

# The Rise of Wellness Initiatives in Health Care

Using National Survey Data to Support Effective Well-Being Champions and Wellness Programs



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- American Academy of Family Physicians (AAFP)
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- Accreditation Council for Graduate Medical Education (ACGME) Wellness Consortium
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## EXECUTIVE SUMMARY

Urgent concerns about the well-being and mental health of health care professionals were made more significant through the COVID-19 pandemic, and institutions nationwide are acting to address these concerns. One critical step in supporting well-being within a health care organization is to develop wellness initiatives, and another is to identify an individual (or teams) to oversee wellness initiatives. This report presents data from two recent surveys of health care professionals highlighting common elements of wellness programming and describing the roles of the well-being champions (WBCs) who lead and support wellness efforts. The data provide new information and insights to help institutions establish and continue to develop wellness leaders and initiatives.

Survey findings indicate a large majority of institutions (88.9%) have at least one wellness program, but the breadth of those programs varies widely. About 48.5% of respondents reported their institution had programs for all health professional populations (learners, faculty, and staff). Respondents with programs that served multiple audiences reported having WBCs at different levels throughout their organization, with 54.4% having an organization-level WBC, such as a chief wellness officer (CWO). However, of the respondents who identified as a WBC, only 30.9% received formal training for their roles, and while 50.0% of CWOs and 54.1% of wellness directors reported having at least 31% full-time-equivalent (FTE) allocated to their role, many WBCs have no formal FTE allocation for their wellness role.

Results also show that wellness programs are implementing a range of curricular (mandatory) and extracurricular (optional) programs. In describing how wellness programs were delivered, a large portion of respondents (92.0%) indicated they were “presently using or hoped to add” optional wellness activities to their wellness programs. However, a majority of respondents (56.2%) reported that either wellness program funding occurs only when return on investment (ROI) is demonstrated (28.6%) or the organization has no budget for wellness programs (27.6%). Furthermore, only 28.9% of all respondents reported that their organization’s wellness programs had formal results or outcomes demonstrating efficacy.

Analysis included a review of several WBC job descriptions from across academic medicine institutions to identify common job characteristics for this critical role. By examining the roles and responsibilities of WBCs with different titles and reporting structures, this report identifies the common responsibilities among two primary groups of WBCs: those with broader organizational positions and those across the institution with embedded roles. This review found that the organizational and embedded roles typically have different areas of focus and provide different services, and both generate value for the institution and its health care professionals.





A wide variety of wellness programs and WBC roles exist within health care institutions to support the unique needs of each institution. Institutions that have identified a WBC at the organizational level are well-positioned to align their institutional vision for well-being and specific goals to realize that vision across the entire organization. Based on this analysis, this report presents the following 10 recommendations to help organizations promote a culture of well-being:

- 1.** Approach organizational wellness initiatives within an improvement framework to lead change.
- 2.** Develop and communicate an organizational vision for well-being.
- 3.** Establish an organizational-level well-being champion to coordinate and align a network of wellness efforts across the organization.
- 4.** Embed well-being champions throughout the organization to coordinate efforts for specific audiences.
- 5.** Standardize the job characteristics of well-being champions and set clear expectations.
- 6.** Support the role of all well-being champions by introducing training, providing resources, and dedicating funding.
- 7.** Promote well-being as a core competency for all health professionals.
- 8.** Incorporate program evaluation when designing comprehensive wellness initiatives.
- 9.** Conduct ongoing assessments of individual well-being.
- 10.** Prioritize well-being as a professional development goal.





## Introduction



“A proactive approach to well-being prior to traumatic events lays the foundation for an agile and evidence-based organizational response at a time when resources are strained by an ongoing crisis. It allows the organization to anticipate the needs and concerns of the workforce.” (Brower et al. 2021)

In their 2014 article, Bodenheimer and Sinsky argued that the concept of the Triple Aim — enhanced patient experience with quality care, improved population health, and lowered health care costs — would not be possible without a direct focus on provider well-being. They suggested the concept of the Quadruple Aim, which expands the Triple Aim to include improving the well-being of health care providers and has been widely advocated to support the well-being of faculty, staff, and learners within health care institutions. Research has demonstrated that declining provider well-being is related to poorer patient outcomes, including increased incidents of medical errors, infection rates, patient mortality, and patient dissatisfaction, as well as higher employee dissatisfaction, staff turnover, and health care costs, reduced productivity, and more (Brigham et al. 2018; Dyrbye et al. 2017, 2020; Ripp and Shanafelt 2020; Rotenstein et al. 2018; Shah et al. 2018). Diminished well-being can also lead to emotional exhaustion, depersonalization, and a low sense of accomplishment, depression, anxiety, suicidal ideation, and completed suicide among health care providers and physicians working at academic health centers (medical schools, teaching hospitals, and health systems) (Brigham et al. 2018; Dyrbye et al. 2017; Rotenstein et al. 2018; Shah et al. 2018).

Institutions nationwide are acting to address urgent concerns about the well-being and mental health of health care providers. One critical step is to identify an individual (or teams) to oversee wellness initiatives and the process of change — assessing need, designing and implementing wellness programs, and measuring outcomes at a departmental, school, institutional, or system level. While these leaders of change are being named across health care systems, standardization of their roles has been limited (Dyrbye et al. 2020; Ripp and Shanafelt 2020). Some health care organizations have used recent research about these roles to define and structure *organizational-level* positions such as chief wellness officer (CWO) (e.g., Dyrbye et al. 2020; Ripp and Shanafelt 2020).

Institutions have established other positions — such as a director or dean of well-being — in response to national requirements of accreditation organizations like the Liaison Committee on Medical Education (LCME®) or the Accreditation Council of Graduate Medical Education (ACGME). *Embedded* well-being positions are being developed within medical departments and divisions and among hospital staff. For the purposes of this report, the term “well-being





champion” (WBC) was chosen to generically and inclusively represent all individuals responsible for creating the vision and directing change to address the crisis of burnout among health professionals and promote their well-being.

WBCs are leaders of change responsible for overseeing the wellness initiatives and outcomes within a defined portion of an organization. Despite the emergence of WBCs, it remains unknown whether the creation of these new positions ensures diminished burnout and improves health professional well-being. It is also unknown whether organizations are providing the necessary training, resources, and infrastructure to ensure the person holding the position is successful and the wellness initiatives are sustainable.

Finally, it is not always apparent to the institution (or to the WBC) which wellness strategies to use, how best to drive provider engagement and culture change, and

which metrics to use to evaluate the desired outcomes. The heterogeneity of health care organizations (e.g., some are academic medical centers; others are stand-alone community hospitals) underscores the point that “one size does not fit all”; nevertheless, it is essential to begin to identify realistic expectations, levels of support, and metrics for the various types of WBC positions.

To understand the trends in promoting well-being among health care professionals, members of the Faculty Resilience Committee within the AAMC’s Council of Faculty and Academic Societies led an initiative involving the administration of two surveys. They assessed the current state of WBCs, including the characteristics of WBC roles, levels of support, and responsibilities, and wellness initiatives underway at a wide range of institutions. This report — the product of that initiative — highlights the surveys’ results and presents recommendations to advance the scope, effectiveness, and sustainability of these critical positions and the wellness initiatives WBCs are designing and delivering.

The objectives of this report are to:

- 1. Highlight the importance of advancing individual and organizational well-being.**
- 2. Discuss results of surveys designed to understand the current and evolving state of organizational wellness programs and well-being champions.**
- 3. Provide recommendations and resources to advance national efforts for organizational change that support wellness programs and well-being champions.**





## Methods: Study Design and Data Collection



The Organizational Well-Being Survey was created to better understand the current state of wellness initiatives that support health care professionals and to understand more about the specific role of WBCs (Appendix A includes the survey questions). The anonymous, web-based survey was distributed via Survey Monkey between October 2019 and May 2021. The Medical University of South Carolina (MUSC) Institutional Review Board approved the study.

The survey was piloted April 27, 2019, during Train the Trainers Wellness Curriculum Workshops at the Society of Teachers of Family Medicine (STFM) annual meeting in Toronto, Canada, and Nov. 1, 2019, at the Family Medicine Education Consortium (FMEC) annual meeting in Lancaster, Pennsylvania. Leadership from the following organizations supported the subsequent implementation and/or the development of the survey, and 532 of their members or meeting attendees responded to the survey:

- **American Academy of Family Physicians (AAFP)**
- **AAMC Council of Faculty and Academic Societies (CFAS)**
- **AAMC Group on Faculty Affairs (GFA)**
- **ACGME Wellness Consortium**
- **CaseNetwork**
- **Center for Innovation and Leadership in Education (CENTILE)**
- **Family Medicine Education Consortium (FMEC)**
- **Society of Teachers of Family Medicine (STFM)**

Because there is no standardized description of a WBC, a second web-based survey was developed to further identify their skills and responsibilities. The Well-Being Champion Job Characteristics Survey was disseminated in late 2020. Individual emails were sent to known WBCs asking them to submit job descriptions for the study. Responses to specific questions within these surveys were combined with like questions and reviewed for common themes. The Well-Being Champion Job Characteristics Survey closed in May 2021 and included 18 responses.





Results

ORGANIZATIONAL WELL-BEING SURVEY

This study analyzed responses from the 532 health care professionals who responded to the Organizational Well-Being Survey regarding the nature of wellness programs within their organization and the specific characteristics of the people who assume the WBC role. Nearly 90% of respondents reported their organization had a wellness program, and of those organizations, more than 83% had identified a WBC. Data from the survey also showed that 30% of respondents identified as a WBC. Responses about characteristics of wellness programs indicated they vary widely in design and maturity, as well as in the adoption of and support for the WBC role within and across institutions.

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- Figure 7. Percentage of effort dedicated to the WBC role among respondents who identified as a WBC.
- Figure 8. Organizational reporting relationship for the WBC role.
- Figure 9. Percentage of respondents who received formal training for the WBC role.
- Figure 10. Percentage of respondents holding additional administrative roles beyond serving as a WBC.

Wellness Program Characteristics

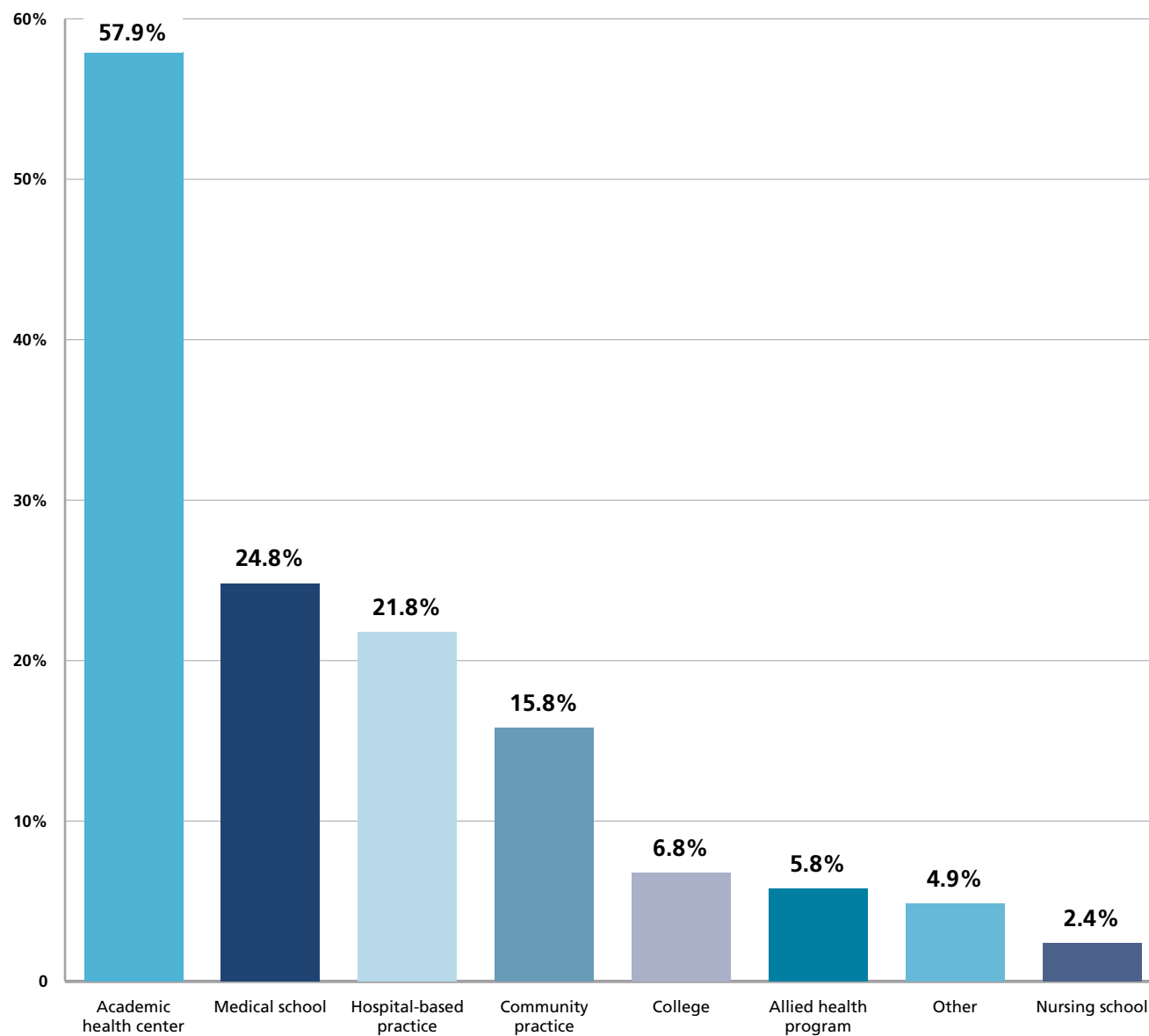
- Figure 11A. Respondent organizations with wellness programming.
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**FIGURE 1.** Organizational setting of respondents.

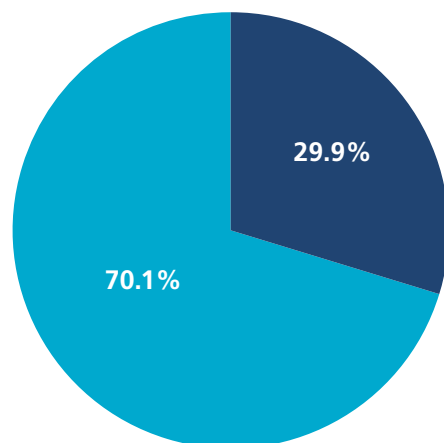


Respondents worked in several different health care settings, and about 70% worked in an academic health center and/or a medical school. (n = 532)

Note: Respondents could choose more than one response to this question, so the percentage values do not sum to 100%.

**FIGURE 2A.** Respondents who identified as well-being champions (WBCs).

■ Identifies as a WBC  
■ Not a WBC

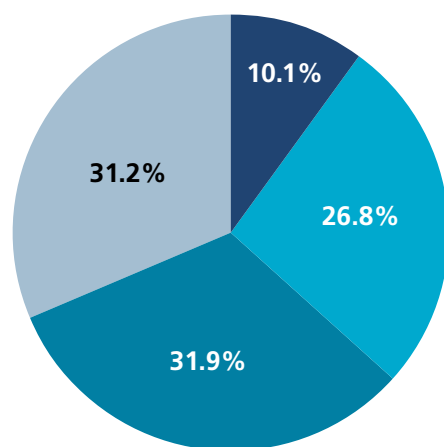


About 30% (n = 138) of all respondents identified as WBCs of some sort at their organization.

Note: This figure represents 461 respondents.

**FIGURE 2B.** Titles of respondents who identified as WBCs.

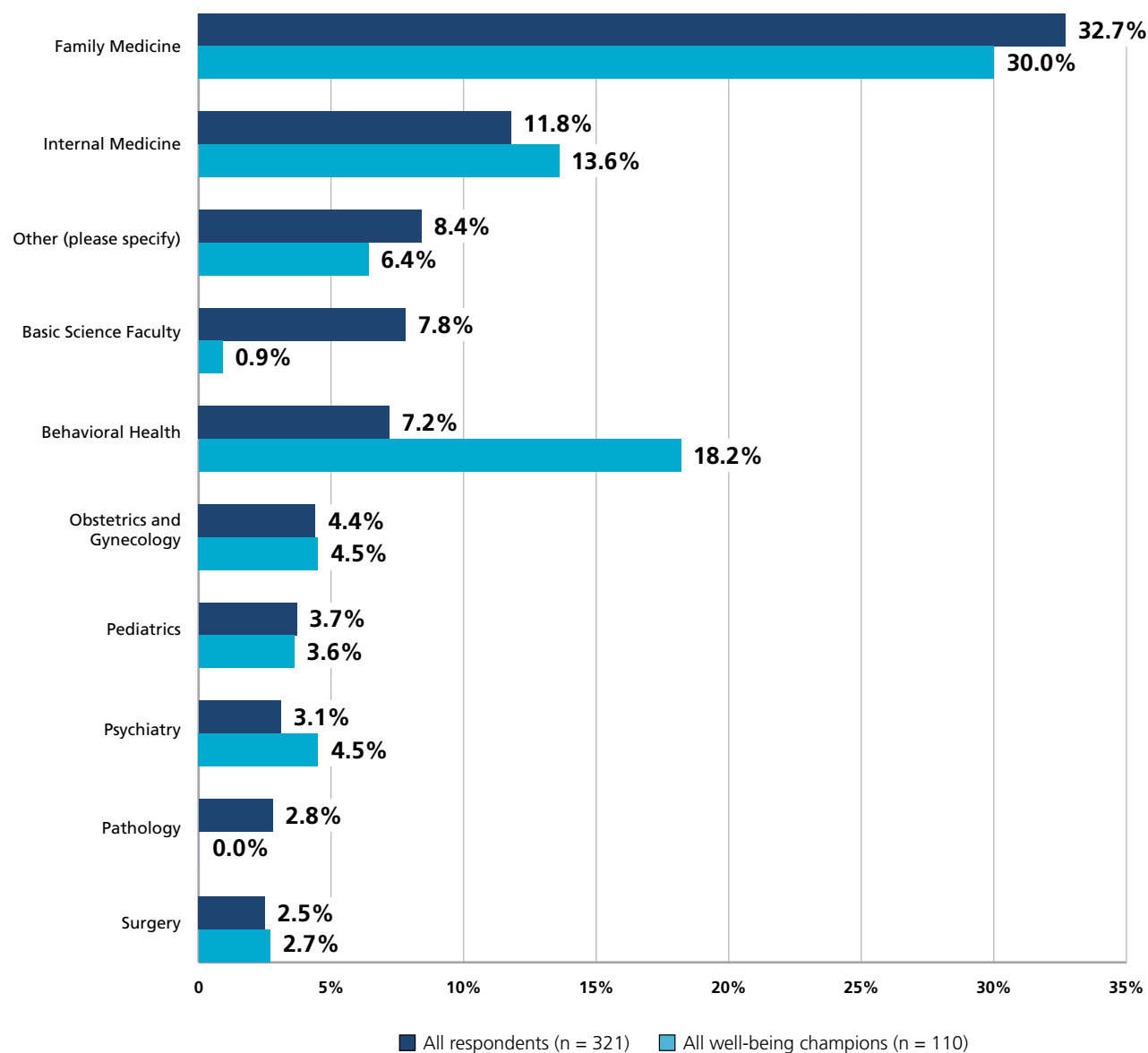
■ CWO  
■ Wellness Director  
■ Wellnes Committee/  
Task Force Chair  
■ Other



Among those identifying as WBCs, their individual titles included chief wellness officer (10.1%, n = 14), wellness director (26.8%, n = 37), wellness committee/task force chair (31.9%, n = 44), or other title (31.2%, n = 43). Additional titles described by respondents included assistant and associate dean of wellness, departmental well-being champion, and wellness committee member.

