



# Strategies for enriching the resident, fellow, and faculty physician experience: a system-based approach to physician well-being

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**Background:** Physician burnout and psychological distress are recognized as a public health crisis that healthcare institutions have a responsibility to address. We share a process for creating, measuring, and iteratively improving systems-level well-being initiatives for faculty physicians and trainees (residents/fellows) at a large urban healthcare system in New York City.

**Methods:** Our institution implemented a three-pronged approach: creating infrastructure to promote well-being, distributing a needs assessment survey, and developing interventions in response to survey results. The needs assessment surveys, one for faculty and another for trainees, included questions ranging from burnout and well-being metrics to proposed well-being intervention components. The infrastructure included Well-Being Champion (WBC) programs for both physician faculty and trainees. We report data from the 2018 faculty survey and 2019 trainee survey that were then used to inform enhancements for well-being programs and infrastructure.

**Results:** In the 2018 faculty survey [response rate 45% (1,870/4,156)], 27.4% of respondents met criteria for burnout and 22% screened positive for depression. From a list of systems-level interventions believed to improve their well-being, faculty respondents most identified opportunity for leadership training, enhanced mentorship and career advancement, documentation assistance, and decreased electronic health record and clerical burden. In the 2019 graduate medical education (GME) trainee survey [response rate 56.5% (1,415/2,504)], 54.8% of respondents met criteria for burnout, 33.1% screened positive for depression, and 49.1% indicated satisfaction with their WBC. GME trainees identified wellness day policy enforcement, workspace redesign, and increased appreciation as top interventions that would most improve their well-being. Survey results informed improvements in existing interventions to address unmet needs, including creating departmental well-being plans, spearheading electronic health record and clerical burden reduction efforts, offering faculty leadership development programming, and enforcing trainee wellness day policies.

**Conclusions:** We seek to share our process for using faculty and GME trainee well-being surveys to inform and improve existing interventions. Via the Office of Well-Being and Resilience, we established the foundational structure to support the well-being of our physician faculty and trainees, surveyed these constituents, and developed programs to address the most prominent needs based on the results.

**Keywords:** Physician well-being; burnout; systems intervention; Well-Being Champions (WBC)

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## Introduction

### *Physician burnout crisis*

Physician burnout and psychological distress have been increasingly recognized as a public health crisis (1). While a national survey demonstrated that the prevalence of physician burnout in 2020 was lower than prior years, physicians are still at approximately 40% higher risk of burnout when compared to the general working population (2). In a meta-analysis of over 20 survey studies, graduate medical education (GME) trainees (residents and fellows) reported a cross-specialty overall burnout prevalence of over 35% (3). A number of studies have suggested several drivers of physician burnout, including excessive clerical work, lack of sleep, longer work hours, and an imbalance between occupational demands and resources (4,5). In our own work, we found that clinical faculty who report spending >90 min/day on the electronic health record (EHR) after work had an almost two-fold increased likelihood of burnout, and those who report spending >60 min/day on clerical tasks had a 1.4 increased risk for experiencing work-related stress (6).

Aside from the moral imperative to address a workforce suffering from these outcomes, physician burnout has been shown to negatively affect the delivery of healthcare by contributing to decreased quality of care, medical errors, poor patient satisfaction, and an increased cost of physician turnover and productivity (7,8). Systems-directed well-being initiatives have been demonstrated to be equally effective, and likely superior to, individual-level programming (9-11). Examples of systems-level initiatives include medical documentation scribes, enhanced or expanded team-based care models, schedule modifications, EHR optimization, and utilization of quality improvement strategies to improve workflows, all of which have been shown to either decrease burnout and stress and/or increase professional satisfaction (12).

### *Background: our response to physician burnout*

Beginning in 2017, leading healthcare organizations began creating Chief Wellness Officer (CWO) positions to guide the organizational well-being strategy and cultural transformation needed to reduce burnout among physicians (13). Our own Mount Sinai Health System (MSHS) formed the Office of Well-Being and Resilience (OWBR) in 2018, sitting within the Icahn School of Medicine at Mount Sinai (ISMMS) and led by a CWO. The OWBR mission seeks to “promote your well-being

and professional satisfaction by advancing a culture that enables you to do your best work in a community that values you.” As the OWBR sits in the Office of the Dean of the medical school, the constituents of the program at our institution include the faculty of the medical school (physicians and scientists), GME trainees (residents and fellows), medical students and biomedical science graduate students and post-doctoral fellows. To address the needs of each of these groups, there is an Associate Dean for each constituency. The Associate Deans create infrastructure and programming to assess and improve the well-being of their constituent groups. The OWBR staff also includes a director, mental health liaison, program coordinator, administrative assistant, associate researcher, clinical research coordinator and a scholarly year medical student. In this paper, we will focus on the 2 clinical constituent groups under the OWBR’s charge—faculty physicians and GME trainees.

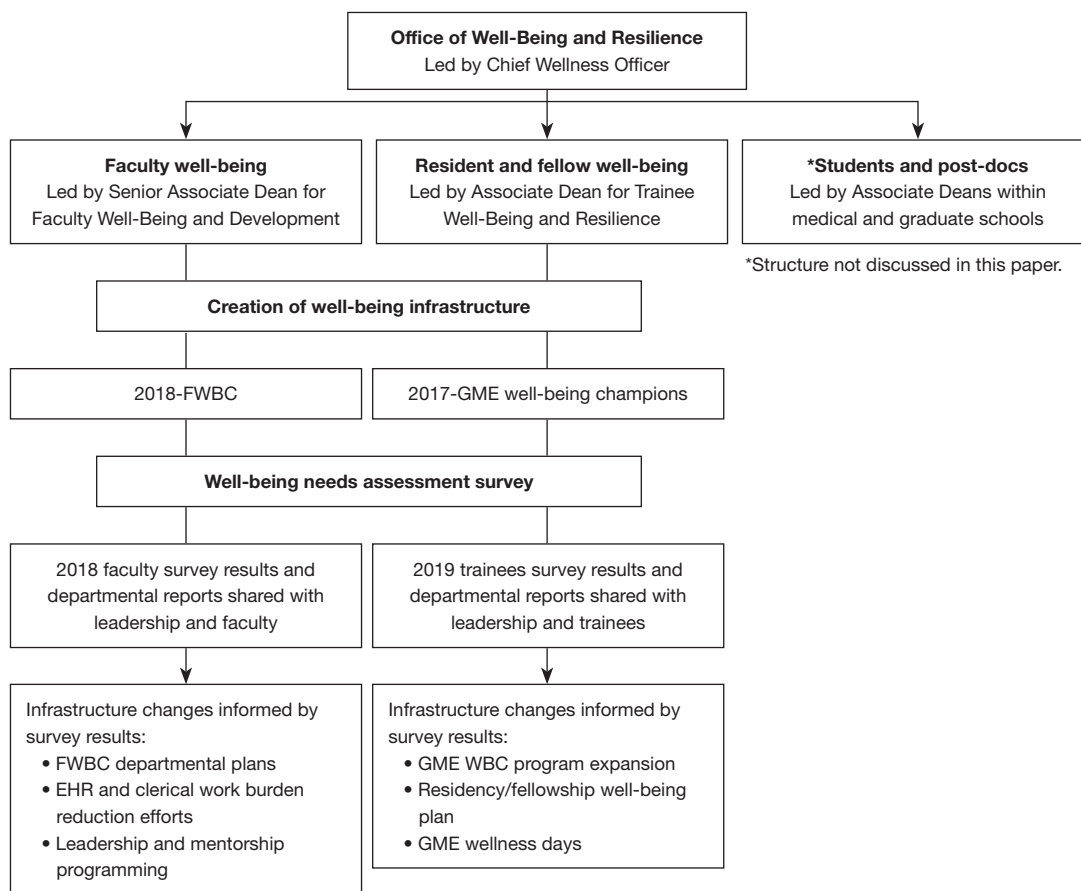
Under the leadership of the Associate Deans of GME Trainee and Faculty Well-Being and to improve the well-being of our physician cohorts (faculty, residents, and fellows), we implemented a three-pronged approach: (I) creating infrastructure to promote well-being via our Well-Being Champion Program; (II) distributing and analyzing needs assessment surveys; and (III) utilizing the infrastructure and survey results to implement interventions targeting the drivers of burnout and stress. *Figure 1* outlines a workflow that summarizes this approach. In this paper, we aim to describe how our infrastructure and needs assessment surveys for both cohorts impacted the development of interventions to improve well-being for faculty and trainee physicians. We report data from the 2018–2019 faculty survey and 2019 graduate medical trainee survey that were used to further create and enhance well-being programs and interventions.

## Methods

The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study was approved by institutional ethics board of the Icahn School of Medicine at Mount Sinai (No. 18-01090 for faculty survey, 17-02885 for graduate medical education survey) and individual consent for this retrospective analysis was waived.

### *Setting and participants*

Our program needs assessment and interventions occur



**Figure 1** Workflow of systems-based approach to measure and implement well-being interventions. FWBC, faculty well-being champions; GME, graduate medical education; EHR, electronic health record; WBC, well-being champions.

across the Mount Sinai Health System, a large urban health care system in NYC (New York City), with eight hospitals and a large ambulatory care footprint across four Boroughs and Long Island. Employed faculty, residents, and fellows in the healthcare system are included in this program.

**Program development and description: Well-Being Champions (WBC)**

Distinct Faculty and GME WBC programs were created given the size and complexity of our institution which leads to variable needs among physicians and GME trainees within different specialties and across practice sites. As such, we aim to have expert ambassadors with a “boots on the ground” perspective to help move the work forward. The WBC programs aim to engage faculty in each department and advocate for efforts to promote the well-being of

their department-level constituents (faculty and/or GME trainees).

