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Seven Habits for Reducing Work After Clinic



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Imagine shutting your office door at the end of the day and not having any work that you need to take home. These shifts in practice can help you reclaim your time.

The administrative burden on family physicians is immense. Prior authorizations, quality reporting, formularies, refills, sign-offs, messages, documentation guidelines, and electronic health records (EHRs) can all frustrate physicians' efforts to focus on providing high-quality patient care. These administrative hassles undoubtedly contribute to the rise in "work after clinic" as well as physician dissatisfaction and burnout.

A recent study of four specialties, including family medicine, found that physicians in ambulatory practice spend one to two hours each night on EHR tasks or paperwork – not to mention all

the time they spend on these tasks during the workday.¹ A separate study found that family physicians spend nearly 30 hours per month working on the EHR after hours, with activity peaking on weekends around 10 a.m. and again at 10 p.m.² This has been dubbed “date night with the EHR.”³

But perhaps it doesn't have to be this way.

Changes are needed at the organizational and national levels to fix our broken system (see “What's being done to address administrative complexity?” on page 13). But in the meantime, physicians have to find ways to regain some control over their time and not burn out.

This article will share practical steps physicians can take to improve efficiency and reduce the amount of time they spend working after hours. These strategies are based on our collective experience and offer a variety of approaches to the problem depending on your personal work style, your practice workflow, your priorities, etc. It is our hope that, by focusing on what physicians can control and applying sound principles to our work, we can reduce the burden and restore the joy of practicing medicine.

1. PAY ATTENTION TO “HOW” AND “WHY” AS YOU START YOUR DAY

How you start your day matters. We all know that arriving at the office late or with no time to prepare for the first patient visit can put us in catch-up mode for the rest of day. A more efficient approach is to arrive at the office with sufficient time before you start seeing patients so that you can look over the schedule, answer messages, or huddle with staff — whatever you need to do to get a jumpstart on the day. You could do some of this prep work at home before you come to the office if you prefer. The point is to put yourself in a more proactive position so you aren't just reacting to situations all day and falling hopelessly behind.

But here's the key to making this habit

WHAT DO YOU THINK?

What strategies have helped you improve your efficiency and reduce work after clinic? Let us know at fpm@afp.org or by commenting on the online version of this article.

KEY POINTS

- While changes are needed throughout the health care system to reduce administrative complexity, physicians must find ways to regain some control over their time and not burn out.
- Time management tactics, improved delegation, message management, and more efficient documentation practices can help reduce the amount of time physicians spend working after hours.
- When addressing the problem of work after clinic, practices should be careful not to apply more pressure on already pressured physicians; a better approach involves empathy, mentoring, and accountability.

stick: Think about your end goal. *Why* do you want to be done with work when you leave the office? Be specific. For example, maybe you have young children and you want your evenings free so you can eat dinner together, go on a walk, and read them a story before bedtime. Having a clear “why” will give you a compelling reason to show up ready for the day. It will also help you be more cognizant of how you are managing your time so you can balance out your attention to the needs of your patients and your practice with the needs of your family and yourself.

Family physicians spend nearly 30 hours per month working on the EHR after hours, with activity peaking on weekends.

2. USE PREVISIT PLANNING

Previsit planning can help you walk into each patient visit with all of the necessary information on hand, organized, and ready. It can take many forms, but there are two essential components.

• **Previsit labs and X-rays:** Where possible, anticipate at the current visit what will be needed at the next visit and pre-order those labs or X-rays so the patient can obtain the needed tests a week ahead of the next visit in most cases. This ensures the results will be available for you to discuss with the patient at that visit and factor into care planning. This can save you time you would otherwise spend reviewing charts between visits or having

staff contact patients to figure out what tests are needed, playing phone tag about test results, and searching for results during visits.

• **Visit prep:** Have your medical assistants (MAs) do a quick review of the patient's record on the day of the visit (or the day before) to see what needs he or she may have and what prep work can be done. Creating prep sheets for common condi-

If the next exam room isn't ready and you have a spare five minutes, find a task you can knock out quickly. Teach your team to do this as well.

tions can be helpful. For example, a diabetes prep sheet can help MAs identify which lab orders to set up ahead of time, which immunizations might be needed, and so on. A sample diabetes prep sheet can be downloaded from the online version of this article at <https://www.aafp.org/fpm/2019/0500/fpm20190500p10-rt1.pdf>.

(For more information on previsit planning, see "Strategies and resources" on page 15.)

