

Attack the WAC (Work After Clinic): Building Resilience and Efficiency

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The logo for FMX, consisting of the letters 'FMX' in a bold, white, sans-serif font, set against a dark orange background with diagonal white stripes.

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Dr. Botsford earned her medical degree from Baylor College of Medicine, Houston, and completed a family medicine residency at Baylor College of Medicine/Kelsey-Seybold Clinic, Houston. She earned her Master of Business Administration (MBA) degree at the University of Houston's Bauer College of Business after graduating from residency. During her nine years in practice, she has been in both employed practice and academics. She recently transitioned from medical director with Memorial Hermann Medical Group: Physicians at Sugar Creek into a role as a market medical director with Iora Health. She has been recognized for her teaching by the Texas Medical Association, receiving Silver-Level Recognition in 2016. She has been actively involved in projects related to quality, registries, electronic health record (EHR) optimization, and population health. She received her certification from the American Board of Medical Quality (ABMQ) in 2017. Dr. Botsford has been active within organized medicine at both the state and national levels. She was a member of the AAFP Commission on Quality and Practice from 2014-2018, serving as chair in 2018. In 2017, she was appointed to the National Quality Forum's Primary Care and Chronic Illness Standing Committee.

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Learning Objectives

1. Determine feasible opportunities to utilize and optimize existing technology to enhance access, patient self-management, quality and coordination of care, etc.
2. Identify new technologies on the horizon that may resolve current challenges in delivering quality, cost effective care.
3. Evaluate existing workflows to determine practice ability to optimize new and existing technologies.

FMX

Audience Engagement System



FMX

Work After Clinic: Why WAC is Whack

- Patients with increasing complexity in primary care
- More competing tasks
- More administrative paperwork
- Technology has made us more accessible
- No training on how to handle it all



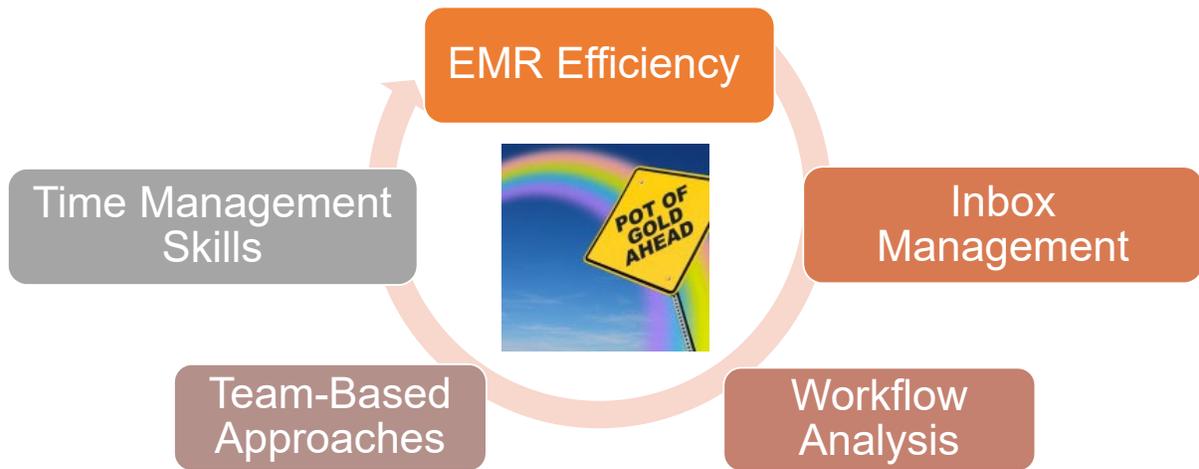
All of this leads to burnout!

Poll Question 1

Which of the following best describes how often you work after clinic?

- A. I finish all work during normal business hours
- B. I rarely bring work home, but I stay late at the office some days
- C. I bring home work most nights
- D. I bring home work most night and on weekends

Roadmap to Burnout Avoidance



Become An EMR Super User

Make EMR documentation work for you



Documentation Basics

- Do something twice? Delegate or Automate
 - Templates, Macros and Autotexts (Phraseexpress.com)
- Documentation **in room** usually more efficient
- Speech recognition software (Dragon®)
 - Dictate **in the room** with patient
 - Hidden or “Ghost” Mode

Identify efficient users and follow them!



