Center for Public Policy Solutions

Addressing over-regulation can help clinician burnout:

Actions to protect patients and the clinicians who care for them

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Overview

At its core, healthcare is a partnership between clinicians and patients. It is a place where expertise meets compassion and care is defined by a mutual trust and shared goal of healing. When external interference creates barriers for the patient-clinician relationship, healthcare outcomes suffer.

While hospitals and health systems work tirelessly to address well-known barriers to care, such as social determinants of health, workforce shortages and rural access challenges, often overlooked are the lesser-known public policies that create the greatest roadblocks. Going forward, however, Novant Health will bring such issues to the forefront. Through its newly established Novant Health Center for Public Policy Solutions (Center), the health system is committed to identifying these overlooked public policies and their negative impacts on both patients and clinicians, and working with policymakers to address them.

Around the country, clinicians must adhere to countless regulatory requirements that directly lead to significant burnout and a growing exodus from the profession. In a 2022 survey conducted by the Novant Health Office of Well-being and Resiliency, 39% of responding physicians and advanced practice providers (APPs) reported experiencing burnout, with 56% citing documentation burdens as their primary source of frustration. While the impact to clinicians is significant, they alone do not experience the negative impacts of over-regulation. These same regulatory requirements create hurdles for patients to navigate the healthcare system, causing many to delay needed preventive care and chronic condition management, incur unexpected costs and endure growing access challenges as their long-trusted clinicians leave the profession.

The time is now to safeguard the patient-clinician relationship and promote care quality, patient satisfaction and affordability by eliminating burdensome regulatory requirements. This paper outlines how over-regulation contributes to clinician burnout and the steep impacts to patients, and the practical, targeted solutions lawmakers and other policymakers can enact to protect access to care, starting with changes that would address an often-overlooked issue that is consistently at the top of the list for clinicians and patients alike: **regulatory requirements surrounding annual checkups.**

Introduction

An unprecedented change in the U.S. healthcare system has occurred in the past two decades. The growth of an aging, often sicker population has moved **government payors** and **commercial payors** to seek ways to move clinicians to focus on preventive primary care, chronic condition management and care coordination across the entire healthcare continuum. To support these efforts, the advent of new technology has driven an industry that was operated exclusively through paper records to a now near-complete reliance on complex **electronic health records** (EHRs). Today, the average hospital produces 137 terabytes of data daily as every facet of patient care is required to be meticulously documented electronically.[2] Annually, that amounts to more than two

"Many mounting system pressures have contributed to overwhelming job demands for clinicians (e.g., workload, time pressures, technology challenges, moral and ethical dilemmas) and insufficient job resources and supports such as adequate job control, alignment of professional and personal values and manageable work-life integration."

– National Academy of Medicine, Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being, 2019[1]

Government payors
Includes U.S. government-funded health insurance plans like Medicare, Medicaid, and the Children's Health Insurance Program. These programs help support certain populations and economic statuses.

Commercial payors
Often refers to publicly traded insurance companies that provide individual and group health insurance plans. Coverage through these plans is provided through employers, direct purchase, or through an insurance marketplace.

Electronic health records
Also known as EHRs, these are electronic versions of a patient's medical history, that is maintained by the provider, and may include all of the administrative clinical data relevant to that persons care under a particular provider.

times the data housed at the U.S. Library of Congress.[2]

The sheer volume of data clinicians are required to capture has consequential impacts beyond a strong dislike for administrative tasks. Regulations now require clinicians to spend significant time satisfying process-driven quality metrics, adhering to complex and inconsistent documentation requirements and navigating administrative processes that minimally contribute to improved healthcare outcomes. Most significantly, the very act of documenting such high volumes of policy-mandated data increases "physician cognitive load and error rates"[3] because of an "overabundance of clinically irrelevant information, poor data display and excessive alerting."[3]

Efforts to prioritize prevention, chronic care management and care coordination are critical, and current policies are well-intentioned. They seek to protect the consumer, improve the overall health of patients and bend the healthcare cost curve. However, these policies often fail to reach their goals because they were created in isolation and without consideration for how they can be simultaneously and practically implemented in daily practice. In short, the situation today is an "unholy mess"[4] in which clinicians face "death by 1,000 clicks."[4]

