The following workshop presentations are from the 2019 American Conference on Physician Health. Presentations included were at the discretion of the author.
HOT-SPOTTING: Making it Safer to Share and to Receive Difficult Feedback

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September 19, 2019
Disclosures

• No disclosures
Agenda

• Why Hot-Spotting?
• Overview of Hot-Spotting
• Phases of the Hot-Spotting Process
  – Activity #1: Discovery & Readiness
  – Activity #2: Sorting through the Feedback
• Q&A
Why Hot-Spotting?

- Identify environmental, cultural and systemic challenges to wellbeing

- Feedback can be scary for leaders and members of the team
What if they bring up things that are out of my control...will that make me appear weak or ineffective?

Will my boss think that I am a complainer if I bring problems forward?

How do I tell my boss that the new process she implemented is not working and making everyone’s job harder?

What if they say horrible things about me and my boss finds out?

Will my boss think that I am a complainer if I bring problems forward?
Overview of Hot-Spotting

• Focus-group based intervention

• Provide Leaders with feedback/recommendations that are:
  – Customized
  – Actionable
  – Based on team’s feedback
  – Timely/Relevant

• 30+ Sessions since September 2017
Primary Hot-Spotting Audience:

- Residents & fellows
- Medical-Dental Staff
  - Employed/Community
  - Ambulatory/Acute
  - Physicians/APCs

We have successfully utilized hot-spotting with all of these sub-groups of our provider population.
Phases of the Hot-Spotting Process

1. Initiate
2. Discovery & “Informed Consent”
3. Prep/Planning
4. Focus Group
5. Co-Develop Recommendations
6. Communication
7. Facilitate Remediation
8. Follow-up

Ongoing Leadership Development Coaching Provided

Draft Report
Final Report

This intervention is based on the Listen-Act-Develop Model of Physician Engagement utilized and validated by Mayo. (Swenson et al., 2016; Shanafelt & Noseworthy, 2017)
Preparatory Steps

Most common reasons to initiate:
- Deep dive into annual wellbeing survey results
- Referrals from senior leadership

Goals of meeting with primary/supporting leaders:
- Confirm senior leaders are aware and supportive.
- Ensure the leader feels fully informed about the process before consenting to continue
- Discover information about the team
- **Unspoken Goal:**
  Gauging receptivity/readiness, contextual history
Interactive Activity #1: Discovery/Readiness
Leadership Development Coaching

Initiate
Discovery & "Informed Consent"
Prep/Planning
Focus Group
Co-Develop Recommendations
Communication
Facilitate Remediation
Follow-up

Ongoing Leadership Development Coaching Provided

Draft Report
Final Report
Leadership Development Coaching

- Initiate
- Discovery & “Informed Consent”
- Prep/Planning
- Focus Group
- Co-Develop Recommendations
- Communication
- Facilitate Remediation
- Follow-up

Ongoing Leadership Development Coaching Provided

Draft Report
Final Report

CHRISTIANA CARE HEALTH SYSTEM
Focus Group Sessions

• Proactively communicated to participants by the leader

• Target existing group meetings, no more than 1 hour

• Leaders are not present
  – Facilitated by Center for Provider Wellbeing
  – Comments are captured electronically but no audio recording

• Can be divided into multiple sessions
Focus Group Structure

- Introduction
- What aspects of your work are going well/rewarding?
- What aspects of your work are frustrating or dissatisfying?
- Short-term and long-term recommendations to improve wellbeing and professional fulfillment?
- Thank you and next steps!

Driver Dimensions of Burnout (Shanafelt & Noseworthy, 2017)
Phases of the Hot-Spotting Process

- Initiate
- Discovery & "Informed Consent"
- Prep/Planning
- Focus Group
- Co-Develop Recommendations
- Communication
- Facilitate Remediation
- Follow-up

Ongoing Leadership Development Coaching Provided

Draft Report
Final Report
Draft Summary Report

• Report structure mirrors the session

• Be objective but don’t lose the “voice” of participants

• Collate themes within each section

• Sent to primary leader in 7-10 business days
Interactive Activity #2: Sorting through the Feedback
Phases of the Hot-Spotting Process

- Initiate
- Discovery & “Informed Consent”
- Prep/Planning
- Focus Group
- Co-Develop Recommendations
- Communication
- Facilitate Remediation
- Follow-up

Ongoing Leadership Development Coaching Provided

Draft Report
Final Report
Phases of the Hot-Spotting Process

Co-Develop Recommendations
- More historical context

Communication handled by Leader

Facilitate Remediation
- Delegate, delegate, delegate

Follow-up
- 30 days and 90 days
Phases of the Hot-Spotting Process

- Initiate
- Discovery & “Informed Consent”
- Prep/Planning
- Focus Group
- Co-Develop Recommendations
- Communication
- Facilitate Remediation
- Follow-up

Ongoing Leadership Development Coaching Provided

Draft Report
Final Report
Resources


Questions?
Resident Physician Wellbeing:

Seminal events and multi-level strategies to embed wellness and health into clinical learning environments

Mark Mason, PhD
Vanessa Downing, PhD
Center for Provider Wellbeing
Christiana Care Health System
Physician Burr

Gail Gazelle, MD1, Jr.
1Division of General Internal Medicine
Gen
Progi

Mental Health During Residency Training: Assessing the Barriers to Seeking Care

Alexandra L. Aaronson1 • Katherine Backes1 • Gaurav Agarwal1 • Joshua L. Goldstein1 • Joan Arata1

Abstract

Objectives: Resident and fellow physicians are at elevated risk for developing depression compared to the general population; however, they are also less likely to utilize mental health services. We sought to identify the barriers to seeking mental health treatment among residents across all specialties at a large academic medical center in Chicago, IL.

Methods: Residents and fellows from all programs were asked to complete an anonymous self-report questionnaire.

Results: Of the 18% of residents and fellows that completed the survey, 61% felt they would benefit from psychiatric services. Only 24% of those who felt they needed care actually sought treatment. The most commonly reported barriers to seeking care were lack of time (77%), concerns about confidentiality (67%), concerns about what others would think (58%), cost (56%), and concern for effect on one's ability to obtain licensure (50%).

Conclusions: Despite feeling that they require mental health services, few trainees actually sought care. This study identifies an overall need for improved access to mental health providers and psychoeducation for medical housestaff.

Keywords: Residency • Mental health services • Barriers • Physicians • Well-being • Stress

Residency and fellowship have long been thought to be exceptionally stressful times in a physician's career [1]. During training, long work hours [2] and financial hardship [3] are coupled with complicated and often emotionally difficult situations with patients as well as colleagues. Stress can lead to burnout—a constellation of symptoms including exhaustion, depersonalization, and decreased sense of personal accomplishment [4], which, previous studies have shown, affects 59-75% of householders [1, 2]. Stress can be insidious or exacerbate underlying tendencies towards mental illness. A meta-analysis of rates of depression among residents showed a prevalence of 28.8% [4]. The rates of both burnout and depression are significantly higher among residents and fellows than the general population [1, 7]. Suicide is the single most common reason for male physician mortality during training, and the second most common reason for female physician mortality during training [8]. Physicians later in their careers have shown to have higher completed suicide rates compared to the general population with male doctors at a 40% increased risk and female doctors at a 130% increased risk [9]. In addition to the morbidity and mortality associated with burnout and depression, residents who screened positively for depression have been shown to make more medical errors [10] than their nondepressed colleagues, meaning depression does not only put physicians at risk, it puts patients at risk as well.

There is little data on what percentage of physicians seek psychiatric care at any point during their careers; however, studies have shown fewer than 65% regularly see a primary care physician [11], suggesting an overall reluctance to seek treatment to avoid seeking preventative healthcare. One study of medical students at a large California medical center showed that of the students that met criteria for major depression, only 22% actually sought psychiatric care [12]. Given that housestaff generally have even less flexibility in their schedules than medical students and senior doctors, one might hypothesize that their rates of seeking any type of healthcare are even lower than either of these cohorts.

This study sought to determine what percentage of residents and fellows felt they would benefit from mental health care during training versus what percentage actually sought care. For those who did not seek care, we asked what barriers
Semi-truck crash spilis millions of bees onto Washington highway

Truck Crashes While Hauling 130 Million Bees - Geek.com
https://www.geek.com/culture/truck-crashes-while-hauling-130-million-bees-1791699/
Jun 12, 2019 - A semi-truck carrying 40,000 pounds of honey bees crashed...were called to deal with a somewhat unique highway accident this week.

Truck Carrying Millions of Bees Crashes on East Texas Highway...
https://modernfarmer.com/truck-carrying-millions-of-bees-crashes-on-east-texas-highway/
Jun 6, 2018 - But the honeybee isn't even native to the U.S., and wild bees are tricky to corral, so...
**Timeline**

**At a glance**

2016-2017

- **2016**
  - **Resident Wellbeing Committee** Established
  - **Wellness Rounds**
    - Quarterly pilot begins with FM & Surgery

- **2017**
  - **Winternfest**
    - Inaugural annual intensive
  - **Referral Helpline**
    - Create dedicated cell phone
  - **GMEC Meetings**
    - Psychologist presents
  - **Wellness Rounds Expanded**
    - 10 residencies & fellowships
  - **Wellness Rounds**
    - Quarterly pilot begins with FM & Surgery
  - **Seminal Event #1**
    - Repetitive themes
  - **JAN**
  - **JUL**
  - **FEB**
  - **MAR**
  - **MAY**
  - **JUL**
  - **SEP**
  - **DEC**
Wellness Rounds
Seminal Event #1

- Background/intentions
- Unintended consequences
- Problem statement
SEMINAL EVENT #1:

- Repetitive themes began to emerge in wellbeing rounds. Anticipated themes would be around resident “complaints” re: being too busy or overextended, but instead, they brought forth specific system- and learning-environment suggestions. But we told them the meetings would be CONFIDENTIAL!!!

- What would you do?
  - What is the dilemma
  - What is the desired outcome
  - Who else cares, could partner with you
  - How to transform this problem into possibility
Timeline
At a glance
2016-2018

2016
- Resident Wellbeing Committee Established

2016
- Wellness Rounds Quarterly pilot begins with FM & Surgery

2016
- Wellness Day ED specific
- Wellness Rounds Expanded 10 residencies & fellowships

2017
- Winternfest Inaugural annual intensive
- Referral Helpline Create dedicated cell phone

2017
- Inaugural Focus Groups Resident & fellows
- GMEC Meetings Psychologist presents

2017
- Wellness Goals Program specific data shared
- GMEC Announcement Focus group & wellbeing goals

2017
- Wellbeing Goals Program specific data shared
- Wellbeing Goals To be created in response to resident feedback/data

2018
- Seminal Event #1 Repetitive themes
- Seminal Event #2 Resident at risk

- Inaugural Focus Groups Resident & fellows
Resident in Crisis
Seminal Event #2

- Background
- Unclear/insufficient procedures
- Problem statement
SEMINAL EVENT #2:

• Received an emergency call from a PD about a resident with suicidal ideation and intent. PD uncertain how to handle, unhappy with policy in place which involved constables & public escort to ED, potential lack of privacy and dignity. Uncertainty about reporting requirements, institutional response, confidentiality concerns in terms of return to work, fitness for duty.

