In Search of Joy in Practice

American Medical Group Association
Orlando, FL
Christine A. Sinsky, MD, FACP
March 10, 2016
9-10:30a

“I should be spending more time on my patients, not on paperwork.”

“Delivering quality care takes a coordinated effort.”

“wish we could be our team more effectively”
Agenda

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

Take-away

4th Aim

- Better Outcomes
- Lower Costs
- Improved Patient Experience
- Physician Wellness
Two Doctors and a Patient
Program Director Geriatrics
UConn

“Working in clinic has become so painful that I have decided to leave my beloved patients—unbearable to think about.”

Gail M Sullivan, MD
Speaking of performance measures: The little things have become the big things—I fear our roles as healers, comforters, and listeners are being lost.”

2008

Ben Crocker, MD
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 $\frac{1}{2}$ of MDs Burned Out

Linzer: Chaos, ↓ control, time pressure, lack of values align leadership
Physician Burnout Rising

28% gen’l pop

Students start med school w/stronger mental health profiles
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 $250,000

- (1999)
Burnout Costs Physicians

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

Physician Career Satisfaction

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

“We have to get the hearts and minds of physicians back. I think we’ve lost them.”
“Pajama Time”
Sat nights belong to Epic
There is growing evidence related to EHR. Physicians spend most time in the EHR doing documentation (33.9%). A retrospective cohort study from 1/1/13 analyzed the EHR access logs of 130 family physicians. The study did not account for the additional physician time spent on EHR systems.

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

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

Context
- There is growing evidence that EHR systems adoption and safety of health care could improve.
- Less is known about EHR systems adoption and their impact on quality of care, satisfaction, work RVUs (or other measures of efficiency), quality outcomes, and care team function including communication style (in-person vs electronic).

Objective
- To assess usage with an EHR system during and after work hours.
- To better understand how much time physicians spend on EHR systems.

Design
- Retrospective cohort study
- System access logs were extracted to create database
- A fuzzy matching model was used to combine data from EHR access logs and patient encounter data.

Setting / Participants
- 130 family physicians (average 5 years) from 18 clinics (4 residents, 4 medical students, 1 community) managed by the University of Wisconsin Department of Family Medicine and Community Health.

Results
- 277,497 records analyzed
- Clinician statistics were based on UW Health's December 2014 panel
- Panel statistics were based on UW Health's December 2014 panel

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>PATIENT CLINICAL INFO</td>
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<tr>
<td>PATIENT CLINICAL INFO (patient)</td>
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<td>PATIENT CLINICAL INFO (physician)</td>
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<td>PATIENT CLINICAL INFO (time)</td>
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<tr>
<td>PATIENT CLINICAL INFO (name)</td>
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</tbody>
</table>

### Work After Work: Evidence From PCP Utilization of an EHR System

#### 38 hours

**Work after Work per month**

1 full week/mo
In Search of Joy in Practice

Co-Investigators

- Christine Sinsky - PI
- Tom Bodenheimer - PI
- Rachel Willard
- Tom Sinsky
- Andrew Schutzbank
- David Margolius

ABIM Foundation

AMCA 2016 Annual Conference
In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

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

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

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

Workflow
Task distribution
Physical space
Technology
Challenges

- Chaotic visits
- Inadequate support
- Teams function poorly
- EHR → work to MD
- Time documentation
Challenges

1. Chaotic visits with overfull agendas

Family doctors are overwhelmed with patients, procedures and paperwork. Many are leaving the field, creating a scarcity of primary-care physicians. (Christopher Serra, For the Times / June 27, 2011)
Fairview: Care Model Redesign
MA pre-visit call
Agenda, Med review
Depression screen
Advanced directive
Mayo-Red Cedar arranges for pre-visit lab
Same day pre-visit lab (15 min)
ThedaCare
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

Pre-visit planning
Enhance the patient experience, increase patient engagement and improve practice efficiency.

