LETTERS TO THE EDITOR

A recent retrospective study of patients treated with antibiotics for diverticulitis at Kaiser Permanente compared outpatients managed without CT with emergency department/inpatients managed with CT. More outpatients had prior diagnoses of diverticulitis, including outpatient-managed episodes, and they had increases in 8 symptom-based somatic and 3 mental comorbidities as well as greater dispensing of antispasmodics, antianxietyotics, and serotonin receptor agonists. The somatic comorbidity that varied most between the groups was IBS, which had been diagnosed in 15.1% (2399/15,846) of outpatients vs 9.6% (361/3750) of emergency department/inpatients. Outpatients with a prior diagnosis of diverticulitis had 1.5-fold greater odds of having IBS than outpatients without this history. Although the investigators could not determine which patients had mild diverticulitis vs an exacerbation of IBS, these and other findings constitute multiple types of indirect and concordant evidence of the misattribution of IBS pain to diverticulitis.

Extrapolation of the Kaiser Permanente data to the US population reveals that a misdiagnosis rate of only 10% in clinically diagnosed outpatients would approximate 40,000 patients a year. Misdiagnosis causes much unnecessary antibiotic use and inherent cost and risk. Thus, in addition to the structural disorders discussed in the differential diagnosis of diverticulitis, practitioners should carefully consider IBS in outpatients with lower abdominal pain, bowel habit abnormality, and abdominal tenderness. Chronicity of symptoms may be a particularly helpful feature. Also, Bharucha et al described details of the physical examination that can help distinguish functional from structural disorders, but there may be uncertainty in some cases. In view of the overlap of clinical features of IBS and mild diverticulitis and recent authoritative advice that antibiotics be used selectively in patients with uncomplicated diverticulitis, management without systemic antibiotic should be considered when the diagnosis is uncertain.

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Editor’s Note: When publishing a letter that comments on an article published previously in Mayo Clinic Proceedings, it is the journal’s policy to invite the author(s) of the referenced article to publish a response. Drs Adil Bharucha and Joseph Feuerstein were invited to respond, and although they were supportive of this letter, they felt the content of the letter did not require a reply.


MACRA Regulatory Burdens and the Threat of Physician Burnout

To the Editor: The research article by Shanafelt et al regarding clerical burden and physician burnout is timely and provides much needed objective data in this arena. No doubt, for most physicians, the current electronic environment has greatly increased the clerical burden of physicians without necessarily enhancing the quality of medical care or workflow efficiency. This burden will be especially heavy for small practices that lack the administrative resources found in large health care organizations.

For example, the Meaningful Use program from the Centers for Medicare and Medicaid Services (CMS) was designed to help make electronic health records (EHRs) fully functional, enabling better coordination of care for physicians and more transparency of information for patients. However, the rollout of this program proved to be much more difficult than intended because errors and communication gaps from poorly designed EHR systems led to practice penalties despite heavy investments and best intentions toward compliance. Physicians were relegated to the role of data entry clerks when many of the measures needed for attestation for Meaningful Use required that the physician (and not clerical staff) be the one to perform all the electronic tasks.

The Physician Quality Reporting System (PQRS) is another mandate from the CMS that has added to the clerical burden of physicians. For those smaller practices that do not have the ability to have quality reporting linked to their EHRs, it is up to individual eligible health care professionals to log on to the CMS website and enter 20 cases every year to avoid a penalty. Because of the multiple hurdles on the CMS website and its propensity to freeze and lose data, a product called PQRSwizard is available for purchase as an interface between the physician and the CMS website.

The regulatory burdens faced by today’s physicians are staggering and will increase with the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA), which will merge the Meaningful Use, PQRS, and Value-Based Payment Modifier programs into an even larger, more complex program called the Merit-Based Incentive Payment System and Alternative Payment Models, to achieve the triple aim of the Affordable Care

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Act: quality outcomes, satisfied patients, and reduced cost. The American Medical Association was joined by over 100 medical societies warning the CMS of the increased regulatory burdens on physicians with implementation of MACRA as it currently stands.

It is no wonder that there has been a proliferation of consultation services available commercially to help medical practices deal with these increased regulatory burdens. Again, small medical practices can rarely afford to pay for such services and must face these regulatory hurdles on their own, forcing many physicians to either close their practices, retire early, or have their practices bought by a larger health care organization.

It is well established that physician burnout leads to decreased quality of care. It is hoped that this study will call the CMS’s attention to the fact that their numerous regulatory reporting and attestation burdens (in the effort to improve quality and reduce cost) may actually backfire and do the opposite: decrease health care quality, worsen patient satisfaction, increase costs in complying with regulations, and, as highlighted by Shanafelt et al in the current issue of the Proceedings, introduce the new burden of replacing physicians impaired by burnout.

Despite the recent release of the MACRA Final Rule, meant to ease the reporting burden on physicians, the final rule 1) does not exempt solo and small group physicians that see mostly Medicare patients in underserved areas, 2) still requires reporting of 6 quality measures and 5 EHR measures, 3) requires quality reporting on 50% of patients, and 4) requires at least a 90-day reporting period to receive a bonus. The threat of burnout persists.

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