Physician Burnout: Changing the EHR from a Liability to an Asset

Alain A. Chaoui, MD, FAAFP
Immediate Past President, Massachusetts Medical Society,
Chair MMS-MHA Task Force on Physician Burnout

Larry Garber, MD
Medical Director for Informatics, Reliant Medical Group

New England HIMSS, Gillette Stadium, May16, 2019

MASSACHUSETTS MEDICAL SOCIETY

RELIANT MEDICAL GROUP
Part of OptumCare®

Today's topics

Burnout Definition and Overview

Identifying the Drivers and the Impact

Changing the EHR from a Liability to an Asset

Definition of Burnout*

- Emotional Exhaustion
- Depersonalization
- Low sense of personal accomplishment

(*burnout is in response to non patient related interferences)

* Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012;172(18):1377-1385.

So profound it is ….

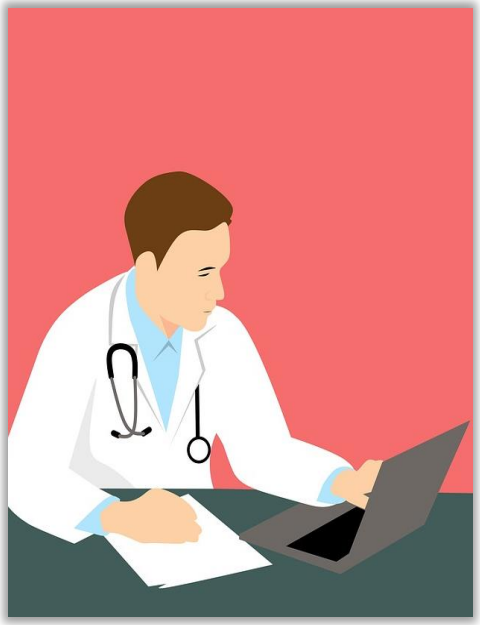
- described as “Moral Injury”
- Burnout results from a collision of norms-- between the physicians mission to provide care and the increasing bureaucratic demands of a new era.

- Talbot SG, Dean W. Physicians aren’t “burning out” They’re suffering from moral injury. STAT

Restoring the joy in practice

Then

Now



Is modern medicine upholding its promise to our patients?

“Conveyor Belt Medicine”

What is the impact of Burnout?