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

AMCA 2016 Annual Conference
# 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>To be completed in anticipation of a patient’s upcoming visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient name:</strong></td>
</tr>
<tr>
<td><strong>Date of previous visit:</strong></td>
</tr>
</tbody>
</table>

<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 21 to 65 years</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 3 years if no history of abnormal PAPs (or every 5 years if over 30 and most recent PAP negative and HPV-negative)</td>
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<tr>
<td>Mammogram</td>
<td></td>
<td></td>
<td></td>
<td>Age 50 to 75 years</td>
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<td></td>
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<td>Every 1 to 2 years; or for those 40 to 50 and &gt;75 screening is optional</td>
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<tr>
<td>Colonoscopy</td>
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<td>Age 50 to 75 years</td>
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<td></td>
<td></td>
<td>Every 10 years (more frequent if history of colon polyp or family history of colon cancer)</td>
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<tr>
<td>Bone density scan (DEXA)</td>
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<td>Age 65 years</td>
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<td>Every 10 years for women if previous results were normal; every 5 years if symptoms of osteopenia exist</td>
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<tr>
<td>Abdominal aortic aneurysm</td>
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<td>Age 65 to 75 years</td>
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<td></td>
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<td>One-time screening for men who have ever smoked</td>
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<tr>
<td>Visual acuity</td>
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<td></td>
<td>Age &gt;65 years (new Medicare enrollees)</td>
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<td></td>
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<td>Can be completed during the “Welcome to Medicare” visit</td>
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<tr>
<td>Glaucoma screen</td>
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<td>Age &gt;65 years</td>
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<td>Annually</td>
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</tbody>
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<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>
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<td></td>
<td>Age &gt;19 years</td>
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<td></td>
<td>Administer Tdap once; boost with Td every 10 years</td>
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<tr>
<td>Influenza vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age &gt;6 months</td>
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<td>Annually</td>
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<tr>
<td>Shingles vaccine</td>
<td></td>
<td></td>
<td></td>
<td>Age &gt;60 years</td>
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<td>Option if &gt;50 years</td>
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<tr>
<td>Pneumococcal vaccine (PCV13 or PPSV23)</td>
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<td></td>
<td></td>
<td>Age &gt;65 years</td>
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<td>PCV13 now, followed by PPSV23 six to 12 months later</td>
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<td></td>
<td>If already received PPSV23, wait at least one year before giving PCV13</td>
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<td></td>
<td>Patients age 18 to 65 with a chronic* or immunocompromising condition may also need a pneumococcal vaccine.</td>
</tr>
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Prescriptions are killing us...my nurse is spending so much time on refills that we can’t seem to get anything done.

Minnesota Family Physician
2007
Annual Prescription Renewals

• “90 + 4”
• Physician time
  – 0.5 hr/d
• Nursing time
  – 1 hr/d per physician
Synchronized prescription renewal
On-line Calculators

Calculate your savings:

1000 \times 5 \times 3 \times 1 = 250 

Hours per year saved

- 1000 patients with chronic illness
- 5 medications per patient
- 3 calls per prescription per year
- 1 minute per call
Challenges

1. Chaotic visits with overfull agendas
<table>
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<tr>
<th>Challenges</th>
<th>Innovations</th>
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<tr>
<td>2. <strong>Inadequate support</strong> to meet the patient demand for care</td>
<td></td>
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</tbody>
</table>

- Sharing the care among the team
  - 2:1 or 3:1
  - Rooming protocol
  - Between visit
  - Health coaching
  - Care coordination
  - Panel mgm't
Mayo Red Cedar: New Model of Nursing (2:1)
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
Expanded rooming & discharge protocols
Empower staff to make patient visits more meaningful and efficient.

