HSG | MITIGATING PHYSICIAN BURNOUT

DEVELOPING A PROACTIVE ORGANIZATIONAL APPROACH

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MITIGATING PHYSICIAN BURNOUT

PHYSICIAN BURNOUT BACKGROUND

- Physician burnout is rampant in America. Although it has been described for more than 40 years[1], awareness was heightened when a 2011 national survey[2] indicated 45.5% of U.S. physicians reported symptoms of burnout. The incidence has not changed since then as current surveys estimate that burnout affects approximately 44% of practicing physicians[3] and some professional organizations are advocating that the situation be declared a public health crisis.[4]

- Physician burnout has many contributing factors but a combination of personal and organizational interventions can make a difference in its prevalence and severity.

- Physician burnout is not unique to physicians. Nurses and other healthcare professionals are also experiencing burnout at record rates – up to 30-50% depending on the study cited.[5,6,7] Burnout is also not unique to healthcare.[8]

- Concentrating on physician burnout is not meant to minimize the impact that burnout has on other health professionals or support staff. However, our focus tends to be on physicians and the role(s) in health care organizations – and the reason for concentrating on this area of concern. Having said that, much of the information and interventions in this whitepaper (though not all[5]) can be applied to other disciplines.

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DEFINING PHYSICIAN BURNOUT

Phy·si·cian Burn·out

/fəˈziSHən/ˈbərn.out/

noun

"Exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration."[9]

This general definition of burnout directly contrasts to the definition of well-being. "In simple terms, well-being can be described as judging life positively and feeling good."[10]

Burnout can be defined clinically as –

"… overcome by fatigue and frustration which are usually brought about when a job, a cause, a way of life, or relationship fails to produce the expected reward … usually high achievers who have intense and full schedules, do more than their share on every project they undertake and won't admit their limitations."[11]

-OR-

"… a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment."[12]

Agreement on a burnout definition is important for developing a baseline understanding of a common frame of reference. The importance is compounded when defining the incidence or prevalence of the condition through surveys, which are commonly used for this purpose. Some critics question the actual prevalence of burnout as some surveys rely on subjective or imprecise perceptions of burnout rather than explicit definitions. Thus, the actual prevalence may be different than the survey data might indicate.[13] For this reason, systematic use of standard tools becomes imperative.

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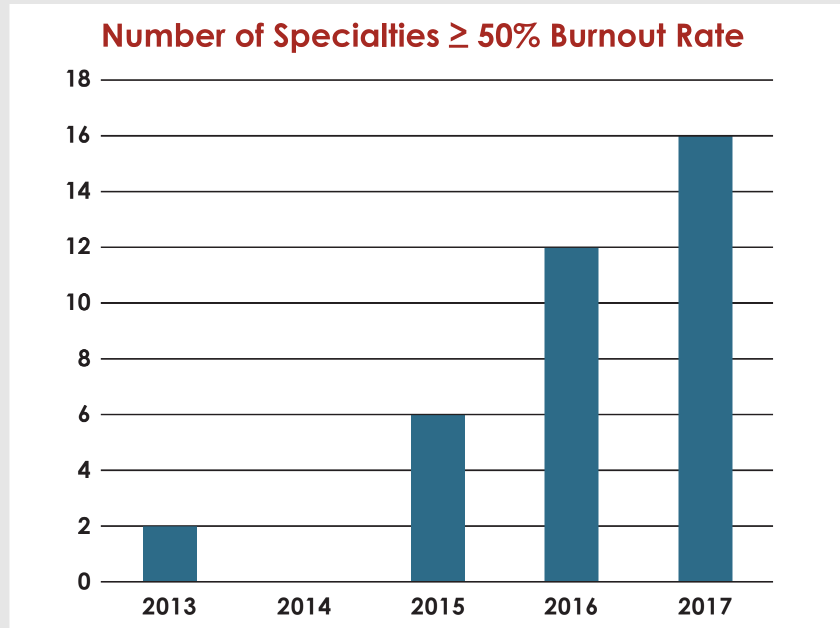
PREVALENCE OF PHYSICIAN BURNOUT

