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FROM THE EDITOR

Alert Fatigue

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It's Saturday morning, and I am sitting at my kitchen table for another session of "death by mouse-click!" Like every primary care physician (PCP) in America, I try my best to keep up with alerts. I complete my progress notes and encounter forms at the point of care. I review and correct deficiencies in documentation as soon as I am notified that they exist. I try to address abnormal lab results as soon as I receive them. There are weeks, however, when the tasks are too many, the meetings are too intrusive, and my "administrative time" is sacrificed in the name of other priorities. Where did the time go this week? It may have been spent planning and presenting a lecture, meeting with students, completing TMS (i.e. mandatory online training), completing student evaluations, or finishing a maintenance of certification module before the end of the year. There are department meetings, quality improvement (QI) projects, and the occasional writing commitment. Dare I mention I have a family? I try not to commit to all of these in the same week, and I'm not writing this to complain. On the contrary, I am no different than any other general internal medicine (GIM) physician in an academic medical center. I saw patients this week, and the electronic health record (EHR) is an unrelenting taskmaster. And so, on this quiet winter morning, the family is sleeping, the coffee is brewing, and I begin.

I logon to the EHR remotely and click "messages" to sort my alerts.

Pharmacy alerts. I usually start here, as they are the most straightforward. Renew a diuretic—potassium, ok? Check…renew…sign. ACEI…check creatinine…normal… renew…sign. Methotrexate… check diagnosis RA…check CBC…normal …renew…sign. These were all appropriate for the PCP to manage.

But docusate, acetaminophen, calcium, and alcohol wipes? Does it really require a five-step process— messaging from patient to a pharm tech to the PCP and back—to renew these?

GI notes for co-signature. I have referred my patient for colonoscopy. There are notes to cosign acknowledging: 1) patient attendance at orientation session, 2) the procedure note, 3) the biopsy result, 4) the consultant's note with recommendations, 5) updates to the problem list ("tubular adenoma, repeat procedure in 3/5 years"), and 6) the patient results letter.

Normal test results. I often receive duplicated notifications about normal test results. A "Birad-1" mammogram generates two radiology reports, a note to cosign from women's health, and a patient results letter. Every vascular ultrasound and pulmonary function test is reported separately when the technician does the test and again when the specialist reviews the result. Every inpatient radiology report comes to me. So do referrals for ambulatory physical therapy, home health care and other services, and "no show" notes from every specialty to cosign when patients miss appointments.

ER visits. Each lab and X-ray report comes back separately in addition to the ER note, which I review and cosign. My PACT team nurse calls every patient, and we do follow-ups for every ER visit and discharged patient. Why do we need to review every result separately? How many different alerts does this generate?

I have now identified multiple QI projects for the coming year. Next steps? It's time to create interest, time to build interdisciplinary collaborations, time to identify targets for change, time to form committees,

time to create solutions, time for provider engagement. It takes time.

Each time I batch my alerts and complete an EHR marathon, I see things a little differently. This exercise gives me an overview of the tasks and the workflow that has been created for the PCP by well-intended but ever-expanding systems of care. "Evolved" is a better word than "created" because rather than develop with purpose and oversight, EHR tasks have been assigned to the PCP from every department and interest group as a final common pathway. We have assumed the role of insurers of patient safety and the ultimate contact point between the health care system and the patient. We may have brought this on ourselves as a remnant of the "PCP as gatekeeper model" from the 1990s. But while everyone else is working "at the top of his/her license," the PCP is serving the efficiency needs of the institution and working for every other department. This needs to change.

I am not writing this to incite anarchy in our profession. Instead, this is a call to arms. GIM divisions everywhere are struggling under the burden of an ever-expanding list of tasks. We can learn from each other. We must share our best practices to reshape the burden of EHR-related tasks. We cannot leave this to the commercial EHR vendors and institutional IT teams. Without our collaboration and input, things will not change.

What have you done to address EHR workflow challenges in your division? Let's start a conversation. Please respond to Editor. SGIMForum@gmail.com or post a response on GIM Connect. Let's get the workflow under control. We owe it to ourselves and to the future of GIM. *SGIM*