

REPORT

6 tactics to reduce EHR burden

Most health systems have already implemented an EHR. Now, health systems must focus on making EHRs easier for clinicians to work with. This playbook presents six tactics to pinpoint where physicians lose time, strengthen EHR adoption, redesign high-burden workflows, and apply AI selectively so technology reduces administrative work and complexity.

Published: October 2026

Audience:

- Hospital and health systems
- Physicians and medical groups

Background

Physician burnout remains tied to administrative and digital workload

Physician burnout remains a major problem across the industry. In 2025, 41.9% of physicians reported at least one symptom of burnout.¹ More than half of physicians in a 2025 study attributed part of their stress to the EHR.²

Administrative and digital workload remain central drivers: physicians must coordinate care across complex teams and systems while managing documentation, messages, and other non-clinical tasks that pull time away from patient care.

56%

of physicians in a 2025 study attributed part of their stress to the EHR²

Two persistent drivers of inefficiency continue to limit progress

Despite years of investment, two core challenges continue to drive inefficiency in EHR use:

- **Limited clinician usage of EHR tools and functionality:** Many clinicians are not fully leveraging available features, shortcuts, templates, and workflows that could reduce documentation and administrative burden.
- **Inefficient workflow and system design:** Many tasks still require excessive clicks, manual work, and physician involvement in activities that could be streamlined, automated, or delegated.

Even when clinicians do become more proficient with EHR tools and functionality, poorly designed workflows and administrative processes continue to drive excess time in the EHR. As a result, a significant portion of physician effort remains focused on low-value or non-physician-level work.

EHR optimization requires workflow redesign, governance, and selective technology adoption

Emerging AI and automation tools can reduce documentation, inbox, decision support, and care coordination burden, but only when they are introduced into well-designed workflows. Without clear governance, training, and change management, new tools can add complexity, shift work to other teams, or scale existing inefficiencies rather than reduce burden.

This report provides six tactics for using data to identify inefficiencies, redesign workflows, and govern optimization efforts that reduce clinician burden.

Table of contents

This playbook details six tactics for EHR optimization:

01

Use data to identify where physician time is being spent inefficiently

02

Optimize clinician workflows through continuous training and adoption support

03

Streamline clinical decision support and automate repetitive work more selectively

04

Redesign inbox and patient communication

05

Use ambient documentation and other note support tools where they meaningfully reduce burden

06

Standardize care coordination workflows and use AI to orchestrate execution

01 Use data to identify where physician time is being spent inefficiently

What problem this solves

Organizations need a more objective way to pinpoint EHR inefficiencies. Many still rely on anecdotal complaints to identify pain points, which can be incomplete or subjective. By using EHR usage data, analytics, and AI, leaders can identify where physicians spend disproportionate amounts of time, uncover workflow inefficiencies, and determine which clinicians or processes are at greatest risk of burnout.

Recommended actions:

- 1. Use EHR usage data and analytics to identify inefficiencies and potential burnout risk.** EHRs provide detailed metrics on time spent across activities like documentation, chart review, inbox management, and order entry. They also capture after-hours charting ("pajama time") and number of clicks or keystrokes. Analyzing this data reveals exactly where inefficiencies exist and which physicians, specialties, or workflows may be at increased risk of burnout.
- 2. Use analytics to uncover low-value activities consuming physician time.** Once inefficiencies are identified, analyze which activities represent low-value or non-physician work that could be delegated, automated, streamlined, or eliminated. This helps organizations redesign workflows, optimize staffing models, and reduce administrative burden on physicians.
- 3. Synthesize metrics into composite scores or real-time dashboards.** Use algorithms or AI to combine multiple measures into an overall efficiency score for each clinician, department, or clinic. Real-time dashboards that continuously track key metrics can trigger proactive support if an individual or group's efficiency indicators suddenly worsen.
- 4. Track broader operational metrics to identify process redesign opportunities.** Look at metrics like documentation time in telehealth versus in-person visits, or time spent switching between systems, to find integration or workflow issues that create extra work. These operational insights can pinpoint processes that need redesign.
- 5. Benchmark performance across peers, specialties, and sites to identify outliers.** Comparing EHR usage metrics across similar providers or locations can highlight best practices and outliers. This context helps target improvement efforts to where they will have the greatest impact.

