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Strategies to Reduce Burnout

12 Actions to Create the Ideal Workplace

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MAYO CLINIC SCIENTIFIC PRESS

<As always, text embedded with angle brackets (< … >) are my observations, comments, criticisms, and questions.>

<This book is important because it presents a comprehensive, evidence-based, deployable “how to” around

1) Leadership development; and
2) Clinical workforce engagement.

There is a general logic chain that underlies clinical workforce engagement as essential to care delivery operations. Swensen and Shanafelt includes citations documenting most of the major elements in the chain. Key idea: **workforce engagement** is the foundation of any high-performing organization.

1. Engagement drives financial performance. Highly engaged workers are 2 to 5 times more productive than disengaged workers.

   Jill Green, while COO of Mission Health in North Carolina, used this to turn around that financially struggling health care system. As the proportion of workers who were fully engaged rose from about 14% to about 40%, financial performance moved from deeply red to impressively in the black (from Jill Green’s talk at Health Catalyst’s Health Analytic Summit 2019).

2. Engagement is a necessary element for safe, high quality health care. Within any health care delivery environment, evidence suggests that it is not possible to deliver high quality, safe care with a disengaged frontline clinical workforce.

3. Engagement drives external ratings of patient experience of care. The level of frontline clinical workforce engagement translates directly into patient experience of care, independent of technical measures of quality of care. Engagement is a very potent lever for achieving high patient satisfaction scores.

4. Engagement is easy to measure, using validated measurement tools. The simplest, but still very effective, measure is Reich’s “pronoun test” – “we/us” versus “they/them.”

While Swensen and Shanafelt frame their title in terms of clinician burnout, burnout is just one extreme symptom associated with, or perhaps even producing, low clinician engagement. This book goes well beyond the idea of burnout, to principles of full engagement, excellent quality, full patient safety, and aligned top-end financial performance.>

Near the end of the book (pgs. 272-275) Swensen and Shanafelt present a general model that outlines the main content of the book. It is built around 3 primary elements: (1) clinician **Well-being** (2) **Depleting Factors**; and (3) the **Intervention Triad** (agency, coherence, and camaraderie). The model is used to describe a series of states that an organization may occupy, balancing **esprit de corps** versus **burnout**:

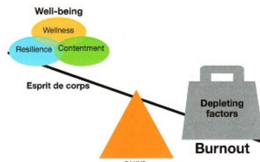

Figure 34.4. Organization Not Attending to the Well-being of Health Care Professionals or Mitigating Depleting Factors. Depleting factors outweigh replenishing factors.

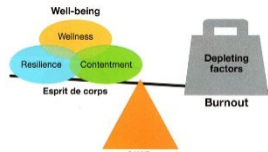

Figure 34.5. Organization Focused on Promoting Well-being Without Mitigating Depleting Factors.

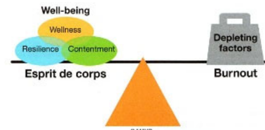

Figure 34.6. Organization Focused on Reducing Depleting Factors Without Attending to Well-being.

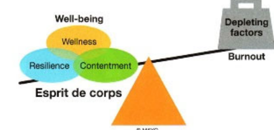

Figure 34.7. Organization Focused on Reducing Depleting Factors and Promoting Well-being Without Implementing the Intervention Triad.

1 – No program | **2 – Focus on Well-being only** | **3 – Focus on Depleting Factors only** | **4 – Focus on both Well-being and Depleting Factors**

Effective programs include all 3 primary elements, addressing Well-being, Depleting Factors, and the Intervention Triad:

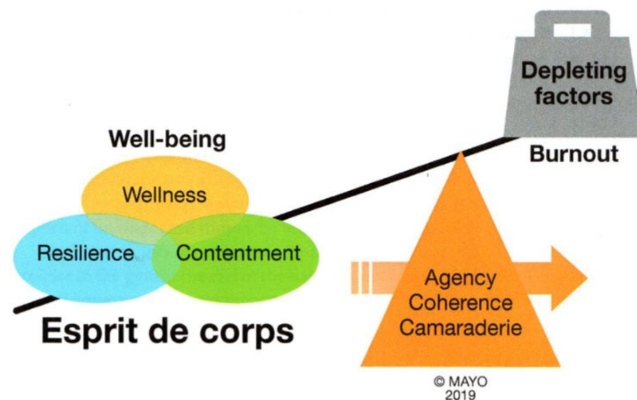

Figure 34.8. Organization Using a Holistic Approach of Implementing Actions of the Intervention Triad. This approach shifts the fulcrum to the right, further mitigating burnout while reducing depleting factors and promoting well-being. This is the ideal state for organizations and health care professionals and can be reached by following the Blueprint for cultivating esprit de corps.

