

Abstracts

THE 2017 ACGME SYMPOSIUM ON PHYSICIAN WELL-BEING

NOVEMBER 29-30, 2017
CHICAGO, ILLINOIS



ACGME

The 2017 ACGME Symposium on Physician Well-Being

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ABSTRACT #1



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KEY PARTICIPANTS

Lesko, M- Faculty Member, APD for Wellness Podolsky, O - Program Coordinator
Adelman, M - Chief Fellow

TARGETED ISSUE / PROBLEM IDENTIFIED

Assess Current Wellness Curriculum; Administer the Modified Maslach Burnout Questionnaire; Reassess and Structure New Wellness Curriculum.

INTERVENTION / PROGRAM DESCRIPTION

Fellow Wellness Program In a Pulmonary/Critical Care Program

TOOLS / STRATEGIES USED

The Modified Maslach Burnout Questionnaire was administered confidentially to our fellows. 22/23 fellows completed the survey.

PROCESS USED TO DEVELOP THIS PROGRAM

Our program had a wellness curriculum which primarily included quarterly bonding and social activities, a work life panel, career planning sessions and education on the topic of sleep deprivation and fatigue. In order to assess our curriculum before we restructured it, we administered the Modified Maslach Burnout Questionnaire to assess burnout. The questionnaire utilizes a likert scale, and has four different groups of questions designed to assess emotional exhaustion, depersonalization, professional satisfaction, and personal accomplishment

CHALLENGES / BARRIERS

Our main challenge is finding time in our already busy fellowship to schedule activities so that a majority of fellows can join. We have added our wellness activities to our monthly fellow meeting agenda so that we can get input from the fellow class as to when they think these activities would be most welcome in their week's schedule, if at all.

OUTCOMES / IMPACT

Our results demonstrate that at least 50% of our fellows have a significant degree of emotional exhaustion which place them at risk for burnout. This number decreases to approximately 13% for the other groups of questions.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Based on the survey results, we restructured our wellness curriculum. We have formed a wellness task force led by our APD for Wellness with two fellows from each class; we have expanded our curriculum to include additional professional development workshops and career counseling sessions. We have expanded our panel discussions on work life balance and improved personal wellness by increasing the focus on healthy lunches during noon conferences. There has been an increase focus on stress reduction and resiliency through financial planning talks and will soon include small group discussions facilitated by our hospital psychologist to help reduce emotional burnout. Other facets of our program include an annual charity drive in its inaugural year chosen by the fellows, and movie nights with films portraying aspects of physician life and motivational talks.

GENERALIZABILITY TO OTHER ORGANIZATIONS

This survey tool and curriculum design is very easy to use across residency and fellowship programs.

LESSONS LEARNED

We have learned that our fellows experience a significant degree of emotional exhaustion despite many tools that we are already using to promote wellness. We plan to use additional surveys to assess if this emotional burnout is in fact a type of emotional fatigue which has been described in other residency programs (1). We also plan to resurvey our fellows after we have fully implemented our new wellness curriculum. (1) Crowe L. Identifying the risk of compassion fatigue, improving compassion satisfaction and building resilience in emergency medicine. *Emergency Medicine Australia* 2016;28:106-8.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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ABSTRACT #2



Sepideh Amin-Hanjani, MD
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KEY PARTICIPANTS

Society of Neurological Surgeons (SNS) - primary organization focused on education and residency training in Neurosurgery

TARGETED ISSUE / PROBLEM IDENTIFIED

To provide education to program directors and Chairs at the SNS annual meeting

INTERVENTION / PROGRAM DESCRIPTION

Programming at the SNS Annual Meeting

TOOLS / STRATEGIES USED

Selection of topics and speakers at the SNS Annual Meeting for a session dedicated to resident well being and resilience

PROCESS USED TO DEVELOP THIS PROGRAM

SNS Annual Meeting Scientific Program Planning Committee

CHALLENGES / BARRIERS

Development of wellness programs

OUTCOMES / IMPACT

Post-meeting survey results

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Potential for future program sessions at SNS

GENERALIZABILITY TO OTHER ORGANIZATIONS

Incorporation of content/education on wellness into specialty society meetings

LESSONS LEARNED

Content generally well-received; additional forum for discussion amongst PDs may be useful.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Marion Aw, MD NUHS Singapore

KEY PARTICIPANTS

1. PGY1 2. Residents 3. Faculty

TARGETED ISSUE / PROBLEM IDENTIFIED

1. Lack of awareness or acceptance of fatigue and burnout as a reality in doctors 2. Relative apathy to act or intervene at the individual level

INTERVENTION / PROGRAM DESCRIPTION

2 Broad themes: 1. Identify the extent of the issue of physician burnout and fatigue in our local setting 2. Physician Health and Resilience - how to promote this amongst physicians as a way to minimize the impact of burnout

TOOLS / STRATEGIES USED

For 1(a) Fitbit to track physical activity and sleep Epworth sleepiness scale as a measure of fatigue ProQoL tool For 1(b) Connor Davidson Resilience Scale Maslach Burnout inventory Cohen Perceived Stress Scale

PROCESS USED TO DEVELOP THIS PROGRAM

1. Identifying the extent of the problem (a) Prospective study over 4 months on burnout and fatigue in PGY1 doctors and Faculty. (b) Cross sectional survey on resilience, burnout and stress amongst trainees and faculty 2. Needs assessment amongst Core Faculty / APDs/PDs regarding perceived importance of burnout and resilience in physicians.

CHALLENGES / BARRIERS

Getting buy-in from faculty on the importance of this topic, and getting them to invest time and energy in promoting this. Identifying appropriate tools/ intervention strategies to promote this across the board for faculty and residents

OUTCOMES / IMPACT

1(a) Whilst Faculty and PGY1s were at similar risk of fatigue, faculty experience less burnout and had higher compassion satisfaction scores compared to PGY1 doctors. Faculty likely possess protective mechanisms, which PGY1s have yet to acquire 1(b) Results not yet available/ analysed 2. CF/ APDs/PDs recognize the importance of identifying burnout in colleagues and residents. However, they acknowledge a gap in awareness of tools and strategies to improve resilience and reduce burnout, and how to in-corporate these tools to

promote holistic wellness.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Currently conducting workshops on Physician Health and Resilience - 2 workshops conducted for faculty. planning 1 workshop for residents (residents identified by programs as being potential “champions” for this in their respective departments)

GENERALIZABILITY TO OTHER ORGANIZATIONS

1. Important to identify extent of the problem in your own institution in order to get the buy in from higher management (may be relevant only if higher management not yet convinced) 2. Needs of programs and people differ - important to identify these in order to get better buy in. 3. Importance of messaging.

LESSONS LEARNED

1. Departments may need to be run by these programs within their departments to gain better traction, rather than centrally by GMEC, especially at the resident level. Response rate when run centrally was relative low for resident sign up. We had to get Program Directors to nominate residents to attend. However, we noted that residents themselves may be interested in the topic, as one program’s CR requested for the contact details of our external facilitator so that they could run workshop themselves. 2. Faculty and residents were more “open” to attending the workshop if the workshop was advertised as “come to learn how to identify burnout in colleagues/ residents” and help them, rather than come and learn how to help yourself.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Jessica Bienstock, MD
Johns Hopkins University**KEY PARTICIPANTS**

Jessica Bienstock, MD Laura A. Hanyok, MD

TARGETED ISSUE / PROBLEM IDENTIFIED

Institutional Safety Culture survey data identified residents and clinical fellows to have some of the highest rates of burnout in our organization. A needs assessment of program directors, program coordinators, and chief residents identified the need for more wellness programming, with time, finances, and lack of expertise as implementation barriers. Additionally, the diversity and breadth of programs (ranging from 1 to over 100 residents per program) at our institution is a challenge as there is a wide range of needs.

INTERVENTION / PROGRAM DESCRIPTION

The Johns Hopkins Resident & Fellow Wellness Initiative is a multi-pronged well-being initiative launched in July 2017 with the goal of reducing resident and clinical fellow burnout. Although this program is primarily targeted at trainees, we have partnered with undergraduate medical education leadership to create resources and programming for learners across the UME and GME continuum. The Wellness Initiative is composed of: (1) a GME-specific Wellness website that serves as a central repository of information; (2) wellness programming directed at residents and fellows; (3) weekly email titled “Wellness Matters,” sent to all trainees and program directors to raise awareness of activities and resources; (4) GME-wide Wellness Committee; (5) faculty role modeling and coaching to promote resilience and thriving in medicine; and (6) outreach to clinical and educational leaders to message the importance of identifying trainees at risk for depression or suicide.

TOOLS / STRATEGIES USED

Several tools and strategies compose our wellness initiative: (1) “Wellness Wednesdays” monthly wellness programming, including pet therapy, yoga, massage therapy, healthy snacks, and reflective writing (2) Weekly “Wellness Matters” updates emailed to all trainees and program directors which includes online resources (e.g. meditation apps), short essays emphasizing professional satisfaction, institutional mental health resources, activities on and off campus (e.g. hospital’s farmers market and city-wide arts festival), etc. (3) A GME-wide wellness committee (4) Faculty role modeling and coaching to promote resilience and thriving in medicine (5) Outreach to clinical and educational leaders to message the importance of identifying trainees at risk for depression or suicide

PROCESS USED TO DEVELOP THIS PROGRAM

We began by reviewing the literature and the internet to identify current GME well-being programs. We used Shanafelt and Noseworthy’s Nine Organizational Strategies to Promote Engagement and Reduce Burnout as a starting point for our wellness committee and GME leadership to determine what strategies should be used to create a multi-pronged initiative. Input from residents, fellows, and faculty physicians from multiple training programs was solicited and incorporated into the program.

CHALLENGES / BARRIERS

Our Initiative is meant to complement, not replace, efforts that some individual training programs have launched in this area. One challenge is how to best plan a GME-wide initiative with a diverse group of training programs, some of which have an extensive focus on well-being and others that have less. How best to reach trainees in small programs is still being determined. Lastly, others in our institution are also focusing on well-being and wellness for employees, faculty, and students. How best to interface with these other groups is still to be determined.

OUTCOMES / IMPACT

As this initiative began in July 2017, we do not yet have outcome data. Anecdotal data suggests that residents and clinical fellows find this program raises awareness of burnout and depression and may encourage trainees to talk more about these issues.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We are currently implementing the final two parts of our initiative: faculty role modeling and coaching to promote resilience and thriving in medicine and outreach to clinical and educational leaders to message the importance of identifying trainees at risk for depression or suicide. In the spring we will survey our residents to see which aspects of the Wellness programming they utilized most and which aspects they found most helpful.

GENERALIZABILITY TO OTHER ORGANIZATIONS

This initiative could serve as one model for a well-being initiative for institutions with a large number of diverse training programs, as well as those wishing to create a well-being initiative that spans UME and GME learners.

LESSONS LEARNED

The highest profile part of our initiative has been our weekly “Wellness Matters” email. This email alerts residents regarding activities going on that week and serves as a prompt to remind them of the resources available. We initially began the website as a resource only for GME learners. The popularity of the site quickly spread and at the request of the Dean’s office we have now included resources for Undergraduate Medical Education and Graduate Biomedical Education (MS and PhD students) as well. Timing of Wellness activities remains a challenge for us. Programming held during working hours is difficult for residents to attend and programming held after working hours has been undersubscribed. We are currently working to bring our programming to the residents in the spaces where they work.

WEBSITE / LINKS

wellness.som.jhu.edu

SUPPORTING MATERIALS

n/a

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Steven Bowman, MD Cook County Health and Hospital System

KEY PARTICIPANTS

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TARGETED ISSUE / PROBLEM IDENTIFIED

Emergency Medicine Resident Physician Access to Mental Health Services at CCHHS

INTERVENTION / PROGRAM DESCRIPTION

Physician well-being is paramount in ensuring proper patient care. An important component of maintaining physician well-being involves having regular access to mental health services for those who require it. Our project sought to identify the options available to emergency medicine (EM) resident physicians requiring mental health services and to identify possible barriers to access to those services.

TOOLS / STRATEGIES USED

Review of residents accounts of challenges during residency
Assessment of state of current mental health services
Review of Resident insurance benefit
Review of CCHHS Employee Resources
Crisis Intervention etc
Interview w/ DIO
Interview of Director of Employee Health Services
Assessment of Resident current Understanding of how to access
Review of Health priorities

PROCESS USED TO DEVELOP THIS PROGRAM

A series of anecdotal experiences including emergency medicine residency program didactics, requests for information by EM residents, and an acute mental health crisis involving a non-EM resident, raised concern within the EM program leadership. We initiated a detailed review of the medical insurance and resources provided to our institution's post graduate physicians and the options available for them to gain access for mental health services. Based on interviews with our graduate medical education office and the director of employee health services, we determined that the optimal pathway for resident physicians to access mental health services is via referral by a primary care provider. Of note is the fact that very few residents, and none of the program leadership, were aware of this. All residents physicians are provided health insurance by the institution as an employee benefit. We discovered that approximately 60% of our residents (a young, healthy cohort with few pre-existing medical conditions) did not have a primary care physician. We decided to initiate

an educational intervention during our annual residency retreat. We reformatted the entire retreat to discuss topics related to physician wellness. Our intervention included educating our residents on the past and current state of affairs with respect to accessing mental health services at our institution, the preferred pathway to obtain mental health services, a review of available health insurance options, and the process to establish primary care. Residents without primary care physicians were instructed to select one, with the expectation that they would attempt to have their initial visit during the current academic year.

CHALLENGES / BARRIERS

There are multiple barriers to our implementation of a system for our residents to access mental health services. All residents are identified by the institution as employees without differentiation from other health system employees. As such, resident physicians must follow the general employee protocol for mental health referral. The pathway in place prior to our intervention consisted of program director or supervisor referral to the Employee Assistance Program (EAP), a voluntary, site-based program that offers free and confidential assessments, short-term counseling, referral, and follow-up services to employees who have personal and/or work-related problems. Recently, EAP was centralized with a simultaneous and drastic reduction in the number of counselors. There is currently only one EAP provider available to assist employees seeking help, which includes the hospital system, and other affiliated non-hospital sites. The wait time is currently 3-4 months to meet with an EAP representative. Residents also expressed concern regarding confidentiality when utilizing in-house referrals with respect to reporting to the program and employee health services. Additionally some voiced concern that seeking mental health services could have negatively impact future employment and complicate medical licensure. We also found that it is difficult to obtain a psychiatrist through a primary care physician in a timely manner. The time it takes to establish care with a PCP through insurance, make an appointment, and then obtain a referral to psychiatry may take as long as 2 months. For a resident with an acute mental health issue, this delay is unacceptable.

OUTCOMES / IMPACT

We met our initial objectives. We discovered that it is very difficult for our residents to obtain timely mental health care without a previously existing primary care physician, given the limitations of our institution's established EAP. The described intervention was effective in pushing the majority of our residents to begin the process of acquiring

a primary care provider. Anecdotally we have confirmed that this allowed some residents to identify primary care providers and obtain timely confidential, mental health care through their provided health insurance benefit. The results of a resident survey, which is currently underway, are pending. The DIO was made aware of our intervention. Its design, implementation, and outcomes will be reviewed and disseminated to other programs within our institution.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Creating the expectation that our residents would establish care with a primary care provider will hopefully shorten the length of time required to access mental health services. In the meantime, our designated institutional official (DIO) has been made aware of the limitations to mental health services for our residents. The DIO and the Graduate Medical Education (GME) office have created a multidisciplinary committee to address physician wellness and implement an improved system for our post graduate physicians. The emergency medicine residency is the first to use a dedicated approach to offer a solution to the gaping defect concerning mental health resources and we will work with the DIO and GME establish a new mental health initiative directed to resident physicians.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Our program is the first in our institution to take steps to improve access to mental health services for resident physicians. This intervention can be easily replicated in other programs both within and outside our institution. Encouraging residents to establish care with a primary care physician is an initial step that can be done universally across programs. In addition, working with the DIO and GME, or their equivalent at other institutions, to create or improve existing resources for post graduate physicians is not only something that can be done, but should be done to ensure that these services are available to all residents.

LESSONS LEARNED

Resident physicians should have easy and immediate access to mental health services. It should therefore be mandatory for all residency programs to ensure this is available for residents. Residency is a stressful time, and proper patient care is dependent on physicians who are mentally and physically capable of providing such care. The pathway to access mental health services should be simple, transparent, and confidential. Encouraging residents to establish care with a primary care physician before such problems arise is the best immediate solution in addressing the barriers

identified. For a long term solution, hospitals with residency programs should establish mental health services tailored to the post graduate physician. Mental health services are just as critical to ensuring resident well-being as are other forms of healthcare. If residency programs prioritize establishing clear and direct access to mental health services for post-graduate physicians, this would not only improve resident well-being, but also as a result, would likely improve patient care.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Mary Yarbrough Reid Thompson Wright Pinson

TARGETED ISSUE / PROBLEM IDENTIFIED

1) Does the VUMC community, particularly the physicians, understand all of the offerings provided by the Office of Health and Wellness? 2) What do our physicians (faculty and residents) need to do their best work and enhance their personal well-being?

INTERVENTION / PROGRAM DESCRIPTION

Improving Communication, Understanding the Issues - While we have a number of excellent wellness programs at Vanderbilt through our Office of Health and Wellness, we raised the question of whether the medical center community under all of the services provided there and whether or not we understood the most important wellness issues affecting our physicians (faculty and house staff)

TOOLS / STRATEGIES USED

1) Health & Wellness "Monthly Happenings" Newsletter 2) Development of a Task Force for Physician Empowerment and Well-Being 3) Two-questions survey to all physicians (house staff and faculty - a) If 10 reflects your optimal health and wellness and 0 reflects burnout or significant personal/professional stressors and concerns, where do you place yourself on this scale {sliding scale}?, and b) as a physician in the VUMC community, what do you need to do your best work and enhance your personal well-being?

PROCESS USED TO DEVELOP THIS PROGRAM

Two specific interventions were developed, one for each issue identified. Issue #1 - The Office of Health and Wellness (OHW) developed a "Monthly Happenings" newsletter that they distribute to the entire medical center population each month. The newsletter highlights the 3 arms of OHW - Health Plus, Occupational Health, and Work/Life Connections-EAP, and, for each of these arms, the newsletter highlights 4 aspects: 1) a program highlight, 2) something they are proud of, 3) a member highlight, and 4) operational highlights. Issue #2 - a Task Force on Physician Empowerment and Well-Being was created, co-chaired by the Director of OHW and by the Chair of Neurosurgery. Importantly, the population of the 14-member committee included 2 house staff, front line clinicians, 2 program directors, and area leaders. As an initial part of their work, they developed a simple two-question survey for all physicians regarding their personal well-being.

CHALLENGES / BARRIERS

For the newsletter, the major challenge is knowing whether the community is reading it and finding it helpful. For the Task Force and survey, it is analyzing the data and deciding what suggestions are quick wins and which ones require more long term solutions.

OUTCOMES / IMPACT

The monthly newsletter conveys to everyone who receives it the 8 service categories covered by Health and Wellness - 1) supporting a culture of wellness, 2) building health competency, 3) outreach/training, 4) population health surveillance & personalized health plans, 5) just in time health programming, 6) coaching, counseling, and consulting, 7) disease prevention, screening and treatment, and 8) disability management. The newsletter also allows the community to see actual & target data from each of the 3 arms - 1) for Health Plus, the number of people receiving health screenings, the number of health risk assessments completed, the number of people receiving wellness coaching, and the number of people attending skill-building programs; 2) for occupational health, the total number of work injuries, the % of work injury visits with no lost time, the % of the population served, and the number of acute care visits seen; and 3) for work/life connections, the total number of new/active counseling clients from nursing, physicians (faculty and house staff) and staff, and the number of high risk cases seen across the full community. The survey of physicians found that the mean well-being score on a 100-point scale (converted from the sliding scale) was 55.7 with a SD of 27.6, with a range from 0 to 100. The median was 62 with a 95% confidence interval of 60-64. For the open-ended second question, answers fell into 7 major categories with suggestions for improvement [listed here in descending order of number of suggestions] - self-care, leadership, staffing, efficiency, control/autonomy, recognition & pay, and EPIC/medical record.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

The Task Force will continue to analyze the data of the survey, looking at data by department, by age group, and other perspectives. One win that will take effect January 1, 2018 is a 67% reduction in the cost of membership in the University Recreation & Wellness Center for those person who complete all 3 steps of our Go For the Gold Program and who use the recreation center at least 30 times per quarter.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Creating a task for physician empowerment and wellbeing is easily generalizable, as is this simple two-question survey of an organization's physician population. While the newsletter is probably equally generalizable, it does require a level of organizational support and administrative time (it is delivered electronically).

LESSONS LEARNED

Valuable information can be gathered by listening to frontline physicians. More lessons will be learned with further analysis of the data and implementation of suggestions for improvement. Normalizing the topic areas highlighted in the newsletter and letting the community know that there are targets for the data may normalize the services offered, particularly in the area of mental health coaching and counseling.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Hospital Corporation of America (HCA)

KEY PARTICIPANTS

n/a

TARGETED ISSUE / PROBLEM IDENTIFIED

This “intro to well-being” may not seem like much of a big idea, but our program administrators need to be introduced and educated concerning the ACGME as a whole, first. Slowly but surely. I am excited to share with them what I have learned and to hear views from a different perspective. I anticipate that the program administrators who are intrigued by this subject will have wonderful, innovative ideas for us to strive toward.

