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Health System Impact: Reducing Physician Burnout

Friday, June 7 | 10:00 a.m. - 11:05 a.m. (Central time)

System-Level Strategies to Reduce Physician Burnout: An AMA Perspective

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Objectives

1. Briefly discuss the problem of physician burnout
2. Provide 3 strategies for effective system-level interventions to combat burnout
3. Describe AMA resources and activities to combat burnout and promote organizational well-being

The Physician Burnout Problem

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Physician Burnout on the Rise

AMA Survey of 2,440 physicians across the US:

"Overall, **62.8%** of physicians had at least one manifest
38.2% in

40% higher than the general population when controlled for hours worked, educational level, age, gender, relationship status

Shanafelt TD, West CP, Dyrbye LN, Trockel M, Tutty M, Wang H, Carlasare LE, Sinsky C, Changes in Burnout and Satisfaction With Work-Life Integration in Physicians Over the First 2 Years of the COVID-19 Pandemic, Mayo Clinic Proceedings (2022)
doi: https://doi.org/10.1016/ j.mayocp.2022.09.002.

Why Should We Care About Burnout?

THE COST OF BURNOUT

Clinical Review & Education

JAMA Internal Medicine | Special Communication | PHYSICIAN WORK ENVIRONMENT AND WELL-BEING

The Business Case for Investing in Physician Well-being

Tait Shanafelt, MD; Joel Goh, PhD; Christine Sinsky, MD

IMPORTANCE Widespread burnout among physicians has been recognized for more than 2 decades. Extensive evidence indicates that physician burnout has important personal and professional consequences.

OBSERVATIONS A lack of awareness regarding the economic costs of physician burnout and uncertainty regarding what organizations can do to address the problem have been barriers to many organizations taking action. Although there is a strong moral and ethical case for organizations to address physician burnout, financial principles (eg, return on investment) can also be applied to determine the economic cost of burnout and guide appropriate investment to address the problem. The business case to address physician burnout is multifaceted and includes costs associated with turnover, lost revenue associated with decreased productivity, as well as financial risk and threats to the organization's long-term viability due to the relationship between burnout and lower quality of care, decreased patient satisfaction, and problems with patient safety. Nearly all US health care organizations have used similar evidence to justify their investments in safety and quality. Herein, we provide conservative formulas based on readily available organizational characteristics to determine the financial return on organizational investments to reduce physician burnout. A model outlining the steps of the typical organization's journey to address this issue is presented. Critical ingredients to making progress include prioritization by leadership, physician involvement, organizational science/learning, metrics, structured interventions, open communication, and promoting culture change at the work unit, leader, and organization level.

CONCLUSIONS AND RELEVANCE Understanding the business case to reduce burnout and promote engagement as well as overcoming the misperception that nothing meaningful can be done are key steps for organizations to begin to take action. Evidence suggests that improvement is possible, investment is justified, and return on investment measurable. Addressing this issue is not only the organization's ethical responsibility, it is also the fiscally responsible one.

JAMA Intern Med. 2017;177(12):1826-1832. doi:10.1001/jamainternmed.2017.4340
Published online September 25, 2017.

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Corresponding Author: Tait Shanafelt, MD, 300 Pasteur Drive, Suite H3215, Stanford, CA 94305 (tshana@stanford.edu).

Figure 2. Worksheet to Project Organizational Cost of Physician Burnout

1. Input data:	Enter values
N = No. of physicians at your center	_____
BO = Rate of burnout of physicians at your center	_____[a]
TO = Current turnover rate per year	_____[b]
C = Cost of turnover per physician	_____[c]

2. Calculations:
Estimated Cost of Physician Turnover Attributable to Burnout

A. TO without burnout (solve for "TO without burnout"):
Formula:[d]
TO = [TO without burnout x (1 - BO)] + [(2 × TO without burnout) × BO]
Simplified formula:
TO without burnout = TO/(1 + BO)

B. Projected No. of physicians turning over per year due to burnout (solve using input variables and TO without burnout value from step A):
Formula:
No. of physicians turning over due to burnout per year = (TO - TO without burnout) × N

C. Projected cost of physician turnover per year due to burnout (solve using input variables and No. of physicians turning over due to burnout per year from step B):
Formula:
Estimated cost of turnover due to burnout = C × No. of physicians turning over due to burnout per year

Example Using N = 450; BO = 50%; TO = 7.5%; C = $500 000

A. TO without burnout:
0.075 = [TO without burnout × (1 - 0.5)] + [(2 × TO without burnout) × 0.5]
or 0.075/(1 + 0.5) = 5%

B. No. of physicians turning over due to burnout per year:
(0.075 - 0.05) × 450 = 11.25

C. Projected cost of physician turnover per year due to burnout:
$500 000 × 11.25 = $5 625 000

[a] National mean, approximately 54%.
[b] National mean, approximately 7%.
[c] Mean cost of $500 000 to $1 000 000 per physician.
[d] Assumes that burned out physicians are approximately 2 times as likely to turn over as non-burned out physicians.

Figure 3. Worksheet to Determine Return on Investment (ROI) in Reduced Turnover Costs Resulting From Intervention to Reduce Physician Burnout (BO)

1. Input data:	Enter values
CB = Estimated cost of turnover due to physician burnout	_____[a]
CI = Cost of intervention per year	_____
R = Relative reduction in BO	_____

2. Calculations:
ROI

A. Savings due to reduced BO:
Formula:
Savings due to reduced BO = (CB × R)

B. ROI:
Formula:
ROI = (Savings due to reduced BO -CI)/CI

Example Using CB = $5 625 000; CI = $1 000 000; R = 20%

A. Savings due to reduced BO:
$5 625 000 × 0.20 = $1 125 000

B. ROI:
($1 125 000 - $1 000 000)/$1 000 000 = 12.5%

[a] From Figure 2.

burnout.[65,67,68,70,71,78-80] A worksheet to estimate the costs of burnout and potential ROI for a given organization are provided in **Figure 2** and **Figure 3**.

Need for Occupation-Specific Interventions

These financial considerations also represent one of several reasons organizations should be careful invoking generic "well-being" initiatives that aim to reduce burnout among all employees. Although efforts to improve teamwork and improve the efficiency of the practice environment may benefit all members of the care team, each discipline also has unique challenges, necessitating targeted interventions to address their unique needs. The system interventions that would be most helpful for an intensive care unit nurse, an operating room nurse, a pharmacist, a physical therapist, a labora-

AMA Interactive Burnout Cost Calculator

https://edhub.ama-assn.org/steps-forward/module/2702510

Dr. Christine Sinsky:

"While burnout *manifests* in individuals,

it *originates* in systems."

Organizational Drivers of Burnout

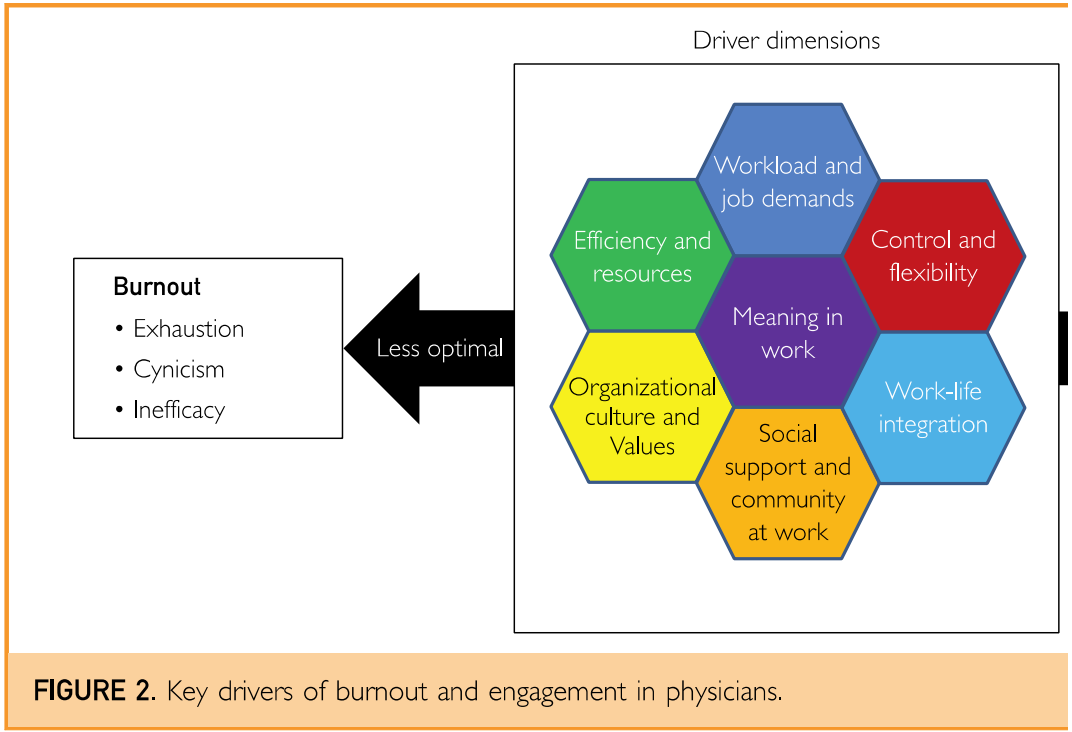

FIGURE 2. Key drivers of burnout and engagement in physicians.

Shanafelt et al, Mayo Clin Proc. Executive Leadership and Physician Well-being:

Nine Organizational Strategies to Promote Engagement and Reduce Burnout. 2017;92(1)129-146.

Burnout mitigators:

Teamwork:
49% vs 88% burnout

Feeling valued:
37% vs 69% burnout

Linzer M, Jin JO, Shah P, et al. Trends in Clinician Burnout With Associated Mitigating and Aggravating Factors During the COVID-19 Pandemic. *JAMA Health Forum.* 2022;3(11):e224163. doi:10.1001/jamahealthforum.2022.4163

JAMA Health Forum™

Original Investigation

Trends in Clinician Burnout With Associated Mitigating and Aggravating Factors During the COVID-19 Pandemic

Mark Linzer, MD; Jill O. Jin, MD, MPH; Purva Shah, BS; Martin Stillman, MD, JD; Roger Brown, PhD; Sara Poplau, BA; Nancy Nankivil, BS; Kyra Cappelucci, BS; Christine A. Sinsky, MD

Abstract

IMPORTANCE The COVID-19 pandemic has affected clinician health and retention.

OBJECTIVE To describe trends in burnout from 2019 through 2021 with associated mitigating and aggravating factors.

