Work Environment & Systems Based Issues Affecting *Physician Health and Patient Outcomes:* A Survey Result

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Introduction

Physician burnout is a serious problem that is affecting the healthcare industry. It is defined as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout can lead to a number of negative consequences, including decreased patient care quality, increased medical errors, and increased turnover of physicians.

Organizational and systems related issues also play a significant role in physician burnout. These include:

• **Work environment:** A stressful work environment can contribute to physician burnout. This can include factors such as long hours, high patient volumes, and inadequate staffing.

• **Culture:** A culture that does not support physician well-being can also contribute to burnout. This can include factors such as a lack of recognition for physicians' work, a focus on productivity over quality, and a lack of respect for physicians' time.

• **Leadership:** Leadership factors contribute to physician burnout. These include a lack of communication, a lack of adequate support for physicians, and a lack of appropriate vision for the organization.

In fact a recent survey was conducted by MSSNY and the Federation of State Medical Boards (FSMB)-an entity concerned with protecting the safety of the public. [1] They found that excessive or moderately high amounts of time using EHRs at home resulted in an estimated 50% increase in the odds of experiencing job stress and a 46% increase in the odds of experiencing burnout, after controlling several demographic and practice factors. Length and degree of documentation requirements and extension of workplace into home life were work-related issues that contributed to their stress and significantly decreased job satisfaction, increased job stress and burnout. Lack of workload control and aligned values, insufficient time for documentation and a hectic, chaotic work environment all contributed to lower odds of physicians being satisfied at their job and higher odds of experiencing job stress and burnout.

Prior Authorization (PA), sometimes called precertification or prior approval, is a process used by health insurance companies to approve or deny coverage for certain medical services, medications, surgeries, devices or supplies. The purpose of prior authorization is to ensure that the care needed is "medically necessary" and that it is covered by your insurance plan. Over the years this process has been used to curtail costs on behalf of insurance plans or third party administrators of the insurance plan.[2] As national and state level attention has reported on the burden and dangers of this business practice and as this report will demonstrate, this is not a reasonable or acceptable method of healthcare insurance cost control. Recent research from the AMA[3] and this more in-depth research

has uncovered the dire negative impact to patients, as well as clinicians of this practice, in the name of cost control must either stop or be drastically reined in.

A recent study about the impact of COVID-19 added to baseline practice of medicine reported that ⅕ physicians, ⅓ Advanced Practice Providers and ⅖ nurses are intending to leave their profession in the next two years due to difficult work expectations and conditions that have become unreasonable in trying to perform their duties.[4] Their calling of why they went into medicine, required enormous personal sacrifice and expense and yet forces in healthcare that could help them, collaboratively, have not. Despite multiple national calls to improve the wellbeing of healthcare workers (HCWs) and reduce the stress upon them, such as the National Academy of Medicine and Office of the Surgeon General [5,6] there are very entrenched business of medicine forces in both payers and hospital systems, and other stakeholders that keep the status quo. Unfortunately, they have been slow to support and improve the experience of providing care for these dedicated individuals, who are the only stakeholders in healthcare delivery who have pledged to 'First Do No Harm.'. As a result, human-made added workload to the baseline workload of taking care of patients has worn down the healthcare works at the front lines of care, creating a true crisis in healthcare delivery.

Methods

Although, this is another survey, there is a unique and compelling story in the results that delve deeply into the mechanisms behind this excessive workload. We hope to gain enough support regionally, from community input, local representatives of the federal and state government to work as a Community Collaborative effort to try to make headway by bridging and uniting many who know firsthand the difficulties of making our local healthcare system work. At some point in the future it would be a needed effort to survey patients in our community and other healthcare workers, but for now we have obtained the input of physicians from Monroe County Medical Society (MCMS), Greater Rochester Individual Practice Association (GRIPA), Accountable Health Partners (AHP), Federally Qualified Health Centers (FQHC's), University of Rochester Medical Center (URMC) and Rochester Regional Health (RRH) physicians. 142 physicians from the community responded via Survey Monkey, and the results will be reported here.