Its both
Personal
and
Professional

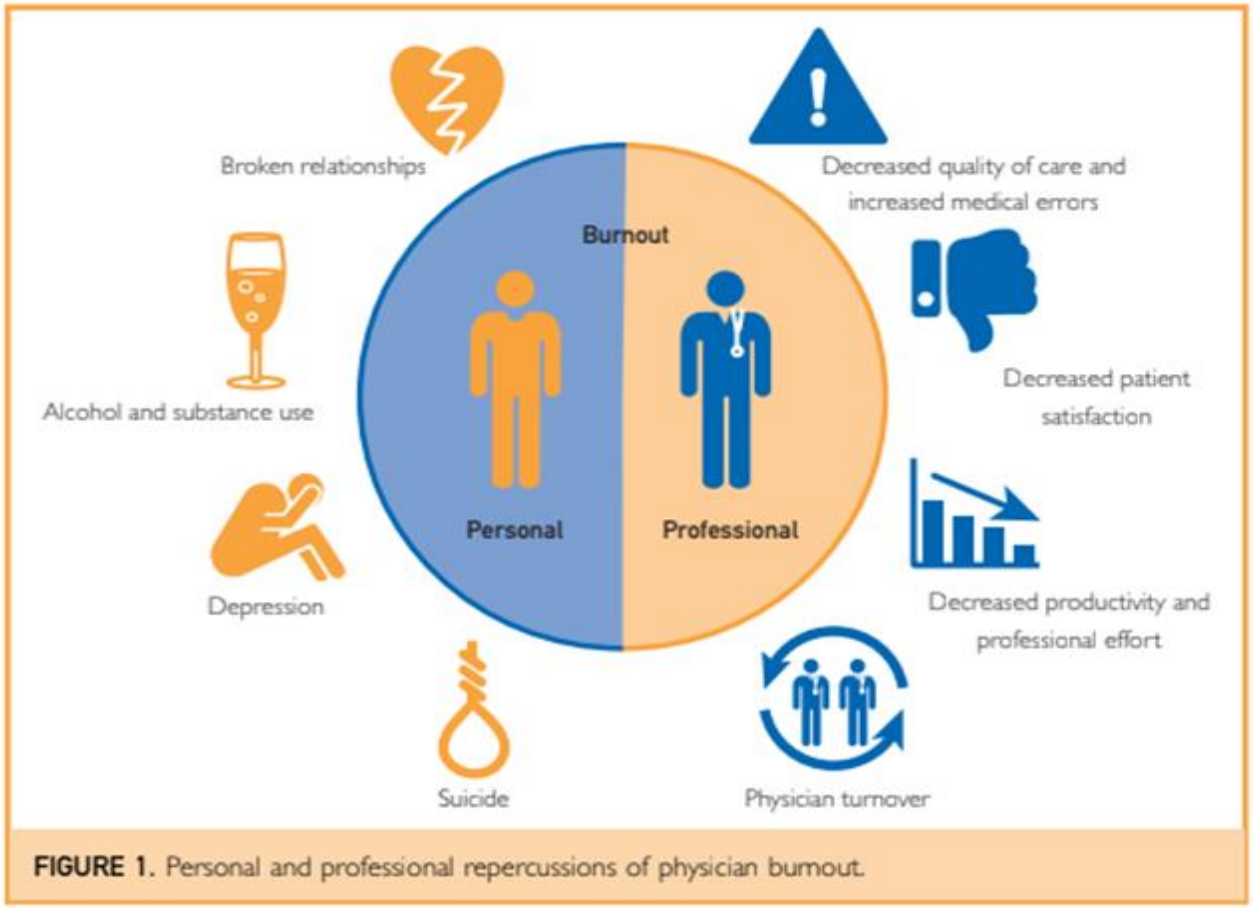


FIGURE 1. Personal and professional repercussions of physician burnout.

- Shanafelt 2017

Prevalence of Physician Burnout

High risk in United States

Close to 50 percent experience at least one symptom*

2X more likely than general population**

Impacts all specialties and career stages

*Mayo Clin Proc. 2015 Dec;90(12):1600-13. doi: 10.1016/j.mayocp.2015.08.023. Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014.Shanafelt TD[1], Hasan O[2], Dyrbye LN[3], Sinsky C[2], Satele D[4], Sloan J[4], West CP[5].

**Leiter MP, Frank E, Maslach C. US: Demands, values, and burnout: relevance for physicians.

How did we get here?

- Physician Burnout can be traced to several events
  - 1999, Institute of Medicine's to Err is Human"- Drawing attention to medical errors
  - 2009, American Reinvestment and Recovery Act- mandate of " meaningful use" of EHRs
  - 2010- Affordable Care Act- most significant change in American HealthCare
  - **All adding additional requirements** including regulatory documentation, quality measurement, coverage expansion, administrative, prior authorization

Drivers of Burnout– Its Multifactorial !!

Management/leadership

EHR inefficiencies/time/clerical burden

Prior Authorizations

Extreme number of Administrative burdens

Long hours/frequent call

Reimbursement issues

Medicolegal issues

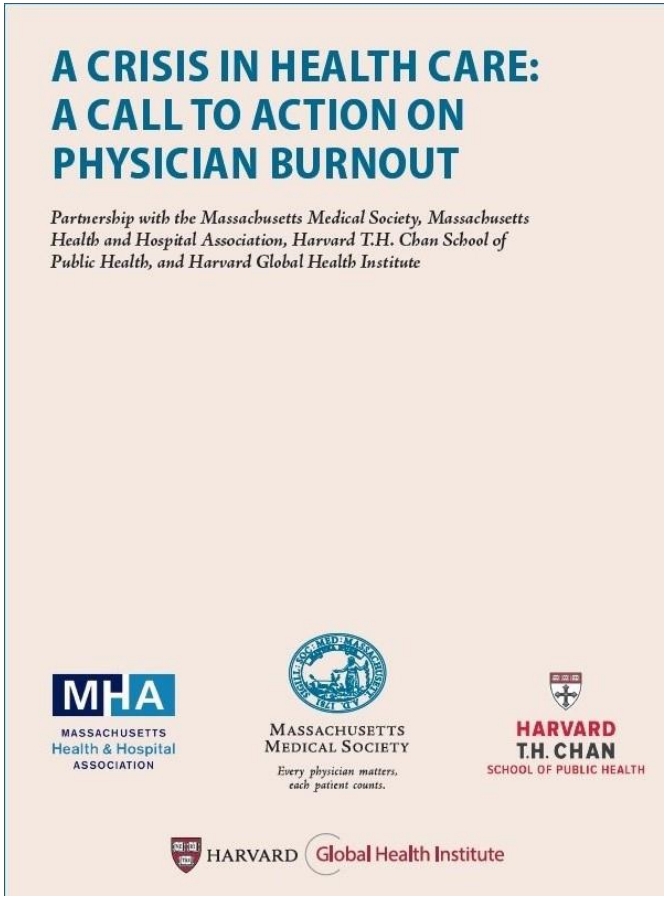
* Gabbard GO. Medicine and its discontents. Mayo Clin Proc. 2013;88(12):1347-1349.

