ADVANCING SHARED ACCOUNTABILITY TO REDUCE REGULATORY BURDEN, PROMOTE WELL-BEING

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Introduction: A different perspective

Within the compliance profession, Cecilia Fellouse has noted, "Under the weight of incessant regulatory demands, individuals and teams often fall prey to compliance fatigue. This phenomenon arises when the sheer volume of rules overwhelms, leading to burnout, decision paralysis, and a loss of sight of broader objectives."[1]

Perhaps not news to the seasoned compliance professional, it has been reported that in the U.S., hospitals, health systems, and post-acute care providers must comply with more than 600 regulatory requirements. It is also no secret that there are significant costs associated with regulatory compliance and administrative burden in healthcare. But are *all* the costs truly considered when it comes to implementing and updating procedures and policies associated with regulations?

The administrative activities associated with regulations cost healthcare organizations nearly $39 billion annually.[2] This estimate does not account for the downstream effects of regulatory burden; however, it can be not only an expensive problem but also an unintended source of patient care hazards. Time spent on administrative tasks meant to fulfill regulatory and payer requirements takes physicians' time and attention away from patients, leading to risks of incomplete communication, misunderstandings, and lower-quality care.

Administrative and regulatory burdens are known drivers of professional dissatisfaction[3] and burnout among physicians.[4] The repercussions of these burdens are considerable, with serious implications for the healthcare system and organizations. Primary care physician turnover that results from burnout is estimated to cost the system $260 million per year, with the costs across the entire physician workforce conservatively estimated at over $5 billion annually.[5] Further, burnout has been associated with medical errors[6] and longer recovery times,[7] which can lead to heightened risk, additional healthcare expenditures, and expensive litigation.

Survey data show that almost 40% of physicians believe regulatory burdens are a major source of dissatisfaction in practicing medicine;[8] likewise, 46% of physicians believe that efforts to reduce administrative burden would be the most effective intervention to reduce burnout.[9] Protecting physicians' well-being and mitigating burnout may not be the compliance professional's first priority; however, with the right amount of collaboration, we imagine a symbiotic system in which improvements to physician well-being happen organically as a result of better, more in-tune compliance policies. We offer a perspective on the complex job of making sure that regulatory compliance works for everyone and doesn't create undue burden or costs in the process: **Involving frontline physicians early and often in the**

development, implementation, and audit of compliance and operations processes can result in significant improvements to multiple aspects of medical care.

Background: On the frontlines

Regulatory requirements ("regulations") are often vaguely worded and fraught with legalese, requiring translation and interpretation before application. In addition, rules considered "regulatory requirements" may come in many forms from a variety of sources. The burden of compliance with healthcare regulations goes well beyond the rules and standards imposed by government agencies, extending to accreditation standards, organizational policies, standard operating procedures, standard workflows, best practices, recommendations, and guidelines.

Organizational policies and procedures are designed and implemented in part to ensure compliance with regulations. The relative risk tolerance of the organization and its leaders influences how regulations are interpreted and applied within the internal workflows to support organizational adherence. In turn, the organizational policies and procedures reflect the interpretation of the regulation and affect the organization, its workforce, and patients. If they are too lenient, there is a risk of audit or accreditation failure. If they are too strict, there is a risk of inhibiting optimal efficiency and instigating unnecessary administrative burdens. Understanding how these nuances in developing and implementing internal policies can affect day-to-day practice is important in achieving shared accountability between frontline physicians and compliance teams.

Considered separately, it is easy to see how compliance professionals and physicians can have very different goals. The primary purpose of a compliance office is to manage risk for the organization's benefit, while the primary purpose of physicians is to preserve and improve their patients' health for the benefit of the population. From a holistic point of view, compliance and clinical teams have much more in common than not. Shared priorities likely include promoting ethical conduct, patient safety, high-quality care, minimizing risk, maintaining accreditation, sustaining the organization's mission, financial viability, and good organizational standing in the community. Recognizing mutual values helps identify areas for improvement and opportunities for better alignment.

