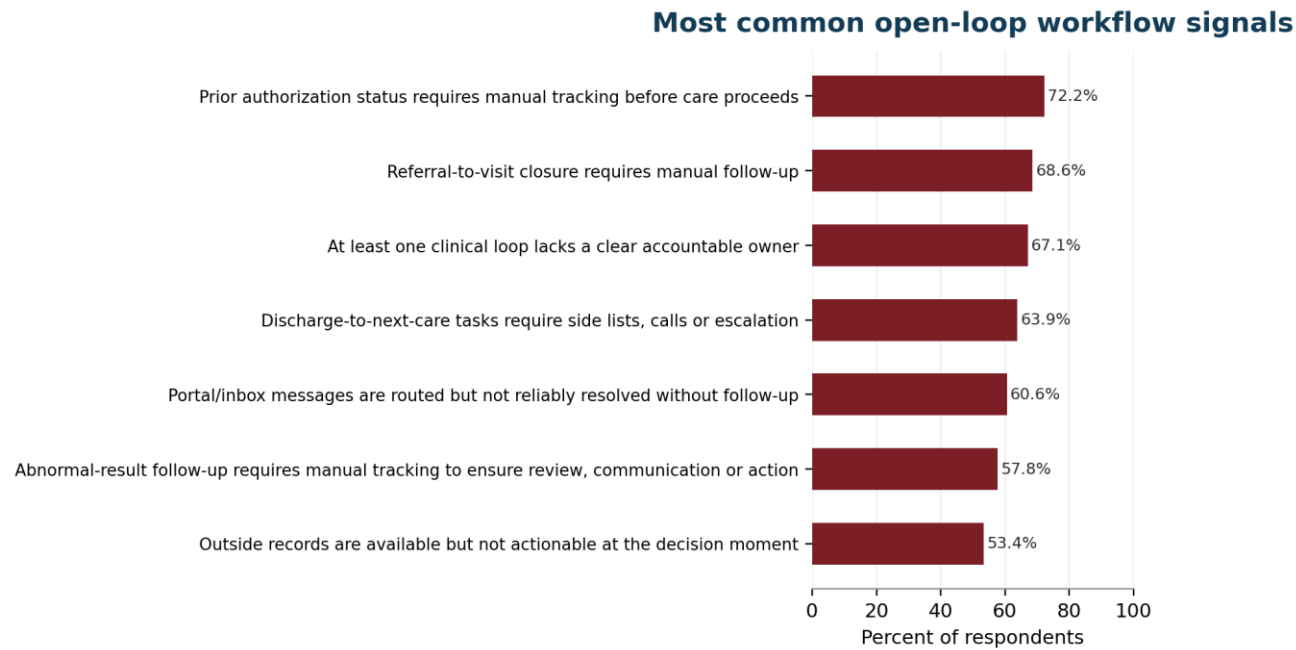


Figure 2. Most common open-loop workflow signals. The AI ownership item is among AI-exposed respondents; other figures are estimated from N=2,040.

Table 5. Detailed global loop-level results.

Open-loop workflow signal	%	Estimated n base
Prior authorization status requires manual tracking before care proceeds	72.2%	1,473
Referral-to-visit closure requires manual follow-up	68.6%	1,399
At least one clinical loop lacks a clear accountable owner	67.1%	1,369
Discharge-to-next-care tasks require side lists, calls or escalation	63.9%	1,304
Portal/inbox messages are routed but not reliably resolved without follow-up	60.6%	1,236
Abnormal-result follow-up requires manual tracking to ensure review, communication or action	57.8%	1,179
Outside records are available but not actionable at the decision moment	53.4%	1,089
AI-exposed clinicians say an AI output created follow-up work without clear ownership	48%	431
Task status is visible from start to closure without extra checking	24.7%	504

INDEX RESULTS

The Black Book Clinical Loop Closure Index

The Clinical Loop Closure Index is a 0-100 burden-removal score. Higher scores indicate workflows are visibly owned, trackable, escalated and completed without hidden manual follow-up. Lower scores indicate that work is being recorded or routed digitally but remains dependent on manual tracking and informal escalation.