This survey digs more deeply into the contributions to burnout in this group, in rank order, and in particular, the contributors to Work Outside of Work (WOW) defined by AMA as 'work on the electronic medical record outside of patient scheduled hours'. We also inquired about details of whether there was a negative impact of PAs and categorized what they were. We also gave respondents the opportunity to give constructive suggestions directly to Chief Executive Officers (CEOs) and senior leaders of hospitals /health systems, health plan payers, while protecting their anonymity, since employees and subordinates fear retribution for their honesty. Also constructive suggestions for patients in general (the public) should know what was queried in the hope that release of this information to the public may better improve awareness of the current, reversible but entrenched, processes that are destroying the sustainability of the very system to take care of the public's health. The public needs to know this to have a chance to do something about it through legislation at the state and federal level. We believe that the best path forward is to amplify clinician and patient voices in a system where they are both unhappy and to work together to improve healthcare. [7]

Results

• Survey was opened January 20, 2023, closed March 17, 2023

• 142 doctors responded from MCMS, GRIPA, AHP, FQHC, URMC, RRH

• 28 specialties where represented. 95.07% of respondents were primarily clinical

• 92% had to do Electronic Medical Record (EMR) work outside of scheduled patient hours, or Work Outside of Work (WOW).

• For 88.32%, this included weekends.

• Based upon three national studies with very high congruence, despite location, on average physicians did 1.77hr WOW per day [8, 9,10]

• Given the need to do this work on weekends, this estimates in our local population of doctors, that:

  o The Average Doctor spends a minimum of 10.94 hrs. WOW per week

  o Primary Care 11.38 hrs. WOW per week

  o Surgeons 10.5 hrs. WOW per week

  o Medical 10.95 hrs. WOW per week.

• Prior Authorizations contribute to this WOW though not the largest contributor.

