Combating Clinician Burnout

September 6, 2019
HCCA
2019 Boston Regional Conference

Causes of stress for compliance officers:

“58% of compliance officers wake up in the middle of the night in a state of anxiety.”

“...increasing concern over personal liability”

Learning objectives

1. Describe the genesis of the clinician burnout crisis in the United States, and our role in combatting this public health issue.

2. How the Compliance Officer and Compliance Program can contribute to mitigating or decreasing the risks of provider burnout among staff.

3. Identify and access concrete best practices, tools, and guidelines for combatting clinician burnout.

Clinician Burnout

1. Problem is huge

2. Largely a system issue, not a personal failing

3. You can help
Causes of stress for compliance officers:

- Keeping up with new laws and regulations
- Identifying risks
- Preventing ethics and compliance violations
- Detecting ethics and compliance violations
- Investigating alleged violations
- Remediating violations

survey -2012 by the Health Care Compliance Association (HCCA)

“The role of compliance professional can be equal parts teacher, therapist, and doctor.”

Causes of stress for compliance officers:

“58% of compliance officers wake up in the middle of the night in a state of anxiety.”


Causes of stress for compliance officers:

“58% of compliance officers wake up in the middle of the night in a state of anxiety.”

“...increasing concern over personal liability”

Remedy:

Leisure time (taking vacation) is important
Self-care
work life balance
systemic stress reduction

Clinician Burnout

1. Problem is huge
2. Largely a system issue, not a personal failing
3. You can help

Clinician Burnout

- Emotional exhaustion
  - Inefficient systems & useless tasks
  - (loss of enthusiasm)
- Depersonalization
  - Loss of empathy, inability to express grief
  - Interpersonal disengagement
  - Cynicism
- Feelings of low achievement and decreased effectiveness
  - As physicians begin to view their work as meaningless, the quality of their work suffers.
Clinician Burnout

54%

Of US physicians show at least 1 symptom of burnout (and 96% think it’s a problem)


Fighting the silent crisis of clinician burnout

- Burnout increased 46% to 54%
- Satisfaction with Work-Life Balance has decreased from 49% to 41%
- All specialties are experiencing increased burnout and more WLB dissatisfaction
- Physicians are faring worse than the general population
- (N=6880)

Nurses and Other Health Care Professionals

• 1999 study: 10,000 Inpatient RNs, 43 percent had high degree of emotional exhaustion
  

• 2011:
Nurses and Other Health Care Professionals

Inpatient RNs:
18 percent had depression (versus a national prevalence of approximately 9 percent)


Burnout effects...

- Physician
  - Satisfaction
  - SUD, alcoholism, divorce, depression, anxiety
  - Suicide
- Patient
  - Satisfaction
  - Engagement
  - Quality
  - Safety
- Practice
  - Income
  - Teamwork and team moral
  - Healthcare costs
Burnout effects...

- Physician
  - Satisfaction
  - SUD, alcoholism, divorce, depression, anxiety
  - Suicide
- Patient
  - Satisfaction
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  - Quality
  - Safety
- Practice
  - Income
  - Teamwork and team moral
  - Healthcare costs

![Diagram](image-url)
Consequences of burnout

These are not theoretical.

Shannafelt, 2017

Consequences of burnout

Decreased Quality, Increased Medical Errors

- BMJ Review: Moderate evidence that burnout is associated with safety-related quality of care.

- NHS study: More engagement is associated with less MRSA in hospitals

- Mayo: "Physician burnout is at least equally responsible for medical errors as unsafe medical workplace conditions."

Shannafelt, 2017
Problem is huge and worsening....
Burnout effects...

- Physician
  - Satisfaction
  - SUD, alcoholism, divorce, depression, anxiety
  - Suicide
- Patient
  - Satisfaction
  - Engagement
  - Quality
  - Safety
- Practice
  - Income
  - Teamwork and team moral
  - Healthcare costs

Consequences of burnout

- Mayo: Every one-point increase in burnout (on a seven-point scale) is associated with a 30-40 percent increase in the likelihood that physicians will reduce their hours in the next two years.

