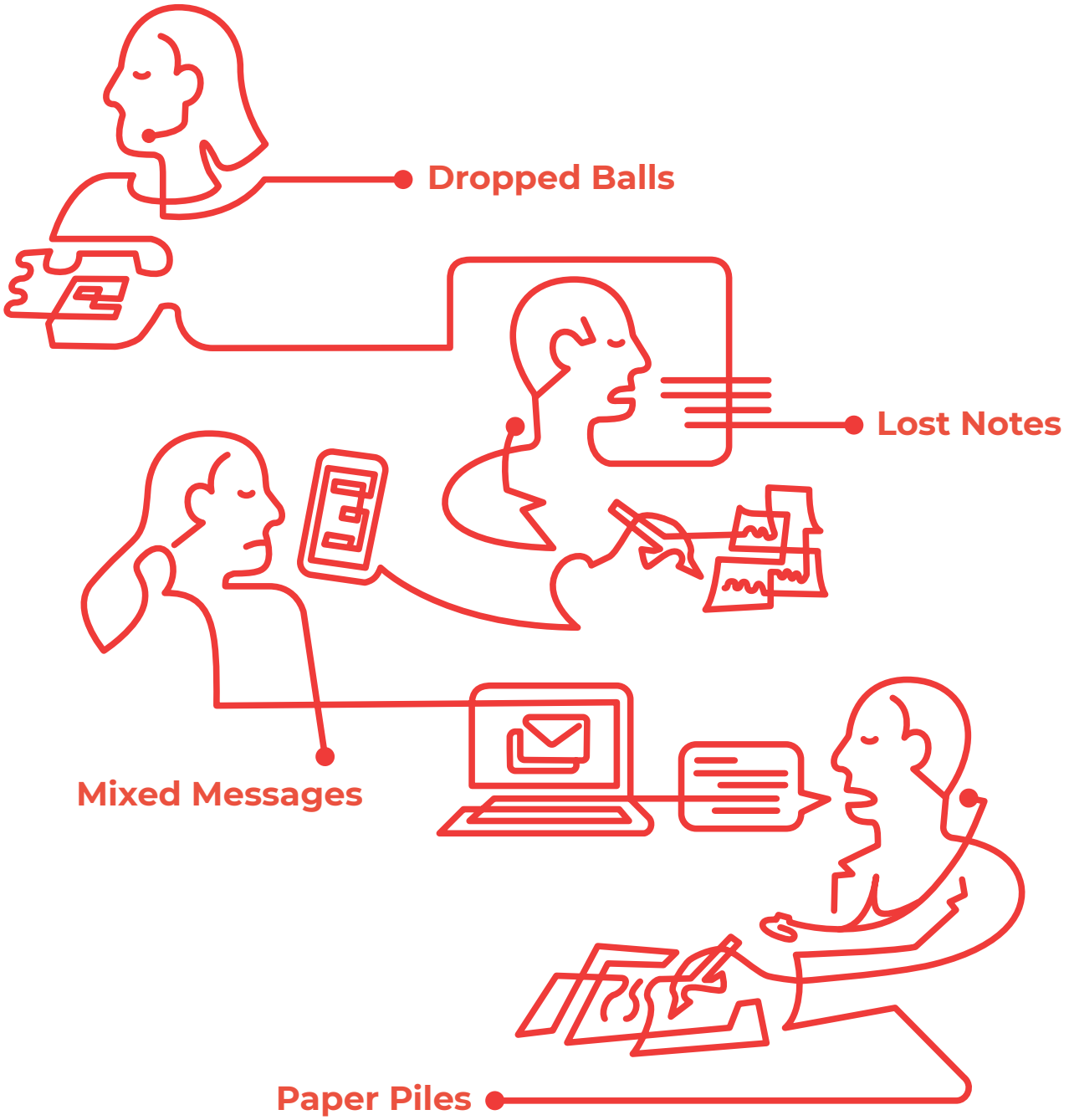
Creating

INTERCONNECTIVITY

to improve patient care and reduce provider burnout



By Michael Docktor, M.D.
Pediatric Gastroenterologist, Boston Children's Hospital
Co-founder & CEO, Dock Health

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“WE HAVE POOR ACCESS TO INFORMATION. WE HAVE POOR CONNECTIVITY. WE HAVE INCONVENIENT CARE FOR MANY PATIENTS.

