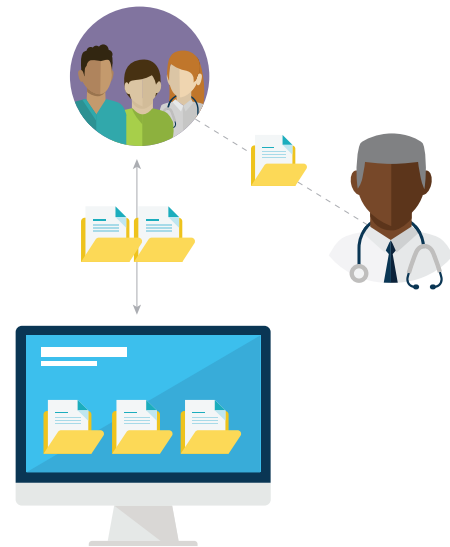


# EHR In-Basket Restructuring for Improved Efficiency

Efficiently manage your in-basket to provide better, more timely patient care



CME  
CREDITS:  
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## How will this module help me more effectively manage my in-basket?

- 1 Details six STEPS to creating an optimal and orderly in-basket
- 2 Answers commonly asked questions about in-basket management
- 3 Provides tools to guide you and your team through the process

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. As the physician’s workload grows, so does the volume of the in-basket, creating a burden that can be difficult to effectively manage during the day. This module will help practices think critically about messages being routed to the physician, guide practices to establish a centralized team in-basket, and suggest ways to empower team members to contribute in a meaningful way to in-basket management.

### EHR In-basket Restructuring for Improved Efficiency

**Release Date:** May 2017

**End Date:** May 2020

#### Objectives

At the end of this activity, participants will be able to:

1. At the end of this activity, the physician will be able to employ an optimal and orderly inbasket.
2. At the end of this activity, learners will be able to determine what type of messages can be routed and assigned to care team members.
3. At the end of this activity, learners will be able to utilize team pools and EHR functionalities to redistribute tasks and streamline work.

#### Target Audience

This activity is designed to meet the educational needs of practicing physicians, other clinicians and practice managers may also be interested in this activity.

#### Statement of Competency

This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

#### Accreditation Statement

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

#### Credit Designation Statement

The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit*<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

#### Claiming Your CME Credit

To claim *AMA PRA Category 1 Credit*<sup>™</sup>, you must 1) view the module content in its entirety, 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

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#### About the Professional Satisfaction, Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

#### Disclosure Statement

The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

#### Media Types

This activity is available to learners through Internet and Print.

#### Hardware/software Requirements

Adobe Flash 9.0.115 or above

Audio speakers or headphones

Screen resolution of 800X600 or higher

MS Internet Explorer 8.0 or higher, Firefox, Opera, Safari, etc.

Adobe Reader 5.0 or higher

#### References

1. Sinsky C, Colligan L, Ling L, et al. [Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties](#). *Ann Intern Med*. Published online 6 September 2016 doi:10.7326/M16-0961.
2. Shanafelt TD, Dyrbye LN, Sinsky C, et al. [Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction](#). *Mayo Clin Proc*. 2016;91(7):836-848.
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# Introduction

One consequence of adopting an electronic health record (EHR) is that the physician’s **in-basket** often becomes the default destination for most forms of communication in the office. As the physician’s workload grows, so does the volume of the in-basket, creating a burden that can be difficult to effectively manage during the day. The physician is then faced with spending long hours before and after clinic to complete “between visit” clerical work. For some physicians, this can add up to an extra one to two hours of work every day.<sup>1</sup>

A recent study found that physicians spend almost half of their day on the EHR and desk work. Even during the patient visit, 37 percent of the time in the room is spent on these tasks.<sup>1</sup> The increase in clerical burden resulting from EHR adoption was cited as a contributor to physician dissatisfaction in practice and subsequent burnout.<sup>2</sup>

The reality is that the majority of in-basket messages in many clinics do not need to be routed to the physician. This module will help you keep unnecessary messages from being routed to your in-basket in the first place, guide you through establishing a centralized team in-basket, and suggest ways to empower team members to contribute in a meaningful way to in-basket management.



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At Bellin Health, we’ve worked hard to redistribute in-basket workloads. An effectively managed in-basket leads to more timely patient care, with the work being distributed to appropriate members of the care team rather than the individual physician. It takes a team to make in-basket management efficient, and this team approach ultimately leads to better, more timely patient care.

