In Search of Joy in Practice

MA Medical Society
Boston, MA
May 6, 2016
Christine A. Sinsky, MD, FACP
Vice President, Professional Satisfaction
American Medical Association

Prescription for Reducing Physician Burnout

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Agenda

• Introduction: Framing thoughts burnout
• Studies
  – AMA Rand: Physician Career Satisfaction
  – ABIMF: In Search of Joy in Practice
• www.StepsForward.org

Notes

• Dr. Dennis Dimitri, president MMS (family physician, U Mass)
  – They are trying to apply Joy in Practice to their dept practices
  – ACP
  – Shattuck lecture: sponsored by NEJM at lunch;
• “Sustaining Joy in the Practice of Medicine” 8-12:15
  – Bridget Duffy
  – Kavita Patel, Brookings: research on efforts to create systems for pt care; CEO of Hitachi Fnd rec’d her, working on teams and workforce; for neighborhood health centers to provide entry level work for residents
  – Jeff Cain, Chair AAFP; Chair of Fam Med at Denver Childrens; speak of patients experience from his own severe illness
• Presentation
  – Synergy without overlap
Agenda

• Introduction: Framing thoughts burnout
• Studies
  – AMA Rand: Physician Career Satisfaction
  – ABIMF: In Search of Joy in Practice
• www.StepsForward.org
• Discussion

Quadruple Aim
On a recent visit to a new doctor I believe we made eye contact twice—upon her arriving and leaving.

And yet, I am much more able to receive advice

From people I feel are thinking of me as a person rather than just the next patient.

Over ½ of MDs Burned Out

EHR

More than ½ of MDs Burned Out

Work induced syndrome
- Chaos
- Lack of control
- Reg burdens
- Unsupportive leadership

Physician Burnout Rising

46 → 54%

Mayo Clin Proc 2015

28% gen'l pop

Students start med school w/stronger mental health profiles
Physician Burnout Rising
46→54%

Students start med school w/stronger mental health profiles

28% gen'l pop
WLB ↑ Gen’l Pop, ↓ MDs
Burnout affects Patients

Physician burnout is associated with…

- ↑ Mistakes
- ↓ Adherence
- Less empathy
- ↓ Patient satisfaction

Burnout Costs Organizations

Physician burnout is associated with...
- ↑ Malpractice risk
- ↑ Part time
- ↑ MD and staff turnover

Replace PCP costs $250,000 (1999)

Am J Man Care Nov 1999;5(11):1431-1438
Am J Man Care Jul 2001;7(7):701-713
Med. Care Mar 2006;44(3):234-242
http://psycnet.apa.org/?&fa=main.doiLanding&doi=10.1037/0021-9010.73.4.727

Burnout May Cost US Healthcare

Physician burnout is associated with...
- ↑ Referrals
- Fewer PCPs

Bright Spotters: PCPs →
- 58% ↓ total expenditures
- $300 billion/yr savings

Social Science and Medicine 1999; (48):547-557
Family Practice doi:10.1093/fampra/cm050.
Arch Intern Med. 2011;171(17):1582-1588
• Satisfied clinicians work longer, retire later, are more productive, have better quality ratings, and have high quality metrics.

Burnout Costs Physicians

Physician burnout is associated with…
- ↑ Disruptive behavior
- ↑ Divorce
- ↑ CAD
- ↑ Substance abuse/addiction
- ↑ Suicide (2-4 x)
Burnout May Cost US Healthcare

- ↑ Referrals
- Fewer PCPs

Milstein: Exemplar Primary Care →
- 58% ↓ total expenditures
- $300 billion/yr savings

Social Science and Medicine 1999; (48):547-557
Arch Intern Med. 2011;171(17):1582-1585

The Widespread Problem of Doctor Burnout

By PAULINE W. CHEN, M.D.

