: Everybody, please remember to change your Zoom name to your Twitter handle / name if you have, and please live tweet. Please also use the chat for active discussion.
: can you make sure I didn't accidentally stop recording this?
: I see the recording light on in the top right
: It says it's recording to me
: I assume (hope?) it is
: Has "burden" of documentation burden been defined — at least for this effort?
:@, there have been a number of useful explanations of burden, but it is loosely defined herein as excess and unnecessary documentation
: As someone who has thought about and written about documentation post regulatory reform — we have been careful to point out that "effort" and "work" are not necessarily burdensome — and that it can be reasonably expected that for clinician note authors, work/effort may increase for those clinicians who are used to documenting mostly noise — where rote phrases that say nothing fill up much of the documentation. Of course, taking the time to create a thoughtful brief note will reduce reading burden (the other side of documentation burden)
: @, agree that work and effort do not necessarily constitute burden
: Good, what I would have expected — we are not defining this as work, but as wasted effort — one could define it as for regulatory purposes (no benefit to the patient) or as duplicative documentation — even where there is benefit to the patient
: Yup!
: wow! Thanks for being here at 2am
: That's dedication. Thank you NT!
: And is it only me who believes that at least for outpatient clinicians in the US, regulatory documentation burden could be mostly (if not nearly completely) gone now, or within this CY — if clinicians fight inertia and fully leverage the changes in E/M that exist today. Obviously much work needs to occur within the house of medicine to move docs who are used to creating verbose notes filled with default negatives — to "medically appropriate" notes… And — of course we need our EHR vendors to help support this.
: +1, and second that for inpatient clinicians
: To the extent, Peter, that the E/M changes allow relaxation of Hx and Px, but one must still detail what labs you reviewed, what calls you made to coordinate care...there is still a demand for details well beyond clear statements that *interpret* the data. If I enter in my note, under say fe-def anemia--"improving with near normal hgb and ferritin" it should be obvious I've reviewed the labs, but some have interpreted the rules to be that I have to mention which labs i reviewed.
: Agree @. IMO, if CMS (or CMS + AMA consortium) modifies inpatient and ED payment codes similar to what was done for outpatient documentation — most of the work going forward (again, IMO) falls to clinicians (for determining the WHAT) and to EHR vendors, for creating enabling infrastructure

: no changes to help inpatient docs yet
: Peter — indeed. As billing is often linked unfortunately to both the +/− symptoms, for example, and +/− exa, findings, so much in those fields is extraneous to clinical decision—making. What a novel idea to streamline...
: I wonder if med student and resident education should be included/ addressed so the concept of "the longest note wins" ends.
: Enter once, use many (for care, for quality measures and more)
: @, or more precisely, enter once, *refer to* often, not use/repeat/ copy—paste
: I don't disagree Richard — but this is our opportunity to script what the right answer is — which can be different based on the EHR system — but as a principal, should never require duplicative documentation. Thus, ideally when you are reading labs / studies / reports — the EHR creates "citations" such that you dictate or use VR to create the appropriate brief narrative, as you describe, and the data / info reviewed is auto—cited… which would satisfy those who want to see detail, and make it easy for those who want to see the source data.
: Agree
: like the list a lot
: Write ONCE, Use MANY times.
: +1 for WORM lol
: Actually Write Once Reuse Many. D'oh!
: If, for example, I look at family history for more than 30 seconds, the computer ought to record "family history reviewed."
: Again, there are systems that put copied material (text and numeric data) in a different font/color
: Agree with Susan et al., "write once, use many times" — basic principle of informatics — which applies in all fields EXCEPT medicine. Our time is push for this. Every min wasted on duplicative documentation is a minute less with patients
: +1 — for so many sections of the chart.
: — part of the issue is not only the effort to get the info into the note but it also slows down everyone reading the note...
: defeinding the system is a LOT of what made Regenstrief, Partners, Vande etc so successful early on but when clinicians lost control of the systems that line of defense was lost
: Our EHRs know what we view and for how long (in a deep audit mode) — completely agree with David that we should be able to see / use that audit material as a starting point for either MDM—based E/M level, or time.
: EPIC, Cener and a few others already use these types of metrics to guide design, training etc and there is an emerging literature using EHR log data like this. I published a look at medicine and pediatrics EHR time use across the US for example
: David Bates also looked comparatively across several countries using this approach recently
: David — what do you mean by "slowing down everyone reading the note?" I am a believer in documentation burden being two—sided.

