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Clinician Well-Being Assessment and Interventions in Joint Commission–Accredited Hospitals and Federally Qualified Health Centers

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Background: Clinician burnout is a longstanding national problem threatening clinician health, patient outcomes, and the health care system. The aim of this study is to determine the proportion of hospitals and Federally Qualified Health Centers (FQHCs) that are measuring and taking system actions to promote clinician well-being.

Methods: This cross-sectional study used an electronic questionnaire from April 21 to June 27, 2022, to assess the current state of organizational efforts to assess and address clinician well-being among a national sample of 1,982 Joint Commission–accredited hospitals and 256 accredited FQHCs. Outcomes of interest included the proportion of hospitals and FQHCs that assessed the prevalence of clinician burnout, established a chief wellness officer position, established a wellness committee, made clinician well-being an organizational performance metric, and implemented other activities/interventions that target clinician burnout.

Results: A total of 481 (21.5%) organizations responded to the survey (hospital $n = 396$ [20.0%], FQHC $n = 85$ [33.2%]). Response rates did not differ by organization size, type, teaching status or urban vs. rural location. Approximately one third (34.0%) of the organizations in the sample conducted an organizational well-being assessment among clinicians at least once in the past three years. Although nearly half of responding organizations reported implementing some kind of intervention to address clinician burnout, only 28.7% of organizations had adopted a comprehensive approach to address clinician well-being/burnout. Only 10.1% of hospitals and 5.4% of FQHCs reported having an established senior leadership position responsible for assessing and promoting clinician well-being at the organization level, and less than half (29.3% FQHCs, 37.6% hospitals) of organizations reported having an established wellness committee. Among 500+ bed hospitals, 61.2% had surveyed, 75.6% had established a well-being committee, 78.0% had implemented interventions to promote clinician well-being, and 26.8% had established a chief wellness officer.

Conclusion: Although half of Joint Commission–accredited hospitals and FQHCs reported taking steps to improve clinician well-being, a minority are measuring clinician well-being, and few are taking a comprehensive approach or established a chief wellness officer position to advance clinician well-being as an organizational priority. Organizational clinician well-being improvement efforts are unlikely to be successful without measurement and leadership in place to drive change.

Clinician burnout is a long-standing national problem, worsened by the COVID-19 pandemic, and threatening clinician health, patient outcomes, and the health care system.[1–6] Even before the pandemic, the National Academy of Medicine (NAM) reported that 35%–54% of nurses and physicians experience burnout,[7] and the American Medical Association (AMA) reported that nearly half of physicians are experiencing at least one sign of burnout.[8] A 2018 report found that provider burnout is a "serious" or "moderate" problem at 83% of health care organizations.[9]

The association between clinician burnout and quality of care, patient safety, and outcomes is well-established.[10–16] Higher levels of burnout among nurses have been associated with higher rates of patient mortality and the transmission of health care–associated infections.[1,4] A cross-sectional study of more than 7,000 surgeons found that burnout was an independent predictor of reporting a major medical error and being involved in malpractice litigation.[11,12] A 2021 systematic review of 20 studies found a correlation between nurse burnout and a decrease in safety and quality of care, patient satisfaction, nurse productivity, and organizational commitment[10]; and a large cross-sectional survey of more than 50,000 registered nurses showed that among nurses who left their job, 31.5% reported the reason for leaving was burnout.[15] A 2019 systematic review of 123 studies found that the majority of evidence suggests a multifactorial relationship between provider burnout and reduced quality of care.[16] Burnout leads to lower levels of staff engagement, which correlates with lower quality of care, patient safety, and patient experience; reductions in clinical work effort; and higher rates of turnover.[17–20]

