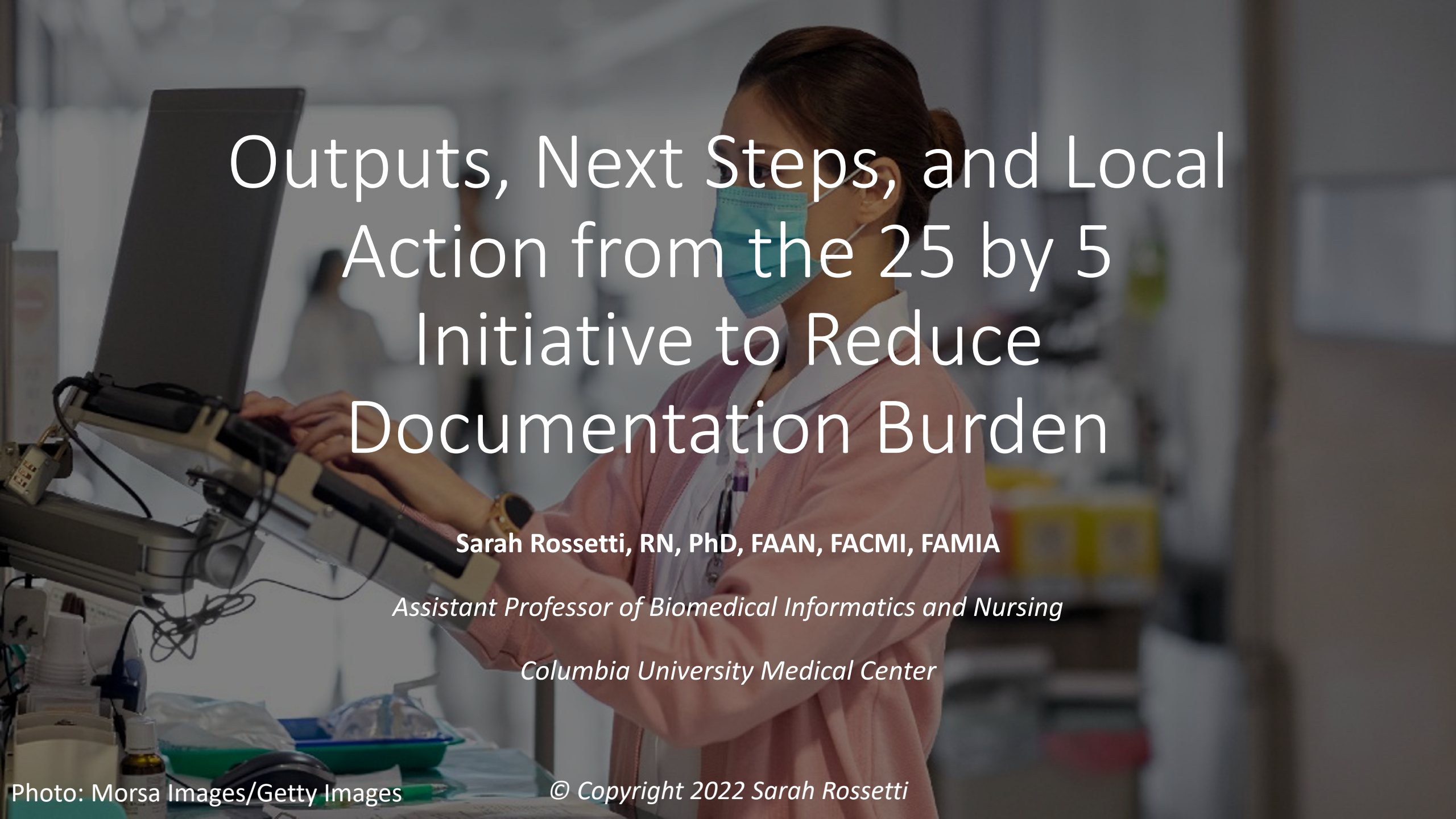


# Outputs, Next Steps, and Local Action from the 25 by 5 Initiative to Reduce Documentation Burden

**Sarah Rossetti, RN, PhD, FAAN, FACMI, FAMIA**

*Assistant Professor of Biomedical Informatics and Nursing*

*Columbia University Medical Center*

Photo: Morsa Images/Getty Images

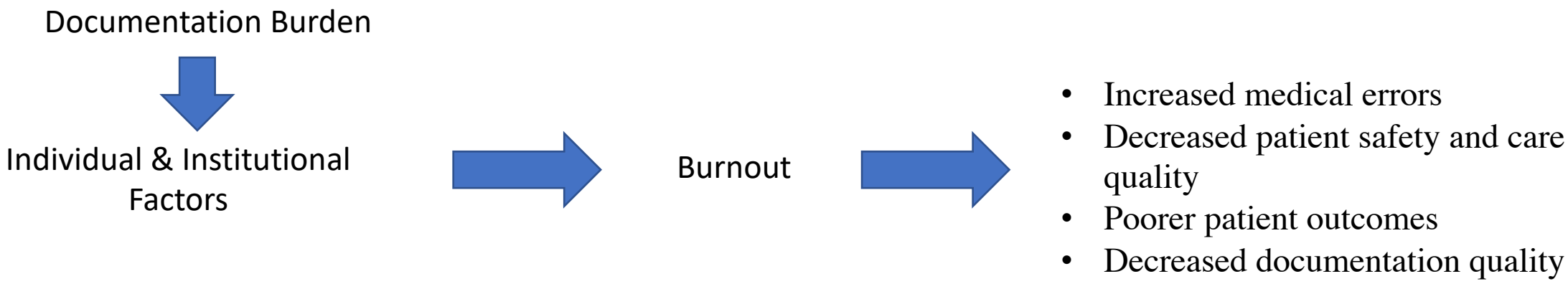
# Clinician Wellness

*35-54% of nurses and physicians experience substantial symptoms of burnout*

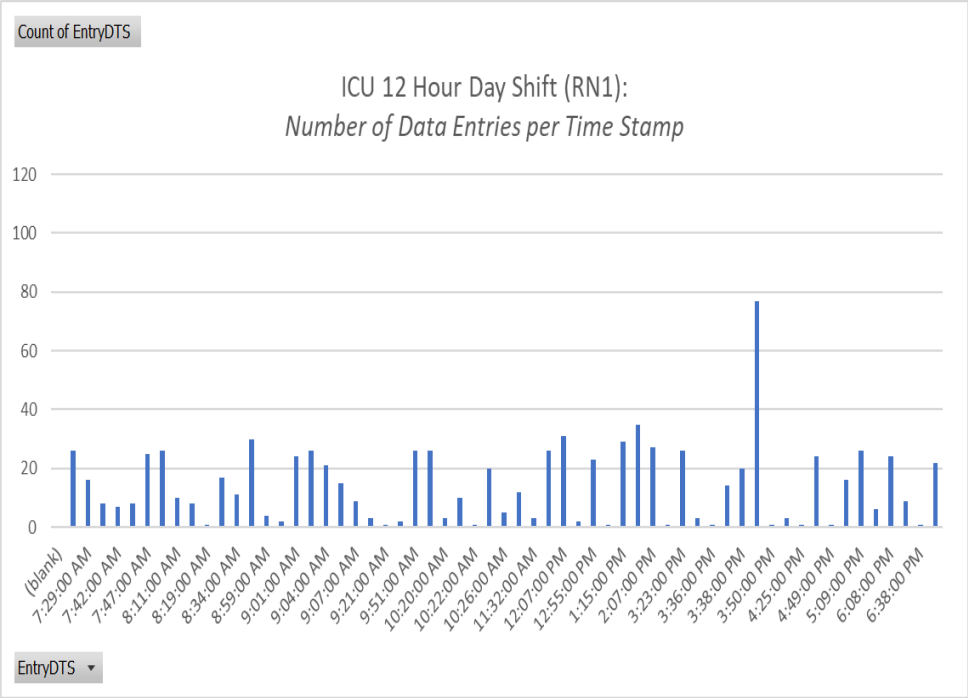
*Clinicians experienced trauma and burnout specific to COVID-19 on top of existing large scale system pressures and alarming stress levels among the health care workforce*

https://nam.edu/initiatives/clinician-resilience-and-well-being/

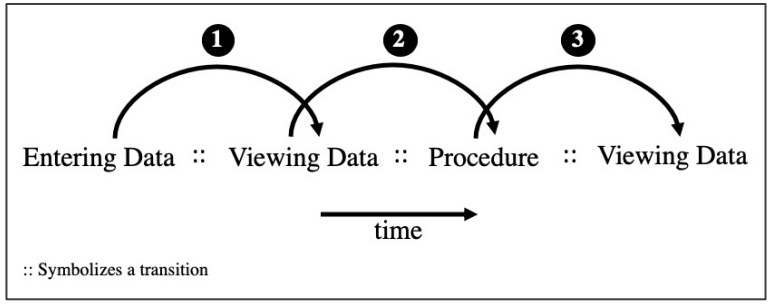
*Nurses are divided between a positive view of documentation as something essential, and a negative one of it being a meaningless burden that distracts nurses from their 'real' work, contradicts their professional identity, and does not benefit the patient*[1]



