: Please feel free to tweet. Use #25x5 as the hashtag.
: Good day, glad to be hear and also support tweeting
: More twitter... NLM = @NLM_NIH, Vanderbilt = @vumcdbmi; Columbia @ColumbiaDBMI; AMIA = @AMIAinformatics
: I presume this entire conversation, given the context Kevin shared, is meant to focus on US-based documentation recommendations?
: Hi Craig, Sorry if I missed it, but is this being recorded?
: Yes, the focus is US-based
: Yes - focused on US Clinicians, given several problems related to doc burden are unique to US clinicians/US healthsystem
: Hi Julie, yes it is, and will be posted to the 25x5 website
: https://www.dbmi.columbia.edu/25x5/
: Thanks much, Craig!
: Do the problems in the USCDI v2 include nursing problems or are they only medical problems?
: Andy, is there a new definition for "Progress Note"? This has been a sticking point for Open Notes.
: Great question Dick
: What about problem lists?
: I am a physican - I spend 56 minutes (I timed it knowing that this session was happening today) on the phone - on hold - being transferred to get authorization for a CT for a patient in acute pain yesterday. Why does nobody ever talk about this burden on physicians. This is a common occurrence when pre auth is needed for a CT or MRI. The insurance will pay $30 for the visit.. It makes care burdensome and I spend more money to keep the lights on than I get reimbursed for things like this.
: https://fixpriorauth.org/
: shouldn't the problem lists be part of the note
: +1 @
: No - problem lists are multi-specialty and persist over time and totally separate from progress notes.
: the diagnosis and the data within the problem lists are part of the note
: Problem lists may have different views based on who is looking at them. I really think they need to be 2 separate items.
: Agree that the problem list should persist but it should update from the note. Should not require double documentation
: Better EHR design would allow it to be more integrated into the documentation workflow
: Not double, separate. Sounds as though this needs to be a separate discussion.
: Agree,
: The eye doc does not need the dermatologist's problem list.
: The family doc needs both.
: - It depends on the audience for the note, which I know will be discussed at this symposium! My vote would be to leave things out of the note that can easily be seen elsewhere in the chart, and to adopt CMS 2021 E+M guidelines to reduce note boat, and to document on either MDM or time. Full problem lists sometimes have things you didn't

discuss in the visit.
: I think it is possible to achieve we are both saying. :)
: The problem list is relatively useless since problems are never
resolved making it difficult to slog through and determining what is
truly an active problem.
: Indeed, there has to be curation of the list or it is worthless.
: I think the problem list is essential. A lot of decision support is
driven from it. But it should be set up so that it is much easier to
curate
: @ — for me the problem list should have "signout" (active issues —
whether specialist or PCP), and chronic stable issue. Epic has option
to prioritize ("High, medium, low") but no one takes the time to do so
(and there is not clear who the "owner" should be)
: Is CMS looking at reducing documentation requirements for low dose
CT scanning for lung cancer screening and advanced imaging clinical
decision support? Both require providers to document many elements to
schedule an advanced imaging test.
: USCDI and IB
: The ambiguity around what is actually required from CMS is a root
cause of much of the problem. There is not one clear source of truth,
so there are many regulatory myths circulating among the compliance
professionals.
: Curating and ownership of the problem list is (I think) a cultural
issue and less a technical barrier
: Low dose CT and mammography for example are instances in which there
is essentially only one indication——that would make it really easy to
streamline
: Agree @. We have been discussing issues with problem lists for so
long. How do we curate and make it more useful?
: Agree completely with myths from compliance professionals.
: @. I think when you prioritize that is to each individual user and
does not carry over to other users. The "Chronic" pin does carry over.
: How about mandatory reimbursement to a provider of at least $100 for
time and effort each time prior auth is required? Even it prior auth
is denied drive industry through economics?
: Craig, how is Kevin notifying speakers about time?
: He must have done a direct message.
: Mmmmm — not sure we can expect the speakers to be watching the chat.
: I couldn't make that clock app work because multiple computers can't
share.
: Less is more in terms of documentation. The notes in the U.S. are
way too long as we have showed.
: I would love to engage in a conversation about problem lists, that
are focused around what we need for care, looking at it from the
perspective of creating, cureating and reviewing the list, and being
careful not to do it all within the box of a certain EHR vendor's
capabilities.
: We have a similar problem with medication lists.. How often is the
list full of medications that the patient is not taking any more?
: The big problem is fee—for—service, which drives both utilization

and need for documentation, prior auth, etc. Capitated payment would leave the appropriateness decisions at the level of the healthcare delivery system.
: Compliance increases as volume of documentation deceases
: England has a national standard for problem lists. I would love to be part of that discussion.
: I agree with you , but CMS requires additional documentation of counseling and patient understanding prior to ordering or the patient can't be scheduled for low dose CT scan. Providers also order low dose CT scan for non lung cancer screening.
: @ — agree, especially if you start with clinical competency and not use required documentation to teach new clinical skills
: @. Yes, I think every organization interprets how problem lists are used and who can or cannot contribute to them differently. Perhaps benefit from standardization?
: I was once almost fired for pointing out that professional auditors only agree 25% of the time on whether a billed chart is compliant.
: Capitation has it's own set of problems. I do not believe it is better than Fee for Service. I participate in both fee for service and capitated plans.
: @ that is what we are finding as you have more focus on delivery vs on documentation.
: Is there an effort to align documentation requirements across settings. For example, nursing homes and home health have very different types of documentation requirements based on differences in assessments and reporting requirements. Different documentation requirements makes it difficult to follow patients across these settings consistently, which has impacts on quality and safety.
: problem lists, please reach out. I've worked at a couple of startups that are actively experimenting with this for homegrown EHRs, so we have a little more flexibility than the commercial shops
: do we think USCDI v2 is part of the problem or part of the solution. I look at adding Date of onset of problems has burdensome for many patients, as an example. Help us understand this!
: I think it is easier to maintain Med Lists than Problem Lists...
: Imagine how much money in healthcare could be saved if we could eliminate the medical coding and clinical documentation improvement departments that are necessary because of the complex documentation requirements. Satisfaction with the EHR would certainly improve if there were less CDI queries.
: I would disagree — when a patient comes in and I review the medication list they are often not able to confirm they are taking the med.. "I don't know I take a water pill"...
: @ — agree med lists are an absolute mess. Especially as an urgent care doc, the auto-pulled in stuff is very out of date and inaccurate
: I agree that we need to be very cautious about adding content to the USCDI process — that's why we made it a very open & transparent process. Problem list is a great example of content that is used variably by different clinicians — so "having the capability" is different than requiring it or how it is subsequently presented to

