Electronic health record optimization
AMA STEPS Forward® podcast

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In this episode of the AMA STEPS Forward® podcast, Daniel Dunham, MD, MPH, chairman of Medicine at Lenox Hill Hospital, discusses how eliminating unnecessary clicks in the EHR ultimately decreases physician burnout and allows care teams to focus their time on what matters most—patient care. Learn more with the AMA STEPS Forward® Taming the EHR Playbook.

Speaker

- Daniel Dunham, MD, MPH, FACP, chairman of medicine, Lenox Hill Hospital

Host

- Kevin Hopkins, MD, family medicine physician, primary care medical director, Cleveland Clinic; senior physician advisor, practice transformation, American Medical Association

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Transcript

Introduction: Hello and welcome to the AMA STEPS Forward® podcast series. We’ll hear from health care leaders nationwide about real-world solutions to the challenges that practices are confronting today. Solutions that help put the joy back into medicine. AMA STEPS Forward® program is open access and free to all at stepsforward.org.
**Dr. Hopkins:** Hello, everyone. Thanks for joining us. I'm your host, Dr. Kevin Hopkins. I'm a family medicine physician and a primary care medical director at Cleveland Clinic in Cleveland, Ohio. I'm also a senior physician advisor to the AMA for practice transformation. And today we're talking about electronic health record optimization with Dr. Daniel Dunham, former chief of the division of general internal medicine at Rush University Medical Center and now chairman of medicine at Lenox Hill Hospital in New York City. Dr. Dunham, thanks for joining us today.

**Dr. Dunham:** Dr. Hopkins, it's my pleasure. Thanks for inviting me.

**Dr. Hopkins:** You're welcome. So, if you could just start off maybe by telling our listeners a little bit about yourself and your background, and to help us know you a little bit better.

**Dr. Dunham:** Sure. Well, I'm a lifelong Chicagoan, recently making a move to New York. I trained at the University of Chicago Medical School and did my residency there as well. After that I worked at an FQHC in the south side of Chicago, joined Northwestern, where I was faculty for approximately 20 years. I rose through the ranks. I was the associate division chief of general internal medicine there, focusing on ambulatory operations. I was hired by Rush in 2015 and at that point as the division chief. All the while my areas of research and areas of interest are in practice optimization quality improvement. So the use of electronic medical records is always something that's been near and dear to me both as a clinician as well as a researcher. Recently I left from Rush to become the chairman of the department of medicine at Lenox Hill Hospital in New York City.

**Dr. Hopkins:** Terrific. So you and I share a lot of the same interests and passions when it comes to practice redesign and transformation. If you could sort of just start off then by walking us through some of the specifics of what you first noticed about a problem that all of us experience in the EHR—unnecessary clicks. What was the problem that you noticed that you felt needed to be solved?

**Dr. Dunham:** That really is a source of frustration for people in the front lines and for us clinicians who are seeing patients. And a lot of time that's a disconnect between people in clinical roles and people in administrative roles. It's easy to minimize and say, “Oh, it's just one or two clicks to get from this point to that point.” But when you have one or two clicks a hundred times a day then it really adds up. I think also we see a lot of times when people who have roles with electronic medical records are very sophisticated, those clicks may be more intuitive to them. For those of us who are not as sophisticated with electronic medical records, we may forget where the pathways are to try to optimize patient care and it can take us more than just a couple clicks.

So this was something that when I worked at Northwestern, there was a pretty heavy investment in clinician's roles with optimizing electronic medical record and we used Epic at that time. When I went from Northwestern to Rush, although they used Epic as well, their Epic system was very different. And so I was fortunate to have a previous experience, but at a different institution. And so going to a new institution when I said, “Well, why can't we do this?” some people who had an experience would say,
“Oh, well Epic doesn't allow us to do that.” That really wasn't the case. It was that this is the way that had been done at the institution for a while and that they weren't aware that it could be changed. And so to me it's a plea for institutional investment in having physicians who are well-versed and sophisticated in understanding electronic medical records. And to give them the time to try to delve into this and try to make practices more efficient.

**Dr. Hopkins:** So it sounds like you recognized one of the facts that maybe we're all a little bit blind to and that is that EHR products are not one size fits all. There's some customizability and there are some settings that are done at a higher level, but then there are some settings that can be variable based on the needs and desires of the specific institution. Is that right?

