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De-Implementation Checklist

In an effort to reduce unintended burdens for clinicians, health system leaders can consider de-implementing processes or requirements that add little or no value to patients and their care teams. The following list includes potential de-implementation actions to consider. Partner with your local EHR and informatics experts to assess the feasibility and impact of these items.

COMPLIANCE

Guiding Principle	Specific Action
☐ **Reduce signature requirements**	• Remove signature line on forms that do not require a physician's signature • Eliminate two-factor authentication (eg, password revalidation, challenge questions, badge tap, bioidentification) to electronically sign orders for anything other than controlled medications when the user is already logged in and actively using the EHR • Eliminate order requirements for low-risk activities that do not legally require a physician signature (eg, pulse oximetry) • Bundle visit orders to have a single sign-off ("shopping cart approach") • Prevent paper forms already seen and signed from passing through the EHR inbox for a second sign-off
☐ **Evaluate mandatory training modules**	• Review current and proposed compliance training modules and consider removing any that are not required by a regulatory agency or have little evidence of benefit • Allow a test-out option for modules
☐ **Reduce attestations required daily or every time one logs in**	• Reduce requirements as legally allowed for attestations that occur daily or at each log-in (ie, consider whether an annual attestation is sufficient)
☐ **Reduce requirements for "break the glass"**	• Review and revise requirements for additional security measures to access certain patient charts for the purpose of direct patient care (eg, consider the option for patients to opt in rather than opt out of "break the glass")
☐ **Allow assisted order entry in appropriate situations**	• Allow the use of assisted order entry (eg, a team member entering orders into the EHR at the directive of a physician) in situations as legally permitted

QUALITY ASSURANCE/IMPROVEMENT

Guiding Principle	Specific Action
☐ **Perform condition screens no more frequently than recommended**	• Be thoughtful when constructing quality metrics for guideline-recommended screening intervals to balance maintaining high quality care with reducing duplicative screening (eg, if a clinical practice guideline recommends annual screening for falls, then set a performance metric with an interval of more than 12 months; otherwise, team members will waste limited clinical resources on screening more often than is required)
☐ **Reduce the rote ascertainment of learning style preference for patients**	• Stop asking patients for their preferred learning style at every visit

EHR

Guiding Principle	Specific Action
☐ **Minimize alerts**	• Evaluate clinical decision support (CDS) alerts and retain only those with evidence of a favorable clinical outcome
☐ **Simplify login**	• Simplify and streamline login processes, leveraging options like single sign-on, RFID proximity identification, bioidentification (eg, fingerprint, facial recognition, badge-in/badge-out)
☐ **Vary auto-logout time by setting**	• Consider extending time for workstation auto-logout in outpatient settings • Customize auto-logout to use patterns of the specific EHR user
☐ **Decrease password-related burdens**	• Consider extending time intervals for password reset requirements • Consider use of password-keeper programs • Remove requirement for users to re-enter username and password to send prescriptions when already signed into EHR, unless required for two-factor authentication (eg, for controlled substances)
☐ **Reduce note bloat**	• Update note templates to include only what is necessary for good patient care and to meet current billing requirements (eg, remove irrelevant ROS, PMH, PSH)
☐ **Simplify order entry processes**	• Reduce requirements for input of unnecessary clinical data when ordering a test • Eliminate requirements for fields that do not make clinical sense when ordering a test (eg, pregnancy status in individuals over 60 years old) • Optimize technology to auto-populate necessary discrete data fields if the information already exists in the EHR (eg, if the last menstrual period date has already been entered by a team member, optimize technology so another team member doesn't have to reenter that data)
☐ **Reduce unnecessary inbox messages and notifications**	• Automatically file outside messages that have no clinically relevant information into the patient chart without going through physician inbox (eg, insurance forms) • Eliminate automatically cc'd charts and test results (those with high-value clinical information can still be manually sent) • Lengthen time (eg to 72 hours instead of 24 hours or less) before notification of incomplete charts and unsigned ordersnotes, and suppress unsigned notes notifications if they are duplicative with incomplete charts

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Check out the complete Saving Time Playbook and more at stepsforward.org.

From the AMA STEPS Forward® Playbook Series: Saving Time Playbook—De-Implementation Checklist, v. 1.0.
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