Workflow Improvements To Reduce Burnout

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Physician burnout appears to be at an all-time high. Consider that a 2021 survey of physicians disclosed that 63% had at least one symptom of burnout, up from 38% in 2020. Levels of professional satisfaction have fallen, while levels of emotional exhaustion, depression and depersonalization (for instance, cynicism) have risen.[1]

Some of these changes may be related to ongoing pandemic stresses upon the health care workforce, including periodic COVID-19 surges, the politicization of vaccines, increases in verbal and physical assaults on health workers, and being required to deviate from standard practices or normal areas of expertise. But given that almost 44% had symptoms of burnout before COVID, it is likely that the pandemic merely exacerbated factors already in place.

In "Physician Burnout: The Root of the Problem and the Path to Solutions," *NEJM Catalyst* reported that the No. 1 source of burnout for physicians was the "increased clerical burden" that has been imposed by electronic health records (EHRs). The second cause was continual expectations and demands to be more productive. Overall, they noted that 80% of burnout is attributable to "workflow issues." While this report — which helped draw attention to the issue — was issued more than five years ago, the problem persists. Just recently, Drs. Anthony DiGiorgio and Praveen Mummaneni of the University of California San Francisco discussed their findings in MedPageToday. Residents at their facility spent 20 hours per on-call shift logged in to the EHR, with nine of those hours interacting directly with the EHR instead of with patients.[2]

As health care organizations continue to look for ways to reduce physician burnout, finding approaches that can help to improve EHR usability and efficiency across all clinical care team members can help offer support and promote well-being for strained physicians.

ADDRESSING WORKFLOW AND CLERICAL BURDEN

In 2022, the U.S. Surgeon General released "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory of Building a Thriving Health Workforce."[3] It discusses the causes and impacts of health worker burnout, calling for a whole-of-society approach to address it, saying that we must immediately:

1. Protect the health, safety and well-being of all health workers.
2. Eliminate punitive policies for seeking mental health and substance use care.
3. Reduce administrative and other workplace burdens to help health workers make time for what matters.
4. Transform organizational cultures to prioritize health worker well-being and show all health workers that they are valued.
5. Recognize social connection and community as a core value of the health care system.
6. Invest in public health and the public health workforce.

The advisory recommends lessening administrative and documentation burdens, "... ensuring health information technology that is human-centered, interoperable, and equitable, and aligning payment models to recognize the value of a

conversation, not just of a procedure." The advisory includes pleas to both insurers and tech companies on this account, noting that providers currently spend two hours on clerical duties for every one hour of patient care.

In their work on burnout, the National Academy of Medicine also cites the importance of addressing workflow and clerical burden, explaining that providers need to have systems that operate reliably and efficiently to do their best, undistracted work. The National Academy of Medicine notes that many physicians spend "nearly an hour per day manually entering orders, another hour processing through a series of drop-down boxes for prescription renewal, nearly 90 minutes per day on inbox work, and hours per week on prior authorization requirements. All of this time could be reduced by re-engineering workflows and empowering teamwork, allowing physicians to spend more time with their patients and engaging in 'deep work,'"[4] the substantive aspects of a person's job that require mental focus and benefit from a lack of distractions.

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Granted, some of the workflow issues are larger than any given office or hospital system, representing fractured practices, charting and reimbursement models. Still, the literature shows that there may be evidence-based ways available to health care practitioners to improve workflow, decrease the menial tasks in physician workloads and hopefully bring back more meaningful "deep work" in the process.

Much of this workflow improvement research has focused on use of EHRs and physicians' clerical burden, on team-based care models, on changes to reimbursement models and on the use of artificial intelligence tools.

EHRs AND OTHER CLERICAL BURDENS

One of the main reasons routinely cited for physician burnout is the current clerical burden, specifically, charting in the EHR. A tool that was supposed to make health care workflow easier and more seamless has instead complicated the lives of many health workers.

