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January/February 2023

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Colleagues,

Here at the Michigan State Medical Society, we feel very strongly about the importance of the physician-led healthcare team. Each member of the team plays a vital role, doing their part to deliver quality care for our patients. This is why as a Society we advocate strongly for the protection, preservation, and strengthening of this healthcare team model.

There are ongoing threats to this model from legislative efforts to expand the scope of practice of team members outside of their training and expertise. State and federal regulations have attempted to tip the balance among members of the healthcare team. In this issue of *Michigan Medicine®*, we focus on another threat to the critical success of these important patient care teams: the changing and challenging realities of the healthcare workforce and workplace.

In order for a healthcare team to be strong, it has to have each crucial role filled with someone who is well-trained. For anyone watching the World Cup, or who roots for Michigan football or Michigan State basketball, you know what can happen to the success of your team if a player is out for a game or two. It's just not the same, and the quality of play suffers.

As you will read in this issue, Michigan's overall available workforce is 191,000 people smaller today than it was before the COVID-19 pandemic. There has been an exodus of baby boomers from the workforce and the millennial and Gen Z replacements come to their professions with new experiences, attitudes, and expectations. Add onto this the physical and mental toll that working on the frontlines of a global pandemic has taken on workers throughout our healthcare community and you have some very real and serious challenges facing medical practices, health systems, nursing homes, and clinical settings across our state.

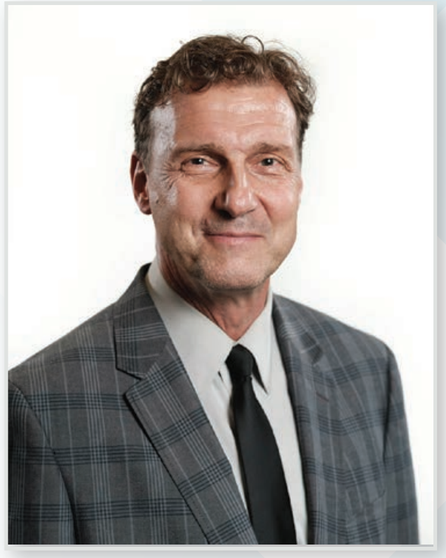
What is the current condition of Michigan's healthcare workforce? What are leaders in our industry doing to find and keep good members of their healthcare teams? How can we build a pipeline of talent to ensure we can care for our patients today and tomorrow? We look to provide some answers to these questions in the pages that follow.

The physician-led healthcare team is the foundation of quality patient care, and we must work together to make sure we can put a full team on the field.

Sincerely,

Thomas Veverka, MD, FACS

MSMS President



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The Changing and Challenging Times for Michigan's Healthcare Workforce

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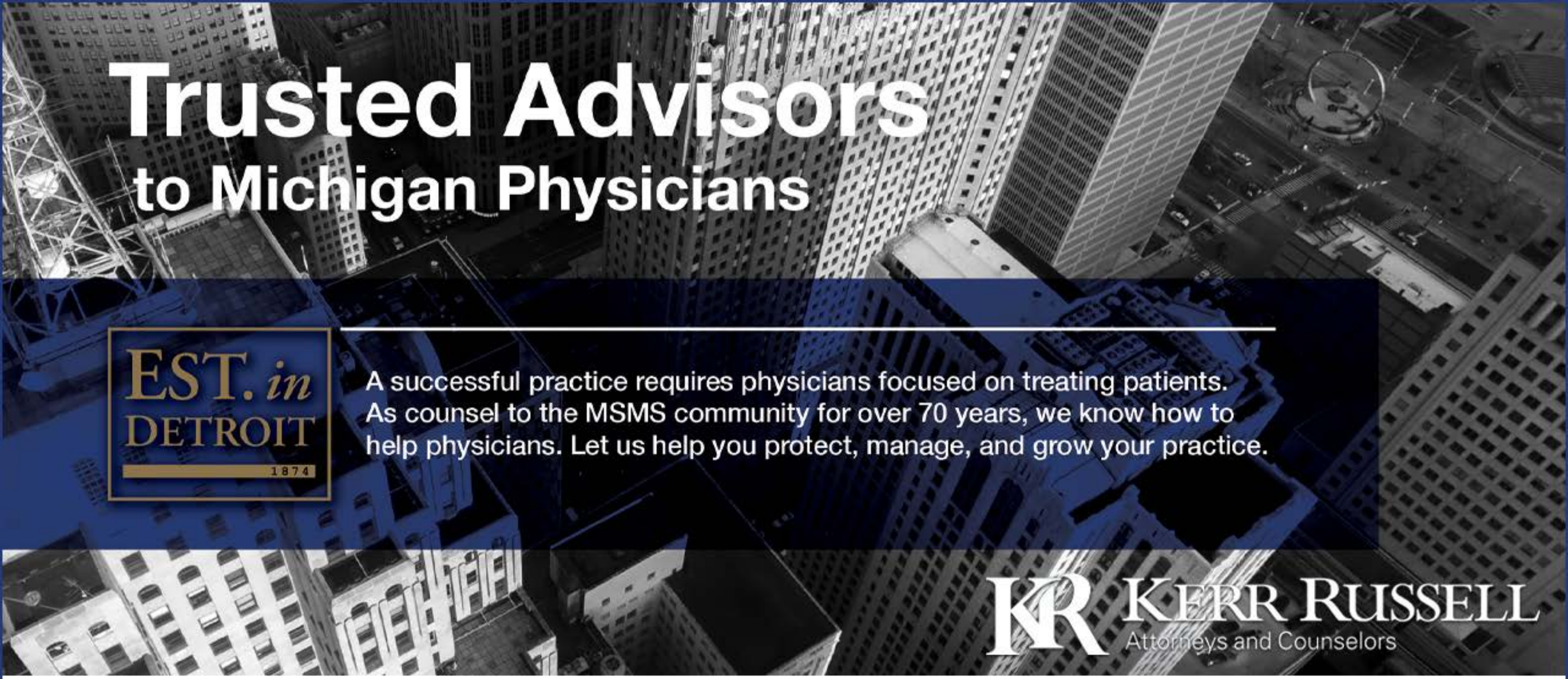
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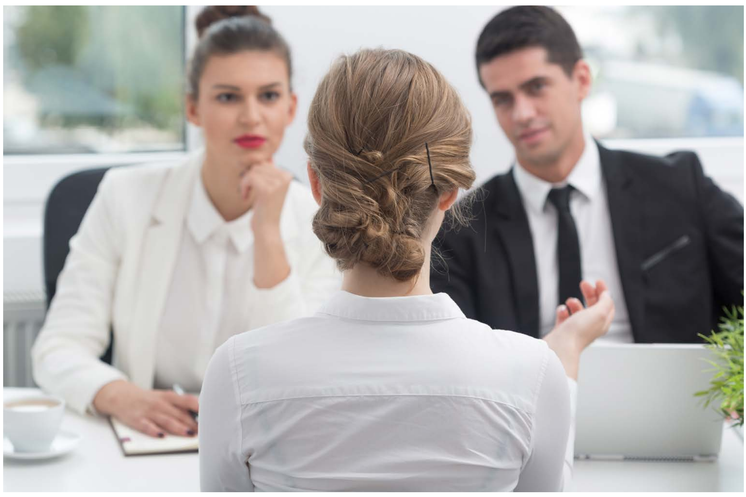
ASK OUR LAWYER

