Help Providers Embrace Innovation, for Their Own and Their Patients' Good

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"What's principally driving burnout ... is the efficiency of practice—it's the work, it's the workflow, it's the demands we've put on the plates of so many clinicians... The tools are not quite as sharp, yet, as they need to be."

—Steven Strongwater, MD, President and CEO of Atrius Health, in "Physicians Are Facing a Crisis," *NEJM Catalyst*, 2017

SUMMARY

To take healthcare where it must go—to fulfill the so-called Triple Aim of improving patient experience, expanding access to care, and reining in costs—the X factor, we propose, is protecting its single most precious commodity: providers' time. And, in the process, building their capacity to embrace change. To realize the Triple Aim, technological innovation is indispensable. Yet from the perspective of providers, the most far-reaching innovation to date—the move to electronic health records—has been a professional and personal catastrophe. This isn't just a perception: studies show that working excessively long hours on EHRs can negatively impact providers' health and motivation, along with the patient relationship. Understandably, this experience has made providers gun-shy of tech fixes in general. Compounding their resistance to change is a fundamentally risk-averse mentality that comes with medical training and the high stakes of the profession. Healthcare leaders belatedly recognized that the Triple Aim ignored caregivers and have outlined a fourth aim centered on provider well-being. Among many approaches proposed to address the growing crisis of burnout, workflow redesign should take precedence. Our experience in scheduling design offers insights on how clinics and practices can enhance providers' working lives and help them embrace innovations essential to healthcare's future. This is not only possible but morally imperative: when we don't utilize all available time, patients don't get timely care. Engaging providers in improving clinical efficiency will make things better for them, their organizations, *and* their patients.

PROVIDERS IN CRISIS

As has been widely reported, more than half of U.S. physicians have experienced at least one symptom of burnout. These numbers have been rising, and healthcare leaders have acknowledged that the scope of the problem threatens not just provider well-being but the industry's progress toward its ambitious goals.

Intense challenge and stress are built into medical careers, but providers are trained to cope with factors such as long hours, night calls, and high-stakes decision making. The current spike in reported burnout, say the authors of a 2017 report in *Health Affairs*,"is directly attributable to loss of control over work, increased performance measurement (quality, cost, patient experience), the increasing complexity of medical

> *"By far the biggest culprit of the mushrooming workload is the electronic medical record, or E.M.R. . . . now 'conveniently available' to log into from home. Many of my colleagues devote their weekends and evenings to the spillover work."*
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> *—Dr. Danielle Ofri, MD, New York Times*

care, the implementation of electronic health records (EHRs), and profound inefficiencies in the practice environment, all of which have altered work flows and patient interactions." In a *New York Times* op-ed from June 2019, a doctor vividly describes how she and her colleagues are trapped between their professional ethic of care and the demands of the current system. "If doctors and nurses clocked out when their paid hours were finished, the effect on patients would be calamitous," she writes. "Doctors and nurses know this, which is why they don't shirk. The system knows it, too, and takes advantage."

Dr. Ofri targets EHR burdens as the chief culprit. As the writer-physician Atul Gawande also observes, computer systems and software—which have infiltrated every corner of medicine—have the potential to improve patient outcomes on a huge scale, but by their nature are inimical to those who provide care. At least at their current stage of evolution.

The consequences are severe and wide-ranging. Many providers have been moved to reduce their commitment to clinical work, retire early, or even leave the profession—contributing to a looming shortage of primary-care providers in particular. Others just push through, coping as best they can with the strains on their health and family lives. Patients' experience of care inevitably suffers: the overly stressed and distracted doctor can't listen as well and becomes more error-prone. Fewer providers mean that patients don't get seen in a timely way, and poor experiences of care can discourage patients from seeking treatment.

Another side effect, not mentioned as often, is nonetheless critical. When people are profoundly stressed over an extended time, they go into protective mode. They close down, reduce input to the essentials (as they perceive them), push away threatening changes to their environment. It's a natural response. Imagine that a manager in a busy practice brings physicians an idea for rejiggering their workdays. Their first reaction—especially if it's a screen-based solution—is to reject it. Again, their struggles with EHR are largely to blame.

Contributing to providers' knee-jerk aversion to change is a conservative mindset instilled by their training. With so much riding on their choices, physicians are conditioned to minimize risk and stick with the tried-and-true. A Mayo Clinic survey yielded this consensus: "Physicians were deeply guided by tradition, and because they bore the responsibility for the patient's life and well-being, they were, as a group, risk-averse. . . .This conservative culture affected doctors' willingness to try not only new drugs and treatments but also new administrative procedures and educational methods."