Over-regulation: a root cause of clinician burnout

Nationwide, clinician burnout has reached crisis levels, where two in three physicians[6] and one in two nurses[7] report experiencing burnout. In 2022, 45.6% of all health workers, both clinical and non-clinical, reported feeling burnout often or very often.[8] For those in clinical practice, this marks a nearly 39% increase in the prevalence of burnout since the start of the COVID-19 pandemic.[9] Burnout among clinicians consistently has been shown to "lead to severe personal and professional consequences if left unaddressed"[10] to include detrimental impacts to mental and physical health, higher rates of depression, substance abuse and even suicidality, chronic fatigue, heart disease and diabetes. Additionally, clinicians experiencing burnout may be less productive, more prone to significant medical error and suffer low job satisfaction.[10]

Increasingly, clinicians report documentation requirements as a key reason for burnout. For example, "primary care physicians spend nearly two hours on EHR tasks per hour of direct patient care."[11] That means they spend double the amount of time documenting the care they provide rather than directly caring for patients. Consequently, even the term "burnout" can trigger frustration. For some, it "suggests that the problem resides within the individual, who is in some way deficient"[12] rather than acknowledging the full weight of the burden created by regulatory and other external mandates.

The result is taking a toll on clinician supply, leaving the ever-increasing demand for care access at risk. In 2022, one in five physicians stated they intend to leave the medical profession[13], and in 2021, the Association of American Medical Colleges[14] estimated a national shortage of up to 124,000 physicians by 2034, including 55,000 in primary care.This leaves the medical profession with unfillable gaps.

Health systems have launched countless efforts to address burnout

"Burnout among health workers has harmful consequences for patient care and safety, such as decreased time spent between provider and patient, increased medical errors and hospital-acquired infections among patients, and staffing shortages… Chronic work-related stress, a precursor to burnout, has been associated with poor physical and mental health outcomes for health workers..."

– U.S. Surgeon General Advisory on Building a Thriving Health Workforce, 2022[5]

"Primary care physicians spend nearly two hours on EHR tasks per hour of direct patient care."[11]

through education programs for managers on how to better support their teams, pay increases for frontline and other support staff[15] and resiliency and other wellness programs to buffer the challenges clinicians face.[16,17] For example, the Novant Health Office of Well-being and Resiliency offers programs for clinicians and other team members to address emotional health, leadership development, self-care and decompression and peer support resources.

To go beyond the individual and address the systemic causes of clinician burden and the resulting burnout, Novant Health has eliminated 26 million clicks in the EHR and removed nearly 1.4 million EHR-generated alerts to which clinicians must respond. This change has resulted in saving clinicians across the system nearly 2,000 hours of administrative work every 90 days. However, such efforts can only go so far before they too run into regulatory and insurer policy barriers.

To truly solve the problem of burnout and protect the patients for whom health systems and clinicians exist to heal, solutions cannot focus on the individual clinician level or on health system actions alone. Healthcare thought leaders must fight to make fundamental changes through public policy solutions that, if enacted, will reduce and eliminate these systemic burdens.

Policy barriers: regulatory limits to people-focused care

In 2023, the Center launched efforts to identify the regulatory and insurer policies creating the barriers for clinicians and patients. Unsurprisingly, the list was exhaustive. The Center will work to address these identified issues until the clinician-patient partnership leads and policies follow. As a first step, the Center will begin its work with an issue consistently at the top of the list of burdens highlighted by clinicians and increasingly, by patients: **regulatory requirements surrounding annual checkups.**

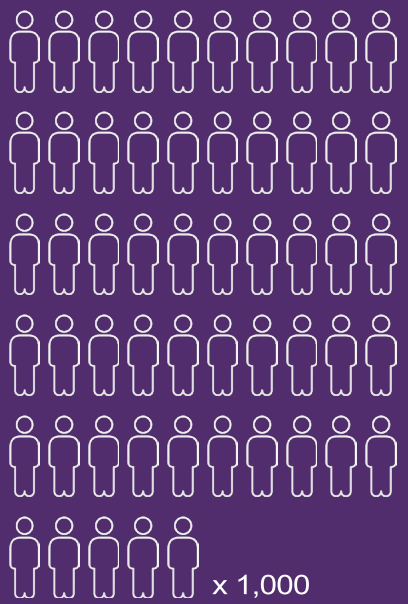
Regardless of a patient's insurance coverage type, the Affordable Care Act (ACA) requires insurers to cover an annual checkup at no cost to the patient. These visits, called "annual wellness visits" (AWV) in traditional Medicare and "complete physical exams" (CPE) for most commercial insurers and Medicare Advantage (MA), seem simple. On the surface, they appear to be the most basic step to ensure patients have access to preventive care. However, the regulatory realities are far from simple.

