BURNOUT WEBINAR SERIES

IMPROVING PATIENT EXPERIENCE BY ADDRESSING CLINICIAN EXPERIENCE

APRIL 18, 2019

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WEBINAR HOUSEKEEPING

IMPROVING PATIENT EXPERIENCE BY ADDRESSING CLINICIAN EXPERIENCE

Eileen Barrett, MD, MPH, FHM, FACP

Division of Hospital Medicine, University of New Mexico

Regent, American College of Physicians

@EileenBarrettNM

WHY DOES CLINICIAN EXPERIENCE MATTER?

Working Conditions in Primary Care: Physician Reactions and Care Quality

Mark Linzer, MD; Linda Baier Manwell, MS; Eric S. Williams, PhD; James A. Bobula, PhD; Roger L. Brown, PhD; Anita B. Varkey, MD; Bernice Man, MD; Julia E. McMurray, MD; Ann Maguire, MD, MPH; Barbara Horner-Ibler, MD, MASW; and Mark D. Schwartz, MD, for the MEMO (Minimizing Error, Maximizing Outcome) Investigators*

Background: Adverse primary care work conditions could lead to a reduction in the primary care workforce and lower-quality patient care.

Objective: To assess the relationship among adverse primary care work conditions, adverse physician reactions (stress, burnout, and intent to leave), and patient care.

Design: Cross-sectional analysis.

Setting: 119 ambulatory clinics in New York, New York, and in the upper Midwest.

Participants: 422 family practitioners and general internists and 1795 of their adult patients with diabetes, hypertension, or heart failure.

Measurements: Physician perception of clinic workflow (time pressure and pace), work control, and organizational culture (assessed survey); physician satisfaction, stress, burnout, and intent to leave practice (assessed by survey); and health care quality and errors (assessed by chart audits).

Results: More than one half of the physicians (53.1%) reported [illegible] reported burnout. Adverse workflow (time pressure and chaotic environments), low work control, and unfavorable organizational culture were strongly associated with low physician satisfaction, high stress, burnout, and intent to leave. Some work conditions were associated with lower quality and more errors, but findings were inconsistent across work conditions and diagnoses. No association was found between adverse physician reactions, such as stress and burnout, and care quality or errors.

Limitation: The analyses were cross-sectional, the measures were self-reported, and the sample contained an average of 4 patients per physician.

Conclusion: Adverse work conditions are associated with adverse physician reactions, but no consistent associations were found between adverse work conditions and the quality of patient care, and no associations were seen between adverse physician reactions and the quality of patient care.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. 2009;151:28-36. www.annals.org

For author affiliations, see end of text.

Research Report

Attitudes and Habits of Highly Humanistic Physicians

Carol M. Chou, MD, Katherine Kellom, and Judy A. Shea, PhD

Abstract

Purpose
Humanism is fundamental to excellent patient care and is therefore an essential concept for physicians to teach to learners. However, the factors that help attending physicians to maintain their own humanistic attitudes over time are not well understood. The authors attempted to identify attitudes and habits that highly humanistic physicians perceive allow them to sustain their humanistic approach to patient care.

Method
In 2011, the authors polled internal medicine residents at the University of Pennsylvania to identify attending physicians who exemplified humanistic patient care. In this cross-sectional, qualitative study, the authors used a semistructured script to interview the identified attending physicians to determine attitudes and habits that they believed contribute to their sustenance of humanistic patient care.

Results
Attitudes for sustaining humanism in this cohort of humanistic physicians included humility, curiosity, and a desire to live up to a standard of behavior. Many of the physicians deliberately worked at maintaining their humanistic attitudes. Habits that humanistic physicians engaged in to sustain their humanism included self-reflection, connecting with patients, teaching and role modeling, and achieving work–life balance. Physicians believed that treating their patients humanistically serves to prevent burnout in themselves.

Conclusions
Identification of factors that highly humanistic attending physicians perceive help them to sustain a humanistic outlook over time may inform the design of programs to develop and sustain humanism in teaching faculty.

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ACADEMIC MEDICINE
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JAMA Internal Medicine | Original Investigation | PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction

A Systematic Review and Meta-analysis

Maria Panagioti, PhD; Keith Geraghty, PhD; Judith Johnson, PhD; Anli Zhou, MD; Efharis Panagopoulou, PhD; Carolyn Chew-Graham, MD; David Peters, MD; Alexander Hodkinson, PhD; Ruth Riley, PhD; Aneez Esmail, MD, PhD

IMPORTANCE Physician burnout has taken the form of an epidemic that may affect core domains of health care delivery, including patient safety, quality of care, and patient satisfaction. However, this evidence has not been systematically quantified.

OBJECTIVE To examine whether physician burnout is associated with an increased risk of patient safety incidents, suboptimal care outcomes due to low professionalism, and lower patient satisfaction.

DATA SOURCES MEDLINE, Embase, PsycInfo, and CINAHL databases were searched until October 22, 2017, using combinations of the key terms *physicians*, *burnout*, and *patient care*. Detailed standardized searches with no language restriction were undertaken. The reference lists of eligible studies and other relevant systematic reviews were hand-searched.