• What would you do?
  • What are the dilemma(s)
  • What is the desired outcome
  • Who else cares, could partner with you
  • How to transform this problem into possibility
Timeline
At a glance
2016-2019

2016
- Resident Wellbeing Committee Established
- Wellness Rounds
  - Quarterly pilot begins with FM & Surgery
- Winternfest
  - Inaugural annual intensive
- Referral Helpline
  - ED specific
  - Create dedicated cell phone
- Wellness Rounds
  - Expanded
  - 10 residencies & fellowships

2017
- Wellness Day
  - ED specific
- GMEC Meetings
  - Psychologist presents
- Seminal Event #1
  - Repetitive themes
- Inaugural Focus Groups
  - Resident & fellows
- Wellbeing Goals Announcement
  - Focus group & wellbeing goals
- PD Support Needed
  - For confidential concerns
  - For confidential concerns
- Isolation/Distress
  - Expressed by Program Directors

2018
- Inaugural Focus Groups
  - Resident & fellows
- Wellbeing Goals
  - To be created in response to data
- Plan Focus Groups
  - Alternate years for Program Directors & residents/fellows
- Wellbeing Goals Finalized for annual program evaluation
- Wellness Rounds
  - Expanded
  - 14 residencies & fellowships
- Wellbeing Goals
  - Finalized for annual program evaluation

2019
- Winternfest
  - Inaugural annual intensive
- Wellness Rounds
  - Expanded
  - 17 residencies & fellowships
- PD Support Needed
  - For confidential concerns
  - For confidential concerns
- Seminal Event #2
  - Resident at risk
Comprehensive Wellbeing Strategy for Clinical Learning Environment: 2016-2019

Wellbeing Education
- Quarterly Wellbeing Sessions for 13 Residency Programs
- Annual Intern Wellbeing Intensive
- Balint Groups for residents
- Reflective Writing Workshops
- Career Development Panels
- Reflective groups for Faculty

Efficiency of Practice
- Bi-Annual Resident Focus Groups
- Bi-monthly GMEC wellness presentations
- EMR Optimization/Making Tomorrow Happen Project

Response to Resident Crises
- Resource Liaison Line/Clearinghouse to Mental Health Services
- EAP program for emergency and mental health resources
- Peer Support Program
- Provider Litigation Program
- GMEC and Hospital Crisis Policy Enhancement

Culture of Well-being
- Annual Performance Evaluation Wellness goals for residency programs
- Resident Wellbeing Committee(s)
  - Program/CCHS
- Resident Council representative
- Psychological/learning assessment services
- Resident retreats (OB/GYN, IM, EM)
- Residents' Day
- Individual well-being screenings and self-assessments

Key:
Black = Current State
Orange = Pending/Pending State
YOUR EVENT:
- What happened?
- Why is it a problem?
- Who else cares?
- Aspirational goal?
Lessons Learned
From the C-Suite to the Dean’s Office
Strategic Partnerships for Organizational Well-Being

Larissa Thomas, MD, MPH
Jonathan Ripp, MD, MPH
Saadia Akhtar, MD
Why All the Attention Now?

Addressing Physician Well-Being

– The Moral Imperative

– The Tragic Episode

– The ACGME requirement

– The Business Case
Is There a Problem Here?

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Medical students, ages 22–32 (n = 4,032)</th>
<th>Population, college graduates, ages 22–32 (n = 736)</th>
<th>Population, college graduates, ages 27–40 (n = 1,489)</th>
<th>Residents/fellows, ages 27–40 (n = 992)</th>
<th>Early career physicians, ages 31–47 (n = 806)</th>
<th>Population, employed, ages 31–47 (n = 1,832)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burned out(^1)</td>
<td>1,976 (49.6)</td>
<td>573 (35.7)</td>
<td>&lt;.0001</td>
<td>739 (50.0)</td>
<td>.0001</td>
<td>297 (37.3)</td>
</tr>
<tr>
<td>Screened positive for depression, no. (%)</td>
<td>2,337 (58.0)</td>
<td>761 (47.5)</td>
<td>&lt;.0001</td>
<td>753 (50.7)</td>
<td>&lt;.0001</td>
<td>319 (39.9)</td>
</tr>
<tr>
<td>Suicidal ideation in the last 12 months, no. (%)</td>
<td>375 (9.3)</td>
<td>171 (10.6)</td>
<td>.25</td>
<td>120 (8.1)</td>
<td>.58</td>
<td>53 (6.6)</td>
</tr>
</tbody>
</table>

TABLE 2. Physician Burnout, Depression, Career Satisfaction, and Satisfaction With Work-Life Integration in 2017 Compared With 2014 and 2011\(^{a,b}\)

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Burned out(^1)</td>
<td>2147/4893 (43.9)</td>
<td>3680/7676 (45.4)</td>
<td>3310/7227 (45.8)</td>
<td>&lt;.001</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Depression</td>
<td>2022/4854 (41.7)</td>
<td>2715/6818 (39.8)</td>
<td>2753/7213 (38.2)</td>
<td>.05</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Figure 1. Physician Burnout: It Just Keeps Getting Worse. Medscape. Jan 26, 2015.

Percentage of burned-out physicians by specialty.

FIGURE 1. Burnout (A) and satisfaction with WLB (B) by specialty 2014 vs 2011. For 1A and 1B, specialty discipline is shown on the y-axis and burnout (A) and satisfaction with WLB (B) are shown on the x-axis. For 1C, satisfaction with WLB is shown on the y-axis and burnout on the x-axis. GIM = general internal medicine; OB/GYN = obstetrics and gynecology; PM&R = physical medicine and rehabilitation; Prev = Preventive medicine; occupational medicine, or environmental medicine; WLB = work-life balance. *p<.05 from comparison 2014 to 2011.
Consequences of Job Burnout

FIGURE 1. Personal and professional repercussions of physician burnout.

- Personal: Broken relationships, Alcohol and substance use, Depression, Suicide
- Professional: Decreased quality of care and increased medical errors, Decreased patient satisfaction, Decreased productivity and professional effort, Physician turnover
The Moral Imperative
Kathryn
David Muller, M.D.

The Opinion Pages | OP-ED CONTRIBUTOR

Why Do Doctors Commit Suicide?

By PRANAY SINHA   SEPT. 4, 2014
The ACGME Requirement

ACGME Common Program Requirements
Section VI
Proposed Major Revisions

• Increased Administrative Support
• Attention to Work Intensity and Compression
• Excusal for residents to receive medical care during scheduled work
• Provision of tools for MDD/suicide self-screening + 24/7 MH resources
The Business Case

Professional Satisfaction and the Career Plans of US Physicians

Christine A. Sinsky, MD; Lotte N. Dyrbye, MD, MHPE; Colin P. West, MD, PhD; Daniel Satele, MS; Michael Tutty, PhD; and Tait D. Shanafelt, MD

- Aug-Oct 2014; ~36,000 MDs contacted; 6,880 (~19%) RR
  - 20% likely/definite decrease clinical effort in next year
  - 27% likely/definite to leave current practice in next 2 years
  - 2% planned to leave the profession altogether
  - BO predicted intent to reduce effort or leave practice
    (OR 1.81, 1.49-2.19, p<0.001)


AMERICAN CONFERENCE ON PHYSICIAN HEALTH ACPH 2019
### The Business Case

#### Figure 2. Worksheet to Project Organizational Cost of Physician Burnout

<table>
<thead>
<tr>
<th>1. Input data:</th>
<th>Enter values</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = No. of physicians at your center</td>
<td>a</td>
</tr>
<tr>
<td>BO = Rate of burnout of physicians at your center</td>
<td>b</td>
</tr>
<tr>
<td>TO = Current turnover rate per year</td>
<td>c</td>
</tr>
<tr>
<td>C = Cost of turnover per physician</td>
<td>d</td>
</tr>
</tbody>
</table>

#### Calculations:

**Estimated Cost of Physician Turnover Attributable to Burnout**

- **A.** TO without burnout (solve for TO without burnout):
  
  \[ \text{TO without burnout} = \frac{\text{TO}}{1 + \text{BO}} \]

  \[ \text{Simplified formula:} \]
  
  \[ \text{TO without burnout} = \text{TO}(1 + \text{BO}) \]

- **B.** Projected No. of physicians turning over per year due to burnout:
  
  (solve using input variables and TO without burnout value from step A):

  \[ \text{Simplified formula:} \]
  
  \[ \text{No. of physicians turning over due to burnout per year} = \text{TO} - \text{TO without burnout} = N \]

- **C.** Projected cost of physician turnover per year due to burnout (solve using input variables and No. of physicians turning over due to burnout per year from step B):

  \[ \text{Estimated cost of turnover due to burnout} = C \times \text{No. of physicians turning over due to burnout per year} \]

**Example Using N = 450; BO = 50%; TO = 7.5%; C = $50,000**

- **A.** TO without burnout:
  
  \[ 0.975 = \frac{\text{TO}}{1 - 0.5} + \frac{0.5}{1.5} \times \frac{\text{TO}}{1 - 0.5} \]
  
  \[ 0.975 = 0.95 \times \text{TO} + 0.5 \times \text{TO} \]
  
  \[ \text{TO} = 11.25 \]

- **B.** No. of physicians turning over per year due to burnout:
  
  \[ \text{No. of physicians turning over due to burnout per year} = 450 \]

- **C.** Projected cost of physician turnover per year due to burnout:
  
  \[ \text{Estimated cost of turnover due to burnout} = 50 \times 11.25 = $562,500 \]

#### Figure 3. Worksheet to Determine Return on Investment (ROI) in Reduced Turnover Costs Resulting From Intervention to Reduce Physician Burnout (BO)

1. **Input data:**
   - \( CB = \text{Estimated cost of turnover due to physician burnout} \)
   - \( CI = \text{Cost of intervention per year} \)
   - \( R = \text{Relative reduction in BO} \)

2. **Calculations:**

- **ROI**

  \[ \text{A. Savings due to reduced BO:} \]
  
  \[ \text{Formula:} \]
  
  \[ \text{Savings due to reduced BO} = (\text{CB} - \text{R}) \]

  \[ \text{B. ROI:} \]
  
  \[ \text{Formula:} \]
  
  \[ \text{ROI} = \frac{(\text{Savings due to reduced BO} - \text{CI})}{\text{CI}} \]

**Example Using CB = $5,625,000; CI = $1,000,000; R = 20%**

- **A.** Savings due to reduced BO:
  
  \[ \text{Savings due to reduced BO} = 5,625,000 \times 0.20 = $1,125,000 \]

- **B.** ROI:
  
  \[ \text{ROI} = \frac{(1,125,000 - 1,000,000)}{1,000,000} = 12.5\% \]
The Business Case

Figure 2. Worksheet to Project Organizational Cost of Physician Burnout

1. Input data:
   - N = No. of physicians at your center
   - BO = Rate of burnout of physicians at your center
   - TO = Current turnover rate per year
   - C = Cost of turnover per physician

2. Calculations:
   - Estimated Cost of Physician Turnover Attributable to Burnout

   A. TO without burnout (solve for TO without burnout):
      \[ \text{Formula} \]
      \[ \text{TO without burnout} = \text{TO} \div (1 + 0.5) \]

   B. Projected No. of physicians turning over per year (solve using input variables and TO without burnout):
      \[ \text{Formula} \]
      \[ \text{No. of physicians turning over due to burnout} = (\text{TO} - \text{TO without burnout}) \times N \]

   C. Projected cost of physician turnover per year due to burnout (solve using input variables and No. of physicians turning over due to burnout):
      \[ \text{Formula} \]
      \[ \text{Estimated cost of turnover due to burnout} = \text{C} \times \text{No. of physicians turning over due to burnout} \]

Example Using N = 450; BO = 50%; TO = 7.5%; C = $500,000

A. TO without burnout:
   \[ 0.075 = [\text{TO without burnout} \times (1 - 0.5)] + [(2 \times \text{TO without burnout}) \times 0.5] \]
   or \[ 0.075/(1 + 0.5) = 5\% \]

B. No. of physicians turning over due to burnout per year:
   \[ (0.075 - 0.05) \times 450 = 11.25 \]

C. Projected cost of physician turnover per year due to burnout:
   \[ $500,000 \times 11.25 = $5,625,000 \]
The Role of Chief Wellness Officer

- Listen
- Measure, Measure, Measure
- Improve Communication and Awareness
- Promote a Culture of Well-Being
- Advocate for Support Services
- Help Drive System Level Change
Reports to
Senior Leadership (CEO, President, or Dean)

Minimum Requirements
- Resources, including team members, to (i) implement and evaluate evidence-based interventions at the individual, group and system level; and (ii) ensures implementation and continuous feedback.
- Coordinates with other executive leaders (e.g., COO) to ensure well-being is prioritized and integrated into executive leadership activities.
- Works closely with marketing and/or communications team to ensure that community-wide messaging is supportive of the well-being for the community served.

