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Redeployment and Burnout among Healthcare Workers During the COVID-19 Pandemic

Varuna Sundaram, MD

NYP-Queens/Weill Cornell Medicine

Co-Authors: Robert Crupi MD, Cynthia X. Pan MD, Phyllis August MD MPH, Rebekah R. Simons, BA, Elizabeth Brondolo, Ph.D.

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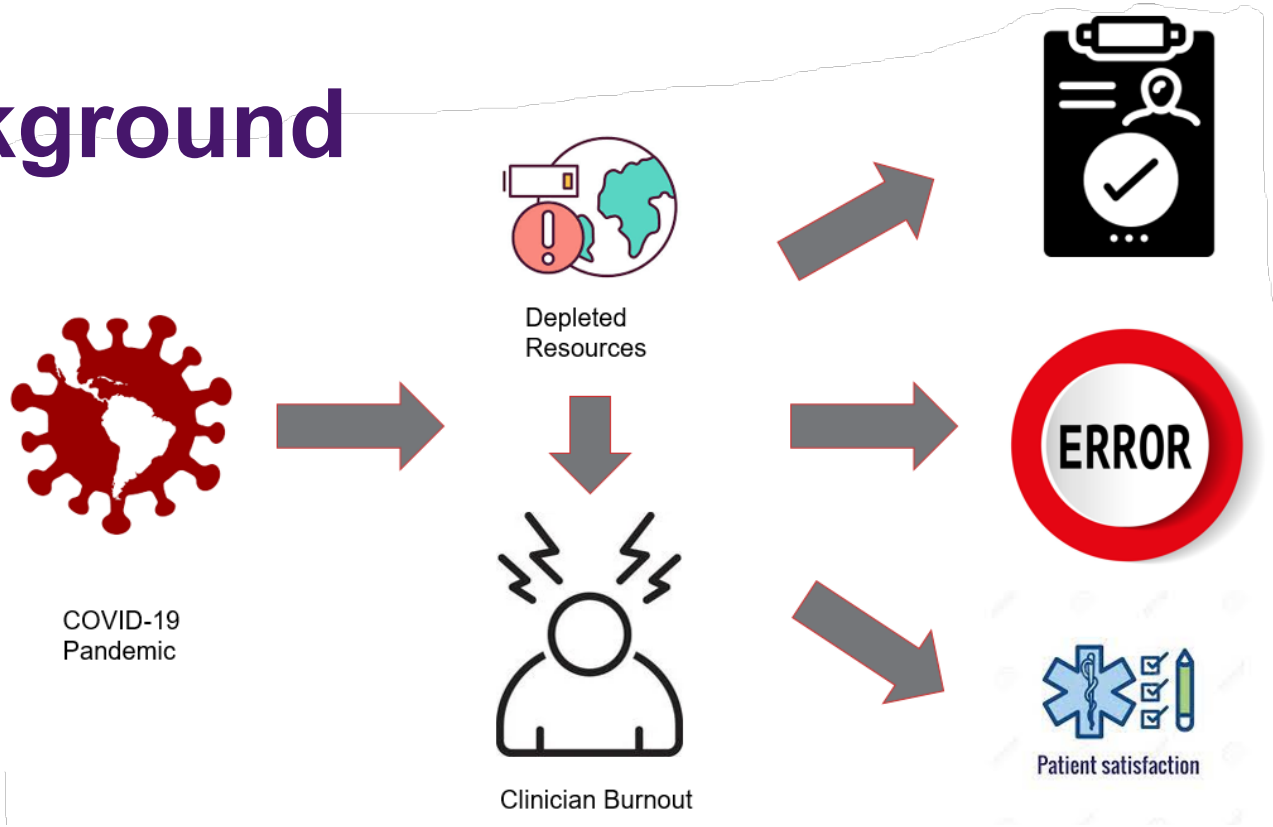
Disclosures

- No disclosures

Objectives

- Evaluate the role of redeployment on burnout of healthcare workers during the covid-19 pandemic
- Understand the extent of burnout in relationship to redeployment and time to recovery
- Evaluate additional factors which can be addressed to help mitigate burnout in the setting of redeployment

Background

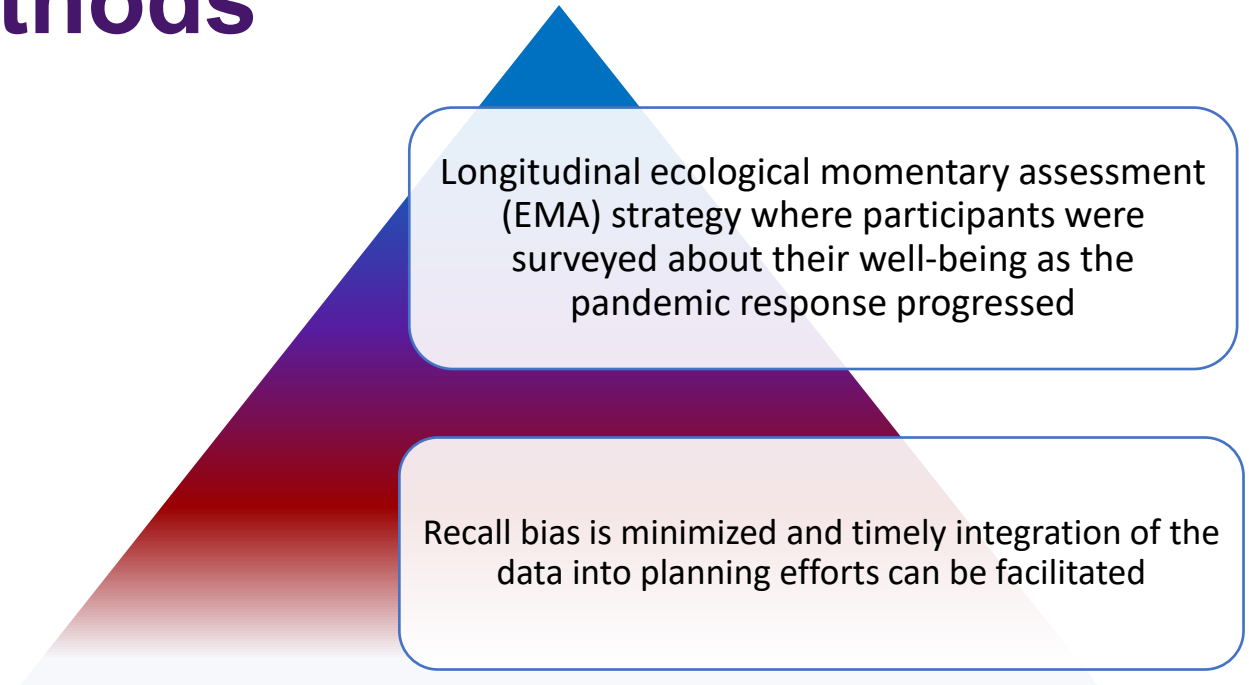

Depleted
Resources
COVID-19
Pandemic
ERROR
Clinician Burnout
Patient satisfaction

Methods

- Online 10-item survey administered via Qualtrics to all healthcare workers (HCW) at an urban academic-affiliated community hospital within six weeks of first COVID-19 admission and every five days thereafter for an entire year
  - This presentation covers period from 4/14/20-6/16/20
- **Burnout:** Primary outcome was burnout, assessed with a single validated item[1].
- **Redeployment:** Those working out of their usual role at the assessment time, were regarded as redeployed for that period.
- The survey also assessed sociodemographic information, self-efficacy, perceived support from the hospital, meaningful work, and professional development.

[1] Dolan et al. *J Gen Intern Med* 2015. doi:10.1007/s11606-014-3112-6

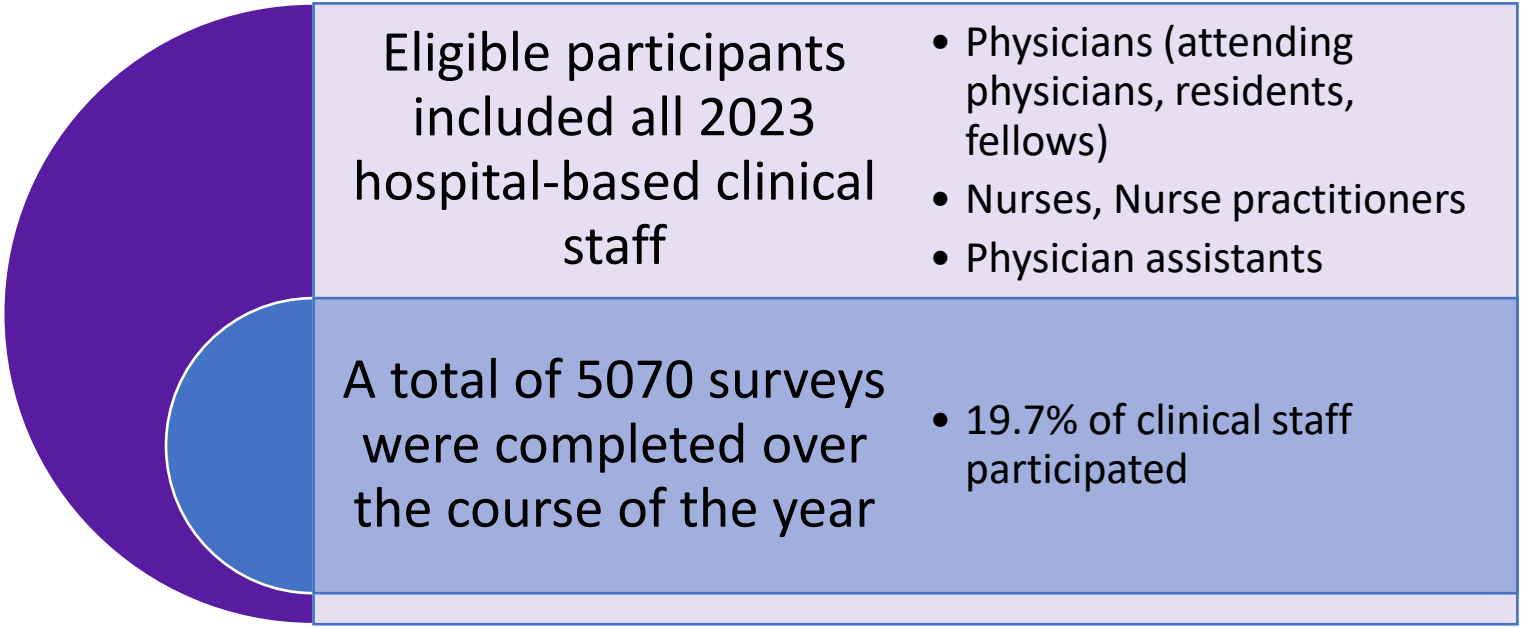
Methods



Longitudinal ecological momentary assessment (EMA) strategy where participants were surveyed about their well-being as the pandemic response progressed

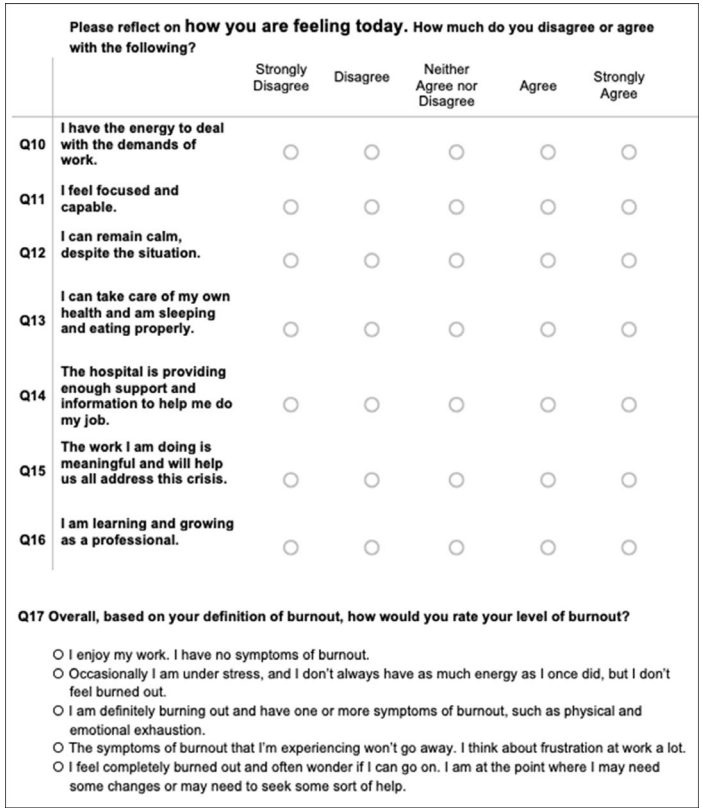
Recall bias is minimized and timely integration of the data into planning efforts can be facilitated

Methods


Eligible participants included all 2023 hospital-based clinical staff
• Physicians (attending physicians, residents, fellows)
• Nurses, Nurse practitioners
• Physician assistants
A total of 5070 surveys were completed over the course of the year
• 19.7% of clinical staff participated

Survey

- Survey administered confidentially
  - Median time to completion; 54 seconds
- 7 items for demographic and professional information obtained only on initial assessment
- 10 questions addressing clinical responsibilities, personal and professional resources and burnout administered ***at every assessment point***
- Open-ended option to provide feedback confidentially



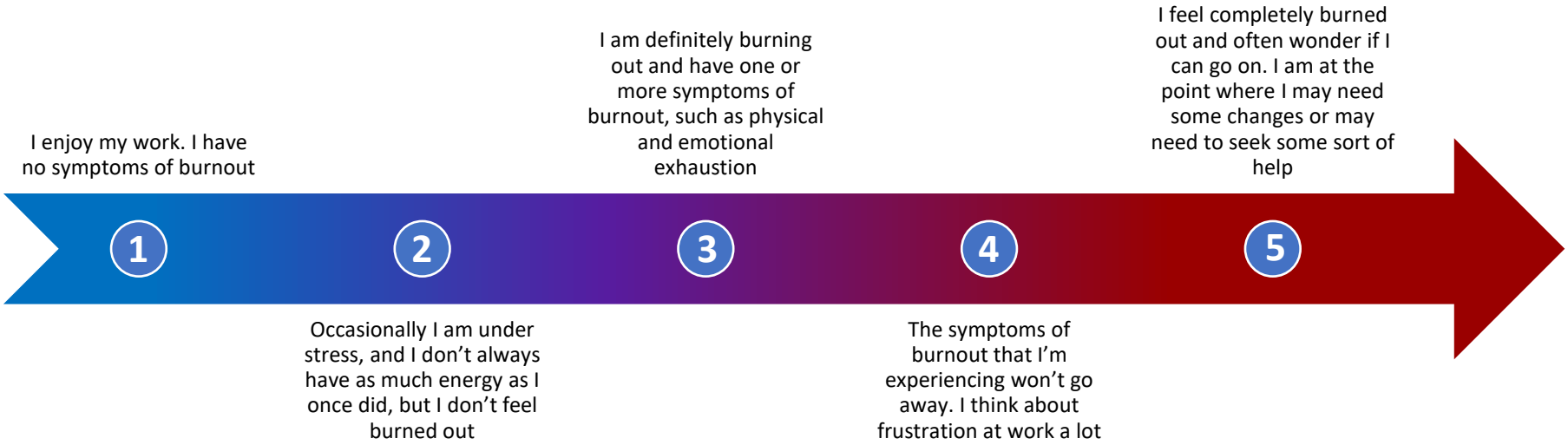
Please reflect on how you are feeling today. How much do you disagree or agree with the following?

		Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Q10	I have the energy to deal with the demands of work.	○	○	○	○	○
Q11	I feel focused and capable.	○	○	○	○	○
Q12	I can remain calm, despite the situation.	○	○	○	○	○
Q13	I can take care of my own health and am sleeping and eating properly.	○	○	○	○	○
Q14	The hospital is providing enough support and information to help me do my job.	○	○	○	○	○
Q15	The work I am doing is meaningful and will help us all address this crisis.	○	○	○	○	○
Q16	I am learning and growing as a professional.	○	○	○	○	○

Q17 Overall, based on your definition of burnout, how would you rate your level of burnout?

- ○ I enjoy my work. I have no symptoms of burnout.
- ○ Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.
- ○ I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.
- ○ The symptoms of burnout that I'm experiencing won't go away. I think about frustration at work a lot.
- ○ I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.

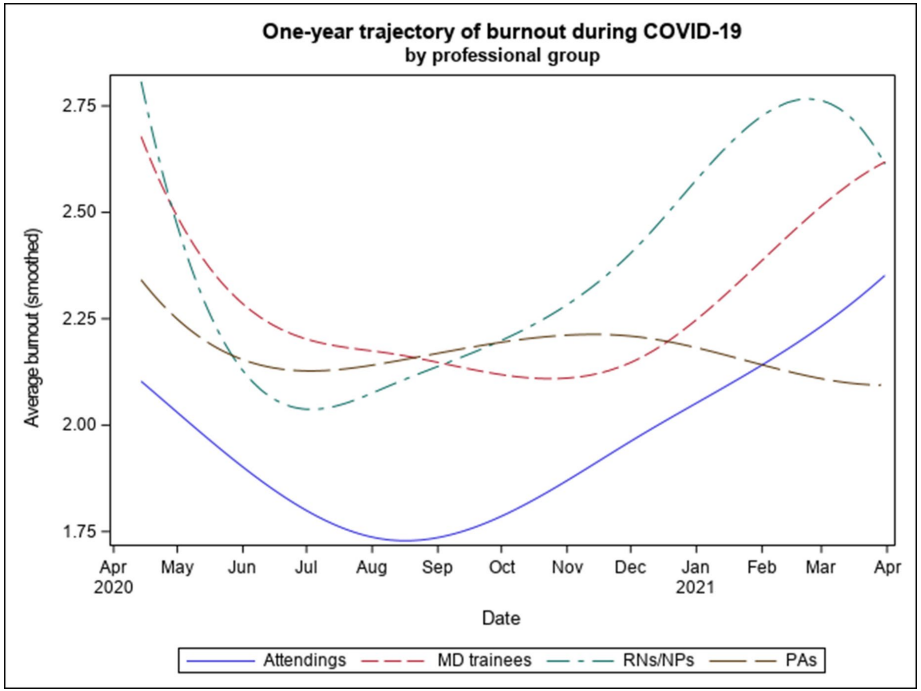
Burnout Score



[1] Dolan et al. *J Gen Intern Med* 2015. doi:10.1007/s11606-014-3112-6

Results

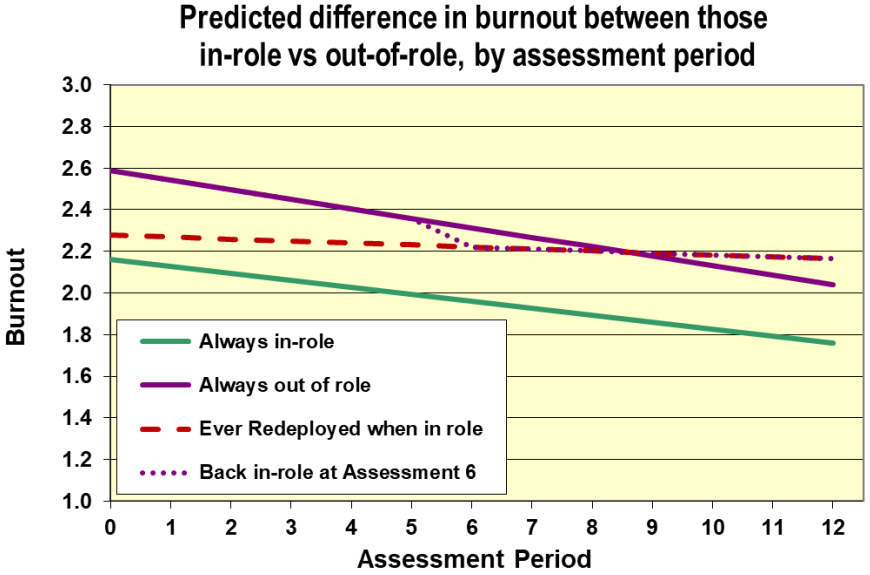
- All professional roles were represented
- Initial survey:
  - 54.7% participants did no report symptoms of burnout (i.e. score of 1 and 2)
  - 32.4% participants reported moderate burnout (score 3)
  - 12.9% participants reported high levels of burnout (score 4 and 5)
- Among these initial respondents who completed more than 1 subsequent survey (n=322), ***burnout was reported on average of 64% of their remaining assessments***



Results

- At the time of initial survey:
  - 146 (40.9%) were redeployed
  - 193 (54.1%) were redeployed at least once as survey progressed
- Those who were redeployed initially had significantly higher levels of burnout (Mean burnout score 2.49; SD =.92)
  - Remained statistically significant even after controlling for gender and professional role ($p<.001$)

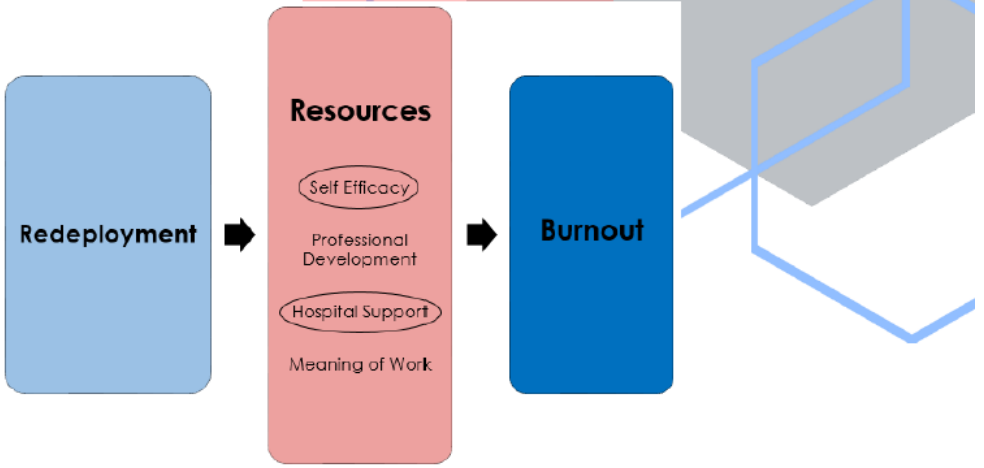
Results



- Over time, those who were ***ever*** redeployed, had higher level of burnout and lower self-efficacy scores, compared to those who were never redeployed
- Effect of redeployment on burnout persisted even after returning to their usual role
- Redeployment was negatively associated with self-efficacy and hospital support
  - In particular, those who were redeployed at any point reported they did not have enough energy and felt less capable of caring for their own health than those who were not redeployed

Results

Self-efficacy	Hospital Support	Professional Development	Meaningful Work
I can take care of my own health and am sleeping and eating properly.	*The hospital is providing enough support and information to help me do my job.*	*I am learning and growing as a professional.*	*The work I am doing is meaningful and will help us all address this crisis.*
I feel focused and capable.			
I can remain calm, despite the situation.			
I have the energy to deal with the demands of work.			



Lower levels of self-efficacy and less perceived support from the hospital were associated with higher levels of burnout.

Thoughts from Participants

On the survey, participants were given the opportunity to write in their own thoughts and ideas.

Many identified the need for more training and direction when assigned to critical care units or other areas outside their usual role.

Some expressed concerns about the quality of care they were delivering when they were working outside their usual role.

When redeployed, participants wrote that it was stressful to manage the new unit routines, procedures, shifts, and personnel.

Recommendations for Leaders

- Redeployment is essential to meet clinical demands, but, on average, redeployment may take a toll on health care workers.
- Hospital leaders may need to explicitly recognize the emotional and physical demands associated with redeployment, and
    - Provide support to help clinical staff take care of their own health.
    - Optimize the ability to share knowledge quickly and efficiently to enhance self-efficacy as clinicians are redeployed to new areas.
    - Develop just-in-time orientation and training procedures for redeployed staff.

Resources that help support employee health and well-being can be found by visiting the Employee Support Resources for COVID-19 Infonet page.

This project is a collaboration of NYP-Queens Hospital and St. John's University

For more information, please email:
Dr. Elizabeth Brondolo at brondole@stjohns.edu or Dr. Cynthia Pan at cxp9001@nyp.org

Conclusions

- Redeployment is essential to meet clinical demands during a pandemic, however hospitals and supervisors need to recognize the emotional and physical demands associated with redeployment.
- The findings on self-efficacy suggest that interventions focused on providing information and supporting people's efforts at self-care might be valuable.
- Improving speed and efficiency of knowledge sharing may enhance self-efficacy. Developing new orientation and training procedures for redeployed staff may also be useful.

Acknowledgement

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We would also like to thank Teressa Ju, M.D., Miri Kim, M.D., Michael Siu, M.D. and Sabiha Merchant, M.D. for their recruitment assistance.

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Stanford HEALTH CARE

Reinventing the After-Hours Call Experience for Physicians: Deployment of an Enterprise-Wide After-Hours Nurse Triage Health Call Center to Improve Patient and Provider Satisfaction and Well-being

American Conference on Physician Health
October 8, 2021

Speakers:

Fouzel Dhebar, MPA/HSA, MSc. Executive Director, Health Navigation Services

Eric Lee G. Escobedo-Wu, DNP, RN, PHN, CCM, NEA-BC Administrative Director, Clinical Navigation Services

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Questions Posed

- Who are we?
- What opportunities was Stanford Health Care and Clinical Advice Services trying to solve regarding physician after-hours calls and clinical triage?
- What were the process considerations in creating Clinical Advice Services?
- What are the key findings: metrics, utilization, and outcomes?
- What are the key reflections?

Stanford Health Care - *Who Are We?*

Stanford Health Care is a not-for-profit academic healthcare system with leading edge clinical capabilities led by world-renowned Stanford University physicians

- Founded in 1959, Stanford Hospital & Clinics – now known as Stanford Health Care – is known for **advanced patient care**, particularly for the treatment of rare, complex disorders in areas such as:
  - Cardiovascular Health
  - Cancer Treatment
  - Neurosciences
  - Organ Transplantation
  - Orthopaedic Surgery

- **Quaternary Care, Teaching Hospital, and Academic Partner** for Stanford University School of Medicine

- **Shared Services** with Lucile Packard Children's Hospital Stanford**:**
  - Catheterization Laboratory
  - Clinical Laboratory
  - Emergency Management
  - Environment of Care & Life Safety
  - Radiation Oncology Department

Clinical Advice Services Core Services

- **Enterprise-wide clinical management solutions health call center that provides:**

Core Services

- Clinical Nurse Triage (Daytime & After-hours)
- ED and Inpatient Post-Discharge Phone Calls
- COVID-19 Response for Patients & Employees:
  - Clinical Triage
  - PCR Test Results Reporting
  - Vaccine and Appointment Scheduling
- Suicidal Ideation and Distressed Callers Clinical Response Management
- SHC Specialty Pharmacy
- Medication Reconciliation and Management
- Online Second Opinion Program – SHC and SCH

Delivery

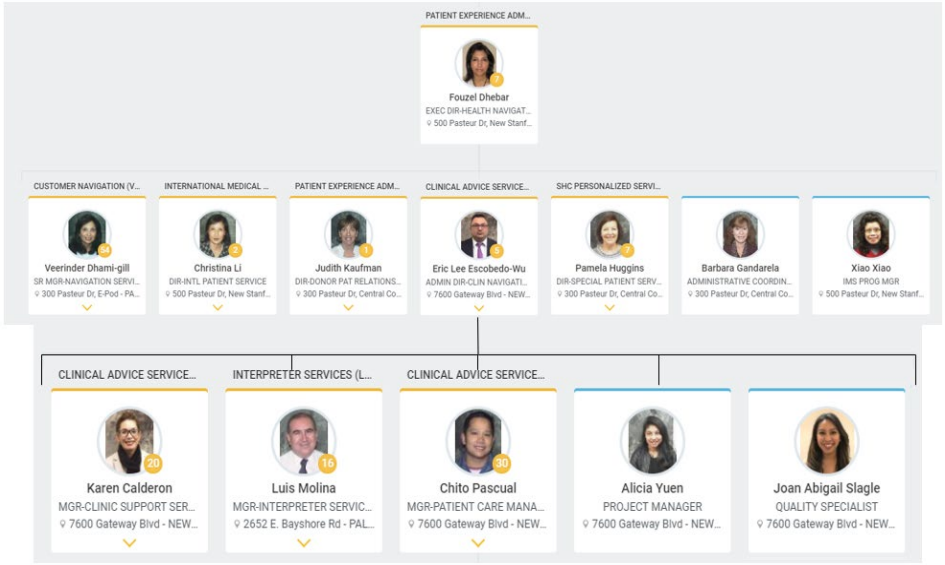
- Quality patient care and experience across continuum of care
- Decreases resource overutilization (ED) & prevents care gaps/delays
- Solution for health plan cost containment
- Enterprise-wide ambulatory clinical data, resource utilization, quality metrics, and outcomes
- Meets requests for enterprise-wide initiatives effectively, as evidenced by:
  - COVID-19 Response
  - Deployment of services across the SHC enterprise

- On November 1, 2019, Clinical Advice Services became a **Utilization Review Accreditation Commission Health Call Center** which:
  - Demonstrates a commitment to quality services
  - Provides accountable and value-based care
  - Serves as a framework to improve business processes
  - Metrics: RN Call Back Time, Average Speed to Answer, and Abandonment Rate

URAC ACCREDITED Health Call Center Expires 11/01/2022

Clinical Advice Services Team

Organizational Leadership



Clinical Advice Services Leadership Team

- Administrative Director
- Patient Care Manager
- Manager
- 3 Assistant Patient Care Managers
- 3 Nurse Educators
- Quality Specialist
- Project Manager
- Supervisor

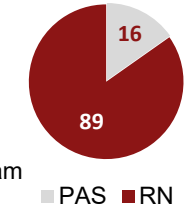
Clinical Advice Services Triage Team

People:

- **Registered Nurses (RN):** Licensed to provide clinical triage based on approved or vetted protocols related to specific conditions or treatment pathways
- **Patient Administrative Specialists:** Non-licensed, non-clinical personnel receiving initial intake, establish consent, and first contact resolution for non-clinical concerns

Team Scope:

- Telephonic Clinical Nurse Triage
- Medication Management & Education Program
- COVID-19 Clinical Telephonic Response Team
- Suicidal Ideation and Distressed Caller Response Team



Patient Administrative Specialists - Work From Home Team

People:

- 5 Patient Administrative Specialists
- Staggered shifts 7 days a week (0600-1700)

Team Scope:

- Post Discharge Phone Calls
  - Emergency Department (Peds & Adults)
  - 500P & 300P Inpatient Discharges (all units)
  - Perianesthesia Units
- Adherence Calls
- Online Second Opinion Program (OSOP) – Stanford Health Care & Stanford Children's Hospital
- Email and CRM management
- All clinical concerns escalated to Nurse Triage Queue

Clinical Advice Services: Using Lean Chassis to Optimize Nurse-driven Telephonic Triage of After-hour calls from patients

Eric Lee G. Escobedo-Wu, MS, RN, PHN, CCM, CHA[1], Fouzel Dhebar, MPA/HSA, MSc[1], Alpa Vyas, MHA[1], Nawal Johansen, MD[2]

[1]Stanford Health Care, [2]Stanford University School of Medicine

PROBLEM STATEMENT

No standardized connectivity between patients and providers after-hours.

