Taming the Electronic Health Record Playbook

About the AMA STEPS Forward™ Playbook series

This Playbook is part of the AMA STEPS Forward™ interactive practice transformation program. Each Playbook in the series highlights key messages and links to free online toolkits, videos, podcasts, and practical tools to start creating change today. The objective of the Playbook series is to offer you a high-level overview of an area that you can choose to dive deeper into at your own pace.

Access the digital Playbook for the optimal experience.

To fully engage with the Playbook and access all the relevant links, scan this QR code to view the PDF on your smart device or computer.

About the AMA STEPS Forward™ practice innovation strategies

The AMA STEPS Forward program offers practice innovation strategies that allow physicians and their teams to thrive in the evolving health care environment by working smarter, not harder. Physicians looking to refocus their practice can turn to AMA STEPS Forward for proven, physician-developed strategies for confronting common challenges in busy medical settings and devoting more time to caring for patients. This collection offers more than 70 online toolkits and other resources that help physicians and medical teams make transformative changes to their practices, including in the areas of managing stress, preventing burnout, and improving practice workflow.

The AMA STEPS Forward™ Innovation Academy expands on the program to give participants the flexibility to customize their practice transformation journey. The Innovation Academy offers a spectrum of opportunities to learn from peers and experts, including webinars, telementoring, virtual panel discussions, bootcamps, and immersion programs.

Learn more at www.stepsforward.org.

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Introduction

50% of the physician's day spent on EHR and desk work[1]

37% of visit time with patients spent on non-clinical tasks[1]

1 to 2 hours of extra work each day, including long hours before and after clinic completing "between visit" work[1]

[1.] Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med.* 2016;165(11): 753-760. doi:10.7326/M16-0961

The EHR Problem: How Did We Get Here?

The electronic health record (EHR) has profoundly changed the practice of medicine and is perceived as both a blessing and a burden by clinicians who use it. Most physicians who did not begin their training and enter practice using a sophisticated EHR only learned enough to "get by." Younger physicians who did go through medical training using a modern-day EHR typically did not have the bandwidth to focus on mastering the EHR along with their medical knowledge. Furthermore, the near-universal adoption of virtual care and telehealth during the COVID-19 pandemic has increased patient expectations and awareness about EHR-based communication tools, resulting in increased physician time spent on the EHR.[2]

Meanwhile, the EHR has evolved dramatically, in both positive and negative ways. While most EHRs now have customizable tools that, if used optimally, can save physicians time, there are also many more unnecessary "clicks" and automated messages clogging up inboxes. The EHR burden is a major contributor to physician burnout, and it has become a problem that individual physicians cannot fix on their own. It is imperative for organizations to learn how to "tame" the EHR by implementing effective team-based care principles and responding to feedback for continuous system-level improvement.

> **"Physicians don't quit their jobs, their patients, or their bosses; they quit their inboxes."**
>
> —CT Lin, MD, FACP, FAMIA;
> Chief Medical Information Officer, UCHealth-Colorado

[2] Holmgren AJ, Downing NL, Tang M, Sharp C, Longhurst C, Huckman RS. Assessing the impact of the COVID-19 pandemic on clinician ambulatory electronic health record use. *J Am Med Inform Assoc.* 2021;ocab268. doi:10.1093/jamia/ocab268

How Can We Tackle This Problem?

The EHR problem can be thought of as encompassing a few buckets:

- the volume of *unnecessary work* that is being done (eg, extra clicks and mental bandwidth spent on filtering signal from noise, patient questions and requests that could have been avoided with better teamwork and workflow re-engineering)

- the volume of *necessary work* that needs to be done, but can be shared by nonphysician team members (eg, chart review, order entry, documentation, inbox management)

- the *technology* itself

This Playbook will focus on addressing each of these buckets so that individual clinicians and their practices can:

1. Minimize the unnecessary work by deimplementing nonessential rules and looking upstream to stop irrelevant notifications and results from entering the inbox

2. Manage the necessary work by utilizing team-based care principles to offload inbox management, order entry, and documentation from physicians alone

3. Become more personally proficient at using EHR technology

What's In Your Control?

To accomplish *any* of these changes, it is imperative to work with leadership. Some changes will be easy to make, others will be more difficult. Some changes may be institution- or organization-specific, while others may be governed by federal regulations. Having a shared understanding between leaders and practicing clinicians of "what's in your control" helps overcome inertia (or resistance to change) while building trust and transparency (Table 1).

Who Is This Playbook for?

This *Taming the EHR Playbook* is for:

- Daily EHR users (eg, physicians, physician assistants, nurse practitioners, nurses, medical assistants)

- Organizational leaders (eg, Chief Medical Information Officers [CMIOs] and Chief Compliance Officers [CCOs])

- Medical directors

- Practice managers

- Operations leaders

Anyone interested in maximizing the benefits and minimizing the burdens of the EHR can learn from the content outlined and linked to within this Playbook.

This Playbook contains highlights from 11 AMA STEPS Forward™ toolkits.

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Table 1. What's In Your Control?

Each EHR has default settings that will affect common workflows and user experiences. However, many of these can be changed by the user or organization. This table provides examples of some EHR features that affect the physician experience that can be modified at your local level.

	EHR User Control	Organizational Control	Federal Regulation
Shortcuts, note templates, autocorrect, or spellcheck functions	○		
Notifications and results that enter your EHR inbox	○	○	
Time to auto-logout		○	
Pop-up alerts upon login		○	
Team members or patients performing pre-visit medication reconciliation		○	
Team members or patients filling out pre-visit questionnaires or entering HPI components		○	
Character limits on patient portal messages		○	
Team documentation functionality		○	○
E&M coding requirements			○

Strategy 1: Stop the Unnecessary Work

The idea of getting rid of unnecessary work can feel so simple yet so daunting at the same time. Many physicians, especially those already experiencing burnout, feel resigned to whatever unnecessary work they are given. With visible leadership commitment, concrete examples to work from, and an IT and governance structure in place to evaluate and implement effective changes, unnecessary work does not have to be "just how it is."

This section will help you *tame the EHR* by:

