Creating the Organizational Foundation for Joy in Medicine™

Organizational changes lead to physician satisfaction

How will this module help me create the organizational structural elements that support joy, purpose and meaning in work?

1. Nine STEPS to create the organizational structures that can result in more satisfied and productive physicians and other health professionals.
2. Answers to commonly asked questions.
3. Tools to guide the executive leadership team in creating a joyful practice environment and thriving workforce.

Copyright 2018 American Medical Association
Introduction

A more engaged, satisfied workforce will provide better, safer, more compassionate care to patients, which will, in turn, reduce the total costs of care. The Triple Aim of better care for individuals, better health for populations and at lower costs has been updated to the Quadruple Aim, with the fourth aim of clinician well-being.

The costs of burnout are widely under-recognized. Health professional burnout poses a significant threat to the clinical, financial and reputational success of an institution. But burnout can be prevented with intentional organizational initiatives. The return on investment for organizations that address burnout can be substantial.

Figure 2: Key drivers of burnout and engagement in physicians

Q&A

How many physicians experience burnout?

More than half of US physicians experience some sign of burnout, a condition that impacts all specialties and all practice settings.1
Is burnout limited to physicians?

While burnout appears to impact all caregivers, it is especially prevalent among physicians.

What drives burnout?

The predominant drivers of burnout are systems-level factors rather than individual physician-level factors. Burnout is driven by high workloads; workflow inefficiencies, especially those related to the design and implementation of electronic health records (EHRs); increased time spent in documentation; loss of meaning in work; social isolation at work; loss of control over the work environment and a cultural shift from health values to corporate values.

Why should an organization care about burnout?

- **Quality reasons**: Burnout negatively impacts quality of care, patient safety, patient satisfaction and productivity. For example, each 1-point increase in burnout correlates with a 3-10% increase in the likelihood of physicians reporting major medical errors.
- **Humanitarian reasons**: Burnout impacts the personal lives of individual healthcare professionals, and is associated with greater rates of dissatisfaction, divorce, drug and alcohol abuse, depression and death by suicide.
- **Financial reasons**: Burnout results in higher levels of physician turnover and reductions in professional work effort. For example, physicians who are burned out are more likely to leave their current practice or reduce to part-time as those who are not burned out. Replacement costs attributable to burnout are significant for organizations (see calculator). For example, consider an organization with 450 physicians with an annual turnover rate of 7.5% and typical replacement costs of $500,000 per physician. This organization would be expected to incur costs of over $5 million annually related to burnout-associated physician turnover.

The aim is to go beyond reducing burnout to increasing professional fulfillment—to create the organization environment that allows clinicians to thrive.

What, then, are the organizational foundations that can foster joy, purpose and meaning in work and reduce the risk of burnout for clinicians?

Video

The Health Evolution Summit

Health Evolution Summit is an invitation-only gathering that engages leaders of companies deeply involved in the transformation of health care. CEOs, C-suite executives, innovators, policymakers and investors from across health care services, IT and life science convene for the Summit’s intimate environment to candidly debate ideas, build relationships and inspire creative solutions essential to the industry’s future. For more information, please visit [www.healthevolution.com](http://www.healthevolution.com).

---

Nine STEPS to creating the organizational foundation for Joy in Medicine™

The nine steps to creating the organizational foundation for Joy in Medicine™ are presented within the three domains of the Stanford Wellness Framework: Culture of Wellness, Efficiency of Practice, and Personal Resilience.
Culture of Wellness
Defined as the creation of a work environment with a set of normative values, attitudes and behaviors that promote self-care, personal and professional growth, and compassion for colleagues, patients and self.

1. Engage senior leadership
2. Track the business case for well-being
3. Resource a wellness infrastructure
4. Measure wellness and the predictors of burnout longitudinally
5. Strengthen local leadership
6. Develop and evaluate interventions

Efficiency of Practice
Defined as the value-added clinical work accomplished, divided by time and energy spent. Factors that contribute to physicians’ efficiency of practice include workplace systems, processes and practices that help physicians and their teams provide compassionate, evidence-based care for their patients.

7. Improve workflow efficiency and maximize the power of team-based care
8. Reduce clerical burden and tame the EHR

Personal Resilience
Defined as the set of individual skills, behaviors and attitudes that contribute to personal physical, emotional and social well-being, including the prevention of burnout.

9. Support the physical and psychosocial health of the workforce
Culture of Wellness

1. Engage senior leadership

Leadership should define professional wellness as a core organizational priority and dedicate appropriate resources toward it. Establish workforce wellness as a key leadership responsibility, with shared accountability across all domains of leadership. Include the efforts made toward improving professional well-being in the organization's annual strategic plan.

Q&A

How can our organization manifest professional satisfaction as a core priority?

Commitment to professional well-being can be realized in a variety of ways:

- Develop a mission and vision statement that includes professional wellness.
- Educate the governing board about the positive impact that improving clinician joy, purpose and meaning in work can have on the mission of the organization, including quality of care, patient experience, physician retention and a healthy financial bottom line. Use the calculator below to calculate the costs of burnout (Step 2).
- Implement shared accountability for workforce wellness.

How can we implement shared accountability for workforce wellness?

A powerful tool to drive change is to link leadership performance review to improvement in clinician well-being. This prevents sub-optimization around a narrow domain of responsibility, where one division optimizes the organization around its particular goals (e.g., data security or compliance) at the cost to other organizational goals (e.g., patient satisfaction, productivity or workforce well-being).

- As one example, the Chief Executive Officer (CEO), Chief Medical Information Officer (CMIO), Chief Compliance Officer and others on the executive leadership team can be assessed on improvement in the well-being for the entire institution as part of their annual performance review.
- Once structures for shared accountability are in place, it is helpful to create opportunities for administrators and department and division leaders to collaborate with each other in the development of plans for improving workforce wellness.

Shared accountability for wellness across multiple domains of leadership also helps establish trust among the workforce.
How can leadership facilitate effective change?

At the highest level, it can be helpful to identify trust, courage and empowering front-line workers as keys to success.

When creative, committed physicians and others feel powerless or subject to excessive top-down controls or decisions based on fear, change is resisted and drag is added to the system. In contrast, when physicians and their teams are trusted and empowered to solve problems locally, with strong change management support and a light regulatory touch, the innate professionalism of the workforce is allowed to flourish and everyone gains.

Track the business case for well-being

Leadership should regularly estimate and report the organizational costs of burnout. Calculate the costs of burnout using the calculator below.

Physician burnout is expensive to an organization. It contributes to direct costs of recruitment and replacement when physicians leave or reduce their clinical work effort to part-time. Costs can range from $500,000 to over a million dollars per physician. This estimate includes the costs of recruitment, sign-on bonuses, lost billings and ramp-up costs for replacement physicians.

The costs of burnout also include the indirect costs of medical errors, higher malpractice risk, reduced patient satisfaction and damage to the organization's reputation and patients' loyalty. These are not factored into the calculator below.

Visit https://edhub.ama-assn.org/steps-forward/module/2702510 to calculate the cost of physician burnout to your practice.

Organizational cost calculator example:


This calculator is provided to you by the AMA for informational purposes only. No return on investment or other results are guaranteed. ©2017. American Medical Association. All rights reserved.
How does physician burnout impact work effort?

Physicians who are burned out are more likely to reduce their work effort to part-time as their only coping strategy. Studies have shown that every one-point increase in burnout (on a seven-point scale) is associated with a 30-40 percent increase in the likelihood that physicians will reduce their professional work effort in the next two years.  

Medical errors are expensive to our organization, both through malpractice claims and through our global payment contracts. How does physician burnout impact cost and medical errors?

Burned out physicians may make more medical errors. A one-point increase in one domain of burnout has been shown to increase the risk of medical errors by 11 percent.  

Burned out physicians order more referrals, tests and prescriptions. For an emotionally exhausted physician, this may be a socially acceptable way to end a patient visit.

