: Where can we find the recording from last time?
: https://www.dbmi.columbia.edu/25x5/
:@, the videos and slides can be found through the 25x5 website
: Great topics, but should they also have a domain such as acute care, long term care, home health, etc.
: Lets discuss Optimization Processes as well
: data in topics could vary depending on the setting that you discussing
: Topic "usability" should be "usability and use"
: For breakouts, what about person in the center, or will this be a key focus in the interoperability
: All the unnecessary burdens we place on ourselves.
: Or that the lawyers and "compliance" people place on us.
: The discussion should be expanded to include mobile health and wearables - how could we include that information in the healthcare ecosystem documentation?
: I'm not naming names! Sometimes we do it to ourselves, especially if we think it will reduce our risk (as clinicians) of being sued or audited.
: Was also thinking legal implications and what is really needed from that perspective.
: recent E/M regs have relaxed some doc requires, but may introduce new ones. E.g., from the AMDIS listserv this am:
: Breakout - team based documentation
: with the recent E&M coding changes, our rev team is really pushing hard for requiring a multitude of additional sort of “checkbox” or “pick-list” documentation to be in the E&M notes, for example:

: 1+ chronic problem(s) with exacerbation, progression or side effects of treatment. (moderate)
: 0
: 0
: yes
: no
: no
: Low
: +1 @!!!
: @ - push back on that!
: We need consistent vigilance to keep us from getting drowned.
: @, fortunately not me!
: Normalizing data from diverse points of entry could provide relief from duplicate documentation
: We have a real opportunity due to COVID19. Due to COVID staffing shortages, I went back to the bedside as a staff RN in the ICU, and I'm fascinated by 'surge charting'. Nurses are documenting 'just the important stuff' now; many documentation requirements/ items are on hold. As a result nurses have more time with patients. Post-COVID, we may want to keep elements of 'surge charting'.
: Agreed !
: We discussed that at length last week.

: +1
: @. I was working in the ICU last week. :)
: Some of our units are going back to regular charting and I think I may need to hide!
: As a nurse today, I received yet another request asking if nursing can document something on behalf of another discipline. As we think about data capture lets keep in mind who should be capturing the data as well if we really need the data to begin with.
: , we cut back and when our surge went down attempted to keep some of the cut backs and it was denied by our risk and legal department.. very frustrating for the RNs
: Hi! Yes, agree - however in some states, we've already resumed 'normal' charting. Need to study!
: We all agreed. Last week was on What we document. This week is How.
: Organizational infrastructure to effectively manage documentation
: Having worked in Emergency Medicine for 25 years, care there is about speed of throughput without compromising quality. HIT has to enhance throughput, not slow it down as it usually does. Only ED clinicians can understand the flow and how information/data can both enhance or block it.
: Measuring usability by TIME is important, but not enough. It should be measured by the QUALITY OF THE DATA and whether it's actually USED in clinical decision-making.
: bedside device connectivity as well
: @ how would you determine what’s actually used? What is important for the ED visit is different from what may be important if the patient has ED follow up with they PCP 1 week later
: The informatics team and vendor need to look at the output of what is documented with how it reads and usefulnedd!
: It would take human beings looking at the care delivered in individual cases. WHO is using WHAT data? Too often, the answer is NOBODY.
: great visual!
: Please remember to use #25x5 hashtag when you tweet
: +1!
: OMG, that looks just like the ED I grew up in as a Nurse
: +1 , that is my ICU!
: +1 , agree - need to manage the tension between use for CDM vs. regulatory
: CDM?
: CDM = Clinical decision making
: +1 – how is our documentation supporting care coordination, transitions, mutual surveillance for complications, outcome evaluation. Pulling meaningful documentation into shared views support shared CDS
: I was always amazed in China by how much information they can get on one screen - using a character-based language creates denser documentation.
: Need to consider accessibility at all times in assessing usability.