Are My Recruiting Strategies Damaging My Practice?

By Daniel J. Schulte, JD, MSMS Legal Counsel



Almost three years following the start of the COVID-19 pandemic, employers are still facing tremendous difficulty hiring and retaining employees. In fact, according to recent surveys, approximately 85% of healthcare facilities continue to experience healthcare staffing shortages.

Due to these shortages, many employers are increasing their recruiting and retention efforts; however, such efforts are not without legal risk. Although employers are encouraged to speak with legal counsel prior to implementation of any strategies, we have summarized a list of common retention/recruitment strategies and the accompanying protections that employers should consider.

Sign-On Bonus. Many employers are offering sign-on bonuses to new employees. However, there is a risk that new employees may accept the sign-on bonus but resign shortly thereafter, leaving the employer still needing to fill the role, but with less funds to do so. In addition, existing employees may become upset regarding growing pay disparities, or seek out other employment opportunities to obtain their own signing bonuses.

If an employer is offering a sign-on bonus, the employer should require the employee to enter into an agreement, by which the employee agrees to pay back a portion of the bonus if they do not remain employed by the employer for a certain period of time. The employer should consider requiring employees to execute a Confession of Judgment to reduce issues arising with collection efforts. Employers offering sign-on bonuses may also wish to offer retention bonuses to their existing employees. As with sign-on bonuses, an employer should require employees to enter into an agreement defining the terms and conditions of the bonus and specifically advising the employee that such bonus does not impact their at-will status or otherwise constitute employment for a term.

The most effective retention/recruitment strategy for your practice will depend on your specific workforce. Employers are encouraged to speak with legal counsel to evaluate retention and recruitment efforts best suited to their particular workforces.

Restrictive Covenants. To encourage new employees to accept employment, many employers have decided to eliminate or modify restrictive covenant agreements for new employees. There are pros and cons to this approach. Restrictive covenants (such as non-compete, non-solicit, and confidentiality provisions) operate to protect the confidential and competitive business interests of the employer. By employing individuals who owe no legal obligations to the employer following termination of employment, employers may open themselves up to significant losses in the form of patients and employees transitioning to other practices. However, from a practical perspective, it can be difficult and expensive to enforce restrictive covenant agreements.

Rather than eliminating the agreements entirely, employers may wish to consider modifying existing agreements to reduce geographic scope and/or duration. Alternatively, and especially for lower-level employees and for those employees who do not have significant patient interaction, employers may consider removing the non-solicit and non-compete provisions and requiring only a robust confidentiality agreement.

Remote work. Since 2019, the number of US employees working remotely has tripled; however, for the healthcare industry, remote work is rarely an option. Rather than remote work opportunities, many employers are considering job sharing, compressed work weeks, and flex-time arrangements for those employees who must be physically present in the workplace. Unfortunately, allowing only certain employees to have flexible arrangements could lead to discrimination claims. In addition, some employers have complained of reduced productivity in workers with more flexible arrangements.

To reduce the associated legal risks, employers adopting flexible arrangements should institute written policies which clearly delineate an employee's eligibility to work flexibly, performance and productivity standards, work rules, working hours, and the conditions under which the flexible arrangements will be terminated.