Our organization is increasingly financially rewarded/penalized for our patient satisfaction scores. How does physician burnout impact patient satisfaction?

Patients are more satisfied with their care and more adherent to their physician's treatment recommendations when their physicians have higher rates of satisfaction.  

How does physician satisfaction impact patient health-related behaviors?

Physicians who are happier in their careers are more effective in working with patients on behaviors that improve health, which has the potential to lower the overall costs of care. For example, patients of satisfied physicians are more likely to adhere to their physician's medication, diet and exercise recommendations.  

We are entering into more capitated contracts. How can we help our physicians and our patients while at the same time be financially successful?

Highly satisfied physicians are able to contribute more to their organizations in a myriad of ways: going the extra mile for patients, engaging in quality improvement projects and simply providing safer, higher quality, more personalized care.

In addition, a more engaged, satisfied workforce, whose workflow has been optimized, is more effective at controlling population health costs. One study estimated that if all practices adopted the workflows and professional attitudes of those in high-performing practices, health care costs would be reduced by 12.5 percent.  

Our physicians report that they are under-staffed and thus doing work that doesn't require their training, and yet staffing costs are one of our largest expenses. How can we afford additional staff?

Most industries recognize the importance of maximally leveraging the skills of their highest trained workers. Healthcare has been an exception. Yet, by reassessing current assumptions about having minimal staff support, and factoring in the costs of burnout and of replacing physicians who cut back or leave, organizations have an opportunity for a triple win: a win for the patient, a win for the care team and a win for the organization.

Consider a hypothetical population of 6000 patients.

- Clinic A has a 1:1 physician: medical assistant (MA) staffing ratio and a panel size of 1500, and thus requires 4 physicians and 4 MAs to manage the population, at a total salary cost of $1.2 million.*
Clinic B has a 1:2 physician: MA staffing ratio and a panel size of 2000, and thus requires 3 physicians and 6 MAs at a total salary cost of $1.05 million.

3 Resource a wellness infrastructure

Create an executive-level champion position, such as a Chief Wellness Officer, who reports directly to the CEO, on par with other leaders such as the Chief Operating Officer (COO) and Chief Medical Officer (CMO), and is resourced accordingly. This leader should ensure all leadership decisions consider the potential effect on workforce wellness.

Establish a sufficiently resourced Well-being/Clinical Transformation Center responsible for improving clinician well-being, improving clinical workflows and EMR performance and enhancing a sense of community among physicians and other health professionals in the organization.

Q&A

How much shall we invest in our wellness infrastructure?

Leaders are often unaware of the costs their organizations incur due to physician burnout. You can estimate the costs related to burnout using the calculator above.

4 Measure burnout and the predictors of burnout longitudinally

Establish physician wellness/burnout as a critical quality metric on the organization’s data dashboard. Assess burnout, its drivers and the costs to the organization at least annually and report the results regularly to the organization’s governing board.

Q&A

What survey instruments are available to assess physician well-being?

Available measurement instruments include:

- Maslach Burnout Inventory
- Mayo Well-being Index
- Mini-Z 2.0†
- Oldenburg Burnout Inventory

The EHR is a major source of stress for our health professionals. What tools are available to assess EHR inefficiencies?

Many EHR vendors have the capacity to generate EHR-use data. This data can provide insight into practice inefficiencies that can be targeted for improvement. For example, an organization can assess the time their providers spend on inbox work, and then institute in-basket management changes to reduce this. Pre- and post-intervention measurements can demonstrate the impact such changes have made and help spread change throughout the organization.

EHR-use data can identify efficient physicians from whom others can learn best practices. Such data can also identify physicians at high risk for burnout (e.g., because they are spending two hours of their personal time each night doing EHR documentation). This data can also identify physicians who would benefit from new workflows or improved task delegation among their team. For example, a physician
who spends considerably more time on orders than their peers will benefit from process re-engineering assistance to delegate some of this work to team members.

Your organization may want to track additional metrics regarding EHR use. Some of these can be measured behind the scenes with programs supplied by the EHR vendor, others may require direct observation through time-motion studies or diaries.

- **Work after Clinic (WAC):** time spent on EHR when not scheduled with patients
- **Work on Vacation (WOV):** time spent on the EHR while on vacation
- **Total work hours:** Both direct patient care time as well as after-hours work, which is a better measure of clinical effort than scheduled patient care hours
- **Face-to-face (F2F)/EHR:** Direct face-to-face time with patient versus EHR/deskwork time
- **EHR stress:** See Mini-Z, above

**Strengthen local leadership**

The leadership skills of a physician’s direct supervisor have a powerful impact on physician burnout. For example, one study of several thousand physicians found that every one-point increase in leadership score (on a 60-point scale) for a physician’s immediate supervisor was associated with a 3.5 percent decrease in the likelihood of burnout and a 9.1 percent increase in physician satisfaction.

For this reason, it is important to regularly assess the leadership performance of division chiefs, department heads and other direct supervisors of physicians. This can be done directly, by **surveying the individuals they lead**, and indirectly, by evaluating the well-being scores of those under their leadership.

Leaders can also combat physician burnout by ensuring that physicians have some control over their work environment and the nature of their work. For example, having control over the start and stop times of clinic, appointment length and task delegation among the physician’s team will improve career satisfaction and retention.

In addition, it is important to allow time for physicians to pursue their passions. Research has shown that if work is structured so that physicians have 20 percent of their time dedicated to the professional activities they find most meaningful (quality improvement work, community outreach, mentorship, teaching, meeting needs of underserved, etc.) burnout is reduced.

**Physician Opinion of the Leadership Quality of their Immediate Physician Supervisor Survey**
(MS WORD, 27 KB)

**Q&A**

What are the important attributes of leaders who support the professional satisfaction of others?

In the words of physicians, such a leader:

- Holds career development conversations with me
- Inspires me to do my best
- Empowers me to do my job
- Is interested in my opinion
Encourages employees to suggest ideas for improvement
• Treats me with respect and dignity
• Provides helpful feedback and coaching on my performance
• Recognizes me for a job well done
• Keeps me informed about changes taking place at my organization
• Encourages me to develop my talents and skills

Are there other ways leadership can improve communication and relationships with physicians?

• Establish “co-creation” as the standard approach for organizational initiatives, including in the development of institutional policies and regulations. In a co-creation framework, policies are created with input from both organizational leaders and those who will be impacted by the policies. 

• Choose an approach of “empower and encourage” rather than “design and deploy” or “command and control” in rolling out new initiatives. This requires allowing local customization within standard workflows. For example, rather than developing a standard template for daily huddles that is mandated for all practices, invite each practice to develop a template and create the time, location and content of daily huddles that fits best within their workflow. The template users know what is most helpful to them.

• Develop a communication platform for physicians to address daily work challenges and rapidly accelerate sharing of key issues from the front lines to top-level leadership capable of addressing these issues.

Develop and evaluate interventions

We suggest creating a toolkit of interventions and the associated staff available to assist with their implementation, and then inviting individual units to choose where to start. If the organization has a Wellness Center, the Center’s staff can track and report annually on the interventions implemented and their impact on well-being, along with other metrics, such as productivity and retention.

Workflow improvements are among the most powerful interventions to reduce burnout. In addition, combating professional isolation and increasing opportunities to build community within the workforce can improve satisfaction. In the Healthy Work Place trial, three types of interventions were successful: workflow redesign, communication improvements between provider groups, and quality improvement initiatives in chronic disease management in areas of clinician concern. Social isolation has become more prevalent, especially for physicians in ambulatory practice. Organizations can intentionally support collegiality and create community by re-examining how the physical space is designed, activities are scheduled and channels of communication are employed.