Specific Responsibilities
- Provides strategic vision, planning, and direction to the development, implementation and evaluation initiatives to improve health and well-being outcomes
- Regularly monitors and reports outcomes, including measures of engagement, professional fulfillment, health and well-being, return on investment, value on investment, and tracks how they change with the introduction of interventions.
- Raises awareness and provides education about the impact of professional burnout and the benefit of building resiliency and coping skills in clinicians.
- Implements effective evidence-based individual-level interventions, group-level interventions and system-wide interventions
- Implements system-level interventions on efficiency of practice, participatory management, and empowering of healthcare professionals to develop their voice on culture
- Pursues advances well-being research efforts where appropriate.
- Coordinates and works with mental health leaders to decrease stigma and improve access to and awareness of mental health services.
- Creates a culture of wellness to improve organizational health and well-being at the system level.
- Conducts evidence-based quality improvement efforts that support chronic well-being.
- Oversees the business plan development for implementation and delivery of programs and services that support chronic well-being.

Caption: Chief Wellness Officer: Potential Requirements and Responsibilities

### Stages of Readiness for Change

<table>
<thead>
<tr>
<th>Novice</th>
<th>Beginner</th>
<th>Competent</th>
<th>Proficient</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Awareness</strong></td>
<td>Understand driver dimensions</td>
<td>Understand business case</td>
<td>Understand impact of well-being on organizational objectives</td>
<td>Well-being influences all major operational decisions</td>
</tr>
<tr>
<td>Wellness Committee</td>
<td>Peer support program</td>
<td>Practice redesign</td>
<td>Well-being considered in operational decisions</td>
<td>Chief Wellness Officer</td>
</tr>
<tr>
<td>Individual interventions (mindfulness, lifestyle initiatives)</td>
<td>Cross-sectional survey</td>
<td>Coaching resources</td>
<td>Funded well-being program</td>
<td>Strategic investment</td>
</tr>
<tr>
<td></td>
<td>Identification of struggling units</td>
<td>Regularly measure well-being</td>
<td>Leadership training</td>
<td>Knowledge creation</td>
</tr>
<tr>
<td></td>
<td>Well-being considered in organizational decisions</td>
<td>Work-unit level interventions</td>
<td>Assessment of systems interventions</td>
<td>Culture of wellness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opportunities for community-building</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Where is your organization?**

Adapted from Shanafelt *JAMA IM* 2017; 77(12): 1827
Office of Well-Being and Resilience at Icahn School of Medicine at Mount Sinai
Office of Well-being and Resilience at ISMMS

• “The Office of Well-being and Resilience believes that your professional fulfillment is essential to your well-being and the delivery of the best education, research, and patient care.”

• “Our mission is to drive change by promoting initiatives aimed at removing barriers to your well-being and reconnecting you with the meaning of your work.”
Meet Our OWBR Team

Jonathan Ripp, MD, MPH
Chief Wellness Officer
Senior Associate Dean for Well-Being and Resilience

Lauren Peccoralo, MD, MPH
Associate Dean for Faculty Well-Being and Resilience

Alicia Hurtado, MD
Associate Dean for Undergraduate Medical Education (UME) Well-Being and Resilience

Anu Anandaraja, MD, MPH
Senior Director, Office of Well-Being and Resilience

Saadia Akhtar, MD
Associate Dean for Graduate Medical Education (GME) Well-Being and Resilience

Basil Hanss, PhD
Associate Dean for Graduate School Well-Being and Resilience

Sharissa Rivera
Program Coordinator, Office of Well-Being and Resilience
OWBR Resident and Fellow Well-Being and Resilience Initiatives

- Policies
  - GME Wellness Days Policy
  - GME Expectations for the Promotion of Well-Being
  - GME Clinical Work Intensity Grants
  - EPIC optimization

- Wellbeing Skill-building
  - Mindfulness Training
  - Narrative Medicine Workshops
  - Facilitated Discussion Groups

- Survey
  - GME Resident and Fellow Well-Being Committee
  - Wellness Champions Program

2018 Survey
Residents and Fellows Across MSHS
- Meaning and Burnout
- Burden of Burnout
- Work-Life Integration
- Mental Health
- Program Well-Being Activities
Distributed to Chairs & Program Directors

AMERICAN CONFERENCE ON PHYSICIAN HEALTH
ACPH 2019
The UCSF Experience: A 3-Hospital System

All FACULTY at UCSF Health and ZSFG employed by UCSF SOM

Clinical staff employed by UCSF Health

Most STAFF employed by SF DPH, some SOM

All FACULTY at UCSF Health

Residents and fellows employed by UCSF SOM, some benefits site-specific

Faculty and staff employed by VA, faculty have UCSF academic appointments.

Diane Sliwka, MD
Chief Physician Experience Officer, UCSF Health

Jeff Critchfield, MD
Chief Medical Experience Officer, ZSFG

Larissa Thomas MD, MPH
Director of Well-being, UCSF GME (Report to Assoc Dean of GME)
The UCSF Experience: Landscape Assessment
The UCSF Experience: Landscape Assessment

What’s already going well?

<table>
<thead>
<tr>
<th>Pretty good</th>
<th>OK/neutral</th>
<th>Needs some work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common purpose</td>
<td>Goals</td>
<td>Creating knowledge</td>
</tr>
<tr>
<td>Achieving more</td>
<td>Plans</td>
<td>Promoting accountability</td>
</tr>
<tr>
<td>together</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connections/contacts</td>
<td>Adding value</td>
<td>Resources</td>
</tr>
<tr>
<td>Member skills</td>
<td>Working jointly</td>
<td></td>
</tr>
</tbody>
</table>
UCSF GME Well-being Committee Year 1: 2018-19

January:
Define the challenges

Feb-Apr
Identify approaches, get feedback

May:
Retreat, recommendations

Culture
- Define strengths and opportunities in UCSF GME culture
- Candidate deliverable: leader toolkit

Systems
- Define systems issues that cut across programs
- Candidate deliverable: best practice recommendations

Individual/Curriculum
- Identify current interventions and gaps
- Candidate deliverable: curriculum/resource hub

American Conference on Physician Health ACPH 2019
UCSF GME Well-being Priorities 2019-20

Scope definition! Actor vs advocate role

**Actor**: well-being committee has agency and responsibility

**Advocate**: well-being committee gathers information, liaises with responsible party, and follows up

- **Culture**
  - Identify Well-being Champions (CR and faculty)
  - Programmatic consultation

- **Systems**
  - Liaise with work hours taskforce and campus life
  - Address specific QOL issues
  - Align resident and faculty survey

- **Individual/ Curriculum**
  - Knowledge hub
  - Speaker bank
  - GME college train the trainer

- **Mental Health**
  - Feedback on new resources
  - Website/awareness of resources
Partnerships for Information-Gathering and Advocacy

Information-gathering

- Chief resident dinner
- Program reviews
- Resident and fellows council
- GME Well-being
- GMEC

Advocacy and follow-up

- GME Well-being
- SOM/OGME committees (work hours, DEI)
- Site based partners (CPEO)
- Campus life
- C Suites of ZSFG/UC Health
- GMEC
GME Alignment with Chief Physician Experience Work
Multiple Health Systems

Faculty-specific needs*
- Compensation models
- Balancing long-term academic and clinical needs

Residents and Fellows

Areas of alignment:
- Measurement
- Support for non-physician work and workflow/EHR optimization
- Improving culture of medicine (mistreatment)
- Mental health access and destigmatization
- Quality of life: benefits, commuting, etc.

GME-specific needs*
- ACGME requirements:
  - Work hours
  - Excusal to attend medical appointments
  - Requirement to reduce non-physician work
- Curricula
  - Skill-building
  - Professional identity transitions

* Potential areas for zero-sum challenges in limited-resource setting
What If Your Institution Doesn’t Have Designated Well-being Roles?

- **Identify Allies**
  - DIO/Dean
  - Program Directors
  - Department Chairs
  - C-Suite

- **Build Group Collaborations**
  - GME Well-being Committee
  - Departmental Wellness Champions

- **Make the Case**
  - Business case
  - ACGME requirements
  - Successful models from other institutions

- **Define the Scope**
  - Wider scope requires more resources FTE

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ACPH 2019
Activity: Practicing Partnerships and Making the Case

On Own

5 minutes:
Take notes for your role

At Tables

10 minutes: Role play
5 minutes: Debrief

Large Group

15 minutes:
Group representative describe takeaways

Questions for Individual Brainstorm:

• Is there an analogous person who would be in this role at your institution?
• What additional pressures do you anticipate the other parties will face?
• What is your ideal outcome?
• What are you OK settling for (best alternative)?
• What are your 2-3 talking points?
Solutions and Resources

- **ACGME**: [http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being](http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being)
  - Includes cost calculator and practice assessment tools
- **National Academy of Medicine Action Collaborative on Well-being**: [https://nam.edu/clinicianwellbeing/](https://nam.edu/clinicianwellbeing/)
- **CHARM GME Well-being Leaders Network**
- **CWO Network**
Thank you!

- Icahn SOM at Mount Sinai Office of Well-being and Resilience
- Diane Sliwka, Chief Physician Experience Officer, UCSF
- UCSF Office of Graduate Medical Education

- Contact:
  - larissa.thomas@ucsf.edu  Twitter: @LarissaThomasMD
  - saadia.akhtar@mountsinai.org
  - jonathan.ripp@mountsinai.org
Empowering Physicians To Create Change Within The Healthcare System

Sunny Smith MD
Clinical Professor, Family Medicine and Public Health
UC San Diego School of Medicine
Disclosures

- Certified Coach. Empowering Women Physicians Podcast, coaching, and retreats
Learning Objectives

• Define relationship between self-efficacy & well-being
• Describe the Listen Act Develop model to empower physicians to propose and implement change in organizations
• Identify that re-framing beliefs including the perception of self-efficacy may serve physicians re: ability to create and influence change
• List at least 1 action they could take to lead to systems-level change that may improve their own well-being and the well-being of others
• Define the scientific method to test one change and assess outcomes, then move forward iteratively for continuous improvement
Intro & why this matters

- Physicians
  - The most precious resource in healthcare
  - Unique societal role throughout history
Hippocrates

- Founder of Western medicine
- ~2500 years ago
- Diseases caused by natural causes
  - Not punishment of the gods or superstition
- Even discussed SDH
- We all took the Hippocratic Oath
Now being admitted to the profession of medicine, I solemnly pledge to dedicate my life in the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patient will be my first consideration. I will hold in confidence all that my patient confides in me.

I will maintain the honor and noble tradition of the medical profession. I will not permit consideration of race, gender, religion, nationality, ideology, or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life and its quality.

Even under threat, I will not use my knowledge contrary to the laws of humanity.