CASE EXAMPLE

Confluence Health used EHR usage data to target small workflow fixes that reduced daily EHR time for primary care physicians³*Wenatchee, Washington*

Background: Confluence Health identified physician EHR burden as a significant contributor to burnout, with physicians spending substantial time documenting, managing inbox messages, and completing administrative work outside clinic hours. To better understand the problem, the organization began tracking EHR time-based measures and physician workflow metrics, allowing leaders to quantify where burden existed and prioritize improvement opportunities.

Approach: Rather than pursue a single large-scale technology solution, Confluence Health implemented a series of targeted workflow and EHR optimization initiatives. These included ongoing physician training and efficiency coaching, workflow standardization, inbox management improvements, enhanced message routing, self-service patient options, scheduling optimization, and greater use of team-based support models. The organization also used EHR data to monitor usage patterns and guide continuous improvement.

Results: The organization reduced EHR time for primary care physicians by an average of 34 minutes per eight-hour clinic day and significantly decreased “pajama time.” Physicians also experienced substantially lower patient portal message volumes than industry benchmarks. Collectively, these improvements contributed to lower physician burnout rates and gave clinicians more time for patient care.

Things to keep in mind:

- Analytics can feel punitive if positioned as performance monitoring rather than support. Be transparent about how metrics are used and prioritize data quality to maintain clinician trust.
- Insights should trigger workflow redesign or training, not just reporting.

02 Optimize clinician workflows through continuous training and adoption support

What problem this solves

Even mature EHR environments often have a clinician adoption problem, not just a technology problem. Many clinicians underuse available tools, shortcuts, templates, and workflow capabilities that could improve efficiency. Without ongoing training, coaching, and adoption support, physicians may develop inefficient workarounds that increase documentation time, administrative burden, and frustration.

Recommended actions:

- 1. Emphasize ongoing training.** Offer regular EHR skills refreshers (e.g., monthly webinars, brief “tips and tricks” sessions, update briefings) and on-demand microlearning modules. Ongoing education is essential given frequent EHR and workflow updates. Continuous training helps clinicians learn time-saving best practices and adapt to new capabilities.
- 2. Promote peer champions and mentorship.** Identify and leverage peer “super-user” champions who can serve as first-line support. These champions model efficient EHR use in daily clinical settings. Consider pairing clinicians who struggle with EHR efficiency with high-performing peers for practical, workflow-based coaching.
- 3. Use data to target training where it’s needed most.** Employ EHR usage analytics to deliver role-specific and personalized training. For example, if data show a provider rarely uses a particular tool and consistently spends longer on a certain process than peers, that individual would benefit from targeted training on those tasks. This ensures training time is focused on areas of highest impact for each clinician.
- 4. Build dedicated training tracks for AI-enabled tools.** As you introduce new technologies like ambient documentation, AI-assisted clinical decision support (CDS), or other AI tools, provide specialized training on how to review and use AI-generated outputs. Emphasize how to interpret and validate AI suggestions and reinforce that clinicians remain accountable for final decisions and documentation accuracy.
- 5. Reward and recognize training engagement.** Encourage participation in ongoing training by providing incentives such as protected time for training, continuing education credits, formal recognition, or small stipends for those who lead peer training sessions.

CASE EXAMPLE

Franciscan Health standardized EHR training and used provider-specific data to make coaching more relevant⁴

Michigan City, Indiana

Background: Franciscan Health found that EHR training varied significantly across locations, leading to inconsistent clinician proficiency and dissatisfaction with both initial onboarding and ongoing education. Leaders recognized that improving EHR adoption required a more standardized and personalized approach to training.

