Welcome to the Saving Time: Practice Innovation Boot Camp

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Innovation Academy

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Meet Your Faculty

Marie Brown, MD, MACP

Heather Farley, MD, MHCDS, FACEP

Jane F Fogg, MD, MPH

Kevin Hopkins, MD

Alekzander Sayers

Michele Thomas, MD, FAAFP

Overview

Michael Tutty, PhD

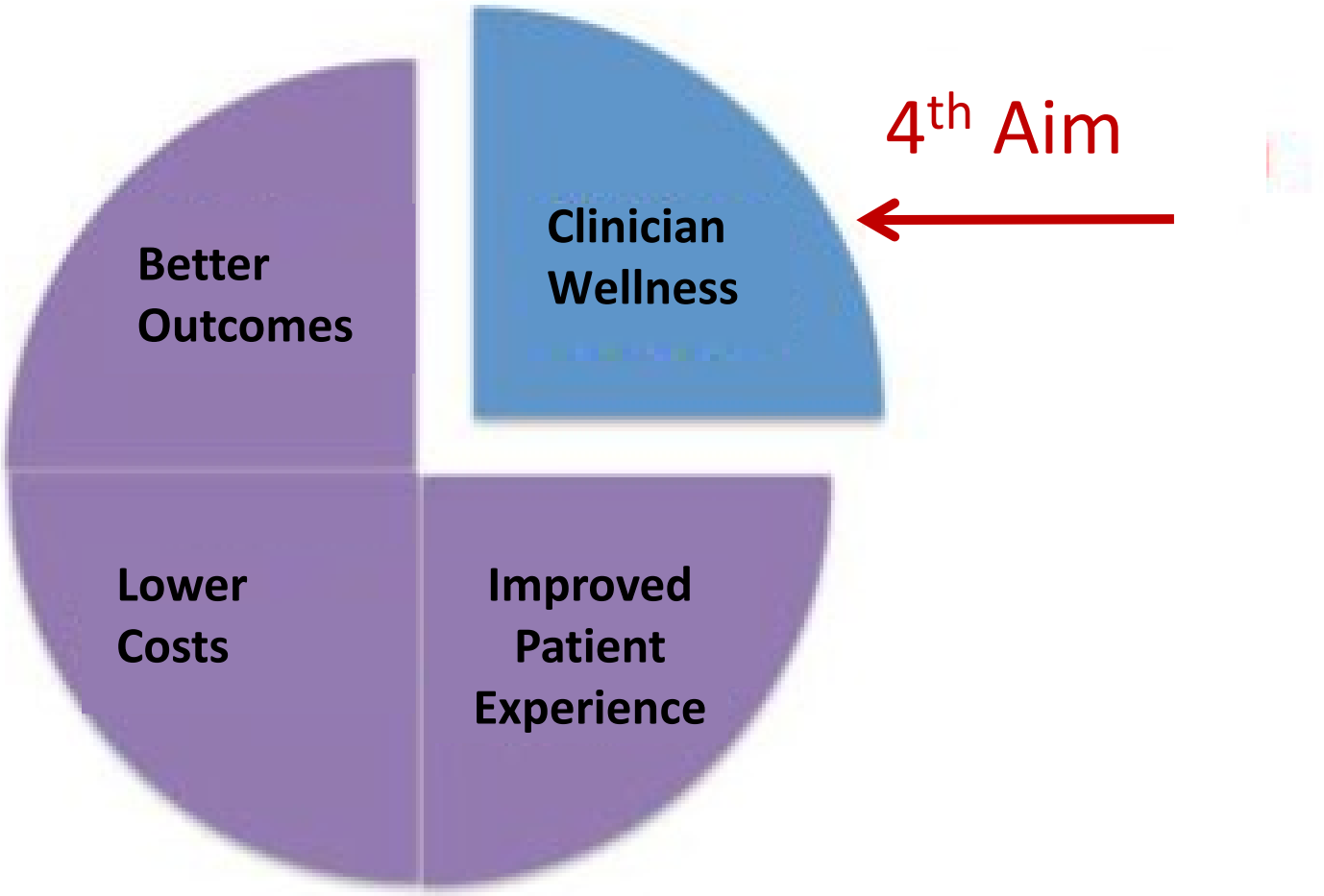
Group Vice President

Burdens Facing Physicians

- Quantity and pace of work
- Excessive documentation
- Increased inbox volume
- Institutional racism
- Professional liability
- Inadequate reimbursement
- Prior authorization
- Conflicting payment models
- Burdensome quality reporting
- Negative on-line reviews
- Expanding knowledge base with insufficient tools
- Insufficient staffing
- Lack of actionable data
- Regulatory burdens
- Assessing new technologies
- Politicization
- Lack of autonomy/work control

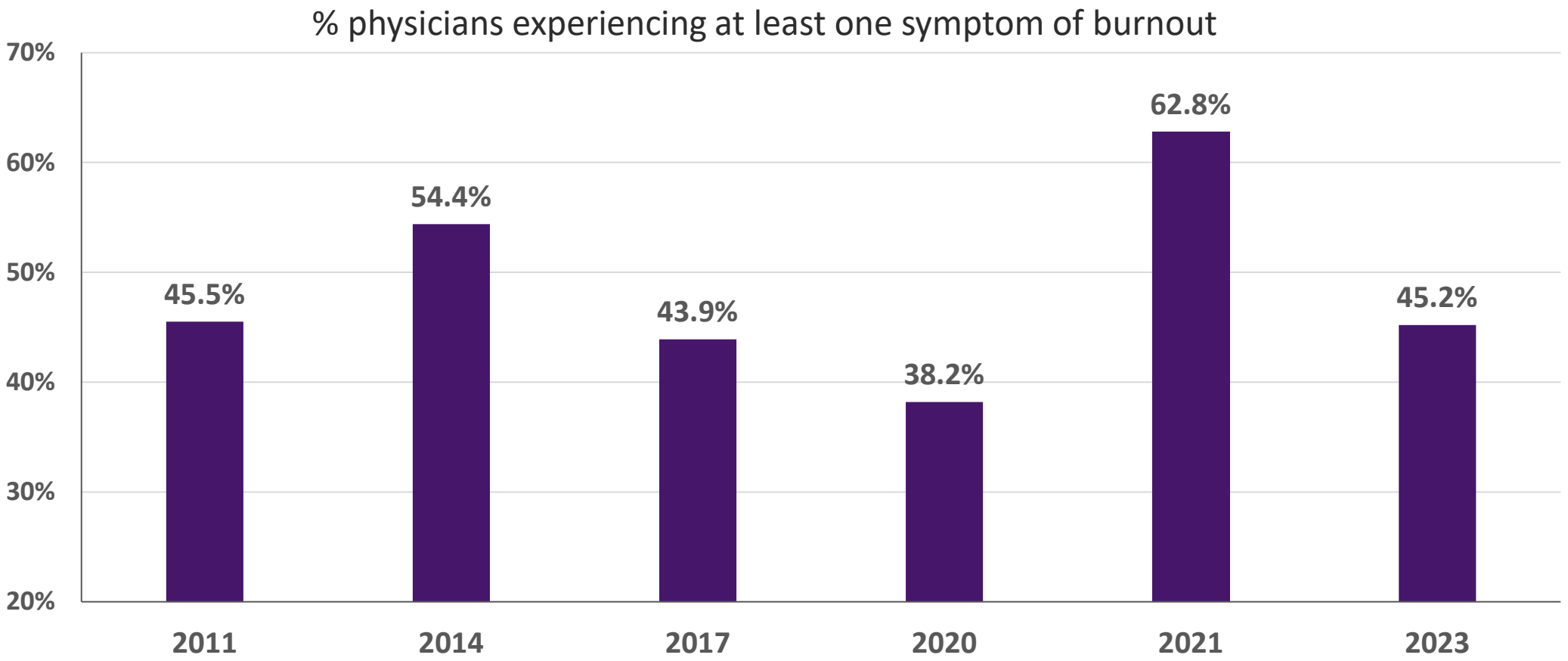
How can you support physicians and the care team (and yourself) to maintain/return joy, meaning and purpose?

Quadruple Aim: Care of Care Team



From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider, Thomas Bodenheimer, Christine Sinsky, *The Annals of Family Medicine* Nov 2014, 12 (6) 573-576; DOI: 10.1370/afm.1713

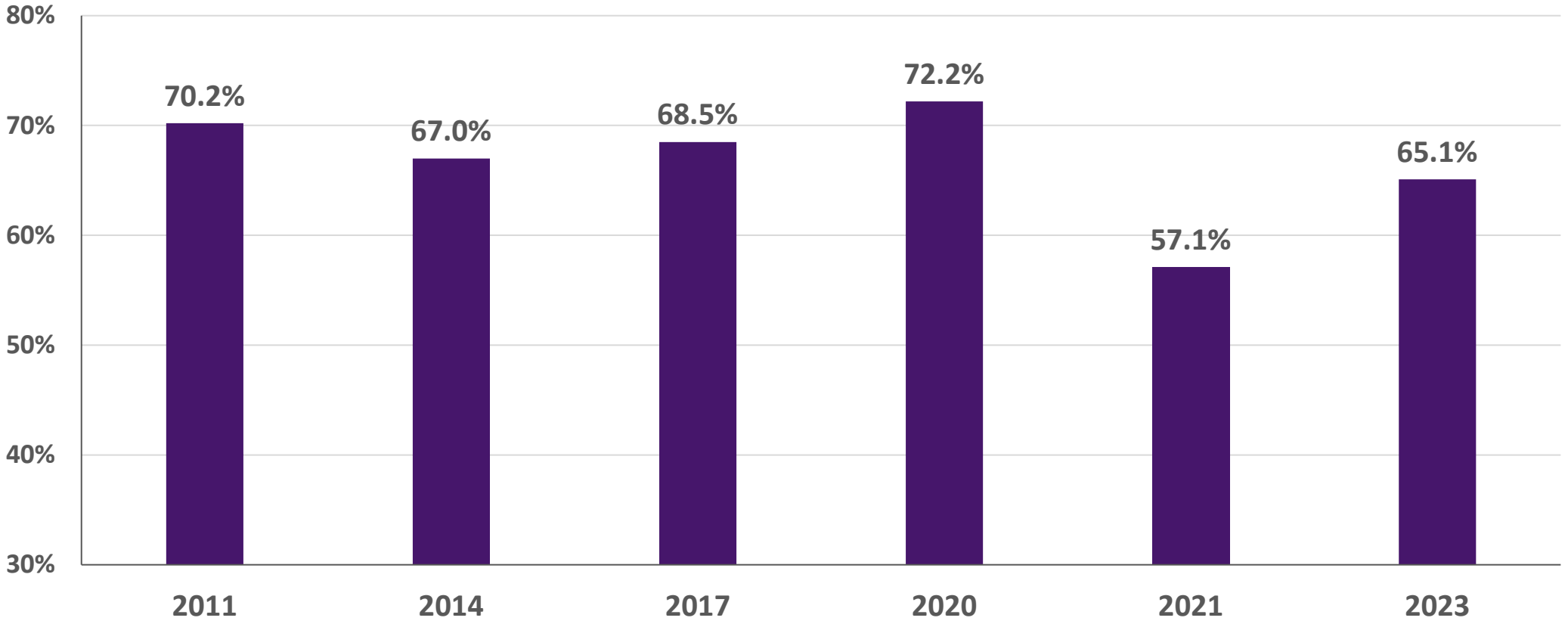
Physician Burnout



Source:; *In Press* Tait D. Shanafelt, Colin P. West, Christine Sinsky, Mickey Trockel, Michael Tutty, Hanhan Wang, Lindsey E. Carlasare, Liselotte N. Dyrbye, Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population between 2011-2023 Mayo Clinic Proceedings.

Choose To Become a Physician Again

% physicians who indicated they would choose to become a physician again if they could revisit their career choice



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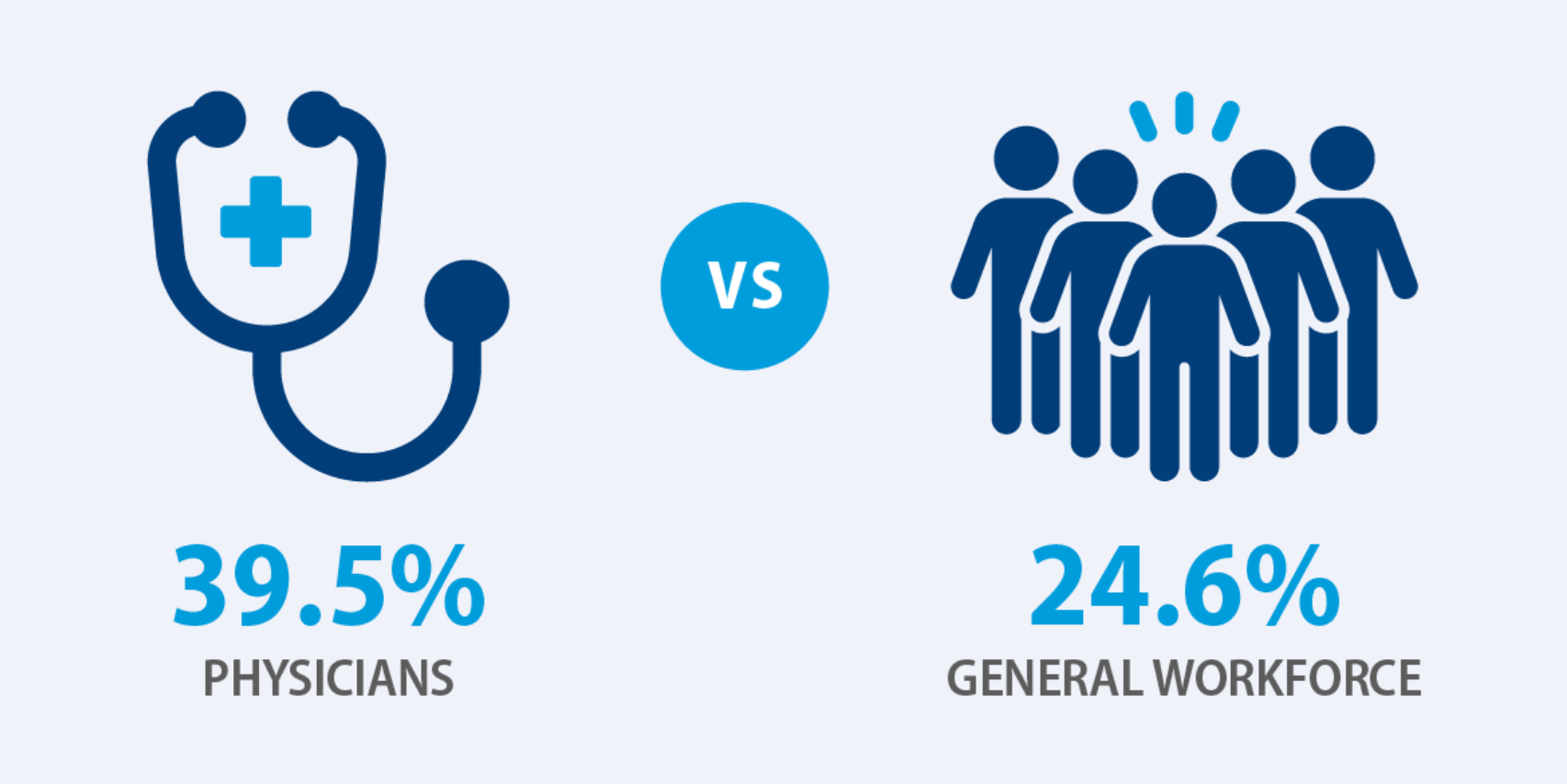
How Do Physicians Compare?



Source:; *In Press* Tait D. Shanafelt, Colin P. West, Christine Sinsky, Mickey Trockel, Michael Tutty, Hanhan Wang, Lindsey E. Carlasare, Liselotte N. Dyrbye, Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population between 2011-2023 Mayo Clinic Proceedings.

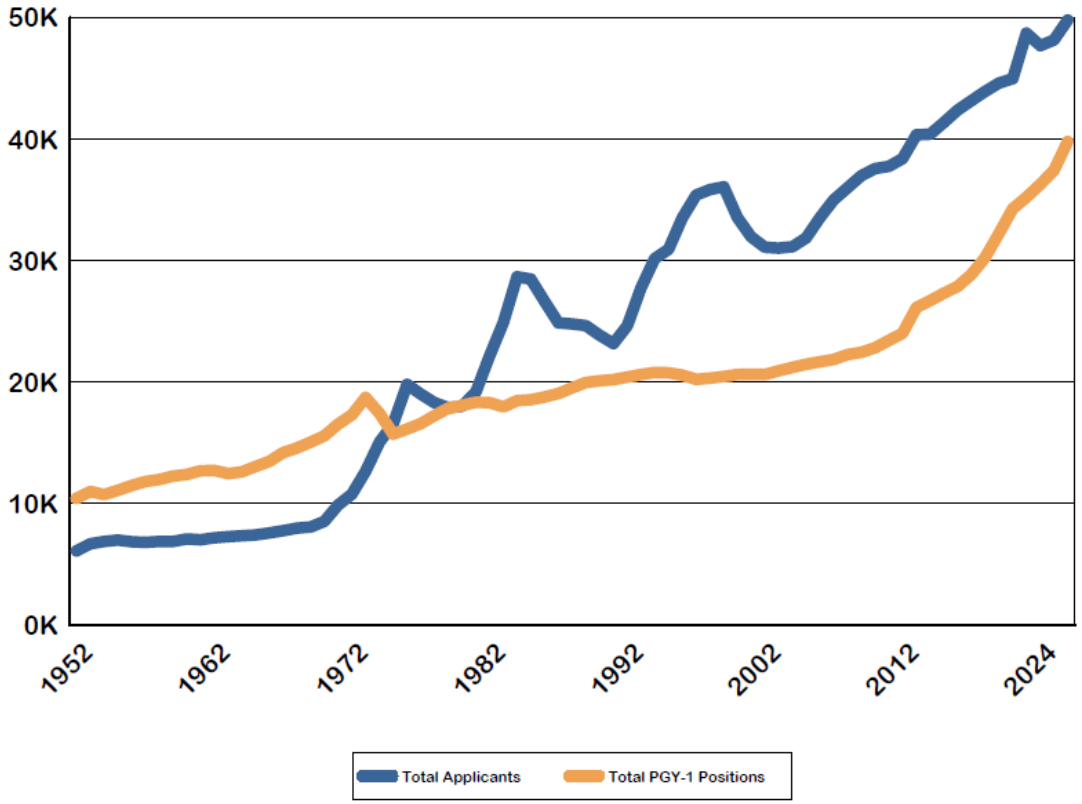
A Growing Number of Medical Students

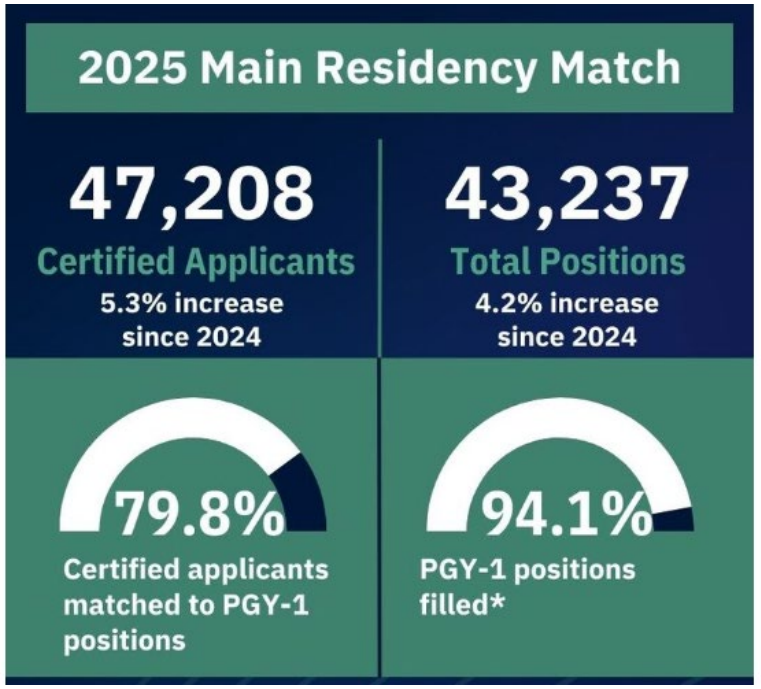
Applicants, Matriculants, Enrollment, and Graduates	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Applicants	52,549	53,042	51,680	52,777	53,369	53,030	62,443	55,189	52,577	51,946
Matriculants	20,631	21,030	21,338	21,622	21,869	22,239	22,666	22,710	22,980	23,156
Enrollment	86,583	88,176	89,727	91,217	92,620	94,068	95,340	96,385	97,797	99,562
Graduates	18,943	19,262	19,562	19,935	20,390	20,926	21,057	20,927	20,869	-

Applicants to medical school decreased after 2021/2022 peak, but medical schools accept the largest incoming class; Similar growth is seen at osteopathic medical schools

Source: AAMC Fall Applicant, Matriculant, and Enrollment Data Tables

Applicants and 1st Year Positions in the Match



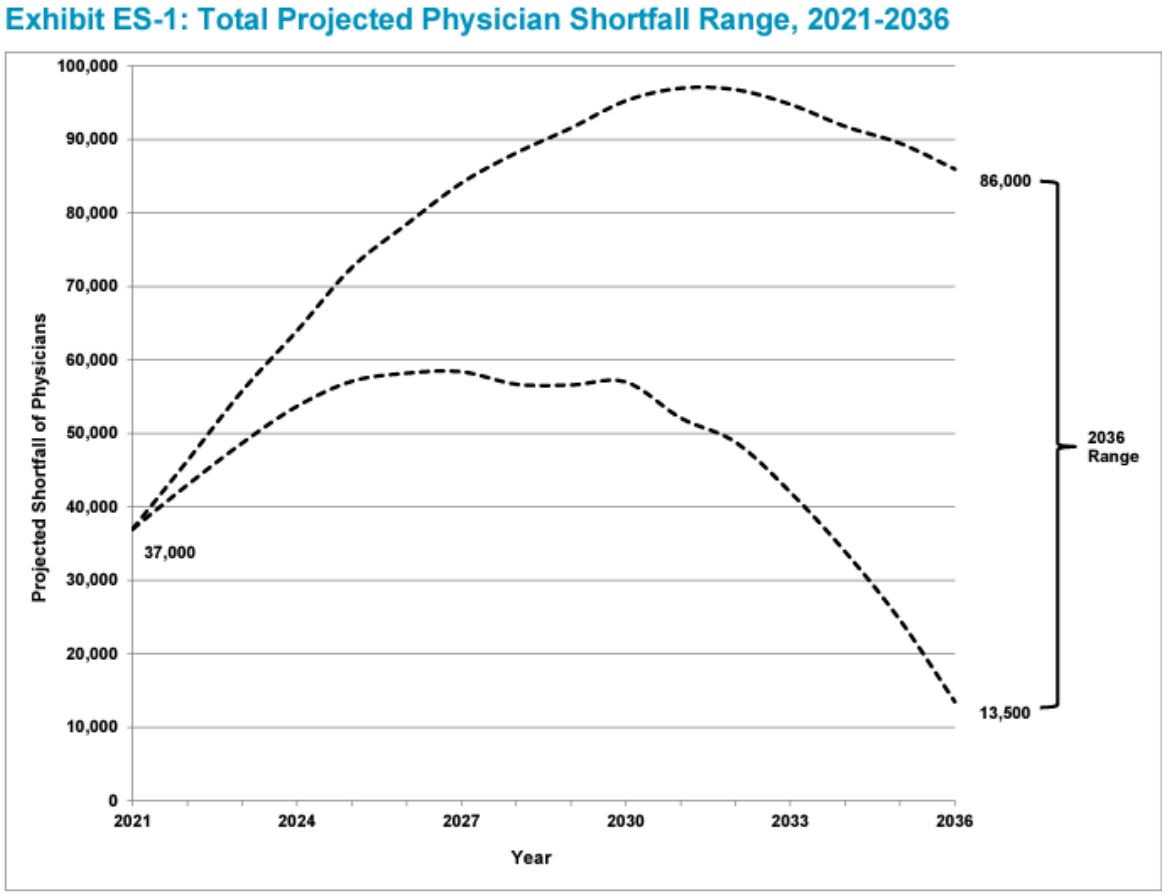


2025 Residency Match offered 43,237 training positions, an increase of 1,736 more positions than the 2024 Residency Match…Yet more spots needed

Source: National Resident Matching Program, Results and Data: 2024 Main Residency Match®. National Resident Matching Program, Washington, DC. 2024; NRMP® Releases Results for 2025 Main Residency Match https://www.nrmp.org/match-data/2025/03/nrmp-releases-results-for-2025-main-residency-match/

Projected Physician Shortages

The projected shortage of between 13,500 and 86,000 physicians by 2036



The shortage is driven by:

- Population growth
- Aging of the population
- Physician retirement
- Physicians leaving clinical care

Source: GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024.

Physicians' Intent To Leave the Profession

Because of burnout/ COVID pressures

> 2/5

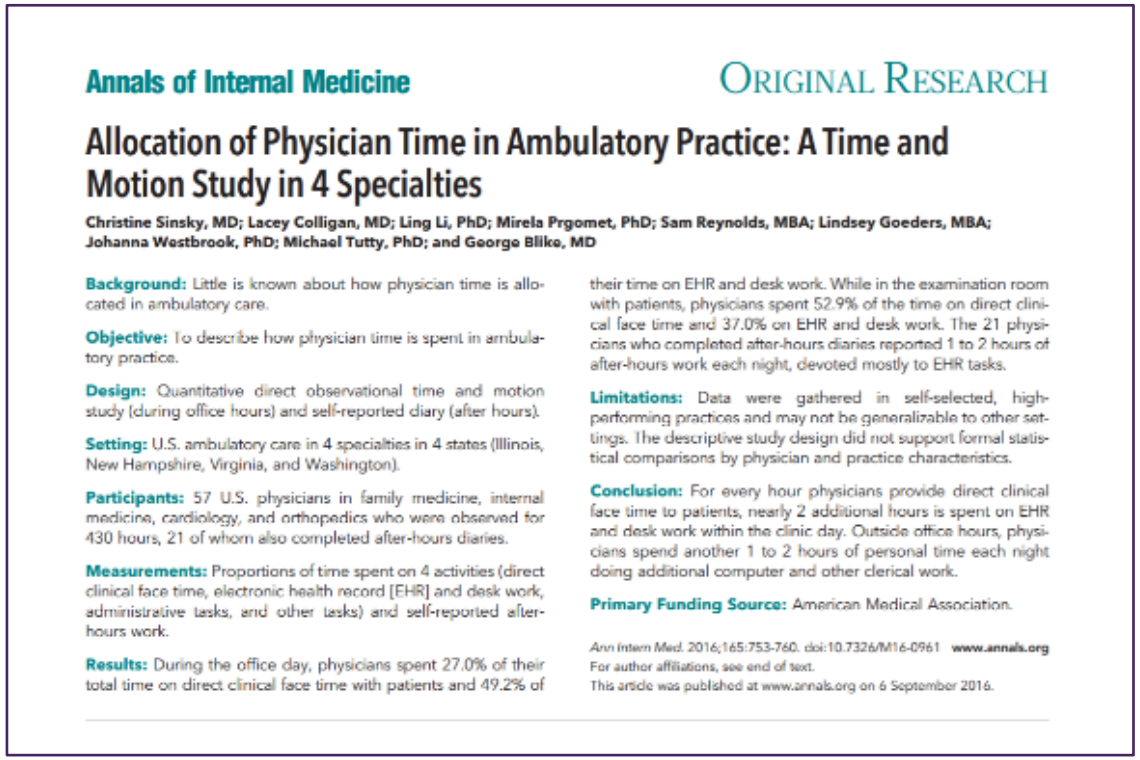
Physicians intend to reduce clinical work hours in the next year

1/4

Physicians intend to leave their current practice in the next 2 years.

Source: Tait D. Shanafelt, Liselotte N. Dyrbye, Colin P. West, Mickey Trockel, Michael Tutty, Hanhan Wang, Lindsey E. Carlasare, Christine A. Sinsky, Career Plans of US Physicians After the First 2 Years of the COVID-19 Pandemic, Mayo Clinic Proceedings, Volume 98, Issue 11, 2023, Pages 1629-1640.

Understanding the EHR Burden



Annals of Internal Medicine

ORIGINAL RESEARCH

Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties

Christine Sinsky, MD; Lacey Colligan, MD; Ling Li, PhD; Mirela Prgomet, PhD; Sam Reynolds, MBA; Lindsey Goeders, MBA; Johanna Westbrook, PhD; Michael Tutty, PhD; and George Blike, MD

Background: Little is known about how physician time is allocated in ambulatory care.

Objective: To describe how physician time is spent in ambulatory practice.

Design: Quantitative direct observational time and motion study (during office hours) and self-reported diary (after hours).

Setting: U.S. ambulatory care in 4 specialties in 4 states (Illinois, New Hampshire, Virginia, and Washington).

Participants: 57 U.S. physicians in family medicine, internal medicine, cardiology, and orthopedics who were observed for 430 hours, 21 of whom also completed after-hours diaries.

Measurements: Proportions of time spent on 4 activities (direct clinical face time, electronic health record [EHR] and desk work, administrative tasks, and other tasks) and self-reported after-hours work.

Results: During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of after-hours work each night, devoted mostly to EHR tasks.

Limitations: Data were gathered in self-selected, high-performing practices and may not be generalizable to other settings. The descriptive study design did not support formal statistical comparisons by physician and practice characteristics.

Conclusion: For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent on EHR and desk work within the clinic day. Outside office hours, physicians spend another 1 to 2 hours of personal time each night doing additional computer and other clerical work.

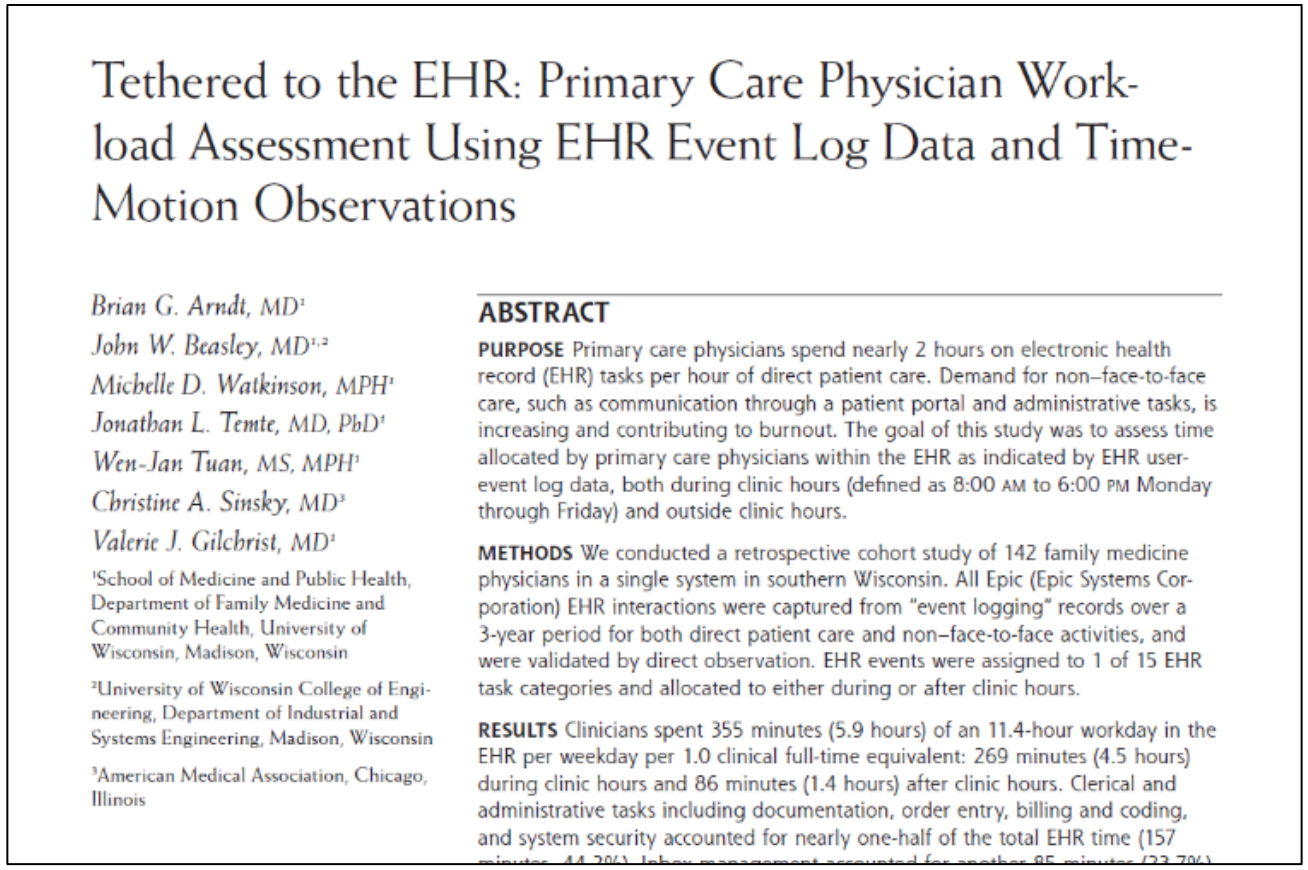
Primary Funding Source: American Medical Association.

Ann Intern Med. 2016;165:753-760. doi:10.7326/M16-0961 **www.annals.org**
For author affiliations, see end of text.
This article was published at www.annals.org on 6 September 2016.

- For every hour of physician clinical face time with patients, nearly 2 additional hours are spent on EHR/desk work.
- Outside office hours, physicians spend another 1 to 2 hours each night doing EHR/desk work.

Source: Christine Sinsky, Lacey Colligan, Ling Li, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med.2016;165:753-760. [Epub ahead of print 6 September 2016]. doi:10.7326/M16-0961

EHR Time: Better Data, Better Opportunity



Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations

Brian G. Arndt, MD[1]
John W. Beasley, MD[1,2]
Michelle D. Watkinson, MPH[1]
Jonathan L. Temte, MD, PhD[1]
Wen-Jan Tuan, MS, MPH[1]
Christine A. Sinsky, MD[3]
Valerie J. Gilchrist, MD[1]

[1]School of Medicine and Public Health, Department of Family Medicine and Community Health, University of Wisconsin, Madison, Wisconsin

[2]University of Wisconsin College of Engineering, Department of Industrial and Systems Engineering, Madison, Wisconsin

[3]American Medical Association, Chicago, Illinois

ABSTRACT

PURPOSE Primary care physicians spend nearly 2 hours on electronic health record (EHR) tasks per hour of direct patient care. Demand for non–face-to-face care, such as communication through a patient portal and administrative tasks, is increasing and contributing to burnout. The goal of this study was to assess time allocated by primary care physicians within the EHR as indicated by EHR user-event log data, both during clinic hours (defined as 8:00 AM to 6:00 PM Monday through Friday) and outside clinic hours.