Note: This figure represents the 138 respondents who identified as a WBC in Figure 2A.

**FIGURE 3.** Medical and scientific discipline of respondents.



Survey respondents represented a variety of specialties, though most were in primary care fields such as family medicine and internal medicine.

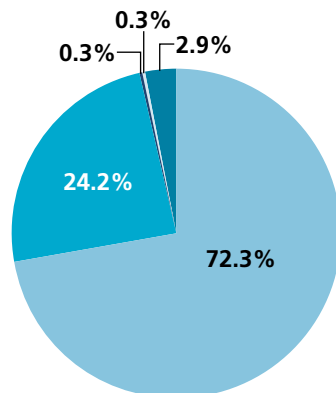
Note: These individual disciplines were redacted from the figure because they had less than 2.5% of the total number of respondents: Preventative Medicine, Orthopedic Surgery, Emergency Medicine, Otolaryngology, Radiology, Physical Medicine and Rehabilitation, Dermatology, Anesthesiology, Ophthalmology, Urology, Neurological Surgery, Medical Genetics and Genomics, Transitional Year, Radiation Oncology, Neurology, Colon and Rectal Surgery, and Allergy and Immunology. The proportion of respondents whose data were redacted was 15.6% of the total number of respondents.



**FIGURE 4.** Gender, age, primary organizational role, and faculty rank of respondents.

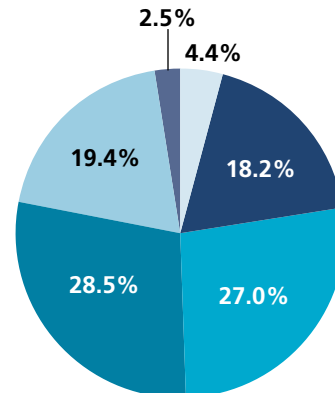
**Gender (n = 318)**

- Female
- Male
- Transgender female\*
- Transgender male
- Gender non-conforming\*
- Not listed
- Prefer not to answer



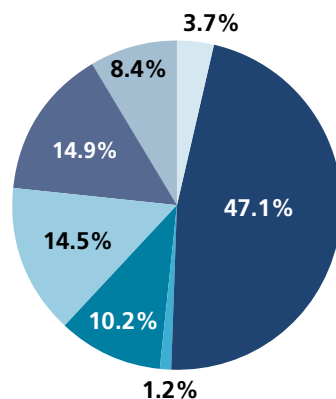
**Age (n = 319)**

- <21years\*
- 21-30 years
- 31-40 years
- 41-50 years
- 51-60 years
- 61-70 years
- >70 years



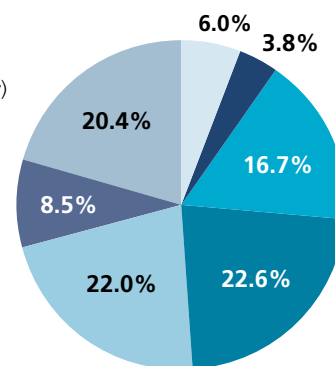
**Primary Organizational Role (n = 323)**

- Student/Resident
- Faculty
- Nurse
- Program Director
- Administrator
- Dean, Associate or Assistant Dean, Chair
- Other



**Faculty Rank (n = 318)**

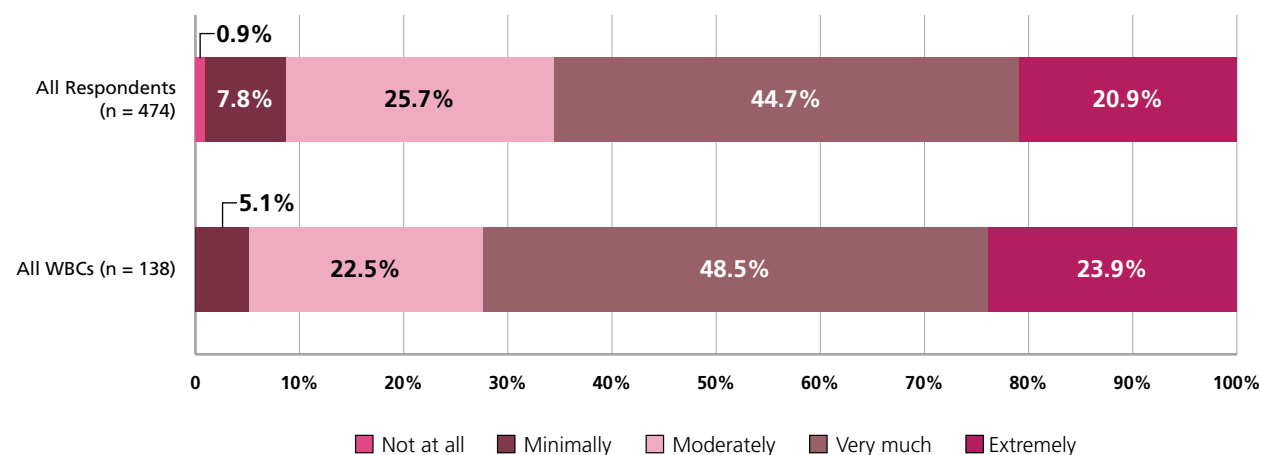
- Adjunct Faculty
- Instructor
- Assistant Professor
- Associate Professor
- Professor
- Other (please specify)
- N/A



A large majority of survey respondents identified as women (72.3%), 31-60 years of age (73.7%), and primarily as a faculty member without an administrative role (47.1%). Among all respondents holding a faculty position, regardless of whether they were also administrators, 61.3% held an assistant (16.7%), associate (22.6%), or full professor (22.0%) rank. Personal characteristics of WBCs were similar to those of all survey respondents: of the WBCs, 77.1% identified as women, 77.1% identified between the ages of 31 and 60, 52.7% identified as primarily a faculty member, with 63.2% at assistant (22.9%), associate (22.0%), or full professor (18.3%) ranks.

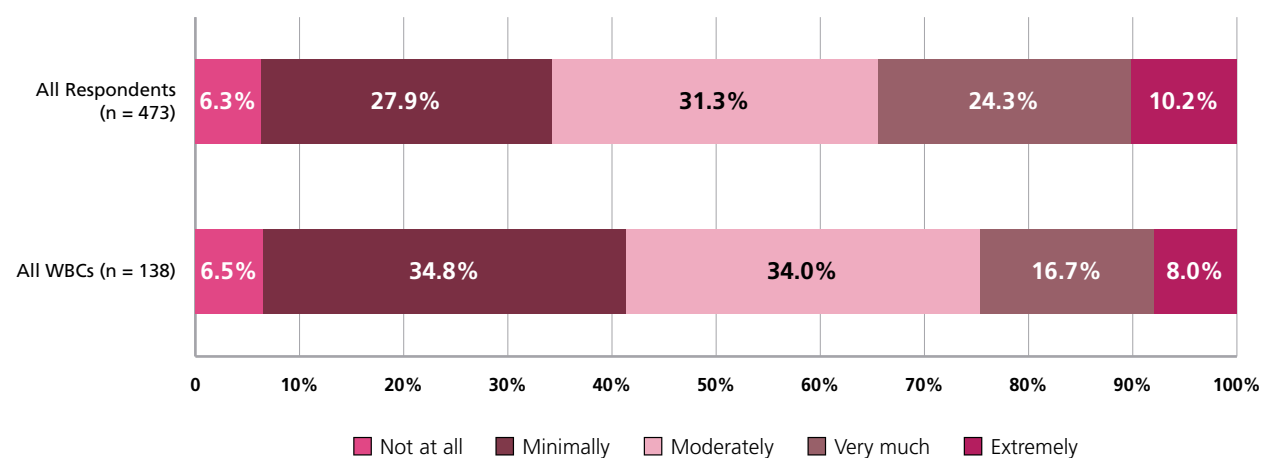
Note: \*Indicates 0.0% of respondents.

**FIGURE 5A.** Concern related to burnout among colleagues.



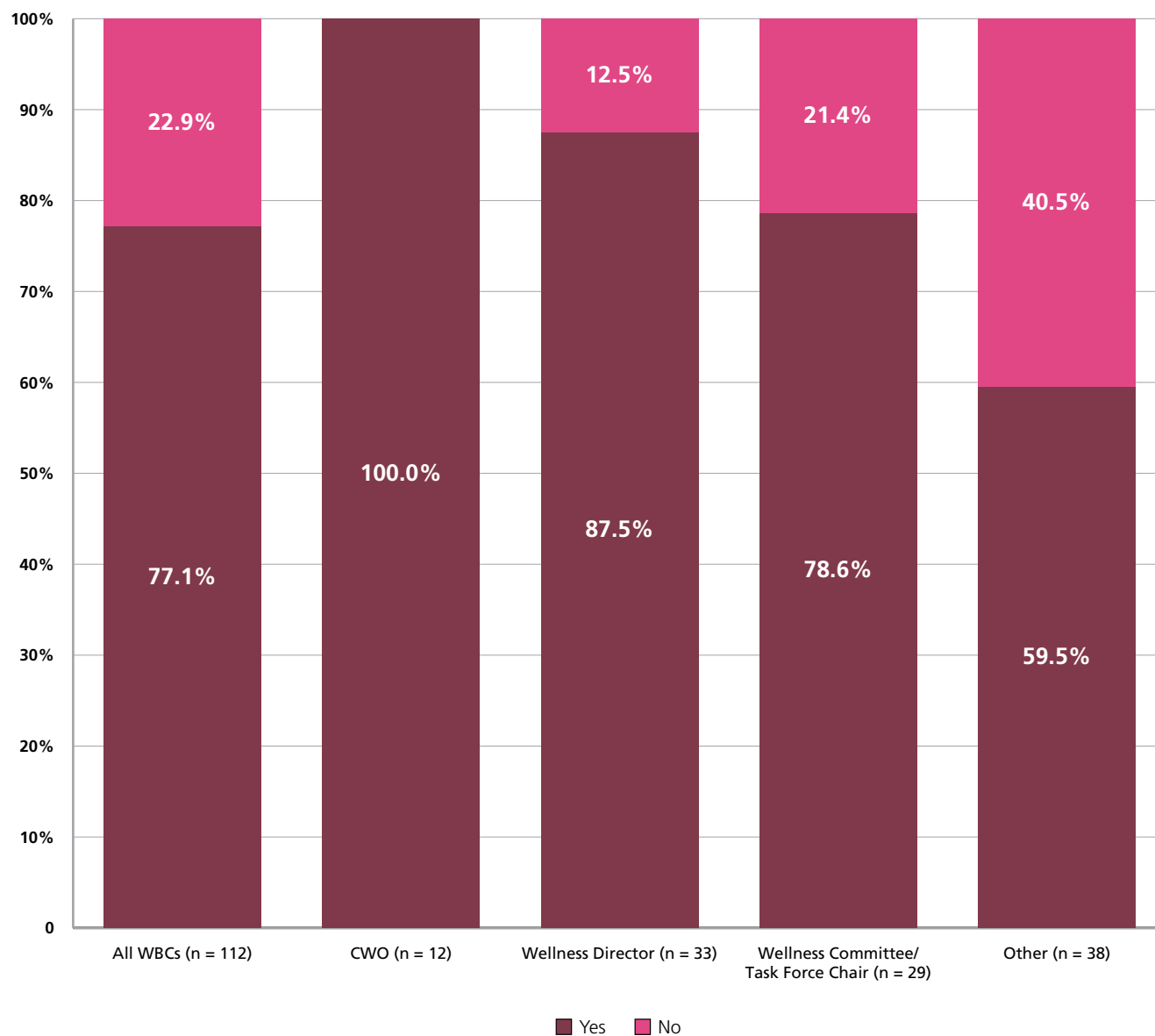
A larger percentage of respondents who identified as WBCs reported concern that burnout was “extremely” or “very much” impacting their colleagues compared with the percentage of all respondents (72.4% vs. 65.6%).

**FIGURE 5B.** Concern related to individual burnout among respondents.



A smaller percentage of respondents who identified as WBCs reported concern that burnout was “extremely” or “very much” impacting them personally compared with all respondents (24.7% vs. 34.5%).

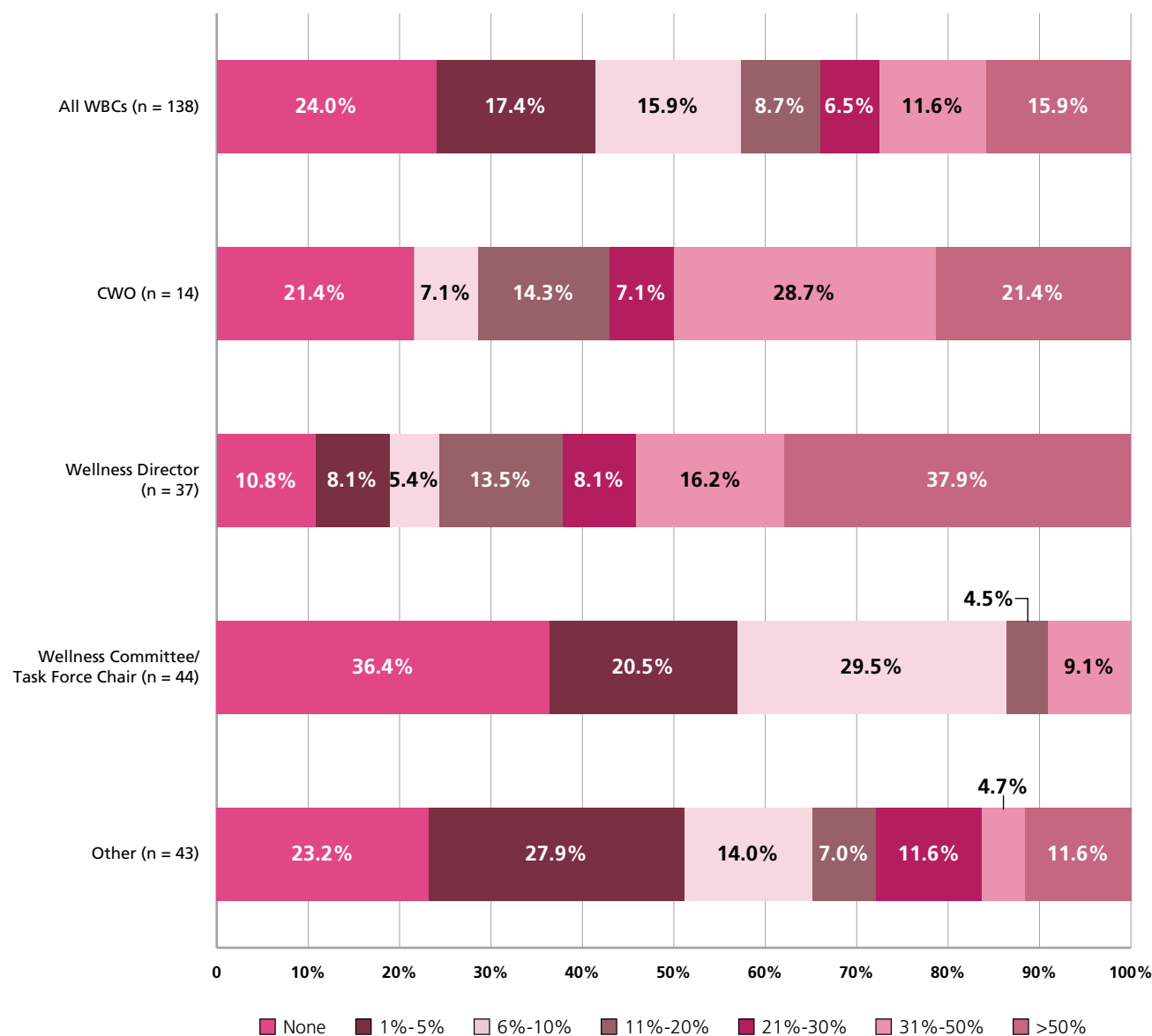
**FIGURE 6.** Percentage of WBC respondents who had personally completed a wellness screening.



Among respondents who identified as WBCs, 77.1% reported having personally completed a wellness screening. Those who identified with a role other than CWO, wellness director, or wellness committee/task force chair reported the lowest percentage of having personally completed a wellness screening (59.5%).