These promises I make freely and upon my honor.
“I WILL MAINTAIN THE UTMOST RESPECT FOR HUMAN LIFE AND ITS' QUALITY.”
Our unique place in history

Those who came before us

2009 American Recovery & Reinvestment Act
EHR, meaningful use. HITECH Act. $36 B.

Us

Unintended consequences

Those who will come after

ACPH 2019
The Cost of Technology

Toll E. The Cost of Technology.

https://www.nrm.org/

‘Hippocrates’ painting
By Robert Thorn
Getty Images

ACPH 2019
More time looking at screens than looking at our patients

- 142 primary care physicians for 3 years
- 11.4 hour day!
  - 5.9 hours on EHR
  - including 1.4 hours after clinic

Food for thought…

• Is the judge expected to be the court reporter?
Intern time motion studies

- Adapted by decreasing time spent with patients & educational activities
- 9-12% of inpatient time is spent with patients
  - Less than half than in 1990s
- 12% of their time is spent in direct patient care
  - Avg 3 hours out of 24 hour shifts

The human consequence...
Distress

- Burnout: ~50%
  - Emotional exhaustion
  - Depersonalization
  - Lack of sense of personal accomplishment
  - ...in reaction to adverse work conditions

- Christina Maslach PhD
  - 1971 Stanford Prison Experiment
Our strengths (& our weaknesses)

• Givers
• Healers
• Moral
• Sacrifice ourselves for others
• Perfectionistic
• Over achievers
Physician mindset

- Culture of self sacrifice
- Do whatever it takes
- There’s a light at the end of the tunnel
- I’ll be happy when… (arrival fallacy)
- Learned helplessness
  - No longer serves us
  - What got us here, won’t get us there
What do you think

- Given the current state of health care and practicing medicine
- What are your thoughts, beliefs, perceptions
What should we do?

• “Training of the mind”
Empathy & compassion

• Empathy
• Compassion
  – act to relieve suffering
  – Includes self-compassion
Change (Act to relieve suffering)

- Needed at all levels
- Individual
- Organizational unit
- Institution
- County
- State
- Country
Change talk

• It’s possible that…
• I’m learning that…
Tipping Point

- “Crisis”
- “Epidemic”
- Mainstream medical organizations & journals
- National Academy Of Medicine 2016
  - Formerly Institute of Medicine (who brought us To Err is Human)
  - Formed Action Collaborative on Clinician Wellness & Resilience
  - Network of over 150 organizations
  - Dzau et al. To Care Is Human - NEJM 2018.
- AAMC, ACGME
Listen, Act, Develop

Listen: Actively seek to identify & understand burnout drivers

Act: Empower physicians to develop & implement solutions to address top burnout driver in their work area

Develop: Develop physician leaders in the context of the improvement work

Repeat: Commit to continuous cycle of improvement, ID next round

Mayo Quality Fellows (>60% of clinic employees are quality fellows). 6000 quality projects – provider identified opportunities to address insufficiencies (physician, nurse, admin supported)

Physicians need

- Choice
- Camaraderie / Social Connectedness
- Excellence
Joy in Work

Institute of Healthcare Improvement
Created w Don Berwick

“What matters to you?” — enabling them to better understand the barriers to joy in work, and co-create meaningful, high-leverage strategies to address these issues.

Identify unique impediments in the LOCAL context – pebbles in their shoes.

Commit to a systems approach to making joy in work a shared responsibility at all levels of the organization - multidisciplinary team, shared responsibility, remove impediments.

Use improvement science to test approaches to improving joy in your organization – leaders and staff to accelerate improvement.

American Conference on Physician Health
ACPH 2019
The Scientific Method
Now your turn

• “It’s possible that I could make change”
• “I’m learning to see that physicians are the most perfectly positioned people to know what change is needed”
• “I’m learning that I have choices”
• “I’m going to stop sacrificing myself for others indefinitely”
• ”I don’t have to stay in learned helplessness anymore”
It’s possible I could…

- Brainstorm a few ideas
- Commit to at least one action
  - Consider allies locally
  - Exchange contact information here for national allies
Be the change you wish to see in the world.
Closing remarks

• This is perhaps the greatest task of our generation of physicians
• We are uniquely positioned to speak up and create change
• We must act to relieve suffering for ourselves & others
  – For now, for us, and for those that follow in our footsteps
Thank you

Contact info:

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sunny@empoweringwomenphysicians.com
Meeting Physicians Half Way: Launching Virtual Counseling for Providers

Damian Gennette, MDiv, LMHC & Ellie Rajcevich, MPA
Provider Wellness Program
MultiCare Health System
Disclosures

- No disclosures.
Learning Objectives

• Understand our journey to providing virtual counseling services to providers
• Conduct a gap analysis to identify the need for virtual counseling services within your organization
• Identify stakeholders who can support offering virtual counseling services to providers
Agenda

• Orientation to MultiCare’s Provider Wellness Program
• Overview of free, confidential counseling services
• Breakout
• Launching telehealth (virtual counseling) services
• Breakout
• Hatching your plan
MultiCare Health System

225 EMPLOYEES
14 CLINICS

6 HOSPITALS
1,050 EMPLOYED PHYSICIANS/PROVIDERS
1,397 LICENSED BEDS

650 EMPLOYEES
3 CAMPUSES

3 CAMPUSES
352 EMPLOYED PHYSICIANS/PROVIDERS
511 LICENSED BEDS

3,600 EMPLOYEES

2 HOSPITALS
86 CLINICS

*Licensed beds include CQN approved beds which may be under construction. Includes 150 beds approved as part of the Behavioral Health joint venture with CHI Franciscan Health anticipated to be operational December 2019.
Provider Wellness Team 2017-2018
Our Approach

Professional Fulfillment
- Culture of Wellness
- Efficiency of Practice
- Personal Resilience

AMERICAN CONFERENCE ON PHYSICIAN HEALTH
ACPH 2019
Our Vision

Partnering to support our physicians and advanced practice providers in achieving satisfaction, fulfillment and longevity in their practice
Provider Counseling Services

- Who?
- What?
- Where?
- Why?
Barriers

- Stigma
- Shame
- Fear of retaliation or discovery
- Fear of what you might find
- Time constraints
Counseling Considerations

- Legal
- Human Resources
- Senior leadership support
- IS&T
- Documentation considerations
- *Free, confidential*
Communication

- About counseling
- Referrals
Reasons for Referral

• Potential to harm self or others
• Substance use problems or addictions
• Domestic violence
• Serious depression
• Debilitating compulsions
Common Themes

- Work-life blend
- Work frustration
- Perfectionism
- Impostor Syndrome
- Addictions
- Anxiety
- Depression
Breakout: Defining Your Journey

• What are the needs and opportunities in your organization?

• What challenges might you have?
Provider Wellness Team 2017-2018

System Medical Group/Medical Operations Leadership Committee

Physician Executive

Practice Optimization Consultant

Practice Optimization Consultant

LMHC
MultiCare Health System

Provider Wellness

*Licensed beds include CON approved beds which may be under construction. Includes 130 beds approved as part of the Behavioral Health joint venture with CHI Franciscan Health anticipated to be operational December 2019.*
Enter: Virtual Counseling

• Reached out to our virtual health gurus to start the discussion
• Explored other options & parallel programs
  – EAP
  – Malpractice insurance
  – State/county medical society
Building the virtual platform

- Identified that our platform was secure & would meet our needs
- Identified licensure requirements & created accounts for team members as necessary
- Adjusted Consent to Receive Services & adjusted policies
- Trial and acclimate
- Create instructions to share with providers
Breakout session

• What next steps would you like to take to begin your counseling or tele-counseling offering?

• What kind of demand exists?
If you build it they will come

- Providers counseled virtually to date: 0
Our next steps

- Communicate!
- Continue to normalize the discussion of counseling needs for providers
- Continue to communicate & demonstrate that wellness is something we can all influence
  - Organization’s role is significant
Thank you! Questions & discussion please.

Ellie Rajcevich, MPA
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Damian Gennette, LMHC, MDiv
genneda@multicare.org
Measurement: A Key Driver of Sustainable Change

MARK ROSENBERG MD,FACP
BECCA HAWKINS MSN,ARNP
Mark Rosenberg and Becca Hawkins have no disclosures or conflicts of interest.
<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Caregivers</td>
<td>76,329</td>
<td>106,000</td>
<td>119,000</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>25,958</td>
<td>39,000</td>
<td>38,000</td>
</tr>
<tr>
<td>Employed physicians</td>
<td>3,579</td>
<td>23,000</td>
<td>25,000</td>
</tr>
<tr>
<td>Physician clinics</td>
<td>475</td>
<td>829</td>
<td>829</td>
</tr>
<tr>
<td>Acute care hospitals</td>
<td>34</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td>Providence Health Plan Members</td>
<td>500,941</td>
<td>1.9 Million</td>
<td>5 million</td>
</tr>
<tr>
<td>Locations</td>
<td>Alaska, Montana, Oregon, Washington &amp; California</td>
<td>+ Texas &amp; New Mexico</td>
<td>Same</td>
</tr>
</tbody>
</table>
Mission and Values of PSJH

Providence Mission Statement:
As people of Providence we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.

St. Joseph Vision Statement:
We bring people together to provide compassionate care, promote health improvement and create healthy communities.
Kotter’s Process for Leading Change

1. Increase Urgency
2. Build the Guiding Team
3. Get the Right Vision
4. Communicate for Buy-in
5. Empower Action
6. Create Short-term Wins
7. Don’t Let Up
8. Make it Stick

Crafting a climate for change
Engaging and enabling the whole organization
Implementing and sustaining change
Burnout by Specialty: 2011 Results

- Emergency medicine
- General internal medicine
- Neurology
- Family medicine
- Orthopedic surgery
- Anesthesiology
- Obstetrics & gynecology
- Radiology
- Physical medicine & rehabilitation

**Mean burnout among all physicians participating**

- General surgery
- Internal medicine subspecialty
- Ophthalmology
- Urology
- Psychiatry
- Neurosurgery
- Radiation oncology
- Pathology
- General pediatrics
- Dermatology

# Burnout in Healthcare

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
<th>Journal/Source</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (national survey)</td>
<td>54%</td>
<td>Mayo Clinic Proceedings</td>
<td>2014</td>
</tr>
<tr>
<td>Emergency Nurses</td>
<td>80%</td>
<td>Journal of Emergency Nursing</td>
<td>2010</td>
</tr>
<tr>
<td>ICU (Nurses and RT)</td>
<td>54%</td>
<td>Ind. Journal of Critical Care</td>
<td>2014</td>
</tr>
<tr>
<td>Ward RNs</td>
<td>47%</td>
<td>Journal of Nursing Management</td>
<td>2009</td>
</tr>
<tr>
<td>PT/OT</td>
<td>58%</td>
<td>Journal of Allied Health</td>
<td>2002</td>
</tr>
<tr>
<td>Mental Health Workers</td>
<td>21-67%</td>
<td>Admin. Policy Journal of Mental Health</td>
<td>2012</td>
</tr>
<tr>
<td>Social Work</td>
<td>75%</td>
<td>Journal of Social Service Research</td>
<td>2005</td>
</tr>
<tr>
<td>Chaplains</td>
<td>68%</td>
<td>Pastoral Psychology</td>
<td>2011</td>
</tr>
</tbody>
</table>
Caregiver Burnout Impacts the Quadruple Aim

**Quality/Cost Impacts**
- Decreased Quality of Care
- Increase in Errors
- Increased Attrition & Cost of Recruitment

**Caregiver Impacts**
- Loss of Meaning and Purpose in Work
- Caregiver Depression, Addiction and Suicide
- Career Dissatisfaction and Attrition

**Patient Impacts**
- Quality Rated Lower by Patients
- Decreased Patient Satisfaction
- Decreased likelihood to recommend

Decreased Patient Satisfaction
- Decreased likelihood to recommend

Decreased Quality of Care
- Decreased patient satisfaction
Our Burning Platform

Compassion is central to our mission and values

Suffering of caregivers is real

Suffering leads to burnout

Burnout worsens all outcomes
Measurement of Burnout and Compassion:

What we measure is important, but even more important is **WHY**?

