# Only a Phone Call Away

Tommy Waddell,* a 55 year-old truck driver, finally sought care from neurosurgeon Andrew Lewis when his back pain became disabling. Waddell's history included spinal stenosis, prior disc surgery, DVTs (for which he took warfarin), diabetes, obesity, and other health issues. Physical therapy provided little relief, such that he ambulated with a walker and could not walk or sit more than fifteen minutes without severe pain. No longer able to earn a living, Waddell scheduled surgery with Dr. Lewis. Both Dr. Lewis and his nurse practitioner, Jason Clark, discussed the expected benefits and risks with Waddell prior to surgery.

Warfarin was stopped, and a seven-day Lovenox bridge was begun prior to spinal decompression, fusion laminectomy, and placement of a Jackson-Pratt drain on April 18. Though not documented in the chart, Dr. Lewis apparently left on a pre-arranged vacation shortly after the surgery, and care was primarily assumed by NP Clark, with Lewis' surgical partners available for consultation. Lewis himself was also available by phone, if needed. The patient did well for the first 24 hours, but during the evening of April 19, he had some difficulty voiding. Catheterization revealed residual bladder volume, for which he was given Lasix and IV push by the hospitalist.

In the early morning hours of April 20, Waddell was incontinent of urine. Clark ordered a straight catheter, and 900 cc was obtained. About 0830, a hospital nurse charted bilateral numbness, tingling, and weakness of the lower legs, but none of Waddell's providers were notified of this change.   At 1000, the dressing was bloody, and NP Clark saw the patient just minutes later. Clark documented the bilateral numbness and weakness, back pain, and difficulty voiding but felt that Waddell had good sensation to touch with full strength in both legs. The patient was later noted by a physical therapist to have difficulty with "push and pull," due to lower leg weakness. About 1400, a hospitalist documented that Waddell was unable to move his toes, along with decreased strength and sensation in his lower legs. At 1600, physical therapy documented the patient was unable to flex his ankles. None of these changes were communicated to Lewis, his partners, or NP Clark.

NP Clark saw Waddell during morning rounds on April 21, acknowledging the nursing notes about bilateral numbness, but Clark still felt the patient had good sensation to light touch, except for the feet. About 1300, physical therapy noted that Waddell was unable to stand and had no movement of either ankle. Twenty minutes later, nurses notified Dr. Lewis (apparently still on vacation) about a decrease in blood pressure and increased bleeding at the surgical site. Dr. Lewis in turn called NP Clark to see the patient. The dressing was reinforced and pressure continuously applied until NP Clark arrived to place a deep suture at the site where the drain had been removed. A CT of the lumbar spine showed a hematoma versus abscess at L2-3, and NP Clark was notified of these findings at 1600. The nurses also notified Clark at 2220 when Waddell had difficulty voiding and

was unable to flex his ankles or wiggle his toes. Shortly after midnight, a Foley retrieved 600cc of urine. The patient had no associated discomfort or sensation upon insertion of the catheter. At 0100 on April 22, Waddell complained of feeling that his legs were "on fire."

About 0930 on April 22, nurses documented swelling of the patient's lumbar incision and no movement of the ankles or feet. There is no documentation any of this was communicated to Dr. Lewis, his covering partners, or NP Clark. A physician's assistant, Janice Holmes, saw Waddell shortly afterward while making rounds on behalf of Dr. Lewis; she ordered a CT myelogram which revealed spinal compression and possible hematoma. Waddell was diagnosed with cauda equina syndrome and promptly taken back to surgery for spinal decompression and hematoma evacuation. Dr. Lewis immediately returned to the hospital to assist his on-call partner with the surgery.

Mr. Waddell had some sensation restored to his feet by the following day - but no movement. On April 24, he was able to lift his knees but still lacked movement in his feet. However, the patient was incontinent of both bowel and bladder, was impotent, and unable to walk when discharged to a physical therapy institution for rehabilitation. Unfortunately, Waddell has not shown much progress and remains incontinent as well as impotent; he still requires a wheelchair for mobility and is totally disabled.