Font/color/contrast usability for a 25 yo with 20/20 vision is very different than for someone older or with visual limitations.
: Context-specific, more “wiki-like” interface. There’s no reason for each “ProgressNote” to be a separate page
: This could be enhanced with clinical filtering of data based on problem or working diagnosis.
: Agree, also consider vision or color impaired individuals.
: Kai Zheng has illustrated this process brilliantly. Followed mice and clicks with the back and forth.
: clinicians should document data needed to care for their patients. Someone else needs to document stuff needed for regulatory, billing, or other purposes. THAT would reduce stress and burnout by 90%, IMHO.
: if the EHR follows WCAG accessibility guidelines that should be taken into account Laura
: Be careful with filtering. Think of a library with closed stacks vs open - the appearance of "novel" data can be really important.
: Some of the problem exists when vendors insist on making their own home screen and are resistant to upgrades unless you take their upgrades along with it :(
: FYI @, the chat may be easier to use if you “pop out” the window, which you can then resize and place in other areas of your screen.
: helpful. I have also seen some filters that are really off.
: @ - of course you know that Larry Weed advocated this in his classic NEJM paper
: @ Our EHR is from a major vendor but adjusting font sizes across all sections of the EHR isn't possible and the contrast can't be adjusted either. In the months while I was waiting for cataract surgery, it become almost impossible to use.
: In today's EHR, I find it hard to find the patient story, I find myself foraging for the information I need to care for the patient.
: So much trouble with simple things like font, color, size.
: 1+@ !!!
: - I have noticed particularly in summary and trending screens, the fonts are remarkable. I'm grateful to be able to see things, and can imagine not all can!
: +1 .
: #PajamaTime !
: Too many exam rooms are set up so the doctor has to have their back to the patient while documenting - which I refuse to do.
: As an inpatient physician, especially with COVID precautions, we are limited in what can be brought into the room. It presents a challenge for synchronous documentation.
: prime reason for using handheld devices in the exam room - so you can interact with the patient
: @, we've really kicked up the scribe debate because of that
: Would like to see talk to text be more utilized!
: The potential for ambient voice documentation could provide relief.
: + ! Too much extraneous stuff in there. Hard to see patient trajectory.
: - very interesting concept. Could help with patients who are not

encephalopathic. In some cases, harder when patients are not able to participate in a traditional way.
: AAFP is partnering / Piloting with Suki on ambient voice work right now - very promising!
: In my practice in 1972-3, the average physician spend 38% of their time "charting" in paper records. And this did NOT include time spent looking for the chart or information from other sources (eg, Xrays).
: It's often perception, even great additions is considered taking more time, even when it doesn't
: Change management is an important factor when changing documentation practices.
: at that time, with 38% charting time, how was that viewed? As too much burden, just right, etc?
: 1+ !!!
: @ YAAS! and governance and maintenance
: Diagnoses on 1 screen and plan on another, for example.
: for documentation. That was also mentioned by John Halamka on a telehealth webinar today
: https://pubmed.ncbi.nlm.nih.gov/4744980/.
: @. Fair point. No one wants to go back to the hunt and peck days of paper records, but had higher hopes that EHRs would help us document and easily see what's important
: So true Susan! I have gone back to review documentation done with RNs and they didn't even realize what they documented, they just click through the screens to get it completed.
: The amount of data foraging has increase over time, more is not always better.. Just because you can document it, doesn't mean you should.
: @ +1
: we must differentiate problems created by regulations and billing vs problems created by bad UIs of the EHRs. So far, most of this is from bad UIs of the EHR. We should not ignore the former.... regs and billing
: So true, and those of us who worked on early EHRs have to accept some of the responsibility for the crap we have today.
: 100%. We need practicing clinicians at the table when we decide how and what to document.
: Ross - or the institution's decisions about what the regs mean.
: +1 @ - this will be great to debate during the breakouts
: It would be interesting to hear from RNs involved with CMS and Joint Com on documentation requirements when reviewing these concerns.
: ...and bad health system administrators who want to get the data they need by forcing the clinicians to enter data that have no use in everyday patient care.
: I recall some of the chat last week touching on this - the variable interpretation of regulations leading to risk-averse documentation policies. (Well, risk averse in the legal sense. As we are seeing here, there are other risks with lots of documentation.)
: @ Even if you could find the chart, not an easy thing, and adding in gathering data not yet in chart (labs, reports, vital signs...), I