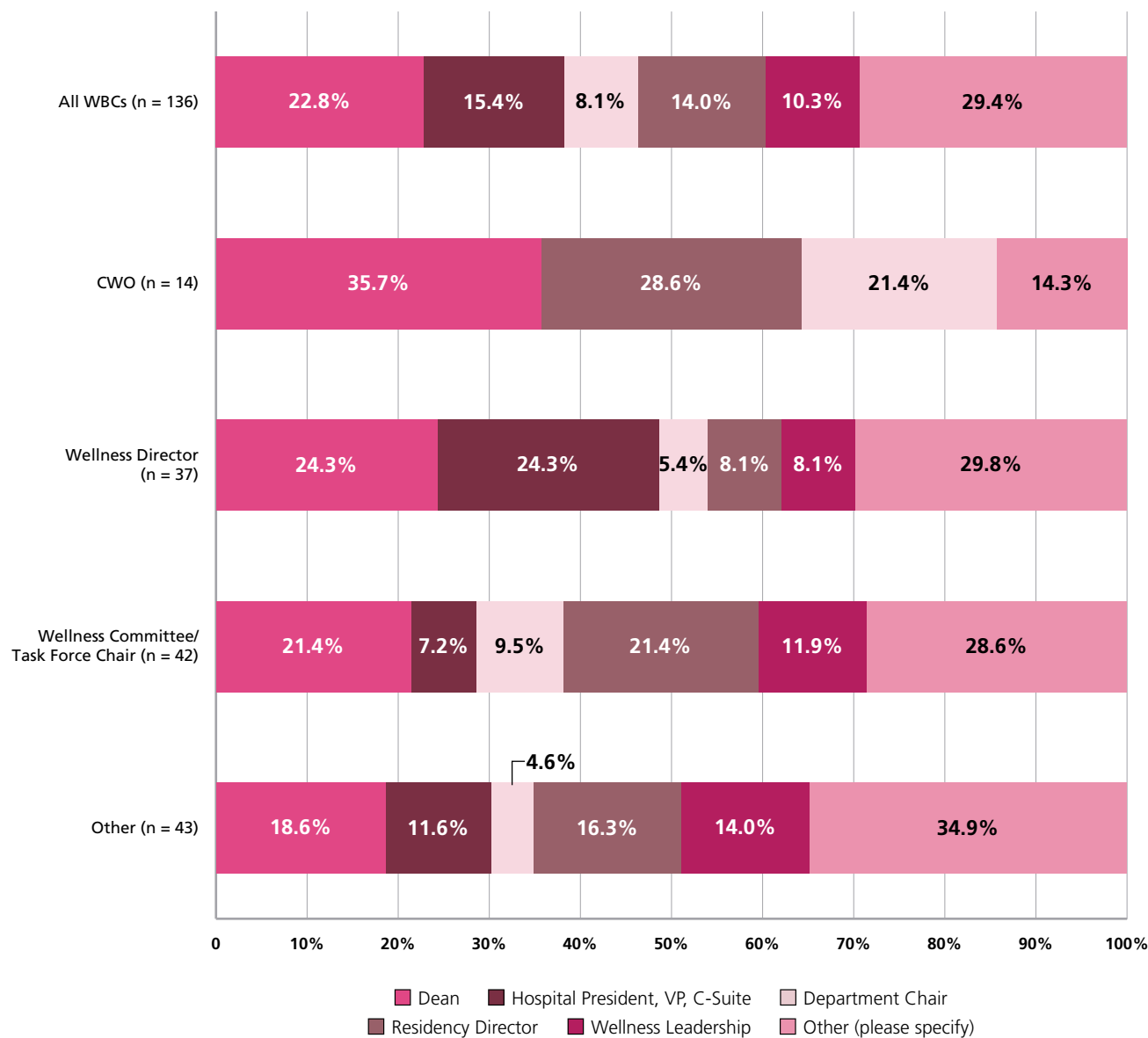


**FIGURE 7.** Percentage of effort dedicated to the WBC role among respondents who identified as a WBC.



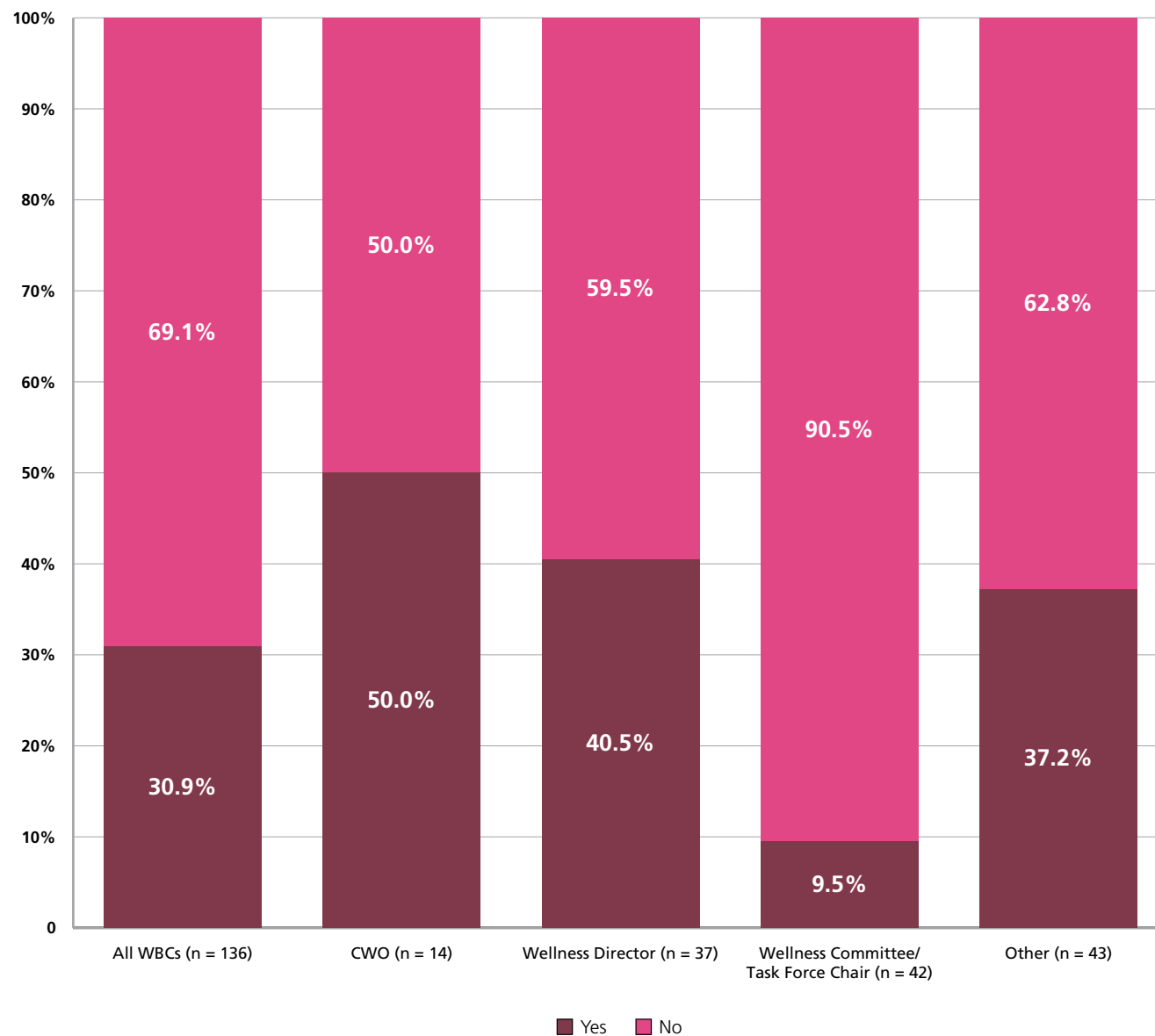
CWOs and wellness directors reported having a larger percentage of effort formally dedicated to their roles compared with other types of WBCs. For example, 50.1% of CWOs and 54.1% of wellness directors reported having at least 31% FTE allocated to their role. However, many WBCs had no formal effort dedicated to their positions, particularly leaders of wellness committees, where 36.4% reported having no dedicated effort to their role.

**FIGURE 8.** Organizational reporting relationship for the WBC role.



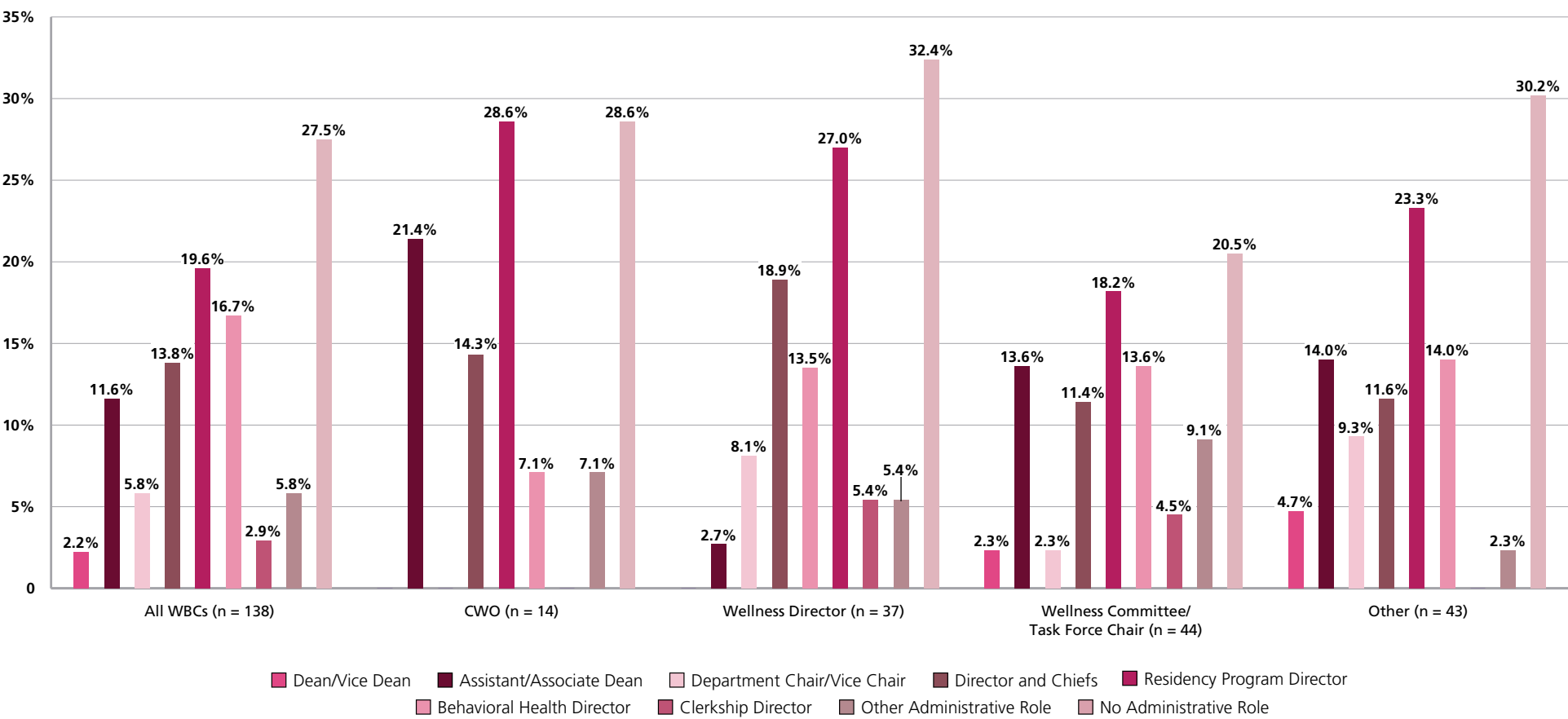
A majority of CWOs (64.3%) and wellness directors (48.6%) reported directly to the dean or hospital leadership at their organizations. However, reporting relationships varied greatly and may be unique to each WBC.

**FIGURE 9.** Percentage of respondents who received formal training for the WBC role.



Overall, only 30.9% of WBCs received formal training for their roles. While responses varied by role, 50.0% of CWOs and 40.5% of wellness directors received training, leaving a large group of individuals with no training at all.

FIGURE 10. Percentage of respondents holding additional administrative roles beyond serving as a WBC.

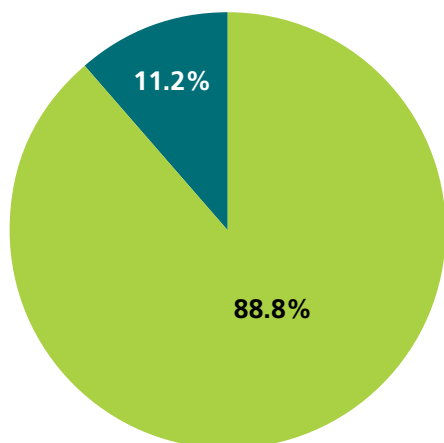


Many WBCs reported holding administrative roles in addition to their WBC role, such as residency program director (19.6%) and behavioral health director (16.7%). However, 27.5% of WBCs reported not holding additional administrative titles.

Note: Respondents could choose more than one response to this question, so the percentage values do not sum to 100%.

**FIGURE 11A.** Respondent organizations with wellness programming.

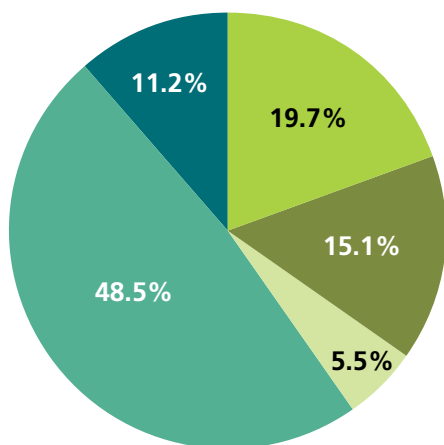
- Yes, organization had one or more programs
- No, organization did not have a program



Overall, 88.8% of respondents were at an organization that had at least one wellness program. (n = 492)

**FIGURE 11B.** Audiences served by wellness programs at respondent organizations.

- Just learners (students and/or residents)
- Learners and faculty only
- Learners and staff only
- Learners, faculty, and staff
- Other

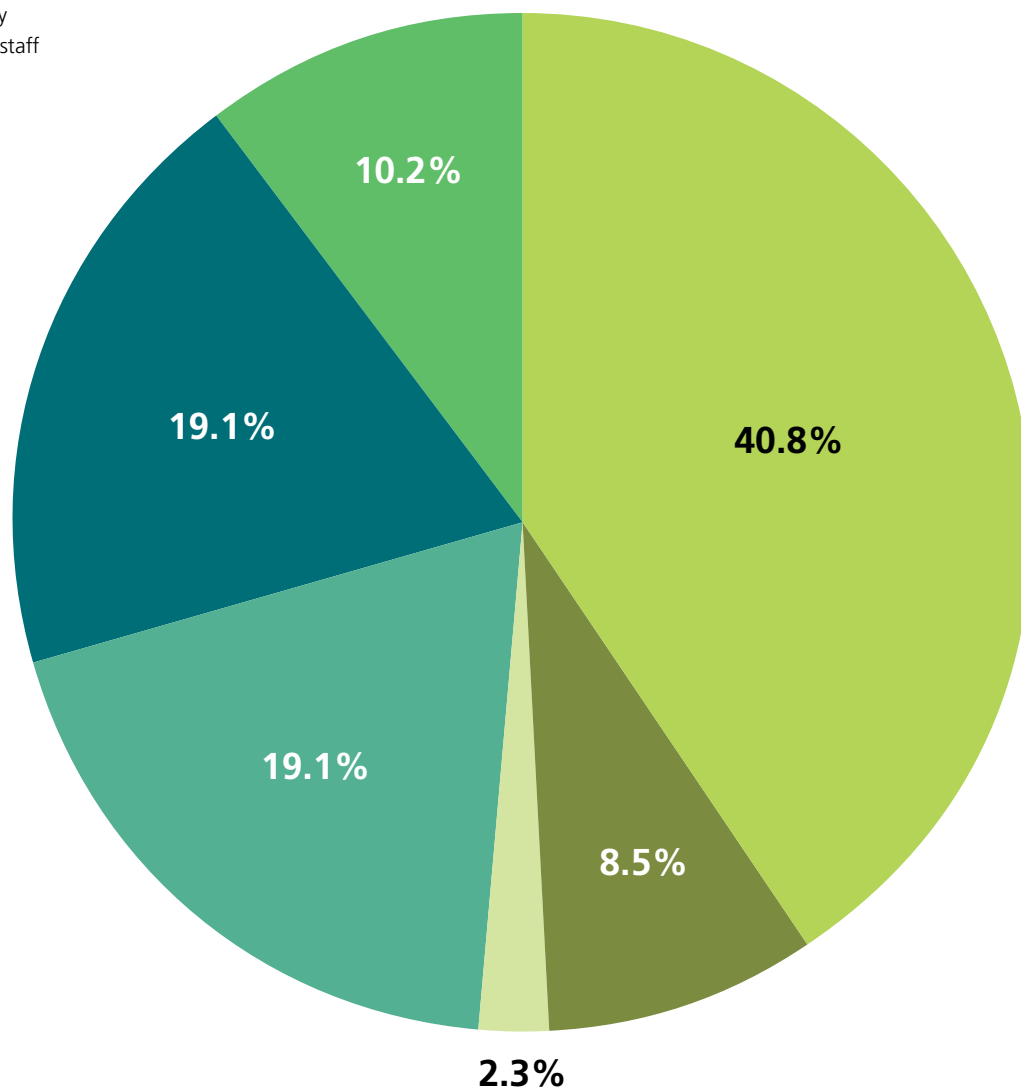


Across all respondents, 48.5% reported their organization had a wellness program established for learners (students and/or residents), faculty, and staff. (n = 437)



**FIGURE 12.** Focal audience for organizational wellness efforts.

- Just learners (students and/or residents)
- Learners and faculty only
- Learners and staff only
- Learners, faculty, and staff
- Other
- Not sure



While organizations may have wellness programming for all health professional populations, 40.8% of respondents indicated their organization's top priority of wellness efforts is dedicated to learners (students and/or residents). (n = 434)

