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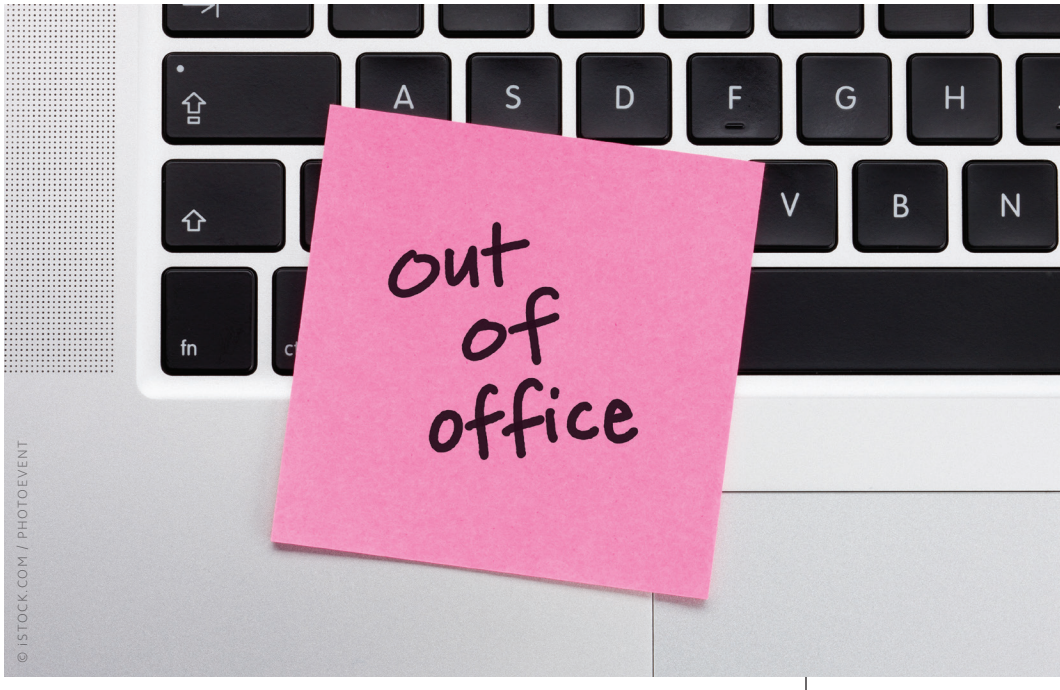
Utilizing a Flex Clinician to Manage Absences and Support Wellness



Physicians shouldn't feel guilty about having to take a sick day. This system provides built-in coverage for illness and other unexpected absences.

Health care workers often feel obligated to work while sick, due to guilt about requiring colleagues to cover their absence.[1] This can be unhealthy for their patients and colleagues, and is one of the many factors that contributes to the national problem of clinician burnout. Attempts to mitigate burnout with family-friendly policies and scheduling flexibility typically focus on clinic start and end times, telehealth sessions that allow for remote work, and adjusting the length of appointments.[2] These policies, while useful, don't address clinicians calling out sick or other unexpected absences. Common strategies for those situations include opening a scheduling template at a later date to reschedule appointments or having other clinicians use their administrative time to cover, both of which can also contribute to burnout. ➤

ABOUT THE AUTHORS

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The COVID-19 pandemic drew attention to the need for better systems to manage the impact clinician absences have on colleagues and patients, but there is still not much described in the literature about best practices for this. In this article, we describe an approach we implemented at a large, urban, academic primary care practice that improved clinician wellness, enhanced patient access, decreased bumped appointments, and maintained patient satisfaction in the event of a clinician call out. It's a flex clinician model that we believe could also be modified to fit smaller practices.

> We aimed to create a flexible scheduling system that could easily move patients to an open clinician template.

HOW WE IMPLEMENTED A FLEX CLINICIAN MODEL

Our practice has 14 patient care sessions per week, with 12-16 clinicians scheduled per session. We average 250 patient visits per day. Clinicians within our university's Department of Family Medicine also manage an inpatient adult hospital service, an inpatient labor floor service, a second smaller faculty primary care practice, and clinical coverage at several partner federally qualified health centers. In the past when a clinician called out, all primary care clinicians would be asked to voluntarily cover the clinician's appointments to avoid bumping patients, and all faculty physicians were asked to forfeit administrative time to cover any precepting absences. If no clinician volunteered, we bumped patients and rescheduled them for the next available visit, which could be days or even weeks away.

To improve clinician wellness and patient satisfaction, we aimed to create a flexible scheduling system that could easily move patients to an open clinician template. Initially, we attempted a sign-up system where clinicians demarcated two sessions per month when they were available to be "on-call" to cover call outs, but this still led to feelings of burnout when we needed to use the coverage system.

To better address this issue, we developed a novel "flex clinician" schedule management system. We listed one person as the "flex clinician" on the schedule each day, instead of assigning them a continuity clinic or precepting session. This clinician had no associated template in the electronic health record (EHR) to prevent unintentional scheduling. If we didn't need call-out coverage that day, we added a clinic template for the flex clinician two hours prior to the start of the session and used it for same-day patient scheduling. If a clinician did call out, the flex clinician was available to cover their patient appointments, or to help the practice manage other specific clinical needs such as precepting or inpatient coverage (see "Sample before and after schedules with multi-way swap"). To maintain patient autonomy, we offered patients who were scheduled with the absent clinician two options: see the flex clinician at their original appointment date and time, or reschedule in the absent clinician's next available slot. To ensure fast and efficient communication about schedule changes, we developed a "Family Medicine Clinician Absence" email list that included the medical director, practice managers, and residency leadership.

