TMF Health Quality Institute

Reducing Administrative Burden: Refocusing on Patient Centric Care

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Table of Contents

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Introduction

Persistent efforts at health care finance and delivery system reforms over the past few decades have led to seemingly constant changes in clinical systems, leading many clinicians to feel the effects of these changes through changing administrative requirements. As the perceived balance between the benefit and burden of administrative and documentation requirements has shifted away from providing clearly apparent improvements in care quality and efficiency, many of these requirements have shifted from "useful tool" to "administrative burden." Increasing recognition of this situation, and its subsequent impact on provider burnout, has led to a variety of recent initiatives from stakeholders across the health care industry. It is hoped that programs to decrease administrative burden levied directly on providers will allow clinicians to return their primary efforts to the area where they most impact care — the direct care of patients and communities. This whitepaper examines the etiology of clinician administrative burden, efforts to systematically identify and categorize those burdens, and strategies to minimize the burden of administrative processes through patient-centric approaches to care.

Expanding Clinician Administrative Burden Associated With EHR Use

Section 4001 of the 21st Century Cures Act, passed in December 2016, calls for reducing the documentation burden on health care providers: "The Secretary of Health and Human Services, in consultation with providers of health services, health care suppliers of services, health care payers, health professional societies, health information technology developers, health care quality organizations, health care accreditation organizations, public health entities, states and other appropriate entities, shall … establish a goal with respect to the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records."[1]

While recognition of the growing challenges of administrative requirements pre-existed the 21st Century Cures Act, it is particularly significant for its legislative intent to actually begin directly addressing the challenges associated with electronic health records (EHRs). Since the passage of the Cures Act, the expanding interest in population-based care and value-based payment has moved the earlier administrative burdens of EHRs beyond simple documentation and have extended those burdens across additional aspects of patient and population care. As a result, the previously direct question of "how can we improve the processes of physician EHR documentation" has been replaced with the need for a more comprehensive and challenging question that looks beyond documentation and into the entirety of patient and population care. For the purposes of this paper, clinician administrative burden thus entails the total level of effort placed upon clinicians to carry out required administrative responsibilities existing outside of direct patient care. As described in the following sections, the sources of clinician burden are widespread.

Sources of Clinician Satisfaction and Dissatisfaction

During the summer of 2015, the American Medical Association (AMA) interviewed 38 physicians at ambulatory care practices in four states to explore sources of physician satisfaction and dissatisfaction, and the effects of administrative work on practices.[2] Table 1 outlines the major reported sources of clinician satisfaction and dissatisfaction, as well as consequences of dis-satisfiers. While this represents a relatively small sample size, it is the anecdotal experience of the authors in widespread discussions with myriad providers across the country that the results correlate with our observational experience.

Table 1: Sources of physician participants' satisfaction and dissatisfaction themes and sub-themes[2]

Sources of Satisfaction

- ***Scientific values:***
  - *Intellectual work*
  - *Assessment*
  - *Management for intended medical outcome*
- ***Humanistic values:*** *Respect, caring, compassion*

Sources of Dissatisfaction

- ***Electronic health record (EHR) and desk work, paperwork and clerical work:***
  - *Electronic health or medical records, meaningful use (MU) or EHR product*
  - *Poor usability*
  - *Patient portals (MU)*
  - *Regulatory control through technology*
- ***Payers:*** *Public payers, Medicaid and Medicare (CMS); private payers, including worker's compensation*
- ***Administration:*** *Management at the specific practice level*
- ***System:*** *External forces that are not payers or practice administration*
- ***Other:*** *Patient non-compliance and poor care by other clinician(s)*

Consequences of Dis-satisfiers

- ***Time:*** *Time, time pressure, limited time*
- ***Patient care***
  - *Care delivered below internalized professional standards*
  - *Inadequate attention to patients*
  - *Patient outcomes*
- ***Disrespect:*** *Loss of autonomy*
- ***Other:*** *Difficult, not fun, frustrating, mind-numbing*

Ultimately, and unsurprisingly, the study found that clinicians derive their greatest satisfaction from providing good medical care and taking care of patients. Major sources of dissatisfaction, however, were EHR/desk work, complexities of the payer systems and practice administrations. The time associated with the completion of these dis-satisfier tasks was perceived by the clinicians as creating artificial time pressures that detracted from patient care. Interestingly, these tasks were not only identified as dissatisfying to providers, but they also reduced the ability of providers to engage in their satisfying activities, amplifying and multiplying the overall negative impacts of these tasks on provider satisfaction in a synergistic manner.