Authorship burden — which we talk more about… and readership burden — which we should also be thinking about
: @ — +1 yet again. I have found that when I write a very effective 'coding/billing' note, it runs a balancing act with efficiency for clinical 'readability' that doesn't slow the 'audience' down. And now balanacing families reading our notes in real time, the competing roles of a single note may need to be better aligned.
: Exactly — the more I have to scroll, the more boiler-plate I have to read the more cognitive burden on the reader, the consumer of the data
: Lens of real time health system and smart hospital/command centers would be of value to consider
: Yes, authorship burden (copy forward, including the entire MRI read in your ER note, etc.)
: I know the vendors are working on improving the usability of the audit data, but it's still a challenge to data mine it and pull out meaningful and actionable insights
: @ agree , author and reader are equally important
: The points brought up are very important. We are all data consumers and when we create documentation we need to approach it from the perspective of the consumer. That will give us notes that create less burden to all.
: Hi Marc — if I remember correctly, a key learning from your study should inform this group — which is its not just documentation burden, but also information retrieval burden. And if we think about documentation post E/M reform — the work of narrative documentation should include the effort in retrieving the contextual information necessary to create that narrative.
: @ — exactly. Thinking of the cumulative time spent 'consuming' the bulkier note that serves many purposes may be unknown vs under-estimated.
: @, that's OK——few of us actually understand our system either!
: Also in my experience the more 'bulky' the note the more likely the note contradicts itself
: So true — are we "romanticizing paper?"
: #NoteBloat
: making the note useless but with the burden of having read a bulk note that we eventually need to disregard because we do not know what to belive.
: LOVE the term "romanticizing paper."
: @ — indeed when we are asked to add features, before we even work on how to make it usable, we ask if it adds value to clinical care
: Romancing the paper!
: Deb and Susan — I might suggest its more than time spent consuming the verbose note. We should also consider the quality, safety, and cost implications of burying the headlines.

: Good term "romanticizing". It used to be "if only I didn't have so much (paper) documentation, I could spend more time with patients." Now, it's the digital equivalent.
: @ — making clinicians drink from an information firehose

: @ — Completely agree. I find it takes more time to write a concise and yet also inclusive inpatient note, while also limiting length and 'bulkiness'. The editing ends up taking time that could be spent at bedside, or in family communication no doubt.
: IMO — We have to "Break out of the Document Paradigm." A document is just a "view" into the data. We've just become accustom to the content we expect to find in a document. So, we "author" documents. We need to think more about how we want data to be visualized.
: I am remembering a book from the early 2000s — "Paper Kills." My response then and now… paper cuts, poorly thought thru processes kill.
: Thank you @ — Yes, Co-Design with Patients and Patient Led!
: We can do better than just words.
: Interesting about fondness on paper — I recall that there were greater delays with completing paper records than electronic. That would infer that electronic was easer to capture.
: every provider/organization has a portal. From a pt perspective that can get unruly. How about developing a health portal and vendors plug in
: That said about paper, it provides "affordances" that EHRs don't have; e.g., you can't write on a graph....this is clearly wrong... possibly from another patient. But of course EHRS offer so many other massive benefits
: +1 Viet — agree, the fact that we still talk in terms of documents is problematic...
: +1 Viet
: +1 Viet
: @ —— yes retrieval was a significant use of time but i think we have to be careful translating time spent to burden. I want my physician to carefully review and be aware of what is in my record ——that is part of taking of a patient. Systems can and should make that way faster than on paper but i get frustrated with those who suggest that time spent caring for our patients (understanding the patinets clinical status, communicating with the care team etc) are clerical or wasted time.   WE certainly want to be efficient and the machine should help with that more but there are tasks we should do as clinicians
: +1 Viet and group
: Actually we have found the document really useful as a way to communicate with the clinicians. The key is to have a system which then liberates the data in the document and allows it to flow through to anywhere it is needed
:@ — Interesting thing that I wonder if others were commenting on is not just 'reviewing' the chart, but then having to write in the note 'I reviewed the chart'.
: @——exactly!
: @ self imposed is challenging to overcome the pet projects of individuals
: digestible data relevant to the current clinical encounter that both clinician and patient understand and drives the best possible decisions. Add to that the current and anticipated technologies, and

