<div align="center">
Primary Care Advisory Group
Recommendation to Eliminate Prior Authorizations in Vermont
Preamble
January 10, 2018
</div>

Section 10 of Act 113 establishes the Primary Care Advisory Group (PCAG) to address and provide recommendations regarding administrative burdens facing primary care professionals, including: *creating opportunities to reduce requirements for primary care professionals to provide prior authorization **(PA)** for their patients to receive radiology, medication, and specialty services.*

Since the first PCAG meeting in September, 2016, the issue of PAs has been reviewed and discussed extensively, including regular discussions with third-party payers (BCBSVT, MVP). At the December 20, 2017 PCAG meeting, PCAG members expressed sincere gratitude for the contributions and willingness of BCBSVT and MVP to address the issue of PAs.

The PCAG recommendations regarding PAs that follow are based on the following points:

> **While the PCAG recognizes that there may be some outliers, the majority of PCPs (primary care physicians, nurse practitioners, and physician assistants) want to provide excellent evidence-based medical care, understand their individual patient's unique medical needs and are in the best position to order the appropriate test, medication or specialist referral for that patient. The PA process interferes with appropriate care, poses a significant administrative burden, and has a major negative impact on PCP career satisfaction and burnout.**
>
> *"Broadly applied prior authorization programs impose significant administrative burdens on all health care providers, and for those providers with a clear history of appropriate resource utilization and high prior authorization approval rates, these burdens become especially unjustified.* [5]
>
> *"The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In addition, administrative tasks are keeping physicians from entering or remaining in primary care and may cause them to decline participation in certain insurance plans because of the excessive requirements. The increase in these tasks also has been linked to greater stress and burnout among physicians."*[1]
>
> *"Interestingly, physicians who reported that their practice made extensive use of information technology actually spent more time on administration…Physicians who spent more time on administration were markedly less satisfied with their careers."* [2]
>
> *"After controlling for several other factors reported to affect physicians' career satisfaction, the proportion of time spent on administration remained a significant (p = 0.01) predictor of dissatisfaction"* [2]
>
> *"Our data suggest that prior authorization measures used were not effective in limiting inappropriate testing, thus questioning the value of this frustrating and time-consuming process."* [6]
>
> *"Doctors devoted, on average, 8.7 hours each week to administrative work, accounting for 16.6 percent of their total work week. These figures <u>exclude</u> all patient-related record keeping and patient-related office work."* [2]
>
> **Major medical organizations (i.e. American Academy of Family Physicians, American Medical Association and the American College of Physicians, etc) recognize the significant burden of PAs and have published**

statements and/ or position papers calling for reform of prior authorizations and reducing administrative burden.[1,5,9]

"Prior authorizations create significant barriers for family physicians to deliver timely and evidenced-based care to patients by delaying the start or continuation of necessary treatment. The very manual, time-consuming processes used in prior authorization programs burden family physicians, divert valuable resources away from direct patient care, and can inadvertently lead to negative patient outcomes. The AAFP believes family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe and/or order without being subjected to prior authorizations"[9]

"Tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely." [1]

"Excessive administrative tasks have serious adverse consequences for physicians and their patients. Stakeholders must work together to address the administrative burdens that prevent physicians from putting their patients first." [1]

Most PA's are <u>approved</u> and for most PCPs, over 90% of all required PAs are ultimately deemed appropriate and approved. The system is tremendously inefficient.

Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.[5]

Data has been presented by BCBSVT noting that in a 1-year period, 71% of PAs by PCPs were ultimately approved, and that the other 29% that were denied saved the plan $1.2 M. There is no information regarding why the 29% were ultimately denied and if the denial was medically appropriate. The PCAG appreciates BCBSVT sharing this information, but also recognizes that there is a lot of information that is not available that would be helpful in creating a complete picture.

"My PA denial rate is close to zero. They always get approved. It is so frustrating that I have to do them and that my patient's care gets delayed" (PCAG member).

"Insurers should redeploy their PA infrastructure to patient and provider education regarding inappropriate testing and medication usage. Insurers are in the unique position of knowing where these educational resources would be best deployed, including the minority of PCPs who cause the majority of inappropriate claims. If they truly cared, they would do that instead of this shotgun PA approach." (PCAG member).

PA's have been shown to increase cost or not change PCP practices around testing or prescribing

"Mandatory referral to a physiatrist before surgical evaluation did not result in persistent reduction in lumbar fusions. Instead, these programs were associated with the unintended consequence of increased costs from more nonoperative care for only a transitory change in the lumbar fusion rate, likely from delays due to the introduction of both PA programs." [4]

"Implementation of a prior authorization process by insurance carriers does not seem to significantly impact appropriate selection for SPECT-MPI. Socioeconomic status does not seem to significantly influence physicians' adherence to [appropriate use criteria] for SPECT-MPI." [6]

The 2015 GMCB study on PAs showed no significant increase for certain imaging tests and mixed results with respect to pharmacy costs. Where the preferred drug option was available at the point of care, the drug arm of the study showed no increase in cost.

Insurers claim that PAs provide a significant return on investment and reduce overall medical costs; however:

Analyses provided to PCAG do not account for a multitude of indirect costs, including:
- ER visits and hospitalizations for patients who did not fill prescriptions or undergo testing due to the PA process
- Time spent on the PA process by pharmacies/ radiology departments/ referral centers waiting for the PA
- Insurer's PA department – which gets passed on to the consumer.
- Employee benefits for PCP staff that work solely on PAs
- Replacing PCPs who leave due to burnout
- Hiring more PCPs to manage patient volume as administrative burden increases
- Patient and resources spent (fuel, time out of work, etc) going to the pharmacy multiple times for a single prescription involving a PA.

Cost information is not provided to PCPs or patients at the point of care:

Clinicians, practices, and other health care provider organizations generally have focused on providing the highest-quality care and often do not have access to the information they need to fully account for the cost of products and services. Also, concern is growing that an increased focus on cost reduction, particularly as it is monitored and enforced by payers and oversight entities, will result in patients not getting the care they need (that is, underutilization). However, clinicians generally recognize that they have to consider the cost of services, particularly as it affects their patients who, for example, may not be able to access certain pharmaceuticals they need because of high prices, as well as how it affects the health care system as a whole.[1]

Time estimates for PA completion used in calculations is highly debatable. Available published reports and anecdotal experience is equally highly variable.

"A 2010 American Medical Association survey found that physicians spend an average of 20 hours per week (a number that some doctors say is too low) on prior authorization activities."[7]

"Doctors devoted, on average, 8.7 hours each week to administrative work, accounting for 16.6 percent of their total work week. These figures exclude all patient-related record keeping and patient-related office work."[2]

"The mean time per prior authorization request ranged from 9.4 minutes to 47 minutes."[8]

AAFP 20 minute video of a doctor doing a prior authorization for a Head CT for a patient with an enlarging skull mass @: http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency *or* https://youtu.be/z20wfv4A604

"If the insurer's had to pay us and our staffs for time spent doing PAs, they would probably get rid of them" (PCAG member)

PA completion is done by different personnel at each practice (PCPs vs nursing or administrative staff) which has varying associated impacts on availability for direct patient care and the practice costs.

PAs can actually increase the overall cost of care for patients who either over-utilize emergency rooms to access care (where PAs are not required but add an associated ER charge), or do not participate in the PA process for medication changes or testing and have subsequent higher medical costs due to decompensation. GMCB-PCAG members have repeatedly expressed concern and provided case examples that this increased

cost impacts our most vulnerable patients who may not possess the financial or intellectual resources required to navigate this increasingly complex system.

"In the evaluation of a PA program seeking to control costs associated with the use of branded type 2 diabetes medications, this study found that members who were prescribed a medication requiring PA, but who never filled the prescription, had higher plan-paid healthcare costs (overall and medical alone), compared with those who qualified for the medication and subsequently filled the prescription within 45 days. A notable number of individuals who were assumed to have met the criteria based on a claims based equivalent, but who never received the medication, made no change to their current therapy despite receiving a prescription for this medication. Failure of a member to take medication deemed necessary by his or her physician could translate to inadequate control of the diabetic condition and result in an excess of resource utilization and costs for treating the disease and associated comorbidities." [3]

"When I am really concerned about a patient who needs a CT or MRI, I will send them to the ER to get the study so they do not have to wait for the PA. It might not be a true emergency, and they end up with an ER bill, but sometimes waiting for several days for a PA to clear is not in the best interest of the patient" (PCAG member)

We all have patients who end up in the ER or hospitalized because they did not fill the new prescription because it required a PA. (PCAG member)

PAs represent an unreimbursed cost-shift from insurers to medical practices.

PAs might have a greater impact on rural and underserved areas, where PCP access is limited and PAs reduce time for direct patient care.

Efforts to use electronic PAs are ineffective as they often require a separate login and screen for each plan, follow up phone calls, faxing or uploading documentation, or involve web sites that malfunction. Up to date point-of-care information regarding preferred medications would be helpful, but integration with the myriad of EMRs in the state and effective regular updates does not seem probable in the near future.

_____

PCAG recommendations to the GMCB regarding PAs:

1. Eliminate PAs for Vermont PCPs.
   a. Insurers concerned about cost-containment could redeploy PA staff to educate certain PCPs and/ or patient groups about appropriate use.
2. PAs for medications prescribed by Vermont PCPs could be reconsidered and implemented only after the insurance and EMR industry creates a reliable system for updating all formulary changes in real-time for point-of-care access for EMRs used in Vermont.
3. Insurers should provide education to both patients and PCPs regarding appropriate use criteria for imaging, medications, step-therapy, and specialty referrals.
4. Insurers should communicate with "outlier" PCPs whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.

References:

1. Erickson et al, Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians, *Ann Intern Med*. 2017; 166:659-661.
2. Woolhandler S., Himmelstein, DU Administrative Work Consumes One-Sixth of US Physicians Working Hours and Lowers Their Career Satisfaction, *Int J Health Services,* 2014; 44: 635–642.
3. Bergeson et al, Retrospective Data Base Analysis of the Impact of Prior Authorization for Type 2 Diabetes Medications on Health Care Costs in a Medicare Advantage Prescription Drug Plan Population, *J Manag Care Pharm*. 2013;19(5):374-84.
4. Goodman RM et al, The Impact of Commercial Health Plan Prior Authorization Programs on the Utilization of Services for Low Back Pain, *Spine*, 2016; 41 (9): 810–815.
5. American Medical Association's *Prior Authorization and Utilization Management Reform Principles*, https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf.pdf, accessed February 7, 2017.
6. Doukky R, et al, Impact of Insurance Carrier, Prior Authorization, and Social Economic Status on Appropriate Use of the SPECT Myocardial Perfusion Imaging in Private Community-Based Office Practice, *Clin. Cardiol.*, 2015; 38, 5:267–273.
7. Bendix J, The Prior Authorization Predicament, *Med Econ,* 2014; 91 (13), 29-35.
8. Morley et al, The Impact of Prior Authorization Requirements on Primary Care Physician's Offices: Report of 2 Parallel Network Studies; *JABFM* 2013; 26: 93–95.
9. American Academy of Family Physicians *Prior Authorization Policy*, https://www.aafp.org/about/policies/all/priorauthorizations.html, accessed December 22, 2017.

STAT

Physicians aren't 'burning out.' They're suffering from moral injury

By Simon G. Talbot *and* Wendy Dean

July 26, 2018

Supporting troops of the 1st Australian Division form a silhouette as they pass towards the front line in Belgium during the first World War. *Frank Hurley/Hulton Archive/Getty Images*

Physicians on the front lines of health care today are sometimes described as going to battle. It's an apt metaphor. Physicians, like combat soldiers, often face a profound and unrecognized threat to their well-being: moral injury.

Moral injury is frequently mischaracterized. In combat veterans it is diagnosed as post-traumatic stress; among physicians it's portrayed as burnout. But without understanding the critical difference between burnout and moral injury, the wounds will never heal and physicians and patients alike will continue to suffer the consequences.

Burnout is a [constellation of symptoms](1)[1] that include exhaustion, cynicism, and decreased productivity. More than half of physicians [report at least one](2)[2] of these. But the concept of burnout resonates poorly with physicians: it suggests a failure of resourcefulness and resilience, traits that most physicians have finely honed during decades of intense training and demanding work. Even at the Mayo Clinic, which has been tracking, investigating, and addressing burnout for more than a decade, [one-third of physicians](3)[3] report its symptoms.

We believe that burnout is itself a symptom of something larger: our broken health care system. The increasingly complex web of providers' highly conflicted allegiances — to patients, to self, and to employers — and its attendant moral injury may be driving the health care ecosystem to a tipping point and causing the collapse of resilience.

Related: [4]
Fighting the silent crisis of physician burnout [4]

The term "moral injury" was first used[5] to describe soldiers' responses to their actions in war. It represents "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations." Journalist Diane Silver describes it[6] as "a deep soul wound that pierces a person's identity, sense of morality, and relationship to society."

The moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of health care.