”



James Jerzak, MD  
Bellin Health, Wisconsin

**In-basket:** Location for any message that flows electronically through the practice’s EHR2 system, including staff messages, telephone messages, lab results, refill requests and patient portal messages.

# Six steps to create an optimal and orderly in-basket

1. Engage IT to prepare for restructuring your in-basket

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2. Identify the types of messages that could be routed to other team members

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3. Work with IT to restructure your EHR to direct messages to the right team members and declutter your in-basket

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4. Create a team pool and team pool in-basket to help redistribute and streamline work

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5. Empower staff to contribute by utilizing principles of team-based care

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6. Develop workflows for common in-basket tasks

1

## Engage IT to prepare for restructuring your in-basket

Let your IT team know that you'll need their help to restructure your EHR with the goal of optimizing your in-basket. You could start by obtaining a list of all possible in-basket folders, and meet with IT to eliminate or consolidate these to simplify the work. You may find that they have suggestions or advice to overcome challenges and make the transition easier on everyone.

2

## Identify the types of messages that could be routed to other team members

EHR systems often have dozens of categories of messages. Here are three overarching categories to consider when you set out to optimize your in-basket:

- Those that require direct physician management
- Those that can be routed to other team members
- Those that are not relevant to patient care or clinic business and should be filtered or deleted

**Re-directing certain types of messages** to a medical assistant (MA), licensed nurse practitioner (LPN), registered nurse (RN) or patient services representative (PSR) on the team can help lighten your workload. Practices have successfully shifted refill requests, referral requests and general patient questions to MAs, RNs or LPNs.

Some practices, particularly those with one or more RNs on the core team, have routed all in-basket messages to the clinical support staff. In this model, messages that require physician input are first researched by the nurse, addressed verbally with the physician and then the response is operationalized by the nurse. This type of team-based approach could save an hour or more of physician time per day.

## Q&amp;A

### What are some examples of messages that do not need to flow into my in-basket?

Examples include:

- Daily progress notes for hospitalized patients
- Nurse visit notes for preventive care, such as immunizations
- Routine physical therapy progress notes
- Test results for hospitalized patients being managed by others. Note: this does not apply to *discharge summaries*.
- Test results ordered by consultants. The final consult note should have all pertinent information for the primary provider. This also unambiguously places responsibility for follow-up of all test results with the ordering physician.
- International Normalized Ratio (INR) results if managed by a central team or by other team members per protocol
- **Pre-visit labs** for upcoming appointments. These can be reviewed by the team and marked as “done” if normal. For significant abnormalities, verbal communication with the physician can help determine if action needs to be taken prior to the upcoming appointment.
- Refill requests. If the request is appropriate and the patient is not due for an appointment, your team should be able to fill these requests per protocol so the patient has enough medication to get by until his or her next visit. If the patient is due for an appointment, your team should be able to refill the medication for 30 days while making sure that a visit is scheduled within that time period.

### What’s the best phased approach to rerouting messages?

Start by tracking the types of messages you’re receiving to get an idea of the volume. Examples of messages you could track include: symptom-based calls, referral requests, refill requests, results requests, requests for lab orders for future appointments, nursing home calls, medication questions, requests for appointments and other. Your practice may find that some types of messages are more common than others and provide a starting point for rerouting. Evaluate where each of these messages is being routed to then determine if a more efficient routing system could be implemented that better utilizes your entire team to the top of their skill sets.

### Do patient services representatives (PSRs) have the right training to assist with in-basket management?

Yes, PSRs can assist with some tasks. Create a **template** for PSRs to follow so that when they receive certain requests they know how to respond. For example, before in-basket optimization, a patient who called with a question about a medication might have been directed to the triage nurse. She would then need to look up the patient, medication and physician’s orders before returning the patient’s call. As part of in-basket optimization, the PSR would use the template to identify and route the call to the MA/LPN attached to the patient’s doctor. Because this MA/LPN has a personal relationship with the patient and is familiar with the physician’s orders, she is able to answer the question more quickly.

Conversely, the MA, LPN or RN can route certain messages to front desk staff so they don’t need to directly tap into the in-basket. Examples include asking the PSRs to complete basic non-clinical information in forms, such as the practice address, physician’s name, unique physician identification number (UPIN), date of last visit, and any upcoming visits and associated labs.

“Done” is an EPIC EHR system check box feature that removes an item from view but does not close or delete it. Other EHRs may have a similar feature under a different name.

If you are implementing a [pre-registration process](#), you may wish to consider having new patient coordinators fulfill some of these in-basket management duties when they are not registering new patients.

