Report of the Yale School of Medicine Clinician Well-being Committee

Background

The Clinician Well-being Committee was convened in May 2018 and charged with seeking ways to address physician burnout, promote a culture of well-being, and ensure that Yale School of Medicine (YSM) clinicians feel supported and able to thrive amidst the many challenges inherent in the clinical environment.

Committee members included co-chairs, Gary Desir and Walter Longo, along with Veronica Chiang, Tom Donohue, Ariadna Forray, Mike Ivy, Lee Katz, Viji Kurup, Darin Latimore, Kristine Olson, Elena Ratner, Mary Hu, Karen Santucci, Adrienne Socci, Steve Southwick, and Lynn Tanoue.

The committee met 13 times over 15 months, and as part of its work reviewed a number of existing reports and data sets, including the results of the Barrett Values Survey, the statement of YSM values, the 2017-18 ACGME Faculty Wellness Survey, and other relevant literature, including a 2018 JAMA Psychiatry paper published by Dr. Southwick on the topic of physician burnout, and a 2017 NEJM paper published by Kristine Olson and others on the topic of physician well-being. In addition, the committee discussed the availability of organizational resources, such as the YNHHS Clinical Redesign Team, the Yale Medicine Clinical Optimization Team, and current investments being made by the YNHHS Medical Director’s office.

Based upon these inputs, the committee focused on four thematic areas relating to clinician well-being:

- Re-establishing autonomy and control
- Encouraging and facilitating belonging and being part of a team
- Achieving work-life balance
- Improving workplace efficiency

In September 2018, the committee approached faculty in 19 clinical departments to learn of their concerns, ideas and suggestions for improvement across the four themes. Working with clinical vice chairs and section chiefs who in turn engaged with a broad range of faculty in their departments and sections, the committee gathered input from across the clinical practice. Committee members then worked in small teams to review and evaluate one of the four themes, identify priority issues to address, and make recommendations on ways to improve faculty well-being.

The committee discussed the current emphasis in organizations on the need for greater resilience in the workforce, and would like to highlight the critical reciprocity that exists between a culture of wellness, practice efficiency and personal resilience in achieving employee well-being. According to scholars in this field, “it is counterproductive to ask physicians to ‘heal themselves’ through superhuman levels of resilience even as the practice environment continues to deteriorate.” Rather, workplace efficiency and wellness should be addressed from an organizational standpoint.

The committee devoted several meetings to the topic of implementation. It was generally agreed that the implementation of well-being initiatives will necessarily occur in the departments and sections, but that these initiatives should be supported by the central administrations of both the school and hospital.
Based upon the results of the survey and committee discussions, the Clinician Well-being Committee presents three overall recommendations, followed by a number of specific subcommittee recommendations relating to the four thematic areas.

**Clinician Well-being Committee Recommendations**

1. Create a joint YSM/YNHH senior position - **Chief Wellness Officer** - focused on wellness and well-being. Various wellness efforts ongoing at Yale New Haven Hospital (YNHH), Yale New Haven Health System (YNHHS) and Yale Medicine (YM) should be consolidated and led by this individual. Importantly, this position should be a key member of the school’s senior administrative team with the ability to influence relevant decisions and allocation of resources. The individual should be in place by September 2020.

2. Appoint a high-level position in every department/section, (Vice Chair or other departmental leader for wellness with some salary support, depending on departmental size. These individuals would meet regularly with faculty and serve as liaisons between the faculty, the department and medical school/hospital administration. As a group, they would serve as a cabinet for the Chief Wellness Officer. They should similarly have the agency and departmental support to enact wellness initiatives and address issues raised at monthly meetings and discretionary funds to support team-building activities at a section or program level.

3. Create a **YSM/YNHH “Wellness Center”** to facilitate interactions among colleagues and to provide a space for faculty to engage in activities that promote wellness. The center could include:
   a. Free gym membership
   b. Reset Room where staff can “re-group” (ex. sit in a lounge chairs in a private calm quiet space)
   c. Hospital/medical school sponsored daily group meditation sessions
   d. Social coordinator to facilitate team building activities and social events
   e. Peer support on site for crisis and other interventions
   f. Human Resources support to coordinate and provide liaison services

A mechanism for regular reporting (i.e., every three months) on the progress related to these initiatives should be established. The existing committee could transition to a steering or advisory committee and provide guidance on ongoing efforts.

**Clinician Well-being Subcommittee Recommendations**

The “**Autonomy and Control**” Subcommittee comprised of Tom Donoghue, Elena Ratner and Lynn Tanoue considered how autonomy and control could be re-established among clinicians in their working environment.

