In Search of Joy in Practice

University of Texas
9.25.17
9:45-10:15a
Christine A. Sinsky, MD, FACP
Vice President, Professional Satisfaction
American Medical Association
Agenda

• Introduction: Dark before light, solvable
• Research
• Solutions
• Also
  – Panel 1-1:45p
  – Discussion 4-5p
Quadruple Aim
Care of the Pt: Care of Provider

Take-away

Ann Fam Med 2014
Two Doctors and a Patient
“Working in clinic has become so painful that I have decided to leave some of my beloved patients—unbearable to think about.”

Gail M Sullivan, MD
Speaking of performance measures: The little things have become the big things—I fear our roles as healers, comforters, and listeners are being lost.”

2008

Ben Crocker, MD
On a recent visit to a new doctor I believe we made eye contact twice—upon her arriving and leaving.

And yet, I am much more able to receive advice

From people I feel are thinking of me as a person

rather than just

the next patient.

Over $\frac{1}{2}$ of MDs Burned Out
Physician Burnout Rising

45→54%

*Twice gen’t pop: controlled for hrs worked educational level, age, gender, relationship status

Also impacts NPs, PAs, RNs, MAs
Burnout affects Patients

Physician burnout is associated with…

- ↑ Mistakes (200% ↑ odds of error)
- ↓ Adherence
- Less empathy
- ↓ Patient satisfaction

Burnout Costs Organizations

Physician burnout is associated with…

- ↑ Malpractice risk*
- ↑ Part time
- ↓ Productivity
- ↑ MD and staff turnover

*Physician stress reduction has the potential to reduce malpractice claims by two-thirds ($400K per claim) Social science & medicine (1982). 2001;52(2):215-222.
Burnout Costs Organizations

6000 MDs
• 50% burned out
• 150 will leave due to burnout
• ($500K/MD replacement)

~ $75 M

(doesn’t include cost due to ↓ Q, Safety, Satisfaction)
Shanafelt et al JAMA IM 2017
The Business Case for Investing in Physician Well-being

Tait Shanafelt, MD; Joel Goh, PhD; Christine Sinsky, MD

**IMPORTANCE** Widespread burnout among physicians has been recognized for more than 2 decades. Extensive evidence indicates that physician burnout has important personal and professional consequences.

**OBSERVATIONS** A lack of awareness regarding the economic costs of physician burnout and uncertainty regarding what organizations can do to address the problem have been barriers to many organizations taking action. Although there is a strong moral and ethical case for organizations to address physician burnout, financial principles (e.g., return on investment) can also be applied to determine the economic cost of burnout and guide appropriate investment to address the problem. The business case to address physician burnout is multifaceted and includes costs associated with turnover, lost revenue associated with decreased productivity, as well as financial risk and threats to the organization’s long-term viability due to the relationship between burnout and lower quality of care, decreased patient satisfaction, and problems with patient safety. Nearly all US health care organizations have used similar evidence to justify their investments in safety and quality. Herein, we provide conservative formulas based on readily available organizational characteristics to determine the financial return on organizational investments to reduce physician burnout. A model outlining the steps of the typical organization’s journey to address this issue is presented. Critical ingredients to making progress include prioritization by leadership, physician involvement, organizational science/learning, metrics, structured interventions, open communication, and promoting culture change at the work unit, leader, and organization level.

Shanafelt, JAMA IM 2017
40 medical school classes

Burnout Costs Workforce

2% MDs “plan to leave medicine in next 2 years”

- Burnout is major driver
- 5000 MDs lost to another career in 2 years (excludes retirement)

Sinsky, MCP 2017, in press
Physician burnout is associated with…

- ↑ Disruptive behavior
- ↑ Divorce
- ↑ Disease (CAD)
- ↑ Drug abuse
- ↑ Death (Suicide 2-4 x)
The Widespread Problem of Doctor Burnout

1 in 2 US physicians burned out implies origins are rooted in the environment and care delivery system rather than in the personal characteristics of a few susceptible individuals.
Occupationally-induced syndrome

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 Blike, MD

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

Objective: To describe how physician time is spent in ambulatory practice.

their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9% 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 after-hours work each night, devoted mostly to EHR tasks.

