Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians

Shari M. Erickson, MPH; Brooke Rockwern, MPH; Michelle Koltov, MPH; and Robert McLean, MD; for the Medical Practice and Quality Committee of the American College of Physicians*

This American College of Physicians (ACP) position paper, initiated and written by ACP's Medical Practice and Quality Committee and approved by the Board of Regents on 21 January 2017, reports policy recommendations to address the issue of administrative tasks to mitigate or eliminate their adverse effects on physicians, their patients, and the health care system as a whole. The paper outlines a cohesive framework for analyzing administrative tasks through several lenses to better understand any given task that a clinician and his or her staff may be required to perform. In addition, a scoping literature review and environmental scan were done to assess the effects on physician time, practice and system cost, and patient care due to the increase in administrative tasks. The findings from the scoping review, in addition to the framework, provide the backbone of detailed policy recommendations from the ACP to external stakeholders (such as payers, governmental oversight organizations, and vendors) regarding how any given administrative requirement, regulation, or program should be assessed, then potentially revised or removed entirely.

The American College of Physicians (ACP) has long identified reducing administrative tasks as an important objective, maintaining significant policy and participating in many efforts with this goal in mind, including developing the "Patients Before Paperwork" initiative in 2015. The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In addition, administrative tasks are keeping physicians from entering or remaining in primary care and may cause them to decline participation in certain insurance plans because of the excessive requirements. The increase in these tasks also has been linked to greater stress and burnout among physicians.

Moreover, defining *administrative tasks* in health care (also colloquially called *hassles* or *burdens*) is nearly as challenging as the tasks themselves. Tasks that become burdensome may differ from payer to payer; appear one month without notice, then reappear modified or changed the next; and often result from not using documentation that already exists in the medical record. Equally if not more challenging is to identify the best means to address these tasks to mitigate or eliminate their adverse effects on physicians, their patients, and the system as a whole.

However, taking an analytic approach to defining and mitigating administrative tasks is critical to addressing them in a more comprehensive, cross-cutting, and holistic manner, rather than fixing one problematic task only to have another arise in its place. The ACP developed a framework (**Figure 1**) and taxonomy (**Figure 2**) for evaluating the sources, intent, effect, and consequences of existing and new administrative tasks. It proposes recommendations to reduce excessive administrative tasks in health care.

This executive summary provides a synopsis of the full position paper (**Appendix**, available at Annals.org).

METHODS

The ACP's Medical Practice and Quality Committee developed these positions and recommendations. The committee is charged with addressing national, state, or local policies on improving access, payment, coverage, coding, documentation, and medical review, as well as developing programs to support the quality, safety, and affordability of patient care. To better understand the effects of administrative tasks on practicing clinicians, their patients, and the physician–patient relationship, the committee analyzed the literature by

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conducting a scoping review and environmental scan. This process involved an extensive search of electronic databases, journals, and Web sites, including *Annals of Internal Medicine*, *Health Affairs*, *New England Journal of Medicine*, *Journal of the American Medical Association*, Commonwealth Fund, PubMed, Academy Health, Kaiser Family Foundation, Urban Institute, Center for Health System Change, Agency for Healthcare Research and Quality, other governmental agencies, and medical associations (see **Appendix Table 1**, available at Annals.org, for a comprehensive list of resources).

The initial literature review was done in early 2014 and later updated with 2 additional searches to identify any relevant new articles. Only articles published in 2000 or later were considered. In total, more than 60 articles were reviewed, with about half meeting the following screening criteria:

- English language articles or reports
- Studies involving U.S. clinical settings
- Studies involving health care professionals in the clinical practice or hospital setting, such as physicians, physician assistants, nurse practitioners, and clinical practice office staff, but excluding oral health professionals

Studies focusing on the burden of disease or illness, cost or financial burden of disease or illness, or cost of drug or health insurance administration were excluded. Priority was given to articles or reports presenting evidence from data-driven research rather than opinion. A limited number of editorial reviews, letters, perspective pieces, and clinical guidelines were included.

Although this paper briefly discusses issues related to physician workforce and burnout, the literature review focused primarily on assessing the effects on physician time, practice and system cost, and patient care due to the increase in administrative tasks, and then to identify recommendations to modify, mitigate, reduce, or eliminate these tasks as appropriate.

Draft recommendations were reviewed by the ACP Board of Regents, Board of Governors, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, Council of Medical Subspecialty Societies, and outside expert reviewers. The ACP's Medical Informatics Committee reviewed draft recommendations referencing the use of health information technology. The position paper and recommendations were reviewed by the ACP Board of Regents and approved on 21 January 2017.

ACP POLICY RECOMMENDATIONS

After considering the sources, intents, and effects of administrative tasks in health care—and the literature addressing these issues—the committee developed the following 7 public policy statements and recommendations as strategies to put patients first by reducing excessive administrative tasks in health care.

1. The ACP calls on stakeholders external to the physician practice or health care clinician environment who develop or implement administrative tasks (such as payers, governmental and other oversight organizations, vendors and suppliers, and others) to provide financial, time, and quality-of-care impact statements for public review and comment. This activity should occur for existing and new administrative tasks. Tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely. (See **Appendix Figures 1** and **2** for examples, available at Annals.org.)

2. Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.

3. Stakeholders, including public and private payers, must collaborate with professional societies, frontline clinicians, patients, and electronic health record

Figure 1. Framework for analyzing administrative tasks.
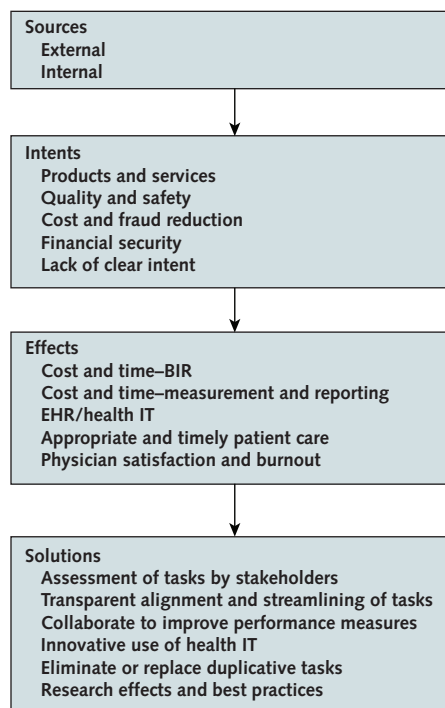
BIR = billing and insurance-related; EHR = electronic health record; IT = information technology.

Figure 2. Taxonomy of administrative tasks external to the practice and health care environment.
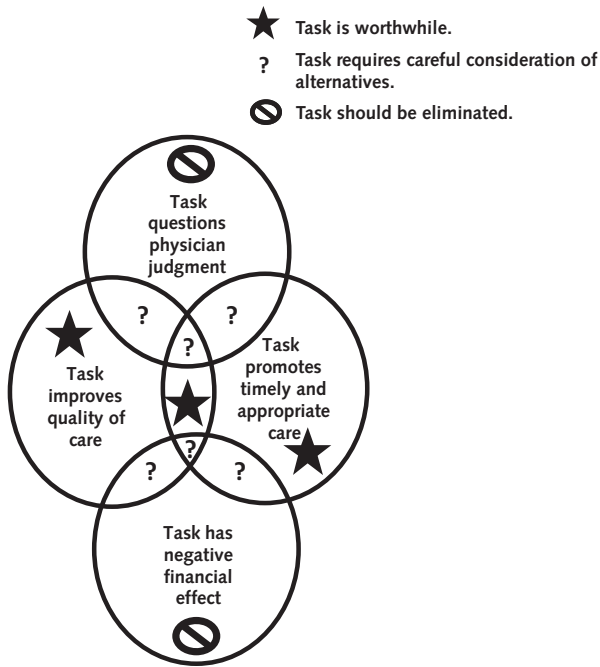
Each circle indicates a characteristic of an administrative task.

vendors to aim for performance measures that minimize unnecessary clinician burden, maximize patient and family centeredness, and integrate the measurement of and reporting on performance with quality improvement and care delivery.

4. To facilitate the elimination, reduction, alignment, and streamlining of administrative tasks, all key stakeholders should collaborate in making better use of existing health information technologies, as well as developing more innovative approaches.

5. As the U.S. health care system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative requirements.

6. The ACP calls for rigorous research on the effect of administrative tasks on our health care system in terms of quality, time, and cost; physicians, other clinicians, their staff, and health care provider organizations; patient and family experience; and, most important, patient outcomes.

