Establishing a Chief Wellness Officer Position

Create the Organizational Groundwork for Professional Well-Being

Introduction

To systematically improve well-being among physicians and other health professionals, organizations need more than ad hoc wellness committees and wellness champions. Vanguard organizations are creating a new C-level executive position to develop an organizational strategy and guide system-wide efforts to improve professional fulfillment. This position has come to be known as the Chief Wellness Officer (CWO). Establishing a Chief Wellness Officer position paves the way for organizations to improve not only care team well-being, but also patient experience, health outcomes, retention of key personnel, and a strong financial position. This module provides a step-by-step guide to laying the groundwork for and establishing a Chief Wellness Officer role in your organization.
Eight STEPS for Establishing a Chief Wellness Officer Position

1. Embrace the Quadruple Aim

2. Create a Well-Being Task Force

3. Establish Why Well-Being Is Important to Your Organization

4. Secure the Support of Key Organizational Leaders

5. Determine the Scope, Role, and Location for the Chief Wellness Officer Position Within the Organizational Structure

6. Determine the Resources to Commit to the Chief Wellness Officer and Associated Team

7. Identify How to Assess Progress and Evaluate the Impact of a Chief Wellness Officer

8. Define the Chief Wellness Officer Job Description and Qualifications

Embrace the Quadruple Aim

A symbolic first step to establishing a Chief Wellness Officer position is shifting the organizational framework from promoting the Triple Aim of health care (ie, improving patient experience, reducing cost, and improving population health) to embracing the Quadruple Aim. This change prioritizes organizational efforts to improve the well-being of the health care team. Embracing the Quadruple Aim signals to both organizational leaders and the general workforce that the organization takes professional well-being seriously.
Create a Well-Being Task Force

Professional well-being is driven by the work environment and organizational culture much more so than by individual factors such as grit and resilience. Meaningful change in the work environment is a result of executive-level leadership, strategy, infrastructure, resources, and a system-based approach to drive progress. A Well-Being Task Force, appointed by executive leadership, can set the foundation for this work, bring other leaders on board, and develop an approach tailored to the needs of the organization (Table 1).

Table 1.
Topics to Be Addressed by a Well-Being Task Force
The Well-Being Task Force should be active for approximately 6-12 months to execute the tasks above, laying the groundwork for this important mission. Many of these tasks are expanded upon in the following STEPS.

**TOPICS TO BE ADDRESSED BY A WELL-BEING TASK FORCE**

- Define the current state of the organization.
- Establish why well-being is important to the organization.
- Determine the impact of well-being on the organization.
- Explain the need for a systems-based approach to address well-being.
- Determine whom to get buy-in from within organizational leadership (e.g., chief executive officer, chief medical officer, key department chairs).
- Determine the appropriate scope and objectives for well-being efforts.
- Define future leadership for these efforts.
- Determine necessary resources.
- Define performance metrics that will be used to assess organizational progress.

The Well-Being Task Force should be active for approximately 6-12 months to execute the tasks above, laying the groundwork for this important mission. Many of these tasks are expanded upon in the following STEPS.

**Q&A**

We already have an organizational wellness committee working on physician wellness; do we still need a CWO?

Once an organization recognizes the importance of physician well-being, and its impact on organizational performance, they often follow a predictable journey in their efforts to make progress. This process often begins with the creation of a wellness committee and promulgating initiatives aimed at personal resilience. Since such committees are typically not resourced and have no formal authority, they tend to function as interest groups that are not positioned to drive lasting organizational change. After one-to two-year intervals without progress, organizations begin to realize that the root of the problem is within the work environment, not the worker, and that the solutions must therefore involve changing the practice environment and organizational culture. A CWO is dedicated to driving organizational change and facilitating the discovery of these solutions.

**Establish Why Well-Being Is Important to Your Organization**

For most health care organizations, overarching priorities include improving quality of care, advancing patient satisfaction, maintaining financial stability, reducing health care costs, increasing access to care, and retaining and recruiting health care professionals. There is extensive evidence that the well-being of physicians intersects with each of these domains. The Well-Being Task Force should identify the 2 to 3 top organizational priorities as determined by the board and executive committees and assemble a summary of the literature and evidence on how physician well-being links to these outcomes.
These priorities can also be broken down into five key arguments, which we have articulated as the moral and ethical case, the business case, the recognition case, regulatory case, and the tragedy case.7

Figure 2.
Five Key Arguments Why Well-Being Is Important to Health Care Organizations

- **The moral and ethical case** is predicated on the belief that organizations have a responsibility to care for their people including a specific duty to protect them from harm sustained from occupational endeavors.