** Dyrbye LN, Varkey P, Boone SL, Satele DV, Sloan JA, Shanafelt TD. Physician satisfaction and burnout at different career stages. Mayo Clin Proc. 2013;88(12):1358-1367.

Shift: Individual to Systems Focus

- Past: Focus on bolstering individuals' resilience skills
- Present: Focus on Organizations needing to redesign the way that clinical care is delivered.

What's the latest in our work?



Report recommendations

- Addressing this crisis will require action by all stakeholders.
- Three concrete steps have the potential to significantly improve on the issue:
  - Support proactive mental health treatment and physicians experiencing burnout and related challenges
  - Improved EHR standards with strong focus on usability and open APIs (e.g. API and AI)
  - Appoint Executive level Chief Wellness Officers at every major health care organization

Improved EHR standards with strong focus on usability and open APIs

- Allow software developers to develop a range of apps that can operate with most/all EHR systems – in doing so hospitals, physicians, and clinics can customize workflow and interfaces based on their specific set of needs
- Development of Artificial Intelligence (AI) technology that would support clinical documentation and quality measurement.
- Include physicians in the EHR development and improving usability processes
- Eliminate duplicative and extraneous requirements and measurements that do not support care

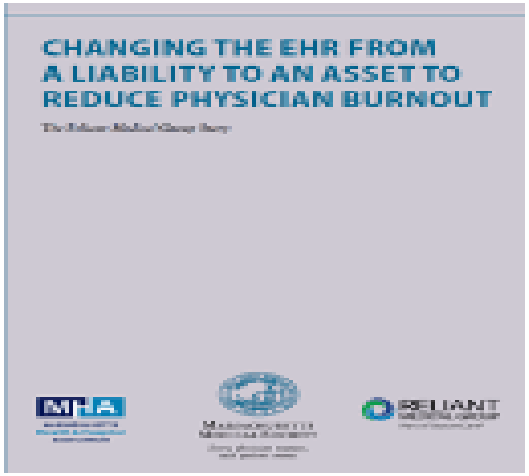
Is it actually possible to improve EHRs?

- Could hospitals, physicians, and clinics customize workflow and interfaces based on their specific set of needs
- Can clinical documentation be made easier?
- Can physicians be included in the EHR development and improving usability processes?
- **Will all of this improve physician satisfaction with EHRs?**

Reliant developed concrete effective solutions

MMS, MHA and Reliant Medical Group publish paper on EHR as an asset

April 22, 2019



A joint Massachusetts Medical Society (MMS) and Massachusetts Health & Hospital Association (MHA) task force on physician burnout released **a white paper in partnership with Reliant Medical Group** that details best practices adopted by Reliant to optimize their electronic health record (EHR) and improve its usability.

A report published in January 2019 by MMS-MHA Joint Task Force on Physician Burnout, Harvard School of Public Health and Harvard Global Health Institute identified inefficient EHRs as one of several leading causes of burnout in the healthcare provider community.

