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Building a Program on Well-Being: Key Design Considerations to Meet the Unique Needs of Each Organization

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Abstract

The current health care practice environment has resulted in a crescendo of burnout among physicians, nurses, and advanced practice providers. Burnout among health care professionals is primarily caused by organizational factors rather than problems with personal resilience. Four major drivers motivate health care leaders to build well-being programs: the moral-ethical case (caring for their people), the business case (cost of turnover and lower quality), the tragic case (a physician suicide), and the regulatory case (accreditation requirements). Ultimately, health care provider burnout harms patients. The authors discuss the purpose; scope; structure and resources; metrics of success; and a framework for action for organizational well-being programs. The purpose such a program is to oversee organizational efforts to reduce the occupational risk for burnout, cultivate professional well-being among health care professionals and, in turn, optimize the function of health care systems. The program should measure, benchmark, and longitudinally assess these domains. The successful program will develop deep expertise regarding the drivers of professional fulfillment among health care professionals; an approach to evaluate system flaws and relevant dimensions of organizational culture; and knowledge and experience with specific tactics to foster improvement. Different professional disciplines have both shared challenges and unique needs. Effective programs acknowledge and address these differences rather than ignore them. Ultimately, a professional workforce with low burnout and high professional fulfillment is vital to providing the best care to patients. Vanguard institutions have embraced this understanding and are pursuing health care provider well-being as a core organizational strategy.

These are challenging times for health care professionals in the United States. An aging population, expanded access to medical care, rapid advances in medical knowledge, and exponential growth in the number of treatments available for many conditions have simultaneously increased the volume of patients needing medical care and the complexity of delivering that care. Efforts to reduce the cost of care have often been achieved by asking physicians, nurses, and advanced practice providers (APPs) to “increase productivity” without parallel efforts to eliminate low-value administrative work or improve practice efficiency. Regulatory requirements, inefficiencies in the payment system, and nascent electronic health records (EHRs) have created clerical burden and often undermine the human interaction at the heart of healing. Collectively, these forces have created a protracted interval of “doing more with less” while simultaneously eroding meaning and purpose in work for health care professionals.

Not surprisingly, this environment has resulted in a crescendo of burnout among physicians, nurses, and APPs.^{1-3,5} Over 50% of physicians have at least one symptom of burnout with the prevalence in nurses and APPs only slightly lower. The crux of this problem is not a lack of personal resilience. Suggesting so may lead to resentment from health care professionals since evidence indicates that the medical profession already selects resilient people. The primary causes of burnout are systemic and organizational, and health care organizations should embrace accountability for mitigating the factors driving this epidemic.¹⁻⁵

Why Should Health Care Organizations Act?

Health care provider burnout harms patients. Extensive evidence demonstrates links between burnout among physicians and nurses with quality of care and patient outcomes, including in-hospital mortality, medical errors, catheter- and line-associated infections, and post-operative

recovery time.^{1,2,5} Burned-out health care professionals are also more likely to work part time, change employers, or leave the profession entirely, which magnifies the physician and nurse workforce shortages and decreases access to care.³ Burnout is also expensive, with one comprehensive analysis suggesting an organizational cost of approximately \$6,600/physician each year.

Four major drivers motivate health care leaders to build well-being programs. First, the moral-ethical case recognizes health care as a public good dependent on the talent, dedication, and commitment of professionals. Organizations thus care for their people not just because they *should* but also because they *must* in order to achieve their mission of providing compassionate and high-quality patient care. Second, the business case focuses on the cost of burnout and its impact on medical errors, patient satisfaction, turnover, and workforce maintenance. Third, the tragic case is inherently reactive and, sadly, is typically precipitated by one or more physician suicides. Institutions involved in graduate medical education may also be motivated by the fourth driver, the regulatory case, created by the Accreditation Council for Graduate Medical Education (ACGME) Common Program requirements. Regardless of the motivation, organization-level interventions can make a difference.⁴

The remainder of this commentary will focus on how to develop a well-being program once its necessity has been recognized.

Purpose of a Well-Being Program

The purpose of a program is to address the occupational risks to well-being that are heightened for health care professionals. All occupations carry unique risks and, like needle-stick injuries, overwhelming evidence has demonstrated that professional burnout, compassion fatigue, and suicide are occupational risks of being a physician, APP, or nurse.^{1,2} Construction workers are

given a hard hat because they have greater occupational risk for head injury. Well-being programs exist to oversee organizational efforts to provide the “hard hat” equivalent for the occupational threats to health care professionals’ emotional health.