Document Judiciously

- Document minimum amount
 - Billing, medico-legal, continuity, regulatory
- Know E/M documentation guidelines
 - 99214 → 4:2:1 for detailed history (4 HPI, 2 ROS, 1 PFSH)
 - Use time-based coding where appropriate
- Is perfection the enemy of the good?
 - Bullets and short phrases



Clerical Documentation Assistance (CDA)

- Non-licensed team member trained to document (“Scribe”)
- Potential to improve physician satisfaction and charting efficiency

- Commercial scribe companies (\$20-\$25/hr)
 - *ScribeAmerica, PhysAssist Scribes, ProScribe, Elite Medical Scribes*

- Virtual Scribes (\$12-\$19/hr)
 - Asynchronous dictation and live options
 - No exam room space needed, flexible availability
 - *PhysiciansAngels, ScribeEMR*



Gidwani R, Nguyen C, Kofoed A, et.al. Impact of Scribes on Physician Satisfaction, Patient Satisfaction, and Charting Efficiency: A Randomized Controlled Trial. *Ann Fam Med* 2017;15:427-433. <https://doi.org/10.1370/afm.2122>.

Team Documentation

- MAs can be trained to do documentation AND coordination
- Will require structured professional development
- Consider branding when approaching with staff
 - Brand as “co-visit” NOT “scribing”
- Requires higher staffing ratio



Misra-Hebert AD, Amah L, Rabovsky A, et al. Medical scribes: how do their notes stack up? *J Fam Pract.* 2016;65(3):155-159.

CDA vs. Team Documentation Model

“Scribes”

- Non-clinical staff
- Training and HR handled by outside company
- Assists with recordkeeping only
- All orders placed at direction of physician; no standing orders
- Turnover can be high: attractive to pre-med and college students

Team-Based

- Specially-trained LPN or CMA
- Training is responsibility of physician
- Assists with rooming and recordkeeping functions
- Can train to do agenda setting, health-coaching, pending refills

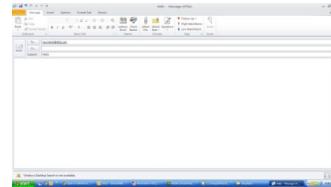
CDA vs. Team Documentation

- How to implement?
 - Consider proposing pilot
 - Cover cost while demonstrating numbers and value
 - Some physicians cover cost and make up with extra RVUs
- AAFP TIPS Module on Team Documentation
 - Eligible for CME and ABFM PI Activity Credit
 - Free to members

<https://www.stepsforward.org/modules/team-based-care>

Inbox Management

Results Management, Refills, Prior Authorizations



Co-Location of Team Members

- Shared space facilitates prompt resolution of questions
- Develop ways to communicate without sending to inbox
 - Technology solutions- Check compliance with office policies
 - Walkie-talkies
 - Secure text messaging (Vocera, TigerConnect, Imprivata®)
 - Instant messaging
 - Dedicated time just after huddle or clinic session end



Decrease The Noise In Your Inbox

- **4Ds: “Delete, Delegate, Defer or Do”**

- Eliminate multiple touches!



- Enable delayed send or holding pen features
- Redistribute inbox workload to team
 - Require first stop with someone other than physician
 - Team pool for refills, referrals, patient questions, portal messages
 - Pre-visit labs: decrease work after a visit
 - Ordered at previous visit or through chart scrubbing

StepsForward[™] Module on EHR In-basket management

Results Management

- Portal, portal, portal
 - 81% in US have smartphone, expect 92% by 2020
- Set standards with patients and staff
 - Follow-up visits for **active** management of results
 - Professional advice = office visit
- Do small tasks at set times
 - Post-huddle or ~11:30 and 4:30

Make Refills More Rational

- Synchronized, bundled renewals for chronic, non-controlled medications at **annual visit**
 - Annual visit may or may not be at a “physical” (-25 modifier)
 - Renew for **max duration (90+4)**
 - Expiration varies by state, most expire after 365 days
 - Discourage linking refills with follow-up interval
- Develop protocols based on state laws
- Consider tools such as *Charlie Practice Automation Platform*©