- Eliminating unnecessary tasks and duplicative work

- Identifying opportunities to improve processes and protocols that are upstream of the day-to-day EHR work
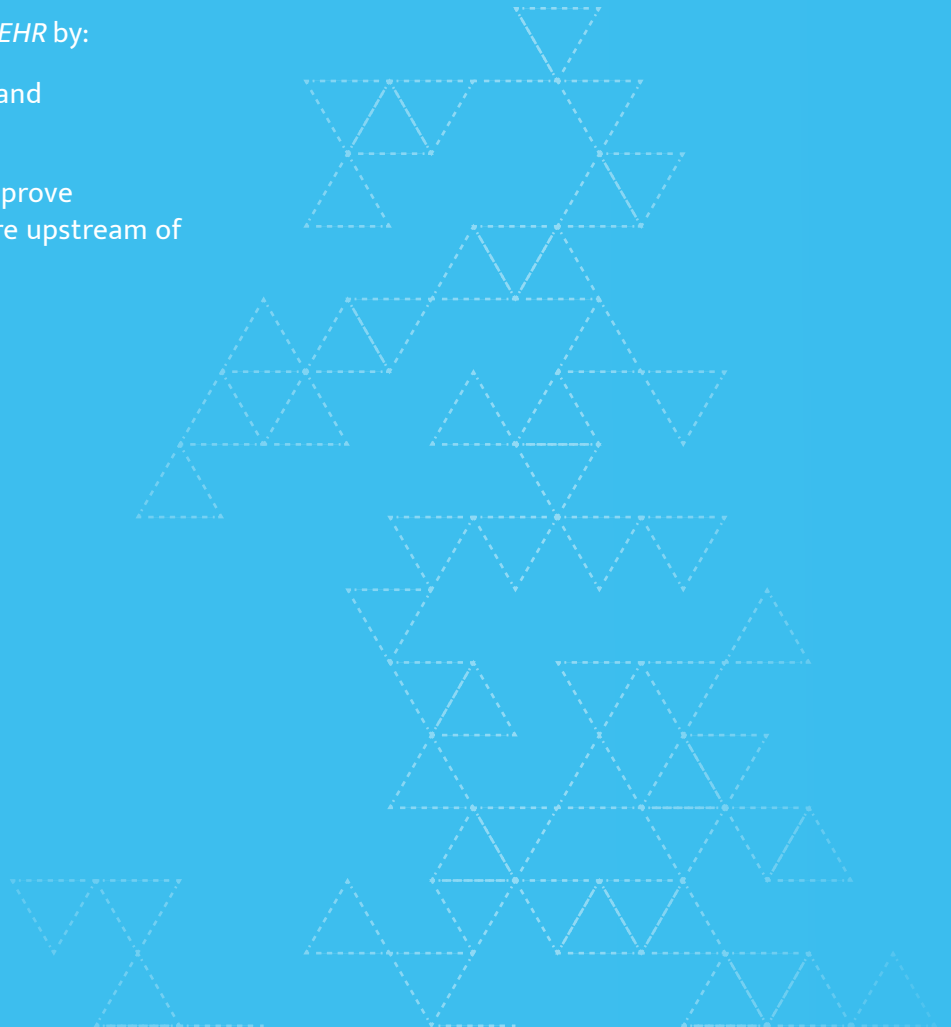
Deimplement, Deimplement, Deimplement

The **AMA STEPS Forward deimplementation checklist** is an excellent starting point for getting rid of unnecessary work. Many of these EHR deimplementation tactics can be accomplished within weeks or even days (Table 2).

Table 2. Opportunities to Deimplement in the EHR

Opportunity to act	Deimplementation action
Extend time before auto-logout	• Extend time for auto-logout depending on workstation location and security. This is under your local control and can vary by department (eg, emergency department vs clinics).
Simplify login	• Simplify and streamline login process, leveraging options like single sign-on, radio-frequency identification (RFID), proximity identification, bioidentification (fingerprint, facial recognition, etc).
Minimize alerts	• Retain only those alerts with evidence of favorable patient outcomes or cost–benefit ratios.
Decrease password-related burdens, including revalidation	• Extend the intervals for password reset requirements. • Help users create passwords that are both strong and easy to remember (ie, by allowing special characters and spaces and by allowing longer passwords that can be passphrases). • Use password manager software. • Identify ways to reduce unnecessary requirements for users to reenter username/password when already signed in to EHR or to send prescriptions for non-controlled substances.
Reduce clicks and hard stops in ordering	• Reduce requirements for the input of excessive clinical data before ordering a test. • Eliminate attesting to possible pregnancy in males or women over 60 years old.

Reduce note bloat	• Reduce links embedded in visit note documentation templates that automatically pull in data from other parts of the EHR, contributing to note bloat, but adding little if any actual clinical value.
Reduce inbox notifications for test results	• Stop sending notifications for tests ordered that do not yet have results or have test results ordered by other physicians. • Stop sending notifications for reports generated by the recipient of the notification. • Eliminate multiple notifications of the same test result or consultation note. • Auto-release normal and abnormal test results to the patient-facing portal with embedded or linked, patient-friendly explanations.
Simplify order entry processes	• Auto-populate discrete data fields if the information already exists in the EHR (eg, if a team member has entered the date of "last menstrual period," optimize your technology so no one has to reenter that data into the order for a pap smear).
Allow verbal orders	• Allow verbal orders in low-risk and crisis situations as legally permitted.
Reduce signature requirements	• Eliminate signature requirements for forms that do not legally require a physician signature. • Remove order requirements for low-risk activities that do not legally require a physician signature (eg, ear wash, fingerstick glucose, oximetry). • Do away with "challenge questions" to electronically sign orders when the user is already logged in and actively using the EHR.
Reduce attestations required daily or every time one logs in	• Eliminate actions as allowed by state or federal requirements (ie, for privacy protection attestation) that occur on a daily or every-time-one-logs-in basis (ie, consider whether or not an annual attestation is sufficient).

Getting Rid of Stupid Stuff

Building upon the deimplementation checklist, the Getting Rid of Stupid Stuff (GROSS) toolkit details a comprehensive program based on clinician feedback to help get rid of unnecessary work.[3]

Key STEPS are:

1. Appoint a high-level champion to lead the GROSS initiative

2. Engage appropriate departments to support the cause

3. Engage teams and clinicians in gathering information

4. Triage suggestions for appropriate next steps (Figure 1)

5. Celebrate success

As suggestions start coming in, it will become evident that while some unnecessary tasks will require investigation, time, and resources to eliminate, many—especially EHR-related requests—end up being "pebble in shoe" fixes that are easy to accomplish but have dramatic effects (eg, those items listed in the above deimplementation checklist.) Remember, getting rid of a click here and there can add up to many hours saved each week!

Dig Deeper:

Getting Rid of Stupid Stuff toolkit

[3] Ashton M. Getting rid of stupid stuff. *N Engl J Med.* 2018;379(19):1789-1791. doi:10.1056/NEJMp1809698

Figure 1. Getting Rid of Stupid Stuff Decision Tree

Triage suggestions to determine appropriate next steps

```
                    ┌─────────────────────────────┐
                    │    Suggestion submitted      │
                    └─────────────────────────────┘
                                  ↓
                    ┌─────────────────────────────┐
                    │  Record and assess suggestion │
                    └─────────────────────────────┘
```

Suggestion is a simple and logical fix to an issue that is minor, or a mistake (ie, was never meant to occur)	Suggestion pertains to a more complex issue and may or may not be feasible to implement from an organizational standpoint	Suggestion pertains to a highly complex organizational-level problem and is probably not feasible to implement at this time

Just do it Make the change	**Needs further investigation** Assign to a work group to investigate	**Not possible to change at this time** Keep suggestion on file and revisit periodically

Document the issue, the suggested change, and the result. Share with the team and celebrate your successes.

Look Upstream: Prevent the Deluge

While deimplementation and GROSS are important, for the inbox portion of the EHR, the ultimate solution lies in looking *upstream;* that is, by thinking about *what changes can be instituted so that things never enter the EHR inbox in the first place* (Table 3).