DESIGN, SETTING, AND PARTICIPANTS Cross-sectional surveys were sent to physicians and advanced practice clinicians throughout 120 large US health care organizations between February 2019 and December 2021. From 56 090 surveys, there were 20 627 respondents.

EXPOSURES Work conditions and COVID-19.

MAIN OUTCOMES AND MEASURES Surveys measured time pressure, chaos, work control, teamwork, electronic health record use, values alignment, satisfaction, burnout, intent to leave, and in 2021, feeling valued. Multivariate regressions controlling for gender, race and ethnicity, years in practice, and role determined burnout, satisfaction, and intent-to-leave correlates.

RESULTS Of the 20 627 respondents (median response rate, 58% [IQR, 34%-86%; difference, 52%]), 67% were physicians, 51% female, and 66% White. Burnout was 45% in 2019, 40% to 45% in early 2020, 50% in late 2020, and 60% in late 2021. Intent to leave increased from 30% in 2019 to more than 40% as job satisfaction decreased. Higher burnout was seen in chaotic workplaces (odds ratio [OR], 1.51; 95% CI, 1.38-1.66; $P < .001$) and with low work control (OR, 2.10; 95% CI, 1.91-2.30; $P < .001$). Higher burnout was associated with poor teamwork (OR, 2.08; 95% CI, 1.78-2.43; $P < .001$), while feeling valued was associated with lower burnout (OR, 0.22; 95% CI, 0.18-0.27; $P < .001$). In time trends, burnout was consistently higher with chaos and poor work control. For example, in the fourth quarter of 2021 burnout was 36% (95% CI, 31%-42%) in calm environments vs 78% (95% CI, 73%-84%) if chaotic (absolute difference, 42%; 95% CI, 34%-49%; $P < .001$), and 39% (95% CI, 33%-44%) with good work control vs 75% (95% CI, 69%-81%) if poor (absolute difference, 36%; 95% CI, 27%-44%; $P < .001$). Good teamwork was associated with lower burnout rates (49%; 95% CI, 44%-54%) vs poor teamwork (88%; 95% CI, 80%-97%; absolute difference, 39%; 95% CI, 29%-48%; $P < .001$), as was feeling valued (37%; 95% CI, 31%-44%) vs not feeling valued (69%; 95% CI, 63%-74%; absolute difference, 32%; 95% CI, 22%-39%; $P < .001$).

CONCLUSIONS AND RELEVANCE Results of this survey study show that in 2020 through 2021, burnout and intent to leave gradually increased, rose sharply in late 2021, and varied by chaos, work control, teamwork, and feeling valued. Monitoring these variables could provide mechanisms for worker protection.

Key Points

Question How have clinician burnout rates changed during the COVID-19 pandemic nationally, and what are the key aggravators and mitigators of burnout?

Findings In this survey study of US clinicians with 20 627 respondents, burnout increased throughout the pandemic, reaching its highest levels (>60%) late in 2021; intent to leave also reached high levels (>40%) late in 2021. Chaotic workplaces and lack of control of workload were associated with higher burnout, while efficient teamwork and feeling valued were associated with lower burnout.

Meaning Knowledge of key indicators of a healthy workplace, such as work control, feeling valued, and clinician outcomes (eg, burnout, satisfaction, intent to leave) may help health systems and their workers adapt to stressful times.

Supplemental content

Author affiliations and article information are listed at the end of this article.

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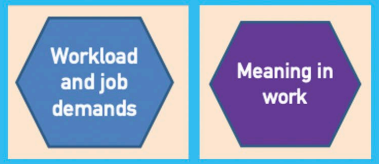
System Level Interventions to Combat Burnout

Strategy 1:
Stop the Unnecessary Work



Strategy 2:
Share the Necessary Work

Strategy 3:
Support the Individual

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Stop the Unnecessary Work: DE-IMPLEMENT!

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De-implementation checklist

In an effort to reduce unintended burdens for clinicians, health system leaders can consider *de-implementing* processes or requirements that add little or no value to patients and their care teams. Physicians themselves are often in the best position to recognize these unnecessary burdens in their day-to-day practice. The following list includes potential de-implementation actions to consider. Learn more on how to reduce the unnecessary daily burdens for physicians and clinicians at stepsforward.org.

EHR

☐ **Minimize alerts**
- Retain only those alerts with evidence of a favorable cost-benefit ratio

☐ **Simplify login**
- Simplify and streamline login process, leveraging options like single sign-on, RFID proximity identification, bioidentification (fingerprint, facial recognition, etc.)

☐ **Extend time before auto-logout**
- Consider extending time for workstation auto-logout
- Consider customizing workstation location and the security level to use patterns of the specific user

☐ **Decrease password-related burdens**
- Consider extending the intervals for password reset requirements
- Help users create passwords that are both strong and easy to remember (i.e., by allowing special characters and spaces, and by allowing longer passwords that can be passphrases)
- Consider use of password keeper programs

☐ **Reduce clicks and hard-stops in ordering**
- Reduce requirements for input of excessive clinical data prior to ordering a test
- Eliminate requirements to fill fields attesting to possible pregnancy in males or women over 60 years old

☐ **Eliminate requirements for password revalidation**
- Identify ways to reduce unnecessary requirements for users to re-enter username/password when already signed in to EHR, to send prescriptions (Note: Organizations may choose to keep this requirement in place for opioid prescriptions.)

☐ **Reduce note-bloat**
- Reduce links imbedded in visit note documentation templates that automatically pull in data from other parts of EHR contributing to "note bloat," but adding little if any true clinical value

☐ **Reduce inbox notifications**
- Stop sending notifications for tests ordered that do not yet have results or have test results *not* ordered by the physician in question
- Stop sending notifications for reports generated by the recipient of the notification
- Eliminate multiple notifications of the same test result or consultation note
- Consider auto-release of normal and abnormal test results to the patient-facing portal with imbedded or linked patient-friendly explanations

☐ **Simplify order entry processes**
- Optimize technology to auto-populate necessary discreet data fields if the information already exists in EHR (e.g., if medical assistant has completed a discreet field for "last menstrual period," optimize your technology so no one has to reenter that data into the order for a pap smear)

Compliance

☐ **Allow verbal orders in low-risk and in crisis situations as legally permitted**

☐ **Reduce signature requirements**
- Eliminate signature requirements for forms that do not legally require a physician signature
- Eliminate order requirements for low-risk activities that do not legally require a physician signature (ear wash, fingerstick glucose, oximetry)
- Consider eliminating "challenge questions" to electronically sign orders when the user already logged in and actively using the EHR

☐ **Evaluate annual trainings and attestations**
- Review current compliance training modules and consider removal of those that aren't required by a regulatory agency or for which evidence of benefit is lacking

☐ **Reduce attestations required daily or every time one logs in**
- Eliminate requirements as allowed by state or federal requirements (i.e., for privacy protection attestation) that occur on a daily or every-time-one-logs-in basis (i.e., consider whether or not an annual attestation is sufficient)

Quality assurance/improvement

☐ **Eliminate the rote ascertainment of learning style preference**

☐ **Perform condition screens no more frequently than recommended**
- Include a "grace period" of at least 30–50% of the guideline recommended time interval when constructing a performance measure from a clinical practice guideline

  Example: If clinical practice guideline recommends annual screening for depression, then set performance measurement with an interval of performing this task within 18 months—otherwise staff will waste limited clinical resources screening more often than is required to meet the 365-day annual interval.

Launched in 2019, the Joy in Medicine Health System Recognition Program provides a roadmap for health system leaders to implement programs, policies, and workflow efficiencies that support physician well-being and enhance joy in medicine. This program is designed to empower health systems to strategically and systematically reduce burnout so that physicians—and their patients—can thrive. This de-implementation checklist can help organizations meet the eligibility criteria for the program. View the program brochure to review the eligibility criteria and learn more.

https://www.ama-assn.org/system/files/ama-steps-forward-de-implementation-checklist.pdf

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Stop the Unnecessary Work: GROSS

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 8, 2018

Getting Rid of Stupid Stuff

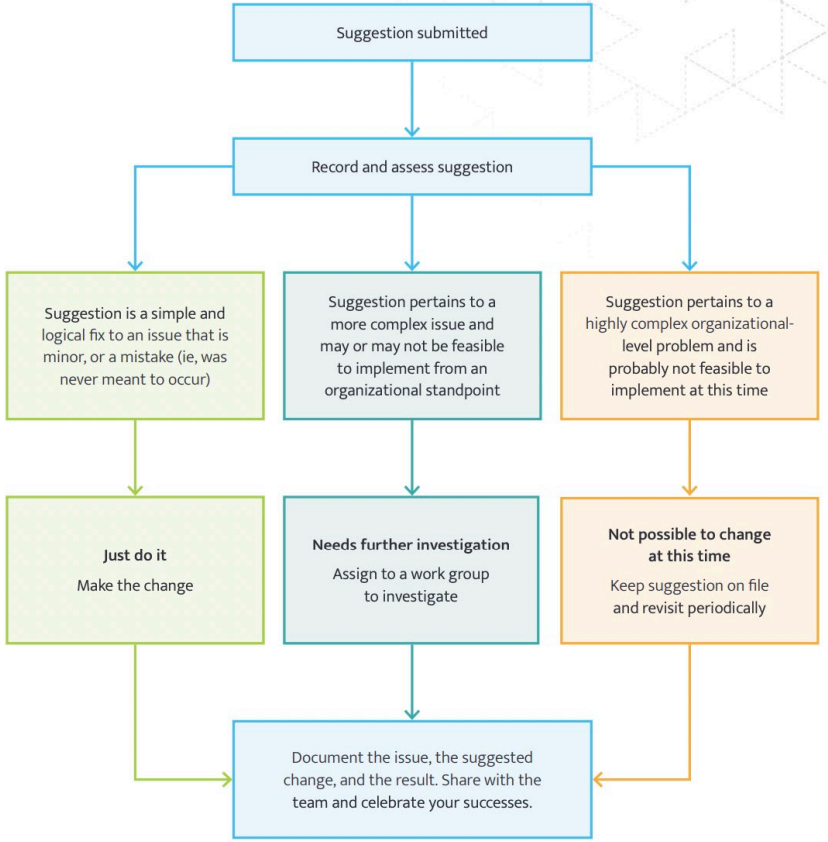
Melinda Ashton, M.D.