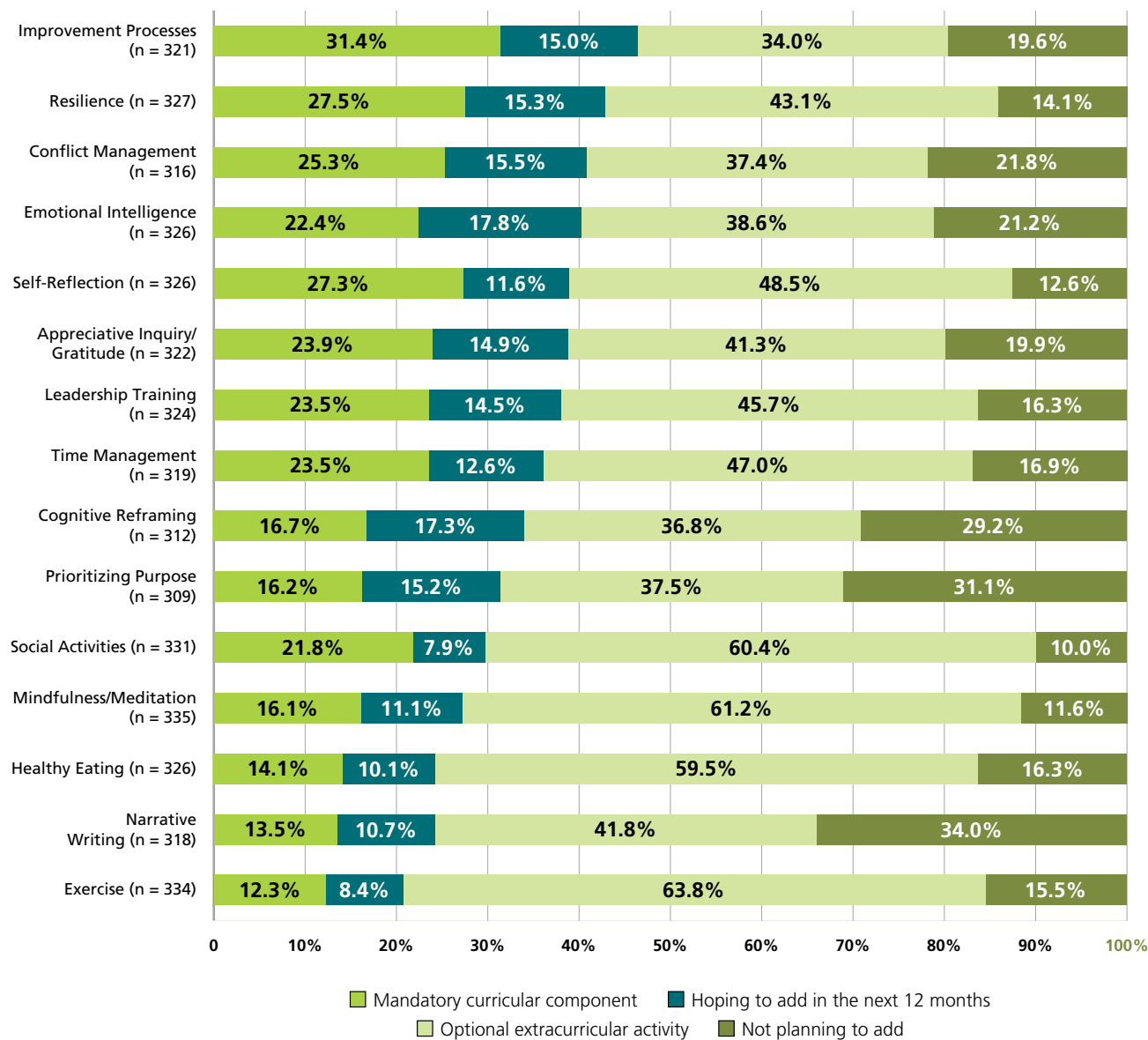
**TABLE 1.** WBCs Identified Across the Organization by Type of Wellness Program

Type of Wellness Program	Level of Well-Being Champion				
	Organizational-level leader WBC (CWO or similar title)	GME WBCs (all residency programs in the institution)	Departmental WBCs (for residents and/or faculty)	Dean's Office WBCs (for medical students)	Staff-level WBCs (for all employees)
All organizations with at least one wellness program (n = 426)	<b>41.3%</b>	<b>48.1%</b>	<b>45.3%</b>	<b>26.3%</b>	<b>30.5%</b>
Organization had programming just for learners (students and/or residents) (n = 86)	<b>23.3%</b>	<b>39.5%</b>	<b>36.0%</b>	<b>22.1%</b>	<b>4.7%</b>
Organization had programming for learners and faculty only (n = 63)	<b>46.0%</b>	<b>69.1%</b>	<b>57.1%</b>	<b>28.6%</b>	<b>7.9%</b>
Organization had programming for learners and staff only (n = 24)	<b>16.7%</b>	<b>37.5%</b>	<b>29.2%</b>	<b>25.0%</b>	<b>37.5%</b>
Organization had programming for learners, faculty, and staff (n = 206)	<b>54.4%</b>	<b>58.3%</b>	<b>55.8%</b>	<b>33.5%</b>	<b>44.7%</b>
Organization had programming for other audiences (e.g., faculty, staff, other health professionals) (n = 47)	<b>23.4%</b>	<b>6.4%</b>	<b>8.5%</b>	<b>0.0%</b>	<b>42.6%</b>

WBCs exist at many levels within an organization, and the types of positions in place at any given organization relate to the types of programming offered. For example, 54.4% of respondents at organizations with programming for learners, faculty, and staff reported their organization had an organizational-level WBC (CWO or similar title). Conversely, 23.3% of respondents at organizations with programs solely for learners reported having an organizational-level WBC.

Note: Respondents could choose more than one response to this question, so the percentage values do not sum to 100%.

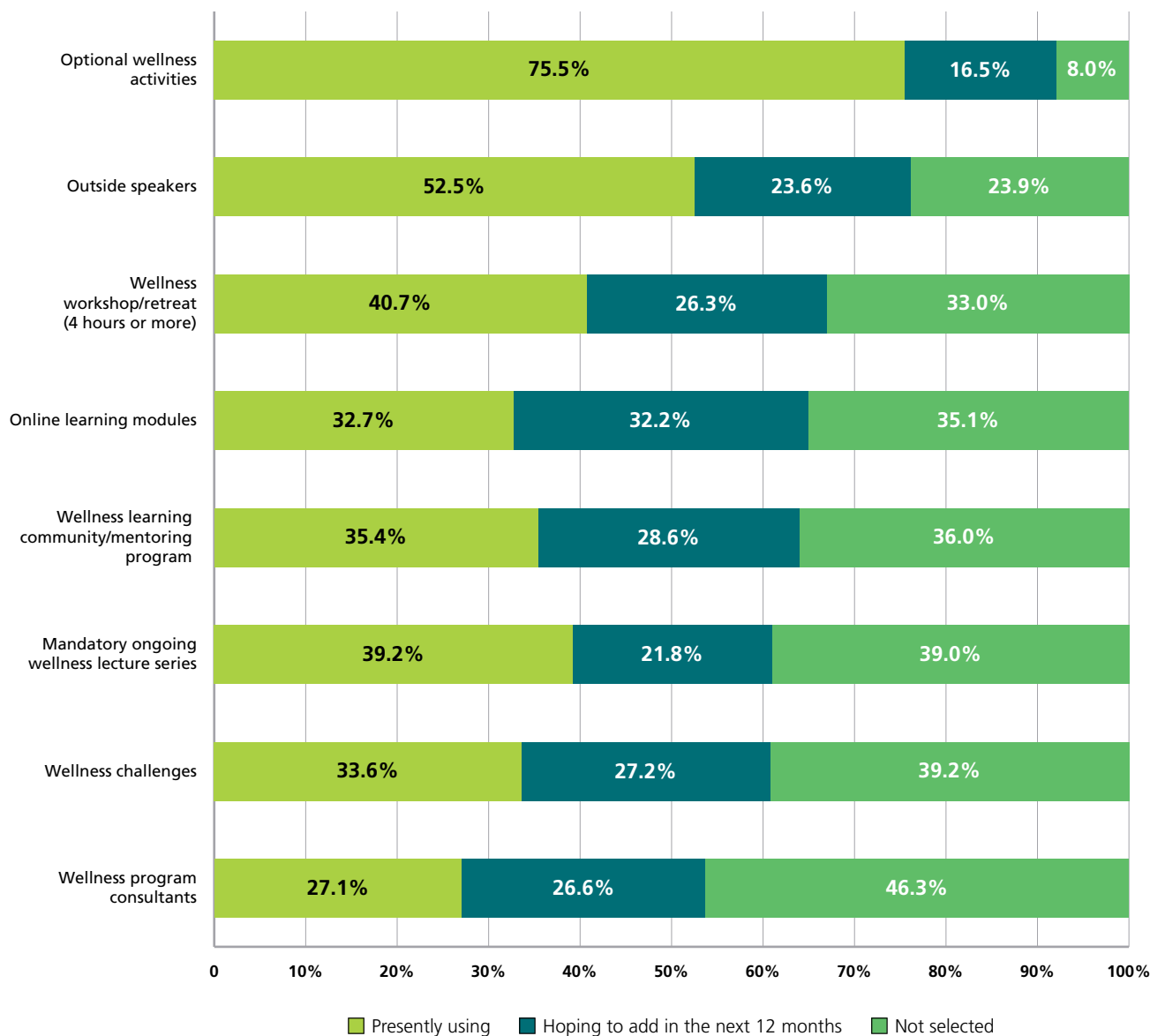
**FIGURE 13.** Curricular elements included in wellness programming.



Organizations reported implementing or planning to implement a wide variety of curricular (mandatory) and extracurricular (optional) programs. The most common mandatory curricular components of wellness programs – either “presently in place” or respondents were “hoping to add in the next 12 months” – included strategies for improvement processes (46.4%), resilience (42.8%), conflict management (40.8%), and emotional intelligence (40.2%). The most common optional extracurricular components were exercise (63.8%), mindfulness and meditation (61.2%), social activities (60.4%), and healthy eating (59.5%).

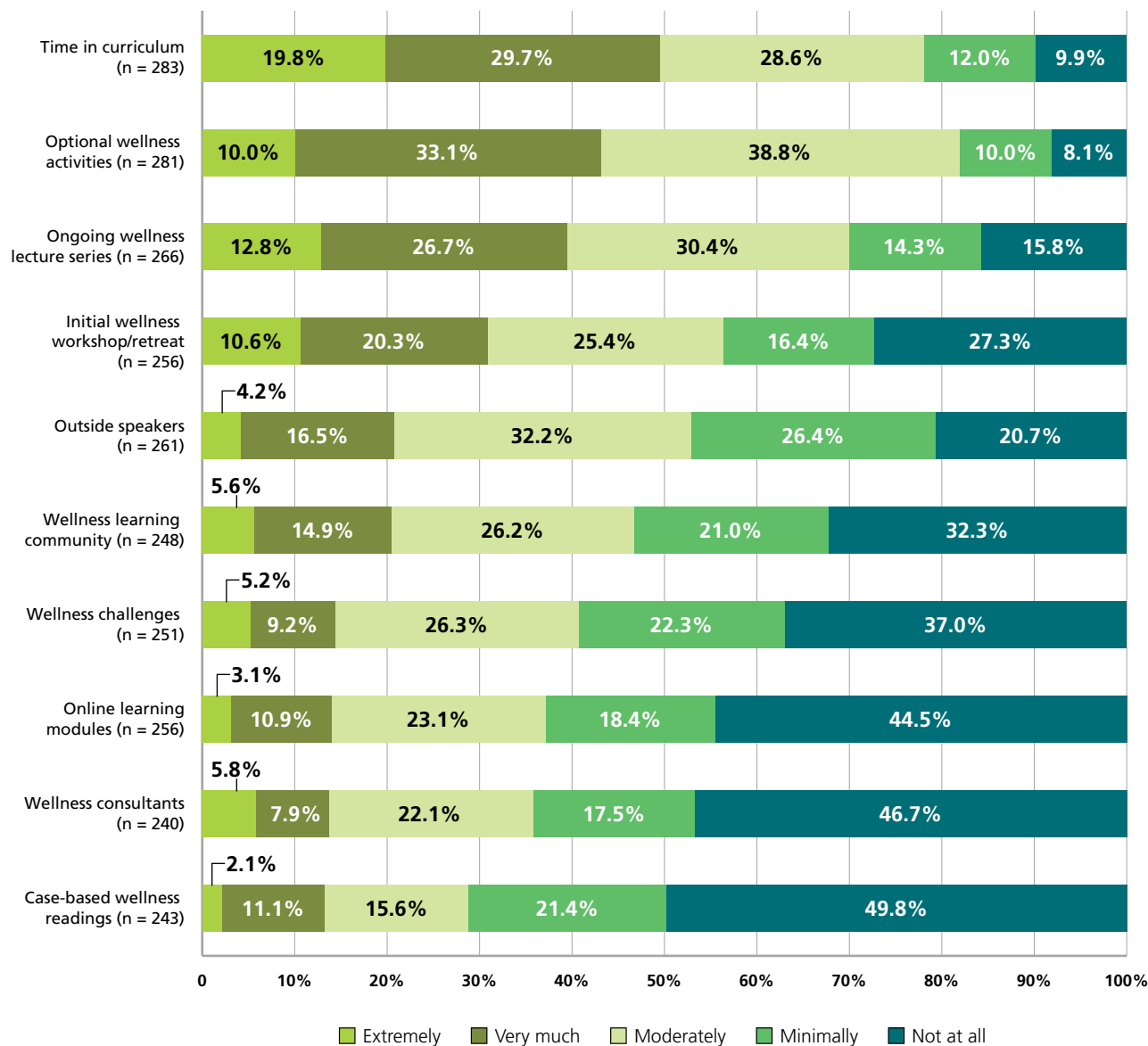
Note: See Appendix B for a list of local and national resources respondents found beneficial in delivering their wellness programs.

**FIGURE 14.** Methods and resources to promote well-being.



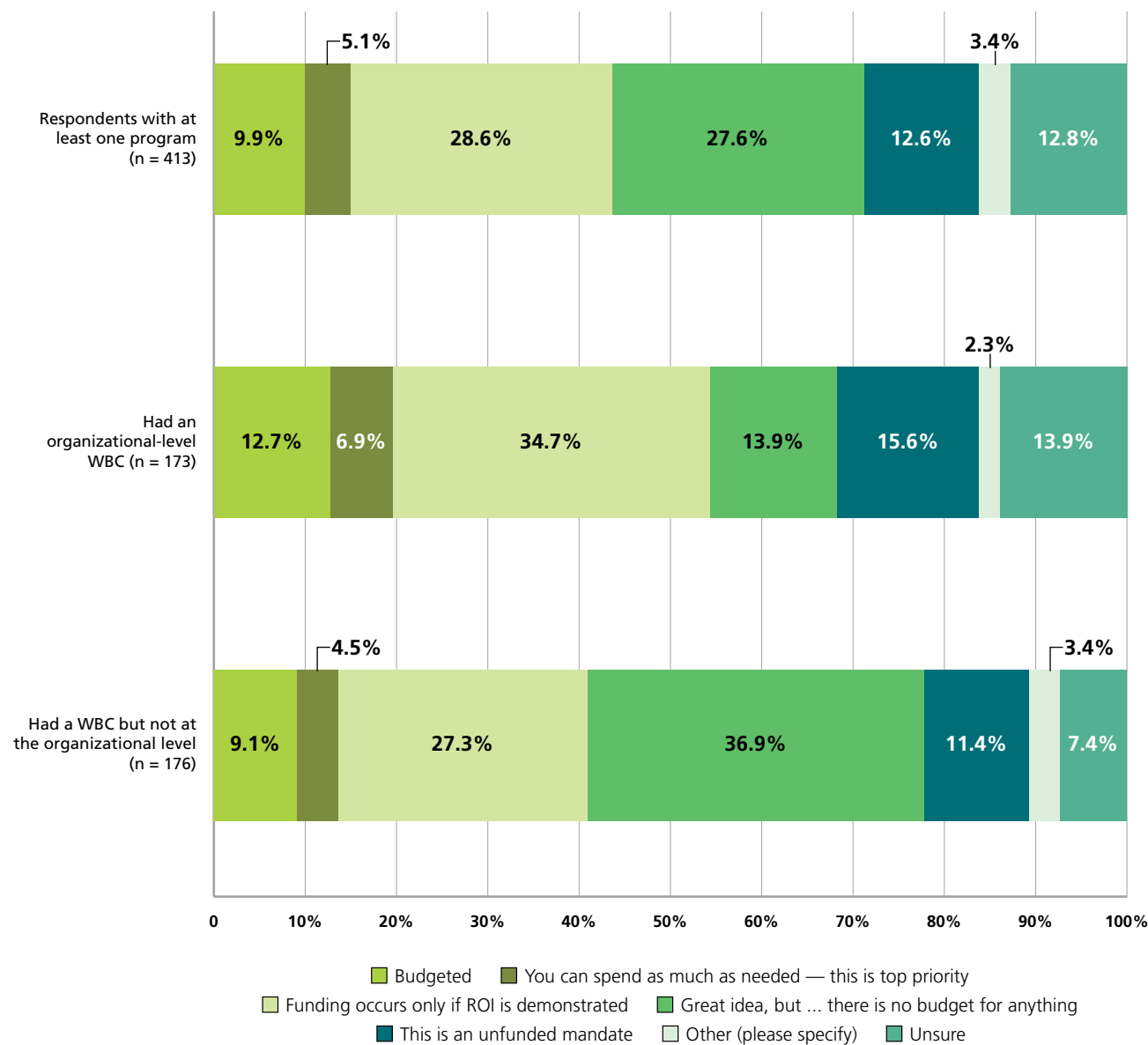
In describing delivery methods for wellness programming, a large portion of respondents (92.0%) reported they were “presently using” optional wellness activities or “hoping to add in the next 12 months.” Outside speakers (76.1%), wellness retreats (67.0%), online learning (64.9%), and learning communities/mentoring programs (64.0%) were also commonly used or being considered for addition. (n = 339)