• Physical space
  The University of Minnesota created “collaboration hallways” in its new ambulatory clinics building. These corridors of communal workspaces cut crossways through patient care hallways. An endocrinologist can walk down the collaboration hallway to easily consult with a dermatologist. A surgeon can walk over to talk with a general internist about their mutual patient.
  At Beth Israel Deaconess Medical Center and Atrius Health, both in Boston, space is assigned to encourage people of different roles to cross paths with each other in the course of the day, increasing the possibilities for communication. For example, Atrius Health co-locates physicians with MAs and nurse practitioners in a common office, on a shared corridor with other teams. Other organizations have found that a provider lunchroom, physicians’ lounge or other meeting space helps to combat isolation and build stronger...
working relationships. Visit the STEPS Forward™ module, Optimizing Space in Medical Practices for more information.

- **Schwartz Rounds/Empathy Forums**  
  Supporting forums for health professionals to explicitly address the emotional and spiritual needs of patients and caregivers can build a sense of community within an organization. Visit the STEPS Forward™ module Listening with Empathy for more information.

- **Physician Engagement Groups**  
  Mayo Clinic offers all of their physicians the opportunity to meet in small groups for dinner at a restaurant in town to discuss topics related to physicianhood every two to four weeks. A discussion question is provided to start the conversation. Mayo Clinic pays for the cost of these meals. Burnout has been shown to decrease in those who participate.¹⁹ (Check out case 2 “How’s it going in Rochester” in the STEPS in practice section to learn more about the Mayo Clinic.)

- **Writing and Literature Groups**  
  Other organizations have supported writing and literature groups among their workforce as a means of strengthening social connections. For example, The Stanford Literature & Medicine Dinner and Discussion series provides an opportunity for physicians to come together and share a meal while discussing works of literature. It is part of a national program to foster the medical humanities in partnership with participating academic organizations such as Harvard University and the University of Chicago.

### Efficiency of Practice

**7**  
Improve workflow efficiency and maximize the power of team-based care

Physicians spend nearly two hours on EHR and deskwork for every hour of direct clinical face time with patients.¹⁹ This is often not satisfying to patients or to physicians. Many practices can save several hours of physician and support staff time per day by strategically re-engineering the way the work is done, the way technology is used and the way care is shared according to ability within the team.

For example, some work, such as prescription renewal or results reporting, can be re-engineered out of the physician's workflow; other work, such as visit note documentation and order entry, can be shared with other members of the team.

**Q&A**

Where can I learn more about improving workflow efficiency?

The STEPS Forward™ portfolio of toolkits can provide guidance and practical tools and actionable downloads, including sample policies, checklists and metrics for each intervention. A practice team or pilot group can use the Practice Assessment Tool to assess their organization's current state and guide their choice as to where to start. Many organizations have also found that including patients and families in the change process results in better outcomes.

STEPS Forward™ toolkits for improving teamwork and efficiency include:

- Pre-visit planning
- Pre-visit labs
- Team documentation
- Daily huddles
- Expanded rooming and discharge protocols
- Implementing team-based care
Prescription renewal
In-basket management

Where can I learn more about leading change?

Change management techniques, such as Lean and PDSA cycles, can be helpful in empowering front-line workers to choose the problems they want to solve and to create and assess solutions themselves, with the support and guidance of organizational leaders. It is important that those doing the work have some control over how their work is done, both on a day-to-day basis and during times of significant process redesign.

STEPS Forward™ offers several toolkits for facilitating organizational change:
- Team meetings
- Lean
- Medical assistant professional development
- Quality improvement using PDSA
- Preparing your practice for change
- Select sustainable change initiatives

8 Reduce clerical burden due to the EHR

The EHR is a significant source of stress and burnout for our physicians. Some of this relates to the design and regulation of EHRs, but much of the stress relates to organizational decisions made during implementation. Many of these decisions have pushed more work to the physician, work that may not require a medical education, and thus contributes to time pressure and demoralization.

What have organizations done to reduce the burden of the EHR?

Atrius Health has created a “Joy in Practice IT bundle” to improve physician efficiency and reduce stress. This bundle includes:
- Wide screen monitors
- Provide efficiency assessment through the use of Epic's EHR-use tool (Physician Efficiency Profile) to generate data on EHR-use and then target interventions to improve efficiency
- Workflow assessment involving a comparison of a given unit’s workflow to Atrius Health's ideal practice model, with change management assistance to transform toward the ideal model if desired
- Electronic prescribing of controlled substances (EPCS) using a smartphone application. For more information, visit the Drug Enforcement Administration's Diversion Control Division website.
- Clinical leadership and operations leadership engagement that encourages “teaming” between clinical and IT leadership.

Other organizations have implemented the following to reduce the clerical burden of EHRs
- Tap and Go badge sign in
Voice recognition software with natural language processing
Team documentation

Our doctors report they spend too much time on data entry. What does it cost for physicians to perform data entry that others could do?

Asante Physicians Partners in Grants Pass, OR, calculated that it costs $8 per patient for the MA to record elements of the patient's history into the record, compared with $32 per patient if this same work is done by the physician.

Consider the costs of data entry performed by an MA versus a physician for visit note documentation, billing and order entry. An MA doing this work at 10 minutes per patient at $25/hour for 20 patients a day results in data entry costs of roughly $80/day. For the physician to do this same work at $150/hour costs the organization $500/day. In addition, there are the indirect costs of reduced professional satisfaction and retention when highly trained professionals perform repeated tasks that do not require their training.

Personal Resilience

Support the physical and psychosocial health of the workforce

While the majority of physician well-being is driven by systems factors within the institution or the healthcare system at large, it is also important to support self-care efforts at the individual level.

To support wellness, some organizations provide assistance for physicians in accomplishing basic life tasks. For example, one organization has arranged for on-site dry-cleaning drop-off, another arranges for home delivery of healthy meals as a thank you for service on institutional committees, and another has an office that provides resources and referrals for physicians as they manage childcare or care for aging parents.

An organization may also choose to regularly assess physician self-care as part of an annual survey.

Q&A

What are some additional measures that an organization can take to support personal wellness and resilience:

• Provide access to healthy food and beverages.
• Provide training in mindful eating and the time to mindfully eat.
• Provide on-site exercise facilities.
• Provide on-site showers (so that workers can bike or run to work or exercise during a work break).
• Provide convenient opportunities for yoga, tai chi, mindfulness or other resiliency-oriented classes.
• Establish a quiet “refresh and recharge” room for physicians to go to after a stressful event.
• Provide peer support from physicians trained to listen to their peers undergoing trauma from lawsuit, medical error, career misgivings, etc.
• Provide financial counseling via an annual review of financial health with a financial professional.
• Include self-care in the institution's code of ethics.
• Establish after-hours, off-site and confidential psychological counseling services.
• Integrate presentations on personal resilience and well-being into the calendar of scheduled grand rounds or other organizational presentations.
• Teach compassion and self-compassion.

“Best practices to create an organizational structure to help clinicians thrive #STEPSforward”

Conclusion

At a time of dynamic change in medicine, improving the experience of the caregivers is essential, and is dependent on recognizing the costs of burnout and the value of a fulfilled professional workforce. Recognizing and quantifying the problem of burnout is the first step toward meaningful systematic change. Creating the organizational foundation for Joy in Medicine™ can be achieved by addressing issues within the three domains of physician well-being: efficiency of practice, culture of wellness and personal resiliency. Executive leadership teams have an opportunity to improve the health and well-being of patients, and their organization’s financial bottom line, by improving the health and well-being of physicians and their practices.

STEPS in practice

Creating Joy in Medicine™ in St. Paul, MN: A Case Study

HealthPartners wants to support physicians’ and clinicians’ joy and passion for the practice of medicine by intentionally reducing the time spent working. Since 2005, HealthPartners has been using the American Medical Group Association (AMGA) Physician Satisfaction with Practice Survey to benchmark against other similar organizations that use AMGA’s survey and identify areas for improvement. One subject area of the survey, “Time Spent Working,” correlates highly with HealthPartners care group’s overall satisfaction. This subject area includes administrative work done outside of the time physicians and clinicians spend directly with patients.

