A system-level approach to EHR inbox reduction
AMA STEPS Forward® podcast

A System-Level Approach to EHR Inbox Reduction

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Jane Fogg, MD, MPH, shares her experience leading a system-level initiative aimed at reducing the burden of the EHR in-basket. Host Christine Sinsky, MD also follows up with some audience-submitted questions about regulatory compliance, the initiative’s impact on patient care, and more.

Resources

- View the webinar that this episode was pulled from
- Taming the EHR Playbook
- EHR Inbox Management Toolkit
- De-implementation Checklist (PDF)
- Annual Prescription Renewal Toolkit
- Debunking Regulatory Myths Series

Speaker

- Jane Fogg, MD, MPH, chair of internal medicine, Atrius Health

Host

- Christine Sinsky, MD, vice president of practice transformation, American Medical Association

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Transcript

**Transcript**

**Speaker:** 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. Sinsky: Good morning everyone, or good afternoon depending on where you are. It’s really a pleasure this morning to be talking about inbox. One of the priorities that we’ve put at the AMA for the last two years has been to address EHR inbox burden and reduction.

And so with that, it is my great pleasure to introduce Dr. Jane Fogg. Dr. Fogg is the chair of internal medicine and family medicine at Atrius Health in Boston, and she leads a team focused on primary care redesign for reliable systems that are team-based, patient-centered and return joy to the practice of medicine. Who could ask for a better mission statement? She also leads programming and palliative care, geriatrics and hospital services and the organizational initiatives to advance care. I know that Jane is really committed to improving the patient experience and the physician and other health care worker experience. She’s committed to value-based care. She has been an innovator in practice both as a physician and as a health system leader.

So with that, I’d like to turn it over to you, Dr. Fogg.

Dr. Fogg: Good morning, afternoon, evening. Thank you so much. It’s really a pleasure to be here. Today I will be talking about in-basket reductions, specifically how I made some progress at our organization and also really to highlight the STEPS Forward® module, which shares really fantastic information on how you can do the same yourself. To sort of start with the headline, which is, what did we do? This is Atrius Health data. This is the in-basket message volume for PCPs, specifically spanning over 2016 up until most of 2022. Over that time, the total message volume normalized by FTE has actually reduced by about 25%, which is considerable. We’re not done yet, but this shows we’ve actually made some real progress.

So how did we actually get to this place of in-basket reduction? Specifically, we used a strategy of elimination, automation, delegation and collaboration to find a multitude of tactics to reduce the total volume. We really understood that there was no one single fantastic solution that would solve it all and that we had to tackle this piece by piece to get the results we wanted.

So our process and what we think is a very sound way to start is this simple five step process and the beginning is always understanding your current state, getting your strategic approach, creating governance and work groups, who’s going to participate, how decisions will be made, establish and execute on those tactics and measure the impact. Make sure that you’re actually making progress. So as I reflect on this process, I think one thing that has become clear to me is how you start is very important and who you involve. I think of this in sort of two ways. The first is that, who are we involving in this work? And one might assume that we should just involve clinicians to get together, design what they think would be best and ask someone to build it for them. I would actually argue that if you combine your clinical, your technical and your operational experts at the very beginning of your work, you’re going to find solutions you didn’t know were possible. The co-development of solutions between the technical experts and the clinical experts really led us to find new ideas. As example, we didn’t know we could eliminate certain routing pathways. We didn’t know why some things were getting routed into our in-baskets, and so when we sat down together to examine what we wanted to do, we learned from our technical experts and they learned what was important to us, both the clinical leaders and the operational leaders. So we really blended new perspectives on what inbox design could be by sitting at the table from the beginning.

I would actually argue that if you combine your clinical, your technical and your operational experts at the very beginning of your work, you’re going to find solutions you didn’t know were possible. The co-development of solutions between the technical experts and the clinical experts really led us to find new ideas. As example, we didn’t know we could eliminate certain routing pathways. We didn’t know why some things were getting routed into our in-baskets, and so when we sat down together to examine what we wanted to do, we learned from our technical experts and they learned what was important to us, both the clinical leaders and the operational leaders. So we really blended new perspectives on what inbox design could be by sitting at the table from the beginning.