The ambitions of the Triple Aim will be hard enough to realize; without caring for the caregivers it will be even harder. An article in Health Leaders Media demonstrates "the correlation between low staff engagement or clinician burnout and lowered patient satisfaction, poor outcomes, and higher costs." Conversely, there's every reason to believe that alleviating burnout and restoring a sense of predictability and control to the work of medical professionals will be a key strategy in pursuing the Triple Aim (some call this effort the fourth aim). As one writer put it, "Staff are much more likely to be enthusiastic and positive about securing the best outcomes for patients when they feel supported, empowered, and respected."

> *Medical institutions have tended to address the problem of physician burnout...by giving their doctors inspirational talks about 'resilience', patting them on the shoulder, and then sending them back into their deteriorating clinical lives with no material change in circumstances. Sometimes they throw in a yoga mat.*
>
> *– Peter D. Grinspoon, MD*

PRIORITIZE WORKFLOW REDESIGN

Strategies for addressing provider burnout or disengagement run the gamut from implementing team documentation to developing metrics for provider well-being. A model has emerged that targets 1) a culture of wellness, 2) the need for personal resilience, and 3) efficiency of practice. The same three factors can drive high professional fulfillment when they trend up instead of down.

It's accepted that all these factors are important. In practice, though, the burden of implementation tends to fall on the providers. A 2017 article in *NEJM Catalyst* observes that "the majority of interventions and research related to physician wellness have focused on personal resilience (e.g., mindfulness training), while organizational interventions are more difficult and are only beginning to emerge."

Though it's surely helpful to promote better self-care, it's the difficult organizational changes that will have the greatest impact. In her analysis of "5 best practices to achieve the 'quadruple aim' and prevent physician burnout in the post-EHR era," Dr. Bridget Duffy identifies as number one: *Deploy Technologies that Ease the Burden of Being a Clinician.* "The key to improving quality, safety, efficiency, and the patient experience is adopting a human-centered approach to technology that simplifies workflows and streamline processes for care teams that remove barriers to care," she writes. Atrius Health CEO Steven Strongwater is more blunt: "It's efficiency of practice … it's the workflow. …"

Efficiency of practice is defined as "the value-added clinical work accomplished divided by time and energy spent." It hinges on workplace systems, processes, and practices that help medical teams provide compassionate, evidence-based care for their patients. And raising efficiency feeds back into the other two domains: those who practice in an efficient clinical setting are more able to pursue activities that enhance personal resilience. As their well-being improves, they can better contribute to their organization's culture of wellness.

OPTIMIZE SCHEDULING

As healthcare organizations start to focus on workflow redesign, suggested interventions range from pre-visit planning and lab testing to co-locating medical teams to reduce wasted motion and time. To date, *optimizing scheduling* hasn't gotten as much attention—perhaps because it's widely perceived as an issue of patient management. However, our experience at Kairoi Health (where scheduling is our focus), indicates that **real improvement comes not from trying to change patient behavior but through exploiting persistent inefficiencies in practice systems with targeted, affordable, provider-friendly technology.**

> *Being thoughtful about technology is central to prioritizing physician and care team well-being and performance, and ensuring better care experiences for patients.*
>
> *– Bridget Duffy, MD*

Providers stand to benefit significantly from thoughtful, data-informed re-architecting of practice schedules. Physicians tend to resist changes to the structure of their workday, feeling that their schedules are already maxed-out. On paper, at the start of a day, that schedule might look full—but at the end of most days, the actual record of patients seen doesn't match the number assigned. Patient no-shows punch holes in the paper: time gaps not long enough to accomplish anything meaningful but disruptive to the doctor's rhythm. Uninformed scheduling manifests in other ways, too: at a rural New Mexico clinic, a staff physician says that schedulers "give short visits to folks who should have long visits and vice versa," which "blows up his day."

Fine-tuning scheduling at a clinic or large practice can make a big difference in smoothing out providers' days and opening up time they can use for recovery, to catch up with EHR work (instead of bringing it home), for team huddles, inbox management, or to add a 15-minute walk-in appointment.

The data analysis and schedule generation we do at KairoiHealth zeroes in on high no-show rates and how to minimize their impact. It employs techniques such as strategic capacity loading (carefully placed double booking that uses the probability of no-shows based on each clinic's historical experience), schedule compression, and optimized room use. So instead of just feeling ultra-busy and thrown off by bumps in the schedule, providers can settle into a smooth flow and be more productive—on the order of 20 to 30 percent for some clinics. Over time, this means more patients seen and helped by the practice, and a saner, more predictable workday for providers.