How Administrative Burden Contributes to Clinician Burnout

Recognizing the negative internal feedback loop associated with the findings of the AMA study, it is not surprising that clinician dissatisfaction has escalated to its most severe form: provider burnout. A range of factors drives clinician burnout, including workload, time pressure, clerical burden and professional isolation.[3] 9Clerical burden, especially documentation of care and order entry, is a major historic driver of clinician burnout and has been recognized as a potential challenge since the earliest evaluations of the potential promise of EHRs. Recent studies have shown that physicians spend over 50 percent of their time completing clinical documentation,[4] while nurses similarly spend up to half their time fulfilling clinical documentation requirements and data entry for other demands, such as quality reporting and meeting accreditation

standards.[5] With the exception of improving medication safety, nurses and other clinicians report dissatisfaction with the design and cumbersome processes of electronic documentation.[6] Moreover, many clinicians devote significant amounts of time to nonclinical activities, which often carry on into afterhours.[7] Considering that the majority of current providers trained in the pre-EHR environment, primarily with dictation as their primary method of documentation, it isn't surprising that they might find the combination of checklists and typing, typified in many modern EHR interfaces, a slower and more frustrating process. While voice recognition software continues to provide promise, the continued challenges associated with both its precision and the ability to extract discrete data elements from narrative notes continues to create a challenge beyond the capabilities of most primary care physicians to resolve.

Increasingly, clinicians feel burdened by administrative tasks that do not appear to add value to patient care and are unrelated to the reasons they chose their professions. This disconnect between one's calling and one's daily work has been identified as a key contributor to distress — leading to alienation, isolation, depersonalization, cynicism, emotional exhaustion and burnout.[7]

Documentation-Related Sources of Clinician Burden

Administrative and clinical documentation requirements of modern health care are a common source of clinician and health care workforce burden. There are multiple etiologies of burden associated with documentation, and each contributes to the whole.

Meaningful Use (MU) criteria, later continued as the Advancing Care Information (ACI) criteria under the Merit-based Incentive Payment System (MIPS), can be considered a regulatory source of documentation-associated burden. A 2018 study released by the American Academy of Family Physicians (AAFP) noted that of 480 family physicians queried, the majority of respondents found 17 of the 31 ACI criteria were burdensome and not beneficial to patient care.[8] An overlooked aspect of these findings is the demonstration that the respondents actually did find many of the requirements useful, confirming that providers can potentially be actively and meaningfully engaged in efforts to revise the requirements.

Regulatory guidance and requirements around the submission of Evaluation and Management (E&M) coding for clinical services has a long history through both the AMA Common Procedural Terminology coding manual and subsequent Centers for Medicare and Medicaid Services (CMS) published guidance. The disparity within this guidance is the simple fact that they were established in order to implement required documentation elements that streamline the billing review/audit processes, not to improve documentation for medical purposes. These disparities have since led to observable inaccuracies in documentation of services provided, via both under- and over-coding.[9] The current E&M standards were created well before the widespread adoption of EHRs in clinical practice and do not reflect the capabilities of a computer system to gather significant volumes of data elements (nor to evaluate a note and prompt for specific elements that would justify an increased E/M level). When considered in light of the inherent disparity of purpose and the expanded use of EHRs, the changing health care payment and documentation environments have created a system requiring frequent and significant review and manual correction of computer-based Current Procedural Terminology (CPT) coding by humans, erasing the potential efficiencies that are provided in a paper-based health care ecosystem.

Prior authorizations for medical care is an area of documentation in which little standardization exists. Public and private payers alike maintain different processes for obtaining authorization for requested care, each with its own required forms and eccentricities. With clinicians and practices interacting with multiple payers on a regular basis, completion of

the tasks associated with obtaining prior authorization consumes a significant amount of clinician and practice time, and significantly adds to their burden, dissatisfaction and loss of the joy of work (described later).

