



# DENVER MEDICAL BULLETIN

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## Survey Finds Significant Increase in Physician Burnout Rates

Physician burnout has increased alarmingly in the US in the past two years, up 16%, according to a new national survey, Medscape's Physician Lifestyle Report 2015. US physicians suffer higher rates of burnout than other American workers, with 46% reporting burnout in this year's survey compared to 39.8% in 2013. Burnout is defined as a loss of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment. Other sources have reported burnout rates ranging from 30% to 65% across specialties with the highest rates of burnout among physicians at the front lines of care, such as emergency medicine and primary care physicians. The 2015 Medscape survey found the highest burnout rates in critical care (53%) and emergency medicine (52%) while over half of family medicine, internal medicine, and general surgery respondents reported burnout. The only specialties reporting less than 40% burnout rates were pathology (39%), psychiatry (38%), and dermatology (37%).

Factors related to burnout are also associated with higher rates of physicians leaving practice. Physician suicide rates are higher than in the general public and have been linked to job stress. In the survey, physicians were asked to rate the severity of their burnout from 1

(does not interfere with my life) to 7 (so severe that I'm thinking of leaving medicine). Specialties reporting the highest severity (nephrology 4.30, cardiology 4.29, and plastic surgery 4.28) were not those with the highest percentage of physicians reporting burnout. Burnout has also been shown to negatively affect patient care.

Physicians place primary blame for their stress on having to perform too many bureaucratic tasks (4.74 on a 7 point scale) while working too many hours (3.99) was the second most significant factor listed. Other studies have shown that bureaucracy and loss of autonomy are associated with stress. Insufficient income (3.71) and computerization (3.68) were ranked 3<sup>rd</sup> and 4<sup>th</sup> in this year's survey, while the Affordable Care Act dropped from third place in 2013 to fifth place this year.

Burnout seems to peak in mid-life, with over half of physicians in the age categories 36-45 (51%) and 46-55 (53%) reporting burnout. Physicians under 35 report a burnout rate of 44% but after age 66 the rate declines to 22%. National data reports burnout rates among female physicians to be higher than their male peers. The Medscape survey reports 51% of female physicians experiencing burnout compared to 43% of males, but both report higher rates than in 2013 when the rates were 45% and 37%, re-

spectively. Studies suggest that men and women may experience burnout differently with women describing emotional exhaustion while in men it may be characterized by depersonalization.

Physicians who take more than 2 weeks of vacation each year report lower rates of burnout than those who take less. Of those reporting no burnout, 70% take more than 2 weeks of vacation compared to 59% of those experiencing burnout. Among those who take no vacation, the difference is slight with 5% of this group reporting burnout and 3% reporting no burnout. Those who do some form of volunteer work seem to suffer less burn out overall than those who do not volunteer at all. Thirty-seven percent of the burnout group never volunteer compared to 28% of the non-burnout group. This is an increase in non-volunteering among burned-out physicians from 2013, when 31% of the burned-out group responded that they didn't volunteer.

When asked to rate their own personal health, 70% of physicians who are not burned out rated their health very good to excellent compared to 54% of burned-out physicians. Physicians experiencing burnout reported lower rates of exercise, higher rates of obesity and overweight, but similar rates of alcohol and marijuana use. However, higher rates of alcohol consumption seem to be associated with higher levels of marijuana use and among age cohorts, those 56-65, the baby boomers, have the highest rate (32%) of having used marijuana followed by the under 35 cohort with 25%.

Financial well-being seems to play a role in burnout as well. In the current report, 39% of burned-out physicians consider themselves to have minimal savings to unmanageable debt, compared with 28% of their less stressed peers. Only 56% of burned-out physicians believe that they have adequate savings or more, compared with 66% of their less stressed peers. These findings are essentially unchanged from the 2013 report.

Slightly less than half (45%) of physicians who are living with partners are burned out, while just over half (53%) of those without partners experience burnout. When looking at specific living status, the highest rates of burnout (57%) were among those who were never married and are living alone. Those who were widowed had the lowest burnout rates (37%), followed by physicians who were in a first marriage (45%) or remarried (44%).

Recognizing the challenges physicians face today, Colorado Medical Society, in partnership with the Behavioral Health and Wellness Program at the University of Colorado Anschutz Medical Campus, has launched a wellness toolkit for physicians. The toolkit addresses eight dimensions of wellness with a focus on reducing stress and burnout. This free resource is intended to promote the health of all Colorado physicians.