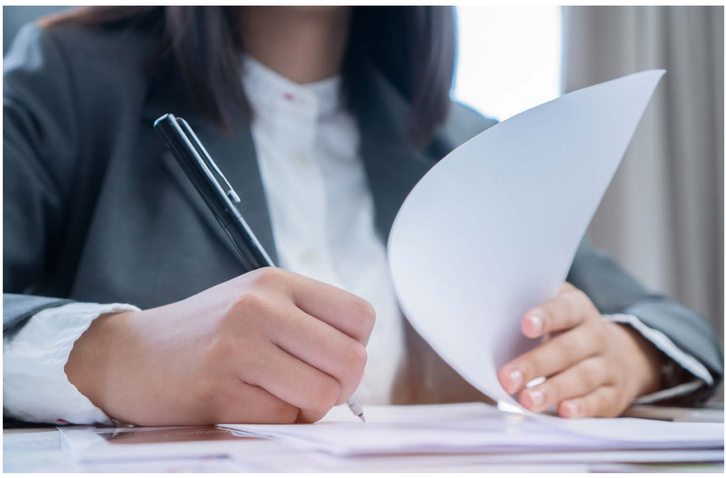
Overall, the most effective retention/recruitment strategy for your practice will depend on your specific workforce. Employers are encouraged to speak with legal counsel to evaluate retention and recruitment efforts best suited to their particular workforces.

DANIEL J. SCHULTE, JD, MSMS LEGAL COUNSEL IS A MEMBER AND MANAGING PARTNER OF KERR RUSSELL.

ASK HUMAN RESOURCES

I-9 Forms: What Every Employer Needs to Know

By Jodi Schafer, SPHR, SHRM-SCP | HRM Services | www.workwithhrm.com



Q: I'm new to my position and recently attended a training on human resources administration. There I heard about something called the I-9 form. What is the I-9 form and what are the requirements that our practice needs to follow?

To begin, the I-9 is a document required by the federal government that every employer has to complete with every new employee regardless of your practice size or the employee's status (e.g. full-time, part-time, temporary, seasonal etc.). If they are a W-2 employee on your payroll, then you need to have an I-9 on file for them. The process of completing the I-9 form documents the employee's eligibility to lawfully work in the United States, and it applies to both citizens and noncitizens. As part of the process, the employee must produce documents to verify their status, such as social security card, passport, driver's license, permanent resident card, etc. The employer must physically inspect these documents within three days of hire and sign off that they viewed them via the I-9 form. Photocopies of documents are not valid.

Once the forms are completed, you do not send them anywhere. You keep them on file ready to produce if ever audited. For recordkeeping, I recommend keeping all your I-9's together in one folder, binder, or digitally. If you were ever audited, you only want to show the documents you are asked for. You must retain completed I-9 forms for one year after the date an employee separates from employment or three years after their date of hire, whichever is later.

The current I-9 form had an expiration date of 10-31-22. On October 11, 2022, the Department of Homeland Security posted an Employer Alert stating that "Employers should continue using the Form I-9, Employment Eligibility Verification, after its expiration date of October 31, 2022 until further notice. The Department of Homeland Security will publish a Federal Register notice to announce the new version of the Form I-9 once it becomes available." You can continue to check for the most recent form by going to the DHS website at www.uscis.gov.

I know this process can feel a bit daunting, but failure to comply with I-9 requirements can be costly. Fines for a missing, incomplete, or inaccurate I-9 form can range from hundreds of dollars to over $1,000 per form! As they say, an ounce of prevention is worth a pound of cure.

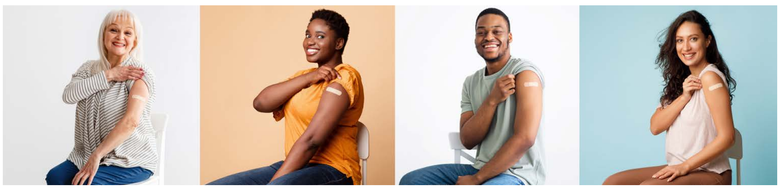
As I mentioned previously, employers have been required to physically examine an employee's documents, but due to the COVID-19 pandemic, the Department of Homeland Security has allowed the examination of these documents virtually through web conferencing, fax, etc. This temporary loosening of the rules was supposed to expire on October 31, 2022; however, on October 19, 2022, "The Department of Homeland Security (DHS) announced an extension of the flexibility in complying with requirements related to Form I-9, Employment Eligibility Verification, due to COVID-19. This temporary guidance was set to expire October 31, 2022. Because of ongoing precautions related to COVID-19, DHS has extended the Form I-9 flexibilities until July 31, 2023."

I know this process can feel a bit daunting, but failure to comply with I-9 requirements can be costly. Fines for a missing, incomplete, or inaccurate I-9 form can range from hundreds of dollars to over $1,000 per form! As they say, an ounce of prevention is worth a pound of cure, so I would recommend conducting an internal I-9 audit to see how your practice measures up. Determine if you have completed I-9 forms for all your current employees and previous employees (refer to record retention requirements above). Review the I-9 forms you have on file to see if the forms are fully and accurately completed. If you find mistakes, cross them out (do not use white out), write in the correct information, then initial and date the correction. If you do not have completed I-9 forms for current employees, complete them quickly, but do not backdate the form. Once you have an overall picture of where your practice stands in meeting this requirement, draft a memo to keep with your I-9s that summarizes what you found and what you did to resolve the issues. It is better to document what happened previously and show that you have corrected errors moving forward rather than trying to cover up mistakes. If audited, auditors look more kindly on companies that attempt to correct and rectify their processes.