When patients arrive for their no-cost AWV or CPE, the way the visit is conducted is highly regulated. Depending on the type of insurance and subsequent plan specifics, how clinicians can provide care, address concerns and even physically examine patients is strictly prescribed. While patients often seek to utilize this annual opportunity to bring up issues surrounding a current health concern or chronic condition like diabetes, high blood pressure, depression or acne, care for such concerns is often barred from being discussed and covered as a part of an annual exam. As a result, clinicians are unable to address chronic conditions or acute complaints during the exam without triggering the addition of a second concurrent visit. This undermines the patient's expectation of a no-cost visit because they will now receive a bill.

Furthermore, because the visit is concurrent, the clinician will be

"There is confusion about whether it is permissible to bill for acute or chronic care, as well as [a] preventive service, in the same visit. Sometimes physicians are advised that they cannot bill for both services, other times they are told they can bill for both but only one will be paid, and sometimes there is patient pushback when they receive a billing statement with charges they were not anticipating."

– American Medical Association, Debunking Regulatory Myths Series[18]



55,000

ESTIMATED SHORTAGE OF PRIMARY CARE PHYSICIANS BY 2034[14]

reimbursed less by the insurer than if they had asked the patient to come back on a separate day for a separate visit to focus only on an acute health concern or chronic condition. In a nation where nearly half the population lives with at least one chronic condition and 90% of annual healthcare expenditures are attributable to chronic and mental health conditions, this regulatory failing is having a significant impact.[19,20]

At the bedside, clinicians must filter their training and medical care through highly varied regulatory requirements and insurance plans. Practically, when acute concerns or chronic condition questions arise, this leaves the clinician with three options:

1. **Document and bill for the acute and chronic conditions discussed.** Continue the exam, complete the required additional documentation, brace to accept patient frustration when they receive an unexpected bill and acknowledge little recourse to lower reimbursement from the insurer.
2. **Ask the patient to return for a separate appointment on a different day.** While this complies with regulatory requirements and ensures clinicians are fully reimbursed for the services they provide, it also generates a need for an additional bill for the patient and prevents consideration of other factors like a patient's ability to take additional time away from work or find transportation to yet another appointment.
3. **Address the patient's chronic condition without documenting the care provided.** While perhaps the most practical human approach to care, this option violates some regulatory and insurer requirements around providing care at no cost and asks clinicians to repeatedly provide unreimbursed expertise. Of note, in other sectors, unreimbursed services or products are simply not an option.

Thus far, efforts to reform annual checkup requirements have not identified solutions to the issues outlined above. The Center will address that solutions gap.

Policy solutions

The Center asked frontline practicing clinicians what would solve the annual visit challenge and the prevailing, common-sense solution was simple: **ensure insurers, regardless of the type, cover chronic condition management and acute health concern care during annual checkups.**

Expanding what is covered in AWVs is not unprecedented. In 2023, the Centers for Medicare & Medicaid Services finalized the 2024 **Physician Fee Schedule**[21] to incorporate social risk factor screenings into AWVs. The proposed rule adds an enhanced reimbursement if clinicians perform a **social determinants of health** risk assessment during the visit. This policy change will prevent additional cost and time commitments from the patient and create a reimbursement structure that appropriately reflects the increased level of care provided during the visit.

NOVANT HEALTH NUMBERS*

19%

Of new commercially insured patients were billed outside of a well visit and faced additional costs. For established patients, it jumped up to 22%.

1/3

Of established patients over 65 years old were billed outside of a well visit.

63%

Of Medicare patients — both new and established — incurred additional billing during annual visits. This was likely due to Medicare patients expecting an exam and the ability to discuss chronic conditions, but AWV regulations only provided coverage for a series of prescribed questions.

Data collected over a year

Physician Fee Schedule
A complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis.

Social determinants of health
Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Even a simple solution becomes complicated when it requires action from state and federal lawmakers and government agencies. Here's what policymakers need to do:

1. **Federal lawmakers:** ensure commercial payors and MA cover chronic condition management and acute health concern care as part of annual checkups at no cost to the patient. Ensure statute changes create coverage consistency across all commercial payors and MA plans.
2. **Federal agencies:** ensure all Medicare and MA reimbursements include chronic condition management and acute health concern care, and appropriately reflect the increased level of care provided during annual checkups.
3. **State lawmakers:** ensure commercial payors and Medicaid cover chronic condition management and acute health concern care as part of annual checkups at no cost to the patient. Ensure statute changes create coverage consistency across all commercial payors and Medicaid plans.
4. **State agencies:** ensure all Medicaid reimbursements include chronic condition management and acute health concern care and appropriately reflect the increased level of care provided during annual checkups.