STUDY SELECTION Quantitative observational studies.

DATA EXTRACTION AND SYNTHESIS Two independent reviewers were involved. The main

Invited Commentary
page 1331

Supplemental content

JAMA Internal Medicine June 2018 Volume 178, Number 6

PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Correlates and Outcomes of Physician Burnout Within a Large Academic Medical Center

Physician burnout is increasingly recognized as a systemic health care problem.[1] Prior research has identified the adverse impact on physician health and patient care.[2] Recently, studies have begun to examine the impact on health care delivery.[3] We assessed the correlates and outcomes of physician burnout in a single health system.

Methods | Data for this study come from the Cleveland Clinic Health System, a large nonprofit academic health system. Physicians completed the Maslach Burnout Inventory prior to a mandatory communication skills course between August 1, 2013, and May 1, 2014. The Maslach Burnout Inventory measured burnout in 3 domains: emotional exhaustion, depersonalization, and personal accomplishment, as well as burnout overall (defined as emotional exhaustion ≥27 and/or depersonalization ≥10).[4] Outcomes included leaving the

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Placing a priority on mental health enables healthcare professionals to better take care of themselves and their patients.

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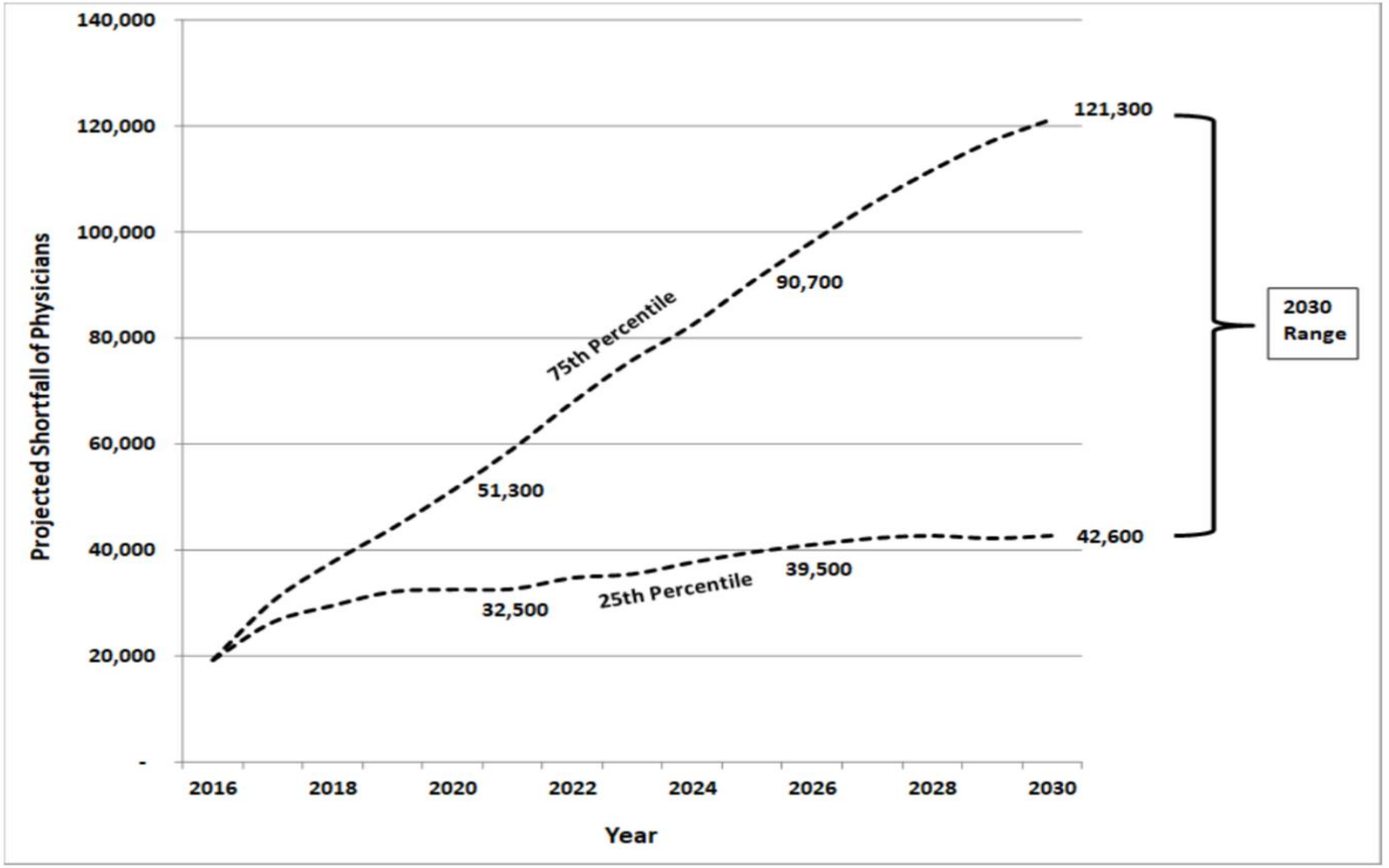
Exhibit ES-1: Total Projected Physician Shortfall Range, 2016–2030



AMA Journal of Ethics
Illuminating the Art of Medicine
FEB 2013

"No Margin, No Mission" Is Too Simplistic

Alessandra Colaianni

Citation PDF Print

BUT WE *CAN* TURN THE TIDE

- Clinician burnout is not inevitable
- Dissatisfaction can be cured
- Burnout can be prevented
- Well-being can be promoted **and** can improve patient experience and care!

