Enhancing the Value of Clinical Work—Choosing Wisely to Preserve the Clinician Workforce

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The Choosing Wisely campaign, established by the American Board of Internal Medicine Foundation in 2012, identifies health care services that patients and clinicians should consider ending due to limited clinical benefit.1 More than 80 clinician specialty societies across multiple health disciplines have generated more than 600 recommendations to help clinicians and patients choose care that is high value and avoid services that may be unnecessary or harmful. Choosing Wisely has changed the national conversation about the need to reduce low-value care.2 Now, this decade-long quest to improve the value of health care delivery has collided with a demoralized health care workforce, creating a unique opportunity to improve health care work environments by applying a Choosing Wisely mindset to clinical management practices.3

In 2019, the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being recognized that the imbalance between clinicians’ job demands and available resources was a driver of burnout. The COVID-19 pandemic has since underscored the scarcity of health care resources, including insufficient supplies and too few clinical personnel, a scarcity worsened by clinician burnout and resignations. As a result, NAM has now published a National Plan for Health Workforce Well-Being, which included addressing management and regulatory burdens among the several needed solutions to tackle clinician burnout.4

In this Viewpoint, we outline how to extend Choosing Wisely principles to identify clinical management practices that lead to unnecessary burdens; propose approaches to identify and prioritize those low-value practices; describe the partnerships between clinicians, health system leaders, regulators, payers, and policy makers needed to reduce burdens; and recommend a research agenda for evaluating the consequences of change.

Defining the Principles

By adapting Choosing Wisely principles, clinicians and health care leaders can identify low-value management practices that: (1) create unnecessary burdens on the clinician workforce; (2) do not have a sufficient evidence base to improve clinical quality, organizational outcomes (eg, efficiency, financial performance), or equity; (3) do not address outcomes patients care about; and/or (4) are duplicative or waste time.

Identifying Problematic Practices

As a first step, clinicians can identify low-value clinical management practices. Leaders can expand this list by identifying and addressing regulatory and payment hurdles to progress. The “Getting Rid of Stupid Stuff” program at Hawaii Pacific Health asked employees to nominate anything in the Electronic Health Record (EHR) that was poorly designed, unnecessary, or “just plain stupid,” resulting in streamlined documentation requirements.5 The American Medical Association’s Saving Time Playbook details some potential unnecessary practices, including EHR and documentation requirements, compliance and risk-management requirements, mandatory training, and billing.6

We propose 3 paths to identify and assess recommendations for choosing wisely to preserve the clinician workforce. First, health care organizations can crowdsource nominations from clinicians

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for low-value clinical management practices that include and extend beyond the EHR. Organizations can triage the recommendations (as described later). Second, health care leaders, both within and across organizations, can endorse clinical management practices that should be abandoned without changes to external regulations and identify others that require regulatory reforms. Third, as this process will identify existing practices of questionable value because of external regulatory mandates (eg, accreditation, safety, performance monitoring, payers), health care leaders should partner with regulators and stakeholders to change, scale back, or eliminate burdensome requirements and regulations.

Evaluating the Evidence

The AMA Saving Time Playbook describes a clinician-generated nomination process in which simple fixes should be prioritized for implementation. However, some nominations will require further investigation to assess whether deimplementing the practice could lead to quality deficits, regulatory concerns, or organizational disruption. We recommend assessing nominations with 4 questions.

1. Has this practice been demonstrated to improve the quality or safety of care for patients, organizational efficiency, or equity? For example, the widely adopted EPIC Sepsis Best Practice Alert showed poor discrimination and calibration upon rigorous evaluation. Unfortunately, most management practices are not rigorously evaluated, and evidence may be lacking; therefore, the process of assessing the recommendations must also ask the converse—how do we ascertain that safety would suffer if the practice was eliminated?

2. Is the practice duplicative, too frequent, or not performed by the most appropriate personnel? For example, many mandatory staff trainings are too frequent, have no evidence base for benefit, or are not targeted to those who most need them, and yet clinicians are often assigned 10 hours or more of annual trainings regardless of past proficiency or training in the topic.

3. Is the practice driven by outdated internal policies? For example, some mandated internal practices, like requirements for routine preoperative physical exams, are based on expired external regulations.

4. Is the practice by external rules or regulations (eg, accreditation, compliance, payer requirements) in need of reform? For example, coverage of a home blood glucose monitor under Medicare requires that a physician or advanced practitioner complete an in-person examination documenting a diagnosis of diabetes. Yet, this documentation could be done without an in-person visit and by a clinical pharmacist or nurse.

Prioritizing What to Stop

Once a system identifies problematic practices and reviews the evidence, the next important step is to prioritize what to stop. These efforts require partnerships between clinicians, health care executives, and clinical specialty organizations. Several strategies are available, both locally and nationally. For example, clinicians within a health care system could rank order clinical management practices based on prespecified criteria, or a specialty society could enlist their membership to similarly rank low-value practices. For practices driven by regulations or where strong evidence is unavailable, specialty societies could convene Delphi panels with stakeholders to assess priorities for regulatory reform or identify practices that require additional evidence to guide decisions.

Coordinating Regulatory Efforts

Although clinicians, health system leaders, and specialty organizations can help identify and, in some cases, modify burdensome practices, there will be a critical need to coordinate efforts with policy makers, payers, and regulators to fully deimplement low-value management practices. A recent positive step has been the change in documentation and coding requirements for many ambulatory
visits by the Centers for Medicare & Medicaid Services (CMS). Yet, the CMS Office of Burden Reduction and Health Informatics often targets reducing administrative requirements that do not create meaningful burden reduction for practicing clinicians. Therefore, it is essential that we have both a bottom-up approach, with clinicians identifying candidates for burden reduction and specialty societies promoting change, and a top-down approach in which regulators and insurers, working with clinicians, modify existing burdensome and low-value regulations.

Supporting Research to Reduce Problematic Practices

The NAM recommends greater funding for research on reducing clinician burnout. Applying the Choosing Wisely model to preserving the clinician workforce represents an opportunity to evaluate the effects, including unintended consequences, of deimplementing practices on patient, clinician, and system outcomes, using an established research framework for the deimplementation of low-value clinical services. Prospective evaluation of new practices prior to widespread implementation may prevent burdensome and low-value practices from being established in the first place. Funders can work with researchers to prioritize studies that identify ways to decrease burnout through system-level solutions that decrease administrative burdens and improve the well-being of clinicians.

Conclusions

The Choosing Wisely framework, applied to clinical management practices, can help clinicians, health system leaders, policy makers, payers, and regulators drive transformational change by excising low-value clinical management practices and supporting the clinical workforce in delivering safe, equitable, and patient-centered care. Implementing this agenda, in concert with other needed changes to improve clinicians’ work lives, can result in substantial positive changes to clinicians’ everyday lives, changes that are essential to addressing continued operational disruptions due to workforce departures that threaten gains in quality, safety, equity, and trust in the US health care system.
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REFERENCES