Many health care organizations are searching for ways to engage employees and protect against burnout, and involvement in meaningful work has been reported to serve both functions. According to Bailey and Madden, it is easy to damage employees' sense of meaningfulness by presenting them with pointless tasks that lead them to wonder, "Why am I bothering to do this?"[1] An increase in administrative tasks has resulted in less time for the activity that clinicians find most important: interacting with patients. Some commentators have recently suggested that it may not be the electronic health record (EHR) per se that leads to burnout, but rather the approach to documentation that has been adopted in the United States.[2]

Although my health system, like most in the United States, cannot magically eliminate the documentation required for billing and regulatory compliance, my colleagues and I had reason to believe that there might be some documentation tasks that could be eliminated. Our EHR was adopted more than 10 years ago, and since then we have made a number of additions and changes to meet various identified needs. We decided to see whether we could reduce some of the unintended burden imposed by our EHR and launched a program called "Getting Rid of Stupid Stuff." Starting in October 2017, we asked all employees to look at their daily documentation experience and nominate anything in the EHR that they thought was poorly designed, unnecessary, or just plain stupid. The first thought we shared as we kicked off this effort was, "Stupid is in the eye of the beholder. Everything that we might now call stupid was thought to be a good idea at some point."

We thought we would probably receive nominations in three categories: documentation that was never meant to occur and would require little consideration to eliminate or fix; documentation that was needed but could be completed in a more efficient or effective way with newer tools or better understanding; and documentation that was required but for which clinicians did not understand the requirement or the tools available to them.

Since we kicked off the program, we have received nominations in all three categories. Some reports of unintended documentation requirements resulted in quick changes. In several cases, requirements were being applied to patients of different ages than originally planned. For example, we received a request from a nurse



Stop the Unnecessary Work: Reduce EHR Inbox Burden

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EHR Inbox Reduction Checklist for Health Care Organizations

Eliminate unnecessary burdens and improve workflows in the EHR at the organizational level with this checklist.

Guiding Principles

☐ **Establish an inbox reduction task force**	The task force may include the following: • An organizational champion at the C-suite level • Clinical operational leaders • IT operational leaders • Compliance professionals • Patient experience leaders • Practicing physicians • Care team members • A process improvement specialist (in-house or consultant) • An EHR vendor representative Financial investment may be required to ensure the task force has adequate time and resources for this effort.
☐ **Use EHR audit-log data**	This data will help the task force understand the current state and assess the impact of interventions to reduce inbox volume. For example, Epic's Signal data or Oracle Cerner's Advance program data can help identify variations in the number of messages per 8 hours of patient scheduled time within and across specialties. Additionally, with this data, the task force can analyze the volume of messages in different subcategories.
☐ **Create a culture of a shared team inbox**	Establish the cultural norm that the inbox belongs to clinical teams or pods. Use nomenclature that reflects this culture, for example, by referring to the "practice's inbox" or the "care team's inbox" rather than the "physician's inbox."
☐ **Go upstream**	Start with a goal of preventing unnecessary messages from entering the inbox in the first place rather than increasing the efficiency of message handling (though both are important).

Starting Tactics

☐ **Consider deleting most inbox messages that are >6 months old**	Some organizations have found that starting with a grand gesture like this establishes credibility, ensures buy-in, and gives hope that inbox reduction will be successful (Note: This may take several weeks to complete because of the volume of messages).
☐ **Auto-expire any message >3 months old**	Let teams know that this will be the norm from this point on unless messages are individually marked for exception.
☐ **Empower patients to identify the topic of their messages for appropriate triage**	Patients know the nature of their requests best. Guide them through the message navigation and triaging process with an "I want to..." sorting window. For example, "I want to...ask for medical advice, ask a question about a test result, refill a prescription, make or cancel an appointment, request a referral, or other."
☐ **Provide patients with self service options**	Facilitate opportunities for patient self-service, such as self-scheduling in select departments.
☐ **Establish team pools**	A team pool consists of care team members, including RNs and MAs. All patient messages within a practice or clinical unit should go to this pool first, not directly to the physician. In this model, only questions that MAs or RNs cannot handle are managed by physicians, ideally in a conversation with the support staff who have researched the message as opposed to the practice of simply forwarding the message to the physician (see next row).
☐ **Assign an RN or MA to each physician as the primary manager of their inbox**	This care team member takes ownership of the inbox and manages all incoming messages, resolving anything they can on their own. For messages outside their scope, they should "mature the message" to make it as useful and actionable as possible, using their training and skills, before delegating to another team member. After additional research on a message, if it is necessary to consult a physician or APP, verbal communication is preferred when possible, as it may be more efficient and safer than forwarding the message.
☐ **Establish the expectation that physicians and advanced practice providers (APPs) do not access their inboxes while not working (for part-time clinicians) or on vacation**	Set the precedent that clinicians do not check messages when they are out of the office and not on call. Employ the training and skill of RNs to manage most of the inbox, with backup assistance from the covering APP or physician. Some organizations pair physicians to cover for each other while one is away if there is anything the RN can't resolve. The expectation is to "treat it as your own" so that physicians leave with and come back to an empty inbox.

Tactics for Individual Message Types

Patient requests for medical advice	
☐ **Leverage the training and skill of MAs and RNs**	Team members should thoroughly research all patient requests for medical advice and take action to the full extent of their ability and within their scope of practice before "delegating up" to a physician or APP. This is sometimes described as "maturing the message." Avoid light "touch and pass" transfers with comments such as "please advise." Encourage information coupling (presenting information necessary for clinical action on a result, such as previous hemoglobin levels with a newly abnormal level) as well as proactively pending orders for review and signature (in those settings where a signature is required).
☐ **Institute reimbursable patient portal encounters**	Several organizations have recognized that care delivered through the patient portal can and should be reimbursed and are piloting programs to that effect.
Prescriptions	
☐ **Implement 90 x 4 refills**	Establish a 90-day supply with 4 refills as the default setting for medication orders for chronic medications.
☐ **Automate refills**	Develop protocols for automated refills if they meet defined criteria (eg, lab and appointment monitoring).
☐ **Create a refill pool**	Ensure refill requests route to a distinct team pool, not the physician's inbox. Examples of sources of refill requests to direct to the refill pool include those from pharmacies, patients, or created by another teammate.
☐ **Create intake templates for refills**	Develop templates for the call center or front desk to capture all pertinent details when taking a refill request—this will capture all necessary information before the request is sent to the refill pool.

https://www.ama-assn.org/system/files/ehr-inbox-reduction-checklist.pdf

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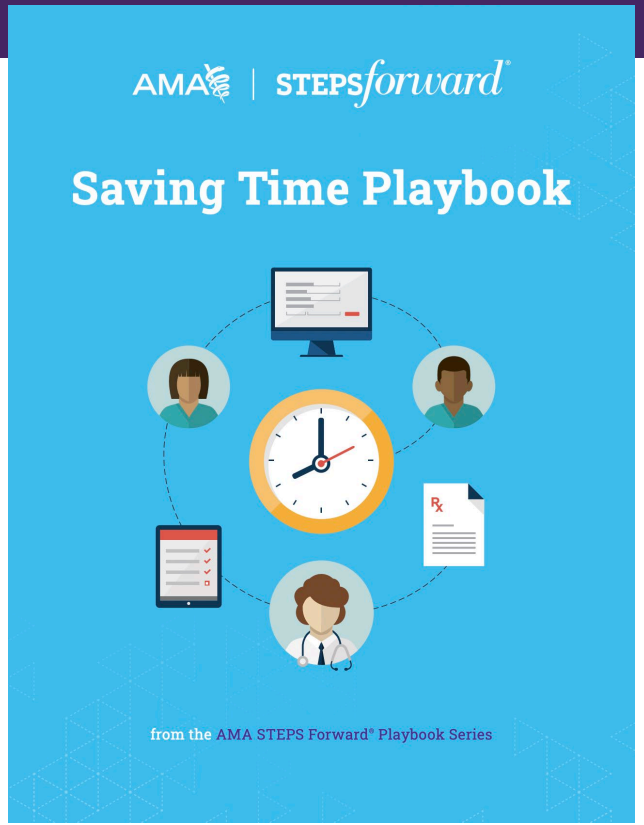
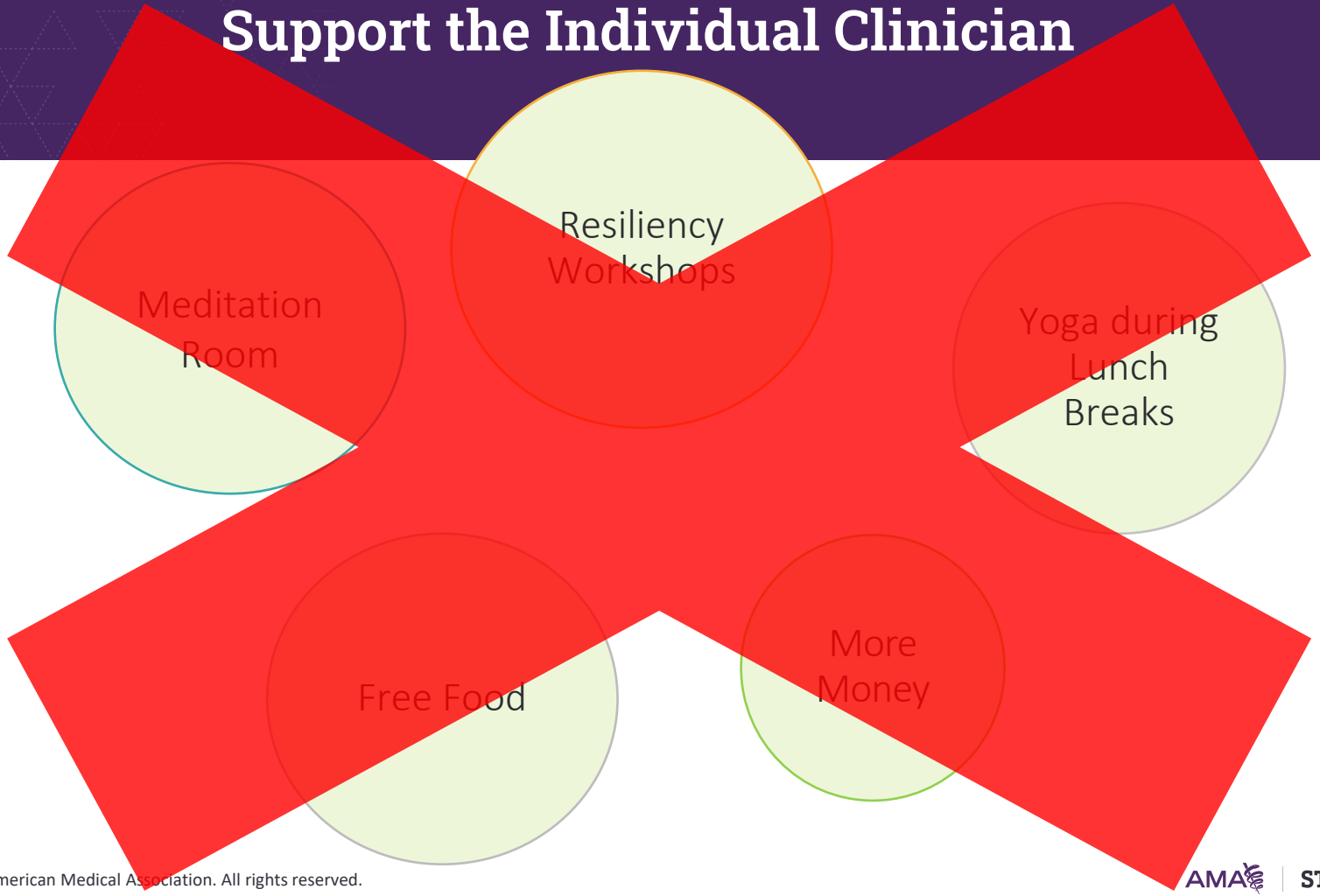
Share the Necessary Work: Advanced Team-Based Care

1. Incorporate team-based patient care workflows: pre-visit planning, pre-visit lab testing, standing order protocols, annual prescription renewals (“90*4” renewals”)
2. Implement team-based management of EHR inbox messages, including patient portal messages
3. Utilize team documentation



Support the Individual Clinician



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Support the Individual Clinician: Avoid the muffin rage!

