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Effective teamwork is increasingly recognized as an essential tool for the creation of a safer, more patient-centered health care delivery system. The reasons for this are many, ranging from the growing complexity of medical care to greater comorbidities in aging populations to economic pressures and physician shortages. While shared responsibility—with interacting professionals practicing at the top of their training—offers many benefits, it can also result in risks due to inadequate or poor communication, unclear roles or workplace cultures that don’t promote healthy teamwork.

Research shows that team members are most engaged and effective when they’re connected to their personal mission and the vision of their organizations. This kind of engagement can positively impact patient satisfaction and business results.

In this issue of Brink, we look at multiple ways to promote healthy-functioning care teams. One message that comes through loud and clear in many of our articles is the importance of leaders—of all kinds and at all levels—in creating cultures where effective teams can flourish. As Amy Edmondson, a Harvard professor of leadership and management, notes in her book Teaming (reviewed in this issue), “The activities of teaming—taking risks, confronting failure, and crossing boundaries—are anything but natural acts in large organizations.” Leaders play an important role in creating psychological safety and promoting trust.

You’ll see how the leaders of one progressive Midwestern health care organization launched a campaign to provide its employees with tools to help create a respectful, collaborative, accountable environment.

Such environments can have a significant positive impact on clinician burnout, a problem in almost every health care organization, and one with downstream implications for patient care and safety. The business case for increasing joy, purpose and meaning in medicine can be made on all fronts: enhancing quality of care, increasing patient satisfaction and loyalty, improving clinician recruitment and retention, and reducing errors and malpractice claims.

The good news for administrators and practice leaders is that there are many ways to make things better for health care teams, from tackling workflow and documentation challenges to increasing team members’ sense of belonging by addressing implicit bias in the workplace. Optimal delegation of medical and nonmedical tasks among staff also has great potential to increase efficiency, enhance patient safety and improve job satisfaction.

Read on for ideas, practical advice and action steps you can take immediately to make your organization a more thriving, collaborative, health-promoting place, for your care teams and their patients.

Thank you for the opportunity to serve you.

Bill McDonough
President and CEO, Constellation
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CONSTELLATION, MMIC AND CRICO STRATEGIES WORK TOGETHER TO REDUCE DIAGNOSTIC ERROR

Constellation and its growing portfolio of MPL insurance companies have long believed in proactive, data-driven patient safety solutions. Since 2013, our partnership with Harvard-based CRICO Strategies has enhanced our ability to deliver clear insights and guidance that support our policyholders in fearlessly practicing good medicine.

Constellation pairs CRICO Strategies’ coding and analytic capabilities with knowledge of policyholders’ needs and concerns. This deep analysis of claim history has confirmed diagnosis-related claims as a primary area of opportunity, representative of a national issue affecting providers across multiple specialties—predominantly in the outpatient setting.

Read about preventing diagnostic error at MMICgroup.com/UMIA.com > Risk Management > Bundled Solutions > Preventing Diagnostic Error

CLAIM DATA RISK REPORTS HELP POLICYHOLDERS PREVENT PATIENT INJURY

Constellation’s data analytics team works to minimize risk by doing deep-dive analyses of claim allegations, which can help other policyholders identify common underlying factors for risk. These data-driven insights have been gathered and integrated to create risk reports for various types of organizations to help proactively manage risk.

Two risk reports are currently available on MMICgroup.com or UMIA.com > Risk Management > Bundled Solutions:
- Preventing Diagnostic Error Risk Report
- Long-Term Care Risk Report

Forthcoming reports include a Hospital Risk Report and an Advanced Practice Provider Risk Report.

Our risk and patient safety experts can work with policyholders individually to help identify risks and outline a proactive action plan to minimize risk and enhance patient/resident safety.

Learn about risk identification and patient safety solutions by contacting Patient Safety@MMICgroup.com or PatientSafety@UMIA.com or Rebecca.Tutton@ArkansasMutual.com

BRINK WINS BEST PUBLICATION AWARD

Constellation’s Brink magazine won an award earlier this year for Best Print Publication from the Minnesota Health Strategy and Communications Network. The award included our 2017 issues:
- “Improving the Diagnostic Process: Lessons from Malpractice Claims Data,” a data-filled benchmarking issue
- “The Opioid Dilemma,” which focused on this health crisis from physician, hospital and health systems perspectives
- “The Call for Telemedicine,” which highlighted the latest developments in this quickly evolving health care topic.

View these—and all—Brink magazine issues at MMICgroup.com/resources/stay-current/brink-magazine

CONSTELLATION’S CMO PUBLISHES ARTICLE ON DIAGNOSTIC ERROR

Constellation’s chief medical officer, Laurie Drill-Mellum, MD, was published in the Medical Professional Liability Association’s Inside Medical Liability magazine. Read her article, “Diagnostic Error: Impacts and Opportunities” at bit.ly/2zU5t6E.

MMIC, UMIA and Arkansas Mutual are members of Constellation, a collective of MPL insurance and partner companies offering solutions that are good for care teams and good for business.
CONSTELLATION’S PEER SUPPORT PROGRAM PROMOTES CLINICIAN WELLBEING

Shortly after a Midwest health system physician suffered through a devastating lawsuit—ultimately decided in the physician’s favor—the system’s director of risk management learned about Constellation’s Clinician Peer Support program. “Since then,” the director said, “I’ve encouraged physicians involved in difficult or particularly sad claims or lawsuits to use the service. We’ve had nothing but positive feedback. Our providers are appreciative that the peer support consultants are there if they feel the need to talk with a peer who understands what they’re going through.”

The program is offered by Constellation insurance companies to physicians and other care providers who have experienced adverse medical events or are named in a lawsuit. Peer support can be key to helping clinicians maintain emotional wellbeing and physical health throughout the process. With positive reviews from both physicians and administrators, the service is now introduced when claim consultants first meet with clinicians facing legal action.

“We strongly urge clinicians to use it,” said Dawn Domsten, the MMIC claim consultant who worked with the health system. “We tell them that talking with a peer can help them manage their emotions so they can better assist their defense and continue to serve their patients effectively.”

Once introduced to an assigned peer support consultant from a team of experienced physician leaders, clinicians may call at any time—when and how often they talk is the clinician’s decision. “Sometimes they begin talking with a consultant right away,” Domsten said. “Other times they wait to see if the claim will go into formal litigation. Some clinicians don’t believe they’ll need emotional support, but as the trial begins and pressure builds, they’re glad to have the ability to talk with another professional who can relate to their concerns.”

Another of the health system’s physicians, a surgeon facing a lawsuit charging negligence, welcomed phone discussions with a consultant. Like many who use the service, the physician found the discussions especially helpful during high-stress periods, such as before and after the deposition and before the trial.

Following the jury’s defense verdict, the surgeon reflected on the program. “There’s a temptation to respond negatively—maybe you become suspicious of every patient or even think of quitting practice,” he said. “Talking with a peer can help you realize that there’s a bigger picture to your life and practice, and this is just one part of it. It allows you to be able to say, ‘I will not allow this to ruin all that I am involved in.’”

WHAT’S GOOD FOR CLINICIANS IS GOOD FOR BUSINESS

When clinicians are supported in managing their emotional wellbeing, they’re more likely to:
✓ Continue to be focused, productive members of the care team
✓ Remain with the practice instead of pursuing other employment or retiring early, saving the organization both time and money to recruit and onboard a replacement
✓ Maintain a healthy trust in their patients—key to relationships that are foundational to patient satisfaction
✓ Avoid future claim, saving the organization further financial and reputational risks (claim data show that physicians named in a claim are three times more likely to face another claim in the next two years.)

To learn more, read Minnpost’s “Physicians, heal thyself: Peer support reduces errors, improves practitioner mental health” at bit.ly/2Ekhq6O
Factor of Me

What we bring to our teams as individuals matters.

By Betty VanWoert, RN, BSN, CCM, CPHRM
Individuals. Teams are made of them. So it follows that each person’s ability to manage their own performance, each day, is every bit as essential to how a team functions as developing communication skills is essential to collaboration.