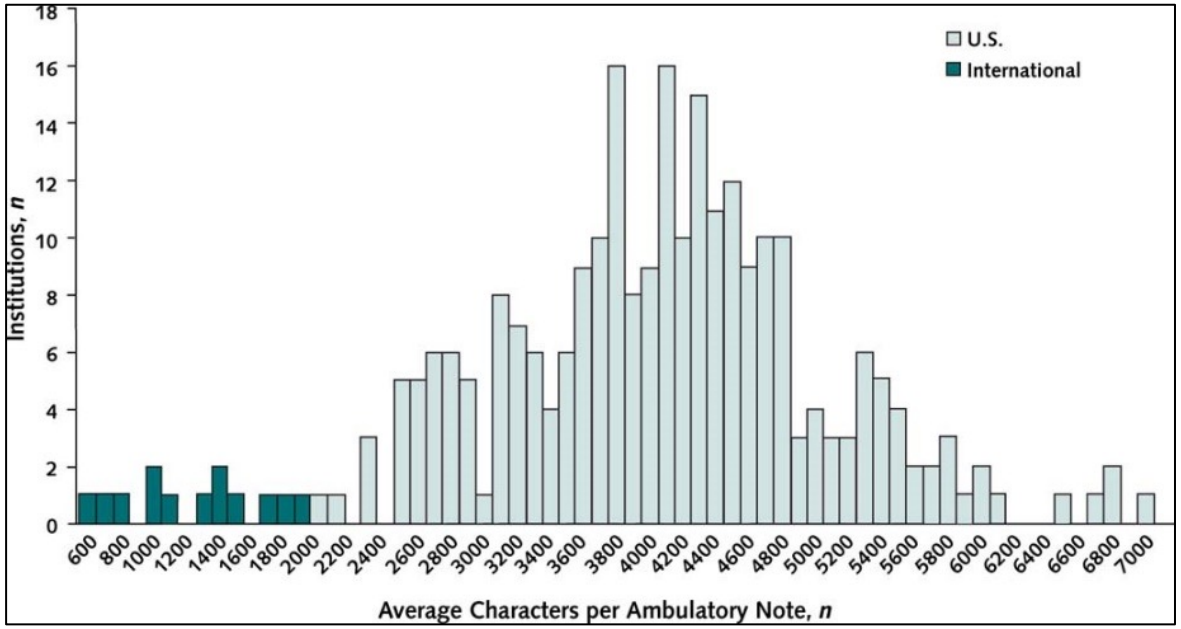

[1]Olivares Bøgeskov B, Grimshaw-Aagaard SLS. Essential task or meaningless burden? Nurses' perceptions of the value of documentation. Nord J Nurs Res. 2019



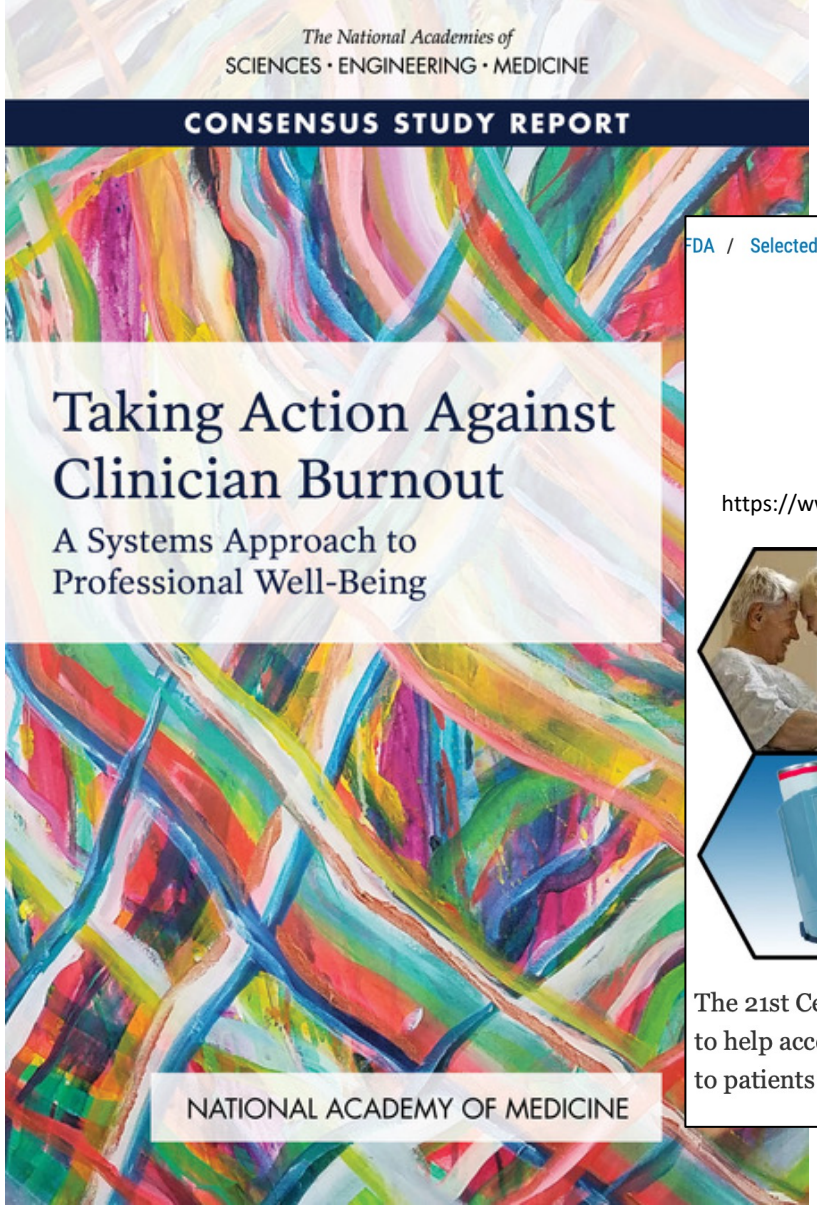

1 data point manually entered about every minute on average
(Collins et al, AMIA 2018)




1.5 switches / minute on average
(Moy et al., AMIA 2020)