7. The ACP calls for research on best practices to help physicians and other clinicians reduce administrative burden within their practices and organizations. All key stakeholders, including clinician societies, payers, oversight entities, vendors and suppliers, and others, should actively be involved in the dissemination of these evidence-based best practices.

CONCLUSION

The ACP presents a framework for analyzing administrative tasks through the lenses of sources, intents, effects, and solutions. This framework enables a better understanding of each administrative task that a clinician and his or her staff may be required to complete. This framework is the backbone of ACP policy recommendations for stakeholders outside the physician practice or health care provider environment (such as payers, governmental and other oversight organizations, and vendors and suppliers) regarding the assessment of each administrative requirement, regulation, or program to determine whether it should be challenged, revised, or eliminated entirely. These recommendations also outline steps that key stakeholders can and should undertake to align and streamline, transparently and cohesively, administrative tasks that remain in place. These guidelines are particularly important as the health care system evolves from one based on the volume to one based on the value of services provided. The ACP also calls for meaningful collaboration to improve the development, testing, and implementation of measures and to ensure that health information technology is used as innovatively as possible to streamline processes and reduce burden. In addition, although some consistency was found in the literature analysis on the effects of administrative tasks, much more research is needed in that area, as well as on the subject of best practices to mitigate or reduce the burden of these tasks. Once defined, best practices must be disseminated widely. Excessive administrative tasks have serious adverse consequences for physicians and their patients. Stakeholders must work together to address the administrative burdens that prevent physicians from putting their patients first.

From American College of Physicians, Washington, DC.

Current Author Addresses: Ms. Erickson, Ms. Rockwern, Ms. Koltov, and Dr. McLean: American College of Physicians, 25 Massachusetts Avenue NW, Suite 700, Washington, DC 20001.

Author Contributions: Conception and design: S.M. Erickson, B. Rockwern, M. Koltov, R. McLean.
Analysis and interpretation of the data: S.M. Erickson, M. Koltov, R. McLean.
Drafting of the article: S.M. Erickson, R. McLean.
Critical revision for important intellectual content: S.M. Erickson, B. Rockwern, M. Koltov, R. McLean.
Final approval of the article: S.M. Erickson, B. Rockwern, M. Koltov, R. McLean.
Provision of study materials or patients: S.M. Erickson.
Administrative, technical, or logistic support: B. Rockwern.
Collection and assembly of data: B. Rockwern, M. Koltov.

APPENDIX: PUTTING PATIENTS FIRST BY REDUCING ADMINISTRATIVE TASKS IN HEALTH CARE: A POSITION PAPER OF THE AMERICAN COLLEGE OF PHYSICIANS

The ACP has long identified reducing administrative tasks as an important objective, maintaining significant policy and participating in many efforts with this goal in mind. The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. In addition, administrative tasks are keeping physicians from entering or remaining in primary care and may cause them to decline participation in certain insurance plans because of the excessive requirements. The increase in administrative tasks also has been linked to greater stress and burnout among physicians.

The ACP developed this paper to assess the effect of increased administrative tasks on patient care; propose a framework for evaluating the intent, effect, and consequences of existing and new administrative tasks; and offer comprehensive solutions to modify, mitigate, reduce, and even eliminate administrative tasks.

The ACP is the largest medical specialty organization and the second-largest physician group in the United States. Its members include 148 000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Background

What Are Administrative Tasks?

Defining *administrative tasks* in health care (also colloquially called *hassles* or *burdens*) is challenging—one simply knows a hassle when it appears. Tasks that become burdensome may differ from payer to payer; appear one month without notice, then reappear modified or changed the next; and often result from not using documentation that already exists in the medical record. Equally if not more challenging is to identify the best means to address these tasks to mitigate or eliminate their adverse effects on physicians, their patients, and the system as a whole. However, taking an analytic approach to defining and mitigating administrative tasks is critical to addressing them in a more comprehensive, cross-cutting, and holistic manner, rather than fixing one problematic task only to have another arise in its place.

The ACP developed the following framework to guide the consideration of administrative tasks and serve as the backbone for its policy recommendations (**Figure 1**). This framework categorizes tasks through several lenses to best identify a set of solutions. First, one must consider the source of the task. Is it external to the clinician practice or health care organization, or is it being generated within the practice? In many cases, the task may arise from both external and internal drivers. Second, what is the ultimate intent of the administrative task? Is the intent clear? Third, what is the effect of this task? Is it completely negative, resulting in wasted time for the clinician and a lack of improved care or outcomes for the patient; generally negative, with some positive outcomes; positive in the end but with adverse or unintended consequences; or overall positive? Perhaps the value added to patient care is high enough that activities that typically are viewed as burdensome—and that increase administrative work—are instead viewed as worthwhile. Finally, once the source, intent, and effect of the tasks are understood, what approaches may be broadly applied to address several of them in a more focused and cohesive way? In addition, to whom should these approaches be directed most appropriately: policymakers, payers, industry, health systems, professional organizations, practices, patients, or other key stakeholders? These framework components are discussed in greater detail later. **Figure 2** illustrates a taxonomy for administrative tasks, and **Appendix Figure 1** provides an example assessment of an administrative task determined to be worthwhile and that should be retained. **Appendix Figure 2** provides an example assessment of an administrative task determined to be burdensome and that should be eliminated.

Sources of Administrative Tasks

External Sources. The most numerous and well-known tasks faced by physician practices and other organizations that provide health care are imposed by outside forces. These external sources include, but are not limited to, public and private payers; governments and policymakers; private certification, accreditation, and recognition organizations; vendors and suppliers; health care consumers; and other clinician practices and health care provider organizations.

Public and Private Payers. All payers, whether public or private, have their own approaches, rules, and requirements related to insurance eligibility verification; appropriate billing for services; prior authorizations for medications, procedures, and other services; appeals for lack of payment; reporting of quality and resource use measures, as well as feedback reports on those measures; referrals and treatment plans; alternative payment model (APM) participation; and many other areas.

Governmental Entities and Oversight. Many governmental entities also impose administrative tasks on physicians—either directly or indirectly. During the past several years, Congress passed laws intended to reform and improve the health care system, including the Patient Protection and Affordable Care Act (ACA); the Health Insurance Portability and Accountability Act (HIPAA); the Stark Law and Federal Anti-Kickback Statute; and, more recently, the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA). With regard to the complexity of health care administration, these laws have changed operating rules for health plans, initiated and advanced quality and other reporting programs for physicians and other clinicians, and facilitated the development of value-based payment approaches and APMs. Once such laws are passed, the regulatory agencies, most notably the Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology, are responsible for implementing them. Other entities are involved as well, including the Agency for Healthcare Research and Quality (AHRQ), Government Accountability Office, National Committee on Vital and Health Statistics, and Office of the Inspector General. External advisory entities, such as the Medicare Payment Advisory Committee, Medicaid and CHIP Payment and Access Commission, and Congressional Budget Office, also provide input to both Congress and the agencies on issues related to health care payment and delivery system reform.

Beyond the previously outlined administrative hassles that apply to all payers, unique programs and requirements, such as the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBM) program, and Medicare (and Medicaid) Electronic Health Record (EHR) Incentive Payment Program (typically referred to as Meaningful Use [MU]), are relevant for physicians participating in Medicare. However, compliance is difficult for internal medicine practices and other health care provider organizations. Each of these programs is complex and presents challenges for physicians and practices to participate in them successfully. Moreover, each was established by a different law; therefore, despite efforts by CMS and the Office of the National Coordinator for Health Information Technology to align the programs as much as possible, PQRS, VBM, and MU have had to use different measures, as well as variable reporting, feedback, payment approaches, criteria, and time frames. The MACRA law is intended to better align these different reporting and payment programs within Medicare fee-for-service (that is, Medicare Part B) plans by combining the PQRS, VBM, and MU programs into a new payment approach called the Merit-Based Incentive Payment System (MIPS). However, concerns exist regarding how MIPS and other components of the MACRA law will be implemented and whether the system will be a new source of administrative tasks for practices. In particular, the ACP has strongly recommended that CMS actively work to improve the measures to be used in the MIPS quality performance category and that it not consider the existing quality measurements in the PQRS, VBM, and MU as the starting point for MIPS implementation. Further, the ACP has stressed the importance of CMS continuing to improve the measurements and reporting systems to be used in MIPS to ensure that they are evidence based and measure the correct items; move toward clinical outcomes, patient- and family-centered measures, care coordination measures, and measures of population health and prevention; and do not create unintended adverse consequences. Also important is for these measures and reporting systems to be aligned with those of Medicaid and the Government Performance and Results Act program maintained through such departments as the Veterans Health Administration and Indian Health Service, as well as private payers over time. Along these lines, the ACP has called on CMS to collaborate with specialty societies, frontline clinicians, EHR vendors, and patient representatives in developing, testing, and implementing measures, with a focus on decreasing clinician burden and integrating performance measurement and reporting with quality improvement and care delivery (1). The final rule for the first year of MACRA implementation, released in October 2016, contained several improvements over the proposed rule; however, how this implementation will play out in the real world remains to be seen.