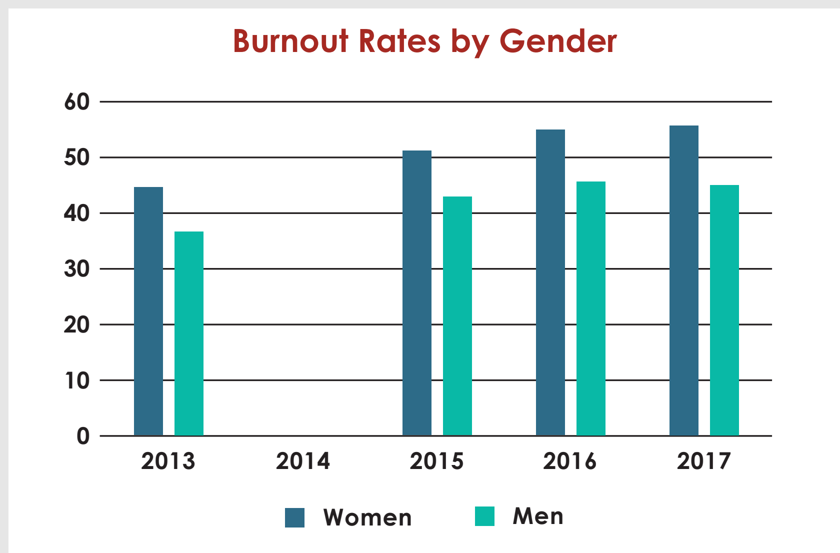
As previously mentioned, physician burnout has received increasing attention over the past decade. Medscape surveys, which are commonly cited source data for physician burnout discussions, indicate an increasing prevalence year over year as noted in the following graph:



Medscape Physician Lifestyle Reports[14,15,16,17]
Total number of specialties represented vary by year but include responses from as many as 29 different specialties. The Medscape Physician Lifestyle Reports of 2014, 2018, and 2019 did not directly address burnout statistics.

Internal Medicine, Family Medicine, Emergency Medicine, Critical Care, General Surgery, and OB/GYN tend to be among the specialties with the highest reported burnout rates.

Women tend to be affected more than men – though the underlying reasons remain a matter of conjecture.[18]



Medscape Physician Lifestyle Reports[14,15,16,17]
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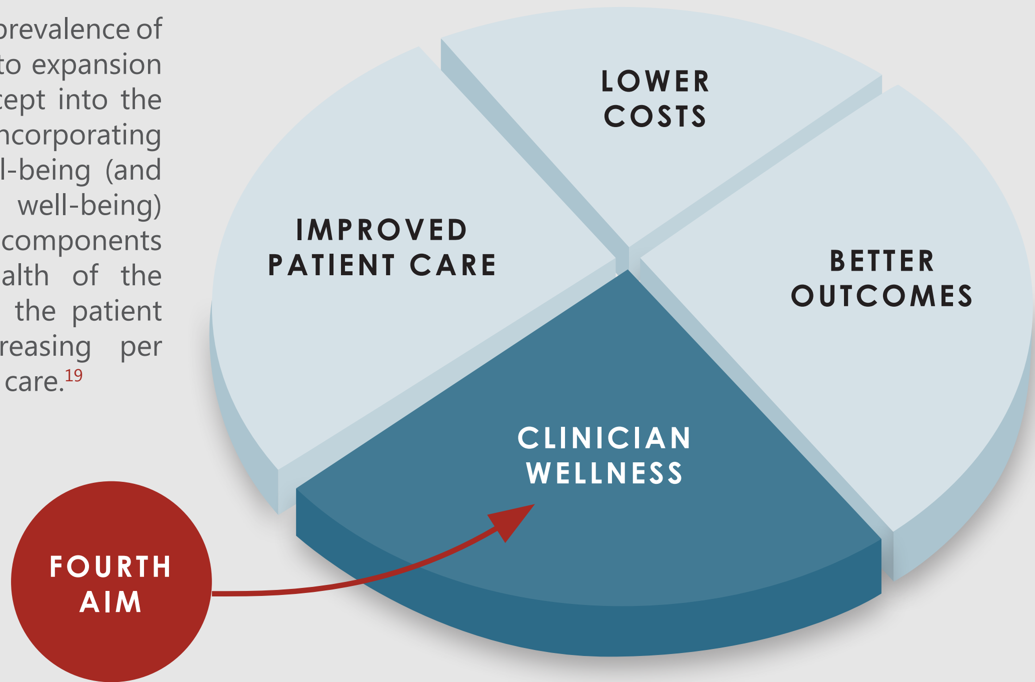
In 2014, the increasing prevalence of physician burnout led to expansion of the Triple Aim concept into the Quadruple Aim – incorporating physician/provider well-being (and more globally, staff well-being) with the original three components of improving the health of the population, enhancing the patient experience, and decreasing per capita (or total) cost of care.[19]



MAJOR DRIVERS OF PHYSICIAN BURNOUT

The most commonly mentioned drivers of physician burnout are noted in the table below. Each can be imputed as representing obstacles to achieving the physician's desired end – professionally caring for the patient.

