The following poster presentations are from the 2019 American Conference on Physician Health. Presentations included were at the discretion of the author.
A Consultative Approach to Enhancing the Wellness of Department-Based Teams

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Learning Objectives
1. Understand the key systemic drivers of wellness and engagement in department-based teams.
2. Understand how A3 problem solving can be used to develop a consultative wellness initiative.
3. Apply a consultative approach to address department-specific wellness needs of physicians and staff.

Objective/Background:
Burnout is a critical issue affecting the health care industry nationwide, and its impact is not limited to physicians alone. This systemic problem can affect any member of a health care team, with potentially adverse effects on patient care. Health care organizations often respond with personal wellness programming aimed at supporting the individual. While these well-intentioned efforts can have benefits, they do not always address the needs of department-based teams. With this in mind, we developed a consultative wellness initiative and piloted it in the Gastroenterology (GI) department. The leadership of this department was engaged early on to ensure an understanding of specific needs and alignment on expected outcomes. We developed a 16-item wellness survey that measured how individuals experienced key drivers of wellness and engagement in the workplace and deployed the survey to GI after these introductory meetings. A total of 16 physicians and 14 employees responded to the survey. Based on survey results, we codesigned action plans that targeted specific barriers to wellness at work. A follow-up survey will be administered after the implementation of these interventions.

Methods
Using an A3 problem-solving process, we developed a consultative wellness initiative and piloted it in the Gastroenterology (GI) department. The leadership of this department was engaged early on to ensure an understanding of specific needs and alignment on expected outcomes. We developed a 16-item wellness survey that measured how individuals experienced key drivers of wellness and engagement in the workplace and deployed the survey to GI after these introductory meetings. A total of 16 physicians and 14 employees responded to the survey. Based on survey results, we codesigned action plans that targeted specific barriers to wellness at work. A follow-up survey will be administered after the implementation of these interventions.

Results
The survey results showed that physicians and staff were most concerned about the following:
• Increasing collegiality and teamwork
• Having manageable workloads
• Ensuring psychological safety

The lowest scores for many items were seen among mid-career physicians. A disparity among leadership and non-leadership roles was also demonstrated, with those in non-leadership roles scoring lower on items addressing psychological safety, recognition and professional development.

Conclusions
Through a consultative wellness approach, we actively engaged teams of physicians and staff in identifying department-specific wellness needs and codesigning programs intended to bridge the gap between their current state and one of improved health and well-being.
A Longitudinal Assessment of Moral Distress and Burnout during Pediatric Residency

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Background
- Residency is a highly stressful period when residents work long hours and have enormous responsibilities (Geurts. Soc Sci Med. 1999).
- Assessment and amelioration of moral distress and burnout may be important elements in improving physician wellness and patient safety.

It is not known how moral distress and burnout evolve during the course of residency, and whether specific residency rotations are associated with more distress.

Goals and Objectives
- Identify the frequency of moral distress and burnout in pediatric residents.
- Describe the effect of demographics and stage of training on levels of moral distress and burnout.
- Explain the connection between certain clinical rotations and levels of moral distress and burnout.

Methods
- We distributed electronic versions of the Moral Distress Scale-Revised (MDS-R; Hamric 2012) every 4 months, and the Maslach Burnout Inventory annually, to all residents within the pediatric post-graduate program at the University of British Columbia from July 2016 to October 2018. We also collected demographics.
- Residents were asked to base their responses on experiences during rotations in the four months preceding the questionnaire. Names of these rotations were obtained. A single moral distress score for each of these four rotations was also derived.
- No personal identifiers were collected; unique codes were used to link individual responses over time.
- We used longitudinal mixed effect modeling (Singer & Willet, 2003) to examine longitudinal trajectories of change in moral distress and burnout over time.

Main Findings

Demographics:
- N=88/101 potential respondents: 52 female, 20 male, 14 did not disclose.
- Mean age (SD) 31 years (SD=3.5; range 28 to 43).

Moral distress:
- Average moral distress score was relatively low (M=20, SD=24; maximum possible 336).
- 10% of pediatric respondents stated that they had considered quitting residency in the past due to moral distress, but did not leave, 2% stated that they were currently considering quitting their position.

Residency cohort analysis:
- Moral distress did not differ as a function of residency cohort over time, but the fall 2015 cohort had a trend toward higher moral distress over time (Figure 1).
- Propensity to consider leaving a position due to moral distress differed among residency cohorts over time; in the fall 2015 cohort, that propensity was higher during the winter of R2 compared to the winter of R3 and onwards (p=0.02; Figure 2).

Gender analysis:
- Moral distress did appear to differ as a function of gender (Figure 3).
- Female residents were more likely to consider leaving a position in Feb 2017, relative to Feb 2018 and Oct 2018 (p=0.05; Figure 4).

Burnout analysis:
- 7% of respondents met criteria for burnout (experiencing symptoms of burnout weekly or more).
- Residency cohort analysis:
  - Percent burned out did not differ as a function of residency cohort over time (Figure 5).
  - Burnout scores increased in the fall 2016 cohort between R1 and R2 (p<0.02; the finding was explained by a decrease in personal accomplishment in the same cohort over the same time period (p=0.004).
  - No change in emotional exhaustion or depersonalization as a function of residency cohort.

Gender analysis:
- Female residents had a trend toward being more likely to be classified as burned out (7%) relative to men (5%), but this was not statistically significant (p=0.14; Figure 6).
- Female residents reported higher burnout scores, on average, relative to male residents (p=0.04; this appeared to be driven by higher emotional exhaustion, on average, in females compared to males (p=0.03).
- Male residents had a decrease in personal accomplishment from the 2017 to 2018 assessment (p=0.01).

Moral distress did not differ as a function of gender (Figure 3).

Rotation analysis:
- Higher levels of moral distress were reported after rotating through international electives and PICU rotations, when compared to emergency, community pediatrics, neonatal float, endocrinology, nephrology, and nephrology (p<0.04 and p<0.05, respectively; Figure 7).
- Lower levels of moral distress were noted after rotating through community pediatrics, when compared to CTU, NICU, neurology, surgery, PICU, and international electives (p<0.05; Figure 7).

Results

Figure 1: Trajectory of Moral Distress by Residency Cohort

Figure 2: Percent Reporting they had Considered Leaving a Position in the Past Due to Moral Distress By Gender

Figure 3: Moral Distress Scores by Gender Over Time

Figure 4: Percent Reporting they had Considered Leaving a Position in the Past Due to Moral Distress By Gender

Figure 5: Percent Burned Out (experience burnout symptoms weekly or more) by Residency Cohort

Figure 6: Percent Burned Out (experience burnout symptoms weekly or more) by Gender

Figure 7: Rotation-Specific Moral Distress (Mean Estimates)

Strengths
- First Canadian study on serial measures of moral distress and burnout in residents, as well as looking at the effects of certain rotations.

Limitations
- Limited to one academic institution.
- Small sample sizes.
- Variable participation in the survey over time.

Conclusions
- Moral distress is low in pediatric residents, but the distress that is present contributes to potential attrition.
- Female residents had higher burnout scores than male residents, due to emotional exhaustion.
- High-acuity rotations may predispose residents to increased levels of moral distress.
- Actions to prevent and mitigate moral distress and burnout should be focused based on these findings.

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Addiction and Personality among Physicians: The Impact of an Integrated Treatment Program on the NEO
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Results

Significant changes:
Neuroticism significantly decreased over the course of the program (t = 6.840, p < 0.001) and openness significantly increased ( t = 5.892, p < 0.0055).

Predictive variables, univariate:
The following personality variables were from the beginning of the program.
Continuing care
Poly drug use

In logistic regression:
A logistic regression model was constructed and the decision to attend continuing care was a significant negative predictor of relapse. The predictive utility of the model was increased by having personality variables present as judged by pseudo R squared (0.616).

Discussion

Points of discussion:
• Overall changes seen, fitting with prior literature
• Changes and how they affect chance to relapse
• Importance of continuing care
• Effect of profession and monitoring on adherence rates
• Overall utility of adding personality variables in analysis

These results also provide needed reinforcement to patients, emphasizing that rather than a fixed personality that they are "stuck with" so to speak, that instead engagement with a committed treatment team can lead to at least temporary changes in the personality and consequent reductions in overall relapse rates.

Limitations:
• Single center study
• Not all patients had a known outcome; only patients with known relapse were included in final data analysis, similarly some were not able to take the second personality test due to relapse during the program
• Testing effect of personality tests
• Multiple hypothesis testing

Conclusions

These data show that the NEO personality inventory continues to be a useful assessment tool in the addiction setting. With a mixed modality approach, it is possible to modify these personality features and an initially high neuroticism for instance does not necessarily mean poor outcomes in treatment. With a personality test at the beginning and the conclusion of treatment, one can identify higher risk patients and focus the appropriate resources on them.

Contact
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References

3. Orford, J. "Addiction is a major neglected contributor to the global burden of adult ill health." Social Medicine 78.6 (2013): 70-77.
Anonymous vs. Confidential Burnout Surveys
A Novel Approach to Measuring and Addressing Burnout

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Intro
Burnout is defined as emotional exhaustion, depersonalization and reduced personal accomplishment, and has negative consequences for providers and the healthcare system, including depression, physician turnover and decreased patient satisfaction. Most burnout surveys are anonymous, which limits local leadership’s ability to reach out to struggling providers. We examined whether providers would respond confidentially with their identity known by a wellness officer within the department.

Methods
- Large academic department, 109 providers at multiple sites
- Maslach Burnout Inventory distributed within department
- Respondents chose to be anonymous or confidential with results going only to the wellness officer.
- “Burnout” = Top tertile scores in either emotional exhaustion or depersonalization

Results
67 responses out of 109 providers (response rate = 61%)
- Confidential (Conf): 21 responses, 31%
- Anonymous (Anon): 46 responses, 69%
- Anon respondents opted to share minimal demographics

Overall Burnout = 31 (46%); Conf = 48% Anon = 43%, p=0.71

Conclusions
- Confidential, non-anonymous surveys are feasible in large academic departments.
- There were more confidential respondents than anticipated.
- Potential influences include an existing culture of trust, a sense of job security and the use of an intradepartmental wellness officer as an honest broker.

Next Steps
- Address burnout with individualized and systematic interventions
- 1:1 interviews with very high risk individuals
- Unit-based working groups to mitigate stressors
- Institution level advocacy
- Explore why providers chose anonymity or confidentiality

The majority of providers chose to respond non-anonymously to this burnout survey.

There was no difference in burnout levels between anonymous and non-anonymous respondents.
Bringing Joy Back into Primary Care

Relation to conference theme:
The “Primary Care Best Job” initiative was put forth by our medical group to decrease administrative burden and bring joy back into practicing medicine.

Project objective/background:
The Stanford WellMD Model identifies three key domains contributing to professional fulfillment, including efficiency of practice. Administrative burden is a leading cause of work-related stress for physicians. Primary care providers, especially, spend much of their day doing data entry, medication refills, form completion, virtual care (phone visits/e-visits) and in-basket management. Increased regulatory burden and widespread use of EMR systems, have changed the practice of medicine; yet, the anatomy of the day has remained the same. This initiative demonstrates how an integrated medical group redesigned primary care to make it the “Best Job”.