Table 6. Clinical Loop Closure Index component structure.

Index component	Weight	What it measures
Manual tracking dependence	30%	Need for side lists, follow-up calls, payer portals, spreadsheets, screenshots or manual checks
Ownership clarity	20%	Whether unresolved tasks have a named accountable role or team
Status visibility	20%	Whether clinicians can see a task from initiation to closure without extra checking
Delay or safety impact	20%	Clinician-reported delays, risk signals or care disruption from open loops
Escalation reliability	10%	Whether overdue or unresolved loops escalate predictably before patient impact

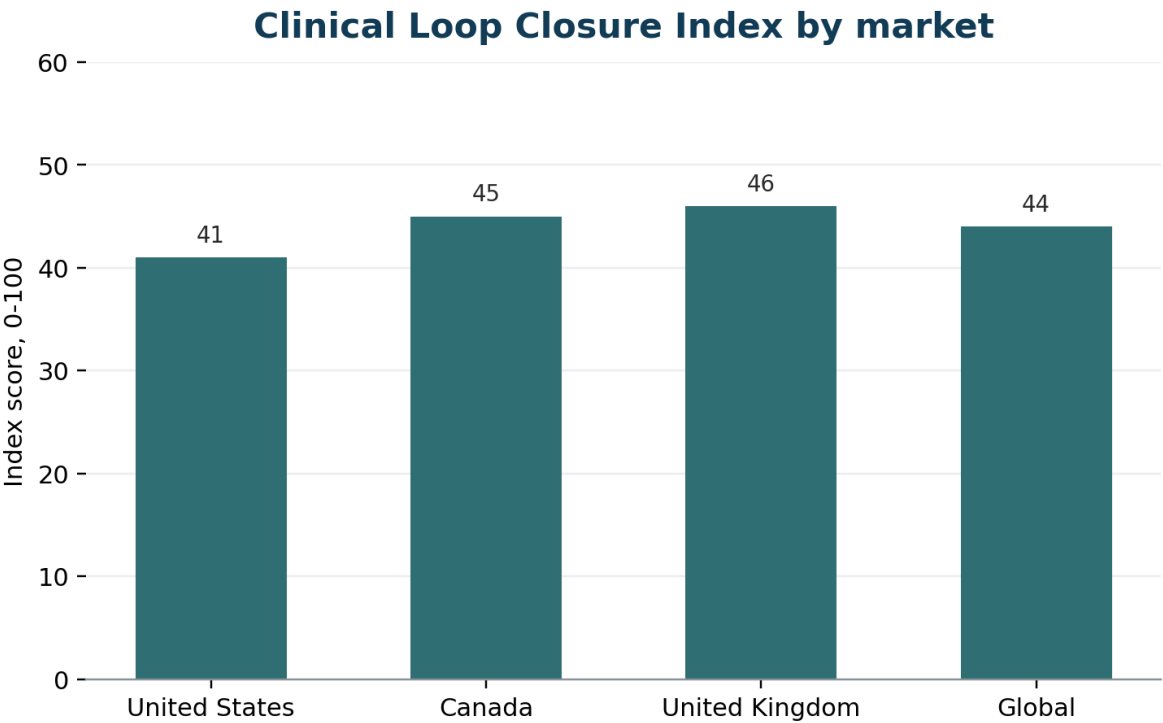


Figure 3. Clinical Loop Closure Index by market, where higher indicates stronger closure reliability.

The global score of 44/100 indicates that loop closure remains a high-friction area even where health IT modernization is visibly advancing. The United States recorded the lowest score at 41/100, primarily because of payer and portal complexity. Canada scored 45/100, reflecting connected-care progress with persistent provincial and cross-system fragmentation. The United Kingdom scored 46/100, showing EPR progress but continued pathway, discharge and handoff friction.