Reliant Medical Group

2600 EMPLOYEES

300 PHYSICIANS

200 ADVANCED PRACTITIONERS

324,000
PATIENTS

>50%
Risk-Sharing

27 LOCATIONS

30 SPECIALTIES

- Pediatrics
- Adult Medicine/Hospitalists
- Specialty (Medical/Surgical) Care
- Behavioral Health
- Urgent Care
- Occupational Health
- Durable Medical Equipment

Reliant's Guiding Principles for EHR

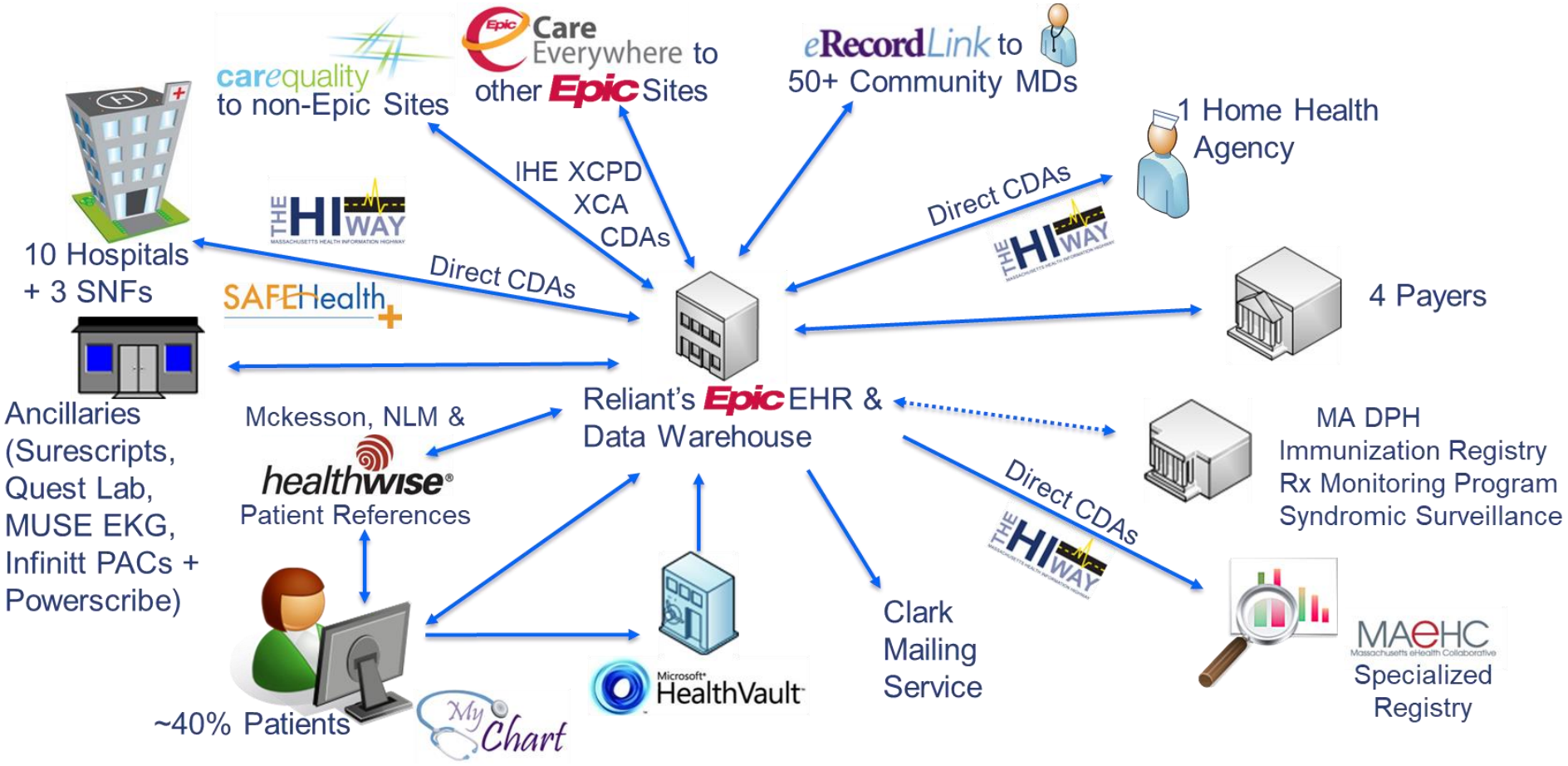
3 Keys to Success:

- Value to all stakeholders
- Fit into real-world workflows
- Trust among stakeholders

Also known as the "3 U's":

