

:Please remember to change your Zoom name to your actual name, use the chat function to advance the conversation, and to live tweet.

: Breakout Survey: https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8?

Q_DL=0ktUCTLgXUubneoM_cGF9IQgS9axLsB8_MLRP_8uLdoHxfYf30t0S&Q_CHL=email

:Please fill out survey for breakout rooms – link above! If you are interested in being a breakout room facilitator let us know in the survey

:If I filled out the survey a couple of days ago do I need to do it again?

:To clarify survey is for your breakout room preferences. Only need to fill it out once.

:@, only need to fill out once

:@ no

:We have you down!

:Please re-post survey link

: Breakout Survey: https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8?

Q_DL=0ktUCTLgXUubneoM_cGF9IQgS9axLsB8_MLRP_8uLdoHxfYf30t0S&Q_CHL=email

:We are in progress with our TNA/TONL, ANIA project, the distribution and analysis of a survey via ANIA with an instrument piloted in Texas. We are assessing Nursing experiences with documentation burden and how the COVID crisis impacted efforts in reduction of documentation. We've found nursing POC is a big dissatisfier they'd like to get rid of as well.

:@, can you please spell out the abbreviations? I don't recognize them all. Except COVID :)

:lol of course

:Please post any questions about the survey results in the chat. thx

:Is this slide deck posted somewhere for us to review after ?

:We are in progress with our Texas Nurses Association/Texas Organization of Nurse Leaders, American Nursing Informatics Association (ANIA) project, the distribution and analysis of a survey via ANIA with an instrument piloted in Texas. We are assessing Nursing experiences with documentation burden and how the COVID crisis impacted efforts in reduction of documentation. We've found nursing plans of care were a big dissatisfier they'd like to get rid of as well.

:The boilerplate bloats the note. What about "this visit was done by video after the patient consented." Why a half page of junk?

:Slides will be posted to <https://www.dbmi.columbia.edu/25by5-symposium/>

:We will post this slide deck on the 25x5 website after the session ends.

:I question eliminating Plans of Care. Isn't one goal of the EHR to indicate the "go forward" plan for all clinicians?

:Thx

:+, especially during care transitions

:From my POV nursing plans of care continue to care continuity and safe transitions of care. Look forward to nursing plans of care

included in interoperability documentation (CCD, CCDAs)
:i'm concerned about the 67% with no response/category
:Breakout Survey: [https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8?](https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8?Q_DL=0ktUCTLgXUbneoM_cGF9IQgS9axLsB8_MLRP_8uLdoHxfYf30t0S&Q_CHL=email)
Q_DL=0ktUCTLgXUbneoM_cGF9IQgS9axLsB8_MLRP_8uLdoHxfYf30t0S&Q_CHL=email
:Anything that can make the plan of cares better will be a plus!
:Plans of care need to be patient specific. If just jargon and checkboxes they are useless.
:+1
:@, just to clarify, those 67% were reporting no additional strategies besides those already mentioned in the survey. So it didn't mean that they experienced no burden reduction strategies overall.
:@ - agree, almost all of it can be automated in a personalized way. And if we are using AI to inform treatment plans, let's look to use AI to inform nsg care plans.
:The link to the breakout sessions survey says "the session has expired." Is participation limited? Thanks.
:+1 - most nurses do not find value in the plan of care
:Thanks. Understood
:@ I have to ask without a plan how do you know where you going. I agree that we need to have a patient centered plan of care with all disciplines communicating and working together. It should not be a nursing care plan, but a patient care plan
:+1 , agreed
:Yes@ PATIENT care plan
:+1 @
:There is definitely value in a Patient Plan of Care which is multidisciplinary and patient specific. Most nursing care plans are check lists that many do not find valuable or direct patient care.
:@ - clarifying... 'nursing documented' care plan - in many orgs, nurses get dinged for it not being filled out.
:@, I'm all about plans of care, they just need to be more usable. Their survey results referred to waived nursing plan of care requirements
:We have yet to see how the payers will audit with the new Documentation/Coding guidance. There are national payers who are still targeting and creating obstacles to appropriate payment that is not Medicare
:The fact that coding has a direct relationship with documentation is what drives note bloat.
:activities of daily living and function. Let's code nursing care and have the ability to make nursing care plan dynamic
:+1
:@ - do you see the AMA/CPT moving further towards value-based-payment, how do you see that affecting the burden changing with respect to CMS and other payers.
:While children are about 1/3 of the population, the chronic care model and testing is not well represented in the MDM guidance
:plan of care should be related to medical diagnosis and treatment plan

:For children that is. The CPT/AMA guidance works well for adults, for kids, not so much

:Medicare Advantage carriers get paid based upon diagnosis codes. The same should be true for providers. Move away from pay based upon service to pay based upon condition and outcomes.