Market comparisons: three countries, one open-loop pattern

The survey found different root causes by market, but the same operating conclusion. Digital expansion is increasing the visibility of tasks faster than it is eliminating the follow-up work required to complete them.

Table 7. Cross-market comparison of index score and dominant friction patterns.

Market	n	Index	Weekly manual follow-up	Dominant friction pattern
United States	1,072	41/100	79%	Payer authorization, EHR/RCM fragmentation, inbox growth, payer portals, AI review
Canada	471	45/100	72%	Provincial interoperability, referral/waitlist visibility, medication reconciliation, cross-setting data
United Kingdom	495	46/100	70%	EPR expansion, discharge coordination, RTT/waiting-list tracking, shared-care records, pathway visibility
Global	2,040	44/100	75%	Common failure pattern: status visibility, ownership clarity and cross-organization completion

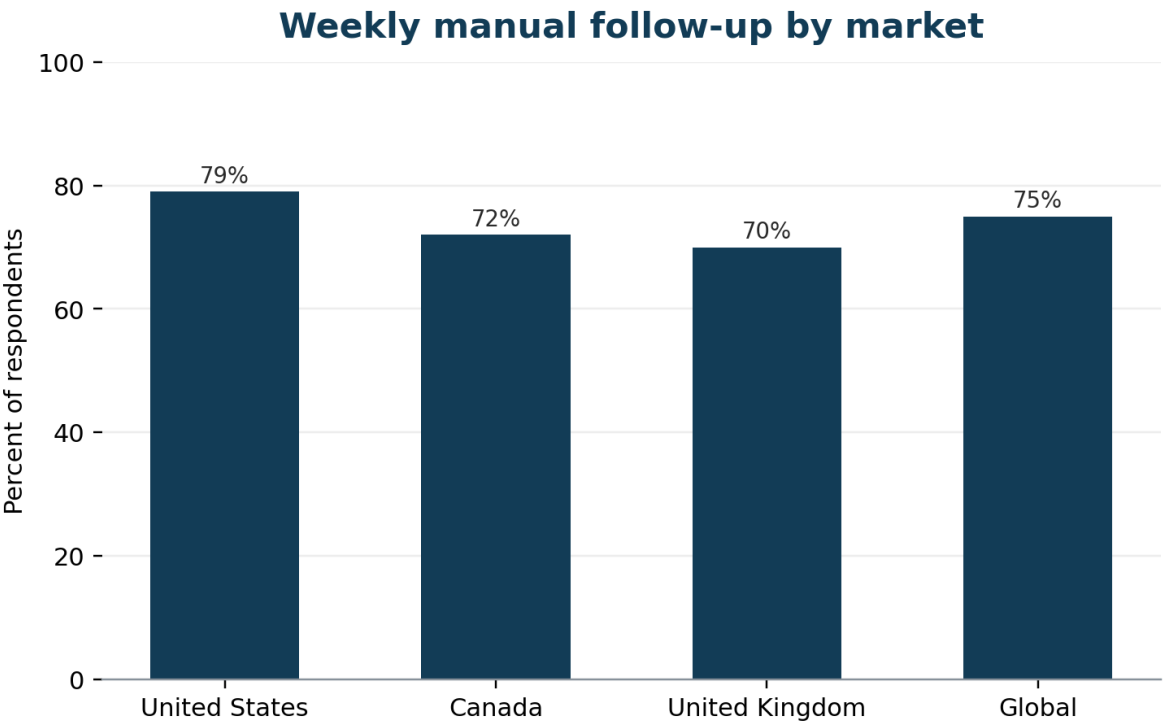


Figure 4. Weekly manual follow-up by market.

REGIONAL DEEP DIVE

United States

Payer friction and portal overload remain the most visible open loops

The U.S. sample included 1,072 clinicians across hospitals, health systems, ambulatory groups, post-acute settings and specialty practices. U.S. respondents reported the lowest regional index score at 41/100. The defining U.S. pattern is not simply EHR usability. It is the convergence of EHRs, payer portals, prior authorization rules, claims logic, referral leakage, patient messages and AI outputs that still require human ownership.