- Useful
- Useable
- "U" have to develop trust

Reliant's interfaces – Data whenever/wherever



Changed workflows to help InBasket

- Guidelines integrated into EHR so staff can do work/ordering without asking physician
- Teambuilding to develop trust to reduce need for “FYIs to CYA”
- Policies/flags so staff can help manage test results
- Automatically display relevant data so MAs stage medication renewals with appropriate number of refills
- Reduced consult notes that auto-route to PCP
- Changed routing of many notes from outside organizations (ERs, Hospitals) to the PCP’s nurse

Easy for right person to do the right thing

- Alerts present correct order or reminders about tests already ordered based on age, gender, payer, diagnoses, meds, and existing results/future orders
- 1-Click radiology orders: correct test/indication are faster to select with fewer errors/rework
- Alerts to appointment secretary 3 days after hospital discharge if no follow-up appointment
- Alerts to Anticoag Clinic if antibiotic prescribed
- Radiologist “ALRT” macro automatically adds patient to Incidental Finding Registry for tracking by staff to ensure proper follow-up

Have the right “person” do documentation

In order of preference:

1. The computer (last note, history, results, keyboard macros)
2. The patient (patient portal or waiting room tablet)
3. The nurse triaging problem on phone
4. The medical assistant that rooms patient
5. The doctor assisted by speech recognition
6. The doctor assisted by transcriptionist
7. The doctor typing
8. A scribe typing

Clinician involvement in EHR implementation

- 4 physicians (still see patients 20-60%), 1 PA and 1 MA are integrated into EHR implementation and optimization team which is run by a nurse
- Most are Epic Certified Analysts and attend EHR user group meetings twice a year to provide vendor feedback, learn best practices and what's coming
- 2 MDs are Caché programmers (Epic provides the source code and a development studio for free)
- Additional physician and clinical staff "superusers" help with training and optimizing their colleagues (along with other dedicated trainers and optimizers)

Clinician involvement in EHR implementation

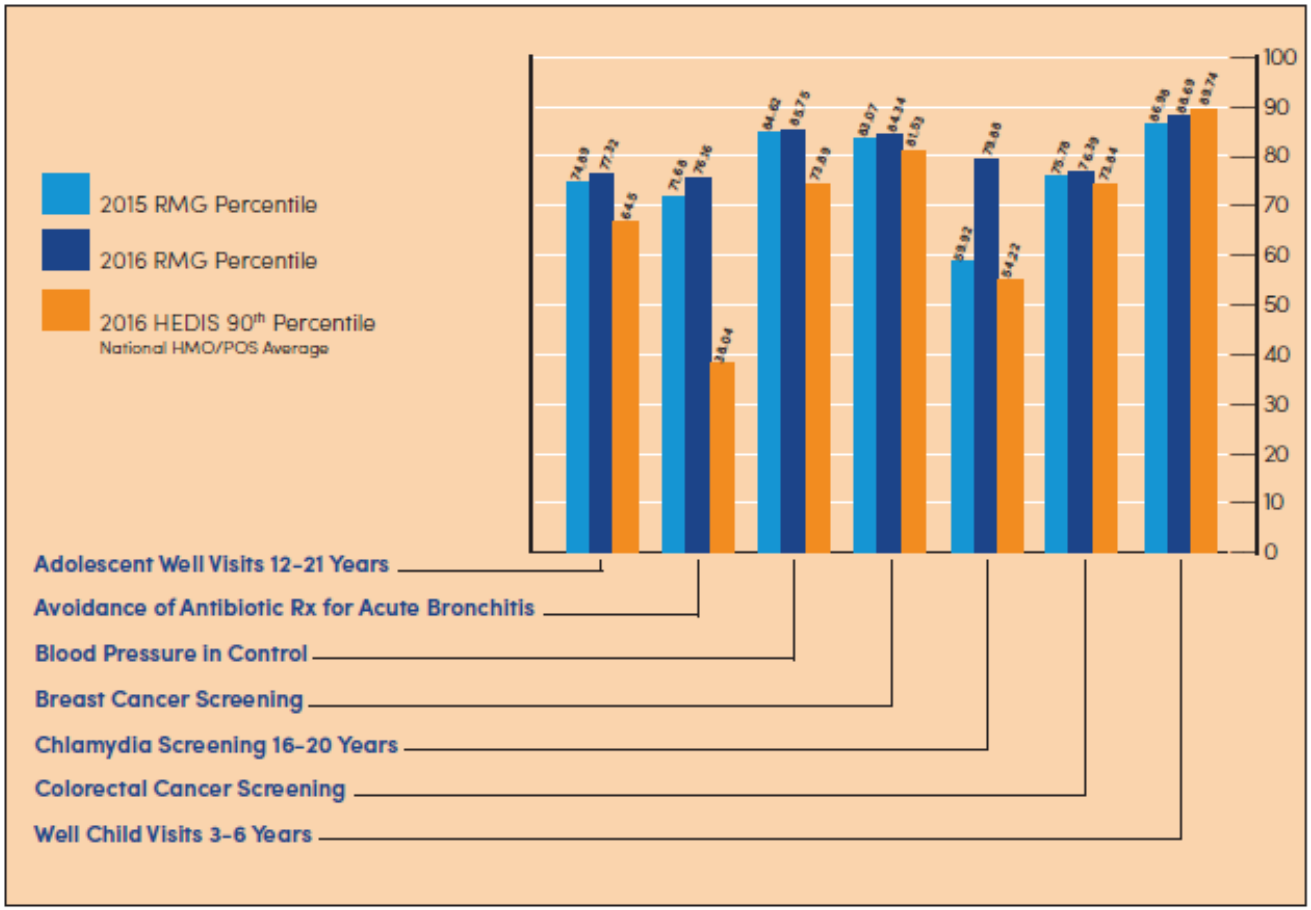
- Any physician or clinical staff can easily submit issues or ideas by phone, email, or through EHR
- Fixes/enhancements are implemented daily, weekly, or monthly depending on priority
- IT clinicians and optimization team drive solution-brainstorming and prioritization every day
- A multidisciplinary (degree/role, specialty, location) EHR Governance Council meets a few times a year for most controversial decisions