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Factors associated with clinician burnout are well understood,[11,12,21–23] as are interventions designed to address these causes.[24–28] Comprehensive or multicomponent programs exist that focus on organization-level approaches to address the drivers of burnout.[24,29–34] These programs emphasize the need to start with an assessment to understand which primary drivers and/or organizational factors should be targeted. Studies from multiple institutions indicate that organization-level efforts can decrease burnout at the organization level.[32,35,36] Despite the importance of this issue, we know of no study evaluating how organizations are attempting to address this serious issue. The primary aim of this national study is to answer the question: What is the current state of assessing and addressing clinician well-being in Joint Commission–accredited hospitals and Federally Qualified Health Centers (FQHCs) in the United States? The specific objectives are to (1) determine what proportion of hospitals and FQHCs conducted a clinician survey to assess the prevalence of burnout in the past three years; (2) determine what proportion of hospitals and FQHCs have taken actions to address clinician burnout and the nature of those interventions; (3) identify resources that are being used to help address clinician burnout and the perceived usefulness of those resources; and (4) determine what proportion of hospitals and FQHCs have established a funded senior leadership position directly responsible for assessing and promoting clinician well-being at the organization level.

METHODS

Study Design

This cross-sectional study used an electronic survey (from April 21, 2022, to June 27, 2022) to assess the current state of organizational efforts to assess and address clinician burnout among a national sample of Joint Commission–accredited hospitals and FQHCs. This study did not undergo submission to the Institutional Review Board, as survey questions were exclusively focused on organizational practices (that is, responding individuals represent organizations and not the subjects of the research) and was, therefore, not considered human subjects research.

Study Population Selection

The Joint Commission accredits 3,863 hospitals and 279 FQHCs. For postsurvey analysis purposes (evaluating binary outcomes of interest, assuming the most conservative estimate that the proportion in the population was 50%, with the estimate proportion within 5% error rate and 95% confidence), we needed at least 349 hospitals and 59 FQHCs to respond to the survey. Assuming a 20% response rate, a random sample of 1,982 hospitals and 256 FQHCs were invited to participate.

Survey Instrument Development

The research team collaborated with experts from the AMA and Stanford Medicine to develop a 17-item survey (see Appendix, available in online article). For this survey, and as defined by the Centers for Medicare & Medicaid Services, *clinician* included physicians, advanced practice providers, nurses, or other allied health professionals.[37] The survey instrument was modeled after the AMA's competency criteria for their Joy in Medicine Health System Recognition Program described elsewhere.[29] Prior to implementation, the survey was pilot tested with 18 organizations (9 hospitals, 9 FQHCs) to evaluate question clarity, comprehension, response categories, flow, and burden of time to complete the survey, with revisions based on feedback.

Statistical Analysis

The Joint Commission dataset of accredited hospitals was matched with an American Hospital Association (AHA) dataset to obtain hospital characteristics in order to explore any potential differences in well-being practices that may be observed among organizations related to their characteristics. We used descriptive statistics to summarize the characteristics of the hospitals in the study sample. The characteristics of interest were system affiliation (freestanding, part of a system), hospital size (number of inpatient beds), and hospital location (urban, rural). A chi-square analysis was conducted on select survey items against the hospital characteristics to determine whether there was a statistically significant difference between the response distribution by hospital characteristic. A comparison of differences between some hospital types was not possible due to the small numbers of hospitals in certain categories (for example, inpatient rehabilitation hospital). These hospitals were grouped as "Other" during the analyses. Chi-square tests were used to determine statistical significance. Qualitative data were aggregated, coded, and analyzed using a secure, Web-based application (Dedoose, version 9.0.17, 2021).

RESULTS

Respondent Characteristics

Of the 2,238 organizations that received a survey, 481 (21.5%) participants completed ($n = 372$) or partially completed ($n = 109$) the survey, including 396 hospitals and 85 FQHCs. All data were used for the analysis. Of the hospital respondents, 43.4% ($n = 172$) were community hospitals, 57.1% ($n = 226$) were nonteaching, 68.2% ($n = 270$) were part of a health care system, and 58.1% ($n = 230$) had fewer than 100 inpatient beds. Most of the individuals completing the survey on behalf of their organization were performance/quality improvement professionals ($n = 153$), executive-level leaders ($n = 116$), accreditation specialists/professionals ($n = 37$), or administrators ($n = 29$). The response rate was significantly higher for