The pandemic has taught us that there are some massive failures in the American healthcare delivery system.

We have caregivers that do not work as teams with each other in the way we would really like them to work with each other. And we have some serious delays in learning and in sharing information between caregivers.”

George Halverson
Chair of the Institute for Intergroup Understanding
Former CEO, Kaiser Permanente

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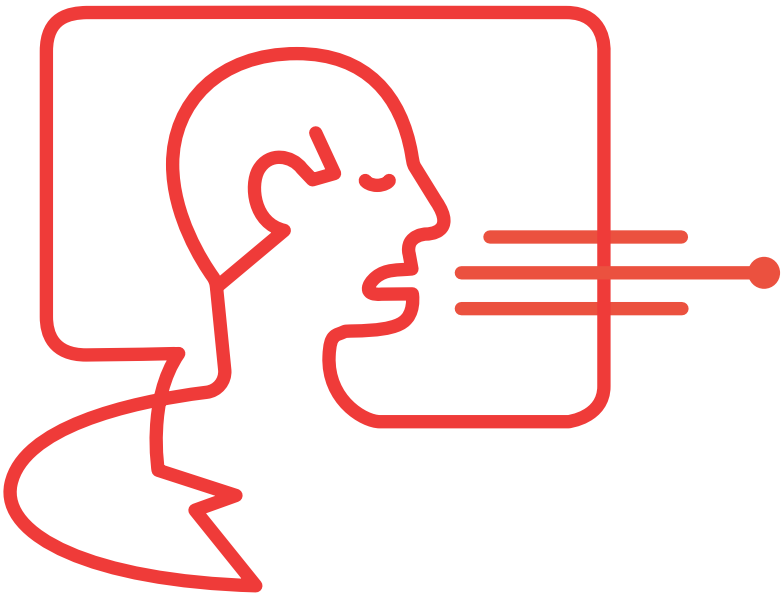

Confusing Context

WHAT WE HAVE IS A DISTINCT **INABILITY TO COLLABORATE** EFFICIENTLY AND EFFECTIVELY

The COVID-19 pandemic has caused an unprecedented level of distress amongst frontline healthcare professionals: Long hours, the anguish and risk of treating infected patients and becoming infected themselves – or bringing infection home to their families – and the separation from family, both immediate and extended, to avoid spreading infection. All of these factors have contributed to a previously unseen level of physical, mental and emotional fatigue among healthcare workers.

Many practitioners are also confronting the stress of financial and sustainability pressures, trying to keep practices open, care for their patients, and keep their people employed.

The pandemic has also exposed one of the most problematic, underlying conditions of our healthcare delivery system: A distinct lack of interconnectivity at the care-delivery level on up to the national and health-system levels.

Across the healthcare ecosystem, the use of electronic health records (EHR) has kept patient data (that could potentially have improved the coordination and care of COVID patients) siloed and difficult to access across providers and their systems.

At the patient level, the pandemic has further contributed to cognitive burden, administrative errors, and time management challenges for healthcare providers and administrative staff as they try to manage all the tasks related to care under very difficult conditions.

While the pandemic has exacerbated the issue, the reality is that once it passes, the underlying problems will remain and need to be addressed. This lack of interconnectivity – and the associated administrative and care management issues – will continue to contribute to what we refer to as the **"Three Pillars of Pain"** for those in the healthcare delivery system:

1. **Cognitive overload** (inefficiency)
2. **Medical errors** (dropped balls)
3. **Staff burnout** (moral injury)

In this ebook, we take a closer look at all three pain pillars.

BRAINS ARE COMPUTERS, BUT **HUMANS AREN'T MACHINES.**

Clinicians have a lot to deal with. And yes, that's certainly an understatement. When I was a full-time pediatric gastroenterologist, on a busy clinic day I might see 15-20 patients and receive 75 emails, 10 secure messages, three urgent pages and five EHR messages in my inbox. For many providers, that communication load happens every day.

Clinicians and their teams, across the spectrum, often have to process and manage a massive flow of information from many directions – everything from phone calls, emails, texts, secure messages, EHR communications, hallway conversations and more – on a daily basis. That involves scheduling tests, following up on chronic care, writing prescriptions, contacting family members, and other administrative paperwork, forms for schools and prior authorizations, while also attempting to keep team members in the loop. This happens often by memory or by using disparate, highly inefficient systems like email or non-secure tools like spreadsheets, Post-Its or, in my case, little check boxes on the back of clinic notes.