**Faculty Well-Being Champion (FWBC) program**

Overseen by the Associate Dean for Faculty Well-Being, the FWBC program was developed in 2018 (just prior to our first faculty survey administration) to better understand the well-being needs of faculty and to begin to improve well-being at the departmental level. Since drivers of well-being and professional fulfillment are complex and vary by clinical site, specialty, and years in practice, we sought to create a learning community of well-being leaders in all clinical departments across the Mount Sinai Health System (MSHS). The group shares challenges and barriers, explores best practices, serves as the collection of local experts knowledgeable of existing MSHS support resources, and functions as a supportive network. To recruit faculty

members into this role, the CWO and the Associate Dean met with the chairpersons from each department to gain buy-in and commitment (with the support of the Dean of the Medical School) for this program. Each chairperson was then asked to appoint one or more faculty members to the role of FWBC for their department. Appropriate candidates for this role are faculty peers who are well-respected by both their colleagues and their leaders and have the leadership skills to identify and bring faculty together around challenging issues which they then bring to their supervisors with a solutions-oriented approach. In some instances, after a few months in the role, some FWBCs were determined not to be the best fit and asked to step down in place of others.

The Associate Dean and CWO provide mentorship and training for the FWBCs to guide and coach them in their work to improve well-being in their departments. The program is also supported by both a program coordinator and research coordinator who assist with meeting planning, scheduling and resource distribution. Chairpersons are encouraged to provide incentives for the FWBC role but there is no mandatory compensation required. As a result, in the current state of the program, some FWBCs have salary support, some receive stipends or bonuses, some receive extra CME funds, while others remain financially unsupported for their role.

The FWBCs create a direct line of communication and collaboration to faculty across sites, departmental leaders, and our office. The roles of the FWBCs include (I) asking questions and listening to their departmental colleagues about the challenges and barriers to their well-being at work through individual discussion, focus groups or short surveys, (II) collating and summarizing data gathered into themes and priorities, (III) sharing the core themes and priorities with departmental leadership, and (IV) devising a plan and advocating for initiatives aimed at addressing those core priority areas. In our first iteration of the program, we created several resources for the FWBCs including a WBC manual that included: roles and responsibilities of the FWBC and curriculum goals and objectives, a focus group guide, and a top 10 list of effective interventions for well-being guide (Appendixes 1,2). FWBC are also asked to meet with their department chairperson at least twice per year (once with the CWO and Associate Dean present) and to meet with the Associate Dean and the other FWBCs once monthly.

In interactive 30-min monthly meetings led by the Associate Dean, FWBCs receive an interactive curriculum and the opportunity to share report-outs regarding the

well-being challenges and programs in their departments. Approximately one half of the sessions each year incorporate the delivery of didactic or informational resource material while the other half is spent in discussion, including the sharing of best practices. The curricular elements focus on the evidence behind well-being and burnout in physicians, burnout intervention effectiveness, strategies to improve well-being and decrease burnout, and institutional resources that may help them in their work. The interactive monthly curriculum includes training in burnout and well-being assessments tools, effective systems- and personal-level well-being interventions, wellness-centered leadership skills, and information-sharing about institutional resources and programs with the potential to positively impact well-being. Report-outs include discussions of the current challenges to well-being in each department, outcomes from piloted interventions, and opportunities to brainstorm about department- and institution-level interventions.

We currently have approximately 37 faculty FWBC who represent 26 departments. Our eventual goal is to have all FWBCs compensated for their time and effort through their departments. Interestingly, there is a broad range of engagement of our FWBCs which does not necessarily correlate with the level of compensation they receive for their role. While attendance is not mandatory for the monthly meetings, monthly meetings are offered on two dates each month to maximize turnout. Certain departmental representatives have a harder time attending due to their schedules (such as certain surgical specialties); and because of this issue, we have created a surgical specialty group that meets quarterly at an earlier time to accommodate schedules. On average, 20–25 champions attend the meetings monthly.

### **GME WBC program**

The Office of GME, in collaboration with the ISMMS GME Training Programs, created the GME WBC program in 2017. In this program, faculty members are appointed to work towards promoting a culture of well-being within a given residency or fellowship training program. The GME WBCs work in collaboration with the training program director, program administrator, and GME trainees (residents and fellows). GME WBCs are physician faculty members who specifically are not members of the GME training program leadership team. To ensure that well-being is prioritized among the many competing demands in academic medicine, the GME WBCs work to ensure that well-being efforts are incorporated into the daily operations of the training

program in both curricular and extracurricular domains.

Our current GME WBC program consists of 50 faculty members representing 36 specialties across 8 hospital sites. The program is funded by the Office of GME and each GME WBC receives an annual stipend as compensation for their role. The GME WBC has several responsibilities, including identification of drivers that erode GME trainee well-being, establishing a residency/fellowship level well-being committee, development of a well-being curriculum, educating faculty and trainees about the importance of seeking mental health treatment when indicated, ensuring the availability of mental health resources, and serving as a role model for physician well-being to both faculty and trainees. For example, the GME WBC facilitates and/or leads well-being events and curricula, disseminates information about institutional well-being programs, and encourages participation in such programs. In addition, the GME WBC reviews program-specific data from the annual Accreditation Council for Graduate Medical Education (ACGME) resident/fellow survey and the ISMMS GME Well-being survey. By reviewing the data, the champion can gain a better understanding of areas for improvement within their program and develop systems- and program-level initiatives to enhance the well-being of our trainees.

The GME WBC program is overseen by both a Director of GME WBCs and the Associate Dean for GME Well-Being and Resilience. The Director and Associate Dean provide mentorship and training to the WBCs to facilitate their examining areas for change, including efforts to decrease the work intensity and clerical burden within a residency/fellowship program. Formal semi-annual and annual reports are submitted by the GME WBC to the Director and Associate Dean to document progress within each program. The WBCs are also evaluated regarding their performance on an annual basis by OWBR and GME leadership.

Further, the GME WBC is expected to serve as a member with active participation on the Program Evaluation Committee (PEC). The PEC plays a central role in the development of residency and fellowship training programs. The committee takes part in reviewing the program annually and guiding ongoing program improvement, including development of new goals, based on outcomes. As a member of the PEC, the GME WBC has an integral role within the residency or fellowship program.

### *Needs assessment*

In order to create a robust and effective program to enhance

the well-being of our faculty and trainees, we created a needs assessment survey for both constituencies. The following describes the survey methods for both faculty and trainees. For the purpose of this innovations report, we will present here brief descriptive data that drove our interventions.

### **Faculty survey**

In 2018–2019, we developed and administered our first faculty well-being survey, which was conducted online as an anonymous, institution-wide effort, approved by our institutional IRB (18-01090). Participants reviewed a consent document at the beginning of the survey but did not have to sign consent as our IRB deemed the study exempt. The goal was to deliver this survey every other year; however, the second survey was put on hold due to coronavirus disease 2019 (COVID-19) and will be delivered again in 2022. Eligible participants in 2018–2019 included all 4,156 clinical and non-clinical faculty of the school, and survey items included demographics, burnout, resilience, and well-being indices, as well as potential current drivers of and solutions for burnout. The survey utilized the Maslach Burnout Inventory (MBI) 2-item scale (14), which assessed two dimensions of burnout (emotional exhaustion and depersonalization); the Mayo Well-Being Index, which assesses 7 dimensions of well-being (15); the CD-RISC 2-item scale (16), which assessed levels of resilience, elements of the mini-Z (17); the Mayo Leadership Index, which assessed leadership behaviors of respondents' supervisors (18); as well as items on overall professional satisfaction, meaning in work and work-life balance (19). We also asked questions to evaluate quality of mentorship (20) and screened for depression using the PHQ-2 (21). In addition, we asked faculty to select from a list of potential systems- and personal-level interventions, informed in part by existing evidence, to indicate which they believed would most likely improve their well-being. Supplemental [Appendix 3](#) details a list of questions and proprietary indices used in the 2018 faculty survey.

### **Residents and fellows survey**

In 2018, 2019, and again in 2021, the GME Office developed and administered a GME well-being survey that was conducted throughout the healthcare system. The anonymous, online survey was approved by our institutional IRB (17-02885). Participants reviewed a consent document at the beginning of the survey but did not have to sign consent as our IRB deemed the study exempt. As with the



faculty survey, the GME survey included the MBI 2-item scale, the PHQ-2, and questions surrounding meaning in work. The GME survey also included program-specific questions about systems-level well-being initiatives already in place. In 2017, the Accreditation Council for Graduate Medical Education (ACGME) revised its Common Program Requirements for all accredited residency and fellowship programs to include a section on well-being. The requirement stated that in partnership with the sponsoring institution, the program must include attention to scheduling, work intensity, work compression and efforts to minimize non-physician obligations that impact resident well-being. As a result, our Office of GME had already implemented a number of well-being initiatives. For example, residents and fellows were asked about utilization of wellness days, and if they knew how to access mental health resources for (I) themselves if they felt depressed or in need of emotional support or (II) their colleagues if found to be in emotional distress or experiencing suicidal ideation. Residents and fellows were also asked to select from a listing of individual-level and systems-level interventions, in part informed by existing evidence, which they believed would enhance their well-being. Data reported in this present manuscript are from the 2019 annual GME well-being survey. [Appendix 4](#) details a list of questions and proprietary indices used in the 2019 trainee survey.

### *Analysis plan*

For both surveys we present demographic and descriptive statistics of the items described above and in the supplemental chart. We also calculated indices including the Mayo Leadership Index, the PHQ-2 (positive if the answer to either question was yes), and the MBI-2 score (property of Mind Garden Inc for which we obtained the appropriate license). The Mayo Leadership Index was calculated using the approach in Dyrbye *et al.* (22) whereby scores on all 7 items were tallied for a total possible score of 45 and averaged across all participants. Higher scores indicate more effective well-being focused leadership behaviors.

## **Results**

### *Faculty needs assessment*

Of the 4,156 faculties invited to complete the inaugural survey, 1,870 responded (45% response rate). Demographic and descriptive data are shown in *Table 1*. A proportion

of 27.4% of faculty met criteria for burnout on the MBI and 22% screened positive for depression on the PHQ-2. A proportion of 94.3% of faculty believe their work to be meaningful, yet only 65.9% of faculty reported satisfaction with their job. Of faculty working in a research setting, 13.9% reported “definitely” or “likely” to leave their position within the next two years; of these respondents, insufficient funding (23.2%) and pressures associated with their position (23.2%) were the top two reasons for leaving. Of faculty working in a patient care setting, 16.8% were “definitely” or “likely” to leave their position within the next two years; of these respondents, emphasis on metrics and performance over patient care (18.7%), frustration within the medical system (12.1%), and feeling that career interests were not being supported (11.8%) were the top three reasons for leaving.