While intended to protect the organization from risk, over-interpreting regulations or standards can lead to unnecessary administrative burdens, contributing to inefficiencies, safety risks, bottlenecks, and stress. For example, physicians may—because of a process or policy driven by an over- or misinterpreted regulation—find themselves performing tasks that could be done by someone else or eliminated completely. Such tasks may include reviewing a patient's medication list with them, determining which chronic daily medications are due for renewal, pending orders, and attaching the patient's preferred pharmacy—none of which require a physician's skills and training. This type of administrative burden is associated with lower professional satisfaction, higher job stress, and higher burnout[10] and takes time that could be spent on higher-value, more engaging work for which a physician is uniquely qualified. Another example is training that helps organizations maintain compliance with laws, but when implemented inefficiently and without consideration of the physicians' schedule or learning preferences, can collectively require significant amounts of uncompensated time, taking attention away from patient care, and creating unnecessary burden for physicians and organizations.[11]

Recognizing mutual values helps identify areas for improvement and opportunities for better alignment.

In identifying areas for improvement, physicians and compliance professionals have an opportunity to work together to reduce unnecessary regulatory and administrative burdens for physicians in support of our shared values of patient safety and high-quality care. For example:

- Despite many organizations implementing a requirement for patient consent at every visit or regular intervals for chronic care management (CCM) services, the Centers for Medicare and Medicaid Services (CMS) only requires consent be obtained *before* the start of CCM services

and/or if the patient changes to a new billing practitioner for these services.[12] **Reducing the number of times consent is required for CCM services can save time for both physicians and patients**.

- Some practices for all prescription orders require two-factor authentication; however, no federal regulation or security rule requires this, and the Drug Enforcement Agency only requires it for controlled substances.[13] **Eliminating unnecessary authentication for non-controlled substances can reduce electronic health record (EHR) tasks and allow for more face-time with the patient**.
- Some hospitals automatically deliver all electronic patient event notifications, such as admission or discharge notifications, to a physician for post-acute care coordination or treatment purposes. However, CMS does not require this automatic delivery directly to a physician's inbox. Organizations can coordinate with clinical leaders and physicians to develop processes to prioritize and tailor the delivery of event notifications in ways that align with physician and organization preferences and reduce redundancy. **Working with physicians to have patient event notifications routed away from their inbox for appropriate handling can reduce inboxes volume and allow for on-demand access that saves the physicians' time**.[14]

Improving areas like these, where implementation of policies in the name of compliance can hinder efficiency or create unnecessary work, can be achieved by collaboration and shared accountability between the affected physicians and the responsible compliance and operations teams.

Working together: Strategies and tactics

We propose the following set of collaboration strategies for compliance and clinical leaders to reduce "compliance fatigue" as part of their efforts to address physician and clinician burnout.

Commit to the Quadruple Aim

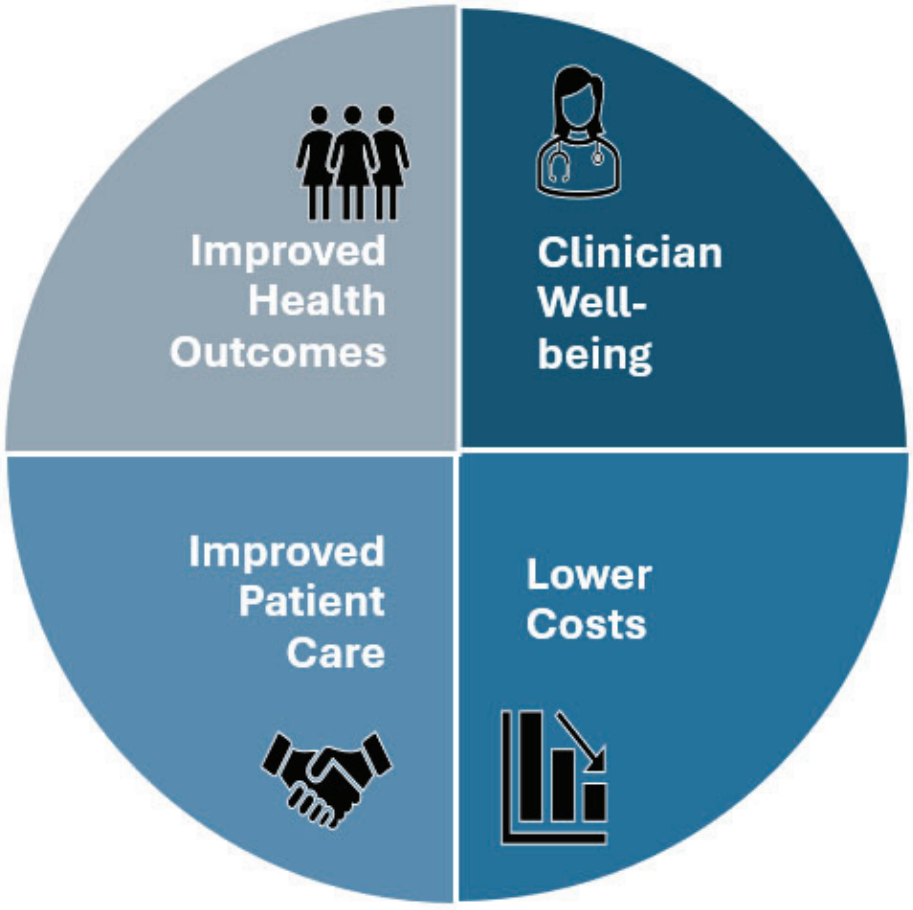
Compliance and clinical leadership can partner to demonstrate their shared commitment to advancing the Quadruple Aim (see Figure 1):[15]