Although the ACA is relatively new, it has been in place longer than MACRA; therefore, enough time has passed to evaluate whether it truly has increased administrative tasks. When the ACA was enacted, the pri-

mary concern at the practice level was whether and how practices could accept a potentially large number of new patients, particularly those covered by Medicaid, and avoid a negative effect on their ability to provide high-quality patient care. To date, such concerns seem to be unfounded. Although Medicaid enrollment grew by 15.4 million members from October 2013 to July 2016 (2) and the number of persons younger than 65 years directly purchasing coverage increased by 16.5 million between 2013 and 2015 (3), most primary care clinicians have not had to close their doors and have been able to provide high-quality care to all their patients since January 2014, regardless of whether their Medicaid or newly insured populations have increased (4). Of importance, however, is that when practices do absorb new patients and perhaps increase the number of health plans they accept, their administrative burden likely increases (5).

Outside the ACA, Medicaid also may be a source of burden for physicians and their practices, because it is administered under both state and federal regulations regarding financing and implementation while also being subject to broad federal oversight. Practices located near state borders face additional burdens in complying with different state program requirements. Many states also contract with managed care companies to administer their Medicaid programs, and each company has a distinct set of requirements.

The 1995 and 1997 Evaluation and Management (E&M) guidelines are another burden resulting from government oversight and involvement that affects physicians in practice. These guidelines were developed by Congress, are regulated and maintained by CMS in conjunction with other federal agencies, and are used by all public and private payers. To receive reimbursement, all practicing clinicians must follow these guidelines when documenting their provision of E&M services; noncompliance may result in billing fraud, potential fines, restriction from participation in Medicare and Medicaid, and even criminal penalties. Although organized medicine initially supported the development of these guidelines as a means to ensure that documentation of cognitive services could be externally verified, these rules have since been implemented in a manner that is "difficult to understand and use, and even counterintuitive" (6–8). For example, determining the "level of service" to code and bill for is overly complex and time consuming because of ambiguity among the 5 levels of service defined in the E&M documentation.

In addition, federal and state regulatory agencies, as well as Congress, impose health care–related administrative tasks on physicians and practices beyond payment and coverage issues. One example is HIPAA, passed by Congress in 1996 and strengthened by additional laws and guidance over time. Practices must continually keep up to date and comply with HIPAA rules, or they may face civil monetary penalties. Another example is the Occupational Safety and Health Administration (OSHA) standards that medical offices must meet to ensure worker safety.

Oversight by Private Entities. In addition to the government entities and oversight discussed earlier, physicians face administrative tasks resulting from oversight by private entities, including but not limited to certification boards and accreditation organizations. Approaches to board certification and maintenance of certification vary among specialties, with the American Board of Internal Medicine serving as the primary certification organization for internal medicine physicians. Although board certification and maintenance of certification technically are voluntary, they typically are required for physicians to practice in certain systems and are viewed as critically important for patients to be able to ensure that their physician has the necessary expertise and knowledge to practice in a particular specialty. However, becoming certified and maintaining certification often are viewed as burdensome (9), although the environment has been evolving rapidly, and many changes have been made or are in progress.

Accreditation or certification by such private entities as the Joint Commission, National Committee for Quality Assurance (NCQA), and URAC represents another source of administrative tasks. The Joint Commission accredits many types of health care organizations, including hospitals, physician offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services, and certifies programs or services based within or associated with a health care organization (for example, Primary Care Medical Homes). The NCQA accredits health plans and provider organizations, such as Accountable Care Organizations (ACOs), and certifies programs and specific services. In addition, the NCQA offers recognition programs for clinician practices, including Patient-Centered Medical Homes (PCMHs) and Patient-Centered Specialty Practices, and for clinical areas of care, such as diabetes, heart and stroke, and back pain. Similarly, URAC offers accreditation programs for health plans, case management programs, PCMHs, and others. All these accreditation, certification, and recognition programs are intended to assist payers, clinicians, patients, families, and other key stakeholders in determining whether a health care organization is providing high-quality care, and several have been used to facilitate uptake of new payment models by both public and private payers (10–12). However, these programs often are associated with significant cost, staff time, and administrative burden. Collecting the data and information to report on the standards and elements associated with these programs involves a great deal of work and attention to detail,

which may affect the ability of a clinician and his or her staff to spend enough time tending to their patients' needs. In addition, many concerns have been raised about the ability of these programs to improve quality, patient outcomes, and experience with care.

Vendors and Suppliers. Physicians and other clinicians in practice must interact in some way with external vendors and suppliers, including EHR vendors; suppliers of other health information technology (IT), such as registries; durable medical equipment (DME) companies and sellers; pharmaceutical companies and their representatives; home nursing associations; and various consultants. Although all these entities can and often do provide significant value and important services to patients, physicians, and practices, they also may be a source of burden and cost. Purveyors of EHR systems are working to comply with regulations, such as MU and the E&M documentation guidelines, but at the expense of being unable to offer tools that are tailored to a practice's workflow and the clinical needs of its patients. In addition, EHR vendors have not yet had adequate discussions with frontline clinicians to better understand their needs, often leading to workarounds that create additional steps and burden. Therefore, the lack of usability and meaningful interoperability of EHRs has become one of the greatest sources of dissatisfaction among clinicians (13). Another problem practices face is the ever-rising costs of health IT products and services. Every new health IT module needed to perform a specific function comes with added costs. Often, EHR vendors charge additional fees for every interface to another system or service, as well as ongoing fees for moving data. Currently, a practice may be required to submit data to dozens of agencies. In the future, a practice also may have to exchange data with thousands of health care apps that patients may want to use. Moving large quantities of patient data from one system to another may be costly.

With regard to DME, when physicians prescribe or order certain equipment for their patients, the processes and paperwork are very tedious and confusing, often leading to delays in patients receiving necessary devices. Physicians also may be frustrated by unsolicited requests by DME companies and sales representatives to prescribe equipment, such as power wheelchairs and diabetic test strips, partly as the result of direct-to-consumer advertising as well as fraudulent tactics by some DME companies that are considered "bad actors" in the system (14).

Other Practices and Health Care Organizations. High-quality and longitudinal care for patients requires that all parties involved in providing that care coordinate as a team. However, the need to regularly interact with other practices and health care organizations may be another source of administrative tasks for physicians and other clinicians in practice. These interactions oc-cur, for example, among specialists in primary care, internal medicine subspecialists, and other clinicians; ambulatory physician practices and hospitals; and other care sites, such as urgent care centers and retail clinics. Often, physicians in practice are unaware that their patients have been seen by other clinicians or providers, or they become aware too late to meaningfully contribute to or provide the needed follow-up care. When information is shared, it is not always relevant, appropriate, or helpful, or may not be what the physician needs to ensure high-quality care.

Physicians in practice also interact with public health authorities, often via data submission to surveillance registries. Although gathering data on public health threats is critically important, the Health and Medicine Division of the National Academies recently acknowledged that "collecting and entering the data into the proper forms and format requires time and effort beyond the usual health care delivery processes. Because resources devoted to the registry often do not immediately benefit the practice or its patients, clinicians may be reticent to register patients or collect and record data on busy days" (15). These requirements may be even more burdensome if the obligation to report is not satisfied via a standard report into a single utility.