BACKGROUND AND IMPORTANCE

- It is challenging for patients to navigate through healthcare systems after-hours.
- This leads to delay in care, patient/provider dissatisfaction, inappropriate resource utilization, readmissions, and higher costs.
- It is important to provide our patients and providers with effective clinical decision-making tools to allow seamless connectivity and coordinated care at all times.

GOALS

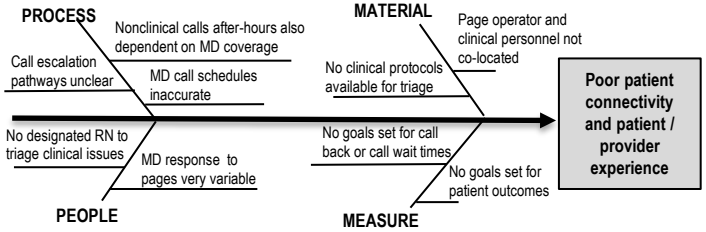
Process Measures:

- Achieve clinical protocol adherence by Clinical Advice Services staff of >90%

Outcome Measures:

- Achieve physician (MD) call escalation rate of <10%
- Achieve emergency department (ED) triage rate of <10%

PROBLEM ANALYSIS



KEY LEARNING

A seamless connectivity vision, cascading, multidisciplinary ownership of the problem, and synergistic enterprise improvements have contributed to this success while we strive for continuous improvement.

FUTURE STATE AND IMPLEMENTATION

- In August 2015, patient-centric Clinical Advice Services (CAS) was established to provide clinical decision support after-hours.
- CAS is founded on key Lean principles: Value stream mapping, empathy mapping, waste walk, takt time calculations, standard work, plan-do-check-act cycles, and active daily management.
- At CAS, Clinical Assistants take the initial call and manage all non-clinical calls (eg. appointments, directions, general information).
- If the patient has a clinical symptom, the CAS nurses take the call, and utilize standardized clinical protocols to triage the patient to home, clinic, urgent care, emergency department, or 911. Nurses may contact the on-call physician based on the clinical protocol.

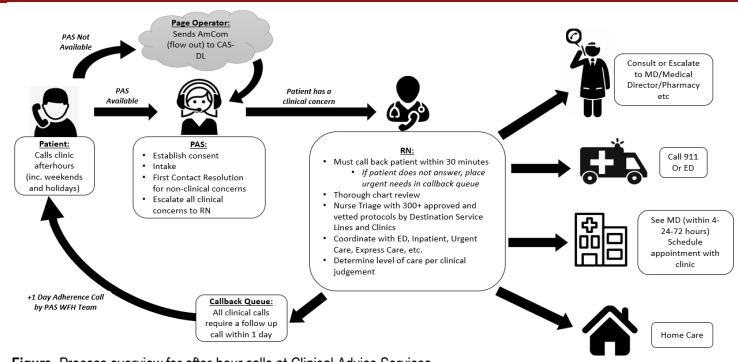


Figure. Process overview for after-hour calls at Clinical Advice Services

FOLLOW UP AND SUSTAIN RESULTS

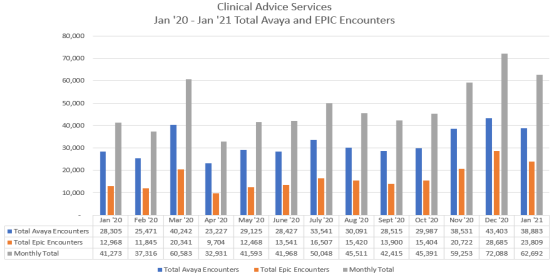


Figure. Distribution of after-hour calls received between Jan '20 through Jan '21.

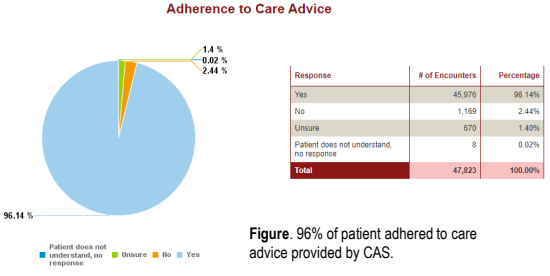


Figure. 96% of patient adhered to care advice provided by CAS.

- Since August 2015, CAS has managed >700,000 calls from over 100 clinical specialties.
- Reporting is built into our electronic health records.
- 92% of patients had all of their needs met.
- Average 10% of primary care calls were escalated by CAS staff to the physician on call.
- Average <5% of the patients were triaged to ED by CAS.

Opportunities to Improve Physician Wellness

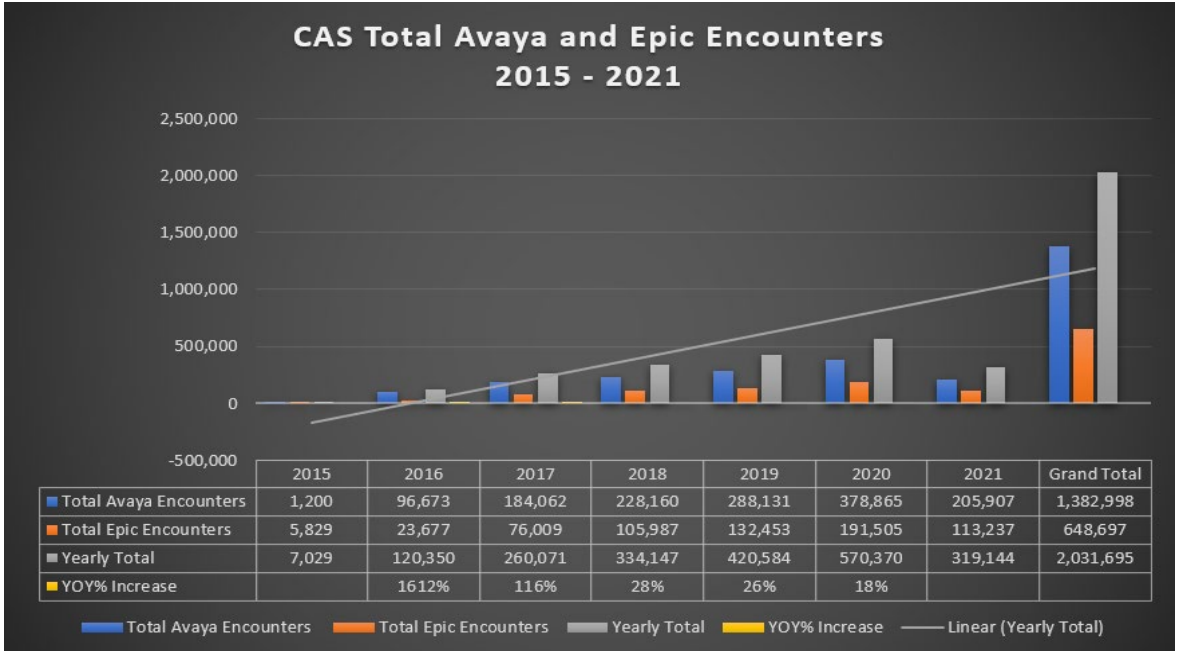
- A seamless, premier, customer-centric portal is critical for providing exceptional clinical care, service and access, especially during transitions of care.

- State of afterhours calls **prior** to Clinical Advice Services:
  - Clinical call management process and documentation variation
  - Clinical interruptions during patient care, hospital rounding, and surgical cases
  - Lack of coordinated care with appointment scheduling and follow-up appointments
  - Physician dissatisfaction, burnout, and lack of work-life balance
  - Patient frustration with after-hours experience and delays in care

- Clinical Advice Services Design & Operations influenced and supported by Lean principles:
  - Value Steam Mapping
  - Waste Walk
  - Takt time Calculations
  - Standard Work
  - Plan-Do-Check-Act Cycles
  - Active Daily Management
  - Quality Assurance

Clinical Advice Services Key Metrics – Nurse Triage

Metric Overview Reporting Period (8/1/2015 – 7/31/2021)	
Epic Encounters	Epic Encounters – 2,031,695
Calls Escalated to MD	3% ****average over reporting period****
Patients referred to ED	4% ****average over reporting period****
Top 3 Utilizers	Corona Virus / Primary Care Neurology Eye
Top Call Types	▪ Appointment / Scheduling ▪ Medication Question ▪ Patient Question ▪ COVID-19 Screening
Top Call Dispositions	▪ Information or Advice Only (COVID-19) ▪ Home Care ▪ Call Routed to PC Special Response Pool



	2015	2016	2017	2018	2019	2020	2021	Grand Total
Total Avaya Encounters	1,200	96,673	184,062	228,160	288,131	378,865	205,907	1,382,998
Total Epic Encounters	5,829	23,677	76,009	105,987	132,453	191,505	113,237	648,697
Yearly Total	7,029	120,350	260,071	334,147	420,584	570,370	319,144	2,031,695
YOY% Increase		1612%	116%	28%	26%	18%		

Findings:

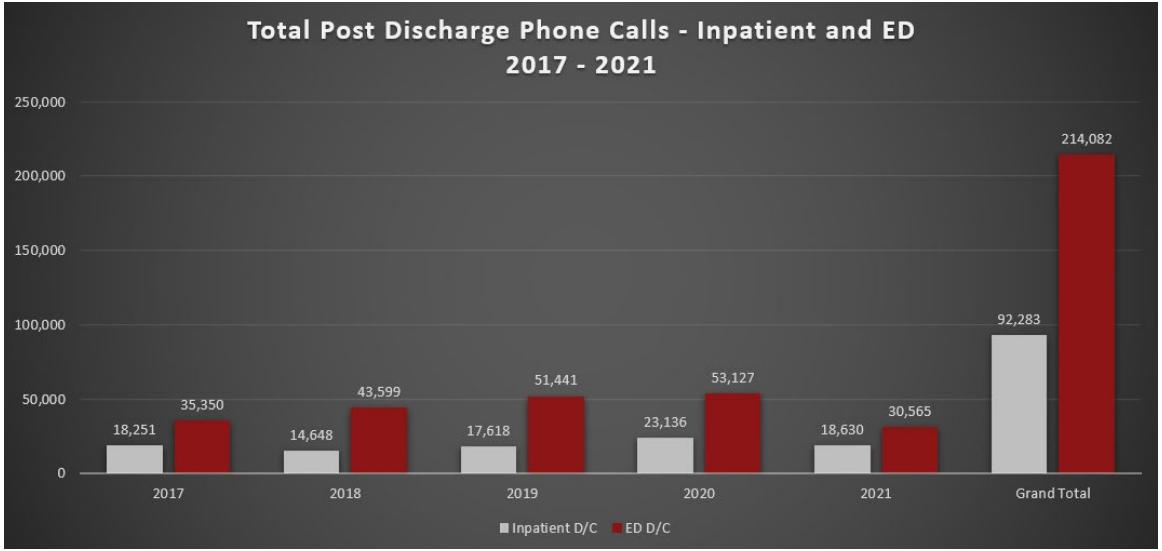
- Approximately 40% of call volume is addressed by a Clinical Assistant
- Primary Care as top utilizer supports the purchase of Thompson Nurse Clinical Pathways since they are geared for this population
- Opportunities exist for more upstream management of medication questions/refills/perioperative education
- An average of < 5% ED reinforces appropriate use of clinical pathways

Actions:

- Facilitate protocol optimization with Heme/Onc leaders for Cancer Fever and Cancer Pain clinical pathways
- Work with deployed services to optimize medication management and education during daytime hours
- Work with Surgical Sub-specialties on education and training of CAS RNs to ensure competence in pre and post op instructions
- Provide feedback to surgical services to reinforce discharge instructions

Post Discharge Phone Calls – Inpatient and ED Metrics

Metric Overview Reporting Period (1/1/2017 – 7/31/2021)	
Inpatient	Total Encounters**: 92,283** Total Encounters Resolved: **62,506** Resolution Rate: **68%**
Emergency Department	Total Encounters**: 214,082** Total Encounters solved: **176,714** Resolution Rate: **83%**



Actions:

- Scaled to All SHC Inpatient Units
- CAS closes the loop for all patient questions and unresolved items
- Winter 2020: CAS piloted ED Physician Tele-Triage Project
- Capture caregiver information for a grant initiative for Dr. Nirav Shah
- Currently WFH staff of non-clinicians perform all Post Discharge phone calls and escalate to RNs for any clinical issues or routing
- March 2021: CAS began conducting Medication Reconciliation
- June 2021: Post discharge calls scaled to Perianesthesia units

SARS-CoV-2 Summary YTD

Triage Calls

19,598
Calls Offered

8,037
Epic Encounters

898
Positive Screens

Non-ED Test Results

68,701
Total Results

4,061
Positive Results

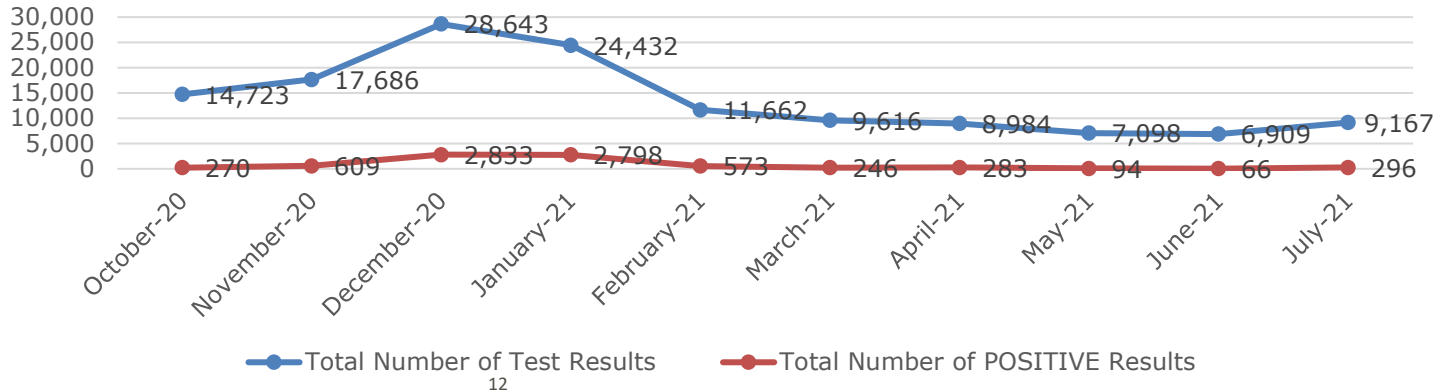
Occ Health

1,093
Calls Offered

1,547
Epic Encounters

Non-ED Test Results

- Go-Live 10/1/2020
- Total Test Results: 138,920
- Total Positive Results: 8,068



Utilization Review Accreditation Commission Metrics 2020 - 2021

RN Call Back Time

(responding to clinical communications within an average of 30" once patient is in the nurse triage queue)

Target:
30 min.

Actual:
29 min. (all calls)
26 min. (excluding med refills and COVID-19)

Abandonment Rate

(% of calls offered that disconnect after 30 seconds when a live person would have answered the call)

Target:
5%

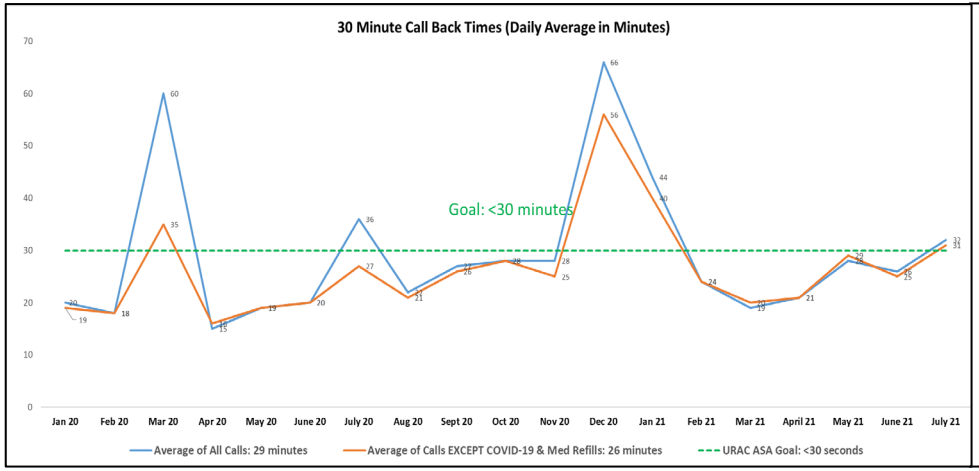
Actual:
7%

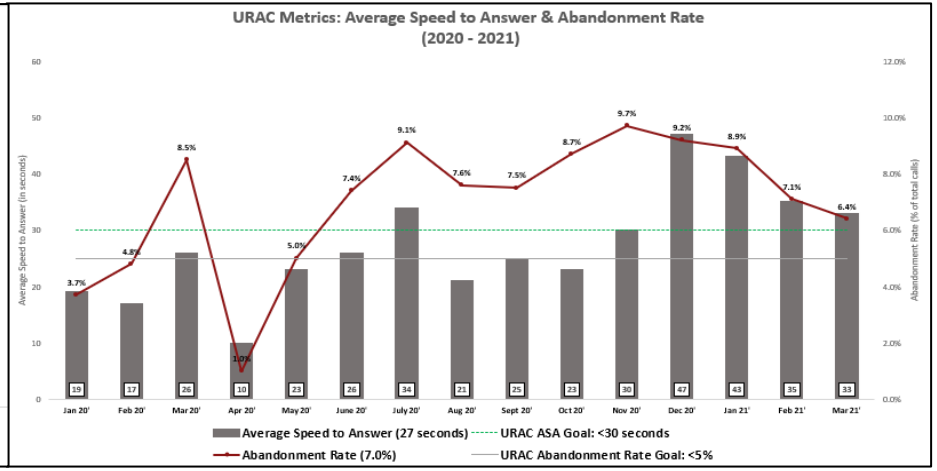
Speed of Answer

(delay in seconds that inbound calls encounter waiting in the phone queue)

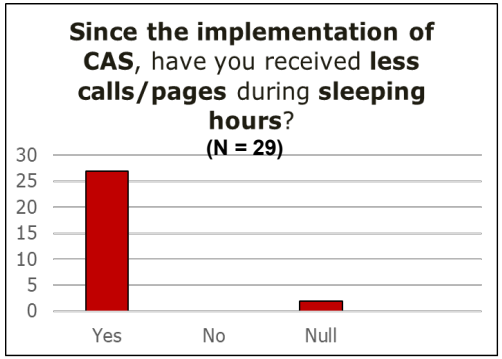
Target:
<30 sec.

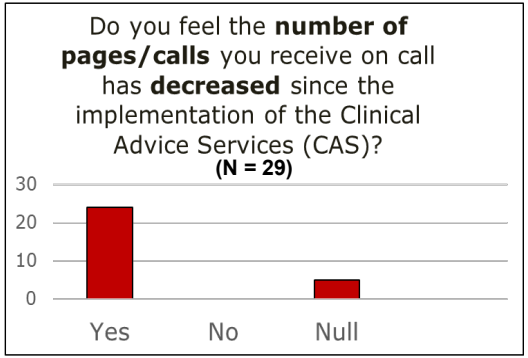
Actual:
27 sec.

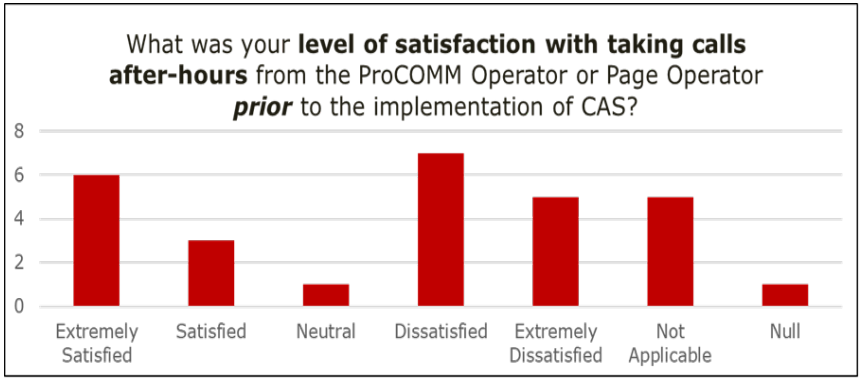


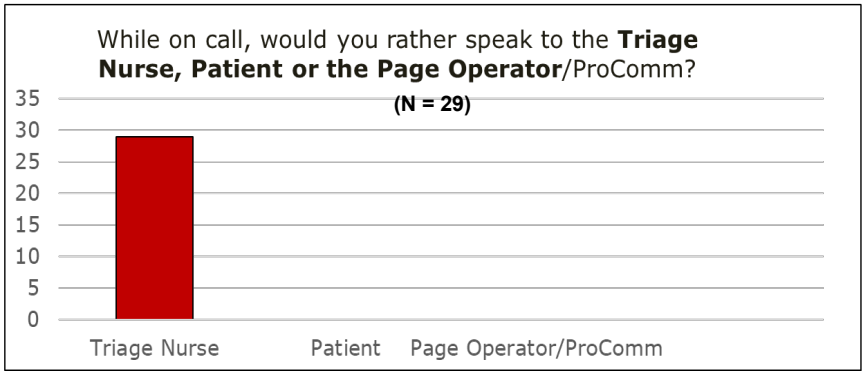


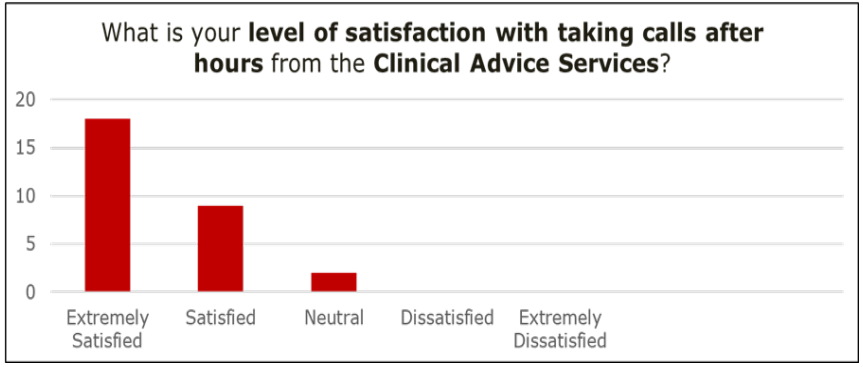
2019 Primary Care Physician Faculty Survey











Reflections

- Establishing an enterprise-wide health call center is attainable, scalable, and decreases physician after-hours workload
- A centralized health call center allows for collaboration to resolve clinical concerns and establish an immediate response solution to public health matters, such as a pandemic
- A robust partnership with Service-specific Subject Matter Experts: Providers, Operational Leaders, and Administrative Staff is essential
- A noteworthy 350+ library of custom and modified Nurse Triage protocols and clinical algorithms provides safe, quality, and efficient care
- >95% patient satisfaction experience
- Increased Physician wellness due to partnership with Clinical Advice Services:
  - Decreased clinical interruptions while caring for sick patients
  - SBAR by triage RN before MD is called –more meaningful MD-RN interaction
  - Standardized documentation of call encounters
  - Consistent process for Medication refills

Contact Information

Fouzel Dhebar, MPA/HAS, MSc.
Executive Director, Health Navigation Services
Office: (650) 725-6032
Cell: (650) 892-0404
Email: fdhebar@stanfordhealthcare.org

Eric Lee G. Escobedo-Wu, DNP, RN, PHN, CCM, NEA-BC
Administrative Director, Clinical Navigation Services
Office: (650) 721-5555
Cell: (650) 683-5819
Email: elescobedo@stanfordhealthcare.org

Question and Answer

AMA
AMERICAN MEDICAL ASSOCIATION

Caring for Caregivers During COVID-19 and Beyond

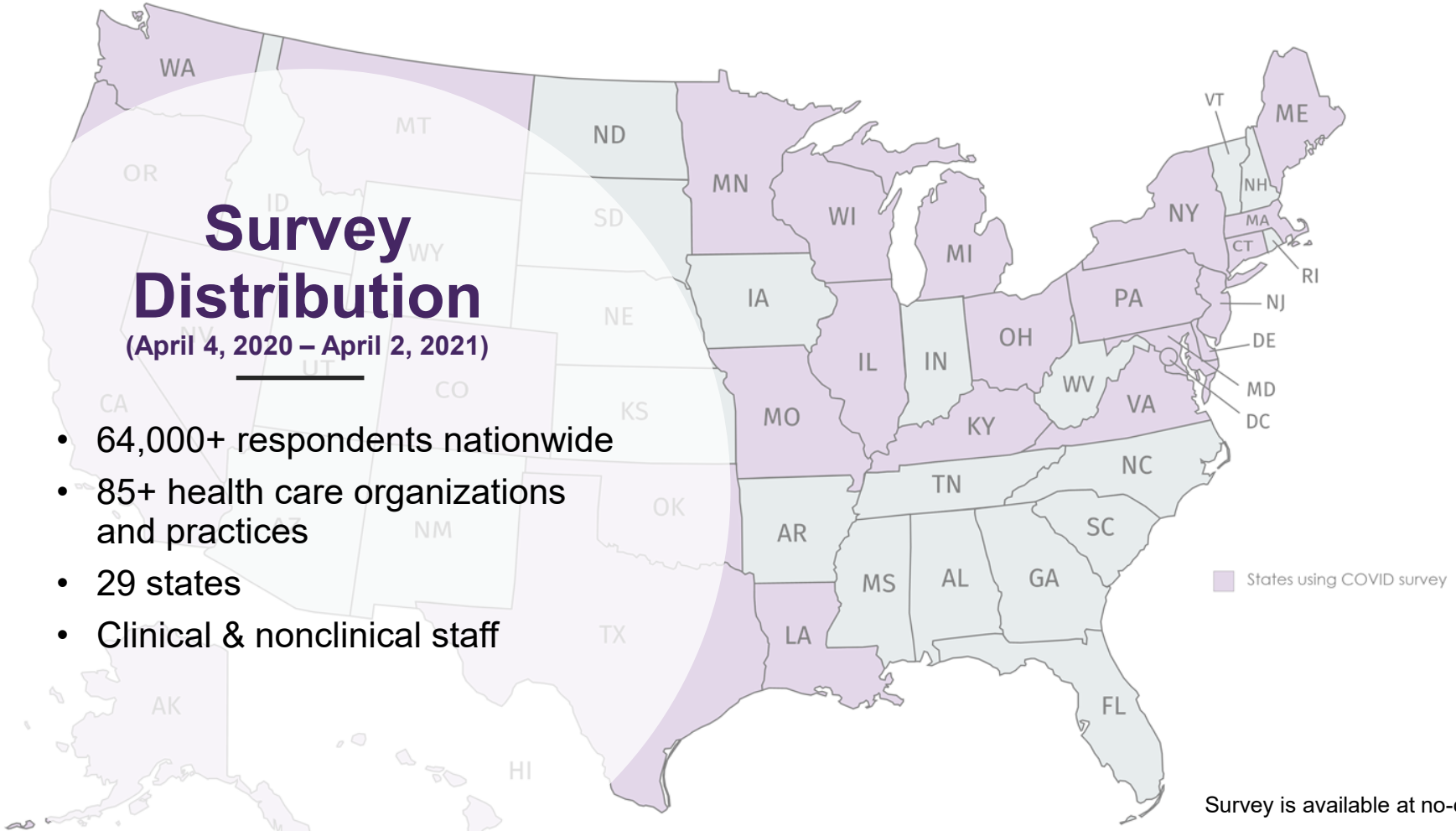
Results: AMA Coping with COVID-19 for Caregivers Survey

