

Position Statement
on
Electronic Documenting and Administrative Burdens
(Approved by the Board of Directors: November 2, 2019)

The Academy has observed with disconcertment the escalating electronic-documenting and administrative burdens physicians must endure. While workflow and technology solutions may ameliorate some burdens, the Academy recognizes that many burdens stem from regulatory and legislative mandates, and therefore this must be addressed through advocacy and leadership efforts.

The Academy has thus formulated a series of principles to support alleviating clinical documentation and administrative burdens amongst dermatologists:

1. The burden of documentation placed on dermatologists should never detract from care and effective treatment of patients, which is the central purpose of dermatologists
2. Government officials, third-party payer representatives, and all other interested parties need to recognize that poorly designed documentation requirements and administrative burdens directly produce and/or aggravate professional burnout in physicians.
3. Electronic documenting for the medical record was intended to provide an opportunity for enhanced patient care through interoperability, but the documentation efforts for routine patient encounters should not be a burdensome component of those encounters.
4. For routine patient encounters, the physician's role to spend the majority of a patient encounter actually seeing and treating a patient should take precedence over efforts to collect information for population health.
5. Documentation for official quality measures should be directed toward efforts that are feasible within the many duties of a clinical practice setting.
6. Documentation requirements promulgated by government and commercial payers should reflect current technological capabilities, and not outmoded paper-associated documenting approaches, and should not incorporate schemes that poorly link the extent of physician work during a patient encounter with documentation requirements.
7. Medical records in an interoperable universe that are intended for medical professional end-users should be well-organized, pertinent to care, and succinct.
8. Medical records in an interoperable universe that are intended for patients should incorporate structured data that facilitates care with current or future physicians and providers.
9. EHR (Electronic Health Record) developers should prioritize practicing-physician input from the earliest stages of coding and development of EHR systems, so that unnecessary clicks and steps and poorly refined workflow processes are eliminated; moreover, post-release individual-user EHR customization should be a programming priority for EHR developers.
10. An interoperable universe for medical records is facilitated by the transparent sharing of medical data and information through a common programming language organized with structured data elements but with the capability to also share unstructured notes and images; additionally, information that is shared should be up-to-date and accurately reflect a patient's current circumstances and condition.
11. Healthcare generally is rendered best within a stable infrastructure and delivery system, and thus, government and commercial entities should infrequently institute changes or add additional regulations to programs and paradigms that physicians and providers are compelled to pursue.
12. Healthcare generally is rendered best when government and commercial entities respect physician time and reduce administrative burdens like convoluted prior-authorization schemes, make-work medical records requests, and irrelevant documentation requirements.

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