Table 8. United States clinician findings.

United States finding, n=1,072	%	Estimated n
Weekly manual follow-up outside expected digital workflow	79%	847
Prior authorization or payer status requires manual checking before care proceeds	74%	793
Payer portal or coverage checks occur outside the clinical workflow	69%	740
Portal/inbox demand has grown faster than staffing or triage support	66%	708
Referral-to-visit closure requires manual follow-up	68%	729
Outside records are available but not decision-ready during care	57%	611
AI-generated notes, summaries, coding prompts or prior-auth outputs require substantial human review	54%	579

U.S. market signal: payer friction has become clinical loop friction. The work often cannot close until authorization, coverage, scheduling or appeal status is visible and owned.

The U.S. results are consistent with a market where multi-payer complexity and revenue cycle dependencies push administrative requirements into clinical workflows. Clinicians often experience payer rules, authorization status, coverage requirements and medical-necessity documentation inside the same workflow where they document care, making payer burden appear as EHR burden.

Common U.S. vendor environments include large enterprise EHR platforms such as Epic, Oracle Health and MEDITECH, along with ambulatory, PM, RCM, patient-access and specialty workflow platforms. The U.S. challenge is not only the platform in use, but the way payer, portal, referral, claims, AI and local build decisions combine into one clinician-facing workload.

Canada

Connected-care progress is constrained by provincial and cross-system fragmentation

The Canada sample included 471 clinicians across hospital, ambulatory, provincial, community and specialty-care environments. Canada scored 45/100, slightly above the U.S. but still in a high-friction range. Canadian respondents most often described loop failures around provincial interoperability, specialist referral visibility, waitlist status, medication reconciliation, cross-setting data access and duplicate documentation.

Table 9. Canada clinician findings.

Canada finding, n=471	%	Estimated n
Weekly manual follow-up outside expected digital workflow	72%	339
Outside data exists but is not usable at the point of care	70%	330
Referral, eReferral, consult or waitlist status requires manual tracking	64%	301
Provincial viewer, repository or local system data must be reconciled manually	62%	292
Medication reconciliation across settings remains manually intensive	58%	273
Digital intake or documentation still requires re-entry	55%	259
AI-generated output or decision support lacks clear follow-up ownership	46%	217

Canada market signal: connected care is advancing, but clinicians still report manually reconciling provincial, regional and local data before the clinical loop closes.

Canada shows the difference between digital adoption and connected operational closure. Provincial viewers, regional repositories, local hospital EHRs, eReferral workflows and medication systems may each contain partial information. Clinicians still report that the information is not always reconciled, actionable or visible at the point of work.

Common Canadian EHR environments vary by province and health authority and include MEDITECH, Epic, Oracle Health/Cerner and provincial digital health assets. The most distinctive Canadian loop-closure burden is the handoff between provincial data assets, local workflows, referral/waitlist visibility and clinical reconciliation at the point of care.

REGIONAL DEEP DIVE

United Kingdom

EPR progress is visible, but pathway, discharge and handoff closure remain weak

The United Kingdom sample included 495 clinicians across NHS acute, community, mental health, ambulatory and care-transition environments. The U.K. scored 46/100, the highest of the three regions, but still below a level indicating reliable closure of digital workflows. Respondents emphasized discharge coordination, referral-to-treatment tracking, waiting-list visibility, shared-care data and medicines workflows.

Table 10. United Kingdom clinician findings.