3. MAKE EVERY SECOND COUNT

The time you have with patients in the exam room is short, so you have to make the most of every second. Using effective communication skills, such as building rapport quickly and not interrupting, can help the visit stay on track. Additionally, working with patients to set an agenda for the visit can help you avoid being derailed or blindsided late in the visit. Your front-desk staff can gather the initial list of concerns from patients using a form they fill out ahead of the visit, and your MAs can help patients prioritize the list and reinforce the message that not everything can be handled in a single visit. When you enter the exam room, you can then quickly clarify what the patient hopes to accomplish today and negotiate as needed.

You also need to make the most of your time between visits. These moments may seem insignificant, but how you spend them can reduce the amount of work waiting for you at the end of the day. For example, if the next exam room isn't ready and you have a spare five minutes, find a task you can knock out quickly. Finish charting, complete a prescription refill request that requires your attention, answer a message, sign off on an order, etc. While you're in the medical record, see if there are any other refills or tasks that can be done quickly, as

A WORD ABOUT PANEL SIZE

There are limits to the number of patients you can effectively care for. For most physicians, having too many patients will exacerbate the work-after-clinic burden.

To assess whether you have too many patients on your panel, you can compare your practice to benchmarks from the AAFP for family physicians:

- **Average panel size:** 1,974 patients (the number of patients attributed to the physician and seen in the past two years)¹
- **Hours worked each week:** 51 hours (10 of which are after hours)²
- **Hours spent weekly in face-to-face patient care:** 28 hours²
- **Patient encounters per week:** 82 (72 in the office)²

Whether your panel size is manageable may also depend on factors such as your scope of practice, years of experience, patient severity of illness, teaching or administrative responsibilities, and organizational decisions, such as requiring physicians to see their colleagues' overflow versus protecting physicians' schedules.

1. AAFP Practice Profile 2017.
2. AAFP Practice Profile 2018.

WHAT'S BEING DONE TO ADDRESS ADMINISTRATIVE COMPLEXITY?

Reducing the administrative burden on family physicians is a strategic objective of the AAFP (see <https://www.aafp.org/advocacy/informed/legal/simplification.html>). It has combined advocacy efforts with five other specialty societies, representing more than 560,000 physician and medical student members, and drafted the Joint Principles on Reducing Administrative Burden (<https://www.aafp.org/about/policies/all/principles-adminsimplification.html>). The issues the AAFP is addressing include advocating for less onerous documentation and billing guidelines, interoperability of EHRs to support care across the continuum, a core set of primary care quality measures that would be used by all payers, reduced prior authorization demands, and other issues.

As part of its Patients Over Paperwork project, the Centers for Medicare & Medicaid Services (CMS) recently made some changes to ease physicians' documentation requirements:

- For the history and exam, physicians are now required to document only what has changed since the last visit or pertinent items that have not changed; they do not need to rerecord these elements if the record contains evidence that they reviewed and updated the previous information.
- For both new and established patients, physicians no longer must re-enter information in the medical record regarding the chief complaint and history (including the history of present illness) that either ancillary staff or the patient have already entered.
- Teaching physicians no longer need to personally document their participation in the medical record for E/M visits and to document the extent of their participation in the review and direction of services furnished to each Medicare beneficiary; the notes of a resident or other member of the medical team may suffice instead.
- Physicians do not have to document the medical necessity of furnishing a visit in the home rather than in the office. If the encounter is medically necessary, where it occurs is immaterial.

For more information on these changes see "The 2019 Medicare Documentation, Coding, and Payment Update," *FPM*, January/February 2019, <https://www.aafp.org/fpm/2019/0100/p23.html>. More documentation reforms are expected from CMS later this year.

this could save you time down the road.

Teach your team to do this as well. It's about squeezing tasks into those little moments, instead of batching them for later.

(For more information on these topics, see "Strategies and resources" on page 15.)

4. RETHINK WHO DOES WHAT

Throughout your workday, you probably have moments when you think to yourself, "Why am I the one doing this task?" You then have two choices. You can either keep doing it, or you can consider delegating the task to the most appropriate person (or automating it if possible). For example, set up standing orders for when your MA can give certain vaccines, enter refills in the EHR for certain medications, or perform diabetic foot exams. MAs can also help with documentation (discussed later in the article), carry out needed screenings such as the PHQ-2 for depression, or educate patients about topics such as inhaler use.

If your staff aren't working at the top of their licenses, consider whether it's because

they aren't capable (meaning there's a performance problem or training opportunity you need to address) or whether they simply haven't been empowered to do so. Ultimately, their productivity and efficiency will affect yours, so it's in your best interest to resolve these issues even if you aren't their "boss."