**FIGURE 15.** Importance of key elements to successful wellness programs.

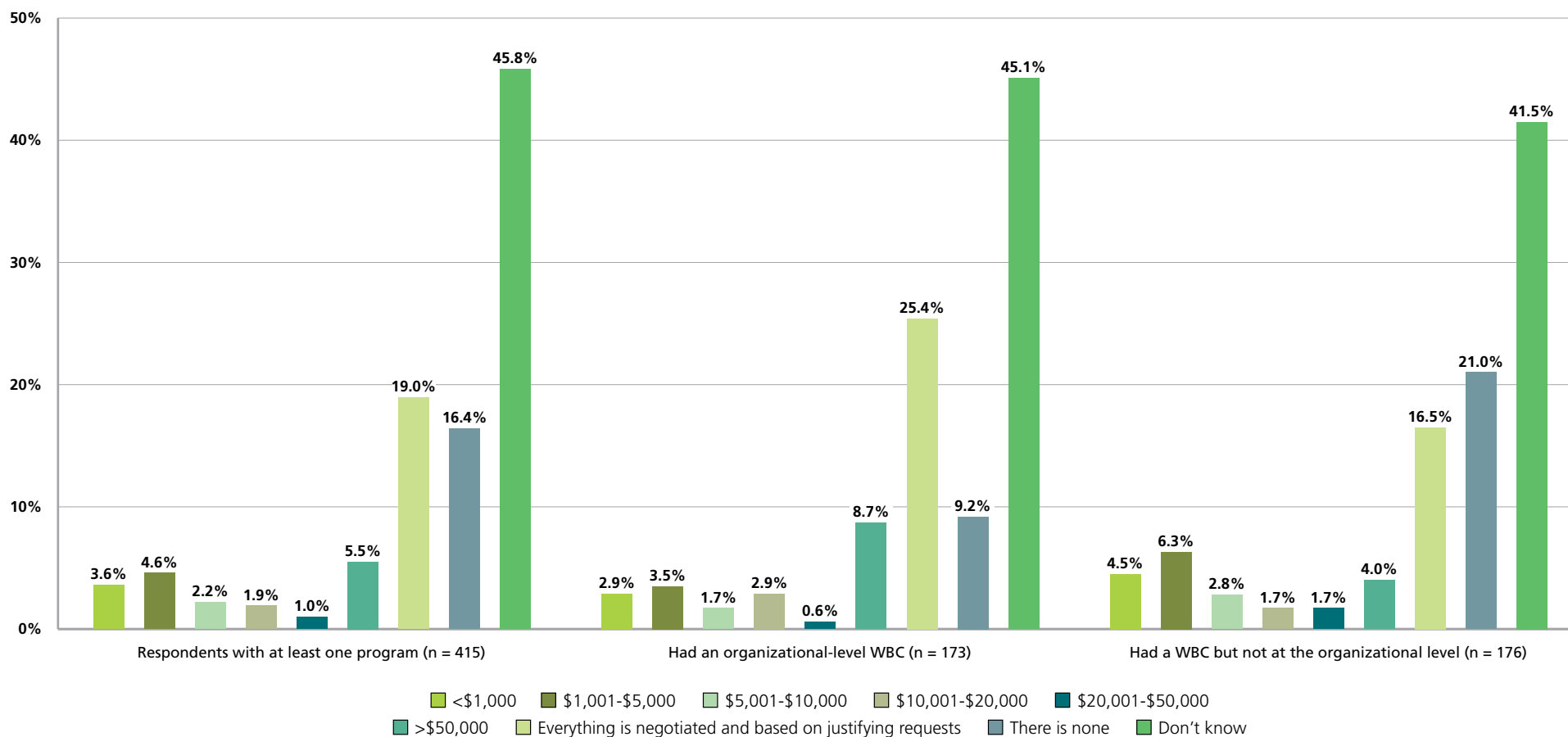


While many components are critical to the implementation of wellness programming, respondents identified the top three components of “extreme” or “very much” importance to their programs as time spent in the curriculum (49.5%), offering of optional wellness activities (43%), and use of ongoing lecture series (39.5%).



**FIGURE 16.** Philosophy for funding wellness programs.

Organizational approaches to funding wellness programs varied greatly. About 56% of respondents reported funding occurs only when return on investment (ROI) can be demonstrated (28.6%) or there is not a budget for wellness programs (27.6%). Additional comments by respondents varied greatly and included, "We can't finance recreation," "Requested on case by case initiatives," "It's kind of hit or miss, have gotten some small grants and departments do fund some initiatives," and "No formal budget, but I have never had an issue with getting needed funding."

**FIGURE 17.** Range of funding available for wellness programs.

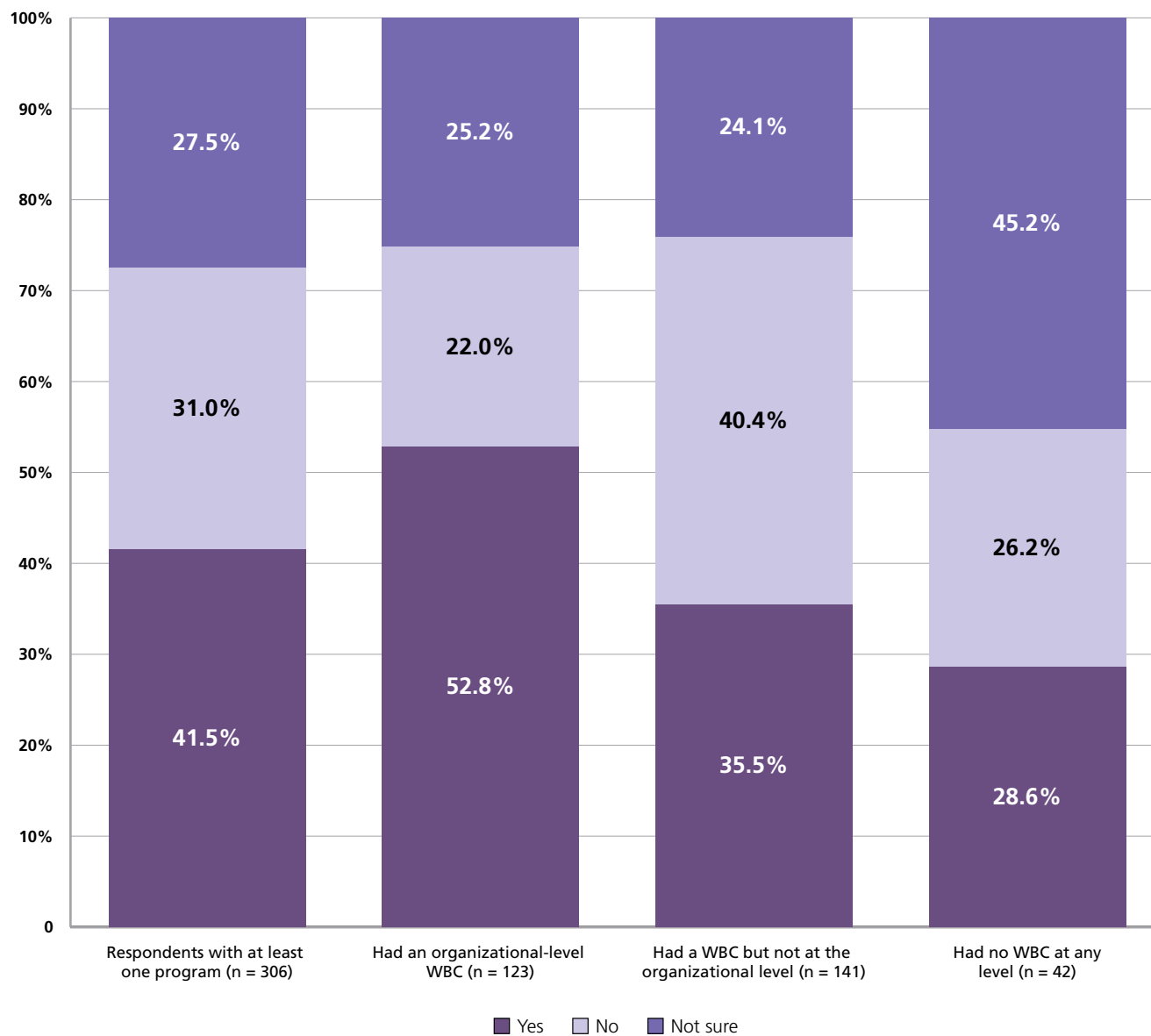
The funding available for wellness initiatives varied greatly. A large percentage of respondents (45.8%) did not know what funding level was available for wellness activities. Others reported funding was dispersed only when negotiated for (19.0%) or no budget was available at all (16.4%). A small percentage of respondents reported having budgets greater than \$50,000 (5.5%), and this was more common in institutions with an organizational-level WBC.

**TABLE 2.** Establishing Well-Being as an Institutional Priority

	Is well-being an explicit part of your institution's vision, mission, and strategic plan? (% Yes)	Does your institution have goals to drive a culture of wellness? (% Yes)	Do the goals include initiatives at the individual level?* (% Yes)	Do the goals include initiatives at the system level?* (% Yes)
Institution had an organizational-level WBC	<b>77.8%</b> (n = 176)	<b>88.1%</b> (n = 176)	<b>79.5%</b> (n = 166)	<b>90.4%</b> (n = 166)
Institution had a WBC but not at the organizational level	<b>60.9%</b> (n = 179)	<b>64.8%</b> (n = 179)	<b>66.7%</b> (n = 141)	<b>73.0%</b> (n = 141)
Institution had no WBC at any level of the organization	<b>40.8%</b> (n = 71)	<b>56.3%</b> (n = 71)	<b>58.5%</b> (n = 53)	<b>50.9%</b> (n = 53)

A higher proportion of respondents from institutions with an organizational-level WBC reported their institution had a vision, mission, strategic plan, and goals around well-being than respondents from institutions without an organizational-level WBC or with no WBC. For example, 77.8% of respondents whose institution had an organizational-level WBC reported their institution had an institutional vision, mission, and strategic plan that included well-being compared with 60.9% of those whose institutions had WBCs who were not at the organizational level and 40.8% of those whose organizations did not have WBCs.

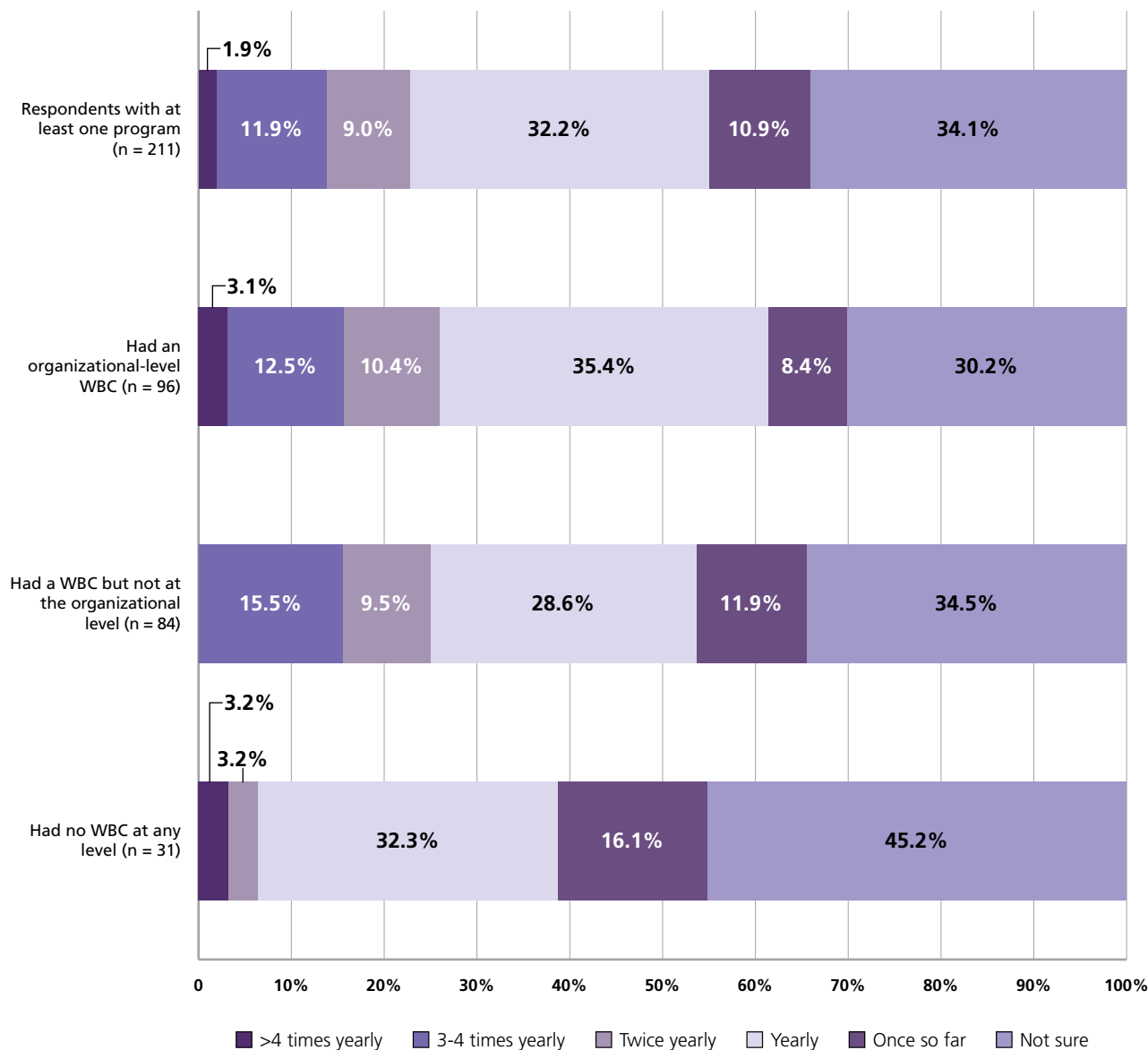
Note: \*These questions were asked if the response was "yes" or "not sure" to the question "Does your institution have goals to drive a culture of wellness?" Respondents who responded "no" were excluded.

**FIGURE 18.** Established metrics for measuring well-being.

Respondents noted 31.0% of programs had no well-being metrics. Institutions with an organizational-level WBC were more likely to have metrics for measuring well-being than institutions with a WBC not at the organizational level (52.8% vs. 35.5%). Programs with no WBC were even less likely to have metrics (28.6%).



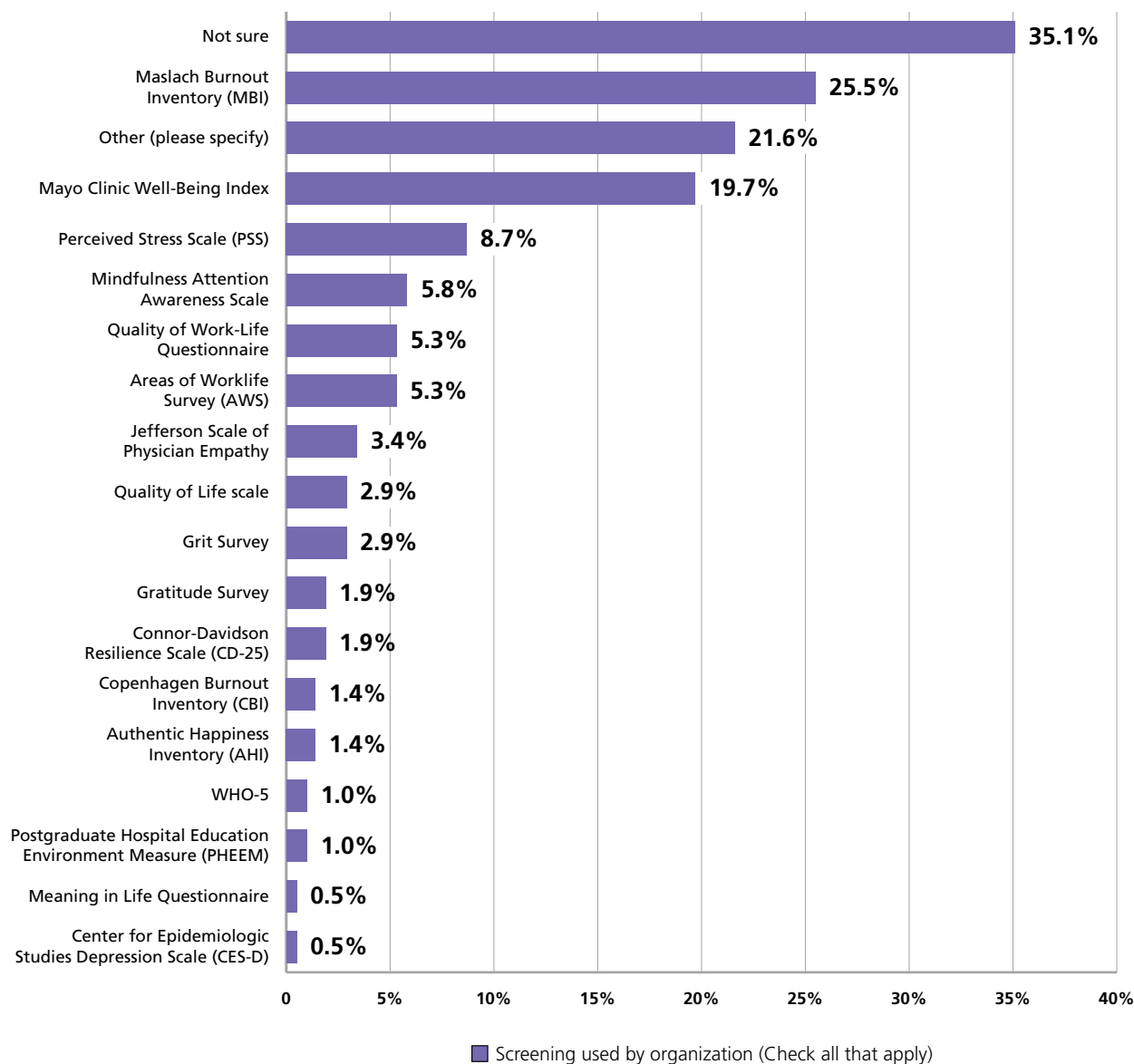
**FIGURE 19.** Frequency of wellness screenings conducted at institutions.



