A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY January 2017

Primary Care Provider Burnout: Implications for States & Strategies for Mitigation

Jennifer Reck

EvidenceNOW: Insights for State Health Policymakers Series (No. 1, January 2017)

EvidenceNOW and the Heart of Virginia Healthcare Cooperative

The Agency for Healthcare Research and Quality EvidenceNOW initiative is a significant federal investment to advance evidence-based cardiovascular disease prevention in primary care through seven regional cooperatives reaching 1500 practices nationwide. The National Academy for State Health Policy is collaborating with the Virginia Cooperative, known as the Heart of Virginia Healthcare (HVH), to share relevant insights for state health policymakers.

Introduction:

The Heart of Virginia Healthcare (HVH) aims to accelerate the uptake and use of patient-centered outcomes research (PCOR) in practice, with an initial focus on cardiovascular disease prevention through the ABCS: Aspirin in high-risk individuals, Blood pressure control, Cholesterol management, and Smoking cessation. This work positions HVH not only to make demonstrable quality improvements, but also offers a snapshot of current workforce, payment, and health information technology (IT) issues affecting small- to medium-sized primary care practices. States have actively sought to engage primary care providers in an unprecedented number and variety of quality improvement, delivery system and payment reforms over the past decade. Insights based on HVH's outreach to practices can inform future engagement efforts, helping states to anticipate and successfully navigate potential barriers to the successful recruitment and retention of practices.

Burnout Threatens Provider Engagement in Quality Improvement, Health Care Delivery, and Payment Reform

When the HVH cooperative set out to recruit primary care practices for their quality improvement initiative to advance cardiovascular disease prevention, they realized the bandwidth of the practices they wanted to engage was already highly saturated. For example, a Duke University study estimated that if primary care physicians fulfilled all the recommended preventive care for a panel of 2,500 patients, they would need to work 21.7 hours a day.[1]

Likewise, a 2014 survey conducted by the American Medical Association and the Mayo Clinic found that physician burnout levels are increasing: 55 percent of physicians met criteria for burnout, up from 45 percent three years earlier.[2]

States attempting to recruit primary care practices for delivery system or payment reforms should be aware of the extent of provider burnout among the practices they are attempting to recruit. HVH realized they could not afford to burden practices with another demand on their time and attention without addressing burnout. That insight led to the HVH focus on restoring joy in practice through practice transformation tools and supportive coaching, with the aim of making workflow changes to help alleviate burnout. Despite the positive value proposition for practices, HVH encountered recruitment challenges that delayed implementation of their project. According to the project's Principle Investigator, Anton Kuzel, MD, "Unfortunately, some practices were at such an advanced stage of burnout that they couldn't chose to grab the lifeline we were offering."

Burned out providers not only make recruitment more difficult, there is also evidence from a systematic review demonstrating that provider burnout threatens patient safety outcomes.[3] States have a variety of strategies and policy levers at their disposal to help mitigate burnout and restore joy in practice which will be discussed below.

Restoring Joy in Practice Through Team-based Care: Barriers and State Policy Options

Restoring joy to primary care practice is not a luxury but rather a prerequisite before expecting practices to have the capacity to take on further quality improvement initiatives, delivery system, and payment reforms. Indeed, joy in practice has been argued to be so foundational to the effective functioning of our health care system that it has been included in the "Quadruple Aim,"[4] in addition to the original Triple Aim's focus on quality improvement, cost control, and patient-satisfaction.[5]

HVH's approach to restoring joy in practice is based on the work of Drs. Tom and Christine Sinsky. The Sinskys define joy in practice as "a high level of physician work life satisfaction, a low level of burnout, and a feeling that medical practice is fulfilling." Their recommendations for practice transformation include elements such as pre-visit planning and labs, working with medical scribes, and, most importantly, a more team-based, less physician-centric, approach to care, facilitated by brief daily team huddles.[6] HVH practice coaches have worked with over 220 Virginia-based primary care practice teams with the dual aims of 1) practice transformation to restore joy in practice and 2) quality improvement in cardiovascular disease prevention. A number of barriers have been identified during the course of the coaches' work with these practices:

1. Scope of Practice Issues May Inhibit Team-based Care

Some practices have encountered scope of practice issues related to team-based care in which various duties that were previously performed by a physician are delegated to clinical support staff such as nurses or certified medical assistants. For example, legal counsel at one practice advised providers that most of the standing orders related to closing gaps in care to improve the quality of cardiovascular prevention were outside the scope of practice for certified medical assistants. Though Virginia statute does indeed allow delegation to certified medical assistants, scope of practice laws vary by state.[7] Real or perceived barriers surrounding scope of practice must be addressed on a state-by-state basis to enable successful team-based care.

