Primary Care Cures

Episode #21 Dr. Paul DeChant

Ron Barshop: You know, most problems in healthcare are fixed already. Primary care is already cured on the fringes. Reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high deductible insurance that squeezes the docs and is totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost and the deceleration of reimbursements. I want you to meet those on this show that are making a difference. With us, Ron Barshop, CEO of Beacon Clinics. That's me.

Well, listeners you're in for a real treat today. We have an expert on physician burnout, a national thought leader. So is burnout really caused by EHR turning docs into more of a typist than a clinician? Two hours of typing, they say, for every one hour of face time. No, I don't think that's the key. Are pre-authorizations the issue because 90% of docs claim that delays care and negatively affects outcomes. No, that's not the root cause. Is it the pay because four out of the six top burnout category lists for PCPs, they're at the bottom of the pay scale as well, not a coincidence. Nurses are right behind doctors in burnout, a little publicized truth. But I don't think that's it either. Why do 70% of docs not recommend their own profession to their own kids, that gets to the root of the problem.

All of these metrics I call a stressor. Stressors like the HR pre-auths, pay, they're soil, they enrich the seed. What is the seed? What is the root cause of physician burnout in my opinion? And I can't wait to hear what our guest says today. No survey ever asked this question and I believe there's an answer, if you're ready for it. It's the model itself. If you saw your cruise ship you were boarding had massive rust holes in the hull, you might not board that. But first year med students interested in primary care have a giant blind spot. They're waking up now to avoiding primary care. In my grandfather's generation, 70% chose primary care. Dad's generation is 30%, today it's less than half that.

There's very good news though. But, before I go there, let's talk about the primary care as a model, as a business model, which is the root cause, in my opinion. There's a very nice download I'm going to send you to on Google that will show you how to rate models. It's a 12 score scorecard, if you will. And I'll just tell you, Google, The Ideal Business, with Richard Russell. He was a newsletter writer who started the year I was born and

wrote for 60 years to a various elite audience. This was his most popular piece, the Ideal Business, Richard Russell. I'm not going to go into the model because that would take too much time, but the good news is, you can do it yourself and score yourself, your own business.

The good news is, there's two 6's to a bad model. The first one is to simply turn around the bad model is jettison as many of these 12 negatives as possible. So direct primary care is a great model, instead of rating a 1 or 2 like primary care as a traditional model, it is a 4 to 7. It jettisons a lot of the bad pieces of the model. But, today only 11 hundred practices out of a quarter of a million PCPs are direct primary care, so it's a baby. It's in its infancy and really just started about nine, ten years ago. There's a 2.0 fix, that I'm in the middle of, is ancillaries. Added value and convenience in a clinic is literally a phone call for most physicians that want to add this. There are many specialists, tests and labs that can be handled by you, as a PCP, many treatments too. You can keep life simple by fixing a bad model by adding ancillaries. It's not you, it's the model.

So ancillaries will bump the model from a 1 or 2 to a 5 or 6, out of 12. My favorite PCP, that we'll talk about on an episode by itself, took in two million dollars through 12 ancillaries. So if you think of Mickey Mouse's head, that was his practice, his ears of the Mickey Mouse were his ancillaries.

Today's guest is a leading authority, leading thought leader, on this subject. And I can't wait to hear Paul DeChant's thoughts. Paul DeChant is a family physician, ER physician, but he also evolved into a CEO of a three hundred doc practice with 11 hundred head count under the grid. They excelled under Paul. He served under many CEO roles, but his passion has always been burnout, what's working to fix it, identify it, repair it. He impressively also works as a senior advisor to Simpler Healthcare. If you haven't heard of that, that's the IBM Watson Health Initiative. And he provides executive coaching healthcare leaders pursuing lean transformations in their organizations, and, as I said earlier, is a thought leader in clinical operations innovations in addition to this burnout question.

