Innovation Project Charter:
Title: System Level Drivers of Workforce Resilience and Retention
Wave: 63
June 30, 2022

Executive Summary:
Healthcare workforce wellbeing is struggling in the US. IHI has extensive experience and tools from our Joy in Work collaboratives. In addition, we have a well-developed online course. During this wave of activity, we have put together an outline for a course to be taken by leaders who have responsibility for healthcare workforce wellbeing. We created a planning tool that can be used during the course and an assessment tool that will be used as prework for the course.

Project Type:
90-Day Innovation Project

Team:
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Intent & Aim:
The aim of this innovation cycle is to identify the common challenges and facilitators of chief well-being officers to deliver improved workforce well-being and retention.

Secondarily, we are seeking input on the product design that would most effectively reach those well-being officers.

Background:
Since 2016, the average hospital turned over about 90 percent of its workforce and 83 percent of its RN staff. In 2020, the turnover rate for staff RNs was at 18.7 percent, a 2.8 percentage point increase from 2019.[1] "Thirty-two percent of registered nurses (RNs) surveyed in the United States in November said they may leave their current direct-patient-care role, according to McKinsey's latest research."[2] And there are other surveys that show high levels of dissatisfaction. The takeaway is that for many nurses there is a high level of dissatisfaction with work, particularly at the hospital level. Another sign of dissatisfaction is the enormous number of traveling nurses in the US at this time. Based on recent IHI research about traveling nurses, nurses are simply considered

[1] 2021NSI National Health Care Retention & RN Staffing Report, Nursing Solutions, Inc. March 2021

[2] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/surveyed-nurses-consider-leaving-direct-patient-care-at-elevated-rates

as a commodity.[3] Reinforcing this view: "Nursing productivity is usually quantified as the cost of required care for a defined number of patients"[4]. Nowhere in this simple input measure is the consideration for quality or safety that nurses provide every day.

When nurses were asked what was important, they said: safe work environment, work-life balance, caring and trusting teammates, doing meaningful work, and having a flexible work schedule.[5] Perhaps three measures of nursing well-being are: RN turnover rate, RN vacancy and RN net promoter score. "Nursing is the nation's largest healthcare profession, with more than 3.8 million registered nurses (RNs) nationwide"[6], they need our support.

Just as nurses need health system level support, physicians, the second largest group with a little over 1 million active needs help too.[7]A recent survey "*Medscape Physician Burnout & Depression Report 2022: Stress, Anxiety and Anger* found a five-percentage point increase in burnout overall, from 42% in 2020 to 47% in 2021, with an increase in ER physician burnout from 43% to 60% last year. Most physicians said that burnout permeates most aspects of their lives, with 54% indicating that the impact was strong to severe, including with their relationships. Burnout increased for both male and female physicians, from 36% to 41% and 51% to 56%, respectively. Physicians said they cope by exercising (48%), isolating from others (45%), eating junk food (35%) and drinking (24%)".[8] The issues that are leading to physician burnout are: too many bureaucratic tasks, lack of respect from administrators, colleagues, or staff, too many hours at work, lack of autonomy among others.[9]

Obviously, this stress/burnout is having an impact on the individual practitioners, you would also expect that this is having an impact on the health system as a whole and patients and patient care. In a NEJM Perspective piece authors from CMS report the following "Central line-associated bloodstream infections in U.S. hospitals increase 28% in the second quarter of 2020 (as compared with the second quarter of 2019). There were also increases in catheter-associated urinary tract infections, ventilator-associated events, and methicillin-resistant *Staphylococcus aureus* bacteremia. Safety has also worsened for patients receiving post-acute care, according to

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[3] Wave 62 IHI innovation series Traveling Providers – Final Report

[4] Rethinking Nursing Productivity to Enhance Organizational Performance

Joanne Disch, PhD, RN, FAAN, Professor ad Honorem, University of Minnesota School of Nursing Nanne M. Finis, RN, MS, Chief Nurse Executive, UKG

[5] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/surveyed-nurses-consider-leaving-direct-patient-care-at-elevated-rates

[6] https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet

[7] https://www.statista.com/topics/1244/physicians/

[8] https://www.prnewswire.com/news-releases/medscape-physician-burnout--depression-report-2022-shows-pandemics-continued-impact-301465333.html

[9] https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?faf=1#1

data submitted to the Centers for Medicare and Medicaid Services (CMS) Quality Reporting Programs: during the second quarter of 2020, skilled nursing facilities saw rates of falls causing major injury increase by 17.4% and rates of pressure ulcers increase by 41.8%."[10] Healthcare is less safe today than it was in 2019. Ignoring nursing, physician and other clinician well-being will not improve the quality and safety of healthcare.

IHI has been working for years on clinician well-being. We have a white paper, change package, experience from two collaboratives to draw upon for this innovation wave.[11] The challenge is in adapting this content to support these emerging leaders leveraging IHI's experience in the early days of supporting Chief Quality Officers and the recent CQO Europe offering.

