CLINICIAN BURNOUT AND MEDICAL INFORMATICS CAUSE AND EFFECT?

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→ SUTTER HEALTH

LETS LOOK AT IT A LITTLE DIFFERENTLY

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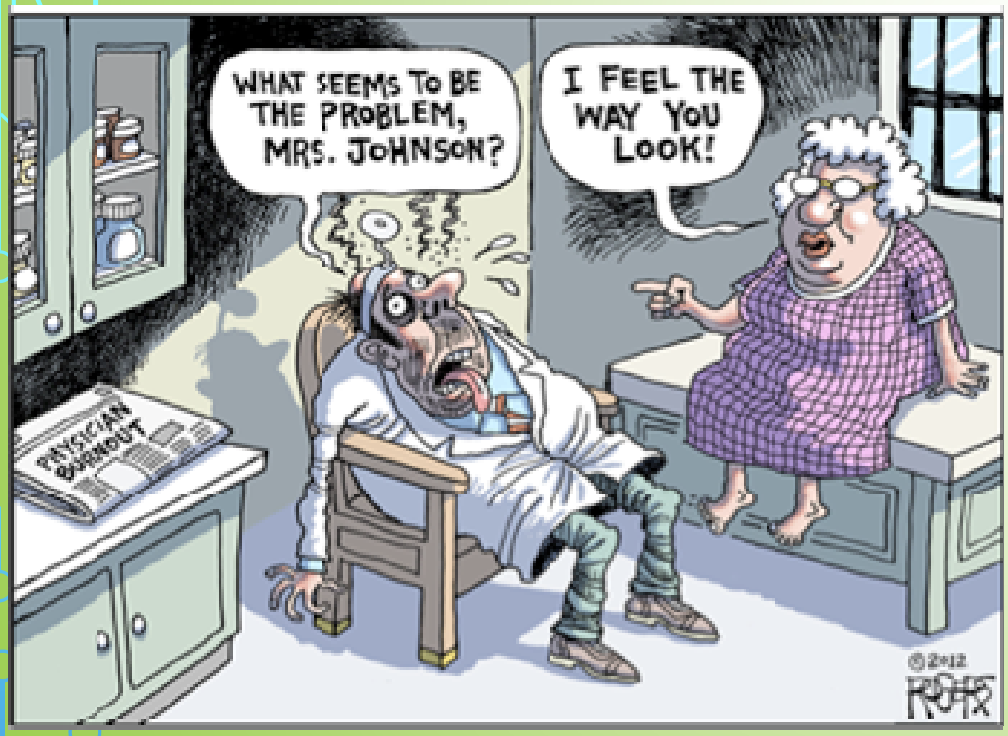
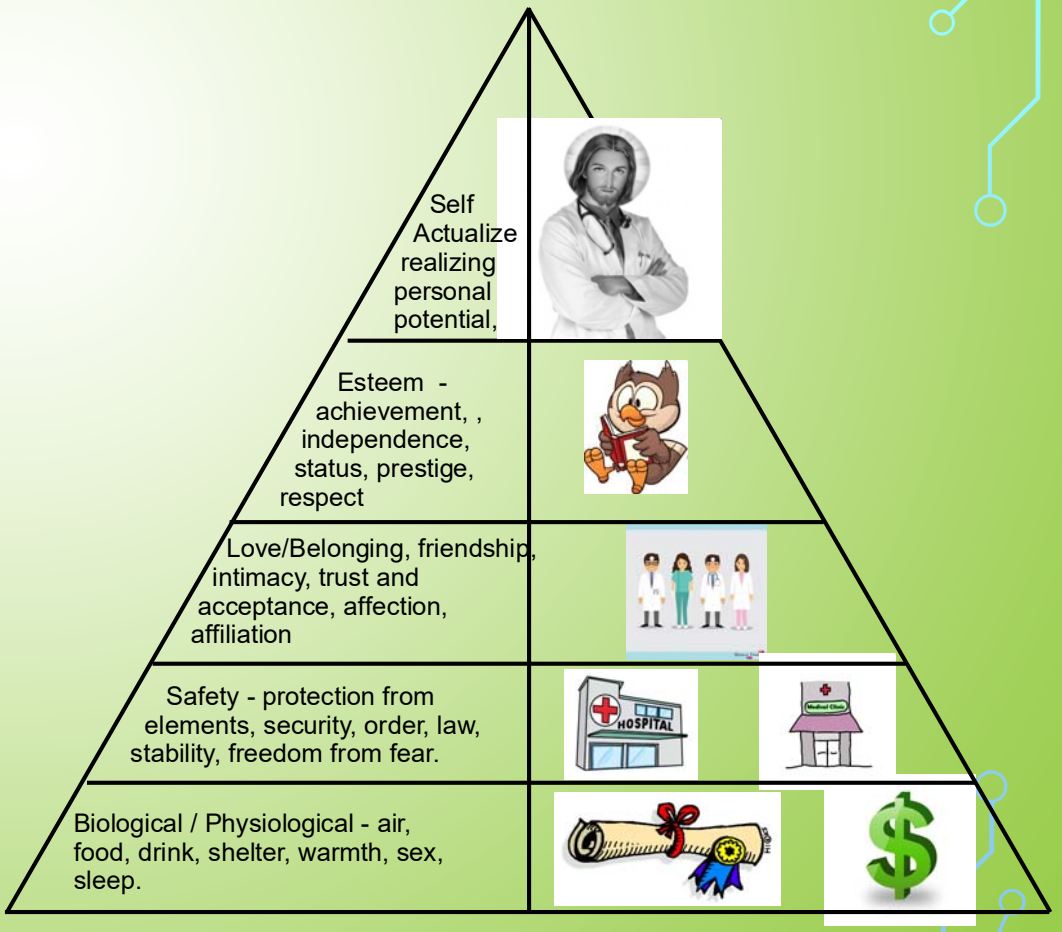
Figure 2. The Fourth (missing) Aim is improved clinician experience.