another clinician or the patient
: I guess depends on the lens. As a PCP maybe I have pruned the med lists over time. I find it easier to DC. The ones that are borderline are those PRNs that they take every once in a while.
: Excellent ...thank you all so far !
: Exactly! We have found the same results with our team based Primary Care Redesign program at U. of CO across multiple domains. Give these tasks to the staff and it will happen. Providers can focus on patient's individual and complex needs
: Is there a way to save the chat? It seems blocked for me.
: the best way to view the Q&A is through speaker view
: @ do you think the form of clinically relevant documentation will impact burden? If so how might CMS think through that aspect (forms versus structured data, versus text)
: Problem lists are entered from several disciplines. this gets confusing too!
: We seem to be spending a lot of time on reducing burden, but I have to ask, wouldn't it be better to spend time on eliminating burden? When you consider that clinical information is now digital and no longer on paper, we have not changed our administrative paradigm to take advantage of that transformation. We could eliminate turning clinicians into clerks, creating clinically unnecessary documentation, adding to note bloat, or spending time on hold if we reimagined our processes for a digital paradigm.What are the barriers to simply eliminating documentation requirements for billing or quality and pulling the data administrators need from the record?
: What about the burden of requirements for physicians to sign "reams and reams of PT, OT, Speech therapy forms". (I happened to just receive an email from a physician not involved in this conference asking this question.)
: +1.
: Documentation requirements. Different documentation requirements, specifically different code sets for billing and interoperability, makes accelerating health information exchange challenging
: Patient engagement in problem list reconciliation needed as patients move across encounters and care settings like advanced hospital care in the home
: struggles on which problem to select and who owns ensuring it's accurate
: The first improvement would be to link each problem in a problem list to the provider who added that problem to the list who is managing the problem.
: Exactly !! Still is an issue today !! No one maintains it or updates it and therefore becomes a cumbersome tool
: Problem lists that are not accurate hinder nursing care delivery., but so do notes/ I can't say how many times my doc notes are not accurate and I need to remind them to change their notes. I understand they are busy, but it really hurts care that is delivered overnight when there is not a physician readily available.
: Very much agree that Electronic Clinical Quality Measures and the

lifecycle of those measures is a real problem and often does not reinforce quality. Yet, the US clearly has quality and cost issues with many worldwide measures of evaluating quality/cost of care. So, my question is, how do we address accountability as an industry on cost, safety and quality? Is it a measures develop and execution issue?

: @ agree. Though I would offer that there is still paper everywhere. We spend way too much time writing information on paper and transcribing it back and forth between different places.

: By linking the problem to the person who is managing it, we then make somebody accountable for 'curating' that problem.

: Also agree that we need to redesign how we chart based on what is capable in an digital world

: IF we eliminate requirements, then we don't need to align them

: As we change some of the burden around required content (and we'll have to start developing some new tools to handle patient-generated health data), we also need to make it easier to record our clinical thinking. We like to talk with our colleagues to coordinate care — how about talking with the EHR?

: There needs to be more provenance in the record — especially when being shared across care settings.

: Aligning documentation requirements key for safe care transitions, e.g. the PACIO project

: http://pacioproject.org/

: does CMS have an actual count of the number of quality measures that must be documented and reported? just wondering so we can get a baseline

: http://pacioproject.org

: +1 michael brody

: , long time no talk :-)

: There is also the issue of the need of marking the problem list, med list, allergies as reviewed for meaningful use. Is this really necessary? If we are adding problems, meds etc. Shouldn't that indicate that we reviewed those lists?

: @ — yes these certification signatures are a huge zero-value problem, likely only create barriers to timely care. Brings up larger question that much of provider documentation is designed to prevent fraud (a real problem but much less expensive than our massive regulatory infrastructure) and cost shifting.

: Can we also align behavioral health and hospital standards? The fact that a psych unit in a hospital has very burdensome requirements that go far beyond the burden in the rest of the hospital is a long-standing issue and behavioral health stakeholders clearly want duplicate documentation and formal interdisciplinary treatment planning eliminated.

: Has anyone analyzed the contents of international notes referred to in Kevin's earlier slide? Is it a minimum data set?

: Why not simply learn from the efforts of others?

: Physicians have been involuntarily conscripted into the enforcement arm of payers to prevent fraud by other providers. Is this appropriate

use of physician resources? Are MDs the proper people to police PTs, OTs, etc/
: +1 for repatriation of innovation lok
: lol
: We counted the number of quality metrics too--didn't come up with quite as many as Brent, but it is far too many. In Massachusetts we established something called the Mass Hospital Quality Partnership which has been very successful. It standardized the main quality metrics across the state across payers and this dramatically reduced the burden (but it is still too big). When I was CQO at BWH we were sending metrics to ~35 organizations. Some federal coordination here would be really helpful.
: I am wondering how many people in this conversation are actually clinicians that experience the burden
: +1
: @ I'm an internist. I recognize several physicians on the thread
: Especially metrics that are mostly similar with subtle denominator or numerator differences
: It is analogous to the movement to remove strings from international aid, and just give poor people money. Much better outcomes at lower costs. The financial and opportunity costs and burnout costs of the compliance regime is way more expensive than avoided fraud. We should have smarter ways to deal with fraud than we have currently.
: The new changes for outpatient are VERY confusing in terms of the medical complexity based documentation. For people who cover inpatient and outpatient, the difference in medical complexity documentation requirements are even more confusing.
: +1 a model to iterate from
: @ — that was one of the recommendations that we made in the Burden Report — hoping the next administration prioritizes that work too
: Brent James' design issue concept could be translated into a confusion of quality assurance and quality improvement. His left hand pathway is QA, the right hand pathway is QI.
: @. Totally agree. No changes to IP vs. the new 2021 update simplified changes means still remembering both systems.
: In terms of reducing the documentation burden, though, I think the key steps are 1) simplify the billing requirements (underway, the new ones are MUCH better), 2) set up better interfaces for clinicians to document, 3) leverage AI to help docs out, 4) consider one can be done with new modalities like recording conversations in some instances
: Nursing has had a bad documentation burden going back to paper charts.
: To be fair I think the nurses have had a high clerical burden at baseline though
: absolutely. need more collaborative, dynamic documentation
: 100% agree, we actually are contracted by the union to decrease nursing documentation
: +1-- more research on nursing documentation burden
: Would agree, think nursing has not been as vocal regarding this subject, but I hear it every day.

: https://www.healthit.gov/topic/usability-and-provider-burden/strategy-reducing-burden-relating-use-health-it-and-ehrs
: Need more BMDI, Verbal transcription into flowsheets and use of AI for all clinicians
: Nurses are getting killed with Covid , the burden has to stop now! Many good nurses are leaving the bedside in droves!
: nursing document move in the EHR than any other discipline. Ask to capture data for others, information that has nothing to do with nursing practice... such as tracking patient belongings
: the burden of documentation is no just on physicians, the burden on nursing has been extensive since the 90's. it is not just an EHR issue >> actually the EHR just made it visible. (on paper, nursing completed much of the 'documentation' that was endorsed/attested to by the provider through a simple signature (much of which was suddenly deemed inappropriate in an electronic world)
: Surprising Sharon — all of my experiences have supporting reducing the clinical documentation for all clinicians, and the impact on the care team as a whole. Eager to Hear if you considered alternatives to leverage forms of team documentation to compliment and reduce the burden for all
: ty Andy
: +1 — we also need mechanisms for nurses to voice their concerns re documentation
: Yes cringe at a hard stop...
: give 4 million nurses an hour back and watch care be transformed
: Amen!
: until the inpatient and outpatient documentation requirements are harmonized, there will continue to be confusion from providers who work in both venues. Moreover they will not change their "learned" habits until they are harmonized. Easier to just continue what you are doing than try to figure it all out by venue. Not to mention re-learning how to document clinically and "billingly" relevant notes ...
: This is such an important discussion for the future of nursing documentation.
: +1 !
: +2 !
: Alignment of incentives is the hardest thing to accomplish
: @ and making the electronic systems support that too
: We are on "disaster documentation" standards for nurses...it's more than adequate. Why can't the standard all the time be "disaster" level documentation, and proceed to reduce documentation burden further from that level??
: There should be some consideration about the effect of new data forms (i.e. longitudinal sensor data to recognize change in condition on LTPAC) that are being integrated into the EHR in some settings. With novel technologies that are capable of collecting and reporting data about people 24/7 there becomes a great burden on clinicians to interpret and react to these new data forms in a timely, effective way. How does big data impact burden?
: +3