Description of the Work:

We interviewed the following individuals along with a reading a variety of literature pertinent to the subject. We reached out to a wider group and had a 50% success rate to get an interview

Christine Hein, MD Maine Medical Center
Anna Legreid Dopp, PharmD American Society of Health-System Pharmacists)
Ann Lewis CEO CareSouth Carolina
Bernadette Melnyk, PhD, APRN-CNP Dean and Professor, College of Nursing and Vice President for Health Promotion and University Chief Wellness Officer, OSU
Crystal Morales RN Oversees Nursing Wellness Medstar
Kevin Sowers, RN MSN President, John Hopkins Health System
David Bucher MD Park Nicolet Methodist FP Residence Program
Kari Sue Bernard, PA-C, PhD Orion Behavioral Health
Elisa Arespacochaga, MBA VP of PA, AHA
Mark F. Carroll, MD Chief Medical Officer/Staff Vice President Medicaid Plans Blue Cross® Blue Shield® of Arizona

For our deliverables we created an outline for a course, a planning guide and an assessment tool to be taken prior to the course. Please see Appendices A, B and C

The design for this course is based on this driver diagram

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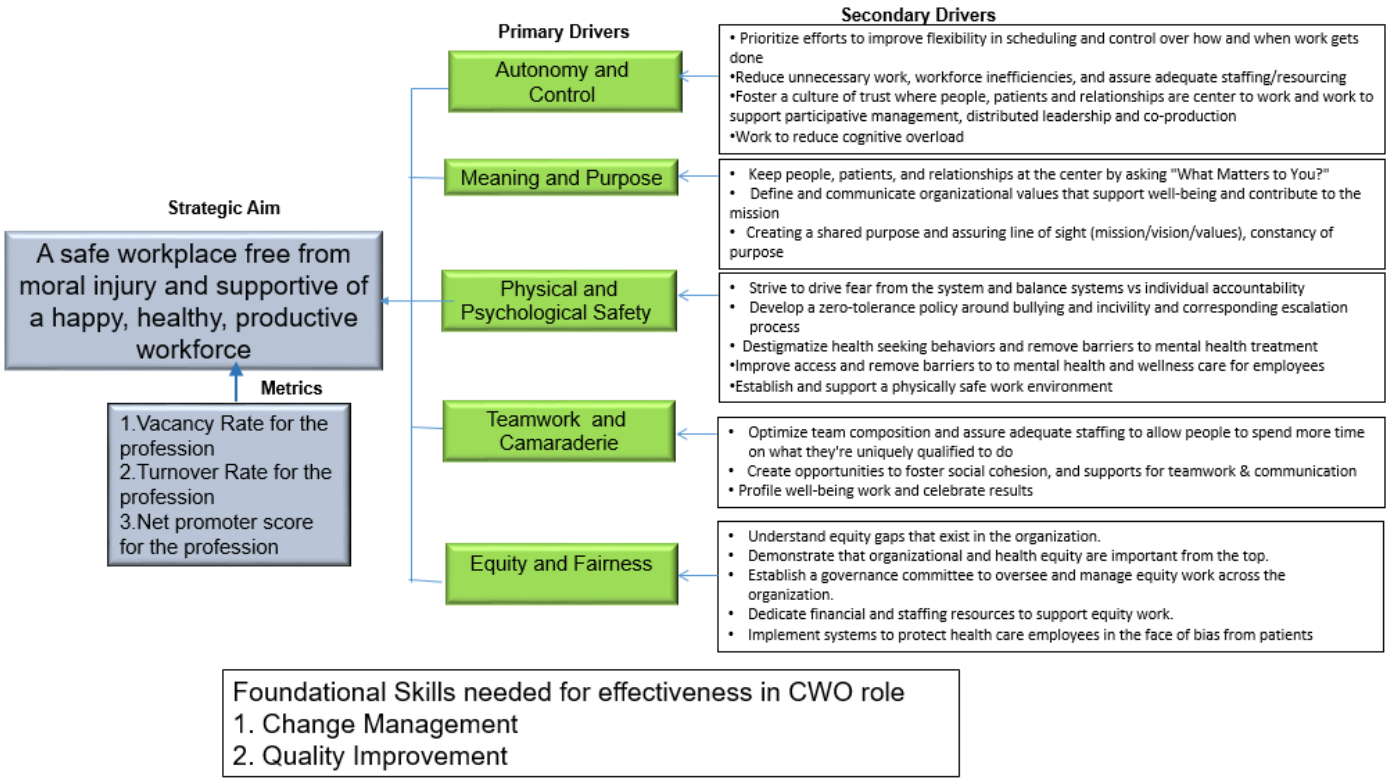
[10] NEJM 386;7 nejm.org February 17, 2022 Lee A. FleFisher, M.D., Michelle Schreiber, M.D., Denise Cardo, M.D., and Arjun Srinivasan, M.D. Health Care Safety during the Pandemic and Beyond — Building a System That Ensures Resilience

[11] http://www.ihi.org/Topics/Joy-In-Work/Pages/default.aspx



Conclusions and Recommendations:

Healthcare workforce wellbeing is struggling in the US. IHI has extensive experience and tools from our Joy in Work collaboratives. In addition, we have a well-developed online course. During this wave of activity, we have put together an outline for a virtual course lasting 6 to 9 months to be taken by leaders who have responsibility for healthcare workforce wellbeing. We created a planning tool that can be used during the course and an assessment tool that will be used as prework for the course.

