

Addressing the Key Drivers of Burnout: Transforming Ambulatory Practice.

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Agenda

Burnout – quantity and quality of work

Teams

- Can reduce quantity of work
- Can improve quality of work

Teams in specialty care

- **Neurology**
- **Orthopedics**

Teams in primary care

Burnout and quantity of work

45% of physicians work more than 60 hours per week compared with fewer than 10% of workers in other fields. Reducing professional work hours can help physicians recover from burnout.

- Shanafelt and Noseworthy, Executive leadership and physician well-being. Mayo Clinic Proc 2017;92:129-146

At Mayo Clinic, burnout and declining satisfaction was associated with physicians reducing their work hours.

- Shanafelt et al. Longitudinal study evaluating the association between physician burnout and changes in professional work effort. Mayo Clinic Proc 2016;91:422-431

Burnout and quantity of work

Mid-career physicians work more hours and have more night call than early or late career physicians. Mid-career physicians have higher emotional exhaustion and burnout than early or late career physicians

- Dyrbye et al, Physician satisfaction and burnout at different career stages. Mayo Clin Proc 2013;88:1358-1367.

One source of burnout is too much work pressure and not enough time with each patient

- RAND/AMA Factors Affecting Physician Professional Satisfaction 2013

However it's not just quantity. Adjusting for hours worked, burnout among physicians is more common than among the general population. Also, burnout increased from 2011 to 2014 despite no increase in hours worked.

- Shanafelt et al. Mayo Clin Proc 2015;90:1600-1613

Burnout and quality of work

Major study of 30 practices in 6 states, including Texas, primary care and specialty:
interviews with 220 physicians and staff plus survey of 447 physicians

Main sources of dissatisfaction were:

Obstacles to providing
high-quality care

EMR: unproductive time
spent and interference with
physician-patient
relationship

Autonomy/control over
work – burdensome
external regulations

Doing work that support
staff could do

RAND/AMA Factors Affecting Physician Professional Satisfaction 2013

Burnout and quality of work

Direct observation of 57 physicians in family medicine, internal medicine, cardiology and orthopedics in 4 states

27% of practice time was face time with patients. 37% of face time with patients was spent on EMR and desk work. Thus true face time with patients was 17% of the physicians' day

1 – 2 hours of after-hours work on EMR tasks

Sinsky et al. Ann Intern Med 2016;165:753-760

Burnout and the interaction between quantity and quality of work

2011 national survey of physicians with 1289 respondents (65% response rate). 40% primary care, 60% specialists. Tak HJ et al, JGIM 2017;32:739-746

Divides physician work into personally-rewarding hours (increases career and life satisfaction) and unfulfilling hours (increases burnout)

Satisfaction increases as meaningful hours increase, but only up to 7.5 hours per day

More than 7.5 meaningful hours per day leads to burnout increasing

Therefore, quality of work is important up to a point, but then too much quantity of work takes over and burnout goes up

Addressing burnout: reducing quantity of work

Medical home pilot at Group Health in Seattle

- Reid et al. Am J Managed Care 2009;15(9):e71-87.

Panel size was reduced from 2300 to 1800

Visit length was increased from 20 - 30 minutes

Physician burnout dropped from 25% to 14% in medical home pilot clinics

Burnout in control clinics grew from 28% to 35%

The Group Health medical home pilot was not financially sustainable due to reduced productivity per physician

Burnout and teams

High-performing teams can both reduce the quantity and increase the quality of physician work

Working with adequate numbers of well-trained, trusted, and capable allied health professionals and support staff was a key contributor to greater physician satisfaction.