I simply had too many to-dos throughout my day. Whether it was in-clinic – being tasked with patient care followup – or addressing phone calls, emails or EHR inbox messages, there were so many tasks that came in throughout the day, delivered in various formats, with no secure place to log, track, and delegate them.

“THE FEDERAL GOVERNMENT SPENT OVER $35 BILLION ON THE EFFORT TO GET DOCTORS TO USE ELECTRONIC HEALTH RECORDS

...NEW TECHNOLOGY THAT IS MAKING THEIR WORK MORE DIFFICULT, NOT LESS — CAUSING MORE PHYSICIAN BURDEN AND BURNOUT.”

Seema Verna
Administrator, Centers for Medicare & Medicaid Services

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ELECTRONIC HEALTH RECORDS AREN'T DESIGNED FOR THIS...

...neither are human beings. The end result is too much information for the brain to process and keep track of – often referred to as cognitive overload. This leads to the **second "Pillar of Pain."**

BALLS GET **DROPPED.**

In the simplest terms, administrative steps get missed and balls get dropped. The result can be anything from a minor inconvenience, to a delay in care, all the way up to a life-threatening situation if, for instance, a critical step in preparing for a procedure or therapy is missed. But none of these misses are acceptable.

I pride myself on making sure my patients and their families feel cared for and supported; yet here I was dropping balls on administrative elements of care, overwhelmed by emails, camp forms, prior authorizations, orders to place, and callbacks to make.

CHICKEN SCRATCHES ON CLINIC NOTES AND POST-ITS JUST DON'T CUT IT.

Keeping track of every next step and status in your head is exhausting. These are also poor ways to collaborate with a department or organizational team of nurses, schedulers, techs and administrators. It leads to taking an inordinate amount of time and effort trying to close loops on patient care – often failing, certainly with anxiety, always with inefficiency. For example, when patients would contact me wondering where they were in the process of waiting for their critical infusion, I unfortunately had no idea or visibility into the process. As a result, it started to feel like I wasn't doing my job as well as I'd like to do it.

My default was resorting to memory – finding a corner or cabinet of my brain to store these steps, this information, until I needed to share it with someone. Inevitably, what would happen throughout the clinical day or week is that I'd forget something. Invariably, I'd get a second or even a third email: *Hey doc, have you done this?* Medically, I am inspired and passionate about the work I do. The administrative side of care is neither of those to me – but they are two sides of the same coin, and doing one less well than the other can cause feelings that, despite my best intentions and desires to care for my patients, I felt I was falling short.

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$1 TRILLION IS WASTED IN U.S. HEALTHCARE COSTS PER YEAR DUE TO INEFFICIENCY[1].

$730 BILLION COULD BE SAVED SIMPLY BY REDUCING ADMINISTRATIVE COMPLEXITY[2].

1) CMS.gov: https://go.cms.gov/1UFHHer
2) HBR.org: https://bit.ly/1Lsv8ko

This, in large part, contributes to our **third** "**Pillar of Pain.**"

HEALTHCARE WORKERS ARE BURNING OUT. **BADLY. DANGEROUSLY.**

The COVID-19 pandemic didn't *create* the burnout issue among frontline healthcare workers (that problem existed long before), but it certainly has exacerbated and accelerated the burden of burnout. Teams are thinner and more distributed than ever. Collaboration and coordination are more essential than ever, yet harder while teams work from home offices and kitchen tables.

Once this pandemic is finally under some measure of control in the U.S., the problem of burnout will still be there. Needless to say, how we practice, how we interact with our patients virtually and with our teams virtually has changed, yet nothing has changed about how we work together as a team. And this is a big problem.

Studies have shown that 50 to 80 percent of all providers are suffering some measure of burnout[3]. That burnout manifests in numerous ways, from behavioral changes – a shorter fuse or less willingness to go the extra mile – to procrastination and to the extreme: The suicide rate among physicians is 2x the rate of the general population[4].

Clinical data entry is often cited as the primary reason for burnout. Doctors and nurses have made tremendous investments in time, money and energy to attain the training required for what they feel is their primary task: caring for patients. Often, they find themselves spending large parts of their days managing to-dos rather than focusing on patient care, and operating at the top of their license.