Innovation, ops, burnout, what a juicy smorgasbord we have today. I don't even know where to start with you, Paul DeChant. So, set the stage. Why are people burning out? What's going on there?

Paul DeChant: Well, thanks, Ron. I really appreciate the opportunity to share my message on this great podcast. The problem is not the worker. We started out thinking about burnout as we need to give doctors more resilience. Well, doctors are the most resilient people in the world. We survive organic chemistry, and medical school, and internships, and everything. So that's

not the problem. The problem is not the worker, the problem is the workplace because the workplace has become so dysfunctional that it's impossible to provide great patient care without being constantly vigilant and focused to make sure that nothing's going wrong.

And we can be vigilant and focused for short periods of time. It's pretty exciting if a big, tough case comes into ED, there's a challenging delivery, a family melts down and we help them through things. But to be constantly vigilant and focused without any chance to recover from that, wears us down and turns into things we see when people get into depths of burnout, the depression, substance abuse, family dysfunction and suicide. So that's true toxicity when we put people into a workplace that results in those outcomes.

Ron Barshop: What influenced you to work for this change?

Paul DeChant: It was my own experience as a family doctor. I never thought I'd get into leadership. I just couldn't keep my mouth shut when things didn't go well in my clinic. So I got put on the committee, then I'd get the chair of the committee, and then I became a medical director and eventually I became a CEO. It really was all about fixing my workplace and then ultimately fixing the workplace for as many physicians as I could that I was working with.

Ron Barshop: Let's talk about how to fix a workplace that's rampant with 50 to 60% burnout from the physicians. What has to change?

Paul DeChant: You know, there's six drivers of burnout that Maslach talks about. First one is work overload and we're totally overburdened. Our workplaces are chaotic, they're time pressured and there's more and more information overload. And when we get overloaded, we really feel like we're losing control. And that's that second driver of burnout. And control's important to us, it's a real value that we hold dear, and in fact, it's a reward we look for when we set out into our profession. That's one you mentioned the PCP model, people are regaining control by regaining their own practices. It's an intangible reward that we look for, similar to the intangible rewards of professional respect and collegiality amongst our fellow physician peers. And, in fact, the next thing that's hurting from that is the loss of that collegiality, the breakdown of community, another defined driver of burnout.

Doctors' lounges in hospitals are either nonexistent or empty. And when doctors are in the same room together, they're simply sitting next to each other typing away at a computer prove that we do not have the connections that we used to have with each other. When we lose those connections, we start to wonder if we're being treated fairly compared to

everyone else and that's actually the fifth driver of burnout, is absence of fairness. That's even, I think, becoming more an issue as the workforce becomes more diverse, more diverse from a gender standpoint, from an ethics standpoint. It's tough for me as a pale skinned white guy to talk about the challenges of people who had to work harder just to prove they were equally good, but that's, I think, becoming a bigger issue for all of the healthcare workforce.

And then lastly, it's the mismatch of values. When we work within a health system, and those leaders are making decisions that don't seem to jive with what their expectations are, what their missions have stated. The missions are usually about great quality in patient care and yet, just in trying to figure out how to manage healthcare, people are cutting resources in order to keep the doors open and the lights on, and yet they're expecting higher performance while they're cutting those resources. So there's a real question of, "Am I working in an organization that's really aligned with my thought process?" So you look at all the six drivers and it's a question of how do we redesign the management system to address those drivers effectively. And there is a way to do that, but most places have not seriously pursued that.

Ron Barshop: So if you're consulting with a large group of physicians, primary care physicians, you can do all the lean management training in the world, but if half of them are burned out, good luck. My question is, are you suggesting that they add a physician's lounge that has a no electronic zone? I mean, where they actually have to talk to the guy sitting next to them. Is that part of the solution or are there more practical on the ground solutions other than culture has to change? Because that's just, it's a lovely thought and it's very hard to implement.