Table 3. Things That Should Not Enter the EHR Inbox

WHAT	HOW TO SOLVE THE PROBLEM
Things that should not enter the physician inbox	
• Results of tests not ordered by the physician • Notifications of canceled orders or overdue (expiring) orders • Notifications of scheduled appointments • Patient Event Notifications which are not federally required. Notifications are not required to be sent for outpatient procedures (eg, admissions to hospital outpatient departments, colonoscopies, pharmacy visits, other ambulatory visits)	**Turn off automatic notifications for physicians. Can also consider batched notifications.**
• Notifications of canceled appointments or no-shows for appointments with specialists	**Institute system-wide patient outreach protocol for canceled/missed appointments initiating from the department that appointment was made for.**
• Any untriaged patient portal messages	**Use a patient portal protocol for triaging messages.**
• Refill requests for medications that treat chronic conditions	**Implement a refill protocol with standing orders (as allowed by state regulation).**
• Scanned copies of documents that are already signed • Automated (non-personalized) specialist correspondence for specialist visits	**Turn off automatic CC function.**

Things that should not enter the care team inbox

• Logistical questions regarding tests, procedures, or appointments	**Reroute to clerical/administrative inbox.**
• Billing questions	**Reroute to billing department.**
• Questions about routine lab results	**Implement pre-visit planning with pre-visit labs. Consider adding FAQs about routine results as a smart phrase!**
• Refill requests outside of an annual visit	**Implement synchronized annual prescription renewals ("90x4").**

Some of the key tactics used to curb the inflow of inbox messages or notifications are described in Strategy 2, such as:

- **Annual prescription renewals**—to prevent unnecessary refill requests from entering the inbox

- **Inbox and patient portal management**—to address messages that do not need to be seen by physicians

- **Pre-visit planning and pre-visit laboratory testing**—to minimize after-visit questions about results and follow-up appointments by discussing them during the actual visit time, eg, "flipping the visit"

Other ways to reduce unnecessary inbox messages even further upstream include **sharing clinical notes with patients**—writing clear notes that patients can read and use to refresh their memory on their own after the visit—and **Choosing Wisely**® when determining what tests to order in the first place. Careful and appropriate test selection can be an impactful shift in practice culture—the fewer tests you order, the fewer results that enter your inbox! These 2 tactics are covered in the following pages.

1

Sharing Clinical Notes With Patients

Shared visit notes, sometimes called "open notes," are everyday clinician notes made readily available ("open") to patients via the EHR patient portal. Recent US regulation as of April 2021 mandated that all US health care organizations adopt shared visit notes. Though some physicians felt (and may still feel) skeptical about the concept of open notes, one potential benefit is that it allows patients to readily access their care plans in detail, which may decrease follow up questions and concerns, saving time for both patients and clinicians (Figure 2).

The **Sharing Clinical Notes With Patients toolkit** describes in detail the STEPS you can take to effectively write and share clinical notes in order to reap the benefits depicted in Figure 2.

The STEPS are:

1. Educate your team about the benefits of open notes
2. Address practice-specific concerns
3. Prepare patients and their care partners
4. Adapt documentation style
5. Learn how to handle challenging topics
6. Collect feedback and refine your approach

Dig Deeper:

- Sharing Clinical Notes With Patients toolkit
- Adopting OpenNotes webinar
- Sharing Clinical Notes With Patients podcast

Figure 2. Benefits of Sharing Clinical Notes[4]

Benefits for Patients	Benefits for Clinicians
Research shows that patients who read their notes say they:	Research shows physicians and other clinicians who shared their notes reported:
• Feel more in control of and engaged in their health care	• Improvements in patient satisfaction, safety, communication, and education
• Recall their care plan more accurately	• Improvements in the patient–physician relationship, including enhanced trust, transparency, communication, and shared decision-making
• Are better prepared for visits	
• Have a better understanding of their medical conditions and medications	• Patients who are better prepared for their clinic visits and are becoming more actively involved in their own care
• Are more likely to adhere to their medications	
• Are able to identify clinically important errors in their notes	• No increase in time needed to address patient questions about their notes
• Are not more worried or offended after reading their notes	• Willingness among physicians to recommend to colleagues the use of open notes
• Have more successful conversations and stronger relationships with their doctors	

4. Miralles P, DesRoches C, Brown M. Sharing clinical notes with patients: a new era of transparency in medicine. American Medical Association STEPS Forward™. June 17, 2021. Accessed April 8, 2022. https://edhub.ama-assn.org/steps-forward/module/2781026

Choosing Wisely®

Finally, the ultimate upstream approach to decreasing inbox workload is to ask yourself, as a clinician: are you only ordering tests or treatments for your patients that are truly necessary and beneficial? Choosing Wisely is a campaign from the American Board of Internal Medicine (ABIM) Foundation and Consumer Reports that aims to promote conversations between patients and clinicians to choose care that is supported by evidence, is not duplicative of other tests or procedures already received, has the lowest possible risk for harm, and is truly necessary.

The **Choosing Wisely toolkit** describes in greater detail how you can use this strategy in your practice. It is not a set of rigid guidelines, but rather a strategy for engaging with patients and colleagues.

Dig Deeper:

Choosing Wisely® toolkit

AMA Pearls

Getting Rid of Stupid Stuff

- Start getting rid of stupid stuff with the help of a deimplementation checklist.

- Record and revisit "unsolvable" problems periodically.

Sharing Clinical Notes With Patients

- Tell patients during their visits that they can access their visit notes to help clarify any questions that come up about the care plan after the visit.

- Minimize "note bloat" to prevent unnecessary patient questions or points of clarification: only include what is truly necessary in the note (eg, no review of systems, no social history).

Choosing Wisely

- Tailor Choosing Wisely recommendations to your patient panel, and share the resources with patients to help them understand why oftentimes "less is more."

Strategy 2: Share the Necessary Work

Of course, after optimal deimplementation to reduce unnecessary work, at the end of the day, there is still much necessary work to be accomplished in the EHR. The key here is involving the entire care team to share this workload—this is essential for effectively taming the EHR.

Core team-based care workflows for managing the EHR include:

- EHR inbox management

- Patient portal optimization

- Annual prescription renewal and medication management

- Pre-visit planning and pre-visit labs

- Team documentation

These workflows are briefly described below and further detailed in the linked toolkits. Furthermore, the **EHR Inbox Management toolkit** provides an excellent summary of strategies for sharing, delegating, and improving team-based EHR workflows.

This section will help you *tame the EHR* by:

- Implementing fundamental team-based care workflows to help you manage necessary EHR work
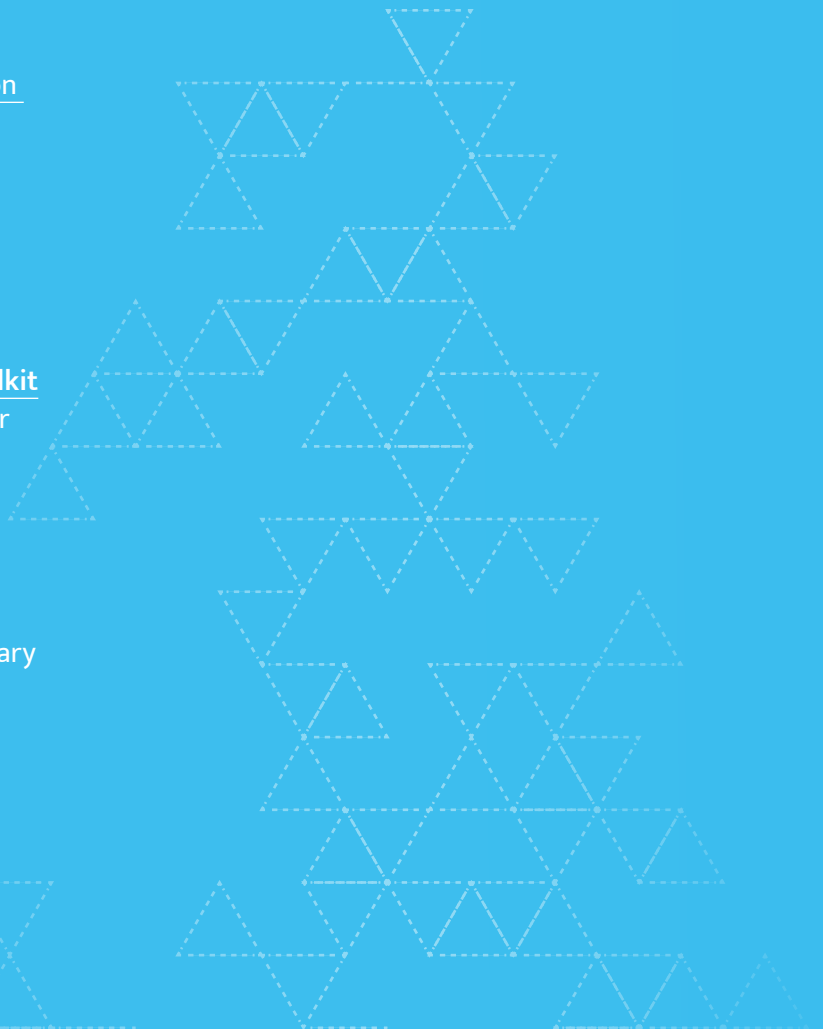
EHR Inbox Management

For physicians, perhaps the biggest source of frustration with the EHR is the inbox, or in-basket. The inbox has become the default destination for most forms of communication within the office. As the physician's patient panel grows, so does the volume of the inbox, creating a workload that is impossible to manage alone.

The **EHR Inbox Management toolkit** will help you keep unnecessary messages from being routed to your inbox in the first place, guide you through establishing a centralized team inbox, and suggest ways to empower team members to contribute in a meaningful way to inbox management.

Dig Deeper:

- EHR Inbox Management toolkit
- EHR Quick Wins podcast
- Success Story: The Inboxologist
- Success Story: Leverage Standing Orders and Protocols to Ease In-Basket Burdens
- Success Story: Teamwork Tames the Inbox

Patient Portal Optimization

For those EHRs that include an electronic patient portal, messages originating from patients via the portal make up a large proportion of inbox tasks. Many physicians feel frustrated that these portals seem to only serve patients while burdening the care team. However, when used effectively, patient portals can also reduce workload for both physicians and the care team by transferring routine administrative tasks, such as medication reconciliation or depression screening, from the care team to the patient.
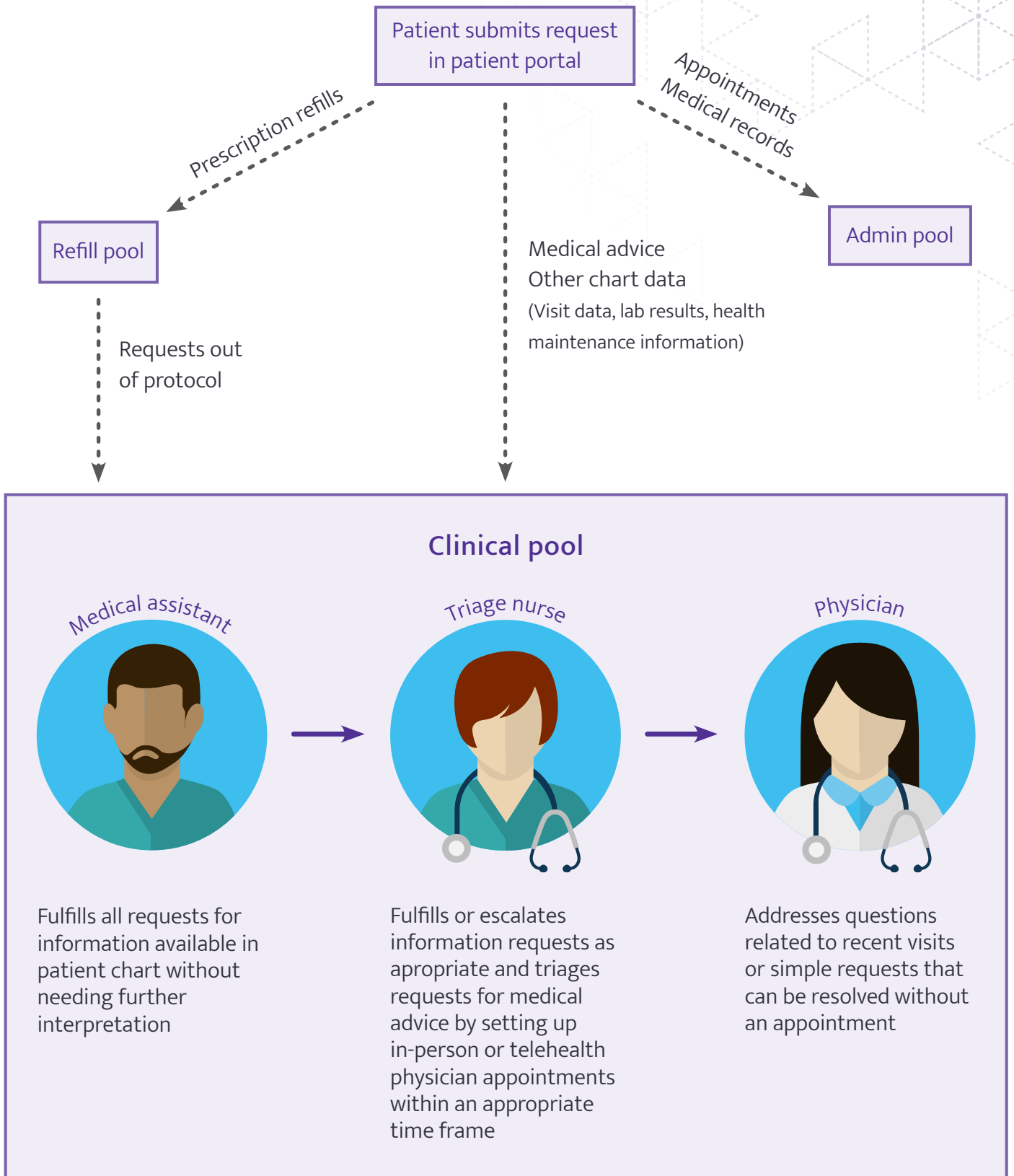
The Patient Portal Optimization toolkit provides further detail on effectively managing this component of the EHR inbox. Among other things, the toolkit describes how using an established workflow improves how the care team uses the patient portal to respond to messages (Figure 3).

Dig Deeper:

Patient Portal Optimization toolkit

Figure 3. Suggested Workflow for Handling Patient Portal Messages

Patient submits request in patient portal

Prescription refills

Appointments
Medical records

Refill pool

Admin pool

Medical advice
Other chart data
(Visit data, lab results, health maintenance information)

Requests out of protocol

Clinical pool

Medical assistant

Triage nurse

Physician

Fulfills all requests for information available in patient chart without needing further interpretation

Fulfills or escalates information requests as apropriate and triages requests for medical advice by setting up in-person or telehealth physician appointments within an appropriate time frame

Addresses questions related to recent visits or simple requests that can be resolved without an appointment

Annual Prescription Renewal and Medication Management

Medication management of multiple medications is another time sink for physicians: during a brief visit, how do you fill or refill medications efficiently, reconcile all medications, and ensure that patients are taking them as prescribed? Using effective team-based workflows for medication management and refills not only reduces this burden on physicians but also helps the team by preventing unnecessary refills requests or medication questions from patients.