From a list of interventions that would most likely improve well-being, faculty identified improved appreciation (44.1%), enhanced mentorship (35.1%), documentation assistance (28.8%), enhanced teamwork (27.4% for improved communication among team members), and EHR solutions (27.5% for automatic EHR sign-in) as the top system-level interventions, while leadership training (41.1%) was the top individual-level intervention (*Figure 2*).

Overall, faculty rated their direct/immediate supervisor with a mean Mayo Leadership Index score of 31.4, a standard deviation of 10.2 and a range from 1 to 45. When examining the breakdown of leadership behaviors, leaders on average scored lowest on the following items: “holds career development conversation with me” (45% strongly agree/agree), “provides helpful feedback and coaching on my performance” (49% strongly agree/agree), and “encourages me to develop my talents and skills” (51% strongly agree/agree) (*Figure 3*). A proportion of 26.8% of faculty reported having a mentor for career development within the health system; 90.8% of these respondents were “very satisfied” or “satisfied with their mentor, with over 50% indicating that their mentor was “extremely skilled in” providing constructive feedback, setting career goals, and active listening (*Figure 4*). Of faculty without a mentor within the health system, no guidance in finding a mentor (22.9%), not wanting a mentor (14.1%), lack of time to find a mentor (13.6%), and not sure what to look for in a mentor (13.6%) were the top barriers listed.

### *Residents and fellows needs assessment*

Of the 2,504 GME trainees asked to complete the

**Table 1** Faculty personal and professional characteristics from 2018 well-being survey

Variables	N (%) or mean [SD]
Participant demographics	
Gender	
Female	744 (47.6)
Male	753 (48.2)
Non-binary/other gender minority	4 (0.2)
Prefer not to say	63 (4.0)
Missing	306
Age	
20–39 years	429 (27.6)
40–59 years	808 (52.0)
60+ years	317 (20.4)
Missing	316
Professional characteristics	
Faculty level	
Instructor	91 (5.9)
Assistant professor	748 (48.5)
Associate professor	307 (19.9)
Professor	260 (16.9)
Other	135 (8.8)
Missing	329
Full-time status	
Full-time	1,311 (83.4)
Part-time >60%	128 (8.2)
Part-time <60%	43 (2.7)
Voluntary	89 (5.7)
Missing	299
Hours worked per week	
≤40	268 (17.1)
41–60	786 (50.0)
>60	517 (32.9)
Missing	299
Department <sup>†</sup>	
Anesthesiology, Perioperative & Pain Management	102 (5.5)
Dermatology	18 (1.0)

**Table 1** (continued)**Table 1** (continued)

Variables	N (%) or mean [SD]
Emergency Medicine	115 (6.1)
Family Medicine & Community Health	29 (1.6)
Geriatrics & Palliative Medicine	30 (1.6)
Medical Education	19 (1.0)
Medicine	339 (18.1)
Neurology	50 (2.7)
Neurosurgery	17 (0.9)
Obstetrics, Gynecology & Reproductive Services	89 (4.8)
Ophthalmology	24 (1.3)
Orthopedics	25 (1.3)
Otolaryngology/Head & Neck Surgery	14 (0.7)
Pathology	48 (2.6)
Pediatrics	108 (5.8)
Psychiatry	157 (8.4)
Radiation Oncology	13 (0.7)
Radiology	57 (3.0)
Rehabilitation Medicine	15 (0.8)
Surgery	45 (2.4)
Urology	18 (1.0)
Research Departments	147 (7.9)
Depression, meaning, and resilience	
Depression (PHQ-2)	
Screen positive	389 (22.0)
Screen negative	1,382 (78.0)
Missing	99
Work I do is meaningful to me	
Disagree/strongly disagree	41 (2.4)
Neither agree nor disagree	58 (3.3)
Agree/strongly agree	1,630 (94.3)
Missing	141
Resilience (CD-RISC-2)	7.0 [1.3]
Missing	147

**Table 1** (continued)

Table 1 (continued)

Variables	N (%) or mean [SD]
Burnout, work-life integration, and professional satisfaction	
Maslach Burnout Inventory	
Burned out	470 (27.4)
Not burned out	1,243 (72.6)
Missing	157
Mayo Well-Being Index	
Not well	587 (34.2)
Well	1,130 (65.8)
Missing	153
Work leaves enough time for family (WLI)	
Disagree/strongly disagree	668 (38.7)
Neither agree nor disagree	367 (21.3)
Agree/strongly agree	691 (40.0)
Missing	144
Overall I am satisfied with my job (PS)	
Disagree/strongly disagree	279 (16.2)
Neither agree nor disagree	309 (17.9)
Agree/strongly agree	1,138 (65.9)
Missing	144
What is the likelihood that you will leave your current research setting within the next 2 years?	
None	136 (38.5)
Slight/moderate	168 (47.6)
Likely/definite	49 (13.9)
Missing	1,517
Primary reason you are considering leaving your current research setting within the next 2 years?	
Insufficient funding	50 (23.2)
Pressures associated with your position	50 (23.2)
To spend more time with family	16 (7.4)
Personal health problems	2 (0.9)
A family member's health problems	2 (0.9)
To pursue administrative/leadership opportunities	20 (9.2)

Table 1 (continued)

Table 1 (continued)

Variables	N (%) or mean [SD]
To pursue research or medical education opportunities	9 (4.2)
I'm not considering leaving	30 (13.9)
Other	37 (17.1)
Missing	1,654
Likelihood that you will leave your current patient care setting within the next 2 years?	
None	436 (31.0)
Slight/moderate	733 (52.2)
Likely/definite	236 (16.8)
Missing	465
Primary reason you are considering leaving your current patient care setting within the next 2 years?	
Frustration within the medical system	117 (12.1)
Emphasis on metrics and performance over patient care	181 (18.7)
Frustration with EHR	30 (3.1)
Feeling overburdened with clerical work	75 (7.8)
Frustration with insurance companies	12 (1.2)
Do not enjoy caring for patients anymore	11 (1.1)
Feeling that your career interests are not being supported	114 (11.8)
Declining reimbursement for clinical care	40 (4.1)
Personal health problems	9 (0.9)
A family member's health problems	6 (0.6)
To pursue administrative/leadership opportunities	76 (7.9)
To pursue research or medical education opportunities	28 (2.9)
I'm not considering leaving	120 (12.4)
Other	147 (15.2)
Missing	904

Table 1 (continued)



Table 1 (continued)

Variables	N (%) or mean [SD]
What do you plan to do if you leave your current practice?	
Look for a different clinical/patient care opportunity and continue to work as a physician	658 (69.7)
Look for a different job in medicine (e.g., admin, other) and no longer work as a physician	110 (11.7)
Leave the practice of medicine altogether to pursue a different career	38 (4.0)
Retire	82 (8.7)
Other	56 (5.9)
Leadership and mentorship	
Please indicate the title of your direct/immediate supervisor <sup>†</sup>	
Medical director of practice	212 (12.8)
Division chief	508 (30.6)
Department chair	632 (38.0)
Institute director	90 (5.4)
Other	219 (13.2)
Leadership index score (overall) (see Figure 3 for breakdown of index)	31.3 [10.2]
Missing	236
Do you have a mentor(s) for career development within the Mount Sinai Hospital System? <sup>†</sup>	
Yes	437 (26.8)
No	1,196 (73.2)
What are the barriers to obtaining a mentor? <sup>†</sup>	
No one with shared interests	109 (5.83)
Lack of time on my part to find one	259 (13.6)
Lack of time on the part of potential mentors	130 (6.9)
Previous negative experiences with mentors	32 (1.7)
No one to guide me in finding a mentor	428 (22.9)
Not sure what I should look for in a mentor	255 (13.6)
I do not want a mentor	263 (14.1)
Other	133 (7.1)

Table 1 (continued)

Table 1 (continued)

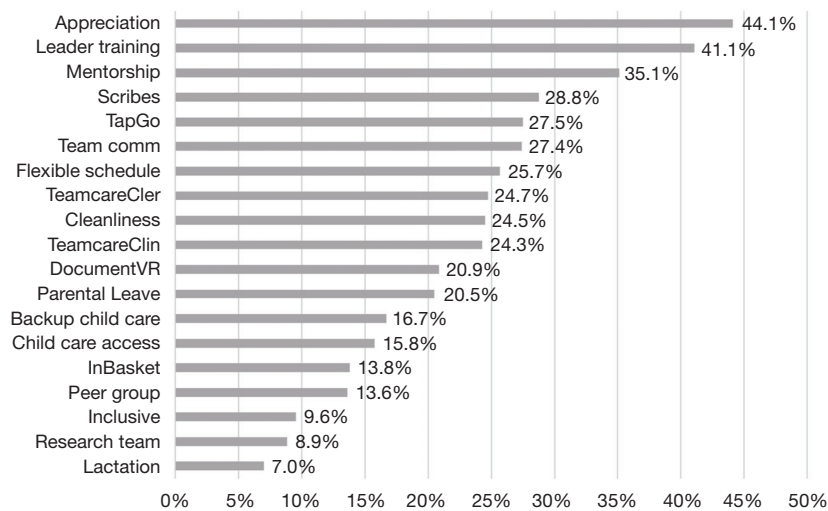
Variables	N (%) or mean [SD]
Overall, how satisfied are you with your mentor?	
Very dissatisfied/dissatisfied	11 (2.5)
Neither satisfied nor dissatisfied	29 (6.7)
Satisfied/very satisfied	395 (90.8)
Missing	1,435

<sup>†</sup>, numbers and percentages may not add up to 1,870 as some respondents did not answer all questions. PHQ-2, Patient Health Questionnaire-2; CD-RISC, Connor-Davidson Resilience Scale; WLI, work-life integration; PS, professional satisfaction; EHR, electronic health record.

