AMA
AMERICAN MEDICAL ASSOCIATION

JOY IN MEDICINE

Health System Recognition Program

Health System Roadmap

Program criteria, resources, case examples, and submission samples

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Introduction

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.

JOY IN MEDICINE

The goal of the program is to unite the health care community in building a culture committed to increasing joy in medicine for the profession nationwide.

The program aims to build awareness about solutions that promote professional fulfillment and spur investment within health systems to reduce physician burnout.

The program is also designed as a roadmap for health system leaders to implement programs and policies that support physician well-being.

The Joy in Medicine Roadmap is laid out in this document. The pages that follow share the research and strategy that the program is built on – alongside resources and tools, case examples, and submission examples. **This roadmap is a step-by-step guide to building well-being across a health system.**

We encourage organizations to use the Joy in Medicine Roadmap whether your organization has been on the path for years or your organization's journey is just beginning. This is a roadmap we are building and traveling together.

"Our vision with the Joy in Medicine Health System Recognition Program is that it will help organizations develop their strategic plan in a way that results in the conditions for physicians and their teams where joy, purpose, and meaning in work are possible."

**– CHRISTINE SINSKY, MD
VICE PRESIDENT OF PROFESSIONAL SATISFACTION,
AMERICAN MEDICAL ASSOCIATION**

History

The inaugural **Joy in Medicine Health System Recognition Program** ran in 2019.

The program was born from years of research on the science of burnout and a desire to build awareness of the impact that burnout has on the health care community. Although researchers, thought leaders, and individual organizations were steadfastly working to spotlight the issue of physician burnout, there was not yet widespread discussion of the problem or adoption of solutions.

In the first year of the program, **22 health systems from across the country were recognized** for their efforts to support physician well-being. We celebrated these organizations for being at the vanguard of a movement toward bettering the conditions of the health care workforce.

As the Joy in Medicine Health System Recognition Program was preparing to launch for a second year in March of 2020, the health care community was upended by an unprecedented global pandemic. The COVID-19 pandemic pushed physician burnout to the forefront of not just the health care community, but of the country at large. Physician burnout was no longer being discussed just in health care – this issue reached the front page of newspapers and crossed into the consciousness of the country.

The Joy in Medicine Health System Recognition Program returned in 2021 to provide guidance and an opportunity for collaboration. Since its inception, over 100 organizations have been recognized by the program. View a list of all current and previously recognized organizations. Key to the goals of the program is ongoing collaboration with health systems and shared learnings from the health care community. We are informed by the health systems we work with and adapt the program to changes in the field of health care.

→ LEARN MORE ABOUT THE PROGRAM
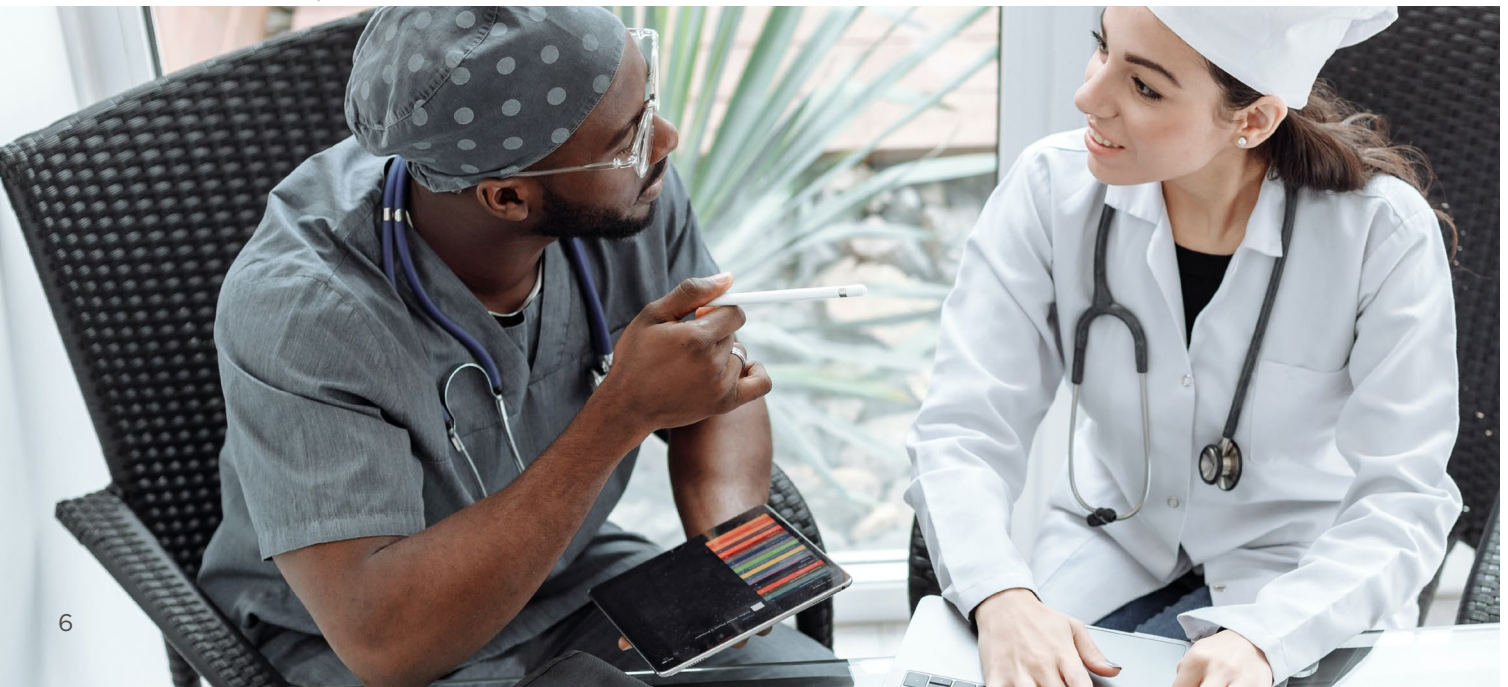
What Recognition Means

Recognized organizations join a community of physicians, health system leaders, and thoughts leaders dedicated to the well-being of the health care workforce.

Applications to the program are reviewed by a committee of physicians and AMA staff. Organizations that are on the road to recognition, but do not yet qualify, receive targeted feedback on their progress from subject matter experts and thought leaders in the field.

Organizations that earn recognition receive access to resources and events, coaching, press materials, and opportunities for their work to be highlighted by the AMA. Recognition levels are valid for two years before an organization must renew at the same level or apply to increase their recognition level. Once an organization is recognized, the AMA fosters connections with the organization between application cycles, including learning about their ongoing work or meeting with organizations to prepare for future renewals.

To view a current list of all recognized organizations, visit our website.
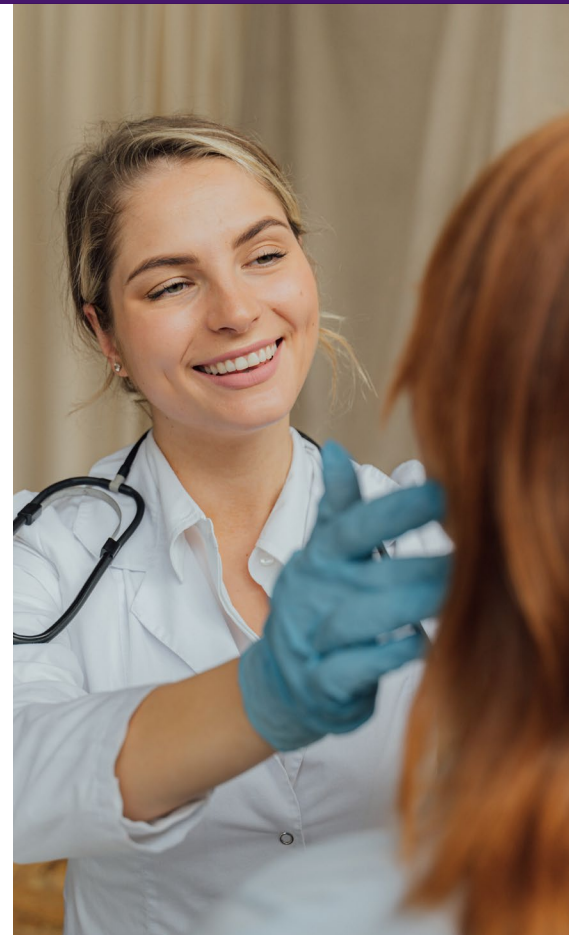
Hear from recognized organizations using the Joy in Medicine Program as a strategic roadmap to build well-being in their health systems.

→ WATCH NOW

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.

Before applying, systems must meet the following eligibility criteria:

1 CHARM Charter

Sign the **Collaborative for Healing and Renewal in Medicine (CHARM) Charter**. The CHARM Charter on physician well-being is intended to inspire collaborative efforts among individuals, organizations, health systems, and the profession of medicine to honor the collective commitment of physicians to patients and to each other.

2 Size of Organization

The Joy in Medicine Health System Recognition Program is intended for health systems with 100 or more physicians and/ or advanced practice providers (APPs). If your organization has at least 100 physicians and/or APPs, proceed to Step 3.

If your system has fewer than 100 physicians and/or APPs, please sign the CHARM Charter in Step 1 and engage with other resources offered by the AMA.

3

Assessment of Physician Well-being

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

→ AMA 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

Only after attesting to these eligibility criteria can an organization proceed to the full application. All applications should be submitted on behalf of the organization – not individual departments, GME programs, or affiliated practices within your system.

