REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-24

Subject:	Time-Limited Patient Care (Resolution 705-A-24)
Presented by:	Stephen Epstein, MD, MPP, Chair
Referred to:	Reference Committee J

At the June 2024 Annual Meeting, the House of Delegates adopted Resolution 705 (Policy D-450.951), which asks our AMA to "study the impacts of time-limited physician visits on patient care quality, patient satisfaction, and physician satisfaction." Testimony at the 2024 Annual Meeting regarding the resolution was supportive, highlighting a need to study this issue beyond primary care. The Council wishes to note that the core of physician time pressures is not an issue of coding, but rather one of arbitrary time-limits enacted as a result of insurer, administrative, and/or hospital system policies. Therefore, the following report will not focus on coding, but rather on the root causes and possible solutions for this issue. Additionally, this report covers the history of time-limited care and the impact of time limits on patients and physicians, highlights American Medical Association (AMA) advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

While time-limited physician visits are not a national standard or requirement, it is not an uncommon experience for many physicians and patients. The time limits placed on visits, typically 15-20 minutes, have largely been implemented as a result of the need to foster profitability within payment models, especially in large health care systems. When surveyed, only 14 percent of physicians indicated that they felt the time allotted for patient visits was adequate to provide patient care at the desired quality level.[1] For new patient visits, health systems allowed physicians an average of 35 minutes, yet physicians reported needing nearly 46 minutes. Similarly for established patients, physicians indicated that they were allotted an average of 20 minutes but needed close to 24 minutes to satisfactorily meet the patient's needs.[2] Physicians who work in managed care and/or health maintenance organization settings tend to experience these time pressures at an elevated level compared to physicians practicing in other settings. However, pressure to maintain time-limited visits is pervasive throughout the health care system.[2]

Time pressures are thought to be a reflection of the health care system as a whole working to treat acute conditions rather than working preventively, and research has demonstrated that it may be impacting health care disparities. Specifically, patients who are insured through private payers tend to be allotted more time for visits than beneficiaries of public insurance or the uninsured.[3] It has also been shown that Non-Hispanic Black patients had, on average, shorter visits than Non-Hispanic White patients when under the care of the same physician.[3] Additionally, patients dealing with mental health diagnoses, those with disabilities or chronic conditions, and those with limited English proficiency often need more time with their physician(s).[2,3,4] Patients who have more

complex care needs and/or are at higher risk to experience adverse social determinants of health (SDOH) need more time with physicians, and this research demonstrates that they may actually be getting less.[2,3,4]

PHYSICIAN SATISFACTION

Time-limited visits have increased likely as a result of the pressure from payers, hospital systems, and practice administrators to provide short visits, in order to maximize revenue.[2,6] Physicians who report more time pressures, or the inability to complete necessary work in the allotted time, also report decreases in their overall job satisfaction.[1,9] Additionally, strict time pressures on patient visits have been linked to increases in physician stress, burnout, job dissatisfaction, and intent to leave practice.[1,5,9] Interestingly, when physicians consciously choose to ignore the time pressures, associated job satisfaction increases, despite the potential consequences from employers or management.[9] When supported by management or systems to take the necessary time with patients, physicians report better overall personal outcomes, tend to rate their workplace more positively, and are less likely to indicate they are considering leaving practice.[1,5]

With the increase in managed care arrangements, physician pressure to limit visit length seems to be intensifying.[2,3] On average, physicians report being able to spend about 18-20 minutes per visit but are strongly encouraged by administrators to limit visit time to as short as 10 minutes. These pressures have been shown to be more intense for female physicians as opposed to their male counterparts.[5,6] Importantly, this pressure can also stem from low payment rates from insurers and force many physicians to maintain short visit lengths in order to ensure adequate payment.[3,4] Research justifies physician concerns that imposing time limits has negative impacts on patient care and workforce sustainability.

This issue is particularly well studied among primary care physicians (PCPs), as they often face extreme time pressures to maintain the financial viability of a practice or health system. Estimates indicate that PCPs would need to practice for 26.7 hours per day to meet the needs of an average patient panel and maintain financial viability.[7] While much of the research in this area is focused on primary care, there is some research that reveals that physicians across specialties are being pressured by insurers and/or administrators to limit visit length. For example, physicians in the specialties of cardiology, oncology, and urology reported spending as little as nine minutes with patients. Averages from this study indicate that the majority of subspecialists do not spend more than 24 minutes with patients, echoing the trend seen in primary care.[7,8]

PATIENT SATISFACTION & QUALITY OF CARE

Both patients and physicians are in agreement that inappropriately short visits are not just frustrating but can negatively impact patient care and the patient-physician relationship.[1,2,9] When patients feel they have their physician's attention for an adequate amount of time to address concerns, they are more likely to report satisfaction with the specific visit, as well as the physician, practice, or system.[4] This is particularly important as patient satisfaction has been linked to increases in patient willingness to attend appointments and comply with medical advice.[4] In order for physicians to be able to provide effective care, it is essential that patients are comfortable not only attending visits but following advice from their physician.