Healthcare costs

- Direct costs:
  - Turnover
  - Early Retirement
  - Reduced hours
  - Reduce discretionary effort
  - Absenteeism
- Indirect costs:
  - Reduced quality
  - Medical errors (including medication errors)
  - Unnecessary testing and referrals
  - Worsening malpractice risk

The Business Case for Investing in Physician Well-being
JAMA Internal Medicine December 2017 Volume 177, Number 12

1. Input data:
   - N = No. of physicians at your center
   - BO = Rate of burnout of physicians at your center
   - TO = Current turnover rate per year
   - C = Cost of turnover per physician

2. Calculations:
   - Estimated Cost of Physician Turnover Attributable to Burnout
     - Formula:
       \[ \text{TO without burnout} \times (1 - \text{BO}) \times \left[ (2 \times \text{TO without burnout}) \times \text{BO} \right] \]
     - Simplified formula:
       \[ \text{TO without burnout} = \frac{\text{TO}}{1 + \text{BO}} \]
   - B.Projected No. of physicians turning over per year due to burnout
     (solve using input variables and TO without burnout value from step A):
     - Formula:
       \[ \text{No. of physicians turning over due to burnout per year} = \frac{(\text{TO} - \text{TO without burnout}) \times N}{N} \]
   - C. Projected cost of physician turnover per year due to burnout (solve using input variables and No. of physicians turning over due to burnout per year from step B):
     - Formula:
       \[ \text{Estimated cost of turnover due to burnout} = C \times \text{No. of physicians turning over due to burnout per year} \]
The Business Case for Investing in Physician Well-being

**Example Using N = 450; BO = 50%; TO = 7.5%; C = $500,000**

A. TO without burnout:
\[
0.075 = [TO \text{ without burnout } \times (1 - 0.5)] + [(2 \times TO \text{ without burnout}) \times 0.5] \\
or 0.075/(1 + 0.5) = 5\%
\]

B. No. of physicians turning over due to burnout per year:
\[
(0.075 - 0.05) \times 450 = 11.25
\]

C. Projected cost of physician turnover per year due to burnout:
\[
$500,000 \times 11.25 = $5,625,000
\]

---

**The Business Case for Investing in Physician Well-being**

**1. Input data:**
- CB = Estimated cost of turnover due to physician burnout
- CI = Cost of intervention per year
- R = Relative reduction in BO

**2. Calculations:**
- **ROI**
  - A. Savings due to reduced BO:
    - **Formula:**
    - Savings due to reduced BO = (CB × R)
  - B. ROI:
    - **Formula:**
    - ROI = (Savings due to reduced BO - CI)/CI

**Example Using CB = $5,625,000; CI = $1,000,000; R = 20%**

A. Savings due to reduced BO:
\[
$5,625,000 \times 0.20 = $1,125,000
\]

B. ROI:
\[
(\$1,125,000 - $1,000,000)/$1,000,000 = 12.5\%
\]
What is NOT included in the calculation

- Malpractice Liability
- Patient Satisfaction
- Organizational reputation
- Decreased productivity of those who stay
- The Domino effect - larger load for remaining providers

Evidence for recent improvement

FIGURE 2. Changes in burnout (A) and satisfaction with work-life integration (WLI) (B) in physicians and US working population.

https://www.mayoclinicproceedings.org/article/S0025-6196(18)30938-8/fulltext
Problem is huge and worsening...
Slide courtesy of Michael R. Privitera MD, MS University of Rochester Medical Center

**Cognitive Workload Risks:**
Cognitive workload is known to be a risk factor to **workers and the people they serve** in such professions as:
– **Airline pilots**
– **Air traffic controllers**
– **Nuclear power workers.**
– **Simultaneous Translator at UN**

Yet...... little attention to these risks discussed in the delivery of healthcare by clinicians.
Spike in reported burnout...