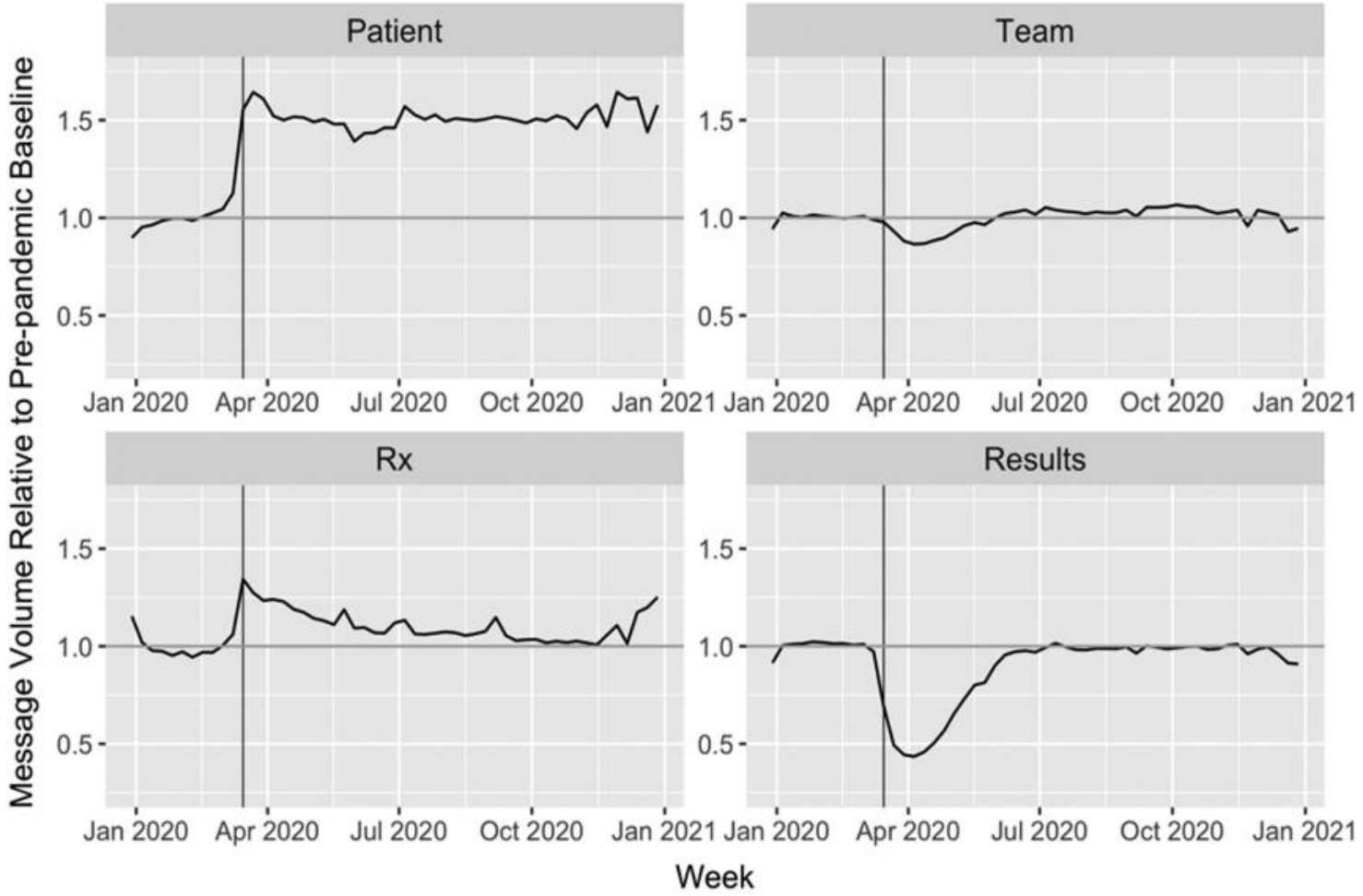
METHODS We conducted a retrospective cohort study of 142 family medicine physicians in a single system in southern Wisconsin. All Epic (Epic Systems Corporation) EHR interactions were captured from "event logging" records over a 3-year period for both direct patient care and non–face-to-face activities, and were validated by direct observation. EHR events were assigned to 1 of 15 EHR task categories and allocated to either during or after clinic hours.

RESULTS Clinicians spent 355 minutes (5.9 hours) of an 11.4-hour workday in the EHR per weekday per 1.0 clinical full-time equivalent: 269 minutes (4.5 hours) during clinic hours and 86 minutes (1.4 hours) after clinic hours. Clerical and administrative tasks including documentation, order entry, billing and coding, and system security accounted for nearly one-half of the total EHR time (157

- Physicians spent an average of 5.9 hours out of an 11.4-hour workday working in the EHR.
- Clerical and administrative tasks accounted for 44 percent of the total EHR usage time.

Source: Brian G. Arndt, John W. Beasley, Michelle D. Watkinson, Jonathan L. Temte, Wen-Jan Tuan, Christine A. Sinsky, and Valerie J. Gilchrist, *Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations,* Ann Fam Med September/October 2017 15:419-426

157% Increase in Message Volume Post-Pandemic



"The greatest increase was in messages from patients, with clinicians receiving 157% of their pre-pandemic average per day; that increased level of messages remained consistent through the end of the year."

Source: J Am Med Inform Assoc, Volume 29, Issue 3, March 2022, Pages 453–460, https://doi.org/10.1093/jamia/ocab268

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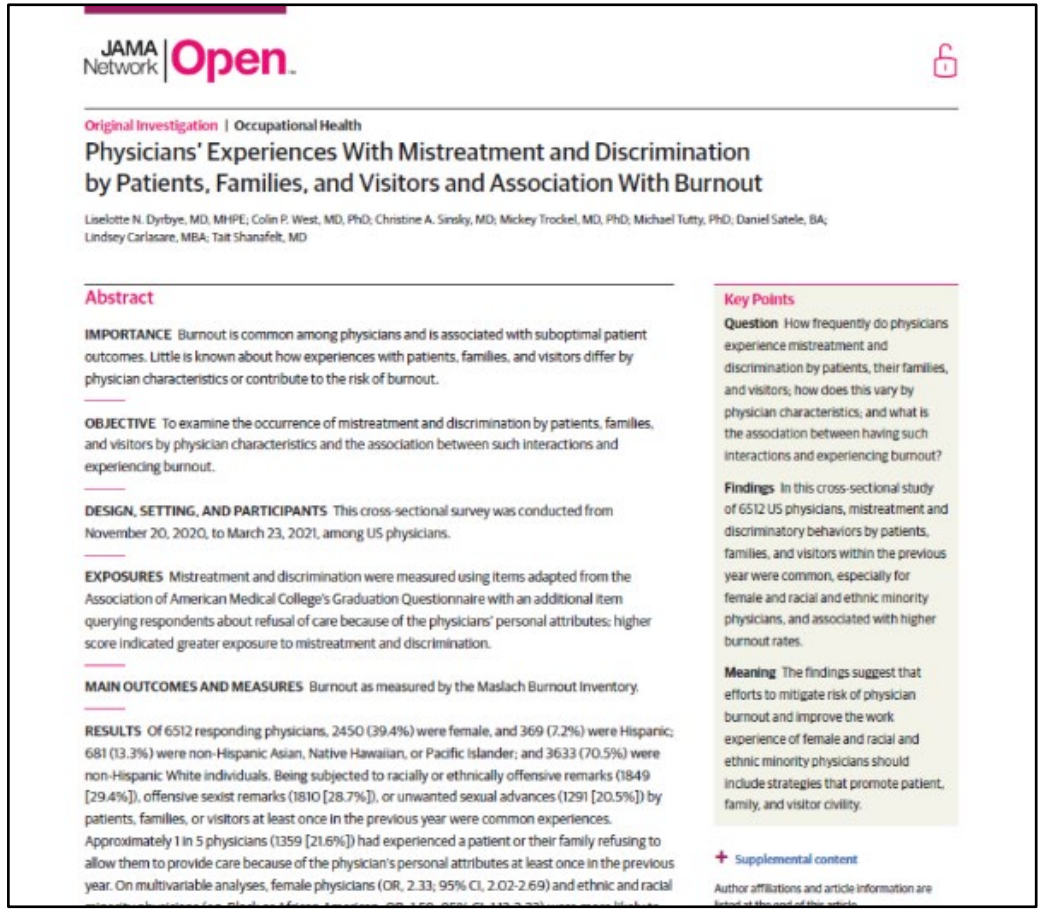
Mistreatment and Discrimination of Physicians

- In this study, mistreatment and discrimination by patients, families, and visitors were common, especially for female and racial and ethnic minority physicians, and associated with burnout.



JAMA Network | Open.

Original Investigation | Occupational Health

Physicians' Experiences With Mistreatment and Discrimination by Patients, Families, and Visitors and Association With Burnout

Liselotte N. Dyrbye, MD, MHPE; Colin P. West, MD, PhD; Christine A. Sinsky, MD; Mickey Trockel, MD, PhD; Michael Tutty, PhD; Daniel Satele, BA; Lindsey Carlasare, MBA; Tait Shanafelt, MD

Abstract

IMPORTANCE Burnout is common among physicians and is associated with suboptimal patient outcomes. Little is known about how experiences with patients, families, and visitors differ by physician characteristics or contribute to the risk of burnout.

OBJECTIVE To examine the occurrence of mistreatment and discrimination by patients, families, and visitors by physician characteristics and the association between such interactions and experiencing burnout.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional survey was conducted from November 20, 2020, to March 23, 2021, among US physicians.

EXPOSURES Mistreatment and discrimination were measured using items adapted from the Association of American Medical College's Graduation Questionnaire with an additional item querying respondents about refusal of care because of the physicians' personal attributes; higher score indicated greater exposure to mistreatment and discrimination.

MAIN OUTCOMES AND MEASURES Burnout as measured by the Maslach Burnout Inventory.

RESULTS Of 6512 responding physicians, 2450 (39.4%) were female, and 369 (7.2%) were Hispanic; 681 (13.3%) were non-Hispanic Asian, Native Hawaiian, or Pacific Islander; and 3633 (70.5%) were non-Hispanic White individuals. Being subjected to racially or ethnically offensive remarks (1849 [29.4%]), offensive sexist remarks (1810 [28.7%]), or unwanted sexual advances (1291 [20.5%]) by patients, families, or visitors at least once in the previous year were common experiences. Approximately 1 in 5 physicians (1359 [21.6%]) had experienced a patient or their family refusing to allow them to provide care because of the physician's personal attributes at least once in the previous year. On multivariable analyses, female physicians (OR, 2.33; 95% CI, 2.02-2.69) and ethnic and racial

Key Points

Question How frequently do physicians experience mistreatment and discrimination by patients, their families, and visitors; how does this vary by physician characteristics; and what is the association between having such interactions and experiencing burnout?

Findings In this cross-sectional study of 6512 US physicians, mistreatment and discriminatory behaviors by patients, families, and visitors within the previous year were common, especially for female and racial and ethnic minority physicians, and associated with higher burnout rates.

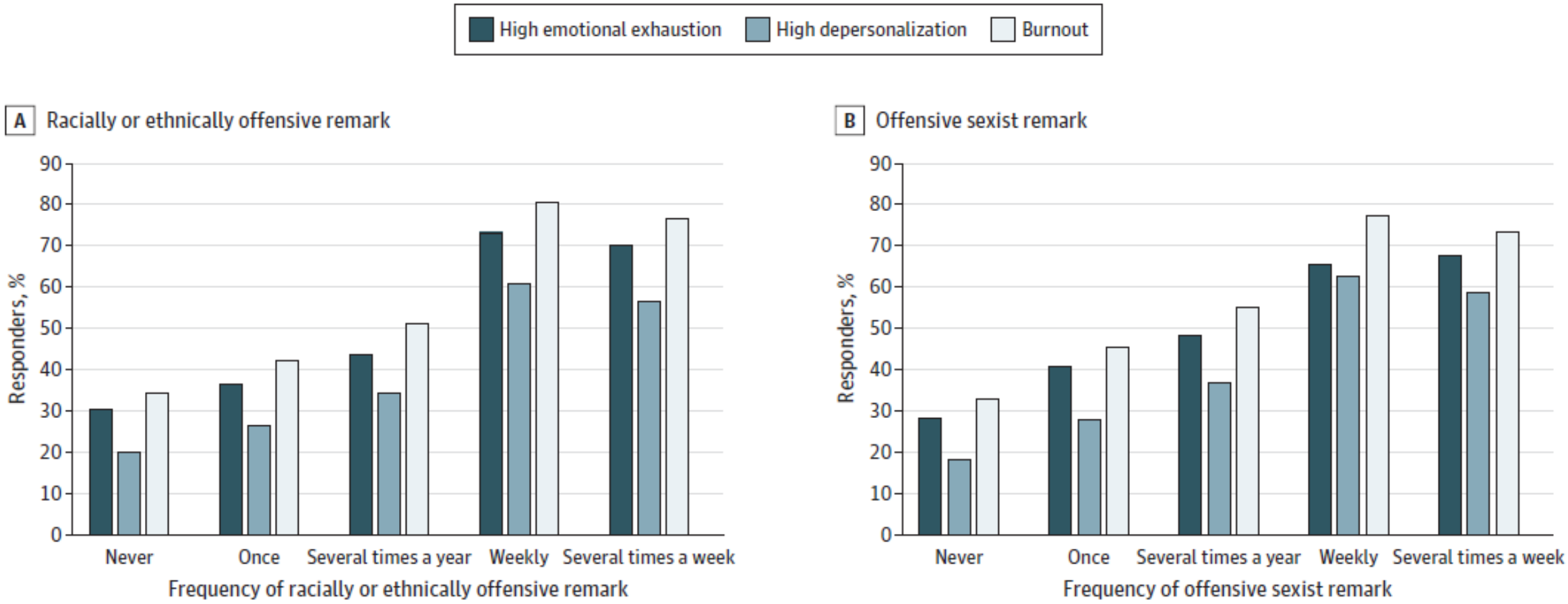
Meaning The findings suggest that efforts to mitigate risk of physician burnout and improve the work experience of female and racial and ethnic minority physicians should include strategies that promote patient, family, and visitor civility.

+ Supplemental content

Author affiliations and article information are

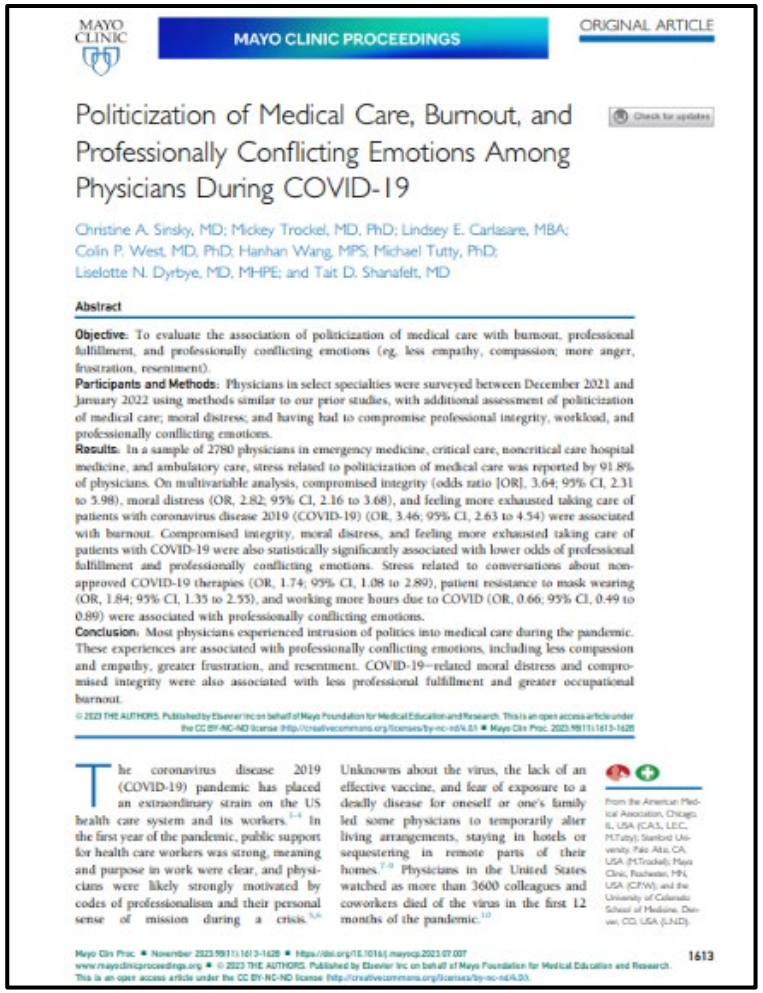
Source: Dyrbye LN, West CP, Sinsky CA, et al. Physicians' Experiences With Mistreatment and Discrimination by Patients, Families, and Visitors and Association With Burnout. JAMA Netw Open. 2022;5(5):e2213080. doi:10.1001/jamanetworkopen.2022.13080

Percentage with Emotional Exhaustion, Depersonalization and Burnout



Source: Dyrbye LN, West CP, Sinsky CA, et al. Physicians' Experiences With Mistreatment and Discrimination by Patients, Families, and Visitors and Association With Burnout. JAMA Netw Open. 2022;5(5):e2213080. doi:10.1001/jamanetworkopen.2022.13080

Politicization of Health Care



MAYO CLINIC PROCEEDINGS

ORIGINAL ARTICLE

Politicization of Medical Care, Burnout, and Professionally Conflicting Emotions Among Physicians During COVID-19

Christine A. Sinsky, MD; Mickey Trockel, MD, PhD; Lindsey E. Carlasare, MBA; Colin P. West, MD, PhD; Hanhan Wang, MPS; Michael Tutty, PhD; Liselotte N. Dyrbye, MD, MHPE; and Tait D. Shanafelt, MD

Abstract

Objective: To evaluate the association of politicization of medical care with burnout, professional fulfillment, and professionally conflicting emotions (eg, less empathy, compassion; more anger, frustration, resentment).

Participants and Methods: Physicians in select specialties were surveyed between December 2021 and January 2022 using methods similar to our prior studies, with additional assessment of politicization of medical care; moral distress; and having had to compromise professional integrity, workload, and professionally conflicting emotions.

Results: In a sample of 2780 physicians in emergency medicine, critical care, noncritical care hospital medicine, and ambulatory care, stress related to politicization of medical care was reported by 91.8% of physicians. On multivariable analysis, compromised integrity (odds ratio [OR], 3.64; 95% CI, 2.31 to 5.98), moral distress (OR, 2.82; 95% CI, 2.16 to 3.68), and feeling more exhausted taking care of patients with coronavirus disease 2019 (COVID-19) (OR, 3.46; 95% CI, 2.63 to 4.54) were associated with burnout. Compromised integrity, moral distress, and feeling more exhausted taking care of patients with COVID-19 were also statistically significantly associated with lower odds of professional fulfillment and professionally conflicting emotions. Stress related to conversations about non-approved COVID-19 therapies (OR, 1.74; 95% CI, 1.08 to 2.89), patient resistance to mask wearing (OR, 1.84; 95% CI, 1.35 to 2.55), and working more hours due to COVID (OR, 0.66; 95% CI, 0.49 to 0.89) were associated with professionally conflicting emotions.

Conclusion: Most physicians experienced intrusion of politics into medical care during the pandemic. These experiences are associated with professionally conflicting emotions, including less compassion and empathy, greater frustration, and resentment. COVID-19–related moral distress and compromised integrity were also associated with less professional fulfillment and greater occupational burnout.

The coronavirus disease 2019 (COVID-19) pandemic has placed an extraordinary strain on the US health care system and its workers.[1-4] In the first year of the pandemic, public support for health care workers was strong, meaning and purpose in work were clear, and physicians were likely strongly motivated by codes of professionalism and their personal sense of mission during a crisis.[5,6] Unknowns about the virus, the lack of an effective vaccine, and fear of exposure to a deadly disease for oneself or one's family led some physicians to temporarily alter living arrangements, staying in hotels or sequestering in remote parts of their homes.[7-9] Physicians in the United States watched as more than 3600 colleagues and coworkers died of the virus in the first 12 months of the pandemic.[10]

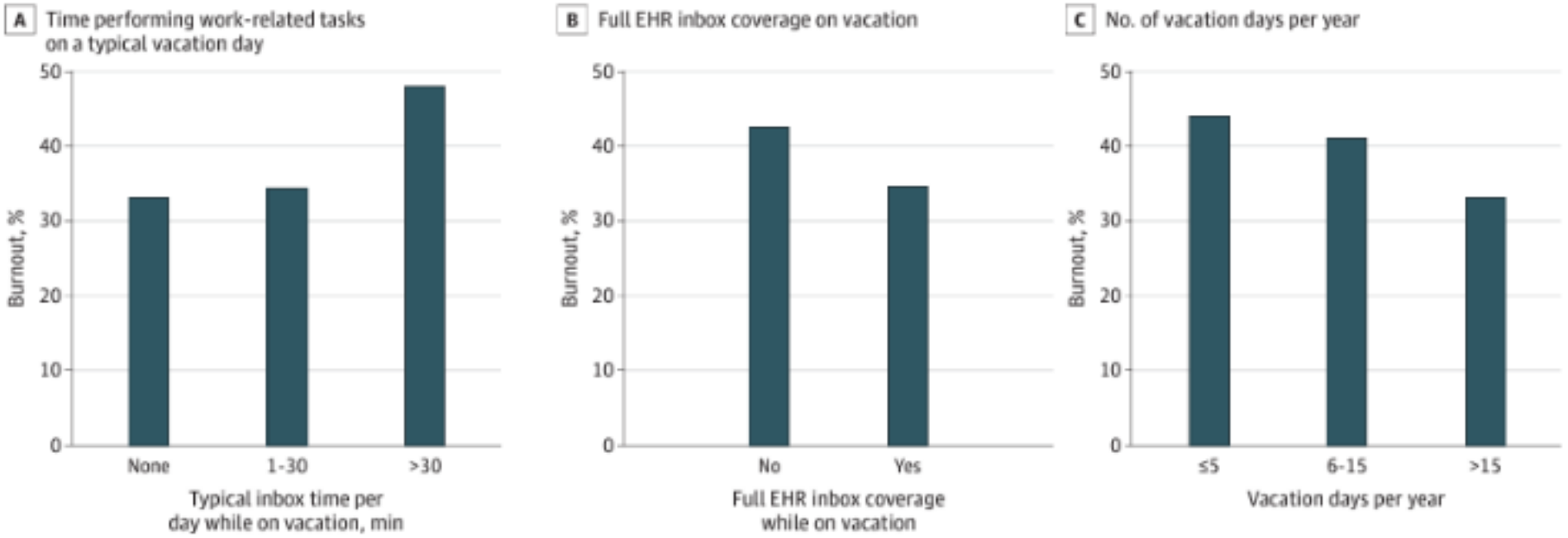
From the American Medical Association, Chicago, IL, USA (CA.S., LE.C., M.Tutty); Stanford University, Palo Alto, CA, USA (M.Trockel); Mayo Clinic, Rochester, MN, USA (C.P.W.); and the University of Colorado School of Medicine, Denver, CO, USA (L.N.D.).

- Most physicians experienced intrusion of politics into medical care during the pandemic.
  - These experiences are associated with professionally conflicting emotions, including less compassion and empathy, greater frustration, and resentment.
- COVID-19–related moral distress and compromised integrity were associated with less professional fulfillment and greater occupational burnout.

Source: Christine A. Sinsky, Mickey Trockel, Lindsey E. Carlasare, Colin P. West, Hanhan Wang, Michael Tutty, Liselotte N. Dyrbye, Tait D. Shanafelt, Politicization of Medical Care, Burnout, and Professionally Conflicting Emotions Among Physicians During COVID-19, Mayo Clinic Proceedings, Volume 98, Issue 11, 2023, Pages 1613-1628.

Vacation Days and Burnout Among Physicians

Figure. Personal and Institutional Vacation Behaviors and Prevalence of Burnout

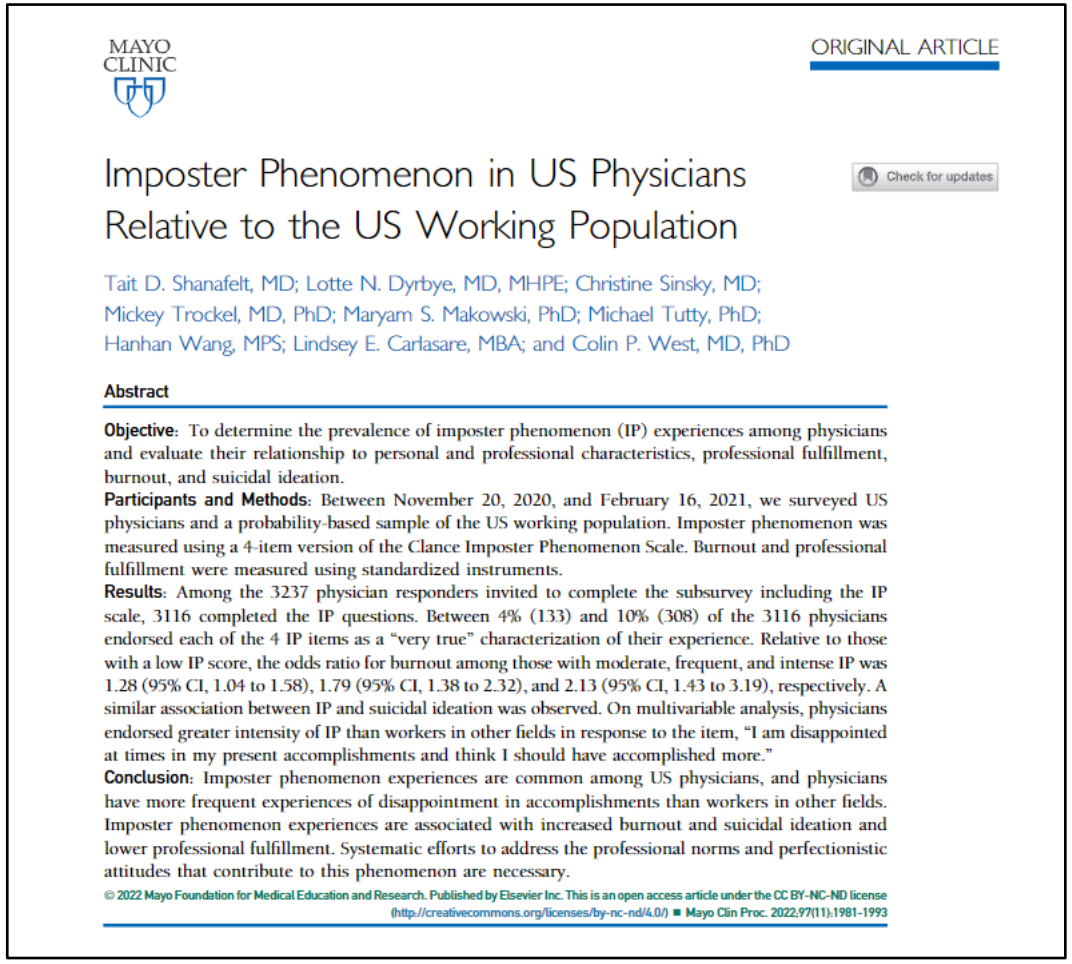


Graphs show burnout rates in relation to time performing work-related tasks on a typical vacation day (A), full electronic health record (EHR) inbox coverage during vacation (B), and number of vacation days per year (C).

Source: Sinsky CA, Trockel MT, Dyrbye LN, et al. Vacation Days Taken, Work During Vacation, and Burnout Among US Physicians. JAMA Netw Open. 2024;7(1):e2351635.

Imposter Phenomenon in US Physicians

- Imposter phenomenon experiences are common among US physicians
  - Physicians have more frequent experiences of disappointment in accomplishments than workers in other fields
- Imposter phenomenon experiences are associated with increased burnout and suicidal ideation and lower professional fulfillment



MAYO CLINIC

ORIGINAL ARTICLE

Imposter Phenomenon in US Physicians Relative to the US Working Population

Check for updates

Tait D. Shanafelt, MD; Lotte N. Dyrbye, MD, MHPE; Christine Sinsky, MD; Mickey Trockel, MD, PhD; Maryam S. Makowski, PhD; Michael Tutty, PhD; Hanhan Wang, MPS; Lindsey E. Carlasare, MBA; and Colin P. West, MD, PhD

Abstract

Objective: To determine the prevalence of imposter phenomenon (IP) experiences among physicians and evaluate their relationship to personal and professional characteristics, professional fulfillment, burnout, and suicidal ideation.

Participants and Methods: Between November 20, 2020, and February 16, 2021, we surveyed US physicians and a probability-based sample of the US working population. Imposter phenomenon was measured using a 4-item version of the Clance Imposter Phenomenon Scale. Burnout and professional fulfillment were measured using standardized instruments.

Results: Among the 3237 physician responders invited to complete the subsurvey including the IP scale, 3116 completed the IP questions. Between 4% (133) and 10% (308) of the 3116 physicians endorsed each of the 4 IP items as a "very true" characterization of their experience. Relative to those with a low IP score, the odds ratio for burnout among those with moderate, frequent, and intense IP was 1.28 (95% CI, 1.04 to 1.58), 1.79 (95% CI, 1.38 to 2.32), and 2.13 (95% CI, 1.43 to 3.19), respectively. A similar association between IP and suicidal ideation was observed. On multivariable analysis, physicians endorsed greater intensity of IP than workers in other fields in response to the item, "I am disappointed at times in my present accomplishments and think I should have accomplished more."

Conclusion: Imposter phenomenon experiences are common among US physicians, and physicians have more frequent experiences of disappointment in accomplishments than workers in other fields. Imposter phenomenon experiences are associated with increased burnout and suicidal ideation and lower professional fulfillment. Systematic efforts to address the professional norms and perfectionistic attitudes that contribute to this phenomenon are necessary.

 ■ Mayo Clin Proc. 2022;97(11):1981-1993

Source: Tait D. Shanafelt, Lotte N. Dyrbye, Christine Sinsky, Mickey Trockel, Maryam S. Makowski, Michael Tutty, Hanhan Wang, Lindsey E. Carlasare, Colin P. West, Imposter Phenomenon in US Physicians Relative to the US Working Population, Mayo Clinic Proceedings, Volume 97, Issue 11, 2022, Pages 1981-1993, ISSN 0025-6196,

Association of Work Control With Burnout and Career Intentions Among Us Physicians

Poor control, influence → higher odds burnout

Burnout	aOR	95% CI	P-value
Control over **patient load volume** (vs adequate)			
Poor	1.35	(1.04, 1.75)	0.02
Control over **who is on my team** (vs adequate)			
Poor	1.66	(1.3, 2.12)	<0.001
Influence over **clinical schedule** (vs adequate)			
Poor	1.32	(1.01, 1.74)	0.04
Sufficient **authority/autonomy over that which accountable** (vs agree)			
Disagree	1.26	(1, 1.59)	0.04
Control over **workload** (vs adequate)			
Poor	3.83	(2.99, 4.9)	<0.001

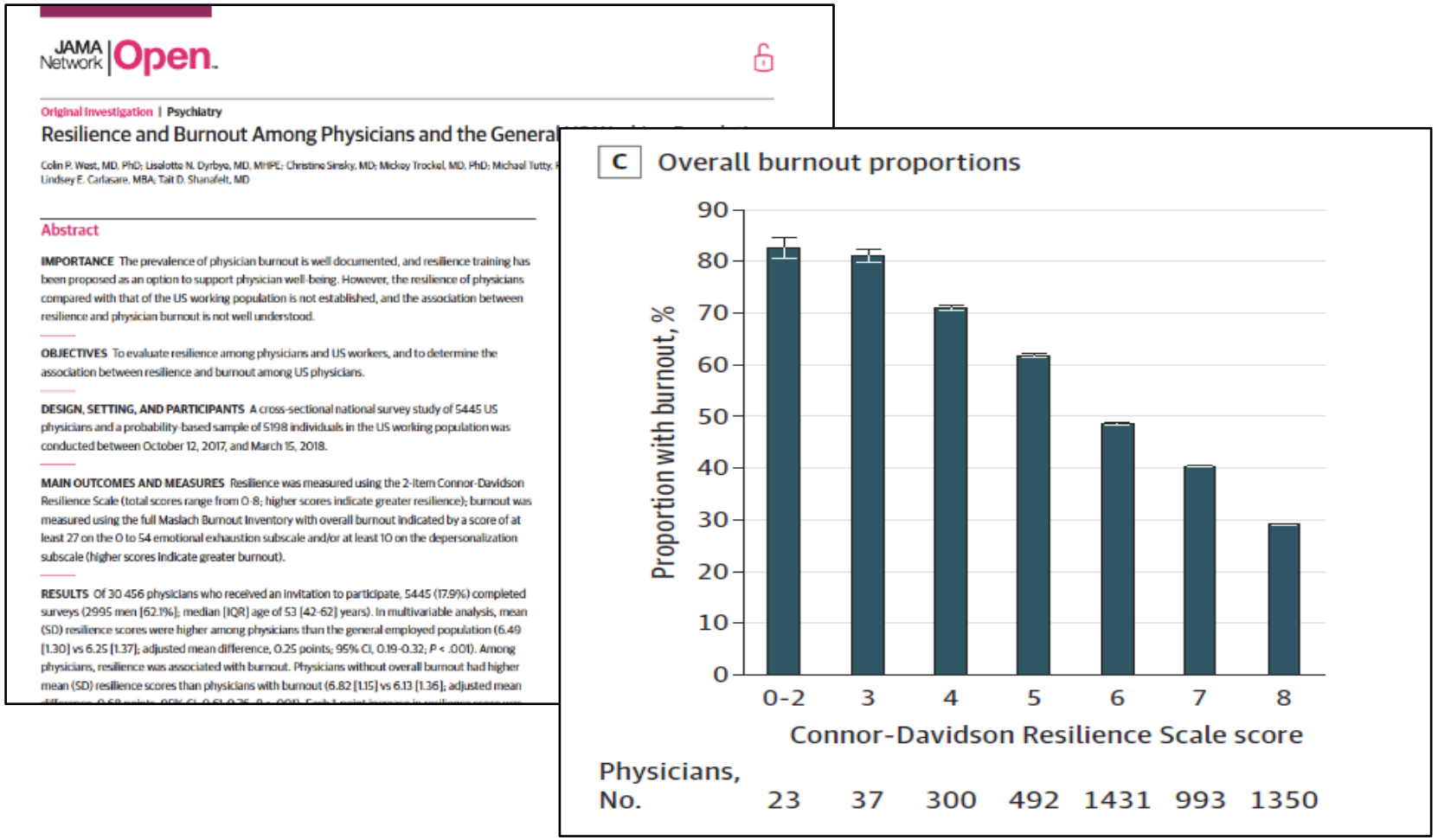
Poor control, influence → higher odds ITR and ITL

Intent to Reduce Clinical Hours	aOR	95% CI	P-value
Control over **patient load vol**. (vs adequate)			
Poor	1.61	(1.21, 2.13)	<0.001
Control over **workload** (vs adequate)			
Poor	1.40	(1.07, 1.83)	0.01

Intent to Leave	aOR	95% CI	P-value
Influence over **hiring staff** (vs adequate)			
Poor	1.61	(1.18, 2.19)	<0.001
Sufficient **authority/autonomy over that which accountable** (vs agree)			
Disagree	1.40	(1.05, 1.87)	0.02
Control over **workload** (vs adequate)			
Poor	1.41	(1.03, 1.93)	0.03

Sinsky, C., Brown, R., Rotenstein, L, Carlasare, L, Shah, P. Shanafelt, T. Association of Work Control With Burnout and Career Intentions Among U.S. Physicians: A Multi-institution Study. Ann Intern Med.2025;178:20-28.