United Kingdom finding, n=495	%	Estimated n
Weekly manual follow-up outside expected digital workflow	70%	347
Discharge, transfer-of-care or next-care tasks require manual tracking	68%	337
Referral-to-treatment, waiting-list or pathway status requires manual follow-up	66%	327
Shared-care, EPR or analytics data is not consistently actionable at the point of work	61%	302
Medicines administration, ePMA, handover or reconciliation exceptions require manual escalation	57%	282
Patient app, portal or digital-access routing creates additional triage burden	55%	272
AI, ambient documentation or analytics output lacks consistent clinical follow-up ownership	49%	243

U.K. market signal: EPR progress is real, but the next measure is whether discharge, referral-to-treatment, medicines and shared-care loops close without manual pursuit.

The U.K. findings should be interpreted in the context of major EPR expansion and national data infrastructure programs. EPR adoption is progressing, and national platforms aim to connect information and support operational insight. Clinicians nevertheless report that the hardest loops still cross trusts, services, waiting lists, discharge pathways, medicines workflows and community or post-acute handoffs.

The English EPR supplier environment includes Oracle Health, MEDITECH, Epic, System C, Nervecentre, Dedalus and Altera among major reported suppliers. The distinctive U.K. loop-closure challenge is less payer-centric than the U.S. and more focused on pathway visibility, discharge completion, shared-care records, ePMA exceptions and referral-to-treatment status.

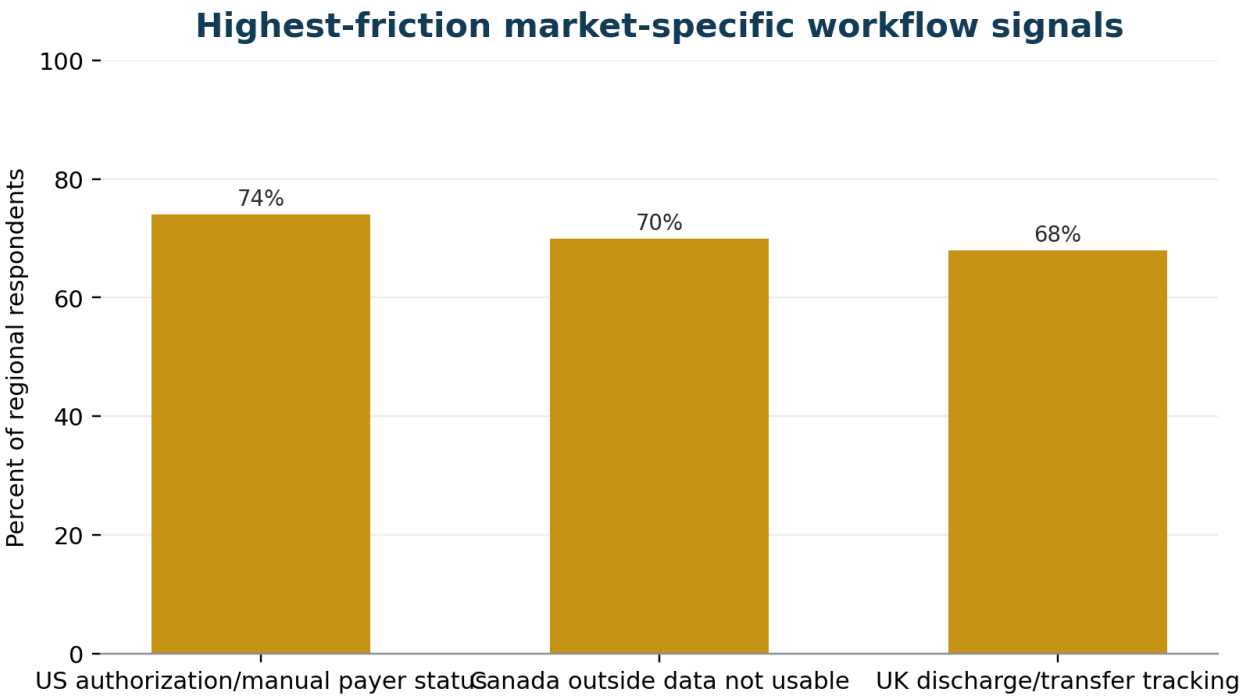


Figure 5. Highest-friction market-specific workflow signals.

