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Institute for Healthcare Improvement

An Evolving Case Study in the Process of Policy-Driven Change in Healthcare

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Key Takeaways

The First Step – Defining an Issue & Building Awareness

- "Health worker burnout" is gaining focus as a national issue
- Burnout stems from a web of root cause variables
    - Clinical documentation administrative burden
    - Benchmarking and reporting requirements
    - Value-based care requirements
    - Cybersecurity & technology demands
    - Risk management
    - Process rigidity and lack of creativity
    - Suboptimal staffing levels and / or ratios
    - Provider training & education
    - Reimbursement incentives
    - Poor manager-clinician relationships
- Without a detailed study, the government is typically unable to rally around any issue.
    - **Prior precedent:** A report on growing complexity in healthcare coding and administration was followed by new laws issued from Congress that led to the first revision/ simplification of ambulatory E&M codes since 1992

Early Signs of Pending Change & A Prediction of What to Expect

- This is the first time in history that the federal government has dispersed funds to address the issue of physician and other health worker burnout - over $100 million was dispersed to 44 institutions.
- We now have a government blueprint with clear recommendations to alleviate this issue, which will lead to many changes taking place across our industry over the next decade.
- I learned to have patience and play the long game.

Structural Precedents for Defining Goals for Addressing Provider Burnout

- The Clinton Administration resulted in issuing an executive order, the Patient's Bill of Rights which set patient safety standards across health systems. We are looking for something similar for Clinicians.
- To me, it's about cognitive load reduction and looking outside US healthcare, the best example is how the airline industry works. Cockpits and pilot labor safeguards have been redesigned so that the pilot is protected and can focus on the task at hand without getting distracted.

Interview with Dr. Tina Shah

I am a board-certified physician in internal medicine, pulmonary and critical care. I still work in ICUs across the country. My story really starts with thinking about how I really wanted to help people but got burned out before I even finished my training. And it had gotten to the point where I was thinking, "Okay, what do you do when you have an MD and you pass your boards but you no longer want to work as a doctor?" I literally remember Googling, "What to do when you don't want to be a doctor anymore." And thankfully I stayed in the profession, but it put me on a different path to think about healthcare and how we can reconstruct it. My focus has been thinking about the most important assets we have in healthcare, which are us clinicians that work in healthcare, that touch every patient. And so really my work over the last decade has been focusing on redesigning healthcare, so that our highest value assets, our clinicians can work at the top of their game and keep everyone healthy in this country. I've been fortunate to serve on both the frontlines and within government agencies, bringing what I learned in the field to Washington D.C. As examples, during the first part of the pandemic I served as the acting CMIO at Wellstar Health System in Georgia. But I have also had the honor of serving in two White House administrations in both the Obama and Trump Administrations and was a special advisor to the Secretary of Veterans Affairs. I also served as senior advisor to the current Surgeon General, Dr. Vivek Murthy, with a focus on how to address the "great resignation" we are continuing to experience across healthcare.

What were your primary achievements and lessons learned during your experience in D.C.?

My greatest accomplishment was in helping the Federal Government plant the flag and announce that "health worker burnout" is a national issue, highlighting related issues such as the continued growth in medical errors and medical administration that deals with growing complexity and technology driven demands on clinicians. We are now at a point where clinicians spend 2 out of 5 workdays dealing with administrative burdens, the result of which is they are extending their work hours into late nights and weekends. We have introduced so many technology driven solutions, cyber security counter measures, increased benchmarking and reporting, and implemented risk management but we haven't stopped to ask who exactly is going to be responsible for inputting all this data? The answer has consistently been clinicians. But clinicians already have a full-time job taking care of patients. We haven't stopped to think about what we are doing here, it's simply not sustainable. The recent formal government declaration by the US Dept. of Health and Human Services required a lot of behind-the-scenes work and we've started the conversation on a variety of larger issues such as financial incentives, how we pay our physicians, and how we have built the industry, including a recognition of current influences, such as the growing role of telemedicine and remote patient monitoring.

Part of my role as senior advisor included finding common ground, coordinating across the many entities in federal government that can influence the healthcare workplace including CMS, OSHA, the White House, and legislators. Ultimately my work resulted in the Surgeon General releasing a lengthy advisory report on the growing issue of health worker burnout this past Summer.

We now have a government blueprint with clear recommendations to alleviate burnout in the clinical workforce, which will lead to many changes taking place across our industry over the next decade.