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 AMA Organizational Biopsy®, the practice transformation journey, and how to get started using the AMA's no-cost burnout assessment.

Application Process

1

Review the Joy in Medicine Roadmap and Annual Program Guidelines

The Joy in Medicine Health System Recognition Program is meant to serve as a strategic roadmap for organizations to support physician well-being. The first step in this process is to familiarize yourself with this Roadmap and review the annual program guidelines. Based on the outlined criteria, evaluate the current efforts of your organization to determine your level of recognition. Supporting documentation is required throughout your application.

→ **REVIEW THE ANNUAL PROGRAM GUIDELINES**

2

Submit an Intent to Apply form

Organizations interested in applying for recognition can submit an Intent to Apply form for upcoming or future application cycles at any time of the year via our application portal. By submitting an Intent to Apply, your organization will automatically receive updates on upcoming application cycles and will receive access to the application when the cycle opens.

3 Apply for the Joy in Medicine Health System Recognition Program

The main point of contact for well-being work at your organization must complete and submit your application. Applications will open every year in January and will remain open until March. Exact dates for each year's application cycle can be found on our website.

4 Review process

A review committee composed of recognized national leaders in physician well-being will review all applications to affirm an appropriate recognition level.

5 Achieve recognition

Organizations meeting the criteria for a designated level will be recognized for their achievement. Recognized organizations will be highlighted in press releases, on the AMA website, and spotlighted through AMA podcasts, videos, and news stories. Organizations that do not achieve recognition will receive feedback on their application and opportunities to connect with the AMA about preparing for future applications.

6 Recognition status

Recognition is valid for two years. After two years, each organization must resubmit an updated application for review. Organizations may renew to maintain their current level or apply for recognition at a higher level. We encourage organizations to thoughtfully consider when to apply for a higher level of recognition and expect that some organizations may take multiple application cycles to apply for a higher level.

→ **SUBMIT YOUR APPLICATION**

Program Criteria

The Joy in Medicine Health System Recognition Program criteria offer a strategic roadmap to guide health systems through an evidence-informed strategy to ensure well-being is a core institutional value.

The strategic roadmap is comprised of six pillars with criteria that build on one another over time.

It is expected that most organizations may take several years to achieve Bronze, and then additional time to advance their initiatives from the Bronze level to Silver and then to the Gold level. These strategies are intentionally designed to offer direction to health system leaders for long-term sustainable success in their organizational well-being efforts.

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 demonstrated competencies: 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 evidence that supports the completion of criteria and supporting documentation outlined in detail below. Applicants for Bronze must complete five of six Bronze criteria. Applicants for Silver must complete five of six Bronze criteria **and** five of six Silver criteria. Applicants for Gold must complete five of six Bronze criteria, five of six Silver criteria, **and** five of six Gold criteria. These criteria must be the same at each level. Assessment and Commitment are required at each level.

Important Notes:

1 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.

2 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.

3 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. If reviewers have any questions about your submission during the review process, the AMA will proactively reach out to your organization.

4 For criteria that require sharing information about assessments or interventions, please note that your application will not be reviewed based on rates or results. Rather, reviewers are interested in learning about your overall approach to reduce work outside of work and improve the work environment.

5 All information submitted to the AMA will remain confidential.

Criteria at a Glance

Please note that this chart is meant only to assist organizations in reviewing a short summary of the criteria at each level. Please use the full criteria and supporting documentation when preparing to apply. Organizations must complete five of six criteria in the preceding levels to achieve recognition (e.g., a Gold organization must achieve five Bronze and five Silver criteria. These criteria must be the same at each level.)

	Bronze	**Silver**	**Gold**
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 three years. **AND** Establish targets for improvement in collaboration with executive leadership.	Measure work intentions (intent to leave) at least once in the last three years. Measurement should also assess reasons for leaving or reducing hours.
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, TW$_{ORD}$, EHR metrics) with entire 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 dismantle at least three administrative burdens that contribute little/no value to care, impede the work of physicians, and waste time/resources.	Normalize EHR$_8$ and WOW$_8$ to 8 hours of patient scheduled hours. **AND** Implement intervention based on EHR audit results.
TEAMWORK	Assess teamwork once within the last two years.	Measure teamwork via EHR audit data (TW$_{ORD}$). **AND** Share results with frontline physicians.	Implement intervention based on teamwork assessment and EHR audit results.

	Bronze	Silver	Gold
LEADERSHIP	Implement a leader listening campaign.	Assess leadership skills for all frontline leaders at least once in the last two years.	Implement a leader development program based on the individual needs of each leader identified in the leadership assessment. 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** Change invasive or stigmatizing language around mental health and substance use disorders in your credentialing applications and process.	Implement two or more programs or policies aimed at broader issues of physician support. **AND** Communicate changes to credentialing application and process, assuring physicians that it is safe to seek care.	Develop structured program(s) to actively cultivate community at work. **AND** Review existing policies related to mental health and psychological safety, and, if needed, implement policy changes that further destigmatize mental health and enhance psychological safety inside the organization. **AND** Provide access to confidential 24-hour mental health services/support.

Assessment

Well-Being Assessment

Overview

Measuring physician well-being and burnout is critical to understanding and addressing system issues.

By measuring the operational effectiveness of your organization and the well-being of your physicians, you can readily identify and target meaningful interventions. An annual or semi-annual well-being assessment will help you (1) identify and assess underlying drivers of burnout, (2) understand your organization's unique needs to support professional well-being, and (3) proactively initiate institutional support to help physicians thrive. It is important that validated measurement tools are used that provide insight into the system drivers of burnout so that organizations can effectively implement system-level solutions.

"Assessments help us tell our frontline clinicians that we do care very much about them, that we're working hard to fix this, and that we're doing it in an evidence-based, informed manner. Assessment is our ability to formalize what we do, standardize how we approach our initiatives, and to measure if we're making a difference."

– ELIZABETH HARRY, MD
SENIOR MEDICAL DIRECTOR OF WELL-BEING,
UCHEALTH

Bronze Criteria

Measure burnout in all physicians at least once in the last three calendar years using a validated tool and share results with individuals eligible to participate in the survey.

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(s) of most recent assessment(s)
→ Validated tool used to measure burnout
→ Aggregate mean burnout scores or burnout rate for organization. If using the Well-Being Index, please provide the aggregate distress score
→ 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 AMA's Organizational Biopsy® (which includes the Mini-Z). Measuring physician "engagement" is not sufficient for this criterion. Organizations must assess physician burnout specifically.

The AMA offers no-cost assessments, which include burnout, teamwork, and leadership assessments. To learn more about this opportunity, please visit our website or reach out to us at Practice.Transformation@ama-assn.org

Supporting documentation:

→ Summary of findings from organization's most recent burnout assessment. This summary should include your most recent burnout rate, the validated tool used to measure burnout, who was surveyed, and any other relevant information you would like to share.

→ 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).

Silver Criteria

Measure burnout in all physicians at least twice in the last three years using a validated tool and share results with the individuals eligible to participate in the survey.

Provide aggregate findings from at least two burnout assessments in the last three 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
→ Validated tool used to measure burnout
→ Aggregate mean burnout scores or burnout rate for organization (per assessment/year). If using the Well-Being Index, please provide the aggregate distress score
→ 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 AMA's Organizational Biopsy® (which includes the Mini-Z). Measuring physician "engagement" is not sufficient for this criterion. Organizations must assess physician burnout specifically.

AND

In collaboration with the executive team, set a target for improvement (e.g., establish well-being directors in six of the largest clinical departments).

Articulate improvement goals/targets. You must also include a brief summary (2-3 sentences) of how your organization established its target for improvement.

Supporting documentation:

→ List of months/years that you conducted two burnout assessments in the last three years.

→ Name of validated tool used to measure burnout.

→ Summary of findings from at least two burnout assessments. This summary should include burnout rates within your organization and any other relevant information you would like to share.

→ Articulate improvement goals/targets. You must also include a brief summary (2-3 sentences) of how your organization established its target for improvement.

Gold Criteria

Measure work intentions (intent to leave organization and/or intent to reduce hours) at least once in the last three years. Measurement should also assess reasons for leaving or reducing hours.

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/or reduce hours. Additionally, measurements should also assess reasons for leaving or reducing hours.

Work intention questions are accepted from the AMA's Organizational Biopsy®, or by including the work intentions questions included in Appendix A in your annual assessment. If you use a different set of questions to measure work intention, please provide these questions in your application.

Supporting documentation:

→ Instrument used to assess work intentions. If you used questions other than those in the AMA Organizational Biopsy® (see Appendix A) please provide the question(s) used to measure work intentions.

→ Provide summary of work intention results from at least one assessment in the last three years. Summary should include assessment on WHY people intend to leave or have left the organization.

Research and Publications

→ The Mini Z Worklife and Burnout Reduction Instrument: Psychometrics and Clinical Implications

This article provides the psychometric validation of the Mini-Z burnout assessment tool.

→ A Brief Instrument to Assess Both Burnout and Professional Fulfillment in Physicians: Reliability and Validity, Including Correlation with Self-Reported Medical Errors, in a Sample of Resident and Practicing Physicians

This article assesses the performance characteristics of the Professional Fulfillment Index to measure professional fulfillment and burnout.

→ Professional Satisfaction and the Career Plans of U.S. Physicians

Nearly 1 in 5 US physicians intend to reduce clinical work hours in the next year, and roughly 1 in 50 intend to leave medicine altogether in the next 2 years to pursue a different career.