- **The business case** is related to the effects of burnout on quality of care and the evidence of the financial costs of physician burnout to the organization (eg, turnover, patient satisfaction, risk of malpractice suits).

- **The recognition case** relates to the desire to be recognized as a top-tier organization as it pertains to physician wellness through programs such as the AMA’s Joy in Medicine Recognition Program.

- **The regulatory case** relates to the Accreditation Council for Graduate Medical Education (ACGME) accreditation requirements to attend to well-being for health care organizations that train residents, fellows, and medical students.

- **The tragedy case** typically results from the organization’s reaction to a suicide by one or more health care professionals in their organization.

A Special Consideration for the Business Case

Regardless of which case above speaks most strongly to the organization, it is essential that the business case is understood by leaders. Given the economic pressures on healthcare organizations, financial investment in physician wellbeing must be justified and substantiated.

The business case has been most clearly defined in relation to the costs of physician burnout and turnover. Studies from multiple institutions have demonstrated that actual attrition (ie, turnover) from the organization is double among physicians experiencing professional burnout.9 The economic costs of physician turnover are substantial and include not only recruitment and replacement costs but also lost revenue during the interval between a departure and a new hire being fully productive. Although these costs vary by specialty, the ballpark estimate across all specialties is roughly 2-3 times the annual salary of the physician (ie, at least $500,000 per physician departure).7

Measuring the Costs of Physician Burnout

Part of the Well-Being Task Force’s initial action should include measuring professional well-being and burnout among physicians in the organization, as well as related aspects such as turnover and costs of burnout (see the
Organizational Cost of Physician Burnout Calculator. These results can be eye-opening and motivating for leadership. For example, an organization of 500 physicians with an average burnout of 44% and turnover rate of 7% can be expected to lose approximately 13 physicians a year due to burnout. Using conservative estimates for the costs of replacement, this organization is likely to invest over $5 million replacing those physicians. Total costs to the organization will be higher, when accounting for the costs of decreased patient satisfaction, increased medical errors and malpractice claims, reduced clinical quality, reduced productivity, reduction in work effort, and other consequences of low morale within the workforce.

Q&A

What impact does physician burnout have on clinical effort (ie, cutting back to part-time)?

Prospective longitudinal studies have demonstrated that physicians who experience burnout are more likely to reduce their professional work effort, which can add substantial economic costs to organizations. This trend is present in both men and women and is greater among physicians over the age of 50 than it is younger physicians.

How does burnout impact malpractice risk?

Studies have also indicated that there is a dose-response relationship between burnout and behaviors that increase risk of malpractice, and have demonstrated a link between burnout and malpractice suits.

What is the relationship between burnout and quality of care?

Perhaps most importantly, extensive evidence has linked burnout to medical errors and quality of care.

How does burnout impact the culture of an organization?

In addition to these financial costs, physician burnout has substantial effects on the care team including erosion of professionalism and teamwork. All of these outcomes undermine the health of the organizational culture, the altruism of health care professionals and their commitment to the organization's mission.

Secure the Support of Key Organizational Leaders

Once the task force has assembled a summary of the existing evidence from the published literature and collected information on their local experience, they should engage organizational leaders to share this information and demonstrate the need for action. The task force leaders should hold individual meetings with other key organizational leaders (eg, chief executive officer, chief operations officer, chief medical officer, chief marketing officer, chief quality officer, chief experience officer, key department and section leaders) to review and summarize the information assembled.

These meetings should emphasize that the primary problem of physician burnout is not related to personal resilience, but rather to variables in the system and practice environment. The Stanford model of professional fulfillment (see interactive below) provides a helpful breakdown of the various aspects of physician wellness, and can be used as a framework for engaging leaders on the importance of these initiatives. This model outlines a simple construct that acknowledges the critical role of the organizational culture, the practice environment, and the role of the individual in cultivating an environment that promotes professional well-being.

The Stanford WellMD Model

Click each plus sign to define key terms in the Stanford WellMD Model
Seven key dimensions can serve as a foundation for the conversation with senior leadership (Figure 3).

**Figure 3.**
Key Talking Points to Engage Leadership in Care Team Well-Being

Key Talking Points to Engage Leadership in Care Team Well-Being

- Burnout is prevalent among health care professionals.
- The wellbeing of health care professionals impacts patient care.
- Burnout costs organizations financially.
- Greater personal resilience is not the answer.
- Different occupations and disciplines have different needs.
- Evidence and tactics are available to address the problem.
- Interventions work.

A number of common questions or objections can be anticipated during these conversations with leadership (Table 2). The task force should be prepared to articulate responses to these items.