Los Angeles Times SUBSCRIBE

Op-Ed: Hand a burned-out healthcare worker a baked good, and 'muffin rage' may follow

I was angry because I didn't need a *muffin*. I needed years' worth of good sleep. I needed time to see my family, a mere thousand miles away. I needed a vacation. I was so burned out and depressed I should have been seeing a psychiatrist. I was deep, deep inside a black hole, and instead of a rope and a flashlight, somebody had offered me a muffin.

I often speak to groups of healthcare workers about burnout, and whenever I tell this story I only half-jokingly describe the phenomenon as "muffin rage." Muffin rage is what we feel when there is a vast chasm between our actual needs and what another person or an institution *thinks* we need.

By Jillian Horton

Support the Individual Clinician: How do you make clinicians feel VALUED?

- Flexibility and autonomy with daily schedules
- Option to work from home (telehealth)
- Option to decrease FTE if needed (and reduce patient panel size accordingly)
- Vacation/PTO policies that include clinical coverage (particularly EHR inbox coverage) without guilt about burdening colleagues
- Peer support and coaching/mentoring programs
- Professional development opportunities and CME time/funding
- Open communication (“listening”) channels between physicians and their administrators/organizational leaders
- Formal and informal gatherings to promote collegiality

A note about burnout vs mental health conditions

Burnout prevention and reduction efforts

Treatment for mental health conditions (eg anxiety, depression, PTSD, substance abuse)

AMA Resources

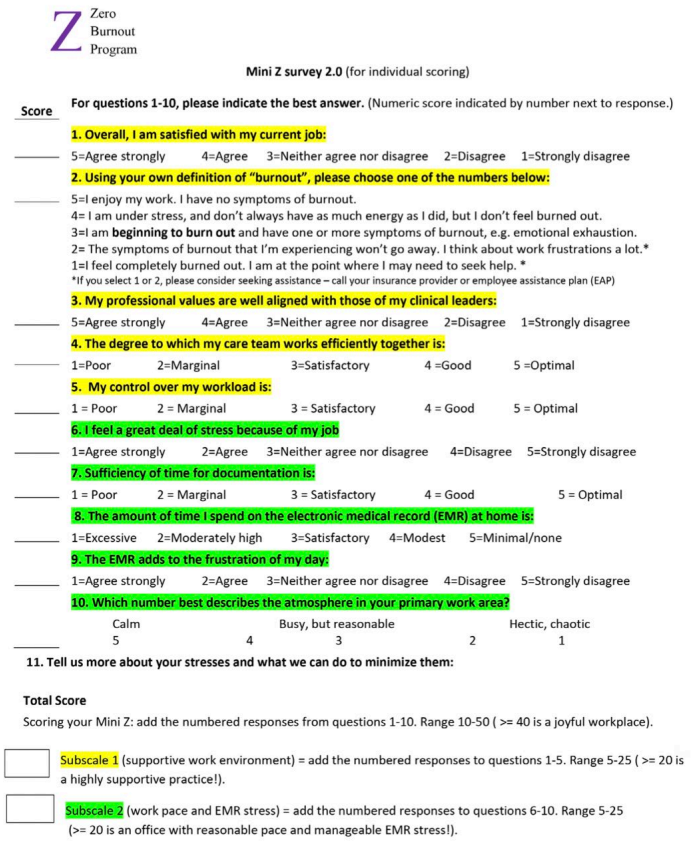
Assessment: AMA Organizational Biopsy

Intervention: AMA STEPS Forward Resources

Recognition: AMA Joy in Medicine Recognition Program

Assessment: AMA Organizational Biopsy®

- Comprehensive assessment tool that measures:
  - Burnout and Well-Being using the **validated Mini-Z assessment**
  - Organizational Culture
  - Practice Efficiency
  - Self-Care
  - Work Intentions
- Includes information on demographics



Zero Burnout Program

Mini Z survey 2.0 (for individual scoring)

Score

For questions 1-10, please indicate the best answer. (Numeric score indicated by number next to response.)

1. Overall, I am satisfied with my current job:

5=Agree strongly 4=Agree 3=Neither agree nor disagree 2=Disagree 1=Strongly disagree

2. Using your own definition of "burnout", please choose one of the numbers below:

5=I enjoy my work. I have no symptoms of burnout.
4= I am under stress, and don't always have as much energy as I did, but I don't feel burned out.
3=I am **beginning to burn out** and have one or more symptoms of burnout, e.g. emotional exhaustion.
2= The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot.*
1=I feel completely burned out. I am at the point where I may need to seek help. *
*If you select 1 or 2, please consider seeking assistance – call your insurance provider or employee assistance plan (EAP)

3. My professional values are well aligned with those of my clinical leaders:

5=Agree strongly 4=Agree 3=Neither agree nor disagree 2=Disagree 1=Strongly disagree

4. The degree to which my care team works efficiently together is:

1=Poor 2=Marginal 3=Satisfactory 4 =Good 5 =Optimal

5. My control over my workload is:

1 = Poor 2 = Marginal 3 = Satisfactory 4 = Good 5 = Optimal

6. I feel a great deal of stress because of my job

1=Agree strongly 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

7. Sufficiency of time for documentation is:

1 = Poor 2 = Marginal 3 = Satisfactory 4 = Good 5 = Optimal

8. The amount of time I spend on the electronic medical record (EMR) at home is:

1=Excessive 2=Moderately high 3=Satisfactory 4=Modest 5=Minimal/none

9. The EMR adds to the frustration of my day:

1=Agree strongly 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

10. Which number best describes the atmosphere in your primary work area?

Calm 5 4 Busy, but reasonable 3 2 Hectic, chaotic 1

11. Tell us more about your stresses and what we can do to minimize them:

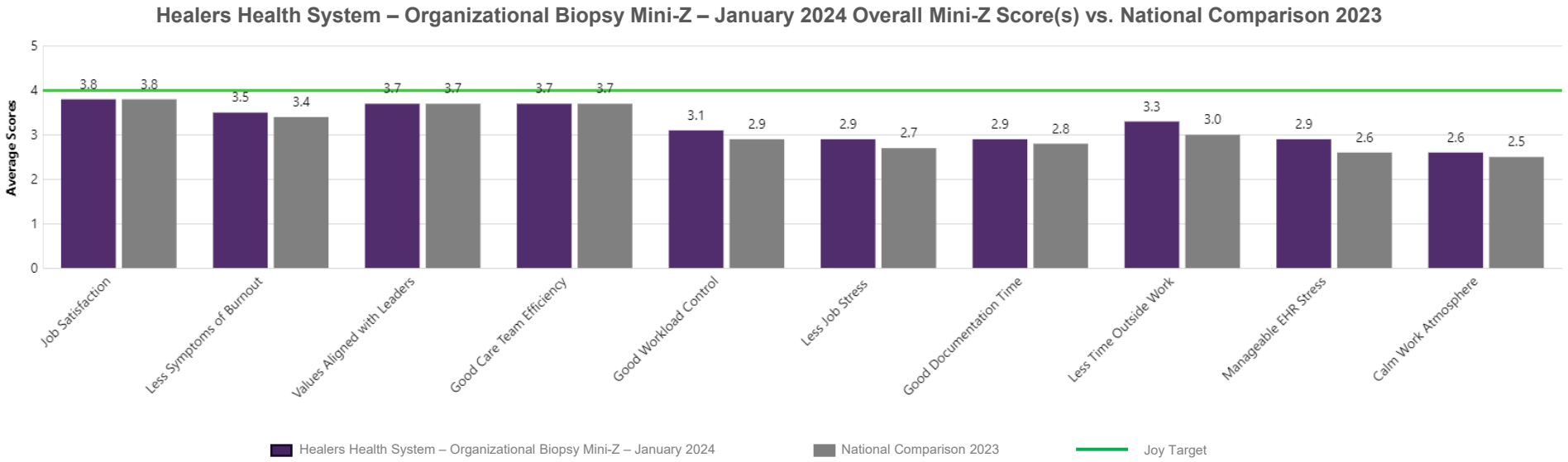
Total Score

Scoring your Mini Z: add the numbered responses from questions 1-10. Range 10-50 (>= 40 is a joyful workplace).

Subscale 1 (supportive work environment) = add the numbered responses to questions 1-5. Range 5-25 (>= 20 is a highly supportive practice!).

Subscale 2 (work pace and EMR stress) = add the numbered responses to questions 6-10. Range 5-25 (>= 20 is an office with reasonable pace and manageable EMR stress!).

Assessment: Report-Outs



AMA | STEPSforward

Intervention: AMA STEPS Forward Resources

Playbooks and Toolkits

STEPS Forward Playbooks

AMA STEPS Forward® playbooks combine the best elements of our open-access program—toolkits, webinars, podcasts, success stories, and ready-to-use resources—into topical guides with practical, actionable strategies and tactics to help you create change in your practice.

Wellness-Centered Leadership Playbook

Develop a culture of wellness across your organization to improve clinician well-being, patient care and population health outcomes.

Start Learning

Saving Time Playbook

Save time by stopping unnecessary work while sharing the necessary tasks with the broader team and gaining organizational leadership support.

