EXECUTIVE INSIGHTS

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# IMPROVING CLINICIAN EXPERIENCE TO DRIVE WELL-BEING

Using technology to support the clinical workforce

American Hospital Association™

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# Improving Clinician Experience to Drive Well-being

## Using technology to support the clinical workforce

**Severe staffing shortages and the pandemic have had a traumatic impact on clinicians and amplified the need to support and improve their well-being.** Burnout is not new, but COVID-19 has highlighted the challenges clinicians face when administrative burdens, suboptimal communication systems and teams working at capacity collide with an extended crisis. Burnout not only affects our clinicians, but also has deep implications for the health care system, in such areas as safety, quality and cost. Understanding the experiences of clinicians is paramount to driving wellness efforts, staff retention and recruitment. This executive dialogue explores strategies to improve clinician well-being and how technology can play a critical role in supporting the clinical workforce.

## 9 Proven Ways Technology Can Ease the Burden on Clinicians

1. **Give clinicians a voice at the table** and create a culture and governance of shared accountability as to how technology is going to enable their work to increase satisfaction.

2. **Test new processes, technologies and creative solutions in patient care in an innovation unit,** an interdisciplinary team-based model of care, to improve the staff and patient experiences as well as patient safety and outcomes, e.g., virtual nurses for admission and discharge.

3. **Track electronic health record (EHR) usability by clinician** and target those that are least efficient for training and coaching. Improve EHR usability by having expert physician EHR users shadow and work with physicians one-on-one to make improvements in real time to help them become more efficient and happier.

4. **Intentionally design features in the EHR with clinician input.** Optimize the copy-and-paste function (CPF) so that it's more effective and easily identifiable for clinicians. Provide comprehensive staff training and education regarding the appropriate and safe use of CPF. Audit its use to prevent CPF errors and EHR bloat and inform health care providers when their documentation is inaccurate or redundant.

5. **Balance virtual education and training with coaching and education at the point of service,** in huddles or roadshows to keep up with staff needs, increased agency staff and changing roles. Use ongoing training and coaching to drive efficiency and reduce burnout.

6. **Use quantitative data with qualitative data** from nurse well-being navigators rounding on the floors to identify pain points and change programming.

7. **Lessen the time physicians spend managing EHR inbox messaging** by delegating it to other staff if clinician expertise is not required and, for time-intensive medical issues, have staff set up an in-person or telehealth visit. Some organizations have started to charge for certain messaging that requires extensive medical advice.

8. **Create a psychologically safe environment for staff** by utilizing training, data, EHR screening and support tools to identify patients with behavioral health concerns and how that impacts care delivery. Use the EHR to communicate to staff in different departments whether a patient with whom they may interact is a security risk.

9. **Explore new technologies to positively impact clinical users,** such as ambient listening technology, artificial intelligence virtual scribe, integration and automation of administrative tools and advanced interoperability platforms.

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**MODERATOR** *(Robyn Begley, American Hospital Association and American Organization for Nursing Leadership):* **Burnout not only affects our clinicians but also has deep implications for our health care system regarding safety, quality and cost. Understanding the experiences of a clinician is paramount to driving wellness efforts, staff retention and recruitment. What signs of clinician burnout are you seeing in your organizations and what caregiver shortage are you experiencing?**

**LISA SMITHGALL** *(Ballad Health):* We're a rural health system in Northeast Tennessee and Southwest Virginia and, right now, we have a lot of vacant positions, not just in nursing but in every clinical discipline. We have the largest number of contract team members that we've ever had, and we're trying to keep existing staff to ensure that we have the right providers to deliver care. It's an unsustainable model for health care delivery.

Unfortunately, in Tennessee, enrollment in nursing programs is down. In our regional programs, we're unable to fill current slots, let alone the increased need in the pipeline for the retirees and others who have left the profession.

The indications of high stress we see are increased vacancy rates at the bedside and the departure of tenured staff who never considered leaving. We see it with incivility in the organization as well. People have short tempers. They decompensate rapidly. And even the nursing leadership or other leaders who are there to support them can't put in the effort and energy because they're being staff nurses as well. We don't have enough resources many days, or when we experience an influx of patients.

We don't have a lot of resources, but we put some lavender rooms into our three large tertiary facilities where staff can go to de-stress. Realistically, people can't get away from the bedside. We're trying to increase resources related to mental health support and our employee-assistance programs. We take resources to the units to make sure our people are feeling value in what they're doing; and we try to support them through active listening and focusing on their concerns, because we know they're not reaching out for these resources. We don't want them to just walk away.

