**INTRODUCTION: BACKGROUND**

- 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."
- Our FM residents identified lack of time to manage patient related "in-boxes" as a barrier to their well-being.

**AIM/PURPOSE/OBJECTIVES**

Improve resident well-being & patient satisfaction by explicitly designating one ½ day per week as "clinical resource/administrative time."

**METHODS: INTERVENTIONS/CHANGES**

**Clinical Resource/Administrative Half Day**

- ONE ½ day per non-call clinical week
- 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, MAs, and support staff
  - Program curriculum requirements, scholarly projects (research, QI), modules, longitudinal track-related work

**PDSA Cycle 1:**

- Oriented residents/faculty during standing meetings, core curriculum sessions, e-mails from NI-VI leaders

**PDSA Cycle 2:**

- Created 11" x 17" poster to improve awareness, explain scheduling details, and distinguish the Clinical Resource/Admin ½ days from the GME and FM Program ½ days already in place
- Re-oriented all residents/faculty

**RESULTS: PROGRESS TO DATE**

**CG-CAHPS Percentile:** 2 Family Medicine Residency Clinics (FCC and FPC) [2017 vs to date 2018 (July)]
- Between Visit Communication
  - FCC ↑ 3 points
  - FCC no change
- Test Results
  - FCC ↑ 12 points (N=141 Jan-July 2018)
  - FCC ↑ 8 points (N=266 Jan-July 2018)

**DISCUSSION: BARRIERS & STRATEGIES**

**Barriers**

- Residents are aware of the resource ½ days, but how to actually schedule the ½ days still confusing
- Strategy: Identify underlying "gaps" in knowledge and then educate

- Residents are deciding not to use resource ½-days and seeking to increase preceptor 1-on-1 contact time
- Strategy: Seeking to revise scheduling so that preceptor time is increased and schedules are predictable
- Program leadership will explore increasing preceptor availability/time

**Next Steps and Sustainability**

- Launch PDSA #3 focused on identified barriers and engage program coordinators (e.g., scheduling prioritization)
- Track data and compare to baseline and national norms
- Sustainability:
  - Junior Chiefs were added to the team
  - GMEC requires well-being updates in APE

**METHODS: MEASURES/METRICS**

**Outcomes:**

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

**Process Measures**

- 4 items added to required end-of-rotation evaluation focused on Clinical Resource/Administrative ½ 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"
- Progress Check In Survey implemented PDSA Cycle 2
  - Likert scale items adapted from existing surveys
  - 1 demographic question and a comment box

**RESULTS: PROGRESS TO DATE**

**Resident Wellness Check-In Survey**

My ability to utilize and navigate EPIC to work for me is

I feel that I am growing/learning in my career/specialty in ways that I care about

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