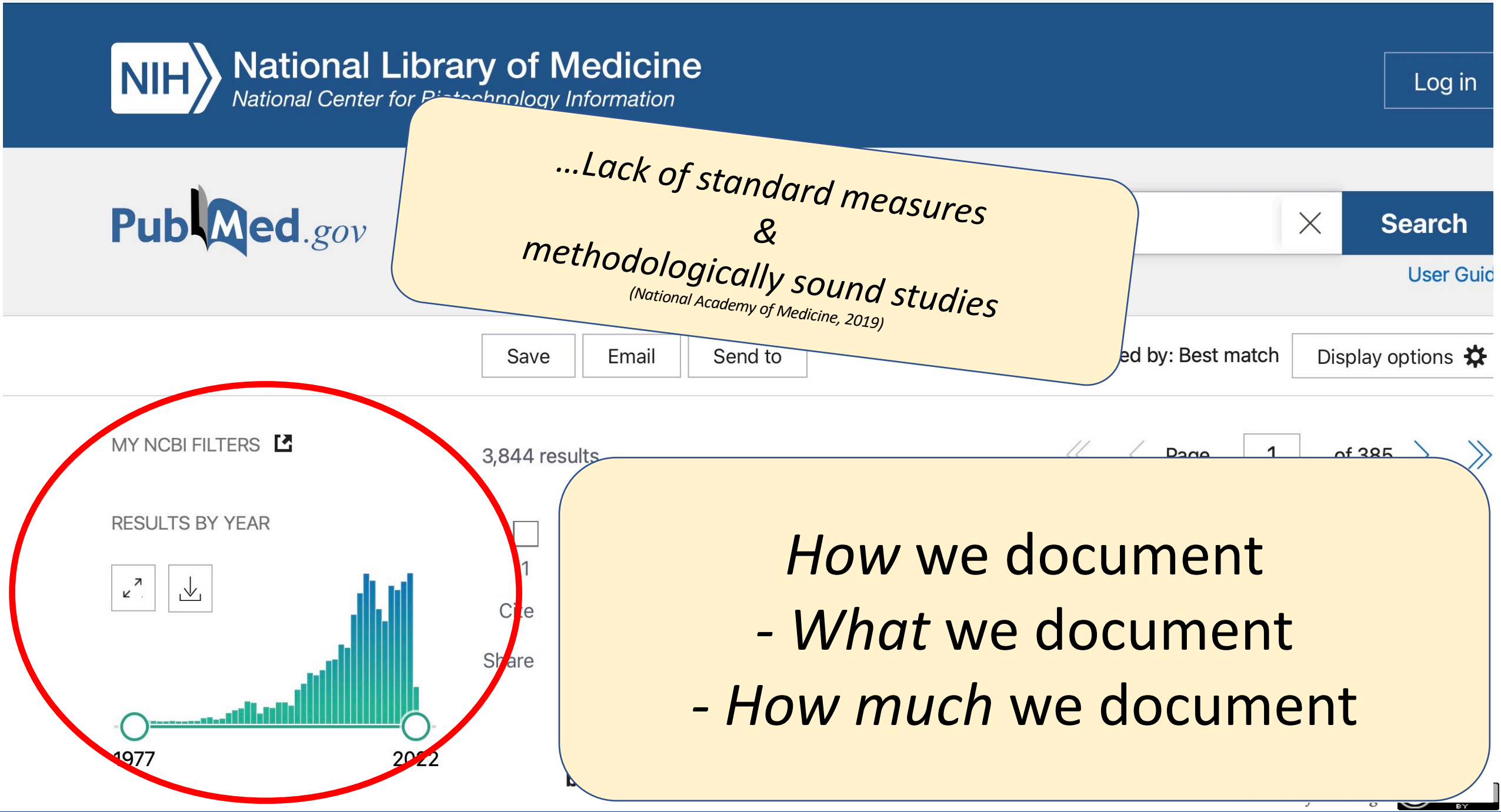

MD notes in U.S., on average, 4x longer than other developed countries
*(Downing, et al. 2018)*




*Reduce requirements and adopt approaches that incorporate human-centered design, human factors and systems engineering and that also are technology-enabled*


*Congress directed the Department of Health and Human Services (HHS) to establish a goal, develop a strategy, and provide recommendations to reduce EHR-related burdens that affect care delivery.*


*Collaborative effort between ONC and CMS. Targets burdens tied to regulatory and administrative requirements that HHS can directly impact through the rulemaking process*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methodologically sound studies
(National Academy of Medicine, 2019)
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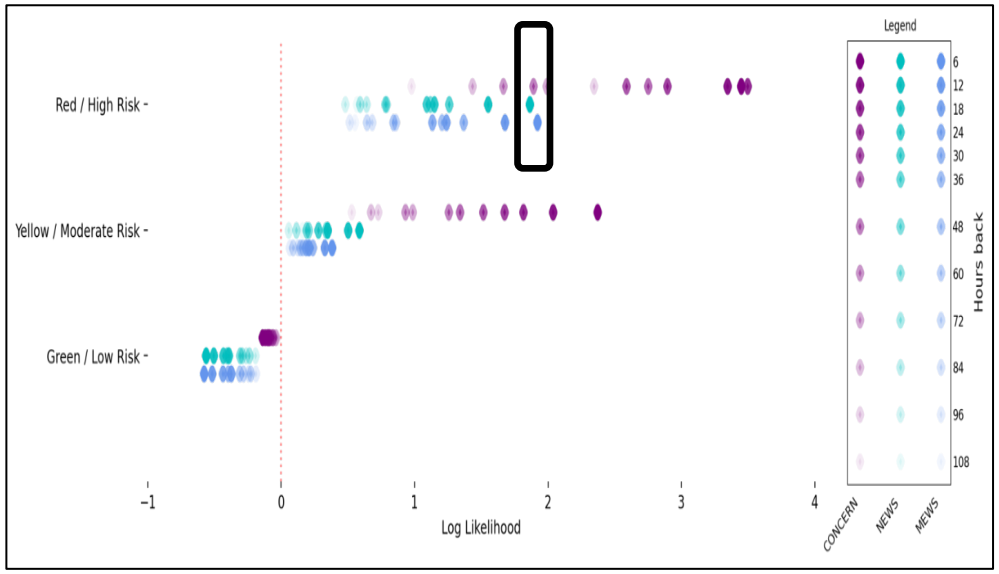
MY NCBI FILTERS
RESULTS BY YEAR
1977
2022
3,844 results
Page
1
of 385
Cite
Share
How we document
- What we document
- How much we document

# EHR Configurations & Opportunity Costs

- EHR configurations => implicit decision architectures that drive clinicians' behavior
  - Overtime data fields are added, but rarely removed
- Opportunity costs of using clinical time for data entry versus knowledge generating activities and direct patient care
  - Nurses spend extra effort and time and workarounds in order to "tell the patients story"

*ROI for optimizing the EHR for nurses?*

# Nurse as Expert:
# Signal & Opportunity in “Optional” Documentation




*CONCERN Predictive Model…*

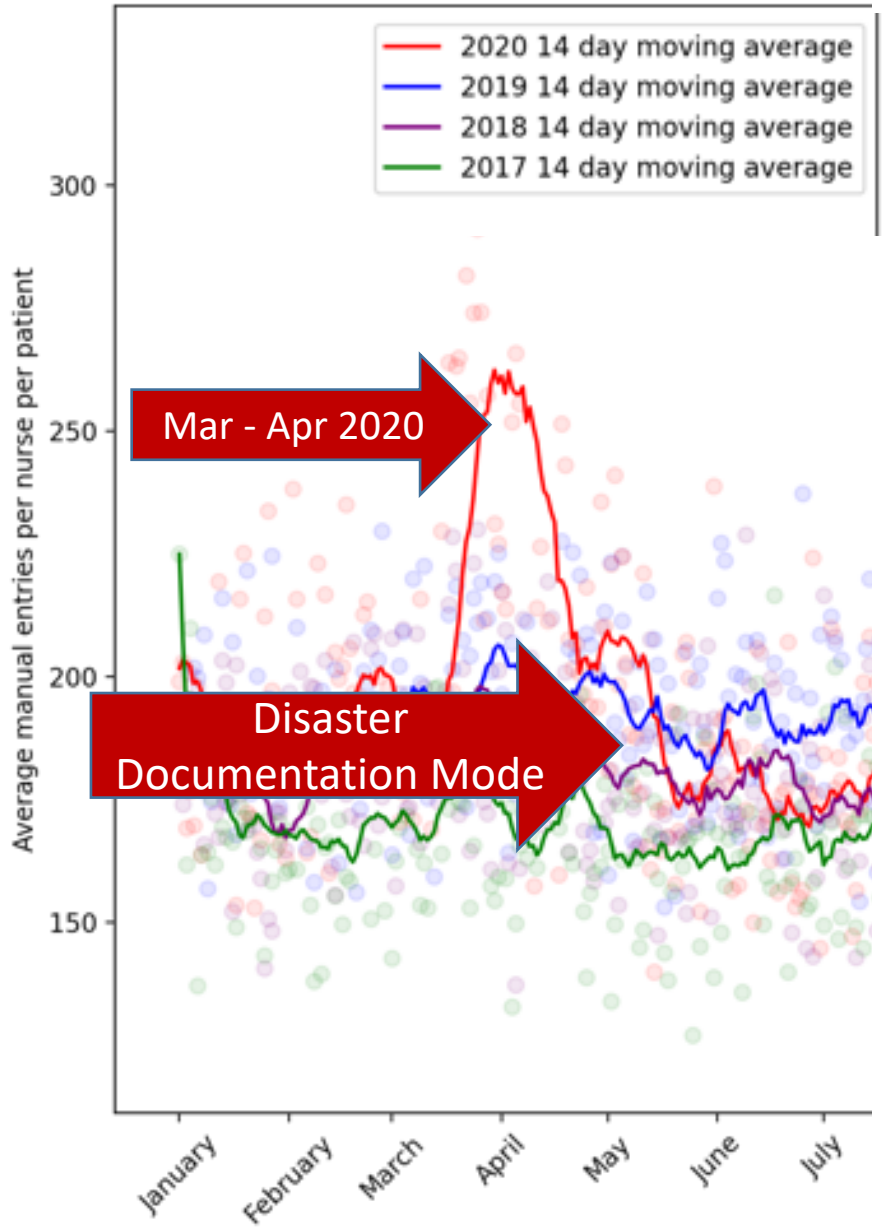
*…able to predict high risk patients 42 hours earlier than MEWS or NEWS early warning scores*

The act of documenting a free-text comment or other optional data in a flowsheet row

Information that the nurse likely determined an event or observation was clinically significant enough to record

*Do nurses increase their documentation (and presumably increase patient surveillance activities) due to a patient state in the absence of requirements?*

- Would expect lower than prior years since intent of “disaster documentation” mode is to decrease documentation burden
- As nurses encountered COVID-19 patients did they increase their documentation rates due to clinical concern or uncertainty?
  - We found no correlation between documentation rates and acuity