Learning objectives:
- Redefining Care Access: Introduce innovations to manage face-to-face and virtual care needs
- Describe ways to leverage non-physician resources to manage workload
- Learn how information was gathered and practice efficiencies developed

Methods/approach:
- Leadership Gemba (“go and see”) walks to gather information from the front-line
- Primary care dyad meetings during which physician and nursing leadership share ideas and best practices
- Development of Practice Efficiencies:
  - Patient care access needs
  - Call center optimization
  - Template flexibility with virtual care access
  - Robust same-day care staffing model to enhance access for acute care
  - Leveraging non-physician resources
  - Refine RN role
  - Standardize RN on-boarding and professional development
  - Further develop and standardize PA model in same-day care
  - Optimize and standardize workstreams
  - “Make It Simple Team” (MIST)
  - Opioid Steering Committee
  - EMR optimization
  - Form completion process
  - Shared resources
  - Fuel gauge for clinic staffing and sharing of provider/nursing resources
  - Remote in-basket program—virtual provider vacation coverage

Results:
On our annual Quality of Work Life Survey, one question pertains to whether providers feel their “workload is reasonable”. We see increases — starting at 54% in 2010, up to 69% in 2014, and 79% in 2017. In an era of rising administrative burden, it’s encouraging to see an upward trend for perceived reasonability of workload. We feel “Primary Care Best Job” initiatives have helped our organization reduce workload stress.

Conclusion:
The Stanford WellMD Model describes efficiency of practice as playing a key role in clinician health and professional fulfillment. We hope our “Primary Care Best Job” initiative continues to reduce workload stress and increase joy in the practice of medicine.
We believe that creating a culture of wellness in the workplace is foundational to the promotion of physician well-being, professional fulfillment, and organizational success.

**Individual Initiatives:**
- **Career Pathways:** Identification of career development opportunities designed to cultivate providers’ talents and passions.
- **Physicians Helping Physicians Program:** Developed to assimilate new hires into the workplace and culture.
- **Connection:** Semi-annual clinic visits by leadership, annual visits by the Board of Directors, and Clinic Chief roundings to increase transparency and exchange information which helps providers thrive at work.
- **Communication Skills Workshops:** Developed to optimize provider communication skills.
- **Primary Care Best Job:** 21 initiatives to increase efficiency, decrease administrative tasks, and reduce workload.
- **SELF CARE Incentive:** Bonus for completing personal SELF CARE goals. (Sleep, Exercise, Love & Laughter, Food, Compassion, Awe, Resilience, Engagement) — Model to optimize individual health.

**System-wide Initiatives:**
- **Medical Group provides an environment that supports health and wellness:**
  - 2016: 89%
  - 2017: 95%
  - 2018: 97%
  - Increase: +8%
- **Satisfied with the way I am taking care of my own health:**
  - 2016: 77%
  - 2017: 81%
  - 2018: 87%
  - Increase: +10%

**Conclusion:**
Cultivating a Culture of Wellness in our medical group is intentional, valued, and substantiated by the results of our annual QWL Survey. Health and wellness, a living part of our vision/mission, demonstrates that caring for the caregiver is imperative. As we care for ourselves, we strengthen foundations of joy and meaning in our work.
Encountering Negative Experiences due to Gender:
A Component of Burnout in Women Providers

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Abstract

Introduction
- Hennepin Healthcare’s Office of Professional Worklife (OPW) annually measures burnout across 700 providers (physicians and advanced practice providers).
- Interest in gender disparities and discrimination led the OPW to consider negative experiences due to gender as a potential contributor to burnout (1,2).
- The objective of this project was to assess frequency of negative experiences and whether they correlate with burnout and its predictors.

Methods
- Ten-item annual wellness survey, the Mini Z, is derived from validated measures and quantifies satisfaction, burnout, and workplace contributors including work control, chaotic workplaces, electronic medical record system, and values alignment (3,4).
- New gender-related item requests frequency of negative experiences due to gender, providing multiple examples for reference. It is a 5-point Likert scale item based on Pew Research’s 2017 STEM Survey (5).
- Logistic regression was used to assess relationships between negative experiences and burnout, teamwork, and values alignment.

Results
- Women reported negative experiences due to gender more often than men (p = 0.001).
- Every one-unit increase (on a Likert scale) in the frequency of negative gender experiences was associated with an increase in burnout.

Conclusion
- Over one in ten women providers reported negative experiences due to gender.
- These experiences correlated with burnout, poor sense of teamwork, and low values alignment with leaders.

Learning Objectives
- Identify connections between negative experiences due to gender and the provider burnout epidemic.
- Incorporate an item about negative experiences due to gender into a wellness survey at an individual’s own institution.
- Discuss burnout, its components, negative experiences due to gender, and how they intersect as system-level forces that may affect provider well-being.

Novel Gender Item

How often do you encounter negative experiences at work due to your gender and/or race?
(e.g. being denied work opportunities, being isolated or treated as if you were not competent, experiencing repeated, small slights at work, or other forms of discrimination)


Demographics

JOb Title
- Physician 50%
- Physician Assistant 13%
- Nurse Practitioner 25%
- Physician Assistant 9%

Job Status
- Full Time 85%
- Part Time 15%

Race
- White 85%
- Black 5%
- Asian 5%
- Other 5%

Gender
- Men 30%
- Women 63%

Excerpts from Qualitative Data

Female providers do not often receive the same admin help but yet the expectation on what we do is higher.

I don’t feel I get as much respect from female ancillary staff and patients as my male colleagues.

We are dealing with both gender and racial tensions.

Support staff have an expectation that because of my gender, I should be doing more non-physician related work to “help out.” I am not sure (and doubt) my male colleagues have the same experience.

Belittling comments from male physician colleagues.

A very clear pregnant and new mommy tax exists and is frustrating and unacceptable.

Conclusions

- Negative experiences due to gender correspond with overall well-being, team dynamics, and perceptions of leadership.
- Like burnout, negative experiences due to gender could operate at the system level.
- These experiences may comprise appropriate targets for institutional change, such as implicit bias training, pursuing pay equity, improving family and medical leave, and career development training (2).

Limitations & Future Directions

- Cross-sectional data
- Limited racial diversity in the sample
- Future studies will track negative experiences due to gender annually and investigate interventions.

Gender Differences in Negative Experiences
- Women reported negative experiences due to gender significantly more often than men (p < 0.001 from Cochran-Armitage test).
- Over one in ten women reported negative experiences due to gender fairly often or frequently.
- Only 35% of women reported never encountering negative experiences due to gender, compared to 70% of men (see below).

October 2018 Survey: Of 679 eligible providers, 461 participated for a response rate of 68%

- 79% odds of experiencing BURNOUT (p<0.001)
- 55% odds of experiencing POOR TEAMWORK (p<0.001)
- 91% odds of experiencing poor VALUES ALIGNMENT with leadership (p<0.001)
How do general practitioners act when they are ill? A qualitative study to their health care utilization

Sven Schulz\textsuperscript{1}, Ulf Sauerbrey\textsuperscript{1}, Friederike Hecker\textsuperscript{1}

Introduction

What we know...

- Physicians (particularly General Practitioners) represent a special population regarding health care utilization.
- International recommendations (e.g., CPSO Canada, GMC, RACP Australia) state that:
  - Physicians should be registered with a GP
  - Physicians should not self-treat
  - Physicians often fail these recommendations
- Studies mostly focus on barriers (Fox 2009)
- In Germany, studies to health care utilization of physicians are lacking.

Aim of our study

To identify beneficial and obstructive factors for health care utilization of General Practitioners in Germany.

Methods

- Qualitative study design
- Convenience sample of general practitioners
- Development of interview guideline (Initial Question: I suppose you felt yourself very sick at least once in your life as a physician, so that you thought of visiting a doctor. Could you please tell me about it?)
- 16 open, guideline-based, audio-taped interviews between 12/2014 and 03/2015 (65 min on average)
- Questionnaire to sociodemographic factors
- Verbatim transcription of the interviews
- Qualitative content analysis according to Kuckartz
  - Development of a code-system with an inductive-deductive method
  - Framework-analysis of the code health care utilization

Results

Sociodemographic Data

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age: 40-50 years: 6x</th>
<th>50-60 years: 7x</th>
<th>60-70 years: 1x</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>1:1 (8 w, 8 m)</td>
<td>17 years (4 - 42 years)</td>
<td>2 x salaried</td>
</tr>
<tr>
<td>Males</td>
<td>1:1 (15 m, 15 m)</td>
<td>Duration of work in outpatient care: 0.17 years</td>
<td>6 x single practice</td>
</tr>
<tr>
<td></td>
<td>Practice form: 10 x cooperative practice</td>
<td></td>
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</tr>
</tbody>
</table>

Code-Theory-Model

We identified 16 main categories in our code system, presented in the code-theory model.

Framework analysis of the code health care utilization

In the analysis of the association between health care utilization and the other factors, it became apparent that the particular factors included each beneficial and obstructive aspects. We show these different aspects exemplarily for the factor „Medical Knowledge“ and „Values and Attitudes“.

Discussion

- We found a complex spectrum of factors influencing health care utilization of German GP’s.
- Many known barriers are echoed in our study.
- We found no distinct obstructive or beneficial factors but beneficial and obstructive aspects of these factors.
- Some factors are normal part of the health care seeking process.
- Some factors (e.g., knowledge, imprinting,...) may be of particular relevance for physicians.
- A deeper analysis of these factors and aspects seems worthy.

Literature

The 2017 SELF CARE initiative demonstrates the commitment of our physician-led medical group to improve the health of its providers through its SELF CARE model. This model is formulated on eight evidence-based practices, proven to have a positive impact on personal resilience and wellness. The Stanford WellMD Model identifies three key domains contributing to professional fulfillment, with “Personal Resilience” and “Culture of Wellness” being two out of the three. Our medical group recognizes the foundational importance of provider wellness to personal and organizational success and promotes a wellness culture through widespread incorporation of the SELF CARE Model. The 2017 SELF CARE initiatives, through analysis of Quality of Work Life Survey (QWL) and participation rates in SELF CARE Regional Incentive Goals.

Results:
Our medical group issues an annual Quality of Work Life Survey (QWL), which includes two questions pertaining to health and wellness:
1. Medical group provides an environment that supports health and wellness
2. Satisfied with the way I am currently taking care of my own health
Survey results between 2016 and 2018 validated the goals of the 2017-2018 SELF CARE initiative, showing a 8% positive response to question #1, from 89% (2016) to 97% (2018), and a 10% increase in question #2, from 77% (2016) to 87% (2018). We received 95% participation in our regional SELF CARE goal, where providers watched a SELF CARE video and chose two measures to practice for three months. The goal encouraged providers to engage in their own SELF CARE.

S - Sleep
E - Exercise
L - Love & Laughter
F - Food
C - Compassion
A - Awe
R - Resilience
E - Engagement

Relation to conference theme:
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Co-authors: David Bell, MD; Lois Chiu, MD; Patricia Cole; Joshua Fouts, BCBA-D; Lois Gregg, MD; Peggy Latare, MD; Burt Moritz, MD; Scott Nishikawa, MD; Kimmie Ouchi, MD; Richele Thomburg, MS

Learning objectives:
• Introduction of our evidence-based SELF CARE model.
• Learn how intentional incorporation of SELF CARE initiatives improves both the wellness culture of an organization and individual wellness.

Methods/approach:
• Development of evidence-based “CARE” acronym, used with “SELF” model, developed by one of our partnering medical groups.
• SELF CARE Model presentation to organizational leadership to promote organizational endorsement.
• SELF CARE promotion through Professional Development Days and other events.
• SELF CARE incorporation into publications, marketing, website, recruitment, grand rounds, mentoring programs, and regional incentive goals.
• Measure results of 2017 SELF CARE initiatives, through analysis of Quality of Work Life Survey (QWL) and participation rates in SELF CARE Regional Incentive Goals.

Conclusion:
We found by creating a comprehensive SELF CARE model and prioritizing its intentional incorporation into our organization, we achieved increased personal wellness for our providers and improved wellness for our organization.
Physician wellness is essential for the optimal functioning of a health care system. Concerned about the national trends of increasing physician burnout, we evaluated the extent of burnout at Dayton Children’s Hospital in 2018, then initiated a physician wellness committee. The committee implemented multiple wellness initiatives with the aim of promoting physician wellness.