[I'm inundated with messages from skilled nursing facilities \(SNFs\). Is there a special technique for managing these?](#)

The volume of calls from these facilities can be overwhelming. It can also be confusing if tests ordered by your SNF team flow to both their in-basket and yours. How to handle them depends on the approach your practice takes toward these patients.

If you are working with advance practice clinicians (APCs) to manage patients in nursing homes or SNFs, then it is most efficient to have test results and other messages go to the APCs instead of your in-basket.

If you have no particular program for helping with SNF patients, then work with these facilities to develop standing orders to decrease the number of calls they need to make. Communicate that your triage nurses are empowered to answer many of the questions from SNFs per protocols. Encourage SNFs to make all non-emergency calls during office hours and work with skilled nursing facility staff to batch their communications so that they make only one or two contacts a day. Be sure to order lab tests that may need follow-up, such as routine INRs or electrolyte tests, early in the week. This avoids having to contact the doctor on call—who may not know the patient as well as your team—during the weekend.

[What role can an advanced practice clinician \(APC\) play in in-basket management?](#)

In some organizations, the role of the APC is structured so that roughly half of the APC's time is spent on direct patient care and half the time is devoted to in-basket management and other deskwork support for the practice. In these models, the APC manages the majority of messages in the physician's in-basket, bringing to the physician any situations that require additional expertise.

3

### Work with IT to restructure your EHR to direct messages to the right team members and declutter your in-basket

IT support is essential for establishing a manageable in-basket. Ask your IT team to help you configure the filtering capabilities of your EHR to decrease the number of items you are not actively managing.

Next, ensure that the appropriate types of messages are coming into your in-basket. Consolidate essential messages if possible and eliminate any that don't truly need your expertise.

Lastly, get rid of old and/or duplicate messages. An excessive volume of old messages in in-baskets can slow down the speed of the entire EHR. The Bellin Thedacare EPIC system at Bellin Health in Green Bay, WI, for example, had almost five million messages over one year old in their system. After notifying the clinicians, the system was purged of these messages, which greatly improved EHR speed and allowed for faster in-basket refreshing. Duplicate messages or reports should be avoided at all times.



## Q&amp;A

### What other IT techniques can I use to make in-basket management easier?

You may consider working with IT to:

- Consolidate folders to decrease the number of different items flowing to your in-basket.
- Use filters to prevent items from going into your in-basket that you are not directly responsible for handling, or that have no direct bearing on patient care.
- Develop **smart phrases or dot phrases** that can be used by team members as shortcuts for responding to items in the in-basket such as normal lab results.
- Create smart phrases that promote standardization for prescriptions and other items.
- Incorporate flags or check boxes to help prioritize or route messages that need a particular team member's prompt attention.
- Develop a system that would allow team members to mark a message for follow-up on a future date, then divert that message to a "holding pen" folder. On the specified date, the message would be resent to the in-basket and appear as a new message. Many EHRs make it possible to delay sending a message and this capability can be used to improve follow-up care. For example, after seeing a sick child in the office, the physician may ask the MA/LPN to put in a future note to follow up with the family in two days. That allows the team to stay on top of the clinical situation and/or catch a worsening situation before it gets out of hand. These types of unexpected follow-up calls from the care team can greatly increase patient and family satisfaction.

### How does this apply to my paper in-basket? What techniques from my EHR in-basket restructuring can I use to make paper messages easier to manage?

The paper in-basket can be managed in much the same way as the electronic in-basket, with a non-physician team member triaging and managing the majority of items. Much of the paper in-basket are forms and prior authorizations. For example, you may see an influx of school forms at the end of summer. Each team member should complete as much of the form as they are able, based on their role and training before sending it on. In a sample scenario, the front desk or PSR could fill out demographics and dates of visit on the form, and the MA/LPN could fill in the rest, involving the RN if needed. This way the form should be complete or almost complete before coming to you for review and signature. Once signed, the form could be routed back to the PSR to be scanned into the record for future reference and then sent to the patient. For organizations where all paper forms are scanned into the computer, the responsible team member can complete the task and have it scanned into the EHR upon completion.

**Smart phrases or dot phrases:** A smart phrase or dot phrase is a type of macro that allows users to create shortcuts for documenting patient information via telephone call or at the time of visit. Terminology may vary based on the EHR you have in your practice.