Table 1. Organization Characteristics and Survey Response Rates

Organization Characteristics	Sampled *n*	Response Rate* *n* (%)	*p* Value
Federally Qualified Health Center (FQHC)	256	85 (33.2)	p < 0.001
Hospitals	1,915	396 (20.7)	
Hospital Type			
Behavioral Health/Psychiatric Hospital	446	96 (21.5)	0.12
Children's Hospital	90	25 (27.8)	
Community Hospital	843	172 (20.4)	
Long Term Acute Care Hospital	224	35 (15.6)	
Other†	310	67 (21.6)	
Hospital Teaching Status‡			
Major/Minor Teaching	742	169 (22.8)	0.07
Nonteaching	1,172	226 (19.3)	
System Affiliation			
Freestanding	434	126 (29.0)	p < 0.001
Part of a health care system	1,317	270 (20.5)	
Hospital Size (inpatient beds)			
< 100	1,138	230 (20.2)	0.58
100–499	512	111 (21.7)	
500+	213	49 (23.0)	
Hospital location			
Rural	306	75 (24.5)	0.14
Urban	1,526	316 (20.7)	

* Response rate = Response *n* / Sampled *n*. Note: *n*'s may differ due to partially completed surveys. The hospital types do not add up to the total number of hospitals due to overlap between categories; that is, community, rural. There were some hospitals with missing information that were not included in the table.

† Other: Inpatient rehabilitation hospital, musculoskeletal hospital, Veterans Health Administration (VHA) medical center, system-level hospital with other service offering (ambulatory clinic, skilled nursing facility).

‡ Teaching hospital: A hospital engaged in an approved graduate medical education residency program in medicine, osteopathy, dentistry, or podiatry (Source: Centers for Medicare & Medicaid Services, 42 CFR § 415.152 – Definitions).

FQHCs than hospitals (33.2% vs. 20.7%, $p < 0.001$). Freestanding hospitals were more likely to respond than hospitals that were part of a larger system (29.0% vs. 20.5%, $p < 0.001$). No statistically significant differences in response rates were observed based on hospital type, teaching status, size, or location (Table 1).

Assessment of Clinician Well-Being

Approximately one third of all hospital and FQHC respondents reported that they conducted a well-being assessment of clinicians at least once in the past three years (34.0%, $n = 160$ of 471), of which 27.5% ($n = 44$) plan to reassess clinician well-being annually. Among the 311 respondents (66.0%) that had not conducted an assessment 114 (36.7%) reported that they planned to assess clinician well-being in the future (Figure 1a).

Overall, an assessment of organizational leader well-being was conducted by 22.2% ($n = 88$ of 397) of respondents, of which 69.3% ($n = 61$) incorporated leadership-related questions into their clinician well-being survey. Only 15.1% ($n = 60$ of 397) of responding organizations measured teamwork as a component of their well-being assessment.

Assessment Tools Utilized

Approximately one third (33.8%, $n = 54$ of 160) of respondents used a valid and reliable survey instrument designed to measure burnout and other well-being dimensions: Maslach Burnout Inventory (31.5%, $n = 17$), Mini-Z (29.6%, $n = 16$), Mayo Well-Being Index (25.9%, $n = 14$), Stanford Physician Fulfillment Index (11.1%, $n = 6$), and the Copenhagen Burnout Inventory (1.9%, $n = 1$). Other organizations used assessment tools developed internally, or added questions related to well-being to existing surveys, such as an annual employee satisfaction survey or safety culture survey (66.3%, $n = 106$).

Comprehensive Programs Used to Address Clinician Burnout

Only 28.7% ($n = 73$ of 254) of respondents reported that their organization used existing comprehensive programs to foster clinician well-being; of these, 50.7% ($n = 37$ of 73) used more than one comprehensive program to address clinician burnout. The most frequently used comprehensive programs were the AMA Joy in Medicine Health System Recognition Program[29] (43.8%, $n = 32$), the NAM Resource Compendium for Health Care Worker Well-Being[30] (64.4%, $n = 47$), the American Nurses Credentialing Center (ANCC) Magnet Recognition Program[31] (43.8%, $n = 32$), the ANCC Pathway to Excellence Program[38] (27.4%, $n = 20$), and other programs (26.0%, $n = 19$) such as the Gallup Strengths-Based Leadership Programs.[39] Nearly all respondents indicated that the

