Reducing Burnout by Letting Clinicians Be Clinicians: A Clarion Call To Informaticists

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While burnout was originally described more than 40 years ago, clinician burnout has become a national crisis more recently. To resolve burnout, we must focus on root causes. Sometimes symptoms are obvious, but root causes are less easily identified: covering a bullet hole may stop observable bleeding but cannot resolve the root cause of imminent death. In this essay we focus on one of the root causes of clinician burnout, billing documentation burden, and propose using informatics policies, standards and tools to resolve this specific root cause.

Burnout has reached rampant levels among United States (US) healthcare professionals, with over one-half of physicians and one-third of nurses experiencing symptoms.[1]

[B]urnout is a combination of exhaustion, cynicism, and perceived inefficacy resulting from long-term job stress.[2]

Clinician burnout is "a syndrome characterized by emotional exhaustion, depersonalization, and a low sense of personal accomplishment…"[3,4]

Although clinician burnout has many root causes, this perspective focuses on the root cause the authors believe is most amenable to an informatics solution. Burdensome billing documentation requirements rob time from the clinical encounter and augment clinicians' feelings of powerlessness and a low sense of personal accomplishment. The administrative billing rules force highly trained professionals to do tasks that a) are unnecessary to practice their profession, and b) could be performed by someone else, so it is no surprise that clinical professionals are disconnected from their goals and unhappy about it.[5] Because billing

documentation rules are so embedded in our healthcare system, there is no easy solution. This perspective proposes a path to success that does not presume the details of the final answer.

The authors propose that our nation begins a conversation to shift our thinking about healthcare billing from the historical paper paradigm to a digital one that takes advantage of our relatively recent transition to digital health records. When we change the locus of administrative burdens by reallocating those costs to health plans, we lift a huge burden from clinicians to reduce clinician burnout and improve the utility of clinical documentation. Health plans are not likely to give up power over clinicians or accept higher administrative costs willingly. It is therefore likely that an informatics policy component will ultimately be required to mandate these changes, consistent with the original American Recovery and Reinvestment Act of 2009 that accelerated our digital transformation. To be successful in this effort it is likely representatives of many stakeholder groups will need to collaborate over many years to define the ultimate solution. The solution cannot be defined in an article, only the path we must all agree to take to reach the solution. We direct the focus of informaticists to leverage informatics policies, standards, and tools to reduce clinician burnout by eliminating the billing documentation burden.

Burnout was defined in 1974,[1,2] but not described in clinicians until 1996.[1] Much has changed since 1996 to make clinician burnout the crisis it is today. Contributing root causes include clinicians:

- acting like a clerk to abstract required billing elements[4, 5]

- sacrificing patient time to optimize billing documentation[4, 6]

- cluttering notes with clinically unnecessary documentation[7]

The burden of billing documentation is about 40 years in the making. Starting in the 1980s, managed care changed the payment process from clinicians simply submitting a bill for services rendered to having to justify *why* they should be paid for any services.[8] Because health plan costs to retrieve paper medical records were prohibitive, the cost was transferred to clinicians. Health plans started requiring clinicians to send relevant records to them by fax or mail.

Over time, the granularity of the documentation and the cost to clinicians has increased to the monumental challenge it is today. With the bulk of records in a digital format, the original payment justification for requiring clinicians to document specific details in their clinical notes is no longer valid and fails to take advantage of our digital data, standards, or tools. Our billing paradigm is still acting as though all the data is on paper, hard to find and expensive to reach, even though it is not.

We advocate for finding a path to move the justification burden to health plans. Doing so is likely to require legislation because it is unlikely that health plans will voluntarily increase their costs and reduce their power over clinicians. While health plans often follow the lead of Medicare and Medicaid, they are not required to do so. It is unlikely that limiting this change to Medicare, through the Medicare Payment Advisory Committee, would cause private health plans to make the same change because it reduces profits and power, rather than expanding either profits or power.

Our health system needs a path that ultimately:

1. Requires health plans to pay extra for access to data that is necessary only to support claim evaluation.

2. Ends clinicians' need to document according to non-clinical rules.

3. Establishes informatics standards and processes that enable health plans to retrieve defined digital data with specific restrictions that protect patients.

Efforts to reduce burnout are unlikely to succeed if we simply mitigate its symptoms. Consider two examples. Informatics tools that help create or enhance documentation do not address the root cause of the burden; they merely mirror the cover-a-bullet-hole approach. Recommendations for meditation or stress reduction are intended to reduce the impact of the symptoms but do not resolve any root cause. To address this root cause we must make the data abstraction and documentation burdens go away completely.