Objectives
The objective of this study was to gauge the impact of the physician wellness initiatives on physician wellness.

Methodology
We conducted 2 surveys in February of 2018 and 2019. These were based on Maslach Burnout inventory and were identical in content. After the results of the first survey in 2018 were available, the newly formed physician wellness committee initiated a number of interventions to address some of the issues. These included:
- Starting meditation classes
- Creating a frequently asked question document for all the physicians delineating the resources for enhancing participation in research, education, quality improvement, safety etc
- Creating a peer support program
- Organizing multiple socials celebrating festivals belonging to different religions.
- Conducting town hall meetings to discuss mindfulness, the burden of electronic medical record and system issues affecting physician wellness.

Results
In 2018, 86 physicians (67%) responded while in 2019, 94 (65%) physicians responded to the survey. The measure that showed statistically significant improvement was ‘sense of professional fulfillment’ where 82% of the physicians reported a 7/10 or more score in 2018 compared to only 68 % in 2018. The trend was overall positive with less physicians feeling a lack of control, burnout and disengagement and more physicians feeling rewarded at work.

The top most important priorities for wellness were work life balance, autonomy at work, peer support, culture of support and personal health. The top 3 interventions desired by physicians included increasing physician role in determining workflow, increasing physician input in decisions of strategic importance and decreasing the burden of electronic medical record.

Conclusions
Physician burnout is a major problem nationwide. Specifically designed interventions can have a positive impact on physician burnout. Building a sense of community and focusing on personal wellness initiatives while working on the more challenging system issues can have an impact on reducing burnout.

References

Acknowledgement
We acknowledge the contribution of the other members of the physician wellness committee and the support from the senior leadership.
Professional Dissonance in Primary Care: Practitioners’ Perceptions of Contributars and Solutions to Burnout and Low Professional Fulfillment

Sumit D. Agarwal, M.D., M.P.H, Erika Pabo, M.D., M.B.A., Ronen Rozenblum, Ph.D., M.P.H., Karen Sherritt, MD

Abstract

- Clinician burnout has become a health crisis in our nation. Primary care practitioners (PCPs) have particularly high rates of burnout.
- This qualitative study of PCPs at a large academic institution and its affiliate practices investigated the causes of burnout, barriers to professional fulfillment, and potential solutions.
- Three external factors and three internal manifestations emerged:
  - Externally, participants expressed experiencing excessively high workload, less “doctor” work and more “office” work, and unreasonable expectations
  - Internally, participants felt demoralized by work conditions, undervalued by both the local and broader systems, and conflicted by competing priorities
- More broadly, PCPs conveyed a sense of professional dissonance, i.e. psychological discomfort from working in a system that seemed to counter their values as clinicians.
- Potential solutions clustered around 8 themes: managing the workload, creating a culture of caring, disconnecting from work, setting more realistic expectations, promoting the PCP’s voice, supporting professionalism, fostering community, and advocating for extra-institutional reforms.

Learning Objectives

- Identify unique causes of burnout and barriers to professional fulfillment in Primary Care Internal Medicine
- Use qualitative techniques to elicit the voice of front-line clinicians
- Identify interventions to decrease burnout and improve professional fulfillment

Methods

- Focus groups were conducted with PCPs (physicians, nurse practitioners, and physician assistants) in the Division of Primary Care at Brigham Health between February and April 2018.
- 189 PCPs invited by email, 26 participated
- In total, 4 focus groups that ranged from 3-11 participants and 2 interviews took place.
- Sessions were moderated by a practicing PCP using a semi-structured format with at least one observer present.
- Interview guide included open-ended questions on causes of burnout, barriers to professional fulfillment, and potential solutions in addition to questions about workplace culture and efficiency, work life balance, and resilience.
- Due to ongoing institutional efforts to address the electronic health record (EHR), we did not discuss EHR-specific solutions in addition to questions about workplace culture and efficiency, work life balance, and resilience.
- This study was approved by the Partners Human Research Committee (protocol number: 2018P0043I)

Results

Themes Identified as Contributors to Burnout and Low Professional Fulfillment

- Disconnecting from Work
  - Inefficient, redundant, unnecessarily cumbersome work
  - Increasing over time
  - “undoable”
  - “overwhelming”
- Feeling Conflicted
  - Sense of little ability to say no
  - “like a funnel” for all the parts of the system that do not work well
- Feeling Undervalued
  - Unrealistic expectations from patients
- Feeling Demoralized
  - Researching a patient’s medical condition vs no time
  - Typing vs connecting
- Responsibility-Authority Mismatch
  - Cognitive vs procedural compensation
  - Increasing amount of uncompensated work

Core Findings

- Engaging front-line clinicians for their views on burnout revealed several important insights and also reinforced findings from the current literature.
- Internal conflict and professional dissonance emerged as underrecognized aspects of burnout, in addition to other factors that may be more PCP-specific such as authority-responsibility mismatch and feeling undervalued.
- In addition, many of which reinforce current literature, may also be considered by institutions as they consider investing in activities to reduce burnout rates and improve professional fulfillment.

Conclusions

- This qualitative study of PCPs at a large academic institution and its affiliate practices investigated the causes of burnout, barriers to professional fulfillment, and potential solutions.
- Three external factors and three internal manifestations emerged:
  - Externally, participants expressed experiencing excessively high workload, less “doctor” work and more “office” work, and unreasonable expectations
  - Internally, participants felt demoralized by work conditions, undervalued by both the local and broader systems, and conflicted by competing priorities
- More broadly, PCPs conveyed a sense of professional dissonance, i.e. psychological discomfort from working in a system that seemed to counter their values as clinicians.
- Potential solutions clustered around 8 themes: managing the workload, creating a culture of caring, disconnecting from work, setting more realistic expectations, promoting the PCP’s voice, supporting professionalism, fostering community, and advocating for extra-institutional reforms.

Acknowledgements

The authors gratefully acknowledge Dr. Richard S. Gitomer and Dr. Lipika Samal for supporting this project and Ms. Anjali Moin for her administrative assistance. We have no conflicts of interest. Dr. Agarwal’s salary is supported by National Research Service Award (NRSA) for Primary Care (T32-HP10251) from the Health Resources and Services Administration (HRSA) and the Ryoichi Sasakawa Fellowship Fund.
**Where We Are and How We Feel:**
Devising a Tool to Measure Medical Students’ Perceptions of Learning Environment and Their Sense of Wellbeing

Eva Waino MD, R. Brent Stansfield PhD, Jason Booza PhD, Hannah Kopinsky, Jody Chou, Margit Chadwell MD, Tsveti Markova MD

**BACKGROUND**
- Studies of North American medical students show a higher prevalence of anxiety and depression than age-matched peers.1
- Burnout impacts clinical practice, including reduced empathy, patient satisfaction, and productivity.2-3
- These studies demonstrate the need for greater understanding of the influences on physician wellbeing from the start of medical training.
- We developed a Medical Student Check-In Survey (MSCIS) alongside responses to the Medical Student Learning Environment Survey (MSLES) at the largest single-campus allopathic medical school in the U.S to evaluate influences of perceptions of learning environment on wellbeing.

**AIMS**
- Introduce the newly developed Medical Student Check-In Survey (MSCIS) alongside the well-established Medical Student Learning Environment Survey (MSLES): to:
  1. Discuss the process of creating a tool to measure the relationship of medical students’ sense of wellbeing to perceptions of medical school learning environment.
  2. Explore ways to make informed institutional changes which positively impact students’ wellbeing and inspire joy in medicine.
  3. Share initial findings and discuss their implications for future changes study and changes to impact medical student wellness.

**METHODS**
- Medical students and faculty reviewed available resources to measure wellbeing components and perceptions of learning environment.
- They collaboratively worked on the Medical Student Check-In Survey (MSCIS), a novel form derived from the published and validated Resident Wellness Scale (RWS).4
- The MSCIS is based on the group’s review of the literature including the RWS and discussion of the nature of wellbeing in medical students. It is designed to measure frequencies of behaviors and thoughts indicative of student wellbeing.
- The Medical Student Learning Environment Survey (MSLES) is a well-used instrument measuring medical students’ perceptions of their learning environment.5
- The MSLES and the MSCIS were sent together to the entire medical school student body of approx. 1,100 students across years one through four with a 93-96% response rate (depending on the year).
- Data from 1,023 completed student surveys was analyzed.
- Missing data was imputed using listwise means.
- Principal components analysis was conducted for the wellness scale with varimax rotation of components with eigenvalues greater than 1.
- Principal components analysis was conducted for the wellness scale with varimax rotation of components with eigenvalues greater than 1.
- The MSCIS component 1 (confidence) and 2 (support) correlate with items on the MSLES. These correlations suggest a pattern of validity.

**RESULTS CONTINUED**
- Students’ sense of wellbeing is influenced by multiple factors, although the process is complex we are able to measure certain impactful factors.
- A steady increase in support throughout each year of medical school is encouraging. Further study is needed to see what factors influence this change and how we may be able to increase support early on in M1 year.
- Confidence steadily increases with preclinical study, and drops sharply during M3 year, perhaps influenced by the Step 1 exam and the first months of exposure to clinical work. Considering this, future interventions may be targeted at this student group.
- Confidence climbs 4th year with more clinical exposure. In the future, we will study the impact of match day on this result.
- WSUSOM is in the midst of curriculum changes, which may influence the MSCIS.
- Comparing the MSCIS with MSLES is promising. The MSCIS may be a way to evaluate impact of changes.
- Continuing to provide this survey annually will lead to ability to measure how these factors change across the same cohort of students.
- Although more studies are needed, preliminary validity evidence on comparing the MSCIS with MSLES is promising. The MSCIS may offer another useful assessment tool for components of medical student wellness.
- Collaboration between students and faculty is vital in accessing and addressing wellbeing issues in medical students.
- Understanding the impact of students’ perceptions of learning environment and level of training on perceptions of wellbeing can guide effective institutional changes that cultivate joy in learning & in medicine.

**REFERENCES**
Gaps in Recognition Among Family Medicine Providers: An Opportunity to Reduce Work-Home Conflict and Improve Retention
Timothy Riley, MD1; Julie Radico, PsyD, ABPP2; Jessica Parascandola3, MPH; Arthur Berg, PhD4; Tamara K. Oser, MD5
1Department of Family Medicine and Community Medicine, Penn State University, Hershey, PA
2Department of Public Health Sciences, Penn State University, Hershey, PA
3Department of Family Medicine, University of Colorado School of Medicine, Aurora, CO

Intro
Clinicians frequently work extra hours to provide patient care or meet administrative needs. Research has found that early attrition is associated with feeling unappreciated. Therefore, novel interventions are needed to decrease factors that lead to increased work-home conflict and feeling underappreciated.

Objective: To identify gaps in and opportunities for recognition related to exceptional work effort in the department in order to improve work-home balance and retain employees.

Methods
- Cross-sectional survey with Likert scale and open-ended questions
- Distributed to physicians, advanced practice providers, and residents in the department of Family & Community Medicine at Hershey and University Park
- Outcome measures: sense of appreciation, work-life facets, and gaps and potential ways to improve recognition

Results
52 responses out of 157 physicians/providers/residents (response rate = 33.1%)
- 44.2% male, 55.8% female
- 59.6% faculty, 31.4% residents and other providers
- 26.9% performing duties regularly at work that are not being recognized
- 19.2% seriously considering leaving Penn State because they did not feel appreciated

Conclusions
- Over one in four providers expressed a lack of recognition for their efforts, particularly related to clinic and education duties.
- Respondents did not prefer any method of recognition.
- A system of recognition and reward in the department must be objective, transparent, and fair.

One in four providers felt they were not being adequately recognized.

There was no consensus regarding desired method of recognition or reward.

There were concerns regarding fairness and feeling left out with a new recognition system.