then work back on how to best design a system that interfaces with clinicians, patients, clerks, and other support people. Instead, we start with the paper record and try to convert it into an electronic format, using the same workflow as we did with paper charts. We need to rethink and redesign the entire health IT infrastructure starting with the desired end state. IMHO.

: Yes @ !

: @ – that should be a function of the log – it demonstrates you reviewed the chart

: – I have mixed feelings about not spending the time to create a good note. If we think of the note as primarily reflecting the thinking of the clinician (summarizing history, physical, data…) – I have always found that re-telling of the story and one's thinking to be of exceeding high value. A highly trained clinician's role (IMO) is in fact making sense of data… Or the old paradigm of data – information – knowledge. Yes, we could spend more time with patients if we didn't "document" – but the value of our thinking would get lost. I think that is the balance between removing documentation and administrative burden + use anticipatory decision support and advanced informational visualizations to reduce information retrieval burden… and take that time (which is substantial) to have the clinician think + document what is important – and spend the rest of the time with the patient.

: @ – true for a log. I understand from coding/billing perspective, that it is not captured unless documented in the note text. Hence the dilemma.

: Dr Phillips, do you have data on how much time your nurses spend in the EHR and in Flowsheets?

: @ that is a failing of the system.   the information is captured in the log. The billing module needs to have access to the log.

: Telling the story and clicking data elements are incompatible.

: @ – sorry if I was not clear – I am not suggesting that clinicians should strive for an "information free" visit – but that time is not wasted on information retrieval.

: @ +1

: @ –– didn't think so but i wanted to underscore that we aren't trying to take time on these important tasks to zero (but we certainly want to decrease them to the optimal amount of time)

:   A few issues @:

– Increasing employment by large systems that prioritize "access" (eg volume) in FFS-heavy environments often don't leave time for documentation in the day w/out help.

: – Little time / funding in these settings to optimize EHRs. I'm lucky @ to have MD-IT colleagues like @ who head up EMR "Sprints" with practices, but it's a rarity.

: – *Unnecessary* work/effort is what is burdensome, when there is little time for self care, professional development or professional relationships (aka "work-life integration"). As we see opportunity (team -based care, scribes, AI based documentation etc.), our definition of what's unnecessary changes.

: –As long as FFS remains dominant and pays more for two 15-min visits

than one 30-min visit we'll see these issues, and increased volume
demand will continue to push folks out of practice early or taking fte
reductions, which just exacerbates the access problems. The snake will
keep eating its tail.