Most physicians enter medicine following a calling rather than a career path. They go into the field with a desire to help people. Many approach it with almost religious zeal, enduring lost sleep, lost years of young adulthood, huge opportunity costs, family strain, financial instability, disregard for personal health, and a multitude of other challenges. Each hurdle offers a lesson in endurance in the service of one's goal which, starting in the third year of medical school, is sharply focused on ensuring the best care for one's patients. Failing to consistently meet patients' needs has a profound impact[7] on physician wellbeing — this is the crux of consequent moral injury.

In an increasingly business-oriented and profit-driven health care environment, physicians must consider a multitude of factors other than their patients' best interests when deciding on treatment. Financial considerations — of hospitals, health care systems, insurers, patients, and sometimes of the physician himself or herself — lead to conflicts of interest. Electronic health records, which distract from patient encounters and fragment care but which are extraordinarily effective at tracking productivity and other business metrics, overwhelm busy physicians with tasks unrelated to providing outstanding face-to-face interactions. The constant specter of litigation drives physicians to over-test, over-read, and over-react to results — at times actively harming patients to avoid lawsuits.

Patient satisfaction scores and provider rating and review sites can give patients more information about choosing a physician, a hospital, or a health care system. But they can also silence physicians from providing necessary but unwelcome advice to patients, and can lead to over-treatment to keep some patients satisfied. Business practices may drive providers to refer patients within their own systems, even knowing[8] that doing so will delay care or that their equipment or staffing is sub-optimal.

Navigating an ethical path among such intensely competing drivers is emotionally and morally exhausting. Continually being caught between the Hippocratic oath, a decade of training, and the realities of making a profit from people at their sickest and most vulnerable is an untenable and unreasonable demand. Routinely experiencing the suffering, anguish, and loss of being unable to deliver the care that patients need is deeply painful. These routine, incessant betrayals of patient care and trust are examples

of "death by a thousand cuts." Any one of them, delivered alone, might heal. But repeated on a daily basis, they coalesce into the moral injury of health care.

Physicians are smart, tough, durable, resourceful people. If there was a way to MacGyver themselves out of this situation by working harder, smarter, or differently, they would have done it already. Many physicians contemplate leaving heath care altogether, but most do not for a variety of reasons: little cross-training for alternative careers, debt, and a commitment to their calling. And so they stay — wounded, disengaged, and increasingly hopeless.

Related: [9]
On the other side of physician burnout [9]

In order to ensure that compassionate, engaged, highly skilled physicians are leading patient care, executives in the health care system must recognize and then acknowledge that this is not physician burnout. Physicians are the canaries in the health care coalmine, and they are killing themselves at alarming rates[10] (twice that of active duty military members) signaling something is desperately wrong with the system.

The simple solution of establishing physician wellness programs or hiring corporate wellness officers won't solve the problem. Nor will pushing the solution onto providers by switching them to team-based care; creating flexible schedules and float pools for provider emergencies; getting physicians to practice mindfulness, meditation, and relaxation techniques or participate in cognitive-behavior therapy and resilience training. We do not need a Code Lavender team[11] that dispenses "information on preventive and ongoing support and hands out things such as aromatherapy inhalers, healthy snacks, and water" in response to emotional distress crises. Such teams provide the same support that first responders provide in disaster zones, but the "disaster zones" where they work are the everyday operations in many of the country's major medical centers. None of these measures is geared to change the institutional patterns that inflict moral injuries.

What we need is leadership willing to acknowledge the human costs and moral injury of multiple competing allegiances. We need leadership that has the courage to confront and minimize those competing demands. Physicians must be treated with respect, autonomy, and the authority to make rational, safe, evidence-based, and financially responsible[12] decisions. Top-down authoritarian mandates[13] on medical practice are degrading and ultimately ineffective.

We need leaders who recognize that caring for their physicians results in thoughtful, compassionate care for patients, which ultimately is good business. Senior doctors whose knowledge and skills transcend the next business cycle should be treated with loyalty and not as a replaceable, depreciating asset.

We also need patients to ask what is best for their care and then to demand that their insurer or hospital or health care system provide it — the digital mammogram, the experienced surgeon, the timely transfer, the visit without the distraction of the electronic health record — without the best interest of the business entity (insurer, hospital, health care system, or physician) overriding what is best for the patient.

A truly free market of insurers and providers, one without financial obligations being pushed to providers, would allow for self-regulation and patient-driven care. These goals should be aimed at creating a win-win where the wellness of patients correlates with the wellness of providers. In this way we can avoid the ongoing moral injury associated with the business of health care.

Simon G. Talbot, M.D., is a reconstructive plastic surgeon at Brigham and Women's Hospital and associate professor of surgery at Harvard Medical School. Wendy Dean, M.D., is a psychiatrist, vice president of business development, and senior medical officer at the Henry M. Jackson Foundation for the Advancement of Military Medicine.

About the Authors

Simon G. Talbot

sgtalbot@bwh.harvard.edu[14]

Wendy Dean

wdean@hjf.org[15]

Tags

Links

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4911781/
2. https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#1
3. https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20170328.059397&format=full
4. https://www.statnews.com/2016/06/29/fighting-physician-burnout/
5. https://www.sciencedirect.com/science/article/pii/S0272735809000920
6. https://psmag.com/books-and-culture/beyond-ptsd-soldiers-have-injured-souls-34293
7. https://www.rand.org/pubs/periodicals/health-quarterly/issues/v3/n4/01.html
8. https://catalyst.nejm.org/high-performing-hospital-employed-physician-groups/
9. https://www.statnews.com/2018/05/17/physician-burnout-working-part-time/
10. https://www.ncbi.nlm.nih.gov/pubmed/12813122
11. https://consultqd.clevelandclinic.org/code-lavender-offering-emotional-support-holistic-rapid-response/
12. https://www.ncbi.nlm.nih.gov/pubmed/23588900
13. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4646475/
14. https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/mailto:sgtalbot@bwh.harvard.edu
15. https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/mailto:wdean@hjf.org
16. https://www.statnews.com/tag/mental-health/
17. https://www.statnews.com/tag/physicians/

Physicians Experience Highest Suicide Rate of Any Profession

Pauline Anderson

May 07, 2018

NEW YORK — With one completed suicide every day, US physicians have the highest suicide rate of any profession. In addition, the number of physician suicides is more than twice that of the general population, new research shows.

A systematic literature review of physician suicide shows that the suicide rate among physicians is 28 to 40 per 100,000, more than double that in the general population.

Physicians who die by suicide often suffer from untreated or undertreated depression or other mental illnesses, a fact that underscores the need for early intervention, study investigator Deepika Tanwar, MD, Psychiatric Program, Harlem Hospital Center, New York City, told *Medscape Medical News.*

"It's very surprising" that the suicide rate among physicians is higher than among those in the military, which is considered a very stressful occupation, Tanwar told *Medscape Medical News.*

The findings were presented here at the American Psychiatric Association (APA) 2018 annual meeting.

Stigma, Access to Lethal Means

Using MEDLINE and PubMed, the investigators conducted a systematic literature review of physician suicide that included articles published in peer-reviewed journals during the past 10 years.

The review showed that the physician suicide rate was 28 to 40 per 100,000; in the general population, the overall rate was 12.3 per 100,000.

The results also showed that although female physicians attempt suicide far less often than women in the general population, the completion rate for female physicians exceeds that of the general population by 2.5 to 4 times and equals that of male physicians.

Experts are trying to understand why physician suicide rates are so high, said Tanwar. She pointed out that their review shows that some of the most common diagnoses were mood disorders, alcoholism, and substance abuse.

One study showed that depression affects an estimated 12% of male physicians and up to 19.5% of female physicians, a prevalence that is on par with that of the general population.

Depression is more common in medical students and residents, with 15% to 30% screening positive for depressive symptoms.

The investigators note that mood disorders in the medical profession is not restricted to North America. Studies from Finland, Norway, Australia, Singapore, China, and elsewhere have shown an increase in the prevalence of anxiety, depression, and suicidality among medical students and practitioners alike.

Stigma, said Tanwar, is a major obstacle to seeking medical treatment. She pointed to a study in which 50% of 2106 female physicians who completed a Facebook questionnaire reported meeting criteria for a mental disorder but were reluctant to seek professional help because of the fear of stigma.

The new review showed that poisoning and hanging are among the most common means of physician suicide. The findings also suggest that greater knowledge of and easier access to lethal means account for the higher rate of suicide completion in physicians.

The review also showed that of all medical specialties, psychiatry is near the top in terms of suicide rates.

There is growing awareness of physician suicide, and initiatives to prevent it are increasing.

Tanwar noted that several sessions at this year's APA meeting address physician wellness and burnout, which may help reduce suicide rates.

Alarming Rates

Commenting on the findings for *Medscape Medical News*, Beth Brodsky, PhD, associate clinical professor of medical psychology in psychiatry at Columbia University and the Irving Medical Center, New York City, who is an expert in this field, said the very high rate of physician suicide is "alarming."

However, she added, it is not surprising, given the stressors physicians face.

The stress starts in medical school and continues in residency with the high demands, competitiveness, long hours, and lack of sleep. This may contribute to substance abuse, another risk factor for suicide, said Brodsky.

This high stress is exacerbated by dwindling healthcare resources and residency positions, she noted. There are many stories of individuals dying by suicide after not securing one of these coveted spots.

When medical students graduate and enter the profession, they face different but equally challenging stressors, said Brodsky.

As more women enter the medical profession, they are becoming increasingly vulnerable to the fallout from work stressors. As a result, their rate of suicide is also increasing, said Brodsky.

Brodsky is among the experts advocating for better ways of addressing these problems, which may start with simple semantics. People do not "commit" suicide but "die by suicide," she said. She noted that suicide is an "illness and not a crime."

Brodsky welcomes the APA's focus on physician suicide because it raises awareness of the issue and will ultimately lead to improved prevention and intervention initiatives.

Openly discussing suicide as an illness helps "bring it out of the darkness" and shed the stigma shadowing this problem, she said.

The investigators and Dr Brodsky have disclosed no relevant financial relationships.

American Psychiatric Association (APA) 2018. Abstract 1-227, presented May 5, 2018.

For more Medscape Psychiatry news, join us on Facebook *and* Twitter.
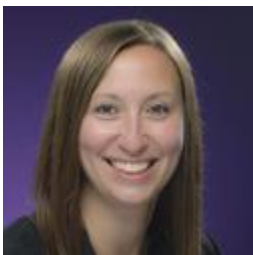
Medscape Medical News © 2018

Cite this article: Physicians Experience Highest Suicide Rate of Any Profession - *Medscape* - May 07, 2018.

LIFE & CAREER

At Stanford, physician burnout costs at least $7.75 million a year

NOV 17, 2017

Sara Berg
Senior Staff Writer
AMA Wire

@SaraTheIceBerg

Maryam Hamidi, PhD, is part of a team that has
analyzed the cost of physician burnout at Stanford.

Physician burnout is a major predictor of physician turnover, which has a high cost. At Stanford Medicine, replacing a physician who leaves because of burnout can cost at least $250,000. So addressing the organizational factors that contribute to burnout becomes more than just a question of helping physicians. It's a matter of the bottom line.

"If we don't do anything about burnout, what would happen?" asked Maryam Hamidi, PhD, during a presentation at the American Conference on Physician Health. Hamidi and Mickey Trockel, MD, PhD, of the Stanford Medicine WellMD Center and Department of Psychiatry and Behavioral Sciences led this study.

"Physicians who are experiencing burnout are more than twice as likely to leave their organization within two years," said Hamidi. "This results in significant financial burden to academic medical centers and health care organizations."

Editor's note: *This story is part of a new topic hub that centralizes the AMA's essential tools, resources and content to help you in* **Reinventing Medical Practice**. *Explore other* **Medical Topics That Matter**.

If nothing were done to address burnout, Hamidi and Dr. Trockel estimated, almost 60 physicians would leave Stanford within two years. The cost of recruitment for each

physician—depending on the specialty and rank of faculty—would range from more than $250,000 to almost $1 million. And, for those 58 physicians, Stanford's economic loss over two years would range from a minimum of $15.5 million to a maximum of $55.5 million.

These figures grew out of research at Stanford that sought to better quantify the relationship between physician dissatisfaction and their likelihood of leaving to work elsewhere.

"We do know there are a lot of studies on how people affected by burnout are more likely to say they are going to leave an organization, but we don't know how many actually do," Hamidi said.

In 2013, Dr. Trockel and the Stanford Physician Wellness Committee administered the survey to a random sample of physicians and 65 percent responded. They then sent the survey to remaining medical staff with a 31 percent response rate. The survey included questions on burnout, work hours, surgical specialty, anxiety, depression and sleep-related impairment.

Related Coverage

[Investing in physicians' well-being is just good business](#)

The team then looked at data between 2013 and 2015 based on unique identifiers, which are associated with each employee or student at Stanford. If a person leaves the organization

and comes back, they will receive the same identifier.

When identifiers were not found in the roster, names were manually searched in the internal directory. And if they were still missing, they were considered to have left the organization.

The group of physicians that left had slightly higher scores of anxiety, depression and sleep-related impairment, but there was not a significant difference between the groups.