For the Young Doctor About to Burn Out

Professional burnout is the sum total of hundreds and thousands of tiny betrayals of purpose, each one so minute that it hardly attracts notice.

Richard Gunderman, MD

The Atlantic

In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

Christine A. Sinsky, MD[1]
Rachel Willard-Grace, MPH[2]
Andrew M. Schutzbank, MD[3,4]
Thomas A. Sinsky, MD[5]
David Margolius, MD[2]
Thomas Bodenheimer, MD[2]

[1]Medical Associates Clinic and Health Plans, Dubuque, Iowa

[2]Center for Excellence in Primary Care, University of California, San Francisco, California

[3]Beth Israel Deaconess Medical Center, Boston, Massachusetts

[4]Iora Health, Cambridge, Massachusetts

Conflicts of interest: none reported.

CORRESPONDING AUTHOR

Christine A. Sinsky, MD
Medical Associates Clinic and Health Plans
Dubuque, IA 52001
csinsky1@mahealthcare.com

ABSTRACT

We highlight primary care innovations gathered from high-functioning primary care practices, innovations we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing primary care practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

Ann Fam Med 2013;11:272-278. doi:10.1370/afm.1531.

Working at Starbucks would be better.
Benjamin Crocker, MD, October 3, 2007

I look forward to going to work each day. I'm loving it!
Benjamin Crocker, MD, July 13, 2011

INTRODUCTION

By all reports, primary care physicians are at high risk of burnout.[1-3] Fewer physicians are choosing primary care, many are leaving it.[4-6] Although waning interest in adult primary care careers is multifactorial, driven by such forces as the primary care–subspecialty income gap, medical schools' devaluing of primary care, and the unsustainable primary care work life, we focus on the work life issue. One study suggests that the difficult work life may be the most influential factor discouraging medical students from primary care careers.[7]

Those who practice adult primary care are often deeply dissatisfied,[1] spending much of their days performing functions that do not require their professional training.[8] More than one-half of general internists and family physicians have symptoms of burnout.[3] Time pressure, chaotic work environments, increasing administrative and regulatory demands, an expanding knowledge base, fragmentation of care delivery, and greater expectations placed on primary care contribute to the strain.[9] Workdays are getting longer[10] and rewards are diminishing. Joy is in short supply.

We propose *joy in practice* as a deliberately provocative concept to describe what we believe is missing in the physician experience of primary care. The concept of physician satisfaction suggests innovations that are limited to tweaking compensation or panel size. If, however, as the litera-

Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis

Colin P West, Liselotte N Dyrbye, Patricia J Erwin, Tait D Shanafelt

Lancet 2016; 388: 2272–81

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See Comment page 2216

Division of General Internal Medicine and Division of Biomedical Statistics and Informatics (Prof C P West MD), Division of Primary Care Internal Medicine (Prof L N Dyrbye MD), Medical Library (P J Erwin MLS), and Division of Hematology (Prof T D Shanafelt MD), Mayo Clinic, Rochester, MN, US

Correspondence to: Prof Colin P West, Division of General Internal Medicine and Division of Biomedical Statistics and Informatics, Mayo Clinic, Rochester, MN 55905, USA west.colin@mayo.edu

Summary

Background Physician burnout has reached epidemic levels, as documented in national studies of both physicians in training and practising physicians. The consequences are negative effects on patient care, professionalism, physicians' own care and safety, and the viability of health-care systems. A more complete understanding than at present of the quality and outcomes of the literature on approaches to prevent and reduce burnout is necessary.

Methods In this systematic review and meta-analysis, we searched MEDLINE, Embase, PsycINFO, Scopus, Web of Science, and the Education Resources Information Center from inception to Jan 15, 2016, for studies of interventions to prevent and reduce physician burnout, including single-arm pre-post comparison studies. We required studies to provide physician-specific burnout data using burnout measures with validity support from commonly accepted sources of evidence. We excluded studies of medical students and non-physician health-care providers. We considered potential eligibility of the abstracts and extracted data from eligible studies using a standardised form. Outcomes were changes in overall burnout, emotional exhaustion score (and high emotional exhaustion), and depersonalisation score (and high depersonalisation). We used random-effects models to calculate pooled mean difference estimates for changes in each outcome.