- Improving the health of populations
- Enhancing patients' experience of care
- Reducing the per capita cost of healthcare
- Improving the work life of clinicians and staff

Achieving the Quadruple Aim can't be done without reducing burnout and promoting physician and clinician well-being. Compliance and clinical leadership can collaborate to help address the sources of burnout for physicians and other clinicians.

Burnout is expensive for practices and health systems because of costs

Figure 1: Quadruple Aim



> related to turnover of clinicians and other staff, as well as reduced clinical hour [. . .] Practices and health systems therefore have an economic incentive to invest in strategies to reduce burnout. Organizations that make these investments and promote staff well-being reap the benefits of having an engaged workforce capable for delivering high-quality and efficient healthcare.[16]

Improving the work life of physicians and other clinicians, which in turn can improve patient outcomes[17] and reduce turnover and associated organizational costs,[18] can be achieved by first measuring factors that drive burnout and reduce professional satisfaction. If clinical leadership is seeking institutional support to conduct a formal assessment of professional burnout, compliance professionals should offer their advocacy and endorsement.

Many assessment tools are available for healthcare organizations to measure burnout and well-being among physicians, including the American Medical Association's Organizational Biopsy® assessment.[19] The Organizational Biopsy is an assessment tool and set of services to support health systems in holistically measuring and taking action to improve the health of their organization. Other tools include the Mini-Z Worklife and Burnout Reduction Instrument, the Stanford Professional Fulfillment Index, and the Maslach Burnout Inventory.[20]

Co-facilitate PDSAs

Plan-Do-Study-Act (PDSA) testing offers an opportunity for enhanced collaboration between compliance and clinical leadership. PDSA testing cycles are used within clinical settings for performance improvement projects to document progress with tests of change (see Figure 2).[21]

A PDSA cycle will document:

- *Plan*: What exactly are we going to do?
- *Do*: When and how will we do it?
- *Study*: What were the results?
- *Act*: What changes are we going to make based on our findings?

The PDSA model for improvement poses three questions:

1. What are we trying to accomplish (aim)?
2. What change can we make that will result in an improvement?
3. How will we know that change leads to improvement (measures)?

The PDSA model can easily be adapted by compliance and clinical leadership for a rapid test of a proposed change to workflows of mutual interest. PDSAs can be designed to develop and implement targeted interventions based on feedback elicited from an organization's

Figure 2: PDSA Model

burnout and well-being survey. For example, PDSAs could be initiated to test changes to any of the following processes:

- A simplified compliance training format
- Coding review workflows
- Credentialing and re-credentialing workflows
- Inbox management
- Piloting the use of a scribe for clinical documentation

Conduct executive leadership rounds

Compliance and clinical leadership may jointly propose that the organization pilot a system of executive leadership rounds or reinstitute this process if it was put on hold during the COVID-19 pandemic. The Agency for Healthcare Research and Quality has recommended rounds as an effective method for leaders in nursing facilities to hear what is going well and what issues need to be addressed.[22] This process can be used in any healthcare setting.

