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Geri Amori, PhD, ARM, DFASHRM, CPHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I'm joined by Marisha Burden, MD, the division head of hospital medicine and Professor of Medicine at the University of Colorado School of Medicine and recipient of the Society for Hospital Medicine Award for Excellence in Clinical Leadership for Physicians. As a working hospitalist, her interest is in the building of a thriving workforce and building clinical staffing models that drive outstanding patient and institutional outcomes.

I'm also joined by Susan Dorr Goold, MD, professor of internal medicine, as well as Professor of Health Management and Policy at the University of Michigan School of Public Health. Dr. Goold has special interest in public health policy and ethics and is a practicing primary care physician.

Gina Symczak, patient and family advisor serving on the council of HOMERuN, the Hospital Medicine Reengineering Network. Gina has been an active member of patient and family advisory councils at the University of California San Francisco and a representative on patient-centered initiatives for national organizations since 2012. Her service follows a career in marketing and brand strategy in the consumer packaged goods industry.

And finally, we're joined by Luci Leykum, MD, affiliate Professor of Medicine, Dell Medical School at the University of Texas Health Science Center, and a general internist, as well as a health services research investigator focusing on assessing and improving healthcare system function.

Welcome, everyone. Welcome to our panelists and to our audience. Today we're talking about the impact of the effects of upstream administrative decisions and assigned administrative burdens on healthcare providers. The high workloads and complicated systems in which our nation's healthcare providers care for patients has been recognized as a major contributor to the burnout, exhaustion, and decreased work satisfaction of providers.

So to me, as a patient, it seems that healthcare providers deal with the effects of two types of administrative burdens. One, the impact of decisions made at the border C-suite level that create the environment in which I deliver care. And two, the administrative burdens of navigating the system of electronics interfacing with insurance companies and the complexity of the system in which they have to provide care. It is endless. According to the existing AMA policy on physician decision making in healthcare systems, certain professional decisions that are critical to high-quality patient care should always be the responsibility of the physician in any practice setting, and that was a quote from the AMA.

And yet, healthcare providers don't get to decide staffing levels. They don't get to determine the configuration of the electronic record. They don't get to choose where supplies are stored or determine the daily census or the budget or which insurance companies they have to interact with, or if patients are boarded in the emergency room, or many other things that influence the environment in which they provide care.

According to a 2024 *JAMA Internal Medicine* article by Dr. Burden and Associates, the consequences for organizations and patients include increased turnover risk, reduced clinical effort, poor clinician

health, suboptimal patient safety outcomes, and significant financial costs at the organizational, community, and societal levels. The costs of burnout and turnover are estimated in the billions, emphasizing the need to reevaluate how organizations measure profits and success. And one thing that isn't mentioned in this study is the suicidality among physicians too, which is another statistic I follow, and that's pretty scary to me. So we've got a lot of pressures on our providers.

I'd like to start first with you, Gina. What has been your experience related to administrative burdens on healthcare providers? Have you, as a patient, noticed anything? Or has it all been behind the scenes? You know, a smiling face to the patients, but things not going well that the patient never detects.

Gina Symczak: Well sadly, Geri, it hasn't all been behind the scenes. I have two examples of burned-out doctors who couldn't hide their stress, both which show you that healthcare providers are people too, and they're impacted by the stress of their jobs as well as the stresses in their personal lives. First, I know of an experience where an elderly patient with Stage III colon cancer was having a preop clinic visit the day before surgery, potentially life-changing surgery for her. And she was told by the provider doing the exam that her lungs were "like crap." You can imagine the moral injury, the deep discouragement, and insult that blow delivered. After a letter of complaint was sent to the Chief Medical Officer of the hospital, the provider later sent a heartfelt letter of apology, noting that they were going through a divorce at the time.

Secondly, on the flipside almost, I've seen an overworked cardiologist, one whose patients have to book a year in advance, break out in tears of surprise and joy when a deeply appreciative patient told them that since he'd last seen her, she'd actually saved his life. A year earlier, she had noticed something on a routine cardiac scan that was unrelated to his cardiac issue, which encouraged him to have it explored, despite his PCP telling him not to worry about it. As it turns out, he had very early-stage kidney cancer. And thanks to her caring attention – despite being overworked and this being outside her specialty – he was able to beat cancer that's very rarely caught early.