Paul DeChant: I think, if I put a physician lounge in that had no electronics in it, very few people would go there. The key is to free up physicians' capacity and docs know what's wrong. They know what needs to get fixed. The real key is to empower people on the front line to pare, to start to fix the problems that they deal with every day while we align together across the organization around what our common goals are. And most health organizations do have very common goals about quality, safety, service, access and financial performance. It's just that we're so buried with the work that we never have a chance to step back and think about those things.

Ron Barshop: So in your consulting, what are lessons that you're learning as the best way to roll out a change that eliminates, or certainly declines, the burnout? Is it see less patients, less pressure to spend seven, eight minutes with a patient and maybe stretch that to 20 or 30 minutes. What's the magic key to giving autonomy back to these doctors?

Paul DeChant: At the point of care right now, the biggest issue is data entry. We spend so much time typing rather than interacting with our patients. We're in a professional ... when we try to think what's the opposite of burnout, people talk about joy in practice or other things. A nice way to describe this professional fulfillment, which really comes when we're able to have that deep connection with the patient. When we can walk in the room, look them in the eye, use our hands to examine and comfort our patients rather than having our eyes glued to a screen and our fingers on a keyboard. It's makes all the difference in the world.

We used to have that before all the technology came along, before all these other business models got in the way. So it's a question of how to get back to that. That's where redesigning workflows, adding support for physicians at the point of care to get them away from that and there's multiple ways to do those things. Ultimately the question is, if the workplace is this dysfunctional, the question is, who's actually responsible for the conditions in the workplace? And my question then becomes, who actually has say over the budget, HR issues, office design and informatics issues. That's really the C-suite ultimately. So when I see burnout, it tells me that there's some dysfunction in management, where management is not recognizing this and not putting into place the kind of systems and cultures that are needed to help docs solve these issues.

Ron Barshop: So when I think of systems and culture, I'm thinking of a scribe, for example. The problem in hiring a scribe is, at 20 bucks an hour, that's the margins sometimes of a pediatrician. That's half the income or take home of an internal medicine doctor, in some cases. Your scribe is going to be destroying your ability to have take home and you can't have a scribe in every room, it'd just be terribly expensive for a large group. And then the voice technology, let's call it Dragon Speak, or whatever, is just not there yet. I mean, we can talk to Siri and have a lovely conversation today and unfortunately, that is not ... we don't see that in the exam room. What is the solution to less face time with a keyboard and more face time with a patient? Is there something on the ground practical that makes sense?

Paul DeChant: Yeah, there's a number of ways to go about this. Scribes are one option and if you add a scribe and you don't improve productivity, then you're right, you're going to be, you may be breaking even at best. So the key is to add a scribe and be able to increase productivity without burning yourself out. What we find oftentimes, and scribes have their own challenges. Mostly, they're premed students who are trying to get into med school and they'll come and go from a practice, and 20 bucks an hour is pretty darn expensive. What we'd look at is a team, there are a couple ways to do it with people, one is creating a team around the docs supporting them and that makes a big difference. A lot of times if we just redesign the workflow, we realize there's a tremendous amount of things

we're doing unintentionally that just got added on over the years as we kept changing insurances, kept changing EHRs, that if we analyze it carefully, we can actually take those things that are no longer of value out and free up time that way as well.

When we can free up time for the physicians and for the medical assistants, or nurses in the office, then we can use the medical assistants and nurses as part of our team where they actually can do a lot of the information gathering for us, can even stay in the room part of the time, act as a scribe. But at the end of the day, when we're done, we've actually had capacity to see more patients and go home with the work all done, so we're not spending hours at home again in our pajamas trying to get our charts done.

Ron Barshop: I really like the idea of taking out replication in the HR. There's another solution that I've heard, there's groups now that are meeting with their insurance carriers and saying, "You know, you're pre-auths are 100% approved in these four areas of our practice. Do we really need to call in a pre-auth when we know it's basically going to get approved virtually every time?" So just saving on the pre-auths, really that's really more of a [inaudible 00:15:28] function, but it does increase the efficiency because sometimes, a doctor can't move forward with that patient until the pre-auth is approved and it can take a day, two days.