Resources

Organizational Biopsy®

The AMA has worked with nearly 200 health systems to provide no-cost organizational assessments to health systems interested in holistically measuring and taking action to improve well-being. The Organizational Biopsy® is an assessment tool and set of services that provide a comprehensive assessment (including the validated Mini-Z) across four domains:

→ Organizational Culture (leadership, teamwork, trust, etc.)
→ Practice Efficiency (team structure, team stability, workflows, etc.)
→ Retention (work intentions)
→ Self-Care (post-traumatic stress, post-traumatic growth, work-life balance, etc.)

Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy® data through an online reporting platform. This platform also includes national comparison data. To learn more about this no-cost resource, please see here. You can also learn more about the Practice Transformation efforts of the AMA here.

Case Examples

Hear from 2021 Joy in Medicine recognized organizations

Watch this short video to hear how organizations from around the country have implemented a system-wide annual burnout assessment and leveraged data to inform decision-making.

Bayhealth Working to Bring Joy Back to Medical Staff

This health system spotlights provides an overview of Bayhealth's efforts to measure the well-being of their physicians and incorporate those learnings into their long-term strategy to foster joy in medicine.

Southern California Permanente Medical Group (SCPMG) Recognizes Joy in Medicine and the Value of Transparency

This health system spotlight highlights the SCPMG's use of data and well-being assessments to inform strategic solutions, honest communications, and transparent leadership.

Submission Samples

The following examples are intended to help guide organizations in their submissions to the program. Organizational submissions may vary but should address the key components requested in the program criteria.

Sample 1   SILVER

Organization A has measured burnout using the Mini-Z validated burnout assessment tool for the past four years (June 2019, July 2020, June 2021, June 2022). All physicians and APPs were surveyed. At baseline (June 2019), our burnout rate was 57%. In 2020, this decreased to 53% and in 2021, our burnout rate increased to 64%. Our most recent assessment (June 2022) showed a burnout rate of 61%. This is 7% higher than the current national average. These data were shared in an all staff meeting last month. These data have also been shared with both our executive team (including our CEO, COO, CFO, and CHRO) and our Board of Directors. As part of our Board meeting this past spring, we collaboratively set a target to appoint a wellness liaison in each specialty area of our hospital. Our executive team has approved protected time for wellness liaisons to partake in our quarterly wellness committee meetings and to spearhead one improvement project based on assessment results in their specialty.

Sample 2   GOLD

Organization B has instituted a system-wide burnout assessment since 2020 using the Stanford Professional Fulfillment Index. In 2021, burnout was 47% for physicians and 46% for APPs. In 2022, burnout was 51% for physicians and 46% for APPs. Interestingly, burnout was highest in our family medicine physicians (62% in 2021). These data were used to develop a practice efficiency program for our family medicine physicians over the past 6 months.

Our Board has targeted a 5% improvement in overall burnout by January 2026.

Additionally, we measured work intentions using the following questions:

- What is the likelihood that you will leave your organization in the next 3 years?
- What are the top three reasons you would consider leaving your organization in the next 3 years?

In 2023, intention to leave the organization was 27% (definitely, likely, moderately). The top three reasons for people wanting to leave included: Leadership disengagement, compensation, and being understaffed.

Commitment

Organizational Commitment

Overview

A cross-cutting organizational commitment to workforce well-being is essential to preventing burnout within an organization.

Commitment from an organization may include different strategies over time such as the establishment of a wellness committee or office on well-being, appointing a Chief Wellness Officer, and developing well-being as part of an organization's strategic plan. Gaining institutional buy-in and establishing a plan of action is one of the first key steps in the Joy in Medicine Roadmap.

"Addressing physician burnout is not as simple as one meeting or one day or one initiative. It must be a comprehensive set of steps in order to be impactful. This is about having a longstanding commitment and investment in your most important asset—your people."

– LUIS GARCIA, MD, FACS, MBA, FASMBS
PRESIDENT, SANFORD HEALTH CLINIC

Bronze Criteria

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

Documents related to your well-being committee and/or Office of Well-Being 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. 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 that includes the following: composition and structure of committee (committee members and their roles), key objective(s) of committee, scope of committee, cadence of committee meetings, and reporting structure of committee. All five components listed must be present in your summary.

→ Estimated costs of burnout at your organization as an annual dollar value.

Silver Criteria

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. This individual must report directly to a C-suite leader (e.g., CEO, CMO). The 0.5 FTE allocation should not 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.

Gold Criteria

Develop an organizational physician well-being strategic plan.

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.

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.

Research and Publications

→ Health Care Expenditures Attributable to Primary Care Physician Overall and Burnout-Related Turnover: A Cross-sectional Analysis

This article estimates that turnover in primary care providers results in approximately $979 million in excess health care expenditures with $260 million attributed to burnout-related turnover.

→ The Business Case for Investing in Physician Well-Being

Addressing burnout is part of the fiscal responsibility of all health systems. Burnout can cost organizations millions of dollars per year. This article outlines the business case for investing in well-being and shows that return on investment is measurable.

→ Estimating the Attributable Cost of Physician Burnout in the United States

Using results of recently published research, this article estimates that approximately $4.6 billion in costs related to physician turnover and reduced clinical hours is attributable to burnout each year in the U.S.

→ Estimating Institutional Physician Turnover Attributable to Self-Reported Burnout and Associated Financial Burden: A Case Study

Awareness of the economic cost of physician attrition due to burnout in academic medical centers may help motivate organizational level efforts to improve physician wellbeing and reduce turnover. Institutions interested in the economic cost of turnover attributable to burnout can readily calculate this parameter using survey data linked to a subsequent indicator of departure from the institution.

Resources

→ **Organizational Cost of Physician Burnout**
(calculator)

Use this online calculator to calculate your annual cost of physician burnout based on burnout and turnover data from your organization.

→ **Organizational Evidence-Based and Promising Practices for Improving Clinician Well-Being**

An organization seeking to reduce burnout and improve well-being among its clinicians can create a better work environment by aligning its commitments, leadership structures, policies, and actions with evidence-based and promising best practices. In this discussion paper, the authors outline organizational approaches that focus on fixing the workplace, rather than "fixing the worker," and by doing so, advance clinician well-being and the resiliency of the organization.

→ **Establishing a Chief Wellness Officer Position**

To systematically improve well-being among physicians and other health professionals, organizations need more than ad hoc wellness committees and wellness champions. This toolkit explains the purpose and role of a Chief Wellness Officer (CWO), identifies how a CWO could benefit your organization, and describes how organizations can leverage existing task forces to create the CWO position.

→ **Chief Wellness Officer Road Map**

Once a Chief Wellness Officer (CWO) position has been established within an organization, it is important that the CWO implement specific and effective strategies for change. This toolkit is designed to help new CWOs design their scope and develop an organizational strategy for wellness. It also identifies common pitfalls that new CWOs may experience.

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

The purpose of a well-being program is to address the risks to well-being that are heightened for health care professionals. This article outlines the scope and role of a well-being program, then guides readers through the structure and resources needed to successfully implement a well-being program based on a defined scope and provides a framework for action with metrics for success.

→ **Making the Case for the Chief Wellness Officer in America's Health Systems: A Call to Action**

The establishment of a Chief Wellness Officer will have significant impact on organizational culture, success, and patient outcomes. This article outlines minimum requirements and specific responsibilities for the CWO role.

→ **Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being**

Building upon two groundbreaking reports from the National Academy of Medicine (To Err is Human and Crossing the Quality Chasm), this report provides a framework for a systems approach to professional well-being and recommendations for the field.

→ **A Blueprint for Organizational Strategies to Promote the Well-being of Health Care Professionals**

From the NEJM Catalyst, this resource offers four fundamental components that organizations can use to build a strategy for well-being that is tailored to meeting the unique challenges, opportunities, and goals of each organization.

Case Examples

Hear from 2021 Joy in Medicine recognized organizations

Watch this short video to hear how organizations from around the country have committed to organizational well-being and their advice for organizations that are just getting started.

Ochsner Health Demonstrates Flexibility and Transparency on the Path to Improve Physician Well-Being

This health system spotlight provides a peek into Ochsner's strategic efforts and investment into the professional well-being of their clinicians as they seek long-term culture transformation.

Laying the Groundwork for a Chief Wellness Officer at ChristianaCare

This brief case study provides detailed insight into how ChristianaCare made the case to institutional leadership to establish a Chief Wellness Officer position and the five-year journey of their Center for Worklife Well-Being.

Submission Samples

Program and Committee Charters (samples)　BRONZE

See Appendix B for samples of Committee Charters and structures. These samples come from real organizations but have been anonymized.

Chief Wellness Officer Job Descriptions (samples)　SILVER

See Appendix C for two samples of job descriptions for the Chief Wellness Officer role. These samples come from real organizations but have been anonymized.

Sharing Well-being Metrics with Executive Leadership (sample)　SILVER

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 2023 to review. These results were then reviewed again in our quarterly leadership retreat in September 2023. Our EHR results were also part of this presentation and we were able to leverage this retreat to wholistically describe the intersections of our EHR results with our other survey outcomes (e.g. teamwork results, etc.)

Efficiency of Practice Environment

EHR Metrics and Efficiency

Overview

Operational efficiency is key to supporting well-being. Workflow and technology inefficiencies – in addition to documentation requirements – play a central role in driving burnout among physicians.

Organizations can leverage data from their electronic health record (EHR) to characterize physician time and the clinical work environment to identify inefficient processes or requirements that are prime for intervention. The AMA has outlined several standard metrics that organizations can use to understand the time physicians spend on the EHR, inbox, documentation, and work outside of normal scheduled hours. These metrics will support targeted interventions aimed at improving the underlying work environment so that physicians can spend more time doing meaningful work with patients.