State Strategies and Policy Options

• States play an important role establishing credentials and scope of practice for various medical practitioners through medical licensing boards. While in some cases, it may be a task for an individual primary care practice to enable their staff to work at the top of their existing license, in other cases, state licensing boards and legislatures may wish to review and adjust scope of practice for clinical support staff to enable effective team-based care. Examples include measures relating to prescribing and dispensing medications (including controlled substances), performing certain diagnostic and treatment procedures, and oversight requirements for clinical support staff (i.e. requiring oversight by a physician). For an overview, including state legislation related to scope of practice through 2013, please see the National Conference of State Legislatures' resources[8] and Kaiser Family Foundation's maps of scope of practice laws for nurse practitioners[9] and physicians assistants.[10]

• State can also support the development of emerging professions, such as community health workers, that can enhance team-based care, by defining certification requirements. For a national overview of state community health workers, please see NASHP's map and charts on the topic.[11]

•States that do not already have a leadership role and/or board accountable for oversight of healthcare workforce issues may wish to consider formalizing a structure to enable a proactive response to emerging workforce issues.

These strategies have the potential to not only mitigate burnout by enabling team-based care, but also represent important measures to address looming shortages in the physician workforce by expanding the scope of practice for nurses.[12]

2. Fee-For-Service Payment Models Inhibit Team-based Care

Traditional payment models, such as fee-for-service, may be barriers to team-based practice redesign to the extent that they are modeled around reimbursement for office-based care with a physician and often lack a means for reimbursing the time and efforts of clinical support staff who play a vital role coordinating services in team-based models. Another payment related issue identified involved pre-visit labs. Despite the desirability of pre-visit labs from a clinical perspective, charges for two separate office visits may create a cost barrier for patients. It is important to emphasize that the payment issues raised were not necessarily calls to pay primary care providers more, but calls to pay them differently in order to enable team-based care.

State Strategies and Policy Options

• States could design and implement Medicaid and multi-payer alternative payment models which support team-based, coordinated care to replace traditional fee-for-service payments with value-based incentives. Many states, including State Innovation Model (SIM) Round One and Two test states have already implemented alternative payment models on a large scale, including patient-centered medical homes and accountable care organizations.[13] Payment reform is a strategy that aligns with national, bipartisan approaches to health policy, including the Quality Payment Program incentives to be implemented in 2017 under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation.[14]

• The Health Care Payment Learning & Action Network (HCPLAN),[15] a national workgroup on payment reform issues, recommended in their draft white paper on Primary Care Payment Models that "Primary Care Payment Model (PCPMs) will support population-focused, patient-centered, and team-based care," including rewards for teams that provide care that improve patient outcomes as opposed to teams that perform services that do not add value[16].

• States could actively work to engage primary care providers in the design of primary care payment models to replace fee-for-service. Providers that engage in the design of alternative payment models are more likely to willingly participate in them and the resulting models are more likely to succeed to the extent that they reflect the reality of the current primary care practice environment. HVH coaches encountered significant diversity in that practice environment, regarding primary care practices' readiness for team-based, population-based care. This variance in readiness depended on factors such as their relative size, geography (rural vs. urban), and whether they were affiliated with a large health system or were an independent practice. In short, one size does not fit all when it comes to payment reform models.

3. Mutliple Reporting Requirements Contribute to Burnout

Though value-based payment reform is essential to support team-based care, it depends upon creating accountability for care through measuring performance on various quality, utilization, and cost metrics. The resulting reporting requirements are a major source of burnout for primary care practices accountable for multiple measures from various public and private payers and, for practices operating within health system requirements as well. One HVH practice coach documented an example of this burden as follows:

"… this (health) system is focused on 27 different quality measures, all with modified definitions of the numerator and denominators as it relates to the specific payer. This dynamic is requiring that each provider know the insurance of the patient, know which quality metrics are being targeted for that payer, conduct the appropriate screenings and interventions, and document accordingly."

State Strategies and Policy Options

• States can utilize their role as conveners in order to foster alignment of measures across payers to minimize burdens on primary care practices. State business groups on health representing large, self-insured employers should be engaged alongside commercial payers and Medicaid to search for common ground across measures.

• Another strategy for policymakers highlighted by a HVH practice coach is to seek balance between the need for standardization of measures with the freedom for practices to tailor their approaches. For example, when possible, providers should be allowed some degree of self-determination to select which quality measures are priorities for their practice and their patients over other measures.

4. EHRs Have Interoperatbility and Functionality Limitations

Electronic health records (EHR) are prerequisites for producing actionable data to help drive quality improvement efforts such as the Heart of Virginia Healthcare's focus on improving cardiovascular prevention. However, lack of interoperability of EHRs and the inability for various EHRs to extract and report on the "ABCS" was a major challenge for participating practices as well as a delaying factor to the work not only of the Virginia EvidenceNOW cooperative, but to cooperatives nationwide. In some cases, practices left the task of resolving those issues to already over-burdened staff.

ERHs also change the provider/patient dynamic in ways that can contribute to burnout.[17] For example, a 2016 study which observed 57 physicians reported that 50 percent of their time was spent on EHR and desk work as opposed to just 27 percent spent with patients,[18] a situation which can be mitigated by including medical scribes on care teams.