As noted above in the AMA study examining sources of dissatisfaction, time spent completing required electronic documentation is the significant cognitive requirement associated with EHR use. Two recent studies (released in 2017 and 2018) funded by the Agency for Healthcare Research and Quality (AHRQ) demonstrate that the use of EHR technology is associated with a significant cognitive load. The authors of the report detailing the 2018 study summarize the effects of this increase in cognition well in a single sentence, describing it as a "high burden frequency and time at task to attend to EHRs along with high subjective workload."[10]

The execution and application of modern health care has transitioned to systems that require the use of software and electronic platforms to perform its various and many required tasks. When the amount of cognitive activity required to complete documentation tasks is considered simultaneously with the noted increases in clinician time spent interacting with EHRs, there is little room to debate the significant amount of burden that has resulted from this change in the culture and function in health care.

Initiatives to Reduce Administrative Burden

While originally created as a method of maintaining continuity across visits (e.g. continuity of record and continuity of plan),[11] modern documentation exists for medical, financial, population health and medicolegal purposes. Each of these expanded uses have coalesced into the modern administrative burden of documentation as described above. Too frequently, modern medical records for a simple visit entail pages of relatively extraneous information, undercutting the value of the medical record as a tool for continuity of record and plan. Until the myriad of demands placed upon modern medical records can be relieved, a collaborative approach is needed to reduce the administrative burden of fulfilling these extensive electronic documentary, regulatory and payment requirements from payers and others. Many federal agencies and clinician organizations have focused on burden reduction. Some recent initiatives include:

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience – In 2017, the National Academy of Medicine launched the Action Collaborative on Clinician Well-Being and Resilience, a network of more than 50 organizations committed to reversing trends in clinician burnout, with the following goals:

- Improve baseline understanding of challenges to clinician well-being;
- Raise the visibility of clinician stress and burnout; and
- Elevate evidence-based, multidisciplinary solutions that will improve patient care by caring for the caregiver.

Healthcare Leaders Consensus for Improvements to Prior Authorization and Patient-Centered Care – In January 2018, the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), American Medical Association (AMA), American Pharmacists Association (APhA), Blue Cross Blue Shield Association (BCBSA) and Medical Group Management Association (MGMA) released a consensus statement outlining their shared commitment to reduce the number of health care professionals subject to prior authorization (PA), regularly review services and medications requiring PA, improve channels of communication between stakeholders, protect continuity of care for patients, and accelerate industry adoption of electronic standards related to PA, formulary information and point-of-care coverage restrictions.

Reducing Clinician Burden – CMS has committed to limiting the burden caused by Medicare documentation requirements and medical reviews performed to protect Medicare Trust Funds. Listed below are several of the activities CMS has undertaken.

- ***Targeting Medical Review (Targeted Probe and Educate)***: In October 2017, CMS launched a nationwide program to better target medical review, limit the number of medical records requested, and put an emphasis on education and assistance in correcting claims errors. This program focuses on clinicians who have unusual billing patterns or billing practices that vary greatly from their peers.
- ***Deprioritizing Certain Clinicians from Medical Review (Medical Review Reduction Pilot)***: In January 2017, CMS started an 18-month pilot to reduce medical review for clinicians participating in certain Advanced Alternative Payment Models.
- ***Simplifying and Clarifying Documentation Requirements***: CMS is working to reduce paperwork with simplified, streamlined Medicare documentation requirements for claims payment. Clinicians can submit suggestions to ReducingClinicianBurden@cms.hhs.gov to help CMS simplify requirements.
- ***Creating Detailed Denial Reason Statements***: In 2015, CMS began to standardize denial reason codes and statements to help clinicians better understand why claims were denied.

Patients Over Paperwork – In the February 2018 combined Office of the National Coordinator for Health Information Technology (ONC) and CMS public meeting on reducing clinical burden, CMS indicated putting patients first is the top priority at CMS. Some aspects of this initiative include:

1. **Quality and safety oversight requirements**
    a) Directed surveyors of long-term care (LTC) facilities to focus on education rather than penalties related to implementation of Requirements of Participation (RoPs) for 18 months
    b) Simplified the submission requirements for clinicians writing Conditions of Participation (CoP) Plans of Correction
    c) Reduced penalty amounts for non-compliance with CMS CoPs by moving to a per-instance Civil Monetary Penalties (CMPs) instead of per-day CMPs
    d) Allowed hospice clinicians to use contract nurses in areas with a nursing shortage

