AMA | JOY IN MEDICINE®
Health System Recognition Program

2026 Program Guidelines

Table of Contents

An organizational road map to reduce burnout

Joy in Medicine® Health System Recognition Program

The American Medical Association developed the Joy in Medicine® Health System Recognition Program to empower health systems to reduce burnout and build well-being so that physicians – and their patients – thrive.

The Joy in Medicine Health System Recognition Program is designed to:

- Provide a road map for health system leaders to implement programs and policies that support physician well-being
- Unite the health care community in building a culture committed to increasing joy in medicine for the profession nationwide
- Build awareness about solutions that promote joy in medicine and spur investment within health systems to reduce physician burnout

To learn more, visit ama-assn.org/joyinmedicine or contact us at joyinmedicine@ama-assn.org

→ VISIT OUR WEBSITE

Program Eligibility

The Joy in Medicine Health System Recognition Program is designed for the unique challenges faced by health systems in building organizational well-being. Because this program is built for large health systems, there are eligibility requirements that organizations must meet before applying.

1. The Joy in Medicine Health System Recognition Program is intended for health systems with 75 or more physicians. As of the 2025 program, eligibility is based on total number of physicians. Non-physician providers are not included in this number.

2. All applications should be submitted on behalf of your organization — not individual departments, GME programs or affiliated practices within your system. A single enterprise-level application representing a whole health system is preferred where possible. If one or more subsidiaries of a health system (e.g., individual locations or regions) are interested in applying to the program, please reach out to the AMA for guidance on preparing your application.

3. Complete an assessment of physician well-being in the last three years using one of the following validated tools:

   - Organizational Biopsy® (which includes the Mini-Z)
   - Mini-Z (or single item Mini-Z burnout question)
   - Maslach Burnout Inventory
   - Mayo Well-Being Index
   - Stanford Professional Fulfillment Index

If you have not yet completed a burnout assessment and would like to do so in preparation for next year's application cycle, learn more about the Organizational Biopsy and how to get started using the AMA's no-cost burnout assessment.

If your organization is not currently eligible for the program, you are still encouraged to use the Joy in Medicine Recognition Program resources such as these guidelines and are invited to access no-cost resources from AMA STEPS Forward® to help inform and adopt practice solutions that support physician well-being.

We also encourage you to engage with CHARM: the Collaborative for Healing and Renewal in Medicine.

Application Process

Review the Joy in Medicine Guidelines

1

The Joy in Medicine Health System Recognition Program is meant to serve as a strategic road map for organizations to support physician well-being. The first step in this process is to familiarize yourself with the Joy in Medicine Program Guidelines outlined in this document. Based on the outlined criteria, evaluate the current efforts of your organization to determine the level of recognition that you will apply for. Please read the full program criteria and supporting documentation requirements (not just the criteria-at-a-glance) and consult the submission samples in Appendix A as you compile your application. Due to a high volume of inquiries from applicants, the Joy in Medicine team asks that you thoroughly consult this document before reaching out with questions about the program.

Submit an Intent to Apply form

2

Organizations interested in applying for recognition can submit an Intent to Apply form for 2026 in our application portal. By submitting an Intent to Apply, your organization will automatically receive updates on upcoming application cycles and direct access to the application when the cycle opens.

If your organization is interested in the program but not yet ready to apply, we would encourage you to share your contact information with us via the Stay Connected form in our application portal.

→ VISIT APPLICATION PORTAL

Apply for the Joy in Medicine Health System Recognition Program

3

The primary point of contact for well-being work at your organization must complete and submit your application. Applications will open Jan. 8 and will close Feb. 27, 2026.

After Applying

Below is an overview of what to expect from the coming year after your application is submitted.

SPRING 2026

Review process

A committee composed of national leaders in physician well-being will review applications to confer an appropriate recognition level. If reviewers determine that your application should receive a lower recognition level than you applied for or if reviewers determine that your application does not qualify for recognition, feedback will be shared directly with your organization.

Organizations that achieve recognition are subject to AMA internal review before public announcement of their recognition status.

SUMMER 2026

Private notification and accepting recognition

All organizations that apply for recognition will receive private notification about the outcome of their application in the summer of 2026.

If your organization achieves recognition, you will be asked to formally accept your recognition and verify your organization's public-facing name and headquarters location, along with other information that will be used in public announcements and materials produced by the AMA. You will also be asked to connect with your organization's leadership and press/communications team to prepare for public announcement.

If your organization does not achieve recognition, your name will not be publicly shared. Only applicants that achieve recognition are named publicly.

FALL 2026

Public announcement

2026 Joy in Medicine recognized organizations will be publicly announced in the fall of 2026. Public announcement is issued via an AMA press release. The Joy in Medicine team will provide your organization with materials such as recognition badges, logos, sample press release language and social media graphics to support you in sharing your recognition status with your community.

Public announcement precedes either the biannual American Conference on Physician Health™ or the International Conference on Physician Health™. Recognized organizations are encouraged to attend these conferences to celebrate their achievements and connect with others in the health care community dedicated to improving physician well-being.

Renewing Recognition

Renewal process

Recognition is valid for two years. Organizations recognized in 2026 will have valid recognition until 2028 and will be asked to reapply to the program in the 2028 cycle. Organizations may choose to renew their recognition at any level (higher, lower or current).

- Your organization will receive a direct notice that your recognition is up for renewal. Renewal notices will be sent to the primary point of contact for well-being work that submitted your previous application.
- It is recommended that you review the program guidelines annually to stay connected with the program, application process, and any criteria clarifications or updates (e.g., 2026 recognized organizations should review the 2027 program guidelines to keep current with the program ahead of the publication of the 2028 guidelines).
- Organizations that are renewing are required to complete all components of the application for their applied level of recognition in order to re-attest that they still meet the program criteria and offer any relevant updates on their work. Reviewers do not consult previous applications in their review of renewal applications.
- You may consult your previous application(s) when preparing your renewal application. Applications from 2022-2025 are accessible via Submittable. Applications from 2019 and 2021 are available upon request. Please reach out to us at joyinmedicine@ama-assn.org if you need assistance accessing previous applications.

Early renewals

Organizations are permitted to renew early in pursuit of a higher level of recognition. For example, an organization recognized in 2026 may reapply for recognition in 2027 at a higher level (e.g., a 2026 Bronze recognized organization may reapply a year early in 2027 for Silver recognition).

We do not accept early renewal applications for the same level of recognition your organization has previously achieved (e.g., a 2026 Bronze recognized organization cannot submit a 2027 application for Bronze level recognition, and should instead apply when their recognition is up for renewal in 2028).

Lapsed recognition

Organizations that do not renew after two years are considered lapsed and are publicly listed as "previously recognized" instead of "currently recognized."

2026 Application

This document is designed to guide your organization through the annually updated program criteria and includes:

- criteria-at-a-glance
- detailed program criteria
- supporting documentation requirements
- appendices, including submission samples

Please review this document fully as you prepare to apply.

The Joy in Medicine Health System Recognition Program is based on three levels of organizational achievement in prioritizing and investing in physician well-being. Each level—**Bronze**, **Silver** and **Gold**—is composed of six domains: Assessment, Commitment, Efficiency of Practice Environment, Leadership, Teamwork and Support. An organization's achievement level (i.e., Bronze, Silver or Gold) will be designated based on submitted evidence that supports the completion of criteria and supporting documentation outlined in detail in these guidelines.

Organizations must meet five of six domains to be eligible for a recognition level. Domains must be the same across levels (e.g., Silver applicants must apply for five of six domains in Bronze and the same five of six domains in Silver).

Innovations

Sharing your organization's innovations

This year, we will be introducing a section of the application where your organization can choose to provide information about other noteworthy programs, policies and initiatives supporting physician wellbeing that were not captured elsewhere in your application.

This section is optional and information submitted for this topic will not affect eligibility or recognition. These submissions will help inform the AMA about other innovations from the field and may be used to inform future program content.

Examples of innovation areas include:

- Diversity, Equity and Inclusion
- Staffing
- Technology/AI
- Resident/Fellow education

Important Notes

1. Organizations are required to meet at least five of six domains to be eligible for recognition, but are encouraged to submit supporting documentation for all six domains if all domains can be met by your organization's work. This provides reviewers with ample opportunity to grant recognition, should reviewers determine that your organization does not meet one of the domains in your application.

2. Only activities that have been executed will count in fulfilling each criterion. Activities still under development or planned for the near future (but not yet executed) are not sufficient for recognition. Please only submit information for completed activities, unless the criterion specifically asks for future plans.

3. Where criteria require activity within a stated date range (e.g., "within the last three years" or "every two years"), that date range should be counted from January of the application year.

4. Please submit supporting documentation only in the format requested and do not submit links to externally hosted files. Where possible, we have requested written summaries in lieu of raw data. We ask that organizations streamline their submissions to only include the requested and essential information. Submitting extraneous information will slow the review process and may lead to confusion rather than provide clarity.

5. For criteria that require sharing information about assessments or interventions, please note that your application will not be reviewed based on results. Rather, reviewers are interested in learning about your overall approach to reducing work burden and improving the work environment.

6. Review decisions are made based on the information provided directly in the application. Applicants will not be able to submit additional information or documentation once they have submitted their application. We recommend thoroughly reviewing your application with multiple team members to ensure consistency and completeness prior to submission.

7. All information submitted to the AMA will remain confidential.

Criteria at a Glance

IMPORTANT: The Criteria at a Glance previews the criteria at a high level, but the detailed information for each criterion provided later in these guidelines must be thoroughly consulted to submit a successful application. Please refer to the full criteria in the pages following the Criteria at a Glance to prepare your application.

Organizations must meet five of six domains to be eligible for a recognition level. Domains must be the same across levels (e.g., Silver applicants must apply for five of six domains in Bronze and the same five of six domains in Silver).

	 **Bronze**	 **Silver** All Silver applicants must also complete five of six Bronze domains.	 **Gold** All Gold applicants must also complete five of six Bronze and five of six Silver domains.
ASSESSMENT ***Required at all levels***	☐ Measure burnout at least once in the last three years. **AND** ☐ Share burnout results with individuals eligible to participate in the survey.	☐ Measure burnout at least twice in the last four years. **AND** ☐ Establish targets for improvement in collaboration with executive leadership.	☐ Measure intent to leave at least once in the last two years. Measurement should also assess reasons for leaving.
COMMITMENT ***Required at all levels***	☐ Establish formalized well-being committee or Office of Well-Being. **AND** ☐ Estimate annual costs of burnout to organization and share with executive leadership.	☐ Establish executive leadership position (0.5 FTE) devoted to well-being. **AND** ☐ Share all relevant survey and EHR results (i.e., burnout assessment, teamwork assessments, TWORD, EHR metrics) with executive leadership team.	☐ Develop an organizational strategic plan to address physician well-being.
EFFICIENCY OF PRACTICE ENVIRONMENT	☐ Measure time on EHR via EHR audit data in a minimum of four specialties. **AND** ☐ Share EHR results with specialty leaders.	☐ Normalize two or more EHR metrics to either 8 hours of patient scheduled hours or to appointment volume. **AND** ☐ Actively de-implement/ completely remove at least three administrative burdens that contribute little/no value to care, impede the work of physicians and waste time/ resources.	☐ Normalize EHR8 and WOW8 to 8 hours of patient scheduled hours. **AND** ☐ Implement intervention based on EHR audit results.

CRITERIA AT A GLANCE

	Bronze	Silver	Gold
TEAMWORK	☐ Assess teamwork once within the last two years through a teamwork survey or via staffing data, including staffing ratios for physicians and support staff. Staffing data should also include information on the stability of these teams.	☐ Measure teamwork via Orders with Team Contribution (TW_{ORD}).	☐ Implement intervention based on teamwork assessment and/or Orders with Team Contribution (TW_{ORD}).
LEADERSHIP	☐ Implement a leader listening campaign.	☐ Assess leader behaviors that support physician well-being for all frontline leaders at least once in the last two years. **AND** ☐ Share leader assessment results in a psychologically safe manner with the leaders who were evaluated.	☐ Implement an individualized leader development program based on the individual needs of each leader identified in the leader assessment provided by a survey of their direct reports. Leader development program should help individual leaders develop skills that promote the five core leader behaviors.
SUPPORT	☐ Establish peer support program to deal with adverse events. **AND** ☐ Share the current state of your organization's work to remove invasive questions or stigmatizing language around mental health and substance use disorders in your credentialing applications (initial and renewal) and peer reference forms. Attest to your organization's verification through ALL IN/Dr. Lorna Breen Heroes' Foundation **or** submit an action plan to align your credentialing applications with best practices for removing stigmatizing language around mental health and substance use disorders.	☐ Implement two or more programs or policies aimed at broader issues of physician support.	☐ Develop structured program(s) to actively cultivate community at work. **AND** ☐ Provide access to confidential 24-hour mental health services/support.

Assessment

Well-Being Assessment

BRONZE

Measure burnout in all physicians at least once in the last three calendar years using a validated tool and share results with individuals (e.g., frontline physicians) eligible to participate in the survey. A minimum 20% response rate is recommended by the AMA. Higher response rates provide more representative and applicable findings and may reflect greater organizational commitment.

Provide aggregate findings from your most recent burnout assessment within the last three years and demonstrate that these data are shared transparently with the individuals eligible to participate in the survey. You will be asked to provide the following information in your application:

- Date of most recent assessment
- Response rate of most recent assessment
- Name of validated tool used to measure burnout
- Aggregate mean burnout score or burnout rate for organization. If using the Well-Being Index, please provide the aggregate distress score. Burnout scores should be for physicians specifically, if non-physician providers were also surveyed
- Information on how/when results were shared with individuals eligible to participate in the survey

Your well-being assessment must use a validated tool to assess burnout. The following tools will be accepted in your application: Maslach Burnout Inventory, Stanford Professional Fulfillment Index, Mayo Well-Being Index, Mini-Z Well-Being Assessment, Single-Item Mini-Z Burnout Question (MZSI), or Organizational Biopsy (which includes the Mini-Z). Measuring physician "engagement" is not sufficient for this criterion. Organizations must assess physician burnout specifically.