Approach: Franciscan centralized its information systems education team and standardized training across all locations. For nurses, the organization redesigned onboarding around evidence-based adult learning principles, reducing training materials from 575 pages to 75 pages and focusing on 17 essential workflows. Training also incorporated multimedia learning, quizzes, demonstrations, and hands-on personalization labs to improve engagement and help clinicians tailor Epic to their needs.

For physicians, Franciscan replaced poorly attended webinars with one-on-one mastery training sessions that used Epic Signal data and provider-specific workflow analysis to identify inefficiencies in documentation, ordering, chart review, and inbox management. Trainers then delivered targeted coaching aligned with each physician's workflow. Franciscan offered continuing medical education credit and compensated physicians for clinic time, which drove participation.

Results: Between 2018 and 2021, nurse satisfaction with initial training improved from the 26th percentile to the 75th percentile among Epic organizations. Physician satisfaction with ongoing training increased from the 20th percentile to the 85th percentile. Across all clinicians, the organization reported a 25% increase in the percentage of nurses who felt initial training was sufficient, a 60% increase in the percentage of providers who felt ongoing training was sufficient, and a 36% improvement in net EHR experience score.

Things to keep in mind:

- Training alone will not resolve inefficiencies if underlying workflows are poorly designed.
- One-size-fits-all training often fails. Keep sessions short and personalized to make training feel worth the time taken away from clinical work.
- Clinicians may be skeptical of new AI features, so training should address the "why" (burden reduction, accuracy) alongside the "how."

Source: The source would go here, and it would be correctly formatted.

03 Streamline clinical decision support and automate repetitive work more selectively

What problem this solves

Poorly designed CDS can overwhelm clinicians with low-value alerts and often fails to influence care decisions in a meaningful way. Many organizations have deployed a high volume of alerts and reminders — most of which are overridden or ignored. Furthermore, clinicians still spend substantial time on manual, repetitive tasks that could be streamlined or automated. If not carefully managed, adding more CDS or automation could increase cognitive burden and noise rather than improving efficiency or outcomes.

Recommended actions:

- 1. Evaluate existing alerts to reduce noise.** Conduct a thorough review of existing CDS alerts and notifications. Retire or consolidate alerts that have low clinical value or high override rates. Reducing the total volume of alerts is often a necessary first step before introducing any new decision support, since alert fatigue is one of the most common EHR complaints.
- 2. Deploy predictive analytics that work in the background.** Use predictive models (e.g., sepsis early warnings, readmission risk scores, or advanced diagnostic suggestions) that monitor patient data behind the scenes. These tools should only alert the care team when a significant risk or recommendation is identified, rather than interrupting clinicians with constant low-value pop-ups.
- 3. Let clinicians personalize their alerts.** Where appropriate, give providers some control over which non-critical alerts they see. User-customizable settings can help fit decision support into individual workflows and rebuild trust in CDS, since clinicians can tailor it to their preferences.
- 4. Establish governance for CDS design and management.** Effective CDS requires ongoing oversight to ensure alerts and automated actions remain up to date and truly helpful. Without governance, even well-intentioned CDS can become outdated, irrelevant, or excessive over time. Implement a multidisciplinary governance committee to review and manage CDS rules, address provider feedback, and oversee the introduction of any new decision support.

CASE EXAMPLE

Lehigh Valley Health Network redesigned medication alerts around patient-specific context to reduce alert fatigue⁵*Allentown, Pennsylvania*

Background: Lehigh Valley Health Network (LVHN) was struggling with medication alert fatigue, as clinicians were overriding large volumes of CDS alerts that were often too generic to be clinically useful. One hyperkalemia alert in particular was being overridden 81% of the time, raising concerns that meaningful warnings were getting lost among low-value notifications.