Three strategies that hospital leaders can use when rounding include:[23]

1. Ask questions that matter to staff:
   i. How can this turn out to be better than we could have ever imagined?
   ii. What will success look like if we do this right?
   iii. Can you tell me what this idea will look like in action?
   iv. What can we do today that will help us stay engaged and improve patient outcomes?
2. Shine the light on what's right.
3. Emphasize the importance of well-being.

Ensure clinical representation on the compliance committee

On an annual basis, the compliance officer or chair of the compliance committee should reassess the committee's membership to ensure that clinical leadership is well represented. The committee's charter should also be reassessed when mergers or acquisitions occur.

Depending on the healthcare organization's structure and clinical care delivery system, the committee's charter should be evaluated with clinical leadership to ensure that there is robust representation. For example, does the organization provide any of the following services? Do all these clinical departments report to the same physician/clinician leader?

- Ambulatory surgery
- Behavioral healthcare
- Dental and oral healthcare
- Home health and hospice care
- Post-acute care
- School-based healthcare
- Substance use treatment
- Urgent care

Clinical leadership's engagement in the compliance committee is vital to developing and evaluating the organization's compliance work plan, assessing education and training programs, and assessing and improving policies and procedures.

Provide succinct communication

In circumstances when it is necessary to communicate with physicians in writing, either by electronic mail or a memorandum, compliance professionals should rely on principles of "plain writing," which is "clear, concise, well-organized, and follows other best practices appropriate to the subject or field and intended audience."[24]

Best practices include:[25]

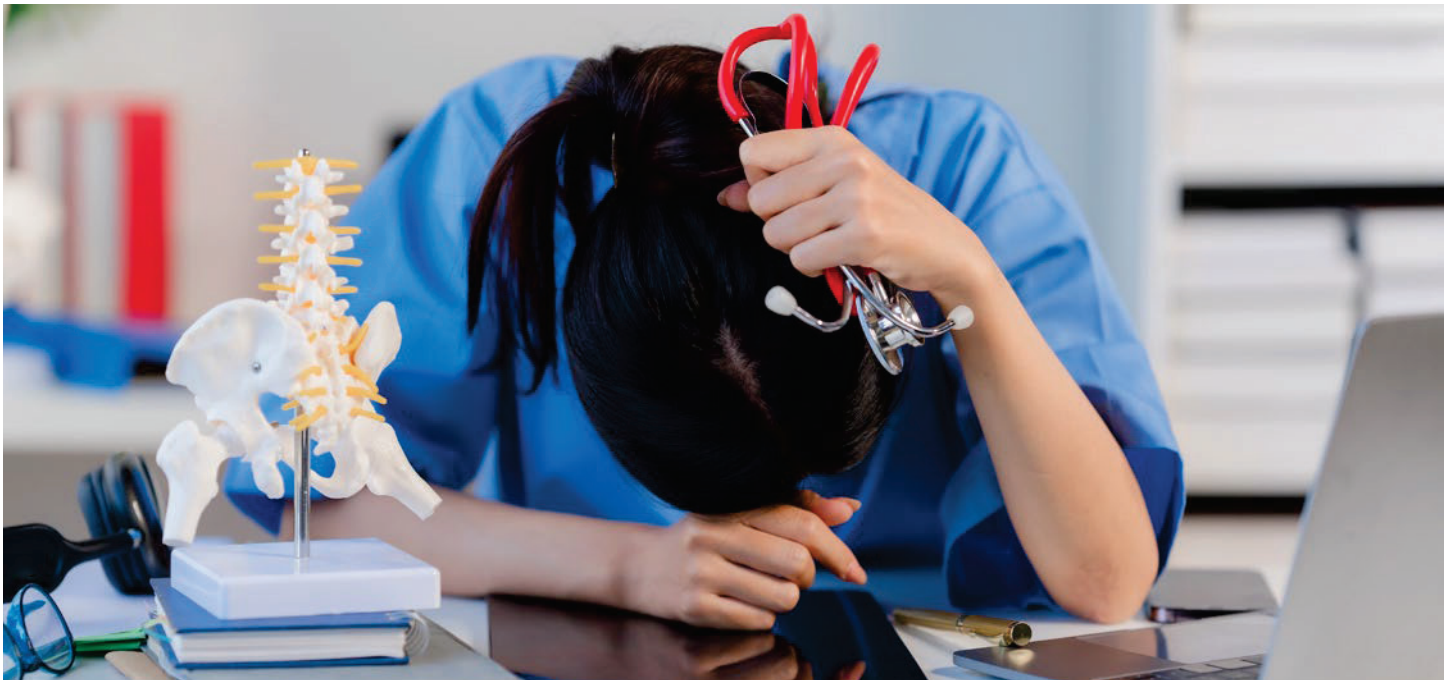
- Keep sentences brief, 20 words or less
- Limit paragraphs to two or three sentences
- Use active voice, not passive voice
- Use common, simple words
- Avoid legal, technical, medical, or marketing jargon, and references to laws and regulations unless necessary