Measurement of Patient Experience and Evolving Consumer Expectations. The primary goal of physicians and other clinicians is to provide their patients with the best care possible, regardless of administrative tasks or other barriers. In general, most physicians also want a better understanding of their patients' expectations, concerns, and interests. Currently, one of the main approaches to assessing patient experience is through surveys, primarily the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys developed by AHRQ. These instruments have undergone extensive testing and generally are considered the most valid method available for evaluating patient experiences (16–18). However, at the practice level, the CAHPS surveys may be burdensome and costly to conduct, evaluate, and report. In addition, some payers have added even more complexity and cost to these surveys; for example, CMS requires larger practices to use an external CMS-certified survey vendor to report on CAHPS for PQRS.

Consumers have substantial needs (such as completion of disability forms and timely communication of laboratory results), and their expectations are evolving, with patients and families becoming more engaged in their own care, seeking access to their records both in person and remotely (via telephone, the Internet, apps, patient portals, and other means), and direct communication with their physicians and care team (including inquiries related to direct-to-consumer advertising for DME and pharmaceuticals). Physicians may welcome

and appreciate these changes because they may lead to more effective patient care and increased patient and family satisfaction. However, reshaping practices to be more centered on the patient and his or her family requires concerted effort and attention so that it does not become a source of administrative complexity.

Internal Sources. Although external sources of administrative tasks are the most well-known and cited, internal sources of burdens and hassles also exist for physician practices and other health care provider organizations. Often, these internal sources are related to external administrative tasks that a practice is approaching in a way that is understandable but less than ideal. Two major internal sources of practice burden are inefficient workflows and lack of effective team-based care both within the practice and in interactions with other practices and health care organizations. Several effective approaches have been identified, tested, and implemented within and across practices to improve workflows and facilitate team-based care, including active previsit planning, team huddles, standing orders, revision of staff roles and responsibilities, and care coordination agreements (19–21). Establishing certain workflow protocols and appropriate nonphysician staffing conventions that consider scope of practice is crucial in addressing internal sources of burden. For example, studies have shown that practices that adopt new forms of delegation and care processes using teamwork approaches have reported improved clinician satisfaction and productivity (22, 23). In addition, use of standing orders, for example, is a methodology that authorizes nurses and other clinical staff to carry out medical orders according to a preapproved protocol without the clinician's direct examination (24). However, within a largely volume-based reimbursement system, implementing these approaches is extremely challenging and resource intensive, particularly in the absence of strong clinical and key staff leadership or if the opportunities to engage in training on these different approaches are limited or nonexistent.

Practices also may face administrative burdens if they cannot efficiently and effectively use the available technology, such as EHRs, registries, and population health management software. Although EHRs have many inherent problems and are affected by several environmental and regulatory drivers, as discussed earlier they still may offer benefits, such as the ability to track laboratory results effectively, view patient information both longitudinally and discretely, manage patient populations, and access patient records remotely—but only if the practice understands these benefits and is trained to take advantage of them.

Finally, in the changing delivery and payment system environment, which is moving toward paying for value rather than volume, practices may not be able to institute the effective management approaches needed to be fully successful, such as establishing new policies and procedures, ensuring access to the most up-to-date clinical guidelines, revising budgeting and compensation structures, and rethinking their scheduling and rooming procedures. These management challenges then may exacerbate existing administrative tasks or even become their own source of burden themselves.

Intents of Administrative Tasks

As outlined earlier, the sources of administrative tasks are diverse. Likewise, their intentions are varied, but overall they may be classified into 5 main categories according to whether the task
- Provides and pays for products and services
- Ensures high-quality, high-value, safe, and effective provision of products and services
- Reduces excess and inappropriate costs and prevents or identifies fraud and abuse in the health care system
- Ensures financial security and potential profitability for the stakeholder
- Lacks a clear intent

Products and Services. Public and private payers and many vendors, as described earlier, are responsible for providing many products and services, such as health insurance, pharmaceuticals, EHRs, and DME, to clinicians, practices, health care organizations, employers, and patients. These products and services must be paid for by the recipients, and payment arrangements in health care are tremendously complex, often involving third and fourth parties. Therefore, the service providers have a strong need to ensure that they are receiving appropriate and timely payment, leading to the creation of several tasks that affect all relevant stakeholders, including claims processing delays, payment denials and appeals processes, insurance eligibility verifications, discount programs, and more.

High-Quality, High-Value, Safe, and Effective Services. The intention of all the sources of tasks outlined here is to ensure that the products and services provided, as well as the health care system as a whole, are safe, effective, and of the highest possible quality and value. Of course, this intent must be balanced against the other intentions discussed in this section, such as product sales and profit (and, at times, one may argue that the latter takes precedence). Examples of differing intentions from the sources described in this paper that are related to high-quality, high-value, and safe care include the following:

Public and private payers, who have an interest in keeping their beneficiaries healthy (which can keep premiums low and attract new clients), and in ensuring that the clinicians who use their products and participate in their programs are providing high-quality, high-

value, and safe care (such as through quality measurement and reporting, prior authorizations, and feedback reports). Public payers also have an obligation to the citizens they serve to ensure their tax dollars are used wisely, including via public reporting of quality data.

Oversight entities, including regulatory agencies and Congress, who want to protect the country's citizens from undue harm (such as through HIPAA and OSHA standards) and improve the health care system (such as through the ACA and MACRA), as well as private entities working to ensure that individuals and organizations have the necessary judgment, skills, activities, and processes in place to provide high-quality, high-value, and safe care.

Vendors and other suppliers, who must ensure that their products and services meet the needs of their users.

Clinicians, practices, and other health care organizations, who want to provide the best possible care to their patients and patient population and therefore may choose to participate in new payment and delivery systems, projects, or programs.

Patients and their families, who want to receive the best care possible at the most appropriate and accessible time and place.

Cost Reduction and Fraud Prevention. Along with ensuring quality and safety, administrative tasks also intend to reduce excess and inappropriate costs and prevent or identify fraud and abuse in the health care system. These intents are common across all sources of administrative tasks; however, each source has somewhat different reasons for wanting these outcomes, and sometimes these reasons conflict. In addition, the complexity of the U.S. health care payment system leads to significant waste, overuse or inappropriate use of services, and intentional or unintentional fraud or abuse by several entities.

All public and private payers must address these issues—and do so in various ways, including through prior authorizations, appropriate-use criteria programs, audits, documentation guidelines, and referral and treatment plan requirements. In fact, if a payer manages to reduce utilization (that is, costs), regardless of whether it is appropriate or inappropriate, then the savings generated may benefit the company. Today's health care system is evolving from one that incentivizes payment for the volume of services to one that pays for value, which typically is defined as an equation involving both quality and cost–resource use metrics. Therefore, many payers are using new approaches to measuring resource use, adding to the evolving area of quality measures. Along these lines, most stakeholders anticipate a growing movement toward measuring outcomes of services and treatments for patients and their families, as well as patient and family experience, as a better way to ensure that the most appropriate care, in

terms of both cost and quality, is provided. As the delivery and payment system environment continues to evolve from volume to value based—largely via the implementation of APMs, which measure both quality and resource use and offer opportunities for practice transformation—many of the burdens outlined here may be addressed more meaningfully and less problematically. In other words, once we can accurately measure and incentivize improvements in patient outcomes and experience, many of the tasks described here, such as prior authorizations, might be eliminated or significantly limited.

Clinicians, practices, and other health care provider organizations generally have focused on providing the highest-quality care and often do not have access to the information they need to fully account for the cost of products and services (25, 26). Also, concern is growing that an increased focus on cost reduction, particularly as it is monitored and enforced by payers and oversight entities, will result in patients not getting the care they need (that is, underutilization). However, clinicians generally recognize that they have to consider the cost of services, particularly as it affects their patients who, for example, may not be able to access certain pharmaceuticals they need because of high prices, as well as how it affects the health care system as a whole.

Patients and their families also are interested in reducing costs, perhaps more so today because of the increase in high-deductible health plans and growth in other out-of-pocket expenses (27, 28); however, patients also want to ensure that they receive all the services they need. Meeting the needs of patients and their families, as well as providing the outcomes they desire, is central to ensuring that our health care system evolves into one that is truly patient centered; however, clinicians may find challenges in fulfilling these goals given the stresses caused by the current health care payment and delivery environment. Certain strategies, such as shared decision making (for example, AHRQ's SHARE approach) (29), may help to facilitate meaningful discussions that lead to higher-quality and cost-effective care in the eyes of both clinicians and patients.

