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Taming the Electronic Health Record Playbook

from the AMA STEPS Forward® Playbook Series

About the AMA STEPS Forward® Playbook Series

This playbook is part of the AMA STEPS Forward® practice innovation program. Each playbook curates the best content AMA STEPS Forward has to offer—toolkits, videos, podcasts, and ready-to-use tools, templates, and resources—into practical, actionable strategies and tactics to help you create positive change in your practice today.

For the optimal experience—GO DIGITAL!

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The AMA STEPS Forward program offers practice innovation strategies that allow physicians and their teams to thrive in the evolving health care environment by working smarter, not harder. Physicians and leaders looking to refocus their practice can turn to AMA STEPS Forward for proven, physician-developed strategies for confronting common challenges in busy medical settings and devoting more time to caring for patients. This collection offers more than 70 online toolkits and other resources that help physicians and medical teams make transformative changes to their practices.

The AMA STEPS Forward® Innovation Academy expands on the program to give participants the flexibility to customize their practice transformation journey. The Innovation Academy offers a wide range of opportunities to learn from peers and experts, including webinars, tele-mentoring, virtual panel discussions, boot camps, and immersion programs.

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Introduction

50%

of the physician's day spent on EHR and desk work[1]

37%

of visit time with patients spent on nonclinical tasks[1]

1 to 2 hours

of extra work each day, including long hours before and after clinic completing "between visit" work[1]

"

Physicians don't quit their jobs, their patients, or their bosses; they quit their inboxes.

"

—CT Lin, MD, FACP, FAMIA;
Chief Medical Information
Officer, UCHealth-Colorado

The EHR Problem: How Did We Get Here?

The electronic health record (EHR) has profoundly changed the practice of medicine and is perceived as both a blessing and a burden by clinicians who use it. Most physicians who did not begin their training and enter practice using a sophisticated EHR only learned enough to "get by." Younger physicians who did go through medical training using a modern-day EHR typically did not have the bandwidth to focus on mastering the EHR along with their medical knowledge. Furthermore, the near-universal adoption of virtual care and telehealth during the COVID-19 pandemic has increased patient expectations and awareness about EHR-based communication tools, resulting in increased physician time spent on the EHR.[2]

Meanwhile, the EHR has evolved dramatically in both positive and negative ways. While most EHRs now have customizable tools that, if used optimally, can save physicians time, there are also many more unnecessary clicks and automated messages clogging up inboxes. The EHR burden is a major contributor to physician burnout, and it has become a problem that individual physicians cannot fix on their own. It is imperative for organizations to learn how to tame the EHR by implementing effective system-level policies and responding to feedback for continuous system-level improvement.

How Can We Tackle This Problem?

The EHR problem encompasses a few buckets:

- the volume of **unnecessary work** that is being done (eg, extra clicks, extraneous or duplicative messages, note bloat)
- the volume of **necessary work** that needs to be done but can be shared with nonphysician team members (eg, chart review, order entry, documentation, and inbox management)
- the **technology** itself (eg, interfaces or functionalities that users may not be familiar with)

This playbook will address each of these buckets so that individual clinicians and their practices can:

1. Minimize the unnecessary work by de-implementing unnecessary regulations at the system level and reengineering the flow of messages into the EHR inbox

2. Manage the necessary work by utilizing team-based care principles to offload inbox management, order entry, chart review, and documentation from physicians alone

3. Become more personally proficient at using EHR technology

EXPLORE MORE!

- Taming the EHR webinar
- Taming the EHR podcast

What's In Your Control?

Working with leadership is imperative to accomplish any of these changes. Some changes will be easy to make; others will be more difficult. Some changes may be institution- or organization-specific, while others may be governed by federal regulations. Having a shared understanding between leaders and practicing clinicians of "what's in your control" helps overcome inertia (or resistance to change) while building trust and transparency (Table 1).

Who Is This Playbook For?

This *Taming the EHR Playbook* is for:

- Daily EHR users (eg, physicians, physician assistants, nurse practitioners, nurses, and medical assistants)
- Organizational leaders (eg, Chief Medical Information Officers [CMIOs] and Chief Compliance Officers [CCOs])
- Medical directors
- Practice managers
- Operations leaders

Anyone interested in maximizing the benefits while minimizing the burdens of the EHR can learn from the content outlined and linked to within this playbook.

This playbook contains highlights from 11 AMA STEPS Forward® toolkits.

For the optimal experience—GO DIGITAL!

Scan this QR code to fully engage with the playbook and access all relevant links on your computer or mobile device.

Table 1. What's In Your Control?

Each EHR has default settings that will affect common workflows and user experiences. However, the user or organization can change many of these settings. This table provides examples of some EHR features that affect the physician experience that can be modified at your local level.

	EHR User Control	Organizational Control	Federal Regulation
Shortcuts, note templates, autocorrect, or spellcheck functions	O		
Notifications and results that enter your EHR inbox	O	O	
Time to auto-logout		O	
Pop-up alerts upon login		O	
Team members or patients performing pre-visit medication reconciliation		O	
Team members or patients filling out pre-visit questionnaires or entering HPI components		O	
Character limits on patient portal messages		O	
Team documentation functionality		O	O
E&M coding requirements			O

Strategy 1: Stop the Unnecessary Work

The idea of getting rid of unnecessary work can feel so simple yet so daunting at the same time. Many physicians, especially those already experiencing burnout, feel resigned to whatever unnecessary work they are given. However, with visible leadership commitment, concrete examples to work from, and an IT and governance structure in place to evaluate and implement effective changes, unnecessary work does not have to be "just how it is."

This section will help you **tame the EHR** by:

- Simplifying documentation to reduce note bloat, based on the 2021 outpatient E/M coding updates

- Creating a unified organizational strategy for EHR inbox reduction

- Going upstream to optimize information-sharing with patients and reduce unnecessary ordering of tests to minimize what ultimately enters the EHR inbox

Simplify Documentation

The documentation burden of writing patient notes is a major contributor to EHR-related burnout for clinicians.[3] A physician sitting at a computer performing the clerical task of note-taking and order entry is a low-value use of a high-dollar resource. While implementing team documentation is the best way to offload these clerical tasks from physicians (see Strategy 2: Share the Necessary Work), it may take some time for practices to overcome obstacles to implementation, such as staffing shortages and training limitations.