"Burnout was the variable that explained the difference," she said. "Physicians who were experiencing burnout in 2013 were more than twice as likely to leave compared to those not experiencing burnout."

For the group of doctors that left Stanford, 23 percent had symptoms of burnout, while 16 percent of those who did not leave the organization exhibited signs of burnout. The cost of physician recruitment was very conservative, reported Hamidi.

"Aside from the humanistic reasons, we're also trying to make a point that organizations should invest money into preventing burnout," she said. "If they don't do that, it can have a significant financial cost associated with it."

The AMA's STEPS Forward collection offers free online modules that help physicians and system leaders learn their risk factors for burnout and adopt medical practice solutions to reignite professional fulfillment and resilience, including modules that focus on how to change key workflows and processes,

such as pre-visit planning and synchronized prescription renewal.

Several modules come thanks to a grant from, and in collaboration with, the Transforming Clinical Practices Initiative (TCPI), an effort designed to help clinicians achieve large-scale health transformation through TCPI's Practice Transformation Networks. The AMA, in collaboration with TCPI, is providing technical assistance and peer-level support by way of STEPS Forward resources to enrolled practices. The AMA is also engaging the national physician community in health care transformation through network projects, change packages, success stories and training modules.

More on this

- Taming clinical chaos means fewer physicians eyeing exit: study
- Burnout best addressed at the organizational level, research shows
- Report reveals severity of burnout by specialty
- What makes doctors great also drives burnout: A double-edged sword

Physician Wellness   Profession News

Practice Sustainability   Practice Sustainability

Submitted by skshrews on Saturday, November 25, 2017 - 15:27

"...workflows and processes, such as pre-visit planning and synchronized prescription renewal." Nonsense EMR's need to be addressed. Until the EMR companies are held as accountable as physicians are-medical-legally, legally, economically-they will continue to foist their loathsome products on the medical community and feed the "burnout" problem.

Submitted by fantin on Saturday, November 25, 2017 - 18:46

We may be using the term burnout too lightly. Most of us leave a job because of unfair practices, disconnect between work load and compensation, difficulties getting the material and personnel support required to perform well. Managers may like burnout because they have an opportunity of hiring a new physician at a much lower rate.

Membership Moves Medicine™

- Fight regulatory burdens
- Free access to JAMA® and CME
- Save hundreds on insurance

Join the AMA Today

LIFE & CAREER

Burned out? You're not alone. Here's how 2 doctors overcame it.

SEP 17, 2018

The phenomenon is widespread, but so are stories of physician burnout recovery. Read the burnout testimonials of two physicians.

Read More

6 women awarded for research on gender bias in medical training

SEP 12, 2018

4 qualities women leaders in medicine need to succeed

SEP 12, 2018

The AMA's president-elect feels called to create history

SEP 12, 2018

Oncologist helps patients handle scariest thing they've ever faced

SEP 11, 2018

The AMA promotes the art and science of medicine and the betterment of public health.

Careers

Contact Us

Events

Press Center

AMA Alliance

AMPAC

AMA Foundation

AMA Insurance

IN THE JOURNALS

Burnout, dissatisfaction drive 1 in 5 physicians to plan on reducing work hours

Sinsky CA, et al. *Mayo Clin Proc*. 2017;doi:j.mayocp.2017.08.017.
November 10, 2017

➕ ADD TOPIC TO EMAIL ALERTS

Survey results published in *Mayo Clinic Proceedings* reveal a significant level of discontent among physicians, with many considering scaling back or leaving practice altogether.

The primary sources of frustration are the burden of practicing medicine and dissatisfaction with electronic health records, according to the researchers.

"[HHS] projects a shortfall of 45,000 to 90,000 physicians by 2025, even after accounting for an influx of advanced practice health care professionals, as the U.S. population ages and the prevalence of chronic disease increases," **Christine A. Sinsky, MD,** from the AMA, and colleagues wrote.

"The United States has begun to address this issue by increasing the flow of physicians *into* the workforce, establishing 11 new medical schools between 2001 and 2011," they added. "The factors influencing the flow of physicians *out* of the workforce and the magnitude of this phenomenon are not fully understood."

Between Aug. 28, 2014, and Oct. 6, 2014, Sinsky and colleagues conducted a survey to investigate how burnout, satisfaction with EHRs and work-life integration affect the career plans of U.S. physicians. The researchers contacted 35,922 physicians across all specialties and 6,695 completed the survey and were currently in clinical practice. Physicians were asked how likely they were to reduce clinical hours in the next 12 months and leave current practice in the next 24 months.

Data from the survey indicated that 19.8% of respondents reported that they would likely or definitely reduce their clinical works hours within the next year, noting reasons such as the desire to spend more time with family (28.6%) and frustration with work characteristics (26.2%), including Medicare and insurance issues.

In addition, 26.6% of physicians reported that they would likely or definitely leave their current practice within the next 2 years. These physicians reported plans to either retire (37.4%), pursue a different practice opportunity (35.2%), work as a health care administrator (9.7%) or pursue a different career (7.4%).

Physicians were more likely to intend to cut clinical work hours if they were burned out (OR = 1.81; 95% CI, 1.49-2.19), dissatisfied with work-life integration (OR = 1.65; 95% CI, 1.27-2.14) or dissatisfied with the EHR (OR = 1.44; 95% CI, 1.16-1.8). Burnout (OR = 2.16; 95% CI, 1.81-2.59), dissatisfaction with work-life integration (OR = 1.49; 95% CI, 1.17-1.89) and dissatisfaction with the EHR (OR = 1.57; 95% CI, 1.27-1.93) were also associated with physicians' intentions to leave their positions within 2 years.

Burnout was the most influential factor for physicians intending to leave medical practice for a different career (OR = 5.79; 95% CI, 2.47-13.56).

"If physicians follow through on these intentions, they have the potential to profoundly worsen the projected shortage of U.S. physicians," Sinsky and colleagues concluded. "Burnout, dissatisfaction with EHR and problems with work-life integration appear to be major factors influencing physician career plans. Concerted efforts are needed to address these issues at the national and organizational level to preserve the adequacy of the physician workforce."

In a related press release, the AMA stated that these findings elucidate the "troubling" association between the growing issue of burnout, technology dissatisfaction and administrative fatigue and physicians' career plans, as well as highlight the need for national policymakers and health care delivery institutions to develop a comprehensive approach to address the problem.

"An energized, engaged, and resilient physician workforce is essential to achieving national health goals," **David O. Barbe, MD, MHA,** president of AMA, said. "Yet burnout is more common among physicians than other U.S. workers, and that gap is increasing as mounting obstacles to patient care contribute to emotional fatigue, depersonalization and loss of enthusiasm among physicians."

"The AMA is urging Congress, hospitals and health plans to recognize the coming crisis as an early warning sign of health system dysfunction. America's physicians are the canary in the coal mine," he continued. – *by Alaina Tedesco*

➕ ADD TOPIC TO EMAIL ALERTS

Physician Burnout—A Leading Indicator of Health System Performance?

CrossMark

Like the proverbial canary in the coal mine that alerts miners to the need for course correction, physician burnout provides an early indicator of health system dysfunction in time for decision-makers to change course and avoid health system failures. In this issue of *Mayo Clinic Proceedings*, Sinsky et al[1] report that physicians may be exiting their careers in medicine faster than they enter; their intentions to withdraw are highly correlated with burnout (odds ratio [OR] 5.8). Also in this issue, Shanafelt et al[2] advocate to proactively monitor and manage professional burnout and wellbeing in individuals as a way to avert crises. To this end, they offer an organizational blueprint for duplicating the Mayo Clinic Office of Staff Services [OSS], and explain how to reduce the barriers for professionals seeking support.

By monitoring burnout, threats may be identified and addressed in a cost-effective manner before disrupting patient care. As Sinsky et al describe, if a third of the physicians follow through with their intention to reroute into a different career in the next 2 years, the United States stands to lose 4762 physicians (equivalent to eliminating the graduating class from 19 medical schools for 2 years, assuming 125 students per class). Whereas, the 11 medical schools built between 2001-2011, at an estimated cost of $100 million each, added 784 medical graduates in 2016. Losses may outpace gains. This would exacerbate the physician shortfall of 45,000 to 90,000 expected by 2025, and impede patients' access to care.

Clinical Practice Tied to Burnout

Physicians' work or their workplaces put them at risk for burnout. Burnout is a syndrome of emotional exhaustion and depersonalization.[3] Compared with the general population, physicians enter clinical practice healthy, with a higher quality of life, lower rates of burnout and depression,[4] and lower rates of cancer and cardiovascular disease.[5] Once in practice, they register lower work-life satisfaction (40.9% vs 61.3%) and higher rates of burnout (54.4% vs 28.4%),[6] and the risk of suicide becomes 1.4 and 2.3 times higher for male and female physicians, respectively.[7] The fact that burnout increased across all medical specialties between 2011 and 2014, while remaining stable in the general population, is further evidence that this is a workplace issue. Exposure to clinical work hours demonstrates a dose effect with burnout, thereby suggesting cause and effect.[6] Most physicians are now employed in large hospital organizations and may not have the authority to resolve this without organizational leadership. Indeed, there is an emphasis on institutional strategies to alleviate burnout and its adverse consequences.[8,9] In this issue of *Mayo Clinic Proceedings*, Sinsky et al[1] and Shanafelt et al[2] describe how surveying for burnout in health systems and individuals can avert crises and improve performance.

Physically Withdrawing From Clinical Practice

Sinsky et al[1] reported burnout as the factor most strongly related to physicians' plans to withdraw from the clinical workforce by reducing to part-time within the next 12 months (19.8%); leaving the clinical workforce within the next 2 years by retiring (9.9%), rerouting their careers into nonclinical work (2.6%), or rerouting into a different career altogether (1.9%); entering a revolving door of different practice opportunities in search of satisfaction (9.3%); or a combination of these (2.7%). Turnover costs are estimated to be $800,000 per physician. Still, there are additional ways that physicians physically withdraw from clinical practice. They may restrict their scope of practice to avoid clinical stressors (eg, fewer obstetricians/gynecologists may deliver babies and fewer primary care physicians may accept insurance). The risk of suicide accounts for 300 to 400 physicians lost each year.[10] Withdrawal from clinical work is protective against burnout but may potentiate burnout in the remaining physicians by

shifting work. Physician withdrawal from clinical work has adverse effects on access, continuity of care, patient satisfaction, productivity, and costs.

The analysis by Sinsky et al[1] was conducted with 6695 practicing physicians sampled from and similar to the 835,451 physicians in the American Medical Association Physician Masterfile, a nearly complete record of all the physicians in the United States. The Canadians performed a similar analysis using the Canadian Medical Association Masterfile of 70,000 physicians and found that the cost of reduced work hours and early withdrawal from practice directly attributable to burnout was CaD$213.1 million; 58.8% could be attributed to family physicians. Family physicians represent most physicians; they see nearly twice as many patients per hour at approximately half the cost per service and are more likely to reduce or withdraw from practice at an earlier age compared with surgeons and specialists.[11] The physician workforce in the United States is 12 times the size of that in Canada, with 2.6 times the prevalence of burnout using more inclusive criteria and potentially higher costs per service.

Psychologically Withdrawing From Clinical Practice

Burned-out physicians who are not able to physically withdraw from clinical practice may be unable to modulate their well-being and, therefore, may psychologically withdraw. A burned-out physician may lack empathy or the cognitive vigilance required to prevent errors. Burned-out physicians perceive that they make more errors, and self-perceived errors portend more burnout, suggesting a reciprocal relationship.[12] Physician stress reduction has the potential to reduce malpractice claims by two-thirds,[13] an average of $371,054 per claim.[14] Frontline disciplines are most affected by burnout and malpractice claims. They may be at increased risk for substance abuse, suicide, and troubled relationships.[8] A burned-out physician workforce may be less efficient and more costly if they are prone to reducing their pace, resisting work, rebelling against bureaucratic tasks with workarounds,[15] or reluctant to engage in organizational initiatives. Physically present but psychologically withdrawn, a burned-out workforce may have adverse effects on quality and safety, patient satisfaction, efficiency, productivity and costs.

Support Individual Performance

Shanafelt et al[2] aimed to proactively secure the well-being of the professional workforce. Typically, the OSS at Mayo Clinic provides 75% of their eligible staff with financial services and 5% to 7% with peer support as needed. In this study, 39 professionals were invited to schedule an appointment without a perceived need, and 26 accepted. A brief previsit checklist introduced potential topics to be discussed. The financial planners met each participant and were trained to encourage a visit with peer support. Of the 77% who accepted peer support, the following topics were discussed: work-life integration (38%), career satisfaction (29%), self-care (8%), and personal medical needs (0%). All the participants found the checkup helpful and satisfying, and 84% endorsed the proactive checkup annually at a minimum.