The **Annual Prescription Renewal toolkit** is devoted to explaining how to synchronize all prescription renewals at the same visit once per year. You could save up to *5 hours a week* by writing prescriptions for medications that treat chronic conditions so that all patients receive a 90-day supply filled 4 times a year.[5] The shorthand for this is "90x4."

Choose one visit, such as the annual wellness visit, to renew all medications, even if there are still a few refills left on some of the older prescriptions. It may be helpful to write a note to the pharmacist that states, "This prescription replaces all prior prescriptions for this medication and dose. Please synchronize all chronic medications from Dr Smith on the same day each year and refill every 3 months." This may seem intuitive, but you'd be surprised to find that many practices don't have standard processes for synchronizing and standardizing recurring patient prescriptions.

Building on the Annual Prescription Renewal toolkit, the **Medication Management toolkit** details additional STEPS you can take to use the EHR to effectively manage medications, including optimizing medication reconciliation, streamlining prior authorizations, and communicating with pharmacies. Again, the key is to empower team members to contribute in a meaningful way to inbox management.

Dig Deeper:

- Annual Prescription Renewal toolkit

- Medication Management toolkit

- Success Story: Annual Prescription Renewals Could Save Hundreds of Hours Each Year for Your Organization

- Success Story: Four Interventions Stemmed the Tide of Refill Requests

[5] Sinksy TA, Sinsky CA. A streamlined approach to prescription management. *Fam Pract Manag*, 2012;19(6):11–13.
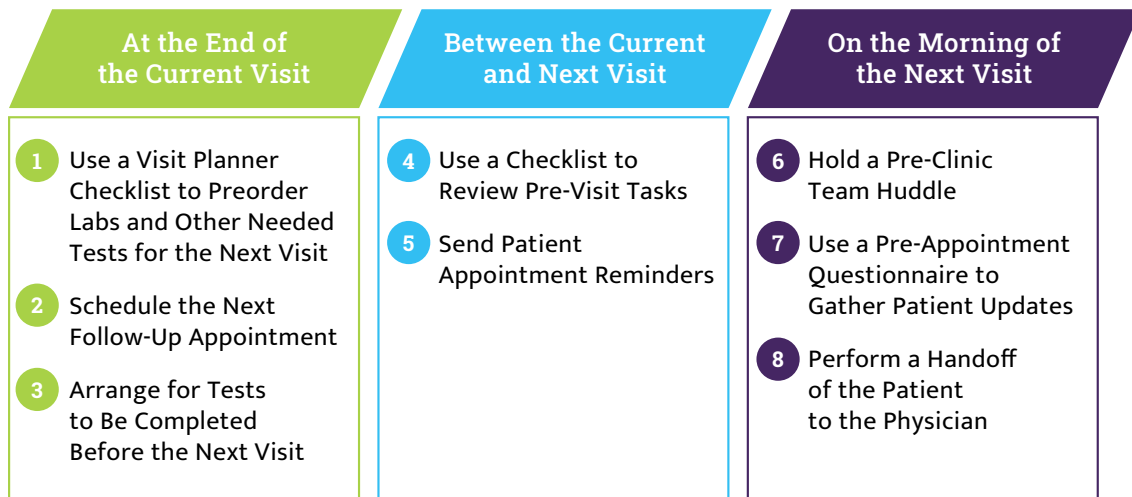
Pre-Visit Planning and Pre-Visit Laboratory Testing

In addition to medication management, pre-visit planning and pre-visit laboratory testing are powerful tools for reducing physician EHR burden while also alleviating stress on the team by preventing unnecessary follow-up calls/messages from patients about lab and test results, follow-up appointments, and care gaps. This concept of "flipping the visit" takes practice and teamwork, but will ultimately benefit patients, team members, and physicians.

The **Pre-Visit Planning toolkit** describes STEPS for implementing a comprehensive pre-visit to day-of-visit workflow, as illustrated in Figure 4.

The **Pre-Visit Laboratory Testing toolkit** hones in on the process of pre-ordering labs before the patient's next visit, delegating order entry, and empowering team members to act appropriately when lab results are returned to the inbox.

Figure 4. Optimal Pre-Visit Planning Workflow

At the End of the Current Visit	Between the Current and Next Visit	On the Morning of the Next Visit
1 Use a Visit Planner Checklist to Preorder Labs and Other Needed Tests for the Next Visit	4 Use a Checklist to Review Pre-Visit Tasks	6 Hold a Pre-Clinic Team Huddle
2 Schedule the Next Follow-Up Appointment	5 Send Patient Appointment Reminders	7 Use a Pre-Appointment Questionnaire to Gather Patient Updates
3 Arrange for Tests to Be Completed Before the Next Visit		8 Perform a Handoff of the Patient to the Physician

Dig Deeper:

- Pre-Visit Planning toolkit
- Success Story: Decrease Patients With Poorly Controlled Diabetes By One-Third
- Pre-Visit Laboratory Testing toolkit
- Success Story: Pre-Visit Laboratory Testing Can Improve Communication With Patients About Test Results

Team Documentation

Team documentation is a cornerstone of taming the EHR. This is the process where either clinical team members (eg, MAs, LPNs, or RNs) or nonclinical documentation assistants (eg, scribes, students) assist physicians during a patient visit to document certain parts of the visit notes, enter orders and referrals, and prepare prescriptions (Figure 5). Even patients themselves can contribute to writing their HPIs with some newer EHR functionalities. The training and skill level of the team member will determine the scope of responsibility. This process improves patient-centered care as the physician is less focused on EHR documentation and can give undivided attention to the patient. The **Team Documentation toolkit** describes this process in greater detail.