bet it was >50% of the time documenting. And, docs still had their noses buried in the chart and not facing the patient eye-to-eye.
: How can we as a profession promote better the "best practice" (evidence- whether or not formally published) and actually get it to the people who are really making the decisions/build at the informatics/front lines IT within health care settings? So many of them really do not understand or have training in usability concepts?
: I find a lot of redundant documentation is driven by the fact that there are multiple ways to enter data and some feel they must all be completed. As well as initiatives from Quality to have information entered to automate audit data.
: True! A
: +1!!! Not all that is to blame is the EHR; consider regulations, and our own over-OCD habits.
: 1+
: A third of the time, all I got for a "chart" was a blank piece of paper -- chart not found.
: +1. very true!
: @ - haha, guess that was a hint to start the chart with that paper!
: We had to keep a pack of 3X5 cards in our black bags with updated patient lists and meds for the times when the chart never showed up.
: And of course, much of what was in the paper chart was illegible, often including the physician's name.
: perception of interaction matters, checking a box with pen and paper is ostensibly the same as ticking a box with a mouse on a screen but the "feel" of the interactions are very different to the user...
: Very glad to see the discussion of weak/strong clicks, and distinction between clicks vs. decisions.
: Yes we did. It was eye opening Patty.
: Were the EHRs invented by hand surgeons? Certainly it keeps them busy.
: As a HIM professional, I don't recall the paper chart as fondly.
: Clinical Documentation – Ensuring End-to-End Fidelity. The graphic asks the question "How Might We Ensure End-to-End Fidelity as We Collect, Share and Use Clinical Documentation?", considering what the author sees/intends and how that corresponds to what the end user sees. This is a draft. https://wiki.hl7.org/w/images/wiki.hl7.org/5/55/Reducing_Clinician_Burden-End_to_End_Fidelity_Clinical_Documentation-20201230.pdf
: •provenance, •clinical facts, findings and observations, •order detail, •prior authorization detail, •billing/claims detail, •quality/performance data, •public health data, •administrative data, •finance/cost data, •registry data... Each segment represents a purpose of collection and a corresponding purpose of use, based on stakeholder needs. This is a draft. https://wiki.hl7.org/w/images/wiki.hl7.org/8/87/Reducing_Clinician_Burden-Data_Segmentation_for_Clinical_Integrity-20201230.pdf
: Epic already filters by user type and it's very frustrating because we can't help each other and doctors and nurses don't see things in the same way.

: Also important to think about font size for patients. If they can't read it, they can't use it.
: That's where too much customization can cause problems as well
: Not only patients - not all users have good vision.
: Agreed! End the large blobs of text!
: In our ethnography study of outpatient encounters in the paper chart days, 81% of the time physicians could not find the information they were looking for to make decisions on that specific day. On average, docs were unable to find 4 pieces of critical information relevant to decisions for that day .
: My recent doctoral work (awaiting publication) was to define the applied cognitive informatics competencies for practicing informaticists (human factors/human computer interaction/usability). Thank you to many of you on the call who likely (anonymously) contributed to the consensus of those 26 competency statements.
: There needs to be an agreed upon standard for BPAs and banners or headers. We have no rhyme or reason to what some use. we use red obviously for high risk alerts but let's figure this out.
: nobody thinks about us colored blind people either in customization options
: During Katrina in NOLA, the only sources of patient information was chain pharmacies and the VA--they were the only ones with electronic records. The paper records for all health systems were usually in the basement, and hence underwater and lost forever.
: this week I completed a quick time/motion comparison of desktop vs mobile documentation workflow for vaccination. The mobile process currently has more clicks and takes more time but was preferred by some users, likely bc the form factor provides other benefits not captured by time or click count.
: + - doctors and nurses dont see things in the same way in the EHR! Do we know the implications of that on safety and burden?
: @ - agree, colors, font, etc. is just makeup... need to summarize and contextualize the data for CDM
: The mantra GROSS (Get Rid of Stupid Stuff) has to be specific to the data user. What's stupid for me as a clinician may be key to a person generating a bill. So the stupidity is asking the person NOT being served by the data to enter them.
: yes - used to be it was missing (our "MIA" JAMA paper on this), now it's in there but buried and we have no time to dig it out
: @, great point
: @ - agree with standardized alerts for BPAs. Audio vs interruptive vs background firing
: I used an EMR that used different fonts for different clinical roles - it was great because you could tell who wrote it w/o looking for a signature.
: Different fonts is a terrific idea, thnks
: The problem with video is that it takes too much time and energy to get the info back out of the EMR into my brain.
: And too much space in the EHR as well
: Agree with @ - abstraction not recording is needed