In the meantime, individual clinicians can control how they write patient notes. They can decrease note bloat and improve documentation efficiency based on 2021 outpatient E/M coding updates. This update affected all new (99201–99205) and established (99211–99215) outpatient visit billing standards. Only the medically necessary and appropriate portions of history and physical exam are required, thus reducing documentation burden. **In other words, determination of the appropriate level of service no longer includes history and physical exam documentation but rather depends solely upon either medical decision-making (MDM) or the total amount of time spent providing care for a patient on the day of the visit (including before and after the visit, not just face-to-face time).** Furthermore, the update recognized that social determinants of health could contribute to the complexity of patient issues and, as a result, may affect both the time spent during an encounter as well as the level of MDM.

The **AMA STEPS Forward Simplified Outpatient Documentation and Coding toolkit** describes these updates in detail, providing several sample patient notes and explanations on how to determine the appropriate level of coding and billing (Figure 1). These guidelines apply to telehealth visits as well.

EXPLORE MORE!

- Simplified Outpatient Documentation and Coding toolkit
- E/M Documentation and Coding: Update for Ambulatory Visits video
  Part 1 | Part 2

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Simplified Outpatient Documentation and Coding

- The 2021 E/M changes took away many unnecessary documentation requirements and are considered a "win" for physicians in the ambulatory setting
- Start by cleaning up your note templates to reduce note bloat and time spent on unnecessary documentation
- Training medical assistants or other non-clinical staff to participate in team documentation is an additional key to increasing documentation efficiency.

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Figure 1. Sample Progress Notes Using Simplified Outpatient Documentation and Coding

Clinical Vignette 1. Sample Progress Note, Level 4 MDM

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HPI

60 y/o male here for follow up HTN and HL.

Doing well, no complaints.

Meds reviewed.

See A/P for remainder of HPI.

PEX

Vital signs: normal including blood pressure - 120/72

Heart: RRR, no murmurs

Lungs: clear to auscultation

A/P

1. HTN - well controlled on lisinopril 20 mg and thiazide diuretic 25 mg daily. Continue current medications.

2. HL - on atorva 20 mg daily. No side effects. Last lipid panel 6 mo ago at goal. Continue current treatment.

Next visit in 6 mo for follow up and wellness check.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
This case meets criteria for **moderate** number of diagnoses (any criteria below met)	This case meets criteria for **straightforward** complexity of data (minimal or no data)	This case meets criteria for **moderate** risk of morbidity from additional diagnostic testing or treatment	This case meets **Level 4 criteria** for number of diagnoses and risk
○ ≥1 chronic condition with exacerbation		Example:	
● **≥2 stable chronic conditions**		● **Prescription medication management** *(can be prescribing new medication, continuing same dose of current medication, or changing dose of current medication)*	
○ 1 acute illness or injury with systemic symptoms			
○ 1 acute illness or injury with uncertain prognosis			
Moderate/99214	Straightforward/99212	**Moderate/99214**	**OVERALL CODE: 99214**

Figure 1, continued

Clinical Vignette 2. Sample Progress Note, Level 4 MDM

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HPI

40 y/o female with diet-controlled diabetes and obesity presents to establish care after moving from another state. No meds. States she had a visit with her old PCP about 6 mo ago, and blood work was done at that time.

Currently living with her cousin while looking for jobs. She is a single parent to 2 teenagers. She has not found many grocery stores in the neighborhood and is not comfortable with public transportation. She sometimes can borrow a car from her cousin, but mostly uses this for job hunting, or transporting her children to school events. Asks to defer lab testing until her next visit due to possible out-of-pocket costs.

PEX

BP 120/72   P 74   BMI 35.12

A/P

1. Diet-controlled DM. States had labs done 6 mo ago, does not recall last A1c. Will work on transfer of records and defer testing until next visit.

2. Obesity - discussed daily exercise, adding more vegetables to her diet.

3. SDOH - Patient's care may be negatively impacted by food insecurity due to her current lack of income. Based on this, patient will not be able to access healthy foods to manage her diabetes and obesity. Will consult SW for community resources and social support.

Notes for the coding and documentation exercise:

Each element (number of diagnoses, complexity of data, and risk) can be classified as straightforward, low, moderate, or high.

For CPT coding, 2 of 3 MDM elements need to meet the moderate level to be considered Level 4 MDM.

Number of Diagnoses	Complexity of Data	Risk	CPT Code
This case meets criteria for **moderate** number of diagnoses (any criteria below met)	This case meets criteria for **minimal** complexity of data (minimal or no data)	This case meets criteria for **moderate** risk **of morbidity from additional diagnostic testing or treatment**	This case meets **Level 4 criteria** for number of diagnoses and risk
⭕ ≥1 chronic condition with exacerbation		**Example:**	
🔴 **≥2 stable chronic conditions**		🔴 **Diagnosis or treatment significantly limited by social determinants of health**	
⭕ 1 acute illness or injury with systemic symptoms			
⭕ 1 acute illness or injury with uncertain prognosis			
Moderate/99204	Straightforward/99202	**Moderate/99204**	OVERALL CODE: 99204

Reduce EHR Inbox Burden

Of all the EHR-related tasks and burdens, the EHR inbox is perhaps the single most frustrating time sink for physicians. **Senior organizational leaders need to prioritize and adopt a system-level approach to EHR inbox reduction.** A checklist can help organize these efforts and serve as a starting point (Table 2). The resource "A System-Level Approach to EHR Inbox Reduction" (PDF) provides more details, with specific examples from 3 organizations.

Many of the key tactics for inbox reduction also depend on effective team-based care workflows, which are described in more detail in Strategy 2: Share the Necessary Work. These include:

- **Annual prescription renewals**—to prevent unnecessary refill requests from entering the inbox
- **Inbox and patient portal management**—to triage and address messages that do not need to be seen by physicians
- **Pre-visit planning** and **pre-visit laboratory testing**—to minimize after-visit questions about results and follow-up appointments by discussing them during the actual visit time, eg, "flipping the visit"

EXPLORE MORE!

- EHR Inbox Management toolkit
- Electronic Health Record Optimization podcast
- Improve Practice Efficiency with EHR "Quick Wins" podcast
- Reduce Pajama Time and Work Outside of Work (WOW) podcast
- Taming the EHR podcast

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Table 2. EHR Inbox Reduction Checklist

Eliminate unnecessary burdens and improve workflows in the EHR at the organizational level with this checklist.