MDHHS UPDATE

New Year, Same Goal: Ensure All Your Patients Are Up-to-Date on Vaccines!

Alyssa Strouse, MPH, Adult and Adolescent Immunization Coordinator, MDHHS Division of Immunization



With the start of a new year, we often reflect on years past and how we can improve moving forward. These last few years, the medical and public health field has been bombarded with struggles due to the COVID-19 pandemic: constantly changing COVID-19 vaccine recommendations, declining vaccination rates across the board, and an overall uptick in vaccine hesitancy. Further, the 2022–2023 flu season is already overwhelming, while vaccination rates have been lagging. As we enter 2023, now is the time to encourage patients of every age to get caught up on all recommended vaccines in the new year.

According to the Michigan Care Improvement Registry (MCIR), statewide coverage for children 19 through 35 months with the 43133142 (4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 PCV, 2 HepA) series as of September 2022 remains about 3.5 percentage points below pre-pandemic levels. Further, statewide coverage for adolescents 13 through 17 years of age for the 1323213 (1 Tdap, 3 Polio, 2 MMR, 3 HepB, 2 Varicella, 1 MenACWY, 2 or 3 HPV) series fell by less than 1 percentage point from 43.2% in Jan 2020 just before the pandemic to 42.9% in September 2022, whereas coverage for the same series without HPV fell by more than 4% from 77% in Jan 2020 to 72.8% in March 2022. Finally, comparing the total number of doses administered in January–September 2022 to the January–September, 2018–19 average, we find that the overall number of non-COVID doses administered lags pre-pandemic levels by 11.5%. With reduced vaccine administration and lagging vaccination rates, unvaccinated or under-vaccinated patients are susceptible to preventable illness and communities are at risk for outbreaks. Now is the time to implement strategies to promote vaccination schedule adherence and ensure catch-up vaccination for patients at every age.

Now is the time to catch your patients, at every age, up on any vaccines they may need, including COVID-19 vaccine and boosters. Healthcare providers are strongly encouraged to utilize the MCIR to generate reminders and recall letters of patients that are overdue or coming due for recommended vaccines. Make this year the year that all your patients are up to date on all ACIP recommended vaccines, so that together we can have a happy, healthy 2023.

Routine vaccination prevents illnesses that lead to unnecessary medical visits and hospitalizations, and further strain the healthcare system. The Advisory Committee on Immunization Practices (ACIP) recommends the use of COVID-19 vaccines for everyone ages six months and older. Further, COVID-19 vaccine and other vaccines may be administered on the same day. Visit the COVID-19 Vaccine: Interim COVID-19 Immunization Schedule for more information on COVID-19 vaccine recommendations.[1] All recommended vaccines due or overdue should be administered according to the recommended CDC immunization schedules during each visit unless there is a specific contraindication.[2] This will provide protection as soon as possible and minimize the number of healthcare visits needed to complete vaccination.

The COVID-19 pandemic emphasized just how quickly disease can spread among unvaccinated persons, especially within the adult population. It is crucial that adult patients are not only up to date on their COVID-19 vaccines and boosters, but also on all recommended vaccines as well. Healthcare professionals are the most valued and trusted source of health information for adults. Research shows that most adults believe vaccines are important and that a recommendation from their healthcare professional is the strongest predictor of adults getting vaccinated. Healthcare personnel, whether they administer vaccines or not, should take steps to ensure their patients continue to receive vaccines according to the Standards for Adult Immunization Practice.[3]

Now is the time to catch your patients, at every age, up on any vaccines they may need, including COVID-19 vaccine and boosters. Healthcare providers are strongly encouraged to utilize the MCIR to generate reminders and recall letters of patients that are overdue or coming due for recommended vaccines. Make this year the year that all your patients are up to date on all ACIP recommended vaccines, so that together we can have a happy, healthy 2023.

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Now HIRING!

The Changing and Challenging Times for Michigan's Healthcare Workplace

It's happened to all of us in recent years. We head out in the morning to stop at our corner coffee shop only to find it "Closed. Short staffed." Or we wait six weeks for an appointment to get our car's brakes replaced because the mechanic "just can't find techs to show up every day." Or an evening out is derailed when we find our favorite restaurant is only open Wednesday through Saturday now because they can't staff the kitchen.

The pandemic's lasting impact touches almost every part of our lives. While the experiences listed above represent inconveniences for each of us—especially when compared to real loss of life and health suffered by so many—the effect COVID-19 has had on Michigan's workforce is real.

Workforce trends that had been emerging for years—aging baby boomers and new attitudes toward work from millennials, to name just a couple—were accelerated and exacerbated during COVID-19, and these realities are dramatically impacting healthcare.

Shay Raleigh, MPH, Executive Director of Great Lakes Physicians Organization in Midland, MI, said the most common challenge facing his and his colleagues are staff turnover, staff burnout, and stiff competition with health systems over wages and benefits.

"Not having adequate resources at a practice level and seeing different staff regularly are real challenges that are impacting patient care," Raleigh said.

So, what to do? What is the current status of Michigan's healthcare workforce? How did COVID-19 change this status? What can leaders in Michigan's healthcare sector do to attract and, maybe more importantly, retain good staff in these changing and challenging times?

Michigan Medicine went to an expert to find out.