**BRUCE McNULTY** *(Swedish Hospital):* Whether from a physician or an administrative perspective, you can see the impact of burnout on patient experience scores. If your score stayed flat, then you've improved this year compared to the pack, and modest improvements in scores have resulted in significant improvements in percentile ranking. That tells you that those caring for our patients are crispier than they were a couple of years ago due to COVID-19 staffing, pay and civility.

The most experienced nurses have left the profession, leaving the least experienced doing the work without traditional mentoring, even in some of our most critical areas. There are generational differences in how we view work and how much we're willing to take in the workplace; and those changes are having an impact as well.

From the physician aspect, there are issues with the electronic health record (EHR) workload, especially in primary care. We've done two things. First, we found a physician who was extremely enthusiastic and adept at using our new EHR. It's a great EHR, but it's complex and you can do things a thousand different ways. We carve out time for the tech-savvy physician to work with a physician for a two- to three-hour session, providing suggestions such as, 'You're going to be more efficient if you do this,' or 'You're going to be happier if you do this.' The feedback we've received from physicians has been positive and they have appreciated having someone invest the time and being able to make improvements in real time. It's been a dramatic improvement in the lives of our physicians.

Second, inbox messaging is out of control. Patients

believe that they can text physicians for just about anything, and there's no charge. Physicians want to engage with their patients; yet, at a certain point, it's taking a toll on physicians' lifestyles and productivity. In some cases, you can have other staff to respond and try to save your physicians. In response, NorthShore rolled out a policy whereby patients would be charged for certain time-intensive inbox messages that require medication changes or medical advice, underscoring that text messaging isn't a substitute for coming in to see your doctor or a virtual visit.

**LU DE SOUZA** *(Oracle Health):* Bruce, you mentioned a decrease in patient experience scores. What about quality and safety?

**McNULTY:** In several areas, that has been a struggle throughout COVID-19. For example, our central-line blood-stream infection rates deteriorated — overwhelmed staff maybe not doing things exactly the way that they had always done, people getting redeployed or leaving positions. Since the pandemic has subsided, there's been a refocus and we're seeing improvements across those areas.

**MODERATOR: Does anyone else want to share what you're experiencing in your organization?**

**RAMONA CHEEK** *(Bon Secours Mercy Health):* We opened a med-surg innovation unit in August 2022. For nursing productivity, we're at 12 hours per patient day, which equates to about a 4:1 nursing ratio. So far, the outcomes are the reverse of what most people have experienced: We are seeing an increase in patient experience scores. We've had zero falls with injury and zero health care-acquired infections. Nurses now have time for themselves and for each other, and they have time for their patients. It's a big cultural shift. We're now trying to figure out the scalability.

We also want technology to be an enabler in the innovation space and, we'll be looking at available technology that will add to the nurses' ability to spend time with and care for patients. It's been an exciting learning experience and we're getting results.

**TIMOTHY QUIGLEY** *(South Shore Health):* Nurses and all the members of the care team need to feel psychologically safe to be able to provide their best care. We've created a psychologically safe environment and we now measure workplace violence by using data vs. anecdotes. We found that more of our staff are injured from patients with dementia and delirium than those with substance-use disorders. We're doing a lot of work on how we approach the patients who are difficult to predict in terms of lashing out and becoming physical because of their dementia.

While we don't have any inpatient psych beds, we've added resources, training and support tools to identify patients who have behavioral health concerns and how that translates into challenges with their nursing practice and care delivery. We've done a lot of work on order sets with public safety officers, our psychiatric team, nursing and our physicians. We've built screening tools (e.g., Broset Violence Checklist) into the EHR. To communicate across the EHR, we've created a highly visual security flag component that moves with every screen; everyone in every area — registration, transport, imaging, nursing — sees the care plan and whether the patient is a security risk. We've been successful in scaling it across the system, but we still have pockets of opportunities.

**MODERATOR: The issue of workplace safety is critically important when we talk about burnout. We've been hearing that it continues to be a major issue across the country.**

**Tim, and Bruce, you've done a few things related to the EHR that have had a positive impact on our care teams. Would anyone else like to share additional ideas from an EHR perspective?**

**And as you adopt these changes or actions into your EHR, how do you know that they're bringing value? When I was a CNO in a health system in Southeastern New Jersey not long ago, the providers and the clinicians did the best job of determining what was helpful to them, not those of us in offices, even though we were well-intentioned.**

**RENEE SMITH** *(Blanchard Valley Health System):* The solution that our physicians are proposing to help them in the EHR is using copy-forward or copy-and-paste notes. They haven't gone in this direction before, and now there's a strong push from the physicians in the organization to move forward in this direction. What do others think and are there alternatives?