Several themes emerged from the surveys of clinical faculty across departments and from subcommittee discussions. There is a general sense of poor communication between YNHH and YM leadership and the medical staff with a widely-held perception that these entities assume a top-down leadership approach with little attention paid to the viewpoint of the physicians. While a corporate leadership style is necessary for the successful functioning of the hospital system, it results in a productivity assessment paradigm that seems to trump all other measures of physician effectiveness. There is a sense on the part of the medical staff regarding loss of control over their work environment, including scheduling, staff management, unmanageable workloads leading to burnout and increased liability risk, Epic
documentation demands that sacrifice time with patients, and expanding outreach responsibilities all in the interest of market dominance.

There is significant overlap in how physicians feel about YM and YNHH with faculty feeling caught up in the complex relationship between the two organizations. YM is felt to have a similar hierarchical approach to decision making with limited input from the most affected faculty, lack of respect or understanding of workloads, limited acknowledgement of the need for and demands of education in the clinical environment, and the mandate for unfunded work (committees, program development), while simultaneously holding faculty accountable for productivity. In addition, there are significant concerns regarding limited mentoring, inadequate orientation, and poor interdepartmental relationships leading to issues of professionalism in faculty interactions. There is also the perception that there is a paucity of genuine leadership of clinical faculty in the clinical environments as well as programatic development.

Specific recommendations include:

1. Revamp the current leadership paradigm to promote a collaborative and transparent organizational structure with robust involvement of faculty in decision making, both at the departmental and section levels and for any hospital business strategies.

   An inclusive leadership structure recognizes faculty talent, broadens perspective, improves responsibility and ownership of departmental/hospital initiatives, and could promote improved intra- and inter-departmental professional relationships, which are currently hobbled by a siloed corporate and university culture. Collaborative leadership should also improve the frequency and quality of feedback that is essential to career development – both at the junior and senior faculty levels.

2. Curtail the current “stretching” of faculty to achieve ever greater output with the mutual development of improved metrics regarding productivity and effectiveness.

   Physicians should have the right to say “no” when safe limits on workloads are being exceeded that will likely necessitate further investment in clinical faculty/staff and innovation in care models. Administrative responsibilities, especially in the clinical sphere, should be passed off to more appropriate individuals.

3. Provide physicians with genuine leadership roles in clinical environments. Titles must come with the ability to change/improve workflows, oversee schedules, and collaboratively control staff distribution. With these adjustments and with apropriate administrative support, physician leaders could then be reasonably held accountable for productivity and results.

The “Belonging and Being Part of a Team” Subcommittee comprised of Ariadna Forray, Viji Kurup, and Adrienne Socci considered the challenges and opportunities related to a sense of belonging and being part of a team among clinicians.

Several themes emerged from the surveys of clinical faculty across departments and from subcommittee discussions. There is a general sense among clinical faculty of not feeling valued. Faculty feel there needs to be better communication within sections and departments, the medical school and faculty, and between the faculty and hospital staff. There is a general sense of lack of transparency, and the communication that does exist (i.e., RL Solutions) is usually negative in connotation. Critically, faculty also expressed the need to address micro-aggressions, and at times, bullying.
Specific recommendations include:

1. Hold regular faculty meetings **and** provide protected time for faculty meetings
   a) Have monthly faculty meetings with the Vice Chair for Wellness
   b) Have weekly or bi-monthly clinical problem-solving meetings within sections or programs
   c) Include mindfulness into meetings

2. Enhance positive communication and create bi-directional communications forums
   a) Develop a means to recognize and praise colleagues within clinics, inpatient services or sections for something positive they have contributed to the team, other faculty or during patient care
   b) Create a solution box or mechanism to bring in ideas/highlight opportunities for improvement
   c) Have regular emails from the Dean’s Office, Department Chair and/or Section Chief with the purpose of highlighting something positive

3. Support faculty team building activities within departments and across the medical school, including activities at satellite sites.

The “Work-Life Balance” Subcommittee comprised of Steven Southwick, Lee Katz, Walter Longo, Kristine Olson considered how to assist clinicians in achieving a better balance between their personal and working lives.

Several themes emerged from the surveys of clinical faculty across departments and from subcommittee discussions. Current clinical workloads are heavy and not well matched with resources, staffing and efficiency. Physicians spend too many hours at work and still bring work home, which has a negative impact on both home and work life. Resources and staffing are unequally distributed across clinical practice sites and limited flexibility in work schedules negatively impacts physicians’ lives outside of clinical care.

Addressing the overall challenge of creating a more positive work-life balance for YM clinicians will require some broad-based interventions, including the establishment of criteria for appropriate productivity requirements and sustainable work-loads; and the hiring of an adequate number of physicians and non-physician providers to maintain a sustainable work-load and to cover illness, vacations, leaves and departures. There is an overall perception that work life balance is not a priority for leadership, which creates a negative feeling in the workplace.