For patients without complex care needs and/or who are not impacted by SDOH, shorter visits may be appropriate, without any negative impact on quality of care or patient outcomes.[6] However, other research has shown poorer outcomes for all patients when visit time is restricted.[1,10] For example, among patients with chronic noncancer pain (CNCP), time pressures are linked to less

effective pain management, a particular problem as patients with CNCP may be prescribed opioids in lieu of taking the time to explore other pain management options.[11] Similarly, research demonstrates that shorter visits may be linked to less appropriate antibiotic prescribing practices. Due to the time limits, physicians are unable to fully discuss treatment options with patients and may be forced to rely on the "quick fix" of prescribing antibiotics.[3] As previously mentioned, increased time pressures tend to be linked to poorer quality care. This is particularly important as a lack of comprehensive preventive care may lead to higher levels of avoidable downstream health care utilization that burdens an already overwhelmed system.[6]

MANAGEMENT STRATEGIES & OPPORTUNITIES

While the issue of time pressures and its solutions are wrought with complexity, there are some strategies that physicians may utilize to help physicians cope with this stressor. Importantly, none of these strategies are able to fix the core issue of time pressures but may assist physicians in operating in their current systems or employment settings. One of these opportunities is to utilize established management principles and strategies. Research suggests that, among others, strategies like, prioritization, limiting interruptions, and the delegation of responsibilities can assist physicians and yield higher satisfaction and lower stress.[12] Additionally, physician education around cognitive-based principles like cognitive load theory and time-management inventory allowed for physicians to implement changes in their time-management and utilize time more effectively.[13] Finally, established time-management principles, like the Lean Principles,[14] can be helpful for physicians to utilize to manage time pressures. In conjunction with or addition to time-management strategies, physicians may be able to utilize tools which could include virtual scribes, medical or ambient speech recognition, and/or artificial intelligence-based assistants.[15]

In addition to tools and strategies previously mentioned, physicians may be able to utilize collaborative strategies to manage time-pressures. First, physicians could utilize population health management (PHM), a strategy that focuses on improving population health, improving patient experience, and reducing costs. PHM relies on a collaboration between physicians, or other health care providers, social services, and public health departments.[16] Research has begun to show that the utilization of PHM may not only improve patient satisfaction, but also patient outcomes and physician satisfaction.[17,18] Some research has even suggested that PHM may work to reduce health disparities.[19] A second collaboratively-based opportunity that could be utilized by physicians to manage time pressures is medical-legal partnerships (MLPs). In these partnerships, physicians, or other health care providers, work in collaboration with legal professionals to address the legal and social needs that are harming their patient's health.[19] These partnerships can be especially helpful in dealing with time-pressures as physicians caring for patients facing SDOH often report needing more time to address the litany of complex issues their patient is facing.[6] Research has demonstrated that physicians engaged in MLPs not only have partners to rely on in addressing their patient's needs, but also report higher job satisfaction. Additionally, patients treated by physicians in MLPs have shown more positive health outcomes.[20] Not only could MLPs assist in physician time-management through delegation and collaborative teamwork, but they have also been shown to improve outcomes for both patients and physicians.[20] While none of these opportunities are a guaranteed fix, nor do they address the root cause of time pressures, physicians may wish to utilize them in order to operate within the current health care system.

AMA POLICY & ADVOCACY

AMA policy supports physician autonomy, including determination of visit length. Policy H-285.969 outlines AMA efforts to ensure that physicians are able to maintain autonomy in care arrangements or settings. Policy H-70.976 monitors attempts by the third-party payers to institute

time limits on visits and discourages payers from adopting time limit policies. In addition to the policy outlining support for physician autonomy, AMA policy also highlights the importance of ensuring that physicians have the opportunity to be involved with governance structures. Specifically, Policy D-225.977 details support ensuring that employed physicians not only have autonomy, but that opportunities for them to be involved in leadership, self-governance, and partnerships are promoted.

AMA policy also advocates for reducing physician burnout and increasing physician satisfaction. Policy D-310.968 addresses the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient workflows, and regulatory oversight. Policy H-405.948 outlines the variety of factors that cause many physicians and medical students to experience burnout. Policy H-405.972 supports an accreditation program for hospitals and systems that facilitate physician well-being. Policy H-405.957 supports the implementation of programs that are aimed to identify and manage stress and burnout in physicians and medical students.

