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
Physician Burnout on the Rise

AMA Survey of 2,440 physicians across the US:

“Overall, **62.8%** of physicians had at least one manifestation of burnout in 2021 compared with 38.2% in 2010, 43.9% in 2017, 54.4% in 2014, and 45.5% in 2011.”

Why Should We Care About Burnout?

Health worker burnout can have many negative consequences

**Health Workers**
- Insomnia, heart disease, and diabetes
- Isolation, substance use, anxiety, and depression
- Relationship and interpersonal challenges
- Exhaustion from overwhelming care and empathy

**Patients**
- Less time with health workers
- Delays in care and diagnosis
  - Lower quality of care
  - Medical errors

**Health Care System**
- Health workforce shortages and retention challenges
  - Limited services available
- Risk of malpractice and decreased patient satisfaction
  - Increased costs

**Community and Society**
- Erosion of trust
  - Worsening population health outcomes
  - Increased health disparities
- Lack of preparedness for public health crises

“I can’t provide the best care to my patients…”

“I can’t get the care I need…”
THE COST OF BURNOUT

Tat Shanaforj, MD, Joel Golt, PhD, Christine Sims, MD

Figure 2. Worksheet to Project Organizational Cost of Physician Burnout

1. Input data: Enter values
   N = No. of physicians at your center
   BD = Rate of burnout of physicians at your center
   T0 = Current turnover rate per year
   C = Cost of turnover per physician

2. Calculations:
   a. Estimated Cost of Physician Turnover Attributable to Burnout
      A. T0 without burnout (solve for “T0 without burnout”): formula
         \[ T0 \text{ without burnout} = \frac{T0 \times (1 - BD) + (1 - T0) \times BD)}{1 - BD \times (1 - T0)} \]
      B. Projected No. of physicians turning over per year due to burnout (given input variables and T0 without burnout value from step A):
         formula
         \[ \text{No. of physicians turning over due to burnout per year} = (T0 - T0 \text{ without burnout}) \times N \]
      C. Projected cost of physician turnover per year due to burnout (given input variables and No. of physicians turning over due to burnout per year from step B):
         formula
         \[ \text{Estimated cost of turnover due to burnout} = C \times \text{No. of physicians turning over due to burnout per year} \]

   Example (Using N = 450, BD = 50%, T0 = 7.5%, C = $500000)
   A. T0 without burnout:
      0.075 = T0 without burnout \times (1 - 0.5) + (1 - T0 without burnout) \times 0.5
      or 0.075/(1 - 0.5) = 0.3333
   B. No. of physicians turning over due to burnout per year:
      (0.075 - 0.00) \times 450 = 33.75
   C. Projected cost of physician turnover per year due to burnout:
      $500000 \times 33.75 = $1687500

   Example (Using N = 100, BD = 70%, T0 = 7.5%, C = $500000)
   A. T0 without burnout:
      0.075 = T0 without burnout \times (1 - 0.7) + (1 - T0 without burnout) \times 0.7
      or 0.075/(1 - 0.7) = 0.3333
   B. No. of physicians turning over due to burnout per year:
      (0.075 - 0.00) \times 100 = 7.5
   C. Projected cost of physician turnover per year due to burnout:
      $500000 \times 7.5 = $375000

   a. National mean, approximately 54%
   b. National mean, approximately 7%
   c. Mean cost of $500000 to $1000000 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 (ROI)

1. Input data: Enter values
   CR = Estimated cost of turnover due to physician burnout
   CI = Cost of intervention per year
   N = Relative reduction in BD

2. Calculations:
   a. ROI:
      A. Savings due to reduced BD:
         formula
         \[ \text{Savings due to reduced BD} = (\text{ROI} \times CR) - \text{BD} \]
      B. ROI:
         formula
         \[ \text{ROI} = \frac{\text{Savings due to reduced BD} \times CI}{\text{BD} \times CI} \]
   Example (Using CR = $562500, CI = $1000000, N = 20%)
   A. Savings due to reduced BD:
      $562500 \times 0.20 = $1125000
   B. ROI:
      $1125000 / ($1000000 / 0.20) = 11.25

   a. From Figure 2.