October 2021

Survey Distribution

(April 4, 2020 – April 2, 2021)

- 64,000+ respondents nationwide
- 85+ health care organizations and practices
- 29 states
- Clinical & nonclinical staff



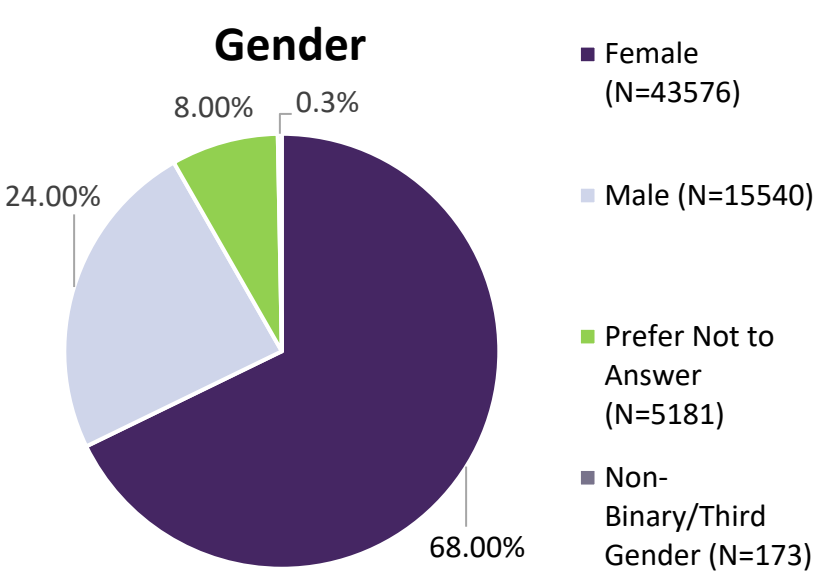
Survey is available at no-cost

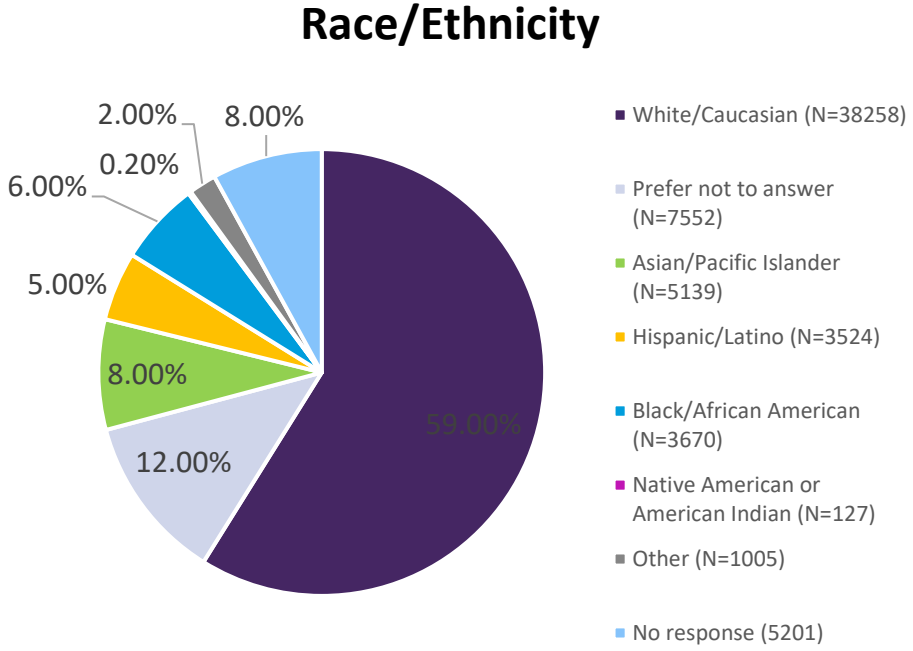
Demographics

Betty Chu, MD
Member since 1997

Demographics

Gender and Race/Ethnicity

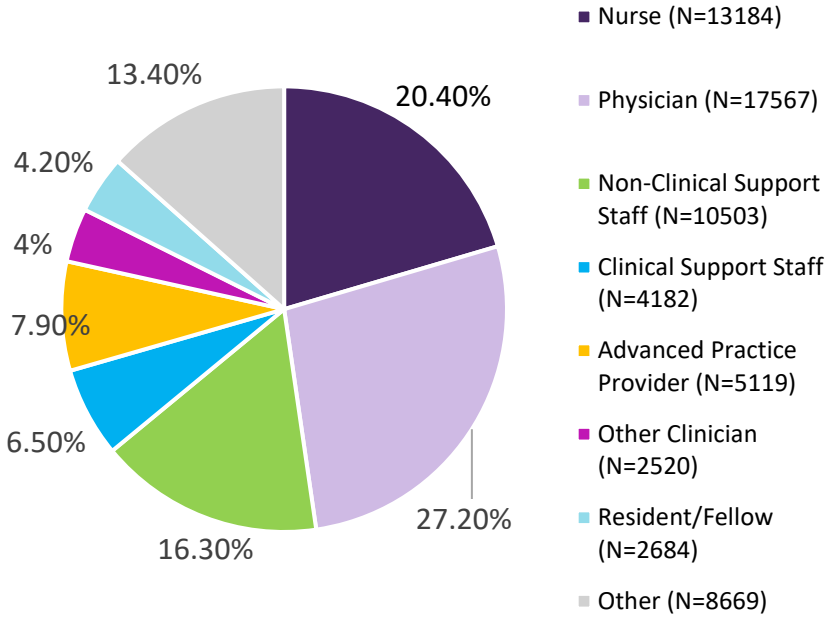




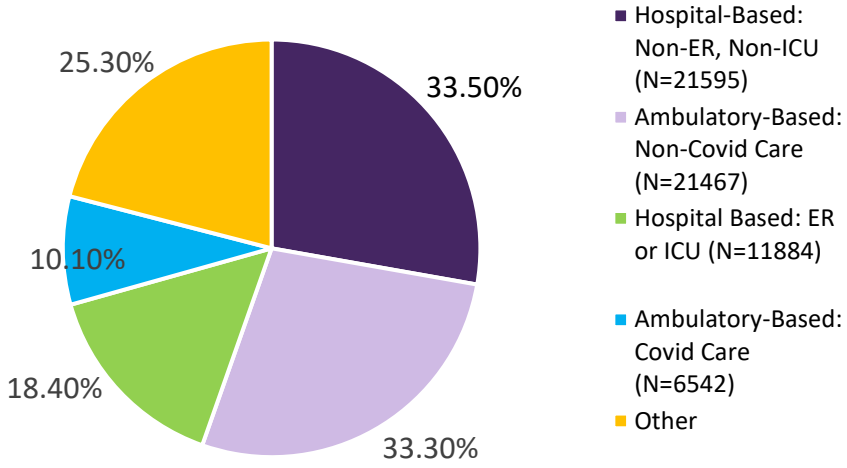
Demographics

Role Type and Practice Setting

Role Type



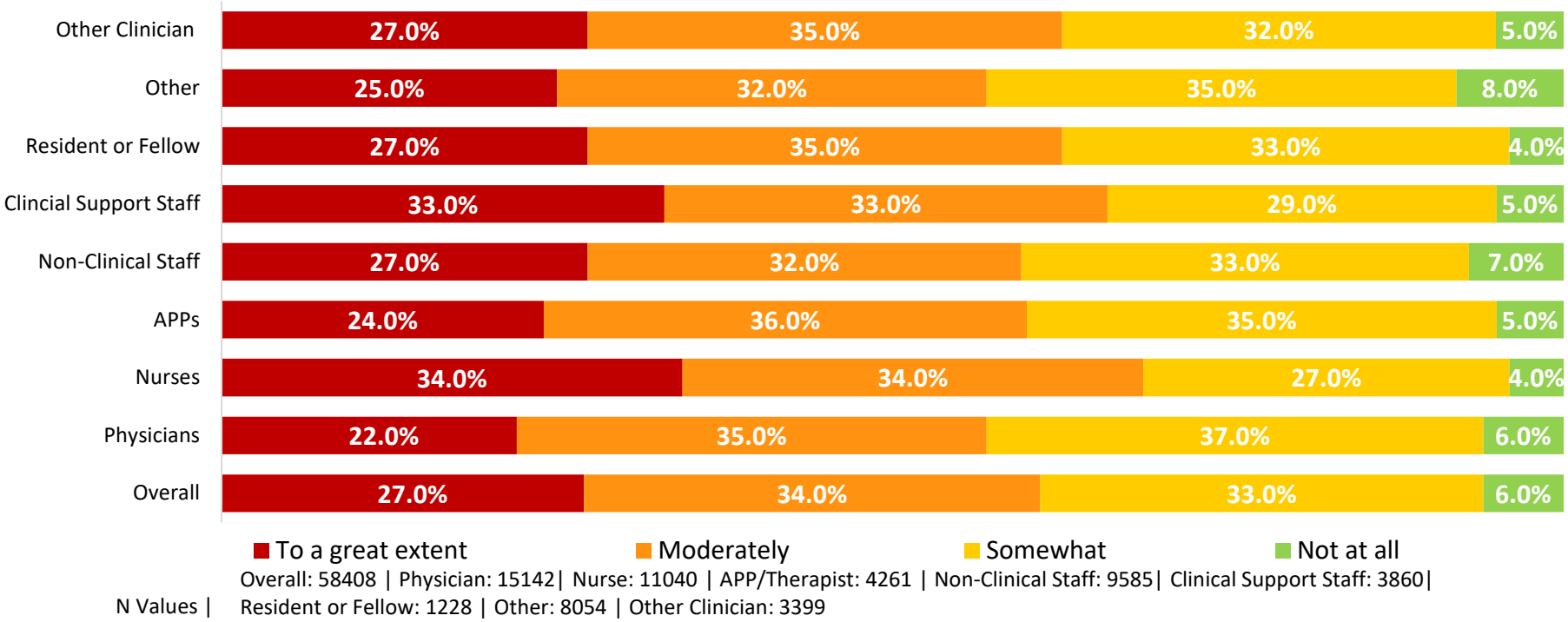
Practice Setting



National Survey Results

Fear of Exposure to COVID-19

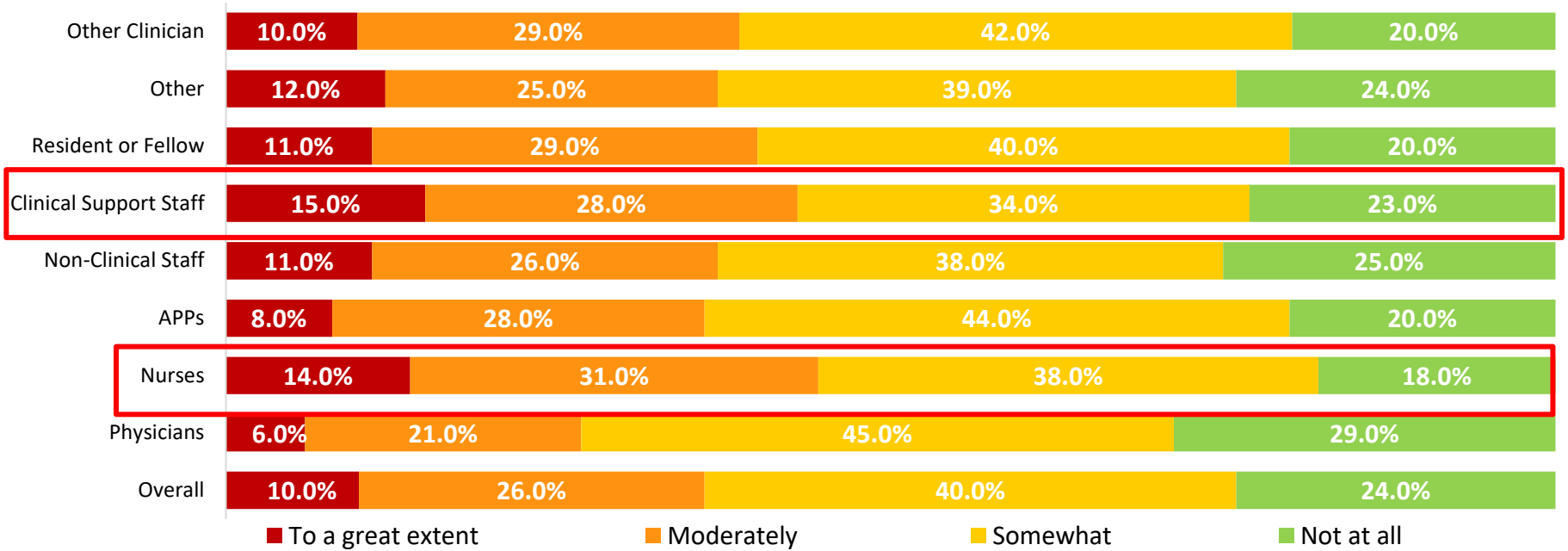
I worry about exposing myself and my family to COVID-19



N Values | Overall: 58408 | Physician: 15142| Nurse: 11040 | APP/Therapist: 4261 | Non-Clinical Staff: 9585| Clinical Support Staff: 3860| Resident or Fellow: 1228 | Other: 8054 | Other Clinician: 3399

Self-Reported Anxiety and Depression

Due to the impact of COVID-19, I am experiencing anxiety and depression.



N Values | Overall: 64463 | Physician: 17567 | Nurse: 13180| APP: 5118 | Non-clinical staff: 10500| Clinical Staff: 4182| Resident or Fellow: 2684 | Other: 8667 | Other Clinician: 2520

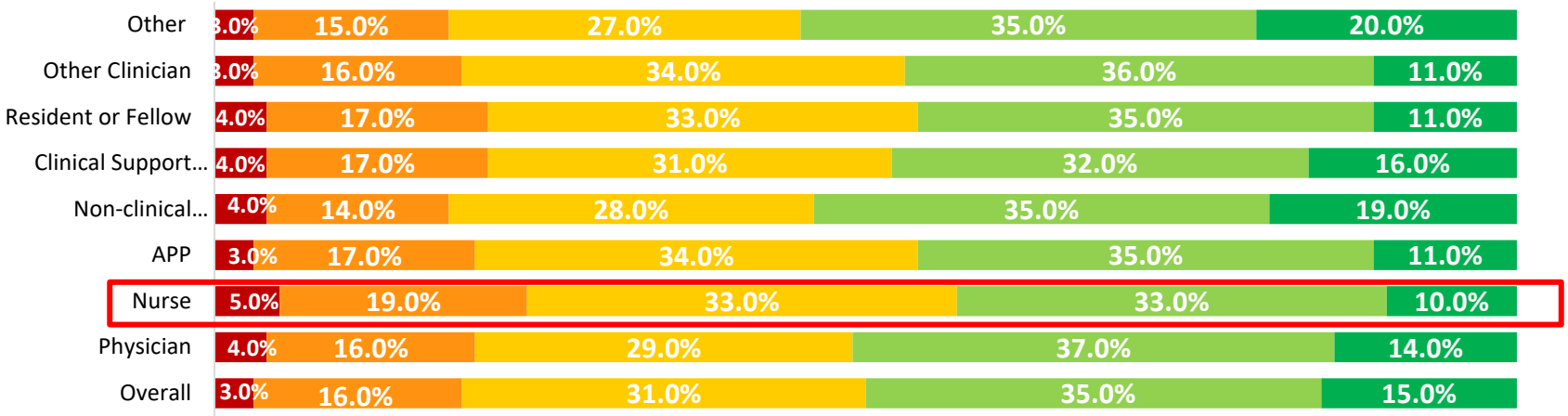
Self-Reported Anxiety/Depression

- Overall, **36% of all respondents** indicated higher levels of self-report anxiety/depression

- Self-reported anxiety/depression was highest in:
  - Nurses (45%)
  - Hospital-Based Employees in the ER or ICU (39%)
  - Critical care medicine (50%)

Self-Reported Burnout

Using your own definition of “burnout,” please choose one of the answers below.



N Values | Overall: 59276 | Physician: 16124| Nurse: 12242 | APP: 4544 | Non-clinical staff: 10398 | Clinical staff: 4049 | Resident or Fellow: 2636 | Other Clinician: 2338 | Other: 6900

Self-Reported Burnout

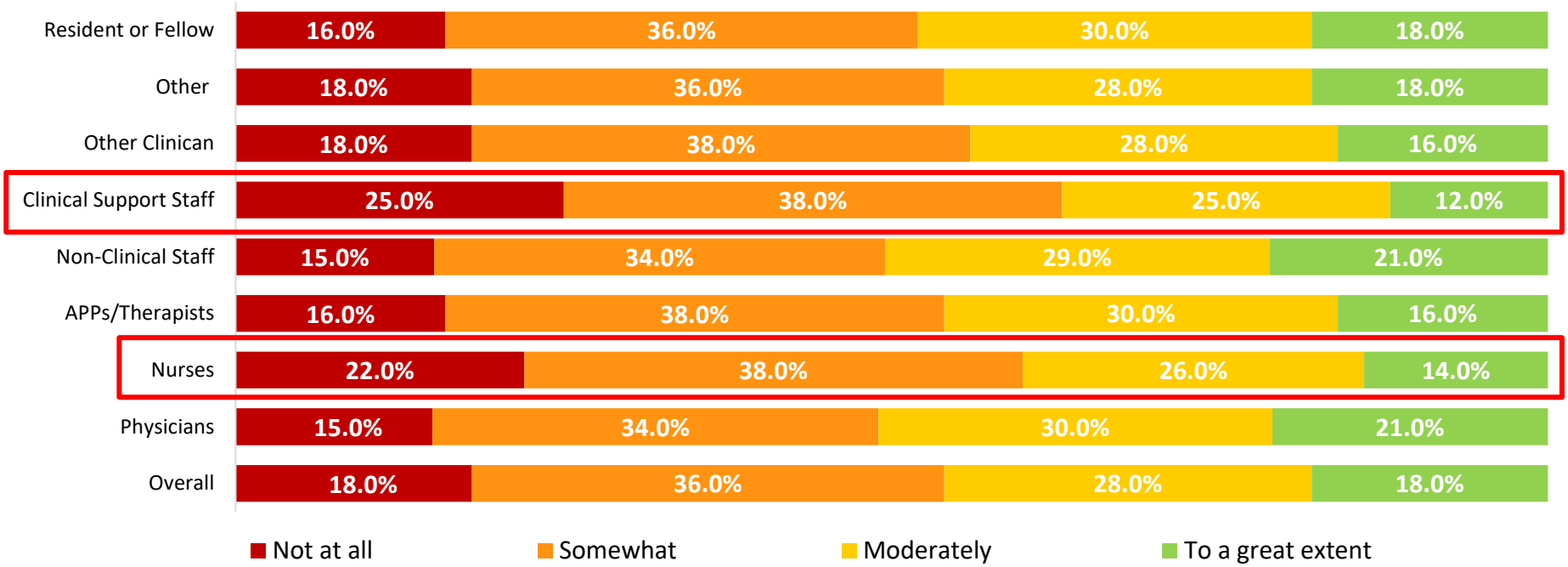
- Overall, **50% of all respondents** indicated burnout

- Burnout was highest in:
  - Nurses (57%)
  - Hospital-Based Employees in the ER or ICU (55%)
  - Critical care medicine (65%)

AMA

Feeling Valued

I feel valued by my organization.



N Values | Overall: 58309 | Physician: 15138 | Nurse: 11036 | APP/Therapist: 4256 | Non-clinical staff: 9579 | Clinical Support Staff: 3858| Other: 8049| Other Clinician: 3397 | Resident or Fellow: 1228

Work Intentions

- 27% of respondents note a moderate, likely, or definite chance of reducing clinical hours in the next 12 months
  - Highest in nurses (33%)
  - Physicians (31%)
- 28% of respondents note a moderate, likely, or definite chance that they will leave their current practice in the next two years
  - Highest in nurses (38%)
  - Physicians (25%)

Q1 2021 Key Findings

Anxiety and depression

- highest levels of self-reported anxiety and depression since May 2020, with 40% of respondents reporting “moderately” or “to a great extent”

Burnout symptoms

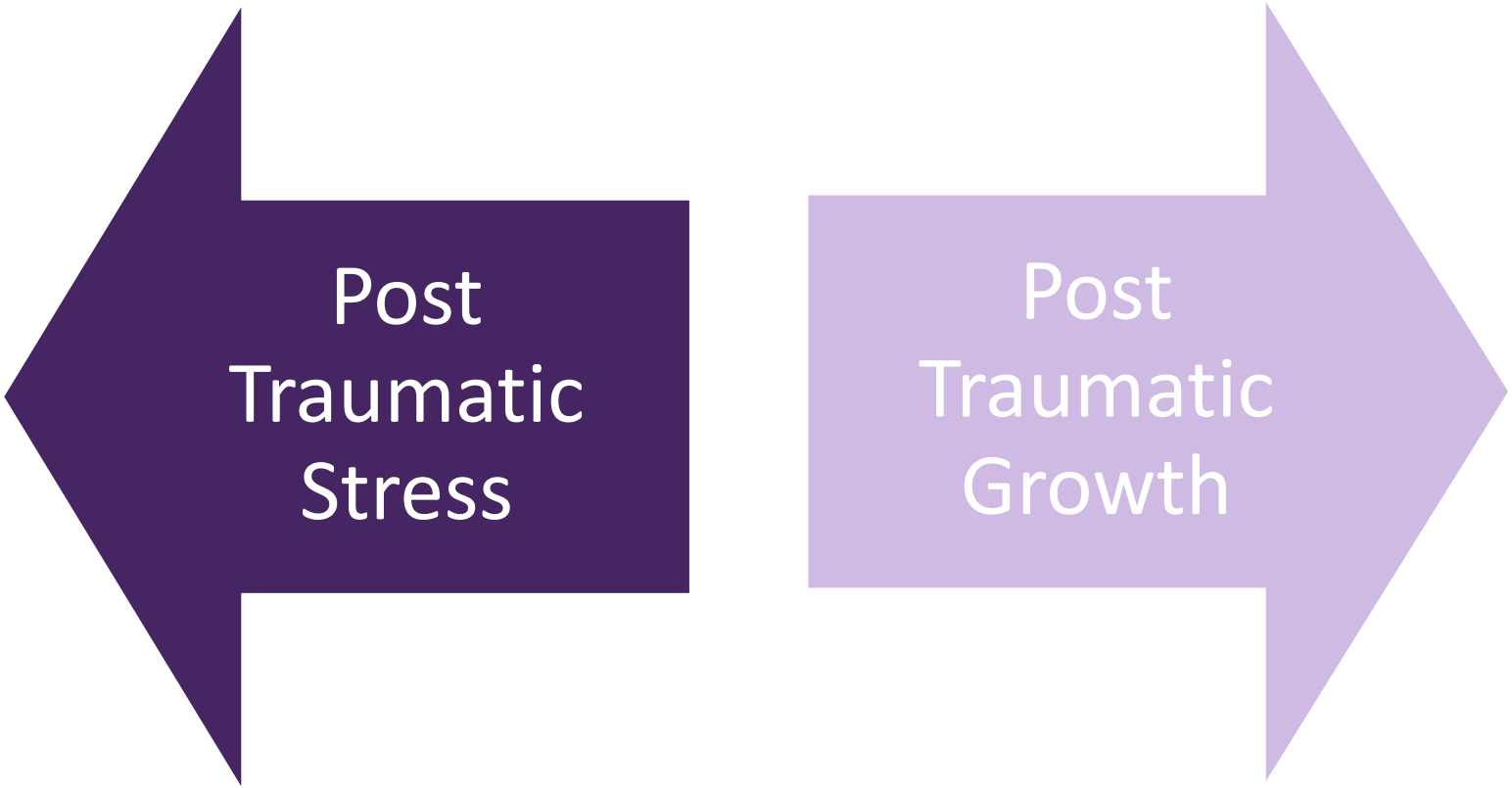
- peaked at 26% which exceeded previous peak of 21% in November 2020

Work overload

- peaked with 53% of respondents indicating they felt work overload “moderately” or “to a great extent” due to the impact of COVID

Feeling valued by organization

- showed highest reported levels of feeling valued by one’s organization since May 2020, with 51% of respondents indicated they felt valued “moderately” or “to a great extent”



Reversion, Transition, or **Transformation**?

Tactical Actions

Workflow Support (inbox, documentation, order entry)

- 2/3 of ambulatory respondents
- Highest in GIM and FM

Healthy Food Easily Available

- Highest in ER and ICU

Personal Access to Mental Health Care

- 66% of all respondents

Organizational Actions

- Transparent, Timely Communication
- Consistent, Empathetic Leadership
- Attention to Basic Human Needs
- Formal and Informal Peer Support
- Ongoing Measurement and Response
- Effective Operational Re-sets

Final Comment

Corey Feist
CEO; University of Virginia Physicians Group
Founder; Dr. Lorna Breen Heroes Foundation & All In Campaign

> “Let’s face it, healthcare is one of the most emotionally and physically demanding fields out there. The old approach of telling clinicians to maintain a stiff upper lip and download meditation apps for stress relief is not the antidote.

We don’t need stronger canaries. We need to redesign the coal mine.”


Thank you.
Access additional resources at **clinician.health**

ACPH 2021

American Conference on Physician Health™

AMA AMERICAN MEDICAL ASSOCIATION

MAYO CLINIC

Stanford MEDICINE

COVID-19
Traumatic Stress & Post-traumatic Growth

Kristine Olson, MD MSc

Tait Shanafelt, MD

Steve Southwick, MD

Disclosures

- Dr. Shanafelt royalties from Mayo Clinic related to the Well-being Index And Participatory Management Leadership Index, for the book Mayo Clinic Strategies to Reduce Burnout: 12 Actions to Create the Ideal Workplace. Honorarium for speaking/advising.
- Dr Southwick royalties for the book Resilience: The Science of Mastering Life's Greatest Challenges.

BACKGROUND:

After acute traumatic stress events…

PTSD may be experienced by those impacted
Ex. 15-30% after the trauma of combat

PTG (post-traumatic growth) may be experienced by
30-70% of people impacted as a result of the struggle with the event.
(Domains of PTG later defined.)

The Covid-19 pandemic
May have been experienced as a traumatic stress event (later defined).

AIMS:

1. Were medical professionals who were exposed to pandemic-related traumatic event(s) fairly to very often more likely to experience PTG? depression? anxiety?

2. If so, which domains of PTG were they more likely to experience as a result of the traumatic event(s)?

3. Were those medical professionals who experienced PTG less likely to experience depression or anxiety?

Methods:

Annual Medical Staff Wellness Assessment: >7K, 5 Delivery Networks, 3 Practice Model, 3 Levels
Covid-19 Pandemic, September-October 2020

Criterion A: traumatic stress event was assessed using a single-item adapted from DSM-V (yet to be validated). Responses were dichotomized into “never-sometimes” and “fairly-very often”.

During the COVID-19 crisis, how much exposure to death or threat of death did you perceive for yourself or your loved ones, or through witnessing it in others, or through repeatedly hearing the extreme adverse details?

1) Never 2) Almost never 3) Sometimes **4) Fairly often 5) Very often**

PROMIS 4-item depression scale and **4-item anxiety scale**, 5pt Likert
Depression defined as score >=8 of 20pt, per convention
Anxiety defined as score >=8 of 20pt, per convention

Post-traumatic growth was assessed with a 6-item version of the Post-traumatic Growth Inventory (Tedeschi & Calhoun,1996) abbreviated and validated by Pietrzak et. al (2010). The six domains assessed include

Because of the COVID-19 Pandemic…

I changed my priorities about what is important in life
I can better appreciate each day
I know better that I can handle difficulties
I have a greater feeling of self-reliance
I am better able to accept the way things work out
I have a stronger religious faith

0 I did not experience this change as a result of COVID-19
1 A very small degree
2 A small degree
3 A moderate degree
4 A great degree
5 I experienced this change to a very great degree as a result of COVID-19

Results:

5 hospital-based delivery networks, 3 practice models (academic, employed, private practice), 3 degrees (attending, APP, GME)

Of 7404 invitees, 2469 responded – a 33.3% response rate.

- 1783 responded to the traumatic stress exposure question
- 1713 responded to the post-traumatic growth scale
- 1747 responded to the 4-item depression scale
- 1728 responded to the 4-item anxiety scale

Compared to the invitees, the sample was demographically similar in degree and specialty. There was an over-representation of the main academic hospital in the sample compared to the invited population, 62.6% vs. 53.9% respectively.

Based on descriptive statistics, the subset that responded to the above questions and scales were demographically similar to the overall sample.

(Descriptive statistics available upon request.)

POST-TRAUMATIC GROWTH IN MEDICAL PROFESSIONALS OFTEN EXPOSED TO DEATH OR THREAT OF DEATH DURING COVID-19 COMPARED TO THOSE WITH LESS EXPOSRE.