INTERVENTION / PROGRAM DESCRIPTION

My commitment to change began by hosting monthly program administrator specialty conference calls throughout our enterprise to introduce the idea of physician well-being. My original goal was to share with program administrators what I’ve learned, to gather ideas from them, and to encourage collaboration across our facilities for an enterprise-wide Physician Well-Being Program that can be used each year by all facilities, with additions as warranted.

TOOLS / STRATEGIES USED

Once ACGME accreditation is obtained, more time and energy can and will be directed toward well-being of our faculty/attending and residents/fellows.

PROCESS USED TO DEVELOP THIS PROGRAM

In the last year, we have become the largest provider of GME in the United States. We are opening new programs across the country at our facilities, converting most current AOA programs to ACGME.

CHALLENGES / BARRIERS

Some of our programs have a well-being initiative at their local facility that includes players from many departments; other programs that have just been accredited are still working toward this topic. I have observed program administrators “removing themselves from their silos” when we are together having these conversations.

OUTCOMES / IMPACT

The monthly program administrator specialty calls are going well. Program administrators are actively participating, sharing their own ideas with peers, and thinking about

physician/resident well-being. They are enthusiastically volunteering topics for the calls, and most are even agreeing to speak up and share during the conversations.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

I was honored to present “Coordinator Well-Being” as faculty at the ACGME’s inaugural Experienced Coordinators Course, which included approximately 70 program administrators from across the nation. During the course, reflection on my experience at the past two Physician Well-Being symposia was communicated, and some of my personal experiences as a coordinator were shared. We discussed topics such as work-life balance vs working life, burnout coping and prevention strategies, and six core competencies of the coordinator and how they fit into wellness. We also talked about the importance of analyzing our own thought system and identified values that are building blocks for happiness. To help foster the idea of wellness, the program administrators participated in writing an “I Am” poem, completed a “Wheel of Life”, and participated in a self-reflection activity. We need to remember the individuals who keep our programs running successfully on a daily basis. Healthy coordinator = more healthy program. This is what I am striving toward.

GENERALIZABILITY TO OTHER ORGANIZATIONS

I gathered an enterprise-wide group that is interested in well-being. Research and information from the inaugural symposium were shared. It energized the group, and those individuals will be used to help lead our company’s GME enterprise-wide well-being initiative in the future.

LESSONS LEARNED

I most recently supported our program administrators in Las Vegas, where we have three hospitals that were involved in treating patients from the Route 91 shooting. Although there is a system in place that runs from the C-Suite through physician leaders, the program administrators will be and are the individuals looking at the residents closely to see if there are any needs that have not been or will not be voiced. The program administrators are the ones seeing their residents’ haggard faces, listening to their experiences from this event, and supporting them. My responsibility, in turn, is to think about the program administrators: How are they processing and digesting the experiences the residents are sharing with them? How are they dealing with their own feelings of extreme empathy for their residents? In our conversations, I could hear the pain in their voices. The hurt I heard in their voices for their residents was stirring.



WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

CONTACT

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ABSTRACT #8



Patrick Cocks, MD NYU School of Medicine

KEY PARTICIPANTS

Patrick Cocks, MD Margaret Horlick, MD Barbara Porter, MD MPH Louis Miller, MD Sandra Zabar, MD

TARGETED ISSUE / PROBLEM IDENTIFIED

recent needs assessment of our faculty and chief residents showed deficit in knowledge and skills related to approaching a struggling house staff.

INTERVENTION / PROGRAM DESCRIPTION

The focus on housestaff wellness has uncovered skills gaps in program leadership and faculty in approaching struggling housestaff officers. In an innovative approach to faculty development, we have used group OSCEs to develop these skills.

TOOLS / STRATEGIES USED

group observed simulated teaching experience (GOSTE) incorporating direct observation and feedback and peer/peer learning.

PROCESS USED TO DEVELOP THIS PROGRAM

small session group discussion

CHALLENGES / BARRIERS

the greatest barrier we have seen continues to be finding time for faculty to participate in our program

OUTCOMES / IMPACT

Currently we hold post encounter debriefing sessions with faculty and chief resident participants. Common Debriefing themes: Tendency to normalize Confidentiality issues Escalation Need for risk assessment

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

we have expanded recruitment of our session to include local partners in GME (APDs and Chief Medical Residents). post intervention survey instruments will be developed to determine if these structured encounters can change institutional culture around wellness.

GENERALIZABILITY TO OTHER ORGANIZATIONS

We currently have 3 cases (a intern struggling with burnout, an intern struggling with at risk drinking behavior, and an intern struggling with depression) that can provided to

interested institutions.

LESSONS LEARNED

A wellness curriculum can include experiential learning for all members of the community. An OSCE is acceptable to trainees and makes an impact on interns/residents. A group OSTE is a unique faculty development method. Common experiential learning can start a culture change in a residency community.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

changing_culture_through_experiential_learning_2016_aaim_skills_development_conference_final.pptx

CONTACT

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KEY PARTICIPANTS

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TARGETED ISSUE / PROBLEM IDENTIFIED

Create family support during residency and fellowship
Create residence through peer support Integrate the resident and fellows in one community Identify the high risk population for burn out

INTERVENTION / PROGRAM DESCRIPTION

Each new resident will have a “padrino”, this mean a senior resident who will be like a big brother to that person. This “padrino” will guide the new fellow in daily activities. These things include how to manage the stress, what I need to learn in the first month, protocols, etc. The “padrino and ahijado” will exchange phone, email and address. They will establish an excellent relationship with the main objective of supporting each other. The “padrino” whenever is possible will help in giving UM tour, calling the “ahijado”, having lunch with him and other things. At the end, the “ahijado” should feel like in family. They can meet whenever they want. The meeting can be one to one or in group. Two weeks before the orientation each resident will have the name of his/her “ahijado”. Then they will try to locate this “ahijado” via email, facebook, twitter, phone, arrange a meeting if they are here. There will be a core topics that all the “padrinos” should review and talk to their “ahijados”. Besides these core curriculum any other thing that the padrino consider to be important and that will help the new intern he can give it. The first general meeting of the “padrino” program will be on the orientation day. Here all the “padrino” and “ahijados” will have a little party where they can share experience (this doesn’t mean that this will be the first time that the padrino-ahijados will meet). The “padrino” should be available almost all the time to answer question or help his/her “ahijado”. This is the main key of the program “Family like structure”

TOOLS / STRATEGIES USED

The result will be evaluated in two ways. 1. Subjective: seen how the new fellows are doing, by talking to them and having feedback. 2. Objective: with a survey after the third month where we can really know what is happening and if the program is working and the last survey at the end of the year.

PROCESS USED TO DEVELOP THIS PROGRAM

Every 3 months the “padrino” program will have a social meeting where everybody can share with the others and some “ahijado” can learn from other “padrino”. Besides this meeting will be a great opportunity to integrate more us. At the end of 3 months, they will be a survey (one for the “ahijados” and other for the “padrinos”) to evaluate the program and to know if it is working and what things we should improve. The program will continue the entire year. After the adaptation process finish, the mentoring process will start and all the topics for the area will be send latter.

CHALLENGES / BARRIERS

Time Cost of the monthly meetings engagement of the participants

OUTCOMES / IMPACT

Having a familiar-like structure where peers can support other peers has demonstrate in other countries to work and improve the wellbeing in the work area. The impact of this program is create camaraderie among trainees and help create resiliency since the beginning of their training Result The expected result of this program will be 1. Better and faster orientation and adaptation of the new trainees 2. A family environment, 3. A better success of the new ones 4. The integration of the resident/fellows 5. Exchange and support new ideas 6. Stimulate the humanity and partnership within resident .

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

1. Expand this program from endocrinology fellowship to the entire GME at Phoenix VA 2. Expand the program to the entire GME of UACOMP 3. Expand the program to the entire GME of Phoenix 4. Share experiences among institutions and improve the program

GENERALIZABILITY TO OTHER ORGANIZATIONS

This is an easy project that can be use by any institution as a way to support their trainees

LESSONS LEARNED

The Program will start in January 2018 so I don’t have any results.

WEBSITE / LINKS

n/a



SUPPORTING MATERIALS

n/a

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Sydney Ey, PhD
Oregon Health and Science University**KEY PARTICIPANTS**

Medical residents, fellows (N=906) and faculty (approx. 2000) in midsize academic medical center and through a community hospital residency program

TARGETED ISSUE / PROBLEM IDENTIFIED

High rates of physician burnout, depression/anxiety symptoms and suicide risk starting in medical school and worsening in residency and practice highlight the need for systems of care for physicians. Despite knowledge of mental health treatment benefits, a number of physicians report significant barriers to accessing counseling or medication evaluation/management for themselves.

INTERVENTION / PROGRAM DESCRIPTION

In 2004, my colleagues and I set about to create an easily accessed, confidential, free wellness program for burned out and/or distressed medical residents. Faculty became eligible for our services in 2008. Through outreach workshops, groups, trainings with program leaders and GME support, we encourage physicians to attend to their emotional and physical well-being and to seek professional counseling if needed. Individual counseling, coaching, psychiatric evaluation and medication management and coaching are offered.

TOOLS / STRATEGIES USED

Developed in house, easily accessed, free comprehensive counseling program, educational outreach workshops in 2004 for medical residents and fellows Expanded program to offer counseling to clinical faculty starting in 2008 Started suicide prevention initiative with AFSP Interactive Screening Protocol and outreach workshops in 2013 Launched Peer Support Program in 2016 for faculty and residents coping with adverse events

PROCESS USED TO DEVELOP THIS PROGRAM

Developed a pilot program with funding from GME leadership to provide counseling to residents and fellows. Specifically designed program to try to reduce known barriers to physicians seeking counseling. Clinical team conducted annual outreach presentations and trainings to residents and faculty to promote resilience, resources for physicians and knowledge of this program. Conducted program evaluation to show increased utilization and win additional funding for expansion to faculty and to increase clinical FTE to 2.25 psychologists and psychiatrist time. Now conducting program evaluation of suicide prevention

screening tool and psychological outcomes for residents and faculty who seek treatment through our program

CHALLENGES / BARRIERS

Taking time away from clinical duties continues to be a stated barrier for many residents and fellows. In addition, our ISP data suggest that a number of highly distressed trainees and faculty complete this survey but do not end up coming in for treatment and are not seeking professional help elsewhere. More research is needed on how to reach this group. Finally, more preventive efforts at an organizational or residency program level are needed to have a bigger impact on lowering resident burnout and distress.

OUTCOMES / IMPACT

Utilization of the program grew from 5% of all residents/fellows seeking care through our program in 2004 to 23% of all residents/fellows seeking care in 2016-17. Faculty utilization rates are approximately 6% of all clinical faculty seen annually. In 2016-17, the RFWP clinicians (2.25 FTE) provided direct care to 323 medical trainees and faculty across 1752 visits. Prior publications (Ey et al., 2013;2016) included results of a resident survey showing that most trainees know about this program, are willing to seek help if needed and those who sought help (N=116; 97%) and program directors who referred trainees (N=23; 88%) were highly satisfied with services. Since 2013, 360 physicians also have completed the Interactive Screening Protocol and received individualized feedback on their level of distress and risk. Finally, we are currently investigating who seeks treatment and shows a treatment response on a standard measure of distress and risk. Preliminary analyses suggest that more women (68%), trainees (71%) sought treatment; 20% of participants identified as being ethnic or racial minorities and 6% as International Medical Graduates. Interns were the highest number of trainees seen. Clinical levels of distress were reported by 44%, suicidal ideation in 22%, and burnout in 27% of participants at intake.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Areas of growth include: 1. being proactive and offering formal peer support to physicians who experience an adverse medical event, litigation, professional setback (we developed and now run the OHSU Peer Support Program in consultation with Jo Shapiro, MD, Brigham and Women's Center for Professional and Peer Support) 2. making our program more accessible to residents working in rural locations by offering telehealth appointments with our psychologists and psychiatrist 3. conducting program

evaluation to look at physician response to treatment on measures of burnout, distress, and suicide risk

GENERALIZABILITY TO OTHER ORGANIZATIONS

For several years my colleagues and I have been contacted by other academic medical center leaders who are interested in strengthening resident wellness efforts and learning about our programmatic efforts. This type of comprehensive wellness model can be generalized to other academic medical centers with the proper funding and support from GME and hospital leadership and a dedicated clinical group to develop and run this program.

LESSONS LEARNED

When describing our model of care, the number one concern from attendees at our workshops is “how will I be able to get my institution to fund this type of program?” So I think helping GME leaders to see the importance of advocating for this resource and being willing to start small to pilot a program that fits within their institution would be good first steps. In addition, when developing new wellness programs, ongoing consultation/support from outside experts may lead to a better outcome than a one time consultation/presentation. Telehealth represents a new area of development for reaching physicians in rural communities or with very limited personal time to seek care but requires a great deal of training, resources, and clinician competence with technology to put in place.

WEBSITE / LINKS

www.ohsu.edu/rfwp; www.ohsu.edu/peersupport

SUPPORTING MATERIALS

[ey_decade_of_caring_pdf.pdf](#)

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KEY PARTICIPANTS

Cheryl Stetson, PC for Anesthesiology Fellowships Program Coordinator Representative to GME Leadership Group
 Leslie Johnson, Registrar, Duke GME Office GME staff member to Program Coordinator Wellness & Resilience Group
 Catherine M. Kuhn, MD DIO and Director of Duke GME

TARGETED ISSUE / PROBLEM IDENTIFIED

In March, 2017 at our Annual PC Retreat and Workshop we used table topics and group report out to facilitate a discussion where we received valuable feedback about the stress inducers and needs of our PCs. We were committed to acting on the information we had gained in these discussions; thus, in August of 2017, (following Match and onboarding seasons) at our monthly PCs meeting, we revisited the issues and surveyed our PCs about their work-life balance and overall level of wellness. This was a 20 question anonymous survey completed on paper and later entered into Qualtrics for analysis. All PCs in attendance completed surveys, representing an 81% response rate (43 PCs total). The survey showed in part that 37% of our coordinators felt they had little or no control over their work life and 26% did not take time to do something just for themselves each week. Seventy-six percent (76%) were frequently thinking about work when not working. Not surprisingly, 57% answered that they often feel guilty because they cannot make time for everything they want to do and 57% also feel overwhelmed and over-committed. With this knowledge, and the impact we knew this could have on the programs, program directors and the trainees they support, we knew we had to address the pressures our PCs were feeling.

INTERVENTION / PROGRAM DESCRIPTION

Program Coordinator (PC) resilience and overall well-being has become an area of heightened focus for the Duke Program Coordinators over the last year. Having a healthy, resilient, professionally developed and engaged Program Coordinator contributes to the health, wellness and resilience of a training program, its trainees, and the overall learning environment. As the position of the Program Coordinator has evolved, the impact that she/he has on the learning environment has also grown. As a first-time attendee representing the Program Coordinator Advisory Group at the November 2016 ACGME Symposium on Physician Well-Being, I returned to my institution excited about my "Commitment to Change". As a result, with the help of our GME department staff, we kicked off our Program Coordinator wellness initiative in March at our

Annual Program Coordinator Retreat and Workshop. We spent the last several months developing and implementing opportunities to engage, encourage and teach our Program Coordinators using wellness-related activities. These activities appear to be building a stronger sense of community, building relationships and fostering a peer support system. We have also created a shadowing experience that is allowing Program Coordinators to strengthen their relationships with their trainees and better understand the demands of residency training.

TOOLS / STRATEGIES USED

With our Institution's "Week of Wellness" soon approaching, the committee was able to hold their first event during that same week; Sundae Monday. This event brought the PCs and GME department staff together for ice cream treats and conversation. The conversation was encouraged by using note cards with topics about things outside of work. The second event took place later that same week. Interested PCs and GME department staff met in a central location and together walked to our Employee Health and Wellness facility, where an open house event was being held. During this event PCs and GME staff received information on BP screening, BMI checks, nutrition and fitness support, smoking cessation, and others. In addition to having meaningful conversations, obtaining health related information and resources, both events allowed our PCs and GME department staff to start building relationships and establishing comradery with one another that we anticipate will lead to a happier and more supportive work environment. The group has also enrolled in a group messaging app. This mobile application allows us to send out group texts to encourage wellness and socialization. When one coordinator feels the need for a walk to re-energize or a cup of coffee with a friend to decompress, the coordinator member can send a text to the group and any and all that are free can meet to participate in whatever the activity might be.

PROCESS USED TO DEVELOP THIS PROGRAM

In late August, with the support and encouragement of our DIO, we formed our first committee for PC Wellness and Resilience. This committee consists of 12 PCs, 1 GME staff member, and the GME Office manager who facilitates the meeting and provides guidance. The formation of the committee alone was a morale booster as the Coordinators felt valued in the institution's commitment and support of their wellness. The committee was energetic in discussing this new challenge. The first meeting was used to discuss each participant's reason for wanting to be a participant in the committee, why they felt it was important and what

outcomes they would like to see. Ideas were discussed and three were prioritized as ones that could be accomplished in the next few months. In true action-oriented coordinator style, action plans were in place by the end of the one and a half hour meeting.

CHALLENGES / BARRIERS

As with any group initiative, trying to get all of our 43 PCs to participate is not only a challenge, but unrealistic. Scheduling of events during times that everyone can attend is a struggle. It is also important that we are sensitive to the demands of properly administering a training program and that we continue to have the support of our program director community. Our hope is that as we move forward, scheduling events with consistency in day, time, and monthly reoccurrence, will help resolve this .

OUTCOMES / IMPACT

It is too early to measure or assess change in our PCs wellness or perception thereof; however, if enthusiasm is a predictor, we are optimistic.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Through conversations with our PCs, at both our Annual Retreat and with the Wellness and Resilience Committee, we recognized that although PCs are aware of the responsibilities of their trainees, they do not know exactly what a trainee encounters each day; this can sometimes make it hard to empathize and be supportive. Because of this, we have designed a Shadowing Experience for our PCs. The activity will allow PCs to better understand and appreciate the day-to-day activity of a trainee with the goal of gaining an enhanced understanding of how they can enhance their support of their trainees. The experience was presented to our Residency Council and program directors who are supportive of the initiative. We created goals and objectives for the experience as well as an outline of responsibilities for the PC and trainee to review together in a face-to-face meeting prior to the experience. Any shadowing experience must have the approval of the program director and the PCs must ensure that they are current with all institutional compliance requirements, including a review of HIPPA guidelines before the experience takes place. Our hope is that this experience will elevate the PCs understanding of the trainee's work, increase the trainee's trust in his/her coordinator and gradually increase trainee awareness of the role, responsibilities and value of the PC. We are looking forward to feedback from our first four PC-Trainee participants by the end of this calendar year. Additionally, later this fall we have

scheduled talks from our institutional Personal Assistance Services counseling group. These talks will be focused on the PCs ' overall well-being and designed to be specific to the stressors they encounter in their administrative roles. We are also in the process of scheduling yoga and meditation classes and other social and wellness activities. We continue to strive to make our PCs a better resource to their programs, program directors and trainees by increasing their engagement with each other, their overall wellness and nurturing a connection to the larger GME community and the demands facing our trainees. Our hope is that the strengthening of these connections will enhance the overall wellness and resilience of our coordinators resulting in a positive impact to the learning environment , PC attrition and job satisfaction.

GENERALIZABILITY TO OTHER ORGANIZATIONS

These initiatives are a relatively low-cost and potentially high-impact intervention that could be created for the PC community at any sponsoring institution. PCs are very busy but have some flexibility in their schedules allowing these activities during normal business hours, making this potentially an easier intervention than one with trainees or program directors. Enhancing PC's sense of self-worth and value will positively impact their work performance, offering benefits to their trainees, who often see them as a trusted confidant and support and for the program directors who rely on competent PCs to help them manage the accreditation and other challenges in residency training.

LESSONS LEARNED

The full impact of the effort will be seen later as the program rolls out completely but the initial response to the initiative demonstrates that attention to PC development is likely to reap benefits. The PC role in individual training programs and the institution is one of great significance. They are a vital contributor to the GME team and important in the success of the greater GME community.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

shadowing_a_resident_or_fellow.pdf

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Kellie Gates, MD
Loyola University Medical Center**KEY PARTICIPANTS**

Kellie Gates, MD, Michael Wiisanen, MD

TARGETED ISSUE / PROBLEM IDENTIFIED

Physician Burnout, waning resident satisfaction, increasing symptoms of burnout amongst residents and staff.

INTERVENTION / PROGRAM DESCRIPTION

Multiple small, minimal-cost interventions were undertaken to help boost resident morale in the Department of Anesthesiology. Resident Town Halls were instituted to help address tangible resident-centered problems, mentorship programs were instituted, monthly merit-based recognition was put in place, physician databases created to increase accessibility to healthcare for the residents, and a wellness committee was formed to meet once monthly and address opportunities to improve upon resident wellness. At the end of the year, a two-session Wellness curriculum was put in place for the incoming CA-1s to help educate residents on burnout, promote symptom identification, and provide resources for management should these symptoms arise. We also had a Grand Rounds dedicated to the discussion of physician burnout and wellness, which was readily received.

TOOLS / STRATEGIES USED

-Easily-accessible, open-forum meetings. -Frequent discussion and acknowledgement of outstanding resident and attending performance. -Simple, straight-forward education on symptoms and consequences of burnout. -Database of Physician, dental, and mental health practitioners for residents to use that are recommended by their peers. -After-hours Wellness Committee meetings. -Flexible wellness and social events. -Individual class Wellness discussions targeting specific concerns.