**Table 2.**
Responses to Common Questions or Objections from Leadership
<table>
<thead>
<tr>
<th>COMMON QUESTION OR OBJECTION</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Why start with physicians when burnout impacts all health care workers?”</td>
<td>While true that burnout affects many health care professionals, the drivers are quite different, as are the solutions among these groups. Since they must focus on the things that are relevant to all, generic programs trying to drive progress for the entire workforce are at risk of devolving to a focus on personal resilience and individual wellness activities, making them less effective or even ineffective.</td>
</tr>
<tr>
<td>“The Human Resources team is already covering these issues.”</td>
<td>Human resources leaders are not able to address inefficiencies in clinical practice environment that are a major contributor to distress in physicians, nor can they lead efforts to explore new practice models (eg, team-based documentation) or workflow redesign.</td>
</tr>
<tr>
<td>“This is part of HR/the Chief Human Resources Officer’s role.”</td>
<td>Engagement and burnout are different. Research as well as the experience from other organizations has demonstrated that organizations can have favorable scores for physician engagement and high levels of physician burnout simultaneously, with adverse consequences for quality of care and patient satisfaction.</td>
</tr>
<tr>
<td>“Our engagement scores are fine.”</td>
<td>Physician burnout is costly. An organization of 1000 physicians is already likely experiencing costs related to burnout of over $10 million each year (see the Organizational Cost of Physician Burnout calculator) due to costs for recruitment and replacement for physicians who leave because of burnout. The real costs are likely much higher since this estimate does not factor in the costs of burnout associated with malpractice risk, patient safety issues, and reduced clinical productivity. Proactively investing a portion of this sum to prevent and reduce burnout in our physicians can have a significant ROI.</td>
</tr>
<tr>
<td>“It will cost too much and we can’t afford it.”</td>
<td>Be able to cite the literature and draw the connection between these priorities (often including access to health care, patient satisfaction, quality, cost reduction, teamwork, etc.) and burnout.</td>
</tr>
<tr>
<td>“We have other priorities.”</td>
<td></td>
</tr>
</tbody>
</table>

**Q&A**

Our Chief Executive Officer is on board with establishing a CWO position, but many other executive leaders don’t see the need. How do we take the next step in getting more executives on board?

The realization that a CWO and formal program are needed is typically recognized by some executive leaders before others. At this stage, it is necessary to build a broader consensus among the leadership with respect to the elements outlined in Table 2. The Well-Being Task Force is key in leading this effort.

What precedent has there been among other leading organizations?

After Stanford University became the first academic medical center to appoint a health care Chief Wellness Officer in 2017, over 25 leading organizations have followed suit and, in 2019, the presidents
of the Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), and National Academy of Medicine (NAM) suggested that all health care organizations should appoint a chief wellness officer. In 2019, the AMA also created the **Joy in Medicine Recognition program** to help advance organizational progress and recognize leading organizations. The award is equivalent to the Magnet designation for nursing and specifies 6 specific domains in which organizations must act to be recognized. A gold, silver, and bronze level status is available in each of these domains with the aggregate designation defined by the organization’s overall profile. Over 20 leading health care institutions were recognized in 2019 with 2 organizations, Stanford Medicine and the Cleveland Clinic, receiving the highest level designation.

### 5 Determine the Scope, Role, and Location for the Chief Wellness Officer Position Within the Organizational Structure

CWO roles in organizations outside of health care (eg, in manufacturing or technology companies) typically oversee all employees. These roles are typically human resources positions whose primary purpose is to reduce the organization’s health care expenditures by encouraging healthy living (eg, exercise, diet, weight loss, smoking cessation) and individual approaches to foster stress reduction and personal resilience. The need to reach all workers in dramatically different job types also typically results in such efforts devolving to an individual-focused approach (eg, personal resilience, mindfulness, exercise, self-care).

The health care CWO has a dramatically different role and function. This role focuses on addressing the unique needs of health care professionals by improving the efficiency of the practice environment (eg, reducing EHR documentation times, improving operating and turnaround times, optimizing schedules and cross coverage) and improving elements of organizational culture (creating collegiality and community between health care professionals, advancing leadership behaviors among clinical and section leaders, creating peer support and other support resources for those in distress).

The key roles of the CWO include the ability to advocate and lead through influence (Table 3). In collaboration with their team, the CWO must communicate the vision of why addressing the well-being of health care professionals is important to the organization’s success. They must evaluate the current state of organizational culture and help advance key qualities such as fairness, participatory leadership, collegiality, mutual respect, and professionalism. Part of their role is to ensure that physician well-being is considered as part of all key organizational decisions.

