Becoming a Value-Add For Your Medical Practice

2024 Summer Breakaway and Annual Assembly

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Objectives

- Know the reasons behind sharing "GRITS" at your office
- Explain the quality metrics needed for success in primary care
- Be able to define which employee needs added focus to have an office excel on multiple fronts (and how to meet their needs)

G2211: Visit Complexity Code

- New for 2024: Discussed in 2021, but "unfunded" at last minute
- For providers who primarily use E&M (vs surgical) coding in scope
  - 99212-99215, regs say also 99202-99205 (read further….)
  - Need to be "the focal point for all needed health care services" indicated by a definite provider-patient relationship
- CMS feels there is a "cognitive load" at baseline as part of this "focal point" role which merits this add-on code
- No documentation or cadence on guidance, so more clarity is needed
- The assumption is the new encounter ("provider-patient relationship") CAN have G2211 applied ….

G2211

- When to use this….. (knowing more clarity is needed….). Not for
  - Medicaid, Commerical payors (but that is changing)
  - the 99211 "nurse visit"
  - encounters for treatment of a simple virus… for counseling related to seasonal allergies… for initial onset of GERD… Or treatment of a simple fracture, which needed limited care … unless chronic disease mgt takes place under your care
  - Where comorbidities are either not present or not listed as being addressed
  - When the billing provider has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity of care
  - visits which use the "-25 modifier" (but what about Medicare Wellness and chronic disease and "-25" seems "no") …. Need clarity
- Total RVU is 0.49 ($16.04). wRVU is 0.33

2024 CMS Final Rule, pp 428-445; *(85 FR 84570-84574)*

G2211

- Other things that have come up
  - NPP working in tandem with Physician (incident to): Yes
  - Partner physician seeing my patient while I am away: Yes
  - Residency Faculty in oversight of residents: Yes
- Is a -25 modifier needed, if so, then "No"

Is a -25 modifier needed, if so, then "No"

- Annual Wellness Visit Yes, -25 needed if E&M added, so "No" G2211
- Injection of Medication Yes, -25 needed if E&M added, so "No" G2211
- Injection of Medication only (Depo, shot and go visit) No (99212-205 only)
- Electrocardiogram: No -25, so OK to use E&M and G2211
- Ultrasound: Joint (shoulder, knee, hip): No -25, so OK with E&M to use G2211
- Radiography: No -25, so add on and G2211
- Ambulatory Continuous Glucose Monitoring - ditto
- Removal of devitalized tissue from wounds non-selective debridement (97602)
- Audiometry (92557): Ditto – no -25 needed, so can add this and G2211
- Spirometry, inhalation treatment, PFTs NEEDS a -25, so NO G2211

Objectives: Being a Value-Add

- Know the reasons behind sharing "GRITS" at your office
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- Be able to define which employee needs added focus to have an office excel on multiple fronts (and how to meet their needs)

The Physician/Team Needs to Serve GRITS to Succeed

Team – must know what it takes in care delivery to a patient and to their colleagues

Success: GRITS

Team Deliverables (lead by example)

- Greet the patient/team member. Welcoming.
- Relationships matter
- Inform without empty words
- Treat (respect) and Treat (clinically) at highest level
  - Must deliver on quality

How to attain quality….incentives?

- Quality metric attainment is usually a part of the payment calculation as well as the cost management (high quality/low cost is optimal)
- Some insurers incentivize providers to meet targets to help promote quality and allow for additional revenue opportunities
  - Meeting 4 or 5-Star quality ratings gets Medicare Advantage plans bonuses from CMS (and 5-Stars market year-round)
  - What measures…what thresholds..?

