Reflections on the Documentation Burden Reduction AMIA Plenary Session through the Lens of 25 × 5

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Summary

Documentation burden, defined as the excessive effort expended on health care documentation, is associated with a number of adverse outcomes, including clinician burnout, reduced quality of medical care, and disruption of clinical data contained in the electronic health record. With the growing concern for the wellness of the clinical workforce, documentation burden is receiving national attention. The American Medical Informatics Association (AMIA) has taken the lead by establishing the 25 × 5 Task Force ("Task Force") in December 2021, which aims to reduce clinician documentation burden to 25% of the current state in the coming 5 years. Aligned with the timing of the Task Force launch, the AMIA Clinical Informatics Conference (CIC) 2022 co-chairs, Rosemary Kennedy (Connect America) and Paul Fu (City of Hope), conceptualized an opening plenary panel in a "fireside chat" format focused on clinical documentation burden. In this editorial, the authors describe the panel discussion, identify key themes from the panel, and offer recommendations to address documentation burden. The proceedings of the AMIA CIC 2022 Fireside Chat serve as an opportunity to acknowledge those who are engaged and passionate about addressing documentation burden from the vantage point of different stakeholders and institutions.

Introduction

Documentation burden is defined as the stress resulting from excessive work required to generate clinical records of health care-related interactions, which can occur as a result of the imbalance between usability and satisfaction of systems of health record-keeping along with clinical and regulatory demands of entering and consuming health records data.[1] Across health care domains, increasing efforts to identify and address contributing factors to burnout often include documentation burden as a potential point of intervention. The U.S. Surgeon General Dr. Vivek Murthy recently released a comprehensive advisory calling for attention to documentation burden as an element of health worker burnout and describing interventions to address it.[2] The American Medical Informatics Association (AMIA) has taken the lead by

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establishing the 25 × 5 Task Force ("Task Force") in December 2021, which aims to reduce clinician documentation burden to 25% of the current state in the coming 5 years.[3] The Task Force builds on prior work AMIA and its members did leading the 25 × 5 Symposium.[1,4]

In this editorial, we reflect upon a remarkable expert panel and a critical moment in the effort to address documentation burden. We will report on the content of the panel discussion, identify key themes from the panel, and offer recommendations to address documentation burden. The proceedings of the AMIA Clinical Informatics Conference (CIC) 2022 Fireside Chat acknowledged documentation burden in its many forms, from the vantage point of different stakeholders and institutions. We recognize the value in discourse and stakeholder engagement, and the need to be deliberate in managing various viewpoints, to develop equitable solutions to documentation burden.

Aligned with the timing of the AMIA 25 × 5 Task Force launch, the AMIA CIC 2022[5] co-chairs, Rosemary Kennedy (Connect America) and Paul Fu (City of Hope), conceptualized an opening plenary panel in the form of a "fireside chat" focused on clinical documentation burden. We commend the contributions of the knowledgeable panel members, as well as the attendees from various stakeholder domains including clinicians, informaticians, researchers, and vendors.[6] The panel included Mary Greene (Director of Office of Burden Reduction & Health Informatics, Center for Medicare & Medicaid Services), Robert Bart (University of Pittsburgh Medical Center), Bonnie Clipper (Innovation Advantage), and Victoria Tiase (University of Utah).[6] The energy of the discussion was notable, and we want to capitalize on this moment to move the conversation forward.

This plenary panel built upon the work done as part of the National Library of Medicine (NLM)-funded 25 × 5: Symposium to Reduce Documentation Burden on U.S. Clinicians by 75% by 2025. The Symposium aimed to advance the overarching goal of developing a unified national action plan focused on short-, medium-, and long-term approaches to reduce documentation burden.[1] The Symposium activities centered upon a key theme: clinician documentation should support patient care delivery and clinician–patient communication.

Identification of themes: we met multiple times as a group and reflected upon the content of Fireside Chat and identified three themes that emerged from the panel discussion. For each of three themes, we describe what was discussed during the AMIA Fireside Chat, provide context-setting, and offer opportunities for policy and research.

Theme I: Regulatory Requirements that Contribute to Documentation Burden

Mary Greene opened the Fireside Chat with remarks on current work at CMS and future opportunities to reduce the documentation burden.[6] She noted that current regulatory and payor-driven documentation requirements have a significant impact on burden of documentation, and present opportunities for reduction. The panelists observed that there has been much focus on prior authorization, reflecting the reality that documentation requirements are not always related to regulations, but may be associated with payors or other pressures.

The panelists recognized that documentation serves multiple purposes. Alignment of the goals of EHR development was discussed to span stakeholder groups (clinicians, insurers, regulatory agencies, consumers, among others). Patient-centered and patient-oriented workflows were a recurring point of discussion.