:Patient care planning tools using decision support, structured documentation and AI to streamline workflow are available as plug-in tools for legacy EHR's. They help to address the work effort problem while still providing patient specific multidisciplinary plans to guide care

:Agree that chronic care management needs to be valued more.

:At least in mental health, the interdisciplinary treatment plans that are mandated by CMS and Joint Commission are well intended, but they are pure duplication with what also has to go into the daily physician progress note and the latter are more up to date and reflect the team discussion. Making every single person interact with "the plan" is cumbersome. Also, there are various requirements in the wording of the plans that are cumbersome and don't add anything to actual patient care, yet that's what the regulators get hung up on. It sounds intuitive that a plan of care is needed but the devil is in the details. I for one think the plan of care as currently formulated should be eliminated.

:Our EHR fail to tell the patient story and have a coherent plan so all that are contributing to the care activities are on the page.

:My organization has also just rolled back the reduced documentation standards; it feels like a mistake.

: https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8

: If you not had a chance to fill-out the breakout survey, please do so at the following updated link: https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8

:We are also getting focused on episodes of care which loses the life health trajectory of the patient

:There is so little attention to past medical, surgical, and family history – that's part of the loss of attention to the whole patient and trajectory of the patient.

:There is also no where in many EMRs to document what the patient's plans are.

:Exactly all driven by CPT code driven documentation. If documentation was driven by problems / diagnosis we would truly have a longitudinal record.

:And social drivers of health!

:It would be useful to hear why AMA supports the current approaches to medical decision making complexity. Both the "simplified" version and the inpatient version are still very confusing. The idea that you need an app to know what to code shows how problematic the overall design is. For people who work in both domains it's a nightmare. Yes, it's good to be rid of the idiotic "bullet point" approach but the new version isn't that much better. For those of us in psychiatry who also do psychotherapy as well as E/M, we can't bill the E/M by

time and we are stuck with the medical complexity framework.

: If it's the patient's care plan, who should be documenting it? My opinion: it's a shared, living, changing document and not one that is "written" shared,, then updated, and re-shard. Let the patient and their caregiver team use it as a shared, living tool

:Is AMA doing anything to address the insidiously negative effects of RVU driven medicine on clinician burnout? When organizations require productivity above the 50th percentile for continued employment, there is a hamster wheel effect where everyone has to keep running faster and faster. And the RVUs depend on documentation as much as what's actually done so they are interconnected.

:@, I agree. If the plan is going to be truly useful, it has to be dynamic

:A care plan must be curated by the entire care team. Patients often have multiple problems, that involve multiple systems and the problems impact the whole patient. The care plan must be a collaborative document.

:Why do we accept the complexity of E/M coding as a baseline (and OK)? Is it because the complexity is valuable, because it grew over time as a paper based relic, or for some other reason?

:Congrats on your new Anthem gig, Marc Overhage!

:I agree

:A smart visit record should be the organized, easily navigable compilation of documentation from each provider what they uniquely contributed to the patient's care.

:+1 to both of @ comments. We seem to have exchanged an ROS bullet point list for an MDM bullet point list, which is a somewhat incremental improvement.

:Congrats Marc! Do many national plans have CMI0s?

:We really shouldn't accept a system where two physicians can see the same patient and order the same treatments but one is paid more because they are more knowledgeable able the intricacies of coding

:With AI/voice to documentation one concern is that notes are not simply transcriptions of what is said out loud but instead there needs to be clinical reasoning and processing that happens when the note is written

:It's important to remember that the provider's relationship with the computer has to be bidirectional. It's not just about getting the data into the chart, it's also about getting info back out again - both at the time of the visit and later.

:+1

:What is there to loose when we rely on AI and process less? There needs to be a balanced and thoughtful approach

:+1

: As CMI0 at a Payer Organization, how might the new interoperability rules requiring sharing of data with payers and providers inform AND change our current documentation systems?

:Yes @. It's about documentation, retrieval and meaningful synthesis. I don't want to replace overwhelming note bloat with overwhelming coded data that makes me feel like an accountment with excel pivot

tables

:+ 1

:I'm also talking about my looking at the X-ray or the labs or the consultant's note while I'm in the visit.

:@ - that is a UI Issue, some systems I have used allow that.