You can access the toolkit at <http://www.cms.org/uploads/BHWP-Physician-WWB-Toolkit-web.pdf>.

**Denver Medical Bulletin:** Aaron J. Burrows, MD, DMS President and Publisher / Aris M. Sophocles, Jr., MD, JD, Chair of the Board / Stephen V. Sherick, MD, President Elect / Christopher J. Ott, MD, Treasurer / Kathy Lindquist-Kleissler, Executive Director. The **Bulletin** is the official publication of the Denver Medical Society, established April 11, 1871, as the first medical society in the Rocky Mountain West. Published articles represent the opinions of the authors and do not necessarily represent the official policy of the Denver Medical Society. All correspondence concerning editorial content, news items, advertising and subscriptions should be sent to: The Editor, **Denver Medical Bulletin**, 1850 Williams Street, Denver, CO 80218. Phone (303) 377-1850. Fax (303) 331-9839. Web [www.denvermedsociety.org](http://www.denvermedsociety.org). Email [info@denvermedsociety.org](mailto:info@denvermedsociety.org). Postmaster: Send address changes to 1850 Williams Street.

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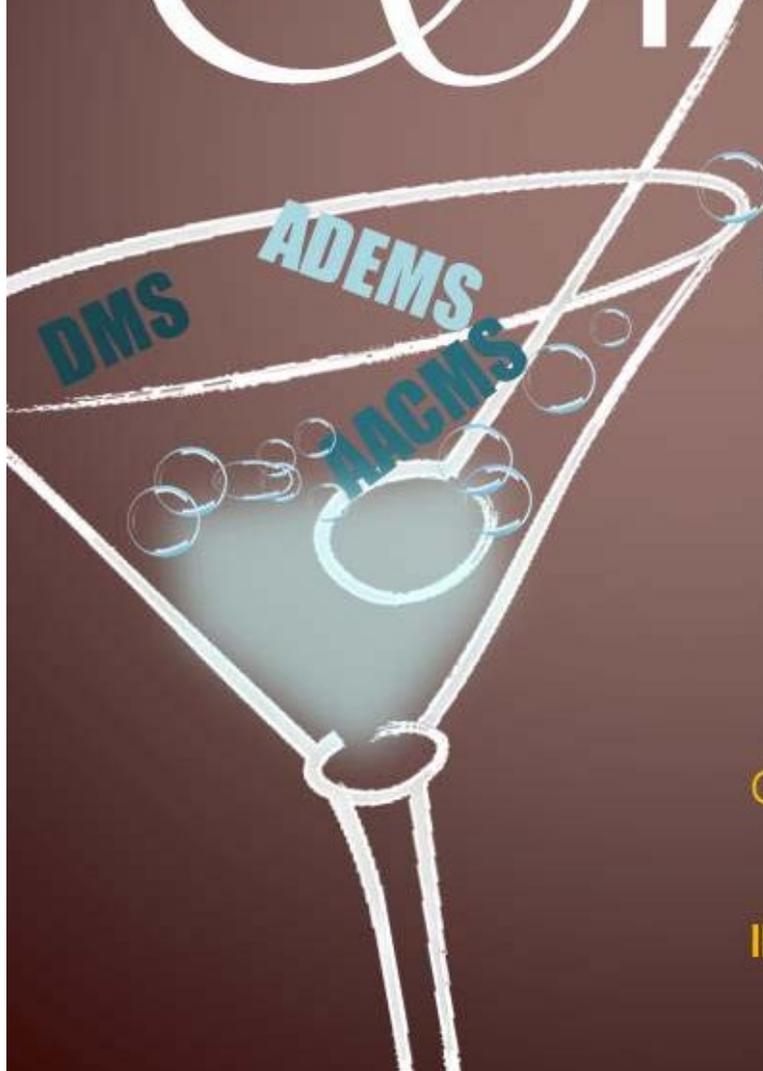
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## **Work Place Law Essentials for Physicians and Administrators**

**Presented by: Judy Holmes, Judith Holmes & Associates, LLC**

### **Highlights of Judy's presentation will include:**

- Hiring Headaches---new statutes and EEOC guidelines that make the hiring process trickier than ever and how to avoid costly mistakes
- Wage & Hour Traps---identifying the most frequent wage and hour-related errors employers make
- Marijuana in the Workplace---with legalized marijuana, how does that new law affect your practice?
- Social Media and Digital Communications---new issues are constantly cropping up
- Credit reports and background checks---how new laws will restrict their use
- Other significant recent developments regarding employers' Legal rights