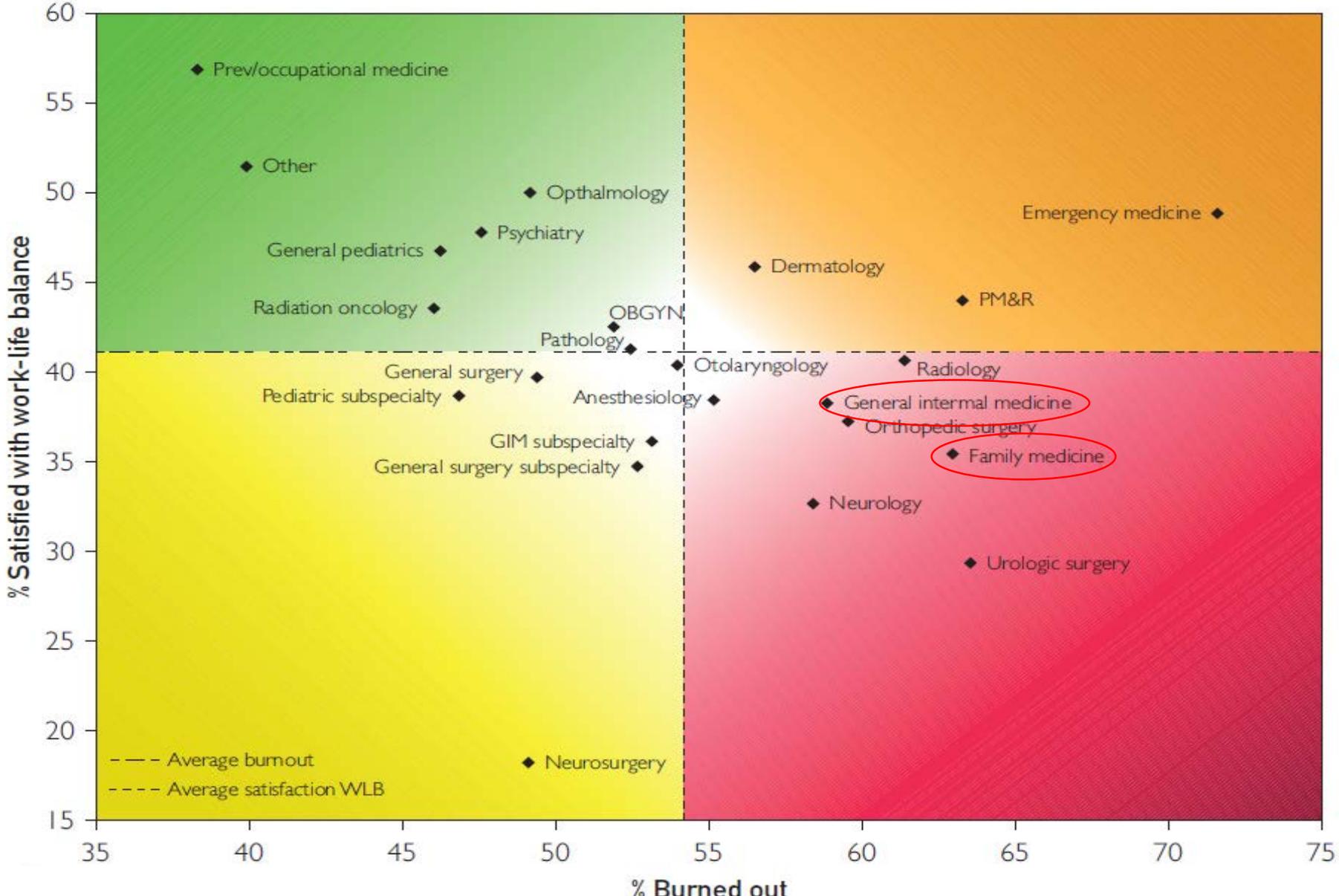
- RAND/AMA Factors Affecting Physician Professional Satisfaction 2013

Team burnout (PCPs, nurse care managers, MAs, front desk personnel) in VA primary care clinics dropped by 30% if 1) the team was fully staffed, 2) there was no turnover on the team, and 3) the team was not overpaneled

- Helfrich et al, JGIM 2017;32:760-766

Burnout and teams in specialty care

Shanafelt et al. Mayo Clin Proc 2015;90:1600-1613



Burnout among neurologists

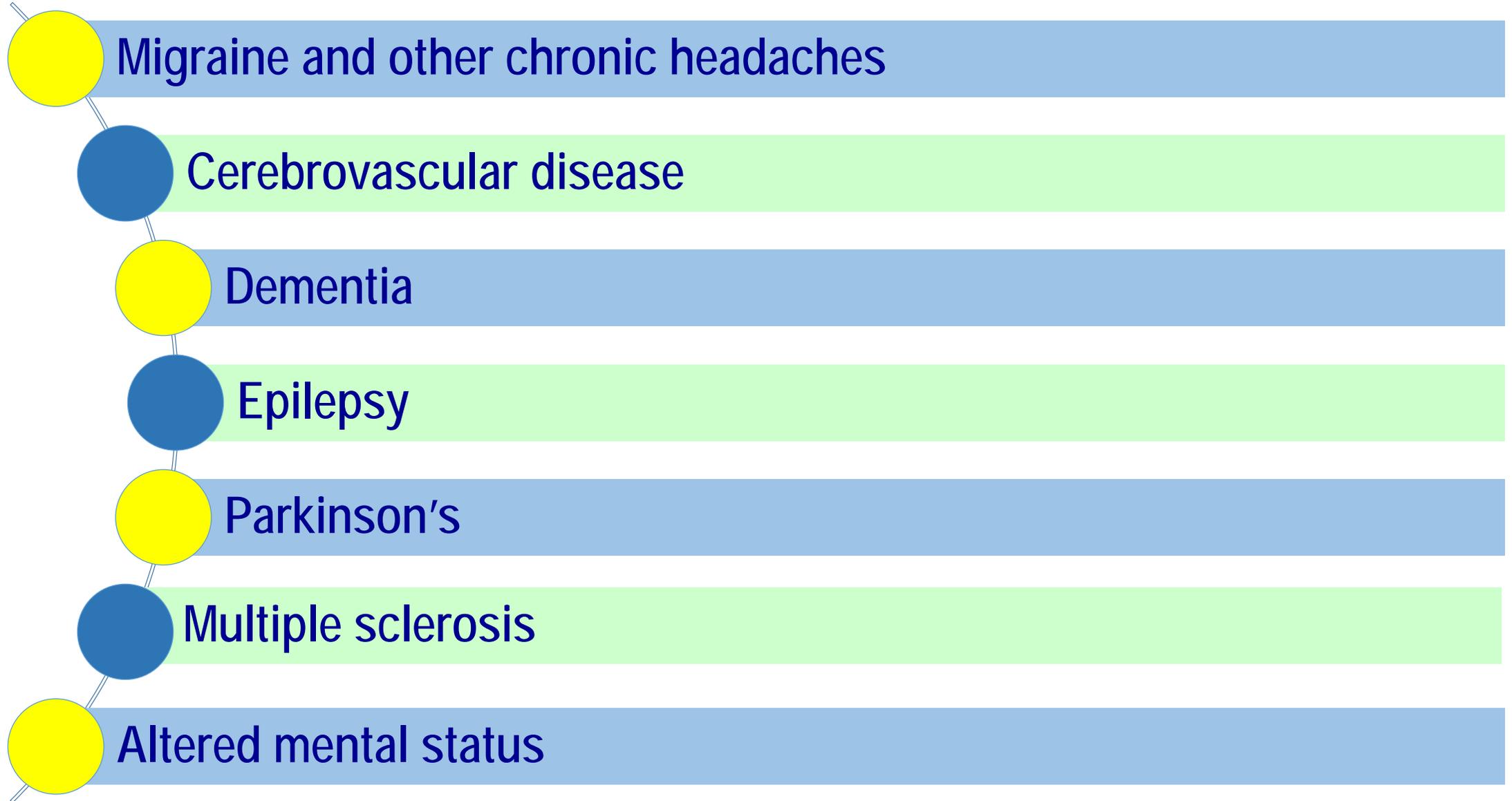
Over half of neurologists report at least one symptom of burnout.