The second important piece is, take some time to evaluate your current state. Don’t minimize that. We all know the in-basket is terrible, but I think you really want to explore quantitatively and qualitatively what’s happening in your in-basket at your institution.

Certainly, we start with the volume of messages. How do we measure it? How do we know what it is and what type of messages, how are they categorized? What are the relative proportions of each message type? That’s basic. But then I think the next part, which was a little more qualitative, was what was the intent of that message? Did I need to do something or is that an FYI for me? Did I need to see it or did somebody else need to
see it? As that leads us into who is really the ideal team member to address that particular message type. Typically today, most organizations route things to a physician and expect that they will then send it on to other folks on their team to take next steps. I don’t think that’s a durable solution. There is simply too much volume coming at us.

We need to get it to the team first and they need to delegate up, to you the physician. The important part of building a strategy in this, stop wishing there was one thing you could do and you’d be done. There’s going to be several things that you have to do and we think that if we can first look at ways to eliminate waste, that takes things away without having to change workflows for a lot of your clinical team and you. And then moving towards automation where you’ll have to do deeper work with your teams, and I’ll explain through some examples on how we can change workflows, how we can trust automation. And in delegation, it’s incredibly important that you have a strong team structure and so you can’t start delegating in the in-basket if your clinical practice doesn’t have a good team structure to build off of.

Collaboration I think is such a key point. Most in-baskets were designed as if there’s a singular user and that’s all that’s needed. The reality is, is that the in-basket is clinical information, it’s clinical care and it belongs to the team, and so we need to figure out how we can have multiple people participate, how we can reach across departments and participate.

What I’d like to do now is actually dig into a few examples to really show you how we did it. So I’m going to start with a place that we started, which was CC chart, which is that carbon copy chart or the note that is sent to you by a specialist, an urgent care colleague, or perhaps one of your cross coverings, and they’re sending you their note and it comes in CC chart. And when we looked at this back in 2017, it was 16% of our total message volume. At that time when we looked at the total message volume for a full-time PCP at Atrius Health, they received 100 messages per business day, 500 a week.

So this was 16 a day, so the volume was too big. But then we actually started looking at the messages themselves and when we looked at them, we saw that many of them held low clinical value, meaning it was a normal dermatology check. We’ll see them next year or saw for a sore throat, did a strep test, gave them antibiotics, things that you don’t actually need to take an action on. And when there was something valuable such as a specialist making a new diagnosis of significance in your patient, the CC chart was sent and you had to read the whole thing to find that.

So we looked at that and we saw this high variation in clinical value. We also sat with our Epic partners, who showed us why and how things were routed to the PCP. We had no idea that long ago people had made decisions about which department routes to which PCP office and why. And so we had this very messy, highly variable routing framework that didn’t make a lot of sense and was based on decisions made many years ago.

So what we first did is we just got rid of that. We said, no more automatic routing. If you’re going to send me a message, you have to push it. You have to actively send it. We then sat with our colleagues outside of primary care and came up with practice agreements. What should you send me and why? And if you send it, I’d like you to put a little header so I can see new diagnosis, change in prognosis, something needs to be done, so I’ll know when I look at my CC charts, there’s something I actually need to do. So we ended the automatic routing. We set up the practice agreements at advising our colleagues on what to send us, and then we purged.

We found that a lot of folks had kept CC charts in their in-baskets for years, even. We purged any CC chart out of an in-basket that was over 60 days. Mind you, these are all notes that are going to be in the chart. You’re not eliminating data, but you’re taking it out of an in-basket. We quickly achieved about a 40% reduction, which persisted, and we found that people were saying, now when I see a CC chart, I know it’s more likely to have something valuable for me. So that was an elimination of low value clinical work that came out of the investment.
After we did that, we moved on to media manager. Now media manager is that folder for us that has all those scanned documents, anything that comes in and has to be scanned and sent in that way, and it usually gets scanned in a central medical records department and then routed out to the PCP who would have to read it and then it was filed in the chart. It was a small volume across the board for us, but when we looked at some of our sites who are closer to outside facilities, outside hospitals, they had a higher volume. So it was plaguing certain sites more than others, and most importantly, uniformly, people said, “I can’t find it. There’s something valuable in here, but it’s not that frequent and I have to read a lot of stuff to find it.”

