

3 ways to begin to reduce clinical documentation by 75% by 2025

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Sara Berg, MS

Senior News Writer

While physician burnout saw a decline prior to COVID-19's emergence, it is still a major professional problem that demands systemic responses. As physicians navigate the ongoing pandemic, they also struggle with too much paperwork, lack of time for patient-centered care, and poor work-life balance. But what if health systems could put a huge dent in clinical documentation burdens that are such a big contributor to doctors' burnout?

"If we put our heads together, those of us with a clinical background and those with an informatics background can come together and really achieve that vision of reducing documentation by 75% by 2025," said AMA Vice President of Professional Satisfaction Christine Sinsky, MD, during the virtual 25x5: Symposium to Reduce Documentation Burden on U.S. Clinicians by 75% by 2025. The American Medical Informatics Association, the US National Library of Medicine, Columbia University Department of Medical Bioethics and Vanderbilt Medical University collaborated on this initiative to establish strategies and approaches to reduce physician documentation burden in the U.S. to 25% by 2025.

"We have a \$3 trillion industry in health care that is underperforming and in large part it's underperforming because the individuals within are dispirited and, in some cases, despondent," Dr. Sinsky added. "And part of that is related to the fact that as clinicians, we often spend more time documenting care than delivering care, and that doesn't align with our mission. That doesn't align with why we went to nursing school or medical school or other professional training."

Here are some action steps Dr. Sinsky shared to help health systems begin to reduce documentation burden.

Rethink documentation

“We've moved so far away from the primary purpose of documentation, which is clinical communication and medical decision-making,” said Dr. Sinsky. For example, her practice often received six pages of documentation from emergency departments “but there was no meaning.”

“And like many barriers to both quality of care and satisfaction, the origins of this documentation are complex, but the end result was that there was a compromise in clinical quality, efficiency and communication,” she said,

“If we structurally ask our clinicians to do things like document through a series of generic dropdown boxes, we will not only begin to record the history in a generic way, but we will also begin to see and interact with our patients in a more generic way,” said Dr. Sinsky.

Less is more

“If we can document it with smart phrases and dropdown boxes, we should reconsider whether we should document it at all,” said Dr. Sinsky. “None of us like to read through a maze of all that structured text output—it’s a waste going in and it’s a hazard to the next user.”

“The other piece I’d like us to reconsider is this notion that if it wasn’t documented, it wasn’t done,” she said. “It simply isn’t possible to document to a scale of one-to-one everything that happened within a human encounter.”

“We can easily eliminate 1 billion clicks a day,” said Dr. Sinsky, adding that her all-time high click count was the 32 clicks it took record having ordered and administered an influenza shot. “I know we can do better than that,” she said.

Read about how even small drop in task load can cut the odds of physician burnout.

Conduct sludge audits

“I suggest we begin to socialize and normalize the idea of sludge audits,” said Dr. Sinsky. The idea here is to eliminate “policies that may have made sense at one time, but are no longer needed, no longer up to date or really didn’t have an evidence base to begin with.

“We have to recognize that sludge is not just something to shrug our shoulders at, but really is

hazardous,” she added. “Part of the way we're trying to get rid of some of that sludge at the AMA is we've created an initiative on debunking regulatory myths,” along with a de-implementation check-list.

“We currently have seven different myths posted; oftentimes something was well-intended at the federal regulatory level—the EHR has enabled it—but then the problem is exacerbated by over interpretation of those regulations at the local level,” said Dr. Sinsky. “It is important that the AMA provide authoritative clarification regarding these common misunderstandings.”