- Loss of control over work
- Increased performance measurement (quality, cost, patient experience)
- Increasing complexity of medical care
- Implementation of EHRs
- Profound inefficiencies in the practice environment

John Noseworthy, James Madara, Delos Cosgrove, Mitchell Edgeworth, Ed Ellison, Sarah Krevans, Paul Rothman, Kevin Sowers, Steven Strongwater, David Torchiana, and Dean Harrison
March 28, 2017

### To Whom Have You Mentioned Thoughts of Suicide?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td>34%</td>
</tr>
<tr>
<td>Family member</td>
<td>33%</td>
</tr>
<tr>
<td>Friend or colleague</td>
<td>23%</td>
</tr>
<tr>
<td>Counselor on a suicide hotline</td>
<td>2%</td>
</tr>
<tr>
<td>None of the above</td>
<td>42%</td>
</tr>
</tbody>
</table>

### Do You Plan to Seek Help for Burnout or Depression?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, currently seeking professional help</td>
<td>13%</td>
</tr>
<tr>
<td>Yes, planning to seek professional help</td>
<td>3%</td>
</tr>
<tr>
<td>No, but under professional care in the past</td>
<td>13%</td>
</tr>
<tr>
<td>No, and have not sought professional care in the past</td>
<td>64%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>7%</td>
</tr>
</tbody>
</table>
Clinician Burnout

1. Problem is huge
2. Largely a system issue, not a personal failing
3. You can help
Clinician Burnout

Burn-out an "occupational phenomenon"

International Classification of Diseases (ICD-11)
28 May 2019

Burn-out is not classified as a medical condition.
Not a Disease

Environmental Drivers of Clinician Burnout

- Workload and time constraints
- Inefficiencies/frustration (EHR)
- Lack of autonomy/control
- Ineffective leadership
- Mission/values mismatch (loss of meaning)
- Culture of incivility
- Perception of fairness and respect
- Diminished rewards
Problem is huge and worsening...

Slide courtesy of Michael R. Privitera MD, MS University of Rochester Medical Center

Technology Is Driving Burnout

• Radically disrupted established workflows
• Radically disrupted patient interactions
• A source of interruptions and distraction
• Very time intensive

John Noseworthy, James Madara, Delos Cosgrove, Mitchell Edgeworth, Ed Ellison, Sarah Krevans, Paul Rothman, Kevin Sowers, Steven Strongwater, David Torchiana, and Dean Harrison

March 28, 2017
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Strategies from the Mayo Clinic

- 2011-2013: burnout rose to national average
- 2013-2015:
  - National burnout rose 11%
  - Mayo burnout dropped 7%
- Recently, 33% burnout rate (vs 49% nationally)

“Deliberate, sustained, and comprehensive efforts by the organization to reduce burnout”

Shannafelt, et. Al 2017
Potential Solutions: 2009 study of 465 physicians

- Overall burnout = 34%
- Time spent on most meaningful activity:
  - < 20% of their time: burnout = 53.8%
  - 20%+ of their time: burnout = 29.9%
  - $P < .001$
- 68% found patient care “most meaningful”

MMS-MHA Joint Task Force on Physician Burnout

A CRISIS IN HEALTH CARE: A CALL TO ACTION ON PHYSICIAN BURNOUT

Partnership with the Massachusetts Medical Society, Massachusetts Health and Hospital Association, Harvard T.H. Chan School of Public Health, and Harvard Global Health Institute


MMS-MHA Joint Task Force on Physician Burnout

The Boston Globe
Report raises alarm about physician burnout

By Priyanka Dayal McCluskey GLOBE STAFF JANUARY 17, 2019

Physician burnout has reached alarming levels and now amounts to a public health crisis that threatens to undermine the doctor-patient relationship and the delivery of health care nationwide, according to a report from Massachusetts doctors to be released Thursday.