"If you ask physicians about the electronic health record, they'll tell you a lot of positives, but they'll also tell you about a lot of stress points. Some of the solutions to these stress points come down to creating standard metrics, a shared language, and a shared way of thinking about the EHR. The goal at the end of the day is to decrease the amount of screen time and increase the amount of face-to-face time that physicians and patients have."

**– DANIEL MARCHALIK, MD, MBA
EXECUTIVE DIRECTOR, CENTER FOR
WELL-BEING, MEDSTAR HEALTH**

Bronze Criteria

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 should include family medicine and general internal medicine (if these specialties are represented within your organization) in their data pulls.

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 Cerner can be found in Appendix D of the Joy in Medicine Health System Roadmap. Please note that these metrics are NOT synonymous with what may be labeled as "pajama time" 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. If you use an EHR other than Cerner or Epic, please provide the metric that most closely aligns with those above and include information about how that metric is calculated in your EHR.

Measurement should be completed for physicians within a minimum of four specialties. 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 less than four specialties within your organization, the entire physician population should be analyzed and reported in your application.

AND

Share results from EHR audit log 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:

→ Summary of organization's EHR audit results. Summary should include number of physicians in audit, departments audited, and a summary of results. Do not upload actual data files. Please include results for a minimum of four specialties.

→ 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 Cerner or Epic, please include information on how your EHR calculated these metrics using the audit log data.

→ 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.

Silver Criteria

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-Time$_8$), Time on Encounter Note Documentation (Note-Time$_8$), Total EHR Time (EHR$_8$), or Work Outside of Work (WOW$_8$).

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 Cerner can be found in Appendix D of the Joy in Medicine Health System Roadmap. You may also see Table 2 in this article in the Journal of American Medical Informatics Association. 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 Cerner or Epic, 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).

Measurement should be completed for physicians within a minimum of four specialties and 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 less than four specialties within your organization, the entire physician population should be analyzed.

AND ....

Silver Criteria

Actively dismantle 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.

Interventions or dismantling should focus on specific suggestions by physicians that support streamlining their workflows or addressing outdated policy issues. 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 remove or dismantle burdens that provide no value to care.

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

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, departments audited, and a summary of results. Do not upload actual data files.

→ Summary and rationale of methodology used to normalize metrics to account for part-time clinical physicians.

→ Provide summary of at least three administrative burdens you are actively working to dismantle. 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.

Gold Criteria

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.

Formulas for calculating these metrics and normalizing them to 8 hours of patient scheduled hours for Epic or Cerner can be found in Appendix D of the Joy in Medicine Health System Roadmap. You may also see Table 2 in this article in the Journal of American Medical Informatics Association. 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. If you use an EHR other than Cerner or Epic, 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 the normalization to 8 hours of patient scheduled hours.

Supporting documentation:

→ Summary of organization's EHR$_8$ and WOW$_8$ results, normalized to 8 hours of patient scheduled hours.

→ 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.

Measurement should be completed for physicians within a minimum of four specialties. and 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 less than four specialties within your organization, the entire physician population should be analyzed.

AND ···

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

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.

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 pilot or 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 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.

Research and Publications

→ Metrics for Assessing Physician Activity Using Electronic Health Record Log Data

Electronic health record log data has shown promise in measuring physician time spent on clinical activities, contributing to a deeper understanding and further optimization of the clinical environment. This paper outlines 7 core measures of EHR use that reflect multiple dimensions of practice efficiency. These measures are a core component of the Joy in Medicine Health System Recognition Program.

→ Characterizing Physician EHR Use with Vendor Derived Data: A Feasibility Study and Cross-Sectional Analysis

This cross-sectional analysis of ambulatory physicians' EHR use offers methods of implementation across Epic and Cerner and finds that for every 8 hours of scheduled patient time, ambulatory physicians spend more than 5 hours on the EHR.

→ Gender Differences in Time Spent on Documentation and the Electronic Health Record in a Large Ambulatory Network

This cross-sectional study across ambulatory specialties demonstrated that female physicians spend more time on the EHR overall, after hours, and on EHR-based documentation than male physicians. Clinical documentation is the primary activity driving gender differences in EHR time.

→ Electronic Health Records and Burnout: Time Spent on the Electronic Health Record After Hours and Message Volume Associated with Exhaustion but Not with Cynicism Among Primary Care Clinicians

This study finds that primary care physicians and advance practice providers with more than 300 inbox messages per week have six times the odds of burnout compared to those with less than 150 messages per week.

Resources

→ **Extracting EHR Use Metrics from Cerner or Epic**

This brief summary document provides a helpful overview of the EHR metrics requested in the Joy in Medicine Health System Recognition Program and how organizations can extract those metrics from log data in Epic and Cerner. Definitions and example of these measures are provided in addition to formulas that may be used for the calculation of these measures.

→ **Playbook: Taming the Electronic Health Record**

This STEPS Forward® playbook is designed to support daily EHR users, medical directors, practice managers, and operations leaders in minimizing the volume of unnecessary work that is being done, streamlining the workflows around necessary work, and improving proficiency of end users in the EHR.

→ **Playbook: Saving Time**

This STEPS Forward® playbook is designed for anyone interested in process improvement, timesaving workflows, efficiency of practice, and physician well-being. The playbook outlines three strategies that practices and systems can adopt to save time: (1) Stop doing unnecessary work, (2) Incorporate practice fundamentals, and (3) Gain organizational leadership support.

→ **De-Implementation Checklist**

In an effort to reduce unintended burdens, health systems can consider de-implementing processes or requirements that add little or no value to patients and their care teams. This STEPS Forward® checklist includes potential de-implementation actions to consider.

→ **Getting Rid of Stupid Stuff: Reduce the Unnecessary Daily Burdens for Clinicians**

This STEPS Forward® toolkit provides a step-by-step guide to help health systems identify the "stupid stuff" in their day-to-day workflows and provides a standard, organizational process to eliminate these unnecessary burdens.

→ **Reducing Pajama Time and Work Outside of Work (Bozeman Health)**

Dr. Melissa Reily and Dr. Melissa Wolf, Co-Directors of Physician Wellness at Bozeman Health, discuss how to reduce pajama time and work outside of work (WOW) at both the individual and organization-wide level so you can have "more great days."

Case Examples

Hear from 2021 Joy in Medicine recognized organizations

Watch this short video to hear how organizations from around the country have leveraged EHR data to measure physician activity in support of high-yield interventions to reduce time spent on the EHR.

Bozeman Health Takes Small Steps toward a Big Difference in Physician Well-Being

This health system spotlight offers insight into Bozeman Health's "pebble in the shoe" program—an 8-week program for physicians to meet and identify small nuisances in the EHR that prevent them from doing their jobs more efficiently. Bozeman leverages EHR data to measure the impact and success of this program.

Make the Electronic Health Record Work Easier and Cut Down on Daily Clicks

Atrius Health developed a 5-component intervention in collaboration with their IT department to reduce clinician burnout and improve satisfaction associated with the EHR.

Optimizing Electronic Health Record Use in Any Clinic Setting with a Dedicated IT-Focused Team

University of Colorado Health (UCHealth) initiated a Sprint program to create EHR efficiencies through observation, re-training, fixing technical issues, and deploying new tools.

Erlanger Health: Empowering the Team

Erlanger Health deployed an intervention bundle for primary care and inpatient care focused on decreasing provider documentation burden, increasing EHR usability, and automating repetitive tasks.

Submission Samples

Sample 1 BRONZE

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, 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. All summary results were provided to department chairs. See summaries below:

Average Inbox-Time summaries per specialty

→ **Family medicine** (N=117): 3.4 hours per day
→ **OBGYN** (N=56): 2.7 hours per day
→ **Cardiology** (N=37): 2.0 hours per day
→ **Neurology** (N=25): 2.1 hours per day

Sample 2   SILVER

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

Average WOW_8 summary:

- → **Internal medicine PHYSICIANS** (N=78): 2.6 hours per 8 hours of patient scheduled time
- → **Internal medicine APPs** (N=37): 2.5 hours per 8 hours of patient scheduled time
- → **Family medicine PHYSICIANS** (N=56): 3.7 hours per 8 hours of patient scheduled time
- → **Family medicine APPs** (N=46): 3.4 hours per 8 hours of patient scheduled time
- → **Anesthesiology PHYSICIANS** (N=22): 0.6 hours per 8 hours of patient scheduled time
- → **Anesthesiology APPs** (N=8): 0.4 hours per 8 hours of patient scheduled time
- → **Psychiatry PHYSICIANS** (N=11): 1.2 hours per 8 hours of patient scheduled time
- → **Psychiatry APPs** (N=0): N/A

Average $Note\text{-}Time_8$ summary:

- → **Internal medicine PHYSICIANS** (N=78): 34 min per 8 hours of patient scheduled time
- → **Internal medicine APPs** (N=37): 37 min per 8 hours of patient scheduled time
- → **Family medicine PHYSICIANS** (N=56): 120 min per 8 hours of patient scheduled time
- → **Family medicine APPs** (N=46): 107 min per 8 hours of patient scheduled time
- → **Anesthesiology PHYSICIANS** (N=22): 2 min per 8 hours of patient scheduled time
- → **Anesthesiology APPs** (N=8): 2 min per 8 hours of patient scheduled time
- → **Psychiatry PHYSICIANS** (N=11): 34 min per 8 hours of patient scheduled time
- → **Psychiatry APPs** (N=0): N/A

Sample 2   SILVER   – Continued

Average Inbox-Time$_8$ summary:

→ **Internal medicine PHYSICIANS** (N=78): 56 min per 8 hours of patient scheduled time

→ **Internal medicine APPs** (N=37): 109 min per 8 hours of patient scheduled time

→ **Family medicine PHYSICIANS** (N=56): 110 min per 8 hours of patient scheduled time

→ **Family medicine APPs** (N=46): 127 min per 8 hours of patient scheduled time

→ **Anesthesiology PHYSICIANS** (N=22): 23 min per 8 hours of patient scheduled time

→ **Anesthesiology APPs** (N=8): 0.9 min per 8 hours of patient scheduled time

→ **Psychiatry PHYSICIANS** (N=11): 17 min per 8 hours of patient scheduled time

→ **Psychiatry APPs** (N=0): N/A

AND ···

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 2022. 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.

