



## CLINICIANS HAVE TREMENDOUS INFLUENCE IN CARE DELIVERY.

**They have the power to lower the cost of care and improve patient outcomes and satisfaction, as well as to develop and enact innovative care strategies. Yet many clinicians feel disconnected from the decisions being made in their organizations that directly impact care, and sometimes believe that their feedback about care today and innovations for the future aren't fully valued.**

In this eBook, based on a year of NEJM Catalyst Insights Council surveys and one-on-one interviews with Insights Council members – a qualified group of executives, clinical leaders, and clinicians directly involved in health care delivery – we examine the role of the clinician as care delivery evolves: how clinicians are viewed today and how those views must change for health care to progress. We use data points gathered throughout a year of Insights Council surveys to show that clinicians want to have a central role in care delivery and innovations, that executives and clinical leaders understand the power of clinician involvement, and that patient engagement/satisfaction depends on clinician buy-in about the direction of care delivery.

In the near future, clinicians increasingly will be tasked with finding the compromise between the convenience of care that patients experience with retail health models and the quality of care they receive from primary care. They will have to embed newer technologies such as remote monitoring, telehealth, and analytics deep into their practices to better engage patients, provide more targeted diagnoses and treatments, and prevent the overburdening of their schedules. Clinicians will have to advocate to executives and administrators for greater leadership pathways and opportunities so that they can have a strong voice in all aspects of care delivery and innovation.

For health care costs to be lowered and outcomes to improve, clinicians must have a strong and valued voice when it comes to new models of care, new technologies, and new leadership structures. The first-person perspectives and advice of Insights Council members – across a range of profiles, regions, and settings – throughout the following pages will bring to life this imperative and how to get there from where the industry stands today.

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**JAMES STEWART, MD, FACS**

*Chief of Thoracic Surgery at the University of Missouri–Kansas City School of Medicine*

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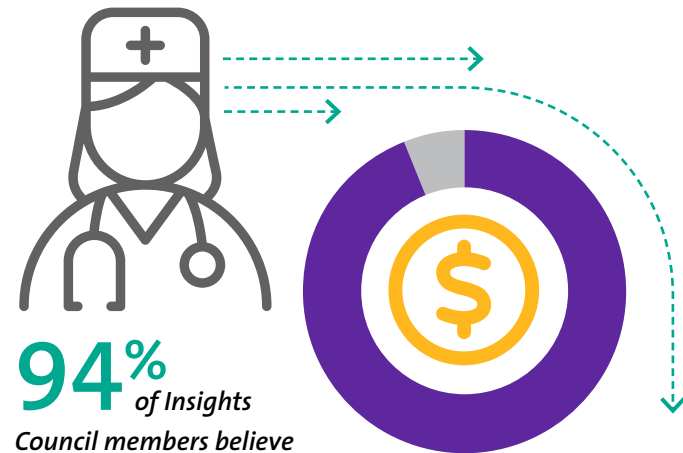
## Obstacles to Innovation: Hearing the Clinician Voice

Innovating care delivery is not an easy feat. Just ask James Stewart, MD, FACS, Chief of Thoracic Surgery at the University of Missouri–Kansas City School of Medicine.

In 2014, Stewart developed an enhanced recovery program to improve pain management after thoracic surgery. His milder drug protocol decreases opioid usage post-surgery by 72%, and, in doing so, avoids the nausea and constipation opioids can cause and the need for bladder and epidural catheters to deal with these side effects. Patients can eat, get up and around, and go to the bathroom sooner and more independently, resulting in a two-day reduction in hospital stays at a savings of nearly \$16,000. Despite these results, his transformative idea was left unadopted by leadership until 2018.

“It used to be rather easy for clinicians to make changes in how care is delivered and to adjust different protocols,” he says. “As medicine becomes more complicated, it’s tougher and tougher to get things done. I don’t think frontline clinicians are seen by administrators as people who can innovate in developing better patient care.”

Many of the health care professionals in this eBook agree with Stewart about the misperception of clinician interest in innovation. They also agree, as 94% of Insights Council members do, that clinicians are responsible for lowering the cost of care. However, how can clinicians lower the cost of care if they aren’t trusted to innovate how care is delivered?



**94%**  
of Insights  
Council members believe  
that clinicians are responsible  
for lowering the cost of care.



**ROBERT WIDMER, MD, PHD**

*Assistant Clinical Professor at Texas A&M College of Medicine.*

“The real innovators not only identify the problem, but they look for new solutions to some of the issues,” he says. The more engaged clinicians are, the better the outcomes for patients and the organizations.

Andrew Plaut, MD, Staff Physician at Tufts Medical Center in Cambridge, Massachusetts, says it’s important to bridge the gap between clinical and business needs. “If a clinician can put innovation in financial terms, managers will likely pay closer attention,” he says.

To change the current perception of clinician interest in innovation requires greater clinician engagement, according to Robert Widmer, MD, PhD, Assistant Clinical Professor at Texas A&M College of Medicine. “Traditionally, clinicians have just complained. The real innovators not only identify the problem, but they look for new solutions to some of the issues,” he says. The more engaged clinicians are, the better the outcomes for patients and the organizations. More than half of Council members agree that higher clinical quality (72%), improved patient satisfaction (55%), and improved clinician satisfaction (51%) are all achieved through clinician engagement.

Burritt Hess, MD, FAAFP, WFMRP, Associate Program Director, Heart of Texas Community Health Center, says, “Clinicians already are innovators – they like to get their hands dirty and solve problems. They just need an organization that supports them in that.”