2019 survey, 1,415 responded (56.5% response rate). Demographic and descriptive data are shown in *Table 2*. Among the respondents, 54.8% met criteria for burnout on the MBI, down from 62.8% burnout on the prior 2018 survey. A positive PHQ-2 was identified in 33.1% of residents and fellows compared with 38.6% in the previous 2018 survey. A proportion of 69.9% of respondents indicated that their programs had a dedicated faculty member (i.e., WBC) who supports trainee well-being. Of a list of potential system-level interventions, GME trainees identified enforcing wellness day policies without backlash (51.4%), redesigning physical workspace/stations (49.7%), increasing efforts to recognize and appreciate trainees (48.7%), and reducing clerical burden (43.9% for hospital discharges, 41.9% for scheduling patient appointments) as what they believed most likely to improve their well-being (*Figure 5*). Pet therapy (53.1%) increased mental health resources (33.5%), and mindfulness (30.2%) were the top individual-level interventions identified as most likely to improve their well-being (*Figure 6*).

### Intervention development

Using our survey results and literature on well-being interventions as a guide, our team, including the CWO, the Associate Deans for GME and Faculty Well-Being, the Dean of the School, and the Designated Institutional Official created an institutional plan to improve well-being for both the faculty and trainees. We (I) leveraged the WBC infrastructure as well as other institutional programs to guide the direction of future work and (II) created new programs and protocols to meet the well-being gaps of



Appreciation = enhanced faculty appreciation efforts; Leader Training = leadership training opportunities; Mentorship = enhanced mentorship for promotion/career development; Scribes = assistance with documentation with scribes; TapGo = automated EPIC sign-in with ID; Team Comm = improved communication among existing team members; Flexible Schedule = more scheduling flexibility (not a decrease in hours) in specific hours worked during the day; TeamcareCler = better use of team-based care to unload excess clerical burden (e.g., supplies ordering) to other team members; Cleanliness = cleanliness of work environment; TeamcareClin = better use of team-based care to task-shift clinical work (e.g., medication reconciliation) to other team members; DocumentVR = assistance with documentation with voice recognition software; Parental Leave = improved parental leave time/benefits; Backup Child Care = backup child care options; Child Care Access = increased child care access; InBasket = improved distribution of EPIC inbox management tasks (e.g., results review, medication refills); Peer Group = enhanced peer group support; Inclusive = increased attention to inclusivity/diversity; Research Team = better use of research team to share the administrative burdens of a lab; Lactation = improved lactation room options.

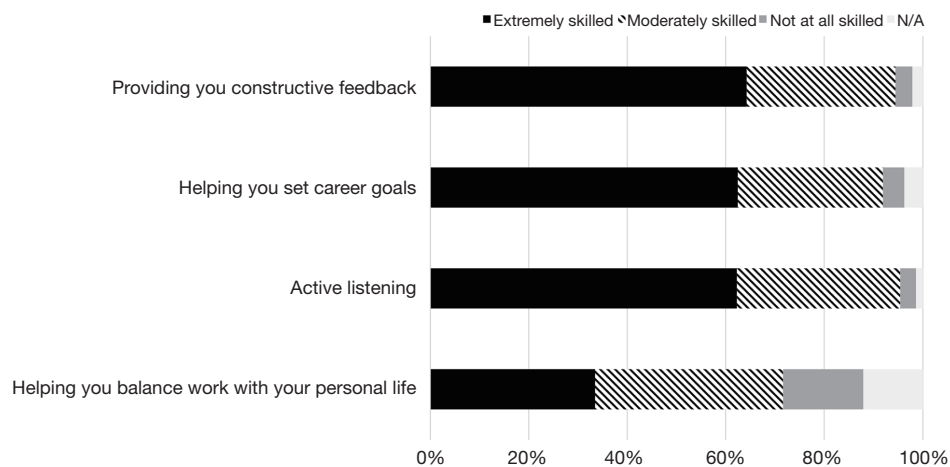
Figure 2 Top systems-level well-being interventions identified by faculty from 2018 well-being survey.



Figure 3 Leadership index breakdown: percent of faculty who “Strongly agree” or “Agree” from 2018 well-being survey.

our faculty and trainees identified by the survey. While some well-being programming existed prior to survey development and dissemination, survey results informed enhancements to current programming as well as the development of new programs. Our process for creating the interventions included: (I) utilizing the survey data to determine core themes and priority areas, (II) devising

potential strategies to improve these priority areas that were relatively low cost and required moderate effort with potential for moderate to high impact, (III) presenting potential solutions to leadership including the CWO, Dean of the School and the DIO, (IV) revising our intervention plan based on feedback and offered support from leadership, (V) piloting the interventions, and (VI) creating assessments



**Figure 4** Faculty mentorship characteristics.

and opportunities for feedback to then allow for iteration of the interventions.

### *Core themes and priorities*

Three core areas for improving faculty well-being emerged from the survey: (I) documentation assistance and teamwork, (II) EHR and clerical work burden, and (III) leadership and mentorship initiatives that enhance career advancement and appreciation. These three identified core needs served as the basis for and were addressed by three interventions: (I) Faculty Well-Being Champion Departmental Plans, (II) EHR and Clerical Work Burden Reduction Programs and (III) Leadership and Mentorship Programming.

Three core areas for improving physician trainee well-being emerged from the GME survey: (I) increased, but not ubiquitous, presence of WBC in each program, (II) improved, but still high, burnout and depression rates, and (III) the importance of clear wellness day policies and access. These three identified core needs served as the basis for and were addressed by the following three interventions: (I) Expansion of the GME WBC Program, (II) Development of a Residency/Fellowship Well-Being Plan, and (III) Wellness Day Policy enforcement.

### *Faculty well-being interventions*

#### **WBC departmental plans**

Upon review of our survey results, we streamlined our FWBC program and began to provide even more guidance

on interventions focused on “efficiency of practice” (i.e., documentation assistance, teamwork, EHR and clerical work burden) and “culture of well-being” (i.e., leadership and mentorship initiatives that enhance career development and appreciation). This led to our development of a Departmental Well-Being Plan Template ([Appendix 5](#)) that is completed by all FWBCs.

The departmental well-being plan is now a core component of the FWBC Program. The plan aims to outline a department’s annual proposal to implement systems-level (efficiency of practice and cultural) well-being interventions. The process of creating a departmental well-being plan involves gathering data (i.e., system-wide faculty surveys, departmental-level surveys, focus groups, one-on-one discussions with faculty), choosing 2–3 priority areas based on data, and then brainstorming and choosing solutions based on the effort-impact matrix (23). We advise FWBCs and department chairs to consider solutions that serve multiple purposes, particularly in the domains of efficiency of practice, improvement of culture, and career advancement. We also advise FWBCs to lead a departmental well-being committee, which allows for representation across sites, divisions, and interests. Solutions are then devised using the collective efforts of the committee, WBC, department chair, and OWBR. Ideally, these departmental well-being plans are written and submitted to OWBR near the end of each calendar year, a time when departments create their budgets for the upcoming year. In this way, well-being interventions that may require financial support can be included in the annual budget. In addition, the CWO and Associate Dean can provide feedback and

**Table 2** Resident/fellow personal and professional characteristics from 2019 well-being survey

Variables	N (%) or mean [SD]
<b>Participant demographics</b>	
Gender <sup>†</sup>	
Female	658 (47.3)
Male	733 (52.7)
Non-binary/other gender minority	2 (0.7)
Missing	22
Age	
≤25 years	12 (0.9)
26–30 years	786 (56.4)
31–35 years	490 (35.1)
≥36 years	106 (7.6)
Missing	21
<b>Professional characteristics</b>	
Average hours worked per week	
≤70	920 (65.0)
71–80	411 (29.0)
>80	84 (6.0)
Department <sup>†</sup>	
Anesthesiology	120 (8.6)
Cardiovascular surgery	10 (0.7)
Dermatology	32 (2.3)
Dental & Oral Maxillofacial	29 (2.1)
Emergency Medicine	65 (4.7)
Family Medicine	30 (2.2)
General Surgery and Subspecialties	43 (3.1)
Internal Medicine and Subspecialties	534 (38.3)
Neurology	33 (2.4)
Neurosurgery	18 (1.3)
Obstetrics & Gynecology	49 (3.5)
Ophthalmology	23 (1.6)
Orthopedic Surgery	20 (1.4)
Otolaryngology	22 (1.6)
Pathology	31 (2.2)
Pediatrics	63 (4.5)

**Table 2** (continued)

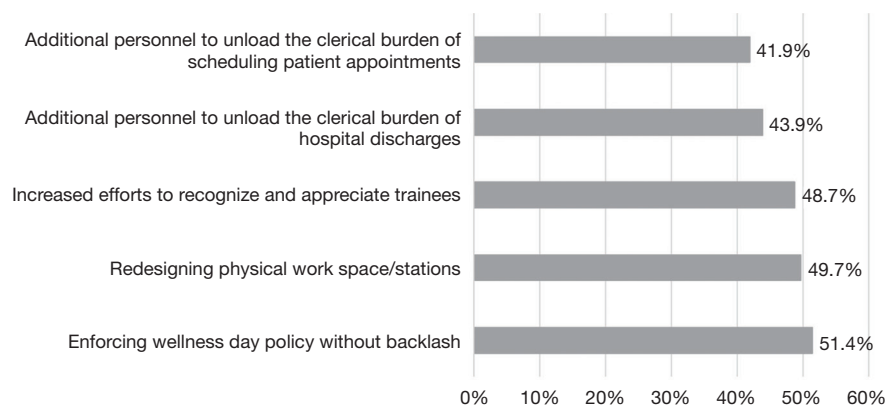
**Table 2** (continued)