As the reader may imagine, suit was filed against numerous care providers. Plaintiffs alleged that the hospitalist and nurses were negligent by failing to notify Dr. Lewis or his partners about the changes in Waddell's neurological status. Likewise, physical therapists documented loss of motion but also failed to notify a surgeon. Though the surgery itself was done correctly, plaintiff alleged that Dr. Lewis was negligent for failing to have his partners round on the patient during his absence, and also negligent in his supervision of NP Clark. Because NP Clark was an employee of the neurosurgery group, plaintiff alleged the group was negligent in not having established protocols for advanced practice providers, by failing to properly train its nurse practitioners (especially in recognizing complications), and for failure to properly communicate with each other. Note that when the nursing staff did call Dr. Lewis about the brisk bleeding, he sent the same nurse practitioner who had been providing care; he apparently did not notify his on-call partners of this or any other complication of which he may have been aware.

How could this tragic outcome have been avoided? Swelling, bleeding, hematoma…all of these issues are known potential complications of spinal surgery, even the extreme of cauda equina syndrome. Neurosurgery experts opined the damage was likely irreversible by the time Mr. Waddell first experienced urinary incontinence and paresthesia. However, one phone call to sound an alarm may have changed the outcome by lessening the severity of Mr. Waddell's injuries. Dr. Lewis or the nurse practitioner asking one of the on-call surgeons for a consult, proper written protocols in place for advanced practice providers, a better understanding of NP Clark's experience level, and documentation of a hand-off to another surgeon---all of these components may possibly have led to a better outcome for both the patient and the involved providers.

*All names have been changed to protect the identities of the parties.

# Prevent Physician Burnout Part 2: 8 Ways to Lower Practice Stress and Get Home Sooner

**By Dike Drummond, MD**

In Article One of this three-part series, we discussed the causes, effects, and pathophysiology of burnout. If you have not read that article, it is important you do so. The tools that follow are more effective if you understand the fundamental blind spots and conditioning of our medical education.

In this article, we will concentrate on methods to lower stress in your practice.

Before we begin, you must understand that burnout is not actually a problem. Let me explain.

Problems have solutions. When you apply a solution to a problem, what happens to the problem? It goes away … yes? So often physicians come to me asking, "What is the one thing I can do to lower my stress levels and make burnout go away?" Notice how this request presumes burnout is a problem that has a solution. When you can't find that "one thing," many doctors simply slide back into their old work habits and give up on the possibility that things could be different.

In reality, burnout is a dilemma. It does not have a solution, because it is not a problem in the first place.

Dilemmas are perpetual balancing acts. You are "between the horns of a dilemma" taking specific actions every day, week, and month to maintain the balance you seek. You address a dilemma with a strategy, not a solution. By its nature, a strategy has multiple parts, and in order to maintain balance you have to be measuring how you are doing in some fashion.

The fundamental question at the heart of preventing burnout is this: "What is your burnout prevention strategy and how are you measuring your effectiveness?" The horns of the burnout dilemma are the amount of time and energy you put into your practice on one side and your ability to maintain a positive energy balance coupled with your desired quality of life on the other.

Dilemmas are very common in healthcare. Here are just a few examples: burnout, your

compensation formula, the best care at the lowest cost, your call schedule, your accounts receivable, work-life balance, and EHRs.

From this point forward, we will be discussing tools to lower stress by increasing your efficiency at work and decreasing the time it takes to complete the tasks of your practice. One way to measure your effectiveness in this effort is to track the amount of time between your last patient leaving the office and you getting home – with your charts done.

Each tool is a potential component of your personal burnout prevention strategy. You may be utilizing some of these already. If so, make sure you read the Power Tips for that technique. As you read, take note of the tools that seem simplest to implement or feel most attractive to you. I will be giving you implementation pointers at the end of the article.

Remember, nothing changes unless you change your actions. This is an active learning process. If you read this article and do not change your actions, you remain trapped in Einstein's insanity definition. I encourage you to comb through this article actively looking for one tool you can begin to practice ASAP. Ready? Let's begin.

## 1) A Five-Part EHR Strategy

Here are five EHR strategy components we have tested and found effective in the real world.