Q&A

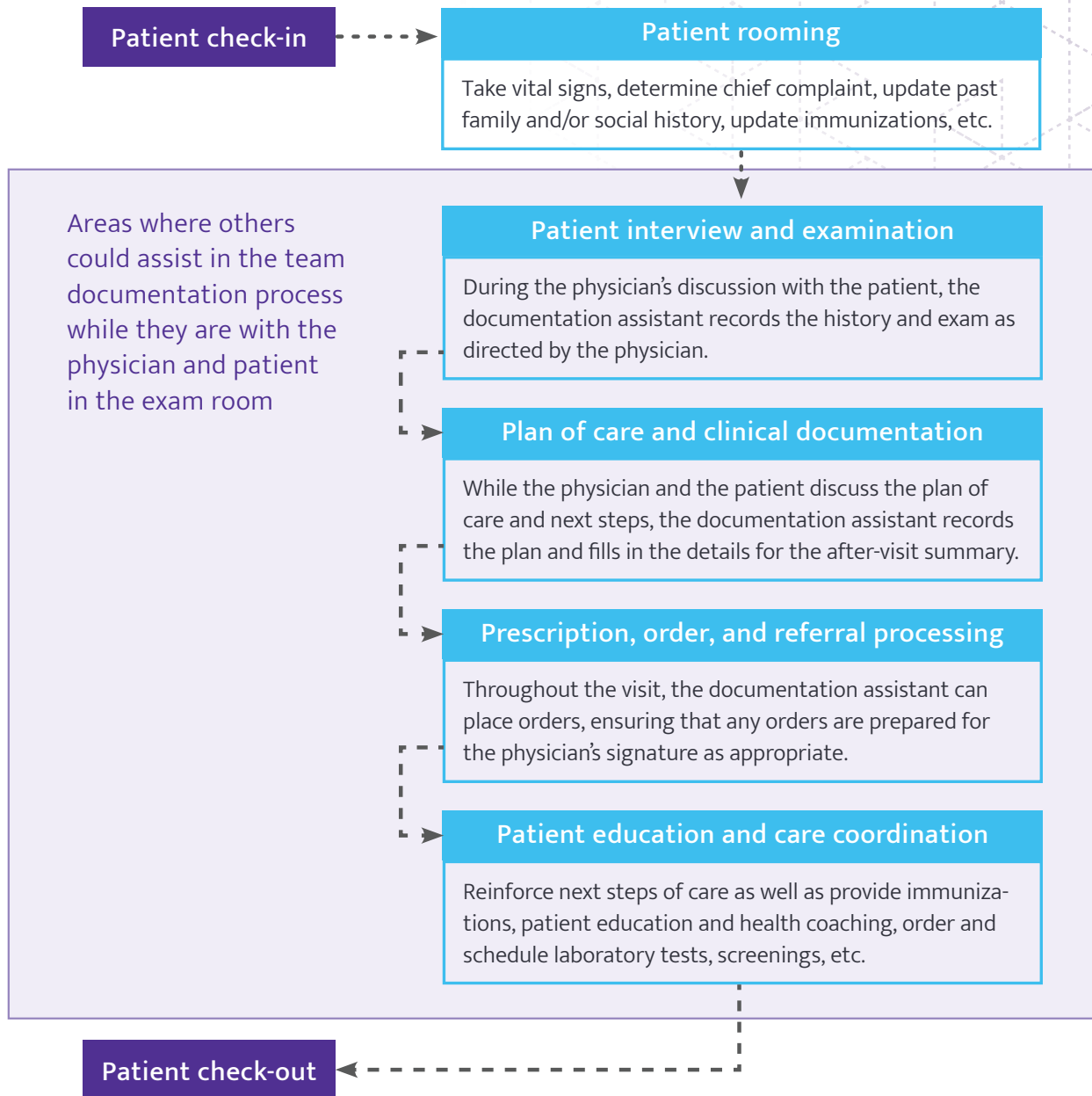**Can a documentation assistant enter orders dictated by a physician during a visit?**

According to the Joint Commission, any licensed, certified, or unlicensed team member, including registered nurses, licensed practical nurses, medical assistants, and clerical personnel, may enter orders at the direction of a physician.

Team members who are not authorized to "submit" orders should leave the order as "pending" for a certified or licensed team member to activate or submit after verification. The authority to pend vs activate or submit orders varies based on state, local, and professional regulations. In either case, the use of repeat-back of the order by the documentation assistant is encouraged, especially for new medication orders. The Joint Commission does not consider orders transcribed into the EHR to be verbal orders.

While the Centers for Medicare & Medicaid Services (CMS) is silent on who may enter orders, in general, CMS considers diagnostic test order requirements met if there is an authenticated medical record by a physician supporting their intent to order the tests. Again, this may vary by state, local, and professional regulations.

Figure 5. Sample Team Documentation Workflow

Patient check-in ----→ **Patient rooming**

Take vital signs, determine chief complaint, update past family and/or social history, update immunizations, etc.

Areas where others could assist in the team documentation process while they are with the physician and patient in the exam room

Patient interview and examination

During the physician's discussion with the patient, the documentation assistant records the history and exam as directed by the physician.

Plan of care and clinical documentation

While the physician and the patient discuss the plan of care and next steps, the documentation assistant records the plan and fills in the details for the after-visit summary.

Prescription, order, and referral processing

Throughout the visit, the documentation assistant can place orders, ensuring that any orders are prepared for the physician's signature as appropriate.

Patient education and care coordination

Reinforce next steps of care as well as provide immunizations, patient education and health coaching, order and schedule laboratory tests, screenings, etc.

Patient check-out ←----

EHR Inbox Management

- Physical colocation or brief huddles between team members and physicians can eliminate unnecessary back-and-forth message exchanges.

- Instead of setting aside time, encourage team members to use any free moments to check the EHR inbox.

- Longer appointments may give team members who aren't part of the visit a 10- to 15-minute window to check the EHR inbox throughout the day.

- Use a "delete, delegate, defer, or do" strategy to get to "done" and eliminate multiple EHR inbox touches on the same message.

Patient Portal Optimization

- Make patients aware that portal messages are addressed by the entire care team using a standardized protocol so they are not expecting immediate and personalized responses from physicians.

- Give both positive and constructive feedback to care team members to help with appropriate triaging of messages.

Annual Prescription Renewal and Medication Management

- 90x4 is one of the easiest, most impactful ways to change how you manage medications.

- Incorporate medication reconciliation into existing workflows

Pre-Visit Planning

- Empower care team members to use a checklist to close potential gaps in care before the physician sees the patient.

- Take a long view: schedule several future planned care visits at once.

- Use a pre-appointment questionnaire for patients on the day of their visit to gather updates.

Team Documentation

- With proper training, both clinical and non-clinical documentation assistants can perform the same documentation duties.

- Team documentation instills a sense of cooperation and empowerment among care team members, resulting in greater professional satisfaction.

- Team documentation enhances the patient-physician relationship by allowing physicians to give their undivided attention to patients.

Strategy 3: Optimize Personal Proficiency with EHR Technology

While the system and organizational level efforts described in Strategies 1 and 2 are foundational for successfully conquering the EHR problem, becoming more personally proficient with the technology itself can offer some valuable time-saving tricks.

This section will help you *tame the EHR* by:

- Boosting confidence and morale from the outset with easy wins—small changes that add up to big effects and save you hours each week