Although EHRs have offered some benefits, their design has emphasized billing and administrative needs over clinical decision-making and care delivery, often imposing outdated paper-based workflows onto a digital environment capable of doing things differently. Because of this, most clinicians spend one half to two-thirds of their workday on the EHR and other clerical tasks, often at the expense of spending time with patients.[5]

Even with so much office time on the EHR, many physicians have to extend their day beyond office hours just to complete their documentation. In 2019, the U.S. Centers for Disease Control and Prevention found that 91% of office-based physicians routinely spent time outside office hours documenting clinical care. About a quarter were spending an extra two to four hours per day performing these tasks, and about 9% were spending an additional four hours per day documenting their care.[6] This extra clerical work performed outside of work hours is sometimes referred to as "pajama time" and contributes significantly to burnout. Those with more than three hours per day of after-hours work were shown to have 13 times the odds of burnout compared with those who spent less than 30 minutes on it per day.[7]

IMPROVEMENT OF THE EHR ITSELF

The Surgeon General's advisory on burnout includes a section called "What Health Care Technology Companies Can Do," arguing that tech companies have a part to play in health worker well-being. From the time systems are designed, they suggest that developers of these electronic records examine factors that may contribute to information overload, clinical complexity and interruptions. Improvements can include reducing the records' pop-up messages, minimizing mouse clicks needed to complete a task, and curating health data in such a way as to better visualize a patient's information. The report also recommends that systems be designed at the outset for interoperability to optimize communication from disparate sources such as care teams, laboratories and public health.[8]

On an institutional level, staff can be encouraged to engage in multidisciplinary improvement "sprints" with EHRs, where clinician "pain points" are determined and more appropriate workflows are created.[9] This can include creating procedures for routine medication refills, prior authorizations and other time-consuming clerical duties that can be delegated to nonphysician staff.

Staff at all levels can take a lesson from an EHR initiative launched by Hawaii Pacific Health in Honolulu, Hawaii, called "Getting Rid of Stupid Stuff," where all system physicians and nurses were encouraged to nominate aspects of the EHR that they thought were "poorly designed, unnecessary, or just plain stupid." More than three-fourths of the nominations were from nurses, mostly regarding eliminating documentation not required by regulations or internal policies, and more than half of the suggestions wound up being implemented.[10] (The "Getting Rid of Stupid Stuff" initiative is now available as a training through the American Medical Association. See resource box below.)

TRAINING ON THE EHR

Some improvements of the EHR interface for providers can happen through appropriate training. Protected time for "at-the-elbow" EHR training — where someone works directly with providers to train and answer questions — is key to provider satisfaction and efficiency. Such education can happen upon hire, upon implementation of changes and at regular intervals thereafter. Surveys have shown that providers who received poor EHR training were three-and-a-half times more likely to report that their EHR did not "enable them to deliver high-quality care."[11]

RESOURCES

BURNOUT AND WELL-BEING

National Academy of Medicine
Resource Compendium for Health Care Worker Well-Being: Contains nearly 100 resources from across health care, arranged in six subject areas: 1) advancing organizational commitment, 2) strengthening leadership behaviors, 3) conducting a workplace assessment, 4) examining policies and practices, 5) enhancing workplace efficiency and 6) cultivating a culture of connection and support.

https://nam.edu/compendium-of-key-resources-for-improving-clinician-well-being/

American College of Physicians
Practice Resources: Physician Well-Being and Professional Fulfillment

https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment

U.S. Surgeon General
Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce, 2022: Figure 4 on page 30 in the report below includes many helpful related resources.

https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html

American Association of Critical-Care Nurses
Healthy Work Environments

https://www.aacn.org/nursing-excellence/healthy-work-environments

988 Suicide and Crisis Lifeline
https://988lifeline.org/
(or call "988" on your phone)

EHRs AND ADMINISTRATIVE TASKS

National Academy of Medicine (NAM)
Checklist for Health Care Leadership on Health IT and Clinician Burnout

https://nam.edu/systems-approaches-to-improve-patient-care-by-supporting-clinician-well-being/checklist-for-health-care-leadership-on-health-it-and-clinician-burnout/

The Office of the National Coordinator for Health Information Technology
Health IT Playbook

https://www.healthit.gov/playbook/

American Medical Association
EHR Inbox Management: Tame Your EHR Inbox

https://edhub.ama-assn.org/steps-forward/module/2798925

American Medical Association
Getting Rid of Stupid Stuff (GROSS): Reduce the Unnecessary Daily Burdens for Clinicians

https://edhub.ama-assn.org/steps-forward/module/2757858

PAYMENT/REIMBURSEMENT

American Academy of Family Physicians
Direct Primary Care Toolkit

https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/direct-primary-care/toolkit.html

