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CME

Clinical Workflow Efficiencies to Alleviate Physician Burnout and Reduce Work After Clinic

Reducing physician burden starts with four key changes.

Burnout rates among physicians continue to rise. In the 2023 Medscape Physician Burnout and Depression Report, 57% of family medicine physicians reported feeling burnt out — up 10 percentage points in five years.[1] Among all specialties, 53% of physicians reported burnout. The top contributor was "too many bureaucratic tasks," such as paperwork and charting requirements. Too many working hours and the increasing computerization of practice were also cited as key causes.

A prior study helped quantify this burden. It showed that family physicians spent an average of 5.9 hours of an 11.4-hour workday in the electronic health record (EHR), with an average of nearly 90 minutes of "pajama time" (work outside of normal working hours) per day.[2] ➤

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Recently, the U.S. Surgeon General called on health systems, insurers, government agencies, and others to implement system-level changes to address health worker burnout.[3] But many of us are looking for more immediate ways to alleviate this burden. To address this need in my practice, part of my time is dedicated to working one-on-one with primary care physicians and advanced practice providers to find meaningful ways to improve clinical workflows and optimize use of the EHR to decrease their pajama time and reduce burnout. We cannot fix everything, so we focus on what we can control. This article shares the top four tips that work for us again and again, and some lessons we've learned about the process.

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DELEGATE, DELEGATE, DELEGATE

A recent simulation study showed that primary care physicians would need to work 27 hours per day to meet current guidelines for preventive, chronic disease, and acute care for their patient panels.[4] No wonder we feel overwhelmed. The study found that team-based care decreased this time commitment by more than half, which results in a workload that is still not doable but is moving in the right direction. Decreasing physician burden requires that team members help share the load. We've found that there is no one-size-fits-all strategy for this, even for practices employed by the same health system. You need to assess the staff and resources you have and what you can reliably delegate to others, who must be working at the top of their licenses.

Here are two potential areas to delegate.

First, consider creating a refill protocol for common, non-controlled substances so your medical assistants or nurses can take over your routine refills. Include stipulations about how often the patient should be seen and what lab monitoring is required while the patient is taking the medication. Artificial intelligence (AI) programs are also available that can work with your EHR and take a first pass at refills via protocols to alleviate this burden.

Second, empower your medical assistants or nurses to handle most phone calls and electronic patient messages, and route to you only those that truly require a physician's training.[5] Many of the messages physicians receive can be answered easily by staff, such as directing patients to schedule an appointment for a new problem or looking into referral issues from a previous visit. Physicians should not be doing this work.

TRAIN YOUR PATIENTS

This strategy can be called many things — agenda setting, guiding the visit, setting expectations, etc., all of which involve boundary setting. I personally like to use the term "training my patient."

The first step is working to set an agenda at each visit so that you avoid the situation where a patient says "Oh, by the way" at the end of the visit and then presents a long list of health complaints. Staff can aid the process at the beginning of the visit when asking for the chief complaint. If the patient starts listing multiple items, the medical assistant should kindly let the patient know that there likely will not be enough time to cover each of the items today and do them justice. When you enter the exam room, you should recap this information and work with the patient to prioritize the concerns, sharing the decision making about what will be covered today. If a concern cannot be covered during the current visit, agree to schedule another visit soon. Throughout the visit, continue to put up

KEY POINTS

- Top contributors to physician burnout are "too many bureaucratic tasks," such as paperwork and charting requirements, too many working hours, and the increasing computerization of practice.
- While system-level changes are needed, physicians can take immediate steps to alleviate their burden, such as delegating key tasks to other team members and practicing lean documentation.
- Implementing change can be difficult and team efficiency may decrease in the short term, but investing in the present will pay off in the future.

guardrails to keep the visit moving toward a plan for each of the problems on the agenda. I find it helpful to avoid jumping ahead to my assessment and plan for the patient while I'm still gathering information. It saves me from having to rehash that information later if something unexpected arises. Close the visit with a summary and ask if the patient has any questions about *what was covered today*. This helps avoid opening the visit to new complaints. Over time, as you develop a long-term relationship, the patient will fall into the agenda-setting pattern on their own, knowing this is the expectation for each visit.

The next step is to help set patient expectations regarding in-basket tasks. With greater use of patient portal messaging, it is now more important than ever to set boundaries with patients to maintain your own well-being. Patients need to understand that you can't personally answer every message and clinical staff will take the first pass. Patient messages regarding new problems, extensive questions, and requests for medication changes will likely need to be converted to virtual or in-person office visits. Set the expectation that you will review test results in a timely manner, but patients may see their results in the portal before you do because they are often automatically released. Knowing your interpretation is coming will head off patient messages about what the results mean. By being consistent with these boundaries, you and your staff can help patients know what to expect and what is expected from them.

PRACTICE LEAN DOCUMENTATION

When it comes to documentation, common issues we encounter in primary care are excessive time spent in clinical notes and "note bloat." The recent evaluation and management (E/M) coding changes have simplified the items that are essential to the clinical note for billing purposes.[6] Because medical decision making is the key component, you can focus on documenting what is needed for good patient care rather than checking all the right boxes or counting bullet points. Keep the note simple and easy to review in the future — for other physicians and yourself. You are not being graded on your composition and grammar like you were in training, though this mindset can be difficult to leave behind.