PDF Globe 2019 1 17 Burnout Front Page

**MMS-MHA Joint Task Force on Physician Burnout**

**The Boston Globe**

**OPINION | ALAN CHAOUI, STEVEN DEFOSSEZ, AND MICHELLE WILLIAMS**

**Doctor burnout is real. And it’s dangerous**

By Alan Chaoui, Steven Defossez and Michelle Williams JANUARY 17, 2019

Burnout — a condition characterized by emotional exhaustion, cynicism, and feelings of reduced effectiveness in the workforce — impacts all caregivers and, in particular, threatens to undermine the physician workforce, endangering our health care system.


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**Results of the Colorado Study**

**Team-based care model**

**COREY LYON, DO, AIMEE F. ENGLISH, MD, AND PETER CHABOT SMITH, MD**

**A Team-Based Care Model That Improves Job Satisfaction**

Expanding the role of medical assistants to better support providers can improve not only traditional outcomes but also job satisfaction.
• Administrative burden drives suboptimal access, poor outcomes, and escalating burnout.

• Increasing the MA-to-provider ratio to 2.5:1 and expanding the role of MAs: “Quadruple Aim.”

• Increased visit volume and patient access, improved clinical quality, and cut provider burnout in half.
Local Investment in Training Drives Electronic Health Record User Satisfaction

Christopher A. Longhurst1  Taylor Davis2  Amy Maneker3  H. C. Eschenroeder Jr4  Rachel Dunscombe5  George Reynolds6  Brian Clay1  Thomas Moran7  David B. Graham8  Shannon M. Dean9  Julia Adler-Milstein10  on behalf of the Arch Collaborative*

Table 1  Variation in experience by EHR

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Number of organizations with vendor deployed (and &gt;10 surveys collected)</th>
<th>Lowest organization net EHR experience score</th>
<th>Highest organization net EHR experience score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor 1</td>
<td>104</td>
<td>−13</td>
<td>73</td>
</tr>
<tr>
<td>Vendor 2</td>
<td>26</td>
<td>−51</td>
<td>43</td>
</tr>
<tr>
<td>Vendor 3</td>
<td>13</td>
<td>−58</td>
<td>31</td>
</tr>
<tr>
<td>Vendor 4</td>
<td>12</td>
<td>−41</td>
<td>54</td>
</tr>
<tr>
<td>Vendor 5</td>
<td>7</td>
<td>−26</td>
<td>42</td>
</tr>
<tr>
<td>Vendor 6</td>
<td>5</td>
<td>−15</td>
<td>21</td>
</tr>
<tr>
<td>Vendor 7</td>
<td>5</td>
<td>−60</td>
<td>−42</td>
</tr>
</tbody>
</table>

• Less than 20% of all variation was explainable by the EHR in use
• Over 50% of variation explained at the physician user level
• A very unsuccessful provider organization was identified in each customer base
• A successful customer was identified in six of the seven customer bases
Results Individualized Training Study

Local Investment in Training Drives Electronic Health Record User Satisfaction

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- EHR Training/Education is the Major Predictor of Positive User Experience
- Physicians Indicate Higher Quality EHR Training Drives Better Care
- EHR Personalization Tools—A Key to Success