- Enhancing Epic or Cerner skills with efficiency-boosting tips developed exclusively for AMA STEPS Forward™
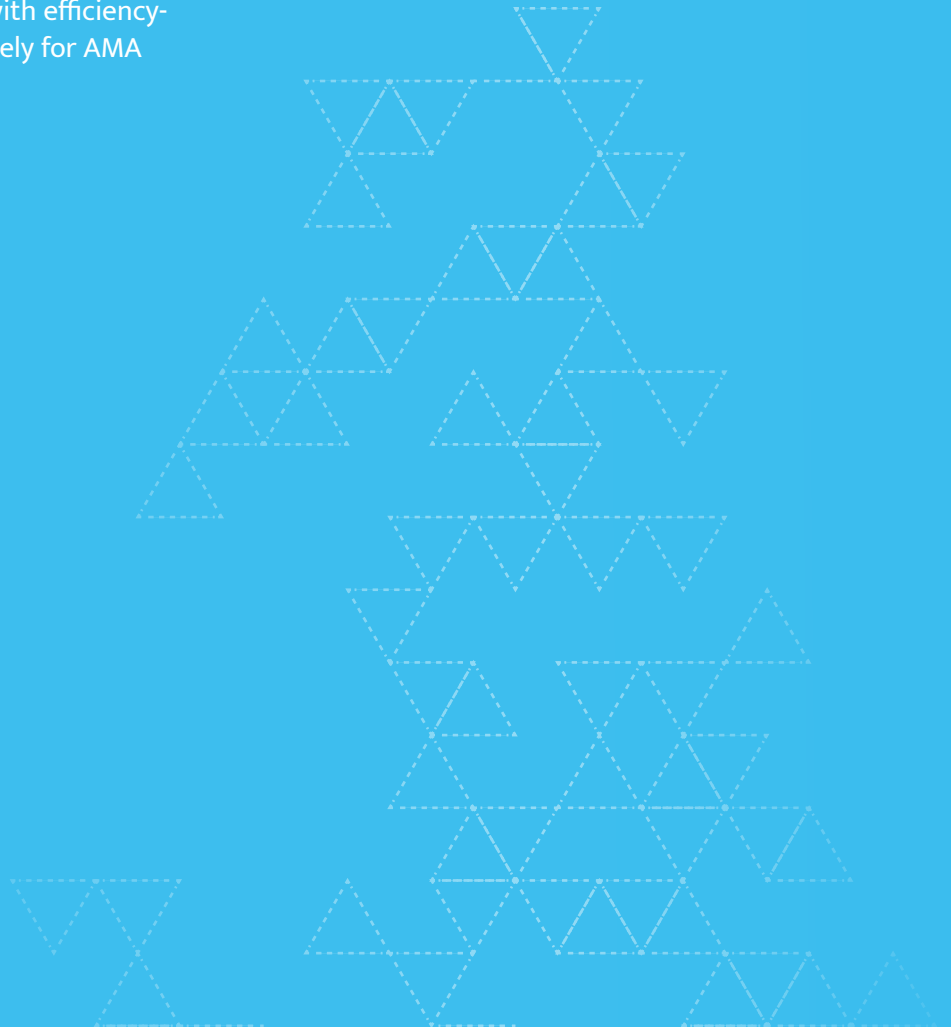
EHR Tips and Tricks

First, recognize that the EHR is an intimidating entity for even the most technologically savvy individual. If you are a physician struggling with your relationship with the EHR, do not feel the need to master it right way. Start with "easy wins" that can save hours each week, which will boost both confidence and morale and motivate you to keep making small changes that add up to big effects (Table 4).

Table 4. Tips for Daily EHR Users

ASK...	CUSTOMIZE...
...your colleagues to share their most useful EHR tip(s) with you	...chart review with filters or shortcuts
...if your organization has EHR physician champions or IT experts who are able to meet with you one-on-one for 30 minutes to provide some tips	...note-writing by setting up autocorrect or removing unnecessary sections, such as "history"
...internal or external experts if your EHR has desired functionality or features that would make your day-to-day easier	...order entry by using standing order sets or protocols for common orders, such as immunizations, screening tests, and labs

Next, employ the efficiency-boosting tips described for Epic users (Table 5) or Cerner users (Table 6). Find a link to a more detailed list of tips for both vendors on the Resources and Information page.

The AMA does not endorse any products. EHR vendors are welcome to email stepsforward@ama-assn.org to share additional EHR tips and tricks for consideration.

Table 5. Efficiency-Boosting Tips for Epic Users

Epic Tips for Efficiency

1. Turn off notifications
2. Create future reminders for yourself
3. Perform quick chart searches
4. Use chart filters
5. Use Autocorrect
6. Use Smartphrases
7. Save favorite orders
8. Use the "Make me the author" function for team documentation

**Table 6.** Efficiency-Boosting Tips for Cerner Users

Cerner Tips for Efficiency

1. Customize workflows with add/remove/move
2. Acquire a contextual view with split screen
3. Use the document's Mpage component
4. Set up documentation accelerators, such as Auto-Texts and Smart Templates
5. Share custom Auto-Texts with other team members
6. Use the Quick Orders Mpage
7. Develop Order Entry shared folders
8. Create Favorites folders and add them to your Quick Orders Mpage

Strategy 4: Gather Data

Gathering accurate and up-to-date EHR use data or metrics is essential for measuring progress and success as well as identifying areas of continued focus for the organization.

This section will help you *tame the EHR* by:

- Establishing key EHR use metrics

- Leveraging EHR data to both identify areas of need as well as to track improvement and progress
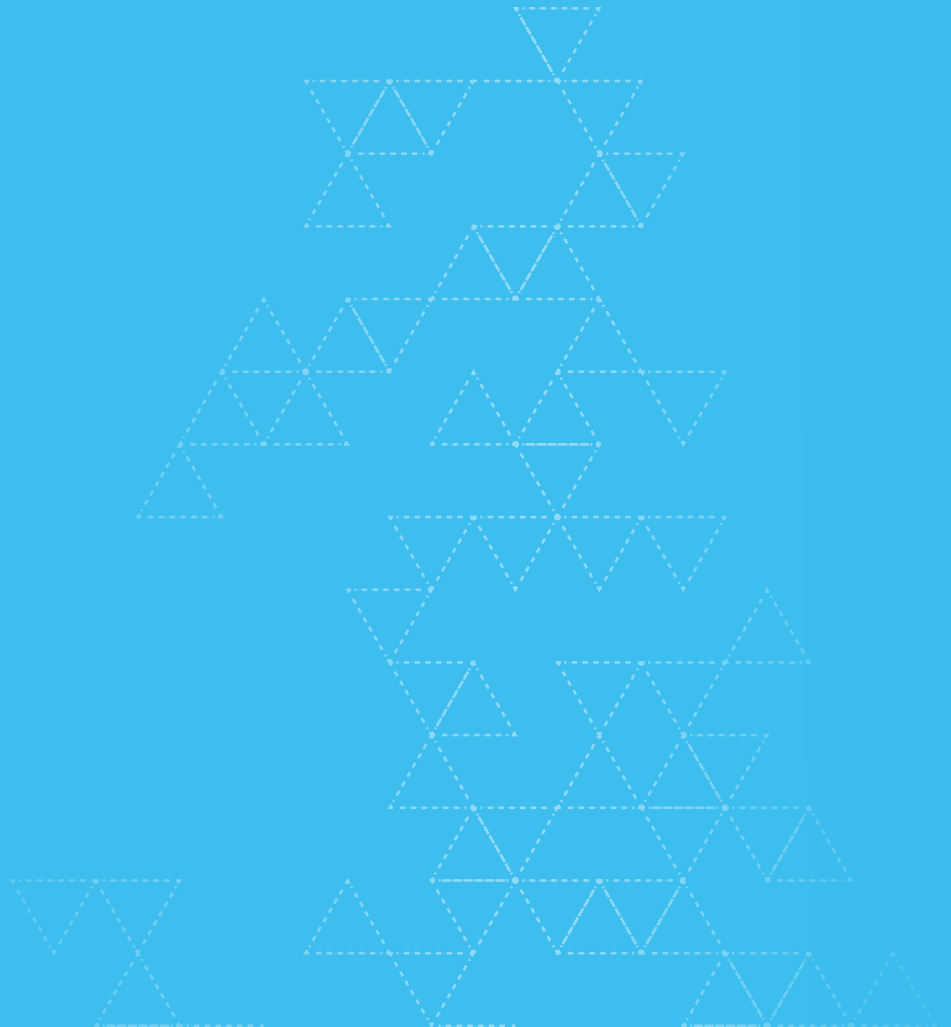
Key EHR Use Metrics

The **EHR Optimization toolkit** describes valuable EHR-use metrics to track, including:

- *Total EHR Time*: Total time on EHR (during and outside clinic hours) per 8 hours of patient-scheduled time

- *Work Outside of Work*: Total time on EHR outside clinic hours (nights, weekends, vacation) per 8 hours of patient-scheduled time, also known as "pajama time"

- *Click Counts:* Clicks per task or clicks per day

- *Time on Encounter Note Documentation:* Hours spent on documentation per 8 hours of patient-scheduled time

- *Time on Inbox:* Hours spent on inbox tasks per 8 hours of patient-scheduled time

- *Teamwork*: Percentage of orders with team contribution (not just physician contribution)

This data can be used at a high level to understand where clinical resources are being directed. For example, an organization can identify the amount of time their physicians are doing inbox and documentation work during personal time, then develop organizational countermeasures to reduce this time. The organization can also use this data to identify particularly efficient individuals from whom others can learn; alternatively, the data can identify those in need of assistance and for whom increased staffing, training, or both may be prudent.

