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CME

Improving Physician Well-Being Through Organizational Change

Wellness Wednesdays and yoga breaks aren't sufficient. Here's how health care organizations can begin to address physician well-being.

The health, well-being, and success of an organization is directly linked to the health, well-being, and success of the individuals who belong to the organization. In many hospitals and health systems, leaders are beginning to understand that organizational goals that were traditionally aligned to patient outcomes must now include a broader set of metrics, including physician and staff well-being. Burnout, which more than 50% of physicians report experiencing, affects not only individual well-being but also hospital and health system revenue and patient care.[1-5]

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Physician burnout has been attributed to a multitude of complex factors, many of which stem from challenges and stressors at the organizational level. In 2019, the National Academy of Medicine (NAM) issued a 333-page report titled *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*.[6] The report stated that numerous organizational, environmental, individual, regulatory, and sociocultural factors contribute to physician burnout, and called on health care leaders and organizations to target the following organizational factors:

1. Excessive workload, administrative burden, and bureaucracy,
2. Diminished professional relationships, trust, resources, autonomy and engagement, workplace safety and inclusion, and professional development,
3. Ineffective compensation and reimbursement structures, performance policies and recognition processes, leadership and mentorship, team functionality, and EHR systems.

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Health care organizations have many complex sets of metrics and goals, such as those related to productivity, which can unintentionally threaten physician well-being. Understanding even the inadvertent factors related to burnout is necessary to design effective solutions and produce high-functioning, high-value health care organizations. Health care systems have traditionally tried to achieve the Institute for Healthcare Improvement's "triple aim": better care, better health, and lower costs. But many are now embracing the "quadruple aim" proposed by Drs. Thomas Bodenheimer and Christine Sinsky, who argued that "health care providers can't achieve the Triple Aim's core ideals without first prioritizing their own health needs."[7] The triple aim depends on a healthy workforce with a manageable workload. As organizations push for high-quality, low-cost patient care in the current delivery model, they often add to the workload, negatively affecting the well-being of health professionals and inadvertently delivering lower quality care at higher costs. Doing more with less is not working.

In addition, COVID-19 has added significant challenges and diminished revenues to health care systems, which could intensify factors that already limit well-being among health professionals. Systems facing new pressures must invest in the health of their employees now more than ever.

Organizations are not inherently evil, of course. They are simply entities run by people who follow cultural norms and generally maintain the status quo. In high-functioning institutions, this is called success. But in broken systems with dysfunctional or toxic cultures, resilient leaders must be empowered to break with the status quo and serve as role models and wellness champions so the organization as a whole can undergo major culture change and experience well-being.

Where should an organization begin its change efforts to improve well-being, and what role can physicians play? This article will illustrate several key steps, centered around vision and leadership.

KEY POINTS

- The well-being of an organization is directly linked to the well-being of those who belong to the organization.
- Organizations may need to undergo major culture change to improve well-being.
- Change begins with an effective vision aligned with the organization's actions, programs, and resources, along with effective leaders who have the authority, responsibility, and resources to initiate change.

VISION AND LEADERSHIP: CRITICAL ELEMENTS OF ORGANIZATIONAL CHANGE

In the business world, *Leading Change* by John P. Kotter is considered the bible for major organizational transformation. While its principles are not specific to health care, they are adaptable and can be applied in medicine. Kotter's "Eight-stage

process for creating organizational change" begins with establishing a sense of urgency, getting the right people at the table, and developing and communicating a vision for change.[8]

Vision, according to Kotter, is "a central component of leadership." An effective vision clarifies a direction for the future, motivates all stakeholders to take realistic action, is easy to communicate, and has the power to lead transformational change. A vision that is too vague, too specific, or authoritarian will be ineffective. But a well-articulated vision changes culture by aligning and directing an organization's actions, programs, and resources. To guide an organization's decisions, Kotter suggests asking one simple question: "Is this process/policy/step in line with our vision?" (in this case, the vision for physician and organizational well-being).

The other key element in organizational change is leadership — having someone at the senior leadership table who has the authority, responsibility, and resources to address well-being. This can range from a well-resourced physician wellness champion to a chief wellness officer.

A TALE OF TWO HOSPITALS

To understand the importance of vision and leadership, let's consider two organizations — Hospital 1 and Hospital 2 — representing different approaches to organizational well-being.

Hospital 1 decided to rewrite its vision, replacing the phrase "We are committed to improving the health of our patients" with "We are committed to health for all" — patients, physicians, and staff. It appointed a physician, Dr. Dewey Moore, as director of well-being. It also implemented Wellness Wednesdays — but kept its hierarchical structure, "patient first" culture, and productivity-based policies in place.