Jodi Schafer is a certified Senior Professional in Human Resources (SPHR, SHRM-SCP) and the owner of Human Resource Management Services. She is also a long-time HR partner and advisor to the Michigan State Medical Society. For this issue, she sat down with the Michigan Medicine to answer some of the difficult questions facing Michigan's healthcare workforce and workplace.

***Michigan Medicine*: Jodi, thank you very much for taking the time to talk with us today. Can you start by talking a little bit about the current labor market in Michigan? What are employers facing?**

Jodi Schafer: Of course. Thank you for reaching out on this important issue.

Let me start here. There's something called the labor participation rate, and this is a figure that has been measured for many, many years. Michigan's labor participation rate has never been stellar, and right now it sits at 60%. Sixty percent of folks who are eligible to be working in Michigan are actually in our workforce.

***MM*: How does that compare historically and to other states?**

JS: Michigan ranks 40th in the nation for the worst labor participation rate. It's not great. If we look back at participation rates of the past, we reached a peak of around 68% back in the 2000s, and of course, it dropped off the table completely during the pandemic.

40th in the nation.

That's Michigan's place for worst labor participation rate.

Generally speaking, when we're in a period of a recession, we see our labor participation rate drop. Oftentimes that's because there aren't the available jobs for people, but in this case that's not true. We have more openings than we have people to fill them. That's where employers are really feeling the crunch.

This is something that has been trending for a number of years, but COVID-19 just sort of pushed it over the edge. We've had many individuals voluntarily choose to exit the workforce during COVID-19 because perhaps they had childcare needs that they didn't have when schools were open. Or someone with young ones at home trying to help them with online learning. Or maybe their childcare center closed down.

Add to that what we call the "sandwich generation." Individuals who are still raising children and also have parents or family members who are aging to a point where they also need care. Oftentimes, it falls to a person who is of working age, the prime folks we want in our workforce, having to juggle those two competing needs. And as a result, some of them step out of the workforce completely, or scale back hours from full-time to part-time. And this kind of personal situation is not going away.

***MM*: Where have the workers gone? Is this "sandwich generation" the biggest contributor to the supply problem? Or are there other places workers have gone?**

JS: It's part of it. You have some people voluntarily opting out of the workforce altogether or opting out of full-time hours. You have other individuals who are working, but they're not working in Michigan.

Michigan has long been considered an exporter of talent. We have a decline in our net population growth and that's been going on for years. And right now, of those who are leaving our state, their median age is 30, and 45% of them have a college degree. The ability to work remotely has really impacted this trend. In many industries where work was historically done in person but could be done remotely, COVID-19 really pushed that remote work option. This isn't so much the case in healthcare because many jobs by their nature are face-to-face and in-person jobs, but there are more remote type opportunities for healthcare employers now than there ever have been before, with telehealth and some of the administrative functions able to be done remotely.

***MM*: How much of this was exacerbated by COVID-19 and its challenges?**

JS: In Michigan specifically, we have 191,000 fewer people in our workforce post-COVID-19 as compared to our pre-COVID-19 numbers. COVID-19 absolutely pushed this. And of those 191,000, a significant proportion are women, millennials, Black, indigenous, and people of color. Part of that was for the childcare and dependent care reasons we talked about before. Also, when you think about the types of businesses that were shuttered during COVID-19, a lot of them employed those demographic groups in higher percentages. And not all of them have returned to the workforce or if they have, they haven't returned full-time. And that's a trend that we are seeing, and I don't think that's going away.

191,000 Fewer People.

Michigan's workforce post COVID-19.

COVID-19 also accelerated some changing attitudes around work among the millennial and Gen Z generations. These generations don't seem to have the same intentional focus on planning for the future that their parents had. People are wanting to work much more flexible schedules. Maybe they want to piece together two part-time jobs, because it gives them the flexibility to do the things in their personal life that they want to do.

Opportunities for remote work, expanded dramatically as a result of COVID-19, also greatly contributed to this idea of "working to live, not living to work." So now, where before you might have needed one baby boomer to fill a role that was traditionally a 40-plus hours a week, an employer may be hard pressed to find one millennial or Gen Z who wants to work a traditional 40-plus hours a week.

***MM*: Healthcare employees were literally on the front lines of the COVID-19 pandemic and are exhausted and fatigued by it. What are you seeing as far as the status of the mental health of the current healthcare workforce?**

JS: There was a recent Fisher Phillips survey that came out, and while it was not specific to healthcare, I think it's exacerbated in healthcare for all the "front-line" reasons you just said. The survey looked at all industries and found 43% of employers have seen a spike in Americans with Disabilities requests for accommodations for mental health related reasons since the pandemic started.

And then, another portion of that same survey said 51% of employers said they have fielded reports of burnout or mental fatigue, while 46% said they faced higher turnover rates, and 34% said they faced higher absenteeism rates during the last two years. This is real. It's real across all industries, but it's especially poignant in healthcare, and you've seen it with folks who are doing front-line, direct patient care.