As we developed this new approach, we worked to obtain key stakeholders' support, starting with our practice manager — the person responsible for creating daily scheduling templates and managing patient notifications in the event of a clinician call out. Because this system created a same-day solution for patients who would otherwise

KEY POINTS:

- Having a system to easily move patients to an open "flex clinician" scheduling template can promote wellness by making clinicians feel less guilty about calling out sick.
- Utilizing a flex clinician prevents access problems when clinicians have unexpected absences, and creates same-day visits when clinician coverage is not needed.
- Allowing patients to choose a same-day visit with a covering flex clinician or reschedule with their primary clinician maintains patient satisfaction and clinic continuity.

be bumped, our practice manager felt that the extra effort of laying templates twice daily was worthwhile. Our nurse manager liked the potential improved same-day access if a call out did not occur. To gain support from primary care clinicians, we previewed the system at a practice-wide meeting, allowing individuals to ask questions and express concerns. The key concern we heard was the impact on continuity scheduling access for the times we assigned clinicians to flex coverage. We agreed to monitor this measure during a six-month trial period.

At full implementation, we aimed to have flex clinician coverage for all morning and afternoon sessions. Flex assignments are proportional to each person's clinical FTE (e.g., a clinician with 0.8 FTE has roughly eight flex clinician sessions per year). We have a small cohort who have agreed to a routine weekly flex clinician assignment, and they have appropriately adjusted primary care panels to mitigate the impact on continuity access. The flex clinician assignment is part of routine clinical expectations for all clinicians, so it does not create any additional clinical time. This was a budget-neutral intervention because it generated the same number of visits with equivalent relative value units (RVUs).

RESULTS OF TRIAL INTERVENTION PERIOD

In planning for this intervention, we determined that one-third of clinicians called out sick in a six-month period, while many reported avoiding calling out because they felt guilty about needing coverage. After implementation of this system, clinician anxiety about calling out decreased from 92% of clinicians reporting guilt or anxiety to 61%. We did not measure clinician burnout during implementation, due to the confounding factors impacting it during multiple COVID waves. During our trial period, patients appreciated having options for rescheduling, and there was an increase in satisfaction related to improved same-day scheduling access. The "flex" templates had an average fill rate and an above-average show rate compared to standard department clinical templates, justifying this as a budget-neutral clinical activity compared with a continuity-based session.

SAMPLE BEFORE AND AFTER SCHEDULES WITH MULTI-WAY SWAP

The "before" and "after" schedules shown below illustrate how physician assignments might shift under the "flex clinician" system when a colleague calls out sick. This example involves an added complication because the absent physician was assigned to precept but the flex physician is not a preceptor.

Before swap:

Assignment	Last Name
AM Precept	Dr. Wang
AM Continuity	Dr. Lee
AM Continuity	Dr. Patel
AM Continuity	Dr. Teel
AM Acute Care	NP Angela
AM Flex	Dr. Kurash

Email:

To: Family Medicine Clinician Absence list

Subject: URGENT – Dr. Wang OUT in a.m., flex needed

Dr. Wang will be out sick tomorrow morning and cannot precept. Dr. Kurash is on flex, but she is not a preceptor. Can we move Dr. Lee to precept and have Dr. Kurash cover Dr. Lee's patients in the morning unless they prefer to reschedule?

After swap:

Assignment	Last Name
AM Precept	Dr. Lee
AM Continuity	Dr. Kurash
AM Continuity	Dr. Patel
AM Continuity	Dr. Teel
AM Acute Care	NP Angela
Out sick	Dr. Wang

We monitored the percent of patients who saw their own clinician and percent of patients on each clinician's schedule who were his or her own. Both stayed at about 55-58% before and after the intervention.

VARIATIONS TO CONSIDER WHEN ADOPTING A FLEX CLINICIAN MODEL

Other primary care practices could likely replicate our flex clinician scheduling and coverage system with small modifications, depending on the practice size and setting.

In our academic medical system, the

flex clinician model has also been useful for minimizing the impact on the primary care schedule when residents are pulled in to cover inpatient hospital rotations. Similarly, large practices integrated with hospital systems could use a flex clinician to manage a multi-part coverage system that allows a clinician to cover an inpatient service while maintaining coverage of their originally scheduled appointments. In a group practice with multiple sites, clinicians who are credentialed at more than one site could be used to manage call outs by taking turns as the flex clinician. Smaller primary care practices could consider creating a partial scheduling template for a flex clinician, for example, adding an afternoon-only flex clinician. In that scenario, it may be more reasonable to aim for accommodating only urgent visits from patients who would otherwise be bumped due to their clinician calling out. If there are no call outs that day, the flex clinician's afternoon session is likely to fill with same-day sick visits.

Smaller primary care practices could consider creating a partial scheduling template for a flex clinician.

There are a wide variety of options for implementing a flex clinician system. Acknowledging and planning for the ongoing realities of illness and unpredictable life events that impact clinician availability and patient access can help improve clinician wellness and patient satisfaction. FPM

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