Is your documentation method leading to burnout?

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While a variety, and combination, of factors contribute to physician burnout, it is indisputable that burnout is real, and it is increasingly pervasive in the medical community.

There is, in fact, a code for it. The ICD-10 code for burnout is Z273.0, categorized under Z273, “Problems related to life management difficulty.”

“The rising tide of burnout, coupled with its effects on quality of care and access, make burnout a major threat to the health care delivery system,” says Tait Shanafelt, MD, Program Director of the Department of Medicine Program on Physician Well-Being at Mayo Clinic. “We need to stop blaming individuals and treat physician burnout as a system issue,” he argues. “If it affects half our physicians, it is indirectly affecting half our patients.”[1]

MedScape’s 2015 Physician Lifestyle Report found an increase in physician-reported burnout from 39.8% in 2013 to 46% in 2015. [2] In MedScape’s 2017 Physician Lifestyle Report, the percentage of physicians reporting burnout increased to 51%.[3]

A survey of 579 physicians, nurse practitioners, and physician assistants by Linzer et al., published in the Journal of General Internal Medicine (JGIM)[4], reported a 67% stress rate, and a 38% average burnout rate (10%-56%, across 15 divisions). Among the factors surveyed were “EMR stress/documentation burden”; “Work-home balance” with responses citing after-hours EMR charting at home; and “Staff Support,” a lack thereof cited as leading to providers putting in up to 14-hour days due to “overwhelming clerical work.” According to JGIM web editor Neil Mehta, the survey found: “very high levels of stress and burnout with the major causes being heavy workloads and documentation requirements encroaching into personal time after hours and on weekends and limiting time for exercise and family.”[4, 5]

The Maslach Burnout Inventory (MBI) is generally accepted as the leading measure of burnout. As characterized by the MBI, “Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity... The consequences of burnout are potentially very serious for workers, their clients, and the larger institutions in which they interact.”[6]

In Special report: suicidal ideation among American surgeons, Shanafelt et al.[7] write, “Suicide is a disproportionate cause of death for US physicians.” A total of 7905 surgeons participated, with 6.3% reporting suicidal ideation (SI) during the previous 12 months. The report concluded that “[r]ecent SI among surgeons was strongly related to symptoms of depression and a surgeon's degree of burnout.”

Many more research studies and news articles about the crisis of physician burnout could be cited, but the leading question for a medical practice is obviously, what can be done to prevent or ameliorate this crisis? The burden of documentation, clerical tasks, and EHR time-

demands consistently emerge as some of the top sources of physician frustration. When physicians spend extra hours in the office and even at home performing charting for the EHR, their job description has in effect expanded to include clerical tasks that don't require their experience and specialized education. These tasks could be competently handled by others.

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"We need to stop blaming individuals and treat physician burnout as a system issue," states Tanafelt.[1] If the "system" needs to be fixed, the documentation process is surely a top contender for a paradigm change in many practices. Shifting the workflow in order to free physicians and other highly paid medical staff from data entry does not mean that a physician relinquishes control over the information entered into the patient health record. The physician and other healthcare professionals such as nurses and PAs, are after all, the experts who are ultimately responsible for documenting their encounters. But the process of getting that documentation into the EHR does not have to be the onerous burden that it is currently for so many.

In the past, transcription was the typical go-to solution for generating complete reports to include in a patient's paper file. The doctor dictated, the transcriptionist typed, the report was reviewed and signed, and a copy was printed and added to the medical record file. As EHRs have replaced paper charts, doctors have found themselves typing and navigating computer screens. The results have often been a reduction in the quality and duration of their interactions with patients, and an increase in frustration due to the perception of time spent on clerical tasks at the expense of actually practicing medicine.

If the solution is taking the clerical data entry aspect of documentation off the practitioners' plate, there are various options to consider: speech recognition, scribes, transcription, and hybrid methods. While there are pro's and cons of each, transcription is enjoying a resurgence because it's a natural, non-intrusive, and accurate way of capturing complex thoughts. Dictation has been shown to be 2.5 times faster than typing into the EHR.[8] With technological advances, cloud-based AI-driven transcription is highly efficient. While it must be HIPAA-compliant, and must employ extreme security protocols, it still utilizes the tried and true process of a doctor freely dictating a complete narrative, not cognitively restricted by checkboxes and limited response choices. The difference is that transcribed dictation can now be easily reviewed and e-signed online by the doctor, and automatically entered into the appropriate sections of the EHR by the transcription service. Because the data is captured and entered electronically, it can be further used for coding and billing assistance, clinical documentation improvement, audit support, analytics, and structured reporting to satisfy government requirements such as for MIPS and MACRA.

Whatever documentation methods best fit your medical practice's workflow, they should help alleviate, not contribute to, the stress levels of your medical staff. Reducing excessive time spent by doctors on EHR data entry will positively impact the doctors, the patients, and ultimately your bottom line.

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