Findings We identified 2617 articles, of which 15 randomised trials including 716 physicians and 37 cohort studies including 2914 physicians met inclusion criteria. Overall burnout decreased from 54% to 44% (difference 10% [95% CI 5–14]; p<0·0001; I^2=15%; 14 studies), emotional exhaustion score decreased from 23·82 points to 21·17 points (2·65 points [1·67–3·64]; p<0·0001; I^2=82%; 40 studies), and depersonalisation score decreased from 9·05 to 8·41 (0·64 points [0·15–1·14]; p=0·01; I^2=58%; 36 studies). High emotional exhaustion decreased from 38% to 24% (14% [11–18]; p<0·0001; I^2=0%; 21 studies) and high depersonalisation decreased from 38% to 34% (4% [0–8]; p=0·04; I^2=0%; 16 studies).

Interpretation The literature indicates that both individual-focused and structural or organisational strategies can result in clinically meaningful reductions in burnout among physicians. Further research is needed to establish which interventions are most effective in specific populations, as well as how individual and organisational solutions might be combined to deliver even greater improvements in physician wellbeing than those achieved with individual solutions.

Funding Arnold P Gold Foundation Research Institute.

Introduction

A more complete understanding than at present of the

JAMA Internal Medicine | Original Investigation | PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

Controlled Interventions to Reduce Burnout in Physicians
A Systematic Review and Meta-analysis

Maria Panagioti, PhD; Efharis Panagopoulou, PhD; Peter Bower, PhD; George Lewith, MD; Evangelos Kontopantelis, PhD; Carolyn Chew-Graham, MD; Shoba Dawson, PhD; Harm van Marwijk, MD; Keith Geraghty, PhD; Aneez Esmail, MD

IMPORTANCE Burnout is prevalent in physicians and can have a negative influence on performance, career continuation, and patient care. Existing evidence does not allow clear recommendations for the management of burnout in physicians.

OBJECTIVE To evaluate the effectiveness of interventions to reduce burnout in physicians and whether different types of interventions (physician-directed or organization-directed interventions), physician characteristics (length of experience), and health care setting characteristics (primary or secondary care) were associated with improved effects.

DATA SOURCES MEDLINE, Embase, PsycINFO, CINAHL, and Cochrane Register of Controlled Trials were searched from inception to May 31, 2016. The reference lists of eligible studies and other relevant systematic reviews were hand searched.

STUDY SELECTION Randomized clinical trials and controlled before-after studies of interventions targeting burnout in physicians.

DATA EXTRACTION AND SYNTHESIS Two independent reviewers extracted data and assessed the risk of bias. The main meta-analysis was followed by a number of prespecified subgroup and sensitivity analyses. All analyses were performed using random-effects models and heterogeneity was quantified.

MAIN OUTCOMES AND MEASURES The core outcome was burnout scores focused on emotional exhaustion, reported as standardized mean differences and their 95% confidence intervals.

RESULTS Twenty independent comparisons from 19 studies were included in the meta-analysis (n = 1550 physicians; mean [SD] age, 40.3 [9.5] years; 49% male). Interventions were associated with small significant reductions in burnout (standardized mean difference [SMD] = −0.29; 95% CI, −0.42 to −0.16; equal to a drop of 3 points on the emotional exhaustion domain of the Maslach Burnout Inventory above change in the controls). Subgroup analyses suggested significantly improved effects for organization-directed interventions (SMD = −0.45; 95% CI, −0.62 to −0.28) compared with physician-directed interventions (SMD = −0.18; 95% CI, −0.32 to −0.03). Interventions delivered in experienced physicians and in primary care were associated with higher effects compared with interventions delivered in inexperienced physicians and in secondary care, but these differences were not significant. The results were not influenced by the risk of bias ratings.

CONCLUSIONS AND RELEVANCE Evidence from this meta-analysis suggests that recent intervention programs for burnout in physicians were associated with small benefits that may be boosted by adoption of organization-directed approaches. This finding provides support for the view that burnout is a problem of the whole health care organization, rather than individuals.

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Supplemental content
CME Quiz at jamanetworkcme.com

Author Affiliations: Author affiliations are listed at the end of this article.

Corresponding Author: Maria Panagioti, PhD, NIHR School for Primary Care Research, Manchester Academic Health Science Centre, Oxford Rd, Williamson Bldg, Manchester M13 9PL, United Kingdom (maria.panagioti@manchester.ac.uk).

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Published online December 5, 2016.

"Physician Well-Being: The Reciprocity of Practice Efficiency, Culture of Wellness, and Personal Resilience". NEJM Catalyst: April 26, 2017

IMPROVING THE CULTURE

- Include peer support and reflection in meetings
- Highlight successes
- Debrief after stressful events
- Consider an 'Inside Scoop'

INCREASE CONNECTIONS

- Work with a partner
- Think of a patient who changed you
- Tell your partner about that person

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Q&A | JANUARY 2016

‘The pause’ allows for moment of silence after a patient death

The RN who developed it sees it as “a means of honoring a patient after they pass away”.