⊘ Guiding Principles

☐ **Establish an inbox reduction task force**	The task force may include the following: • An organizational champion at the C-suite level • Clinical operational leaders • IT operational leaders • Compliance professionals • Patient experience leaders • Practicing physicians • Care team members • A process improvement specialist (in-house or consultant) • An EHR vendor representative Financial investment may be required to ensure the task force has adequate time and resources for this effort.
☐ **Use EHR audit-log data**	This data will help the task force understand the current state and assess the impact of interventions to reduce inbox volume. For example, Epic's Signal data or Oracle Cerner's Advance program data can help identify variations in the number of messages per 8 hours of patient scheduled time within and across specialties. Additionally, with this data, the task force can analyze the volume of messages in different subcategories.
☐ **Create a culture of a shared team inbox**	Establish the cultural norm that the inbox belongs to clinical teams or pods. Use nomenclature that reflects this culture, for example, by referring to the "practice's inbox" or the "care team's inbox" rather than the "physician's inbox."
☐ **Go upstream**	Start with a goal of preventing unnecessary messages from entering the inbox in the first place rather than increasing the efficiency of message handling (though both are important).

⤭ Starting Tactics

☐ **Consider deleting most inbox messages that are >6 months old**	Some organizations have found that starting with a grand gesture like this establishes credibility, ensures buy-in, and gives hope that inbox reduction will be successful (Note: This may take several weeks to complete because of the volume of messages).
☐ **Auto-expire any message >3 months old**	Let teams know that this will be the norm from this point on unless messages are individually marked for exception.
☐ **Empower patients to identify the topic of their messages for appropriate triage**	Patients know the nature of their requests best. Guide them through the message navigation and triaging process with an "I want to..." sorting window. For example, "I want to...ask for medical advice, ask a question about a test result, refill a prescription, make or cancel an appointment, request a referral, or other."
☐ **Provide patients with self service options**	Facilitate opportunities for patient self-service, such as self-scheduling in select departments.
☐ **Establish team pools**	A team pool consists of care team members, including RNs and MAs. All patient messages within a practice or clinical unit should go to this pool first, not directly to the physician. In this model, only questions that MAs or RNs cannot handle are managed by physicians.

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Table 2, continued

⤬ Starting Tactics (cont.)

☐ **Assign an RN or MA to each physician as the primary manager of their inbox**	This care team member takes ownership of the inbox and manages all incoming messages, resolving anything they can on their own. For messages outside their scope, they should "mature the message" to make it as useful and actionable as possible, using their training and skills, before delegating to another team member. After additional research on a message, if it is necessary to consult a physician or APP, verbal communication is preferred when possible, as it may be more efficient and safer than forwarding the message.
☐ **Establish the expectation that physicians and advanced practice providers (APPs) do not access their inboxes while not working (for part-time clinicians) or on vacation**	Set the precedent that clinicians do not check messages when they are out of the office and not on call. Employ the training and skill of RNs to manage most of the inbox, with backup assistance from the covering APP or physician. Some organizations pair physicians to cover for each other while one is away if there is anything the RN can't resolve. The expectation is to "treat it as your own" so that physicians leave with and come back to an empty inbox.

🗩 Tactics for Individual Message Types

Patient requests for medical advice	
☐ **Leverage the training and skill of MAs and RNs**	Team members should thoroughly research all patient requests for medical advice and take action to the full extent of their ability and within their scope of practice before "delegating up" to a physician or APP. This is sometimes described as "maturing the message." Avoid light "touch and pass" transfers with comments such as "please advise." Encourage information coupling (presenting information necessary for clinical action on a result, such as previous hemoglobin levels with a newly abnormal level) as well as proactively pending orders for review and signature (in those settings where a signature is required).
☐ **Institute reimbursable patient portal encounters**	Several organizations have recognized that care delivered through the patient portal can and should be reimbursed and are piloting programs to that effect.
Prescriptions	
☐ **Implement 90x4 refills**	Establish a 90-day supply with 4 refills as the default setting for medication orders for chronic medications.
☐ **Automate refills**	Develop protocols for automated refills if they meet defined criteria (eg, lab and appointment monitoring).
☐ **Create a refill pool**	Ensure refill requests route to a distinct team pool, not the physician's inbox. Examples of sources of refill requests to direct to the refill pool include those from pharmacies, patients, or created by another teammate.
☐ **Create intake templates for refills**	Develop templates for the call center or front desk to capture all pertinent details when taking a refill request—this will capture all necessary information before the request is sent to the refill pool.
Cc'd charts	
☐ **Turn off automatic cc'd charts (ie, "d/c the cc")**	Establish that charts should be cc'd only in limited, specific circumstances and that this is not the default setting ("say bye to the FYI"). If a physician wants to send their visit documentation to another physician, they must attach a note explaining why they are sending it. If the sender is requesting a specific action from the receiving team, they must indicate this via a personal, attached communication.

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Table 2, continued

💬 **Tactics for Individual Message Types (cont.)**

Results	
☐ **Establish single delivery of test results**	Route test results only to the ordering care team ("If you order it, you own it"). The ordering care team is responsible for following up on tests they ordered. If the care team wants another team or practice to take action, they must individually communicate with that team or practice.
☐ **Route "normal, normal" results directly to the patient portal rather than the physician inbox**	Do not route "normal, normal" results (within the laboratory normal limits and normal in all clinical circumstances) to the physician's inbox. The only exceptions is if, at ordering, the physician ticked a box requesting this result land in their inbox even if normal. The automatic release of results to patients is federally mandated, and sending normal results directly to the patient portal (bypassing the physician's inbox) can safely reduce inbox burden. Abnormal results, or results with high dependency on clinical context, should still be routed to the ordering care team in addition to the patient. Ideally, the practice performs pre-visit lab testing and thus has the opportunity to address all results at an upcoming appointment.
☐ **Don't route tests ordered without results**	Turn off notifications of tests ordered without results.
☐ **Batch non-urgent results**	Batch all non-urgent ordered tests (excluding those that take longer than 24 hours to result) drawn at the same time for a given patient to arrive in a single inbox message.
☐ **Establish protocols for results from routine screening tests**	Don't route normal screening results (eg, mammogram, colonoscopy, DEXA scan) to the care team's inbox. The only exceptions is if, at ordering, the physician ticked a box requesting this result land in their inbox even if normal. For abnormal results, use protocols to schedule a follow-up visit and initiate referrals as needed.
Referrals	
☐ **Create a process for declined referrals**	Route notifications about declined referrals to the appropriate team pool rather than the referring physician's inbox. This includes notifications about an office being unable to contact a referred patient or a patient declining a referral. Forwarding the notification to the physician with "please advise" is not recommended. Instead, implement a close-the-loop process that ensures the inbox manager has a clear path and guidelines to follow when a patient declines the referral.
☐ **Create intake templates for new referrals**	Create a referral template for the call center, front desk, or clinical teammates to use when a patient requests a new referral. This template will ensure vital information is captured. Ideally, the inbox manager researches the request and discusses it with the physician or APP, who can decide whether the patient needs to be seen or a referral can be provided without a visit.
Admission, discharge, and transfer (ADT) notifications	
☐ **Don't route ADT alerts to physician inboxes**	Switch from push to pull notifications. Route all ADTs directly to an organizational dashboard where clinicians can pull the information rather than having it routinely pushed to their inboxes.
Media manager	
☐ **Bypass the inbox so documents go directly into the chart**	Establish protocols to file outside consultation notes, urgent care visit documentation, or results of tests not ordered by a clinician within the team straight into the chart, bypassing the team's inbox. Route any results of tests performed at an outside facility but ordered by a clinician within the team to the Results folder (if a result is "normal, normal" it would bypass the team's inbox, just as such results that originate within the organization do).