According to Nance McClure, Chief Operating Officer of HealthPartners care group, “It would be great if decreasing time spent working only required a single work plan or initiative; however, we learned our approach must include multiple initiatives working towards the same goal.” Some of the most impactful strategies include:

• Standardized workflows and stable teams (estimated time savings per day = 30 minutes):
  HealthPartners clinics have adopted a “care model process” that defines a standard set of workflows for delivering evidence-based care. The focus is on procedures and protocols for care teams to provide a consistent clinical experience for patients. Clinic staff members are organized into care teams to meet patient needs and may be composed of a physician or clinician, rooming nurse, receptionist and others, such as pharmacist or dietitian. The goal is to make the best use of collective team skills. This results in enhanced communication to ensure that care is well-coordinated and responsive. Teams plan for patient...
interactions in defined cycles that include scheduling, pre-visit planning, check-in, visit and post-visit. Defining the elements of the interaction with patients allows the care team to anticipate patient needs, remind patients of health issues and provide follow-up after the visit. For example, pre-visit planning may include identifying preventive care services that will need to be provided at the visit and contacting the patient to schedule lab tests before the visit so that results are available for review during the visit. At the visit, the team uses the electronic health record (EHR) to address the patient’s health maintenance or chronic care needs, prescription refills and schedule future appointments. The objective is to have consistent or stable care teams when possible; however, standard workflows (care model process) and training makes switching teams by care team members seamless when needed due to turnover, sick days or vacations.

- **Collaborative and streamlined documentation (estimated time savings per day = 30 minutes):** Since HealthPartners implemented its EHR in 2004, continual improvements have been made to achieve more consistency and clarity of clinical documentation. HealthPartners tries to standardize where possible and customize when needed to meet individual patient needs. Some successful approaches include judicious use of best practice alerts (BPA), 40+ templates housed in the EHR for collaborative documentation between nurse and clinician, co-located workspaces, wider monitor screens and printers in exam rooms. Also, shared registered nurse (RN) visits make for a more meaningful visit for patients, allowing the physician to spend less time documenting. During the shared visit, the documentation template selected from the EHR identifies the areas the nurse can document, rather than the physician. In addition, medication reconciliation and history of patient illness are covered during the rooming process to leave more time for the physician to discuss other concerns with the patient.

- **Inbasket management (estimated time savings per day = 15 minutes):** Similar to progress being made in the area of documentation, work to efficiently manage inbaskets is ongoing. The elimination of “blinded” inbaskets (only visible to one user) for physicians and consolidation and standardization of folders have proven to be effective approaches. “Unblinded” inbaskets allow the work to be redistributed across entire care team so it is not resting solely on the physician. For example, the rooming staff can prioritize messages for review and handle non-emergent messages appropriately. This is possible due to consistent training and resources such as the Test Results Guide. The intent is to have as many messages as possible handled by someone other than the physician, allowing them to only review what they need to see. Specific action was also taken to streamline test results that collect in the inbasket. Now, about 95 percent of lab test results are released to patients automatically within four hours via the patient portal. Patients appreciate the speed and this ultimately reduced the number of calls received from patients wondering when they'd receive their results.

Care teams are continuously innovating and improving to build upon this foundational work. These initiatives and others have helped move HealthPartners from the 13th percentile in 2005 to 61st percentile in 2016 in the area of “physician satisfaction with time spent working” in the AMGA survey. “Overall satisfaction with practice” for the same period increased from the 23rd percentile to the 84th percentile. HealthPartners’ vision is “health as it could be, affordability as it must be, through relationships built on trust.” The group recognizes that to achieve this vision, joy and passion are fundamental to practices and that a balance in both personal and professional lives is required for physicians and clinicians to be at their best.

---

**Creating Joy in Medicine™ in Rochester, MN: A Case Study**

In 2007, the Mayo Clinic Department of Medicine created the Program on Physician Well-Being (PPWB) to better understand the entire spectrum of personal, professional and organizational factors that influence physician well-being. This effort was led by Drs. Tait Shanafelt, Lotte Dyrbye and Colin West. The program spanned across disciplines, including medicine, psychology and health science research. In the first few years, the focus of the PPWB was on establishing the epidemiology of burnout and distress. Based on institutional and national survey studies, it became evident that burnout is highly prevalent among physicians across all specialties. The drivers vary from practice to practice, but include excessive workload, inadequate support at work, work-home conflicts, loss of control and diminished meaning and purpose from work.

The PPWB’s research on the epidemiology of stress and burnout made it clear that they had to address these problems, but they weren't sure what would work best. Therefore, they decided to conduct randomized trials of interventions designed to reduce distress and promote well-being. One of the ideas tested was to hold small,
organizationally supported physician group meetings oriented around topics reflecting common stressful physician experiences. This initiative was called COMPASS — COlleagues Meeting to Promote And Sustain Satisfaction.

COMPASS groups build on a sense of shared community as one of the great virtues of physician-hood. Mutual support from colleagues to deal with the challenges of their field has long helped physicians manage the stress related to practicing medicine and derive meaning from their work. Increased productivity expectations and other changes to practice over the last several decades have decreased the time physicians must interact with colleagues and have eroded personal connections to colleagues. The goal of the COMPASS group meetings is to encourage collegiality, shared experience, connectedness, mutual support and meaning in work, thereby promoting well-being and a reduction of burnout and distress.

COMPASS groups consist of six to ten physicians, with one group leader responsible for organizing hour-long meetings twice per month over a six-month period. Each group is asked to meet in a relatively private setting (e.g., a restaurant near campus or a reserved meeting room) rather than a public space where interruptions are likely. Group leaders are provided with three to four discussion topics or specific questions for each session. Examples include:

- Think about one of your most satisfying days at work over the last month. What made this day so professionally satisfying? Share with your colleagues.
- Brainstorm ways to promote collegiality in your hallway or work unit.
- Choose one stressor that you can control, come up with two concrete ways you can reduce it, and commit to trying one approach within the next week.

The first 15 minutes of each meeting are dedicated to semi-structured discussion involving a check in and a dialogue about one of the assigned topics for the session as selected by the group. The remainder of the time can be used for additional discussion or socializing and building relationships with colleagues.

Internal studies found measurable benefits from participation in the COMPASS group meetings, including reduced burnout, increased well-being, improved meaning from work, reduced social isolation and improved job satisfaction. Due to the success of these early studies, Mayo Clinic leadership continues to support this program with funding derived from clinical sources within each hosting department. As of July 2017, nearly 1,500 physicians and scientists have signed up to participate in a COMPASS group, representing 40 percent of eligible individuals across all Mayo Clinic sites. At the end of the first six-month period, more than 95 percent of group leaders reported that the groups were valuable and that they planned to continue meeting.

Although this program is successful, lessons were learned during implementation that may prove helpful for other institutions and practices considering a similar effort.

1. **Administrative support is required.** Although groups are responsible for their own scheduling, sometimes they need assistance to keep track of members and maintain a point of contact should issues arise. To support this task, an internal website was built with links to contact information, lists of discussion topics and other guidance for participants. The program also has a dedicated support staff member with a small amount of institutionally directed time for this role.

2. **Anticipate the needs of group members who want to participate beyond six months.** Many groups expressed interest in extending their enrollment beyond the initial 12-session period. Discussion topics are available to support roughly three rounds of the program. Beyond that, groups may need to repeat topics as additional content is developed.

3. **Be flexible with group assignments.** Some individuals will only participate if their close colleagues also sign up, whereas others will only participate in groups outside of their clinical circles. Flexibility in group assignments is critical to respect these wishes and provide each participant with the optimal setting for maximal benefit.

4. **Identify a suitable mechanism to protect time and resources.** Reimbursement through existing institutional mechanisms such as a corporate travel card is much less resource-intensive than processing thousands of one-off receipts for payment. According to participants, the most challenging aspect of the COMPASS groups is actually making the time to engage meaningfully with their colleagues. This challenge speaks to the importance of efforts to prioritize opportunities for physicians to engage together as a community.
Mayo Clinic leadership, the PPWB and COMPASS participants have spread the word about the effort. This opportunity for community building is presented to all new staff during their orientation process. Many physicians have joined in the “second wave” of groups based on word-of-mouth from members of earlier groups—even as finding time to meet proves challenging, groups find value in the program and have continued to enroll.