***MM*: How are you seeing these workforce trends impacting healthcare, because many healthcare jobs don't have the ability to be remote and also have rigorous physical demands and long hours that may be less appealing to some people now?**

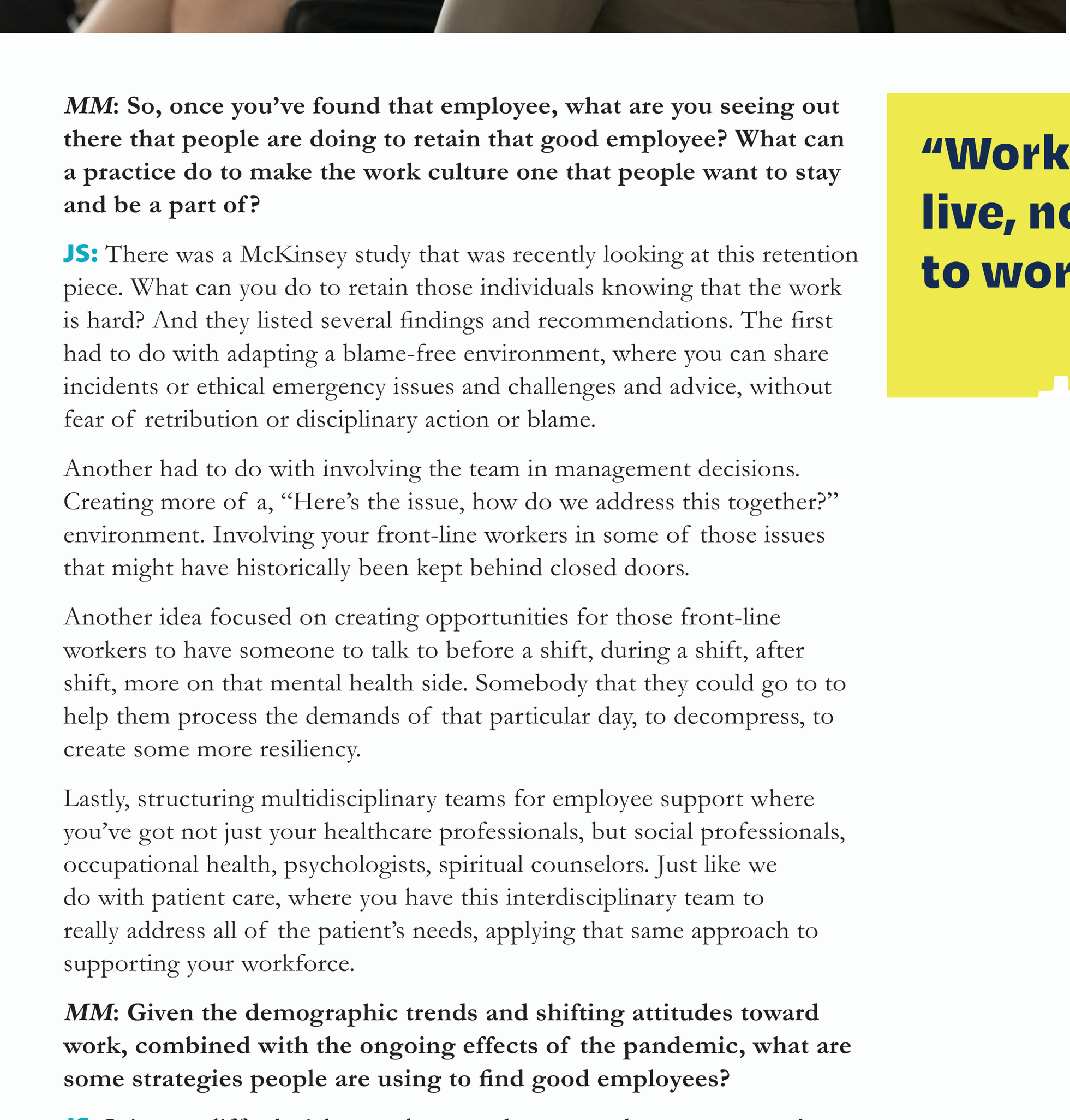
JS: So, when you look at the number of applicants to four-year nursing programs, applicants actually increased by 1.5% in 2020. But when you compare that against the two prior years, the increases were north of 4% and 8%. So, it's slowing, and I think it points again to the shift from, "What sort of job do I want to pursue?" to, "What sort of life do I want to have?" The rigors of work, how much I get paid to do the work, and what trade-off do I have to make for that pay are absolutely part of the equation.

We also have a very savvy up-and-coming workforce. Information is more readily available than it ever has been before. And there's no taboo on sharing that information. I mean, it used to be considered in poor taste to tell somebody how much money you made or ask someone what they make. That is not the case anymore. We also have websites like Glassdoor where current employees and past employees can go on and easily leave reviews of their experience. As a culture, we are now becoming more and more used to looking at reviews, doing our research before we decide not only is it a job we want to do, but if I do decide I want to do this job, do I want to do it for this employer? Choice is really prevalent right now, especially in the healthcare sector, and we have a very savvy workforce making the most of their choices.

***MM*: When you talk with employers, what is their greater concern, attracting new employees or retaining current employees?**

JS: Right now, I think there is a lot of focus on the recruiting side of things, because that's where employers are feeling the pinch. But when you ask me what is their greater concern, I would put my money on retention strategies over recruitment strategies, because if you don't have a culture that people want to be a part of, you're going to lose them as quickly as you can hire them.

Also, we have this impending brain drain. We have an aging population and are at the tail end of the baby boomer generation leaving the workforce. We can't keep relying on them. We've got to figure out ways to pass institutional knowledge down. And that doesn't happen in the course of weeks or months, that's years. And so, once you finally have that well-trained staff that understands who you are as a business or practice and your patients, you know them by name, you've got some history, the cost of losing that employee is exponentially higher than the cost of losing somebody that's only been with you for six weeks.



