Abstract:
As a result of the Meaningful Use program, commercial electronic health record (EHR) systems have been adopted nationwide before the availability of consensus solutions for widely known problems such as poor usability, and suboptimal clinical decision support (CDS) systems. The increased adoption also coincided with the implementation of the Affordable Care Act (ACA), which introduced more complex billing requirements, contributing to documentation burden and physician burnout. To compensate for the documentation burden, physicians frequently create their clinical notes by using the patient’s previous notes, a practice known as “copy-and-paste.” As a result, they often produce (and later deal with) uninformative, bloated notes that often contain redundant information and, in some cases, may never be read. This presentation will discuss preliminary data from studies that aim to create more effective electronic clinical documentation systems with the potential to mitigate the documentation burden faced by clinicians at the point of care. The studies include a systematic review of electronic clinical documentation systems and the development of an ontology to represent medical cognition. The ontology will be used to map the semantic relationship between clinical concepts stored in the EHR. We hypothesize that such mappings will enable development of EHR functionality to facilitate creation and use of clinical documentation, and more accurate CDS systems.

Zoom link: https://uab.zoom.us/j/491849069

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