BECAUSE WE'RE DRIVEN TOWARD PROVIDING THE BEST CARE, WE PUT OURSELVES AT RISK.

We forgo the dance recitals and soccer games and the nights and weekends free. We get maniacally focused on taking care of our patients and making sure all those to-dos get done, without acknowledging the anxiety of juggling all these balls and not knowing with certainty that patient tasks were completed and the loops were closed. It starts to pile up.

My colleague at Dock Health, chief operating officer, Jonathan White, notes that the solutions many healthcare systems currently employ to address the burnout – and the associated fall-out – are rather lacking, even while well-intentioned: "Chief wellness officers are hired. Hospitals offer yoga, or types of training to make providers more resilient. Rather than solving the problems or disease, these organizational moves treat the symptoms of overwork, cognitive overload and burnout."

Trying to play a team sport without a focus on and value for team mentality, inevitably breeds a losing environment.

The question then is, how do we solve the problem?

HOW DO YOU TREAT THE DISEASE?

3) The Physicians Foundation: https://bit.ly/2PEOkRs
4) American Psychiatry Association, Annual Meeting, May 2018

"$980 BILLION IS LOST TO MEDICAL ERRORS IN PRIMARY CARE[5]. ADMINISTRATIVE ERRORS ACCOUNT FOR UP TO HALF OF THOSE ERRORS[6]."

MORE THAN 250,000 PEOPLE EACH YEAR DIE FROM MEDICAL ERRORS. IT'S THE 3RD LEADING CAUSE OF DEATH PER YEAR IN THE U.S.[7]

5) J Health Care Finance. 2012 Fall;39(1):39-50.
6) Health Aff (Millwood). 2011 Apr;30(4):596-603. doi: 10.1377/hlthaff.2011.0084.
7) BMJ. 2016 May 3;353:i2139. doi: 10.1136/bmj.i2139.

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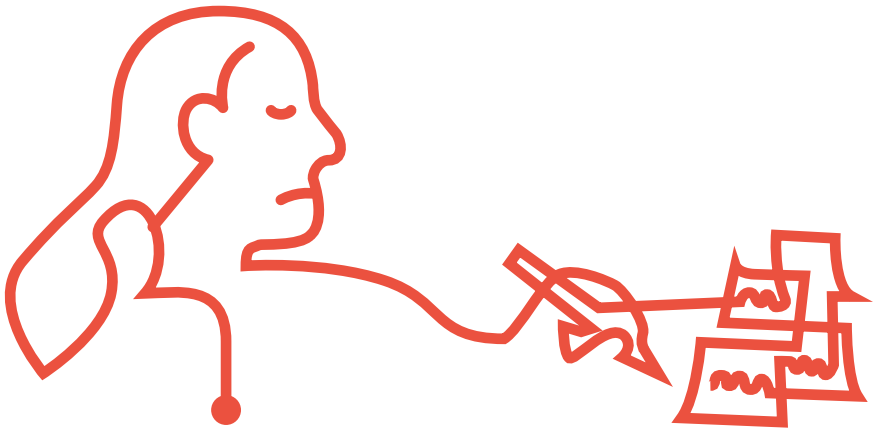


TREATING THE UNDERLYING CONDITION:

HOW TO SOLVE THE INTERCONNECTIVITY PROBLEM.