COMPARATIVE ANALYSIS

Common failure points and regional variations

Across all three markets, clinicians identified four common failure points. Each appears differently by region, but the underlying burden is similar: the workflow is visible digitally but not reliably complete operationally.

Table 11. Common failure points across the three markets.

Failure point	What clinicians experience	Regional variation
Status visibility is incomplete	Clinicians cannot reliably see whether an order, referral, result, authorization, message or discharge task has been completed.	Highest U.S. pressure in authorizations and payer portals; highest Canada pressure in outside data and referral/waitlist visibility; highest U.K. pressure in pathway and discharge visibility.
Ownership is unclear	Digital workflows create tasks without a clearly accountable owner, due date or escalation path.	Most acute where work crosses departments, payers, provinces, trusts, ICSs, pharmacies, labs, imaging and post-acute providers.
AI creates review loops	AI output accelerates drafting, summarization or prediction but frequently creates validation, correction or accountability work.	U.S. AI review is more concentrated in documentation, coding, prior authorization and messages; Canada and the U.K. emphasize ownership and governance around AI-generated work.
Workflows cross organizational boundaries	The most difficult loops move between systems and entities rather than within a single screen.	The U.S. boundary is often payer/provider; Canada is often provincial/local; the U.K. is often trust/community/pathway. All require loop ownership beyond the original system entry.

Progress without fixes: the international expansion signal

The three-market results do not argue that health IT has failed. They show that the next phase of progress requires a different scorecard. Adoption, go-live completion, portal enrollment, AI activation, interface counts and dashboard availability are incomplete measures if clinicians still manually verify whether care actually happened.

The global issue is not improving substantially because many modernization programs still stop at digital initiation. The task is entered, routed, resulted, referred, authorized, messaged or discharged, but the closing proof remains outside the workflow. Expansion without closure produces a bigger digital footprint and a larger shadow workflow.

The central measure for the next stage should be completion reliability: whether the task has a visible owner, visible status, predictable escalation and documented endpoint without requiring informal clinician tracking.

Vendor, regulatory and workflow context

The survey findings should be read as a workflow study, not a vendor ranking. Vendor environment matters because systems structure the work, but the open-loop problem is rarely caused by one platform. Product design, local configuration, payer rules, national regulation, staffing, training, interoperability and governance combine into the clinician experience.

Table 12. Market context for interpreting loop-closure burden.

Market	Vendor environment	Regulatory policy context	Workflow pattern
United States	Epic, Oracle Health, MEDITECH and large ambulatory/PM/RCM ecosystems are common reference points.	CMS interoperability and prior authorization rules; multi-payer utilization management; TEACA and API-based exchange pressures.	Prior authorization, coverage checks, claims status, patient messaging, medical-necessity documentation and AI review.
Canada	MEDITECH, Epic, Oracle Health/Cerner and provincial digital health assets vary by province and health authority.	Pan-Canadian Interoperability Roadmap, connected care standards and cross-provincial data exchange priorities.	eReferral, specialist consult status, waitlist visibility, provincial viewer reconciliation and medication reconciliation.
United Kingdom	Oracle Health, MEDITECH, Epic, System C, Nervecentre, Dedalus and Altera are among major reported EPR suppliers.	NHS Frontline Digitisation, EPR convergence, Federated Data Platform and trust/ICS pathway modernization.	Referral-to-treatment tracking, discharge-to-next-care, shared-care records, ePMA exceptions and waiting-list/pathway status.

ACTION FRAMEWORK

Actions for health systems, vendors and policymakers

The findings point to a practical conclusion: organizations should measure loop closure directly. A digital event should not count as success until the work has a visible owner, visible status, a defined closure point and an escalation path when the task stalls.

Table 13. Vendor-agnostic action framework for improving clinical loop closure.

