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APRIL 2019 V42, NO.4

SIGN OF THE TIMES

GRASSROOTS INSTITUTIONAL ADVOCACY: A PATH TO WELLNESS AND A HEALTHY WORKPLACE

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Employee well-being is an important issue for healthcare institutions. Increasing evidence links burnout and demoralization to decreased quality, safety, and efficiency[1] as well as staff turnover with estimated costs of up to $1 million per physician recruited and hired.[2] Strategies adopted by health systems to increase efficiency, safety, compliance with mandates, and market competitiveness are associated with known drivers of burnout.[1,3] Yet, current trends seem to show organizations opting to create wellness initiatives focused on individual resilience as opposed to making the systems-based long-term, and sometimes costly, changes to address the fundamental drivers of burnout.[2,4] In this setting, advocates of clinician well-being can rightfully feel overwhelmed, isolated, and discouraged. A grassroots approach unifying these advocates to promote institutionally-based change may counter these adverse outcomes.

We took this approach at our institution, a large academic health center (AHC) closely affiliated with a Veterans Affairs medical center. Longstanding concerns about employee well-being had been spotlighted from results of system-wide employee engagement surveys. Many of us were already working on wellness initiatives in individual silos to address manifestations of staff and trainee burnout (e.g., depression, turnover, closing of programs). We felt the institutional response to the survey results were likely insufficient: they were uncoordinated and lacked an overarching strategy and appropriate investment of resources.

A visit by an expert in leadership and organizational transformation gave us an opportunity to bring together some of the people working on wellness initiatives. During our informal breakfast meeting, the discussion illuminated a common feeling that the institution could do more. Attendees decided to form an *ad hoc* group to collectively advocate for an enhanced institutional approach to employee wellness.

Advocacy and Community Building

That decision, by a group of mostly strangers from different departments and disciplines, to come together outside of normal channels to work for change, was our first step into grassroots mobilization. Such an approach is not typically seen within AHCs, where approaches to organizational transformation tend to be driven by central leadership through technical plans disseminated to frontline workers. There, leaders focus on the creation of such plans and enforcement and compliance.[5] Outside of health care, grassroots approaches to change tend to be more common. Examples include efforts by teachers to change school policies, collective mobilization of workers in large retailers to shift working conditions, and targeted collective action by concerned consumers to shift policies at various companies.

The common feature of these approaches and what makes them powerful lies in groups of people, with similar stories and values, coordinating efforts in a longitudinal way to effect changes they could not bring about on their own.[5] In a world where AHCs are increasing in size and power and leaders are increasingly pressured to optimize financial margins with little input from important frontline stakeholders, collective action represents a unique means for concerned parties to be heard and felt. But how can this be done in a way that appropriately balances concerns about clinician well-being with pre-existing organizational priorities, norms about dissent and an overarching need to maintain a level of

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professionalism and collegiality with institutional leadership?

Our Approach

With our *ad hoc* group launched, we used our meetings and conversations as opportunities for collaboration and synergy, forming new bonds built from shared stories and values. One of our first steps was to agree to a distributive leadership model where all take turns running meetings and advancing various subcommittee work. We were fortunate to have a project manager who lent time to schedule meetings, create a listserv, and send reminders. Our meetings start with introductions and emotional check-ins; our agenda is fluid to respond to newly made connections. We named ourselves the Leaders for Wellness and use an inclusive decision-making process.

Another step was to create an inventory of people and programs involved in well-being efforts to build relationships across the institutional silos of departments, schools, and hospitals. We agreed to open membership with the intent that every participant invites others in their respective networks to join. This has been key to building a diverse community and decreasing the likelihood our group would be painted as advocating for a self-interested agenda. Instead, we used our relationships to mobilize and unite many voices and perspectives to build a larger constituency. Our group engaged with leaders of the AHC through active involvement in town hall events, email-based surveys, institutional strategic planning, as well as holding individual meetings and joining pre-established committees addressing employee wellness.

A sense of community and possibility has emerged as groups realized they could combine constituencies, partner, coordinate, amplify, share best practices, and support each other's programs. This has built momentum for wellness initiatives and has been a positive disruption to the traditional processes for decision-making at our AHC. Our social network, with its diversity of perspective, inclusivity of position, and numbers of people, has contributed to the influence this group has had. New sets of ideas, ideals, and identities are spreading through our network likely because our people are more closely connected and—as increasing amounts of sociological research suggests—influenced by one another.[6]

This is an unfamiliar approach to change at AHCs. It is meant not to replace the pre-existing approach that relies on structure, data, and formal lines of decision-making but to complement it.[5] The focus on relationships and finding programmatic synergies has breathed new life into well-being work at our AHC and has amplified previously unheard perspectives. The open, trustful, and cooperative space that enabled such common purpose also ended up proving therapeutic, improving participants' sense of wellness and agency.

Our Challenges

This process has had challenges, beyond finding time to meet and a project manager willing to coordinate efforts. Success has required the ability to hold the tension of a leadership model that is dispersed and strategies and tactics that feel fluid due to shifts in response to evolving issues, opportunities, and realities. Meeting outcomes initially prioritized relational over task goals, which felt odd at first, given the highly structured nature of traditional healthcare committees. It can feel foreign and create conflict that needs to be managed as members navigate a group without clearly defined structures and team processes.

Lessons Learned

A grassroots effort such as ours can complement traditional strategies for change. The following are suggestions for getting started:

1. Find a core group. Be inclusive and break bread together when possible—it's the fastest way to put hierarchy aside and connect to each other as humans.
2. Focus on relationships initially and resist the tendency to strictly adhere to a traditional meeting agenda. Instead, spotlight personal stories, shared values, and connections, and later, how these connections have subsequently made a difference (e.g., collaboration in programs that would not otherwise have occurred).
3. Understand your institution's stakeholders and decision makers. Listen to what they care about and identify resources and relationships you possess to leverage those interests to move a wellness agenda forward. Your support can be mobilized through letter writing campaigns, participation in surveys, coordinated meeting attendance, and spaces where public feedback is sought.
4. Commit to distributed leadership. Making room for diverse membership requires that the leadership not be held too tight by any single person or group.
5. Be flexible in the outcome and trust the process. One of the most valuable outcomes of our group has been the act of connecting people from across the mission areas and silos of our AHC. The power and synergy this created is an outcome of an intentional process of relationship building.

Bringing strategies of advocacy and grassroots organizing into the world of AHCs may accelerate change as well as enhance participants' sense of wellness, connection,

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and purpose. As we collectively undertake the marathon that healthcare reform represents, such benefits of collective action may not only raise our chances of ultimately reaching the finish line—where the wellness of the workforce is no longer an afterthought—but potentially arriving in a better state than when we started the journey.

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