WHAT SEEMS TO BE THE PROBLEM, MRS. JOHNSON?
I FEEL THE WAY YOU LOOK!
PHYSICIAN OVERDOSE


Self Actualize realizing personal potential,
Esteem - achievement, , independence, status, prestige, respect
Love/Belonging, friendship, intimacy, trust and acceptance, affection, affiliation
Safety - protection from elements, security, order, law, stability, freedom from fear.
HOSPITAL
Biological / Physiological - air, food, drink, shelter, warmth, sex, sleep.

BURNOUT

- Burnout is an experience of emotional exhaustion, depersonalization, and feelings of low achievement and decreased effectiveness. It is a serious problem for ALL clinicians
- As many as half of physicians reported experiencing some degree of burnout.
- Most physicians are altruistic and committed and understand the needs for grueling training, ongoing night call, and long work hours.
- Burnout is more attributable to
  - Loss of control
  - Increased (and perceived inappropriate) performance measurement
  - Increasing complexity of medical care
  - EHR and resultant inefficiencies
- All resulting in increased stress and frustration causing Early retirement, Career change and markedly decreased professional satisfaction.

BURNOUT MITIGATED BY

- Perceiving medicine as “their calling.”
- Perceiving work as a top priority in their lives.
- Higher number of “rewarding hours”
- Improved work/life balance

RESEARCH

- "We found that a sense of calling was most strongly associated with high life meaning and commitment to direct patient care, and that personally rewarding hours were most strongly associated with career and life satisfaction and commitment to clinical practice."

BURNOUT ATTRIBUTED TO:

- Loss of control
  - Patient demands (Satisfaction, Expectation, etc.)
  - Organizational (Schedule,. Management, etc.)
- Increased (and perceived inappropriate) performance measurement
- Increasing complexity of medical care
- EHR and resultant inefficiencies
- Personal (generational) expectations.

MY OWN ADD: TRAINING

- In the past
  - 40 hour days / 100 hour weeks / **Accountability**
  - Lower Acuity, Identified Physician-in-Charge,
  - Tech: ICU, Transplant, E.g. Pre-pulse Ox
  - Modest documentation and reporting requirements →More complete training

TODAY

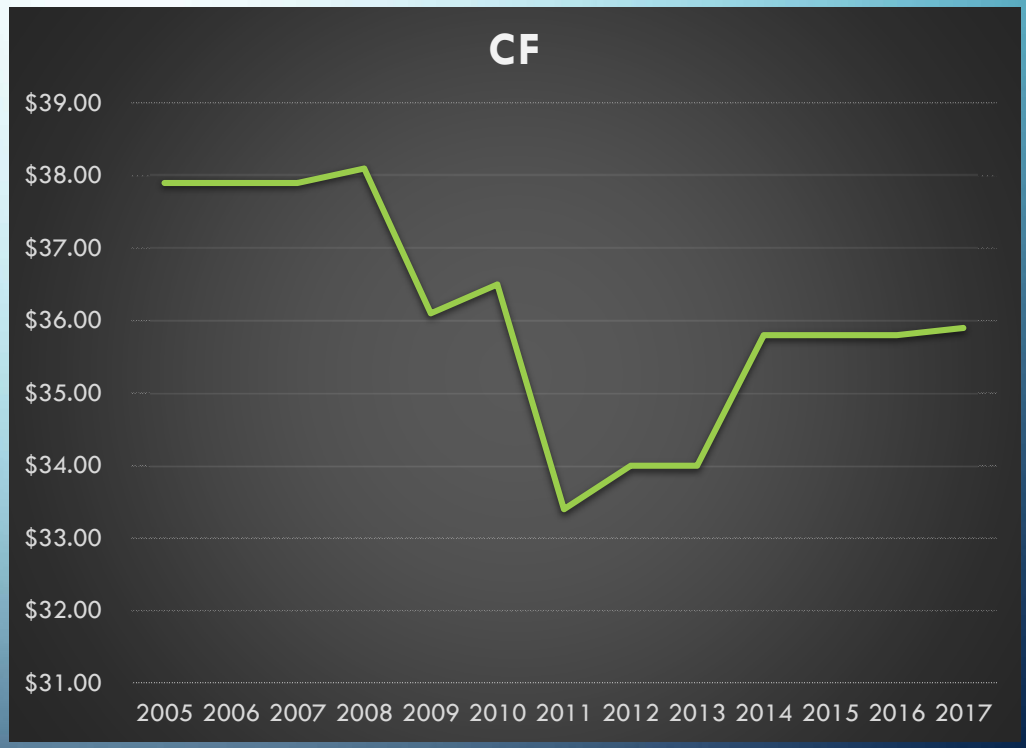
- Constrained work week/work day **without change in training duration**
- Higher Acuity, Higher complexity/High Technology / Team Approach (shared **responsibility**)
- Higher documentation and reporting requirements