So we sat down, we created a governance group, and this governance group had PCPs, some of my chiefs of my departments who are practicing PCPs, it had our Epic colleagues and it had the leader of our information health systems, the one who did the categorizing, and they set up a grid and they categorize things as what these documents were. Do you need to send it to the PCP or can it be what we call filed silently, meaning it goes in the chart, but it doesn’t have to be checked off by a PCP, just goes right into the chart.

We also found things that were misfiled or miscategorized and they were valuable. One of the things that was most common was a discharge summary from a psychiatric hospital. That’s something we want to have, and so we recategorized it to a folder where you could find it if you were looking for it. So we made new assignments, we eliminated a lot of things that you don’t need to see, and in the end we had a 98% reduction in that folder, which continues to persist. The other thing I’d say in this space is that sometimes we found workflows that were creating more waste in here. Specifically, someone would send a consult note on paper to a PCP. The PCP would read it, sign it, send it to medical records, it would get scanned and sent back to you to read it again in the in-basket.

So we sat down and we really worked on those workflows to make sure that we weren’t sending things to people twice. So we found waste that we created ourselves. We got pretty excited by that and we went to the next folder where we thought we could find some waste, and this is actually a very important folder. We have a folder of emergency room and hospital notifications. We, working in Boston, work with about 14 or 15 hospitals on a routine basis and they send automatic feeds. They’re called ADT feeds or admission, discharge and transfer. These are automated feeds that will send a message to our organization. It goes straight into the in-basket and tells you if your patient is in the ER, in the hospital, getting discharged, going to a skilled nursing facility, going home. Unfortunately, what we found is because of the automation, there was a lot of duplication in here.

For every admission there were about six notifications, and that can get kind of annoying. We also have our nurses look at daily registry reports of who’s being discharged from the hospital so we can do the appropriate outreach and make sure we’re caring for our patients—so we could take this away from the physicians without impacting that. When we considered all our options, this is one where we completely removed it from the in-basket and our IT team built a dashboard that you could pull. They took this information and created a PCP-centric dashboard that you pull whenever you’d like to. It lists all your patients who are admitted or discharged in whatever timeframe you want to look at, but it was also designed to give you the information you need as a clinician. Where’s the discharge summary? Has someone called them? Do they have an appointment with me? Those are the most important things. So we made sure that was highly visible, so this was a 100% reduction and putting information in a much more user-friendly format.

Then we moved to automation and this was actually a very deep and involved project that took our entire organization over a couple of years and has been absolutely fantastic. We know in primary care and in many specialties, there are many routine reliable tasks that happen again and again and don’t necessarily need you, the physician, to sign off on them each time. Prescription renewals is one of these. It’s not unusual that beyond our patients requesting renewals, pharmacies, insurance companies, there are multiple ways that people request renewals from us. We tried very hard to get people to give longer refills, 90 days for refills, which we think is a best practice to eliminate waste, but we still had a very high volume. In fact, 16 per day per full-time PCP back
in 2017.

So we thought about what are we doing when we renew a prescription and we’re typically checking the chart, making sure the patient’s up-to-date with their care needs, deciding if we’re going to renew it or if we’re going to ask them to come in for something to check or if we just need to remind them to book a follow-up in months to come. We wanted to find a solution to automate this and we wanted to move quickly. So we decided to work with an outside vendor that had a mature product that was essentially an automation platform that we could put right into our electronic health record. We are on Epic at Atrius, but this same platform could be put in a multitude of other EHRs.

What the platform is doing is when the request comes in, it is the automation is scrubbing the chart. It’s looking to see, do they have the appropriate blood pressure readings to get their antihypertensives? Do they have the appropriate visits set up in the future in the past? Is there any lab work or any other care gap that I as the physician would be looking for when I renew a medication?

It worked well. We did do some piloting and we made some adjustments so that we could align the clinical operations with how we worked, but we also made sure that we had physician governance, ensuring that these protocols had great oversight and were endorsed by a body of physicians, nurses and clinical pharmacists. So we reviewed every protocol to make sure it matched the Atrius health standards. After we finished our pilot of two sites, we spread it to 21 and in that work, so in an adult primary care space, we reduced the prescription renewals that go to the PCP in-basket by 50%. They do not require a physician to sign off on them. They are automated under your name.

It continues to work well and we centralized our team over time to take advantage of some level-loading and some efficiencies. We saw a big backlog every Monday. We wanted to apply some resources so that we would be caught up on Monday and not wait until Thursday to get caught up on renewals. We made sure to have some metrics that looked at patient experience, specifically, how quickly are we getting their renewal to them, what’s our service standard. So there were a lot of pieces of that to make sure that patients were having a good experience while we did this, and it continues to be an incredibly successful automation that we’ve enjoyed and we’ve been spreading it to other service lines beyond adult primary care.

So, emboldened by the ability to put automation in clinical practice, which doesn’t happen a lot in primary care, we thought about another automation that we might do, and so this was looking at normal lab results. We know in total the results folder of most EHRs is almost 20% of it. It’s quite a bit. We do a lot of preventative medicine at Atrius Health, and so we certainly are checking hemoglobin A\textsubscript{1C} and lipid profiles and so on, and we were sort of shocked to see that across the board we had a pretty high number of normal results. We looked at current state, almost 70% of my adult primary care practice, the results were actually normal.

We talked about the idea and we dedicated a physician leader who had a multidisciplinary group working with them, including lab leadership, several physicians, nurses and others, and they set about the task of saying, which of these normal labs could we not tell the PCP about or the ordering provider, simply go straight to the patient?

Now we are all working in an environment with greater transparency of clinical information. Our patients have access to their data much faster. So this is very much aligned with the patient’s ability to see things on the portal in real time, but we really discussed and figured out what’s normal. Normal meaning it’s normal in any clinical circumstance, there’s no circumstance in which it could be abnormal.

So things we couldn’t work on are things like a thyroid stimulating hormone because if a woman is pregnant or there’s other conditions going on, you can’t rely on the reference range to say it’s normal. But we were able to identify a fair amount of things that are normal in all clinical circumstances. We vetted this extensively with our physician leadership. We have leadership at all of our 21 sites and all of those chiefs were involved in thinking
about the professional change to not see the labs you ordered.

We thought about when you’d want to see the lab, even if it was normal because it might spur you to do something else. And so we gave a little checkbox that will say, CC to me no matter what, in case you really want to know even if it’s normal. We piloted it. We had a little pandemic disruption, so it was a longer pilot than expected, but when we were done with the pilot, we were able to expand pretty seamlessly across 21 sites and it took 30% of the lab results out of the PCP investment. So a good reduction there for the normal labs. I think delegation and collaboration are such important tactics and this is where these tactics start to involve your team relationships, the design of your team and how you change culture and how we all need to take care of our patients as a team and not an individual.

And what I found over the years is that the in-basket rarely reflected a good team-based primary care model. We do it in our clinic, but then we go to the in-basket and we practice solo. So when we thought about delegation, we realized we really need to embed it in the in-basket routing structure. Instead of sending me an abnormal labs or one of our current pilots is, abnormal vitamin D, instead of sending it to me and saying, “Jane, you can send it to a nurse and they can, by protocol, manage it.” Why don’t we send it straight to the nurse and we have a protocol for them to manage it. They certainly can ask a question if something’s not clear, but they can do this independently by protocol, call the patient, review the results, figure out the next steps, follow up and so on.

So it’s really more top of license work for nursing and although the volume of abnormal vitamin D as you can see is not that big, the important part is this is a message that takes some time to manage. You have to find the patient and make the plan. And so it is actually removing some time management, but it is also ensuring that we have a consistent approach to abnormal vitamin Ds and how we manage them. So we feel like the success of this will lead us to do many more like this, where we are going to use the in-basket to enforce delegation.

(The) biggest problem across the country, PMAR, or patient medical advice request. We too also had 100% doubling of the medical advice requests. Now we have long had our EHR set up so that when the patient is writing a medical advice request email, they can check a box saying, this is for renewal, this is for a referral, this is a medical question, not urgent. And so they’re already sort of self triaging. So our 100% increase was in the ones where it was a medical question, not a renewal or anything else. And we had again, well, the doctor will just send it on to somebody else, so let’s reverse that.

Let’s send it to somebody else and let them triage it up to the doctor. A lot of people are doing this across the country. I think it’s incredibly important work. What we did perhaps a little differently is we experimented with the difference between sending it to a nurse first or to a clerically trained person—we call them PSRs—first and we actually found that PSRs were able to eliminate a fair chunk and then delegate up to a nurse if they needed and up to a physician or advanced practice clinician if they needed to. And when they do this, the sites where this is active, it’s about a 40% reduction.

It is definitely a more involved project. You have to do a lot of work training people and setting up what’s appropriate for you to manage and what needs to be delegated up to someone with a licensure or clinical training. But as you can see, there’s already low-lying, 40% of those messages didn’t even need to go to a nurse. So quite a bit we can do there and quite a bit more that we can all do.

Another example of measurement that was helpful for us, we looked at who’s touching and who’s “done-ing” or completing a message. And this kind of measurement’s really helpful when you’re trying to ensure that your team is consistently doing the routing and the responsibilities that you’ve designed. So finally, I always think it’s important to talk about the non-technical, the collaboration aspects. I was inspired by a group, a Kaisser group, who had a clinical coverage department that covered in-baskets for any leave or departure over a week, and we developed our own department like this in 2021. We currently cover extended leaves such as a medical leave.
We cover when a physician or APC leaves and we need some help at the site to cover their in-basket. But we also jump in and help cover when we have a struggling clinician who is really falling behind in their work, showing signs of burnout, and they need some time to get new habits, such as a scribe or other things that they can do, they need some time to figure out how they’re going to develop their own efficiencies or what we might do to support improving their workload. And so we can come in and sort of help cover their in-basket temporarily while the local team can really work with that clinician and figure out what is the best path for them. It’s called the Clinical Coverage Department. And we’ve had a lot of retired PCPs who like to do some part-time work because they can do a lot of this virtually and a couple of APCs, and it’s been one of our more successful endeavors in the last few years. As all of when your colleague is out or away and you’re covering their in-basket, it is undoable, very stressful for everybody, so this has been a huge help.

The other initiative that we’re doing, which takes time to build, but I think is a really important part of primary care going forward, which is the idea of having an advanced practice clinician and a primary care clinician sharing a panel and having dedicated continuity so that...for years I worked with a nurse practitioner, she and I shared a panel of patients together and patients knew they had two of us, not one of us. They never lost me, they just had two people. And our goal is to stop saying, “cover me” and start saying, “let’s share the care of our panel including the in-basket work.” So this is work that’s ongoing and I think important for all of us.

I think again, the codevelopment from the very beginning will enhance your success, engage your chief medical information officer, engage your EHR leaders. They need to be at the table with you because much of this is technical and much of this is team and you need to be together to make those decisions and find your opportunities. A second important piece is about decision making. I find that a lot of us don’t know who made the decision that somebody’s sending me this document and I don’t know, do I need to see it? Who decided that it was sent to me? I hear that from PCPs every day, why am I getting this? You can make decisions about what you and your team should see, and if you employ clinical governance and you think about the clinical value about safety, about all those parameters, I think you will find there are a lot of decisions you can make about things you actually don’t need to see or could be seen by somebody else.

And sometimes you need to standardize a certain workflow to achieve something such as automation. We had to have certain standards in our refill management in order to automate refills for 350 providers. Couldn’t customize it to each individual provider. So I think it’s an important thing to think about standardization in the right spots where it allows you to drive forward something that supports everybody and that’s why making decisions is really important and having that clinical governance, a good in-basket is as good as a good team. Think about your team roles and how your MAs, nurses and everybody else on your team works today. I also think that ongoing EHR trainings to support personal efficiency skills complement this work.

I never want anyone to believe that it’s just about your own efficiency. It’s not. It’s a messy system and very few people can be efficient in it, but even if we designed it perfectly, I didn’t learn this in medical school, not all of us are born with great efficiency skills to look at a large volume of work and try to sort out how to work smoothly and efficiently for you and your team. So I think that that’s a really important part of what we all need to do in our institutions.

**Dr. Sinsky:** Dr. Fogg, I want to thank you so much for sharing this incredible work that you have done over the last five years. Not only for the results that you’ve attained, but really for the insights that you have gleaned about how we can all help to reduce the burden of inbox for our health care professionals, for our physicians and for our teams.

How do we encourage, enforce, necessary follow-up, clinical follow-up if we no longer are using an expired prescription as the hook, as the enforcer for bringing people in for their appointments?
Dr. Fogg: Great question. When we were looking at our refill automation years ago, it sparked a lot of great conversations in this area. And one thing that really struck me then that I hadn’t thought of before is, we’re relying on the refill, the renewal to remind ourselves that a patient might need care, but what about all the patients that don’t call us for renewals, don’t take their medications? What are we doing to remind ourselves about them?

So it’s a really uneven and highly variable way to keep track of your patients. You’re just keeping track of the people that are actually taking the medicine and asking you for it. It kind of shifted my thinking to our outreach mechanisms to ensure that patients are getting great care should not rely on renewals. That’s sort of the first premise. So what can you do?

And I think this gets into the area of there are a lot of emerging automation systems coming out of Epic and others where you can do reminders for people who need to come in for annual exams, need to come in for certain screenings that is outside of the renewal system. So I’d encourage you to look at what’s available to you not using the renewal system because I think you’re then only focusing on a subpopulation.

Dr. Sinsky: So I really like that and I often think about how expensive it is to use the prescription renewal as the hook, the enforcer for prescriptions. And another strategy is to simply reappoint people at the end of today’s visit for the next appointment and to match that with the prescription renewal volume that you give. So maybe others have had the same experience I’ve had, come back and see me in a year, here’s a six-month refill for your whatever.

Well, if that’s your approach to managing patients, you will automatically burden your staff with additional work to be done between visits. If you feel that the patient needs to be seen in six months and needs lab, then schedule that, reappoint that at the end of today’s visit.

Another question that’s come up is around unintended consequences. What are some of the unintended consequences that you might have seen for some of your inbox reduction efforts?

Dr. Fogg: It’s interesting to me that the lab automation of normal labs, we didn’t have unexpected consequences and actually people sort of doubted that it would be acceptable to physicians and patients. But it turns out we’ve been scanning, we’ve been looking at the comments, we’ve been asking people, nothing.

I would say, though, that the trickiest thing is the patient medical advice request. And I think that there are many patients who still believe that they are just emailing you and you are sitting there ready to email them back. One of the challenges we found is some patients being upset or surprised that another team member got back to them. Another is really, and I’m sure you’re all experiencing this, this emerging sort of sense from our patients that they should be able to get care via these medical advice portal emails that really you should bring into the office or at least do a video visit.

And so I think I’ve learned in that it’s a combination of we have to figure out how to change our patients’ expectations and culture around what’s appropriate for sort of in-basket health care. We also need to figure out better ways to train our staff because as you know, especially those of you in adult primary care, you get a lot of messages that are two or three things mixed together and it’s very hard to parse that all out as a staff member. But I think you can do it, we just need to invest more time in that. So that was probably one of the unexpected consequences is performance complaints in the patient medical advice world.

Dr. Sinsky: Did you have an approach to either direct patient questions that were urgent away from the portal altogether or to float those to the top? How are you dealing with making sure you’re not missing urgent requests that come in through the portal or that attempt to come in through the portal?
Dr. Fogg: One important component of how we are having our team look at the portal message first is for them to be empowered to see certain things and say, that is a visit and that’s a visit today. We’ll get them in today. And so we found pretty uniformly, our PCPs were crying out for their team to say, just get them in. That’s not unusual on the sites that are doing that where the clerical person will call the patient and say, I can get you in today. And the nice thing about having video visits still is that for patients that didn’t want to come in, well let’s at least get a video visit if that’s appropriate.

So I think that we do empower our staff to do that. The other thing that our radiology department did, which was very helpful a couple of years ago, is they separated out a folder of significantly abnormal radiologic exams from radiologic exams. So you’re not plowing through the mammograms to find the one mammogram where there’s actually a very suspicious finding. PCPs say, oh, go to that folder first for the really abnormal, make sure I’ve done that. Then I go to the other one where might be an incidental finding are completely normal. So that was a real help from our radiology department.

Dr. Sinsky: Wonderful. And that shows how having multidisciplinary members of your team and your planning team can make a difference. How did you deal with staff or administration resistant to change? How did you get leadership to support this and how did you get MAs and nurses who were on the clinical teams to recognize that this was an important contribution that they could make and it was really part of their job responsibility?

Dr. Fogg: So starting with leadership, what I think is most important is you need to find where is your alignment of your C-suite’s priorities and yours? And I think they’re often matched, but it may not be initially apparent to everybody. And so working with my C-suite, and I had a very supportive CEO, we are a growing organization. We need to retain and recruit more PCPs and so we can get aligned around that. Well, what is the reason why PCPs are dropping off or are not wanting to join? Well, the work and what’s changed about the work. And so part of what I had to do is help illustrate what the work is in primary care. And this is true in any specialty as well. And specifically that the days of you see patients in the office and you take call at night and that’s it, are gone.

What we’re really doing is we’re seeing patients in the office. We’re managing a lot of care through documentation and through in-basket. And that balance of face-to-face time with in-basket care has really tipped heavily. And many people have done great work measuring how much EHR time is happening in relation to how much face-to-face. So demonstrating that through data but also through national studies was very helpful. I even had one of my clinical informatics colleagues went into the C-suite and she opened up Epic and she showed them how to document an annual exam, and they didn’t know. And so I think when they had an understanding that our work has shifted in this space, then I had a little more mind to say, if I’m going to attract PCPs and retain the great group that I have, I have to help them with this body of work.

And we all want to recruit more and hire more. We want our PCPs to accept patients, we want them to be accessible. It’s not going to happen unless I can get that in-basket in a better state. And so I think that that got leadership excited by this.

Working with our teams back in 2016 and ’17, I remember some uncomfortable conversations. That’s your email, that’s your in-basket. I’ll wait for you to look at it and you send it to me. I think what engaged us is first as a leadership group, my nurse leader and I would make sure we were aligned before we went out together to talk to our teams. And sometimes I would speak on behalf of nurses and she would speak on behalf of doctors. We showed that we are looking across, we are sharing this work, these are our patients and that we need to have mutual respect for each other and mutual accountability.

We spend some time that qualitative look at current state. One of my leaders stood up in a meeting and read the first 10 message types in her in-basket. And I just remember people’s mouths opening, saying, I didn’t know that was in there. And so I think we really worked on, we don’t like to call it an in-basket, it’s clinical information,
it’s care. And so this is our care, that opened up that conversation.

It’s really important to reward your teams when they take steps forward on new tasks. We have one site that did a really amazing job engaging their medical assistants in prepping and scrubbing their schedules for the next day, but also working on in-basket. And I think it was really a little bit of leveling of our hierarchies and saying, you are important to the team as a medical assistant, I need your help with this. Thank you for getting that done. So that culture of empathy and accountability really goes a long way and you’ve got to take some steps to build that.

