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

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Lindsay Botsford, MD, MBA, CMQ, FAAFP

Family physician, Iora Health, Houston, Texas

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.
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.

Audience Engagement System

Step 1

Step 2

Step 3
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

- EMR Efficiency
- Inbox Management
- Workflow Analysis
- Team-Based Approaches
- Time Management Skills

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


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

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

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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](http://www.Covermymeds.com)
• Use peer-to-peer sooner if getting denials

**Fight back- Insurance games don’t always make sense**

• [www.Cpap.com](http://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


Standing Orders and Care Protocols

<table>
<thead>
<tr>
<th>Type</th>
<th>Example</th>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>Dysuria</td>
<td>Urine Dip</td>
</tr>
<tr>
<td>Chronic</td>
<td>Diabetes</td>
<td>In-house A1c, Fundus photo, Urine microalbumin</td>
</tr>
<tr>
<td>Preventive</td>
<td>Colon cancer screen</td>
<td>FIT testing</td>
</tr>
</tbody>
</table>

• 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

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
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

<table>
<thead>
<tr>
<th>Preventive Screen</th>
<th>Due</th>
<th>Done</th>
<th>N/A</th>
<th>Target population and recommendation</th>
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</thead>
<tbody>
<tr>
<td>PAP</td>
<td></td>
<td></td>
<td></td>
<td>Age 21 to 65 years, every 3 years or abnormal PAPs. Every 5 years for women over 30 and positive PAP negative and HPV-negative</td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 75 years, every 1 to 2 years (optional for age 40 to 50 and &gt;75)</td>
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<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 75 years, every 10 years</td>
</tr>
<tr>
<td>Fecal Blood Test</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 75 years, annually</td>
</tr>
<tr>
<td>Bone density DXA</td>
<td></td>
<td></td>
<td></td>
<td>Females 65-85 years, once</td>
</tr>
<tr>
<td>Abdominal Aortic Anomaly</td>
<td></td>
<td></td>
<td></td>
<td>Age 65-75 years, annual screening for men who smoked &lt;100 cigarettes</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
<td></td>
<td>Adults born between 1945-1965</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Age 55-80 with 30 pack year history, annually if smoking cessation or quit &lt;15 years ago</td>
</tr>
<tr>
<td>Chlamydia and Gonorrhea</td>
<td></td>
<td></td>
<td></td>
<td>Annually in men &lt;25 and sexually active</td>
</tr>
<tr>
<td>Lipid panel</td>
<td></td>
<td></td>
<td></td>
<td>Age 40 to 75 years, every 5 years</td>
</tr>
<tr>
<td>HIV</td>
<td></td>
<td></td>
<td></td>
<td>15-65 years, once in lifetime</td>
</tr>
<tr>
<td>Diabetes (A1C)</td>
<td></td>
<td></td>
<td></td>
<td>Age 40 to 75 years, if overweight or obese, every 3 years</td>
</tr>
</tbody>
</table>
Technology Can Streamline Pre-Visit Work

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*

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**"Eisenhower Matrix"**

<table>
<thead>
<tr>
<th>URGENT</th>
<th>Less URGENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPORTANT</td>
<td>Patient call with chest pain</td>
</tr>
<tr>
<td></td>
<td>Presentation due in 2 days</td>
</tr>
<tr>
<td></td>
<td>Workflow change initiatives</td>
</tr>
<tr>
<td></td>
<td>Review long-term goals</td>
</tr>
<tr>
<td></td>
<td>Process improvements</td>
</tr>
<tr>
<td></td>
<td>Work email</td>
</tr>
<tr>
<td></td>
<td>FMLA, disability paperwork</td>
</tr>
<tr>
<td></td>
<td>Prior Authorizations</td>
</tr>
<tr>
<td>Less IMPORTANT</td>
<td>Document visit in EMR</td>
</tr>
<tr>
<td></td>
<td>Medication refills</td>
</tr>
</tbody>
</table>

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/)


<table>
<thead>
<tr>
<th>Size</th>
<th>Time (min)</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>&gt; 60</td>
<td>Require uninterrupted time</td>
<td>QI proposal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Schedule when most alert</td>
<td>Research or writing</td>
</tr>
<tr>
<td>Medium</td>
<td>30-60</td>
<td>Require concentration</td>
<td>Clinical documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prepare presentation</td>
</tr>
<tr>
<td>Small</td>
<td>5-10</td>
<td>Require minimal concentration</td>
<td>Returning phone calls</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Schedule as mental break or during less alert times of day</td>
<td>Completion of forms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Results review</td>
</tr>
<tr>
<td>Tiny</td>
<td>&lt;5</td>
<td>Require little concentration</td>
<td>Sorting mail</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use to fill time prior to clinic start, while on hold on phone</td>
<td>Signing paperwork</td>
</tr>
</tbody>
</table>
Threat | Strategy to Avoid Wasted Time
---|---
Phone messages | Return non-urgent calls 1-2 times a day
Email | Check no more than 3-4 times a day; 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


“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

- 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
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


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