1 in 2 US physicians burned out implies origins are rooted in the environment and care delivery system rather than in the personal characteristics of a few susceptible individuals.
Physician Career Satisfaction

• **Quality**: Major Driver of Satisfaction


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Physician Career Satisfaction

• **EHR**: Major Driver of Dissatisfaction
  – Too much time per task, clerical
  – ↓ Face-to-face time
  – ↓ Quality of visit note

Burnout: Work induced syndrome
• Environmental barriers Q
• Reg burdens
• Insurers don't cover necessary care
• Unsupportive leadership

CMS’ Andy Slavitt, says MU will be over in 2016
1/11/16

“We have to get the hearts and minds of physicians back. I think we’ve lost them.”
“Pajama Time”

In Search of Joy in Practice
Co-Investigators

- Christine Sinsky- PI
- Tom Bodenheimer-PI
- Rachel Willard
- Tom Sinsky
- Andrew Schutzbank
- David Margolius
In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Christine A. Sinsky, MD
Rachel Willard-Grace, MPH
Andrew M. Schutzbank, MD
Thomas A. Sinsky, MD
David Margolius, MD
Thomas A. Bodenheimer, MD

1. Medical Associates Clinic and Health Plaza, Dubuque, Iowa
2. Center for Excellence in Primary Care, University of California, San Francisco, California
3. Beth Israel Deaconess Medical Center, Boston, Massachusetts
4. Iora 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 teaming protocols, standing orders, and panel management; (3) sharing clinical tasks with collaborative documentation (charting), 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 work-flow 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 staff support per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

Places Where PC Physicians & Staff are Thriving?

- Where the work of primary care is do-able
- Enjoyable as a life’s vocation
Joy in Practice

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

Workflow
Task distribution
Physical space
Technology

Challenges

Chaotic visits

EHR → work to MD

Inadequate support

Teams function poorly

Time documentation
Challenges

1. Chaotic visits
   with overfull agendas

Innovations

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

Annual Prescription Renewals

- “90 + 4”
- Physician time
  - 0.5 hr/d
- Nursing time
  - 1 hr/d per physician

40 million PC visits/yr

200,000 PCPs x 220d/yr x 1 visit/d
Script Renewal Calls

• $10,000/yr per MD
  – Surescripts estimate as reported in WSJ
  – (Similar to our observation of 1 RN: 6-8 MDs)

• Each call costs $15-20

Challenges

1. Chaotic visits with overfull agendas

Action Steps
Challenges

2. **Inadequate support** to meet the patient demand for care

Innovations

Challenges

2. **Inadequate support** to meet the patient demand for care

Action Steps

- Educators
  - MA, nurse: MI, SMS

- Institutions/Regulators
  - Staffing
  - Scope of practice ↑

- Payers
  - Fund non-MD services
Challenges

3. Vast amounts of time spent documenting care

Innovations

I used to be a doctor. Now I am a typist.

Personal communication, Beth Kohnen, MD, internist Fairbanks, AK 8.3.11
“I am no longer a physician but the data manager, data entry clerk and steno girl. I am frustrated, unhappy and I am unable to do my best in caring for my patients. I became a doctor to take care of patients. I have become the typist.”

physician, Boston 2013

Challenges

3. Vast amounts of time spent documenting care

Innovations
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.
Team Documentation
Cleveland Clinic

• Pre-visit (nurse)
  – Med Rec
  – Agenda, HPI

• Visit (nurse + MD)
  – med, lab, x-ray orders
  – followup

• Post-visit (nurse)
  – Reviews visit summary
  – Health coaching

• MD → next patient

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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
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.

We have turned the EHR into an ally rather than an adversary.

James Jerzak, M.D. Bellin Health personal communication 1.24.16
Our CMAs and LPNs do the computer work, including order entry, refills, care gap closures, and team documentation. The physicians and advanced practice clinicians are able to focus totally on the patient during the entire visit.

James Jerzak, M.D. Bellin Health
personal communication 1.22.16
Team Documentation
Bellin Health Green Bay

• New Model
  – 2 MA: 1 RN: 1 MD
  – Extended care team
  – ↑ prevention metrics
  – ↑ chronic ill. metrics
  – ↑ in margin
  – ↑ staff/MD satisfaction

Bellin Results

Quality Metrics (screenings)
Breast Screening
  Baseline 55.37%
  Goal (6 months) 58.13%
  Actual 59.51%
Cervical Screening
  Baseline 69.61%
  Goal (6 months) 73.09%
  Actual 78.64%
Colorectal Screening
  Baseline 79.41%
  Goal (6 months) 83.38%
  Actual 83.5%

Financial Metrics (operating margin for Dr. Jerzak)
  Baseline – negative 2.2%
  Goal – negative 1.2%
  YTD Actual – positive 6.1%
Team Documentation
Bellin Health Green Bay

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>

Google Glass Pilot
Palo Alto Medical Foundation

- **10 internists x 1 yr**
  - video (wear glasses) or audio (around neck)
- Physicians are delighted as takes away an average of 2 hours of documentation time per day
- 95% charts closed 2-5 minutes after visit
- 97% patient acceptance
- Cost: $25,000/MD/yr (1/3 cost of MA)
  - Source: GPIN newsletter 12.15
I get to look at my patients and talk with them again. We’re reconnecting…. Our patient satisfaction numbers are up, our quality metrics have improved, our nurses are contributing more, and I am going home an hour earlier to be with my family.