Sample 3 `GOLD`

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 biyearly 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 EHR8 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 WOW8 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:

Sample 3   GOLD   – Continued

→ 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 5 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 month 3 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

Team-Based Care

Overview

Effective teamwork can have a tremendous impact on the overall well-being of physicians and care teams.

Effective teamwork has been linked to less stress, higher job satisfaction, and improvements in patient care. Teamwork and team-based care must be purposefully cultivated and must consider more than just whether team members "get along." Rather, cultivating effective teamwork and team-based care must consider a wide range of factors such as team structures, role functions, and workflows that enhance the ability for teams to work together more seamlessly.

"We weave a social fabric in which our patients and families can feel safe and cared for. It only takes one person to create a wrench in that fabric. Teamwork—and focusing on the well-being of our staff—is crucially important to creating that social fabric."

– JAY KAPLAN, MD, FACEP
MEDICAL DIRECTOR OF CARE TRANSFORMATION, LCMC HEALTH

Bronze Criteria

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.

Organizations may use AHRQ's TeamSTEPPS assessment (must include team structure, mutual support, and communication subscales), the 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), AMA's Organizational Biopsy® (see Appendix E) or similar instrument.

Measurement should be completed for physicians within a minimum of four specialties. Family medicine and general internal medicine should be included if these specialties are represented within your organization. If you have less than four specialties within your organization, the entire physician population should be analyzed.

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).

The AMA offers no-cost assessments, which include burnout, teamwork, and leadership assessments. To learn more about this opportunity, please visit our website or reach out to us at Practice.Transformation@ama-assn.org

Silver Criteria

Measure teamwork for orders (TW$_{ORD}$) in a minimum of four specialties (must include family medicine and general internal medicine) via EHR audit within the last 2 years. Share results with frontline physicians from each specialty included in measurement.

Formulas for calculating TW$_{ORD}$ using audit log data from Epic or Cerner can be found here. 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 less than four specialties within your organization, the entire physician population should be analyzed.

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

Results must be shared with all frontline physicians from each specialty included in measurement.

Supporting documentation:

→ Summary of organization's TW$_{ORD}$ results from EHR audit. (Please do not upload actual data files)

→ Share methodology for calculating teamwork for orders.

→ Describe when and where TW$_{ORD}$ results were shared with frontline physicians.

Gold Criteria

Develop and implement an intervention to improve teamwork based on results from teamwork assessment and TW$_{ORD}$ results.

This criterion should be focused on specific interventions in pilot or advanced stages that have been executed (with data to measure their effectiveness) to support improved teamwork and practice efficiency. Details should include: short description of intervention and rationale for intervention, date of intervention, and **pre- and post-results**. Rationale for intervention should be rooted in data from the assessment and EHR.

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 pre- and post-results of the intervention.

Research and Publications

→ Metrics for Assessing Physician Activity Using Electronic Health Record Log Data

Electronic health record log data has shown promise in measuring physician time spent on clinical activities, contributing to a deeper understanding and further optimization of the clinical environment. This paper outlines 7 core measures of EHR use that reflect multiple dimensions of practice efficiency. These measures are a core component of the Joy in Medicine Health System Recognition Program.

→ Powering Up Primary Care Teams: Advanced Team Care with In-Room Support

Evidence shows that advanced team care with in-room support makes primary care more satisfying to clinicians, staff, and patients, while enhancing care quality. This article outlines the team-based care model, evidence to support the implementation of this model, and opportunities for organizations to adopt this model.

→ The Solution Shop and the Production Line: The Case for a Frameshift for Physician Practices

From the NEJM, this commentary reflects on how organizations should strategically direct necessary production-line work in medical practices away from the professionals with the most clinical expertise so that physicians' skills are preserved for the nuanced work of problem solving, medical decision making, and relationship building.

Resources

→ Team-Based Care: Improve Patient Care and Team Engagement Through Collaboration and Streamlined Processes
This STEPS Forward® toolkit describes key elements of team-based care, how to implement team-based care in your organization, and the myriad benefits of team-based care in pursuit of the Quadruple Aim.

→ Daily Team Huddles: Boost Practice Productivity and Team Morale
This STEPS Forward® toolkit identifies the value of daily team huddles to the operations of your organization and identifies ways to make daily team huddles routine.

→ Appreciative Inquiry Principles: Ask "What Went Well" to Foster Positive Organizational Culture
This STEPS Forward® toolkit provides a guide to incorporating appreciative inquiry into daily work and existing performance improvement initiatives in order to empower teams to problem solve together.

→ Extracting EHR Use Metrics from Cerner or Epic
This summary document provides a helpful overview of the EHR metrics (including TW_{ORD}) requested in the Joy in Medicine Health System Recognition Program and how organizations can extract those metrics from log data in Epic and Cerner. Definitions and example of these measures are provided within in addition to formulas that may be used for the calculation of these measures.

→ Organizational Biopsy®
The AMA has worked with nearly 200 health systems to provide no-cost organizational assessments to health systems interested in holistically measuring and taking action to improve well-being. The Organizational Biopsy® is an assessment tool and set of services that provide a comprehensive assessment (including the validated Mini-Z) across four domains:

- *Organizational Culture (leadership, teamwork, trust, etc.)*
- *Practice Efficiency (team structure, team stability, workflows, etc.)*
- *Retention (work intentions)*
- *Self-Care (post-traumatic stress, post-traumatic growth, work-life balance, etc.)*

Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy® data through an online reporting platform. This platform also includes national comparison data. To learn more about this no-cost resource, please see here. You can also learn more about the Practice Transformation efforts of the AMA here.

Case Examples

Hear from 2021 Joy in Medicine recognized organizations

Watch this short video to hear how organizations from around the country are evaluating leaders in order to identify development opportunities for leaders to improve.

Leverage Standing Orders and Protocols to Ease In-Basket Burdens

This case study highlights how Bellin Health implemented new in-basket protocols to ensure that the right team members were handling the right messages.

Medical Assistants Are the Cornerstones of Successful Team-Based Care

This case study highlights how Stanford Coordinated Care has shifted more responsibilities to their medical assistants to improve both physician and overall practice efficiency.

Virginia Mason Kirkland Medical Center: Workflow Optimizations and Team-Based Care

Through the adoption of the Virginia Mason Production System (VMPS), the Virginia Mason Kirkland Medical Center has built a system-wide quality improvement methodology in which standardized processes reduce variation and improve outcomes for patients and the health care team.

Submission Samples

Sample 1   BRONZE

Our health system has measured teamwork using the subscales provided in the AMA's 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 2022 assessment.

Team Structure Summary:

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 1 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 3 other physicians
→ **Gastroenterology** (N=27): 93% of our EM physicians share clinical support staff with 3 other physicians.

Sample 1 BRONZE **– Continued**

Team Function Summary:

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 APP 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

Sample 1 BRONZE – Continued

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%

Sample 1   BRONZE   – Continued

Barriers to Teamwork Summary

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%

Sample 2   SILVER

Leveraging our EHR (Epic) data, we were able to calculate Teamwork for Orders (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 2023.

Sample 3 GOLD

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 6 months. The department targeted at 20% improvement in TW$_{ORD}$ within 6 months and TW$_{ORD}$ scores were pulled monthly during the 6-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 6-month intervention period, TW$_{ORD}$ had increased from 34% at baseline to 56% at the 6-month mark, 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

Leader Development and Dismantling Administrative Burdens

Overview

Leadership behaviors set the foundation of organizational culture, a primary indicator of organizational well-being.

Leaders cultivate teams and directly support their growth, development, and overall well-being. Immediate leaders are particularly important in driving professional satisfaction and fostering teamwork. Measuring leader behaviors inside an organization is an important step to understand how leaders are perceived by the teams they lead and where improvements in leader behaviors can have the highest impact. Effective leadership is foundational to the health and well-being of an organization.

"Leadership (or a lack thereof) is an upstream driver of physician burnout. By addressing leadership and leadership skills specially, we can try to prevent burnout before it becomes an issue."