The next steps would be to select a director and then pull together an expert meeting and identify some key faculty to further develop and lead this course.

Appendices:

Appendix A

Introduction

We are proposing a well-being course that is focused on the health care workforce. Health systems are struggling with clinician burnout leading to serious retention problems throughout their workforce. We believe this course will help them with burnout and retention. To be clear our goal is not just to decrease burnout and increase retention but to create an environment in which people thrive and genuinely have joy in work

The following are high level aims for this course.

1.Improve recruitment and retention of the health care workforce

2.Support the use of improvement methodologies to foster workforce well-being, improve mental health and combat burnout

3.Equip leaders with the necessary skills and promising approaches to leading systems improvements to workforce well-being

These are a set of key measures to consider for this work. These are outcome measures that all health systems are already tracking. The goal for this course is to improve these measures over time.

1.OSHA recordables

2.DART rate

3.Vacancy rate,

4.Turnover rate

5.Net promoter score

In addition to these measures, you will want to have some internal measure of wellbeing for individuals.

The following are a set of Important definitions that will form part of a common vocabulary for this work.

Health care workforce: all the people engaged in work to protect and improve the health of individuals, communities, and populations, including those who assist in operating health care facilities

Burnout: a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment occurring from chronic workplace stress.

Depression: a prolonged episode of at least two weeks characterized by depressive mood or anhedonia occurring most of the day, nearly every day. Context dependent.

Moral Distress: a psychological response to morally challenging situations. This can be a result of a situation in which a healthcare professional is prohibited from taking the morally correct course of action or in a situation where there is moral uncertainty regarding decisions surrounding patient care

Professional Well-Being: a function of being satisfied with one's job, having a high-quality working life, and finding professional fulfillment in one's work, as a result of constructive conditions in the workplace.

Resilience: ability of a person, community or system to withstand, adapt, recover, rebound, or even grow from adversity, stress or trauma

The target audience for this work is anyone who has responsibility for workforce well-being within a health care organization

Course Description:

This course will be taught virtually over a 6–9-month time frame. It will be focused on at least 8 modules as described below. We will start with a high-level introduction to our overall framework and then explore each module over time. During this course all participants will develop an actionable plan that will incorporate the drivers and the measures for this work. It will outline the group/population of employees that they have responsibility for and the other executives that they have to partner with. Coaching should be part of this course. The coaching should be used to develop their plan.

Prior to actually starting the course participants will use an assessment tool to explore and understand their own organizational status.

The modules below describe a framework that the faculty will work from. Each module should start with the driver and some discussion around the secondary drivers. Then the faculty should provide a set of tactics/change ideas that are relevant to the driver and secondary drivers. They might even teach a particular program or skill like peer coaching if it makes sense for their module.

The eight modules that we recommend for the course are identified below. We recommend a virtual expert meeting in which you discuss the topics in the modules and how they might be changed and what examples/tactics should accompany each module. High level without detail tactics is not helpful and tactics without a framework is also not helpful. The other comment I would make is well known faculty from the well-being space who want to work with IHI is essential.

Eight Modules

Introduction

During this session the overall framework and measures need to be discussed. You might want to include some aspects of how to get started. In the white paper and the online course there is a 4-step platform that you discuss in great detail. How much if any of the 4-step platform do you want to include? It should at least get a mention. The introduction would also be a time to share a few observations from prior collaborative and show how past joy in work ties into this course. How do we think about what matters and pebbles and boulders? They can be introduced after the pertinent section below. The other technique is breaking the rules, does it have any bearing in this course?

Autonomy and Control

1.Prioritize efforts to improve flexibility in scheduling and control over how and when work gets done.

2.Reduce unnecessary work, workforce inefficiencies, and assure adequate staffing/resourcing.

3.Foster a culture of trust where people, patients and relationships are centered to work and work to support participative management, distributed leadership and co-production.

4.Work to reduce cognitive overload.

Some change ideas to support the above:

> Flexibility at the beginning and end of the day may be particularly helpful. For example, eliminating mandatory early morning and late afternoon meetings or allowing clinicians to flexibly schedule patients during the first and last hours of the day (e.g., through virtual visits) to maintain their productivity while decreasing work-life conflict

and commuting times. The changes did not impact patient access, relative value units, or total patient visits, and resulted in significant improvement in clinician turnover and burnout scores.

Create a standardized organizational process to identify and eliminate non value adding work through a rapid improvement process, for example: http://www.ihi.org/Engage/collaboratives/LeadershipAlliance/Pages/Breaking-the-Rules.aspx.

"Start to view cognitive lifting as we do physical lifting — create a culture where cognitive load is shared. Children's Hospital of Philadelphia redistributed cognitive work in the radiology department by (1) dividing tasks between x-ray techs and nurses and (2) creating an "x-ray triage" role to handle calls and scheduling so that individual x-ray techs weren't being interrupted while working with patients. NASA Task Load Index: https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/nasa-task-load-index"

Float pools and per diem are also a good tool but probably most health systems have already deployed this

Meaning and Purpose

1.Keep people, patients, and relationships at the center by asking "What Matters to You?"