Resilience and Burnout Among Physicians



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Original Investigation | Psychiatry

Resilience and Burnout Among Physicians and the General

Colin P. West, MD, PhD; Lisalotte N. Dyrbye, MD, MHPE; Christine Sinsky, MD; Mickey Trockel, MD, PhD; Michael Tutty, ; Lindsey E. Carlasare, MBA; Tait D. Shanafelt, MD

Abstract

IMPORTANCE The prevalence of physician burnout is well documented, and resilience training has been proposed as an option to support physician well-being. However, the resilience of physicians compared with that of the US working population is not established, and the association between resilience and physician burnout is not well understood.

OBJECTIVES To evaluate resilience among physicians and US workers, and to determine the association between resilience and burnout among US physicians.

DESIGN, SETTING, AND PARTICIPANTS A cross-sectional national survey study of 5445 US physicians and a probability-based sample of 5198 individuals in the US working population was conducted between October 12, 2017, and March 15, 2018.

MAIN OUTCOMES AND MEASURES Resilience was measured using the 2-item Connor-Davidson Resilience Scale (total scores range from 0-8; higher scores indicate greater resilience); burnout was measured using the full Maslach Burnout Inventory with overall burnout indicated by a score of at least 27 on the 0 to 54 emotional exhaustion subscale and/or at least 10 on the depersonalization subscale (higher scores indicate greater burnout).

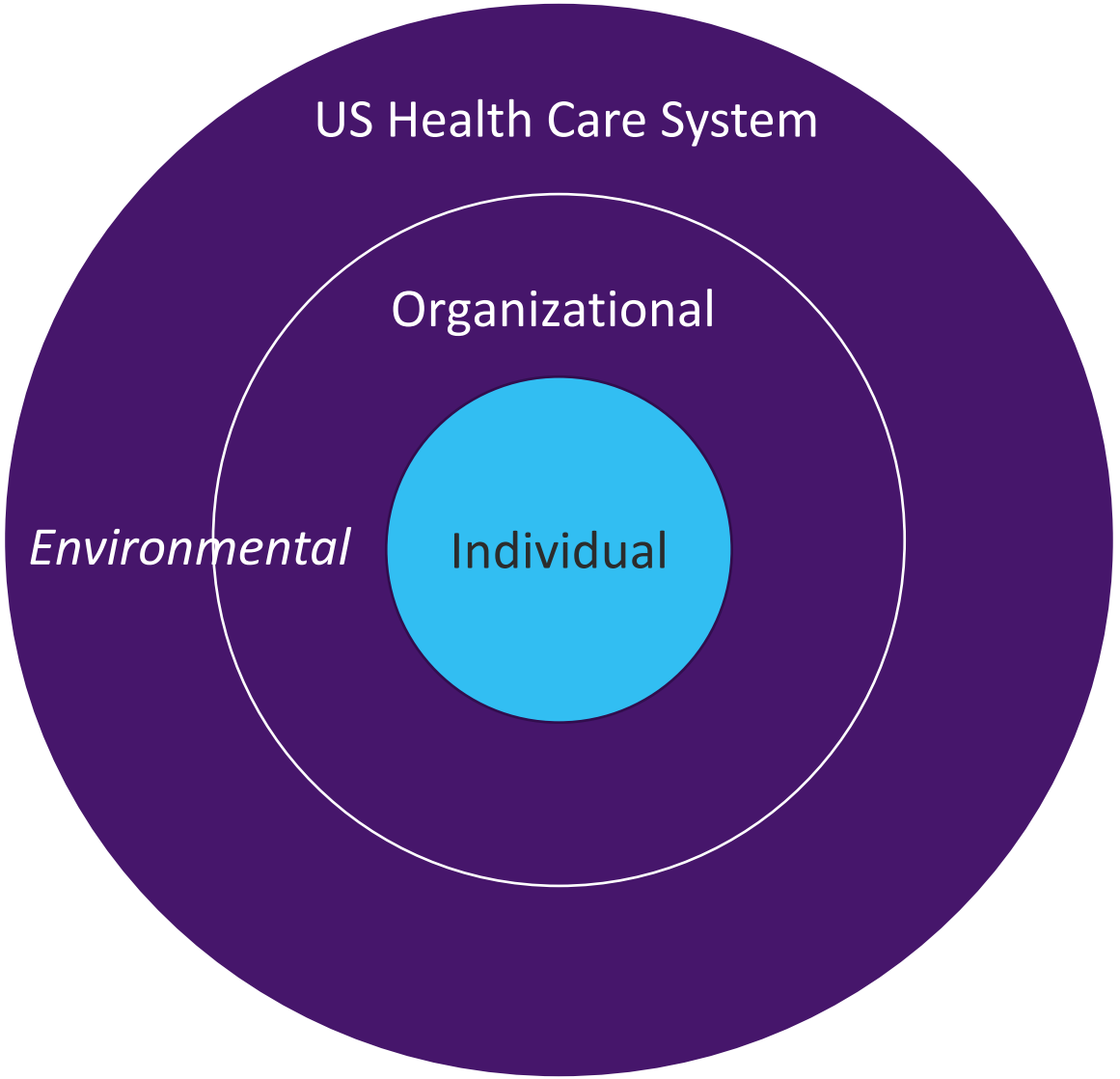
RESULTS Of 30 456 physicians who received an invitation to participate, 5445 (17.9%) completed surveys (2995 men [62.1%]; median [IQR] age of 53 [42-62] years). In multivariable analysis, mean (SD) resilience scores were higher among physicians than the general employed population (6.49 [1.30] vs 6.25 [1.37]; adjusted mean difference, 0.25 points; 95% CI, 0.19-0.32; $P < .001$). Among physicians, resilience was associated with burnout. Physicians without overall burnout had higher mean (SD) resilience scores than physicians with burnout (6.82 [1.15] vs 6.13 [1.36]; adjusted mean

- Physicians have higher resilience than the general employed US population.
- Even highly resilient physicians have substantial rates of burnout.

Source: West CP, Dyrbye LN, Sinsky C, et al. Resilience and Burnout Among Physicians and the General US Working Population. *JAMA Netw Open.* 2020;3(7):e209385. doi:10.1001/jamanetworkopen.2020.9385

AMA's Focus To Address Burdens and Burnout

AMA's Focus



While burnout *manifests* in individuals,

it *originates* in systems.

Patient satisfaction
Vaccine rates
Outcomes
Retention
Full time effort
Trust
Productivity

Physician satisfaction high when able to deliver quality patient care

Physician burnout occurs when obstacles interfere with patient care

Patient mistrust
Intent to leave practice
Medical errors
Referrals
Vacancy rates
Cost
Suicide

"Be curious, not judgmental" - (Not) Walt Whitman

“If you could break or change any rule in service of a better care experience for patients or staff, what would it be?”

“Contrary to initial expectations, although wasteful statutory and regulatory barriers existed, the majority (265/342 [78%]) of obstructive and wasteful rules identified by patients and staff were fully within the administrative control of health care executives and managers to change.”

Source: Berwick DM, Loehrer S, Gunther-Murphy C. Breaking the Rules for Better Care. JAMA. 2017;317(21):2161–2162. doi:10.1001/jama.2017.4703

You have much more control over your practice environment than you might think.

Saving Time:

The Crisis Behind the Clock—and the Power of Purposeful Work

Heather Farley, MD, MHCDS

VP, Professional Satisfaction

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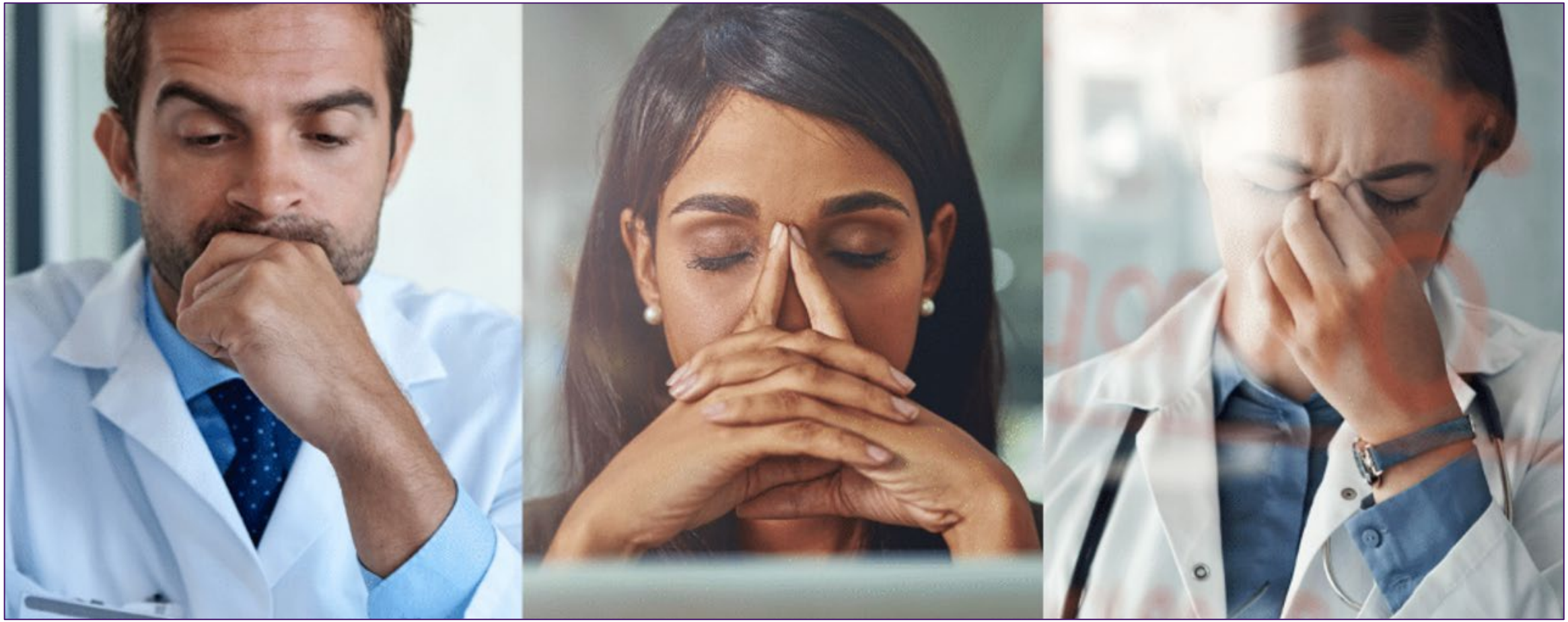
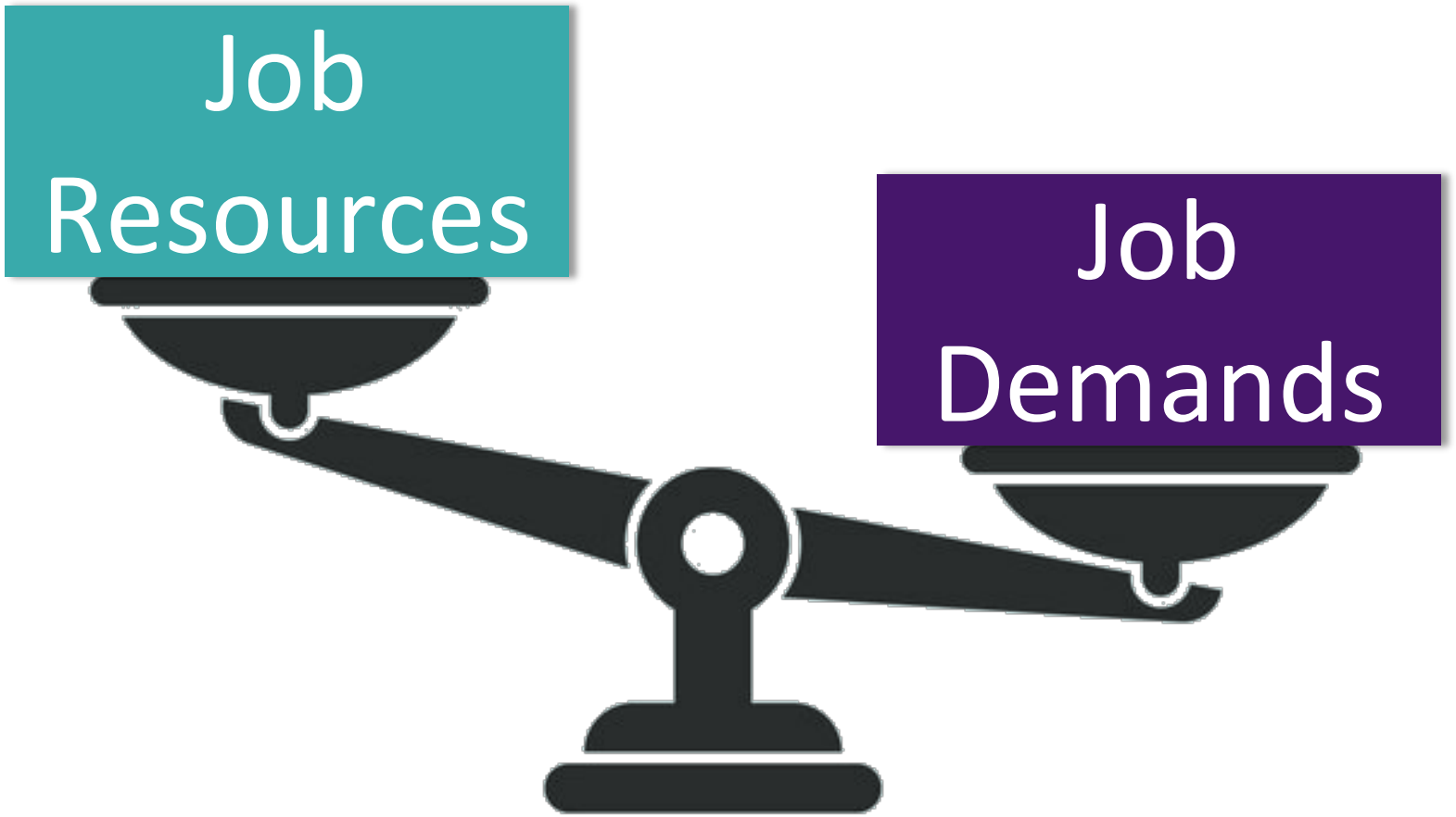
WHY Are We REALLY Here?

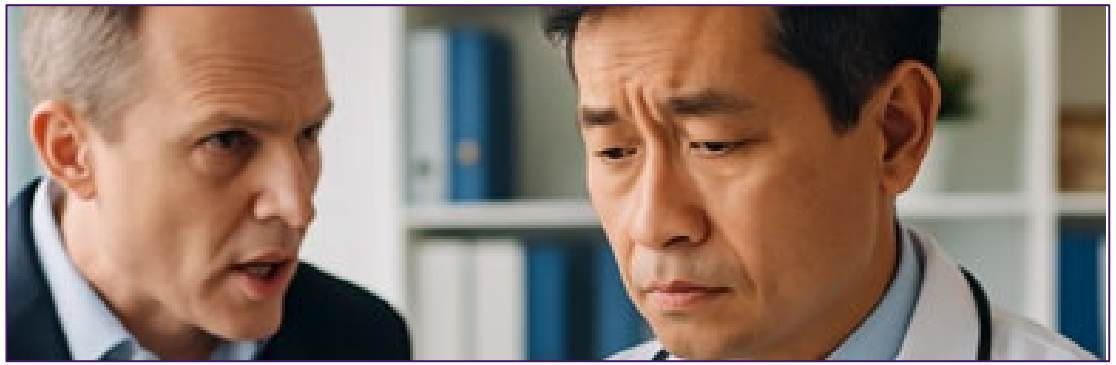
The Crisis Behind the Clock



Job Demands > Resources = BURNOUT



Time Isn't NEUTRAL - It's EMOTIONAL



Beyond Burnout...

Build Better Systems, Not Just Stronger Canaries


TikTok

Build Better Systems, Not Stronger Canaries

Stanford Well-Being Model 2.0

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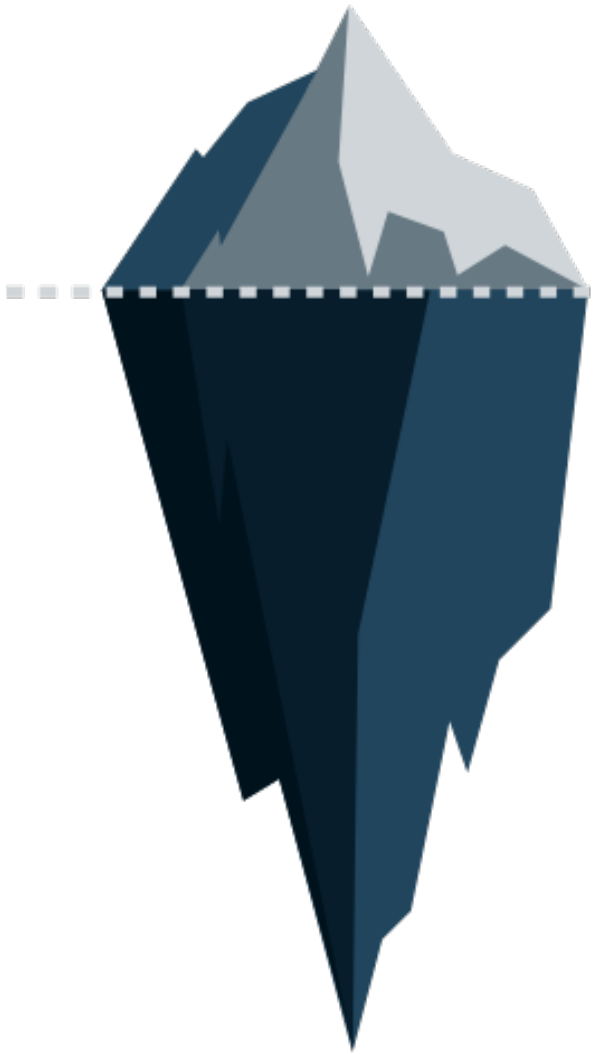
Better Systems, Not Stronger Canaries

Saving Time: Think Bigger

The Power of Purposeful Work

Restoring Humanity in Health Care: It's Good Business



ROI

Return On Investment

- Cost savings

VOI

Value On Investment

- Increased productivity
- Elevated employee morale
- Improved retention
- Enhanced organizational culture
- Better employee engagement
- Fewer safety incidents
- Decreased absenteeism

Change is POSSIBLE

What Will YOU Do With the Time We Save?

Physician and Patient Perspective

Marie T. Brown, MD, MACP

Director, Practice Redesign, American Medical Association

Professor Emeritus, Rush University

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THE PRINCIPAL DRIVER OF PHYSICIAN SATISFACTION IS DELIVERING QUALITY PATIENT CARE

Today's Appointment: Mrs. Garcia 10:20-10:40

65 y/o woman retired teacher here for follow-up.
She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills. She arrives late due to bus breakdown.

On Your Plate:

1. You are 35 min behind schedule
2. Your inbox has 100 messages
3. Your quality measures are **red**
4. Her A1c was 8.5% 6 months ago
5. No record of TSH or BMP
6. BP today is 180/100 no HBPM
7. Heart rate 90
8. She has gained 5 lbs. since last visit
9. She thinks she needs refills
10. She is not sure which blood pressure medicines she is taking
11. PHQ-9=14 (takes 10 min to complete in room)

Problem List:

Diabetes
Depression
Obesity
HTN
Hypothyroidism
Osteoarthritis
Low back pain
Asthma

Meds:

Metformin
Glyburide
Sitagliptin
Hydrochlorothiazide
Lisinopril
Metoprolol
Paroxetine
lorazepam
Estrogen
Atorvastatin
Levothyroxine
Pantoprazole
Vit D,E,A
Albuterol
Fluticasone

You recognize an opportunity to taper or substitute six of her meds, but all you have time to do is write refills.

Today's Appointment: Mrs. Garcia 10:20-10:40

As you leave the room, she remembers that:

- She needs a mammogram
- A handicapped parking sticker
- Eye referral
- Something more to help her sleep
- She asks when she is due for another colonoscopy
- Cannot afford her spacer
- When can she stop her BP meds – she feels fine!
- Something for the pain

What Happens With Mrs. Garcia Between This Visit and Next?

	Staff	Minutes
1. Phones for a refill on her metformin as soon as she gets home	1	2
2. She calls asking for medication for her knee pain	2	4
3. She calls for lab results, and you note her TSH is high	3	6
4. You increase her levothyroxine and order a repeat TSH in 6 weeks	1	2
5. You increase her lisinopril and send in a refill	2	4
6. You order labs for 1 month after she starts a higher dose of lisinopril	3	6
7. You note her A1c is 8.2, you increase her metformin and send in a refill	1	2
8. She would like an X-ray of her back	2	4
9. She calls for her TSH result in 6 weeks	3	6
10. She calls for her mammogram result, which is normal	1	2
11. She asks if she should get a shingles shot	2	4
12. Quality metrics report: no cancer screening, Tdap, influenza, PCV, PPSV, zoster	3	6
13. BP and A1c not at goal – tied to evaluation/organization reimbursement	1	2
14. Patient satisfaction is low due to being 1-2 hours behind schedule	2	4
15. She calls as an emergency as the BP at local pharmacy reads 200/130	3	6
16. Lab in 1 month shows creatinine 1.4 and K+ 5.4	1	2
17. She calls to ask if she should take both the old and the new dose of lisinopril	2	4
	3	6
	30 staff	**60 min**

What Is The Cost?

1. Phones for a refill on her metformin as soon as she gets home
2. She calls asking for medication for her knee pain
3. She calls for lab results, and you note her TSH is high
4. You increase her levothyroxine and order a repeat TSH in 6 weeks
5. You increase her lisinopril and send in a refill
6. You order labs for 1 month after she starts a higher dose of lisinopril
7. You note her A1c is 8.2, you increase her metformin and send in a refill
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Staff	Minutes
1	2
2	4
3	6
1	2
2	4
3	6
1	2
2	4
3	6
1	2
2	4
3	6
1	2
2	4
3	6
30 staff	**60 min**

1 hr between each visit = **4 hrs/year** for **1** patient

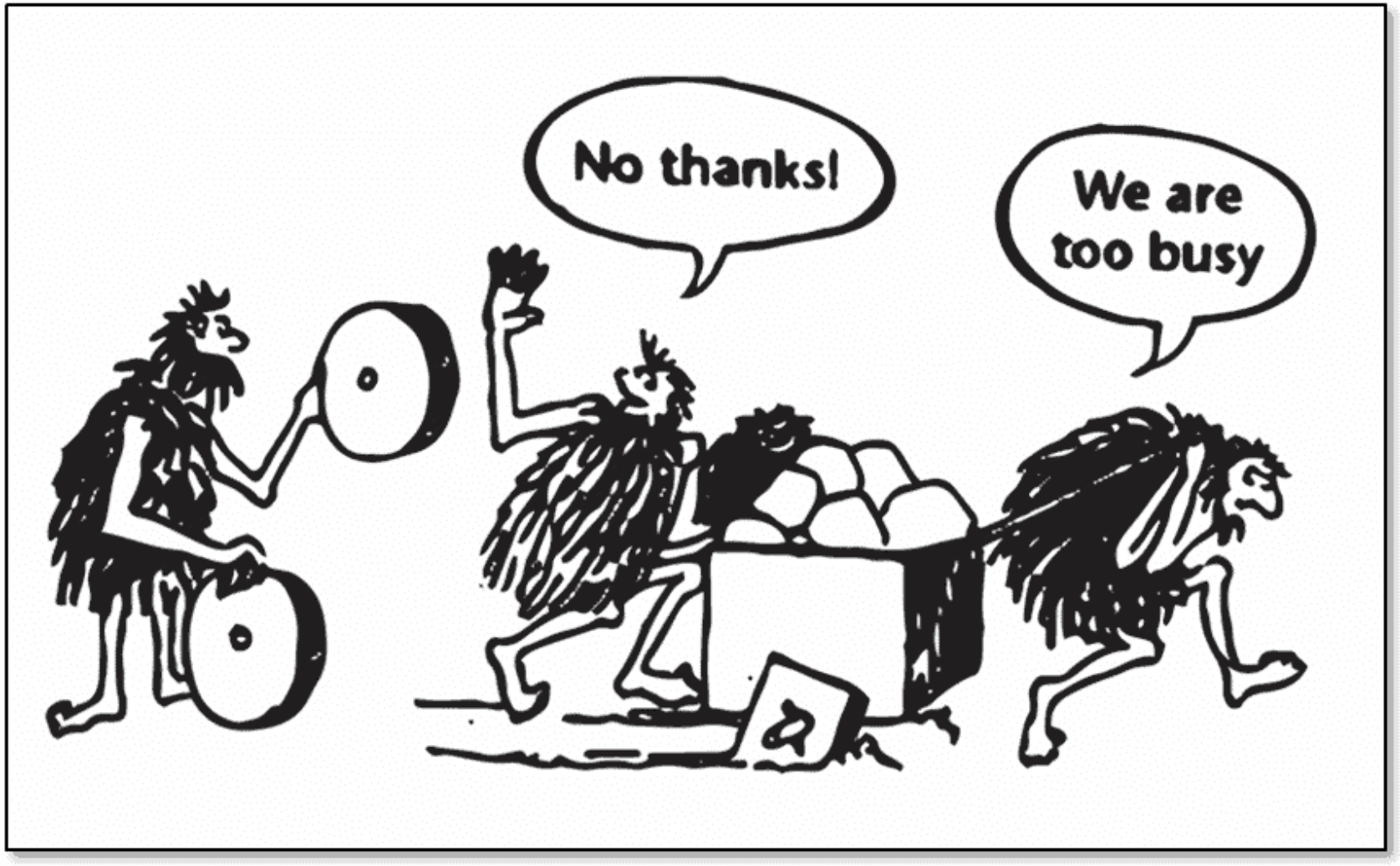
1,000 patients x 4 hrs = 4,000 hrs/year

1 full-time employee = 2,000 hrs/year

Physicians Are Trained To Think of the Exception Lives Are Saved in This Way!

We are asking them to think differently…

… like an efficiency expert!



I can't ask my physicians to do one more thing….
Until I take something off their plate. *-Chair of Medicine*

AMA | STEPS FORWARD®

Saving Time Playbook

Build a Well-Run Ambulatory Practice by Optimizing Teamwork and Clinical Operations

from the AMA STEPS Forward® Playbook Series

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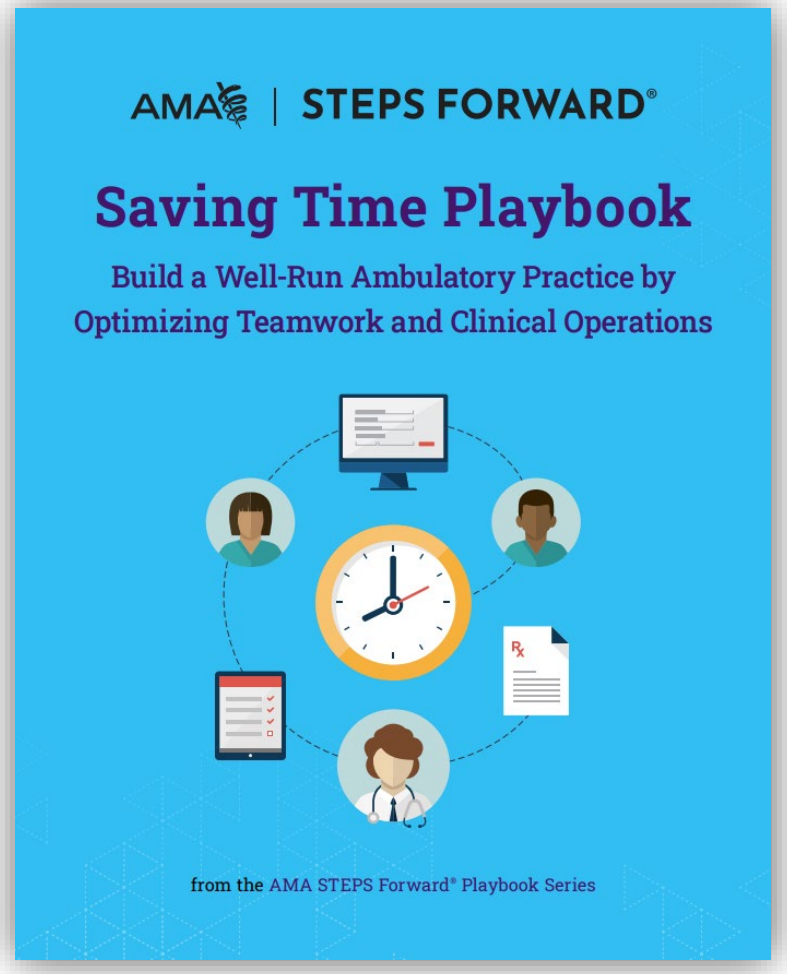

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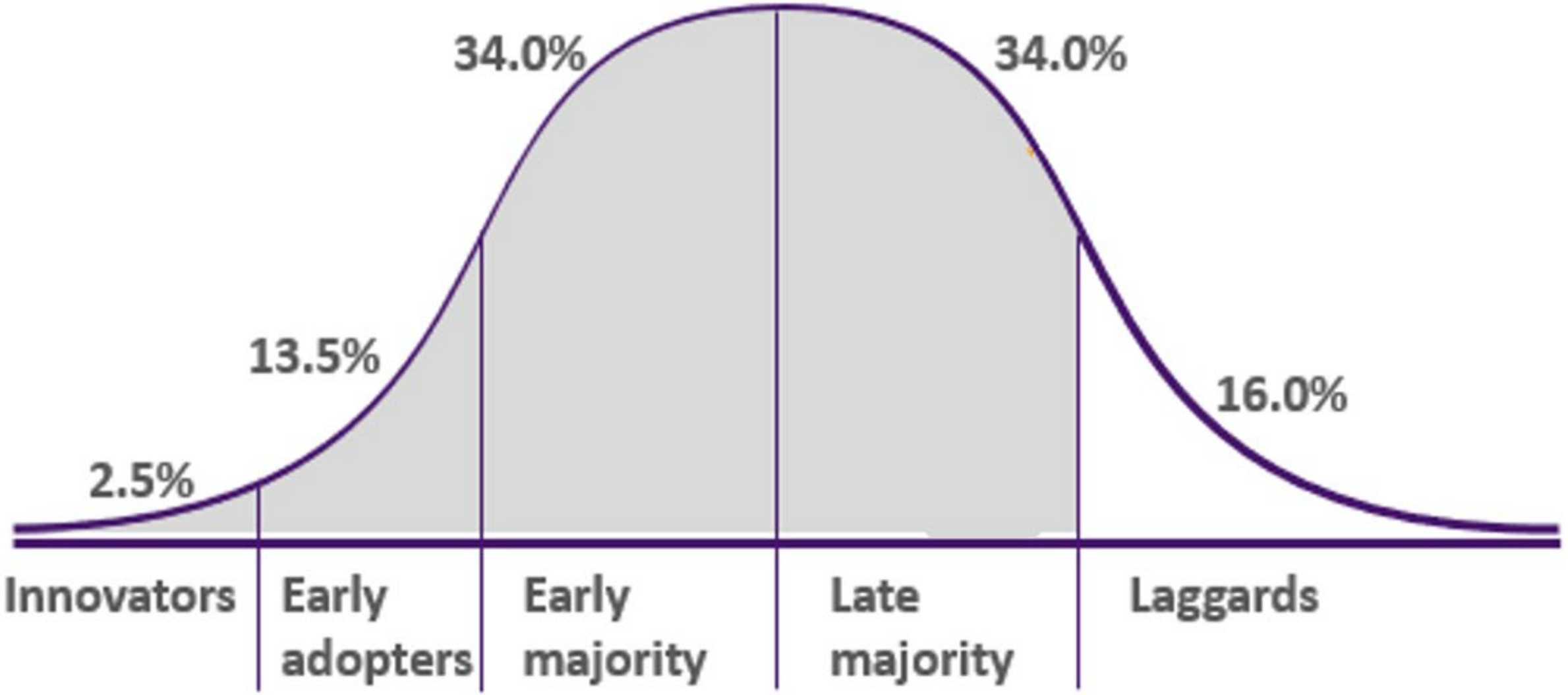
Go for the early win!



“If you want to achieve change in behavior, there is one good way to do it and one bad way.”

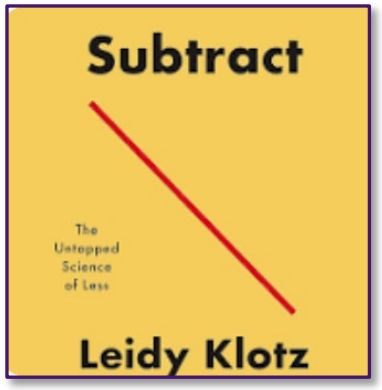
Which one would your physicians say their organization uses?

Carrot: Stand up if you think the majority of your physicians feel their organization uses incentives to drive behavior.

Stick: Stay seated if you think the majority of your physicians feel they are given negative feedback to drive behavior.

“If you want to achieve change in behavior, there is one good way to do it and one bad way.”

“If you want to achieve change in behavior, there is one good way to do it and one bad way.”



The “bad way” is to add – whether incentives for good behavior or punishment for bad behavior – because this increases the tension in the system.

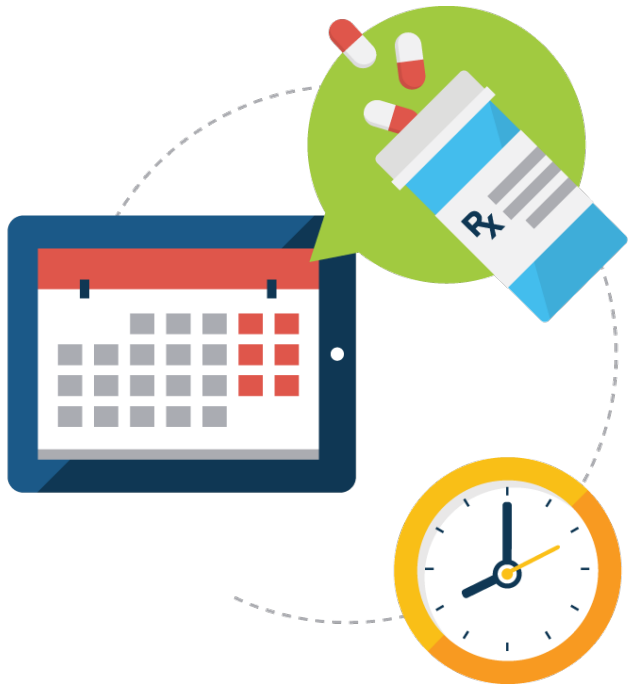
The “good way” is by diminishing restraining forces, not by increasing the driving forces.

