Wellness Grand Rounds Series

- Promote a culture where there is the expectation that we care for our colleagues and ourselves
- Foster ongoing dialogue on physician wellness and eliminating burnout
- Demonstrate DoIM leadership in physician health and wellness

[Logos of UNM Health Sciences Center, Department of Internal Medicine, Society of Hospital Medicine, American College of Physicians New Mexico Chapter]
EHR Related Stress and Burnout, Results from the MS-Squared Study
COI/Funding

• I and my spouse have no relevant relationships with commercial interests to disclose
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Thank you to the MS-Squared team!

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• Nancy Morioka-Douglas, MD, Stanford
• Sharry Veres, MD, Centura Health, CO
• Katherine Pollock, LISW, MN
Learning objectives

After attending today’s talk, the learner will be able to:

1. Define stress and burnout
2. List several features of EHRs and other HIT associated with stress and burnout

3. List several coping strategies for HIT-related stress and burnout
The Yerkes-Dodson Law (not all stress is bad)
What is burnout?*

A long term stress reaction comprised of 3 dimensions:

1. Emotional exhaustion
2. Depersonalization
3. Lack of sense of personal accomplishment


Demand-Control Model of Job Stress

• Demands balanced by control
• Stress increases if demands rise or control diminishes
• Support can facilitate impact of control
• Bottom line... support and control prevent stress

**Demand-control model of job stress plus HICT stress**

- Demands still balanced by control
- Need more control or support to balance HICT demands

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Source: Linzer et al. Hennepin County Medical Center, Minneapolis, MN, 2016
The nation’s health care workforce is not healthy: Burnout at 54%


Tait D. Shanafelt, MD; Omar Hasan, MBBS, MPH; Lotte N. Dyrbuye, MD, MHPE; Christine Sinsky, MD; Daniel Satele, MS; Jeff Sloan, PhD; and Colin P. West, MD, PhD

Abstract

Objective: To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

Patients and Methods: From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

Results: Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 54.4% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n=3310) in 2011 (P<.001). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; P<.001). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and hours worked per week, physicians remained at an increased risk of burnout (odds ratio, 1.97; 95% CI, 1.80-2.16; P<.001) and were less likely to be satisfied with work-life balance (odds ratio, 0.73; 95% CI, 0.68-0.78; P<.001).
Physicians are more stressed than the general working population

- Physician stress is increasing while general working population stress remains unchanged
- Percent who screen positive for one or more signs of burnout:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2014</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>45.5%</td>
<td>54.4%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>General Population</td>
<td>28.4%</td>
<td>28.6%</td>
<td>0.85</td>
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Other troubling signs
• The total cost of losing a PCP at an academic institution is approximately $250,000.00 (1991 dollars!)

• There is a culture of endurance amongst physicians

**MS Squared Study:**
Minimizing Stress Maximizing Success of HICT

• Qualitative design -- six focus groups + Mini-z physician stress questionnaire

• 3 institutions (UNM, Stanford and Centura Health) • 3 different EHR vendors
• Goals:
  • Determine HICT causes of stress and burnout
  • Determine solutions users find helpful
  • Inform better HICT design

**Mini-z questionnaire results**

• 41 clinicians participated in 6 focus groups
• 72% women
• 95% MDs
• 73% primary care

• 22% indicated sufficient time for documentation
• 56% agreed with “I feel a great deal of stress because of my job.”
Mini-z questionnaire results

- 42% reported “poor” or “marginal” control of workload
- 90% reported satisfactory or better proficiency with EHR
- 56% felt that amount of time spent on EHR at home was “excessive” or “moderately high”

Focus groups, 2 per site

- Formal content analysis, themes and sub-themes identified
- 5 categories:
1. What works?
2. What doesn’t work?
3. What are personal consequences?
4. What will make it better?
5. How can we better cope with it?

Participants: Clinicians who work in ambulatory settings

What works?

• Fast access to all patient information in one place
• Remote access and from home
• ePrescribing
• Decision support (*but not implemented well*)
• Access to labs used for patient education
What doesn’t work?

- Spending more time with chart than patient
- Increased time to complete documentation
- Data entry time consuming and frustrating
- Seeing potential for benefit of HICT that is not implemented, e.g., health information exchanges
- No control over upgrades
- Inadequate connection speed

What are personal consequences?

- Pt documentation at home and on weekends
• Using HICT to document takes time that is not provided during the work day
• Difficult to maintain ethical standards of care and have time for family and outside activities
• HICT disrupts relationships
• Physicians not valued for other important things they do (i.e., reassurance to patients and families, bearing witness to suffering, etc.)
• **Ergonomics** (eye strain, wrist and back pain)

What will make it better?

• Make HICT faster and more reliable
• Improve interoperability
• Improve user interface design
• Provide physicians more time to complete documentation tasks
• Make HICT more adaptable and customizable
• Reduce data entry burden for physicians

How can we better cope with it?

• Treat EHRs as “exposure to toxic substances at home” and don’t access them from home unless no other choice
• Learn by taking more training -- Embrace physician training opportunities
• More concise notes
• Resilience training, exercise, yoga, taking walks, breaks (scheduled)
• Some sacrifice quality of notes for better worklife balance

Summary of MS² focus group phase
• HICT/EHR a significant source of clinician stress
• Number of factors identified amenable to improvement
• Organizational improvements, HICT design improvements, and coping strategies can be of great benefit
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