Based on 15 years' experience, the OSS recommends exercising care to minimize stigma and barriers for professionals seeking help; professionals may be averse to appearing imperfect or vulnerable. The OSS chose a location near the lobby, away from entities related to mental health, employee assistance, human resources, and administrative offices related to professional misconduct. The OSS is managed by a medical director. It maintains the strictest confidentiality, with no identifying information and minimal notes; the notes are not discoverable in a lawsuit. The OSS fosters familiarity by meeting with new hires and new chairpersons and by promoting the OSS widely. Financial planners help manage high debt burdens, retirement, taxes, insurance, investing, and other financial concerns, thus normalizing visits. The traffic to the financial planners obscures visits to peer support. The peer support panel assists with a range of personal and professional services to improve well-being in work-life, enabling physicians to focus on patient care involving high-stakes decision making and long hours.

Stigmatizing of physicians who experience burnout should be avoided. Although lack of cognitive vigilance may lead to errors, errors are not necessarily attributable to burned-out individuals. A burned-out workforce may indicate a system prone to errors. It is plausible that physicians who are most cognitively vigilant and

TABLE. R-Factors: Physicians' Reactions to Burnout

Type of reaction	R-factors
Physically withdrawing from clinical practice	Reduce work effort (hours)
	Retreat (paid time off, sick days)
	Retire early
	Reroute career (leave career in medicine altogether)
	Reroute career (nonclinical: administrative, research, etc)
	Restrict scope of practice (avoid stressful work)
	Revolving door (recruiting and retaining)
	Risky (suicide)
Psychologically withdrawing from clinical practice	Reduce work effort (productivity)
	Resist (work stoppages, incentives to motivate work, etc)
	Rebel (work-arounds, manipulations to bypass hassles)
	Reluctant (disengaged from organizational initiatives, innovation, and improvement)
	Reckless (lack of cognitive vigilance, resulting in errors)
	Risky (substance abuse, broken relationships, suicidality, etc)

committed to providing safe, high-quality, patient-centered care are especially prone to burnout if their efforts are frustrated by a dysfunctional system; they may thus withdraw. These physicians may be the ones who organizations want to retain. Physician burnout may be the best early indicator of system dysfunction, before errors can occur.

Support Health System Performance

Sinsky et al[1] highlighted a selection of stressors found in the clinical workplace that contribute to burnout: loss of control and flexibility, inefficient processes (the electronic health record, computer physician order entry, clerical burdens), and poor work-life integration. Burnout was most highly correlated with physicians' intent to reduce work hours and their intent to leave clinical medicine (OR=1.81 and OR=2.16, respectively). Work-life integration was also more correlated with the intent to reduce work hours (OR=1.65), and the electronic health record was more highly correlated with the intent to leave one's current practice (OR=1.57). Of those who planned to reduce their work hours, 28.6% wanted to spend more time with family and 26.2% were frustrated with the work environment. Achieving workplace efficiency with the electronic health record, computer physician order entry, or clerical work will likely require a concerted sustained effort with major stakeholders.

Monitoring physician burnout can detect dysfunction in the health system before it affects

patient care. The process of withdrawing physically or psychologically (Table) is a mechanism by which physician burnout interferes with the process of providing the population access to cost-effective, safe, high-quality, patient-centered care. As such, physician well-being is also an important quality indicator. Burnout detectors can be used to evaluate the workplace for instigators and drivers of the burnout phenomenon. Monitoring physician well-being is especially important now that most physicians are employed in large organizations and may lack authority to act independently. In this issue of *Mayo Clinic Proceedings*, Sinsky et al[1] and Shanafelt et al[2] demonstrate the value of tending to the well-being of systems and individuals.

Kristine D. Olson, MD, MSc
Department of Internal Medicine
Yale School of Medicine
New Haven, CT

Correspondence: Address to Kristine D. Olson, MD, MSc, Assistant Professor of Clinical Medicine, Yale School of Medicine, 20 York St, New Haven, CT 06510 (kristine.olson@yale.edu).

REFERENCES

1. Sinsky C, Dyrbye L, West C, Satele D, Tutty M, Shanafelt T. Professional satisfaction and career plans of US physicians. *Mayo Clin Proc.* 2017;92(11):1625-1635.
2. Shanafelt T, Lightner D, Conley C, et al. An organizational model to assist individual physicians, scientists, and senior

healthcare administrators with personal and professional needs. *Mayo Clin Proc.* 2017;92(11):1688-1696.

3. Maslach C, Jackson S. The measurement of experienced burnout. *J Occup Behav.* 1981;2:99-113.

4. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med.* 2014;89(3):443-451.

5. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA.* 2003; 289(23):3161-3166.

6. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc.* 2015;90(12):1600-1613.

7. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry.* 2004;161(12):2295-2302.

8. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc.* 2017;92(1): 129-146.

9. Bohman B, Dyrbye L, Sinsky C, et al. Physician well-being: the reciprocity of practice efficiency, culture of wellness, and personal resilience. NEMJ Catalyst website, http://catalyst. nejm.org/physician-well-being-efficiency-wellness-resilience. Accessed April 30, 2017.

10. American Foundation for Suicide Prevention. Physician and medical student depression and suicide prevention. https:// afsp.org/our-work/education/physician-medical-student-depression-suicide-prevention. Accessed May 1, 2017.

11. Dewa CS, Jacobs P, Thanh NX, Loong D. An estimate of the cost of burnout on early retirement and reduction in clinical hours of practicing physicians in canada. *BMC Health Serv Res.* 2014;14:254.

12. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA.* 2006;296(9):1071-1078.

13. Jones JW, Barge BN, Steffy BD, Fay LM, Kunz LK, Wuebker LJ. Stress and medical malpractice: Organizational risk assessment and intervention. *J Appl Psychol.* 1988;73(4):727-735.

14. Studdert DM, Bismark MM, Mello MM, Singh H, Spittal MJ. Prevalence and characteristics of physicians prone to malpractice claims. *N Engl J Med.* 2016;374(4):354-362.

15. Werner RM, Alexander GC, Fagerlin A, Ubel PA. The "hassle factor": what motivates physicians to manipulate reimbursement rules? *Arch Intern Med.* 2002;162(10):1134-1139.

Professional Satisfaction and the Career Plans of US Physicians

Christine A. Sinsky, MD; Lotte N. Dyrbye, MD, MHPE; Colin P. West, MD, PhD; Daniel Satele, MS; Michael Tutty, PhD; and Tait D. Shanafelt, MD

Abstract

Objective: To evaluate the relationship between burnout, satisfaction with electronic health records and work-life integration, and the career plans of US physicians.

Participants and Methods: Physicians across all specialties in the United States were surveyed between August 28, 2014, and October 6, 2014. Physicians provided information regarding the likelihood of reducing clinical hours in the next 12 months and the likelihood of leaving current practice within the next 24 months.

Results: Of 35,922 physicians contacted, 6880 (19.2%) returned surveys. Of the 6695 physicians in clinical practice at the time of the survey (97.3%), 1275 of the 6452 who responded (19.8%) reported it was likely or definite that they would reduce clinical work hours in the next 12 months, and 1726 of the 6496 who responded (26.6%) indicated it was likely or definite that they would leave their current practice in the next 2 years. Of the latter group, 126 (1.9% of the 6695 physicians in clinical practice at the time of the survey) indicated that they planned to leave practice altogether and pursue a different career. Burnout (odds ratio [OR], 1.81; 95% CI, 1.49-2.19; $P<.001$), dissatisfaction with work-life integration (OR, 1.65; 95% CI, 1.27-2.14; $P<.001$), and dissatisfaction with the electronic health record (OR, 1.44; 95% CI, 1.16-1.80; $P=.001$) were independent predictors of intent to reduce clinical work hours and leave current practice.

Conclusion: Nearly 1 in 5 US physicians intend to reduce clinical work hours in the next year, and roughly 1 in 50 intend to leave medicine altogether in the next 2 years to pursue a different career. If physicians follow through on these intentions, it could profoundly worsen the projected shortage of US physicians.

© 2017 Mayo Foundation for Medical Education and Research ■ Mayo Clin Proc. 2017;92(11):1625-1635

The United States Department of Health and Human Services projects a short-fall of 45,000 to 90,000 physicians by 2025, even after accounting for an influx of advanced practice health care professionals, as the US population ages and the prevalence of chronic disease increases.[1,2] The United States has begun to address this issue by increasing the flow of physicians *into* the workforce, establishing 11 new medical schools between 2001 and 2011.[3] The factors influencing the flow of physicians *out* of the workforce and the magnitude of this phenomenon are not fully understood.

National studies suggest that more than half of US physicians are experiencing professional burnout and that this proportion continues to increase.[4] A host of factors including excessive clerical burden,[5-7] inefficiencies related to the electronic health record (EHR) and computerized physician order entry (CPOE),[7,8] loss of control and flexibility,[5] and problems with work-life integration[9-15] contribute to physician burnout. Single-specialty studies suggest that burned out physicians are more likely to report that they intend to reduce the amount of time they devote to clinical work over the next 12 to 24 months.[11,16,17] A prospective, longitudinal study within a single institution found that physician burnout and professional satisfaction predict actual reductions in professional work effort independently measured using payroll records.[18] Other studies indicate that professional burnout and satisfaction with work-life integration also impact whether physicians intend to leave their current position in the next 24 months.[11,19] National studies across all specialties evaluating how burnout and other dimensions of

From the American Medical Association, Chicago, IL (C.A.S., M.T.); and Division of Primary Care Internal Medicine, Department of Medicine (L.N.D.), Division of General Internal Medicine, Department of Medicine (C.P.W.), Division of Biomedical Statistics and Informatics (C.P.W., D.S.), and Division of Hematology (T.D.S.), Mayo Clinic,

Affiliations continued at the end of this article.

professional satisfaction such as satisfaction with work-life integration or the EHR affect career plans have not been conducted to date. To evaluate the career plans of US physicians as well as the personal and professional factors that may influence these plans, we conducted a national survey of US physicians in active practice in 2014.

PARTICIPANTS AND METHODS

We conducted a survey of US physicians between August 28, 2014, and October 6, 2014. A description of the survey administration process, participation rates, and demographic characteristics of the overall survey has been reported previously.[7,12,20] The physician sample for the survey was assembled using the American Medical Association Physician Masterfile, a nearly complete record of all US physicians independent of American Medical Association membership, which includes physicians of all specialty disciplines. Participation was voluntary, and all responses were anonymous. As previously reported, 6880 (19.2%) of the 35,922 physicians who received an invitation to participate completed surveys.[12] The demographic characteristics of participants relative to all 835,451 US physicians in the Physician Masterfile were generally similar, although participants were slightly older (median age, 56 years vs 51.5 years).[12] Among these 6880 participating physicians, the 6695 (97.3%) who were in active clinical practice at the time of the survey were included in the present analysis on career plans.

Study Measures

The full-length survey included 60 questions. Standardized survey tools were used to assess burnout[21] and quality of life.[22-24] Physician burnout was measured using the Maslach Burnout Inventory, a validated 22-item questionnaire considered the criterion standard for measuring burnout.[21,25,26] Consistent with convention,[27-29] we considered physicians with a high score on the depersonalization or emotional exhaustion subscale of the Maslach Burnout Inventory as having at least 1 manifestation of professional burnout.[26] Responding physicians provided information regarding basic demographic characteristics (age, sex, and relationship status) and professional characteristics (specialty, practice setting, and hours worked per week). Satisfaction with work-life integration was assessed by asking participants to rate their level of agreement with the statement, "My work schedule leaves me enough time for my personal/family life" (response options: strongly agree, agree, neutral, disagree, strongly disagree). Individuals who indicated "strongly agree" or "agree" were considered to be satisfied with their current degree of work-life integration. This item has been used to assess satisfaction with work-life integration in other studies of physicians[11,12,30,31] and studies of the general US population.[12]

Career Plans

Items from previous national physician surveys were used to assess intent to reduce clinical work hours or move to a new position in the near future (Supplemental Appendix, available online at http://www.mayoclinicproceedings.org).[11,19] Based on previous studies,[17,32,33] physicians who indicated they were "likely" or "definitely" planning to make a change in work hours or move to a new position were considered to be at higher risk to do so.

As previously reported,[7] responding physicians also provided information regarding characteristics of the electronic environment in which they practiced. Specifically, physicians indicated whether they used an EHR and CPOE. Physicians who reported that they used an EHR and CPOE were asked to rate their level of satisfaction with these tools (response options: very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, very dissatisfied). Individuals who indicated "very satisfied" or "satisfied" were considered to be satisfied with their EHR and CPOE, those who answered "neither satisfied nor dissatisfied" were considered to have a neutral view, and those who indicated "dissatisfied" or "very dissatisfied" were considered to be dissatisfied with the EHR and CPOE. Satisfaction with clerical tasks directly related to patient care was assessed by asking physicians to rate their level of agreement with the statement, "The amount of time I spend on clerical tasks related to direct patient care (eg, order entry, dictation, reviewing lab results, communicating with patients via an electronic portal) is reasonable." Responses were indicated using a standard agreement scale (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree).