:you can also add Med Rec as one of the burden to clinicians.

:Thanks :)

:completely agree - there is value in AI/NLP *augmenting* documentation, but we need physician experience, medical decision making and definitely need clinicians to learn to critically think themselves as well.

:+1

:With AI and ambient documentation, will patient's be less likely to truly talk to the provider? There are things that people convey to their doctors in more detail than they would ever want to have documented in a medical record. How will that work? (i.e. keep the doctor/clinician relationship secure)

:Yes +1 Subha and Ross! When a clinician sits down to write a note there is so much clinical reasoning/processing that happens and is particularly important from the MedEd context

: - you just equated coding and documentation - that's something we need to get away from.

:+1 - really important question from a trust perspective

:we are trying to fit a square peg in a round hole by continuing to use new technology to support a payment system that needs to be totally turned on it's head to show VALUE (and that includes value to the patient)

:Particularly now with the OpenNotes rapid rollout with the Cures Act, clinicians are already trying to figure out how to document the clinically important gist of what patients convey without having all of the specific details. This is crucial in psychotherapy where the insurer or others reading the note don't need to know all the specifics of what a patient says and most patients don't want insurers to know all of those specific details.

:Very interesting conversation about involving patients in their care plan. I think Helen Palomino was trying to get at this issue with cancer survivorship planning last week.

:Unfortunately AMA has a stake in the CPT system.

:If you pay based on log data do you reward inefficient providers?

:When are we going to get to salaried doctors and junk all this stuff?????

:It seems like the computer log approach will further incentivize providers to spend more time with the computer and even less time with patients.

:+1

:Let the company do the billing while the clinicians provide the care.

:Also need ways to include supporting members delivering team based care. For example, I'm interviewing/examining the patient in an exam room and my MA or scribe is running the EMR for me. Need to accurately integrate these times and activities as long as we have "dollars for

documentation"

:Even those of us who are salaried physicians still have to deal with all of this stuff...

:@erictopol Yes!

: 🙌 🙌 🙌

:Preach Dr. Topol!

:there is no reason to think that more time is better. i don't think anyone would suggest that EHR time should be tied to coding beyond the obvious relationship between the intensity of data review and ordering with clinical decision making

:@David Newman - salaried docs wont get rid of this. The bean counters of the employer will make sure of that. The change has to do with the payment paradigm.

:@Laura Yes, we need to ensure (even outside of psych areas) that patient's trust and feel safe interacting with their doctors and nurses (and everyone in the system). That is part of the filtering role that an experienced clinician can do as they truthfully document, yet maintain those very personal/confidential details that patients (especially those who are vulnerable and sick) share with nurses/ doctors.

:we did find that we could ,using time data from video and EMR log data predict the CPT code for an encounter with an AUC of 94% or so

:@erictopol - direct consumer engagement

:We are anticipating significant changes when the 21st Century Cures rules are fully operational & patients will have access.

:Thinking the payment system and interoperability documentation should be harmonized. Why use different code sets?

:@erictopol we need to engage patient, it is their health and no one knows more about themselves than they do.

:Think about patient populations. 50% of my practice does not even have a smart phone.

:+1

:Streamlining documentation recording pertinent clinical needs supports open notes

:+1

:Then we need to figure out on how to communicate in terms that those with health literacy and technology literacy challenges can also find value in. we have a huge disparity issue and have to make sure the technology doesn't make this worse

:Many of our patients want the doctor to take control - they have no time or energy to engage with their care.

@ - important equity issue! We need to also do more to provide devices/access and different modes of communication for patients and not just leave them out by saying they don't have a smartphone

:To the open-notes movement, that is beginning to allow for patient involvement in reviewing and helping correct/improve their notes. There's also been some work (but not enough) on enabling patients (who are interested) in helping to inform/contribute to the creation of notes. Seems a logical and important parallel work stream for this initiative to be even more proactive.

:@ I agree that most patients aren't upset by notes and that it's true for the vast majority of patients. But I do think the system needs to consider different exceptions where this may not work (e.g., acutely psychotic psychiatric inpatients are one example).

:And think about patients with limitations in language understanding (non-English speakers, blind, deaf, etc.)

:I have some experience and insight into the matter of "time out" logic in inpatient nursing EHR time in system data. There is a big difference in outcomes between a 30 second time out and 5 second time out is large. My EHR data suggests that nurses in my health system are in and out of the EHR something like 140 times per shift, which itself requires some attention. More work needed on these data. related point is that Epic has studied these time outs and learned that the overwhelming portion of user system pauses 5 seconds in duration remain pauses after 30 seconds.