2. **EHR projects**
    a) Clarified guidance that clinicians may use scribes for EHR documentation so long as the clinician validates and signs off on the documentation
    b) Developed an Application Programming Interface (API) for data submission under the Quality Payment Program (QPP) that can be used for reporting to MIPS for clinicians using Qualified Registries (QRs) or Qualified Clinical Data Registries (QCDRs)
    c) Developed a user friendly website for QPP for obtaining information and submitting data
    d) Clinician-to-payer document exchange – revised the Electronic Submission of Medical Documentation (esMD) system to accept structured medical records (CCDA)
    e) Clinician-to-clinician document exchange – published an Electronic Medical Documentation Interoperability (EMDI) implementation guide

3. **Working with Standards Development Organizations (SDOs)**
    a) Improve "Payer to Clinician" information exchange
    b) Improve "Clinician to Clinician" interoperability
    c) Empower better clinical decision-making by integrating administrative decisions into the clinician workflow
    d) Activities to accomplish these goals include: creating or revising standards (FHIR), implementation guides and reference implementations (sample code), launching pilot projects to test solutions

4. **Clinical Decision Support (CDS)**
    a) Published eClinical Templates and Clinical Data Elements
    b) Exploring working with payers to develop libraries of prior authorization and coverage rules that could be accessed by clinicians at the point of service and unified through HL7 standards.

2018 CMS IPPS/LTCH Proposed Rule: As part of CMS-wide efforts under the Meaningful Measures Initiative to use a parsimonious set of the most meaningful quality measures for patients, clinicians and providers, and the Patients Over Paperwork Initiative (described above) to reduce costs and burden and program complexity, CMS proposed the elimination of dozens of measures across several programs (e.g. Hospital Value-Based Purchasing [VBP] Program, Hospital-Acquired Condition [HAC] Reduction Program, and Hospital Inpatient Quality Reporting [IQR] Program) for hospital providers impacted by the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System.

Via these initiatives and rulings, CMS is focused on aligning measures and, ultimately, reducing quality measures that are duplicative or no longer relevant. Particularly, CMS wants quality measures that meet critical criteria including: 1) eliminating disparities; 2) tracking to measurable outcomes and impact, not process; 3) achieving cost savings; and 4) improving access for communities. It is expected that the alignment, elimination and de-duplication of provider-reported measures will significantly reduce administrative burden over the next few years.

A Patient-Centric Refocus

The Clinician-Patient Team

Successful clinicians in today's administratively complex environment systematically and diligently utilize teams, including the patient as a central team member. Previously discussed studies suggest that the use of these teams to minimize the time clinicians spend on administrative tasks could be an effective strategy toward reducing physician dis-satisfaction. A physician-led team working cohesively allows clinicians to nurture the patient-physician relationship, actively engaging in overall patient care, while administrative tasks can be appropriately offloaded to team members. Through a combined use of standard orders and workflows based upon best practices, staff can be empowered to expand their roles in the care and documentation of patient encounters, allowing physicians to more directly focus their efforts on care processes and to focus more wholly on the patient.

Fully engaging patients through engagement in their own care, as an integral part of the care team, both empowers patients and clinician-led teams through the development of shared care plans. The impact of this strategy on patient satisfaction has been well documented. The combination of increased patient satisfaction and the increased emphasis of a provider's time on achieving these joint goals could potentially result in a significant reduction in physician burnout, as well as improvements in care.

Improving Patient Engagement

The provision of patient-centered care can lead to better engagement between patients and their health care teams,[12] promoting relationships that are frequently associated with decreased provider burn-out. Although not yet studied, the authors surmise that this reinforcement of the provider-patient relationship supports increased resiliency in providers assessing the value versus burden of specific administrative measures. Ensuring the patient's voice is central in their care may not be easy. Strategies such as incorporating a data-driven approach, using feedback from patient and caregiver advisory councils, and shared decision-making and self-management support tools put into practice have all demonstrated success.