	During the COVID-19 crisis, how much exposure to death or threat of death did you perceive for yourself or your loved ones, or through witnessing it in others, or through repeatedly hearing the extreme adverse details?									
	never-sometimes (969)			**fairly-very often** (814)			**Unknown exposure** (11)			Comparison between proportions never-sometimes and fairly-very often **2-sample z-test, p<0.05**	
Domain of Post-traumatic growth[1] (N=1716 total)	n	**>=great degree**	total	n	**>=great degree**	total	n	**>=great degree**	total	Z^2	P-value
Changed priorities	143	**15.5%**	922	234	**30.0%**	780	3	27.3	11	-7.17	<0.0001
Better appreciate	143	**15.6%**	919	197	**25.4%**	777	1	9.1%	11	-5.02	<0.0001
Handle difficulties	141	**15.3%**	920	186	**23.9%**	777	1	9.1%	11	-4.48	<0.0001
Self-reliance	149	**16.2%**	919	184	**23.85**	774	1	9.1%	11	-3.90	<0.0001
Able to accept	130	**14.2%**	914	157	**20.4%**	770	1	9.1%	11	-3.35	=0.0008
Stronger faith	70	**7.6%**	917	85	**11.0%**	773	0	0%	11	-2.40	=0.0168
>=1 of 6 PTG	286	**31.0%**	924	355	**45.5%**	781	4	36.4%	11	-6.16	<0.0001

Standard descriptive statistics are shown to describe the frequencies and proportions for each item's responses. The proportion of PTG in each domain was statistically significant in relation to exposure to this potential covid-19 acute traumatic stress and between groups registering a great degree of PTG within a domain across those who were and weren't often exposed to this potential acute traumatic stress. ($p<0.05$), If medical staff were fairly or very often exposed to the covid-19 acute traumatic stress they were more likely to experience some PTG than those who were less exposed, after adjusting for age, race, gender, specialty, delivery network, OR 1.66 (1.31-2.10).

DEPRESSION AND ANXIETY IN MEDICAL PROFESSIONALS OFTEN EXPOSED TO DEATH OR THREAT OF DEATH DURING COVID-19 (COMPARED TO THOSE WITH LESS PERCIEVED EXPOSER)

	During the COVID-19 crisis, how much exposure to death or threat of death did you perceive for yourself or your loved ones, or through witnessing it in others, or through repeatedly hearing the extreme adverse details?										
TRAUMATIC STRESS EVENT(S)	**never-sometimes** (969)			**fairly-very often** (814)			**Unknown exposure** (11)			Comparison between proportions never-sometimes and fairly-very often **2-sample z-test p<0.05**	
	n	% **>=often**	total	n	% **>=often**	total	n	% **>=often**	total	Z^2	P-value
Depression	243	**25.7**	945	278	**35.2**	791	7	63.6	11	-2.34	0.019
Anxiety	240	**25.7**	932	302	**38.6**	783	6	46.2	13	-3.18	0.001

DEPRESSION AND ANXIETY IN MEDICAL PROFESSIONALS WITH >=1 POST-TRAUMATIC GROWTH DOMAIN (COMPARED TO THOSE WITH NO POST-TRAUMATIC GROWTH)

	>=1 of 6 POST-TRAUMATIC GROWTH DOMAINS										
PTG	**No PTG**			**Yes PTG**			**Unknown PTG**			Comparison between no vs. yes >=1 PTG domain **2-sample z-test p<0.05**	
	n	% **>=8**	total	n	% **>=8**	total	n	% **>=8**	total	Z^2	P-value
Depression	297	**28.2**	1054	197	**31.5**	625	34	50.0	68	-0.79	0.308
Anxiety	306	**29.3**	1046	216	**34.5**	627	26	47.3	55	-1.26	0.208

POST-TRAUMATIC GROWTH IN MEDICAL PROFESSIONALS OFTEN EXPOSED TO DEATH OF THREAT OF DEATH DURING COVID-19 COMPARED TO THOSE WITH LESS PERCIEVED EXPOSRE

	Acute Traumatic Stress fairly-very often (vs. never-sometimes)			Depression (vs. not depressed)			Anxiety (vs. not anxious)		
Domain of Post-traumatic growth[1] >=great degree	OR	**CI**	p	OR	**CI**	p	OR	CI	p
Changed priorities	**2.33**	1.83-2.97	<0.01	**1.41**	1.09-1.81	0.006	**1.45**	1.13-1.86	0.003
Better appreciate	**1.84**	1.43-2.36	<0.01	0.79	0.60-1.05	0.092	0.98	0.75-1.28	0.895
Handle difficulties	**1.73**	1.35-2.23	<0.01	**0.65**	0.48-0.87	0.003	**0.73**	0.55-0.97	0.025
Self-reliance	**1.61**	1.26-2.07	<0.01	0.86	0.64-1.13	0.272	**0.76**	0.57-1.01	0.050
Able to accept	**1.54**	1.19-2.01	<0.01	**0.65**	0.47-0.89	0.005	**0.72**	0.53-0.98	0.030
Stronger faith	**1.49**	1.06-2.11	<0.01	0.92	0.61-1.35	0.652	1.06	0.72-1.53	0.769
>=1 of 6 PTG	**1.86**	1.52-2.28	<0.01	1.17	0.94-1.46	0.146	**1.27**	1.02-1.58	0.026
Depression (ref: not depressed)	**1.57**	1.27-1.93	<0.01						
Anxiety (ref: not anxious)	**1.81**	1.47-2.34	<0.01						

2x2 contingency tables. Unadjusted Odds Ratios.

Conclusions:

In this sample of medical professionals, in the period immediately after experiencing the first wave of the Covid-19 pandemic,….

1. Those who were exposed to pandemic-related traumatic stress event(s) fairly-very often were more likely to experience PTG (31.0% v. 45.5% $p<0.05$, OR 1.86 CI 1.52-2.2), Depression (25.7 v. 35.2 $p<0.05$, OR 1.57 CI 1.27-1.93), and Anxiety (25.7 v. 38.6 $p<0.05$, OR 1.81 1.47-2.34).

2. The top 3 domains of PTG that medical professionals were most likely to experience, if exposed to pandemic-related traumatic stress event(s), were changing priorities of what is important in life, better able to appreciate each day, and knowing one can handle difficulties.

3. In this sample, those that experienced >=1 PTG domain were not less likely to experience depression or anxiety.

Implications:

In the immediate aftermath of the first wave of the covid-19 pandemic, those who were exposed to pandemic-related traumatic stress event(s) fairly-very often were not only more likely to experience depression and anxiety, but also post-traumatic growth (PTG). PTG often occurs in the presence of PTSD and other trauma-related psychopathology. Evidence suggests that the traumatic event must cause enough distress that the trauma survivor begins to question fundamental beliefs, and through struggle to reassess and revise his or her world view. There is also evidence in military veterans that those who develop PTG as a result of one event may be more resilient to subsequent traumas, perhaps due to the development of coping skills.

Southwick & Charney, *Resilience, The Science of Mastering Life's Greatest Challenges*, 2nd edition, Cambridge University Press, New York NY, 2018


In these times, the healthcare community heals sharing memories, grief, hopes, dreams.
DIGITAL DISK
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Share your story here-->
Shine your light at Yale New Haven Hospital

Appendix:

DEPRESSION AND ANXIETY AMONGST MEDICAL PROFESSIONALS WHO EXPERIENCED AN ACUTE TRAUMATIC STRESS EVENT WITH AND WITHOUT >=1 POST-TRAUMATIC GROWTH DOMAIN (COMPARED TO THOSE WITH NO POST-TRAUMATIC GROWTH)											
	EXPOSED TO AN ACUTE TRAUMATIC STRESS EVENT										
PTG	**No PTG**			**Yes >=1 PTG**			**Unknown PTG**			Comparison between no vs. yes >=1 PTG domain **2-sample z-test p<0.05**	
	n	% >=8	total	n	% >=8	total	n	% >=8	total	Z^2	P-value
Depression	147	**35.0**	420	121	**35.7**	345	10	38.5	26	-0.119	0.904
Anxiety	159	**38.5**	413	136	**39.1**	348	7	31.8	22	-0.105	0.912

36. Maslach C, Jackson S. The Measurement of Experienced Burnout. *Journal of Occupational Behaviour.* 1981;2:99-113.

AMERICAN CONFERENCE ON PHYSICIAN HEALTH

Decreasing Burnout and Isolation During Anesthesia Fellowship Training Through a Year-long Integrated Coaching Program

Jessie Mahoney, MD, Pause & Presence

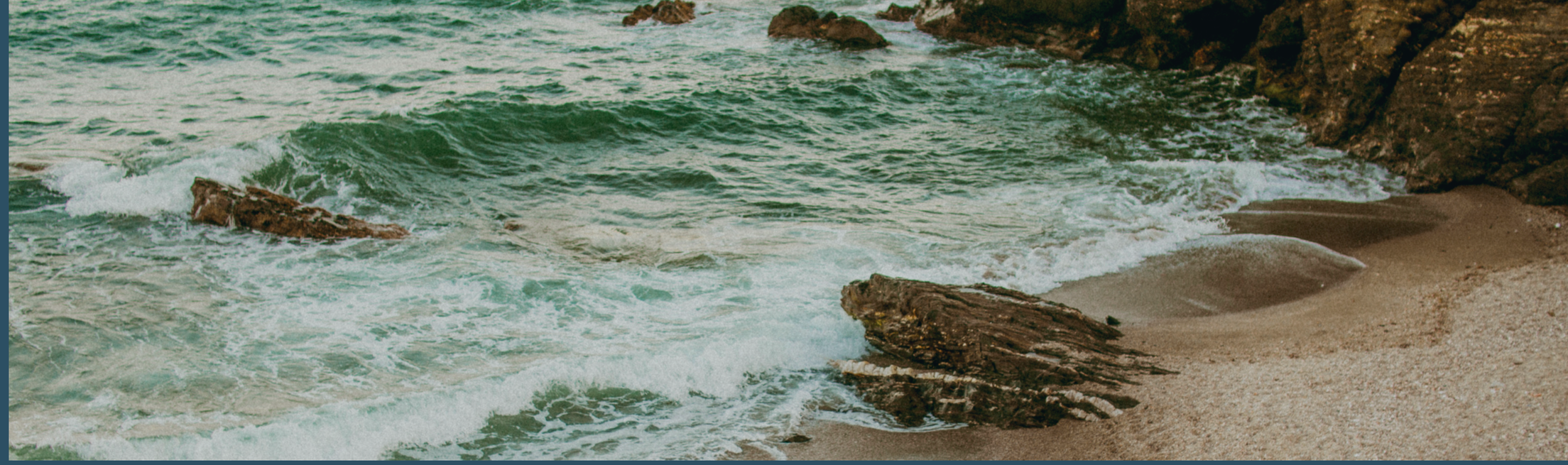
Disclosures

Founder of Pause & Presence where I offer Mindful Coaching to individual physicians, groups of physicians, and in institutions (including in this program)

Objectives

- Discuss strategies to advocate for and implement an effective coaching program within a large academic fellowship program.
- Discuss strategies to both optimize engagement in and increase the impact of coaching in a fellowship program.
- Share the short-term impacts of 1:1 coaching on fellows.

Professional group coaching is an evidence-based intervention known to lessen burnout and emotional exhaustion, and improve resilience and quality of life for physicians. (JAMA, 2019)



Why is fellowship the perfect time in physician development to introduce coaching?

Learn to approach career in medicine differently **from the outset.**

Prevent burnout & exhaustion

Improve learning and quality of care by supporting key players in hospital setting and on academic teams

Key components of this program

Year long integrated component of fellowship training

GOALS

- to help “ease the transition to becoming thriving attending physicians"
- "respond to additional stress on fellows during the pandemic and social injustice experienced during 2020.”

Key components of this program

METHODS

- **Pilot program** - group coaching was offered May-July 2020 in response to urgent COVID stress.
- Based on feedback and ongoing stresses, the program was extended for 2020-2021
- Now extended for 2021-2022 with minor adaptations
- The year-long program includes 6 individual coaching opportunities each month and one drop-in group coaching session.
- Participation is voluntary/ open to all.

Key components of this program

METHODS

- 60 anesthesia fellows
- various subspecialties: CCM, Cardiac, Ob, Peds, Adult and Peds Pain, and Pain Psych.
- Feedback survey sent quarterly to any fellow who has participated in 1:1 coaching.
- Utilization by each subspecialty is tracked.

Results

~~After~~ the initial 3 month pilot:

“Coaching is one of the best things about their fellowship in terms of feeling that the department cares for their well-being.”

9 months of data:

- 1:1 coaching: 25 of 60 fellows participated voluntarily, many did 3-5 sessions each
- 100% of those who returned the survey (72% response rate) “found coaching helpful.”
- (Update #’s)
  - 100 percent said they would recommend it to their colleagues.
  - 91.7% said that they felt more in control,
  - 83.3% said they were less stressed and felt less isolated and alone.
  - 50% reported feeling less burnt out.

Verbatim Comments

“normalized my experience, made me feel more connected to my peers,”

“even after one session, it helped give me a framework to address some of the challenges I'm facing personally.”

Helped to “mitigate feelings of burnout and helplessness.”

"Nothing to lose, lots to gain."

Verbatim Comments

"100% worth your time"

"It is very validating and wonderful that it is confidential!"

"It is a great opportunity to learn more about yourself."

"Do it!! It can give you ideas and perspective that you can't think of on your own."

"Just try it!"

Verbatim Comments

"It's helpful to have a coach who has experienced your training, and who has insight into the medical culture.
It doesn't solve all your problems, but it will help you to see yourself as more capable, and leave behind perspectives that limit your perception of your self-worth and your capacity to improve."

"It's an incredibly helpful resource. Highly recommend it. We are so lucky to have it as an option."

Conclusion

Offering 1:1 and group coaching as an integral part of fellowship training is a helpful intervention to decrease stress, isolation, and burnout, and to increase a sense of control in Anesthesia fellows.

Dr. Jessie Mahoney

Pause & Presence Coaching
www.jessiemahoneymd.com
Jessie@jessiemahoneymd.com

ACPH 2021

American Conference on Physician Health™

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MAYO CLINIC

Stanford MEDICINE

The low commitment, rotating Message-a-Colleague program has a positive impact on participants in a surgical department.

Holly N Blackburn, MD; Department of Surgery

Lucy Ruangvoravat, MD, FACS; Department of Surgery

Yale School of Medicine

08 October 2021

Disclosures

- No disclosures.

The burden of burnout among healthcare workers is high and compounded by Covid-19.

Review > JAMA. 2015 Dec 8;314(22):2373-83. doi: 10.1001/jama.2015.15845.

Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Sy and Meta-analysis

Douglas A Mata [1], Marco A Ramos [2], Narinder Bansal [3], Ric

> Gen Psychiatr. 2021 Sep 6;34(5):e100577. doi: 10.1136/gpsych-2021-100577. eCollection 2021.

High levels of psychosocial distress among Australian frontline healthcare workers during the sectional survey

rk [5] [6], Mark Putland [7] [8],

> Int J Environ Res Public Health. 2021 Sep 1;18(17):9243. doi: 10.3390/ijerph18179243.

The Impact of the COVID-19 Pandemic on ICU Healthcare Professionals: A M

Cristina Moreno-Mulet [1] [2], Noemí Sansó [1] [2], Alba Carr
Laura Galiana [3], Patricia García-Pazo [1] [2], Maria Magda
Margalida Mi [1] [2]

> JAMA Netw Open. 2020 Mar 2;3(3):e203976. doi: 10.1001/jamanetworkopen.2020.3976.

Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus

> Int J Environ Res Public Health. 2021 Aug 27;18(17):9031. doi: 10.3390/ijerph18179031.

Impact of the COVID-19 Pandemic on Burnout in Primary Care Physicians in Catalonia

Gemma Seda-Gombau [1] [2] [3], Juan José Montero-Alía [1] [3] [4], Eduard Moreno-Gabriel [1] [3],

Vei [1],
, Lihua Yao [2],
[1]

Determinants of wellness can have a negative impact on physical health.

Factors related to burnout[1]:

1) work factors (hours, **workload**, **documentation**, malpractice risk)[2]

2) personal (self-critical, **sleep deprivation**, work-life imbalance)[3]

3) organizational factors (poor leadership, **expectations**, limited interpersonal collaboration) [4]

In healthcare workers, poor sleep and reported burnout correlated with an increase risk of Covid-19.[5]

In adult women, loneliness correlated with increased incidental heart disease (controlling for comorbidities, age, smoking).[6]

1. Pantel et al. *Behav Sci*, 2018.
2. West et al. *J Intern Med*, 2018.
3. Shanafelt. *JAMA*, 2009.
4. Shanafelt et al. *Mayo Clin Proc*, 2015.
5. Kim et al. *BMJ Nutr Prev Health*, 2021.
6. Thurston and Kubzansky. *Psychosom Med*, 2009.

Isolation/loneliness is a major cause for burnout and depression among healthcare workers.

> J Am Board Fam Med. May-Jun 2021;34(3):531-541. doi: 10.3122/jabfm.2021.03.200566.

Loneliness, Burnout, and Other Types of Emotional

Can we proactively combat burnout with increased workplace connections?

burnout symptoms, depression, and higher fatigue

Program description:

An **OPT-IN** messaging program that provides **random and rotating weekly assignments** to send one message (text or email) to a colleague (with a similar departmental role) and receive one message.

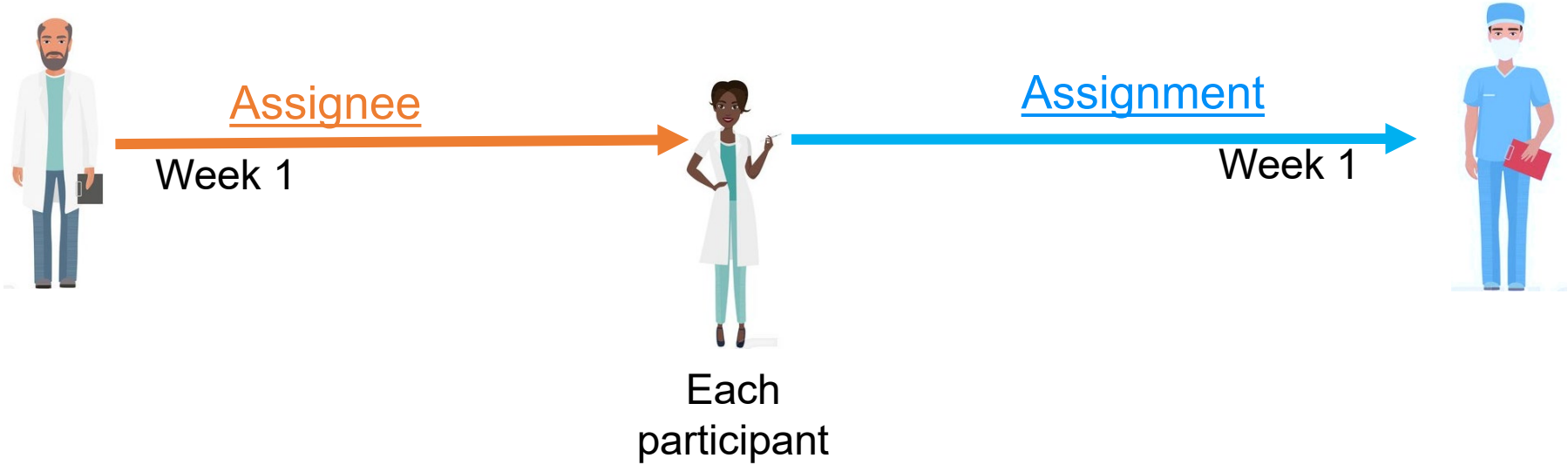
Program goals:

1. Create a sense of **connection** between peers or colleagues 
2. Decrease feelings of **loneliness** or **isolation** 
3. Foster community through **brief interactions** 

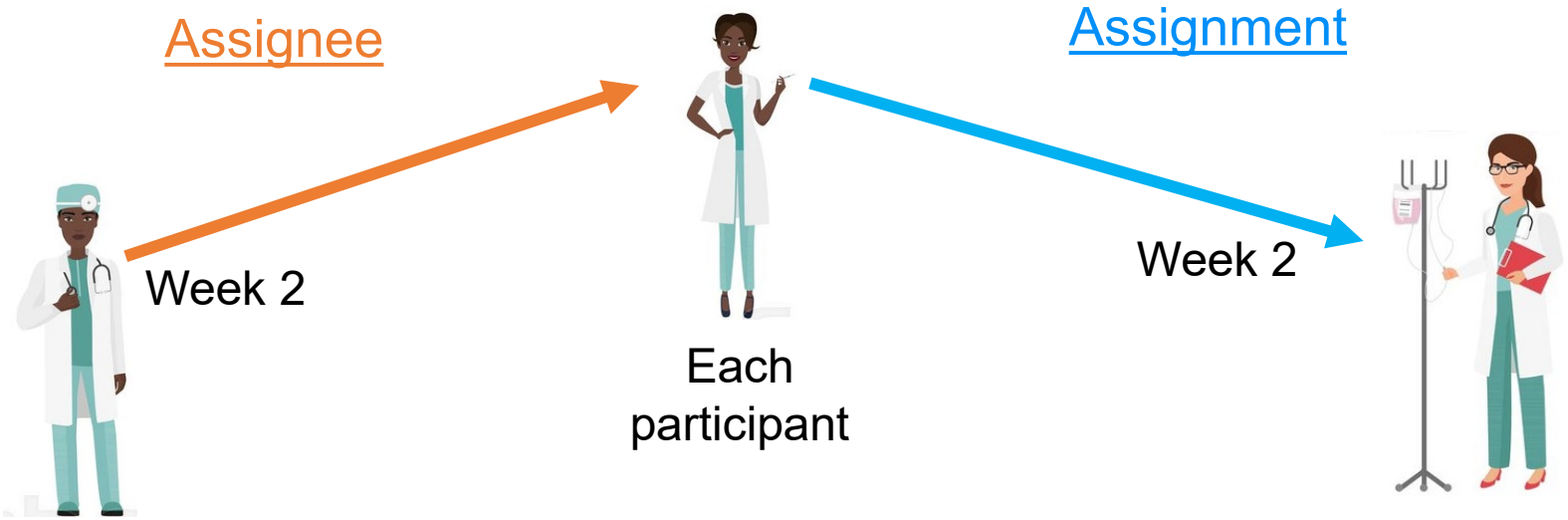
4. **NO** *responsibility of identifying or providing mental health*

5. **NO** *committment to long-term support of any one individual*

Visual depiction of participant's experience



Visual depiction of participant's experience



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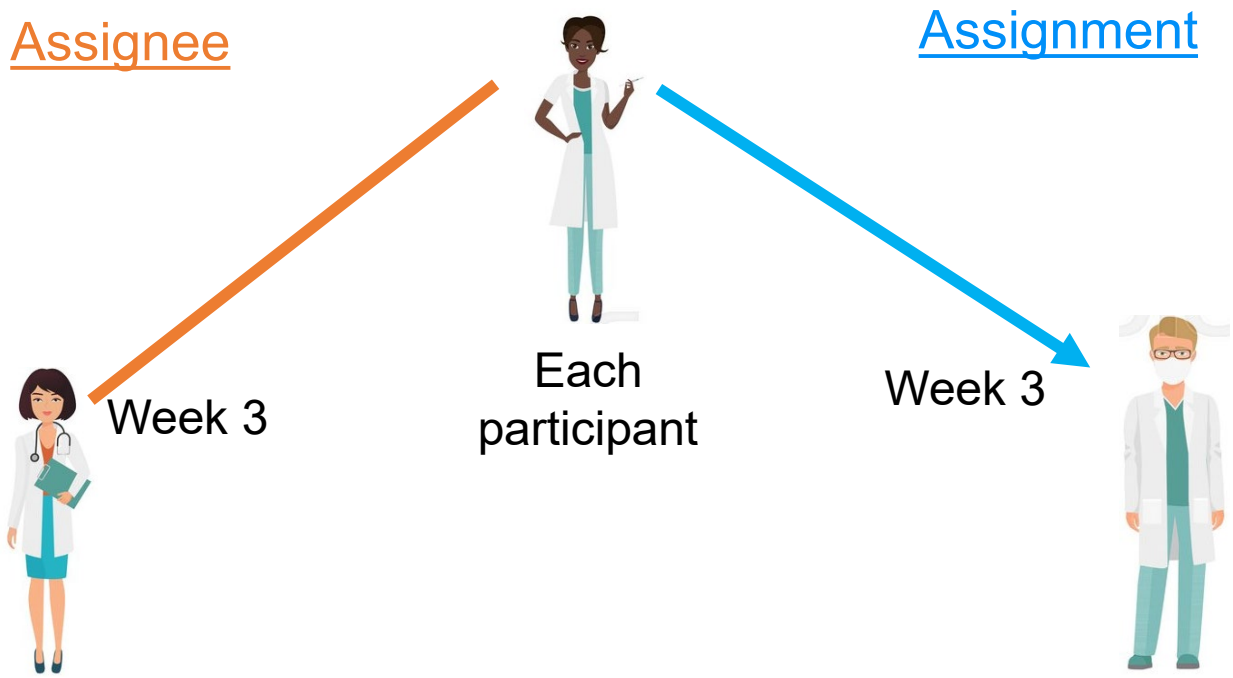
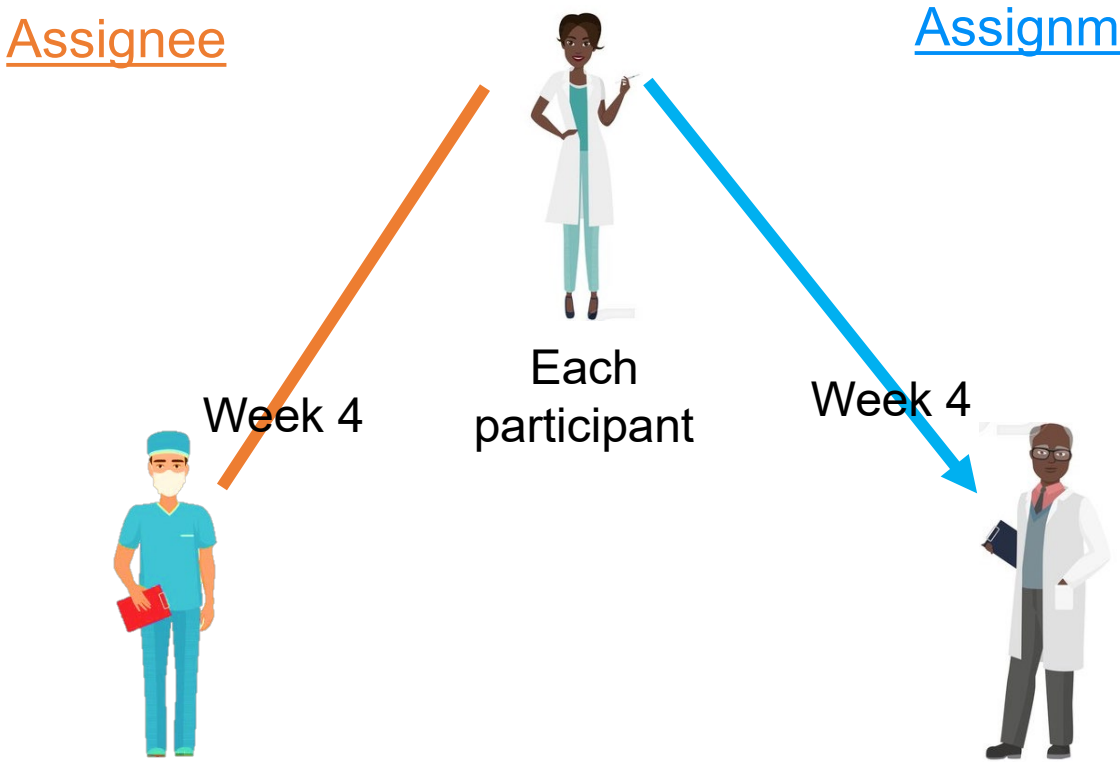
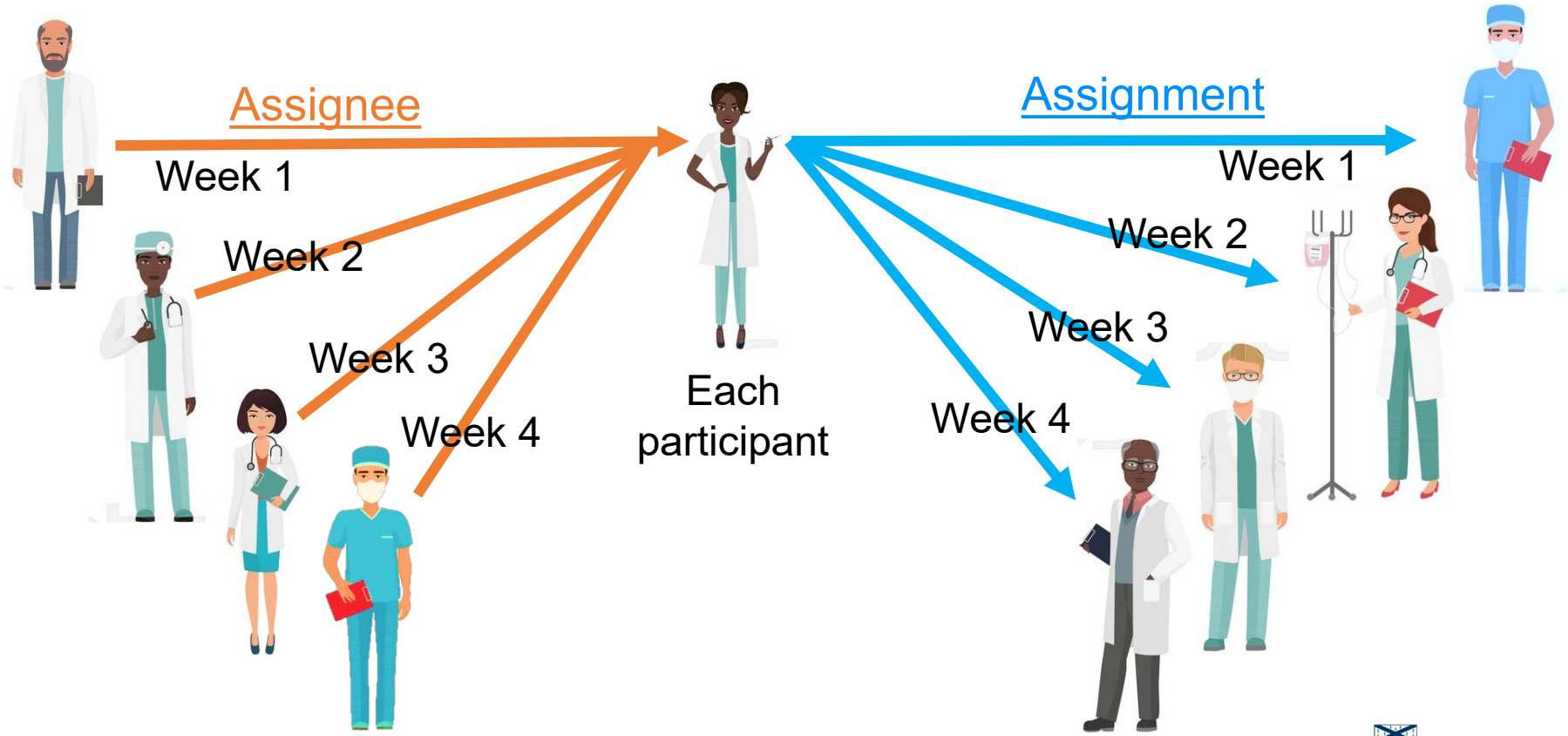