**– AMY LOCKE, MD, FAAFP
CHIEF WELLNESS OFFICER,
UNIVERSITY OF UTAH HEALTH**
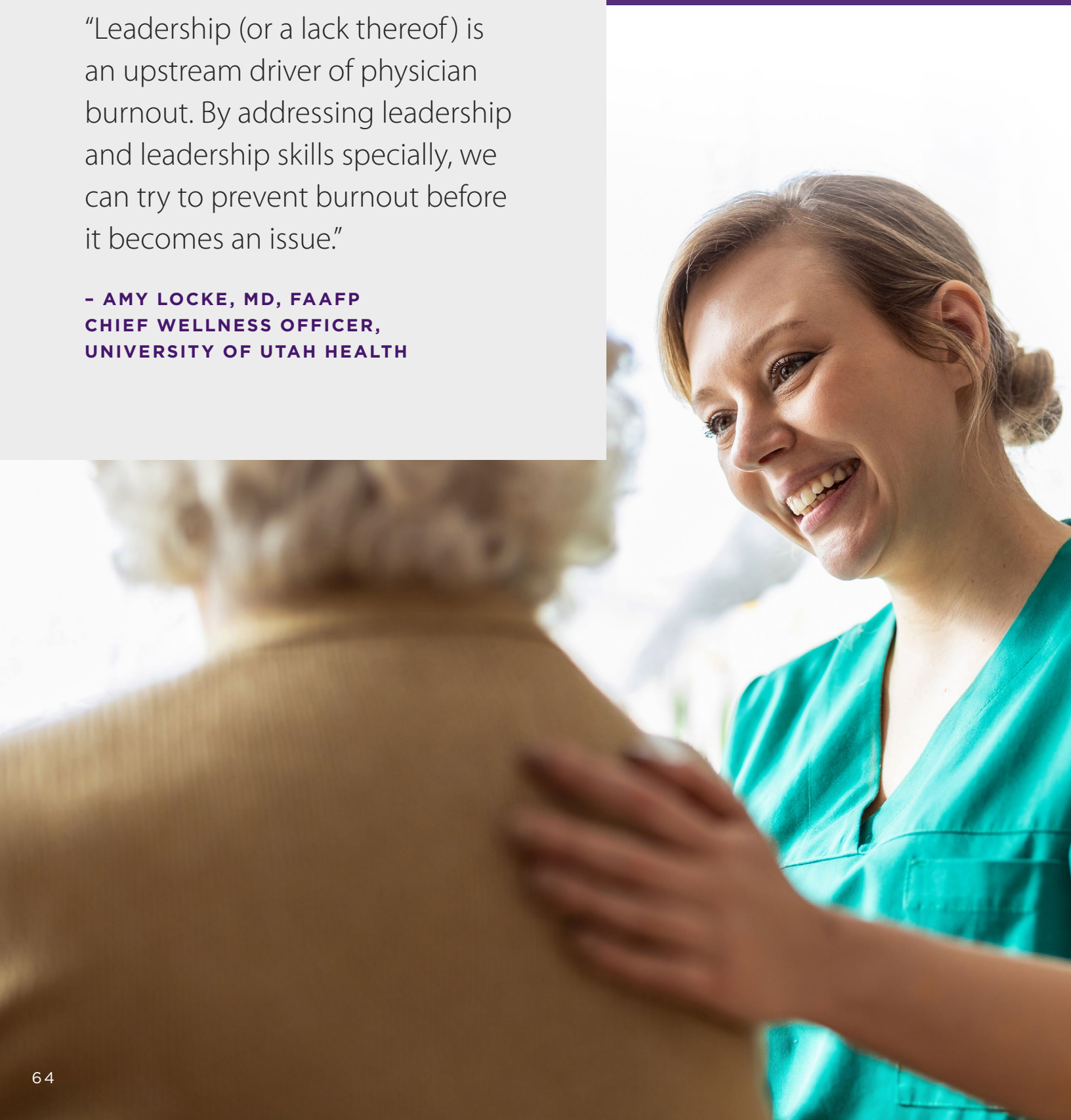
Bronze Criteria

Implement a leader listening campaign to engage physicians to uncover and address sources of burnout.

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 physicians. 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 a brief (3-5 sentences) narrative summary of listening campaign. Summary should include: who led the listening campaign, when the listening campaign took place, and key insights learned from the listening campaign.

The AMA offers no-cost assessments, which include burnout, teamwork, and leadership assessments. To learn more about this opportunity, please visit our website or reach out to us at Practice.Transformation@ama-assn.org

Silver Criteria

Measure core leadership behaviors that support physician well-being in all frontline leaders at least once in the last two years and share results (in a psychologically safe manner) with the leaders who were evaluated.

Assessment of leaders should be completed by the physicians who report to the leader, not the general administration of the organization. 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 everyone is psychologically safe

→ Inform: Transparently share what you know with the team

→ Inquire: Consistently solicit input from those you lead

→ Develop: Nurture and support the professional development and aspiration of team members

→ Recognize: Express appreciation and gratitude in an authentic way to those you lead

Organizations may use the Mayo Leadership Index, AMA's Organizational Biopsy® (see Appendix F), or similar instrument. If you use an assessment other than the Mayo Leadership Index or the AMA Organizational Biopsy®, you will be asked to provide the questions used to assess each of the five leadership behaviors above. Results should be reported by specialty. Family medicine and general internal medicine should be included if they are represented in your system.

Supporting documentation:

→ Provide name of instrument and/or list of questions used to assess five core leader behaviors that support physician well-being and summary of leadership 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).

Gold Criteria

Implement a leader development program based on the individual needs of each leader identified through the leadership survey completed by physicians within that leader's unit.

Leader development program should also help individual leaders develop skills that promote the five core leader behaviors and should support leaders in enhancing their core leader behaviors based on the specific feedback they received from physicians in their unit through the leadership assessment.

This 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. Leader development program should support leaders in enhancing their core leader behaviors based on the feedback they received in the leadership assessment.

Supporting documentation:

→ Description of leader development program. Description should include information on the overall curriculum, objectives of the program, and who is eligible to complete the program and how customized feedback and coaching is provided to individual leaders based on survey responses from physicians in their unit. Description should clearly include a summary of skills that physicians will gain by participating in the program and should show how the curriculum supports leaders' development in the five core leader behaviors. The documentation should also show how leadership assessment results were incorporated into leader development program so that leaders can use feedback to improve leadership skills.

Research and Publications

→ Impact of Organizational Leadership on Physician Burnout and Satisfaction

From the Mayo Clinic Proceedings, authors found that an increase in composite leadership score for a physician leader was associated with a decrease in likelihood of burnout and an increase in likelihood of satisfaction of physician supervised.

→ Association of Burnout, Professional Fulfillment, and Self Care Practices of Physician Leaders with Their Independently Rated Leadership Effectiveness

From JAMA, this article outlines the need to consider training, skill building, and support to improve leader well-being.

→ Executive Leadership and Physician Well-Being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout

From Mayo Clinic Proceedings, this article identifies nine organizational strategies to promote engagement and reduce burnout as well as how the Mayo Clinic is operationalizing some of these approaches. Deliberate, sustained, and comprehensive efforts by the organization to reduce burnout can make a difference. Many effective interventions are relatively inexpensive and small investments can have a large impact.

→ Wellness-Centered Leadership: Equipping Health Care Leaders to Cultivate Physician Well-Being and Professional Fulfillment

Authors propose a new Wellness-Centered Leadership model centered on 3 key elements: care about people always, cultivate individual and team relationships, and inspire change.

→ Impact of Leadership Behaviour on Physician Well-Being, Burnout, Professional Fulfilment and Intent to Leave: A Multicentre Cross-Sectional Survey Study

Perceived leadership behaviors have a strong relationship with burnout, professional fulfilment and intent to leave among physicians. Organizations should consider leadership development as a potential vehicle to improve physician wellness and prevent costly physician departures.

Resources

→ **Cultivating Leadership: Measure and Assess Leader Behaviors to Improve Professional Well-Being**

Leaders matter. From AMA STEPS Forward®, this toolkit explains the significance of leadership in promoting well-being and outlines steps an organization can take to measure and improve leader behaviors to reduce burnout and improve physician satisfaction.

→ **Organizational Biopsy®**

The AMA has worked with nearly 200 health systems to provide no-cost organizational assessments to health systems interested in holistically measuring and taking action to improve well-being. The Organizational Biopsy® is an assessment tool and set of services that provide a comprehensive assessment (including the validated Mini-Z) across four domains:

- *Organizational Culture (leadership, teamwork, trust, etc.)*
- *Practice Efficiency (team structure, team stability, workflows, etc.)*
- *Retention (work intentions)*
- *Self-Care (post-traumatic stress, post-traumatic growth, work-life balance, etc.)*

Following an assessment, organizations receive an executive summary of their key findings and access to the Organizational Biopsy® data through an online reporting platform. This platform also includes national comparison data. To learn more about this no-cost resource, please see here. You can also learn more about the Practice Transformation efforts of the AMA by clicking here.

→ **Learn How to Design and Lead a Physician Well-Being Program (Stanford CWO Course)**

This executive program, offered by Stanford Medicine WellMD & WellPhD Center, is a one-week immersion course and year-long alumni community for physician well-being leaders who are carefully selected based on their role and scope.

→ **De-Implementation Checklist**

In an effort to reduce unintended burdens, health systems can consider de-implementing processes or requirements that add little or no value to patient and their care teams. This list includes potential de-implementation actions to consider.

→ **Getting Rid of Stupid Stuff: Reduce the Unnecessary Daily Burdens for Clinicians**

This STEPS Forward® toolkit provides a step-by-step guide to help health systems identify the "stupid stuff" in their day-to-day workflows and provides a standard, organizational process to eliminate these unnecessary burdens.

Case Examples

Hear from 2021 Joy in Medicine recognized organizations

Watch this short video to hear how organizations from around the country are evaluating leaders in order to identify development opportunities for leaders to improve.

Atrius Health Promotes Joy in Medicine through Local and Global Improvements

This health system spotlight on Atrius Health provides an inside look at the early days of Atrius Health's well-being program, their approach to actively engage all departments in their well-being efforts, and a coaching program available to all leaders inside the organization to help leaders focus on developing core leader behaviors and activating their teams to identify solutions.