*More than 50% Council members agree that higher clinical quality (72%), improved patient satisfaction (55%), and improved clinician satisfaction (51%) are all achieved through clinician engagement.*



## The Need for Leadership and Responsive Feedback

*“It’s incumbent on physicians to provide solid feedback and steps on which to grow institutions and on which to improve care for patients. If they don’t do it in a tactful and constructive way, then they won’t be heard.”*

ROBERT WIDMER, MD, PHD

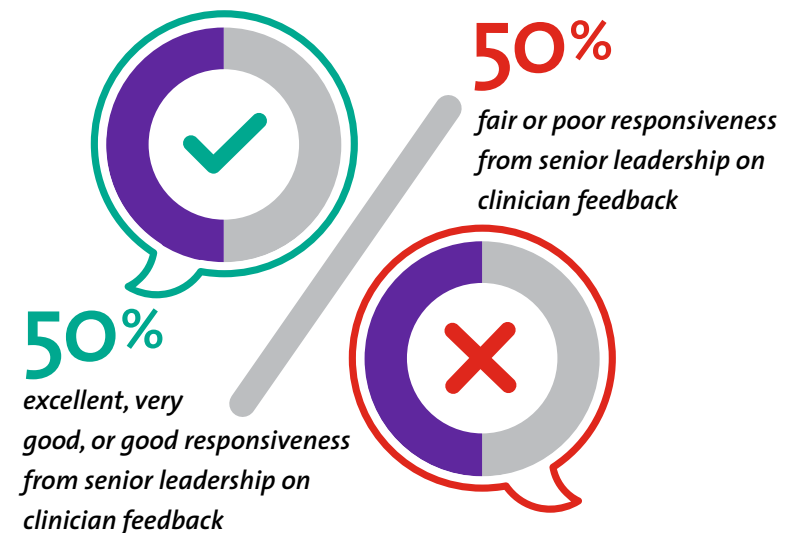
When Stewart was lobbying for his post-surgery pain management protocol, he went “door-to-door” presenting his findings to hospital leaders as well as pharmaceutical and therapeutic committees, and even then, he didn’t always feel heard. The fallout of not being heard, he says, oftentimes is burnout. “No question about it that burnout comes because clinicians aren’t listened to,” he says.

Only half of clinician respondents to an Insights Council survey believe senior leadership responsiveness to clinician feedback at their organization is excellent, very good, or good. The remaining half indicate it is fair or poor.

Widmer says acceptance of ideas lies in how they are presented: “I think that senior leadership [at his organization] does a pretty good job of acting on good and reasonable feedback. It’s incumbent on physicians to provide solid feedback and steps on which to grow institutions and on which to improve care for patients. If they don’t do it in a tactful and constructive way, then they won’t be heard.”

Xiaoyan Huang, MD, MHCM, FACC, Medical Director for Clinical Transformation at Providence Heart Institute in Portland, Oregon, believes that executives

and clinical leaders have a responsibility to draw engagement and innovation out of clinicians. “You can trust that clinicians will figure out the best way if they are informed of what makes a difference and if incentives are appropriately aligned,” she says. However, right now, she finds clinicians aren’t told what they are doing is making a difference in patient care quality and cost and are given mixed signals on incentives. “In medicine, we have not engaged frontline doctors to improve their own work environment. We’ve always relied on their resilience and hard work – we’ve given them the patients and let them work everything out. That’s not working anymore.”



Clinicians, in his view, should be afforded opportunities to engage in plan-do-study-act (PDSA) cycles to analyze what happened, identify the pieces that caused the failure, and develop interventions to address those and get the project back off the ground, or to say that's not going anywhere and put it aside.

BURRITT HESS, MD, FAAFP, WFMRP



Executives can show they value innovation by giving clinicians margin in their schedules as well as opportunities to develop ideas more robustly and to network with colleagues, Hess says. Freedom to fail is also essential. “They can’t be penalized because they stuck their necks out and worked hard at a project,” he says. Clinicians, in his view, should be afforded opportunities to engage in plan-do-study-act (PDSA) cycles to analyze what happened, identify the pieces that caused the failure, and develop interventions to address those and get the project back off the ground, or to say that’s not going anywhere and put it aside.

When he worked at Mayo Clinic, Widmer was given the dedicated time to innovate what Hess prescribes, and he found it incredibly productive. For instance, he was

able to collaborate with his colleagues on a system that would help patients in Minnesota, where there is snow on the ground eight months out of the year, to be consistent in their cardiac rehabilitation. “We know that people who go to cardiac rehabilitation once a week for 12 weeks after surgery will live longer,” Widmer says, adding that the weather makes that difficult for patients. His team used a combination of portals and mobile apps to deliver rehabilitation electronically, offering the same education about activity levels, nutrition, and metrics such as blood pressure as if they were in person. “We kept people out of emergency departments and hospitals and patients had substantial reductions in weight and increases in dietary habits,” he says.



**LYNDA YOUNG, MD, FAAP**  
*Professor of Pediatrics, UMass  
Medical School in Worcester,  
Massachusetts*

*“Innovation doesn’t have to be  
rocket science to make a  
difference.”*

## Feeling Invested in Innovation

Not all innovation has to be grand. Some of the simplest ideas for improvement can make a big difference, according to Lynda Young, MD, FAAP, Professor of Pediatrics, UMass Medical School in Worcester, Massachusetts.

For 35 years, Young was in a three-physician practice and was responsible for every aspect of the business. So, when certain health plan patients began calling her office or showing up for their appointments confused about their benefits, she paid attention. She discovered that the health plan had sent out membership cards with the health plan’s name but no easy indicator of the patient’s benefit package category. Patients would arrive for their office visit only to find the plan limited them to select clinics. They would then have to cancel their appointment or pay out of pocket. Young called the health plan and suggested that they color-code the cards so that when patients called in, relaying the color of the card would enable office staff to crossmatch their allowable services. “It seemed so simple. Innovation doesn’t have to be rocket science to make a difference,” she says.