Amori: Wow, that's a wonderful story.

Symczak: Good news and bad news.

Amori: Yeah, yeah, yeah, Luci, your focus is on improving healthcare system function using – something I don't know anything about – complexity science as a framework. For years now, the process of prior authorization has created confusion and prevented patients from getting care. That feels complex to me. At times, it can feel like the insurance company is practicing medicine. All right, so now I can see the need for prior authorization if you don't know what your insurance covers, and you don't want to be surprised. But most of the time that's not the case. I mean, my spouse, who's a physician, ultimately left practice because he was like, I don't want the insurance company telling me how long my psychotic patients need to be in the hospital. I know they don't. Anyway, what are your thoughts about administrative harm caused by authorizations? And do you have a complexity model of that to apply?

Luci K. Leykum, MD, MBA, MSc: Well, of course I do. So, I think the saying that the whole is greater than the sum of the parts is a very useful way of thinking about complex systems. So you can't predict outcomes in a complex system based on your knowledge of the component parts in isolation. It's really how those parts interact with each other that's critical to outcomes. And in healthcare systems, those

parts are actually people. So, much of the healthcare system function is based on how people interact with and relate to each other. So when people are able to talk to each other, they develop these shared understandings of what's happening. And we call them shared mental models.

And they can be about a specific person's care plan, about their care, or about, you know, the right steps in a process to accomplish things. But they're very important because those are the scripts from which people act. So, coming back to prior authorizations, I think a key thing – from a complexity perspective – is how do we make sure that the entire team, including the patient and their family and their payer, has all the information that they need so that the rationales are clear, everyone's advocating with a consistent message, and our health records make it easy to record and support that clinical understanding to advance care plans quickly.

Amori: Okay, thank you. That explains about the complexity too. I like that. So Susan, it's been opined by the American College of Physicians that prior authorizations is one of the many administrative burdens that contribute significantly to physician burnout. Now I know that's just one thing, but how big is it really, and do you consider it an ethical issue?

Susan Goold, MD, MHSA, MA: Yeah, actually people have talked about and looked at burnout in a number of ways. Suman Agarwal and colleagues published something about burnout where they identified something they called professional dissonance. Okay, and that's basically physicians reporting being demoralized and conflicted that their values, as physicians, were in conflict with the values of the system. And I have known physicians who have either substantially cut back or even left clinical practice who reported feeling that way. I can't work long enough hours to take care of patients the way I feel like I should, so I'm just not going to do it anymore. Yeah, I think we need to recognize that there's burnout, and then there's sort of this professional commitment issue. And we may lose some of the best doctors – the ones who care the most about patients – if they don't feel like they can work in the system.

Amori: Understood. Understood, okay. Marisha, in an original study published by you and your colleagues in *JAMA Internal Medicine*, in 2024, you stated – and I'm going to quote you – “the changing healthcare landscape has made many clinicians feel they are cogs in a wheel.” Increasing workloads and administrative duties for clinicians leading to cognitive overload can directly affect the care for their patient and not for the better. Overwork and the inability to provide care aligned with patient needs leads to moral injury and burnout.

So now my question to you. As a hospitalist, can you give us examples of the impact of administrative

Marisha Burden, MD, MBA, SFHM: Yes, as this entire podcast has highlighted, healthcare today is increasingly shaped by organizational decisions that prioritize short-term financial gains, often at the expense of safe and sustainable care. And these decisions directly affect how teams are structured, how many patients each clinician is expected to manage, and the resources that are allocated to support that care. Take, for example, a hospitalist who is assigned unmanageable number of patients. When they can't return a family's call, follow-up on an abnormal lab in a timely fashion, or spend more than a few rushed minutes at the bedside, that gap between what we should do and what we can do becomes a source of moral injury. And it's not about a lack of dedication. It's a design problem built into the system, built by individuals within that system.

And one concerning thing that we found in our research on administrative harm highlighted what I would call a very concerning trend that organizations are even outsourcing some of these decisions around work design to third-party consultants. And this was brought up in numerous focus groups. And I thought I would provide a quote from that study that I thought was very powerful, and this is from a participant. “We actually paid a very high-cost consulting company to tell us what we needed to eliminate, which was their administrative time and staff to 18 to 20 patients per hospitalist and cut vacant positions, and the list goes on and on. They were being paid a ton of money to tell us how to do our work. And then on top of it, they were basically trying to create a burn and turn program. It's these conditions that lead to moral injury and harm.”