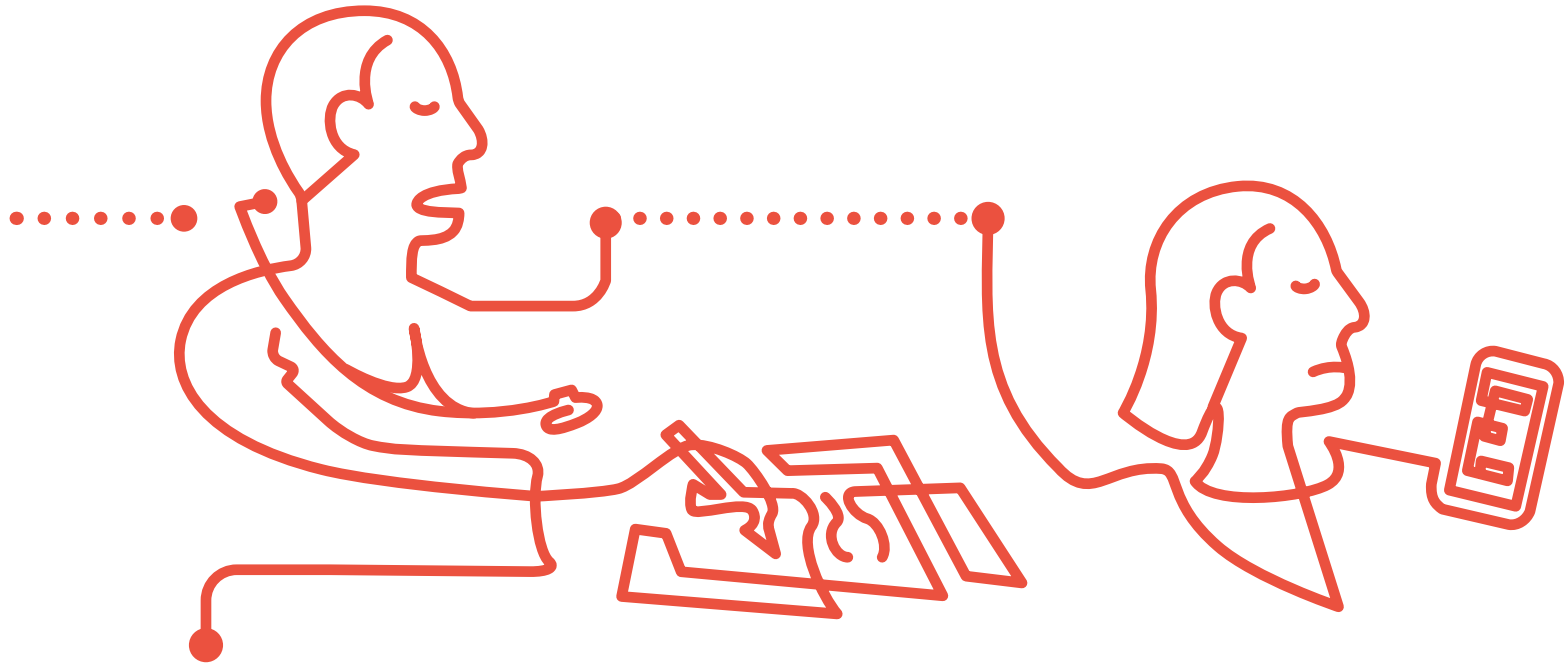
The first step to solving the interconnectivity problem is to actually acknowledge the interconnectivity problem exists. The healthcare system has done things a certain way for a long time, and many people don't give it a second thought. That's just how it's been done. True, there have been improvements such as the adoption of EHRs and various health information exchanges (HIEs), but those improvements are incomplete. Additionally, there isn't a sense of empowerment or autonomy for individuals to drive team-wide improvements.

> **"The system has spent billions on the EHR, on clinical documentation," White said. "We've focused the attention and technology on the practitioners and given them the tools to document the care, but we've spent nothing on the administrative tasks and operations and staff required to help deliver that care."**

We, as clinicians, spend the bulk of our administrative time in the EHR; however, the number and variety of administrative needs correlated to the patient's clinical needs aren't intuitively part of the current EHR. Nobody thought that healthcare would turn into the administrative nightmare that it has, and nobody designed for the collaboration necessary to tackle it as a team. There's an inbox that works like email from 1996. There are all these administrative tasks that have to get done once an order is placed in the EHR, and the only way to do that is over email, or knocking on someone's door and handing them your checklist.

THE PANDEMIC ILLUMINATED HOW INEFFICIENT OUR ADMINISTRATIVE PRACTICES HAVE BEEN.

There is both a literal and figurative disconnect between clinical and administrative functions. How does that manifest every day? The whole system operates inefficiently, clinicians experience cognitive overload, balls get dropped and people burn out, and ultimately, both the patients and the providers suffer.



REDEFINING THE CARE TEAM

The other part of this equation is that we need to adjust how we think about healthcare delivery holistically. For so long, the term “provider” has really only applied to the physician or nurse, but left out of that is the fact that the people providing administrative functions are also part of the patient care team.

We really need to start thinking of everyone on the team as a provider. We are united in our desire to take the best care of our patients. We’re on the same team, but we too-often use disparate tools and technology. We need a platform that allows all providers to seamlessly work together, ultimately providing more affordable, reliable and efficient care while improving the provider experience....The Quadruple Aim.