Note that a successful program makes well-being bigger, depleting factors smaller, and slides the Intervention Triad fulcrum in a favorable direction.

A mistake to avoid (pg. 281)**: "**It should be emphasized that burnout is mainly caused by systems, leaders, and characteristics of the work environment, not by a deficiency in personal well-being or resilience. Leaders … often make the mistake of starting individual-focused programs that imply that the cause of burnout is … lack of resilience on the part of the health care professional. … Organizational and occupational scientists refer to this of the "strong worker" mindset … [I]t was debunked as an inaccurate and flawed framework decades ago."

Losada Ratio (pg. 49-50): the proportion of the positivity in a system (i.e., the number of comments or events that showed support, encouragement, or appreciation) relative to its negativity i.e., the number

of comments or events that showed sarcasm, disapproval, or cynicism). **A Losada Ratio of 3 positives for every negative is the minimum ratio for satisfactory team performance. A Losada Ratio of ~6:1 is highly correlated with superior team performance**. By way of example, decreasing clinical work or making work more efficient increases the Losada Ratio by decreasing negativity, while cultivating community, celebrating achievement, or telling a story about a great patient outcome increases the Losada Ratio via the positive side.

Introduction to Intervention Triad Action Sets (pg. 50): Lists of specific management actions around 3 essential areas – **Agency** (autonomy – the capacity of individuals or teams to act independently); **Coherence** (where all parts of an organization fit comfortably together to form a united whole); and **Camaraderie** (social capital, mutual respect, and teamwork, plus eliminating internal boundaries to shared ownership of the organization's mission)

8 Ideal Work Elements (pg. 56):
1) Community at work and camaraderie
2) Intrinsic motivation and rewards
3) Control over and flexibility around one's work
4) Fairness and equity that acknowledges human limitations, in a framework of self-evaluation and compassionate improvement (not shame and blame)
5) Professional development and mentorship
6) Partnership – participative management, functioning as teammates and allies in co-creation and continuous improvement of the work environment
7) Safety – physical and psychological security
8) Trust and respect

The 20% Rule (pg. 58) – is your workplace a job (the paycheck), a career (advancement, titles, recognition), or a calling (an end rather than a means, leave the world a better place, connect to intrinsic purpose in life)

A top determinant of happiness (in general) is meaningful work. The 8 Ideal Work Elements are the building blocks of meaning and purpose in work. **Physicians who spent >20% of their time in their most meaningful work-related activity had half the burnout rate of those with smaller percentages**. Although everyone would like to spend 100% of their work time on the things that they care the most about, the critical lower threshold amount is 20%. So, identify and rank the work-related things that give purpose to people, and make sure the high end gets enough time.

<In other publications, Swensen expresses these ideas as "ikigai" and "kindness." "*Ikigai* is an ancient Japanese concept meaning 'one's reason for being'. Ikigai is associated with longevity and may be one of the reasons that Okinawa, Japan, has the highest proportion of centenarians in the world. Ikigai is a helpful concept to understand intrinsic reward and recognition in our professional lives. It is the confluence of three personal determinations: (a) what one finds meaningful, (b) what one is good at and (c) what the world needs." To Swensen, "kindness is helping others do better," within the context of ikigai.>

The 4 motivators that cause managers to focus attention on burnout (pg. 61):
1) The moral-ethical case – a focus on worker welfare and well-being
2) The business case – evidence showing that burnout damages quality, patient safety, patient experience, productivity, and financial performance
3) The regulatory case – external pressures from groups like the Joint Commission and ACGME
4) The tragic case – a tragic event, such as a suicide, either has happened or is perceived as likely to happen

Critical Success Factors Worksheet (pg. 68): An 8-question self-assessment form, using a 5 point scale (1 = no action, 5 = achieved/completed), to be applied at the level of senior leaders. Really a deployment plan.