**PATRICIA FISHER** *(Ocean University Medical Center):* Copying and pasting notes into the EHR can lead to a misrepresentation of what is going on with the patient. I hover over every note now to see what is added daily because, otherwise, you just have a long list of everything that's happened in the hospitalization to date. I don't know what the solution is for clinicians and for EHR use.

**McNULTY:** We allow it, and I agree that it creates duplication and increases the time required for other clinicians to discern which information is accurate. The hovering function allows you to see it, but it slows you down when reading a note. Most organizations allow this to occur because it's how physicians want to deal with documentation burden.

**SUSAN PARISI** *(Geisinger):* Maybe the question is: How could we copy and paste differently so that it's more effective and works for our clinicians? If this is a feature that we know most of our physicians like, how do we use technology to optimize that feature?

**"Nurses and all the members of the care team need to feel psychologically safe to be able to provide their best care. We've created a psychologically safe environment and we now measure workplace violence by using data vs. anecdotes."**

— Timothy Quigley — South Shore Health

**QUIGLEY:** We use the copy-and-paste function for some features and then block it for others that we think are more important. There was an extensive clinical discussion with nursing, providers and staff. We have a large hospitalist program and they found it helpful. At the same time, you must audit its use, or you end up with EHR bloat.

This gets into intentional design. You don't want to drive people crazy with structured data fields. For narratives, it's easier for people to grab a whole section of notes vs. a component of a note. The hospitalists find it helpful for handoffs to look at one note rather than clicking through multiple pages. But if the information inherited in it is flawed, then you're ingesting flawed data. We pull audits so that people receive individual feedback if they're copying and pasting garbage.

**DE SOUZA:** Not a day goes by that we don't discuss with our clients in the Oracle Health base as to whether to do it or not. I agree with Susan that there are better ways. We are investing more into the concept of conscious decision-making before you carry forward a piece of your note. For instance, I am presented with my assessment and plan from last time. I can review and see if it's still applicable, and then carry that forward into my new note.

What we forget is the importance of training and the reduction of documentation burden. Our physicians are still documenting a review of systems, but the Centers for Medicare & Medicaid Services no longer requires it. We must do a better job of explaining that these are not the days of paper charts. We have everything in the record.

We don't need to have everything in the record

replicated in a note. There are several strategies that put you on a better path. Yes, my colleagues are still going to ask for copy-forward because it is one click. But they also will tell you that they dislike their colleagues' notes because they're bloat notes and don't make any sense. We must do a better job with change management and recruit people, their peers, to help drive this conversation in a more productive way.

**SMITH:** I appreciate the idea around training and appropriate use. Everything is about a tool and how to use the tool appropriately.

I want to weigh in on behaviors I've seen. When people become stressed, they tend to go to things they can control, like their schedules. Now they can't even control that, which can lead to incivility, the short frustration. The frustrating times right now are being felt by everyone.

Lastly, financial resources are in short supply right now, so we must be conscientious about where we allocate those resources. It adds one more layer to our conversations, which is challenging.

**MODERATOR: The concern about financial resources is real for every one of our health care organizations and hospitals. Yet, we know that ongoing training and coaching are important.**

**Would you share some strategies in how you've been able to continue training and coaching for clinicians? Whether it's around technology and the EHR or changes in regulations, how do you communicate and train your staff with the challenge of even finding the staff available to listen?**

"The promise of a health care operating system, a single foundational data set of patient information that can go everywhere the patient goes, is exciting. Regardless of what door I step into, you know me, and you can treat me. That's important for our patients, and it's going to facilitate their care and help improve quality and safety."

— Lu De Souza —
Oracle Health

**RYAN SLEDGE** *(HCA Healthcare):* Our training modalities have changed over the past couple of years. Now, we have more virtual training. There's a balance between the best way to get the right level of engagement and effectiveness and being sustainable.

We've been forming new initiatives related to how we can support mental health and emotional well-being within our workplace to support clinicians who are working through the trauma of the last few years. We view it as an important way to protect and support our colleagues. It is also a long-game return on investment (ROI). If we're able to invest up front, then that helps reduce turnover and presenteeism.

**KIMBERLEE FREEMAN** *(Wayne HealthCare):* To keep up with all the demands of education and training, we're changing our approach. As an organization we are trying to meet our staff where they are by providing more efficient approaches to coaching and education. We are utilizing more remote/electronic education in addition to the huddle and roadshow concept. This method seems to be effective in keeping up with the never-ending changes.

**MODERATOR: How do you use data to drive the priorities for training and coaching? As I talk all over the country to our hospitals and health system leaders, people are trying several different communication modalities to connect with their staff.**

**PARISI:** We're all used to looking at quantitative data, but I'm finding that some of the best data is from more qualitative sources. On the nursing floors, managers are asking questions and having a personal conversation with the nurses: What makes

you stay here? What makes you feel valued?