- Judgment vs Support
- Organizational vs Individual
- Engagement vs Caring
Measuring The Organization
How Do YOU Measure Organizational Wellness?
Key Organizational Measures:

Engagement

Burnout

Compassion

Organizational Wellness
The Evolution of Engagement

Sustainable Engagement

Engaged
Enabled
Energized

“Traditional” Engagement

Satisfaction
Commitment
Engagement
Think
Feel
Act

Are my basic needs being met?
Do I intend to stay here?

19
Measuring Organizational Engagement

**Provider**  
Press Ganey

- Recommend my clinic
- Satisfied with my clinic
- Intent to stay
- Proud of my clinic

**Caregiver**  
Willis Tower Watson

- Engaged: Strong belief, extra effort, proud
- Enabled: Access to equipment, obstacles, meet challenges
- Energized: Personal accomplishment, sustainable energy
Overall Engagement

- Highly Sustainably Engaged: 43%
- Unsupported: 31%
- Detached: 15%
- Disengaged: 10%
HR: Final Push for Engagement

Strengths and Successes:

• What’s been working well lately?
• What are you personally most proud of?
• How has the progress been on your development goals?
• How can I help you?
• What’s the most important thing you’re working on this week?
• How can I best support you today?
Burnout Predicts Engagement

Not Burned Out

Overall

Burned Out

- Highly Sustainably Engaged
- Unsupported
- Detached
- Disengaged

26% 62%
24% 37%
27% 37%
Power of Correlations

Highly Sustainably Engaged
- Not Burned Out: 72
- Burned Out: 28

Disengaged
- Not Burned Out: 13
- Burned Out: 87
Highly Sustainable Engagement and Burnout

“I’d call burnout the “Godzilla” to providing great caregiver and patient experiences.”

Matt Griffin
Senior Manager, PSJH
Organizational Strategy
Measuring Organizational Burnout

Caregiver (WTW)
- I experience burnout at work (frequency)
- I feel more callous in my job
- I find meaning in my work

Provider (Press Ganey)
- Single Item: “I rarely experience burnout”
- Resilience = Activation + Decompression
Prevalence of Burnout

**CAREGIVERS**

- % Unfavorable: 36%
- % Neutral: 26%
- % Favorable: 38%

“I feel burned out from my work”

**PROVIDERS**

- % Unfavorable: 42%
- % Neutral: 25%
- % Favorable: 33%

“I rarely feel burned out from my work”
PSJH Caregiver Burnout

- **Executive**
  - 2016: 32%
  - 2017: 44%
  - 2018: 54%

- **Supervisor**
  - 2016: 43%
  - 2017: 55%
  - 2018: 57%

- **Clerical/Admin**
  - 2016: 45%
  - 2017: 53%
  - 2018: 55%

- **Overall**
  - 2016: 48%
  - 2017: 56%
  - 2018: 59%

- **Clinical Aide**
  - 2016: 50%
  - 2017: 58%
  - 2018: 61%

- **RN**
  - 2016: 52%
  - 2017: 62%
  - 2018: 65%

- **EVS**
  - 2016: 54%
  - 2017: 51%
  - 2018: 55%

2016 = 54,700 Responses
2017 = 80,000 Responses
2018 = 84,832 Responses
Impact of Burnout

Highly Sustainably Engaged
- Low Burnout: 69%
- Moderate Burnout: 43%
- High Burnout: 20%

Intending to Stay
- Low Burnout: 92%
- Moderate Burnout: 84%
- High Burnout: 66%

Have a “positive” Safety Domain Score
- Low Burnout: 84%
- Moderate Burnout: 75%
- High Burnout: 57%

PSJH Caregiver Survey Oct 2018
Compassion-Suffering Connection
Measurement of Compassion

**Providers**
- None

**Caregivers**
- Organization promotes and supports
- Supervisor promotes and supports
- I am able to give compassion

**Patients**
- I am shown compassion
- Are sensitive to my needs (medical group)
Compassion: It Really Matters

Intending to Stay
- 82% Able to Give Compassion
- 44% Not Able to Give Compassion

Feel Safe if I were a Patient
- 91% Organization Promotes Compassion
- 53% Organization Does Not Promote Compassion

Highly Sustainably Engaged
- 54% Supervisor Supports Compassion
- 5% Supervisor Does Not Support Compassion
Press-Ganey Survey: Was I Shown Compassion?

<table>
<thead>
<tr>
<th>Clinical Sites</th>
<th>% Top Box (Lowest-Highest %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>58.0% (49-75%)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>71.0% (61-85%)</td>
</tr>
<tr>
<td>Medical Group*</td>
<td>76.0% (68-81%)</td>
</tr>
</tbody>
</table>

*was the staff sensitive to my needs?
Compassion & Patients’ Rating of Quality

ED | Inpatient | Medical Group | Home Health
---|-----------|---------------|-------------
92.3 | 89.3 | 93.5 | 94
Compassion = 5

(9/10)
Compassion and Patients’ Rating of Quality

<table>
<thead>
<tr>
<th>Service</th>
<th>Rating</th>
<th>Compassion ≥5</th>
<th>Compassion &lt;5</th>
</tr>
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<tbody>
<tr>
<td>ED</td>
<td>92.3</td>
<td>92.3</td>
<td>19.2</td>
</tr>
<tr>
<td>Inpatient</td>
<td>89.3</td>
<td>48.2</td>
<td>51.8</td>
</tr>
<tr>
<td>Medical Group</td>
<td>93.5</td>
<td>53.2</td>
<td>46.8</td>
</tr>
<tr>
<td>Home Health</td>
<td>94</td>
<td>56</td>
<td>44</td>
</tr>
</tbody>
</table>
Organizational Measurement: Things We’ve Learned

• Measurement creates momentum
• Organizations conform to national trends
• Organizational change is a team sport
• There is no finish line
• Power of correlations
  ◦ Recognizing that correlation does not equal causation
  ◦ Recognizing that everyone doesn’t recognize this
Measuring Teams
Strengthening Compassion in Outpatient Practice
Strengthening Compassion Curriculum

- Twelve 60 minute sessions
- Focus on team building, mindfulness, self reflection
- Videos, exercises, reflections
- Clinic facilitators trained and supported
- 50 item composite survey
  - Maslach Burnout Inventory
  - Santa Clara Compassion Scale
  - Mindful Attention Awareness Scale
  - Internal Satisfaction Scale
Strengthening Compassion Curriculum

Cohort 1: Randomized, 11 clinics (2016-7)
- Reduced burnout (55% → 46% p<0.05)
- Increased caregiver engagement (9% difference HSE and disengaged p=.01)
- Improved patient experience (Improved LTR p=0.06)
- Increased visits/month and panel size in intervention despite closing clinics during work hours (P<0.001)
## Burnout Severity (subscales)

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>End of Trial</th>
<th>6 month f/u</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C-Total Burnout</strong></td>
<td>24.44</td>
<td>25.89</td>
<td>25.05</td>
<td>0.02*</td>
</tr>
<tr>
<td><strong>I-Total Burnout</strong></td>
<td>24.46</td>
<td>22.64</td>
<td>21.79</td>
<td></td>
</tr>
<tr>
<td><strong>C-Exhaustion</strong></td>
<td>10.6</td>
<td>11.39</td>
<td>11.22</td>
<td>0.03*</td>
</tr>
<tr>
<td><strong>I-Exhaustion</strong></td>
<td>10.88</td>
<td>10.31</td>
<td>10.24</td>
<td></td>
</tr>
<tr>
<td><strong>Depersonalization</strong></td>
<td>8.0</td>
<td>7.97</td>
<td>7.8</td>
<td>0.05*</td>
</tr>
<tr>
<td><strong>I-Depersonalization</strong></td>
<td>8.13</td>
<td>7.02</td>
<td>6.63</td>
<td></td>
</tr>
<tr>
<td><strong>Achievement</strong></td>
<td>36.16</td>
<td>35.47</td>
<td>35.71</td>
<td>.2</td>
</tr>
<tr>
<td><strong>I-Achievement</strong></td>
<td>36.55</td>
<td>36.62</td>
<td>37.08</td>
<td></td>
</tr>
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</table>
## Strengthening Compassion Curriculum

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>◦ Reduced burnout</td>
<td>◦ Non-randomized</td>
</tr>
<tr>
<td>◦ Increased caregiver engagement</td>
<td>◦ 60 minute sessions</td>
</tr>
<tr>
<td>◦ Improved patient experience</td>
<td>◦ Key results available:</td>
</tr>
<tr>
<td>◦ Increased visits/month and panel size (despite closing clinics during work hours)</td>
<td>◦ Provider Engagement</td>
</tr>
<tr>
<td></td>
<td>◦ Patient Experience</td>
</tr>
<tr>
<td></td>
<td>◦ Visits/month</td>
</tr>
</tbody>
</table>
Provider Engagement Domains 2018
Cohort 2 vs. Non Participating Clinics

<table>
<thead>
<tr>
<th></th>
<th>Cohort 2</th>
<th>Non Participating Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>4.53</td>
<td>4.05</td>
</tr>
<tr>
<td>Alignment</td>
<td>4.27</td>
<td>3.83</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.26</td>
<td>3.87</td>
</tr>
<tr>
<td>Organization</td>
<td>4.32</td>
<td>4.04</td>
</tr>
</tbody>
</table>
Provider Engagement: Changes from 2016-2018

Cohort 2:
Direction of Change by Clinic (N=11)

- Improved >.01: 70%
- Neutral: 30%
- Worsened >.01: 0%
Provider Engagement: Changes from 2016-2018

Cohort 2:
Direction of Change by Clinic (N=11)

- Improved, >.01: 70%
- Neutral: 30%
- Worsened, >.01: 0%

Non Participating Clinics:
Direction of Change by Clinic (N=26)

- Improved, >.01: 52%
- Neutral: 16%
- Worsened, >.01: 32%
- Improved, >.01: 16%
- Neutral: 16%
- Worsened, >.01: 32%
Impact on Patient Experience: Cohort 2 vs Non Participating Clinics

Change from Baseline*

Recommend Provider: Participating 0.6, Non Participating 0.3
Recommend Practice: Participating 1.0, Non Participating 0.01
Sensitivity to Needs: Participating 2.4, Non Participating 0.6

*Baseline = 12/17->2/18
Intervention = 3/18->9/18
Compassion Curriculum: Impact on Productivity

Average Visits/Month
(Change During Curriculum Period)

<table>
<thead>
<tr>
<th>Avg. Visits/Month</th>
<th>Cohort 2 Clinics</th>
<th>Non Participating Clinics</th>
</tr>
</thead>
</table>
| Baseline
Dec 2017-Feb 2018| 19,451           | 39,445                    |
| Curriculum
March-August 2018| 20,222           | 40,328                    |

Visits
- Cohort 2: 3.96%
- Non Participating Clinics: 2.24%
**Strengthening Compassion Curriculum**

<table>
<thead>
<tr>
<th>Cohort 1: Randomized</th>
<th>Cohort 2: Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 clinics (2016-7)</td>
<td>11 clinics (2018)</td>
</tr>
<tr>
<td>Reduced burnout</td>
<td>Non-randomized</td>
</tr>
<tr>
<td>Increased caregiver</td>
<td>60 minute sessions</td>
</tr>
<tr>
<td>engagement</td>
<td>Key results available:</td>
</tr>
<tr>
<td>Improved patient</td>
<td></td>
</tr>
<tr>
<td>experience</td>
<td>Improved Provider</td>
</tr>
<tr>
<td></td>
<td>Engagement</td>
</tr>
<tr>
<td></td>
<td>Improved Patient</td>
</tr>
<tr>
<td></td>
<td>Experience</td>
</tr>
<tr>
<td></td>
<td>Increased Visits/month</td>
</tr>
</tbody>
</table>

- Increased visits/month and panel size (despite closing clinics during work hours)
These conversations are transforming our day to day interactions and equipping us to move forward in our care giving of our patients and for each other.

