NEXTGEN® MOBILE

DECREASE DOCUMENTATION DEMANDS TO (ALMOST) ZERO

How to free yourself from your EHR

nextgen® healthcare

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Introduction

The burden of documentation, which weighs so heavily on clinical practice, is familiar to every healthcare provider as well as the administrative staff who support them. Widespread adoption of electronic health records (EHRs) as medicine's primary charting tool increases efficiency, but in some ways makes the documentation nightmare even worse, chaining practitioners to computers and keyboards.

By reading this eBook, you'll gain meaningful insights into how healthcare got into the fine mess we're in right now. More importantly, you'll discover ways—available now—to free yourself from the ball and chain of excessive documentation, ways to take back time, improve productivity, and achieve better work-life balance.

An answer exists now that can reduce the administrative burden of documenting in your EHR to (almost) zero.

PART 1

INNOVATION AND ITS RISKS

Technological breakthroughs touted as innovations to advance healthcare also create new risks—the EHR is no exception. While EHRs provide many benefits, such as more accurate and complete patient information, quicker access to patient records, and improved ability to share data,[1] they have also contributed to an increasing documentation burden and excessive screen time for clinicians and staff.

From meaningful use to misery

Much of the current dissatisfaction with EHRs dates back to the introduction of meaningful use standards—minimum U.S. government standards for EHRs, enacted as part of the American Reinvestment & Recovery Act in 2009. "Under meaningful use, every practice was required to have certain functionality," explains Dr. Robert Murry, chief medical information officer at NextGen Healthcare.

"You have to use this plain-vanilla, generic workflow that everyone else was using.

"Then came subsequent add-ons from the federal government, states, and local payers—leading to all of these little things you have to document in the computer in order to get paid, not get sued, get meaningful use money, or meet other program requirements," says Dr. Murry. "All of that crap has added up to a miserable experience using the EHR. Doctors are performing clerical roles. The EHR is not suited to their workflow. It's built by some other doctor somewhere that doesn't practice the way they do.

"Physicians can't get the information out of their EHR they want. They have to click everywhere to fill all these stupid requirements for programs that they don't understand and don't believe in. The whole thing has just gotten so FUBARed."

In search of a better option

In most ambulatory practices, care is delivered in a tightly timed environment, with the performance of each team member dependent on a workflow that needs to move efficiently.

Implementation of an EHR in the scheduled world of office-based medicine can lead to a variety of unintended consequences:

- Not uncommonly, clinical and administrative staff log into the practice's computer system all at once, causing processing speeds to slow down.
- Physicians become frustrated waiting for the EHR screens they need, adding to time pressure and stress.
- The quality of the clinical note is likely to suffer when findings must be hammered out on a keyboard in this tight timeframe.

"Time, or the lack of it, is key. Physicians have two opportunities for documenting a patient visit in the EHR," says Dr. Murry. "Option one is to document in the exam room when they're with a patient. However, having a computer in the exam room is distracting and can erode the relationship between patient and physician.

"Option two is to document after the visit. The problem is there's no EHR system that can keep pace with the physician's needs. You've got another patient waiting or multiple patients waiting, so you just try to fly through the screens. You barely get enough stuff down so that you don't forget it for later. And then you may have to finish at the end of the day or at home.

"Neither of these options is satisfying," says Dr. Murry.

The EHR and physician burnout

Studies demonstrate the relationship between EHR usage and physician burnout. For example, using an EHR is number three in a list of ten factors that cause burnout, according to the Medscape National Physician Burnout, Depression & Suicide Report 2019. The first two are administrative tasks and spending too much time at work.

Although EHR software was a major step forward in many respects, the technology has forced physicians to spend less time with patients. Physicians can spend nearly six hours a day on the EHR, according to a study by the University of Wisconsin and the American Medical Association. Not uncommonly, more than half of their working day is devoted to facing a computer rather than engaging with patients.[2]

EHR usage not only reduces time with patients; it can be a significant distraction during the visit. During the patient exam, physicians struggle to avoid looking at the computer too frequently.

> "Our providers are able to streamline the process, spend more time with their patients, which is very important, and less time documenting in the EHR."