TABLE 1. Personal and Professional Characteristics of the 6695 Study Participants

Variable	No. (%) of participants
Sex (N=6490)	
Male	4355 (67.1)
Female	2135 (32.9)
Age (y) (N=6488)	
<40	941 (14.5)
40-49	1226 (18.9)
50-59	1906 (29.4)
≥60	2415 (37.2)
Relationship status (N=6502)	
Single	700 (10.8)
Married	5436 (83.6)
Partnered	267 (4.1)
Widowed	99 (1.5)
Age (y) of youngest child (N=6457)	
No children	1057 (16.4)
1-18	2380 (36.9)
≥19	3020 (46.8)
Specialty (N=6637)	
Anesthesiology	233 (3.5)
Dermatology	164 (2.5)
Emergency medicine	351 (5.3)
Family medicine	527 (7.9)
General surgery	246 (3.7)
General surgery subspecialty	371 (5.6)
Internal medicine, general	448 (6.8)
Internal medicine, subspecialty	765 (11.5)
Neurology	238 (3.6)
Neurosurgery	56 (0.8)
Obstetrics and gynecology	287 (4.3)
Ophthalmology	231 (3.5)
Orthopedic surgery	232 (3.5)
Otolaryngology	161 (2.4)
Other	231 (3.5)
Pathology	168 (2.5)
Pediatrics, general	359 (5.4)
Pediatrics, subspecialty	311 (4.7)
Physical and rehabilitation medicine	170 (2.6)
Preventive and occupational medicine	105 (1.6)
Psychiatry	550 (8.3)
Radiation oncology	62 (0.9)
Radiology	255 (3.8)
Urology	116 (1.7)
Hours worked per week (N=6643)	
<40	1118 (16.8)
40-49	1325 (19.9)
50-59	1650 (24.8)
60-69	1511 (22.7)
70-79	533 (8.0)
≥80	506 (7.6)

Continued on next column

TABLE 1. Continued

Variable	No. (%) of participants
No. of nights on call per week (N 6360)	
0	2079 (32.7)
1	1450 (22.8)
2	1039 (16.3)
≥3	1792 (28.2)
Primary practice setting (N=6695)	
Private practice	3605 (53.8)
Academic medical center	1625 (24.3)
Veterans hospital	104 (1.6)
Active military practice	58 (0.9)
Other	1303 (19.5)
Method of compensation (N=6609)	
Salary	2155 (32.6)
Salary plus bonus	2207 (33.4)
Pure productivity-based pay	2247 (34.0)

Statistical Analyses

Standard descriptive summary statistics were used to characterize physician responses. Associations between variables were evaluated using the Kruskal-Wallis test (continuous variables) or χ^2 test (categorical variables) as appropriate. All tests were 2-sided with type I error rates of α=.05. Multivariate analysis was performed to identify personal and professional characteristic variables independently associated with intent to reduce clinical work in the next 12 months and or leave their current practice position in the next 24 months. Dummy variable adjustment for missing values was conducted to confirm multivariate results and did not meaningfully alter the results. In these models, satisfaction with work-life integration, clerical burden, the EHR, and CPOE were treated categorically as neutral (reference), satisfied (satisfied or very satisfied), or dissatisfied (dissatisfied or very dissatisfied). All analyses were performed using SAS statistical software, version 9 (SAS Institute).

RESULTS

The personal and professional characteristics of the 6695 physicians in active clinical practice at the time of the survey who were included in this analysis are summarized in Table 1. The median age was 56 years, two-thirds were men, more than half were in private practice, and the average hours worked per week was 52.2. We found minimal

TABLE 2. Career Plans of 6695 Study Participants

Variable	No. (%) of participants
Reducing clinical work hours	
Likelihood of reducing clinical work hours in next 12 mo (N=6452)	
None	2784 (43.1)
Slight	1619 (25.1)
Moderate	774 (12.0)
Likely	723 (11.2)
Definite	552 (8.6)
Primary reason for considering reducing clinical work hours (N=1267)[a]	
Spend more time with family	362 (28.6)
Frustration with Medicare and insurance issues	185 (14.6)
Age/retirement/leisure pursuits	173 (13.7)
Frustration with work environment	147 (11.6)
Declining reimbursement for clinical care	128 (10.1)
Pursue administrative/leadership opportunities	93 (7.3)
Personal health problems	52 (4.1)
Pursue research/education opportunities	46 (3.6)
A family member health problems	20 (1.6)
Other/combination of other reasons	61 (4.8)
Leaving current practice	
Likelihood of leaving current practice in the next 2 y (N=6496)	
None	1747 (26.9)
Slight	1896 (29.2)
Moderate	1127 (17.3)
Likely	984 (15.1)
Definite	742 (11.4)
What do you plan to do if you leave your current practice? (N=1712)[b]	
Retire	640 (37.4)
Pursue different practice opportunity	603 (35.2)
Administrative job in medicine but no longer work as a physician	166 (9.7)
Other/combination of other options	177 (10.3)
Leave practice altogether and pursue different career	126 (7.4)

[a]Among the 1275 participants reporting a likely/definite chance of reducing clinical work hours in the next 12 months.
[b]Among the 1726 participants reporting a likely/definite chance of leaving current practice within the next 24 months.

differences between early responders and late responders (a standard approach to evaluate for response bias) with respect to age, sex, or specialty.[4]

A description of the career plans of participating physicians is presented in Table 2.

In aggregate, 1275 of the 6452 responders (19.8%) reported it was "likely" or "definite" that they would reduce clinical work hours in the next 12 months. Among those who indicated it was likely or definite that they would reduce clinical work hours, the most commonly reported reason was "to spend more time with family" (362 of 1267 responders [28.6%]). Frustration with specific characteristics of work (eg, Medicare and insurance issues, frustration with the work environment) collectively were reported as the primary reason to cut back by 332 of the 1267 responders (26.2%).

With respect to the likelihood of leaving their current position in the next 24 months, 1726 of the 6496 responders (26.6%) indicated it was "likely" or "definite" that they would leave their current practice within the next 2 years. Among these, 640 of the 1712 responders (37.4%) planned to retire, 603 (35.2%) planned to pursue a different practice opportunity, and 166 (9.7%) planned to take an administrative position in health care but no longer work as a clinically active physician. An additional 126 (7.4% of the 1712 responders indicating it was likely or definite they would leave, 1.9% of all 6695 participants) indicated that they planned to leave practice altogether and pursue a different
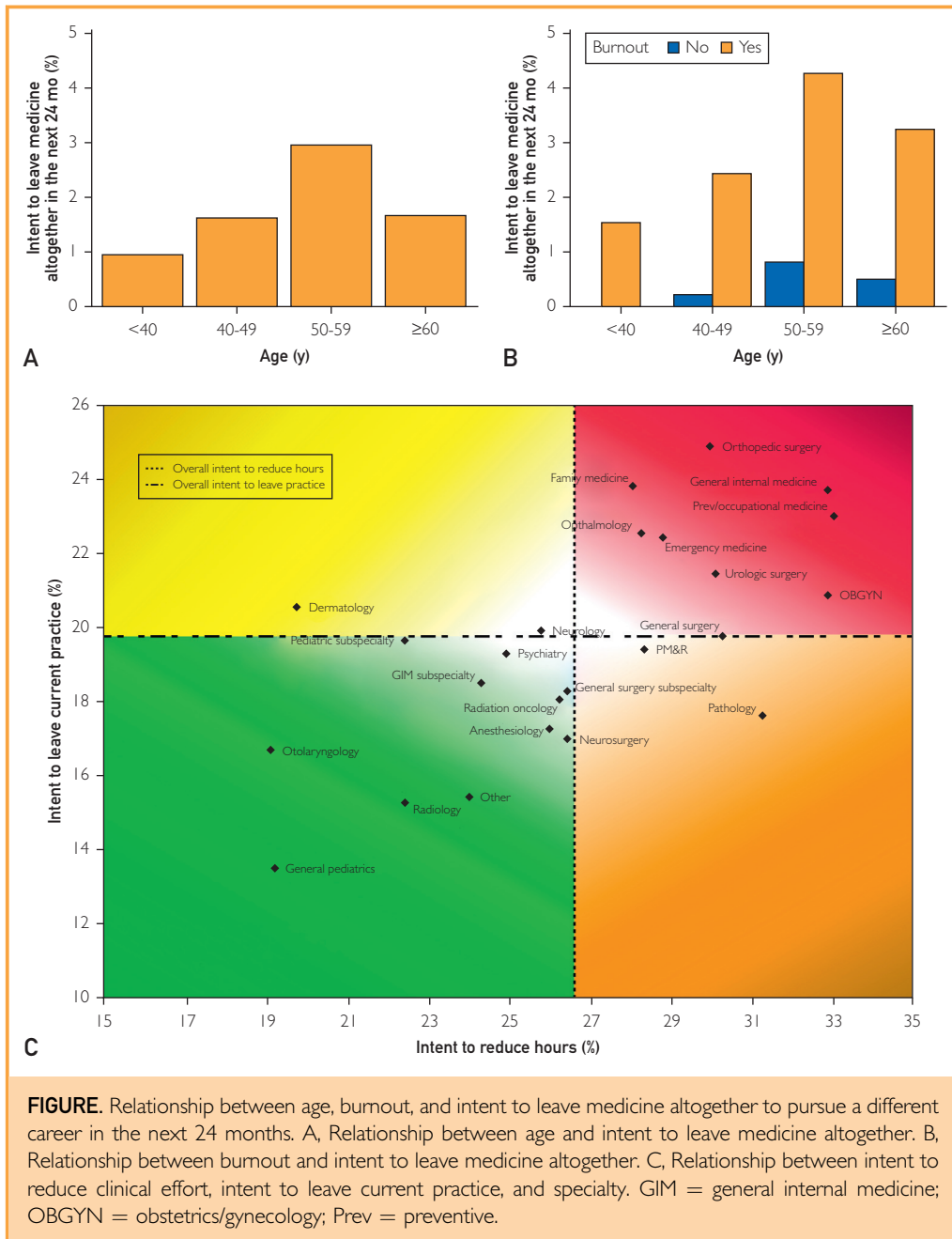
FIGURE. Relationship between age, burnout, and intent to leave medicine altogether to pursue a different career in the next 24 months. A, Relationship between age and intent to leave medicine altogether. B, Relationship between burnout and intent to leave medicine altogether. C, Relationship between intent to reduce clinical effort, intent to leave current practice, and specialty. GIM = general internal medicine; OBGYN = obstetrics/gynecology; Prev = preventive.

career. The proportion of physicians who intended to leave medicine altogether in the next 24 months varied by age and was highest among those aged 50 to 59 years (Figure, A). Burnout was also strongly related to the intent to leave medicine altogether (Figure, B). Among individuals with low, intermediate, and high emotional exhaustion scores, 0.7% (14 of 2152), 1.0% (12 of 1222), and 3.8% (116 of 3022) indicated that they intended to leave medicine to pursue a different career in the next 24 months ($P<.001$). Among individuals with low, intermediate, and high depersonalization scores, 1.3% (37 of 2775), 1.6% (22 of 1359), and 3.7% (83 of 2237) indicated that they intended to leave medicine to pursue a different career in the next 24 months ($P<.001$). The relationship between

TABLE 3. Relationship Between Personal and Professional Characteristics and Career Plans[a,b]

Variable	Intend to reduce clinical hours in next 12 mo[c] (N=1275)	P value	Intend to leave current practice in next 24 mo[d] (N=1726)	P value
Age		<.001		<.001
<40	132 (14.1)		214 (22.8)	
40-49	170 (14.0)		224 (18.3)	
50-59	301 (16.0)		353 (18.7)	
≥60	661 (27.8)		922 (38.4)	
Missing	12		13	
Total responders	1264		1713	
Sex		.001		.32
Male	897 (20.9)		1166 (26.9)	
Female	366 (17.4)		547 (25.8)	
Missing	11		13	
Total responders	1263		1713	
Children		<.001		<.001
No children	179 (17.1)		319 (30.2)	
Youngest child 1-18 y	350 (14.8)		416 (17.5)	
Youngest child ≥19 y	735 (24.6)		976 (32.4)	
Missing	11		15	
Total responders	1264		1711	
Hours worked per week		.15		<.001
<40	228 (21.1)		382 (35.0)	
40-49	247 (19.4)		334 (26.1)	
50-59	283 (17.8)		375 (23.3)	
60-69	290 (19.9)		341 (23.3)	
70-79	104 (20.1)		122 (23.5)	
≥80	110 (22.6)		157 (32.1)	
Missing	13		15	
Total responders	1262		1711	
No. of nights on call per week		.02		<.001
0	394 (19.8)		568 (28.2)	
1	246 (17.5)		306 (21.7)	
2	189 (18.8)		237 (23.5)	
≥3	375 (21.7)		509 (29.4)	
Missing	71		106	
Total responders	1204		1620	
Primary practice setting		.07		<.001
Private practice	733 (21.1)		882 (25.3)	
Academic medical center	286 (18.3)		391 (24.8)	
Veterans hospital	16 (16.0)		27 (27.3)	
Active military practice	10 (18.2)		30 (53.6)	
Other	230 (18.3)		396 (31.1)	
Total responders	1275		1726	
Method of compensation		<.001		<.001
Salary	372 (17.9)		630 (30.1)	
Salary plus bonus	402 (18.8)		512 (23.8)	
Pure productivity-based pay	487 (22.6)		555 (25.5)	
Missing	14		29	
Total responders	1261		1697	
Time spent on clerical tasks related to patient care is reasonable		<.001		<.001
Strongly agree	72 (14.3)		104 (20.6)	
Agree	311 (16.6)		451 (23.9)	
Neutral	156 (16.8)		232 (24.8)	
Disagree	286 (19.6)		366 (25.1)	