INBOX MANAGEMENT

Many EHR systems push notifications to physicians by default, unnecessarily increasing their cognitive burden. Secure messages received from electronic record systems have become a significant source of burnout. Researchers have found that providers with more than 300 messages per week have six times the odds of burnout compared with those with less than 150 messages per week. It is worth noting that the average family physician has approximately 100 inbox messages per day.[12]

The American Medical Association has a step-by-step training to help manage inbox messages generated by the EHR. (See resource box on page 12.) The training recommends that the information technology department be engaged at the outset to determine which kind of messages should never enter the physician inbox in the first place, and what IT can do to remedy a variety of issues that physicians encounter with EHR inboxes as currently designed. Similarly, the training offers guidance on how various "buckets" of messages can be created and how those buckets can be delegated to various other nonphysician team members.[13]

SCRIBES AND LANGUAGE SOFTWARE

In a 2018 study of the use of scribes in primary care, researchers found that scribes significantly decreased administrative burden, leading to significantly less after-hours charting. It found 85% of the providers in the study were able to spend 75% of the visit interacting with the patient (as opposed to 13% without scribes), and only 25% of the visit interacting with the EHR. It found 94% of the PCPs reported greater job satisfaction with scribes, and 89% reported that they had improved clinical interactions with patients when they used scribes. The majority of patients (61%) also reported that the use of a medical scribe had a positive impact upon their visit.[14]

Speech recognition programs (like Dragon) are also commonly used to dictate into the record and have been in use for about three decades. A 2016-2017 survey showed that 77% of physicians felt speech recognition systems helped to improve their efficiency. Natural language processing is a similar artificial intelligence tool that is sometimes used to extract information from free text that can be used for billing. There are emerging technologies referred to as "digital scribes" that combine speech recognition, language processing and other tools, technologies that range from artificial intelligence otoscopes to algorithms that aid in the detection of cancerous lesions. Some of these artificial intelligence tools are built in to current EHRs, and some exist as "add-on apps."[15]

Some people have hopes that extensive artificial intelligence development might help to take immense pressure off physicians in the future. Currently, researchers note that the technology cannot be relied upon to truly understand language or to perform diagnostic functions, but some are hopeful that artificial intelligence may someday aid physicians enough to restore what can seem like the currently fractured doctor-patient relationship.[16]

IMPROVED ORDERING

Order bundles can be helpful to ensure that evidence-based interventions that belong together can be ordered together. When auditing for efficacy, an "all-or-none" model is used to assess compliance, but this is made easier by bundling them together in the record in the first place.[17] Although EHRs commonly have bundles for admissions, discharges or common procedures, bundles can be developed for any multi-order process routinely performed by a team.

AVOIDING THE EHR ALTOGETHER

One way of avoiding the stress and clerical burden that EHRs impose is to avoid them altogether. Not all providers use an EHR, especially office-based physicians.[18] And some providers who have had EHRs have ditched them in favor of a return to paper charting.[19]

TELEHEALTH

There's no question that the pandemic hastened the use of telehealth appointments, so much so that it has been the recent focus of a separate *Health Progress* article.[20]

When COVID hit, reimbursement and provider willingness to engage in telemedicine skyrocketed.[21] In the intervening three years, telemedicine has become incorporated into the workflow of many practices, allowing patients to be seen easily and relatively conveniently for both patients and providers. Because some follow-up appointments may not require a physical examination, those patients can often be seen sooner, even rapidly scheduling an appointment

through a waiting list if the previously scheduled patient is a no-show.

TEAM-BASED CARE

In an article published in *STAT* in December 2022, Audrey Provenzano, MD, a practicing primary care physician and Harvard Medical School instructor, argues primary care is fundamentally broken and that the problems have only been exacerbated by the COVID pandemic. She argues that physicians simply can't do it all, and that attempting to do so leads to disproportionately high rates of depression and suicide. The gap between what patients need and how primary care is resourced is simply too wide, she says. In order to be sustainable, primary care particularly must move to a team-based model and physicians must learn to set limits on their time. Physicians shouldn't be expected to do it all, she argues, but they must also accept their own limitations.[22]

When a team is involved in the care of a patient, some clinical documentation can be performed by nonphysician staff, and this approach also seems to have high rates of provider and patient satisfaction.[23]

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For health care teams to work well, the provider must be able to delegate confidently. The provider must have a highly functional team where everyone operates at the top of their skill set and licensure.[24] This allows for clerical work to be delegated to administrative personnel, while medical assistants can perform tasks within their scope, and LPNs, RNs, NPs, PAs and social workers can do similarly. Clerical and clinical tasks can be assigned and triaged to the appropriate personnel, only making its way to a physician or nurse practitioner/physician assistant if truly needed due to clinical scope or licensure.