Significant Findings

<table>
<thead>
<tr>
<th>Category</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women are more likely to want tangible goods as a source of recognition</td>
<td>0.008</td>
</tr>
<tr>
<td>Advance Practice Providers (APPs) are more likely to want to be recognized based on survey of office staff</td>
<td>0.007</td>
</tr>
<tr>
<td>APPs prefer recognition through word of mouth more often than providers</td>
<td>0.043</td>
</tr>
<tr>
<td>Faculty are more likely to prefer that all of Penn State Health knows who is recognized (but not how)</td>
<td>0.013</td>
</tr>
<tr>
<td>Assistant and associate professors are more likely to want a monetary raise</td>
<td>0.047</td>
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<tr>
<td>Assistant and associate professors are more likely to prefer awards</td>
<td>0.025</td>
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<tr>
<td>Associate professors prefer not to have recommendations for recognition made by office staff</td>
<td>0.005</td>
</tr>
<tr>
<td>Associate professors prefer for recognition to be private</td>
<td>0.017</td>
</tr>
</tbody>
</table>

Qualitative Themes

- Recognition can lead to unintended consequences such as possible negative feelings.
- Concerns can arise regarding the objectivity of recognition.
- Patient care, including the associated administrative work, was the most common venue for faculty feeling they were going above and beyond.
- Lack of recognition for teaching, though some reported recognition there.
- There was no consensus as to one or two mechanisms by which faculty would like to be recognized.
- Faculty are involved in diverse and numerous activities that are not being recognized.
- Some faculty (feel no) need for further external recognition.
- There is no consistent way faculty feel they are being recognized.
Decreasing Vitamin D Levels with Changes in Habits of Entering Medical Students

Spencer Jackson1, William McAllister1,Kori Brewer1,2
1 Brody School of Medicine, East Carolina University
2 Department of Emergency Medicine at East Carolina University

Background

Vitamin D serves many functions in human health and physiological function, like bone health and development. Recent studies have also correlated Vitamin D deficiency with learning difficulty. [1] The main sources of vitamin D are from dietary intake and conversion by Ultraviolet B radiation.

[2] Previous studies have demonstrated changes in medical student health from the first year to graduation, reporting increased diastolic blood pressure and HDL-cholesterol levels, reduced physical activity as well as a variety of dietary changes. [3]

A study of a single Saudi medical school found that 92% (233/253) of students had inadequate vitamin D levels (< 20 ng/mL). [4]

This study sought to identify changes in the health habits and Vitamin D levels of medical students upon entering medical school compared to their pre-medical school habits.

Methods

• This study was a prospective cohort study consisting of entering Brody School of Medicine students (n=18)
• Participants completed both a health habits questionnaire and provided a blood sample at the beginning and two months into the semester.
• REDCap Questionnaire for self-reported daily health habits
  – BMI
  – Weekday and Weekend Sun Exposure and Sunscreen Usage
  – Physical Activity (converted to METs)
  – Time spent Sitting or Reclining
  – Hours Spt
  – Vitamin D Consumption (based on vitamin D containing food and converted to IUs)
• Serum 25(OH) Vitamin D quantified by Enzo Life Sciences 25(OH) Vitamin D ELISA Kit
• Corrected Sun Exposure was calculated based on weekday and weekend sun exposure adjusted for % of body exposed to the sun, % of body covered in sunscreen, % of time wearing sunscreen, and amount of UV protection provided by reported sunscreen SPF.
• Data analyzed by IBM SPSS Statistics 25

Initial Data Collection

• Medical Student samples were collected after completion of their first year of medical school
• Questionnaire and blood draw for reporting habits and 25(OH) Vitamin D PRIOR to starting medical school

Final Data Collection

• Questionnaire and blood draw for reporting habits and 25(OH) Vitamin D AFTER being established in medical school or an undergraduate semester

Learning Objectives

1. Understand adverse effects associated with low vitamin D levels
2. Understand common lifestyle changes associated with medical school
3. Understand how lifestyle changes alter vitamin D levels

Entering medical school significantly altered medical students’ health habits

| Vitamin D deficiency risk is linked with differing habits during the semester |

<table>
<thead>
<tr>
<th>Initial</th>
<th>Final</th>
<th>Δ</th>
<th>% Δ</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Serum Vitamin D (ng/mL)</th>
<th>Mean Difference</th>
<th>Difference Std. Error</th>
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<tbody>
<tr>
<td>Initial Avg</td>
<td>Final Avg</td>
<td>Δ</td>
</tr>
<tr>
<td>BMIs</td>
<td>20.87</td>
<td>26.90</td>
</tr>
<tr>
<td>Vitamin D Consumed (IU/day)</td>
<td>319.27</td>
<td>202.93</td>
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<tr>
<td>Weekday Sun (min)</td>
<td>123.75</td>
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<td>Weekday Corrected Sun</td>
<td>50.38</td>
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<tr>
<td>Weekned Sun (min)</td>
<td>531.13</td>
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<tr>
<td>Daily Sun (min)</td>
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<tr>
<td>Daily Corrected Sun</td>
<td>56.42</td>
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<tr>
<td>Daily Average Activity (METS)</td>
<td>330.85</td>
<td>221.77</td>
</tr>
<tr>
<td>Sit or Recline (Min/Day)</td>
<td>260.56</td>
<td>440.36</td>
</tr>
<tr>
<td>Sleep (Hours/Day)</td>
<td>7.36</td>
<td>6.96</td>
</tr>
</tbody>
</table>

Correlation Table: Pearson Correlation coefficients for initial, final, change, and percent change of the measured medical student health habits. Green indicates p<0.01 and yellow indicates p<0.05

Conclusions

Beginning medical school is associated with significant reductions in various health habits. These health habits may play a role in decreased levels of Vitamin D.

Providing information or guidance to medical students prior to entering medical school would allow students to establish improved health habits before the semester which is correlated with better health habits during the semester.

Data from these students could be furthered studied to see the relationship of changes in health habits with student stress, health outcomes, or student performance during their ongoing medical education.

Acknowledgements and Citations

Funding: Department of Emergency Medicine at East Carolina University
Blood Draws: Allison Mainhart
Lab Assistance: Jacob Yow
ECU Honors College Staff


Contact Info:
jacksons12@students.ecu.edu & mcallisterw17@students.ecu.edu
An Innovative and Longitudinal Resilience Curriculum for Internal Medicine Residents

Tricia James MD, Ryan Dix, PsyD, MS, NCTTP

Background
- Burnout and depression are highest in trainees
- Residency is one of the most challenging organizations to modify
- ACGME instituted new program requirements in 2017 stating "programs have the same responsibility to address well-being as they do to evaluate other aspects of resident competence."
- Very few interventions in residents have been proven to decrease burnout or depression
- We created a fully integrated and longitudinal curriculum for our community based internal medicine residents

Learning Objectives
- Burnout and depression continue to affect residents at disproportionately high rates
- Organizational change in residency is even more challenging with multiple competing demands
- More studies are needed to identify the most effective approaches in this population

Methods
- GM faculty, licensed psychologist and psychiatrist faculty designed and implemented curriculum for 30 community IM residents
- Curriculum was integrated fully into a regular work day rather than being an addition to usual work expectations
- IM and FM residents in our larger system served as the control
- Residents filled out surveys at 3 time points with PHQ-9, MBI, and Jefferson Empathy Scale
- Residents were also asked about which wellness services they had and would access as well as well-being interventions they found most useful and where they would like to see expansion

Results

Burnout Rates High for Both Groups

<table>
<thead>
<tr>
<th>Intervention Group</th>
<th>No. (%)</th>
<th>Control Group</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st DP</td>
<td>0 (0.0%)</td>
<td>15 (53.6%)</td>
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</tr>
<tr>
<td>2nd DP</td>
<td>2 (7.1%)</td>
<td>3 (17.7%)</td>
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</tr>
<tr>
<td>3rd DP</td>
<td>4 (14.8%)</td>
<td>2 (7.1%)</td>
<td></td>
</tr>
<tr>
<td>1st PA</td>
<td>0 (0.0%)</td>
<td>3 (11.5%)</td>
<td></td>
</tr>
<tr>
<td>2nd PA</td>
<td>2 (7.1%)</td>
<td>13 (46.7%)</td>
<td></td>
</tr>
<tr>
<td>3rd PA</td>
<td>4 (14.8%)</td>
<td>13 (46.7%)</td>
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</table>

Depression Rates High for Both Groups

<table>
<thead>
<tr>
<th>Intervention Group</th>
<th>No. (%)</th>
<th>Control Group</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st DP</td>
<td>9 (30%)</td>
<td>15 (53.3%)</td>
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</tr>
<tr>
<td>2nd DP</td>
<td>16 (53.3%)</td>
<td>23 (76.7%)</td>
<td></td>
</tr>
<tr>
<td>3rd DP</td>
<td>12 (40%)</td>
<td>18 (60%)</td>
<td></td>
</tr>
<tr>
<td>1st EE</td>
<td>0 (0.0%)</td>
<td>5 (16.7%)</td>
<td></td>
</tr>
<tr>
<td>2nd EE</td>
<td>1 (3.3%)</td>
<td>2 (7.1%)</td>
<td></td>
</tr>
<tr>
<td>3rd EE</td>
<td>4 (13.3%)</td>
<td>4 (13.3%)</td>
<td></td>
</tr>
</tbody>
</table>

Utilization of Services

- Most Beneficial Interventions
  - Mindfulness
  - Retreats
  - Cognitive Behavioral change
  - Service Learning
  - Community free resources

- Areas for Expansion
  - Mindfulness
  - Retreats
  - Cognitive Behavioral change
  - Service Learning
  - Community free resources

Areas of Most Benefit and Ideas for Future

- No significant difference between control and intervention groups
- Trends toward worsening at mid point for both groups, not statistically significant

Conclusions
- Burnout and depression continue to be major challenges facing residents
- More studies are needed to identify the most effective changes
- Our data help identify possible areas for expansion
- While our curriculum did not statistically influence the items we monitored, the resident feedback was excellent. One resident noted that "Resiliency week is something I believe I will look back on as one of the most valuable weeks of my residency training.

References

Introduction

It has been estimated that the prevalence of burnout among resident physicians ranges from 40-80%. In particular, compared to medical students and attending physicians, studies have suggested that resident physicians have lower overall wellness.

In particular, a previous survey with anesthesiology residents at Stanford conducted by Hasan & Tanaka demonstrated low rates of belongingness (28%), sense that others take a personal interest in them (20%), and overall satisfaction with work environment (47%). In addition, they reported work-related stress to be high (51%), negative emotional and mental health (49%), and negative physician health (83%).

Formalizing a Chief Wellness Resident position, a novel approach, builds upon already existent wellness programs. In addition, formalizing this position may reflect a system’s commitment to appointing key members and measuring wellness in a manner similar to other commonly held positions and metrics which assess the long-term institutional viability.

Stanford WellMD Model

A resident physician from each class would be elected for a 12-4 month term. A baseline survey with questions which have been shown to be previously validated, will be sent to residents and compared to medical students and attending leadership, which will assess multiple areas including communication, burnout, awareness of wellness efforts, and wellness lecture effectiveness. Next, the elected Chief Resident of Wellness will then send out an anonymous survey to elicit input into specific areas in which other residents deem to be challenging. These will be ranked according to a previously established schema: 1) situational (workload, sleep deprivation, learning), 2) Personal (family, isolation, financial) and 3) professional (responsibility, information).

In the event that the responses are not robust, then one of four areas, which have been shown to be strongly correlated with burnout (quantitative work overload, perception of work as stressful, anticipation of debt, conflict between work and home) will be selected. Using the results, a lecture and small group workshop will be created to address the particular area.

This will be created with expert guidance and support from faculty members who are already involved in wellness initiatives. Marketing material will highlight current wellness efforts in addition to the elected upon areas of interest will also be created after the intervention. A post-intervention survey will then be sent.