2.Define and communicate organizational values that support well-being and contribute to the mission.

3.Creating a shared purpose and assuring line of sight (mission/vision/values), constancy of purpose.

Some change ideas to support the above:

Implement a short daily team huddle to focus on what matters most to teams (e.g., high-risk patients). Run tests to find the ideal time, agenda, and leadership structure.https://edhub.ama-assn.org/steps-forward/module/2702506

Physical and Psychological Safety

1.Create a just culture that is free from fear (i.e., one that balances a system's approach and individual accountability).

2.Develop a zero-tolerance policy around bullying and incivility and corresponding escalation process.

3.Destigmatize health seeking behaviors and remove barriers to mental health treatment (remove questions for licensure and privileging application, deploy group debriefings/peer support, etc.).

4. Improve access and remove barriers to mental health and wellness care for employees (screening, trained providers, appropriate treatment, affordable care).

5.Establish and support a physically safe work environment.

Some change ideas to support the above:

Offer small-group peer support program by discipline to promote meaning in work and reduce burnout.

Track workplace violence and to put in place measures to ensure the physical safety of employees (regular and contracted)

Teamwork and Camaraderie

1.Optimize team composition and ensure adequate staffing to allow people to spend more time on what they're uniquely qualified to do

2.Create opportunities to foster social cohesion, and supports for teamwork & communication,

3.Profile well-being work and celebrate results,

Some change ideas to support the above:

> Invite medical assistants and nurses to take a larger role in appointments, in-room support, Electronic Medical Record (EMR) use, and/or scribing.

Equity and Fairness

1.Understand equity gaps that exist in the organization. Link this work with equity, HR, safety, and quality teams to connect the dots across various existing workforce workstreams,

2.Demonstrate that organizational and health equity are important from the top.

3.Establish a governance committee to oversee and manage equity work across the organization.

4.Dedicate financial and staffing resources to support equity work.

5.Implement systems to protect health care employees in the face of bias from patients and staff.

Some change ideas to support the above:

> "The Institute for Healthcare Improvement (Boston) stratified data from its quarterly employee satisfaction "Pulse Survey" by race and shared results with staff, with a commitment to reduce gaps between white staff and staff of color. IHI created a team to co-create solutions. IHI's Health Equity Self-Assessment Tool for Health Care Organizations: http://www.ihi.org/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx"
>
> Bystander Training

Change Management

1.Make well-being & workforce safety a core organizational aim – commit to and communicate this priority

2.Activate the executive team in support of workforce well-being and safety. This will require committees to support the work and resources committed to the team responsible for this work.

3.Develop strong leadership behaviors that support participative management, psychological safety and trust Link with equity, HR, safety, and quality teams to connect the dots across various existing workforce workstreams

4. Build out the measurement system to support the work and the leadership team

Quality Improvement

1.Use existing staff satisfaction data to establish baseline and contribute to aim statement (Augment measurement system with real time assessments that offer more frequent insights and include metrics around organizational aims (burnout, mental health, suicide, well-being, etc.))

2.Develop improvement capability at all levels with core improvement tools

3.Establish processes to prioritize frontline improvement projects to improve workforce well-being

* Improvement projects are integrated into daily work

* A learning system exists for reporting, evaluation & feedback

* A process exists to implement standard work to scale

•Visual Management: process performance and continuous process improvement tools are utilized

Appendix B Organization Assessment Tool

Organizational Assessment of Conditions to Foster Joy in Work

This self-assessment tool is intended to help teams and individuals evaluate their current situation around well-being.

Consider your organization, practice, unit, or team to assess where you are in your journey toward well-being. Circle one box (Level 1, Level 2, Level 3, or Level 4) next to each element in the left-hand column. Then, after circling a Level for each element, write down related strengths, opportunities for improvement, and potential next steps below. As with many assessment tools, use your best judgment (with input from others as needed) in considering the various domains. Elements with low scores may suggest places to start your improvement efforts; elements with high scores may not be done consistently and still require effort, or may provide a "bright spots" to test for spread and scale.

Autonomy and Choice:

Environment supports choice, autonomy and flexibility in work, participative management is expected of all leaders, team members are part of designing systems that affect their work processes.