Stanford Medicine case study (pg. 68): A nice case study of significant positive effects achieved over 2 years by applying the ideas outlined so far. Definitely worth a look.

Social capital is a key element (pg. 73) – pronoun test (defined here, but see pg. 91 below)
Assessing social capital

1) annual survey – content (pg. 74)
2) measures of efficiency of practice, e.g., pajama time (pg. 75)

What leaders choose to measure and focus on sends a message to employees (pg. 75)

3) Actual measures
    a. Leadership behavior
    b. Teamwork and team dynamics
    c. Professional fulfillment, burnout, and personal wellbeing
    d. Psychological safety
    e. Alignment with mission

Swensen & Shanafelt's list of key clinical service processes in an outpatient setting (pg. 86):

1) Triage
2) Scheduling
3) Rooming
4) Team-based (actual) care delivery
5) Order entry and execution
6) f/u planning

Outline of "Agency Actions" and "Primary Burnout Drivers Addressed by Agency Actions", and "Ideal Work Elements cultivated by Agency Actions" (pg. 89)

Agency Actions:

1) Measuring leadership behaviors
2) Removing pebbles
3) Introducing control and flexibility
4) Creating a Values Alignment Compact

Graphic mapping the detailed Action Set management actions across the 8 Ideal Work Elements (pg. 87; Figure 10.2). Includes **primary objectives within each of the 3 Action Sets**. Each of the 8 Ideal Work Elements maps into every one of the 3 Action Sets. More detailed descriptions of each of the management actions contained in the 3 Action Sets, is back on pg. 50.

Action Sets of the Intervention Triad	Ideal Work Elements							
	Community at Work and Camaraderie	Intrinsic Motivation and Rewards	Control and Flexibility	Fairness and Equity	Professional Development and Mentorship	Partnership	Safety	Trust and Respect
Agency			★			★		★
Measuring leader behaviors					X	X		X
Removing pebbles	X		X			X		X
Introducing control and flexibility		X	X			X		X
Creating a Values Alignment Compact		X		X		X		X
Coherence				★	★		★	
Selecting and developing leaders				X	X			X
Improving practice efficiency			X		X			X
Establishing fair and just accountability		X					X	X
Forming safe havens				X			X	
Camaraderie	★	★						
Cultivating community and commensality	X	X				X		
Optimizing rewards, recognition, and appreciation		X		X				X
Fostering boundary-lessness	X		X			X	X	

★ Primary objective of the Action Set
X Ideal Work Element impacted by the action

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Figure 10.2. Association of Ideal Work Elements and Action Sets.

Key Aim: Partnership (pg. 91)
"Health care professionals should be treated as partners, never as employees."

Expansion of pronoun test, within a partnership framework (pg. 91)
Pronoun test (Robert Reich, former U.S. Secr of Labor): Do employees refer to the organization and its leaders as "we/us" in contrast to "they/them." This is a direct, accurate measure of social capital in the organization. "We/us" implies trust, inconnectedness, and shared mission.

Organizational structure: Farmer's Market vs. Partnership Market (pg. 92-93)
Farmer's Market = a location where independent "farmers" sell their products, to the benefit of the farmers and the market itself
- organizer wants as many merchants as possible and to fill all the stalls
- not aligned to any sort of shared mission
- difficult to build high-trust multidisciplinary teams
- hard to standardize care processes for safety and efficiency
- physician-hospital relationship is based on volume or operating margins generated
- compensation based on production; "work harder" approach – leads directly to burnout
- MD = "dispensable/replaceable" revenue center
- physicians speak of organization as "they/them"

Partnership Market = culture is purposefully one of collaboration, coordination, and cooperation
- physicians selected and developed so that behaviors and actions are aligned with the mission, strategy, and vision of the organization
- care professionals feel a sense of shared ownership built around mission, vision and values – "anti-burnout"

- "work smarter" / more efficiently approach
- speak in terms of "we/us"
- view their relationship with the organization as a partnership

Trust is the key element; TRUST = RESPECT (pg. 95)
Groups that show high levels of trust/respect, compared to those that do not, empirically have:

1) 4x higher productivity
2) 90% lower turnover
3) 3x higher stock market returns
4) Much higher levels of innovation

Excessive performance metrics imposed on professionals by management directly implies lack of trust; whenever possible, such metrics should be eliminated and professionals trusted to do the right things.