Start Learning

Taming the EHR Playbook

Reduce the burden of EHR work through de-implementing unnecessary rules, utilizing team-based care and optimizing personal proficiency with EHR technology.

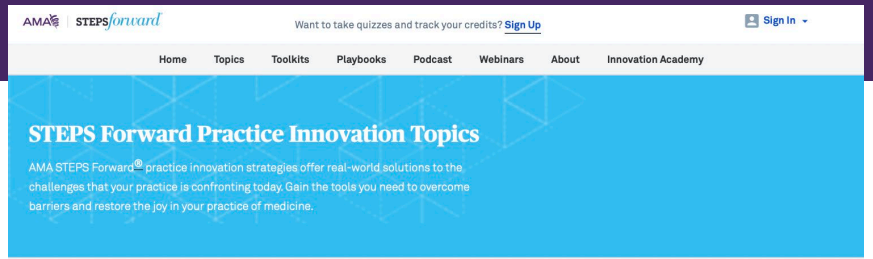
Start Learning

Private Practice Playbook

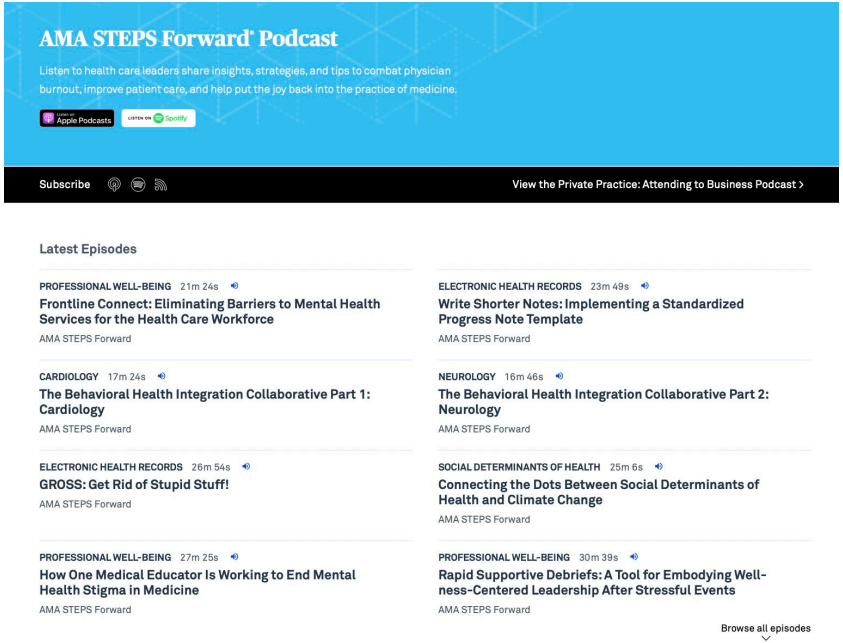
Start or sustain a successful private practice by understanding the characteristics, benefits and challenges of this practice model.

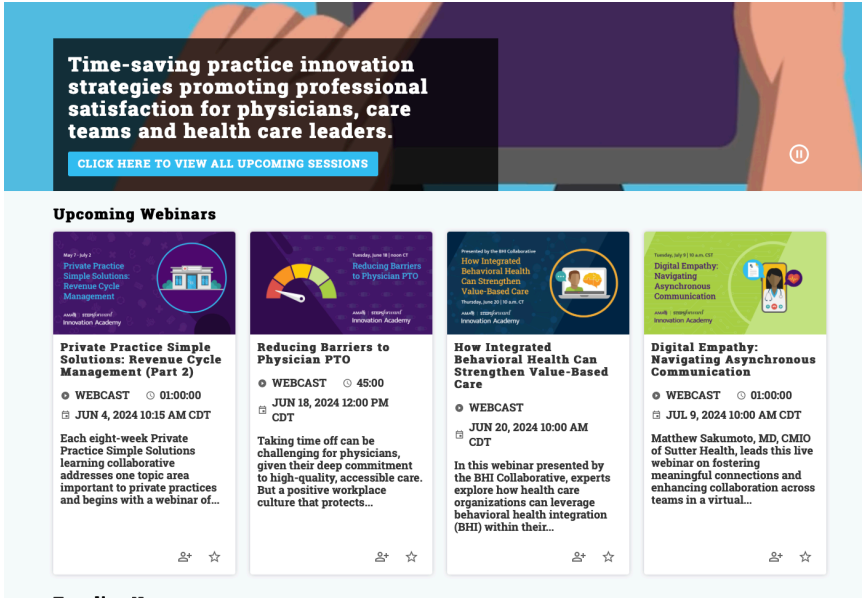
Start Learning

www.stepsforward.org



Intervention: AMA STEPS Forward Resources
Podcasts and Webinars

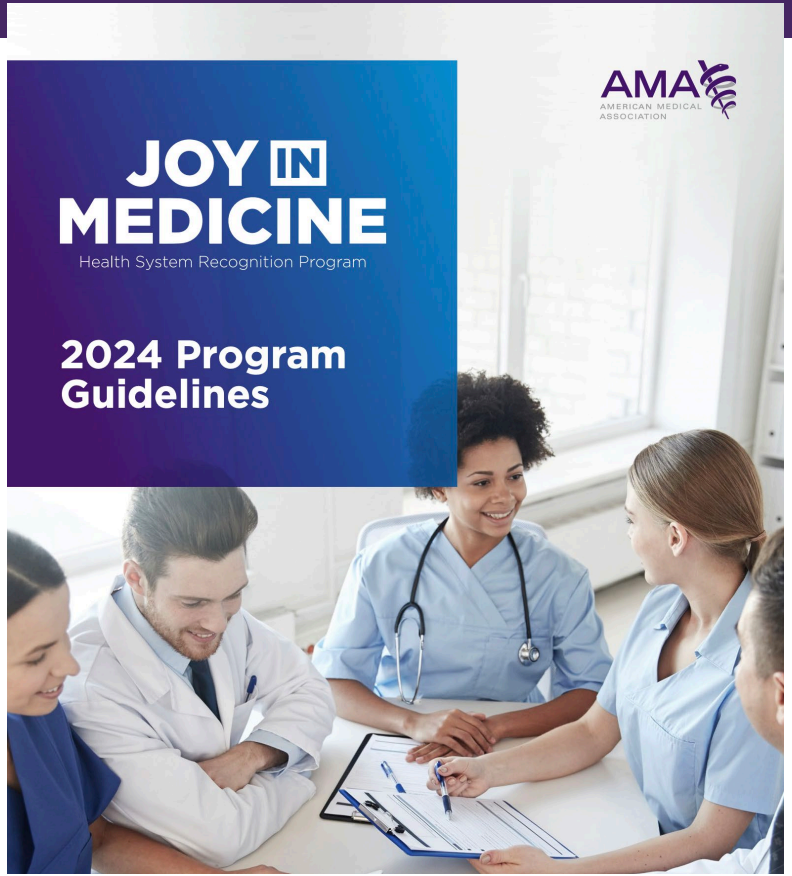




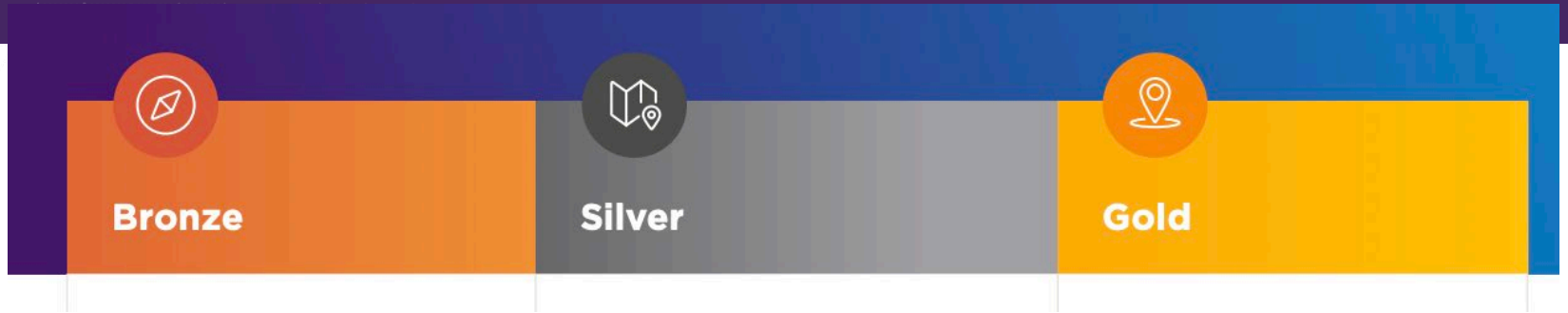
AMA | STEPSforward

Recognition: AMA Joy in Medicine Recognition Program

https://www.ama-assn.org/system/files/joy-in-medicine-guidelines.pdf



Recognition: AMA Joy in Medicine Recognition Program



1. Assessment
2. Commitment
3. Efficiency of Practice Environment
4. Teamwork
5. Leadership
6. Support

Recognition: AMA Joy in Medicine Recognition Program

The following organizations here today have been recognized:

1. Ochsner Health
2. The Permanente Medical Group
3. Sanford Health
4. Southern California Permanente Medical Group
5. Mayo Clinic
6. RUSH University Medical Center
7. Geisinger
8. Rogers Behavioral Health
9. The Southeast Permanente Medical Group
10. Washington Permanente Medical Group
11. Atlantic Health System