There is, in a manner of speaking, an “I” in team.

As individuals, we’re responsible for assessing and managing the attributes we bring to work each day. Called “human performance factors,” these attributes direct our actions and can help—or hinder—our ability to meet team goals and expectations. They include our state of being, our fitness for duty and our preparedness to focus on the tasks before us.

Day-to-day service in health care can fluctuate from long periods of routine, redundant activity to sudden bursts of complex activities requiring intense focus. Precursors of human error, like fatigue, inattention, distraction and personal stress affect our performance factors and can interfere with our ability to reliably respond to any situation.

But we’re not without resources. Performance monitoring and mutual support are assistive tools that can help when we’re able to work but aren’t at our personal best.

Performance monitoring

We’re human. We sometimes forget things, have relatively short attention spans and don’t perform well when we’re tired. As such, it’s important to self-monitor and manage our performance factors. Questions like, “Am I in my best place to give care today?” or, “What adjustments can I make to be my best today?” can be useful in helping us identify what’s interfering with being our best selves.

The following are things we should actively monitor; they can influence our ability to effectively plan, solve problems and perform consistently and reliably:

- **Fatigue:** It’s well documented that the human body must rest. Every hour of sleep we lose contributes to a “sleep debt.” Restorative sleep is required, and sleep debt must be repaid. For optimal function, we need seven to nine hours of sleep daily. If we’re tired, we’re less likely to recognize our level of fatigue, fuzzy thinking or irritability—not to mention the long-term risks for diabetes, heart disease, stroke and memory loss. Life happens. That’s why developing a strategy to get adequate sleep and chip away at accumulated sleep debt is important.

- **Stress:** Stress has been described as a plague on our society, and the Occupational Safety and Health Administration includes it as a workplace hazard. Keeping stress at bay or compartmentalized can be challenging. Consider individuals who are concerned about an ill loved one or caring for an elder parent. Understandably, some stressors simply cannot—or will not—be pushed aside. Employee Assistance Programs and personal leave policies may help. And, sometimes, allowing individuals to fully attend to their immediate situations may best serve team functioning.

- **Resilience:** Health care work frequently requires coping with some of the most heart-wrenching and stressful situations. Adaptability and resilience to unexpected events gives us the ability to positively adjust—and even thrive—under conditions of adversity. The resilience and wellbeing of individual workers can be a leading indicator of the overall health of the workplace. Team members who model work-life balance and support others in finding meaning in their daily work create a work experience where co-workers flourish rather than burn out. (See Resources, below, for wellbeing and resilience assessments and tools.)

- **Openness to support:** In a resilient workplace, backup can come from teammates who understand without necessarily knowing the specifics that we’re not at our best. They may offer support. Take it. Asking for help and knowing when to ask for help are skills we can cultivate, too. Support goes both ways, so openness to support means the converse as well—being open to supporting teammates.

Fear and lack of trust create the risk of not identifying errors and mitigating their consequences—especially relevant in health care, where team members sensing psychological safety are more likely to report adverse conditions or events.
Mutual support
Sometimes, our co-workers seem better able to recognize our human frailty than we are! When we’re able to work but aren’t at our personal best, that’s where mutual support makes an important difference. But in order to manage our performance effectively, we need to be able to recognize when we need help and ask for it.

Recognizing we need support and asking for backup from colleagues takes trust and psychological safety, a concept first introduced by organizational behavioral scientist Amy Edmondson to describe a work climate characterized by interpersonal trust and mutual respect. “Simply put,” Edmondson says, “psychological safety makes it possible to give tough feedback and have difficult conversations without the need to tiptoe around the truth. In psychologically safe environments, people believe … that others will not resent or humiliate them when they ask for help or information.”

Fear and lack of trust create the risk of not identifying errors and mitigating their consequences. This is especially relevant in health care, where team members sensing psychological safety are more likely to report adverse conditions or events. In fact, psychological safety is critical to decreasing the occurrence of adverse events, but rarely do we find addressing psychological safety on a list of action items following an event investigation.

The leader’s role
Not surprisingly, leaders play an important role in creating psychological safety and promoting trust among teams. Telling health care workers and practitioners, “Do better!” or, “Don’t make mistakes!” isn’t an effective strategy. Education is even considered to be a somewhat weaker response to event investigation findings, at least in part because it depends on human memory.

Leaders can foster psychological safety by promoting respect and active listening, and encouraging team members to speak up. Learning, personal engagement and truly collaborative team performance are possible only when every member of the team feels safe.

Effective leaders build effective teams by modeling personal responsibility and authentic concern for each person on the team. Creating and sustaining a sense of trust and mutual support, in turn, will positively impact safe, effective patient and resident care.

Each of us factors in
Team trust requires everyone to reflect on their own attitude and actions. It requires us to be accountable for assessing our preparedness to perform the tasks required of us. And, it requires us to value others’ contributions and seek to understand and respect—not judge—the lives of those with whom we work closely every day.

Monitoring ourselves, supporting each other, working together, leading by example—these actions daily will strengthen us as individuals, build stronger teams and lead to a better work environment and better patient outcomes.

Each of us can and does make a difference: for ourselves, for the team and for the organization.

References

Resources
The Wellbeing Center has assessment tools and resources for health care professionals and organizations to combat burnout and improve resilience at MMICgroup.com or UMIA.com: Login > Risk Management > Tools and Resources/Wellbeing Center.

Modeling personal responsibility
Leaders can model respect, civility, transparency and personal responsibility so that individuals across an organization understand what’s expected of them in order to contribute to a safe, joyful workplace. Here are some ways to model personal responsibility:

- Take care of personal wellness, health and resilience.
- Commit to self-improvement.
- Focus on contributing to the mission, vision and values of the organization.
- Be responsible and respectful in all interactions with others.
- Speak up with ideas, concerns and questions.
- Encourage others to speak up.

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Culturally Speaking

CentraCare Health’s organization-wide culture campaign effects positive change for individuals, teams and patients.

By Liz Lacey-Gotz
“Team-based care—that we talk to each other, that we collaborate, that we have a lot of partners working together—that’s what best for our patients and for us, too.”

When Ken Holmen, MD, was named CEO of CentraCare Health in 2015, he saw an opportunity. The organization was growing, the industry was experiencing dynamic and at times disruptive change, and the needs of the communities CentraCare serves were evolving. “Health care is a business, but it is fundamentally about people,” says Dr. Holmen. “Our goal is to create a culture that supports people—our patients, families, employees and our communities.”

So in January 2016, the organization began its culture journey. Called “Our Best Begins with Me,” it’s rooted in the idea that in order for the organization to be its best, every employee needs to be at their individual best. “Change starts with each one of us,” Dr. Holmen says. “More top-down management is not the solution. Rather, a common commitment to be our best, together, will make us a better organization. And while we support our employees on this journey, we’re also working to identify our shared purpose across geographies that unify us.”

Everyone must be a leader
The culture effort began with senior leaders but is based on the idea that, in order to manage the complexity of what CentraCare does, everyone in the organization must also be a leader.

“If you want to have a really strong culture, everybody needs to be a part of that,” says Alan Olson, MD, a family practice physician and one of several employee-facilitators trained to implement culture workshops for groups of 25 to 35. More than 11,000 of CentraCare’s 12,244 employees have undergone the two-day training since 2016. “Part of my responsibility,” Dr. Olson continues, “is to be an example of trying to live the culture, live the practice, and use the tools we give people to help them. We talk about casting a ‘positive shadow’ for others.”

Facilitators come from all professions and roles within CentraCare, again reflecting the foundational concept that everyone brings something to the table and that the collective effort of every person is needed for positive change. “To be collaborative and truly effective requires respect for others. It requires good communication. We need to stop and listen to others and hear their viewpoints,” says Dr. Olson. “In the end, that improves our ability to care for people, and it improves the safety of the organization.”