: Agree that "disaster documentation" levels might be a good starting point.
: And as a data base, there needs to be clean data. Do no contribute to the dirty data in the EHR.
: Surge documentation really helped us operationalize reduction during Covid times
: The main point seems to be that we need to figure out what data adds value and getting rid of everything that does not.
: this is a data insights problems............and EHRs are not designed to address insights
: +1 — we need to leverage active and passive PGHD from sensors, wearables, phys. monitors, etc.
: In my experience, a lot of the willingness to cut nursing documentation from the record rests on the partnership of CNOs and their regulatory partners at a given facility. It is scary for some to remove items that have been in the record for a long time. They may not be tied to a reg (or maybe they ARE tied to a safety event from 15 years ago)...but you have a have a pretty brave crew to be willing to sign off on pulling out large chunks of the nursing documentation record. Even if they are pretty sure those chunks provide no value and are never reviewed again.
: +1
: +1
: @ — AGREE — similar to the freeing up of virtual care in the pandemic. COVID is exposing a host of absurdities that if eliminated will be transformative. Thanks to 25x5 for taking the global view beyond providers.
: COVID has allowed us to think about what can be cut back, we need to be careful not to just add back..
: Agree around the surge/disaster reductions... all came due to the CMS waiver which speaks to me that we need those in that space to understand the impact their requirements are having to people
: @ 100% agree
: +1
: When you read the CMS document for this COVID emergency, nurses were excused from Care Plans. Is that really where the burden is on a daily basis?
: 2+
: @ — great point. Need to work on ridding the culture of 'if it wasn't documented, wasn't done'
: Practice and Policy Reset Post COVID, Health Affairs article. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00612
: @ yes great point
: If it was documented , it may not have been done!
: +1 (esp in quality and legal departments)
: Documentation does not drive practice either
: Is there any representatives from Compliance on this call?
: +1 (esp, things like "bathroom offered q 2hrs" !! none value add to care
: A lot of our nursing documentation burden comes from one-off

"corrective actions" either required by Joint Commission or others after an adverse outcome, with absolutely no evidence that "corrective action" would have made any difference if it had been in place in preventing the event.
: "If it can be templated, it probably shouldn't be documented." Low value note bloat relates to smart phrases and templates.
: Not that I disagree with decreasing data documentation burden (because I suffer the pain also), but it will impact data science discovery opportunities
: +1 ...so much!
: ...and let's keep in mind that burdensome documentation to prove that you did something means you don't have time to do it! Talk about unintended consequences!!
: It is important that we generate consensus on what constitutes crisis documentation standard for across all care settings. Also, agree this is a place to start with in terms of what can be eliminated.
: Agree! As much as we try to reduce unnecessary documentation for nursing, we get requests from nurses to add documentation fields to serve as reminders or "ticklers" to complete tasks and assessments
: When we talked about releasing nursing notes as part of our new info-releasing initiatives I said, "That's great! 5,000 versions of, "Pt to CT via stretcher..." for the patient to review! :)
: @ bet that one has to do with some quality measure related to an event
: changes in 'if it was not documented it was not done'   requires changes to the 'medical legal' landscape.
: there is great conversation in this chat, but I am having a hard time listening to the presenters and reading the chat.... will the chat be saved and sent out afterward so we can review it?
: @ for sure!
: @ …. LOL... that made me laugh... the 5000 versions of Pt to CT...
: +1 @
: Interface patient documented information into the EMR   not only during the OP environment but into the IP enviornment
: @. What are the reasons Clinical Notes went from 8 to 5 from USCDI V1 to USCDI V2?
: Yes chat will be saved!
: might have been asked already. is mtg being recorded and sent out and or decks to be sent?
: @ – based on community feedback & moving lab/rad notes to a different category
: Sad to say I remember this trifold shhet
: trifold is used for downtime documentation ofent
: Would be great if those quality measures and Joint Commission requirements would have to have evidence that they make a difference before we would be required to meet them. So many are just created in order to have a requirement, not because they are evidence based, but then detract from what is truly important for patient care.
: Yes we are recording and will make available

: "If it wasn't documented, it wasn't done" is a toxic victim to safe
care. Consider instead "The Map is not the Territory." A map (a note)
attempting a 1:1 to reality (care delivered) is unmanageable. https://
www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00338-X/
fulltext
: The GROSS efforts is so important. It made sense when implemented
but need to avoid "this is how we have always done it" mentality.
: +1 !! Yes; evidence-based documentation
: When EHRs were designed the only option for "reporting" etc. was
discrete fields , so we built forms, tables, etc.----------that is no
longer the case -- with natural language processing "unstructured
data" (aka notes with meaning and value) can be queried for the
secondary needs of teams such as quality and regulatory.
: Yes" but no info as to what PRN it was or why.
: We had a 26-day downtime that started last October. The trifold
emerged from someone's locker *very* quickly.
: … and in most instances, when time is returned to nurses, that time
is now taken back to do some other administrative, non-patient value-
added activity, which may or may not be new documentation
: Sherri, would value your perspectives on the relationship between
cognitive burden and situational awareness. Are you deploying any
strategies to lift up situational awareness for care team partners and
the patient
: Frequently said doctors don't read nursing documentation!
: I never looked at the graphs — I always read the narrative.
: For step by step guidance on Getting Rid of Stupid Stuff, please see
this STEPS FORWARD module on the same, written by Melinda Ashton. All
of these modules are completely open access; all free. https://
edhub.ama-assn.org/steps-forward/module/2757858
: +1 , ohh what you learned during these 26 days
: As a psychiatrist, we used to read our nursing notes ALL the time in
the paper world because they actually gave a 1 paragraph quick picture
of how the patient was actually doing.
: What needs to be documented will vary based upon the clinical focus
(specialty) of the person doing the documentation.
: @ many lessons learned from your experience, thanks for sharing
: the docs were the ones at my large trauma center that insisted that
nursing bring back the end of shift summary note in the EHR == only
thing they read.

despite the thousands of entries in flowsheets, forms, care plans,
etc.
: HAs anyone here ever heard of linen change as a requirement? Isn
: In Canada we have the same issue — nurses don't want to let go of
some of the things they document.
: No, we are not documenting linen change.
: Let's not forget all we have learned because of COVID!
: I usually read nurse notes, frequently that was how I figured out
what happened over night, esp. if I was making rounds late and missed
shift change when I could ask the night nurses directly