Some remedies:

- Identify and eliminate meaningless hassle factors such as EMR clicks and insurance mandates
- Redesign practice to remove pressure to see patients in limited time slots and **shift to team based care**

Sigsbee and Bernat, Physician burnout: a neurologic crisis.
Neurology 2014;83:2302-2306

Common adult neurologic disorders: a challenging list



Teams for chronic headaches, stroke, and chronic progressive neurologic disease

Headache

- PT, OT, behaviorist: team care improves pain, quality of life, depression. Sahai-Srivastava S et al. Headache July 25, 2017 epub

Stroke

- Teams of PT, OT, speech therapy, social worker, starting in hospital and continuing at home, reduce hospital days and increase likelihood of regaining independence. Walker et al. Stroke 2013;44:293-297

Many patients die after long neurologic illness with neurologist the principal or consulting physician

- Only 8% of neurology residencies provide a clinical rotation on palliative care.
- Team: palliative care specialist, RN care manager, social worker, family counselor with spiritual training, pharmacist. Boersma et al. Neurology 2014;83:561-567.

Burnout among orthopedists

Orthopedic burnout rates in range of 50–60%, higher than surgeons in general

Burnout related to quantity and quality of work

- Quantity: excessive hours, work overwhelming
- Quality: lack of autonomy, feeling that career is unrewarding

Arora M et al. Burnout in orthopedic surgeons: a review. ANZ J Surg 2013;83:512-515

Teams in spine care: Virginia Mason Spine Center in Seattle

All patients initially seen by PT and physiatrist

If they can't solve the problem, referral to neurologist if diagnostic problem, orthopedist or neurosurgeon if surgery indicated, anesthesiologist if pain issue

Patients lose 4.3 days of work per episode compared with community average of 9 days per episode

Use of MRI scans decreased by 23% when Spine Center was started

Burnout not measured as a quality measure

Porter and Lee, Harvard Business Review, October 2013; Virginia Mason Spine Center website

Teams in primary care -- context

Only 5% of the healthcare dollar goes to primary care

Many patients have trouble accessing primary care

Panel sizes are too large for primary care physicians to manage

Worsening shortage of adult primary care physicians means that panel size may increase, not decrease

Larger panels means poorer access for patients and more physician burnout, causing physicians to reduce their work hours

