: Lesson learned: Informatics rule #1: If you don't know, "google it"
:And don’t assume the first few Google “hits” are the most accurate, relevant, unbiased or useful.
:That meeting was the last trip I was on too! Glad you made it :)
:Me too!
:Novlett Paul here from Elsevier. Please assign me to a breakout session. I unfortunately had to miss a few sessions
:I disagree that documentation isn't part of providing care for our patients. the thinking that is enabled by documenting and the recording of observation that we have made and rational for our decisions are, IMHO, part of providing care
:Hi @! :)
:like so many things, we want to eliminate the low value stuff and keep the high value stuff
: that is especially true in a collaborative / cooperative setting - we're not treating patients in a vacuum.
:+
:Definite Myth. Can not document and care at the same time
:We can go further and eliminate the no value stuff
:Can we agree what constitutes the low value stuff?
:@ - it is the documentation where I took the time to collect my thoughts and make decisions frequently... I see it a as a core part of my job, so agree with you
:+. When trying to focus so much on the documenting, something has to be decreased, whatever that might be (inter-team communication, bedside time, communicating with families, or all of what Dr Sinsky mentions).
:Why was it that 30 years ago we actually were able to do the work and document it? The myth is that we can't do it and document it NOW with all of the extraneous stuff that's been thrust upon us.
:I think we can do the work and document the work - we just haven't found the right balance of that yet
:nor should all documentation be expected to be a minute by minute record of all care provided by the interprofessional team.
:+1 @
:@ we could document because we documented what we thought was important; now we document what everyone thinks is important also
:😊
:+1
:+1 @
:Woo! @!
:+- I very much appreciate what Chris has been trying to do over the years, but I am concerned that by making this a choice between relationship and information - we serve no one. There is technology and workflow that can fully support information-enabled visits. Information free visits may feel good to the doc and patient - but they are not leading to good care.
:sometimes the low value data to one discipline could be high value for another specialty.
:@, @ - agree, relational work is best uninterrupted. We now know how

bad we are at relational work just on zoom as we miss non-verbal cues. Same in the exam room. And the hard important work of synthesis is degraded when there is too much chaff and not enough wheat.
:@ - we could do it when we documented what was clinically relevant. Now there is far too much that is not relevant. Not only does it take time, but it requires context switching.
:It's the visit "OM R, Amox 60/kg/d. Recheck 2 wks."
:@, is this being disseminated widely? What barriers are you facing?
:I believe we need to think about the definition of documentation differently. To me documentation should be the translation into narrative of the synthesis of the patient's story and the clinician's thinking. Do we really want to do away with that
:+1
:@ - agree in principle but in practice not all data is information, not all information is wisdom, and there are tradeoffs. Goal is to maximize everything of value including healing relationships.
:Yes. Synthesis of information is crucial. I'd also like to be able to bring back "rule outs" as "allowable" diagnoses. This is the way people think and keeps key possibilities from getting missed as well as understanding, easily, why certain tests are being done.
:@ point is well taken - and I would posit that if we think about documentation in that way - then documentation is thinking + whatever modalities are used to put that thinking into a narrative… That is not burdensome, that is a clinician's work.
:+1 @
:less is more only works if we have payment reform
:+1
:And liability reform.
:I think of the attending addendum as a good example of "Just the important stuff - key history/physical, +MDM and Plan"
:YES.... I hate that so much...left over from paper world "if it didn't document it didn't happen."
:Easier said than done
: How about the EHR-centric approach: If it wasn't done, it wasn't done….
:Liability issues
:+1 !
:+1
:The only reason we need all of those structured phrases is related to the CPT requirements for billing. Will AMA commit to getting rid of all of the bizarre billing requirements under CPT?
:How might there be systemic incentives for documentation that is well written for clinical synthesis and understanding? Is there a way to reward those who take the time to write better notes?
:@ - perhaps you misunderstood what I wrote. I never said (nor implied) that all data is information (and informational). I don't think we disagree on any of this
:They have for ambulatory E&M CMS and AMA changed documentation requirements this year
:+1 . We get conflicting guidance from billing/coding and also ensure