	Level 1	**Level 2**	**Level 3**	Level 4

Choice and Flexibility: The extent to which individuals and teams have control and flexibility over their daily work.	Scheduling systems and policies are rigid. Precertification is required for tests and treatments. Affiliations restrict referrals. Compensation practices disincentivize vacation time or are productivity based.	Staff have moderate input into scheduling, start and end times, vacation and call schedules (i.e., staff may start the work day earlier/later or to work longer hours on certain days of the week and shorter hours on others). Where productivity pay cannot be eliminated, other dimensions (e.g., patient satisfaction and quality measures) are included in the productivity-based pay formula.	Organizational policies are linked to the local drivers of joy and wellbeing. Organization comprehensively examines the structure of vacation benefits, coverage for life events (i.e., birth or death in the family), approach to scheduling, and strategy for coverage of nights and weekends.	Organizational processes ensure adequate rest and a manageable workload including coverage systems for staff when they are ill, adequate staffing, provisions for family leave, flexibility for time off to address nonwork interests and obligations, and integration of administrative time within the clinical schedule.
Autonomy: Indicates the degree to which there is freedom or independence in one's work, the extent to which individuals can shape their careers to focus on their interests, and the extent to which the work itself matches the interests of individuals.	There are very few opportunities for professional development within the organization. Regulations increase clerical or administrative work significantly.	The organization has taken steps to address inefficiencies around electronic health records, appointment or ordering systems, or other standard systems. There is an effort to decrease time spent on administrative work and documentation to enhance meaning and the patient experience by increasing the time delivering care. Allied health professions are leveraged and engaged.	There are opportunities for involvement in education, research, or leadership as it aligns with individual interests across teams.	There are adequate practice resources to manage the pace and volume of work and designing spaces that streamline work and communication, such as by co-locating teams. The organization uses quality improvement strategies to improve technology and the physical environment and reduce administrative burden (i.e., automated prescription lines, having medical assistants enter patient data into electronic health records, and more efficient patient flow through the clinic).

System Design and Quality Improvement: QI work starts with the organization's underlying systems of care, not just the skills and abilities of the people working in it.	Systems and processes are redesigned without team members involvement.	Staff are asked for their input into redesign efforts, but the new process is defined by leaders or a senior QI team.	Staff are trained in improvement basics, but the work is led and managed by the quality improvement department.	Staff are trained and skilled in improvement, and lead the improvement work supported by site and quality improvement leaders to achieve results in all work sites. No changes in work systems that affect team members without team involvement.
Feedback: The extent to which staff have knowledge of results which are clear, specific, details, actionable information about the effectively of his or her job performance.	Staff feedback is elicited via engagement surveys annually. Nothing comes of the surveys.	Staff have opportunities to voice what matters to them, in public (e.g., at meetings and on feedback boards) and anonymously. The organization periodically posts the concerns and makes efforts to improve the area of concern.	Staff report (through surveys or other measures) the level of choices that brings them joy in work and the organization acts.	The whole organization is responsive to team member feedback and is transparent about what is being improved and what cannot be improved.
Things my team or organization are doing well and existing workstreams/efforts to engage: **Opportunities for improvement:** **Next steps:**				

Meaning and Purpose

Meaning and Purpose are exemplified by a linkage between daily work and the "why" of one's work. They are closely linked to organizational mission, an understanding of the patient or customer experience, leadership's connection with the front-line staff, and representation of the patient or customer voice as supported by a Patient or Family Advisory Group. They can be measured by the extent to which staff experience meaningfulness, responsibility, and knowledge of results.

	Level 1	**Level 2**	**Level 3**	**Level 4**

Connection with Organization's Mission: **The extent to which staff see a line of sight between their work and the strategic goals of the organization. In addition, this reflects the degree to which staff experience the work as intrinsically meaningful and can present one's value to other people.**	Staff successfully perform their duties, but cannot articulate the overall mission and strategic priorities of the organization.	Staff can articulate the mission of the organization and know how their daily work contributes to the mission.	To facilitate honest self-appraisal, staff are regularly asked by leadership to evaluate how well values are lived out in daily practice. Staff are most likely to 'agree' or 'strongly agree' to the following statements (or similar statements): • I have a good understanding of how my job contributes to achieving mission, vision, and strategic plan. • I personally contribute to our success. • Team members participate in critical analysis of the mission and goals, and contribute to vision setting with leaders.	Organization assesses ways to keep purpose and values fresh and meaningful, and periodically take stock of whether actions and values are aligned. Staff mostly 'agree' or 'strongly agree' with following statements: • I have a good understanding of how my job contributes to achieving mission, vision, and strategic plan. • I personally contribute to our success. • Team members participate in critical analysis of the mission and goals, and contribute to vision setting with leaders.
Connections between Leaders and Staff: Leaders can articulate how staff work contributes to the organizational mission and are accessible to front line staff.	Leaders are remote from the work. They assume they know what happens in daily work.	Leaders strive to regularly round, but are inconsistent due to competing demands.	Leaders have daily presence with team members, clearly link the mission to daily work in their communication, and articulate that mission during their rounding.	All staff can clearly communicate the direct connections between the organization's goals and their work.