Acute Care Units Day Shift Manual Entries Per Nurse Per Patient

# *Implications for how to address the problem of documentation burden*

- Reduction of requirements and data elements within the EHR insufficient
- Need innovative modalities to better support nurses' data capture
- Nurses' *decisions* related to documentation require further investigation
  - Self-imposed documentation burden is a product of organizational culture[1]

1. Sengstack PP, Adrian B, David R-B, Boyd L, Davis A, Hook M, et al. The Six Domains of Burden: A Conceptual Framework to Address the Burden of Documentation in the Electronic Health Record Position Paper of the American Nursing Informatics Association Board of Directors [Internet]. [cited 2021 Mar 10]. Available from: https://www.ache.org/-/media/ache/about-ache/corporate-partners/the-six-domains-of-burden_cerner-documentation.pdf

# Could we shift our approach to documentation?

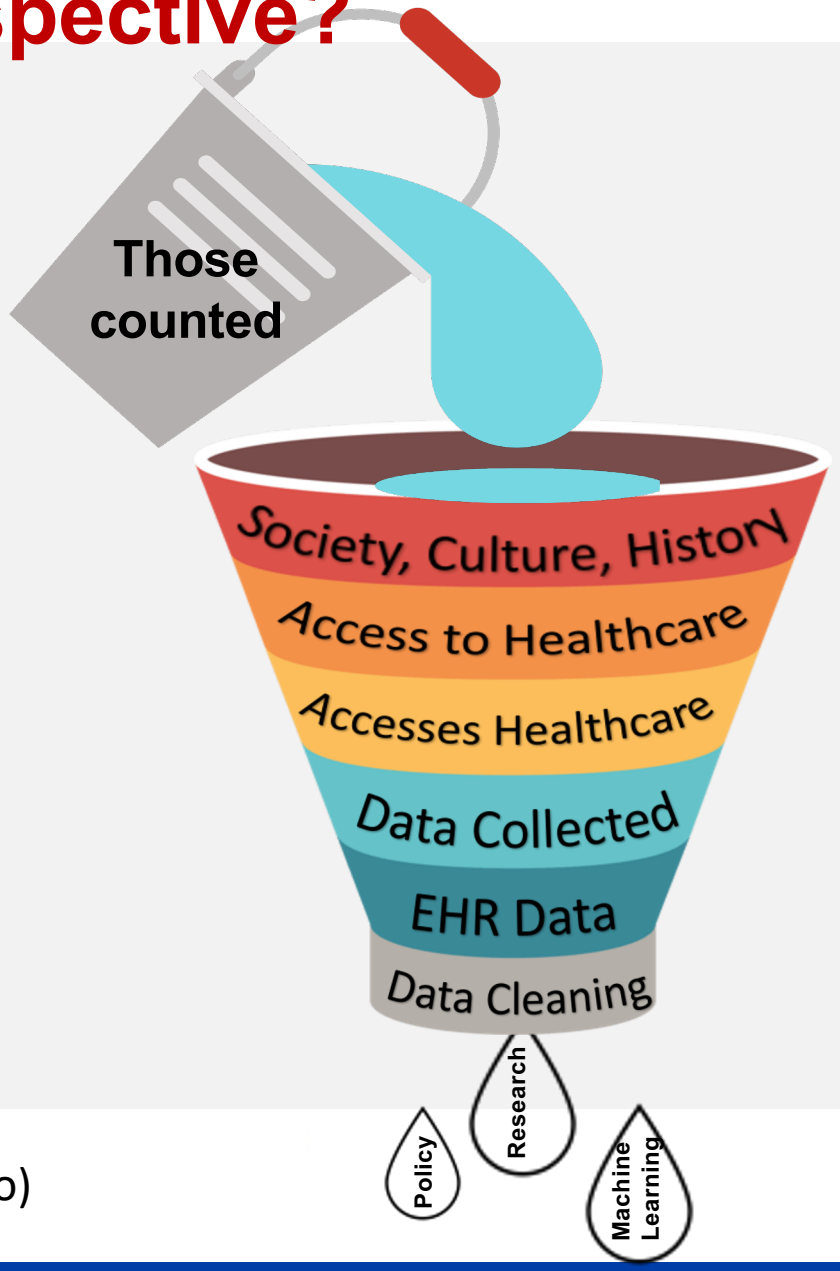
**Recognize nurse as expert**

**Reduced requirements may allow…**

- Nurses to practice at top of license
- Generation of patient story to emerge
- Leverage nurse observational skills as valuable signals of patient states
- Elevate clinical decision support for nurses
  - Goal of improved patient outcomes *not* improved nurse documentation/adherence to requirements
  - Tailored and dynamic based on patient *and* nurse characteristics
    - Novice vs expert

# How different would the documentation be if it were written from the patient's perspective?

- Who defines the goals of documentation process? (e.g., regulatory requirements)
- Information is filtered through systems and processes
- Downstream data is biased
- Effect of data collection on analysis






(slide borrowed with permission from Kenrick Cato)

*Many burdens are multi-factorial therefore solutions must be too…require more than just government action*

- HHS, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020

# Potential Partners















# The Six Domains of Burden: A Conceptual Framework to Address the Burden of Documentation in the Electronic Health Record

## Position Paper of the American Nursing Informatics Association Board of Directors

American Nursing Informatics Association

ANIA

Where caring and technology meet



Sengstack PP, Adrian B, David R-B, Boyd L, Davis A, Hook M, et al.

The Six Domains of Burden: A Conceptual Framework to Address the Burden of Documentation in the Electronic Health Record Position Paper of the American Nursing Informatics Association Board of Directors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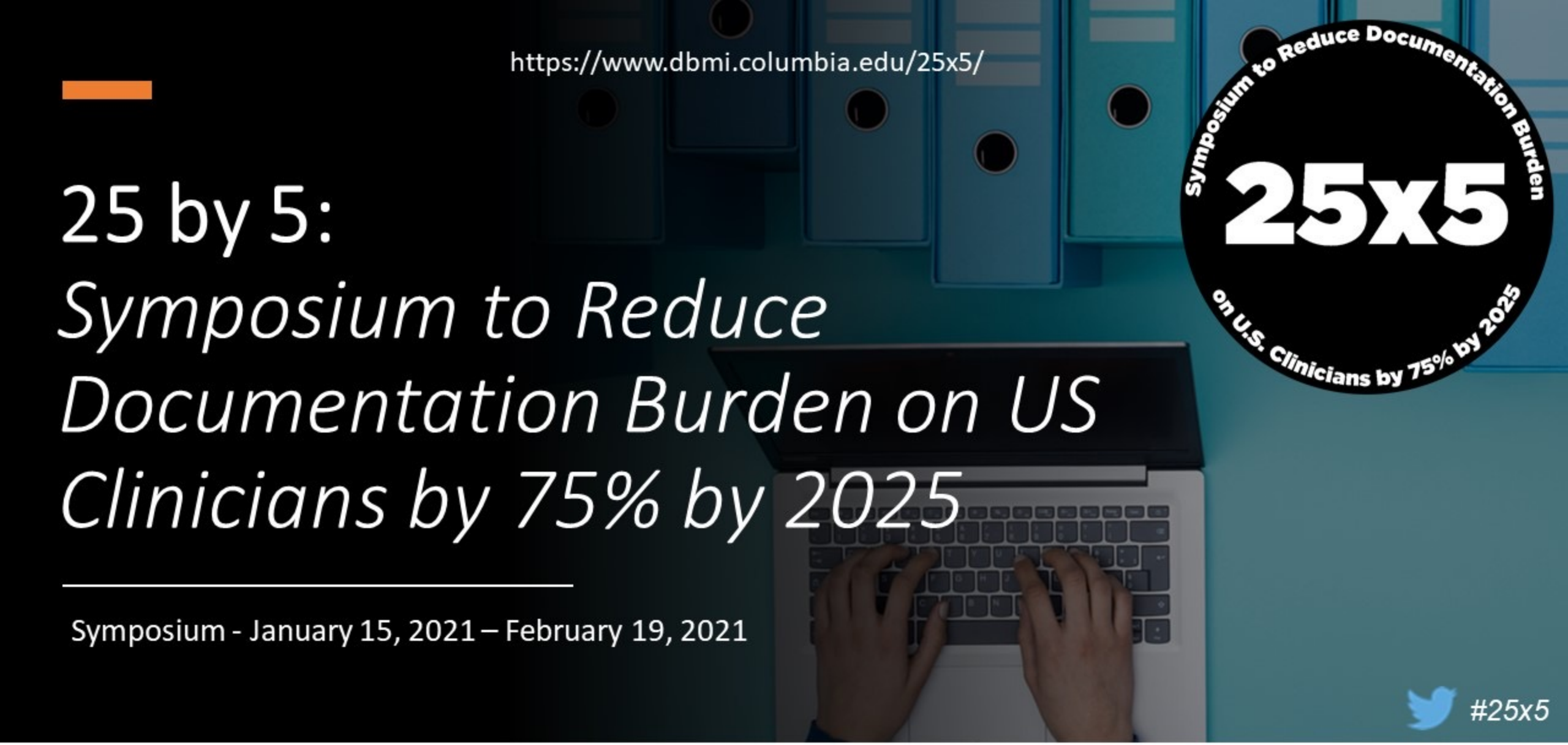
https://www.dbmi.columbia.edu/25x5/