  o 70.68 % thought small extent

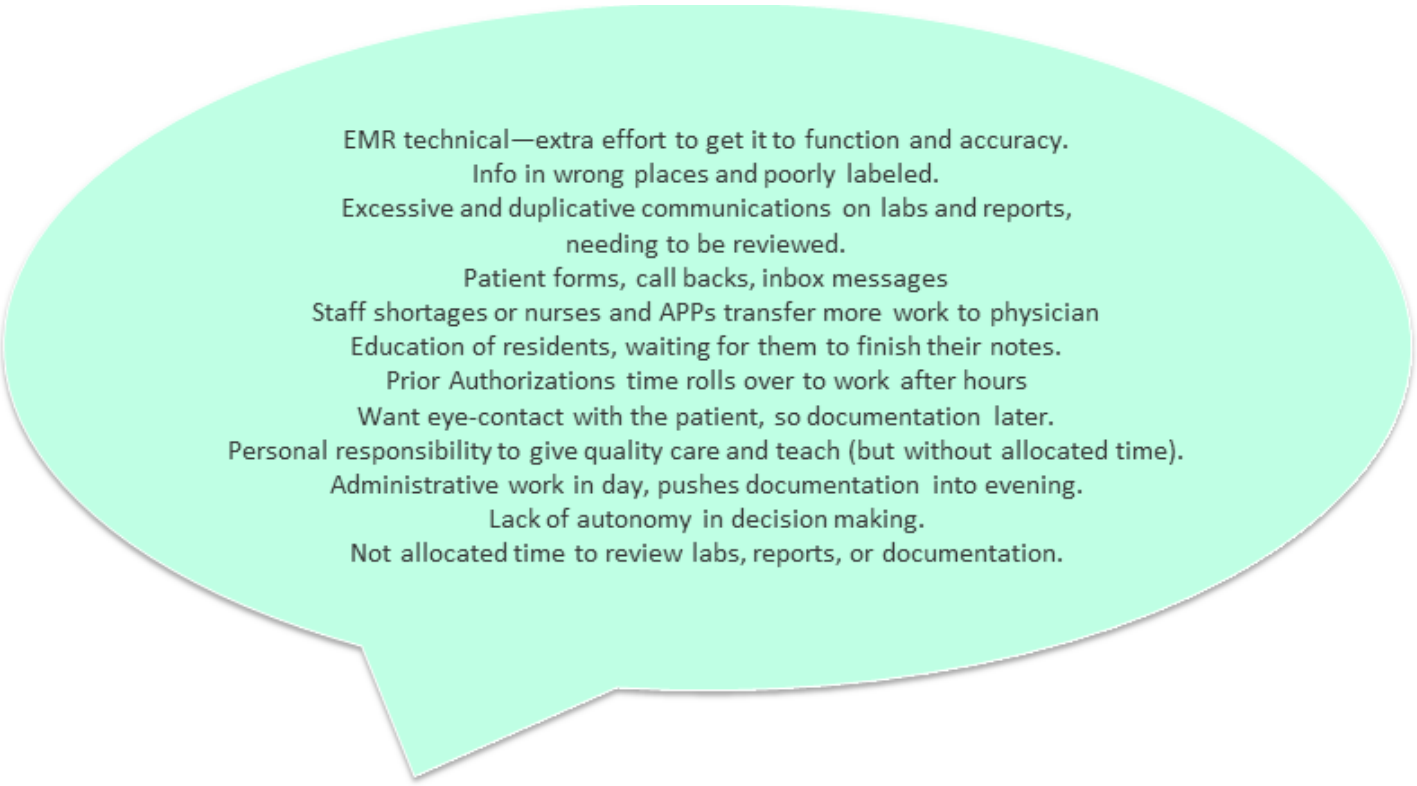
  o 23.31% moderate extent

  o 6.02% large extent.

Top 10 Reasons for Doing Work Outside of Work

RANK ORDER, LARGEST TO SMALLEST CONTRIBUTORS.	Rank Order Contribution to WOW	% Selected as reason	Number Respondents
Time doing Inbox Messages from patients expands EMR work into off hours.	#1	66.67%	92
Inadequate time allocated for clinical documentation at work	#2	64.49%	89
Time doing mandatory trainings for work, expands EMR work into off hours	#3	56.52%	78
Hospital/clinic does not track hours needed to accomplish work, Only tracks work units accomplished	#4	51.45%	71
Inadequate administrative support to meet the administrative work of practice.	#5	42.03%	58
Time doing preparation for Maintenance of Certification expands EMR work into off hours	#6	35.51%	49
Although excessive documentation requirements is still a reason I cannot finish EMR work at work, I am glad that I have the option to finish EMR work at home for personal reasons.	#7	33.33%	46
Other (please specify)	#8	23.91	33
Time doing Prior Approvals during the workday expands EMR work into off hours	#9	22.46%	31
Work expected of me is reasonable and not excessive. I am glad I have the option to finish EMR work at home for personal reasons.	#10	7.97%	11

WOW "Other Sample, 33 physicians added comments here



o If employed, only 23% of physicians thought that their healthcare system showed authentic and specific measures that show that they are concerned about physician wellbeing addressing their workload.

System based/organizational factors contributing to burnout.

RANK ORDER LARGEST TO SMALLEST CONTRIBUTORS	Rank Order Contributor	% Responded	#
Insufficient Staffing	1	75.74%	103
EMR related constitutional stressors	2	62.50%	85
Lack of response by leadership to your suggestions, nor explain why they can't respond.	3 (tied)	42.65%	58
Burdensome quality reporting	3 (tied)	42.65%	58
Lack of commitment by leadership to work on culture change for the organization	4 (tied)	38.24%	52
Lack of autonomy/work control	4 (tied)	38.24%	52
Lack of visibility of leadership for listening to your needs	5	36.03%	49
Lack of communication bridges built between C Suite and working staff	6	30.88%	42
Other (please specify)	7	27.94%	38
Lack of wellness resources	8	19.12%	26
			505

Q10 "Other system bades/rog factors for burnout. Sample, 38 physicians added comments here

Reimbursement rates woefully inadequate.
Working harder to get paid, being paid less, patients shouldering more costs.
Lack of respect.
MOC, inequity of pay. Excessive corporate compliance notification burden.
Was told effort to decrease inbox work months ago. I have yet to see any changes.
Hospital A uncooperative because I am not an employee.
Status quo bias.
Corporatizing healthcare. Push to generate RVUs
Do my best to ignore bureaucracy of organizations., Higher levels of leadership are increasingly focused on meeting metrics that increase financial reward to the system, but not improve quality care, although presented under guise of "access"
Chief Wellness office euphemistic jargon to placate physicians without actual achievement that relieves mindless meaningless tasks that contribute nothing to patient care.
Hospital B administration doesn't care about physicians.
Too much "resilience and wellness' not substantive correction of root causes.
Lack or clear boundaries to work. Unfair work assignments. Push is for RVUs not quality Incompetent staff telling me to see more patients, gut won't pay staff to stay overtime if run over.
Not enough nurse and secretarial help. Increase admin burdens from insurance companies for PAs but decline in reimbursement.
Solo private practice is 50% direct patient care, 50% administrative work.
Can't work at top of my license.
Insufficient supporting staff.
Administrative decisions made without physician input, ore disregarding physician input.
Arbitrary barriers to staffing/improvement.

o Of those who knew, 92.12 % responded that PAs always, often or sometimes delayed access to necessary care.

