

Cut burnout by following these 3 steps to optimize the EHR

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For physicians at Reliant Medical Group, a 500-provider multispecialty group practice in Massachusetts, the electronic health record (EHR) isn't a dreaded part of the workday. Instead, it's living up to the hype surrounding the technology when it was first unveiled—improving the physician, health care team and patient experience.

Committed to making physician burnout a thing of the past, the AMA has studied, and is currently addressing issues causing and fueling physician burnout—including time constraints, technology and regulations—to better understand and reduce the challenges physicians face. By focusing on factors causing burnout at the system-level, the AMA assesses an organization's well-being and offers guidance and targeted solutions to support physician well-being and satisfaction.

Reliant Medical Group scored 59% above the national average—among the highest in the nation—when it came to users assigning scores to EHR implementations in a national 2015 Press-Ganey survey. Then in 2016, Reliant's EHR ranked in the 97th percentile nationally for usability, according to a white paper from the Massachusetts Medical Society, Massachusetts Health and Hospital Association and Reliant Medical Group.

Changes to the system led to increased trust between physicians and their teams, “and resulted in a 25% reduction in physician in-basket message volume over an 18-month period.”

Establish EHR team with clinical and technical competencies

The team, which consists of five physicians, one physician assistant and a nurse who work with 12 members of the IT team, meets weekly to make decisions and changes on the spot. Because of their ongoing clinical work, these individuals are well positioned to help limit lower value alerts and questionnaires while identifying ways to improve efficiency.

“Not only can we do the technical work ourselves, but we also understand what can be done and the best way to do it, as well as what can’t be done,” said Reliant Medical Director for Informatics Larry Garber, MD, a practicing internist in Worcester, Massachusetts. “This is relatively uncommon. Other EHR teams may have individuals who know how to make documentation tools or alerts, but we have programmers that can do things that otherwise were impossible with an EHR.”

For example, this team created “One-click orders,” which are “common orders that already include the time frame in which it is to be completed and an associated diagnosis code.” This has dramatically reduced the number of incorrectly placed orders for imaging studies.

Automate tasks when possible

Reliant created a system that can automatically gather and share information that makes visits easier for physicians and patients alike. The interface allows them to subscribe to patient information from their affiliated hospitals and home health agencies. All laboratory results, x-ray reports, transcribed notes and Continuity of Care Documents go directly into Reliant’s EHR.

The group is also connected to health plans, so patients’ claims data flows into the EHR. This allows physicians to know when a patient had preventative procedures such as mammography at another system. This automation eliminates the need for physicians or their health care team members to call other organizations for information.

Assign tasks to person whose role incorporates those duties

Documentation burden is a major source of physician burnout. Reliant has made efforts to allow others to assist with documentation. For example, medical assistants—based on individual physician preferences and appointment type—gather information from the patient and enter it into the EHR before the doctor enters. This includes chief complaints, preferred pharmacy, vital signs and medication renewals, among others.

The physician’s in-basket is also another source of burnout. However, inbox management systems have made it faster to process in-basket messages, reducing the amount physicians receive. For example, when a patient is discharged, labs in the hospital EHR, which were reported out during the hospital stay—and hence were available to be reviewed by the hospital physicians during the hospitalization—are filed silently into the EHR without a physician inbox notification. Only hospital laboratory results which were pending at the time of discharge, and which have become available after the discharge, are sent to the primary care physician’s inbox for review.

Many routine consultation notes, such as ophthalmology and podiatry, also no longer automatically go to the primary care physician's inbox.

Researchers from the AMA and MedStar published a study last year that found big differences in efficiency and error rates when physicians used EHRs. The results of this study reinforce the assessment that ensuring the usability and safety of the EHR is a joint responsibility between physicians, technology vendors and technology purchasers that requires collaboration at each stage of design, development and implementation.

As part of the "Everybody Has Responsibilities" campaign, the AMA and MedStar have created a website that includes videos of health professionals experiencing the risks and challenges faced when EHRs can't be used efficiently. Additionally, physicians can participate in the AMA's EHR Connect platform, which joins key stakeholders to collaborate around EHR development, usability, optimization and interoperability for improved end-user experiences.