Priority action	Implementation focus	Required metric
Measure manual tracking as a cost	Inventory side lists, calls, payer portal checks, screenshots and manual reconciliation by workflow.	Manual touches per loop; clinician minutes lost; cost per unresolved task
Assign accountable owners	Every high-risk loop should have a named role or team responsible for closure, not simply routing.	Percent of loops with named owner and due date
Make status visible from start to closure	Status should be visible across referral, result, authorization, discharge, message and AI-generated work.	Percent of tasks visible end-to-end without extra checking
Integrate payer and referral status into clinical workflows	Prior authorization, payer status, referral acceptance, appointment scheduling and visit completion should not live in disconnected queues.	Avoidable authorization delays; referral leakage; patient not scheduled rate
Require AI closure governance	AI-generated work should include owner, due date, confidence signal, escalation and auditability.	AI outputs accepted without rework; AI tasks with clear owner; net labor reduction
Redesign digital front-door staffing	Patient messages and digital intake should be measured as clinical workload, not only engagement volume.	Message turnaround time; misrouted messages; after-hours message work
Close the governance feedback loop	Clinician workflow reports should produce visible fixes, not just closed tickets.	Fix-through rate; time from issue to workflow change

Black Book Research recommendation: stop calling a workflow digital when completion still depends on side lists, staff memory, disconnected portals or informal escalation.

Executive implications by audience

Table 14. Executive implications of the Clinical Loop Closure Index.

Audience	Implication
CIO CTO	Reframe digital maturity around closure reliability, status visibility and cross-system completion rather than module activation.
CMIO CNIO	Use loop-closure findings to prioritize high-risk workflow redesign around results, referrals, discharge, messages and AI outputs.
CFO revenue cycle leaders	Treat prior authorization, payer portal checks and manual status chasing as clinical workflow costs, not only billing work.
COO clinical operations	Assign operational ownership to loops that cross departments, service lines and post-acute transitions.
Vendors	Prove value by reducing manual follow-up and improving closure visibility, not only by adding dashboards, alerts or queues.
Policymakers	Measure whether interoperability and prior authorization modernization reduces clinician manual follow-up, not just whether APIs or platforms are available.

METHODS AND INDEPENDENCE

Methodology, confidence and independence statement

The survey included 2,040 clinicians across the United States, Canada and the United Kingdom with direct exposure to digital clinical workflow loops during the prior 90 days. Respondents included physicians, nurses, nurse practitioners and advanced practice clinicians, pharmacists, laboratory clinicians, diagnostic imaging clinicians, rehabilitation and allied health professionals, dietitians, care-management clinicians, informatics clinicians, quality leaders and clinical operations respondents.

The instrument measured loop-closure reliability across orders, referrals, results, authorizations, messages, medications, AI-generated tasks, outside records and discharge workflows. Survey items evaluated manual follow-up frequency, ownership clarity, status visibility, escalation reliability, delay or safety impact and perceived workflow improvement.

At a 95% confidence level, the full sample of N=2,040 carries an estimated maximum sampling error of approximately +/-2.2 percentage points under a simple random sample assumption. Regional subgroup margins are wider: approximately +/-3.0 percentage points for the U.S. sample of 1,072, approximately +/-4.5 percentage points for the Canada sample of 471 and approximately +/-4.4 percentage points for the U.K. sample of 495. Subgroup findings should be interpreted according to cell size, and all survey research remains subject to response, selection, recall and nonresponse bias.

The research is independent of EHR vendor influence, consulting firm sponsorship, health system affiliation, payer sponsorship, implementation partner sponsorship or technology supplier editorial control. No vendor, consulting firm, health system, payer, investor or respondent organization controlled the survey instrument, sampling, tabulation, scoring, analysis, graphics, conclusions or report language. Results are presented in aggregate and do not identify individual respondent organizations.

Source notes and public context

The report combines Black Book Research survey findings with public context from government, public-sector and market sources. External sources are used to support market context only; survey percentages and index scores are Black Book Research survey findings.

Table 15. Source notes for regulatory, policy, AI and market context.