Approach: LVHN partnered with First Databank (FDB) to redesign medication alerts around patient-specific clinical context rather than one-size-fits-all rules. A governance team of physicians, pharmacists, and informatics leaders reviewed high-volume alerts and prioritized opportunities to improve alert precision. The organization initially focused on hyperkalemia alerts, replacing generic thresholds with patient-specific potassium criteria and redesigning alert presentation so recommendations were easier for clinicians to interpret and act on.

Results: Over a six-month period, targeted hyperkalemia alerts decreased from 15,057 traditional alerts to 4,590 alerts, a 70% reduction. Alert acceptance increased from less than 20% to more than 60%, while override rates fell from 81% to 38%.

Things to keep in mind:

- Turning off alerts carries patient safety implications. Any CDS rationalization effort should involve clinical leadership.
- Monitor clinician experience alongside performance metrics as poorly designed CDS can shift cognitive burden rather than reduce it.
- Predictive models require ongoing validation; a model trained on one population may not be generalizable. Monitor performance and recalibrate regularly.

Source: The source would go here, and it would be correctly formatted.

04 Redesign inbox and patient communication

What problem this solves

Patient messages and other inbox tasks have become a growing source of workload and after-hours effort for physicians. Many patient communications do not require a physician's level of expertise yet still end up in doctors' inboxes due to unclear workflows or inadequate triage rules. As patient portal use has increased, organizations have struggled to manage rising message volumes efficiently, contributing to physician burnout and reducing time available for direct patient care. Effective inbox management requires routing routine requests to appropriately trained team members while reserving physician involvement for clinically complex issues.

Recommended actions:

- 1. Adopt a top-of-license message management model.** Route routine patient inquiries to the appropriate non-physician team member, reserving physician involvement for issues that require clinical judgment, diagnosis, or treatment decisions. Develop clear protocols defining what nurses, pharmacists, front-desk staff, and physicians can address independently, and provide template responses and standing orders so non-physician team members can resolve common questions. Use well-defined escalation criteria to identify when a message needs physician input. Organizations can further support this model with AI-driven triage tools that categorize incoming messages or draft responses for staff review.
- 2. Even without a call center, optimize how in-basket tasks are handled within clinics.** For instance, assign dedicated "inbox time" blocks or rotate inbox duty among team members so that responding to patient messages doesn't continuously interrupt face-to-face care and doesn't spill over into personal time.
- 3. Use analytics (from Tactic 1) to track inbox volumes and rebalance workload.** Monitor inbox volumes and response times for each provider and team member. Redistribute tasks if one person is overloaded. Ensure response times remain within acceptable ranges by tracking metrics like inbox volume per clinician, average response lag, and after-hours message counts.

CASE EXAMPLE**Grace Grove Healthcare* redesigned inbox work so routine messages reached the right team member first**

Background: As patient portal use increased, Grace Grove Healthcare (pseudonym) saw in-basket messages increase 325% between 2017 and 2023. During this period, providers were spending 32 minutes per day managing inbox messages, which was equivalent to roughly two patient visits.

Approach: The organization implemented a comprehensive inbox redesign strategy centered on top-of-license work. Grace Grove eliminated low-value message categories, redesigned routing processes to ensure messages reached the appropriate team member the first time, expanded use of standing orders and protocols for non-physician staff and implemented natural language processing tools to automate message triage. The organization also created protected time for inbox management and piloted generative AI tools that summarized messages and drafted responses for clinician review.

Results: The effort reduced provider inbox workload substantially. Providers received approximately 780 fewer messages annually, spent 27% less time managing individual messages, and reduced total inbox management time by 34%, from 32 to 21 minutes per day. Leaders also saw improvements in physician work-life balance and after-hours workload.