Bureaucratic/administrative burdens of medical practice	**Work hours - including "pajama time"**
Loss of autonomy	**Work-life balance**
EMR complexities	**Income dissatisfcation**
Productivity expectations	**Litigation risk**
Progressive complexity of care	**Maintenance of certification requirements**
Insurance issues - including pre-authorization, denials	**Feeling unappreciated**

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MAJOR DRIVERS OF PHYSICIAN BURNOUT (CONTINUED)

The risk of physician burnout is inherent in modern medical practice, which represents a classic, high-stress combination of great responsibility and little control.[20] These circumstances are accentuated in an employed environment. Physician training (and physician personality traits[1]) compounds the risk as it traditionally conditions physicians to put patient interests first, to ignore their own physical and emotional state, and to carry on despite exhaustion – never show weakness. The training promotes self-sacrifice, even to the point of self-neglect, in the service of others. This creates superhuman expectations. As a group, physicians tend to be perfectionistic and tend to feel that patient care responsibility rests squarely on their shoulders.[20]

Burnout most commonly occurs through chronic stressors – the proverbial "death by a thousand cuts." As such, burnout prevention and intervention require chronic, ongoing strategies to counter an chronic, ongoing situation.

While classically attributed to job stressors, the situation is routinely complicated by stressors in the individual's personal life – whether in the daily routine or through major life stressors. These stressors include a job loss or change, moving, major illness, divorce, or the death of a loved one. The influence can be profound, whether experienced personally or through a significant other. Rather than building in the traditionally insidious fashion, burnout can, in fact occur acutely and dramatically, being triggered by one of the major life stressors just delineated or through other types of traumatic outcomes such as a lawsuit, a devastating medical error, or other personal tragedy.

Basically, burnout represents an outcome of situations in which the demands for time and productivity combine with insufficient time for recuperation to create a combination of physical and emotional exhaustion that leads to a continuing cascade and downward spiral.[1]

SIGNS AND SYMPTOMS OF PHYSICIAN BURNOUT

A prominent symptom of burnout is exhaustion. Other symptoms include decreased empathy and cynicism, a diminished sense of accomplishment, and decreased satisfaction with life in general and work in particular. Individual impressions of "burnout" can be highly variable. Identifying burnout can be clarified by employing standardized, validated assessment tools.

The Maslach Burnout Inventory (MBI) was published 1981 and remains an industry leading assessment tool validated by extensive research. Considered the gold standard, the MBI is a self-administered survey that takes approximately 10-15 minutes to complete. Responses reflect how often the individual feels the way the statements are presented. Responses will normally vary over time depending on the circumstances of the moment so repeat evaluations are extremely valuable to determine progress or regress over time.

The MBI consists of 22 elements divided into three sections – Emotional Exhaustion, Depersonalization, and Reduced Personal Accomplishment.

1. The first section evaluates Emotional Exhaustion. The nine elements center on feeling emotionally exhausted and depleted, which affects mental and physical health and well-being. Symptoms include altered diet and activity levels, cloudy judgement, forgetfulness, indecisiveness, and impaired ability to respond in a crisis.
2. The second section evaluates Depersonalization. The five elements center on being less able to be sensitive, patient, and empathetic (compassion fatigue). Symptoms include anger, irritability, and negativity.
3. The third section evaluates Reduced Personal Accomplishment. The eight elements center on decreased self-esteem, decreased motivation, reduced productivity, and social withdrawal.

The MBI is likely the best "evaluation" of burnout but barriers to utilization include its length and its proprietary status, which requires a small fee – though some professional organizations, such as the American Academy of Family Physicians (AAFP), have made the tool available for members without charge.

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ADVERSE CONSEQUENCES OF PHYSICIAN BURNOUT

Clearly, physician burnout can lead to grave consequences for the individual.

Personal Consequences

Interpersonal relationships suffer, potentially leading to loss of friends or marital separation or divorce. The individual may self-medicate, leading to substance use disorders. The symptom complex can progress to major depression and an increased risk for (or successful) suicide.

Professional Consequences

Interpersonal relationships with patients and staff suffer. Productivity declines. Medical error rates, adverse patient outcomes, and malpractice litigation risks increase. The individual's reputation and professional future are jeopardized. Premature early retirement becomes more likely.

Physician burnout also adversely affects many aspects of the organization, including:

- Provider availability on a daily basis and provider attrition on a long-term basis. Physician turnover/loss rates are higher for physicians with burnout.[7]
- Patient experience suffers – with risk of patient loss.
- Staff morale declines – with risk of impaired retention and increased turnover.
- Operational efficiency decreases.
- Quality of care and patient safety decline as medical errors increase.
- Malpractice litigation risk increases.
- Cost of care surges through physician indecisiveness, increased referral and testing rates, and adverse malpractice judgements.

Preventing physician burnout, or identifying and addressing burnout in its earliest stages, is mutually beneficial to the affected physicians, the patients they serve, the staff with whom they work, and the organizations which they support.

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PREVENTION OF PHYSICIAN BURNOUT

Prevention can be defined as activities designed to protect patients or other members of the public from actual or potential health threats and their harmful consequences.[21] Stated another way, preventive efforts are activities aimed at reducing risks or threats to health whose interventions target the primary contributing etiology(ies) (or driver(s)) of the condition.