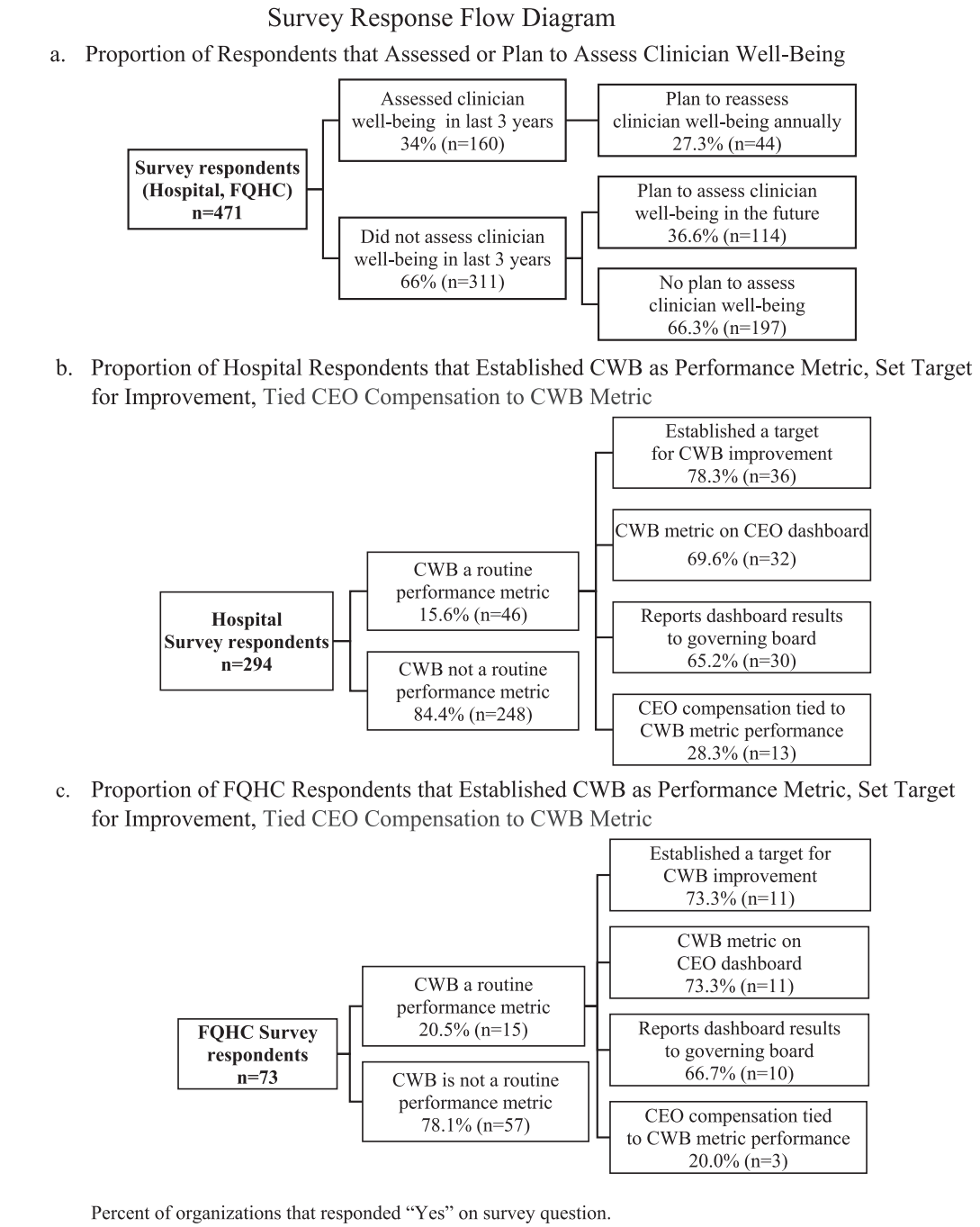

Figure 1: The flow diagram shows the percentage of organizations that responded "Yes" on survey question. FQHC, Federally Qualified Health Center; CWB, clinical well-being.

comprehensive program(s) used by their organization was useful or very useful (95.9%, $n = 70$ of 73).