Things to keep in mind:

- Inbox redesign is as much a continuous workflow and change management effort as it is a staffing or technology intervention — volumes shift with portal adoption, seasonal demand, and organizational changes.
- Changes to message routing requires clinician and patient buy-in. Clearly communicate how the care team model works and when physicians will remain involved.
- AI-drafted responses and triage models still need human review and can shift burden to other team members without improving overall efficiency if poorly designed.

* Pseudonym

05 Use ambient documentation where it meaningfully reduces burden

What problem this solves

Clinical documentation remains one of the most time-intensive and burdensome aspects of physician work. Much of the work involved in writing visit notes is manual and repetitive, which encroaches on time that could be spent on direct patient care or other higher-value activities. Documentation support tools — including ambient documentation, medical scribes, AI-assisted drafting, templates, and other workflow enhancements — can help reduce this burden when they are integrated into clinical workflows and adopted consistently by clinicians.

Recommended actions:

- 1. Deploy ambient clinical documentation tools and integrate them into workflows.** These AI-driven systems listen to the patient-clinician conversation and produce a draft clinical note, which the clinician then reviews and finalizes. It's crucial to integrate ambient documentation into existing processes (such as in-room scribing or immediate post-visit note review) rather than layering it on top of current routines.
- 2. Identify best-fit scenarios and scale gradually.** Begin in specialties or settings that have high documentation burdens, such as primary care or urgent care, where each day is packed with brief visits. These areas often see the greatest return on investment from ambient documentation or other support tools. Start with willing early adopters who can champion technology and help refine workflows. Use small pilots with robust training, feedback loops, and leadership support before scaling up organization wide.
- 3. Build trust through training, governance, and oversight.** Educate clinicians on what the ambient documentation AI does and doesn't do, emphasizing the need to review the AI-generated notes for accuracy. Establish governance to monitor note quality and safety, including periodic audits and an easy way for clinicians to report errors in AI-generated notes. This oversight will help ensure any issues are caught early and that clinicians maintain confidence in the tool.

CASE EXAMPLE

Sunny Peak Health System* paired documentation redesign with AI support to reduce note-writing and chart-review burden

Background: Clinical documentation remained a persistent source of physician burden at Sunny Peak Health System (pseudonym), a nonprofit health system with six medical centers, 2,600 active physicians, and more than 900 beds. Leaders found that providers continued to spend significant time both creating and reviewing notes, driven by overdocumentation, inconsistent templates, and underutilized EHR support tools. Documentation work frequently extended beyond clinic hours, contributing to burnout and reducing time available for patient care.

Approach: Sunny Peak implemented a three-part strategy designed to reduce the burden of note writing and chart review. First, the organization established a multidisciplinary SUCCESS team of clinical leaders and EHR specialists to identify provider-specific documentation pain points and deliver tailored support. Second, the team redesigned note templates to remove unnecessary content and make documentation more concise. Finally, Sunny Peak introduced AI-enabled documentation support to off-load manual documentation tasks and reduce repetitive work. Unlike many organizations that focused solely on accelerating note creation, Sunny Peak also targeted the amount of information clinicians needed to review later in the workflow.

Results: The initiative significantly improved documentation efficiency and provider experience. Sunny Peak reduced median after-hours time spent in clinical notes by 61% and increased same-day and two-day note closure rates by 17%. Provider satisfaction with the documentation process increased by 24%, while provider-reported burnout decreased by 13%. Leaders also saw improvements in documentation quality, data completeness, information sharing, and collaboration across care teams.

Things to keep in mind:

- Ambient tools work best in structured visit types and can drift toward generic language — clinicians should personalize and verify clinical detail, and expect more manual editing for complex or multi-problem encounters.
- Patient consent and privacy considerations vary by state and organization. Ensure compliance with recording/listening policies.
- Benefits/ROI is dependent on workflow integration and clinician adoption.