Like many conditions encountered in clinical practice, burnout lends itself to all three levels of preventive efforts – primary, secondary, and tertiary.[22]

PRIMARY PREVENTION

Efforts targeting primary prevention are actions taken to help avoid developing certain health problems or unbeneficial conditions. These actions are taken before the problem(s) occur with the goal of actually preventing a condition from occurring.

Methods of primary prevention include preventing exposure to causal hazards, altering unhealthy or unsafe behaviors, and increasing resistance should an unsafe exposure occur.

In general medical practice, the classic example is administering immunizations.

Prevention of burnout involves heightening personal resilience and developing organizational programs that create a less stressful work environment.

In spite of best efforts and intentions, primary prevention efforts may not be 100% effective in preventing the targeted condition (e.g., influenza vaccination). This does not mean that practical efforts to prevent the condition from arising should not be undertaken. It means that the condition may still arise in spite of these efforts – but is less likely to do so.

SECONDARY PREVENTION

Secondary prevention efforts attempt to interrupt an asymptomatic condition before it becomes symptomatic – or at least catching a condition in its early stages, when few signs and symptoms are present. The goal is to intervene early to halt or slow the progression of the condition and afford long-term benefit.

In general medical practice, examples include early detection screenings, such as those for breast cancer or cervical cancer.

Applied to burnout, the goal is to detect early symptoms of burnout (or symptoms that indicate a risk of burnout) and intervene before it negatively impacts the individual and those around him/her. Regular screenings for evidence of burnout would be a secondary prevention effort.

TERTIARY PREVENTION

Tertiary prevention attempts to minimize the adverse consequences of an established, ongoing condition. These interventions improve the ability to function with the condition and improve quality of life. In this instance, interventions try to prevent the consequences of a diagnosed condition from being any worse than it currently is and to minimize adverse effects from it.

In general medical practice, examples include chronic disease management programs or cardiac rehabilitation after a heart attack.

In burnout, the individual meets diagnostic criteria for burnout and intervention is intended to avoid further deterioration of relationships, adverse professional consequences, substance use disorder, severe depression, or suicide.

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KEY ELEMENTS OF AN ACTIVE PHYSICIAN BURNOUT MITIGATION PROGRAM

Physician burnout mitigation programs strive to promote individual traits and create organizational operations that reliably minimize the risk of developing burnout.

The program elements are based on the previously outlined primary, secondary, and tertiary prevention concepts, but are not explicitly delineated as such. The program institutes mechanisms to minimize the risk of developing physician burnout (primary prevention) and to detect any evidence of physician burnout and actively intervene to minimize consequences (secondary and tertiary prevention depending on degree).

Program elements involve both individual and organizational approaches. Organizational interventions offer greater opportunities for success. Although personal characteristics definitely impact the incidence of burnout,[23] physician burnout risk tends to be centered on workplace stressors – which are complicated by personal stressors. When physician burnout efforts are concentrated on boosting individual resiliency, physicians frequently complain "Don't fix me, fix the system that I work in." Studies have confirmed that impression – organizational interventions have the greatest impact.[1,24] Thus, it pays greater dividends to concentrate on and invest in these areas.

INDIVIDUAL INTERVENTIONS

Individual – or personal – interventions are intended to promote individual resiliency. The concept is similar to vaccinations making an individual's immune system stronger to prevent or diminish certain illnesses. Individual interventions promote the ability to better deal with stressors as they are encountered. Thus, preventing the start (primary prevention) or progression (secondary prevention) of the downward spiral toward burnout – or the progression of burnout to substance use disorders, major depression, or suicide (tertiary prevention).

Individual interventions include any one or combination of the following:

- **Stress management and relaxation techniques**
- **Meditation**
- **Mindfulness**[25]
    - ◊ Mindfulness is present moment awareness[26] – a state of active, open attention on the present rather than dwelling on the past or anticipating the future. A goal is to carefully observe our thoughts and feelings without judging them as good or bad. Mindfulness can also be a healthy way to identify and manage hidden emotions that may be causing problems in our personal and professional relationships. Its positive benefits include lowering stress levels, reducing harmful ruminating, improving our overall health, and protecting against depression and anxiety.[26]

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INDIVIDUAL INTERVENTIONS (CONTINUED)

- **Exercising emotional intelligence**[23]
  - ◊ For those not familiar with emotional intelligence, "[It] is the ability to identify and manage your own emotions and the emotions of others." It is generally acknowledged to consist of the following "three skills:

    1. Emotional awareness, including the ability to identify your own emotions and those of others;
    2. The ability to harness emotions and apply them to tasks like thinking and problems solving;
    3. The ability to manage emotions, including the ability to regulate your own emotions, and the ability to cheer up or calm down another person."