o Of those who knew, 90.7% responded that PAs always, often or sometimes led to abandoning treatment.

o Of those who knew, 64.5% responded that PA criteria always, often or sometimes were based upon evidenced-based medicine and/or guidelines from medical societies.

o Of those who knew, 46.8% of respondents thought that PA criteria always, often or sometimes was salient to the patient population they served, with respect to severity of cases seen, or socioeconomic status of their patients or other reasons.

o Regarding transparency of the approval criteria prior to doing the PA form or phone call, only 7.9% thought that these were transparent always or often, with an additional 23.7 % thinking it was transparent sometimes.

o Prior Approvals had a very high negative impact on clinical outcome. Of the patients that required PAs...

- 85.29% responded that they had a somewhat or significant negative impact
- 8.09% said no impact
- 6.62% said that PAs had a somewhat or significant positive impact on clinical outcome

o Within this group of 137 physicians:

- At least 3 of their patients died
- 4 patients had disability, permanent bodily damage or congenital anomaly or birth defect
- 21 patients had life-threatening event or required intervention to prevent permanently impairment of damage
- 32 patients needed to be hospitalized due to prior authorization process.

o PAs had a high interference with either preventing a working patient from becoming disabled (due to this interference with treatment) or in getting a disabled patient treated and being able to return to work

Of those who knew:

- 88.6% said that PAs interfered with their working patient's ability to perform their job, or delayed their ability to return to work. Thus a health insurer PA as a cost control method, is increasing the cost of the employee's business that is paying the healthcare insurance premium. Also the healthcare insurance business method is increasing the cost to the disability carrier.

Effect on Intention to Keep Working Clinically.

If the total administrative burdens in current work conditions do not improve sufficiently in the next 6 months:

Impacting Access to Care for Patients in Our Community

	Likely or Highly Likely in the next year
To retire early:	29.5%
To cut back on hours:	45.0%
To leave clinical work to work in a non-clinical position	23.6%
If currently in Primary care, would consider leaving Primary care:	31.8%

Serious Adverse Events Due to Prior Authorization Process

ANSWER CHOICES	OF THOSE 95 DOCS THAT KNOW IMPACTS	Minimum # of patients affected/ Respondents
Yes, death	3.2%	**3**
Yes, disability/permanent bodily damage, congenital anomaly/birth defect	4.2%	**4**
Yes, life-threatening event or required intervention to prevent permanent impairment of damage	22.1%	**21**
Yes, hospitalization	33.7%	**32**
No	31.6%	**30**
Other (please specify)	5.3%	**5**

Characteristics of Prior Approval Process Experiences (I)

	N/A	1	2	3	4	5	TOTAL	Salient Weighted Average ★Score
Complexity of form to be filled out {0= N/A; scale: 1 = simple, not complex, 5 = very complex)	23	4.9% 5	15.5% 16	49.5% 51 ★	25.2% 26	4.9% 5	126	**3.11**
Needless repetition for information they already have on the patient {0= N/A; Scale: 1 = only asks for information to identify the patient, 5 = had to provide excessive information that they already had on the patient.	17	2.7% 3	8.2% 9	10.9% 12	30.9% 34 ★	47.3% 52	127	**4.128**
Phone Prior Approvals- **Warm transfer but a technical problem with dropped calls/start over-** {health plan employee hands off information to another health plan employee in an attempt to prevent the clinician from having to repeat information but technically dropped call and had to start over by calling in general number again with new people. {0=N/A, Scale: 1= has happened. 5= has happened many times.)	41	14.8% 12	16% 13	27.2% 22 ★	18.5% 15	23.5% 19	122	**3.2**

Characteristics of Prior Approval Process Experiences (II).

	N/A	1	2	3	4	5	TOTAL	★ Salient Weighted Average **Score**
Phone Prior Approvals- **Cold transfers:** Cold transfer = hand-off to another person in the health plan without explaining the problem internally to the next staff, such that you have to repeat the entire story again to the next person. (0= N/A. Scale: 1 = explained situation to staff once, 5 = multiple transfers and multiple repeat stories)	36	10.5% 9	15.1% 13	29.1% 25 ★	15.1% 13	30.2% 26	122	**3.39**
Friendliness of clerical staff (0= N/A; Scale: 1 = friendly/ pleasant, 5= unfriendly/rude)	27	10.4% 10	32.3% 31	40.6% ★ 39	12.5% 12	4.2% 4	123	**2.68**
Effectiveness of clerical staff (0= N/A; Scale: 1 =solved issue, 5 = not solve issue)	28	9.6% 9	24.5% 23	36.2% ★ 34	18.1% 17	11.7% 11	122	**2.99**