2024 Stars/ACO Quality Metrics

Measure	Program		Star Category & Weight		Thresholds 10/17/2023	
	Stars	ACO	Part C or D?	Weight	4 Star	5 Star
Care for Older Adults - Medication Review	✓		C	1	93%	98%
Care for Older Adults - Pain Assessment	✓		C	1	91%	96%
Medication Adherence for Diabetes	✓		D	3	88%	90%
Medication Adherence for Hypertension (RAS)	✓		D	3	89%	91%
Medication Adherence for Cholesterol (Statins)	✓		D	3	89%	93%
TRC: Medication Reconciliation Post-Discharge	✓	✓	C	0.5	68%	82%
TRC: Patient Engagement After Inpatient Discharge	✓		C	0.5	64%	78%
Follow-Up After ED Visit for MCC	✓		C	1	60%	68%
Plan All-Cause Readmissions	✓		C	3	10%	8%
Osteoporosis Management in Women w/ Fracture	✓		C	1	55%	71%
Kidney Health Evaluation for Patients with Diabetes	✓		C	1	TBD	TBD
Statin Use in Persons with Diabetes	✓		D	1	88%	92%
Diabetes Care - Eye Exam	✓		C	1	73%	81%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	80%	87%
Breast Cancer Screening	✓	✓	C	1	71%	79%
Colorectal Cancer Screening	✓	✓	C	1	71%	80%
Controlling Blood Pressure	✓	✓	C	3	74%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	86%	90%
Reducing the Risk of Falling		✓				
Depression Screening		✓				
Influenza Immunization		✓				
Tobacco Screening and Cessation Intervention		✓				

Success: GRITS

Team Player

- **G**reet the patient/team member
- **R**elationships matter
- **I**nform without empty words
- **T**reat (respect) and Treat (clinically) at highest level
- **S**alutation: send-off thanks, quick f/u, birthday card, etc. to build relationships

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Influenza Immunization		✓				
Tobacco Screening and Cessation Intervention		✓				

Risk Stratify the Population for Direction for Quality/Cost

- High Costs that can be corrected (cancers, condition mgmt, debility,?)
  - Prevention (colon CA screening, Mammograms, DEXAs, etc.)
- High Costs that can be corrected (high utilizers)
  - Emergency Department use that is inappropriate
  - Admissions to the hospital (due to ED, or advanced comorbid illnesses)
- High costs that can be corrected (meds, tests, etc)
  - Generic vs name brand and step therapy re: treatment paths (semaglutide now vs 1500 cal diet with exercise x 6wks…?)
  - Right test, right time (MRI of the C/L/T spine before plain films and PT for LBP)
- Chronic disease burden – address now (manage lipids, weight) to avoid negative outcomes (MI → cath → CABG → debility → etc.)

Colon CA Screening

- Due to the ACA, this is a "first dollar" covered service for all individuals with a group insurance (unless a waiver applies) since screening test USPSTF A/B rating
- Multiple options (see MLN)
  - MT-sDNA (Cologuard®) and blood-based biomarker tests, screening colonoscopies, guaiac/fecal occult blood tests (FOBTs), flexible sigmoidoscopies, and barium enemas

Sensitivity needs to be 74% or greater and Specificity needs to be 90% or more (colonoscopy standards) and the Epi proColon test does not meet those standards.

Colon CA Screening

- CMS covers for the multi-target stool-DNA test for screening (Cologuard®)
  - Quantitative real-time target and signal amplification of 10 DNA markers for CRC or precancerous polyps
- CMS covers blood-based biomarker tests for CRC (none available yet)

Coverage for BOTH is

- Asymptomatic is now aged **45** to 85 years and asymptomatic
- At average risk of developing colorectal cancer
- Repeat every 3 years
- ICD-10 screening codes
  - Z12.11 (colon) and Z12.12 (rectum)

Colon CA Screening

- Due to the ACA, this is a "first dollar" covered service for all individuals with a group insurance (unless a waiver applies) since screening test USPSTF A/B rating
- Multiple options (see MLN)
  - FOBT: yearly
  - Flexible sigmoidoscopy: every 48 mo*
  - Colonoscopy: every 10 years*
  - Screening Barium Enema: 48 mo* years

*https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#COLO_CAN

Colon CA Screening

- Due to the ACA, this is a "first dollar" covered service for all individuals with a group insurance (unless a waiver applies) since screening test USPSTF A/B rating
- Multiple options (see MLN)
  - MT-sDNA (Cologuard®) and blood-based biomarker tests, screening colonoscopies, guaiac/fecal occult blood tests (FOBTs), flexible sigmoidoscopies, and barium enemas
  - **High Risk (any one):**
    - Personal history of adenomatous polyps; personal history of colorectal cancer (CRC); personal history of IBS (including Crohn's Dz and Ulcerative colitis); close relative (sibling/parent/child) w CRC or adenomatous polyp; FH of familial adenomatous polyposis; FH of hereditary nonpolyposis CRC