Test a series of compliance and clinical leadership huddles

To promote enhanced communication between compliance and clinical leadership, a scheduled series of brief huddles may be piloted. Traditionally, clinical huddles were interdisciplinary, face-to-face, short (no more than 15 minutes) meetings at the start of a shift, aimed at improving team communication, collaboration, and coordination.[26] Huddles can be adapted for virtual communication on a weekly or as an as-needed basis to share updates, view progress, and go over priorities.[27]

Compliance and clinical leadership may pilot a series of huddles to establish a process for regular communication. In addition to any standing concerns that clinical leadership may prioritize, huddles might initially focus on the following:

- Anticipated new clinical services and their timeline for implementation
- Areas of audit focus by the U.S. Department of Health and Human Services, the regional Medicare Administrative contractor, and the state's Medicaid agency
- Emerging CUS ("I am concerned! I am uncomfortable! This is a safety issue!")[28]
- Key findings from any patient or staff satisfaction surveys



- Outcomes from any external audits or regulatory site visits
- Scheduled audits by payers
- Upcoming visits by state regulators or accrediting bodies

Translate regulations by serving as a "regulations whisperer"

Compliance professionals should demonstrate their willingness to maintain an "open door" for physicians and other clinicians to bring forward questions about federal and state regulations as well as requirements attributed to accrediting organizations. For example, a compliance professional was asked, "Why does HIPAA require 'break the glass' on all or most patient records?"

"Break the glass" is a security feature in an EHR system that can provide an extra safeguard to protect patient record privacy. The EHR's audit data stores details of when and by whom the record has been accessed. When an individual accesses a record that has "break the glass" function enabled, a reason for accessing the patient's health record is required, such as billing, coding, direct patient care, research, or scheduling.

Depending on how a healthcare organization configured the EHR, a notification of this access may be sent to a supervisor or a designated department, such as Information Security or HIPAA Compliance. Additional verification or approval from a supervisor may also be required.

In responding to this inquiry, the compliance professional clarified that HIPAA regulations do not require an institution to universally apply "break the glass."[29] Considering the potential burden this function could create if applied unnecessarily, the question was worthy of further fact-finding within the institution. Compliance and clinical leadership could jointly recommend to the administrator with responsibility for the institution's EHR system that the "break the glass" procedure be reviewed collaboratively with shared goals of minimizing administrative burden while safeguarding patient privacy.

Conclusion

Compliance professionals and physician/clinician leaders share many mutual values, including their commitment to:

- Assuring the delivery of safe, high-quality patient care
- Avoiding actual, potential, or perceived conflicts of interest
- Demonstrating integrity in their actions
- Safeguarding patient privacy
- Serving as role models for ethical behavior

Working together to achieve the Quadruple Aim, these leaders can help build a culture of integrity and shared accountability in which patient safety, compliance, and physician well-being all benefit. CT

Note: The opinions offered in this article are those of the authors and do not necessarily reflect American Medical Association policy.

Endnotes

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Takeaways

- Compliance and clinical leadership should identify shared values, explore opportunities for collaboration and mutual support, and develop mechanisms for regular communication, such as huddles.
- Compliance should maintain an open-door policy and respond to requests from physicians and other clinicians. Encourage them to contact compliance when correspondence comes in from regulators or payers.
- Compliance should demonstrate its commitment to serve as a "go-to" resource for the institutional or practice-level interpretation of regulatory requirements and accreditation standards.
- Language is powerful; time is finite. Written messages from compliance should be clear and succinct, clarifying what is "for your information" versus "please respond by."
- Compliance and clinical leadership should partner with Quality Improvement in designing rapid cycle Plan/Do/Study/Act projects to address key findings from burnout and well-being assessments.