PROCESS USED TO DEVELOP THIS PROGRAM

Independent research and resident/faculty opinion.

CHALLENGES / BARRIERS

The initial stigma regarding Wellness and the lack of desire to put time towards meetings/commitments to the field. There was also a barrier regarding the general culture of medicine as a “work hard and complain little” kind of field, which quickly dissipated with the Grand Rounds discussion of burnout and risks of depression, substance abuse, and suicide within the field of medicine.

OUTCOMES / IMPACT

An increase in resident and attending morale was noted approximately six months after implementation of these interventions. After grand rounds specifically, there was an increase in attending interest in the Wellness Committee and multiple members came forward to be more heavily involved. With the intern-specific curriculum, the class identified symptoms of burnout within themselves and devised a plan to help maintain the morale and promote wellness amongst their class and to other classes. They identified multiple goals that they would like to pursue within themselves both professionally and personally in the first year of their training with hopes of continuing throughout their careers. The merit-based recognition (mainly, attending and resident of the month as voted by the residents) improved morale immensely and was something that was looked upon favorably by the entire department.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

A more structured wellness curriculum that could be given to incoming interns or PGY-2s prior to starting their anesthesiology residency would be the next steps. The curriculum could continually address burnout and possible symptoms, but could also assess coping strategies for adverse events among other stress-maintenance tools.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The above listed interventions are very low-cost, low-maintenance strategies to increase wellness within a department. It requires very little research and is easily implemented by personnel at all levels of knowledge regarding wellness and burnout.

LESSONS LEARNED

Small interventions can have a big impact on morale in the workplace, which can also improve wellness. Education is overwhelmingly the most important step to getting people on board with the promotion of wellness. There are multiple surveys available online that calculate burnout score so that people can assess if they are at risk.

WEBSITE / LINKS

https://www.mindtools.com/pages/article/newTCS_08.htm

SUPPORTING MATERIALS

n/a

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Elizabeth Gauferberg, MD, MPH

Arnold P. Gold Foundation/Harvard Medical School

KEY PARTICIPANTS

Elizabeth Gauferberg MD MPH Colin West MD PhD Richard Levin MD

TARGETED ISSUE / PROBLEM IDENTIFIED

Mapping the Landscape, Journeying Together (MTL) is the Gold Foundation's Initiative for research-based advocacy in humanism in healthcare. A substantial proportion of our projects focus on physician wellbeing/burnout prevention. Attached is a poster we will show at the American Conference on Physician Health in San Francisco on October 12-13. If accepted, we will update the poster with any new information/insights for the ACGME symposium. Also attached is a logic model showing our anticipated short-term, intermediate and long term outcomes for the MTL initiative. A commentary about MTL will be published in the December issue of Academic Medicine, on-line on October 11th, and we will forward when available.

INTERVENTION / PROGRAM DESCRIPTION

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TOOLS / STRATEGIES USED

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PROCESS USED TO DEVELOP THIS PROGRAM

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CHALLENGES / BARRIERS

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OUTCOMES / IMPACT

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FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Mapping the Landscape, Journeying Together (MTL) is the Gold Foundation's Initiative for research-based advocacy in humanism in healthcare. A substantial proportion of our

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CONTACT

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GENERALIZABILITY TO OTHER ORGANIZATIONS

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LESSONS LEARNED

Mapping the Landscape, Journeying Together (MTL) is the Gold Foundation's Initiative for research-based advocacy in humanism in healthcare. A substantial proportion of our projects focus on physician wellbeing/burnout prevention. Attached is a poster we will show at the American Conference on Physician Health in San Francisco on October 12-13. If accepted, we will update the poster with any new information/insights for the ACGME symposium. Also attached is a logic model showing our anticipated short-term, intermediate and long term outcomes for the MTL initiative. A commentary about MTL will be published in the December issue of Academic Medicine, on-line on October 11th, and we will forward when available.

WEBSITE / LINKS

<http://www.gold-foundation.org/programs/research/mtl/>

SUPPORTING MATERIALS

acph_poster_10317.pdf

Matthew Goldman, MD, MS
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KEY PARTICIPANTS

Matthew L. Goldman, Carol Bernstein, Lyuba Konopasek, Richard Summers, Laurel Mayer, Rashi Aggarwal, Julie Chilton, Melissa Arbuckle, and the rest of the American Psychiatric Association's Workgroup on Physician Wellbeing and Burnout (see attachment for complete list).

TARGETED ISSUE / PROBLEM IDENTIFIED

The APA Workgroup developed a Toolkit (see attached) to support APA members to serve as ambassadors to their home institutions with the goal of improving wellbeing and reducing rates of burnout, depression, and suicide among the physician workforce, including psychiatrists and physicians of all specialties.

INTERVENTION / PROGRAM DESCRIPTION

The American Psychiatric Association (APA) Workgroup on Physician Wellbeing and Burnout was convened to make recommendations regarding the development of activities and products to assist APA members to facilitate interventions aimed at improving physician wellbeing and burnout. In particular, ready-made resources are needed to equip advocates to easily provide expertise and knowledge to others in the health care professions, especially with strategically providing interventions at various institutions.

TOOLS / STRATEGIES USED

This Toolkit provides guidance for APA members to: 1. Spread awareness at their home institutions with the use of slide decks and a Speaker's Bureau; 2. Conduct a needs assessment to identify best practices for advocacy and specific interventions to promote wellbeing within an organization; and 3. Gain access to additional resources including a recommended reading list and an inventory for screening tools.

PROCESS USED TO DEVELOP THIS PROGRAM

After reviewing the literature and identifying key evidence-based interventions, the Toolkit and needs assessment were developed with expert input from the APA Workgroup on Physician Wellbeing and Burnout.

CHALLENGES / BARRIERS

There is a lack of a validated needs assessment tool to determine the level of advancement of wellbeing interventions at a given institution.

OUTCOMES / IMPACT

This Toolkit was recently developed and has not yet been launched for dissemination, but APA member feedback will be actively solicited to further refine the toolkit to improve future iterations.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Once the Toolkit is released by the APA, steps will be taken to disseminate it to members and encourage multi-stakeholder input on its content and overall utility. Furthermore, the needs assessment tool will be tested for its validity in the future.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The Toolkit under development by the APA has been developed with a key focus on ensuring broad generalizability to various organizational settings for use by trainees, psychiatrists and other health care leaders.

LESSONS LEARNED

There is a large demand for concrete resources to address physician wellbeing, and it is feasible for a team of experts to assemble recommendations for evidence-based practices in a comprehensive, user-friendly package.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

[apa_wellbeing_ambassador_toolkit4.pdf](#)

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P. Bradley Hall, MD
Federation of State Physician Health Programs

KEY PARTICIPANTS

P. Bradley Hall, M.D.

TARGETED ISSUE / PROBLEM IDENTIFIED

Illness versus impairment; burnout; mental illness; addiction and suicide. Components of signs and symptoms of potential impairment.

INTERVENTION / PROGRAM DESCRIPTION

Powerpoint presentation to medical students and residents on potentially impairing conditions, wellness and physician health programs as a resource for assistance and guidance. Includes barriers to detection and the interface of PHPs with licensure boards and training institutions. Includes WV program statistics and FSPHP national collaborations.

TOOLS / STRATEGIES USED

Powerpoint, education on definitions, processes and outcomes.

PROCESS USED TO DEVELOP THIS PROGRAM

Multi-year presentations to the medical schools and incoming residency classes and associated refinement including updated statistics.

CHALLENGES / BARRIERS

Access to early career students and residents in training.

OUTCOMES / IMPACT

Increased referrals from medical schools and residencies to the PHP in excess of 15%. Overall continued growth of total PHP referrals.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Continue to expand on education, collaborations with medical schools and other components of organized medicine.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Early intervention through education and prevention, as a well established model for all chronic medical diseases.

LESSONS LEARNED

Early intervention during training is effective. PHP Model

and associated education, including availability mitigates barriers to referral. The PHP model mitigates many risk factors, including mental illness, addiction and suicide.

WEBSITE / LINKS

www.wvmphp.org

SUPPORTING MATERIALS

june2015wvbom_newsletter.pdf

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Diane Hartmann, MD
University of Rochester**KEY PARTICIPANTS**

Diane Hartmann, MD Beth Danehy, MA, MS MFT, CEAP

TARGETED ISSUE / PROBLEM IDENTIFIED

For trainees, entering into the academic disciplinary process is a crisis with potentially career and life altering outcomes. The option for a trainee in educational crisis to decide whether to pursue wellness assessment should be converted from a recommendation to a process-neutral requirement, thereby minimizing the effect of stress, shame, fear, grief, and anger that impact decisions to access self-care.

INTERVENTION / PROGRAM DESCRIPTION

Development and implementation of a GME policy requiring referral of all residents/fellows entering or progressing through the academic disciplinary process to the institutional Employee Assistance Program (EAP).

TOOLS / STRATEGIES USED

Issues impacting policy development were identified & debated including: trainee confidentiality, legality, common use of required wellness assessments at crisis points in other professional settings, and need to maintain neutrality & independence of the employee assistance program within the process.

PROCESS USED TO DEVELOP THIS PROGRAM

Committee-based policy development including representatives from GME, Psychiatry, EAP, Office of Counsel, and the Faculty & Resident Wellness Committees.

CHALLENGES / BARRIERS

Obtaining and reporting outcome data was challenging on multiple levels. 1. To ensure the integrity of the EAP system, clients must believe their decision to access EAP and their personal information are confidential. To this end, we requested that EAP provide data according to their own guidelines and preferences rather than request specific information. 2. Very few trainees enter the academic disciplinary process in a given year and this information is confidential. 3. The GME policy includes the ability of program directors to require a mandatory EAP visit according to their own judgment before a trainee enters the formal academic disciplinary process. This may increase the number of “mandatory” visits occurring but not specifically related to residents in a formal academic disciplinary process. 4. Promoting and easing access to EAP by trainees is an institutional goal. Strategic planning toward achieving

this goal involves entities across the institution including GME, EAP, Behavioral Health, Well-U, PR, etc. and may lead to increased access unrelated to our GME policy.

OUTCOMES / IMPACT

In the 4 months preceding formal policy implementation (9/1/16 - 1/9/17), 4 residents were seen at EAP. In the 4 months following (1/10/17 - 5/10/17), 18 residents were seen at EAP. From the time of policy implementation to today, 29 residents have been seen at EAP. This represents a substantial increase in EAP access by residents over time. [Data on number/percent of EAP visits classified as mandatory and related specifically to policy implementation is pending EAP review for release.]

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We will continue to collect data regarding EAP access by trainees including which visits were “mandatory”. Multi-year data will allow a better sense of how the policy is being used and any changes needed over time to optimize outcomes.

GENERALIZABILITY TO OTHER ORGANIZATIONS

We believe the UR policy on mandatory EAP for residents entering the academic disciplinary process is generalizable to other academic institutions. Most institutions have an independent EAP process available and those that do not should be able to create a similar process through their institutional behavioral health resources or local medical society resources.

LESSONS LEARNED

The key to the success of the policy development discussions was the interdisciplinary approach and mutual agreement that the reasons for developing such a policy were valid and high-stakes. Resident buy-in was considered essential for the success of the policy.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

raftws_pd_faq.docx
raftws_resident_faq.docx
raftws_policy_final.docx

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Helen Haskell, MA Mothers Against Medical Error

KEY PARTICIPANTS

IPASS Study Group

TARGETED ISSUE / PROBLEM IDENTIFIED

Problem: fragmented communication due to lack of structure and lack of patient/family involvement. Goal: Improved communication between residents and patients/families leading to improved patient safety and increased work satisfaction for residents

INTERVENTION / PROGRAM DESCRIPTION

Structured family-centered rounds including family introduction of problem, plain language and heal

TOOLS / STRATEGIES USED

My role: head of the family advisory council, which had patient/family representatives on every subcommittee, advised on all materials and strategies, participated in resident and faculty training, and collaborated to answer questions on patient engagement as they came up during implementation.

PROCESS USED TO DEVELOP THIS PROGRAM

Complex interprofessional structure with subcommittees working on separate aspects of the program

CHALLENGES / BARRIERS

Challenge is to see if any of the data could be used to establish a connection between improved patient communication and greater meaning in work for residents.

OUTCOMES / IMPACT

The project itself has been completed and is awaiting publication. A curriculum is being created. Data analysis shows significant reduction in adverse events and patient harm and improvement in patient experience, patient engagement, and frequency of patients and families expressing concerns to caregivers. Medical students have expressed gratification at the use of plain language, which allows them to follow cases with more understanding. The potential for this project to affect resident satisfaction and increase the meaningfulness of resident interaction with patients seems evident but has not been assessed.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Examining data for insights into improvement of resident

work satisfaction Looking at ways it might be tweaked to optimize and further study the patient/resident relationship
Dissemination of the program beyond the nine study centers

GENERALIZABILITY TO OTHER ORGANIZATIONS

This is a complete program tested in multiple centers.

LESSONS LEARNED

This program has reinforced the connection between teamwork, communication, patient safety, and patient experience – ie, patient well-being. The question is how much of this is mirrored in providers' sense of well-being. If not, what is missing?.

WEBSITE / LINKS

<http://ipasshandoffstudy.com/about#PatientandFamilyCentered>

SUPPORTING MATERIALS

family_brochure_updated_82715.pdf

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ABSTRACT #17



Dink Jardine, MD
ACGME CRCR

KEY PARTICIPANTS

Members of the Council of Review Committee Residents

n/a

TARGETED ISSUE / PROBLEM IDENTIFIED

Meaning in Work

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INTERVENTION / PROGRAM DESCRIPTION

Back To Bedside

TOOLS / STRATEGIES USED

Incentive funding

PROCESS USED TO DEVELOP THIS PROGRAM

Appreciative Inquiry Group Work and Subcommittee development

CHALLENGES / BARRIERS

New initiative with uncertain interest. Transient population. Institutional inertia

OUTCOMES / IMPACT

223 resident led projects with support of their institutions/ programs applied and 30 projects have been assigned full or partial funding

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Broad dissemination of outcomes Continue support of projects

GENERALIZABILITY TO OTHER ORGANIZATIONS

Goal is to produce series of options with “must have” characteristics to support resident led initiatives

LESSONS LEARNED

Residents/Fellows are ready to partners in innovative projects to improve patient care delivery while simultaneously improving their meaning in work.

WEBSITE / LINKS

Acgme.com/backtobedside

SUPPORTING MATERIALS

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Hackensack Meridian Health Palisades

KEY PARTICIPANTS

Robert Piccinini DO, Kenya McRae, Dink Jardine MD

TARGETED ISSUE / PROBLEM IDENTIFIED

Physician Burnout and Suicide Prevention Through the life cycle of the physician from pre-med to retirement

INTERVENTION / PROGRAM DESCRIPTION

Through Resident Wellness Task Force - list of best practices and initiative of implementing practices within programs Through AOA Physician Wellness Task Force - Online Toolkit/App with videos on warning signs and available resources for help, working with physician advocates (spouses and family members) to help with overall physician wellness, and a "train the trainer" program to start implementing changes in the way we teach/train residents and treat older physicians with symptoms of burnout

TOOLS / STRATEGIES USED

Determining which factors caused the greatest impact on physician wellness throughout the physician life cycle and worked to find solutions from there to combat these factors

PROCESS USED TO DEVELOP THIS PROGRAM

Task Force composed of AOA Members and Mental Health specialists, epidemiological study of overall physician burnout, and task force comprised of medical students, residents, young physicians, and those in mid career and close to retirement

CHALLENGES / BARRIERS

*Hard to change culture of medicine *Having to work around the system *Campaign awareness *Continuation of practices

OUTCOMES / IMPACT

*Currently implementing best practice of educating incoming interns about burnout symptoms and using the Maslach's Burnout Index to follow them every 6 months - interns more willing to discuss any stresses they have with senior residents than previous class *Multiple advocate groups open to discussing their struggles with the stresses of being in a relationship with physicians *Working with AOA to create website *Awareness campaign

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

*Launch of website by 2/2018 *Launch of awareness campaign, including yellow ribbon campaign *Work with physician spouses/advocates who are also affected

GENERALIZABILITY TO OTHER ORGANIZATIONS

Train the trainer can be implemented by AMA and other accrediting organizations as well as ACGME for all those involved in resident education

LESSONS LEARNED

Must look at the varying life factors as well that could be contributing to stress and burnout in physicians in all aspects of their career Advocates are a physicians strongest ally Must implement institutional changes.

WEBSITE / LINKS

<https://nam.edu/wp-content/uploads/2017/03/Addressing-Burnout-Depression-and-Suicidal-Ideation-in-the-Osteopathic-Profession.pdf>

SUPPORTING MATERIALS

n/a

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Catherine Kuhn, MD
 Duke University Health System

KEY PARTICIPANTS

David A. Turner, M.D., Andrew S. Silberman, M.S.W., Terry Nicotra, Ph.D., Sarah Rivelli, M.D., Suma Das, M.D., Rebecca Meekins, M.D., Rhea Fortune, Catherine M. Kuhn, M.D.

TARGETED ISSUE / PROBLEM IDENTIFIED

Addressing the broad issue of creating a supportive learning environment has been an ongoing institutional priority for several years. The focus of this work sharpened after the death of one of our residents by suicide. We took advantage of the urgency of response to the resident suicide to consider the elements that constitute wellness and a supportive learning environment broadly. Of the multiple priorities, the most pressing was to provide enhanced behavioral health services for our residents and fellows. This was also the focus of my (CMK) commitment to change from the 2016 Symposium. Although our institution offers counseling services for all of its employees, the practical utilization of these by GME trainees was very low, approximately 2% of trainees per year. In partnership with our Employee Health directors, we learned that the number of entering residents and fellows who report at least one medical or behavioral health issue prior to matriculation has increased steadily over the past few years. For example, in the summer of 2017 approximately 20% of the cohort of residents and fellows matriculating at Duke reported one or more medical or behavioral health conditions during their preemployment screening and of those trainees, 60 percent had preexisting behavioral health conditions. Given the demands of residency and fellowship training, along with increased awareness about the problems of burnout and depression, an institutional approach to wellness was imperative.

INTERVENTION / PROGRAM DESCRIPTION

A Multifaceted Approach toward Support for Resident and Fellow Well-Being

TOOLS / STRATEGIES USED

A. Provision of Medical and Behavioral Health Services for trainees
 1. Behavioral Health Care: routine and crisis
 • Expansion of available counseling services to include several prime-time, early morning and late afternoon appointments exclusively for GME trainees, in addition to regular appointment times
 • Support for trainees in crisis during off hours (and their program directors) with a uniform access plan to reach the on-call psychiatry attending for advice.
 2. General Medical Care: • Development and

deployment of a toll-free number for GME trainees to use for concierge scheduling for appointments with the Duke Primary Care practice (DPC), including many options for weekend and evening appointments • Liaison with DPC and Employee Occupational Health to establish care for trainees matriculating to the institution.
 B. Education about Wellness, Burnout, and Depression and available Resources
 1. New Trainee Orientation • All new trainees participated in small group exercises incorporating scenarios about mistreatment, fatigue, and depression, and received ID badge buddies listing available resources • DIO welcoming comments included the importance of self-care, and the prevalence of burnout
 2. Chief Resident Leadership Retreats • Two day-long retreats were held for all chief residents, which allowed inter-program networking, and included interactive learning experiences to support them in their roles. Topics included the struggling trainee, burnout/depression, and resources available.
 3. Program Director Leadership Retreats • Semiannual daylong interactive retreats for program directors, which address many topics, including burnout/depression/suicide, remediation of the struggling trainee, and resource identification.
 4. General Education and discussion about new Common Program Requirements • For program directors, coordinators, and Resident Council members
 C. Creating a Supportive Learning Environment
 1. Continued work on addressing learner mistreatment • Confidential reporting system and an interdepartmental committee to address reports • Collaboration with School of Medicine and faculty professionalism committees to align expectations and approaches across the institution • Incorporation of nursing leaders in conversations about student and trainee mistreatment
 2. Support for the struggling trainee • Continued work with program directors to identify and address problems earlier • Standardized process for remediation of trainee deficiencies • Incorporation of required appointment with Employee Health for all trainees on corrective actions (normalizing the process), often with live hand-off to counseling services
 3. Hospital Sponsorship of GME Week: a hospital-wide demonstration of appreciation of trainee contributions • Publicity about role of residents and fellows in hospital (banners, electronic message boards) • Free meals for trainees • Appreciation note from hospital CEO for each trainee • Raffle for iPads • Baseball game for trainees and families
 4. Holiday Cards for every trainee • Included a note of appreciation, and a card with wellness tips, provided by the GME department
 5. Initiation of a Professional Development Coaching Model for faculty-trainee dyads • Supported by the institution, implemented as a pilot in the internal medicine program, with plans to expand to other programs in the next year
 D. Program Coordinator Education and Support (see abstract submission by R. Fortune) • Projects intended to support

the career development and well-being of our GME program coordinators, recognizing their important role supporting residents and fellows

PROCESS USED TO DEVELOP THIS PROGRAM

Our DIO convened a Task Force on GME Wellness and the Learning Environment, which developed and prioritized recommendations about efforts that would enhance resources and well-being for residents and fellows. An institutional approach to enhanced behavioral health resources was a priority, but parallel attention was given to other priorities identified by the Task Force, which included existing efforts to enhance the learning environment through appropriate management of reports of mistreatment, reported as an abstract at the 2016 Symposium. As we have implemented elements of the program, detailed in the next section, we are utilizing a variety of data resources to assist with our planning and evaluation of the effectiveness of our interventions. These include the ACGME surveys, institutional work culture/engagement surveys, an annual institutional GME survey, and de-identified, aggregated data from our Employee and Occupational Health (EOHW) and Personal Assistance Services (PAS) groups. We also dedicated 0.5 FTE in the GME Department for an administrative coordinator to assist with these efforts.