Annual Prescription Renewal

Save Time and Improve Medication Adherence

Christine A. Sinsky, MD, MACP

Former Vice President, Professional Satisfaction, American Medical Association



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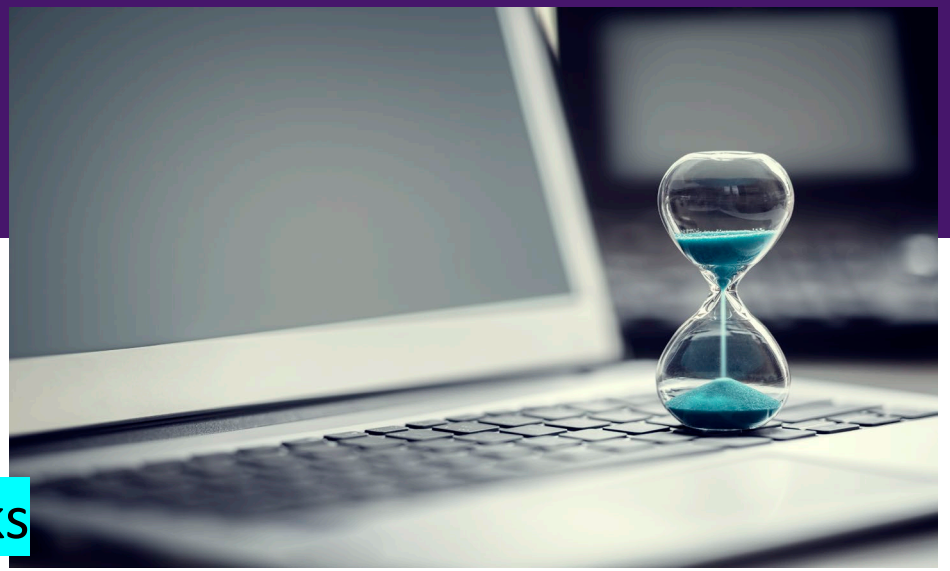
Calculations



Time spent on refills = 20 min/day= 5,000 min/year (20x250 days);
5,000 min/60 min/hr = 80 hrs = roughly two 40 hr weeks

If annual salary = $250,000 /250 days; salary is $1,000/day

For 1 provider: 2 weeks spent on refills = $10,000 (10 days at $1,000/day)

For 10 providers: 20 weeks spent on refills = $100,000

For 100 providers: 200 weeks/yr spent on refills = $1,000,000 = 1 million dollars/year!!!

Boston Children's Hospital

- Attended Saving Time Boot Camp in Spring 2025
  - Received funding by planning and completing an intervention within the year
  - Decided upon Annual Rx Renewal "90 x 4, call me no more" at boot camp
  - Engaged leadership and CMIO
  - Engaged physicians
  - Identified which drugs had the greatest opportunity for time saving
    - Oral contraceptives and steroid inhalers targeted
  - Rolled out the EHR change (default 90 x 4) July 2025
  - Already seeing benefits
  - Started and completed MOC IV

Elisabeth DiPietro, MD, CWO
Michelle Lock, MD, CMO

Naveed Rabbini, MD, CMIO

"I was just on call this weekend and couldn't believe someone was calling me for a refill on OCP when she was just seen in clinic last week!"

Save 3-5 Hours/Day

- Practice Re-engineering
  - Pre-visit lab and planning ½ hr
  - Prescription mgt ½ hr
  - Expanded rooming/discharge 1 hr
  - Tame the inbox 2 hr
  - Team documentation 1-2 hr

3-5 hours/day!

Pre-Visit Laboratory Testing 0.5 Credit CME

Ordering pre-visit lab tests allows the patient and physician to have a face-to-face conversation about the results, improving care and efficiency.

Pre-Visit Planning 0.5 Credit CME

Understand how pre-visit, team-based workflows can save time, improve care and strengthen satisfaction among the care team.

Team-Based Care

Improve patient care and team engagement through collaboration and stream-lined processes.

Advanced Rooming and Discharge 0.5 Credit CME

Understand how to involve team members in advanced rooming and discharge activities.

Can't be done with ½ MA/clinician

Today's Appointment With Practice Redesign: Mrs. Garcia 10:20-10:40

65 y/o woman retired teacher here for follow up. She notes fatigue, insomnia, back and knee pain. Unsure if she needs refills. PHQ-9 = 12 (completed prior to visit)

1. Your staff called her yesterday, set the agenda and averaged and recorded HBPM readings.
2. Staff chart prep: diabetes educator, eye/GI referral, vaccines. Labs, scope, mammogram ordered. Physical therapy form completed. PHQ-9 completed via patient portal. Needs flu vaccine 3-4 min.
3. All refills for 1 year were handled last visit.
4. She had labs drawn 3 days ago and they are ready for review.

Problem list:

T2DM	HTN
Depression	Hypothyroidism
Obesity	Osteoarthritis
Asthma	Low back pain

1. She had pre-visit labs and these are reviewed with her and meds adjusted.
2. Her A1c was 8.2 3 days ago, annual TSH is normal, annual ACR normal.
3. BP today is 150/90 in office, readings at home 120/75 machine accurate.
4. You increase her metformin and switch her from paroxetine to bupropion.
5. You discontinue estrogen, taper lorazepam, pantoprazole, Vit A and E.
6. You received notice your health maintenance levels were at goal.
7. You leave on time!

Mrs. Garcia Between Appointments After Practice Redesign

1. Phones for a refill on her metformin as soon as she gets home
2. She calls asking for medication for her knee pain
3. She calls for lab results and you note her TSH is high
4. You increase her levothyroxine and order repeat TSH in 6 weeks
5. You increase her lisinopril and send in refill
6. You order lab for 1 month after she starts higher dose of lisinopril
7. You note her A1c is 8.2, you increase her metformin and send in refill
8. She would like an x-ray of her back
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15. She calls as an emergency as the BP at local pharmacy reads 200/130
16. Lab in 1 month shows creatinine 1.4 and K+ 5.4
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Staff	Minutes
1	2
2	4
3	6
1	2
2	4
3	6
1	2
2	4
3	6
1	2
2	4
3	6
1	2
2	4
3	6
30 staff	**60 min**

4 hours/year for **1** patient saved!

If you saved only 2 hr/yr/patient x 1,000 patients = 2,000 hrs

2,000 hrs/yr = 250 days = 1 full time employee!

Mrs. Garcia's Next Appointment After Practice Redesign

65 yo woman retired teacher here for follow up. She notes more energy and less pain.
She brings in her meds and does not need refills. PHQ in waiting room=4 (was 12)

1. HBPM readings are accurate and at goal!!
2. Seeing physical therapist and diabetes educator regularly and has lost 3 lbs
3. Your staff called her yesterday and set the agenda **3 min**
4. Staff chart prep: health maintenance up to date, diabetes educator, vaccines **3 min**
5. No refills needed

Problem list:
T2DM
~~Depression~~
Obesity
HTN
~~Low back pain~~

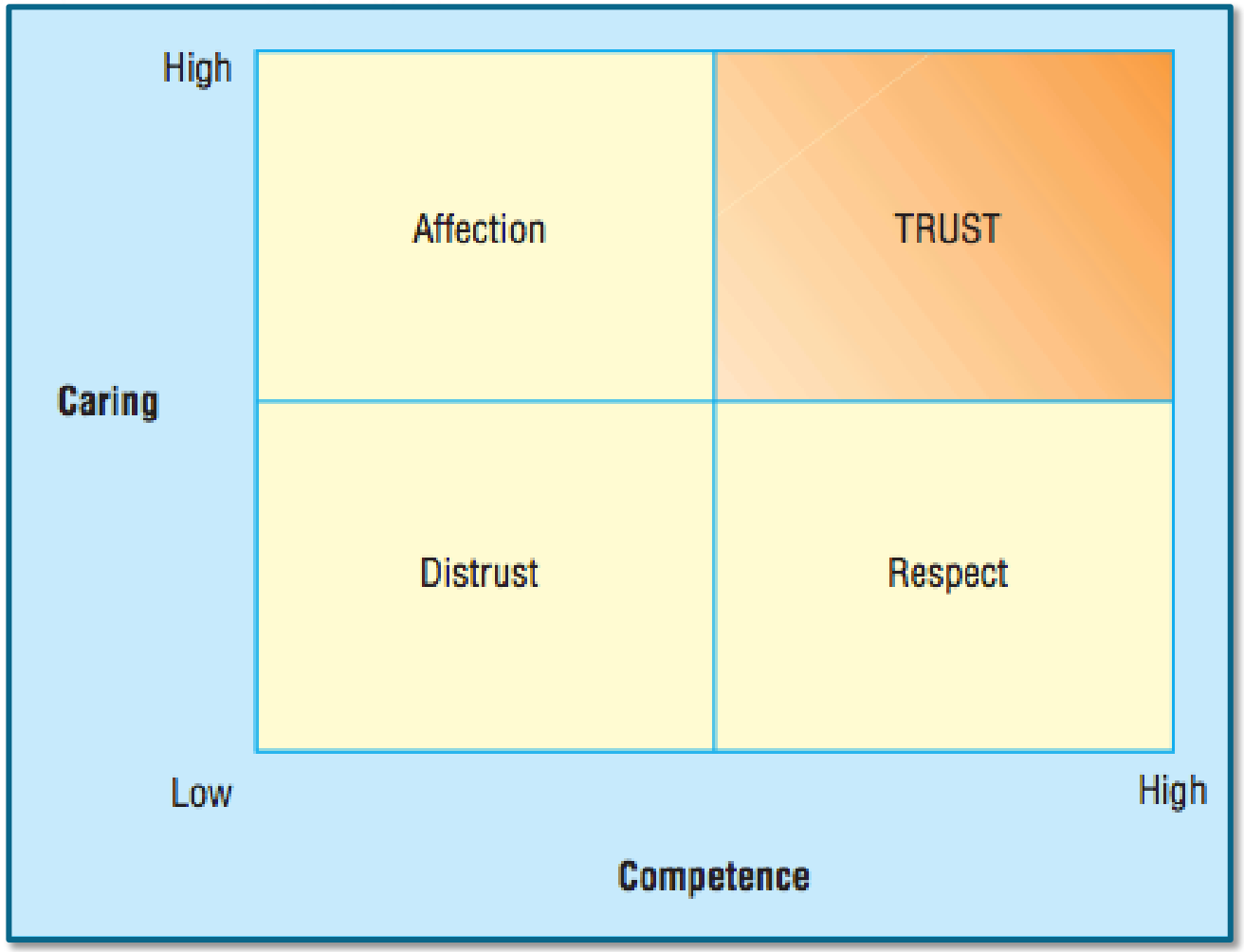
Meds:
Metfor
Atorvas
Chlorthalidone
Lisinopril
Vit D,B12

No calls between this visit and next visit!

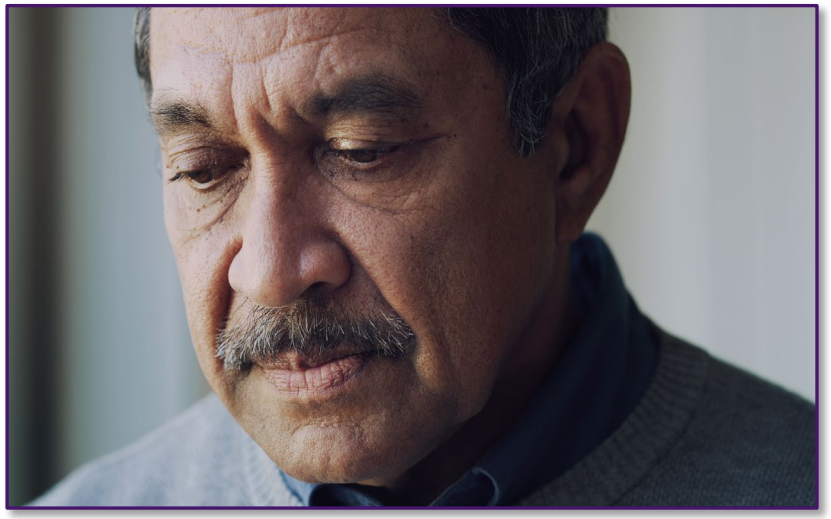
You feel almost as good as she does!

1. She had previsit labs and these are reviewed with her and med adjustments
2. Her A1c was 7.8 2 days ago, annual TSH is normal, annual ACR up to date
3. Vit D and B12 maintenance levels were at goal
5. You leave on time!

Competence and Caring In Relation To Building Trust



Trust takes time to build
Seconds to break
Forever to mend



Paling,J BMJ 327: 9/27/2003

Questions?

Break

10:15 – 10:30 a.m.

Scan the QR code to access the resources hub!

Reducing Regulatory Burden & De-implementation Fundamentals

Kevin D. Hopkins, MD
Physician Director, Health System Engagement
Professional Satisfaction & Practice Sustainability (PS2)
American Medical Association (AMA)

AMA | STEPS FORWARD®

The Time Problem (2022)

A panel of 2,500 primary care patients

Chronic disease management	7.2 hrs/day
Preventative Care	14.1 hrs/day
Acute Care	2.2 hrs/day
Documentation/Inbox	3.2 hrs/day
Total	26.7 hrs/day

Porter, J., Boyd, C., Skandari, M.R. *et al.* Revisiting the Time Needed to Provide Adult Primary Care. *J GEN INTERN MED* (2022). https://doi.org/10.1007/s11606-022-07707-x

Physicians and their teams need more time.

What can we do?

Two Key Strategies for Saving Time & Reducing Burnout

1. Reduce the Unnecessary, Low-Value Work

2. Share the Necessary, Value-Adding Work

De-implementation

Reducing unnecessary, low-value work

AMA | STEPS FORWARD® Innovation Academy

De-implementation/Getting Rid of Stupid Stuff (GROSS)

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 8, 2018

Getting Rid of Stupid Stuff

Melinda Ashton, M.D.

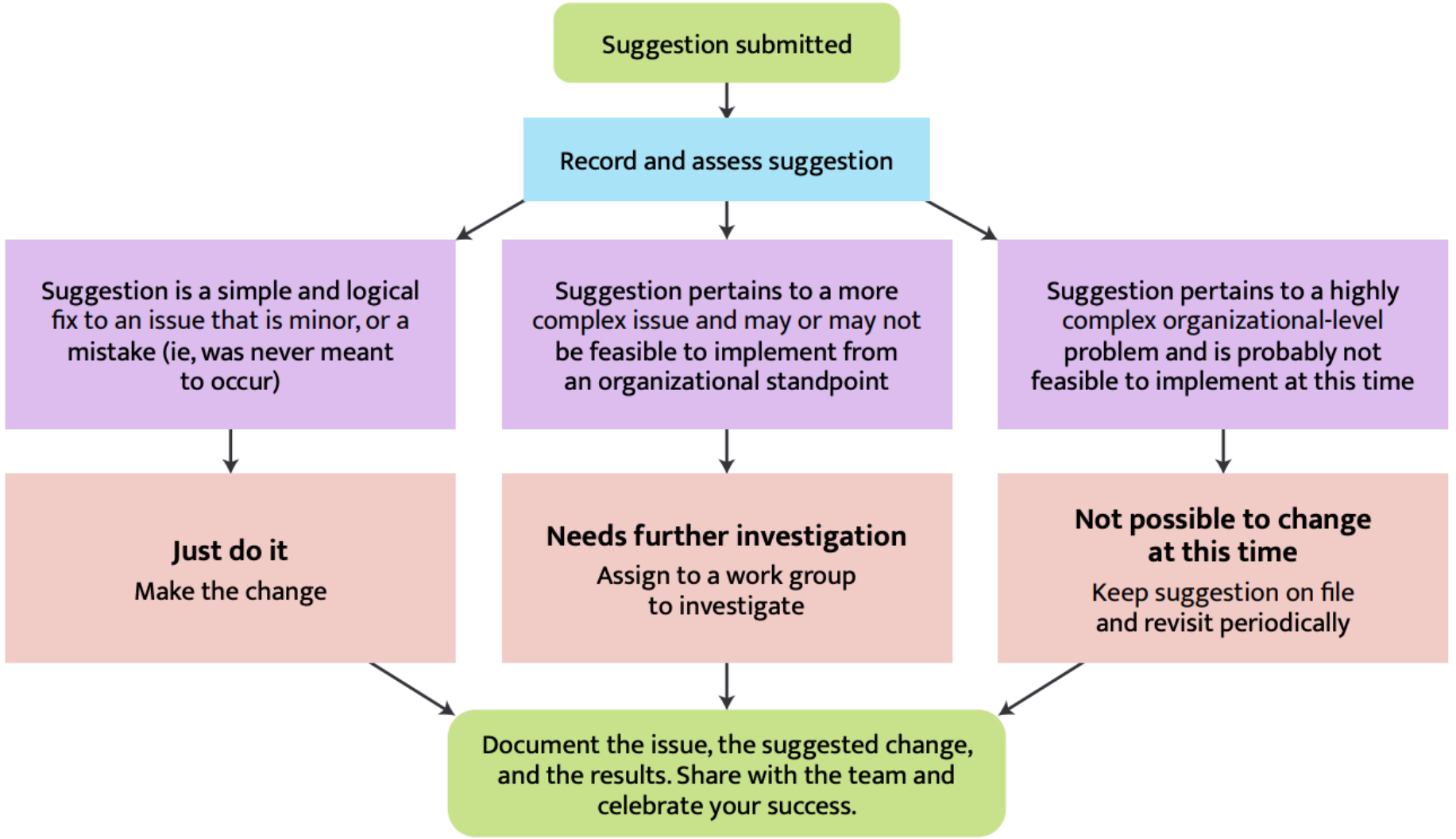
Many health care organizations are searching for ways to engage employees and protect against burnout, and involvement in meaningful work has been reported to serve both functions. According to Bailey and Madden, it is easy to damage employees' sense of meaningfulness by presenting them with pointless tasks that lead them to wonder, "Why am I bothering to do this?"[1] An increase in administrative tasks has resulted in less time for the activity that clinicians find most important: interacting with patients. Some commentators have

my colleagues and I had reason to believe that there might be some documentation tasks that could be eliminated. Our EHR was adopted more than 10 years ago, and since then we have made a number of additions and changes to meet various identified needs. We decided to see whether we could reduce some of the unintended burden imposed by our

of the beholder. Everything that we might now call stupid was thought to be a good idea at some point."

We thought we would probably receive nominations in three categories: documentation that was never meant to occur and would require little consideration to eliminate or fix; documentation that was needed but could be completed in a more efficient or effective way with newer tools or better understanding; and documentation that was required but for which clinicians did not understand the requirement or the tools available

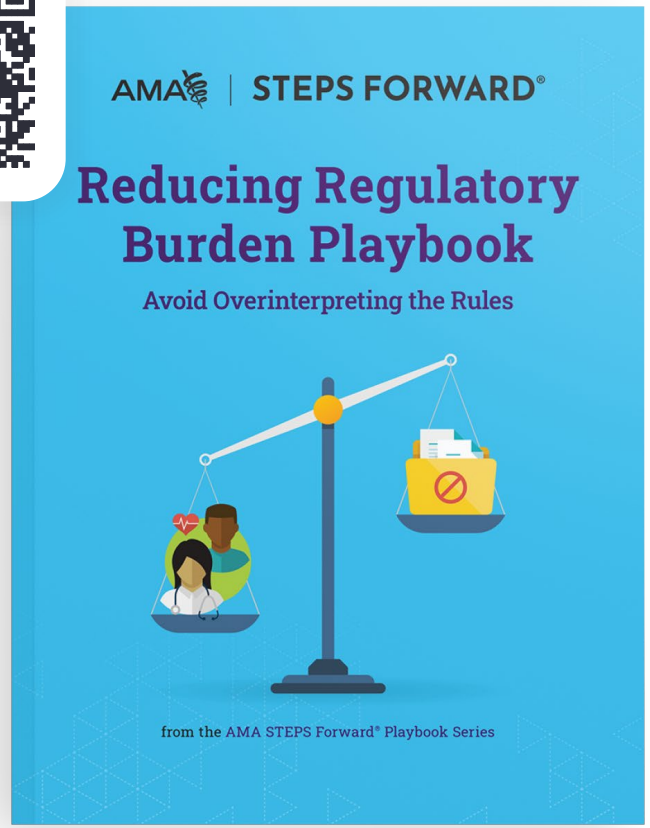
De-implementation/Getting Rid of Stupid Stuff (GROSS)



GROSS Toolkit

AMA STEPS Forward® Playbook Series

Read the Playbook



Four core strategies for approaching regulatory compliance burdens to practice redesign, innovation, and efficiency.

1. *Stop* This
2. *Start* That
3. Leverage the Business Case for Change
4. Share and Celebrate Success Stories

The Regulatory Challenge in Healthcare

AMA | STEPSforward
Innovation Academy

Who Makes the Rules?

- Federal Regulatory Agencies?
- State Boards of Medicine, Nursing, & Pharmacy?
- Health Systems & Practices?
  - Compliance
  - Revenue cycle
  - Risk management
  - Information technology

"Organizations frequently establish stringent requirements well beyond our standards, and they then get scored as being out of compliance. We get blamed for this, and that's how myths arise that we require things when we do not!"

- David Baker, MD, MACP

Former Executive Vice President

The Joint Commission

Categorization of Regulatory Burdens

- Technical/EHR
- Documentation requirements
- Billing & coding
- Workflow/efficiency
- Scope of practice
- Patient quality and safety

What's the Difference?

- **Regulatory Requirement:** Mandatory compliance with a legal obligation from federal or state agency
- **Organizational Policy:** Institutional rule developed to ensure adherence to and compliance with a determined legal obligation
- **Standard Operating Procedure (SOP):** Organizational process, "How we do this"
- **Standard Workflow:** What is done - where, when, how, and by whom
- **Recommendation/Best-Practice:** Non-binding guidance or suggestion

“But it’s out of our control…”

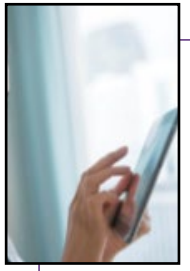
“The majority (78%) of obstructive and wasteful rules identified by patients and staff were fully within the administrative control of health care executives and managers to change.[3]”

Donald Berwick, MD, MPP, FRCP

Debunking Regulatory Myths

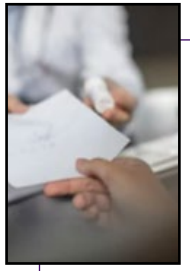
Interested in debunking a myth?

Scan the QR code to access the submission form or visit us online at ama-assn.org/regulatory-myths.



Two-Factor Authentication for Prescriptions

Is two-factor authentication required for all prescriptions?

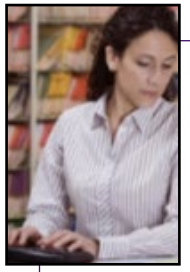


Review of Patient Test Results

Must all test results be reviewed by patients' primary care physician?

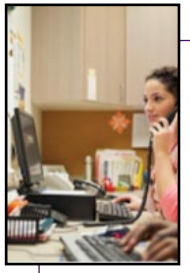
Admission, Discharge, & Transfer Messages

Must hospitals send ADT notifications to physicians' EHR inbox?



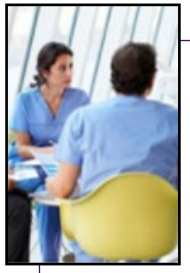
EHR Gag Clauses

Can physicians openly discuss EHR issues?



Protected Health Information (PHI) Disclosures

Does HIPAA require that health care providers obtain patient authorization to disclose PHI for treatment purposes?



Mental Health

Must licensing/credentialing bodies probe into clinicians' past mental health?

“It’s a regulatory requirement.”

Show Me the Regulation!

“Can you please show me that regulation and where it comes from?”

Effects of Overinterpreted Regulatory Requirements

01

WORKLOAD

- Administrative burden
- Excessive documentation

02

COGNITIVE

- Cognitive overload for clinicians
- Dissatisfaction among physicians and other team members
- Clinician burnout

03

ORGANIZATIONAL

- Eroding trust between physicians and health system leaders
- Care team dysfunction
- Building an adversarial relationship between clinicians and policymakers

04

PATIENT CARE

- Impeding the patient-physician relationship
- Reducing patient care capacity and access to care
- Raising health care costs
- Harming patients

Process: Eliminating Unnecessary Regulatory Burden

CLINICAL CARE:

Low-value clinical care → de-intensification → right-sized care

PRACTICE/HEALTH SYSTEMS MANAGEMENT:

Low-value clinical work → de-implementation → right-sized regulations

Stop This

“One password is enough.”

Stop unnecessary EHR password revalidation and two-factor authentication.

Success Story

“The sound of keyboard tapping and mouse clicking has become the sound of joy leaving physicians through their fingertips.”

- Kevin Hopkins, MD

Vice Chief, Primary Care Institute

Cleveland Clinic

Success Story

“Our physicians are no longer required to use password revalidation when signing ambulatory orders for non-controlled medications in our EHR. Across our health system, this single change affects 11 million orders per year and over 12,000 hours of physician time at an estimated cost of $2 million per year.”

Kevin Hopkins, MD
Vice Chief, Primary Care Institute Cleveland Clinic

Success Story

“We learned that not all organizations require password authorization [for EHR order entry].”

Ken Robinson, MD
Physician Lead for Systems Solutions & Deployment, Kaiser Permanente Southern California

“Thanks, but no thanks.”

Stop routing “thank you” patient portal messages to EHR inboxes.

Success Story

“We made the change to suppress routing patient portal ‘thank you’ messages, preventing an estimated 50,000 messages per year from coming into care teams’ EHR inboxes.”

Jennifer Parker, MD
Chief of General Internal Medicine Division University of Nebraska Medical Center

“Stick with the vital, vitals.”

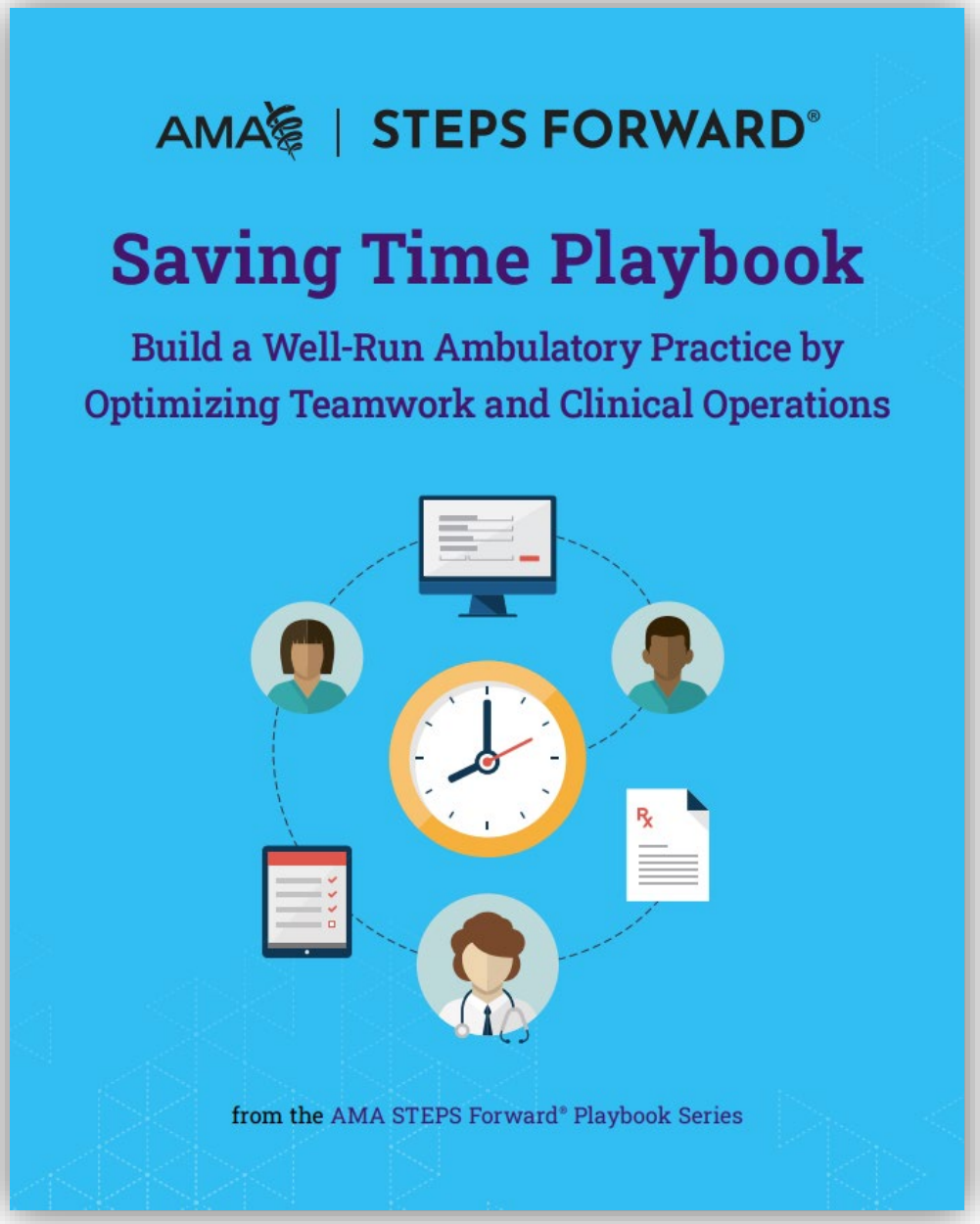
Stop recording unnecessary vital signs.

“Notification not necessary.”

Stop routing Patient Event Notifications
directly to physicians’ inboxes.

Start That

- Practice Efficiency
- Delegation
- Team-Based Care Fundamentals



Saving Time Playbook

1

Stop doing unnecessary work

- Get rid of unnecessary /redundant tasks
- Streamline prescribing and management of prescriptions for chronic illnesses
- Optimize the EHR

2

Incorporate practice fundamentals

- Use current visit to prepare for the next
- Work as a team to increase efficiency
- Document the visit as a team

3

Make the case to leadership

- Identify key messages to convey the value of physicians' time

AMA | Physicians' powerful ally in patient care

“90 + 4, call me no more.”

Start writing chronic medication prescriptions for the maximum allowed length of time.

Success Story

“I found this 1 simple change of standardizing prescriptions for chronic daily medications being written for a 15-month supply (90-days x 4 refills) once a year saved my staff and me at least 1 hour per day. With that extra hour, we had time to identify patients who missed appointments and reach out to provide health coaching.”

Marie Brown, MD, MACP
Internal Medicine, Former Governor (Illinois), American College of Physicians

“Keep me logged in.”

Start adjusting EHR automatic logout time to fit the practice setting.

“Deflate the note bloat.”

Start using updated billing and coding guidelines to decrease documentation.

“Share the care.”

Involve other team members in documentation and other necessary task work.

Team-Based Care Fundamentals

A “Team Care” model utilizes a team approach in caring for patients

- Responsibilities are delegated and shared
- Each individual in the chain of patient care functions to the highest level of their qualifications & training

Share the Necessary, Value-Adding Work

- Team documentation
- Advanced rooming and discharge
- Pre-visit planning and pre-visit laboratory testing
- Annual prescription renewals and prescription management
- EHR inbox management

Team Documentation

- Real-time, in-room documentation support
  - Clinical team member (MA or nurse)
  - Trained documentation specialist (scribe)
  - Ambient generative AI platform
    - Visit note
    - Update chart
    - Attach diagnoses
    - Pend orders

Tasks Medical Assistants or Other Team Members Can Complete Under Advanced Protocols

During Rooming

- Identify the reason for the visit and help the patient set the visit agenda
- Perform medication reconciliation
- Screen for conditions based on protocols
- Update past medical, family, and social history
- Administer immunizations based on standing orders
- Pend or order preventive services based on standing orders
- Assemble medical equipment, if needed, before the physician enters the exam room

During Discharge

- Print and review an updated medication list and visit summary
- Review other after-visit instructions, such as home blood pressure monitoring or referrals to subspecialists
- Coordinate the next steps of care, such as scheduling future appointments and labs

Expanded Rooming Protocols

Rooming Checklist:

- Review last clinic note and interval care
- Review any completed questionnaires
- **Prepare test results**
- Compile relevant data
- Greet the patient
- **Establish the agenda**
- **Gather and document CC, HPI, ROS**
- Welcome new patients to the practice
- **Review medications & pend refills**
- Review allergies
- **Update histories & problem list**
- **Update care team**
- **Address and update health maintenance**
- **Initiate condition-specific screening**
- Evaluate status of chronic conditions
- Provide information about advance directives
- Provide self-management support
- **Perform symptom-driven testing**
- Provide immunizations based on standing orders
- Collect and record vital signs
- **Pend orders**
- Prepare patients for exam
- Assemble equipment and supplies
- Prepare the physician

Expanded Discharge Protocols

Discharge Checklist:

- **Complete any forms or letters**
- **Print and review the visit summary**
- **Review and reiterate instructions**
- Provide supplemental materials
- Orient patients to the patient portal
- **Schedule the next visit and pre-visit labs**
- Coordinate any additional care and testing
- Provide contact information for questions
- **Charge entry**
- **Warm handoff to next team member**

Pre-Visit Planning and Lab Testing

- Pre-visit planning protocols
- Bulk ordering based on EBM protocols
- Overdue health maintenance/care gaps
  - Chronic Disease Management
  - Screening
  - Preventative Care

Medication Refill Management

- Whenever a patient requests a refill on a chronic, daily medication:
  - Check medication list for other meds due to be refilled
  - Ask if OK to renew now
  - Confirm proper pharmacy(ies)
  - Pend new Rx with proper quantity & maximum allowable refills
  - Ideally done at time of medication review
- Some practices only refill medications at office visits
- Refill protocols, handled by a refill team of APPs, pharmacists, or RNs
- Some direct all refill requests to the patient's pharmacy

Team-Based EHR Inbox Management

BUCKET 1	What	Routes to	First pass by
	Information or questions about clinical care from patients or clinicians outside the practice	Clinical pool	MA, escalate to triage RN or physician as needed

BUCKET 2	What	Routes to	First pass by
	Nonclinical questions from patients or others (eg, scheduling questions, billing questions)	Administrative pool	Patient liaison or PSR, escalate to MA or billing staff as needed

BUCKET 3	What	Routes to	First pass by
	Medication refill requests from patients or phramacies	Refill pool	Refill nurse (RN or LPN)

BUCKET 4	What	Routes to	First pass by
	Requests for forms or letters	Administrative pool, then may need to be forwarded to the clinical pool	Administrative pool, then MA or RN for any clinical information, lastly by a physician for signature is needed

Patient Portal Messages

- All incoming patient messages should first be reviewed by a member of the care team
- Most messages can be adequately addressed by someone other than the physician (80%)
- Small percentage of messages should actually reach the doctor (20%)

Office Visit Workflow Efficiency Opportunities

1. Equipment & Supplies
2. Patient Forms
3. Vaccine Administration
4. In-Office Labs & Testing
5. Patient Questionnaires
6. Documentation Support
7. Rx Refills
8. Pre-Visit Planning & Labs
9. In-Basket Management
10. Expanded Rooming & Discharge Protocols

Questions?

How To Say YES!