If these solutions are implemented, policymakers can anticipate a significant reduction in clinician burden, a positive impact to patient satisfaction and an increase in patient engagement in preventive care, which is proven to be an essential component of quality, affordable care.[22] This overall alignment among health systems, clinicians, patients and lawmakers is a step towards ensuring healthcare's long-term viability and affordability.

Summary

For patients and clinicians, regulatory burdens like those surrounding annual checkups are not niche or granular gripes that can be ignored. They shape patient care, clinician job satisfaction and an overall healthcare environment that, without action, will move further and further away from the people it is built to serve. The Center and hundreds of Novant Health clinicians who provide annual checkups stand ready to work with state and federal policymakers to achieve meaningful change to annual visit care.

To learn more or join the Center's latest efforts to place the patient-clinician relationship at the center of public policy, email PublicPolicySolutions@NovantHealth.org.

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About Novant Health

Novant Health is an integrated network of hospitals, physician clinics and outpatient facilities that delivers a seamless and convenient healthcare experience to communities in North Carolina and South Carolina. The Novant Health network consists of more than 1,900 physicians and over 36,000 team members who provide care at more than 800 locations, including 16 hospitals and hundreds of outpatient facilities and physician clinics. In 2022, Novant Health provided more than $1.5 billion in community benefit, including financial assistance and services.

About the Novant Health Center for Public Policy Solutions

The Novant Health Center for Public Policy Solutions shapes and advances public policies to address what matters most to our clinicians and patients. We move beyond theory and drive action on public policies to combat clinician burnout, address access and affordability challenges, and enable innovation. Our approach utilizes the latest research, direct expertise from frontline clinicians, and collective experience as a leading not-for-profit health system to ultimately enable human-centric healthcare.

Table 1 – Commercial insurance coverage of annual visits in Novant Health payor relationships					
Payor A	*Payor B*	*Payor C*	*Payor D*	*Payor E*	*Payor F*
Separately identifiable E/M office visit must be billed with Modifier 25. Preventive office visit paid at 100% of allowable, E/M office visit paid at 50% of allowable. Policy varies by clinician type.	Separately identifiable E/M office visit must be billed with Modifier 25. Preventive office visit paid at 100% of allowable, E/M office visit paid at 50% of allowable.	Separately identifiable E/M office visit must be billed with Modifier 25. Preventive office visit paid at 100% of allowable, E/M office visit paid at 50% of allowable. Policy requires specific criteria be met.	Separately identifiable E/M office visit must be billed with Modifier 25. Preventive office visit and E/M office visit paid at 100% of allowable when billed with Modifier 25.	Separately identifiable E/M office visit must be billed with Modifier 25. Preventive office visit and E/M office visit paid at 100% of allowable when billed with Modifier 25.	Separately identifiable E/M office visit must be billed with Modifier 25. Preventive office visit paid at 100% of allowable, E/M office visit paid at 50% of allowable. Policy limited to specific E/M codes.

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Table 2 – Visit coverage by insurance type		
Traditional Medicare FFS	*Medicare Advantage*	*Commercial Coverage*
Covers “Welcome to Medicare” visit, which includes a physical exam, at no cost to the patient (discussion of chronic condition or acute health concern triggers additional visit and patient cost-sharing)	Covers “Welcome to Medicare” visit, which includes a physical exam, at no cost to the patient (discussion of chronic condition or acute health concern triggers additional visit and patient cost-sharing)	No equivalent to “Welcome to Medicare” visit
Covers initial and subsequent AWVs, which do not include a physical exam, at no cost to the patient (discussion of chronic condition or acute health concern triggers additional visit and patient cost-sharing)	Covers initial and subsequent AWVs, which do not include a physical exam, at no cost to the patient (discussion of chronic condition or acute health concern triggers additional visit and patient cost-sharing)	No equivalent to initial or subsequent AWVs
Does not cover CPEs	Covers CPEs at no cost to the patient (discussion of chronic condition or acute health concern triggers additional visit and patient cost-sharing)	Covers CPEs at no cost to the patient (discussion of chronic condition or acute health concern triggers additional visit and patient cost-sharing)

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