By Mollie Durkin

JOURNAL OF PATIENT EXPERIENCE

Do I buy it? How AIDET™ training changes residents' values about patient care

Andrea Mechanick Braverman, PhD,[a] Elisabeth J. Kunkel, MD,[b] Leo Katz, MD,[c] Austin Katona, BS,[c] Teresa Heavens, BA, CLSS,[d] Andrew Miller, MD, MPH,[e] Jennifer Jasmine Arfaa, PhD[f]

Abstract

Objectives: Acquiring communication and interpersonal skills is an important part of providing patient-centered care and improving patient satisfaction. This study explores whether residents' own values about patient communication can be influenced by training.

Methods: As part of service excellence, a three-hour communication skills training in AIDET™ (Acknowledge, Introduce, Duration, Explanation, Thank You) was delivered to first and second Post-Graduate Year (PGY) residents (n = 123). A survey was designed to measure the value of patient communication and administered pre/post communication skills training.

Results: Residents' scores about communication values improved significantly for all areas pre- to post-training for patient communication skills ($p<0.04$). After training, there was little difference by medical specialty, other than surgical specialties, which showed the greatest increase in valuing requesting permission ($p=0.034$). Gender was also not associated with differences in values, except men showed a greater increase in valuing sitting down ($p=0.021$) and introductions ($p=0.005$) than women who already valued these specific behaviors prior to training.

Conclusions: Residents value communication, and AIDET™ training is a useful tool to increase the values of good communication and interpersonal skills to enhance service excellence.

Palliative care training and burnout in oncology fellows

Background: Burnout among physicians is associated with fatigue, exhaustion, and depression, and can result in increased medical errors and sub-standard patient care. We sought to determine rates and predictors of burnout in oncology fellows. **Methods:** As part of a larger study on fellows' attitudes, education, and experiences in palliative care, we administered the 22 item Maslach Burnout Inventory (MBI) to second year U.S. oncology fellows. The 104 item instrument, modified from a survey of medical students, was revised after field testing and a pilot survey. The MBI measures three domains: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA); higher EE and DP scores and lower PA scores indicate burnout. Bivariate and multivariate analyses were used to find associations between burnout and fellow demographics, attitudes, and educational experiences. To accommodate for multiple testing, $p<0.01$ was considered statistically significant. **Results:** The response rate was 63.2% (254 of 402 eligible fellows). Gender, race, and location of medical school (U.S. vs. other) did not differ between respondents and non-respondents. Among respondents, 28.1% reported high EE, 30.0% reported high DP, and 26.8% reported low PA. Over half reported burnout in at least one domain (32.9% in one, 16.5% in two, and 5.5% in all three domains). The following associations were found on

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ONLINE FIRST APRIL 25, 2018 – ORIGINAL RESEARCH

"We've Learned It's a Medical Illness, Not a Moral Choice": Qualitative Study of the Effects of a Multicomponent Addiction Intervention on Hospital Providers' Attitudes and Experiences

Honora Englander, MD[1,2*], Devin Collins, MA[1], Sylvia Peterson Perry, MD, MPH[1], Molly Rabinowitz MD, MPH[1], Elena Phoutrides, MD, MPH[1], Christina Nicolaidis, MD, MPH[1,3]

[1]Oregon Health & Science University, Portland, Oregon; [2]Central City Concern, Portland, Oregon; [3]School of Social Work, Portland State University, Portland, Oregon

BACKGROUND: Substance use disorders (SUD) represent a national epidemic with increasing rates of SUD-related hospitalizations. However, most hospitals lack expertise or systems to directly address SUD. Healthcare professionals feel underprepared and commonly hold negative views toward patients with SUD. Little is known about how hospital interventions may affect providers' attitudes and experiences toward patients with SUD.

OBJECTIVE: To explore interprofessional hospital providers' perspectives on how integrating SUD treatment and care systems affect providers' attitudes, beliefs, and experiences.

MEASUREMENTS: We conducted a thematic analysis using an inductive approach at a semantic level.

RESULTS: Before IMPACT, participants felt that hospitalization did not address addiction, leading to untreated withdrawal, patients leaving against medical advice, chaotic care, and staff "moral distress." Participants felt that IMPACT "completely reframes" addiction as a treatable chronic disease, improving patient engagement and communication, and humanizing care. Participants valued post-hospital SUD treatment pathways and felt having systems to address SUD reduced burnout and provided relief. Providers noted that IMPACT had

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VIEWPOINT

Michael P. Botticelli, MEd
White House Office of National Drug Control Policy, Washington, DC.

Howard K. Koh, MD, MPH
Harvard T.H. Chan School of Public Health, Boston, Massachusetts; and Harvard Kennedy School, Cambridge, Massachusetts.

Changing the Language of Addiction

Words matter. In the scientific arena, the routine vocabulary of health care professionals and researchers frames illness[1] and shapes medical judgments. When these terms then enter the public arena, they convey social norms and attitudes. As part of their professional duty, clinicians strive to use language that accurately reflects science, promotes evidence-based treatment, and demonstrates respect for patients.