- **Spirituality**
- **A wellness focus with proper diet and adequate exercise**
- **Diversion – defined as scheduling time away from work on a regular basis … especially true vacation time (think unplugged). This is recommended on a quarterly basis.**
- **Developing a social support system – including a peer support system**
- **Pursuing counseling services**
- **Practicing "Serenity"**[1]
  - ◊ Accept the things we cannot change,
  - ◊ Work to change the things we can, and
  - ◊ The wisdom to know the difference.

The organization also plays a role in promoting resiliency initiatives by developing a culture that is supportive of the individual, offering opportunities to pursue resiliency initiatives, and setting organizational expectations in line with them. Examples include:

- Developing workplace wellness programs and affording time in work schedules to access them
- Assuring the availability of counseling services and creating an environment that does not stigmatize their use
- Encouraging use of vacation time as "unplugged" vacation time.

The organization's role goes farther than promoting individual resiliency initiatives, however.

ORGANIZATIONAL INTERVENTIONS

Organizational interventions are designed to decrease stressors in the workplace environment and minimize the presence or impact of the major physician burnout drivers.

Organizational interventions tend to fall under three major categories – providing direct programmatic support; promoting direct physician input into practice and group operations; and enhancing direct physician support in clinical operations, including consideration of transitioning to a team-based care delivery model.

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PROVIDE DIRECT PROGRAMMATIC SUPPORT

Just Culture

A Just Culture sets the tone for open reporting without fear of retribution and establishes a non-punitive foundation for systemic improvement. Embracing a Just Culture "ensures balanced accountability for both individuals and the organization responsible for designing and improving systems in the workplace."[28] A Just Culture does not create a blameless environment as staff are held accountable for their choices and decisions, but it recognizes that neither humans nor systems are infallible and that individuals should not be blamed for systems issues. A Just Culture "balances the need for an open and honest reporting environment with the end of a quality learning environment and culture"[28] necessary for looking out for each other and reporting potential impairment.

Provider Impairment Policy

The creation, implementation, and promotion of a Provider Impairment Policy is another foundational element. While physician burnout is only one type of provider impairment, these policies clearly define the mechanisms and framework through which individuals can seek self-help or can help others receive help for any type of suspected impairment. Having and supporting a strong Provider Impairment Policy formally establishes organizational processes and openly sets cultural expectations related to impairment.

Screening and Monitoring

Beyond expecting (or hoping for) vigilance and reporting, developing an ongoing monitoring program for the presence of physician burnout characteristics actively conveys interest in and concern for provider well-being. Regularly having providers (or all staff members) complete the Maslach Burnout Inventory (MBI) introduces objectivity to physician burnout identification and demonstrates organizational concern for well-being. Tracking individual responses over time permits ready recognition of worrisome trends to allow effective intervention. On the other hand, tracking aggregate responses over time permits a relative understanding of the state of the work environment. Reporting them back to the providers and staff on a regular basis reinforces the concern for provider well-being, permits an open dialogue to develop, and helps establish the desired open culture about the topic. Measurement, along with tracking and reporting, also permits targeted improvement efforts.[24,29]

A number of validated physician burnout survey tools are available[30] that can be used to screen for and monitor physician burnout, including the following:

The Maslach Burnout Inventory (MBI) was introduced and described in the Signs and Symptoms section.

The Mini Z is a 10-item survey developed by Mark Linzer, MD, in 2013 and has been validated against the MBI.[5] The 'Z' stands for "Zero Burnout Program." The Mini Z is available through a number of resources, including the American Medical Association (AMA). This tool seems to be a good substitute for the longer MBI.

West and colleagues validated a single item from the MBI:EE (Emotional Exhaustion) section as a standalone burnout assessment.[31,32] The single item is the subjective statement of "I feel burned out from my work." Responses are measured on a seven-point frequency scale ranging from 0 "Never" to 6 "Every day" with "high levels of burnout" as reporting feeling burned out at a frequency of "once a week" or more (a score greater than or equal to 4). Though subjective, the single item question could be used as an initial screen with more in-depth follow up for positive results.

Dolan and colleagues completed a VA study that validated another single-item burnout measure assessment.[32] In this assessment, respondents define burnout for themselves with the question: "Overall, based on your definition of burnout, how would you rate your level of burnout?" Responses are scored on a five-category ordinal scale, where

1 = "I enjoy my work. I have no symptoms of physician burnout"
2 = "Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out"
3 = "I'm definitely burning out and have one or more symptoms of burnout, such as physical/emotional exhaustion"
4 = "The symptoms of burnout that I'm experiencing won't go away. I think about frustration at work a lot"
***5 = "I feel completely burned out and often wonder if I can go on. I am at* the point where I may need some changes or may need to seek some sort of help"**

Responses 1 and 2 indicate no symptoms of burnout and responses 3 through 5 indicate increasing degrees of burnout symptoms. Though very subjective, this single item question can be used as an initial screen with more in-depth follow ups for positive results.

