INTRODUCTION: BACKGROUND & CONTEXT

- **Primary care residents/faculty** who spend 6 hrs/wk (median) on EHR work outside normal clinical hrs are 3x more likely to report burnout & 4x more likely to attribute it to EHR.
- **Family Medicine (FM) residents** perform an average of:
  - 13.6 hours per month of "non-visit care".
  - 84 minutes/day spend on in-box work.
- Our FM residents identified lack of time to manage patient related “in-boxes” as a barrier to their well-being.

MEASURES/METRICS

**OUTCOMES:**

- Mayo Well-Being Index
- Clinic metrics for patient experience (CGCAHPS test results, between visit communication)

**PROCESS MEASURES:**

- 4-items added to required end-of-rotation evaluation focused on Clinical Resource/Administrative Half Day to track:
  - # of ½ days taken during rotation, scheduling barriers, how time used
  - Degree to which ½ day “made me feel that things were more under my control”

MISSION/VISION STATEMENT

**VISION:** Aurora Health Care’s GME programs will be nationally recognized for preparing our current and future physicians to help people live well – our patients, each other, and ourselves.

**MISSION:** Apply IHI Model for Improvement to program specific well-being initiatives to address well-being drivers from workload and control/flexibility to culture/community and work-life integrations to promote meaning in work.

AIM/PURPOSE/OBJECTIVES

Improve resident well-being and patient satisfaction by providing one ½ day/week explicitly designated as “clinical resource - administrative time”

METHODS/INTERVENTIONS/CHANGES

**CLINICAL RESOURCE/ADMINISTRATIVE HALF DAY**

- **ONE ½ day per non-call clinical week**
- ½ days are scheduled by residents AFTER all other call and clinic schedules have been created
- Time intended for:
  - In-Box (digital or paper) management including medication refills, lab results, and patient calls
  - Chart documentation
  - Collaborate with clinic team nurses, MA, and support staff
  - Program Curriculum Requirements, scholarly projects (research, QI), modules, track-related work
- Oriented residents/faculty during standing meetings, core curriculum sessions, e-mails from NI-VI leaders

BARRIERS – STRATEGIES

- **IDENTIFICATION OF WELL-BEING TARGET:** Several priority areas each requiring infrastructure changes were identified
  - **STRATEGY:** Focus on one target (½ day/week) that was realistic and feasible for PDSA cycles within NI-VI timeframe
- **TEAM MEETING TIME:** Team members have conflicting schedules making it difficult to have consistent planning meetings
  - **STRATEGY:** AS NI-VI leaders include residency program leaders (resident chiefs, program directors) used existing meeting time
- **FACULTY WELL-BEING:** Initial focus of project team efforts emphasized resident well-being
  - **STRATEGY:** Identify and select target(s) for faculty well-being that have “multiplier” effects (e.g., make it count x3)

DISCUSSION: NEXT STEPS & AREAS SEEKING INPUT

**WHAT ARE CRITICAL NEXT STEPS?**

- Use end of rotation data to determine PDSA Cycle change(s)
  - Ex: Core curriculum “how to” sessions on clinical management
- Implement faculty well-being target (stressor well-child check as new metric) and make it meet multiple requirements
  - PI-CME Credit for Part IV MOC for Faculty & Residents
  - Meet clinical metrics & ACGME expectations residents’ clinical data

**AREAS SEEKING GUIDANCE/INPUT**

- Transitioning to new chiefs as senior resident chiefs graduate and sustaining project “ownership”
- Altering and individualizing intervention based on individual resident in-box (in)efficiency (how use ½ day non call clinic time)

GROUP FEEDBACK