Paul DeChant: Right. And we can free that MAF to do other things to help support the doc. Looking carefully, there's so much waste in the way our clinics and hospitals work now. We think about the three trillion dollars we spend on healthcare every year, and probably a third of it's waste. Being able to identify and take much of that out which is a lot of what we do, free up those resources so you can do things like have additional people at the shoulder helping you out while you're caring for patients. And I love the idea of working with the insurance companies to get rid of unnecessary prior auths. That's important as well.

There's things just in terms of cleaning up how the office works. It surprises me how many major clinics still have doctors typing in passwords as opposed to using a single sign-on technology. And we're talking anywhere from eight to 15 clicks per password doing those hundred times a day, you're looking at over a thousand clicks a day just in password entry when there's good technology that can fix that. I talk with C-suites about it and they'll say, "Oh, yeah. We were going to do that last year, but our budget got tight so we pulled that back." Just shows a basic lack of understanding of where the actual economic engine is, where the opportunity is to make improvements. And that's just one very small example.

Ron Barshop: I was talking with a healthcare CEO this week and he said he has a thousand, I'm sorry, one million cyber attacks per day on his company. So if you told him you've got to have one password for every employee, he would laugh at me. I think what you're addressing, there's technology solutions to give everybody a unique password with just the push of a button.

Paul DeChant: Oh, yeah. Some of them actually, you can use fingerprints, or retina, or other things like that to identify. That's what my computer does that I'm talking to you from right now. Whenever we go in a hotel room now, we swipe a little card on a button on the door, that's single sign-on, same technology that can get people into other computers. So there's many different ways to go about this.

Ron Barshop: You know, we don't talk about this much, but one of the direct links to burnout is medical errors. There's 10 thousand medical errors committed, I don't remember if it's every day or every hour, but it's a huge number. And there have been estimates somewhere between two hundred and 440 thousand deaths attributed to medical error. The reason it's such a swing is because coroners don't have to report the cause of death being a medical error in a hospital in many states. So the statistics are quite sketchy at best and a good guesswork at worst. But if medical errors were able to be cut way back because there's less burnout, people are prouder of their profession, that really affects the patient directly where the rubber meets the rim, doesn't it?

Paul DeChant: Oh, absolutely. And a lot of the work that goes on to reduce errors and create high reliability organizations is very similar to the work we do in redesigning workflow processes because we're trying to design ways so that it's very hard to make an error. The problem isn't the worker, the problem is the way the management has designed the work so a well-intentioned worker struggles to be successful.

And management's just learning this issue. It's not easy being a manager. Peter Drucker, famous management consultant, said that healthcare is the most chaotic and complex and challenging industry to lead. So it's not to come down on healthcare managers, it's just we need to understand this when we're in these leadership positions, take that responsibility seriously and change. Because we're using an industrial age approach to managing in the information age and we cannot rapidly adapt to all the challenges that are happening around us if we think that the top leadership has all the answers and we're not empowering frontline people to solve problems.

Ron Barshop: So let's go to the problem of doctor shortages in primary care. There are, of course, shortages across the board, but primary care is especially critical because if we don't have primary care funneling at the mouth of

the Mississippi, the Mississippi can dry up. Most referrals are coming from PCPs, most care starts with PCP visits. What would you do if you were the czar, besides setting up the waste czar sub office, for a trillion dollars? What would you as czar do to recruit more people into primary care, to change the model of primary care to make it more attractive for these kids?