THE BAD NEWS

burnout. Stringent intervention policies are expensive. 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 in 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

Calculate the Cost of Physician Burnout for Your Organization

1,000 physicians
Number of physicians in your organization

63% burnout
Rate of physician burnout in your organization

7% turnover
Current physician turnover rate (all causes) in your organization

$500,000 / physician
Cost of turnover in your organization, per physician

Impact of Physician Burnout in Your Organization

27 / year
Number of physicians in your organization turning over due to burnout per year

$13,527,607 / year
Estimated cost of physician turnover per year due to physician burnout
Dr. Christine Sinsky:

“While burnout manifests in individuals, it originates in systems.”
Organizational Drivers of Burnout

Burnout
- Exhaustion
- Cynicism
- Inefficacy

Driver dimensions
- Workload and job demands
- Efficiency and resources
- Control and flexibility
- Meaning in work
- Organizational culture and values
- Social support and community at work

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

Burnout aggressors:

- High chaos (work environment and pace): 78% vs 36% burnout
- Low control (over workload): 75% vs 39% burnout

Burnout mitigators:

- Teamwork: 49% vs 88% burnout
- Feeling valued: 37% vs 69% burnout

System Level Interventions to Combat Burnout
Strategy 1: Stop the Unnecessary Work

Strategy 2: Share the Necessary Work

Strategy 3: Support the Individual
Stop the Unnecessary Work: DE-IMPLEMENT!

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 passphrase-compliant)
  - Consider use of passwordless 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 radiation in minors 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 discrete data fields if the information already exists in EHR (e.g., if medical assistant has completed a discrete field for “last menstrual period,” optimize your technology so no one has to reenter that data into the order for a pop 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, fingertip 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 time on clinical resources screening more often than is required to meet the 365-day annual interval.

Stop the Unnecessary Work: GROSS

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?” 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.

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

EHR Inbox Reduction Checklist for Health Care Organizations

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

Guiding Principles

- Establish an inbox reduction task force. The task force may include the following: Clinical operations leaders, IT leaders, and compliance professionals. Patient experience leaders, Practicing physicians, Care team members, and those who handle EHR messages. An EHR vendor representative and 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 volumes. For example, Epic's Signal Health or Oracle's Cerner's Inbound program's 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 load among the care team. Establish the cultural norm that the inbox belongs to clinical teams or pods. The nomenclature that reflects this culture, for example, refers to the "practicing clinicians" or the "care teams 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 16 months old. Some organizations have found that starting with a grand gesture like this establishes credibility, earns信任, and gives hope that inbox reduction will be successful. This may take several weeks to complete because of the volume of messages.

- Keep any message that is over 16 months old. Messages that are too old may not be useful or relevant to the recipient. Let teams know that this will be the norm from this point on unless messages are individually marked for exception.

- Provide patients with self-service options. Facilitate opportunities for patients to self-service, such as self-scheduling in select departments.

- Build a team of experts. A team pool consists of care team members, including NPs and NMs. All patient messages within a practice or clinical unit should go to this pool first, and then directly to the physicians. This model, only questions that NPs or NMs cannot handle, is managed by physicians, ideally, in a secure environment with support staff who have accessed the message as opposed to the practice of simply forwarding the message to the physician (see next step).

- Assign an RN or PA to each physician as the primary manager of their inbox. This care team member takes ownership of the inbox and manages incoming messages, reserving anything they can on their own. For messages outside their scope, they should "forward the message" to make it as useful and actionable as possible, using their training, skills, and authority to delegate or to another team member. Additional research shows that it is necessary to consult a physician or APP when 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 (i.e., when physicians are on vacation).

Tactics for Individual Message Types

Patient requests for medical advice

- Develop a system that manages all forms of inquiries. Team members should thoroughly research all patient requests for medical advice and take action to the best of their ability and within their scope of practice before "flagging up" to a physician. This is sometimes described as "restraining the message." Avoid light "touch and pass" transfers with comments such as "please white.

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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
Los Angeles Times

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)
**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

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 = 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.

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. Efficiency of time for documentation:
   - 1 = Poor
   - 2 = Marginal
   - 3 = Satisfactory
   - 4 = Good
   - 5 = Optimal

8. The amount of time I spend on the computer at work (good, fair, or bad):
   - 1 = Excessive
   - 2 = Moderately high
   - 3 = Satisfactory
   - 4 = Modest
   - 5 = Minimal/none

9. The ER helps to reduce 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
   - Busy, but reasonable
   - Heated, chaotic
   - 1 = Calm
   - 2 = Busy, but reasonable
   - 3 = Heated, chaotic
   - 4 = Calm
   - 5 = Heated, chaotic

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 1-6. 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

Healers Health System – Organizational Biopsy Mini-Z – January 2024 Overall Mini-Z Score(s) vs. National Comparison 2023

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Intervention: AMA STEPS Forward Resources
Playbooks and Toolkits

www.stepsforward.org
Intervention: AMA STEPS Forward Resources
Podcasts and Webinars

AMA STEPS Forward® Podcast
Listen to health care leaders share insights, strategies, and tips to optimize physician burnout, improve patient care, and help put the joy back into the practice of medicine.