Prior Authorizations

Prevent

- Maximize generic usage
- Use evidence-based guidelines
- Educate patients about prior auth process during visit
- Document well if you anticipate authorization needed

Streamline

- Standardize workflows for receipt- single staff
- Ask your eRx/EHR vendor about ePA capabilities
- www.Covermymeds.com
- Use peer-to-peer sooner if getting denials

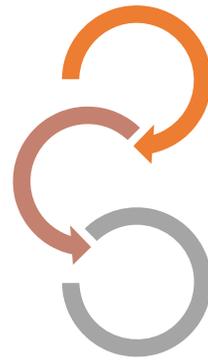


Fight back- Insurance games don't always make sense

- www.Cpap.com, GoodRx®, Walmart \$4 List

Workflow Evaluation

Agenda Setting, Room Design, Standing Orders, Protocols



Agenda Setting

- “What would you like to accomplish today?”
 - Followed by “And anything else?”
 - Verbal or written prompts
 - Rooming staff or physician can initiate
 - Proactively ask about refills and referrals
- Pre-charting can help keep you on task
- Set boundaries early
 - Do not go back in room once you leave



Exam Room Changes

- Standardize exam room supplies and procedure trays
 - Can turn into team-building activity
 - Place printers in exam rooms or nearby hallways
- Consider room without exam table for certain visits
- 2+1 room model
- Consider timers or prompts to stay on task
 - Watch, stopwatch, kitchen timers
 - Staff can interrupt- “Can I help you with anything”



Poll Question 2

Which of the following best describes who can enter electronic orders, such as laboratory or x-ray requests?

- A. A physician must enter orders directly to avoid regulatory penalties
- B. A physician signature is not required for lab tests when ordered in an office setting if there is documentation of intent to order in the medical record
- C. Orders can be entered by licensed staff, but must always be authenticated by the physician
- D. Orders can be entered by staff only when there is a standing order or protocol in place

Delegate and Automate

- A physician signature is **not** required for lab tests when ordered in an office setting if there is documentation of intent to order
- Standing orders can empower your staff
- Delegate things like PHQ-2 administration, education
 - “Nurse Closer” at end of visit
- Interruption list can help identify pain points



Fisher C, Brady B, Maier R, Gabel J, Windholz D. **The Nurse Closer: Using Nonclinician Staff to Make Patient Visits More Efficient.** *Fam Pract Manag.* 2019 Jul-Aug;26(4):13-17.

Standing Orders and Care Protocols

Type	Example	Order
Acute	Dysuria	Urine Dip
Chronic	Diabetes	In-house A1c, Fundus photo, Urine microalbumin
Preventive	Colon cancer screen	FIT testing

- Standing orders for immunizations (www.immunize.org)
- Need approval & oversight by clinic leadership
- Train and supervise when implementing

Expanded Rooming Protocols for MA

- Agenda setting
- Medication reconciliation
- Update histories and ROS
- Immunizations per protocol
- Preventive care gap closures through standing orders
- Prepare equipment/supplies in room
- Patient education
 - Use QR codes for common sites
 - Post patient education videos on youtube

Consult with your Medicare Administrative Contractor for rules on HPI/CC documentation

Poll Question 3

What is the main innovation behind a “team rooming” model?

- A. The medical assistant scribes for the physician during the visit
- B. The physician rooms the patient while the medical assistant rooms the next patient
- C. The medical assistant conducts the history while the physician documents it in the same room
- D. Two medical assistants room each patient, with one documenting and the other performing vitals and rooming tasks

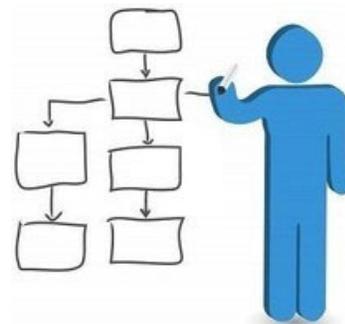
Team Care Assistants

- “Team Rooming”
 - MA conducts history and vitals while physician documents
 - Decreases down time between patients
 - Hybrid model without needing conversion to scribing
- Effective when coupled with pre-visit planning

Rethinking Workflow: Team Rooming for Greater Efficiency Arnold E. Cuenca, DO, CAQSM, FAAFP, and Lisa Perry, CMA
Fam Pract Manag. 2018 Jan-Feb;25(1):15-20.