Hospitals

Less than half (33.7%, $n = 131$ of 389) of hospital respondents conducted an assessment among clinicians at least once in the past three years. Of the hospitals that did not conduct an assessment, 35.4% ($n = 85$ of 240) indicated that their organization plans to do so in the future. An assessment of organizational leaders was conducted by 29.9% ($n = 75$ of 251), and an assessment of teamwork was conducted by 30.7% ($n = 98$ of 319) in the past three years. Only 10.1% ($n = 31$ of 306) of hospitals established a funded senior leadership position, such as a chief wellness officer (CWO), whose role is directly responsible for assessing and promoting clinician well-being at the organization level. Less than half (37.6%, $n = 118$ of 314) of the hospitals have established a wellness committee.

A small proportion of hospitals made burnout a routine organizational performance metric (15.6%, $n = 46$ of 294). However, only a subset of those organizations established a target for improvement ($n = 36$), incorporated

Table 2. Number and Type of Implemented Interventions Focused on Addressing Clinician Burnout (Hospital *n* = 147, FQHC *n* = 41)*

Intervention Type	Hospital % (*n*)	FQHC % (*n*)
Made workflow changes at the unit level	63.7 (93)	73.2 (30)
Instituted flexible work arrangements	52.7 (77)	70.7 (29)
Made improvements to the current electronic health record system (for example, streamlined clinical workflows, built specialty-specific EHR protocols, reduced or redirected EHR notifications)	50.0 (73)	75.6 (31)
Conducted QI projects aimed at addressing clinician concerns	49.3 (72)	48.8 (20)
Provided dedicated, individual mental health support for clinicians in distress provided by a psychologist or psychiatrist expert in dealing with clinician distress	48.6 (71)	29.3 (12)
Actively dismantled outdated or unnecessary administrative burdens	39.0 (57)	43.9 (18)
Implemented individualized training for clinicians to help them use the EHR more efficiently	37.0 (54)	51.2 (21)
Implemented a peer support program that supports dealing with adverse clinical events (separate from the Employee Assistance Program)	39.7 (58)	19.5 (8)
Implemented physician-led initiatives (for example, physician peer-mentoring program, physician leadership training)	19.2 (28)	31.7 (13)
Restructured benefits related to personal time off	19.9 (29)	22.0 (9)
Other†	23.3 (34)	24.4 (10)

* Percentage of organizations that responded "Yes" on survey question. This was a check-all-that-apply (CATA) survey question.

† Other included the following: Established a relaxation/quiet room; increased focus on recruitment and retention; incorporated burnout into orientation for residents and medical staff; monthly "Safe Table" discussions; resiliency training; rounding; pastoral care; wellness representative at the department/unit level; reduced after-hours responsibilities; employee-developed action plans focused on reducing work stressors at the department level; education around Joy at Work; created a Joy Team; engaged a workflow consultant; intensive listening sessions with senior leadership; changed compensations plan and time-off policy; physical wellness activities (for example, food delivery, online dance and exercise classes, healthy eating classes).

FQHC, Federally Qualified Health Center; EHR, electronic health record; QI, quality improvement.

a well-being metric on the CEO or executive leadership team's dashboard ($n = 32$), report the dashboard results to the governing board ($n = 30$), and tied leadership compensation to performance on their well-being metric ($n = 13$) (Figure 1b).

Nearly half of hospital respondents implemented interventions to target burnout (48.4%, $n = 147$ of 304), with the most frequently implemented interventions being Made workflow changes at the unit level (63.3%, $n = 93$), Instituted flexible work arrangements (52.4%, $n = 77$), and Made improvements to the current electronic health record (EHR) system (49.7%, $n = 73$) (Table 2). Among these hospitals, 42.2% ($n = 62$ of 147) used a comprehensive program, with the most frequently adopted option being the NAM Resource Compendium for Health Care Worker Well-Being.

Federally Qualified Health Centers

Less than half (35.4%, $n = 29$ of 82) of FQHC respondents conducted an assessment among clinicians at least once in the past three years. Of the FQHCs that did not conduct an assessment, 56.6% ($n = 30$ of 53) indicated that their organization plans to conduct one in the future. An assessment of organizational leaders was conducted by 18.3% ($n = 13$ of 71), and an assessment of teamwork was conducted by 28.2% ($n = 20$ of 71) in the past three years. Only 5.4% ($n = 4$ of 74) of FQHCs established a funded senior leadership position, such as a CWO, responsible for assessing and promoting clinician well-being at the organization level. Only 29.3% ($n = 22$ of 75) of FQHCs established a wellness committee.