As part of the shift toward employee leadership, more advanced practice providers (APPs) have assumed leadership roles. Bobbie Bertram, MBA, APRN, CNP, clinical lead for the specialty care division and an APP leader for the culture effort, is impressed with progress so far. APP satisfaction is up significantly on surveys, and the turnover rate for APPs is lower than the national average. “Really, it comes down to collaboration. It’s not about a piece of paper or license,” says Bertram. “Team-based care—that we talk to each other, that we collaborate, that we have a lot of partners working together—that’s what best for our patients and for us, too.”

Many new initiatives have grown from the conversations employees have had with leaders, including a gender clinic for the LGBTQ+ community and outreach programs for Somali and other immigrant and minority populations.

It starts with the individual
The culture effort is centered on principles that help individuals to be better people, in all realms of their lives. Workshop exercises are based on ideas from the consulting firm Senn Delaney, including “Be here now,” “Accountability,” “Positive intent” and “Know your mood.”

In an industry undergoing disruption and incredible challenge, the culture effort attempts to minimize the stress that comes from simple misunderstandings. “If you assume positive intent, you’re going to get positive intent back. So cultures kind of build on themselves,” explains Tom Schrup, MD, physician champion for the culture work. “If you start asking questions, you usually find that what someone else did makes sense. If you approach it from judgment and negativity you tend to get that back.”

So how does centering on the individual help to support care team operations and efficiency? Dr. Schrup says, “It’s changed the way we have conversations. Not only do the patients benefit, but the physicians and other employees benefit from avoiding wasted negative energy that was the result of misunderstandings.”
Dr. Holmen recognizes that teamwork is important, and also notes that, “Teams are made up of individuals, and at the end of the day, individuals have to be accountable.”

A powerful, positive shift
A culture journey is a long-term engagement, according to Dr. Holmen. That said, he sees it already having a significant effect on CentraCare employees and their community.

The campaign’s positivity is infectious. “People are sharing their stories—how the workshop and the culture effort has impacted them both personally and professionally, how they’ve changed as a person,” says Stephanie Lang, program director for the overall culture effort.

“Ultimately, it’s about the customer experience, and we’re all customers to each other—employee to employee, and employee to patient,” Lang continues. “One of our concepts, ‘Be here now,’ is grounded in listening and skills we can work on as a whole system that will increase our listening skills—things like making eye contact, looking directly at someone or stopping to talk with someone.”

Dr. Olson agrees things are changing. “We’re more conscious of being team players. At one time there was an attitude of, ‘I’m the doctor and what can you do to support me in my practice?’ instead of ‘What can we do as a team to support our patients?’ In one of my workshops, a new employee said to me, ‘You know, I noticed right away there was something really different about the atmosphere, the way people speak to each other, the way they think about things … and I like what I see.’”

Building resilience, together
With all the positivity, CentraCare leaders recognize it’s not simply as easy as changing the way employees think. They’re also addressing burnout using multiple models to redesign their care and, according to Dr. Schrup, “remove pebbles from people’s shoes—the annoyances that distract us from the love of medicine.”

And burnout is not just an issue for physicians. “Burnout in health care is blind to who you are: there’s management burnout, there’s nurse burnout, there’s physician burnout, there’s APP burnout,” says Dr. Holmen. “Our biggest challenge is that the business is changing so fast, and the market drivers are big, strong, powerful and fast—like swimming in the Mississippi river.”

But this doesn’t mean the culture efforts don’t affect resilience and wellbeing. “The culture work helps with internal resilience because challenges are going to happen, and the concepts help us to reframe our thinking in such a way that it takes less energy,” says Dr. Schrup. “So we work together on what we can do to minimize the impact of external forces, while not dwelling on things that we cannot change.”

A bright future
While only two years into their efforts, CentraCare is optimistic that the culture work will effect broad-based, long-term changes that will help them retain top talent, build resilience, minimize stress despite change and better serve their patients and communities.

“I’ve been at CentraCare for 10 years, and I’ve seen people in difficult situations come together more as a team, support each other, and assume positive intent,” says Lang. “All of this impacts the results we get and how we approach our growth and the opportunities that come with change.”

Dr. Holmen agrees. “It’s been a neat thing to see people who were somewhat adversarial or in the past disagreed, and are now saying, ‘Okay, we can get past this.’ I can see levels of interaction throughout our organization and the positive impact that comes from a unifying culture that is patient- and family-centered.”

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A creative campaign was developed to reinforce workshop concepts. Tactics included posters, floor graphics, screensavers, a microsite, Facebook page, employee newsletter and daily email inspirations.
The ratio of physicians to patients is out of balance and projected to get worse: More are leaving the profession than are entering. Among the causes of the shortage is physician burnout, the rate of which is 54 percent, compared to 29 percent in the general population.¹
Are Physicians an Endangered Species?

What leaders can do now to retain existing physicians and plan for recruiting.

By Anne Geske

Physicians are the fulcrum of our health care system, according to Merritt Hawkins, the leading physician recruitment company in the United States. They handle over 1.2 billion patient visits a year, generate $1.6 trillion in economic output collectively—and each physician’s workload is estimated to support up to 14 jobs.

“Doctors are job creators,” says Nathan Piller, director of marketing at Merritt Hawkins. “When we add a physician to an organization, that’s creating jobs. Each physician sees an average of 20 to 30 patients per day, has multiple exam rooms with a nurse or other clinician for each room and several schedulers.”

Physicians are great for the economy and essential for patients. So, why aren’t there enough of them?

Supply and demand
Simple supply and demand, for one thing. There are more people in the United States, yet the number of physicians has remained relatively static over the past couple decades.

Then there’s the aging population. Between 8,000 and 10,000 Americans turn 65 every day, says Piller. Their care needs are more complex, requiring more time and attention. Many older patients have multiple chronic conditions like diabetes and COPD, and they access health care two to three times more than others.

Physicians are aging, too, just like the rest of the population. One-third of active doctors will be 65 or older in the next 10 years.1 By 2030, the shortage of physicians is projected to be up to 121,300, while the 65-and-older general population is projected to grow by 50 percent.3

Medical schools have tried to help, increasing enrollment by 30 percent in the past decade. But there’s been no proportionate increase in physician training positions due to the Balanced Budget Act of 1997, which limits Medicare payments to teaching hospitals for residencies and fellowships. “There are only 26,000 to 27,000 new medical graduates every year—that’s for all specialties,” states Piller.

Our nation’s pipeline of new grads is limited and therefore insufficient to meet the projected needs of our population.

Burnout negatively impacts quality of care, patient safety, patient satisfaction and productivity.

Burnout
Negatively impacts quality of care, patient safety, patient satisfaction and productivity.

Another important factor is burnout, which plays a significant role in physicians deciding to retire early or go locum tenens.4 Burnout is a public health crisis—for physicians, for patients...
and for health care organizations. This is true not just because of patients’ access to physicians, but also because of the effect burnout has on patient safety and satisfaction:

- Burnout negatively impacts quality of care, patient safety, patient satisfaction and productivity. Each one-point increase in burnout correlates with a 3–10 percent increase in the likelihood of physicians reporting major medical errors.\(^5\)
- Burnout has a substantial effect on health care quality and safety. In studies of more than 7,100 U.S. surgeons, major medical errors were strongly related to the surgeon’s degree of burnout.\(^6\)

Health care delivery is undergoing significant transformation, according to Laurie Drill-Mellum, MD, chief medical officer of Constellation. “Part of it is the industry’s attempts to address the physician shortage; part is due to attempts to decrease the cost of providing health care,” says Dr. Drill-Mellum. “But changes in care delivery include what a care visit even looks like. We’re seeing an evolution of multi-disciplinary care teams, work-flow redesign, and virtual health care delivery models—among other things.”

Dr. Drill-Mellum recognizes that these evolving models of care can decrease cost as well as increase access and efficiencies. But the transformation of health care will not be without ripple effects on patient safety. “A lot of care is being provided by people who don’t have the same amount of training and education as physicians,” she says. “Add to that problems getting information communicated between disparate models, and we’re anticipating there will be inherent risks in these new models of care.”