Visual depiction of participant's experience



Visual depiction of participant's experience



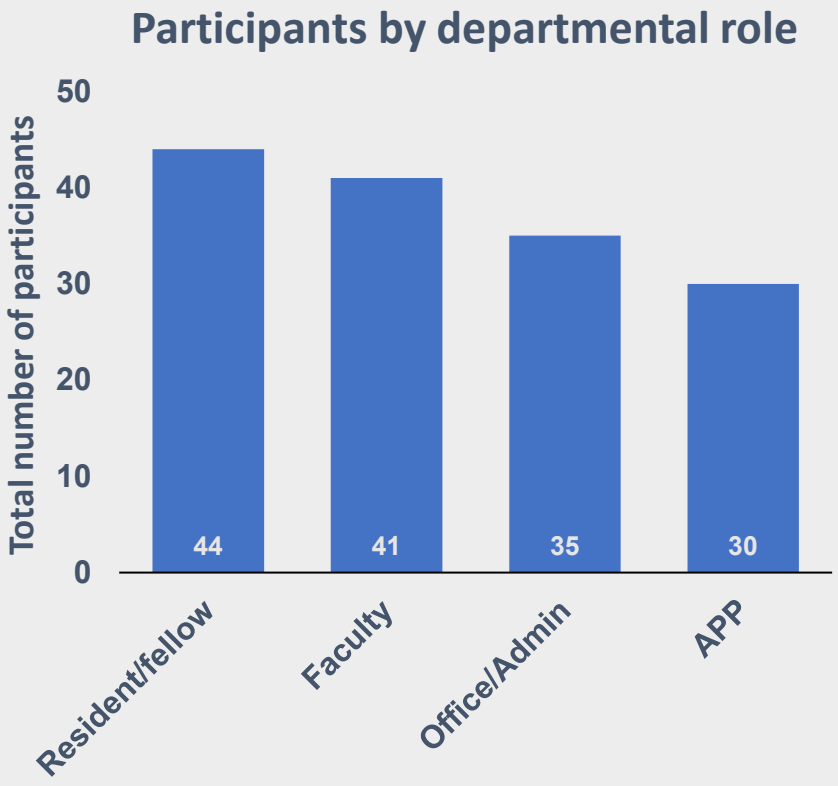
Program applicability:

Intended for all members of a department:

- Residents/fellows
- Faculty
- APPs (NP/PA)
- Research staff
- Office/administrative staff
- Nursing/patient-facing
- Fully remote staff
- Support staff

Program implementation:

- Yale-New Haven Hospital
- Department of Surgery
- Two rounds
  - April 2020 (9 weeks)
  - December 2020 (4 weeks)
- Participants:
  - Faculty
  - Advanced practice providers (PA/NP)
  - Resident/fellows
  - Office/administrative staff



Survey implementation:

- Round 1: April 2020
  - Positive anecdotal feedback

- Round 2: December 2020
  - IRB-approved exit survey
    - Online
    - Anonymous
    - One week after program end date
  - 50 participants
  - 56% survey completion (28/50)

Determining program success:

1) Are the program requirements burdensome to participants?

2) Does the program have a positive impact on participants?

3) Does the program increase the sense of connection?

Determining program success:

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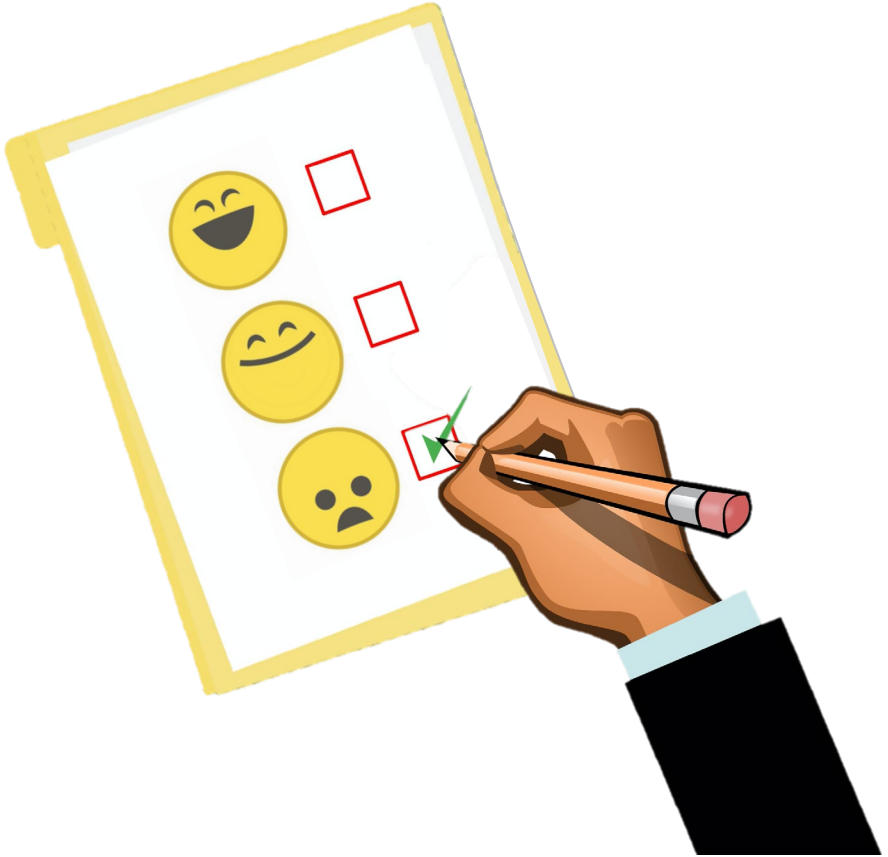

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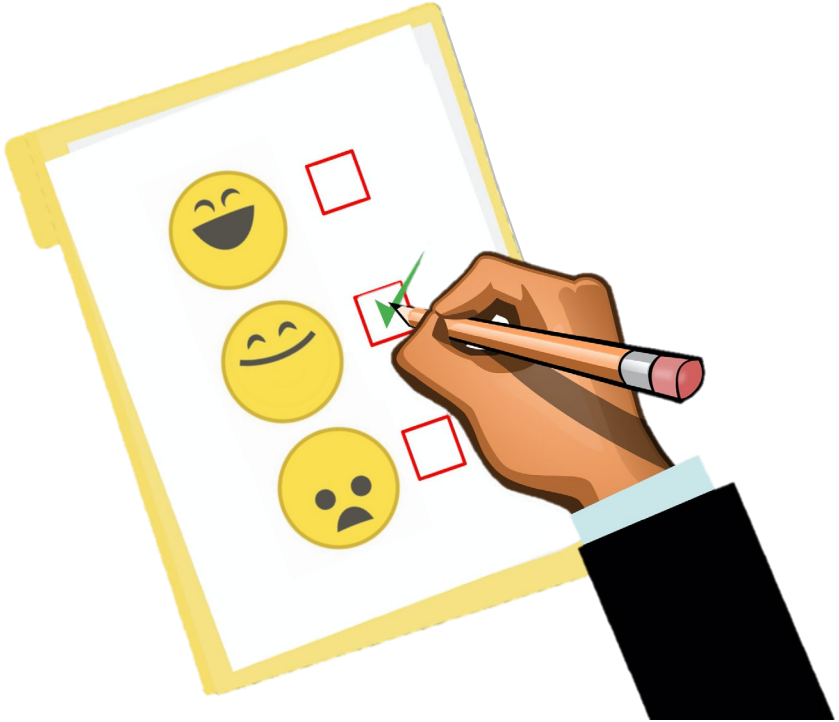


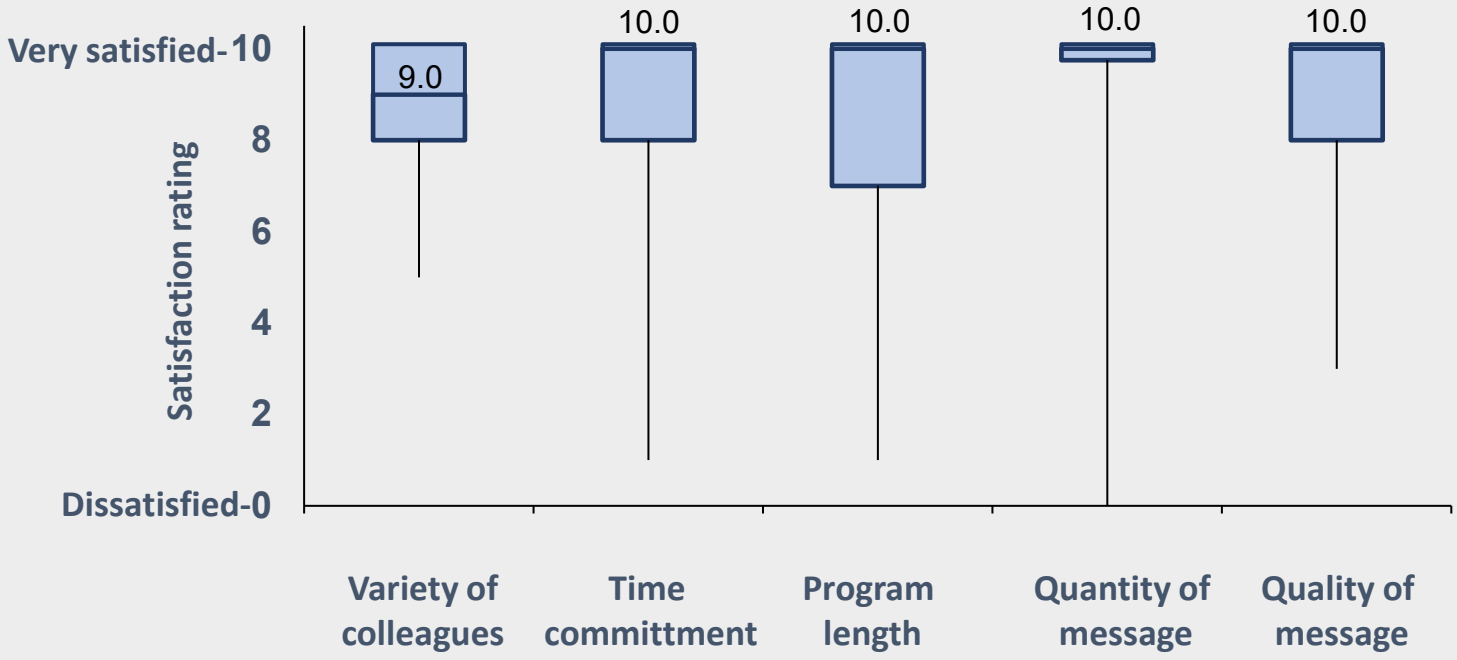
Determining program success:

1) Are the program requirements **burdensome** to participants?

2) Does the program have a **positive impact** on participants?

3) Does the program increase the sense of **connection**?

The program was well-received across multiple aspects



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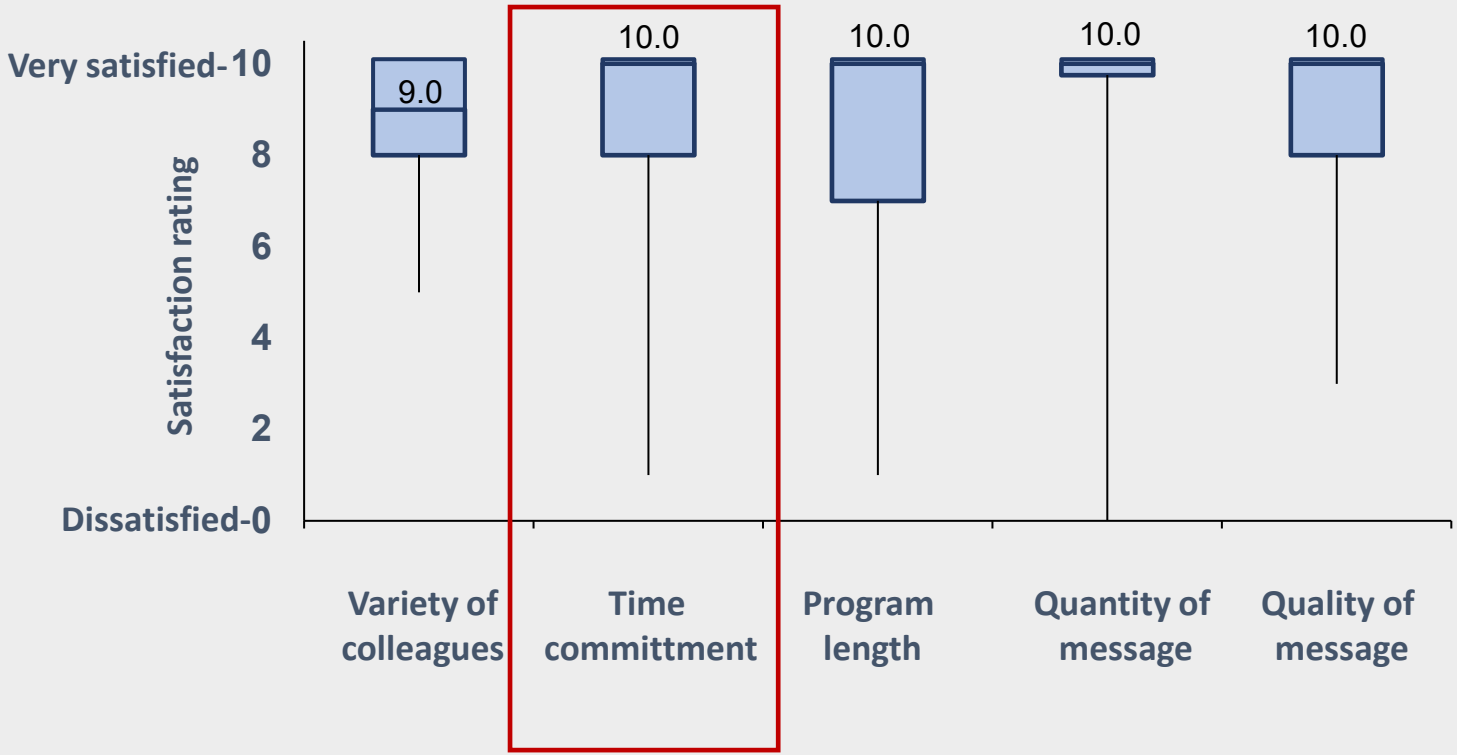
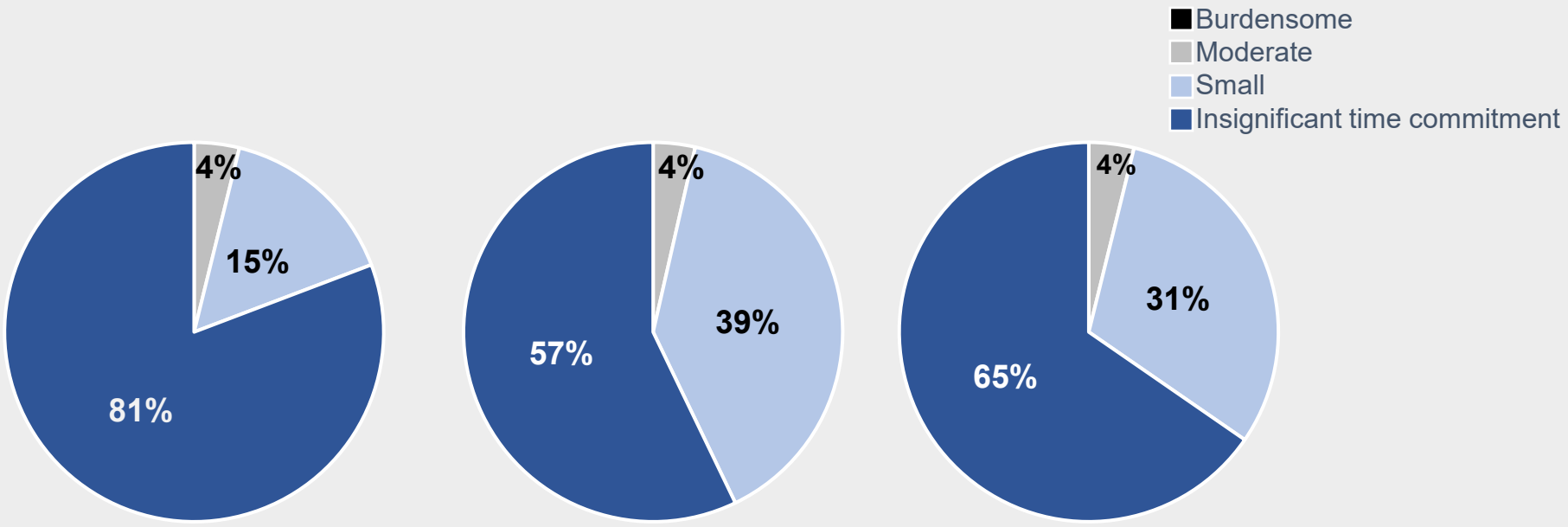
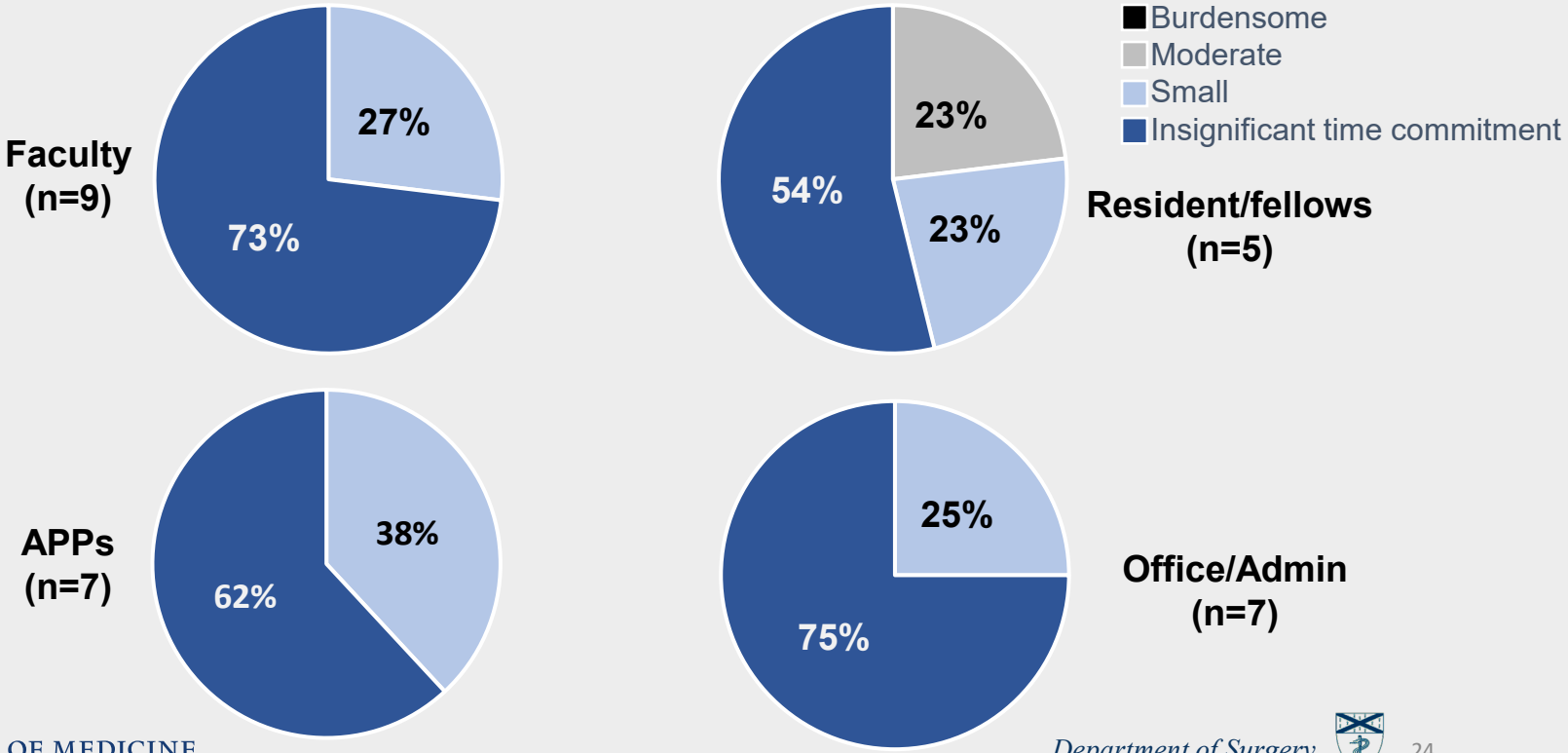


Participants reported that the time commitment was small or insignificant.



Regardless of departmental role, majority consider burden to be small/insignificant.



Determining program success:

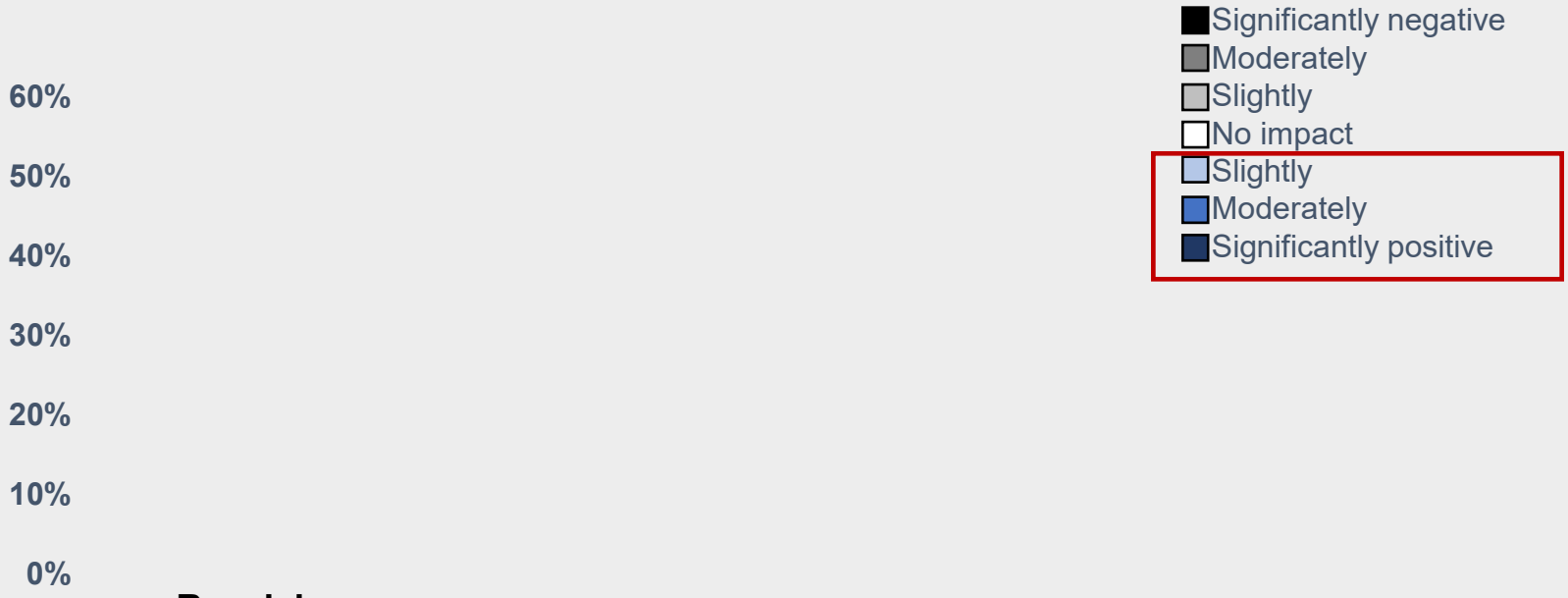
1) Are the program requirements **burdensome** to participants?

NO

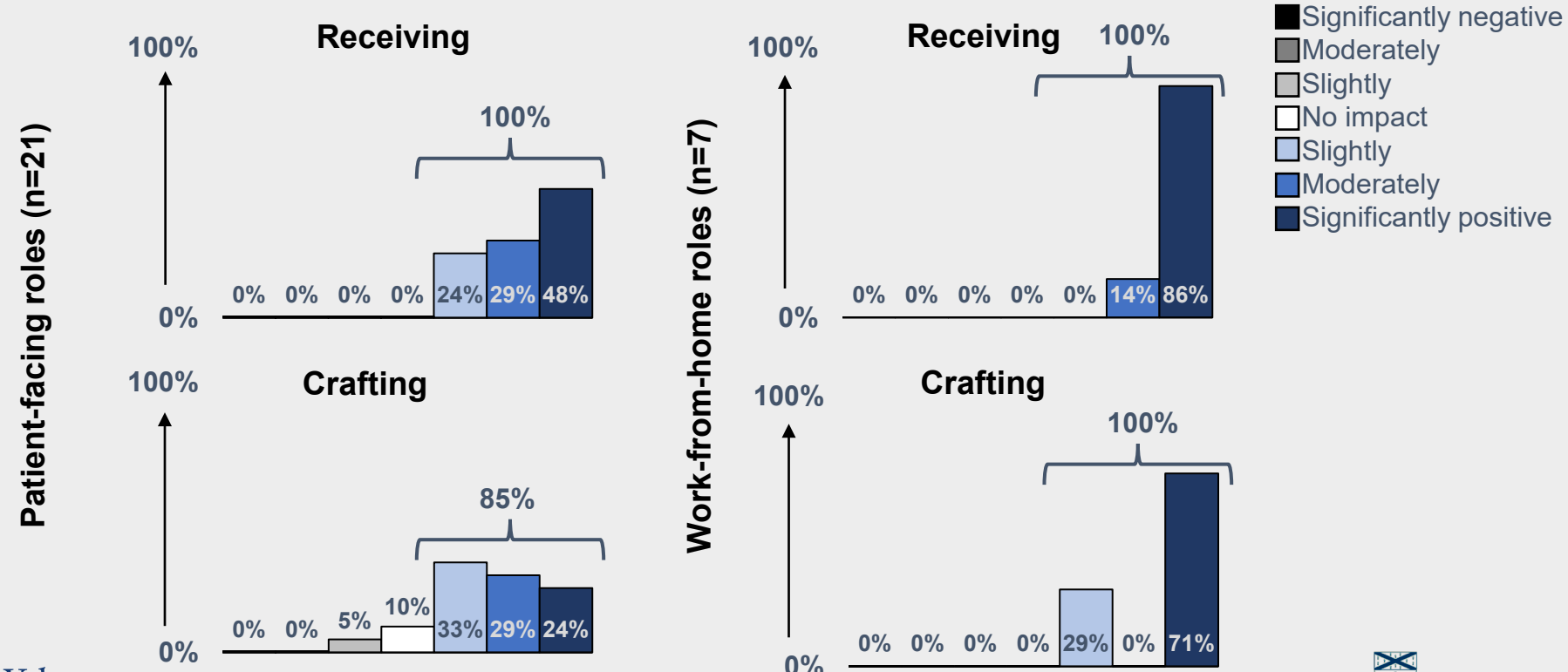
2) Does the program have a **positive impact** on participants?

3) Does the program increase the sense of **connection**?

Participants reported a positive impact on the stress/outlook of their day.



Positive impacts persist across *patient-facing* and *work-from-home* roles.



Determining program success:

1) Are the program requirements **burdensome** to participants?