About 61% (61.4 %) of respondents from institutions with an organizational-level WBC reported wellness screenings were conducted at least once a year compared with 53.6% of respondents from institutions with a WBC who is not positioned at the organizational level and 38.7% of those without any WBCs at their institution.

Note: The question "How often are wellness screenings being conducted at your institution?" was asked if the response was "yes" or "not sure" to the question "Does your institution have specific metrics for measuring wellbeing?" Respondents who responded "no" were excluded.

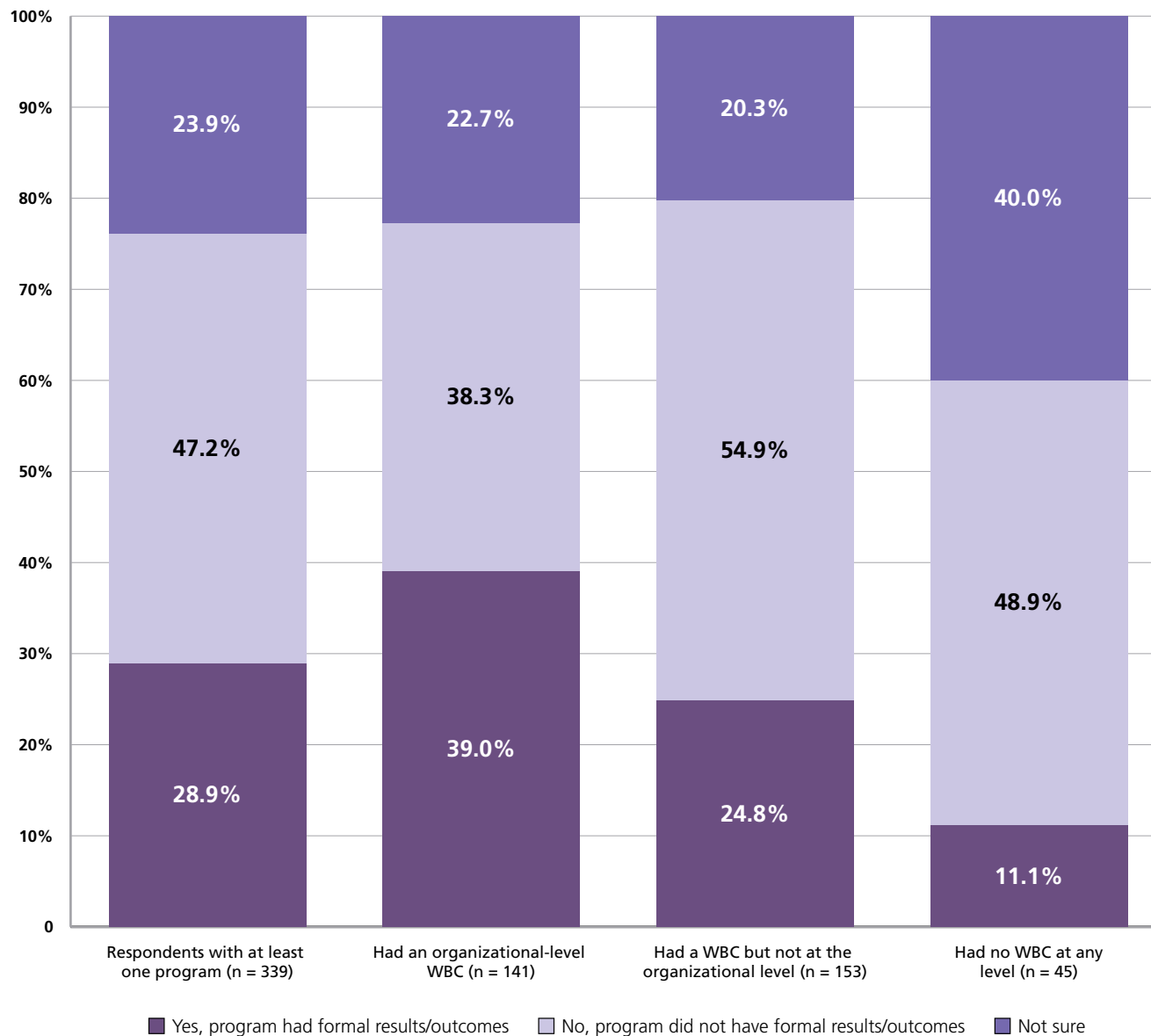
**FIGURE 20.** Wellness screenings used by organizations.



There is a large variation in the tools reported for assessing health care professional well-being. While 35.1% of respondents were unsure what tools were used by their organization to assess well-being, 25.5% used the Maslach Burnout Inventory, 21.6% used other tools such as the Mini-Z Survey or the Stanford Professional Fulfillment Index, and 19.7% used the Mayo Clinic Well-Being Index. (n = 208)

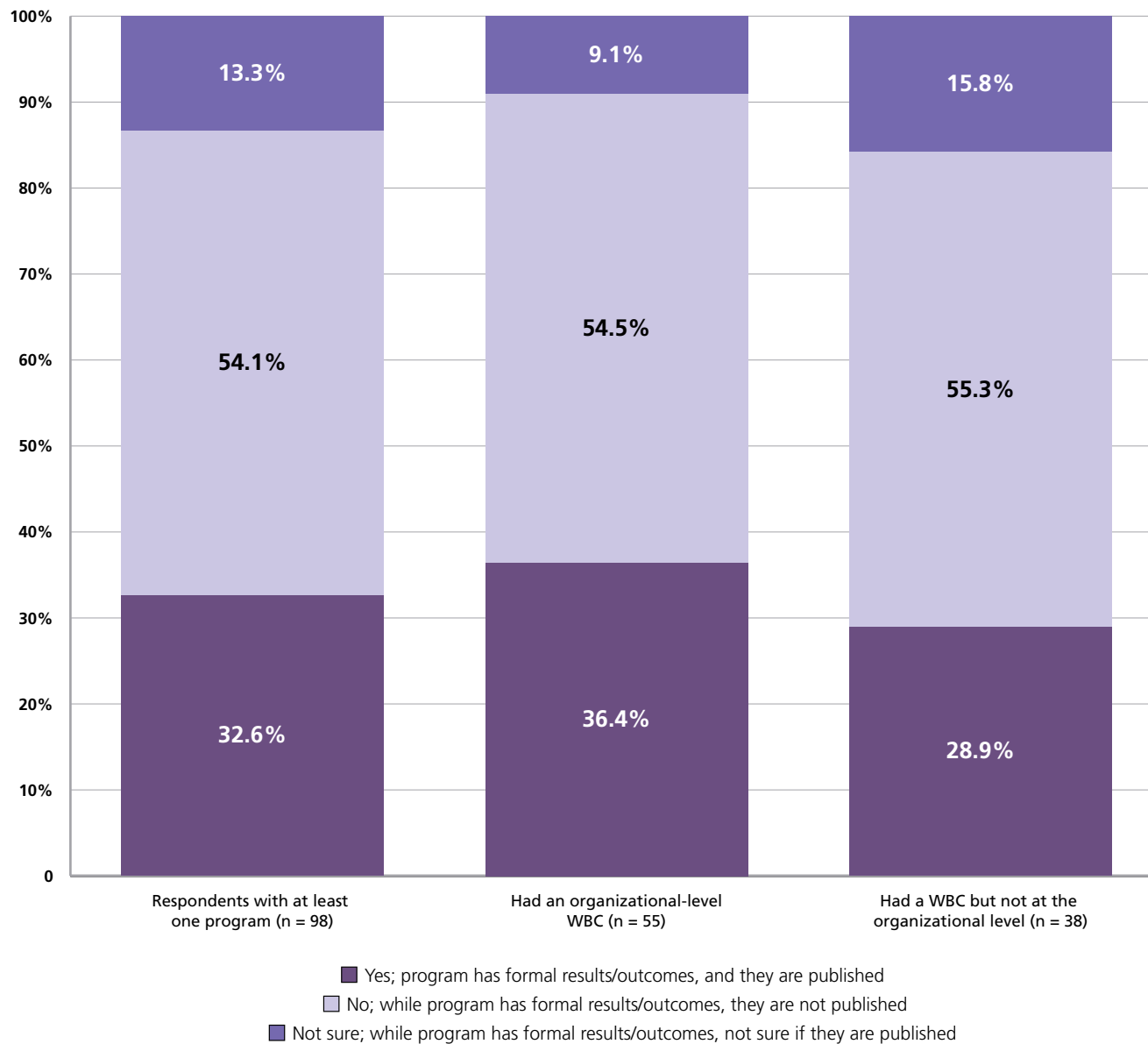
Note: The question "Which wellness screenings is your organization using?" was asked if the response was "yes" or "not sure" to the question "Does your institution have specific metrics for measuring wellbeing?" Respondents who responded "no" were excluded. See Appendix C for information about accessing these different wellness screenings. Respondents could choose more than one response to this question, so the percentage values do not sum to 100%.

**FIGURE 21.** Evaluation of wellness program results and outcomes.



Only 28.9% of all respondents reported their wellness program had formally identified results and outcomes. Respondents at institutions with an organizational-level WBC reported higher rates of formal evaluation of results and outcomes of their wellness programming (39.0%) than respondents from institutions with WBCs who are not at the organizational level (24.8%) and 11.1% of institutions with no identified WBC.

**FIGURE 22.** Publication of wellness program results and outcomes.

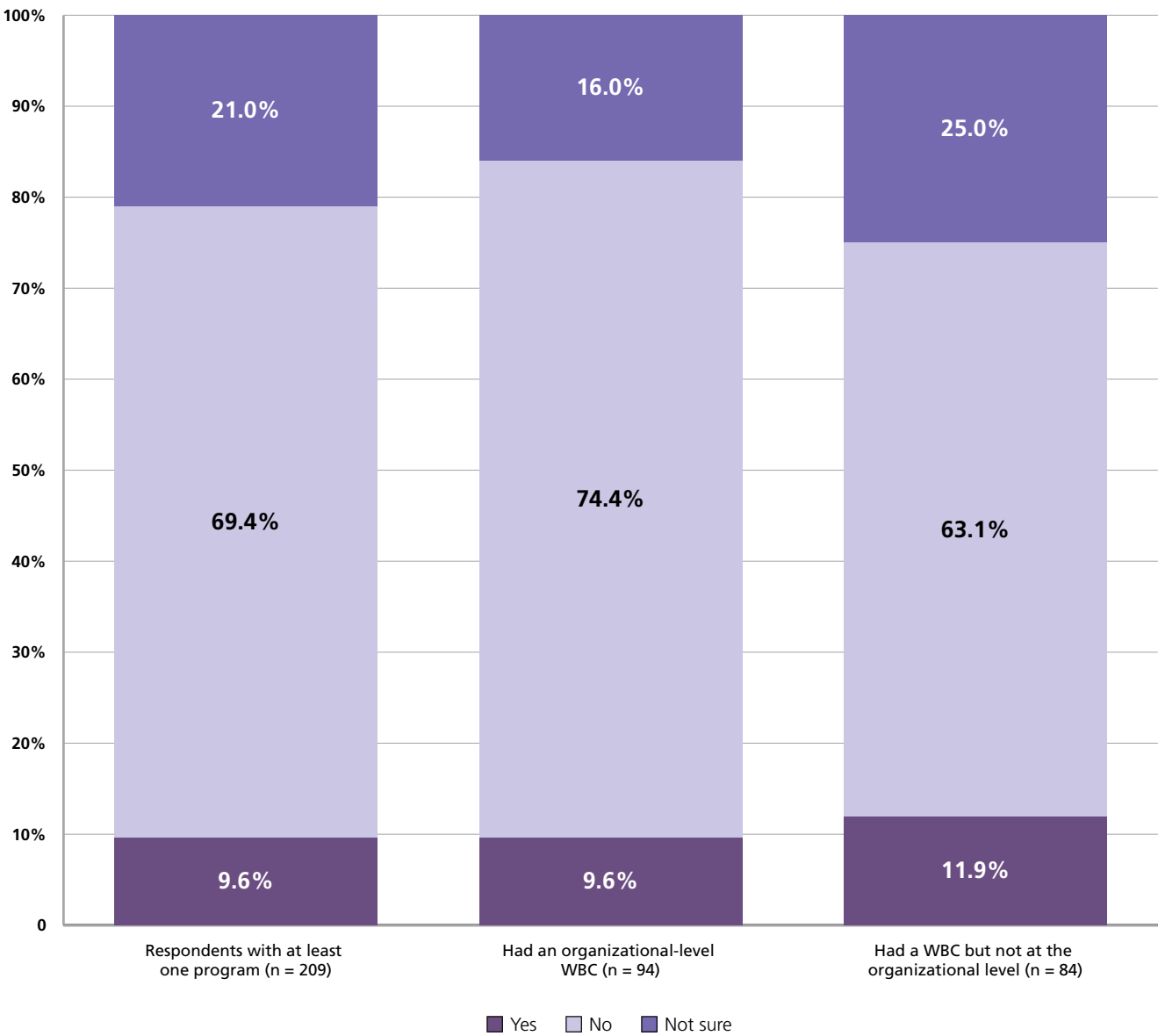


Of the 98 respondents who reported their institution's wellness programs had been evaluated and outcomes identified, about one-third (32.6%) reported that results had been published. Again, respondents at institutions with an organizational-level WBC reported higher rates of publication of their wellness programming (36.4%) than respondents at institutions with WBCs not at the organizational level (28.9%).

Note: Data reflect only those who responded "yes" to the question, "Does your program have formal results/outcomes on program initiatives?" Respondents who responded "no" or "not sure" were excluded. Five of the 98 respondents had programs without a WBC.



FIGURE 23. Well-being metrics included in individual performance evaluations.



Very few respondents (9.6%) were at organizations where well-being metrics were part of individual employee annual performance evaluations.

Note: Thirty-one of the 209 respondents had programs without a WBC.

## WELL-BEING CHAMPION JOB CHARACTERISTICS SURVEY

The compilation of job characteristics was an essential exercise in describing the current state of WBCs. By examining the roles and responsibilities of WBCs with different titles and reporting structures, we were able to identify and highlight two primary groups: those with broad organizational roles and those with embedded roles across the institution. Data were obtained from the primary Well-Being Job Characteristics Survey and supplemented with information from job descriptions provided by individuals in these WBC positions at institutions across the country.

### Organizational-Level Well-Being Champion Characteristics

People in broader and more formal organizational roles — the vast majority of whom are chief wellness officer (CWO) and directors of wellness programs — are more likely to:

- Report to either a dean or the hospital administration C-suite, with the chief medical officer serving as the primary supervisor.
- Work in institutions with an established well-being vision and institutional goals on both system and individual provider levels.
- Have responsibilities that include a larger segment of employees, including learners, faculty, and staff.
- Have people serving in a broader organizational role, such as a CWO, with supervisory responsibility and alignment with people in more specific, or embedded, positions such as those with roles in undergraduate and graduate medical education, nursing, research, and department administration.
- Have a formal job description with performance metrics.
- Have protected time for their position, with over half of respondents having a minimum of 30% FTE and a quarter having more than 50% FTE.
- Have had formal training. On average, 40%-50% of these individuals received formal training and with that training, have an established network of individuals to engage.
- Have an established budget (19%), but over half of organizational-level WBCs still had little or no budget or a budget where expenditures were negotiable (65%).
- Have the responsibility for screening employee well-being (70% of respondents) and, most commonly, screened only once per year.

### Embedded Well-Being Champion Characteristics

Embedded roles (departmental, program, or other more specialized focus) have often arisen organically from within academic programs, including clinical and basic science departments. These positions often:

- Begin within individual departments or within the Office of Undergraduate Medical Education (UME) or Office of Graduate Medical Education (GME).
- Report within the academic hierarchy of department chairs, deans, and health science center presidents. A second level of oversight for those in UME or GME programs is through accreditation organizations with formal requirements related to wellness and mental health support. The LCME and ACGME have specific requirements and provide oversight for medical students — LCME Standard 12 requirements include knowledge about health services, personal counseling, and the learning environment (2021), and for residents, fellows, and faculty, refer to ACGME's Common Program Requirements, Section VI (2021).
- Focus on their specific constituents (e.g., medical students) and tend to have a greater role in the creation of wellness curriculums, educational offerings, scholarly activity, and oversight of behavioral health providers and counseling services.
- Have much less protected time, about 10% FTE, or one half-day per week.
- Are less likely to have formal training. On average, only about 20% of these individuals have had formal training.
- Either have no budget or their budget was negotiable after they made a case for the funds.
- Are much less likely to have a formal job description.
- Have accreditation requirements serving as the metrics for evaluation.
- Are much less likely to have an established well-being vision or goals or to use metrics for evaluation.
- Are responsible for screening employee well-being (65%) and, most commonly, screening only once per year.

## STUDY LIMITATIONS

This study's limitations should be considered when interpreting the results:

- The role of a WBC is not a standardized or defined position, so experiences and perspectives of survey respondents vary.
- The potential for sampling bias exists because many respondents to the Organizational Well-Being Survey were invited to participate in the survey at well-being conference sessions and were likely interested in the topic.
- Because the Organizational Well-Being Survey was distributed to a targeted number of specialty groups and promoted at professional conferences, a large portion of respondents work in Family Medicine and Internal Medicine specialties.
- Only 30% of respondents to the Organizational Well-Being Survey self-identified as WBCs. While these data improve our understanding of WBCs, more research is needed to better describe how WBCs are fulfilling their role.
- Data for the Organizational Well-Being Survey were collected before and since the emergence of the COVID-19 pandemic. Some organizations may have bolstered or grown their resources dedicated to well-being during the survey period.
- The Organizational Well-Being Survey data reflect responses from many types of health care settings. Most respondents work in academic health centers, which vary in structure and governance, with some owning their hospitals and others not. The affiliation of health systems to educational institutions also varies, so the presence of a dean's structure may or may not be present. This report's recommendations are for any type of health care institution and should not require the presence of a certain title or position, including that of CWO.
- Only 18 responses were received to the Well-Being Champion Job Characteristics Survey. While this is a small sample, it may reflect the fact that few WBCs have formalized job descriptions.