Amy Haupert MD, family physician, Allina-Cambridge
11.29.11 personal communication

Team Documentation
Kaukauna, WI

• “4 weeks/year”
  – 2 MA: 1LPN: 1 MD
  – 2 pt/d cover cost
  – 21 → 28 visits/d
  – 30% ↑ revenue
I have seen 235 more patients in the first 6 months (the equivalent of 4 additional weeks of patient care), I have more that paid for the additional RN...and I have actually had time to do some fun reading. In brief, I have done more, billed more, dictated less, have more face time with patients, and my family gets to see me.

Michael Werner M.D.
family physician, Kaukauna WI, personal communication

9.29.15

UCLA: saves 3 hr/d
JAMA IM 2014
Team Documentation
UCLA

- “Physician Partners”
  - Scripts/COE
  - Charting/Charge
- JAMA IM 5.14
  - Pt satisfaction w/MD time ↑
  - Save 1.5 hr/4hr
- Training Academy

Team Documentation

- Six sites
- Similar results
  - Access 20-30% ↑
  - Costs covered
  - Satisfaction ↑
  - Quality metrics ↑
  - Physician
    - home hour earlier
    - no work at home
Business Case
Panel 4000 patients

– Clinic A 1:1
  • 4 MDs @ $250k $1,000,000
  • 4 MAs @ $50k _______ 200,000
  _______ $1,200,000

– Clinic B 3:1
  • 2 MDs _______ = 500,000
  • 6 MAs _______ 300,000
  _______ $ 800,000

Save $400,000 per 4000 patients

(+ Happier docs,
staff, pts, better recruitment,
retention)

Business Case
Panel 4000 patients

– Clinic A 1:1
  • 4 MDs @ $250k $1,000,000
  • 4 MAs @ $50k _______ 200,000
  _______ $1,200,000

– Clinic B 3:1
  • 2 MDs _______ = 500,000
  • 6 ADNs @ $75k _______ 450,000
  _______ $ 950,000

Save $250,000 per 4000 patients

(+ Happier docs,
staff, pts, better recruitment,
retention)
Assistant Order Entry

• U Alabama GIM
  – Positive deviant 2015 ACGLIM survey of 20 GIM depts
  – Productivity
    • 16% ↑ wRVU/session
  – Work-life balance
    • Notes completed in clinic 0% → 43%
    • Weekend charting 86% → 57%
  – Marked reduction in burnout
• “I feel like I’m taking better care of my patients because I’m not doing everything.”
The miracle of scribes is that I rediscovered what I didn’t even know I had lost—the beauty of reconnection with my patients. It is so much fun. I haven’t had fun in the clinic in years.

Mark Linzer, MD General internist, Hennepin County, MN

2.17.15 personal communication
Challenges

3. Vast amounts of *time spent documenting care*

Action Steps

- Regulatory Institutions
  - Team log-in
  - Meaningful Use Stage 2

- Technology
  - Seamless transitions between users

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**Stage 2**

*Eligible Professional*  
**Meaningful Use Core Measures**  
**Measure 1 of 17**

*Date issued: October, 2012*

Order as it becomes part of the patient’s medical record, these orders would count in the numerator of the CPOE measure.

Any licensed healthcare professionals and credentialed medical assistants, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.

4. Computerized technology that pushes more work to the clinician

The worklist is unbearable. I spend 1.5 hours clearing out my worklist before leaving and another 1.5 hours at home after the kids go to bed.