## 4

## Create a team pool and team pool in-basket to help redistribute and streamline work

In addition to the physician's in-basket, many practices also have separate in-baskets for triage, refill requests and patient questions. It is often difficult to determine where various messages or results should be sent and which team members should be checking the numerous in-baskets. Messages can end up in the wrong basket, and with multiple care team members checking these baskets, any breakdown in communication or documentation can cause duplication of work. Messages or results may fall through the cracks because no

one knows they haven't been addressed or completed. This poorly organized process creates confusion and is inefficient. One way to bring clarity and order to in-basket work is to create a team pool.

In a team pool structure, each physician or advanced practice provider has their own core team of MAs/LPNs/RNs who are always assigned to the pool. Only these core members can sign into the team pool in-basket. It is advantageous to form this cohesive unit because everyone is familiar with the physician's patients and their care plans. A single in-basket for this team pool fields all requests for that physician. Items such as patient questions, results notes, refill encounters, and carbon copied charts are sorted into to sub-folders within the team pool in-basket. The MAs/LPNs/RNs working with that physician are permanently checked into the team pool, which allows them to handle these items for their team to the top level of their licensure. With this approach, any high priority messages can be rerouted to the physician's in-basket or the physician can be verbally notified that something requires immediate attention.

Q&A

What are some of the sub-folders in the team pool in-basket?

Your EHR may use different labels, but some examples include:

- Refills
- Carbon copied (CC'd) charts
- Patient calls
- Patient portal requests
- Results notes
- Staff messages

Isn't creating a master in-basket and then sub-folders making more work because we'll have to re-sort our incoming messages and lab results?

No. It is very likely that your EHR system will automatically sort messages based on the "reason for encounter" selected. There should be minimal, if any, manual sorting of messages. For example, a request sent through the patient portal would automatically be labeled as a "Patient portal request" and sorted into that sub-folder.

Should test results go to the physician's in-basket or the team pool in-basket?

You could have them go to either in-basket, however, you should not have them go to both because actions taken in one in-basket may not be reflected in the other. If it makes the most sense in your practice for results to go to your in-basket, make sure that the members of the team pool can check into it and that specific workflows are in place for managing results.

How do I know that my team is responding to messages and addressing questions?

Ask that your team insert flags to denote that something needs follow-up, needs a signature or was completed. If your practice uses EPIC, you can ask that they mark a task "done" when completed, which removes it from view but doesn't delete it. Marking an item "done" keeps the in-basket clean.

How many people should be part of a team pool?

One possible composition for a team pool would be the MA/LPNs working with the physician, an RN and a PSR. The number of people and composition of the team pool can be adapted to fit your unique practice setting.



How can a team pool help me manage ticklers or reminder files?

Adding reminders to the team pool in-basket will ensure that any abnormal labs get the attention they need. This shifts responsibility to the team as a whole rather than one particular clinician. A protocol with a pre-determined follow-up period of one to three weeks for specific labs is one approach. You may consider automating reminders to patients as part of the protocol. Another approach is to designate a specific folder to create and store reminders for yourself. This folder is not permanent and doesn't go in the chart.

If the team pool in-basket is linked to me, does management fall apart when I'm out of the office?

A team pool with access to the physician's in-basket allows for ongoing management while the physician is away and prevents the accumulation of work that must wait until the physician returns. Anyone on the team pool can check in and help prioritize the few items that need physician attention. Consider establishing protocols for common in-basket tasks that do not require your review and signature. Also be clear about who is responsible for monitoring the in-basket when you are away so important messages or abnormal results are not overlooked. With these processes and protocols in place, the MA/LPN should be able to continue to work on routine tasks such as normal test results and refills while you are gone.

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Time management is crucial! Do small tasks in between patients—everyone thinks they don't have the time, but even in a couple of minutes you can get a result or refill done.

When your physician is in with a long appointment you could get more in-basket work done.

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Jami Burroughs, MA, Bellin Health



5 Empower staff to contribute by utilizing principles of team-based care

Empowering and trusting staff, encouraging critical thinking and always putting the patient's needs first are **team-based care principles** that support efficient in-basket work. In general, the core concepts for successful team-based care apply directly to in-basket management. This includes co-location, where the team members' and physicians' **work stations are in close proximity**, along with standard messaging and communication. Here are some team-based care techniques that could contribute to your success.