However, history has also demonstrated how language can cloud understanding and perpetuate societal bias. For example, in the past, people with mental illness were derided as "lunatics" and segregated to "insane asylums." In the early days of human immunodeficiency virus, patients were labeled as having "gay-related immune deficiency," with public discourse dominated by moral judgments. Other examples apply to disability and some infectious diseases. In all of these cases, stigma and discrimination can arise when patients are labeled, linked to undesirable characteristics, or placed in categories to separate "us" from "them."

Today, these complex themes have special relevance for addiction. Scientific evidence shows that addiction to alcohol or drugs is a chronic brain disorder with potential for recurrence. However, as with many other chronic conditions, people with substance use disor-

Stigma isolates people, discourages people from coming forward for treatment, and leads some clinicians, knowingly or unknowingly, to resist delivering evidence-based treatment services. The 2014 National Survey on Drug Use and Health[4] estimates that of the 22.5 million people (aged ≥12 years) who need specialty treatment for a problem with alcohol or illicit drug use, only an estimated 2.6 million received treatment in the past year; of the 7.9 million specifically needing specialty treatment for illicit drug use, only 1.6 million received treatment. The survey noted that reasons for not seeking treatment included fears that receiving it would adversely affect the individual's job or the opinion of neighbors or other community members. Lack of insurance coverage, cost concerns, and not perceiving a need for treatment also contributed. Among health care professionals, negative attitudes regarding people with SUDs have led to diminished feelings of empowerment among patients, lower levels of empathy and engagement among health care professionals, and poorer outcomes.[5] Not surprisingly, medication-assisted treatment remains isolated within SUD treatment systems, which in turn have historically been separated from the rest of health care.

To help address these concerns, the American Medical Association has called on physicians across

The Grace of Denial

Heather Sher, M.D.

I sat listening to the case presentation about a woman who waited far too long to seek care for advanced breast cancer. By the time she presented for medical evaluation, her right breast was twice the size of her left and hung like a misshapen butternut squash hidden under her blouse. The physical exam revealed that the tumor was breaking down her skin, which was ulcerated and excoriated, with the orange-peel texture common in advanced breast cancer. I listened quietly to the familiar conversation among the surgeons, oncologists, radiation oncologists, and presenting medical student. The "wonder why she waited so long" commen-

Outlining the way in which function would decline until the patient was left with no ability to move even a single muscle, the professor described the disease as "a front-row seat to one's own death." "What a horrible fate," I thought, mentally cataloguing ALS as one of the worst diagnoses imaginable.

Then, during my second year of medical school, my father was diagnosed with ALS. To be honest, he wouldn't be formally diagnosed until my third year — a delay caused by my own denial. During a hurried call I made from a pay phone at the library, my dad mentioned that he was becoming slow to get to the ball

cold. I had just heard another lecture on ALS, in which my neurophysiology professor had described lower motor neuron disease with dry, clinical detachment and opined that ALS is perhaps the worst of all diseases, because cognition remains intact while the body fails. A patient ultimately becomes "locked in" — fully aware but unable to communicate.

My father saw a neurologist within the next few weeks, and a full laboratory and imaging workup ensued, complete with a brain MRI, a lumbar puncture, electromyography, and a sural nerve biopsy. Meanwhile, I vigorously researched alternative diagnoses in the medical school library. In those

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The NEW ENGLAND JOURNAL of MEDICINE

Learning Empathy from My '97 Camry

C. Nicholas Cuneo, M.D.

There was an improbable air of intrigue about the black 1997 Camry I'd inherited from my mother. As I packed it for my trip to Baltimore to begin medical school, I began rediscovering its quirks — the spattering of orange paint across the front bumper, the elaborate crack in the vanity mirror (from which an occasional shard would still fall). Its incongruous rear spoiler served only as a weighty, ostentatious hazard to those who dared access the trunk.

Before long, I became immersed in the day-to-day struggles of the first year of medical school. First, we were taught how to practice empathy by following clever mnemonics. Then we got charade. Were these just bad actors, or was I fundamentally flawed in my inability to connect with them? Was this really the best way to learn how to be a good doctor?

Thankfully, in January we graduated to interacting with real patients when we were paired with community physicians for one afternoon each week at clinics around the city. Mine was across town, more than 30 minutes away, and I became newly grateful for the Camry's service. I eagerly jumped into eliciting exhaustive histories and performing detailed exams on the generous few patients who'd acquiesce. My visits with patients quickly evolved into confessionals, as I harnessed the through a hypertensive patient's alarming vital signs. *If only he'd been more adherent to begin with,* I'd lament, identifying worsening signs of lipodystrophy in a patient with HIV who'd been relegated to a third-line drug regimen. I bit my tongue as a woman expounded on her newly discovered "chronic Lyme disease," which she self-diagnosed after perusing an online forum. The embracing acceptance I'd cultivated began to break down.

And then it started happening.