Financial Security and Profit. Related to the intents of cost reduction and fraud prevention are those of ensuring overall financial security and profitability for an individual or organization. Payers must have appropriate funds available to pay for the products and services they insure in the health care system, with some having the further intention of garnering a profit for their shareholders. Government oversight entities have a responsibility to protect and appropriately use the taxpayer money that funds their operations. Private oversight organizations, as well as vendors and other suppliers, also must ensure their security and perhaps realize a profit, depending on their organizational

structure. Many vendors, including those that supply health IT, devices, and pharmaceuticals, have a significant need to reinvest funds into ongoing development, research, and innovation, although analysts have found it difficult to determine precisely how much new or reinvested funding goes into or is needed for research and development versus how much is acquired as profit (30). On the clinician side, practices and other health care provider organizations also must protect their financial security to continue providing services in their communities.

Lack of Clear Intent. Finally, some sources of administrative tasks have no clear intent, leading to additional administrative tasks. This situation is particularly relevant to clinician practices and other health care provider organizations, who, for instance, may be performing an obsolete task simply because it has always been done that way, even though the environment has evolved. As discussed earlier, several sources of burdens and hassles are internal to a physician's practice; these typically are related to external pressures, such as inefficient workflows and a lack of effective team-based care. Often, these tasks indicate a lack of necessary resources, including funding and staff, to make effective changes, as well as inadequate practice leadership (from clinicians or key staff members), knowledge, and training.

Effect of Administrative Tasks

Methods of Literature Review. To better understand the effects of administrative tasks on practicing clinicians, their patients, and the physician–patient relationship, the ACP did a literature analysis, which entailed a scoping review and environmental scan that included an extensive search of electronic databases, journals, and Web sites (**Appendix Table 1**). Articles were screened to ensure that they focused on practicing physicians and their patients rather than on disease burden, implementation of mental health parity, administrative claims data, malpractice-related costs, or oral health and dentistry. The specific screening criteria were as follows:

- English-language articles or reports
- Studies involving U.S. clinical settings
- Studies involving health care professionals in the clinical practice or hospital setting, such as physicians, physician assistants, nurse practitioners, and clinical practice office staff but excluding oral health professionals

Studies that focused on the burden of disease or illness, cost or financial burden of disease or illness, or cost of drug or health insurance administration were excluded. Priority was given to articles or reports presenting evidence from data-driven research, rather than opinion. Only a limited number of editorial reviews, letters, perspective pieces, and clinical guidelines were included.

In addition, articles published before 2000 were excluded because of the extensive changes to the health care system since then. Further review narrowed the focus to original research studies, secondary research and reviews, and policy papers. The initial literature review was done in early 2014 and was updated with 2 additional searches to identify relevant new articles. In total, more than 60 articles were reviewed, about half of which met the screening criteria. Of importance is that although this paper touches briefly on issues related to physician workforce and burnout, the literature review focused primarily on assessing the effects on physician time, practice and system cost, and patient care due to the growth in administrative tasks, leading to the development of recommendations to modify, mitigate, reduce, or eliminate administrative tasks as appropriate.

Results and Discussion of Literature Review. Overall, the findings of the literature analysis were consistent regarding the effect of administrative tasks on time spent by clinicians and their staff on billing and insurance-related (BIR) activities (3 to 5 hours per week) and quality measurement and reporting (potentially up to 15 hours per week).

The related cost effects of BIR time were found to be approximately 12% to 14% of revenue, or about $68 000 to $85 000 per year per full-time equivalent (FTE) physician. Prior authorizations alone may cost around $3000 per year per physician. Documentation within EHRs and other health IT, although it may be considered part of the BIR as well as of performance measurement and reporting activities, has been studied separately, with findings indicating that for every hour a physician spends with a patient, he or she spends an additional 2 hours on EHR and other "desk" work. Research also is beginning to show that excessive or unnecessary administrative tasks may have important effects on patient care, as well as leading to increased physician burnout. These findings are discussed in more detail later.

Measurement of Patient Experience and Evolving Consumer Expectations. The literature on BIR and other administrative activities generally focuses on the effect of these tasks on costs or time (**Appendix Table 2**, available at Annals.org). On the basis of available research, physicians and their staff spend an estimated 3 to 5 hours per week on administrative tasks—largely on BIR activities (EHR effects are discussed more specifically later in this paper)—with some estimates as high as 8.7 hours per week (31–35). If time is converted to cost effects, practices spend approximately $68 000 to more than $85 000 per year per FTE physician on administrative tasks, which some experts have translated

to an estimated 10% to 14% of net practice revenue (31, 32, 34, 36). One study that focused specifically on the cost effects of prior authorizations by using real-time self-observation found that the average burden on primary care physicians ranged from $2161 to $3430 per FTE physician annually for these activities (37). Other researchers reviewed the cost effect of BIR activities at the national level and found that these aggregate costs are in the hundreds of billions of dollars, significantly greater than the cost of similar activities in Canada (33, 35, 38).

Measurement and Reporting Impacts. Casalino and colleagues (42) found that physicians and staff spent more than 15.1 hours per physician per week dealing with external quality measures, with 2.6 of those hours spent by the physician. These activities included tracking measure specifications, data collection processes, data entry into the EHR, and data transmission. Translated to cost, this time spent represents approximately $40 069 per physician per year, or a total of $15.4 billion annually for general internists, family physicians, cardiologists, and orthopedists in the United States. Although earlier studies found lower and more variable estimates of time and cost (43, 44), given the growth of value-based payment approaches in health care, one may reasonably assume that the burden of quality measurement and reporting has increased.

Another study, in 2008, focused specifically on the burden of quality reporting in hospitals. The researchers found that in addition to the increase in quality-reporting programs, the number of conditions measured and data that must be gathered also increased. In addition, the variation across quality-reporting programs contributes to the administrative burden on hospitals. Hospitals in this study identified various approaches to help manage quality-reporting activities; however, administrative burden persisted (45).

EHR/Health IT Impacts. Although documentation within EHRs may be considered a component of BIR and even performance measurement and reporting administrative burden, increased use of EHRs and other health IT tools has led to interest in exploring the effects of using them on a daily basis. A time-and-motion study in ambulatory practice across 4 specialties found that for every hour a physician spent providing direct clinical care to patients, he or she spent nearly 2 hours on EHR and other desk work, plus another 1 to 2 hours each night (46). The EHR and desk work included documentation and review, accessing test results, and arranging medication orders; other administrative tasks, such as BIR activities and scheduling, were considered separately. In addition, a 2012 survey of internal medicine physicians showed that the average time spent on EHR documentation was 6.5 hours per week greater than that spent on paper record systems (47). In an-

other study, Goldberg and colleagues (48) reviewed EHRs in primary care practices to identify challenges faced by practices using this system. They found that costs, lack of knowledge of EHR functions, and problems transforming office operations were barriers to meaningful EHR use. In addition, practices reported that during system upgrades, major disruptions in patient care occurred.

A recent study examining the productivity of physicians using EHRs in the emergency department found similar problems, with 43% of physician time spent on data entry and an average of 4000 total mouse clicks for charting functions and documenting patient encounters during a busy 10-hour shift (49).

An ACP policy paper by Kuhn and colleagues (6) cited several related articles on the effects of EHRs and outlined the evolving purposes and drivers of clinical documentation in EHRs that have contributed to these outcomes. One of these drivers is the ease at which previous entries can be carried forward, thus making it difficult for physicians to find the most useful and actionable information. Perhaps the most significant driver cited in this article, however, was the issuance of the E&M guidelines of 1995 and 1997, which created a complex system of rules that seem to have overridden clarity and conciseness (7, 8).

Impacts on Clinical and Patient Care. The aforementioned studies focused largely on the effects of administrative tasks on physicians, their practices, and the health care system, particularly those related to time and cost; however, these tasks also affect patients. Although the effects on patients may be inferred from reviewing the available data on physician time, more direct research on patient effects is severely limited. A 2013 nationwide survey of residents found that the workload created by clinical documentation may be a barrier to optimal patient care as well as to education, with 73% reporting compromises in patient care due to documentation requirements (50). In addition, a time–motion study of hospitalists found that they spend more time reviewing and documenting EHRs than interacting with patients (51).

Related work by Sinsky and colleagues (46), also discussed earlier, focused on how physician time is allocated in ambulatory care and found that physicians spent 49.2% of their time on EHR and desk work, versus 33.1% on direct clinical face time with patients and staff. Although the authors noted that EHR activities may be hypothesized to decrease physicians' time engaging with patients, they drew no specific conclusions along those lines. Also of note, the study included time in which physicians and patients interact together with the computer (for example, in discussing relevant information presented by the EHR during an in-person visit) as part of the EHR work, which might be addressed via follow-up studies evaluating the challenges and oppor-

tunities associated with EHR use and its effect on patient care in greater depth.