Continued on next page

	Intend to reduce clinical hours in next 12 mo[c] (N=1275)	P value	Intend to leave current practice in next 24 mo[d] (N=1726)	P value
TABLE 3. Continued				
Variable				
Time spent on clerical tasks related to patient care is reasonable, continued				
Strongly disagree	407 (27.2)		499 (33.3)	
Missing	43		74	
Total responders	1232		1652	
Satisfied with EHR		<.001		<.001
Very satisfied	54 (15.2)		83 (23.3)	
Satisfied	218 (13.7)		321 (20.1)	
Neither satisfied/dissatisfied	186 (17.1)		242 (22.1)	
Dissatisfied	348 (23.9)		447 (30.6)	
Very dissatisfied	247 (27.7)		322 (36.0)	
Missing	222		311	
Total responders	1053		1415	
Satisfied with CPOE		<.001		<.001
Very satisfied	50 (15.2)		76 (23.0)	
Satisfied	248 (16.3)		327 (21.4)	
Neither satisfied/dissatisfied	175 (17.9)		237 (24.2)	
Dissatisfied	325 (23.7)		405 (29.5)	
Very dissatisfied	176 (26.7)		241 (36.3)	
Missing	301		440	
Total responders	974		1286	
Work-life integration		<.001		<.001
Dissatisfied	725 (25.0)		866 (29.7)	
Satisfied	542 (15.4)		846 (23.8)	
Missing	8		14	
Total responders	1267		1712	
Burnout		<.001		<.001
Yes	847 (24.1)		1121 (31.8)	
No	413 (14.4)		582 (20.0)	
Missing	15		23	

[a]CPOE = computerized physician order entry; EHR = electronic health record.

[b]Data are presented as No. (percentage) of participants.

[c]"Likely" or greater chance participant will reduce clinical work hours in the next 12 months.

[d]"Likely" or greater chance participant will leave current practice in the next 24 months.

intent to leave and reduce clinical work hours by specialty is presented in Figure, C.

The relationship between personal and professional characteristics and career plans is presented in Table 3 and the Supplemental Table (available online at http://www.mayoclinicproceedings.org). On univariate analysis, a variety of personal and professional characteristics including burnout, dissatisfaction with the EHR, CPOE, and time spent on clerical tasks, and work-life integration were associated with intent to reduce clinical work hours and/or leave current practice.

Finally, we performed multivariate analysis to identify personal and professional characteristics independently associated with intent to reduce clinical work hours or leave current practice. A variety of personal and professional characteristics were associated with each outcome (Table 4). Notably, after adjusting for other personal and professional characteristics, physicians who were burned out (odds ratio [OR], 1.81; 95% CI, 1.49-2.19; $P<.001$), dissatisfied with work-life integration (OR, 1.65; 95% CI, 1.27-2.14; $P<.001$), and dissatisfied with the EHR (OR, 1.44; 95% CI, 1.16-1.80; $P<.001$) were more likely to intend to reduce clinical work in the next 12 months. Similarly, after adjusting for other personal and professional characteristics, physicians who were burned out (OR, 2.16; 95%

CI, 1.81-2.59; P<.001), dissatisfied with work-life integration (OR, 1.49; 95% CI, 1.17-1.89; P=.001), and/or dissatisfied with the EHR (OR, 1.57; 95% CI, 1.27-1.93; P<.001) were more likely to intend to leave their current position in the next 24 months. Burnout (OR, 5.79; 95% CI, 2.47-13.56; P<.001) was even more strongly related to whether physicians intended to leave medicine altogether to pursue a different career.

DISCUSSION

Currently, information on the career plans of US physicians is limited. In this large national study across all specialty disciplines, roughly 1 in 5 physicians indicated that they would likely or definitely reduce their clinical work hours in the next 12 months. Similarly, roughly 1 in 4 physicians indicated that they would likely or definitely leave their current practice position in next 24 months. Although intent to leave is an imperfect predictor of actual behavior, multiple studies have found that intent to leave among physicians correlates with actual departures.[17,32,33]

These findings have potentially profound implications for the adequacy of the US physician workforce. Reduction of clinical work hours results in reduced access to care for patients and thus has a direct effect on the adequacy of physician supply. Leaving current practice, even for another practice, erodes continuity of care and results in reduced access during the transitions, as the physician is either ramping down capacity in their old practice or ramping up in their new practice.

A more substantial reduction occurs when physicians leave practice altogether to pursue nonclinical work or a different career. It is striking that 126 of 6695 physicians in our sample (approximately 2% of the overall cohort) indicated that it is likely or definite that they will leave the practice of medicine altogether to pursue a different career in the next 24 months.

Our findings have potentially profound implications for health care organizations. Replacing physicians is costly to institutions,[34] with one recent analysis suggesting costs of $800,000 or more per physician.[35] In addition, turnover is disruptive to patients, staff, and organizational culture. A physician workforce that has one eye on the door may not be optimally engaged and aligned with advancing the institution's goals.

In this regard, the factors related to physicians' intent to reduce clinical work hours and/or leave medicine to pursue a different career may provide insights to inform efforts to address this issue. For example, understanding the factors that relate to physicians' intent to reduce clinical hours or leave their current position may inform organizational efforts to reduce turnover and avoid recruitment and replacement costs. On multivariate analysis, burnout and dissatisfaction with the EHR and work-life integration were all independent predictors of both intent to reduce clinical work hours and intent to leave a current position. Burnout and age were the strongest factors related to intent to leave medicine altogether to pursue a different career in the next 24 months, with those burned out and aged 50 to 59 years at particular risk.

We have previously estimated that the increase in burnout observed in US physicians between 2011 and 2014 likely translated into an approximately 1% reduction in the professional effort of the US physician workforce due to physicians reducing clinical work hours.[18] This conservative estimate did not include the effects of physicians leaving practice altogether because of burnout. If physicians follow through on their reported intentions, the present study would suggest that up to an additional 2% of the physician workforce are considering leaving practice altogether in the next 2 years and that professional burnout is the largest factor influencing this decision. The available data suggest that 25% to 35% of physicians who indicate that they intend to leave medicine actually leave practice over the next 3 to 5 years.[17,32,33] At the national level, if 2% of physicians intend to leave practice altogether in the next 24 months and 30% followed through on this intention, approximately 4759 physicians would leave the workforce. This loss would be roughly equivalent to eliminating the graduating class of 19 US medical schools (average class size, 125 students) in each of the next 2 years.

To meet the societal need for medical care, it will be necessary to not only train more physicians but also address potential problems with attrition in the physician workforce due

TABLE 4. Multivariate Analysis to Identify Factors Independently Associated With Career Plans[a]

Group	Predictor	OR (95% CI)	P value
Intent[b] to reduce clinical hours[c-f]	Age ≥60 y (vs age <40 y)	2.81 (2.18-3.63)	<.001
	Dissatisfied with work-life integration (vs neutral)	1.65 (1.27-2.14)	<.001
	Burned out (vs not)	1.81 (1.49-2.19)	<.001
	Dissatisfied with EHR (vs neutral)	1.44 (1.16-1.80)	.001
Intent[b] to leave current practice[c-f]	Age 40-49 y (vs age <40 y)	0.68 (0.52-0.87)	.003
	Age 50-59 y (vs age <40 y)	0.61 (0.46-0.79)	<.001
	Age ≥60 y (vs age <40 y)	1.88 (1.40-2.52)	<.001
	Youngest child aged 1-18 y (vs no children)	0.60 (0.48-0.75)	<.001
	General pediatrics (vs family medicine)	0.59 (0.39-0.90)	.01
	Otolaryngology (vs family medicine)	0.51 (0.29-0.91)	.02
	Psychiatry (vs family medicine)	0.64 (0.42-0.98)	.04
	Active military practice (vs private practice)	4.64 (2.44-8.80)	<.001
	Other practice (vs private practice)	1.23 (1.00-1.50)	.05
	Hours worked per week (each added hour)	0.99 (0.99-1.00)	<.001
	Dissatisfied with work-life integration (vs neutral)	1.49 (1.17-1.89)	.001
	Burned out (vs not)	2.16 (1.81-2.59)	<.001
	Dissatisfied with EHR (vs neutral)	1.57 (1.27-1.93)	<.001
Likely or definitely intend to leave medicine altogether in the next 24 mo to pursue different career	Age 50-59 y (vs age <40 y)	4.15 (1.57-10.95)	.004
	Single (vs married)	3.35 (1.94-5.78)	<.001
	Academic setting (vs private practice)	0.30 (0.14-0.61)	<.001
	Other setting (vs private practice)	0.39 (0.19-0.81)	.01
	Hours worked per week (each add hour)	1.02 (1.00-1.03)	.01
	Burned out (vs not)	5.79 (2.47-13.56)	<.001

[a]EHR = electronic health record; CPOE = computerized physician order entry; OR = odds ratio.

[b]Likely or definite.

[c]Personal characteristics in all models: age, sex, children, relationship status.

[d]Professional characteristics in all models: specialty, practice setting, total work hours per week, hours spent seeing patients per week, nights on call per week.

[e]Distress and satisfaction characteristics in all models: burnout (yes/no).

[f]Additional factors in model: dissatisfied with work-life balance, satisfied with clerical tasks directly related to patient care, satisfaction with EHR, satisfaction with CPOE.

to physicians reducing clinical work hours or leaving the profession. A comprehensive approach by national policymakers and health care delivery institutions will be necessary to address this challenge.[36,37] Given the magnitude of the problem, the investment in such efforts should be equal to or greater than efforts to increase the size of the pipeline. In this regard, it is notable that 784 physicians graduated in 2016 from the 11 new medical schools opened between 2001 and 2011.[3,38] Although the average costs of establishing these new schools are not publically reported, such costs are estimated to approach or exceed $100 million per school (M. Whitcomb, MD, oral communication, March 30, 2017).[39] The number of new physicians entering health care from this investment is far lower than

the more than 4000 that may be anticipated to leave practice because of professional burnout in the next 2 years based on the current analysis.

Our study is subject to a number of limitations. Although consistent with other national survey studies of physicians,[30,40,41] the participation rate among physicians in our study was 19.2%. Although we found minimal differences between early responders and late responders (a standard approach to evaluate for response bias) with respect to age, sex, or specialty, physicians intending to make career changes may be either more or less likely to participate. Our study is cross-sectional and cannot determine cause and effect. We do not know how many physicians who indicate an intent to cut back or leave current practice carry out these

intentions, although the relationship between intention and action is established.[17,32,33,42]

CONCLUSION

Nearly 1 in 5 US physicians responding to our survey intend to reduce clinical work hours in the next year and roughly 1 in 50 intend to leave medicine altogether in the next 2 years to pursue a different career. If physicians follow through on these intentions, they have the potential to profoundly worsen the projected shortage of US physicians. Burnout, dissatisfaction with EHR, and problems with work-life integration appear to be major factors influencing physician career plans. Concerted efforts are needed to address these issues at the national and organizational level to preserve the adequacy of the physician workforce.

SUPPLEMENTAL ONLINE MATERIAL

Supplemental material can be found online at http://www.mayoclinicproceedings.org. Supplemental material attached to journal articles has not been edited, and the authors take responsibility for the accuracy of all data.