Objectives

The overall objectives of creating a Chief Wellness Resident would be multiple.

1. To increase, streamline, and organize the communication from residents to the wellness committee or administrators via a formalized manner.
2. To create a small group intervention focusing on topics which residents have formally decided to be most important.
3. To provide training to select residents who have an interest in wellness who may incorporate this into their post-residency training career.

Preliminary Themes Discovered

Preliminary Themes Discovered

1. Financial benefits
2. Predictability in scheduling
3. Flexibility in scheduling
4. Interprofessional relationships and communication
5. Organizing consistent communication

Preliminary Solutions Discovered

Preliminary Solutions Discovered

1. Survey to ascertain specific drivers of burnout
2. Survey to crowdsource innovative and creative solutions to burnout
3. Having senior residents join dedicated protected wellness sessions
4. Town-hall meetings with administrations for question and answers

Methods/Approach

A resident physician from each class would be elected for a 12 month term. A baseline survey with questions which have been shown to be previously validated, will be sent to residents and leadership, which will assess multiple areas including communication, burnout, awareness of wellness efforts, and wellness lecture effectiveness. Next, the elected Chief Resident of Wellness will then send out an anonymous survey to elicit input into specific areas in which other residents deem to be challenging. These will be ranked according to a previously established schema: 1) situational (workload, sleep deprivation, learning), 2) Personal (family, isolation, financial) and 3) professional (responsibility, information).

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This will be created with expert guidance and support from faculty members who are already involved in wellness initiatives. Marketing material will highlight current wellness efforts in addition to the elected upon areas of interest will also be created after the intervention. A post-intervention survey will then be sent.
1. Can we teach physician leaders and managers a compact formula for participatory management…?

At Atul Healthcare, we developed a training program that introduced physician leaders and managers to key targets and behavioral strategies borrowed from the coaching field. While we believed we would be able to drill them into the participatory style. These strategies also have a robust evidence base for improving leadership engagement and well-being (SEL) and improvements in productivity to drive to strategic improvement.

In a 2-hour experimental training, participants learned behavioral strategies (“how”) for promoting emotional connection, psychological safety, self-determination, and open-mindedness in their management style. They practiced the behaviors in small groups to receive feedback and opportunities to apply them. We found that participants were often surprised by the strong emotional engagement and sense of alignment and support they felt.

Our results showed promise. Evaluation methods (At 177) departmental performance and 176 were asked to complete an anonymous online survey before and after the program, regarding their perceptions of management behavior (the Management Engagement Scale, MERS), Sharkey et al., 2011, and resistance and burnout at work (the Professional Fulfillment Index). To evaluate participants’ knowledge, we developed a pre–post evaluation tool based on the program content.

In addition, managers reported executing the participatory leadership actions and practices they were taught. These included:

- Facilitating sessions on personal development
- Establishing clear expectations and timelines
- Encouraging open and honest communication
- Supporting team members in achieving their goals
- Providing regular feedback and recognition
- Encouraging employees to take ownership of their work
- Promoting a culture of collaboration and innovation

These are the central elements of naturally occurring differences among managers. The participatory style also showed higher engagement levels compared to managers who had not gone through the program. These findings suggest that the program successfully transferred knowledge and skills to managers.

The impact of the coaching program was measured using various metrics, including:

- Increased team cohesion
- Improved communication
- Greater trust and respect among team members
- Enhanced decision-making processes
- Increased job satisfaction

These improvements were also linked to a reduction in burnout and stress levels among participants, highlighting the program's potential to positively impact both personal and professional well-being.

We believe that this compact form of participatory management training can be effectively delivered in healthcare settings to improve leadership effectiveness and overall organizational performance.
Does Family Inclusion in Employee Wellness Events Improve Wellness? A Pilot Study

Madison Goss BS¹, Alexa Hughes BS¹, Molly Carney BS¹, Tyler Bruinsma BS¹, Rachel Rothstein BS MPH¹, Amy Burns MD²
¹Penn State College of Medicine, ²Penn State Health Milton S. Hershey Medical Center, Division of Urology, Hershey, PA

Relation to Conference Theme
• The concept of family inclusion in wellness events as a tool for increasing hospital employee wellbeing has not, to our knowledge, previously reported in the literature.
• We sought to explore if wellness events and activities that involve interpersonal interaction and joy enhance employee wellbeing; as most burnout interventions are typically inwardly focused and solitary endeavors, i.e. mindfulness, meditation and exercise.

Methods
1. The wellness event was a “Character Meet and Greet” where medical student volunteers dressed up as different characters (i.e., princesses, superheroes) and interacted with hospital employees and their families.
2. Employee participants were given surveys using the Likert Scale to score this event in terms of overall impression, impact on wellness, comparison of this intervention to others at our institution and the meaningfulness of family incorporation.

“Wonderful event. Great to see kids’ joy and energy of the students in being the source of that joy.”

“More BraveCubs events. My family loved it. Great interactions. Wonderful way of introducing my kids to my workplace.”

“Wellness event which can involve a family are appreciated. Wellness events which take me away from my family are not the ones I attend.”

Results
• Approximately 125 employees, family members and students attended the event.
• Twenty-six hospital employees responded to the survey where 1 was the lowest score and 10 was the highest score.
• The average score for “Did incorporating your family into this wellness event make it more meaningful for you?” was 9.6/10.
• Participants rated this character event 9.1/10 when asked to quantify how this wellness event compared to other institutional wellness events/initiatives.

Conclusions
• This pilot study evaluated the impact of family incorporation into hospital wellness initiatives and preliminary results were very positive.
• Externally focused wellness initiatives, which incorporate interpersonal interactions and joy, may enhance hospital employee wellbeing.
• Family incorporation into wellness interventions and outwardly focused strategies to reduce burnout warrant further study.

Learning Objectives
1. Understand that burnout is a multifaceted condition so interventions to promote wellness should also be multifaceted.
2. Explore the benefits of family incorporation into hospital employee wellness initiatives.
3. Examine if externally focused and joyful wellness interventions promote employee wellbeing.

Acknowledgements
A Wellness Mini-Grant from the Office of Faculty and Professional Development at Penn State Health Milton S. Hershey Medical Center funded this event. This study was done in partnership with BraveCubs, a non-profit organization run by medical students at the Penn State College of Medicine. BraveCubs is funded by donations, grants and student organized fundraising events.

Like us on Facebook! Facebook.com/BraveCubsPSUCOM
Evaluation of a formal transformation curriculum to improve quality of care in the practice setting: A pilot study

Authors: Meghan Kwiatkowski, American Medical Association and Ashley Cummings, American Medical Association

LEARNING OBJECTIVES
1. Recognize the potential contribution of collaborative learning to practice transformation
2. Identify the purpose and appropriateness of a co-designed curriculum
3. Describe the outcomes of a pilot study

PROJECT OBJECTIVE/BACKGROUND
Within the scope of a practice transformation initiative, the opportunity exists to apply a collaborative learning approach based on adult learning and human-centered design principles that indicate that for information to be retained it must be relevant to the learner’s professional needs. A corollary of these principles is that the members of a learning collaborative should dictate the focus of their learning efforts and follow a formal curriculum that addresses their areas of need.

METHODS/APPROACH
Of 29 Practice Transformation Networks (PTNs) enrolled in the CMS-funded Transforming Clinical Practice Initiative (TCPi), the AMA initialized and completed two learning cohorts. PTN-enrolled practices completed a practice assessment at the onset and upon completion of the collaborative engagement.

RESULTS
The pilot study measured improvement across nine milestones in primary care settings. On average, PTNs within the AMA pilot study cohorts demonstrated 40% improvement in their selected areas of focus.

CONCLUSION
Learning and practice transformation supported by quality improvement advisors (QIAs), PTNs and the AMA Support and Alignment Network (SAN) was observed in the two collaboratives reported. Co-design of AMA curricula with the PTNs and their enrolled practices—informed by a clear understanding of baseline performance and identified goals—and delivered to QIAs through peer-to-peer learning and mixed modalities (didactic with discussion, interactive tools) was associated with improvement across nine milestones.

SAN COLLABORATIVE RESULTS

<table>
<thead>
<tr>
<th>PRIMARY CARE MILESTONE 4: Patient/family engagement</th>
<th>QUALITY IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE MILESTONE 5: Patient and family survey distribution</td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE MILESTONE 8: Panel management</td>
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<tr>
<td>PRIMARY CARE MILESTONE 9: Risk stratification</td>
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<td>PRIMARY CARE MILESTONE 10: Care management for complex patients</td>
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<td>PRIMARY CARE MILESTONE 15: Whole-person care</td>
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<tr>
<td>PRIMARY CARE MILESTONE 16: Use of population reports/registries for care gaps</td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE MILESTONE 23: Sound business operations</td>
<td></td>
</tr>
<tr>
<td>PRIMARY CARE MILESTONE 26: Readiness for APM migration</td>
<td></td>
</tr>
</tbody>
</table>

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Fostering a Culture of Health and Wellness Through Professional Development Meetings

Corresponding author: Patricia Cole Co-authors: David Bell, MD; Lois Chu, MD; Benjamin Chun, MD; Joshua Fouts, BCBA-D; Lois Gregg, MD; Peggy Latare, MD; Burt Mottz, MD; Scott Nishikawa, MD; Kimmie Ouchi, MD; Richele Thornburg, MS

Relation to conference theme: A Culture of Health and Wellness is critical for individual fulfillment and organizational success, as delineated by the Stanford WellMD Model. Our medical group strives to enrich this culture in a multifaceted and deliberate way that is based on a foundation of shared values and our guiding vision of being “The Best Place to Work, Deliver, and Receive Care.”

Project objective/background: In 2015, national thought leaders updated the Institute for Healthcare Improvement’s “Triple Aim” to a “Quadruple Aim,” emphasizing care of the provider. As part of our mission to be “The Best Place to Work, Deliver, and Receive Care,” we hosted our first Professional Development Day (PDD) dedicated to physician health and wellness. The response was highly enthusiastic, which led to another PDD that was held in June 2017, June 2018, and June 2019 with over 500 physicians and providers attending.

Learning objectives: To promote a culture emphasizing care of the provider and supporting the incorporation of SELF CARE into the lives of physicians/providers through an annual Professional Development Day

Methods/approach: Robust PDD educational program was developed:
- Welcome: Executive Medical Director highlighted the necessity of care of the provider in meeting the challenges of health care delivery today, affirming a commitment to invest and support a culture of health and wellness
- Inspirational testimonial of resiliency: Physician colleague facing career, personal and/or health challenges
- Keynote speaker: Provided context and scientific support for concepts of physician wellness and well-being
- Breakout sessions: Activities and classes based on recommendations from the medical group at large, designed to support the concept and philosophies of SELF CARE, with leaders and instructors recruited from the medical group itself. Attendees selected their sessions and enjoyed time with colleagues.

Results: When surveyed, 98% of attendees stated they were “Very Satisfied/Satisfied” with the PDD program. In our 2018 Quality of Work Life Survey, 97% agreed that we provide an environment that supports health and wellness, trending up from 89% in 2016. Similarly, 87% felt satisfied with the way they were currently taking care of their own health, up from 77% in 2015.

Conclusion: Group-wide Professional Development Days dedicated to health, wellness and well-being are effective engagement tools to promote a culture of wellness and encourage adoption of individual SELF CARE practices within a large, multidisciplinary medical group, demonstrating strong investment in care of the provider by medical group leadership.
INTRODUCTION

University of Missouri Health Care, an academic health system in Columbia, Missouri, provides comprehensive health care services to people in central Missouri and beyond while training the next generation of physicians. UMHC employs approximately 625 faculty physicians, 493 residents and fellows, and 225 advanced practice clinicians, and graduates a medical school class of 116 MDs annually. Although a formal physician burnout/well-being survey had yet to be conducted, annual Gallup Engagement surveys of UMHC employees demonstrated that faculty physicians had the highest levels of active disengagement of any employee subgroup. Additionally, the 2018 AAMC StandPoint survey indicated that 28% of UMHC physicians were either burned out or burning out. Despite this data, UMHC had not yet developed a formal clinician well-being program.