Dig Deeper:

- EHR Optimization toolkit
- Success Story: Make the Electronic Health Record Work Easier and Cut Down on Daily Clicks

Conclusion

In this era, no one wants to go back to paper charts. But as with any technological tool, physicians and health care systems need to learn how to harness the power of the EHR and use it effectively. The key to mastering and taming the EHR is not better training for the EHR users (though this is helpful), but in creating and maintaining the necessary system-level procedures and resources to maximize team-based care and eliminate unnecessary work.
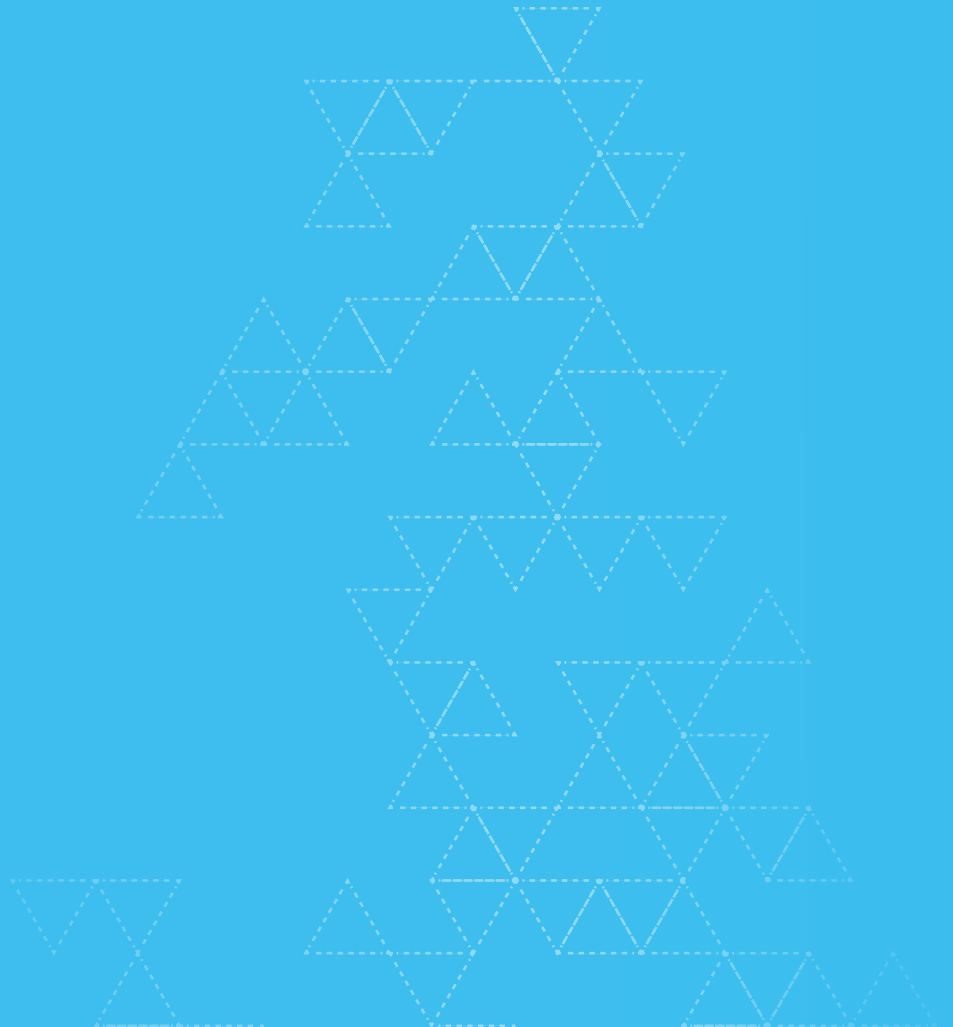
Resources and Further Information

Practical Tools

The selected practical tools listed here are to get you started on several of the new or adapted processes outlined in this Playbook. The individual toolkits on the AMA STEPS Forward™ website include these and additional resources. Click on the following links for direct access to the listed resources.

Sharing Clinical Notes With Patients • Pocket card	**Medication Management** • Questions to help uncover medication nonadherence
Choosing Wisely® • Using Choosing Wisely® Tools to Empower Patients	**Pre-Visit Planning** • Pre-appointment questionnaire
EHR Inbox Management • Team pool inbox assignment worksheet • Sample shortcuts for telephone and refill encounters	**Pre-Visit Laboratory Testing** • Visit planner checklist
Annual Prescription Renewal • Synchronized prescription renewal checklist	**EHR Optimization** • Eight Efficiency Boosting Tips for EPIC Users • Eight Efficiency Boosting Tips for Cerner Users

Access the digital Playbook for the optimal experience.

To fully engage with the Playbook and access all the relevant links, scan this QR code to view the PDF on your smart device or computer.

Dig Deeper:

- Taming the EHR webinar
- Taming the EHR podcast

Key References

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Learn More About Practice Innovation

Take the next steps on the journey with the AMA STEPS Forward™ practice innovation resources and assets.

Use the 5-pronged approach (Act, Recognize, Measure, Convene, Research) as your guide. Employ the evidence-based, field-tested, and targeted solutions described below to optimize practice efficiencies, reduce burnout, and improve professional well-being.

Act

- View the comprehensive portfolio of AMA STEPS Forward™ resources at STEPSForward.org, including:

  - Toolkits
  - Playbooks
  - Videos
  - Webinars
  - Podcasts
  - Calculators

- Email STEPSForward@ama-assn.org to connect with a physician coach to support practice intervention efforts (include "Request for physician coaching" in the email subject line)

Recognize

- Participate in the AMA STEPS Forward™ Recognition of Participation certificate program and find new ways to engage with your team

- Use the Joy in Medicine™ Health System Recognition Program as a road map to support your organization's strategic efforts

Measure

- Take our practice assessment to identify and prioritize your workflow intervention efforts

- Encourage your organization to measure professional well-being on an annual basis

Convene

- Join us at the AMA STEPS Forward™ Innovation Academy for timely and relevant webinars and more

- Attend upcoming conferences, summits, and events as they are announced

Research

- Stay abreast of meaningful research to guide your professional well-being strategies and interventions

Learn more at www.stepsforward.org.

About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient–physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for—the operational, financial, and technological aspects of a physician's practice. To learn more, visit https://www.ama-assn.org/practice-management.

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