- **Co-locate team members.** It may seem counterintuitive, but in-person communication is a key component of effective in-basket management. Co-location is a principle of team-based care that promotes verbal communication between all team members, resulting in less need for electronic communication that clutters the in-basket. Consider co-locating team members such as triage nurses, rooming staff and schedulers. This will facilitate prompt resolution of questions or issues that arise during triage, rooming and scheduling. While face-to-face communication is ideal, if co-location is not possible in your clinic layout, find another way to enhance communication between team members to decrease the need for electronic messaging. Some practices use secure mobile or text-based platforms such as **Vocera**, **TigerText** or **Imprivata**<sup>®</sup> to improve communications, whereas others keep in contact with walkie talkies.\*

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- **Incorporate a daily huddle.** **Daily huddles** can help you reduce unnecessary electronic communication. For example, you may use the huddle to identify appointment times for additional patient access that day instead of messaging back and forth.
- **Empower staff with new responsibilities and autonomy.** Empowering staff to make decisions and take on additional tasks is a valuable technique for cutting down on messaging. Consider training rooming staff to make decisions regarding additional patient access as the need arises. Or, you could create protocols to enable rooming staff to pend refills for 90 days with refills at appointments for annual checkups or chronic disease management. If there is hesitancy to refill all meds for one year, start with a safe chronic medicine that doesn't need close monitoring such as a statin, metformin or calcium channel blocker. Training can take the form of **professional development programming** to help your team members perform to the top of their licenses.
- **Start using pre-visit laboratory testing.** **Pre-visit labs** rely on scheduling labs for the next appointment before the patient leaves. Results are sent in advance of the next visit. With protocols in place, empowered staff can perform a preliminary review and flag those that are abnormal to save time for the physician. In some practices, the MA or nurse will research the patients' previous abnormal labs (e.g., for a low potassium result, the nurse may call the patient to determine adherence to medications and provide this information to the physician along with the cumulative trends of the lab result, the medication list and last visit note). The nurse may verbally review accumulated messages with the physician several times per day, allowing the physician to efficiently make safe, informed decisions.
- **Use verbal messaging rather than electronic messaging whenever possible.** Verbal messaging is more efficient and is a richer form of communication. It is supported by co-location, but can be the predominate form of communication in any setting.

Q&A

I'm using pre-visit labs. How can I leverage my team pool to review and flag results?

Some systems have all results screened by MAs prior to the results getting to their physician's in-basket and have built extensive protocols to guide that process. In these organizations, normal pre-visit labs are handled by the staff, rather than being sent ahead of time to the physician. The physician thus is able to do "just in time" information processing, "touching" these results only once: at the time of the face-to-face visit. This decreases the need to handle normal results more than once and decreases the workload.

How frequently should a team pool member check the in-basket for results?

Time management is extremely important for effective in-basket management. For example, at Bellin Health in Green Bay, WI, the most efficient MAs/LPNs learn to check the in-basket on a continuous basis during the day. They make every minute count, such as doing a quick refill request in the brief time they may have between patients. For normal lab results, the team member can notify the patient via phone, patient portal or letter, and mark the task "done" in the in-basket in these short windows of time. An RN at Bellin who oversees the in-basket for three or four providers checks into the pool at least every half day. At Medical Associates Clinic in Dubuque, IA, the core team is comprised of RNs and LPNs. In that clinic, the nurses check the in-basket on a continuous basis during the day and then once or twice per day they verbally address any messages with the physician that will require his or her input.

What's the best approach for managing abnormal results?

For abnormal results, the physician should give direction to team pool members regarding the results, either verbally (preferred) or electronically, or handle the communication to the patient themselves. If the MA, LPN or RN handles the communication of abnormal results to the patient, they should mark the results as "done" in the physician's in-basket. If the patient is unable to be reached, the MA, LPN or RN should continue to try to contact the patient on a regular basis, each half day at a minimum.

If the physician is not in the office, the team pool member(s) should monitor the in-basket for significant abnormal results each half day at a minimum. Abnormal results should be communicated with the covering clinician. If the MA or LPN is in the office in a different role, they can help monitor the in-basket as time allows.

If there is no office RN, one approach is for the identified covering clinician to monitor the in-basket each half day.

6

## Develop workflows for common in-basket tasks

Creating standardized and simplified workflows will help everyone on the team perform more efficiently. Here are some examples of areas where you can start:

- **Standardize prior authorizations.** Develop standardized workflows so that your team can fill out prior authorizations as much as possible before coming to you for completion or signature. This approach shifts the bulk of this task to appropriate office staff working to the top of their skill set. Consider developing a centralized prior authorization team composed of RNs and MAs. Maximize the use of generic medications to minimize the need for prior authorizations and be sure the patient is **adhering to their current medications** before adding or escalating therapy.
- **Eliminate, automate or centralize repeated tasks.** First, try to decrease the need for repetitive work. For example, with medication refill requests, **synchronized bundled renewals** can markedly decrease the volume of refill requests. Second, for those refill requests that still come through, consider an automated refill request system or a centralized refill team. This may be the same team that handles prior authorization requests. Eventually, you may want to extend this standardized approach to handling requests for controlled substances refills.