Get Rid of Stupid Stuff

Aside from documentation and inbox burden, there is plenty of other unnecessary EHR work to be tackled—some much more easily! The EHR De-Implementation Checklist describes examples of additional EHR de-implementation tactics (Table 3).

Table 3. EHR De-Implementation Checklist

Opportunity to act	Deimplementation action
Extend the time before auto-logout	• Extend time for auto-logout depending on workstation location and security. This is under your local control and can vary by department (eg, emergency department vs clinics).
Simplify login	• Simplify and streamline the login process, leveraging options like single sign-on, radio-frequency identification (RFID), proximity identification, and biometric identification (eg, fingerprint, facial recognition).
Minimize alerts	• Retain only those alerts with evidence of favorable patient outcomes or cost–benefit ratios.
Decrease password-related burdens, including revalidation	• Extend the intervals for password reset requirements. • Use password manager software. • Reduce unnecessary requirements for users to reenter their username or password when already signed in to the EHR or when sending prescriptions for non-controlled substances. Note: make sure steps taken are consistent with HIPAA best practices
Reduce clicks and hard stops in ordering	• Reduce requirements to input excessive and illogical clinical data before ordering a test. (eg, eliminate attesting to possible pregnancy for males or women over 60 years old).
Simplify order entry processes	• Auto-populate discrete data fields if the information already exists in the EHR (eg, if a team member has entered the date of "last menstrual period," optimize your technology so no one has to reenter that data into the order for a pap smear).
Allow verbal orders	• Allow verbal orders in low risk and crisis situations as legally permitted.

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Table 3, continued

Opportunity to act	Deimplementation action
Reduce signature requirements	• Eliminate signature requirements for forms that do not legally require a physician signature. • Remove order requirements for low-risk activities that do not legally require a physician signature (eg, ear wash, fingerstick glucose, oximetry). • Do away with "challenge questions" to electronically sign orders when the user is already logged in and actively using the EHR.
Reduce attestations required daily or every time one logs in	• Eliminate actions as allowed by state or federal requirements (ie, for privacy protection attestation) that occur on a daily or every-time-one-logs-in basis (ie, consider whether or not an annual attestation is sufficient).
Reduce note bloat	• Delete unnecessary sections of patient notes that are not important for patient care and are not required for billing/coding purposes.
Reduce inbox notifications	• Prevent unnecessary messages and notifications from entering the EHR Inbox via upstream system-level interventions • See the EHR Inbox Reduction Checklist (Table 2).
Reduce the frequency of reminders for screening questions or tests	• Include a "grace period" of at least 30% to 50% of the recommended screening interval when constructing a performance measure from a clinical practice guideline. For example, if the clinical practice guideline recommends annual screening for depression, then set performance measurement with an interval of performing this task within 18 months. Otherwise, team members will waste limited clinical resources screening more often than is required to meet the 365-day annual interval.

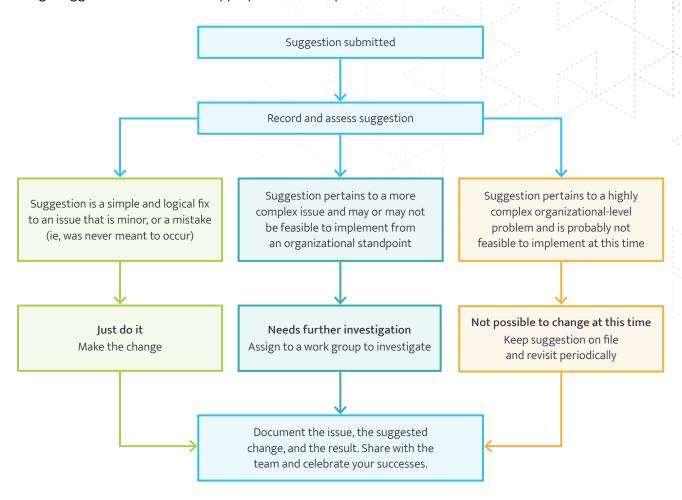## Involve Your Frontline Clinicians

In addition to following the checklists in this playbook, solicit feedback and ideas for "getting rid of stupid stuff" from your frontline clinicians. The Getting Rid of Stupid Stuff (GROSS) toolkit details how to set up a comprehensive de-implementation program based on clinician input. You will be surprised by how many suggestions fall into the "just do it" category!