Expanded rooming and discharge protocols

CME CREDITS: 0.5 INFORMATION ABOUT CME

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

## Preventive Screening

<table>
<thead>
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Every 1 to 2 years; or for those 40 to 50 and >75 screening is optional |
| Colonoscopy        |                |      | Age 50 to 75 years  
Every 10 years (more frequent if history of colon polyp or family history of colon cancer)            |
| Bone density scan  |                |      | Age 65 years  
Every 10 years for women if previous results were normal; every 5 years if symptoms of osteopenia exist |
| Abdominal aortic   |                |      | Age 65 to 75 years  
One-time screening for men who have ever smoked                                                 |
| Aneurysm           |                |      |                                                                                                      |
| Visual Acuity      |                |      | Age >65 years (new Medicare enrollees)  
Can be completed during the “Welcome to Medicare” visit                                          |
| Glaucoma Screen    |                |      | Age >65 years  
Annually                                              |

## Immunization

<table>
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</table>
| Tdap vaccine      |                |      | Age >19 years  
Administer Tdap once, boost with Td every 10 years                                                |
| Influenza Vaccine |                |      | Age >6 months  
Annually                                                |
| Shingles Vaccine  |                |      | Age >60 years  
Option if >50 years                                      |
| Pneumococcal      |                |      | Age >65 years  
Patients age 18 to 65 with a chronic* or immunocompromising condition may also need a pneumococcal vaccine |
| Vaccine (PCV13 or PPSV23) |        |      | PCV13 now, followed by PPSV23 six to 12 months later    |
|                   |                |      | If already received PPSV23, wait at least one year before giving PCV13  |

[Download a Sample Rooming Checklist]
[Download a Sample Discharge Checklist]
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
Undivided attention
Continuous partial attention
Challenges

3. Vast amounts of time spent documenting care

Innovations
Team documentation at Cleveland Clinic
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
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.
Collaborative Care at Bellin
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
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>
UCLA: saves 3 hr/d

JAMA IM 2014
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
Team Documentation

• Six sites
• Similar results
  – Access 20-30% ↑
  – Costs covered
  – Satisfaction ↑
  – Quality metrics ↑
  – Physician
    • home hour earlier
    • no work at home
Team documentation
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
On-line Calculators

**YOUR PRACTICE**
- Cost of physician's time: $3.00/min
- Work day: 8 hours
- Clinic days per year: 220 days/year

**PHYSICIAN**
- Total visits per day: 20/day
- Physician documentation time: 10 min/visit

**FULL-TIME DOCUMENTATION SPECIALIST**
- Documentation specialist hourly rate (including benefits): $23.00/hour

**TOTAL TIME SAVINGS**
- Physician documentation time saved: 3h 20m/day

**TOTAL FINANCIAL SAVINGS**
- Gross annual savings with team documentation: $132,000
- Annual cost of dedicated documentation specialist: ($40,480)
- Net practice savings with team documentation: $91,520
Team Documentation
Challenges

3. Vast amounts of time spent documenting care

Action Steps

- Team log-in
- Meaningful Use Stage 2 Institutions
- Staffing ratios
- Assistant order entry
- Technology
- Seamless transitions between users
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.

Fairview: Filtering Inbox

Reduce “backpack” 90min/d to few min
Optimize Physical Space
Fairview: Filtering Inbox

Reduce “backpack” 90min/d to few min

Line of Sight
Semi-circular desk, APF
RFID Sign On
“Tap and Go”

• Dean Clinic
  – 73 signs to 2 sign ins per day
  – Saved **14 min/d**
Flow station at North Shore Physicians Group

HP: Saves 30 min/day/physician
Printer in every room University of Utah Redstone

HP: Saves 20 min/day/physician
Daily Huddles
Prepare for a Smooth Day
Team Meetings
Do Work + Make Work Better
Challenges

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

Action Steps

- Co-location
- Line of sight
- Space for huddles
- Time for meetings
Introducing AMA
STEPSforward™

Revitalize your practice and help improve patient care.

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

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

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

• Technology
  – Telemedicine
  – EHR implementation

• Culture
  – Preventing Burnout
  – Resiliency
  – Wellness in Residency
  – Transforming culture
Checkback 2011

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
Our Work Going Forward

How can we contribute to transformation

“Hearting in clinic is unbearable”

Entrusted and empowered by tech, team, policy

“I’m loving it”
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
“Medical care must be provided with utmost efficiency. To do less is a disservice to those we treat, and an injustice to those we might have treated.”

Sir William Osler, 1893