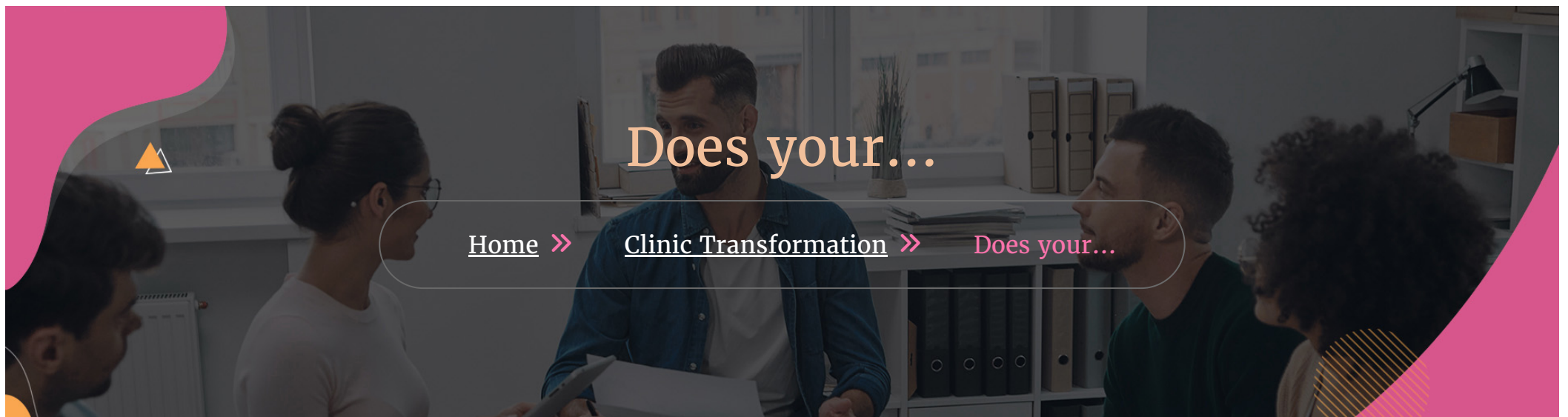




Does your health center suffer from Clinical Chaos Syndrome, or CCS?

Does your health center suffer from Clinical Chaos Syndrome, or CCS? What is CCS, and what are the telltale signs? Read below to learn how to recognize CCS and what you can do about it!

Clinical Chaos Syndrome (CCS) is the all-too-familiar feeling of dread, frustration, and loneliness clinical staff feel when their day is going poorly. Its causes can be many, including but not limited to intra-clinical causes (those factors under your control), to extra-clinical causes (e.g., a physical therapist showing up late). It's experienced in your head as negative thoughts or as a more visceral feeling, like a punch to your gut or an internal feeling of dread. Sweating is common. Language changes occur as work becomes "This place" and patients are known as "Those people". Advanced stages of CCS are characterized by indifference to coworkers, patients, and mission; the intensity around poor performance is replaced by apathy. CCS can occur at any time. CCS can be anticipatory: "The schedule looks awful today. We are never going to get out of here." It can be real-time: "Where is everyone? This is the third time today I had to leave the exam room because it wasn't stocked!!! And every time I open the door, I get crickets and tumbleweeds—not a soul to be found. Again." And, finally, it can be post hoc: "Between the agony, I feel worrying if I'll make it to my kids soccer game, which I've missed twice in a row now, to constantly getting looks of disapproval from the patients I know I've kept waiting forever, it takes me about an hour to calm down after I leave this place." Because of this, CCS can have profound adverse effects.

CCS can effect staff differently. Front desk/call center personnel are often sheltered from CCS, and this may be due to their physical location or because the clinical team never really talks to them. However, adding a patient to the schedule unexpectedly can cause acute CCS upfront, as other clinical staff may become upset—angry even—receiving this news. As a defense, front desk/call center workers have learned to ask before adding or, better yet, don't add at all. They've also learned to dodge questions from patients that call for specifics about what "being seen soon" really means.

Clinical support staff are common sufferers of CCS. Straight out of school, wanting to make a difference in people's lives, and idealistic, these staff soon learn that's their function is not to change lives in the ways they had imagined. Instead of holding meaningful clinical roles, they quickly become relegated to mundane tasks. They become clinic assistant equestrians, riding a chart into an exam room so they can drop off their passenger, only to go get another. Sometimes they are allowed to draw blood, but this is rare; they're told there's a lab close by and to send the patient there so that the room can be freed up. They are allowed to do medical histories, but have learned so little on the job that they've been asking the same questions for years. They sit waiting, often praying, for their clinician to finish the exam. They leave the exam room because they are four patients behind again. When they offer to do more, clinical support staff are often told by their clinician, "Oh that's ok. I'm fine. You're awesome to offer, though." In fact, at

that very moment, awesome is the last thing they feel, unless awesome lives next to useless and frustrated. They wonder why they aren't being used: "Am I not a hard worker? Do they think I'm not smart enough? Why hasn't my job grown here?" They recognize that low expectations for them translates into low opportunity, and they either leave or settle into late-stage CCS (which typically happens to more experienced staff).