:+1 , sometimes it is a matter of simple instructions on some functions.

:@ exactly, we need to demystify the medical record and provide access to patients

: Do any panelists have an opinion or experience using the EHR's audit ability to "document" clinician information retrieval and review so data does not need to be re-documented or referenced in clinician notes?

:tell us the story of your journey with Google Glass. What can we learn from that experience as it relates to people, process, technology?

:All psychiatrists know about the river in Egypt

:Thing is, patients have long had access under HIPAA. ON just makes it more convenient.

:YES. we need patient language!

:@ can't agree more we need to engage patients but part o that is meeting them where they are -- the level of ownership they can and want to assume. There is a broad spectrum among patients and part of our job as clinicians is to assess where they are and help them be engaged as much s they can be

:Patients can and do request and obtain copies of their records now. 21t Century makes it faster.

:And then there is the CYA medical legal documentation

:Has it not been the interest of payers to increase the documentation burden? Is that not why we are in the situation we are in now?

:Health literacy training is needed as the next step on the journey.

But we have to look at banking and moving to ATMs - It can happen

:If clinicians are charting things and thinking a patient will not see it, that is mistake. Today more than ever patients are obtaining copies of their records

:+1 on the video approach!

:Ross, would love to have that conversation with about payers, including CMS, considering AI.

:A video can not document the thought process behind clinical decision making.

:@ but now we are starting to see clinicians EXCLUDE important documentation because they don't want the parent to see it
:The problem with video recording is that the next doctor to see the patient, or even my reminding myself about what I did in the last visit. Doesn't work at all.
:the lawyers would certainly love that, the video could be as damning as exonerating in what is frequently can be he said/she said situations
:Those who work with adolescents often exclude important documentation because the patient doesn't want the parent to see it.
:The only place I see video being of value is in documentation of informed consent.
:Yes @ I've has social workers lock notes in highly stealable filing cabinets to avoid it being put in the EHR
:We absolutely have to figure out the sensitive data sharing issue
:@ I would challenge the ethics if they are omitting health data.
:In the 'old' days of paper records, we used the time and the effort of writing a progress note to synthesize what we know and to share our thought processes of where we're headed (for diagnosis or treatment) – for ourselves and others. We would miss that synthetic and communication function in automated documentation from ambient utterances. Also, on the flip side, when we forage through the EHR, what we're looking for are insights, not pieces of data. We should use AI to glean the insights from the written documentation.
:@ – important point – @ Kressly, myself and other's are working on these sensitive data challenges particularly with adolescents
:yes! clinicians need a space to think, and write, and share thoughts that aren't automatically part of the "legal record"
:👏 ! So important to elevate the synthesizing and communication function of notes
:+1
:+2
:+1 @ross in terms of video. Few read the notes, even fewer will look at the videos. Clinician thought processes have been grossly impaired by current state. The ability to document "rule out a specific diagnosis" was a crucial piece of differential diagnosis that's been lost.
:+1
:+99
:If we knew which elements are not typically used later (e.g. earlier example of documenting the patient's belongings), we could take those elements out of documentation and just refer to video if necessary. Another example is clicking around to document which arm an injection is given in – rarely needed for future clinical care I suspect.
:Great point Ross. Clinician confidential thoughts are especially important in Mental Health notes.
:Totally agree with @
:<https://blogs.jwatch.org/hiv-id-observations/index.php/how-did-our-medical-notes-become-so-useless/2019/01/02/>
:+1 – There are lots of doctors who try to complete the note in the

exam room. I think that removes my ability to synthesize the data. I'm always coming up with things I forgot when I finish my notes.

:@laurie novak with long acting injectable antipsychotic meds, we need to alternate sides from injection to injection that are months apart

:This point is the last chapter of @EricTopol's Deep Medicine. Love that chapter!

:This illustration from Grace Ferris on this article encapsulates this challenges of tools to make documentation vs understand documentation

:<https://blogs.jwatch.org/hiv-id-observations/index.php/how-did-our-medical-notes-become-so-useless/2019/01/02/>

:The notes I read from physicians glean very little insight for me as a nurse. I only get insights from rounds. I feel like I am the AI when I read their synthetic notes!

:@ - I think that is because the notes we currently write are burdensome and often useless. The goal is to make it easy to write useful notes.

:The knowledge that they are being recorded can often change the way patients and clinicians interact and what they are willing to say. The information captured will be different and influenced by the very fact of the recording.