For those physicians working with medical students, don't forget to use their skills to the maximum ability too. They can do patient call backs, spend extra time counseling patients while you move on to the next visit, and help look up information. This can be a learning experience for them and also helpful to you and your patients.

5. DOCUMENT LESS BUT BETTER

When it comes to documentation, everyone has a different style – typing vs. dictating, documenting in the exam room vs. documenting later, team documentation vs. physician documentation, and so on. It's OK to have a preferred style, but be cognizant of where your habits and your process

might be failing you and be open to new ways to document more efficiently. This includes asking your most efficient colleagues what they do that helps speed up their documentation within your EHR.

One of the most common problems is over-documenting. It's easy to get compulsive when you have to worry about medicolegal risk, you're trying to gather rich psychosocial information, and you feel pres-

Not all EHR boxes need checking, and not all visits require that you write an opus.

sure to check all the boxes you can. But not all EHR boxes need checking, and not all visits require that you write an opus. Instead, be brief, focused, and clear enough that someone looking at your note will understand your clinical reasoning and your plan. Over-documenting not only wastes your time but can be problematic for other reasons as well. For example, think about whether you would be comfortable with, say, your patient or his podiatrist seeing your entire note detailing sensitive psychosocial issues. Remember that less is often more.

Wasted time spent clicking boxes and navigating lengthy drop-down menus just to complete a simple task is another common EHR complaint, described recently as "death by a thousand clicks."⁴ In some

cases, EHRs can be customized to reduce clicks if you tell your vendor what you need. For example, having certain data that you use most often displayed on the initial screen, instead of buried deep in a drop-down menu on a later screen, can save you from clicking or scrolling to review that information.

Additionally, EHR templates and macros can help reduce the amount of data entry required for tasks you perform routinely, and your EHR system might have some of these options already built in. You can also create your own (see "A starter list of EHR macros"), or enlist the help of a colleague who enjoys this kind of work. Then, when you're seeing a patient for a well-woman exam, for example, you can load the relevant template or use a macro that autofills key information, and simply adjust it as needed. This is faster than starting from scratch. Be aware, however, that overusing templates and macros can generate notes so lengthy that they're practically meaningless.

The use of scribes (live or virtual) or team documentation can also help ease the documentation burden on physicians. In the team documentation model, nurses or MAs are trained to do more during the rooming process, so the record is started before you enter the room, and they can even assist with documentation throughout the visit. (For more information on team documentation, see "Strategies and resources.")

Dictation is another option for saving time on documentation. With a little practice using voice-recognition software, you can quickly dictate your notes directly into the EHR while in the exam room or immediately afterward. To improve the accuracy of speech recognition, make sure you use a good microphone placed close to your mouth, speak clearly and in complete phrases, and reduce background noise.

If you've dismissed in-room documentation because you believe it interferes with the patient interaction, you might want to give it another try, at least for your more routine visits. Consider the following tips: focus on the patient before you focus on the EHR, put the computer monitor where both you and the patient can see it as well as each other, get comfortable typing and navigating your EHR system (get help if

A STARTER LIST OF EHR MACROS

Using EHR macros in your documentation can save time because you don't have to type out words or phrases that you use repeatedly. For example, once you set up your macros, you can type "bcc," and your EHR will input "Birth control counseling provided, with discussion of barrier methods, hormonal methods including combination pills and progesterone only methods, implants patches, ring, and IUDs. Discussed the pros and cons, effectiveness, and side effects."

A starter list of macros that can be helpful in family medicine can be downloaded from the online version of this article at <https://www.aafp.org/fpm/2019/0500/fpm20190500p10-rt2.xls>.

Got a macro you'd like to share? Comment on the online version of this article, or send it to fpmedit@aafp.org. We may edit submissions for inclusion in the macro spreadsheet.

you need it), and involve the patient in what you're doing on screen (e.g., "Let's see when you had your last mammogram" or "Let's go ahead and order that test right now").

Finally, whatever documentation method you use, make it a goal to finish your chart before seeing the next patient. Improve on the adage "Do today's work today," and aim to "Do this visit's work this visit." (For more information on efficient documentation practices, see "Strategies and resources.")

6. TOUCH MESSAGES ONCE

Whenever possible, have messages go directly to the person who should handle

them, rather than having them all funneled through you. Fewer handoffs is a key principle in quality improvement, so your goal should be to have fewer people touching each message and minimize the number that you as the physician must handle.

Likewise, you should aim to touch each of your messages only once. Read it, take action (which may involve delegating it), and then move on to the next task.

