	Target	Nebraska Nov 2018
Overall satisfied with job (Agree, Strongly agree)	>80% satisfied	80% satisfied
Symptoms of burnout (Definitely, Won't go way, Completely)	<20% burned out	44% burned out
Professional values well aligned with department leaders (Agree, Strongly agree)	>80% aligned	68% aligned
Degree patient care team works efficiently together (Satisfactory, Good, Optimal)	>80% with efficient teamwork	89% with efficient teamwork
Control over workload (Poor, Marginal)	<25% poor control	28% with poor control
Great deal of stress because of my job (Agree, Strongly agree)	<30% stressed	50% stressed
Time for documentation (Poor, Marginal)	<25% time pressured	42% time pressured
Amount of time spent on EMR at home (Moderate, High, Excessive)	<20% excessive EMR at home	59% excessive EMR at home
EMR adds to frustration of my day (Agree, Strongly agree)	Not included in 2015 study	63% frustrated with EMR
Work atmosphere description (Very busy, Hectic-chaotic)	<40% chaotic	21% chaotic
Total Score Average (>40 = joyful workplace)	Target = 80%	14% joyful workplace
Subscale 1 ((supportive work environment) = add the numbered responses to questions 1-5. Range 4-25 (>= 20 is a highly supportive practice!)	Not included in 2015 study	43% highly supportive practice
Subscale 2 (work pace and EMR stress) = add the numbered responses to questions 6-10. Range 4-25 (>= 20 is an office with reasonable pace and manageable EMR stress!).	Not included in 2015 study	8% reasonable pace/ manageable EMR stress

no enough support

the desire for us to spend 80% of our work day face to face with patients and only 20% with documentation, which is actually in reverse of actual practice. I come in several hours before my shift to work on EMR. a large part of my day is doing nonphysician things that should be done by ancillary staff

i dont think you can do too much. Whoever is making my work schedule should use some common sense. You can not make our social workers more efficient and change our IT support. But thanks for asking.

I don't take notes home. I finish them in the office. I bring lunch and dinner dailey and eat at my desk. I know the cleaning people well.

I retired from the practice of medicine because of my difficult time dealing with the documentation required to be an effective physician. Our hospital hired "hospitalists" further separating me from my patients. The less than caring attitude that the hospitalists projected, and perceived lack of concern, coupled with their seeming excessive concern regarding their pay scale was an indication to me that medicine has become merely a job. It is no longer a"calling", or even a profession. Thus I am now retired.

Ensuring that the documentation is comprehensive and reflects what has been said during the office visit.

I work for CHI and sense that physicians have little sway in many critical decisions. My fate not at risk, as I am near retirement. However, younger physicians are at the whim of administrators who have little clinical experience or patient interest at heart. Too bad, really.

Scribes!

I am a retired general internist since 2011, but answered the questions based on my thoughts/feelings in my last year of work. I was an academic internist in Florida with about 70% of my time in some type of patient care (linked to my teaching responsibilities) and the other 30% other academic responsibilities.

Have good administration that responds accordingly to stressors, i.e. workloads, excessive # of shifts worked, stressful pts, difficulties with EMR, hiring appropriately, etc...

Need less documentation mandates in last software that is not clinically useful/efficient

Change of Division leadership.

The EMR is the primary source of my burnout. Seeing patients revitalizes me, and I value this part of my job. I would like to know more about successful balance at other practices (especially academic!) to understand how they achieved that.

Recertifications and EHR adds to the stress between work and home. Making recert 2 yr knowledge check-in as a no penalty and no consequence open book ABIM will help

There are changes at my current job that will have negative effects on the schedules of other members of my household. That is causing more personal stress than I have had in the past. The fact that I am unsure what can be done to minimize these situations also adds to my stress

I work part time and take no call-not sure I can be included in this!

Administration continues to ask us to do more and more non-clinical work that takes my time away from patient care (problem lists, peer-peer calls, patient status calls, coding etc). Patient satisfaction is completely inaccurate compared to patient care for physicians.

Insurance justifying my decisions and what I prescribe. Prior authorization must go. Paper work documentation for medicare. Computer garbage required to fill up space and not get to the heart of the matter especially from consultants and ED. Over use of diagnostic tests in the ED without evaluating the patient first.. Cost of meds my pts cannot afford.

Too much paperwork from insurance companies, nursing homes, and patients is piling up. Patients are also expecting much more to be handled over the phone than they used to which makes it very difficult.

Rural practice with limited access to specialty referral.