Outcomes…

Reliant's implementation/use of their EHR ranks in the top 3% of the country for physician EHR satisfaction!

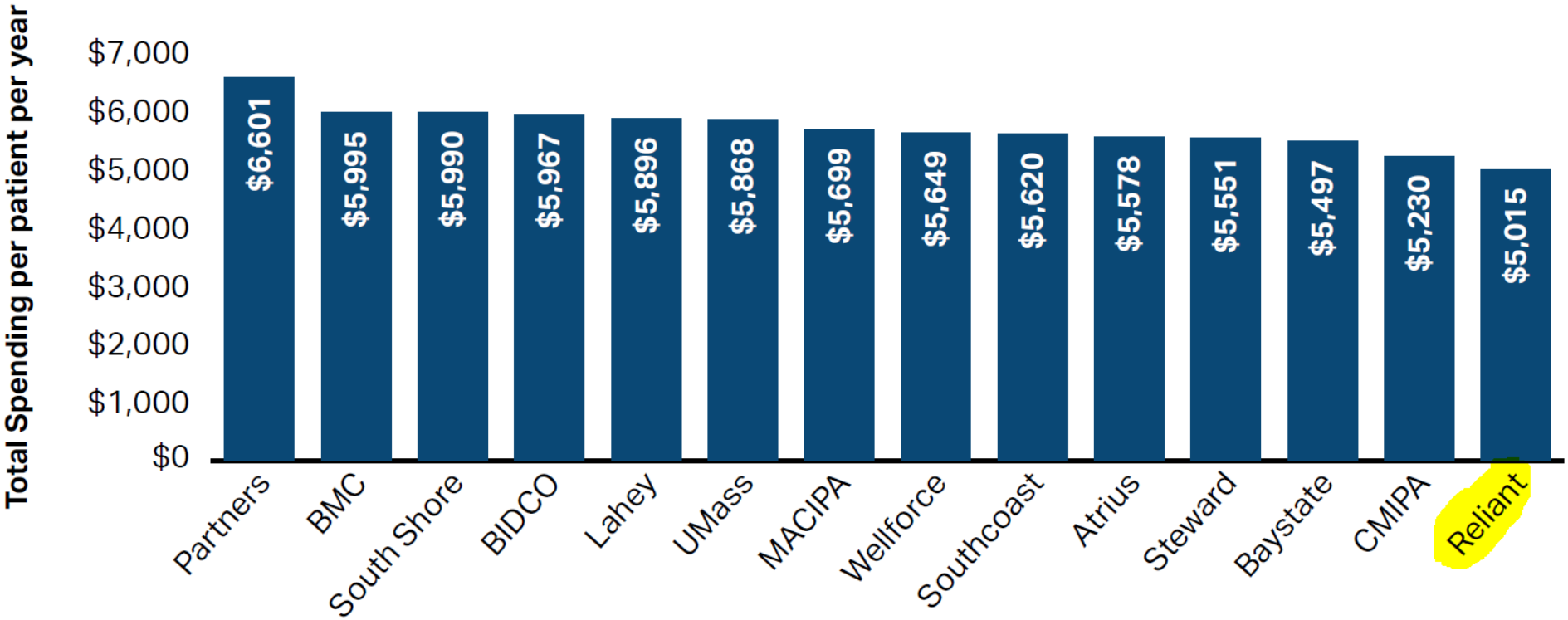
Press-Ganey 2016 EHR Usability Score	Reliant's EHR
Score (scale of 0-4)	2.96
Reliant's National Percentile	**97%**