* Pseudonym

06 Standardize care coordination workflows and use AI to orchestrate execution

What problem this solves

Care coordination workflows — such as managing referrals, handoffs at discharge, or follow-up processes — are often fragmented and manual. This fragmentation leads to delays, dropped handoffs, redundant work, and added burden on both clinicians and staff. While automation can accelerate individual tasks, orchestration ensures that multi-step processes move forward, dependencies are managed, and unresolved work is escalated when necessary. If the underlying workflow is unclear or key data cannot move across systems, adding automation will simply scale the inefficiency.

Recommended actions:

1. **Establish clear ownership, handoffs, and escalation paths across care coordination workflows.** For key processes such as referrals, discharge transitions, and follow-up care, define responsibilities at each step, standardize handoff protocols, and create escalation mechanisms when tasks stall. Prioritize interoperability and standardized referral data so information can move across teams and systems without manual rework.
2. **Use AI to automate referral processing, triage, and scheduling.** Intelligent automation can interpret unstructured referral information, route urgent cases immediately, and even initiate scheduling of appointments without manual intervention.
3. **Focus on creating closed-loop workflows so referrals, transitions, and follow-ups are completed, not just initiated.** Redesign care coordination processes so every task has a defined endpoint and confirmation of completion (e.g., referral scheduled, patient seen, or follow-up conducted). Track task status across team and system boundaries and automatically escalate unresolved or delayed tasks to the appropriate team member. Pay special attention to hospital-to-clinic transitions and post-acute follow-ups, where incomplete handoffs most often lead to readmissions or patient frustration.
4. **Use AI to orchestrate multistep workflows across teams and systems.** Consider using AI agents or automation to coordinate tasks across clinical, administrative, and operational teams. An AI “orchestrator” can sequence tasks, assign work to the right person at the right time, and ensure prerequisites are met. Ideally, these AI systems should both act (execute routine tasks) and alert (flag exceptions or delays to the team) as needed.

CASE EXAMPLE

Castell automated chart review so care coordinators could spend more time on patient outreach

Salt Lake City, Utah

Background: Care coordinators at Castell, an Intermountain Health company, were spending up to four hours per day manually reviewing patient charts to identify preventive care gaps. Coordinators reviewed roughly 100 charts per day, and the manual work limited their ability to perform higher-value activities such as patient outreach and care management.

Approach: After identifying chart review as a major workflow bottleneck, Castell partnered with Notable to deploy AI-powered digital assistants that could review patient records, interpret documentation, and surface preventive care recommendations directly within the EHR. Operational leaders, care coordination leaders, quality teams, and physicians collaborated to ensure the technology reflected existing care coordination workflows and supported provider decision-making. Castell initially piloted the solution with 29 providers and focused on mammography and colonoscopy workflows before expanding across more than 400 primary care providers.

Results: The initiative reduced daily chart-review time by 75%, from four hours to one hour per care coordinator. Time spent per chart fell by 70%, equivalent to approximately 1.7 minutes saved per chart. Castell estimated the solution created capacity equivalent to 47 additional FTEs and generated \$2.8 million in annual savings while allowing care coordinators to spend more time on patient outreach and other top-of-license activities.

Things to keep in mind:

- AI tools only perform as well as the inputs and integrations behind them — they need to span across EHR, scheduling, and payer platforms, and depend on standardized, complete referral data to be effective.
- Closed-loop coordination depends on clear ownership and trust. Define accountability for each handoff and start with a human-in-the-loop model where staff verify AI recommendations before fully automating.
- Throughput optimization can inadvertently prioritize speed over quality. Ensure patient outcomes and experience metrics are tracked alongside efficiency gains.

Parting thoughts

EHR optimization is not a one-time cleanup effort. It is an ongoing discipline that requires organizations to continually reassess where physician time is being spent, redesign workflows before adding new technology, and apply stronger governance and change management as digital tools evolve.

The goal here is reducing administrative burden, improving clinician experience, and creating more capacity for higher-value patient care. In that context, AI can be a meaningful enabler, but only when it is introduced in ways that simplify work rather than add new complexity.

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Endnotes

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