Variables	N (%) or mean [SD]
Podiatry	13 (0.9)
Physical Medicine & Rehabilitation	13 (0.9)
Plastic Surgery	12 (0.9)
Preventive Medicine	9 (0.6)
Psychiatry	142 (10.2)
Radiation Oncology	9 (0.6)
Radiology	58 (4.2)
Urology	11 (0.8)
Vascular Surgery	6 (0.4)
Depression, burnout, meaning, and Well-Being Champion program	
Depression (PHQ-2)	
Screen positive	469 (33.1)
Screen negative	946 (66.9)
Maslach Burnout Inventory	
Burned out	775 (54.8)
Not burned out	640 (45.2)
Work I do is meaningful to me <sup>†</sup>	
Disagree/strongly disagree	86 (6.4)
Neither agree nor disagree	60 (4.4)
Agree/strongly agree	1,208 (89.2)
Does your program have a dedicated faculty member (i.e., Well-Being Champion) who supports trainee well-being? Yes	
	989 (69.9)

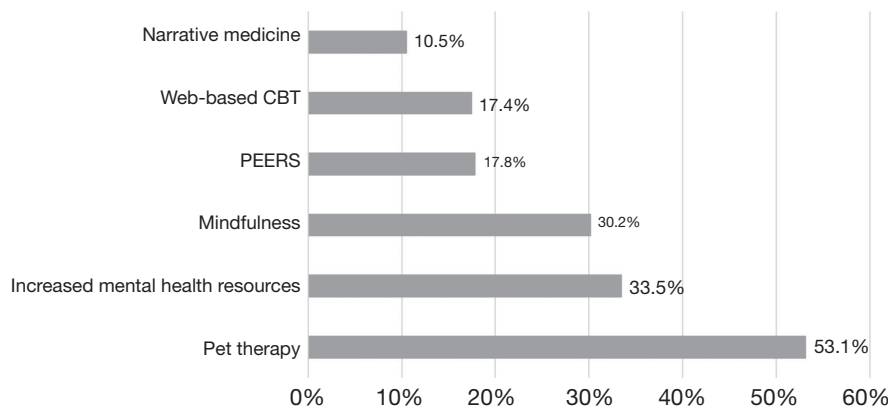
<sup>†</sup>, numbers and percentages may not add up to 1,415 as some respondents did not answer all. PHQ-2, Patient Health Questionnaire-2.

guidance regarding potential interventions, institutional resources, and evaluation planning.

Examples of some departmental-level solutions include the creation of more flexible schedules, mentorship programming (i.e., pairing junior faculty with senior faculty with similar interests), the hiring of scribes to reduce documentation burden, and devising team trainings and huddles to improve communication and clarify job roles. Additional efforts aimed at streamlining practice efficiency using the EHR are described in the next section.



**Figure 5** Top systems-level well-being interventions identified by residents/fellows from 2019 well-being survey.



**Figure 6** Top individual-level well-being interventions identified by residents/fellows from 2019 well-being survey. PEERS, practice enhancement, engagement, resilience, support longitudinal curriculum; CBT, cognitive behavioral therapy.

### EHR and clerical work burden reduction efforts

Our survey showed that faculty desire enhanced team-based care, better team communication, and more support for clerical burden to reduce burnout. In addition, our research demonstrated that more reported clerical burden (>60 min/day) and time on the EHR outside of work (>90 min/day) was associated with increasing levels of burnout (6). Since the advent of our office, the OWBR has partnered with information technology (IT) leadership and met regularly with IT to discuss challenges, goals, and potential IT/EHR solutions that could support faculty well-being. By establishing this collaboration, we were able to leverage our relationship to create interventions based on our needs assessment results. Two examples of programs born out of this collaboration were the EHR and Clerical Work Reduction Program and the InBasket Management Workgroup.

### EHR and clerical work reduction grant program

In the peri-pandemic world, many ambulatory practices shifted to hybrid (in-person and telehealth) models of care. This transition required significant efforts from administrative and IT staff to redesign schedules and workflows, create novel EHR visit types, and manage insurance, billing, and compliance for virtual visits. The pandemic also greatly impacted the well-being of faculty and staff working on inpatient services and emergency departments as a result of staff shortages, workflow challenges, and ongoing clerical and documentation burdens. Prior research has demonstrated that increased clerical burden and ineffective teamwork is associated with decreased well-being and increasing levels of burnout (6,24).

To address these factors, the OWBR team devised the EHR and Clerical Work Reduction Grant program with the support of the Dean, to provide pilot grant funding



to projects that aim to facilitate the reduction of EHR or clerical burden in ambulatory practices and promote efficiency in the work environments of clinical faculty. The expectation for the grant funding was to support pilot initiatives that demonstrated one of several potential impacts, including a shift of clerical or administrative burden away from clinical physicians, improved efficiency of the team, optimized EHR functionality, or enhanced team-based work and communication. The ultimate anticipated outcome of this grant program was to identify initiatives that (I) produce measurable effects on clinical faculty well-being and productivity, and (II) can be sustained and replicated across practices and departments.

In 2020, we began the grant application process. We created an application, assembled a review committee of 9 faculty experts in quality improvement, well-being, information technology and scholarship. We received 13 applications and after an initial and secondary review process, we awarded the inaugural grant funding to four projects that involved collaboration among faculty, departmental or divisional leaders, and clinical or administrative support staff in four departments and practice sites. Grant funding ranged from \$25,000 to \$80,000 for each project to be utilized over 18 months. The projects included (I) Creating and Disseminating a Principal Care Management Services Program of Billable, Coordinated Team Care for Patients With Chronic Conditions and Multiple Providers, (II) Enhancing Team-Based Care in Primary Care Geriatrics Practices through Patient Coordinators to Decrease Physician Burnout, (III) Optimizing InBasket management: An innovative team-based approach to digital patient care at Mount Sinai Doctors, and (IV) Promoting Telehealth Physician Wellness via Integrated Remote Team Workflow and Examination Technology. All projects are nearing the end of their grant funding and may publish their findings in the near future. A brief description of the Inbasket related projects is listed below.

### **InBasket Management Workgroup**

The OWBR partnered with Mount Sinai Doctors Faculty Practice (physician practice group), IT, and our institutional and national EHR vendor representatives with the aim of reducing physician InBasket burden. This multidisciplinary team has worked on two main elements of the InBasket to reduce clerical burden: (I) InBasket structure and functionality, and (II) workflows for message triaging (particularly around patient calls and patient advice requests). Structural and functional changes have included

updates to both patient- and provider-facing message views to improve communication and tracking of messages for care teams, as well as broadening the choices for patient subject lines (i.e., referral request, question about labs, appointment change, etc.) and updating messaging to patients to set clear expectations regarding types of questions patients can ask (nonurgent), when to expect a response (within two business days), and the team member who may respond to their message (physician or a staff member on the care team).

For message triaging, as part of the EHR grant program, two primary care practices were awarded funding to more efficiently route non-clinical InBasket messages away from the providers and towards trained staff members who can review and address requests in a timely fashion. The two practices were relatively small—3 to 8 providers. The smaller practice in which there existed a 1:1 provider to medical assistant ratio, utilized current staff to manage the Inbasket workflow. In this practice the grant funding was utilized to support 10% of the medical director's and practice manager's time to support their organizational and training work. The slightly larger practice hired 2 additional administrative members partially funded by the grant, to manage the message triaging. Staff were trained to address different messages and provide templated responses for typical requests. For example, messages regarding referral requests, medication refills, form requests, and appointment requests could all be handled by non-physician staff members. Workflows for this type of triaging included leveraging provider or practice levels staff pools or using the InBasket attach function. In addition, staff could also assist with clinical questions by scheduling patients into same or next-day urgent in-person or video visits, such that providers could fully assess new clinical questions during scheduled patient care time (as opposed to after-hours via messaging or phone calls).

The workgroup has also implemented a real-time InBasket management dashboard to help practices gain better insight into InBasket activity. The dashboard included the number of messages received by providers and staff in each InBasket folder, time to closure of the message, time spent in the InBasket, and other metrics. Data is currently being collected to assess reductions in the number of messages providers receive and time spent after hours working within the EHR InBasket folder.

### ***Leadership and mentorship programming***

Both mentorship and coaching can decrease burnout and stress, and higher rating of a leader's feedback and coaching

is correlated with lower burnout in their supervisees (18,25,26). Similarly, the effectiveness of a leader's ability to show appreciation is inversely associated with burnout and can increase productivity and engagement of workers (18,27). In response to our faculty's desire for greater mentorship and career development, and lower ratings of supervisors on their coaching and appreciation skills, faculty leadership workshops and increased mentorship programming were developed. A team of leadership and teaching experts from our Talent Development & Learning team (human resources department responsible for creating learning modules and programs for all employees), the Mount Sinai Doctors Faculty Practice, Office of Excellence in Patient Care (office led by the Chief Medical Officer to improve quality of patient care and patient experience) and the Associate Dean for Faculty Well-Being collaborated to create well-being focused leadership workshops. Over the course of a few months, the first two workshops which focused on the core leadership skills of coaching and appreciation were developed and piloted in February and March of 2020. Utilizing feedback from participants, these workshops were refined and subsequently delivered each fall and spring to over 300 faculty in total. Overall, these workshops were well-received by faculty leaders who participated and are currently being expanded in reach and scope to include additional sessions on the topics of Psychological Safety and Challenging Conversations (28). Further analysis is underway to assess the effectiveness and impact of these workshops on workplace culture and well-being.

In 2020, the OWBR partnered with the Office of Faculty Development (OFD) to further advance the quality and accessibility of mentorship for faculty across the institution. Currently, the OWBR-OFD teams are working on three core programs to enhance mentorship for faculty across the institution: (I) a web-based faculty mentor matching program, (II) the creation of a brief mentorship training curriculum for scientists and physicians, and the (III) enhancement of departmental mentoring leadership programs for which each department identifies one or more mentorship leaders responsible for overseeing departmental mentorship programs.