: @, definitely a big no lol
: Linen change used to be required daily, now it is when deemed 'dirty' to decrease cost.
: We are not documenting linen changes but are documenting patient valuables
: #COVIDLife?
: care plans??
: We are trying to no longer expect nurses to document standard care that is expected for all patients.
: @ we also removed patient valuables
: document extensions of self versus pt valuables
: Now we read the nursing shift hand-off report and don't bother with the nursing chart notes.
: Why are care plans needed for every patient especially with short stays. Look at the reality of requirement of care plans for patients in hospitals less than 48 hours
: @ … same with belongings and valuables. struggles. I think HCA did something to remove this from nursing, if I remember correctly.
: @ and the documenting patient valuables have contribution nothing to nursing practice or outcome.. but the risk manager wants it to remain. sigh
: @ and @ we have a very big list for belongings
: Releasing nursing notes reminds of other uses to for nurse documentation such as for evidence-based practice analytics and to predict and deploy nursing resources
: @ >>> the dentures and hearing aids! in some orgs we had to document their safety in transfer from floor to floor !
: Patient perspective - I have patients walk into my office each day with their MD degree they earned from the internet with huge amounts of mis-information. Any patient generated information in the EHR has to be properly attributed to help those reviewing the information can process it with the proper filters.
: Thanks so much for this discussion/platform around DEI. So needed
: Ad education on that last bullet
: @ - YES.
: whatever the content, provenance is always key; PGD is fine, even if it's full of "huge amounts of mis-information." but at least I'd know the source
: I agree 100% I do not have a problem with PGD it is a problem with lack of attribution - and often that attribution can get lost when sharing information from one EHR system to another.
: Transgender is essential - or at least some way to know what organs exist in which patient.
: +1 - that misinformation can provide a lot of information, esp. related to DEI
: Pts who come with internet-driven knowledge, even if wrong, are actively seeking information, which is GOOD. So I congratulate them for that, reinforce it, and then say, "There is a lot of bad info out there, and I can't possibly have the time to look at every website." And I refer them to sites that I trust and ask them to look there for

good information. Then we can talk.
: many of our front line staff are uncomfortable recording race, and even more uncomfortable asking the patient to clarify it.
:
: sometimes patients are also uncomfortable being asked those things, esp. now
: https://www.annfammed.org/content/annalsfm/16/5/467.full.pdf
: Definitely need to build pt characteristics into electronic systems. In the meantime, how can we use indirect assessment of SDOH/place (e.g., census, pop data) if improvement is the end goal
: From a family member perspective, valuables aren't a minor thing. This is especially true for things like dentures, eyeglasses, and hearing aids. THey can't just be sent home with family but when they get lost during transfers, the patient is hugely disadvantaged in terms of their care (if they can't hear/see/eat) and the costs of replacement and timeliness of replacement can be prohibitive.
: @ — I am not saying it is not good.   It spurs conversation but I am saying that when it is documented — the next person reading the documentation needs to know the attribution of the data.
: Thanks Kenrick! I was not expecting DEI and much appreciated. There's much to be done in these sectors also. And then the impact it has to the healthcare workers on documentation to ensure equity for patients by not identifying the immigration status/undocumented individual. ReAL is so important to achieve much of these goals and yet uncomfortable bc of the unintended consequences.
: When I visit a doctor the visit is recorded
: At least for my primary care
: linen change likely came from a patient complaint that their linen was not changed. so it gets added to prove it was done. I'm not in agreement in it just sharing how it likely got there
: I would challenge the assumption that poor outcomes would e due to "disaster documentation" in any post assessment

the system is in crisis .... lets make sure to take a systems view of this event
: There are times where paper is easier — and then scan the paper.
: +1 ——— it's a use interface issue as much as a doc issue

: considering dictating notes for nursing.
: There is an empirical way to do this too — actually measure how often different information is viewed, which can be done w/ EHR audit data.
: a really smart nursing leader told me once that if a patient says we lost their dentures, glasses, etc. we will end up replacing their dentures, glasses, etc. That the patient belongings list doesn't actually protect you from anything — and as a leader, she removed it from the record. That always stuck with me.
: Do any organizations use predominantly touchscreens? Are those better than just keyboard/mouse combination?
: +1 Brent

: @ and @ – agree, looking forward to seeing voice as the norm.
: @ I would argue that paper often seems easier because the design of our digital systems has not lived up to what we need it to be
: I have a touchscreen computer and I find the keyboard better.
: +1 we did a similar study >> and leaders were still unwilling to remove fields that were vary rarely used.........it's a cultural issue as much as a technology one
: Also agree that if the interface were better then the electronic chart would be better.
: I'm hopeful predictive analytics can continue to grow as a way to help reduce cognitive burden
: @ so true
: We can intentionally design in Team based real time situation awareness for patient safety, complication surveillance, care coordination and shared outcome evaluation
: How are we addressing SDOH in the record?
: Agree . Looking forward to sharing the work we have done in that area! Need less walls between disciplines in the EHR
: @ and @ short status of patient care/status using handheld device.
: +1
: We have been looking at the initial clinical use of this data as we talk about documentation (primary purpose), But as data and real world evidence use increases, how do we ensure we create "meaningful" documentation for multiple possible uses?
: Way to go Kendrick
: Will we be bringing the top three EMR Corp's into these Roundtable discussions ?
: +1 Kenrick!
: So much great conversation in the chat and I'm having a hard time keeping up. Will it be possible to get the chat transcription afterwards?
: +1 Kenrick Cato on SDOH!!!!!!
: What does that mean to you Kenrick? Would love an example of what you mean
: YES Kenrick!
: I think the challenges with multiple assessments such as SDOH, ACEs, Development etc and there is a significant overlap in the different tools and there is a challenge as to which visits and who completes all the assessments.
: I have seen system generated notes generated by EHR systems that are internally contradictory – one thing in the generated note and one in the narrative from the EHR user.   has anybody else ever run into that?
: Would be helpful for all of us to get CHAT transcription between sessions
: SDOH is yet another abstraction which can be a playground for bias!
: SDOH and Populomics data. both
: SDOH must be more than just collecting another data point.
: @ I see Cerner physicians on the participant list
: @ – all the time. The problem (one of them at least) is that we