State Strategies and Policy Options

- To ensure successful implementation, state payment reform efforts should be advanced in tandem with investments in building and advancing data infrastructures. The push toward value-based payment reform is a major driver of state health information technology (IT) efforts for example, among SIM test states.

- In addition to dedicating available federal and state funds to advancing health IT infrastructure, states can also provide necessary technical assistance to individual practices to help them generate actionable data reports and/or learn how to work with data reports for quality improvement.

Conclusion:

The experiences of primary care practices participating in the HVH cooperative point to a number of practice challenges including issues related to scope of practice, payment reform, reporting requirements, and electronic health records. In each of these areas, states have a variety of strategies and policy options for mitigating these challenges related to state roles as licensing boards, legislatures, payers, and conveners. These state strategies and policy options are in alignment with major, bipartisan trends in health policy toward implementing value-based payment and advancing team-based, coordinated care. They also hold the potential to help alleviate provider burnout, which is increasing over time and threatening provider engagement as well as patient outcomes.

Endnotes:

1. Justin Altschuler, et al., "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation," Annals of Family Medicine 10, no. 5 (September/October 2012): 396-400.
2. Tait D. Shanafelt, et al., "Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population between 2011 and 2014," Mayo Clinic Proceedings 90, no. 12 (December 2015): 1600-1613.
3. Louise H. Hall, et al., "Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review," PLOS ONE 11, no. 7 (July 8, 2016).
4. Thomas Bodenheimer and Christine Sinsky, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," Annals of Family Medicine 12, no. 6 (November/December 2014): 573-576.
5. Donald M. Berwick, Thomas W. Nolan, and John Whittington, "The Triple Aim: Care, Health, and Cost," Health Affairs 27, no. 3 (May 2008): 759-769.
6. Christine A. Sinsky, et al., "In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices," Annals of Family Medicine 11, no. 3 (May/June 2013): 272-278.
7. Further information on state scope of practice laws regarding medical assistants can be found at: http://www.aama-ntl.org/employers/state-scope-of-practice-laws. Retrieved November 29, 2016.
8. Kara Nett Hinkley, "Scope of Practice Overview." (Last updated: September 1, 2015). National Conference of State Legislatures. Retrieved November 21, 2016. http://www.ncsl.org/research/health/scope-of-practice-overview.aspx
9. Kaiser Family Foundation. "Nurse Practitioner Scope of Practice Laws." (Last updated: July 24, 2015). Retrieved November 21, 2016. http://kff.org/other/state-indicator/total-nurse-practitioners/?currentTimeframe=0
10. Kaiser Family Foundation. "Physician Assistant Scope of Practice Laws." (Last updated: July 24, 2015). Retrieved November 21, 2016. http://kff.org/other/state-indicator/physician-assistant-scope-of-practice-laws/?activeTab=map&currentTimeframe=0&selectedDistributions=-full-prescriptive-authority
11. National Academy for State Health Policy. "State Community Health Worker Models." Retrieved November 21, 2016. http://www.nashp.org/state-community-health-worker-models/
12. Thomas Bodenheimer and Laurie Bauer, "Rethinking the Primary Care workforce—An Expanded Role for Nurses," The New England Journal of Medicine" 375 (September 15, 2016): 1015-1017.
13. Center for Medicare and Medicaid Innovation. "State Innovation Models Initiative: General Information." (Last updated: November 18, 2016). Retrieved November 21, 2016. https://innovation.cms.gov/initiatives/state-innovations/

14. Centers for Medicare and Medicaid Services. “MACRA: Delivery System Reform, Medicare Payment Reform.” Retrieved November 21, 2016. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html
15. Center for Medicare and Medicaid Innovation. “Health Care Payment Learning and Action Network.” (Last updated: October 11, 2016). Retrieved November 21, 2016.https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/
16. The Primary Care Payment Model (PCPM) Work Group, Primary Care Payment Models: Draft White Paper (Washington DC: Health Care Payment Learning & Action Network, October 19, 2016), 1-39.
17. Elizabeth Whitman, “When physicians burn out, solutions are elusive. Support groups can’t counter the root causes of a crisis,” Modern Healthcare, October 29, 2016. http://www.modernhealthcare.com/article/20161029/MAGAZINE/310299983
18. Christine Sinsky, et al., “Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties” Annals of Internal Medicine (September 6, 2016).

About the National Academy for State Health Policy:
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

Acknowledgements:
The author wishes to thank the state officials from Virginia who generously agreed to review this brief, as well as Anton Kuzel, MD (Professor and Chair, Department of Family Medicine and Population Health, Virginia Commonwealth University School of Medicine), Beth Bortz (President and CEO, Virginia Center for Health Innovation), and NASHP’s Trish Riley and Maureen Hensley-Quinn for their assistance. This project was supported by the Heart of Virginia Healthcare, an Agency for Healthcare Research and Quality EvidenceNOW regional collaborative. (Agency for Healthcare Research and Quality, U.S. Department of Health & Human Services, 1R18HS023913-0.) Any errors or omissions are those of the author.

Heart of Virginia Healthcare
Restoring the joy in primary care