Characteristics of Prior Approval Process Experiences (III)

	N/A	1	2	3	4	5	TOTAL	Salient Weighted Average ★ Score
Convenience of availability of Health plan reviewer (0= N/A; scale. 1= easily available, 5 = very inconvenient availability.)	25	11.3% 11	12.4% 12	30.9% 30	22.7% ★ 22	22.7% 22	122	**3.331**
Clinical training of health plan reviewer (0 = N/A or unknown; Scale. 1 =Board Certified, same specialty as you, 5= Board certified in a specialty that doesn't apply to your patients.)	38	6% 5	18.1% 15	26.5% 22	24.1% ★ 20	25.3% 21	121	**3.446**
Speed of PA response (0=N/A, 1=Same day, 2=Next day 3=up to 48 hrs- or 2 days, 4.=up to 72 hrs -or 3 days, 5= > 72 hours or more than 3 days)	20	4.9% 5	27.2% 28	23.3% 24 ★	23.3% 24	21.4% 22	123	**3.294**

Suggestions to Hospital and Health Systems CEOs and Senior leaders

Sample suggestions to Hospital CEOS and Senior leaders

Engage physicians to solve problems. We are not the problem.

Let them understand the time documentation takes us. Help us.

Administrative decisions are often made with insufficient physician input.

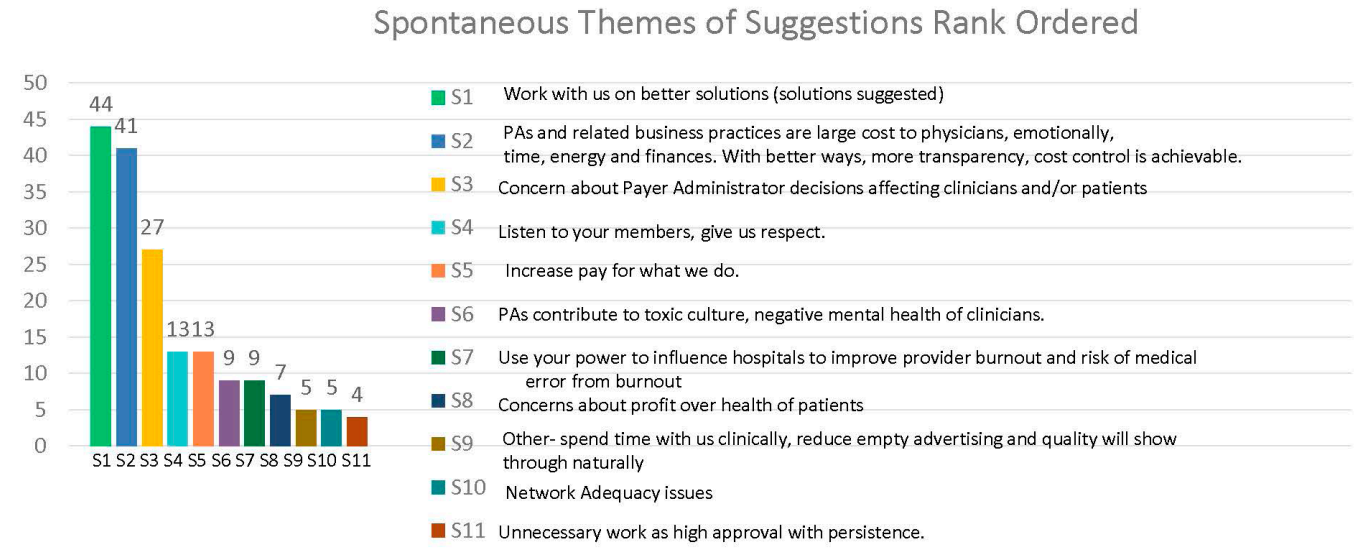
Please get us the resources we need to do our work. Please do not overspend on big capital items when every-day resources are needed, and we're suffering without them and so are the patients.

Stop hiring Locums and travel nurses. Increase the pay for those that are dedicated and want to stay. High quality, intelligent, independent thinking and hard working support staff are beyond essential to making patient encounters run smoothly and reduce documentation burden.

Invest in physician and hospital wellness "now". It will be increasingly difficult to adequately staff many hospitals. It is critical to retain staff.