OBJECTIVE

With the support of a committee within the faculty physician practice group, an associate professor of clinical medicine and pediatrics advocated for the development of a formal clinician well-being program.

METHOD

From October 2017 to August 2018, this faculty physician advocated for the creation of a clinician well-being program by presenting to various governing bodies such as the executive committee of medical staff, council of clinical chairs, and the committee of clinical medical directors and departmental administrators. He also met individually with key stakeholders in high level leadership positions including the hospital CEO, dean of the school of medicine, chief clinical officer, chairman of the faculty practice group, and executive director of faculty practice group.

From Zero to Sixty: a CWO’s Story of a Clinician Well-being Program Start-up

Stephen T. Keithahn, MD, FACP, FAAP
Chief Wellness Officer for MU Health Care and the University of Missouri School of Medicine, Columbia, MO, 65201

SUPPORTING DATA

Gallup Engagement

<table>
<thead>
<tr>
<th>Engagement Index by Faculty - Ratio of Engaged to Actively Disengaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
</tr>
<tr>
<td>MUHC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Cost Savings: Increased Productivity and Decreased Turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Faculty Turnover Rate</td>
</tr>
<tr>
<td>• UMHC turnover rate FY18 = 9.3%</td>
</tr>
<tr>
<td>• National average for all institution types = 7%</td>
</tr>
<tr>
<td>• 57 and 55 faculty physicians resigned (not terminated or retired) in FY18 and FY17, respectively, with an average tenure of 3-4 years</td>
</tr>
<tr>
<td>• Estimated cost of replacing a faculty physician is double their salary</td>
</tr>
<tr>
<td>• Estimated that half of resigning physicians leave because of burnout</td>
</tr>
</tbody>
</table>

AAMC StandPoint

Burnout & Wellness

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty Physical</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workplace culture activates faculty wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
</tr>
</tbody>
</table>

Data is critical when advocating to leadership. Surrogate survey data for clinician burnout was utilized in this case, but if such data is unavailable, the Mini Z survey is non-proprietary and available at: stepsforward@ama-assn.org. Calculating physician turnover rates is straightforward, and the results can be eye-opening. Building a coalition of allies within the institution will accelerate the process. National recommendations from prominent health care institutions and physician organizations support the mandate; see references below.

CONCLUSIONS

Physician and non-physician leaders of academic health centers are often skeptical of the benefits of clinician well-being programs despite mounting evidence supporting the positive effects on clinician well-being, quality of patient care, education of physician learners, compliance with outside regulators, and overall benefits to institutional finances. Strategies such as collecting local data, recruiting allies, and presenting to the broader leadership, are key to engaging and compelling leadership to successfully develop and fund a physician well-being program.

REFERENCES


On September 1, 2018, the faculty physician was named UMHC’s first chief wellness officer, a position jointly funded by the school of medicine and hospital system.

On July 1, 2019, the clinician well-being program was granted a budget substantial enough to hire an additional 1.5 FTE and support the initial well-being initiatives.

Optimizing clinician well-being is now included in UMHC’s strategic plan.

RESULTS

The budget request for the clinician well-being program? 0.000375 of $800 million!

The budget request for the clinician well-being program? 0.000375 of $800 million!
ABSTRACT
Implementation of a provider peer support program is done as the first part of a provider wellness initiative. Literature shows that patient safety is impacted by provider burnout and that providers do not usually seek formal support after an adverse event or error. This program was operationalized as the first part of a multi-phase provider wellness initiative over a 10-month period. This poster details how an organization whose providers straddle multiple health systems and hospital sites initiated and implemented a formal peer support program. We show a favorable impact on burnout and details of how multiple asynchronous communication methods were used to raise awareness, bridge silos, and promote a culture of safety.

OBJECTIVES
1. Demonstrate an approach to foster buy-in and engagement for a Peer Support Program.
2. Establish a feasible timeline from conceptualization to implementation.
3. Show impact of a formal Peer Support Program on provider burnout and engagement levels.

METHODS

JANUARY 2018
• We developed a project with a reference to Dr. Jo Shapiro’s 2008 Peer Support article and sent electronically to all managing partners and clinical directors of operations.
• The project was approved by the Oregon Patient Safety Commission’s 2018 Peer Support Program.

MARCH 2018
• The project was made to the 5 member Executive Board of our organization and the pilot project was approved.

APRIL 2018
• Our president elect and 5 other volunteer peer supporters participated in the first approved Peer Support meeting led by Dr. Jo Shapiro.

JULY 2018
• A Survey Monkey approved by our Executive Board and crafted by our internal communications team was sent to all providers with four single item questions about burnout, depersonalization, engagement and control.
• The first two single item questions have been previously validated by other organisations.
• The survey also requested nominations of trusted and respected peers to attain provider support for an adverse event or error.

SEPTEMBER 2018 | FEBRUARY 2019
• We were able to train 37 volunteers and multiple sessions of operational overview at one session (One in September 2018 and a second in February 2019) as all compatible providers scheduled.

OCTOBER 2018
• Emails, Written and Verbal communications were utilized to promote the program to providers.
• Program formally went October 1, 2018.

JULY 2019
• We sent a follow up survey monkey to all providers with the same four questions and in a flip, follow up questions about Provider Wellness & the Peer Support Program.

RESULTS
We made 27 peer support outreach calls to 13.1% of our physician providers. Of those outreach calls 51.8% were accepted which matches our survey questions (T/F) have received a peer support outreach call in the past 9 months “Yes” (N=27) and 1.9% “Yes” but would have liked to receive a peer support call in the last 9 months “Yes” (N=14). 95% of respondents were aware of the multiple ways to access/refer to the Peer Support Program (Text, Email, Call).

CONCLUSIONS
Utilization of our confidential Peer Support Program matched that of a large East Coast Hospital system within the first 6 months of program implementation. Utilization is averaging 4 support outreach calls per month. Reduction in provider burnout levels is documented using previously validated single item questions. Peer Support Program initiation is feasible and fundamental to provider wellness in this complex medical climate. It is possible to operationalize a formal peer support program in under 12 months.

Jill Shaw, DO, FACOG | The Oregon Clinic

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 дополнительно, ведомство большинства респондентов показало, что стратегический план для Поддержки биллдера в Отмеченный клиник нужен включать в себя Culture of Wellness (96.7%), Efficency of Practice (98.9%) и Personal Resilience (85.5%) состоит с Ваффл модель на стандартной университе.
Impact of Mental Health First Aid Training on Medical Students’ Ability to Intervene in Mental Health Crises amongst Peers

Tiffani Strickland, Anita Ukani, Eva Waino MD
1 Resident, Sutter Medical Center of Santa Rosa; 2 Medical student, Wayne State University School of Medicine; 3 Assistant Professor, Wayne State University School of Medicine

BACKGROUND
- Studies show medical students have a higher prevalence of anxiety and depression than age-matched peers and up to 11% admit to suicidal thoughts in the past year.
- Students also experience obstacles to seeking treatment, leaving many concerns unaddressed.
- Recent studies have shown the importance of peer engagement in addressing mental health and supporting those experiencing distress.
- Mental Health First Aid Training (MHFAT) is an 8-hour long nationally available course which teaches participants how to recognize and respond to a mental health crisis. Studies of this course among the public and among students in the UK demonstrated improved attitudes, confidence & knowledge.
- This pilot study aims to evaluate the impact of MHFAT upon medical students at the largest single campus allopathic medical school in the US, and its potential for incorporation into wider efforts to expand mental health resources.
- MHFAT covers the diagnosis of mental health disorders, how to apply an action plan in different clinical situations, and the opportunity to practice intervention strategies.

GOALS
1. Recognize importance of peer intervention in mental health crises among students.
2. Understand the components of MHFAT and its utility as a resource to guide response to a mental health crisis.
3. Assess potential for MHFAT to promote wellness and improve student health outcomes.

METHODS
- MHFAT is available to all interested students at WSUSOM.
- MHFAT was organized and scheduled for the street medicine student organization by their student leadership team.
- The initial goal of the training was to increase knowledge and comfort level in addressing the mental health needs of the homeless patient population in the Detroit community.
- Surveys were anonymously administered to participants (n=22, 59% female, 41% male) before, immediately after, and 2 months following the training.
- 100% of participants answered surveys before and immediately after the training, and 73% answered the 2 month follow-up survey.
- Surveys assessed students’ self-reported attitudes, confidence, and knowledge about mental health problems and ways to intervene as well as how they anticipated to use the information gained from the training in the future.
- Surveys included questions directly from MHFAT and additional questions created by the street medicine student leadership team.

MAIN TAKE HOME POINTS
- Mental Health First Aid Training provides an already established, effective 8 hr. curriculum that empowers medical students to recognize peers in distress and offer support/resources – almost 2/3ds believe they will use the skills learned in the role of a peer/friend.
- Following MHFAT, medical students showed an increase in confidence in recognizing & acting when someone experiences a mental health crisis and increased knowledge of mental health disorders.

RESULTS
- Following the training, students reported:
  - Confidence levels in coping with knowledge regarding positive attitudes and beliefs towards mental health issues & challenges in college students.
  - 94% of students felt more comfortable making a referral after MHFAT.
- Almost two-thirds of students believed they will use the skills they learned from MHFAT in the future with a peer/friend, over a third as a family member, and almost all as a volunteer.
- In what way do you see your mental health first aid training being of use?
  - Mental Health First Aid Training provides an already established, effective 8 hr. curriculum that empowers medical students to recognize peers in distress and offer support/resources – almost 2/3ds believe they will use the skills learned in the role of a peer/friend.
  - Following MHFAT, medical students showed an increase in confidence in recognizing & acting when someone experiences a mental health crisis and increased knowledge of mental health disorders.

DISCUSSION & CONCLUSIONS
- This pilot study demonstrated that after completing the MHFAT 8 hour curriculum, students felt better equipped with mental health knowledge, more confident in reaching out to peers and offering appropriate assistance, and reported a further decrease in already low levels of stigmatizing attitudes and beliefs towards mental health.
- Considering most medical students who experience mental health symptoms in training turn to a peer/colleague for support, empowering the student body to recognize peers in distress and offer help/resources may improve student health and wellbeing. It may also serve as one avenue to overcome the obstacles students face in seeking treatment.
- The initial goal of MHFAT was to improve patient care during volunteer experiences as part of the street medicine student organization, yet most students thought the training could be of use as a peer/friend. This demonstrates use of curriculum applicable in multiple areas of training.
- Future training will incorporate a larger student number and longer follow-up to determine sustainability and track behavior to determine if it leads to changes in students’ interactions with their peers and if it proves useful during clinical rotations.
- MHFAT may also be considered in the future to educate support staff and faculty who regularly work with students and further increase support.

REFERENCES
3) Shanafelt TD, Grotzinger SC, Gelinek S, et al. A Pilot Randomized Controlled Study of the Mental Health First Aid training course with UM Medical School students, 2016. 16.06.25.
Implementation of a Gender Equity Task force in the Department of Surgery
Sam Van Horne, Ph.D. & Julia MacRae, M.D.
Christiana Care Health System, Newark, DE

Activities of Task Force in Department of Surgery
The Gender Equity task force, under the umbrella of the Center for Provider Wellbeing, is a group of CC physicians, surgeons, and staff who are interested in promoting equity for all CCHS staff. We are starting specifically focusing on women in the surgical arena, but our goal is to create a culture that supports and encourages all.