Alekzander Sayers

Program Administrator, PS2

AMA | STEPS FORWARD®

Who Am I?

- Mainer
- Husband
- Artist

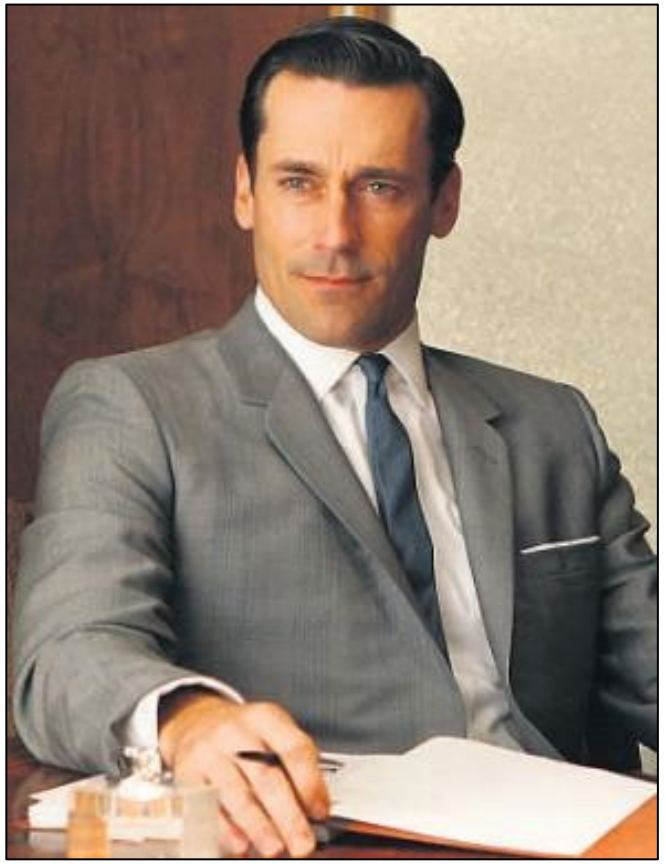
YOU belong to a culture of optimism and doers!

Today, We Are Going To Play

- Excited? Excellent!
- Worried? Even better. Follow the fear.

The Ad Game - Demonstration

- Everyone at your table is now part of a highly skilled advertisement agency
- You'll be given an ordinary product that has an extraordinary ability
- The deadline is tight! You'll have 90 seconds to prepare the full pitch for the client



The Ad Game – Your Turn!

Within 90 seconds, deliver:

- Product name
- Target audience
- A slogan
- A jingle
- A famous spokesperson
- Commercial look/storyboard
- …and anything else!

Simple rules:

- YES is the only word!
  - ~~“No” “But” “Or”~~
- Share the space, make room for all to speak
- Note-taking is fine, but still participate

Let’s hear your pitches!

Two Creative Processes: Imaginative and Practical

- **Imaginative**: Generate and play with ideas
- **Practical**: Evaluate and execute on those ideas
- These two steps are friends, but could hinder if they encroach on one another

Professional Application: Workforce Recruitment

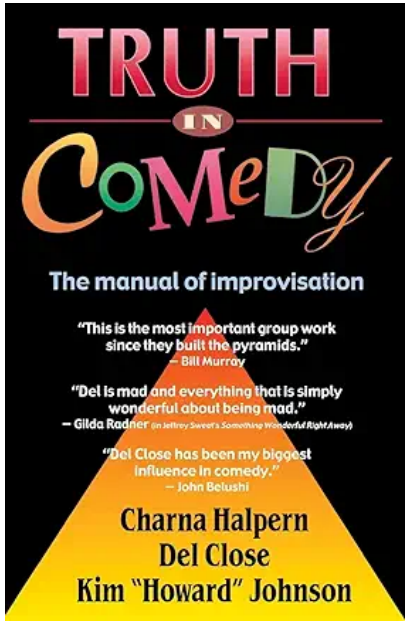
30% of your employment opportunities are vacant at your center.

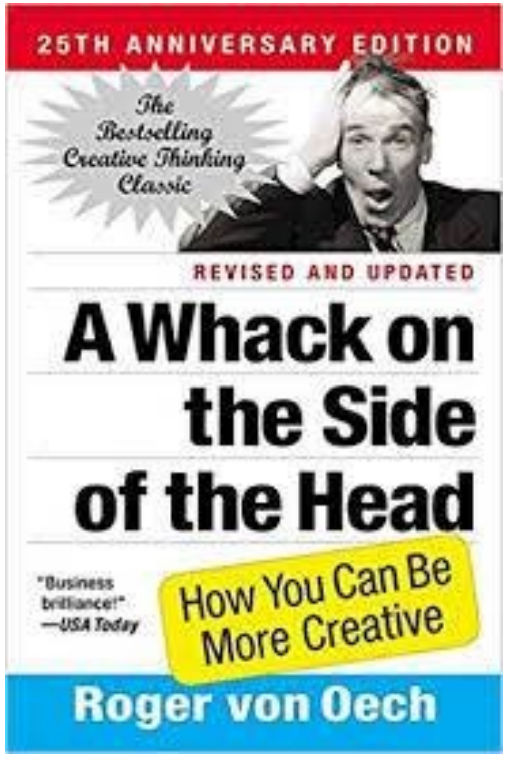
What is your recruitment strategy?

- What is your target group? (Nurses/MAs/Physicians etc.)
- How are you approaching them?
- What kind of training do we need?
- Who are you recruiting for?
- What's the pitch? Why work with you?
- What does success look like with this hire?

End of the Ad Game – Wrap Up

- Imaginative and practical thinking are your best friends – if you don't let them get in each other's way!
- Not every brainstorm yields a practical solution, but flexibility eventually will





A Whack on the Side of the Head Chapter 2

Truth in Comedy: The manual of Improvisation p. 52-56

Lunch

noon - 1:00 p.m.

Scan the QR code to access the resources hub!

Designing Clinical Technology to Support Clinical Practice

Jane F Fogg, MD, MPH
Physician Director, Organizational Transformation,
American Medical Association

Michele Thomas, MD, FAAFP
Senior Physician Advisor, Digital Health Innovation,
American Medical Association

AMA | STEPS FORWARD®

Agenda

- Introduction
- In-Depth Case Study
  - In-Basket
- Quick Wins
  - Orders
  - Referrals & eConsults
  - Problem List
  - Ambient Listening

Example of a Multiyear EHR Optimization Initiative

Atrius Health 2016-2023 initiatives

Structure

Ongoing clinical and operational governance structures:

- Executive health system leadership
  - IT Clinical Governance — Chair
- Service Line Governance
  - SL Epic Design Committee
  - SL Triad Leadership Team — Chair

Annual Hoshin goals

- Level 0,1,2 Charters — Chair

Tactics

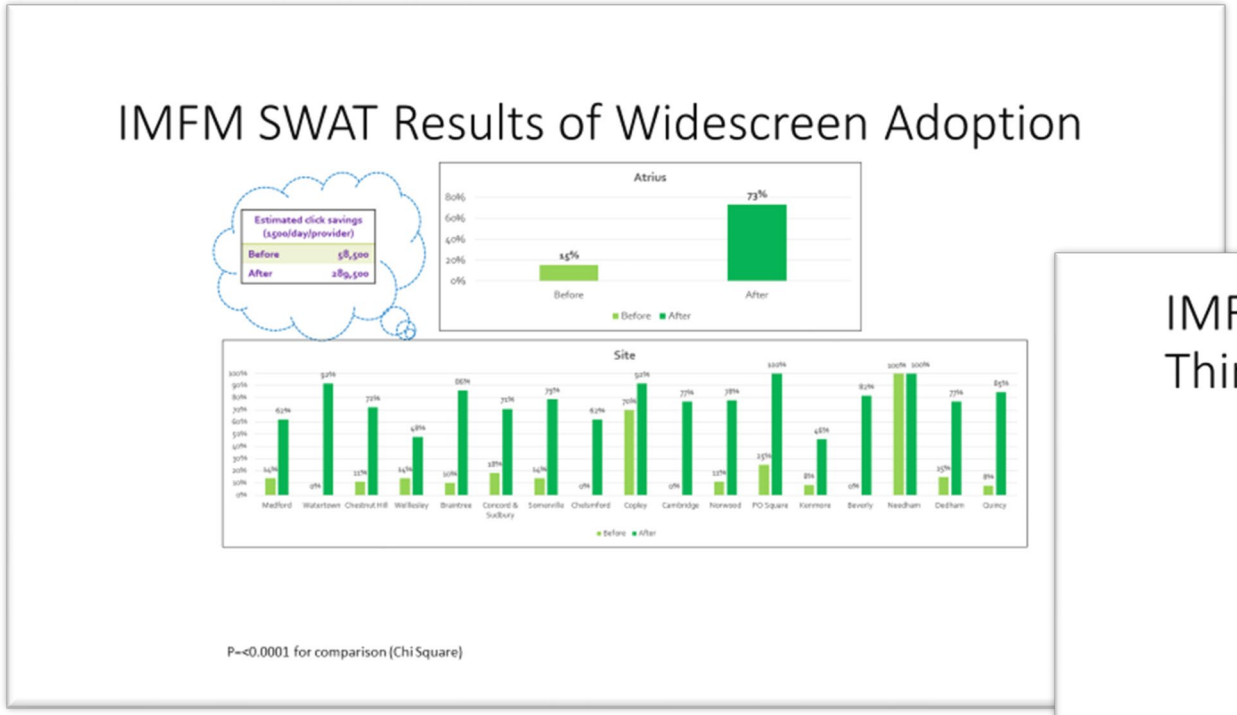
Internal Medicine Family Medicine (IMFM) “SWAT”, 2017

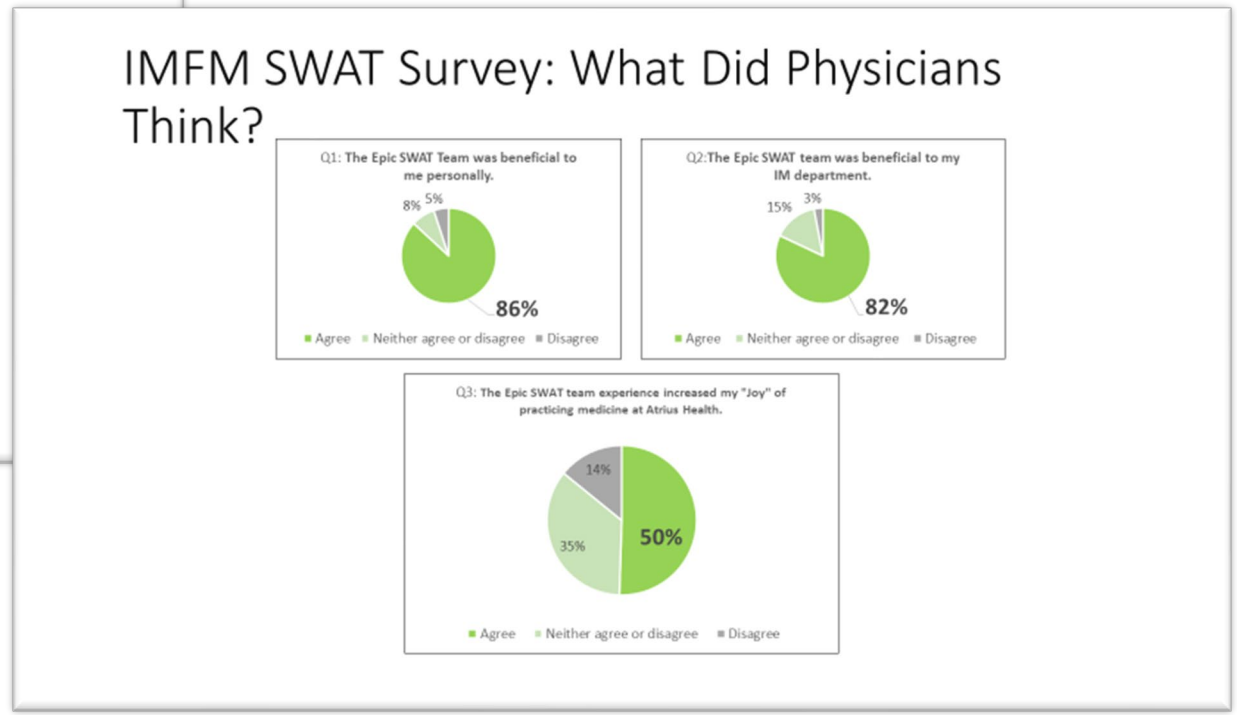
IMFM Service Line Optimization project, 2016-2018

IMFM In-Basket Reduction, 2017-2023

“Home for Dinner,” Epic refresher, 2022-ongoing

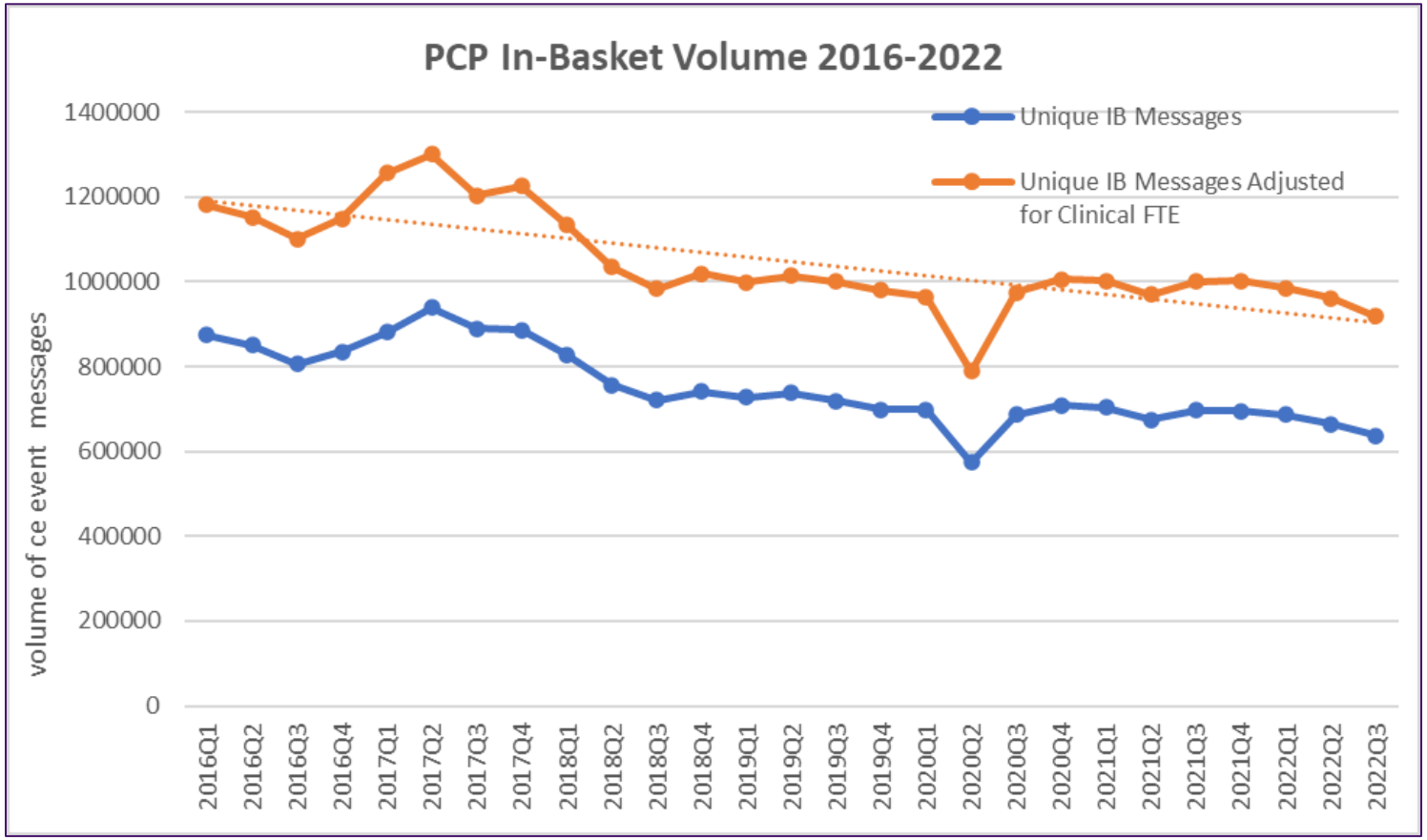
Measure Impact: Adoption Rate, Experience





Survey results from Atrius Health SWAT 2017; furnished by author

Measure Impact: Results at Atrius Health
2016-2022 PCP In-Basket Reduction 25%



***Fogg JF**, Sinsky CA. In-Basket Reduction: A Multiyear Pragmatic Approach to Lessen the Work Burden of Primary Care Physicians. NEJM Catal Innov Care Deliv 2023;4(5)*

In-Basket Strategy and Resulting Volume Reduction

Approach	Action/Goal	Message Type	Results
Eliminate	Eliminate low-value clinical information, waste, and duplication	Media Manager	98%
		CC Charts	35%
		ED/Hospital messages	100%
Automate	Embed protocols and automated pathways into the in-basket to resolve routine repetitive tasks	Prescription renewals	50%
		Normal lab results	30%
Delegate	Direct tasks to team members who can resolve them within their scope of practice and with clinical protocols	Portal message triage	n/a*
		Abnormal lab results	
Collaborate	Share accountability for tasks between two or more team members	Patient medical advice request	40%

***Fogg JF**, Sinsky CA. In-Basket Reduction: A Multiyear Pragmatic Approach to Lessen the Work Burden of Primary Care Physicians. NEJM Catal Innov Care Deliv 2023;4(5)*

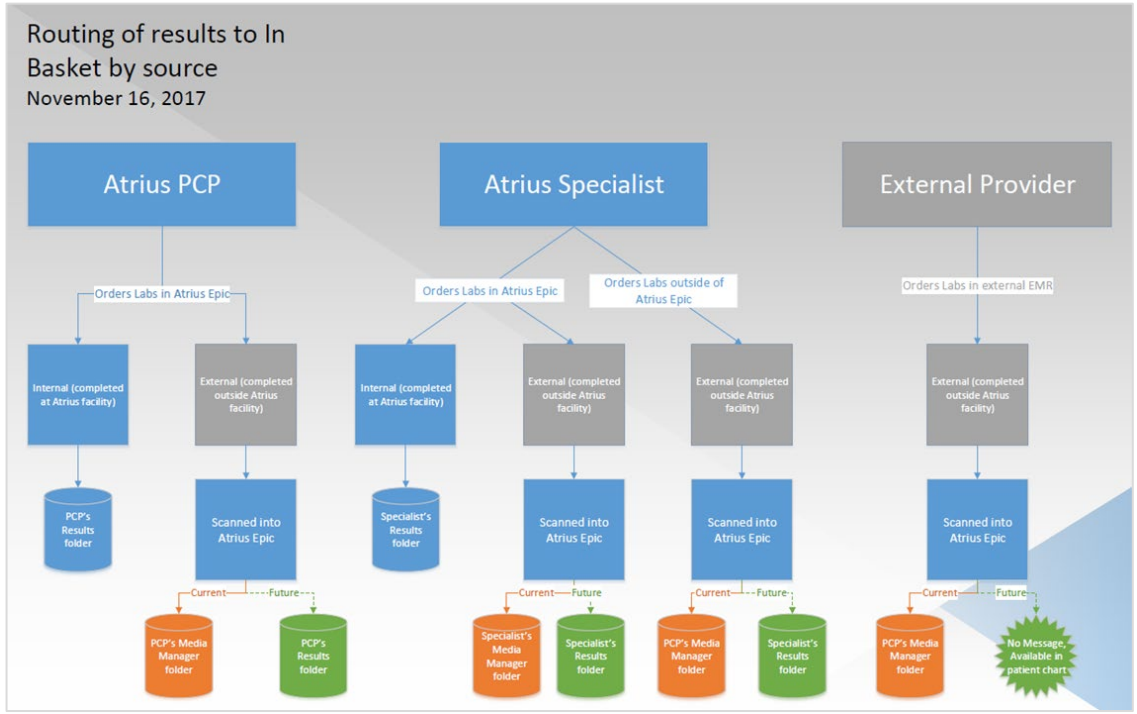
* Portal message triage pre-existed 2016 and abnormal results delegation is in process

Start By Reducing Waste

- Start with “behind the scenes” changes that don’t require new workflows
- Build trust
- With measurable success, you can advance to changes requiring new workflows

De-Implement,
De-Implement,
De-Implement…

Elimination Tactics: Media Manager



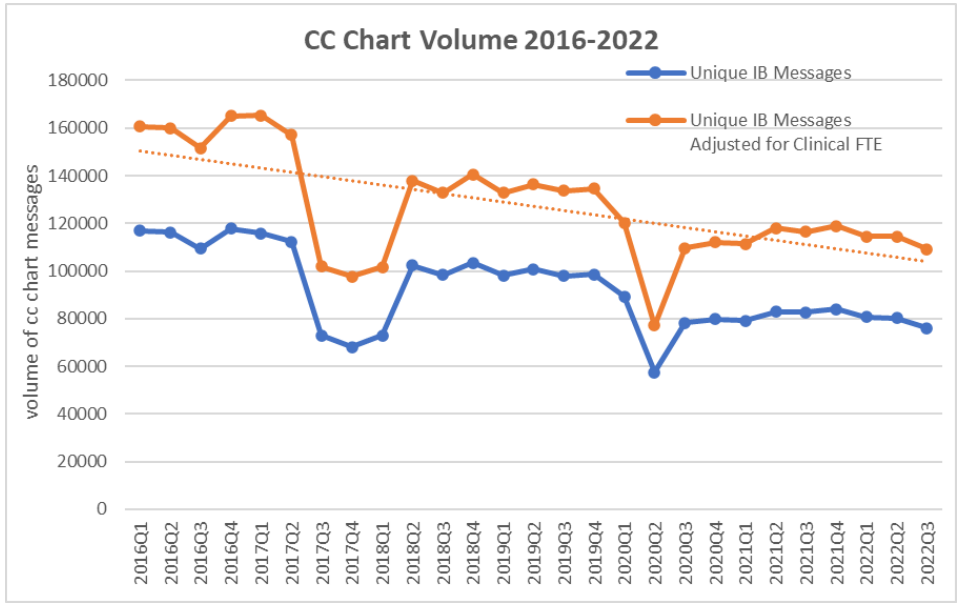
- Media Manager = scanned documents from multiple sources ranging from administrative to clinical; 5% of in-basket volume (2017)

✓ Approach: governance committee evaluated the contents with leadership of our medical records and **set new guidelines** on use of message type

  - **Revised folder assignments**: BH discharge summaries
  - **Eliminated routing schemes**: specialty labs

  ✓ **98% reduction**

Elimination Tactics: CC Chart



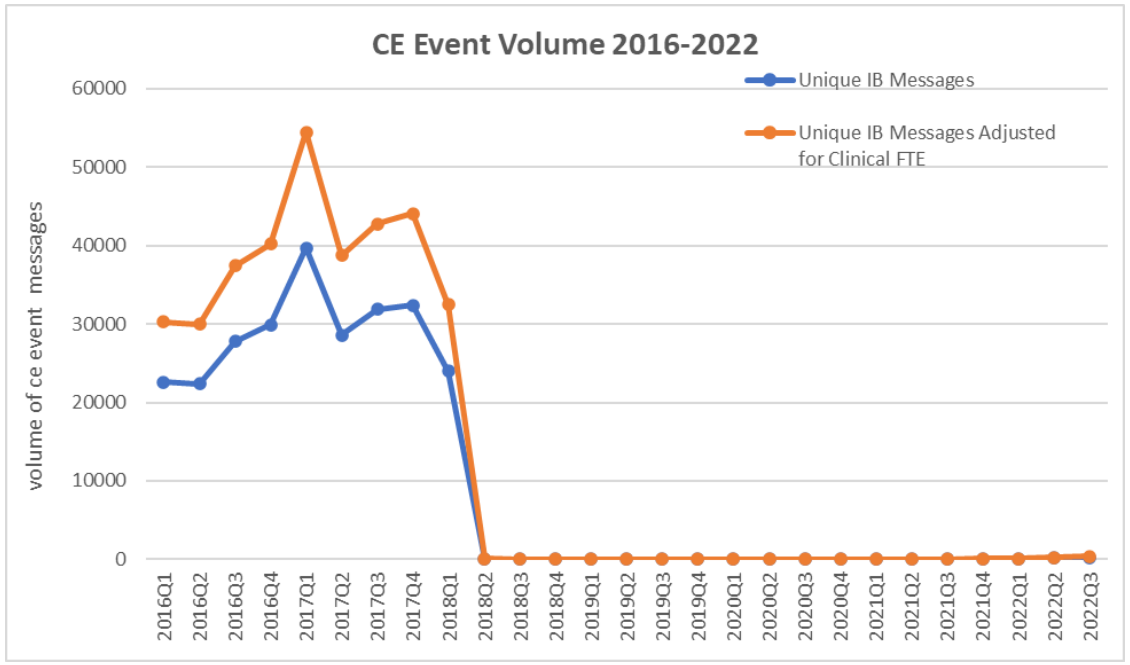
- **CC Chart** = consult notes from specialists, urgent care, and cross coverage; 16% of in-basket volume (2017)
- **Variable clinical value** – "no change" or "normal evaluation"
- **Routing guidelines** were individualized by site and specialty – **high variation** and based on historical preferences
- Common default was "route to PCP" in Epic and in our practice norms

✓ **Approach to reduce CC Chart volume**

- Ended automatic routing for all
- Implemented intentional routing – specialist must choose to route within practice agreement rules
- Purged CC chart > 60 days

✓ **40% reduction**

Elimination Tactics: ED/Hospital Notification



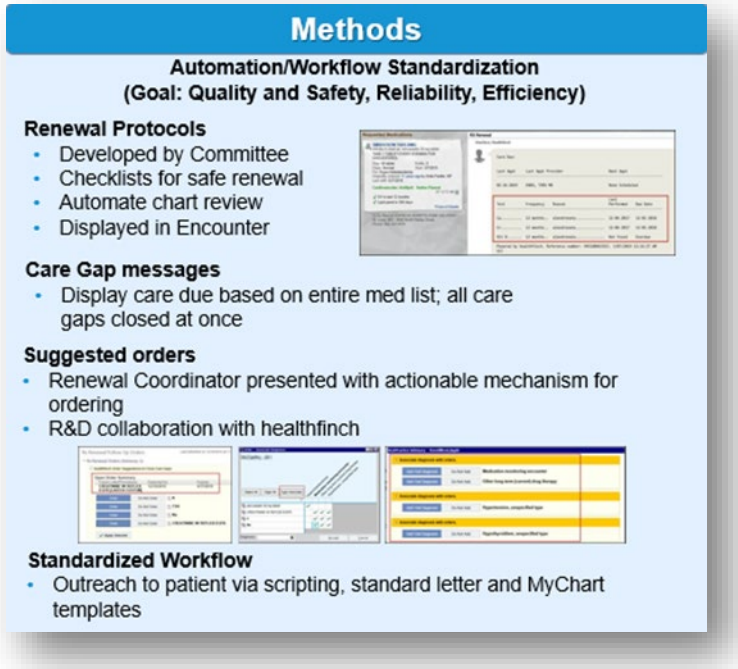
- CE Event = automated notifications via ADT feeds (admission discharge transfer); 3% of in-basket volume (2017)
- **Significant duplication** for each admission/discharge from automation of feeds to EHR (six notifications per admission) and incomplete messages

✓ Approach was to remove all in-basket notifications and **consolidate in a dashboard**

- "Push" converting to "pull"
- Dashboard contains relevant information for efficacy, such as post-DC call, post-DC visit date, discharge summary, etc.

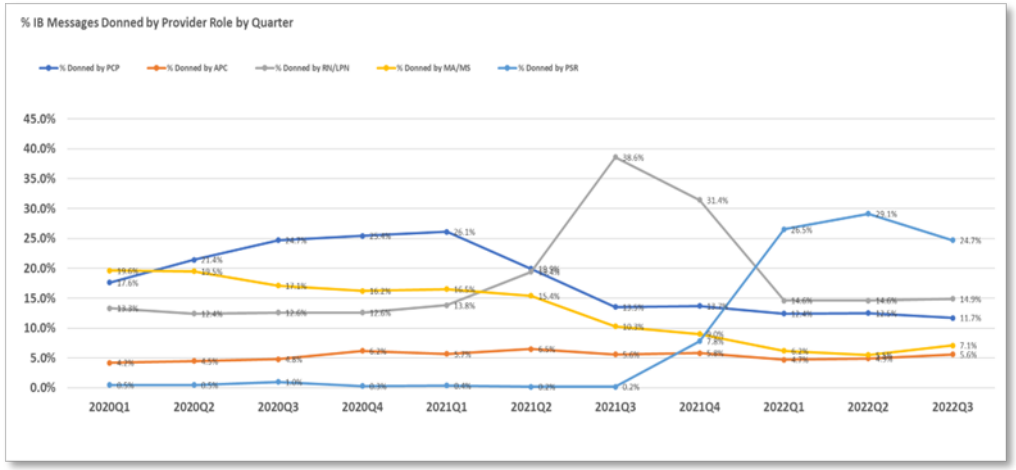
✓ **100% reduction**

Automation Tactics: Rx Renewals & Normal Labs



- Reduced 50% of the Rx renewals requests from PCP in-baskets with a protocol to check for care gaps in the EHR
- Reduced 30% of lab results in PCP in-baskets by sending “normal” lab directly to the patient
- Both automation projects shared a multidisciplinary clinical governance and workgroup to design the policy and protocols
- Piloted and shared results

Delegation: Patient Medical Advice Requests

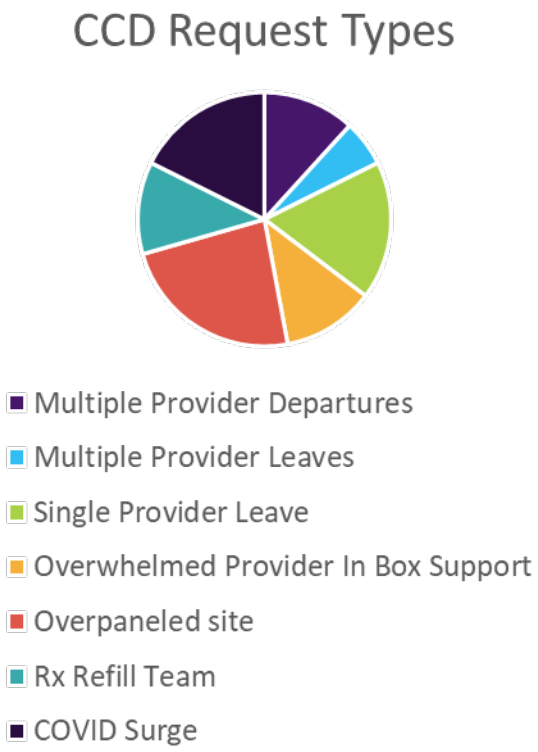


Atrius Health data set 2020-2022

- **PMAR team management**
  - Embed delegation into routing structure of EHR
  - Care team receives patient portal messages and triages “up”
  - Patient Service Rep (PSR) first touch - resolves or routes to nursing or physicians
  - Required staffing adjustment to match volume
  - Measurement of teamwork shows change in completion of PMAR messages

✓ **40% reduction** of messages for PCP in early adopter sites

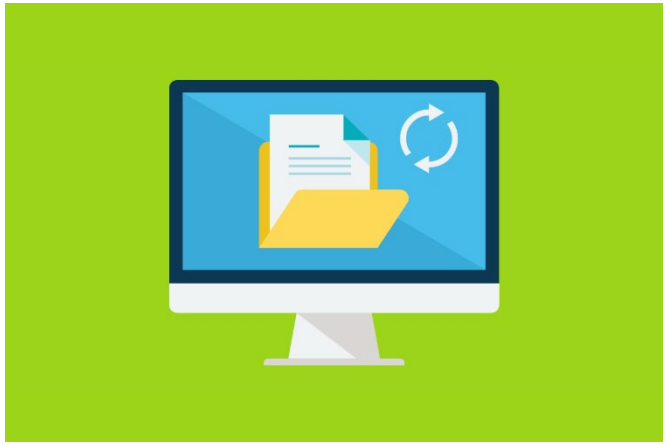
Collaboration Tactics: Coverage Systems and In-Basket Sharing



- **Clinical Coverage Department CCD - 2021**
  - MD and APC with primary care experience who provide a combination of in-person visits, virtual visits, and in-basket coverage
  - In-basket coverage for extended provider leaves, departures, and intermittent coverage for struggling providers (falling behind in charting or expressing burnout symptoms)
- **PCP + APC Partnering - 3-year initiative -2020-2023**
  - Share all aspects of panel management – acute, chronic, preventative
  - Vision is to share in-basket - avoid “covering my in-basket” and promote “sharing our in-basket”
  - Obstacles – culture and expectations, Epic limitations

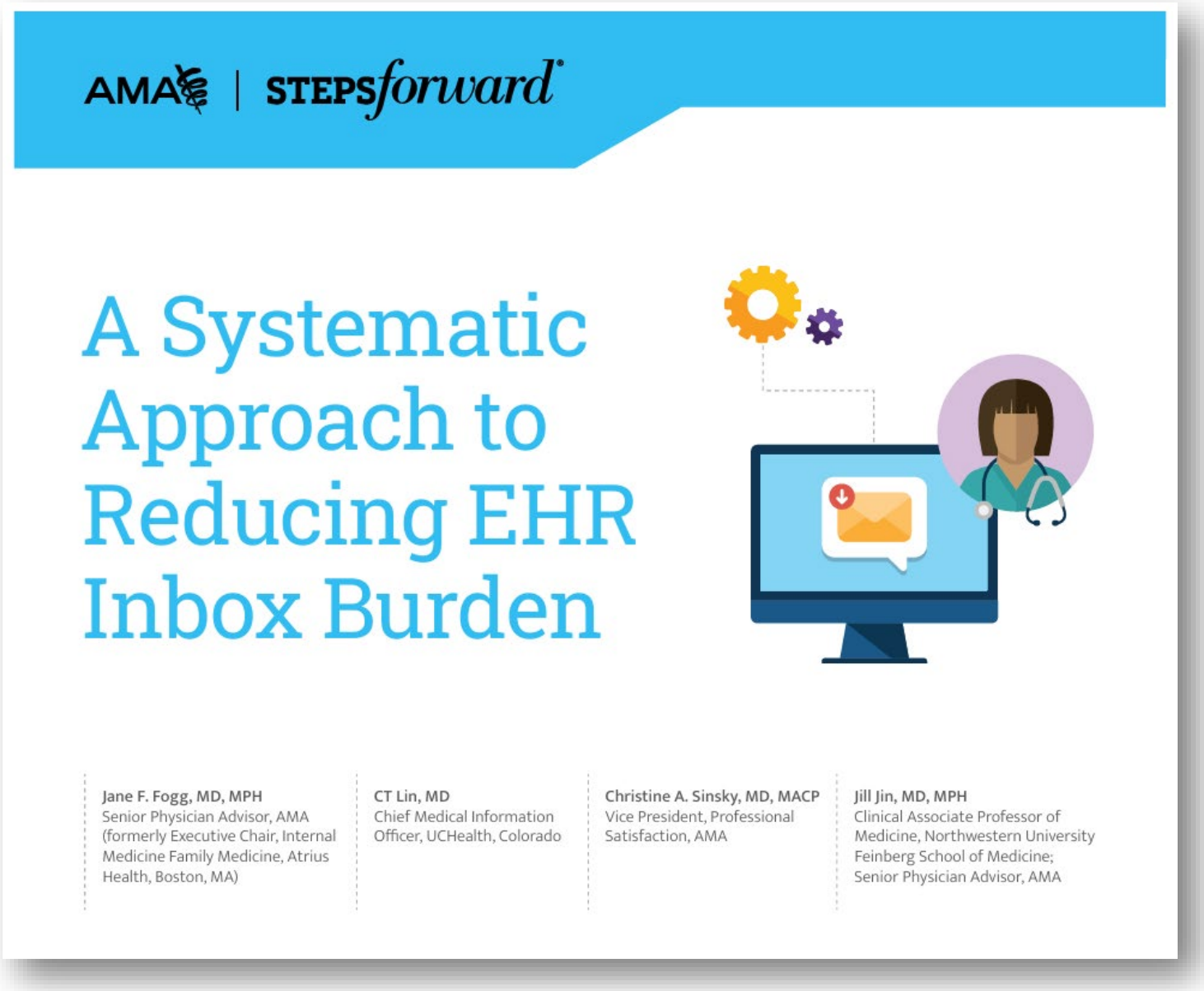
Clinical Leadership & EHR Optimization

Elimination Automation	• Will removal of this message type impact clinical outcomes, quality and safety, and professional needs?
Delegation	• What are our team-based office workflows today and how do we mirror them in the EHR-based workflows?
Collaboration	• How do we design programs and manage teams that share in-basket work and systematically provide coverage for PTO?