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Figure 2. Getting Rid of Stupid Stuff Decision Tree

Triage suggestions to determine appropriate next steps.

```
                          ┌─────────────────────────┐
                          │   Suggestion submitted   │
                          └─────────────────────────┘
                                      │
                          ┌─────────────────────────┐
              ┌───────────│ Record and assess        │───────────┐
              │           │ suggestion               │           │
              │           └─────────────────────────┘           │
              ▼                      ▼                           ▼
  ┌─────────────────────┐ ┌─────────────────────┐ ┌─────────────────────┐
  │ Suggestion is a     │ │ Suggestion pertains │ │ Suggestion pertains │
  │ simple and logical  │ │ to a more complex   │ │ to a highly complex │
  │ fix to an issue     │ │ issue and may or    │ │ organizational-level│
  │ that is minor, or a │ │ may not be feasible │ │ problem and is      │
  │ mistake (ie, was    │ │ to implement from   │ │ probably not        │
  │ never meant to      │ │ an organizational   │ │ feasible to         │
  │ occur)              │ │ standpoint          │ │ implement at this   │
  │                     │ │                     │ │ time                │
  └─────────────────────┘ └─────────────────────┘ └─────────────────────┘
              │                      │                           │
              ▼                      ▼                           ▼
  ┌─────────────────────┐ ┌─────────────────────┐ ┌─────────────────────┐
  │ Just do it          │ │ Needs further       │ │ Not possible to     │
  │ Make the change     │ │ investigation       │ │ change at this time │
  │                     │ │ Assign to a work    │ │ Keep suggestion on  │
  │                     │ │ group to investigate│ │ file and revisit    │
  │                     │ │                     │ │ periodically        │
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              │                      │                           │
              │                      ▼                           │
              │    ┌─────────────────────────────────┐          │
              └───▶│ Document the issue, the          │◀─────────┘
                   │ suggested change, and the result.│
                   │ Share with the team and          │
                   │ celebrate your successes.        │
                   └─────────────────────────────────┘
```

EXPLORE MORE!
- Saving Time playbook
- Getting Rid of Stupid Stuff toolkit
- Building Trust: Addressing Inefficiencies video
- Joy in Medicine – Efficiency of Practice Environment video
- Improve Practice Efficiency with EHR "Quick Wins" podcast
- Reduce Pajama Time and Work Outside of Work (WOW) podcast
- Treating Attention as an Asset podcast
- Small Interventions Matter podcast

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Look Upstream: Prevent the Deluge

Looking even more upstream than the system-level approaches previously described, physicians can further reduce their extraneous EHR work by:

1. **Sharing clinical notes with patients**—writing clear notes that patients can read and reference as needed on their own after the visit

2. **Choosing Wisely®** when determining what tests to order in the first place. Careful and appropriate test selection can be an impactful shift in practice culture—the fewer tests you order, the fewer results enter your inbox!

Sharing Clinical Notes With Patients

Shared visit notes, sometimes called "open notes," are everyday clinician notes made readily available to patients via the EHR patient portal. In April 2021, US regulation mandated that all US health care organizations adopt shared visit notes. Though some physicians felt (and may still feel) skeptical about the concept of open notes, one potential benefit is that it allows patients to readily access their care plans in detail, which may decrease follow-up questions and concerns—saving time for both patients and clinicians (Figure 3).

The **Sharing Clinical Notes With Patients toolkit** describes in detail the STEPS you can take to effectively write and share clinical notes in order to reap the benefits depicted in Figure 3.

EXPLORE MORE!

- Sharing Clinical Notes With Patients toolkit
- Adopting OpenNotes webinar
- Sharing Clinical Notes With Patients podcast

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Sharing Clinical Notes With Patients

- Tell patients during their visits that they can access their visit notes to help clarify any questions that come up about the care plan after the visit.
- Minimize "note bloat" to prevent unnecessary patient questions or points of clarification: only include what is truly necessary in the note (eg, no review of systems, no social history).

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Figure 3. Benefits of Sharing Clinical Notes[4]

Benefits for Patients

Research shows that patients who read their notes say they:

- Feel more in control of and engaged in their health care

- Recall their care plan more accurately

- Are better prepared for visits

- Have a better understanding of their medical conditions and medications

- Are more likely to adhere to their medications

- Are able to identify clinically important errors in their notes

- Are not more worried or offended after reading their notes

- Have more successful conversations and stronger relationships with their doctors

Benefits for Clinicians

Research shows physicians and other clinicians who shared their notes reported:

- Improvements in patient satisfaction, safety, communication, and education

- Improvements in the patient–physician relationship, including enhanced trust, transparency, communication, and shared decision-making

- Patients who are better prepared for their clinic visits and are becoming more actively involved in their own care

- No increase in time needed to address patient questions about their notes

- Willingness among physicians to recommend to colleagues the use of open notes

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Choosing Wisely®

Finally, the ultimate upstream approach to decreasing inbox workload is to ask yourself, as a clinician: are you only ordering tests or treatments for your patients that are truly necessary and beneficial? Choosing Wisely® is a campaign from the American Board of Internal Medicine (ABIM) Foundation and Consumer Reports that aims to promote conversations between patients and clinicians to choose care that is:

- supported by evidence
- not duplicative of other tests or procedures already received
- determined to have the lowest possible risk for harm
- truly necessary

The **Choosing Wisely® toolkit** describes in greater detail how you can use this strategy in your practice. It is not a set of rigid guidelines but a strategy for engaging with patients and colleagues.

EXPLORE MORE!

- Choosing Wisely® toolkit

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Choosing Wisely

- Tailor Choosing Wisely recommendations to your patient panel, and share the resource with patients to help them understand why sometimes less is more.

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Strategy 2: Share the Necessary Work

Of course, after optimal de-implementation to reduce unnecessary work, there is still much necessary work to accomplish in the EHR at the end of the day. The key here is involving the entire care team to share this workload—this is essential for effectively taming the EHR.

Core team-based care workflows for managing EHR work include:

- EHR inbox management (including patient portal optimization)

- Annual prescription renewals and medication management

- Pre-visit planning and pre-visit labs

- Team documentation

This section will help you **tame the EHR** by:

- Implementing fundamental team-based care workflows to help you manage the necessary, value-adding EHR work

EHR Inbox Management

While the crux of EHR inbox management lies in looking upstream to prevent unnecessary messages and notifications from being routed to the inbox in the first place (see Strategy 1: Stop the Unnecessary Work), the EHR Inbox Management toolkit describes the next downstream phase: empowering team members to contribute meaningfully to the necessary aspects of inbox management (Figure 4).

Key STEPS are:

1. Engage the IT department
2. Group different types of messages into common buckets
3. Create team pools corresponding to each bucket of messages
4. Assign team members to cover team pools
5. Develop workflows and train team members to manage team pools

For additional focus on the patient portal component of the EHR inbox, the **Patient Portal Optimization toolkit** suggests ways to triage and manage patient portal messages effectively.

EXPLORE MORE!