Primary Care Physician, Des Moines, IA; 2011
<table>
<thead>
<tr>
<th>Challenges</th>
<th>Innovations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Computerized technology that pushes more work to the clinician</td>
<td><strong>RFID Sign On</strong></td>
</tr>
<tr>
<td></td>
<td><strong>“Tap and Go”</strong></td>
</tr>
<tr>
<td></td>
<td>• Dean Clinic</td>
</tr>
<tr>
<td></td>
<td>– 73 signs to 2 sign ins per day</td>
</tr>
<tr>
<td></td>
<td>– Saved 14 min/d</td>
</tr>
</tbody>
</table>

"I thought you were supposed to be user-friendly!"
Challenges

4. Computerized technology that pushes more work to the clinician

Action Steps

Institutions
- ↓ message generation
- Nurses filter inbox

Regulators
- Modifications to accommodate teamwork
- Technology
- Improved usability
- Team-based design

Challenges

5. Teams that function poorly and complicate rather than simplify the work

Innovations

Teams that function poorly and complicate rather than simplify the work
RFID Sign On
“Tap and Go”

• Dean Clinic
  – 73 signs to 2 sign ins per day
  – Saved 14 min/d

Challenges

5. Teams that function poorly and complicate rather than simplify the work

Action Steps
Observations from 23 Teaching Practices Across the US

“Clinic First”
Small core faculty (40 → 10 MDs for 4 FTE)
2 wk scheduling blocks
Stable team pairings
Sufficient staff
Engage residents in transformation

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

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

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

• Technology
  – Telemedicine
  – EHR implementation

www.stepsforward.org

Six steps to pre-visit laboratory testing

1. Re-appoint the patient at the conclusion of each visit
2. Pre-order labs and other needed tests
3. Use a visit planner checklist to arrange the patient’s next appointment(s)
4. Arrange for tests to be completed before the next visit
5. Delegate computerized order entry
6. Empower staff to manage the inbox

Pre-visit laboratory testing
Save your practice time and effort while improving care and enhancing the patient experience with pre-visit laboratory testing.
Pre-visit planning

Ten steps to pre-visit planning

During the current visit
1. Re-appoint the patient at the conclusion of the visit
2. Use a visit planner checklist to arrange the next appointment(s)
3. Arrange for laboratory tests to be completed before the next visit

Before the next visit
4. Perform visit preparations
5. Use a visit prep checklist to identify gaps in care
6. Send patients appointment reminders
7. Consider a pre-visit phone call or email

During the next visit
8. Hold a pre-clinic care team huddle
9. Use a pre-appointment questionnaire
10. Hand off patients to the physician

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></td>
<td>Age 2 to 65 years, every 3 years; history of abnormal PAPs (or every 5 years if over 30 and most recent HPV negative and HPV-negative)</td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 74 years, 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></td>
<td>Age 50 to 71 years, every 10 years (more frequent if history of colon polyp or family history of colon cancer)</td>
</tr>
<tr>
<td>Bone density scan (DEXA)</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 years, every 5 years for women if previous results were normal; every 7 years if symptoms of osteoporosis exist</td>
</tr>
<tr>
<td>Abdominal aortic aneurysm</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 75 years; screening for men who have ever smoked</td>
</tr>
<tr>
<td>Visual acuity</td>
<td></td>
<td></td>
<td></td>
<td>Age ≥ 45 years (new Medicare enrollees) Can be completed during the “Welcome to Medicare” visit</td>
</tr>
<tr>
<td>Glaucoma screen</td>
<td></td>
<td></td>
<td></td>
<td>Age ≥ 45 years, 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></td>
<td>Age &lt; 10 years; 2 doses at birth followed by 1 dose every 10 years</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age ≥ 9 months; annually</td>
</tr>
<tr>
<td>Shingles vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age ≥ 50 years; postherpetic neuralgia at risk</td>
</tr>
<tr>
<td>Pneumococcal vaccine (PCV13 or PPV23)</td>
<td></td>
<td></td>
<td></td>
<td>Age ≥ 65 years; postherpetic neuralgia (at risk) or chronic illness requiring anti-infective prophylaxis; patients age 19 to 65 with a chronic heart condition may need a pneumococcal vaccine.</td>
</tr>
</tbody>
</table>
### QI Metrics

<table>
<thead>
<tr>
<th>Clinic week</th>
<th>Time spent documenting and performing administrative functions</th>
<th>Total # of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 4:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 5:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add daily totals to determine total number of hours per clinic week (numerator)

Number of days completed per clinic week (denominator)

Average time spent documenting and coordinating patient care by the clinician (numerator divided by denominator)

*Data to include in Step 2 →*
PRE-VISIT PLANNING

DURING THE CURRENT VISIT

Patient is at the office for their current visit

Receptionist schedules follow-up appointment(s) for patient before they leave the office

Uses the patient's e-mail to notify the patient of any work or other diagnostic test results before their next appointment

Uses a visit planner checklist to arrange next appointment(s)