Incorporating Patient-Reported Outcomes (PROs) — patients' own accounting of their symptoms, functional status and quality of life — is an emerging strategy to incorporate patient-centered measurement into clinical practice and may even improve clinician satisfaction. These outcomes can shed light on valuable information that only the patient can provide, such as the patient's experiences of symptoms, quality of life and functioning; values and preferences; and goals for health care.[12]

Patient-reported outcomes can play a role in successful shared decision-making with clinicians. These outcome measures can complement existing physical examinations, as they provide standardized assessments of how patients function or feel with respect to their health, quality of life, mental well-being or health care experience. Assessment of PROs can encourage conversations between patients and doctors that lead to better individualized care, improving clinician satisfaction and lessening impact of clinician burden.

Clinician Approaches for Addressing Administrative Burden

Identifying and Reducing Administrative Burden

The American College of Physicians (ACP) has long identified reducing administrative tasks as an important objective, maintaining significant policy and participating in many efforts with this goal in mind, including developing the "Patients Before Paperwork" initiative.[13] With an analytic approach to defining and mitigating administrative tasks in a comprehensive, cross-cutting and holistic manner, the ACP developed a framework, taxonomy and recommendations for evaluating the sources, intent, effect and consequences of administrative tasks.

ACP Framework

The ACP framework to guide the consideration of administrative tasks looks through several lenses to best identify a set of solutions. This consideration involves a series of questions.[14]

First, one must consider the source of the task. Is it external to the clinician practice or health care organization, or is it being generated within the practice? In many cases, the task may arise from both external and internal drivers.

Second, what is the ultimate intent of the administrative task? Is the intent clear?

Third, what is the effect of this task? Is it: completely negative, resulting in wasted time for the clinician and a lack of improved patient care or outcomes; generally negative, with some positive outcomes; positive in the end, but with adverse or unintended consequences; or overall positive? Perhaps the value added to patient care is high enough that activities typically viewed as burdensome — and that increase administrative work — are instead viewed as worthwhile.

Finally, once the source, intent and effect of the tasks are understood, what approaches may be broadly applied to address several administrative tasks in a more focused and cohesive manner? In addition, to whom should these approaches be directed most appropriately: policymakers, payers, industry, health systems, professional organizations, practices, patients or other key stakeholders?

ACP Taxonomy

Using the framework questions above, the ACP developed a taxonomy to determine if administrative tasks should be kept or eliminated. As depicted in Figure 1, tasks are categorized as: questioning a physician judgment (eliminate task), improving quality of care (worthwhile task), having a negative financial impact (eliminate task), and promoting timely and appropriate care (worthwhile task).[14]