:v

:Topol's Deep Medicine - <https://www.basicbooks.com/titles/eric-topol-md/deep-medicine/9781541644649/>

:@ totally agree that recording will change the interaction and probably not in a good way

:1+ - as we enter the OpenNotes era at CU, we are trying hard to do that respectfully with reasonable accuracy and using "code"/doctor speak when needed ("functional condition" "supertentorial" "accidental or o/w" "growth/lesion" "mitotic concerns"). There are probably other *less* discoverable areas in the record than the PN. Finally, careful transparency/honesty around most Ddx can help patients prepare for both good and bad results.

:Time and money are in inverse relationship. If we were willing to accept less money we would get more time.

:TO comment on the medical legal CYA for patients to have a copy, it is proven to be honest with patients and explain what occurred creates less anger and the attorneys will get a copy anyway so it will go to the patients attorney anyway. not sure this is a sustainable argument.

:I feel strongly that saying exactly what we mean, rather than obfuscating or coding our notes is better for the patient. I mean, if you told the patient you think they have cancer, write that.

:We also recently launched an AI in Health cont ed course for Nurses and Doctors--fundamentals, in partnership with the American Hospital Association. I encourage ppl to take a look at it as you look to educate your professionals. <https://sponsored.aha.org/HFC-Microsoft-AI-in-Healthcare.html>

:Our thoughts, differential, and speculations are all valid, too. We *should* discuss with patients what our concerns are.

:I often talk about documentation burden and cognitive burden as

aspects of EHR burden. I like the thread in the conversation here (thanks Molly and Ross!) about not just the amount of cognitive burden but also its cadence. It is one thing to have too much information to process 10x a day and another thing to have small amounts of information thrown at you 150 times a day. The impact on cognition is different. Do we have language for this? If not, we need it.

:What about building a process where the patient updates their medication list that we can input to any EMR.

:That's what happens when you enter the payer world Marc!!!

:with all of the information we have access to – think in terms of the medical–legal environment – What information are we responsible to be aware of and what if there is information that we may have had access to but did not have time to review due to the financial need to optimize patient throughput? In addition to everything else we need tort reform.

:Great discussion–I wonder if we can draw an analogy between the belief that clinicians cannot think if AI composes the clinical note reminds me of how as a grad student I needed to learn how to calculate some statistical analysis by hand (pencil and paper) to help me understand the logic of the statistical test. Since that assignment, all of us moved onto using software to run our analyses. We still have to think to use software for statistics.

:You can't keep informaticists from chatting

:We need AI to go through the Chat.

:lol

:+1

:maybe ask in CAPS

:@ – questions earlier about the burdens from CPT/coding, and a concern that AMA is in conflict here?

:We ways to ensure that healthcare systems that employ providers don't fill any time we free up for thinking with increased demands for access regardless of complexity/need. How can this be achieved?

:How do we make sure that these patient centric technology based approaches don't worsen health inequities? How do we make sure AI doesn't perpetuate structural racism and other forms of discrimination?

:and how would you adjudicate conflicting data coming in from multiple sources?

:Patients often want me to remove what I think are valid and important diagnoses.

:+1 Laura

: 1) Health literacy 2) Digital literacy 3) Normalizing data via standards across platforms 4) Big data stratification with focus

:We started to identify many of the concerns raised today with the earliest transitions from paper–based to computer–based documentation, but we haven't made much progress. One of the issues I've spent some time on is changes to training clinicians on how to document properly in the EHR environment. We tend to teach how to use the technology to document what we can, but not the qualitative aspects of what we should. Thoughts on the need for training changes?

:We've seen with the pandemic how hard it is for many subsets of the population to get a vaccine appointment, never mind engage in technological collaboration on their notes.

:In school aged youth who do not have a medical home, most health services are delivered in schools. Must integrate beyond EHR's

: the malpractice bugaboo is often raised in discussions of documentation. Yet a number of prior studies (eg: <https://pubmed.ncbi.nlm.nih.gov/10718350/>) have shown that there is no correlation between bad care and malpractice suits or their outcome. The biggest factor that guards against malpractice is a good provider-patient relationship and effective, open communication.

:+1

:As all of this AI and innovation is exciting to contemplate the likelihood it will have unintended consequences on patient safety is high as is the likely resistance by many clinicians--then the haves and have nots and who can and cannot afford these innovations. Particularly the rural and small clinics--is it feasible to get this done due to sheer cost. I would like to hear the panel address the issues that are simply logistics and cost.