This is the first time in history that the federal government has dispersed funds to address the issue of physician burnout. This year over a hundred million dollars was dispersed to 44 institutions as a result of the Dr. Lorna Breen Health Care Provider Protection Act. Some of these are health systems, some are med schools, nursing schools, some are professional medical societies. And this sum of over a hundred million is 100% focused on addressing burnout and mental health issues that our healthcare workforce experiences due to their jobs.

Please describe the process of building the Surgeon General's lengthy report.

Within HHS the Office of the Surgeon General is responsible for the health and the welfare of everyone within our borders. It's a small office that relies on promoting science and using a large "flashlight" to influence, increase awareness, and promote action, for example on critical public issues like tobacco use and COVID-19. To accomplish this work, we hold round tables with tech sector leaders, the CEOs of major health systems, nurses, and doctors, and leaned on the leading researchers to define the problem and find solutions. I am a national expert on burnout and have frequently published research on the subject. I therefore came in as an SME and was the senior advisor in charge of this priority. My role involved using my connections to obtain critical information as fast as possible, bring all the stakeholders quickly to the table, and create a coordinated strategy.

What are the larger anticipated results of this high impact report?

There are of course no guarantees, but without a detailed, written strategy, the government is typically unable to rally around any issue. We are already seeing changes to reduce what causes burnout in healthcare. A good example is a report that highlighted the growing complexity in healthcare coding and administrative paperwork, which was then followed by new laws issued from Congress that then led to revisions/simplification of ambulatory E&M codes last year. This was the first extensive revision since the office coding set was introduced in 1992. Once you publish a far-reaching high impact report, you're giving every single person across every agency that cares about the issue the 'ammo' they need to go back to their sphere of influence to say, "What are we doing about this?" It rallies the troops. This report on burnout looking across the largest stakeholders will help us go from band-aids to lasting solutions to improve care delivery and reduce clinician burnout.

Part of the long game is changing the narrative in a discourse and the general understanding of what is standard practice and what is unacceptable practice?

That's right. And I think just as we've had discussions with how SCALE works, right? There's not one thing that SCALE does. SCALE finds problems and then it starts to try and solve them, whether it's on your consulting side or in your education department.

This is analogous to our government and introducing industry wide change. There are many elements, from financing, holding the tech industry and regulators accountable, giving physicians and patients a voice, and so forth.

If you recall the Clinton Administration started the patient safety movement by issuing an executive order for a Patient's Bill of Rights. We are looking for something similar for Clinicians, to set standards for health workplaces for a nurse or doctors' health and patient safety.

Is physician burnout another way of describing the concept of supply and capacity constraint? Can we solve this problem by simply creating more supply? Either through technology or a focus on how we graduate new clinicians? Foreign-based supply, immigration visas, work visas, global technology implications, telemedicine with all the different plethora of solutions that are out there?

We need to say what the standard should be and then we need to redesign the reimbursement so that we incentivize the right things. We all know what fee for service has done in our industry and there are some pitfalls and then there are some shining lights as we've gone on this value-based care journey. I'll give you an example from working as an ICU doc. One day a woman in her 70s gets admitted under my care and she is having trouble breathing because she is in an emphysema flare. As I speak to her more, I learn she was supposed to get all these treatments, but she couldn't afford her inhalers, and she couldn't go see her pulmonologist because her insurance changed. Our poor design of financing US healthcare comes into play and crowds the very thing that we set out to do, which is take care of the people in front of us.

85% of the issue is how the workplace is designed, which is why I've been fixated on making tech work for humans in healthcare because that's a lot of what's in the workplace. The data shows right now that doctors spend two-thirds of their time on paperwork, or we'll put it this way, two hours on paperwork for every one hour with patients. So do we really have a supply issue or do we have a workplace issue? We might have all the supply we need, but if we misuse the resources, the fact that we are creating a supply problem that doesn't necessarily exist before we rush to the schools and start pounding the table for transformative change there that why don't we look at ourselves, our own industry and what we are doing?

Physicians have been heavily driven by a desire to cure, to heal, to help others, but in the context of a large industry, large macro dynamics you sometimes get these unintended outcomes, where not enough has been built to create a fair and sustainable working environment.

What have you learned in dealing with and helping national physician associations that outsiders might not necessarily appreciate?