Supporting documentation:

- Date of most recent assessment.
- Response rate of most recent assessment.
- Name of validated tool used to measure burnout.
- Aggregate mean burnout score or burnout rate for organization. If using the Well-Being Index, please provide the aggregate distress score. Burnout scores should be for physicians specifically, if non-physician providers were also surveyed.
- Description of how results were shared with the individuals eligible to participate in the survey. Please provide details as to how, when and to whom your burnout results were shared within your organization (e.g., in an all-staff meeting).

SEE APPENDIX A FOR SUBMISSION SAMPLES

Learn more about the Organizational Biopsy, the AMA's no-cost assessment tool that includes burnout, teamwork and leadership questions online or reach out to the Organizational Biopsy team at Practice.Transformation@ama-assn.org

Assessment

Well-Being Assessment

SILVER

Measure burnout in all physicians at least twice in the last four years using a validated tool and share results with the individuals (e.g., frontline physicians) eligible to participate in the survey. A minimum 20% response rate is recommended by the AMA. Higher response rates provide more representative and applicable findings and may reflect greater organizational commitment.

Provide aggregate findings from at least two burnout assessments in the last four years and demonstrate that these results are shared transparently with the individuals eligible to participate in the survey. You will be asked to provide the following information in your application:

- Dates of most recent assessments
- Response rates of most recent assessments
- Name of validated tool(s) used to measure burnout
- Aggregate mean burnout scores or burnout rates for organization (per assessment/year). If using the Well-Being Index, please provide the aggregate distress score. Burnout scores should be for physicians specifically, if non-physician providers were also surveyed
- Information on how/when results were shared with the individuals eligible to participate in the survey

Your well-being assessments must use a validated tool to assess burnout. The following tools will be accepted in your application: Maslach Burnout Inventory, Stanford Professional Fulfillment Index, Mayo Well-Being Index, Mini-Z Well-Being Assessment, Single-Item Mini-Z Burnout Question (MZSI), or Organizational Biopsy (which includes the Mini-Z). Measuring physician "engagement" is not sufficient for this criterion. Organizations must assess physician burnout specifically.

AND

CONTINUED ON NEXT PAGE

Supporting documentation:

- Dates of most recent burnout assessments.
- Response rates of most recent assessments.
- Name of validated tool(s) used to measure burnout.
- Aggregate mean burnout scores or burnout rates for organization (per assessment/year). If using the Well-Being Index, please provide the aggregate distress score. Burnout scores or rates should be for physicians specifically, if non-physician providers were also surveyed.
- Description of how results were shared with the individuals eligible to participate in the survey. Please provide details as to how, when and to whom your burnout results were shared within your organization (e.g., in an all-staff meeting).
- Articulate three improvement goals/targets. You must also include a summary (2-3 sentences) of how your organization established its targets.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Assessment

Well-Being Assessment

SILVER

CONTINUED FROM PREVIOUS PAGE

In collaboration with the executive team, set three targets for improvement (e.g., establish well-being directors in six of the largest clinical departments). Improvement targets should focus on goals that are aimed toward reducing physician burnout.

Articulate improvement goals/targets. Improvement targets should be future state, not work that has already been completed. You must also include a summary (2-3 sentences) of how your organization established its target for improvement. This summary should explicitly state how your executive team was involved in the development of these targets. Improvement targets may be quantifiable (e.g., decrease documentation time by 10%) or process-focused (e.g., establish wellness leaders in all departments by end of year) but should clearly focus on reducing physician burnout. If global targets are developed to address other members of the care team, physicians should still be measured as a component. For example, if training up all medical assistants is a target, reducing physician burnout should still be explicitly stated as an intended outcome and information about how physician well-being will be measured should be included in your summary. Providing additional EHR training for physicians or providing individually focused wellness activities, such as mindfulness or yoga, would not qualify. Please see Appendix A for submission samples.

Learn more about the Organizational Biopsy, the AMA's no-cost assessment tool that includes burnout, teamwork and leadership questions online or reach out to the Organizational Biopsy team at Practice.Transformation@ama-assn.org

Assessment

Well-Being Assessment

GOLD

Measure intent to leave at least once in the last two years. Measurement should also assess reasons for leaving. A minimum 20% response rate is recommended by the AMA. Higher response rates provide more representative and applicable findings and may reflect greater organizational commitment.

Provide aggregate work intentions findings from assessment completed in the last three years. Findings should include results related to intention to leave current organization and assess reasons for leaving. Please report physician data separate from non-physician provider data if non-physician providers were also surveyed.

Intent to leave questions are accepted from the Organizational Biopsy, or by including the intent to leave questions included in the Appendix B in your annual assessment. If you use a different set of questions to measure work intentions, please provide these questions in your application.

Supporting documentation:

- Instrument used to measure intent to leave. If you used questions other than those in the Organizational Biopsy (see Appendix B) please provide the question(s) used to measure work intentions.
- Provide summary of intent to leave results from at least one assessment in the last three years. Summary should include reasons **why** people intend to leave.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Learn more about the Organizational Biopsy, the AMA's no-cost assessment tool that includes burnout, teamwork and leadership questions online or reach out to the Organizational Biopsy team at Practice.Transformation@ama-assn.org

Commitment

Organizational Commitment

BRONZE

Develop a formalized physician well-being committee and/or Office of Well-Being.

Documents related to your well-being committee should clearly define the following: committee composition and structure (committee members and their roles), key objectives of committee, scope of committee, cadence of committee meetings and reporting structure of committee. Committees should have a defined cadence of meetings over the year and committees that are focused solely on impaired physicians will not be accepted for this criterion.

Documents related to an Office of Well-Being should clearly define the following: staffing, composition and structure (including staff names and roles), staff responsibilities, primary goals of the Office of Well-Being, scope and reporting structure.

Your well-being committee and/or Office of Well-Being must be separate from other employee assistance or corporate wellness programs you may have.

AND

Estimate the annual costs of burnout at your organization and share these results with the executive leadership team.

Please use the AMA's "Organizational Cost of Physician Burnout" calculator to estimate costs of burnout based on your current burnout and turnover rates. Please provide information on when and how these results were shared with your full executive leadership team. Results should be shared with the entirety of your executive leadership team or Board (including the CEO). It is not sufficient to have an individual member of the leadership team solely aware of the data. Results are best shared in a meeting where discussion, reflection and action planning can take place.

Supporting documentation:

- Provide a summary of your well-being committee and/or Office of Well-Being.
- Estimated costs of burnout at your organization as an annual dollar value.
- Description of how estimated costs of burnout were shared with your full executive leadership team or Board (including the CEO). Please provide details as to how, when and to whom results were shared.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Commitment

Organizational Commitment

SILVER

Establish an executive leadership position (at least 0.5 FTE) that is directly responsible for physician well-being.

The 0.5 FTE allocation should be devoted to well-being and not a more generic role within medical administration. Role may also include oversight on operational optimization and change management. This individual must report directly to a C-suite leader (e.g., CEO, CMO). The 0.5 FTE allocation cannot be split across multiple individuals or multiple roles.

AND

Share all well-being metrics from the Bronze and Silver criteria included in your application with the executive leadership team and/or Board of Directors in a meeting where results can be discussed.

Results from all surveys noted in Bronze and Silver as applicable should be included in this discussion, including burnout assessment results, teamwork survey results, metrics, TW_{ORD} results, etc. Results are best shared with the entirety of your executive leadership team or Board (including the CEO). It is not sufficient to have an individual member of the leadership team solely aware of the data. Results should be shared in a meeting where discussion, reflection and action planning can take place (sharing results via email is not sufficient).

Supporting documentation:

- Provide name of individual in executive leadership position, FTE allocation for time related to well-being work, job description and reporting structure.
- Summary of how and when well-being metrics were shared with executive leadership and/or Board of Directors. Leadership should include the executive leadership or Board as a whole. Please clearly denote which metrics were shared.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Commitment

Organizational Commitment

GOLD

Develop an organizational physician well-being strategic plan. Strategic plan should be focused on system interventions to improve physician well-being, not on addressing individual wellness.

The strategic plan should have a coherent vision, mission and tactics as well as clear indicators for how it fits within the broader organizational strategic plan. This plan should not solely be a set of tactics.

Your strategic plan for physician well-being must be approved by leadership and integrated into the organization. Your submission should clearly define well-being goals and tactics for your organization and the resources required to reach stated goals. Your strategic plan should include systems-level issues that you are addressing. Strategic plans that do not address systemic or structural issues on physician workflows, technologies and culture will not be accepted. Submissions should also include staffing information for your well-being efforts. For example, if your organization has an Office of Well-Being, how many staff members (with FTE allocation) do you employ? What are their roles? Are there others in the organization with FTE allocation to specifically support organizational well-being, such as department level well-being directors?

Supporting documentation:

- Provide a copy of organization's formal strategic plan to support physician well-being. The plan should have clearly stated objectives, resources required to achieve goals (e.g., staff) and key metrics.

Due to confidentiality issues, we are unable to provide anonymized submission samples from previous applicants for the Gold-level Commitment criterion.

Efficiency of Practice Environment

EHR Metrics and Efficiency

BRONZE

Measure physician time (within a minimum of four specialties) on the EHR via EHR audit log data. Measurement must use one or more of the following metrics: Time on Inbox (IB-Time), Time on Encounter Note Documentation (Note-Time), Total EHR Time (EHR-Time), or Work Outside of Work (WOW).

Applicants are encouraged to partner with their Chief Medical Informatics Officer and informatics team to review these metrics. Measurement should be completed for physicians within at least four specialties and results should be reported by specialty, not in aggregate. This should include family medicine and general internal medicine if these specialties are represented in your system. Each specialty should include at least 30% of the physicians within that specialty for the calculation (e.g., if you have 100 family medicine physicians, a minimum of 30 should be included in the aggregated calculations as part of your submission). If you have fewer than four specialties within your organization, the entire physician population should be analyzed and reported in your application.

Applicants are asked to leverage existing audit log data and calculate one or more of the above metrics. Formulas for calculating these metrics and normalizing them to 8 hours of patient scheduled hours for Epic or Oracle Health (formerly Cerner) can be found in Appendix C. You may also see Table 2 in this article in the Journal of American Medical Informatics Association. Instructions for requesting direct support from Epic to provide a Joy in Medicine data extract report for this criterion can also be found in Appendix C. Please note that "Work Outside of Work" is not synonymous with what may be labeled as "pajama time" or even "work outside of work" or "after hours work" in the off-the-shelf metrics of the EHR. If using the Work Outside of Work (WOW) metric, organizations must use time outside of patient scheduled hours, not clock time (i.e., 7 a.m. to 7 p.m.) to define WOW.

CONTINUED ON NEXT PAGE

Supporting documentation:

- Summary of organization's EHR results. Summary should include number of physicians in audit, specialties audited and a summary of results reported by specialty. Please include results for a minimum of four specialties. Internal medicine and family medicine must be included if they exist in your organization.
- Summarize methodology for calculating one or more of the metrics outlined in the criteria for EHR activity. If your organization uses an EHR other than Epic or Oracle Health (formerly Cerner), please include information on how your EHR calculated these metrics using the audit log data.

SEE APPENDIX A FOR SUBMISSION SAMPLES

SEE APPENDIX C FOR EHR DATA EXTRACTION INSTRUCIONS

Efficiency of Practice Environment

EHR Metrics and Efficiency

BRONZE

CONTINUED FROM PREVIOUS PAGE

If you use an EHR other than Epic or Oracle Health (formerly Cerner), please provide the metric that most closely aligns with those above and information about how that metric is calculated in your EHR and how the vendor metric has been modified to meet the intention of capturing work that occurs outside of patient scheduled hours. Please also tell us how your WOW metric adjusts for physicians who work less than full time for whom work on a weekday during business hours may still be Work Outside of Work.

AND

Share EHR metric summaries with specialty leaders (e.g., Department Chairs).

Please clearly denote which specialty leaders were provided with your EHR metric results. Results are best shared in a meeting where discussion, reflection and action planning can take place.

Supporting documentation continued:

- Summary of how and when EHR results were shared with specialty leaders. This should include names of specialty leaders and description of how results were shared with them. Results should be actively shared with them (i.e., simply stating that a dashboard is available to them will not be accepted for this criterion). If results are shared via dashboard, please also include information about how leaders are able to discuss these results and are incentivized to improve.

Efficiency of Practice Environment

EHR Metrics and Efficiency

SILVER

Measure physician time (within a minimum of four specialties) on the EHR via EHR audit log data and normalize two or more of the following metrics to either 8 hours of patient scheduled hours or to appointment volume: Time on Inbox ($IB\text{-}Time_8$), Time on Encounter Note Documentation ($Note\text{-}Time_8$), Total EHR Time (EHR_8), or Work Outside of Work (WOW_8).

Applicants are encouraged to partner with their Chief Medical Informatics Officer and informatics team to review these metrics. Measurement should be completed for physicians within at least four specialties and results should be reported by specialty, not in aggregate. This should include family medicine and general internal medicine if these specialties are represented in your system. Each specialty should include at least 30% of the physicians in that specialty for the calculation (e.g., if you have 100 family medicine physicians, a minimum of 30 should be included in the aggregated calculations as part of your submission). If you have fewer than four specialties within your organization, the entire physician population should be analyzed.

The AMA recommends the normalization to 8 hours of patient scheduled hours to account for part-time physicians. This normalization ensures that part-time physicians are accurately counted and do not skew the data. If you are unable to normalize these metrics to the recommended 8 hours of patient scheduled hours, please share your methodology for normalizing your measures to account for part-time physicians. The AMA may be unable to accept your methodology if it does not accurately account for part-time clinical physicians.

Formulas for calculating these metrics and normalizing them to 8 hours of patient scheduled hours for Epic or Oracle Health (formerly Cerner) can be found in Appendix C. You may also see Table 2 in this article in the Journal of American Medical Informatics Association. Instructions for requesting direct support from Epic to provide a Joy in Medicine data extract report for this criterion can also be found in Appendix C.