protections against what isn't documented, as well.
:I agree with getting rid of the notion of "If it wasn't documented, it wasn't done." Do we have evidence to support this? Does anyone know of publications?
:The challenge here is how we merge the various users/uses of the clinical encounter (patient, clinicians in the moment and in the future, payers, quality and secondary use of data). Each has different ideas of what is important. How do we find consensus here?
:+1
:Please add questions for Christine in chat
:+1
:I have found time-based billing under 2021 E&M for ambulatory transformative in my documentation, quite freeing and focusing. Anyone else having this experience? It's a big first step.
:Let's stop blaming the lawyers for over-documentation to protect our asses. A number of well-done studies have shown that there is NO relationship between quality of care and lawsuits. The greatest correlation is with the clinician's ability to communicate with their patients. And we do NOT do that well if we spend too much time documenting to cover our legal asses. IMHO.
:Whi invented Sludge audits >? What did she say?
:case sunstein
:cass
:Cass Sunstein at Harvard
:Thanks Kathleen!
:- I review charts for lawyers. When we document things that are not true (which happens all the time) we lose.
:@ The billing is now even more confusing because it's different for inpatient and outpatient and many of us do both. The medical complexity requirements are still convoluted even with the "improved" changes. Those of us in psychiatry can't do psychotherapy plus E/M based on time. So we're stuck with outpt E/M based on complexity. The new and improved outpatient codes have been an even bigger nightmare for us than the old way.
:@ - at least for outpatient care, CPT has changed for 2021. Aside from documenting total time day of service OR elements of medical decision making - the note is now defined as whatever the clinician determines to be medically appropriate. We have to learn to accept YES as an answer. IMO - we have sufficient leeway (at least in ambulatory) to have 75%+ reduction in documentation burden today - if we care to leverage these revisions.
:+1 @
: is so good. Can we eventually separate out the needs of medicine (i.e., summarizing case, pointing to solutions and actions; and conveying it to others) from the need to get paid via "documenting" the work?
:@ See above. For those of us in psych. It's worse than before
: some of the secondary uses of EHR data are fueling precision medicine. What’s your vision for how we keep the baby and throw out the bathwater?

:@ - I agree 100% with both the new time-based E/M guidelines, as well as the MDM-based guidelines
:agree , in and outpatient documentation needs to be harmonized before we will ever really be able to improve it
:Powerful last slide!
:Thank you Christine- your talk felt healing.
:Great presentation!
:Great presentation, thank you
:Agree. Poor documentation, esp. hitting buttons that aren't true (e.g. in ROS) and cutting-and-pasting, increase risk of errors and probably liability.
:Given the just published AMIA paper on why we didn't see burnout coming, what things will come out of this current initiative will we look back on as problematic? (Personally, I can't believe no one saw burnout or at least lots of dissatisfaction occurring from 10+ years ago.)
:Now to change hospital billing, and psych billing - keep on with the changes.
:I think the new 2021 E&M changes were highly enabling. I have changed my documentation back to the paper world, where I wrote what I needed (and used the time for summary and synthesis and communication).
:OK so when does the inpatient side come for H&P not requiring the unnecessary "negative"documentation for billing?
:Many of us saw burnout. Not every concern made it into the paper.
:Definitely agree on most quality measures being unhelpful and not really improving outcome.
: Don Berwick has been quite good on the harm of over-measurement - see "Era 3: Foundational Values for a Sound Future (2015)"
:Is it really overmeasurement or is it measuring things that don't matter that then misguide your actions?
:Seconday use includes the benefit for the patient for carrying forward longitudinal health story
:The changes began with the ambulatory setting; work is already underway to change the requirements in other settings. The first wave provides a framework for adoption in new settings.
:The challenge with less collecting of information is how do we measure improvement. How can we improve what we cannot measure? I'm not just thinking the formal quality measures.....
:+1
:I experienced burnout long before the EMR, it didn't help, but burnout was a real topic before the EMR came along. it is an oversimplification of a complex process leading to burnout to say that it is all on the EMR.
:In our quality measure breakout we definitely felt the value (or lack of value) was not worth the escalating level of effort to record the input to the (not so) ‘quality measures.’
:IMO much of the discrete data that might be useful for secondary purposes can be in the EHR without having to be in the note
:+1
:Good programming can turn those check boxes into real text. We