Today's environment leads to Inadequate training→ Increases stress, decreases control and impedes "Rewarding work"

62% of statistics are made up on the spot

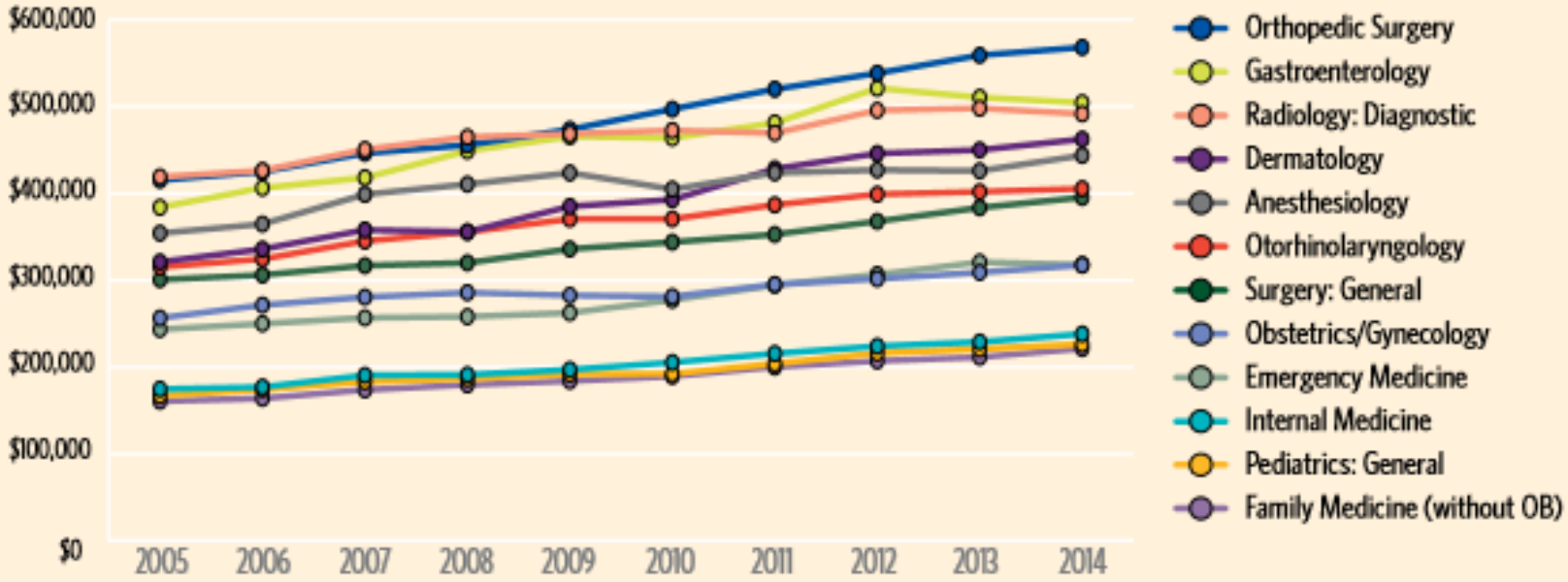
- CPT payment decreasing
- Medicare payments decreasing
- PCP Panel size increasing
- Patient volume increasing
- Visit length decreasing
- Data requirements increasing

CONVERSION FACTOR



WILLY SUTTON

10-Year Compensation Trends for Select Specialties



WHAT IF BEFORE EHR WERE IMPLEMENTED

- Data reporting requirements were put into place
- The pay for quality from pay to volume transition occurred
- Patients demanded real-time access to their information
- Portal enabled convenience functionality was expected

EHR: VILLAIN OR SCAPEGOAT? DOES IT MATTER?

- HIT Usability
- EHRs Electronify paper →Clinical Transformation
- Provider empowerment (aka control)
  - Change management technique
- Patient and Provider Synergy
  - Work
- Patient empowerment
  - Patient technology
  - Support not requiring Health Human Resources
- Futurism

EXAMPLES SUPPORTING THE QUADRUPLE AIM

- AI: Lots of hype but lots of interest. A little scary
- IOT devices: Lots of hype, but big and bulky, expensive, limited
- Patient engagement strategies/beyond portals
- Volume to value

LEARN TO LOOK AT IT DIFFERENTLY

Figure 2. The Fourth (missing) Aim is improved clinician experience.