Comments from Texas Nurses Association /Texas Organization of Nurse Executives
Health IT Committee
Comments on Documentation Burden Proposal
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Observation [what the report says]	Comment [negative and positive aspect]	Practitioner Observations and Evidence [from literature]
Clinical Documentation		Summary: Involve all providers such as nurses, who reflect 80% of the documentation in the EHR.
Coordinate billing codes	Agree with the need to coordinate billing requirements with regulatory reporting and nursing/medical practice to ensure efficient use of clinician time and not take away time from patient care.	
Work with working with vendors to identify technology solutions	Agree with working with vendors to identify technology solutions to facilitate meeting the needs of billing and regulatory requirements with minimal impact to clinician workflow.	Sittig, D. F., & Ash, J. S. (2011). *Clinical information systems: Overcoming adverse consequences.* Sudbury, MA: Jones and Bartlett Publishers.
More collaboration among players	Agree that compliance will rise, data integrity will be ensured, and patient care will improve with more collaboration among players	And absolutely see nursing with a huge share of the burden in the hospital setting. I know our facility is not alone when they resort to requiring nursing to document certain elements because they can't get physicians to do so.
Health IT Usability and the User experience		Summary: Provider experience is fundamental to success use of an EHR for patient care delivery and this is emphasized in the Quadruple Aim. Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine, 12*(6), 573-576. doi:10.1370/afm.1713
Better align EHR system design with real-world workflow; improve decision making and documentation tools	Think this is essential around the comments to create a balance between the standardization and customization – both are important and necessary.	While requiring nursing to document certain elements because they can't get physicians to do so, is a culture issue as well, it absolutely speaks to the heavy burden of hospital

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	Decrease the number of clicks or screens the user must access – copy paste can be used, but must be used safely.	reporting and the impetus behind collecting the data.
Promote interface optimization to improve efficiency	Basic workflows to foundational processes should be consistent across systems – key ones are medication reconciliation, medication, lab and imaging ordering, results review and problem list.	We also see a trend toward nursing staff sharing more of the burden of documentation and see a need for the regulatory and quality data to be pulled from the shared interaction of physicians and nursing.
Standardized content in the health IT record for consistency and to reduce burden	Standardization of medication information (generic name, use of tall man lettering) order entry content (test codes, naming conventions) and results display (standard results display, abnormal results, and reference ranges) is important so that as users work between systems, these processes and the data provided are the same.	Throughout this document there is a lot of focus on provider visits, but many of these same strategies would benefit workflow on the inpatient / RN documentation side – whether hospital, rehab or Long Term Care.
Promote the importance of implementation decisions for clinician efficiency, satisfaction and lowered burden	The importance of technical support, ongoing training, upgrades and system back-ups be understood; often these are easy to cut when budget constraints occur	I like all of the recommendation, but it needs to benefit both provider and RN! McBride, S., Tietze, M., Hanley, M. A., & Thomas, L. (2017). Statewide study to assess nurses' experiences with meaningful use-based electronic health records. CIN: Computers, Informatics, Nursing, 35(1), 18-28. doi:10.1097/CIN.0000000000000290
EHR Reporting		Summary: Metrics that are reported for improvement of patient safety, can't cause unsafe workflow and documentation burdens for those providers who delivery the care!
Better manage eCQMs	Agree with the need to better manage eCQM configuration and requirements to product more accurate measure calculation and a higher level of data integrity.	
Make eCQMs more relevant	Agree with the need to make eCQMs more relevant reporting for a broader range of hospitals and physicians.	Joint Commission as indicated this need as well. See . . .

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		Sittig, D. F., & Singh, H. (2017). Toward more proactive approaches to safety in the electronic health record era. *The Joint Commission Journal on Quality and Patient Safety*, *43*(10), 540-547. doi:10.1016/j.jcjq.2017.06.005
Facilitate ease of reporting	Agree with the need to facilitate greater ease of reporting for smaller and/or rural facilities/providers	In the physician practice setting I'm seeing physicians relying on the nursing staff to meet the documentation requirements so they can see more patients which pulls nursing from the patient care as well as limiting time for the patients with the physicians.
Shorten documentation burden	Agree with the point of short implementation timelines being a burden for implementation and accurate data integrity.	Caution: Poor, short implementations of workflow are a safety hazard for providers as evidenced by: Institute of Medicine (U.S.) Committee on Patient Safety and Health Information Technology. (2012). *Health IT and patient safety : Building safer systems for better care*. Washington, DC: Institute of Medicine. Retrieved from http://www.nationalacademies.org/hmd/Reports/2011/Health-IT-and-Patient-Safety-Building-Safer-Systems-for-Better-Care.aspx
Create better partnerships	Encourage a better partnership with resource challenged facilities to potentially develop better avenues for participation	We also see a trend toward nursing staff sharing more of the burden of documentation and see a need for the regulatory and quality data to be pulled from the shared interaction of physicians and nursing.
Public Health Reporting		Public reporting is about data integrity across many disparate sources and this should be of great focus for HHS. Including the key stakeholders such as providers, is paramount to success.
Involve key stakeholders	Agree with	The trend toward merging with larger healthcare systems/facilities endangers those providers that are

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Standardize/harmonize requirements Maximize HIPAA requirements that facilitate information exchange	HHS should convene key stakeholders to inventory reporting requirements, and work together to identify commonly reported data for state and federal programs.** • HHS should continue to work to harmonize reporting requirements across federally funded programs requiring the same or similar EHR data from health care providers to streamline the reporting process across state and federal agencies using common standards. • HHS should provide guidance about HIPAA privacy requirements and federal confidentiality requirements governing substance use disorder health information in order to better facilitate electronic exchange of health information for patient care	serving rural populations and increasing the difficulty for our patients to find care without traveling.