The *AMA Joy in Medicine Health System Recognition Program* utilizes tools to enable health care systems to evaluate themselves in six competency areas toward reducing physician burnout and increasing physician well-being: (1) assessment of burnout and well-being, (2) commitment to improving workforce well-being, (3) efficiency of practice environment, (4) teamwork, (5) supportive leadership, and (6) a supportive environment. Additionally, the AMA *Physician Well-Being Program* aims to raise awareness and advance change to reduce physician burnout and increase physician well-being by better understanding system-level factors associated with physician burnout and its consequences. Similar to the *Joy in Medicine Program*, it offers organizations a tool to assess the supportiveness of their environment as well as resources for improving or maintaining these efforts. Finally, the *AMA Steps Forward* program provides physicians with educational resources and solutions to address a number of topics, including burnout. These resources include playbooks, podcasts, webinars, toolkits, and real-world examples.

DISCUSSION

While a small body of research indicates that for some low-risk patients, time-limited visits may not negatively impact patient care, the majority of available research demonstrates that time-limited visits can be linked to a decrease in quality of care. Therefore, the Council recommends the adoption of new policy to support efforts to ensure that physicians are able to determine the length of patient care visits without undue influence from outside entities like payers, administrators, and health systems. Not only is it important that physicians have autonomy in the length of visits, but it is also important that those caring for patients with more complex issues or dealing with SDOH are able to incorporate these complexities into visit length. Therefore, the Council recommends the adoption of new AMA policy that supports efforts to ensure that patient complexities and SDOHs are factored into the calculations of the appropriate visit length.

In addition to the new policy, it is recommended that Policy H-70.976 be reaffirmed, as it monitors and seeks to prevent attempts by third party payers to institute time limits on visits and stresses the importance of ensuring that physicians maintain their autonomy as it pertains to determining the length of visits. Finally, in order for physicians to be able to have the autonomy and voice in visit length desired, it is essential that they are involved in the governance and leadership of their employers. Therefore, the Council recommends reaffirmation of Policy D-225.977, which supports employed physician autonomy in clinical decision-making and self-governance.

It is clear that physicians who are practicing in settings with more intense time pressures are more likely to experience burnout, dissatisfaction, and stress, along with burgeoning desire to leave

practice. While it is important to ensure that physicians are able to practice in a setting that is conducive to their staying in practice, it is particularly important in the face of a physician shortage. Therefore, the Council recommends reaffirmation of Policy H-405.957, which supports the implementation of programs that are aimed to identify and manage stress and burnout in physicians and medical students.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support efforts to ensure that physicians are able to exercise autonomy in the length of patient care visits free from undue influence from outside entities such as, but not limited to, payers, administrators, and health care systems. (New HOD Policy)

2. That our AMA support efforts to incorporate patient complexities and social determinants of health in calculating appropriate amounts of expected patient care time. (New HOD Policy)

3. That our AMA reaffirm Policy H-70.976 which monitors and seeks to prevent attempts by third-party payers to institute policies that impose time and diagnosis limits. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-225.977 that details support for employed physician involvement in self-governance and leadership. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-405.957 that describes AMA efforts to study, promote, and educate on physician well-being and to prevent physician burnout. (Reaffirm HOD Policy)

6. Rescind Policy D-450.951, as having been completed with this report. (Rescind HOD Policy)

Fiscal Note: Modest – between $1,000-$5,000.