Plaut says clinician innovation comes into play when faced with typical industry issues such as wait times for clinic appointments and diagnostic procedures. He regularly reviews his panel of patients scheduled for appointments, such as an endoscopy, and calls them to determine if they need to be seen sooner. “If the delay is having an impact on their family, school attendance, or job, that isn’t tenable,” he says, and he tries to move their testing up. If nothing else, he says the call begins contact with a new patient, offers the opportunity to judge the urgency of the issue, and to appropriately reassure the patient if that is warranted. This then begins what has been called “occupied waiting time”, a well-known way to give the patient confidence that waiting for an appointment is unlikely to be detrimental. He acknowledges that to do this as a more standardized practice would require more staff hours and language translation availability.

At one clinic that Young worked at, a lack of [weight] scales forced patients to wait to enter the exam rooms. “This then put the physicians behind schedule,” she says. “You had patients and physicians dissatisfied.” Simply purchasing a several-hundred-dollar scale, which administrators initially balked at, alleviated the stress on the whole system.



### THOMAS JENKINS, MD

*Cookeville Primary Care Associates  
in Tennessee*

His two-person practice  
“constantly outperforms  
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in terms of quality.”

What helps in such scenarios, she believes, is being invested in the business. “We felt we had a voice when we wanted to change processes that were difficult,” she says, and has found as she’s moved across roles and settings that hospital-employed physicians do not seem to feel they have a voice. Empowering them to speak up and offer suggestions for improvement, she believes can make a difference.

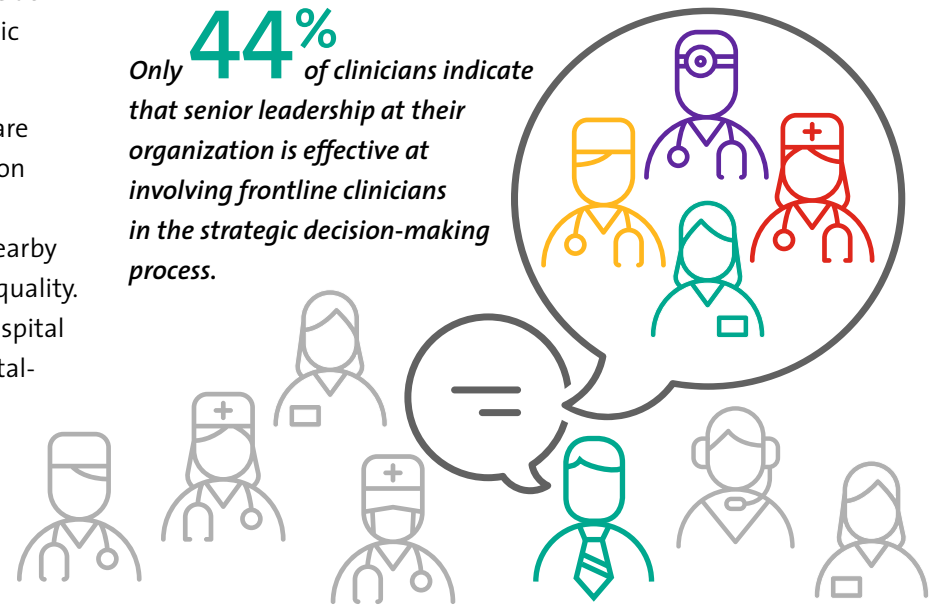
Senior leadership falls short in bringing frontline clinicians into such decision-making, according to our Insights Council members. Survey results find that only 44% of clinicians indicate that senior leadership at their organization is effective at involving frontline clinicians in the strategic decision-making process.

Thomas Jenkins, MD, Cookeville Primary Care Associates in Tennessee, says his two-person practice “constantly outperforms hospital-employed physicians (more than half of nearby practices are hospital-owned) in terms of quality. They are not in charge of anything. The hospital is constantly complaining that their hospital-employed physicians aren’t productive.”

Huang attributes this discrepancy to underlying business practices. Physicians who are employed by hospitals or health systems often are less engaged with the business and operations of their practice because they are not given the incentive nor the opportunity to do so, she says. Furthermore, their clinical workload is overwhelming. As a result, they perceive changes are happening to them and they have no control over how they deliver care and practice medicine the way they were trained to do. “They feel victimized by the system and get burned out,” she says.

“Neither one of us are burned out and yet you see that all the time [at the hospital] across the street,” Jenkins says.

Only **44%** of clinicians indicate that senior leadership at their organization is effective at involving frontline clinicians in the strategic decision-making process.







**XIAOYAN HUANG, MD,  
MHCM, FACC**

*Medical Director for Clinical Transformation at Providence Heart Institute in Portland, Oregon*

*“Frontline clinicians should be inspired to come up with new designs to solve operational problems in their day-to-day practice.”*

## Finding a Path to Inspiration

Innovation can be a key to preventing burnout, according to Huang. Physician leaders need to inspire the providers to affect change, instead of passively suffer. “If you don’t like it, make it better,” she says. One Insights Council survey reveals that the initiative most effective at engaging clinicians is involving them in organizational decision-making (57%).

Providence Heart Clinic in Portland has had significant success in transforming specialty care in preparation for value-based payment and building a more contemporary version of the medical neighborhood, which might be coined as Medical Neighborhood 2.0. They have discovered four key tenets in this transformation: leadership and vision; creating a culture in leading change; working with technology; and using design thinking and critical making (hands-on activities) to solve problems.

Instead of being victimized by change, clinicians should be enabled to find enjoyment in their profession, Huang says. Design thinking and critical making are two methods they can use to improve their environments “rather than continuing in an unsustainable rut.”

“Frontline clinicians should be inspired to come up with new designs to solve operational problems in their day-to-day practice,” she says. In addition, they need to be given the tools and opportunity to go through an iterative process to operationalize and implement the design. For instance, if someone finds a smart solution to a problem within the EMR, the organization should have a way to standardize that innovation, disseminate this information, and save the time and frustration for everyone else who might encounter the same problem.