<Discussion point: How does this idea of trust/respect link to engagement?>

20% threshold (pg. 100)
MDs who spend at least 20% of their time focused on the aspect of their work that they find most personally meaningful will have 50% lower burnout rates

<this matches Michael Marmot's findings, in *Status Effect*, regarding health effects associated with control of one's personal life>

Signature size (pg. 105)
Leaders with large signatures had higher compensation than those with small signatures, but their organizations performed significantly more poorly. "Big signature" leaders tended to focus on themselves, while "small signature leaders" focused on the organization and the people working within it.

Leadership Behavior Index (pg. 107)
A person's immediate leader/manager is the single biggest driver of professional satisfaction – nothing else even comes close. People quit their supervisor, not their job.

See the 12-item questionnaire by which Mayo employees annually evaluate their supervisor, to whom they report – Box 15.2, pg. 107. Each evaluated on a 1 to 5 scale, then added up.

1. Holds career development conversations with me
2. Inspires me to do my best
3. Empowers me to do my job
4. Is interested in my opinion
5. Encourages employees to suggest ideas for improvement
6. Treats me with respect and dignity
7. Provides helpful feedback and coaching on my performance
8. Recognizes me for a job well done
9. Keeps me informed about changes taking place at (*my organization*)
10. Encourages me to develop my talents and skills
11. I would recommend working for (*name of my immediate supervisor*)
12. Overall, how satisfied are you with (*name of my immediate supervisor*)

5 Leadership Behaviors (pg. 108)
A way to organize the Leadership Behavior Index, above. Leaders –

Include: Treat everyone with respect and create a culture where all are welcome, with psychological safety
Inform: Transparently share what they know with the team
Inquire: Consistently solicit input (participatory management)
Develop: Nurture and support the professional development and aspirations of staff
Recognize: Express appreciation and gratitude in an authentic way

Questions to ask in leadership development interviews (pg. 111)
Framework: The leader in conversation with each person they supervise

1. What brings you the most meaning (or professional fulfillment) at work right now?
2. How do you see that interest developing over the next several years?
3. What next steps do you want to pursue as you develop that interest?
4. How can I help?

<u>**Removing Pebbles**</u> (Chapter 16)
It starts with "what matters to you?" (pg. 122)
Recommended "tool:" Ask-Listen-Empower-(and Repeat)

<Also take a look at Melinda Ashton's Get Rid Of Stupid Stuff (GROSS) article in the New Engl J Med>

A detailed layout of DMAIC (6 Sigma) as an approach to "data-based problem solving" (pg. 131)

Conclusion (pg. 133) – a nice summary
"Removing Pebbles … involves engaging and empowering frontline health care professionals to identify and solve local sources of frustration." The section then notes how this links to the other leadership actions, making them "real."

List of Mayo principles for differentiating managers from leaders (pg. 139): Managers demand adherence to process, while leaders focus on outcomes and involve front line people in working out the process.

<u>**Agency**</u> (Chapter 18)
Professional Values Alignment Compact (IMPORTANT!!) (pgs. 147-151): A structured conversation between care delivery leaders and clinicians that results in a mutual understanding (and a document) that articulates shared goals and clarifies goals: What clinicians can expect from their organization (and hold the organization accountable to), and what the organization can expect from the clinicians (and hold them accountable to).

- Lists shared goals, starting with (and emphasizing) a patient and community focus
- Forms a strong bond between clinicians and administration
- Central – creates engagement, meaning, and purpose; a key element to counteract burnout
- Must be authentic – administration's actions and behaviors must follow the Compact; actions reflects words

- Mutual understanding, articulating shared goals; clarifies roles: What clinicians can expect from their organization, and vice versa
- Can change culture over time

See Mayo Clinic example on pgs. 149-151.

Also see example on pg. 151, describing an unplanned encounter / conversation between the Mayo CEO and a group of custodians. "This group of custodians was trusted and treated with respect. Because they were treated as partners, they behaved like partners. They understood that they had two jobs: to do their work and to improve their work. This was their Values Alignment Compact. [Mayo's] leaders were sending the following message to the continuous improvement teams: 'Your work matters and we trust you.' Through partnerships, [the CEPO] was aligning values at all levels of the organization."