CONTINUED ON NEXT PAGE

Supporting documentation:

- Summary of organization's EHR audit results for at least two metrics in a minimum of four specialties. Summary should include number of physicians in audit, specialties audited and a summary of results reported by specialty. Internal medicine and family medicine must be included if they exist in your organization.
- Summary and rationale of methodology used to normalize metrics to account for part-time clinical physicians.

SEE APPENDIX A FOR SUBMISSION SAMPLES

SEE APPENDIX C FOR EHR DATA EXTRACTION INSTRUCIONS

Efficiency of Practice Environment

EHR Metrics and Efficiency

SILVER

CONTINUED FROM PREVIOUS PAGE

If using Work Outside of Work (WOW_8), please note that organizations must normalize the metric to time outside of patient scheduled hours or appointment volume, not clock time (i.e., 7 a.m. to 7 p.m.) to define WOW_8. Normalization to "workday" is also not sufficient.

If you have not normalized these metrics to 8 hours of patient scheduled hours, please tell us how you normalized your measures to account for part-time physicians. If you use an EHR other than Epic or Oracle Health (formerly Cerner), please provide the metric that most closely aligns with those above and include information about how the metric is calculated in your EHR (in addition to your normalization methodology).

AND

Actively de-implement/completely remove three specific administrative burdens that contribute little or no value to care, impede the work of physicians and waste time/resources. These initiatives should be focused on removing administrative burdens that provide little or no clinical value, not simply workflow optimization efforts such as delegation of task work from the physician to another care team member.

Initiatives that focus solely on providing education or proficiency training to physicians will also not count for this criterion. The intent of this criterion is that organizations will fully de-implement or remove cumbersome and unnecessary policies or tasks. Initiatives should not reassign or delegate work to other care team members.

See the AMA's De-implementation Checklist, Inbox Reduction Checklist, or the Getting Rid of Stupid Stuff Toolkit for guidance. Please provide a specific example of each activity. This can include a local-level initiative within a department or division or a system-wide improvement effort. These examples should go beyond workflow optimization efforts. Rather, they should seek to de-implement or completely remove burdens that provide no value to care.

CONTINUED ON NEXT PAGE

Supporting documentation continued:

- Provide summary of at least three administrative burdens you are actively working to de-implement/completely remove. Please be as specific as possible: What burdens are you addressing? How are you addressing them? What challenges do you continue to face in doing so? Please provide a specific example of each activity. This can include a local-level initiative within a department or division or can include a system-wide improvement effort.

Efficiency of Practice Environment

EHR Metrics and Efficiency

SILVER

CONTINUED FROM PREVIOUS PAGE

Some examples may include:

- Decreasing password-related burdens in the EHR
- Minimizing alerts
- Reducing note bloat (i.e., reducing the number of embedded links in a visit note documentation that automatically pull in from other parts of the EHR that provide little to no clinical value)
- Reducing signature requirements
- Evaluating required annual training and attestations

Efficiency of Practice Environment

EHR Metrics and Efficiency

GOLD

Measure total physician time on the EHR (EHR_8) and Work Outside of Work (WOW_8) within at least four specialties, including family medicine and general internal medicine, normalized to 8 hours of patient scheduled hours.

Applicants are encouraged to partner with their Chief Medical Informatics Officer and informatics team to review these metrics. Measurement should be completed for physicians within at least four specialties and results should be reported by specialty, not in aggregate. This should include family medicine and general internal medicine if these specialties are represented in your system. Each specialty should include at least 30% of the physicians in that specialty for the calculation (e.g., if you have 100 family medicine physicians, a minimum of 30 should be included in the aggregated calculations as part of your submission). If you have fewer than four specialties within your organization, the entire physician population should be analyzed.

Formulas for calculating these metrics and normalizing them to 8 hours of patient scheduled hours for Epic or Oracle Health (formerly Cerner) can be found in Appendix C. You may also see Table 2 in this article in the Journal of American Medical Informatics Association. Instructions for requesting direct support from Epic to provide a Joy in Medicine data extract report for this criterion can also be found in Appendix C. If using Work Outside of Work (WOW_8), please note that organizations must use time outside of patient scheduled hours, not clock time (i.e., 7 a.m. to 7 p.m.) to define WOW. Normalization to "workday" is also not sufficient. If you use an EHR other than Epic or Oracle Health (formerly Cerner), please provide the metric that most closely aligns with those above and include information about how the metric is calculated in your EHR (in addition to your normalization methodology).

AND

CONTINUED ON NEXT PAGE

Supporting documentation:

- Summary of organization's EHR_8 and WOW_8 results, normalized to 8 hours of patient scheduled hours. Summary should include number of physicians in audit, specialties audited and a summary of results reported by specialty. Internal medicine and family medicine must be included if they exist in your organization.
- Summary of intervention. Summary should include overview of intervention, target group, length of intervention and any improvements or challenges you have experienced throughout the intervention. Summary should also include pre- and post-results of the intervention.

SEE APPENDIX A FOR SUBMISSION SAMPLES

SEE APPENDIX C FOR EHR DATA EXTRACTION INSTRUCIONS

Efficiency of Practice Environment

EHR Metrics and Efficiency

GOLD

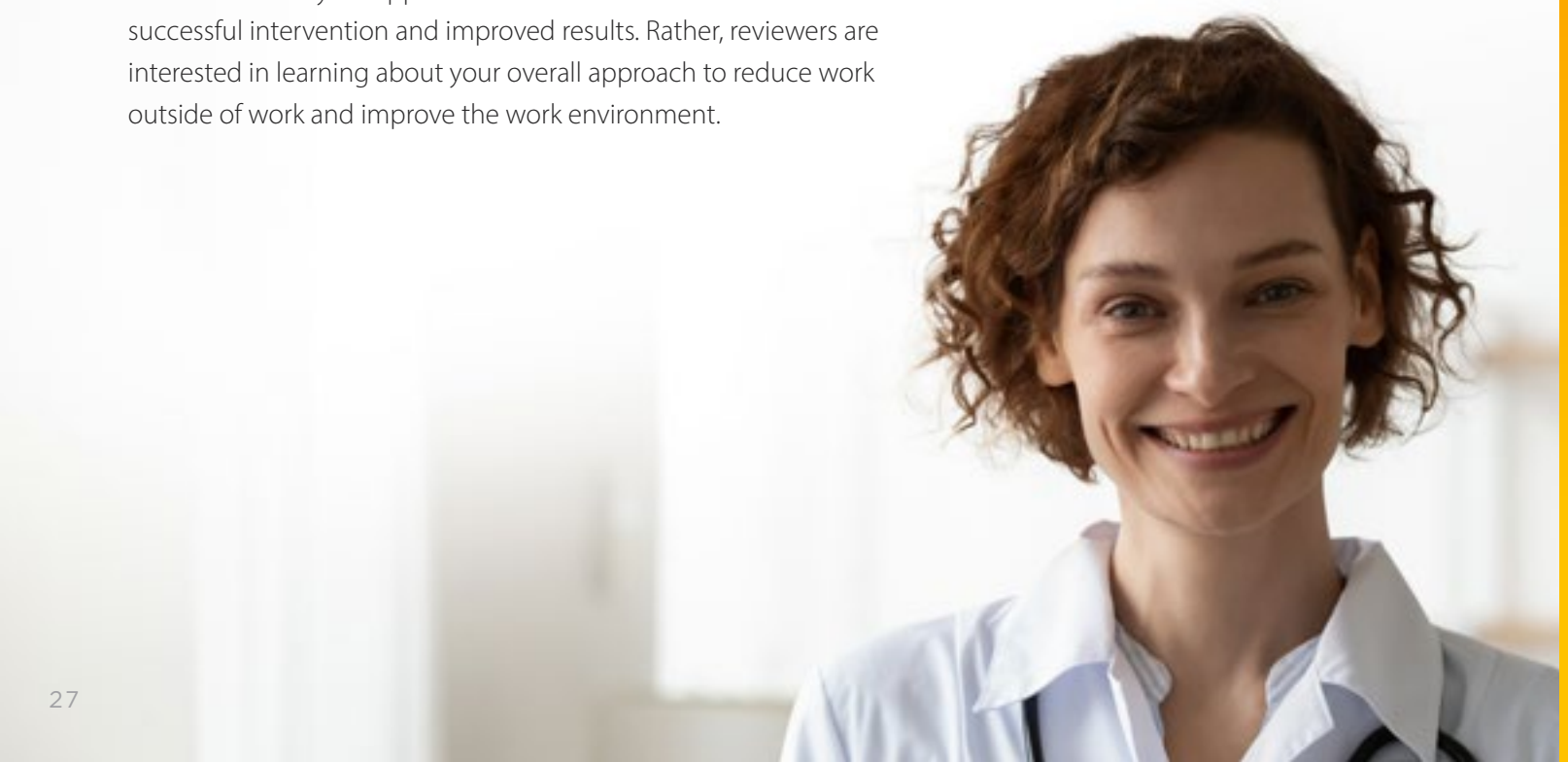
CONTINUED FROM PREVIOUS PAGE

Develop and implement an intervention based on results from EHR metrics.

Please note that the chosen intervention cannot be based solely on an EHR training program. The goal of this criterion is not to train physicians to be more proficient EHR users. Rather, it is to change the work environment so that fewer tasks are required of the physician. Examples might include improving teamwork, task delegation, or changes to the EHR software itself that improves WOW[8], EHR[8], or Note-Time[8]. These are all things that can positively affect the work environment. This intervention should be distinct from the intervention submitted for the Teamwork criterion at the Gold level.

We kindly ask that you do not provide a list of all improvement efforts that are in development. Rather, this criterion should be focused on a specific intervention in advanced stages that has been executed (with data to measure its effectiveness) to support improved practice efficiency. Details should include: short description of intervention and rationale, date of intervention and both pre- and post-results.

Please note that your application will not be reviewed based on successful intervention and improved results. Rather, reviewers are interested in learning about your overall approach to reduce work outside of work and improve the work environment.



Teamwork

Team-Based Care

BRONZE

Measure teamwork once within the last two years in at least four specialties (e.g., family medicine, internal medicine, pediatrics). Teamwork assessment should measure at least three of the following components: team structure, team function, team stability, barriers to teamwork, or collegiality. Teamwork questions should go beyond generic safety questions or collegiality questions and should seek to better understand how teams operate and the systems barriers to better collaboration, delegation and support. Additional information on these categories is included below. In lieu of teamwork survey, organizations may also submit actual staffing ratios, staff training levels and team stability information for at least four specialties.

The intent of the teamwork assessment is to measure operational aspects of teamwork and shared work. It is not enough to simply ask about collegiality or cooperation across departments, nor is it enough to ask a generic question such as, "Is there teamwork in this organization?" Reviewers will specifically want to see questions that address staffing, delegation, team consistency and cooperation. See definitions below.

Organizations may use one of the listed instruments below or a similar instrument:

- Organizational Biopsy (see Appendix B)
- AHRQ's TeamSTEPPS assessment (must include team structure, mutual support and communication subscales)
- Safety Attitudes Questionnaire (SAQ) (at least three of the six domains of the SAQ must be used)
- One of AHRQ's Surveys on Patient Safety Culture (SOPS) (must include at least five of the composite measures from the tool, including the teamwork composite measure)
- Healthcare Professional Well-Being Academic Consortium (PWAC) teamwork survey

Supporting documentation:

- Provide name of instrument and/or list of questions used to assess at least three of the teamwork domains (team structure, team function, team stability, barriers to teamwork or collegiality).
- Summary of teamwork results by specialty (please include a minimum of four specialties).
- If you have chosen to submit staffing data in lieu of a teamwork survey, you will be asked to submit actual staffing data for at least four ambulatory specialties, including family medicine and internal medicine.

SEE APPENDIX A FOR SUBMISSION SAMPLES

CONTINUED ON NEXT PAGE

Teamwork

Team-Based Care

BRONZE

CONTINUED FROM PREVIOUS PAGE

Whether your organization uses one of the listed instruments above or a similar instrument, you will be asked to share the questions used in your assessment, mapped to at least three of the corresponding required teamwork components. This mapping should be done by your organization. Please note that AMA staff is unable to provide this mapping or pre-approve measurement tools ahead of your application. It is not enough to simply ask about collegiality or cooperation across departments, nor is it enough to ask a generic question such as, "Is there teamwork in this organization?" Reviewers will specifically want to see questions that address staffing, delegation, team consistency and cooperation. See definitions below.

Measurement should be completed for physicians within a minimum of four specialties and results should be reported by specialty, not in aggregate. Family medicine and general internal medicine should be included if these specialties are represented within your organization. If you have fewer than four specialties within your organization, the entire physician population should be analyzed.

In lieu of a teamwork survey, organizations may choose to submit actual staffing data for at least four ambulatory specialties, including family medicine and internal medicine. Data must include current staffing ratios of physicians and support staff (nurses and medical assistants), staff training levels (e.g., MA vs. RN) and stability of their staffing model (e.g., "majority of physicians work with the same medical assistant or nurse every day.") If your staffing ratios and training levels vary by clinic, please include data for the three largest ambulatory locations.

Learn more about the Organizational Biopsy, the AMA's no-cost assessment tool that includes burnout, teamwork and leadership questions online or reach out to the Organizational Biopsy team at Practice.Transformation@ama-assn.org

Teamwork

Team-Based Care

BRONZE

Definitions of teamwork categories:

- Team structure: Questions that assess the ratio of clinical support staff (i.e., nurse or medical assistant) to physicians in the ambulatory clinic. (i.e., "In Family Medicine there is 1.5 MA:MD and 0.5 RN:MD")
- Team stability: Questions that assess the consistency of the team (e.g., do physicians work with the same nurse(s) or medical assistant(s) every day?)
- Team function: Questions that assess shared work and task delegation among team members.
- Barriers to teamwork: Questions that assess systemic issues that get in the way of shared work, task delegation and cooperative teamwork.
- Collegiality: Questions that assess cooperation and companionship between colleagues that share responsibilities.