**Dr. Dunham:** I think that's exactly right. Dr. Hopkins. And I think in particular, if you want to have a successful system in place?and I think both of us come from primary care backgrounds where we're in the front lines and do a lot of the documentation?it's really important to have clinicians involved with this optimization and investing in that.

As I said my experience has primarily been with Epic and I found right away that Epic is very different from institution to institution. And it largely depends on who were the decision makers at the institution and the amount of time that they were allowed to have to try to look in to try to optimize the plan. I think we're all looking to try to make our job sustainable. There's been tremendous stressors in the past couple years. I mean, COVID is the obvious one, but for us primary care physicians there's a lot of responsibilities that we have that are in addition to taking care of patients. And if we can try to minimize the time that we spend away from direct patient care, it's going to help ameliorate our frustrations. It's also going to let us optimize our time with patients where our time is probably best spent.

**Dr. Hopkins:** Yes. You said something that really resonated with me and that's the importance of clinical folks being involved in the design, build, iteration of our EHR programs, because we're the ones that are literally using it every day. And I think that's of vital importance. I sometimes use the phrase?you know the phrase death by a thousand paper cuts. I think of like death by 10,000 clicks. And I have a colleague who says the sound of a mouse clicking in a medical office is the sound of a little bit of joy leaving the clinician's fingertip.

**Dr. Dunham:** Yeah. That's very good and very true. And I would even expound a little bit further in saying we should have clinicians involved, but also not the most technologically savvy ones, because if you can get somebody?the person who has the least understanding of electronic medical record?if they can be bringing their problems to the table, that's something that will probably impact everyone to some extent. If we have the people who are really sophisticated, they may not kind of understand the things that bother the people who need the most help. And so I would say that it's necessary to have clinicians involved, but it's not sufficient just to have any clinicians involved. You need to have people who are representative of the people who are doing patient care. And a lot of times the people who
Dr. Dunham: Yeah, I can give a couple examples. Well the first example when I first came, I noticed that in order for us to do prescription refills we had to both do sign-on and do our password. I mean, not only a couple clicks but you have to enter your name and your password. And so for a busy clinician in primary care, as you know you can have 40 to 50 prescriptions and refills a day, easily. I know AMA has done a lot of good work with trying to make that more efficient, but even in a more efficient practice, still a big part of what we do is do prescription refills. So within our practice, not only do we have to like, do a click or two, but we actually had to do a sign-on and do the password. So if you had 40 prescriptions you had to do that 40 times. And I came from an institution where they didn't have to do that.

And so one of the first questions I had is, “Well, why do we have to do this?” And I think that where I was previously, the physician's voice was maybe a little bit stronger than the legal team's voice. And so I think legally there was a fear that, well, we want to make it more difficult to do prescriptions so that the person doing the prescription is the appropriate person. And well I certainly don't want to minimize the importance of doing that. I would've argued?and I did argue?that that's really not a big concern. If somebody's forwarding me a prescription to refill, we have to assume that the person who is doing that knows what they're doing, and we don't need to have the extra step just to make sure that I'm the right person to be able to do that.

And so really within the first couple weeks or couple days, actually, I was able to identify this is a problem, and eventually to move this through our institution?Rush at that time?and to simplify that so that we didn't have to do well, sign your name as well as do your password just to fill a prescription that a patient had asked to be filled. And I think this is kind of the juxtaposition of institutions worried about patient protection, patient confidentiality. And I know that you and I were certainly not advocating to minimize that because it was really important that patients have their medical records be held in confidence. But there's a cost to doing that.

Right now, I'm sure your institution has had to deal with this as well. A lot of times we have patients?you're in Cleveland, I've been in Chicago and then in New York?we have some patients who don't stay within our practice the whole time. And so I've had some patients?there's five academic medical centers in Chicago, more than that in New York City?and so we'll have patients who will see different specialists in different areas. And kind of the culture of many of the institutions will be proprietary to the information for their patients. But as a primary care physician, I would say that's not in the patient's best interest. And I'm sure you, like me, will have patients who come and see me and
say, “I saw this specialist, they did this, but I'm not quite sure what my take-home message was from that. Can you tell me what I should do based on that?” And if it's a person at another academic medical center or another hospital, and I don't have that information, I'm doing a disservice to my patients.