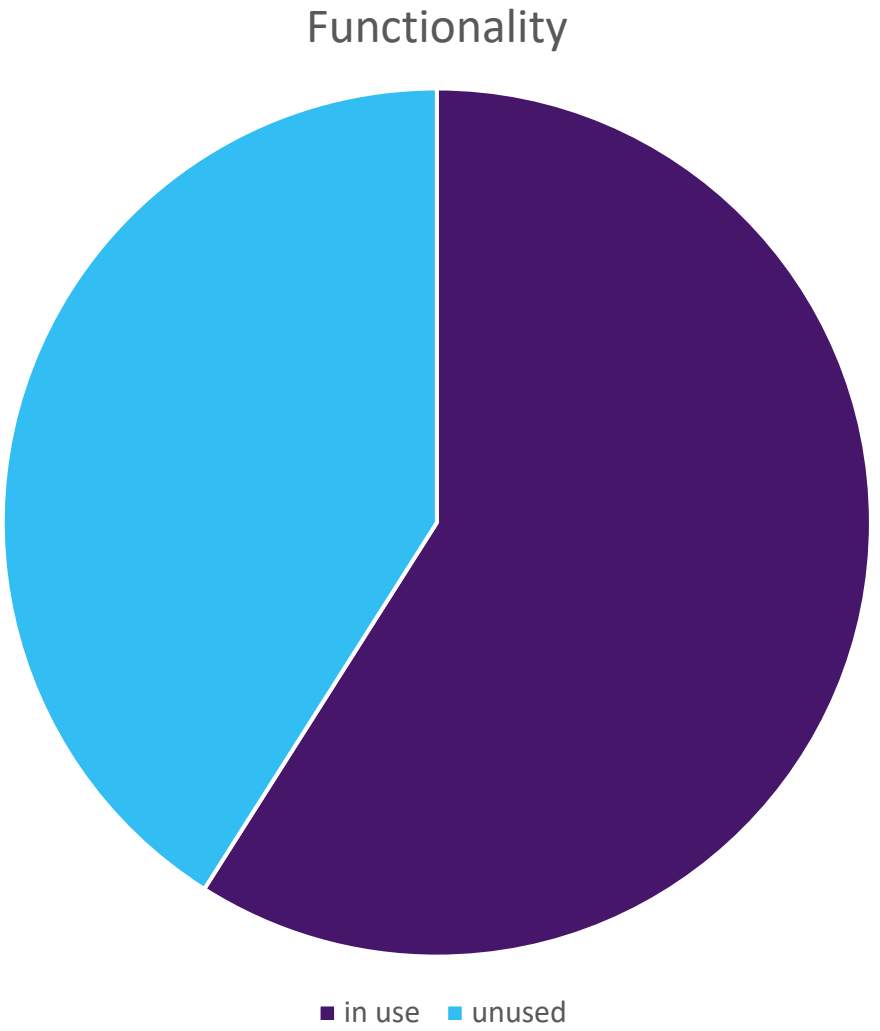
https://edhub.ama-assn.org/steps-forward/module/2821565

This AMA STEPS Forward® toolkit will help you develop and execute tactics to reduce the work burden of the EHR inbox. Providing eight STEPS to optimize the EHR inbox, the toolkit explains how to mitigate low-value and unnecessary work, reducing message volume and, ultimately, physician burnout. This approach increases efficiency through team-based care, applying an effective strategic framework to inbox work: “Eliminate, Automate, Delegate, Collaborate.”



Invest In What You Already Own

- Use your EHR purchase to the fullest extent possible
- Average for Epic organizations is just under 60%



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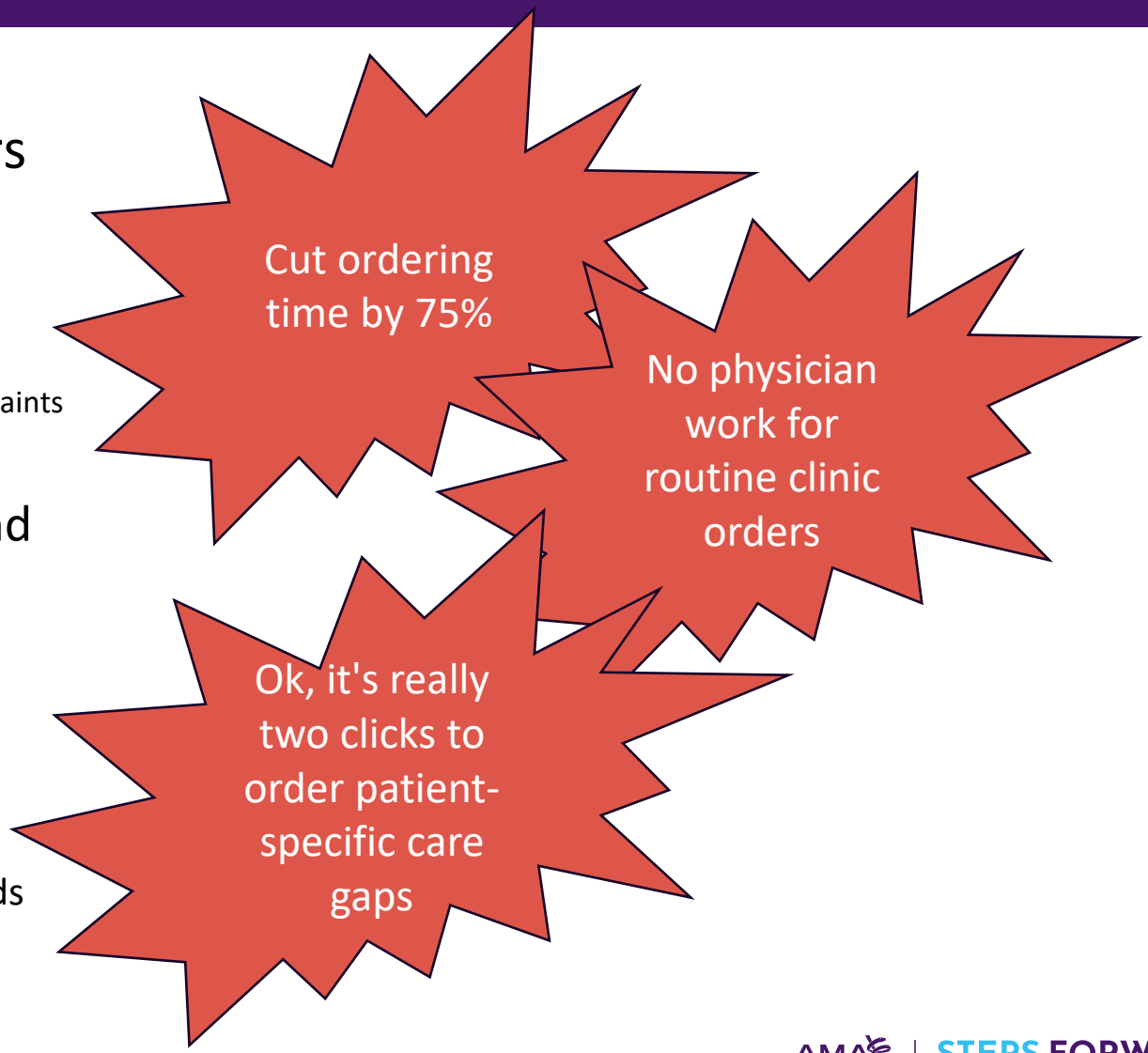
Orders Can Be Easier

- Examples of new functionality for orders
  - Order panels
    - Group frequently ordered tests
      - HbA1C, BPM, Cholesterol Panel, TSH
    - Group diagnostic work-up for less common or vague complaints
      - Work-up for anemia, dizziness, fatigue
  - No cosign needed with standing order and procedure document
    - Vaccines, POC tests, health maintenance
  - One-click ordering for care gaps
    - Defaulted dx code and lab facility
    - Order set defaulted per patient's individual needs



Referrals Can Be Appropriate and Faster

- Most medical specialists estimate around 30% of their new patients don't need a specialist
  - The PCP needs support
  - PCPs and specialists are siloed in their ambulatory practices
  - Clinical conversations and decisions need to be documented
- Across the board, patients are waiting 3-6 months to see a specialist
  - Specialty practices require a bundled patient summary before scheduling
  - More work for PCPs to gather and send this info
  - More work for specialists to review and prioritize

eConsults to the Rescue

- Free up the specialist schedule by using eConsults
  - Availability for the patients who need the specialist
    - Be seen within 14 days rather than 6 months
    - Specialists gain patients who are not “one and done”
  - Quick support for the PCP to continue to manage the condition
  - Quick determination if patient needs specialist & tests completed before specialist visit for greater efficiency
  - Both PCP and specialist can bill for this work
- Asynchronous physician-to-physician consult
  - eConsult with question is ordered
  - Specialist reviews and answers via in-basket within
  - Specialist can initiate an in-person visit if needed

The Problem List Can Be Less of a Problem

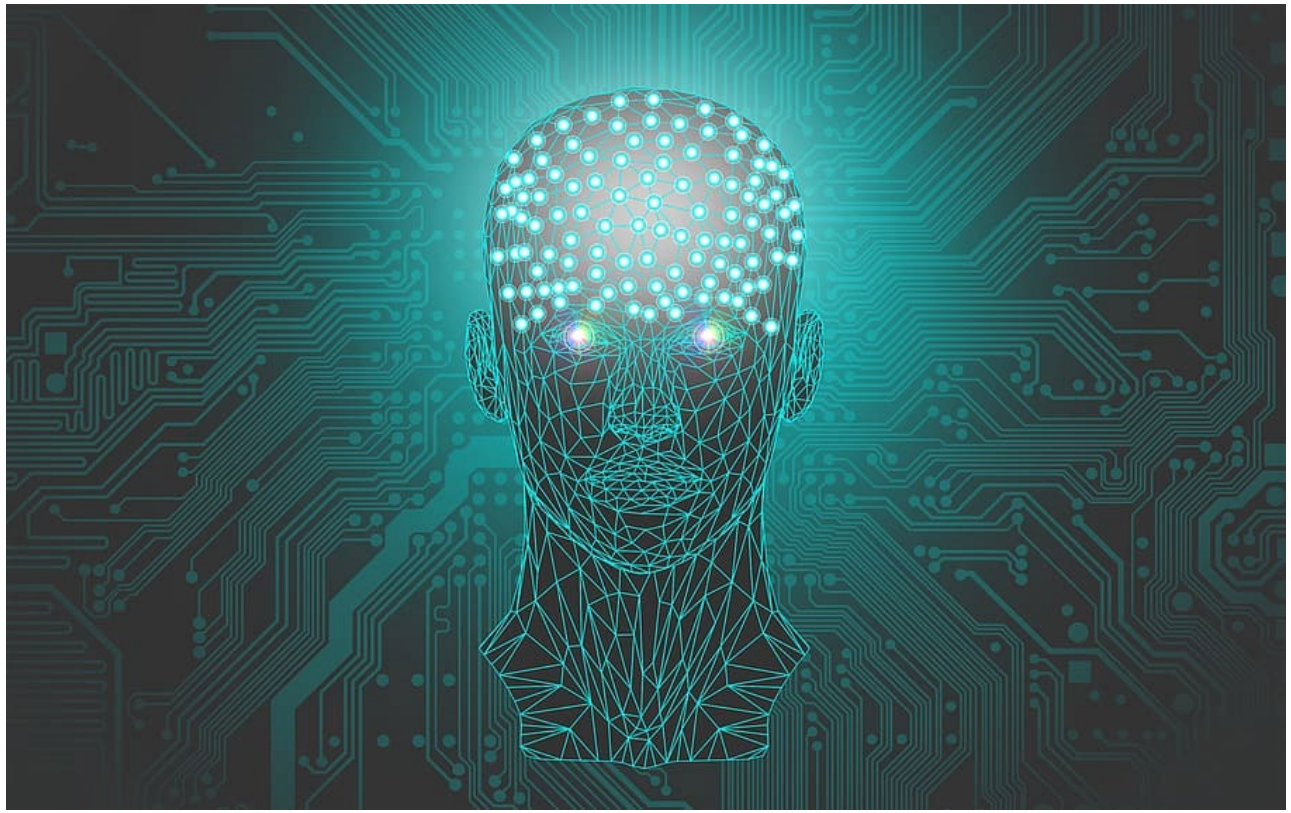
- Reality
  - Busy clinicians will never keep a clean problem list
  - The problem list is a handy place to store info that belongs somewhere else in the chart
  - Everyone's problem is no one's problem
  - My problem is better than your problem
- Understand the most common causes of “bad” problems in the problem list
  - Discharge from hospitalization with multiple symptoms and test findings
  - Screening tests
  - PMH and FMH
  - Near-duplicates

The Problem List Can Be Less of a Problem

- Automate clean-up of the problem list
  - Monthly utilities to resolve acute and time-limited problems
  - Manual run of clean-up algorithm
  - Utility run at time of discharge from HSO
- Required data entry to ensure most granular and specific ICD-10
  - Laterality
  - Acute vs chronic
- Routine Find-and-Replace Queries
  - Patient has DM type 2, controlled (E11.9)
  - Patient has CKD stage 3 (N18.3)
  - Replace E11.9 ($1726.79) with E11.22 ($3047.89)

Hands-Off Keyboards

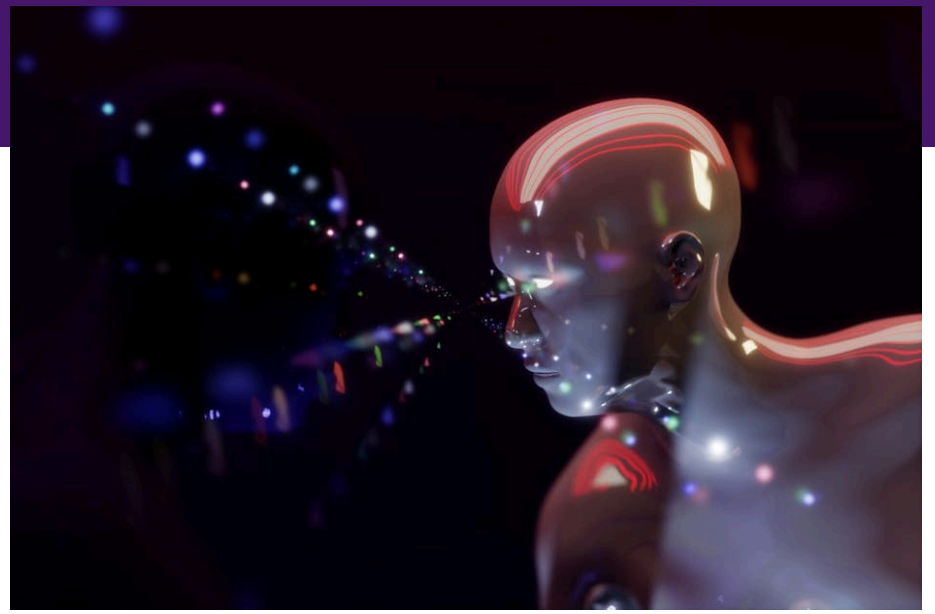
- Augmented Intelligence-Ambient Listening
  - Today
    - Draft the note
    - Pend medication orders
    - Pull visit dx into note
    - Draft patient instructions



Hands-Off Keyboards

- Augmented Intelligence-Ambient Listening
  - This year
    - Draft the note
    - Pull visit dx into note
    - Draft patient instructions
    - Pend all orders
    - Pull problem list diagnosis into note
    - Add diagnosis to Problem List
    - Flowsheet completion

Hands-Off Keyboards



- Augmented Intelligence-Ambient Listening
  - Next year
    - Draft the note
    - Pull visit dx into note or push to Visit Dx List
    - Draft patient instructions
    - Pend all orders
    - Pull problem list diagnosis into note or push chronic problem to problem list
    - Flowsheet completion
    - Suggest LOS
    - Real-time info on prior authorization criteria
    - MEAT criteria for coding support
    - Refresh and suspected condition support for HCC coding

In-Basket

- Quickest wins I've seen
  - Auto-expire message types
    - 120 days
  - Purge old messages
    - Go-live in 2017 to today
    - Started 120 days after auto-expire commenced
  - Removed 13 million messages
    - 13,482, 350
  - Decreased time in IB by 2 minutes per day
    - Saved 9 hours per year per provider

“No individual can win a game by himself.”
– Pelé

Effective IT Governance for Technology Optimization

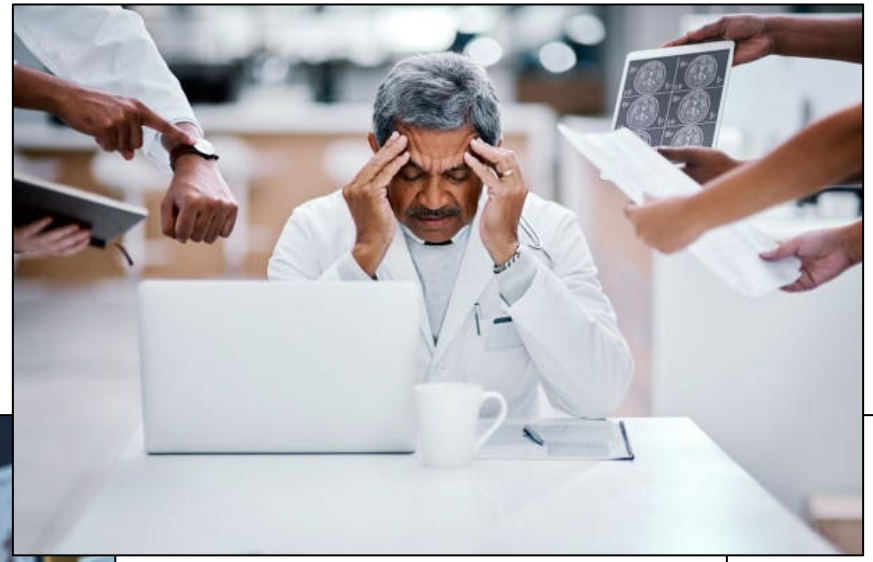
Michele Thomas, MD, FAAFP

Senior Physician Advisor
Digital Health Innovation
American Medical Association

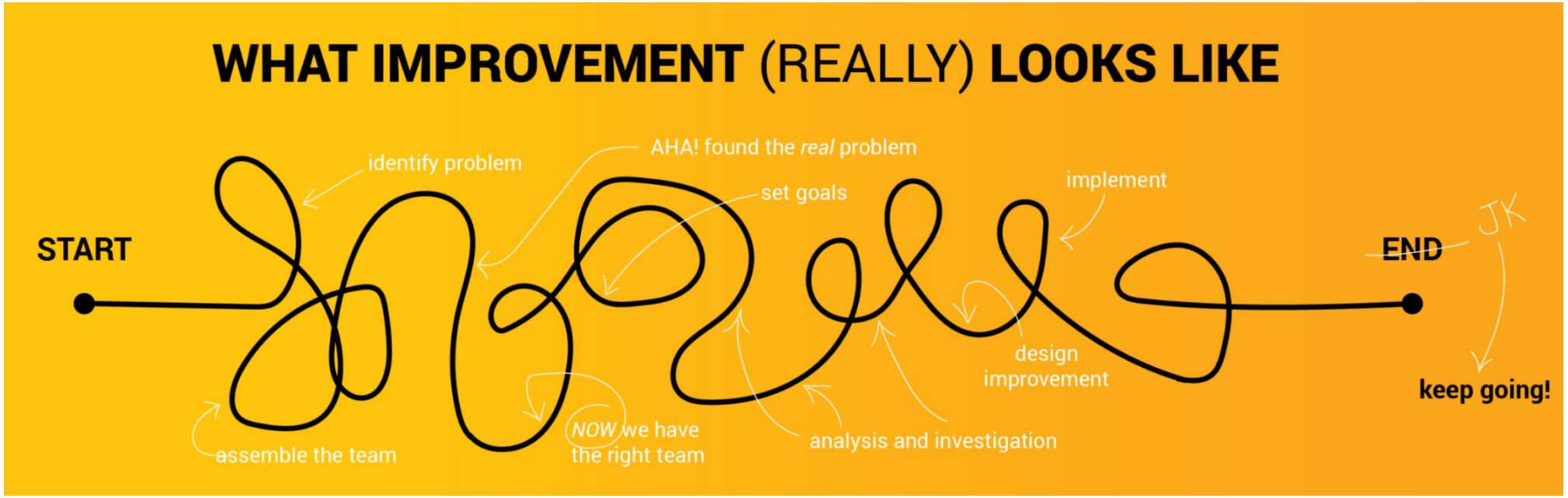
Agenda

- Introduction
- What is Clinical Informatics?
- Clinical Technology Governance
- High Impact Work

Have You Ever Been Frustrated by Technology?



What Improvement Is Supposed To Look Like

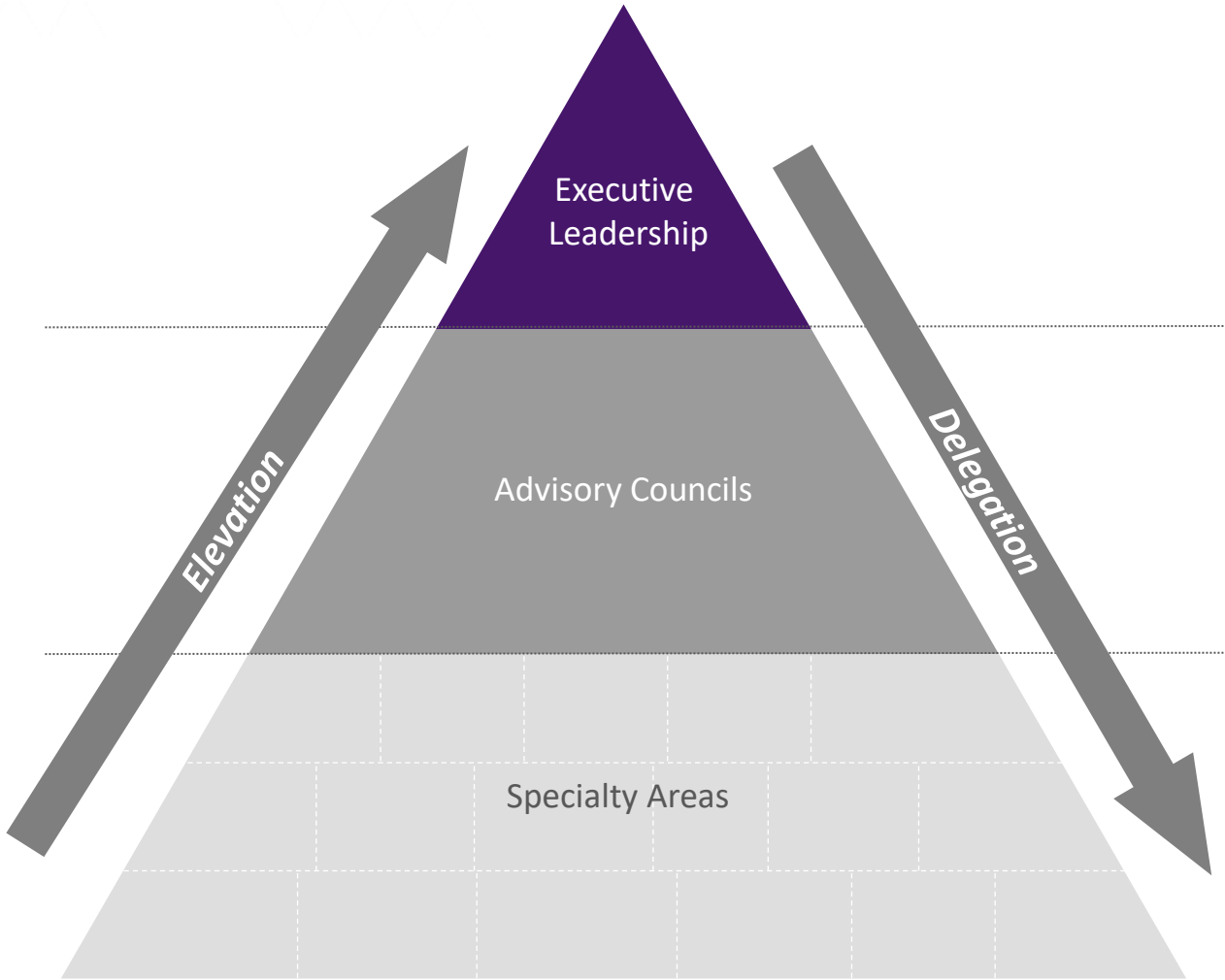


What is Clinical Informatics?

Why Is Governance Important?

- Establishes structure for oversight, decision making, leadership
- Defines decision making processes
- Delineates accountability/responsibility
- Promotes change management

Overall Governance Model Example



Strategic

- Define the strategic direction and vision to align with priorities set by executive team
- Serve as final decision-making body for issues not resolved at subgroup or champion levels
- Address issues / risks of enterprise-wide concern

Advisory

- Understand and provide guidance on all upcoming clinical technology changes
- Champion and communicate changes to colleagues
- Update leadership on critical technology enhancements and elevate topics with significant enterprise-wide impact

Clinical Ops

- Monitor execution of updates
- Manage milestone delivery to ensure timely, effective, and efficient rollout of clinical technology solutions
- Elevate topics requiring guidance and support to Leadership

Attributes of Governance

Transparency

Organization understands decision making processes

Builds consensus

Promotes IT/operational collaboration

Prioritization

Facilitates alignment between IT and operations

Establishes accountability

Governance Guiding Principles

The Path Forward

Charter all levels of governance

Intake Process

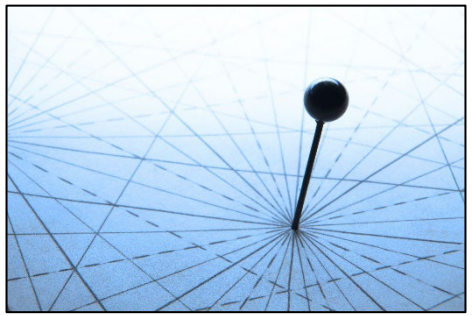
Engaged Team Members

Transparency and Accountability

Decisions

Will this project solve the problem?

Is the timing right?



Is the current state understood?

How will you measure outcomes?

Clinical and Operational Leadership & EHR Optimization

What is our role as clinical and operational leaders in optimizing the EHR?

- ✓ ***Define what we are trying to solve for***
- ✓ ***Identify the impact on quality, safety, patient experience, outcomes***
- ✓ ***Explore impact on clinician workflow and feasibility for team***
- ✓ ***Determine the clinical protocols, policies, and workflows***
- ✓ ***Engage our stakeholders and partners***

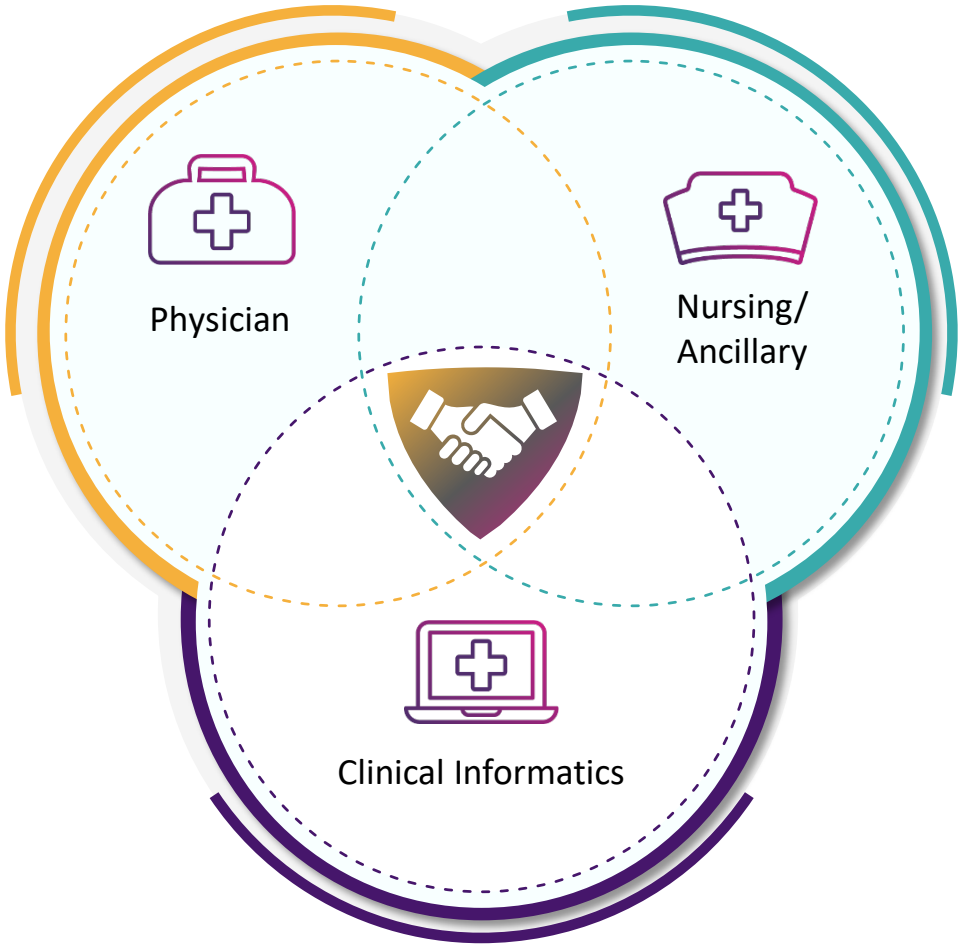
Understanding Clinical Technology

- Definitions of the scope of technology in ambulatory practice
- EHR vendor design
- The value of clinical informatics
- Clinical technology governance is a partnership with IT and operational leadership

Examine Current State

“Place a ticket for that”	Black hole Find a buddy method
No coordination within clinical areas	
Analysts performing initial review of request	Phone tag
No clear prioritization	Reactive approach
No transparency	

Asking the Right Questions



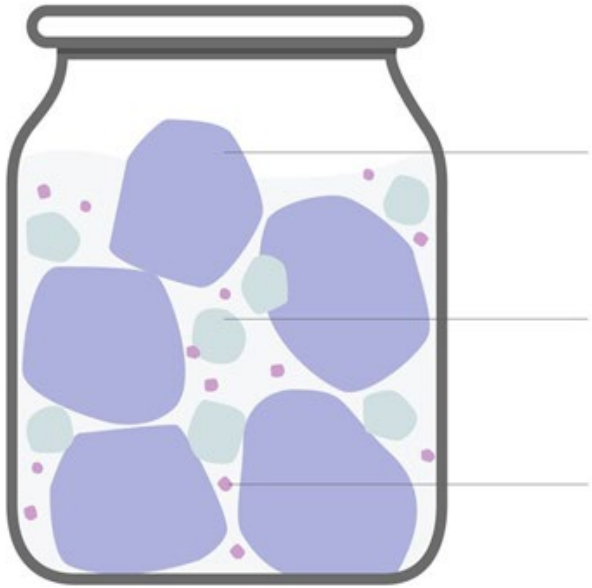
Questions

- What is the problem that we are trying to solve?
- Who are the stakeholders?
- What is the desired future state clinical workflow?

Considerations

- Prioritization
- Cost
- Implementation/Training/Adoption

How Is Work Prioritized?



Rocks

Projects with high effort and impact

Pebbles

Projects with medium effort and impact

Sand

Minor improvements and enhancements

CATEGORY	IMPACT SCORE	DESCRIPTION	WEIGHT
Quality of Care	4 = Very High Impact	High risk to quality of care issue with no/unacceptable workaround	8
	3 = High Impact	High risk to quality of care issue with acceptable workaround	
	2 = Medium Impact	Low risk to quality of care issue with no/unacceptable workaround	
	1 = Low Impact	Low risk to quality of care issue with acceptable workaround	
	0 = No Impact	No quality of care impact	
Patient Experience	4 = Very High Impact	High patient experience issue with no/unacceptable workaround	4
	3 = High Impact	High patient experience issue with acceptable workaround	
	2 = Medium Impact	Low patient experience issue with no/unacceptable workaround	
	1 = Low Impact	Low patient experience issue with acceptable workaround	
	0 = No Impact	No patient experience impact	
Compliance/Regulatory	4 = Very High Impact	Immediate Jeopardy	4
	3 = High Impact	Clear CMS/Joint Commission/Regulatory mandate	
	2 = Medium Impact	Organization Standard of Care	
	1 = Low Impact	Organization Policy or Local Policy	
	0 = No Impact	No compliance impact	
Productivity/employee experience	4 = Very High Impact	High employee experience/high productivity benefits	6
	3 = High Impact	Low employee experience/high productivity benefits	
	2 = Medium Impact	High employee experience/low productivity benefits	
	1 = Low Impact	Low employee experience/low productivity benefits	
	0 = No Impact	No employee experience/productivity benefits	
Revenue Impact / ROI	4 = Very High Impact	More than $100k per month if integration isn't in place	4
	3 = High Impact	Between $50k and $100K per month if integration isn't in place	
	2 = Medium Impact	Between $25k and $50k per month if integration isn't in place	
	1 = Low Impact	Between $10k than $25k per month if integration isn't in place	
	0 = No Impact	Less than $10K per month	
Replacement/EOL	4 = Very High Impact	Past EOL	6
	3 = High Impact	EOL w/i 6 months	
	2 = Medium Impact	EOL w/i 12 months	
	1 = Low Impact	EOL w/i 24 months	
	0 = No Impact	EOL > 24 months	
Organizational Impact	4 = Very High Impact	System-Wide	5
	3 = High Impact	All departments in multiple areas (ie, ED and Inpt but not Amb)	
	2 = Medium Impact	All departments in one area (ie, all of Ambulatory)	
	1 = Low Impact	All departments in multiple specialties in one area	
	0 = No Impact	all departments in one specialty in one area	
% of Patients Affected in applicable departments	4 = Very High Impact	All patients in applicable departments	5
	3 = High Impact	Most of the patients in applicable departments	
	2 = Medium Impact	Half of the patients in applicable departments	
	1 = Low Impact	Less than half of the patients in applicable departments	
	0 = No Impact	Very few of the patients in applicable departments	
Strategic Alignment	4 = Very High Impact	Strategic Imperative	8
	3 = High Impact	Strategic alignment	
	2 = Medium Impact	Partial strategic alignment	
	1 = Low Impact	Minimal strategic alignment	
	0 = No Impact	No clear strategic alignment	
Work Effort Required	4 = Little or no effort	Less than 4 hours	5
	3 = Low effort	4 - 12 hours	
	2 = Moderate effort	12 - 24 hours	

Low

- Non-Urgent Enhancements

Medium

- Next Sprint

High

- Bypass sprint process

Organizational Guiding Principles Example

- Design patient-centric processes focusing on quality, safety, and patient outcomes
- Single enterprise solution with necessary variation only
- Decisions shall be based on doing what is best for the patients
- Decision-making and validation will be driven by frontline clinicians and providers
- Provide timely and complete communication, training, and tools to ensure successful adoption of technology
- Enable technologies that allow full patient engagement in their health care plan

Lessons Learned

- Every organization is unique – understand your culture/structure
- Partnership between IT, clinical operations and clinical informatics is key!
- If you build it, they will not come
- Learn to say no to low impact requests
- Sometimes you need to move slow to go fast
- Tailor your message to the audience (WIFM)
- This is an iterative process, be flexible and adjust as needed
- It’s a journey…

Break

2:15 – 2:30 p.m.