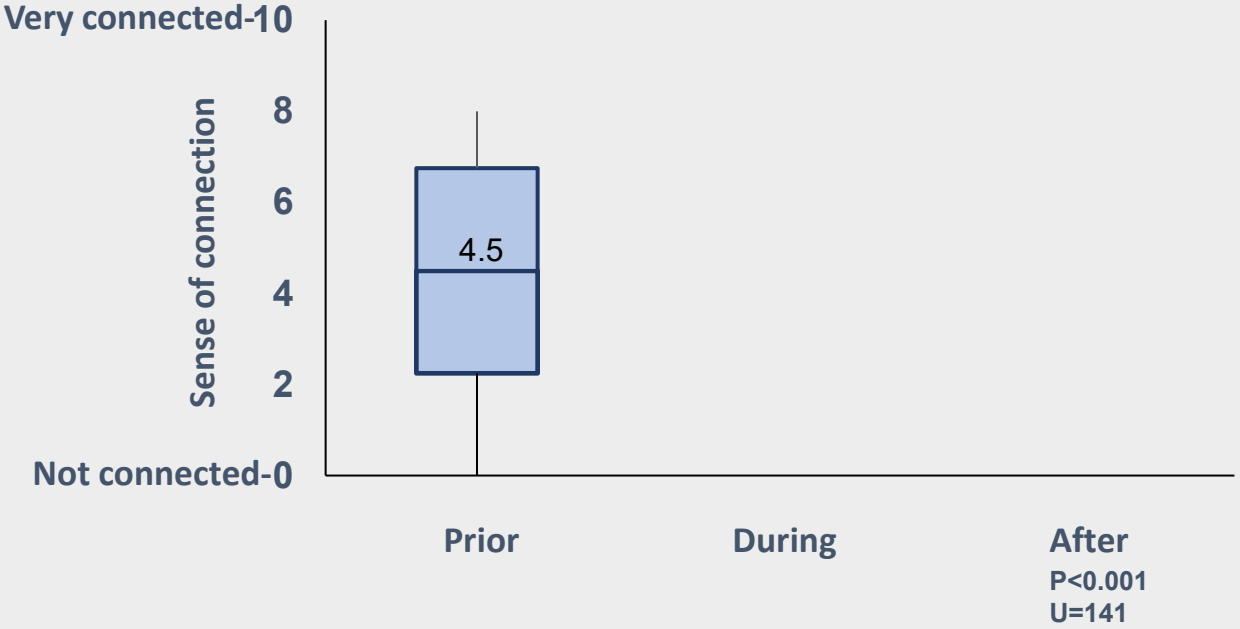
NO

2) Does the program have a **positive impact** on participants?

YES

3) Does the program increase the sense of **connection**?

Participants reported an increase in sense of connection during and after the program.



Determining program success:

1) Are the program requirements **burdensome** to participants?

NO

2) Does the program have a **positive impact** on participants?

YES

3) Does the program increase the sense of **connection**?

YES

Qualitative data support the hypothesis that the program had a positive impact.

What was the most memorable aspect/experience from this program (positive or negative)?

"Having conversations with colleagues who I normally would not have conversations with"

"Just having the feeling that other people want to connect as well"

"The appreciation of the messages I sent and to know it had a positive impact"

"I was assigned to a more senior resident on the first round…and I had never met them before, but we got along incredibly well and got to meet through texts…. Then when they were my chief, it was such a positive experience…"

Next steps:

- Developed an implementation tool kit
- Recently completed cycles in other departments (ie. medicine, graduate medical education)
- Working to expand to other roles (ie. nursing, IT services, etc.)

Summary:

- An **OPT-IN** messaging program of weekly assignments to send and receive **ONE** message with colleagues.
- Demonstrable **positive impact** on stress/outlook and sense of connection **without** contributing to burden.
- Expanding the program to new hospital systems and workplaces.

Interested in implementing? Contact:

Holly Blackburn

holly.blackburn@yale.edu

Acknowledgements

Yale Department of Surgery

Covid Wellness/Resilience Team: Dr. Walter Longo, Dana Forlano, Pamela Mulligan, Evans Simmons, Korina Dacunto

Dr. Andrea Asnes

Dr. Nita Ahuja

Dr. Peter Yoo

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3. Moreno-Mulet et al. The impact of the COVID-19 Pandemic on ICU healthcare professionals: a mixed methods study. *Int J Environ Res Public Health*. 2021; 18(17); 9243.
4. Lai et al. Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Netw Open*. 2020; 3(3): e203976.
5. Seda-Gombau et al. Impact of the COVID-19 Pandemic on burnout in primary care physicians in Catalonia. *Int J Environ Res Public Health*. 2021; 18(17): 9031.
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12. Ofei-Dodoo et al. Loneliness, burnout, and other types of emotional distress among family medicine physicians: results from a national survey. *J Am Board Fam Med*. 2021; 34(3): 531-541.

Interested in implementing? Contact:

Holly Blackburn

holly.blackburn@yale.edu

Yale SCHOOL OF MEDICINE

Department of Surgery


AMA
AMERICAN MEDICAL
ASSOCIATION


MAYO
CLINIC


Stanford
MEDICINE

An Upstream and Downstream Approach to Threat Management in Medicine

The Kaiser Permanente Orange County Journey

Lance Brunner, MD
Pam Honsberger, MD

KAISER PERMANENTE® thrive

Learning Objectives

Understand what systems should be in place within a medical practice or organization to address verbal, written, or physical threats from patients and families to physicians and staff – including sexual harassment

Incorporate evidence-based de-escalation tools to minimize escalation of incivility to disruption or threats of violence/actual violence.

Recognize what tools are potentially available within a medical organization to address all levels of threats.

Levels of Threat

Level 0.5	Level 1	Level 1a	Level 2	Level 2a	Level 3	Level 3a
Microaggressions	Letters/Calls Angry or Rude Statements Vague Responses	*Aggression towards KP organization*	Verbal Abuse Bullying "…isms" *(gender, race, ethnicity, religion, etc.)*	Sexual Harassment Minor Sexual Assault *(minor physical contact)* Code Grey Property Damage Psychological Safety	Direct Threats Weapons Sighted Physical Assault Letter / Calls *(content)*	Sexual Assault Stalking

Threat Management Team Members

Physician Leaders
Security
Behavioral Health

Administration
Nursing
Human Resources

Membership Services
Employee Assistance

https://sp-cloud.kp.org/sites/teams-oc-secure/ThreatManagement/SitePages/Submit%20Threat%20Report.aspx

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Micro-agression

- Subtle, insulting, discriminatory comments or actions that communicate a demeaning or hostile message to non-dominant group1
  - Micro assault is a form of microaggression involving purposeful discriminatory action, such as a verbal attack or avoidant behavior

- Negative implications are severe and lead to long-term psychological distress[2]

- Microaggressions *may* play a major role in physician burnout[3]

1. Merriam-Webster Dictionary
2. Derthick A. The Sexist Mess. P*roQuest Dissertations Publishing. 2015*
3. Maslach C et al. Job burnout. *Annu Rev Psychol.* 2001;52:397-422

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Helpful Definitions

Implicit Bias

- Refers to attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

Explicit Bias

- Refers to attitudes or beliefs we have about a person or group on a conscious level. Much of the time, these biases and their expression arise as the direct result of a perceived threat.

Bullying

- A person who uses strength or power to harm or intimidate those who are weaker.

Relational Aggression

- A type of aggression in which harm is caused by damaging someone's relationships or social status.

Helpful Definitions

Gender Discrimination

- Refers to the act of treating a person unfairly because of their sex

Sexual Harassment

- Involving unwanted sexual advances or obscene remarks

Sexual Assault

- Any type of sexual contact or behavior that occurs without the explicit consent of the recipient

Code of Conduct

Kaiser Permanente is committed to ensuring a safe, secure and respectful environment for everyone - patients, members, visitors, physicians, providers, healthcare teams and employees.

It is our expectation that all individuals will demonstrate civil and respectful behavior while on our premises.

We expressly prohibit:

- **Abusive language including threats and slurs**
- **Sexual Harassment**
- **Physical assault**
- **Weapons**

To maintain a safe, secure and respectful environment for all, we reserve the right to take appropriate measures to address abusive, disruptive, inappropriate or aggressive behavior.

If this is an immediate threat, call 911 and Security - Anaheim: (714) 644-5511 Irvine: (949) 932-5511

Confidential Threat Report

Your Information

Name: Gina Watkins

Note: If using a shared computer, please enter your name or NUID here.

Ext.:

Building:

Department:

Threat Details

When did this occur?:

Date Time

Where did this occur?:

Is this report based on:
- Direct Interaction
- Reported from other(s)

What type of threat was this?
- Verbal
- Physical

Who was involved? Please select all that apply
- Aggressor(s)
- Victim(s)
- Witness(s)
- KP Physician

Additional Threat Details

Relationship between person threatened and aggressor:

What occurred?:

Attachments

Are witnesses willing to make a written statement?:

Please add attachments here: Click here to attach a file

Examples of attachments: HealthConnect notes, member cover sheet/current appointment information, additional statements

Are you a Manger/Supervisor?

Submit

Kaiser Permanente Orange County

Safe & Secure Environment Story

Reporting System

KAISER PERMANENTE® thrive

KAISER PERMANENTE®
Orange County

Vivianna R Martin,

Your threat report has been successfully submitted

Reported By

Name:	Vivianna R Martin
Ext:	714-830-6551
Location:	Harbor- MacArthur Medical Offices (HBM), O/P Pharmacy 1st Floor A

Threat Details

When did this occur?:	Wednesday, June 27, 2018
Where did this occur?:	Harbor- MacArthur Medical Offices (HBM)
Was a KP Physician Involved?:	False
What Occured?:	06/27/18 Around 8:00/15 PM. Patient called regarding CII prescription refill. Advised patient that we are unable to fill the prescription until tomorrow, Day 22, due to MD request. Patient became irate and began to yell, name call, and curse. He stated that he talked to his doctor today and the doctor stated his prescription was ready. I informed patient that MD states his prescription must last 22 days and the 22nd day is tomorrow. He kept yelling "do the math, you all are stupid, today is the day, it's been 21.4 days." I advised the patient that I would have to disconnect if he continued to curse and use aggressive language. I advised, again, that we can fill it tomorrow due to the doctor's request. Patient insisted that he was not yelling and shouted that we are "Liars" and we are "refusing to fill his prescription because it's him". I advised him that I did not know who he was and I would be happy to fill his prescription on the next available date. He continued to scream, curse, state that he was going to come down here and "was not going away". He did arrive to the pharmacy 15 minutes later and yell at the Pharmacist and pharmacy staff. Security was called and he stated that "he is not leaving until he is heard and gets what he came for". He continued to yell and shout and was extremely hostile, belligerent, aggressive, and threatening. When he finally left, he stated that "he would be back".

Threat Management – Sharepoint Leaders Email

(Sample - Confirmation email)

- ***Confirmation Email sent to both Submitting Party & TMT Leaders***
- ***Immediate notification of threat***
- ***Proper response & action***
- ***Immediate outreach to law enforcement, Manager/Admin and/or victim***
- ***Timely security involvement***

Create Scalable, Digital processes: *New process built leveraging new digital tools*

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Orange County Service Area

VIA CERTIFIED MAIL DELIVERY

Date

Name
Address

Dear Name:

We are writing on behalf of Kaiser Permanente Orange County. The goal of everyone at Kaiser Permanente Orange County is to provide the highest quality of care to each patient in a safe, nurturing environment where all patients, physicians, and support staff can fully focus on your clinical concerns. That goal can only be met when a healthy level of trust sustains the physician-patient relationship. This can be accomplished through civil communications in all interactions.

We have become aware that you have sent numerous emails to your treatment team that have been perceived as angry and confrontational. This type of communication with your physician and treatment team is potentially harmful to your physician-patient relationship and will not be tolerated. Our expectation is that future email communications, when needed, will be cordial and civil. The ability to send your team email communications is a privilege and this capability can be revoked if we see further problematic activity.

Controversial clinical concerns are always best addressed through a phone call or a face to face visit. You can communicate with your physician and team by contacting Kaiser Permanente at 1-888-988-2800 for appointments and phone messages.

We appreciate your cooperation in this matter and sincerely hope that you can follow this instruction, so that we can re-focus our attention on our provider-patient relationship and your health care needs.

Sincerely,

Kaiser Permanente Orange County Administration

Kaiser Permanente Orange County

Letter of Concern

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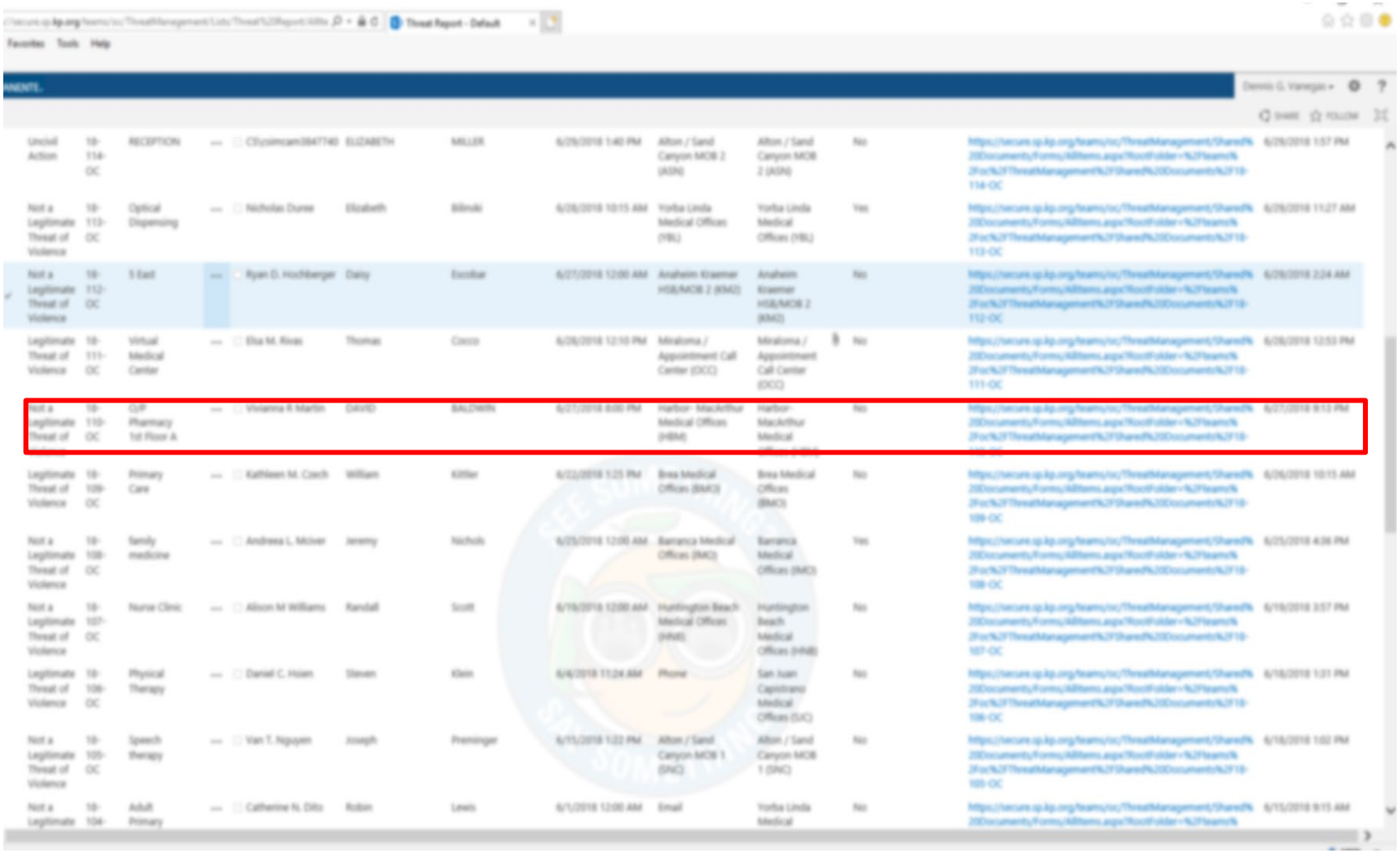
Assigned TMT Administrator – Case Log Access



KAISER PERMANENTE® thrive

Potential Management Levers Orange County

In the moment feedback

Outreach by office/ department/ security / threat management leadership

Patient reassignment

Flag chart – Demographics Section and FYI

Letters of understanding

Security at future visits

Combative patient alert

Kp.org email suspension

Behavioral health outreach

Compliance

APS/CPS

Law enforcement

Regional Legal in conjunction with MSAAT

Background / Court Record Check
Gun Registration Check
Temporary Restraining Orders
National Special Investigations Unit
Private Detectives
Forensic Psychologist Assessment
Personal Security

Disenrollment

Orange Aid (physician support) / EAP

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Questions

Thank You!

Pam Honsberger, MD

Pamela.e.Honsberger@kp.org

ACPH 2021

American Conference on Physician Health™

AMA AMERICAN MEDICAL ASSOCIATION

MAYO CLINIC

Stanford MEDICINE

Disclosures

- No Financial Disclosures

Heartfulness Meditation Improves Loneliness and Sleep in Physicians and Advance Practice Providers During COVID-19 Pandemic

Jay Thimmapuram, MD
Clinical Assistant Professor of Medicine
PennState College of Medicine
Academic Hospitalist in Internal Medicine
WellSpan York Hospital

Background

- The pandemic has led to high work demands, irregular break-times, and stress among physicians and advance practice providers.
- Unprecedented work pressures and social isolation during COVID-19 pandemic may worsen loneliness and sleep problems among health care professionals.

Loneliness

- Loneliness is defined as a painfully experienced absence of social contact, belongingness, or a sense of isolation.
- An important social determinant of health and well-being.
- Loneliness poses a significant health problem with increased risks for depression, anxiety, suicidal ideation, and mental health behavior impairment.

Mushtaq R et al. J Clin Diagn Res. 2014

Beutel ME et al. BMC Psychiatry. 2017

Sleep

- Sleep problems significantly impair mental well-being and are associated with reduced safety, increased errors and ultimately impacting quality of care for patients.
- Poor sleep has been implicated as one of the factors playing a role in the perception of loneliness.

Simon EB, Walker MP. Nat Commun. 2018

Meditative practices

- Meditation practices are known to have a positive impact on psychological well-being and sleep.
- In recent years, there has been a significant increase in the use of meditation practices among the US adults from 4.1% in the year 2012 to 14.2% in the year 2017 to likely improve psychological well-being.
- Heartfulness Meditation is a simple Heart-based meditation practice that is aimed at achieving an inner state of balance.

Clarke TC et al. NCHS Data Brief. 2018.

Methods

- 4-week prospective randomized controlled study.
- Randomized to either Heartfulness audio guided meditation arm or the control arm (no intervention offered)
- No change to the schedules or additional interventions.
- UCLA loneliness and PSQI scores collected at baseline and at the end of the study.
- Intervention was virtual with no in-person contact with the participants.
- Participants assigned to the Heartfulness meditation arm were asked to listen to guided meditation audio lasting for approximately 6 minutes in the morning and before going to bed.

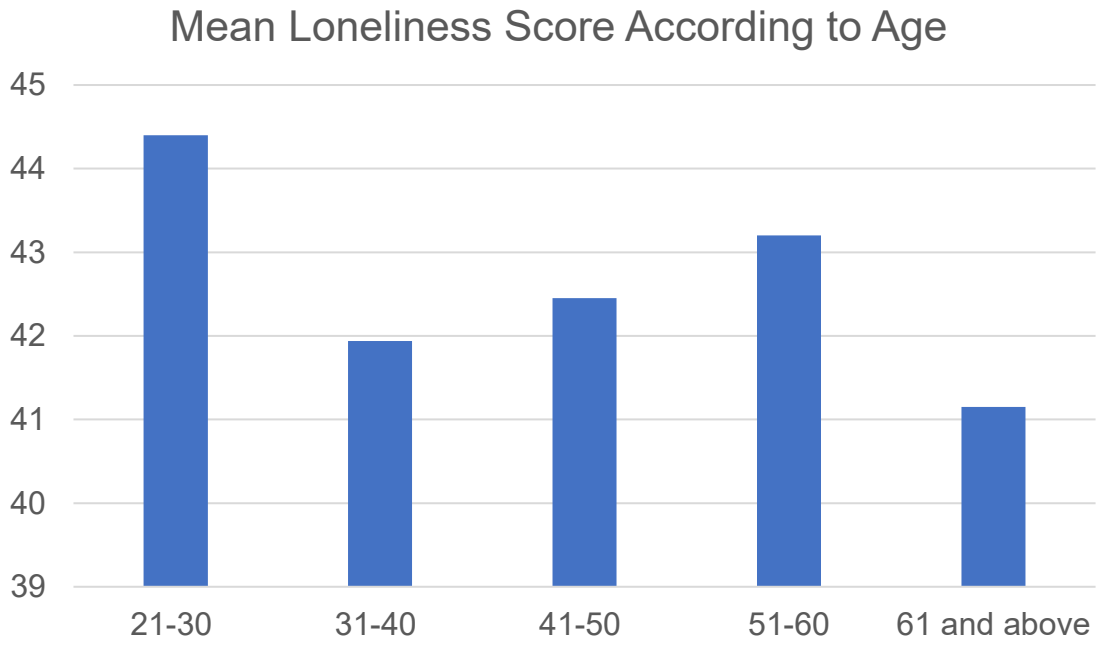
Results

Baseline Characteristics	All Participants (N, %)	Heartfulness Meditation Group (N, %)	Control Group (N, %)
Participants (N)	155	77 (50%)	78 (50%)
Mean Age	46 (SD 11.03)	46 (SD 11.18)	46 (SD 11.06)
Sex			
Male	46 (30%)	21 (27%)	25 (32%)
Female	103 (66%)	54 (70%)	49 (63%)
Prefer Not to Disclose Gender Identity/Left the field blank	6 (4%)	2 (3%)	4 (5%)
Marital Status**			
Married	114 (74%)	57 (74%)	57 (73%)
Single, but cohabiting with significant other	10 (6%)	5 (6%)	4 (5%)
In a domestic partnership or civil union	4 (3%)	1(1%)	3 (4%)
Single, never married	12 (8%)	8 (10%)	4 (5%)
Divorced/separated	10 (6%)	5 (5%)	5 (6%)
widowed	1 (1%)	0 (0%)	1 (1%)
Role/Designation			
Attending physician	61 (39%)	28 (36%)	33 (42%)
Resident physician	12 (8%)	4 (5%)	8 (10%)
CRNP	58 (37%)	35 (46%)	23 (30%)
Physician Assistant	18 (12%)	9 (12%)	9 (12%)
Other*	6 (4%)	1 (1%)	5 (6%)
Work Environment**			
Hospital based	72 (46%)	35(45%)	37(47%)
Office based	41(26%)	27(35%)	14(20%)
Hospital and Office based	35 (23%)	12(16%)	23(29%)

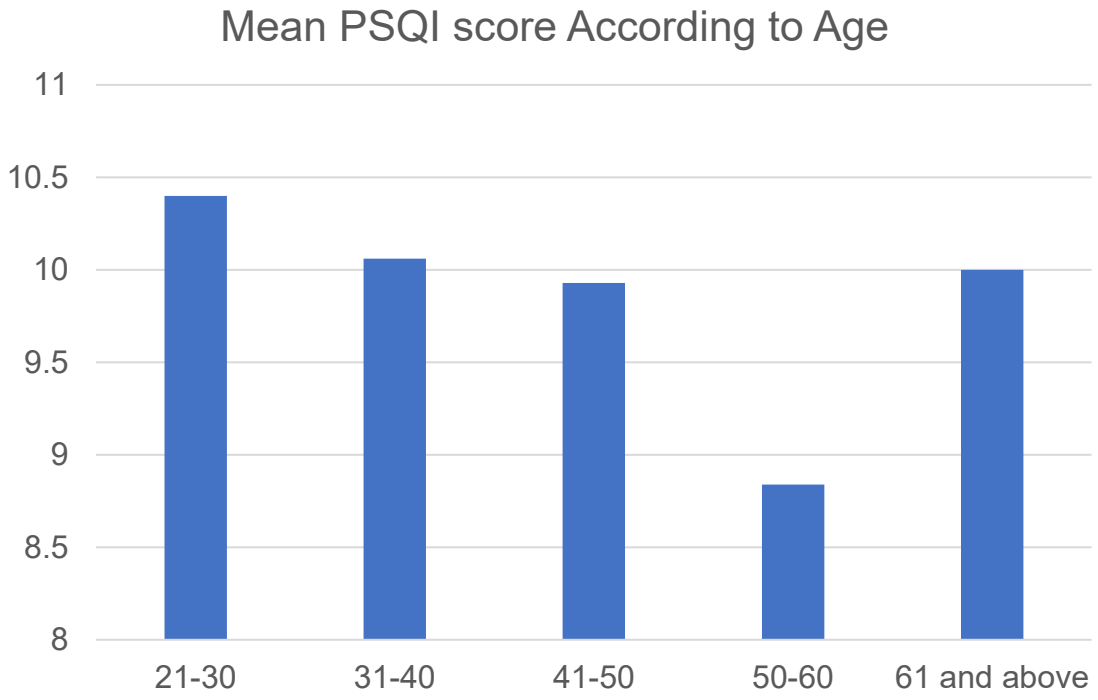
*Participants who left the designation field blank were categorized as other
**Participants not wishing to disclose marital status and work environment are not included

Thimmapuram et al. Hospital Practice. 2021.

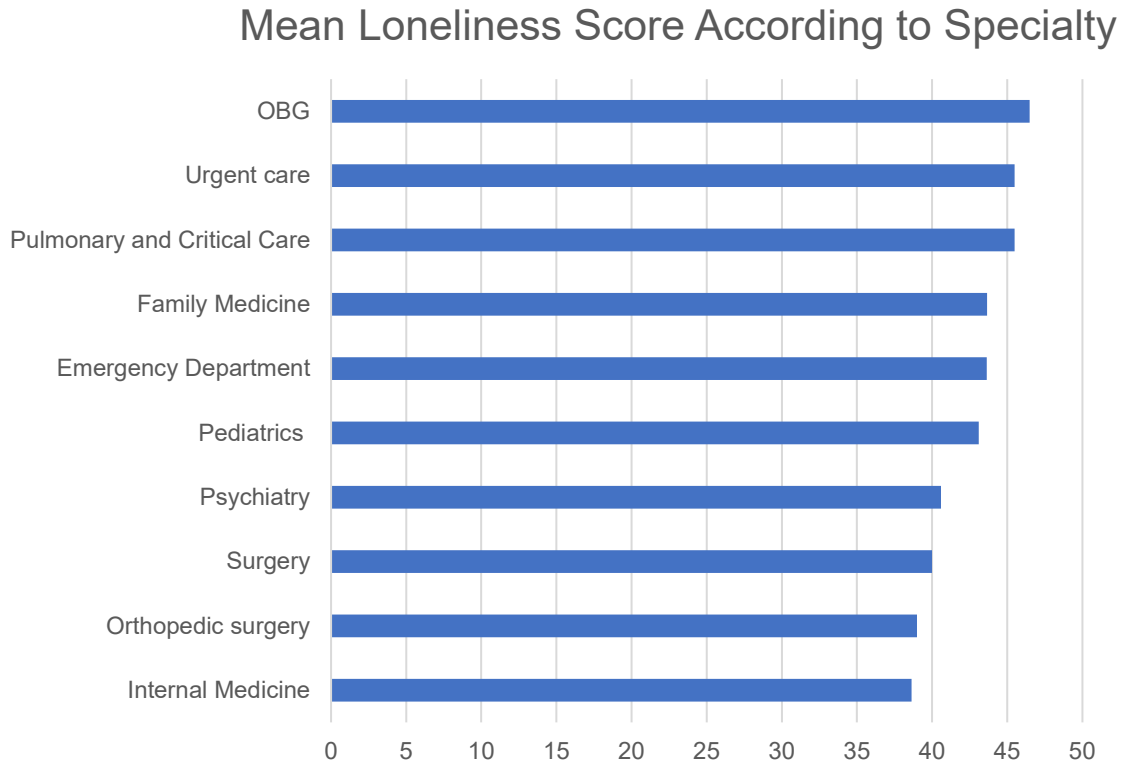
Results


Mean Loneliness Score According to Age
45
44
43
42
41
40
39
21-30
31-40
41-50
51-60
61 and above

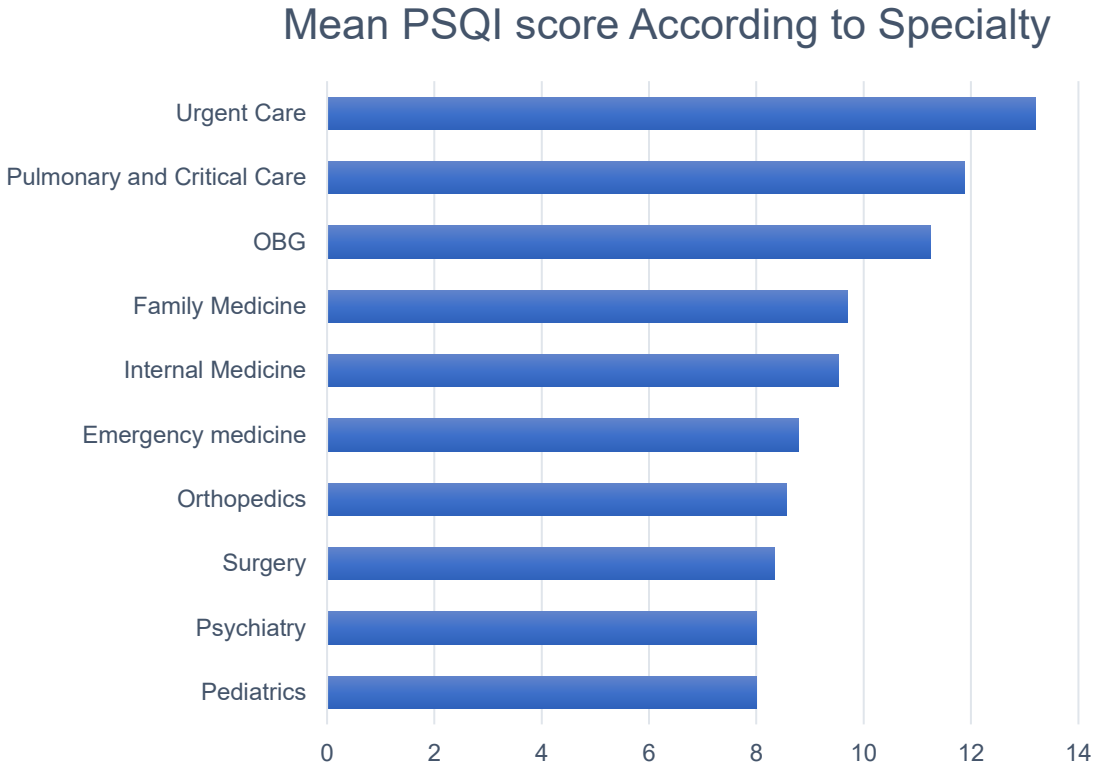
Results


Mean PSQI score According to Age
11
10.5
10
9.5
9
8.5
8
21-30
31-40
41-50
50-60
61 and above

Results

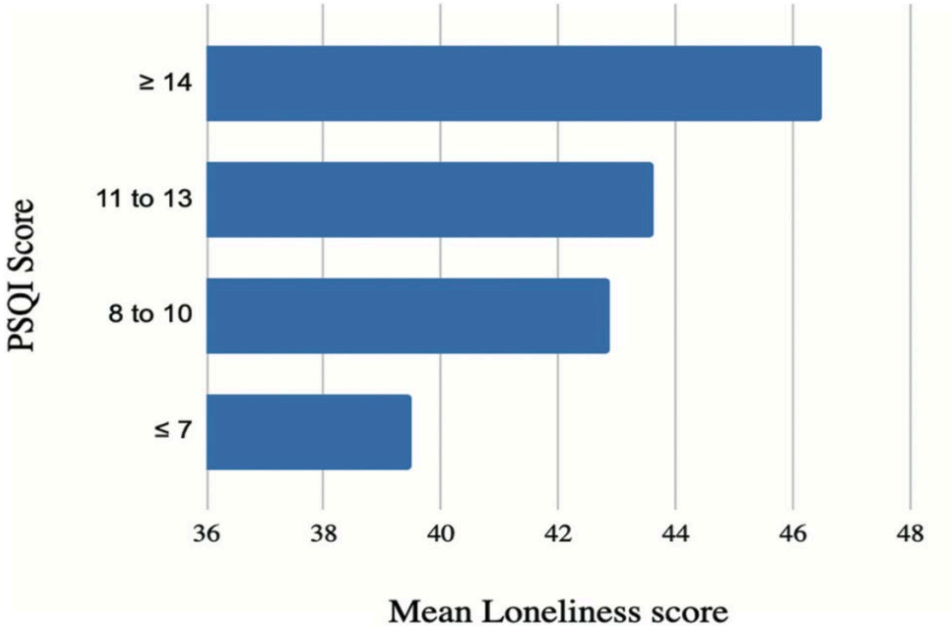

Mean Loneliness Score According to Specialty
OBG
Urgent care
Pulmonary and Critical Care
Family Medicine
Emergency Department
Pediatrics
Psychiatry
Surgery
Orthopedic surgery
Internal Medicine
0
5
10
15
20
25
30
35
40
45
50

Results


Mean PSQI score According to Specialty
Urgent Care
Pulmonary and Critical Care
OBG
Family Medicine
Internal Medicine
Emergency medicine
Orthopedics
Surgery
Psychiatry
Pediatrics
0
2
4
6
8
10
12
14

Results

PSQI and Loneliness Scores



Results

1 out of 2 of Physicians and APPs were lonely.