Thank You

jill.jin@northwestern.edu

SANFORD HEALTH'S INVESTMENT IN CLINICIAN EXPERIENCE TO REDUCE BURNOUT

SANFORD HEALTH

Heather Spies, MD, MBA

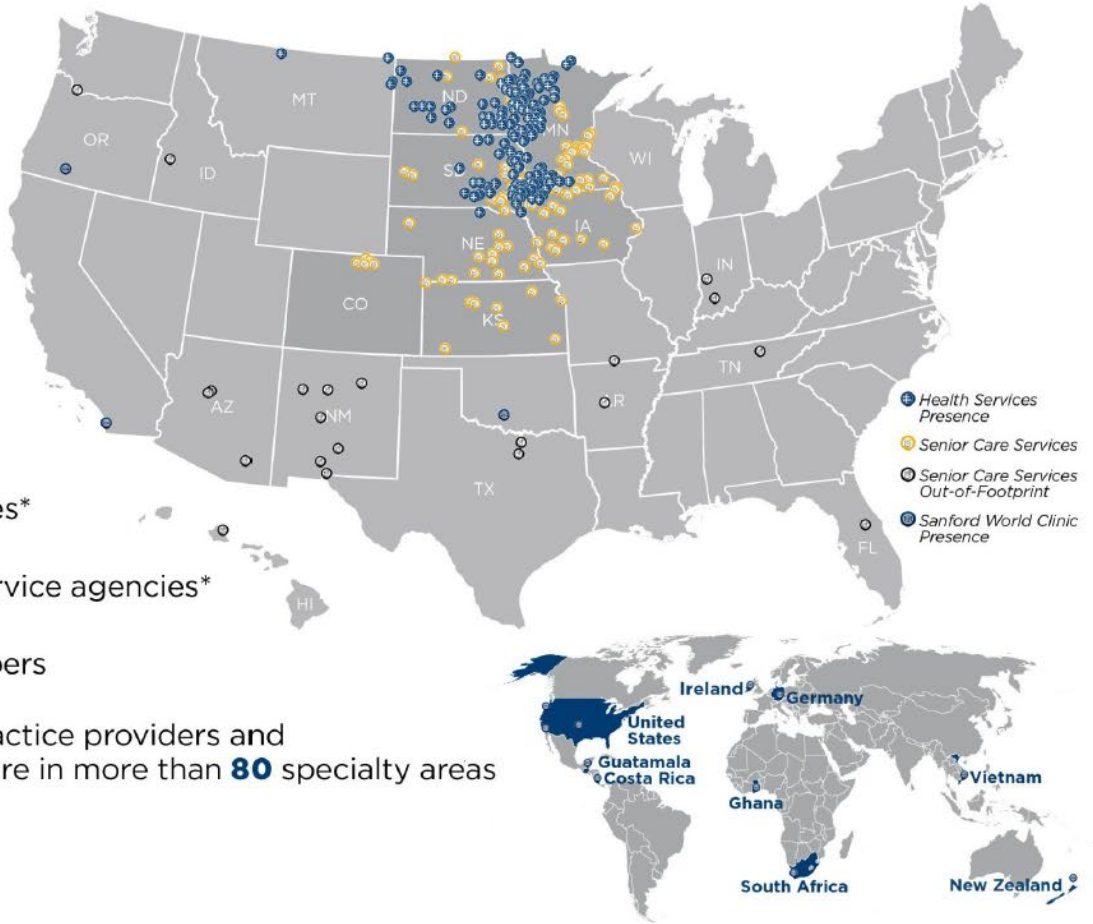
Medical Director Clinician Experience and Well-being

OBJECTIVES

- Describe how development of a health system-wide clinician experience team provides organizational-level support for clinicians
- Describe how intentional collaboration, communication, recognition and clinician leadership development improve clinician engagement.
- Learn how utilization of the AMA Joy in Medicine Roadmap can be utilized in organizational strategies to promote clinician well-being
- Understand how improving efficiency in practice support affects clinicians
- Learn how a premier clinician leadership development program promotes a culture of well-being for the organization.

SANFORD HEALTH

- **45** medical centers*
- **$7.2 billion** in annual revenue
- **211** clinic locations*
- **168** senior living centers*
- **122** skilled nursing and rehab facilities*
- **50** home- and community-based service agencies*
- **200,000** Sanford Health Plan members
- **1,553** physicians, **1,395** advanced practice providers and **8,291** registered nurses delivering care in more than **80** specialty areas
- **42,775** employees



* Facilities include owned, managed, leased and affiliate facilities.
** As of January 1, 2024. Approved by Data Governance Committee.

LIFESPAN OF ENGAGEMENT & EMPLOYMENT

FOLLOWING THE DATA

COMMITMENT

Clinician Experience Office

Dedicated 0.5 FTE physician leadership to clinician well-being

1 FTE Co-Director

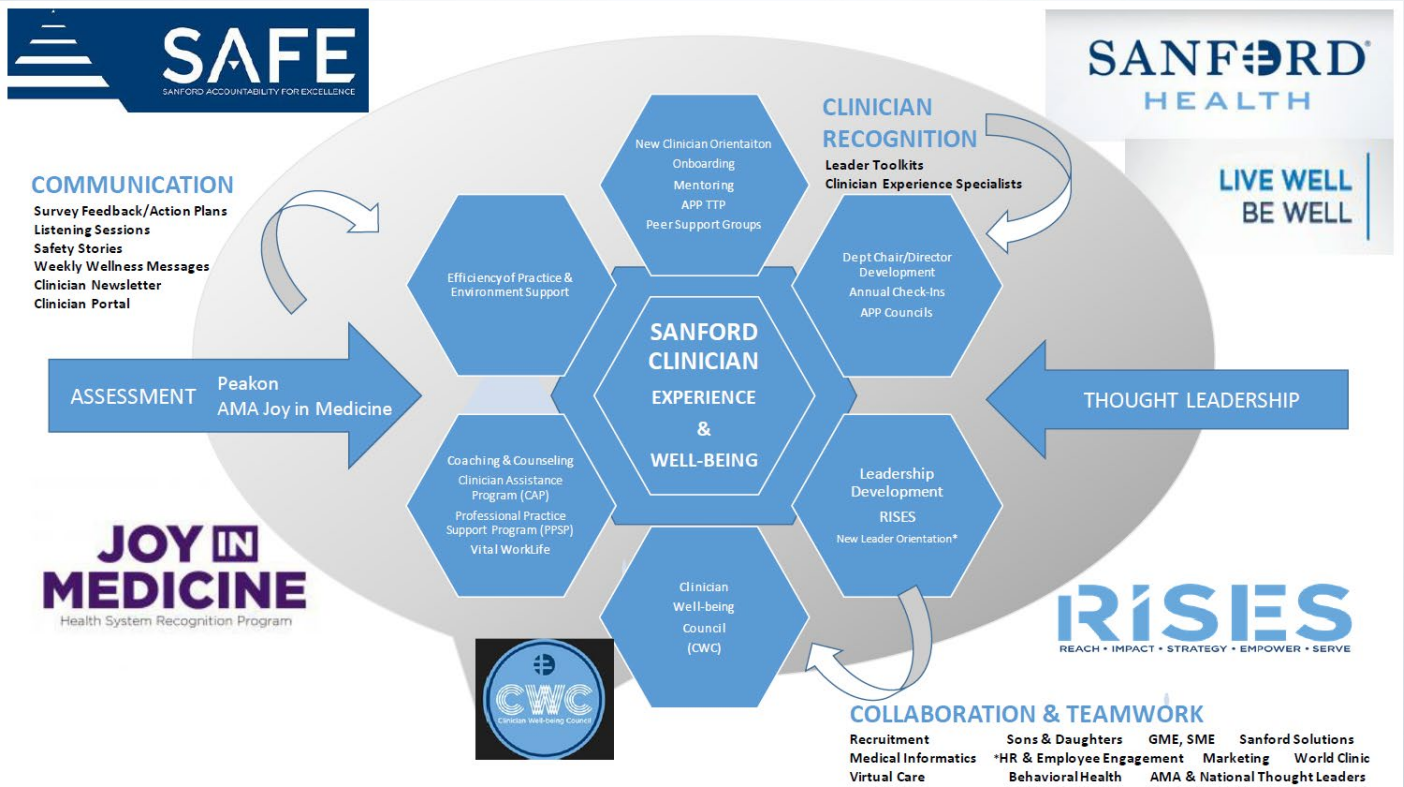
Clinician Well-being Council

Organizational Formal Strategic Plan

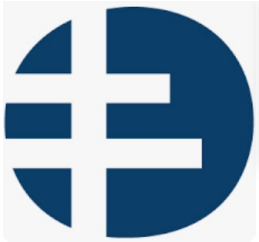
Growth and Development

4 FTE Regional Specialists + 1 EA support

EXPERIENCE & WELL-BEING AT THE CENTER



Sanford Health Clinician Experience
Culture & Well-being



COLLABORATION

COMMUNICATION

RECOGNITION

LEADERSHIP DEVELOPMENT

JOURNEY TO GOLD

TEAMWORK

Teamwork

- Measured with AMA Assessment & Peakon Survey
  - Assessed Team Function
  - Barriers to teamwork
  - Collegiality
- Examined Summary of TWORD* Results
  - 4 key specialties (IM, FM, OB, Peds)
- Develop/Implement intervention to improve teamwork
  - Patient message triage workflow
  - “Reply to me” for patient MyChart message
  - Automate refill requests
  - Refill protocols

$$TW_{ORD} = \frac{\text{Number of orders with team contribution}}{\text{Total number of orders placed by physician}}$$

LEADERSHIP

LEADERSHIP

RISES

REACH • IMPACT • STRATEGY • EMPOWER • SERVE

CLINICIAN LEADERSHIP DEVELOPMENT PROGRAM

SANFORD HEALTH

SANFORD HEALTH

RISES
REACH • IMPACT • STRATEGY • EMPOWER • SERVE

Clinician Leader Development Program
Nomination Package

Due: February 22, 2023

Eligibility Criteria:

- Employed by Sanford Health
- Credentialed & in good standing
- No recent or unresolved disciplinary action on file
- Not on a Performance Improvement Plan

Ideal candidates for this program will demonstrate:

- Motivation & desire to build on existing leadership skills
- Ability to take on greater responsibility in more demanding contexts
- Willingness to collaborate with and learn from other Sanford clinicians & leaders
- Ability to self-reflect & identify areas of personal growth opportunity

Nominator Information

Name _____ Title: _____ Location: _____

Name of nominee: _____

Describe how this clinician has led by example & contributes to the Sanford culture & family and why he/she should be considered for participation in RISES. (to be completed by Nominator)

INTENTIONAL SELECTION OF PARTICIPANTS

- **Statement of Interest (by nominee)**
- **Commitment to Attend (in person, dates provided)**
- **Endorsement by market Chief Physician**

2 YEAR CURRICULUM

- Adaptive Leadership
- Coaching
- Crucial Conversations
- Diversity, Equity & Inclusion
- Ethics
- Healthcare Finance
- Healthcare Law
- Human Resources
- Leading vs. Managing
- Leading Change
- Mentoring
- Meyers-Briggs Type Indicator (MBTI)
- Strengths Finder
- Well-being
- Wellness Centered Leadership

Leading Practice

Remember that 90% of your development is based on your application of skills and knowledge and interactions with others. Reflect on how you are doing with the following:

- Leading Change
- Showing Gratitude
- Managing resistance
- Showing your authentic self

"I would maintain that thanks are the highest form of thought; and that gratitude is happiness doubled by wonder."

—G.K. CHESTERTON

What went well? What are you proud of? What insights or moments of clarity did you gain?