If your practice sees a high volume of patients on oral anticoagulants, consider developing a centralized INR management team to handle these results per protocol. If your clinic has an **embedded pharmacist**, adding them to your team pool to manage in-basket tasks related specifically to these patients could be valuable.

- **Simplify form completion.** Timely completion of paper forms in the in-basket is always a challenge; however, if paper forms are not handled expeditiously, the originator of the form will likely send a second request, which then doubles the work. Specific workflows and defined responsibilities are necessary for this paperwork to be as complete as possible. Assign forms to appropriate team members to be filled in so all you need to do is review and sign. Other team members can easily complete the date of last visit, diagnoses and current medications. Attaching a printed list of medications instead of writing the medications out may save time and reduce errors.
- **Delegate screening of portal requests.** Patient portal messages should not go, by default, directly to the physician. Have these messages screened by appropriate staff, and completed by them whenever possible. The use of team pools allows these messages to be routed to the appropriate team member who can handle the requests.
- **Anticipate the needs of complex patients.** A robust transitional care program for complex patients leaving a hospital or SNF could avert complications. Anticipating and meeting their needs before a crisis may in turn decrease in-basket work and phone calls to the office.



## AMA Pearls

### Every team member has a role in managing test results

When managing test results, it is important that all members of the core team (MA/LPN, RN, and physician) play a role and are accountable to the patient.

### Test new approaches early and often

Being hands on as soon as possible will benefit you. You'll quickly recognize when an approach to routing messages is working—and when it isn't. Don't be afraid to try new approaches and workflows, and be ready to adjust swiftly if changes don't work out as well as expected or if unanticipated barriers arise.

### Manage your time

Consider the “delete, delegate, defer, or do” strategy. Use this strategy in getting to “done” and eliminating multiple touches. Time management issues are often the underlying problem with in-basket management inefficiencies. Look at the in-basket at least each half day but don't set aside a specific time to manage it. Encourage the entire team to take every opportunity to do in-basket work when there is a free moment. Avoid putting this work off until the end of the day. Longer appointments may give team members who aren't part of the visit a 10- to 15-minute window to check the in-basket.

## Conclusion

Managing the in-basket should not rest solely on the physician. There are many ways to reduce the amount of time spent on this task. Leverage the skills of the care team to apply the principles and workflows of team-based care to be more efficient, redistribute the in-basket workload and ultimately get more done during the clinic day.



## STEPS in practice



### How's it working in Green Bay, WI?

“I was at a conference recently and checked my inbasket—it was amazing to see things getting done by my team with our standing orders and protocols. Setting up processes to handle these tasks and then empowering the team to do it really works!” says James Jerzak, MD, Physician Lead, Team-based Care, Bellin Health Ashwaubenon.

Not long ago, inbasket management was very disorganized at Bellin Health Ashwaubenon (Bellin), a family medicine practice in Green Bay, WI. “We practice standardized rooming, but each medical assistant had seven or eight inbaskets they were checking throughout the day. No one knew what was going on or where they were supposed to be. We needed a process to keep on top of the inbasket and to make sure that the right team members were handling the right messages,” said Jami Burroughs, CMA. To understand the extent of the disorganization, they performed an audit of inbasket communication and then used this information to guide improvements.

Physicians, nurses and medical assistants (MAs) worked together to look at all the inbasket subfolders and categorize the types of messages that came to each folder. Commonly received messages included symptoms-based calls, requests for refills, appointments, medical records, orders, results and questions about immunizations, medication or a recent office visit. Then, the group determined if what was coming into each folder was useful or redundant. They filtered out information that the recipient was not directly responsible for managing and evaluated which team member would be most appropriate for handling each type of message or inbasket item. They made sure to have representation from each specific role in the practice when determining where certain messages could be routed.