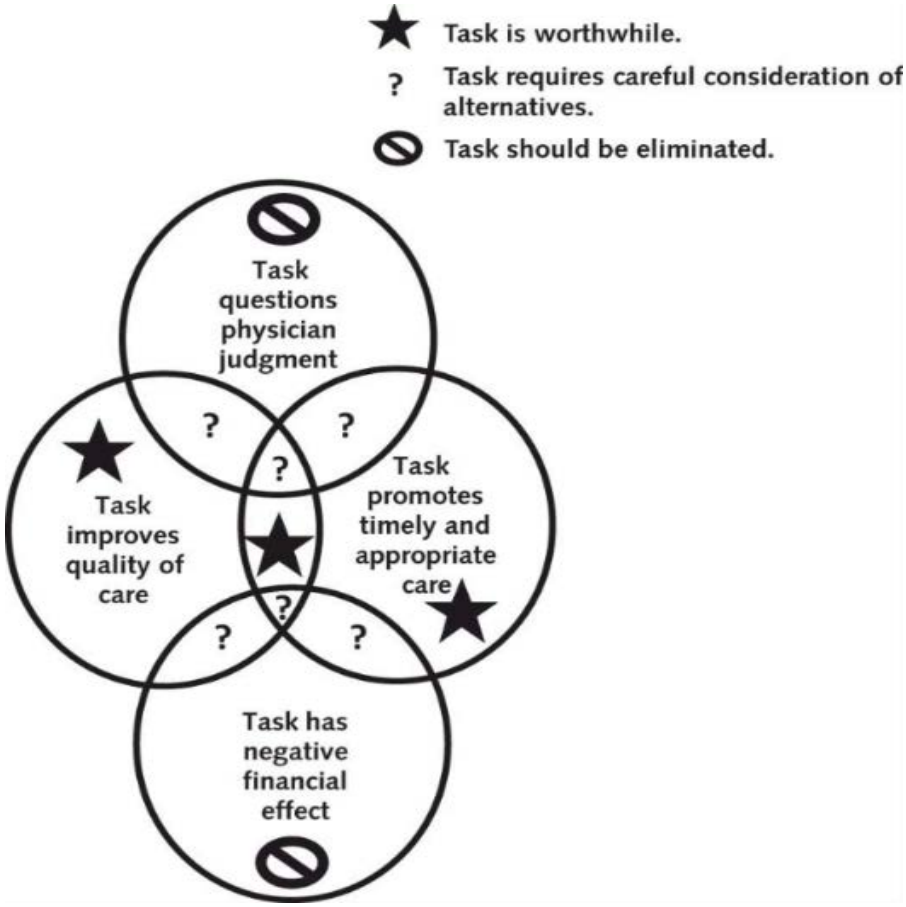

Figure 1. Taxonomy of administrative tasks external to the practice and health care environment. Each circle indicates a characteristic of an administrative task. [14]

Key Strategies for Burden Reduction by Level of Care

With ACP's guidance on identifying clinician burden, it is important to focus on how to minimize the administrative burden once identified. The following strategies and initiatives may provide some solutions.

Primary Care

According to Shipman and Sinsky,[15] numerous opportunities exist in primary care to substantially expand workforce capacity and improve clinician and patient experience. These opportunities can be grouped into the following categories: teamwork, work flow, technology and policies.

Teamwork: Other staff members could perform tasks that physicians spend on patient care activities outside of patient visits. For example, beyond their roles as flow managers and scribes, team members can help meet patients' clinical needs more effectively and comprehensively with less use of the physician's time. For example, medical assistants and nurses can be trained, within limits, to provide routine preventive counseling and to "close" the visit with any additional patient education requirements and verifying patient understanding of their overall care plan.

Work Flow: Redesigning the clinical work flow has the potential to improve clinician experience through the identification of redundant efforts, improving the physical layout of a practice and other factors. Primary care practices that have designed new clinical spaces, for instance, have placed physicians not in private offices but side by side with the rest of the primary care team in "flow stations." This arrangement facilitates real-time communication and reduces the downtime that can occur when team members cannot locate one another in order to request assistance or share information.

Technology: In time and with feedback from clinicians, the EHR user interface could be improved to reduce the cognitive burden of information input and retrieval, thereby reducing the time required to complete tasks in the electronic record. In addition to the EHR, other technologies (such as e-mail, patient portals and home monitoring devices) may be used to digitally transfer patients' health data to clinicians, in order to offer physicians a growing range of methods to reduce the need for face-to-face visits with some patients.

Policies: A reexamination of policies at the institutional, state and federal levels could lessen clinician burden in practices. For instance, varied state licensing body interpretations and limitations on non-clinician activities limit the ability to develop and uniformly implement standardized national protocols that might allow non-physician care team members to order routine laboratory studies, such as a fasting cholesterol level, under established protocols. Scope-of-practice regulations could be standardized to allow all team members to consistently function at the level appropriate to their training and skills.

Team-based Care

Team-based care is defined by the National Academy of Medicine as, "…the provision of health services to individuals, families, and/or their communities by at least two health clinicians who work collaboratively with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated, high-quality care."[16,17] "Well-implemented team-based care has the potential to improve the satisfaction of

patients and clinicians."[17] However, the measurement of the application of this definition within health care systems has overlooked the very important caveat, "to the extent preferred by each patient." Applying — and meaningfully achieving — this caveat would drive to the heart of patient-centered and goal-directed care, recognizing that clinical discretion is required at the individual patient care level. To achieve this potential, the transition to team-based primary care requires (for most practices): profound changes in the culture and organization of care; changes in the nature of interactions among colleagues and with patients; changes in education and training; and changes in the ways in which primary care personnel and patients understand their roles and responsibilities,[18] as well as changes in how the outcomes of care are measured and reported.

