Examining the Phenomenon of Administrative Burden in Health, Allied Health & Respiratory Care

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Objectives

• Examine Major Factors Influencing Administrative Duties for Clinicians
• Review Prominent Literature Related to Administrative Burden (AB) in Healthcare
  – Real or Perception?
  – Different Medical Disciplines
  – Medical Education
  – Dearth of Literature in Allied Health
• Examine the Methods & Results of a Pilot Study
• Review Impact of Administrative Burden
• Offer Strategies to Mitigate & Reduce Administrative Burden
• Examine Additional Research Opportunities
• Provide Additional Resources
Operational Definition

**Administrative Burden**: An excessive amount of non-clinical duties which reduce the amount of time available for direct patient care activities and/or which otherwise result in negative consequences including poor morale or excessive overtime.
Major Factors Influencing Documentation

Duties for Clinicians

• Traditional Factors
  – Record Diagnostic & Therapeutic Procedures
  – Track Patient Progress
  – Reimbursement
  – Legal Record

• Contemporary Factors
  – Voluntary Reporting
    • Medical Error Reporting
  – Mandatory Reporting
    • Meaningful Use
    • Value-based Purchasing
  – “Clunky” & Unintegrated EHR/EMR Systems
  – Transition Period from Paper to Digital Records
  – Ad-Hoc: In Response to Adverse Events
Organizations Driving Documentation & Reporting

- CMS
- Organizational QA/QI
- Joint Commission
- Dept. of Health
- Leapfrog Group
Related Literature-Central Themes

• Administrative Burden is a real phenomenon
  – The term itself, appears frequently in the literature
  – It can be found as far back as the 1990’s

• Not unique to the US

• Applies to clinicians, students and faculty

• Applies to multiple disciplines

• Most commonly cited for physicians and nurses
Administrative Burden (AB) Appears to be a Global Issue

- Canadian MDs: Handle as much as 17,000 pages of documentation per year.
- British Government: Aims for a 1/3 ↓ in paperwork.
- Denmark & Germany- Physicians spend only 30% of their time on direct and indirect patient care activities.
- Switzerland- 25% of physicians’ time on administrative work.
Patterns in The US-Descriptive Statistics

• Most of the Studies Related to MDs & RNs
  – Physicians (MD) ~ 60%
    • Hospital Attending MDs 32%
    • General Practitioners 18%
    • Residents 9%
  – Nurses (RN) 23%
  – Allied Health & Other
    • Registered Dietitians 4%
    • Pharmacists 4%
    • Respiratory Therapists 4%: Heuer, et al.
Administrative Burden Among Healthcare Practitioners

PERCENTAGE OF TIME

CLINICIANS

Time Spent Directly With and Indirectly On Patients
Time Spent on Administrative Work
Studies Related to Practicing Physicians

- Golob (2016) – 46% of the trauma surgeons’ charges were procedural & attributable to a “documentation burden”.
- Woolhandler (2014) – 17% of their time on administrative burden. (n = 4,700)
  - Psychiatrists (20.3%)
- Ammenwerth (2009) – 27% of physician time on documentation (n = 5,000)
- Doll & Aroa (2010) – EHR/EMR have little impact on reducing administrative burden.
- Brady & Shariff (2013)
  - Growing EHR data entry challenge is perceived as a burden
  - Some Physicians are hiring Medical Scribes to help
Studies Related to Physician Education

- Christiano, et al. (2013) 92% medical residents reported excessive administrative burden.
- Oxentenko, et al. (2010) – Medical residents spend 50% of their day on documentation. (n = 16,000)
Studies Related to Administrative Burden for Nurses in US

- **Trossman (2002)**
  - Acute care nurses spend 25% of their time on administrative duties
  - Homecare nurses spend 50% of their time on administrative duties

  - Used a non-nursing duties tracking tool (interview)
  - Identified several tasks done by nurses which could be delegated to clerical, housekeeping & transport
Few Studies Related to Allied Health Professions

- Nurses and allied health professionals spend too much time on “hunting & gathering activities” as opposed to direct patient care
  - **Goal**: redesign care processes & physical work environment
    (Donebadian Theory of Quality Improvement: Process + Structure = outcomes.)
  - **Recommendation**
    - Produced a series of recommendations
    - Integrate Allied Health into Primary Care
    - (RPH, RD/RDN & RN)
Few Studies Related to Allied Health Professions (cont.)

  - Evaluated all paperwork for redundancy
  - Streamlined documentation & reporting
  - ↓ admin. duties by 4 - 6 hours /wk.