: +1
: @ yep, we have to have a standard approach otherwise clinicians ignore the seriousness of the alert. The EMR can't be a rainbow of colors with no reason :)
: What we were really hoping for with the EHRs was that not only would the data be IN the EHR (and that the EHR would be available 100% of the time (vs 70% for paper charts)), but it would also help us with FINDING the information. So far, that hasn't really come true (the FINDING part).
: A lot of best designed elements for clinicians was defined by this project funded by ONC previously. May be helpful to look at and consider an update to this as a handbook? http://inspiredehrs.org/
: The EHR interface (especially colors/contrast/size) should also take into account the physical setting. Some offices use smaller screens, or old laptops that have screens with poor contrast. The modern trend in OS's for lower contrast can be hard. I find Epic's "high contrast" theme should be the baseline.
: Interesting what is thought about the duplication of data entered across various members of the clinical team, especially in an ED or inpatient setting.
: Multi-tasking is cognitively expensive and expensive from a safety and satisfaction stand point. Errors are greater when MDs and others are doing deep clinical work while also documenting the work. We don't ask this of lawyers and judges in the courtroom.
: @ - Bob Wachter's digital doctor book had a great example comparing medical alerts to Aviation industry alerts
: the hardware and UI designs that would be useful.
: Clicks work best when a) they can be navigated in clinically reasonable ways, and b) the interface is created by the clinicians using it, and c) the clicks replace typing, i.e. save time.
: the use of automated documentation apps integrated within the EHR to optimize and workflow and capture structured data can make a huge improvement for the clinician
: Or thinking about clinical documentation differently
: An excellent tool, used poorly, produces poor results; a common tool, used wonderfully, produces good results. DaVinci's paintbrush in my hand produces Stick Figures; my pencil in DaVinci's hand produces brilliant stuff. This shows a bit of the tension between the desire to create a highly-usable system -- and the need to develop pretty good documenters.
: Glad people are emphasizing voice. Would love to see more work in this area for nursing documentation.
: @ YES. Different data displays and formats were a contributing factor to missing the initial Ebola case in Texas. Sittig et al
: mobile devices are great and these require nurses to learn a whole new skill to speak to the mobile device to document. and the usability on the mobile device is a whole other challenge. We have struggled a bit to have nurses throughout the spectrum of experience and generation to pick it up. Usability is not exactly similar enough to how we speak to Siri, Google, Alexa etc.

: I agree with Laurie about verbal entry. Very exciting to consider.
: 1+ @
: I do miss the days of giving verbal orders/telephone orders
: Im looking forward to this with scribes and team documentation!
: NLP conversion to structured data can transform user experience and data quality
: Everyone talks about NLP but are we really sophisticated enough in our NLP for this to be accurate/helpful vs. just another impediment. If documentation requirements were reduced to what's clinically necessary, we may not need it.
: dictated notes are far longer, with wasted words and bulk, as opposed to telegraphic style. the latter is equally information rich and readable
: Cool, Teamlets!
: 1. The patient informs this reporter that he/she has not any chest pain recently.
: How can patients co-produce the Team Based Sidekick?
: or 2. No chest pain
: I can document "no recent CP" without a while paragraph.
: + 1. So often clinicians have no understanding of how/why things are designed and entered as they are. Not that they need to know "how to make the sausage", but there could be a better understanding if there was a general understanding of the how/why of how data flows, not just where to "click". This speaks to "informatics literacy" need among all types of clinicians as part of their education (formal academic and work based).
: , it's improving all the time, but I agree, it's far from perfect but improving. At the moment it's very useful for research. There are other automation tools for nursing and physician documentation that automate the process and create structured data
: @ - the promise of NLP has not quite gotten there to turn prose into structured data…interested to get opinions of those on the cutting edge what realistic timelines might be
: To me, one benefit of writing a visit note is thinking comprehensively about the pt's problems, treatments, etc. If someone else is writing the note--even if I'm reading it--my thinking will simply not be as complete. As a PCP, that's a big problem.
: Centralized services are not personal - they don't know the patient. Primary care works best when the entire team knows and relates to the patients.
: All of these models assume that there is enough revenue to support all of these "helpers". In outpt behavioral health, we don't have MAs, nurses, scribes, or anything. Some sites don't even have front desk staff.
: +1
: #CoProduction opportunities are significant for us to to explore before, during and after visit care mashing up new #digital technologies with transparency for patients and care teams with the Teamlet and Team of Team models. Hope this can be one of our breakouts
: @ - I like the ethos of this ACP paper “Restoring the Story and