MAKING THE CASE FOR CHANGE

A data-informed, customizable approach to scheduling is one of many workflow redesign innovations that can improve working conditions for providers and thus move healthcare closer to achieving its big aims. But clinic and practice leaders will need to make a strong case to overcome entrenched, well-founded resistance stemming from providers' experience of "unsharp tools." They can't just say "you must change"—they must enable providers to see how the change will work to their advantage.

We offer these strategies for building greater receptivity:

*1) **Find a likely early adopter.*** What provider in your practice is best suited to lead the charge? It should be someone willing to be a key player and capable of influencing others. It's probably someone who will be personally affected by the change you propose; perhaps even someone who has been vocal about the problem. For example, says an article in ***Physicians Practice***, "if you are going to centralize scheduling and it requires all the physicians to agree, then seek the physician who is the mostly likely to have a vision for how [s/he] will benefit from the change—improved access for patients, fewer missed appointments, fewer complaints, and getting out of the office on time each night."

*2) **Produce a "test case."*** Work with your targeted early adopter to revise their schedule using (for example) a new tool such as KairoiOptimize™.

*3) **Promote the potential rewards*** of implementing an innovation. Even if the change won't directly increase a provider's compensation, a clinic- or practice-wide rise in productivity will bring in more revenue. Which in turn could enable the hiring of new staff to spread out the workload. Also, as patient outcomes improve due to the change, the organization can receive a higher rate of reimbursement, building greater financial stability. Giving providers direct feedback about achieved goals helps them understand how their contributions have improved their work lives.

*4) **Tailor the approach to the provider.*** Providers whose experience is limited to individual patients (rather than patient populations) may need more help in seeing the bigger picture and benefits of a workflow redesign. And clinic managers must account for wide variations in productivity among providers, depending on specialty and other factors. Some "specialize" in taking on difficult cases; for example, a clinician in an OB/GYN practice we worked with focused on GYN surgical patients, so she needed fewer but longer appointments in her schedule. Primary-care providers are especially taxed by EHR requirements; some may need not just schedule adjustments but enhanced tech training or time management coaching.

*5) **Appeal to buried idealism.*** Most who choose medical careers really do so from a desire to help patients, even if that sense of mission has been eroded. An article on improving EHR systems advises that, "it's important to stress the benefits of EHRs to doctors in terms of what they'll allow docs to do for their patients and not so much in terms of saving time." Remind them that increasing practice/clinic revenue translates to hiring more providers and thus makes more time available for patient care.

> *We ultimately need systems that make the right care simpler for both patients and professionals, not more complicated. And they must do so in ways that strengthen our human connections, instead of weakening them.*
>
> *– Atul Gawande, MD*

IN CONCLUSION

As we've seen, study after study shows a pervasive decline in provider engagement, linked with less satisfied patients, poorer health outcomes, lowered productivity and thus higher costs, and increased risk of medical errors—a package of troubling news that directly threatens healthcare's highest aims. Not to mention the well-being of those on the front lines of care.

A paradoxical spinoff of this trend is that providers are inclined to reject the very innovations needed to move healthcare forward. The best innovations also have potential to reduce stress and raise satisfaction for providers—but their experience with EHR systems so far makes providers skeptical of such claims. Healthcare tech innovators must develop better tools, and clinic and practice leaders must find effective ways to enlist providers in implementing them. The use of scribes to relieve doctors' burden of note-taking and restore meaningful patient contact is one such adaptation. A recent trend toward customizing medical records systems with need-specific "apps" is another.

The "X factor" remember, is safeguarding and recovering providers' time. How best to use that found time is a matter for providers and their organizations to creatively explore. Growing the organization is one use, restoring some balance to life for individual providers is another. On the highest professional level, suggest the authors of a *Scientific American* article, we must address "the dearth of time and space to think and to talk about patients, the connection with colleagues that is required to optimize care, and the inspiration required to innovate and to consider better ways to care for our patients."

Dr. John Golenski cofounded Kairoi Health in 2014 and has guided its growth and evolution from a services group to a company creating products that target the most urgent issues in healthcare. His depth of experience spans clinical services management, health policy, physician leader training, and primary care redesign. Over his long career of industry leadership, he has worked in 49 of the 50 United States, in widely varied regional medical cultures and both inpatient and outpatient settings, on key issues from benefits design to personnel management, and from patient bedsides to forums of national and international health policy. ***Read his full bio.***

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