CHALLENGES / BARRIERS

The challenges to developing a comprehensive program for wellness for our trainees was complicated by a tension between the urgency of the work, and the inevitable difficulty in creating changes in a very complex organization as quickly as desired. As an example, what began as a desire to establish a GME-unique resource for behavioral health services was challenging because of somewhat artificial boundaries between behavioral health practice groups (hospital-employed versus faculty), the need to establish a separate medical record, and even the desired location where services could be offered (hospital facility versus practice plan facility). Eventually we decided to utilize existing resources for behavioral health but with modifications to the resources to address trainee needs better. The heightened attention to the challenges of burnout, resilience and wellness have promoted efforts to address this at many levels of our institution, including the main university, the School of Medicine, the health system, and the hospital. This is another example of organizational complexity that created some difficulty in initiating our efforts. It was tempting to latch onto one or more of these efforts, but none of them adequately addressed the needs of the GME community. One strategic decision related to whether we should hire a single individual

to help implement our wellness program (combining provision of behavioral health services with other educational and administrative functions). Recognizing that the uptake for clinical services might be gradual, we decided to collaborate with our PAS colleagues and funded partial FTE's for counseling services, and a partial FTE for administrative support. This will allow us to invest incrementally as program utilization increases, and provides an opportunity to identify the individuals who have the greatest interest and skill in working with trainees. The new Common Program Requirements dictate that trainees should have opportunities to attend to their health care needs during normal work hours. Although our programs are adapting to this requirement, many of them are reluctant to leave during the day, fearing they will burden their colleagues. Additionally, the need for health care will not always be predictable. Therefore, we feel our efforts to provide easier scheduling and flexible appointment times are important.

OUTCOMES / IMPACT

The availability of prime-time appointments for counseling services has resulted in an increase in the number of GME trainees taking advantage of PAS. In the initial month of the new program, 35% of available slots were filled, in addition to several appointments during regular hours. If this utilization is sustained over the year, approximately 8% of GME trainees will have accessed PAS services. This correlates with a reported utilization rate on our institutional survey of approximately 9% for PAS, and 10% for utilization of a personal behavioral health provider (non-Duke). The data about trainee perception of the prevalence of burnout in each other, their faculty, and themselves has not improved between AY16 and AY17. This result may represent increased attention and discussion about burnout, insufficient time for our interventions to have an impact, or the need for additional strategies to address work compression and other workplace contributions to burnout. Our efforts have been successful in decreasing the incidence of mistreatment as reported on surveys, (including the AAMC Graduation Questionnaire and an institutional GME survey) as well as improved rates of medical student and trainee reporting of mistreatment. The percentage of GME trainees who witnessing or experiencing mistreatment and subsequently reported the mistreatment has increased from 18% in AY14 to 37% in AY17. The percentage of medical students reporting they experienced mistreatment on the AAMC Graduation Questionnaire has decreased by 10 percentage points, now consistent with the national average, and residents no longer represent the largest source of mistreatment for medical students. Perhaps the most encouraging development over the past year has been a conscious alignment of professional expectations

for students, GME trainees and faculty, and standardized approaches to address the consequence of mistreatment at any level.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We intend to continue to develop and expand the resources we provide as part of an overall wellness program for our trainees. The major elements of this process include: Tracking utilization of both behavioral health and primary care appointments for GME trainees An institutional commitment to expansion of these services as required Development of additional outreach and education programs related to wellness In the near-term several initiatives are planned, including: Implementation of American Foundation for the Prevention of Suicide's interactive depression screening tool by January 2018. Incorporation of a psychiatrist in both EOHW (to improve risk assessment) and the PAS counseling service (to provide prescribing as necessary) On-site dental services for GME trainees (summer-fall 2018) Improving primary care access for GME trainees through E-visits (AY19) Continued attention to the learning environment across the continuum of medical education Ultimately, we would like to partner with our departments and training programs to identify and catalogue their efforts along with institutional efforts, developing best practices. We hope to demonstrate the effectiveness of our plan in order to expand these strategies to other members of the health care community, including faculty and other team members.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The ability of any institution to address the behavioral, general healthcare and wellness needs of its GME community will vary depending on the unique characteristics of the institution. The generalizable principles from our experience include a broad definition of wellness, incorporating factors that impact both the learning environment and individual trainee's resilience and well-being. Additionally, the following process measures have been useful and could easily be adapted to other institutions: Needs assessments: trainees, programs, institution Careful evaluation of existing resources and suitability Enhancement of existing resources versus creation of new system (timing of investment) Incremental, versus wholesale implementation of a plan Utilization/modification of existing institutional surveys and databases for needs assessment and to track the progress of interventions

LESSONS LEARNED

Creating a new program in a complex healthcare system is a difficult and inefficient process. Achieving small victories can go a long way toward assuring the GME community that the institution is committed to improving its resources for trainees. The effect of individual interventions may not be apparent within a year, but continued attention to difficult issues promotes conversation, adoption, and improvement.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

2017_supporting_data_kuhn.pptx

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Monica Lypson, MD MHPE

Office of Academic Affiliations, Dept. of Veteran Affairs

KEY PARTICIPANTS

Christopher G. Pelic, MD

TARGETED ISSUE / PROBLEM IDENTIFIED

One aspect of our educational work would be to understand how OAA and VHA could collaborate to improve wellness and prevent burnout for all of our health professional trainees. Over the past, year VHA has begun to look in depth into issues of provider burnout. Using the same methods to compare our VA data to the private sector, we find that there is less burnout in VA: 1/3 VA physicians have burnout, compared to ~1/2 physicians in the private sector. Among VHA physicians, burnout level varies a lot depending upon the physician specialty. However, we do not know the impact of burnout on our physician resident trainees.

INTERVENTION / PROGRAM DESCRIPTION

The Medical and Dental Education Section for the Office of Academic Affiliation (OAA), Veterans Health Administration (VHA), Department of Veterans Affairs provides leadership, oversight, and coordination for VA's graduate and undergraduate medical and dental education program. This section develops and implements policies and guidelines related to academic affiliations. We analyzes data to identify opportunities for improvement; we share results in a manner that is informative and useful in decision-making processes that facilitate continuous improvement which support VHA's mission, vision, values, strategic goals. One of VHA's four statutory missions is to provide future health professionals for the VA and the nation. In addition, we work in a collaborative matter across our external partners (academic and federal) that enhance educational policy and support inter-professional education that enhances trainees' experiences.

TOOLS / STRATEGIES USED

Needs assessment survey of VHA Educational Leaders (DEO) Leadership Training/Faculty Development Conference Calls/Webinars Dissemination of VHA tools related to Whole-health, Provider Burnout, Wellness Policy Review

PROCESS USED TO DEVELOP THIS PROGRAM

• Review key policies (Directives and Handbooks) to understand how OAA can incorporate consideration of trainee wellness into our procedures • Provide Designated Educational Officials (DEOs – VHA Educational Leaders) with information and tools that focus on burnout and

trainee wellness o Address the issue during a monthly conference call o Focus on this issue during DEO orientation o Incorporate inquiries into trainee wellness activities in a DEO needs assessment • Follow up with VHA Whole-health Initiatives and Burnout Assessment to understand the impact we might have on trainees rotating throughout VHA

CHALLENGES / BARRIERS

• VHA is the largest integrated health system in the country, isolating our impact on individual trainees is difficult • VHA does not sponsor its own physician trainee programs, all work must be done in collaboration with ACGME sponsored physician residency programs

OUTCOMES / IMPACT

We hope to have the results of the DEO survey in the next 6-8 months. We will follow up and meet with VHA whole-health during that same time frame. OAA has begun to review all relevant documents and policies to determine how wellness can be incorporated into requirements. The new 2018 quarterly DEO orientation will include a focus on the topic of trainee wellness.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Delineate our policy changes Disseminate survey results Enhance VHA educational leadership training and faculty development Work cooperatively on wellness both internal and external to VHA

GENERALIZABILITY TO OTHER ORGANIZATIONS

• Lessons learned within VHA have the potential to impact well over 120,000 health professional trainees, including approximately >40,000 physician residents. • Enhancing OAA's focus on trainee wellness, enhances the cooperative relationship with our academic affiliates where educational innovation moves back and forth as we often share trainees as well as faculty

LESSONS LEARNED

It takes creativity to re-imagine policies that focus on wellness.

WEBSITE / LINKS

n/a



SUPPORTING MATERIALS

n/a

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Laurel Mayer, MD
NYP-Columbia University Medical Center**KEY PARTICIPANTS**

Laurel Mayer, Sara Siris Nash and Linda Golding Burnout among physicians in training is a common and potentially dangerous experience for doctors and patients alike. Awareness of burnout and efforts to diminish its negative effects have gained attention in graduate medical education. Studies have shown the effectiveness of individual and work-centered group interventions, including mindfulness and small group discussions, in decreasing both overall burnout levels as well as features of burnout including emotional exhaustion and depersonalization (West, 2016). Little data exists as to the exact format of these group interventions, and or the effect of different group design strategies.

TARGETED ISSUE / PROBLEM IDENTIFIED

These groups aim to provide a regular, supportive and confidential space for residents to discuss issues related to the daily life of a resident, learn healthier coping skills and strengthen the sense of community among the residents.

INTERVENTION / PROGRAM DESCRIPTION

Wellness group were initiated by request. Participation was encouraged and voluntary, and group discussions were kept confidential. Group makeup varied in terms of including residents from a single PGY class, across all years, or a combination (e.g. PGY-IIs and PGY-IIIs). An attending psychiatrist or hospital chaplain moderated monthly group meetings which ranged from free-form conversations to more highly structured discussions.

TOOLS / STRATEGIES USED

Group facilitators met monthly for group supervision and to discuss format and process of sessions (some groups followed assembled curricula, others were less structured) and content that arose during discussions. Emergence of common themes across groups were identified. We also explored whether group format elicited issues, and if issues existed that were unique to specific departments.

PROCESS USED TO DEVELOP THIS PROGRAM

Wellness group requests were made by department chairs, program directors, and/or chief residents and ranged across several disciplines. Group leaders participated in monthly peer supervision.

CHALLENGES / BARRIERS

Consistent attendance in groups was difficult to achieve

given the residents various rotation schedules, and some residents chose not to attend.

OUTCOMES / IMPACT

The overall number of wellness groups at our institution has increased steadily. Currently, there are six residency wellness groups facilitated by a psychiatrist or chaplain, as well as additional three peer-moderated or Balint-format housestaff groups. Within the groups that we have facilitated, several common themes have emerged, regardless of format or discipline. These themes include: professional development (e.g. dealing with death and adverse outcomes), working within a system (issues of hierarchy/power/control), the current culture of medicine and how to change culture, tensions between educational goals and service needs and balancing life in and out of the hospital.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

The increase in requests for wellness groups suggests both a desire and need to help housestaff manage burnout and their overall wellbeing. Despite the range of formats (structured to free-form), common themes emerged across the disciplines, suggesting common experiences across residency training programs. These common themes can be used to inform curricular development and design for future wellness programming. Further qualitative and quantitative data is necessary to identify residents' perceptions of these groups and objective measures of improvement would also strengthen support for these increasingly used interventions.

GENERALIZABILITY TO OTHER ORGANIZATIONS

We are developing a curriculum based on our experiences that can be broadly disseminated to other institutions and organizations.

LESSONS LEARNED

Overall, the residents spoke highly of the groups and promoted them as strengths of their respective programs. Despite occurring across a wide range of programs, several common themes emerged. This suggests that regardless of specialty, resident training experiences are more similar than different.

WEBSITE / LINKS

n/a



SUPPORTING MATERIALS

n/a

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KEY PARTICIPANTS

Cristin McDermott, MD, Sansea Jacobson, MD; WPIC Wellness Committee; WPIC PGY1-5 residents; WPIC Office of Residency Training

TARGETED ISSUE / PROBLEM IDENTIFIED

During small group sessions, intergenerational groups of residents participated in an Appreciate Inquiry as a way to identify program strengths and needs. During the larger forum session, small groups presented a report out of their top ideas. While nearly one hundred ideas were generated, they fell into one of ten general categories: protected time, the ideal learning environment, food options, community space and community building, administrative support, predictability and reliability, parking/transportation, formalized feedback, mentorship and access to gym/physical fitness area.

INTERVENTION / PROGRAM DESCRIPTION

In January 2017, Western Psychiatric Institute & Clinic (WPIC) hosted its first Wellness Week. During the week, noontime activities focused on “Wellness at Work,” with topics ranging from finance (what to do with your paycheck, how to repay student loans, basics of investing, etc.) to addressing the shared responsibility of the individual and the organization to improve physician well-being. Following recommendations from Dr. Shanafelt’s November 2016 paper, “Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout,” WPIC psychiatry residents participated in an Appreciative Inquiry afternoon. Appreciative Inquiry was used to identify starting points not only for individual physician well-being, but also for identifying starting points for cultural/institutional change. The afternoon was entirely resident-run. Small groups consisting of intergenerational residents collaborated to brainstorm these themes. Groups then met in a larger forum to discuss ideas and develop a priority list of action items. The Co-Chairs of the WPIC Wellness Committee presented the ideas generated to the Office of Residency Training (ORT). ORT collaborated with the Wellness Committee to begin addressing action items. Since this activity, work has commenced on creating a community/social space, developing “wellness missions,” and initiating a weekly wellness curriculum, among other interventions and ideas.

TOOLS / STRATEGIES USED

In place of afternoon lectures, the WPIC Office of Residency Training supported a wellness afternoon, in which – following

a grand rounds on wellness at work – residents participated in an Appreciative Inquiry, as outlined above.

PROCESS USED TO DEVELOP THIS PROGRAM

Appreciative Inquiry was employed to begin the conversation and brainstorming session with WPIC residents. Appreciative Inquiry consists of a multi-step, focused discussion about current strengths, needs, available resources and goals for implementing change. The Appreciate Inquiry generally progress through four stages: discover (the identification of organizational processes that work well), dream (the envisioning of processes that would work well in the future), design (planning and prioritizing processes that would work well), destiny (the implementation of proposed design).

CHALLENGES / BARRIERS

Residents identified a number of ways to promote wellness at work, some practical and easy to begin working on, others more systemic and a bit more difficult to enact quickly. Implementing change will remain a challenge in many settings, though we hope that with resident and faculty support, these changes will have a large impact. Resident support is necessary for this project, and while all participated in the Appreciative Inquiry, not all wish or are able to dedicate time to building upon these ideas. The Wellness Committee serves as the core and continues to recruit resident support and assistance.

OUTCOMES / IMPACT

Residents at WPIC now have an integrated wellness curriculum based on the “wellness wheel” developed by the committee. The wheel includes six spokes: emotional, physical, social, spiritual, financial, and career. The curriculum is organized by the Wellness Committee and occurs weekly on Tuesday afternoons. Lunch is provided, and each week a lecture, discussion or activity takes place. Attendance is not mandatory, though all are encouraged to use the Tuesday 12p-1p hour for wellness. This year, we are working to expand this curriculum to include faculty members. Identifying community/social space was highlighted as a top priority during the Appreciative Inquiry. To that end, we are in the midst of identifying community space for resident and faculty socializing and networking. Ideas have included Wednesday morning coffee hour and afternoon tea/coffee break times. While the space is being identified, the Wellness Committee organizes monthly happy hours, inviting all residents and faculty to attend. These have been well received in the training community. The Wellness Committee continues to work on action items identified

during the Appreciative Inquiry, and is currently working on expanding wellness initiatives to include faculty well-being. Last year, two faculty leads were part of the committee. This year, we have expanded to include six faculty mentors and leads.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We would like to develop a survey to assess current levels of wellness at work, as we begin to implement our new wellness curriculum and initiatives. The action items list from the Appreciate Inquiry will continue to be explored, and will likely need to be reassessed, perhaps in a shorter discussion with current residents.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Using Appreciative Inquiry is a reasonable strategy for any institution or program, and the principles of Appreciative Inquiry can be adjusted to fit varying time constraints. The Appreciative Inquiry serves as a needs assessment, and empowers participants to identify what is going well, and what can be improved upon. Through this method, a sense of personal investment is attained and support is garnered.

LESSONS LEARNED

There is great benefit in promoting conversation about well-being. It is helpful to have resident/fellow input when designing a well-being curriculum and committee.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Michael Myers, MD
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KEY PARTICIPANTS

Michael F Myers

TARGETED ISSUE / PROBLEM IDENTIFIED

Decrease morbidity and mortality in physicians

INTERVENTION / PROGRAM DESCRIPTION

Publication of book “Why Physicians Die By Suicide: Lessons Learned From Their Families and Others Who Cared.”

TOOLS / STRATEGIES USED

Qualitative semi-structured interviews with individuals bereaved by physician suicide: family members; medical colleagues and friends; training directors; patients. I also interviewed physicians who made near lethal suicide attempts but did not die.

PROCESS USED TO DEVELOP THIS PROGRAM

Literature review Discussions with physician health colleagues Book proposal reviewed by Oxford University Press with important feedback

CHALLENGES / BARRIERS

1. Entrenched stigma about mental illness in physicians. 2. Licensing applications need to adopt recommended AMA and APA wording that they ask about current impairing illnesses only. Ditto for hospital credentialing applications. 3. Many parts of the country do not have treatment resources for ailing physicians that are state-of-the-art, confidential and at arm’s length.

OUTCOMES / IMPACT

1. 10-15 percent of interviewees lost an ailing physician loved one who received absolutely no evaluation or treatment before dying. 2. Bereaved others are desperate for more information about mental illness in physicians. 3. They also recommend that non-psychiatric physicians themselves need more basic information about symptoms to watch for in themselves and each other. 4. Survivors of physician suicide want to get involved in prevention. They are committed to saving the lives of other doctors so that their loved one will not have died in vain. 5. Stigma is pernicious in doctors and works against receiving and cooperating with life-saving treatment.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Continue to support the systemic efforts of national groups like ACGME, AAMC, NAM, AMA, NMA, etc to combat burnout and other stressors for trainees and practicing physicians. Continue to teach the basics of how to treat medical students and physicians when they become patients so they don’t fall through the cracks.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Very generalizable to any other physician organizations. There may be some overlap with other health professionals like nurses, physician assistants and others but with major differences.

LESSONS LEARNED

Suicide is a unique, painful and stigmatized event. Bereavement is protracted and variable in its course. There were individuals whom I interviewed who were open and candid but when I sent them the release to sign, I never heard from them again even after more than one attempt. Also stigma reaches into the survivor. Many families were willing to share their insights with me but did not want to disclose their name(s) or the name of their departed loved one, even if the death by suicide was publicly known. I also learned that many physicians are extremely dedicated to their patients and careers but do not take care of themselves at all.

WEBSITE / LINKS

www.michaelfmyers.com

SUPPORTING MATERIALS

physician_suicide._what_you_can_do_to_save_a_life._montefiore_grand_rounds.pptx
critical_issues_in_the_treatment_of_suicidal_physicians.pptx
the_silent_problem_that_is_not_going_away._aamc_template._7.26.2017.pptx

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ABSTRACT #23



Karen Nichols, DO
MWU/CCOM

KEY PARTICIPANTS

Kyle Henderson, PhD and Wellness Task Force Carrie Torgerson, PhD and Wellness Center Teresa Dombrowski, PhD and Student Services Bridget Condon, OMS II and the Student Wellness Committee Beth Longenecker, DO and Sophie La Salle, PhD, CCOM Dean's Office

TARGETED ISSUE / PROBLEM IDENTIFIED

Working primarily on prevention with the Wellness Center for intervention as needed

INTERVENTION / PROGRAM DESCRIPTION

We have 5 programs: Faculty Wellness Task Force Wellness Center Mindfulness Program Student Wellness Committee with "Stop the Crazy Talk" Dean's Office programming through the year Student Services programming through the year

TOOLS / STRATEGIES USED

General communication processes at MWU/CCOM

PROCESS USED TO DEVELOP THIS PROGRAM

Students, Faculty and Administration asked to consider how to address prevention

CHALLENGES / BARRIERS

Students are focused on passing courses and mastering material, so any programming cannot compete with exams and cannot take on a life at its own.

OUTCOMES / IMPACT

No specific outcomes at this point, too early

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We are deep into these programs/offerings and need to continue to assess the success of different programs in order to plan for the future

GENERALIZABILITY TO OTHER ORGANIZATIONS

Easy-peasy!

LESSONS LEARNED

Engage everyone at all levels.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

CONTACT

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Shirley Ooi, MBBS, FRCSEd, MHPE
National University Health System, S'pore**KEY PARTICIPANTS**

1. Program Directors 2. Residency Faculty 3. Residents

TARGETED ISSUE / PROBLEM IDENTIFIED

1. An initial small study among faculty has shown trend towards correlation between certain personality profiles types with higher risk of burnout and lower resilience. 2. A survey done among residents has shown significant percentage of burnout.

INTERVENTION / PROGRAM DESCRIPTION

1. Faculty are trained to understand and correctly interpret the DISC and Trait Emotional Intelligence Questionnaire (TEIQ) tools to coach their residents using these tools. 2. We hope to help residents build up their resilience and further develop their strong areas once they understand themselves better through the use of DISC and TEIQ tools and with coaching from their mentors.