Methodology

Survey Instrument
- HB-approved study of physicians, advanced practice clinicians, and residents/fellows
- Administered in cooperation with the Physician Wellness Academic Consortium

Demographic/Background Items
- Gender, Race/ethnicity, relationship status, employment status of significant other, parental status
- Practice Environment
- Full-time/part-time status, employment arrangement, % of time spent in clinical care, % time spent in academic writing.

Wellbeing/Attitudes Toward Environment
- Includes variety of questions to assess Professional Fulfillment, Emotional Exhaustion, Interpersonal Disengagement (Frohlich et al., 2016)
- Quality of Leadership, Level of Peer Support, Gratitude and Appreciation, Alignment of Values (AAMC, 2019)

Survey Results
- Overall response rate for credentialed staff of 35%
- Includes variety of questions to assess Professional Fulfillment, Emotional Exhaustion, Interpersonal Disengagement (Frohlich et al., 2016)
- Quality of Leadership, Level of Peer Support, Gratitude and Appreciation, Alignment of Values (AAMC, 2019)

Key Differences in Outcomes for Physicians (Overall and in Surgery)

Men Women
% whose partner works PT outside home 44 19.91% 9 7.09%
% whose partner works FT outside home 99 42.70% 102 82.03% <.0001
% whose partner works PT outside home 44 19.91% 9 7.09%
% whose partner doesn't work outside home 88 39.82% 18 12.80%

Table of Statistics Related to Family and Work Arrangement (2019 Results)

<table>
<thead>
<tr>
<th>Work/Life Arrangements and Its Relationship to Control of Workload</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part Time</td>
<td>14</td>
<td>5.43</td>
</tr>
<tr>
<td>Has Young Children</td>
<td>44</td>
<td>10.99</td>
</tr>
<tr>
<td>Employed (fully or part-time)</td>
<td>173</td>
<td>66.80</td>
</tr>
<tr>
<td>Living with dependent children</td>
<td>142</td>
<td>54.80</td>
</tr>
<tr>
<td>Living with S.O.</td>
<td>235</td>
<td>90.70</td>
</tr>
</tbody>
</table>

| Of Those Living with S.O. and who are FT | % whose partner works PT outside home | 89 | 40.27% | 102 | 82.03% <.0001 |
| % whose partner works FT outside home | 44 | 19.91% | 9 | 7.09% |
| % whose partner doesn't work outside home | 88 | 39.82% | 18 | 12.80% |

| Average for “Control of Schedule/Workload” Items for Full-Time Physicians | % whose partner works PT outside home | 89 | 40.27% | 102 | 82.03% <.0001 |
| % whose partner works FT outside home | 44 | 19.91% | 9 | 7.09% |
| % whose partner doesn't work outside home | 88 | 39.82% | 18 | 12.80% |

p | value | 90 40.27% | 102 82.03% <.0001 |

p | value | 44 19.91% | 9 7.09% |

p | value | 88 39.82% | 18 12.80% |

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For references, contact Sam Van Horne at Samuel.A.VanHorne@ChristianaCare.org

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Background Information
- Compensation
- Salaries for women physician researchers were lower than what men earned even after adjusting for work performed (Jagsi et al., 2013)
- Women physicians earned 2.5% less than men physicians (Stompro, 2013)
- Women surgery residents expected a lower salary than male peers (Gray et al. 2013)
- Leadership and Professional Advancement
- 0% of respondents perceived gender discrimination (Adams et al., 2017)
- Women physicians were underrepresented as speakers in medical conferences (Russo et al., 2019)
- Women physicians reported maternal discrimination that obstructed career advancement (Ruzycki et al., 2019)
- Women physicians were underrepresented as authors of research in medical journals (Jagsi et al., 2013)
- Successful interventions to Promote Gender Equity
- Correcting Salary Inequities
- Identity-conscious salary corrections (Wright et al, 2007)
- Women in Medicine and Health Science (WIMHS) (Bauman et al., 2015)

Activities of Task Force in Department of Surgery
- Compensation analysis was performed for all employed physicians by a third party.
- Human Resources has shared the task force's compensation philosophy, including target percentiles based on comparable national averages and incentives based on factors such as education, experience, market dynamics, and internal equity.
- Networking Events
- This meeting allows female surgeons at our institution to get to know each other better, allowing for sponsorship and mentorship opportunities.
- There will be a series of networking events for female surgeons which will include a speaker as well as open time for networking/mentoring opportunities beginning in September 2019.
- The first networking event is to highlight the new women physician hires in surgery and surgical subspecialties. Two surgeons are putting together sessions with topics such as how to balance life work as a surgeon.
- Activities to promote culture change
- Make the culture of the OR more supportive of women surgeons.
- Meeting with all of the surgical specialties to discuss implicit bias, gender equity, and collaborative ideas.
- Ombuds Role
- The purpose of the Ombuds would be to provide a confidential resource for caregivers who are experiencing a work-related problem.
- Organizations is currently looking into the feasibility of having such a position.
- There are challenges related to confidentiality.
- Becoming a signatory to TIME'S UP Healthcare
- Demonstrate commitment to gender equality in the work environment.
- CCCHS has decided to become a signatory to TIME'S UP.

Conclusions / Next Steps
- Conclusions from the Survey
- Women physicians who are full time are more likely to have a partner who works full time outside of the home. These differences in work/life arrangements contribute to the “second shift” phenomenon.
- Women physicians not living with children reported lower amounts of control, compared with women living with children. Women physicians may have protections built into their schedule that prevent them from taking on extra work.
- There are sizeable differences between the mean scores on the “Quality of Leadership” and “Alignment of Values” between men and women surgeons. It is hoped that the activities of the task force can help to ameliorate these differences.
- Preliminary Conclusions and Lessons learned from Task Force
- Essential to have a physician representation and involvement of system leadership.
- Difficult to have transparent discussions of salaries and how they differ for women and men physicians with similar responsibilities.
- Implementing an Ombuds role involves detailed discussions with multiple stakeholders to ensure a position can be created that is a true confidant.

Next Steps
- Expand successful strategies to other units in the system.
- Continue to use the Provider Wellbeing Survey to examine outcomes of women physicians and their perceptions of leadership.
- Continue using our focus group interventions (such as Hot Spotting), facilitated by the Center for Provider Wellbeing, to identify obstacles to gender equality.

Table of Statistics Related to Family and Work Arrangement (2019 Results)

Center for Provider Wellbeing
Joy in a Primary Care Clinic: Work-Related Factors

Courtney Goetz¹, Sukhesh Sudan¹, Judy Arnetz¹, John Vanschagen¹,², Frederic Reyelts³, Bengt Arnetz¹

¹Michigan State University, East Lansing, MI; ²Mercy Health, Grand Rapids, MI

Abstract

Background: This study examined factors that influence joy in a primary care clinic. Joy was operationalized as a combination of positive experiences and satisfaction. The authors hypothesized that joy would be positively correlated with measures of individual and organizational factors. Multiple regression analysis of all variables was used to determine their predictive power on joy. The findings suggest that individual factors are the most important contributors to joy, with organizational factors playing a smaller role.

Results

Joy was significantly correlated with individual factors, such as energy, skills, and work experience. Organizational factors, such as clinic environment, were also found to influence joy, but to a lesser extent. The regression model explained 77% of the variance in joy. These results suggest that interventions aimed at improving individual factors may have the greatest impact on increasing joy in the workplace.

Learning Objectives

1. Identify malleable workplace factors that influence joy.
2. Examine a conceptual model of healthcare workplace joy.
3. Identify possible intervention strategies to achieve higher workplace joy.

Figure 1: Conceptual model of healthcare workplace joy.

Figure 2: Efficiency-focused primary care intervention.

Figure 3: Frequency distribution of ratings of joy at work.

Figure 4: Time trend of joy vs. documented efficiency during intervention period.

Table 1: Linear regression for individual, organizational, and quality related variables associated with joy (β values).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>Standard Error</th>
<th>t-value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy</td>
<td>0.233**</td>
<td>0.09</td>
<td>2.58</td>
<td>.01</td>
</tr>
<tr>
<td>Skills</td>
<td>0.24*</td>
<td>0.11</td>
<td>2.13</td>
<td>.04</td>
</tr>
<tr>
<td>Subjective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic environment</td>
<td>0.10</td>
<td>0.05</td>
<td>2.00</td>
<td>.05</td>
</tr>
<tr>
<td>Quality of care</td>
<td>0.420**</td>
<td>0.10</td>
<td>4.20</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

*p ≤ .05, **p ≤ .01

Conclusion

The findings suggest that interventions aimed at improving individual factors, such as energy and skills, may have the greatest impact on increasing joy in the workplace. Organizational factors, such as clinic environment, also play a role but to a lesser extent. Future research should focus on developing specific interventions to address these factors.
AMA Practice Transformation Initiative: Solutions to Increase Joy in Medicine™

Colleen McLoughlin, MPH, Bernadette Lim, Nancy Nankivil – American Medical Association

Learning Objectives
• Evaluate professional satisfaction and test workflow redesign that supports improvement in practice efficiency.
• Understand the framework of practice transformation by means of research, interventions, and assessment.
• Identify methods to support practice transformation that promote clinician well-being, improve patient experience, result in better outcomes, and lower cost.

AMA PTI Program Background
We acknowledge the prevalence, systematic causes, and consequences of burnout on physicians and the care team, while recognizing the lack of knowledge and research regarding solutions that address professional well-being.

 AMA Practice Transformation Initiative

Joy in Medicine™ Conceptual Model

Work Load

Work Environment

Solutions

Impact / Consequences

CAUSE

Frequency / Prevalence

Research Trajectory

Methods
Our conceptual model evaluates the balance between workload and work environment. Within each health system, research will involve a case/control design. Health systems will implement at least one identified practice efficiency intervention selected from AMA STEPS Forward™ around workload and workflow enhancements. Along with pre, interim and post measurement of well-being using the Mini-Z burnout assessment, health systems will also provide other data sources, such as work after work metrics, to further evaluate the impact of the intervention.

Results
This project is ongoing and final outcome results will be available in 2020. Results thus far relate to planning, application, and selection process.

2018 Request for Applications (Pilot)
21 organizations invited to apply -> 12 applications received (57% submission rate)
2 sites selected

2019 Request for Applications
33 organizations invited to apply -> 21 applications received (63% submission rate)
8 organizations selected

Conclusions
The goal is to publish and disseminate evidence-based information regarding the impact of studied interventions on physician well-being. Furthermore, we will promote professional well-being assessment as a standard for effective and sustainable practice transformation.
## Introduction

- Reduced satisfaction in the patient care arena is leading to an exodus of healthcare providers, coinciding at a time when more clinicians are in an employed status.
- Healthcare for all has largely become a reality, but future services could be endangered if clinician turnover trends continue.
- Lovelace Medical Group (LMG)—a growing multi-specialty group of 140+ clinicians in the Southwest noted high levels of clinician turnover, particularly in primary care since its purchase by a large health system in 2013.
- The result for patients was disrupted access and continuity of care; increased patient complaints.
- Providers shouldered increased patient load left by these disruptions, further increasing the risk of burnout.

## Objective

As part of the Quadruple Aim, improve the well-being of LMG clinicians by addressing irritation points contributing to reduced work satisfaction and burnout.

## Processes

- Administration commits to invest in burnout prevention.
- National burnout expert kicks off initiative at an all provider dinner meeting. Providers given copy of Drummond (2014) Stop Physician Burnout.
- Form guiding coalition/card of peers: physicians and NP/PA/CNs.
- Include 1 senior leadership member so decisions carry authority of management.
- Committee chooses chair, administration approves ¼ release time for work leading the initiative.
- Name/brand & develop logo for the group.

