Reclaiming Your Joy: Strategies to increase professional satisfaction in your clinical practice

American College of Physicians
New Mexico Chapter Meeting
November 2, 2018

Suja Mathew, MD, FACP
Governor, ACP Northern Illinois
Practice Transformation Consultant,
American Medical Association
Chair of Medicine,
Cook County Health
Objectives

• Define burnout
• Identify the prevalence of burnout among American physicians and the factors correlating with low physician satisfaction
• Recognize consequences of physician burnout on individual physicians, organizations, and society
• Identify possible strategies to combat physician burnout
No relevant financial disclosures
Percent of Physicians Who Report “Burn-Out”

100%  0%

45% in 2011  54% in 2014  ? in 2018

Physician Burnout and Depression

- Burned out: 42%
- Colloquially depressed: 12%
- Clinically depressed: 3%
Physician vs Population

Not Quite the Same as Dissatisfaction or Disengagement

Dissatisfaction

Disengagement

“I don’t want to do this”

“I don’t like this”

BURN OUT
I Can’t Do This!
Three Components of Burnout

1. Emotional exhaustion*
2. Depersonalization, cynicism, or dehumanization
3. Inefficacy, diminished sense of personal accomplishment

Burnout in Action

- High turnover
- Difficulty recruiting
- Disruptive physician behavior/complaints
- Lack of engagement in QI/strategic projects
- Poor attendance at staff meetings
- Flat refusal to see patients
- Angry complaints about work environment
- Disengagement with low patient satisfaction scores
- Demand for compensation

Burnout May Cost US Healthcare

Physician burnout is associated with…

- More Referrals
- Increased Testing
- Fewer PCPs
- Higher rates of self-reported errors
- Longer post-discharge recovery time

Social Science and Medicine 1999; (48):547-557
Arch Intern Med. 2011;171(17):1582-1585
http://content.healthaffairs.org/content/29/5/835.full
Patient Safety

• Surgeons
  – Shanafelt (2010) found that 9% of surgeons reported a major medical error in preceding 3 months, and they were significantly more likely to have symptoms of burnout

• Trainees
  – West (2006) showed that burned out residents were more likely to make medical errors, by self-report
  – Fahrenkopf (2008) found increased risk of medication errors among residents who were depressed of burned out
Health systems can’t perform well with widespread burnout

**Burnout Costs Organizations**

Physician burnout is associated with…

- ↑ Malpractice risk
- ↓ Productivity
- ↑ Part time
- ↑ MD and staff turnover

Replace PCP costs $250,000

- (1999)

Shanafelt et al. Physician Burnout and Reductions in Professional Work Effort
Mayo Clinic Proc 2016;911(4):422-431
Am J Man Care Jul 2001;7(7):701-713
BMC Health Services Research, 14(325).
Med. Care Mar 2006;44(3):234-242
http://psycnet.apa.org/?&fa=main.doiLanding&doi=10.1037/0021-9010.73.4.727
More Consequences of Physician Burnout…

On organizational vitality
Burnout affects Patients

Physician burnout is associated with…

- Decreased Patient Adherence
- Less empathy
- ↓ Patient satisfaction
- Increased risk of patient changing providers

Is the professional satisfaction of general internists associated with patient satisfaction?


**MAIN RESULTS:** After adjustment, the patients of physicians who rated themselves to be very or extremely satisfied with their work had higher scores for overall satisfaction with their health care (regression coefficient 2.10; 95% confidence interval 0.73–3.48), and for satisfaction with their most recent physician visit (regression coefficient 1.23; 95% confidence interval 0.26–2.21). In addition, younger patients, those with better overall health status, and those cared for by a physician who worked part-time were significantly more likely to report better satisfaction with both measures. Minority patients and those with managed care insurance also reported lower overall satisfaction.

**CONCLUSIONS:** The patients of physicians who have higher professional satisfaction may themselves be more satisfied with their care. Further research will need to consider factors that may mediate the relation between patient and physician satisfaction.
Physician burnout is associated with…

- ↑ Divorce
- ↑ Substance abuse
- ↑ Accidents
- ↑ Death (Suicide 2-4 x)
Physicians frequently are early adopters of healthy behaviors based on their knowledge and economic resources. The mortality patterns of physicians in the United States, particularly suicide, have not been rigorously described for over a decade. Previous studies have shown lower all-cause mortality among physicians yet reported conflicting results about cause-specific mortality such as suicide. In this study, we compared all-cause and cause-specific mortality in a sample of physicians to the age-gender matched general U.S. population from 1948 through 1998. We also compared the mortality experience across medical specialities.