: Great potential with standards to decrease burden.
: @ — as someone who used to practice on paper — you are recalling
correctly. In the late 1990s — the lead headline in many of the
journals was "I spend more time on paperwork than I do with patients."
The EHR was positioned as a tool to #1 — reduce inefficiencies of
practice, and then #2 — make care better. Is it just me, or somewhere
along the road to universal implementation, job #1 — using the EHR to
reduce administrative burden.. this was just forgotten.
: @ Larry Ozeran and I recently submitted a paper on one aspect of
unnecessary documentation burden, pre-authorization and 'documenting
and submitting to insurance, to get paid'. In a digital paradigm
insurances should have access to what they need (e.g., to prove the
surgeon actually did the surgery they billed for) rather burden the
physician to prove they did what they said they did.
: @ — I suppose the point of my presentation was that job #1 is very
achievable, as long as it stays job #1
: @ … I'm very interested in the work done to get to a national data
set for nursing. How did this contribute to perhaps consistency in
documentation and therefore a "same language" between clinicians as
the patient changes caregivers while in the hospital and out of the
hospital?
: @ — Agree — likely made it worse — at what point can we stop proving
the level of interoperability, CPOE etc that we've been attesting to
for years?
: DaVinci has the potential to decrease the administrative burden
between payer and provider.
: We are currently in conversation with some payers on a FHIR IG
related to advanced treatment for wounds.
: @ agree Dr. Cheung. The US healthcare "system" gets in the way of
this, and thank you BTW for your work and excellent presentation
: @ reduce admin burden was not forgotten but supervened by "well,
it's so easy to pull information in an EHR that we'll increase the
burden/requirements (e.g., meaningful use)" IMO
: @ — Well done!
: Unfortunately I didn't have time to describe how we have built our
system to have this functionality (automatic extraction of relevant
data) from wherever in the system it was previously documented
: We currently have 1 EHR, 1 Application and 1 CMS approved registry
using this IG in real time production.
: This study done in 197-72 (https://pubmed.ncbi.nlm.nih.gov/4744980/)
showed that physicians spend 38% of their time "charting" on paper.
That did not include the time spent calling on lab results, walking to
the Xray Dept to look at films, etc. So the time per visit that
physicians spend on documentation and information management probably
hasn't changed much. What's changed are (a) the clinicians are not in

control of the medium, and (b) they have to see more patients today (by a factor of 2+) than in the early 1970s. Oh, and a fire in the hospital in the 1980s destroyed all xrays and many paper records.
: @ – brilliant – #breadcrumbs for insurers! Only issue is I suspect prior auth is a form of cost shifting through annoyance/delay. If it becomes simple / automatic, will they find new ways to shift these costs?
: @Dr Cheung. Thank you for your excellent presentation. Would definitely be interested in how that longitudinal data that is collected is presented in the EHR, if it is.
: Dr. Nguyen – this is great work and should be very helpful. However, IMO – what would make this work even better… where you need PA, don't just say "You need PA" but why, as often the order could be subtly modified to obviate the need for PA. The current approach still follows (although DAVINCI makes in more efficient) the PA approach of "guess what I'm thinking." Remember, the most efficient prior auth is avoiding prior auth
: @Dr. Cheung likewise would be interested in hearing how you built that system.
: It will take leaders to help resolve the distrust between payers and providers in gaining these benefits.
: Reduction of clinician burden means adjudicating prior authorization without any documentation beyond patient care, as described in the DaVinci FHIR endpoint to FHIR endpoint model.
: As a practicing doc who stopped filling out PA forms and instead called the payer to find out why PA why necessary – I found (most examples with meds) that a slight change to a prescription often negated the need for PA
: Thank you Chuck and Viet
: FHIR has potential to resolve many of the administrative burdens in healthcare now.
: @ – my philosophy – collect data as necessary for *clinical* documentation in as structured and standardised way as we can make it whilst preserving usability – then allow any other module/system to access that data. Master vocabulary management and context management allows us to preserve the semantic content
: @ – There are already conversations around retrieving information at that first step and using that information to determine that PA is not required because the provider has already met the PA needs.
: @Dr Cheung – Thanks. Appreciate the insights.
: Capturing data in a structured way is unfortunately much more time consuming to do and way too much structured data ends up being garbage in/garbage out because the information you would have documented in free text doesn't have an accurate structured representation. So you pick something that seems closest.
: @ – our experience is that if you pare down the structure to what is manageable, and allow narrative to top up, it can work
: Yes! Governance!
: @ – good point. I was wondering if instead the 'fields' could be standardized but not the text content. So that the same field could be