**Wednesday, February 11, 2015**

**7:00—9:00 AM**

**Breakfast Provided**

**Curtis Ballroom at the Landmark**

**Comedy Works 5345 Landmark Place**

**Greenwood Village, 80111**

**Please register with your RSVP by February 6th to [info@denvermedsociety.org](mailto:info@denvermedsociety.org).**



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## The New ICD-10 Compliance Date is October 1, 2015

All services provided on or after October 1, 2015 will be required to be coded using ICD-10. This means that the necessary programming upgrades must be installed and functioning in the various systems throughout your practice in order for you to be able to send and receive the ICD-10 codes in the necessary transactions and reporting processes.

A necessary step in your implementation of the ICD-10 code set is to test the systems that send and receive diagnosis codes, such as your practice management system (PMS). The testing will be of your transactions and systems, but the focus is on ensuring that the ICD-10 codes are sent from your system, received by the receiving system, and processed appropriately. Each HIPAA covered entity (i.e., provider, payer, and clearinghouse) is responsible for its own compliance with the ICD-10 code set requirements. Testing your systems using the ICD-10 codes prior to the compliance date is a critical step that you can take to ensure that you can:

- Send ICD-10 codes on transactions and reports (e.g., quality, public health) to the appropriate entities, either directly or through a clearinghouse,
- Receive ICD-10 codes on transactions and reports in your system, and
- Ensure payments and cash flow will not be interrupted after October 1, 2015.

### What Types of Testing Do I Need to Do?

Overall, there are two types of testing; internal and external. During both phases of testing, you will want to work closely with your vendor to address any systems issues you identify.

**Internal Testing:** Internal testing is done within an organization to determine if the programming or software changes for the ICD-10 code set have been installed correctly and the systems are functioning properly. You will want to talk to your vendor about whether or not they will assist you with internal testing. Completing

internal testing will allow you to identify and resolve any internal systems issues that may occur with creating or receiving the different transactions that include ICD-10 codes. This is also the time that you will want to test any manual and work flow processes you use to collect and report diagnosis codes for various reasons, such as “superbills”, encounter forms, and data reporting forms.

If your practice works exclusively with a billing service or clearinghouse and sends them all the necessary data for them to submit administrative transactions, you will need to contact them about what changes you need to make to the data you currently collect and send. In this situation, internal testing will then be limited to ensuring that your practice has processes in place to collect the necessary data that you will then send to the billing service or clearinghouse.

**External Testing:** External testing involves sending and receiving transactions that include ICD-10 with your business associates (e.g., billing service, if you use one) and trading partners (e.g., clearinghouses and payers) through the channels you use today to conduct the various transactions. If the test transactions you are sending with ICD-10 codes include real patient protected health information (PHI), be sure to follow all appropriate security and privacy measures to protect the data, such as sending the transactions using a secure connection.

If your practice works exclusively with a billing service or clearinghouse, external testing will involve sending them test data with ICD-10 codes for them to conduct the transactions electronically on your behalf and receiving test data back into your practice. You will also want to verify that your billing service or clearinghouse is conducting the necessary external testing with payers and other clearinghouses to ensure that they are prepared to meet the compliance deadline. Without their ability to meet the compliance deadline, your cash flow could

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## Remote Patient Monitoring: Real-Time Patient Data, Real Liability Risks

Three million patients worldwide are currently connected to a remote monitoring device that sends personal medical data to their healthcare provider.<sup>1</sup> Each year, 600,000 cardiac patients are implanted with pacemakers, one of the most common monitoring devices.<sup>2</sup>

Remote medical devices help doctors catch potential problems earlier, when they're easier to treat, and can reduce the number of hospitalizations, improving patient health and containing healthcare costs.

Despite the many advantages, remote patient monitoring has liability risks. Because remote monitoring devices transmit patient data over the Internet or through phone lines, there is a risk of a data breach if the information is not properly encrypted.

Medical devices may be vulnerable to viruses and malware. The U.S. Food and Drug Administration (FDA) noted that providers must take steps to safeguard patient information within their network, such as ensuring antivirus software and firewalls are up to date, monitoring the network for unauthorized use, and reporting any medical device cybersecurity problems to the device manufacturer.