**57%** *of Insights Council members reveal that the initiative most effective at engaging clinicians is involving them in organizational decision-making.*



**ROBERT OLIVER, MD, FACEP**

*Self-employed telemedicine physician*

*“Your greatest job as a clinician is patient education. Right there, you could lower the cost of care.”*

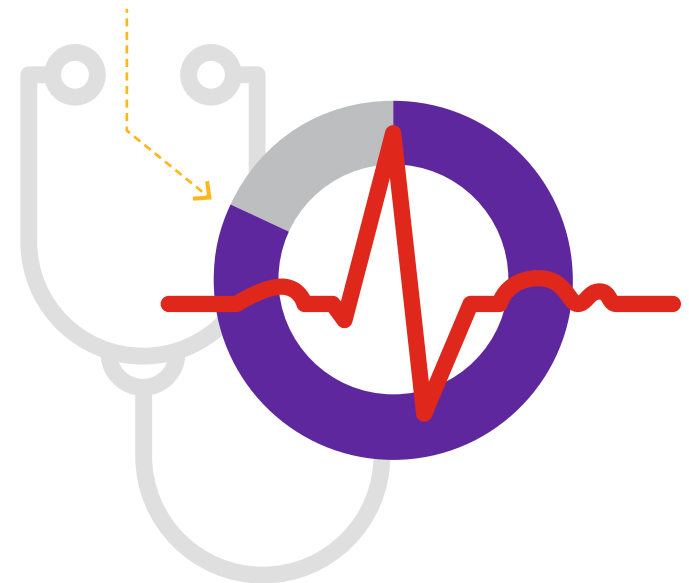
## Innovating Chronic Care

Chronic disease care, one of the most expensive aspects of health care, is ripe for innovation. With the number of patients and costs skyrocketing, ideas for improvement are in great demand.

Most Insights Council members, 82%, indicate that primary care impacts chronic disease management. Hess is among them: “I think that primary care is the principal context for innovation in medicine going forward. We have a unique advantage because we get to see all of the different threads that are working their way through each of the disciplines and we get the most holistic view of the medical profession from that vantage point.”

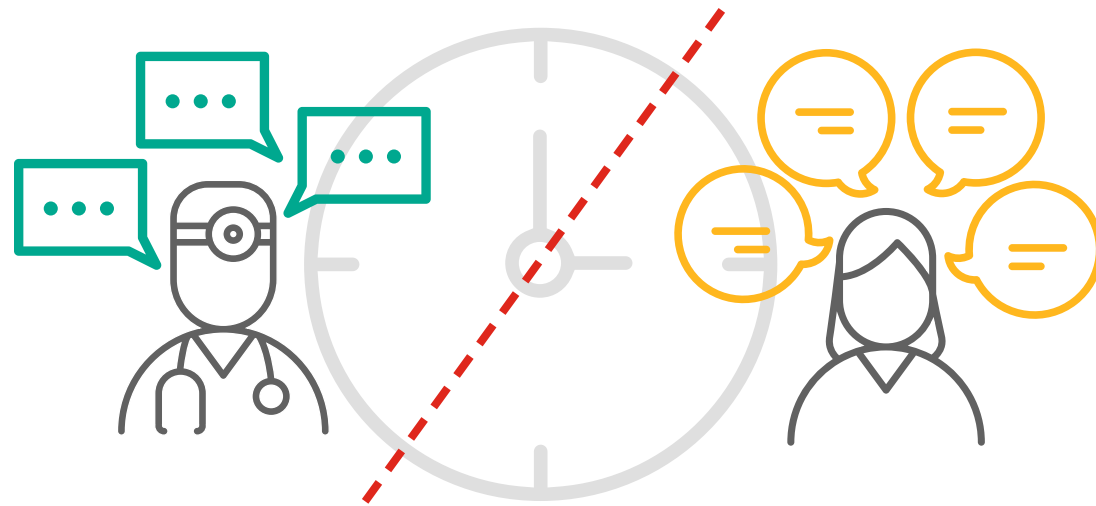
Robert Oliver, MD, FACEP, a self-employed telemedicine physician, believes primary care physicians are going to have to step outside of their comfort zones to better engage those with chronic disease. “I think clinicians should be more aggressive in their outbound messaging for chronic care patients. Not just a tickle file, but a way to reach out to everyone in nearby zip codes to educate them about their disease and encourage them to check their blood pressure and sugars, exercise, eat right, etc. It may seem like an intrusion, but it’s not,” he says. He points to Madison Avenue marketers as an example of how bold physicians should be. Done correctly, he believes marketing would help patients take charge of their own care, ask questions, and adhere to treatment. “Your greatest job as a clinician is patient education. Right there, you could lower the cost of care.”

**82%** of Insights Council members indicate that primary care impacts chronic disease management.



“You need time to let them answer your questions,” he says. “Anyone can type and talk, but listening is not merely additive, it is essential. My idea of innovation in medicine is to do the things that put patient first and make the caregiver a listener.”

ANDREW PLAUT, MD



Almost **50%** of clinicians in an Insights Council survey say they lack the necessary time for patients with chronic conditions.

Education can take time, though, which Insights Council members say they don't have. Nearly half of clinicians in an Insights Council survey say they lack the necessary time for patients with chronic conditions. Plaut likes to ask his patients about the stressors in their lives, which “opens the floodgates,” yielding clues as to why they are not responding to therapy even if compliant, or in understanding the origin of the health issue in the first place.

“But you need time to let them answer your questions,” he says. That extra time often keeps them from getting unnecessary testing, which he points out can lower the overall cost of care. “Anyone can type and talk, but listening is not merely additive, it is essential. My idea of innovation in medicine is to do the things that put patient first and make the caregiver a listener.”