have the write the same information in so many diff places. So there
are naturally contradictions because we cant Keep it ALL updated
: +1 @
: Absolutely need to drive to a LPOC
: I have also seen contradictory notes — esp doctors and nurses saying
different things — or one doctor contradicting another.
: patient self-report should be part of the solution. we should not
shift doc burden to patients, though. right size the capture and
frequency of patient goals and characteristics too.
:...thank you :)
: That's why it's a plan!! LPOC is essential!
: Is this Paul Fu from YNHH ?
: @, I'm a physician at Epic. Emily Barey is a nurse at Epic, and we
have a couple of User Design experts (usability experts) from Epic on
the call too.
: 1) there aren't widely accepted coding standards yet; and 2) until
health care providers can deal with problems by referring to social
care providers the way we refer to specialists, with bidirectional
flow of information, then SDOH data show problems that just frustrate
clinicians.
: All of the above
: I would vote different for MDs vs others.
: @ nope! from City of Hope, previously LA County
: +1 Ruth!
: I have heard it described as Social *Drivers* of Health rather than
determinants
: @ yes we will be saving the chat
: Ok we have issues with the Medication LIst, The problem list,
issues with attribution, contradictory statements in the medical
recode..   Can we consider the EHR a 'source of truth' for medical
decision making?
: I would offer that the regulatory and reimbursement requirements
could be better met with BETTER design and usability, without adding
so much (if at all) to burden
: But also agree should rethink requirements :)
: the larger question is not electronic documentation burden but "what
constitutes quality clinical documentation. In all of the burden
discussions related to the EHR we don't address that question that
history of evaluating quality of documentation and instruments to do
so are largely lacking. So, we need to ask what is the fundamentals of
quality documentation that ties to essential documentation.
: self-imposed also included inaccurate interpretation of reg/
reimbursement requirements (one auditor, says one thing, and suddenly
its a documentation requirement in the record)
: We need to make sure that SDOH don't get used to propagate even
greater health disparities. There is unfortunately ample evidence
that seemingly well intentioned algorithms/initiatives have made
disparities worse.
: A lot of documentation requirements are due to "perceived"
regulatory requirements (may or may not be accurate) so I think what

we impose on ourselves is greater burden
: @ great point
: I would recommend we consider the role of registries and how we can leverage interoperable data exchange with clinical documentation and how this might be an approach to reduce the burden
: @ - completely agree! There is value to documentation that has been lost in all of this
: An interesting topic for discussion is how much the clinician/staff documentation burden can be diminished and how much the comprehensiveness and quality of data can be improved if we can come up with effective ways for patients to self-document things like demographics, social determinants, symptoms, family history, etc.
: +1
: our attention should be on what determines quality of documentation you don't have that radial option :)
: we need to make sure the EHR is a tool we can use reliably to make medical decisions. that is the most important thing we can do.
: @ - agree 100%. I guarantee you 14 point ROS will continue to be documented, despite regulatory changes
: +1
: Sounds like a fund-raiser
: Totally agree with Patti. Sometimes, even the regulatory experts at a given hospital aren't necessarily correct in their interpretation of regs. At smaller hospitals, the job of interpreting regulations often falls to someone who has 5 other jobs....
: In oncology, the biggest challenge is documenting extractable disease status/progression of disease/treatment response. Have to make it easier to document that critically important stuff.
: Completely agree @
: none of the above. We should stop treating the EHR as the electronic version of the paper chart --> utilize the ability to manage data so clinicians only add their unique value.
: @ >> in the 90's pre-EHR we were having patients contribute the their record (admission histories, problem lists, goals, priorities)-- and we took most all of that away with EHRs ....crazy.
: Tough question as all have some impact
: I picked regulatory this time bc i think it's more easily moved
: Is usability so low on this poll (#2) because it seems so hard to do ? Hard to get EHR vendors to make a change?
: if the burden of regulation/billing wasn't there, we wouldn't add to the burden by our self-imposed work. Remove the root cause!!
: there is not a clear division between quality measures vs accreditation. for example, stroke center of excellence data requirements are quality but we regard this certification as necessary so, it on par with regulatory for us.
: Hard to hit the target when there are 6 divergent targets
: I chose that we should focus on the self-regulated ones, because I agree with the comments on *perceived* external requirements of regulation and reimbursement, and how they translate into self-imposed criteria that are even more burdensome.

: +1
: @ agree, we need to check to be sure if it is required.
: Doesn't Self imposed come from Education level
: Documentation request adding to the burden is often to support survey not necessarily to meet regulatory requirement -- therefore self imposed
: When we use standards for interoperability (USCDI), I wonder how much of aligning those items will actually help with some of the other issues.....
: Agree with @ that we should look at different interfaces for documentation that can work with EHRs
: We need comprehensive education about documentation (doing less) during our medical school and restraining. We don't know how to use it.
: Nursing and Medical School
: Clear regulatory/accreditation requirements would help remove barriers self imposed along the way. Time for a clean RESET!
: I think if we understand what we "should" document from a regulatory/accreditation requirements will help to see the self imposed burden
: useful in the space of self-imposed criteria from someone else or some other entity
: When we teach documentation in school, we need to make sure we teach about ELECTRONIC documentation. The system and its usability (lack thereof) directly affects how we document
: Many burdens begin at the regulatory and payment policy level, but then exacerbated by hyper-interpretation at the institutional level.
: @—YES!
: Under advanced payment models regulatory and quality and reimbursement becomes a single massive intermingled problem.
: it would be interesting to parse out physician from nursing responses in those polls … I wonder how they might or might not differ...
: In other words, reimbursement + regulatory are interpreted into self-imposed burdens, perhaps in the name of quality measurement.
: and from a nursing perspective" If you didn't document it you did not do it philosophy
: The biggest problem with poor usability is all the workflow problems with excessive documentation. If you fix the other stuff first, then usability will be less of an issue and more easily fixed.
: we need to work with joint commision
: Poll3 none of them ---- legal drives most everything (fear based, defensive documentation)
: Don't forget the joint commission
: ONC doesn't require documentation. :)
: I struggle a little bit with the categories, there are self imposed elements that the users think are reimbursement/regulatory requirement. Like we need to pull all labs in because some thinks it improved billing. So I would call that self imposed but my users think is billing requirements.

: TJC is not on the list
: ACGME
: lack of education, misinterpretation of regulatory standards, over zealous risk managers, squeaky wheels, etc
: to let nursing decide does not work. Nursing has a huge cognitive burden to see so many fields, they feel responsible to document on each one.
: CMS, because the others follow
: +1 for legal as driver.
: specify.
: 1+
: Agree with that if we get CMS to help, our other payers will follow.
: +1 - that's the institutional/self-imposed, legal is also an issue
: We address some regulatory myths here with the goal of reducing unnecessary burden from over-interpretation of regulation by local institutions. https://www.ama-assn.org/amaone/debunking-regulatory-myths
: The "we" would be different depending on whether we are talking about what *I* can do, vs what we can do together
: There is no transparency or public reporting from TJC and lack of harmonization across TJC and CMS. CMS conditions of participation significant leverage
: Joint Commission definitely needs to be on the list!!!
: what can we eliminate that doesn't add value to practice. We had a list of items and they wanted to continue to collect everything on the list
: Generally, everything documented for reasons other than clinical (care, coordination, etc.) should be considered "stupid stuff". There are exceptions to every broad statement like that, but it is generally true.
: I agree with the Joint Commission....we have added documentation burden based on "interpretations" of TJC citations
: +1 Susie!!!
: I pick Epic to work with!
: agree
: Would responses differ depending on role too (MD, RN, PT, OT, etc.)
: would be good to standardize documentation aimed at regulatory/acced requirements and have the agencies vet what is actually required
: I think people feel hopeless about being able to make EHR vendors change
: +2 agree risk has had a large influence.
: That's cause you said what we document, not how
: Its not the vendors that are the issue -- its the organizational decisions about how to configure the EHRs!
: if Vendors would like us to move to "model" content then they need to absorb the responsibility.
: It would be interesting to see if the answers can be broken down based upon care setting (outpatient / inpatient)
: +1