And a lot of our patients come to us as primary care physicians and they use a term like quarterback, point guard, leader of my health care team, and if we can't get information because the specialist is at a different institution, and said institution doesn't want to share the electronic medical records, then we're doing a disservice to the patient. Certainly by not sharing it precludes me from hacking into the information. But really, I don't know how much of a problem it is. If someone went to see a cardiologist at another institution, I don't know how it's going to hurt them if I have access to that information, especially as a primary care provider. And certainly there are ways that we can look and make sure?with electronic medical records we can see who is seeing patients' results. And certainly, there's certain boundaries?you can do it so that you have to break a glass to be able to do that. That's the terminology I'm sure you're familiar with.

And yeah, if I have a coworker who's seeing another doctor, if I'm going to look into their records, there should be a record of me doing that and that's inappropriate. So I think that's a reasonable compromise, is to look into that, making sure the right people are looking into it, but putting these obstacles to me as a primary care physician to get information about a patient, it doesn't serve our patients well. And hopefully we're kind of evolving away from that, but I think we need to continue to do that. And certain electronic medical records are able to share pretty well, others less well, but fortunately, in the past decade or so, I've seen there's been a movement to try to make it more easy for physicians to share information with each other. And that's really one of the potential benefits of electronic medical records that hasn't always been optimized.

**Dr. Hopkins:** Absolutely. There’s still significant opportunity for optimization, as we all experience every day. And I heard you say phrases like, “This is in the patient's best interests,” or “This is a patient quality and safety issue.” And oftentimes when we use language like that, or there's policies and procedures in place at an institution, we're told “Well, this is a regulatory requirement,” or “This is just how it is with our EHR; it can't be any different.” You recognized and realized that that wasn't accurate. And I always encourage people to say, Show me the policy; show me the regulatory requirement for this,” because sometimes the restrictions that we encounter that cause frustration throughout the course of a day, and inhibit our efficiency, are self-imposed and things that we've created usually out of good intention but may not serve that intention any longer.

So how did you move past those type of barriers, if you encountered them, specifically at Rush, and how did you make a case and convince the key stakeholders that something needed to change and could change?
Dr. Dunham: Well, I think that really, you look at the landscape right now for primary care physicians. I think every institution is mindful and committed to trying to retain them and make the job sustainable. And so as a division chief for general internal medicine while at Rush, there was the commitment to do so. And I think that led to dialogues: “What do we need to do to make it so that your job is sustainable?” And I think what we need to do in health care is to first commit to take great care of patients. First and foremost, we need to do that. And having information readily available allows us to do that.

Two, to take care of as many patients as we can in a safe, effective manner. There’s not enough primary care providers and going forward a lot of specialists are not going to be enough. So how do we make it so a given doctor can take great care of more patients without having to do more work? And so eliminating these barriers allows us to do this.

And then I think the other thing is we need a commitment to do it regardless of their ability to pay for it. I mean, unfortunately in this country we still have a lot of people who are not insured. Those are the people who historically have the worst health outcomes, but if we commit resources to allow physicians to be as efficient as possible, we can provide great care at the lowest possible cost. But this requires a communication between people and leadership positions and those of us on the front lines so that we can communicate. “These are the things we need to provide better care to patients, and it’s really not going to cost you anything, but it’s going to need some flexibility for you to look at certain policies that have been longstanding ones and which ones don’t really make sense anymore.”

Dr. Hopkins: So as far as the outcome, then, was the need to re-enter your credentials or type in your password at Rush to approve prescriptions—is that resolved?

Dr. Dunham: Yeah, that was resolved, fortunately, that was resolved relatively quickly, to their credit.

Dr. Hopkins: Were there other specific barriers or obstacles that you encountered with trying to get that changed? And if so, how did you help overcome those?

Dr. Dunham: Yeah, I think it kind of depends on the institutional culture. I think a lot of time academic medical centers is kind of a matrix system and so there’s not like a kind of a straightforward hierarchy. So I would say I think I spend most of my time talking to physician leadership, working with the department of medicine. We were able to get quick buy-in working through the legal team there, working for operational administrative people and trying to make the case for it. So a lot of times institutions, physicians don’t necessarily have the final say so it really kind of took some time understanding the culture and who are the decision makers, making the case for them. And so once you kind of understood that then I was able to be more effective in my role.