In many ways, the field of health care provider well-being is at an inflection point similar to the quality movement in the 1990s. At that time, most organizations believed they delivered high-quality care because they had well-trained people, a nice mission statement, and a reputation of being a “good medical center.” They had no metrics, no approach to evaluate system flaws, no insight into how organizational culture impacted quality, and no continuous improvement process. If a sentinel event occurred, the response was to blame the individual. After the *To Err is Human* and *Crossing the Quality Chasm* reports, nearly every organization developed a robust quality and safety program, charged with objectively measuring quality, and empowered and resourced to improve quality by engaging teams and work units. Tangible tactics such as structured handoffs, sentinel event reporting, root cause analysis, plan-do-study-act, and cultivation of healthy teams have been devised to promote psychologic safety, just culture, and an iterative process of continuous improvement. These efforts are led by a chief quality officer who is typically a C-suite officer advocating for and advancing quality on behalf of the organization. These organizational characteristics have become so commonplace that nearly all organizations now view them as compulsory. Vanguard institutions have moved beyond that view and integrated quality as a core strategy.

In an analogous manner, the purpose of a program on well-being is to assess, develop expertise, coordinate, and lead the organization’s efforts related to engagement and professional fulfillment.^{1,3,4}

Scope and Role

An effective program will measure and longitudinally assess burnout and professional fulfillment across the organization. Ideally, the metrics used will allow external benchmarking against like professionals by specialty and job type. This defines the current state, allows assessment of the efficacy of interventions, and measures progress toward institutional goals. It also enables the organization to deploy attention, energy, and resources to the most challenged work units.¹

The successful well-being program will develop deep expertise regarding the drivers of professional fulfillment among health care professionals as well as knowledge and experience with specific tactics to foster improvement in these domains.¹ At the enterprise level, program leaders will oversee efforts to drive improvement, including critical review and refinement of relevant strategies, policies, support services, and resource allocation. These efforts and initiatives should align with other organizational priorities (quality and safety, patient satisfaction, growth, integration) and support their achievement.

With respect to local, work unit-level interventions (e.g., division, department, unit, clinic), the program will most often advise and support the local team as they develop and implement relevant tactics rather than oversee their execution directly.¹ This, again, is analogous to organizational approaches to improve quality in which the central resources support local work units, which are accountable for their own outcomes. Although the program should be aware of the diverse well-being activities across the enterprise and coordinate them to the extent possible, it should not try to control, direct, or fund all of these activities. A diverse array of local projects is the hallmark of a vibrant organizational effort.^{1,4} As long as they are not redundant or misaligned with organization-level efforts, local efforts should be encouraged to help address specific work-unit needs.

While broad interdisciplinary initiatives may have great political appeal, their execution often becomes diffuse and ineffectual. Professional disciplines have both shared challenges and unique needs (Figure 1). A family physician, thoracic surgeon, and pathologist face different stressors. Likewise, an intensive care unit nurse working nights and weekends will likely have different stressors than a community-based public health nurse. Non-clinical support staff (e.g., administrators, information technology) experience a different set of challenges. Within academic medical centers, the function of a well-being programs for health care professionals certainly must be distinct from global university-wide well-being programs targeting undergraduate students and university employees outside of health care. Ultimately, the broader the program's scope, the greater the resources necessary and the greater the risk that it will not effectively address the unique needs of different health care professionals (List 1). Decisions about scope influence both the structure of the program and the resources required for it to be effective.

Structure and Resources

Having a well-being program symbolizes organizational commitment to well-being but results are what ultimately matter. The program's structure and resources influence what it is able to accomplish. We believe the wellness efforts of large health care organizations should be led by a C-Suite leader—a Chief Wellness Officer (CWO) or similar position—advocating for and advancing the professional fulfillment and well-being of healthcare workers on behalf of the organization. This individual should be a health care professional (e.g. physician, nurse) with extensive experience providing clinical care and should report directly to the dean or chief executive officer. The program should be empowered, staffed, and resourced to engage teams and work-units to deploy specific tactics in an iterative process of continuous improvement.

CWOs should have content expertise in the drivers of professional fulfillment of health care workers, knowledge on how to assess this, and experience leading organizational interventions to effect change. The role demands a sophisticated understanding of organizational culture and the principles of culture change.