Patient Experience: In addition to regularly collected experience data, there is real-time understanding of the patient experience and plans for system-wide improvement. This understanding includes staff knowledge of the circumstances associated with the patient's positive and negative comments.	Patient experience and team engagement data are collected annually; data is not widely distributed or used for improvement.	Patient experience and team engagement data are examined monthly within some sites and is being used as opportunities to improve.	Patient experience and team engagement data are used in all areas of the organization, shared publicly, and effectively mined for improvement.	Patient experience and team engagement data are used as critical feedback to feed daily improvement with measurable results. Leaders across the system demonstrate through stories they understand staff feel more meaningfulness in a job that substantially improves either psychological or physical well-being of others than a job that has limited effect on anyone else.
Patients as Partners: Engaging patients and families (or customers) to gather their knowledge, skills, ability and willingness to the improvement efforts. Advisory councils or customer panels provide valuable insight into patient-centered care. In any setting, these can be a value-added asset to help on the transformational journey.	No patient/family advisors. Doing 'to' patients/ families; partnership behavior absent.	Patient/family advisors involved in a few activities. Limited, fearful view of patients/families as partners by team members; tend to do 'for' patients/families.	Patient/family advisors are growing in number; a small advisory council is formed. Beginning to view patients/families as partners. Numerous examples of working 'with' patients/ families in improvement activities.	"Nothing about me without me": Patient/ family advisors are members of a majority of improvement teams, orientation, and board meetings to share their expertise. "Nothing about me without me": Patient/ family advisors are members of majority improvement teams, orientation, board meetings to share their expertise.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Physical and Psychological Safety

Workforce safety is critical to the well-being of the workforce and integral to the safety of the organization.

	Level 1	Level 2	Level 3	Level 4
Data: Data of the types and prevalence of physical injuries in the organization, service line/unit, or practice; for example, push/ pulling injuries from helping patient on and off stretchers, slips, trips and falls, physical threats or injuries.	Team member harm data is collected, but few at organization know of its existence. Organizational aims to decrease employee physical harms are absent.	Team member harm data is reviewed by some leaders, mainly the occupational health department.	Data on physical harm is collected, tracked over time, analyzed, and reported to leaders. Clear aims exist to reduce employee physical harm rates compared to best-known industry rates. Measures show progress in reducing harm.	Data on physical team harm is collected, tracked over time, analyzed, compared to best-known industry rates, and reported quarterly as an improvement measure to the board. Harm reduction matches best-known industry rates.

Assistive Devices: Systems, assistive equipment, and policies and practices that address workplace injuries. As you develop a better understanding of your harm data, it is up to you and your leadership to determine if and what type of assistive devices and/or trainings would support and mitigate physical safety issues in your health care setting.	Few assistive devices, e.g., lifting, are available to reduce harm.	Limited assistive devices are available; limited use by team.	Assistive equipment available in 50% of clinical areas with an emphasis on areas with highest harm rates.	Systems, assistive equipment, and policies and practices that address workplace injuries are used reliably throughout the organization. Physical plant redesigns integrate assistive devices into facilities.
Harm Reduction Training: A set of practical strategies that reduce the negative consequences of physical injuries.	No harm reduction strategies are in place.	Team members participate in educational programs on how to avoid physical injuries in the workplace; emphasis is on safe lifting.	Acute care team members receive rigorous training on prevention of ALL physical injuries, including assault prevention in the workplace.	Team members in all settings – acute care, clinics, home health, skilled nursing facilities – receive training on physical injuries and assault prevention with actions plans in all areas.
Systems to Address Workforce Violence: Staff are prepared to de-escalate and respond to the potential for violence toward staff and other patients	Workforce violence not acknowledged.	Violence against team members is acknowledged in some areas, e.g., Emergency Department, mental health unit; each unit addresses it themselves.	Violence against team members is acknowledged in all areas with protocols for action in place and consistently used.	Violence against team members is acknowledged in all areas with significant reduction achieved and sustained.

Just Culture: A culture in which front-line staff and others are not punished for actions, omissions, or decisions they take which are commensurate with their experience and training. At the same time, gross negligence, willful violations, and destructive acts are not tolerated. When an error or harm occurs, leaders are trained to first examine for problems within the system that allowed the error or harm to occur.	Culture of blame is prevalent. Disrespectful communication to team members is not measured or addressed.	Leaders have been trained in Just Culture concepts, but the concepts are rarely applied. No Just Culture algorithm in use. A no-tolerance policy is written to address bullying, but not reliably implemented in all sites; response varies by positions of power.	All leaders and team members have been trained in the concepts of Just Culture and algorithm use. Approximately 50% of leaders use Just Culture principles consistently. Organization has a standard process in place for reporting bullying and disruptive behavior and is handled with a clear protocol 50% of the time.	A Just Culture is used reliably by 100% of leaders at all levels of the organization, including human resources. The organization examines system issues when a harm or near miss occurs. Disrespect is considered a harm at the organization, consistently addressed, and rarely seen.
Safety Surveys and Culture Assessments: Reporting systems and resources for understanding of the safety culture.	Safety culture surveys are not done regularly but team members receive training on the importance of entering near misses or patient harms into the safety reporting system.	Data demonstrate that team members are only using the reporting system to report obvious harms; additional harms learned through rumors/unofficial channels. Safety culture surveys are administered annually with low participation rates; little is done with the data.	Organization has steady increase in number of the near misses and harms within the safety reporting system. Data is used as a measure of psychological safety and commitment to safety. Safety culture surveys administered annually with steadily increasing participation rates; results at 50th percentile participation; aims in place to achieve 90th percentile; action plans are in place to address findings.	Culture supports sustained frequent reporting of medical errors and safety events; team members feel free to express relevant thoughts and feelings, and speak up about unsafe conditions as evidenced in culture survey. Staff recognize the role of the culture of safety through achievement of 90th percentile participation. Organization commitment to culture change seen through harvesting and spreading effective practices in improving the culture of safety.