List of questions to help generate a Compact (pg. 152)

<u>Coherence</u> – introduction and outline (Chapter 19)
Coherence limits and provides a health balance to agency (pg. 153) – <u>must be consciously managed</u>.

(a) **Primary burnout drivers addressed by Coherence Actions**:

1) Excessive workload and job demands
2) Inefficiency and inadequate resources
3) Challenges with work-life integration

(b) **Ideal Work Elements cultivated by Coherence Actions**:

1) Profejssional development and mentorship (Chapter 20)
2) Fairness and equity (Chapter 21)
3) Safety (Chapter 22)

and (c) **the actual Coherence Actions**:

1) Selecting and developing leaders (Chapter 23)
2) Improving practice efficiency (Chapter 24)
3) Establishing fair and just accountability (Chapter 25)
4) Forming safe havens (Chapter 26)

<u>Coherence: Professional Development and Mentoring</u> (Chapter 20)
Health care delivery is a "weak link" sport (pg. 155): It depends on coordinated excellence, not the ability of one superstar. Things fail if any single link fails.

The best leadership development approaches blend <u>mentoring</u> and <u>leadership</u> (pg. 156): Defines and contrasts these 2 terms.

<u>Coherence: Fairness and Equity</u> (Chapter 21)
Fairness (pg. 159):

- Essential element
- Humans have an innate sense of it
- Depends on appropriate transparency
- Not a satisfier, but can be a MAJOR dis-satisfier <see paragraph top of pg. 161>
- Comparisons of workers are "the thief of joy" (TR Roosevelt) in non-transparent systems
- Needs fair, just, transparent accountability <the obverse of comparisons – see box on "Salary Transparency at Mayo Clinic", top of pg. 161>

<u>Coherence: Safety</u> (Chapter 22)
Essential role of psychological safety (pg. 163):

- Does not tolerate disruptive and/or abusive behavior, including dismissive or uncivil language
- No punishment for mistakes (link to Reason's flowchart for culpability) or for speaking one's mind
- Mutual respect, within a team culture, where all can contribute
- People must feel comfortable to ask questions and share insights – must train how to do this

Box 22.1 defines and discusses the "power-distance" index (pg. 164): Those with power (e.g., physicians) "should have set the tone for open two-way communication among members of the care team."

Safe haven – basically == Just Culture (patient safety) (pg. 164)

Physical safety, violence, and mistreatment (pg. 165)

<u>Coherence: Selecting and Developing Leaders</u> (Chapter 23)
First of 4 "actions" to create Coherence (pg. 169)

Canada Geese flight model (pg. 169)
The idea of rotating the leadership position, shifting at fixed intervals

<Within Mayo, if I have it right, physician leaders are appointed to a leadership position for 3 years. They can re-up one time, if they do well. Then they must move on. For example, Steve Swensen was the Mayo system CQO for 6 years, but then was forced to move on. At that point he became the Mayo system head of leadership development. After 6 successful years, that ended too – at which point he retired. This turnover creates a career path for those coming up in the organization. It applies to all positions, including Mayo's CEO.>

VUCA model for today's challenges: Volatile/Uncertain/Complex/Ambiguous (pg. 170)

5 Leadership Behaviors (pg. 173) – teachable, measurable
Detailed in Chapter 15, pg. 108 – Include/Inform/Inquire/Develop/Recognize

Discussion of **emotional intelligence / humble inquiry** as essential elements (pg. 174)

Leadership dyads and triads as leadership team structure (pg. 176)

People don't leave organizations, they leave ineffective leaders (pg. 178)

Playbook: 6 rules that senior officers can use to create effective leadership (pg. 179)

1. Consider adopting a leadership dyad or triad model
2. Consider term limits and role rotations
3. Consider engaging clinicians in the selection of all leaders who impact clinical matters
4. Make certain that all senior leaders understand and role model the 5 key leader behaviors
5. Begin leader development of the 5 behaviors through assessment, feedback, training, sharing best practices, skill building activities, and coaching

Coherence: Improving Practice Efficiency (Chapter 24)
Makes the case that the primary role of effective leaders is to thoughtfully build the systems/workflows that define frontline lives, involving frontline staff in the effort (fundamental knowledge). The frontline is where all value is created, upon which the organization depends for success and survival. Lots of specific examples, especially around data, metrics, IT, and EHRs.