-Jordan Roth MD
PMG Orenco

Staff are more understanding of the context of patients’ lives. I think it is very helpful to do this as a whole clinic team as opposed to focus just on the providers.

-Matthew Breeze MD
PMG North Portland
Strengthening Compassion Curriculum

Cohort 1: Randomized
- Reduced burnout
- Increased caregiver engagement
- Improved patient experience
- Increased visits/month and panel size

Cohort 2: Volunteer clinics
- Improved provider engagement
- Improved patient experience
- Increased visits/month

Additional Impacts: (2018-2019)
- Cohort 3: Thirteen clinics
- Cohort 4: Eight subspecialty clinics
- Cornerstones: Ten clinics
Team Measures: Lessons Learned

• A well measured pilot creates disproportionate momentum
• Consider stakeholders when selecting measures
• Utilizing existing system measures is very resource effective
Measuring Individuals
Examples of Measures for Individuals

• The Mindfulness Attention Awareness (MAAS)
• Gratitude Questionnaire (GQ-6)
Compassion Cornerstones

Tier I
- Gratitude
- Mindful Pause

Tier II
- Self-Compassion
- Finding Meaning

Connection | Teams
---|---
Wellbeing | Individual
The Mindful Attention Awareness Scale

- 15 item scale self-report designed to assess characteristics of mindfulness
  - Receptivity of attention
  - Awareness of present
  - Observes what is occurring

- Public domain
- Validated instrument
- Easy to administer and score

The Mindful Attention Awareness Scale
Sample

Answer Using Likert Scale

1 2 3 4 5 6
Almost always Very Frequently Somewhat frequently Somewhat infrequently Very infrequently Almost never

1. I could be experiencing some emotion and not be conscious of it until some time later.
2. I break or spill things because of carelessness, not paying attention, or thinking of something else.
3. I find it difficult to stay focused on what’s happening in the present.
4. I tend to walk quickly to get where I’m going without paying attention to what I experience along the way.
5. I tend not to notice feelings of physical tension or discomfort until they really grab my attention.

Scoring: To score the scale, simply compute a mean (average) of the 15 items.
Gratitude Questionnaire (GQ-6)

- Six item self-report scale, designed to assess daily gratitude
- Public domain
- Validated instrument
- Easy to administer
- Scoring and interpretation are a little challenging

Gratitude Questionnaire (GQ-6)

Answer Using Likert Scale

1 = strongly disagree  2 = disagree  3 = slightly disagree  4 = neutral
5 = slightly agree    6 = agree     7 = strongly agree

1. I have so much in life to be thankful for.
2. If I had to list everything that I felt grateful for, it would be a very long list.
3. When I look at the world, I don’t see much to be grateful for.*
4. I am grateful to a wide variety of people.
5. As I get older I find myself more able to appreciate the people, events, and situations
   that have been part of my life history.
6. Long amounts of time can go by before I feel grateful to something or someone.*
Gratitude Questionnaire (GQ-6) Scoring

**Scoring Instructions:**

1. Add up your scores for items 1, 2, 4, and 5.

2. **Reverse your scores for items 3 and 6.** That is, if you scored a "7," give yourself a "1," if you scored a "6," give yourself a "2," etc.

3. Add the reversed scores for items 3 and 6 to the total from Step 1. This is your total GQ-6 score. This number should be between 6 and 42.
Benefits:
• Helps with evaluation of programs
• Gives feedback to individuals on “self”

Draws Backs:
• Measures might not be sensitive or specific
• How to administer to multiple individuals
• How to utilize the data of individuals
Measuring For Meaningful Change
Thank You
Championing Practice Innovation Through Physician Empowerment

Susan Rehm, MD
Associate Chief of Staff
Cleveland Clinic

Katherine Bulava, MA, PMP
Department Manager, PIPFO
Cleveland Clinic
Disclosures

• None
Our Approach: The Practice Innovations & Professional Fulfillment Office

• We commit to maximizing professional fulfillment by:
  - Driving innovation and practice enhancements
  - Strengthening the group practice
  - Supporting well-being

• We engage our staff, listen and respond.
Highly engaged teams

Strong safety culture

Exemplary patient experience

World-class outcomes
Why It Matters

- According to our 2019 PFI Clinician Well-Being Survey:
  - 34% of Cleveland Clinic physicians and 36% of APPs are professionally fulfilled
  - 45% of Cleveland Clinic Physicians and 40% of APPs are experiencing burnout
Multiple Consequences

• Personal impact
• Quality and safety
• Turnover and departure from profession

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Loss of Downstream</td>
<td>$990,034</td>
</tr>
<tr>
<td>Revenue/FTE</td>
<td></td>
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<tr>
<td>Estimated Recruiting</td>
<td>$61,200</td>
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<tr>
<td>Cost/FTE</td>
<td></td>
</tr>
<tr>
<td>Average Annual Start-Up</td>
<td>$211,063</td>
</tr>
<tr>
<td>Cost/FTE</td>
<td></td>
</tr>
<tr>
<td>Total Turnover Cost/FTE</td>
<td>$1,262,297</td>
</tr>
</tbody>
</table>

Physician and Advanced Practitioner Well-Being Solutions Survey Report

How PIPFO supports Cleveland Clinic

• Provide and interpret data
• Measure impact of local efforts on fulfillment and burnout
• Inspire, lead and support practice innovations
• Inform and connect staff to support resources
Collaboration = Increased Impact

- Diversity
- Wellness
- GLLI
- Quality
- Practice Innovations & Professional Fulfilment
- CI
- Education
- OCE
- OPE
Professional Fulfillment

Adapted from the Stanford WellMD model with permission; the Stanford WellMD model remains property of Stanford University. The Cleveland Clinic Professional Fulfillment Model is not related to or sponsored by Stanford University.
PIPFO Approach:

Maximize professional fulfillment for staff through
- Data
- Innovation
- Support
Innovation: Champion Teams

The purpose:
- Empower staff to drive solutions to enhance professional fulfillment through local culture and well-being projects

The program:
- PIPFO provides support to a Team or Champion appointed by Institute leadership to shepherd a series of cultural and well-being improvements
- Through bi-monthly or quarterly touch points, PIPFO guides Champion Teams through the identification and implementation of solutions
- PIPFO opens doors, works through challenges, helps develop concepts and ensures the Champion Teams stays focused and engaged
Champion Team Formation

Option 1:
- Staff Initiated

Option 2:
- Leader Initiated

Option 3:
- PIPFO Initiated
Champion Team Formation

Option 1:
- A staff member calls our office or offers an idea at a session that could promote local change
- Someone from PIPFO meets with them to explore the idea and share the Champion Team concept
- Having secured interest, PIPFO reaches out to local leadership to co-propose the creation of a team, including the interested staff member

Option 2:
- A leader reaches out to PIPFO and asks for help in “enhancing engagement” or “improving culture and well-being”
- Someone from PIPFO meets with them to discuss their challenges and share the Champion Team concept

Option 3:
- While reviewing data or supporting improvements within an institute, a PIPFO team member notices that staff have good ideas or just a desire to do something positive
- PIPFO pitches the creation of a team to institute leadership
Champion Team Formation

Membership
- All Teams must have local leadership support
- An administrator must participate in the Team, coordinate internal administrative processes and schedule Team sessions
- Ideal Team size ranges from 3-8 team members
  - A single passionate champion can act alone, but must have time and support secured from leadership
  - Succession plans are recommended for an individual Champion approach
- Teams can be all physicians or a mix of physicians and APPs
- Teams must have a formal reporting structure to institute leadership
Champion Team Launch

Phase I:
- Identification of the opportunity
  - Review available data
  - Generate a list of potential projects separated into three categories:
    - Well-Being
    - Culture
    - Efficacy of Practice
- Consider a survey or town hall to gather and rank ideas
- Prioritize the top 3 to 5 projects
- Select a project in each category
- Assign roles and project tasks
- Determine individual project metrics
Champion Team In Action

Phase 2:

- Set up a progress report out structure for the team
  - Newsletter
  - Email blast
  - Staff meeting announcement
- Bi-monthly meetings provide a forum to:
  - Review project progress
  - Develop and modify next steps
  - Troubleshoot challenges
Champion Team In Action

Phase 3:
- Measure impact
  - Review impact of project
  - Make modifications as necessary
- Celebrate success:
  - Publicly share project results through Institute communication channels
  - Praise individual staff contributions
Champion Team In Action

Phase 4: REPEAT
What Makes a Good Champion Team Project?

- Meets objectives:
  - Enhance culture
  - Increase well-being
  - Improve efficacy of practice
- Has impact on the majority
- Has leadership support
- Staff are empowered to participate or feel empowered as a result
Exercise: Generating Project Ideas
Exercise: Putting Your Ideas Into Action

- Prioritization of our ideas
  - Actionable
  - High reward
  - High impact
  - Low barriers to implementation
- Project Selection
Successful Champion Team Projects

• Emergency Services - well-being team competition
• Pathology and Lab Medicine - Secretarial pool revamp
• Endocrinology and Metabolism - MyChart Best Practice Initiative
• Pediatrics - Town Halls
• Imaging - Social Connectivity
• Anesthesia & Neurology - CPR training (Civility, Professionalism, Resilience)
Neurological Institute:

Strategic Engagement Efforts

Amy Sullivan, PsyD, ABPP
NI PIPFO Champion
Chair, NI Engagement Office
Civility, Professionalism, Resiliency

- Focus on Improving Resiliency, Professionalism, and Civility
- Goal: To improve burnout and engagement
- 2 hour interactive course
- 1 AMA PRA Credit
A WPSA / NI Partnership
“Cohort of 9”  
Source: Machado APR

• **Goal:**
  Increase the representation of women in leadership

• **Current State:**
  Underrepresented in the NI operational org chart

• **Hypothesis:**
  Lack of early leadership opportunities results in a “lag” in experience

• **Method:**
  To promote experience by means of exposure and classroom training
“Cohort of 9”

- Marzena Buzanowska
- Sara Davin
- Leslie Heinberg
- Lara Jehi
- Taylor Rush
- Jessica Vensel Rundo
- Harneet Walia
- Alissa Willis
- Dolora Wisco
Women in Leadership

The WPSA Executive Board established the Champion Award in 2015 to recognize an individual for her or his contribution to the advancement, development and well-being of the women professional staff at Cleveland Clinic.

Dr. Nancy Foldvary-Schaefer – 2018 WPSA Champion Award Winner.
NI Women’s Leadership Retreat

- June 20, 2018, 2nd annual retreat
- **Theme**: Targeted bullying
- Joined and supported by male colleagues
- **Result**: Task force and stance on bullying
- Next retreat September 26, 2019
- **Theme**: Highlighting Strengths
Engagement Dinners

• Regular engagement dinners with the professional staff

• Focus on connection, de-siloing, reducing loneliness, communication, collaboration, support, morale, balancing work/life
NI Wellness Initiative

• The NI recognizes the importance of caregiver health and wellbeing

• Burnout and poor health impact clinician’s well-being and patient care

• Optional Staff participation

• Program components:
  - Live presentations, videos and educational tools

• Goals: promote self-care, improve compassionate patient care, improve stress management and reduce burnout

• Roll-out in September, 2019
Preliminary NI OKR
CI: Shook, Walia and Wyeth

- Improve Caregiver Engagement
  - Reduce Burnout
  - Improve Diversity in Leadership
Exercise: What Are Your Ideas?
Exercise: Putting Ideas into Action

- Metrics
- Roles/Responsibilities
Acknowledgements:

- Herb Wiedemann, MD – Chief of Staff
- Brad Borden, MD – Associate Chief of Staff
- Amy Sullivan, PsyD
- Matt Donnelly, JD – Executive Director, OPSA
Promoting Physician Resilience Through Centers for Physician Wellbeing: Organizational Challenges and Solutions

Wayne M. Sotile, Ph.D.
Founder
CENTER FOR PHYSICIAN RESILIENCE
Davidson, North Carolina

Center for Physician Leadership
Carolinas HealthCare System
Charlotte, North Carolina

Disclosure & Disclaimer

Cajun Logic:
Right Concept, Wrong Application
Ignoring the Obvious

Respect the Contexts
**Toxic Stress**
High Demand
Low Control
Low Support

How can we use our resources to build resilience?