Juliana Duffy, Senior NextGen Developer
University Clinical Health

Burnout reaches crisis levels

By eroding patient relationships and tying the physician to a computer throughout the day, EHRs contribute to stress that can adversely affect a physician's physical and mental health. Burnout and related stress have been linked to health risks; for example, fatigue, insomnia, substance abuse, and family problems.[3]

The severity of burnout among physicians was declared a public health crisis by the Harvard T.H. Chan School of Public Health, the Harvard Global Health Institute, the Massachusetts Medical Society, and the Massachusetts Health and Hospital Association in a report published January 2019. Risks to a physician's wellbeing hinder their abilities to provide effective patient care. The report highlights a significant need to recognize burnout and initiates strategies to mitigate it.[4]

Approximately $4.6 billion is lost each year in costs related to physician turnover and reduction in their clinical hours due to burnout, according to a study published by the Annals of Internal Medicine.[5]

To effectively overcome burnout, physicians and other healthcare providers need technological solutions that relieve them from administrative burdens. This technology should help:

- Providers return to a personal and authentic connection with patients
- Reduce stress and alleviate time pressure
- Restore passion for providing care

PART 2

A SOLUTION EMERGES

Ironically, there is a solution available in the marketplace that can eliminate frustration with EHRs and alleviate the pressure associated with excessive documentation demands—but many medical practices don't know about it. This solution reduces the burden of computer work for clinicians in medical practices from the size of a boulder down to the size of a pebble; it is an elegant combination of today's technology with professional services.

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“The answer to physician burnout is the strategic use of EHR technology, combined with a strong mobile offering that allows most physicians to complete their work on a mobile device.”

Karen Clark, Chief Information Officer
OrthoTennessee

Going mobile

Mobile technology changes everything—including the delivery of healthcare. A smartphone can now be turned into a working extension of the EHR by integrating mobile technology into your practice's EHR platform.

Quite simply, integration of mobile technology enables physicians and other providers to dictate clinical notes into their smartphone, anywhere, anytime. This goes a long way to making it more convenient to meet documentation requirements.

"You're using your smartphone, a device you're carrying around everywhere all the time, anyway," explains Dr. Murry. "The app is simple to use. You open the app and dictate your medical notes into your phone. The information flows into your EHR. It's that simple. You can get on with your life. It could not be better designed from the standpoints of ergonomics, workflow, and user-friendliness."

Introducing mobile technology into an EHR platform also enables physicians to:

- Capture images
- View and share clinical content in an instant, including problems, allergies, medications, lab results, and vital signs
- View the clinical schedule
- View images and documents from the EHR
- Text securely with colleagues
- Capture diagnosis codes and charges, ensuring records are up-to-date and billed accurately

"For most of us, being a physician occupies a huge fraction of our waking time," says Dr. Murry.

"When you use mobile, you're carrying around your schedule, your notes, and portions of the medical record as a matter of routine. You've got them all with you in your pocket."

> "The ability to do a lot of your documentation from your phone is critical."

Aaron Rucker, Director of Clinical Information Systems
University Clinical health

Remote scribe for ultimate mobile

Implementing mobile technology into the EHR expands your practice's options for documenting the clinical encounter. You can use:

1. **Front-end speech recognition** – which relies on automatic voice-to-text technology; a member of the practice staff must edit the content
2. **Back-end transcription** – the voice-to-text transcript is edited by a professional service
3. **A remote scribe** – to free clinicians from the documentation burden that weighs down contemporary healthcare, practices should seriously consider this professional service option

With the third option, a professionally trained scribe in a separate location listens to the recording of the mobile dictation and uses it to complete all required documentation and other related tasks directly inside the EHR via secure remote access. This means, in terms of fulfilling documentation requirements, the physician can be done with their work in minutes and pass it along to the remote scribe.

Using a fully HIPAA-compliant process, a scribe logs in to the physician's EHR using secure access from a remote location and performs a careful check to ensure the correct patient and encounter. The scribe then reviews the dictation and performs the necessary documentation.

The scribe edits clinical notes to ensure accuracy and completes structured and unstructured templates in your practice's EHR platform. For example, the scribe may document SOAP notes or procedures and progress notes, utilizing your preferences, macros, and workflow. They complete the documentation, enter evaluation and management (E&M) codes, generate the note, and send it to the physician for review and sign-off.

Combining professional service with technology

Remote scribe, a value-added professional service, enables your practice to achieve the full benefit of implementing a mobile solution. It ensures structured and non-structured templates will be completed accurately without overburdening physicians and clinical staff. It lessens time spent on data entry and clerical duties and allows more time to focus on patient care.