We also use retired nurses who previously left to come back and round on the floors as nurse navigators or well-being navigators. They ask what the pain points are. They're bringing back some qualitative data that we can use to change our programming.

**MODERATOR: Susan, that's important because you're getting the voice of front-line workers. The front line will say, 'I don't have time to take another survey or go to a class.' That's a creative way to use retired staff to collect qualitative information.**

**DE SOUZA:** I love those approaches. Ryan, I think you're so on point with the ROI approach. There's a big body of data that might help you in your business case from the KLAS Arch Collaborative. Those data show that organizations that invest in the culture and governance of shared accountability and how technology is going to either hurt or enable their work are more satisfied. Clinicians need to have a voice at the table.

Also, the organizations that focus on training, not just the initial onboarding, but ongoing training and coaching are more successful in driving efficiencies, which are directly related to burnout. And burnout is directly related to why staff leave.

The KLAS data showed that those two items were more important than changes in technology. They compared organizations that only made technology changes to try to improve efficiencies and satisfaction with their EHR vs. the ones that focused on governance and training. The latter were more successful.

**SLEDGE:** That's excellent. It's means having a conversation around whether we shape the environment in such a way that supports our clinician and employee well-being or try to fix a workflow for a specific process.

**DE SOUZA:** Most EHRs today give you information or data on usability. Ours allows you to see how our clinicians are utilizing the tools so that we can target the ones that are least efficient with the limited resources that may be available for training and coaching. This proactive approach allows you to see who your stars are, the superusers and the clinicians who use the EHR well so that they can help their peers.

**MODERATOR: When you put technology up against culture, perhaps culture will win the day or have the most impact. But we know that emerging technologies are part of our future. And our job is to figure out how to use them to positively impact our clinicians. Lu, how are we going to make technology part of the way we do our work? And what are the elements that are most beneficial?**

**DE SOUZA:** This must be a multipronged approach. It cannot just be technology. It cannot just be governance. We all need to come to the table to resolve the burnout issue.

As far as technology is concerned, I believe that artificial intelligence (AI) has played a major role in other industries and has yet to make its big debut in health care by improving and driving clinical insights to decrease the administrative burden for clinicians. We must improve the clinical experience, which means making clinicians efficient and providing the decision support they need, as well as the tools for better care team collaboration.

Right now, our clinicians are siloed, but if they work together as a care team, we see that they are happier and feel less burned out, have less duplication of work and improved communication, coordination and care for their patients.

I am excited about ambient listening technology, an app that runs on mobile devices, listens to a clinician's conversation with a patient and then creates a note for the clinician to review.

Prior authorizations are another area of frustration for clinicians and delays in patient care. Integration and automation of administrative tools will handle prior authorizations automatically in the background.

Interoperability must be seamless, meaning our clinicians don't have the time to get all that information. Today, records are connected. They can exchange information, but it's still on the shoulders of the clinicians to consume and ensure that it's appropriate information. Most of the time, the information is not even in the right place. In the future, an advanced interoperability platform will allow clinicians to go directly into a chart, into the right location and provide the right data with the insights that clinicians need.

The promise of a health care operating system, a single foundational data set of patient information that can go everywhere the patient goes, is exciting. Regardless of what door I step into, you know me, and you can treat me. That's important for our patients, and it's going to facilitate their care and help improve quality and safety.

Robots are also important tools that are here now and are continuing to improve. Some organizations are using this type of technology to assist with clinician shortages and burnout.

**MODERATOR: Lu, you certainly brought up several areas on which we can reflect. Is there anything missing from a technology perspective?**

**SMITHGALL:** As Lu said, it's how we maximize technology for our clinical providers at the bedside. We've implemented virtual assistants during the pandemic, which has helped clinical care providers. Patient Care Companions/Nursing Assistants can document in the EHR from an alternate location. They're able to assist the clinical providers who may have higher workloads than previously in watching patients to prevent falls.

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— Lisa Smithgall—
Ballad Health

In our organization, we use virtual nurses — we roll the cart into the room — to handle admission and discharge while the care provider assigned to the patient is doing other things. That's how we've used retired nurses or nurses with light duty. When patients are boarding in the emergency department until a bed is available, the virtual nurses complete the admission process so that when that patient gets to the floor, the unit nurse orients the patient to the room and does the physical assessment. We save 35-45 minutes of each nurse's time by doing that admission virtually.

**SLEDGE:** We're also looking at alternative care models to support our care teams, but one of our major priorities is the use of technology to help save time. A key part is that it must be done in a way that the technology doesn't add additional burden, and it's helping. We must have the input from the clinicians at the bedside who are using the technology as a part of that process so it doesn't add to the responsibilities they are already managing.

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