:@ - I think there is a huge role for medical education in writing notes - particularly in a new world of notes also being co-produced with patients - it is something I bring up as I work with and precept pediatric trainees at Stanford.

:On the topic of value based care - both to Mark and to Jesse - how do you think the move to value based care will affect documentation burden? Both via the changes to coding, and the requirement to have "more/better" data to support the payment

:Lifetime record should include all aspects of care delivery including schools beyond current "bricks and mortar". Semantic framework - @DoctorJesseMD

:And where are there opportunities to make that better

:@ - the training on "how to write a note" needs to start in medical school/undergrad medical training, and must also include "how to access clinical data effectively" so that people don't reproduce into notes

:Prior auth and much of the documentation burden that's been introduced over the past 30 years has, at it's heart, avoiding payment for care. Of course, that's never the way that it's typically framed but burdening providers so they won't provide meds, care, etc. is at the heart of the current system. That's the elephant in the room regardless of whether you frame it in terms of quality, value, etc.

14:13:53 From Amanda Moy (she/her) : If you not had a chance to fill-out the breakout survey, please do so at the following link: https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8

: @ - for the question about patient's requesting changes in Diagnosis - Amy Porter has a great paper on reconciling the problem list - and the idea of co-production of clinical identify <https://pubmed.ncbi.nlm.nih.gov/32346726/>

:+1000 Kenneth Mandl!

:@, I agree that a new approach to documentation has to also be built

into a rising generation. So much of the EHR training I've seen/done so far is a fire-hose of click-functionalities. So little on the purposes of documentation.

:+100 Ken. We need grammarly for health care notes.

:@

:Integration of EHRs into high fidelity simulation centers helps
:The EHR is the tool of the clinician's trade, yet we don't actively teach medical, nursing, and other health profession students on how to use it effectively. AND how to work with their EHR providers to make them better.

:Crazy!

:Amen @!

:@Jesse, interesting to hear about AMA working on a clinical knowledge graph. Is this the domain of institutions to lower the barrier to access? Would you be concerned if specific vendors start to build their own unique graph?

:+1 @

:It was awesome!!! Enjoyed participating!

:I often describe the difference between the education we do vs. what we need to do in documentation training as analogous to learning how to drive a car based on training at the car dealership vs. drivers-ed. One leads to knowledge on how to use the bells-and-whistles of a particular vehicle, the other teaches you how to drive safely and effectively regardless the particular model.

:@Ross, can you say a little bit about your journey with google glass/ What lessons about new technology in health care?

:(need to write that up! ;)

:agree bill. I've started teaching our medical students how to write notes in an electronic world, professionalism in copy/paste, and how to integrate tech in to patient encouragers more effectively. need more of it!

:@ - certainly other businesses (like ours) have built clinical knowledge graphs.

:please share the Hackathon information. Thank you!

:Agree @. For some EHRs where residents are still typing notes, we need to help them capture what is important for the patient trajectory.

:www.nursehack4health.org May 14th-16th this year

:Yes, CMS allowing students to contribute to billable notes has dramatically increased engagement from students and providers as they share this duty.

:@. we also do nothing to incentivize experienced front line clinicians to work with their EHR vendors to improve usability and support for clinical workflow. Those who do lose time and often lose compensation with very little results to show for their efforts.

:A different question - does the panel feel we're all "on the same page" regarding the point/goal(s) of documentation, and if not, then how important is it and how do we clarify and prioritize the various "masters" we're trying to serve with our clinical documentation today?