Teamwork

Team-Based Care

SILVER

Measure Orders with Team Contribution (TW_{ORD}) in a minimum of four specialties (must include family medicine and general internal medicine) via EHR within the last two years. Share results with frontline physicians from each specialty included in measurement.

Team-based care can reduce physician burnout. Team-based ordering workflows can have positive impacts on time-savings, patient volume, and more. Research has shown that lower rates on Orders with Team Contribution is associated with physician departure, indicating that teamwork may help prevent physician turnover. A recent study also suggests a spillover effect related to team-based ordering, showing that physicians with higher Orders with Team Contribution also have decreases in time on documentation, chart review, inbox time, and other dimensions of EHR usage. Team-based ordering offers a measurable element of teamwork to support physicians. There is also evidence that the team has higher capacity when there is more TW_{ORD} (as measured by higher wRVUs).

Formulas for calculating TW_{ORD} using audit log data from Epic or Oracle Health (formerly Cerner) can be found in Appendix C. Measurement should be completed for physicians within a minimum of four specialties. Each specialty should include at least 30% of the physicians in that specialty for the calculation (e.g., if you have 100 family medicine physicians, a minimum of 30 should be included in the aggregated calculations as part of your submission). If you have fewer than four specialties within your organization, the entire physician population should be analyzed.

If you use an EHR other than Epic or Oracle Health (formerly Cerner), please provide the metric that most closely aligns with those above and include information about how the metric is calculated in your EHR.

Supporting documentation:

- Summary of organization's TW_{ORD} results from EHR audit. Summary should include number of physicians in audit, specialties audited and a summary of results reported by specialty. Do not upload actual data files. Internal medicine and family medicine must be included if they exist in your organization.
- Share methodology for calculating Orders with Team Contribution

SEE APPENDIX A FOR SUBMISSION SAMPLES

Teamwork

Team-Based Care

GOLD

Develop and implement an intervention to improve teamwork based on results from teamwork assessment and/or TW_{ORD} results. Intervention should focus on improving teamwork but need not be exclusively focused on improving Orders with Team Contribution.

This criterion should be focused on specific interventions in advanced stages that have been executed (with data to measure their effectiveness) to support improved teamwork and practice efficiency. The intervention should be primarily focused on improving team-based workflows, not simply on team building exercises. Interventions that simply provide physician education, peer safety coaching or leader rounding will not be accepted. Rationale for intervention should be rooted in data from the assessment and EHR. Details should include a short description of intervention, rationale for intervention, date of intervention and both pre- and post-results. **This intervention should be distinct from the intervention submitted for the Efficiency of Practice Environment criterion at the Gold level.**

We kindly ask that you do not provide a list of all improvement efforts that are in development. Please note that your application will not be reviewed based on successful intervention and improved results. Rather, reviewers are interested in learning about your overall approach to reduce work outside of work and improve the work environment.

Supporting documentation:

- Summary of intervention. Summary should include overview of intervention, its intended impact on teamwork, target group, length of intervention and any improvements or challenges you have experienced throughout the intervention. Summary should also include both pre- and post-results of the intervention.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Leadership

Wellness-Centered Leadership and Leader Development

BRONZE

Implement a leader listening campaign to engage frontline physicians to uncover and address sources of burnout. The listening campaign should occur within the last 18 months.

Listening campaign should include one or more listening sessions and should be focused on learning insights related to systemic factors that negatively affect the day-to-day work experience of frontline physicians. Listening campaign should clearly engage frontline physicians, not just leaders. While the design of the listening campaign(s) may vary, reviewers will be seeking campaigns that provide an opportunity for frontline physicians to share feedback directly with leaders. Helpful tips for how to conduct a listening campaign inside your organization can be found in the AMA's "Listening Campaign Toolkit." Listening campaign can be conducted at either a unit or executive level **but it must be separate and distinct from regularly-occurring department meetings**.

Supporting documentation:

- Provide brief (3-5 sentences) narrative summary of listening campaign. Summary should include: who led the listening campaign, when the listening campaign took place, topics discussed in the listening campaign, who was invited to attend the listening sessions and key insights learned from the listening campaign.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Leadership

Wellness-Centered Leadership and Leader Development

SILVER

Measure core wellness-centered leader behaviors in all frontline leaders at least once in the last two years.

Assessment of leaders should be completed by the physicians who report to the leader, not the general administration of the organization. Leader assessment should clearly ask about a specific person and results should be identifiable back to that leader (e.g., "My **direct supervisor** supports me in my work"). Individual assessment results should be shared back with the individual leader. Assessment should measure the five core leader behaviors and should go beyond generic leadership questions. These questions should be aimed at understanding how leaders support their direct reports and should clearly map to the following five core leader behaviors, as outlined below:

- Include: Treat everyone with respect and nurture a culture where all are welcome and ensure team members feel comfortable with words, body language and actions
- 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

Organizations may use the Mayo Leadership Index, Organizational Biopsy (see Appendix B) or similar instrument. Whether your organization uses one of the listed instruments above or a similar instrument, you will be asked to share the questions used in your assessment, mapped to the five core leader behaviors. This mapping should be done by your organization. Please note that AMA staff is unable to provide this mapping or pre-approve measurement tools ahead of your application.

CONTINUED ON NEXT PAGE

Supporting documentation:

- Provide name of instrument and list of questions used to assess five core leader behaviors that support physician well-being.
- Summary of leader assessment results by specialty. Please include a minimum of four specialties. Family medicine and general internal medicine should be included if they are represented in your organization.
- Summary of how and when leader assessment results were shared in a psychologically safe manner with leaders who were evaluated.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Leadership

Wellness-Centered Leadership and Leader Development

SILVER

CONTINUED FROM PREVIOUS PAGE

Results should be reported to the AMA within at least four specialties and results should be shared by specialty, not in aggregate. Family medicine and general internal medicine should be included if they are represented in your system.

AND

Share leader assessment results in a psychologically safe manner with the leaders who were evaluated.

The evaluated leaders should receive their results in a psychologically safe manner. Ideally, unit leaders will confidentially receive their results from a senior leader with whom they have an ongoing relationship. The senior leader can provide personal feedback on individual leader evaluations. Evaluated leaders should work with senior leaders to develop an action plan to improve these scores in the upcoming year (see Gold criterion). For more information, please see the AMA's Wellness-Centered Leadership Playbook.

Leadership

Wellness-Centered Leadership and Leader Development

GOLD

Implement an individualized leadership development program and/or action plan based on the individual needs of each leader identified through the leadership survey. Individualized programs should support leader in improving their wellness-centered leadership competencies.

This individualized program should include content that supports leaders in building skills for managing people and relationships, managing teams, communication, change management, fostering a productive work environment and guiding physicians' careers. This program should not solely focus on the business of health care. Rather, it should support leaders in developing the five core leader behaviors that support physician well-being. Additionally, your application should make clear how the leadership training is individualized based on the feedback leaders have received from their direct reports. For example, it should clearly show how leaders with low leadership scores are offered activities, such as coaching and leadership classes, to improve those scores and develop individualized follow-up plans for each question. The intent of this criterion is to support existing leaders in improving wellness-centered leadership skills and behaviors. It is not simply to offer pathways for non-leaders to become leaders within the organization. Importantly, this individualized training should be available to all existing leaders, not a select group.

Illustrative example of leadership development program:

A leader received low scores on her leadership assessment, specifically as it pertained to offering development opportunities for her direct reports and regularly soliciting input from her team. Based on that feedback, the leadership development team coordinated various approaches to help the leader with her development. This included leadership coaching (including role playing how to hold career conversations with team members), leadership classes and operational support. This leader also built in goals to her annual review related to holding listening sessions with her team quarterly to regularly receive input about team decisions. One year later, direct reports completed the leadership assessment again. This year, all of this leader's scores had improved.

Supporting documentation:

- Provide a summary of how leaders receive individualized feedback about their survey results.
- Provide a summary of how leaders receive individualized coaching and/or development based on their suboptimal scores.
- Provide an illustrative example of this individualized leadership development program. See example provided to the left.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Support

Organizational Support for Individual Resiliency

BRONZE

Implement a peer support program to support physicians after adverse clinical events.

Peer support program(s) should specifically show peers supporting peers and should include a description of how peer supporters are trained to respond to physicians after an adverse event. Program should be launched and in use at least six months prior to the application deadline. Employee assistance programs (EAPs) are not sufficient for this criterion.

AND

Share the current state of your organization's work to remove invasive questions or stigmatizing language around mental health and substance use disorders in your credentialing applications (initial and renewal) and peer reference forms.

If your organization has previously worked with ALL IN: Wellbeing First for Healthcare, a coalition led by the Dr. Lorna Breen Heroes' Foundation, to remove overly invasive mental health questions from your credentialing applications and peer reference forms, you will simply be asked to attest to verification through ALL IN/Dr. Lorna Breen Heroes' Foundation. AMA staff will confirm your verification with ALL IN. You will be asked to provide the date that these new credentialing applications were implemented. These credentialing applications should be in use at all hospitals/medical centers within your health system. Please only select this option in your Joy in Medicine application if verification from ALL IN is complete.

If you have not received verification of your credentialing application(s) through ALL IN, please submit an action plan to align your credentialing applications with best practices for removing stigmatizing language around mental health and substance use disorders. This plan should include a summary of barriers your organization has faced in updating your credentialing questions, if relevant.

CONTINUED ON NEXT PAGE

Supporting documentation:

- Provide summary description of peer support program as it relates to dealing with adverse clinical events. Your description should include how long your program has been in place and details about how the program operates within your system, including how peer supporters are trained.
- Attest that you have worked with ALL IN and the Dr. Lorna Breen Heroes' Foundation to update your credentialing applications and peer reference form **or** submit a one-page action plan that outlines how you plan to address the removal of stigmatizing questions and language in your credentialing applications and peer reference form.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Support

Organizational Support for Individual Resiliency

BRONZE

CONTINUED FROM PREVIOUS PAGE

This plan should also include information on the stakeholders from your organization that need to be engaged to make changes in addition to tentative timelines for changing these questions.

Resources for aligning credentialing applications with best practices and pursuing future verification through ALL IN:

- Your organization's approach to changing language may differ from others but the changes should remove stigmatizing or invasive language around mental health and substance use disorders and should refrain from asking physicians and other credentialed medical staff about past treatment or experiences with mental health and substance use disorder treatment.
- Recommendations for changes can be found in the Wellbeing First Champion Challenge toolkit available for free when logging in to the Dr. Lorna Breen Heroes' Foundation website. For first-time login, please select "I'm here for the Credentialing Toolkit."
- Additional information can also be found through the AMA's Debunking Regulatory Myths series, the AMA Advocacy Resource Center issue brief, "Campaign to support medical student, resident and physician health and wellbeing," and the National Institute for Occupational Safety and Health (NIOSH) supportive statement.
- If you have not yet worked with ALL IN and the Dr. Lorna Breen Heroes' Foundation but feel that your credentialing applications (initial and renewal) and peer reference forms are aligned with current recommendations to remove overly invasive, broad, or stigmatizing language around mental health, we invite you to submit your information for verification through the Wellbeing First Champion Challenge program. For first-time login, please select "I'm here for the Credentialing Toolkit." ALL IN and the Foundation have legal experts available to assist your organization in ensuring that your credentialing applications and peer reference forms align with best practices.

Support

Organizational Support for Individual Resiliency

SILVER

Implement two or more programs or policies aimed at broader issues of physician support beyond adverse clinical events. This can include proactive planning for support during a crisis (e.g., pandemics, natural disasters, violence against staff, etc.).

Basic HR policies for childbirth or caregiver leave will not fulfill this criterion, nor will workflow improvements such as providing technology-assisted documentation. You will also be asked to include usage data for programs, where applicable.

Some examples may include:

- Create a plan in coordination with hospital incident command system leadership to proactively respond during times of crisis
- Develop a policy in select specialties for inbox/patient portal cross-coverage so physicians do not feel pressure to work on their inbox while on vacation
- New PTO/vacation policies that incentivize usage. Please note: Standard HR policies, such as maternity or caregiver leave, will not count for this criterion
- Other examples based on information collected through organizational assessments and survey feedback

For more strategies to help physicians and other leaders build a culture of wellness and work-life integration, please see The Value of Feeling Valued Playbook.

Supporting documentation:

- Provide description for at least two programs or policies that have been implemented to support physicians beyond adverse clinical events. Organizations are encouraged to provide more than two examples in their application such that reviewers have additional programs to consider in scoring this criterion. Description should include rationale for implementation of policy or program, relevant details for the program and how long the program or policy has been enacted. Program usage data should also be included, where applicable.

SEE APPENDIX A FOR SUBMISSION SAMPLES

Support

Organizational Support for Individual Resiliency

GOLD

Develop and implement a program that actively engages physicians to cultivate community at work and allow for deeper social connections between team members.

The intent of this criterion is to foster community building for the physician population. Reviewers will not accept programs that are in place for other reasons (e.g., response to an adverse event) and re-purposed for the sake of this criterion. The program(s) submitted for this category should clearly show how they are being used to foster community. Periodic virtual forums will also not be accepted in this category.

Some examples may include:

- COMPASS physician dinners
- Developing meeting and/or breakroom spaces and providing lunch and dinner for physicians to connect with one another throughout their shifts

AND

Provide access to 24/7 mental health services/support.

Briefly describe how your organization provides access to 24/7 confidential mental health services. These services must clearly offer immediate, confidential support to physicians. These services must allow physicians to seek mental health support without the fear or undue repercussions to their career and/or medical license. These services must also allow the physician to speak directly with a behavioral health counselor either virtually or in-person. Relaxation or meditation apps will not count.

Supporting documentation:

- Summary description of how your organization actively engages physicians to cultivate community at work (please be specific) and include rationale for implementation of programs (e.g., needs assessment).
- Brief description of how your organization provides access to 24/7 confidential mental health services.