Dr. Moore was a junior faculty member and was viewed as a compassionate clinician, hard worker, devoted educator, and skilled researcher, but he had no training in leading system-level initiatives. He contributed to writing the new vision but was not given a seat at the senior leadership table. He received no funding, no resources, no team, and no authority to change schedules or processes. His charge was to reduce the rate of burnout among health professionals, but his new role was never clarified across the system.

EIGHT-STAGE PROCESS FOR CREATING ORGANIZATIONAL CHANGE

1. Establish a sense of urgency,
2. Create the guiding coalition,
3. Develop a vision and strategy,
4. Communicate the vision,
5. Empower broad-based action,
6. Generate short-term wins,
7. Consolidate gains and produce more change,
8. Anchor new approaches in the culture.

Source: Kotter JP. *Leading Change*. Harvard Business Review Press; 1996.

As pressures at Hospital 1 escalated due to COVID-19, Dr. Moore enhanced offerings on Wellness Wednesdays: morning stretches, noon yoga, healthy snacks, and virtual speakers on wellness strategies. But while he sent inspirational emails inviting all staff to mindfulness workshops, the management team sent emails pushing for increased productivity, such as the following:

"The senior leadership team requests plans from all departments with a negative variance for closing this fiscal year's budget gap. Our projected monthly gap is approximately 600 appointments. We anticipate this gap will continue to grow through the end of this year due to the pandemic and our loss of clinical staff. We are therefore asking each of you, as providers, to help us make up a portion of this deficit through adding eight patients per week per full-time-equivalent

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provider (prorated for others). Options include adding in patients during administrative time, overbooking patients during regular clinic time, eliminating student teaching time, removing weekend call compensation time, reducing visit time by 5-10 minutes, etc. Please send your individual plan by Monday."

Not surprisingly, Hospital 1's new vision for a culture of well-being was not driving outcomes or reducing burnout. Here's why:

> Margin-centric organizations marginalize health and well-being.

"With a vision" versus "visionary." If you asked any employee outside the strategic planning committee to recite the vision, no one could. The difference between an organization "with a vision" and a "visionary" organization is described by Souba.[9] In the former, vision sits on a shelf (or in a computer); in the latter, leaders and staff live and breathe the vision. Its words and ideas are shared broadly, inspire action, and are referred to often. Not only was Hospital 1's vision not known, it was overshadowed by a demotivating and conflicting message of "finances first." No one enters medicine to build variance sheets or deliver relative value units. A living vision is invaluable to direct strategic decision making and resource allocation, and to avoid unintended consequences and conflict.

Lack of alignment. When Hospital 1's new vision for well-being didn't align with its actions, physicians responded with anger, resentment, frustration, and anxiety, and they disengaged. They lacked a forum to talk about their feelings and voice their ideas. Integrating new initiatives in an existing system can be complex; analogous to driving a bus while changing the tires. But not aligning initiatives with vision undermines success. Hospital 1's unaligned approach resulted in further losses in workforce and productivity. Margin-centric organizations marginalize health and well-being.

Hospital 2, on the other hand, heard the same urgent call for organizational change to improve physician well-being and completely rewrote its vision: "Healthy professionals contributing to healthy patients." This became not just a document but a principle hospital leaders referred to every day as they made decisions. They funded a chief wellness officer position to direct an institutional well-being collaborative and to oversee the integration of well-being across all health professionals. This senior leader had a seat at the strategic table with other senior leaders, and they followed Kotter's eight stages for organizational change — in order. The chief wellness officer instituted an institution-wide plan to promote engagement and reduce physician burnout, which included three stages:

Assessment and acknowledgement. The chief wellness officer followed Shanafelt et al's "Nine organizational strategies to promote engagement and reduce physician burnout,"[10] collaborating to complete a system-wide assessment of burnout and adding well-being measures to the institutional, departmental, and individual dashboards. The assessment results were disturbing, but she shared them anyway, acknowledging publicly that a problem existed and moving toward a culture of transparency. She engaged colleagues in open discussions to validate real challenges and shifted from town halls (which resembled "pep talks") to forums for

NINE ORGANIZATIONAL STRATEGIES TO PROMOTE ENGAGEMENT AND REDUCE PHYSICIAN BURNOUT

1. Acknowledge and assess the problem,
2. Harness the power of leadership,
3. Develop and implement targeted work unit interventions (often focused on improving efficiency and reducing clerical burden),
4. Cultivate community at work,
5. Use rewards and incentives wisely,
6. Align values and strengthen culture,
7. Promote flexibility and work-life integration,
8. Provide resources to promote resilience and self-care,
9. Facilitate and fund organizational science.

