

5 simple changes to help cut doctors' EHR burdens

APR 30, 2021

Sara Berg, MS

Senior News Writer

While the electronic health record is here to stay, it is often a prime source of frustration and burnout for physicians. But the good news is physician practices and health systems might have more control over the EHR than originally thought. It's time to learn what is under the control of a physician or health system and how to save hundreds of hours.

"We know that EHRs have transformed our work in health care and none of us want to go back to paper. However, it's a source of great frustration and it can lead to burnout," Marie Brown, MD, professor of internal medicine at Rush Medical College and director of practice redesign at the AMA, said during a recent webinar, "Taming the EHR."

During the webinar, Dr. Brown shared simple changes that physicians and health systems can make to tame the EHR and reduce administrative burden.

Eliminate unnecessary work

"Inbox messages are a great source of unnecessary work," which is why "all messages that are sent to the physician's inbox should be carefully triaged within your organization," Dr. Brown said. "Only those messages that need physician action should appear in the inbox."

"Your organization, and even the individual physician, can turn off unnecessary notifications such as copied charts, admissions, discharges, transfers, future appointments, and previously signed and now scanned documents," she added. "Results of tests ordered by other physicians should not routinely be copied to other physicians as this can lead to confusion regarding whose responsibility it is to address an abnormal result."

"When I turned off these notifications, my inbox messages decreased by half," said Dr. Brown.

Follow this AMA STEPS Forward™ de-implementation checklist to reduce unintended burdens.

Work with compliance department

"Quite often we blame the vendor for our concerns and some of the unnecessary work we think we're forced to do," said Dr. Brown. "However, we have seen around the country that the compliance department or your IT department, risk management or coding are actually over-interpreting the regulations."

It's about "working closely with the compliance department and other committees to make sure that they're accomplishing what they need to accomplish, but with the understanding that the user experience should be incorporated into any decisions that they make," she said.

Use indication prescribing

"We can also improve adherence, our experience and the patient's experience by using indication prescribing," said Dr. Brown, adding that if the EHR is set up with the top 10 drugs that you most commonly use, it can be easily added into the instruction.

"For instance, you're ordering atorvastatin, you could add into it that this is to lower your cholesterol and prevent heart attack and stroke," she said. "If the patient understands why they're taking it, you don't have to write that over and over again every time you order atorvastatin. Patients and families really appreciate that, and the pharmacist reminds the patient as well"

Read about how even small drop in task load can cut the odds of physician burnout.

Replace shorthand writing

Another helpful tool is similar to autocorrect on an iPhone, said Dr. Brown. "This is simply replacing your shorthand—how you write a quick note to yourself."

"If you use abbreviations one time, teach your EHR to replace your shorthand with the correct terms specific to your specialty," she said. "If you put that in once, every time you write PAD and then hit the space button, it will write peripheral artery disease.

Additionally, "SOB becomes shortness of breath—this is very important as all patients have access to

their notes in 2021," Dr. Brown added, noting that "this probably saved me a good hour a day and made my notes much more readable for my colleagues as well."

Incorporate team documentation

"We want the doctor to be developing the diagnosis, building relationships and we want to be sure that what you don't need an MD to do, could be safely handed off to somebody else on the team," said Dr. Brown. "We want to be sure that we incorporate team documentation.

"And that involves your IT team providing access for the chief complaint, the HPI, SH, ROS and pend orders," she added. "Depending on your state rules, scope of work can be entered or at least pended, so that the physician relies on other team members to follow protocols." "We can eliminate a billion clicks a day," Dr. Brown said, emphasizing that "team documentation saves time and money, and improves patient care."

Learn more from the AMA STEPS Forward™ webinar series, which focuses on physician well-being, practice redesign and implementing telehealth during COVID-19.