MMS-MHA TF: Guidelines / recommendations

CHANGING THE EHR FROM A LIABILITY TO AN ASSET TO REDUCE PHYSICIAN BURNOUT

The Reliant Medical Group Story

Results from the Frigoletto Committee Poll

<table>
<thead>
<tr>
<th></th>
<th>Total Response</th>
<th>Highly Valuable</th>
<th>Somewhat Valuable</th>
<th>Highly or Somewhat Valuable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegation of non-physician work</td>
<td>616</td>
<td>78%</td>
<td>16%</td>
<td>94%</td>
</tr>
<tr>
<td>Increased Epic optimization support</td>
<td>533</td>
<td>39%</td>
<td>40%</td>
<td>80%</td>
</tr>
<tr>
<td>Advanced personal Epic training</td>
<td>548</td>
<td>38%</td>
<td>36%</td>
<td>73%</td>
</tr>
<tr>
<td>Improved access to urgent specialty consultation</td>
<td>482</td>
<td>25%</td>
<td>37%</td>
<td>62%</td>
</tr>
<tr>
<td>In-room scribe</td>
<td>545</td>
<td>35%</td>
<td>23%</td>
<td>58%</td>
</tr>
<tr>
<td>Virtual scribes</td>
<td>499</td>
<td>21%</td>
<td>29%</td>
<td>50%</td>
</tr>
<tr>
<td>Faculty lounge</td>
<td>548</td>
<td>21%</td>
<td>27%</td>
<td>48%</td>
</tr>
<tr>
<td>Physician peer coaching service</td>
<td>490</td>
<td>13%</td>
<td>30%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Problem is huge and worsening...
Slide courtesy of Michael R. Privitera MD, MS University of Rochester Medical Center

EMR Work Bleeds into Home Life.

- Access to the medical records when at home => has extended the physician work day
- ≥ 10 hours per week on EHR after they go home, on nights and weekends.

“Pajama Time”
Sat nights belong to Epic

Compliments of Christine Sinsky MD, VP for Clinician Satisfaction, American Medical Association, and Brian Arndt, University of Wisconsin.
University of California, Davis, Health

- **Academic health system**
  - 1 hospital, 627 beds
    - 17 clinics
    - 1,473 physicians
    - ≈35,000 admissions/year
    - ≈950,000 outpatient visits
  - 1 connect hospital
    - 190 connect physicians

Slide courtesy of Scott MacDonald, M.D., EMR Medical Director, UC Davis Health

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University of California, Davis, Health

- **Part 1**: Four hours *individually tailored*, one-on-one training for each physician

- **Part 2**: Weekly “PEP Talks” to discuss areas where the entire clinic struggles

Slide courtesy of Scott MacDonald, M.D., EMR Medical Director, UC Davis Health
One-on-one Training

- Held during clinic time to allow for practice charting
- 50% reduction of schedule
  - Plan 3 months in advance to block schedules

One-on-one Training

- Prior to 1-1 sessions, team develops individual training plan for each physician by:
  - Shadowing during first week of engagement
  - Evaluating Epic Provider Efficiency Profile metrics
  - Conducting in-system analysis
  - Reviewing pre-engagement survey
Metrics: Improving Efficiency

• Increased proficiency in:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Task</th>
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</thead>
<tbody>
<tr>
<td>16%</td>
<td>Notes</td>
</tr>
<tr>
<td>20%</td>
<td>Orders</td>
</tr>
<tr>
<td>30%</td>
<td>In Basket</td>
</tr>
<tr>
<td>17%</td>
<td>Chart Review</td>
</tr>
<tr>
<td>32%</td>
<td>Schedule</td>
</tr>
<tr>
<td>27%</td>
<td>SmartTools</td>
</tr>
<tr>
<td>43%</td>
<td>Widescreen</td>
</tr>
<tr>
<td>28%</td>
<td>Haiku</td>
</tr>
</tbody>
</table>

*All values are significant at the .05 or .01 level

Slide courtesy of Scott MacDonald, M.D., EMR Medical Director, UC Davis Health

Metrics: Reducing Pajama Time

• Physicians felt they had a more acceptable level of after-hours work after training
• Increased from 2.43 to 3.06

- Median reduction of 25 hours/month in time physicians spend working after hours
- What would you do with an extra day?

*All values are significant at the .05 or .01 level

Slide courtesy of Scott MacDonald, M.D., EMR Medical Director, UC Davis Health
What drives happiness at work?

• Autonomy
• Mastery
• Meaning

-Drive by Daniel Pink

(And appreciation)
What drives clinician happiness at work?