### Masiach’s Burnout Inventory (MBI) and Areas of Worklife Survey (AWS)

<table>
<thead>
<tr>
<th>License Purchase for Each Provider (~ $17.00 each)</th>
</tr>
</thead>
</table>

## Results

- 67 of 140 providers (MD/DO/DPM/NP/PA/CNM) across the specialties completed the MBI/AWS in May 2018 for a total response rate of 47.8%.
- Primary Care (71%) and Women’s Health (58%) responses accounted for most robust return rates correlating with areas of clinician turnover.
- Burnout symptoms: primary care 85%; women’s health 70% (answering ≥ 1 “emotional exhaustion” question at level 4 (once/wk).

## Actions

<table>
<thead>
<tr>
<th>EMR: Multiple log ins</th>
<th>Fast Pass</th>
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<tbody>
<tr>
<td>Getting help</td>
<td>Help Tickets</td>
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<th>Control</th>
<th>Quarterly provider-centric manager 1:1’s</th>
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<tr>
<td>Communication</td>
<td>Senior leadership rounds</td>
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<td>Life Savers monthly newsletter spot</td>
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<tr>
<th>Reward/Recognition</th>
<th>Promote collegiality: Quarterly socials</th>
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<td></td>
<td>Crisis/Help Sheet</td>
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## Future Directions

- Year 2: Focus changed from burnout prevention to provider advocacy.
- Develop process for providers experiencing burnout.
- Create 5 minute video introduction to EAP resources. Include personal provider testimonials.
- Collect coaching resources for providers in need.
- Outlook/email class for providers to improve communication.
Promoting A Healthy Workforce: Development and Implementation of a Statewide Program for Medical Student Well-being

Alexandria Polles, MD, ABPN, ABAM; Lisa J. Merlo, PhD, MPE

Methods (continued)

PRN’s Board of Directors added two medical students (DO and MD) to its Advisory Board, supporting their travel and attendance at Board Meetings. The student representatives serve 2-year terms, with the approval of their medical schools, with a goal of providing true peer support for student participants.

A financial hardship fund to cover the cost of independent evaluations for students was jointly supported by the DOH and the medical schools to decrease the burden that extensive and thorough evaluations can entail. Eligibility is determined by the individual schools.

Several program-approved evaluators agreed to a 30-day delay in payment and to discounted rates for students.

Results

PRN has seen increased referrals from 2 students in 2006 to 23 active student participants in 2018-2019.

This reflects and increase in the number of medical schools referring students from 3 programs in 2009 to 10 programs by 2019.

Since the initiation of the medical student hardship fund on 6/21/18, 17 medical students have been referred to PRN, with 16 taking advantage of the fund.

The primary diagnoses of all students (medical and other health professions) is represented below:

Conclusions

Improving medical student access to PHP services is one way to benefit the future physician workforce, by promoting early referral/intervention for students with potentially-impairing conditions.

Establishing medical student access to PHP services may require collaboration and cooperation between multiple entities (e.g., the PHP, medical schools, state legislature, state medical association, Department of Health and/or Board of Medicine).

The financial cost of PHP participation is a significant barrier to student access; however, establishing a financial assistance fund can help to relieve this burden.

Students who participate in PHP services report personal and professional benefit, even when taking into account the required investment of time and money.
Promotion of SELF CARE Practices Through a Group-wide Day of Volunteerism

Corresponding author: Richele Thornburg, MS
Co-authors: David Bell, MD; Lois Chiu, MD; Benjamin Chun, MD; Patricia Cole; Joshua Fouts, BCBA-D; Lois Gregg, MD; Peggy Latore, MD; Burt Moritz, MD; Scott Nishikawa, MD; Kimmie Ouchi, MD

Relation to conference theme:
SELF CARE initiative demonstrates the commitment of our physician-led medical group to improving the health of its providers through its SELF CARE model. This model is formulated on eight evidence-based practices, proven to have a positive impact on personal resilience and wellness.

Learning objectives:
To encourage broader connections with community and colleagues and promote SELF CARE practices through an Annual Day of Service.

Methods/approach:
Employees of our organization, along with family and guests, partnered with local non-profits supporting educational programs to preserve Hawaii’s cultural traditions, environmental/ecological systems, and promote economic/agricultural sustainability.

Results:
Nearly 1100 volunteers across eight sites on four islands participated in the Annual Day of Service, with > 95% of those surveyed rating the experience as “good” or “excellent.”

Conclusion:
Our Annual Day of Service is an enriching, fulfilling, and rewarding experience of volunteerism and partnership for physicians fulfilling our mission to improve the health of the communities we serve, and has been a fruitful investment inspiring SELF CARE practices at work, in the home, and in the broader community.

Project objective/background:
Starting in 2010, our medical group has hosted an Annual Day of Service on the Martin Luther King Jr. holiday, enhancing physician connections in communities we serve. Since 2017, it has served as a time to promote the SELF CARE practices of personal resilience, an aim of the Stanford WellMD Model. The January 21, 2019 event was themed “hoʻokuʻikahi” (to unify), speaking to cultural, professional, and personal bonds that form when individuals from diverse backgrounds come together for a common goal.

Programs were set in mountain/coastal portions of ahupuaʻa (traditional and historical wedge-shaped land divisions from mountains to sea) on Oahu, Maui, Hawaii Island, and Kauai. Activities included: preparation/maintenance of loʻi (terraced patches used to farm taro, a critical staple of the Hawaiian agricultural society), restoration of native forests, removal of invasive species, planting native species, restoration of ancient Hawaiian fishponds, removal of mangroves/invasive limu (algae), trail-building, and coastal/stream restoration.
The Impact of Physician/Colleague Testimonials on a Culture of Wellness

Corresponding author: Peggy Latare, MD Co-authors: David Bell, MD; Lois Chiu, MD; Benjamin Chun, MD; Patricia Cole; Joshua Fouts, BCBA-D; Lois Gregg, MD; Burt Moritz, MD; Scott Nishikawa, MD; Kimmie Ouchi, MD; Richele Thornburg, MS

Relation to conference theme:
Using a personal testimonial from a colleague who had a health journey has added a powerful message to our medical group’s professional development programs: we need to take care of ourselves and each other. Creating a culture of wellness is part of the strategy, and finding ways to “activate” individual commitment to their own health is key.

A culture of wellness is foundational in the Stanford WellMD model of physician well-being and professional fulfillment. Inclusion of opportunities to promote self-care values and behaviors, including compassion for self and colleagues, is important within the organizational work environment.

In our 2018 Quality of Work Life Survey, 97% agreed that we provide an environment that supports health and wellness, trending up from 89% in 2016. Similarly, 87% felt satisfied with the way they were currently taking care of their own health, up from 77% in 2016.

Methods/Approach:

Use of physician/professional colleague testimonials in group-wide professional meeting to develop empathy, demonstrate investment by leadership in provider well-being and engage individuals in promoting healthy self care behaviors.

As part of our medical group’s mission to make our group the “Best Place to Work, Deliver and Receive Care,” we have hosted three Professional Development Days (PDDs) over the past four years dedicated to physician health and wellness. The most recent Health and Wellness PDD in June 2019 was attended by over 500 physicians, providers and staff.

In each meeting, after the President and Executive Medical Director highlighted the Institute for Healthcare Improvement’s “Quadruple Aim” and the necessity of care of the provider in meeting the challenges of healthcare delivery today, an inspirational testimonial of resiliency from a physician colleague was presented, which navigated their personal journey through a career, personal or health challenge.

With 78% of physicians reporting at least some symptoms of professional burnout, increasing numbers of physicians at risk for reducing work hours or leaving medicine entirely (http://www.massmed.org/News-and-Publications/MMS-News-Releases/Physician-Burnout-Report-2018/), and the highest suicide rate of any profession – over twice that of the general population (American Psychiatric Association (APA) 2018) – the executive leadership felt it critically important to reinforce a supportive professional environment without stigma or obstacles to seeking appropriate care and treatment. Further, these personal messages served to further develop empathy and mindfulness for our colleagues and ourselves.

The testimonials also helped to introduce incentive measures for that year: in 2015, viewing of a video outlining SELF CARE practices for personal and professional resilience, followed by attestation of mindful engagement in at least two areas of SELF CARE over a 3-month period. In 2017 and 2018, attention to, and closure of, individual health maintenance and preventive care gaps.

Results:
In our 2018 Quality of Work Life Survey, 97% agreed that we provide an environment that supports health and wellness, trending up from 89% in 2016. Similarly, 87% felt satisfied with the way they were currently taking care of their own health, up from 77% in 2016.

Conclusion:
Personal testimonials of resilience in both personal or professional challenges shared by physician colleagues in the setting of a professional meeting sponsored by Executive Leadership, is an effective and impactful way to foster awareness of the critical need for care of the caregiver, as well as supporting a destigmatized culture of wellness in a health care delivery organization.

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Background
Given widespread levels of burnout among surgery residents, this study measured the impact of an abbreviated Mindful Self-compassion course on resident wellbeing.
Mindful Self-compassion raises awareness of self-criticism and teaches kindness toward self.
Courses that teach mindfulness and self-compassion skills have been found to lower depression, stress, anxiety, and burnout.

Mindful Self-compassion Tenets
- Self Kindness
- Common Humanity
- Mindfulness

Methods
Surgery residents completed a 4-week (6-hour) Mindful Self-compassion course. Wellbeing was measured by pre and post course changes in the Maslach Burnout Inventory, Personal Health Questionnaire-9, Perceived Stress Scale, Spielberger State-Trait Anxiety Scale, Brief Resilience Scale, and the Short Self-compassion scale.
Based upon focus group data, the second iteration of the course was offered exclusively to first year residents.

Quantitative results
Within the first cohort (n=32), 100% met the Maslach scale criteria for burnout pre- and post-intervention. No pre-to-post intervention measure showed statistically significant changes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre to Post Intervention Change in Mean per Measure</th>
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<tbody>
<tr>
<td>Spielberger State-Trait Anxiety Scale (SP)</td>
<td>0.32 - 2.17</td>
</tr>
<tr>
<td>Maslach Burnout Inventory (PD)</td>
<td>0.22 - 0.61</td>
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<tr>
<td>Maslach Burnout Inventory (EE)</td>
<td>0.13 - 0.24</td>
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<tr>
<td>Maslach Burnout Inventory (PA)</td>
<td>-0.16 - 0.10</td>
</tr>
<tr>
<td>Short Self-compassion Scale</td>
<td>-0.10 - 0.40</td>
</tr>
<tr>
<td>Brief Resilience Scale</td>
<td>0.01 - 0.12</td>
</tr>
<tr>
<td>Personal Health Questionnaire-9 (PHQ-9)</td>
<td>0.16 - 0.32</td>
</tr>
<tr>
<td>Perceived Stress Scale</td>
<td>0.09 - 0.12</td>
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</tbody>
</table>

Results: First Cohort
- “The reason this is all so uncomfortable is that we were bad at it.”
- “The initiative to try to help us meant a lot”
- “Younger residents couldn’t be vulnerable with chiefs in the room.”
- “I didn’t fit and didn’t translate well”
- “I can’t believe it actually happened. It was kind of amazing. Not perfect, but amazing.”
- “The discrepancy in power level is disconcerting”
- “Maybe I am too far gone at this point.”

Results: Second Cohort
- “Really looked forward to it and it was also a bonding experience with our co residents”
- “I don’t know how we got that food, but that was sooo nice”
- “I think everyone can benefit from this”
- “Time to sit down and think about how I am feeling”
- “Our pagers were always going off, so it was a little disruptive”
- “It was amazing to be able to come here... I am so sad this is over”

Conclusions
Physician burnout is a pervasive and systemic problem. This study highlights the importance of focus group data to reveal nuances in participant experience. These nuances were not captured by quantitative measures of wellbeing. Qualitative findings suggest that limiting the course to first year surgery residents created an environment where residents were more receptive to learning mindful self-compassion skills.

Acknowledgements: Well-Being Program, UNC-CH; Department of Surgery, UNC-CH; NIH T32 Postdoctoral Research Fellowship