:<https://www.thieme-connect.de/products/ejournals/html/10.1055/>

s-0041-1722872?society=65duLqtyrvr9khSy4DZp5Nzsdcx5CHEadcAGvsZe
:RE: training on how to write helpful notes. When we were training NLP on how to find insights in progress notes, the physician labelers of ground truth commented on how the process of reading and labeling notes taught them how they should be writing better notes.
:Regenstrief has developed an online Teaching EHR with de-identified data for 10,000 patients that a few medical schools and nursing schools and a pharmacy school are using to teach EHR use. An article describing it is in press in JAMIA Open.
:@ - serving on a CDI committee did the same thing for me.
:Can't wait for that, Bill!
:Da Vinci - FHIR project has a use case with Prior Auth - that could resolve documentation burden in this use case. Adoption by providers is slowing adoption.
:my son has a degree in Aviation and Flight Sciences and is a Delta Pilot, I have to say that the way they teach in Aviation is very different from how we traditionally do in medicine... Safety and team management is beaten into their heads from day one
:Amen @Don
:Our deidentified EHR domain in the simulation center has helped out considerably
:@Peter Embi - so true, it is not the how as much as also the why we do things that is important. But if we only focus on students with this education, change will take too long..... those clinicians in practice need to also be educated. There is a tremendous need in practice of many current clinicians (nurse, doctors, etc) to understand basic informatics concepts. Not just learn a particular EHR, but understand the underlying concepts.
:<https://www.ama-assn.org/press-center/press-releases/ama-regenstrief-institute-help-increase-ehr-training-med-schools>
:@ - thx for sharing. Would be helpful to hear from the AMA/Jesse on how to rethink the RUC. Perhaps we can figure out how to pay for critical thinking.
:In case anyone is interested in a tutorial for the Regenstrief Teaching EMR, see: <http://clinicallearning.how/tutorials/temr.html>.
:Should health literacy training start in primary schools?
:Many aspects of the Da Vinci Project are related to alleviating preauthorization burdens <https://www.hl7.org/about/davinci/>
:Well said @@Kressly
:completely agree @. we need space for clinicians to express their thoughts and reasoning. NLP should be able to pull from that without constraining clinician thought
:Sorry have missed these webinars to date (have a standing conflict unable to move) I am most interested in the content of notes in terms of the "A" capturing the assessment in a meaningful way to improve diagnosis and communication around diagnosis. (yes the narrative as was just mentioned) We have created a tool for Assessing the Assessment and we also have been piloting of a voice recognition drive tool to help clinicians convey clinical diagnostic uncertainty to patients to build situational awareness and safety needs for safer

follow-up

:Thank you Gordy. As a reminder to all - prior videos are available at <https://www.dbmi.columbia.edu/25by5-symposium/>

:Please share any questions you have for panelists here.

:Integrating Jeff and @'s perspectives via NLP in a more lenient regulatory environment with less or no dollars for documentation starts to feel like a desirable future!

:How about one big note that everyone can see? It could be one screen and segmented by provider.

: All of the panelists: How do we educate users in the changes and even the basics of use of the EMR. So much is not intuitive or "just try it" accessible.

Clinicians don't think in a structured form. Forcing them to enter structured data adds very significant cognitive load, time delay, and potential for error. Often a clinician will randomly pick from a list of structured data choices just to get on with the workflow. When that data gets reused: GIGO. Yes, structured data is valuable for secondary uses and a learning healthcare system. But letting the burden of translating clinical thinking into structured form fall on front line clinicians is ultimately counterproductive. We need better tools for the translation process to be automated.

:@ like a living google doc with comments/edit rights!

:@jeff wall Can you comment on the logistics of shared care planning when no one seems to even be able to get an accurate useful shared problem list to be actualized

:@ - exactly what we worked on. problem based approach where all clinicians contribute

:Or pull the computer up with the patient. Let them be right there with you when you write.

: Yes--each member of the health care team documenting what they do. But we don't have to have a single "note." That is an anachronism of the paper chart. How best to display the various info documented before, during, and after an encounter by everyone involved: clinicians, patients, family members, etc.

:@. Good point, we need to help our youngest generations learn how health and digital literacy can be effectively used as they mature.. Just like typing used to be taught in 10th grade in my "era" and moved to kindergarten in my kid's "era", we need to improve digital health literacy starting in elementary school. Kids easily learn the technical, we need to maximize that to align that to taking care of their health (under the appropriate parental supervision for minors as legally required).

:Or maybe figure out the "stenographer" scribe thing so the patient/clinician are face to face and a very intelligent combination of people and technology document

:@ yes, that would also help the patient aid the clinician in cleaning up and correcting inaccuracies in the record real-time during the visit.

:@ AMEN@!

:conversational speech is probably not enough! there is a great deal

that goes into documentation that isn't said out loud, found on exam, or thought by the clinician. The data from the conversation represents a modest portion of the data that goes into the note
:+100

:- I do much better when I listen to the patient in the exam room, just documenting the things I will forget (like which side) and finish my note when I have time to think about it. Specialists can do it differently – when I deal with 8 problems in one 30 minute visit, that doesn't work well with the patient in the middle.

:Billing has so deeply encroached on our clinical documentation – the fact that the problem list is ICD10 driven drives a lot of the problem list bloat. We need to keep problem based documentation at a higher level in the hierarchy and keep the left/right/acute/chronic/controlled/uncontrolled details out of the problem list.

:Dr. makes a critical point. Medicine in actual process is messy, nonlinear, often iterative...with circles getting tighter and more accurate.