Panelists raised the potential need to align documentation and information uses of EHR data including clinical use and billing, and information or data management, among others. Panelists discussed the opportunity to shift from making minor adjustments to data inputs, to leveraging data that is already being collected for clinical purposes, without requiring additional steps. From a regulatory perspective, enhancing interoperability was raised as a potential component of the documentation burden solution.

Panelists shared concerns with embedding prior authorization into documentation workflows due to the risk of creating more work for certain parties including clinicians. Panelists also offered solutions to documentation burden including the creation of a core dataset that all insurers or payors would be encouraged to adopt, with a minimum dataset necessary to facilitate their work. Prior authorization was raised as an example where regulatory effort is being focused, but panelists noted that prior authorization alone in isolation will not fully address documentation burden.

Analysis and Recommendations: Theme I

Uses of clinical documentation and the data contained within a clinical document have evolved over time.[7] The multiple roles of clinical documents deserve consideration, aiming to align uses and goals for EHR documentation. In the regulatory and payor domains, there are opportunities to leverage data within health records without necessitating end-user clinicians to include all content within a given encounter. It is worthwhile to consider the broader regulatory impacts of documentation burden, where prior authorization solutions represent one component to reduce documentation burden.[8] Care is needed to ensure that documentation burden is not shifted or increased with the proposed solutions to prior authorization.[9] Other factors that are not directly regulatory, but may be confounders, include payor-driven requirements and malpractice coverage best-practice suggestions. Importantly, quality and safety regulations, EHR payment incentives such as the Merit-Based Incentive Payment System (MIPS), institutional culture, and the changing landscape of novel coronavirus disease 2019 (COVID-19) and pandemic reporting requirements should remain under discussion as documentation burden reduction efforts are pursued.[3,8,10]

Theme II: Right-Sizing Documentation

The panelists discussed emergency orders during the COVID-19 pandemic as an exemplar use case for the

complexity of right-sizing documentation. For the purposes of this editorial, reference is made to the 25 × 5 Symposium framework, including defining "right-sizing documentation" as a reduction in overall documentation while maintaining the quality of documentation, as opposed to merely shifting documentation responsibilities between clinical team members without addressing the larger issue.[1]

The panelists described regulatory changes put in place during emergency phase of the pandemic, where inpatient documentation of specific domains and fields was eliminated for certain use cases.[11] For example, in some cases, nurses were not required to document the education provided or plans of care.

Many EHR products have become very complex as they strive to support multiple regulatory and clinical requirements leading to increased training requirements to optimally take advantage of workflow configurations. Panelists highlighted the opportunity to implement approaches that integrate interdisciplinary or team-based documentation in clinical workflow as a path to right-size documentation, especially in the inpatient setting. Panelists expressed caution with reducing or removing items from documentation, without first quantifying the potential negative implications or the lack of impact on documentation burden.

Panelists discussed other factors impacting right-sizing documentation including the role of health care institutional culture. Even with emergency regulations during the pandemic, the volume of documentation did not decrease; in some instances, nurses were observed to document more,[12] although this observation is consistent with nursing documentation patterns that are a proxy for patient status and have been used to predict patient deterioration.[13] Consequently, a multifaceted, innovative approach is necessary to reimagine documentation and implement changes.

Analysis and Recommendations: Theme II

As a part of right-sizing documentation, we recommend consideration of the focus and use of clinical documentation, as well as alignment across all stakeholder groups. Moving forward, there is an opportunity to reimagine and/or create documentation workflows that meet the needs of all stakeholder groups including those who will consume the documents. Inbox management and inattention highlight that traditional "note" documentation is not the only aspect of clinician documentation in need of repair.[14,15] Most EHRs support the ability of end users to personalize their views to reduce documentation burden but the views may still not contain complete or sufficient content, particularly in the inpatient environment. EHR vendors have added tools designed to allow users to pull relevant data into clinical documentation. These tools are sometimes used instead to pull in whole sections of the chart to aid in reviewing information. While this can be useful for the note creator, it can mask relevant clinician synthesis amidst the volume of data. Changes to clinician documentation practices require change management efforts to drive behavior change and change culture, even as requirements may be adjusted. One example is emergency orders during the COVID-19 pandemic that allowed for reduced nursing documentation.[12] They were rolled back prior to determination of the full impact of these temporary changes to documentation requirements on clinical outcomes. We recommend that further investigation is needed retrospectively to examine the clinical impact that these emergency orders may have had, and to inform future requirements.