# 25 by 5: *Symposium to Reduce Documentation Burden on US Clinicians by 75% by 2025*

Symposium - January 15, 2021 – February 19, 2021

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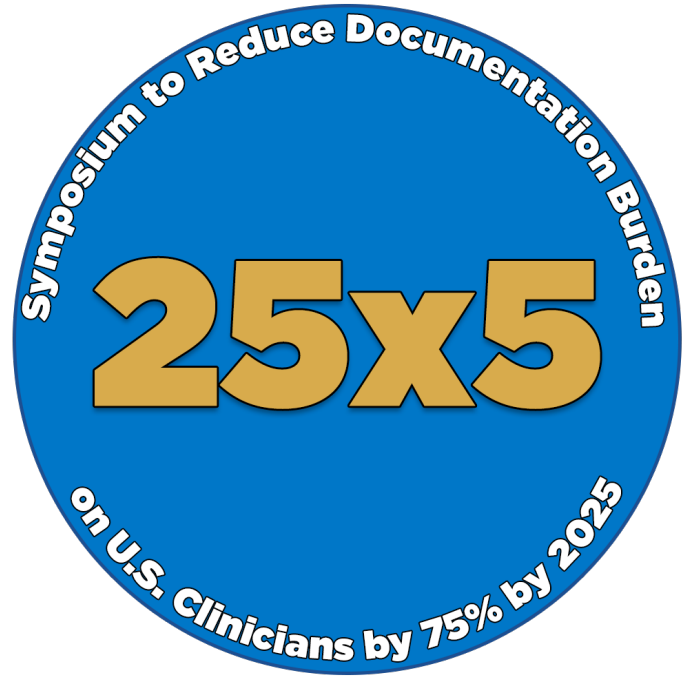
# Symposium Committee

Co-Chairs

- **Sarah Collins Rossetti, RN, PhD, FACMI, FAMIA** Assistant Professor of Biomedical Informatics and Nursing, Columbia University
- **S. Trent Rosenbloom, MD, MPH, FACMI** Vice Chair of Faculty Affairs & Associate Professor, Departments of Biomedical Informatics, Internal Medicine & Pediatrics, Vanderbilt University

Steering Committee Members

- **Don Detmer, MD, FACMI** Professor of Medical Education, Dept. Public Health Sciences, University of Virginia School of Medicine
- **Kevin Johnson MD, MS, FAAP, FACMI** Professor and Chair of Biomedical Informatics, Vanderbilt University
- **Kenrick Cato, RN, PhD, FAAN** Assistant Professor of Nursing, Columbia University
- **Dasha Cohen** Director of Meetings, AMIA
- **Jeff Williamson M.Ed.** Vice President of Education and Academic Affairs, AMIA
- **Judy Murphy, RN, FACMI, LFHIMSS, FAAN** Previous IBM CNO and ONC Deputy National Coordinator for Programs and Policy
- **Amanda Moy, MPH** National Library of Medicine Pre-doctoral Trainee, Columbia University
- **Jessica Schwartz, RN, BSN** National Institute of Nursing Research Pre-doctoral Trainee, Columbia University
- **Eugene Lucas, MD** Internal Medicine Physician, Clinical Informatics Fellow, Columbia University
- **Mollie Hobensack, RN, BSN** PhD Student, National Institute of Nursing Research Predoctoral Trainee, Columbia University School of Nursing
- **Rachel Y. Lee, RN, PhD** Postdoctoral Research Fellow, National Institute of Nursing Research Postdoctoral Trainee, Columbia University School of Nursing
- **Jennifer B. Withall, RN, PhD** Postdoctoral Research Fellow, National Institute of Nursing Research Postdoctoral Trainee, Columbia University School of Nursing
- **Craig Sachson** Associate Director of Cross Campus Communication and Collaboration, Columbia University




*Funded by the National Library of Medicine*
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# Symposium Goals

- Create a meeting that engages a diverse group of key stakeholders and leaders focused on reducing documentation burden
- Assess the likely potential for burden reduction within each category of documentation burden tasks
- Establish approaches for immediate (6 months), short-term (12 months), and longer term (30 months) elimination of clinical documentation burden
- Develop a 25x5 Community of stakeholders and allies to keep momentum going and to support dissemination and change
- Maximize techquity* of any proposed solutions

*defined as the consideration, design, development, and implementation of technology solutions that promote, assure and potentially enhance health equity

# Principles of Engagement

- Leverage technology and existing data inputs where appropriate (e.g., reduce re-documentation of items already captured during other intake processes)
- No erosion of care standards (e.g., quality, safety, value, efficiency, access, etc.)
- Maximize clarity of proposed rules to minimize misinterpretation by health systems and providers
- No wholesale shifting of work from one clinician to another clinician: seek to eliminate unnecessary documentation all together

# Symposium's Agenda

**Jan 15, 2021**

**Session 1: Introduction & Current Challenges Related to *What* We Document**

- *Keynote Panel + QA: Policy and Reimbursement Issues*
- *Keynote Panel: Clinical Practice and Documentation Issues*
- *Summarization & Prioritization of Challenges/use audience polling*

**Jan 22, 2021**

**Session 2: Current Challenges Related to *How* We Document**

- *Keynote Panel 1 + QA: Data Entry Challenges*
- *Keynote Panel 2 + QA: Alternative Data Entry*
- *Summarization & Prioritization of Challenges/use audience polling*

**Jan 29, 2021**

**Session 3: Exemplars and Key Successes**

- *Exemplars panel Parts 1 and 2, + Discussion*

**Feb 5, 2021**

**Session 4: Emerging and Future Innovations as Solutions**

- *Moderated Panel Discussion: What is the Job of Documentation in the Future?*
- *Industry Panel Discussion - What are the solutions coming out of industry?*
- *Review of COVID-19 Survey*

**Feb 12, 2021**

**Session 5: Reactor and Prioritization Session for Actions**

- *Breakout Sessions to identify actions based on prior sessions and prioritize as short-term, medium term, long-term actions*

**Feb 19, 2021**

**Session 6: Plenary on Insights for Action**

- *Plenary Speaker for convergent actions*
- *Breakout Sessions to refine actions based on prior sessions and prioritize as short-term, medium term, long-term actions*

*Over 300 Participants!*

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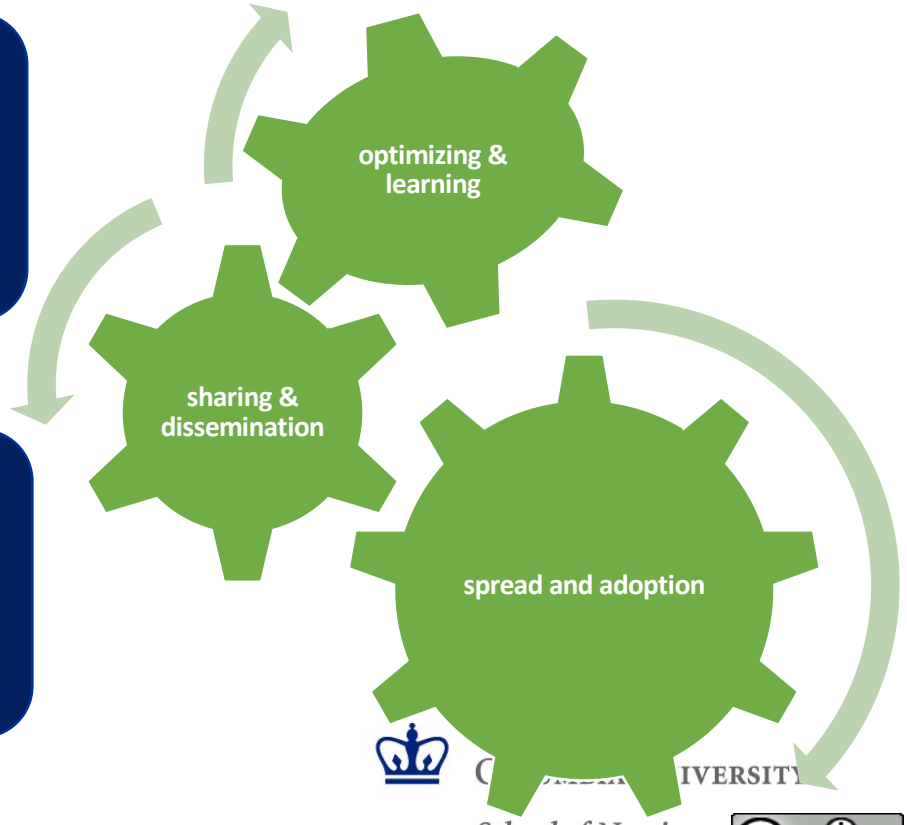
# Take-Aways