There is no single solution to the physician burnout crisis. However, each additional evidence-based tool added to the menu of interventions an organization can provide increases the chance that every physician will benefit in some way. Ultimately, the hope is that patients will receive care from physicians who find joy, purpose and meaning in their work.

Creating Joy in Medicine™ in Baltimore, MD: A Case Study

Johns Hopkins Medicine (JHM) is an academic health center located in Baltimore, MD, that employs more than 40,000 full-time faculty and staff and has more than 900,000 outpatient visits annually. Like others across the country, the center faces the pressures of learning to use electronic health records (EHR) systems, reimbursement challenges and new reporting requirements. Recognizing the negative impact this ever-changing healthcare environment could have on its faculty and staff, JHM leadership decided to be intentional about cultivating joy so that clinicians are cared for and have the support they need to thrive.

JHM identified concrete strategies that would make their practice environment supportive, nurture careers, protect work-life balance and most importantly, help all members of the care team retain fulfillment in their work. Several efforts described here have been underway for years under the auspices of the Office for Faculty Development, the Clinical Practice Association, Human Resources and other groups throughout JHM. To centralize and accelerate this work, JHM recently established a Joy in Medicine Task Force that will focus on identifying the main barriers to professional enjoyment and outlining strategies to preserve and enhance joy. The Joy in Medicine Task Force will produce a white paper assessing the current environment at JHM, reviewing peer institutions and issuing specific recommendations for improving satisfaction. The task force has broad representation of volunteers from the organization’s six hospitals, physician practices and nursing community. The five workgroups within the task force focus on support for academic and clinical success, EHR workflow, culture and work-life balance, regulatory training and clinical operations.

Although JHM conducted an annual employee engagement survey and used the results to develop interventions long before the Joy in Medicine Task Force was formed, they understood that “joy” and the repercussions of losing joy in practice may not be fully measured with this method. Their first step to gauge how staff felt was simply to ask them. To generate the blueprint for all the work around “joy,” they needed feedback. Ongoing polling of teams, meeting with various groups and most importantly, listening, led to a better understanding of what the organization can do to support clinicians, make their work more rewarding and help them achieve their professional goals. They recently introduced departmental reviews to give faculty members a confidential forum to comment on their work climate and provide feedback about how the organization can help to better facilitate their work. They also developed a new survey based on a validated burnout survey with additional questions tailored to the JHM practice environment. This new survey does not replace the engagement survey but will be administered to faculty, clinicians and nurses to specifically measure job satisfaction.

With the help of these surveys, the task force and feedback from clinicians, JHM identified the following programs and resources to improve the practice environment and keep clinicians engaged:

- A new awards program to recognize and honor excellent clinicians and care teams
- A clearly outlined path to promotion for clinically focused faculty
- Small-group leadership programs that not only provide career development but also forge strong bonds among the graduates in each cohort
- A Research Council that is wholly focused on identifying and decreasing barriers to scientific productivity across the enterprise
- Methods to improve processes, such as a project addressing perioperative throughput and hiring outside consultants to advise on operational efficiency. They built a command center at the flagship...
hospital, which co-locates teams and equips them with real-time data so that they can more effectively communicate with each other to improve patient flow and reduce wait times

- Continuing education courses, such as “Thrive After Go-Live” for community physicians using EPIC to address EHR pain points and “Economics of Clinical Operations,” which aims to educate clinicians about practical finances, funds flow and new payment models
- A program aimed explicitly at buffering against burnout called “Finding Joy and Cultivating Joy at Work”
- A mindfulness-based stress reduction workshop open to all faculty, which proved so popular that one course was filled in under an hour after registration opened
- A speaker series that invites experts in the areas of humanism in current-day medicine and professional satisfaction and burnout
- Emphasis on improving culture by creating a supportive work environment that respects and promotes work-life balance for physicians

Above all, JHM recognizes that clinicians derive fulfillment from their relationships with patients—getting to know them, partnering on their care plans and watching their health improve. They have introduced scribes in some specialties and are soliciting more strategies for freeing up time for clinicians to spend on direct patient care - recommendations that will be included in the task force’s white paper.

JHM also identified the need to provide its medical trainees with a similarly supportive work environment. Medical residents work long hours at the edge of their abilities, in a setting that makes it hard to call on their social support system, making the risk of depression very real. To mitigate this, JHM added introspective and restorative elements to the residency program and encouraged trainees to embrace self-care strategies. For example, the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center now cover the annual cost of a membership for every resident to the fitness center on their respective campus. In addition, the School of Medicine hired an Assistant Dean for Graduate Medical Education who will devote half of her effort to wellness initiatives for residents and fellows. JHM realizes these earlier interventions are needed—and may lay the groundwork for resiliency over one's career.

Dr. Paul Rothman, Dean/CEO for JHM, says “It’s hard to imagine a more critical issue for health care leaders than combatting burnout and attrition, because our people truly are our most precious asset—the heart and soul of our institutions. Moreover, study after study shows that happier care providers are better care providers, so this is not just a human resources issue. It’s about quality of care and doing what's best for our patients.”

Creating Joy in Medicine™ in Roanoke, VA: A Case Study

Carilion Clinic is the largest not-for-profit, multi-specialty integrated health system in Western Virginia. Nearly one million people are served by the system’s seven hospitals and more than 220 physician practice locations. Seven hundred physicians and over 200 residents and fellows work at Carilion. Carilion leadership recognized early after the Clinic formed in 2007 that the integration of technology and the rapid change happening in the healthcare system at large would likely take an emotional toll on clinicians. They recognized that there was uncertainty about how best to create a foundation for clinician well-being while focusing on the Clinic’s mission of patient-centric care during this time of rapid change.

Over the years, Carilion tried numerous approaches to address and prevent burnout. These programs evolved with the changing practice environment and in response to physician feedback. Carilion leadership thought that these efforts would prevent, or at least minimize, burnout. Early organization-wide initiatives included:

- A series of programs overseen by the Office of Continuing Professional Development (OCPD), including a physician leadership academy, a faculty development fellowship and a service excellence initiative for physicians (Physicians Leading Service Excellence, or PleaSE)
- A four-month “virtual book study” for physicians to discuss the teachings in the book “The Resilient Physician” to help them navigate changes
- A Professional Wellness Committee whose goal was to provide structure for organizational work focused on professional well-being. This committee brought together interested thought leaders from different sectors of the organization, including undergraduate and graduate medical education, OCPD, nursing, the Jefferson College of Health Sciences (JCHS), the employee assistance program, human resources and the chaplain service. At first, this group served as a repository for initiatives throughout the system, and
eventually became a catalyst for integrated action. The committee chair met with the clinical chairs and Vice President dyad partners to educate them about national burnout data and to raise organizational awareness of the committee's work in furthering wellness.