Medical assistant rooms patient and updates patient record based on information on pre-visit questionnaire, conducts medication reconciliation

Physician portion of visit begins. Pre-visit planning commences at the "current visit"

DURING THE NEXT VISIT

Medical assistant reviews notes from prior visit and confirms that documentation from interval care has been obtained

Prints copies of lab results and other important results

Use a visit planner checklist to arrange next appointment(s)

Terminal point

Process

Decision

Improvement opportunities

WAIT TIME PROCESS FLOW

Patient arrives at clinic

Patient services representative (PSR) greets patient and hands over paperwork for review & signature

PSR collects copay and insurance information

Medical assistant takes patient back on "first ready" basis, takes vitals & updates history and completes medication reconciliation

Patient has encounter with physician

Are additional diagnostic tests required in the office?

No

Yes

Physician waits while physical/emotional problems are discussed, instructions are given, medications are discussed, follow-up orders are entered

Diagnostic test is completed

Patient waits for physician to enter & start visit

Terminal point

Process

Decision

Improvement opportunities

Patient waits for the physician, nursing team to complete the purpose of the patient's visit

Patient receives referrals, orders, after-visit summary and instructions, schedules follow-up appointments as necessary and completes check-out

Patient leaves clinic
### MOST COMMON PROCESS MAP SYMBOLS

Which symbols should you use? Most process maps can be created using a few basic flowchart symbols. Here are some common symbols and their meanings. To create your own map, copy and paste these symbols into a new slide.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Process" /></td>
<td>Process represents a step or activity in your process.</td>
</tr>
<tr>
<td><img src="image" alt="Terminal points" /></td>
<td>Terminal points indicate the starting or ending points of a process.</td>
</tr>
<tr>
<td><img src="image" alt="Delay" /></td>
<td>Delay represents a waiting period where no value-added activity takes place.</td>
</tr>
<tr>
<td><img src="image" alt="Decision" /></td>
<td>Decision indicates a point where the outcome of a decision dictates the next step. There can be multiple outcomes, but often there are just two - yes and no.</td>
</tr>
<tr>
<td><img src="image" alt="Document" /></td>
<td>Document represents a step that requires or results in a document.</td>
</tr>
<tr>
<td><img src="image" alt="Kaizen bursts" /></td>
<td>Kaizen bursts indicate improvement opportunities.</td>
</tr>
<tr>
<td><img src="image" alt="Preparation" /></td>
<td>Preparation indicates an action that helps prepare for the next step in the process.</td>
</tr>
<tr>
<td><img src="image" alt="Manual operation" /></td>
<td>Manual operation indicates an operation or adjustment to the process that can be made manually.</td>
</tr>
</tbody>
</table>

### CONNECTORS

Connectors are lines that link different flowchart symbols. Once placed, connectors will stay connected to the symbols they are linked to. Move linked symbols and their connectors will automatically reorient with them.

<table>
<thead>
<tr>
<th>Connector</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Solid lines" /></td>
<td>Solid lines are used to connect the flowchart symbols.</td>
</tr>
<tr>
<td><img src="image" alt="Dotted lines" /></td>
<td>Dotted lines indicate an alternate process.</td>
</tr>
<tr>
<td><img src="image" alt="Arrow on both ends" /></td>
<td>Arrow on both ends indicates that the process flow can move in either direction between the two steps.</td>
</tr>
<tr>
<td><img src="image" alt="Arrow on one end" /></td>
<td>Arrow on one end indicates the direction of the process flow.</td>
</tr>
<tr>
<td><img src="image" alt="Swim lanes" /></td>
<td>Swim lanes can be used to delineate roles and responsibilities within your practice. Lanes can be arranged horizontally or vertically. See EXAMPLE 2 for swim lane element.</td>
</tr>
</tbody>
</table>
Five steps for involving staff in rooming and discharge activities

1. Identify current workflows
2. Create a rooming checklist
3. Refine the rooming checklist
4. Create a discharge checklist
5. Provide ongoing staff training

