JUNE 2019

PROVIDER QUALITY NEWSLETTER

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

Interpreta – https://portal.interpreta.com

Are you signed up for Interpreta yet? Interpreta is MedPOINT's new real time quality platform. To request a login, please email **interpreta@medpointmanagement.com**. You will receive an email from MedPOINT with a link to set up your password (this must be done within 24 hours).

If you would like to schedule a Training (in-person or Webinar), please contact your HEDIS/Stars Specialist by email at qualitymeasures@medpointmanagement.com or call 818-702-0100, x1353.

Stay Healthy. Ask me how!

MedPOINT has launched a new initiative to increase awareness of preventive screenings and you are part of the fun! Your HEDIS/Stars Specialist will be distributing colorful buttons to your staff that say, "Stay Healthy. Ask me how!" The goal is to inspire conversations about the importance of preventive screenings and raise awareness with the staff that it is everyone's job to make sure their patients receive their screenings.

Please wear your pin and share your feedback on the reaction you receive. If you would like, we can also mail you the buttons. Please contact us at (818)702-0100 ext. 1353 or email us at **qualitymeasures@medpointmanagement.com**.

Important Best Practices

Please see the attached Best Practices reference sheet that LA Care has compiled from the Performance Improvement Action Plans submitted in 2018 for the Medi-Cal Value Initiative for IPA Performance (VIIP) + Pay for Performance (P4P) program.

This great resource includes ideas and tips on:

1. HEDIS measures for Cervical Cancer Screening (CCS) and Childhood Immunization Status (CIS10)
2. Member Experience for overall provider rating, timely care/service for adults and appointment availability/after-hours compliance
3. Utilization Management for reducing hospital readmissions and emergency room visits
4. Encounter information on improving timeliness and data volume

Please distribute this to your quality staff and other departments as needed.

Lead Screening for Children

On October 22, 2018, the Department of Health Care Services (DHCS) released an All Plan Letter (APL) to health plans that imposed specific responsibilities on providers conducting periodic health care assessments on children age six months to six years (72 months). The DHCS letter can be reviewed here: **https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-017.pdf**.

Federal law requires States to screen children enrolled in Medi-Cal for elevated blood lead levels (BLLs) as part of required prevention services offered through the Early and Periodic Screening, Diagnosis, and Treatment

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(EPSDT) Program. In addition, health plans are contractually required to cover and ensure the provision of blood lead screenings in accordance with California state regulations.

HEDIS includes the Lead Screening in Children (LSC) measure, which requires children up to 2 years old to have one or more capillary or venous lead blood test for lead poisoning by their second birthday. This measure is included in Interpreta and you can review the details of the measure by clicking on a member who is due for the measure and then click on the measure name.

Controlling Blood Pressure Tip Sheet

Health Net has created the attached Tip Sheet to assist you in increasing rates for the Controlling Blood Pressure (CBP) measure for patients with hypertension. Common barriers are identified by patient level, institutional/administrative and financial areas, and recommendations are listed to improve performance and obtain an accurate measurement. It is important to use the Blood Pressure CPT II codes as this measure will be incentivized through the IHA AMP Program (Integrated Healthcare Association, Align. Measure. Perform.) in the future.

3074F - Systolic <130
3075F - Systolic 130-139
3077F - Systolic >/= to 140
3078F - Diastolic less than 80 mm Hg
3079F - Diastolic 80-89 mm Hg
3080F - Diastolic >/= to 90

PM 160 Forms 2019

Health plans are no longer accepting PM 160 forms! Credit for the child exams are now captured through encounters/claims.

Seven Habits for Reducing Work after Clinic

It's hard for many providers to imagine shutting the office door at the end of the day and not having any work that they need to take home. We encourage you to review the attached article to see what steps can be implemented in your office to increase efficiencies and reduce provider burnout. Then share this article with your providers so the whole team can make shifts in practice and help reclaim your time. This article is from the May/June 2019 newsletter from the American Academy of Family Physicians (AAFP) at **aafp.org/fpm** and is well worth the read.

June is Men's Health Month

The purpose of Men's Health Month is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys. Take advantage of this recognition by educating your male members to schedule their preventive screenings for colorectal cancer screening (50-75 years), diabetes care (eye exam, nephropathy and A1c test), blood pressure (if the patient has documented hypertension and/or diabetes) and BMI. Even though prostate screening is not a HEDIS measure, it is also an opportunity to create awareness of the health issues that are associated with a man's prostate, BPH, prostatitis and prostate cancer.