- Exemplars are doing excellent work, with tangible results

**360 Million fewer "clicks" a year**

*Project Joy, UC Health*

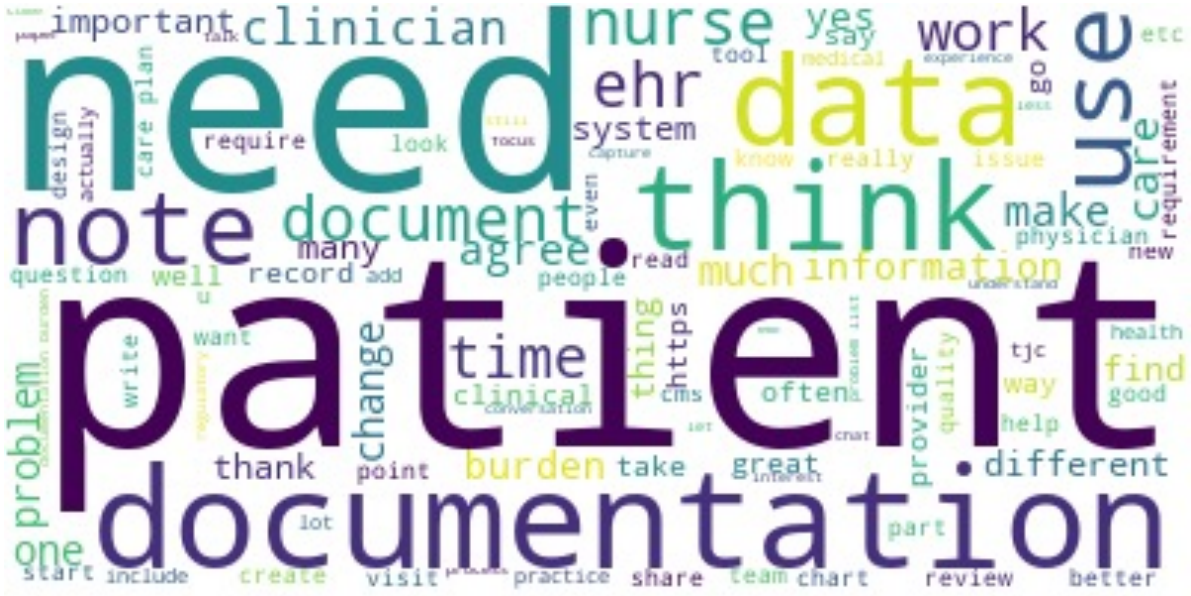
- Broad learning, dissemination, and spread to other providers/health systems are not happening
  - Spread to Vendors and Policy/Advocacy groups also not apparent




- International groups do not have the same reimbursement and regulatory constraints, but still experience burden and are focused on decreasing "size" of EHR content and notes

# Using Topic Modeling to Elicit Insights from *25x5 Symposium* to Reduce Burden Chat Logs

**Figure 1.** Top 100 most frequently used terms in *25x5* chat messages




Moy AJ, Withall J, Hobensack M, et al. 2022 (work in progress)

**Table 1.** Distribution of topics uncovered among *25x5* chat logs

| Topic Label | Topic Grouping | Frequency (%) |
|---|---|---|
| Symposium insights and feedback from clinicians | Administrative | 129 (7.2) |
| Regulatory impact on usability and workflow | Current State | 61 (3.4) |
| Evolution of clinical documentation and future innovation | Current State | 190 (10.6) |
| Achieving consensus on important and valuable documentation | Directives | 550 (30.8) |
| Maintaining what works in current documentation | Directives | 169 (9.5) |
| Role of clinicians in training and next steps | Future Directions | 104 (5.8) |
| Future collaboration between clinicians and vendors/payors | Future Directions | 71 (4.0) |
| Technological innovation to improve safety and access | Future Directions | 91 (5.1) |
| Involving stakeholders (i.e., patients) in clinical care and data capture | Patient-centeredness | 179 (10.0) |
| Need for patient-centeredness and capturing patient contributions | Patient-centeredness | 243 (13.6) |

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# Methods for Synthesis of Actions & Recommendations


**82 Action Items**

## 4 Themes

- **Accountability**
  - "Not working in silos"
  - Clarity of roles
  - Cohesive understanding/requirements among agencies and stakeholders
- **Evidence matters**
  - Evidence-based practice informing measures
  - Generation of evidence
  - Clinician input
- **Education and training**
  - Documentation requirements and standards
  - Brevity and clarity training for new clinicians
  - Focus on quality over quantity
  - Incentivize training
- **Innovation of technology**
  - Integration of tech variety
  - Increased interoperability

## 3 Stakeholder Groups

1. **Provider and Health System Calls to Action**
2. **Vendor Calls to Action**
3. **Policy Advocacy Calls to Action**

# Call to Action: **Providers/Health Systems** should …

## Accountability and Evidence

- Establish guiding principles for adding documentation to EHR with multidisciplinary collaboration led by clinician experts
- Generate evidence for reduced documentation and impact on risk/compliance and removing documentation that isn't positively impactful

## Education and Training

- Develop and host national roadshow; directed towards professional clinicians & clinicians in training
- Med Student & Resident education: Universities and Health Centers to train brevity in addition to completeness

## Technical Innovation

- Expect/support real time information retrieval, documentation, and ordering
- Implement interdisciplinary notes/team-based documentation

# Call to Action: **Vendors** should …

## Accountability and Evidence

- Promote ecosystem of interoperable systems to allow for complementary technology beyond single EHR vendor
- Develop metrics to review and grade a user's documentation based on length/efficiency/redundancy; provide ongoing user feedback and peer benchmarking

## Education and Training

- Package best training practices into toolkits to promote user's workflow revisioning and "best practice" EHR use
- Plan recognition programs and publicize exemplars to incentivize the sharing of documentation burden reduction success stories

## Technical Innovation

- Create simplistic EHR views to see that new clinical data has been reviewed - then bookmark for user and document as reviewed by that user in the EHR
- Implement personalized CDS with AI to drive user-specific workflows and care recommendations

# Call to Action: **Policy/Advocacy Groups** should …

## Accountability and Evidence

Urge NIH (NLM, PCORI), AHRQ, ONC, & NIST to do & fund research related to capturing all coding information (E&M & CPT, etc.) w/o engaging any clinician time

Means: Payers to clarify & unify rules; develop data handoff 'handshakes'; create prior authorization call centers; assume responsibility for code validation

## Education and Training

Select 'best of breed' & implement systems throughout the Health Care System

Means: mixture of public & private funding

## Technical Innovation

Develop technology to reliably & accurately create reimbursement/payment data for all care settings w/o clinician engagement

Means: A/V components in care settings to capture all information relevant to coding & note generation

# *Immediate Call to Action*

| Providers/Health Systems | Health IT Vendors | Policy/Advocacy |
| --- | --- | --- |
| • **Goal: Establish guiding principles for adding documentation to the EHR and generating evidence for reduced documentation** | • **Goal: Promote an ecosystem of interoperable systems to allow for complementary technology** | • **Goal: Urge agencies to fund research that captures billing code information without engaging clinician time** |

# • Key Takeaway Points –

- 25x5 Symposium brought together stakeholders to consider how to reduce documentation burden by 75% in 5 years
  - Presentations from 33 formal stakeholder representatives

- Documentation burden has numerous contributing factors
  - Work to date has untangled contributors to burden
  - We have presented several action-oriented next steps
  - We found exemplars from other industries and clinical settings
  - Next steps will involve working with providers/health systems, HealthIT vendors, and national policy/advocacy groups

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Symposium to Reduce Documentation Burden

25x5

on U.S. Clinicians by 75% by 2025

#25x5

# 25x5: At a Glance

*Symposium to Reduce Documentation Burden on U.S. clinicians by 75% by 2025*

dbmi.columbia.edu/25x5

Funded by the National Library of Medicine (1R13LM013581-01)

| 6 | 33 | 140 | 300 |
|---|---|---|---|
| 2-Hour Sessions | Presentations | Organizations | Participants |

SCAN ME

82 Action Items

## Calls to Action

### Providers & Health Systems

- Establish guiding principles for adding documentation to EHRs and generating evidence for reduced documentation
- Develop a national roadshow and educate clinicians and clinicians in training on balancing brevity and completeness in documentation
- Increase support of functions like real-time information retrieval, documentation, and ordering in the EHR
- Implement interdisciplinary notes to decrease redundant documentation

### Health IT Vendors

- Promote an ecosystem of interoperable systems to allow for complementary technology
- Develop measurement tools to categorize documentation practices
- Package best training practices into toolkits to promote best practice EHR use and plan recognition programs to publicize exemplars
- Create simplistic EHR views to see that new clinical data has been reviewed, then bookmark for the user and document as reviewed by that user in the EHR
- Implement user-personalized Clinical Decision Support to drive specific workflows

### Policy & Advocacy Group

- Urge agencies to fund innovative research that captures all billing code information without taking up clinicians' time
- Select the best of breed approaches to documentation and implement throughout the health care system
- Develop technology to reliably and accurately create reimbursement and payment data for all care settings

All 82 action items, as well as all 33 presentations, can be found at www.dbmi.columbia.edu/25x5.