watched over time, and compared. Agree that 'click boxes' doesn't inherently enhance usability
: @ — I firmly believe that the collaborative work between payers and providers has helped closed the trust gap. Doing the work under HL7 and its antitrust rules reminds everyone that we're doing work for the greater good.
: YES~
: Love Evidence-based and NOT Consensus-based! This is my mantra.
: @VietNguyenMD — I know, and thank you.. But what I am referring to are instances where PA is not met, but where a change in the order obviates the need for prior auth. For example, as an internist, I know very little about different mobility devices and attachments for them — so I might order what the patient requests. This order might specify arm or foot rests, or components where one piece of the order makes the entirety of the order not covered, except with an extensive prior auth. And because I don't have the payer rules available, I don't know what the trigger is… So I either have to bring the patient back and go thru the multiple page PA form, or I "probe" payer rules by resubmitting the order with modifications — until it goes thru. That's what I mean by "guess what I'm thinking." Using FHIR to speed up "guess what I'm thinking" is an incremental win, but aiming for eliminating the game of "guess what I'm thinking" should be the goal
: @ Absolutely!
: @, there are software tools available to make capture of structured documentation actually very easy and fast. They can be integrated to the EHR for best-practice workflow and evidence based documentation
: @ +1
: @ +2
: @ — Agree 100%.
: @WmDanRoberts this is really impressive. Trying to coordinate the units within ONE hospital is difficult let around hundreds!
: @ can you be more specific? My experience has been that things like intermediate vocabularies actually clutters up the chart without adding accuracy.
: +1 @
: @VietNguyenMD — thank you. And please don't misinterpret my comment as negative to your excellent work. What you are doing is very valuable and will help to move us towards greater efficiency. I was just suggesting that at some point (and with the willingness of payers — which will be the major challenge) we attempt to leverage FHIR to go to this next step
: Dr Roberts — say something about the amount of these data that are shared w/ other care givers in HCA? Can MDs add data to nursing documentation?
: Yes Laura, are you looking for nursing, physician or both?
: Yes!!! @Natasha
: Embracing the bold!! Yes!! @Natasha
: Ditto @
: @ — Interested in your thoughts on this. I observe that much of clinician and nursing notes, and particularly inpatient consultants,

therapy teams (in the post acute setting), are referencing what others have said at their own most recent visit. All of this aligns with what @Natasha just noted.
: Is it trusting the patient data or normalizing across platforms?
: @ Both
: Either. just as another example, we have 3 separate fields that describe the patient disposition in differing levels of detail but in a structured format. concordance on things as basic as whether the patient was admitted or went home is only about 60%
: Clinician should be creating KNOWLEDGE, not data. We should use other mechanisms for inputing data into our systems.
: @ – + 1
: Smart EHR2.0 and Smart PHR2.0 – opportunities for #CoProduction
: Sorry…. Clinicians, not clinician
: +1
: +2
: +3 !
: +4
: NT, do you see FHIR adding value to HK, or are we solving the wrong problem?
: What if EHRs were designed for knowledge creation?
: We need FHIR to share interpretive knowledge as well… And as a clinician – it is what I still find most often missing when "data" is made fluid – interpretation, thinking, etc.
: You're welcome. The application integrates with your core EHR, so it's a plug in, not a replacement. We can plug in to Cerner, no problem
: When we get to the point that patient self-entered data replaces some of what today is clinician-entered, will documentation burden shift to patients or will our Patient Experience departments insist on only asking for only truly useful data to be entered by patients.
: Interesting question Bonnie? And not sure about answer
: @ – we had to create a lot of technology along FHIR-like lines ourselves. But I think having an global effort is only going to be a good thing
: Sadly, the main reason why documentation is so stressful and there is so much "pajama time" is to see more patients to support high MD salaries. And data has shown that the more money an MD makes, the unhappier they are with their profession. One approach to reducing documentation stress is to lower MD salaries. Sounds harsh, but (a) they'll make enough to get by, and (b) they will be happier. That said, it ain't likely to happen. So another approach, esp. in primary care where there are not enough MDs, is to rely more heavily on APPs (NP, PA) for routine care and have MDs spend their time on more complicated patients needing more time –– and a greater use of their intellectual resources.
: I would think that the importance of much of that information is much higher to the patient. @Bonnie, that changes what is 'necessary' and 'useful'.
: Such an important question – a lot of our drivers of trying to

change documentation has been drivers of reducing burdens on 'creating documentation' very little underlying drivers addressing 'reading & understanding documentation'

: @ – you are on to a key concept. Clinicians hate EHRs because the EHR is now primarily framed as a vehicle for data input. We as clinicians are knowledge workers – our paradigm is backwards. The value of EHRs is in what they display and how they display it – which permits us to see data/information/knowledge in such ways that we can have "information-enabled" visits.