REFERENCES

[1] 2016 Survey of America's Physicians: Practice Patterns and Perspectives. 2016. The Physician's Foundation. https://physiciansfoundation.org/wp-content/uploads/2017/12/Biennial_Physician_Survey_2016.pdf
[2] Geraghty E M, et al., 2007. Primary Care Visit Length, Quality, and Satisfaction for Standardized Patients with Depression. J Gen Intern Med 22(12):1641-7. https://doi.org/10.1007/s11606-007-0371-5
[3] Nephrash H T, et al., 2023. Association of Primary Care Visit Length with Potentially Inappropriate Prescribing. JAMA Health Forum 4(3). https://doi.org/10.1001/jamahealthforum.2023.0052
[4] Ulrich M R. 2022. Why Money is Well Spent on Time. AMA J Ethics 24(12). https://doi.org/10.1001/amajethics.2022.1155
[5] Prasad K P, et al., 2019. Time Pressure During Primary Care Office Visits: A Prospective Evaluation of Data from the Healthy Work Place Study. J Gen Intern Med 35(2):465-72. https://doi.org/10.1007/s11606-019-05343-6
[6] Swanson K M, Matulis J C, & McCoy R G. 2022. Association Between Primary Care Appointment Lengths and Subsequent Ambulatory Reassessment, Emergency Department Care, and Hospitalization: A Cohort Study. BMC Primary Care 23(29). https://doi.org/10.1186/s12875-022-01644-8
[7] Porter J, et al., 2022. Revisiting the Time Needed to Provide Adult Primary Care. J Gen Intern Med 38(1):147-55. https://doi.org/10.1007/s11606-022-07707-x
[8] Physician Compensation Report 2017. 2017. Medscape. https://www.medscape.com/slideshow/compensation-2017-overview-6008547
[9] Rabin R C. 2014. 15-Minute Doctor Visits Take a Toll on Patient-Physician Relationships. PBS News. https://www.pbs.org/newshour/health/need-15-minutes-doctors-time
[10] Linzer M, et al. 2015. The End of the 15-20 Minute Primary Care Visit. J Gen Intern Med, 30(11):1584-6. https://doi.org/10.1007/s11606-015-3341-3
[11] Satterwhite S, et al., 2019. Sources and Impact of Time Pressure on Opioid Management in the Safety-Net. J Am Board Fam Med 32:375-82. https://doi.org/10.3122/jabfm.2019.180306
[12] Brunicardi FC, Hobson FL. Time management: a review for physicians. J Natl Med Assoc. 1996;88(9):581-587.
[13] Pitre C, Pettit K, Ladd L, Chisholm C, Welch JL. Physician time management. Med Ed.2018;14:10681. https://doi.org/10.15766/mep_2374-8265.10681
[14] DoD. The Five Principles of Lean. 2017 https://theleanway.net/The-Five-Principles-of-Lean
[15] Technologies for Reducing Documentation Burden. 2024. AAFP. https://www.aafp.org/family-physician/practice-and-career/administrative-simplification/doc-burden/technologies-doc-burden.html
[16] Population Health Management. AMCP. 2019. https://www.amcp.org/concepts-managed-care-pharmacy/population-health-management
[17] Wang J, Leung L, Jackson N, et al. The association between population health management tools and clinician burnout in the United States VA primary care patient-centered medical home. BMC Prim Care. 2024;25(1):164. Published 2024 May 15. doi:10.1186/s12875-024-02410-8
[18] Schmittdiel, J.A., Gopalan, A., Lin, M.W. et al. Population Health Management for Diabetes: Health Care System-Level Approaches for Improving Quality and Addressing Disparities. Curr Diab Rep 17, 31 (2017). https://doi.org/10.1007/s11892-017-0858-3
[19] AMA J Ethics. 2024;26(8):E593-595. https://doi.org/10.1001/amajethics.2024.593
[20] Beeson T, McAllister BA, Regenstein M. Making the Case for Medical-Legal Partnerships: A Review of Evidence. 2013. National Center for Medical-Legal Partnerships, George Washington Health Policy School of Public Health and Health Services. https://www.medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf

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Policy Appendix

Corporate Investors H-160.891

1. Our American Medical Association (AMA) encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
    a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
    b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
    c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
    d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
    e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
    f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
    g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
    h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
    i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
    j. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
    k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine. (CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23)

Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding H-70.976

Our AMA (1) adopts as policy that the time element in the new Evaluation and Management codes in the CPT-4 manual may be used to assist physicians and their staffs in determining appropriate levels of coding;

(2) opposes the use of the time elements to (a) judge how many of any given type of visit may be performed in any one hour; and (b) deny or downgrade services submitted based on a cumulative time;
(3) adopts as policy that there shall be no list of diagnoses used by third party payers to compare against the Evaluation and Management codes in such a fashion as to deny, downgrade, or in any other way seek to limit the submission of any CPT-4 code visit;
(4) will monitor attempts by the third party payers to institute such time limits and diagnosis limits; and
(5) will work with third party payers to prevent them from attempting to adopt and institute policies that would impose such time and diagnosis criteria. (Res. 823, A-92; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-1; 0Reaffirmed: CMS Rep. 01, A-20)

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications. (Res. 723, A-22; Reaffirmation I-22)

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. (Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19)

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. (CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmation: A-22)

Factors Causing Burnout H-405.948
Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. (Res. 208, I-22)

Physician Independence and Self-Governance D-225.977
Our American Medical Association will continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance.
Our AMA will promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (Res. 801, I-11; Modified: BOT Rep. 6, I-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

Managed Care Education H-285.969
The AMA will continue to emphasize professionalism, patient and physician autonomy, patient and physician rights, and practical assistance to physicians as key principles to guide AMA advocacy efforts related to managed care. (Sub. Res. 707, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)