

## VIEWPOINT

# How to Measure Progress in Addressing Physician Well-being Beyond Burnout

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Supplemental content

**In the last decade**, significant progress has been made in recognizing *physician burnout*, traditionally defined as a work-related phenomenon characterized by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment, as a key public health issue.<sup>1</sup> There is enhanced understanding of demographic differences in well-being, such as greater compassion fatigue and lower professional fulfillment among female compared with male physicians and differences across specialties. The widespread prevalence of emotional exhaustion, depersonalization, and decreased personal accomplishment among physicians and their relationship with quality, safety, patient outcomes,<sup>2</sup> and physician turnover<sup>3</sup> are increasingly recognized, with health systems and influential bodies across the country actively seeking to address these issues.

The work ahead involves continued identification of interventions that effectively address occupational distress and enhance professional satisfaction. The National Academy of Medicine has called for action at the level of national policy, health care systems, and clinical microsystems and has called for rigorous ongoing measurement of burnout.<sup>4</sup> Accordingly, medical

can't make progress on metrics as holistic as burnout or its subcomponents, especially when single interventions are minor as compared with the magnitude and complexity of the problem.

Nevertheless, **demonstrating outcomes is crucial for understanding the effectiveness of programs to address physician well-being and** for making the case for continued investment in well-being to clinic, hospital, system, and national leadership. As with the patient safety and quality movements, intermediate outcomes (upstream of the big, important outcomes such as mortality or, in this case, burnout) will be needed to help evaluate specific interventions and assess progress on efforts to enhance physician well-being. Information gained through measures of leading indicators of occupational distress should complement that garnered from higher-level well-being outcome measures.

**Structure and process measures are the most straightforward candidates for** these intermediate outcomes. Examples can include establishment of a chief wellness officer position with a dedicated budget and resources or completion of specific programs linked to reduced emotional exhaustion and increased professional fulfillment, such as communication skills programs or coaching interventions. These approaches might involve the number of hours that physicians work without time off in various shift schedule configurations, the number of messages sent on average to resolve a

prior authorization issue before **and after a workflow intervention, the percentage of orders written with team contribution, or the number of notes written with documentation assistance.** Alternatively, ideal intermediate metrics may be those known to be associated with quality of care, such as the presence of regular **multidisciplinary team huddles or the availability of standardized handoff procedures** by clinical setting.

As in the field of health care quality, the next step involves linking current structure and process metrics to the downstream outcomes of interest and priority. Given that **reductions of time spent on the electronic health record (EHR) and increases in staff support are linked to reductions in emotional exhaustion and increased professional satisfaction,** respectively, these measures could serve as valid end points for improvement efforts. Although often challenging to achieve, ideally, evaluations linking process metrics to well-being outcomes would be conducted in a multisite, experimental fashion to enhance the quality of the evidence underlying metrics decisions.

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institutions are putting into place programs and strategies to enhance well-being and measuring its key drivers longitudinally. How will institutions know if their efforts have succeeded?

As leaders embark on enhancing well-being in their own systems—whether through peer support, advanced models of team-based care, or digital applications, among many approaches—interventions will necessarily be small and require refining and spread over time. Existing instruments, such as the Maslach Burnout Inventory, the Mayo Well-being Index, the Stanford Professional Fulfillment Index, or the Mini-Z Burnout Assessment, measure the components of burnout and some of its drivers and consequences. Yet, by design, these tools represent holistic and aggregate assessments, for which answers can vary based on numerous external factors, independent of local interventions meant to address well-being. Although these instruments represent important overall outcome metrics that institutions should be tracking, it is unclear to what extent it is realistic for any single intervention to signifi-

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Surrogate outcomes that help more deeply, quickly, and regularly characterize the present sense of well-being of the physician workforce are a next priority. Examples of these outcomes include physicians' sense of community, reductions in intention to leave a current position, or perceptions of being appreciated in the workplace. Regular query regarding these surrogate outcomes could help organizations identify areas of focus for intervention and additionally provide room for deeper inquiry into daily experiences of providing care. For example, a recent study across 5 specialties in an academic medical center was able to detail how inadequate staffing, devaluation by colleagues, poor communication, and patient and family anger helped to shape experiences of low perceived appreciation at an urban academic medical center.<sup>5</sup> This knowledge subsequently provided a basis for initiatives across these specialty departments.

Moreover, but perhaps most important, leveraging existing data and minimizing expenditure of participant time for data collection should be emphasized. Doing so will allow enhanced understanding of the experiences of work without adding to the numerous measurement requirements already faced by physicians. Examples of these types of data include usage logs automatically generated from the EHR or human resources data regarding physician use of all vacation days, time spent logged into the EHR during vacation days or days not scheduled for clinical work, clinician turnover, and reductions in clinic effort. These types of outcomes have shed light on significant cross-specialty differences in time spent on the EHR,<sup>6</sup> uncovered potential workflow and documentation contributors to significant gender differences in workplace experiences,<sup>7</sup> and helped describe the relationship of physicians' emotional exhaustion, depersonalization, and dissatisfaction with work-life integration with turnover.<sup>8</sup>

In 2019, the National Academy of Medicine laid out priority areas for enhancing clinician well-being. These include creation of positive work and learning environments, reductions in administrative tasks, enabling technology solutions, and providing support to cli-

nicians and learners. Expanding on the well-being investigations it has supported through the Minimizing Error, Maximizing Outcome Study, the EvidenceNOW Initiative, and the Healthy Workplace Study, the Agency for Healthcare Research and Quality (AHRQ) now has an opportunity to develop measures that correspond to each of the focus areas outlined by the National Academy of Medicine, as well as to the area of organizational culture (eTable in the Supplement). The AHRQ could, for example, recommend choosing from a core set of validated, evidence-based intermediate measures in their funded studies focused on physician experience. This could facilitate more standardized evaluation of interventions to improve well-being.

Identifying, rigorously evaluating, and assessing potential biases in metrics that are directly correlated with well-being outcomes of interest could help compare programs and outcomes across diverse types of practice. This approach could also potentially pave the way for future efforts that tie recognition to clinician experience metrics. Two examples include The American Nurses Credentialing Center's Magnet Recognition Program and the American Medical Association's Joy in Medicine Health System Recognition Program, each of which incorporate such structure and process measures within their criteria. At the individual system level, leadership teams could make well-being-related metrics a regular component of their updates to organizational boards, with compensation tied to these metrics. Similarly, local clinical leaders could have incentives built into their compensation packages for leading efforts that positively affect the well-being of physicians within their work unit.

Now is the right time for the pursuit of the quadruple aim in health care, which involves enhanced patient experiences and improved population health at a lower cost, while also supporting clinician well-being. Understanding the extent of progress toward the fourth pillar of this aim—well-being—will be crucial for future progress. Ongoing measurement of holistic outcome measures such as burnout must be complemented by more intermediate measures that assess the efficacy of interventions and inform their design.

#### ARTICLE INFORMATION

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