: With increased use of APPs, communication within the practice through effective documentation becomes even more necessary.

: Aren't these mitigations based on the formerly romanticized paper record? Wouldn't it make more sense to address the underlying problem, which is the documentation requirement in the first place? For example, for prior auth, shouldn't a plan wanting data just pull from the clinical record, rather than any clinician have to document for the plan according to rules defined by the plan as opposed to simply documenting the clinical aspects of the patient state and need?

: A healthcare provider who takes the time to write a well crafted note that other colleagues depend on is not rewarded by the system

: +1 . There is so much stress that comes with trying to FIND the information you need quickly. surfacing key data takes too long

: @ +++1

: @WMDanRoberts +1 – What is the data you need ,at the time you need it, and what is the best representation of the data that supports your decision making needs. SMART on FHIR and the growing list of FHIR-based data will help in making your visualizations real.

: We're about 8-10 minutes over right now. You may need to set up Stage 4 in 1-2 sentences.

: We are not seeing the slides advance!

: @ – APPs are an important part of a team based strategy. FWIW PCP salaries are largely stagnant when adjusted for inflation. Late Princeton Economist Ewe Rheinhardt did interesting wrk on physician salaries – high to attract talent vs. other areas, no tnecessariy reflecting absolute value. https://economix.blogs.nytimes.com/2008/11/14/do-doctors-salaries-drive-up-health-care-costs/

: Connecticut Children's did a similar project and we also saved 18 min per 12 hour shift!

: @ – what you describe is what we do with these FHIR IGs. Unfortunately, not all data needed for a PA is structured and/or available to via FHIR. We are continually increasing that data set via the USCDI.

: Patients will have very different understandings of "useful" or "important" information––different from each other and different from what clinician 1 or clinician 2 etc thinks is important. Talcott Parsons noted that the patient is supposed to have great wisdom in presenting his/her problem, and then be a docile child in listening to the doctor. A stunning role shift...that so often fails

: increasing numbers of our providers want all historical info that they need for their decisions and to have a one stop look at the

overview of a complex patient. it contributes to note bloat but it's easier than having to try to find prior info, even things that you know you documented yourself previously. it was much easier to quickly flip through a patient chart and find what you needed. I can electronically search 15+ years of old emails and usually find what I need pretty quickly but I can't search easily in the EMR and get a decent longitudinal med hx or easily find their last MRI results

: This work clearly takes time and resources. It's more tedious than most imagine. No one really wants to do it because it's not glamourous or sexy. Kudos to Bonnie and her team for slogging through the minutia to lead to some joy!

: @ — I would respectfully disagree. Pajama time (IMO) occurs for multiple reasons — and at the top of the list — either lack of familiarity with the EHR system in use (thus making even routine use take 2-3x longer), and regulatory documentation requirements — where key items are scribbled in during the visit, and notes are "backfilled" at night — to make sure that enough documentation bullets are entered to justify a billing code. This should decrease substantially for outpatient docs this year — assuming that docs document smartly.   And, to another point — documentation burden is also added to by inordinate time finding necessary historical information and timeline views — and this is something that vendors can help with

: there are definitely successful strategies to reduce pajama time

: @ — As an inpatient clinician, I now have patient's families telling me 'I like so & so's notes, more than 'a different clinician'. Such an interesting transparency. What would you make of this opportunity?

: for those on Epic, using the PEP reports is a fantastic starting point

: And I would recommend NEAT for IP Nursing as Bonnie used here (+process and governance as others have mentioned makes a big difference).

: PEP?

: Provider Efficiency Profile

: post exposure prophylaxis

: :)

: 😂 @trent

: Great point on EHR template construction. Flowsheets or forms that are not smart and just have empty fields can easily lend themselves to unnecessary documentation… particularly where there are lots of temps… easier to fill in all fields then ask — which items need documentation for what types of patients

: +! dan

: It is a crude tool though.