The risk of all-cause mortality was 56% lower than expected in men, and 26% lower in women, compared to the general population. Standardized mortality ratios (SMRs) were markedly lower for diseases strongly linked to smoking, e.g., cardiovascular diseases, respiratory diseases, and lung cancer. Suicide was the only cause of death where risk was greater than the general population. Overall, we found that physicians are at substantially lower risk of dying compared to the general population for all causes of death except suicide. The findings for suicide are strikingly different than other causes of death and should provide impetus for new research on the mental health of physicians.
More Consequences of Physician Burnout…

**On Physician Health**


Why Does Burnout Happen?

- Result of Interaction between
  - the worker and
  - the workplace
- Highly motivated professional into a dysfunctional workplace where unable to succeed without constant vigilance and focus
- Unstainable => Toxicity

Adapted from Maslach, 2001
<table>
<thead>
<tr>
<th>Negative</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Burnout</strong></td>
<td><strong>JOY</strong> (Work Engagement)</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Energy</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>Involvement</td>
</tr>
<tr>
<td>Inefficacy</td>
<td>Efficacy</td>
</tr>
</tbody>
</table>

Quadruple Aim
Expanding the Triple Aim

Bodenheimer and Sinsky. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Ann Fam Med 2014
Burnout Spectrum

Mark Linzer 2016, personal communication
In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Christine A. Sinsky, MD¹
Rachel Willard-Grace, MPH²
Andrew M. Schutzbank, MD³,⁴
Thomas A. Sinsky, MD¹
David Margolius, MD²
Thomas A. Bodenheimer, MD²

¹Medical Associates Clinic and Health Plans, Dubuque, Iowa
²Center for Excellence in Primary Care, University of California, San Francisco, California
³Beth Israel Deaconess Medical Center, Boston, Massachusetts
⁴Iora Health, Cambridge, Massachusetts

ABSTRACT

We wanted to gather innovations from high-functioning primary care practices that we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing family practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and workflow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.
Joy in Practice

Site visits to 23 high-performing practices (most PCMHs)

Workflow
Task distribution
Physical space
Technology
Drivers of Burnout

Work overload
Chaotic work environment
Time pressure
Loss of Control
Insufficient reward
Breakdown of community
Absence of fairness
Conflicting values

What Contributes to Physicians' Burnout?

- Too many bureaucratic tasks (eg, charting, paperwork) - 56%
- Spending too many hours at work - 39%
  - Lack of respect from administrators/employers, colleagues, or staff - 26%
- Increasing computerization of practice (EHRs) - 24%
- Insufficient compensation - 24%
- Lack of control/autonomy - 21%
- Feeling like just a cog in a wheel - 20%
- Lack of respect from patients - 16%
- Government regulations - 16%
- Decreasing reimbursements - 15%
- Emphasis on profits over patients - 15%
- Maintenance of Certification requirements - 12%
How Ambulatory Physicians Spend Our Time

- 38.5% EMR documentation and review
- 19.1% Administrative tasks related to insurance or billing
- 10.7% EMR review of test results, medication and other orders
- 6.1% Logistical arrangements, clinical planning

Save 3-5 hours/day

- Team doc/dictation to transcription: 1-2 hr
- Expanded rooming/discharge: 1 hr
- Pre-visit lab: ½ hr
- Prescription management: ½ hr
- Optimize physical space: 1 hr
- Automatic log in: ¼ hr
- Paper/verbal order entry: ½ hr

3+ hr/d
No thanks!

We are too busy
4000 Clicks per day

ER
- 10 hr shift
- 44% data entry
- 4000 clicks
- 28% patient

PCPs
- 11 hr day
- 50% computer
  - COE, inbox
- 20% patient
  - 1/3 screen gaze*

EHRs (esp. CPOE) → Burnout

- 44% dissatisfied with EHR
- 63% “EHRs make my work less efficient”
- Nearly half: “Spend too much time on clerical tasks”
- 41%: “EHRs did not improve care”
- EHR/CPOE use assoc with burnout (59% v 45% p <0.005)

“American physicians have become the most expensive data entry work force on the face of the planet.”

https://www.youtube.com/watch?v=RbWgJIOWQmQ&feature=youtu.be
Work after Work: Evidence From PCP Utilization of an EHR System

Brian Arndt, MD; John Beasley, MD; Jon Temte, MD PhD; Wen-Jan Tuan, MS MPH; Valerie Gilchrist, MD
University of Wisconsin Department of Family Medicine and Community Health