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Health Net
We're invested in supporting provider practices.

Health Net® COMMUNITY SOLUTIONS

Cardiovascular Conditions

Hypertension – Controlling Blood Pressure *Tip Sheet*

Health Net Community Solutions, Inc. (Health Net) wants to help you improve your quality scores on Healthcare Effectiveness Data and Information Set (HEDIS®) measures. To assist your practice in increasing your HEDIS rates, we have created this Controlling Blood Pressure (CBP) Tip Sheet outlining key aspects of the HEDIS measure, codes associated with this measure and guidance for proper documentation.

What is HEDIS?
HEDIS, developed and maintained by the National Committee for Quality Assurance (NCQA), is a set of standardized performance measures that evaluates plan performance on important dimensions of care and service. NCQA develops HEDIS measures through a committee represented by purchasers, consumers, health plans, health care providers, and policymakers. HEDIS allows for standardized measurement, standardized reporting, and accurate, objective side-by-side comparisons of quality across health plans and against benchmarks.

Controlling High Blood Pressure Facts
High blood pressure (HBP) can lead to heart disease, stroke, kidney disease, and death.[1] About one in three adults in the United States has HBP, and approximately half of them have it under control.[2,3] You can work with your patients to improve control of their HBP by following the evidence-based measure guidelines below.

HEDIS Specifications — **Line of business: Medi-Cal**

Description: Patients ages 18–85 who had a diagnosis of hypertension (HTN) in the first six months of the measurement year and whose HBP was adequately controlled during the measurement year based on the following criteria:

Years of age	Diagnosis	Systolic	Diastolic
18–59	HTN	<140	<90
60–85	HTN	<150	<90
60–85	Diabetes	<140	<90

The reading should be the most recent blood pressure (BP) reading during the measurement year in the record of the provider who is managing BP, as long as it occurred after the diagnosis of HTN. If no BP is recorded during the measurement year, assume that the patient is "not controlled."

Note: The BP reading cannot be utilized if:
- Taken during an acute inpatient stay or emergency department visit.
- Taken on the same day as a diagnostic test, or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Reported by or taken by the patient.

The CBP measure is ultimately evaluated by chart review; however, Health Net can help providers keep track of successful BP monitoring by having providers submit codes for BP values. Provider groups are notified of Health Net members who fall outside of the compliance window for this measure. Therefore, continue to submit the codes[4] below for BP readings.

CPT II Code	Definition
3074F	Most recent systolic blood pressure < 130 mmHg
3075F	Most recent systolic blood pressure 130–139 mmHg
3077F	Most recent systolic blood pressure ≥ 140 mmHg
3078F	Most recent diastolic blood pressure < 80 mmHg
3079F	Most recent diastolic blood pressure 80–89 mmHg
3080F	Most recent diastolic blood pressure ≥ 90 mmHg

References
[1]Centers for Disease Control and Prevention. About High Blood Pressure. July, 2014. Available at www.cdc.gov/bloodpressure/about.htm.
[2]Merai R, Siegel C, Rakotz M, Basch P, Wright J, Wong B; DHSc., Thorpe P. CDC Grand Rounds: A Public Health Approach to Detect and Control Hypertension. MMWR Morb Mortal Wkly Rep. 2016 Nov 18;65(45):1261-1264.
[3]Centers for Disease Control and Prevention. High Blood Pressure Home. November 30, 2016. Available at www.cdc.gov/bloodpressure/about.htm.
[4]Practice Management Information Corporation CPT Plus 2017: Digital Series, Los Angeles, CA, 2016.