Coherence: Establishing Fair and Just Accountability (Chapter 25)
Makes the case for a Just Culture, with advice on how to deploy it – could have more detail

Coherence: Forming Safe Havens (Chapter 26)
Basically a functional extension (what and how) for the last chapter on Just Culture

Just-in-time Disclosure Coaching (pg. 206, 2nd paragraph)
For when clinicians need to meet with patients / families around a bad event; builds trust for all involved.

Includes specific recommendations regarding how to support those facing malpractice lawsuits.

Outline of the **Camaraderie Action Set** (Chapter 27)

Primary burnout driver: Isolation, loneliness, and lack of social support at work
Ideal Work Elements: (1) Community at work and camaraderie; (2) Intrinsic motivation/rewards
Actions: (1) Cultivating community and commensality; (2) Optimizing rewards, recognition, and appreciation; (3) Fostering boundarylessness

Camaraderie: Community at Work (Chapter 28)
Mayo Clinic in the Great Depression (pg. 213)
During the Great Depression, Mayo Clinic experienced a 40% decrease in patient visits to fewer than 50,000 per year. Approximately 1 in 4 of the patients who were seen did not have the money to pay for their care. Yet, all patients were served regardless of their ability to pay. Of course, this turn of events left Mayo Clinic with vast excess capacity and not enough money to pay salaries and bills. Many organizations would have "decreased the head count" to meet payroll. But at Mayo Clinic the leaders instead decided to have everyone take a pay cut to a "bare bones" salary. Because everyone was treated equally, no one felt singled out. And, everyone knew they needed to pull together as a team to make it through the difficult times. The lead administrator, Harry Harwick, reflecting on this dark time, termed it "the most unifying influence in Mayo Clinic history." Everyone was in it together.

Professional community is a key element of good practice (safe, high quality care) (pg. 214)
- Inoculates against burnout and other bad stuff
- The key element is teamwork, which fosters a sense of belong
- <This is a key element in patient experience of care>

– Reduces turnover, which by itself degrades team performance (a vicious cycle)

Case study comparing Mayo to another top-end AMC (pg. 215)
Mayo is an orchestra, not just a bunch of soloists **(very good example – worth a read)**

Camaraderie: Intrinsic Motivation and Rewards (Chapter 29)
Discussion of significant limitations of extrinsic rewards, as compared to intrinsic rewards, with data. See also pg. 239

Making more money does not reduce burnout. (pg. 219)

Paying professionals to do what they would normally do for altruistic reasons can have profound negative consequences. (pg. 220, paragraph 4)

Use of metrics (around patient experience) should always be coupled with targeted training. (pg. 225, paragraph 3)

Which (Compensation) Model Is Best?
Ultimately, there is no right or wrong model of compensation. It is important to recognize, however, that every compensation model has both intended and unintended consequences and that the model used may impact the well-being of patients and professionals and change the way health care professionals view their work. Organizations must consider all ramifications of the model and apply appropriate safeguards and mitigation strategies (see Figure 29.1).

Productivity models may incentivize overwork, increase rates of professional burnout, favor competition over cooperation, emphasize independence over collaboration, and prioritize individuals over teamwork.

Salary models run the risk that some individuals (e.g., those who are not intrinsically motivated) might take advantage of the system (e.g., through laziness, spending too many hours on personal issues, being less productive than colleagues). For these models, safeguards and mitigation strategies include supervisors holding people accountable to maintain equity and fairness or transparently communicating the productivity of each individual in the group to all members. <See "Brent's observation of compensation at Mayo," next page>

Hybrid models can strike a happy medium or incorporate the worst of both worlds.

The key is recognizing both the intended and potentially unintended consequences of each model, putting in appropriate safeguards and mitigation strategies to prevent undesirable consequences, and continually evaluating how the model is working and whether adjustments are needed.