**The cost of replacing physicians**

Burnout is costly not only in terms of its effect on patient safety, but also in terms of replacing physicians who leave or go part-time. A departure can mean lost revenue, workplace disruption and overwork among care teams. It can also mean disruption for patients—sometimes even disruption of an entire community, depending on its size.

The monetary cost of replacing a physician is estimated to be between $500,000 and $1.5 million.\(^5\)

Costs are creeping up for salaries as well. “If you guarantee a $250,000 salary—about the national average—it’s hard to make that up in the clinic,” says Piller. “That’s why systems are employing physicians all under one roof—they combine their hospitals with clinics to make up the costs.” Five years ago, the average family medicine physician’s salary was $190,000. That number is now over $230,000.\(^2\)

What’s more, physicians entering the profession are now subspecializing more and working fewer hours than the previous generation, according to Piller, leading to a reduction in the provider workforce output. “The old days of providers working 60-plus hours a week are becoming a thing of the past,” he says.

**Keep the ones you have**

Organizations can’t afford to lose physicians to burnout, something over which there is a measure of control.

For instance, the two biggest drivers of burnout are loss of clinical autonomy and organization-level factors. Autonomy is related to physicians’ ability to make what they believe are the best decisions for patients, and it’s increasingly being undercut by third parties and bureaucratic requirements.\(^4\) Organization-level factors are things like high workloads and inefficiencies related to the design and implementation of electronic health records (EHRs). Other factors are loss of meaning in work, social isolation at work, and a cultural shift from health values to corporate values.\(^5\)

Fortunately, effectively addressing the drivers of burnout are the same efforts that will retain existing physicians and attract new ones (see page 13). The AMA’s robust STEPS Forward website is an excellent place to start.

And change is afoot. “A consensus is developing that health systems, clinics and hospitals need to direct their energies toward three main areas to effectively address burnout,” states Dr. Drill-Mellum. “They are: organizational culture, efficiency in the work environment and supporting individual resiliency skills.”

For more steps your organization can take to decrease burnout and increase joy in medicine, read an interview with Dr. Christine Sinsky, the AMA’s vice president of professional satisfaction, page 15.

**References**


**Resource**

AMA STEPS Forward Practice Improvement Strategies. stepsforward.org/

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**ANNE GESKE**

Managing Editor, Brink
Six steps to attracting top talent

Attracting physicians is a competitive business. The number of candidates is limited—each one interviewing at upward of five to 10 places, says Nathan Piller, director of marketing at Merritt Hawkins. This makes the recruiting process longer, increasing costs.

The good news is that it’s not just about compensation or geography. “Not everyone has beaches and mountains, so focus on the primacy of the workplace. The culture, work-life balance and professional autonomy are quality-of-life issues. So have everything nailed down in terms of culture. Be proud and excited about where your organization is going, and be able to talk about clinic and physician leaders.”

Piller offers proactive steps for leaders to make their organization as attractive as possible to candidates:

1. **Recruit proactively, not reactively.**
   Find out what the average age of your physician team is, broken down by specialty. Plan, because it takes time to find physicians.

2. **Assess and analyze your data.** Physicians are scientists in their own right; they like data. So, analyze workflows, EHR stats, average visits per physician, Affordable Care Act factors, patient satisfaction, how you measure quality. Be able to show how you’re doing as an organization—and that you’re working to solve workflow and EHR issues.

3. **Create a rock-solid recruitment plan.**
   Day-to-day details matter, such as alleviating the number of calls, timely lab test turnarounds and a friendly staff. Start by surveying your current medical team to find areas for improvement.

4. **Articulate your vision.** Using your organization’s data, craft your vision and be able to articulate it well. What’s your strategic plan? What population health initiatives do you have for patients? What about work-life balance and joy in medicine?

5. **Promote engaged physician and clinic leadership.** Physicians want to have a voice. Candidates ask about their ability to have a say in how they run their practice, so having an effective physician leadership team is important.

6. **Make connections.** Designate clinic and physician leaders who can take an active role in forming connections with new grads or external physicians. Having physician leaders convey this promotes the organization and the direction the medical team is going.
The High Cost of **Burnout**

**Over HALF** of U.S. physicians are now experiencing professional **burnout**²

**Burnout negatively impacts quality of care, patient safety, patient satisfaction and productivity**³

The cost to replace a physician is between **$500K** and **$1.5M** or 2-3 times their annual salary³

**Burn•out** (noun) a work-related syndrome involving emotional exhaustion, depersonalization and a sense of reduced personal accomplishment²

**By 2030, the shortage of physicians** is projected to be **up to 121,300**, while the 65-and-older patient population is projected to grow by **50 percent**⁴

**Buried in Paperwork** Physicians spend almost half their day on the EHR and desk work; even during the patient visit, 37 percent of time in the room is spent on these tasks⁵

**Joy in work** improves patient experience, outcomes, and safety, resulting in **substantially lower costs**⁶

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Joy to the Work

When physicians thrive, so will business metrics.

An interview with Dr. Christine Sinsky

Physician wellbeing has direct implications for patients, says Christine Sinsky, MD.
But the absence of burnout is not enough—the goal is joy in work.
When clinicians can reconnect with their mission, not only is meaning and purpose restored, patient outcomes improve as well.
Christine Sinsky, MD, serves as vice president, professional satisfaction, at the American Medical Association (AMA). She also practices as a general internist at Medical Associates Clinic in Dubuque, IA. Dr. Sinsky has authored and co-authored many journal articles and studies on the subjects of joy in medicine and physician burnout.

**BRINK**: Why is joy in medicine so important?
**Dr. Christine Sinsky**: We intuitively understand as patients that we will receive better care when our physicians feel they are spending their days doing meaningful work for us. We also understand that if our physicians are despairing because of the chaotic or unsatisfying environment in which they work that our care won’t be as good as it could be. The bottom line is that physician wellbeing has direct implications for patients. We have a lot of data that support that notion. When physicians are not burned out, mistakes are fewer, quality metrics are achieved at a higher rate and malpractice rates are lower.

**BRINK**: Does less burnout equal more joy?
**CS**: The absence of burnout is not enough. The goal is to get to **thriving**. We believe that patient care is better if team members can connect daily with their mission, with why they chose their profession in the first place. One of my professional goals at the AMA is to help create the conditions where joy, purpose and meaning are possible. This is also a very worthy goal for administrators and leaders; in fact, working toward this goal may be one of the fastest ways leaders can achieve many of their other goals—patient satisfaction, financial viability, good outcomes and a good patient safety environment.

**BRINK**: How do we reduce burnout and make space for joy?
**CS**: Improving workflow is the most powerful intervention to reduce burnout. Improving workflow creates time for physicians and other health professionals to reconnect with the reasons they chose their professions and with their families. It is my observation that most practices can save three to five hours [per physician] per day by re-engineering the way the work is done—eliminating work that doesn’t add value to the patient and strategically distributing work among the team according to ability. Physicians can give an hour of that time to providing more access for patients, an hour to the practice to further improve processes and an hour to their families. Improving workflow can be a win for all.

**BRINK**: How do we make the business case for increasing joy, purpose and meaning in medicine?
**CS**: One can make the case for investing in workforce wellbeing on many fronts—improved quality, patient experience, patient loyalty, physician recruitment and retention, along with reduced errors and malpractice claims. All have financial repercussions for an organization. At the AMA, we put together a calculator that allows organizations to understand what burnout is already costing them in terms of replacing physicians who leave because of it. The calculator is pre-populated with national rates of burnout and turnover, and the cost per physician. The cost of replacement per physician is estimated to be
between $500,000 and $1.3 million; we went conservative and pre-populated with $500,000. Organizations can put their own numbers in. A group of 100 physicians is already spending over a million dollars every year replacing physicians who leave their organization because of burnout. This doesn’t include the cost of replacing physicians who leave for other reasons, nor does it include the costs of physicians who reduce their clinical effort to part time as a coping mechanism for burnout.

