Curing Z73.89 (a.k.a. Physician Burnout)

Technology might be the key to finding balance.

BY MICHAEL SHERLING, MD

Dr. Dawes glanced at the clock. It was 6:00 pm and she had just finished with her last patient. There was no way of knowing that her final patient of the day would be a young woman with a new diagnosis of systemic lupus erythematosus and the one before her, a kind, elderly man with refractory pruritus who couldn't quite hear her instructions and needed several prior authorizations for medications. Dr. Dawes's daughter's dance recital was in 30 minutes. She would have to leave immediately to get there on time. Her notes for the day would have to wait. Dinner would be on the run and forget about working out (she couldn't remember the last time she had exercised, anyway). Dr. Dawes let out a deep, exhausted sigh—it was going to be another long day.

Dr. Dawes's case is far from unique. With each passing year, and new requirements from private and government insurers, physicians are faced with greater demands on their time. The problem of physician burnout rooted in the inefficiencies produced by documentation requirements is a prevalent one—so pervasive across all specialties that Time magazine recently ran an article on this topic. The Time article referenced a study from the Mayo Clinic in which almost half of doctors felt that they spent too much time on clerical tasks.[1,2]

According to Time, "Doctors may loathe the electronic parts of their jobs because of more information overload, interruptions and distractions. But there might be a deeper reason doctors hate digital busy work: it eats up time they would otherwise spend with their patients, which is where a large number of physicians derive professional pleasure."

Indeed, physicians are on a daily treadmill of seeing patients, dealing with prior authorizations, handling phone calls, and documenting everything—from the details of the visits to making sure that quality measures are being met for incentive-based reimbursement. The time pressures to get it all done are felt in the exam rooms with patients and even into their private lives, where early and mid-career physicians hurriedly put their children to bed so that they can get back to their after-hours charting.

Physicians can be said to have "documentation fatigue." According to a recent article in the Annals of Internal Medicine, nearly half of physician office-based time was spent at his or her desk doing clerical tasks, mostly dealing with electronic health records. Physicians also reported one to two hours of working on the computer at home.[3]

FIGHTING DOCUMENTATION FATIGUE

Documentation requirements have evolved. Once merely an organized way for one physician to communicate with another, documentation has become more than just clinical notes. Documentation now includes medical necessity clauses for surgical repairs, quality measures for MIPS, ICD-10 codes, and a plethora of other requirements without a concomitant increase in reimbursement for this additional work. So, if physicians are spending half of their time on computer work, as noted in the above study, they have much less time to see the same number of patients. In the zero-sum game of time—there are only 24 hours in a day—physicians need to find ways to cut down on documentation time, so that they can preserve their time with patients and their sanity. There are several strategies to do so.

TECHNOLOGY'S ROLE TO PLAY

Collect Structured Data Upfront to Reduce Double Entry of Data

Most EHR systems may seem easy to use with macros or templates, or open text boxes in which to dictate, but such workflows put extra burden on the physicians to double enter their quality information for MIPS or coding information for ICD-10 later. Relying on structured data is vital and the EHRs must capture the necessary quality measures for MIPS within the natural workflow. It is absolutely imperative that any system a physician uses be able to carry forward information that is input once to the quality measures later.

Interoperability

While physicians can utilize structured data to reduce double entry of clinical data, a huge piece of efficiency gains will come from EHRs that are truly interoperable—meaning that instead of each physician's office being responsible for re-entering the same information on each patient on their system, once it is entered in one EHR, it is entered for all. Instead of spending time with data entry, physicians can validate existing medical information from a network of EHR vendors, called CommonWell Health Alliance. As a contributing member of the Alliance, Modernizing Medicine will enable its users to view and import problem lists, allergies, medications, social history, procedures and lab results from other hospital and ambulatory EHRs as structured elements into EMA. This has long been a goal of EHRs and it is finally being realized.

Providing Transparency and Visibility for Value Based Reimbursement

Saving time can help physicians balance their lives better, but having autonomy over how they practice and get reimbursed is another key to preventing burnout.[4] To support physicians in the value based healthcare era, EHRs need to evolve past clinical documentation systems, to full reimbursement platforms. EHRs that incorporate all of the components of MIPS, including quality registries, clinical improvement activities, cost metrics and advancing care, and give providers real time dashboards with comparative benchmarking to see where they stand can empower physicians to achieve upward reimbursement adjustments and avoid downward reimbursement adjustments.

REDEFINE THE ROLE OF THE MEDICAL ASSISTANT

Medical assistants (MAs) are a critical component to a physician's ability to be efficient. Traditional job requirements of an MA include rooming patients, calling patients with results, documenting the medication list, and setting-up biopsy trays. But in this brave new world of increasing documentation requirements, an additional skill is required of MAs—the need to be computer savvy and quick with a smart phone. Successful practices scale MAs to act as scribes, writing parts of the note on an iPad, freeing up the doctor to connect with their patients. Physicians can then edit or amend the note and check the bill for accuracy. The note gets documented in real time, reducing the physician's need to chart after hours. For physicians that have only one medical assistant, an MA can scribe at least part of the visit, reducing the doctor's documentation burden.

Like anything else in medicine, being set up ahead of time pays off in dividends later. Some doctors spend time correcting their scribe's notes for better accuracy at the end of a visit—perhaps not the most efficient use of time. Setting up preferences ahead of time can help the EHR be more tailored to the individual physician's style. Physically positioning the MA near the patient and the physician, so both can view the lesions on the patient, increases the accuracy of lesion documentation on body diagrams. When outside of the room, having the physician charting at the nurses' station (or near to where the MA works) improves coordination so scribes and physicians can be sure that they are working collaboratively.

Ultimately, physician societies should be working with local community colleges and MA training programs to update the training of MAs to better meet today's physicians' needs. Modernizing Medicine has begun such a program with Palm Beach State Community College to ensure that graduates of its program are skilled in scribing and familiar with the navigation of EMA before they graduate.

GETTING PATIENTS TO PARTICIPATE

Patients want to be more involved in their own care. With the use of internet-based patient portals, patients can fill out key elements of their past medical history, medication list, and social history ahead of their visit, freeing up the MA and the physician during the visit. If the patient is new to the practice or not yet set up on a portal, they can input that information in an office-based kiosk. Patients can fill out medical information, but also answer questions to support quality requirements for MIPS.

ACHIEVING BALANCE

Ultimately, we will be able to achieve life-work balance if we reduce documentation time. By engaging our existing staff, our patients, and the technology that should be working for us, we can relieve ourselves of some, or even of most, of our documentation load.

With the right processes and technology in place, our documentation should be done when the office door closes. ■

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1. Oaklander, Mandy: Doctors Are Burned Out by Busywork: Study, June 26, 2016, Time.
2. Shanafelt, Tait D. et al. Changes in Burnout and Satisfaction With Work-LifeBalance in Physicians and the General US Working Population Between 2011and 2014. Mayo Clinic Proceedings , Volume 90 , Issue 12 , 1600 – 1613.
3. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016;165:753-760. doi: 10.7326/M16-0961
4. Rabatin J, Williams E, Baier Manwell L, Schwartz MD, Brown RL, Linzer M. Predictors and Outcomes of Burnout in Primary Care Physicians. J Prim Care Community Health. 2016 Jan;7(1):41-3. doi: 10.1177/2150131915607799. Epub 2015 Sep 28.