## Discussion and Recommendations

Findings from these surveys reflect both the nationwide trend to develop well-being leaders and wellness programs and the wide variation in the design and maturity of these programs and the role of WBCs.

WBCs in organizational-level positions and those in embedded positions can significantly contribute to the well-being of the health care professional. However, the organizational and embedded roles typically have different areas of focus and provide different services. In our analysis, compared with embedded WBCs, having organizational-level WBCs was more often associated with the presence of an institutional vision, system-level and individual-level goals, and performance metrics.

The reporting structure was typically through either a dean-level position or the hospital administration, often to the chief medical officer. An official job description, significant protected time, and formal training were more common in the broader organizational-level positions. However, clearly identified budgetary resources were not always guaranteed for organizational-level WBCs, and WBCs in embedded positions generally experienced a lack of budgetary support and were less likely to evaluate programs and publish outcomes. All WBCs, regardless of their reporting structure, were engaged in curriculum development. To ensure the best possible outcomes, organizations with many types of WBCs should attempt to align the roles of embedded WBCs throughout the WBC network and connect the work of WBCs to the organizational vision and goals, established metrics, available funding opportunities, and other resources.

Given institutions' unique needs, we expected to find variations in specific elements of wellness programs and details of the WBC position. The data, however, indicate there is an association between organizations that have wellness programs with identified WBCs and the prioritization and advancement of wellness initiatives. Furthermore, institutions that have identified an organizational-level WBC show greater uptake of wellness initiatives. A primary task for an organizational WBC is to align the institutional vision for well-being and the specific goals and resources that will work to realize that vision across the entire organization.

Based on these results, we identified 10 recommendations all organizations can consider as they advance on their path to creating a culture of well-being at the system level.







The following 10 recommendations are for senior leaders and WBCs in organizations engaged in creating and promoting meaningful and measurable initiatives to successfully address well-being for all health professionals.

Refer to Appendix D for sample tools, resources, and practices to use when implementing these recommendations.

**1. Approach organizational wellness initiatives within an improvement framework to lead change.**

Addressing the well-being of all health professionals requires both culture and systemic changes within an organization. Applying an organizational improvement framework can be helpful when designing an institution's wellness strategies.

**2. Develop and communicate an organizational vision for well-being.**

Wellness programming is best supported when institutional goals and resources are clear. A primary task for an organizational-level WBC is to align the institutional vision for well-being and the specific goals and resources that will work together to realize that vision across the entire organization. Once developed, leaders from across the organization, in addition to the WBC, should consistently communicate this vision for well-being, along with other stated strategic goals.

**3. Establish an organizational-level well-being champion to coordinate and align a network of wellness efforts across the organization.**

While having numerous WBCs operating at various levels within an organization has benefits, our analysis shows institutions with a dedicated individual overseeing well-being have prioritized the advancement of wellness initiatives. The organizational-level WBC should have some oversight of embedded WBCs to ensure alignment of wellness efforts.

**4. Embed well-being champions throughout the organization to coordinate efforts for specific audiences.**

WBCs are needed throughout the organization, not only at levels of leadership but also within departments and divisions and embedded alongside health professionals on the front lines. WBCs embedded throughout the organization can focus their efforts on the well-being needs of specific audiences.

**5. Standardize the job characteristics of well-being champions and set clear expectations.**

As more organizations establish WBCs within their ranks, the health care community should build consensus around key responsibilities of the WBC role so champions are prepared, tasked with reasonable and achievable objectives, and positioned to receive the institutional support they need to succeed.

**6. Support the role of all well-being champions by introducing training, providing resources, and dedicating funding.**

Because each organization is unique, the role of WBCs will vary based on institutional factors. However, a defined budget, protected time, and training are required regardless of the WBC's title or level of responsibility. Institutions should consider the following when establishing the WBC role:

- This role should not be a volunteer position: Each WBC should have time allocated for overseeing wellness initiatives, clear expectations for the role, and a direct reporting structure to ensure accountability.
- WBCs should receive training specific to this role (e.g., wellness practices for institutions and assessment strategies).
- Organizations should provide WBCs with a defined set of resources to accomplish their work, including a budget adequate to address the degree of needed change.
- WBCs should be encouraged to use protected time to connect with national networks to gain new insight into partnerships and possible new program ideas.

**7. Promote well-being as a core competency for all health professionals.**

Based on survey responses, learners are considered the primary audience for wellness programs, but it is just as important to enhance the well-being of faculty and staff whose job it is to support the learners. Educational content and methods must align to ensure all health professionals and trainees are competent to model and sustain personal well-being, as well as promote a culture of well-being within their health care environment. Prioritizing well-being as a competency, defining the criteria needed to demonstrate the competency, and offering a menu of well-being programming to allow individuals to maintain autonomy and to successfully sustain their own well-being will benefit all health professionals.







**8. Incorporate program evaluation when designing comprehensive wellness initiatives.**

WBCs who develop and implement wellness programming should use a set of evaluation criteria to assess the success of their initiatives. WBCs should identify wellness metrics that are best suited for their particular setting and the types of programming offered. Additionally, WBCs and institutions should consider publishing their findings around promising practices for wellness initiatives.

**9. Conduct ongoing assessments of individual well-being.**

To ensure the programs are positively affecting the community, well-being assessments should be conducted at regular intervals. A variety of tools are available to assess different components of well-being (refer to Appendix C). Using the same metrics over time to assess individual well-being allows for a better understanding of what is working and what is not working for the organization.

**10. Prioritize well-being as a professional development goal.**

Part of evolving the culture of medicine is demonstrating that well-being is a priority. Annual performance reviews are an opportunity to discuss an individual's well-being and how one's supervisor or mentor could further support well-being in the workplace. Institutional leaders, including department chairs, should also establish goals and measures to support the improvement of the well-being of learners, faculty, and staff.

It is in the best interest for all in health care — whether they are care providers, educators, trainees, or patients — for institutions to establish dedicated wellness programs and elevate the role of well-being champions.

Many WBCs have a great deal of responsibility in designing programs to overcome challenges to the health and well-being of health care professionals and, therefore, need formalized training and dedicated time allocated to these roles, in addition to budgeted resources to support wellness programming. Wellness initiatives should identify and use metrics to monitor and assess their progress toward promoting well-being among those in the health care working and learning environments. While some institutions may still be in the early stages of prioritizing, appointing, and empowering WBCs across the organization, this work is an essential step in building and sustaining a culture of wellness.

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## Appendices



## Appendix A. Organizational Well-Being Survey Questions

**Q1.** Institutional Setting (Select all that apply)

- ☐ Academic health center
  - ☐ Hospital based practice
  - ☐ Community practice
  - ☐ Medical school
  - ☐ Nursing school
  - ☐ Allied health program
  - ☐ College
  - ☐ Other (please specify)
- 

**Q2.** Is wellbeing an explicit part of your institution's vision, mission, and strategic plan?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q3.** Does your institution have goals to drive a culture of wellness?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q4.** Do the goals include initiatives at the individual level?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q5.** Do the goals include initiatives at the system level?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q6.** Are wellness initiatives in place at your institution for the following audiences? (Select all that apply)

- ☐ Students
- ☐ Residents
- ☐ Faculty
- ☐ Staff
- ☐ Other health professionals
- ☐ Not sure

**Q7.** On what audience is your institution most focused? (Select all that apply)

- ☐ Students
- ☐ Residents
- ☐ Faculty
- ☐ Staff
- ☐ Other health professionals
- ☐ Not sure

**Q8.** To what degree are you concerned that burnout may be affecting your colleagues?

- ☐ Not at all
- ☐ Minimally
- ☐ Moderately
- ☐ Very much
- ☐ Extremely

**Q9.** To what degree are you concerned that burnout is affecting you?

- ☐ Not at all
- ☐ Minimally
- ☐ Moderately
- ☐ Very much
- ☐ Extremely

**Q10.** Does your organization have wellness champions at the following levels? (Select all that apply)

- ☐ Organization (chief wellness officer or similar title)
  - ☐ GME (all residency programs in the institution)
  - ☐ Departmental (for residents and/or faculty)
  - ☐ Dean's office (for medical students)
  - ☐ Staff level (for all employees)
  - ☐ Not sure
  - ☐ Other (please specify)
- 

**Q11.** Do you personally hold a position as a wellness champion?

- ☐ Yes
- ☐ No

**Q12.** What is your official wellness champion title?

- ☐ Chief wellness officer
  - ☐ Wellness director
  - ☐ Wellness committee/Task force chair
  - ☐ Other (please specify)
-

**Q13.**What percentage of time is provided for your wellness champion position?

- ☐ None
- ☐ 1-5%
- ☐ 6-10%
- ☐ 11-20%
- ☐ 21-30%
- ☐ 31-50%
- ☐ Greater than 50%

**Q14.**To whom do you report as a wellness champion?

- ☐ Dean
  - ☐ Hospital president
  - ☐ Department chair
  - ☐ Residency director
  - ☐ Other (please specify)
- 

**Q15.**Did you receive formal training for this role?

- ☐ Yes
- ☐ No

**Q16.**In addition to being a wellness champion, what other role(s) do you have? (Select all that apply)

- ☐ Chairman
  - ☐ Residency program director
  - ☐ Dean
  - ☐ Assistant/Associate dean
  - ☐ Behavioral health director
  - ☐ Clerkship director
  - ☐ Chief resident
  - ☐ HR director
  - ☐ Other (please specify)
- 

**Q17.**What budget is available for your wellness initiatives?

- ☐ There is none
- ☐ < \$1,000
- ☐ \$1,001-\$5,000
- ☐ \$5,001-\$10,000
- ☐ \$10,001-\$20,000
- ☐ \$20,001-\$50,000
- ☐ Greater than \$50,000
- ☐ Everything is negotiated and based on justifying requests
- ☐ Don't know

**Q18.**The following best describes my organization's philosophy for funding wellness initiatives

- ☐ You can spend as much as needed — this is a top priority
  - ☐ This is an unfunded mandate
  - ☐ Funding occurs only if ROI is demonstrated
  - ☐ Great idea, but ... there is no budget for anything
  - ☐ Other (please specify)
- 

**Q19.**Please list local resources that you have found beneficial in helping you to deliver your wellness program.

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**Q20.**Please list national resources have you found beneficial in helping you to deliver your wellness program.

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**Q21.** Which of the following strategies are you including or hoping to include in your wellness initiatives? (Select any that apply)

*Response options: Mandatory curricular component, Optional extracurricular activity, Hoping to add in the next 12 months, Not planning to add*

- ☐ Mindfulness/Meditation
  - ☐ Self-reflection
  - ☐ Resilience
  - ☐ Narrative writing
  - ☐ Healthy eating
  - ☐ Exercise
  - ☐ Social activities
  - ☐ Time management
  - ☐ Leadership training
  - ☐ Emotional intelligence
  - ☐ Improvement processes
  - ☐ Prioritizing purpose
  - ☐ Cognitive reframing
  - ☐ Appreciative inquiry/Gratitude
  - ☐ Conflict management
  - ☐ Other (please specify)
- 

**Q22.** Which methods are you using or hoping to add to promote wellbeing? (Select any that apply)

*Response options: Presently using, Hoping to add in next 12 months*

- ☐ Wellness workshop/retreat (4 hours or more)
  - ☐ Mandatory ongoing wellness lecture series
  - ☐ Optional wellness activities
  - ☐ Wellness challenges
  - ☐ Online learning modules
  - ☐ Wellness learning community/mentoring program
  - ☐ Outside speakers
  - ☐ Wellness program consultants
  - ☐ Other (please specify)
- 

**Q23.** Does your program have formal results/outcomes on program initiatives?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q24.** Has your program published results/outcomes on aspects of your wellness program?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q25.** How important have the following components been to your implementation of a wellness curriculum? (Select any that apply)

*Response options: Not at all, Minimally, Moderately, Very much, Extremely*

- ☐ Time in the curriculum
  - ☐ Initial wellness workshop/retreat
  - ☐ Ongoing wellness lecture series (built into the curriculum)
  - ☐ Optional wellness activities
  - ☐ Wellness challenges
  - ☐ Case based wellness readings
  - ☐ Online learning modules
  - ☐ Wellness Learning community
  - ☐ Outside speakers
  - ☐ Wellness program consultants
  - ☐ Other (please specify)
- 

**Q26.** Have you personally completed a wellness screening?

- ☐ Yes
- ☐ No

**Q27.** Does your institution have specific metrics for measuring wellbeing?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q28.** How often are wellness screenings being conducted at your institution?

- ☐ Once so far
- ☐ Yearly
- ☐ Twice yearly
- ☐ 3-4 times yearly
- ☐ More than 4 times yearly
- ☐ Not sure

**Q29.** Which wellness screenings is your organization using? (Select all that apply)

- ☐ Areas of Worklife Survey (AWS)
- ☐ Authentic Happiness Inventory (AHI)
- ☐ Center for Epidemiologic Studies Depression Scale (CES-D)
- ☐ Connor-Davidson Resilience Scale (CD-25)
- ☐ Copenhagen Burnout Inventory (CBI)
- ☐ Gratitude Survey
- ☐ Grit Survey
- ☐ Jefferson Scale of Physician Empathy
- ☐ Maslach Burnout Inventory (MBI)
- ☐ Mayo Clinic Well-Being Index
- ☐ Meaning in Life Questionnaire
- ☐ Mindfulness Attention Awareness Scale
- ☐ Perceived Stress Scale (PSS)
- ☐ Postgraduate Hospital Education Environment Measure (PHEEM)
- ☐ Quality of Life scale
- ☐ WHO-5

☐ Quality of Work-Life Questionnaire

☐ Not sure

☐ Other (please specify)

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**Q30.** Are wellness metrics included in performance evaluations at your institution?

- ☐ Yes
- ☐ No
- ☐ Not sure

**Q31.** Primary role (Select all that apply)

- ☐ Student
  - ☐ Resident
  - ☐ Faculty (clinical, basic science, behavioral health, community)
  - ☐ Dean
  - ☐ Associate or assistant dean
  - ☐ Chair
  - ☐ Nurse
  - ☐ Administrator
  - ☐ Program director
  - ☐ Other (please specify)
- 

**Q32.** Discipline

- ☐ Allergy and Immunology
- ☐ Anesthesiology
- ☐ Basic Science Faculty
- ☐ Behavioral Health
- ☐ Colon and Rectal Surgery

- ☐ Dermatology
  - ☐ Emergency Medicine
  - ☐ Family Medicine
  - ☐ Internal Medicine
  - ☐ Medical Genetics and Genomics
  - ☐ Neurological Surgery
  - ☐ Neurology
  - ☐ Nuclear Medicine
  - ☐ Obstetrics and Gynecology
  - ☐ Ophthalmology
  - ☐ Orthopedic Surgery
  - ☐ Osteopathic Neuromusculoskeletal Medicine
  - ☐ Otolaryngology
  - ☐ Pathology
  - ☐ Pediatrics
  - ☐ Physical Medicine and Rehabilitation
  - ☐ Plastic Surgery
  - ☐ Preventative Medicine
  - ☐ Psychiatry
  - ☐ Preventative Medicine
  - ☐ Psychiatry
  - ☐ Radiation Oncology
  - ☐ Radiology
  - ☐ Surgery
  - ☐ Thoracic Surgery
  - ☐ Transitional Year
  - ☐ Urology
  - ☐ Other (please specify)
-

**Q33.** Your age

- ☐ <20 years old
- ☐ 21-30 years old
- ☐ 31-40 years old
- ☐ 41-50 years old
- ☐ 51-60 years old
- ☐ 61-70 years old
- ☐ >70 years old

**Q34.** Gender

- ☐ Female
- ☐ Male
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Gender Variant/Non-Conforming
- ☐ Prefer Not to Answer
- ☐ Not Listed

**Q35.** Academic title (for faculty)

- ☐ Instructor
  - ☐ Assistant professor
  - ☐ Associate professor
  - ☐ Professor
  - ☐ Adjunct faculty
  - ☐ N/A
  - ☐ Other (please specify)
- 

**Q36.** Collated de-identified results will be shared with the following organizations (Please select all to which you are affiliated)

- ☐ Association of American Medical Colleges (AAMC)
- ☐ Family Medicine Education Consortium (FMEC)
- ☐ Center for Innovation and Leadership in Education (CENTILE)
- ☐ CoreWellness Research and Learning Collaborative (CWRLC)
- ☐ Society of Teachers of Family Medicine (STFM)

**Q37.** Please select the source of the funding for your school or organization

- ☐ Private
- ☐ Public

## Appendix B. National and Local Resources to Support Wellness Initiatives

With a growing number of well-being champions, national organizations are creating networks and resources to support those in the role. For example, the National Academy of Medicine publishes regular reports and recommendations on physician wellness. Additionally, specialty organizations have subgroups focused on well-being to create learning communities for champions. Accreditation boards are also taking notice and now have questions related to wellness within training programs for GME and UME.

The following resource list includes information submitted by survey respondents in response to a question about what national or local resources they have found beneficial in helping deliver wellness programs.