## Residents and fellows

### *GME WBC program expansion*

Given that the presence of a dedicated faculty member serving as a GME WBC may be associated with better outcomes for the well-being of residents, we have worked to expand the GME WBC program in the various residency

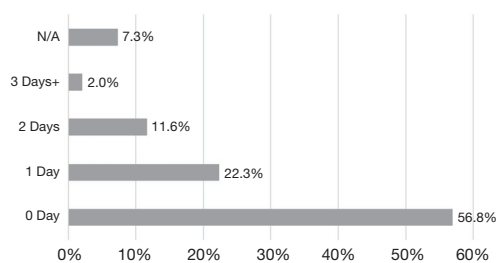
and fellowships over the past 5 years to improve the trainee experience (29). While 69.9% of trainees in the 2019 survey identified their programs as having a dedicated WBC, we aspire to place a WBC in all training programs to meet trainee needs. The GME WBC focus areas have included: increasing protected time for educational activities, revising call schedules, and redesigning physical workspace and on-call rooms. The champions also direct efforts towards the restructuring of trainee clinics, EHR optimization, and decreasing documentation burden. Trainee professional development is another key focus area for the GME WBC. Programs conduct career and financial counseling sessions for graduating residents and fellows and integrate professional development style workshops on communications and team building into the GME trainee didactic curriculum.

### *Development of a Residency/Fellowship Well-Being Plan*

The 2019 GME well-being survey results identified residency and fellowship programs within our healthcare system with high burnout (defined as burnout  $\geq 70\%$  of GME trainees) and high depression scores (defined as  $\geq 40\%$  of trainees). In an effort to have more focused discussions with leadership of these specific programs, leadership from OWBR and GME meet with the Program Director and GME WBC within these groups. The meetings create an opportunity for a collaborative discussion centered around well-being and are now part of an ongoing effort by the GME Office and OWBR to advance the well-being of trainees in all our programs.

As a mechanism to establish a more formal process to assist training programs, the GME Office and OWBR have created a template for residency and fellowship programs to develop plans to address trainee well-being with a continued focus on system-level initiatives. GME WBCs are asked to work in conjunction with residency/fellowship program leadership to design well-being infrastructure and a plan for their specific training programs. The development of a GME well-being plan is a stepwise process. An initial step is the formation of a residency/fellowship Well-Being Committee led by the GME WBC and consisting of trainee representatives. The GME WBC and program director then review relevant data (i.e., results from the ISMMS GME well-being survey, ACGME resident/fellow survey, training program survey, and focus groups with trainees) as part of the needs assessment.

Upon reviewing these data, 2–3 priority areas are identified to focus on system-level or program-level initiatives so that solutions can be implemented. Programs



**Figure 7** Resident/fellow wellness days utilization from 2019 well-being survey.

are encouraged to examine the efficiency of trainee workflow initiatives that lead to well-being. This can be effectuated in some instances even without additional resources by shifting existing resources or leveraging technology or novel workflows (e.g., rotation schedules, call schedules, EHR optimization, and creation of auto-populated patient visit templates). As part of the template for the residency/fellowship well-being plan, programs are also asked to detail how solutions will be implemented and assessed for success on an ongoing basis.

#### **GME wellness days**

The ACGME common program requirements have highlighted the importance of resident/fellow well-being. Each ACGME-accredited program is expected to provide appropriate tools for mental health self-screening and access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 h a day, 7 days a week (30).

In 2017, the ISMMS GME Office established the use of Wellness Days for our trainees. With this initiative, residents and fellows are given protected time to attend to their personal health and wellness, including medical, dental, and mental health appointments. Trainees are provided with four wellness days in addition to other leave time (including sick and vacation leave) each academic year. These wellness days are earned quarterly (one wellness day per quarter) and cannot be accrued or used to extend any other type of leave (vacation; sick or Family and Medical Leave Act; conference/educational). The wellness day process was structured with the goal of minimizing disruptions to both patient care and training, while allowing residents and fellows sufficient protected time for appropriate personal health maintenance and wellness. At our institution, wellness days can also be used to care for the child of a resident/fellow who has a health condition requiring treatment or supervision or to care for

an ill family member (parent, spouse, or child) or partner, including medical, dental, and mental health appointments where the resident/fellow's presence is needed.

Residency and fellowship programs are required to make every effort to accommodate a resident or fellow's use of a wellness day during scheduled duties and are asked to establish policies and procedures that allow usage of this time. Programs are asked to track the wellness days utilization for each trainee; however, they do not require that residents and fellows provide documentation of appointments. Advance notice of at least seven days should be provided by the trainee to their Program Director or designee prior to using the wellness day so that adequate coverage can be ensured. Programs are encouraged to implement a system of coverage to ensure that use of wellness days does not produce an undue burden on other residents and faculty and minimizes disruptions to patient care and resident or fellow education. Since our health system has over 200 training programs that vary considerably in terms of size, scheduling systems, and coverage demands, individual programs are allowed flexibility in enabling the use of wellness days so long as policies and procedures are applied consistently.

Among the system-level interventions identified by GME trainees as likely to enhance their well-being, enforcing the wellness day policy without backlash was one of the highest interventions noted. In order to address this gap, the Office of GME and OWBR worked to change the culture by organizing public forums with key stakeholders (i.e., program directions, GME WBCs, and trainees). In these public settings, GME and OWBR leadership review the policy with all stakeholders and stress the importance of ensuring policy protection without backlash. The efficacy of this intervention is demonstrated by results from 2019 trainee well-being survey, in which 35.9% of trainees used 1–3 wellness days during the past 6 months of the survey (*Figure 7*), in comparison to 30.2% of trainees in 2018.

## **Discussion**

The OWBR has seen the impact of burnout and psychological distress firsthand and has been at the forefront of initiatives around physician well-being, albeit with challenges related to the immense size and varied needs of our workforce. COVID-19 heightened the acuity of the well-being needs of physicians across the globe. Our own MSHS workforce, which for a time in the Spring of 2020

was at the epicenter of the global pandemic, has experienced elevated symptoms of depression, anxiety, post-traumatic stress disorder, and burnout across health professions (31,32). Now more than ever, we look to share well-being resources and lessons learned from our own experience with our regional, national, and international colleagues.

We summarize a three-pronged approach—creating infrastructure to promote well-being, distributing a needs assessment survey, and developing interventions in response to survey results—to address physician faculty and trainee well-being in a large urban healthcare system. Although well-being needs vary widely across settings, our institution found that faculty physicians most valued opportunities for leadership training, enhanced mentorship and career advancement, documentation assistance, and decreased electronic health record and clerical burden, while trainee physicians most valued enforcement of the wellness day policy without backlash. Both groups valued improved appreciation efforts. These survey results have informed numerous interventions to improve the well-being of both our faculty and trainees. For our faculty, these interventions have included (I) annual faculty well-being departmental plans, (II) implementation of EHR clerical work burden reduction programs, and (III) enhancement of our leadership and mentorship programming via new and enhanced training programs. For our trainees, these interventions have included (I) expansion of our GME well-being champions program, (II) development of trainee well-being plans, and (III) implementation of protected wellness days for all trainees.

Beyond MSHS, other peer institutions are doing similar work, such as Vanderbilt University Medical Center (VUMC) and Weill Cornell Medicine. VUMC assembled a taskforce that developed a five-step approach to implement recommendations supporting and measuring physician well-being, and they closely monitored the progress via validated survey metrics (33). Similarly, using surveys and focus groups, Weill Cornell developed a Top 10 list of tenets to inform their grassroots approach to building a more nurturing, supportive environment for physicians and their clinical care teams, and they have measured their progress over time using the Mayo Clinic Well-Being Index (7).

Our current work is limited in that we have not yet evaluated the impact of all our interventions, and there are likely multiple confounding factors in assessing their effects. In addition, our survey findings are specific to a single institution in one geographic region; however, we identify a three-pronged approach that can be generalized and

implemented across many types of institutions.

## Conclusions

This article summarizes the well-being needs assessment and systems-level interventions for faculty and GME trainee physicians at a large urban healthcare system in New York City. The OWBR and other collaborators have supported enhancements to existing well-being infrastructure, which addressed the needs of our constituents as captured in the surveys and established the foundational structure to support the longevity of these interventions. Although this work is challenging, our data supports the increasing importance of prioritizing the well-being of healthcare providers. Future work will continue to focus on the collection of well-being, burnout, and other professional fulfillment data to assess the impact of our interventions and to enhance our understanding of the needs of our physician community. Our hope is that other institutions recognize the value of this work and consider implementing similar data-informed interventions to enhance physicians' and medical trainees' sense of well-being and professional fulfillment—enabling them to deliver high quality, effective, and compassionate patient care while feeling cared for in their workplace.

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## Footnote

*Provenance and Peer Review:* This article was commissioned



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*Data Sharing Statement:* Available at <https://jhmhp.amegroupp.com/article/view/10.21037/jhmhp-22-47/dss>

*Conflicts of Interest:* All authors have completed the ICMJE uniform disclosure form (available at <https://jhmhp.amegroupp.com/article/view/10.21037/jhmhp-22-47/coif>). The series "Shaping Tomorrow's Healthcare Systems: Key Stakeholders' Expectations and Experiences" was commissioned by the editorial office without any funding or sponsorship. LP received honoraria for speaking engagements at Atrium Health Wake Forest Baptist, American Society of Health-System Pharmacists, Stanford University, and the University of Montana. JR received honoraria for numerous speaking engagements at professional societies, academic medical centers, healthcare institutions; worked as a consultant for the well-being program at the NYU School of Medicine Long Island; served as a non-fiduciary board member of the Lorna Breen Foundation; and served on a temporary advisory board established by PEPSICO to inform employee well-being efforts. The authors have no other conflicts of interest to declare.

*Ethical Statement:* The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study was approved by institutional ethics board of the Icahn School of Medicine at Mount Sinai (No. 18-01090 for faculty survey, 17-02885 for graduate medical education survey) and individual consent for this retrospective analysis was waived.