## Embracing Convenient Care

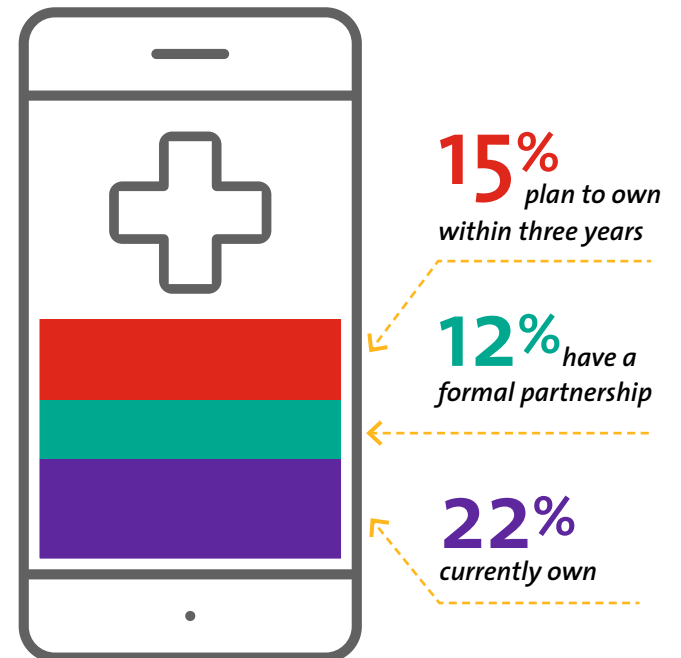
For patients without insurance, telemedicine is incredibly beneficial. He acknowledges that there are limitations based on the technology, but overall the convenience of telemedicine is a plus.

ROBERT OLIVER, MD, FACEP

On any given Saturday night, Oliver, who counts several of the largest telemedicine providers among his clients, will hear a text alert on his phone and log on to see his next customer. It could be a trucker at a rest stop in Texas, 80 miles from the closest town, calling about painful hemorrhoids. It might be a shift worker hopping online during break to consult about a concerning rash that's spreading. Self-employed as a telemedicine consultant, Oliver is happy to see them all. He recommends the trucker get immediate relief by buying a donut cushion from a drug store and that the worker with the rash should head to the ER as the rash seems to be spreading cellulitis. "I give them advice on where to go and what to do if I can't take care of it right now," he says.

For patients without insurance, a \$39 to \$59 consultation using telemedicine is incredibly beneficial for them, according to Oliver. He acknowledges there are limitations based on the technology (you can't look inside someone's ear when they complain of an ear infection, for instance), but overall the convenience of this innovation is a plus. Almost half of Council members' organizations currently own (22%), have a formal partnership (12%), or plan to within three years (15%) with direct-to-consumer telemedicine.

Council members' organizations involvement with direct-to-consumer telemedicine



Shortages in primary care and specialty access have pushed people toward telemedicine and retail health, but Oliver believes “the office-based, schedule-bound physicians themselves have caused the gap” that is filled by these kinds of services.

ROBERT OLIVER, MD, FACEP

Shortages in primary care and specialty access have pushed people toward telemedicine and retail health, but Oliver believes “the office-based, schedule-bound physicians themselves have caused the gap” that is filled by these kinds of services. “Family doctors don’t want to be bothered with walk-ins like sore throats or minor trauma, even though their training has equipped them to handle many minor orthopedic injuries, so they are using the ER and retail health to decompress their waiting rooms,” he says. In his opinion, if PCPs were accessible for same-day appointments, “most people would rather see their own doctor.”



Hess agrees, adding that primary care practices should embrace remote technology such as telemedicine, telehealth, and remote monitoring to alleviate the access burden because the relationship the patient already has with the clinician will help improve the outcome. “The efficacy of this technology is predicated on mutual trust between physician and patient. It can save patients hours of travel time and if I know them, I can still observe their unique personalities and quirks [via a teleconference]. If I’ve known that patient 20 years, it will carry him or her further than if I’m telemonitoring from some remote location with no existing relationship,” he says. For instance, if a patient gets feedback that their activity level was 10% higher than the previous week, a comment of “that’s great work” will mean more if it comes from someone they value and trust. “They’ll find that more motivational than from some unknown person or generated for them by an algorithm.”

Jenkins believes convenient care is still in need of change. “We have the standard walk-in clinics who do things for marketing, not because it’s good patient care,” Jenkins says. “They give antibiotics for colds and cortisone shots for pain when the patients don’t need it. And we have patients that if we don’t give them the antibiotics, they’ll go to the walk-in clinic and get them. Quality medical care is not something the average population understands.”

The way to make convenient care successful is to properly integrate convenient care clinics with existing health systems.

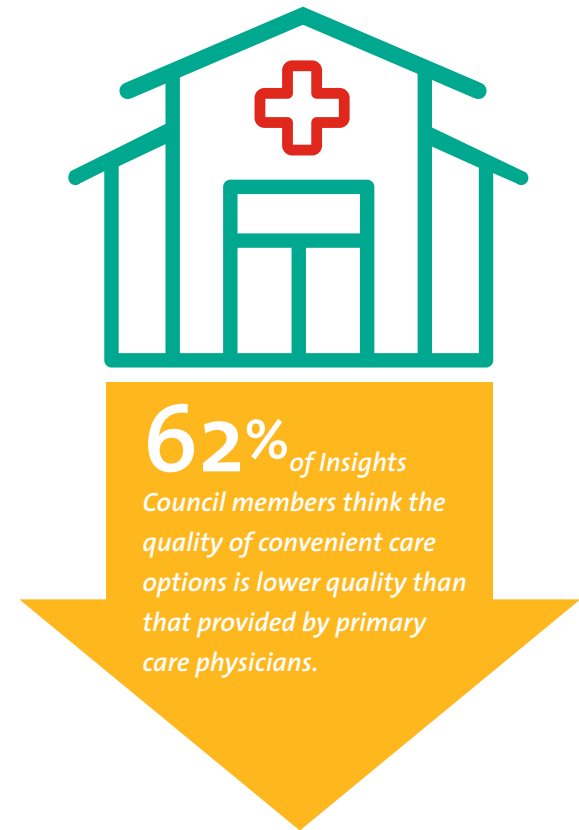
ROBERT WIDMER, MD, PHD

He's not alone. A majority, 62%, of Insights Council members think the quality of convenient care options is lower quality than that provided by primary care physicians.