- EHR Inbox Management toolkit
- Patient Portal Optimization toolkit
- Improve Practice Efficiency with EHR "Quick Wins" podcast
- Success Story: The Inboxologist
- Success Story: Leverage Standing Orders and Protocols to Ease In-Basket Burdens
- Success Story: Teamwork Tames the Inbox

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Figure 4. Suggested Team-Based EHR Inbox Management Workflow

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

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EHR Inbox Management

- Physical co-location or brief huddles between team members and physicians can eliminate unnecessary back-and-forth message exchanges.
- Instead of setting aside time, encourage team members to use any free moments to check the EHR inbox. For example, longer appointments may give team members who aren't part of the visit a 10- to 15-minute window to check the EHR inbox throughout the day.
- Make patients aware that patient portal messages are addressed by the entire care team using a standardized protocol, so they are not expecting immediate and personalized responses from physicians.

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Annual Prescription Renewal and Medication Management

Managing multiple medications is another time sink for physicians: during a brief visit, how do you fill or refill medications efficiently, reconcile all medications, and ensure that patients are taking them as prescribed? Using effective team-based workflows for medication management and refills reduces this burden on physicians and helps the team by preventing unnecessary refills requests or medication questions from patients.

The **Annual Prescription Renewal toolkit** is devoted to synchronizing all prescription renewals at the same visit once per year. You could save up to **5 hours a week** by writing prescriptions for medications that treat chronic conditions so that all patients receive a 90-day supply filled 4 times a year.[5] The shorthand for this is "90x4."

Choose one visit, such as the annual wellness visit, to renew all medications, even if there are still a few refills on some of the older prescriptions. It may be helpful to write a note to the pharmacist that states, "This prescription replaces all prior prescriptions for this medication and dose. Please synchronize all chronic medications from Dr Smith on the same day each year and refill every 3 months." This may seem intuitive, but you'd be surprised to find that many practices don't have processes for synchronizing and standardizing recurring patient prescriptions.

The **Medication Management toolkit** builds on the Annual Prescription Renewal toolkit with additional STEPS to use the EHR to effectively manage medications, including optimizing medication reconciliation, streamlining prior authorizations, and communicating with pharmacies. Again, the key is to empower team members to contribute in a meaningful way to medication management.

EXPLORE MORE!

- Annual Prescription Renewal toolkit
- Medication Management toolkit
- Success Story: Annual Prescription Renewals Could Save Hundreds of Hours Each Year for Your Organization
- Success Story: Four Interventions Stemmed the Tide of Refill Requests

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Medication Management

- 90x4 is one of the easiest, most impactful ways to change how you manage medications.
- Training team members on proper medication reconciliation is key to improving medication management.

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Pre-Visit Planning and Pre-Visit Laboratory Testing

In addition to medication management, pre-visit planning and pre-visit laboratory testing are powerful tools for reducing physician EHR burden while also alleviating stress on the team by preventing unnecessary follow-up calls or messages from patients about lab and test results, follow-up appointments, and care gaps. This concept of "flipping the visit" takes practice and teamwork but will ultimately benefit patients, team members, and physicians.

The **Pre-Visit Planning toolkit** covers STEPS for implementing a comprehensive pre-visit to day-of-visit workflow, as illustrated in Figure 5.

Figure 5. Optimal Pre-Visit Planning Workflow

At the End of the Current Visit	Between the Current and the Next Visit	On the Morning of the Next Visit
1 Use a Visit Planner Checklist to Preorder Labs and Other Needed Tests for the Next Visit	**4** Use a Checklist to Review Pre-Visit Tasks	**6** Hold a Pre-Clinic Team Huddle
2 Schedule the Next Follow-Up Appointment	**5** Send Patient Appointment Reminders	**7** Use a Pre-Appointment Questionnaire to Gather Patient Updates
3 Arrange for Tests to Be Completed Before the Next Visit		**8** Perform a Handoff of the Patient to the Physician

The **Pre-Visit Laboratory Testing toolkit** hones in on the process of pre-ordering labs before the patient's next visit, delegating order entry, and empowering team members to act appropriately when lab results are returned to the inbox.

EXPLORE MORE!

- Pre-Visit Planning toolkit

- Success Story: Decrease Patients With Poorly Controlled Diabetes By One-Third

- Pre-Visit Laboratory Testing toolkit

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Pre-Visit Planning

- Empower care team members to use a checklist to close potential gaps in care before the physician sees the patient.

- Take a long view: schedule several future planned care visits at once.

- Use a pre-appointment questionnaire for patients on the day of their visit to gather updates.

Team Documentation

Team documentation is a cornerstone of taming the EHR. This is the process where either clinical team members (eg, MAs, LPNs, or RNs) or nonclinical documentation assistants (eg, scribes, students) assist physicians during a patient visit to document certain sections of the visit notes, enter orders and referrals, and prepare prescriptions (Figure 6). Even patients themselves can contribute to writing their history of present illness (HPI) with some newer EHR functionalities. The training and skill level of the team member will determine the scope of responsibility. This process improves patient-centered care as the physician is less focused on EHR documentation and can give undivided attention to the patient. The **Team Documentation toolkit** describes this process in greater detail.

QUESTION:

Can a documentation assistant enter orders dictated by a physician during a visit?

According to the Joint Commission, any licensed, certified, or unlicensed team member, including registered nurses, licensed practical nurses, medical assistants, and clerical personnel, may enter orders at the direction of a physician.

Team members who are not authorized to "submit" orders should leave the order as "pending" for a certified or licensed team member to activate or submit after verification. The authority to pend vs activate or submit orders varies based on state, local, and professional regulations. In either case, the use of repeat-back of the order by the documentation assistant is encouraged, especially for new medication orders. The Joint Commission does not consider orders transcribed into the EHR to be verbal orders.

While the Centers for Medicare & Medicaid Services (CMS) is silent on who may enter orders, in general, CMS considers diagnostic test order requirements met if there is an authenticated medical record by a physician supporting their intent to order the tests. Again, this may vary by state, local, and professional regulations.

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Figure 6. Sample Team Documentation Workflow

Patient check-in ┈┈┈→ **Patient rooming**

Take vital signs, determine chief complaint, update past family and/or social history, update immunizations, etc.

Areas where others could assist in the team documentation process while they are with the physician and patient in the exam room

Patient interview and examination

During the physician's discussion with the patient, the documentation assistant records the history and exam as directed by the physician.