Paul DeChant: I would turn it into team care. Most physicians when they go into an exam room, are going in there by themselves and the exam room has gotten far more complex than it used to be with all the demands that are on us. You know, no surgeon would go into an OR by themself without a team to help them manage that operation. And yet, the vast majority of primary care doctors going into a room by themselves with the patient. They're trying to track all the past social family history, make sure they get all the billing codes right, making sure they closed all the care gaps possible, making sure the patient's extremely happy with them by the end of that visit because patient satisfaction now impacts how much we get paid. And, as a result, what's happened is, and AAFP actually has numbers, American Academy of Family Physicians, has numbers on this. From 2010 to now, the average family doctor has gone from seeing 99 patients a week down to 83 patients a week. That's a 16% drop in productivity.

When you realize a family doctor produces around two million dollars a year of downstream net revenue for a health system that they're part of and we see a 16% drop in that revenue, the opportunity to help a health system regain financial stability and deal with the narrow margins is completely overlooked when we have reduced our volumes by this degree. It's all happened gradually. We didn't walk in one day and all of a sudden docs went from seeing 100 patients a week down to 80. If that had happened quickly, everyone would recognize it and start to do things urgently about it. But because all of this has been very gradual, the level of urgency that we should be responding with is simply not there, and that's a real problem.

Ron Barshop: You know, we're not going to talk about IBM Watson today, but I'm watching this young man on Jeopardy who's going to hit two million dollars today in winnings, which nobody's even come close to that number. And I really would love to put him up against, I don't know if it was IBM Watson or somebody else that beat the last Jeopardy champ, but this guy still cannot probably beat AI. Isn't a virtual team really going to look more like a digital team that's, I think of like JARVIS talking to Iron Man and his mask. Eventually, PCPs are going to have a JARVIS to talk to about diagnostics and about treatments and about conditions and have something in their ear whisper to them on almost like a team basis, "Here's where we need to go with this."

Paul DeChant: Absolutely. There's a lot of things happening in the realm of first, gathering the information, producing a progress note and orders at the end of the visit simply by having techology that's in the exam room listening to a discussion between the doc and the patient and turning that into the progress note and orders. There's also a lot of technology developing that will help guide physicians to choose the proper treatment, and that's going to radically change the way we make our treatment decisions. There's groups that are looking at ... you know, when you review a cohort of 200 thousand patients, you're going to say, "Well, this patient's got problems with blood pressure, diabetes and thyroid." We do study this where we isolate one of those three and come up with our best treatment recommendation, but it's not common to be able to make those decisions when you're looking at the combination of all those. But using AI, we can identify those patients who have that combination, identify how they responded to different treatment changes and then really make a recommendation about which is the most efficacious approach.

Ron Barshop: It seems to me you Freudian slipped the word fear in your first answer. And I think a lot of physicians have a fear that they are going to be replaced by a machine. They don't want that to happen so they resist this team approach that AI and other technologies can give them. Isn't that fear really largely misplaced?

Paul DeChant: Absolutely. AI can do some things better than humans, humans do an awful lot of things better than AI. And it's going to be the combination of the two. IBM Watson we talk about it, that is artificial intelligent, but it's augmented intelligence because it's really the partnership between people and the machine that makes things work much more effectively.

Ron Barshop: What thought leaders, Dr. DeChant, are people you follow that really guide you on the issues of burnout and about efficiency of physicians. So if I'm a patient, what should I be reading? If I'm a doctor, what should I be reading?

Paul DeChant: Not to shamelessly self-promote, but I was very fortunate to have a good co-author in Diane Shannon. The two of us wrote this book called Preventing Physician Burnout where we identify the drivers of burnout and go into quite some depth on it. We were able to interview 60 experts around the world on healthcare lean and burnout and bring those together into something that's quite helpful. There are, I would say, trying to think of which leaders truly resonate for me. There's work that is done by John Toussaint out of, he'd previously been the CEO at ThedaCare. He was one of Simpler's original partners in figuring out how to do lean in healthcare. And he's certainly very good. Jeff Thompson who was the CEO at Gundersen Clinic in LaCrosse, Wisconsin, worked that job for 14 years

and now is a national, in fact international, speaker on leading with values and speaks very well to these issues also.