: ++ !!
: I am not surprised the her is not the solution as most clinicians have given up on that front
: have to start with what do we need to document, not what we "think" we need to document
: I voted CMS bc TJC surveys for a number of CMS requirements.
: We can't learn best practices from other HCOs, unfortunately.
: +1
: With recent E&M changes, we are learning how hard it is when CMS changes but commercial payers DON'T
: The whole Meaningful use/MACRA requirements made matters worse as well.
: So we need better approach for how commercial payers can follow CMS (or vice versa!)
: For sure the rules are important, but we absolutely have to improve usability, and that is provider groups plus vendors
: CMS CMMI over 89 experiments with care and payment model innovation – which, if any have produced innovation in clinical documentation. Mary Greene, would value more from you on this
: +1
: +1 – great point!
: Joint Commission
: I am interested in interoperability and is key!
: Data flow is an issue
: same info is structured/modeled differently at times too
: Interoperability – how can we "fly" documentation across encounters, clinicians and settings
: @. Check out this debunking regulatory myth fact sheet that clarifies that private payers need to follow CMS guidelines for 2021 E/M coding changes. https://www.ama-assn.org/practice-management/cpt/are-commercial-health-plans-required-adopt-revisions-em-codes
: where we have multiple discreet fields that are identical
: @, that is why I voted for standards and interoperability as a key in the process.
: Interoperability isn't the real problem -- you can't trust what someone else has documented.
: yes exactly—duplication! (and I also voted for interop and EHRs)
: TJC!!!!!
: TJC follows a lot of CMA
: TJC versus CMS – is a problem
: CMS is a bigger burden for us
: CMS
: CMS >>>>>>> TJC
: Interoperability is actually creating a mess so far--as a doc you have to filter through a lot of things to figure out which few you want to add
: I think it's both
: Interoperability only addresses moving the data from one place to another >>> not what needs to be documented, how, and in a means that "sharing it" is worthwhile

: TJC follow CMS
: TJC is a vendor for CMS to go survey
: Its both TJC and CMS
: I am going to be the odd man out here but I think Epic does a
phenomenal job at creating an EHR that is very easy to use when you
use it in the way they intended it be used. What causes issues is when
organizations take it and change it to fit their needs. We are in a
new world with EHR documentation and paper documentation guidelines
are incorrectly applied to EHR. I think old school mindsets actually
hold us back.
: TJC has no impact on documentation in the outpatient environment.
: Yes Thank you Mary and Molly
: I suspect nurses will tell you TJC drives most of their inpatient
documentation worry... [But I could be wrong....]
: TJC has increased certifications that is increasing the demand for
specific requirements
: Have to take greater advantage of automation, pulling in that data
from instruments and monitors as well as trusting each other's
documentation as opposed to duplicating same.
: They are closely aligned. Much of what TJC requires relates to CMS
requirements. TJC is it's own separate animal that adds greater
burden and illogic.
: TJC has an impact on outpatient services that are connected to a
hospital
: Is there a CMS v TJC split by MD v RN? Does TJC impose more burden
on nursing documentation?
: @ – Sarah and I did once propose a consultation with vendors, to see
what would foster change/adoption of better design; I'm still
interested in what could be done for this.
: Agree...we should not document numbers that can be interfaced
: The problem is that theres so much anxiety around TJC citations that
organization do things that are very burdensome and there seem to be
more TJC citations or citations by mock TJC then there are by CMS
: I recently looked at TJC certification programs and surprised how
many metrics are still chart attracted, in their transition from e–
CQMS to dQMs
: We are so TJC focused . We can lose services if we don't comply
: part of the TJC problem is that as hospitals turn into HC systems,
TJC doesn't adequately differentiate between inpatient and ambulatory
care, leading to Kafkaesque absurdities
: Oops, chart abstracted (not attracted)
: if organizations lose money due to poor electronic documentation, it
will fall back to EHR vendors to ensure that the documentation is up
to snuff to fulfill the billing and regulatory requirements of
documentation, thus EHRs have become the defacto enforcement arm for
compliance. Digital documentation follows the needs.
: @ yes
: TJC surveys create a lot of knee jerk additions to documentation
burden. If there is a finding, a requirement is added quickly and it
piles up

: Thank you Don Detmer for your vision and we all value the historical work you have done to lay this foundation. Fun to walk recently through some of your early publications here!
: @, yes need time to digest. Great day today
: @ +1
: relationship between CMS and TJC https://www.jointcommission.org/-/media/tjc/idev-imports/topics-assets/facts-about-federal-deemed-status-and-state-recognition/federal_deemed_status_12_12_181pdf.pdf
: This has been a brilliant start – thank you!
: Word cloud would be interesting...
: please make the chat log available also – great session!! Many thanks!
: Are you sharing the 25X5 Zoom background? :)
: Agree automation is important; however, must also focus on issues such as lack of standardization for business processes; operational issues, technical issues, workforce implications; alignment and accuracy of vocabulary standards; data integrity, privacy; and, trust and representation.
: @ – Hello
: What is the hashtag for twitter?
: #25x5
: #25x5
: Every Joint Commission citation requires long term ongoing monitoring and data collection– even when it does not impact improved patient care/safety
: @!! Hello
: Thank you for organizing this high value session with wonderful panelists.
: Awesome presentations and discussions !
: @ I can share the background if you're interested!
: I'm so glad the cancel notice was in error! This is an exciting journey we are on!
: Great start – interesting dicussions
: Will next session include #digitalhealth innovations for data entry/capture/synthesis including NLP
: I especially appreciate the time management of the organizers. Well done! Thank you.
: Outstanding start. So important.
: @ Please! I like it
: Listen to the "tape"!
: Thank you for fantastic momentum and the cadence for our collaborative interactive work!
: Thank you for a wonderful kick off meeting.
: We're ready! Bring on the homework!
: CMS and TJC, every psych facility I know routinely gets cited for interdisplinary treatment plans. There is no agreement on what they need to include. They have no documented value. They are totally duplicative and should be eliminated. https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf

: Very nice start. Well organized!
: I agree Susan Hull about Innovation
: TY all — excellent start!!
: Thank you!
: Fantastic session and extremely well coordinated!!!
: Excited and feeling positive that there will be future improvements.
Thank you!!
: Great launch! CMSS delighted to be collaborator on this effort!
: Great start.. looking forward to the next sessions
: Great discussion——thanks everyone!
: Thanks All
: Thank you everyone!
: Good job!!
: Thank you!
: thank you
: ty!
: Excellent session!
Medical School
14:45:06 From Lane, Karen C. (ELS-HBE) : Clear regulatory/
accreditation requirements would help remove barriers self imposed
along the way. Time for a clean RESET!
14:45:10 From Holly Pollex : I think if we understand what we "should"
document from a regulatory/accreditation requirements will help to see
the self imposed burden
14:45:12 From Wm Dan Roberts : it's the difference between useable and
useful: useful in the space of self-imposed criteria from someone else
or some other entity
14:45:26 From Subha Airan-Javia : When we teach documentation in
school, we need to make sure we teach about ELECTRONIC documentation.
The system and its usability (lack thereof) directly affects how we
document
14:45:30 From christinesinsky : Many burdens begin at the regulatory
and payment policy level, but then exacerbated by hyper-interpretation
at the institutional level.
14:45:37 From Lane, Karen C. (ELS-HBE) : @hollypollex-YES!
14:45:40 From Peter Smith : Under advanced payment models regulatory
and quality and reimbursement becomes a single massive intermingled
problem.
14:45:46 From jeff wall : it would be interesting to parse out
physician from nursing responses in those polls … I wonder how they
might or might not differ...
14:45:53 From Randall Grout : In other words, reimbursement +
regulatory are interpreted into self-imposed burdens, perhaps in the
name of quality measurement.
14:45:58 From Carla Kovacs : and from a nursing perspective" If you
didn't document it you did not do it philosophy
14:46:02 From Laura Fochtmann : The biggest problem with poor
usability is all the workflow problems with excessive documentation.
If you fix the other stuff first, then usability will be less of an
issue and more easily fixed.