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  - Frontline Connect: Eliminating Barriers to Mental Health Services for the Health Care Workforce
  - AMA STEPS Forward

- **CARDIOLOGY** 15m 35s
  - The Behavioral Health Integration Collaborative Part 1: Cardiology
  - AMA STEPS Forward

- **ELECTRONIC HEALTH RECORDS** 26m 54s
  - GROSS: Get Rid of Stupid Stuff!
  - AMA STEPS Forward

- **PROFESSIONAL WELL-BEING** 27m 27s
  - How One Medical Educator Is Working to End Mental Health Stigma in Medicine
  - AMA STEPS Forward

- **ELECTRONIC HEALTH RECORDS** 23m 48s
  - Write Shorter Notes: Implementing a Standardized Progress Note Template
  - AMA STEPS Forward

- **NEUROLOGY** 16m 46s
  - The Behavioral Health Integration Collaborative Part 2: Neurology
  - AMA STEPS Forward

- **SOCIAL DETERMINANTS OF HEALTH** 25m 46s
  - Connecting the Data Between Social Determinants of Health and Climate Change
  - AMA STEPS Forward

- **PROFESSIONAL WELL-BEING** 30m 30s
  - Rapid Supportive Debriefs: A Tool for Embodying Wellness-Centered Leadership After Stressful Events
  - AMA STEPS Forward

Upcoming Webinars

- **Private Practice Simple Solutions: Revenue Cycle Management (Part 2)**
  - WECAST
  - 01:00 AM CT
  - JUN 4, 2024 10:00 AM CDT

- **Reducing Barriers to Physician PTO**
  - WECAST
  - 04:00 PM CT
  - JUN 18, 2024 12:00 PM CDT

- **How Integrated Behavioral Health Can Strengthen Value-Based Care**
  - WECAST
  - JUN 20, 2024 10:00 AM CDT

- **Digital Empathy: Navigating Asynchronous Communication**
  - WECAST
  - 01:00 AM CT
  - JUL 9, 2024 10:00 AM CDT

Matthew Sakamoto, MD, CMD of Sutter Health, leads this live webinar to explore how health care organizations can leverage behavioral health integration (BHI) within their...
Recognition: AMA Joy in Medicine Recognition Program

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
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 Obaa Governance Committee.
LIFESPAN OF ENGAGEMENT & EMPLOYMENT

PRE-EMPLOYMENT
- Medical Training
- Credentialing and Privileging
- Residency Fellowship

ONBOARDING
- Branding Initiatives
- Practice Development Support
- Engagement and Retention

CLINICAL PRACTICE
- Mentoring
- Leadership Development
- Community Involvement
- Early Talent Identification
- Work-Life Balance

SUCCESSION PLANNING
- Recruitment
- New Provider Orientation
- Department Chair Development
- Governance Involvement
- Wellness Programs
- Retirement Planning
- Leadership Transitions
FOLLOWING THE DATA

Clinician Burnout

Quality care

Efficiency

Productivity
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
Sanford Health Clinician Experience
Culture & Well-being

COLLABORATION
COMMUNICATION
RECOGNITION
LEADERSHIP DEVELOPMENT
JOURNEY TO GOLD
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
LEADERSHIP

[Image: AMA Joy in Medicine Recognized Organization 2023]
LEADERSHIP

RiSES

REACH • IMPACT • STRATEGY • EMPOWER • SERVE

CLINICIAN LEADERSHIP DEVELOPMENT PROGRAM

SANFORD HEALTH
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
<table>
<thead>
<tr>
<th>2 YEAR CURRICULUM</th>
</tr>
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<tbody>
<tr>
<td>Adaptive Leadership</td>
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<tr>
<td>Coaching</td>
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<tr>
<td>Crucial Conversations</td>
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<tr>
<td>Diversity, Equity &amp; Inclusion</td>
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<td>Ethics</td>
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<tr>
<td>Healthcare Finance</td>
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<tr>
<td>Healthcare Law</td>
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<tr>
<td>Human Resources</td>
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<tr>
<td>Leading vs. Managing</td>
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<tr>
<td>Leading Change</td>
</tr>
<tr>
<td>Mentoring</td>
</tr>
<tr>
<td>Meyers-Briggs Type Indicator (MBTI)</td>
</tr>
<tr>
<td>Strengths Finder</td>
</tr>
<tr>
<td>Well-being</td>
</tr>
<tr>
<td>Wellness Centered Leadership</td>
</tr>
</tbody>
</table>
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

“Ai 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?