Initiate screening @ 40 or 10 yr before family member CRC dx

Colon CA Screening (as of 01/01/2023)

- If initial non-invasive stool-based screening test (FOBT or MT-sDNA test) is positive, Medicare will cover follow-up colonoscopy as a screening test.
  - The patient pays nothing for the screening test(s) (if provider accepts assignment)
  - The frequency limitations described for screening colonoscopy do not apply
- If a screening colorectal cancer procedure (flex sig/colonoscopy) becomes a diagnostic (due to finding) then add modifier –PT to at least 1 code on the claim
  - Deductible is waived and, for dates of service from January 1, 2023–December 31, 2026, will apply a reduced coinsurance of 15% for all procedure codes identified here that are performed on that date of service and billed on the same claim ("polyp penalty")

Managing the Hospital cost of care

- ED visit reduction
  - Medicare patients with chronic conditions, being seen in office within 7 days after ED visit
  - Quality focus since 2022 and expected to be a bigger player re quality

Transitional Care Management: Managing the Hospital to Home Journey

- ED visit reduction
- Readmission reduction

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TCM Update: 99495

- Communication (direct contact, telephone, electronic) with the patient/caregiver (includes home health agencies) within 2 business days by clinical staff
  - Goal is call is to be made to connect (at least 2 documented)
  - Discuss caretaker education, care management, ADLs
  - Assess for support and treatment adherence
  - Identify available community health resources
  - Assist in access to care and other services as needed by family
- Non face-to-face services provided by physician, or other qualified healthcare provider
  - Discharge summary review
  - Lab f/u issues
  - Contact other providers of care to coordinate healthcare delivery
  - Educational outreach
- MDM of **moderate** complexity during the service period
- Face-to-face visit within **14** calendar days of discharge

TCM Update: 99496

- Communication (direct contact, telephone, electronic) with the patient/caregiver (includes home health agencies) within 2 business days by staff
  - Goal is call is to be made to connect (at least 2 documented)
  - Discuss caretaker education, care management, ADLs
  - Assess for support and treatment adherence
  - Identify available community health resources
  - Assist in access to care and other services as needed by family
- Non face-to-face services provided by physician, or other qualified healthcare provider
  - Discharge summary review
  - Lab f/u issues
  - Contact other providers of care to coordinate healthcare delivery; Educational outreach
- MDM of **high** complexity during the service period
- *Face-to-face visit within **7** calendar days of discharge* BEST PRACTICE: f/u within 7 days D/C
- Bill on date of service (like 99495)

Transitional Care Management (MDM Based on 2 of 3 Components)

E/M LEVEL, MDM	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (Each unique test, order, or doc. reviewed counts)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99495 Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury	**(Must Meet 1 of 3 Categories: Moderate)** Category 1: Tests, documents, historian (any 3) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test 4. Assessment requiring an independent historian. ***OR*** Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another provider (not separately billed) ***OR*** Category 3: Discussion of management or test interpretation • Discuss mgmt./interpretation of test with another provider (not separately billed) **(Must Meet 2 of 3 Categories: High)**	Moderate risk of morbidity from additional tests/treatment Consider: • Rx mgmt., • Discussion regarding minor surgery w/ patient or procedure risk factors • Discussion regarding elective major surgery w/o risk factors • Diagnosis or treatment significantly limited by social determinants of health
99496 High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects • Acute/chronic illness that may pose threat to life or bodily function		High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care (admit/escalate), Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to de-escalate care/decide DNR due to poor prog, IV controlled substance use

Optimize Revenue

- I can always do a 99214 or 99215 … right?
- Yes: (#wRVU/Medicare PFS $$/NPP $$)
  - 99214: 1.92/$122.77/$104.35
  - 99215: 2.80/$173.20/$147.22
  - 99495: 2.78/$203.30/$172.80
  - 99496: 3.79/$275.00/$233.75

- wRVU for the 99495 equals 99215
- 99495 reimbursements are much higher (staff)
- 99496 outperforms substantially