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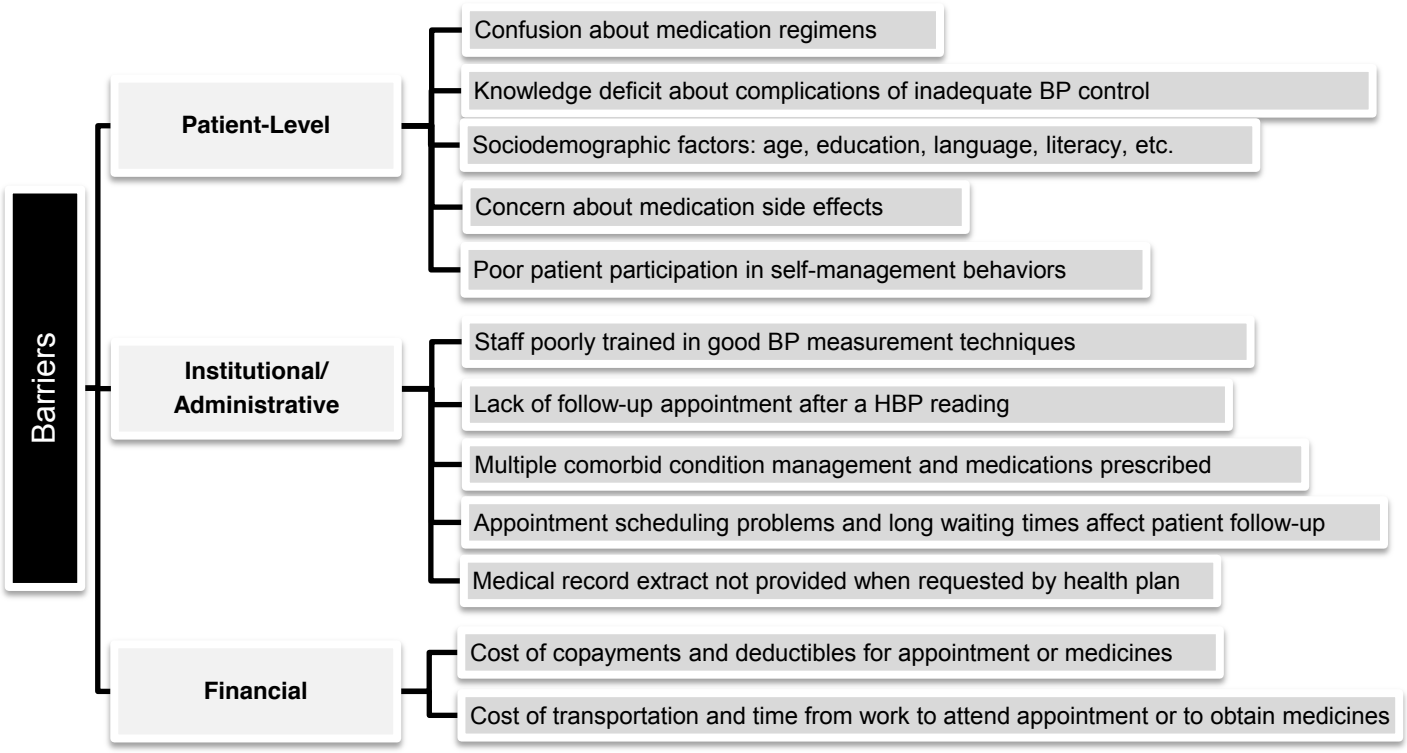
Hypertension – Controlling Blood Pressure *Tip Sheet*

Common Barriers to Controlling Blood Pressure



Recommendations to Improve Performance

- This measure is collected through chart review, so it is essential to provide medical records as requested by the health plan to improve performance. For all outpatient visits, record BP readings in the patient chart with the date of service. Record the diagnosis of hypertension in the chart.
- Perform outreach to patients with HTN who have not had a follow-up appointment.
- Review diet, medications, exercise regimen, and treatment adherence with the patient at each visit.
  - Educate patients on the intended actions of medicine to control their BP and the importance of medication adherence.
  - Encourage members to use the mail-order pharmacy service to save on the cost of medications.
  - Encourage healthy lifestyle activities, such as increasing physical activity and following a heart-healthy diet.
- Assess whether transportation is a concern and encourage patients to inquire about health plan and public transportation services available to them.
- Submit timely claims and encounter data. Audit claims for proper codes and provide education to staff on coding as indicated. Verify that capitated providers are submitting records of services provided.

Best Practices for Obtaining Accurate Blood Pressure Measurement

1. Ask if the patient avoided caffeinated beverages and smoking for at least 30 minutes before the examination. If not, you may need to repeat the BP reading as there is a greater chance of having an elevated reading.
2. Have the patient sit calmly for five minutes with the back supported and feet flat on the floor before taking BP.
3. Patient's arm should be bare. Cuff may be applied over a smoothly rolled-up sleeve, provided there is no tourniquet effect. Support the patient's arm on a firm surface at heart level, slightly flexed at the elbow.
4. The health care staff and the patient should refrain from talking while BP is measured.
5. Use appropriate cuff size. The inflatable part should be long enough to encircle at least 80 percent of the arm and wide enough to encircle 40 percent of the arm at midpoint. When in doubt, select the larger size.
6. Wrap the cuff snugly around the bare upper arm. The lower edge should be centered two finger-widths above the bend of the elbow, and the midline of the bladder should be over the brachial artery pulsation.
7. The dial or mercury column should be clearly visible and facing you.
8. Using light pressure, position the stethoscope over the brachial artery without touching the cuff.
9. For patients experiencing pain, anxiety or distress at the time of the initial BP reading, repeat the reading after five minutes of rest and at the end of the appointment, if needed, following the steps above. If the BP is still elevated, schedule the patient to return the next week to assess the BP and treat accordingly.