Before intervening with a clinical team, it is important to assess the team's current functionality. All team members should be included in the process of developing workflows and standards of behavior in how to treat each other. Results of the exploratory process should never be used to punish people, and all results should be shared with the team. Everyone should be allowed to participate in brainstorming ideas about how to improve the culture, and a written compact on how staff should treat each other should be developed.[25]

Research on interprofessional team collaboration found that major barriers included a lack of time and training, a lack of clear roles, fears relating to professional identity and poor communication. Facilitating factors for team-building included tools to improve communication, colocation enabling face-to-face communication and the recognition of others' skills and contributions.[26]

CHANGES TO PAYMENT MODELS

Although not an option open to all practices, some practices have found that changing their billing and payment model has helped their burnout and workflow. Both the National Academies of Science, Engineering, and Medicine and the Surgeon General's advisory argue that the fee-for-service model is not working, especially for primary care.

As Shirlene Obuobi, MD, noted in her recent heartbreaking editorial in *The Washington Post*, "There's a clear disconnect between what most patients value in health care and what hospital systems and insurance companies want. The American medical system rewards procedures, imaging, tests, and other diagnostics that generate revenue and have high reimbursement rates. ... Because they don't generate revenue from procedures, non-procedural specialists are pressured to increase their patient volume and are often given appointment slots as short as 10 minutes."[27]

To avoid these broken reimbursement models, some providers have gone to alternative reimbursement models like Direct Primary Care (DPC) or to concierge medicine. Both models gained popularity in the 2000s as a reaction against rising operational costs, increased administrative burden and cuts in reimbursement. By restructuring their practices and reimbursement, many physicians found that they could earn more

money while cutting their patient panel from approximately 2,000 down to 500 or 600. Some people are worried that these models further diminish the number of primary care providers available in a time of increasing shortage. Alternatively, some people argue that these models might keep some providers in practice who might otherwise burn out and quit medicine.[28]

Direct Primary Care

The Direct Primary Care model charges patients a monthly, quarterly or annual retainer fee that covers all or most of primary care clinical and laboratory services, consultative services, care coordination and care management. Fees are paid exclusively by patients and sometimes patients' employers, with no billing to insurance companies or government programs.

Direct Primary Care practices sometimes recommend that participants have a high-deductible plan in event of emergencies. Direct Primary Care is not synonymous with concierge medicine, which sometimes bills insurance or government programs. Instead, it tries to avoid the fee-for-service third-party payer model entirely.[29]

Concierge Medicine

Concierge medicine allows for more access to physicians and comes at a cost of $200 per month on average. Unlike Direct Primary Care, concierge care can be primary care or cover a wide gamut of specialties. This cost is in addition to insurance, as concierge medical practices also bill insurance. Currently, approximately one in five of the United States' wealthiest 1% pays extra fees for direct access to their doctor. While providing more one-on-one care may prevent burnout, one concern is that such an approach clearly isn't available to those who can't afford it.[30]

NATIONWIDE ADMINISTRATIVE IMPROVEMENTS NEEDED

If implemented nationwide, there are administrative improvements that could potentially help with workflow and save significant amounts of money. Much like grocery stores have gone to universal product codes (a.k.a. "barcodes") rather than having their own, standardizing certain industry-wide practices could lead to efficiency of time and money.

Researchers argue that having a centralized claims clearinghouse and allowing insurers and providers to share computer systems could save $55 billion a year. Standardizing the information that insurers require could save another $35 billion per year and greatly reduces the back-and-forth and stress of the authorization process on providers and on patients.[31]

In a 2020 survey, 85% of physicians described the burden associated with prior authorization as "high" or "extremely high," and 34% reported that the prior authorization process had led to a serious adverse event for a patient in their care. When the Office of the Inspector General looked at the issue in 2018, it found a high rate of inappropriate prior authorizations. It is estimated that transitioning to all-electronic prior authorization systems could save $417 million annually. A fully electronic prior authorization system would also save health workers up to 12 minutes per transaction, a time burden that quickly adds up.[32]

By addressing workflows, health care systems can make a dent in health care worker burnout.

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NOTES

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