90th Percentile for 90% of Quality Measures



***Note**: Data includes all capitated payers (BCBS, FCHP, HPHC & Tufts) and all products (Commercial, Medicaid, & Medicare) and is benchmarked against the HEDIS 2016 90th percentile National HMO/POS Average. The benchmark data is taken from the NCQA Quality Compass 2016.*

Lowest Total Cost of Care in Massachusetts



Source: Massachusetts Health Policy Commission – March 1, 2018

Can everyone be like Reliant?

- Larger organizations
  - ✓Do they have a highly-configurable EHR?
  - ✓Do they dedicate/train total of 1 clinician FTE (that still sees patients 20-60% of the time) per 100 providers?
  - ✓Do they delegate decision making to these clinicians?
  - ✓Have they earned the trust of their physicians?
- Smaller practices
  - ✓Do they have a highly-configurable EHR?
  - x Can't get value out of a 0.1 FTE MD in 10-MD practice
  - x Implementers are vendors who aren't incentivized to proactively optimize physicians

How do we support the small practices?

- Need clinicians whose job is to proactively optimize small physician practices
- 2009 HITECH Act empowered ONC to create 60 “Regional Extension Centers” for every state
  - To implement EHRs to meet “Meaningful Use”
  - Not measured on effective optimization
- Possible solutions:
  - EHR vendors incentivized to optimize practices
  - HIT industry consultants use more clinicians
  - Public funding for optimization to help with this crisis

How do we do better than Reliant? 6 Key stakeholder engagements

1. **Health Plans, Insurers, and the NCQA:**
   - Streamline/reduce Prior Authorization processes
   - Reduce measurement requirements that do not directly address patient care

2. **State and Federal Agencies:**
   - Eliminate physician documentation/measurement requirements that do not directly address patient care
   - Require EHRs to make mandated quality measurements easily extractable

3. **Medical Schools and Residency Programs:**
   - Actively support self-care
   - Provide and support counseling services for trainees and ensure adequate staffing of counseling services during off hours with positive role-models

Key Stakeholder Engagements

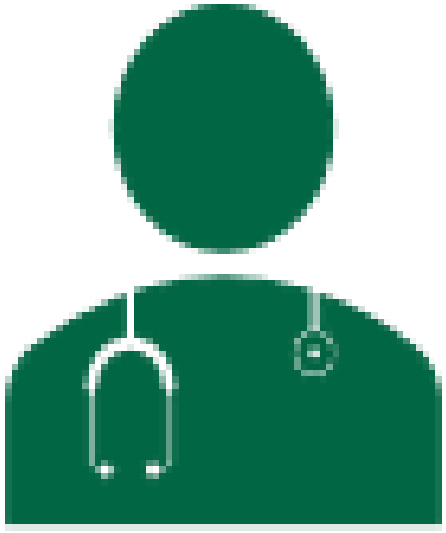
4. **EHR Vendors:**
   - Collaborate with physicians to implement stronger usability measures, meet quality measures, and assure interoperability

5. **Hospitals, Health Systems and Provider Organizations:**
   - Hire and fully support the position of a physician executive leader focused on wellness such as a Chief Wellness Officer

6. **Board of Registration in Medicine**:
   - Cooperate with and adopt FSMB recommendations and, in doing so, help reduce the stigma of seeking and receiving self-care and treatment among physicians

Patient Centered Care –
Get back to the Joy of Medicine “the Patient”

Thank you!



- achaoui@mms.org
- LGarber@massmed.org