**BRINK: What do we know about physicians moving to part-time work?**

**CS:** Some physicians compensate for burnout by pushing the only lever available to them—cutting back on their official work hours. As the volume of “work after work” (i.e., visit note documentation, managing the inbox) expands, some physicians have gone down to part time. Now they’re working 50 to 60 hours a week instead of 70 to 80 hours a week, but they’re only getting paid 75 percent time. In fact, many physicians across the country are being paid part time but working full-time work hours. As the volume of “work after work” (i.e., visit note documentation, managing the inbox) expands, some physicians have gone down to part time. Now they’re working 50 to 60 hours a week instead of 70 to 80 hours a week, but they’re only getting paid 75 percent time. In fact, many physicians across the country are being paid part time but working full-time work hours because that was the only way they could cope with the increased workload and preserve time for their families. That’s costly to organizations; it’s also costly to individuals.

**BRINK: How do patients experience the electronic health record (EHR) documentation model?**

**CS:** The MD Anderson Cancer Center at the University of Texas in Houston did an interesting study where cancer patients were shown videos clips of doctor-patient interactions. The patients rated the physicians in the videos as having more compassion, more advanced communication skills and more professionalism if the physician interacted with the patient without the computer present. The EHR has been a major driver not only of physician dissatisfaction but also of patient dissatisfaction regarding communication with their physician.

**BRINK: How do you use the EHR in your own practice?**

**CS:** We have an advanced model of teamwork, including team documentation. One of my nurses is in the room with me for each patient; we provide the care for the patient together. I review the patient’s record in the EHR before entering the room, but I don’t routinely interact with the EHR during the patient encounter, allowing me to give my undivided attention to the patient. If I need an additional data point, my nurse is able to pull that for me. I’ll look over her shoulder and review the test results or the trend and bring the patient into that conversation. I’m not doing data entry and data retrieval while with the patient.

**BRINK: Is it possible for an organization to turn things around quickly?**

**CS:** My belief is that the most powerful intervention an organization or care team can implement is advanced team-based care with team documentation. The University of Colorado Department of Family Medicine reduced burnout among their faculty from 53 percent to 13 percent in one year by implementing a similar advanced model of care.

**BRINK: What tools are available for organizations to implement team support in their own EHR process?**

**CS:** The most effective means of addressing burnout is to improve workflow and efficiency. On the AMA STEPS Forward home page, there is an assessment tool that helps practices self-assess their current state for key workflows. Most practices will find that there are major opportunities to improve workflow and efficiency, thereby shortening the workday. There are 50 practice transformation toolkits freely available to all at stepsforward.org. The brief, 10-question assessment helps direct practices to the particular modules they may want to start with.

**BRINK: What actions can CEOs and administrators take to assess their organizations and make changes?**

**CS:** First, measure the rates of burnout in your organization, and do it transparently. Tell the workforce that you’re measuring physician or clinician burnout—that you’re working on it. Just letting the faculty and staff know that they’re part of an effort to reduce burnout is important. I would also advise leaders to look at the series of commitments fellow CEOs have publicly made, and pattern after that. In 2016, we brought together 11 CEOs from the largest organizations across the country for the first-ever CEO consortium on joy in medicine. Out of that came the Health Affairs blog post, “Physician Burnout Is a Public Health Crisis: A Message to Our Fellow Health Care CEOs.” These CEOs publicly committed to regularly measuring and responding to burnout, tracking its cost and reducing it. The steps outlined in this blog post may serve as a roadmap for organizations.

**BRINK: What can clinicians do to create the conditions for joy, purpose and meaning in work?**

**CS:** Physicians and other health professionals can adopt a mindset of continuous improvement of workflow processes and teamwork. Invest time and energy in knowing each other—developing trust and reliance over time. In addition, when a process is broken, make note of it, bring it to the team meeting and work together to create a better process.

**Resources**


AMA STEPS Forward: Practice Assessment [bit.ly/2L7nCCp]

AMA STEPS Forward: Practice Improvement Strategies [stepsforward.org]


Christine Sinsky, MD, will present a webinar in partnership with Constellation. See back cover for details.
Implicit bias is everywhere. Since Starbucks’ decision to close 8,000 stores for bias training, an international conversation on implicit bias has entered the mainstream. Research on implicit bias training in health care suggests that how teams function is the key to understanding how bias erodes trust and wellbeing, and what we can do about it.

Implicit bias and toxic stress
We’re all familiar with the concept of explicit bias—those attitudes and behaviors about certain groups with the intent to harm or exclude. In contrast, implicit biases are stereotypes that are formed by our experiences. By their very nature, they work outside of our awareness and influence us despite our best intentions, leading to discriminatory behaviors and biased decisions.

Implicit biases have a vastly disproportionate influence on certain populations. For those in certain minority groups, discriminatory behaviors stemming from implicit bias can profoundly affect an individual’s self-belief and sense of achievement. Minority and under-represented clinicians often live under the thick cloud of stereotype threat—the concern of being seen through the lens of a negative stereotype—which can lead to poor performance.

For example, under-represented individuals may experience or witness prejudice, which contributes to stress that accumulates over time. Eventually, they begin to feel like imposters who are not deserving of their accomplishments. When some members of the team lack motivation or become disengaged because they feel like they don’t belong, a sense of trust is difficult to establish.

Dealing with implicit bias helps promote equity and wellbeing.

By Javeed Sukhera, HBSc, DABPN, MD, FRCPC
Stigma and stoicism

As health systems are beginning to recognize the consequences of workplace stress, wellness interventions that include psychological support are being offered. But do all clinicians access them? The answer is a resounding no. Simply offering help is not enough because seeking help is often perceived as a weakness, especially in health care work settings. Research identifies stigma (negative biases regarding mental illness) as one of the most prominent barriers to help seeking, particularly among minority and underrepresented clinicians. Collectively, clinicians live and breathe within traditional workplace cultures where stoicism is rewarded and self-care is perceived as selfish. Research on stigma has taught us that people who are struggling with symptoms of depression or anxiety often blame themselves for their struggles and are afraid to seek help because they don’t want to be perceived as weak or inadequate.

When I began my career, I knew that stigma wasn’t a new concept. It has been researched extensively. But eventually, I drew connections between what we know about bias and my daily clinical life. As a stigma researcher and practicing psychiatrist, I became a junior faculty member and experienced my own struggles. Survival meant disconnecting myself from what it meant to be human. It seemed like the only way to honor my physician’s oath was to be less than human. The tacit messages I received during my training were similar: numb yourself, harden yourself and protect yourself from feeling anything too deeply. Like many of us, I didn’t follow the same advice I give to my patients. Instead of demonstrating self-compassion, I fell victim to the virus of self-blame. It took introspection and support to realize I was not alone.

Starting the conversation

Whether we focus on reducing stigma or on reducing the adverse impact of implicit bias, the conversation can only begin once we humble ourselves by recognizing that we’re all deeply flawed and imperfect human beings. We all exhibit bias despite our best intentions. My research program has shown that acknowledging our shortcomings instantly normalizes the experience of stigma as we move toward fostering broader social and cultural change through implicit bias awareness.

By exploring how health professionals respond to feedback about their implicit bias and following participants for 12 months after implicit bias training, I learned that awareness is just the beginning. To recognize and manage implicit bias, we can start by seeking feedback, which allows us to become aware of our own biases—then, we are able to reflect on how our biases impact ourselves and others. This makes setting and practicing tangible changes in our behavior toward others possible.

During our training programs and workshops, we have open conversations about our biases and how we can change our behavior. We also discuss what to do when witnessing bias within the workplace. People often discard feedback unless it comes from a trusted source. Challenging biased behavior requires opening the conversation and recognizing what unites both victim and perpetrator. Our research suggests that challenging others to check their privilege is best achieved through modeling for others how we check our own.

Co-constructing social change

Reducing the adverse impact of bias is most effective when team members who work together learn together, and when interdisciplinary teams feel comfortable being open about their biases with one another. We must be willing to be open and seek dialog to reconcile our biases. Peers can help motivate us to change our behavior. In our most recently published study, we found that once awareness was triggered, participants in implicit bias training began to reflect on their biases and make behavioral changes. Together, our participants actually began co-constructing social change.