The resources required depend on the previous considerations regarding scope. We believe the core resources necessary for a program include funded time for the CWO (0.5-0.75 full time equivalent [FTE]), an administrative director (1.0 FTE), and administrative assistant (1.0 FTE). To be effective, each professional discipline or group the program serves (e.g. physicians, nurses, APPs, pharmacists, residents/fellows, medical students) should also have a director with funded time (0.1-0.5 FTE depending on number of individuals in the group). This team must have a budget to facilitate organization level programs, interventions, and assessment processes. The size of this budget should be informed by the number and type of professionals served and reflect both cost and return on investment (ROI). A conservative approach might be to allocate 10-15% of the annual cost of burnout per provider with the expectation that, over time, a corresponding *relative* reduction in burnout would thus yield a positive ROI. For example, if the organizational cost of burnout is estimated at \$6,600/physician per year, the budget for a program in an organization with 1,000 physicians would be \$660,000–\$990,000/year.

The program should not function in a silo but develop intimate collaborations with institutional efforts on quality, patient experience, human resources, and improvement science. Regular interactions with the chief medical officer, chief quality officer, chief operating officer, chief experience officer, chief nursing officer, department chairs, the ACGME designated institutional official/dean of graduate medical education and other executive leaders should constitute a large amount of the CWOs calendar and professional effort.

Framework for Action and Metrics of Success

High professional fulfillment, rather than just burnout mitigation, should be the goal for a well-being program.^{1 6} This objective creates a higher standard than simply mitigating burnout. The Stanford model for health care provider well-being incorporates three domains as drivers of professional fulfillment: culture of wellness (leadership, values, community-at-work, appreciation, voice/input), efficiency of practice (triage, scheduling, team-based care, EHR usability), and personal resilience (self-care, self-compassion, meaning in work, work-life integration, cognitive/emotional flexibility).⁶ We assess progress toward this goal using an annual survey based on the Stanford Professional Fulfillment Index.⁷ It should also be noted that an organization with 18 departments functioning with high autonomy does not have one problem set, it has at least 18. We recommend basing the organizational goal on the proportion of departments or units exceeding national benchmarks for professional fulfillment. This framework provides a line of sight to the entire executive team on which areas are struggling and provides a framework to focus time, attention, and resources to achieve the enterprise-level goal. Like the road to quality, cultivating engagement and professional fulfillment for health care providers is a journey, not a destination. Organizations must aspire to “be the best at getting better”. Ultimately, professional fulfillment is affected by executive decisions, organizational strategies, priorities, information technology, staffing, work-flow, and local leadership.¹ Even the most effective program and CWO can no more be solely *accountable* for professional fulfillment in the organization than the chief financial officer (CFO) is solely accountable for financial performance. Financial performance is driven by many factors the CFO does not control including payer mix, clinical volume, contracting, billing practices, and organizational decision making on staffing, and other expenses. The CFO is responsible for helping set

financial goals, making sure the accounting is accurate and timely, providing line of sight to problem areas, and guiding the organization when it deviates from goals (e.g., to recommend a cost-cutting initiative if projected revenue is off target). Similarly, the CWO is *responsible* for accurately monitoring engagement and its repercussions for the organization, advocating and advising on how other organizational strategies are likely to impact professional fulfillment, identifying problem areas, and guiding the organization's efforts to achieve its goals in this domain.

Conclusion

All ethical health care organizations aim to provide the best care to patients in a financially sustainable manner, with academic medical centers adding teaching and research to their missions. A workforce with minimal burnout and maximal professional fulfillment is highly desirable from a moral-ethical perspective, and the evidence in support of the business case for promoting clinician well-being is strong and growing. A sustained and appropriately resourced well-being program led by a capable and empowered CWO provides an increasingly vital infrastructure for health care organizations to achieve their mission.

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Figure Legend

Figure 1

An illustration of how relative importance of stressors may differ by occupation and discipline.

1A: Illustration of how relative importance stressors may aggregate differently by occupation.

1B: Illustration of how relative importance of stressors may vary between different disciplines within the same occupation.

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Key Considerations When Determining the Scope of a Well-Being Program

- Will the program's role be primarily advocacy and advising or will it help design and lead interventions?
- Is the program directly responsible for designing and administering surveys and other assessments to evaluate burnout, engagement, and professional fulfillment or will these be assessed as part of other organizational efforts?
- What type of professionals will the program be responsible for (physicians, advanced practice providers, nurses, social workers, pharmacists, technologists, biomedical scientists, all employees)? How many individuals are there in each group?
- Will the program be responsible for learners (e.g. medical students) and physicians in training (residents and fellows)?
- How many different hospitals and clinics are involved? How geographically dispersed are the professionals the program is overseeing?
- What type of relationship does the organization have with its physicians (employed, affiliated, open staff model, hybrid)?
- Do organizational leaders primarily define the success of the program in terms of cost-effectiveness (moral case) or cost-benefit (business case)?
- Is the program responsible for creating, staffing, and overseeing the peer-support activities for the professionals disciplines they will work with?
- Are any of the staff for which the program is responsible unionized and how might that influence development of interventions?
- Is the program responsible for developing or collaborating with existing mental health resources? How are the program's responsibilities distinct or related to existing mental health resources?
- Is there a desire or expectation that the program will create and share generalizable knowledge (e.g. scholarly activity) to guide the work of other programs?