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

Transitional Care Management: Managing the Hospital to Home Journey

- Set up the process
  - … call the patient within 2 business days
  - … see the patient within 1 calendar week
  - … select correct MDM (if within 1 wk, otherwise 99495 if w/in 2 wk)
  - … engage the patient for the entire 30d as needed

Where else to focus our efforts? 2023 Triple Weighted

- Controlling BP (<140/<90) **3**
- Diabetes Care – blood sugar control (A1c < 9)* **3**
- Medication Adherence (taking med 80% time prescribed)
  - For Diabetes (meds other than insulin) **3**
  - For Hypertension (RAS) **3**
  - For Lipids (Statins) **3**

*varies with ACO or Stars or Commercial insurance

Controlling Blood Pressure (CBP)

- Was a single-weighted measure in 2022, now triple-weighted
- The percentage of patients (18–85 years of age) who had a diagnosis of hypertension reported on an outpatient claim and blood pressure adequately controlled (<140/<90 mm Hg) as of December 31 (last BP) of the measurement year. (need CPT II code or data feed to report)
- Capture in office visit, video visit, telephone (patient reported), or e-visit
- Patient reported need to be collected with a digital device and in record
- 4 Star ≥73% to <80%; 5 Star is ≥80% ideal control (<140/<90 is goal)

Diabetes Care – Blood Sugar Control

- The percentage of diabetic enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator).
  - "Reverse measure": To calculate this measure, subtract the submitted rate from 100. So, here higher is better.
  - Poor control of DM patients leads to higher complications (renal, ocular, etc.)
- DM that is "out of control" can be re-assessed before 90d if so.
- 4 Star ≥75% to <83%; 5 Star is ≥83% (% patients w A1c <9)
  - [25%/17% are 4/5 Star % for patients > 9]

Medication Adherence Defined

- A patient taking their medications (getting the med filled on time) over the course of the year 80% of the time (292 days if on med 01/01/2022)
  - If new Rx during the year, then it is 80% of the time left in the year
  - 90d Rx have higher fill rates and more likely to pass measure
    - Only requires 3 refills in the year rather than 11 with 30d supply
      - Allows for more wiggle room on late days at each refill
- Exclusions: hospice, ESRD

What counts in DM Med Adherence?

- Certain medication classes (NOT insulin) are tracked
  - Biguanides, sulfonylureas, Di-Peptidyl Peptidase (DPP)-IV Inhibitors, Glucagon-like peptide-1 (GLP-1) receptor agonists, sodium glucose cotransporter 2 (SGLT2) inhibitors, thiazolidinesdiones, and meglitinides.
    - 2 prescription claims in the calendar year for any of the above medications will put the patient in the adherence measure
  - 4-Star is having 88+% adherent, 5-Star 92+%
  - Exclusions: if on insulin, if in hospice or with ESRD

What counts in HTN Med Adherence?

- Medication nonadherence is a major contributor to poor control of hypertension and several studies show improved clinical outcomes for patients who are adherent to their medications[3]
- Controlling BP was TRIPLE weighted starting in 2022 (so this is DOUBLE important)
- Renin-angiotensin system (RAS) antagonists commonly used in the treatment of hypertension and proteinuria in patients with diabetes, in which these drugs have been shown to delay renal failure and heart disease[1,2]
- Patients 18 years of age and older
- Diagnosis of HTN **and** given a Rx for treatment for Renin-Angiotensin System (RAS) Antagonist drugs
  - Angiotensin Converting Enzyme Inhibitor (ACEI), Angiotensin Receptor Blocker (ARB), or Direct Renin Inhibitor (DRI)
- Exclusions include those patients in hospice, those with ESRD, and those who have one or more Rx fill for sacubitril/valsartan
- 4-Star success is at 89% compliance, 5-Star is 91+%

[1]Lau DT, Nau DP. Oral antihyperglycemic medication nonadherence and subsequent hospitalization among individuals with type 2 diabetes. Diabetes Care. 2004; 27(9):2149-53.
[2]Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Soc Hypertens. 2018; 12(8):579.e1-579.e73.
[3]Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005; 43(6):521-30.

What counts in Cholesterol Med Adherence?