14:46:03 From Jeff Nielson : we need to work with joint commision
14:46:11 From Kelly Resco-Summers, DNP, RN [AWS] : Poll3 none of them
---- legal drives most everything (fear based, defensive
documentation)
14:46:11 From Peter Smith : Don't forget the joint commission
14:46:11 From A. Gettinger : ONC doesn't require documentation. :)
14:46:15 From Kevin O'Bryan : I struggle a little bit with the
categories, there are self imposed elements that the users think are
reimbursement/regulatory requirement. Like we need to pull all labs
in because some thinks it improved billing. So I would call that self
imposed but my users think is billing requirements.
14:46:17 From Paul Fu, Jr. : TJC is not on the list
14:46:19 From Jacqueline Shreibati : ACGME
14:46:20 From Patty Sengstack : Self imposed: lack of education,
misinterpretation of regulatory standards, over zealous risk managers,
squeaky wheels, etc
14:46:22 From Kat Collard : to let nursing decide does not work.
Nursing has a huge cognitive burden to see so many fields, they feel
responsible to document on each one.
14:46:28 From Richard Schreiber : Poll 3: CMS, because the others
follow
14:46:34 From Bonnie Adrian : +1 for legal as driver.
14:46:34 From Andrea Pitkus : need Other: specify.
14:46:45 From Cindy Russell : 1+ Patty Sengstack
14:46:53 From Adam Wright : Agree with Dick that if we get CMS to
help, our other payers will follow.
14:46:55 From Vicky Tiase : +1 Carla — that's the institutional/self-
imposed, legal is also an issue
14:46:56 From christinesinsky : We address some regulatory myths here
with the goal of reducing unnecessary burden from over-interpretation
of regulation by local institutions. https://www.ama-assn.org/amaone/
debunking-regulatory-myths
14:47:02 From Aimee Brecht-Doscher : The "we" would be different
depending on whether we are talking about what *I* can do, vs what we
can do together
14:47:02 From Susan Hull : There is no transparency or public
reporting from TJC and lack of harmonization across TJC and CMS. CMS
conditions of participation significant leverage
14:47:02 From Laura Fochtmann : Joint Commission definitely needs to
be on the list!!!
14:47:05 From Peggy White : We have done a survey of nurses in Canada
re: what can we eliminate that doesn't add value to practice. We had
a list of items and they wanted to continue to collect everything on
the list
14:47:09 From Dr. Larry Ozeran : Generally, everything documented for
reasons other than clinical (care, coordination, etc.) should be
considered "stupid stuff". There are exceptions to every broad
statement like that, but it is generally true.
14:47:15 From Holly Pollex : I agree with the Joint Commission....we
have added documentation burden based on "interpretations" of TJC

citations
14:47:23 From Paul Fu, Jr. : +1 Susie!!!
14:47:28 From Michele Berg : I pick Epic to work with!
14:47:28 From Kevin O'Bryan : agree with TJC
14:47:29 From Andrea Pitkus : Would responses differ depending on role too (MD, RN, PT, OT, etc.)
14:47:32 From Patricia Dykes : would be good to standardize documentation aimed at regulatory/acced requirements and have the agencies vet what is actually required
14:47:40 From Subha Airan-Javia : I think people feel hopeless about being able to make EHR vendors change
14:47:42 From Paula Wolski BWFH : +2 Patty agree risk has had a large influence.
14:47:45 From Howard Bregman : That's cause you said what we document, not how
14:47:49 From Kelly Resco-Summers, DNP, RN [AWS] : Its not the vendors that are the issue -- its the organizational decisions about how to configure the EHRs!
14:47:52 From Kat Collard : if Vendors would like us to move to "model" content then they need to absorb the responsibility.
14:47:56 From Michael Brody : It would be interesting to see if the answers can be broken down based upon care setting (outpatient / inpatient)
14:47:58 From Richard Schreiber : +1 Larry
14:48:00 From Vicky Tiase : ++ Kelly!!
14:48:03 From Marie Brown : I am not surprised the her is not the solution as most clinicians have given up on that front
14:48:03 From Carla Kovacs : have to start with what do we need to document, not what we "think" we need to document
14:48:05 From Bonnie Adrian : I voted CMS bc TJC surveys for a number of CMS requirements.
14:48:09 From Jacqueline Shreibati : We can't learn best practices from other HCOs, unfortunately.
14:48:18 From Paul Fu, Jr. : +1 Kelly
14:48:19 From Julia Adler-Milstein : With recent E&M changes, we are learning how hard it is when CMS changes but commercial payers DON'T
14:48:30 From Laura Fochtmann : The whole Meaningful use/MACRA requirements made matters worse as well.
14:48:47 From Julia Adler-Milstein : So we need better approach for how commercial payers can follow CMS (or vice versa!)
14:48:47 From David Bates : For sure the rules are important, but we absolutely have to improve usability, and that is provider groups plus vendors
14:48:48 From Susan Hull : CMS CMMI over 89 experiments with care and payment model innovation — which, if any have produced innovation in clinical documentation. Mary Greene, would value more from you on this
14:48:52 From Paul Fu, Jr. : +1 JAM
14:48:57 From Vicky Tiase : +1 Julia — great point!
14:48:59 From llaking : Joint Commission
14:49:10 From Sherri Hess Banner Health : I am interested in