Limiting keystrokes will decrease your time spent writing notes and your future time spent reviewing the chart. Several techniques can help with this.

First, experiment with using "smartphrases." Each EHR system has a different name for this (dot phrases, quick phrases, macros, etc.), but most have the capability to save your commonly used phrases, directions, or information and insert them into future notes or communications with only a short phrase or keystroke. My personal rule is to never type something more than twice without making a smartphrase for it. For example, I have smartphrases for all common acute and chronic assessments and plans, as well as responses to common message types. (For smartphrase ideas, see "A starter list of EHR macros to save time on documentation," *FPM* Quick Tips blog, https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/starter-list-macros.html.)

Second, consider dictating your notes and other communications, which saves time for almost all users. It is a learned skill but worth investing in, especially with advances in voice recognition. Some dictation software can even insert smartphrases or create lab orders via voice command.

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Dictating during the visit or immediately after tends to be more efficient than dictating at the end of the day because the details of the visit are fresh in your mind.

Finally, consider cutting note bloat by writing in short phrases rather than full sentences and including only what is essential. This will help the note be a quick reference the next time you see the patient, rather than a short story to read through. Certain items, such as a patient's past surgical history, do not need to be repeated in every note. ➤

USE THE EHR AS A DATABASE, NOT A PAPER CHART

When every part of the note is added manually, it can feel like the EHR is a hindrance, a more cumbersome version of old paper charts with additional clicks. Take advantage of the capabilities of the EHR as a powerful database. In our system (Epic), we can build custom note templates that automatically pull in much of the information we need for each visit type. As mentioned above, we try to minimize the information in each template to avoid note bloat. Rather than type in the assessment and plan for each problem covered at each visit at the end of my note, I can document the assessment and plan (often using smartphrases) under each chronic problem on a patient's problem list. This simplifies chart review for that specific problem in the future because I don't have to dig through each clinic note. For example, if I need to change a patient's medication for depression, I just look under "depression" on the problem list to see what has been tried previously without sifting through entire clinic notes.

Speaking of chart review, use the EHR's search feature and filters to find the information you need more quickly. For example, you can filter the search results to show only the notes you have written or to find the patient's last cardiology visit. This wasn't possible before we had this database at our fingertips, but due to the staggering amount of information held in the patient chart now, it is essential that we leverage the tools available.

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The EHR can also make responding to lab results or messages quicker, thereby decreasing the burden of inbox management. Our EHR has a feature called QuickActions that allows for one-click responses to common messages and lab results. For example, I use this feature for all normal mammogram results to send a message to my nurse inbox or the patient portal letting them know the result was normal and to repeat the screening in one year. If your EHR doesn't offer this, you can simply use smartphrases to have common lab result messages at the ready.

Customizing the EHR to better suit your practice style is an often underutilized strategy that can yield huge benefits as well. Some options include rearranging tabs or sections to fit your workflow, creating buttons to quickly populate fields for common levels of service or follow-up intervals, changing defaults when opening a new chart, and saving your commonly ordered labs and commonly used diagnoses for quick selection. For example, in our EHR we can save lab panels for diabetes, which includes an A1C, lipid panel, comprehensive metabolic panel, and urine albumin-to-creatinine ratio. This allows access to all four of these labs with one click. Similar panels can be made for many different indications, such as annual physical labs, bariatric surgery follow-up labs, or hypercalcemia evaluation.

LESSONS LEARNED

Implementing change is hard. To start making any of the above changes, you need to allow yourself the space and grace to try and learn new things. It might be a bit clunky at first when you change a note template or customize the EHR to your preferences. You might find that as clinical staff learn to handle standard refills, the process initially takes longer than it would take you to do it yourself. Avoid giving up too soon on any new initiative. Invest in the present to reap the benefits in the future. You might try something new and find that it's not efficient and won't fit into your workflow. That happens and shouldn't discourage you from trying new initiatives later.

Ask for help. Find out what resources are available through your organization or externally. Are there colleagues who are working efficiently and seem to use the EHR to their advantage? Consider asking them for tips or shadowing them for a few hours. Many organizations have clinical informaticists — members of the IT team that work with clinicians on

improving EHR efficiency and workflows. They may be able to pull data from your EHR (e.g., your time spent on documentation, prescriptions, or inbox messages) to find target areas that will provide the most return on your time investment. Some organizations also have EHR "super users" who can help you navigate through problems that arise. Look for CME or online resources that address workflow optimization as well as courses from your EHR company.

Lastly, set boundaries early and reevaluate often. The sheer volume of documentation and inbox messages in primary care can be overwhelming. By setting boundaries through strategies such as effective delegation and patient training, discussed above, you can help protect your well-being and fend off burnout. Boundary setting may also require discussions with practice leadership about panel size, dedicated time for administrative work, and expectations around work after clinic. While these conversations aren't easy, they are crucial to prioritizing your well-being and caring for yourself while you care for others. FPM

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