Some FQHCs have made burnout a routine organizational performance metric (20.5%, $n = 15$ of 73), while only a subset of those organizations established a target for improvement ($n = 11$), incorporated a well-being metric on the CEO or executive leadership team's dashboard ($n = 11$), report the dashboard results to the governing board ($n = 10$), and tied leadership compensation to performance on their well-being metric ($n = 3$) (Figure 1c).

More than half of FQHC respondents implemented interventions to target burnout (55.4%, $n = 41$ of 74), with the most frequently implemented interventions being: Made improvements to the current her system (75.6%, $n = 31$), Made workflow changes at the unit level (73.2%, $n = 30$), and Instituted flexible work arrangements (70.7%, $n = 29$) (Table 2). Among the FQHCs that implemented interventions, 24.4% ($n = 10$) used one or more comprehensive programs, with the AMA Joy in Medicine Health System Recognition Program being the most frequently adopted option.

Differences Associated with Organizations Appointing a CWO

There were several statistically significant differences among hospital and FQHC respondents that appointed a CWO or similar position (Supplemental Table 1). Organizations

Table 3. Comparison of Survey Responses by System Affiliation, Size, and Location*

Survey Item	System Affiliation		Hospital Size (Inpatient Beds)			Hospital Location	
	Freestanding %	System %	< 100 %	100–499 %	500+ %	Urban	Rural
Has your organization conducted a wellness assessment of burnout among clinicians at least once in the last three years?	**22.3**	**38.8**†	**28.3**	**32.7**	**61.2**‡	35.4	26.7
• [For organizations that have not conducted a wellness assessment] Does your organization plan to conduct a survey to assess the level of burnout among clinicians?	36.7	34.7	34.2	39.1	31.6	37.2	28.8
Has your organization established a Well-Being Committee (separate from your Employee Assistance Program)?	**27.8**	**42.7**†	**26.5**	**43.2**	**75.6**‡	**40.6**	**26.2**§
Has your organization established a funded senior leadership position, such as Chief Wellness Officer or other executive leadership role, which is directly responsible for assessing and addressing clinician well-being at the organizational level?	5.7	12.5	**6.1**‡	**10.7**‡	**26.8**‡	11.5	4.8
Has your organization made burnout and other measures of clinician well-being a routine organizational performance metric?	**6.5**	**20.9**†	**14.1**	**12.6**	**31.7**§	17.3	10.8
• [For organizations that have established a routine organizational performance metric] Has your organization established a target for improvement?	100.0	74.4	84.6	63.6	76.9	76.7	85.7
• [For organizations that have established a performance metric on the CEO dashboard] Is workforce well-being a metric on the CEO's and/or the executive leadership team's dashboard?	71.4	67.4	73.1	63.6	61.5	65.1	85.7
• [For organizations that have established a performance metric on the CEO dashboard] Are the results of this dashboard reported to the board?	100.00	93.1	89.4	100.0	100.0	92.9	100.0
• [For organizations that have established a performance metric on the CEO dashboard] Is the CEO's and/or the executive leadership team's compensation tied to performance on this workforce well-being metric?	20.0	44.8	42.1	71.4	12.5	39.3	50.0
Has your organization implemented intervention(s) that target clinician burnout?	41.5	52.0	**44.1**	**43.0**	**78.0**‡	49.4	44.4

* Percentage of organizations that responded "Yes" on survey question.
† Statistically significant at $p < 0.001$.
‡ Statistically significant at $p < 0.001$.
§ Statistically significant at $p < 0.05$.

with a CWO were more likely to conduct a well-being assessment among clinicians (62.9% vs. 23.9%, $p < 0.001$), more likely to establish a well-being committee (74.3% vs. 31.9%, $p < 0.001$), more likely to make burnout and other measures of well-being a routine organizational performance metric (45.7% vs. 12.8%, $p < 0.001$), and more likely to implement intervention(s) that target clinician burnout (85.7% vs. 45.3%, $p < 0.001$).