"Patients love these clinics because of access," but Young says she does not. She often gets faxed five pages from the retail clinic's EHR, showing that a child presented with a sore throat but 70% to 80% of the time, the throat culture was negative for strep. Yet, she says, the child leaves with an antibiotic for 10 days. "The parent thought the experience was wonderful because they got amoxicillin and the kid was better in three days."

She spoke with the medical director of the nearby walk-in clinic, but nothing changed. "I realize that it takes more time to have a discussion about the downsides of antibiotics than to just send off an electronic prescription, but it's better for the patient," she says.

The way to make convenient care successful, according to Widmer, is to properly integrate these facilities with existing health systems to ensure diagnostics and other tests aren't being repeated and that they are practicing evidence-based care.



## The Power of Data – Improving Outcomes

“What people don’t understand is that you can make more money – and lower the cost of care – when quality is good and when you’re innovative around data.”

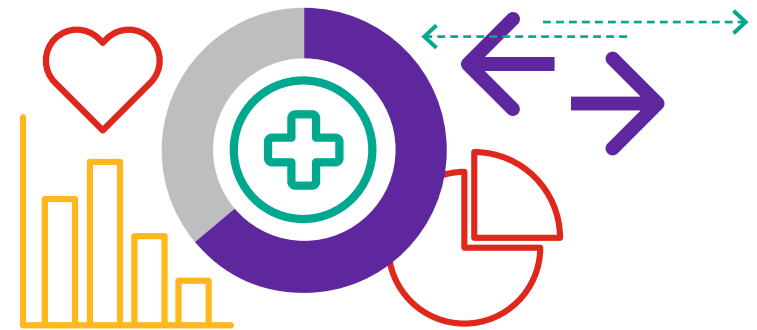
THOMAS JENKINS, MD

“We know our data every day,” Cookeville Primary Care’s Jenkins says, pointing to recent QDR data, his CMS MIPS score, which is 99.7, and other critical metrics that come from being a NCQA patient-centered medical home and 5-Star Medicare Advantage Blue Cross practice. The intense insight he has into every aspect of care delivery enables him to innovate within the bounds of evidence-based medicine. For instance, when the CDC announced a recent measles outbreak that affected Tennessee, his practice could quickly locate the patients at risk and get them into the office. Because of data and analytics, he says, their colon screenings are in the high 90 percentile.”

Nearly two-thirds (64%) of Insights Council members indicate the current emphasis on data and analytics in health care improves clinical care.

“What people don’t understand is that you can make more money – and lower the cost of care – when quality is good and when you’re innovative around data,” Jenkins says. “If there is any kind of payment for quality, we get it. That’s one of things that keeps you from burning out. If you look at numbers and see how well you’re doing, that’s great for you. I’ve been at this for 50 years and I’m still having fun.”

**64%** of Insights Council members indicate the current emphasis on data and analytics in health care improves clinical care.



“I think clinicians respond well to data, but it has to be presented properly,” Huang says, adding that quality metrics used to measure provider performance or quality are often too distant from what the individual clinician does. “If there are 10 clinicians who might touch the same patient and affect the ultimate clinical outcome I’m being measured on, then I assume it’s out of my control,” she says. “How quality metrics are selected, measured, and attributed to an individual clinician and how incentives are set affect behavior.”



**KATHLEEN SCHATZ, ARNP**  
 Sacred Heart and Holy Family  
 and Providence Health Care  
 Spokane Region

“RNs can make a huge difference in the delivery of care, especially around chronic illness. They have the critical thinking skills to collaborate and unburden APNs and physicians.”

## Innovative Pathways for Clinician Leadership

**54%** of Council members indicate that nurses' leadership abilities are widely unrecognized at their organizations.



You want more innovation, bring more RNs and advance practice RNs to the table. That's the message from Kathleen Schatz, ARNP, Sacred Heart and Holy Family and Providence Health Care Spokane Region. “If nurses were given a voice, they could help to lower the cost of care,” she says.

Fewer than half of Council members (46%) indicate that nurses' leadership abilities are widely recognized at their organizations, and Schatz considers that unfortunate.

“RNs can make a huge difference in the delivery of care, especially around chronic illness. They have the critical thinking skills to collaborate and unburden APNs and physicians,” she says. “RNs within their scope of practice

can call patients, assess how they are doing, and help to intervene before a crisis occurs. Ongoing collaboration and communication with NPs and physicians will reduce hospital admissions and mortality.”

Her hospitals are currently boosting staff nurses' input into enhancing quality patient care as well as leadership and financial skills by participating in an American Association of Critical Care Nurses program called Clinical Scene Investigator. The yearlong program focuses on a team-based approach to improve clinical and fiscal outcomes. They chose sepsis – and nurses from the different units and hospitals determine what will make the biggest impact to improve sepsis care for patients. They collect data, design interventions, and



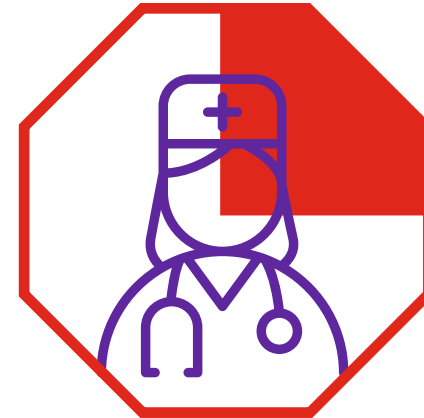
“To take on greater leadership responsibilities, nurses, would need to train for a broader view of care delivery. They take care of patients and everything within that patient’s room. Clinicians see more of a ward or census list.”

