# IMPROVING DOCUMENTATION FOR CHILDHOOD-ONSET SLE USING A STANDARDIZED HEALTH SURVEILLANCE BUNDLE: AN EHR-BASED AMBULATORY INTERVENTION

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**Background:** Childhood-onset systemic lupus erythematosus (cSLE) is a chronic, autoimmune disease with multiorgan involvement that is associated with significant morbidity and mortality. Thorough documentation of clinical manifestations and laboratory values is crucial in these patients, particularly for purposes of clinically meaningful research. A standardized workflow for documentation of quality metrics at our institution is currently limited. Through this QI initiative, we aim to standardize and improve documentation practices by implementing a health surveillance bundle which includes recommendations for comprehensive cSLE care.

**Materials/Methods:** Initial surveys were completed to review existing documentation practices. Chart reviews for all encounters over a 1-month period were performed to ascertain baseline documentation data. Inclusion criteria included all established patients ≥ 2 to < 25 years old with cSLE and were evaluated at our main rheumatology clinic. Using the initial provider survey results, we designed a consensus drive EHR smart phrase. Within a 12-month period, we aimed to increase utilization of the EHR smart phrase to 75%. Two PDSA cycles were performed between 10/2017-01/2019. Interventions included quarterly verbal reminders and education to providers. Chart review was repeated over a 1-month period following cycle 1 and a 4-month period following cycle 2 for each provider. All providers completed a survey regarding documentation barriers after cycle 2. A focus group discussion was led to identify barriers to successful utilization of smart phrase.

**Results:** Pre-intervention, review of 20 cSLE charts showed no standardized method for documentation of quality metrics. Initial provider surveys demonstrated a need for standardized documentation practices and major barrier included time. Following the introduction of the smart phrase, utilization increased to 40% (cycle 1), but then subsequently decreased to 26% (cycle 2). Fellows had higher documentation rates (97%) compared to attending physicians. Post-intervention survey results revealed that the major barriers to documentation included lack of time and forgetfulness, ultimately leading to decreased utilization of the smart phrase in cycle 2.

**Conclusions:** This standardized EHR QI initiative was not able to meet proposed smart AIM goals. Future cycles will include monthly focus groups, quarterly education, and weekly reminders. Unfortunately lack of physician time may warrant building of an EHR best practice alert.