Once the audit was complete, they started work on improving the inbasket. First they created team pools, with specific MAs, licensed practical nurses (LPNs) and registered nurses assigned to a particular provider. Next they selected a naming convention for the team pools. The standard name might consist of the clinic location and/or provider name. For example, Dr. Jerzak’s team pool is named “Jerzak Team.” This made it easier for individuals from an outside clinic to know the pool names. Typically, the MA/LPN for that provider’s team logs into the team pool inbasket and manages only that inbasket. In bigger clinics, each team consists of a larger team referred to as a pod. If a specific team within the pod is out on a particular day, the other MAs and LPNs within that pod can check the inbasket for the absent team pool. All messages now flow into the team pool inbasket. The only exception is the triage inbasket, which allows separation of the registered nurses’ (RNs’) work and the MA/LPNs’ work. Instead of having a triage nurse for each provider, the triage inbasket contains messages from all the providers within the larger “triage team” or pod. The team pool arrangement encourages members to work together to get the inbasket work completed in a timely manner. When time allows, the RN checks into team pools to help with the work.

The biggest challenge was determining what work should go to the team pool inbaskets and what work should go to the triage inbasket. In the past, the majority of messages, no matter what they were, ended up in the triage inbasket, making it difficult for the RN to see patients and complete the inbasket work. The team pool approach to inbasket work reduces the size of the triage inbasket and frees the RN to be more involved in direct patient care, such as diabetes education, blood pressure checks and Medicare wellness visits.

As with any process change, training individuals on the new process can be challenging. In the past, the RNs working triage received all symptom-based calls, handled the majority of results, and were the default contact for almost any issue that arose in the office. One of the first things discovered at Bellin is that it made more sense to have MAs or LPNs start handling some of those messages, especially those related to a recent office visit. Patients seemed to prefer to receive a call back from the MA/LPN who was in the room with the provider during their visit, since they had developed a relationship with that team member. This approach was definitely different, but providers caught on quickly to routing some results to the MA/LPN instead of always sending them to the RN. Being co-located helped make this process easier. For receptionists, Bellin developed standard messaging templates so that if a patient calls with a question, the receptionist is prompted to ask the patient if he or she was seen in the last two weeks. If the patient’s message does not require triage, the receptionist sends the message to the MA/LPN through the team pool inbasket instead of to the RN and the triage inbasket. In addition to being more efficient, this process increases patient satisfaction, as the patient knows the person who is communicating with them.

Many times, staff will flag messages as reminders or to let anyone working the inbasket know about something, e.g., a message was left with the patient to call the office or for the office to call once results are available. The receptionist also uses a red arrow, a functionality that is specific to EPIC, that indicates high priority messages that need to be addressed promptly by either the RN or MA/LPN. If a message in the inbasket does not need

to be addressed until the following week, a reminder can be placed on the message so that it comes off the workload, and then automatically reappears as new on the specified date. These techniques help the team with time management and prioritization of the inbasket.

There are still some paper forms that come into the office, such as nursing home orders. For these forms, the receptionist drops it off in the RN paper inbasket and the RN enters it into the electronic health record (EHR) and routes it to the provider. For paperwork such as disability, FMLA or wellness statements that require the physician to complete and sign, each team member completes as much information on the form as they can to the level of their licensure before passing it on to the next person for completion. The receptionist fills in demographics and last office visit date before passing the form on to the MA/LPN. If the MA/LPN is unable to complete the form, it is passed to the RN to complete. The goal is for the provider to sign the complete or near-complete form, since the appropriate staff completes as much of the form as possible before it gets to the provider.

“Inbasket work also improves as your office visits improve because you’re addressing refills, referrals, scheduling follow-up appointments and documenting so your team can communicate effectively with patients if issues later arise. You are getting tomorrow’s work done today. It’s just way more efficient,” says Jami Burroughs, CMA.

Bellin is so satisfied with the new process that they are building on it. They are currently piloting a centralized refill team to handle all refill requests. They have also developed an anticoagulation clinic where either the pharmacist or trained RN handles INR results based on a protocol, eliminating the need to send those results to the provider’s inbasket. They are also using EHR smart phrases, such as “results reviewed at recent office visit,” to help streamline work.

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## How’s it working in Minneapolis, MN?

At HealthPartners Medical Group, inbasket management was initially tackled as part of a larger quality improvement effort that coincided with a system-wide rollout of EPIC in 2004. A group of local leaders, providers and staff, supported by informatics experts, worked to standardize workflows, including inbasket management. The standardized workflows combined evidence-based medicine and practice efficiencies and became known as the Care Model Process. After the introduction of the new workflows, both patients and providers noticed that communication could be further improved, particularly follow-up after patient phone calls, which clinics tracked through the electronic health record (EHR) inbasket. Results from the organization’s American Medical Group Association (AMGA) satisfaction survey in 2006 showed that providers wanted even more standardization to be applied to the inbasket work. A quality improvement pilot to further standardize inbasket management was initiated in primary care settings and then extended to all medical and surgical specialty groups at HealthPartners. The success of this effort was captured in the results of the 2016 AMGA survey, in which providers reported that eliminating inbasket inefficiencies decreased the burden of work and increased satisfaction in the practice.