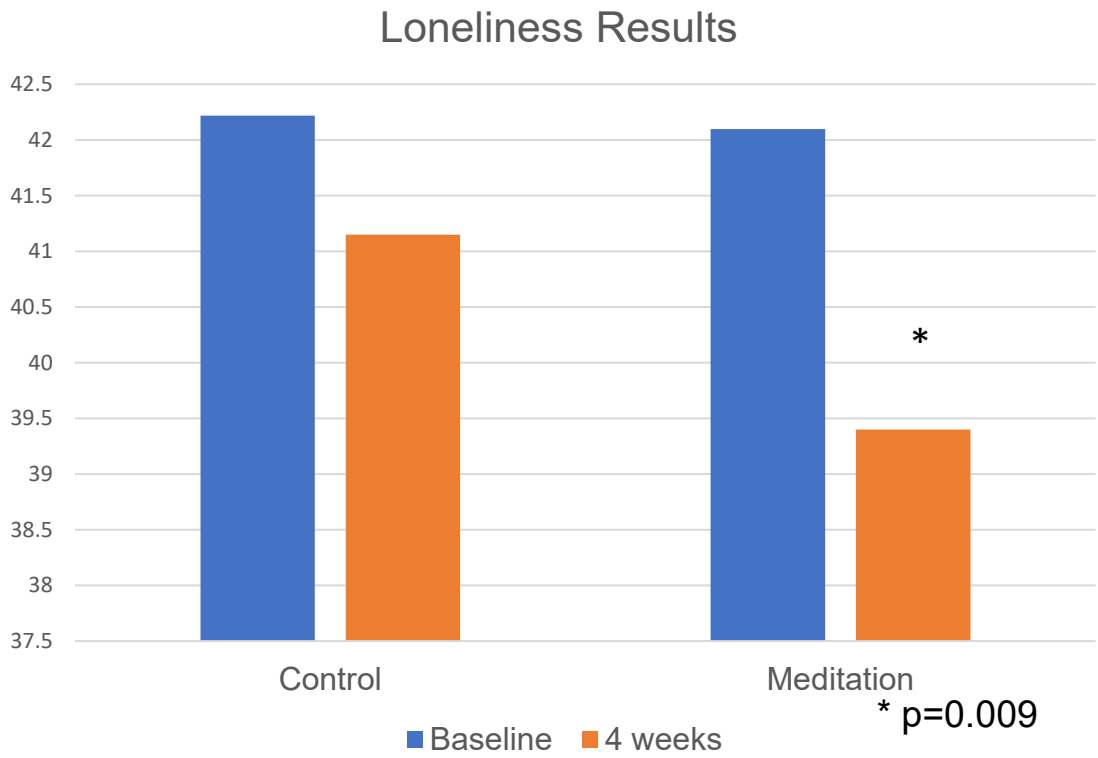
9 out of 10 Physicians and APPs reported sleep problems.

Frequency of meditation practice

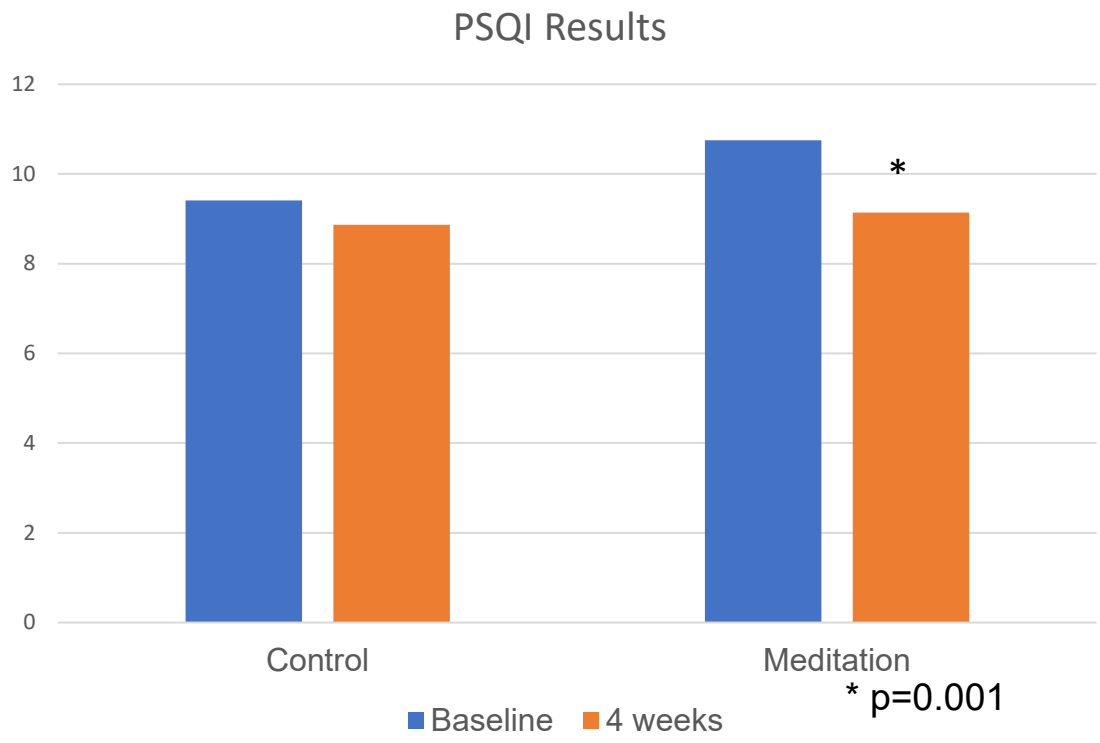
Results

Number (%)	Frequency of meditation practice
11 (26.8%)	Daily
8 (19.5%)	4–6 times per week
9 (21.95%)	2–3 times per week
8 (19.5%)	once a week
5 (12.2%)	none

4-Week Results



4-Week Results

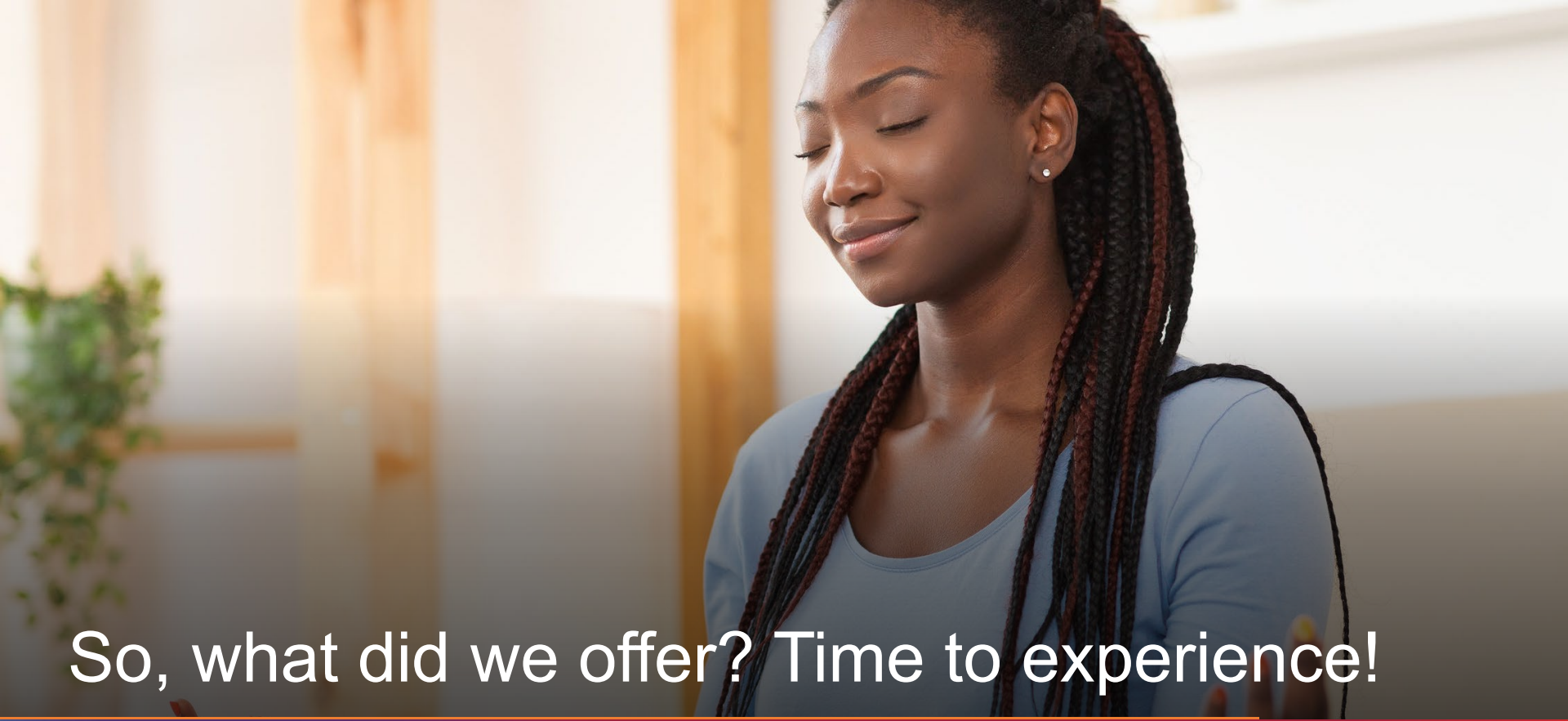


Limitations

- Single health system was involved.
- Relatively smaller sample size.
- Personal life factors could have played a role.
- Lack of an active control.
- Unclear of clinical significance.
- Long term data not available.

Conclusions

- The current research is one of the first attempts to assess loneliness and sleep problems among physicians and advance practice providers during COVID-19 pandemic in the US.
- Heartfulness meditation appears to provide an improvement in the perception of loneliness and sleep quality.
- Given the hectic schedules among health-care workers, a virtually accessible program that could be easily incorporated into the current lifestyle can be practically applicable.



So, what did we offer? Time to experience!

References

- Thimmapuram J, Pargament R, Bell T, Schurk H, Madhusudhan DK. Heartfulness meditation improves loneliness and sleep in physicians and advance practice providers during COVID-19 pandemic. *Hosp Pract (1995)*. 2021;49(3):194-202.
- www.Heartfulnessinstitute.org

Acknowledgments

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- Ridge Salter, MD


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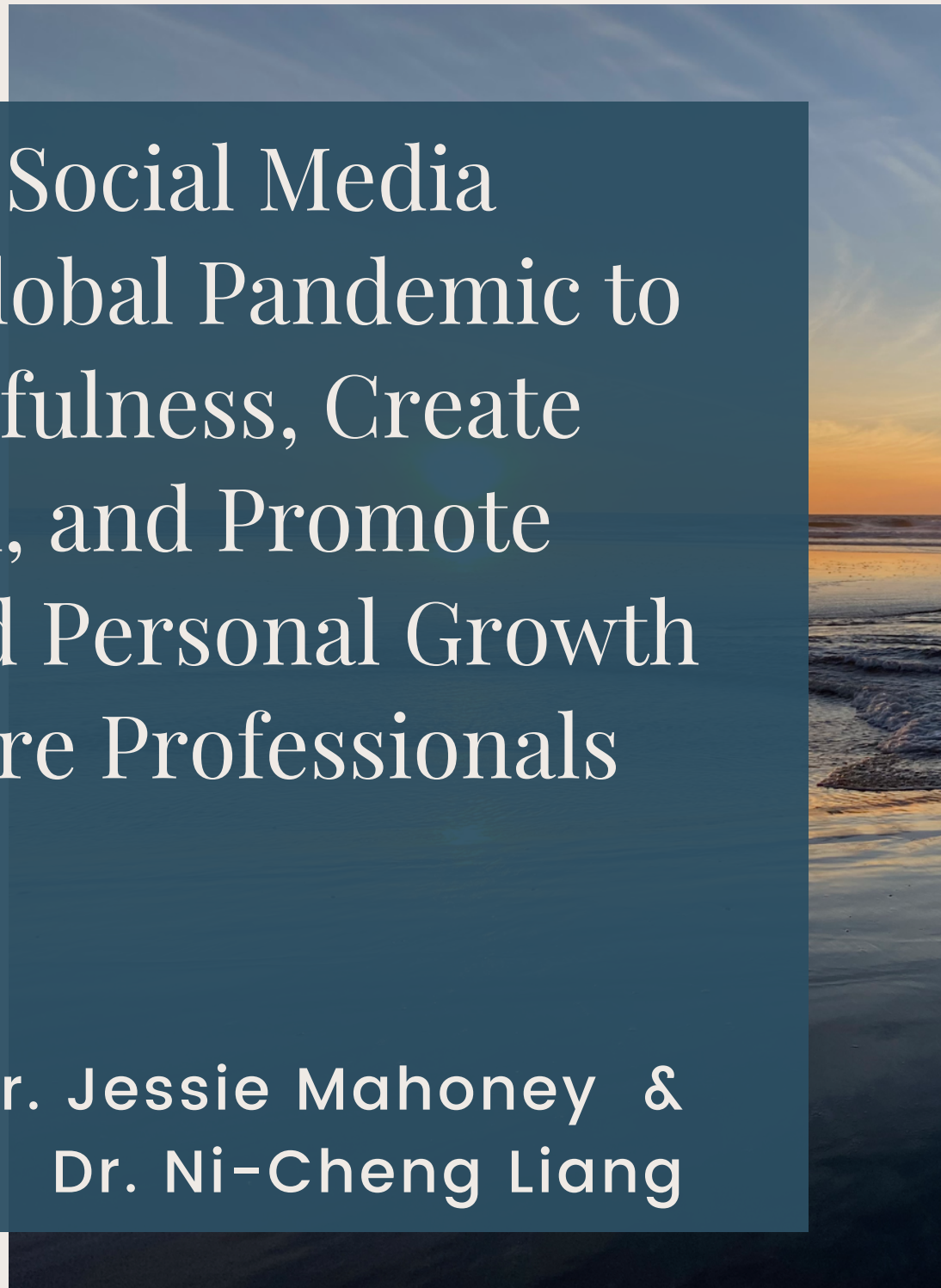
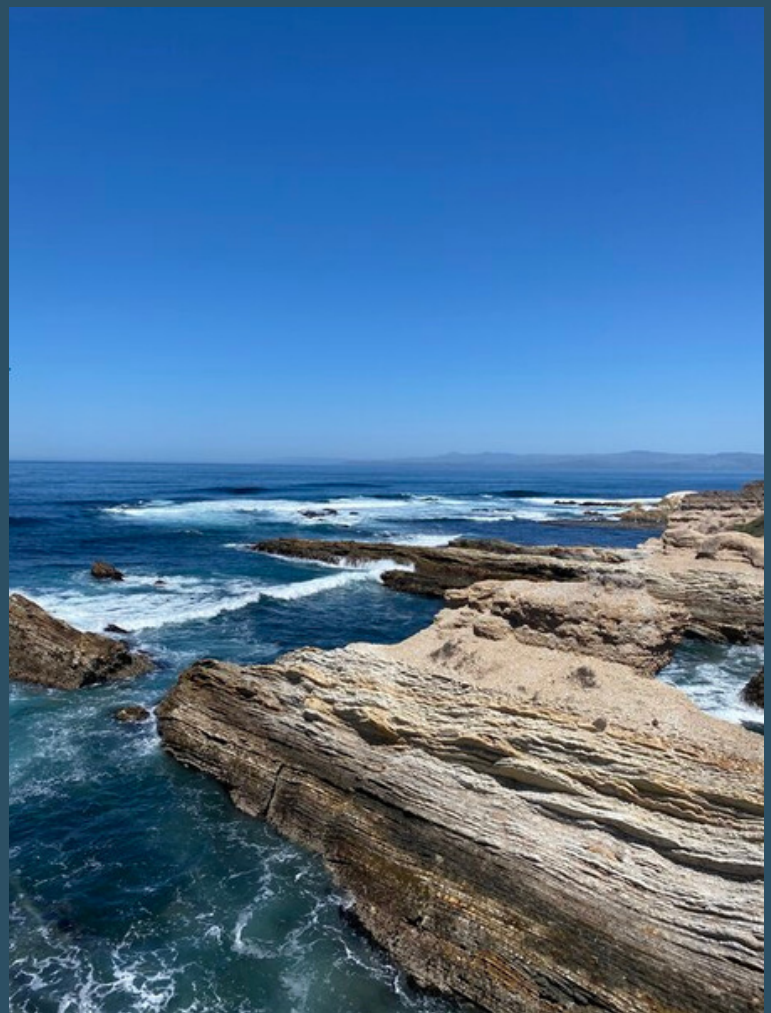
AMERICAN CONFERENCE ON PHYSICIAN HEALTH

Leveraging Social Media During A Global Pandemic to Share Mindfulness, Create Connection, and Promote Healing and Personal Growth in Healthcare Professionals

Dr. Jessie Mahoney &
Dr. Ni-Cheng Liang



Disclosures



Pause & Presence, LLC

Awaken Breath, LLC

Objectives

- Learn to utilize social media platforms to foster community
- Learn to utilize virtual platforms for live educational & interactive sessions to reduce stress and burnout amongst healthcare professionals
- Acquire an understanding of mindfulness-based offerings that appeal to healthcare professionals

The Mindful Healthcare Collective

What is it?

A Facebook Group

&

Website mindfulhealthcarecollective.com

- An innovative grassroots solution to address unprecedented stress and isolation in healthcare professionals during the pandemic

- A virtual inclusive space for healthcare professionals to connect, heal, restore, and grow.

Mindful Healthcare Collective Leadership

Board certifications: Internal Medicine, Pulmonary Medicine, Pediatrics, Med/Peds, Integrative Medicine, Pediatric Anesthesia, Dermatology, OB/GYN, Lifestyle Medicine, Family Medicine

Additional Certifications/Trainings: Mindfulness, coaching, Emotional Freedom Technique, yoga, Brene Brown Dare to Lead curricula, Herbal Medicine

Leadership Experience: Academic faculty, Residency Program Directors, Department Chiefs, Physician Wellness Chiefs, Medical Directors, Medical Societies

FaceBook Group

April 2020- 0 members

Oct 2021- 2200+ members

Programming

- 2 weekly free virtual sessions
- Zoom and FB Live
- "In community"
- For 18 + months

Programming

- Mindful yoga
- Coaching
- Tapping (EFT)
- Writing meditation
- Mindfulness
- Book clubs

Results

- Since April 2020 - over 175 live Zoom sessions.
- 6 - 40 participants attend each session
- Sessions have goals of:
  - Reducing stress, anxiety
  - Providing safe space for sharing of experience, trauma, shame, and anti-racism.

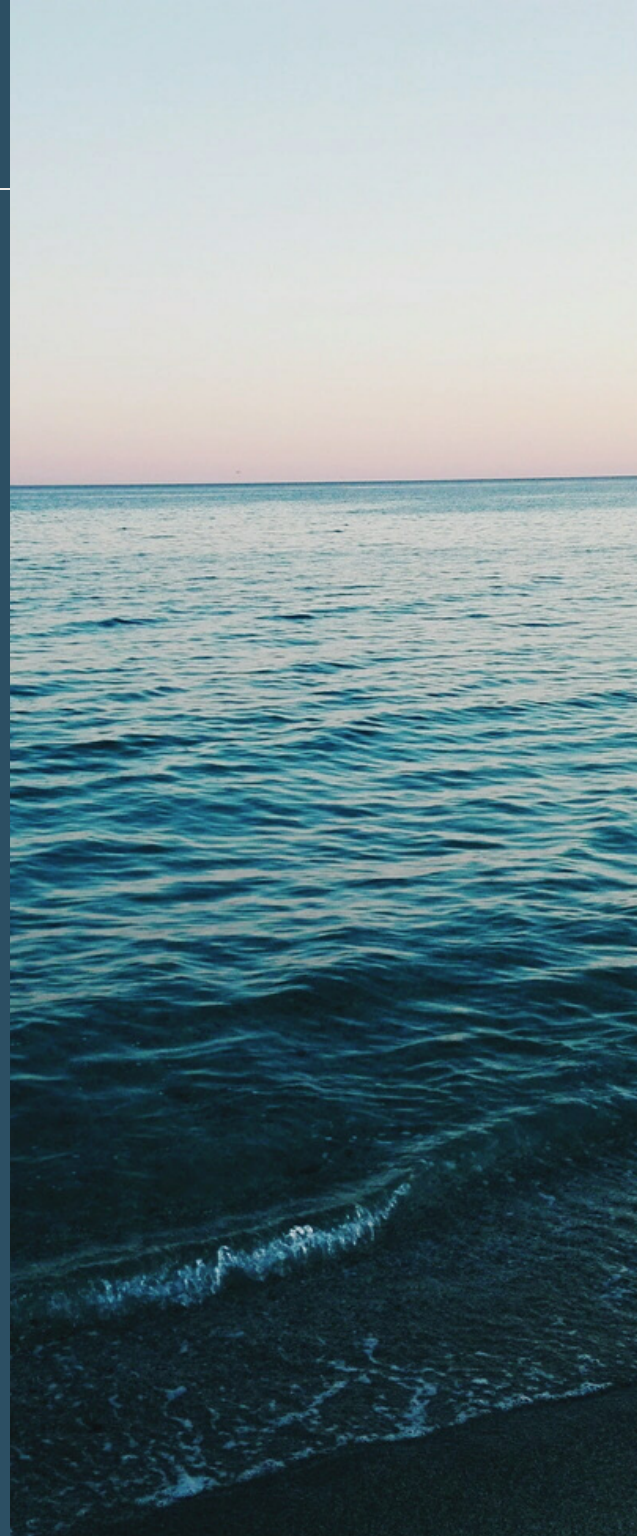
Feedback

October, 2020

- 45 members responded
- 86.6% (39) of the respondents --“I love the variety and offerings. Keep doing what you are doing!”

Unsolicited qualitative feedback from group members:

"I appreciate this group and the wisdom you all share. The posts … remind me that I am part of a healing community of like minded physicians nurturing ourselves and each other during these pandemic times."



Unsolicited qualitative feedback from group members:

"I appreciate when tidbits pop up on my feed. Keep it up!"

"I love knowing you all are out there. It's very comforting."

Unsolicited qualitative feedback from group members:

"Being able to be part of a group that acknowledges, allows, and provides support through burnout has helped me not feel isolated. More aware of assistance that is available, to be able to reach out for help, and especially to see and hear from others who are struggling at times. Very grateful to feel I am a part of something."

Unsolicited qualitative feedback from group members:

"...especially for me it was the group coaching sessions, and the opportunities to sometimes listen, sometimes be coached. That was really helpful to have an available resource without having to worry about cost or overcommitment."

What has evolved out of the collective?

The Mindful Healers Podcast

> 11,000 downloads
< 8 months

Yoga for Healers

- Offered weekly
- Attendees from across the globe
- Featured on mindful.org

Session offerings for The Mindfulness for Healthcare Summit sponsored by Mindful.Org including yoga and Mindful Anti-Racism

Conclusions

Grass roots physician-led collaborative efforts can be a powerful conduit to reduce stress, provide support through meaningful community

A FaceBook group, website, & online sessions

- **led by physicians**
- **focused on mindfulness**

Are an effective and sustainable way to

- **create community and connectedness, inclusion**
- **promote resiliency**
- **help sustain physician well-being**

even and especially during a pandemic

What's happening 18 months later

- Growth
- Ongoing offerings
- Amplification of our efforts e.g. San Diego County Medical Society, SF Marin Medical Society, American Thoracic Society, and via Mindful.org.

Join the community:

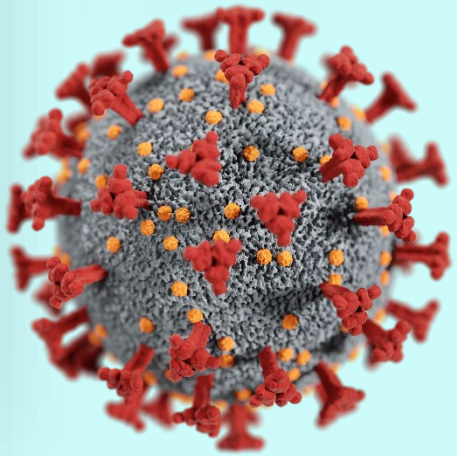
Mindful Healthcare Collective on Facebook
https://www.facebook.com/groups/mindfulhealthcarecollective

mindfulhealthcarecollective.com

Fast Tracking Change Management
and
Enhancing Well-Being During the COVID-19 Pandemic Crisis

Saadia Akhtar, MD, FACEP
Maria Moreira, MD, FACEP

C	O	V	I	D
Change	Management	AND	Well	Being



Saadia Akhtar, MD, FACEP

Associate Dean for Trainee Well-Being and Resilience

Associate Dean for Graduate Medical Education

Associate Professor of Emergency Medicine

Associate Professor of Medical Education

Icahn School of Medicine at Mount Sinai

Maria E. Moreira, MD, FACEP

Medical Director of Continuing Education & Simulation
Denver Health & Hospital Authority Office of Education

Director of Professional Development & Wellbeing
Denver Health & Hospital Department of Emergency Medicine

Associate Professor of Emergency Medicine
University of CO School of Medicine

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OBJECTIVES

PRINCIPLES	WELLNESS IMPACT	COVID	IMPLEMENTATION	CASE STUDIES
Define change management principles	Discuss change management impact on well-being	Application of change management as relates to COVID pandemic	Review templates and tools for application of change management principles	Apply principles together through case scenarios to learn from each other

“The application of a structured process and tools to enable individuals or groups to transition from a current state to a future state to achieve a desired outcome.”