: Throwing out an idea here: completely change the paradigm of documentation. If we configure it as "telling the patient's story", then create something like a Wiki, a continuous diary-like flow, NOT repeating anything/no copy-paste, insisting each contributor adds only at the top of their license. Do away with pulling in data (e.g., VS-- put them in a separate area, as now). Eliminate details of the exam except pertinent positives (describe a rash, a murmur...). Doctors focus on their thoughts/differential/analysis/recommendations. Nurses focus on bedside assessments (NOT all the flowsheet rows, but what do they see/know). Physical/speech/occ therapists--how is the patient walking, talking, adapting to stroke... You get my point.

:+1. Ideally, we'd be able to dictate or document what we wanted to remind ourselves about thinking, and these other tools would create "system of record" documentation and use video/audit to collect more data for secondary use.

:@ – agreed! There is a big difference between documenting what is VS. planning what will be (plan of care).

:Agree with @@! We need more STORIES in the record. The medical data already exists (it needs to be assimilated – hoping the computer can help us with that), but we don't have enough about the holistic person (e.g preferences, SDOH, health literacy) – the biggest determinant of engagement in the care plan and health outcomes.

:It has to be yes/and. We don't even document the exam that really reflects ALL of our findings that are so subtle as experienced clinicians the are sometimes in the background/and doesn't "rise" to the documentatin

:Of course, depends on changing the payment paradigm, too

If you not had a chance to fill-out the breakout survey, please do so at the following updated link: https://cumc.co1.qualtrics.com/jfe/form/SV_cGF9IQgS9axLsB8

:Marc 0 is dead right (says the sociologist) No one talks they way we one writes. We start 5 sentences and have interruptions.... to get to

the point. If you analyze transcripts, it appears everyone is scattered in thought. But that's what conversation is!

:+1 @Ross. Not to mention non-verbal communication (body language, facial expressions, eye glances, etc.)

:But if you look at the pilot model, the rest of the people on the back of the plane with their seat belts on, do not have a clue what that language means nor sure they

:The chat in this section is 🔥🔥🔥🔥🔥

:Ken - are we having bandwidth problems? Is that why people are hanging? Should people who are not presenting turn off their cameras?

:Nursing moved to very structured documentation and the common complaint is it does not tell the story of the patient.

:+1 @!

:Would like Nuance to create the patient's story (STORY, not just a transcribed conversation) and the doc to concentrate on creating the thoughtful Assessment and Plan.

:yes, non verbal is super important in dr pt discussions. how/where you point; hand movements to indicate ambiguity...etc etc etc

: so true

:Each patient is different with different medical problems, different social determinants of health, what works for one patient will not work for another due to many issues including but not limited to patient resources. What is not said during a conversation is sometimes more important than what is said. That can not be captured in any way by voice dictation. Why was something not mentioned or discussed?

:yes @ - a great anecdote from our work using video in the exam room. we were reviewing encounters with a physician and after about 5 min they said, wait, wait, play that back. They got a horrified look on their face and said "Oh my!! I didn't realize i did that!" they tended to close the encounter by standing up near the patient who was often still sitting and being a rather, tall, large individual they towered over and could easily be perceived as threatening by the patient. The value of body language!

:@1+ and the same has happened with physician documentation as CPT requirements have become more complicated and clinical productivity ratings and salaries are RVU dependent.

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:The newer generation of voice recognition is a game changer. (try Dragon Anywhere app in your smart phone if not already using) The speed and accuracy has crossed a threshold to qualitatively transform the use of speech for writing notes quickly and easily. We need to grapple with what that transformation means/portends/requires. Capturing/transcribing the conversation is less the way to go with this new power than working dictation into the workflow (both structured and unstructured)

:@, and the care plan is garbage!

:And how much is all this AI and dictation going to cost?

:In my book on pt safety, we have a case of a teen answering a

question with a lot of handwaving. The doc missed it because he was typing into his computer. The hand movement seriously negated what the teen said.

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:And all of our assumptions about privacy and sharing are totally different when it comes to teens. It's medical, legal, family, etc etc

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: 👏 👏
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:+ – not only integrated but paid for.

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: – that is an op-ed waiting to happen!

:Terrific session, everyone!

:+1

:Thanks all!

:using dragon and built in tools like smart phrases allow you to enter std text with variables and structured data. this is in use a lot in the field

:Another excellent session!!

:Thanks for including me in the conversation!

:That was a fantastic session. We are all so lucky to have your contributions to this effort!

:Thanks all!

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:What does 'self imposed' mean in the breakouts

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:Thanks!

:Thanks all!

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