Write your "leading practice" on a post-it note.
Adhere the post-it note to the Leading Practice page on the wall.

Do Differently

Exercise

3. Write down three things that resonated with you from today.

2. Write down two things you found most interesting and relevant in leading others more effectively.

1. Write down one thing you plan to commit to continuously improve or "do differently" prior to next session.

Write your "do differently" on a post-it note.
Adhere the post-it note to the Do Differently page on the wall..

SANFORD HEALTH

RISES SPOTLIGHTS

- Clinician spotlights
  - Powerpoints, Poem, Podcasts, Song/Performance

All About Dev

- Grew up: India; moved to the states in 2008

Family

What I do for Fun

- Dog: Olive 3.5 yrs old Golden Doodle

Why I Became a Doctor

IMPACT PROJECTS

Project Expectations & Overview:

- Develop a project within your market based on the group's observation of a:
  - Clinical or Leadership Need
  - Opportunity for:
    - Advocacy
    - Education
    - Improvement
      - Clinician Culture, Engagement & Well-being
      - Enhance Quality/SAFE work
    - Operational Efficiencies
- Must be:
  - Measurable
  - Objective
  - Sustainable
- Excluded foci:
  - Call
  - Compensation & benefits

**Project selected by group in collaboration with the Chief Physician*

CELEBRATE THE GROUP

- Graduation
- Certificate
- Recognition in multiple platforms
- Collaboration with local university
  - MBA credits

SANFORD RISES – COHORT 2


Krishna Arudra, MD


Megan Bowen, MD


Amy Cook, MD


Josh Doorn, MD


Bruce Evink, MD


Maxwell Gessner, MD


Danielle Hohbein, MD


Bud Johnston, DPM


Josh Kelsey, PA-C


Brad Kohoutek, MD


Jason Lehr, DO


Dev Mannuru, MD


Carlos Miranda, MD


Amber Neugebauer, DO


Zach Nolz, MD


Andrea Patten, MD


Dave Saxon, MD


Erica Schipper, MD


Andrew Skattum, DO


Kari Smith, CRNA


Andrew Stahl, MD


Ana Tobiasz, MD


Renae Welhouse, NP


Mitch Wyffels, MD


Ryan Zimmermann, MD

RISES

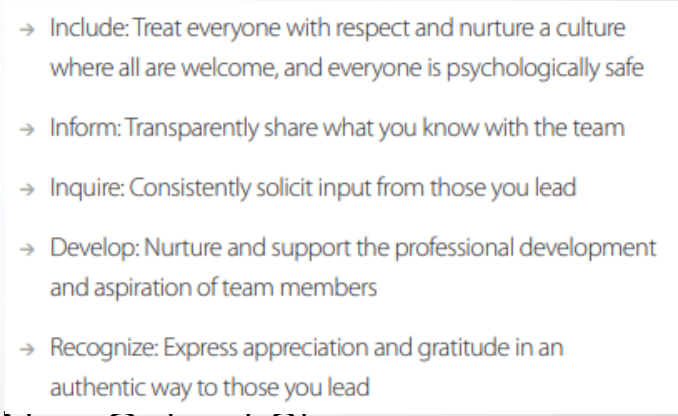
REACH • IMPACT • STRATEGY • EMPOWER • SERVE

WHAT WE LEARNED

- RISES
  - Psychologically safe space
  - Tailor to needs
  - Became the Go-To Sounding board
  - The talent we have in our organization- INTERNAL candidates
- Be ready to shift
- Communication
- Survey Fatigue
- Resource Allocation – start with a pilot/ proof of concept

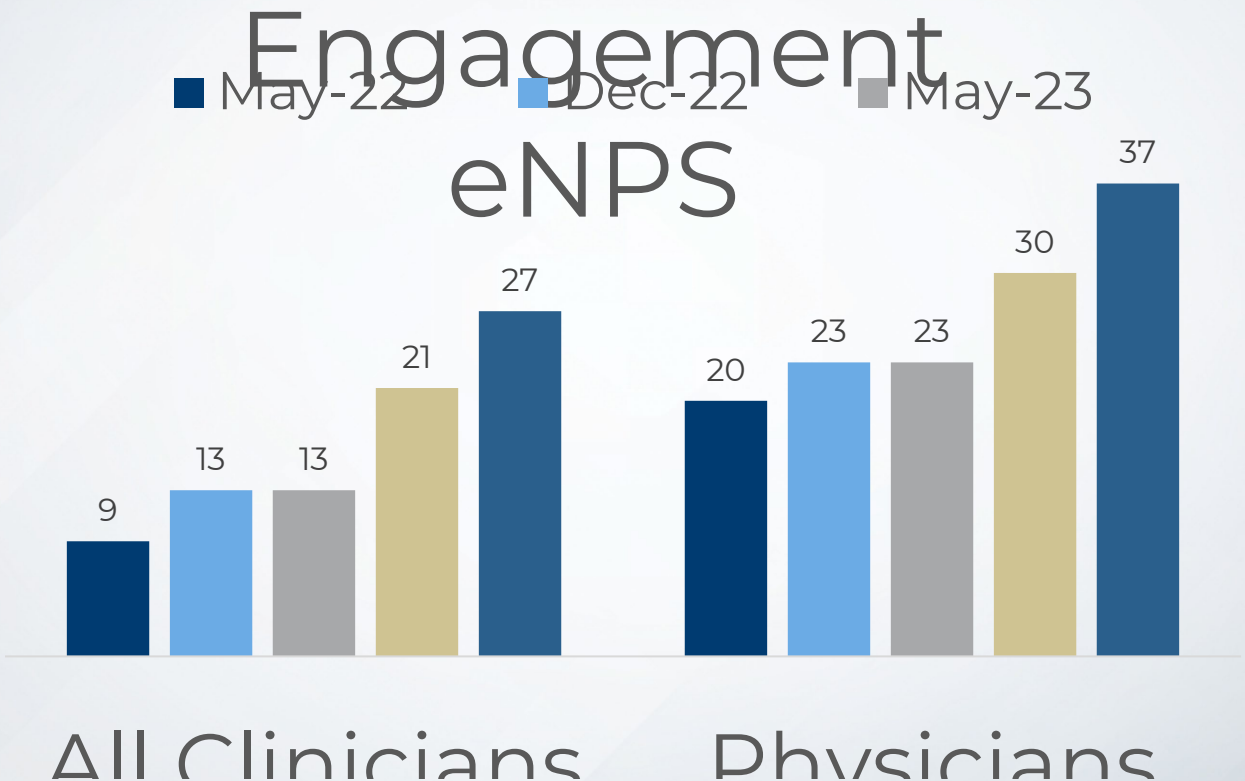
METRICS & OUTCOMES

- Peakon Engagement Survey
- AMA Organizational Biopsy
  - Burnout
  - Leader behaviors
- Efficiency in Practice
  - Sprint Pilot
- Retention
  - RISES Program (100% RETENTION in Cohort 2)
  - Clinicians in Organization



Engagement

eNPS



Aggregate participation: All clinicians 65%, Physicians 63%

Well-being & Organizational Support eNPS

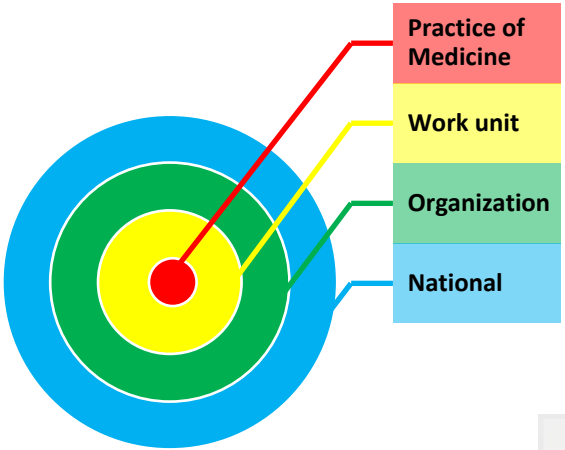
Health System Impact: Reducing Physician Burnout

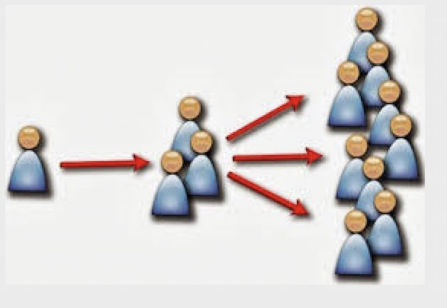
Integrated Physician Practice Section
AMA
June 7, 2024

Alpa Shah, MD
Marshfield Clinic Health System

Marshfield Clinic Health System

Reducing Burnout





Marshfield Clinic Health System

2024

65 Clinical Locations in 45 Communities

170+ Specialty Services

225,000
Security Health Plan members
Products available in every Wisconsin county.

Home to the area's only
Children's Hospital
1 of only 4 in Wisconsin

Marshfield Clinic Research Institute
With **5 research centers,** it is one of the largest private medical research institutes in Wisconsin.

3.7 million
Patient Encounters

350,000
Unique Patients

11,000
Employees

$601.4 million
Community Benefit
*Data as of CY2021

Academic Location *for the*
University of Wisconsin
School of Medicine & Public Health

11
Hospitals

19
Pharmacies

36
Clinical Laboratories

1,400 Providers

91% of providers
with **4.5 Stars** or higher

We collaborate with
400 Community Organizations
on **Community Health Initiatives**

30301-006

Our system growth story

1916
Marshfield Clinic is founded

1959
Marshfield Medical Research and Education Foundation is established

1971
Greater Marshfield Community Health Plan is created (now Security Health Plan)

2002
Partners with Family Health Center to provide dental services to rural communities

2007
With a sophisticated electronic health record, converted to chartless medical environment

2008
Lakeview Medical Center is integrated with System

2012
Marshfield Clinic Health System is incorporated

2014
MCHS names first CEO, Susan Turney, MD & BOD decision made to remain independent

2015-2022 Period of Significant Growth

2016: Home Recovery Care

2017: St. Joseph's Hospital joins MCHS - renamed Marshfield Medical Center
Stevens Point Cancer Center opens
Eau Claire Cancer Center opens

2018: MMC-Eau Claire opens its doors
Rusk County Memorial joins MCHS - renamed MMC-Ladysmith
Memorial Medical Center joins MCHS - renamed MMC-Neillsville

2019: Beaver Dam Community Hospital joins MCHS - renamed MMC-Beaver Dam

2020: MMC-Minocqua opens its doors
St. Clare's Hospital joins MCHS - renamed MMC-Weston
Flambeau Hospital joins MCHS - renamed MMC-Park Falls