For additional information, visit www.measureuppressuredown.com/HCProf/find/Toolkit/Plank1.pdf.

Value Initiative for IPA Performance (VIIP) + Pay for Performance (P4P)

Best Practices

Derived from Measurement Year 2018 Action Plans

L.A. Care has compiled these best practices from the performance improvement projects (Action Plans) that were submitted in 2018 from the Medi-Cal network. The intention of sharing this document among the network is so that provider groups are aware of what has worked well for other groups so that they may implement some of the ideas put forth in this document.

HEDIS

Improving Cervical Cancer Screening (CCS) Rate

- Provide PCPs with care gaps of their assigned members.
  - *Note:* Assigned members can encompass more than just those members who come in for appointments.
- Send reminders to encourage timely submission of encounter data
- Monitor compliance rates and quarterly request, submit and verify with health plans the acceptance of lab data files from contracted labs
- Target outreach to PCPs with high volumes of members who are not up-to-date on screenings
- Perform data analysis and validation of Provider Opportunity Reports (PORs) to ensure data is captured and to identify potential issues for resolution
- Educate staff and PCPs on the importance of getting members in to close care gaps

Improving CIS-Combo 10 Rate

- Provide POR reports to provider offices.
- Encourage provider offices to integrate with CAIR2 or enter data daily, while providing User Guides and offering training
- Educate provider offices on the importance of correct CPT coding as well as distinguishing of combination vaccines
- Utilize the CAIR2 registry's reporting capabilities to identify members due for vaccines before every office visit
- Member outreach

Value Initiative for IPA Performance (VIIP) + Pay for Performance (P4P)

Member Experience

Improving Overall Provider Rating

- Physician-to-Physician coaching
- Performance reviews with leadership conducted on a monthly basis
    - Conduct analysis on provider comments to identify trends for improvement

Improving Adult Timely Care and Service for PCPs

- Review office policies on managing appointment scheduling and ensure they are in accordance with health care guidelines
- Encourage office staff to leave open slots for walk-ins and emergencies
- Work with office staff on best way to communicate appointment delays
- Encourage use of mid-levels
- Conduct annual satisfaction surveys
- Inform all new providers about Access to Care and all measures by providing the L.A. Care Health Plan (L.A. Care) Provider Manual
- Provide in service lunches for all providers
- Provide Access to Care quick tips to all providers

Increasing both Appointment Availability and After Hours compliance

- Distribute “after-hour” phone script to non-compliant providers and confirm with random after hours calls
- Send letter to non-compliant providers with access standards
- Continue monitoring by conducting “access survey” internally
- Review non-compliant providers with Peer Review Committee
- Collaborate with Provider Services team & outreach to providers for additional training as needed
- Educate providers of the “access” standards via memo, fax blast, & provider in-services

Utilization Management

Reducing Acute Readmission rate.

- Transition of Care (TOC) methods:
    - All members discharged from an acute care setting receive a Transition of Care (TOC) call within one (1) business day of discharge

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  - For members admitted with the top four (4) diagnoses (Pneumonia/Respiratory, Cardiac/Chest Pain, Stroke, Syncope/Collapse), a 14 day TOC call is made and follow-up visit is confirmed
  - Admission identified as a "readmission" receives an automatic case management referral and will fall into the 14 day TOC call protocol
  - Completion and success rates of the TOC calls are monitored
- If follow up visit has not occurred, a call is placed to the PCP to encourage member contact
- Identify and monitor members at risk of readmission and/or with a history of readmission
- Track and monitor readmission rates quarterly

Reducing Avoidable Emergency Room (ER) Visits

- Track and monitor avoidable ER rates
- Ongoing efforts to continue educating the members and the public regarding access to Urgent Care (UC) services vs. Emergency Department (ED)
- Inform the full network of hours of operations as well as making efforts to increase the number of UC across the network to members
- Ongoing communication with PCPs and reviewing members medical record to identify if there is a new address or phone number in an effort to update this information in the IPA database
- Review any recent hospital admission records, if applicable, and verify if there is an updated address or phone number for members