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PROVIDE DIRECT PROGRAMMATIC SUPPORT (CONTINUED)

Chief Wellness Officer

Many organizations are adding a Chief Wellness Officer position to senior leadership. Advocates for this role[4,5] indicate that the position elevates the stature of and awareness for physician wellness and dedicates sufficient attention and resources to it. Designating a senior leader whose primary administrative role is to focus on this issue ensures that robust programs are established, maintained, and expanded; that potential interventions and solutions are explored and implemented; that educational programs are consistent and effective; and that an objective, "uninvolved" senior leader can advocate for both the physicians and the organization.

Education

A cornerstone of most programs, educational curricula ensure that light is shined brightly on this serious issue. All staff, including physicians, APPs, and non-provider staff at all levels should be educated about physician burnout risk, recognition, and intervention. Education should start with new employee orientation and onboarding and should be reinforced annually. All staff should embrace the primary expectations of identifying and alleviating system risk, recognizing individuals suspected of being affected, and helping oneself and each other for the benefit of all, including patients and the organization. Mechanisms to intervene should be clearly delineated (often through the Provider Impairment Policy) and wholly supported.

Culture

The aforementioned programmatic elements ultimately drive organizational culture, which includes:

- A culture that is open and sincere in its desire to promote physician well-being. A culture which everyone looks out for each other
- A culture that embraces sincere communication and collaboration
- A culture that values work-life balance
- A culture that embraces meeting regularly to interact and socialize as a group (which helps combat social isolation – a risk factor that allows negativity to take hold and progress[29])

Culture is sustained and reinforced by recruiting and hiring for cultural fit so that potential new members see themselves fitting into the described practice environment – followed by collegial and administrative onboarding processes that permit relatively seamless assimilation into the practice and re-emphasis of individual and group expectations.

PROMOTE DIRECT PHYSICIAN INPUT INTO PRACTICE AND GROUP OPERATIONS

This category of intervention addresses burnout drivers associated with loss of autonomy, input, and control within the work environment. It brings the "physician voice" to the problem-solving and decision-making process and involves openly and freely sharing data and information about organizational status and function. It builds trust and mutual respect – and allows the physicians to feel appreciated and supported.

An indispensable means to accomplish these ends is formally involving physician leadership in the organizational structure and operations. Common mechanisms include creating designated physician leadership positions, such as Chief Medical Officers and Medical Directors, and creating a Physician (or Provider) Leadership (or Advisory) Council. Pursuing these initiatives not only decrease the risk of physician burnout but predictably yield other organizational benefits as direct physician leader involvement is crucial to success in value-based care delivery/ reimbursement and progress toward becoming a high performing organization.

Transparent, open, bidirectional communication between Administration and physicians is advocated to mitigate the risk of burnout. Informed physicians feel more respected by and involved in the organization, which minimizes the risk of feeling alienated, unappreciated, and unsupported. Though the physicians may not agree with everything that is communicated, openly sharing information without filters is mutually beneficial. Transparency is also crucial to enhanced organizational function.

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ENHANCE DIRECT PHYSICIAN SUPPORT IN CLINICAL OPERATIONS

Providing patient care has become increasingly complex. The patients are more medically complex. As life expectancy has increased, so have the number of co-morbid conditions. Preventive efforts and treatment breakthroughs have transformed previously lethal conditions like cancer, HIV, cardiovascular disease, and organ failure into chronic conditions. As a result, patients are living longer with more chronic conditions to consider than ever before. The medical knowledge related to these conditions continues to burgeon, available treatments continually expand, and associated technological advances can be mind-blowing.

Patients have also become more socially complex. Social determinants of health are receiving more attention than ever before. They have become a primary focus of care and are being targeted to improve patient outcomes. Addressing these patient issues often requires greater interfaces with community resources, which further adds to the complexity of care. In many practice settings, responsibility for addressing these issues often falls on the physician– or requires the practice to add nursing and social work staffing with attendant overhead and the added pressure to cover the expense.

Increasingly complex patients are cared for in an increasingly complex practice environment complicated by increasing healthcare legislation and regulations. Stark Law and regulations. The Anti-Kickback Statute. The False Claims Act. CMS (Centers for Medicare and Medicaid Services) practice regulations. State medical board and health department regulations and requirements. Coding and documentation requirements. All combine to make some opine that healthcare is the most regulated industry in America[33] – and complicates the physicians' role in it.