Submission Samples

Sample 1   SILVER

Using the Mayo Leadership Index, we assess all leaders within our system once every 2 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 leadership 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 leadership survey results for 4 specialties from our 2022 leadership 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 7 frontline leaders)
    Index Score Average: 45

→ **Emergency Medicine** (N=46 total responses, representing 9 frontline leaders)
    Index Score Average: 52

→ **Neurology** (N=14 total responses, representing 3 frontline leaders)
    Index Score Average: 49

→ **Oncology** (N=28 total responses, representing 5 frontline leaders)
    Index Score Average: 42

Sample 2   GOLD

Our health system recently implemented a professional development series for physician leaders that covers several key leadership topics, including communication, transitioning to leadership, team culture, and critical practices for leading a team. This series includes a 60-min didactic session and 2 one-hour breakout sessions for each topic area. Supervisors are required to attend and are provided with protected time to attend these sessions. As part of this development series, leaders are assessed annually using an index like the Mayo Leadership Index, which assesses several domains: team cultivation (how leaders empower their team and encourage employees to suggest ideas for improvement), career development (how leaders foster career development for their team and hold conversations to support such development), and communication (transparent and frequent communication about the organization and team as a whole). Immediate supervisors are provided their aggregated, anonymized responses annually and department directors hold 1:1 conversations with supervisors to review results and identify areas for improvement in the next year. Physicians also have the ability to opt-in to individual coaching sessions based on their leadership results. These coaching sessions are designed to support leaders in the areas that they scored lowest on the Leadership Index.

In addition to our development series noted above, we have also developed an early career faculty development program and a mid-career faculty leadership program to meet the unique needs of these individuals and keep them engaged in our organization.

Support

Organizational Support for Individual Resiliency

Overview

Cultivating connections at work is an important means to driving professional satisfaction.

These connections may be fostered through both formal and informal programs. These programs may include peer-to-peer discussions (buddy systems), small group dinners, formal peer support programs, or peer coaching programs. Peer support is a key component of building a culture of trust and collegiality.

"Supporting our physicians is an important value to us as an organization. We take care of each other; we serve together with love and excellence. The more that we invest in one another's well-being, the better the experience becomes for each of us and the more motivated we are to continuing serving in that way."

**– HEATHER FARLEY, MD, MHCDS, FACEP
CHIEF WELLNESS OFFICER,
CHRISTIANACARE**

Bronze Criteria

Implement a peer support program dealing with adverse clinical events.

Peer support program(s) include both informal and formal avenues by which physicians support their physician colleagues after an adverse event. Employee assistant programs (EAPs) are not sufficient for this criterion.

AND

Review and, if present, change invasive or stigmatizing language around mental health and substance use disorders in your organization's credentialing applications/process.

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 about past treatment or experiences with mental health and substance use disorder treatment.

Suggestions for changes can be found in the All In Campaign's toolkit (page 7). The Federation of State Medical Boards also has recommended language, in which they suggest the use of one question that addresses all mental and physical health conditions as one, with no added explanations or fine print:

Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (yes/no)

Additional information can also be found through the AMA's Debunking Regulatory Myths series, the AMA Advocacy Resource Center issue brief, "Confidential care to support physician health and wellness," and the National Institute for Occupational Safety and Health (NIOSH) supportive statement.

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.

→ Provide draft of updated credentialing application, including revised questions based on the recommendations above. Please provide information about when these newly revised questions will be available and implemented in your system.

Silver Criteria

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.).

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

→ Other examples based on information collected through organizational assessments and survey feedback

AND

Communicate changes made to credentialing application and credentialing process, assuring physicians that it is safe for them to seek care.

Communication should be direct, specific, and transparent and should include supportive language, assuring physicians that it is safe for them to seek care. Applications should be available and easily accessible (e.g., on your website). Communication templates can be accessed via the All In Campaign's toolkit.

Supporting documentation:

→ Provide description for at least two programs or policies that have been implemented to support physicians beyond adverse clinical events. 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.

→ Share brief summary about how you have communicated credentialing changes, including samples communication materials used.

Gold Criteria

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

Some examples may include:

→ Formal peer support program wherein peer supporters are trained to use empathetic listening, question-asking, and sharing of personal experiences

→ 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 ···

Review existing policies related to mental health and psychological safety and, if needed, implement policy changes that further destigmatize mental health and enhance psychological safety inside the organization.

Share any changes made to existing policies to further reduce mental health stigma and expand access to mental health services.

AND ···

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

Briefly describe how your organization provides access to 24/7 confidential mental health services.

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 your organization's process for reviewing existing policies related to mental health and psychological safety. Describe any changes made to existing policies to further reduce mental health stigma and expand access to mental health services.

→ Brief description of how your organization provides access to 24/7 confidential mental health services.

Research and Publications

→ Colleagues Meeting to Promote and Sustain Satisfaction (COMPASS) Groups for Physician Well-Being: A Randomized Clinical Trial

Authors from the Mayo Clinic describe a self-facilitated small-group meeting intervention used to improve burnout, depressive symptoms, and job satisfaction.

→ Physicians' Needs in Coping with Emotional Stressors: The Case for Peer Support

Physician colleagues ranked peer support as their most desired options of support, outnumbering traditional mechanisms such as employee assistance programs or mental health professionals.

→ Battle Buddies: Rapid Development of a Psychological Resilience Intervention for Health Care Workers During the COVID-19 Pandemic

Authors from the University of Minnesota Medical Center describe an evidence-informed peer support "Battle Buddy" program deployed throughout COVID-19.

→ Childcare Stress, Burnout, and Intent to Reduce Hours or Leave the Job During the COVID-19 Pandemic Among US Health Care Workers

In this survey study, childcare stress was disproportionately described across different subgroups of HCWs and was associated with anxiety, depression, burnout, intent to reduce hours, and intent to leave. Addressing childcare stress may improve HCWs' quality of life and HCW retention and work participation.

Resources

→ **Peer Support Programs for Physicians Mitigate the Effects of Emotional Stressors Through Peer Support**

This STEPS Forward® toolkit describes five essential steps to building a peer support program and ways to address common challenges that may arise when first implementing a peer support program.

→ **PeerRxMed**

PeerRxMed is a free, peer-supported program designed to help physicians and others on the care team move toward thriving both personally and professionally.

→ **What Matters to You? Conversation Guide for Improving Joy in Work**

From the Institute for Healthcare Improvement, this resource can help leaders understand what's meaningful to staff and the factors contributing to their burnout.

→ **The RISE Program: Armstrong Institute for Patient Safety and Quality**

From Johns Hopkins Medicine, the RISE Program provides training to health care professionals on peer responder basics.

Case Examples

Hear from 2021 Joy in Medicine recognized organizations

Watch this short video to hear how organizations from around the country have developed peer support programs and why this has been essential in their overall strategy to reduce burnout.

COMPASS Groups Rejuvenate Relationships and Reduce Burnout

This case example highlights how the Mayo Clinic Department of Medicine developed and implemented COMPASS group dinners to encourage collegiality, shared experience, connectedness, mutual support, and meaning in work.

Scaling Peer Support from Pilot Project to Hospital-Wide Service

Northwestern Medicine developed their Scholars for Wellness Program to help develop physician champions into well-being experts capable of channeling their unique insights and personal experiences into developing and launching well-being programs for their colleagues. Learn how Northwestern designed, launched, and scaled this innovative program.

How ChristianaCare Provides System-Wide Peer-To-Peer Support

This case example highlights ChristianaCare's approach to providing trained peer supporters throughout the organization to support clinicians in response to specific stressful events.

Ohio State Wexner Medical Center: Peer Support and Trauma Debriefings

Through the use of Brief Emotional Support Teams (BESTs), Ohio State's Stress, Trauma, and Resilience (STAR) Program offers mental and psychological support to clinicians after stressful and traumatic events, such as the loss of a patient.

Submission Samples

Sample 1   SILVER

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 2 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 APPs 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 6 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.

AND ·

Sample 1 SILVER **– Continued**

Following the changes to our credentialing applications, we made it an institutional priority to clearly communicate these changes to our physicians via a 6-month communications campaign.

- Our CEO shared a message to all employees in January 2023, emphasizing organizational support for employees needing to seek mental health care. This video message (sent via email) also emphasized existing mental health resources that are available to all employees and how they can be accessed. Included in this message was also information about how credentialing questions have been updated and that these changes are effective immediately.

- Department chairs were provided with an email template and were encouraged to email their departments about these changes as well. This template included the exact language that will now be used in our credentialing applications.

- Our credentialing application can now be located on our public-facing website and we are working with our web team to make this more accessible/viewable when on the website.

- Flyers were posted throughout our institution describing these changes and communicating our organizational support for mental health.

- Our intranet site's homepage features these changes and easy links to mental health resources.

Sample 2 GOLD

Four years ago, our health system developed its first Peer Support Program prompted by surveys showing that 47.91% of staff had experienced a stressful patient-related event in the prior year causing significant depression, anxiety, or concern about their ability to perform their job. Staff nominated trusted colleagues for the Peer Connection Program. Peer Supporters attended two 6-hour trainings and were introduced to resources available to distressed staff.