: And for the Ambulatory Providers — Use Signal

: We need financial tools to nudge larger health care systems to make the EMR a repository of just-in-time information that is effortlessly and immediately available to end users at the POC, esp in ambulatory. Right now the 3 main incentives for HCS's are access access access — these investments are not a priority.

: No health system should expect it's employees to work from home. Documentation is part of care and should all take place at work, after the visit/encounter, preferably before going onto the next outpatient and before going home at the end of a hospitalist's day. If that takes scheduling fewer patient visits per day to the MDs, so be it. MDs and all other clinicians should refuse to do "homework."
: Is it only me or does "Provider efficiency profile" make it feel like it is the clinician's fault if they take longer? Instead of relating to how the UI was designed?
: Brava Deb for that insight. Yes, the families etc reviewing the record/notes is another and very valuable part of getting to the truth. Alas, so seldom part of the "conversation"
: How impactful was that period of misalignment?
: PEP reports is a great dashboard metric that shows where the providers spend time in the system
: @subhaairan +1
: @subhaairan 1+ Too true
: It is reassuring to hear we are all having the same struggle and can still achieve wins for our nurses. I am also one of Patty's biggest fans :)
: @ – agreed about not expecting employees to work from home. However, sometimes pajama time is a choice. I would often (pre-EHR) take my charts home with me at night because I chose to do so – get home in time for dinner and time with kids before they went to bed – and then I chose to do my documentation afterwards. As my kids got older I stopped that practice and stayed at work to finish everything up first.
: Sorry to hear that interpretation @subhaairan. The tool primarily measures time in various parts of the chart with one metric being comparing across co-horts of physicians and departments. We certainly also that data to drive Really &D teams and UI design decisions.
: Do you use a third party evidence based for careplan and documentation
: Also, for employed docs, number of patients seen per day is not a choice.
: Continue to circle back to regulatory burden.
: Thanks @Bonnie – loved how you framed your remarks, scaling the closet much broader to include CMS, TCJ and vendor community
: @ Yes, it's a matter of how leadership interprets the data – can they localize the lesion?
: Brava Subha for noting that. So much easier to blame the clinician than to demand improvement to the UI
: I've never seen that type of tool to point blame. Data only.
: And opportunity for documentation improvement as well as workflow redesign
: Dr Koppel – Another great point on the importance of including the family perspective in all things. At present, gaining trust will be a different process when our thought process and decision-making style is so visible. I have been so fascinated hearing directly from families informally, and do wonder when feedback will be more formally

captured and rewarded.
: @ great to hear you are using to drive UI design as well
: for every new flowsheet added to nurses' workflow, nurses will spend
10.4% more time in Flowsheets!
: LOVE THIS !! Feedback
: great use of r/t feedback in the tool
: BPAs will have this feedback cycle built in going forward, out of
the box.
: User centered design is SOOOO important. At UCHealth, over a 6
month period Epic users were presented with 26,604,011 alerts, of
which 2,997,446 interrupted their workflow ("popped up"). Only 12%
had any action taken — 88% override rate.

