March 15, 2024

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Dr. Valdez,

Thank you for the opportunity to submit comments to AHRQ Documentation Burden Technical Brief. As you know, this Brief is of particular interest to the American Medical Informatics Association (AMIA), as it was AMIA's 25x5 Task Force that nominated this topic to be briefed in June 2022 to identify the need to better understand how co-production of documentation improvement efforts with patients and caregivers could be successful and to understand and develop the evidence on measurement of documentation burden. AMIA applauds the AHRQ on this thorough Brief. AMIA's comments focus on next steps for addressing documentation burden.

AMIA is the professional home for more than 5,500 informatics professionals, representing frontline clinicians, researchers, public health experts, and educators who bring meaning to data, manage information, and generate new knowledge across the research and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across care settings and patient populations. The AMIA 25x5 Task Force is working to reduce health professionals' documentation burden.

Comments on Documentation Burden

AMIA offers that while many of the items mentioned in the report are measurable, such as the EPIC signal data, many of them are measurable only in isolated or academic centers. As such, the use of the metric is limited. For information to be effective in better understanding our patients, patient populations, treatment options, and outcomes, the metrics collecting and measuring the information must be applied to diverse populations and must be reproducible in other environments to be accurate. AMIA recommends making this clear and would appreciate the opportunity to work with AHRQ to develop metrics that may be used broadly.

AMIA also urges an emphasis on the documentation burden for the entire clinical team, not just physicians.

AMIA also makes the following technical recommendations for the Brief:

1. Replace the word "doctor" with "physician".
2. In the last line of the "Findings" paragraph in the Structured Abstract, please change "her" to "EHR".

3. The Moy et al. paper was foundational to burden measurement work and a precursor to the current measures identified, due to the overlaps in measurement constructs. See below. AMIA encourages AHRQ to cite this paper directly and has included the citation in footnote 1.

AHRQ Brief

ES Figure 1. Measures of documentation burden

Overall Time Spent in EHR	Mean time per day, per patient/encounter, or per provider/FTE
EHR Related Activities	Time or proportion of EHR time spent on specific activities Perceived sufficiency of time for documentation Documentation length, number of notes, and number of actions taken to complete a note
Inbox Management	Time spent on inbox management or number of messages received or completed
Time Spent in Clinical Review	Time or proportion of time spent on looking or or reading information from the patient record
Time Spent in Orders	Time or number of orders
Work Outside Work	Time or proportion of total time spent after scheduled hours or via remote access
Administrative Tasks	Activities such as billing and filling forms Time or proportion of total time
Fragmentation of workflow	Number of task switching, interruptive alerts completed documentation while residents were actively staffing cases
Measures of Efficiency	Timely completion of documentation, closing encounters, responding to messages, responding to test results, prescription refills Measured as time to completion of activities or proportion of completed activities
EHR Activity Rate	Number of actions (clicks, keystrokes, transitions, mouse-keyboard switches, mouse miles (pixels) per minute, number of logins per shift)
EHR Usability	Usability scales, satisfaction with EHR, surveys about ease of documentation Technostress (stress related to EHR)

Original Paper[1]

Identified measurement characteristics from study findings

Documentation Burden Concepts	Measurement Constructs	
Effort	EHR usage and workload	
	Clinical documentation/review	
	EHR work afterhours and remotely	
	Administrative tasks (eg, inbox management)	
	Cognitively cumbersome work (eg, multitasking)	
	Fragmentation of workflow	
	Patient interaction	
Time	Average time spent	
	Proportion or percentage of time spent	
	Binary of timeliness of completion (eg, documenting within shift or policy time frame)	
	Activity rate	
Units of analysis	Clinically-oriented units of analysis	Temporally-oriented units of analysis
	Encounter	Seconds
		Minutes
	Provider	Minutes
	Patient	Seconds
		Minutes
	Event/Task	Seconds
		Minutes
		Hours
		Shifts
		Days
		Weeks

Comments on Documentation Quality

AMIA recommends a second, similar brief that solely addresses what constitutes a "quality document". The current Brief does not adequately address metrics for documentation quality, but AMIA considers this appropriate and believes documentation quality is a massive topic that deserves its own report. Until the development of such a report, given that quality is mentioned by the Key Informants on page 7 and is in the title of several of the cited papers, AMIA recommends including quality in the limitations section of the Brief to make it clear that metrics for documentation quality are not being addressed in this Brief.

Documentation quality and burden are not the same, but they can be linked. Quality of documentation has not been adequately defined in a standard, reproducible way. Certain criteria

[1] Journal of the American Medical Informatics Association, Volume 28, Issue 5, May 2021, Pages 998–1008, https://doi.org/10.1093/jamia/ocaa325.

may be more obviously important for measuring quality in documentation, such as correctness, concise language, and consistency. However, the specific characteristics of what constitutes a high-quality document may vary across clinical professions, specialties, and documentation types. In addition, some concepts, such as completeness, have very different meanings in the context of quality versus burden. For example, the status of the patient and their condition should drive the appropriate scope of clinical information needed for documentation to be complete from a quality perspective. The number of fields or the structure of an EHR form should have no bearing on a measure of completeness from a quality perspective, but rather may provide insight into how burdensome that form is to complete by clinicians.

Poor quality documentation increases the burden associated with the documentation process and requirements and is itself ineffective in conveying the necessary information to help patients. This can result in confusion for the patients and miscommunications between the patient and their clinical team regarding the important work and results they have already completed together. This is especially true in situations where the diagnosis is in doubt, complications have occurred, and/or results are pending. Ultimately, the burden of this process is not only time-consuming and frustrating, but can result in poor or dangerous outcomes. Creating metrics for documentation quality will help highlight areas where burden can be reduced, but also highlight what documentation requirements are truly necessary for effective patient care. Poor documentation includes, but is not limited to, capturing the same information repeatedly.

AMIA recommends emphasizing the importance of information being captured once in clinical documentation, when it aligns within clinical workflows, and be easily retrieved by clinicians as needed and reused with automated methods by the EHR for any secondary data needs. Collecting redundant information wastes time and resources and frustrates healthcare workers as well as patients. Capturing the same information repeatedly creates note bloat, making it difficult and time-consuming to find and grasp the relevant information.

AMIA would be pleased to continue serving as a resource to AHRQ to address documentation burden in healthcare. If you have questions or require additional information, please contact AMIA's Vice President of Public Policy, Reva Singh, at rsingh@amia.org.

Sincerely,

Genevieve Melton-Meaux, MD, PhD, FACMI
AMIA Chair/President