Source	Relevance citation
Black Book Research source report	The Clinician Reality Gap 2026. Black Book Research respondent-driven report on hidden work, AI cleanup, payer friction, low-value digital tools and bedside risk behind EHR experience scores.
CMS	Interoperability and Prior Authorization Final Rule (CMS-0057-F), released January 17, 2024. https://www.cms.gov/initiatives/burden-reduction/overview/interoperability/policies-regulations/cms-interoperability-prior-authorization-final-rule-cms-0057-f
ASTP/ONC	Hospital Trends in the Use, Evaluation, and Governance of Predictive AI, 2023-2024. HealthIT.gov data brief reporting that 71% of hospitals used predictive AI integrated into their EHR in 2024, up from 66% in 2023. https://www.healthit.gov/data/data-briefs/hospital-trends-use-evaluation-and-governance-predictive-ai-2023-2024/
Health Canada	Advancing on our Shared Priority of Connecting You to Modern Health Care, including the Pan-Canadian Interoperability Roadmap. https://www.canada.ca/en/health-canada/news/2023/05/advancing-on-our-shared-priority-of-connecting-you-to-modern-health-care.html
Canada Health Infoway	Connected Care and interoperability materials describing interoperable health systems across provinces and territories. https://www.infoway-inforoute.ca/en/what-we-do/connected-care/interoperability
Canada Health Infoway CMA	2024 National Survey of Canadian Physicians: physicians embrace digital tools, but integration gaps remain. https://www.cma.ca/about-us/what-we-do/press-room/canada-health-infoway-canadian-medical-association-survey-shows-physicians-are-embracing-connected
NHS England	Digitising the Frontline and Frontline Digitisation Programme, including investment to establish baseline digital capability across trusts. https://www.england.nhs.uk/digitaltechnology/digitising-the-frontline/
NHS England NHS Digital	Federated Data Platform materials describing connection of information across the NHS to support staff and clinicians. https://digital.nhs.uk/services/federated-data-platform
Digital Health Intelligence	EPR contract wins and migrations coverage identifying Oracle Health, MEDITECH, Epic, System C, Nervecentre, Dedalus and Altera among leading EPR suppliers in the English market. https://www.digitalhealth.net/2024/01/dh-intelligence-releases-report-on-epr-contract-wins-and-migrations/
Definitive Healthcare	Top EHR vendors in Canadian hospitals overview, including comparative reference to MEDITECH, Epic and Oracle Cerner presence. https://www.definitivehc.com/blog/top-canadian-hospitals-ehr-vendors

ORGANIZATION PROFILE

About Black Book Research

Black Book Research conducts independent market research, user-experience studies, buyer intelligence and performance evaluation across healthcare technology, clinical operations, financial workflows and administrative services. Black Book research emphasizes respondent-driven evidence from the stakeholders who use, buy, implement, govern and support healthcare technology in real operating environments.

Black Book Research reports are designed to help healthcare leaders, clinicians, buyers, vendors, consultants and policy audiences distinguish adoption from value, satisfaction from work removal and digital availability from operational completion. The organization maintains a vendor-agnostic research posture and publishes findings based on aggregated respondent evidence, structured survey instruments and defined scoring methods.

The Research Insights format is intended for strategic market interpretation. It is written to preserve the statistical detail of the underlying survey while translating findings into practical implications for CIOs, CMIOs, CNIOs, CFOs, COOs, clinical operations teams, informatics teams, revenue cycle leaders, procurement teams, vendors and policymakers.

Use of this report

This report may be used to support executive briefings, market education, workflow redesign planning, vendor roadmap discussions, procurement evaluation, policy discussion and internal clinical operations review. Findings should be cited as aggregate Black Book Research survey results and should not be used to identify or infer performance of any individual respondent organization.

Media and research contact

Black Book Research Tampa FL, Chicago IL, New York NY, London GB
Research@BlackBookMarketResearch.com 1. 800 863 7590
www.blackbookmarketresearch.com