5-2020

From Burnout to Wellness: Using Appreciative Inquiry to Shift MidMichigan Health towards a Strengths-based Perspective

Kunal Chohan
University of Pennsylvania, chohan.kunal@gmail.com

Karen Fetzer
University of Pennsylvania, fka@sas.upenn.edu

Sophia R. Heiser
University of Pennsylvania, sheiser@sas.upenn.edu

Seth Norman
University of Pennsylvania, seth.norman@gmail.com

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Abstract

Over half of providers in the healthcare field experience burnout. Burnout syndrome is defined by the prolonged psychological and physiological response to chronic and interpersonal job stressors, and can result in a number of symptoms that negatively affect workplace morale and performance, including physical exhaustion, job dissatisfaction, and feelings of hopelessness. MidMichigan Health (MMH), a division of the University of Michigan Health system that serves nearly 1 million people in Michigan, has created the Provider Wellness and Burnout Council (PWBC) to address issues of burnout within the organization. To build on their initial work, we propose a long-term intervention based on the science of physician well-being, appreciative inquiry, goal-setting, and employee engagement. This intervention is intended to promote well-being among MMH providers through the creation of a clear, robust positive vision for provider well-being that involves all organization stakeholders throughout the development and execution of this vision. In light of the emerging COVID-19 pandemic and the subsequent strain on our nation's healthcare resources, we have also proposed a short-term intervention for addressing provider well-being by sharing with providers easy, evidence-based resilience interventions.

Keywords

burnout, resilience, appreciative inquiry, positive psychology, strengths, COVID-19

Disciplines

Community Health and Preventive Medicine | Community Psychology | Health and Medical Administration | Industrial and Organizational Psychology | Medicine and Health | Occupational Health and Industrial Hygiene | Organizational Communication | Organization Development | Service Learning

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Kunal Chohan, Karen Fetzer, Sophia Heiser, and Seth Norman

University of Pennsylvania

A Positive Psychology Service Learning Project Submitted

In Partial Fulfillment of the Requirements for MAPP 714: Applying Positive Interventions in Institutions

Master of Applied Positive Psychology

May 5, 2020

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Table of Contents

INTRODUCTION

Review of Organization

MidMichigan Health

Founded in Midland, Michigan in 1984, MidMichigan Health (MMH) is a non-profit healthcare provider in central Michigan and part of the University of Michigan Health System since 2013. With 8,700 employees, MidMichigan Health is one of the largest employers in the state of Michigan, and the seven MidMichigan clinical sites serve nearly 1 million residents of the state across 23 counties, generating more than $2.3 billion in revenue in 2019. In addition to providing inpatient and outpatient services to the community, MidMichigan Health is also committed to excellence in medical education, supporting onsite training for Family Medicine residents and medical students from both Michigan State University and Central Michigan University.

Provider Wellness and Burnout Council

In 2018, MidMichigan Health created a Provider Wellness and Burnout Council (PWBC), chaired by Dr. Kathleen Regan, to address the worsening effects of clinician burnout within the organization. In the past two years, Dr. Regan and her colleagues have begun measuring burnout at MMH using the Mini-Z inventory (Linzer et al., 2016) and organizing interventions to reduce burnout based around the Stanford WellMD Professional Fulfillment Model (Stanford Medicine WellMD Center, 2017), which incorporates three core dimensions: 1) developing a Culture of Wellness, where employees are encouraged to prioritize well-being and work engagement; 2) supporting an Efficiency of Practice, where workflows and care processes are evaluated for overall quality and ease of delivery for providers, as well as positive outcomes

and experiences for patients; and 3) the Development of Personal Resilience, including the training and education of staff members in order to cultivate the skills of psychological well-being.

In line with this model, MMH has deployed a series of offerings to their clinical providers, including: 1) an annual offsite weekend retreat for providers, which focuses on teaching resilience skills and encouraging community development amongst co-workers; 2) Connecting with Colleagues, another community-building program that encourages providers to gather in small groups for a system-sponsored dinner and discuss various well-being topics; 3) Peer Support, a program where peer-group volunteers are trained to proactively reach out to other providers who have experienced recent sentinel events, including malpractice lawsuits and patient deaths, and 4) Wellness Rounds, a program that gathers providers for breakfast, networking, and learning about resilience tools. Continuing medical education credits (CME) are offered for participation in this program.

Successes & Future Goals

The efforts of the PWBC have already engendered positive change, with a reported 32% year-over-year decrease in provider-reported burnout in 2019, as measured by the Mini-Z. Dr. Regan ascribes some of that success to the council's creation of a fourth pillar of well-being—Thriving Community Practices—which is unique to the MidMichigan Health System. By emphasizing the importance of interpersonal dynamics and organizational well-being, the council believes that their events are better attended, and that their attendees are more engaged with both the training and their colleagues. This success has also been made possible through excellent support on the part of senior executives at MidMichigan Health. Dr. Regan notes the

commitment to provider wellness by MMH's executives is a key enabler of program design and execution, driver of employee engagement with well-being services, and factor in limiting skepticism to the council's outreach.

However, the council also acknowledges room for considerable growth of their well-being initiatives. They strive to continue reducing burnout beyond their current rate. Additionally, while committed to reducing provider burnout, the council has yet to articulate a clear vision for their work that explicates their long-term intentions and short and long term goals to achieve them. They also currently frame their work in a deficit orientation focused exclusively on reducing burnout rather than in a positive orientation that also acknowledges the promotion of well-being and thriving beyond mere absence of burnout. Furthermore, despite significant success so far, the council admits their work is not yet reaching enough providers at MMH. Mini-Z survey data indicates that 38% of providers at MMH did not participate in the most recent burnout survey; an even larger percentage of providers do not participate in PWBC wellness events. Consequently, the PWBC aspires to greatly expand their outreach. Acknowledging these tangible successes, our team identifies key areas where positive psychology can support and strengthen the council's ongoing work. We aspire to guide future growth in the following categories: 1) reducing provider burnout and promoting provider well-being beyond merely burnout; 2) development of a robust, concrete, positive vision and goals for provider well-being; and 3) greater outreach and involvement of providers in PWBC programs.