- Autonomy: Control over their schedule and decision-making
- Mastery: Delivering high-quality healthcare
- Meaning:
  - Congruent values,
  - Aligned missions,
  - Absence of moral injury

(And appreciation)

Annals of Internal Medicine

Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties
Christine Sinsky, MD; Lacey Colligan, MD; Ling Li, PhD; Mirela Prgomet, PhD; Sam Reynolds, MBA; Lindsey Goeders, MBA; Johanna Westbrook, PhD; Michael Tutty, PhD; and George Bilke, MD

Background: Little is known about how physician time is allocated in ambulatory care.

Objectives: To describe how physician time is spent in ambulatory care. Little is known about how physician time is allocated in ambulatory care.

their time on EHR and desk work. While in the examination room with patients, physicians spent 37.0% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of

- 50% day EHR/desk
- < 1/3 Face to Face (F2F)
- 1 hr F2F: 2 hr EHR
- 1-2 hr EHR at night “Pajama time”
Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs

John Noseworthy, James Madara, Delos Cosgrove, Mitchell Edgeworth, Ed Ellison, Sarah Krevans, Paul Rothman, Kevin Sowers, Steven Strongwater, David Torchiana, and Dean Harrison

March 28, 2017

CEO Commitment, Noseworthy et al

• **Regularly measure burnout** using one of several standardized, benchmarked instruments.

• Include measures of physician well-being in our **institutional performance dashboards**

• Evaluate and **track the institutional costs** of physician turnover, early retirement, and reductions in clinical effort.
CEO Commitment, Noseworthy et al

• Emphasize the importance of **leadership skill development** for physicians and managers leading physicians throughout our organization.
• Understand and **address more fully the clerical burden** that is contributing to professional burnout.
• Team-based models of care where physician expertise is maximally utilized. **Tasks that do not require the unique training of a physician delegated to other skilled team members.**

Strategies from the Mayo Clinic

• 1. Acknowledge and Assess the Problem
  – a. Survey
  – b. Focus groups
• 2. Harness the power of leadership
• 3. Develop targeted interventions
• 4. Cultivate Community at Work
• 5. Use Rewards and Incentives wisely
• 6. Align Values and Strengthen Culture
• 7. Promote Flexibility and Work-life integration
• 8. Provide Resources to Promote Resilience and Self-Care
• 9. Facilitate and Fund Organizational Science

• Shannafelt, et. Al 2017
• G.R.O.S.S.

• Getting Rid Of Stupid Stuff

The NEW ENGLAND JOURNAL of MEDICINE

Getting Rid of Stupid Stuff

Melinda Ashton, M.D.
Findings:

**Perceived stupid stuff:**
1. Documentation that was never meant to occur
2. Needed Documentation could be completed more efficiently
3. Required documentation for which clinicians did not understand the requirement or the tools available to them.

---

**How to Create a Joyful, Engaged Workforce**

**Outcome:**
- ↑ Patient experience
- ↑ Organizational performance
- ↓ Staff burnout

1. Ask staff “what matters to you?”
2. Identify unique impediments to *Joy in Work* in the local context
3. Commit to making *Joy in Work* a shared responsibility at all levels
4. Use improvement science to test approaches to improving joy in your organization
List of Evidence Based Solutions: Human

- Improve efficiency
- Customized EHR training / optimization (paid)
- Increase MA/Physician ratio “top of their license.”
- 20% of time spent on, “what matters most”
- Leadership training
- Pick a measure of clinician wellness (Monitor and improve it)
- Designate a Chief Wellness Officer
- Engaging front-line to identify system issues
- Empowering front-line to develop solutions
- Increase employee recognition
- Cultivate community: “Collegiality time”

List of Evidence Based Solutions: Human

- Eliminate barriers to mental health services
- Peer support program for clinicians under stress:
  - Named in litigation
  - Traumatic clinical situation
  - Death of close family member
Technological solutions to be considered:

- Single sign-on technology for EHR's
- Electronic prior authorization
- Employer based concierge service offered to clinicians
- EHR *user specific* optimization
- EHR workflow optimization
- Scribes, virtual vs. remote scribe versus on-site scribe
- Inbox management
- Previsit labs, planning
- Medication management