Due to confidentiality issues, we are unable to provide anonymized submission samples from previous applicants for the Gold-level Support criteria.

Appendix A:
Submission Samples

Assessment BRONZE SILVER
Burnout Assessment Information

Most recent burnout assessment:

- **Date:** June 2025
- **Survey instrument:** Mini-Z
- **Response rate:** 56%
- **Burnout score:** 42% of physicians were burned out
- **When/how results were shared:** The results of our annual burnout assessment are shared in a variety of forums. First, an overview of the aggregated data is shared with the executive leadership team and then with all employees via a quarterly town hall. This town hall includes remarks from our CEO and CMO and includes a separate Q&A session for attendees. The aggregate data are also shared on our intranet website so that physicians can re-review the data when needed. Additionally, department chairs are provided with specialty-specific reports within 90 days of the survey closing. Our Office of Well-Being walk through specialty-specific reports with department leadership and asks them to share their specific reports with their teams in upcoming staff meetings for action planning and transparency.

Second most recent burnout assessment:

- **Date:** April 2024
- **Survey instrument:** Mini-Z
- **Response rate:** 47%
- **Burnout score:** 47% of physicians were burned out

Assessment SILVER
Articulate Three Improvement Goals/Targets

Our Office of Well-Being has established several targets for improvement based on our annual burnout survey data. This includes:

- Decrease 'Work Outside of Work' in top three specialties by 25% in the next two years.
- Establish wellness lead in all departments with at least 25 physicians. Wellness leads will have at least 0.1 FTE allocation to attend wellness committee meetings and propose wellness initiatives for their departments based on their survey data. Wellness leads will be established by EOY 2026.
- Reduce overall burnout by 5% by EOY 2026.

These targets for improvement were established via discussions and proposals with the executive leadership team and informed by our survey data. Survey respondents noted a lack of individual department-level initiatives and there were many suggestions to appoint wellness leads in each department with dedicated FTE to lead well-being initiatives and represent their departments on the larger well-being committee. These targets were first proposed by our system well-being committee and were then further refined and agreed upon with our executive leadership team. They have since been added to our organizational dashboard for tracking.

Assessment GOLD
Summary of Work Intentions Results

- **Date:** June 2025
- **Survey instrument:** Other
- **Response rate:** 56%
- **Questions used to assess work intentions:**
  - What is the likelihood you will leave your organization in the next two years?
  - What are the main factors influencing your response to leaving your organization in the next two years?

- **Results:**
  - 34% of respondents were likely to leave in the next two years. The top three reasons for leaving included: compensation, frustration with leadership and wanting a new opportunity.

Commitment BRONZE
Wellness Committee Charters and Objectives

Wellness Committee Charter SAMPLE A

PURPOSE:

To develop and maintain a program and strategies that enable clinicians to maintain balance between work and personal life.

VISION:

Organization A clinicians are energized and inspired by taking care of patients.

MISSION:

Promote clinician wellness through system- and individual-based initiatives designed to improve efficiency and resiliency.

Committee Objectives:

- Annual burnout assessment and identification of strategies to prevent burnout and promote professional fulfillment
- Develop a curriculum (speakers, meetings) to enhance clinician resiliency
- Develop strategies/events to maintain a culture of wellness
- Work with CMIO and IT to develop Epic solutions to enhance clinician efficiency
- Work with leadership on institutional strategies to improve clinician well-being

SCOPE OF COMMITTEE:

Physicians and non-physician providers

Membership Composition:

LEADERSHIP CHAIRS:

Director of Provider Wellness and Chief Medical Officer

- 9 to 12 Organization A providers
  (number may fluctuate depending on needs of Committee)
  - Variety of ages and geographic regions
  - Term limits: three year terms will be enacted in 2022 (with gradual rollout)
  - Members may serve for two consecutive terms
  - After serving for two terms, members may reapply after a respite of one year

MEMBERS:

[List of members redacted]

MEETING FREQUENCY:

Every month to every other month as needed based on needs of organization and the Board of Directors.

REPORTING:

The Provider Balance & Provider Well Being Committee will report to the Board of Directors as needed and per the direction of the Board.

Wellness Committee Charter SAMPLE B

Well-being Steering Committee Strategic Goals 2021

MEMBERS:

[List of names redacted]
*Chair = Chief Wellness Officer (reporting to SVP and CMO)

WORKGROUP CHARTER:

- Serve as Steering Committee to share a vision and strategy for professional well-being of faculty, staff and trainees at Organization
- Follow through to make sure that strategy is implemented
- Communicate to leadership and others
- Approval of strategy by SVP Cabinet, Ops Council

Proposed SMART goals

Transition our well-being workgroup to a chartered committee tasked and resourced to steer wellness initiatives and ensure Organization remains a marquee employer of choice.

- Manager/executive sponsor: [Name redacted]
- Funding: no additional required

Use data to support an exceptional workplace

Expand the Home for Dinner project to service all clinics within two years.

- Manager: [Name redacted]
- Executive sponsor: [Name redacted]
- Funding: [Redacted]

Develop, test and validate a predictive model for burnout and well-being using EMR metrics.

- Manager: [Name redacted]
- Executive sponsor: [Name redacted]
- Team: [Names redacted]
- Funding: [Redacted]

Evaluate drivers of faculty burnout associated with workload and efficiency in education, research and clinical areas and assess where to start to address.

- Manager: [Name redacted]
- Executive sponsors: [Names redacted]

Cultivate a wellness culture and community

Expand the clinic wellness champion program to 2-4 additional interested clinics.

- Manager: [Name redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Improve employees' reported physical and psychological safety scores by strengthening safety environments and access to resources across Organization.

Step one: Define psychological safety framework for Organization.

- Manager: [Name redacted]
- Team: [Names redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Launch a childcare committee that will recommend how best to support long term Organization approach to childcare of employee children by April 2021.

- Manager: [Name redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Expand and empirically analyze a three-tiered peer support program that includes general training tier, a tier of identified volunteers and peer support specialists who will engage in quarterly training and individual consultations with professionals as the final tier for those who experience adverse events.

- Manager: [Name redacted]
- Team: [Names redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Expand awareness and access to system-wide support, resilience and self-care resources

Identify a leadership position in colleges/schools and departments to coordinate local approaches to professional well-being.

- Manager: [Name redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Develop a proposal for an expanded support network for individuals that coordinates EAP, Counseling Center, GME, Wellness Program, community practitioners for seamless access to employees and learners.

- Manager: [Name redacted]
- Team: [Names redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Develop Resiliency Center model that matches faculty and staff to appropriate resiliency resources.

- Manager: [Name redacted]
- Team: [Names redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Develop evidence-based strategies through organizational science

Implement a comprehensive system wide intervention to address the SAMSA psychological phases of disaster reconstruction phase.

- Manager: [Name redacted]
- Team: [Names redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

Identify factors that contribute to burnout and resilience among health care worker (HCW)/academic groups at risk of discrimination and evaluate the impact of interventions designed to support equity and social justice.

- Manager: [Name redacted]
- Sponsor: [Name redacted]
- Funding: [Redacted]

REPORTING STRUCTURE:

Chief Wellness Officer/Director of Resiliency Center reports to SVP and CMO. Wellness Committee includes a Program Manager, Wellness Champions Program Director, Director and Medical Director. Research assistants, administrative staff and behavioral health providers are integrated within the program.

Commitment SILVER
Chief Wellness Officer Job Descriptions

CWO Job Description SAMPLE A

Job Description

The Chief Wellness Officer (CWO) oversees the organizational strategy to advance the professional fulfillment and well-being of Health System caregivers. The CWO oversees advocacy programs and initiatives aimed at optimizing the caregiver experience and fostering an organizational culture of well-being. The CWO collaborates closely with leaders in multiple key departments whose operations impact caregiver well-being.

Principal Duties and Responsibilities:

- Oversees the work of the Center for Provider Well-being
- Oversees longitudinal assessment of burnout and professional fulfillment across the organization
- Oversees assessment of the efficacy of well-being interventions and progress toward organizational goals
- Integrates efforts with other relevant departments, including but not limited to, human resources, patient experience, organizational excellence, GME, quality and safety and legal
- Oversees implementation of well-being programming which is commensurate with the needs of different populations of caregivers. Scope of potential work encompasses all employees and credentialed medical dental staff, including residents/fellows, as resources allow
- Works with other system leaders and stakeholders to advise and support service line and essential services led initiatives centered on fostering caregiver well-being

- Ensures alignment of well-being and caregiver experience efforts with organizational priorities
- Oversees review and refinement of relevant strategies, policies and procedures impacting caregiver well-being
- Assesses relevant support services and allocates resources to match caregiver needs
- Partners with organizational leadership in evaluating and mitigating environmental risk factors for burnout
- Collaborates with other leaders in the field to benchmark and share best practices
- Oversees efforts to create and share new knowledge in the well-being field

Scope Purpose and Frequency of Contacts:

Frequent contact with other hospital executives, medical staff and other employees, as well as patients, families of patients, personnel from other hospitals, government and regulatory agencies, vendors and members of the Board of Trustees and Board of Directors

Direction/Supervision Received:

Chief Executive Officer and Chief People Officer

Education, Experience and Special Requirements:

- Successful completion of LCME approved medical school curriculum with MD or DO degree
- Must be licensed or eligible for licensure in state of [Redacted]
- Advanced degree in management/administration (MBA, MMM, MHCSD)
- Extensive health care system administration experience

Knowledge, Skill and Ability Requirements:

- Expertise regarding the drivers of burnout and professional fulfillment among health care professionals
- Knowledge and experience with specific tactics to foster improvement in professional fulfillment
- Sophisticated understanding of organizational culture and principles of culture change
- Strong public speaking skills
- Ability to utilize data to make strategic and operational decisions
- Knowledge of health care principles and the functioning of an acute care hospital
- Strong influencing skills
- Ability to establish and maintain collaborative partnerships with subordinates, peers and leaders
- Effective coaching skills
- Excellent communication skills

CWO Job Description SAMPLE B

Job Description

The Chief Wellness Officer will oversee the development and implementation of programs that foster physician, trainee and learner wellness across the [Name of health system redacted] community. This includes facilitating the development of lifelong skills for achieving and maintaining optimal physical and mental health. The leader will provide expert guidance to support and identify needs for program development, serve as a liaison and advisor to health system leadership in advancing system/practice-level changes that promote well-being and educate the greater health system community regarding the influence of physician well-being on the optimal function of a health system.

Reports directly to the Chief Executive Officer | FTE: 0.70

Responsibilities and Related Initiatives

- Manage a team of dedicated staff/faculty committed to overarching well-being initiatives
- Meet regularly with school/hospital/health system leadership to identify system/practice level drivers of MD burnout and dissatisfaction and implement interventions to promote well-being
- Collaborate with internal media resources to communicate with the health system community about existing resources/activities, serve as a spokesperson for the health system on matters of wellness
- Continue to participate, contribute and direct national efforts aimed at promoting physician well-being
- Encourage research into physician and trainee wellness
- Provide support for external accreditation (e.g., ACGME Core Program Requirements/CLER visits, LCME visit) on the topic of faculty and trainee wellness

- Collaborate with outside organizations, faculty and staff on well-being events and programs
- Enable regular monitoring of well-being measures to identify high-need cohorts and track progress
- Develop a protocol and team for acute response to tragic events, including but not limited to representatives from mental health, hospital leadership, media and legal to ensure quick and frequent messaging with near-immediate implementation of standard supports and emergency response
- Monitor the evaluation of well-being at the learner, trainee and faculty level
- Measures may include but not be limited to: burnout, depression, resilience, engagement, purpose, productivity, turnover, patient satisfaction
- Develop a Wellness Dashboard that will provide individual Chairs and the Dean with departmental metrics of success in order to hold Chairs accountable for the well-being of their faculty
- Establish a process whereby leadership, likely at chair level, are asked to put into place an annual "Plan to Address Physician Wellness" linked to wellness dashboard metric, discretionary funds (i.e., grant) and school's bonus structure
- Develop an internal Web page that provides information about wellness with the list of all wellness resources/activities
- Oversee the implementation of a "menu" of evidence-based programming (e.g., mindfulness, trainee, reflection-based discussion, positive psychology training) across the health system to be provided during protected time for learners, trainees and faculty with an expressed interest
- Oversee a Mental Health "point person" who will work with EAP and Employee Health to ensure/promote the awareness, availability and affordability of robust mental health resources for all learners, trainees and faculty
- Work with Epic champions/experts to minimize EHR-related burden and dissatisfaction

Commitment SILVER

Sharing Well-being Metrics with Executive Leadership (sample)

Our burnout assessment, teamwork and leadership results have all been shared with executive leadership of the organization. Our executive leadership team consists of our CEO, COO, CMO, CIO and CHRO. They all received our survey results via email in July 2024 to review. These results were then reviewed again in our quarterly leadership retreat in September 2024. Our EHR results were also part of this presentation and we were able to leverage this retreat to holistically describe the intersections of our EHR results with our other survey outcomes (e.g., teamwork results, etc.)

Efficiency of Practice Environment BRONZE
Summary of EHR Results

Organization A measured time on inbox (Inbox-Time) via EHR log data from Epic. Inbox-Time was measured in all physicians from the following specialties: Family medicine, internal medicine, OBGYN, cardiology and neurology. These data are not yet normalized to an 8-hours of patient scheduled hours. Rather, these data were calculated at an average per day for each specialty for physicians only. All summary results were provided to department chairs. See summaries below:

INBOX-TIME

SPECIALTY	TOTAL NUMBER OF PHYSICIANS IN SPECIALTY	TOTAL NUMBER OF PHYSICIANS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY
Family medicine	187	117	3.4 hours per day
Internal medicine	221	197	2.7 hours per day
OBGYN	56	56	2.7 hours per day
Cardiology	46	37	1.1 hours per day
Neurology	25	25	0.7 hours per day

Efficiency of Practice Environment SILVER
Summary of EHR Results

Using EHR log data from Oracle Health, Organization B has measured WOW_8 and Inbox-$Time_8$—all normalized to 8-hours of patient scheduled time. These measures were conducted in four specialties and across role types (physicians vs. non-physician providers), as outlined below. Overall, family medicine physicians had the highest WOW_8 and Inbox-$Time_8$. These data have helped guide our organization to focus an initial set of interventions in family medicine to help streamline workflows.