TOOLS / STRATEGIES USED

1. The residents will do their Maslach Burnout survey and the Resilience survey before and after 1 year of coaching. 2. A survey will also be done to determine the success of this approach compared to the exiting approach without the use of these 2 tools in the regular faculty-resident mentoring meetings.

PROCESS USED TO DEVELOP THIS PROGRAM

1. Training of PDs and faculty in the use of DISC and TEIQ tools. 2. Residents do the DISC and TEIQ questionnaire. 3. Faculty goes through the residents' DISC and TEIQ profiles in the regular 3 monthly meetings and help them understand themselves better and to overcome the challenges through more targeted coaching.

CHALLENGES / BARRIERS

1. This is a new initiative and the faculty will need buy-in and guidance from the professional coach in this area. 2. The tools and training requires funding for long-term sustainability.

OUTCOMES / IMPACT

No outcomes yet as this is in the training phase of the faculty.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We are piloting this in the NUHS Emergency Medicine (EM) residency programme initially as I, the DIO and my EM PD have gone through a formal certification course in these 2 tools. We hope to extend to all the residency programs in NUHS.

GENERALIZABILITY TO OTHER ORGANIZATIONS

This is possible to generalize to other programs. The key challenge would be the buy-in from the faculty to want to undergo training and their comfort level in using these tools to coach their respective resident mentees.

LESSONS LEARNED

1. As in any new initiative, there is a lot of convincing to get buy-in from the various stakeholders. It is important to get the key opinion leaders early in the discussion so that their support can be obtained. 2. Messaging is also very important as one's personality and emotional intelligence profiles can be quite sensitive for some to want them to be revealed. There has to be a system of trust and assurance of confidentiality for this to work.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

CONTACT

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Mukta Panda, MD MACP

University of Tennessee, College of Medicine, Chattanooga TN

KEY PARTICIPANTS

-Mukta Panda MD MACP, Professor of Medicine, Assistant Dean of Medical Student Education -R. Bruce Shack, MD, FACS, Professor and Dean UTCOMC, Chair, Department of Plastic Surgery -Robert C Fore, EdD, FACEHP, CHCP, Professor and Associate Dean for Academic

TARGETED ISSUE / PROBLEM IDENTIFIED

#NAME?

INTERVENTION / PROGRAM DESCRIPTION

This initiative was implemented at different levels strategically designed to address the varied learners and members of the health care team at our academic medical school University of Tennessee Health Science Center College of Medicine (UTHSC-COM), clinical campus University Of Tennessee College Of Medicine Chattanooga (UTCOCM) and its affiliated hospital partner Erlanger Health System (EHS). The strategy was developed with key support and guidance from our Dean, R. Bruce Shack, MD, FACS Professor and Dean UT College of Medicine Chattanooga Chair, Department of Plastic Surgery and the assistance of key stakeholders from each of the institutions. Our initiatives at each level are briefly summarized below: Institutional: Academic: Leadership: University Of Tennessee College Of Medicine Chattanooga and Erlanger Health System (EHS) 1. Established a wellness task Force with the key stakeholders of each Organization and following Aims: The University Of Tennessee College Of Medicine Chattanooga, (UTCOCM) is committed to promote physician and trainee wellbeing and engagement. This issue is of high priority for us, and we have partnered with our affiliate hospital The Erlanger Health System (EHS), in this endeavor. With the assistance of the wellness task force which draws on the experience and participation from UTCOCM GME leadership, the Chief Medical Officer, Chief Nursing Officer, Chief of Staff and a faculty and resident champion from most departments we have initiated a program which is dedicated to: • Understanding and promoting physician and trainee engagement and well-being • Providing resources for physicians and trainees that help them promote their own wellness • Discovering personal and organizational approaches to prevent and address physician and trainee distress • Creating a workplace culture that is energy replenishing We meet every other month and the information is shared at every GMEC meeting. 2. EHS and UTCOCM: Enhancing Health Care Provider Engagement and Promoting A Healthy And Well Organization-created An Erlanger Health System (affiliate hospital) and University of Tennessee, College of Medicine Chattanooga Partnership

with all stakeholders to create an allied vision and mission based learning environment promoting quality education and patient care, engagement and wellness. Promoting the other “R” in RVU-Relationship Valued Unit: Enhancing Health Care Provider Engagement and Promoting A Healthy and Well Organization We developed and administered a survey to establish the baseline of faculty, medical staff and residents’ engagement, burnout and QOL. The data was broken down by various demographics and specialties. Each was given their data and with the help of their representative on the Wellness Task Force develops strategies to promote wellness. We are conducting another survey in October 3. Wellness in the CLER is a standing agenda item in every monthly GMEC meeting 4. Created a Physician Wellbeing Tab on the UTCOCM Home page under GME that is easily acceptable by all at both organizations and statewide campuses. I post regular informational materials regularly and communicated it with all. 3. Annual 1 day retreat: Held a one day off site retreat with representation from all stake holders. Reignite Your Passion: Connecting Passion With Purpose In The Clinical And Learning Environments Learning Objectives: 1. Identifying challenges to engagement and professional satisfaction 2. Understand the impact of burnout of physicians on health care organizations and physicians 3. Help participants share strategies and identify resources to promote healthy clinical and learning environments Facilitators: -Timothy P. Brigham, MDiv, PhD Chief of Staff Senior VP, Department of Education ACGME - Donald W. Brady, MD Senior Associate Dean for Graduate Medical Education and Continuing Professional Development Designated Institutional Official Vanderbilt University - Mukta Panda MD MACP Professor Department of Medicine and Medical Education Assistant Dean Medical Student Education Past Chair Department of Medicine University of Tennessee College of Medicine Chattanooga Facilitator Center for Courage and Renewal Students Statewide: University of Tennessee Health Science Center College of Medicine (UTHSC-COM): I have had multiple in person and videoconferences with the UME leadership in Memphis to initiate and promote the culture of support and wellbeing for the students. With assistance from partners in Memphis we have initiated a multipronged approach. Some examples are below. • M1 student orientation session • GHHS • Humanism society • Learning Communities I physically travel to Memphis and lead a session quarterly. Chattanooga Campus: University of Tennessee College of Medicine Chattanooga (UTCOCM) and PA Students: • From STEEEP to STEEPE2R3 Project Reference to STEEEP health care matrix for patient care • The healthcare matrix was developed by John Bingham and Doris Quinn of Vanderbilt University Medical Center, this evaluation tool links the six IOM (Institute of Medicine)

STEEEP (acronym for safe, timely, efficient, effective, equitable, patient care) aims for improvement evaluation markers with the six ACGME core competencies of Patient care, Medical Knowledge, Interpersonal communication skills, Professionalism, Systems based practice and Practice Based learning and Improvement). • We have expanded it to STEEPE2R3 Empathy and Relationship, Reflection and Rejuvenation Bingham John, MHA and et al.: Using a Healthcare Matrix to Assess Patient Care in Terms of Aims for Improvement and Core Competencies. Journal on Quality and Patient Safety. February 2005; Vol. 31, No. 2:98-105. Art of Balance, Art of Diagnosis: Caring for Physician and Patient Both these programs are part of the curriculum designed for 3rd and 4th year medical school students and physician assistant students at the University of Tennessee College of Medicine at Chattanooga This monthly program is developed in partnership with the medical faculty and staff at the Hunter Museum of American Art (HMAA) and the Southeast Center for Education in the Arts (SCEA). The program is designed to build physician resiliency through a focus on teamwork and empathy. The program incorporates written assessments as well as recorded dialogue for each session which are submitted to the school of medicine for assessment and development of future models. All students sign release forms to allow for these assessment tools. Additional outcomes for the program include • Increased self awareness • Increased effectiveness of interpersonal interactions with patients. • Increased understanding of personal values and beliefs relevant to a medical practice • Increased understanding of cultural difference Improved ability to contextualize and recognize important details that inform sound interpretations and/or diagnoses. • Increased understanding of external stressors that lead to physician burnout. • Improved ability navigating stressful situations in high stakes settings. • UTCOMC-Residents: • Resident membership on Wellness Task Force • Resident Orientation session • Regularly scheduled Town Hall Style Interactive Meetings with all Residents and key Leadership UTCOMC-Department of Medicine Residents • Resident Wellness Chair and Committee • Regular monthly sessions (hOURglass sessions, COMPASS sessions) • Individual counseling • Annual retreat • Mindfulness in Medicine curriculum • RRRnR sessions (Relaxing , Rejoicing and Rejuvenating in Residency) UTCOMC-Department of Medicine Faculty: 1. Conference sessions 2. Interprofessional team discussions 3. Retreat to be planned Regional: Created and Chair a wellness committee at the 1. Chattanooga Medical Society and have a retreat planned for the community physicians November 9th 2. Tennessee Chapter of the ACP: Developed and administered a survey to all members across the state using the Mini Z and shared the data and a presented an interactive 2 hour workshop which review the current data, interventions

and discussed mitigating strategies. National: 1. CHARM-member of the steering committee and chair the Faculty development subgroup that has presented multiple workshops and presentations all across the nation at various individual institutions and national and regional forums. Currently working on a paper collating these. 2. ACP 3. SGIM 4. ACGME Research: 1. Publication: Busireddy KR, Miller JA, Ellison K, Ren V, Qayyum R, Panda M. Efficacy of Interventions to Reduce Resident Physician Burnout: A Systematic Review J Grad Med Educ. 2017 Jun;9(3):294-301. doi: 10.4300/JGME-D-16-00372.1. Review. 2. Manuscripts submitted and in preparation: Completed 2 research projects-1 manuscript submitted, other in preparation -Spirituality and Hospitalization Experience of Patients Study (SHEPS) -Relationship between Psychological well-being and Patient Satisfaction with Physicians during Hospitalization. 3. Workshops: Facilitated 5 workshops at national meetings Facilitating 3 hour Minicourse at the 2018 ACGME Annual Educational Conference: Leadership for Transformative Change: Creating a Culture of Well-Being in Medical Education

TOOLS / STRATEGIES USED

discussed together with Intervention/Program Description

PROCESS USED TO DEVELOP THIS PROGRAM

discussed together with Intervention/Program Description

CHALLENGES / BARRIERS

- Inertia in engaging key stakeholders -Lack of time from real or perceived overwhelming clinical requirements-Service vs Education -lack of trust between C Suite and academia -Lack of the feeling of this work being valued -Financial resources lacking -lack of perceived immediate ROI

OUTCOMES / IMPACT

This has been a slow process, requiring persistence, patience and resilience among key kindred spirits. However we have made progress and are collaborating with the human resources department of the hospital to establish an ongoing regularly scheduled longitudinal series of workshops for small groups of faculty, physicians, and health care providers throughout the year. We have a preliminary outline and plan to start in January.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

as outlined in the sections above

GENERALIZABILITY TO OTHER ORGANIZATIONS

principles and approach easily applicable to all clinical and academic environments as this approach involves and addresses all the stake holders.

LESSONS LEARNED

I have learnt a lot about myself during this process over the past year. I have learnt to be kind to myself, slow and patient. I was getting ‘burnt out’ with the lack of support for preventing “burnout”. This has helped me move forward with the support of key stakeholders. Networking and involvement with the ACGME, AAIM, ACP, CCHARM and AMA has provided skills and resources that we have mutually used and shared.

WEBSITE / LINKS

<http://www.utcomchatt.org/subpage.php?pagelId=1419>

SUPPORTING MATERIALS

n/a

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Miguel Paniagua, MD
National Board of Medical Examiners (NBME)

KEY PARTICIPANTS

Elisa Moll, Steve Haist, Nicole Taylor, Michelle Goldberg, Monica Cuddy, Michael Barone, Craig Mills

TARGETED ISSUE / PROBLEM IDENTIFIED

The inability to acknowledge and address stressors faced by healthcare trainees can result in higher personal and organizational burdens and even illness. Further, our system of education, and in particular, assessment, adds to an already potentially stressful educational journey.

INTERVENTION / PROGRAM DESCRIPTION

Our goal in this initiative is to address the challenge of physician wellness and acknowledge the stress caused by working in the health professions which begins during the educational process, with the first targets being in the undergraduate (UME) and graduate/residency (GME) domains. The objective of this project is to convene a summit of leaders in the field to develop and execute a research agenda that will lead to actionable interventions to promote wellness in this context.

TOOLS / STRATEGIES USED

To be determined by the expert task force to convene in first quarter of 2018

PROCESS USED TO DEVELOP THIS PROGRAM

This project was established with the approval of the governance of NBME after discussion with like-minded organizations in the house of medicine, USMLE faculty, and other stakeholders.

CHALLENGES / BARRIERS

This will challenge current conventions in regards to how USMLE is reported (e.g. three digit scores), and the secondary uses of the exams for determination of trainee readiness/competence for residency.

OUTCOMES / IMPACT

To foster a meaningful discussion about the effects of high-stakes exams such as USMLE on learner wellness.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

The long-term objective is to establish a unique niche alongside other healthcare professional organizations who are also addressing this issue, and contribute to a better

functioning healthcare system.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Applicable to GME, UME organizations represented in AAMC, and FSMB.

LESSONS LEARNED

To be determined.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

CONTACT

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Amanda Pannu, MD
University of Rochester

KEY PARTICIPANTS

Steve Schultz MD

TARGETED ISSUE / PROBLEM IDENTIFIED

In April of 2017, an appreciative inquiry activity was done with the entire department to brainstorm ways in which wellbeing can be improved throughout the department. A list of about 100 ideas was created.

INTERVENTION / PROGRAM DESCRIPTION

At the University of Rochester Family Medicine Program, we have founded a Wellbeing Committee. This committee has representation from residents, faculty, nursing, and support staff.

TOOLS / STRATEGIES USED

The department used appreciative inquiry and group work to brainstorm ideas for change. This method obtained buy-in from each member of the department, as well as ensuring that all ideas were considered.

PROCESS USED TO DEVELOP THIS PROGRAM

Using the comprehensive list of ideas, the committee divided the ideas into different categories: social and food, environment, and physical and mental health. The committee then divided into three subcommittees of about 4-5 individuals; these subcommittees each focused on one of the categories to improve efficiency. Some ideas were discarded for various reasons (physically impossible, cost-prohibitive etc). The remainder of the ideas were further fleshed out then brought to the committee as proposals. The committee as a whole then decided if that idea should be implemented.

CHALLENGES / BARRIERS

One of our biggest challenges was financial strain. We were able to advocate to our department chair to get a small amount of money for the rest of the academic year. Our hope is that this will be written into the budget for next year. We are also currently searching for an intern from the University to help with administrative tasks.

OUTCOMES / IMPACT

To date, the wellbeing committee has made many small but concrete changes to our clinic to improve wellbeing of the entire clinical staff. We have started a community garden, a community supported agriculture site, a twice weekly lunchtime meditation, a lunchtime walking group, a dedicated bike storage

area, brought in a speaker to teach about healthy cooking techniques, trained residents and faculty in peer support techniques after critical events, and hosted a fall bake-off. These interventions have helped to build camaraderie and improve morale of residents, faculty and staff members. Although we do not have any concrete data to support an improvement in wellbeing, we have quite a lot of anecdotal evidence that our interventions are making small but meaningful change in the lives of our residents, faculty and staff. As we have representation from each discipline on the committee, it is the responsibility of the representative to go back to their colleagues and obtain feedback about any of the interventions. We have received largely very positive feedback from residents, faculty and staff.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

In the future, we hope to expand our interventions to a more sweeping cultural change. The Wellbeing Committee hopes to implement a tool for evaluation of our wellbeing interventions. We also hope to, with more financial and administrative support, to enact more time-intensive and costly interventions.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Our process of making change is very generalizable to other organizations. We found quite a bit of success in first performing a department-wide needs assessment, followed by the gradual application of the various ideas.

LESSONS LEARNED

The most important lesson that we learned was that clear communication about resources is imperative. Before we realized our budgetary constraints, we spent time brainstorming interventions that would prove impossible with the resources allocated. After more clear communication, we were able to focus our time and energy on ideas that could be more realistic. Hopefully, with more financial support next year, those ideas can be realized in the future.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

CONTACT

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Linda Pololi, MD, FRCP
Brandeis University**KEY PARTICIPANTS**

• We purposefully sampled 14 academic health systems to assure diversity by: region of the U.S., size, population served, and institutional funding (public or private). • All (35) residency programs in Internal Medicine, Pediatrics and General Surgery at each hospital site were invited to participate, 34 program directors agreed to include their programs in the resident survey study. • 1708 of 2452 invited medical residents (70% response rate): 956 Internal Medicine, 441 Pediatrics, and 311 General Surgery; 879 (51%) women, 268 (16%) under-represented in medicine minority (URMM), and 305 (18%) international medical graduates. All post graduate years were included.

TARGETED ISSUE / PROBLEM IDENTIFIED

We define vitality as the vigorous commitment to ongoing intellectual and personal growth, full professional engagement, enthusiasm, energy, and a positive feeling of purpose. The concept of vitality captures the joy and meaningfulness of work, and the absence of burnout. Thus, we believe that vitality may be a more useful attribute to assess in residents because it is more precise than well-being, and because it is an important aspirational target. We suggest that vitality affects learning and professional engagement, and is critically important to enhancing competence and compassion. Most prior work on resident well-being has employed assessment of depression, suicidal ideation, burnout etc. in residents. Organizational factors and the culture are increasingly recognized drivers of burnout and impaired well-being, and some have proposed an approach to improve residency training - that is complementary to psychiatric services - by suggesting that we first attend to the culture and environment of residency programs. To our knowledge, there is no prior published assessment of vitality in U.S. residents, nor of what aspects of the culture in academic health systems predict resident vitality. For a decade, the National Initiative on Gender, Culture and Leadership in Medicine: C - Change has been studying the culture of academic health centers and measuring vitality in medical school faculty and medical students.

INTERVENTION / PROGRAM DESCRIPTION

This initiative documented the vitality of a national sample of residents, and sought to identify which individual and programmatic characteristics, and which dimensions of the organizational culture predict resident vitality. We administered electronically the reliable and validated C - Change Resident Survey,(1) which measures dimensions of the culture of academic medical centers from the perspective

of residents to residents in 34 programs in Internal Medicine, Pediatrics and General Surgery in 14 academic health systems. We use the construct of vitality as the lens through which to study the relationship between culture and resident well-being.

TOOLS / STRATEGIES USED

The 69-item C - Change Resident Survey (CRS) assessed resident perceptions of 13 dimensions of the culture: Vitality; Self-efficacy in Career Advancement; Institutional Support; Relationships/Inclusion; Values Alignment; Ethical/Moral Distress; Respect; Mentoring; Leadership Aspirations; Work-life Integration; Gender Equity; Under-Represented in Medicine Minority Equity; and Competencies. We also collected resident demographic data on gender, sexual orientation, race/ethnicity, age, U.S. versus international medical degree, presence of children at home <18 years, and PG year. Program characteristics included specialty, institutional funding (public/private or both), program size, percent of Medicaid patients served, and region of the country. Data were analyzed by hierarchical models to accommodate clustering, including models in which individual dimensions of culture predicted Vitality up to a model in which nine dimensions of culture predicted Vitality. This allowed us to describe within-program and between-program variation.