Leaders play a key role in addressing bias within their organizations. In addition to implementing bias training programs for individuals, attention must be given to teams and psychological safety within the workplace as well. If team members are encouraged to have the courage to question biased norms, they must not then be punished for their disclosure through regulatory retribution or harassment in their workplace.

We cannot accomplish change without structural and organizational reforms. But while implicit bias training is a start, it’s not enough. We must be the change we seek. Improving equity and promoting wellbeing starts with a hard look in the mirror. Health care leaders must consider their workplace culture and whether they are achieving a balance between psychological safety and cultivating the courage to be vulnerable.

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When some members of the team lack motivation or become disengaged because they feel like they don’t belong, a sense of trust is difficult to establish.
Anyone who winces at memories of “group projects” gone awry in middle school can be forgiven for approaching a book on teamwork for adults with a jaundiced eye. Those early forays into collaboration often weren’t accompanied by much advice on how to work effectively together (maybe that was part of the plan) and, while a finished product may have somehow gotten delivered and graded, the experience left many of us less than thrilled at the results and not eager to repeat the process. All the more reason to welcome a book that provides the grounding we might have missed and, further, opens our eyes to what working well together makes possible.

Fewer and fewer things can be done by individuals without an awareness of how their work fits into a bigger picture. As Harvard Business School educator Amy C. Edmondson points out in “Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy,” today’s complex work environments mean that solving almost any problem (including how to stay in business) requires continuous learning. And learning means interacting with others. Teaming.

“Teaming is a verb,” she emphasizes, a word more dynamic than the static noun “team.” It better suits the “teamwork on the fly” that happens today, where you may not even know your temporary associates. You may not have all done the Myers-Briggs together and know your way around each other. You may come together for a shift and disband just as quickly. Still, you have work to do.

Edmondson explores the subject from multiple angles that include historical overviews, results of her research, interesting case studies (many drawn from health care), a framework for establishing a
learning environment, and lots of good advice you can use today.

“Anything but natural”
Refreshingly, Edmondson starts where most of us are—in the real world, where she admits, “The activities of learning—taking risks, confronting failure, and crossing boundaries—are anything but natural acts.”

In an opening section that explores the barriers to teaming, such as fear of speaking up, she notes, “We are hard-wired, and then socialized, to be acutely sensitive to power, and to work to avoid being seen as deficient in any way by those in power.”

Most of us also don’t handle conflict well. And tensions are a natural part of teaming, even on well-functioning teams. Conflicts are not something to be afraid of, but transforming them into positive results requires patience, wisdom and skill. She provides lots of suggestions for cooling conflicts and encouraging difficult conversations.

As you might guess, changing mindsets and behaviors to gain the full advantages of teaming requires good leadership.

Leaders can help teams learn
In the book’s excellent middle section, Edmondson explores how leaders can create environments conducive to teaming. She focuses on four activities:

- Framing projects for learning
- Creating psychological safety
- Learning to learn from failure
- Spanning occupational and cultural boundaries

The way leaders frame projects offers powerful opportunities for helping team members recognize their interdependence and understand the bigger picture their work is part of.

Edmondson shares an interesting example from her research, in which she investigated 16 hospitals attempting to adopt a new less invasive technology for performing cardiac surgery, an innovation that could offer a potential competitive advantage to the hospitals. As she states, “I didn’t set out to study leaders’ framing, but … it turned out to be the single most powerful factor explaining success.” (Of the four hospitals she focuses on in her retelling, two were successful and two abandoned the effort.)

How the leaders framed (1) their roles, (2) the roles of their fellow team members, and (3) the project’s purpose played a crucial part in determining the effort’s success or failure.

In another chapter, Edmondson articulates the many benefits of psychological safety and describes many ways leaders can cultivate it. Helpfully, her case study highlights how the best-intentioned efforts can fail to gain traction. In exploring one organization’s “Safe-to-Say” initiative, she concludes that, while employees applauded the goal, they did not understand how the value of openness connected to improved performance and, as a result, failed to engage.

It’s a cautionary note Edmondson sounds at several points in her book: initiatives on culture change must be connected to the work of the organization and not presented as ends in themselves.

Learning while doing
The final section of the book, “Execution-as-learning,” will be heartening to anyone who worries that Edmondson’s teaming model isn’t practical to implement. Indeed, she describes her model as one that combines continuous learning with high performance, one that results in “getting the work done while simultaneously working on how to do it better.”

In a competitive environment, it’s important to do both—to attend to the present and the future. Edmondson notes that “each assembly line in a Toyota production facility works as a team—not because the nature of automotive assembly work requires teaming, but rather because continuous improvement activities require it.”

Edmondson explores how teaming plays out in routine operations, complex operations and innovation operations—different points on what she refers to as the Process Knowledge Continuum. A single organization may have projects occurring in all three arenas. Applying the wrong learning activities for a specific level of process knowledge can undermine the effectiveness of teaming efforts.

She shares a real-life example of each type of operation. To illustrate effective teaming in a complex operation, she chooses a patient safety initiative introduced at Children’s Hospital and Clinics in Minneapolis, MN.

“Teaming” provides an excellent framework that leaders can use to advance their organizations’ growth as learning organizations. The book offers extensive references, concise chapter summaries, plenty of sidebars and graphics that make it easy to identify things you can do right now, and an inspiring vision for a future of better organization performance and more engaging and satisfying work environments.
Maximizing Potential

Working to the top level of training and licensure can help teams increase efficiency and satisfaction.

By Betty VanWoert, RN, BSN, CCM, CPHRM

We frequently hear the terms multidisciplinary approach and interdisciplinary expertise. Actually practicing them is another story. If we don’t truly utilize all team members to the full potential of their education, training, experience and licensure, we may be missing the point.

Health care has been described as “hyper-complex,” and in health care, teams are more routinely faced with life-threatening situations than in other high-reliability industries. A sense of control is rarely achieved.

Of more than 35,000 respondents to the Agency for Healthcare Research and Quality’s 2018 Medical Office Survey on Patient Safety Culture, only 46 percent thought there were enough staff and practitioners to handle the patient load and that the pace of office work was not hectic.¹ That response rate is not surprising. In many practices, some clinicians drown in tasks others could perform. As a result, overwork, stress, burnout and work-life balance issues are rampant.

Are there resources on your teams that could be better tapped? When was the last time you examined your organization’s workflows? The volume of physician administrative tasks has monumentally increased in the years following implementation of the electronic health record (EHR). To stem the tide, some practices have begun streamlining EHR documentation by implementing team-based care, a strategic redistribution of work among members of a practice team.²

The correct delegation of medical and nonmedical tasks among staff has great potential to increase efficiency, enhance patient safety and improve staff satisfaction. Determining which tasks to reassign and who should perform them should be considered carefully and deliberately (see “Delegate tasks appropriately,” next page). There are risks for allowing tasks beyond a staff member’s scope of practice, so ensuring every team member has the skills and licensure to do everything assigned is critical (see “Plan, Do, Study, Act,” next page).
Before you delegate tasks, review your state’s statutes for guidance. The following questions can give additional direction:

1. Is the individual trained and qualified to do the task?
   Training can be formal (e.g., classes or certificate programs) or informal (e.g., practice and proficiency demonstrated to a qualified individual).

2. As necessary and appropriate, is the task supervised by a physician or RN in the practice setting?
   Supervision can be direct, or supervisory staff can take responsibility for the actions of the team member.

3. Are workflows audited periodically?
   Audits should evaluate correct delegation and whether or not team members trust each other to take on assigned responsibilities within their scope of practice. Without trust, workflow efficiency gains may not be realized. Moreover, lack of trust may result in double work by those who don’t have confidence in new methods or teammates.

4. Are onboarding and training checklists reviewed periodically for needed additions?
   Carefully reviewing these resources can help ensure new team members get all the training and information they need.

