Goals
Short-term
Medium-term
Long-term

Stakeholders	
Providers/Health systems	PHS
Vendors	V
Policy/Advocacy	PA
Others	O

Table 1. 25 by 5 Breakout Session Output and Associated Action Items

		Five Key Themes												
		1. Accountability			2. Evidence is critical			3. Education & Training				4. Innovation of technology		5. Other
		Implementing mechanisms to assure collaboration between systems and structures	*Ensure roles are clear*	*Facilitate cohesive understanding of requirements among agencies and stakeholders*	*Evidence-based practice should inform changes*	*Generation of evidence and approaches that decrease burden*	*Clinician input matters most*	*Develop and disseminate optimal documentation requirements that meet the standards*	*Train on brevity and clarity for new clinicians*	*Prioritize quality over quantity*	*Incentivize training*	*Integrate advanced technological features*	*Increase interoperability*	
Six Domains of Burden	**1. Reimbursement**					Urge the NIH (NLM, PCORI), AHRQ, & ONCHIT to fund research that will capture all coding information (E&M and CPT coding) accurately but indirectly (e.g., by means that do not engage the clinicians delivering care services (PA)						Implement nationally the 'remote' payment & reimbursement technology whichever strategy prevails. (PA) Eliminate system entirely by automating all coding through 'hands-off' data collection & AI coding (PHS/V)		
	2. Regulatory	Regulatory/Accrediting agencies to establish federal common ground (PA)	Regulatory/Accrediting agencies process planning to follow-up among regulators after potential items for de-implementation identified; shared accountability among regulatory/accrediting agencies for de-implementation of regulations (PHS/PA)	Regulatory/Accrediting agencies to establish a working group to identify and prioritize the tenets that regulations should consider from medical care perspective (PHS/PA)	Regulatory/Accrediting agencies to perform curation that will thin out requirements to meet criteria that are based on evidence, value, and safety; specific areas to prioritize: A more focused approach to adverse events (better than a litany of corrective actions), outcomes need to be evaluated and reassessed; revisit care plans and behavioral health treatment plans: their use, purpose, and value (PHS/PA)			Professional organizations to embark on myth busting campaigns (PHS)						
		Regulatory/Accrediting agencies curation to de-duplicate requirements from different organizations and identify variations across states. Review regulations for myths and outdatedness (PHS/PA)		Regulatory/Accrediting agencies to identify a single governance body to establish evidence and a single source of truth. Plan for engaging stakeholders and lobbying (PA) Regulatory/Accrediting agencies process planning will dedicate personnel; a single source of truth could be organized by domain; shadowing and collecting evidence on pain points (PA) Regulatory/Accrediting agencies and healthcare organizations to partner for communication clarity: Healthcare organizations partner with regulatory/accrediting agencies to sit down and understand requirements and hear their perspective and get direction for how to implement them; set up communication channels with healthcare organizations' compliance officers (PA/PHS) Regulatory/Accrediting agencies curation will engage accreditors to look at quality rather than quantity of elements; establish updated and standardized regulatory framework; stakeholder engagement and ongoing analysis (PA)									

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Six Domains of Burden	**3. Quality**	Federal government will reach out to professional organizations/bodies to begin to plan how they can play a greater role in informing and approving quality measures (PA)	Federal policy will allow for professional organizations/bodies to play a greater role in informing and approving quality measures (PA)	Federal and health system policy will allow for a standard of care (i.e.,checklists) that does not require documentation (PA) Government policy will include a description of the additional value extra documentation will provide. (e.g., does the quality metric help to describe the patient's story?) (PA)	Federal policy will allow for quality measures to be automatically collected from real-time data (PA) Government mandate will encourage payers to focus on evidence-based measures ("that matter") (PA)	Federal policy will allow for benefits to clinicians to be measured and presented after entering quality metric (PA)						Federal policy allows voice/text to drive decision support and quality metrics (PA)	Government allows patient entered information to be a part of the chart for providers to view (PA) Vendors to implement patient-reported outcomes accessibility at point of care (V) Vendors to implement fully operational external data (V)	
	4. Usability	Executive decision-makers, trainers, learners to build "simulation centers" for both training and research purposes to evaluate documentation reduction effectiveness (PHS) All to learn from cumulative training experience- evaluate, redesign, implement and act on an ongoing basis (PHS/V)	Executive decision-makers and trainers will facilitate accountability between those who authorize training and those who organize training- discontinue counterproductive measures including training that contributes to the problem (PHS)		Healthcare organizations will review regulatory documentation, EHR implementation, and best practices for utility (PHS) Regulatory and accrediting agencies will update regulatory policy to prioritize usability in vendor products (PA)	Healthcare organizations will promote a culture of continual change and innovation (PHS) Professional societies and philanthropic organizations to share and disseminate toolkits for best practices (e.g. PEW Trust recommendations) (PHS/PA)	EHR vendors to improve their responsiveness to user suggestions/complaints; amplify the voice of the users; improved transparency with user feedback/problems (V) Regulatory agencies increase monitoring and research on user design (PA)	Trainers to package best practices into tool kits to facilitate deployment and instructions for training teams (V) Executive decision-makers, trainers, learners to change training mindset from technical training on a system to training around optimal processes enabled by the system (PHS) Executive decision-makers, trainers, and learners to cultivate training as an ongoing trusted relationship using mixed methods such as peer-to-peer and/or a smart autonomous agent (PHS)	Trainers will organize training by clearly specifying levels (basic, intermediate, & advanced) (PHS)	Trainers and health system continuing professional development departments to customize and personalize appropriate training to career stage with more focus on best practices recognize continuing professional development (PHS) Executive decision-makers and trainers to use protective time to simulate training in "documentation reduction" by involving clinicians in the design, testing, and evaluation of the efficacy of the training technique (i.e. simulation) as an intervention (PHS)	Professional societies and philanthropic organizations to incentivize training by creating various award types to create reproducible models and cases (e.g. Davies Award/Baldridge) (PHS/PA) Trainers and health system CPD departments to offer CME, CNE, CPE, and other relevant forms of continuing education to recognize continuing professional development (PHS) Professional societies and philanthropic organizations to develop approaches and build a mechanism and process to establish award & identify awarding organizations (PHS/PA) Health systems, professional societies, philanthropic organizations, vendors, and learners to execute award programs and publicize exemplars to generate individual/team recognition and visibility around success stories (PHS/PA/V) Government, health systems, professional societies, philanthropic organizations to develop and nurture streams of training/research funding in federal, philanthropic, industry sectors (PHS/PA)	EHR vendors to create a simplistic view to see new patient data has been reviewed (i.e., bookmarked for the user, and documented as seen by the user in the EHR) (V) Healthcare organizations to expect and support real-time information retrieval, documentation, and ordering whenever possible (PHS) Healthcare organizations to provide device options-one size doesn't fit all; variety is important based on the user's role and task (PHS) Industry to create tools and examples to promote workflow revisioning (V) Industry to develop better and more affordable voice recognition integration into workflow (V) Thought leaders will consider different devices for information collection and documentation (PHS/V) Vendors and industry develop more flexible interfaces that are workflow tailored (V) EHR vendors to implement personalized clinical decision support using AI/heuristics to drive user-specific workflows and recommendations (V) Clinical subject matter experts and thought leaders will discover new ways to exchange patients in portal usage (PHS) Regulatory and accrediting agencies hold vendors accountable for developing usable tools that can be locally customized and optimized (PA)	Industry to promote ecosystem with options for complementary technology beyond single EHR vendor (V) Healthcare organizations to implement interdisciplinary notes/team-based documentation (PHS)	Vendors and clinical subject matter experts will improve user resources such as workflow-centric assistance and shared knowledge databases (V/PHS)