If a remote device fails or malfunctions, physicians may be named in the lawsuit against the manufacturer, under the claim that the physician failed to use the device properly. Physicians should stay up to date on the latest information for the device, including manufacturer's warnings, the device's safety record, and the device's approved uses. Providers should also be aware of any FDA alerts or recalls.

Providers should also be aware of the need for additional staff members to handle the incoming data. In the case of a potential problem, these staff members should respond either directly to the patient or alert the appropriate professional for intervention. Each practice should have written guidelines for:

- At what times the device will be monitored.
- Which members of the care team will monitor the data at each point in time.
- Under what circumstances the appropriate clinician will be alerted to a potential problem.

Successful remote patient monitoring is dependent on each patient's motivation to actively manage his or her health, as well as the patient's ability to understand and use the technology. To help ensure patients effectively use remote devices:

- Complete and document a thorough informed consent process.
- Educate the patient on:
  - How to use the device. Explain the treatment plan, such as at what times the device will be monitored and how alerts will be handled by the healthcare team.
  - What device failure or malfunction looks like, and what the patient should do if that happens.
  - How to properly maintain the device.

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### References

1. Report: 19 million will use remote patient monitoring by 2018. MEDCITY News. <http://medcitynews.com/2014/06/biggest-market-remote-patient-monitoring/>. Accessed Dec. 1, 2014.
2. Remote monitoring proven to help prolong life in patients with pacemakers. Heart Rhythm Society. <http://www.hrsonline.org/News/Press-Releases/> Accessed Dec. 1, 2014.

*Contributed by The Doctors Company. For more patient safety articles and practice tips, visit [www.thedoctors.com/patientsafety](http://www.thedoctors.com/patientsafety).*

## ICD-10

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be compromised.

Through external testing, you will be able to identify any issues that occur when you send ICD-10 codes to another organization or you receive ICD-10 codes from another organization. If any issues are found, you will be able to resolve them now prior to the compliance deadline.

Completing your external testing means that you have completed “end-to-end” testing with your trading partners and you are ready to move to “live” production of the transactions. This testing period is the time that you will use to become fully ready to exchange and process ICD-10 codes.

The regulation does not allow the use of the ICD-10 code set before the compliance deadline. Once you complete your testing, you cannot begin to use the ICD-10 codes until October 1, 2015.

### Which Trading Partners Should I Test With?

Ideally, you should test with all your trading partners. You, however, likely have dozens, if not hundreds of trading partners, and it may be impractical to test with them all. Your priority should be to test with the trading partners that make up the largest number or largest revenue of your transactions. For example, if you work primarily with a clearinghouse, you will want to test with that organization. If you submit transactions directly to your payers, then you will want to test directly with those payers from which the largest percentage of your revenue comes, (e.g., Medicare or specific commercial plans). If you use a clearinghouse, you may not need to test directly with your payers if your clearinghouse can guarantee they will be compliant and will do the testing with your payers for you.

### When Should I Begin Testing?

Completing both internal and external testing will take time. You should allow 2-3 months

for internal testing and 6-9 months for external testing.

Internal testing can begin as soon as your vendor completes the installation of the system or software changes and you make any necessary changes to your manual and/or work flow processes. If your vendor does internal testing as part of the installation, complete your own internal testing to ensure that you can create and receive transactions with ICD-10 codes.

For external testing, begin contacting the clearinghouses and payers with whom you wish to test as soon as you have a date for your system installation. Clearinghouses and payers will be in various stages of readiness and have many customers. You will need to schedule a time to work with them. If you will be testing with a large number of trading partners, allow plenty of time to complete the process.

### Which Transactions Should I Test?

Testing each of the transactions that will include ICD-10 codes is best. You will want to test the transactions and work processes that have the biggest impact on your practice, such as claims submission, verifying eligibility, quality reporting, etc.

### Conclusion

Testing, both within your system and with your trading partners, is the best opportunity you have to insure that the transactions and work flow processes that include ICD-10 codes will function properly after the compliance deadline. A smooth transition to the ICD-10 code set will also minimize any delays in transaction processing and claims payment after October 1, 2015.

Visit the AMA’s website for more resources for implementing the ICD-10 code set: [www.ama-assn.org/go/ICD-10](http://www.ama-assn.org/go/ICD-10).

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