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## Appendix 1 Mount Sinai Hospital System Departmental Faculty Well-Being Champion Program: Role Description and Curriculum

### Faculty Well-Being Champion Role Description

- Gather data on well-being, burnout and faculty satisfaction in your department
  - Conduct focus groups with your faculty (the guide and moderator instructions will be provided)
  - Send brief surveys to understand current state and stressors of faculty
  - Utilize the institution wide data from the biennial faculty survey
  - Present the findings to Departmental Leadership and the Office of Well-being and Resilience
- Attend monthly Well-Being Champion meetings
- Promote/encourage faculty completion of the institution-wide well-being survey
- Develop the knowledge set to independently “make the case for well-being”
  - Participate in / Review 4 “faculty well-being training sessions”
  - Develop a message of well-being that fits your department and share it with your departmental faculty and leadership
  - Promote the principles of well-being in your participation on hospital/departmental committees
- Develop an annual “Departmental Plan to Address Well-Being” with the assistance of the Office of Well-being and Resilience and in partnership with your department chair.
  - Consider creating a small faculty Well-being committee within your department to assist
  - Using data from focus groups and the survey, devise a few potential departmental-level interventions that address specific identified problem areas
  - Review these options with departmental leaders and the Office of Well-being and Resilience
  - With the support of department leadership and faculty – implement 2-3 of the devised interventions
  - As part of your “Departmental Plan to Address Well-Being” you may also consider implementing individual level interventions (such as mindfulness, narrative medicine or discussion groups) to improve the culture of your practice.
    - The Office of Well-being can provide the funding and expertise to run these sessions
  - Provide periodic updates on your process during regular Well-Being Champion meetings
  - Provide a brief summary annually of the major steps, plans and accomplishments of your departmental well-being program.

### Faculty Well-Being Champion Curriculum

This curriculum is designed for the faculty well-being champions (FWC) across the Mount Sinai Health System. Each department will identify 1 or more faculty physicians (s) to serve as the departmental well-being champion. The champions will aim to:

- Gather data on well-being, burnout and faculty satisfaction in your department
- Attend regular Well-Being Champion meetings
- Promote/encourage faculty completion of the institution-wide well-being survey
- Develop the knowledge set to independently “make the case for well-being”
- Develop a “Departmental Plan to Address Well-Being” with the assistance of the Office of Well-being and Resilience for approval by the department chair and the Dean’s office

In order to accomplish the above, the Office of Well-being and Resilience will provide an interactive curriculum to prepare, guide and support the FWC in their work.

Goals: Create a cohort of faculty well-being champions with skills in well-being/burnout assessment, leadership, information gathering and departmental well-being plan development.

Objectives: By the end of the curriculum, participants will:

- Explain common metrics for burnout and well-being and their role in our institutional-wide survey and dashboard
- Develop an understanding of the evidence for systems-level change to decrease burnout and promote well-being in physician faculty members
- Delineate the evidence behind personal-level well-being initiatives to improve well-being
- Describe Mount Sinai's model of professional fulfillment and the OWBR's mission and message these consistently to departments
- Describe current offering across the system that are likely to enhance provider well-being
- Develop skills to promote strong relationships with and between co-faculty and leadership
- Utilize a faculty well-being committee to assist in obtaining feedback and creating solutions for multiple sites and practice venues making sure all faculty are represented
- Gain comfort in collecting, filtering, and summarizing feedback on well-being related concerns
- Elicit and develop ideas for potential solutions for well-being concerns in a specific department
- Create a plan for addressing faculty well-being in a specific department or division in a problem-oriented fashion

Curriculum sessions:

Didactic/discussion:

- Mount Sinai's Model and Mission and background of the office
- Effective leadership to promote well-being and how to engage leaders in these efforts
- Top ten system level interventions to improve well-being
- The AMA steps forward program to promote well-being
- Current systems-level and personal-level offerings that may improve well-being and review of the Office of Well-Being and Resilience website
- Recognizing the difference between constructive criticism vs. complaints and how to kindly filter out the complaints
- Developing a plan for addressing well-being / burnout (i.e., brainstorming solutions, running pros and cons, effort, cost, likely impact, basic QI principles for small change PDSA)
- How to "sell" the plan for well-being to leadership

Report out sessions on:

(Each of these will take more than one session to get through all of the departments)

- Focus groups/interviews on challenges and potential solutions
- Draft of departmental plan to improve well-being
- Feedback from leadership regarding the departmental plan to improve well-being

## Appendix 2 Faculty Focus Group Guide

Office of Well-Being and Resilience, Icahn School of Medicine at Mount Sinai (ISMMS)

Population of Study

ISMMS Faculty (clinical and non-clinical)

Session Breakdown (60 min)

2-3 Facilitators; 7-10 physicians from each department present

### 1. Introduction (5 min)

- Thank you/Introduce facilitator and recorder (who will be taking de-identified notes)
- Provide Framework/Rationale
  - o We are here to discuss your thoughts about factors which contribute to faculty wellness and/or burnout in our department, and suggestions you have to improve faculty well-being.
  - o In this discussion, we have invited faculty members in the department to discuss their thoughts about how their work and work environment affect their level of well-being.
  - o Ultimately, we plan work with departmental leadership and the Office of Well-being and Resilience to utilize the results of this focus group as well as an institution wide survey (please fill it out) to devise and implement interventions that can decrease burnout and improve well-being for our departmental faculty.
- Set the stage
  - o To guide the discussion, we will be using a set of guiding questions (listed below).
  - o The sessions are not being recorded and individual names and responses will not be tracked. We will take notes during the sessions so that your groups' comments, ideas and suggestions can be included in the overall needs assessment and can inform our department's future wellness program.
  - o We hope that you will participate fully. However, if you do not feel comfortable with any question or part of the discussion you can choose not to answer or participate, and are also free to leave the session at any point.
  - o We expect to finish the session by \_\_\_\_ (end time).
  - o This session is confidential – since we all know each other and work together, it's important that anything we say in this room, stays in this room.
  - o This is meant to be an open and honest discussion, as well as a safe space, so please be respectful of those people both in and outside of this room.
- Does everyone here consent to participate? (get verbal agreement)

### 2. Ice Breaker Question (5 min)

- Let's start with an ice breaker (may differ depending on how familiar the group is with each other but it's a critical step even with the most familiar of groups)
- Please introduce yourself and tell us xx (where you went on your last vacation, what you did for fun last month/weekend, what you are grateful for, something this group might not know about you, etc.)

### 3. Discussion/Key Questions (45 min)

- What are the biggest workplace-related barriers to your own well-being?
  - a. Macro factors contributing to burnout/engagement (5 min).  
What institutional factors affect your well-being?
    - i. State that these comments will be recorded and collated with comments from other departments for senior leaders to consider, but that most of this time should be spend discussing local challenges and solutions.

b. Local factors contributing to burnout/engagement.

What are the major local (departmental, practice level) factors that affect your well-being?

- i. How are these factors manifested, please give examples of problems (can name areas - workflow, communication, team dynamics, scheduling, work after work, culture (safe or unsafe), IT problems etc- get granular (40 min)
  - ii. What are some possible solutions for the problems/challenges you have mentioned?
- What change or intervention (or top 2-3) is most likely to improve your well-being?
  - Do you have ideas about how to promote a culture in which the well-being of the physician is valued equally with other goals of the health system?

4. Closing (5 min)

- Is there anything else about burnout/well-being you'd like to share with us?
- Thank you for your time and participation. We value your feedback. If you are interested to know the results of these focus groups, please feel free to follow up with us in the next few months.

Moderators Debrief

- Run through notes and fill in any gaps, clarify any points
- Make sure all pages are numbered, dated and are labeled with name of the department and facilitators
- Send confirmation email with attached notes to focus group leaders
- Review focus group notes for common and reoccurring themes. Also note the outliers.
- Create summary document with major common themes as well as noting outlier opinions
- Send to leadership with planned meeting to review as well as to the Office of Well-Being and Resilience



### Appendix 3 Faculty Personal/Professional Characteristics Questions from 2018 Faculty Well-Being Survey

Participant Demographics	Gender (Multiple choice: Female, Male, Non-binary/third gender, Prefer not to say, Other); Age (Multiple choice: 20-39, 40-59, 60+)
Professional Characteristics	Faculty Level (Multiple choice: Instructor, Assistant Professor, Associate Professor, Professor, Other) Full-time Status (Multiple choice: Full-time, > or = 60% Part-time, < 60% Part-time, Voluntary) - What is your faculty FTE designation? Hours worked per week (Multiple choice: <30, 31-40, 41-50, 51-60, 61-70, 71-80, >80) - On average, how many hours do you work per week? Department (multiple choice with alphabetical list of departments) - Please select your Department:
Depression, Meaning, and Resilience	Depression (PHQ-2) (yes/no response) - During the past month, have you often been bothered by feeling down, depressed, or hopeless? - During the past month, have you been bothered by little interest or pleasure in doing things? Meaning in work (Responses on 5-point Likert scale ranging from strongly disagree to strongly agree) - The work I do is meaningful to me. Resilience (CD-RISC-2) (2 items, 4-point Likert scale [see citation, (16)]+ N/A ranging from Rarely true to True nearly all of the time)
Burnout, Work-life Integration, and Professional Satisfaction	MBI (2-item) (Responses on 7-point Likert scale [see citation, (14)]) Mayo Well-Being Index (6 items, Yes/No responses based on the past month [see citation, (15)]) Work-life balance (WLI)/ Job satisfaction (PS) (Responses on 5-point Likert scale ranging from strongly disagree to strongly agree) - My work schedule leaves me enough time for my personal/family life. - Overall, I am satisfied with my current job. Leave position likelihood (Multiple choice, 5-point Likert ranging from None to Definite) - What is the likelihood that you will leave your current research setting within next 2 years? - What is the likelihood that you will leave your current patient care setting within next 2 years? Reason for considering leaving (Multiple choice, 14 options check all that apply - see table 1 for options) - What is the primary reason you are considering leaving your current research setting within the next 2 years? Plans if leaving position (Multiple choice, 5 options check all that apply - see table 1 for options) - What do you plan to do if you leave your current practice?
Leadership and Mentorship	Direct supervisor title - Please indicate the title of your direct/immediate supervisor Mentor (Yes/No response) - Do you have a mentor(s) for career development within the Mount Sinai Hospital System? Barriers to obtaining mentor (8 options check all that apply, see table 1 for options) - What are the barriers to obtaining a mentor? Mentor satisfaction (5 point Likert-scale ranging from Very satisfied to very dissatisfied) - Overall, how satisfied are you with your mentor? Mentor Index Score (3 point Likert-scale ranging from Not at all skilled to Extremely skilled + N/A) Please rate how skilled you feel your mentor is in each of the follow areas - Active listening - Providing you constructive feedback - Helping you set career goals - Helping you balance work with your personal life

