CLINICIAN BURNOUT AND MEDICAL INFORMATICS CAUSE AND EFFECT?

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LET'S LOOK AT IT A LITTLE DIFFERENTLY...
Biological / Physiological - air, food, drink, shelter, warmth, sex, sleep.

Safety - protection from elements, security, order, law, stability, freedom from fear.

Love/Belonging, friendship, intimacy, trust and acceptance, affection, affiliation.

Esteem - achievement, independence, status, prestige, respect.

Self Actualize realizing personal potential.

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
"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
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

The Missing Aim

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