Plan of care and clinical documentation

While the physician and the patient discuss the plan of care and next steps, the documentation assistant records the plan and fills in the details for the after-visit summary.

Prescription, order, and referral processing

Throughout the visit, the documentation assistant can place orders, ensuring that any orders are prepared for the physician's signature as appropriate.

Patient education and care coordination

Reinforce next steps of care as well as provide immunizations, patient education and health coaching, order and schedule laboratory tests, screenings, etc.

Patient check-out

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EXPLORE MORE!

- Team Documentation toolkit
- Team Documentation: Improve Efficiency of EHR Documentation video
  Part 1 | Part 2
- Training Medical Assistants as "Encounter Specialists" podcast
- Success Story: Working Smarter in Primary Care Means Transitioning to In-Room Physician Support
- Success Story: Team Approach to Visit Documentation Saves Time
- Success Story: Encounter Specialist Model Promotes Physician and Team Satisfaction

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Team Documentation

- With proper training, both clinical and nonclinical documentation assistants can perform the same documentation duties.
- Team documentation instills a sense of cooperation and empowerment among care team members, resulting in greater professional satisfaction.
- Team documentation enhances the patient–physician relationship by allowing physicians to give their undivided attention to patients.

Strategy 3: Optimize Personal Proficiency with EHR Technology

While the system- and practice-level efforts described in Strategies 1 and 2 are foundational for successfully taming the EHR, becoming more personally proficient with the technology itself can offer some valuable time-saving tricks.

This section will help you **tame the EHR** by:

- Boosting confidence as an EHR user with easy wins and small changes that add up to save you hours each week

- Enhancing Epic or Oracle Cerner skills with efficiency-boosting tips developed by vendor experts for AMA STEPS Forward®

EHR Tips and Tricks

First, recognize that the EHR is intimidating for even the most technologically savvy individual. If you are a physician struggling with your relationship with the EHR, do not feel the need to master it immediately. Start with easy wins that can save you hours each week (Table 4).

Table 4. Tips for Daily EHR Users

ASK…	CUSTOMIZE…
…your colleagues to share their most useful EHR tip(s) with you	…chart review with filters or shortcuts
…if your organization has EHR physician champions or IT experts who can meet with you one-on-one for 30 minutes to provide some tips	…note-writing by setting up autocorrect and creating note templates without unnecessary sections, such as PMH, PSH, ROS
…your practice manager to block off 1 to 2 appointments each month to update your EHR features to save you time in the long run	…order entry by using standing order sets or protocols for common orders, such as immunizations, screening tests, and labs

Next, employ the efficiency-boosting tips described for Epic users (Table 5) or Oracle Cerner users (Table 6). Find a link to a more detailed list of tips for both vendors on the Resources and Information page.

The AMA does not endorse any products. EHR vendors are welcome to email stepsforward@ama-assn.org to share additional EHR tips and tricks for consideration.

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Table 5. Efficiency-Boosting Tips for Epic Users*

Epic Tips for Efficiency

1. Turn off notifications

2. Create future reminders for yourself

3. Perform quick chart searches

4. Use chart filters

5. Use Autocorrect

6. Use Smartphrases

7. Save favorite orders

8. Use the "Make Me Author" function for team documentation

Table 6. Efficiency-Boosting Tips for Oracle Cerner Users*

Oracle Cerner Tips for Efficiency

1. Customize the Workflow navigator

2. Use the Documents Mpage component

3. Set up split screen documentation in Contextual View

4. Set up documentation accelerators, such as Autotexts and Smart Templates

5. Share custom Autotexts with other team members

6. Use the Quick Orders Mpage

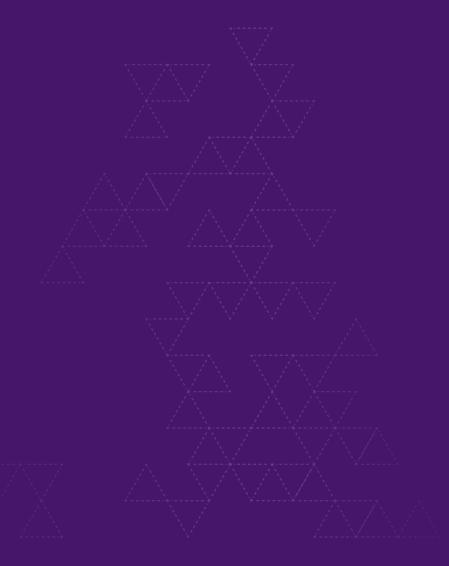7. Use Shared Orders folders

8. Create Favorites folders and add them to your Quick Orders Mpage

Tips current as of April 2022; check with your IT department or vendor service representative for the latest information.

Strategy 4: Gather Data

Gathering accurate and up-to-date EHR use data or metrics is essential for measuring progress and success as well as identifying areas of continued focus for the organization.

This section will help you **tame the EHR** by:

- Defining core EHR use metrics

- Using EHR data to identify areas of need and measure progress

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Core EHR Use Metrics

EHR-use metrics offer the opportunity to quantitatively measure the physician work experience and assess the impact of interventions designed to improve it. Metrics extracted from EHR audit log data can answer questions such as:

- **How much time are physicians spending on the EHR during the clinic day?**
- **How much time are physicians spending on EHR work after hours?**
- **Have the number of inbox messages that physicians and their teams manage changed over time?**
- **Are the interventions implemented to reduce clerical burdens making a difference?**

The organization can also use this data to identify particularly efficient individuals from whom others can learn; alternatively, the data can identify those needing assistance and for whom increased staffing, training, or both may be prudent.

Table 7 defines helpful core EHR use metrics.[6] All time-based EHR-use metrics are normalized to 8 hours of scheduled patient time.

QUESTION: How do you extract the data to calculate the EHR-use metrics from the vendor-provided data?

An organization with a sophisticated and well-resourced IT department can go into its EHR's audit logs and extract the information needed for the above metrics. Two vendors provide "off-the-shelf" measures of EHR use: Oracle Cerner via its Advance program and Epic via Signal. Organizations cannot directly compare data from Oracle Cerner's Advance program to Epic's Signal program because of differences in how the data is extracted and categorized. Off-the-shelf measures from vendors other than Epic or Cerner will require additional time and discussion with your IT team or vendor implementation specialists to fully understand the capture of their measures and how they can be transformed into the EHR use metrics above.