Suggestions to Insurance Payer CEOs and Leadership

New



Sample suggestions to Insurance Payer CEOs and senior leadership

Make the process more transparent. View us as partners. Please listen to our feedback and why we are doing something for the specific patient in front of us.

Stop the nickel and diming of medicines, give us clues how something might be covered if written a certain way instead of "not covered". Let the pharmacist know this. Work with us to reduce **unnecessary** work on our end. You could help us.

I have no non-expletive laden feedback for them. Especially the MA plans. My life sucks.

PAs are too burdensome, take enormous time. Cost saving method is to slow us down, hassle, wear us down. Its cruel.. Some denials are unreasonable. We have a doctor shortage problem, and will get worse. Treat us and patients as humans instead of just numbers.

Have them all follow a standard Quality Measures Program so that we are not chasing different measures for different plans and not able to meet any due to ambiguous goals.

For Patients and Public to Know to Help Congress or Legislation.

Sample quote what Patients as a group should know.

Clinicians are people who chose their field because they genuinely care about people and patient well-being...administrative burdens drain the humanism out of the providers from whom you seek a humanistic approach to medicine.

The system is approaching a breaking point—they should be aware of what is at stake. Solutions are needed but is not more regulations.

In order to keep systems financially sustainable, we have to see large volumes of patients, but it decreases quality. Would help if reimbursements increase

There is no work-life balance for physicians. We are drawn in so many conflicting directions that limits our face time with patients but doesn't reflect the effort behind the scenes.

We are working hard for you. The burnout conversation is very much about you as well. We are advocating for more time with you so that we can provider better care.

Physicians are human too, (trying to) have a life and family.

Table 4: Financial Impact Issues

1. Payer Reimbursement flat to 1% increase (below inflation) (Revenue per patient is stymied by insurance carrier)

2. Workflow Efficiency slowed down by high justification of efforts in order to get paid, so counter incentive to compensatory volume increase of patients. Smooth flow of patient care delivery is impaired by insurance administrative requirements layered in. Any compensatory volume increase is forced to come out of your own added efforts and own personal time.

3. Practice Overhead is increased by insurance company requirements needing staff to justify payment PAs, coding issues, documentation processing requirements, calling carriers, medical reviewers, etc..