It could be a downward spiral

Panel sizes are too large for primary care physicians to manage

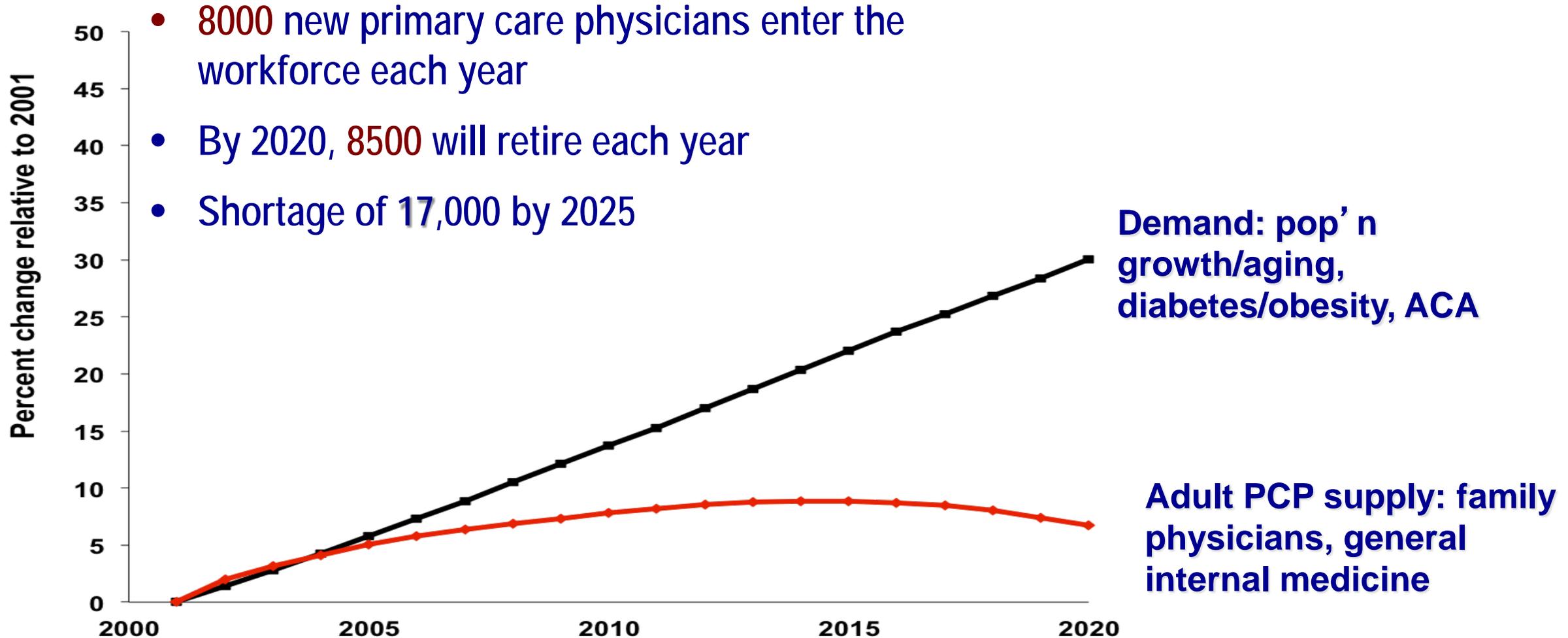
Average panel size in US: 2300

Primary care physicians with panel of 2500 average patients would spend 7.4 hours/day doing recommended preventive care and 10.6 hours for chronic care. Total 18 hours/day

Yarnall et al. Am J Public Health 2003;93:635; Ostbye et al. Annals of Fam Med 2005;3:209



Worsening primary care shortage



Colwill et al., Health Affairs, 2008:w232
Petterson et al, Ann Fam Med 2015;13:107

To reduce burnout in primary care, teams are necessary

With overly large panels, there is too much work

Some is unnecessary work, but much is necessary work

The only solution is teams that

- Reduce quantity of work
- Increase quality of work



Team intervention reduces burnout in primary care

135 primary care clinicians at 32 clinics, cluster randomized trial

Interventions: teams to reduce quantity and increase quality of physician work

- Transferring responsibilities to nonphysician staff
- Medical assistants enter patient data into EMR
- Consistently pairing MAs and clinicians
- Clerks instead of clinicians doing administrative tasks

Burnout dropped from 41% to 34% for clinicians in intervention sites, and increased from 30% to 33% for clinicians in control sites