Context
- There is growing evidence related to EHR systems adoption and safety of health systems.
- Less is known about the impact of EHR on primary care, including:
  - When work is done in front of the EHR system during and after work hours
  - How much physician work in the EHR is related to face-to-face and non-face-to-face interactions:
  - Patient encounters
  - Smartsets activity selected for patient

Objective
- To assess usage with an EHR system during and after work hours
- Retrospective cohort study from 1/1/13 to 12/31/13
- System access logs were extracted to compute PCP time spent on various face and non-face tasks
- A fuzzy matching algorithm is used to restructure physician activities into events, and a manner to depict each physician's EHR interactions:
  - PATIENT ORDERS
  - PATIENT CLINICAL INFO
  - PATIENT CLINICAL INFO
  - CONNECTION EVENTS

Setting / Participants
- 130 family physicians (average age 3 years) from 18 clinics (residential and community) managed by the University of Wisconsin Department of Family Medicine and Community Health

Design
- Retrospective cohort study from 1/1/13 to 12/31/13
- System access logs were extracted to compute PCP time spent on various face and non-face tasks
- A fuzzy matching algorithm is used to restructure physician activities into events, and a manner to depict each physician's EHR interactions:

Results
- Average Time per Individual Encounter Type
- Average Time by EHR Task per Month
- Average Time by EHR Task per Month
- Average Time by EHR Task per Month
- Average Time by EHR Task per Month
- Average Time by EHR Task per Month

Work after Work: Evidence From PCP Utilization of an EHR System

32 hours Work after Work per month

1 full week/mo
“Pajama Time”
Sat nights belong to Epic

EHR Usage Frequency by Time of Day

1-2 hr/night
• Downing NL, Bates DW, Longhurst CA. Physician Burnout in the Electronic Health Record Era: Are We Ignoring the Real Cause?. Ann Intern Med. ;169:50–51. doi: 10.7326/M18-0139
AnnFamMed study results
(taken verbatim)

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 minutes, 44.2%).
Inbox management accounted for another 85 minutes (23.7%).

Scribes: What’s all the fuss?

• The fastest growing medical field
  – Nearly 20% of physicians now use scribes
  – 10% plan on hiring scribes in the near future
• May enhance physician efficiency, improve physician satisfaction, and increase billing.

# AMA On-line Calculators

**YOUR PRACTICE**

<table>
<thead>
<tr>
<th>Cost of physician's time</th>
<th>Work day</th>
<th>Clinic days per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3.00 /min</td>
<td>8 hours</td>
<td>220 days/year</td>
</tr>
</tbody>
</table>

**PHYSICIAN**

<table>
<thead>
<tr>
<th>Total visits per day</th>
<th>Physician documentation time</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 /day</td>
<td>10 min/visit</td>
</tr>
</tbody>
</table>

**FULL-TIME DOCUMENTATION SPECIALIST**

<table>
<thead>
<tr>
<th>Documentation specialist hourly rate (including benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$23.00 /hour</td>
</tr>
</tbody>
</table>

## TOTAL TIME SAVINGS

- **3h 20m** /day
  - Physician documentation time saved

## TOTAL FINANCIAL SAVINGS

- **$132,000**
  - Gross annual savings with team documentation
- **($40,480)**
  - Annual cost of dedicated documentation specialist
- **$91,520**
  - Net practice savings with team documentation

[https://www.stepsforward.org/modules/team-documentation#](https://www.stepsforward.org/modules/team-documentation#)
Physician, Scribe, and Patient Perspectives on Clinical Scribes in Primary Care