- HMG-CoA reductase inhibitors, also known as statins, are recommended for management of dyslipidemia and/or primary prevention of cardiovascular disease (CVD) in several treatment guidelines.[1,2,3]
- By lowering LDL cholesterol, statins decrease the risk of CVD morbidity and mortality.[4]
- There are several studies showing improved clinical outcomes for patients who are adherent to their medications.[5]

[1]Jellinger PS, Handelsman Y, Rosenblit PD, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease. Endocr Pract. 2017; 23(Suppl 2):1-87.
[2]Taylor F, Huffman MD, Macedo AF, et al. Statins for the primary prevention of cardiovascular disease. Cochrane Database Syst Rev. 2013; (1):CD004816.
[3]Stone NJ, Robinson JG, Lichtenstein AH, et al. American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014; 129(25 Suppl 2):S1-45.
[4]Cholesterol Treatment Trialists' (CTT) Collaborators, Mihaylova B, Emberson J, Blackwell L, et al. The effects of lowering LDL cholesterol with statin therapy in people at low risk of vascular disease: meta-analysis of individual data from 27 randomised trials. Lancet. 2012; 380(9841):581-90.
[5]Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005; 43(6):521-30.

What counts in Cholesterol Med Adherence?

- Patients 18 years and older prescribed a statin medication
- Adherence is filling the medication 80% or more of the time during the calendar year
- Exclusions include those patients in hospice or those with ESRD
- 4-Star success is at 88% or higher compliance (5-Star is 92%)

Where to focus our efforts? 2023 Single Weighted

- Diabetic Eye Exams
- Statin Use in Persons with Diabetes
- **Diabetic Kidney Disease Monitoring (new in 2023)**

Diabetes Kidney Disease Monitoring

- Former Comprehensive Diabetes Care measure is retired
- Replaced by Kidney Health Evaluation for Patients w DM ("KED")
  - If 18-85 at end of the year with DM in current or prior year, or medication for blood sugar control filled
  - Need BOTH done EACH year
    - uACR is the urine albumin-creatinine ratio
    - eGFR is the estimated glomerular filtration rate
  - Excluded if in hospice, palliative care, or ESRD. If > 66 with long-term institutional facility and/or frailty and advanced illness. 81 or older w frailty.
- 4 Star: 95% 5 Star: 97% → check at least once/year

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- 4 Star: 95% 5 Star: 97%

Over 30 is abnormal (microabuminuria) and if >300 macroalbuminuria if persistent for 90d -- indicative of nephropathy. If eGFR is < 60, then there is CKD of at least stage III

Who is the most important staff (a "value-add")

- My CMA/"nurse" (always one step ahead of me)
- Lab tech ("one stick" and less patient headaches for me to deal with)
- Office (practice) manager (keeps my staff on point – hire/fire/encourage)
- System administrative lead (helps me get things done)
- My partners (or I would never have vacation…)
- My billing person (group) (or I would not get paid)
- My wife (spouse) – "they run my practice through me"

Burnout Definition and Prevalence

- A psychological syndrome in response to chronic interpersonal stressors found on the job coupled with inadequate behavioral coping skills that lead to emotional exhaustion and a lacking sense of accomplishment.
- 2024 Medscape Physician Burnout and Depression Report physicians have declined slightly, but the length and severity of burnout continue to be quite high overall.
  - Most respondents felt burned out for at least 13 months or more
    - 42% saying that they have been burned out for over two years.
    - Slightly more women than men
    - Emergency medicine continues to top the list with the highest rates of burnout at 63%, followed by ob/gyn (53%), oncology (53%), pediatrics (51%), family medicine (51%), and radiology (51%).

Burnout Manifestations

- Physician's personal lives are negatively affected
  - More MVAs, relationships suffer as providers withdraw socially, isolation worsens all
- Nearly three quarters of millennial physicians (25-39) and GenXrs (40-54) and two-thirds of boomers (55-73) said burnout has had adverse affects on their personal relationships.

https://www.medscape.com/2021-lifestyle-burnout

Treatments – Anxiety, Depression, Stress Reduction

- Self Care (or with a mentor to guide)
  - General Health/Wellness: 20-30 min on most days of the week, regular sleep
  - Relaxation techniques: Deep breathing, medication, yoga
  - Stress management: Engage in activity you like (hiking, etc), verbalize frustration to decompress, etc.
- Therapies include medication and counseling
  - Mindfulness Therapies: Intense focus of attention and meditation (keep work at work)
  - Cognitive Behavioral Therapy: Talk therapy focused on modifying negative thoughts, behaviors, and emotional responses associated with psychological distress
  - Psychotherapy/Counseling: managing mental issues through talk therapy