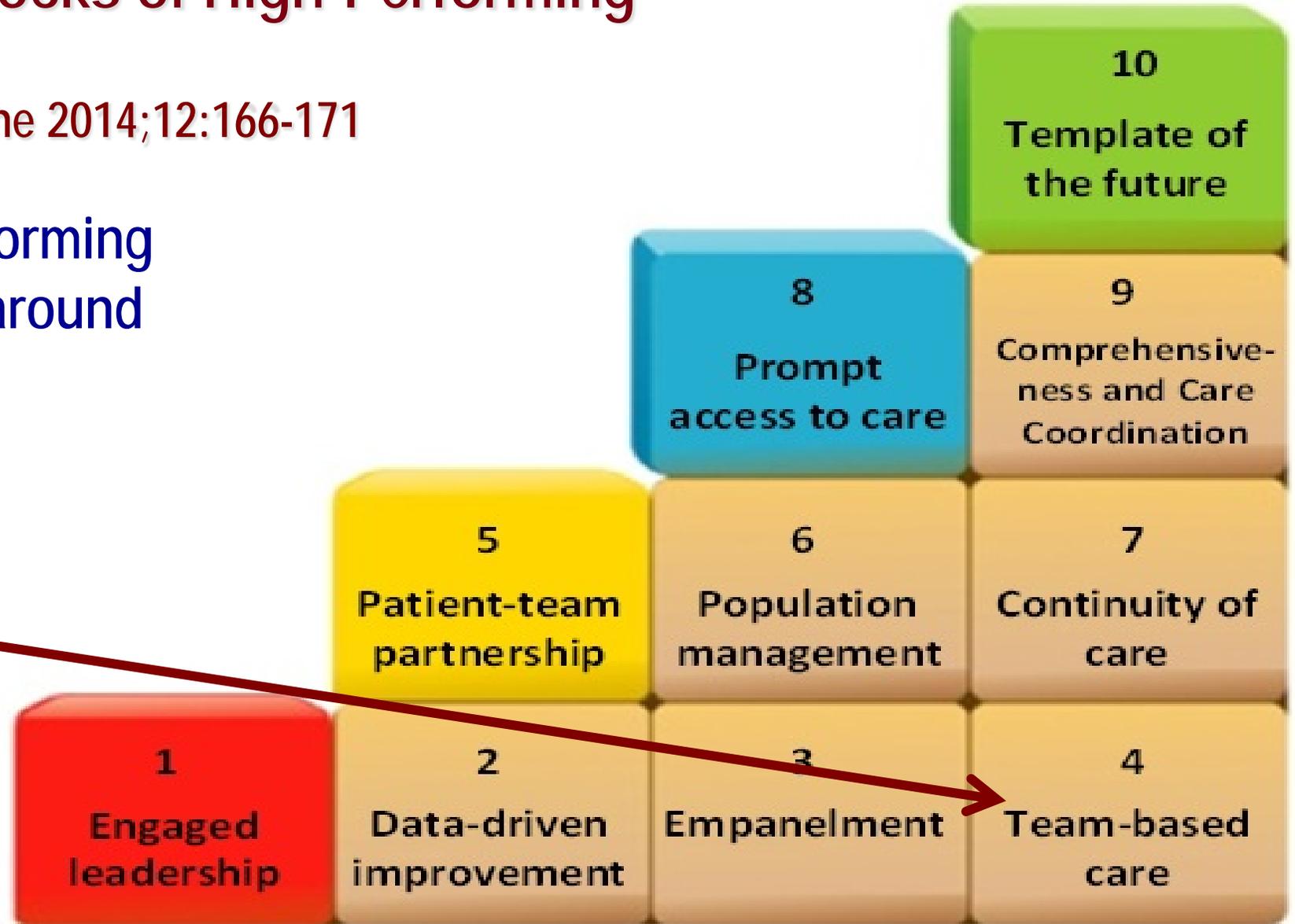
Linzer M et al. JGIM 2015;30:1105-1111

The 10 Building Blocks of High-Performing Primary Care

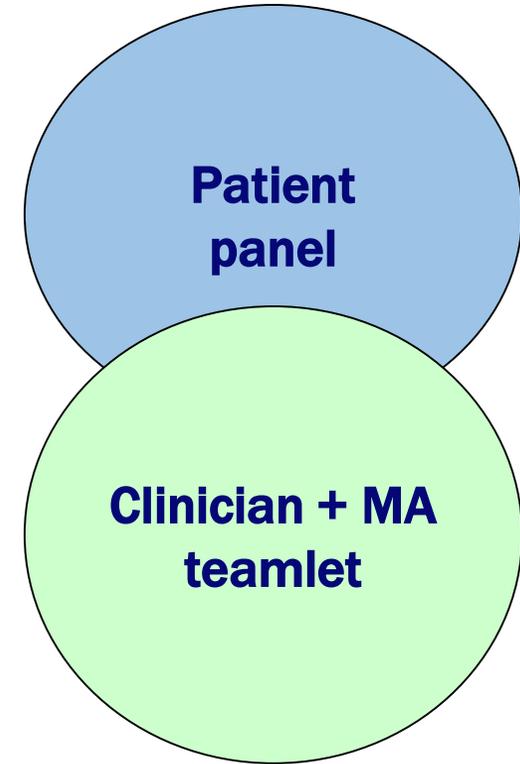
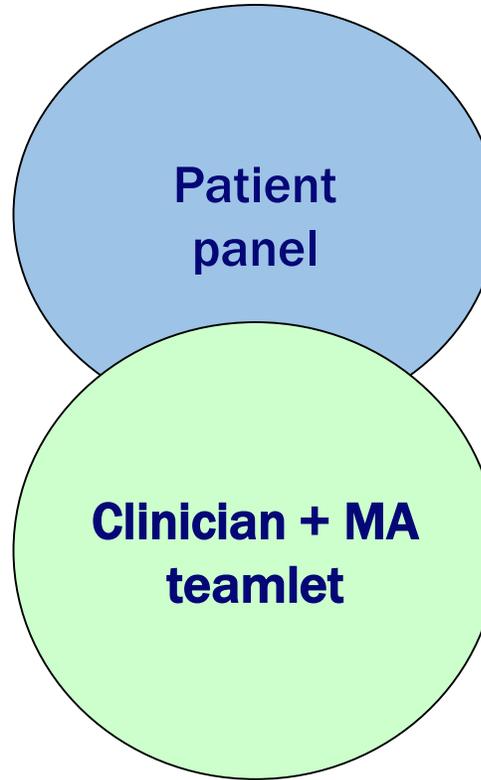
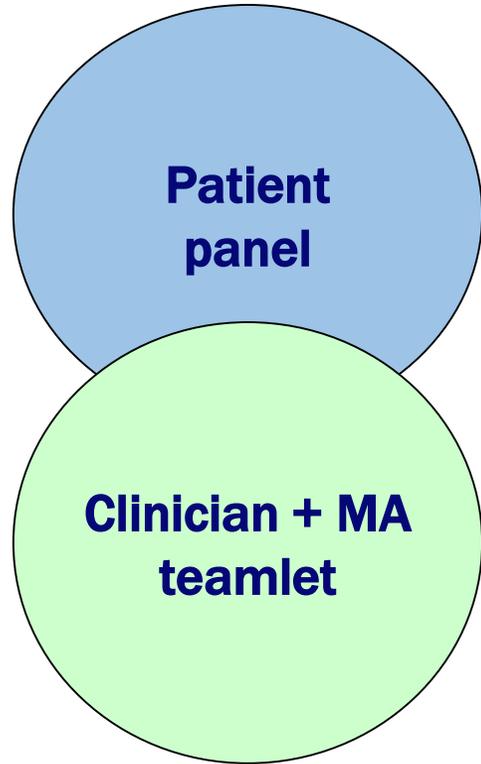
Annals of Family Medicine 2014;12:166-171