REFERENCES

1. Dall T, West T, Chakrabarti R, Iacobucci W. *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025.* Washington, DC: Association of American Medical Colleges; 2015. https://www.aamc.org/download/426242/data/ihsreportdownload.pdf?cm_mmc=AAMC-_-ScientificAffairs-_-PDF-_-ihsreport. Accessed February 7, 2015.
2. Bureau of Health Professions. *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand.* Washington, DC: US Department of Health and Human Services; 2008. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/physiciansupplyissues.pdf. Accessed April 17, 2017.
3. Shipman SA, Jones KC, Erikson CE, Sandberg SF. Exploring the workforce implications of a decade of medical school expansion: variations in medical school growth and changes in student characteristics and career plans. *Acad Med.* 2013;88(12):1904-1912.
4. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014 [published correction appears in *Mayo Clin Proc.* 2016;91(2):276]. *Mayo Clin Proc.* 2015;90(12):1600-1613.
5. Friedberg MW, Chen PG, Van Busum KR, et al. *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.* Santa Monica, CA: RAND Corporation; 2013.
6. Rao SK, Kimball AB, Lehrhoff SR, et al. The impact of administrative burden on academic physicians: results of a hospital-wide physician survey. *Acad Med.* 2017;92(2):237-243.
7. Shanafelt TD, Dyrbye LN, Sinsky C, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc.* 2016;91(7):836-848.
8. Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med.* 2016;165(11):753-760.
9. Shanafelt TD. Finding meaning, balance, and personal satisfaction in the practice of oncology. *J Support Oncol.* 2005;3(2):157−162, 164.
10. Shanafelt T, Dyrbye L. Oncologist burnout: causes, consequences, and responses. *J Clin Oncol.* 2012;30(11):1235-1241.
11. Shanafelt TD, Raymond M, Kosty M, et al. Satisfaction with work-life balance and the career and retirement plans of US oncologists. *J Clin Oncol.* 2014;32(11):1127-1135.
12. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med.* 2012;172(18):1377-1385.
13. Dyrbye LN, Freischlag J, Kaups KL, et al. Work-home conflicts have a substantial impact on career decisions that affect the adequacy of the surgical workforce. *Arch Surg.* 2012;147(10):933-939.
14. Dyrbye LN, West CP, Satele D, Sloan JA, Shanafelt TD. Work/home conflict and burnout among academic internal medicine physicians [letter]. *Arch Intern Med.* 2011;171(13):1207-1209.
15. Dyrbye LN, Sotile W, Boone S, et al. A survey of U.S. physicians and their partners regarding the impact of work-home conflict. *J Gen Intern Med.* 2014;29(1):155-161.
16. Shanafelt TD, Dyrbye LN, West CP, Sinsky CA. Potential impact of burnout on the US physician workforce [letter]. *Mayo Clin Proc.* 2016;91(11):1667-1668.
17. Hann M, Reeves D, Sibbald B. Relationships between job satisfaction, intentions to leave family practice and actually leaving among family physicians in England. *Eur J Public Health.* 2011;21(4):499-503.
18. Shanafelt TD, Mungo M, Schmitgen J, et al. Longitudinal study evaluating the association between physician burnout and changes in professional work effort. *Mayo Clin Proc.* 2016;91(4):422-431.
19. Shanafelt T, Sloan J, Satele D, Balch C. Why do surgeons consider leaving practice [letter]? *J Am Coll Surg.* 2011;212(3):421-422.
20. Shanafelt TD, Hasan O, Hayes S, et al. Parental satisfaction of U.S. physicians: associated factors and comparison with the general U.S. working population. *BMC Med Educ.* 2016;16(1):228.
21. Maslach C, Jackson SE, Leiter MP. *Maslach Burnout Inventory Manual.* 3rd ed. Palo Alto, CA: Consulting Psychologists Press; 1996.
22. Ware JE, Kosinski M, Turner-Bowker D, Gandek B. *How to Score Version 2 of the SF-12 Health Survey.* Lincoln, RI: QualityMetric Inc; 2002.
23. Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression: two questions are as good as many. *J Gen Intern Med.* 1997;12(7):439-445.
24. Ware J Jr, Kosinski M, Keller SD. A 12-item short-form health survey: construction of scales and preliminary tests of reliability and validity. *Med Care.* 1996;34(3):220-233.
25. Rafferty JP, Lemkau JP, Purdy RR, Rudisill JR. Validity of the Maslach Burnout Inventory for family practice physicians. *J Clin Psychol.* 1986;42(3):488-492.

26. Lee RT, Ashforth BE. A meta-analytic examination of the correlates of the three dimensions of job burnout. *J Appl Psychol*. 1996;81(2):123-133.

27. West CP, Dyrbye LN, Satele DV, Sloan JA, Shanafelt TD. Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. *J Gen Intern Med*. 2012;27(11):1445-1452.

28. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *JAMA*. 2011;306(9):952-960.

29. West CP, Dyrbye LN, Sloan JA, Shanafelt TD. Single item measures of emotional exhaustion and depersonalization are useful for assessing burnout in medical professionals. *J Gen Intern Med*. 2009;24(12):1318-1321.

30. Shanafelt TD, Balch CM, Bechamps GJ, et al. Burnout and career satisfaction among American surgeons. *Ann Surg*. 2009; 250(3):463-471.

31. Busis NA, Shanafelt TD, Keran CM, et al. Burnout, career satisfaction, and well-being among US neurologists in 2016. *Neurology*. 2017;88(8):797-808.

32. Rittenhouse DR, Mertz E, Keane D, Grumbach K, et al. No exit: an evaluation of measures of physician attrition. *Health Serv Res*. 2004;39(5):1571-1588.

33. Buchbinder SB, Wilson M, Melick CF, Powe NR. Primary care physician job satisfaction and turnover. *Am J Manag Care*. 2001;7(7):701-713.

34. Buchbinder SB, Wilson M, Melick CF, Powe NR. Estimates of costs of primary care physician turnover. *Am J Manag Care*. 1999;5(11):1431-1438.

35. Schutte L. What you don't know can cost you: building a business case for recruitment and retention best practices. *J ASPR*. Summer 2012. Association of Staff Physician Recruiters website, http://www.aspr.org/?696. Accessed February 7, 2017.

36. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017;92(1): 129-146.

37. Shanafelt TD, Dyrbye LN, West CP. Addressing physician burnout: the way forward. *JAMA*. 2017;317(9):901-902.

38. Association of American Medical Colleges. Table B-2.2: Total Graduates by U.S. Medical School and Sex, 2011-2012 through 2015-2016. https://www.aamc.org/download/321532/data/factstableb2-2.pdf. Published 2016. Accessed April 17, 2017.

39. Texas Higher Education Coordinating Board. Basic Steps to Establish a New Medical School. http://www.thecb.state.tx.us/reports/pdf/1515.pdf. Published September 2008. Accessed April 17, 2017.

40. Allegra CJ, Hall R, Yothers G. Prevalence of burnout in the U.S. oncology community: results of a 2003 survey. *J Oncol Pract*. 2005;1(4):140-147.

41. Kuerer HM, Eberlein TJ, Pollock RE, et al. Career satisfaction, practice patterns and burnout among surgical oncologists: report on the quality of life of members of the Society of Surgical Oncology. *Ann Surg Oncol*. 2007;14(11): 3043-3053.

42. Steel RP, Ovalle NK. A review and meta-analysis of research on the relationship between behavioural intentions and employee turnover. *J Appl Psychol*. 1984;69:673-686.

Prior Authorization and Utilization Management Reform Principles

Patient-centered care has emerged as a major common goal across the health care industry. By empowering patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction with provided services and ultimately improve treatment quality and outcomes.

Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care.   However, health plans and benefit managers contend that utilization management programs are employed to control costs and ensure appropriate treatment.

Recognizing the investment that the health insurance industry will continue to place in these programs, a multi-stakeholder group representing patients, physicians, hospitals and pharmacists (see organizations listed in left column) has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers and the health care system. **This group strongly urges health plans, benefit managers and any other party conducting utilization management ("utilization review entities"), as well as accreditation organizations, to apply the following principles to utilization management programs for both medical and pharmacy benefits.** We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.

Clinical Validity

1. Health care providers want nothing more than to provide the most clinically appropriate care for each individual patient. Utilization management programs must therefore have a clinically accurate foundation for provider adherence to be feasible. Cost-containment provisions that do not have proper medical justification can put patient outcomes in jeopardy.

> **Principle #1**: Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.

2. The most appropriate course of treatment for a given medical condition depends on the patient's unique clinical situation and the care plan developed by the provider in consultation with his/her patient. While a particular drug or therapy might generally be considered appropriate for a condition, the presence of comorbidities or patient intolerances, for example, may necessitate an alternative treatment. Failure to account for this can obstruct proper patient care.

> **Principle #2**: Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.

3. Adverse utilization management determinations can prevent access to care that a health care provider, in collaboration with his/her patient and the care team, has determined to be appropriate and medically necessary. As this essentially equates to the practice of medicine by the utilization review entity, it is imperative that these clinical decisions are made by providers who are at least as qualified as the prescribing/ordering provider.

> **Principle #3**: Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.

Continuity of Care

4. Patients forced to interrupt ongoing treatment due to health plan utilization management coverage restrictions could experience a negative impact on their care and health. In the event that, at the time of plan enrollment, a patient's condition is stabilized on a particular treatment that is subject to prior authorization or step therapy protocols, a utilization review entity should permit ongoing care to continue while any prior authorization approvals or

step-therapy overrides are obtained.

Principle #4: Utilization review entities should offer a minimum of a 60-day grace period for any step-therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.

5. Many patients carefully review formularies and coverage restrictions prior to purchasing a health plan product in order to ensure they select coverage that best meets their medical and financial needs. Unanticipated changes to a formulary or coverage restriction throughout the plan year can negatively impact patients' access to needed medical care and unfairly reduce the value patients receive for their paid premiums.

Principle #5: A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.

6. Many conditions require ongoing treatment plans that benefit from strict adherence. Recurring prior authorizations requirements can lead to gaps in care delivery and threaten a patient's health.

Principle #6: A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment.

7. Many utilization review entities employ step therapy protocols, under which patients are required to first try and fail certain therapies before qualifying for coverage of other treatments. These programs can be particularly problematic for patients—such as those purchasing coverage on the individual marketplace—who change health insurance on an annual basis. Patients who change health plans are often required to disrupt their current treatment to retry previously failed therapeutic regimens to meet step therapy requirements for the new plan. Forcing patients to abandon effective treatment and repeat therapy that has already been proven ineffective under other plans' step therapy protocols delays care and may result in negative health outcomes.

Principle #7: No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.

Transparency and Fairness

8. Prior authorization requirements and drug formulary changes can have a direct impact on patient care by creating a delay or altering the course of treatment. In order to ensure that patients and health care providers are fully informed while purchasing a product and/or making care decisions, utilization review entities need to be transparent about all coverage and formulary restrictions and the supporting clinical documentation needed to meet utilization management requirements.

> **Principle #8**: Utilization review entities should publically disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request.

9. Incorporation of accurate formulary data and prior authorization and step therapy requirements into electronic health records (EHRs) is critical to ensure that providers have the requisite information at the point of care. When prescription claims are rejected at the pharmacy due to unmet prior authorization requirements, treatment may be delayed or completely abandoned, and additional administrative burdens are imposed on prescribing providers and pharmacies/pharmacists.

> **Principle #9**: Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.

10. Data are critical to evaluating the effectiveness, potential impact and costs of prior authorization processes on patients, providers, health insurers and the system as a whole; however, limited data are currently made publically available for research and analysis. Utilization review entities need to provide industry stakeholders with relevant data, which should be used to improve efficiency and timely access to clinically appropriate care.

Principle #10: Utilization review entities should make statistics regarding prior authorization approval and denial rates available on their website (or another publically available website) in a readily accessible format. The statistics shall include but are not limited to the following categories related to prior authorization requests:

  i. Health care provider type/specialty;

  ii. Medication, diagnostic test or procedure;

  iii. Indication;

  iv. Total annual prior authorization requests, approvals and denials;

  v. Reasons for denial such as, but not limited to, medical necessity or incomplete prior authorization submission; and

  vi. Denials overturned upon appeal.

These data should inform efforts to refine and improve utilization management programs.

---

11. A planned course of treatment is the result of careful consideration and collaboration between patient and physician. A utilization review entity's denial of a drug or medical service requires deviation from this course. In order to promote provider (physician practice, hospital and pharmacy) and patient understanding and ensure appropriate clinical decision-making, it is important that utilization review entities provide specific justification for prior authorization and step therapy override denials, indicate any covered alternative treatment and detail any available appeal options.

Principle #11: Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.

Timely Access and Administrative Efficiency

12. The use of standardized electronic prior authorization transactions saves patients, providers and utilization review entities significant time and resources and can speed up the care delivery process. In order to ensure that prior authorization is conducted efficiently for all stakeholders, utilization review entities need to complete all steps of utilization management processes through NCPDP SCRIPT ePA transactions for pharmacy benefits and the ASC X12N 278 Health Care Service Review Request for Review and Response transactions for medical services benefits. Proprietary health plan web-based portals do not represent efficient automation or true administrative simplification, as they require health care

providers to manage unique logins/passwords for each plan and manually re-enter patient and clinical data into the portal.

Principle #12: A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.

13. Providers have encountered instances where utilization review entities deny payment for previously approved services or drugs based on criteria outside of the prior authorization review process (e.g., eligibility issues, medical policies, etc.). These unexpected payment denials create hardship for patients and additional administrative burdens for providers.

Principle #13: Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.

14. Significant time and resources are devoted to completing prior authorization requirements to ensure that the patient will have the requisite coverage. If utilization review entities choose to use such programs, they need to honor their determinations to avoid misleading and further burdening patients and health care providers. Prior authorization must remain valid and coverage must be guaranteed for a sufficient period of time to allow patients to access the prescribed care. This is particularly important for medical procedures, which often must be scheduled and approved for coverage significantly in advance of the treatment date.

Principle #14: In order to allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received.

15. In order to ensure that patients have prompt access to care, utilization review entities need to make coverage determinations in a timely manner. Lengthy processing times for prior authorizations can delay necessary treatment, potentially creating pain and/or medical complications for patients.

Principle #15: If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.