Review of Sector

Burnout

Burnout is as prevalent and harmful as it is misunderstood. Far from the casual expression of frustration found in the everyday banter of coworkers, burnout is now defined as a psychological syndrome by the World Health Organization's International Classification of Diseases Manual (World Health Organization, 2018). Burnout syndrome is a prolonged response to chronic emotional and interpersonal job stressors, and is diagnosed using three core symptomatic dimensions: 1) exhaustion, recognized by a lack of both the physical and emotional resources necessary for typical functioning; 2) depersonalization, characterized by the development of a cynical or hopeless attitude about the meaning or impact of one's work; and 3) a reduced sense of accomplishment, identified by the tendency to evaluate both one's workplace and work performance in negative and dissatisfied terms (Maslach, Schaufeli, & Leiter, 2001).

The effects of burnout are far-reaching: by some estimates, nearly two-thirds of the American workforce experiences burnout syndrome in a given year (Fisher & Deloitte, 2017), and $190 billion is lost to preventable healthcare spending, productive output, and employee turnover each year (Goh, Pfeffer, & Zenios, 2016). In fact, this figure is likely an under-estimate, as it does not factor in the effects of the leading burnout comorbidities including anxiety, depression, and substance abuse disorders (Koutsimani, Montgomery, & Georganta, 2019).

Burnout in Medicine

Currently, it is predicted that as many as one-half of all physicians and one-third of all physician assistants and nurse practitioners meet the criteria for a burnout diagnosis at any given time (Reith, 2018). Physician burnout occurs at a rate nearly double that of workers in other

professions, even after controlling for hours worked, age, sex, and other factors (Shanafelt et al., 2012).

Of note, much of the research in burnout pertains to physicians, whereas much less research has been conducted among physician assistants, nurses, and other medical providers. At times we extrapolate from research on physicians to other provider populations to guide our assessment and proposals, but we acknowledge that more research is necessary to make definitive conclusions about burnout in all provider populations.

The impact of burnout on physicians is tremendous; in addition to increased risk for anxiety, depression, and substance abuse, this group is also 1.5-4.5 times more likely to commit suicide (Rothenberger, 2017). Furthermore, the cost to the patients under the care of burned out providers is also worrisome, as burnout syndrome is associated with a decrease in professionalism, empathy, and altruism (Shanafelt, Oreskovich, & Dyrbye, 2012), more treatment errors (Rothenberger, 2017), increased patient mortality (Welp, Meier, & Manser, 2015), and decreased patient satisfaction. (Halbesleben & Rathert, 2008).

The nature and stressors of medical practice align well with major contributors to burnout (Rothenberger, 2017). Maslach, Schauefeli, & Leiter (2001) note six critical dimensions of burnout: 1) excessive workload; 2) perceived lack of control; 3) misalignment of values; 4) insufficient compensation; 5) unfair treatment; and 6) the sense that the workplace is not a positive community (Rondeau, et. al., 2002). Recent statistics support this model's dimensions, as more than 40% of physicians report routinely working more than 80 hours a week, while only a quarter of the average physician's workday is spent with patients (Anim et al., 2009; Sinsky et al., 2016). Clinicians also report a perception of relative decreases in status and compensation, especially when compared to other professions (Lipworth et al., 2013).

Though there is a general lack of research supporting the effectiveness of positive interventions for reducing and preventing burnout, there is a growing dialogue within medicine about the importance of addressing burnout at the individual and organizational level (West et al., 2016).

Impact of COVID-19

The ongoing COVID-19 pandemic poses additional considerations for MidMichigan Health's goal of promoting well-being and reducing burnout. Major surges in health care demand due to COVID-19 place considerable strain on medical providers who are working in settings that are understaffed and under equipped to accommodate these surges. This pressure, alongside additional societal challenges like social distancing and economic recession, make medical providers especially vulnerable to burnout at this time, underscoring the need for greater attention to provider well-being. However, due to these intense demands on the health care system, institutions currently lack the available bandwidth to effectively prioritize provider well-being or make meaningful organizational changes as they struggle to treat rising numbers of COVID-19 patients. Therefore, major organizational change ought to be deferred in favor of easily implementable, low-resource interventions that support provider well-being during this period of crisis.

This deferral does not preclude attention to long-term interventions, however. To the contrary, we expect this crisis will clearly illustrate the need for comprehensive attention to provider well-being in the long-term given the unique, urgent threats to provider well-being this crisis poses. Early research from Wuhan, China, the origin of the pandemic, suggests high risk

for symptoms of depression, anxiety, insomnia, and distress among providers treating COVID-19 patients (Lai et al., 2020).

Indeed, this situation may prove to be a compelling call to action for health care organizations to prioritize provider well-being and resilience once we return to relative stability; this type of preparatory action will ensure that our nation's providers and health care systems are more prepared for the next crisis. Consequently, we believe this is a critical opportunity for the PWBC to build significant traction and advance their provider well-being mission within MidMichigan Health.

Moreover, we anticipate that healthcare organizations (including MidMichigan Health) and the healthcare industry will experience transformative restructuring post-pandemic. The ongoing COVID-19 pandemic is revealing strengths and vulnerabilities in our health care infrastructure. Plausibly, institutions will enact new policies, realigning and shifting priorities in response to these revealed insights; health care policy will likely adapt as well. While it is challenging to predict the outcome of these changes, we believe this forthcoming period of significant restructuring and rebuilding will also be a powerful opportunity for the PWBC to advance organizational changes in the service of provider well-being during this period of overall change.

Therefore, we propose both short-term and long-term interventions for MidMichigan Health to reduce burnout and support well-being among providers. In the short-term, we emphasize immediate resilience skills, designed for maximum adoption and minimal effort, for medical providers to manage the stress of the COVID-19 crisis. In the long-term, we encourage the development of a clear, comprehensive, inclusive vision for provider well-being across MidMichigan Health.