Creating a Valuable Clinical Note” https://www.acpjournals.org/doi/10.7326/m20-0934
: Agree one big value of documentation is the synthesizing into clinically relevant information and tying that to medical decision making.
: I love telegraphic documentation. Keep it as concise as possible to communicate the meaning. It felt good to overcome the “guilt” of thinking I had to always write full sentences in notes.
: State based regulation of professional practice will be an issue for us to address for scale of #25X5 interventions – outdated regulatory compliance systems are not current with digital health capabilities. Thanks Peter
: Good point - team is shifting documentation overload not getting us to the right amount
: Agreed @
: Perhaps lost in translation as I’m from a different healthcare system - UK but I see risk with others documenting care and a s a nurse a key role is joining up care anyway - acting as translator for the patient. Focus of reducing doctor workload seems the wrong starting point. Of course I don’t understand the billing and regulatory issues you have so perhaps underestimating issue. Sounds like the doctors handmaiden role???
: @; excellent presentation. Thank you! Here is a related article. https://www.annfammed.org/content/17/4/367
: @, Yes, and as health systems cross state lines that complicates designs in the EHR as scope of practice things can be different across state lines.
: @ great presentation
: +1 @
: Agree with those noting the importance of synthesizing information when documenting. This cognitive process was one of the major pluses of documenting on paper. Also, concurrent documentation while with the patient doesn't allow for that, which is another way that important aspects of clinical decision making can get missed.
: how many people's echos are trying to upgrade right now?
: lol
: lol
: Sometimes how much services actually cost are guesstimates -- there's a long-standing need to collect standardized data on staff workloads, particularly in nursing
: We need cultural linguists to help with voice HCI issue. Right now it's a clash of dialects.
: @ “The nuance of speech to text” <- I see what you did there
: it is important to distinguish data about DICTATIONAL speech vs CONVERSATIONAL speech. these are very different beasts
: "poor sign valve"
: Although who hasn’t accidentally said “period” in conversation?
: +1!!
: The biggest thing Dragon struggles with in my practice is THE PATENT'S NAME - a big problem with open notes

: The safest and most efficient documentation system that I have experienced as a physician was dictation to transcriptionist, whose role was to over-edit the voice recognition output. The human understood context and avoided the homophone and other silly voice recognition output.
: I don't think linearly enough to dictate efficiently.
: great point -- there are certainly BEST methods for different providers. For some dictation is great, for some typing, for other structured enty. multiple modalities are needed
: Me too. Documenting is part of organising my thoughts. Different tools for different people?
: bruits -> breweries
: +1 - I think this not only about recognition of words correctly but also construction of the idea. Asking Alexa a question means you have to construct the question more like a Google search.
: I think the value of dictation might change with a person's experience in providing care. Think resident/new attending vs seasoned provider.
: If we want t reduce by 75% what is the baseline we are reducing from. Apologies new to the conversation
: she hasn't mentioned privacy -- more difficult to protect privacy when you are talking particularly in the open settings so many of us practice in now
: Beyond the person creating the note, there is also the issue of who is using the note. Is it better to have parsimony or completeness?
: Has anyone successfully implemented speech to flowsheet doc for nursing?
: It takes time to train your brain to synthesize your thoughts in dictation. It does help with problem script recognition.
: My experience is that clinicians have never reviewed in DETAIL (only skim) either human transcribed or machine transcribed documentation --- which is scary when there is at least 5 % error in both.....
: @ copy-pasta vs bad transcription?
: I would love to see this for nursing!
: don't practice if you have currently have covid. :)
: +1 for nursing!
: 3M M*Modal has a speech to flowsheet product for nursing.
: copy-pasta LOL
: Dictation or transcription will not work for all clinicians. How can we make this work for all? Will we all be wearing earpieces!
: @ - good question. Would also love to see hospital policies r/t speech to flowsheet for nsg
: @ vendors starting to offer "ambient" audio transcription
: 1+@
: @ - Haha, but many esp in private practice only stayed open by doing telehealth @home while down w/the 'Rona!
: Dictating through a mask isn't always efficient for me.
: Nicely done, Yaa!
: Great succinct presentation!
: So thoughtful, Yaa. Thank you!