**a) From hater to power user**

Notice your attitude. Do you feel your EHR program was written by the Devil himself in the fires of hell and his fingernails are digging into the backs of your hands every time you touch the keyboard? That is the definition of a hater. This attitude creates amazing avoidance behavior. You probably avoid your documentation until the end of the day and self-sabotage any attempts to improve your charting skills.

I have a simple question. Do you think the EHR is ever going to go away? Then this behavior is insanity. It destroys your ability to get home on time. Take a big breath and let it go.

Devote yourself to becoming a Power User instead. The first step is to find and study the Power Users around you. Typically they are hidden, since to stand up and announce you like the EHR is not a popular thing to do in most groups. Notice that these people are using the same software, seeing basically the same patients, and getting home on time. They know things you don't.

Ask the nurses who the Power Users are. If you are solo, ask your EHR vendor to connect you to one. Ask if you can watch them chart – they always say yes. Then sit right behind them while they are at the computer and get ready to yell "STOP" when they do some keystroke combination that magically completes a chart note. Take notes. Ask how they

did that. Pick up 2 – 3 tools you can use. Before you leave, ask if you can have their templates - they always say yes.

Two or three sessions later you are well on your way to becoming a Power User too. When the little hater voice comes up in your head, just say "Thank you for sharing," and let it go.

**b) Always and only document a minimal data set**

There are three reasons to write a chart note: billing, medicolegal, and what I will call "continuity" – providing the next person who sees this patient with enough information that they can take over where you left off. If what you write in the chart does not support your billing code, cover your "legal part," or help the next provider in the chain, don't put it in your note.

**c) Use the software**

The use of EHR software is meant to semi-automate your chart notes through the use of templates. Here is a test. If you piled up all your documentation from a week into a heap on your desktop … how much of it was produced by you free typing into the chart? If your answer is more than 30%, you are not as automated as you could be. The secret is to look for "Broken Record Moments" (BRMs).

This is when you notice, "This is the fourteenth time I have written the same note this week." The typical reaction to a BRM is to become frustrated. Don't stop there. Realize a BRM is a golden leverage point to get you home sooner. It marks an opportunity to automate. Use this process:

- As you notice BRMs, just write them down. Make a list.
- Once a week, take one off the list and template it. Ask I.T. or your Power User friend to help if you need to.

The template process will only take 30 minutes or so. Here is the power.

- How many times do you need to make a template?
- For how long can you use that template?

In a month you will have transformed four BMRs into simple keystroke combinations and be getting home sooner.

**d) Team documentation**

You are programmed to be a Lone Ranger superhero perfectionist. You are almost certainly doing too many of the charting chores yourself. You don't have to do it all. However, if you want your team to help, you will have to ask them. Because of your position at the apex of the care team and the one who gives the orders, your staff will not usually suggest that you delegate a charting task to them.

Ask for help in an open ended way and see how they respond. It could sound like this. "*Hey everyone, I am working on ways for us to become more efficient at charting. We are a team and all of us are in the chart at some point. What are your ideas about how we can share the work more effectively so I can get from patient to patient more efficiently?*" Then be quiet and see what they say. This is much more effective than trying to figure it out yourself and giving them orders.

**e) Hire a scribe in a risk free pilot project**

Across the nation, physicians are pounding their administrator's desks demanding a scribe. They always say, "*If I had a scribe, I could see more patients.*" I assure you the administrator is thinking, "*Prove it.*" You see, administrators have two concerns: money and manpower. For you to have a scribe, they have to come up with the money and the scribe. That is a risk for them.

Here is how you can get a scribe with a process I have never seen fail. Take all the risk yourself.

There are several national scribe companies. They will find, hire and train a scribe for you. All you pay is about $25/hour for their services. Try this...

- Get your administration to approve a risk free scribe pilot in your practice.
- Run a detailed production and billing report for your last three months.
- Hire and implement a scribe in your practice. You pay all the costs. The scribe provides the manpower.
- Dial them in as well as you can over a 3–6 month period, until you feel you are working at maximum efficiency.
- Run another three month production and billing report, now with your scribe.
- Prove you are now seeing more than enough patients to pay for the cost of the scribe.
- Ask your group to take over those payments. This is known as a "claw back."