For instance, sorting patient telephone calls may be done by reception and scheduling personnel using an approved decision-making tool. However, assessment and care of patient symptoms should only be performed by licensed registered nursing staff or higher-level team members. And using scribes trained in coding and billing could maximize accuracy and minimize rework. Order entry might be completed by nonclinical staff provided with clear parameters and instruction. Physician inbox volume could be decreased if initial sorting of lab results could be done by nonlicensed staff using an algorithm.²

Awareness is key to team-based care—awareness of appropriate delegation and watchfulness for team members unconsciously drifting into doing tasks that aren’t within their purview. Everyone must understand each other’s roles, but not to the point of attempting to perform an advanced role—one for which a member hasn’t been trained or licensed.

Teamwork is key to keeping up with increasingly complex care: coordination of patient needs, the demands of new technology and the requirements of payers. Focusing on improved workflow will increase team engagement and resilience as it decreases burnout. We can regain a sense of balance by honoring individuals with the ability to work to their maximum potential.

References

Delegate tasks appropriately

Plan, Do, Study, Act
A cardiovascular surgeon performed CABG (coronary artery bypass graft) surgery on a 55-year-old man with a previous history of CABG surgery and multiple catheterization procedures. The CABG surgery went as planned, with the physician assistant (PA) performing the radial artery harvests. Following the procedure, the man was transferred to ICU with orders to elevate both arms on pillows and monitor with hourly circulation checks. The PA was responsible for monitoring the man post-operatively and reporting to the surgeon if there were any issues.

During the evening and overnight, his nurse documented normal capillary refill, as well as hands and fingers pale in color. The surgeon and PA examined the man early the next morning, removed the ace wraps, and noted both arms to be bruised and swollen, but with good capillary refill. The surgeon ordered Lidocaine patches for both upper extremities, as well as continued hourly circulation checks.

During the rest of the morning, the man complained of increasing pain in both arms. His nurse documented capillary refill times for both arms of greater than two seconds and hands dusky in color. The nurse did not report the man’s condition to the PA.

At noon, the man was transferred from ICU to the cardiac unit, where his nurse noted 3+ edema in both upper extremities, blisters forming on both upper extremities and a pain level of 8/10. At 2:00 p.m., the nurse called the PA about the increasing formation of blisters on both arms and increasing complaints of pain. The PA ordered a wound care consultation but did not examine the man.

At 5:00 p.m., after a call from a second nurse concerned about circulation in both arms, the PA examined the man’s arms. He then called the cardiovascular surgeon, who examined the man at 6:00 p.m. The surgeon called in a hand surgeon who diagnosed bilateral forearm compartment syndrome and bilateral carpel tunnel syndrome. The hand surgeon took the man to the operating room for surgery.

**Facts of case**

A cardiovascular surgeon performed CABG (coronary artery bypass graft) surgery on a 55-year-old man with a previous history of CABG surgery and multiple catheterization procedures. The CABG surgery went as planned, with the physician assistant (PA) performing the radial artery harvests.

Following the procedure, the man was transferred to ICU with orders to elevate both arms on pillows and monitor with hourly circulation checks. The PA was responsible for monitoring the man post-operatively and reporting to the surgeon if there were any issues. During the evening and overnight, his nurse documented normal capillary refill, as well as hands and fingers pale in color. The surgeon and PA examined the man early the next morning, removed the ace wraps, and noted both arms to be bruised and swollen, but with good capillary refill. The surgeon ordered Lidocaine patches for both upper extremities, as well as continued hourly circulation checks.

**Communication Breakdowns on Care Teams**

A man suffers permanent injury to both arms when compartment syndrome is not diagnosed in time due to improper post-surgical monitoring and lack of communication among the entire care team.

35% of claims involve a communication failure, and these claims average $17,600 more in cost than the overall total incurred average.
room for emergency fasciotomy. The man developed rhabdomyolysis and had significant muscle necrosis that resulted in severe neuromuscular deficits and post-surgical wound infections in both arms. The man eventually had a right-hand amputation at the distal forearm level and was left with significant functional deficits in his left arm.

The man filed a malpractice claim against the cardiovascular surgeon, the PA and the hospital, alleging improper post-surgical monitoring and failure to timely diagnose bilateral arm compartment syndrome.

**Disposition of case**
The malpractice case was settled against the cardiovascular surgeon, the PA and the hospital.

**Patient safety and risk management perspective**
The experts who reviewed the case felt there was a substantial delay in the diagnosis of compartment syndrome. They criticized the nursing team for failing to properly monitor and communicate the patient’s condition to the PA when circulation in both arms became compromised. The experts also criticized the PA for not examining the patient sooner after calls from his nurses, and failing to communicate with the cardiovascular surgeon regarding the patient’s condition. The cardiovascular surgeon was criticized for not having a more collaborative relationship with the PA he left in charge of monitoring the patient post-operatively.

**Surgical-related malpractice claims**
In our examination of Constellation malpractice claims, allegations involving surgical treatment were found to be the most prevalent and costly. When focusing on hospital-based malpractice claims, surgical treatment-related allegations remained at the top, but dropped behind diagnostic errors in total cost. Deeper analysis reveals that adverse events during each surgical phase are driven by different factors. For example, challenges during the pre-operative stage occur more during decision-making and communication, while intra-operative events show challenges regarding procedural techniques or complications. As in this post-surgical case, factors contributing most concern errors in clinical judgment and failures in communication. Two of the three operative stages involve communication failures and warrant a further look.

**Breakdowns in communication among the care team**
Thirty five percent of claims involve a communication failure, and these claims averaged $17,600 more in cost than the overall total incurred average. Among these claims, communication failures within the care team contributed to patient injury 42 percent of the time, most frequently regarding the patient’s condition.

Another perspective of care team communication comes from those claims involving advanced practice providers (APPs), including nurse practitioners and physician assistants. Constellation malpractice data shows that when APPs are involved, overall claim occurrence is similar to physicians working in corresponding specialty areas. But of special note, 67 percent of high severity APP claims involve communication failures within the care team, especially regarding the patient’s condition.

This malpractice case illustrates how vulnerabilities in team-based care can contribute to patient injury when collaboration and communication break down.

**Questions for senior leaders**
The following questions may help to ascertain which next steps your organization can take to enhance patient safety and reduce malpractice claims:

- Does your organization have a formal post-operative communication trigger protocol or hand-off communication process and tool?

- Do your nursing care team members undergo competency assessments and receive monitoring skills training?

- Do you invest in teamwork and communication skills training for your care teams?

- Do you cultivate a culture of collaboration among physicians and APPs?

**Team-related factors indicate more steps must be taken to prevent patient injury, key among which are:**
- Promoting a collaborative practice environment
- Implementing formal communication triggers and protocols
- Educating team members on team-based communication skills

**Resources**
Find links to patient safety resources on the MMIC and UMIA websites by navigating as follows: www.MMICgroup.com or www.UMIA.com Login > Risk Management > Bundled Solutions > Surgery and Anesthesia.

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Facts of case
A 78-year-old man had right hip replacement surgery after falling at home. He was hospitalized for four days and then transferred to a senior living residence for short stay rehab. The rehab physician assumed care of the man and ordered warfarin to prevent blood clots, along with twice weekly INR levels to monitor the anticoagulant therapy. The rehab physician documented the plan to keep the INR level between 2 and 3.

During the first week, the man’s INR levels were reported to the physician by a nurse as being 2.1 and 3. The second week, the senior living nurse called the rehab physician to report that the man was complaining of increased pain, had a swollen right lower leg and had an INR level of 6.1. The rehab physician heard 2.1 and ordered an increase in the warfarin dosage. The senior living nurse did not question the order and increased the man’s warfarin dose.

The next day, a Friday, the man complained that his right leg was feeling numb and his family called his orthopedic surgeon who recommended keeping the surgical follow-up appointment on Monday. At that visit, the orthopedic surgeon diagnosed a right leg hematoma. The man was rehospitalized.