Aspects of team-based care implementation to reduce administrative burden:

- Allowing Advanced Practice Clinicians, RNs, LVNs and MAs to collaborate to work at the top of their licenses
- Developing and utilizing protocols and standing orders so that non-physician staff appropriately perform tasks and processes that divert administrative work from physicians
- Use of scribes as appropriate
- Use technology – email, text messaging, video (VTC, web video) to reduce number of patients seen in the office

Identifying Potential Primary Care Practice Administrative Burden:

- *Deploy a clinician survey to identify processes that are most burdensome*
- *Rank inefficient tasks within the practice*
- *Assess highest-rated clinician dis-satisfiers*

Ambulatory Care

There are aspects of ambulatory care that could be simplified to reduce clinician burden and refocus on patient-centric care. Some potential improvements are listed here for consideration.

Technology

- Customization of EHR components and functionality to fit the practice culture and workflow[19]
- Advocating state and federal policies and legislation through all stakeholders requiring interoperability of systems involved in health information exchange
- Modification of Meaningful Use (MU)/Advancing Care Information (ACI) criteria to eliminate burdensome measures that have little or no benefits to patients and outcomes[20]
- Use technology to educate and communicate with patients
    - The use of patient portals to engage, educate and communicate with patients is growing as an effective use of technology to reduce administrative burden (Kohl R, Calderon K, & Daly, S). An approach to engaging patients in patient portals is described in a TMF Health Quality Institute whitepaper, Patient Portals: A Streamlined Approach to Engaging Patients.

Payment

- Streamline and add transparency to authorizations or eliminate pre-authorization altogether
- Unify regulatory and billing data requirements
- Improve payment efficiency, including single payer schemes

Administration

- Increase staff support
- Reallocate time demands
- Allow for increased time with patients

System

- Decrease regulation of controlled substances
- Reduce liability exposures
- Coordinate scope of work regulations

Inpatient and Post-Acute Care

For inpatient and post-acute care facilities, clinician burden does not just exist among health care clinicians but among all staff. The administrative burden experienced across health care staff must be addressed to improve patient-centric care. See the ***Appendix: Checklist for Reducing Administrative Burden for Inpatient and Post-Acute Facilities*** for a checklist of strategies for both inpatient and post-acute care facilities to consider to reduce burden and refocus on patients, such as facility assessment, addressing nursing challenges, QI measures and coordination of care.

Stakeholder Recommendations

ACP Recommendations

ACP developed the following seven public policy statements and recommendations as strategies to put patients first by reducing excessive administrative tasks in health care.[14]

1. The ACP calls on stakeholders external to the physician practice or health care clinician environment who develop or implement administrative tasks to provide financial, time and quality-of-care impact statements for public review and comment.
2. Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.
3. Stakeholders, including public and private payers, must collaborate with professional societies, frontline clinicians, patients and electronic health record vendors to aim for performance measures that minimize unnecessary clinician burden, maximize patient and family centeredness, and integrate the measurement of and reporting on performance with quality improvement and care delivery.
4. To facilitate the elimination, reduction, alignment and streamlining of administrative tasks, all key stakeholders should collaborate in making better use of existing health information technologies, as well as developing more innovative approaches.
5. As the U.S. health care system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative requirements.

6. The ACP calls for rigorous research on the effect of administrative tasks on our health care system in terms of quality, time and cost; physicians, other clinicians, their staff and health care clinician organizations; patient and family experience; and, most important, patient outcomes.
7. The ACP calls for research on best practices to help physicians and other clinicians reduce administrative burden within their practices and organizations. All key stakeholders should actively be involved in the dissemination of these evidence-based best practices.

Improving Joy in Work

According to the Institute for Health Improvement (IHI), joy in work is more than just the absence of burnout or an issue of individual wellness; it is a system property. Clinician burnout leads to lower levels of staff engagement, impacting patient care, and limits clinicians' empathy — a crucial component of effective and person-centered care.[21] There are proven methods for creating a positive work environment. IHI researchers recommend that health care leaders can take four steps to increase joy in work, including:

1. *Asking staff what matters to them*
2. *Identifying unique impediments to joy in work in the local context*
3. *Committing to a systems approach to making joy in work a shared responsibility at all levels of an organization*
4. *Using improvement science to test approaches to improving joy in work within an organization*

AAFP Principles of Administrative Simplification

According to the American Academy of Family Physicians (AAFP), the administrative and regulatory burden among clinicians is one of the top reasons for closure of independent private practices and is a leading cause of physician burnout. Hence the AAFP has developed the following prioritized list of principles on administrative simplification. Per the AAFP, adherence to these principles will ensure that patients have timely access to treatment while reducing administrative burden on physicians. The four major AAFP principle areas are listed here. Details under each of these areas are available at the AAFP website listed in the Resources section.