Figure 1A

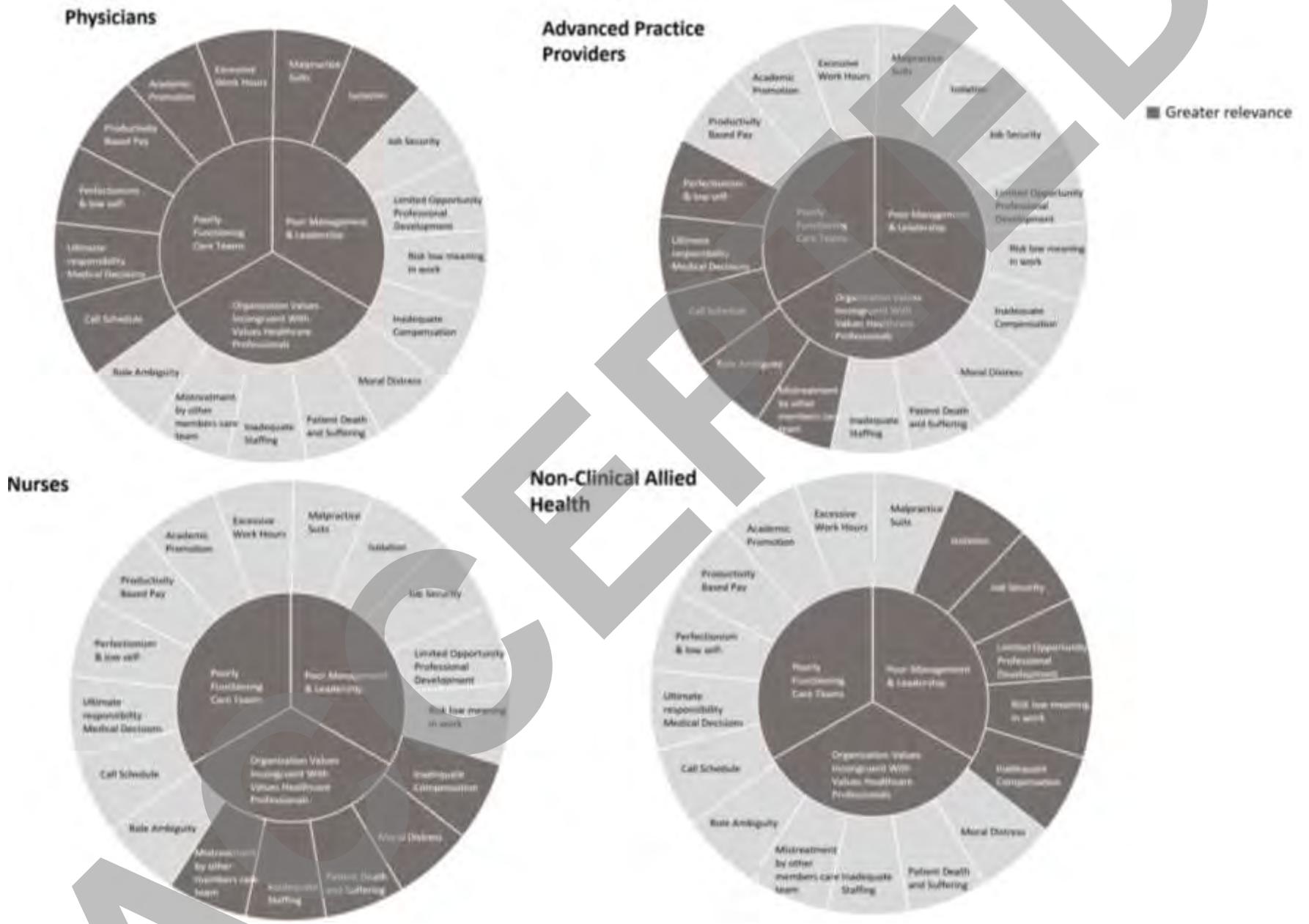


Figure 1B

