

Correspondence

Re: Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs

To the Editor: Physician burnout is a critical issue that may affect patient safety¹ and deserves appropriate attention across policy levels. The rate of reported physician burnout has increased in the past decade,² likely due, at least in part, to the advent of value based care, and the increased burden of documentation and reporting of quality metrics, for instance.

We read with interest the recent study³ that examined the association between physician burnout and the medical practices' capability to address social determinants of health (SDoH)-related barriers. We would like to offer a few additional comments that may support addressing this multipronged issue from a data and analytics perspective.

Having access to staff support to address SDoH-related challenges is important but only 1 part of the equation. For example, identifying an SDoH-related barrier is not always straightforward during the office visit. While SDoH information is now available from public resources as well as third-party commercial entities, provider-facing population health platforms reporting SDoH insights are only in their infancy. There are many reasons behind this.

Aggregating the information from public data are challenging as the information is dispersed among many resources. Its value is further limited by the fact that the data are typically available only at the group level, such as by ZIP code. However, some commercial sources do report SDoH at the individual patient level. The challenge here is the sensitivity of this information, which is sometimes perceived to be even more sensitive than health care data itself.

Even though patient privacy remains a concern, there are ways to blind the user from very detailed individual SDoH information. One very promising option is to use that data to inform predictive risk models. Such models would only report on the risk of a particular SDoH barrier (eg, transportation, housing, food, and access to care) that would impact future need for care. SDoH-informed predic-

tive models would only consume but not disclose specific and sensitive information (such as income, financial debt levels, or criminal history) to providers.

Another advantage to using SDoH-informed predictive models is to enable physicians and their support staff to gain greater actionable insights from SDoH data. For example, individual bits of data about a patient's income level or home address may not seem relevant to a patient's care and therefore become yet more data the physician needs to wade through. Conversely, when a physician sees an elevated aggregated SDoH risk score for a patient, it could encourage conversation between the patient and physician, which may lead to greater patient engagement and a physician focused more on the patient than the data.

SDoH are top of mind in US health care today, as increased awareness and policy changes could potentially help address disparities in health care, reduce overall health care costs, and ultimately improve patient health outcomes.⁴ Using appropriately aggregated data may help facilitate applicable interventions. As De Marchis et al³ argue, it is now apparent that patients are not the only ones who may benefit from data-driven social and health interventions. Physicians will benefit as well, as having access to SDoH driven insights may reduce physician burnout and help restore the joy of medicine to many practicing providers.

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs

To the Editor: We thank Ingerick and Iuga for their interest in our work on provider burnout.¹ Our findings suggested that family physicians working in clinical settings equipped to address patients' social risk factors had lower odds of reporting burnout symptoms. The results highlight an underexplored rationale for bolstering clinic-based social services: these services may decrease clinician burnout. Clinic-level strategies to collect and respond to social risk data—and the multi-level impacts of these strategies—should be the focus of future research.

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1. De Marchis EH, Knox M, Hessler D, et al. Perceived clinic capacity to address patients' social needs and family physician burnout. *J Am Board Fam Med* 2018;32:69–78.

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Re: Signs and Symptoms That Rule Out Community-Acquired Pneumonia in Outpatient Adults: A Systematic Review and Meta-Analysis

To the Editor: Dr. Marchello et al¹ make an important contribution to clinical medicine and patient care by creating evidence for how to combine key clinical findings to confidently position the possibility of pneumonia in adults further down in the differential diagnosis in patients with

acute respiratory illness. Although their findings seem to ring true from clinical experience, their clinical tool requires prospective validation per the authors.

While most family physicians currently do not have point-of-care ultrasound (POCUS), the majority will in the future. Use of pocket ultrasound is becoming common among medical students, training in family medicine residencies is increasing, and POCUS continued medical education training is very accessible. Point-of-care lung ultrasound (POCLUS) is more reliable than a chest radiograph to rule in or rule out pneumonia in adults and children.^{2,3,4,5} The author's suggested future prospective research might also include a research arm to evaluate the potential additive benefit of combining POCLUS with their clinical decision-making tool.

Respectfully submitted,

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The above letter was referred to the author of the article in question, who offers the following reply.

Response: Re: Signs and Symptoms That Rule Out Community-Acquired Pneumonia in Outpatient Adults: A Systematic Review and Meta-Analysis

To the Editor: We thank Dr. Kazal for the comment on our publication “Signs and Symptoms That Rule out Community-Acquired Pneumonia in Outpatient Adults: A Systematic Review and Meta-Analysis.”¹ Not only is lung ultrasonography a possible alternative to chest radiography (CXR) for the diagnosis of community-acquired pneumo-