---

Rooming Checklist

<table>
<thead>
<tr>
<th>Preventive screening</th>
<th>Due</th>
<th>Up-to-Date Code</th>
<th>N/A</th>
<th>Target population and recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDP</td>
<td></td>
<td></td>
<td></td>
<td>Age 0 to 62 years: Every 2 years. For those over 62 years old, if a positive PAP test, then every 1 year. Special note: Women over 62 years old may choose to discontinue mammography.</td>
</tr>
<tr>
<td>Pap smear</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 62 years: Every 3 years. For those over 62 years old, if a positive PAP test, then every 1 year. Special note: Women over 62 years old may choose to discontinue mammography.</td>
</tr>
<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 65 years: Every 2 years. For those over 65 years old, if a positive mammogram result, then every 1 year. Special note: Women over 65 years old may choose to discontinue mammography.</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 74 years: Every 10 years. For those over 74 years old, if a positive colonoscopy result, then every 1 year. Special note: Women over 74 years old may choose to discontinue colonoscopy.</td>
</tr>
<tr>
<td>Cystoscopy</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 74 years: Every 10 years. For those over 74 years old, if a positive cystoscopy result, then every 1 year. Special note: Women over 74 years old may choose to discontinue cystoscopy.</td>
</tr>
<tr>
<td>Skin and breast cancer</td>
<td></td>
<td></td>
<td></td>
<td>Age 65 to 75 years: Every 2 years. For those over 75 years old, if a positive colonoscopy result, then every 1 year. Special note: Women over 75 years old may choose to discontinue skin and breast cancer screening.</td>
</tr>
<tr>
<td>Visual acuity</td>
<td></td>
<td></td>
<td></td>
<td>Age 40 to 65 years: Every 2 years. For those over 65 years old, if a positive colonoscopy result, then every 1 year. Special note: Women over 65 years old may choose to discontinue visual acuity screening.</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td></td>
<td></td>
<td></td>
<td>Age 40 to 65 years: Every 2 years. For those over 65 years old, if a positive colonoscopy result, then every 1 year. Special note: Women over 65 years old may choose to discontinue cataract surgery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Due</th>
<th>Up-to-Date Code</th>
<th>N/A</th>
<th>Target population and recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age 11 years: All children should receive 5 doses by the age of 11 years.</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age 6 months: Ages 6 to 35 months.</td>
</tr>
<tr>
<td>Hepatitis vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age 40 years: All children should receive 3 doses by the age of 40 years.</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age 65 years: All children should receive 3 doses by the age of 65 years.</td>
</tr>
<tr>
<td>Pneumococcal vaccine (MAR/NOG)</td>
<td></td>
<td></td>
<td></td>
<td>Age 65 years: All children should receive 3 doses by the age of 65 years.</td>
</tr>
</tbody>
</table>

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Making the business case

**Eight steps to team documentation**

1. Create a change team
2. Decide who will help with documentation
3. Determine the model: Clerical Documentation Assistant (CDA) or Advanced Team-based Care
4. Start with a pilot
5. Select the pilot personnel based on commitment
6. Define your workflow
7. Start small
8. Meet weekly

**Making the business case**

<table>
<thead>
<tr>
<th>YOUR PRACTICE</th>
<th>PHYSICIAN</th>
<th>FULL-TIME DOCUMENTATION SPECIALIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 3.00 /min</td>
<td>20 /day</td>
<td>$ 23.00 /hour</td>
</tr>
<tr>
<td>8 hours</td>
<td>10 min/visit</td>
<td>D</td>
</tr>
<tr>
<td>220</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL TIME SAVINGS**

3.20 M

**TOTAL FINANCIAL SAVINGS**

$132,000 - ($40,480) = $91,520

Gross annual savings with team documentation
Annual cost of dedicated documentation specialist
Net practice savings with team documentation
Team Documentation

APF: pt centered, team-based and mindful of care team well being.

The biggest difference -- is team, culture and time. Time with patients to better understand who they are, their story.

I wouldn't trade that for anything. I'm loving it.

Ben Crocker, MD
Internist
MGH

Checkbox 2011
Our Work Going Forward

How can we contribute to transformation

“Working in clinic is unbearable”

Entrusted and empowered by tech, team, policy

“I’m loving it”

Quadruple Aim

Better Outcomes

Physician Wellness

Lower Costs

Improved Patient Experience

Missing Aim
What patients want is that deep relationship with a healer; this is the foundation upon which we need to build healthcare.

Paul Grundy, MD
IBM, PCPCC
personal communication
1.30.09

The Map is not the Territory

"If you didn't document it, it didn't happen,"
Fresh ears are told in medical school.

But then one day we realize that documenting doing doesn't make it so,
Experiencing makes it so.
"Visited patient in her basement.
Ascites worsening as she drinks more
after death of son in motor vehicle accident."