- Adoption of the “Quadruple Aim,” which gradually became part of the organizational vernacular at the direction of the Chief Medical Officer, sparking ideas for other initiatives dedicated to improving professional satisfaction

At the local level departments, independently launched tailored initiatives to address clinician well-being and burnout in their practice environment. For example:

- “Schwartz Rounds™,” a program that offers healthcare providers a regularly scheduled time to openly and honestly discuss the social and emotional issues they face caring for patients and families
- A “Second Victim” program, titled the “TRUST Team,” which was created to provide resources and support to struggling healthcare providers involved in unanticipated adverse patient events
- Other areas of the organization focused on mindfulness training or introduced support groups to improve well-being

Despite these efforts and high level of understanding of stress within the medical community, the Professional Wellness Committee leadership team believed they needed a more formalized process to further identify specific local challenges. A research project started in the spring of 2016 sought to measure the level of burnout at Carilion and use this data to raise awareness of how important professional well-being is to advance the organizational mission. A survey that included the Maslach Burnout Inventory (MBI), the Physician Well-Being Self-Assessment Tool (PWSAT) and a few Carilion-generated questions focused on items measuring employee engagement was distributed to all physicians, residents/fellows, advanced care practitioners and medical students in the system. The results indicated that 59 percent of Carilion physicians were experiencing high burnout; this was slightly higher than the national average based on studies available at the time. From this latest information came a heightened awareness of the extent of clinician burnout and a renewed focus from organizational leadership to rectify it. They brainstormed innovative ways to address this concern and fast-tracked initiatives already being developed. Some examples include:

- **Aggregating resources for students and clinicians.** The medical school created a web portal to provide additional education and resources to support the well-being of medical students. The health system is currently developing its own web portal to consolidate information about a variety of support services and well-being initiatives in a single location.
- **Individualized wellness committees that meet the needs of practitioners in a specific department.** Several departments started their own small wellness committees to tease out the most pressing challenges faced by their teams that lead to burnout. These committees are tasked with implementing local changes. For instance, the Department of Family and Community Medicine started a “4th Aim Better Life Team” that found inefficiencies with the electronic health record (EHR) and the need to create a culture of clinical consistency and decreased clinical variation, while at the same time allowing for appropriate autonomy, were important factors. Some of these inefficiencies included:
  - **Extensive time spent after hours on the EHR:** The department began tracking time and noting the specific clinicians who were impacted. Physicians are contacted to learn more about their charting patterns. Physician champions selected for their EHR skills form teams to work one-on-one with their colleagues to increase proficiency with EHR systems so they spend less time in them.
  - **Inefficient keyboarding/data-entry skills:** The department actively promotes the use of either Dragon® speech recognition software or scribes to assist clinicians. Those who use the voice recognition software (particularly with the most recent upgraded version) have been pleased with how it has impacted their charting efficiency. “The AMA does not endorse specific products
  - **Ineffective EHR templates leading to a breakdown in charting workflows:** These challenges are found with the collection of regular feedback. The committee keeps a running list and systematically addresses them with the information technology (IT) team.
  - **Overuse of EHR “Best Practice Advisories,” or BPAs:** The phenomenon of “BPA fatigue” was once cited regularly by the group, and the committee was tasked with prioritizing the BPAs based on departmental and organizational priorities.
• **Enhanced visibility and sharing between groups.** Ongoing support groups for both residents and faculty physicians have become more visible. There is a more active and successful sharing of structure and process between the various groups and across clinical departments.

• **Considering every member of the care team.** An organizational well-being/burnout survey for all nurses was recently completed. The results will be used to help advance the culture of well-being for all Carilion clinic nurses. The division of Graduate Medical Education has also renewed its work addressing resident well-being and burnout.

• **Celebrating successes and sharing updates on wellness initiatives in email newsletters.** The Department of Family and Community Medicine included a regular column on the “4th Aim” in their weekly clinical e-newsletter, which is sent to all clinicians and staff in the department (and throughout the country), called “Take 3 – Practical Practice Pointers.” A more system-wide electronic newsletter is also being developed.

• **Demonstrated administrative and managerial support.** The original Professional Wellness Committee re-launched to focus more specifically on physician well-being, in collaboration with other committees focusing on specific constituent groups. The OCPD also hired a full-time administrative manager to help advance the ongoing work pertaining to leadership development and clinician well-being.

• **Acknowledging the contribution of adverse events to burnout and collaborating with the appropriate departments.** Process improvements are underway to more closely align the work of both the Professional Wellness/Physician Well-Being committees and the Second Victim team with the work of Carilion Clinical Advancement and Patient Safety, which oversees all quality, safety, compliance and risk management work.

• **Follow through, revise and refine based on feedback.** Initial plans are in place for repeat surveys of the clinicians. Some individual clinical departments intend to repeat the burnout/well-being survey one year from the original survey to determine the impact of the initial interventions. As anecdotal evidence of successes or challenges comes in, education and development programs for physician and administrative leaders have expanded to include understanding the impact leadership has on clinician well-being and burnout. For example, Family and Community Medicine received positive feedback on improvements to EHR efficiency made at the behest of their department’s wellness committee. Providers regularly comment on how much they appreciate being part of a department that is placing this as a priority.

Carilion is committed to helping other organizations identify and address physician burnout by sharing their story. The Professional Wellness Committee created and circulated an internal “white paper” that laid out an organizational roadmap for addressing burnout. Carilion has also presented their data and efforts in this area at the local, regional and national level and continue to publish on this topic. In October 2016, Dr. Mark Greenawald, a physician at Carilion Clinic, shared his own powerful story of burnout in a U.S. News and World Report special report, “Diagnosis Burnout.”

Carilion offers some tips for creating an organizational foundation that furthers wellness:

• Have a centralized, diverse well-being committee with the necessary resources to drive this work and increase visibility across the organization.

• Embed Quadruple Aim language in the organizational mission.

• Establish a baseline of local data on clinician burnout/well-being using a validated instrument with national comparative data. Widely and openly share the results of local data and use it as a consistent measure of burnout within the organization.

• Make an explicit connection between addressing clinician well-being/burnout and organizational quality, safety and risk management initiatives.

• Create both a global organizational plan as well as department-specific plans to address pressure points that are interfering with achieving the 4th Aim: improving “the experience of caring.”

References:

Creating Joy in Medicine™ in Salt Lake City, UT: A Case Study

University of Utah Health (UUH) is a large academic medical center that relies on more than 1,400 physicians to staff their integrated health system. UUH recognizes that prioritizing the health of their workforce is vital.

In the winter of 2016, in response to increasing rates of burnout at the national level reported in the literature and lay press and a perceived need to address this issue at the system level, the chief executive officer (CEO) of UUH asked for a concerted effort to address the needs of faculty across the institution and to develop reportable metrics around wellness. This effort began with the addition of a Chief Wellness Officer, who expanded existing efforts and helped initiate many new wellness-specific programs, including the establishment of a Resiliency Center with the help of a multidisciplinary committee. This work not only focused on the needs of UUH faculty, but also took a thoughtful look at how the organization supports staff and medical trainee well-being. Under the direction of its Graduate Medical Education (GME) office, a multidisciplinary GME Wellness Committee was convened in 2015 to outline a GME-specific wellness program. A Director of GME Wellness was hired in the spring of 2016.

UUH initiated a multifaceted assessment of the current state of burnout among their faculty to guide the new wellness program creation. UUH partnered with the American Medical Association (AMA)-American College of Physicians (ACP) Wellness Pilot for data analysis and guidance. UUH conducted the AMA's Mini-Z survey with additional questions geared toward understanding the needs of academic faculty, such as:

- Hours of direct outpatient or inpatient care
- Average number of patients seen in a four-hour shift
- Average daily census
- Feeling of support/appreciation by peers, patients, families and/or immediate supervisor
- The three main sources of dissatisfaction with practicing medicine
- Ratings of clinical support from medical assistants and nurses

The Mini-Z data was collected along with a needs assessment of possible programmatic targets. This data was also complemented by additional surveys to gain an understanding of burnout challenges as they relate specifically to the institution. The Diversity Engagement Survey (developed by the Association of American Medical Colleges; AAMC) is disseminated by the UUH Office of Health Equity and Inclusion every two years to faculty, staff and students in the health sciences. This survey is conducted to understand how diverse groups engage with the institution. Additional information was gathered from the StandPoint Faculty Engagement Survey (formerly known as Faculty Forward). Faculty Forward is run by Human Resources and is used to diagnose areas of faculty engagement and effectiveness of faculty-related institutional policies and practices in the domains of engagement.