Visits to 23 high-performing primary care clinics around the country

Teams



Common structure of team-based primary care



RN, behavioral health professional, social worker, pharmacist, complex care manager

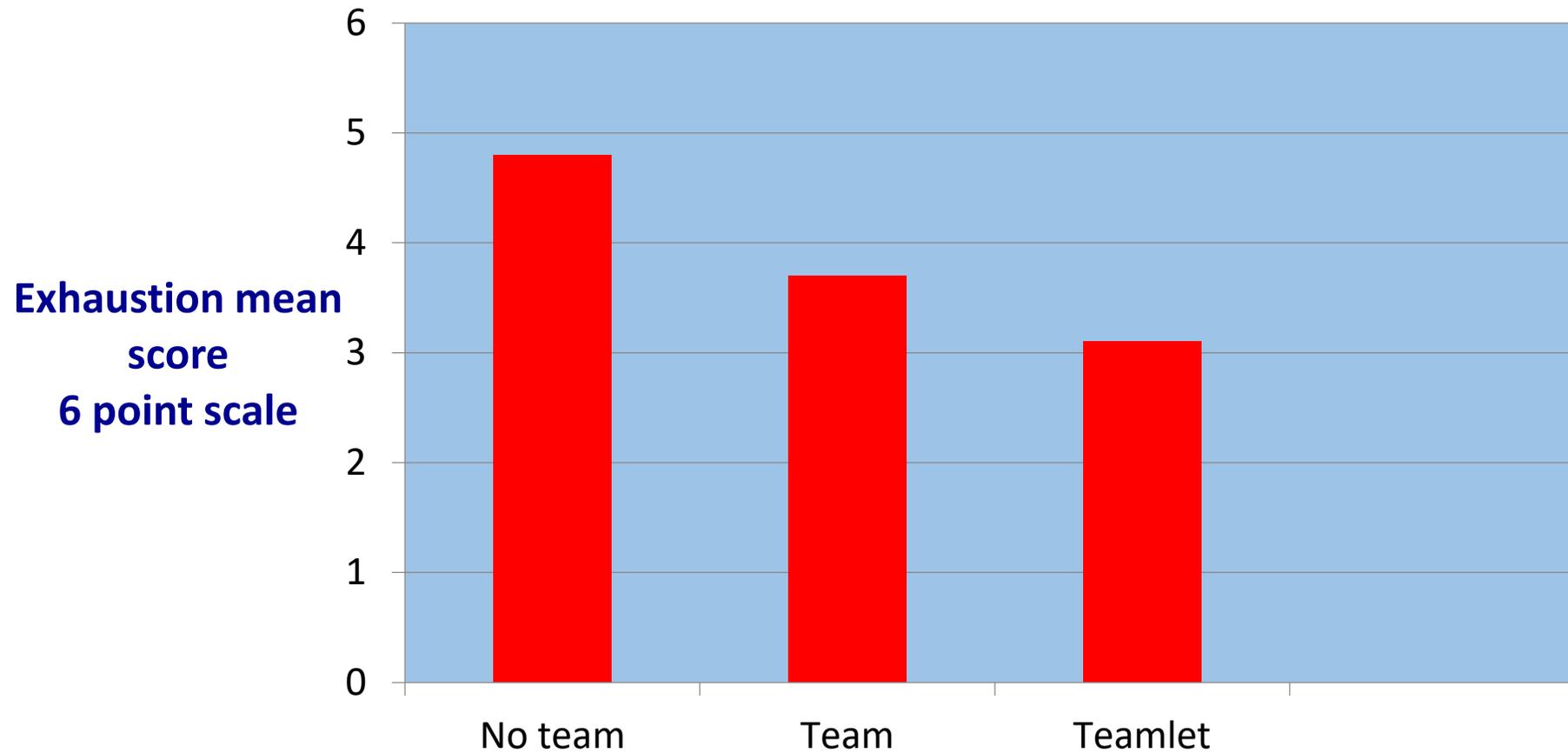
1 team, 3 teamlets

High-performing teamlets



Burnout and high-performing teams

Team structure and emotional exhaustion using the Maslach Burnout Inventory
2012 survey of 231 clinicians in 16 primary care clinics.