In the HealthPartners quality improvement project, the inbaskets themselves and the way they were managed were completely restructured. To ensure that everyone on the team could contribute to appropriate and timely follow-up, “blinded” inbaskets for physicians were eliminated. Instead, the physician’s rooming support team for the day are responsible for checking into that physician’s inbasket. Each team member is responsible for reviewing, responding or routing messages as appropriate. This approach has been helpful for managing patient messages and prepping those items for the clinician so messages no longer bounce back and forth between team members.

Folders within the inbasket were consolidated, reorganized and standardized.

- A “for information only” category was created to filter consult notes and notifications of hospital discharge that did not require immediate attention.
- “Action needed” items, such as test results and questions from patients, went to another folder and could be flagged to draw the physician’s attention.

The reception staff use standard messages, specific lines of questioning and smartphrases to make sure that all fielded calls are placed in the correct folders for the care team. Specific types of information are placed into an encounter to prepare it for the clinician and appropriate concerns are converted to a phone visit. This approach has been particularly useful for vetting test results, messages that should be sent directly to the physician, and symptom-based calls for the registered nurse (RN).

The RN is the only team member who still has a separate inbasket. When the revised team inbasket workflow was piloted in three clinics, they discovered that having the RN check into the same inbasket with the rest of the care team was very inefficient. There were too many “touches” by multiple team members and it was difficult to see when tasks were completed. With one word or phrase entered by reception, calls about symptoms are routed immediately to the RN inbasket.

“The AMGA survey showed that our physicians wanted to see specific aspects of the inbasket streamlined: medication refills and test results,” said Joan Flaaten, RN, Director of the Care Model Process. “Now about 95 percent of lab test results are released to patients automatically within four hours via the patient web portal. Patients appreciate this speed because it means that if they have questions, they can call in and get answers while the encounter is still fresh in everyone’s mind. In addition, this approach ultimately reduced the number of calls we received from patients who were wondering where their test results were and when they’d receive them.”

There was some initial resistance to having results available so quickly to patients because physicians worried they wouldn’t have time to review the results before release. HealthPartners developed a test result guide to train staff on varying degrees of abnormality in test results so they could accurately flag those that warranted a phone call from the physician. The test result guide explains what is a normal, minimally abnormal or clinically abnormal result for several common tests. For example, Lyme disease and hepatitis testing are included in this guide, which allows team members to prepare patients in the exam room in the event their results come back abnormal. For clinically significant results, patients are contacted directly by the care team to enable follow-up. Reporting test results to patients can also be delayed in some circumstances. For example, CT scans, MRI results and pathology findings are often manually released because they require interpretation from a physician.

Patients who prefer to receive test results by phone or letter are notified by their chosen method.

HealthPartners also took a unique approach to simplifying the paper inbasket. Several clinics established a goal to reduce paperwork by 15 to 20 percent. They were consistently finding that everything in paper form ended up in one spot on the physician’s desk. This made it hard to prioritize important documents amidst a single pile of paper. Over a one-month period, clinic staff collected every piece of paper routed to the physicians and scanned it in so it could be tracked. Some of these scans, such as FMLA forms, were added to the EHR or patients’ medical records so they could easily be pulled up in the future and fields would already be completed. They found that the best approach was to give physicians three baskets for scanned paper forms: read, priority and outbox. This clear demarcation between scanned paperwork that is important vs. less important eased the paperwork burden for busy physicians.

Training team members to direct messages to the appropriate paper or electronic folders, as well as being clear about their roles in managing the inbasket, is critical for success and sustainability. New hires at all levels are trained on the inbasket workflow during orientation. The expectations are clearly defined and local supervisors understand their team’s responsibilities regarding the inbasket.

“Inbasket management is not plug and play. Figure out your best team, work with them to design the management approach, pilot it and then finally spread it to others,” said Beth Averbek, MD, Senior Medical Director of Primary Care. “That’s what worked at our organization because our team care model is a living, breathing organism — we were embedding the philosophy and supporting the work locally.”

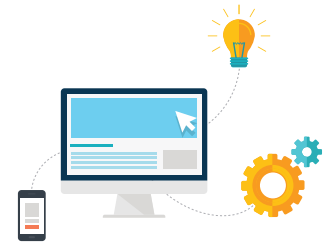


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