Encounters

Increasing encounter data timeliness

- Offer provider level reporting and incentives
- Provide coding and IT support
- Submit data more frequently, (i.e. twice a month) and increase timeliness
- Create processes for provider outreach to educate on the importance of getting data in quickly and accurately

Increasing encounter data volume

- Offer provider level reporting and incentives
- Monitor encounter data per member per month (PMPM) by PCP each month
- Monthly meetings with higher volume, low performing providers to review medical records
- Remind PCPs who fall under the benchmark to increase encounter data submissions
- Encourage electronic medical record (EMR) system conversion and provide coding and IT support

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Seven Habits for Reducing Work After Clinic

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

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

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

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

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

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

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

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

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

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

KEY POINTS

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

WHAT DO YOU THINK?

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

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

2. USE PREVISIT PLANNING

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

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

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

• **Visit prep:** Have your medical assistants (MAs) do a quick review of the patient's record on the day of the visit (or the day before) to see what needs he or she may have and what prep work can be done. Creating prep sheets for common conditions can be helpful. For example, a diabetes prep sheet can help MAs identify which lab orders to set up ahead of time, which immunizations might be needed, and so on. A sample diabetes prep sheet can be downloaded from the online version of this article at https://www.aafp.org/fpm/2019/0500/fpm20190500p10-rt1.pdf.

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

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

3. MAKE EVERY SECOND COUNT

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

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

A WORD ABOUT PANEL SIZE

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

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

• **Average panel size**: 1,974 patients (the number of patients attributed to the physician and seen in the past two years)[1]

• **Hours worked each week**: 51 hours (10 of which are after hours)[2]

• **Hours spent weekly in face-to-face patient care**: 28 hours[2]

• **Patient encounters per week**: 82 (72 in the office)[2]

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

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

WHAT'S BEING DONE TO ADDRESS ADMINISTRATIVE COMPLEXITY?

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

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

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

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

this could save you time down the road.

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

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

4. RETHINK WHO DOES WHAT

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

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

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

5. DOCUMENT LESS BUT BETTER

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

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

One of the most common problems is over-documenting. It's easy to get compulsive when you have to worry about medicolegal risk, you're trying to gather rich psychosocial information, and you feel pressured to check all the boxes you can. But not all EHR boxes need checking, and not all visits require that you write an opus. Instead, be brief, focused, and clear enough that someone looking at your note will understand your clinical reasoning and your plan. Over-documenting not only wastes your time but can be problematic for other reasons as well. For example, think about whether you would be comfortable with, say, your patient or his podiatrist seeing your entire note detailing sensitive psychosocial issues. Remember that less is often more.

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

Wasted time spent clicking boxes and navigating lengthy drop-down menus just to complete a simple task is another common EHR complaint, described recently as "death by a thousand clicks."[4] In some cases, EHRs can be customized to reduce clicks if you tell your vendor what you need. For example, having certain data that you use most often displayed on the initial screen, instead of buried deep in a drop-down menu on a later screen, can save you from clicking or scrolling to review that information.

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

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

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

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

A STARTER LIST OF EHR MACROS

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

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

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

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

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

6. TOUCH MESSAGES ONCE

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

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

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

STRATEGIES AND RESOURCES

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

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

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

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

7. HELP EACH OTHER

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

If you see a physician struggling (or if this physician is you), the best approach involves empathy, mentoring, and accountability. The practice may need to set standards for when charts are expected to be closed – and enforce those standards. At the same time, a manager or colleague should work with the physician to figure out what's going on, what his or her barriers are, and how to get back on track. Maybe the physician needs to have some time blocked out on the schedule to catch up on charting. Maybe the physician needs some EHR training or an MA to help with in-room documentation. Or maybe the physician just needs some coaching because he or she is trying to do too much in the exam room (for example, trying to address everything on the patient's agenda, over-documenting, and not delegating tasks such as patient education). The barriers and solutions are going to be personal because we are all programmed differently, but most physicians will need some help figuring things out. Don't let a colleague struggle alone, and don't make the mistake of simply applying more pressure on an already pressured physician. There are a lot of good physicians who just need a nudge and some objective help to get past their barriers to better performance.

BALANCE, TRADEOFFS, AND AGENCY

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

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

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