New EHR Reducing the Documentation Time for a Dermatologist to Half?

One of the main criticisms about electronic medical records (EMRs) from dermatologists is the time documentation takes away from the patient visit.

However, a research paper published in the Journal of the American Medical Association Dermatology, experts evaluate the effect medical scribes have on clinical documentation.

While EMRs have the potential to increase efficiency, documentation has increased physician burnout and decreased job satisfaction. In that study, researchers evaluated how employing medical scribes affects clinical documentation time and physician satisfaction.

In order to help physicians become more efficient and reduce their frustration with the EHR system, here are some suggestions for changes that can be implemented. The suggestions include improving the password process so that physicians do not need to spend time typing passwords into workstations.

- Practices should provide or allow dermatologists to attend individualized optimization training in order to personalize EHR settings; the dentist need a minimum of six hours of training, some spent in the classroom and some spent with a trainer.
- EHR users should ascertain where time is being wasted; most systems can show where physician time is being spent in the software. The EHR can be customized to workflow and specialty; customization improves physician satisfaction. Each physician should find the documentation time-saving method that works for them.
- In addition, a review process should be created whereby all items are reviewed by a member of staff before being sent to dermatologists, allowing items to be rerouted as appropriate. Where possible, staff nurses or other licensed clinicians can handle prescription refills.

- Printers should be installed in exam rooms in order to prevent physicians from having to walk back and forth to print information from the EHR. All this will also comply with a smother medical billing services.

Performing several tasks at a time and badly

The EHR is a lot more than merely an electronic version of the patient's chart. It has also become the control panel for managing the clinical encounter through clinician order entry. Moreover, through billing and regulatory compliance, it has also become a focal point of quality-improvement efforts.

While some of these efforts actually have improved quality and patient safety, many others served merely to "buff up the note" to make the clinician look good on process measures, and simply maximize billing.

Have full records of the patients

For EHRs to become truly useful tools and liberate clinicians from the busywork, a revolution in usability is required. Care of the patient must become the EHR's central function. At its center should be a portrait of the patient's medical situation at the moment, including the diagnosis, major clinical risks and trajectory, and the specific problems the clinical team must resolve.

This assessment should be written in plain English and have a discrete character limit like those imposed by Twitter, forcing clinicians to tighten their assessment.

Artificial Intelligence is a must to make the dentist and his clinical smarter

EHRs already have rudimentary artificial intelligence (AI) systems to help with dermatology medical billing, coding, and regulatory compliance. But the primitive state of AI in EHRs is a major barrier to efficient care.

Clinical record systems must become a lot smarter if clinical care is to predominate, in particular by reducing needless and duplicative documentation requirements. Revisiting Medicare payment policy, beginning with the absurdly detailed data requirements for Evaluation and Management visits (E&M), would be a great place to start.