: @- great presentation. you shed light on the state of the art and your images and animations were really great animations.
: Awesome presentation!!
: @ Problem is that there are errors in both copy paste and dictation. How can we minimize errors. Likely less in dictation vs. copy/paste, but still we need to get as low as possible.
: @ - so much truth from you today - Thank You!!!
: @ really great question--i hope we address this one in discussion what is our baseline for measuring success of 75%!
: Ambient audio seems to be a long way from realistically useful. There are better automation tools for nursing documentation
: @ great presentation
: Ambient == conversational speech and requires speech recognition, natural language understanding and sophisticated tools to synthesize the concepts recognized into a note -- ALL of these are very hard and on top of that, not everything we want in the note is said during the encounter -- we observe things that we don't verbalize, we think things that we may not go through verbally during the visit etc.
: @.... describe successful implementation for nursing. we have the Nuance product with phones for nursing. all that @ shared with challenges... we experienced it all. and it is difficult to teach and learn.
: @ great job great points
: @ - sorry data entry error!
: Ideally, copy paste would simply create a reference to the original material rather than duplicate it. When we get there, we can start calling it referring to the original data.
: @ copy paste problem isn’t just in error generation but also error propagation (post op day 3 x 5 days in a row)
: @ yes
: We are currently evaluating copy forward in our genera care units compared to ICU settings...looking forward to this discussion
: if you copy someone else's assessment is there a way to attribute the assessment to the original author?
: Challenge is that everyone has a different definition of what is the “right” amount and quality of information in a note. The only standards are high-level for billing and discrete for quality.
: When it becomes a reference, that should be clear in the metadata
: @, Yes, that why it is so scary if not evaluated critically by the clinician before re-applied.
: @ there is depending on your EHR!
: All forms of documentation have human error components, should we focus on streamlining input, eliminating redundancy and providing our clinicians a means to "double check" prior to publishing.
: @, I rarely copy/paste; but when i do I start with "copied from...note of xx/xx/xxxx"
: Already seeing patients calling out templated notes with "you never did X - why is it in MY note" with OpenNotes
: Family history, social hx and past medical hx are NOT static. We just neglect to ask about changes.

: @ YES
: @ We just went live with expanded copy forward in flowsheets. The NICU nurses say it is life changing
: Mike Wang did an interesting study looking at attribution of copied or auto pulled notes (Epic EHR) https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2629493
: If I had a dollar for every error I see in notes! We don't do this in our nursing practice for flow sheets. Bi NONO where I work in nursing.
: Physicians in our health system started using cut&paste when I was Chair of Medicine. I had to review records with some frequency, and they had become unreadable. New info was embedded into old info, and the old info was often wrong. I outlawed it for my Department, and the residents told me to f*** off. Instead of documenting care, cutting & pasting obscures data/information. And quality and safety suffer.
: Just heard of a clinical case where multiple copy paste by multiple clinicians ALL WRONG and copied forward for multiple days and it wasn't just wrong it related to a dressing that the patient never had and didn't relate to the clinical condition at all
: How often does incorrect information get replicated and negatively impact care?
: There ARE guidelines on use of sloppy/paste, um, I mean copy/paste; e.g., App Clin Inform Ozeran, et al....?2015 I think.
: Is there a benefit into examining why information is copy and pasted instead of relying on the source of truth.
: Pretty often in my experience
: copy & paste is usually a work-around for poor EHR workflow. It should be addressed with optimized design and automation tools
: I once wrote the Joint Commission and CMS begging them to outlaw cutting & pasting. Never heard back.
: @ - you may be kindred spirits with Rob Hirshtick “Sloppy and Paste” https://psnet.ahrq.gov/web-mm/sloppy-and-paste
: @ - completely agree.
: disagree. Lazy note writers and poor templates that can pull in just what you need
: Copying old information increases the data foraging demands on clinicians.
: The sad thing about this discussion is that when copy and paste is used appropriately it saves time and energy
: @ I think it is difficult to make broad claim like that. possible to have excellent notes and crappy notes with same software. very author dependent.
: @ - Copy-Edit is more important I think, not Copy-Paste
: there are some systems that put copied material in different colors or fonts
: templates, dot phrases, copy/edit as an alternative
: @ - here is the ACI paper https://pubmed.ncbi.nlm.nih.gov/23874365/
: to clarify. *good* templates can pull in appropriate data
: I've often heard provider state that copied information from previous sources to pull all information together for their use and