The absence of hassles does not predict resilience

- **Content**
- **Structure**
- **Process**

Centers for Physician Wellbeing:
*What works*
*What doesn't*
Case #1: Floundering

- Champion: Primary care physician with mid-level reputation; allowed .1 FTE (approximately 5 hrs./week)
- Participates in Wellness Committee, Onboarding Committee, Retention Committee, Engagement Committee, Leadership Academy
- Funding: Folded into budget of Med Ed Office
- No physical "home"
- Lobbying to convince Admin to survey med staff re: wellness
- Staged 8 events over course of two years: Wellness screenings × 2, Departmental Grand Rounds x 3, Departmental resident mini-retreat (3 hrs.) x 3
- Criticism: “Nice programs; no sustainable process.”

Instructions:

- Ongoing strengths? (What’s she doing well?)
- Potential change levers?
- Have-to-haves, if to succeed long-term?
- Peer-to-peer advice/encouragement?

Case #2: A Thriving CPW

---

The Foundation FirstHealth

References to PHYSICIAN LEADERSHIP PROGRAM

www.Sotile.com
Case #2: A Thriving CPW

- Made the business case to leadership
- Got senior physician leadership buy-in: CMO; and President of Medical Group
- Articulated a Clear Mission Statement…
  Frame: “a benefit for our providers and their families”
  Scope…”offer any needed professional or personal support”
- Chose a theoretical underpinning: PERMA

Case #2: A Thriving CPW

- Funding: Philanthropy… $1,450,000
- Physical home: Office suite in Hospitality House
- Operating budget
- Manpower: Medical Director (MD), Director (PA), Local coaches (x2), Consultant coaches (x2)

Case #2: A Thriving CPW

- Articulated Strategic Plan
  1. Publish…to increase awareness
  2. Maintain PLA alumni engagement
  3. Expand Foundation support of provider retention
  4. Formal mentor training…and handbook
  5. Increase opportunities for providers to discuss common workplace emotional concerns with colleagues
Thriving CPWs

Crucial Components
(Please see PDF handout)

Effective Resilience Training

Lessons Learned from
35+ Years of Coaching/Counseling
Physicians and Medical Families
The Resilience Challenge

Even if “they” are 90% of the problem, what 10% are you willing to own?

Resilience Training: Vital Variables

- Boost actual and/or perceived support and control
- Learn to counter daily hassles with daily uplifts
- Broaden and deepen relationships...
  - at work and home

PT Growth – Change Factors

- Relating to Others
  - They are resources; they matter; renewed empathy
- Seeing New Possibilities
  - “I will change what needs changing”
- Renewed sense of Personal Strength
  - “I can cope”
- Spiritual Changes
- Appreciation of Life, Family, Career
  - New priorities

PTG: Positive Changes in the Aftermath of Crisis (Tedeschi, Park and Calhoun)
Keys to Resilience

Simonds GR & Sotile WM. Thriving Physicians. At press, 2018

Emotional Intelligence
- Self Management
  - Self-Awareness
  - Self-Regulation
  - Motivation

Wellbeing Meta Factors
- Positive Emotions
- Engagement
- Relationships
- Meaning
- Accomplishment

Relationship Skills
- Empathy
- Social Skill

Don’t just measure burnout; Check your resilience “Vital Signs”

- Joy
- Camaraderie
- Engagement
- Satisfaction

Swensen S. et al. NEJM Catalyst. April 12, 2018

Three Phase of Transition

Time

Ambivalence!

THE NEW NORMAL

OLD NORMAL

THE NEUTRAL ZONE

Psychological Realignment Re-patterning

The Burnout Hysteria Cycle

Fear of Burnout
↓ Work Ambivalence
↓ Quality
↓ Engagement
↓ Fulfillment
Lousy Mood & Behaviors Upon Returning Home
Lousy Attitudes Toward Your Work
Distress from Loved Ones Regarding Your Work
↑ Risk of Burnout for Family

Building Resilience
Develop a Monthly Curriculum
(Please see PDF handout)

Thank You!
Wayne Sotile, Ph.D.
THE CENTER FOR PHYSICIAN RESILIENCE

www.TheResilientPhysician.com
Email: Sotile@SotileMail.com
336/794-0230
Components of an Ideal Center for Physician Wellness

Wayne M. Sotile, Ph.D.

• Make the Business Case

• Senior System Leadership Champions

• Dedicated Funds for Operating Budget and Special Projects

• Manpower: Medical Director (MD), Director (PA), Local coaches (x2), Consultant coaches (x2)

• Have a Physical Home

• A Clear Mission Statement

• Frame the Service as Being a Benefit for Providers and their Families

• Offer a Broad Portfolio of Services for both Professional and Personal Support
  • Range of Services…Crisis intervention, Onboarding, Team-building, Medical family retreat, Hospitality events, PLA, Ongoing leadership coaching
  • Incorporate Programming for Significant Others and Medical Families

• Make Services User-Friendly -- Easily accessed

• Affiliate with National Collaboratives

• Incorporate a Physician Leadership Academy
• Keep Progress/Success in Perspective. Think: “Culture change takes time and relentless commitment”

• Have an Articulated Strategic Plan for Sustaining, Expanding, and Deepening Services; Update it Yearly

• Keep Utilization Metrics
Topic Outline for Comprehensive Physician Resilience Training

Wayne M. Sotile, Ph.D.

Sources:


Track A: What is the Problem?

• Burnout
• Compassion Fatigue
• Anxiety
• Work-related Depression
• Anger
• Imposter Syndrome
• Maladaptive Responses to Stressors .at work and home
• "Un-alignment: Mind/Body/Spirit/Relationships/Values/Behaviors

Track B: Self-assessments

• Stressors: At work, at home
• Burnout
• Compassion Fatigue
• Perfectionism
• Explanatory Style
• Resilience
• Cognitive Patterns
• Stress Symptoms
• Anger Management
• Sleep
• Exercise
• Uplifts/Hassles

Track C: Deepening Insights

• Psychological Style
• Self-esteem
• Efficacy
• Conflict Management Style
• Leadership Style

**Track D: Deepening Empathy**
• Challenges to Empathy
• Attribution Errors
• Re-thinking and Re-framing: “Why are they asking me this?”
• Content, Structure, Process
• Creating Cross-Pollination

**Track E: Where is the Joy?**
• The Importance of Uplifts
• ID and Harvest Uplifts
• Re-thinking and Re-framing .. Broadly and Specifically
• Sometimes Meaning Comes in Disguise

**Track F: The Importance of Good Work**
• Exploding the Mythical Balanced Life
• Facts About “Good Work”
• What is Your “Work Psychology”
• Reflecting on Current Work Psychology
• Re-framing: The “rarified air” of life in medicine

**Track G: Personal Relationships Matter**
• Re-thinking “Balance”
• Friendship Matters
• Family Systems Perspectives
• Incorporating Life Mates
• Content-Structure-Process

**Track H: Targeted Topics**
• Challenges Unique to Women in Medicine
• Between the Genders
• Between the Generations
• Medical Malpractice Stress
• Financial Matters
• How Much Will You Earn?
  Visions of Your Future
Creating a Scalable Wellness Foundation in Your Organization

Ellie Rajcevich, MPA
Provider Wellness Program Director
MultiCare Health System
Disclosures

- No disclosures.
Learning Objectives

• Create a plan for growth and expansion of Provider Wellness activity in your organization
• Complete a well-being needs assessment for your organization
• Learn how to develop a strategic plan to support provider wellness
MultiCare Health System
Provider Wellness Team 2017-2018
Provider Wellness Team 2019

System Medical Group/Medical Operations Leadership Committee

- PSR Provider Business Unit Leadership
- Physician Executive
- Program Director (PSR)
- Rockwood + INW Leadership
- LMHC

EPIC Optimization
POC (PSR)
POC (INW)
EPIC Optimization

Provider Wellness Advisory Group, IS&T, Informatics, CMOs, Clinical Education
Leadership Support

- Physician Executive
- Provider Wellness Steering Team
- Provider Wellness Advisory Group
- Shared cost structure
Laying the Foundation: Measurement

• Identify what you want to learn
• Select the best survey for you
• Some options include:
  – Provider Well-Being Index
  – Stanford Professional Fulfillment Index
  – Mini-Z
  – Engagement survey burnout/resilience bundle
Engage a Provider Wellness Advisory Group

- Comprised of physicians and advanced practice providers (physician assistants, nurse practitioners, nurse midwives, etc.)
- Hold bi-monthly meetings
- Set direction & determine highest priority areas for PWP
Develop Programming
Please share as a group

• What are some of the most important foundational components of your program?
Efficiency of Practice

Plan for visits + Communicate + Team-based approach to care + Epic optimization =

Ambulatory Optimization
**Before PWP**

- **MA conducts standard rooming, including med rec & vitals**
- **Before entering exam room:** MD prints prior visit(s) for reference
- **Patient visit:** MD takes notes on prior visit printout, begins un-templated note in Epic, places orders for labs and diagnostics
- **0-2 days after appt:** MD receives lab results in the in-basket
  - Avg 5 days after appt: MD sends message to MA with notes about results to relay to the patient and instructions for Rx renewals
  - Avg 5 days after appt: MA calls patient and pends follow-up orders & refills
  - Avg 5 days after appt: MD signs off on Rx renewals and additional orders
  - Phone calls
  - Ask Your Doc messages
  - Refill requests
  - Fall through the cracks
After PWP

Orders had been placed at the prior visit that the provider wanted to review at the next visit

Pre-visit activities: Front office, MA or volunteer calls patient to remind the patient to get labs done & complete other testing prior to the visit

During standardized patient rooming: Based on protocols, MA places/pends health maintenance orders as appropriate and pends prescription renewals

Patient visit: MD reviews lab results with the patient, talks about follow up course of action, signs prescription refills and places & signs additional orders

Time saved = 1.5 hours per day
Personal Resilience

- Fellowship events
- CME events (+ guests)
- Hosted meals
- Schwartz Rounds
- Unlimited, confidential, free counseling for individuals, couples, families
Culture of Wellness

• Value ourselves
  – Meaning in work
  – Space for self care/preservation
• Value our colleagues
  – Fellowship & collegiality
• Value our personal relationships
  – Teamwork
Culture Change

- Professional Development & Wellness provider bonus
- Wellness committees, activities & champions
- Ambulatory Optimization booked out through Q2 2021
- Proactive efforts
### Lakewood Results
#### 2 months post-engagement

<table>
<thead>
<tr>
<th>Provider</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARNP1</td>
<td>18.36</td>
<td>17.92</td>
<td>-2%</td>
</tr>
<tr>
<td>MD1</td>
<td>36.37</td>
<td>33.09</td>
<td>-9%</td>
</tr>
<tr>
<td>MD2</td>
<td>23.00</td>
<td>20.61</td>
<td>-10%</td>
</tr>
<tr>
<td>ARNP2</td>
<td>34.56</td>
<td>30.00</td>
<td>-13%</td>
</tr>
<tr>
<td>MD3</td>
<td>48.34</td>
<td>44.37</td>
<td>-8%</td>
</tr>
</tbody>
</table>
Demonstrate ROI

- Time saved per provider
- Reduced turnover
- Improved retention
- Fewer errors, better care

MultiCare
Provider Wellness

AMERICAN CONFERENCE ON PHYSICIAN HEALTH

ACPH 2019
Breakout: Building Your Strategy

• SWOT analysis: Strengths, Weaknesses, Opportunities, Threats

• What could best impact your organization?
Report Out

• Summarize your group’s SWOT analysis

• Did anything stand out to the group?
Takeaways

• Build your foundation
• Strengthen your support network
• Make a measurable impact
• Prepare to grow!
Thank you

Ellie Rajcevich
eirajcevich@multicare.org
The starting line:

Using the appreciative inquiry to conduct a needs assessment
Who we are...