Do Differently

Exercise

1. 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.

3. Write down one thing you plan to commit to continuously improve or “do differently” prior to next session.

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

Write your “do differently” on a post-it note. Adhere the post-it note to the Do Differently page on the wall.
RISES SPOTLIGHTS

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

To it I go through
All About Dev

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

Family

What I do for Fun

Why I Became a Doctor

Dog: Olive 3.5 yrs old Golden Doodle
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

You & a guest are cordially invited to the Sanford RISES Cohort 1 GRADUATION CEREMONY

Friday, April 28, 2023
5:30 p.m. - social
6:30 p.m. - dinner
7:00 p.m. - program

Radisson Blu Fargo
201 5th St N
Fargo, ND 58102

RSVP to Aaste by email: aaste.campbell@sanfordhealth.org
or call 701-334-6969 by Friday April 14, 2023
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

- Include: Treat everyone with respect and nurture a culture where all are welcome, and everyone is psychologically safe
- Inform: Transparently share what you know with the team
- Inquire: Consistently solicit input from those you lead
- Develop: Nurture and support the professional development and aspiration of team members
- Recognize: Express appreciation and gratitude in an authentic way to those you lead
Engagement eNPS

Aggregate participation: All clinicians 65%, Physicians 63%
Well-being & Organizational Support eNPS

- Health & Well-being
- Organizational Support
Reducing Burnout

- Practice of Medicine
- Work unit
- Organization
- National

Wellbeing

- Professional Fulfillment
- Practice Support & Resources
- Community at work
- Physical & Mental Health
- Work Life Integration

Alignment with Organizational Values

Marshfield Clinic Health System
# Marshfield Clinic Health System

## 2024

**65 Clinical Locations**

**225,000**

Security Health Plan members

Products available in every Wisconsin county.

**45 Communities**

**170+ Specialty Services**

**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.

### Key Statistics:

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Encounters</td>
<td>3.7 million</td>
</tr>
<tr>
<td>Unique Patients</td>
<td>350,000</td>
</tr>
<tr>
<td>Employees</td>
<td>11,000</td>
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<tr>
<td>Community Benefit</td>
<td>$601.4 million</td>
</tr>
<tr>
<td>Academic Location</td>
<td>University of Wisconsin School of Medicine &amp; Public Health</td>
</tr>
<tr>
<td>Providers</td>
<td>1,400</td>
</tr>
<tr>
<td>Provider Quality</td>
<td>91% with 4.5 Stars or higher</td>
</tr>
<tr>
<td>Community Organizations</td>
<td>400</td>
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<tr>
<td>Hospitals</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>19</td>
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<tr>
<td>Clinical Laboratories</td>
<td>36</td>
</tr>
</tbody>
</table>
Our system growth story

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

1916
Marshfield Clinic is founded

1959
Marshfield Medical Research and Education Foundation is established

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

2008
Lakeview Medical Center is integrated with System

2008
MCHS names first CEO, Susan Turney, MD & BOD decision made to remain independent

2012
Marshfield Clinic Health System is incorporated

2014
With a sophisticated electronic health record, converted to chartless medical environment

2012
2007

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

TODAY
MCHS has about 1,600 physicians and health professionals and 13,000 employees in 65+ locations
Organizational Biopsy 2024

- Job Stress
- Burnout
- Patient seeing hours

Higher than National

- Time spent on non-MD tasks
- Administrative tasks
- Vacation utilization

Lower than National
High Risk Profession
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

2000
Joint Commission Mandate
Impairment Focus
PHC established

Health & Impairment
Burnout

Peer Support
Coaching
*Advocacy
*Wellbeing
Health & Impairment

Committee Structure

Culture

Professional Experience & Fulfillment

Embrace Wellness
Centered Leadership

Intervention

Intervention & Support

Prevention, Intervention & Support

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:
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Email shah.alpa@marshfieldclinic.org
Intranet http://srdweb1/clinic/provider/phc/default.asp