PROCESS USED TO DEVELOP THIS PROGRAM

The 69-item C - Change Resident Survey (CRS) assesses resident perceptions of 13 dimensions of the culture: Vitality; Self-efficacy in Career Advancement; Institutional Support; Relationships/Inclusion; Values Alignment; Ethical/Moral Distress; Respect; Mentoring; Leadership Aspirations; Work-life Integration; Gender Equity; Under-Represented in Medicine Minority Equity; and Competencies. We also collected resident demographic data on gender, sexual orientation, race/ethnicity, age, U.S. versus international medical degree, presence of children at home <18 years, and PG year. Program characteristics included specialty, institutional funding (public/private or both), program size, percent of Medicaid patients served, and region of the country. Data were analyzed by hierarchical models to accommodate clustering, including models in which individual dimensions of culture predicted Vitality up to a model in which nine dimensions of culture predicted Vitality. This allowed us to describe within-program and between-program variation. Process Used to Develop this Program The Arnold P. Gold Foundation generously funded this study with supplemental funding from the Committee of Interns and Residents (CIR), Brandeis University Women's

Studies Research Center, the University of New Mexico Health Sciences Center, Boston Medical Center, and Oakland University William Beaumont School of Medicine. The C - Change research team includes: Linda H. Pololi, MBBS, FRCP, (PI) Brandeis University; Arthur Evans, MD, MPH, Weill Cornell Medical College; Janet T. Civian, EdD, Brandeis University; Sandy Shea, BA, CIR Policy and Education Initiative; Robert T. Brennan, EdD, Harvard T. H. Chan School of Public Health

CHALLENGES / BARRIERS

Residency programs need resources to administer the C - Change Resident Survey to support the analyses of survey data generated, and also to implement well-being improvement activities. Residents need to be assured of the separation from their supervisors of their responses to sensitive questions

OUTCOMES / IMPACT

Response rate The overall response rate for residents in the 34 participating programs was 70% (range: 51% to 87%), with little variation by specialty (65% for General Surgery, 69% for Pediatrics, and 72% for Internal Medicine). In all, 1708 of 2452 residents responded to the survey. Variation by specialty The overall mean (range 1–5) in resident Vitality was 3.6 (standard deviation 0.9). Data showed large differences (greater than 1 standard deviation) between some programs. However, there were no statistically significant differences in mean Vitality scores across the three specialties. Nevertheless, there were important and statistically significant differences in mean Vitality scores across programs within each of the specialties ($P < 0.001$) and even across programs within the same academic health center. We sorted programs by the percentage of residents in the program with “High Vitality” (mean score 4-5), residents “At Risk” (mean score 3) and “Dispirited” (mean score 1-2). Of note, the program at the top (most residents with High Vitality) was a General Surgery program, the second program was Internal Medicine, and the third and fourth were Pediatrics programs. This is an illustration of the similarity in Vitality across the 3 specialties. Each of the top 4 programs had at least 70% of residents categorized as High Vitality, with less than 1% as Dispirited. In contrast, 3 programs had over 30% Dispirited residents. Within-program and between-program variation When dimensions of culture are added individually to the model, Work-Life Integration explained more within-program variance, 35.5%, than any other single predictor; Relationships/Inclusion/Trust; Respect and Institutional Support each explained 34% variance; Values Alignment 32% variance; and Ethical/Moral Distress 30%. Values

Alignment, Institutional Support, Respect and Ethical/Moral Distress explained the most between-program variance. The inclusion of five dimensions of culture, Work-Life Integration, Relationships/Inclusion/Trust, Respect, Values Alignment and Institutional Support as predictors in a hierarchical model predicted 50% of the variation in Vitality at the within-program level and 90% at the between program level. Only 3% of the variation in Vitality was explained by individual resident demographic variables.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Vitality of residents differed dramatically across programs, ranging from less than 20% to over 70% of residents within a program reporting High Vitality. These differences were not explained by specialty or demographic characteristics, but, instead, were largely explained by the unique cultural dimensions of the residency program. These cultural characteristics were not consistent across programs within the same institution. They are unique to the specific program and include program features that affect work-life integration, relationships, trust, a sense of belonging, alignment of individual and institutional values, moral distress, mentoring, respect, fairness, and support. Other program and institutional characteristics, such as size of program, funding sector, and population served, were unimportant in predicting resident vitality, as were resident individual demographics. Additional residency programs are currently requesting CRS studies of their residents and some programs are using the results to identify areas on which to focus their change activities to enhance well-being in their residents. The CRS is also being used to assess the efficacy of such change activities/interventions, and for diversity needs assessments.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Nationally, variation in program Vitality means is largely explained by resident perceptions of the dimensions of culture, foremost among which are Work-Life Integration, Relationships/Inclusion, Values Alignment and perceptions of Institutional Support. The ACGME CLER initiative is calling for assessment of the culture of residency programs to address concerns about resident well-being. The CRS is a valid instrument for this assessment. The study helps answer the question as to which dimensions of the culture predict resident vitality and well-being, and that are amenable to improvement. Use of the CRS is generalizable to other organizations and is available for use from C - Change at Brandeis University.

LESSONS LEARNED

It is reasonable to conclude that efforts to alter residents' perceptions of dimensions of the institutional culture will achieve higher mean Vitality. Given that most within-program and between-program variation in Vitality can be explained by a combination of the dimensions of culture, targeted interventions including activities to create a more relational culture and trust within programs, work-life support and alignment of individual and institutional values may significantly enhance resident well-being.

WEBSITE / LINKS

<http://cchange.brandeis.edu>

SUPPORTING MATERIALS

[kohli_crs_commentary_jgim_2017.pdf](#)

CONTACT

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Elisabeth Poorman, MD, MPH
Cambridge Health Alliance, Harvard Medical School**KEY PARTICIPANTS**

Elisabeth Poorman Mental health issues, particularly depression, suicidal ideation, and substance abuse are alarmingly common amongst medical trainees. The root causes of this epidemic and how to approach it are not well-understood.

TARGETED ISSUE / PROBLEM IDENTIFIED

Privacy, confidentiality, and the risks of seeking treatment identified by trainees

INTERVENTION / PROGRAM DESCRIPTION

Confidential mental health counselors with no role in the residency who are available to connect residents to mental health care on an as-needed bases.

TOOLS / STRATEGIES USED

Literature review and case residents

PROCESS USED TO DEVELOP THIS PROGRAM

Combining a literature review and case studies conducted with recent residency graduates, this presentation identifies the known life cycle of the mental health epidemic in training, and explores some of the possible causes.

CHALLENGES / BARRIERS

Four cases studies with recent graduates will be presented, with the common theme of fear of loss of privacy as a major barrier to seeking care, as well as the inappropriate use of chief residents as therapists/psychiatrists for trainees, and punitive measures in place for those who do take time to seek treatment.

OUTCOMES / IMPACT

The most reliable studies have found that the prevalence of depression before medical school is lower than the general population, and rises to 28% in a world-wide survey. It improves before intern year to a level of 4%, then increases to 41.8% at any point during the first year of residency. Prevalence rates decrease slightly through residency, but remain approximately double what they were before residency began.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

The predictable life cycle of depression in medical training implies that depression is an occupational health hazard of

medical training. Its prevalence is increasing over time. The long-term implications of depression are important for quality of care, health and well-being of the physician work force, and the elevated suicide rate of physicians. Structures in place to treat depression for residents remain inadequate, stigmatizing, and, in some cases, punitive. The presentation will conclude with some models of treatment that address these concerns.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The model of confidential mental health liaisons is generalizable to any academic medical center, and directly addresses the most common concern raised by residents seeking mental health care.

LESSONS LEARNED

Depression, suicidal ideation, substance abuse, and other mental health disorders are increasing over time in medical trainees. Trainees identify concerns about seeking help due to lack of confidentiality, and punitive measures identified at several programs. In identifying these issues and highlighting a program's response, I hope to offer other programs a scaleable response to this mental health crisis.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

the_stigma_we_live_in_slides.pdf

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Stacy Potts, MD, MEd

University of Massachusetts

KEY PARTICIPANTS

Worcester Family Medicine Residents Faculty: Christine Runyan, PhD, Sherrilyn Sethi, DMH

TARGETED ISSUE / PROBLEM IDENTIFIED

Resident wellness is a critical need in today's health care environment. Family medicine is among the top five specialties in rates of burnout estimated at near 60% of practicing family doctors. Resident physicians have even greater rates of burnout. There is limited evidence of strategies to educate physicians in burnout mitigation and wellness promotion. Reducing burnout among primary care providers is essential to achieving the IHI Triple Aim, but a paucity of effective programs to reduce or prevent burnout among residents has been evaluated. Preventing burnout may best be accomplished by building resiliency – a series of specific skills that, when cultivated, promote wellness. Encouraging resiliency skills during residency may be more effective than trying to undo patterns of thinking and behaving among practicing physicians when patterns are more concretized.

INTERVENTION / PROGRAM DESCRIPTION

Family Medicine Resident Wellness Curriculum: Initial Feasibility Study

TOOLS / STRATEGIES USED

Mindfulness Medical Humanities Journaling Gratitude exercises Self reflection skills

PROCESS USED TO DEVELOP THIS PROGRAM

The Worcester Family Medicine Residency (WFMR; 12-12-12 program) has three health centers serving socioeconomically diverse patient populations (urban, rural, and a Federally Qualified Health Center). All 12 PGY-II family medicine residents (9 females, 3 males) participate in a 4-week Physician as Leader (PAL) rotation. The PAL curriculum (Table 1) began in 2013 as a longitudinal experience that mirrors the IHI Triple Aim, including PAL 1 focusing on population health, PAL 2 on patient care, and PAL 3 on practice management. The wellness curriculum was embedded into the PAL 2 rotation for all residents. A behavioral science faculty member (CR) implemented the wellness curriculum every Friday afternoon for 2 h during the 4-week rotation with four residents per cycle. For 3 months following the curriculum, residents were sent monthly emails with reminders about implementing self-reflection skills, journaling, gratitude, and mindful breathing. The study was

a pre-post within subjects design, with a 3-month follow-up on the same set of four assessment measures. The pre-assessments occurred at the start of the PAL rotation for each site and the 3-month post-assessment occurred at three different times when PGY-IIs gathered for required didactics. Residents were informed of the confidential and non-evaluative nature of these matched pre-post assessments collected by a trained research assistant. Using paper/pencil administration, the measures included: 1) Maslach Burnout Inventory; 2) Self Compassion Scale; 3) Perceived Stress Scale; and 4) Jefferson Empathy Scale. Statistical analysis was primarily descriptive. Paired t-tests were calculated to determine statistically significant changes. Because of the small sample size and non-normal data distributions, the non-parametric equivalent of the paired t-test was used. As results were identical, descriptive data from the paired t-tests are reported for ease of interpreting mean scores.

CHALLENGES / BARRIERS

The challenges of implementation include engendering leadership support, finding curriculum time, and engaging a well-trained faculty member. This specific curriculum required about 40 h of faculty time over the course of the year, including curriculum development time. The positive feedback from residents has led to a curriculum expansion, which is now embedded in all PAL rotations as well as monthly sessions throughout the year with PGYIIs and IIIs. This will permit an enhanced evaluation with follow-up.

OUTCOMES / IMPACT

The strengths of this project include the use of validated instruments as well as development of a defined curriculum in modules that can be easily modified and implemented. Residency wellness scores improved from baseline to the 3-month follow-up period. However, because of limited sample size and a resultant lack of sufficient power, few comparisons of the mean scores showed statistically significant improvements with the exception of the Mindfulness Subscale of the Self-Comparison Scale (SCI; $t=73.51$; $p=0.008$).

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Further research in both curricular development and program evaluation is needed to determine whether introducing resiliency skills during residency impacts downstream outcomes such as burnout prevention, productivity, quality of care, expressed empathy, and patient satisfaction. The program has grown to include a focus for

each year of residency: PGY1: Knowing self, PGY2: Practice Self-Care; and PGY3: Self as Instrument.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Residency programs are increasingly implementing wellness initiatives to improve resident health, prevent burnout, and improve patient outcomes. The long-term impact of this wellness program is unknown; however, the positive subjective experience of residents and the corresponding culture shift to acknowledge, support, and promote longitudinal wellness activities within the WFMR program are meaningful and indubitable benefits.

LESSONS LEARNED

The initial institution of a concentrated physician wellness curriculum led to greater interest and support for a longitudinal program. Small steps over time have led to a fully integrated longitudinal program at our residency.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Denise Purdie, MD
UCLA Pediatrics**KEY PARTICIPANTS**

Authors: Denise Purdie, Myke Federman, Alan Chin, Michael Irwin, Yonca Bulut ** Work will be presented on behalf of primary author and co-authors by conference attendee Lisa Gantz, MD, who is attending the conference as a representative of UCLA Pediatrics **

TARGETED ISSUE / PROBLEM IDENTIFIED

Within the last decade, there has been increased awareness of stress, burnout and depression experienced by individuals in the medical community. Residency training, in particular, causes a significant degree of stress, burnout and depression. In pediatric residents, data suggest that up to 52% “almost always” feel stressed, 25% suffer from depression and 74% experience symptoms of burnout. These factors, in turn, adversely affect physician well-being as well as patient outcomes and patient satisfaction

INTERVENTION / PROGRAM DESCRIPTION

- This is a randomized prospective clinical trial with two parallel groups evaluated via a waitlist control design, which will be conducted from September 2017 – November 2017 at a single academic medical center. Participants will be trainees in a Pediatric residency program.

TOOLS / STRATEGIES USED

An abbreviated Mindful Awareness Practices (MAPs) intervention randomized to participants (n = 30) versus waitlist (n = 30). Participants will receive 1-hour per week of MAPs training over approximately 6 weeks with assigned daily self-directed mindfulness meditation. Instruction will be delivered via a single in-person session during noon conference at four training sites as well as five on-line sessions available through a mobile application.

PROCESS USED TO DEVELOP THIS PROGRAM

Literature review

CHALLENGES / BARRIERS

Daily schedules for residents are very busy and complicated, making it difficult to find times for trainings as well as pre and post surveys.

OUTCOMES / IMPACT

- The study is powered to detect between-group differences in stress measured via the Perceived Stress Scale, a

widely used and validated 14-item self-report questionnaire measuring the perception of stress. Secondary outcome measures include: burnout, depression, anxiety, loneliness and sleep quality.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We have concluded the training portion and are currently conducting final data collection and will be analyzing data in the next few months. Data will be presented both locally to program leadership as well as at National conferences.

GENERALIZABILITY TO OTHER ORGANIZATIONS

- This study could demonstrate that an abbreviated curriculum in mindfulness meditation is beneficial in regards improving well-being and resilience in medical trainees. The results of this study could provide a foundation for future large-scale studies and widespread use of Mindful Awareness Practices as part of the formal residency curriculum.

LESSONS LEARNED

To be determined- so far we have received very positive informal feedback from residents participating in the program.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Jonathan Ripp, MD, MPH**Collaborative for Healing and Renewal in Medicine (CHARM)****KEY PARTICIPANTS**

Larissa Thomas, MD Colin P. West, MD, PhD Hasan Bazari, MD Elizabeth Gaufer, MD, MPH Jonathan A. Ripp, MD, MPH

TARGETED ISSUE / PROBLEM IDENTIFIED

The need for a unified consensus statement on Physician Well-Being

INTERVENTION / PROGRAM DESCRIPTION

Enhancing physician well-being to ensure patient safety, achieve high quality care, and sustain a healthy physician workforce is a national priority and has been described as the “Fourth Aim” of health systems improvement efforts. However, no universal vision or set of standards currently exists to guide those who wish to structure and implement well-being interventions. A charter that outlines guiding principles and steps to enhance physician well-being would benefit individuals, professional societies, health systems, and policy-makers seeking opportunities to improve their own programs and advocate for resources to address unmet needs.

TOOLS / STRATEGIES USED

Consensus In-Person Meeting

PROCESS USED TO DEVELOP THIS PROGRAM

The Collaborative for Healing and Renewal in Medicine (CHARM), a national group established to address well-being in resident physicians and medical students, developed an initial draft of the charter, which was informed by the body of literature on physician well-being. Representatives of multiple professional organizations, in collaboration with CHARM and the Arnold P. Gold Foundation, met over two days to finalize the consensus guiding principles and action plan for physician well-being. The resulting charter document is being disseminated to a wide audience of professional societies for endorsement.

CHALLENGES / BARRIERS

Finding consensus on this complex issue

OUTCOMES / IMPACT

The Charter on Physician Well-being envisions well-being as more than the absence of burnout; physicians should be supported to work in an environment that enhances meaning

and engagement. With a goal of achieving the Quadruple Aim, the charter outlines the following guiding principles as the foundation for efforts to improve well-being: 1) effective patient care both promotes and requires physician well-being 2) physician well-being closely relates to the well-being of all members of the health care team 3) well-being is quality marker for effective and efficient health systems and 4) physician well-being is a shared responsibility between individuals and organizations. The Charter includes commitments for organizations and individuals to optimize well-being, including promoting a culture of well-being, ensuring accountable leadership, establishing policies and systems that support sustainable and meaningful work, addressing physical and mental health needs, and dedicating time to learn and practice self-care skills.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

The Charter on Physician Well-being establishes a shared vision and standards that professional societies can endorse as part of a unified approach to addressing physician well-being. Individuals, professional societies, health systems, and policy-makers can use the charter to understand domains of well-being at the individual and organizational levels, to target strategic interventions to meet identified needs, and to align policies with best practices. With the consensus document now developed, the symposium represents a critical juncture for the charter’s discussion and dissemination to a broader group of stakeholders.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The hope is that this Charter will have broad appeal that numerous other organizations will adopt.

LESSONS LEARNED

Broad consensus can be achieved through an in-person collaborative short-term meeting.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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Paulvalery Roulette, MD
Carolinas Medical Center**KEY PARTICIPANTS**

Carolinas Medical Center Orthopaedic Residents and Faculty Faculty of OrthoCarolina

TARGETED ISSUE / PROBLEM IDENTIFIED

Physician burn out and well being.

INTERVENTION / PROGRAM DESCRIPTION

A formal grand rounds presentation was delivered to the faculty and residents of the Carolinas Medical Center Orthopaedic Residency on physician well-being. It included up to date research on physician burn out and emphasized best practices from the literature that promoted well being in residency, physician practices and large health systems.

TOOLS / STRATEGIES USED

Carolinas Medical Center Orthopaedic Grand Rounds lectures are performed on a weekly basis by residents and faculty in order to provide a comprehensive overview of various clinical topics ranging from basic science, patient care, and business management that affect the practice of orthopaedics.

PROCESS USED TO DEVELOP THIS PROGRAM

After attending the 2nd Annual Wellness Symposium, my commitment to change was to develop a presentation to introduce best practices on physician well being and specific research performed in the surgical community. Assistance with content for the lecture was received through Dr. Elizabeth Ames, University of Vermont Orthopaedic Residency Program Director and Dr. Joshua Patt, Carolinas Medical Center Orthopaedic Residency Program Director.

CHALLENGES / BARRIERS

No significant challenges or barriers were encountered in order to deliver this lecture on well being.

OUTCOMES / IMPACT

The grand rounds presentation spurred a conversation that helped to highlight the resources available to both residents and faculty through the department and the health system. Specifically, Carolinas Healthcare System has a Well-Being sub committee with physician leadership and physician concierge service. The employee assistance program (EAP) provides behavioral health services to help employees address substance abuse and alcohol abuse

issues, as well as mental health, marital, financial and family troubles. Carolinas HealthCare System provides confidential counseling, comprehensive assessments, and prevention and wellness advice that is free to employees. Carolinas Healthcare System also sponsors a Live Well health incentive program that allows employees to participate in health promotion activities that can garner monetary rewards towards a health savings account. The healthcare system also keeps Dr. Wayne Sotile of the Sotile Center for Physician Resilience on retainer for physicians needing additional intervention or support for wellness or resilience. Residents may be referred to him directly through medical education or program directors. Faculty members affiliated with OrthoCarolina, who are involved in resident education, revealed their best practices in promoting well being through formal faculty mentorship relationships and well-being seminar.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Future goals would be to continue to advertise the confidential counseling services that exist within our health system for clinical staff.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The act of providing a lecture on physician burn out and well being to clinical staff can be performed in many existing residency curricula and it can be the best opportunity to further advertise the resources that may exist within their respective department or health system.

LESSONS LEARNED

Many of the tools to help to address burn out and other mental health needs existed within our health system prior to my presentation. There is opportunity for improvement in advertising the counseling services available to employees, including residents and physicians. Furthermore, confidentiality is highly desired by residents when they are considering seeking counseling for mental health issues. Advertising the confidentiality of these services would likely encourage their use amongst the clinical staff.

WEBSITE / LINKS

<https://www.carolinashealthcare.org/medical-services/prevention-wellness/employer-solutions/eap>

SUPPORTING MATERIALS

n/a



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TARGETED ISSUE / PROBLEM IDENTIFIED

Given the apparent need the video met in the GME community, the video was converted to a shorter, streamlined version and combined with educational materials to make available to GME institutions around the country. The primary goals of the video/discussion session are to 1) promote an open dialogue among interns, residents and fellows about depression and suicide within the profession of medicine, 2) confront the stigma surrounding depression and suicide within the profession, and 3) foster an environment that encourages appropriate help-seeking for depression and suicidal ideation among physicians.

INTERVENTION / PROGRAM DESCRIPTION

The culture of medicine is past the tipping point when it comes to behavioral health issues among physicians. Literature on physician wellness, resiliency, burnout, depression, and suicide abounds and continues to garner attention in news and social media outlets. The Accreditation Council for Graduate Medical Education (ACGME) now requires its training programs to “promote resident well-being in a supportive educational environment.” However, the development of tools for institutions to proactively address burnout, depression and suicide among physicians is still in its infancy. “Time to Talk About It: Physician Depression and Suicide” is a video and facilitated discussion module sparked by the tragic death by suicide of a SAUSHEC (San Antonio Uniformed Services Health Education Consortium) intern in August 2014. During intern orientation the following summer, a small group of SAUSHEC physicians came together on stage to share their reaction to the resident’s death as well as their individual struggles with burnout, depression and suicidal ideation. The video recording of their presentation was shared with other institutions and soon, by word of mouth, was frequently requested by others.

TOOLS / STRATEGIES USED

Logistics: The session requires an uninterrupted minimum of approximately 60 minutes, but 75 – 90 minutes may allow for more complete discussion. • Welcome/introduction: 5-10 minutes • Video: 7 minutes • Small group discussion: 30 – 45 minutes • Large group discussion, session evaluation and distribution of resource packets: 10 minutes Required resources: • 1 – 2 group facilitators who are not from the

same GME program as the participants. This is intended to encourage maximum participation from trainees who may not be comfortable sharing sensitive information with members of their program faculty present. • Conference room large enough for an individual GME program’s trainees. • Computer (for accessing video file) and television/projection screen. • Resource folders for distribution after the session evaluation. Ideally, these folders should contain specific contacts/resources in the immediate area. If not available at the local institution, more generalized resources can be substituted. • Given that the video has the potential to evoke strong emotions—especially for trainees experiencing depression/suicidality or with pertinent past experiences—someone with training in counseling should be present, e.g., as facilitator, or available. Preparation: Facilitators should be familiar with the Facilitator Guide prior to the video/discussion session. In an effort to encourage maximum participation, facilitators should carefully consider how they plan to establish group rapport and trust, as well as assure participants of privacy and confidentiality.