Use Data to Improve Your Flow

- Measure cycle time
 - EMR reports or stopwatches
- Process mapping
 - MS Visio, MS Powerpoint- SmartArt
 - Identify bottlenecks
- Interruption Lists
- *AMA Stepsforward* on Lean Health Care



Team-Based Approaches to Care

Huddles, Pre-Visit Planning



Poll Question 4

Which of the following is a key step to creating an effective daily huddle?

- A. Ensure members have a comfortable place to sit
- B. Allow at least 10 minutes so all issues can be covered at each huddle
- C. Develop a checklist or template for the huddle
- D. Be sure to tackle in-depth issues

Team Huddles



- Key features
 - 7 minutes or less
 - Stand up
 - Consistent time, place and team
 - Include anyone that affects patient flow for that session
 - Designate leader and structured agenda

- Anticipate delays and obstacles, maximize schedules, ensure preparation for visit

Helps ensure uniform start time

Getting Started With Team Huddles

- Develop a checklist
- Designate set time
- Practice
- Resources:
 - Institute for Healthcare Improvement
 - AMA *StepsForward*™ modules

PSC Huddle Sheet POD:

	Clinical Staff	Provider	Role
AM			

Preceptor: _____ Phone nurse: _____
 Students or observers: _____

1. Follow-up from Previous Session (Problems encountered) _____
2. "Heads-Up for Today"
 - Procedures? _____
 - Translation or special needs? _____
 - Open slots clinic-wide for session/day? _____
 - Conflicts in time, space or personnel? _____
 - Services unavailable for session? (vaccines, services) _____
 - Time constraints on session? (meetings, etc.) _____
 - Phone notes, paperwork needing urgent attention? _____
3. Review of next session and proactive planning (Suggested c

Attendees: Write team members in clinic & take attendance. Review staffing, nurse-physician pairs.					
Preceptor: Dr. Bauer		Phone nurse: Nurse Jackie		Coordinator: Sarah	
Clinical Staff	Provider	Rooms	Visits to precept?	Open slots?	Procedures?
Nurse Ratched	Dr. House	1-3	7	1	
Nurse Carol	Dr. Grey	4-6	0	0	IUD
Nurse Abby	Dr. Ross	7, 8	2	0	
none	Dr. Howser	9, proc	3	2	

Students or observers present: *Medical student from TCOM working with Dr.*

Follow-up from Previous Session: Problems encountered, changes to schedule	"Heads up" for Today:
Diaper disaster in room 4 this morning. Avoid using it until we get a chance to AM clinic ran late, so nurses staggered lunches and may be late coming back. Be	<p>Procedures? <i>Nexplanon can be done in room. Need procedure room for colposcopy.</i></p> <p>Translation or special needs? <i>Will need language line for 2 patients. Mrs. Smith is in wheelchair and might need larger room.</i></p> <p>Open slots clinic-wide? <i>6 open slots. Michelle is wide open. Chief is here.</i></p> <p>Conflicts in time, space or personnel? <i>4 providers in clinic, so only 2 rooms per doc.</i></p> <p>Services unavailable for session? <i>Out of prevnar. Xray down until tomorrow.</i></p> <p>Time constraints on session? (meetings) <i>Town hall today at lunch</i></p> <p>Phone notes, paperwork needing urgent attention? <i>Dr. Jones has FMLA papers a patient is waiting on, please review. Mrs. K needs a call back about her referral</i></p> <p>Review of Next Session and Proactive Planning: What can be done ahead, suggested changes for clinic</p> <p><i>Hand sanitizer in room 6 needs replacing. Need work order placed. Consider upgrading pap lights to cordless ones in the future.</i></p> <p>Clinic End Time:</p>