16. When patients receive an adverse determination for care, the patient (or the physician on behalf of the patient) has the right to appeal the decision. The utilization review entity has a responsibility to ensure that the appeals process is fair and timely.

Principle #16: Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and (b) was not involved in the initial adverse determination.

17. Prior authorization requires administrative steps in advance of the provision of medical care in order to ensure coverage. In emergency situations, a delay in care to complete administrative tasks related to prior authorization could have drastic medical consequences for patients.

Principle #17: Prior authorization should never be required for emergency care.

18. There is considerable variation between utilization review entities' prior authorization criteria and requirements and extensive use of proprietary forms. This lack of standardization is associated with significant administrative burdens for providers, who must identify and comply with each entity's unique requirements. Furthermore, any clinically based utilization management criteria should be similar—if not identical—across utilization review entities.

Principle #18: Utilization review entities are encouraged to standardize criteria across the industry to promote uniformity and reduce administrative burdens.

Alternatives and Exemptions

19. Broadly applied prior authorization programs impose significant administrative burdens on all health care providers, and for those providers with a clear history of appropriate resource utilization and high prior authorization approval rates, these burdens become especially unjustified.

Principle #19: Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.

20. Prior authorization requirements are a burdensome way of confirming clinically appropriate care and managing utilization, adding administrative costs for all stakeholders across the health care system. Health plans should offer alternative, less costly options to serve the same functions.

Principle #20: Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.

21. By sharing in the financial risk of resource allocation, providers engaged in new payment models are already incented to contain unnecessary costs, thus rendering prior authorization unnecessary.

Principle #21: A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan's benefits.

FRESH PERSPECTIVES
NEW DOCS IN PRACTICE

(http://blogs.aafp.org/cfr/freshperspectives)

« Support, Flexibility... (http://blogs.aafp.org/cfr/freshperspectives/entry/support_flexibility_at_home_work) | Main (http://www.aafp.org/cfr/freshperspectives/) | Singing the Praises... (http://blogs.aafp.org/cfr/freshperspectives/entry/in_praise_of_a_pharma) »

Monday Jul 18, 2016

Prior Authorization Call Shows Inefficiency, Absurdity of Process

A few weeks ago my nurse recorded me making a prior-authorization (PA) phone call for a CT scan I ordered for a patient with a suspicious atraumatic skull mass. I thought, perhaps, the video would show my Facebook followers one of the many hassles of operating within our health care system.

The phone call was fairly typical of interactions with insurance companies -- boring, laborious and nonconclusive. It lasted about 21 minutes. I tried to watch the video right after filming, but I quit after five minutes because I couldn't suffer through the monotonous trauma again so soon.

A few days later, I braved watching it. I made a few edits, including adding a few snarky subtitles, before sharing it. I posted the video to my practice's Facebook page in the evening. Within a few hours, the post had several dozen likes and shares. Within a week, the video had been shared 299 times and viewed by nearly 20,000 people. A few other physicians with large social media followings also posted my video. The upshot: This video, mostly of me waiting on hold, has now been viewed nearly 100,000 times on Facebook!

I have a decent social media following for a solo family physician, but this mundane video quickly surpassed the reach of anything else I had ever shared. Although this may not be "cat riding on a Roomba" viral, I was blown

away at how many people were interested in the video. I have received dozens of messages from doctors and clinic staff thanking me for shining a light on this growing problem.

Why? PA phone calls rank high among physicians' top most burdensome issues (http://medicaleconomics.modernmedicine.com/medical-economics/news/top-15-challenges-facing-physicians-2015?page=full), with one study estimating that physicians spend more than 868 million hours each year in PA-related activities. Researchers have actually quantified the absurd amount of time practices spend on administrative tasks (http://org.salsalabs.com/o/307/images/Physician%20admin%20time_IJHS.pdf).

But most outsiders are unlikely to understand the scope of this daily administrative burden. An AAFP survey found that the average family physician spends two hours each week on prior authorizations (http://www.aafp.org/about/the-aafp/family-medicine-facts/table-7.html) -- and that doesn't include staff time spent on the issue.

The business of medicine has become increasingly complex at all levels, and many organizations are attempting to call attention to this growing problem. The Montana AFP has submitted a resolution to the 2016 AAFP Congress of Delegates about prior authorizations (http://www.aafp.org/about/governance/congress-delegates/2016/resolutions/montana-a.mem.html) that calls for legislative and regulatory remedies that will ensure practices are compensated for the time spent on PA-related activities. Although I understand and appreciate this effort, our convoluted payment schemes are sure to make progress on this issue, if possible, extremely slow. Time matters because this red tape is threatening the viability of small, independent primary care practices in the short term.

And these inefficiencies aren't just a hassle or expense for physicians or our clinic staffs. Ultimately, they distract us from patient care. Every minute we spend waiting on hold is a minute that could've been spent educating a patient about his or her diabetes. From my experience, family physicians are generally strong patient advocates, but these hoops can strain our relationships with patients who don't understand all that happens behind the scenes.

"Can't you just call the insurance company and get it approved today?" is the type of question we often hear from anxious patients.

Given all of the entrenched parties in health care today, I can't offer any easy solutions to this problem. Third-party payers will, understandably, require some form of "determination of need." But clearly, this process could be made more efficient, especially given our amazing computing technologies and automation. I will leave that technological fix up to people who are smarter than me.

On a deeper level, I question the notion that a third party's determination of need leads to better and more economical health care decisions. An alternative solution would be to reduce the prevalence of third-party involvement in transactions altogether. This would require returning some portion of monies to the patient and family to manage themselves, paying simply and directly to physicians and facilities. In consultation with a trusted primary care physician, I believe wise and prudent decisions would be made most of the time.

After all, could patients and their primary care physicians actually be any worse or more inefficient stewards of our health care dollars than third parties have already demonstrated themselves to be?

Ryan Neuhofel, D.O., M.P.H., owns a direct primary care practice in Lawrence, Kan. You can follow him on Twitter @NeuCare (https://twitter.com/NeuCare).

Posted at 02:39PM Jul 18, 2016 (http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency) by Ryan Neuhofel, D.O., M.P.H. | Comments[2]
(http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency#comments)

Comments:

Prior authorizations have become the number one bane of my existence as a non-participating provider of BC/BS and Medicare patients.

When they are required for generic medications, they are clearly an attempt by insurance companies to cajole physicians into realizing that the effort is not worth the cost. They lie to patients and tell them that it is a simple, efficient and routine process for their doctor to complete with a successful outcome all but guaranteed.

The current motivation is clearly for the insurance companies to make the PA process as prolonged and painful as possible for purely economic reasons. The solution is to require insurance companies to reimburse physicians for the actual time spent on the phone or on the computer or doing the requisite paperwork. Only then will the process be streamlined.

Posted by **KEITH DINKLAGE** on July 21, 2016 at 08:20 AM CDT #
(http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency#comment-1469107203267)

That was great. In private practice I did 1-5 of these per week. Thankfully, I had plenty of things to do on hold like charting my office visits. Unfortunately, this is just the first step in this authorization. Insurance companies do not deny care, they just put these roadblocks in place that require so much effort that some providers give up and

then the insurance does not have to pay for the test since it isn't "authorized".

Posted by **Stefan** (http://www.stefanmontgomery.com) on July 21, 2016 at 09:41 AM CDT #
(http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency#comment-1469112115077)

Post a Comment:

Name:

E-Mail:

URL:

Notify me by email of new comments ☐

Your Comment:

- (10,000 character maximum.)

- HTML Syntax: Allowed

- Please answer this simple math question

  2 + 68 =

- Disclaimer: Comments are moderated and will be removed if they are abusive. For more information, see our terms of use (http://www.aafp.org/online/en/home/publications/news/news-now/aboutann/opinions.html).

Preview   Post

Prior Authorization Call Shows Inefficiency, Absurdity of Process : Fresh Perspectives
http://blogs.aafp.org/cfr/freshperspectives/entry/prior_authorization_call_shows_inefficiency

---

The New York Times | https://nyti.ms/2htIZRw

WELL | FAMILY

Taking Care of the Physician

The Checkup

By **PERRI KLASS, M.D.**   NOV. 13, 2017

If I am your doctor, or your child's doctor, is there any reason *you* should worry about how *I'm* feeling? About what kind of shape I'm in, physical or emotional?

Maybe you should. A growing body of research shows that physician burnout and depression are linked to medical errors and to the kind of depersonalized care that is often both less effective and less palatable.

"It has been shown in some studies that if the physician is exercising, if the physician is taking care of themself, eating well, sleeping better, they have patients who have better clinical outcomes," said Dr. Hilary McClafferty, a pediatrician who is an associate professor in the department of medicine at the University of Arizona College of Medicine in Tucson. But the problem may be less the individual doctor's health habits, and more the medical system that is hurting us all.

There is increasing conversation about "physician wellness" these days, as we look at how young doctors are trained, and at the physical, emotional and spiritual pathways of those who are supposedly (and arduously and extensively) trained to take care of others. Researchers use the **Maslach burnout inventory** to measure emotional exhaustion and depersonalization and feelings of competence and

successful achievement in one's work; physicians as a group do pretty well when it comes to the sense of personal accomplishment, but they tend toward emotional exhaustion and a sense of depersonalization, which can breed a cynical and dehumanized attitude toward patients.

In pediatrics, we like to think of ourselves as relatively warm and caring, but in pediatric training institutions, burnout rates among residents are 55 to 60 percent, and that's after all the attempts to regulate and restrict work hours. "I know I have suffered in silence about medical errors, about uncertainty, and I don't know that we do a very good job of supporting each other," said Dr. Janet Serwint, a professor emerita of pediatrics at Johns Hopkins University, where she was formerly the director of the pediatric residency program. She has written about an experience in residency in which a child died, she thought because of an error she had made, but there was no place in the busy day to discuss her reaction.

"It's not that physicians are burned out and so don't care, it's that they care deeply," said Dr. David Schonfeld, a developmental behavioral pediatrician at Children's Hospital Los Angeles. "You can't experience compassion fatigue if you've not had compassion."

Medical faculty members have been shown to have burnout rates ranging from 20 to 49 percent. And the hard-won reductions in resident work hours do not seem to have satisfactorily reduced burnout or depression among residents, perhaps because hospitalized patients are sicker on average than they used to be, perhaps because patient loads are higher (if you reduce work hours but don't increase the number of doctors, well, you can do the math), or perhaps because of the increasing frustrations and time pressures connected to the electronic health record and documentation, which can take up more than half of some doctors' time, often squeezed in at night or by coming in early.

Another statistic often cited in the physician wellness conversation is the suicide rate. Physicians are at approximately twice the relative risk of suicide compared to people in other professions, Dr. McClafferty said. "Women physicians especially are at a significantly higher risk of completed suicide than matched female controls in

other professions," she said. An estimated 300 to 400 physicians commit suicide every year.

If this were happening in any other high-profile industry, Dr. McClafferty said, "I can't imagine people wouldn't be rallying round, saying this is unacceptable, it has to stop."

There is a clear link between physician depression and medical errors. In one study of pediatric residents at three high-powered training programs, those who were depressed made more than six times as many medication errors as those who were not. This study and others also found that residents experiencing burnout were more likely to perceive that they were making more errors, even if they were not.

We place physicians in situations where they are detecting problems, often connected to social conditions or poverty, Dr. Schonfeld said, but then don't give them the support they need to address those problems. And we don't adequately teach the skills in medical training that doctors will need to deal with the realities of taking care of patients. "There are more advanced skill sets, how to deal with conflict, how to deal with negotiation, how to deal with the distress of patients," he said. "We just send trainees in, the training focuses on medications, pathophysiology, genetics, not the skills they need to be able to deal with those broader issues."

So we might look to changes in the ways we train residents, not just limiting work hours but looking more closely at what the content of those work hours is like, and at the skills we teach, and at what we do and do not discuss.

"Because of organizational structures and competing responsibilities there's less time, and physicians are really sad about this, and we need to struggle as a society to make it different," Dr. Serwint said.

Studies are just beginning to be done of workplace interventions that address such issues as time pressure, workplace chaos, and a doctor's sense of control, but the evidence supports the idea that it's more effective to make changes at the level of the institution, rather than just telling the doctors to shape up in the wellness department.

"The solution is not to weed out the ones who don't care, but to support the large number of physicians who are deeply invested and have the capacity to provide excellent care, but lose that capacity over time," Dr. Schonfeld said. "Physicians enter medical school deeply committed to the field, they come with the desire to be empathic and compassionate, if we just create a system that nurtures what they come with then we will have less burnout and higher quality care."

It should not be the doctor's responsibility to feel that "if I'm just more mindful, if I just exercise more or do it better or more consistently, all will be well, and I shouldn't be feeling burned out or exhausted," Dr. McClafferty said.

The fact that nearly half of physicians and over 50 percent of trainees experience burnout at some point "shows that it is not predominantly an individual deficit, but an organizational and system problem," Dr. Schonfeld said

"If you're my physician," Dr. McClafferty said, "I want you to be in good shape mentally, physically and emotionally, so you can be really successful at helping me."