I think your draft strategy is a start. The EHR has slowed me down considerably and sucked all the joy out of emergency medicine. I'm actively pursuing alternate careers. I applaud this initiative, but I'd consider integrating a couple specific concerns-

1- Ethics in charting, especially with regard to billing requirements. The first time I worked with a scribe I began noticing that a whole bunch of things were clicked on ROS that were not pertinent nor discussed. (Also, I HATE that we even need scribes… the fact that I need a whole other person just to satisfy an EMR is a big problem. I'd rather just do my own documentation.) Anyway, the scribes are encouraged by admin to complete 10 systems for billing purposes, regardless of if they were explicitly reviewed. They were shocked that I had a problem with that, but precision in charting is a matter of integrity to me. If the demands of an EHR prohibit me from charting accurately based on my physician judgment of what is or is not important, it's no good to me or any other physician in retrospect. That's why these printed out versions of the EHRs are such a waste… 30 pages of click box info when all you really care about is on one page in the physician MDM. My point is, you have to take it beyond the EHR itself… You have to address the coding. Coding needs to be based on good medicine, we shouldn't be forced into bad medicine or impertinent history taking to satisfy coding requirements.

2- We need to be afforded the charting resources with which to appropriately and safely supervise mid levels. Why do I have to sign charts 2 days after my shift on a patient who already left and was seen by a mid level I've never even met who, by the way, discharged the patient with abnormal vital signs and no MDM? Keep in mind that sometimes the only mid level supervision that's actually allotted for is chart review. It's wrong but it's reality. How do we put all the pertinent info for supervising physician review in a useful and efficient format. Sometimes I have 50 of these to review after every shift, I do not have time to delve into 30 different tabs on one patient's chart. Show me triage note/vitals, H&P, ROS, labs/rads/tests, MDM, plan, discharge vitals all on one screen. Then give me a link to the mid-level's contact info to contact them if any concerns, and a link to the patient contact info in case I need to speak with them.

I realize these are not strictly EHR issues, but perhaps a good EHR could assist with solutions to address them.