Peer Support Programs: Support for team members when there is an adverse event or after a traumatic event or harm occurs.	No support services exist for team members involved in patient harms.	Some sites have informal structures in place to support team members during an adverse event or patient harm.	System to support teams in time of emotional need in early stages of development and utilization.	Formal support peer program in place that is highly utilized.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Teamwork and Camaraderie:

The fundamental concept of teamwork is that a team, a group of individuals, coordinate their actions for a common purpose, which in health care relates to the prevention or treatment of disease in people. A team-based model of care strives to meet patient needs and preferences by actively engaging patients as full participants in their care while encouraging all health care providers to function to the full extent of their education, certification, and experience. Camaraderie relates to the extent to which there is an enabling social structure that facilitates teamwork and a sense of community is actively build. The goal is that individuals are committed to a group effort, which includes trust, respect, and commitment to group goals. In addition, a multidisciplinary team approach to patient care is encouraged and celebrated.

	Level 1	Level 2	Level 3	Level 4

Teaming: Teaming relates to the culture of the organization and is separate and distinct from teamwork below. Teaming is a learning process by which members get up to speed quickly and work together effectively.	Team engagement data are collected annually, but not widely distributed or used for improvement. Productivity is the primary data point for leaders.	Surveys that assess teamwork are clear in their intention; next steps and associated action items, with a clear timeline, are also clear. Conversations occasionally held to understand survey results from team view. Productivity is part of the measures for teaming, but not the sole focus.	Skilled conversations between leaders and team members are routinely held to understand "What Matters" to team members in daily work. Evidence of collecting staff ideas for improvement; frequent, open sharing about collected ideas and how the ideas will be used by the team to improve daily work. Engagement data shows steadily improving performance; turnover and burnout measures. Productivity is used as an indicator of systems effectiveness and efficiency.	"We're in this together" – leaders and team members routinely identify and improve on small, troubling issues — also known as 'pebbles in shoes. Issues are addressed with full transparency. Team members expected role is to do the daily work and improve the work. Team engagement data shows top performance; turnover and burnout measures are in lowest quartile. Measures focus on total value of care not individual productivity measures.
Teamwork: Extent to which individuals feel a commitment to a group effort and the individuals within the group	Teamwork is a core value of the organization, but no training is provided to develop team skills. Leaders have one-way communication with team members.	Team members are trained in Team STEPPSs (a teamwork system designed to improve the quality, safety and efficiency of health care) or equivalent in some areas.	Team members are trained in Team STEPPSs or equivalent in all areas. Teamwork outcomes are part of team engagement measures. Human resources assess teamwork as a necessary skill in the hiring process.	Teamwork is measured across teams with and celebrated through stories across the organization.

Multidisciplinary Teams: Varied disciplines with complimentary experience, qualifications, and skills that contribute to the achievement of the organization's specific objectives. Team members from different departments, disciplines or backgrounds should learn from, with, and about one another regularly.	Silos are the main way team member's function.	Multidisciplinary approach to care is encouraged; few systems in place to achieve this approach.	Multidisciplinary team approaches and skills reinforced. Simulation may be used to develop team skills.	Multidisciplinary team approaches are built into evidence-based protocols and electronic medical record systems.
Participative management: The extent to which staff are given an opportunity to participate in the decision-making process of the management.	There is very little transparency and information sharing.	Training is available, which involves raising the skill levels of staff and offering development opportunities that allow them to apply new skills to make effective decisions regarding the organization as a whole.	Staff are regularly involved in decision making, which can take many forms, from determining work schedules to deciding on budgets or processes.	Leaders regularly solicit ideas from colleagues, and in partnership use the collective ideas and energy of the team. Participative management with collaborative action planning is fundamental for successful servant leadership. The organization has a system for shared responsibility, accountability and ownership ("shared governance")
Camaraderie: Mutual trust and friendship among people in an organization or team.	Very little social support and community exist in the work place.	Support and community exist and is created by medical specialty or in siloes.	Common spaces, such as provider lounges, are available to build community. Commensality, or the act of sharing a meal together or other social gatherings are regularly scheduled and supported by the organizations to promote community.	Collegiality, transparency, and communication are valued in the organization or practice environment.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Equity and Fairness

Equity and fairness are a core part of wellbeing. Everyone needs to be respected and valued within an organization.

	Level 1	Level 2	Level 3	Level 4
Understand equity gaps that exist in the organization. Demonstrate that organizational and health equity are important from the top.	The organization may be contributing to improving well-being for employees and the community as a whole but equity is a not a priority for the organization (i.e. it is not explicitly named as a strategic aim or there are no resources dedicated to identifying and address staff disparities). See IHI Guide: Improving Health Equity: Make Health Equity a Strategic Priority	There are economic and development opportunities for staff at all levels. The organization explicitly focuses on staff development and hiring practices at all levels.	There is active work on multiple processes to decrease institutional racism and improve equity.	Equity is viewed as mission critical — that is, the mission, vision, and business cannot thrive without a focus on equity. Staff are fully engaged, highly diverse, and receive adequate training on implicit bias.