Amori: Okay, wow, that's pretty crazy. Gina, do you feel that patients should support providers in their mental health and administrative burdens? And if so, how; and if not, why not?

Symczak: Absolutely, the providers are their partners. Patients need to recognize – and I think that the vast majority do – that providers are humans trying to practice their profession in a very, very complex system. And those providers have day-to-day, you know, realities that impact their lives and their moods too. So I think patients should try to make their providers' jobs as easy as possible, you know, by being organized with their health history, their questions, etc, so that their visits are the best use of everybody's time. And they should always treat providers and their staff with courtesy. That's just common sense, right? Common sense, common courtesy.

Amori: Common kindness, yeah, yeah. Luci, Lazarus MD stated that healthcare providers feel they can't provide the level of care they believe is necessary due to systemic constraints or administrative decisions. When practitioners are forced to navigate these, they may experience a conflict. I think it's already been addressed. I think even Marisha mentioned it. You know that a conflict between their professional values and the realities imposed by the system. So, this can lead to all kinds of bad feelings, and the components of what we used to call comprehensive, multidisciplinary team care seems or feels like it's been replaced by only those services that are allowed or reimbursed. That's just a feeling sense. What do you think?

Leykum: Yeah, you know, I think the daily interactions that occur between team members – again, including patients and families as part of that team – are so important to frontline clinicians. These interactions allow us to understand what's happening in real time, which is important for good clinical outcomes, but they also promote the positive relationships that make work enjoyable, that make us want to go in every day. So when the way, though, that we work is disrupted because of these administrative considerations, and clinicians don't have those opportunities to provide input, so that even if processes change, those needed daily clinical team interactions are able to be maintained, then you don't have a team anymore, right? You just have people working in isolation, feeling frustrated and unheard in systems that, to them, are driven by priorities that they don't share anymore.

Amori: Got it. Got it. Marisha, in the *JAMA Internal Medicine* article we mentioned a few minutes ago, you identified and measured harms experienced by hospitalists and administrators related to work structures, processes, and programs. So what did you learn? Can you really measure administrative harm?

Burden: It's a great question, and definitely one I often get, can you measure it or not? And the answer, I believe, is yes, and it's essential if we want to fix it. In our recent study, as you all know now, that we assessed both clinicians and leaders about how work structures and policies are affecting their ability to care for patients. And as we discussed, the findings were striking, and most said that it was causing harm to patients and to the workforce but don't feel safe to speak up. And so as we think about how we can start to measure that so we can then mitigate it, I think we have to take multiple approaches. And that's what we're doing in our research today, thinking about how surveys can capture perceptions of staff. You can capture moral injury, cognitive load, test load, and understanding of where people are at with their work.

There's so much operational and financial data. And pairing all these things together is increasingly important and helps to paint a much fuller picture of how an initiative may play out. And the thing I'm really excited about is something called EHR, electronic health record, use data. So we actually, without asking clinicians to do more work than they're already doing, can capture clickstream data. And so we can understand what a workday, at least electronically, looks like. This mindset should guide every single new process or policy. For example, if an organization rolls out a new funds flow model or restructures teams, it shouldn't run on autopilot. We should check did it deliver the intended results, what worked, what didn't, and what unintended consequences did it cause?

I'll use just a quick example from an operations course I once took, in my career, where my team was tasked to redesign a primary care clinic to eliminate idle time, to eliminate that "nonproductive" time. And as a student, we filled that day with back-to-back 10-minute visits, labeled the thinking and planning time as effectively waste. And on paper, it was an efficient system. We got an A. And I may note that this was not a practical approach but, you know, you're trying to do the exercise. But in reality, this plays out in real life. In administrative decisions, when folks don't understand what the actual ramifications are of those decisions, and it's a perfect example of how business thinking sometimes can create administrative harm if you don't actually build in the fact that good care does need time, cognitive time. And so that model that I built, in an embarrassing sort of way, wouldn't last a day in the real world.

Amori: Okay, wow. I'm glad I'm not a patient being seen in one of your 10-minute slots. I'll just say that.