### NATIONAL RESOURCES

Resources and Courses From National Organizations and Professional Societies

- Academic Life in Emergency Medicine Wellness Think Tank: <https://www.aliem.com/wellness-think-tank/>
- Alliance for Academic Internal Medicine Collaborative for Healing and Renewal in Medicine (CHARM): <https://www.im.org/resources/wellness-resiliency/charm>
- American Academy of Family Physicians
  - Leading Physician Wellbeing Training Program: <https://www.aafp.org/family-physician/practice-and-career/managing-your-career/leading-physician-well-being.html>
  - CME Courses on Wellbeing: <https://www.aafp.org/cme/topic/physician-well-being.html>
  - Why Well-Being: <https://www.aafp.org/membership/benefits/physician-health-first/why-wellbeing.html>
- American Academy of Neurology
  - Wellness Resources: <https://www.aan.com/livewell/>
  - Residency Program Wellness Education Resources: <https://www.aan.com/tools-and-resources/academic-neurologists-researchers/program-and-fellowship-director-resources/residency-program-wellness/>
- American College of Emergency Physicians
  - Wellness and Assistance Program: <https://www.acep.org/life-as-a-physician/wellness/>
  - Being Well in Emergency Medicine: ACEP's Guide to Investing in Yourself: <https://www.acep.org/globalassets/sites/acep/media/wellness/cepwellnessguide.pdf>
- American College of Ob-Gyn: <https://www.acog.org/career-support/wellness>
- American College of Physicians
  - Wellbeing Champions program: <https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment/acp-well-being-champions>
  - Physician Wellbeing and Professional Fulfillment Resources: <https://www.acponline.org/practice-resources/physician-well-being-and-professional-fulfillment>
- American College of Radiology: <https://www.acr.org/Member-Resources/Benefits/Well-Being>
- Accreditation Council for Graduate Medicine Education
  - Initiative on Improving Physician Well-being, Restoring Meaning in Medicine: <https://www.acgme.org/what-we-do/initiatives/physician-well-being/>
  - ACGME AWARE Resources: <https://dl.acgme.org/pages/well-being>
- American Medical Association Joy in Medicine Program: <https://www.ama-assn.org/practice-management/sustainability/joy-medicine-health-system-recognition-program>
- American Osteopathic Association: <https://osteopathic.org/wellness/>
- American Psychiatric Association: <https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout>
- American Society of Anesthesiologists: <https://www.asahq.org/advocating-for-you/well-being>
- Council of Residency Directors in Emergency Medicine
  - Wellness and Resilience Resources: <https://www.cordem.org/resources/professional-development/wellness--resilience---resources-page2/>
  - Wellness Leadership Mini-Fellowship: <https://www.cordem.org/resources/professional-development/wellness--resilience---resources-page2/resilience-mini-fellowship/>



- Mayo Clinic Program on Physician Wellbeing: <https://www.mayo.edu/research/centers-programs/program-physician-well-being>
- National Academy of Medicine Clinician Resilience and Wellbeing Initiative: <https://nam.edu/initiatives/clinician-resilience-and-well-being/>
- Physician Wellness Academic Consortium: <https://www.pwac.org>
- Society of Teachers of Family Medicine: <https://www.stfm.org/facultydevelopment/onlinecourses/wellnesscourse/overview/>
- Stanford University WellMD Program: <https://wellmd.stanford.edu>

## WELL-BEING CURRICULUM SAMPLES AND MODELS

- Georgetown University School of Medicine Mind Body Medicine Program: <https://som.georgetown.edu/medicaleducation/mindbody>
- Lessons Learned and Positive Results From a Multi-institutional Wellbeing Curriculum for Medical Students and Residents: <https://vimeo.com/545156199>
- Culture of Wellness Curriculum: <https://journals.stfm.org/primer/2020/montalbano-2020-0002/>

## EMPLOYEE WELL-BEING PROGRAMS

- BurnAlong: <https://www.burnalong.com>
- Limeade: <https://www.limeade.com>
- Virgin Pulse: <https://www.virginpulse.com>
- WellRight: <https://www.wellright.com>

## MENTAL HEALTH ORGANIZATIONS

- American Foundation for Suicide Prevention: <https://afsp.org>
- Happy MD: <https://www.thehappynd.com>
- Mental Health First Aid: <https://www.mentalhealthfirstaid.org>
- Mindfulness Based Stress Reduction: <https://www.mindfulleader.org>
- Zero Suicide: <https://zerosuicide.edc.org>

## WELLNESS APPS FOR COMPUTERS AND SMART DEVICES

- Calm App: <https://www.calm.com>
- Headspace App: <https://www.headspace.com>

## LOCAL RESOURCES

- Academic success counselors
- Advisors
- Behavioralists and LISWs
- Colleagues
- Community gardens
- Employee assistance program
- Fitness centers and campus recreation
- Local chamber of commerce
- Local foundations
- Local restaurants
- Massage therapists
- Meal-planning services
- Medical school offices of faculty affairs, GME, HR, student affairs, student health
- Meditation sessions
- Mental health resources
- Mindfulness magazines
- Outdoor hiking locations
- Social activities
- Spiritual care department
- State or local medical association
- Stress-reduction programming
- Volunteer activities
- Wellness challenges
- Well-being champions (dean of well-being, well-being committees)
- YMCA
- Yoga studios

## Appendix C. Wellness Screening Tools

The Organizational Well-Being Survey asked respondents to identify which wellness screening tools their organizations use (Question 29). The list below includes information about these tools and about additional assessments respondents named in the open-ended-response option for the question.

- Areas of Worklife Survey (AWS):  
<https://www.mindgarden.com/274-areas-of-worklife-survey>
- Authentic Happiness Inventory (AHI):  
<https://www.authentichappiness.sas.upenn.edu/>
- Brief Resilience Scale
  - <https://link.springer.com/article/10.1080/10705500802222972>
  - <https://measure.whatworkswellbeing.org/measures-bank/brief-resilience-scale/>
- Center for Epidemiologic Studies Depression Scale (CES-D):  
<https://cesd-r.com/about-cesdr/>
- Connor-Davidson Resilience Scale (CD-25):  
<http://www.connordavidson-resiliencescale.com/about.php>
- Copenhagen Burnout Inventory (CBI):  
<https://nfa.dk/da/Vaerktoejr/Sporgeskemaer/Sporgeskema-til-maaling-af-udbraendthed/Copenhagen-Burnout-Inventory-CBI>
- EQi-2.0 Emotional Intelligence Quotient: <https://www.eitrainingcompany.com/eq-i/>
- Gratitude Survey: <https://ppc.sas.upenn.edu/resources/questionnaires-researchers/gratitude-questionnaire>
- Grit Survey: <https://angeladuckworth.com/research/>
- Jefferson Scale of Physician Empathy:  
<https://www.jefferson.edu/academics/colleges-schools-institutes/skmc/research/research-medical-education/jefferson-scale-of-empathy.html>
- Maslach Burnout Inventory (MBI)
  - <https://www.mindgarden.com/117-maslach-burnout-inventory-mbi>
- Mayo Clinic Well-Being Index: <https://www.mywellbeingindex.org>
- Meaning in Life Questionnaire: [http://www.michaelfsteger.com/?page\\_id=13](http://www.michaelfsteger.com/?page_id=13)
- Mindfulness Attention Awareness Scale: <https://ppc.sas.upenn.edu/resources/questionnaires-researchers/mindful-attention-awareness-scale>
- Mini-Z 2.0 Survey
  - <https://www.professionalworklife.com/mini-z-survey>
  - <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771447>
- Moral Distress Thermometer: <https://www.fairbankscenter.org/ethics-sub-specialties/fairbanks-program-in-nursing-ethics>
- Perceived Stress Scale (PSS): <https://www.midss.org/content/perceived-stress-scale-pss>
- Physician Wellness Inventory
  - <https://pubmed.ncbi.nlm.nih.gov/28376519/>
  - <https://www.plasticsurgery.org/documents/medical-professionals/wellness/Physician-Wellness-Inventory.pdf>
- Postgraduate Hospital Education Environment Measure (PHEEM):  
<https://www.tandfonline.com/doi/10.1080/01421590500150874>
- Quality of Life Scale:  
<https://eprovide.mapi-trust.org/instruments/quality-of-life-scale2>
- Quality of Work-Life Questionnaire:  
<https://www.cdc.gov/niosh/topics/stress/qwlquest.html>
- Social Network Index: <https://www.midss.org/content/social-network-index-sni>
- Stanford Professional Fulfillment Model and Index
  - <https://wellmd.stanford.edu/about/model-external.html>
  - <https://wellmd.stanford.edu/wellbeing-toolkit/HowWeMeasureWell-Being.html>
  - <https://link.springer.com/article/10.1007/s40596-017-0849-3>
- WHO-5
  - <https://www.psykiatri-regionh.dk/who-5/about-the-who-5/Pages/default.aspx>
  - <https://pubmed.ncbi.nlm.nih.gov/22607094/>

## Appendix D. Sample Wellness Tools, Resources, and Practices

The sample tools, resources, and practices listed below are included to help organizations implement the recommendations of this report. Other examples of successful wellness initiatives have been published, and organizations should identify the ones they believe best align with their vision and mission.

**Recommendation 1:** Approach organizational wellness initiatives within an improvement framework to lead change.

*Sample Resource: To define a comprehensive approach to wellness*

One model commonly used to promote alignment across new strategic initiatives is the “5Ps” framework. It organizes all aspects of strategy implementation into five broad categories: purpose, people, process, products, and policy:

- Leape S, Zou J, Loadwick O, Nuttal R, Stone M, Simpson B. More than a mission statement: how the 5Ps embed purpose to deliver value. McKinsey & Company. Nov. 5, 2020. <https://www.mckinsey.com/business-functions/strategy-and-corporate-finance/our-insights/more-than-a-mission-statement-how-the-5ps-embed-purpose-to-deliver-value>. Accessed Sept. 8, 2021.

To successfully establish well-being as a strategic initiative and develop plans to improve wellness, leadership teams can reflect on the following questions to assess whether their current approach is comprehensive or if a broader approach is needed:

*Purpose:* To what degree is a vision for well-being articulated, shared, and lived?

*People:* To what degree are champions of well-being known, resourced, trained, and authorized? To what degree are champions identified, involved in strategy, and receiving communication?

*Processes:* To what degree are processes clear and frontline professionals empowered, funded, and supported to lead meaningful initiatives and change?

*Products:* To what degree does the organization have well-being metrics and outcomes, such as baseline data and short- and long-term outcomes?

*Policies:* To what degree are policies aligned with a vision for well-being to solidify successful changes?

### *Suggested Reading*

- Kotter JP. *Leading Change*. Boston, MA: Harvard Business Review Press; 1996.
- Pipas CF. Improving physician well-being through organizational change. *Fam Pract Manag*. 2020;27(6):23-28.
- Pryor MG, Anderson D, Toombs LA, Humphreys JH. Strategic implementation as a core competency: the 5Ps model. *J Manag Res*. 2007;7(1):3-17.

**Recommendation 2:** Develop and communicate an organizational vision for well-being.

*Sample Resources: To assist in defining a vision for well-being*

Resources for developing a clear, concise, and meaningful vision statement for wellness are available, such as:

- Bravo. Aligning mission statements and core values with a culture of wellness. June 5, 2019. <https://www.bravowell.com/resources/aligning-mission-statements-core-values-with-a-culture-of-wellness>. Accessed Sept. 8, 2021.
- Tait D, Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc*. 2017;92(1):129-146. <https://doi.org/10.1016/j.mayocp.2016.10.004>.
- Shanafelt T, Trockel M, Ripp J, Murphy ML, Sandborg C, Bohman B. Building a program on well-being: key design considerations to meet the unique needs of each organization. *Acad Med*. 2019;94(12):156-161. doi:10.1097/ACM.0000000000002415.

**Recommendation 3:** Establish an organizational-level well-being champion to coordinate and align a network of wellness efforts across the organization.

*Sample Practice: Identify the role of an organizational-level well-being champion*

MedStar Health is a not-for-profit, regional health care system based in Columbia, Maryland, composed of 10 hospitals and affiliated with Georgetown University. The system has an organizational-level medical director of physician well-being who supervises more than 30 local well-being champions throughout the organization. These WBCs work together with the medical director of physician well-being to support a common vision and mission by providing the oversight, funding, and outcome review.

- MedStar Health. MedStar Health Physician Well-being Team. <https://www.medstarhealth.org/provider-and-associate-wellbeing/about-us/>. Accessed Sept. 8, 2021.
- MedStar Health. Provider and Associate Wellbeing. <https://www.medstarhealth.org/provider-and-associate-wellbeing/>. Accessed Sept. 8, 2021.

**Recommendation 4:** Embed well-being champions throughout the organization to coordinate efforts for specific audiences.

*Sample Practice: Embed well-being champions at various levels within an organization*

Washington University School of Medicine in St. Louis Department of Pediatrics Wellness Program: The Department of Pediatrics is training chiefs and well-being champions in each of their 16 divisions to lead their wellness initiatives. This team meets monthly and uses a train-the-trainer model to learn and apply evidence-based well-being strategies in preparation for rolling out the curriculum for the remaining 400 members of the department. Having well-being champions embedded throughout the department is essential to the successful implementation of the department's vision for well-being among learners, faculty, and staff.

*Suggested Reading*

- Pipas CF. *A Doctor's Dozen: 12 Strategies for Personal Health and a Culture of Wellness*. Hanover, NH: Dartmouth College Press; 2018.
- Pipas CF, Damianos JA, Montalbano L, Matous BA, Hua J, Shoop GH. A curriculum to promote a culture of wellness among medical students and faculty. *PRiMER*. 2020;4:13. doi:10.22454/PRiMER.2020.930805. <https://journals.stfm.org/primer/2020/montalbano-2020-0002/>

**Recommendation 5:** Standardize the job characteristics of well-being champions and set clear expectations.

*Sample Resources: To define the role of the CWO*

Thought leaders within academic medicine and other fields have published recommendations for defining the scope of the CWO role and how CWOs can best understand and address the wellness needs within their organizations. Examples of recommendations for formalizing the role of the CWO can be found in the following resources:

- Brower KJ, Brazeau CMLR, Kiely SC, et al. The evolving role of the chief wellness officer in the management of crises by health care systems: lessons from the COVID-19 pandemic. *NEJM Catalyst*. 2021;2(5). doi:10.1056/CAT.20.0612.
- MacGregor SP, Simpson R. *Chief Wellbeing Officer: Building Better Lives for Business Success*. LID Publishing; 2018.
- Ripp J, Shanafelt T. The health care chief wellness officer: what the role is and is not. *Acad Med*. 2020;95:1354-1358. doi:10.1097/ACM.0000000000003433

**Recommendation 6:** Support the role of all well-being champions by introducing training, providing resources, and dedicating funding.

*Sample Resource: To train new chief wellness officers*

The American Medical Association's Steps Forward program offers a learning module for CWOs to learn successful practices for establishing their position within their organization, the Chief Wellness Officer Road Map: Implement a Leadership Strategy for Professional Well-Being. The module describes the scope of responsibilities for the role and how to successfully create and implement an organizational strategy for wellness.

- Shanafelt T, Sinsky CA. 2020. Chief Wellness Officer Road Map: Implement a Leadership Strategy for Professional Well-Being. American Medical Association. June 25, 2020. <https://edhub.ama-assn.org/steps-forward/module/2767764>. Accessed Sept. 8, 2021.

**Recommendation 7:** Promote well-being as a core competency for all health professionals.

*Sample Resource: To establish well-being as a core competency for health care leaders*

The AAFP Leading Physician Well-Being Certificate Program is supported by the AAFP as a way to train family physicians around the nation to serve as leaders of change, with well-being intentionally defined as a core competency of their leadership training. The program is a grant-funded initiative sponsored by the United Health Foundation (UHF). Scholars in the 10-month program participate in online webinars, skills stations, and team support, and each completes a personal health improvement project (PHIP) and a system well-being improvement project (SWIP).

- American Academy of Family Physicians. Leading Physician Well-being Program. <https://www.aafp.org/family-physician/practice-and-career/managing-your-career/leading-physician-well-being.html>. Accessed Sept. 8, 2021.

**Recommendation 8:** Incorporate program evaluation when designing comprehensive wellness initiatives.

*Sample Resource: To assess employee health programs and their impact on employee well-being*

Assessing employee health and well-being is a critical issue in all industries, including academic medicine. In 2015, the Health Enhancement Research Organization (HERO) and Population Health Alliance (PHA) collaborated to create an online resource guide that provides an initial set of standard measures for assessing employee health programs and their impact on employee well-being, *Program Measurement and Evaluation Guide: Core Metrics for Employee Health Management*. This resource can be adapted by health care organizations designing evaluation strategies for their wellness initiatives.

- Executive Summary: [https://hero-health.org/wp-content/uploads/2014/11/PHA-HERO-Executive-Summary\\_7-1-14v1.pdf](https://hero-health.org/wp-content/uploads/2014/11/PHA-HERO-Executive-Summary_7-1-14v1.pdf)
- Full Guide: <https://hero-health.org/wp-content/uploads/2015/02/HERO-PHA-Metrics-Guide-FINAL.pdf>

**Recommendation 9:** Conduct ongoing assessments of individual well-being.

*Sample Tools: To measure components of individual well-being*

In addition to the list of well-being assessments from the Organizational Well-Being Survey in Appendix C, these measures can also be used to assess components of well-being.

- CoreWellness Index (CWI), a new comprehensive well-being survey for health professionals: <https://www.dropbox.com/sh/fovqt51baktrtpd/AABWdWBg0oTnWgylbNUdfhJQa?dl=0>
- Fordyce Emotions Questionnaire (also known as the Happiness Measure): <https://www.jstor.org/stable/27520745>; <https://sofia.com.sg/wp-content/uploads/2017/11/The-Happiness-Measure.pdf>
- Positive and Negative Affect Schedule (PANAS) Questionnaire: <https://pubmed.ncbi.nlm.nih.gov/3397865/>
- Resilience Factor Inventory: <https://da7648.approbly.com/m/84223279b0001e87.pdf>; <https://www.adaptivlearning.com/assessments>
- Satisfaction With Life Scale: <http://www.midss.org/content/satisfaction-life-scale-sw1>
- Subjective Happiness Scale: <http://sonjalyubomirsky.com/subjective-happiness-scale-shs/>
- Transgression Motivations Questionnaire: <https://ppc.sas.upenn.edu/resources/questionnaires-researchers/transgression-related-interpersonal-motivations-inventory>
- VIA Survey of Character Strengths: <http://www.viacharacter.org>

**Recommendation 10:** Prioritize well-being as a professional development goal.

*Sample Practice: Example for setting individual well-being goals*

One example of creating professional development goals around well-being is for departmental and organizational leaders to proactively encourage employees to use their vacation time. Organizations could track employees' use of leave as a well-being metric and could also consider recognizing departments where a majority of individuals successfully use all vacation time. While this may seem counter to productivity, organizations that seek to enact their wellness vision should recognize that replenishing employees is key to reducing attrition, increasing productivity, and sustaining joy in practicing medicine.



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