Theme III: Ways to Improve Efficiency with Current Documentation Requirements

A central consideration of what the health record is ultimately for, and who should contribute to it may guide efficiency efforts. Implementing technology is often considered a logical next step in reducing documentation effort on the clinician side through automation; however, by increasing inputs using ambient or patient-generated technology, the growing volume of data could further burden clinicians. The panelists outlined the need to consider information needs and displays so as not to cognitively overload or further burden clinicians. The panelists were hopeful for the potential for technologies such as ambient voice capture, or other non-traditional clinical information capture methods, to aid in documentation. The panelists also discussed the need to be mindful of considering the purpose and placement of the large volumes of patient-generated data in the clinical record. Similar to the case of patient-generated data, the panel expressed caution to not increase burden on clinicians in needing to edit or review captured information in fixed time or for accuracy. The panelists discussed the growing complexity of EHR products as they strive to support multiple regulatory and clinical requirements, which can contribute to increased training requirements if a user is to optimally take advantage of workflow configurations.

Analysis and Recommendations: Theme III

Improving efficiency of documentation can be considered from the clinician end user, system, vendor, payor, and regulatory stakeholder perspectives. Ensuring that burden equity is maintained and not shifted between interdisciplinary team members remains a foundational principle of the action items resulting from the 25 × 5 Symposium.[1,4]

Information blocking regulations are fully in effect as of October 2022.[16] These regulations offer an opportunity to explore the clinician and patient perspectives on what note content is needed most. As patients gain the ability to contribute to their record, it is worthy to explore how to bring patient data and patient data needs into the clinical environment. However, it is essential to understand existing clinical workflows in a manner that complements care delivery rather than place additional cognitive workload or burden on clinicians as patient-generated data is incorporated.

Table 1 Authors' analysis and recommendations for each of three Themes from AMIA CIC Plenary Session

Theme I: regulatory requirements that contribute to documentation burden
• Leverage data within health records without necessitating end-user clinicians to include all content in a given encounter
• Consider the broader regulatory impacts on documentation burden, where prior authorization solutions represent one component
• Ensure documentation burden is not shifted or increased as solutions are proposed[8]
• Explore nonregulatory factors such as payor-driven requirements, malpractice coverage best-practice suggestions, quality, and safety regulations, EHR payment incentives such as the Merit-Based Incentive Payment System (MIPS), institutional culture
• Consider pandemic reporting requirements as documentation burden reduction efforts are pursued[7,9,10]
Theme II: right-sizing documentation
• Traditional "note" documentation is not the only aspect of clinician documentation which may offer opportunities for burden reduction
• Further investigations are needed retrospectively to examine the clinical impact of COVID-19 emergency orders
• Reimagine and/or create documentation workflows that meet the needs of all stakeholder groups including those who will consume the documents
Theme III: ways to improve efficiency with current documentation requirements
• Improve efficiency of documentation from the clinician end user, system, vendor, payor, and regulatory stakeholder perspectives
• Ensure that burden equity is maintained and not shifted between interdisciplinary team members remains a foundational principle of the action items resulting from the 25 × 5 Symposium
• Explore how to bring patient data and patient data needs into the clinical environment

Abbreviations: AMIA, the American Medical Informatics Association; CIC, Clinical Informatics Conference; COVID-19, novel corona virus disease 2019; EHR, electronic health record.

Discussion

There are various uses for the products of clinical documentation, to address both care-related documentation burden, and also consider externally imposed burdens including regulatory and quality/safety requirements, malpractice considerations, and organizational culture. The panelists represented these various perspectives eloquently, as content experts across domains, and offered a variety of actionable points for consideration. Potential interventions to reduce documentation burden must also be considered in terms of unintended consequences. ►**Table 1** summarizes our recommendations. We return focus to a key tenet of the 25 × 5 Symposium framework and equitable documentation burden reduction efforts: not shifting burden within the clinical team, which remains a challenge to implement and measure.

The Fireside Chat Panel event at AMIA CIC 2022 offered the ideal combination of context, summary of current practices, and vision for moving the documentation burden reduction process forward in a generalizable and practical manner. The AMIA 25 × 5 Task Force aims to be a central convening incubator to highlight and amplify potential solutions, and ultimately identify generalizable opportunities to reduce documentation burden. As leads and members of the Task Force workstreams, we plan to incorporate these reflections into our workstream efforts. Further work is needed both as part of the AMIA 25 × 5 Task Force, and in the field in general to prioritize action items that address documentation burden and emphasize those which clearly impact clinician wellness.

Note

The contents of this manuscript represent the view of the authors and do not necessarily reflect the position or policy of the U.S. Department of Veterans Affairs or the United States Government.

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Conflict of Interest

None declared.

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