The AMA analyzed the Mini-Z data and the findings were combined with in-house analysis of unique questions and additional surveys to yield benchmark data for UUH. The Chief Wellness Officer and one of the faculty co-directors of the Resiliency Center then met individually with leadership from each of the departments within
the School of Medicine to identify areas of strength and opportunities for improvement. Each department,
both clinical and non-clinical, selected one or more wellness champions to develop projects to meet identified
departmental wellness priorities, using specific and relevant metrics. Metrics included patient satisfaction,
number of patients being served, electronic health record (EHR) efficiency and provider engagement. A range
of projects focused on topics such as personal wellness and resilience and advanced models of teamwork
facilitation, clinic flow, EHR use and flexibility of hours. Quarterly meetings with the Chief Wellness Officer
and co-director of the Resiliency Center are held with the wellness champions to assist them in their project
development and implementation. The last meeting of 2017 will be a poster session where projects will be shared
to encourage future collaboration in wellness initiatives.

Simultaneously, UUH began cataloging existing programs that were already addressing faculty and staff
wellbeing, looking for synergies and opportunities for collaboration. Among these programs, the Office of
Wellness and Integrative Health and the Office of Health Equity and Inclusion collaborate on a weekly Community
Read. The Community Read is similar to a book club or a journal club focused on a specific topic or area. The
focus of the winter 2017 semester’s readings was the science of wellness and exploring the relationship between
inclusion and wellness and wellness and quality. UUH believes that an inclusive environment leads to a well
environment and a well environment leads to quality.

As momentum continued to build around wellness and burnout prevention at UUH in 2016, a group was formed
to specifically discuss provider resilience. Initially sparked by a conversation between risk management and
health system senior leadership regarding concerns around providers dealing with poor outcomes, the group’s
target quickly expanded to include all faculty and staff. It was this group that developed the new Resiliency
Center in 2017. This Center was created to bring together the extensive wellness programs already in existence,
build novel resources, and create a hub that serves as a crucible for innovative ideas. The Center coordinates
closely with undergraduate medical education (UME) and GME wellness efforts, including hosting joint wellness
champion meetings, mindfulness training, and a peer-to-peer counseling program. The Resiliency Center is
helping providers become more resilient by encouraging innovation, helping focus energy, maximize impact and
avoid duplication of effort across organizational wellness initiatives.

UUH wellness efforts have been strengthened by senior leadership support including from the Senior VP’s Office
and the Office for Health Equity and Inclusion. A clear case was made that resiliency and wellness efforts were
likely to advance operational goals, such as provider/staff engagement, patient satisfaction, patient safety,
operational efficiency and productivity. Wellness initiatives at UUH also benefit from access to existing resources,
the collaborative nature of The University of Utah and use of the American Medical Association-American College
of Physicians Wellness Pilot for data analysis and benchmarking.

Over the next year, UUH will continue to look for ways to collaborate with existing programs in the further
development of the Resiliency Center and expand the number of wellness champions to include additional
faculty and staff. Additionally, they plan to complete an annual follow-up burnout survey using the Mini-Z
instrument. UUH knows they must make the wellbeing of people in their system a permanent operational goal.

Creating Joy in Medicine™ in a Boston, MA Physician Organization: A Case Study

The 2014 annual survey at the Massachusetts General Physicians Organization (MGPO) revealed that 41 percent
of their 3,200 physicians scored high on the Maslach Burnout Inventory (MBI) and the Utrecht Work Engagement
Scale (UWES). Specifically, the survey revealed that a lack of autonomy, loss of connectivity with colleagues and
responsibility for non-clinical work were the activities most often correlated with burnout. Around the same
time that the survey data were released, new challenges emerged, including the implementation of an electronic
health record (EHR) system that many felt compromised the joy they once felt in medicine.

MGPO clinicians realized that urgent action was needed to address the root causes of burnout. This led to
the formation of the Physician Burnout Committee, or Frigoletto Committee, to bring the focus back to the
relationship between physician and patient and restore meaning and joy to practice. The Committee is named
after Dr. Fred Frigoletto, a member of the Massachusetts General Hospital faculty who worked tirelessly to
mitigate the impact of administrative burden on clinicians. He passed away shortly after the Committee was
formed and it was renamed in his honor.
More than 90 volunteers responded to an organization-wide call to participate in this important initiative. Committee membership consists of 28 physicians representing primary and specialty care, two residents, a third-year medical student and a Board of Trustees member. The Committee drafted the following charter to guide its charge:

“The Frigoletto Physician Burnout Committee has been chartered by the MGPO to identify, evaluate, prioritize, and offer suggestions to the Physicians Organization Executive Committee (POEC) for immediate and longer-term remediation of the factors contributing to physician burnout within the Massachusetts General Physician Organization.”

The Committee is tasked with ideating initiatives on a regular basis that, if selected for implementation, will have both short- and long-term effects that contribute to fulfillment in practice. To accomplish this goal, the Committee members have been meeting for an hour approximately every six weeks since September 2016. Their work is communicated to MGPO via a weekly newsletter, video, social media platforms and leadership meetings, including the Department Chiefs’ meeting and MGPO Executive Committee meetings.

Volunteers not selected for the main Committee were active on four sub-committees that addressed specific areas associated with burnout at MGPO:
- Workflow
- Information technology (IT) and EHR
- Physician well-being
- Governance

The sub-committees were given an eight-week timeline to report their respective initiatives to the Frigoletto Committee. All MGPO members were surveyed about the initiatives and asked to choose their top initiative from each of the four categories. Initiatives with the most votes were presented to MGPO leadership for funding and implementation. The final products of these meetings will try to address the following: delegation of non-clinical work to a non-MD space, personalized EHR training, enhancement of the EHR platform across practices and optimization of resources to practices (for example, optimal use of medical assistants or nurse practitioners). With their tasks complete, the subcommittees have been disbanded and their initiatives are being rolled out by the Frigoletto Committee.

During the process described above, the Committee identified several “quick fixes” that were readily implemented. These included changing note completion in the EHR from three days to three business days, changing the availability of imaging results for patients from one to three days, and establishing a physician EHR support hotline. Other initiatives will soon be rolled out at the system and department levels. Departments are tasked with identifying the most relevant metrics to measure impact of these initiatives on their clinicians.

MGPO believes that any process that looks at burnout should try to be transparent and inclusive and hold leadership accountable. The process should involve changing culture across organizations and making institutional leaders accountable for burnout. Lastly, some of the initiatives may be appropriate to roll out at the institutional level, whereas others are more appropriate at the local, department or divisional level.
Creating Joy in Medicine™ in a Boston, MA Health System: A Case Study

Physician well-being is critical to both patient care and organizational success at Atrius Health, a Boston area delivery system, with approximately 900 physicians and another 300 advanced practice providers across 36 sites. The leadership agrees that the path forward includes a deliberate focus on improving professional satisfaction.

The operational initiatives to achieve this strategic aim are organized around three reciprocal domains of physician well-being:

- **Practice Efficiency**
- **Culture of Wellness**
- **Personal Resilience**

**Practice Efficiency**

By developing greater efficiency of practice, Atrius Health intends both to improve the quality of care a physician can provide and to explicitly return some personal time to the physician's day.

Atrius Health is focused specifically on shortening the physician workday. As in many organizations, Atrius Health knows that its physicians, particularly in primary care, typically spend an hour or more of their personal time after hours each day completing documentation or working on their inbox.

To address this, leaders are introducing workflow redesign to ensure process reliability. Initial efforts at improving the micro-environment for the care team focus on adult primary care and consist of enhancement of nursing and support roles, routinization of core processes (e.g. rooming patients, refills, referrals, forms, patient onboarding, chronic disease management) and reduction of inbox items in primary care, including reductions in copied (CC'ed) notes to physicians and reducing the influx of messages in certain folders (results, telephone encounters, and media manager). A team in internal medicine spearheaded CC'ed chart changes. 90,000 CC'ed messages are sent each month at Atrius Health. To reduce this clutter, specific guidelines were set and adopted in the entire practice. Referral management has also been substantially removed from the primary care physicians' task lists via a Navigator Center. On behalf of primary care physicians, Navigator staff help patients with referrals and are able answer routine questions and offer guidance, including having difficult conversations when the proposed referral is different than what the patient might have requested.