Draft Task Force Goals for 2019 -2020

- CEO/CMO commitment letter
- Statewide clinician burnout survey
- State-of-the-art clinician burnout playbook
- Individual stakeholder subcommittee goals
Draft Task Force Goals for 2019-2020

**Individual stakeholder subcommittees**
- Medical schools and residencies
- State and federal agencies/EHR vendors
- Hospitals, health systems and provider organizations
- Insurers / NCQA
- BORIM

**Quick Wins**
- **IT** - Secure logons ‘it’s just 3 more clicks’ –
  Track EHR Use at home (WAW-work after work)
  Track time in chart, inbox etc
- **Compliance** - overinterpretation of the rules
- Quality-responsibility *with* power to effect change
- Performance measure fatigue
- **Risk Management** ‘If the doc does it we won’t get in trouble’
- Mandate vacation time

Slide courtesy of Marie T Brown MD MACP, Senior Physician Advisor, American Medical Association
This is a screen shot required by a physician to click on > 100x/day!!!

Brought to you not by the EHR vendor
But by the hospital’s compliance officer!

It can take up to 24 min after a distraction to regain focus on an interrupted task

1 hour/week =
52 hours/year = 6 days/year/doctor!

Healthy Clinicians Give Better Care

- Decreased medical errors
- Increased patient satisfaction
- Better treatment recommendations
- Increased treatment adherence
- Lower malpractice risk
- Better attitudes toward work
- Higher team functioning
- Lower turnover
Clinicin Burnout

1. Problem is huge
2. Largely a system issue, not a personal failing
3. You can help
Thank You!

Massachusetts Health Policy Commission:

Massachusetts payers and providers believe that administrative complexity threatens the Commonwealth’s ability to meet the benchmark.

The challenge of administrative complexity – and its unintended consequences – has been identified in pre-filed testimony before every annual cost trends hearing.

Provider credentialing
Eligibility verification
Prior authorization
Claims submission, denials and appeals
EHR integration, data-sharing, interoperability
Government regulations, reporting requirements
Duplicative care management programs
Quality performance measurement
Variation in risk contract terms

Examples from pre-filed testimony:

- Clinician confusion, discomfort, burn-out
- Decreased time with patients
- Distraction from other priorities
- Confusion and anxiety for patients
Massachusetts Health Policy Commission:

Some areas of administrative complexity add value; others do not.

**Policy Recommendation:**
The Commonwealth should take action to identify and address areas of administrative complexity that add costs to the health care system without improving the value or accessibility of care.

Massachusetts Health Policy Commission:

Proposed Principles for Selecting Focus Areas

1. Reducing complexity in this area would measurably reduce health care costs in Massachusetts without jeopardizing quality or access
2. Massachusetts stakeholders have prioritized action in this area
3. The issue can be addressed at the state level
4. Work in this area could complement without duplicating existing efforts
Massachusetts Health Policy Commission:

Advisory Council Survey: Areas of Administrative Complexity

- Billing and Claims Processing
- Clinical Documentation and Coding
- Clinician Licensure
- EHR Interoperability
- Eligibility/Benefit Verification
- Prior Authorization
- Provider Credentialing
- Provider Directory Management
- Quality Measurement and Reporting
- Referral Management
- Variations in Benefit Design
- Variations in Payer-Provider Contract Terms

Massachusetts Health Policy Commission:

Advisory Council Survey: Results at a Glance

- Billing and Claims Processing
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Each of the top priority areas were identified by multiple types of organizations (i.e., a combination of payers, providers, employers, and patient advocates).
HPC: Prior Authorization

- Demands **significant time and resources** from providers, payers and patients
- Payer ROI does not take into account **costs borne by providers and patients**
- Can lead to **delays and disruptions in care**
- DOI / Mass Collaborative: **Standard forms** (Chapter 224)
- Potential policy solutions raised for consideration:
  - Delegating prior authorization to ACOs
  - Developing a gold carding system to reduce the need for prior authorization for some providers
  - **Automated prior authorization**