Impacts on Physician Satisfaction - Burnout. Also important to acknowledge are the extensive data on the effect of administrative tasks on physician burnout. Research has shown that burnout is more prevalent among physicians than other U.S. workers and is increasing (52, 53). Physician burnout has been linked to several causes, such as workflow, work control, the emphasis on quality and communications in an organization, trust in an organization, cohesiveness, and alignment of values between physicians and their leaders (54, 55). More specifically, with regard to administrative tasks, EHRs and externally imposed regulations have been linked to increased stress and burnout (13, 56, 57). These findings have led to pursuit of the Triple Aim, an initiative to enhance patient experience, improve population health, and reduce costs, to be expanded to the Quadruple Aim, with the added goal of improving the work–life balance of clinicians and their staff (58).

Approaches to Addressing Administrative Tasks: ACP Policy Recommendations

After reviewing the sources, intents, and effects of administrative tasks in health care—and the literature addressing these issues—the ACP outlined a set of public policy statements and recommendations as follows:

1. The ACP calls on stakeholders external to the physician practice or health care clinician environment who develop or implement administrative tasks (such as payers, governmental and other oversight organizations, vendors and suppliers, and others) to provide financial, time, and quality-of-care impact statements for public review and comment. This activity should assess the questions outlined as follows and occur for existing and new administrative tasks:

a. *Could the requirement interfere with or enhance the ability of clinicians to provide timely and appropriate patient care (both in person and remotely, in real time and asynchronously)? What are the expected or potential opportunity costs of the requirement in terms of its effect on time spent by clinicians providing care for patients and on any time spent by patients to address the requirement?*

b. *Does the requirement improve the quality of care delivered to the individual patient and/or to the population? If so, how?*

c. *Does the requirement have a financial impact on the physician practice, provider organization, patient and his/her family, and/or the health system that diverts resources from patient care? To what extent can this impact be quantified?*

d. *Does the requirement call into question physician judgment in terms of expertise, training, education, and experience? If so, what are the reasons these questions are being raised?*

e. *Overall, can stakeholders propose alternative approaches to accomplish their goal for consideration by the public?*

The ACP believes that framing new and existing administrative requirements in this way may help all stakeholders to better identify the need for these requirements and their effect on physicians and other clinicians, practices and other health care provider organizations, and patients and their families, as well as the health care system as a whole. Tasks that are determined to have a negative effect on quality and patient care, that unnecessarily question the judgment of physicians and other clinicians, and/or that increase costs should be challenged, revised, or removed entirely. (See **Figure 2** for an illustration of this recommendation, as well as **Appendix Figures 1** and **2** for specific examples.)

As this paper describes in detail, administrative tasks are developed and implemented by various stakeholders, and each complexity is established with different goals and intents in mind. Some of these intents are valid and reasonable, and others are not; however, all these tasks may and often do result in substantial effects on the health care system; physicians; other clinicians; practices and other health care provider organizations; and, most importantly, patient outcomes and well-being. Therefore, the ACP believes that the stakeholders external to the physician practice or health care provider environment have a responsibility to provide detailed assessments of the effects of their requirements, including identifying any potential alternative approaches to meet the same goals.

2. Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved:

a. *Payers, public and private oversight entities, and vendors and suppliers must work together and actively engage with clinician societies and front-line clinicians to harmonize their administrative policies, procedures, processes, and forms regarding such issues as prior authorizations, payment reviews, reporting requirements, and others.*

b. *Payers, public and private oversight entities, and vendors and suppliers also must be fully transparent with clinicians, health care provider organizations, and patients and families about their requirements in terms of their intent, expected effect, and specific implementation approaches (as described earlier).*

i. *Any approaches by external entities imposing tasks on clinicians that are determined to be fraudulent should be addressed swiftly and appropriately by the Office of the Inspector General or other relevant entities. (For example, a "bad actor" in the DME industry knowingly uses fraudulent tactics to fill unsolicited requests for patients. These requests result in tedious and confusing processes and procedures for clinicians and their practices and may not even be appropriate for the patient.)*

ii. *Further, any administrative tasks imposed by external entities that are intended to address fraudulent activity must be designed to swiftly and appropriately prevent such fraud with the minimum possible burden on clinicians (for example, prior-authorization forms and appropriate-use criteria.)*

c. *Evidence-based approaches that clinician practices and other health care provider organizations can use to best address internal inefficiencies that are a result of external regulations and requirements should be disseminated widely by all stakeholders involved.*

The ACP believes that many issues related to administrative tasks are a result of variation in the requirements across the U.S. health care system, including among payers. On average, physicians contract with nearly a dozen or more health plans. Therefore, a common recommendation within the literature is to reduce the complexity of requirements or payment rules by creating more uniform and standard interactions with payers (both public and private), contractors, and other physicians. Cutler and colleagues (59) noted that although standardization will not solve all the problems, it is a central factor in reducing administrative costs. This effort should include standardizing the information from health plans that is available to physician practices at the time of service with regard to patient cost sharing and how the patient's financial liability varies by service (60). In addition, the Commonwealth Fund recommends integrating administrative record systems, electronic claim submissions, shared provider enrollment and credentialing systems, and common quality reporting to reduce the redundancy and complexity that increase time and staffing costs for practices and hospitals (61). Other experts have called for "more rapid progress toward the timely availability of accurate and actionable information regarding cost and coverage of health IT across the care continuum, particularly before and at the point-of-care, to support more informed and timely shared-decision making and to support prior authorization avoidance" (62). UnitedHealth Group proposes using a single standardized process for accreditation and licensing nationwide to reduce cost without compromising quality (63). In addition, such organiza-

tions as the American Medical Association and Medical Group Management Association recommend standardization of the prior-authorization process (64, 65). In reviewing CMS contractors that conduct postpayment reviews, the Government Accountability Office recognized that differences among contractors impedes efficiency and effectiveness of claims reviews by increasing administrative burden for providers. It recommends that CMS reduce differences in postpayment review requirements if it can be done without impeding the efficiency of its efforts to reduce improper payments (66). Of importance is that the ACA has led to some limited progress through provisions requiring the adoption of operating rules for each existing transaction (such as payments and remittance advice and claims status), a standard unique identifier for health plans, and standards for electronic funds transfer and electronic health care claims attachments. The law also created a new requirement for health plans to certify their compliance with the adopted standards and operating rules, as well as a new set of penalties that may be imposed on health plans for failure to comply or to certify their compliance (67).

One approach often proposed to address variation in requirements across payers and other stakeholders is the implementation of a single-payer system in the United States. The ACP supports a single-payer financing model as an option—one in which one government entity is the sole third-party payer of health care costs—because it can achieve universal access to health care without barriers based on ability to pay. "Single-payer systems generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health care expenditures, high levels of consumer and patient satisfaction, and high performance on measures of quality and access" (68). However, the ACP is aware of the limitations of a single-payer system, including potential delays in obtaining elective procedures and lack of consumer choice. Moreover, the single payer would still have to analyze the effects of its administrative requirements on quality, cost, patient care, and physician judgment transparently to fully address the many regulations clinicians face.

The ACP agrees with many approaches identified in the literature and therefore strongly recommends aligning and streamlining administrative requirements. It also calls on stakeholders to take further steps by actively engaging with clinician societies and frontline clinicians and by being fully transparent in their requirements with regard to their intent, expected effect, and specific implementation approaches.

In terms of streamlining and addressing inefficiencies in clinician practices as they work to comply with external requirements, Shipman and Sinsky (69) examined these issues in primary care today and have

worked to highlight innovative ways to address some of them. On the basis of their research, the authors concluded that inefficiency can be reduced through teamwork, workflow, technology, and a reexamination of policies. Evidence-based approaches such as these should be identified and disseminated widely by all stakeholders, including clinician societies, payers, oversight entities, vendors, suppliers, and others.

3. Stakeholders, including public and private payers, must collaborate with specialty societies, frontline clinicians, patients, and EHR vendors to aim for performance measures that minimize unnecessary clinician burden, maximize patient and family centeredness, and integrate the measurement of and reporting on performance with quality improvement and care delivery.

a. Constant monitoring of the evolving measurement system also will be critical to identifying and mitigating any potential unintended consequences, such as increased clinician burden and burnout, adverse effects on underserved populations and the clinicians who care for them, and attention being disproportionately diverted toward the things being measured to the neglect of other critically important areas that cannot be measured directly (such as empathy and humanity).