Establish a governance committee to oversee and manage equity work across the organization. Link this work with equity, HR, safety, and quality teams to connect the dots across various existing workforce workstreams	A senior leader is appointed on a short-term basis until a long-term resource is identified. This leader has operational authority to oversee and align all workforce well-being equity efforts.	A system chief well-being officer linked with the equity offer is appointed. This leader has operational authority to oversee (with equity lead) and align all workforce well-being equity efforts.	A clear leader and governance structure exists and is utilized.	The governance committee regularly tracks engagement/ staff satisfaction data surveys and linkages are made between Equity, Human Resources or Occupational Development teams, and executive teams. Equity is built into executive compensation plans.
Dedicate financial and staffing resources to support equity work. (Operationalizing a health equity strategy requires dedicated resources, including human resources and data resources, as well as an organizational infrastructure)	The Executive team has a clear plan to improve the leadership team to reflect the workforce equity work.		Workforce Equity work has a dedicated executive sponsor and associated budgets.	All HR policies are reviewed from an equity perspective. The executive team has a plan for the board that will reflect the work.
Implement systems to protect health care employees in the face of bias from patients and staff	To support communities to reach their full health potential, organizations must work in partnership with community members and community-based organizations that are highly engaged with community members.		The organization has: 1) a written policy addressing patient bias; 2) procedures that account for clinical roles and services; 3) procedures for trainees; 4) consideration of role of nurses; 5) reporting mechanism for patient bias toward health care workers; 6) team for staff support and policy/ procedure implementation; 7) tracking and data collection; 8) training for confronting biased behavior	Zero tolerance policy all discrimination by patients for staff. Clear plan in place to transfer patients Training at all levels of the organization

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Appendix C Planning tool

Planning tool

Feel free to use this tool or one of your own choosing to plan out your strategy to improve workforce well-being in your organization. We have included the primary and secondary drivers as reminders for you.

Autonomy and Control

1.Prioritize efforts to improve flexibility in scheduling and control over how and when work gets done.

2.Reduce unnecessary work, workforce inefficiencies, and assure adequate staffing/resourcing.

3.Foster a culture of trust where people, patients and relationships are center to work and work to support participative management, distributed leadership and co-production.

4.Work to reduce cognitive overload.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Meaning and Purpose

1.Keep people, patients, and relationships at the center by asking "What Matters to You?"

2.Define and communicate organizational values that support well-being and contribute to the mission.

3.Creating a shared purpose and assuring line of sight (mission/vision/values), constancy of purpose.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Physical and Psychological Safety

1.Create a just culture that is free from fear (i.e., one that balances a system's approach and individual accountability).

2.Develop a zero-tolerance policy around bullying and incivility and corresponding escalation process.

3.Destigmatize health seeking behaviors and remove barriers to mental health treatment (remove questions for licensure and privileging application, deploy group debriefings/peer support, etc.).

4.Improve access and remove barriers to mental health and wellness care for employees (screening, trained providers, appropriate treatment, affordable care).

5.Establish and support a physically safe work environment.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Teamwork and Camaraderie

1.Optimize team composition and assure adequate staffing to allow people to spend more time on what they're uniquely qualified to do

2.Create opportunities to foster social cohesion, and supports for teamwork & communication,

3.Profile well-being work and celebrate results,

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Equity and Fairness

1.Understand equity gaps that exist in the organization. Link this work with equity, HR, safety, and quality teams to connect the dots across various existing workforce workstreams,

2.Demonstrate that organizational and health equity are important from the top.

3.Establish a governance committee to oversee and manage equity work across the organization.

4.Dedicate financial and staffing resources to support equity work.

5.Implement systems to protect health care employees in the face of bias from patients and staff.

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Change Management

1.Make well-being & workforce safety a core organizational aim – commit to and communicate this priority

2.Activate the executive team in support of workforce well-being and safety. This will require committees to support the work and resources committed to the team responsible for this work.

3.Develop strong leadership behaviors that support participative management, psychological safety and trust Link with equity, HR, safety, and quality teams to connect the dots across various existing workforce workstreams

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps:

Quality Improvement

1.Use existing staff satisfaction data to establish baseline and contribute to aim statement (Augment measurement system with real time assessments that offer more frequent insights and include metrics around organizational aims (burnout, mental health, suicide, well-being, etc.))

2.Develop improvement capability at all levels with core improvement tools

3.Establish processes to prioritize frontline improvement projects to improve workforce well-being

* Improvement projects are integrated into daily work

* A learning system exists for reporting, evaluation & feedback

* A process exists to implement standard work to scale

•Visual Management: process performance and continuous process improvement tools are utilized

Things my team or organization are doing well and existing workstreams/efforts to engage:

Opportunities for improvement:

Next steps: