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De-implementation checklist

In an effort to reduce unintended burdens for clinicians, health system leaders can consider *de-implementing* processes or requirements that add little or no value to patients and their care teams. Physicians themselves are often in the best position to recognize these unnecessary burdens in their day-to-day practice. The following list includes potential de-implementation actions to consider. Learn more on how to reduce the unnecessary daily burdens for physicians and clinicians at stepsforward.org.

EHR

☐ Minimize alerts

- Retain only those alerts with evidence of a favorable cost-benefit ratio

☐ Simplify login

- Simplify and streamline login process, leveraging options like single sign-on, RFID proximity identification, bioidentification (fingerprint, facial recognition, etc.)

☐ Extend time before auto-logout

- Consider extending time for workstation auto-logout
- Consider customizing workstation location and the security level to use patterns of the specific user

☐ Decrease password-related burdens

- Consider extending the intervals for password reset requirements
- Help users create passwords that are both strong and easy to remember (i.e., by allowing special characters and spaces, and by allowing longer passwords that can be passphrases)
- Consider use of password keeper programs

☐ Reduce clicks and hard-stops in ordering

- Reduce requirements for input of excessive clinical data prior to ordering a test
- Eliminate requirements to fill fields attesting to possible pregnancy in males or women over 60 years old

☐ Eliminate requirements for password revalidation

- Identify ways to reduce unnecessary requirements for users to re-enter username/password when already signed in to EHR, to send prescriptions (Note: Organizations may choose to keep this requirement in place for opioid prescriptions.)

☐ Reduce note-bloat

- Reduce links imbedded in visit note documentation templates that automatically pull in data from other parts of EHR contributing to "note bloat," but adding little if any true clinical value

☐ Reduce inbox notifications

- Stop sending notifications for tests ordered that do not yet have results or have test results *not* ordered by the physician in question
- Stop sending notifications for reports generated by the recipient of the notification
- Eliminate multiple notifications of the same test result or consultation note
- Consider auto-release of normal and abnormal test results to the patient-facing portal with imbedded or linked patient-friendly explanations

☐ Simplify order entry processes

- Optimize technology to auto-populate necessary discreet data fields if the information already exists in EHR (e.g., if medical assistant has completed a discreet field for "last menstrual period," optimize your technology so no one has to reenter that data into the order for a pap smear)

Compliance

☐ Allow verbal orders in low-risk and in crisis situations as legally permitted

☐ Reduce signature requirements

- Eliminate signature requirements for forms that do not legally require a physician signature
- Eliminate order requirements for low-risk activities that do not legally require a physician signature (ear wash, fingerstick glucose, oximetry)
- Consider eliminating "challenge questions" to electronically sign orders when the user already logged in and actively using the EHR

☐ Evaluate annual trainings and attestations

- Review current compliance training modules and consider removal of those that aren't required by a regulatory agency or for which evidence of benefit is lacking

☐ Reduce attestations required daily or every time one logs in

- Eliminate requirements as allowed by state or federal requirements (i.e., for privacy protection attestation) that occur on a daily or every-time-one-logs-in basis (i.e., consider whether or not an annual attestation is sufficient)

Quality assurance/improvement

☐ Eliminate the rote ascertainment of learning style preference

☐ Perform condition screens no more frequently than recommended

- Include a "grace period" of at least 30–50% of the guideline recommended time interval when constructing a performance measure from a clinical practice guideline

  Example: If clinical practice guideline recommends annual screening for depression, then set performance measurement with an interval of performing this task within 18 months—otherwise staff will waste limited clinical resources screening more often than is required to meet the 365-day annual interval.

Launched in 2019, the Joy in Medicine Health System Recognition Program provides a roadmap for health system leaders to implement programs, policies, and workflow efficiencies that support physician well-being and enhance joy in medicine. This program is designed to empower health systems to strategically and systematically reduce burnout so that physicians—and their patients—can thrive. This de-implementation checklist can help organizations meet the eligibility criteria for the program. View the program brochure to review the eligibility criteria and learn more.