***MM*: So, once you've found that employee, what are you seeing out there that people are doing to retain that good employee? What can a practice do to make the work culture one that people want to stay and be a part of?**

"Working to live, not living to work."

JS: There was a McKinsey study that was recently looking at this retention piece. What can you do to retain those individuals knowing that the work is hard? And they listed several findings and recommendations. The first had to do with adapting a blame-free environment, where you can share incidents or ethical emergency issues and challenges and advice, without fear of retribution or disciplinary action or blame.

Another had to do with involving the team in management decisions. Creating more of a, "Here's the issue, how do we address this together?" environment. Involving your front-line workers in some of those issues that might have historically been kept behind closed doors.

Another idea focused on creating opportunities for those front-line workers to have someone to talk to before a shift, during a shift, after shift, more on that mental health side. Somebody that they could go to to help them process the demands of that particular day, to decompress, to create some more resiliency.

Lastly, structuring multidisciplinary teams for employee support where you've got not just your healthcare professionals, but social professionals, occupational health, psychologists, spiritual counselors. Just like we do with patient care, where you have this interdisciplinary team to really address all of the patient's needs, applying that same approach to supporting your workforce.

***MM*: Given the demographic trends and shifting attitudes toward work, combined with the ongoing effects of the pandemic, what are some strategies people are using to find good employees?**

JS: It is very difficult right now because there are only so many people to pick from. As an employer, you're either trying to entice folks to stay in the workforce who may be eligible to retire, or maybe getting courted away by other, more lucrative opportunities. You're having to do short term adjustments, either to pay or benefits, to the work schedule, whatever you can to try to keep who you've got, and to turn the heads of the few remaining folks that you can try to pull in, especially in your clinical positions.

For longer-term strategies, I think we need to start looking at a few things. One, organizations have to start, if they're not already, developing very strong relationships with training programs in their area. I've seen employers be very successful in partnering with local programs, so that they are a site for those clinical rotations. And then, for the employer, you have to dedicate staff to making sure that student has a really good experience in your place of work. Relationships with training programs is a big one. People can start doing that now.

I also think there are opportunities to grow your own talent pipelines. And we've not done a lot of this historically, because we've been relying on the "post and pray" method. There were enough folks out in the workforce that we could usually get somebody to respond to our online ad. That's not true anymore. For the last year, I've been on my soapbox saying you've got to go back to old school tactics in terms of pipeline development. And I'm talking about co-op type programs. I think about the different roles within your practice that don't require a specific license where you can train on the job. And how do you connect with potential job seekers who don't even know that's a job they should be considering right now?

Much like this idea of connecting with training programs, I also think there should be connections happening with the local high schools. There are student organizations like the Health Occupation Student Association. Many schools have that program, and if your local school doesn't, could you partner with an educator in a school to get it up and running? This gives you an opportunity to get in front of students and talk about healthcare professions and create opportunities for them to come shadow in your office.

***MM*: Thank you for your time and expertise, Jodi. I wanted to wrap up with one last question. To a physician or a practice manager or someone who's involved in trying to deal with this challenge every day, what do you want to leave with them as they read this?**

JS: I would say, "You're not alone." We are all in this boat together. And that's rare, I think. There are times when an industry feels like they're bearing the brunt of something on the workforce side, but COVID-19 really leveled that playing field, and we are all in this boat together, regardless of industry.

"You're not alone."

There may be ideas, strategies, resources that are in play now that you could learn from someone else. It goes back to this idea of we're more connected now than ever, but sometimes when you're in the middle of it, it certainly doesn't feel that way. It can feel like you're on an island. It can feel like you are the only one. And so, I would say reaching out to other professionals, whether that's connecting through MSMS, for example, to get in touch with other practice managers that you could talk to and bounce ideas off.

There are more resources available to help you than there have been before. But you've got to be head up, eyes open, looking, asking the questions so that you can take advantage. You're not alone.

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2023 Conference Schedule

Grand Rounds

Date(s): January 11, February 8, March 8, April 12, May 10, June 14, September 13, October 11, November 8, and December 13, 2023

Time: 12:00 – 12:45 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

Practice Management

Date(s): January 11, February 8, March 8, April 12, May 10, June 14, September 13, October 11, November 8, and December 13, 2023

Time: 1:00 – 2:00 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

Implicit Bias

Date(s): January 18, January 23, January 30, and March 15, 2023

Time: January 18 and March 15: 12:00 – 1:00 pm; January 23 and 30: 6:00 – 8:00 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Carrie Wheeler or call 517/336-5723.

A Day of Board of Medicine Renewal Requirements

Date: March 10, May 5, and November 10, 2023

Time: 8:30 am – 4:15 pm

Location: In-Person, March 10 and November 10

Virtual Conference: May 5

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

Annual Scientific Meeting

Date: February 27, March 27, April 24, May 22, June 26, August 28, September 18, October 23, November 27, and December 19, 2023

Time: 6:00 – 8:00 pm

Location: Virtual Conference

Intended for: Physicians and all other health care professionals

Contact: Email Brenda Marenich or call 517/336-7580.

27th Annual Conference on Bioethics

Date: November 10, 2023

Time: 8:45 am – 4:00 pm

Location: Hybird

Intended for: Physicians and all other health care professionals

Contact: Email Beth Elliott or call 517/336-5789.

For more information, or to register, please visit: MSMS.org/EO
Questions? Email Beth Elliott or call 517/336-5789.