WOW_8 SUMMARY (PHYSICIANS)

SPECIALTY	TOTAL NUMBER OF PHYSICIANS IN SPECIALTY	TOTAL NUMBER OF PHYSICIANS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY (WOW_8)
Internal medicine	78	78	2.6 hours per 8 hours of patient scheduled time
Family medicine	108	56	2.5 hours per 8 hours of patient scheduled time
Anesthesiology	50	22	0.6 hours per 8 hours of patient scheduled time
Psychiatry	11	11	1.2 hours per 8 hours of patient scheduled time

WOW_8 SUMMARY (NON-PHYSICIAN PROVIDERS)

SPECIALTY	TOTAL NUMBER OF NURSE PRACTITIONERS AND PHYSICIAN ASSISSTANTS IN SPECIALTY	TOTAL NUMBER OF NURSE PRACTITIONERS AND PHYSICIAN ASSISSTANTS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY (WOW_8)
Internal medicine	78	37	2.5 hours per 8 hours of patient scheduled time
Family medicine	108	46	3.4 hours per 8 hours of patient scheduled time
Anesthesiology	8	8	0.4 hours per 8 hours of patient scheduled time
Psychiatry	0	N/A	N/A

$NOTE\text{-}TIME_8$ SUMMARY (PHYSICIANS)

SPECIALTY	TOTAL NUMBER OF PHYSICIANS IN SPECIALTY	TOTAL NUMBER OF PHYSICIANS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY (WOW_8)
Internal medicine	78	78	34 min per 8 hours of patient scheduled time
Family medicine	108	56	113 min per 8 hours of patient scheduled time
Anesthesiology	50	22	2 min per 8 hours of patient scheduled time
Psychiatry	11	11	34 min per 8 hours of patient scheduled time

NOTE-TIME$_8$ SUMMARY (NON-PHYSICIAN PROVIDERS)

SPECIALTY	TOTAL NUMBER OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS IN SPECIALTY	TOTAL NUMBER OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY (WOW$_8$)
Internal medicine	78	37	37 min per 8 hours of patient scheduled time
Family medicine	108	46	107 min per 8 hours of patient scheduled time
Anesthesiology	8	8	2 min per 8 hours of patient scheduled time
Psychiatry	0	N/A	N/A

Efficiency of Practice Environment SILVER
Summary of Administrative Burdens

Administrative burdens:

- **Instituted badge-tap login for EHR.** Based on feedback from our physicians and a short time-study, we realized that they were spending over 10 min per day just typing in their credentials to log in to the EHR. We were able to institute badge-tap login for all providers after piloting it in a small group in 2023. All providers can now simply tap their badge on the computer in order to log in to the portal. We no longer require typing in usernames and passwords, saving our teams many hours per week.
- **Reduced/eliminated password re-validation for prescriptions.** Physicians no longer need to re-enter their username and passwords when sending prescriptions unless the prescriptions fall into a particular category (such as controlled substances). This process followed state law and we will continue to update based on regulatory changes but most prescriptions can now be sent without physicians needing to re-validate their credentials.
- **Eliminated inbox notifications for tests not ordered by physician.** After working with our EHR vendor, we were able to substantially reduce the number of notifications of test results that are sent to physicians who did not order the test (i.e., carbon-copied on the results). Up until 2021, all providers seeing a particular patient would receive an inbox notification for all test results, regardless of whether they ordered that particular test. We have largely eliminated this feature. While all physicians can still see these results, they no longer receive a notification of results in their inbox unless they are the ordering physician.

Efficiency of Practice Environment GOLD
Summary of EHR Results

Using log data from Epic, we normalized total EHR time and WOW time to 8 hours of patient scheduled time in the following four specialties: internal medicine, OBGYN, family medicine and all surgeons. Summaries of these measures are provided below. These data were shared with our executive team during our biannual retreat this past summer. The executive team includes our CEO. These data were also shared in our yearly update to the Board of Directors. Our Chief Wellness Officer presented these data (in addition to our yearly burnout assessment) during our Board meeting and these data were shared in our Board briefing book.

TOTAL EHR_8 SUMMARY (PHYSICIANS ONLY)

SPECIALTY	TOTAL NUMBER OF PHYSICIANS IN SPECIALTY	TOTAL NUMBER OF PHYSICIANS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY (WOW_8)
Internal medicine	78	78	78 min per 8 hours of patient scheduled time
Family medicine	110	78	134 min per 8 hours of patient scheduled time
OBGYN	50	22	178 min hours per 8 hours of patient scheduled time
Surgery	68	67	65 min per 8 hours of patient scheduled time

WOW_8 SUMMARY (PHYSICIANS ONLY)

SPECIALTY	TOTAL NUMBER OF PHYSICIANS IN SPECIALTY	TOTAL NUMBER OF PHYSICIANS INCLUDED IN AUDIT, PER SPECIALTY	METRIC VALUE, PER SPECIALTY (WOW_8)
Internal medicine	78	78	32 min per 8 hours of patient scheduled time
Family medicine	110	78	57 min per 8 hours of patient scheduled time
OBGYN	50	22	65 min per 8 hours of patient scheduled time
Surgery	68	67	21 min per 8 hours of patient scheduled time

Efficiency of Practice Environment GOLD
Summary of Intervention

Using log data from Epic, we normalized total EHR time and WOW time to 8 hours of patient scheduled time in the following four specialties: internal medicine, OBGYN, cardiology and all surgeons. Summaries of these measures are provided below. These data were shared with our executive team during our biannual retreat this past summer. The executive team includes our CEO. These data were also shared in our yearly update to the Board of Directors. Our Chief Wellness Officer presented these data (in addition to our yearly burnout assessment) during our Board meeting and these data were shared in our Board briefing book.

Average EHR_8 summary:

- **Internal medicine** (N=78): 134 min per 8 hours of patient scheduled time
- **OBGYN** (N=32): 178 min per 8 hours of patient scheduled time
- **Cardiology** (N=30): 78 min per 8 hours of patient scheduled time
- **Surgery** (N=67): 65 min per 8 hours of patient scheduled time

Average WOW_8 summary:

- **Internal medicine** (N=78): 87 min per 8 hours of patient scheduled time
- **OBGYN** (N=32): 65 min per 8 hours of patient scheduled time
- **Cardiology** (N=30): 34 min per 8 hours of patient scheduled time
- **Surgery** (N=67): 21 min per 8 hours of patient scheduled time

In response to these data, we have focused initially on interventions for our OBGYN ambulatory settings. Our efforts have been focused within two categories: (1) efforts to help train physicians in EHR functionality and (2) system-level solutions to reduce documentation and streamline inbox utilization. System-level approaches have been the most resources and physicians are most enthusiastic about these. Specifically, in OBGYN, we have implemented the following:

- Trained up our medical assistants to triage inbox messages. A large majority of inbox messages being sent to physicians did not need to be addressed by physicians. We worked with our EHR implementation specialist to route these messages through five trained medical assistants to triage. Medical assistants will either (a) directly respond to inbox messages where appropriate, (b) flag inbox message for nursing staff and/or (c) flag inbox message for physician. This has substantially reduced the number of messages received by our physicians. In the two months since initial implementation, our physicians have received approximately 60% fewer inbox messages. We will re-pull EHR data after three months to determine whether time on EHR has also been reduced. The most challenging aspect of this intervention was training and empowering our MAs to handle messages on their own. Our MAs now feel more equipped and more integrated in the team. It has been a win-win for everyone.
- Standardized workflow for MAs. Within OBGYN, many MAs noted their uncertainty about their responsibilities at the onset of an appointment. Many of them were missing key important steps on patient data entry, leaving physicians feeling frustrated and having to spend more time collecting information than working with the patient. We realized early on through conversations with the MAs and physicians that this was mostly due to lack of clarity in MA responsibilities. We outlined in a new workflow document the main responsibilities of an MA when first rooming a patient so that this was clearly available for all existing and new MAs. This includes the collection of current medication, preferred pharmacy, chief complaint, vitals, standing orders, completion of patient questionnaire and patient instructions and flagging any incomplete lab results. This was posted throughout the facility and shared with both MAs and physicians. Since its implementation, our MAs note much more confidence in their role and feel more empowered to take on this work so that physicians do not have to. Patients have also noted in their experience surveys that they feel our MAs do a very thorough job and that the physician is usually prepared to immediately address their issue.

Teamwork BRONZE
Summary of Teamwork Results by Specialty

Our health system has measured teamwork using the subscales provided in the Organizational Biopsy survey to measure team structure, barriers to teamwork and team function. These questions were included in our annual well-being assessment which is conducted in all physicians in all specialties across our organization. Results are stratified by specialty and provided to the department chair. These questions provided important insights and identified gaps related to teamwork across our organization, but especially in certain specialties. This has allowed us to target intervention and focus groups accordingly. Below is a summary of our teamwork results from our January 2025 assessment.

Team Structure:

QUESTION USED:

Please describe the team (MA, LPN, RN, or others) who works directly with you for patient visits during a typical ambulatory clinic workday.

SUMMARY RESULTS:

- **Family Medicine** (N=108): 69% of our FM physicians described their current team structure as having less than one clinical support staff dedicated to them.
- **Internal Medicine** (N=78): 56% of our IM physicians share clinical support staff with at least one other physician.
- **Cardiology** (N=34): 90% of our cardiologists share clinical support staff with three other physicians
- **Gastroenterology** (N=27): 93% of our GI physicians share clinical support staff with three other physicians.

Team Function:

QUESTION USED:

On a typical ambulatory clinic day, including after-hours work, how much time do you spend on tasks that do not require the unique skills of a physician or non-physician provider and that could be performed by others? (e.g., order entry, medication review, visit note documentation, forms completion, processing prescription renewals)

SUMMARY RESULTS:

- **Family Medicine** (N=108): 3.3 hours
- **Internal Medicine** (N=78): 5 hours
- **Cardiology** (N=34): 2 hours
- **Gastroenterology** (N=27): 1.7 hours

QUESTION USED:

On average, the proportion of face-to-face visit during which I am able to give my patients my undivided attention (i.e., multi-tasking with concurrent chart review, documentation, order entry, other tasks, or interruptions).

SUMMARY RESULTS:

- **Family Medicine** (N=108): 89% noted they spend <25% of visit in undivided attention
- **Internal Medicine** (N=78): 87% noted they spend <25% of visit in undivided attention
- **Cardiology** (N=34): 56% noted they spend <25% of visit in undivided attention
- **Gastroenterology** (N=27): 87% noted they <25% of visit in undivided attention

QUESTION USED:

What proportion of the time are the following tasks typically done by **someone other than you** in your ambulatory practice?

SUMMARY RESULTS (AVERAGES SHARED):

	Family medicine (N=108)	**Internal Medicine** (N=78)	**Cardiology** (N=34)	**Gastroenterology** (N=27)
Conducting medication reconciliation (review medication name, dose, frequency, route) with patient and comparing to medical record	40%	60%	100%	90%
Entering orders for diagnostic tests into the computerized order system	10%	20%	80%	50%
Entering orders for follow-up visits or referrals	25%	30%	80%	70%
Communicating test results to patients outside of regular office visit	10%	40%	30%	100%
Initial triaging patient portal messages and inbox messages (e.g., rerouting concern to appropriate team members, etc.)	25%	25%	85%	85%
Assisting with processing prescription refill requests	100%	100%	100%	100%
Prior authorizations	70%	80%	100%	90%
Tracking follow-up visits or referrals	60%	50%	30%	20%

Barriers to Teamwork

QUESTION USED:

What prevents you from delegating more order entry, medication review, or visit note documentation, forms completion, processing prescription renewals to support staff?

SUMMARY RESULTS (AGREE/STRONGLY AGREE):

	Family medicine (N=108)	Internal Medicine (N=78)	Cardiology (N=34)	Gastroenterology (N=27)
My EHR isn't built to support this delegation	50%	50%	30%	40%
My institution's culture or policies don't support/ allow such delegation	20%	25%	20%	30%
State and federal policies don't allow such delegation	20%	15%	10%	10%
I do not trust my MA or nurse to reliably do the work well	50%	20%	75%	30%
I do not have enough MAs or nurses	90%	100%	85%	95%

Teamwork SILVER

Summary of TW_{ORD} Results from EHR Audit

Leveraging our EHR (Epic) data, we were able to calculate Orders with Team Contribution (TW_{ORD}) for four specialties within our organization. These calculations were completed based on the methodology described by the AMA (percent of orders with team contribution). Summary results are included below:

TW_{ORD}

- **Internal medicine** (N=108): 78%
- **Family Medicine** (N=78): 34%
- **Cardiology** (N=34): 74%
- **Gastroenterology** (N=27): 57%

Our teamwork survey results and TW_{ORD} results were shared with all frontline physicians as part of our annual Physician Well-Being Grand Rounds in July 2025.

Teamwork GOLD
Summary of Intervention

Given both our survey data and our TW_{ORD} data, we identified our Family Medicine department as a high-impact area for intervention to improve teamwork. Department leadership engaged physicians within the OBGYN department (after sharing TW_{ORD} results) to begin discussions on how to improve these scores over the next six months. The department targeted at 20% improvement in TW_{ORD} within six months and TW_{ORD} scores were pulled monthly during the six-month intervention window. Department leadership, in collaboration with physicians and administrative employees within the OBGYN department, implemented several improvements to increase TW_{ORD} for the department. This included:

- Defining and standardizing orders and procedures for the entirety of an episode of care (e.g., pregnancy) and making these easily available (printed and laminated) throughout the office for easy referral.
- Trained up MA staff (through three 90-min training sessions) on which orders can be placed by MA and/or nursing staff to ensure confidence that they would not meet compliance or regulatory issues. Developed rooming checklist for MAs.
- Worked with Epic implementation team and office of the CIO to remove outdated templates (no longer active) from the portal so that physicians do not need to ascertain correct templates when charting.
- Assigned one nurse per shift responsible for reviewing and triaging all In-Basket messages to the correct recipient. In most cases, nurse could directly respond or handle request and/or would send to appropriate physician. This reduced In-Basket messages for our FM physicians by an average of 200 per week per physician.
- Created standing orders annual flu vaccine, rapid strep test and urine dip test. Trained MAs and nursing staff on protocol and implications for standing orders.