Burden: Thankfully, just an exercise in a classroom, never going to implement such a model.

Amori: Thank goodness, right? So speaking of patients, Gina, in what ways do you see the administrative work of healthcare being different from healthcare providers, and in what way are they the same? And then from a patient's perspective, when things are difficult or go wrong, do you think patients blame the providers first and the system second? Or do you think they see it all? What do you think?

Symczak: I think that healthcare administration has business expertise to ensure the functioning of the business aspects of a healthcare system. And like all businesses, healthcare systems have customers, and those customers are the patients. The healthcare providers have the clinical expertise to ensure the wellbeing of those same customers, the patients. And in an ideal world, administrators and providers would work seamlessly. They'd work together, as a team, to positively impact the experience of their shared customer, the patient. I'm fairly confident that patients understand that the medical system is extremely complex, layered, and terribly disconnected, involving providers, insurance companies,

administrators, investors, the government, you know, you name it. But patients are already at a disadvantage in this complex system because they're not feeling well. So I think it's fair to say that a patient, someone who's in a vulnerable position, always will likely give the benefit of the doubt to whomever they trust most, and they'll place blame on whoever is not engendering trust.

Amori: Okay, all right. Luci, our complexity theory specialist here, this sounds like total chaos to me, if you want to know the truth. And it sounds like the providers are suffering, the staff is suffering, and we're caught in a vicious cycle. Do you see, in shorthand, a process that could help us sort out where the issues actually lie and help us figure it out?

Leykum: Yes, so it is chaos, which is why complexity science and the study of unpredictable systems is so appropriate for this conversation. And I really believe the key is enabling people to talk to each other about what's happening in real time. And I had a former colleague who used to express this very nicely. He'd say, we need time and space for conversation and reflection. And that time and space can take many different forms – meetings, huddles, after action reviews, briefings, debriefings, whatever you call them – they're all strategies for bringing people together within and across levels of the organization to bring order to the chaos.

Amori: All right. And on that note, I'm going to ask my favorite question of the day. Two sentences or less, if you had one point you'd like people to remember after they listened to today's *Perspectives 360*, what would that be? And I'm going to start with you, Susan.

Goold: Well, first that doctors and nurses and other clinicians, when they're kept from doing what they sincerely think a patient needs, suffer. They suffer in their professional identity, and of course, the patients suffer, which is even more important when administrative harm interferes with their care. Administrators need to be evaluated both on financial and on clinical and health impacts of their decisions. And those are administrators at multiple levels, from the clinic director to the CEO, C-suit I think you mentioned in an earlier podcast, to the Center for Medicaid and Medicare Services. Yeah, let's not make providers and patients suffer. Let's find out how not to.

Amori: I like that. Let's not make providers and patients suffer. Let's find out how not to. Luci, what would you like...what would be the one point, in two sentences, that you would like people to remember?

Leykum: The importance of people being able to talk to each other as a critical action in daily work. And it sounds so basic, but it's so hard to accomplish, and our leaders need to promote that happening.

Amori: Okay, thank you. Gina.

Symczak: Susan just said something that made me think of something. If you've got basically a three-legged stool here with, you know, providers, patients, and administrators, if two out of the three are suffering, you've got a pretty weak support system. And I think that that really kind of speaks to what's happening here. But I think what I'd like to leave people with is that it's overwhelming for patients to be burdened with the complexities of the system in addition to the complexities of their own health issues. And there is a real human cost to patients, both indirectly from the administrative burdens suffered by their healthcare providers, as well as directly from the administrative burdens to which they're subject.

Amori: Thank you, Gina. Marisha, what would be the one thing, two things you'd want people to remember?

Burden: Yeah, what gives me hope in all of this is that much of administrative harm, I believe, is preventable. The work structures, processes, and decisions that lead to burnout, moral injury, and compromised care don't just happen. They're created, which means they can be rethought, redesigned, and improved.

Amori: Oh, I like that, and that gives me hope, too. I'd like to thank our panelists for being here with us today for this extremely rich conversation. And I'd like to thank our audience for being here with us today listening. And I hope that you've gained some ideas that give you pause for thought and maybe some causes for action. I'd like to thank all of you, in fact, for your thoughts and perspectives, your commitment, and your willingness to listen. Thank you, everyone. See you next time on *Perspectives 360*.

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