PROCESS USED TO DEVELOP THIS PROGRAM

In November 2015, an initial draft of the video was shared with leaders and participants at the first ACGME Physician Well-Being Symposium and feedback was solicited. In March 2016, a field test with 22 interns and residents from our pediatrics program was completed. Based on feedback and the initial field test, it was decided that face-to-face discussion among peers, followed by a larger group discussion, was the most effective first step toward the goals stated above. The video/discussion session consists of a seven-minute video, followed by 30 – 45 minutes of small group discussion (4-6 physicians), and concluding with a 10-minute larger group discussion. The video features the following personal narratives: 1. A resident’s reaction to her (then) intern colleague’s death by suicide; 2. A fellow’s personal struggle with depression and suicidal ideation; 3. A faculty physician’s reflection on the loss of his younger brother (a resident at the time) to death by suicide; 4. A clinical psychologist’s observations regarding the stigma surrounding behavioral health issues among physicians. Target Audience: Interns and residents (or fellows) from the same GME program.

CHALLENGES / BARRIERS

Some of the challenges faced by the video/discussion session included some training programs choosing not to participate because of a variety of perceptions of the utility of the subject matter. This included the belief on the part of some Program Directors that the subject matter was

addressed already in other venues or was already a part of trainees' skill sets. Other barriers included beliefs on the part of trainees that it was still too stigmatizing to discuss the issue of physician depression and suicide.

OUTCOMES / IMPACT

By March of 2017, 32 ACGME-accredited programs completed the video/discussion session and 292 evaluations submitted. The average responses to our primary session evaluation questions (those directly addressing our session objectives) were as follows: 1. "This session was an effective first step in promoting an open dialogue among physicians about depression and suicide within the profession": 4.5 out of 5 (i.e., "Strongly Agree") 2. "This session was an effective first step in confronting the stigma surrounding depression and help-seeking among physicians": 4.4 out of 5. 3. "This session was an effective first step in fostering an environment that encourages appropriate help-seeking for depression and suicidal ideation among physicians": 4.4 out of 5. 99.3% of participants indicated "Yes" to the following question: "Would you recommend this session to other physicians?" In response to an open-ended question at the end of the evaluation about what might improve the session, anecdotal comments suggest an overwhelmingly positive response: • "This is the right way to change the stigma. It's the first useful depression and suicide talk I've ever attended." • "Of all the sessions like this I've attended, this was the most sincere and not just checking the box." • "Helps validate that feelings of anxiety and depression are common among the medical community and may encourage others to get treatment." • "We are a high-risk group, and this will save lives." Several other helpful suggestions were made in this section of the evaluation, to include recommending discussion of the professional implications of a behavioral health visit, including family members in discussion groups, conducting sessions with hospital leadership, and providing more Q&A time at the end of the session.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

This video/discussion session appears to be the first of its kind in the GME community in featuring actual physicians (non-actors) discussing their thoughts and feelings on their own burnout, depression, and suicidality. We hope that it will serve as a valuable resource to institutions around the country as they confront these difficult issues. There are several additional opportunities and next steps currently being pursued to extend both the development of the tool, the populations for which it is most applicable, and its generalizability to other institutions and health care providers. Theoretically, all of them could use the same video with their own, specific facilitator guide: 1. Video/discussion session

exclusively for faculty physicians. Similar to trainees who may not be comfortable discussing these issues with faculty members present, there may be staff physicians who are uncomfortable discussing sensitive topics with their trainees in the audience; 2. Video/discussion session for medical students at a local university; and 3. Video/discussion session for faculty physicians and trainees together. Once the "culture of physician wellness" has been firmly established, we envision a session that includes faculty, interns, residents and fellows.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Using the video/discussion session with other organizations is currently part of the projected path of additional research. A local university has agreed to participate in bringing this educational opportunity to its medical students at its medical school.

LESSONS LEARNED

Based on our experience, the following suggestions for successful implementation are offered: • Facilitators need to be mentally prepared for a wide range of responses from the group—anything from awkward silence (especially at the beginning of the discussion) to personal anecdotes and emotive responses of all varieties. • The provided guided questions are a means to prompt open-ended conversation and should not be treated as ends in and of themselves. In other words, it is not mandatory to get to each of the guided questions. • The session will be most successful if participants are interacting with each other, with as little involvement from the facilitators as possible. This is not designed to be a "Q&A" session—it's intended to get trainees talking to one another.

WEBSITE / LINKS

Nagy C, Schwabe D, Jones W, et al. "Time to Talk About It: Physician Depression and Suicide" video/discussion session for interns, residents, and fellows. MedEdPORTAL Publications. 2016;12:10508.

SUPPORTING MATERIALS

time_to_talk_about_it_facilitator_guide_v2.docx
example_handout_behavioral_health_resources_new_oct_2016_v2.pdf
example_handout_gme_harbor_new_oct_2016_v2.pdf

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Janet Serwint, MD**KEY PARTICIPANTS**

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TARGETED ISSUE / PROBLEM IDENTIFIED

Burnout in trainees has gained attention because of its potential relationship to depression and negative impact on patients. Milestones have been utilized to measure the competency of residents in training.

INTERVENTION / PROGRAM DESCRIPTION

To compare the mean Milestone scores between pediatric residents who met criteria for burnout and those who did not by level of training.

TOOLS / STRATEGIES USED

n/a

PROCESS USED TO DEVELOP THIS PROGRAM

This work was completed as part of the Pediatric Burnout and Resilience Consortium (PBRSC), a consortium of 34 programs, with the support of APPD LEARN. PBRSC conducted a confidential online survey of its members' residents in April – June, 2016, which included the Maslach Burnout Inventory (MBI). In addition, programs submitted their assessment of residents' milestones. Burnout was defined as high range for either emotional exhaustion or depersonalization domains of the MBI. We examined the relationship between burnout and performance as assessed by milestones by domain of competence and stratified by post-graduate year

CHALLENGES / BARRIERS

n/a

OUTCOMES / IMPACT

1494 residents at 31 programs completed the MBI and had milestone data submitted. While residents who met criteria for burnout scored lower on all 21 Milestones compared with those without burnout, when PGY2 and PGY3 residents were examined the association between burnout status and milestone performance was not statistically significant. However, in the PGY1 cohort (n=507), those who screened positive for burnout had lower milestones in the following domains: patient care (2.97 vs 2.76, -0.21, p=0.001),

systems based practice (2.86 vs 2.68, -0.18, p=.004), problem based learning and improvement (2.93 vs. 2.74, -0.19, p=0.002), professionalism (3.24 vs. 3.07, -0.17, p=0.007), and interpersonal and communication skills (3.12 vs 2.93, -0.19, p=0.011) but not in medical knowledge.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Burnout status is most closely associated with decreased milestone for PGY1s in every domain of competence except medical knowledge. Future research needs to address whether strategies to mitigate burnout results in improved PGY1 performance.

GENERALIZABILITY TO OTHER ORGANIZATIONS

n/a

LESSONS LEARNED

n/a.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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KEY PARTICIPANTS

Healthcare team members within our institution.

TARGETED ISSUE / PROBLEM IDENTIFIED

We recognize that our hospital's mission would only be fully realized by supporting the wellbeing of those doing the important work of clinical care, education and research. This requires a psychologically safe and respectful work environment as well as support in managing acute and chronic stressors such as involvement in medical errors.

INTERVENTION / PROGRAM DESCRIPTION

Professionalism: Training in professionalism, conflict management and giving difficult feedback; accountability process for professional behavior to identify and remediate disrespectful behaviors that undermine the wellbeing of team members **Safety Culture:** Applying the principles of Just Culture in event analysis within and across healthcare teams supports both patient safety and clinician wellbeing with a balance of individual and systems accountability. **Peer Support:** Our unique program relies on trained clinician colleagues to support their peers when faced with significant emotional stress such as illness of a colleague, involvement in an adverse event, caring for trauma victims or facing potential litigation. **Disclosure Coaching:** A critical component of clinician support involves coaching physicians and teams as they prepare to speak with patients about adverse events.

TOOLS / STRATEGIES USED

In 2008 we established the Center for Professionalism and Peer Support (CPPS) to strengthen and support a culture of trust explicitly predicated on mutual respect for individuals, teams, the institution, and patients and their families.

PROCESS USED TO DEVELOP THIS PROGRAM

Detailed program descriptions can be found in two primary publications: Shapiro J, Whittemore AW, Tsen LC. Instituting a culture of professionalism: the establishment of a center for professionalism and peer support. *Jt Comm J Qual Patient Saf* 2014; 40(4):168-177. Shapiro J, Galowitz P. Peer support for clinicians: A programmatic approach. *Acad Med.* 2016 Sep;91(9):1200-4.

CHALLENGES / BARRIERS

One ongoing challenge is that of convincing leadership that there is a greater cost associated with failing to address

these institutional needs than the resource cost associated with our work.

OUTCOMES / IMPACT

Professionalism: We have addressed professionalism concerns relating to 376 physicians and 24 different healthcare teams; we have trained more than 3,100 BWH clinicians in interactive professionalism training workshops. Our outcomes, published in 2014 in the *Joint Commission Journal on Quality and Patient Safety*, show significant improvement in the behavior of a vast majority of those physicians about whom professionalism concerns were raised. The mandatory professionalism training sessions that are attended by all credentialed clinicians at our institution continue to be highly regarded. **Safety Culture:** We have developed a best practices framework for event analysis for our institution in collaboration with the BWH department of quality and safety. The framework is designed to bring consistency and standardization to venues where errors/near misses are reviewed. **Peer support:** We have trained 66 peer supporters and have provided 1:1 peer support to over 330 clinicians and group peer support to more than 460 healthcare team members. Dozens of institutions nationally and internationally have adopted our peer support model. **Disclosure Coaching:** We have provided disclosure coaching to over 40 clinicians and teams at our institution – supporting open and honest disclosure and apology to patients following medical error and helping clinicians navigate this challenging time in their practice.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We are currently studying the efficacy and impact of the peer support program. We continue to study and evaluate the outcomes of our professionalism program.

GENERALIZABILITY TO OTHER ORGANIZATIONS

We have shared best practices from our programs both nationally and internationally with dozens of healthcare organizations, many of whom have developed or are working to develop similar programs.

LESSONS LEARNED

We recognize the critical importance of demonstrating to our hospital leadership the return on investment that comes from attending to these institutional needs. We are working to establish reliable qualitative data from our interventions wherever possible.



WEBSITE / LINKS

www.brighamandwomens.org/cpps

SUPPORTING MATERIALS

[professionalism_jqps_april_2014.pdf](#)

[peer_support_for_clinicians_academ_med_2016.pdf](#)

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KEY PARTICIPANTS

Self; numerous personal contacts

TARGETED ISSUE / PROBLEM IDENTIFIED

Insufficient awareness of burnout; reluctance to take on the core issues of toxic work processes and culture

INTERVENTION / PROGRAM DESCRIPTION

Fostering awareness of the burnout epidemic and its underlying causes; promoting the need for fundamental changes in the clinical work processes and organization culture that cause burnout. (Mitigation programs to relieve burnout are not enough.)

TOOLS / STRATEGIES USED

Personal conversations, presentations, blog (in process) Conduct leadership development programs on leading organizational culture change. Coaching and mentoring for change leaders.

PROCESS USED TO DEVELOP THIS PROGRAM

N/A

CHALLENGES / BARRIERS

Unrealistic expectations on the part of many/most organizational leaders regarding what is required for culture change; also their lack of preparation for leading this work. Even while recognizing the importance/consequence of burnout, they have not yet grasped or embraced the level of commitment that is needed, particularly with regard to the time needed for staff development and the need for their own personal reflection and development.

OUTCOMES / IMPACT

With my work being just one drop in a huge wave, workforce wellness/burnout has gained broad visibility, and may soon replace improving patient experience as the most common driver of organizational change initiatives. Some organizations (including my clients) are beginning to integrate communication, relationship and culture activities and perspectives into traditional process improvement activities such as Lean. Seeing good progress for individual leaders who recognize that organizational change proceeds from the inside out; that the work of culture change begins with them.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Continue activities to raise awareness and promote/assist with demonstration projects

GENERALIZABILITY TO OTHER ORGANIZATIONS

N/A

LESSONS LEARNED

Keep at it; showcase the work of innovators to get the early adopters on board. Accreditation criteria for clinical and educational institutions can be a helpful source of leverage.

WEBSITE / LINKS

<http://lohweb.com/blog/>

SUPPORTING MATERIALS

preparing_to_lead_change_reprint.pdf

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TARGETED ISSUE / PROBLEM IDENTIFIED

Develop institution-specific recommendations to address burnout in trainees and to promote a wellness culture in our institution.

INTERVENTION / PROGRAM DESCRIPTION

Drexel/Hahnemann GME Wellness Program (DRAGON M.A.P.S = Maximizing Achievement Pathways to Success) Purpose: 1) create a framework for and develop an institution-specific wellness program 2) foster change at an individual program level 3) empower faculty and trainees to confront burnout 4) create a sustainable culture of wellness and resiliency. The program has three major components: Mental Health Counselling Service, Resident and Fellow Led Wellness Activities, and Interdisciplinary Faculty Mentorship.

TOOLS / STRATEGIES USED

1. GME/System Level: a. Maximize the use of current EAP [contact number, possible in-service session] b. Establish a Mental Health Counseling Service c. Include Program Wellness Plans in the Annual Program Evaluation (APE) d. Establish regular GME Wellness Grand Rounds e. Set up a Wellness Table at the Annual Orientation f. Explore fitness options g. Assess overall trainee wellness by survey h. Invite resident representatives to the GMEC i. Invite internal experts to teach residents and faculty patient safety and quality improvement j. Establish an anonymous method to allow residents to report safety or other concerns within

the hospital k. Create wellness website and facebook page 2. Interdisciplinary Mentorship Program – M.E.N.T.O.R. Encourage the culture of M.E.N.T.O.R - Motivate, Empower, Nurture (self-confidence), Teach (by example), Offer (wise counsel), Raise (the performance bar)(*British Journal of Medical Practitioners 2009: 2(3) 59-63). a. Develop a roster of faculty mentors and encourage interdisciplinary mentor and mentee relationships b. Invite both internal and external experts on mentoring to provide supervision 3. Program Level: a. Form Resident Wellness Committee and appoint a Wellness Chief Resident b. Include Wellness in the APE c. Develop wellness curricula d. Organize Annual Retreats for residents and faculty e. Build a Buddy System for residents to encourage peer support and communications f. Conduct confidential “Resident Process Groups” at least monthly. g. Develop a confidential mechanism at program level to identify and support struggling residents or fellows 4. Residents and Fellow Led Wellness Activities a. Host monthly social activities including holiday potlucks b. Organize mindfulness and meditation training c. Create team building exercises d. Promote a Buddy System – senior residents pair up with junior residents, especially at transitions e. Develop activities to improve professionalism f. Involve faculty members in social events/activities 5. Self-Care Tools (focusing digital toolkits) – placed on website a. MoodTools (an excellent and free APP to target depression). It includes Thought Diary, Safety Plan, Activities Log, Tests, and Information on depression. It also has links to many Guided Meditations and Soothing Sounds b. MoodGYM is a free online tool and a web-based cognitive behavioral therapy (wCBT) intervention that offers a digital and streamlined psychotherapy.

PROCESS USED TO DEVELOP THIS PROGRAM

Meeting with key stakeholders to perform a needs assessment; brainstorming with the group about local resources available to meet the needs of the institution, piloting and implementing projects to engage participants, literature search

CHALLENGES / BARRIERS

Our most significant obstacle has been funding. We have as yet been unable to implement the counselling service or fitness center membership because of insufficient resources. We have also had less than robust responses from faculty volunteering as mentors, and the reluctance of residents to identify mentors. Time and a lack of institutional culture around such activities have been barriers.

OUTCOMES / IMPACT

We have made significant progress. Wellness Grand Rounds for the institution are held four times per year, the website has had page views equal to or higher than the 12-month average monthly since August 2017, we have had a variety of resident wellness activities, including a resident-led mindfulness/meditation group and community volunteering projects (Out of the darkness AFSP walks, etc.)

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Continue to seek funding for mental health services; survey the residents yearly to assess progress, identify mentoring “champions” within each department.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Any program could implement many of these ideas with local resources. ACGME should organize a national webpage to identify and promote resources and specify an institutional GME Wellness officer with funding and time in each institution

LESSONS LEARNED

Starting small counts! Engaging residents as key stakeholders is a valuable part of the process.

WEBSITE / LINKS

<http://drexel.edu/medicine/academics/residencies-and-fellowships/resident-wellness/>

SUPPORTING MATERIALS

n/a

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Carol Bernstein, MD, Co-Chair of the ACGME Task Force on Physician Well-Being; Member, American Psychiatric Association Workgroup on Psychiatrist Wellbeing and Burnout

TARGETED ISSUE / PROBLEM IDENTIFIED

Wellbeing, Burnout and Depression in Psychiatrists

INTERVENTION / PROGRAM DESCRIPTION

The Workgroup on Psychiatrist Wellbeing and Burnout was charged by the President of American Psychiatric Association to assess member wellbeing, burnout, and depression and make recommendations to the organization regarding needs, interventions, programming and continued assessment.

TOOLS / STRATEGIES USED

1) Creation of an online assessment tool, providing immediate feedback to members and guiding them to relevant resources. The assessment data gathered will include demographic and practice characteristics of members and allow for study of predictors of burnout among psychiatrists. This will inform recommendations of the Workgroup. 2) Development of a series of slide decks for psychiatrists to allow them to serve as “Wellness Ambassadors” within their departments and across departments in their institutions. 3) Development of a position statement on “Best Practices for Employed Psychiatrists,” focused on wellbeing parameters.

PROCESS USED TO DEVELOP THIS PROGRAM

Participation by diverse group of APA members; inclusion of an Advisory Committee including additional experts in the field.

CHALLENGES / BARRIERS

1) Membership use of online assessment tool 2) Stigma about burnout and depression 3) Stakeholder buy-in

OUTCOMES / IMPACT

We hope to use psychiatrist-specific data to guide future programming. We expect the Wellness Ambassador slide

decks will promote psychiatrist participation in wellbeing and burnout discussions across specialties, and highlight psychiatrists’ expertise in distinguishing between burnout and psychiatric illness. We expect the “Best Practices for Employed Psychiatrists” to serve as a model job description with respect to enhancement of physician wellbeing and prevention of burnout.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Completion and implementation of online assessment tool, completion of Wellness Ambassador slide decks, completion of “Best Practices” statement.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Unclear at this point.

LESSONS LEARNED

In process.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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TARGETED ISSUE / PROBLEM IDENTIFIED

Silence and stigma around resident/physician suicide has prevented awareness and open discussion of this devastating tragedy.

INTERVENTION / PROGRAM DESCRIPTION

Emergency Medicine Collaboration to Break the Silence and Stigma around Resident/Physician Suicide

TOOLS / STRATEGIES USED

Liaisons were made between emergency medicine and suicide prevention organizations to modify existing suicide prevention programs/tools towards physician suicide awareness. Existing suicide prevention initiatives included: 1) Take 5 to Save Lives 2) # Be the 1.

PROCESS USED TO DEVELOP THIS PROGRAM

In February 2017, an invitation-only Emergency Medicine Wellness Summit was held to develop common wellness objectives. In response to a 2016 resident suicide, a joint physician suicide prevention media campaign was introduced at that meeting. One organization provided video editing and media design support distributing the final content to the participating organizations.

CHALLENGES / BARRIERS

Communication with each individual organizations' board was the biggest challenge. Currently there is no mechanism to disseminate a proposal to all national EM organizations at one time. Ultimately the first official point of contact occurred through the executive directors of each organization.

OUTCOMES / IMPACT

Seven national emergency medicine organizations joined in

a collaborative effort to create a five-flyer suicide prevention initiative targeted towards emergency medicine residents and physicians. Each organization consented to logo usage. Five organizations provided photographs of high level leaders for the media campaign. These seven emergency medicine organizations also partnered to support World Suicide Prevention Day. Each organization's name was included in a partnership list on a suicide prevention website. In addition, organizations sent out texts and emails to create awareness on that September 10. Two organizations (CORD and RSA) and two suicide prevention organizations (AFSP and the National Lifeline) jointly produced a PSA video to highlight the national suicide prevention lifeline as a potential crisis resources for residents.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

The next step is to create specific resources of program leadership in the event of a resident suicide at their institution or program. This toolkit will include a slide deck, a listing of articles, video links, podcasts and a role play as well as experienced contacts.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Any individual organization, hospital system or collaborative can join with the suicide prevention community during September, Suicide Prevention Month, to highlight and initiate conversation regarding suicide prevention.

LESSONS LEARNED

Suicide has touched many more people than we know. Essentially everyone who was asked wanted to participate and many had a personal story to share.

WEBSITE / LINKS

<https://www.youtube.com/watch?v=Ek-cos9gNKY>

SUPPORTING MATERIALS

acgme__collaborative_emergency_medicine.docx

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TARGETED ISSUE / PROBLEM IDENTIFIED

Storytelling can help physicians reflect on their practice, cultivate a sense of empathy, and develop a support network of trusted colleagues. Additionally, sharing experiences through storytelling can decrease emotional exhaustion, an important component of burnout. In addition, reflective practice is an important tool for improving clinical judgment and developing medical expertise. Despite these benefits of storytelling residents and physicians rarely get an opportunity to share their experiences with others in structured supported settings.