After the six-month intervention period, TW_{ORD} had increased from 34% at baseline to 56%, a >20% improvement. Anecdotally, both physicians and support team have noted smoother transitions between patients and all feel more confident in being able to get work done for one another. The most challenging aspect continues to be interpretation and action on standing orders which we believe will take time and team members become acquainted with new workflows and oversight.

Leadership BRONZE
Summary of Leader Listening Campaign

We have held several events in which both executive leadership and department leadership are available to hear directly from frontline clinicians about their experiences:

1. In June 2025, we hosted our annual town hall with our executive team. This occurs each year and all clinicians are invited to attend. This is held in person during lunch hour and has a virtual component. Our CEO, COO, CFO and CMO are the main panelists. The first 15 minutes includes remarks from our CEO about the current state and the CFO also provides a high-level financial update. The rest of the town hall is a Q&A where the leadership team takes live questions. We also accept questions two weeks in advance and some of those are read out loud and answered. Key themes from this past town hall included:
   a) Concern over financial sustainability of our organization (and health care in general)
   b) Frustrations with the adoption and implementation of our new EHR vendor
   c) Ongoing concerns about parking. Our main hospital is currently undergoing a major renovation, which has taken over 300 parking spaces away from staff. This has added to commuting issues.
2. Our CMO did a six-month "listening" tour from June-December 2025. She traveled to all ambulatory sites in our network to spend a few hours with our physicians and in each department of our primary medical center. The goal of this "tour" was simply to listen to our physicians and better understand their needs. The main themes from these sessions were:
   a) Frustration with the slow adoption of our new EHR system and confusion over new templates.
   b) Our primary care physicians were particularly frustrated with high patient volumes and lack of scheduling autonomy. Many felt that unless they marked vacation out one full year in advance, it was nearly impossible to use it. They were also concerned about having too high patient volume and no time to see "day of" patients (even when this time gets blocked).
   c) Compensation concerns
   d) Several departments felt they were understaffed for both nurses and medical assistants so many of our physicians were taking work home with them or staying late to complete tasks that would usually be completed by other team members.

Leadership SILVER
Summary of Leader Assessment Results by Specialty

Using the Mayo Leadership Index, we assess all leaders within our system once every two years. Questions in this Index ask respondents directly about their immediate supervisors. These data are collected in a dashboard and all unit leaders (department chairs) receive access to a dashboard with their results. These results are also shared in a 1:1 discussion between the CMO and the department chair to identify areas for improvement. Leaders that fall within the bottom 25% on the leader assessment are provided with additional support by way of 1:1 conversation with our CMO. A leader development curriculum is currently being developed. Below is a summary of our leader survey results for four specialties from our 2024 leader assessment. Total scores are provided, as the Leadership Index is scored from 12 to 60, with 60 being the highest, most favorable score. While results are best used for immediate supervisors (and we have provided immediate supervisors this information, as stated above), we are providing an aggregate score by specialty as a summary for this application.

- **Family Medicine** (N=62 total responses, representing seven frontline leaders)
  Index Score Average: 45
- **Emergency Medicine** (N=46 total responses, representing nine frontline leaders)
  Index Score Average: 52
- **Neurology** (N=14 total responses, representing three frontline leaders)
  Index Score Average: 49
- **Oncology** (N=28 total responses, representing five frontline leaders)
  Index Score Average: 42

Leadership GOLD
Illustrative Example of Individualized Leadership Program

Our system uses the Mayo Leadership Index to assess all Department Chairs and Division Chiefs each year. This Index is included in our annual survey and provides an opportunity for frontline physicians to assess their leaders. This feedback is shared directly with leaders, assuming that at least six of their direct reports have responded to the survey.

Leaders that score below a 3.0 on each of the items from the Index are then provided with a follow-up meeting with our leadership development team to discuss action plans for addressing the low-scored areas. For example, a physician leader who scores low on "sharing departmental information openly" is then provided with 2-3 coaching sessions related to transparent and open communication to support them in strengthening this skill. Leaders are then re-evaluated each year and these evaluations are a part of the annual performance review process. Leaders that score >3.0 on all the leadership domains are not required to participate in coaching. However, coaching is available upon request for them.

Leaders also have access to a variety of general leadership development programs that support skill-building for communication, building trust, empathetic listening and sustaining teamwork. However, leaders have greatly valued the 1:1 coaching that is provided in direct feedback from their leadership Index scores, as it allows them to focus on skills that their own team members feel they could do better.

Support BRONZE
Summary of Peer Support Program

Our peer support program was formally launched in 2018 and is modeled from Dr. Jo Shapiro's work. Peer supporters are nominated by department leadership and we host biannual full-day training sessions for new peer supporters. In order to become a peer supporter, you must complete this full-day training. One the full-day training is complete, peer supporters' names and contact information are added to our peer support website on our intranet. Peer supporters are also given special badges to wear that identify them as such. Colleagues can get in touch with a peer supporter in a few different ways: (1) they can contact a peer supporter directly, (2) a department lead, or colleague can reach out on their behalf to ask a peer supporter to contact someone or (3) a peer supporter can identify a need and reach out. Peer supporters are not required to report who they work with, but they are asked to submit information about when a conversation or touchpoint occurs. This helps us track how often this service is utilized. To date, we have more than 320 trained peer supporters from across all departments. Since 2018, more than 1,500 connections to peer support have been made.

Support BRONZE
Action Plan to Address Removing Stigmatizing Language from Credentialing Application

We are currently in the process of reviewing and updating our credentialing applications to align with current standards. This work has been underway for three months and we anticipate it being completed by the end of this year. More details are included below:

WORKING PLAN:

- Identify questions in current credentialing application related to mental health or substance use disorder that need to be re-evaluated to align with current standards. (COMPLETE)
- Four questions were identified as being misaligned with the recommendations, as these questions asked about current and past impairment and were likely more invasive than legally necessary.
- A workgroup has been formed through our Office of Well-Being that includes key executives, including our credentialing lead and our legal department.
- This workgroup has met once to scope out any additional approvals needed to make updates to the credentialing language and will meet again to review proposed new language.
- Final approvals are on the Board agenda for Q4.
- With Board approval, we will implement changes in the credentialing application by end of November and these changes will be shared in the December all-staff town hall.

Support SILVER
Two Program or Policies Supporting Physicians Beyond Adverse Events

Our health system has a variety of programs in place to support physicians in dealing with adverse clinical events. Many of these are peer support programs. Specifically, we have instituted a program in which physician representatives from across the system are "on call" to provide peer support in response to adverse clinical events and other sources of distress. These peer responders go through 10 hours of training and wear a designated badge to identify them as such. When an adverse event occurs, our Office on Physician Well-Being facilitates the deployment of a peer responder to the impacted department. Peer responders make themselves available to lead team debriefs and 1:1 sessions. They are given 5% protected administrative time to do so. Our Office on Well-Being also facilitates reflection sessions wherein groups of peers are brought together after an event to debrief and participate in a facilitated discussion about the event. Individuals who may need additional support after the discussion are identified and provided with additional resources.

In addition to these resources for dealing with adverse clinical events, we have also developed a formal peer support program wherein physicians across specialties are matched with a colleague within the system as their peer support partner. Dyads are provided with one protected hour (paid) per month to meet together. Additionally, dyads are given two hours per quarter to meet for lunch in the local area along with a gift certificate to use at a nearby restaurant. This program has been met with very positive feedback from our physicians.

We also recently implemented a vacation coverage plan in our family medicine department to ensure that our FM physicians could take vacation and not be burdened by their inbox during and immediately following vacation. We have one designated MA in each location that provides inbox triage and coverage for all physicians and non-physician providers when they are on vacation. MA is able to respond and resolve appropriate inbox messages and/or triage messages to physicians that are not on vacation. After six months of piloting this effort, our FM physicians have noted anecdotally that they feel less burdened when arriving back from vacation. Based on EHR data, we were able to decrease inbox volume by 65% for physicians returning from vacation. This work is ongoing.

Appendix B: Sample Questions

This Appendix includes sample questions accepted in assessment, teamwork and leadership domains of the Recognition Program. The following questions are denoted from the Organizational Biopsy.

You may also choose to use the questions noted below in an already-existing survey at no cost, with credit provided to the AMA. Please note that these are not the only acceptable questions for the listed criteria but are a no-cost option provided by the AMA.

Assessment Questions

Assessment - Gold

INTENT TO LEAVE

What is the likelihood that you will leave your current organization within 2 years?

- None
- Slight
- Moderate
- Likely
- Definitely

Are you considering leaving your current organization to retire altogether?

- Yes
- No

Are you retiring earlier than you had anticipated retiring?

- Yes
- No

INTENT TO LEAVE, CONTINUED

What would make you reconsider and stay in your current organization? (check all that apply)

- Enhanced workflow efficiency
- Fewer EHR hassles (i.e., less EHR work out of office hours)
- Greater sense of team
- Consistent staffing
- Support for non 'top of license' activities
- Better ability to help patients (fewer roadblocks)
- Less documentation/less work outside of work
- Greater control over setting patient schedule
- Greater opportunities for career advancement
- Greater opportunities to teach
- Greater opportunities for leadership
- Greater opportunities for research
- Greater alignment of personal values with organizational values
- Higher compensation (i.e., higher pay)
- Other (please specify)

Teamwork Assessment Questions

Teamwork - Bronze

TEAM STRUCTURE

Please describe the team (MA, LPN, RN, or others) who works directly with you for patient visits during a typical ambulatory clinic workday.

- ☐ I have 2 or more clinical support staff fully dedicated to me
- ☐ I have more than 1 but less than 2 clinical support staff fully dedicated to me
- ☐ I have 1 clinical support staff fully dedicated to me
- ☐ I share a clinical support staff with 1 other physician or advance practice provider
- ☐ I share a clinical support staff with 2 other physicians or advance practice providers
- ☐ I share a clinical support staff with 3 other physicians or advance practice providers
- ☐ Other (please specify)

TEAM FUNCTION

On a typical ambulatory clinic day, including after-hours work, how much time do you spend on tasks that do not require the unique skills of a physician or non-physician provider and that could be performed by others (e.g., order entry, medication review, visit note documentation, forms completion, processing prescription renewals)?

- Less than 60 min
- 1-2 hours
- 2-3 hours
- 3-4 hours
- More than 4 hours
- Other (please specify)

On average, what proportion of your time during a face-to-face visit are you able to give your patients your undivided attention (i.e., no multi-tasking with concurrent chart review, documentation, order entry, other tasks, or interruptions)?

- <10% (1)
- 10-25% (2)
- 25-50% (3)
- 50-75% (4)
- >75% (5)

What proportion of the time are the following tasks typically done by someone other than you in your ambulatory practice?

Never, Less than 25% of the time, 25-50% of the time, More than 50% but less than 75% of the time, More than 75% of the time

- Conducting medication reconciliation (review medication name, dose, frequency, route) with patient and comparing to medical record
- Entering orders for diagnostic tests into the computerized order system
- Entering orders for follow-up visits or referrals
- Communicating test results to patients outside of regular office visit
- Initial triaging patient portal messages and inbox messages (e.g., rerouting concern to appropriate team members, etc.)
- Assisting with processing prescription refill requests
- Prior authorizations
- Tracking follow-up visits or referrals

TEAM STABILITY

I mostly work with the same MA(s) or Nurse(s) every day I am in clinic (i.e., >75% of the time).

- ■ Yes
- ■ No

BARRIERS TO TEAMWORK

What prevents you from delegating more order entry, medication review, visit note documentation, forms completion, or processing prescription renewals to support staff?

Agree strongly, Agree, Neither agree nor disagree, Disagree, Strongly disagree

- ___ My EHR isn't built to support this delegation
- ___ My institution's culture or policies don't support/allow such delegation
- ___ State and federal policies don't allow such delegation
- ___ I do not trust my MA or nurse to reliably do the work well
- ___ I do not have enough MAs or nurses

COLLEGIALITY

In our organization:

Agree strongly, Agree, Neither agree nor disagree, Disagree, Strongly disagree

- We have a strong sense of belonging
- I believe my teammates have my back
- Diversity, equity and inclusion are highly valued by my colleagues

How often do you encounter negative experiences (e.g., being denied work opportunities, being isolated or treated as If you were not competent, experiencing repeated, small slights at work, or other forms of discrimination or a colleagues' refusal to pitch in because of an "it's not my job" mentality) at work?

Frequently, Fairly often, Infrequently, Rarely, Never

- Due to your gender?
- Due to your race?
- Due to your sexual orientation?
- Due to role type conflict? (e.g., conflict between nurses and physicians)

Respectful communication exists between:

To a great extent, Somewhat, A little, Not at all

- Physicians/non-physician providers and care team
- Physicians/non-physician providers and practice manager or other leaders
- Physicians/non-physician providers and consulting colleagues

Leader Assessment Questions

Leadership - Silver

LEADER ASSESSMENT

Please indicate to what degree do you agree or disagree with the following statements: My immediate specialty leader (i.e., Division Chief/Department Chair)…

Agree strongly, Agree, Neither agree nor disagree, Disagree, Strongly disagree

- Supports me in my work (i.e., by clearing obstacles to patient care)
- Supports my career development (i.e., by holding career development conversations)
- Solicits and follows up on my ideas and perspectives (i.e., for improving workflows, teamwork, policies, practices)
- Shares organizational information openly with me (i.e., regarding finances, quality metrics, reasons behind decision-making)
- Recognizes my contributions

Appendix C:
EHR Data Extraction

NEW OPTION FOR 2026

Support for Epic Users

This year, Epic's team is supporting their users that are applying to the Joy in Medicine Program by providing metrics for the Efficiency of Practice Environment criterion.