## 2) Broken Record Moment Automation, Part Two

You will find another category of BRMs in the patient education side of your practice. Your little voice will point out, "*This is the thirteenth time I have said the same thing to a patient this week.*"

Once again, step one is to make the list of all of these moments. Write them down. Then decide how you will address this teaching going forward. There are four main methods.

**a) Written.** Make patient handouts to cover the BRMs in your practice. Keep them stocked in an accordion file folder. Put them on pastel colored paper. Put your nurse/MA in charge of keeping them stocked.

**b) Video.** Record a video of you doing your best teaching on your BRM subjects. Load it onto a set of cheap tablet computers your nurse/MA gives to the patient to review at the conclusion of the visit. Or put them up on YouTube or load them in your patient portal for the patient to watch in the office or at home.

**c) Delegation.** Train your people to take over the BRM from you.

**d) A combination of the above**, like a handout with a video link, etc.

Document the method and source of patient education in the chart. Eliminating BRMs, in both documentation and patient education, is one of the quickest ways to get home sooner.

## 3) The BID Huddle

The BID team huddle is a time-honored method of preventing fires from breaking out in your day. If you are not routinely holding a huddle in your practice BID, you are getting home later than you need to.

**Huddle Basics**

**a)** Six minutes twice a day before each of the two halves of your day.

**b)** Include all members of your patient flow team. Receptionist, whomever rooms your patients, the float nurse.

**c)** Stand up meeting. You go to them. Do not make them come to your office.

**d)** Make sure one of you has the schedule for the coming half day in hand. Review the schedule together and do two things:

i. Trouble shoot the patients on the schedule already. Know who is sick or upset, who has special needs, who needs specific equipment or a special room. Are all laboratory and x-ray results in the chart?
ii. Let your team know what to do with any open appointment slots. Know when your next available appointment is.

**e)** Address any other issues the team is facing in the next four hours - such as the printer is down or we just ran out of flu vaccine, etc.

**Huddle power tips**

Check in with your team

**a) Ask each team member 'how are you doing today?"**

Get to know if there is anything going on at work or in their personal lives that you need to know about, both good and bad. Know whose child is sick and whose child just got a college scholarship.

**b) Say thank you**

Acknowledge and thank the members of your team for anything they have done in the last several days that helps you or the team do a better job. Praise early and often and be specific. *"Thanks for your hard work, yesterday we accomplished all our charting before going home."*

**c) Delegate appropriately and judiciously at the highest level of someone's scope of practice.**

Ask your team to be on the lookout for things you are doing as the doctor that they could take off your plate and complete instead. *"We are a team. Caring for patients and completing the documentation are team activities. We share the load. Any time you see something you could do instead of me, something that would help the team be more effective ... please bring that idea to the next Huddle."* "Support" staff are meant to "support" physicians so the physicians can concentrate on patient care.

**d) Clear and center the whole team**

Invite your team to take a deep cleansing breath to become clear and centered before you start seeing patients ... you all take this breath together and invite any stress or worry or tension out with your exhale.

## 4) Batch Processing

Doctors are a lot like dogs in some ways. If a dog is sitting on the porch and I get their attention by throwing a tennis ball … they can't NOT chase it. They can't resist.

With doctors … the tennis ball is a refill request that pops up on your EHR screen. It is not urgent or important and yet how often do you drop what you are doing to address it?

We mistake every action as an urgent one and chase them just like the dog and the tennis

ball.

Add in test results, phone messages, referral paperwork … and your day is fractured into a hundred pieces for one simple reason. You are taking care of these items one at a time and allowing them to interrupt your patient flow.

The solution is batch processing. Batch processing is more efficient than continuously switching back and forth between tasks.

Take all the tasks that are non-urgent, put them into piles – batches- and run the batch twice a day at a time when you and your team can address them all at once. In the days of paper charts, we used to put out a basket for each task type. Refills go in this basket, test results go in that one when they return.