Many stakeholders have outlined approaches to ease quality-reporting requirements and measurement processes, including proposals to adopt common quality designation standards and create a single health information database for quality determination (63). Along these lines, the ACP participates in the Core Quality Measures Collaborative organized by America's Health Insurance Plans and involving public and private payers, including CMS; the National Quality Forum; the NCQA; other clinician specialty societies; employers; and consumers, with the goal of creating consistency and alignment across measures being used by both public and private payers (70). The collaborative's participants agreed on core measure sets for select areas of practice: ACO/PCMH/primary care, cardiology, gastroenterology, HIV/hepatitis C, medical oncology, obstetrics and gynecology, and orthopedics. These payers are now expected to focus their quality-reporting programs according to these measures, which might lead to reduced burden for clinicians and practices. However, the ACP strongly recommends that they not abandon their own efforts but continue to improve the measures and reporting systems they already use (1).

Of critical importance is for payers and measure developers to continue improving measures and reporting systems (including relevant health IT capabilities), particularly those used within value-based payment models, to ensure that they measure the right things; move toward clinical outcomes, patient- and family-centered measures, care coordination measures,

and measures of population health and prevention; and do not lead to unintended adverse consequences. This work should be accomplished transparently by engaging in open discussions with key stakeholders, such as practicing clinicians and patients, regarding the next steps toward building a more meaningful measure portfolio.

4. To facilitate the elimination, reduction, alignment, and streamlining of administrative tasks, all key stakeholders should collaborate in better utilizing existing health information technologies, as well as developing more innovative approaches. Restructuring digital approaches to collecting, sharing, and reporting information and responding to requests should be a top priority of key stakeholders and implemented in a manner that involves direct input from frontline clinicians and patients to ensure that these approaches are affordable and truly meet their needs.

a. All stakeholders must actively work to refocus the EHR system to ensure that its primary purpose is to support clinical care delivery. The use of EHR data collection capabilities for secondary or alternative purposes, such as for billing documentation, measure and public health reporting, regulatory compliance, and others, must be redesigned in a manner that does not distract or detract from patient care and that effectively and efficiently provides patients with access to their own information.

b. All stakeholders must work to ensure that reporting requirements are modified and standardized to take full advantage of the capabilities inherent in EHR technology. Reporting burdens would be reduced dramatically if all stakeholders agreed to use the same data and structure definitions. Decision rules could be programmed into EHR systems to eliminate the need for prior authorizations.

On the basis of the literature review, many organizations have recommended the use of technology in the health care system, such as increasing interoperability and implementing electronic payment, to help reduce administrative tasks. UnitedHealth Group has proposed that clinicians be required to receive both claims payments and remittance advices electronically. In addition, it recommends that EHRs be integrated with personal health records to make health care truly interoperable (63).

Although the original intent behind the design of EHRs was to facilitate patient management and care, the technology largely has been co-opted for other purposes. Payers see the EHR as the source of billing documentation. Health care enterprises see it as a tool for enforcing compliance with organizational directives. The legal system sees the EHR as a statement of legal facts. Public health entities see it as a way to use clini-

cians to collect their data at drastically reduced costs. Measurement entities see the EHR as a way to automate the collection of measure data, reducing their reliance on chart abstraction. Governmental entities see it as a way to observe and enforce compliance with regulations. All these impositions on EHR systems have created distractions from their potential value in supporting care delivery. Vendors of EHR systems consider it their primary responsibility to meet the requirements of all of these entities. They argue that the time required to meet all these nonclinical requirements leaves them no time to enhance the value of EHR systems for clinical care. The ability of these systems to support care delivery will not improve unless physicians and others who deliver care insist that the functions needed by clinicians and their patients take priority over nonclinical requirements.

Policymakers and other key stakeholders, therefore, should collaborate with frontline clinicians and their patients to restructure the existing technology to help streamline information and processes in our health care system. The recent ACP article "Clinical Documentation in the 21st Century" notes that EHRs must support the concept of "write once–reuse many times" and embed tags to identify the original source of information when used after its creation (6). An EHR system must allow clinicians to easily search available data during note writing and provide the option to link content from previous entities or copy and paste with appropriate tags. To the extent that the "reusability" of the collected data increases, the need to collect additional data for secondary purposes will decrease (6).

Along with other health IT, EHRs actually may become a solution to the problem of administrative burden. To make this possible, all major stakeholders must agree on and implement several changes, including using the same data elements and reporting formats; enhancing clinical decision support to replace the need for other non–real-time forms of guidance and oversight, such as prior authorization; and using shared registries to collect data from practice reports to then be queried by all agencies to meet their requirements. A major source of reporting burden is the tendency of each agency that collects data to use different data definitions and report formats. All stakeholders must be willing to accept the same clinical definitions for data elements and report formats. If they do, the technology can be programmed to generate and send reports automatically. If technologies, such as clinical decision support, are used to the full extent of their capabilities, many reporting requirements may be eliminated. For example, a physician has no reason to fill out a prior-authorization form to order a prescription or test if the payers' decision rules are embedded in the ordering system. If reporting requirements are standardized, then reports may be shared and collected into reposi-

tories. Physicians would submit one report for use by all interested stakeholders. This standardization also would dramatically reduce practice costs for data interfaces, as well as the time clinicians and their staff spend completing additional forms and reports.

5. *As the U.S. health care payment and delivery system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative requirements.*

   a. *Physicians and other clinicians who demonstrate consistency in their performance on quality, cost, and/or patient experience measures should have the opportunity to receive decreased regulatory and other oversight through transparent and streamlined exception application processes.*

   b. *Further, as physicians and other clinicians take on more innovative and evidence-based care delivery approaches (such as shared decision making, population management, and enhanced patient access) and progress along the continuum toward taking on greater financial risk tied to the health outcomes and experiences of their patients, they should be given exemptions from certain requirements that clearly are tied to the current fee-for-service system, such as prior authorizations.*

   c. *Physicians and practices identified as outliers compared with their peers, after risk adjustment based on their patient population, with regard to their billing patterns, prescribing approaches, quality and cost of care, patient experience measures, and other factors, should be provided with transparent and streamlined appeal opportunities, as well as education and practical resources to address any identified issues.*

The ACP strongly supports the shift to a value-based health care system (71) and believes that policymakers and other key stakeholders must critically evaluate the need for many administrative requirements as the health care system evolves from one based on the volume of services to one based on value, as demonstrated, for example, by the increasing movement toward measuring health outcomes and patient experience; growing implementation of the PCMH, Patient-Centered Specialty Care, and ACO delivery models; and use of shared savings and bundled payment approaches that often involve assuming financial risk. A framework for this evolution has been developed by the Health Care Payment Learning and Action Network (72). Many requirements may no longer be necessary or valid overall or for certain subsets of clinicians who are consistent performers, implement approaches to deliver innovative care, or assume greater financial risk tied to patient outcomes and experiences. Outliers should be evaluated closely, because their billing patterns and prescribing approaches may be appropriate

because of their patient populations, then be given an opportunity for meaningful consideration and provided with educational resources as needed.

CMS has begun to study and potentially address this issue through a long-term effort that "aims to reshape the physician experience by reviewing regulations and policies to minimize administrative tasks and seek other input to improve clinician satisfaction" (73). The first component of this effort is the launch of an 18-month pilot program intended to reduce medical review for certain physicians, particularly those participating in advanced APMs, while keeping program integrity intact. This initiative is encouraging and may begin to address the ACP's call for change, as stated in the aforementioned recommendation.

6. The ACP calls for rigorous research on the effect of administrative tasks on our health care system in terms of quality, time, and cost; physicians, other clinicians, their staff, and health care provider organizations; patients and family experience; and, most important, patient outcomes. Specifically, this research should begin to elucidate the overall effect in terms of quality, time, and cost to our system; the more direct effect on physicians, their practices, and other health care provider organizations; and, most important, the effect on patient outcomes and patient and family experience as a result of these tasks. This research should facilitate the ability of stakeholders to better articulate and understand the need for some requirements, to identify alternative approaches for overly burdensome administrative tasks, and to eliminate unnecessary requirements whenever possible.