Dr. Hopkins: So other folks working in other organizations have maybe this same issue. I’ll tell you here in my practice, I have to do the exact same thing. I’m logged into EHR. I go to file an order,
prescription, whatever. I either have to tap my badge or put in my password. That's something specific I've asked our folks about multiple times and depending on who I talk to I get different answers. But whether it's that issue, because that's just one, right? There are so many other things that are built into the infrastructure and really the fabric of our day-to-day work that cause frustration that is sort of like the pebble in the shoe, that just over time can sort of break your back. What advice would you give to people working in other organizations that might be experiencing this same sense of, “Well, this is silly? why do we do this?” How should they start? What would be their first step?

**Dr. Dunham:** Yeah, that's a great question. I think that you really need to be in an institution that has a culture of trying to make physicians' lives sustainable. A lot of times the people that are decision makers are looking for return of investment, and adding on 10 minutes a day to a primary care provider, in the short term, it doesn't look like it's really going to have a return of investment. But if you can work with the people who are decision-makers and say, “By doing this, what's happening is you're increasing physician turnover. And there's a cost to doing that. By doing this you're making it so it's more difficult for me to see patients. And at the end of the day, we all have the capacity to do a certain amount of work. And if you're filling my capacity with things that are not of benefit to patients, then it's going to push aside direct patient care. And eventually, if you tell me that I can't push aside that then I'm going to eventually leave the institution.”

So for physicians who want to make those changes, I think you have to be able to at least understand where people who are decision-makers come from. Most of us, we go into medicine, particularly primary care physicians, because of the things we talked about earlier, we want to take care of patients, great care of patients. But not everybody in health care is going to prioritize that way. I mean, certainly I think everyone in health care, they want to do those things, but that may not be their primary priority. And so for physicians to understand the decision-makers, you have to understand where they're coming from.

And a lot of times people have come from a business model. And in the short term you may think and say, well, for me to spend five or ten more minutes a day, just more work, that's on me, but what that leads to is attrition of physicians. And eventually will be less efficient in taking care of fewer physicians. And anytime we replace a physician that's costly to an institution and it doesn't help the return of investment in the physicians we have. And anytime that we make it so I'm doing work that is not directly patient related, it's going to decrease my ability to take care of more patients, and that decreases the return of investment an institution has on physicians. So I would encourage physicians to understand the perspective of those who aren't like us, and just because somebody didn't go to medical school doesn't mean that they shouldn't be heard. And certainly many or most of them are in positions of leadership within the health care organization.

But we need to be able to communicate with them and let them know that making our lives easier is the right thing to do for patients as well as for the institution, because it allows us to take great care to
as many patients as we possibly can, help us have joy in our lives, in our professional lives. And that will make kind of the ability to take care of patients sustainable. And that's certainly something that's been thrown into question in the past decade or so.

**Dr. Hopkins:** Sure, as the rates and concern regarding physician and other caregiver burnout continues to increase. And certainly the COVID pandemic has not been helpful with that. And it's not just physicians, right? It's PAs, nurses, MAs, techs, clerical folks and every health care company in the country that I know of struggling with having adequate staffing available and all of those things. So we reach a point where we have to address this stuff. Your point, too, about physician turnover is a great one. For every physician that leaves an organization?whether it's from burnout or something else?the average cost to recruit, hire and onboard a replacement, depending on the specialty, is half a million to over a million dollars. And that can be a significant cost in any year, let alone a year that maybe we're struggling to meet revenue goals and targets and be able to sustain the organization financially.

**Dr. Dunham:** Yeah, and I agree. This problem is certainly greater than physicians. Having a more efficient electronic medical record can help our nursing staff, our medical assistants, pretty much everybody who takes care of patients. So their voices need to be at the table as well. As a primary care physician, I can speak mostly for myself, but certainly our colleagues in medical staff, their voice need to be heard. We need to make the electronic medical record work for them as well. And if we do that, then we're going to decrease turnover of all different people who touch patients.

**Dr. Hopkins:** So going on with that theme here, and this is the last question that I have to ask, although I'll reserve the right to ask a follow-up question. A lot of physician and other caregiver stress, exhaustion, burnout, depending on the degree of severity, seems to center on the EHR. A tool that was supposed to make our lives and careers easier, and in so many ways technology does that, but it also just creates more of everything. So how would you like to see EHR systems evolve in the future, if you were leading one of the giant tech companies that works on these EHR products, how would you like to see them evolve in the future for the good of our patients, for the good of health care systems and for the good of those that provide the care?