In a standard office day where you have an AM and PM schedule, some good times to do batch processing are 11:30 AM and 4:30 PM. That way the morning's work is done before lunch and the afternoon's work before you go home.

EHRs make this a little different because often these non-urgent tasks pop up as alerts on your tablet, laptop, or desktop screen. These prompts are equally enticing to our dog-like "fetch" mechanism and even more powerful time wasters.

Batch these too by NOT addressing them when they come in. Make a "virtual basket" that you run in a batch twice a day.

What can you batch in your practice?

Make a list of all the little things that interrupt your day repeatedly. As with your BRMs above, your first task is simply to make the list. Then bring in your team with a good question. *"What tasks happen every day – things that are not urgent, yet have to be done before the day is over – that can we put in batches and do all at once, in batches twice a day?*" Add their suggestions to the list as well.

Now pick one item on the list and design a batch process.

- Where will you collect the items to be batched? Is it a physical basket where you will put physical forms or a virtual basket that will hold emails or test results?
- Who is doing the batch processing, you or one of your team members?
- What are the screening criteria that mean the physician must get involved?

*Example:* Your nurse screens all lab results as they come in, alerting you to any abnormal values between patients. All labs are batched in a lab folder in your EHR for your review at 11:30 and 4:30.

**Power Tip:**

Many EHR systems have a real time alert system on their face page telling you how many

lab reports or emails or instant messages you have waiting. It is a nearly irresistible distraction and often a complete waste of time since the notice does not tell you about the urgency or importance of the alert.

Work with your EHR vendor to make sure the alerts are appropriate for your practice. Have someone else screen these messages and alert you to the ones that actually demand your urgent attention.

Time to pick a tool and take action.

It is easy to see an article like this one, with multiple suggestions for practice changes, and get completely overwhelmed. Your brain naturally focuses on how you can implement them all at once. The key here is to pick just one and take just the first step. That is all. Once you take the first step, the second one will become clear as crystal.

Go ahead and pick one tool that feels like a good place to start. What is the smallest step you can take to implement it? I suggest you tell your team what you are up to and ask for their help right up front. They always have fresh ideas you can't see when you are in the room with the patients.

DO NOT read this article and fail to take action or you will have missed a chance to step out of Einstein's insanity trap. It is time to build your burnout prevention strategy.

In article three, we will focus on life balance tools that allow you to recharge your energy accounts and build more balance into your week.

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# Hiring the Best Candidate

**By Elizabeth Woodcock, MBA, FACMPE, CPC**

A single bad hire can cost you more than $50,000 according to a CareerBuilder survey. If you have a position open, take the opportunity to hire right – the first time. Consider these proven techniques to get the best candidate for your practice.

**Listen**. While it's difficult to schedule multiple rounds of interviews with candidates for most positions, wisely use the 30 minutes that you have allotted for the interview. Introduce yourself and the practice, but limit yourself to three minutes. Use the remainder of the time for the interview. Don't lead with "tell me about yourself;" instead, "from what you know about our practice, tell me how you'd be a good contributor." Listen, but also observe body language. Persons who are eager for the position will be making eye contact, leaning in, and periodically nodding.

**Appeal.** When you post a position, focus on the annual salary, not the hourly wage. Consider that $31,250 sounds much better than $15, just be careful not to represent it as a salaried position if it is, in fact, an hourly role. Most importantly, salary is only one component of compensation. Document all aspects of the package – insurance(s), leave, retirement, parking, and the other great benefits you offer. Finally, recognize the power of a title. Don't advertise a front office or billing clerk; hire a patient service coordinator or revenue specialist.

**Don't Limit Yourself**. It's common for physicians to avoid interviews with anyone outside of the industry; it's time to think outside of the box for administrative positions. "Fit" trumps function in any service-oriented business, including medical practices. Don't automatically reject candidates with retail or hospitality experience; they often make the best patient-facing administrative team members. If you have a great candidate who only wants part-time, go for it. It's less expensive – because of benefits – to hire two part-timers for the position.

**Examine**. Give candidates basic skills tests – typing and message-taking, for example. Don't limit these to schedulers; in today's EHR-world, everyone needs to be able to type and take a message.