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- Symposium Output and Dissemination
  - All recordings and chats from Symposium Series are available online
    - https://www.dbmi.columbia.edu/25x5/
  - Breakout outputs => action plan
  - Dissemination Materials
    - Reports
      - Executive Summary published
      - Final Report Published
        - Cohesive, overall action plan to fine-tune the actions
    - Other Materials
      - Journal Publications
      - Podcasts
      - Conference Abstract Presentations
  - Dissemination Activities
    - Create Network of Allies
    - Multiple national report-outs & Conversations
    - Convene Key Stakeholders From Community to Mobilize Strategies Nationally
    - Circulation of Final Report and other meeting outputs as needed
  - Sustainability Plan => AMIA ownership and leadership for next phase of the 25x5 work
    - AMIA Connect 25x5 Community with close to 200 members in place

#25x5

# •AMIA 25x5 Task Force

# AMIA 25x5 Task Force Mission & Vision

## Mission

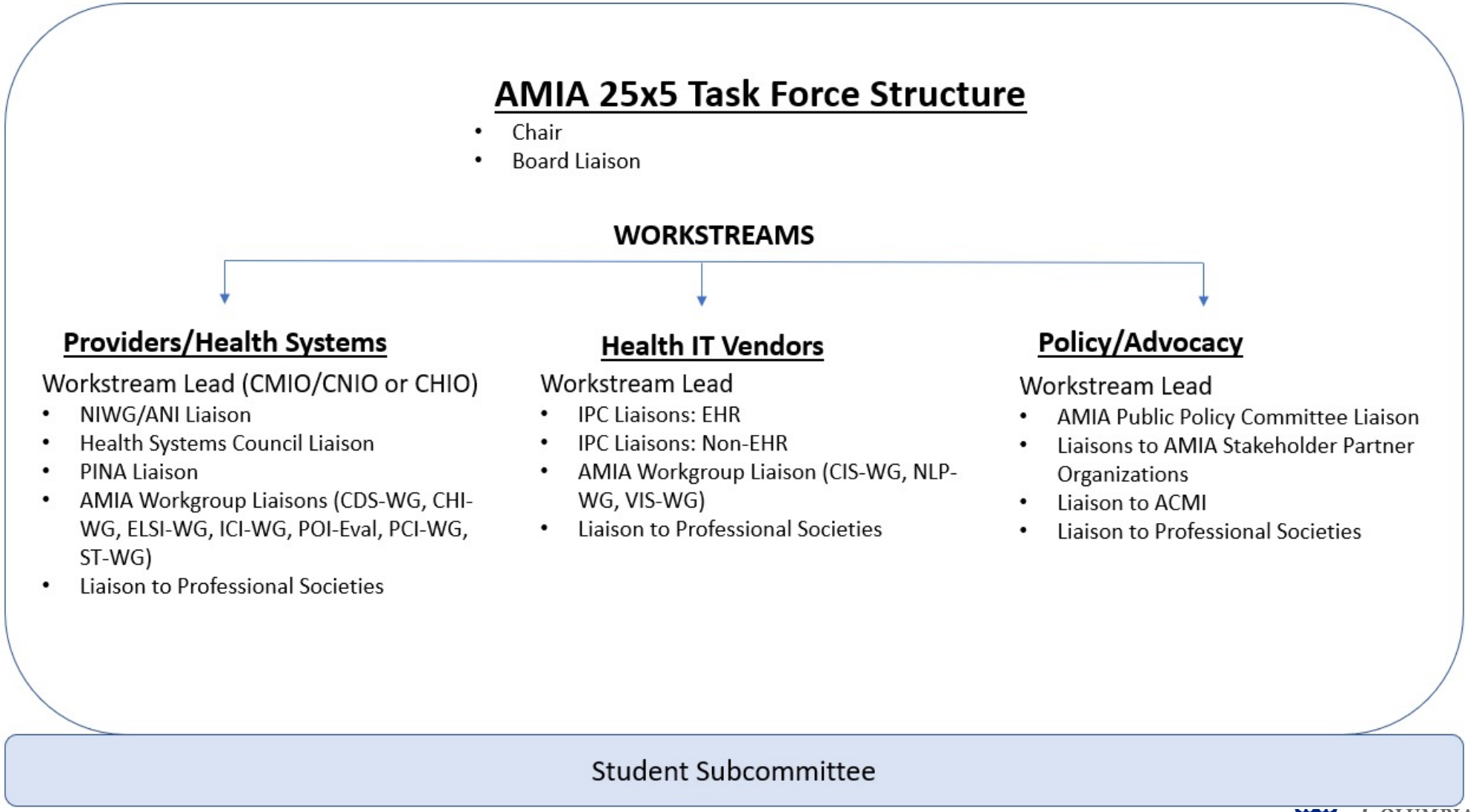
Reduce documentation burden for U.S. Clinicians to 25% of current state in the next 5 years[1] and optimize electronic health record (EHR) and related vendor solutions by prioritizing and implementing the 25x5 Symposium Calls to Action/Recommendations[2] through partnerships and advocacy with health systems, professional societies, and public/private sector organizations in order to spread these solutions across the U.S. health system.

## Vision

- Short-term approach (within 1 year)
- Long-term approach (5 years)

[1] 5-year period of 1/01/2022-12/31/2026
[2] Calls to Action (page 21-22) and recommendations (page 25-26) from the 25x5 Symposium Final Summary Report available here: https://brand.amia.org/m/dbde97860f393e1/original/25x5-Summary-Report.pdf

# Workstream Structure & Roles



# AMIA 25x5 Task Force

**Chair: Sarah Rossetti, RN, PhD, FACMI, FAMIA, FAAN** Assistant Professor of Biomedical Informatics and Nursing, Columbia University Department of Biomedical Informatics
**Board Liaison: Kenrick Cato, RN, PhD, CPHIMS, FAAN,** Assistant Professor of Nursing, Columbia University

Workstreams

| Providers/Health Systems | Health IT Vendors | Policy/Advocacy |
|---|---|---|
| ***Goal: Establish guiding principles for adding documentation to the EHR and generating evidence for reduced documentation*** | ***Goal: Promote an ecosystem of interoperable systems to allow for complementary technology*** | ***Goal: Urge agencies to fund research that captures billing code information without engaging clinician time*** |
| Lead: **Rebecca Grochow Mishuris, MD, MS, MPH,** CMIO, Boston Medical Center / Boston University | Lead: **Sarah Corley, MD**, Chief Medical Advisor, CVET, MITRE Corporation | Lead: **Vicky Tiase, RN, PhD, FAMIA,** Director, Research Science, New York Presbyterian Hospital |
| NIWG/ANI Liaison: **Mayfair Afiah Aboagyewah, MSN, BSN, RN-BC, CAHIMS,** Senior Clinical Nurse, Mount Sinai Hospital | IPC Liaison: **Sam Butler, MD**, Clinical Informatics Physician, Epic | AMIA Public Policy Committee Liaison: **Deb Levy, MD, MPH,** Post-doctoral Informatics Research Fellow, Department of Veterans Affairs, VA-Connecticut |
| Health Systems Council Liaison: **Kathleen Kendle, MD,** CHIO, Veterans Health Administration | IPC Liaison: **Jason Mitchell, MD, MS, FAMIA** Director and Physician Executive, Cerner Corporation | Liaison to AMIA Stakeholder Partner Organizations: **Judy Murphy, RN, FACMI, LFHIMSS, FAAN,** Independent |
| PINA Liaison: **Kyle Marshall, MD, MBI, FACEP, FAAEM, FAMIA,** Associate CMIO, Geisinger | IPC Liaison: **Mary Varghese Presti, BSN, MPH,** SVP & GM, Dragon Medical at Nuance Communications | Liaison to AMIA Stakeholder Partner Organizations: **Scott Fox, MS, MEd, FAMIA, Principal**, Payment Reform and Delivery, MITRE Corporation |
| AMIA Workgroup Liaison (CDS-WG, CHI-WG, ELSI-WG, ICI-WG, POI-Eval, PCI-WG, ST-WG): **Shawna Abdul**, MSE, MSN, RN-BC, CPHIMS Program Director Nursing Informatics, University of Rochester | | Liaison to ACMI: **Jim Cimino, MD, FACMI, FACP, FAMIA,** Director, University of Alabama at Birmingham Informatics Institute School of Medicine |
| AMIA Workgroup Liaison (CDS-WG, CHI-WG, ELSI-WG, ICI-WG, POI-Eval, PCI-WG, ST-WG): **Alicia Beebe, BSN, MHA, RN-BC,** Director Clinical Informatics, Saint Luke's Health System | AMIA Workgroup Liaison (CIS-WG, NLP-WG, VIS-WG): **Christoph Lehmann, MD, FAAP, FACMI, FIAHSI,** Director Clinical Informatics Center, UT Southwestern Medical Center | |
| Liaison to Professional Societies: **S. Trent Rosenbloom, MD, MPH, FACMI, FAMIA,** Professor and Vice Chair, Vanderbilt University Medical Center Dept of Biomedical Informatics | Liaison to Professional Societies: **Kevin Johnson, MD, MS** Professor and vice President for Applied Informatics, University of Pennsylvania School of Medicine | Liaison to Professional Societies: **Don Detmer, MD, FACMI** Professor of Medical Education, University of Virginia |