then added their note to that. Should we be considering asking our vendor partners to facilitate an EHR that pulls all data together but allows for a separate note.
: @ makes perfect sense!
: System perfectly designed for the results it gets
: @ We set system guidelines for flowsheet copy forward. Nurses can copy forward their only their own documentation that is less than 12 hours old. Number, scales, and screens are excluded.
: Yaa Kumah … question … has Nuance made improvements with the work you have done with them?
: How often is "copy and paste" built into EHRs to satisfy regulatory requirements v making note documentation easier? Seems more the former.
: Using scribes brings a person into the provider-patient relationship who does not belong there. There are things that i do NOT say in front of a scribe.
: "Copy and Paste" is a symptom that we need to treat on an individual basis. Could be usability or could be user not familiar with more efficient tools
: copy/paste is a Windows function that you couldn't get rid of if you wanted to!
: I have been using dragon for neonatal/newborn care for about 2 years and it has "learned" over that time.
: +1
: Scribes may work in the ED or specialty offices but not in primary care or psych
: @, you're right. The capability should be within the software, not place additional burden on the clinician
: @ I like the parameters you have in place
: We need to think much beyond scribes and fundamentally rethink the paradigm of the core purpose + digital health innovation
: Most of our historical research related to EHRs improving safety relates to CPOE and CDS place a scribe in the process and it prevents that benefit
: Advanced team-based care with in-room clinical support from a team member is very different than a pure scribing role. The benefits are beyond the reduction in physician/APP documentation time.
: can we learn better approaches to documentation from other industries?
: 1+
: I often think of things after the visit that I did think of during the visit - re-visiting the visit really improves my medical care.
: @ 1+
: That is surprising
: No surprise that we as informaticists believe scribes are a bandaid on a multi-factorial issue
: Let's fix the problem, I didn't go to nursing school to be a scribe. Good grief!
: Yes, we need to step away from typing for dollars!
: +1 - won't be long before scribes hold sessions on doc burden!