Burnout is well-known term that describes clinicians with firmly established CCS. Clinicians, though, have a characteristic behavior special only to them: they become rule-makers. When they don't trust their team, their manager, or both, they develop rules. Some of the more popular ones are:

1. No schedule changes without approval, particularly no add-ons.
2. If you can add an appointment, it has to be a specific type without asking first.
3. If a patient is 15 minutes late they need to be rescheduled, no matter what.
4. Only certain visit types at certain times of day. Typically, this means only easy visits or high no-show visits before lunch and at day's close (the flip side of rule #3)
5. A cap on any specific appointment type. For instance, no more than two annual exams per day.
6. Providers will only work with certain staff members.
7. If a certain support staff member didn't come in today then the schedule needs to change a little.
8. There has to be a cap on the number of patients seen/booked per hour. This is a particularly hard one if you have no shows.
9. Some expressed patient needs warrant the appointment need to be booked over two, three, or four slots. Again when these patients no show it can devastate a schedule.
10. A rule that becomes a policy: no changes in how the day goes. Ever. Anything suggested to improve flow, wait times, or patient experience is immediately shot down.

Paradoxically, while rule-making's intent is to restore or maintain order, an inverse relationship has been observed; CCS intensifies as more rules are added, leading to an almost spiraling effect. Furthermore, interventions aimed at decreasing the number of rules also ironically leads to more rules, as this is seen as a violation of rule#10 (see above).

Lastly, since clinicians are gatekeepers and solely able to see and discharge patients, clinician CCS can be particularly devastating to a workplace and to a healthcare community. Are you starting to feel like you have CCS just by reading this? Click [here](#) to find out how to start preventing CCS and provider burnout today.

CCS isn't just confined to the clinical workspace, it can spread through walls and halls to administrators like CEO's and COO's. Disappointing dashboards and reports mount. Interventions have been attempted. Rule-making was allowed as an attempt to appease clinical staff, but resulted in immediate problems. Specifically, capping certain appointment types for the day led to a waitlist for that specific appointment type, even while open slots for other appointments went unused in the schedule. Limiting patients booked per hour didn't work because of no shows and therefore clinic volume dropped by a third to a half. Here, clinical staff CCS improved as they often saw roughly one to two patients per hour, but administrator CCS became intense, with profuse sweating being a common symptom. Same for booking certain appointment types over multiple slots: one patient or two patients no show and the day is lost, often producing intense administrator chest pain. In addition, believing the schedule was the cause of CCS, many organizations have directed their attention to schedule improvement techniques. The thought is that if the clinic can create schedule types that reflect the actual time visits take, they can take their jigsaw puzzle day, put it together right, and make sense of it.

In practice, this manifests in one of two ways: taking the existing patients and moving them around to fit your day, or the more common way of templating the entire schedule to make the patients fit your schedule. Problems with schedule fixes become apparent immediately. Most health care providers see the same 15 to 20 diagnoses every day, so having 20 or 30 different kinds of appointments types can feel too complex; front desk or call center staff can never get it right. Even decreasing to 10 or so appointment types doesn't seem to work. Complex schedules exacerbate CCS and negatively impact access, thereby worsening administrator CCS. Rarely does an administrator progress to the

 **EN** ^ difference, but isolated cases have been seen after too many attempts to improve clinical operations (again,

as a result of a rule #10 violation –see above). Do you want to learn more about scheduling practices that reduce rules and improve patient access? Click here to read about [Sihttps://colemanassociates.com/simplified-patient-scheduling/](https://colemanassociates.com/simplified-patient-scheduling/)mplified Patient Scheduling or SPS.

Human resource departments are generally too understaffed to deal with CCS. Replacing clinicians, clinical assistants, trainers, and administrators becomes their sole activity. The vitriol and general work dissatisfaction heard at exit interviews becomes internalized by HR staff, leading to their own version of CCS. Soon, HR departments need to hire HR staff, too, as it all just gets to be too much.

It’s important to recognize that CCS isn’t just limited to the clinical workspace. In fact CCS as outlined impacts an entire organization and its patients. Patients choose other providers as waitlists grow and wait times mount. Since care isn’t team-based and all clinical care responsibility falls to the clinician, quality suffers. Patients get tired of answering the same questions from different people over and over again: “Exactly how many times are they going to ask me about my allergies? I’ve told the front desk, the assistant and my clinician!!!” Patients get tired of going to check out and being asked, “When will we see you again?” because frankly, they don’t feel well, and can’t remember everything they were told. In time, patients lose trust.

Recognizing the signs of CSS is an important first step to recovery. Coleman has helped thousands of clinics diagnose, treat, and prevent further cases of CSS. Contact us for more information on our programs so that you can turn that Clinical Chaos Syndrome around and improve your workflows and systems for staff and patients too!

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