An increasingly regulated practice environment is made even more complex by the increasing requirements of third-party payers. Additionally, health plan restrictions and requirements can limit or dictate care options for patients or can directly impact patients' decisions about their care. The sheer number of differing health plans and coverage options within a market, and that change year to year, creates its own challenges for patients and practices. These create difficulties keeping up with varying formulary limitations and expanding pre-authorization requirements. Tracking payments, denials, and appeals can be a full time undertaking. Added to these factors is the difficulty of adjusting to evolving reimbursement structures associated with the ongoing, protracted transition to value-based care (straight fee-for-service to pay-for-performance initiatives to risk-based contracting). Not only do these requirements add complexity to care delivery, they consume progressively more physician time and effort, require additional administrative staff, and incur associated overhead.

External regulations and third-party payer requirements have significantly increased the administrative burden of modern healthcare, which is commonly cited as being among the most notable driver of physician burnout. CMS recognized this impact and created the "Patients over Paperwork" initiative to begin addressing the substantial administrative burden and its adverse impact on physicians and patients.[34] This initiative is in its infancy, so its actual results and the breadth of its influence remain to be seen.

Although patient complexity, external regulations, and third-party payer requirements play key roles generating physician frustration, stress, and burnout, these often pale in comparison to the impact of electronic health records (EHRs). This component of modern medical practice is often the most commonly cited major drivers of physician stress and practice dissatisfaction[4,35,36] – and whose impact should not be underestimated.

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THE SPECIAL IMPACT OF EHR UTILIZATION

Physicians cannot avoid interacting with EHRs in today's practice environment. Studies estimate that family physicians currently spend approximately 24% of their professional time interacting with an EHR.[34] The extent of EHR utilization was driven by regulations arising from the 2009 American Reinvestment and Recovery Act (ARRA)[4] and catalyzed by reimbursement incentives. The ARRA established the "meaningful use" of EHRs which directly led to CMS' Medicare EHR Incentive Program in July 2010. The program linked achievement of EHR capability and utilization parameters to reimbursement rewards … and the rest is history. Although modified, the program lives on in the Quality Payment Program.

The rise of EHR utilization led to linkage of other concerns to EHR capabilities. The quality of care and patient safety concerns that arose out of the 1999 Institute of Medicine publication, "To Err is Human" led to significant focus on these areas of medicine and the opportunities to capture quality and safety data through EHR documentation. Over time, important, but tangential, initiatives became linked to individual patient encounters, such as domestic violence screens, fall risk assessments, and others. Each seemed to increase the "number of clicks" (and time) that physicians and staff spent entering data into the EHR.

While originally touted as the consummate tool to promote clinical information sharing, efficiency of care, and individual productivity, EHR implementation has not lived up to its hype. Instead, many physicians experience increased work hours that spill into personal, after-hours life (creating the term "pajama time" – completing EHR documentation and other functions at home … often after family time and before going to bed). The actions associated with EHR navigation and utilization directly create stress for many physicians but they are indirectly also blamed for issues related to failing to meet productivity expectations, experiencing increased work hours, being unable to effect work-life balance, and increasingly feeling that compensation is inadequate for expectations. Many physicians cite EHRs as a barrier to patient care and patient relationships rather than an ally in these pursuits.

With this background, what is the impact of the EHR on burnout?

- Physicians who reported not having enough time for EHR documentation were 2.81 times more likely to show symptoms of burnout than those who reported having sufficient time[1];
- Physicians who spent moderately high or excessive amounts of time on their EHR at home were 1.93 times more likely to show burnout symptoms than those who spent minimal or no time on the EHR at home[1]; and
- Physicians who agreed that EHRs add to the frustration of the day were 2.44 times more likely to show burnout symptoms than those who disagreed[1].

So, how can the perceived, or actual, negative impact of EHRs on physicians be addressed? On the regulatory side, CMS is trying to help by modifying the original "meaningful use" goals, aligning hospital and physician program requirements, working toward EHR interoperability emphases, and favorably altering reimbursement criteria.

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On the organizational side, a number of interventions can help, but the most significant contribution that organizations can provide is to ensure adequate IT support, which office practices have historically lacked. While adequate support is subjective, it normally includes at least some of the following:

- Platform selection and understanding the differences in usability between the ambulatory modules and inpatient modules. Many health systems are implementing a single EHR platform throughout the system. The conversion usually results in office practice transition from a 'best of breed' ambulatory system to a platform originally designed for acute inpatient care with subsequent development of ambulatory capabilities. Not uncommonly, this results in the EHR working very smoothly on the acute inpatient side but much less so on the office side – with attendant frustrations and decreased productivity related to suboptimal design and workflow. The impact of the transition must be recognized and acknowledged.

- Elbow-to-elbow IT support specialist and superuser support. Direct observation of physicians using the system and offering real-time assistance and suggestions reap significant dividends related to less frustrated, more productive end users.