At first I thought I was imagining the resistance I encountered when turning the Camry's wheel. I concocted all sorts of explanations that would allow me the peace of mind to avoid a poten-

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The NEW ENGLAND JOURNAL of MEDICINE

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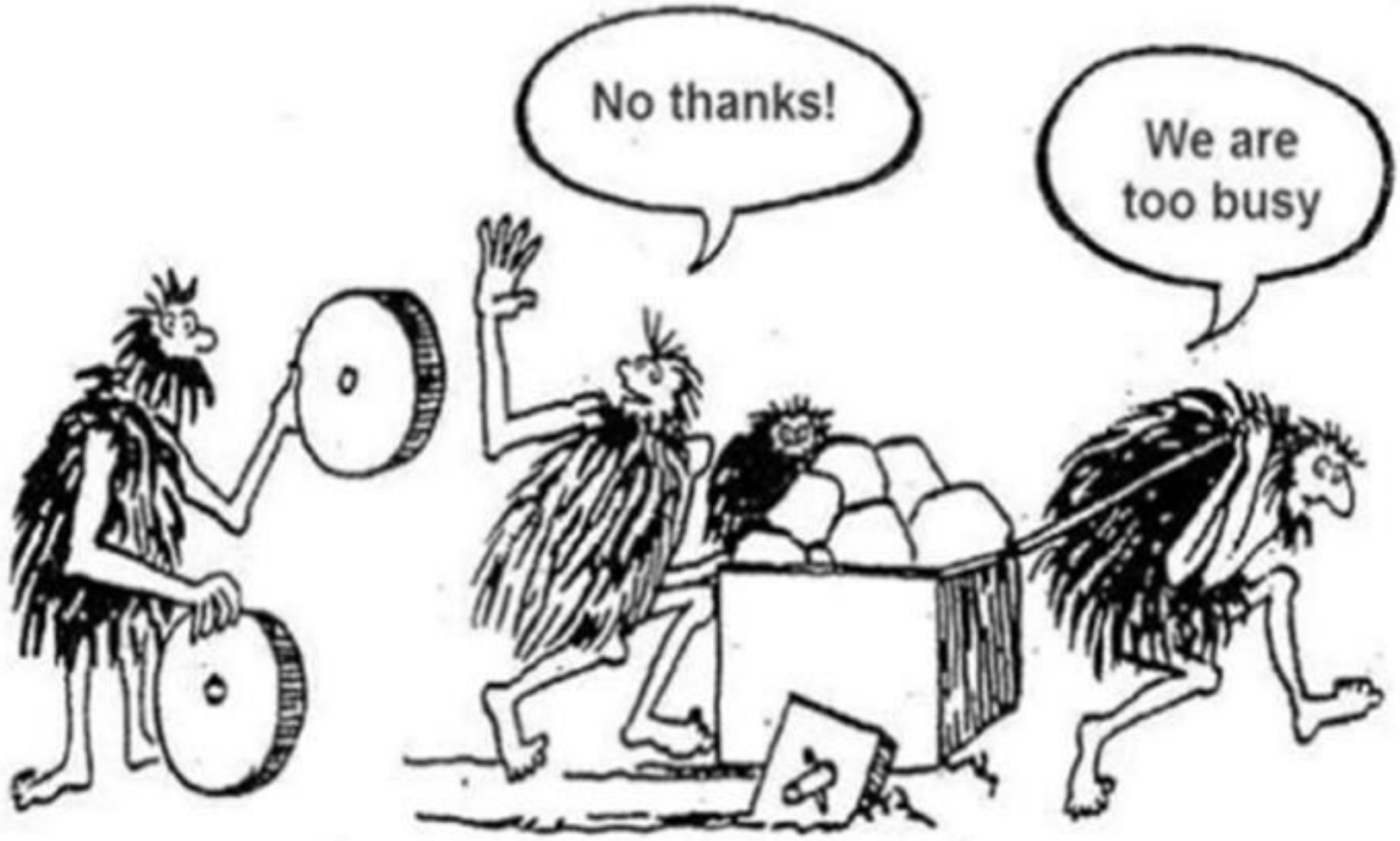
No thanks!
We are too busy

HELP THE EMR HELP RELATIONSHIPS

- Be deliberate in EMR training
- Share updated autotexts/"dot phrases" for common documentation needs
- Update and share commonly used order sets for common diagnoses and less common diagnoses that have complex plans

ORIGINAL RESEARCH

A Prescription for Note Bloat: An Effective Progress Note Template

Daniel Kahn, MD[1]*, Elizabeth Stewart, MD[2], Mark Duncan, MD[1], Edward Lee, MD[1], Wendy Simon, MD[1], Clement Lee, MD[1], Jodi Friedman, MD[1], Hilary Mosher, MD[3], Katherine Harris, MD[3], John Bell, MD, MPH[4], Bradley Sharpe, MD[5], Neveen El-Farra, MD[1]

[1]Department of Medicine, David Geffen School of Medicine, University of California, Los Angeles; [2]Division of Hospital Medicine, Alameda Health System, Oakland, California; [3]Department of Internal Medicine, Carver College of Medicine, Iowa City, Iowa; [4]Department of Internal Medicine, Division of Hospital Medicine, University of California, San Diego; [5]Department of Medicine, Division of Hospital Medicine, University of California, San Francisco.