### Table 3.
Role of the Chief Wellness Officer
The CWO must also be able to help other leaders see the link between their work and the well-being of health care professionals. For example, this would include helping the chief medical information officer (CMIO) understand the opportunities to improve the EHR experience to reduce administrative burden or helping the compliance officer recognize that the way in which they interpret external regulations can create excessive clerical burden for health care professionals.

The CWO and his or her team also have direct responsibility over a number of dimensions and activities. They must evaluate the current state of professional well-being in the organization, benchmark it against other organizations, and monitor it longitudinally. They should report the results of these findings throughout the organization transparently to both practicing health care professionals as well as executive leaders and hospital boards. In collaboration with his or her team, the CWO must develop a strategy to drive progress for the

### DIRECT RESPONSIBILITIES

- Evaluating **the current scope of the problem**, benchmarking, and monitoring impact of interventions
- Reporting the results throughout the organization (helpful to partner with communications department for this)
- Designing an organization-wide strategy
- Implementing appropriate components of the strategy and helping monitor progress of areas responsible for other elements
- Overseeing broad, system-level efforts to drive improvement in the dimensions most relevant to the local organization

### INDIRECT RESPONSIBILITIES

- Communicating the vision, why addressing the well-being of health care professionals is important to the organization’s success
- Assisting in advancing key qualities, such as equity in the organization, participatory leadership, collegiality, mutual respect, and professionalism
- Ensuring physician well-being is considered as part of all key organizational decisions
- Helping other leaders see the link between their work and the well-being of health care professionals
organization and implement tactics aligned with that strategy. The CWO should oversee broad, system-level efforts to drive improvement in the dimensions most relevant to the local organization.

Q&A

Where should the CWO be located within the organization?

Given the importance of professional well-being and its critical function to the mission of health care organizations, it is necessary for the individual leading this effort to be in a senior leadership role positioned to interact with executive leaders and organizational officers. Functionally, the role is analogous to that of the chief quality officer, chief diversity officer, chief nursing officer, or chief experience officer.

To whom should the CWO report?

Most CWOs report directly to the chief executive officer, analogous to other officers of the organization.

We counsel against the CWO reporting to the chief human resources officer, chief experience officer, or chief quality officer to avoid the compartmentalization and narrowing of the scope and role. Given the significant undertaking required to make progress at the system level, it should also be noted that this function cannot simply be added to the duties of other officers, who already have other substantial priorities and responsibilities, if meaningful progress is to be made.37

Should the CWO be part of Human Resources?

This location is not ideal. In many medical centers, physicians are not direct hospital employees and are either independent contractors or employees of other entities such as a university/school of medicine or a practice group. Even in employed practice models, human resources leaders are not able to address inefficiencies in the clinical practice environment, which are the major contributors to physician distress, or lead efforts to explore new practice models (eg, team-based documentation) or workflow redesign. By creating an independent executive-level role, an organization can address these gaps.

Should the CWO be responsible only for physician well-being or for the entire workforce's well-being?

In some organizations CWOs are responsible for addressing the challenge of practicing physicians, while in other organizations their scope may also include residents, fellows, and medical students. In other centers the charge will extend to all clinical staff, including nurses, advanced practice providers, and other health care professionals. It should be recognized that the resources required must expand commensurate with expanding scope. The needs and challenges contributing to occupational distress among practicing physicians, nurses, advanced practice providers, medical students, residents, and fellows are different.

A one-size-fits-all approach is almost certain to fail and will be a waste of resources. In our view, the size of the team and resources allocated typically must increase by 50% to 100% for each group added to the scope (physicians, nurses, advanced practice providers, residents/fellows, medical students).

Many organizations already have extensive programs to advance the well-being and improve the practice environment for nurses through the Magnet program as well as other offerings. Nurses are also often part of a collective bargaining group that negotiates for specific needs and improvements on a regular basis. Since this process has provided a path to address many of the challenges faced by nurses, the largest unaddressed need in most organizations is the well-being of physicians. For this reason, the core function of the CWO in many organizations will initially focus on addressing the challenges of physicians.
for the CWO, the task force should also recommend that appropriate resources are made available to the CWO and the initial team that will support them. The CWO needs to directly lead a team organized in a program or center.¹

At minimum, the CWO-led team requires:

- An administrative partner or administrative assistant
- Several project managers with expertise in improvement methodology to help oversee improvement initiatives
- Team members designated to address discipline-specific needs, such as nurses, medical students, residents, or advanced practice providers

Depending on the CWO’s expertise, collaboration with culture change experts (organizational scientists, business experts, or, occasionally, organizational psychologists) can be helpful when designing programming for culture change.