INTERVENTION / PROGRAM DESCRIPTION

Airway is a voluntary, two-hour, off-campus, "open microphone" storytelling event for residents and faculty to share their personal experiences of being a physician. Stories are brief, usually no more than five minutes in length. While a few stories are solicited and selected in advance, the majority of stories told during these events are spontaneously contributed by the participants. The event supports and encourages a humanity-based perspective of medical practice, encompassing the practitioner, patient, and society at large. In this regard, several components of clinical practice are strengthened, including empathy, reflection, and development of a greater sense of community.

TOOLS / STRATEGIES USED

To encourage informal collegiality while being mindful of sensitive nature of the content, a nearby venue such as a private room at a bar or restaurant typically have been chosen. Weekday nights have kept the cost to a minimum. An emcee from the group is chosen beforehand; this person needs to be able to handle the flow of preplanned as well as spontaneous stories. In addition, the emcee may have to respond to storytellers who chose to tell emotional stories.

PROCESS USED TO DEVELOP THIS PROGRAM

Airway, based on The Moth storytelling events, began in 2015 as a local event among Emergency Medicine residency programs in New York City. The events were held with a surprisingly minimal budget and few logistical details, which included simply arranging for a location, time, and date of

the event. Over the last year, Airway has expanded to other cities across the U.S., including Denver, Murfreesboro, TN, and Cleveland, and to national conferences such as the New York American College of Emergency Physicians (NY ACEP) Scientific Assembly, American Academy of Emergency Medicine (AAEM) Scientific Assembly, Essential of Emergency Medicine (EEM) and the FemInEM Idea Exchange (FIX). Airway is also hosting its first hospital-wide interdisciplinary event at Maimonides Medical Center in Brooklyn, which will include residents from across all specialties.

CHALLENGES / BARRIERS

The importance of HIPAA compliance is clearly emphasized at the beginning of each event, but adherence to the rules is ultimately the responsibility of the storyteller. Recording of live events have not been published to maintain confidentiality and allow for vulnerability of storytellers.

OUTCOMES / IMPACT

Story themes at each of our events range from emotionally devastating patient encounters to humorous pearls and pitfalls over a long career in medicine. Discussion among participants during and after the events often touch on issues of emotional exhaustion, depersonalization, compassion fatigue, medical errors, second victim syndrome, and other stressors. A post-event survey distributed after one of our local events revealed that 97% of responders (n=33) felt the event was worthwhile and they would be "extremely likely" (n=21) or "very likely" (n=11) to attend future sessions. Open-ended resident feedback included: 1) the positive nature of the open, honest, safe, and supportive environment for discussion; 2) the camaraderie and relationships developed between residents and faculty; and 3) that the discussion can help individuals process the complex emotions associated with difficult situations.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Future directions include capturing these shared experiences in the form of audio recordings or a podcast in order to reach an even wider audience who may not have access to a live event. We believe that the benefits of recognizing a shared experience can be derived from simply listening to a story. Additionally, we hope that this model can be used by other residency programs outside of Emergency Medicine to help address our universal challenge of resident burnout, stress, depression, and suicidality.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Given the overwhelming success of Airway and the minimal budget and logistics required, this wellness initiative could easily be replicated at other programs to promote reflective practice, empathy, and a sense of community.

LESSONS LEARNED

Storytelling is a powerful and alternative means to standard classroom didactics to directly combat resident stress, isolation, and shame. It can be done with minimal resources and tailored to both small or large groups of residents, fellows, and faculty. Perhaps the most important thing we learned was how a simple idea, such as storytelling, has the power to transform shame and fear into a celebration of shared community and meaning in practice.

WEBSITE / LINKS

<https://airwaystories.org/>

SUPPORTING MATERIALS

n/a

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TARGETED ISSUE / PROBLEM IDENTIFIED

Physician well-being is a complex challenge requiring a multi-faceted approach to address individual and organizational influences. Physician engagement and shared decision-making promote well-being. We hypothesized that this program would generate new organizational approaches to enhance well-being, and would improve perceived self-efficacy and empowerment for participating residents.

INTERVENTION / PROGRAM DESCRIPTION

Design thinking uses a human-centered approach to develop creative solutions for complex problems. We developed a longitudinal program to engage internal medicine residents in creating well-being interventions using a design thinking framework.

TOOLS / STRATEGIES USED

The curriculum engaged a resident team in design thinking strategies to generate organizational well-being interventions. Participants completed pre- and post- survey with the Psychological Empowerment in the Workplace Scale and Creative Self-efficacy Scale, in addition to completing an exit interview exploring themes of self-efficacy, perceived impact, and personal and organizational well-being.

PROCESS USED TO DEVELOP THIS PROGRAM

For eight months, eighteen resident participants attended a two-hour facilitated design session every other month, with independent work between sessions. This resident design team participants worked to develop well-being interventions for the entire residency (180 residents). In Session 1, participants learned design thinking principles and practiced interviewing to identify well-being themes, then conducted interviews with non-participating residents or residents' family/friends. In Session 2, participants worked in teams to identify salient interview themes, including isolation and self-doubt, value of peer/program support for difficulties, and scheduling/time constraints. Teams used these themes to identify a challenge, applied ideation brainstorming techniques to generate potential solutions, and selected an idea to test. Each team implemented an experiment between sessions, and used feedback to repeat the design cycle and refine their projects in Session 3. In the final session, teams

summarized results and generated recommendations to program leadership.

CHALLENGES / BARRIERS

Due to constraints within the residency schedule, sessions were held in the evening. The primary challenge that residents identified was lack of time to devote to projects outside of the design sessions.

OUTCOMES / IMPACT

A majority of participants had little/no familiarity with design thinking and had never developed well-being interventions. All teams chose to develop projects to enhance community and support. Iterative testing of four innovations over two design cycles elucidated several design principles, including 1) harnessing senior residents' experience 2) building smaller structured communities within the program 3) enhancing team camaraderie and fun through everyday work and friendly competition 4) implementing well-being interventions at the right time and place. These design principles formed the basis for developing a new residency support structure incorporating formal communities and near-peer coaching. Significant increases in the impact domain of psychological empowerment and in creative self-efficacy were observed among participants. Qualitative analysis was notable for changes to participants' views about well-being, positive effects on their views of residency program leadership, and the value of the process to promote "outside-the-box" thinking for difficult problems.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We have scaled and implemented one of the successful prototypes (a near-peer support system), and plan to use this structure to pilot additional interventions based on design principles that emerged from this process. Future study is needed to determine if interventions created as a result of this process enhance well-being residents outside of the design team.

GENERALIZABILITY TO OTHER ORGANIZATIONS

This strategy can be useful for other programs seeking to develop organizational well-being initiatives to address specific needs within their microsystems and to engage residents in creative solution generation.

LESSONS LEARNED

Design thinking techniques can help residency programs develop impactful, learner-driven initiatives to address

organizational well-being challenges. Design principles emerging from this process highlight residents' desire to determine their own needs, enhance community, and provide peer support to improve well-being. These results suggest that design thinking's emphasis on human-centeredness may be especially suited to develop well-being interventions that enhance organizational culture and engagement.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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TARGETED ISSUE / PROBLEM IDENTIFIED

Existing well-being approaches/evaluations had not been standardized across residency programs. The purpose of the presented project was to collect standard data from six residency programs on well-being constructs in order to develop, document, and improve the evaluation of well-being. Data may be used to help direct future resident well-being strategies and initiatives.

INTERVENTION / PROGRAM DESCRIPTION

Well-being survey electronically administered to residents tri-annually starting in June 2017.

TOOLS / STRATEGIES USED

The well-being survey instrument contained four standard tools (i.e., CAGE, Epworth Sleepiness Scale, Maslach Burnout Inventory, and Zung Self-Rating Depression Scale) along with institutionally designed questions. Survey responses were reported by program year with residents in their third year or greater collapsed into a single group.

PROCESS USED TO DEVELOP THIS PROGRAM

A project team was assembled and a literature review on well-being metrics conducted. An initial well-being instrument was developed and pilot tested on a sample of graduating residents serving on the resident quality council.

CHALLENGES / BARRIERS

It is difficult to make the survey instrument voluntary while still achieving a high and representative response rate. Data is self-reported and may be limited due to variability of resident characteristics and intangibles.

OUTCOMES / IMPACT

At the initial time point, 101 (77%) residents completed components of the survey instrument, with 61 (46%) residents completing all survey items. Across PGY groups, approximately a fifth of residents had a high score on sections of the Maslach Burnout Inventory (i.e., Emotional Exhaustion, Personal Accomplishment, and Depersonalization). On the Zung Self-Rating instrument, at least one responding resident within each PGY group

had a score suggestive of clinical depression. A fourth of the respondents had a score reflective of a need for an intervention via the Epworth Sleepiness instrument. At least one responding resident within each PGY group had a score associated with a possible need for an intervention via CAGE instrument. Of residents scoring high on any of the above survey sections, 44% scored high on more than one of the sections.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

Continued data collection is planned along with steps towards potentially using data in the selection and evaluation of residency level activities and during focus groups. Data will also serve as well as a fail-safe mechanism for possible direct resident intervention.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The presented processes are feasible for use in other residencies. Results can serve as comparator values for other programs, historic references, or transported to other populations.

LESSONS LEARNED

Initial resident well-being data were higher, more telling of possible concerns, than a priori assumed by project team members. More information needs to be collected to track consistency and trends related to these preliminary data across time. Additional strategies need to be implemented to increase response rates.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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TARGETED ISSUE / PROBLEM IDENTIFIED

This new focus area recognizes the important role of CLEs in designing and implementing systems that monitor and support the well-being of residents, fellows, faculty members, and other members of the clinical care team.

INTERVENTION / PROGRAM DESCRIPTION

In 2015, the ACGME Clinical Learning Environment Review (CLER) Program began a journey of incorporating a new focus area on Well-being into Protocol 3.0 of the CLER site visit process with the goal of providing individual CLEs with formative feedback in this area and the country with aggregate, de-identified data that may be used to affect positive change. This new area focuses on selected topics of fatigue, burnout, work/life balance, and support of those at risk of or demonstrating self-harm.

TOOLS / STRATEGIES USED

CLER Pathways to Excellence Document: expectations for an optimal clinical learning environment to achieve safe and high quality patient care (Version 1.1) is a tool to promote discussions and actions. The CLER Pathways are designed as expectations rather than requirements. It is anticipated that by setting these expectations, clinical sites that provide education will strive to meet or exceed them in their efforts to provide the best care to patients and produce the highest quality physician workforce.

PROCESS USED TO DEVELOP THIS PROGRAM

Upon achieving approval from the ACGME Board of Directors to develop this new focus area, the CLER Evaluation Committee with support from the CLER program staff developed a series of pathways and properties for inclusion in the CLER Pathways to Excellence Document Version 1.1. The Committee went through an iterative process of consensus building informed by interviews with key stakeholders, and the experience of over 500 site visits under Protocols 1 and 2. Version 1.1 of the Pathways document was publically released in May of 2017. This document formed the basis upon which Protocol 3.0 was developed. Through an iterative process of consensus building, CLER program staff developed questions for use

in group discussions and walking rounds as part of Protocol 3.0 of the CLER site visit process. Protocol 3.0 was piloted in June-August of 2017, and launched in September 2017.

CHALLENGES / BARRIERS

The CLER program is assessing efforts in well-being from the system level. Many sites, might not as yet, have a systematic approach to addressing these issues that is strategic, comprehensive, and includes the steps of ongoing monitoring and evaluation.

OUTCOMES / IMPACT

CLER Protocol 3.0 launched in September 2017 and will likely conclude late in 2019. During that time, the program will conduct site visits to participating sites of over 700 Sponsoring Institutions. Each of these visits includes discussions with executive leadership, patient safety and quality leadership, groups of residents and fellows, faculty members and program directors. New in Protocol 3.0, the protocol includes discussions with individuals leading efforts in well-being identified by the CLE's executive leadership.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

At the conclusion of Protocol 3.0, results will be aggregated, de-identified, and publically shared through a CLER National Report of Findings. This report will serve as baseline data for the focus area of Well-being. Future protocols will continue to explore this area on return CLER visits and subsequent reports will provide the opportunity for comparative data and trending.

GENERALIZABILITY TO OTHER ORGANIZATIONS

The data from the CLER program focuses on systems-level approaches to Well-being. While ACGME's focus is on the physician, the CLE is a space shared by many members of the clinical care team. These other perspectives may find the CLER data to be useful as well.

LESSONS LEARNED

Formative feedback provides a safe space to stimulate new conversations and actions to improve well-being.

WEBSITE / LINKS

http://www.acgme.org/Portals/0/PDFs/CLER/CLER_Pathways_V1.1_Digital_Final.pdf



SUPPORTING MATERIALS

n/a

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TARGETED ISSUE / PROBLEM IDENTIFIED

Physician burnout is a challenge among all physicians and specialties, and we recognize that residency in particular is a vulnerable time for doctors-in-training. The new responsibility of independently caring for patients is challenging, all while working long hours and long work-weeks. Working at a Federally Qualified Health Center with our underserved primarily Latino immigrant community and practicing medicine primarily in Spanish – while rewarding – can be an added challenge. The needs of our patients are great, and we strive to provide the best health care possible, but our resources are often limited. While our curriculum has been created for years to include wellness in our schedules each week, our residency committee has expanded on those curricular elements with resident-led resiliency and wellness activities. Further, our committee has recognized that residents' access to mental health is somewhat limited. Given our program is a stand-alone residency program at a community health center associated with a community hospital, there are challenges in providing accessible and confidential mental health resources to residents. Unlike some large academic hospitals with hundreds or thousands of residents, we have only forty. It would be financially challenging to support an independent mental health provider and it would be difficult to maintain privacy of the use of services given the small program.

INTERVENTION / PROGRAM DESCRIPTION

Our community-based Family Medicine residency has had various curricular elements dedicated to resident wellness. A significant component of this curriculum uses our noon conference time each Friday to address resiliency and burnout. Traditionally, these sessions have been facilitated by our behavioral health faculty and time is dedicated to weekly support group for interns and to Balint groups for senior residents, focused on reviewing challenging cases and considering the often complicated doctor-patient relationship. Since 2015, our residency has had a resident-led wellness committee. The committee now adds to the wellness Fridays by leading one Friday wellness session per month. The sessions have been varied, ranging from narrative medicine, to gratitude activities, to resident-led yoga, to outdoor walks. Since the ACGME symposium on

physician well-being, our wellness committee's focus has expanded further. We have worked to further expand and identify mental health resources for residents and toward making residents feel more comfortable knowing how to reach out for support.

TOOLS / STRATEGIES USED

n/a

PROCESS USED TO DEVELOP THIS PROGRAM

Our wellness committee has met on a near monthly basis to brainstorm how to improve resident wellbeing through new resident-led curriculum. We have designed Balint sessions so that a resident signs up to present a case each session to encourage increased attendance during the busy work day. For the resident-led Fridays, we have leveraged individual skills and training of residents to guide the activities (ie. two residents are yoga instructors, one resident has focused on integrative medicine and leads mindfulness sessions, and another resident has done lots of advocacy and has led a narrative medicine session).

CHALLENGES / BARRIERS

A challenge has been balancing expected demands of residency with dedicated time devoted to wellness. At times we've found it difficult to help support residents in allowing enough time and space to engage in the wellness activities during the lunch hour when they may be simultaneously managing a busy inpatient service. We also have realized residents may feel hesitant to reach out for assistance connecting with mental health resources because of privacy concerns. We have focused on normalizing mental health needs of residents to encourage people to seek help, and also made resources more transparent so residents can more easily reach out on their own.

OUTCOMES / IMPACT

Although we do not have objective measures of the impact of our committee over this last year, we anecdotally feel that the resident-led wellness sessions are valued. Given the diversity of activities, we feel we can provide various strategies and examples of personal wellness activities that people can explore. As for the mental health services, our committee and program identified several useful mental health resources for residents, including local providers who have experience working with physicians, our own employee assistance program, and our state's physician health services. We have had residency-wide discussions

to increase transparency about how to access the various providers. Our scheduling team has also coordinated scheduling adjustments whenever necessary for residents to attend any needed appointments or therapy sessions.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

In the future, we plan to continue to build on our progress of the wellness committee. We plan to continue our resident-led monthly sessions and to create a formal yet flexible year-long curriculum. Our residency will continue to develop relationships with mental health resources to foster connections with residents as needed. We also hope to be able to find a way to evaluate our residency's burnout so we can work to evaluate our interventions in the future.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Our work with our resident-led committee could be generalized to many residency programs, and to community based programs in particular with regards to access to mental health resources.

LESSONS LEARNED

Throughout this past year, we have learned some of the challenges of making changes to a busy system, and yet have been encouraged by the positive response of the residency as a whole to working toward physician wellbeing.

WEBSITE / LINKS

<https://glfhc.org/residency/>

SUPPORTING MATERIALS

n/a

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Edwin Zalneraitis, MD

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KEY PARTICIPANTS

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TARGETED ISSUE / PROBLEM IDENTIFIED

Residents and faculty have been devoting excessive time to documentation in the electronic medical record (EMR), taking away from time with the patients and family professionally, and from their personal time for self-care and renewal. Completion of timely discharge summaries was a major contributor to this issue, and faculty were frequently cited as delinquent in completing summaries, a resident task they supervised. This often resulted in discord between faculty and residents. In addition, ambulatory care providers and families were frustrated when the summaries were not available at time of follow up visits.

INTERVENTION / PROGRAM DESCRIPTION

Making Time for Meaning The Pediatric Chief Resident, working with a senior resident and faculty, convened an interdisciplinary collaboration at Connecticut Children's Medical Center, to develop and implement a revised and real-time discharge summary. This was complemented by resident and faculty training in voice recognition software.

TOOLS / STRATEGIES USED

Requirements for the content of the summaries were established for billing, risk management, regulatory compliance and legal considerations. Desired information and format for optimal continuity of care were identified. Working with the IT Senior Analyst, the consensus format was established in the Epic EMR, with a goal of maximizing the information extracted automatically from the already recorded information. Each iteration was tested, reviewed and revised. Residents and faculty were trained in the completion of the revised, real time summary using Dragon Voice Activated Software, to complete the summaries. This voice activated software was also used for documentation elsewhere. Time for completion was tracked in Epic, and the record of completion compliance was tracked through the Health Information Service. Resident and faculty feedback was elicited in focus groups.

PROCESS USED TO DEVELOP THIS PROGRAM

A working group of a Chief Resident, senior resident, Associate Chair of Pediatrics & Head of Clinical Care Innovation, the Program Director, a Senior Analyst from

Information Technology (IT), Hospital Legal Counsel and representatives from community pediatricians, medical and surgical faculty, billing and coding, risk management and regulatory compliance; all met every other week for 6 months to develop and plan implementation of a revised real-time discharge summary in the Epic EMR. Frequent consultation with the Family Advisory Board was obtained to provide the patient and family perspective. An iterative process for rebuilding the discharge summary in the Epic EMR, followed by a pilot trial, were used leading up to full implementation. Time required for summary completion, completion of the summary in real time at discharge, delinquent summaries, availability of the summary at follow up were tracked. Resident and faculty focus groups provided feedback on the revised summary process.

CHALLENGES / BARRIERS

The biggest challenge was identifying and gaining commitment to the process by the key stakeholders, to meet for a sustained period of time on a regular basis. The ability to build the desired changes into the EMR and institution of, and training for the voice activated software required senior administrative support. Elimination of misinformation about what was essential for the summaries was a challenge initially, but collaboration and research of requirements allowed for rapid resolution. Dissemination and acceptance were not insignificant, but the quality and success of the product quickly overcame these barriers. Testing and piloting to eliminate problems before dissemination was important.

OUTCOMES / IMPACT

The discharge summary was approved for use, counted as the last progress note, suitable for billing. The discharge summary only required the addition of a short overview and final physical exam, and these were easily provided with the voice activated recitation in a short length of time. The time for creating the summary and final progress note combined was reduced from an average of almost 20 minutes to under 5 minutes. The number of delinquent summaries was reduced dramatically to just 3 in this past year since implementation of the revised summary, and none of these 3 involved residents. Resident, faculty and outpatient care providers reported universal satisfaction with the revised summary, starting immediately with full implementation. Residents and faculty reported the new summary provides additional professional and personal time. There were no family complaints.

FUTURE DIRECTIONS / PLAN / VISION / NEXT STEPS

We plan to continue optimizing the use of our EMR to reduce time required for high quality and timely documentation. As part of our Back to Bedside effort, our next step is to link the electronic handoff information to the daily progress note, to avoid duplication of information entry, and to make the progress notes less repetitive, more focused and more relevant. The next project after the above will be to make medication reconciliation more efficient and effective. The residents have created a “Back to Bedside bundle” of changes aimed at increasing collaboration with nursing and enhancing patient and family interactions, thereby increasing meaning in their work as physicians. This bundle is actively being pursued.

GENERALIZABILITY TO OTHER ORGANIZATIONS

Efficient and effective documentation of care is a ubiquitous goal in the clinical learning environment. With administrative support and commitment by the key stakeholders, the process used here has a high probability of success in other organizations.

LESSONS LEARNED

The targeted issue(s) need(s) to be something about which the institution and key stakeholders feel strongly, so all will commit the resources and prioritize the time needed to get the tasks done. Misconceptions and false barriers need to be clarified and resolved early in the process, and shared vision of the outcome realized. Getting right before getting it out is very important. Don't let a flawed product to be interpreted as a bad idea. Keep all informed of the progress of the project, and ask for input often and from those who are going to be asked to use what you are planning. Respond to input, so others know they are heard.

WEBSITE / LINKS

n/a

SUPPORTING MATERIALS

n/a

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APPENDIX