Upon admission to the hospital, the man’s INR level was critically high at 8, and his hemoglobin was critically low at 6.7. The orthopedist ordered Vitamin K for the high INR and transfusions for the low hemoglobin. The hematoma caused sciatic nerve compression that resulted in foot drop. This permanent nerve injury caused severe difficulty in walking and the man was unable to return to his home following hospitalization. He instead moved into an assisted living center. The man and his family filed a malpractice claim against the rehab physician and senior living organization alleging improper management of anticoagulant therapy.

In claims involving skilled nursing, assisted living and independent living organizations asserted from 2010 to 2015, 21% involved improper management of treatment.
Disposition of case
The malpractice case was settled against the rehab physician and senior living organization.

Patient safety and risk management perspective
The investigation into this case revealed that the senior living nurse did not recognize the 6.1 INR level as a critical test result. Because she was not familiar with anticoagulant therapy, she did not question the order to increase the dose of warfarin. The senior living organization was criticized for failing to train and educate nursing team members on critical test results and for failing to have a critical test result policy that included identification of critical test results, read-back communication and clarification of unsafe orders. The rehab physician was criticized for not recognizing the upward trend of the INR from 2.1 to 3.0 and questioning that he heard the INR report correctly.

Critical test result process and policy
Critical test results are those that fall significantly outside of the normal range, may put a resident or patient at risk, and require immediate attention from a clinician. Critical test results should be immediately flagged and communicated directly to the ordering clinician. A closed-loop communication process that includes a read-back of the test result should be used with critical test result reports. The sender should identify the results as critical results, the receiver should record the results and read the results back to the sender, and the sender should verify the accuracy of the results as read back.

A critical test result policy should:

- List critical test result levels that require immediate communication and attention by the ordering clinician.
- Define time frames for reporting critical test results.
- Identify who can communicate critical test results and who can receive critical test result reports. (Generally, critical test results should be communicated directly to the ordering clinician.)
- Establish a back-up plan in the absence of the ordering clinician.
- Outline the closed-loop communication process including read-back verification and documentation requirements.

Senior living malpractice claims
In our analysis of Constellation professional liability claims involving skilled nursing, assisted living and independent living organizations asserted from 2010 to 2015, 21 percent involved improper management of treatment. The top contributing factors involved errors in clinical judgment, failure to have or follow organizational policies, and breakdowns in communication within the care team. Investing time and resources into boosting critical thinking and communication skills in care team members creates a stronger care team and can improve resident outcomes while reducing resident injury and preventing malpractice claims.

Questions for senior leaders

The following questions may help to ascertain which next steps your organization can take to enhance patient/resident safety and reduce malpractice claims:

- Does your organization have a critical test result and communication policy?
- Does your care team receive education and training on anticoagulation therapy?
- Do you allocate time and resources in boosting critical thinking skills for all care team members?
- Do you invest in teamwork skills training for your care teams?
- Do you cultivate a culture of safety that allows care team members to ask for help when they lack education or experience?

Resources
Find links to long-term resident safety resources on the MMIC and UMIA websites by navigating as follows: MMICgroup.com or UMIA.com Login > Risk Management > Bundled Solutions > Long-Term Care.

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Stand in your truth. That’s what I told a physician policyholder who was afraid to move forward to trial because of the potential repercussions of a plaintiff’s verdict in the malpractice case filed against her. I told her we wouldn’t advocate for going to trial on her behalf if we didn’t believe in the care she had provided, for which we had strong support by medical experts we consulted. And I shared my personal experience that settling a case without admission of wrongdoing also has ongoing personal and professional repercussions.
She took my advice, and thankfully, the jury rendered a defense verdict. But even if it hadn’t, she would have known that her MPL provider—as well as the experts we consulted—supported her care.

Do you remember the book The Road Less Traveled by M. Scott Peck? It’s about how painful it can be to confront and solve problems. It comes to mind as I reflect on the most important thing I did this week—walk that scary and very stressful journey of going to trial in a malpractice case with one of our insured physicians. Because this issue of Brink focuses on teams, I want to share some of what our team here looked like as we supported our physician.

Before I do, I want to note first that very few of the cases brought against our policyholders actually end up in trial, and when they do, our success rate (defense verdicts) runs around 90 percent. Most malpractice claims and suits are dropped. Of the rest, most are settled without an admission of wrongdoing. While we believe in—and practice—defending good medicine, we find that often docs need encouragement to go to court to defend their care, even when they believe it was good, and even when we have expert support for it.

Such was the case for the physician named in this lawsuit, which is why we have found it very helpful to think fluidly about the teams we assemble to support our physicians. Needs differ. And they shift.

When one of our insured clinicians is sued, they are assigned a claim consultant who takes charge of coordinating care of the clinician, as well as the evaluation of the case and strategy. As described in Amy Edmondson’s book Teaming (see page 20), several people may become part of the team for a time, and then drop off the team as the needs of the case—and the clinician—change.

Among the things we engage team members to do are: provide clinician peer support, select the legal team, provide office support, and determine the nature and number of expert evaluations. We also consult with in-house experts and our physician advisory council—a group of experienced board members and others who meet on a regular basis to review cases and opine on whether our insured physician has met the standard of care.

In cases where our doc needs a little more support, I might get involved, at the request of the claim consultant, as I did in this case. I was able to share with her my own experience of being sued once and choosing to settle, which I did for several reasons—mostly fear, despite feeling that my care had been good and knowing that I had great expert support. I shared that I regret settling that case to this day, and I encouraged her to go forward knowing that we supported her care.

Just like our clients, who include both executive teams at the hub of health care organizations and care teams on the front lines of patient care, we at Constellation are also interdependent team members with various and broad expertise, who, when aligned and working well together, deliver the best care possible to our policyholders.

We strongly believe that what is good for care teams is good for business. And, because we are a family of mutual medical professional liability insurance companies, our interests start where health care relationships begin—with the insured clinician who has been sought out by a patient seeking care. We believe that tending to clinicians’ needs is paramount to caring for care teams and, ultimately, the people they are asked to help, to heal and to serve.

Know that we are here for you, our insured clinicians and administrators, and committed to serving you in your missions to help, heal and serve not only your patients and residents, but also your team members.

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Calendar

UPCOMING WEBINARS ON WEDNESDAYS
To register for a webinar, go to MMICgroup.com > News & Events
All webinars are presented noon–1 CST and are available on demand at MMICgroup.com after the initial presentation.

SEPTEMBER
5
COMBATTEING CLINICIAN BURNOUT: A RESEARCH-BASED APPROACH TO SOLUTIONS
Presenter: Laurie Drill-Mellum, MD, MPH, Constellation Chief Medical Officer and Liz Ferron, MSW, LICSW, VITAL WorkLife Senior Consultant & Practice Lead

OCTOBER
10
JOY IN MEDICINE
Presenter: Christine Sinsky, MD, Vice President, Professional Satisfaction, American Medical Association

NOVEMBER
7
FOLLOW-UP SYSTEM FAILURES: CLOSING THE LOOP ON THE DIAGNOSTIC PROCESS, PART 1
Presenter: Robert S. Thompson, RT, JD, MBA, LLM, AIC, ARM, AEP, RPLU, CPCU, MMIC Business Development Consultant, Strategic Relationships

DECEMBER
5
ENHANCING YOUR SAFETY CULTURE
Presenter: D. Michelle Kinneer, RN, MSN, JD, CPHRM, CHPC, CHC, MMIC Senior Risk & Patient Safety Consultant

SPEAKING ENGAGEMENTS
On September 14, UMIA Director of Risk Management and Client Services Emily Clegg, JD, MBA, CPHRM, will speak on “HOW TO SURVIVE A DEPOSITION” at the AAMA Annual Conference at the Hilton Salt Lake City Center in Salt Lake City, UT.

On October 11, Constellation CMO Laurie Drill-Mellum, MD, MPH, will speak on “FOLLOW-UP SYSTEM FAILURES: CLOSING THE LOOP ON THE DIAGNOSTIC PROCESS” at the Iowa Hospital Association Annual Meeting at Veterans Memorial Community Choice Credit Union Convention Center in Des Moines, IA.