ROBERT WIDMER, MD, PHD

continue to monitor the data for improvements. “The program helps nurses to learn how to measure data in a meaningful way. Once their interventions are developed, then they can see if the intervention improved care, patient outcomes, and fiscal impact,” she says. This training sets up the nurses to be leaders at the bedside and improve their understanding of the financial realm as well. “They are learning how to show the financial impact of grassroots change. We have had the added benefit of everyone sharing each other’s projects to improve care across units and the hospitals.”

When Oliver was working at a hospital in Sacramento, the nurse managers put together a cross-sectional team of patient care technicians, nurses, radiology technicians, lab personnel, emergency department doctors, department leadership, and janitors. They met every month and reviewed details of department throughput and patient satisfaction. The committees generated ideas that improved patient care. However, he says, “the whole process was greatly undervalued” and it gradually ceased with leadership changes in the department and some pushback on hours by union.

A quarter of Council members indicate that nurses are prevented from being leaders in their organization due to the perception of nurses as “doers” rather than “strategists.”



**25%**

*of Council members indicate that nurses are prevented from being leaders in their organization due to the perception of nurses as “doers” rather than “strategists.”*

Young calls for more co-placement between physicians and nurses so that nurses can sit alongside doctors and easily consult on patient care. “It would be so good for both to have that interaction and get that education,” she says.

To take on greater leadership responsibilities, nurses, in Widmer’s opinion, would need to train for a broader view of care delivery. “They take care of patients and everything within that patient’s room. Clinicians see more of a ward or census list. If you can get the nurses to take a step back and learn a more global view of medicine, that would be a powerful pathway for them,” he says.

## Innovating Patient-driven End-of-life Care

“Being managed by an algorithm is the last thing a dying patient wants to have happen. There is a deep, sacred trust that develops there in that dying space.”

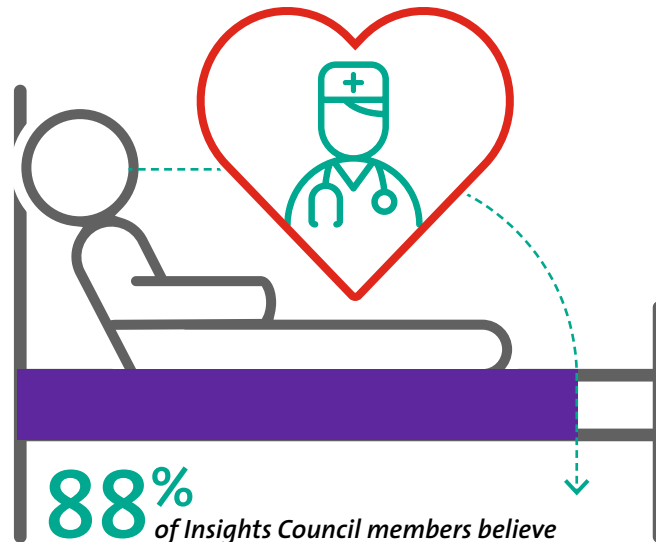
BURRITT HESS, MD, FAAFP, WFMRP

Palliative/end-of-life care is becoming a hallmark for innovation in many institutions, with clinicians being encouraged to advise each patient based on his or her own, unique circumstances.

Huang calls this “a cultural shift.” “You have to have a service available and then you teach the primary care or cardiologist that the service is available, and you make the experience good for the patient, family, and

doctor,” she says. Her health system, Providence St. Joseph Health, has a strong palliative care program that physicians can access for inpatients and outpatients alike. Having a dedicated end-of-life/palliative care service to rely on, according to 88% of Insights Council members, improves clinician work satisfaction.

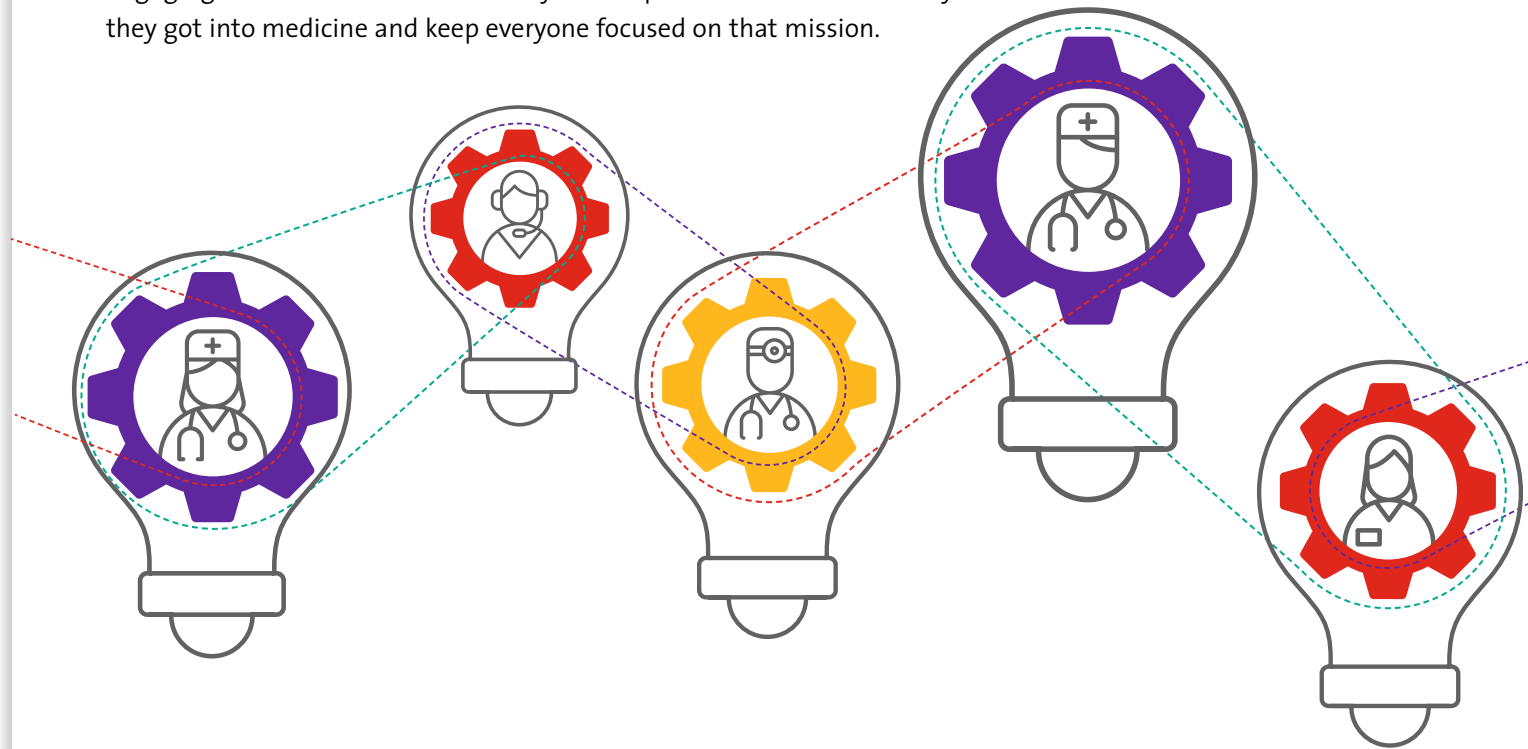
“I do think it’s important to allow clinicians to innovate around palliative care,” Hess says. “Being managed by an algorithm is the last thing a dying patient wants to have happen. There is a deep, sacred trust that develops there in that dying space. I just can’t see being able to tend well and in a nuanced way to the emotional, psychological, and spiritual needs of a patient without the freedom to innovate, as long as it’s done in the context of continuity of care.”