- 50% day EHR/desk
- 1 hr F2F: 2 hr EHR
- 1-2 hr EHR at night
“Pajama Time”
Sat nights belong to Epic

EHR Usage Frequency by Time of Day

Arndt AFM 2017
http://www.annfammed.org/content/15/5/419.full
In Search of Joy in Practice
Co-Investigators

• Christine Sinsky- PI
• Tom Bodenheimer-PI
• Rachel Willard
• Tom Sinsky
• Andrew Schutzbank
• David Margolius
In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Christine A. Sinsky, MD
Rachel Willard-Grace, MPH
Andrew M. Schutzbank, MD
Thomas A. Sinsky, MD
David Margolius, MD
Thomas A. Bodenheimer, MD

1Medical Associates Clinic and Health Plans, Dubuque, Iowa
2Center for Excellence in Primary Care, University of California, San Francisco, California
3Beth Israel Deaconess Medical Center, Boston, Massachusetts
4Iora Health, Cambridge, Massachusetts

ABSTRACT
We wanted to gather innovations from high-functioning primary care practices that we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing family practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life’s vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.
Save 3-5 hours/day

- Practice Re-engineering
  - Pre-visit lab ½ hr
  - Prescription mgt ½ hr
  - Expanded rooming/discharge 1 hr
  - Optimize physical space 1 hr
  - Team documentation 1-2 hr

3+ hr/d
Same day pre-visit lab (15 min)
ThedaCare
Pre-visit Labs

• 89% ↓ phone calls (p<0.001)
• 85% ↓ letters (p<0.0001)
• 61% ↓ additional visits (p<0.001)
• ↑ patient satisfaction
• Saved $26/visit

Annual Prescription Renewals

- “90 + 4”
- Physician time
  - 0.5 hr/d
- Nursing time
  - 1 hr/d per physician
- 40 million PC visits/yr
  - 200,000 PCPs x 220d/yr x 1 visit/d
I used to be a doctor. Now I am a typist.

Personal communication. Beth Kohnen, MD, internist Fairbanks, AK 8.3.11
The Doctor. 1891 Fildes

Undivided attention
Continuous partial attention
Team Documentation
Cleveland Clinic

• New Model
  – 2 MA: 1 MD
  – 2 pt/d cover cost
  – 21 → 28 visits/d
  – 30% ↑ revenue
  – Spread to others (35)
  – We’re having FUN

• Research
  – Q doc as good or better J Fam Pract 2016
UCLA: saves 3 hr/d  Pt satisfaction w/MD time ↑
JAMA IM 2014
Q: ↑ immun, CA, DM
E: ↑ productivity
↓ staff cost /wRVU
↓ cycle time 90” -> 45”
S: ↑ pt, MD. MA satisf.
University of Colorado: FM Residents’ Clinic

**PGY1**: 1 MA, rooming support (PFSH, care gaps, med rec, agenda setting)

**PGY2**: 2 MAs, + initial HPI

**PGY 3**: + team documentation
University of Colorado: Faculty

Burnout rates cut in half in 6mo,

In one yr: 53% → 13%
Fairview: Filtering Inbox

Reduce “backpack” 90min/d to few min

JAMA IM 3/2016
PCP: 77 inbox messages/d
Fairview: Filtering Inbox

Reduce “backpack” 90min/d to few min

Line of Sight
Semi-circular desk, APF
RFID Sign On
“Tap and Go”

• Dean Clinic
  – 102 signs to 2 sign ins per day
  – Saved 17 min/d

Happiness minutes
60 hours/yr
Flow station at North Shore Physicians Group

HP: Saves 30 min/day/physician
Printer in every room University of Utah Redstone

HP: Saves 20 min/day/physician
Action Steps: Institutions

Be Bold
Measure Developers: Meaningful and Manageable

Less is More

Keep it simple, add it up

3hr/d staff/MD time per MD on PMs

Regulators

Align with Team-based Care
Avoid Compliance Creep

Ex: MU CPOE
Eliminate 1 billion clicks/day

32 clicks for flu shot
Action Step

Research

Tests

Treatment

>$100 Billion/yr

<$0.3 Billion/yr

Delivery model
to wisely deploy
Redesign your practice. Reignite your purpose.
AMA's Practice Improvement Strategies.

Module Categories

- **Patient Care**
  - 11 Modules

- **Workflow and Process**
  - 12 Modules

- **Leading Change**
  - 4 Modules

- **Professional Well-Being**
  - 3 Modules

- **Technology and Finance**
  - 5 Modules

Looking for modules?
Try our Practice Assessment tool.
Start Assessment
Team Documentation

Watch case study
Team Documentation
Quadruple Aim
Care of the Pt: Care of Provider

- Better Outcomes
- Lower Costs
- Improved Patient Experience
- Clinician Wellness

4th Aim

Ann Fam Med 2014
What patients want is that deep relationship with a healer;

this is the foundation upon which we need to build healthcare.

Paul Grundy, MD
IBM, PCPCC
personal communication
1.30.09
“Medical care must be provided with utmost efficiency. To do less is a disservice to those we treat, and an injustice to those we might have treated.”

Sir William Osler, 1893