Through our Peer Connection program, Peer Supporters are available to provide brief confidential support to their peers with information and referral to additional resources to promote healing and recovery in the wake of stressful patient-related events. Information about the program is provided through Risk Management, Schwartz Rounds, departmental newsletters, departmental presentations and discussions. The Peer Connections program was re-assessed in 2018-2019, and funding provided for a Physician Lead. Utilization suggested that usage of the program was not consistent with estimated need. In addition, there had been attrition of peer supporters and champions, creating a need for new trainings.

Additionally, our health system has recently formalized a version of COMPASS group dinners for our physicians. These dinners are coordinated by our Office of Well-Being and held in a private room at a nearby restaurant. Groups consist of 8-10 physicians and we typically group physicians together that do not typically work with one another. Physicians are able to sign up for these dinner options through an online portal and must wait 6 months before signing up for a second dinner (to give everyone a chance to participate if they would like). These dinners are not required but are HIGHLY encouraged by our department and executive leadership. One physician facilitator is identified in the weeks leading up to the dinner and are provided with discussion prompts to use throughout the dinner if needed. Since launching this program last year, more than 75% of physicians have participated in at least one dinner.

AND

Sample 2 GOLD **– Continued**

Our current policies related to mental health are focused on encouraging access and in destigmatizing help-seeking. We re-reviewed all existing policies and feel they align with our desire to ensure that our employees feel supported and encouraged to prioritize their mental health and to ensure that there will not be negative consequences for seeking help. We have a zero tolerance policy related to any retribution that is perceived by an employee to be related to them seeking mental health support and we have offered access to 24/7 mental health services for free since 2015. We continue to communicate this through our monthly "Total well-being" newsletter which focuses heavily on eliminating mental health stigma through story-telling and review of existing resources both through our organization and through our community.

AND

We have provided free access to mental health services for all employees since 2015. It is completely anonymous and we are not provided with names or data related to employees using the 24/7 toll-free number. This number is included in the footer of ALL organizational communications and can be readily seen throughout our physical buildings in staff lounges, bathrooms, etc.

AMA Practice Transformation Journey

Moving together toward impact

The Joy in Medicine Health System Recognition Program is one part of the AMA practice transformation journey.

Helping health systems and clinical practices succeed in their journey is critical to the AMA. That's why we offer evidence-based, field-tested solutions to guide physicians and care teams each step of the way.

Increasing efficiencies, improving patient care and enhancing professional satisfaction—these are what increase Joy in Medicine™ and make the journey worthwhile.

Questions? Email us at Practice.Transformation@ama-assn.org.

"It's really important that we focus on fixing the work environment rather than fixing the workers."

– CHRISTINE SINSKY, MD VICE PRESIDENT OF PROFESSIONAL SATISFACTION, AMERICAN MEDICAL ASSOCIATION

Appendix

This Appendix provides sample application materials across various criteria, as noted throughout the Roadmap.

This Appendix also includes sample questions accepted in the Assessment, Teamwork, and Leadership domains of the Recognition Program.

These questions are denoted from the AMA Organizational Biopsy®.

The AMA offers no-cost assessments, which include burnout, teamwork, and leadership assessments. To learn more about this opportunity, please visit our website or reach out to us at Practice.Transformation@ama-assn.org.

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.

Appendix A

Assessment GOLD – Work Intention Questions from AMA's Organizational Biopsy®

Intent to Reduce Work Hours:

What is the likelihood that you will reduce the number of hours you devote to clinical care over the next 12 months?

- None
- Slight
- Moderate
- Likely
- Definitely

What would keep you in your role with at least the current amount of clinical %FTE?
(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 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)

Intention to Leave

What is the likelihood that you will leave your current organization within two 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

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 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)

Appendix B

Commitment BRONZE – Wellness Committee Charters and Objectives

Wellness Committee Charter SAMPLE A

PURPOSE:

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

VISION:

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

MISSION:

Promote provider 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 provider resiliency
→ Develop strategies/events to maintain a culture of wellness
→ Work with CMIO and IT to develop Epic solutions to enhance provider efficiency
→ Work with Leadership on institutional strategies to improve provider well being

SCOPE OF COMMITTEE:

Physicians and APPs

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: 3 year terms will be enacted in 2022 (with gradual rollout)
- · Members may serve for 2 consecutive terms
- · After serving for 2 terms, members may reapply after a respite of 1 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 wellbeing 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 3-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.

Appendix C

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 wellbeing of Health System caregivers. The CWO oversees advocacy programs and initiatives aimed at optimizing the caregiver experience and fostering an organizational culture of wellbeing. The CWO collaborates closely with leaders in multiple key departments whose operations impact caregiver wellbeing.

Principal Duties and Responsibilities:

→ Oversees the work of the Center for Provider Wellbeing

→ Oversees longitudinal assessment of burnout and professional fulfillment across the organization

→ Oversees assessment of the efficacy of wellbeing 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 wellbeing 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 wellbeing

→ Ensures alignment of wellbeing and caregiver experience efforts with organizational priorities

→ Oversees review and refinement of relevant strategies, policies, and procedures impacting caregiver wellbeing

→ 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 wellbeing 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 M.D. or D.O. 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 & 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

Appendix D

Extracting EHR-use Metrics from Cerner or Epic

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 InBasket messages physician 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 (Doc-Time), Inbox (IB). The built-in metrics of the EHR do not fully reflect the experiences of physicians. 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 Teamwork for Orders (TW$_{ORD}$), which measures the percentage of orders that have team contribution.

All time-based EHR-use metrics are normalized to 8 hours of patient scheduled time. Together, these metrics can help organizations more fully understand the experiences of their physicians and identify workflow enhancements and processes that reduce burden.

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 4 weeks or 5 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.

→ The scheduled hours from Epic's relational database (Clarity) are more difficult to obtain. IT personnel must be intimately familiar with the database tables and have a strong command of SQL. The SQL code is complex, involving multiple table joins and advanced logic.

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

MEASURE	ABBREVIATION	DEFINITION AND EXAMPLE
Total EHR Time	EHR-Time$_8$	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	Doc-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$_8$ = 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
Teamwork for Orders	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: Cerner via its Advance program and Epic via Signal. Off the shelf measures from vendors other than Epic or Cerner 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 Cerner'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 Cerner'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.

Epic Formulas

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

EHR_{day}	$$EHR_{day} = \frac{\text{Signal 'Time in System' (min)}}{\text{day}}$$
EHR_8	$$EHR_8 = \frac{\text{Signal 'Time in System' (min)/60 min}}{\text{Scheduled Hours (Clarity)}} * 8$$
WOW_{day}	$$\frac{\text{Signal 'Time Outside Scheduled Hours' (min)} + \text{Signal 'Time on Unscheduled Days' (min)}}{\text{day}}$$
WOW_8	$$\frac{\text{Signal 'Time Outside Scheduled Hours' (min)/60 min} + \text{Signal 'Time on Unscheduled Days' (min)/60 min}}{\text{Scheduled Hours (Clarity)}} * 8$$
$DocTime_{day}$	$$\frac{\text{Signal 'Time in Notes' (min)}}{\text{day}}$$
$Doc\text{-}Time_8$	$$\frac{\text{Signal 'Time in Notes' (min)/60 min}}{\text{Scheduled Hours (Clarity)}} * 8$$
$Inbox\text{-}Time_{day}$	$$\frac{\text{Signal 'Time in InBasket' (min)}}{\text{day}}$$
$Inbox\text{-}Time_8$	$$\frac{\text{Signal 'Time in InBasket' (min)/60 min}}{\text{Scheduled Hours (Clarity)}} * 8$$
TW_{ORD}	$$\frac{\text{Number of orders with team contribution}}{\text{Total number of orders placed by physician}}$$

Cerner Formulas

Table 3: Formulas for Calculating Core EHR-use Metrics with 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	$$\frac{(\text{Advance 'Actual Time Per Patient' (min)}/60) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} * 8$$
WOW_{day}	(% of total EHR time that is afterhours) × (EHR time per day)
WOW_8	$$\frac{(\text{Advance 'Percentage of Time After Hours'})/100 \times (\text{Advance 'Actual Time Per Patient' (min)}/60) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} * 8$$
$DocTime_{day}$	Documentation Time Per Patient (min) x Patients Seen/day
$Doc\text{-}Time_8$	$$\frac{(\text{Advance 'Documentation Time Per Patient' (min)}/60) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} * 8$$
$Inbox\text{-}Time_{day}$	(Time per Patient (min): Messaging + Endorse Results + Approve Orders + Sign Review + Order Refill) × Patients seen per day
$Inbox\text{-}Time_8$	$$\frac{\left(\left(\begin{array}{l}\text{Advance 'Messaging Time Per Patient'} + \\ \text{Advance 'Endorse Results Time Per Patient'} + \\ \text{Advance 'Approve Orders Time Per Patient'} + \\ \text{Advance 'Sign Review Time Per Patient'} + \\ \text{Advance 'Order Refill Time Per Patient'}\end{array}\right) \text{(min)} / 60\right) \times \text{Advance 'Patients Seen'}}{\text{Total Number of Scheduled Hours}} * 8$$
TW_{ORD}	Not readily available

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 Practice.Transformation@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.

Appendix E

Teamwork Bronze – Teamwork Questions from AMA's Organizational Biopsy®

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 APP 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

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).

- <10%
- 10-25%
- 25-50%
- 50-75%
- >75%

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, or visit note documentation, forms completion, 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/APPs and care team
- Physicians/APPs and practice manager or other leaders
- Physicians/APPs and consulting colleagues

Appendix F

Leadership Bronze – Teamwork Questions from AMA's Organizational Biopsy®

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

JOY IN MEDICINE

Health System Recognition Program

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Updated September 2023

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