# Providers/Health Systems Workstream

**Call to Action:** *Establish guiding principles for adding documentation to the EHR and generating evidence for reduced documentation*

**GOAL:** Within the year (2022), generate a tool kit for adding documentation to the EHR and generating evidence for reduced documentation. Success measured by actual downloads or pre/post survey of tool kit impact.

**Priority 1 Task:**

- Documentation burden committee will create working group on documentation reduction to establish standards with regards to documentation for compliance

    (A) Healthcare organizations will review regulatory documentation, EHR implementation, and best practices for utility

**Priority 2 Tasks:**

- Clinician experts at healthcare organizations will review regulatory requirements before making documentation requirement changes and removing existing requirements.
- Healthcare organizations to establish governance to restrict new required info in notes unless we're taking away something else.

# Health IT Vendors Workstream

**Call to Action:** *Promote an ecosystem of interoperable systems to allow for complementary technology*

**GOAL:** Within the year (2022), vendors to come together to start working on operationalization of interoperability and closing gaps. Success measured by:

- each vendor within the workgroup is able to improve functionality of interoperability of 3 clinical actions by 25% (workstream to select the 3 actions); and
- each vendor within the workgroup is able to consume the CCDA of each other vendor within the workgroup; and
- each vendor within the workgroup can implement 1 set of patient reported outcomes at the point of care for inpatient and outpatient encounters.

**Tasks:**

- Vendors and clinical subject matter experts will improve user resources such as workflow centric assistance and shared knowledge databases
- Vendors to create the capability to (decompose) CCDA for granular reuse of data points
- Vendors to implement patient reported outcomes accessibility at point of care

# Policy/Advocacy Workstream

**Call to Action:** *Urge agencies to fund research that captures billing code information without engaging clinician time*

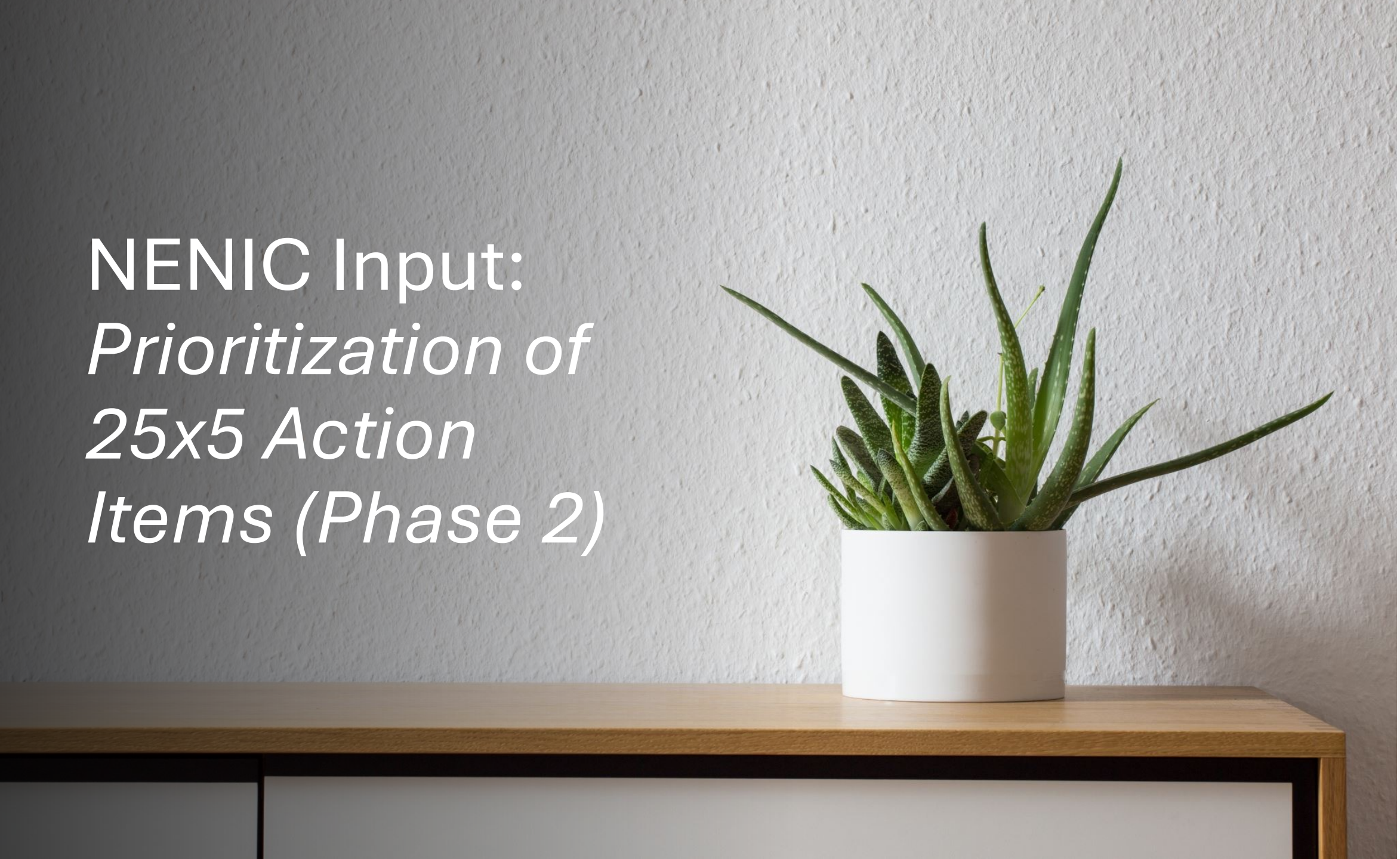
**GOAL:** Within the year (2022), engage in high level meetings with NIH, AHRQ, ONC, NSF and CMS and other relevant agencies. Success measured by:

- a high-level meeting with each stakeholder organization; and
- identifying at least one agency willing to commit to funding and inclusion in their strategic plan.

**Task:**

- 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

# NENIC Input: *Prioritization of 25x5 Action Items (Phase 2)*



# Discussion/Follow-up to Voting

## Perspectives on potential for local actions through NENIC?

- Health System/Provider
- Health IT/Vendor
- Policy/Advocacy

## Key issues for nursing?

- Care planning
- “Decreasing clicks”
  - Usability
    - Innovative technologies for data capture
  - Self-imposed
    - Reduced requirements and “size” of EHR
    - Re-empower nurse as expert
- Patient generated health data

# EHR Documentation Burden in the ED
## (Columbia U. Research Study)

- Recruiting ED Nurses for zoom/phone interviews
  - 45-60min, anonymous
- $100 Amazon gift card
- Study Aim: To understand EHR tasks and functionalities that may contribute to clinical documentation burden and burnout among nurses

- Contact Information: Dr. Sarah Rossetti at sac2125@cumc.columbia.edu or Amanda Moy at am3458@cumc.columbia.edu or (650) 427-0678

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# Conclusion

**There is an increasing recognition of the need to decrease clinical documentation burden, aligned with need to increase clinician wellness**

**Measurement needs exist, but need to move forward simultaneously**

**Successful efforts will require organizational partnerships across health systems, industry, and policy/advocacy groups**

**AMIA 25x5 Task Force focused on short term (2022 goals) and long term (5 years)**

**Collaboration welcome and needed**

**Clinical experts should drive EHR content and functionality build**

**Patient care needs should drive documentation**

# *Thank you!*

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