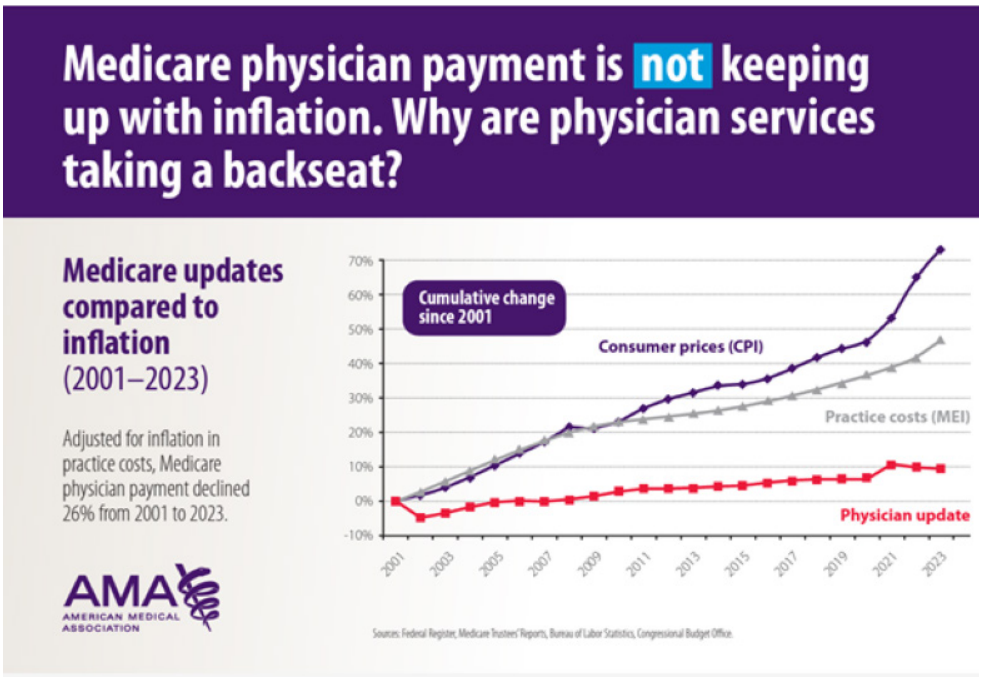


Fig-8: Medicare Physician Payments updates compared to inflation

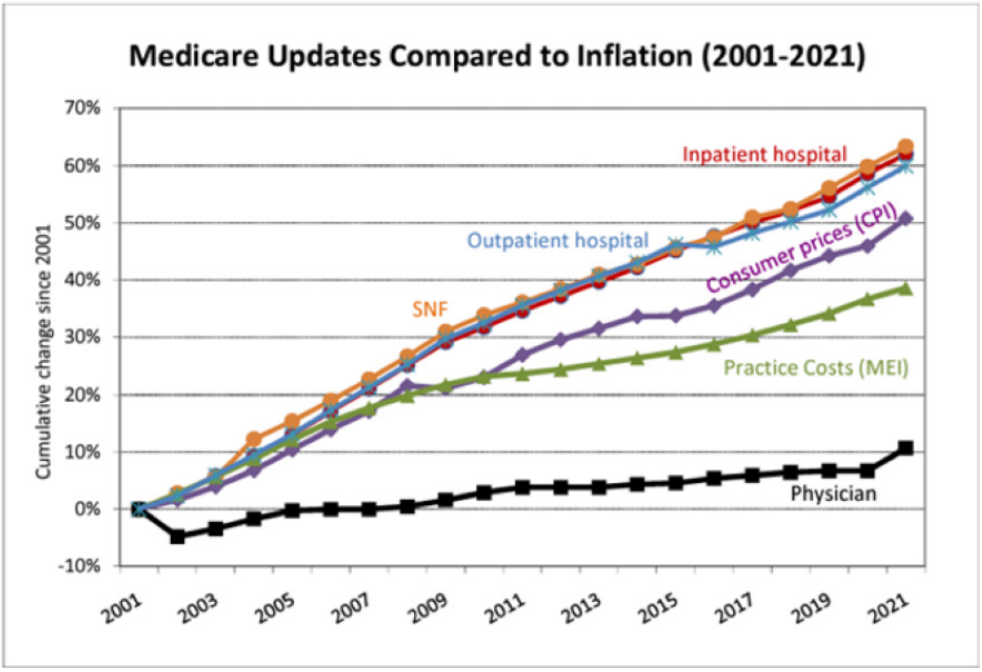


Fig -9: Medicare Updates Compared to Inflation (2001-2021)

TABLE 4: Continued...

PRIOR AUTHORIZATION OVERHEAD COSTS (CONSERVATIVE ESTIMATES).

Survey's Range of Prior Authorization Practice FTE= 0 FTE to 5 FTE among those 52 that know.

Extra FTE Costs for PAs (very conservative figures)

$0- Comes out of WOW

$0 0.1 FTE - $5,200/yr.

1 FTE- $52,000/yr.

5 FTE-$260,000./yr.

your time, or see fewer patients

*Zippia.com Prior Authorization Specialist Range $27,000 to $46,000

RN salary National average $66,212 some much higher to $120,000.

Use very conservative figure /FTE as variety of training level doing PAs. Used $40,000 + 30% benefits = $52,000/

Discussion

This survey uncovers the detailed effect of the harm of the Prior Authorization Process to clinicians and patients. in this study physicians have to contend with poorly designed efficiencies due to the Prior Authorization process, that only can be construed as being done on purpose to control cost by wear down, making the experience onerous, time consuming to affect downward the volume of patients that can be seen, affecting patient access due to human limitations of the physician. Attempts have been made to try to negotiate rate increases from payers to be able to fund resources to cover this onerous load, but kept flat to a 1% increase. Even in light of a lack of progress in rate increases, physician practice overhead goes up requiring numerous staff to process PA requests.

Physician payments have been failing to keep pace with rising inflation for years. Adjusted for inflation in practice costs, Medicare physician payments declined 26% from 2001 to 2023 (Fig-8). This is due to a number of factors, including the increasing use of managed care, which has led to lower reimbursement rates for physicians, and the rising cost of medical malpractice insurance. As a result, many physicians are finding it difficult to make a living, and some are even leaving the practice of medicine altogether.

At the same time, hospital reimbursement rates, both inpatient and outpatient have been increasing year-on-year at a very predictable and sustainable rate (Fig-9). This is due to a number of factors, including the increasing complexity of medical care, the rising cost of medical supplies and equipment, and the increasing demand for hospital services. As a result, hospitals are making more money than ever before, while physicians are struggling to make ends meet.