Source: Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017;92(1):129-146.

genuine sharing of previously suppressed feelings. Permitting short-term conflict helped build long-term trust. By acknowledging system-wide challenges she opened the door for substantial change.

Cultivating leadership and resilience. Hospital 2 recognized the value of leadership by empowering the chief wellness officer to form a team of wellness leaders from each department. She formalized leadership training for this team and modeled a "wellness superuser" initiative after the organization's EHR superuser model. Passionate leaders applied for these roles and the hospital provided them a 10% salary boost to serve as "well-being champions" in their respective departments.

Hospital 2 defined leadership as it's described in *Cultivating Leadership in Medicine* — "not by one's title, but by one's ability to articulate a shared vision, transform challenges into opportunities, contribute to measurable and meaningful outcomes, inspire collaborative partnerships across disciplines, and care for oneself."[11] The chief wellness officer modeled a culture of wellness and leveraged the team of wellness champions to stay connected to the entire organization.

Hospital 2 also recognized that changing the culture of medicine required resilience, so its senior leaders committed to training all leaders to thrive in the face of adversity. The well-being curriculum included resilience training and was based on multiple sources.[12-14] The organization piloted the training with the wellness champions and then disseminated it system wide. Wellness champions modeled the wellness strategies, giving others the tools, time, and permission to follow them.

Continuous alignment and engagement. Because Hospital 2's vision was aligned with all other aspects of the organization, leaders no longer needed to beg for funding for wellness initiatives, or get permission before piloting their ideas for culture change. The vision unified the system and restored autonomy to health professionals. Wellness champion superusers asked frontline clinicians and teams to promote small tests of change to reduce burnout and increase engagement. Microsystems huddled to overcome their daily barriers, and buy-in followed. Well-being initiatives at the local level also resulted in activities that boosted peer-to-peer support and social relationships — not just on Wellness Wednesdays, but every day.

The chief wellness officer was a welcome collaborator with teams across the system — all incentivized to the same vision-directed outcomes. Their efforts crossed departments to address factors known to contribute to burnout. One group studied EHR patterns, recognizing that providers who took work home and remained on the EHR in the evenings and during weekends and vacations were at risk for burnout. The group then aligned the medical assistant/scribe team to offer a scribe pilot program for those at risk.

Another team studied how different compensation models and performance metrics affected productivity, patient outcomes and satisfaction, and provider burnout and well-being. The chief wellness

SERIES OVERVIEW

In this or previous issues:

Creating your personal wellness plan (January/February 2020).

Self-care through mindfulness and strategies for promoting physical health (March/April 2020).

Family well-being through social connectivity and time management (May/June 2020).

Team well-being through conflict resolution and promotion of gratitude in the workplace (July/August 2020).

Organizational well-being through prioritizing purpose and creating resilient leaders (this issue).

In an upcoming issue:

Community well-being through cognitive reframing and building emotional intelligence.

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office charged the wellness champions with adding a well-being metric to departmental dashboards and incorporating the metric into individual performance reviews. One department proposed studying vacation time usage as a means of promoting work-life balance. They believed well-being could be tied to the percentage of employees who took all their vacation annually. The team worked with human resources and providers who were not taking earned time, identified barriers, and made coverage changes to allow them to take much-needed time off. The hospital also gave providers more choices and flexibility in work schedules and hours.

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Making the investment in well-being. Hospital 2 had limited resources but decided to commit to a business model based on a long-term return on investment (ROI). In a 2019 article,[15] Shanafelt et al offered a model well-being program and emphasized the importance of funding both the leadership team and the well-being improvement initiatives. Funding such a program may be possible by investing the savings from reducing burnout among practicing physicians. Shanafelt et al propose that an estimated 10-15% of the $6,600 lost per burned-out physician, per year, could be reinvested into a well-being program, and they argue that "a relative reduction in burnout would yield a positive ROI."[15]

WHICH PATH WILL YOUR ORGANIZATION TAKE?

Will your organization hear the urgency, craft a vision for well-being, and allot resources to achieve that vision? Will it empower a cohesive and integrated well-being leadership team and effectively engage frontline workers in initiatives that support their well-being? Will it commit to a broad and balanced set of metrics and long-term ROI?

The alternative is an organization with competing agendas, in which leaders and staff become worn down and disillusioned, and they revert to survival mode and fending for themselves, unable to make meaningful or measurable change.

The choice seems clear. FPM

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

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