See the Extracting EHR-Use Metrics Guide (PDF) for specific formulas to calculate EHR-use metrics using Epic's or Oracle Cerner's programs and normalize the data to an 8-hour workday.

EXPLORE MORE!

- EHR Optimization toolkit
- Electronic Health Record Optimization podcast
- Taming the EHR podcast
- Success Story: Make the Electronic Health Record Work Easier and Cut Down on Daily Clicks

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Table 7. Definitions of Core Metrics Used to Evaluate EHR Use[6]

MEASURE	ABBREVIATION	DEFINITION AND EXAMPLE
Total EHR Time	**EHR-Time$_8$**	Total time on EHR (during and outside of clinic sessions) per 8 hours of patient-scheduled time. **Example:** A physician with 32 patient-scheduled hours per week, 20 hours of EHR-time during scheduled hours, 10 hours of WOW each week would have EHR-Time$_8$ of 30/32 x 8 = 7.5
Work Outside of Work	**WOW$_8$**	Time on EHR outside of scheduled patient hours per 8 hours of patient-scheduled time **Example:** A physician with 32 patient-scheduled hours per week and a total of 10 hours of EHR time outside of these scheduled hours would have WOW$_8$ = 10/32 x 8 = 2.5
Time on Encounter Note Documentation	**Doc-Time$_8$**	Hours on documentation (note-writing) per 8 hours of scheduled patient time **Example:** A physician with 32 patient-scheduled hours per week and a total of 20 hours of documentation time (both in the room with the patient and outside of the room) per week would have DocTime$_8$ of 20/32 x 8 = 5.0
Time on Prescriptions	**Script-Time$_8$**	Total time on prescriptions per 8 hours of patient scheduled time **Example:** A physician spends 3 hours per week on prescription work and has 24 hours of patient-scheduled time per week. Script$_8$ = 3/24 x 8 = 1
Time on Inbox	**IB-Time$_8$**	Total time on inbox per 8 hours of patient-scheduled time **Example:** A physician spends 10 hours per week on Inbox work and has 20 hours per week of patient-scheduled time. IB$_8$ = 10/20 x 8 = 4
Teamwork for Orders	**TWORD**	The percentage of orders with team contribution **Example:** A physician working with a team that is empowered to pend, send orders by protocol, or operationalize verbal orders, may compose 25% of the orders from start to finish on their own, while the rest are pended or completed by team members for the physician's co-signature. In this case TWORD = 75%
Undivided Attention	**ATTN**	The amount of undivided attention patients receive from their physician. It is approximated by [(Total time per session) minus (EHR time per session)]/Total time per session **Example:** A physician who is actively on the EHR 3 hours of a 4-hour clinic session would have a lower ATTN score (4-3)/4 = 0.25 than would a physician who was actively on the EHR 1 hour of a 4-hour clinic session. (4-1)/4 = 0.75

Conclusion

In this era, no one wants to go back to paper charts. But as with any technological tool, physicians and health care systems need to learn how to harness the power of the EHR and use it effectively. The key to mastering and taming the EHR is not better training for the EHR users (though this is helpful) but creating and maintaining the necessary system-level procedures and resources to maximize team-based care and eliminate unnecessary work.

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Resources and Further Information

For the optimal experience—GO DIGITAL!

Scan this QR code to fully engage with the playbook and access all relevant links on your computer or mobile device.

Related Playbook

For additional time-saving and efficiency-boosting tips, check out the companion AMA STEPS Forward *Saving Time Playbook* (PDF).

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Saving Time Playbook

from the AMA STEPS Forward® Playbook Series

Practical Tools

The selected practical tools listed here are to get you started on several of the new or adapted processes outlined in this playbook. The individual toolkits on the AMA STEPS Forward® website include these and additional resources. Click on the following links for direct access to the listed resources.

Sharing Clinical Notes With Patients • Pocket Card	**Medication Management** • Questions to Help Uncover Nonadherence
Choosing Wisely® • Using Choosing Wisely® Tools to Empower Patients	**Pre-Visit Planning** • Pre-Visit Questionnaire
EHR Inbox Management • EHR Inbox Reduction Checklist • Inbox Buckets and Team Pool Assignments Visual • Sample Intake Processes for Telephone and Refill Encounters	**Pre-Visit Laboratory Testing** • Visit Planner Checklist: Order Sheet for Patient Visits
Annual Prescription Renewal • Annual Prescription Renewal: Implementation Checklist	**EHR Optimization** • Eight Efficiency Boosting Tips for Epic Users • Eight Efficiency Boosting Tips for Oracle Cerner Users • Extracting EHR-Use Metrics Guide

Key Journal Articles

- Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med*. 2016;165(11):753-760. doi:10.7326/M16-0961

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Learn More About Practice Innovation

Take the next steps on your journey with the AMA STEPS Forward® practice innovation resources and assets.

Use the 5-pronged approach (Act, Recognize, Measure, Convene, Research) as your guide. Employ the evidence-based, field-tested, and targeted solutions described below to optimize practice efficiencies, reduce burnout, and improve professional well-being.

Act

- View the comprehensive portfolio of AMA STEPS Forward® resources at stepsforward.org, including toolkits, playbooks, videos, webinars, podcasts, and calculators.
- The AMA's Mentoring for Impact program provides virtual meetings with a Professional Satisfaction and Practice Sustainability Group physician who can help develop a customized approach to remove obstacles that interfere with patient care. For more information, email stepsforward@ama-assn.org (include "Mentoring for Impact" in the subject line).

Recognize

- Participate in the AMA STEPS Forward® Recognition of Participation certificate program and find new ways to engage with your team.
- Use the AMA Joy in Medicine™ Health System Recognition Program as a road map to support your organization's strategic efforts.

Measure

- Take our practice assessment to identify and prioritize your workflow intervention efforts.
- Encourage your organization to measure professional well-being on an annual basis.

Convene

- Join us at the AMA STEPS Forward® Innovation Academy for timely, relevant webinars and more.
- Attend the International Conference on Physician Health™ (ICPH), the American Conference on Physician Health (ACPH), and other upcoming conferences, summits, and events as they are announced.

Research

- Stay abreast of meaningful research to guide your professional well-being strategies and interventions.

Watch the AMA Professional Satisfaction and Practice Sustainability video or visit stepsforward.org to learn more.

About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient–physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for— the operational, financial, and technological aspects of a physician's practice.

Learn more.

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