High-performing teams share the care

Sharing the care is not simply delegating tasks to non-physician team members

It is sharing the responsibility for the health of the team's patient panel with all team members

For example, medical assistants are responsible to make sure that patients on their panel have all their preventive and chronic care routine tasks performed in a timely manner (e.g. immunizations, cancer screenings, diabetes labs).

Reducing burnout by improving primary care access

Patients demanding prompt access is a major primary care stressor

Good patient access requires demand = capacity

Many practices have a demand-capacity gap

Demand for 1 practitioner = panel size x visits/patient/year

For the average US practice, that is $2000 \times 3 = 6000$ visits per year

Capacity for 1 practitioner is visits per day x days per year

If a practitioner works 200 days/year and sees 20 patients/day, capacity = 4000

$6000 - 4000 = \text{demand/capacity gap} = 2000$

How do we close that gap?

Demand, capacity, and access: closing the gap

Have practitioners work more days per year, from 200 to 250

Now, capacity is $250 \text{ days} \times 20 \text{ visits per day} = 5000$.

Demand capacity gap is $6000 - 5000 = 1000$

Then have practitioners see more patients per day, from 20 to 24

Now, capacity is $250 \times 24 = 6000$

Demand-capacity gap is 0. Did you solve the problem?

Burnout!!

You reduced your demand-capacity gap to 0, but your practitioners all quit so now you have no capacity



Closing the demand-capacity gap by sharing the care with non-practitioner professionals

Assume panel of 2000,
creating 6000 visits/year

- 1000 visits by patients with diabetes
- 1000 visits by patients with hypertension
- 1000 visits for uncomplicated low-back, knee, shoulder pain

Assume RNs, pharmacists, PTs can
independently care for 2/3 of these visits
(no practitioner needed)

- Total non-practitioner visits = 2000

Each practitioner provides 4000 rather than 6000 visits/year

Demand-capacity gap closes (6000 total visits), and ideally, burnout drops because practitioner quantity of work is controlled and quality of work goes up, as practitioners share the care with other team members

Some evidence for re-allocating responsibilities



RNs: RCT of patients with diabetes and elevated BP. Patients with RN management (including initiating meds and titrating doses) 3 times more likely to reach BP goal ($p = .003$) than physician management [Denver et al, Diabetes Care 2003;26:2256]



Pharmacists: RCT of pharmacist management of hypertension (including medications) compared with usual care. At 18 months, 72% BP control for pharmacist care vs. 57% in usual care group ($p = .003$) [Margolis et al, JAMA 2013;310:46]

Some evidence for re-allocating responsibilities



Patients with uncomplicated musculoskeletal injuries who directly access physical therapists without seeing a physician have better functional outcomes, greater satisfaction, and lower health care costs. [Ojha HA et al, Physical Therapy 2014;94:14-30]



Primary care behaviorists working as depression care managers in primary care improve depression outcomes compared with physician-only care and can reduce physician visits [Unutzer and Park, Primary Care 2012;39:415]

Complex care management teams for high-need, high-cost patients in both primary and specialty care

Interdisciplinary complex care management teams with RNs, social workers, pharmacists, behaviorists, health coaches, and patient navigators can improve care and reduce costs for high-needs, high-cost patients

The team reduces the quantity, and improves the quality, of physician work by assuming responsibility for patient/family education, day-to-day follow-up and psychosocial support

Bodenheimer T, Berry-Millett R. Care Management for Patients with Complex Healthcare Needs, Robert Wood Johnson Foundation, 2009; Bodenheimer T. Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs. Center for Health Care Strategies, Oct, 2013; Hong C et al. Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program? Commonwealth Fund, August 2014

Sharing the care with non-licensed personnel: health coaching

Health coaching: assisting patients develop the knowledge, skills and confidence to become informed, active participants in their care [Ghorob, Family Practice Management, May/June 2013]

In RCT, diabetic patients with MA health coaches had significant drop in A1c and LDL-cholesterol compared with controls [Willard-Grace et al, Ann Fam Med 2015;13:130]

Estimated 25-30% of chronic care activities could be performed by MA health coaches [Altschuler et al, Annals of Family Medicine 2012;10:396]



Sharing the care with non-licensed personnel: scribes

UCLA internal medicine, Reuben et al, JAMA Int Med 2014;174:1190

Pilot study of 2 scribes

75 minutes of physician time saved in each 4-hour clinic session

79% of patients satisfied

Patients more likely to report that physician spent enough time with them

Purpose of the scribes: To re-establish the physician-patient relationship that has been fractured by the EMR