interoperability and is key!
14:49:13 From Holly Pollex : Data flow is an issue
14:49:16 From Andrea Pitkus : same info is structured/modeled differently at times too
14:49:21 From Susan Hull : Interoperability — how can we "fly" documentation across encounters, clinicians and settings
14:49:32 From christinesinsky : @JuliaAdler-Milstein. Check out this debunking regulatory myth fact sheet that clarifies that private payers need to follow CMS guidelines for 2021 E/M coding changes. https://www.ama-assn.org/practice-management/cpt/are-commercial-health-plans-required-adopt-revisions-em-codes
14:49:38 From Holly Pollex : where we have multiple discreet fields that are identical
14:49:38 From Lynda Hoeksema : @ Mary Greene, that is why I voted for standards and interoperability as a key in the process.
14:49:38 From Laura Fochtmann : Interoperability isn't the real problem -- you can't trust what someone else has documented.
14:49:40 From Molly M : yes exactly—duplication! (and I also voted for interop and EHRs)
14:49:43 From Carla Kovacs : TJC!!!!!
14:49:45 From Susan McBride : TJC follows a lot of CMA
14:49:46 From Susan Hull : TJC versus CMS — is a problem
14:49:46 From Aimee Brecht-Doscher : CMS is a bigger burden for us
14:49:47 From Susan McBride : CMS
14:49:47 From Pete Stetson : CMS >>>>>>> TJC
14:49:49 From David Bates : Interoperability is actually creating a mess so far--as a doc you have to filter through a lot of things to figure out which few you want to add
14:49:49 From Steph Hoelscher : I think it's both
14:49:50 From Kelly Resco-Summers, DNP, RN [AWS] : Interoperability only addresses moving the data from one place to another >>> not what needs to be documented, how, and in a means that "sharing it" is worthwhile
14:49:50 From Cindy Russell : TJC follow CMS
14:49:52 From Sandy Cho (she/her/hers) : TJC is a vendor for CMS to go survey
14:49:53 From Patty Sengstack : Its both TJC and CMS
14:49:55 From Jami : I am going to be the odd man out here but I think Epic does a phenomenal job at creating an EHR that is very easy to use when you use it in the way they intended it be used. What causes issues is when organizations take it and change it to fit their needs. We are in a new world with EHR documentation and paper documentation guidelines are incorrectly applied to EHR. I think old school mindsets actually hold us back.
14:49:56 From Michael Brody : TJC has no impact on documentation in the outpatient environment.
14:50:01 From SC-Bob Stevens : Yes Thank you Mary and Molly
14:50:08 From Rebecca Freeman : I suspect nurses will tell you TJC drives most of their inpatient documentation worry... [But I could be wrong....]

14:50:13 From mburk : TJC has increased certifications that is increasing the demand for specific requirements
14:50:18 From Cathy Turner : Have to take greater advantage of automation, pulling in that data from instruments and monitors as well as trusting each other's documentation as opposed to duplicating same.
14:50:25 From Laura Fochtmann : They are closely aligned. Much of what TJC requires relates to CMS requirements. TJC is it's own separate animal that adds greater burden and illogic.
14:50:29 From Carla Kovacs : TJC has an impact on outpatient services that are connected to a hospital
14:50:34 From Helen Burstin : Is there a CMS v TJC split by MD v RN? Does TJC impose more burden on nursing documentation?
14:50:36 From Yalini Senathirajah : @Subha — Sarah and I did once propose a consultation with vendors, to see what would foster change/adoption of better design; I'm still interested in what could be done for this.
14:50:39 From Holly Pollex : Agree...we should not document numbers that can be interfaced
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14:50:49 From Michele Berg : We are so TJC focused . We can lose services if we don't comply
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14:51:01 From Susan Hull : Oops, chart abstracted (not attracted)
14:51:18 From jeff wall : if organizations lose money due to poor electronic documentation, it will fall back to EHR vendors to ensure that the documentation is up to snuff to fulfill the billing and regulatory requirements of documentation, thus EHRs have become the defacto enforcement arm for compliance. Digital documentation follows the needs.
14:51:39 From Paul Fu, Jr. : @Peter yes
14:51:41 From Carla Kovacs : TJC surveys create a lot of knee jerk additions to documentation burden. If there is a finding, a requirement is added quickly and it piles up
14:51:43 From Susan Hull : Thank you Don Detmer for your vision and we all value the historical work you have done to lay this foundation. Fun to walk recently through some of your early publications here!
14:51:57 From Steph Hoelscher : @Don, yes need time to digest. Great day today
14:52:07 From Paul Fu, Jr. : @jeff +1
14:52:18 From Sandy Cho (she/her/hers) : relationship between CMS and TJC

https://www.jointcommission.org/-/media/tjc/idev-imports/topics-assets/facts-about-federal-deemed-status-and-state-recognition/federal_deemed_status_12_12_181pdf.pdf
14:52:30 From Timothy Crimmins : This has been a brilliant start – thank you!
14:52:36 From Francis Chan : Word cloud would be interesting...
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14:52:54 From Wylecia Wiggs Harris : Agree automation is important; however, must also focus on issues such as lack of standardization for business processes; operational issues, technical issues, workforce implications; alignment and accuracy of vocabulary standards; data integrity, privacy; and, trust and representation.
14:52:55 From Janice Kelly (AORN) : @Ruth Schleyer – Hello
14:52:56 From Michele Berg : What is the hashtag for twitter?
14:53:14 From Jessica Schwartz (she/her) : #25x5
14:53:15 From Steph Hoelscher : #25x5
14:53:18 From llaking : Every Joint Commission citation requires long term ongoing monitoring and data collection– even when it does not impact improved patient care/safety
14:53:28 From Ruth Schleyer : @janice!! Hello
14:53:31 From Kiron Nair : Thank you for organizing this high value session with wonderful panelists.
14:53:39 From nantell : Awesome presentations and discussions !
14:54:00 From Amanda Moy (she/her) : @Chad Caroll I can share the background if you're interested!
14:54:00 From Stephen Essenburg : I'm so glad the cancel notice was in error! This is an exciting journey we are on!
14:54:12 From Peggy White : Great start – interesting dicussions
14:54:24 From Susan Hull : Will next session include #digitalhealth innovations for data entry/capture/synthesis including NLP
14:54:29 From christinesinsky : I especially appreciate the time management of the organizers. Well done! Thank you.
14:54:59 From Pete Stetson : Outstanding start. So important.
14:55:51 From Chad Carroll : @Amanda Please! I like it
14:56:14 From Francis Chan : Listen to the "tape"!
14:56:18 From Susan Hull : Thank you for fantastic momentum and the cadence for our collaborative interactive work!
14:56:26 From Lori Best-Arizona : Thank you for a wonderful kick off meeting.
14:56:28 From Steph Hoelscher : We're ready! Bring on the homework!
14:56:39 From Laura Fochtmann : Re: CMS and TJC, every psych facility I know routinely gets cited for interdisplinary treatment plans. There is no agreement on what they need to include. They have no documented value. They are totally duplicative and should be eliminated. https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf
14:56:42 From Bill Tierney : Very nice start. Well organized!

14:56:43 From nantell : I agree Susan Hull about Innovation
14:56:44 From Vicky Tiase : TY all — excellent start!!
14:56:59 From Holly Pollex : Thank you!
14:57:06 From Patricia Dykes : Fantastic session and extremely well
coordinated!!!
14:57:13 From Deb Peter : Excited and feeling positive that there will
be future improvements. Thank you!!
14:57:15 From Helen Burstin : Great launch! CMSS delighted to be
collaborator on this effort!
14:57:15 From Cindy Russell : Great start.. looking forward to the
next sessions
14:57:16 From David Vawdrey : Great discussion——thanks everyone!
14:57:16 From Dr. Larry Ozeran : Thanks All
14:57:18 From Francis Chan : Thank you everyone!
14:57:19 From Terry Malec : Good job!!
14:57:21 From Paula Wolski BWFH : Thank you!
14:57:25 From Lorraine Possanza : thank you
14:57:34 From Paul Fu, Jr. : ty!
14:57:55 From Laura Fochtmann : Excellent session!