(Epic) just haven't put the resources into it.
:Really like talking about the “needle in the haystack” experience of trying to find relevant information in the EHR. It creates SO much burden. Need more focus on the review an ingestion of notes, in addition to creation of them
:+1 – the headline for most physician satisfaction stories was “I spend more time on paperwork than with the patient.”
:Much of discrete data entry could even be patient-entered prior to visit
:Burnout is a pre-existing condition
:One elephant in the room here is that many health care systems (hospital systems etc.) are very conservative re compliance issues - risk management drives corporate policy that prevents innovation or uptake of innovation. How can we engage these larger systems?
:Thank you @ for the magnificent contribution you have made to this work – yes, your presentation also brought joy and hope today – healing relationships, healing documentation for renewed purpose
:notes are a colossal waste of time now. There is a serious problem of people taking documentation that they already completed in the system, in the proper area, and putting it into the note because "no one else can see it if I don't put it in the note." This drive me CRAZY!
:+1
:Legible gibberish is the term often applied here for the thousands of pages in the EHR. Also Goldhart's rule...about everyone working toward the assigned "quality" measure rather than toward what makes sense.
:+1 , so much of what is already in the chart is also brought into the note, without much thought as to if it really needs to be there if it is already documented in the chart
:+1000 . That is a HUGE challenge.
:+1 and also the drive towards corporate-owned practices yields a lot of one-size-fits-all approaches towards documentation rules
:When I was on NQF board, I advocated for MTM (Measures that Matter) to people. The personal stories probably contain more of what matters (to the individual) than what we’re being asked to capture as discreet data for ‘quality measures.’
:“Note Peer Review” has been implemented at a couple of the startups I’ve worked in. It actually raised the clinical communication quality of the note
:I find myself reading the impression section as I pick up a patient.
:Great points by Christine about the useless much of the time with the required bullet points within the HPI, the ROS, and PE – however, at least for outpatient - we are talking about yesterday’s problem. Doctors in ambulatory who continue to document bloated histories and physicals need to unlearn bad habits
:Even after the E/M coding changes on the ambulatory side, many of our physicians are not changing their notes due to inertia or a preference to leave everything in the note so that they can use it as chart review. They actually don't spend much time writing the note since most is autopopulated. Would there ever be any consideration for negative consequences of writing overly long, prepopulated, copy

forward notes?
:I think we expect the EHR to be able to take on the burden that was already there and get frustrated when it doesn’t.
:We should not let the EHR off the hook. It can be radially transformed to facilitate document speed and quality. Cris talks about dictation -as a time of synthesis. Voice recognition has reached a stage of accuracy that it narrative could become back at center, especially for the "Assessment"   the EMRs need to figure out how to truly integrate this into the workflow
:+1
:Thanks so much Chris!!
:This week I met with the OR RNs for our first roll-up-the-sleeves work session of Project Joy for IntraOp. The screen they showed me where the RN records every person who was in and out of the OR blew me away. For a big case, the work of capturing this information requires well over 100 clicks and a great deal of attention that is diverted from the surgical field. It is considered absolutely mandatory that we know who was in and out at what time. All of this could be captured in a video that is saved and accessed as needed; the information the RN spends so much energy captured is needed only very rarely.
:Great point, Gordy
:We do NOT need to stuff everything into the note. That is a body of work that needs to come next - for both clinicians and informaticists. How do we best enable references / citations to relevant information within the EHR without putting it into the note. This is possible and several EHRs have already come up with decent to elegant solutions.
:Wow too many click Bonnie in that OR!
:Go, Bonnie! This certainly is important work!
:@ -- also with cheap (5 cent) RFID tags embedded in patient's ID bracelets.
:This idea of video recording for later access is one of the ideas that is most frightening to me in terms of the future.   I sincerely hope that this isn't one of our final recommednations.
:+1
:@, can you please articulate your concerns about recordings?
:+1
:Let's have a full discussion about video recordings. We need to explore it deeply.
:how can I get to my group's mural page?
:+1
:@ - the big page is at https://app.mural.co/t/alphachimpvirtualfacilitatio9350/m/alphachimpvirtualfacilitatio9350/1610384522852/df1341e3cf593c345a06b4a2eb91885b9d01d5ba
:You can zoom in from there
:time horizons. passing a federal law is FAST compared to changing healthcare practices\
:Perhaps the concepts of using technology to supplement some of the tasks that can be automated.... i.e. who is present in the room with