Community Connection: Faith-based Support[1,2]

- Various studies link a religious/spiritual influence with positive effects on coping with stress in traumatic situations
  - "apparently protective role"
- Faith-based approaches tend to reframe negative events into less stressful ones, allowing more self-control
- Provides a source of social support and connectivity despite the isolationism of the pandemic
- Positive beliefs about the Divine engenders trust in God, a buffer against anxiety and sadness
- Faith-based practices enhance servanthood and gratitude, as well as including behaviors such as prayer, study, and mindfulness that are linked to lower negative affect
- Beyond this, religious spiritual influence generally involves an affective bond with an omnipresent and omniscient Deity. Research indicates that this attachment provides positive effects on mental health – allowing for an inner peace in times of trial

Partnerships@hhs.gov
J Relig Health. 2020 Jul 23 : 1–14
https://journals.sagepub.com/doi/full/10.1177/0020764020970996

Employee Assistance Programs (EAPs)

- An Employee Assistance Program (EAP) is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees with personal and/or work-related problems.
- EAP counselors consult with managers/supervisors to address employee needs.
- Many EAPs help organizations prevent and cope with workplace violence and trauma
- Linked to employer health insurance. Even if not offered, the employee health plan may have a "light" version with limited services/co-pays to access the counselor network – encourage patients to ask HR for information
  - Usually 4-6 sessions per year, family is included
  - Parenting, marital, isolated mood disorders, eating disorders, grief, alcohol/substance abuse, etc.

[1]https://www.cdc.gov/chronicdisease/resources/publications/factsheets/workplace-health.htm

Burnout: The Downstream Effects[1,2]

- Consequences not limited to the personal well-being of healthcare workers
- Many studies have demonstrated that provider burnout is detrimental to patient care.
  - The number of major medical errors committed by a surgeon is correlated with degree of burnout
  - High rates of physician burnout also correlate with lower patient satisfaction ratings
  - Likelihood of being involved in a malpractice suit increases with burnout
  - Among nurses, higher levels of burnout are associated with higher rates of both patient mortality and dissemination of hospital-transmitted infections
  - In medical students, burnout has been linked to dishonest clinical behaviors, a decreased sense of altruism and alcohol abuse
- Burnout results in greater job turnover and increased thoughts of quitting among physicians
- It also results in decreased workforce efficiency in a Mayo Clinic study

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6367114/
Potential Impact of Burnout on the US Physician Workforce., *Shanafelt TD,others; Mayo Clin Proc. 2016 Nov; 91(11):1667-1668*

Strategies to Douse the Flames of Burnout

- Quadruple Aim: You Matter
  - We are programmed that patients come first, but we must manage that seat
  - Allow partners to cover, have set times that you are "off limits" and protect personal time
  - Rarely what we do as physicians merits "insignificance", so we must manage the little things – not try to do everything – and learn to say "no"
- Deal with the Environment
  - Out of Office message use and similar separations to keep "work at work" and "on work time"
- Time management is a priority through "intention management" process.
  - Write down goals each week and pick one to accomplish before moving to another task
  - If not improving patient care, don't go there

Stop Physician Burnout: What do Do When When Working Harder Isn't Working. Dike Drummond, MD

Other Strategies to Douse the Flames of Burnout

- 2020 National Academy of Medicine report stated personal stress management strategies alone are insufficient to deal with burnout
- A "systems issue" approach also is needed
  - Assess practice inefficiencies/process improvement issues– inbox overload sharing
  - EHR functionality with resource deployment to optimize
  - Education of the "why" behind quality alignment and cost containment
  - Better onboarding: EMR, coding/business of medicine, administrative infrastructure
  - Provider voice to be heard and taken into the discussion for change
    - Communication is KEY: feedback with seamless dialogue to engage physicians. Peer Group Sessions
    - If not being heard, maybe a time for a change

Thanks!

- For Questions
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