- Improved patient-physician interaction
- Improved documentation

Interview sites

<table>
<thead>
<tr>
<th>Site</th>
<th>Location</th>
<th>Recruited</th>
<th>Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleveland Clinic</td>
<td>Beachwood, OH</td>
<td>3 physicians, 4 scribes</td>
<td>3 physicians, 2 scribes</td>
</tr>
<tr>
<td></td>
<td>Brunswick, OH</td>
<td>2 physicians, 0 scribes</td>
<td>0 physicians, 0 scribes</td>
</tr>
<tr>
<td></td>
<td>Cleveland (main)</td>
<td>1 physician, 1 scribe</td>
<td>0 physicians, 0 scribes</td>
</tr>
<tr>
<td></td>
<td>Solon, OH</td>
<td>3 physicians, 4 scribes</td>
<td>2 physicians, 2 scribes</td>
</tr>
<tr>
<td></td>
<td>Twinsburg, OH</td>
<td>1 physician, 2 scribes</td>
<td>1 physician, 2 scribes</td>
</tr>
<tr>
<td></td>
<td>Strongsville, OH</td>
<td>7 physicians, 4 scribes</td>
<td>3 physicians, 3 scribes</td>
</tr>
<tr>
<td></td>
<td>Willoughby, OH</td>
<td>1 physician, 1 scribe</td>
<td>0 physicians, 0 scribes</td>
</tr>
<tr>
<td></td>
<td>Wooster, OH</td>
<td>4 physicians, 4 scribes</td>
<td>2 physicians, 2 scribes</td>
</tr>
<tr>
<td>Bellin Health</td>
<td>Green Bay, WI</td>
<td>1 physician, 1 scribe</td>
<td>1 physician, 1 scribe</td>
</tr>
<tr>
<td>Dekalb Medical Health Group</td>
<td>Auburn, IN</td>
<td>2 physicians, 1 scribe</td>
<td>1 physician, 0 scribes</td>
</tr>
<tr>
<td>Martin’s Point Healthcare</td>
<td>Bangor, ME</td>
<td>2 physicians, 2 scribes</td>
<td>2 physicians, 2 scribes</td>
</tr>
<tr>
<td>Quincy Family Practice</td>
<td>Quincy, IL</td>
<td>2 physicians, 2 scribes</td>
<td>1 physician, 1 scribes</td>
</tr>
<tr>
<td>University of Utah</td>
<td>South Jordan, UT</td>
<td>2 physicians, 2 scribes</td>
<td>2 physicians, 2 scribes</td>
</tr>
</tbody>
</table>
Adjusted MA Role

Before MD
• Rooms patient
• Collects and documents SH, ROS, etc
• Updates background info

With MD
• Presents info to MD
• MD has direct conversation

After MD
• Scribes remainder of visit
• Enters orders
• Reviews plan
Pre-visit (MA)
  - Med Rec
  - Agenda, HPI

Visit (MA + MD)
  - med, lab, x-ray orders
  - followup

Post-visit (MA)
  - Reviews visit summary
  - Health coaching

MD → next patient
Team Documentation
Cleveland Clinic

• New Model
  – 2 MA: 1 MD
  – 2 pt/d cover cost
  – 21 → 28 visits/d
  – 30% ↑ revenue
  – Spread to others
  – “We’re having FUN”

• Research
  – Q doc as good or better J Fam Pract 2016
I used to spend an hour or two in the evening after my family went to bed completing my charts for the day. I haven’t logged on from home in so long, I’ve forgotten how to use the remote access system.

Kevin Hopkins M.D.
The MA’s are more fully engaged in patient care than they have ever been and they enjoy their work...They have increased knowledge about medical care in general and about their individual patients in particular.

Kevin Hopkins M.D.
How satisfied are you in your role?

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Dissatisfied/Dissatisfied</td>
<td>42%</td>
<td>0%</td>
</tr>
<tr>
<td>Neutral</td>
<td>24%</td>
<td>14%</td>
</tr>
<tr>
<td>Satisfied/Very Satisfied</td>
<td>34%</td>
<td>86%</td>
</tr>
</tbody>
</table>
Voice recognition software

• Useful, but technology is still early
• Most impactful for those who struggle with typing

• Stanford Children’s Health
  – Used by 12 out of 200

• Universal health Services (King of Prussia, PA)
  – 60% reduction in transcription costs
  – 36% improved documentation of severity of illness

The Medical Group Leader’s EMR Optimization Playbook.
Other EMR shortcuts

• Templates
• Auto-text
• Smart phrases
  – .risk
  – .lastweight
  – .lastbp
• Sticky notes
  – Remember family member names, favorite vacations
• Many EMRs can track time and performance variables
What Contributes to Physicians' Burnout?