**Dr. Sinsky:** Great. I love that example of physician and the nurse working together and each being empathetic to their particular role types’ situation and speaking across those role types. I think that’s just a wonderful way to message that we are actually all rowing in the same direction for our patients.

Question around legal and compliance review of your processes: Is it kosher with various standard setting organizations or CMS regulations, for example, to send ADTs directly to a dashboard rather than not?

And before I turn it over to you to address that, I want to let the audience know that there are two other resources that relate to this question of, what’s truth and what’s myth around legal and compliance requirements. And so we have an initiative at the AMA called *Debunking Regulatory Myths*. We currently have roughly 16 different myths that are common among health care systems. And we state the myth and then we go to the source and we quote the source, whether it’s in the federal registry or whether it’s with the Joint Commission, and those are available and you can print those out as PDFs and use those to facilitate internal conversations with your colleagues in compliance and legal.

We also have a *de-implementation checklist*, which is a brief list of some things you might want to consider as an organization de-implementing policies and practices that may have at one time made sense but have either outlived their usefulness or never actually lived up to the expectation in the first place. And we sent that list to the Joint Commission who reviewed that list. We made a few minor modifications. So we know that the recommendations for consideration of D implementation in that list are consistent with Joint Commission standards and also therefore consistent with CMS regulations.

So with that discussion of some of the available resources, Jane, I’m going to turn it back to you. What are some of the legal and compliance steps that you took to make sure that you were recommending and implementing defensible practices?

**Dr. Fogg:** Thank you. I’m so glad that we are addressing this because I often have found that regulations lag behind clinical practice. Regulations are often ambiguous. And if you sit down and read the nursing regulations in Massachusetts as I have, you will learn that you could probably interpret it in different ways. And so over the years, I’ve made sure that I have had great access to our chief legal officer who’s a former nurse to discuss, is there a regulation that oversees this particular area or not, or is this just what we’ve done and who’s making the decision? That conversation offline with her has been very helpful. We have a compliance committee. I am a member of the compliance committee, and so I’ve learned in those settings you need clinical voices in compliance because sometimes we’re making or discussing an issue or a problem, but you need the clinical context.

You need a clinical operations person there to inform that decision. If you don’t put people in those committees, you will get decisions that don’t work well for you. So I worked with those two bodies, but I honestly learned there’s a lot we can decide for ourselves. We have great minds to think about what is safe, reliable, effective practice. You should be comfortable saying, why am I getting this? Is this delegation okay? Is there a scope of practice I need talking to your legal team? And I love the fact that the AMAs invested in this debunking of myths because I think we just didn’t question enough as clinical leaders that there are many things we can change and there are many things that nobody’s decided and we will do what’s best and safe for our patients.
**Dr. Sinsky:** And I think much of the work that you’ve done is countering another myth. And that myth is that care is always safer if the doctor does every element of it. We both know that that’s actually a recipe for safety hazards, that we create a very hazardous environment if we are anticipating that our physicians do everything and we have all this multitasking, which means task switching, and we don’t actually give physicians time for the deep work of doctoring.

So, Dr. Fogg, I want to thank you so much for sharing this incredible work that you have done over the last five years. One physician said, “I just feel like I’m drowning. I consider myself responsible and responsive and I just can’t keep up. And I spend more and more time, extra time in order to keep up.” And another who said, “Can you reduce my inbox burden enough to prevent me from quitting medicine before age 45?”

And if we had a mission that really mattered, I think it’s that, to keep our physicians in the practice of medicine and actually doing high-value clinical work by reducing a lot of the low-value work that has turned out to constitute the majority of many physicians’ day. So Dr. Fogg, you are leading the charge and I thank you so much for doing the work you did and then taking the time to share that with us today.

**Dr. Fogg:** You’re welcome. Thank you all for continuing this work.

**Dr. Sinsky:** With that, we’ll sign off. Thank you so much.

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