

REDUCING BURNOUT IN PRIMARY CARE

A Conversation with Dr. Jane Fogg, American Medical Association



Primary care clinicians today spend nearly as much time on administrative work as they do with patients. At the March 20, 2026 Clinical Strategy Committee meeting, Dr. Jane Fogg, Physician Director of Organizational Transformation and Professional Satisfaction at the American Medical Association (AMA), shared national data and practical strategies to reduce administrative burden. Her message was clear: this is more than a workforce issue; it is also a patient safety and system sustainability imperative.

The Administrative Burden by the Numbers

New AMA 2025 AMA survey data from nearly 19,000 physicians highlights that for every hour a physician spends face-to-face with a patient, roughly 45 minutes are spent on administrative and indirect work.

Not All Administrative Work Is Created Equal

Dr. Fogg emphasized that not all administrative work should be treated as a single issue. Instead, tasks generally fall into four categories:

- High value, poorly designed: Important tasks that exist for a reason but are inefficient and need redesigning or automation.
- Essential professional work: Core clinical thinking and relationship-based care that must remain with physicians.
- Low value administrative work: Tasks that add little clinical or system value and should be eliminated.
- Right work, wrong person: Tasks that should be done by another member of the care team but default to physicians.

A Practical Framework for Taking Action

Organizations can take a structured approach to reducing administrative burden: Identify, Analyze, Prioritize, and Build Consensus, then choose to:

- **Eliminate** unnecessary work
- **Delegate** tasks to the appropriate team member
- **Automate** processes using EHR tools or AI
- **Collaborate** by sharing accountability across the care team

Real-World Evidence: Change Is Possible

- **Small practice redesign:** A 6-8 provider BIDMC practice redesigned around four goals: consistent patient access, population management, care coordination, and team-based huddles. The result was stronger value-based contract performance, higher patient experience scores, and a more cohesive team.
- **Large-group in-basket reduction:** A 300-physician, 21-site primary care group achieved a 25% overall in-basket reduction by applying the Eliminate-Automate-Delegate-Collaborate framework to specific message types. Automating normal lab results directly to patients yielded a 30% drop in lab result messages with zero complaints from patients or providers.

The Regulatory Myth Problem

Many burdens attributed to regulation are internal organizational policies, not legal requirements. Research cited by Dr. Fogg found that 78% of obstructive workplace rules were fully within the control of health system administrators. Before accepting any burdensome process as fixed, she encouraged practices to ask one simple question: "Show me the regulation."

Average Physician Weekly Workload:

- 27.5 hours on direct patient care
- 13.0 hours on indirect care (EHR documentation, test interpretation, referrals)
- 7.4 hours on pure administrative tasks (prior authorizations, insurance forms, meetings)

Key Takeaways for Rhode Island

- Physician time is finite – every unnecessary task is time taken from patients.
- Most administrative burden is addressable at the organizational level without legislative change.
- Engage the people doing the work to design the work.
- The AMA STEPS Forward® Playbook Series offers ready-to-use resources for practices ready to start.

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From Conversation to Action: CSC Core Working Group Update

The March Clinical Strategy Committee session with Dr. Fogg was only the beginning. Since then, momentum has been building, and the work is already producing tangible results.



A shared definition of Advanced Primary Care is now in place

At the April 17 CSC Core Working Group meeting, the group refined the Primary Care Collaborative's definition of Advanced Primary Care to better reflect team-based care, community connection, and workforce well-being. The updated definition was approved by the CTC-RI Board on April 24 and has been shared with OHIC:

Advanced Primary Care (APC)

A comprehensive, team-based model in which primary care is accountable for managing the health and clinical risk of a defined population across time, extending beyond traditional visit-based care to deliver coordinated, continuous, patient-centered services that are high-quality, evidence-based, and cost-effective. APC is supported by population health management, integrated services, modern infrastructure, and aligned payment models that improve access, outcomes, affordability, workforce well-being and satisfaction, and health equity across the lifespan, while actively engaging with the communities it serves.

The "how" is still evolving

The group is continuing to develop an APC continuum and measurement framework. There is strong interest in tracking meaningful outcomes while keeping the approach feasible and avoiding added burden on practices. More to come.

Administrative burden remains front and center

Across the board, there was clear agreement: this is one of the biggest barriers to making Advanced Primary Care work. From prior authorizations to inbox overload, the challenges are familiar — and there is growing interest in applying AMA tools and resources to drive real change at the practice level.

What's Next

The group is exploring a learning series and quality improvement initiative in partnership with the AMA.