- Too many bureaucratic tasks (e.g., charting, paperwork) 56%
- Spending too many hours at work 39%
- Lack of respect from administrators/employers, colleagues, or staff 26%
- Increasing computerization of practice (EHRs) 24%
- Insufficient compensation 24%
- Lack of control/autonomy 21%
- Feeling like just a cog in a wheel 20%
- Lack of respect from patients 16%
- Government regulations 16%
- Decreasing reimbursements 15%
- Emphasis on profits over patients 15%
- Maintenance of Certification requirements 12%
OLD MODEL OF PATIENT CARE

- Paper Work
- Medication Refill
- Chronic Disease Management
- Test Results
- Acute Visits
- Preventative Visits
- Patient Orders/Triage

- Referral to Ancillary Services
- CMA/LPN
- RN
- Referral to Specialist
- Managing Messages, Test Results, Calling Patients

PROVIDER
Redistribute Work Strategically

- “Instead of sending all the work to the most highly trained person to distribute...think about how the work can be distributed before it gets to the most highly trained person.”
  – Bruce Bagley 4/1/16 AMA Wire
Daily Huddles

South Huntington BWH
Daily Huddles

• 5-10 minutes long
• All team members present
• Set out the plan for the day
  – Patients requiring additional attention
  – Problems with supplies
  – Room set up needs
  – Etc.
Pre-visit Planning

• Review last note and ensure testing is complete
• Use registry or pre-visit checklist to identify gaps in care
• Remind patients of appointments and what to bring
Mayo-Red Cedar arranges for pre-visit lab
Visit prep checklist

If you have a new complaint, please describe the symptom and indicate how long it has been present, when it is better or worse and any other information that might be helpful to the physician and/or staff.

<table>
<thead>
<tr>
<th>Preventive screening</th>
<th>Due</th>
<th>Up-to-date</th>
<th>N/A</th>
<th>Target population and recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAP</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age 21 to 65 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 3 years if no history of abnormal PAPs (or every 5 years if over 50 and most recent PAP negative and HPV-negative)</td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age 50 to 75 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 1 to 2 years; or for those 40 to 50 and &gt;75 screening is optional</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age 50 to 75 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 10 years (more frequent if history of colon polyp or family history of colon cancer)</td>
</tr>
<tr>
<td>Bone density scan</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age 65 years</td>
</tr>
<tr>
<td>(DEXA)</td>
<td></td>
<td></td>
<td></td>
<td>Every 10 years for women if previous results were normal; every 5 years if symptoms of osteopenia exist</td>
</tr>
<tr>
<td>Abdominal aortic</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age 65 to 75 years</td>
</tr>
<tr>
<td>aneurysm</td>
<td></td>
<td></td>
<td></td>
<td>One-time screening for men who have ever smoked</td>
</tr>
<tr>
<td>Visual acuity</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age &gt;65 years (new Medicare enrollee)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Can be completed during the “Welcome to Medicare” visit</td>
</tr>
<tr>
<td>Glaucoma screen</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age &gt;65 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annually</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Due</th>
<th>Up-to-date</th>
<th>N/A</th>
<th>Target population and recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap vaccine</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age &gt;10 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Administer Tdap once; boost with Td every 10 years</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age &gt;6 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Annually</td>
</tr>
<tr>
<td>Shingles vaccine</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age &gt;60 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Option if &gt;50 years</td>
</tr>
<tr>
<td>Pneumococcal vaccine (PCV13 or PPSV23)</td>
<td></td>
<td></td>
<td>N/A</td>
<td>Age &gt;65 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PCV13 now, followed by PPSV23 six to 12 months later</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If already received PPSV23, wait at least one year before giving PCV13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patients age 18 to 65 with a chronic* or immunocompromising condition may also need a pneumococcal vaccine.</td>
</tr>
</tbody>
</table>

Source: AMA. Practice transformation series: Implementing a daily team huddle. 2015.

*Chronic conditions include: COPD, DM, CVD, CKD, chronic liver disease, splenectomy, etc.

Please note that these clinical guidelines change frequently and are meant as an example only. The checklist can be modified so you can update it based on your patient population and current guidelines. You may use this checklist to build the capability to “flag” upcoming care needs in your electronic health record (EHR).
Rooming Protocols

• 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
• Provide immunizations based on standing orders
• Arrange for preventive services based on standing orders
• Assemble medical equipment, if needed, before the physician enters the exam room

https://www.stepsforward.org/modules/patient-discharge-and-rooming
# Rooming checklist

## Prior to the visit
- Review the last clinic note and completed pre-appointment questionnaire. This will help staff prepare the patient and physician for the visit.
- Gather test results obtained prior to the visit. If the patient had pre-visit laboratory tests completed, prepare the results for the visit. Some clinics print the results to share with the patient.
- Compile relevant data specific to the visit. Gather emergency room notes, hospital discharge summaries, consultations, etc. if relevant to the visit. Use a visit prep checklist to identify what care gaps can be closed during the upcoming appointment.