Differences Associated with Hospital Characteristics

Hospital System Affiliation. There were a number of statistically significant differences between freestanding hospitals and hospitals that are part of a system (Table 3). Compared to freestanding hospitals, organizations that are part of a system were more likely to conduct a wellness assessment (system 38.8% vs. freestanding 22.3%, $p = 0.001$), more likely to establish a well-being committee (system 42.7% vs. freestanding 27.8%, $p = 0.009$), and more likely to make clinician well-being a routine organizational metric (system 20.9% vs. freestanding 6.5%, $p = 0.001$).

Hospital Size. There were a number of large and statistically significant differences between hospitals with 500 or more beds and hospitals with fewer beds (Table 3). Large hospitals with 500 or more beds were more likely to conduct a clinician well-being assessment within the past three years (< 100 beds 28.3% vs. 100–499 beds 32.7% vs. 500+ beds 61.2%, $p < 0.001$), more likely to establish a well-being committee (< 100 beds 26.5% vs. 100–499 beds 43.2% vs. 500+ beds 75.6%, $p < 0.001$), more likely to make burnout and other measures of well-being a routine organizational performance metric (< 100 beds 14.1% vs. 100–499 beds 12.6% vs. 500+ beds 31.7%, $p = 0.012$), and more likely to implement interventions targeting clinician burnout compared to hospitals with fewer beds (< 100 beds 44.1% vs. 100–499 beds 43.0% vs. 500+ beds 78.0%, $p < 0.001$). Hospitals with 500 or more beds were also more likely to establish a funded senior leadership position such as a CWO (< 100 beds 6.1% vs. 100–499 beds 10.7% vs. 500+ beds 26.8%, $p < 0.001$).

Hospital Location. Only one statistically significant difference was observed related to hospital location (Table 3). Hospitals in urban areas were more likely than those in rural areas to establish a well-being committee (40.6% vs. 26.2%, $p = 0.033$).

Hospital Characteristics and Types of Interventions Implemented

Statistically significant differences related to system affiliation and hospital size were observed with intervention implementation. No statistically significant differences were observed with hospital location (Table 4).

DISCUSSION

Despite the high rates of occupational distress among clinicians and its established relationship with quality of care, patient safety, and staffing outcomes, our study found that one third or less of Joint Commission–accredited hospital and FQHC respondents assessed clinician well-being in the past three years, and just half of the responding organizations implemented at least one intervention to target clinician burnout. Hospitals with 500 or more beds, hospitals that are part of a system, and hospitals located in urban areas were more likely to assess and address clinician well-being compared to smaller, freestanding, and rural hospitals. Large hospital systems are likely able to leverage economies of scale, while smaller hospitals (particularly those in rural locations and those providing care to a significant level of uninsured and Medicaid patient groups) are more likely to be limited by financial constraints.[40–42] Although the overall proportion of Joint Commission–accredited hospitals and FQHCs engaged in meaningful organization-level action to promote clinician well-being is discouraging, the degree of engagement by large (500+ bed) hospitals is striking. More than 60% of large hospitals conducted a clinician well-being assessment, > 75% established a well-being committee, > 30% established clinician well-being as an organizational performance metric, and > 75% implemented interventions to mitigate clinician burnout. Among those that established clinician well-being as an organizational performance metric, 100% reported results to the hospital board, and > 60% reported that the metric was part of their CEO/executive team scorecard.

The health care CWO is a relatively new executive leadership position, first established by Stanford Medicine in 2017.[43] Among both hospitals and FQHCs, only a fraction reported having an established senior leadership position responsible for assessing and promoting clinician well-being at the organization level, and less than half of organizations established a wellness committee. Remarkably, however, > 25% of hospitals with > 500 beds established a CWO within the past five years. The observation that organizations who appointed a CWO were more likely to complete an assessment and more likely to implement other targeted interventions may be due to the CWO catalyzing broader organizational efforts; organizations engaged in more substantive improvement efforts may have established an executive to lead and coordinate these activities, or a combination of both. Much like organizational quality and patient experience improvement efforts, appointing a senior leader, such as a CWO, who is tasked with making clinician well-being a strategic priority may be one of the most important actions an organization can take to address burnout at the organization level.[43] The role of the CWO and activities commonly led by CWOs have been described, and road maps for organizations to establish a CWO, develop an organizational strategy, and drive system-level improvement efforts have been reported.[24,43–45]