What more should I write?

How do you document bearing witness?

The Code is not the Care

The Pocket Guide:
It folds like origami
and reads like computer code,
this item we received early in residency.
In small font and syllogism,
It tells us what our time with a patient is worth.
It sustains anachronisms
like the review of systems.
Three chronic conditions is the key
that opens a Level 4 lock.
Now we hear these notes are being poorly done. They have too much. They have too little. They don’t have the right elements. Doctors need better education. They need more detailed notes.

We also hear there is burnout. Access problems for patients. People leaving primary care or not entering it.

We hear EHRs are good. We hear they are bad.

Why don’t we start at the beginning? The care of the patient is what matters most. The map is not the terrain. The code is not the care.

Colleagues have left practice Unable to keep up with the note-production complex.

Charting encroaches on caring. This is what happens when a means for recording meaning is alchemized into a tool for billing, a means for monitoring, a line of defense.
The patient-doctor “conversation” becomes an act of distraction, lapsed eye-contact, and keyboard tapping.

This is pawn activity.

Finishing a patient session becomes prelude to converting it into billable accounts.

We rush.
Patients notice.

The map is not the territory.
The code is not the care.

Doctors got to where we are because we follow rules well.

What to do then, when the rules erode our doctoring?

The map is not the territory.
The code is not the care.
This year over 1,000,000 Americans will lose their doctor.

Not because of unemployment.
Not because of Obamacare.
Not because of insurance coverage or plan changes.

But because of doctor SUICIDE.

An average of 400 US doctors commit suicide every year.
Quadruple Aim

- the most refine, most expensive and most important clinical “instrument” in our health system continues to be the physician.
The most refined, most expensive, and most important clinical “instrument” in our health system continues to be the physician.

Stanford Dean’s report 2015

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**Business Case**

- **Burnout doubles likelihood MD leave**
  (Stanford) (“may cost $1 million”)
Conceptual Model: Matching Work to Worker

Worker is under trained for the task
Worker is over trained for the task

Complexity of work
Training

Sweet spot: worker and work are well matched

Unsafe

Inefficient (Waste)

Modified from A. Mulley

Calculus: wrong work → burnout

Current Work Distribution in PC

High value
Good match
“Solution Shop”

“Production Line”

Current Work Distribution in PC

Complexity of work
Training

High value
Good match
“Solution Shop”

“Production Line”

PA
Vitals
Script renewals

RN
MA
NP
PA
RN
MD

Inbox mgmt
Med rec
Script renewals
Data entry
Data gathering
Prior authorization
Sign for hearing aid battery

Dx and Rx plan
Complex chronic
Relationship bldg
Shared decision making

Current Work Distribution in PC
In few other sectors of the economy is the highest-level professional responsible for the majority of production, customer service, and clerical work.

4000 Clicks

- 6 clicks to order an aspirin
- 8 clicks to order a CXR
- 15 clicks for one prescription
- 40 clicks to record hand and wrist exam
- >40% of ER shift on data entry


370 data EHR actions per visit


- Higher level of EHR use over time did not reflect doing more work, but doing more documentation of the work done.
A DAY IN THE LIFE OF DR. JONES

24 VISITS / 16 HRS / 2,541 CLICKS

6:30 AM
- Dr. Jones arrives, spends time to begin planning the day
- Support staff begins cleaning, preparing for the day

10:42 AM
- An unexpected drop-in with stomach pain entails attention
- Dr. Jones is left waiting through lunch

2:09 PM
- An overly complex case takes nearly 3 hours of Dr. Jones’ time
- By the end of the day, patients are still being seen until 6:30 PM after check-in

http://linkis.com/healthcareitnews.com/5UBZl

10 hours of charting for 6.8 hours of scheduled
A Day in the Life of Dr. Jones

Blue: MA computer time
Green: MD computer time
Each row is a patient

2.5 hours of after hours charting

PCP:
Paperwork Completing Physician?

“The Doctor must be the one to fill out the entire 7 Element order, a member of the staff can no longer fill out any portion.”
Physician burnout is associated with…
  - ↑ Malpractice risk
  - ↑ Part time
  - ↑ MD and staff turnover

Replace PCP costs $250,000 (1999)

Am J Man Care Jul 2001;7(7):701-713
Med. Care Mar 2006;44(3):234-242
http://psycnet.apa.org/?&fa=main.doiLanding&doi=10.1037/0021-9010.73.4.727