A literature review indicates that clear gaps and challenges exist in the currently available research. Many articles acknowledge the difficulty of improving BIR research and the need for more intervention studies (74). In addition, the Center for American Progress determined that data are lacking regarding the time or financial effects of administrative tasks on patients (60). These studies must be done to make policymakers aware of the effect of various interventions on BIR costs, as well as to help other stakeholders to better articulate and understand the need for some requirements, identify alternative approaches for overly burdensome administrative tasks, and eliminate unnecessary requirements whenever possible.

7. The ACP calls for research on best practices to help physicians and other clinicians reduce administrative burden within their practices and organizations. All key stakeholders, including clinician societies, payers, oversight entities, vendors and suppliers, and others, should actively be involved in the dissemination of these evidence-based best practices.

Regarding research on the effects of the administrative tasks themselves, evidence-based literature is lacking on best practices to help clinicians and their practices address these burdens on a daily basis. As discussed earlier, Sinsky (23), Linzer (75), and their colleagues identified key strategies, such as developing practice models to help physicians maintain control over their workload and reduce EHR-associated stress, but more work is needed in this area. Information on best practices and practice redesign also should be incorporated in the medical education curriculum. In addition, greater effort will be required from all stakeholders to disseminate these best practices widely and provide practical advice and tools to help implement them.

Conclusion

The ACP presents a cohesive framework for analyzing administrative tasks through the lenses of sources, intents, effects, and solutions to better understand the tasks a clinician and his or her staff must complete. This framework is the backbone of ACP's policy recommendations for stakeholders outside the physician practice or health care provider environment (such as payers, governmental and other oversight organizations, and vendors and suppliers) that call for assessing each administrative requirement, regulation, or program to determine whether it should be challenged, revised, or eliminated. These recommendations also outline steps that key stakeholders can and should take to align and streamline, transparently and cohesively, the tasks that are kept in place. This guidance is particularly important as the health care system evolves from one based on volume to one based on value of services provided. The ACP also calls for meaningful collaboration to improve the development, testing, and implementation of measures and to ensure that health IT is used innovatively to streamline processes and reduce burden. In addition, although some consistency was found in the literature analysis regarding the effects of administrative tasks, much more research is needed in that area, as well as on the subject of best practices, to mitigate or reduce the burden of administrative tasks. Once defined, best practices must be disseminated widely. Excessive administrative tasks have serious adverse consequences for physicians and their patients. Stakeholders must work together to address the administrative burdens that fail to put patients first.

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Appendix Table 1. Complete List of Resources Used in Scoping Review and Environmental Scan

Literature Search Category	Specific Sources
Electronic databases	PubMed ScienceDirect SpringerLink
Journals	*Annals of Internal Medicine* *Health Affairs* *Journal of the American Medical Association* *Journal of General Internal Medicine* *New England Journal of Medicine* *Medical Care Research and Review* *Annals of Family Medicine* *American Journal of Managed Care* *American Journal of Emergency Medicine* *Journal of Graduate Medical Education* *Journal of Hospital Medicine* *Mayo Clinic Proceedings* *Journal of the American Medical Informatics Association* *Journal of Economic Perspectives* *American Journal of Medical Quality* *Family Practice Management* *Journal of the American Board of Family Medicine* *Journal of the Association of American Medical Colleges*
Government agencies	Agency for Healthcare Research and Quality Centers for Medicare & Medicaid Services Government Accountability Office
Membership associations	American Academy of Family Physicians American College of Physicians American Medical Association Medical Group Management Association Patient-Centered Primary Care Collaborative
Private and/or research organizations	Academy Health Brookings Institution Center for American Progress Center for Studying Health System Change Commonwealth Fund Health Care Payment Learning and Action Network Institute of Medicine/National Academy of Medicine Kaiser Family Foundation Mathematica Policy Research National Committee for Quality Assurance RAND Corporation UnitedHealth Group Urban Institute Health Policy Center

Task: Writing in reason for referral from specialist in primary to internal medicine subspecialists or other clinicians

Analysis based on Figure 1

Source: External–other practices and health care organizations

Additional relevant details:
Through ACP's High-Value Care Coordination Project, a collaboration between ACP's Council of Subspecialty Societies and patient advocacy groups:
Protocols were developed to promote high-quality care coordination among specialists in primary care, internal medicine subspecialists, and other clinicians.
A checklist was developed containing relevant information to include on all referral forms.

Intent: High-quality, high-value, safe, and effective services; cost reduction; and fraud prevention

Effect:

Negative: Additional physician/staff time spent filling out relevant information for referral
Positive: Improves clinical hand-off, thus improving quality of care and making care delivery by the receiving clinician more appropriate and timely, with the potential to save money by avoiding unnecessary duplication.

Solutions: Given positive effects on patient care, this task should be deemed worthwhile and should be kept; however, it should be regularly reviewed to ensure that it aligns with other tasks and the ongoing goal of minimizing burden.

Analysis based on Figure 2

☆	Yes	No
Improves quality care	X	
Timely and appropriate care	X	
Questions physician judgment		X
Negative financial effect		X

ACP = American College of Physicians.

Task: Using a physician decision support system (which in most cases is separate from the EHR) to provide payer and laboratory with advance notification of outpatient laboratary tests

Analysis based on Figure 1

Source: External–private payer

Additional relevant details:
The physician decision support system is designed to provide the payer with advance notice of outpatient laboratory tests (as well as clinical review for appropriateness) and to steer those tests to a subset of in-network labs. The ordering physician also is required to send the notification to the laboratory. If the laboratory does not receive the notification, it will not be paid for the test.

Intent: Cost and fraud reduction

Effect:

Negative: Additional physician time for BIR issues, possible delays in timely andappropriate patient care if laboratory does not receive advance notice from physician, decreased physician satisfaction

Solutions: Given the negative effects, this task should be reviewed and evaluated with careful considerations of alternatives, or eliminated entirely.

Analysis based on Figure 2

🚫	Yes	No	?
Improves quality care		X	
Timely and appropriate care		X	
Questions physician judgment	X		
Negative financial effect			X

BIR = billing and insurance-related; EHR = electronic health record.

Appendix Table 2. Summary of Literature on Billing and Insurance and Other Administrative Effects

Article Title	Time Estimates	Cost Estimates	Other Data
Saving Billions of Dollars—and Physicians' Time—by Streamlining Billing Practices (31)	4 h of professional time per physician and 5 h of practice support staff time could be saved each week; 74% of burden is time costs	12% of net patient revenue to cover costs of excessive administrative complexity	–
What Does It Cost Physician Practices to Interact With Health Insurance Plans? (32)	43 min per workday by physicians (interacting with health plans)—3 h per week, 3 wk per year; primary care physicians spent more time (3.5 h per week)	Cost of the hours per year by physicians spent on interacting with health plans—approximately $68 000	–
The (Paper)Work of Medicine: Understanding International Medical Costs (39)	–	–	2.2 administrative workers for every office-based physician (in the United States) for billing and payment
Billing and Insurance-Related Administrative Costs in United States Health Care: Synthesis of Micro-Costing Evidence (38)	–	BIR costs in 2012: $471 billion, with $70 billion in physician practices	–
The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals (36)	–	Medical groups in California spend 13.9% of total revenues on BIR costs	–
Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings From Washington State (40)	–	–	Paperwork for Medicaid was a problem for 23.6% of physicians
The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies (37)	–	Prior authorization: Annual cost per FTE physician, $2161–3430	–
US Physician Practices Versus Canadians: Spending Nearly Four Times as Much Money Interacting With Payers (33)	3.4 h per week interacting with payers in the United States (vs. 2.2 h in Canada)	Ontario physician practices spent $20 410 per year per physician compared with $82 975 in the United States Difference in time between the United States and Canada could save $27.6 billion per year	–
Peering Into the Black Box: Billing and Insurance Activities in a Medical Group (34)	35 min per day by physicians	At least $85 286 per FTE physician (10% of revenue) per year	0.67 nonclinical FTEs per physician working on billing and administrative functions
Costs of Health Care Administration in the United States and Canada (35)	13.5% of physicians' time spent on administrative tasks	Health administrative costs: $294.3 billion in 1999	–
Administrative Work Consumes One-Sixth of U.S. Physicians' Working Hours and Lowers Their Career Satisfaction (41)	Physicians spend 8.7 h per week on administration (not limited to BIR activities)	–	–

BIR = billing and insurance-related; FTE = full-time equivalent.