Table 4. Statistically Significant Differences in Hospital Characteristics and Intervention Type*

Intervention	System Affiliation		Hospital Size (Inpatient Beds)			Hospital Location	
	Freestanding %	System %	< 100 %	100–499 %	500+ %	Urban %	Rural %
Made improvements to EHR	53.5	48.5	50.0	47.2	53.1	48.3	57.1
Dismantled admin burdens	32.6	41.7	**35.9**	**27.8**	**59.4**†	37.3	46.4
Made workflow changes	65.1	63.1	66.7	63.9	56.3	63.6	64.3
Conducted QI projects	44.2	51.5	44.9	44.4	65.6	51.7	39.3
Instituted flexible work	62.8	48.5	47.4	52.8	65.6	51.7	57.1
Restructured benefits	20.9	19.4	16.7	22.2	25.0	22.0	10.7
Implemented peer support program	27.9	44.7	**24.4**	**36.1**	**81.3**‡	42.4	28.6
Provided mental health support	**32.6**	**55.3**†	**34.6**	**50.0**	**81.3**‡	51.7	35.7
Provided EHR training	37.2	36.9	37.2	30.6	43.8	36.4	39.3
Implemented physician-led initiatives	9.3	23.3	14.1	13.9	37.5*	19.5	17.9

* Percentage of organizations that responded "Yes" on survey question.
† Statistically significant at $p < 0.05$.
‡ Statistically significant at $p < 0.001$.
EHR, electronic health record; QI, quality improvement.

Although approximately half of responding organizations reported having implemented some kind of intervention to target clinician burnout, very few organizations reported implementing comprehensive systems to address the problem. Once again, such approaches were markedly more likely to be reported among organizations with a CWO. Although many studies have found that targeted interventions can be helpful,[27,28] expert panels recommend holistic organization and system-level interventions to address the complex array of factors that affect clinician well-being.[46–50] Reports from multiple institutions that have engaged in holistic organizational improvement work provide evidence of effectiveness.[32,34–36]

Our findings are consistent with a national study conducted in 2019 (pre-pandemic) by the AHA, which found that less than half of the hospitals sampled conducted an assessment of physician well-being.[51] We found no other national study that looked more broadly at how clinician well-being is being addressed at the organization level (for example, appointing a senior leader to lead well-being efforts, establishing a wellness committee, having a well-being performance metric, tying CEO compensation to clinician well-being measures).

Limitations

This study has several limitations. Only 21.5% of the organizations surveyed completed the assessment. Although we delayed the administration of the survey until 2022 due to the COVID-19 pandemic, ongoing pandemic-related challenges may have nonetheless affected participation. Despite the low response rate, we found no systematic response differences according to organizational characteristics. It seems unlikely that a larger response rate would have significantly altered the study's conclusions. Assuming that a response bias might favor organizations that were taking a more active role in addressing clinician well-being, then the results may actually overestimate the proportion of organizations engaged in meaningful activity to promote clinician well-being—which would heighten, rather than diminish, the need for more widespread organizational action. It is also worth noting that the study focused on hospitals and FQHCs. Therefore, results are not generalizable to other health care settings and practice types. Finally, the study sample was limited to Joint Commission–accredited FQHCs and hospitals; it is unknown whether survey results would have differed if non–Joint Commission–accredited hospitals and FQHCs were included in the sample.

CONCLUSION

Clinician burnout and other forms of occupational distress are long-standing problems that have been exacerbated by the COVID-19 pandemic. Despite calls by the NAM, the nation's leading professional societies, and the US Surgeon General for organizational action to address this issue, our results suggest that the majority of hospitals and FQHCs have not addressed this as a strategic priority. Large hospitals appear to be leading the way on this issue. Organizational clinician well-being improvement efforts are unlikely to be successful without measurement and leadership in place to drive change.

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SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jcjq.2023.04.007.

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