**88%** of Insights Council members believe having a dedicated end-of-life/palliative care service to rely on improves clinician work satisfaction.

## Innovation Is for Everyone

The common thread among the discussions of innovation among Insights Council members is that innovation is everyone's responsibility, and everyone has equal opportunity to be an innovator. The first step is to look around the organization and see what isn't working or what could be improved. Collaborate with a team member or colleague on possible solutions. Then present those solutions to organizational leaders. Engaging in innovation in care delivery will help clinicians remember why they got into medicine and keep everyone focused on that mission.



# A new journal for transforming health care delivery

## Practical innovations for health care leaders

NEJM Catalyst accelerates the transformation of health care delivery and now includes a new peer-reviewed digital journal, *NEJM Catalyst Innovations in Care Delivery*. Each bi-monthly issue explores the best ideas and strategies with the most potential for change.

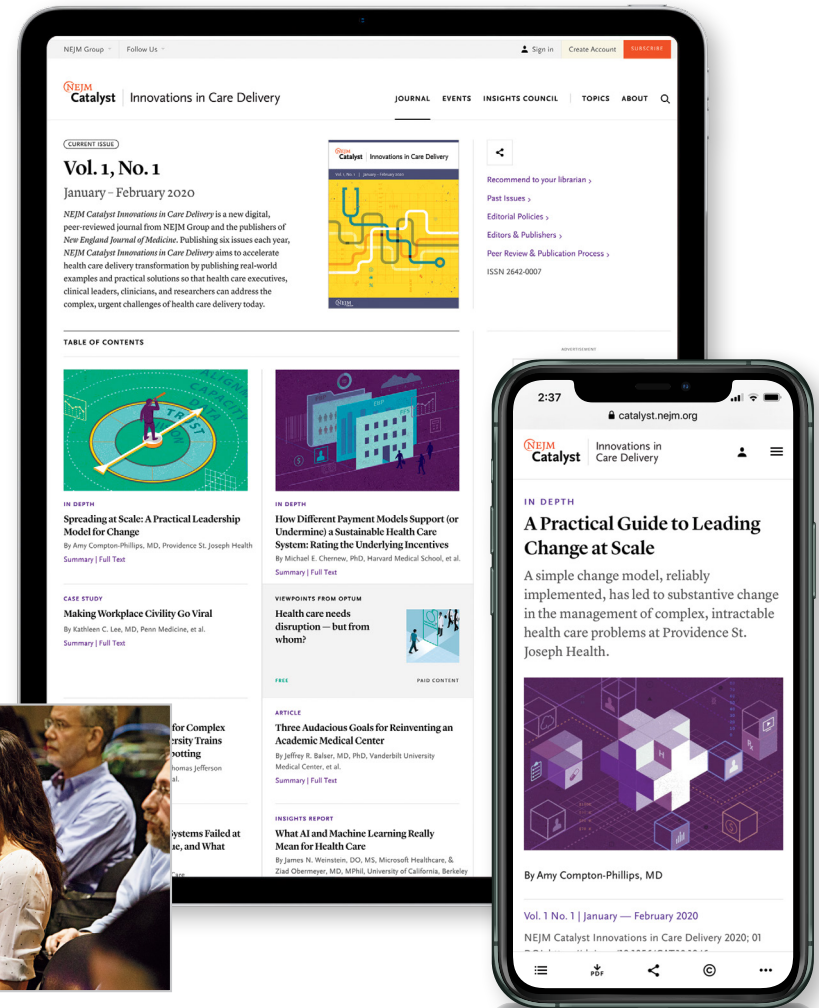
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We'd like to acknowledge the members of the NEJM Catalyst Insights Council. It is through their voice and commitment to the transformation of health care delivery that we are able to provide actionable data that convenes a collaborative dialogue about moving the industry forward in a positive direction. Insights Council members participate in monthly surveys and the results are published as NEJM Catalyst Insights Reports, including summary findings, expert analysis, and commentary from NEJM Catalyst leaders.

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### **About NEJM Catalyst**

NEJM Catalyst brings health care executives, clinical leaders, and clinicians together to share innovative ideas and practical applications for enhancing the value of health care delivery. From a network of top experts and advisors, our digital peer-reviewed journal, live-streamed events, and qualified Insights Council provide real-life examples and actionable solutions to help organizations address urgent challenges affecting health care.



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