Scan the QR code to access the resources hub!

Practice Transformation Strategy

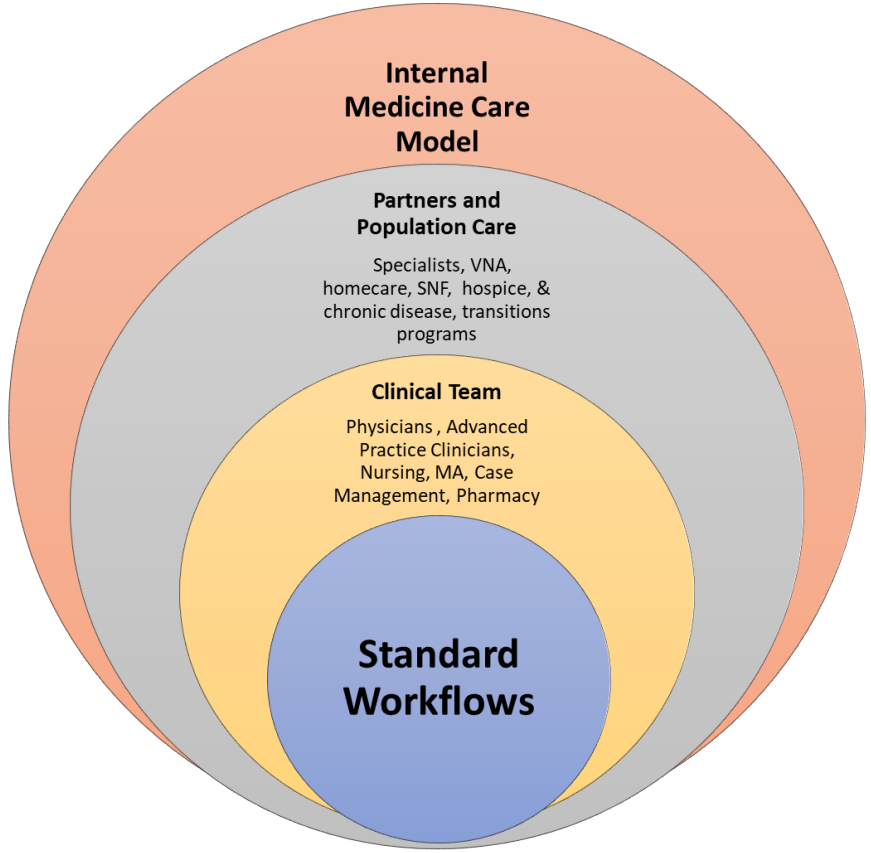
Lessons I have learned about leadership, dyads, processes and more

Jane F Fogg, MD, MPH

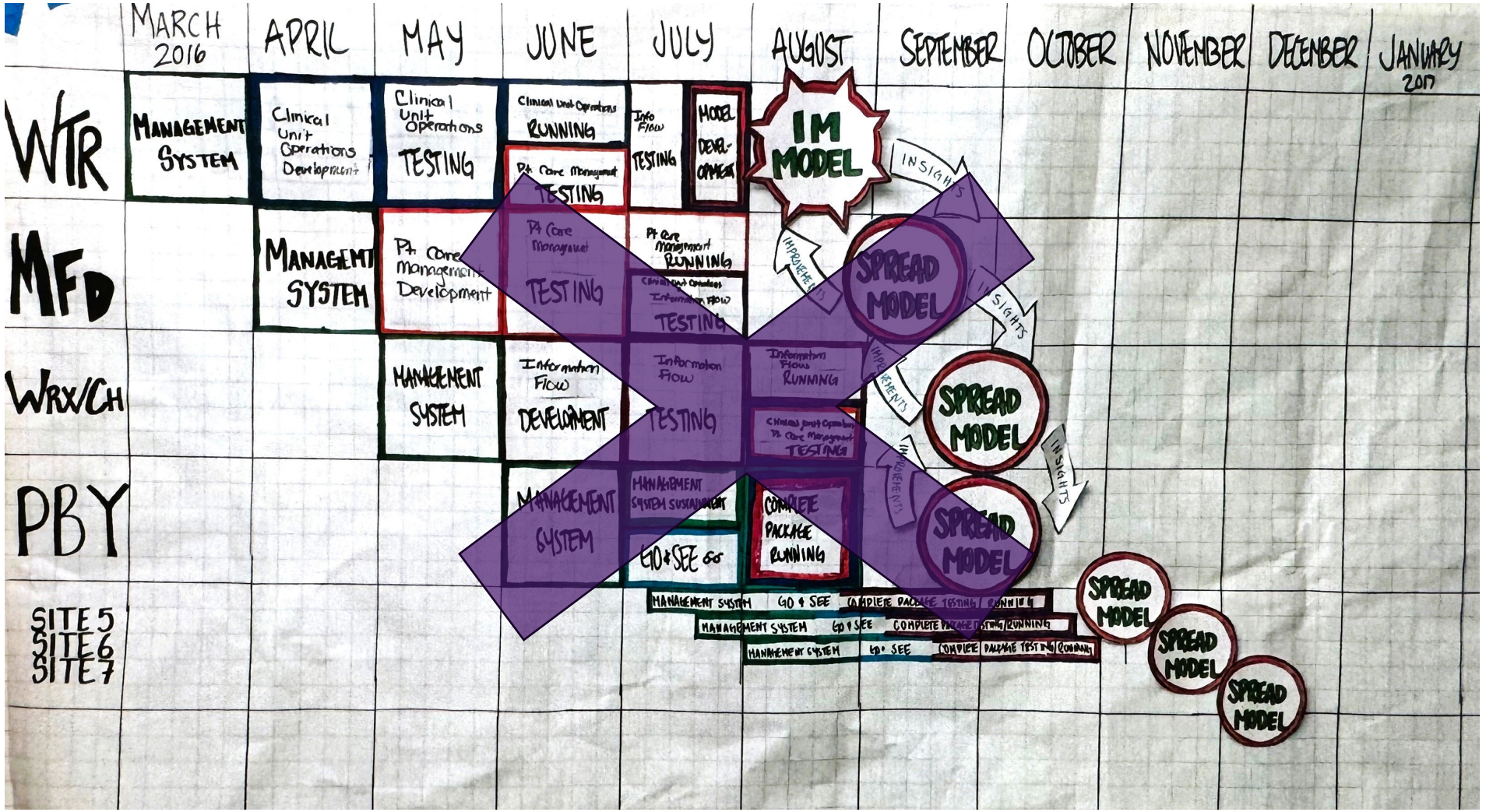
Why do practice transformation efforts fail?

Case Example: Spreading Care Models Across Systems

- A story of failure (and eventual success)
  - 21 site, primary care practice, 300+ MD/APP
  - Goal was to have a unified “care model” creating a seamless experience for patients and leveraging best practices for MDs and APPs, delivering reduction in burnout, turnover, and improving care delivery
  - Defined the scope
  - Chose 3 sites to design the workflows that would create the “model cell” – a perfect practice that we could then replicate



Spreading Care Models Across Systems: Build the Perfect Practice and Then Spread It….

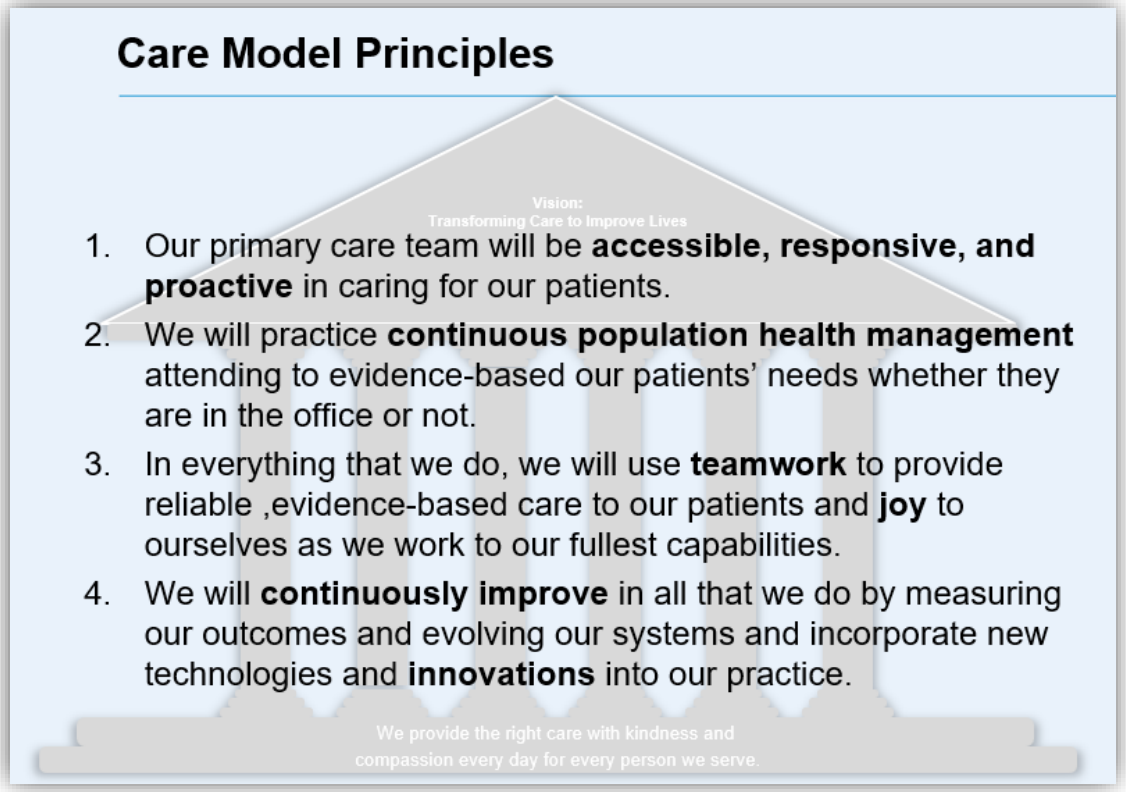


Case Example: Why Did Our Spread Model Fail?

- We tried to spread a “model cell” of standard work across practice sites with variations in staffing, office layout, and culture - our best practice workflows and team roles were too rigid
- Meaning and purpose were not well defined or communicated
- Perceived favoritism reduced trust and engagement
- Our project was understaffed

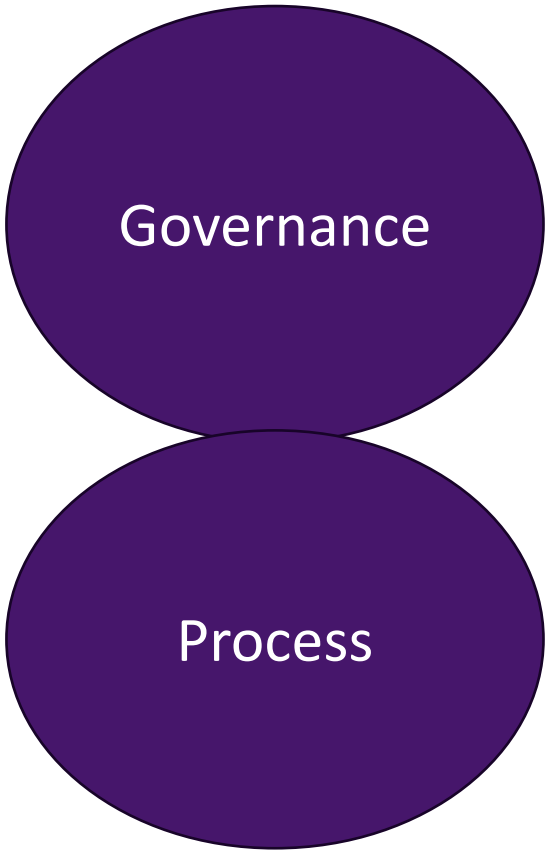
Case Example: What Led Us to Success?

- Defined the vision and spread the burning platform
- We pivoted from “standard work” to “critical success factors”
  - A steppingstone to standard work that conveys intention and purpose
  - Key metrics attached to CSF
- Included the people doing the work and every site worked simultaneously
- Shared outcomes and stories



How can we be successful in spreading practice transformation?

Elements of Successful Transformation



- How we structure leadership and management roles
- How we make decisions
- How we include and engage clinicians and teams in creating change
- How we prioritize
- How we do process improvement and spread transformation

Governance Considerations

- Dyad/triad leadership (and partnership)
- Explicit decision-making criteria and transparency
- Local project improvements co-exist with larger systemic improvements
- Design the work with the people who do the work

Process Considerations

- Prioritize and share your reasoning
- Embed process improvement in everyday operations
- Have a PI model – PDSA, Lean, IHI-QI, etc
- Measure progress and share - metrics and transparency!
- Close the loop!

- Sustaining your work – build auditing processes into new processes

Engage your peers and clinical teams before you try to transform their practice.

How Do These Principles Work in Real Life?

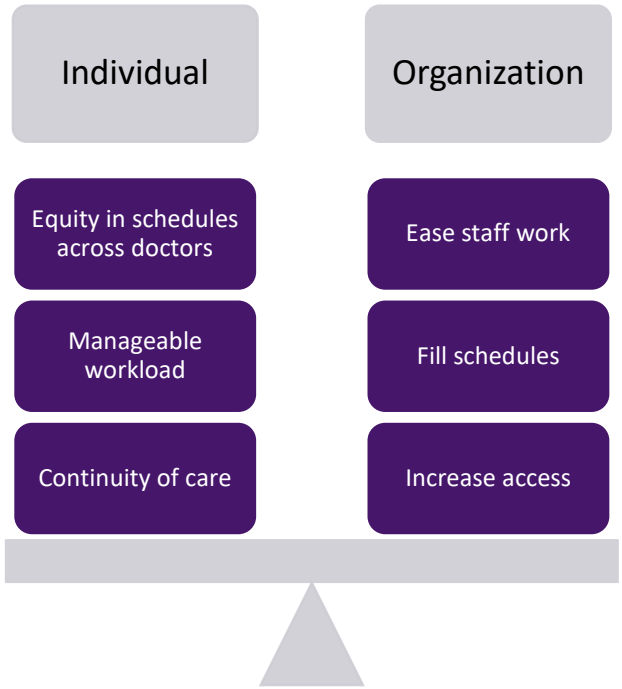
We want to make the prescription renewal process less cumbersome for doctors and their teams.....what can we do?

- Automation, delegation, and 90/4
- Regulation and Rules - resolving conflict
- Implementing a standard – clinical governance

How Do These Principles Work in Real Life?

We want to improve scheduling of patients in the office to ensure continuity, manageable workflow, and improve access....how do we start??

- What are we solving for?
- Stakeholders and balancing their needs
- Define current state (to learn) and future state (to propel)
- Partner across technical and clinical expertise
- Process improvement & pilots



Lastly…. Practice Transformation Pearls

- Dyad leadership is powerful
- Transformation is a continuous process that that should be embedded in clinical operations.
- Data driven transformation - know your expected outcomes, metrics, and share transparently with all involved.
- People doing the work should help design the work

I Hear You

Alekzander Sayers

Program Administrator, PS2

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Time To Play!

Pair off, look for someone new to you

Enjoy our demonstration

60 Seconds To Rant

- Ranter, be as angry as you want!
- Listener, pay attention to what they have to say
- After 60 seconds, go around your table and introduce the ranter
  - However, your job is to walk a mile in their shoes and explain all the good qualities/beliefs they just shared with you

What Would You Like To Rant About?

- Homework
- Deadlines
- Software updates
- Traffic
- Littering
- Cafeteria food
- Printers
- Someone’s cooking
- Summer heat
- Winter freeze
- Potholes
- Weddings
- Plagiarism
- Writer’s block
- Small talk
- Nosey neighbors
- Travel
- Spam
- Public etiquette
- Roommates
- In-laws
- Chores
- Restaurants
- Overrated films
- Reality TV
- HOAs
- Neighbors

Why Do This?

- Communication is a two-way street
- Worth asking, is any anger/negativity coming from a good place?
- Know what drives the person you're with to find common ground

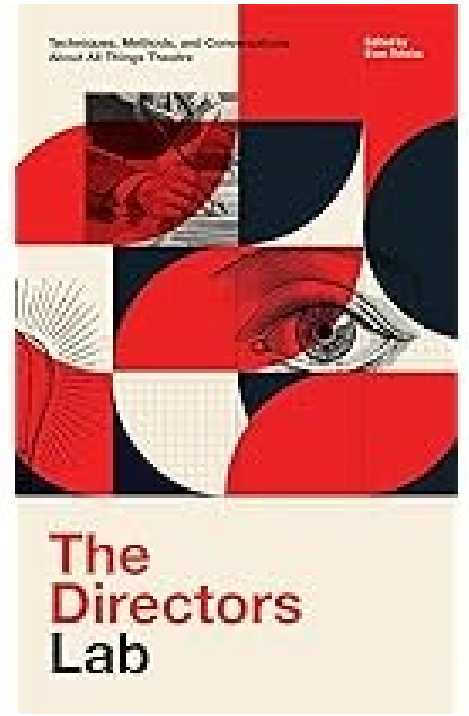
What Would You Like To Rant About?

Choose something from your profession and do the same exercise.

Watch Out Tomorrow!

Some presentations tomorrow may feature more of this.

Be ready to find the positive qualities in the scenarios given.



Heightened language and the art of listening, Chapter by Jeanette Lambermont-Morey in *The Directors Lab*

Roundtable Dialogues

3:15 – 4:00 p.m.

Scan the QR code to access the resources hub!

Getting Rid of Waste (GROW) Sorting Exercise

Marie T. Brown, MD, MACP

Director, Practice Redesign, American Medical Association

Professor Emeritus, Rush University

Getting Rid of Stupid Stuff

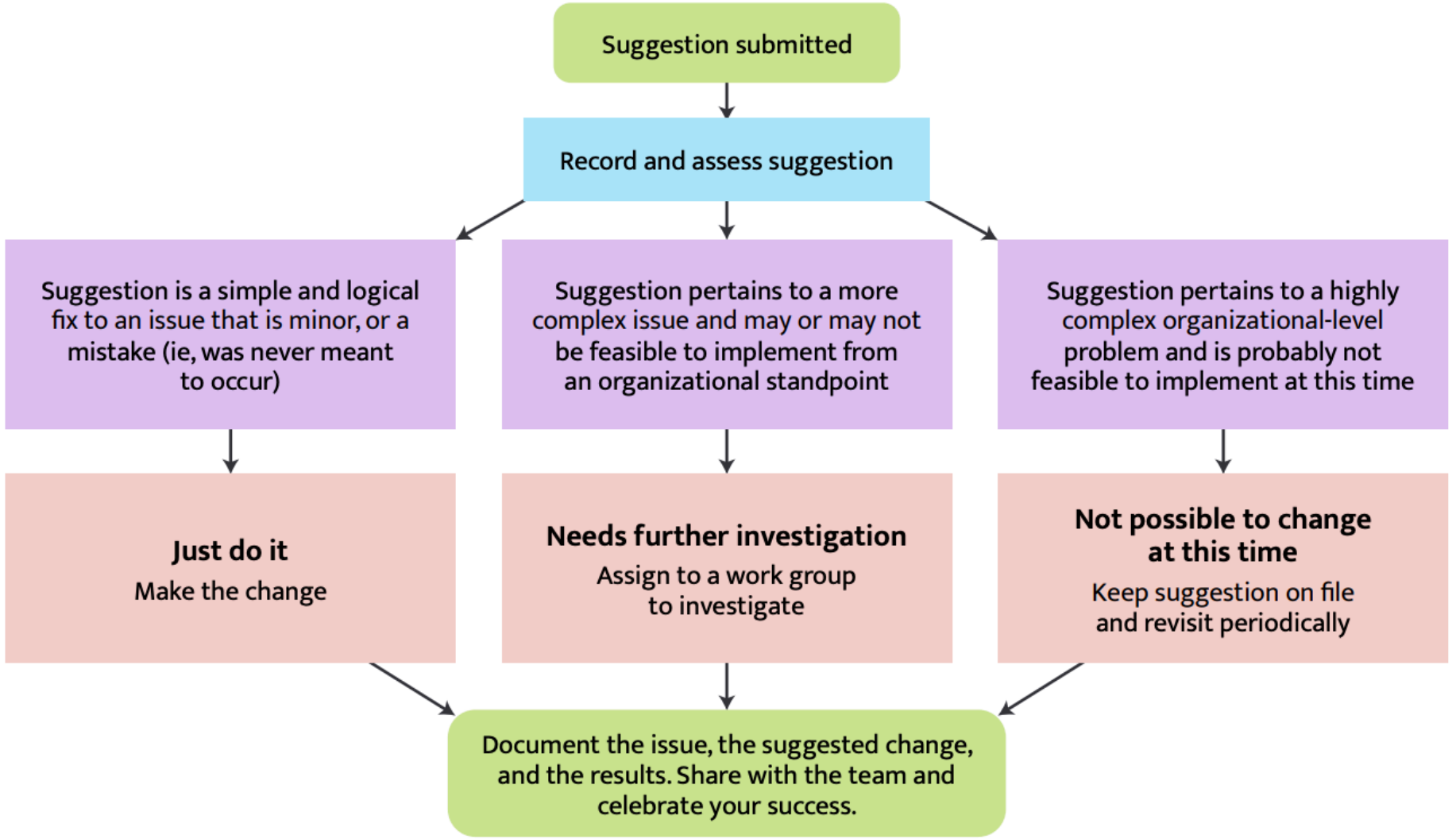
Reduce the Unnecessary Daily Burdens for Clinicians

Melinda Ashton, MD

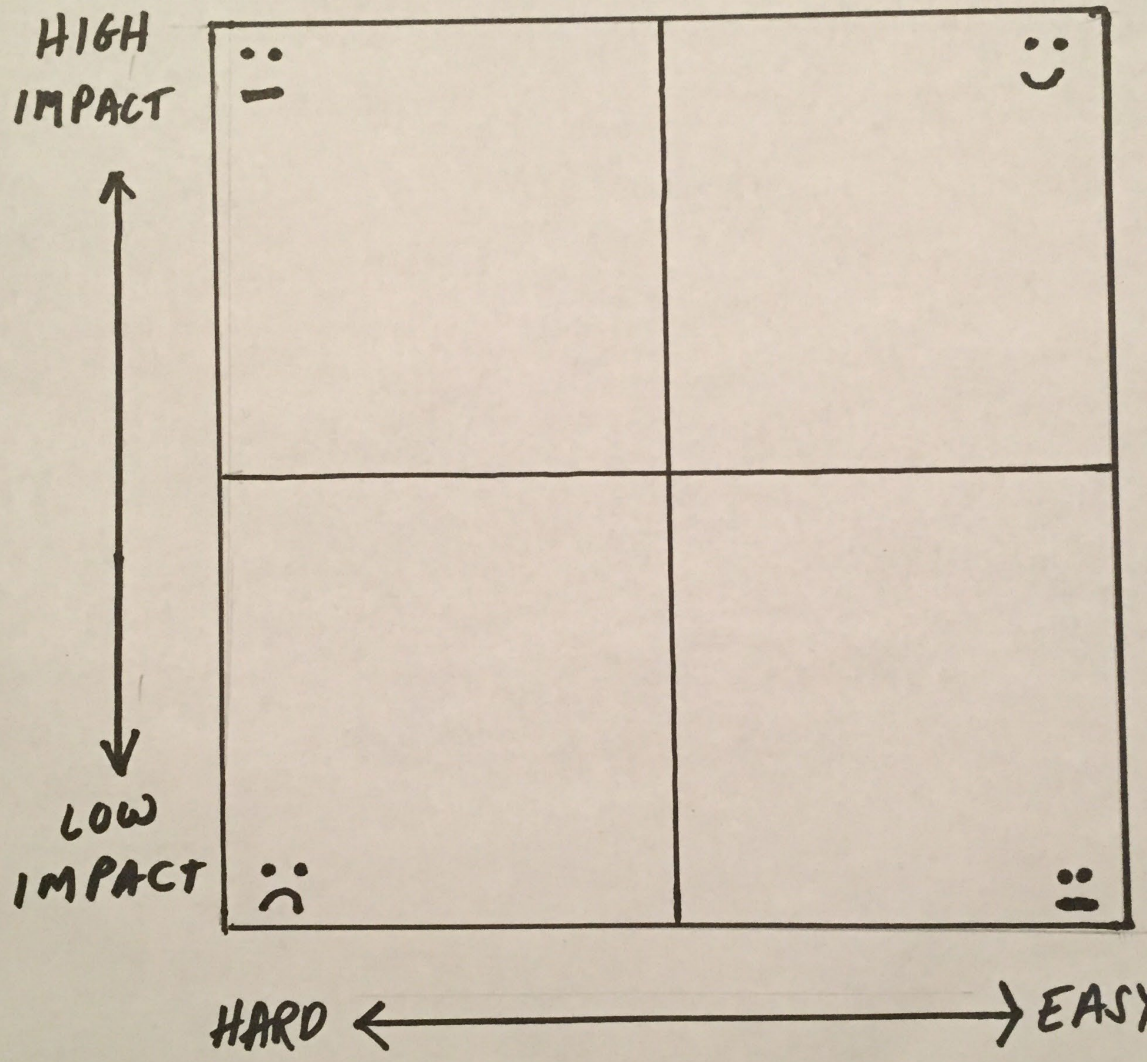
Chief Quality Officer, Hawai’i Pacific Health

Getting Rid of "Stupid Stuff" Decision Tree

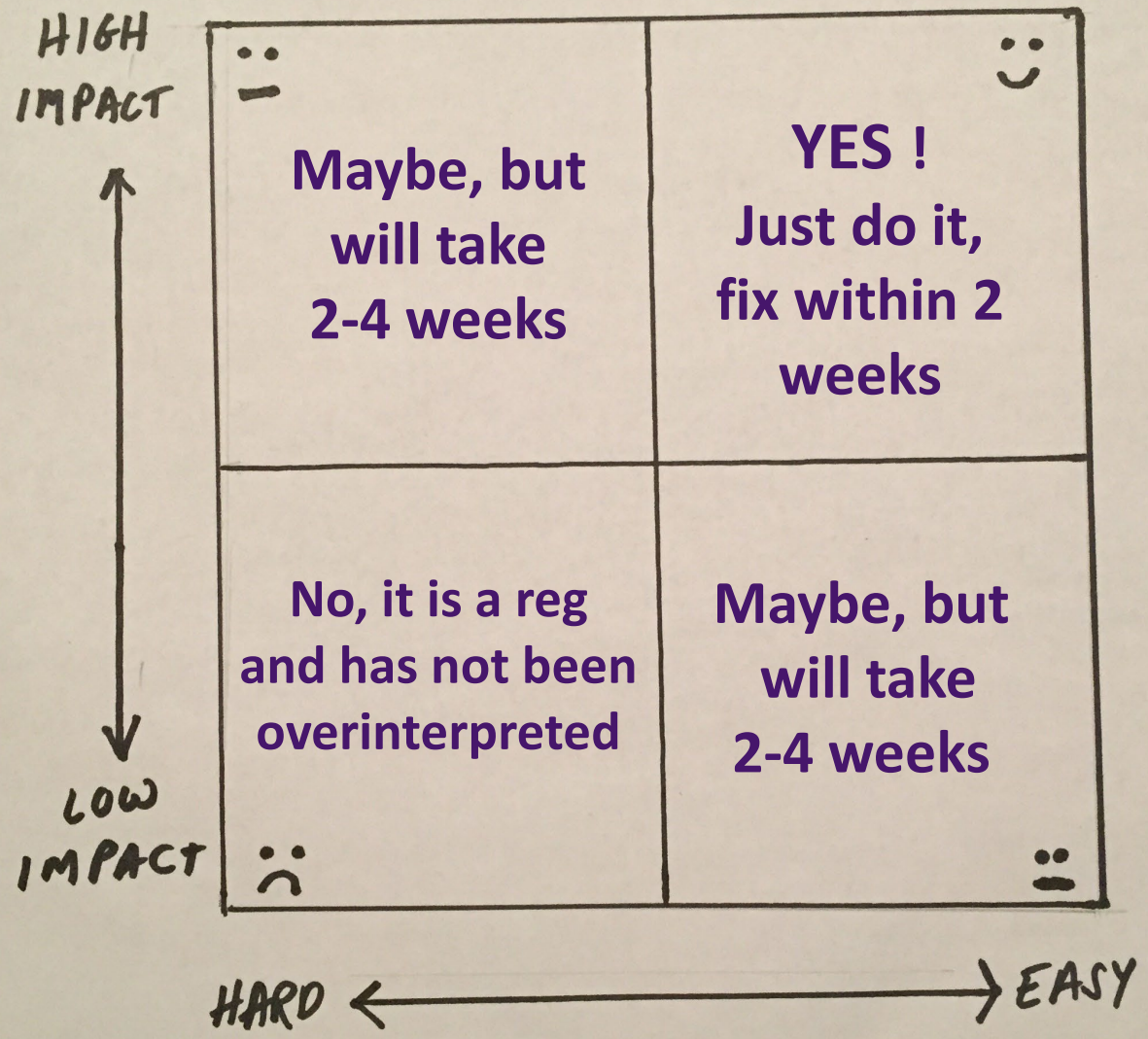
Triage suggestions to determine appropriate next steps



Department	Role	Potential "Stupid Stuff" That Can Be Addressed
Information Technology (IT)	Design, build, and maintain/improve the EHR	EHR inefficiencies
Risk Management	Advocate for liability reduction	Processes implemented to mitigate risk that may be well-intentioned but not useful
Legal	Oversee compliance and risk management activity	Processes implemented to mitigate risk that may be well-intentioned but not useful
Compliance	Interpret regulatory requirements	Misunderstandings about regulatory requirements
Quality	Provide expertise on process improvement and understanding regulatory requirements	Misunderstandings about regulatory requirements
Health Information Management (HIM)	Provide information on documentation, coding requirements, and coding	Overinterpretation of requirements (especially HIPAA rules)
Revenue Cycle	Provide information on payer requirements	Misunderstandings about requirements for accurate billing
Mandatory education	Provide mandatory physician (and other clinician) training	Irrelevant training requirements
Nursing leadership	Represent nurses and provide expertise on nursing workflow	Documentation requirements that are variably determined by managers, rather than standardized. Documentation of nurse activities, rather than patient care provided.
Physician executive leadership	Represent physicians and provide expertise on physician workflow	Medical executive committee requirements that create extra work
Specific departmental leadership (eg, radiology, ER, hospitalist, OB/GYN, pediatrics, surgery, pharmacy)	Provide expertise on specialty-specific workflow	Specialty-specific requirements that create extra work (often thought to be necessary for that specialty, but may not actually be)
Laboratory services	Provide expertise on appropriate lab ordering practices	Unnecessary clicks to accomplish appropriate ordering

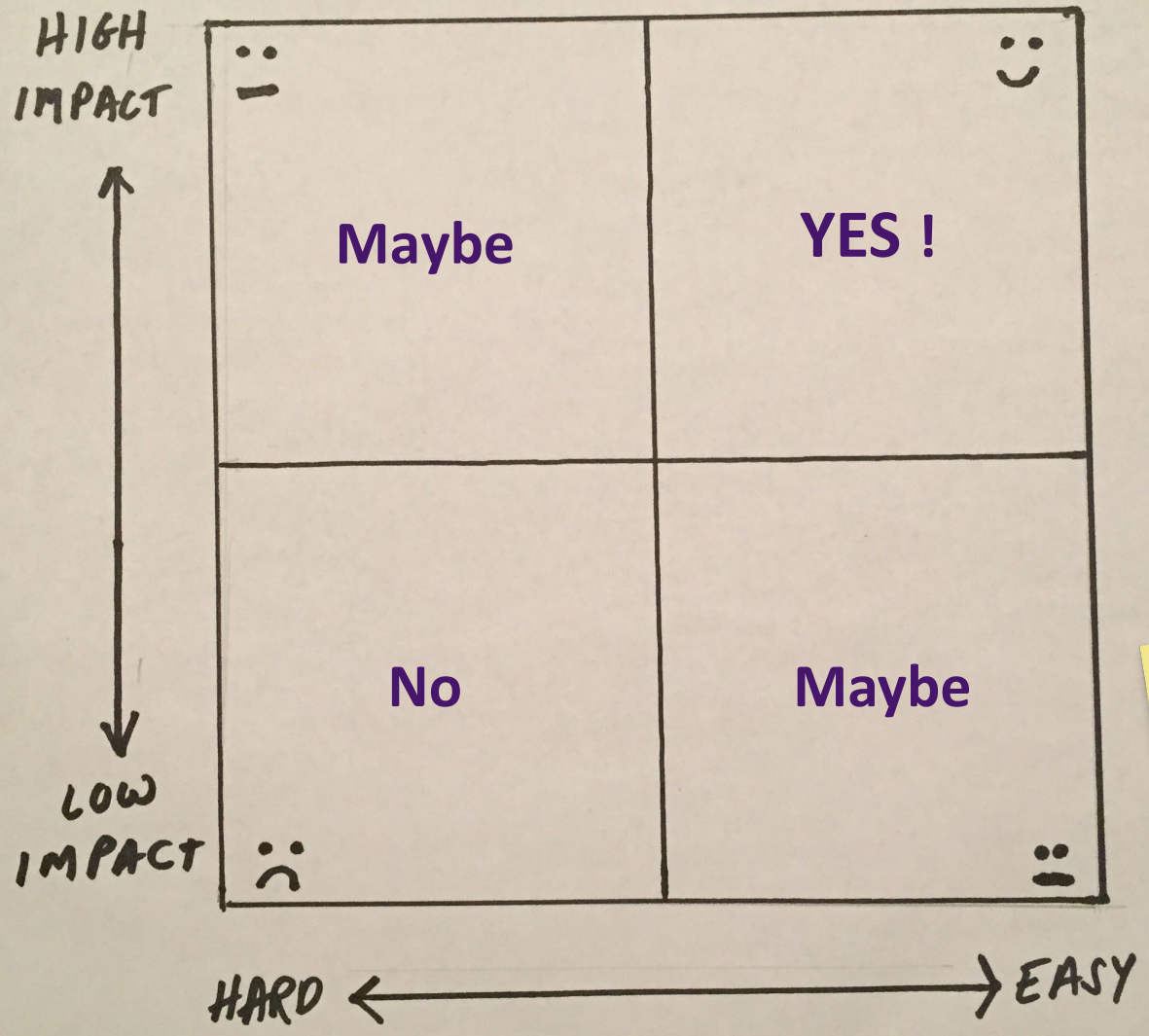


Each table draws 1 grid



Most important question to ask & answer for team?