**Engage**. Don't leave the candidate's supervisor or manager out of the hiring process. Even if you want to interview all candidates, make sure the supervisor or manager is active in the hiring process before the offer is made. Retention is enhanced when managers are committed to their choice. Consider engaging coworkers as well, perhaps via a "working" interview. Unless state or local HR regulations disallow, this is a great tactic to really understand whether the candidate is a good fit.

**Use Effective Interview Techniques**. Avoid situation-based questions like: "What would you do if a patient was upset about his or her wait?" Instead, ask, "Tell me of a time when a customer was upset at you — what did you do?" Prepare questions in advance; give everyone (including yourself) the same evaluation form to ensure consistency.

**Set Expectations**. Before you hire, make them aware of the expectations of the position. If they may have to work a Saturday or two, tell them. Be upfront about the need to handle difficult patients at times. Don't sugarcoat the job; working at a practice is not an easy task. If you're not honest about the position, the results can be disastrous. The employee may leave if you haven't set accurate expectations. Further, you'll earn their trust for being upfront about what the job entails.

**Encourage Referrals**. Pay a bonus to an employee who recommends a candidate who is hired (and stays 30 days). Great employees attract other great employees!

The hiring process is the cornerstone of a successful practice, as people are your best assets. Using your mission and core values to find the right fit between candidates and your practice is essential in this process. An investment in an effective recruitment program pays off.

# Seven Percent on the Line for Practices in 2019 for 2021 Payments

**By Elizabeth Woodcock, MBA, FACMPE, CPC**

The federal government's Quality Payment Program (QPP) is now in its third year, although 2019 is the initial annum for the program's payment adjustments. For those of you who achieved perfect performance in 2017, your current Medicare remittances should reflect a 1.88% boost; a decline of 4% is the reality for those who did not participate in the program's most popular track, the Merit-based Incentive Payment System (MIPS).

The stakes are higher this performance year, with a 7% decrease imposed in 2021 for failure to participate. Successful participants can gain up to 7%, but don't count on that when you consider how many resources to deploy for the program. This year's experience - 1.88%, even for perfect performance - means that you may need to dampen expectations.

That does not, however, mean that you can ignore the QPP. If 7% of all of your Medicare revenue would be a big hit for your practice, make sure you get the minimum points needed to break even.

The threshold is 30 points, so exceeding that is the goal. For small practices - defined by the government as 15 eligible clinicians or less - it's possible to make this work without sinking resources into program participation. Here's how you can achieve this baseline:

First, recognize that you automatically get three points for each quality measure report, even if data completeness is not achieved. Small practices also get an automatic bonus of six points in this category. Apply for the Small Practice Hardship Exemption for Promoting Interoperability (PI), which reallocates the program's weight to Quality. With the reweighting, your 18 points for just measuring a few patients (minimum 3 * 6 measures), plus a 6-point bonus garners 24 points. This 24 translates into 16.8 points towards your total score, as this new "jumbo" category is worth 70% of the program (45% Quality plus the 25% Promoting Interoperability).

As a small practice, also perform one of the "high" weighted activities - requiring a "Yes/No" on the reporting - and grab another 15 points towards your total score. You'll likely get a few points from the cost category as well (the current measurement is all behind the scenes), and there is a high potential to get another few bonus points, including the new "complex patients" bonus.

Regardless, this strategy - submit six measures without rigor, apply for the exemption, and execute one activity - would make sure you're above the necessary 30-point threshold without exhausting your staff - or you.

*NOTE: Practices that don't meet the small-practice threshold won't have access to the automatic quality points or the PI exemption, however, the minimum is still achievable. A perfect score in Quality will guarantee penalty avoidance, but this isn't a reliable strategy. To achieve the minimum, be sure to also choose and acknowledge two high-level improvement activities. Promoting Interoperability – worth 25% of your total points – is a heavy lift particularly if your system doesn't offer all of the required functionality. It's important to develop a business case to determine if the resources you would need to overcome these challenges are worth the upside, noting that perfect scores in 2017 resulted in a 1.88% bonus this year.*

For more information, see https://qpp.cms.gov/.

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