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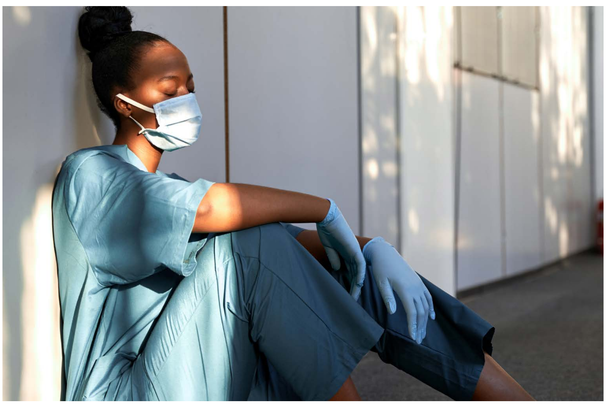
The Patient Safety Risks of Burnout—and the Path to Professional Fulfillment

Christine Sinsky, MD, Vice President, Professional Satisfaction, American Medical Association



A burned-out primary care physician once said, "Working at Starbucks would be better." Four years later, that same physician said, "I look forward to going to work each day. I'm loving it!"[1] How is this possible?

Our professional healthcare landscape has been charred by burnout. Fortunately, we now know how to redesign our practices to restore professional fulfillment and protect patient safety.

Prevalence of Burnout

When we at the American Medical Association (AMA) completed our first survey in 2011, burnout rates were already approaching 50%. In 2021, the second year of the pandemic, our fifth national survey found that burnout had reached the highest level in this series at 63%. In COVID-facing specialties such as emergency medicine, burnout rates approached 80% (Shanafelt, et al., Mayo Clinic Proceedings, in press). We don't need to fix the worker. We need to fix the workplace.

Work Domain

With the EHR, as many of us have experienced, various tasks that were previously completed by the receptionist, pharmacist, or transcriptionist all suddenly became the work domain of the physician. But it doesn't have to be this way. Some researchers have found that 50% of a physician's workday is spent on the EHR, and two-thirds of that time is spent on work that does not need a medical school education—such as order entry, billing, coding, documentation, and processing refills.[2] Most of that work can be done by a team.

Yet, too many physicians shoulder this load alone. The expression goes that people don't leave their jobs, they leave their bosses. Likewise, physicians don't leave their patients, they leave their inboxes. This is because the inbox has become unmanageable.[3]

While burnout manifests in individuals, it originates in systems, so we must implement systemic changes to protect ourselves and our patients.

Consequences of Burnout

If we care about patient safety and the sustainability of our healthcare institutions, we must also care about burnout. We know that when we are burned out, we are twice as likely to make mistakes—which means higher rates of malpractice. For physicians, add personal consequences such as higher rates of disease, substance abuse, divorce, and death by a variety of means.[4]

Fortunately, feeling valued has proved to be protective against both burnout and intention to leave.[5] This is not a feeling generated by an ice cream bar or muffins, but rather by substantial reflections of value that affect an individual's daily work, such as preparing them with personal protective equipment, training, and support.

Professional Fulfillment

Professional fulfillment, the inverse of burnout, is driven by three factors:

1. Organizational culture.
2. Practice efficiency.
3. Personal resilience.

This trio has been identified by the Stanford WellMD model.[6] I would like to showcase two types of change that have an impact on practice efficiency and are readily accessible to many individuals and organizations.

1. De-Implementing Administrative Burdens

At the AMA, we have created the Joy in Medicine™ Health System Recognition Program,[7] which provides a roadmap for organizations to improve professional satisfaction. One of our recommended leadership actions is to appoint someone to begin de-implementing unnecessary administrative burdens.

Our de-implementation checklist, which is available to all, is aligned with The Joint Commission's standards. One checklist item is to decrease password revalidation requirements.

In-Practice Example: The chief wellness officer of a major healthcare system emailed me recently to say how excited she was about the de-implementation of burdensome administrative steps, including no longer requiring password revalidation for medication changes. She said, "My neck is no longer sore from doing the badge login. I'm no longer doing as many username and password entrances." Her organization calculated that they affected 1.5 billion orders per week by de-implementing these requirements for repetitive reentry.

2. Practice Models

At the AMA, we have created a wealth of resources for increasing practice efficiency and recovering clinician time.[8] We've created over 75 practical, actionable toolkits, as well as playbooks, webinars, and podcasts. These tools illuminate accessible action items, like flagging what simply should not enter a clinician's inbox. Organizations can choose to reroute cluttering items, like patient event notifications, and preserve the clinician's attention for higher-priority items.

We also advocate for practice models with built-in support. The least functional model is the doctor-does-it-all model. If we can support physicians to allow them to give their undivided attention to their patients, not the computer, outcomes are better for patients, physicians, and organization finances.

In-Practice Example: A Wisconsin accountable care organization (ACO) piloted an advanced team-based care model by assigning two upskilled medical assistants per physician. Those physicians saw improvements in performance and quality measures and increased likelihood that the patient would recommend the physician to others. They also increased revenue to the ACO by closing more care gaps.

Quadruple Aim Reframed

Catherine Lucey, MD (of the University of California, San Francisco, and a former Chair of the American Board of Internal Medicine), restated the quadruple aim this way: "Care better than we've ever seen, health better than we've ever known, cost we can all afford, delivered by professionals who find joy in their work as they commit to serve others." That's a vision I can sign up for—and it is a vision I believe we can come closer to meeting.

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