**Dr. Dunham:** Yeah. So I think that what I would advocate for is for the people who are designing these systems really have the voice of people who are in the front line taking care of patients. Because all too often in my career, I've seen people in leadership positions say, “Well, we gave doctors, or medical assistants or nurses X, and don't seem to be happy despite us doing this.” And I think part of this is because physicians or staff, it may not be the investment that they want. And so if we're going to be designing things to try to optimize our patient care via the electronic medical record, I would say really look for a partnership between busy clinicians and those people who are doing the designing. As I would see in lots of medical institutions we'll have people who are chief information officers or information officers, and they're people who are really very sophisticated with the use of electronic information. And so the innovations may be helpful for them, but may not be helping the
people in the front lines. They may not be helping the medical assistants, triage nurses or our nursing staff. So, I think there should be better communication between the people who are doing designing and the people who are going to be most impacted by it.

And a lot of times in academic medicine you’ll have people who come in and do a little clinical work and then they kind of migrate up, and they’re out of clinical work, and then they have other roles which are a value to the institution, but they kind of maybe lose the experience of a clinician. If I’m somebody who’s, you know, 10 or 20% clinical and something is inefficient for me and it’s increasing my workload by 10%, so, I go from 20% clinical to 22% of my time is spent doing that. And that may not be as onerous. If I’m a hundred percent clinical person and something is 10% less efficient, I go 110%. So, I’m doing 10% more of my whole life, and that’s really kind of painful. And so those people should be the ones who should be heard and be part of the decision-making process.

Dr. Hopkins: Yeah. I think that hits home for a lot of us. And thinking about your jobs, whether it’s formerly at Rush or now the chairman of medicine at Lennox Hill in New York, thinking about recruitment and retention of providers. So many places are seeing physicians and APPs too, not just leave or resign, but decrease their FTE. So, you’re having an attrition that way, right?

Dr. Dunham: Yeah. I mean, absolutely?I think you can make the business argument to the powers that be as well, most of us, we love seeing patients and we love the relationship with them. But after a while, if it becomes so onerous that we’re not going to completely give that up, but instead of working a hundred percent of the time, we do 80% time. And, you know, if you have five people who work 80% time, that’s the same as, you know?five people go from a hundred percent to 80%, that’s the same as one person leaving. And so that’s really, that is a cost with that. And so unless we can kind of help support them to make it so that they’re having a full-time job as sustainable, that’s a negative impact in the return of investment. And so again those are some languages that people who are financially responsible will respond to. And I think that physicians, it behooves them to become more financially sophisticated so that they can make the point that taking great care of patients and making it easier for providers to provide great care to patients is in all of our best interests.

Dr. Hopkins: Well said. This has been a great conversation, Dr. Dunham. Appreciate your time and willingness to join us today. This is the practical tactics and strategies. What I heard you say?some things just to recap?thinking about coming at the need to change, making the case for it based in provider burnout, retain our caregivers and provide better care for our patients, provide better continuity while still protecting that health information that is so private and precious to our patients. And then the ability to see the EHR system continue to evolve by bringing front line clinicians and end users right up alongside the designers to try to make it more user friendly and improve the efficiency and allow us to take the great care of patients we all want. So thank you so much. I really appreciate you being with us.

Dr. Dunham: Thank you. It’s my pleasure. Anytime.
Dr. Hopkins: For more information on EHR optimization and getting rid of unnecessary clicks, there are several EHR theme toolkits that are available on our website at stepsforward.org. Dr. Dunham mentioned one of them inadvertently earlier in our conversation about synchronized annual prescription renewals. There's also a great toolkit on getting rid of stupid stuff. All the stuff that we each do every day that is not value-added work. I'll also advocate taking a look at the time saving playbook for all of us that want to be more efficient in our practice that want to come to the office, take great care of patients and then go home to our families, other loved ones and have a life outside of the office. So thank you so much for the conversation today. It's been a pleasure. We're thankful to have Dr. Dunham, and take care of each other. Stay safe and stay well. Thanks, everyone.

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