	Model		
	Salary	**Salary + Incentive**	**Productivity**
Intended consequences	Intrinsic motivation Focuses on value without financial conflict of interest with patient Favors cooperation over competition Emphasizes collaboration over independence Focuses on contribution to overall mission, including education, administration, research, and quality improvement Lowest burnout risk Prioritizes team over individuals	Favors value and moderates financial conflict of interest with patient Reduces financial risk of salary to the organization Favors cooperation over competition and collaboration over independence Greater burnout risk Dual focus on quality and production	Extrinsic motivation Focuses on volume Fairness in pay Minimizes financial risk of salary to the organization Prioritizes production over quality and patient satisfaction Highest burnout risk Potential threat to teamwork
Potential unintended consequences	RVU underperformance may be "rewarded" Risk of inequity in pay if the model is poorly managed Salary may be a financial risk to organization if demand or performance inadequate Salary may be a financial risk to organization if not structured properly or inadequate demand	Patient experience incentive may result in overuse of diagnostic tests, procedures, and drugs Risk of inequity in pay if the model is poorly managed Salary may be a financial risk to organization if not structured properly or inadequate demand	Risk incentivizing overwork and increasing burnout Transactional approach to care Financial conflict with patient and stated values of the organization Productivity at cost of patient experience and quality Cognitive dissonance Favors competition over cooperation Emphasizes independence over collaboration Prioritizes individuals over the team
Safeguards and mitigation strategies	Leadership conversations about performance to ensure fairness/ equity Peer pressure Culture Transparency Minimum productivity thresholds	Leadership conversations based on intrinsic rewards Culture Transparency Counterbalancing quality measures Ceiling of maximum reward Counterbalancing measures to promote self-care and personal resilience	Counterbalancing quality measures Ceiling of maximum reward Counterbalancing measures to promote self-care and personal resilience

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Figure 29.1, pg. 221

Figure 29.1. Compensation Model Consequences. RVU indicates relative valve unit.

<Brent's observation of compensation at Mayo:

Everybody gets a salary, determined by role, how many sessions a person chooses to work, and some small seniority effect. However, Mayo also tracks RVUs. That feeds the billing system, but is also one – among a great many – factor that makes up productivity. Consider some examples of "productivity" that a single, simple measure like RVUs don't pick up: There's the senior physician who routinely takes time for "over the back fence consults" sought by younger colleagues. There's that physician who is willing to take on those time-killer, difficult patients that no one else wants to touch.

Clinicians are not given extrinsic rewards or penalties based on RVU production. However, the RVU data are posted, by name, where all team members can see.

Once each year, Mayo has a mechanism by which all members of the team anonymously vote to say who should stay and who should go. If you're not pulling your weight, or adding additional burden beyond the value you add, you can get "voted off the island." This really does happen, with some regularity. The core idea is that those with whom you work have a much better idea of what you really contribute to the team's shared effort. RVUs are but a single, quite limited, metric. In sharp contrast, many organizations base extrinsic financial rewards to RVU production alone – a version of "you eat what you kill.">

Camaraderie: Cultivating Community and Commensality (Chapter 30)
Commensality is sharing food together (pg. 229)

Primary cause of poor health is lack of social connection (Holt-Lundstad *et al*., 2017). **Social connectedness reduces early mortality by half** (Holt-Lundstad *et al.,* 2010) (pg. 229)

Sharing a meal together really works (pg. 230)
- Formal RCT w MDs as subjects – showed it really works
- Examples of how Mayo institutionally supported commensality
- Includes guidelines for group leaders, including ground rules plus list of questions to discuss over dinner
- Directly associated with increased levels of oxytocin = trust building hormone (pg. 236)

Camaraderie: Optimizing Rewards, Recognition, and Appreciation (Chapter 31)
Argues for an emphasis on intrinsic motivators. (pg. 239)

All Mayo leaders are regularly assessed on their performance around this.

More than a "thank you." Includes things like professional development, continuing education, and professional recognition (awards).

No money rewards!!!

A $10.75 pin for completing QI training. The CEO and executive team were the first ones through the course.

More argument and examples on collateral damage from extrinsic rewards. (pg. 240)

Paying for blood donations decreases donation rates – makes an altruistic gift driven by intrinsic motivation, into a financial transaction. (pg. 241)

Hygiene factors (salary, benefits, title, etc.) do not motivate; can only create dissatisfaction because of perceived lack of fairness. Intrinsic factors do motivate.