LITERATURE REVIEW

Physician Wellness

Definitions

Physician well-being is a broad topic and currently there is no consensus around the proper definitions, measurements, and interventions related to this phenomena. In fact, a systematic review of 78 studies attempting to measure physician well-being assessed and synthesized different measures, identifying the following salient points (Brady et al., 2018): 1) only 14% of papers specifically defined physician well-being, whereas others measured collections of outcomes without formally defining the topic. 2) 171 different measures (mental, social, physical, integrated) were proposed across the various studies. At least one mental measure (e.g. burnout, depression, job satisfaction, etc.) was present in 89% of papers, at least one social measure (e.g. impact on relationships) was present in 50% of papers, at least one physical measure (e.g. fatigue, work-rest balance, etc.) was present in 49% of papers, and at least one integrated measure (e.g. satisfaction in life, meaning in work, etc.) was present in 37% of papers. 3) The trend with newer studies is to favor the use of more integrated measures in general.

These findings suggest wide variation in conceptions of physician well-being and point to a multifaceted construct that includes measures of quality in various domains of personal and professional life. Consequently, the authors highlight the need for greater consensus regarding the definition of physician well-being in order to advance the development of reliable measures and ensure comparability across research. However, in the meantime, they propose the following definition of physician well-being:

> "Physician wellness (well-being) is defined by quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being experienced in connection with activities and environments that allow physicians to develop their full potentials across personal and work-life domains." (Brady et al., 2018, p. 15).

Measurement

One common physician-specific measure of this construct is the Physician Well-Being Index (PWBI) (Dyrbye et al., 2012), which is consistent with the predominant focus on negative mental constructs found in most approaches to measuring physician well-being (Brady et al., 2018). The PWBI identifies mental distress among physicians across multiple psychological dimensions and identifies physicians for whom distress may be relevant to practice-related risks. The Mini-Z is another validated measure for assessing physician burnout, noted for its brevity, ease of use, elicitation of dimensions of burnout, and cross-validation with the more widely used Maslach Burnout Inventory (Linzer et al., 2016, Maslach, Schaufeli, & Leiter, 2001). The Mini-Z is currently in use at MidMichigan Health.

Approach

There are many approaches to promoting physician well-being. However, similar to the lack of agreement regarding how this construct should be measured, there is also a lack of consensus regarding which types of interventions are most effective and practical for creating greater well-being amongst providers. A systematic review and meta-analysis of 15 randomized trials evaluating interventions to prevent and treat physician burnout found that both individual

and institutional strategies can meaningfully reduce burnout (West et al., 2016). The authors propose that a combination of the two approaches is likely most effective but identify that the combination has not been studied. Moreover, they note that insufficient data exists to evaluate which classes of interventions are most effective at scale, or for how long they exert their effects.

In a study exploring individual strategies, a survey of 7,197 surgeons identified a commonly accepted set of well-being strategies suitable for providers, including: 1) finding meaning in work tasks; 2) protecting time outside work for building relationships; and 3) focusing on the important things in life as defined by the individual provider, as the most commonly endorsed personal strategies for avoiding burnout (Shanafelt, Oreskovich, & Dyrbye, 2012). At the organizational level, Shanafelt & Noseworthy (2017) discuss 9 evidence-based strategies to reduce physician burnout, including: 1) acknowledging and assessing problems; 2) harnessing the power of leadership; 3) developing and implementing targeted interventions; 4) cultivating community at work; 5) using rewards and incentives wisely; 6) aligning values to strengthen culture; 7) promoting flexibility and work-life integration; 8) providing resources to promote resilience and self-care; and 9) facilitating and funding organizational science.

In summary, many approaches exist for the purpose of defining, measuring, and promoting physician well-being; only a few approaches have been highlighted in this paper. The necessity for further research and greater consensus around these concepts will be critical to promoting the well-being of healthcare professionals in the future. Additionally, given this lack of academic consensus surrounding the definitions and measurements of and solutions to provider burnout, it will be even more critical for the PWBC at MMH to clarify their concept of well-being for their own organization.

Appreciative Inquiry

Thirty years after the inception of appreciative inquiry (AI), Cooperrider (2017) maintains that AI is primarily concerned with the question: "What are the life-giving components of living systems?". Whether the system is a family, organization, neighborhood, country, etc., each has a culture, co-created by the attitudes, protocols, and relationships of the individuals that comprise the system (Cooperrider, 2017). AI asks what is *right* with the way the system functions, rather than focusing on what is wrong, and deliberately appreciates anything and everything that adds value to the whole (Cooperrider, Whitney, & Stavros, 2008). In addition to focusing on the positive, AI is generative in nature, guiding a dialogue geared towards the discovery of new ways of thinking and acting that might improve the organization's collective future (Busche, 2007).

Although the first organizational analysis involving AI was conducted at the Cleveland Clinic in 1980 (Cooperrider, 2017), the number of published studies that evaluate AI as a method for organizational change in the healthcare setting remains limited (Richer, Ritchie, & Marchionni, 2009). Nevertheless, the persistent dissatisfaction among healthcare workers, coupled with the increase in pressures placed on medical providers, are causing experts to call for transformational change in healthcare organizations (Carter et al., 2007); AI has been used by some to answer that call.

A methodological review including studies published between 1989-2011 sought to evaluate and compare the specific uses of the 4D cycle of AI (Discover, Dream, Design, Destiny) in the healthcare setting. From the review, the authors concluded that the strengths-based inquiry process has the potential to be successful among healthcare workers, but cautioned practitioners about the importance of tailoring the inquiry's conduct to suit the particular needs of the

healthcare setting (Trajkovski et al., 2013). For this reason, additional studies identifying the most successful practices in a variety of healthcare settings, including private hospital based practices, academic healthcare practices, private primary care practices, and other outpatient specialty clinics, have also been conducted. The common theme that emerged from this methodological review was that healthcare settings are especially challenging places in which to conduct AI given their uniqueness when compared to other businesses. Specific contributing factors include: 1) the necessity of providing patient care at all times renders it nearly impossible to have all of the team members present at one event, limiting the greater buy-in of the participants (Ruhe et al., 2011); 2) provider work schedules are typically organized into shifts, further complicating the scheduling of an entire workforce and making leadership hesitant to require employees to remain at work after long shifts in order to participate in the process (Williams & Haizlip, 2013); 3) unlike typical business organizations where a single mission statement can align the entire team's purpose, academic healthcare institutions typically have a three-fold mission that includes patient care, teaching, and clinical research (Williams & Haizlip, 2013) with competing leadership hierarchies, funding sources, scheduling demands, and organizational purpose (Williams & Haizlip, 2013); and 4) all healthcare practices, but private healthcare practices in particular, face additional resistance to participating in AI events due to a loss of work hours which negatively affect financial resources (Carter et al., 2007).