In addition, mobile with remote scribe avoids the challenges and expense of employing an onsite scribe. For example, a scribe in the exam room may cause the patient to feel uncomfortable and be less open about personal information, which may harm the accuracy of diagnosis and treatment evaluation, which in turn can adversely affect overall quality of care.[6]

Benefits beyond efficiency

The potential benefits of mobile combined with remote scribe go beyond improved efficiency.

Increased productivity

Freeing physicians from documentation demands allows them to see more patients; it can increase productivity and enhance revenue.

Alleviation of stress

Stress affects not only the medical practice but the lives of clinicians and their families; mobile plus remote scribe frees physicians and other healthcare providers from being chained to a computer, thereby alleviating a significant contributor to work-related stress.

Better professional environment

With mobile and remote scribe incorporated into workflow, the physician experiences the satisfaction of a more reasonable workload and pace, a better work environment, more meaningful patient engagement, and potentially, more time for family, friends, and personal interests.

Improved documentation accuracy

By combining mobile capabilities with a remote scribe, physicians can easily produce a more thorough and accurate clinical note. In addition, a remote scribe can assist the physician by helping identify the proper codes for diagnoses. The medical record becomes more thorough and accurate; this, in turn, strengthens the practice's ability to leverage documentation for incentive and quality payment programs and negotiations with payers.

Better quality of care

Improved accuracy means providers can look at a patient's history, previous encounter notes, and the assessment plan, and gain clearer recollection along with better insight from the patient's previous visit. This can help improve quality of care.

Less frustration

"In medical practices today, even routine tasks are burdened by the number of clicks required to enter information into the EHR, the amount of time that it takes, and the spinning dial that appears while you're waiting for the screen to refresh," says Dr. Murry.

"It's that kind of frustration that physicians and other healthcare providers can do without. Mobile, especially when combined with remote scribe, eliminates 90 plus percent of it."

The bottom line

An answer exists here and now to the excessive documentation demands that threaten the very heart and soul of healthcare. The means exist today to bring your documentation burden down to virtually zero.

“The burnout rate in medicine is insane. A lot of the burnout is because of electronic medical records and the need to be glued to your computer. You’re typing the same stuff over and over again. I think the combination of NextGen Mobile and Remote Scribe services are absolutely the only solution at this point.”

Darryn Band, MD, Physician and Partner
Capital Women’s Care, Silver Spring, Maryland

BETTER STARTS HERE.

For more information on NextGen® Mobile and NextGen® Remote Scribe Services, **contact us at 855-510-6398 or results@nextgen.com.**

1 Leslie Kane, MA. January 16, 2019. "Medscape National Physician Burnout, Depression & Suicide Report 2019, Medscape" https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056?faf=1#5 **2** Rajiv Leventhal. September 13, 2017. "Study: In 11-Hour Workday, Docs Spend 6 Hours on EHR Task" Clinical IT, healthcare innovation https://www.hcinnovationgroup.com/clinical-it/news/13029148/study-in-11hour-workday-docs-spend-6-hours-on-ehr-tasks **3** Mark Ringel. May 1, 2019. "Electronic Health Records and Doctor Burnout" Observations, Scientific American, https://blogs.scientificamerican.com/observations/electronic-health-records-and-doctor-burnout/ **4** News Release: Leading health care organizations declare physician burnout as 'public health crisis" Harvard T.H. Chan School of Public Health. January 17, 2019. https://www.hsph.harvard.edu/news/press-releases/leading-health-care-organizations-declare-physician-burnout-as-public-health-crisis/ **5** Shasha Han, MS; Tait D. Shanafelt, MD; Christine A. Sinsky, MD; Karim M. Awad, MD; Liselotte N. Dyrbye, MD, MHPE; Lynne C. Fiscus, MD, MPH; Mickey Trockel, MD; Joel Goh, PhD. June 4, 2019. Estimating the Attributable Cost of Physician Burnout in the United States. https://annals.org/aim/article-abstract/2734784/estimating-attributable-cost-physician-burnout-united-states **6** "Using Medical Scribes in a Physician Practice,"2018. The American Health Information Management Association. https://library.ahima.org/doc?oid=106220#.XZ9dNkZKg2w.

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