Applicant organizations will work directly with Epic using the process outlined below:

- Reach out directly to your organization's Epic contact to request a Joy in Medicine data extract report. Please reach out as soon as you are able and be mindful of request volume, turnaround times and the application deadline. The results provided by Epic must be included in your application at the time of submission. Deadline extensions will not be possible.
- Epic will run the normalized metrics for Total EHR Time (EHR8) and Work Outside of Work (WOW8) for all specialties, including family medicine and internal medicine (if these are present within your organization). This data extract file will include all necessary information for meeting the Joy in Medicine criteria.
- Epic will send the requested aggregated results to your organization to submit in your Joy in Medicine application as a file upload.

EHR Data Extraction

Extracting EHR-use Metrics from Epic or Oracle Health (formerly Cerner)

EHR-use metrics offer the opportunity to characterize the physician work experience more fully and to quantitatively assess the impact of interventions designed to improve the work experience. Metrics extracted from audit log data can answer questions such as: How much time are physicians spending on the EHR during the clinic day? How much time after hours? Have the number of In-Basket messages physicians and their teams manage changed over time? Are the interventions implemented with a goal of reducing clerical burdens making a difference? EHR-use metrics extracted from the EHR can help answer these questions.

What are the core EHR-use metrics?

The core EHR-use metrics, first proposed in 2020[1], quantify the amount of total time on the EHR (EHR-Time) as well as the time spent on specific activities, such as encounter note documentation (Note-Time) or inbox (IB-Time). The vendor derived measures may underestimate the actual time that physicians spend on various tasks and may not accurately reflect the experiences of physicians with different levels of clinical FTE. The core EHR-use metrics proposed in 2020 are intended to reflect the experiences of physicians more accurately. These core metrics include a measure of the time spent on the EHR outside of scheduled patient hours, a measure known as Work Outside of Work (WOW). An aspirational metric, which currently can be approximated and tracked directionally, is Undivided Attention (ATTN), which is a proxy measure for the amount of undivided attention physicians have available to provide to their patients during scheduled hours. In addition to these metrics of time, there are also metrics of volume, such as Orders with Team Contribution (TW_{ORD}), which measures the percentage of orders that have team contribution.

Extracting EHR-use Metrics from Epic or Oracle Health (formerly Cerner)

EHR-use metrics offer the opportunity to characterize the physician work experience more fully and to quantitatively assess the impact of interventions designed to improve the work experience. Metrics extracted from audit log data can answer questions such as: How much time are physicians spending on the EHR during the clinic day? How much time after hours? Have the number of In-Basket messages physicians and their teams manage changed over time? Are the interventions implemented with a goal of reducing clerical burdens making a difference? EHR-use metrics extracted from the EHR can help answer these questions.

What are the core EHR-use metrics?

The core EHR-use metrics, first proposed in 2020[1], quantify the amount of total time on the EHR (EHR-Time) as well as the time spent on specific activities, such as encounter note documentation (Note-Time) or inbox (IB-Time). The vendor derived measures may underestimate the actual time that physicians spend on various tasks and may not accurately reflect the experiences of physicians with different levels of clinical FTE. The core EHR-use metrics proposed in 2020 are intended to reflect the experiences of physicians more accurately. These core metrics include a measure of the time spent on the EHR outside of scheduled patient hours, a measure known as Work Outside of Work (WOW). An aspirational metric, which currently can be approximated and tracked directionally, is Undivided Attention (ATTN), which is a proxy measure for the amount of undivided attention physicians have available to provide to their patients during scheduled hours. In addition to these metrics of time, there are also metrics of volume, such as Orders with Team Contribution (TW_{ORD}), which measures the percentage of orders that have team contribution.

Why are the core metrics normalized to 8 hours of patient scheduled time?

Physicians work varied schedules. One physician may have 32 hours of patient contact time spread over 5 days, while another may have 16 hours of patient contact time spread over 2 days and yet another has 16 hours of patient scheduled time spread over 4 days per week. How can one be sure they are comparing apples to apples when reviewing EHR-use metrics? Simply averaging the time per calendar day will provide confounding results. For this reason, we recommend ***normalizing*** EHR-use metrics to 8 hours of patient scheduled time.

Below is a list of EHR-use metrics developed by a team of national research and practice experts and first published in the Journal of the American Medical Informatics Association[1].

Normalizing the EHR-use metrics to 8 hours of scheduled patient hours requires integrating the clinical schedule into the formulas, as seen below. In some circumstance, this may be beyond the capability of some health systems or EHR platforms. For those that pursue this important normalization, here are some additional tips.

- Signal provides numbers for a block of weeks that equate to approximately one month (either four weeks or five weeks). The monthly Signal data will have the exact dates so that users know the number of weeks.
- Time Outside of Scheduled Hours (and only on days with scheduled patients) (TOSH) and Time on Unscheduled Days (TUSD) are both provided as discrete values so people can easily extract those and add together.

Table 1: Core EHR-use metrics (adapted from Sinsky et al, 2021)

MEASURE	ABBREVIATION	DEFINITION AND EXAMPLE
Total EHR Time	EHR_8	Total time on EHR (during and outside of clinic sessions) per 8 hours of patient scheduled time ***Example:*** A physician with 32 patient-scheduled hours per week, 20 hours of EHR-time during scheduled hours, 10 hours of WOW each week would have EHR-$Time_8$ of 30/32 x 8 = 7.5
Work Outside of Work	WOW_8	Time on EHR outside of scheduled patient hours per 8 hours of patient scheduled time ***Example:*** A physician with 32 scheduled patient hours per week and a total of 10 hours of EHR time outside of these scheduled hours, would have WOW_8 = 10/32 x 8 = 2.5
Time on Encounter Note Documentation	Note-$Time_8$	Hours on documentation (note writing) per 8 hours of scheduled patient time ***Example:*** A physician with 32 scheduled patient hours per week and a total of 20 hours of documentation time (both in the room with the patient and outside of the room) per week would have $DocTime_8$ of 20/32 x 8 = 5.0
Time on Prescriptions	Script-$Time_8$	Total time on prescriptions per 8 hours of patient scheduled time ***Example:*** A physician spends 3 hours per week on prescription work and has 24 hours of patient scheduled time per week. Script-$Time_8$ = 3/24 x 8 = 1
Time on Inbox	IB-$Time_8$	Total time on inbox per 8 hours of patient scheduled time ***Example:*** A physician spends 10 hours per week on Inbox work and has 20 hours per week of patient scheduled time. IB_8 = 10/20 x 8 = 4
Orders with Team Contribution	TW_{ORD}	The percentage of orders with team contribution ***Example:*** A physician working with a team that is empowered to pend, send orders by protocol or operationalize verbal orders may compose 25% of the orders from start to finish on their own, while the rest are pended or completed by team members for the physician's co-signature. In this case TW_{ORD} = 75%
Undivided Attention	ATTN	The amount of undivided attention patients receive from their physician. It is approximated by [(Total time per session) minus (EHR time per session)]/Total time per session ***Example:*** A physician who is actively on the EHR 3 hours of a 4-hour clinic session would have a lower ATTN score (4-3)/4 = 0.25 than a physician who was actively on the EHR 1 hour of a 4-hour clinic session. (4-1)/4 = 0.75

Please note: The calculations above are included based on existing information at the time of the 2021 *JAMIA* publication. Some organizations have been able to pull these metrics WITHOUT needing to run a separate CLARITY report to get Scheduled Hours.

When you export Epic Signal data into the component Excel spreadsheet, the Epic Signal report typically has enough data for the user (e.g., CMIO) to calculate EHR metrics normalized to 8 hours of patient scheduled hours without needing to pull separate Clarity reports. Please consult with your IT and/or informatics team.

How do you extract the data to calculate the EHR-use metrics from the vendor-provided data?

An organization with a sophisticated and well-resourced information technology department will be able to go into the audit logs of their EHR and extract the information needed for the above metrics.

Two vendors provide "off-the-shelf" measures of EHR-use: Oracle Health (formerly Cerner) via its Advance program and Epic via Signal. Off the shelf measures from vendors other than Epic or Oracle Health will require additional time and discussion with your information technology team or vendor implementation specialists to fully understand the capture of their measures and how they can be transformed into the EHR use metrics proposed above.

Because of differences in how the data is extracted and categorized, data from Oracle Health's Advance program cannot be directly compared to data from Epic's Signal program. The Tables below provide additional information on how to calculate EHR-use metrics using Epic's or Oracle Health's programs and normalize the data to an 8-hour workday. These may serve as a guide for your information technology team to transform "off the shelf" measures into more accurate depictions of time spend.

A note on extracting data from Epic

EHR_8, Note-$Time_8$, WOW_8 and IB-$Time_8$ should not be calculated from the ratio of values that appear on the Epic Signal online dashboard (e.g., "time in system per day" or "scheduled hours per scheduled day," because of differences in the denominator (i.e., in how "per day" and "per scheduled day" are defined). Instead, EHR_8, Note-$Time_8$, WOW_8 and IB-$Time_8$ should be calculated using the raw data downloaded from Epic's Signal platform. For example, EHR_8 is calculated using:

$$EHR_8 = \frac{\text{'Time in System (hours) per reporting period'}}{\text{'Scheduled Hours per reporting period'}} \times 8$$

Epic Formulas

Table 2: Formulas for Calculating Core EHR-use Metrics with Epic Signal Data (adapted from Melnick et al, JAMIA 2021, Vol. 28, No. 7, Pg 1387)[2]

EHR_{day}	$\frac{\text{Signal 'Time in System' (hour)}}{\text{day}}$
EHR_{8}	$\frac{\text{Signal 'Time in System'* (hour)}}{\text{Scheduled Hours*}} \times 8$
WOW_{day}	$\frac{\text{Signal 'Time Outside Scheduled Hours' (hour)} + \text{Signal 'Time on Unscheduled Days' (hour)}}{\text{day}}$
WOW_{8}	$\frac{\text{Signal 'Time Outside Scheduled Hours' (hour)} + \text{Signal 'Time on Unscheduled Days' (hour)}}{\text{Scheduled Hours*}} \times 8$
Note-Time_{day}	$\frac{\text{Signal 'Time in Notes' (hour)}}{\text{day}}$
Note-Time_{8}	$\frac{\text{Signal 'Time in Notes'* (hour)}}{\text{Scheduled Hours*}} \times 8$
Inbox-Time_{day}	$\frac{\text{Signal 'Time in In-Basket' (hour)}}{\text{day}}$
Inbox-Time_{8}	$\frac{\text{Signal 'Time in In-Basket'* (hour)}}{\text{Scheduled Hours*}} \times 8$
TW_{ORD}	$\frac{\text{Number of orders with team contribution}}{\text{Total number of orders placed by physician}}$

* These values must be obtained using the raw data downloaded from Epic's Signal platform for time during the reporting period; they can **not** be obtained using the "Time in System per Day," "Scheduled Hours per Scheduled Day," "Time in Notes per Day," and "Time in Inbasket per Day," that are presented in Signal dashboard.

Oracle Health (formerly Cerner) Formulas

Table 3: Formulas for Calculating Core EHR-use Metrics with Oracle Health (formerly Cerner) Advance and IDX Scheduling Data (adapted from Melnick et al, JAMIA 2021, Vol. 28, No. 7, Pg 1387)[2]

EHR_{day}	Advance 'Actual Time Per Patient' (min) × Advance 'Patients Seen'
EHR_{8}	$\frac{(\text{Advance 'Actual Time Per Patient' (min)}/60) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} \times 8$
WOW_{day}	(% of total EHR time that is afterhours) × (EHR time per day)
WOW_{8}	$\frac{(\text{Advance 'Percentage of Time After Hours'})/100) \times (\text{Advance 'Actual Time Per Patient' (min)}/60) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} \times 8$
$DocTime_{day}$	Documentation Time Per Patient (min) x Patients Seen/day
$Doc\text{-}Time_{8}$	$\frac{(\text{Advance 'Documentation Time Per Patient' (min)}/60) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} \times 8$
$Inbox\text{-}Time_{day}$	$\frac{(\text{Time per Patient (min): Messaging} + \text{Endorse Results} + \text{Approve Orders} + \text{Sign Review} + \text{Order Refill}) \times \text{Patients seen per day}}{}$
$Inbox\text{-}Time_{8}$	$\frac{\left(\left(\begin{array}{c}\text{Advance 'Messaging Time Per Patient' +}\\ \text{Advance 'Endorse Results Time Per Patient' +}\\ \text{Advance 'Approve Orders Time Per Patient' +}\\ \text{Advance 'Sign Review Time Per Patient' +}\\ \text{Advance 'Order Refill Time Per Patient'}\end{array}\right) \text{(min)} / 60\right) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} \times 8$
TW_{ORD}	$\frac{(\text{Standing Orders — Cosign Required}) + (\text{Cosign Required \& Verbal Read Back})}{\text{Total Number of Orders Placed by the Physician}}$

Note to users:

We would like to crowd-source the "how-to" wisdom in this guide. If you have further insights or suggestions for extracting the core metrics from the vendor-derived data, please send us an email at joyinmedicine@ama-assn.org.

1. Sinsky CA, Rule A, Cohen G, et al. Metrics for assessing physician activity using electronic health record log data. Journal of the American Medical Informatics Association. 2020.
2. Melnick ER, Ong SY, Fong A, et al. Characterizing physician EHR use with vendor derived data: a feasibility study and cross-sectional analysis. Journal of the American Medical Informatics Association. 2021.

2026 Program Guidelines

Published July 2025
Updated December 2025

LEARN MORE

- Visit us at ama-assn.org/joyinmedicine
- Contact us at joyinmedicine@ama-assn.org

To view or download an interactive PDF version of these guidelines, scan the QR code below

AMA | JOY IN MEDICINE®
Health System Recognition Program