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Six Domains of Burden	**5. Interoperability**	Regulatory agencies to require functional standards for content and re-use 1) Unique Patient Safety Identifie; 2) Data provenance (PA) Regulatory agencies to require integration of Patient-Generated Healthcare Data (PGHD), inclusive of caregiver generated data from patient portals with data provenance into the EHR (PA)		Regulatory agencies will eliminate the need for redocumentation of data that is already "FAIR" in the EHR (PA) (e.g., allow a pointer to source information when the data are "FAIR" in the EHR – meaning the data should be easy to get to be-Findable, Accessible, Interoperable, Reusable (FAIR principles))									Vendors to create the capability to (decompose) CCDA for granular reuse of data points (V)	
	6. Self-imposed	Healthcare organizations s will educate stakeholders on the standard of care and impact on clinical staff (PHS)	Healthcare organizations will establish governance for enforcing principles established around adding documentation to EHR (to level the load of documentation- i.e., add one, remove one philosophy) (PHS)	Healthcare organizationss will determine compliance rates for priority areas (PHS)	Clinician experts at healthcare organizations will review regulatory requirements before making documentation requirement changes and removing existing requirements. (PHS)	Healthcare organizations/Informaticians will generate evidence for reduced documentation and impact on risk/compliance and removing documentation that isn't positively impactful (PHS)	Healthcare organizations will revise alerts to decrease fatigue (PHS)	Healtcare organizations to establish governance to restrict new required info in notes unless we're taking away something else. (PHS)	Universities and healthcare organizations to train brevity in addition to completeness (PHS/PA)	Healthcare organizations to appoint super users to encourage peer reinforcement (peer review); leave data in their separate homes (doesn't need to be brought into note); cite labs reviewed instead of pulling in (PHS)	Healthcare organizations to appoint super users to encourage peer reinforcement (peer review); leave data in their separate homes (don't need to be brought into note); cite labs reviewed instead of pulling in (PHS)	Vendors/Researchers/Subject matter experts to develop a metric that automatically grades notes on length/efficiency/redundancy; can utilize AI algorithm and schedules training; automated benchmarking/analysis of documentation trend, individual & department level (V/O)	Healthcare organizations to implement/reinforce team-based charting to establish coherent patient story and reduce duplicated efforts (PHS)	Healthcare organizations to appoint Medical Executive Leadership tasked with promoting healthy documentation (i.e.,an advocate on behalf of note readers may be a.k.a chief wellness officer) (PHS)
			Healthcare organizations will determine standards of care (inpatient) (PHS)	Documentation burden committee will create working group on documentation reduction to establish standards with regards to documentation for compliance (ALL)		Subject matter experts work with national groups to define documentation standards and publish policy to decrease content in notes (PA/PHS)	Healthcare organizations to appoint clinical experts/leads to interpret and review all regulations before making doc changes; clinical expert representation for providers and nurses to evaluate the appropriate solutions that can support documentation in a load-leveling way; account for inpatient and outpatient settings (PHS)	Healthcare organizations to sequester the compliance portions into a separate section such that it doesn't contribute to note bloat (PHS)		Governance: job description for clinical expert; review note template contents and length; formalize feature set on minimum amount of content necessary for purpose of note component (PHS)			
				Healthcare organizations will establish guiding principles for adding documentation to EHR with multidisciplinary collaboration led by clinician experts (PHS)				Subject matter experts to facilitate curriculum development, lectures, study results; consider funding for such an effort (PHS/PA)						
				Healthcare organizations will change billing practices so they don't rely on MDs for coding (PHS)				Subject matter experts to develop and host national roadshow; directed towards professional clinicians & clinicians in training (PHS/PA)						