Specific recommendations include:

1. Assess average sustainable workload per physician for each department/service so that informed decisions and recommendations can be made. It may be helpful to hire one or more experts in mathematical modeling to assist departments/services in this process.

2. Increase flexibility/ control of work schedules. This “job crafting” would allow physicians to attend to important activities such as childcare/eldercare and family/school events (e.g. child’s graduation). Examples of job crafting include allowing part-time work or job sharing for physicians (which is known to reduce burnout); in addition, recommend improving access to benefits for physicians who choose part-time positions.
3. Hire an appropriate complement of physicians and non-physician providers

4. Provide institutionally supported educational opportunities to grow (e.g. attending conferences or trainings); half day per week protected time for research/education/ catch-up with notes, email, etc.

The “Workplace Efficiency” Subcommittee considered opportunities to attain greater efficiencies in the clinical setting, with a specific focus on improving Epic functionality.

Several themes emerged from the surveys of clinical faculty across departments and from subcommittee discussions. Epic is isolating: “not talking to patients, not communicating with other physicians, and detracts from the educational teaching mission” There was general consensus that Epic, while clearly essential, has decreased efficiency and increased administrative work. The Epic support team is often unavailable, and at times does not have appropriate training and expertise. It remains a challenge to utilize Epic for investigating clinical outcomes research both individually and programmatically. In addition, there is a general lack of faculty involvement in clinical healthcare delivery design, and a lack of a framework for faculty to create and implement programs.

Specific recommendations include:

1. Have faculty and ancillary staff dedicated to improvement of clinical care delivery efficiency in each section, including:
   a. Clinician-focused Epic workflow simplification/stream lining, including short cuts, dot phrases, order sets, M-modal for physicians only etc. Alerts should be relevant – e.g., no need to alert that patient has AKI when being treated for this on admission.
   b. Physician extenders/ scribes/ ipad translators (Stratus)/ ipad for patients to pre-fill history data etc. to minimize after-hours Epic use
   c. Additional non-physician staffing to reduce in-house time spent doing administrative non-clinical work, such as finding records, scheduling appointments and med reconciliation
   d. MD lead MD-PSM team creation. MD-PSM teams and their administrative staff need to be co-located as direct interaction enhances efficiency. Efforts need to be made to decrease staff turnover.
   e. Adjustment of RVU expectations to include time required to complete Epic chart
   f. On-site real time Epic support staff for physicians – they should be in clinics and on the wards and available by phone in real time (not pull a ticket and wait for call back).
   g. Physician liaisons specifically on site to trouble shoot problems that detract from productivity (glitches with passwords, IDs, parking, keys, access to different buildings, credentialing, renewal of certification, schedules, AMION etc.). This would be like the TechDeck but for other issues.
   h. New faculty on-boarding that begins 3-4 months before their start date. Program should be staffed by a friendly person who is able to support and facilitate difficult transitions.

2. Have a dedicated YNHH-YSM administration team to create and implement adequate new program start packages, both at New Haven and non-New Haven locations prior to the start of the programs
   a. A “how to” and “who to” contact (business office, shared services, GME, VP, Chair etc.)
b. Development of business plan
c. Assistance in staffing and creating staffing models
d. Guidance in resource allocation (clinic space, Social Work, PFAS etc.)
e. Assistance in acquisition of funding (hospital vs. university vs. other source)

Also, if a faculty member is recruited to start a new program at Yale, this should be described in writing with details and resources available at the onset.

3. Create a clinical outcomes research core accessible to all physicians to allow simultaneous collection of clinical data for patient care and research.
   a. Equipment e.g., iPads or direct patient internet access for patient entry of their data prior to consultation/ED visit
   b. Program to recruit and train YNHH/YSM volunteers or staff to assist patients with data entry
   c. Epic staff to assist in ongoing creation of clinical care documentation templates for physician data entry into Epic to standardize how data is entered and to include individualized fields for research data extraction
   d. Opt out initiative for all patients to allow non-deidentified data, specimen and imaging data collected as part of clinical care to be used by patient’s physician in research
   e. University IT Core for single encounter Epic data retrieval or on-going biorepository creation (staffed to help 1400 physicians)
   f. University writing and biostatistics core for data analysis and paper writing or abstract/poster creation (also staffed for possibly 1400 physicians)

Evaluation and implementation of the specific recommendations relating to the four thematic areas presented by the subcommittees will be the responsibility of the Chief Wellness Officer in concert with the cabinet of departmental representatives.

Our organizations have grown tremendously over the past one to three years, and with growth comes chaos. Chaos continues to be a major cause of un-wellness in many organizations. All efforts should be made to minimize chaos moving forward.

The Clinician Well-being Committee appreciated the opportunity to come together to address the critical issue of how to provide a healthier, more supportive environment for our clinicians and to present these recommendations.

Please share your thoughts and suggestions using this link.