Challenges to team-based care

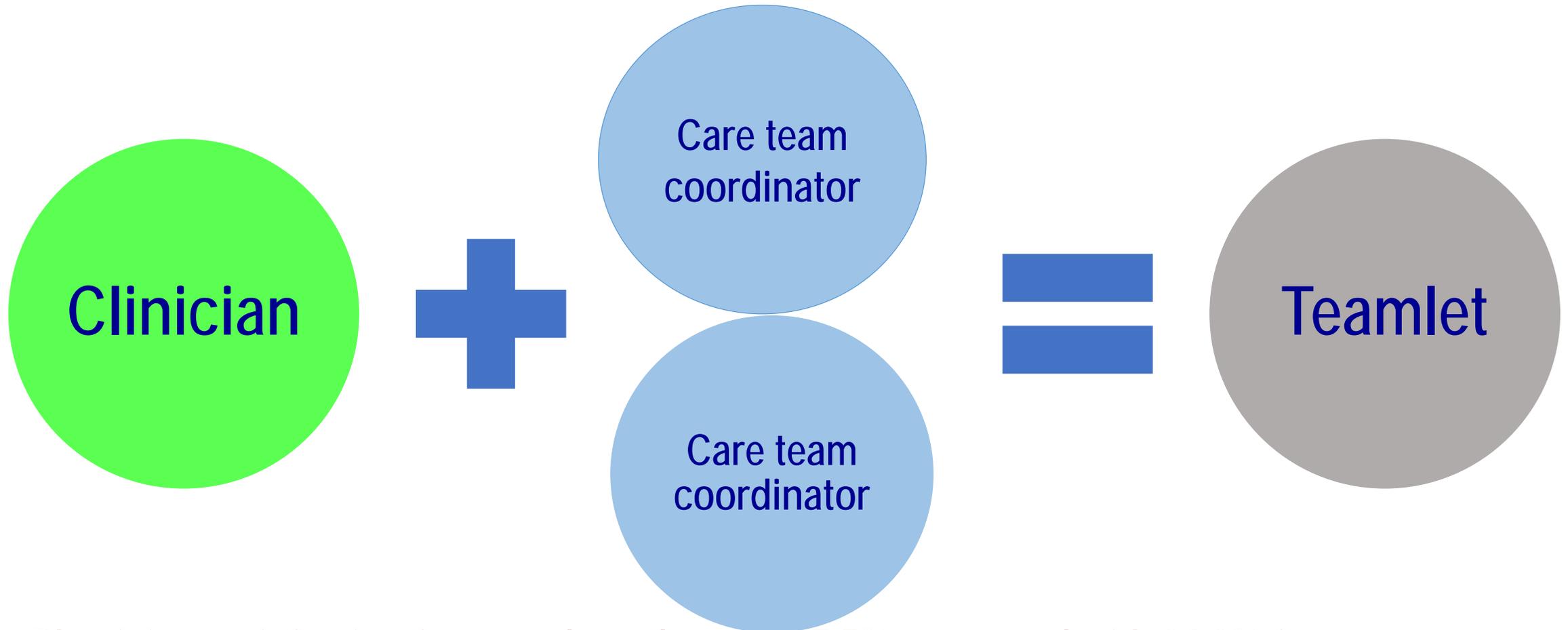
There are big challenges to building teams that reduce the quantity and increase the quality of physician work:

Motivating team members: they need to know they are truly helping patients

Teams need training and mentoring to ensure quality

There needs to be a business case for team-based care; under fee-for-service, physicians need to see a few more patients and optimize appropriate billing for themselves and all team members. Under ACO financing, the team needs to contribute to reduced hospital admissions and ED visits

Fee-for-service, financially sustainable team-based care: BellinHealth's 3-person teamlet structure



Physician satisfaction for team-based care = 87.5% compared with 34.3% for non-team-care.
The additional personnel are paid for by clinicians seeing a few more patients per day and appropriately billing for services provided

Template of the Present

Time	Primary care physician	Medical assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00	Patient A	Assist with Patient A	Triage	Patient H	Assist with Patient H
8:15	Patient B	Assist with Patient B		Patient I	Assist with Patient I
8:30	Patient C	Assist with Patient C		Patient J	Assist with Patient J
9:00	Patient D	Assist with Patient D		Patient K	Assist with Patient K
9:15	Patient E	Assist with Patient E		Patient L	Assist with Patient L
9:30	Patient F	Assist with Patient F		Patient M	Assist with Patient M
10:00	Patient G	Assist with Patient G		Patient N	Assist with Patient N

Template of the Future

Time	Primary care physician	Medical assistant 1	RN	Nurse Practitioner	Medical Assistant 2
8:00	Huddle				
8:10	E-visits and phone visits	Panel management	RN Care management	Acute Patients	
8:30					
9:00	Complex patient		RN Care management	Acute Patients	
9:30	Complex patient				
10:00	Coordinate with hospitalists and specialists	BP coaching clinic	RN Care management	E-visits and phone visits	Panel management
10:30	Huddle with RN, NP				

•30 patients are seen or contacted in the first 3 hours of the day

Take home messages

Excessive workloads (work hours, nights on-call) creates a stressful work-life balance and is a major contributor to burnout

With practitioner shortages in primary care and some specialties, the quantity of work will not improve without teams assuming responsibility for clinical functions

In both primary and specialty practices, sharing the care with a well-trained team, empowered with standing orders, can add substantial capacity and improve quality while reducing physician burnout

Teams need not only re-allocate work to reduce the quantity of physician work; they also need to relieve physicians of work that does not require a medical degree to perform

What's the opposite of burnout?

A recent editorial is entitled "What's the opposite of burnout?"

- Epstein RM. JGIM 2017;32:723-4

As Chris Sinsky and others wrote in 2013, the opposite of burnout is joy in practice

- Sinsky CA et al. In search of joy in practice. Annals of Family Medicine 2013;11:272-278