Despite the unique challenges presented by healthcare settings, it is possible for AI processes to thrive there. In fact, many AI practitioners have reported that the evidence-based nature of AI makes it a natural fit for enticing participation from healthcare providers (Shendell-Falik, Feinson, & Mohr, 2007). Others have praised the inclusive nature of the process which helps to overcome the barriers to communication created by the hierarchical structure of

healthcare organizations (Conn et al., 2010). AI is a dynamic, strengths-based process that has the power to transform living systems, and in the healthcare environment, its flexibility becomes a powerful asset for practitioners who must accommodate the unique demands of the healthcare industry. For these reasons, we believe an AI approach will be highly beneficial to MidMichigan Health's mission to advance provider well-being.

Goal-Setting

Organizations need to engage in effective goal-setting strategies if they expect to succeed. Specifically, research has shown that well-crafted goals lead to higher goal acceptance, effort, motivation, performance, and job satisfaction, as well as more successful goal attainment (Locke & Latham, 1990; Lunenburg, 2011; Fairfield, Wagner, & Victory, 2004; Carper, 2015; Barsy, 2007); while setting unrealistically high or overly demanding goals can be a catalyst or excuse for unethical behavior (Barsy, 2007; Welsh & Ordóñez, 2014).

Locke & Latham's (1990) seminal literature in goal-setting theory describes an explicit model in which they define values and intentions (goals) as the two determinants of human behavior. Goals, by their definition, are simply what an individual (or team, or organization) is consciously trying to accomplish; they affect behavior and job performance by directing attention and action. Values, in their assessment, guide our behavior because we desire to behave in ways that align with our principles. Challenging goals are more likely to lead to higher energy, effort, and persistence, because they motivate people to develop strategies that allow them to perform at the level the goal requires. Accomplishing a goal can lead to satisfaction and further motivation (Lunenburg, 2011). Therefore, the most effective performance results occur when

goals are specific and challenging, when they are used to evaluate performance, and when they enhance the commitment and acceptance of the goal-seeker (see Lunenburg, 2011 for review).

Organizations often don't set just one goal, but rather have a *goal system* with super- and subordinate goals (Gagné, 2018). Superordinate goals delineate an organization's "why", or their mission, while subordinate goals (also called strategic goals) support the greater mission goals of the organization. Organizational goals are also constantly changing, which allows the system to be dynamic, but also makes it challenging to maintain organizational focus long enough to find success. Furthermore, deficit-oriented, problem-focused goals (e.g. reducing burnout) may limit the potential for growth beyond mere remediation of the problem, whereas positive goals (e.g. promoting well-being) direct organizational attention and effort *toward* growth (Cooperider, 2017, Ogbeiwi, 2018). Overall, there is currently a lack of empirical studies on the effectiveness of specific goal-setting strategies within healthcare organizations (Ogbeiwi, 2018).

When creating a goal, it is especially important to include stakeholder's opinions and ideas. In a healthcare organization, this may mean the employees (MDs, NPs, RNs, social workers, etc.) as well as board members, volunteers, executives and patients. Allowing employees to take part in the goal-setting process is especially important, as it not only allows for a more collaborative process, but also makes it more likely that employees will accept and commit to the objectives (Fairfield, Wagner, & Victory, 2004; Carper, 2015; Barsy, 2007). Collaborative leadership styles may be especially valuable for joint goal-setting efforts, as leaders optimize the diversity of backgrounds, knowledge, and styles within the organization enabling achievement of complicated goals (Al-Sawai, 2013). The use of specific and clearly defined goals is especially effective, in this case because goal clarity has been found to improve team collaboration and performance in a variety of settings (Walston & Chou, 2006; Van der

Hoek, Groeneveld, & Kuipers, 2018), as well as reduce turnover and absenteeism (Locke & Latham, 2002).

Well-executed goals are supported by comprehensive implementation plans. Implementation plans, or *how* a goal is to be accomplished, should be as specific as possible and discussed using an 'if-then'-type framework (Gagné, 2018). Effective implementation plans also discuss how to measure progress towards a goal, and establish routines to elicit useful feedback from the organization (Gonzalez-Mulé et al., 2016; Walston & Chou, 2006; Fairfield, Wagner, & Victory, 2004).

An organization is much more likely to succeed in bringing about change when it has a compelling vision to pursue. Accordingly we recommend that the PWBC create a clear and inspiring vision to guide future efforts. Significantly, there is clear evidence that the process of goal-setting, the goals themselves, and the measurement of those goals have a positive impact on the way organizations perform; therefore, the PWBC should also seek to utilize proper goal-setting techniques in order to effectively achieve its goals.

Employee Engagement

If a program is to succeed, it must engage the participants it is meant to serve. Any burnout program created for clinicians faces inherent and significant barriers to adoption due to the particular characteristics of its intended recipients. Feeling overburdened with too many work-related tasks and spending too many hours on work-related activities are the two most frequently reported factors contributing to physician burnout (Medscape, 2020). Recognizing the extreme demands on the time and attention placed on physicians, physician assistants, and nurses, a systematic analysis of 175 articles was used to identify a model of clinician engagement

that identifies the salient components of organizational culture and program design for maximizing clinician engagement (Perreira et al., 2019):

Environment Factors (Antecedent to Engagement):

1. **Accountability—**Clinical staff take responsibility for patient outcomes and system performance, and seek to improve both.
2. **Communication—**Communications between staff favors the sharing of information that is valid and reliable, and feedback that is non-judgmental and objective.
3. **Incentives—**Whether financial or non-financial, incentives for participation are publicly known, aligned with the goals of the organization, and focus on rewarding value over volume.
4. **Interpersonal—**Opportunities for developing relationships across different areas of responsibility and work locations are encouraged in order to promote greater trust and respect, and to reaffirm organizational values.
5. **Opportunity—**Flexibility to partake in improvement projects, as well as to be involved in the creation and delivery of programs.

Program Factors (Design for Engagement):

1. **Tailored—**Designed and delivered with both the needs and constraints of clinician's time and attention in mind.
2. **Feedback Driven—**Actively evolving in response to solicited feedback from participants.
3. **Goal Oriented—**Built to address specific needs within set periods of time as established by participants.

4. **Inclusive—**Actively including clinical staff to serve in the planning, design, and delivery of programs.
5. **Aligned with Performance Objectives—**Outcomes tied not only to the well-being of the program participant, but to the health and well-being of patients served, and the success of the organization.

While this is not an exhaustive list of the factors necessary for successful environmental and program design, they are factors common to several of the most successful hospital well-being programs in the country, including:

1. **WellMD at Stanford Medical Center—**Introduced a "Time Banking" program where staff were allowed paid time for non-clinical services, including mentoring and committee service (Incentives, Interpersonal). Publicly recognized staff for services performed outside of work (Communication, Incentives, Opportunity). Worked with different teams to create programs that suited different sub-cultures within the hospital (Tailored, Feedback Driven, Inclusive) (Fassiotto et al., 2018).
2. **SWADDLE at Baylor Medical Center—** A staff-focused support program geared toward assisting individuals through difficult life events. Used feedback from its staff to ensure services were delivered timely and from peers (Interpersonal, Feedback Driven). Addressed not only the diversity of staff but the diversity of individual presentations of difficult or unanticipated life events (Tailored). Focused on robust communication skills (Communication, Interpersonal) (Fassiotto et al., 2018).
3. **LiveWELL (Work, Eat, Learn & Live) at Carolinas Healthcare Center—**A program designed by a wellness task force made up of representatives from across the entire organization's constituent groups (Opportunity, Accountability). Created new

interventions with outcomes measures tied to both participant well-being and organizational success (Goal Oriented, Aligned with Performance Objectives). Scheduled future planning retreats for program refinement (Opportunity) (Mari, Chapman, & Rink, 2008).

As the Provider Wellness and Burnout Council prepares to expand its reach and build on previous success, it will need tools that not only address well-being requirements, but also program design and deployment needs.

In summary overall, we believe insight into provider well-being, appreciative inquiry, goal setting, and clinician engagement will serve the PWBC's mission of reducing burnout and advancing well-being at MidMichigan Health.

APPLICATION PLAN

Short-Term Plan: Resilience during COVID-19

The main thrust of our proposal for MidMichigan Health is a long-term, AI-driven plan to establish a provider well-being vision that will be embraced by the entire organization.

However, we have also created an immediate-term plan for addressing the need for greater provider resilience. This is not a deferral from our focus on enabling long-term strategy; it is merely the necessary acknowledgement that positive psychology is not practiced in a vacuum, and that the unprecedented strain to our healthcare system caused by the ongoing COVID-19 pandemic requires immediate crisis interventions. By delivering a short-term resilience strategy for MidMichigan Health providers, our team believes we can not only help their employees weather the current period of emergency, but help set the stage for the radical transformation to our healthcare system expected to follow the pandemic. In other words, our first proposal using positive psychology will be to offer hope to the people who are not only enduring this unprecedented moment in history, but will one day thrive as providers in the future, well-being-oriented system of healthcare they can build in the aftermath of this crisis.

Our short-term application is centered on the delivery of micro-interventions targeted at facilitating resilience in healthcare providers. Resilience, and particularly, resilience in provider populations, is a construct supported by three interconnected domains, including: 1) the Individual, or cognitive/knowledge dimension; 2) the Micro-organizational, or team/intergroup dynamics dimension; and 3) the Macro-organizational, or broader organizational/cultural dimension (Jeffcot, Ibrahim, & Cameron, 2009). Using this model, any approach to crafting and deploying resilience interventions within healthcare settings must consider the unique challenges and stressors of each dimension; this includes individual practitioners struggling with burnout, as

well as the cooperative friction between individual teams, and the broader organizational concerns related to occupational safety and efficiency. For this reason, the most widely adopted and successfully implemented resilience-building interventions support the development of psychological resilience in individuals, as well as the development of resilient culture within the organization (Epstein & Krasner, 2013). As a last point of consideration, it is critical in times of crisis that interventions be tailored to require a minimal investment of time on behalf of the intended recipients; thankfully, research has shown that a great variety of micro-interventions for resilience-building have been effective in provider settings (Strauman et al., 2015).

After integrating these many factors influencing the success of resilience interventions, we have developed a poster for use by the PWBC under Appendix A. The poster provides three simple, one-minute, resilience building interventions that are designed to shift perspective and increase well-being. The recommendations include deep breathing, cognitive reframing, and expressing gratitude.. Each of the suggestions are evidence-based. Further description and citations can be found in Appendix A.

Long-Term Plan: An Appreciative Inquiry Approach

After resolution of the COVID-19 crisis, we propose that the PWBC embark on a one-year long, comprehensive appreciative inquiry (AI) effort centered around provider well-being. We believe that an appreciative inquiry process will enable MidMichigan Health to identify its existing strengths, values, and assets, develop a clear and compelling vision to promote well-being (thereby also reducing burnout), and involve stakeholders at every level of the organization, thereby meeting the MMH's biggest goals in support of provider well-being. Below we propose a suggested implementation for this AI, modeled on the 4D approach mentioned earlier in this paper, with adjustments made for practicality constraints. We encourage the PWBC to consider this plan in its entirety and to adapt it however they see fit to meet their needs, goals, and constraints.

Setup (2 months)

An Appreciative Inquiry process begins by identifying a guiding theme for the inquiry. This theme captures the positive, aspirational intent of the inquiry and serves as a powerful statement for igniting interest and engagement with the inquiry. We suggest that this inquiry revolve around provider well-being and engagement at MidMichigan Health. For example, the theme might be "Thriving and Connection at MidMichigan Health". We invite the PWBC to develop a theme that captures their aspirations and focus with compelling language.

Once a theme is identified, a team representative of every stakeholder group at MidMichigan Health will need to be assembled. This team will participate in the year-long AI, directed and coordinated by the PWBC or specific appointed leaders. The AI process emphasizes the value of collecting input from every member of an organization as discussed earlier in this

paper; given the size of MMH, a smaller group representative of the organization as a whole is more practical. Therefore, we propose the PWBC reach out to every arm of MMH to identify motivated, interested volunteers to form this team. It is crucial that this team include participants of every major demographic at MMH; this includes roles (executives, PWBC members, physicians, DOs, physician assistants, nurses, techs, administrative staff, patients, business partners, etc.) and location (representatives from all of MidMichigan Health's various clinical sites). The size of the team will depend on interest among MMH employees and practicality of management by the PWBC; we recommend a minimum of 50 participants.

With a theme and a team created, we next recommend the PWBC formally kick off the AI process. Given the existing well-received annual retreat, we suggest this kick-off may be conducted at the retreat, where members of the AI team can become acquainted, build excitement around the project, and be trained on how to begin the 4D process outlined below.

Discover (3 months)

The Discover process involves identifying the existing positive core (strengths, values, assets, etc) in an institution. During the Discover phase, the AI team will collect people's perspectives across the institution about MidMichigan Health at its best.

We propose the entire team be interviewed and that every member of the team also interview as many people as possible at MMH across every major stakeholder group. We recommend team members interview people both similar and different to them in roles (e.g. nurses interviewing physicians, executives interviewing techs, etc.). We recommend these interviews use structured questions to ensure consistency in inquiry. We recommend these interviews be recorded or summarized to facilitate analysis of the information. Interviews may be

augmented by distribution of online surveys to a wider sample at MidMichigan Health, but we emphasize the importance of the in-person conversations to the Discover process. This process will ensure collection of hundreds (or even thousands) of perspectives, involve every member of the team, initiate positive conversations and interest about the process throughout MMH, and foster dialogue between groups that may not ordinarily communicate much, while also distributing the workload evenly.

These interviews will consist of conversations focusing on existing provider thriving and engagement at MMH. For example, team members might ask employees about what they believe it takes to thrive at MMH, when they feel most alive in their work, when they feel most connected to their peers, who among their peers they feel is thriving, etc. A collection of suitable questions is included in the Appendix and we encourage the team to develop questions as well. The team might further explore MMH's positive core as it pertains to the COVID-19 crisis (e.g. "What helped you survive and thrive most during the outbreak?"). We also encourage the interviewers to ask about people's aspirations for well-being at MMH and imagine MMH at a visionary, future best (this information will become relevant during the Dream phase).

These interviews will provide the AI team with many perspectives on existing excellence at MidMichigan Health, how people already thrive there, and what assets support that thriving. Once the interviews are conducted, we recommend the interviews be analyzed for consistent themes and innovative ideas and that this information be collated into some reference material. This information will be used in subsequent steps of the 4D process, to develop a vision and identify resources to achieve that vision.

Dream (1 month)

The Dream process involves developing a future aspirational vision for an organization at its best. For MidMichigan Health, this will involve conceiving of providers in the organization at their highest level of thriving, engagement, and connection.

One way to approach this process is to imagine the organization five to ten years in the future, having accomplished its greatest goals related to well-being. What does the organization look like? What is the experience of providers like? What is the culture of the institution? What across the institution is different from now? What is the same? See the Appendix for more ideas for the Dream phase.

We recommend the PWBC convene meetings with the AI Team to collaboratively explore these ideas and build a shared dream for well-being and engagement at MMH. This is best accomplished in a summit setting, where all members of the team can be present in one place to engage in this dialogue. If this is impractical, multiple smaller meetings are also acceptable. During this phase, the AI Team will draw upon insights revealed during the Discover process to build an aspirational vision for MMH.

Design (6 months)

The Design phase involves distilling the vision developed during the Dream phase into more concrete, applicable plans. For MidMichigan Health, this phase will involve: 1) developing a multi-dimensional definition of provider well-being and thriving, as discussed earlier in this paper, 2) developing a robust vision statement for provider well-being and engagement (much like a mission statement, this vision statement will serve as a guide for future well-being oriented

work at MMH), and 3) developing explicit, clearly defined, achievable short-term and long-term goals to realize this vision.

During this process, the AI Team will utilize its knowledge of MMH's existing positive core uncovered during the Discover phase to identify potentially fruitful avenues to pursue the vision developed during the Dream phase. In addition to identifying existing assets, we also recommend the AI Team identify what additional resources, support, and collaborators they will need to achieve their goals. Further, we recommend identifying which goals are most essential, most high yield, and most immediately achievable. This will inform big picture priorities, efficient approaches, and places to start, respectively.

We recommend this process be conducted through a combination of large meetings of the AI Team, delegation of various aspects to smaller groups within the AI Team, and consultation and continued input from key stakeholders and members throughout the organization.

Destiny (ongoing)

The Destiny phase involves implementation and ongoing refinement of the plans made during the Design phase. During this phase, the PWBC and the AI Team will reveal their new vision to the entire organization and execute on goals.

We recommend this phase be initiated by a large kick-off campaign, involving centralized communication sent out to every member of MidMichigan Health, as well as meetings, discussions, and town halls held at various clinical sites as the PWBC sees fit. Alongside this central campaign, we encourage every member of the AI Team to engage peers about this well-being vision to build peer-to-peer interest and excitement throughout the organization.

In addition to implementation of the plans made during the Design phase, it will be essential for the PWBC to measure the success of these various efforts. We recommend the continued use of the Mini-Z, in which we expect to see decreasing burnout over time as this vision is implemented. We also recommend use of a measure to evaluate provider well-being. The precise measures used will depend upon the definition of provider well-being conceived by the AI Team. Some suggested tools may include: 1) the Satisfaction With Life scale, a validated, reliable tool to measure overall life satisfaction (Diener, Emmons, Larson, & Griffin, 1985); 2) the Quality of Life inventory, which examines life satisfaction with attention to various, specific life domains (Frisch et al., 1992), and 3) the Work-Life Questionnaire, which evaluates individuals' relationship to their work as either a job, career, or calling, which predicts various features of engagement and satisfaction with work (Wrześniewski et al., 1997). In addition to quantitative data, we further encourage collection of qualitative feedback from employees across MMH.

We also encourage the PWBC to meet regularly to evaluate implementation of the vision and steer this process as needed. In addition to regular oversight by the PWBC, we also encourage a larger meeting at least bi-annually or annually to more rigorously evaluate and continue to refine MMH's well-being vision and plan.

Additional Considerations

The ongoing COVID-19 pandemic poses a major limitation to this plan. We recognize that presently MMH must focus its resources on managing the surge in demand for care due to the epidemic and that the scale of work proposed in this plan is not feasible until the COVID-19 crisis subsides. Moreover, we recognize that even after the crisis stabilizes, MMH's resources

will need to be allocated to rebuilding and capacity development. Therefore, we encourage this plan to be deferred to a time when it is appropriate. However, as noted earlier in this paper, we also believe this period of rebuilding is also an opportune time to advocate for a well-being vision and so we encourage the PWBC to consider preparing for this opportunity in line with this application plan.

We also acknowledge that the scale of this plan is large and entails organization-wide change. This level of change is ambitious and may appear daunting upfront. However, we believe that organization-wide shift in culture and commitment to well-being is the only way to uphold provider well-being and prevent burnout in a meaningful, lasting way. That said, we also respect practicality constraints and encourage MMH and the PWBC to adapt this plan however they see fit. The scale of change, time frame, amount of participants, and scope of inquiry may all be adjusted to levels more fit to the readiness and capacity of the organization. While a less involved appreciative inquiry may mean less overall impact, any amount of organizational growth in service of well-being is worthwhile (especially if the alternative is no growth at all). Moreover, a guiding vision and execution of that vision is revised and renewed constantly throughout an organization's life and therefore the entirety of MMH's well-being potential does not have to be realized in a brief period of time; this is a process that can evolve ongoingly.

We additionally acknowledge that the scale of this plan may be outside the scope of the PWBC, which consists of volunteers with significant clinical and administrative duties in addition to council work. The plan as proposed requires significant resources, time, and coordination of many people across many locations. With this in mind, we suggest the PWBC and MMH's executive team consider avenues to protect time and offer compensation for this

work, convene larger teams and hire experts to direct this work, and leverage a motivated volunteer force to further distribute the work.

Further, we appreciate that MMH is not experienced with conducting an appreciative inquiry. Given the logistical obstacles already noted as well, this inexperience makes execution of our application plan even more challenging. Therefore, we encourage the PWBC to consider hiring outside experts to guide the appreciative inquiry process. The David L. Cooperrider Center for Appreciative Inquiry at Champlain College, for example, is home to a team of skilled appreciative inquiry practitioners and offers opportunities to engage in appreciative coaching sessions in small or large organizational summits (Champlain College, 2020). The Center for Appreciative Practice at University of Virginia also consults on appreciative inquiry as it pertains to healthcare settings (UVA School of Nursing, 2020). We also offer the encouragement that appreciative inquiry has been successfully deployed for major organizational change in health care settings before (Moody, Horton-Deutsch, & Pesut, 2008, Cottingham et al., 2008).

CONCLUSION

In summary, we believe this proposal outlines a clear evaluation of MidMichigan Health, the Provider Wellness and Burnout Council, efforts to support well-being at MMH so far, and evidence-based approaches to strengthen this work using positive psychology using the science of provider well-being, appreciative inquiry, goal setting, and engagement.

We applaud the PWBC for their achievements thus far; they have demonstrated considerable initiative, amassed significant organizational support for their mission, and accomplished meaningful reduction of burnout in only two years. That said, we believe positive psychology can aid the PWBC in their work. In the short-term, we propose deployment of readily available resilience strategies to support providers through the heightened stress of the COVID-19 crisis. In the long-term, we encourage MMH to embark on an appreciative inquiry process to develop a clear, robust positive vision to guide all future well-being work and involve stakeholders at every level of the institution to realize that vision together.

Our proposal is ambitious and bold and, we believe, well matched to the potential and passion of the PWBC and MMH as a whole. By developing an organization-wide commitment to well-being, MidMichigan Health has the opportunity to create an environment of thriving, engagement, and meaning among every member of the organization and distinguish itself as a leader in the future of medicine nation-wide. We believe in you and our team offers our heartfelt support for this journey.