A really interesting gentleman, Michael Privitera at the University of Rochester, he's a psychiatrist who has helped identify the issues around what we call human factors engineering, which demonstrates that the level of stress that we experience in providing clinical care actually starts to have physiologic impact on us, increasing the risk of cardiovascular disease, decreasing the function of things like the dorsal lateral segment of the prefrontal cortex, actually putting people at risk to make more errors as their mental capacities start to decompensate. So there's many different people out there that have a lot of good information available.

Ron Barshop: I'm going to add to your list a fresh voice you may not have heard because she's not out there quite yet, but Tori Sepa is a psychiatrist. She almost exclusively works with physicians who are burned out. She has forums and a practice that deals exclusively on the subject and she's studying this and publishing. And her two drivers that she believes really create burnout, she doesn't go to EHR and pre-auths and all the things we've talked about already, she talks about lost autonomy and she talks about loneliness. I believe it was Mother Teresa who said, "Loneliness is the worst disease."

Paul DeChant: And I absolutely agree with those. Lost autonomy, that's that loss of control that second driver that Maslach identified on burnout. And the breakdown of community is that whole collegiality or loneliness issue. So she's really nailed those. And actually, so Maslach's still very active. She's a great person if you ever get to hear her speak on it. There's a couple of others, Tait Shanafelt who's now the Chief Physician Wellness Officer at Stanford, has been a leading physician researcher in this field. And Dr. Chris Sinsky, who's actually got a VP position with the AMA where the AMA's committed significantly [inaudible 00:27:50] resources to reducing physician burnout and improving practice resiliency and sustainability.

Ron Barshop: Very nice. I like to ask this question of everybody. If you had the world's largest banner and airplane you could fly over America, what message would you want Americans to know about these issues?

Paul DeChant: What would Americans, so we're not talking about docs and patients and administrators, we're talking about the average person out there. I think they need to know that it's real. I think they can expect more of their health ... they should be able to walk in a room, an exam room, and be able to deeply connect with their patient. And when we have that deep connection with a patient, it's amazing, what provides us that great sense of satisfaction is in the relationship. Patients will tell us things they won't tell anyone else in the world. They'll even let us examine parts of their

bodies they won't let anyone else see because they trust that we've got their best intentions at heart and we've got the skills and knowledge needed to help them the way that they need help.

Ron Barshop: Are you still seeing patients?

Paul DeChant: No, I stopped about nine years ago when I started my work as CEO at Sutter Gould Medical Foundation, we're a 300 physician group that I was leading. I was brand new to the area. I tried doing urgent care half a day every other week, and I got to the point I felt like I wasn't doing it enough to stay current and be a great doctor. And the last thing I wanted to do was become a mediocre doctor. And I've committed myself now to helping docs and helping support staff to achieve their greatest potential and fulfillment. And I find that same reward I got out of caring for patients, I can get by caring for staff and physicians. And that's where I get my satisfaction now.

Ron Barshop: Well, with your background, you have about as high street cred as anybody. Let's talk about the best way to reach you. How do fun people find Paul DeChant?

Paul DeChant: I have a website, pauldechantmd.com, that's a great way to reach me. I'm also on Twitter @pauldechantmd and on LinkedIn at pauldechantmd. So those are all three great ways to find me.

Ron Barshop: Very good. We want to thank you for your time and hope to do another visit again soon as we get further along the road of fixing burnout in America.

Paul DeChant: Well, thanks Ron. And I really appreciate what you're doing to further thought on this incredibly important issue.

Ron Barshop: Great. Thank you, again.

Paul DeChant: Thanks.

Ron Barshop: Thank you for listening. You want to shake things up? There's two things you can do for us. One, go to primarycarecures.com for show notes and links to our guests. And number two, help us spotlight what's working in primary care by listening on iTunes, or wherever you get your podcast, and subscribing, and leave us a review. It helps our megaphone more than you know. Until next episode ...