Huddle Examples

Pre-Visit Planning



- Includes constellation of tasks that help clinic run smoothly
- Content can be reviewed at daily huddle
- Examples can include:
 - Scheduling future appointments at the conclusion of each visit
 - Arranging for pre-visit lab testing
 - Gathering information for upcoming visits
 - Identification of gaps in care
 - Spending a few minutes to huddle and handoff patients

Pre-Visit Planning Checklists

- Develop checklist for each patient visit for MA to complete
 - Identify gaps in care
 - Review previous visit notes to ensure results, consult notes available
 - Identify if information or records are needed for visit
- Consider pre-visit phone call or pre-appointment questionnaire
- “Re-appointment” at end of each visit is ideal
 - Tickler file can be used if scheduling not open
 - Appointment reminders can mitigate no-shows

Getting Started With Pre-Visit Planning

- Develop checklist by asking what things interrupt flow?
- Get buy-in and train staff to take ownership
- Allow time to train

Preventive Screen	Due	Done	N/A	Target population and recommendation
PAP				Age 21 to 65 years Every 3 years if no abnormal PAPs Every 5 years if over 30 and most recent PAP negative and HPV-negative
Mammogram				Age 50 to 75 years Every 1 to 2 years (Optional for age 40 to 50 and >75)
Colonoscopy				Age 50 to 75 years, every 10 years
Fecal Blood Test				Age 50 to 75 years, Annually Not needed if colonoscopy in last ten years
Bone density DEXA				Females age 65-85 years, once
Abdominal aortic aneurysm				Age 65 to 75 years One-time screen for men who smoked >100 cigarettes
Hepatitis C				Adults born between 1945-1965 One-time screening
Lung Cancer				Age 55-80 with 30 pack year history Annually if still smoking or quit <15 years ago
Chlamydia and Gonorrhea				Annually in women <25 and sexually active
Lipid panel				Age 40 to 75 years, every 5 years
HIV				15-65 years, once in lifetime
Diabetes (A1c)				Age 40 to 70 years, if overweight or obese, every 3 years

Technology Can Streamline Pre-Visit Work

Patient Information		
Patient Name:	Directives on file: Y/N	Yes
Age: 24	Controlled Substance Contract:	No
Date of birth:	Portal User:	Yes
Gender: F	MHE: Y/N	Yes
Comp Provider: Lee, Andrea	Intra: Consented/Registered	No/No
Last wellness: None		
Insurance: United Healthcare		

Reason for Visit	Due	Done	Target Population and recommendation
PHQ9/Gad		07-2016	Annually for all patients ages 18+ If Diag of Depression then every 4 months
Food Insecurity		07-2016	All patients all ages; If negative, then repeat every 8 months If positive, then no more frequently than ever
Care Plan	X	-	One-time for patients with PHQ9+10, A1c>9 Medicare/Medicaid enrollees, >10 Rx Medica
Preventive Screen			
PAP		11-2014	Age 21 to 65 years Every 3 years if no abnormal PAP's (or every over 30 and most recent PAP negative and h
Chlamydia and Gonorrhoea	X	-	Sexually Active Annually in women 16-25
HRV	X	-	18-65 years, once in lifetime
Immunization			
Tdap vaccine	X	-	Age 10-64 years Administer Tdap once

To Do Before Patient Visit	Things to do at Visit
<input type="checkbox"/> Request Hospital Records <input type="checkbox"/> Ensure testing/imaging results available <input type="checkbox"/> Request recent consult reports <input type="checkbox"/> Call Patient to clarify reason for visit	Request Records <input type="checkbox"/> Pap <input type="checkbox"/> Mamma <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Eye Exam <input type="checkbox"/> Consult Note <input type="checkbox"/> Entire Record

Alternatives to Traditional Office Visits

- Patients with complex needs may need extended visit
 - Not every patient fits neatly in a 15 minute visit
- Consider alternative visit types
 - Shared Medical Appointments
 - Psychiatric Collaborative Care Codes
 - Transitional Care Management
 - Telemedicine
 - Phone or video visits
 - Asynchronous online platforms (Zipnosis™)





Time Management

Fit Tasks to Time, Eliminate Waste



“Eisenhower Matrix”