## During rooming
- Greet the patient in the waiting room. Introduce yourself by providing your name and role (e.g., “Hello Mr. Smith, I’m Ron, the medical assistant working with Dr. Rodgers. I’ll be helping you during your appointment”).
- Establish the patient’s agenda and priorities. Ask the patient, “What is the main goal of your visit?” or “I see that you are here for a follow-up on your arthritis and diabetes. Is there anything else you would like to cover today?” If there are multiple issues, help the patient identify their top priorities.
- Reconcile medications. If a new patient is uncertain about their current medications or doses, contact the patient’s pharmacy. If the patient was recently discharged from the hospital, obtain the discharge medication list.
- Update health maintenance screenings and immunizations. Using standing orders, administer immunizations and schedule screenings, e.g., cancer and osteoporosis.
- Screen for conditions or evaluate status of chronic conditions. Use standardized questions as directed by clinic protocol to support the visit. This might include screening for depression, substance abuse and control of asthma and/or diabetes. For appropriate patients over 65, this might include uploading a patient’s responses to the annual wellness visit questionnaire, which can be distributed to the patient prior to the appointment.
- Provide information about advance directives. Provide information about advance directives to appropriate patients as directed by clinic protocol. Alert the physician if the patient has additional questions.
- Provide self-management support. Use an action plan or similar tool for patients who need self-management support, such as tobacco cessation, weight loss and/or diabetes care.
- Perform symptom-driven testing. Use standing orders and assess patient symptoms to determine whether you need to administer a pulmonary function test, exercise oximetry, electrocardiogram (ECG), strep screen, urine dip stick, pregnancy test, etc. to the patient.
Discharge Protocols

• Print and review an updated medication list and visit summary
• Reiterate to patients the medical instructions prescribed by the physician
• Coordinate the next steps of care

https://www.stepsforward.org/modules/patient-discharge-and-rooming
County Case Study

Neurology clinic
100 inbox messages per day

Information Overload

JAMA Internal Medicine

Research Letter | March 14, 2016

The Burden of Inbox Notifications in Commercial Electronic Health Records

Daniel R. Murphy, MD, MBA¹,²; Ashley N. D. Meyer, PhD¹,²; Elise Russo, MPH¹,²; Dean F. Sittig, PhD³,⁴; Li Wei, MS¹,²; Hardeep Singh, MD, MPH¹,²

[+] Author Affiliations

JAMA Intern Med. Published online March 14, 2016. doi:10.1001/jamainternmed.2016.0209
Daily Inbox Messages

Number of Messages per day

Inbox Restructuring

• Engage IT
• Track current messages to determine volume
• Identify messages that can be rerouted
  – Daily PN for hospitalized patients
  – Routine PT notes
  – Lab results ordered by consultants
  – Refill request
  – Pre-visit labs initial results
• Create a team pool inbox  https://www.stepsforward.org/modules/ehr-inbasket-management#
Fairview: Filtering Inbox

Reduce inbox time 90min/d to few min
County Case Study

General Medicine Clinic
More Time Wasters

• Refill prescriptions outside of visit
• Refill prescriptions q 3 mo rather q15
• Ordering lab between visits
• Processing phone/email request for referral for eye exam, mammogram
• Calling patients back for results reporting
• Calling other physicians for office notes
Annual Prescription Renewals

• “90 + 4”
• Physician time
  – 0.5 hr/d
• Nursing time
  – 1 hr/d per physician
Point of Care Testing

Metrics before and after implementation of POC (HgA1c, lipids, metabolic panel)

Pre-visit Labs

- 89% ↓ phone calls (p<0.001)
- 85% ↓ letters (p<0.0001)
- 61% ↓ additional visits (p<0.001)
- 21% ↓ tests ordered (p<0.0001)
- ↑ patient satisfaction
- Saved $26/visit

Same day pre-visit lab (15 min)
ThedaCare
Introducing AMA STEPSforward™

Revitalize your practice and help improve patient care.

This series of innovative, transformative strategies will show you how. Visit STEPSforward.org to see the entire series of modules.
Transformation Toolkits

• Teams
  – Expanded rooming
  – Team documentation
  – Prescription management
  – Pre-visit planning/lab
  – Team meetings
  – Daily huddles

• Value
  – Panel management
  – Medication adherence
  – Burnout Prevention
  – Diabetes prevention
  – Hypertension

• Culture
  – Preventing Burnout
  – Resiliency
  – Wellness in Residency
  – Transforming culture

• Technology
  – Telemedicine
  – EHR implementation

www.stepsforward.org