I have been highly active with the American Medical Association. Indirectly, this entity represents 99% of practicing physicians. Its membership is a little bit different, but every professional medical society, whether it's the American Urological Association or the California Medical Association, that is state and specialty medical societies, sends representatives. It has the largest influence on the hill among physician professional societies. The AMA has been a place where one physician can have a loud voice. My first year of being an active member I was able to lobby my legislators for change in Chicago. Having those one-on-one conversations with my senator and to some extent

even my mayor gave me agency to make change as a single individual. Organized medicine is fascinating. I'm also part of the American Thoracic Society, and Society of Critical Care, Medicine as a pulmonary and critical care physician.

These organizations conduct their own studies that can lead to changes in local hospital and clinic policy that keeps us at the forefront of scientific breakthroughs in treatment, for example updates in sepsis care that dramatically save lives. The second arm of it is that they're very effective in advocacy, not all, but most of them. And I think that's helpful to again, fix the regulatory and legislative burdens that we have, whether it's at the state level or the federal level. And I think the third piece is some awareness and education. And selfishly, I'm going to say these societies provide a place to gather and build community between doctors because medicine is a lonely sport. Especially if you're in private practice, we are just working so hard that it's challenging to keep up with everything that's happening both with the science and with the business of healthcare.

For some large practice groups who moved to a top of license model, doctors were increasingly burning out because they became bored and lost the variety of activities that they had before. No longer doing ultrasounds, they're no longer reviewing lab results, they're no longer doing a bunch of things that used to break up their day. Have you researched this trend of creating too much focus and efficiency?

I was VA's first national director for clinician wellbeing and most of my work was operational in the ambulatory side, particularly primary care and behavioral health. So, I have a pretty good working knowledge and I've worked as an outpatient doctor as well. There was a paper that came out of Mayo Clinic that showed us that one of the drivers of burnout is actually a lack of creativity. Even though it's high stress, high volume, there's been really good standardization of care. And that's like win, win, win for everybody. But it's been at this expense of, as you said, no longer having the variety. And so in this study, what they showed was having dedicated time to do quality improvement projects reduced burnout. This is what comes to mind for me, it's having protected time. In this case, the study had 10-20% of a physician's time protected to work on care improvement endeavors with whatever their interest was.

While the nature of work and workload varies across the physician workforce, there are some generalities we should look at to mitigate burnout as we evolve our care models. I look at this in four categories.

First is a lack of input, because doctors on the frontlines know what the issues are, we know how to fix it, but when we don't have an ability to articulate and work on it, we burn out.

Second and third are any things that reduce our ability to deliver quality or efficient care. For example, having no MA to support in the clinic, having to communicate by fax, or the MRI machine being broken when you know need it. Last, and free to solve for, is a lack of recognition of the daily heroic works for healthcare workers. These are the four main building blocks of what really drives burnout.

Do you see the topic of burnout as universal applied equally across the market or do you see pockets of higher acuity, lower acuity? Are there any positive examples of success that we can point to either a particular healthcare organization that does a good job of using technology or a precedent from another comparable industry that we can look to from a structural perspective?

Before the pandemic, 50% of docs were burnt out, the most recent statistics have risen to 62.8%. And of course, there's variation by profession. But the rate is quite high as well. In fact, for nurses in their 20s to 30s, the burnout rate is around 80%. It is a ubiquitous problem. And I think some of what is confusing is that there's a stigma attached to this. So many of my colleagues, my physician colleagues will deny that they're burnt out, due to the pervasive mentality that we should be superhuman.

The big focus for me has been thinking about cognitive load and how we reduce that. As an example, we all get notifications from our phones and smart watches, and each time we are interrupted from the task at hand and take longer to finish it. Imagine all the sources of information an average physician has to wrestle with throughout the course of one day, and the pressures of performing surgeries. We get interrupted so many times and every time we switch tasks, we lose a little bit of our "brain battery" to do the high-level thinking. It's about cognitive load reduction and looking outside US healthcare, the best example is how the airline industry works. Cockpits that have been redesigned so that when someone is flying a plane, the pilot, can focus on the task at hand and doesn't get distracted. There are safeguards for minimum hours of rest to keep pilots high functioning.

Here is what I want everyone to take away from this conversation: we know exactly how to diagnose burnout and we have treatments that are evidence-based, proven and they're doable in this current client climate with the limited resources we have. I'll give the example of the VA. When the VA staffed up all of their ambulatory clinics properly, that is a working ratio of a doctor to 1 RN and a mix of MAs and LPNs, turnover was reduced and the burnout rate of every single member in the care team reduced as well. We also saw an increase in patient experience. Addressing burnout is doable, there's evidence to back it up.

Special thanks to Dr. Tina Shah for his insights in this discussion.