Specific resources required depend on the scope of the program, the geographic dispersion of the organization, and whether the organization will perform their own assessments in-house or outsource those efforts.

Identify How to Assess Progress and Evaluate the Impact of a Chief Wellness Officer

The Well-Being Task Force should define the metrics to measure both organizational progress as well as the effectiveness of the chief wellness officer and their team, in addition to outlining the distinction between the two.

Much like improving quality or diversity, organizational progress in well-being requires buy-in and action by all leaders across the organization. Failure to make progress advancing quality or diversity is more often a reflection of the commitment of the organization and its leadership rather than the effectiveness of the chief quality officer or chief diversity officer. In other words, it is possible for a chief quality officer or chief diversity officer to excel in the dimensions under their control but for the organization to make only modest progress due other organizational decisions.

Along these same lines, the CWO cannot be held responsible for the burnout scores of the organization, but can and should be responsible for developing and guiding an organization-wide strategy to advance well-being. Therefore, it is necessary to define the organizational metrics (for which all leaders are responsible) and the distinct responsibilities for which the CWO and their team are accountable and which will be used to measure their performance.

Table 4.
Organization-Level Metrics
<table>
<thead>
<tr>
<th>ORGANIZATION-LEVEL METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional fulfillment versus burnout of the organization relative to benchmarks</td>
</tr>
<tr>
<td>Number of departments with high levels of burnout or professional fulfillment relative to benchmarks</td>
</tr>
<tr>
<td>Employee turnover rates</td>
</tr>
<tr>
<td>Number of physicians reducing clinical effort</td>
</tr>
<tr>
<td>Satisfaction with the Electronic Health Record system</td>
</tr>
<tr>
<td>Assessment of values-alignment between physicians and organizational leaders</td>
</tr>
<tr>
<td>Leadership scores of first-line leaders across the organization</td>
</tr>
<tr>
<td>Recognition within the AMA Joy in Medicine Recognition Program</td>
</tr>
</tbody>
</table>

Table 5.
Responsibilities of the CWO and His or Her Team
Define the Chief Wellness Officer Job Description and Qualifications

The final task for the Well-Being Task Force is to help define the job description and qualifications of the individual who will be appointed as CWO. This individual should be a seasoned leader who knows how to lead by influence and to affect change. The CWO must have experience leading people, knowledge of quality improvement work, and a deep understanding of how organizations function. Such qualities and experience are more important than a deep expertise in the field of physician wellness. The individual must have a fundamental knowledge of physician well-being, but it is easier to enhance knowledge in that domain than to develop the

---

**RESPONSIBILITIES OF THE CWO AND HIS OR HER TEAM**

Developing an organization-wide action plan to advance well-being and professional fulfilment

Providing accurate assessments for:
- Well-being, burnout, and professional fulfillment across the organization
- Efficiency of practice
- Health of organizational culture in domains relative to professional well-being

Providing relevant and actionable data on these domains to other organizational leaders

Identifying improvement targets in these domains

Identifying struggling work units and helping provide support, recommendations, and tactics for these units to improve

Advocating for physician well-being in all organizational decisions

Advocating for the necessary resources to improve physician well-being

Developing a portfolio of resources individual physicians can use to cultivate personal well-being

Developing the system-wide safety net for individual physicians in distress

Developing training to help work-unit leaders effectively cultivate well-being in their departments

Advancing a sense of shared ownership to improve physician well-being
leadership qualities and expertise necessary for an individual to move organizational culture and to be effective as an officer of the organization.

**Conclusion**

Efforts towards well-being need to come from the top-down as well as the bottom-up, and as such, it is becoming increasingly important for healthcare organizations to establish and maintain a Chief Wellness Officer position and CWO-led team.
AMA Pearls

- Physician wellness is an organizational problem, not a personal one.
- Use a task force to lay the necessary groundwork for establishing a CWO position and team.
- Separate organizational metrics from CWO effectiveness on an individual level.

Learning Objectives
1. Explain the purpose and role of a Chief Wellness Officer (CWO)
2. Identify how a CWO could benefit your organization
3. Describe how to leverage a task force to create a CWO position

Activity Information:

AMA CME Accreditation Information

Credit Designation Statement: The American Medical Association designates this enduring material activity for a maximum of 0.50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement: Unless noted, all individuals in control of content reported no relevant financial relationships.

References


20. Welle et al, unpublished data.


34. Shanafelt T, Trockel M, Ripp J, Murphy ML, Sandborg C, Bohman B. Building a program on well-being: key design considerations to meet the unique needs of each organization. Acad Med. 2019;94(2):156–161. doi: 10.1097/ACM.0000000000002415