: Would love to know the how to Build
: Yes! It is sad to see how starved people are to have someone listen
to their feedback and respond!
: We've also had good success with the feedback option
: Click Fatique
: @...my recent NEAT data reveals that nurses spent an average of
50—60 minutes in Flowsheet per shift
: Coveted!!!
: Per our NEAT data UCHealth inpatient nurses were spending 30% of a
12 h shift in the EHR when we got started. We've shaved that down a
bit and have more to do.
: Love the feedback idea. But it only works if the feedback seems to
be taken seriously. Not EHR per se, but Pubmed added a feedback option
with their new version, but when they ignore the feedback or deny that
there's a problem, it actually is more frustrating than not having
feedback at all.
: I've tried so hard to get clinician feedback about EHRs into the
process. I've offered software to make it instantaneous and
frictionless. But no one wants to deal with this. Yes, frustration
over the lost opportunity.
: Nice!
: The "3—D" Model (design, deploy, depart) is common in HCS EMR
initiatives. This tye of work to go back and iterate and "Stop doing
stupid stuff" is essential — bravo!
: Ross as you know we have had great experience with feedback.
Essential component s 1) easy to submit within the app 2) respond to
the user quickly to show you are listening and 3) LISTEN and make
changes when appropriate or help them if there is a reason to do it a
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: @Bonnie...helpful info. I'm on a journey to reduce the burden of
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: I love this Adam! Great job getting people engaged!
: great idea to reward the feedback and celebrate the improvements.
: @VietNguyenMD when you include an exception for unstructured data in
your response, that is an example of what I am focused on eliminated.
It should not matter whether the data is structured or not. It should
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: Great work Adam – in many ways. Best way to engage an angry clinician… listen, and respond back when they take the time to respond to you… Bravo
: @BonnieAdrian – yes, and especially how are the alerts designed – do they come in a meaningful place in the workflow? Are they actionable? Do they actually change behavior and do we fix them if they don't? This is hard and labor intensive work but it needs to be done. Starting with careful user centered design rather than out-of-the-box can help...
: I loved the click buster trophy!
: the EHR was designed for billing, regulation, not clinical care.
: Subhaairan – YES! If documentation was reframed as the output of clinical thinking – then documentation burden is viewed differently… Its more than click burden, its information retrieval and presentation, and supporting that thought process. I am thinking what follows – improved diagnostic accuracy and timeliness
: +1
: @bonnie agree that CMS and TJC are a significant part of the problem. TJC consultants offer suggestions that leadership then thinks they need to adopt to avoid a citation, no matter how illogical the suggestions are. They also tell different organizations around the country different things, so its hard to know what is really essential. They also seem to think that a poorly done study constitutes "evidence" simply because a journal agreed to publish it. Not everything that's labeled "evidence-based" is essential and not everything that has value will have robust evidence (such as RCTs). Common sense is needed and that's what TJC and CMS seem to overlook.
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: CareAlign appears to be a highly valuable tool. Is it available in the public domain or is it limited to your institution?
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: @Bonnie and @ – 1+, also TJC applies inpatient requirements in ambulatory which can reach truly epic levels of absurdity. the MAC infrastructure drives the CMS interpretation problem
: @– completely agree. We have begun the arduous task of reviewing our top firing alerts, reassessing interruptions in workflow and eliminating those that are not changing behavior (users are frequently "dismissing" the alert)
: +2 @
: @ – hi . A friendly amendment to your thought… the EHR was

originally designed for research. For better or worse (I'll go with worse), a perfect storm developed in the mid-1990s, which created the first business case for EHRs for non computer scientists… that being an EHR that made it virtually impossible to fail and E/M audit. E/M – thus made mass sales possible – but also "poisoned the EHR." Recall back to those early days Larry… all EHRs that offered E/M support – but none offered CDS.
: Subha, Is this built like the IPASS handoff?
: @ not just early days with E&M>CDS!
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: @ – Maybe we're not using the same concepts related to Structured vs unstructured. We started with structured data because it's readily codifiable, identifiable and retrievable. FHIR can only retrieve what's available in the EHR and available via FHIR. Vendors I've worked with are also retrieving documents and using NLP and other technologies to extract the unstructured data. It's doable, but given the variety of ways clinicians document, the content of documents are inconsistent. I don't think we can, or should, go away from narrative data completely. I'd like to see us generate data as part of delivering care. Technologies like voice recognition and speech to text will help. Turning that to structured data will also help. We have an incomplete, but very useful solution with FHIR. Freeing the data via FHIR/SMART will also support innovations.
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14:54:13 From Laura : it's on a secure server
14:54:53 From Richard Schreiber : app (correct me if I'm wrong) is
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14:56:00 From Laura : my point is that EHRs need good built in handoff
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14:56:29 From David Newman (he,his) : While Ms. Palomino's talk is
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14:58:12 From Emily Barey, Epic : @ I think it is a good reminder of
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15:01:59 From Larry Ozeran : The volume of chat suggests to me that
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15:02:15 From David Newman (he,his) : I think that's what the
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15:02:20 From Mayfair : We will get an email with the survey