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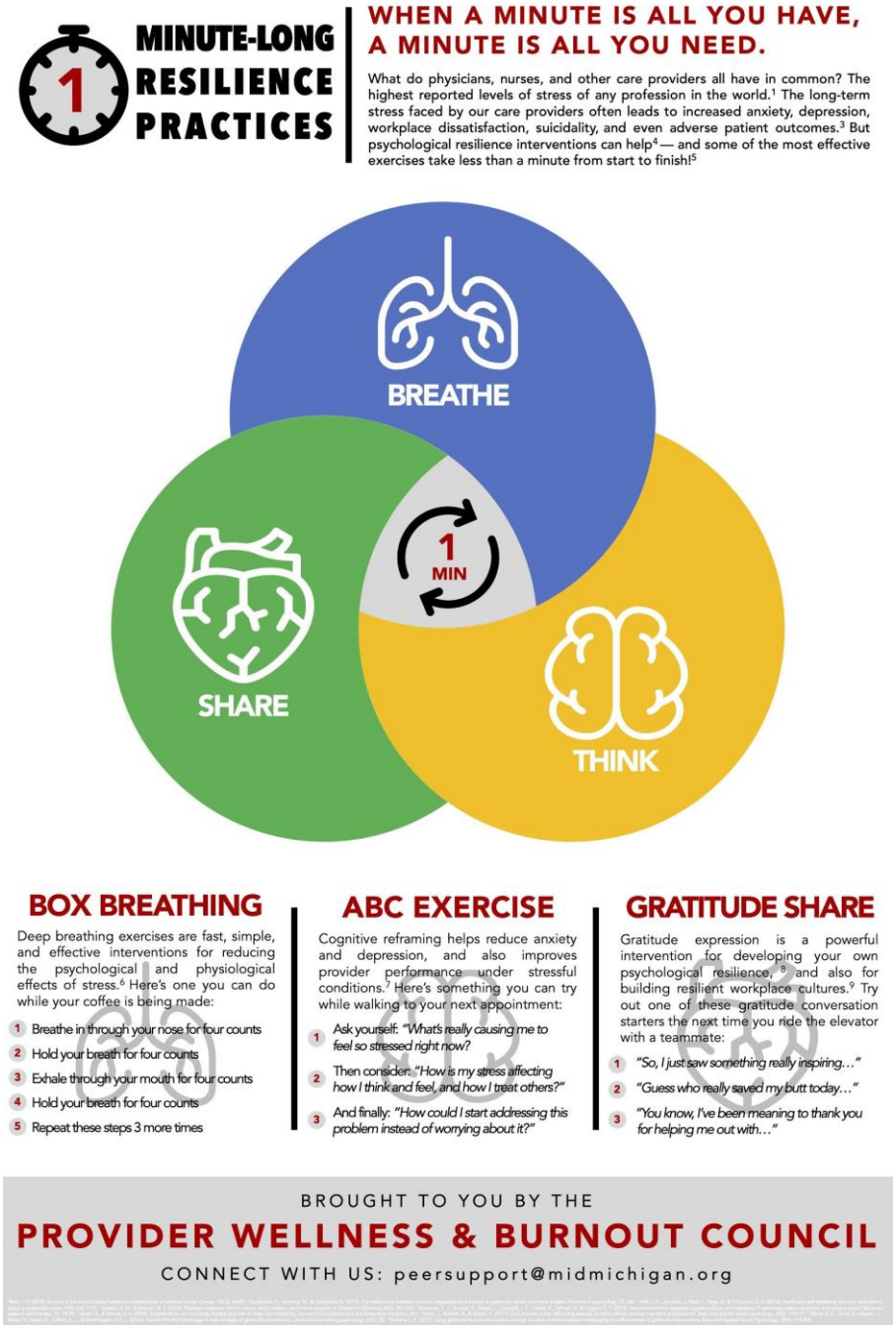
Appendix A

Resilience Materials



Appendix B

Appreciative Inquiry Materials

Stages of Appreciative Inquiry:

Discovery — Acknowledging and appreciating the existing strengths of the organization

Dream — Imagining and appreciating what the organization is capable of achieving

Design — Deciding which dreams are best aligned with the existing strengths and needs of the organization

Delivery — Creating and executing a plan to achieve these organizational dreams

Guiding Principles for Successful AI Events:

Make Positivity the Primary Focus

- Search for strengths to maximize instead of weaknesses to diminish.
- Frame all questions in positive terms, i.e.; "What do patients love about staying in our inpatient unit?" rather than "What is the biggest complaint we hear from patients during checkout from the ICU?"
- Allow examples of positive outcomes from the organization's past to serve as the inspiration and motivation for shaping its future.

Encourage Sharing

- Seek: The most successful AI programs seek to hear from the greatest number and broadest representation of the organizational population.

- Invite: All participants are invited to share personal perspectives and experiences to encourage greater interpersonal relationships and a deeper commitment to the process.
- Experience/Appreciate: All participants will appreciate that engaging with the process of AI produces its own benefits to well-being, including positive emotions and deeper interpersonal relationships.

Leave Room for Innovation and Improvisation

- Encourage the participants to use this time to generate new approaches and apparatuses of success; a successful event will do a good job of generating lots of ideas, rather than the “right idea”.
- Moderate interactions in a way that promotes greater psychological safety and positive risk taking amongst participants.

Appendix C

Designing a vision statement

- *Mission statements* are present-based and designed to convey a sense of why the business exists to both members of the company and the external community.

- *Vision statements* are future-based and meant to inspire and give direction to employees rather than customers. A vision statement is often described as a "north star" – a never-ending goal that your organization commits to strive towards forever. It shouldn't be changed too often.

Guiding Questions:

- What ultimate impact do I want my organization to have on my community/industry/world?
- Why does our organization exist?
- What does success look like in our organization?
- How do we do things differently, better, or more efficiently?
- What should or shouldn't we do to achieve our objective?
- What will the culture of my organization look like, and how will that play out in employees' lives?

Tips:

- Involve as many people as possible in crafting.
- Project five to 10 years in the future.
- Dream big and focus on success.

- Describe a measurable goal.
- Use the present tense.
- Use clear, concise, jargon-free language.
- Infuse it with passion and make it inspiring.
- Align it with your business values and goals.
- Prepare a change team to articulate the vision throughout the organization.
- Be prepared to make hard decisions, give challenging feedback, and disrupt the status quo to reach for the vision.
- Be prepared to commit time and resources to the vision you establish.

Some examples of great vision statements:

- **Nike:** “Bring inspiration and innovation to every athlete* in the world. (*If you have a body, you are an athlete.)”
- **Amazon:** "Our vision is to be earth's most customer centric company; to build a place where people can come to find and discover anything they might want to buy online."
- **Wyclef:** “To lead the way to a healthier world. By carrying out this vision at every level of our organization, we will be recognized by our employees, customers & shareholders as the best pharmaceutical company in the world, resulting in value for all.”

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