Physicians are humans, they should not have 24 hour duties

EMR and pre-qualifications for testing are becoming increasingly frustrating and cumbersome

I would have answered differently two years ago, but have cut back significantly on my practice hours. It was tough for the previous 33 years.

The EMR has slowed me down a lot and increased my work load although there is the convenience of having access to the records from home or another office.

The signatures needed for research are absurd. There are probably a hundred or more every week. Every single lab in addition to lots of other forms

CPT and RBRVRS were defective from inception, and now managers are obsessed with "RVU" production based on these, and the Patient Centered Medical Home seems almost dead in the water.. So national advocacy is what I see needed. My personal frustrations are due primarily to chaotic management in the local/area organization of which I am an employee. I should mention said managers' dissembling devotion to feeble metrics; organized medicine needs to continue to call managers out on this while promoting responsible outcomes metrics. Don't get me started on the sick joke ICD-10 and other clerical tasks that morbidly round out my day. Personally, I (and family) feel anger and frustration over resulting work hours rather than a "lack of energy" burnout." I might join colleagues who have retired earlier than they wanted.

Time pressures

I was tremendously stressed until I left my group (they were toxic), and started my own group with a nurturing culture and proactive approach to the changes in Medicine. It helps a lot to have a hand on the tiller once in a while. This management technique includes giving the younger physicians great input and control of their environment, policies, attitude etc. We have fun and like each other.

EMR, paperwork, billing, click boxes,

Less requirements in every way.

Overall I enjoy medicine, seeing patients and the intellectual stimulation of the changes in practice, the research, and the individual challenges of solving individual problems for patients. I have 6 physicians with whom I share call and hospital duties, and so I do have to admit that the demands on my time are not what they once were many years ago. I understand a lot about why we have emr's and why systems are built--too many cases in the past of mistakes being made with handwritten orders, often not legible, as a prominent example. The emr's are frustrating because in many scenarios you have to know exactly what information to put in in a certain way. For example, the new hospital emr: early I wanted to order an ultrasound. I typed it in many ways, and after a lot of frustration, learned that you had to type in: US. I am 64 so I did not grow up with computers and phones and devices as my constant companions. It is frustrating that you have to find this little square, or this little hidden icon to find things (it is amazing how well hidden things can get on a computer screen). Another big frustration is the idea that lots of "stuff" mentioned in notes equates with better, more thorough care and consequently justifies a higher level of reimbursement. (as a consultant, I sometimes had to go through many pages of other physicians notes, just to find maybe one little sentence that explains what really happens). My favorite example was long ago when I was a resident, working with a community internist. His follow up note for an older patient who came in after treating an exacerbation of COPD: "better!" Wouldn't fly today.

I am not sure a lot of younger physicians see medicine as an intellectual challenge and chance to meaningfully impact the lives of the patients they see. I think some (and maybe always that has been the case) just see it as a fairly well paying job and you got to put in your time. I likely have it better than many. I am close to retirement age, though do not really feel that I need to retire, still feel strong, and I do have a financial security that is very strong should I feel I need to slow down or stop.

Complexity of clicking to order lab, link w diagnosis, add modifiers, update diagnosis to improve billing but not add to clinical communication. Paperwork and documentation for DME and CPAP, etc.

Main source of stress is being a successful female in a male dominated specialty.....

I think that the ehr really takes a lot of time out from the patient physician experience.

I like it for refilling medications and finding records but wish it was more intuitive.

Sometimes I feel the best way to capture the visit would be through a bodycam attached to the physician and every conversation is documented.

We don’t worry about billing and coding and any malpractice issues as it would be recorded. We don’t worry about charting.

The system needs to find something better.

We also need to find better ways to compensate physicians for the out of office time spent on charting etc.

Decrease time of documentation and increase reimbursement which is not keeping up with expenses.

I am in practice by myself!!
Who are my " Clinical leaders"?
Thiese questions were made for residents and unmc employed physicians and no thought was given to modifying them for private practice!!

Conflict: academic vs clinical goals vs scholarly interests
As a sub-specialist, i have a burdensome call schedule, working an average of 18-22 weekends per year and on overnight call for weeks at a time. It is extremely difficult to achieve a reasonable worklife balance. The group could be an advocate for physicians to set limits on unsustainable clinical workload.
I feel like a secretary using a EMR system that is not intuitive or efficient for the doctor. I spend 4x as much time on putting in orders and typing up notes for a patient than I do spending time with that patient- and that's saying alot as I'm talking about PSYCHIATRY.