the RFIDs identification (or swiping a badge or other identification when entering or leaving a room - have to work around OR sterility though)
:+
:In psych training, we had to do video recordings of a fraction of our patients for psychotherapy supervision. We obviously did it only with patient consent. It was useful for training but it definitely changed the way that we interacted with patients and they interacted with us because of the constant knowledge that someone else may be judging you after the fact. As a patient, I certainly would not want my visits with my treating clinician, physical exam, GYN exam, etc. recorded. In truth, no one reads most notes now and even fewer people will take time to review old videos. The only people with that kind of time will be attorneys.
:PDSA approach
:The original scheduled sessions time is almost done, I'd like to thank everybody. Our leadership team now has a LOT of work to do to bring all this together and start all of us working towards goals. Please keep an eye on the website and feel free to join our AMIA community to keep the conversation going. Thanks so much for all your time, energy, thoughts, feedback, and guidance!! And a big kudos to Sarah for steering this ship!
:Great workshop! Looking forward to next steps. how long will the documents on the web site be available?
:thank you for pulling this together it was a great deal of well done work! Looking forward to the outcomes!
:Thank you Sarah and Trent for your leadership as well as the rest of the team! Fantastic event!!!
:thanks everyone for all the work and participation.
:Thank you for a wonderful event!
:Trent, is 25x5 a new AMIA community?
:Sarah and Trent rock! Amazing job and honored to be a small part of the work
:@, yes! We will send that out again.
:Yes, email me and I can add you jeff@amia.org
:@, can you share the link for the communities?
:+1
:Great job--look forward to next steps!
:send me an email - jeff@amia.org to join the community
:How do we stay involved?
:+1
:Thank you for a great series of events.
:is there an oppty for other to give thoughts / input on some of the workgroup recs they were not involved in?
:Thank you for providing the space and time to think deeply about these critical issues. Thoroughly enjoyed the community.
:@ et al, join the AMIA communities, keep an eye on the webpage. Emails to follow as well, and feel free to reach out.
:YOU GUYS WERE FANTASTIC. Thanks for sticking with us for the entire 6 weeks, and for contributing so much information for us to distill and

act upon!
:This was awesome to participate in! Thank you so much for allowing me to be a part of this.
:Webpage - https://www.dbmi.columbia.edu/25x5/
:or google 25x5 burnout :)
:AMIA Connect 25x5 community will be available to all participants to stay in touch. We will have short wrap up with next steps if you can stay an extra couple minutes
:There appears to be a download option in the mural tool, but it refuses to allow a download unless you are logged in. What authentication credentials do we use to get access to the download?>
:Larry, we will get these to yall
:These will be on the website
:thank you for allowing me, as a patient advocate, to not only participate in this process but to made feel that my comments were of value.
:@, we will send out the PDF of these work walls after the event.
:OK, but please consider that we bent process to fit the tool so there would be an immediate result, and now there is no immediate result available to the people who did the work. That seems like a disconnect of incentives to me.
:applause applause - standing O for Sarah and Trent
:+1 @
: Thank you, Design Thinkers! If you would like to use these activities with your teams and students, you can find them here: https://www.ibm.com/design/thinking/page/toolkit
:Thank you so much for allowing so many to contribute to this worthwhile cause! Looking forward to the future:)
:Thank you all so much for your participation. This has been terrific in all respects. Thanks to the leaders and it was so nice to see so many of your faces and get your excellent ideas. On to improvements. Don
:Thank you everyone
:Thank you for including a Canadian…great work
:Thanks everyone!