- Cristin McDermott, MD - Assistant Professor of Pediatrics & Psychiatry
  University of Pittsburgh Medical Center

- Victoria Winkeller, MD – Assistant Professor of Pediatrics & Psychiatry
  University of Pittsburgh Medical Center
Disclosures

- Cristin McDermott, MD – No disclosures.
- Victoria Winkeller, MD – No disclosures.
OBJECTIVES:

• Provide an overview of the Appreciative Inquiry process.
• Discuss the principles of Appreciative Inquiry.
• Review the 5-D stages of Appreciative Inquiry.
• Provide guidance on how to structure an Appreciative Inquiry session.
• Practice using the Appreciative Inquiry.
Timeline

- 9:30am-9:50am – Introduction and Didactic
- 9:50am-10:15am – Small Group Work
- 10:15am-10:25am – Report Out
- 10:25am-10:30am – Wrap Up
Two thoughts before we begin...

Correct the equation by moving only one line:

$$XI - V = IV$$

#1 There is (often) more than one way to solve a problem.
Name a piece of clothing that is truly "one size fits all."

#2 There is no "one size fits all" solution to well-being.
What is appreciative inquiry?
Appreciative inquiry is...

- A strength-based approach to change
- The study and exploration of what gives life to systems when they function at their best
- An approach to personal AND organizational change
Appreciative inquiry

- Key assumption:
  - Questions and conversations about strengths, successes, values, hopes and dreams are transformational.

- Aim:
  - Build or rebuild around what works.
Some basic tenants

Appreciative inquiry asks that we...

- Recognize the best in the people/organization/world around us.
- Affirm past and present strengths, successes and potentials.
- Explore what makes/has made us/our organizations great.
- Ask questions about what else may be possible.
- Be open to seeing, hearing and promoting new potentials and possibilities.
If we continue to look for problems, we will continue to find problems. If we look for what is/has been the best, and learn from it, we can improve and magnify our successes.
1. In every society, organization or group, something works.

2. What we focus on becomes our reality.

3. Reality is created in the moment, and there are multiple realities.
The 8 Assumptions of appreciative inquiry

4. Asking questions of a group influences the group in some way.

5. People have more confidence to journey to the future, when they carry forward parts of the past.

6. If we carry parts of the past forward, they should be what is best about the past.
The 8 Assumptions of appreciative inquiry

7. It is important to value differences.
8. The language we use creates our reality.
In summary, AI allows a group to...

Find new possibilities
Energize the vision
Create a new future
“Human systems grow and construct their future realities in the direction of what they most persistently, actively, and collectively ask questions about.”

—Appreciative inquiry: The Power of the unconditional positive question by JD Ludema, DL Cooperrider and fj barrett
Appreciative inquiry: the process
Appreciative inquiry: the 5-d cycle

- Define: Select and frame the topic of inquiry.
- Discover: Appreciate and value the best of “what is.”
- Dream: Envision “what might be.”
- Design: Develop detailed plans for “what should be.”
- Deliver: Enact planned activities for “what will be.”
Stage 1: define

* Frame the question.
* Consider what it is you would like to focus on.
* What vision would you like to build?
* The question should be...

Positive  Desirable  Motivational
Stage 2: discover

- Identify processes/interventions that currently work well (or have in the past).
- Goal: Understand the best of "what is" and the best of "what has been."
- Tip: Ask for stories.
Stage 3: dream

* Envision processes/interventions that would work well in the future.

* Goals:
  * Explore “what might be.”
  * Explore ideas for community, organization, etc.

* Questions to Consider:
  * What can we build upon?
  * What else do we need?
  * What would help us function at our highest, most productive, collaborative and efficient level?
Tip: Start with a visualization

“Imagine that you return to work and find a transformed organization. Everything works well. It is high-performing with top-notch care. It blends its service mission and its leadership roles in perfect resonance with the needs and aspirations of the community. Its value and contribution are well known, openly appreciated and frequently celebrated.”
Then consider the following...

- What do you see in this vision?
- What are the key elements of your vision?
- How does this feel to you?
- What will help you achieve your vision?
Stage 4: design

* Plan and prioritize processes/interventions that would work well

* Grate

* Make choices about "What is needed"

* Work towards innovation and creating the ideal

* Questions to consider

  * What resources do we need?
  * Who do we need to engage?
  * What is most important to us?

"CREATE"
Stage 5: deliver

* Implement the proposed design.

* Goals:
  * Initiate actions that support innovation and ideas generated in conversation.
  * Discuss “what will be”
  * Develop an action plan

* Questions to Consider:
  * What are our action items?
  * What will we prioritize?
  * How will we present this information?
  * Who needs to know about this?
The process

- Discover
- Dream
- Design
- Deliver
The appreciative inquiry...

- Is inherently flexible
- Requires bidirectional investment
- Brainstorming is best done in small groups
Let’s give it a try! [i.e. small group work]

* Break into groups of 5-7 people.
* Take 5min and individually fill out guided worksheet
* Come together as a group and start working through the AI stages (5min/stage):
  * Discover
  * Dream
  * Design
  * Deliver
* We’ll let you know when to move on to the next section
* At the end we’ll do a brief report out.
Focus question:

What influences your well-being at work? What does your institution do well to promote physician well-being at work?
<table>
<thead>
<tr>
<th>AI Stage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discover</strong></td>
<td>Identifying processes that work well. The best of “what is” and “what has been.”</td>
</tr>
<tr>
<td><strong>Dream</strong></td>
<td>Building upon what already works well. Envision what else is needed/might work well in the future. Explore “what might be.”</td>
</tr>
<tr>
<td><strong>Design</strong></td>
<td>Plan and prioritize ideas/innovations that would work well. Make choices about “what might be.”</td>
</tr>
<tr>
<td><strong>Deliver</strong></td>
<td>Implement proposed design. Develop action plan. Support the innovation of “what will be.”</td>
</tr>
<tr>
<td>AI Stage</td>
<td>Comments</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Discover</strong>&lt;br&gt;Identifying processes that work well. The best of “what is” and “what has been.”</td>
<td>Daily noon conference/educational time for residents and fellows.</td>
</tr>
<tr>
<td><strong>Dream</strong>&lt;br&gt;Building upon what already works well. Envision what else is needed/might work well in the future. Explore “what might be.”</td>
<td>Improving protected time and attendance at noon-time conference.</td>
</tr>
<tr>
<td><strong>Design</strong>&lt;br&gt;Plan and prioritize ideas/innovations that would work well. Make choices about “what might be.”</td>
<td>Engaging faculty members and staff in supporting resident/fellow protected educational time. Obtaining buy-in from administration.</td>
</tr>
<tr>
<td><strong>Deliver</strong>&lt;br&gt;Implement proposed design. Develop action plan. Support the innovation of “what will be.”</td>
<td>Partner with administration to email faculty and encourage prompt rounding and facilitating resident/fellow attendance at noon-time activities. Create noon-time activities for the community such that attendings and staff are able to participate as well.</td>
</tr>
</tbody>
</table>
Report out

- You choose:
  - Share/comment on what was helpful /beneficial about this approach.
  - Share/comment on what was challenging about this approach.
  - Share 1-2 action items that your group developed
  - Share what you might take back to your home institution.
Structuring a session: considerations

How many people will be involved?
Splitting into groups of 5-10 may help with conversation.

Who will be involved?
For example, if looking at resident well-being, would you like it to be resident run? Or would you like to have administration present?

How many facilitators will you need?
It is helpful to have at least 1 facilitator per small group.

What is your time frame?
Knowing how much time you have will help determine how much time to spend on each stage.

Plan this out PRIOR to the session!
The Discover, Dream and Design stages can often run long...it is helpful to have a time keeper!
Structuring a session: considerations (cont.)

How will you gather the information?

- Having handouts or flipcharts are helpful when it comes to organizing.
- Report outs from each small group will help create a “master list” of ideas.

What will you do with the information?

- Ideally this question is answered prior to the session – being invested in working on/towards action items developed in the Appreciative Inquiry will give the session more power.
- If possible, state this at the BEGINNING of the session.
The Wrap-up: Take Home points

- Go to the source!
- The AI method is flexible...
  - It can be done with any size group
  - It can be adjusted to fit various time constraints
- Encourage participation and be ready to listen
- Developing an action plan helps create a roadmap for change and innovation
Passing the baton

- Take it home and give it a try!

- You have:
  - Each other!
  - This presentation
  - A review sheet of AI states
  - A guided worksheet for use as an individual or group

- If you have any questions, please feel free to email us, we’d be more than happy to chat!

  Cristin McDermott, MD – mcdermottc@upmc.edu
  Victoria Winkeller, MD – winkellervs@upmc.edu
“Organizations are, first and foremost, centers of human relatedness, and relationships come alive where there is an appreciative eye, when people see the best in one another and the whole...by making it possible for every voice to be heard, a life giving process is enacted.”
Resources:

- Case Western Reserve University: [https://appreciativeinquiry.case.edu/intro/whatisai.cfm](https://appreciativeinquiry.case.edu/intro/whatisai.cfm)
- The Center for Appreciative Inquiry: [https://www.centerforappreciativeinquiry.net](https://www.centerforappreciativeinquiry.net)
- University of Leicester. “Appreciative Inquiry: An Outline.”
THANKS!

Any questions?
You can find us at:

Cristin McDermott, MD – mcdermottc@upmc.edu
Via Winkeller, MD – winkellersv@upmc.edu
### Appreciative Inquiry: Guided Worksheet

<table>
<thead>
<tr>
<th>STAGE</th>
<th>IDEAS</th>
</tr>
</thead>
</table>
| **DISCOVER** | | Brainstorm the best of “what is” and “what has been.”  
Identify individual/program/system processes that work well. |
| **DREAM** | | Explore “what might be.”  
Build upon what already works well.  
Envision what else is needed to create the ideal. |
| **DESIGN** | | Plan and prioritize ideas and innovations.  
What resources might be needed? |
| **DELIVER** | | Support “what will be.”  
Develop action items and a plan for innovation.  
Who will need to be informed of these ideas?  
How will the information be presented? |
Appreciative Inquiry Quick Review – 5 Stages

Stage 1: Define
Goal: Frame the question.
Questions to consider:
- What would you like to focus on?
- What vision would you like to build?
The focus question should be positive / desirable / motivational

Stage 2: Discover
Goal: Understand the best of “what is” and “what has been”
Questions to Consider:
- What has been working well for?___?
- Can you tell a story of a time when ___ was working well? What contributed to this moment?
- What are the key elements of why these things have worked well?

Stage 3: Dream
Goal: Envision processes/interventions that would work well in the future. Explore “what might be.” Explore ideas for community, organization, etc.
Questions to Consider:
- What can we build upon?
- What else do we need?
- What would help us function at our highest, most productive, collaborative and efficient level?

Stage 4: Design
Goal: Plan and prioritize processes/interventions that would work well. Make choices about “what should be.” Work towards improvement and shaping “the ideal.”
Questions to Consider:
- What resources do we need?
- Who do we need to engage?
- What is most important to us?

Stage 5: Deliver
Goal: Implement the proposed design. Initiate actions that support innovation and ideas generated in conversation. Discuss “what will be.” Develop an action plan.
Questions to Consider:
- What are our action items?
- What will we prioritize?
- How will we present this information?
- Who needs to know about this?