WIFM
What's in it for me?



Lengthen automatic log-off to 15 min

Change security reminder frequency

Get rid of EHR

Send providers reminder to order flu vaccine

Stop requiring PW + User re-entry for non-controlled rxs

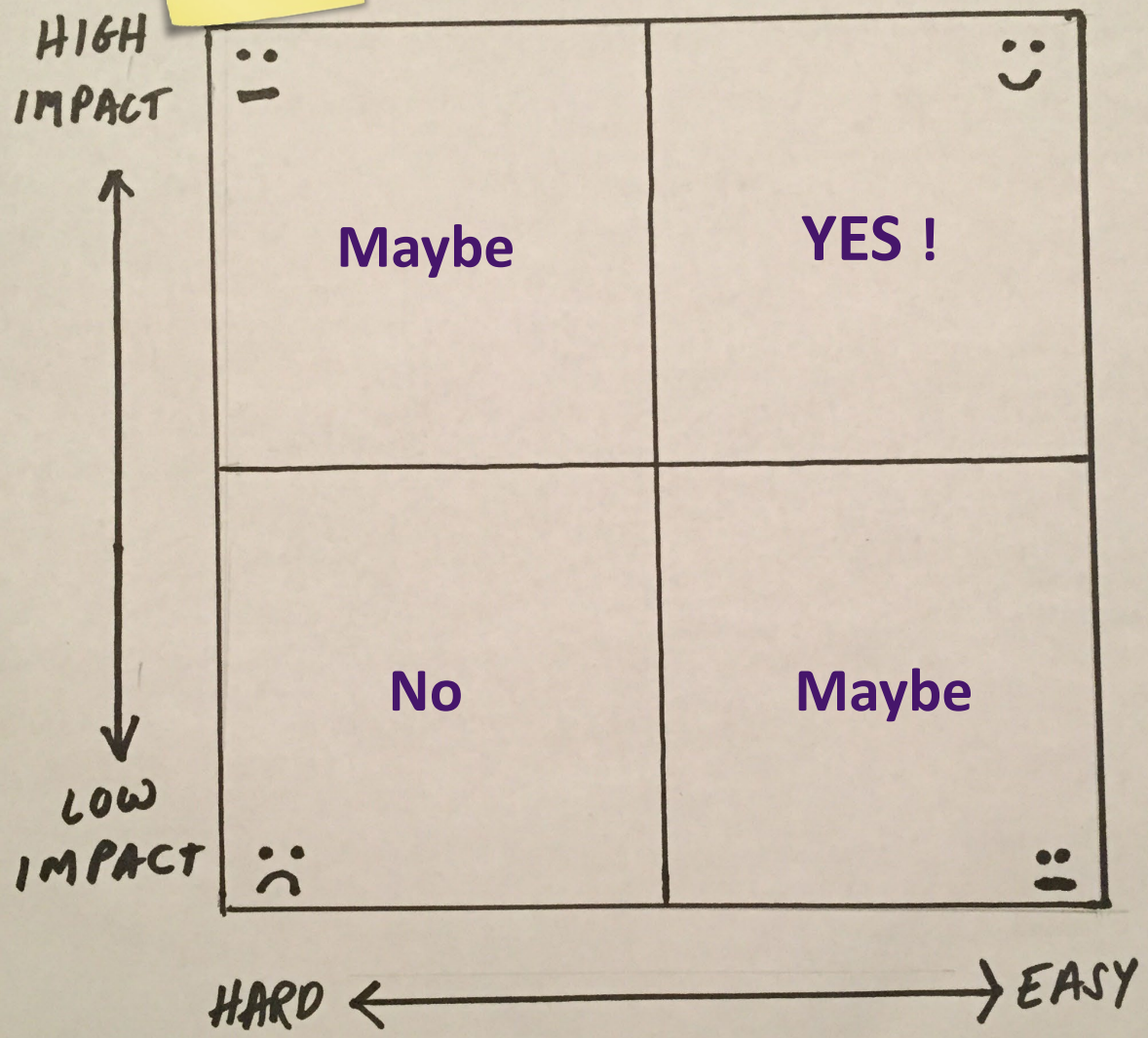
Auto pt call 'bring meds'

Staff button
I got my Tdap vaccine

Lower A1c

Give VIS at check-in

Standing Order DM Ed



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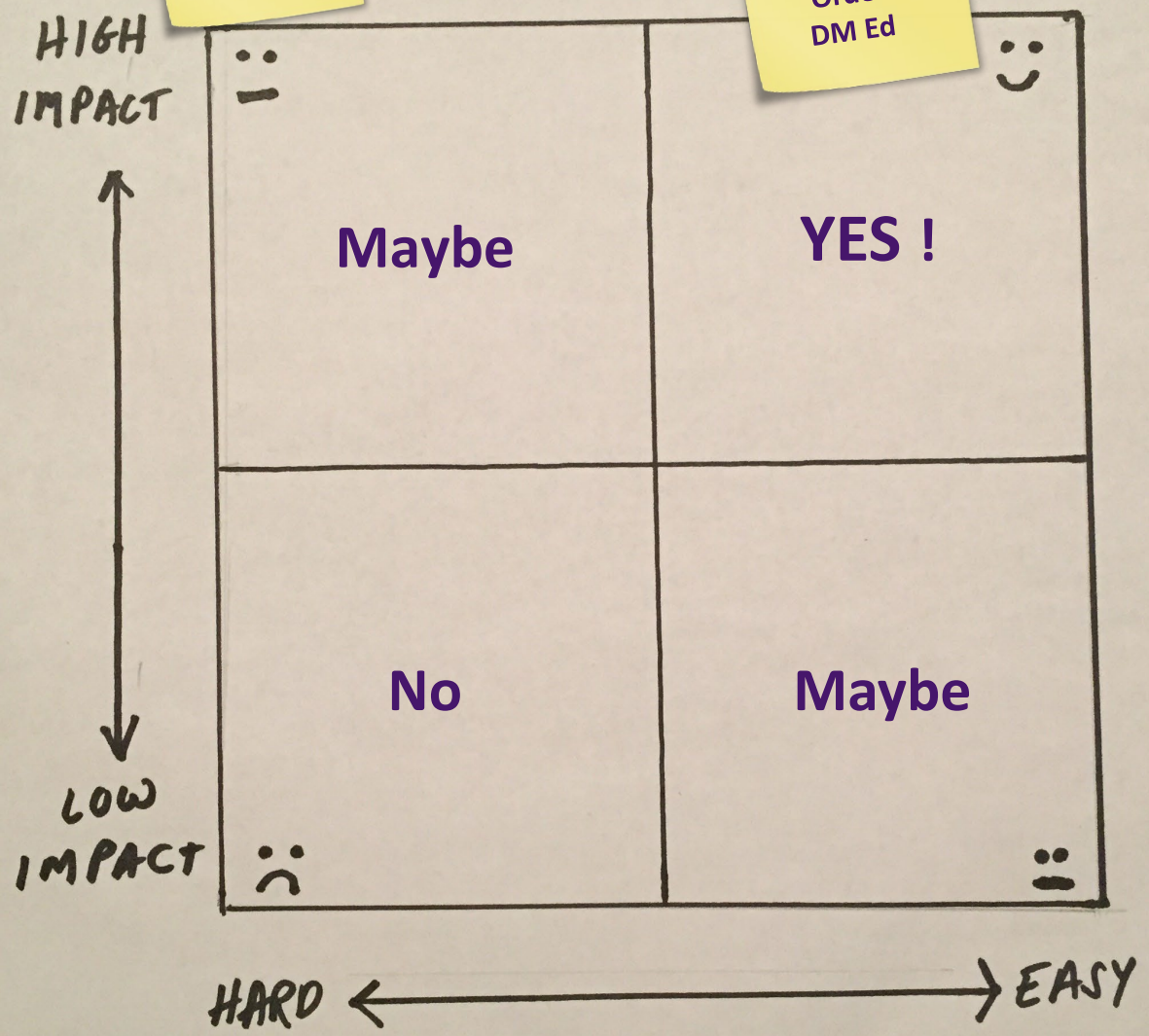

Lower A1c

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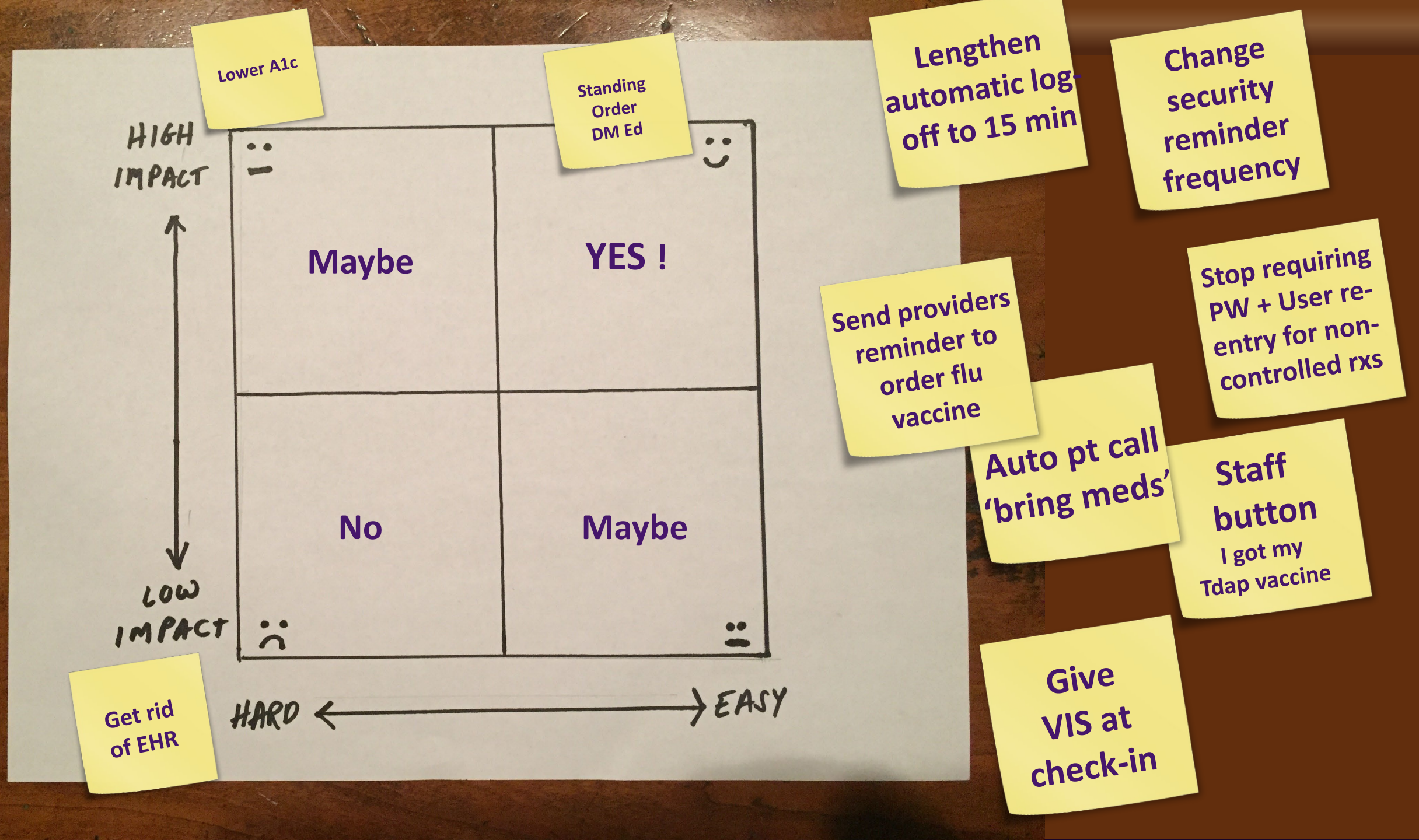

Lower A1c
Standing Order DM Ed
Lengthen automatic log-off to 15 min
Change security reminder frequency
HIGH IMPACT
Maybe
YES !
Send providers reminder to order flu vaccine
Stop requiring PW + User re-entry for non-controlled rxs
Auto pt call 'bring meds'
Staff button
I got my Tdap vaccine
No
Maybe
LOW IMPACT
Get rid of EHR
HARD
EASY
Give VIS at check-in

Take turns reading a suggestion.

When everyone at the table agrees on which quadrant it should be placed, only then do you add it to the grid.

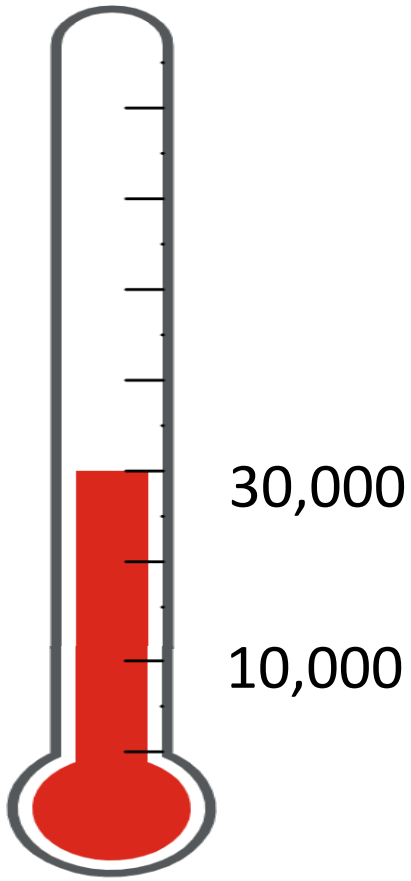
If not unanimous, does everyone agree not to subvert the effort?
If not, move on to another suggestion.

After the break, your table will choose one idea from the “Yes!” square and prepare a pitch.

Stop doing this….	So you can do more of this….
Refills for only 6 months	Build patient and team trust
FYI inbox messages	Code appropriately
Copied charts sent to inbox	Education of MAs
Review of scanned signed items	Build protocols/standing orders
Redocumentation	Increase patient education
Duplicate work	Start team/patient documentation
Unnecessary password entries	Effective team meetings
Notification of normal results	Pre-visit planning
Review tests not ordered by you (exclusions e.g., ER, inpatient)	Address SDOH
FYI test ordered without results	Identify medication nonadherence
Short auto logout	Care for yourself and family

EEH Process Improvement

Clicks Saved!



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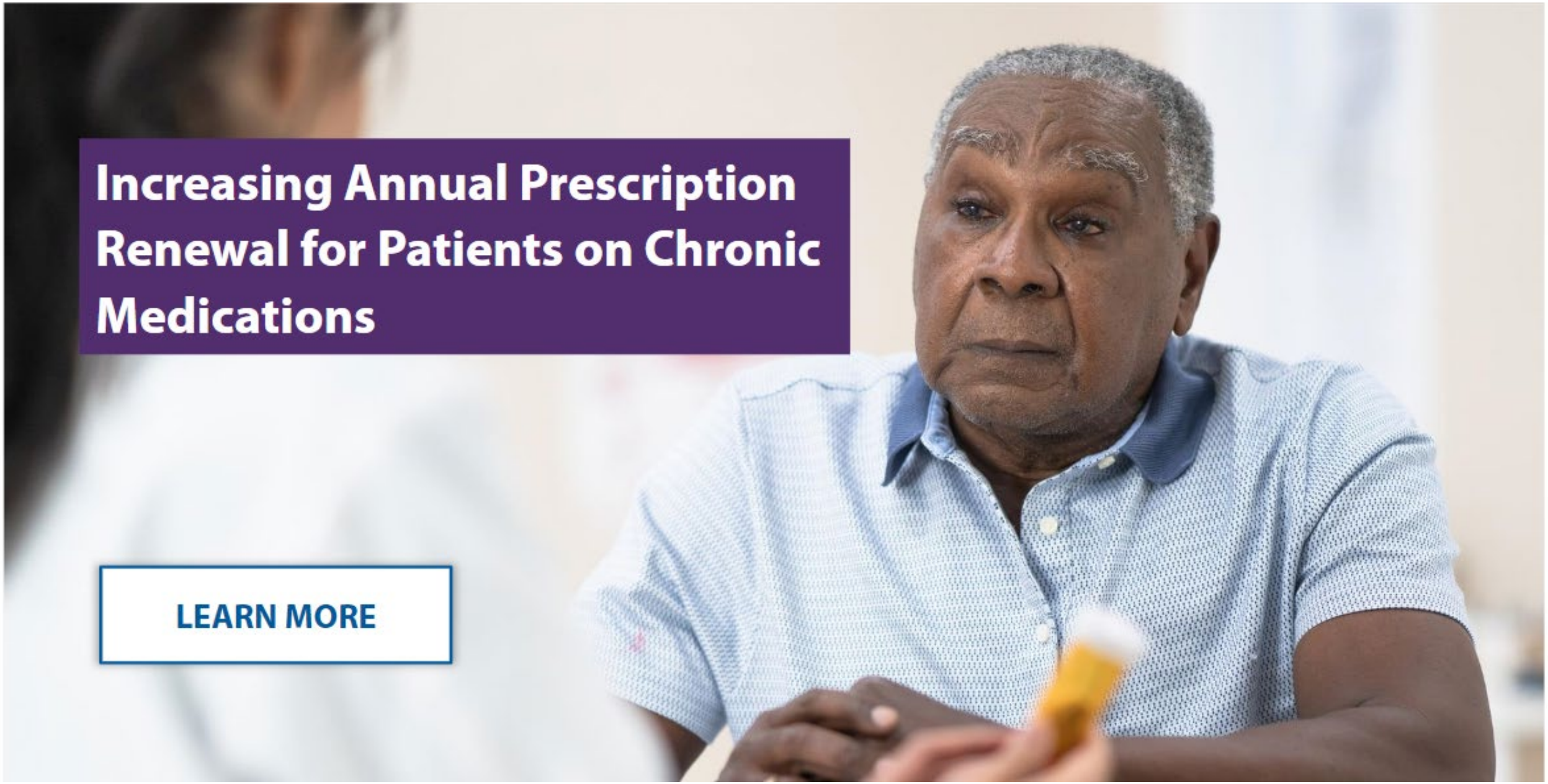
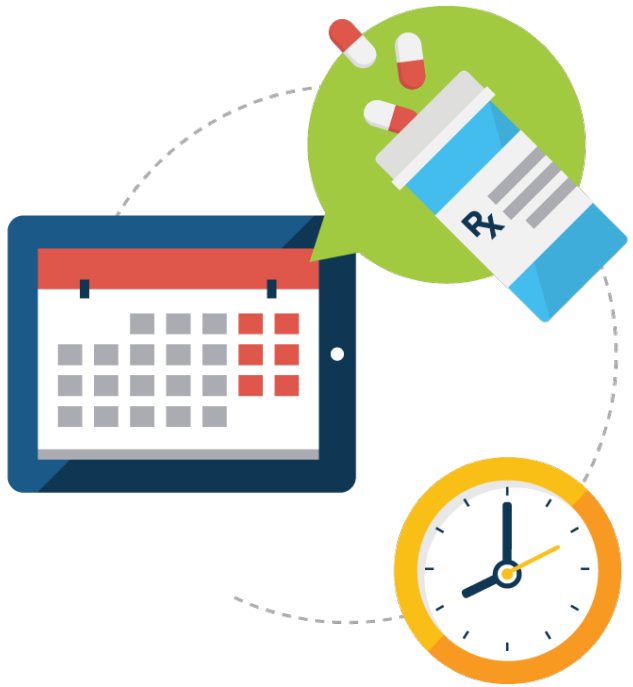


Annual Prescription Renewal

Save Time and Improve Medication Adherence

Christine A. Sinsky, MD, MACP

Former Vice President, Professional Satisfaction, American Medical Association



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Appendix

Actual response to a request from a patient to complete pre-visit labs prior to her annual visit

--Large academic medical center, Chicago, Illinois 9/7/2023

Due to the large volume of messages, we will no longer be ordering pre-visit labs. At your visit, your clinician will review your current clinical condition and order the appropriate tests. This will avoid additional blood draws,potential insurance issues, and allow your physician to perform a complete evaluation.

Thank you for your understanding. We look forward to seeing you.

Sincerely,

Baseline Measurements EHR Burden

Eb

This portion of the activity measures the number of unnecessary inbox messages you receive each day. You could count the number of all unnecessary inbox messages or a subcategory such as labs, patient portal or copied charts.

Instructions: To assess your current practice, select 10 days in the past year and count the number of messages that do not require any action on your part. These could be notifications of a test scheduled/canceled without results, copied labs/tests that a physician other than you ordered, or notifications of routine outpatient procedures (e.g., screening colonoscopy) without results.

Measurements	Baseline	Evaluation
Date Completed (MM/DD/YYYY)		
Total number of inbox messages that do not require action (add # for each of the 10 days) e.g. 20, 25,15, 30, 10, 20,25,15,30,10,20 = 200 messages over 10 days	200	
Divide the total # of messages by 10 (the 10 days is your denominator) In this example your average # of unnecessary messages was 200/10 = 20/day	20	
Performance Rates (average = 20 unnecessary messages/day)	20	

Intervention Planning EHR Burden

Interventions	*Required Intervention
☐ AMA STEPS Forward Getting Rid of Stupid Stuff Toolkit *	View resource
☐ AMA STEPS Forward Saving Time Playbook	View resource
☐ AMA STEPS Forward Taming the EHR Playbook	View resource
☐ AMA STEPS Forward In-Basket Management toolkit	View resource
☐ **Other**	View resource

Follow Up Measurement After Intervention EHR Burden

E_f

You will now reassess your performance by completing the same random chart review as in baseline stage.

Instructions: To assess your follow-up practice, select 10 days and count the number of messages that do not require any action on your part. These could be notifications of a test scheduled/canceled without results, copied labs/tests that a physician other than you ordered, copied labs/tests that a physician other than you ordered, or notifications for routine outpatient procedures (e.g., screening colonoscopy) without results.

Measurements	Baseline	Evaluation
Date Completed (MM/DD/YYYY)		
Total number of inbox messages that do not require action (add # for each of the 10 days) e.g. 10, 15,5,20,5,10,20,5,5,5,10 = 100 messages in 10 days	200	100
Divide the total # of messages by 10 (the 10 days is your denominator) In this example your average # of unnecessary messages was 100/10 = 10/day	20	10
Performance Rates (here a lower # at follow up is better) (there was a decrease of 10 unnecessary messages/day) this is a decrease of 50%	20	10

K.I.S.S.

Keep it Simple Superheroes

Whatever project you are thinking of now…

Simplify it!

Will the change continue when you are not in clinic?

Group Discussion

Day 1 Survey

Welcome to the Saving Time: Practice Innovation Boot Camp

Sept. 17 – 18 | AMA Plaza | Chicago, IL

Transform your practice and focus on what matters most – patient care.

AMA | STEPS FORWARD®
Innovation Academy

Scan the QR code to access the resources hub!

Making the Business Case: The Pitch

Jane F. Fogg, MD, MPH, & Faculty

What Does Making a Business Case Mean?

To implement team-based workflows in my practice, I need to hire more medical assistants and re-design their clinical workflows. This will require updates in the EHR. But I don't control the budget…..

How can I convince leadership to hire, train, and support my staff??

How To Make the Business Case

1. **Define your proposal**

   Clarity, Concrete, Concise

2. **Know your audience**

   How will they make their decisions? What is their incentive to invest?

   Review your proposal with the perspective of each leader’s domain

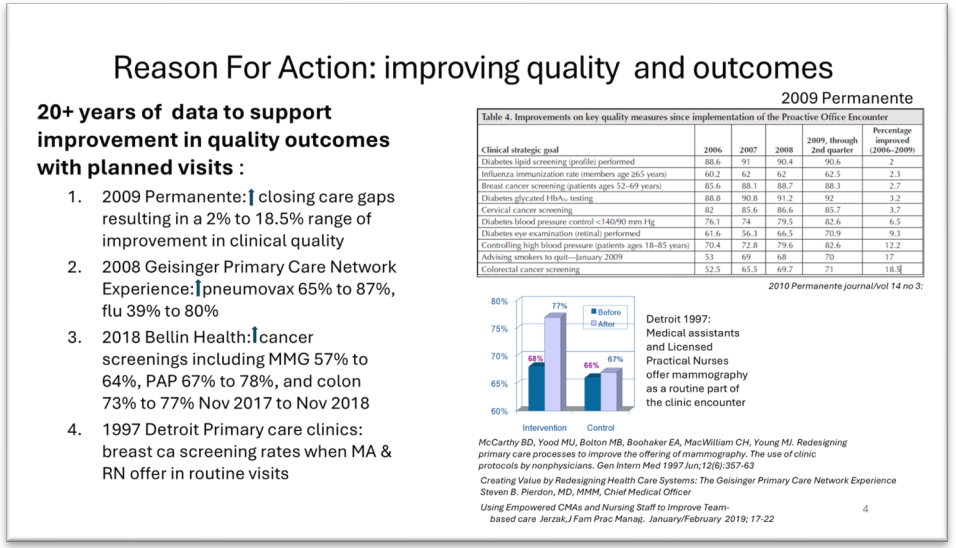
3. **Review and Revise**

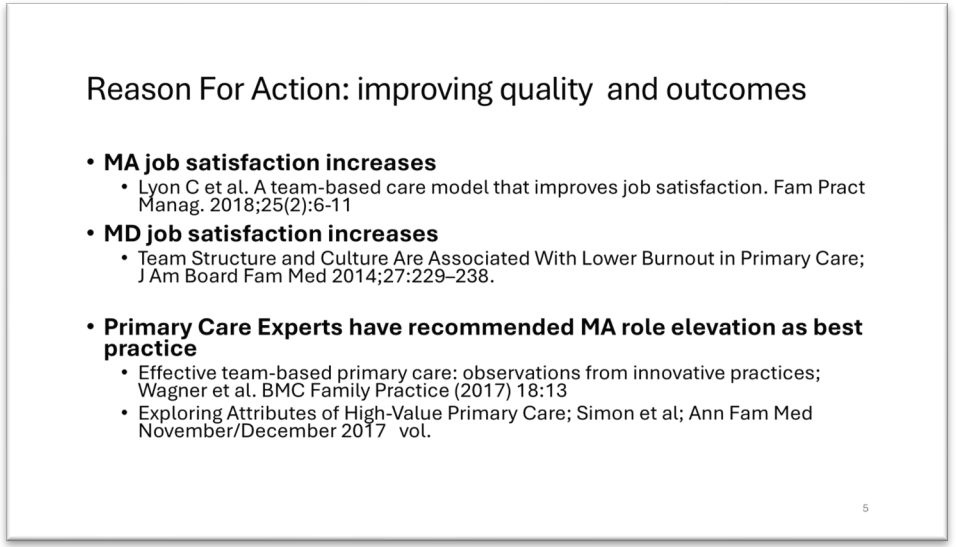
4. **Practice**

Define Your Proposal:
Real Example of a Business Case Pitch

Example of a Business Pitch

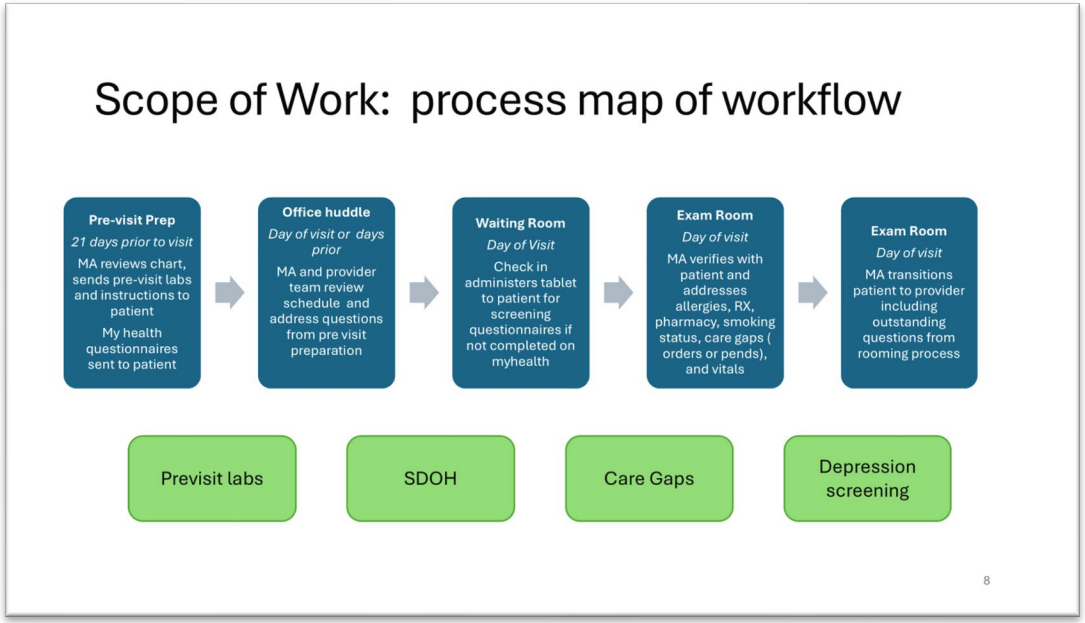
- **The pitch**: IT and informatics resources partnering with IM/FM clinical and operational teams to translate the clinical workflow changes for medical assistants into an updated Epic design
- **Reason for action**: volume/time needed to address all preventative, chronic, quality, and health related social needs is inadequate given productivity expectations. Medical assistants cannot perform task reliably in current EHR design; optimizing it will increase performance.
  - Evidence: quality and safety outcomes from studies
  - Evidence: impact on MA and MD satisfaction studies





Example of a Business Pitch

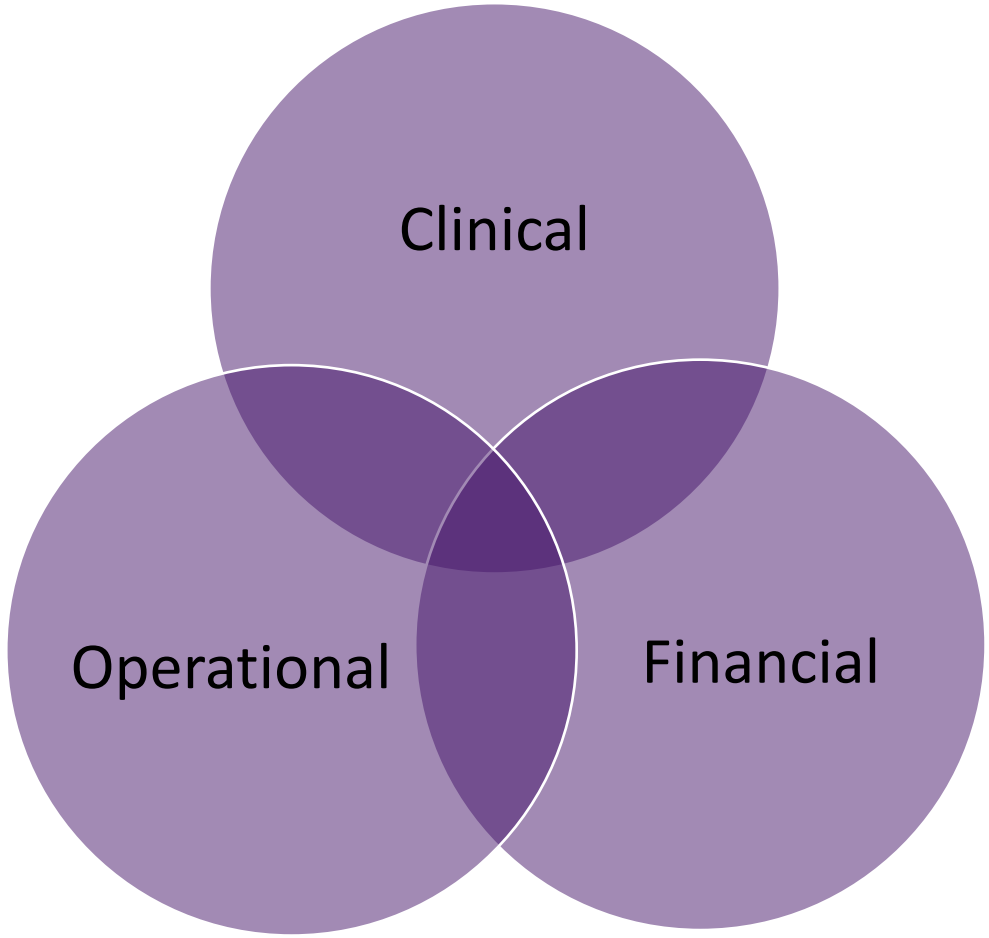
- **Scope of project**: IM/FM service line MA workflows (operational and technical) to address care gaps, immunizations, SDOH screen, depression screen
- **Metrics**: previst labs, PG ‘staff worked well together’, DM A1c process metric, % screens completed, immunization
- **Resources requested**: EHR design team time, informatics and builder, hardware (tablets), training, analytics.



Did I convince the decision makers?

What could I do better?

C Suite: The Currency of the Decision Makers



- **Clinical** decision makers
  - Patient care
  - Quality/safety
  - Workforce
- **Operational** decision makers
  - Feasibility in practice
  - Regulatory
- **IT** decision makers
  - Technical requirements, prioritization
- **Financial** decision makers
  - Impact on revenue and expense
  - Alignment with financial construct

Revising the Pitch

- Did I address the clinical impact?
  - ✓ improved patient care, quality, and clinician experience
- Did I address the operational and technical impact:
  - ✓ partnership with informatics, IT, quality/safety, and clinical operations leadership
- Did I address the financial impact:
  - revenue for FFS ad VBC; budget and timelines

Discussion

Small Group Discussions

Three 20-minute rotations

Panel Discussion

Lunch

noon - 12:30 p.m.

Scan the QR code to access the resources hub!

Sharing Best Practices

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Save the Date!
April 13 –14, 2026

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For further info, please visit us at stepsforward.org.

Thank you for attending the two-day AMA STEPS Forward® Saving Time: Practice Innovation Boot Camp.

We ask that you reflect on your time with us in this brief, anonymous survey.

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