All of this highlights the serious need for a secure, HIPAA-compliant, collaborative patient task management platform. When you boil it down, everything related to patient care can be defined as a task -- schedule this procedure, order this test, make this appointment, write this prescription, fill out this form. Tasks are the actionable units and essence of delivering healthcare, and there is no centralized, interconnected platform for assigning these tasks, and then tracking their progress to completion.

In the world of consumer tech, where the security requirements don't mandate the protection of health information that HIPAA mandates, companies use solutions like Jira, Trello and Asana every day. Software engineers have tools to collaborate with their team members, know their to-dos, understand what's on their task list, how to prioritize and delegate them, and can also track their progress to completion. The concept of task management in healthcare simply doesn't exist yet. We are all too used to doing things the way they have always been done, no matter how unreliable or inefficient. Until now, there hasn't been a system to manage all the to-dos as part of good clinical care that was also HIPAA compliant. Teams struggle to cobble together their own solutions with non-HIPAA compliant applications, making collaboration difficult. When this happens, both patients and providers suffer and compliance with HIPAA is at a greater risk, as are financial outcomes and reputation.

True interconnectivity means that one cannot only collaborate within their own team, but can collaborate across broader organizations, and between organizations. The actionable unit of healthcare delivery or "tasks," can flow with security, transparency and accountability across every sector: physician practices, hospitals, labs, pharmacies, payers, social workers, amongst others. They can draw from all the disparate silos of data such as EHRs, physician directories, and more, in the service of one prime objective: efficient, highly reliable patient care.

MY OWN EXPERIENCE IN THE CLINICAL SETTING HAD ME ASKING ALL THESE QUESTIONS, **SEEKING PATCHWORK SOLUTIONS, AND BELIEVING THERE WAS A BETTER WAY.**

I had a front-row seat to the types of innovations healthcare organizations both need and foster creation of, overseeing this aspect of my hospital in my blended role as a physician, innovator and informaticist. After too many Mondays arriving at the office unsure of where things stood from Friday, I felt empowered and, honestly, called to create a tool that enabled interconnectivity among everyone on the care team, that vastly improved collaboration, and that drove us to all work together securely, across any specialty, any setting, any time.

Along with my co-founder, Keather Roemhildt, an experienced UX designer of consumer products, and an incredible team of healthtech experts, Dock Health was founded to apply the best ideas of popular project management platforms to an experience built specifically for the needs of healthcare. It needed to achieve and ensure HIPAA-compliance, understand how teams interface, know where balls are often dropped, and take into account how new technology is adopted within healthcare environments. The platform puts the patient at the center of the care, and treats every aspect of that care as a task to be completed. Dock gives everyone on the team a central hub to create, track and note the completion of clinical and administrative tasks throughout the day. We help create the structure, process and accountability in a unified platform that otherwise does not exist. Best of all, we've brought much needed design and simplicity to healthcare with an intuitive and integrated solution.

ULTIMATELY, DOCK BUILDS EFFICIENCY AND MAKES ORGANIZATIONS SMARTER AND HEALTHIER.

The day-to-day impacts are analgesic for those three **"Pillars of Pain"**. Dock Health's interconnectivity and ease-of-use can mitigate cognitive overload. The simplicity of creating protocols and templates, and assigning and tracking tasks means fewer balls are in the air and, therefore, fewer of them are dropped. This of course results in fewer medical errors and more highly reliable care. All of this contributes to less time spent on administrative tasks, reduces uncertainty, and creates much needed relief for both patients and providers with greater transparency. From a job-satisfaction and -burnout standpoint, Dock Health means to providers more time with family, and doing what matters outside of work. It means an overall better quality of life, not to mention healthier, satisfied patients.

Michael Docktor, M.D.
Co-founder & CEO
Dock Health

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Demo Dock Health. We realize there's a paradox in solving the problem of the patient care-management system: The problem itself leaves little time to actually solve it; but we're trying to make that easier, too.

YOU CAN TRY DOCK **FREE HERE** OR SCHEDULE A 30-MINUTE DOCK DEMO WITH ME.

It's a new year, we have new hope. Let's put 2020's problems behind us with new solutions that restore our joy for healthcare and foster teamwork.