A technology team has been deployed in primary care practices to re-engineer the EMR to reduce clerical tasks performed by clinicians (e.g. adult wellness visits, medication reconciliation, routine diagnostic orders) and to optimize EMR use among physician users. These efforts are estimated to have already saved hundreds of clicks per clinician per day across the enterprise.

Because visit note documentation consumes substantial physician time, physicians are given the option to pay for clerical assistants (scribes) to assist with documentation. One small study suggests that this form of team documentation has reduced physician burnout while at the same time significantly increasing patient confidence in the physician as well as patient satisfaction with the amount of time spent with their physician. The study indicates that patients are also more likely to recommend the individual physician and the overall practice. In addition, the study authors found that physicians with clerical assistants are more likely to add on patients to their schedule on short notice. Physicians reported fewer after-hours documentation and clerical burdens. To reduce the burden of lower level clinical and clerical tasks while on call, Atrius Health has strengthened its 24-hour clinically-staffed call center and fortified its capacity for urgent care 365 days per year.

To help physicians deliver higher quality care, as both a means of efficiency and of driving satisfaction, via our VNA Care home health subsidiary, Atrius Health has expanded its capacity to provide same day evaluation at home for patients who cannot come to the office and would otherwise go the ED (reducing likelihood of admission and associated work for physician).
The organization also facilitates prompt referrals across specialties, guaranteeing same day consultation in many sub-specialties while also establishing e-consultation as a mainstream method for acquiring sub-specialty guidance for primary care. Similarly, geriatric and palliative care physicians are available to either provide direct care or to guide primary care clinicians as they care for frail, elderly patients, increasing the scope and competency of the primary care workforce, which in turn enhances professional satisfaction. Finally, Atrius Health is beginning to use advanced predictive analytics to identify patients at high risk for hospitalization, thus enabling the team surrounding the physician to proactively recognize patients who require specialized in home or in office support.

**Culture of Wellness**

Atrius Health envisions a shift toward a culture of compassion, one that encourages physicians to extend to themselves and to their colleagues the same natural compassion they show to their patients.

One component of this cultural shift will entail modifying the annual physician review process away from traditional metrics and performance criteria and toward a reflective conversation between physician and chief, focused on individual professional growth and core well-being. This conversation will be used as a pivot point away from “physician who does it all” thinking and toward team expertise and compassion for all team members. Recognizing that facilitating these novel conversations doesn’t come naturally, Atrius Health will conduct specific leadership development activities. These will support this shift in culture and the acquisition of new leadership skills to promote physician well-being.

Atrius Health is also working to rejuvenate, support and expand teaching, learning, and research opportunities through its Academic Institute, with an eye toward rekindling the intellectual and social ties that knit together a community of physicians.

**Personal Resilience**

While strides in physician well-being are driven by organizational and cultural factors, Atrius Health also recognizes the importance of individual efforts toward improving personal resilience. Atrius Health has launched a coaching program, available for individuals and teams, to build the skills, behaviors, and attitudes that contribute to well-being and the prevention of burnout. To date, 30 primary care and specialty doctors are enrolled in individual coaching. Furthermore, a half dozen more have signed up for our first “team client.” This will involve group coaching within a department to facilitate practice improvements. The coach is trained in both psychosocial and individual/team based practices. The goal is to help heighten the workplace environment and improve the clinician’s day-to-day activities.

In addition a two-day Personal Wellness event at a local hotel is being planned. Clinicians will be able to use CME funds to attend this meeting and earn CME credits.

**Lessons Learned**

Improving clinician wellness through the three domains has presented challenges and barriers. In an effort to reduce inbox clutter, regulatory issues were uncovered. Efforts were undertaken to remove normal routine mammograms from the primary care physicians’ inbox, but our compliance office interprets federal regulations to mandate that all results must be communicated to the ordering physician. Furthermore, medication reconciliation of recently hospital discharged patients presented further regulatory issues. Our compliance office interprets that physicians need to sign off on the medication reconciliations although nursing staff actually perform them.

Internal resistance to change has created challenges. Some physicians had difficulty accepting practice efficiency changes and thus, in the past, projects were abandoned. Now, within the Internal Medicine Department, changes are implemented based on majority impact; if most clinicians get a meaningful benefit, the practice efficiency takes precedence and will be implemented.

There is a lot happening, some underway, some in design. Responsive change will take time. Right now, many physicians do not yet “feel” the changes already underway as much as we would like. It is up to leaders to convey hope and uncover incremental opportunities, even as the changes are nascent.
Future Vision
As a core component of its strategy, Atrius Health intends to become a destination medical practice, attracting physicians regionally and nationally due to its success in making practice life better. It will do so by succeeding in the three domains: practice efficiency, fostering a culture of wellness, and the development of personal resilience among its staff. Atrius Health's legacy—a prepaid group practice that pioneered quality improvement, managed care acumen, process improvement, and brought clinician training into the ambulatory practice—makes it distinctly suited to succeed in this new realm challenging all of American medicines.

Introduction:
Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. Organizational development focuses on optimizing management, integration, improvement and adaptability to increase effectiveness and efficiency so that an organization—in this case, a medical practice—can achieve its goals. Optimizing the practice can improve patient experience and outcomes and create a more efficient and satisfying work environment.

Learning Objectives:
At the end of this activity, you will be able to:
1. Explain the business case to prioritizing professional satisfaction and clinician wellness
2. Define three domains to create the institutional architecture that supports Joy in Medicine
3. List instruments available to survey and measure wellness in your practice
4. Describe organizational strategies you can use to implement culture of wellness, workflow efficiency, and personal resilience

Release Date:
October 2017

End Date:
October 2020

Accreditation Statement:
The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Article Information

AMA CME Accreditation Information

Designation Statement: The American Medical Association designates this enduring material activity for a maximum of .50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Target Audience: This activity is designed to meet the educational needs of physician leaders, senior leadership executives, organizational leaders, health professionals, practice managers and may also be interested in this activity.

Disclaimer: Salary assumptions: physician $250K, MA $50K.

†Note: the AMA can survey your organization and provide customized, detailed feedback. Please contact us at stepsforward@ama-assn.org for more information.
Statement of Competency: This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

Planning Committee:

Alejandro Aparicio, MD, CME Program Committee Advisor, AMA
Christine A. Sinsky, MD, FACP, Vice President, Professional Satisfaction, AMA
Bernadette Lim, Program Administrator, AMA
Samantha Leicht, Program Administrator, AMA

Author Affiliations:

Christine Sinsky, MD, FACP, Vice President, Professional Satisfaction, American Medical Association; Tait Shanafelt, MD, Chief Wellness Officer, Stanford Medicine; Mary Lou Murphy, Administrative Director, Stanford Medicine WellMD Center; Patty de Vries, Director of Strategic Projects, Stanford Medicine WellMD Center; Bryan Bohman, MD, Chief Medical Officer, University Healthcare Alliance, Clinical Professor, Anesthesiology, Perioperative and Pain Medicine, Stanford Medicine; Kristine Olson, MD, MSc, Assistant Professor of Clinical Medicine, Yale School of Medicine; Ronald J. Vender, MD, Associate Dean for Clinical Affairs, Chief Medical Officer, Yale Medicine; Steven Strongwater, MD, President & CEO, Atrius Health; Mark Linzer, MD, FACP, Director, Office of Professional Worklife, Hennepin County Medical Center

Faculty:

Hunter L. McQuistion, MD, Chief, Department of Psychiatry and Behavioral health, Gouverneur Health / NYC Health and Hospitals; Russell S. Phillips, MD, Director, Center for Primary Care, William Applebaum Professor of Medicine, Professor of Global Health and Social Medicine, Harvard Medical School

About the Professional Satisfaction, Practice Sustainability Group: The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement:

The project described was supported by Funding Opportunity Number CMS-1L1-15-002 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

References