: 1+
: funny !
: +1 !!!
: @, ha! And yes
: @ couldn’t agree more
: I think that each team member should document what they do during a patient encounter. In such a system, the visit record is the compilation of all of those pieces of info. They can be combined into a "note" for another provider, a "letter" to a referring provider, or a "billing record." Does there have to be a single note? The note is just a display format.
: Nursing as a scribe is very surprising.
: A significant value of HIT is in the bidirectional information flow. Likely to lose that with human intermediaries.
: lol !
: +1
: Very well said!
: In advanced team-based care with nurses, the nurses use far greater independent judgment and have independent relationships with patients than nurses in traditional roles. It is not primarily about record keeping. It is about being partners in the care of patients. I fear that many people hear the word “scribe” and develop a very limited notion of what team approaches to co-visits can be.
: Nursing as a physician scribe makes me sad
: our problem, still, is that we see the EHR as an electronic version of the paper chart. We don't think of documentation in the electronic era and rethink how information is captured, stored, and displayed.
: https://doi.org/10.5334/egems.202
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: The key to effective voice recognition / NLP is to massively reduce the underlying clinical vocabulary. We used clinical QI to do that - the idea of "activity based design," as an ideal approach to deploy QI-based clinical decision support. See James, B. et al. An efficient, clinically natural electronic medical record system that produces computable data. eGems 5(3):8, 1–6. DOI: https://doi.org/10.5334/egems.202
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: I imagine/dream of a time when I can walk into a patient's room, and by voice commands call up the data I want on an in-room screen: VS, lab data, reports, notes,....then interview and examine the patient, answer their questions, and discuss with them the current dx and plans. The computer then synthesize what I did; transcribes in telegraphic notation the discussion, while I add the examination findings. The computer adds the problem list which I've previously built; I add the assessments either in the room or later....basically, I walk into the room, and my note gets generated before I leave the room. All the while I am paying attention to the patient, sharing the information verbally and on screen, and I'm done when I leave the room.
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: My son is a radiation oncologist with a moderate stutter which is most apparent when he tries to dictate. So he can't use VR. But he's working with a startup company that will take the information in a patient's EHR and create a note template that is specific to that patient into which he can hand-enter info. His specialty is highly protocolized, so this could work well. Doing it for primary care or emergency medicine would be tough. You could see it working well for surgery: a custom note template based on what the patient has and the procedure that's being performed.
:The question is how can technology augment the cognition of the clinician.
:Consider use of ambient tech for capture of information that seldom needs to be accessed for CDM but is needed for risk management needs only, to provide evidence of what was and was not done; this is where ambient could save nursing a great deal of time.
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- Reimbursement
- Regulatory
- Quality
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:@ YES!!
:@- absolutely!
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14:57:16 From Bill Tierney : When we first went to typing notes in the '80s, I alternated hand-writing with typing. I type >100 wpm, but there was no difference in time! I found that when writing, i used the typical MD shorthand, but when I typed, it was full words and sentences. Whey I started typing shorthand, typing took MUCH less time.
14:57:18 From Michael Brody : And not enough time is spent 'proof reading' our documentation to make sure it is accurate.
14:57:28 From Christine Sinsky : Does anyone read templated documentation and if so, do you find it useful? I believe if it can be templated, it probably shouldn’t be documented, because it just adds to note bloat.
14:57:30 From Laura Fochtmann : We need to also consider problems with error propagation independent of copy/paste. Examples with Med Rec are legion. A recent one is the HCC suggestions and where the info comes from is not at all obvious. Example: A patient had a surgical procedure for trigeminal neuralgia. However, the HCC suggestion (apparently related to CMS mappings) was for Brain Compression/Anoxia. If I didn't know the patient, I might have reflexively added it to the problem list thinking that it's correct when it clearly was not.
14:57:40 From @KGLusk : As an HIM professional who took records to court in the past - It was not pleasant to read the paper record. Digital is legible.
14:57:47 From @puhfu Paul Fu, Jr. : +!
14:57:54 From @TrentRosenbloom : As a reminder, please consider these current Breakout Topics:
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14:57:58 From Jami Stroh : @ yep...so frustrating
14:58:06 From Ross Koppel : we should talk about open notes here. no

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14:58:21 From Bill Tierney : Capitated payments = less fraud.
14:58:23 From @TrentRosenbloom : @, what do you have in mind?
14:58:43 From Lynda Hoeksema : We haven't spoken about the secondary reuse of clinical EHR data.... a big point needing discussion.
14:58:49 From Michael Brody : Capitation is an incentive to not see patients.
14:58:55 From Bill Tierney : Notes are shorter in the UK because they don't have FFS. The providers just document what care requires.
14:59:12 From Natasha Phillips @NatashaRoseP : It’s almost 8pm here in UK and I have done an early shift in vaccination clinic today. Despite the lateness of the hour and the length of the working day I am energised by conversation and have lots of food for thought. Thank you for including me
14:59:35 From Lane, Karen C. (ELS-HBE) : Need some focus on Flowsheet Documentation, what and how nurses, respiratory therapists, others re documenting or overdocumenting. How patient's change (improve) over hospitalization but flowsheets hold so much more (easy to add, no one wants to remove).
14:59:42 From Bill Tierney : @: not true. My health system has been >90% capitated for >20 years. Look at KaiserPermante. Not creating barriers to care.
14:59:59 From Sarah Visker : @ YES!!
15:00:12 From Christine Suchecki : @- absolutely!
15:00:31 From Paula Wolski @ : Great session- thanks so much for the food for thought!
15:00:35 From Toni Laracuente @ : Thank you for an excellent session!
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