Some portal systems can be set up to automatically direct messages to designated people based on the type of message (appointment scheduling, refills, patient questions, etc.), while other systems allow

STRATEGIES AND RESOURCES

Strategies	Resources from FPM
1. Pay attention to "how" and "why" as you start your day	How to Start Your Workday https://www.aafp.org/fpm/2016/0300/p26.html
2. Use previsit planning	Putting Pre-Visit Planning Into Practice https://www.aafp.org/fpm/2015/1100/p34.html
3. Make every second count	Have You Really Addressed Your Patient's Concerns? https://www.aafp.org/fpm/2008/0300/p35.html Improving Patient Communication in No Time https://www.aafp.org/fpm/1999/0500/p23.html Making Every Minute Count: Tools to Improve Office Efficiency https://www.aafp.org/fpm/2005/0400/p61.html
4. Rethink who does what	Developing Standing Orders to Help Your Team Work to the Highest Level https://www.aafp.org/fpm/2018/0500/p13.html Six Characteristics of Effective Practice Teams https://www.aafp.org/fpm/2012/0500/p26.html Team-Based Care: Saving Time and Improving Efficiency https://www.aafp.org/fpm/2014/1100/p23.html
5. Document less but better	EHRs in the Exam Room: Tips on Patient-Centered Care https://www.aafp.org/fpm/2006/0300/p45.html Eight Ways to Lower Practice Stress and Get Home Sooner https://www.aafp.org/fpm/2015/1100/p13.html Getting Your Notes Done on Time https://www.aafp.org/fpm/2016/0300/p40.html Staying Connected: Eight Tips for Mindful Office Visits With an EHR https://www.aafp.org/fpm/2015/0900/p56.html
6. Touch messages once	Managing Messages https://www.aafp.org/fpm/2012/0900/p25.html
7. Help each other	Effective Work Relationships: A Vital Ingredient in Your Practice https://www.aafp.org/fpm/2006/1100/p45.html Tailoring New Physicians to Fit Your Practice https://www.aafp.org/fpm/2001/0400/p39.html

the patient to decide who receives the message. If you don't have control over what lands in your inbox, you may need to enlist your nurse or MA to go through your messages first and handle what they can, leaving only those messages that require your attention.

The barriers and solutions are going to be personal because we are all programmed differently.

Also, make sure you aren't trying to handle things in messages that should be handled as office visits, such as communicating certain types of test results.

7. HELP EACH OTHER

Having too much work after clinic is often a sign of a system or process problem, or perhaps even a workload problem (see "A word about panel size," page 12). But sometimes, it is a sign of a struggling physician who needs help. For example, let's say there are four physicians in a clinic, each with roughly the same number and same mix of patients. One physician is habitually struggling with work after clinic and is behind on charting while the other physicians are generally on top of this work. The physician's lateness is problematic for the practice because it can affect billing and reimbursement as well as create liability issues if the physician can't remember details when documenting many days after the visit.

If you see a physician struggling (or if this physician is you), the best approach involves empathy, mentoring, and accountability. The practice may need to set standards for when charts are expected to be closed – and enforce those standards. At the same time, a manager or colleague should work with the physician to figure out what's going on, what his or her barriers are, and how to get back on track. Maybe the physician needs to have some time blocked out on the schedule to catch up on charting. Maybe the physician needs some EHR training or an MA to help with in-room documentation. Or maybe the physician just needs some coaching because he

or she is trying to do too much in the exam room (for example, trying to address everything on the patient's agenda, over-documenting, and not delegating tasks such as patient education). The barriers and solutions are going to be personal because we are all programmed differently, but most physicians will need some help figuring things out. Don't let a colleague struggle alone, and don't make the mistake of simply applying more pressure on an already pressured physician. There are a lot of good physicians who just need a nudge and some objective help to get past their barriers to better performance.

BALANCE, TRADEOFFS, AND AGENCY

In the desire to be more efficient and reduce work after clinic, we have to be careful about what we may be sacrificing in the process. If we're gaining efficiency by forgoing pleasantries with patients or staff, by taking shortcuts that could affect quality, or by working so hard that we're at risk of burnout, then we've gone too far. Efficiency isn't everything, and it requires balance and tradeoffs.

It can be challenging to figure out the habits that will serve you best in your aim to improve efficiency and reduce work after clinic. But the bottom line is this: Physicians are not powerless. Although reforms are needed at the national level and perhaps even within our own organizations, we do have agency. Believing we can affect our circumstances and make things better is the first step to actually doing so. **FPM**

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