This disparity in reimbursement rates is having a number of negative consequences. First, it is leading to a shortage of physicians. As more and more physicians leave the practice of medicine, there will be fewer doctors available to care for patients. This could lead to longer wait times for appointments and a decrease in the quality of care.

Second, the disparity in reimbursement rates is contributing to the rising cost of healthcare. Hospitals are passing on the costs of their higher reimbursement rates to patients in the form of higher copays and deductibles. This is making it more difficult for patients to afford the care they need.

Third, the disparity in reimbursement rates is contributing to the financial instability of many hospitals. As hospitals make more money, they are also spending more money. This is due to the increasing cost of medical care, the increasing demand for hospital services, and the need to invest in new technologies and facilities. As a result, many hospitals are operating on thin margins, and some are even in danger of going bankrupt.

The disparity in reimbursement rates is a complex problem with no easy solutions. However, it is a problem that needs to be addressed. If we do not find ways to address this problem, it will have a negative impact on the quality of care, the affordability of healthcare, and the financial stability of hospitals.[11]

Conclusions

Patient's lives have been severely altered and even lost by this Prior Authorization process. Healthcare workers are leaving the field. Status quo bias is not a viable stance to take. Mental Health of clinicians is affected by this constant external, unrelenting, set of expectations that can be reduced but those who have the power to help need to spend time understanding the mechanisms behind increasing expectations on clinicians and take action to reduce them. All of the above discussed factors have significantly affected the mental wellbeing of the physician community leading to unsustainable rates of physician burn out.

Our findings also underscore the importance of addressing systemic issues in the practice of medicine. Individual interventions may be partially helpful to get through acute situations but chronic systemic issues need to be addressed, several outlined here. Technological advances afford 24/7 availability of clinicians to their jobs. Therefore, it will take progressive and integrative-thinking[12] from decision-makers to implement policy, guidelines and cultural change to respect clinician off-time as an essential part of the sustainable safe practice of medicine. Focused efforts are needed to foster change in the physician culture of endurance and hyper-expectation that is perpetuated internally and externally in medicine to the personal detriment of clinicians, their families and the patients they serve. [13,14] The work life of the physician has drastically changed from 20 or 30 years ago and these cultural issues need to be addressed in context. The blurring of the boundaries between work and home must be reduced and eliminated wherever possible.

Improving relationships between clinicians and administrators and other executives will improve two-way listening to the needs of both groups which could synergize more rapid culture and policy change. Too often executives may get input from external consultants in healthcare, listen to consultants but then not listen to their constituents. It is the opinion of these authors based upon organizational literature that front line

to executives will not improve systemic issues. Regular feedback input to organizational leadership from BOTH clinicians and patients is required to improve functionality and efficacy of our healthcare system.[15,16,17] We have Patient Experience data as one of the feedback systems in place. However, executives must have access to honest feedback systems directly from clinicians in a way that does not cost the subordinate their job or interfere with their career, or otherwise perpetuation of an untenable system will persist.

Plan

MCMS, with its partners, are initiating a Community Collaborative including local, county stakeholders in healthcare including patients, clinicians, hospital system leaders, and insurance industry leaders to work together collaboratively. We will also have the assistance and oversight of state and national officials, and Regional Representatives of Health and Human Services (HHS) who have taken particular interest in this community project. If successful, we can serve as a model of a community working together to improve its healthcare delivery for the public's health and sustainable careers in medicine.

• We need to understand how unnecessary complexity got us to this point and what can be done to correct the malignancy of this process.

• We must understand how the business of medicine processes, and even well-intended quality of care efforts, led to overwhelming and inefficient conditions that are not humanly sustainable.

• We know that the business of medicine is also what "keeps the lights on" and keeps care available, but we must be true collaborators and call out processes that are excessive, about power, market-share dominance, divide-and-conquer or "hard-ball" business tactics.

• There has to be more transparency to what is happening in healthcare that is interfering with the public's health, and the public should have this information.

• Organizational mission must have room for reasonable profit in the care of patients but not to the levels that put patients at peril and make the experience of providing care impossible to sustain.

• The point of this effort is to make it human-centric: An effective system that pays attention to the human behind the numbers, operations and processes.

• We may benefit from a facilitated conversation at first, led by a patient advocacy focused professional.

• We need to be vigilant of how no single person has the answer, but needs to be seen from many points of view.[18]

• Patient and clinician voices need to be amplified and get to healthcare decision-makers to utilize this information and neither is currently content.

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