	URGENT	Less URGENT
IMPORTANT	I Patient call with chest pain Presentation due in 2 days	II Workflow change initiatives Review long-term goals Process improvements
Less IMPORTANT	III Document visit in EMR Medication refills	IV Work email FMLA, disability paperwork Prior Authorizations

Gordon CE, Borkan SC. Recapturing time: a practical approach to time management for physicians. Postgrad Med J 2014; 90:267-272

Fit Tasks to Time

- Identify your personal productive times
 - Save emails and phone calls for lower energy times of day
 - Reserve large blocks of time for tasks requiring most attention
- Ensure adequate uninterrupted time for tasks
- Daily, weekly and monthly calendar
 - Bullet journaling (<http://bulletjournal.com/>)



Gordon CE, Borkan SC. Recapturing time: a practical approach to time management for physicians. Postgrad Med J 2014; 90:267-272

Fit Tasks to Time

Size	Time (min)	Description	Examples
Large	> 60	Require uninterrupted time ➤ Schedule when most alert	QI proposal Research or writing
Medium	30-60	Require concentration	Clinical documentation Prepare presentation
Small	5-10	Require minimal concentration ➤ Schedule as mental break or during less alert times of day	Returning phone calls Completion of forms Results review
Tiny	<5	Require little concentration ➤ Use to fill time prior to clinic start, while on hold on phone	Sorting mail Signing paperwork

Threat	Strategy to Avoid Wasted Time
Phone messages	Return non-urgent calls <u>1-2 times a day</u>
Email	Check no more than <u>3-4 times a day</u> ; disable auto-alerts ; enable email filters and discard junk email rapidly; respond in 24 hours
Paper faxes	Only handle it once
Wait times	Perform quick and easy tasks such as paperwork review, refill requests, home health forms
Commute	Podcasts, guided meditation, journal articles

Gordon CE, Borkan SC. Recapturing time: a practical approach to time management for physicians. Postgrad Med J 2014; 90:267-272

“Radical” Strategies

- **Stop** answering the phones
 - Portal strategy to meet patient needs
- **Stop** responding to paper fax refill requests
- **Stop** sending results letters
 - Direct patients to portal use for communication
- Consider new patient intake process prior to appointment scheduling



Self-Preservation

FIX IT!

- Evaluate possible alternatives
 - Refuse to reward unreasonable expectations by work at home
 - Request more staff, longer appointment times
- Consider alternative practice environments
 - Direct Primary Care and hybrid models can remove time pressures
- Fix the system
 - Membership in AAFP and organizations working on advocacy
 - Communicate need for change within your system or practice

To-Do List

1. For one week, log all “broken record” moments on sticky notes and set aside 30 minutes to create templates or shortcuts.
2. Time yourself doing common tasks to identify your personal pain points.
3. Create list of all interruptions in a day and design a plan to either delegate to team members or mitigate by pre-visit planning.



Poll Question 5

Please rate your level of confidence in your ability to change at least one thing to improve your efficiency in clinic?

- A. Extremely confident
- B. Very confident
- C. Somewhat confident
- D. Not very confident
- E. Not at all confident

Practice Recommendations

Sending synchronized, bundled renewals for chronic, non-controlled medications at an annual visit can decrease phone calls and inbox requests. (SORT C)

Implementing a daily huddle can provide an opportunity to anticipate patient needs and prepare for changes so the day runs more efficiently. (SORT C)

Pre-visit planning can reduce the chances of being caught off guard by a patient's unexpected agenda item, decrease time spent dealing with results, and close gaps in care both before and during a visit. (SORT C)

Contact Information

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Questions



FMX

Resources/Supplemental Material

- AAFP Transformation in Practice Series (TIPS)
- American Medical Association *StepsForward*[™]
- *Family Practice Management* topic collections
- Institute for Healthcare Improvement (IHI) Open School

Resources/Supplemental Material

- Gidwani R, Nguyen C, Kofoed A, et.al. Impact of Scribes on Physician Satisfaction, Patient Satisfaction, and Charting Efficiency: A Randomized Controlled Trial. *Ann Fam Med* 2017;15:427-433. <https://doi.org/10.1370/afm.2122>.
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