- Promote automation of areas that permit it, such as templated notes, patient education, and common macros. Create these for recurring types of care, then suggest and demonstrate their use. This becomes a great role for the elbow-to-elbow IT support specialist.

- Create a Clinical Informatics group to provide input and feedback. The area is classically recommended for inclusion in a Physician Leadership Council committee structure but could also be created as a user group if a leadership structure does not exist. Implementing this type of group permits sharing of best practices and soliciting platform improvement and optimization suggestions.

- Ongoing training opportunities. Initial EHR training is often likened to 'drinking from a fire hose' – tons of information to take in during a limited period of time. Providing (or requiring) ongoing training allows progressive uptake of information and helpful hints – preferably in smaller, digestible amounts over time.

- Ensure the presence of adequate hardware – both in quantity and in capabilities.

- Ensure "fast" connectivity – realizing that speed is in the eye of the user. Consider the time it takes to navigate from screen to screen and how that adds up with every click.

- Consider the role of speech recognition software to complete notes and navigate the system. Physicians are often better talkers than typists. This adjunct can make or break the EHR experience for some physicians.

- Consider the use of scribes. Scribes have been shown to alleviate many stressors related to EHR use.[5,38] The benefit may be well worth the cost – especially if physicians can see an additional patient per half day to cover the cost. Better yet, utilize clinical support staff in an expanded role as advocated in the team-based care model below.

Implementing these IT initiatives can have a profound impact on burnout risk – but also increase productivity, revenue, and sustainability.

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THE SPECIAL CASE FOR TEAM-BASED CARE IMPLEMENTATION

Perhaps the intervention with the greatest promise of mitigating physician burnout is also potentially the most disruptive – adopting a team-based care delivery model. The team-based care delivery model is designed to share the care delivery "burden" among all staff and utilize all staff members at the top of their license and capabilities. Successfully implementing this care delivery model has been shown to mitigate physician burnout risk[1,24,39,40,41] but requires significant paradigm shifts for all involved.

As noted in the **Major Drivers of Physician Burnout** section, physicians traditionally accept all responsibility for the patient care burden and place it squarely on their shoulders. While they may complain that they "cannot do one more thing," they also state that they do not want to give up a single thing. This care delivery model absolutely requires physicians to accept assistance and relinquish tasks to other team members. If they do not, their burden may paradoxically increase – as does their risk of physician burnout.[39]

Similarly, clinical support staff members must accept the changes in their roles – and must be adequately trained to assume them.[42]

The model will not be described in detail here but is available in HSG's whitepaper **Clinical Practice Transformation: Fundamental Philosophies – Creating a Team-Based Approach to Patient Care Delivery** and can be found online at http://info.hsgadvisors.com/CPT.

Like many of the interventions recommended to mitigate the risk of physician burnout, team-based care delivery produces additional benefits including:

- Streamlining clinical operations, which predictably leads to increased throughput, enhanced access, and increased revenue
- Generating greater professional fulfillment, job satisfaction, and retention for both providers and non-providers as all are utilized at the top of their professional license and capabilities – and trained to do more than ever before
- Improving comprehensive patient care, including preventive and wellness services
- Increasing patient engagement, satisfaction, and retention

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CONCLUSIONS

Physician burnout is widespread and can have significant impact on individuals and systems.

Organizations that address physician burnout concerns by developing an active program will realize significant benefits related to

- Physician, staff, and patient satisfaction and retention
- Operational efficiency and effectiveness
- Quality and cost of care
- Patient safety and litigation risk reduction

Undertaking primary, secondary, and tertiary preventive efforts can mitigate the evolution of physician burnout and its impact.

Physician Burnout Mitigation Program (or Physician Wellness Program) elements include

- Promoting individual resiliency
- Promoting direct input into operations
- Providing direct programmatic support
- Enhancing direct support in clinical operations

Implementing a team-based care delivery model can provide benefits above and beyond physician burnout risk mitigation.

HSG CAN HELP GET YOU STARTED

We want to help your physician network evolve with a physician burnout mitigation strategy that will solidify physician retention while maximizing your health system's performance. Starting with a full physician network assessment, HSG can help you develop physician leadership structures and programs, evaluate management infrastructure adequacy, assist with EHR support, augment care delivery model transformation, create Provider Impairment policies, and other organizational development needs, and eventually evolve your physician network to a high-performing status.

We urge you to reach out to us to schedule a discussion about an improvement initiative for your Physician Network.

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A University of Pittsburgh School of Medicine graduate, he retired from the US Navy after a career spanning more than 20 years working as a family physician and clinical administrator in a variety of practice environments, including leading multi-specialty clinical operations and physician-hospital alignment. Dr. McWilliams completed a Master of Science in Jurisprudence (MSJ) focused on Hospital and Health Law from Seton Hall University School of Law in August 2015.

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