2021: MMC-Neillsville (New Facility)

2022: MMC-Stevens Point opens its doors
Expand into Michigan when Dickinson County Healthcare joins MCHS

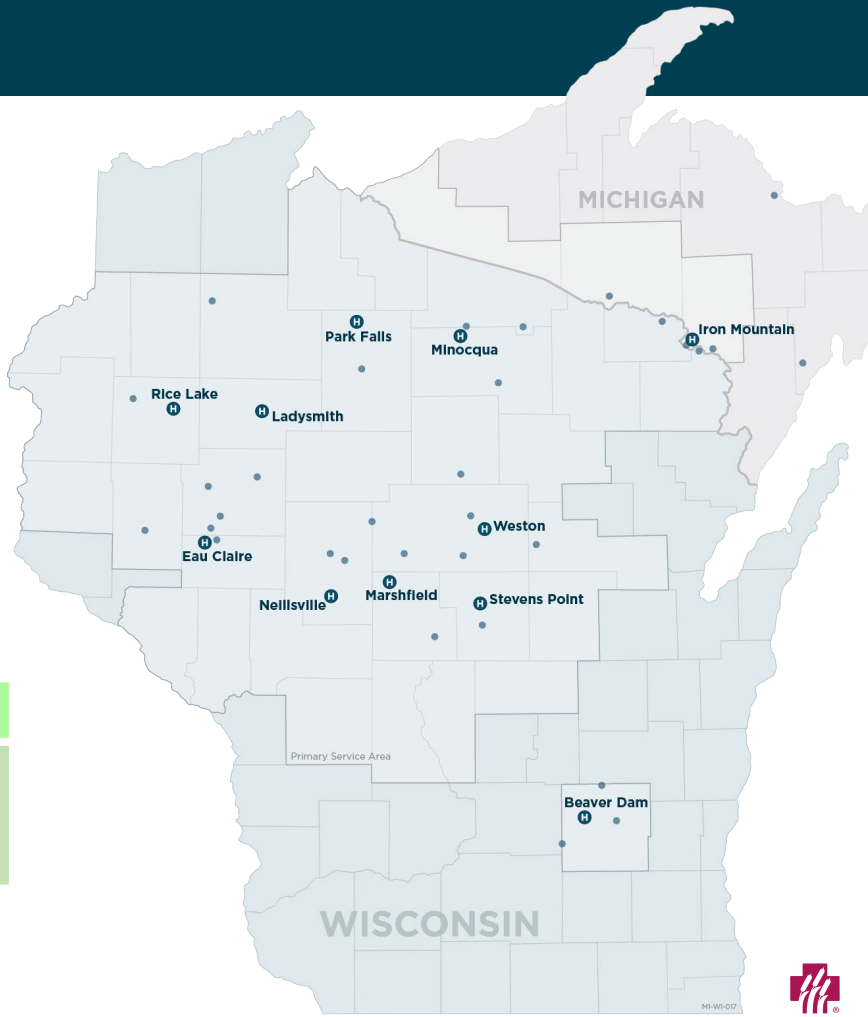
2020-2022: COVID
2021-2023: EHR change implementation

1916
Marshfield Clinic begins as a group practice in Marshfield with six founding physicians

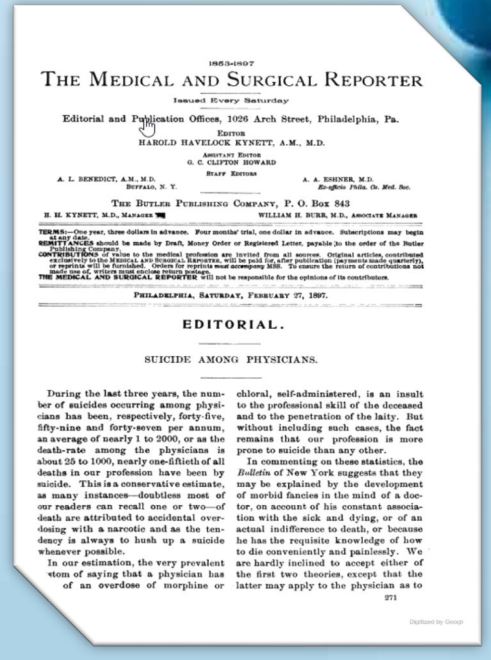
TODAY
MCHS has about 1,600 physicians and health professionals and 13,000 employees in 65+ locations

Organizational Biopsy 2024

Higher than National	Lower than National
-Job Stress -Burnout -Patient seeing hours	-Time spent on non-MD tasks -Administrative tasks -Vacation utilization



High Risk Profession



1853-1907

THE MEDICAL AND SURGICAL REPORTER

Issued Every Saturday

Editorial and Publication Offices, 1026 Arch Street, Philadelphia, Pa.

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THE BUTLER PUBLISHING COMPANY, P. O. BOX 843

H. H. KYNETT, M.D., MANAGER

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TERMS:—One year, three dollars in advance. Four months' trial, one dollar in advance. Subscriptions may begin at any date.

REMITTANCES should be made by Draft, Money Order or Registered Letter, payable to the order of the Butler Publishing Company.

CONTRIBUTIONS of value to the medical profession are invited from all sources. Original articles, contributed exclusively to the MEDICAL AND SURGICAL REPORTER, will be paid for after publication (payments made quarterly), or reprints will be furnished. Orders for reprints must accompany MSS. To ensure the return of contributions not made use of, writers must enclose return postage.

THE MEDICAL AND SURGICAL REPORTER will not be responsible for the opinions of its contributors.

PHILADELPHIA, SATURDAY, FEBRUARY 27, 1897.

EDITORIAL.

SUICIDE AMONG PHYSICIANS.

During the last three years, the number of suicides occurring among physicians has been, respectively, forty-five, fifty-nine and forty-seven per annum, an average of nearly 1 to 2000, or as the death-rate among the physicians is about 25 to 1000, nearly one-fiftieth of all deaths in our profession have been by suicide. This is a conservative estimate, as many instances—doubtless most of our readers can recall one or two—of death are attributed to accidental overdosing with a narcotic and as the tendency is always to hush up a suicide whenever possible.

In our estimation, the very prevalent atom of saying that a physician has of an overdose of morphine or chloral, self-administered, is an insult to the professional skill of the deceased and to the penetration of the laity. But without including such cases, the fact remains that our profession is more prone to suicide than any other.

In commenting on these statistics, the *Bulletin* of New York suggests that they may be explained by the development of morbid fancies in the mind of a doctor, on account of his constant association with the sick and dying, or of an actual indifference to death, or because he has the requisite knowledge of how to die conveniently and painlessly. We are hardly inclined to accept either of the first two theories, except that the latter may apply to the physician as to

271

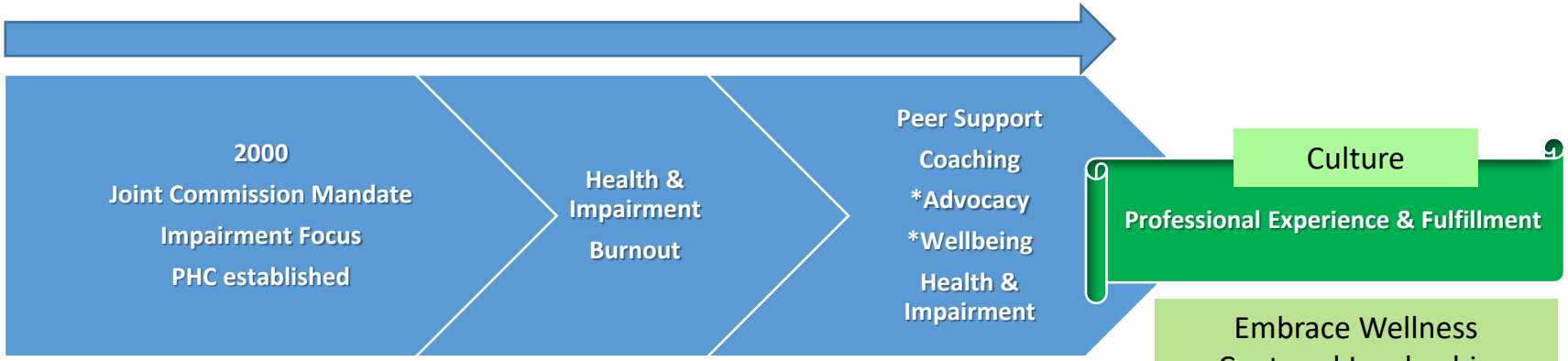
Barriers to Getting Help

Physician & Allied Professionals Health Committee (PHC)

- A committee of peers
- A resource for individuals
- An advocate for work-place wellbeing
- Confidential
- Voluntary
- Not EAP
- Minimal notes, Peer Protected

Physician & Allied Professionals Health Committee (PHC)

Committee Structure



Intervention

Intervention & Support

Prevention, Intervention &

Referrals:
Self, Peer, Leaders

*Inbox
*GROSS
*Financial Planning
*C&P language
* Org. Biopsy

Marshfield Clinic Health System

Supporting the Individual

-Peer Support
-Coaching

-Advocacy
-Connection, community

-Consultation
-Health & Impairment

-Treatment Resources

Requests for PHC Consults

MCHS: PHC Committee Members

Eric Callaghan, MD
Radiology

Alpa Shah, MD
Psychiatry
Chair PHC

Anna Seydel, MD Breast Surgeon

Suzanne Wright, MD
Pediatrics

Jenn Michels, PhD
Psychology, Chair of RWBC

CONTACT INFORMATION:
Email *shah.alpa@marshfieldclinic.org*
Phone **(715) 221-8801 & (715) 387-5765**
Intranet http://srdweb1/clinic/provider/phc/default.asp

Onboarding

WHAT

- **M** - Mentoring
- **C** - Culture, Community, Communication
- **C** - Coordination, Consistency, Compliance
- **A** - Alignment, Assessment
- **R** - Recruitment, Retention
- **E** - Engagement, Evaluation
- **S** - Social

WHY

- Culture
- Community Connection
  - Professional
  - Social
- Practice
- Personal
  - Professional Growth & Development
  - Interest

HOW

- Compact
- Define Experience, Phases, Navigation
- Tools
  - Dashboard
    - 'Pizza tracker' Concept
  - Repository
    - Alumni
    - Interest
    - Cultural
- Socialization

WHO

Roles, Responsibilities & Functions

- Board
- Executive Leaders
- SLMD
- SLA
- VPMA
- CAO
- Regional Director
- Ops Manager
- Recruiter
- Referral Liaison
- Colleagues
- Community/ Chamber of Commerce