## Appendix 4 Resident/Fellow Personal and Professional Characteristics Questions from 2019 Well-Being Survey

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Participant Demographics	Gender (multiple choice: female, male, other [free response]); Age (multiple choice: 20-25, 26-30, 31-35, 36-40, >40)
Professional Characteristics	Average hours worked per week (multiple choice: <30, 31-40, 41-50, 51-60, 61-70, 71-80, >80) - On average, how many hours do you work per week? Department (multiple choice with list of specialties) - Please select the group to which your program belongs (specialties are listed alphabetically).
Depression, Burnout, Meaning, and Program Satisfaction	Depression (PHQ-2) (yes/no response) - During the past month, have you often been bothered by feeling down, depressed, or hopeless? - During the past month, have you been bothered by little interest or pleasure in doing things? MBI (22-item) (Responses on 7-point Likert scale: Never, A few times per year or less, Once a month or less, A few times per month, Once a week, A few times per week, Every day) Meaning in work (Responses on 7-point Likert scale ranging from strongly disagree to strongly agree) - The work I do is meaningful to me. Well-Being Champions (yes/no/not sure response) - Does your program have a dedicated FACULTY member (i.e., faculty wellness champion who supports trainee well-being?)

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## Appendix 5 Departmental Plan Template

Icahn School of Medicine at Mount Sinai  
REVISED Office of Well-being and Resilience  
Department of X Plan to Address Faculty Well-being (Template)

Date:

The world and our health system have changed dramatically during the pandemic. In this era, addressing clinician and staff well-being is more important than ever. We would like to move forward by working with each department to create their plan with a continued focus on system-level initiatives to advance well-being. The operative premise remains that there are ways to promote well-being that also have the potential to enhance productivity, engagement and retention.

Please complete the template below in conjunction with the Chair, Well-being Champion and OWBR keeping in mind the following suggestions:

1. Consider implementing efficiency of practice initiatives that lead to both well-being and productivity—this can be done by adding or shifting resources or by leveraging technology.
2. Consider charging a well-being committee representing all stakeholders in your department to generate ideas for efficiencies. Often, those in practice know best and when empowered to share their ideas there is a salutary effect on their well-being.
3. Consider limiting your initiatives to 2-3 major efforts likely to have impact on the above.
4. Integrate well-being culture, efficiency and resilience initiatives that require an expense into your existing budget and indicate how you will measure their effectiveness.

### Department of X Plan to Address Faculty Well-being

- Departmental Well-Being Infrastructure
  - o Faculty Wellness Champion(s):
  - o Formation of a Faculty Wellness Committee: (Y/N, Composition)
- Initial Needs Assessment [Describe from where you are getting data]
  - o For example  
Process of data collection [briefly describe process of data collection, i.e., we utilized results from the survey and conducted 3 focus groups of approximately x faculty. Data was collated and reviewed by the Faculty Well-being Champion (s) and Departmental Leadership. The following plan reflects the information collected from faculty and joint efforts of the FWC and Leadership to improve well-being in our department. Or: data was collected via informal discussions with faculty and collated by the WBC.

- Identified Well-being Priorities

[List top 2–3 identified departmental level barriers to well-being]

1. Priority 1 [What is the issue/concern]
  - a. Main Barrier and Evidence [briefly describe evidence supporting this item as a barrier to well-being in your department]  
Solution 1 [Name and briefly describe of the plan]
  - b. Stakeholders—identify stakeholders and plan to garner stakeholder support
  - c. Resources—describe needed resources (either re-allocated or additional) [include staff, funding, IT support, space, time, external resources, etc.] and the plan for how to obtain the needed resources
  - d. Process—describe who will be involved in the development and implementation of the plan and how the process will

- unfold and a brief timeline for implementation
  - e. Assessment—briefly describe the ways in this solution will be evaluated for success
    - i. Mechanism for ongoing assessment and feedback
    - ii. Process Metrics (e.g., dashboard)
    - iii. Outcome Measure
- 2. Priority 2 [What is the issue/concern]
  - a. Main Barrier and Evidence [briefly describe evidence supporting this item as a barrier to well-being in your department]
  - Solution 2 [Name and briefly describe of the plan]
  - b. Stakeholders—identify stakeholders and plan to garner stakeholder support
  - c. Resources—describe needed resources (either re-allocated or additional) [include staff, funding, IT support, space, time, external resources, etc.] and the plan for how to obtain the needed resources
  - d. Process—describe who will be involved in the development and implementation of the plan and how the process will unfold and a brief timeline for implementation
  - e. Assessment—briefly describe the ways in this solution will be evaluated for success
    - i. Mechanism for ongoing assessment and feedback
    - ii. Process Metrics (e.g., dashboard)
    - iii. Outcome Measure
- 3. Priority 3 [What is the issue/concern] (optional for 2022)
  - a. Main Barrier and Evidence [briefly describe evidence supporting this item as a barrier to well-being in your department]
  - Solution 3 [Name and briefly describe of the plan]
  - b. Stakeholders—identify stakeholders and plan to garner stakeholder support
  - c. Resources—describe needed resources (either re-allocated or additional) [include staff, funding, IT support, space, time, external resources, etc] and the plan for how to obtain the needed resources
  - d. Process—describe who will be involved in the development and implementation of the plan and how the process will unfold and a brief timeline for implementation
  - e. Assessment—briefly describe the ways in this solution will be evaluated for success
    - i. Mechanism for ongoing assessment and feedback
    - ii. Process Metrics (e.g., dashboard)
    - iii. Outcome Measure

Signatures:

Department Chair

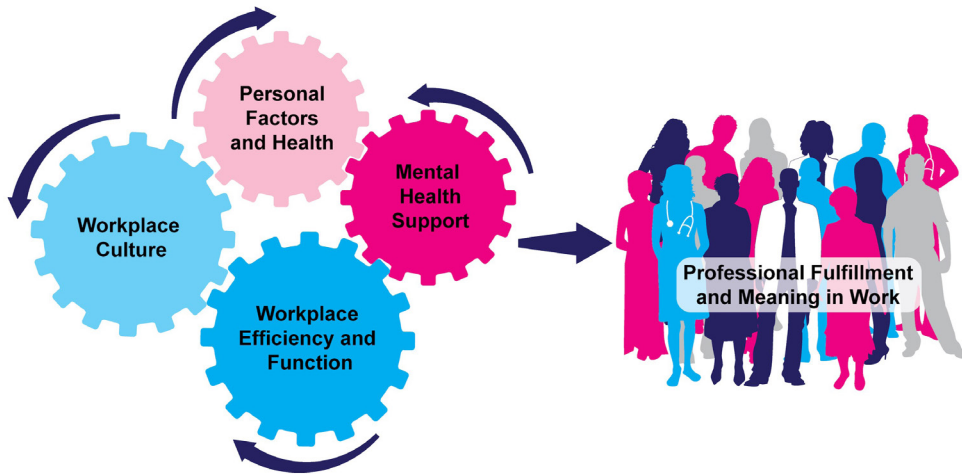
Faculty Well-being Champion (s)

Optional Signatures

Chief Wellness Officer     Associate Dean for Faculty Well-Being and Resilience

## Addendum: Guide for Choosing Priorities and Solutions

### 1. Target multiple areas of the model



In our model there are 4 critical elements that drive Professional Fulfillment and Meaning in Work. These elements are: Workplace Efficiency and Function, Workplace Culture, Personal Factors, and Mental Health Support. Each element is critical to improving the overall well-being but departments should consider interventions focusing on Workplace Efficiency and Function and Workplace Culture first and foremost.

- Workplace Efficiency and Function
  - Electronic health record optimization – individual/small group trainings, epic inbasket management optimization (offload messages from providers)
  - Improved team-based care – workflows, clear roles/responsibilities, incoming message triage
  - Communication skills training
  - Address clinical documentation burden- dictation, scribes, physician extenders
  - Consider low cost interventions that also improve efficiency or practice
- Workplace Culture
  - Create a well-being committee or workflow committee to engage physicians in identifying solutions to improve their well-being
  - Create a mentorship program for career development, promotions
  - Consider schedule flexibility
  - Consider the role of leadership
    - Annual Assessment—may be a good opportunity to practice well-being leadership skills
      - The 20% rule—well-being increases when faculty spend 20% of their time doing what they like the most
      - What is the 20% they most want to be involved in?
      - What other leadership strategies can be used to improve wellbeing (see your survey results on the leadership index breakdown)
  - Novel compensation strategies
- Personal Factors and Health
  - Gratitude/recognition efforts
  - Improve mistreatment identification and resolution efforts
  - Make available relevant individual-level intervention offerings (mindfulness, yoga, massage, resilience and leadership trainings, peer support, pet therapy)



- Mental Health Support
  - o o Normalize stressors and help-seeking behavior
  - o Expand mental health resources when possible
  - o Provide mental health resource information
  - o Advertise employee assistance and other mental health programs available to employees
  
- 2. Synergize with system-level interventions underway
  - o Integration of system-level interventions
    - Leadership Training
    - Mentorship
    - Childcare
    - Parental/family leave
    - Mental Health
  
- 3. (Optional) Create a budget for your proposed solutions along with a brief justification for each item.
  - This can be done in excel or a table in word e.g.

Item	Category	Cost	Justification
	(e.g., personnel, supplies, equipment, hardware, software, food, travel, consultant, IT support, space upgrades, etc.)		(e.g., reason for need and how will improve well-being)