5 element list to evaluate reward & recognition systems:

1. Review your rewards, recognition, and appreciation programs.
2. Systematically assess alignment:
   - Are the programs aligned with the best interests of patients?
   - Are the programs aligned with the stated vision of the organization?
   - Are the programs aligned with the well-being of professionals?
3. Choose best rewards, recognition, and appreciation programs for your institution and circumstances.
4. Assess leader performance around these programs using the "recognize" component of the Leadership Behavior Index (i.e., Does my leader express appreciation and gratitude in an authentic way?).
5. If the current approach is not the ideal long-term solution, identify opportunities, strategy, and timeline to transition from an extrinsic to and intrinsic motivation model**.**

Unintended consequences of productivity-based compensation systems are often at the root of burnout; they (1) can harm patients; (2) misalign with mission; and (3) harm professionals. (pg. 242)

Lays out a 7 step process for planning compensation systems (pg. 243)

Recommends time and resources for professional development (CME) as a positive, effective reward strategy (pg. 244)

Example **(quite good)**: Describes a one-day course on coaching skills and leadership; includes a list of topics in the course.

<u>**Camaraderie: Fostering Boundarylessness**</u> (Chapter 32)

Aim: negligible communication and interaction barriers across roles, ranks, departments, professions, titles, locations, etc. (pg. 249)

This fosters increased social capital, trust, and esprit de corps

Model: Pando – the 80,000 year old quaking aspen in Fishlake National Forest, Utah

The idea of a single root system that supports the whole organism

Boundarylessness is built around a question: How will this/it help the patient? (pg. 250)

The text provides a list of C-level clinical executives who should participate – pretty much everybody

The text also promotes daily team huddles and multidisciplinary rounds as effective tools to help achieve this, when properly organized and executed.

Outlines "tiered escalation huddles", with an emphasis on vertical communications and rapid problem-fixing linkages (pg. 253)

Residents and Fellows (pg. 259)

Burnout starts during training. The text lists related statistics, with a long list of specific challenges.

<u>Nurturing Well-Being</u> (Chapter 34)

Defines well-being as Wellness, Resilience, and Contentment – the "3 Sisters" for well-being:

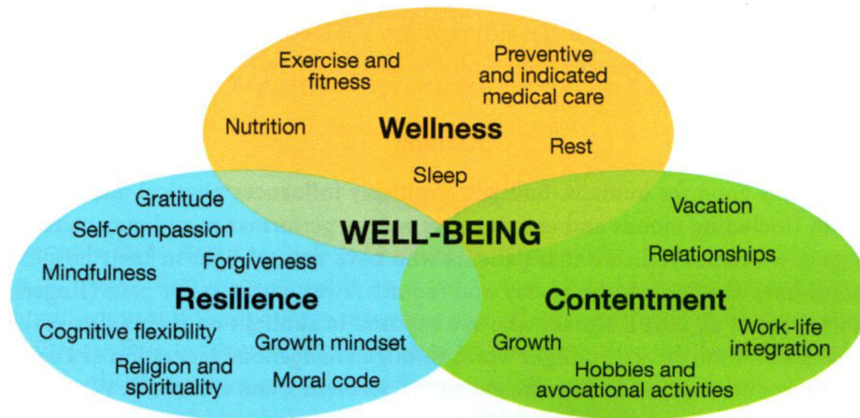

Figure 34.9. Practices That Create Wellness, Resilience, and Contentment: The Three Sisters of Well-being for Health Care.

Practices for creating well-being – breaks out and describes each subcomponent, along with "mistakes to avoid" (pp. 274 – 282)

To repeat a statement included at the start of this summary (pg. 281):

Burnout is mainly caused by systems, leaders, and characteristics of the work environment, not be a deficiency in personal well-being or resilience. When leaders begin the quest to address burnout in their organizations, they often make the mistake of starting programs that focus on the individual. That implies that they believe that the cause of burnout is a lack of resilience (toughness) on the part of the health care professional. Staff are encouraged to 'take better care of themselves" and are given the option of participating in programs that include some of the validated means to bolster resilience. With this, many leaders believe their work is done. However, this approach leaves staff with an unintended message: They are at fault for their burnout because they have not taken care of themselves. Organizational and occupational scientists refer to this as the "strong worker" mindset, and it was debunked as an inaccurate and flawed framework decades ago. Unfortunately, many health care organizations still do not understand the deficits of this approach. Health care professionals, however, immediately recognize efforts that focus primarily on personal resilience as a hollow and insincere effort or, worse yet, they feel as though they are being blamed for the failings of the organization and systems.