BACKGROUND: United States hospitals have widely adopted electronic health records (EHRs). Despite the potential for EHRs to increase efficiency, there is concern that documentation quality has suffered.

OBJECTIVE: To examine the impact of an educational session bundled with a progress note template on note quality, length, and timeliness.

DESIGN: A multicenter, nonrandomized prospective trial.

SETTING: Four academic hospitals across the United States.

PARTICIPANTS: Intern physicians on inpatient internal medicine rotations at participating hospitals.

INTERVENTION: A task force delivered a lecture on current issues with documentation and suggested that interns use a newly designed best practice progress note template when writing daily progress notes.

MEASUREMENTS: Note quality was rated using a impression score, the validated Physician Documentation Quality Instrument, 9-item version (PDQI-9), and a competency questionnaire. Reviewers documented number of lines per note and time signed.

RESULTS: Two hundred preintervention and 199 postintervention notes were collected. Seventy percent of postintervention notes used the template. Significant improvements were seen in the general impression score, all domains of the PDQI-9, and multiple competency items, including documentation of only relevant data, discussion of a discharge plan, and being concise while adequately complete. Notes had approximately 25% fewer lines and were signed on average 1.3 hours earlier in the day.

CONCLUSIONS: The bundled intervention for progress notes significantly improved the quality, decreased the length, and resulted in earlier note completion across 4 academic medical centers. *Journal of Hospital Medicine* 2018;13:378-382. Published online first January 19, 2018.

ENHANCE THE EMR TO REDUCE DISRUPTIONS TO THE PATIENT-CLINICIAN RELATIONSHIP

- Consider having a widescreen view
- Minimize interruptions
- Have printers where they are needed
- Advocate for and employ 'at the elbow' help
- Ease prescribing burden

Synchronized Prescription Renewal

Save physician and staff time by renewing prescriptions until the next annual visit

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Vice President, Professional Satisfaction, American Medical Association

Daniel P. Alford, MD, MPH

Laura J. Zimmermann, MD, MS, FACP
Assistant Professor of Preventive Medicine and Internal Medicine, Rush University

Marie T. Brown, MD, FACP

HELP THE WORKSTATION WORK FOR EVERYONE

Research

JAMA Surgery | Original Investigation

Prevalence of Work-Related Musculoskeletal Disorders Among Surgeons and Interventionalists
A Systematic Review and Meta-analysis

Sherise Epstein, MPH; Emily H. Sparer, ScD; Bao N. Tran, MD; Qing Z. Ruan, MD; Jack T. Dennerlein, PhD; Dhruv Singhal, MD; Bernard T. Lee, MD, MPH, MBA

IMPORTANCE Physicians in procedural specialties are at high risk for work-related musculoskeletal disorders (MSDs). This has been called "an impending epidemic" in the context of the looming workforce shortage; however, prevalence estimates vary by study.

OBJECTIVES To estimate the prevalence of work-related MSDs among at-risk physicians and to evaluate the scope of preventive efforts.

DATA SOURCES AND STUDY SELECTION Systematic search in MEDLINE (Ovid), Embase (Elsevier), Web of Science, PubMed (National Center for Biotechnology Information), and 2 clinical trial registries, without language restriction, for studies reporting on the prevalence and prevention of work-related MSDs among at-risk physicians published until December 2016. The Meta-analysis of Observational Studies in Epidemiology (MOOSE) guidelines for meta-analyses and systematic reviews of observational studies were used. At-risk physicians were defined as surgeons and medical interventionalists. Studies reporting on specific disorders or pain assessed with validated instruments were included.

Author Audio Interview

Supplemental content

HOW CAN WE PROMOTE OUR SHARED VALUES?

- Teach leadership principles
- Promote leaders who understand patient experience
- Include topics on how clinician and patient experience are interrelated in continuing education

"Systems awareness and systems design are important for health professionals, but are not enough. They are enabling mechanisms only. It is the ethical dimension of individuals that is essential to a system's success. Ultimately, the secret of quality is love."

HEROES AND MARTYRS OF QUALITY AND SAFETY

Avedis Donabedian: father of quality assurance and poet

M Best, D Neuhauser

Qual Saf Health Care 2004;**13**:472–473. doi: 10.1136/qshc.2004.012591

QUESTIONS?

UPCOMING WEBINARS IN THIS SERIES

- April 25: Cheryl Fontabene on High Performing Teams
- May 1*: Cheryl Fontabene on Moving Beyond Burnout
- May 9: Cindy Barr on Setting up the Space
- May 16: Dr. Eileen Barrett on Improving R&R By Increasing Professional Satisfaction

Note: This is a change!

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THANK YOU!