  - Survey of job satisfaction for RNs & allied health
  - Workload & AB has ↑
  - Less job security & satisfaction
We Found No Studies Related to Administrative Burden in Several Allied Health Professions

- Radiology Technologists
- Clinical Lab Scientists
- Respiratory Therapists
To Gain Some Insight on this Phenomenon, We Focused on One Allied Health Profession-- Respiratory Therapists

*Title: Pilot Study to Examine Respiratory Therapists’ (RT’s) Perceptions of Administrative Duties*
Methods

• **Survey Pilot Research Study**
  
• Constructed a Survey to Begin to Answer Research Questions in 4 Domains Related to RT’s Perception of Workload:
  
  – Changes in direct patient care activities
  – Changes in administrative duties
  – Impact of any changes on quality of care
  – Organizational support to mitigate any adverse impact

• **Validated by a Panel of Experts**
Methods

• IRB Approved in late 2014
• Targeted Population: 1,244 (of 3,200) RTs in NJ for whom we had valid e-mail addresses.
• Survey administered results collected via Redcap, a digital survey platform.
• Psychometric tests used to assess theoretical coherence of questions within each domain (relationship of each question to each domain)
Think back on your day-to-day work activities 5 years ago and compare them to your current typical work day activities with CRITICAL CARE PATIENTS. How would you compare your average direct patient care workload for a typical shift 5 years ago to your typical work today for the following tasks? Please answer the following questions for ONLY YOUR CRITICAL CARE PATIENTS:

- The number of patients assigned to you in a typical shift
- The average acuity of patients assigned to you
- The amount of time spent assessing your assigned patients
- The amount of time spent administering treatment to your patients (including medications, secretion mobilization, ventilator/patient management, etc.)
- The amount of time spent on patient and family education and follow up
### How do your typical current workday activities in INDIRECT patient care compare to your typical workday activities 5 years ago for the following tasks?

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<th>Much greater 5 years ago</th>
<th>Greater 5 years ago</th>
<th>A little greater 5 years ago</th>
<th>About the same</th>
<th>A little greater currently</th>
<th>Greater currently</th>
<th>Much greater currently</th>
<th>Not applicable</th>
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<td>Overall time spent on all indirect patient care activities (documentation, accessing medical records, clarifying orders, etc.)</td>
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<td>Time spent on hard-copy documentation (other than computerized)</td>
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<td>Time spent on computerized documentation</td>
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<td>Time spent obtaining and clarifying physicians orders</td>
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<td>Time spent accessing the prescribed medication(s)</td>
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<td>Time spent documenting and reviewing assessment and treatment protocols</td>
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<td>Time spent documenting and reviewing the patient education plan</td>
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<td>Time spent documenting and reviewing the Interdisciplinary care plan</td>
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<td>Time spent in non-patient care planning meetings (e.g., budgeting, designing protocols, performance evaluations, research, etc.)</td>
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<td>Time spent documenting and reviewing Other documentation</td>
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If you answered "other documentation" in the previous question, please specify: ____________________________
Our Pilot Study Results

• **Response Rate**
  - 252 valid responses received
  - Only 183 of RTs responding were in the field > 5 years could be used for the study (evaluated differences over time)
  - Response Rate 20%

• **Statistics**
  - SPSS ver. 21
  - Descriptive statistics
  - Frequency data
Descriptive Statistics

- 82% had RRT (Highest) Credential
- 85% Worked in Hospitals
- 52% Female
- 38% Supervisor or Higher
Results (Continued)

- Patient load & acuity levels are greater than 5 years ago
  - in acute & non-critical care settings
- 50% of respondents noted a “much greater increase” in all types of documentation.
- Similar perception related to documentation decreasing time available for patient care
- Small but statistically significant negative impact of documentation burden on quality of patient care.
Results (Continued)

- 57% indicated that the organization provided some degree of support for accounting for increased documentation duties.
- 63% felt the organization made efforts to reduce redundancy and compensate for increased documentation.
- Time allowed for patient interaction was insufficient.
Discussion/Significance to Various Levels Within Healthcare

• **Bedside Clinician:**
  – Every minute on administrative duties is less time for direct patient care
  – Some documentation systems are less burdensome than others

• **Middle Managers: Pivotal Position**
  – Should seek input from stakeholders at all levels
  – Staff need to perceive support

• **Executives: Participative leadership may be best.**
  – Clinicians more likely to feel vested if they help design, implement & evaluate procedures.
  – Less expensive EHR/EMR systems may be less efficient and end up being more costly
    • All-in cost should be considered when purchasing systems
    • Due Diligence, including reference checks for current adopters
  – Value Based Purchasing of CMS now includes *Efficiency of Care Category*, placing a premium on efficient systems of care.
Other Potential Significance

• Emphasizes the importance of using *Quality Improvement Tools* such as **Lean**, when evaluating current documentation systems & designing new ones.

• **Lean**: Quality Improvement Strategy which emphasized minimizing redundancy & waste.
  
  – Often involves conducting *process audit*.
  
  • Careful analysis of every step in a process
  • Redundancy and inefficiency identified and eliminated
  • Streamlining: Emphasizes that every activity & step adds value to the process
Next Steps & Future Opportunities

• Refining the Survey Instrument & Process
  – **Instrument** - More rigorous validation
  – **Process**: Resolve issues with SQR codes & URL’s from forwarded e-mails, which seemed to pose technical issues, reducing response rate

• Broader Studies
  – Involving multiple allied health professions
    • Compare and contrast among professions
  – Larger geographic region(s)
  – More representative sample
  – **Apriori power analysis for sample size**
Collaborators & Feedback Are Welcome

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