1. **Prior Authorization Principles**: Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes and forms physicians and their staff must manage in order to obtain prior authorizations (PAs) for care impede this goal.

2. **Quality Measures and the Need for Measure Harmonization Principles**: Quality measures have proliferated in the past 15 years, leading to a significant compliance burden for physicians. Most of the measures are disease-specific process measures, rather than more meaningful evidence-based outcomes measures. With many family physicians submitting claims to more than 10 payers, the adoption of a single set of quality measures across all public and private payers is a critical first step toward reducing the administrative burden associated with inappropriate or useless measurement.

3. **Certification and Documentation Principles**: Physicians want to efficiently order what their patients need to manage their disease conditions in a way that maintains their health. The current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to the care of patients.

4. **Medical Record Documentation Principles**: Documentation burdens have increased dramatically, despite adoption of EHRs. Adherence to the guidelines consumes a significant amount of physician time23 and does not reflect the workflow of primary care physicians. The guidelines were drafted for use with paper-based medical records and do not reflect the current use and further potential use of EHRs and team-based care. The guidelines negatively impact the usability of EHR software programs.

Future Directions

Despite all of these initiatives, strategies and recommendations to reduce clinician administrative burden, it would be naïve to say that administrative requirements will be rapidly reduced to the levels seen before the introduction of EHRs and the movement toward value-based care. However, with strong efforts from all health care stakeholders to reduce administrative burden and a re-focus on building patient relationships, clinician satisfaction can increase and burnout can be significantly reduced. While administrative burden reduction efforts of today frequently focus on EHRs, the potential for future benefits associated with clinician-patient relationship building technologies could have a significant impact on the view of technology as a primary driver of provider dissatisfaction. Additionally, the evolution of value-based payment by many health care payers has the potential to simplify the coding requirements currently placed on clinicians, potentially resulting in increased provider satisfaction. During times of high stress and frustration, as demonstrated by the current physician burnout rates, it is far more likely that disruptive changes, as opposed to a gradual evolution, will occur in order to truly bring back clinician joy in their work.

Appendix

Checklist for Reducing Administrative Burden for Inpatient and Long-term Care Facilities

- ✓ ***Perform a comprehensive facility administrative burden assessment***
  - Many inpatient (IP) facilities have found improving communication necessary to reduce burnout
  - Including patients and PFACs in IP facility assessments can help keep focus on patient care
  - Note that sources of burden leading to burnout may be very different among LTC administration and staff
  - Address the immediate needs (get the quick wins!) of both administration and staff in IPs and LTCs, as well as develop a plan for longer-term needs

- ✓ ***Create an environment to support clinicians***
  - IP and LTC physicians and administration need to work cohesively
  - Physicians need to participate in improving the IP and LTC environments
  - Leaders need to involve physicians in strategic and financial planning

- ✓ ***Address nursing challenges***
  - Create organizational cultures of retention
  - Bolster the nursing educational infrastructure
  - Establish financial incentives for investing in nursing
  - Have an inviting nursing training and retention program to reduce nursing turnover

- ✓ ***Reduce administrative burden of quality measurement***
  - Assess the quality improvement (QI) programs and activities in which the IP chooses to participate by validating each program and activity's alignment with the vision of the organization
  - Standardize and centralize quality reporting work in IPs and LTCs
  - Increase emphasis on QI and resources dedicated to quality activities

- ✓ ***Prioritize QI measures***
  - Assess the IP QI measure review process for alignment and possible simplification
  - Integrate QI into patient care routine
  - Consider integrating PROs into the IP and LTC QI measure set(s)

- ✓ ***Leverage Health Information Technology (HIT)***
  - Use HIT to reduce staff time spent on retrieving patient information
  - HIT can be used to improve communication among staff as well as between patients and clinicians

- ✓ ***Improve coordination of care across the continuum***
  - Use technology to create interconnectivity between clinicians when coordinating care for patients between IP and LTC
  - Reduce repetitive assessments, care plans and patient problem lists

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