When health plans become accountable for the cost of data collection for their own administrative operations, they will have an incentive to collect only the data they truly need to evaluate a claim. In the new paradigm, more data are associated with greater health plan cost. This resolves three key burdensome requirements on clinicians today: document with unnecessary granularity, repeat elements existing elsewhere in the record, and encode the clinical note into International Classification of Disease 10-CM (ICD) codes in order to request payment, but which does not provide any benefit to the patient or clinician. Rather than health plans forcing a clinician to spend time doing administrative work for the health plan, in the digital paradigm a health plan must decide what data will allow it to make a payment determination from the existing record. Implemented successfully, this will remove the current incentive to require more documentation. Instead, the cost burden would return to the entity that requires the documentation. That outcome is equitable considering billing documentation rules are unnecessary to serve the needs of the patient and harm our entire health system by contributing to clinician burnout and note bloat.

Removing the need to document according to administrative, non-clinical needs will breathe new life into all clinicians as this huge burden is lifted. Though the Centers for Medicare and Medicaid Services (CMS) has proposed rules to decrease Evaluation/Management documentation,[9] this, too, is a treat-the-symptom approach. Requiring clinicians to abstract the record to generate ICD codes, reiterate laboratory values, and document elements already in the chart, such as family and social history, or perform an extensive review of systems only contributes to note bloat and takes valuable time from the clinician without any return on that temporal investment to the clinician, the patient, or our health system. While those who want ICD codes can still abstract them, clinicians would not do it. Clinicians would no longer need to remember required elements for visit codes or face an ethical dilemma trying to document accurately while still documenting 'close enough' so the patient gets health plan authorization for the services they need.

Corollary effects of resolving this root cause of clinician burden impact copy-paste, note bloat, and many other side effects of the current payment documentation rules. These documentation demons should noticeably diminish if not disappear completely. Less time spent documenting allows more time with patients or the opportunity to leave work at a reasonable hour. With the move to immediately release records to patients, this newly available time could be used to actually talk with patients about the meaning of the data in their record.

At the same time, we should be cautious about replacing clinician burden with free flow of patient information to health plans. The risks to patients of sharing entire records with health plans will need to be explored. In this context, policy must consider: individual privacy, sharing of minimum necessary data, authentication and access management, and other issues like cost, restrictions on secondary use of the shared data, and third-party data sharing, while also

providing patients access to their records.[10] A broad stakeholder group reflecting the interests of patients, clinicians, clinical informaticists, healthcare entities, health plans, government, and software developers will be needed to drive policy details of this complex challenge. A subcommittee of patients, health plans, and clinicians may be needed to develop detailed guidance on minimum necessary data to support validating charges, subject to change over time based on how clinicians document care, rather than how health plans want to collect specific parameters. Policy must address health plans reimbursing clinical entities for the cost of providing access to the health record, similar to existing medical record access rules. These charges might help to balance requests for all data when all data aren't needed. Policy must also address how to manage or arbitrate down-coding of charges by health plans. None of this is easy, but what is the alternative to having this difficult discussion? Allow this unnecessary documentation burden to expand burnout until we have too few clinicians to support the health needs of the country? Consider how stressed the country is under the strains of the covid pandemic.

Adjustments may be needed to existing standards to enable health plans to pull the data they legitimately need. Software developers could use both the new policies and the new standards in a manner that allows health plans to define how to use the data they could then collect at their expense to make their determination about payment. Clinicians could focus on treating patients and document only what was clinically relevant.

We intend this perspective to initiate a constructive conversation that will guide the nation to develop a successful path toward eliminating documentation rules for billing altogether. On its own, this perspective is not a solution. We anticipate that health plans, including CMS, and other stakeholders who benefit from the status quo are not likely to simply accept these

administrative costs or give up the power they have over clinicians. We are therefore calling for the nation to acknowledge what has changed in healthcare and serve as a rallying cry to start defining and traveling down a path to adjust our billing paradigm and methods to meet our capabilities. We must eliminate the clinician documentation burden, a deeply embedded root cause of clinician burnout. We advocate for taking full advantage of informatics principles to lighten the load for clinicians. Failure to resolve this burden will allow clinician burnout to continue to grow and the number of underserved patients to grow with it. We must take advantage of the resources we have, modify our data management processes accordingly, and return health plan costs to the health plans to reduce clinician burden, improve clinical documentation, and make our healthcare system. . . healthier.

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