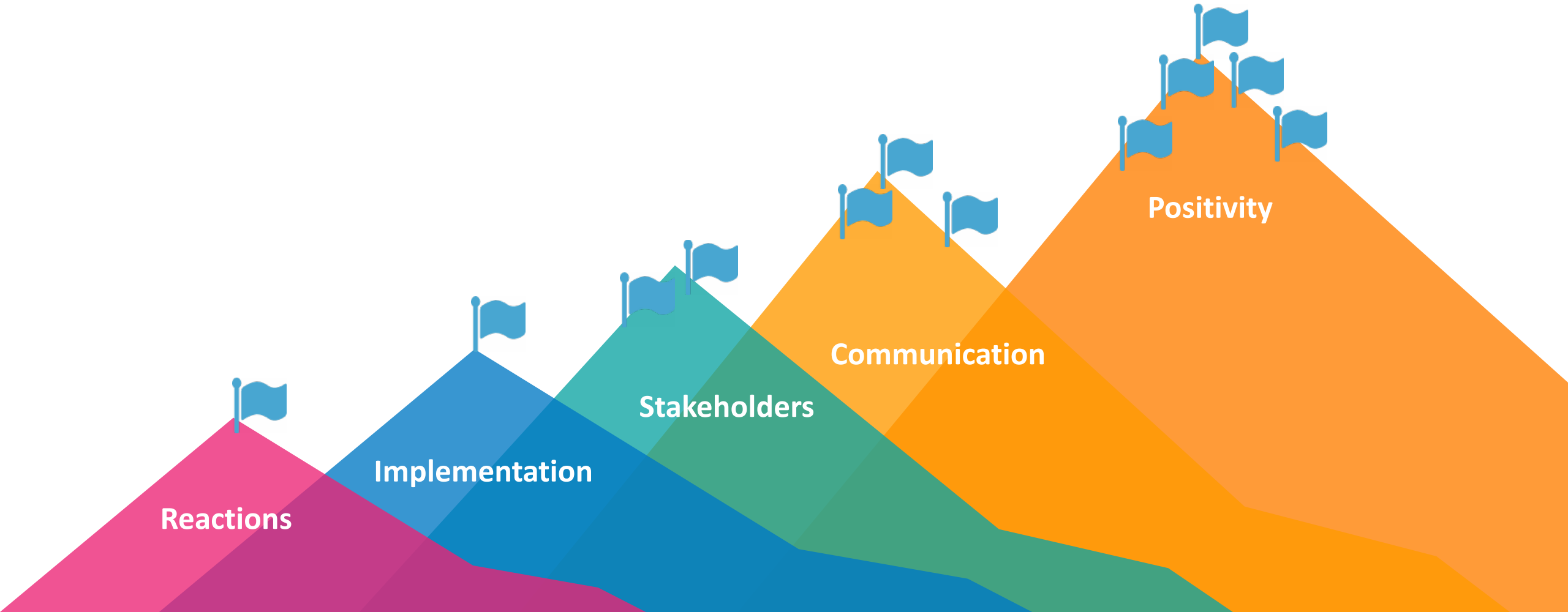
USERS
Who benefits from output

PROVIDERS
Resource sources

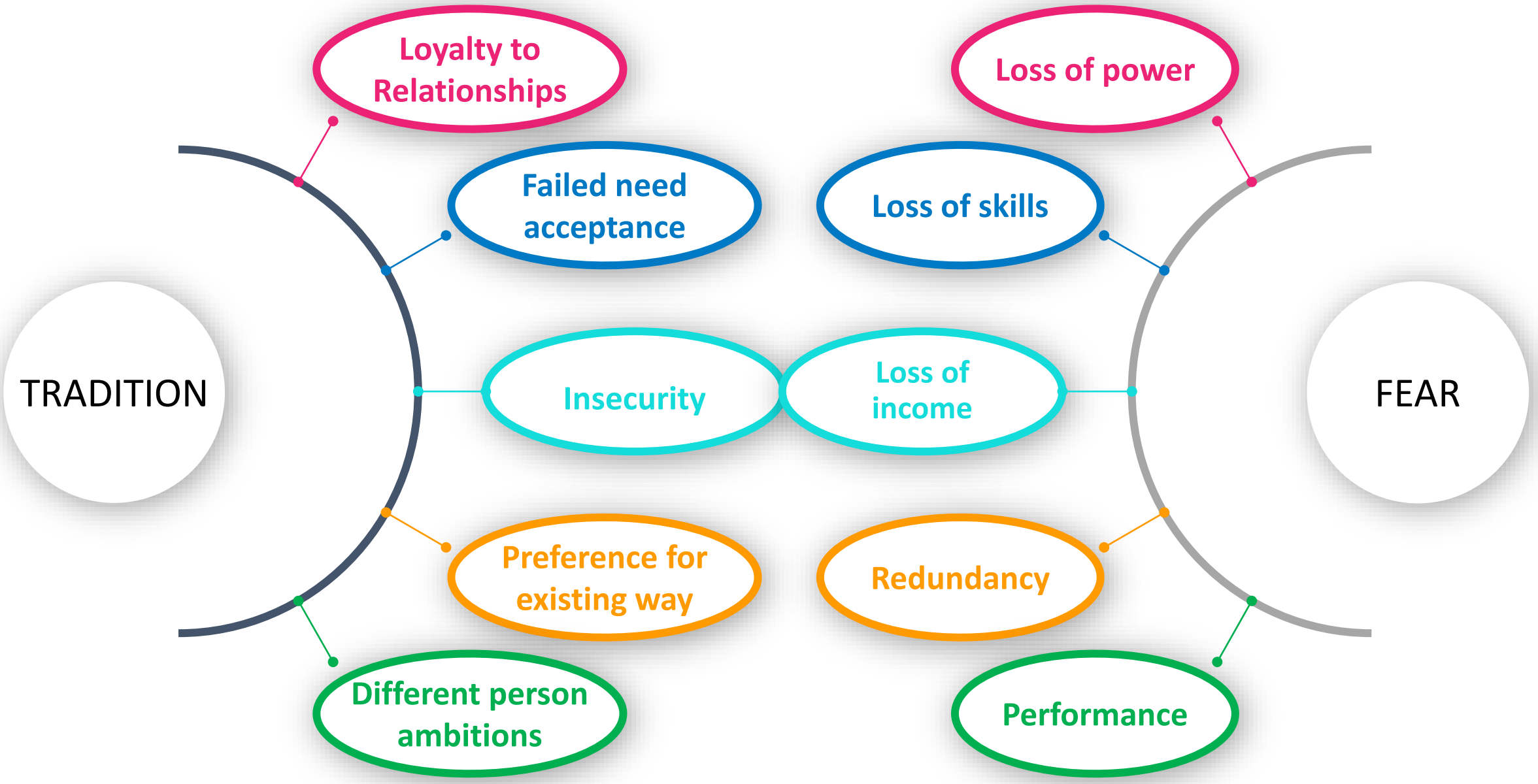
INFLUENCERS
Power to influence decisions

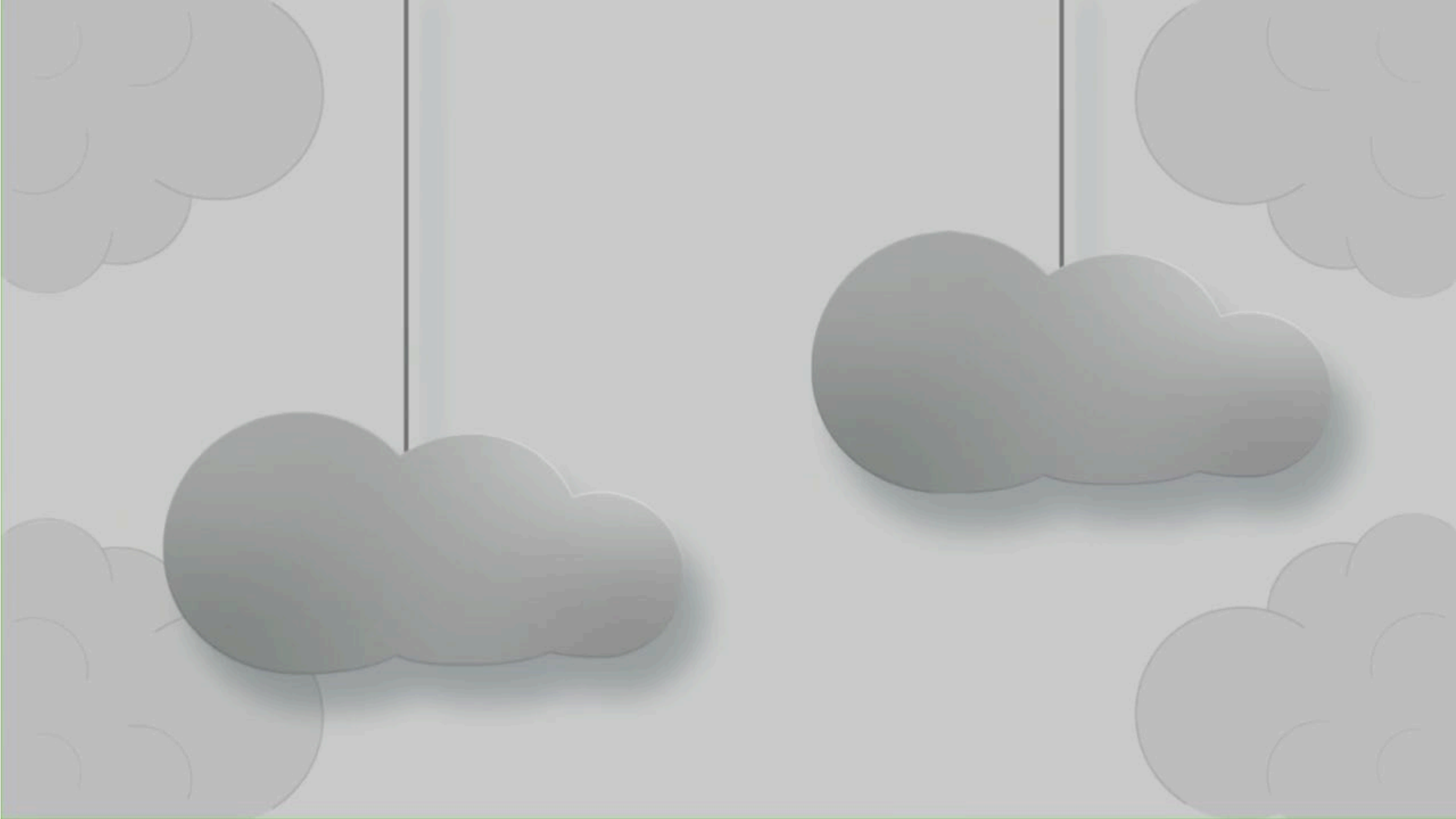
GOVERNANCE
Interest in how things are managed

CONSIDERATIONS

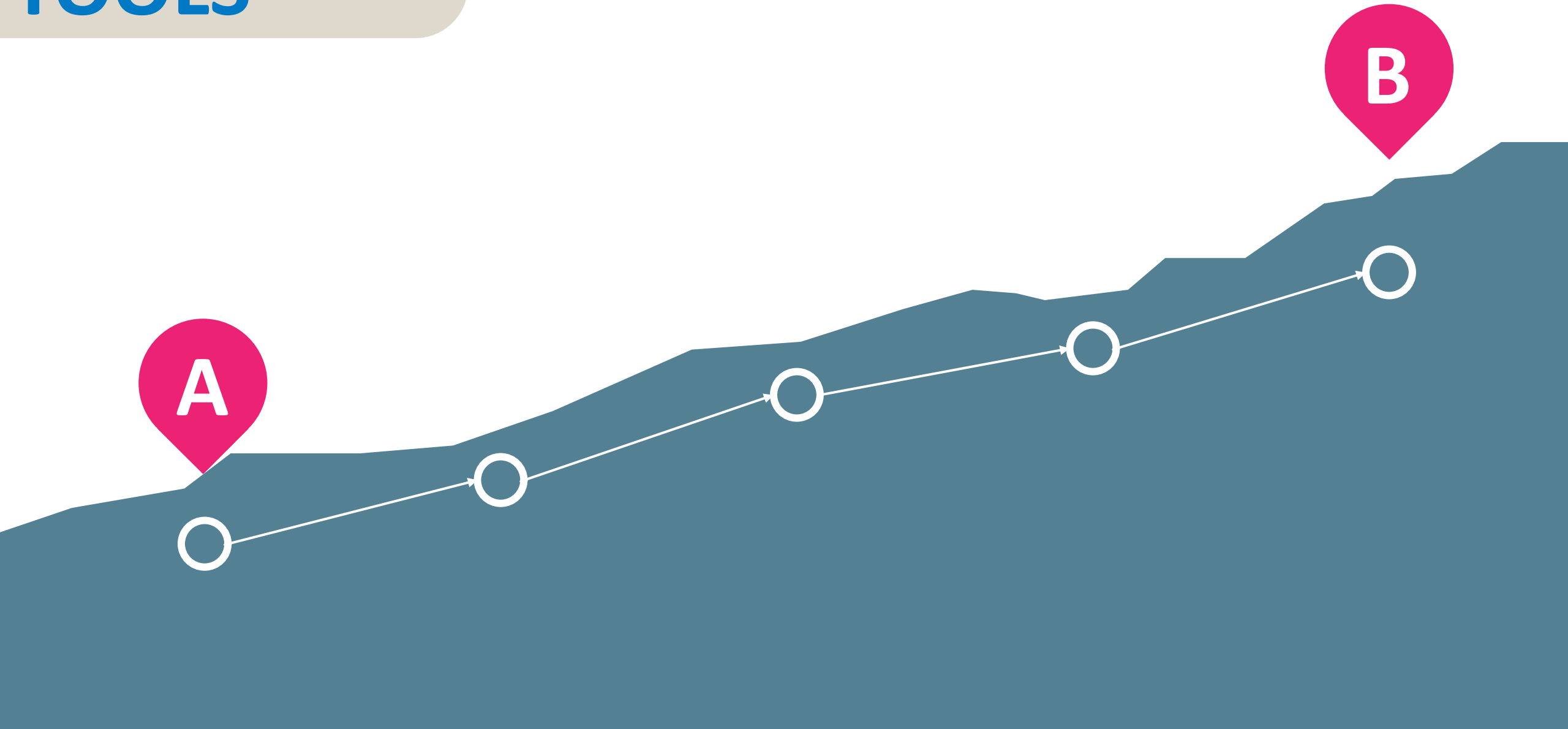


BARRIERS


Loyalty to Relationships
Failed need acceptance
TRADITION
Insecurity
Preference for existing way
Different person ambitions
Loss of power
Loss of skills
Loss of income
Redundancy
Performance
FEAR

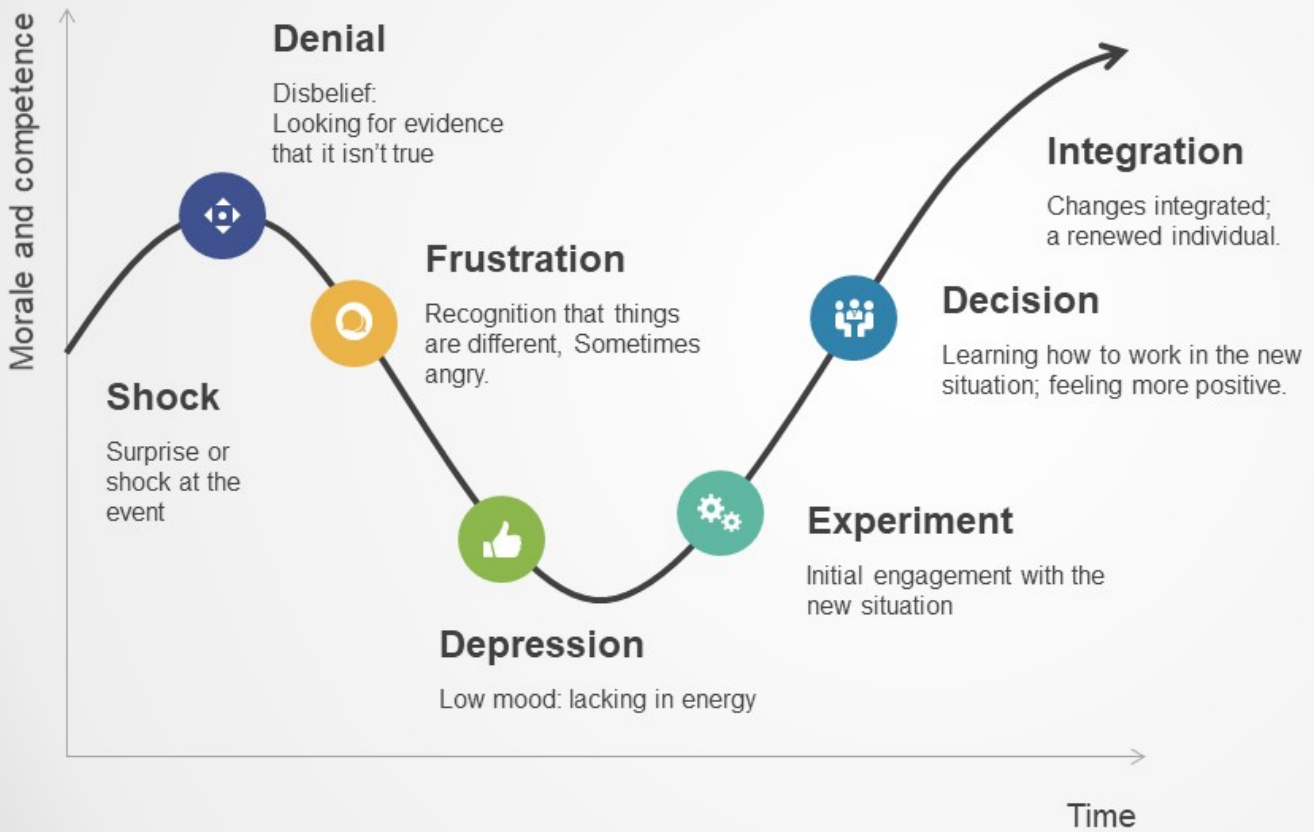


TOOLS



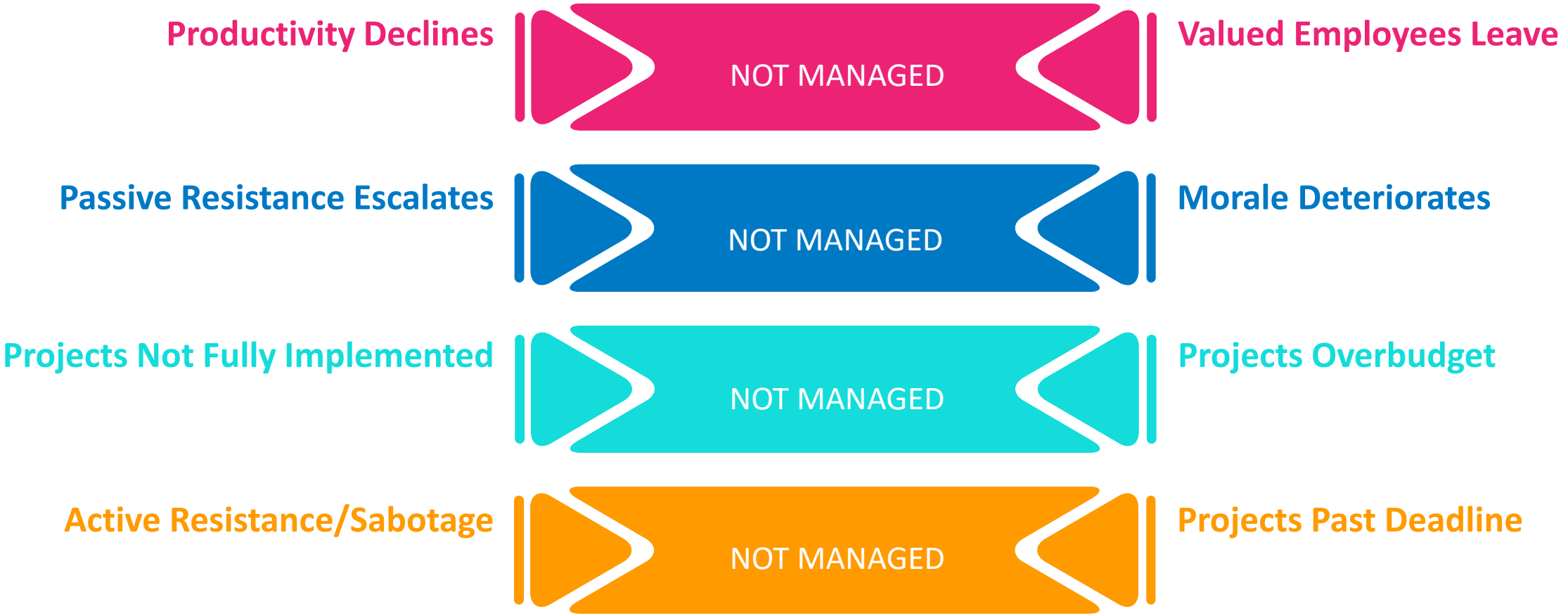
The Kübler-Ross Change Curve

Emotional Response to Change



- Creative Alignment
- Maximize Communication
- Spark Motivation
- Develop Capability
- Share Knowledge

CHANGE


Productivity Declines
NOT MANAGED
Valued Employees Leave
Passive Resistance Escalates
NOT MANAGED
Morale Deteriorates
Projects Not Fully Implemented
NOT MANAGED
Projects Overbudget
Active Resistance/Sabotage
NOT MANAGED
Projects Past Deadline

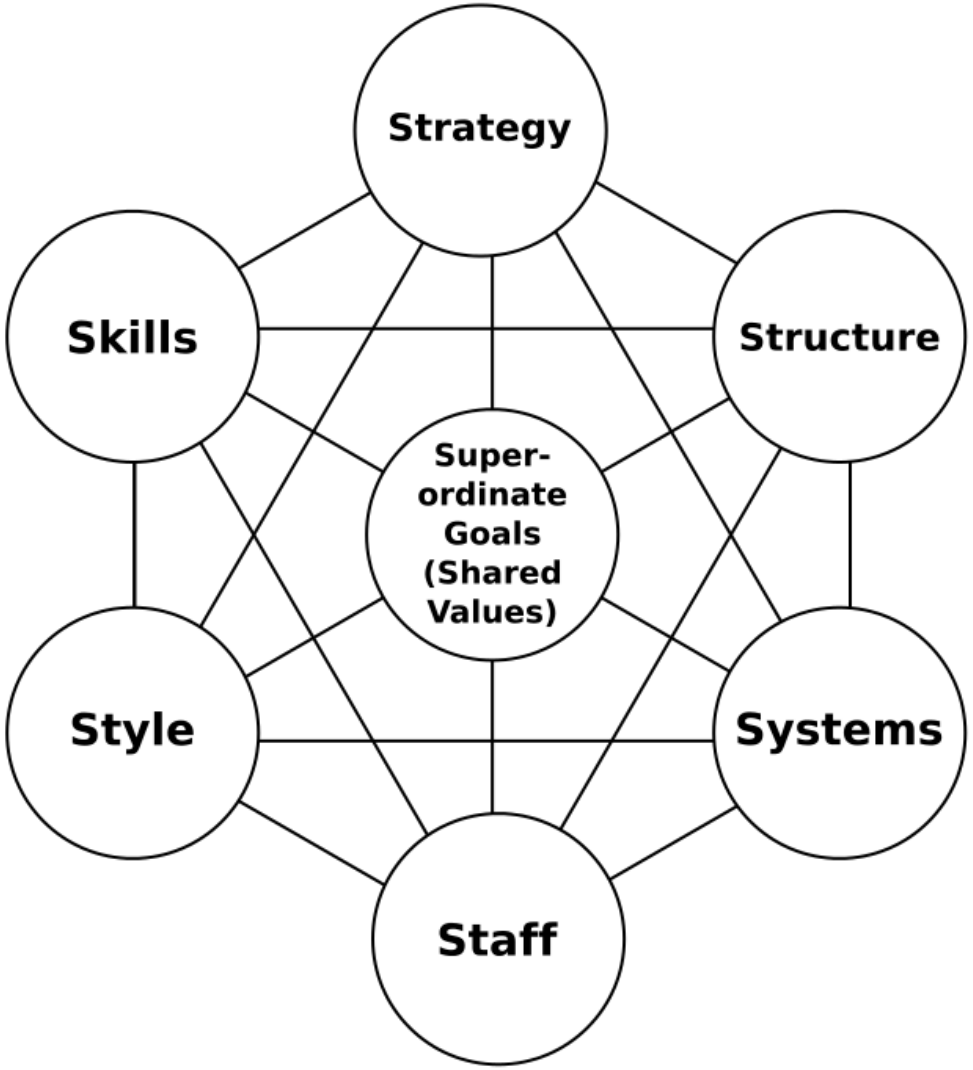

Success
Assess for Change
Prepare for Change
Plan for Change
Implement the Change
Sustaining the Change
Change Management

Lewin's Change Management Model

Unfreezing	Initiation
Change	Adoption
	Adaptation
Refreezing	Acceptance
	Use
	Incorporation

Time

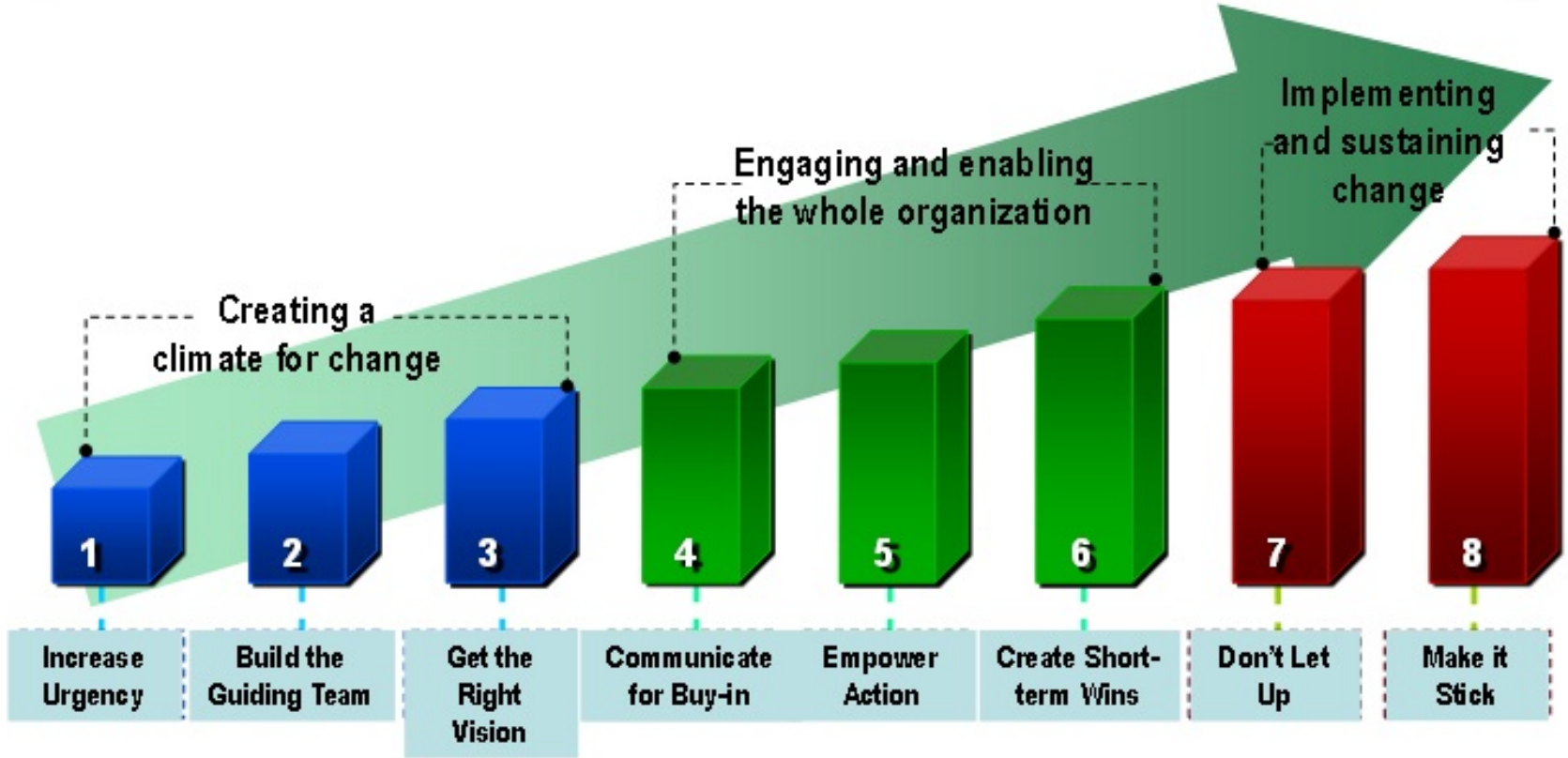
McKinsey 7-S Model



ADKAR Model of Change

www.expertprogrammanagement.com

"Kotters Eight Steps of Change"



[5] Kotter, John P. and Cohen, Dan S. The Heart of Change. Boston: Harvard Business School Press

Nudge Theory

Keep Momentum

Evidence to Show Best Option

Limit Obstacles

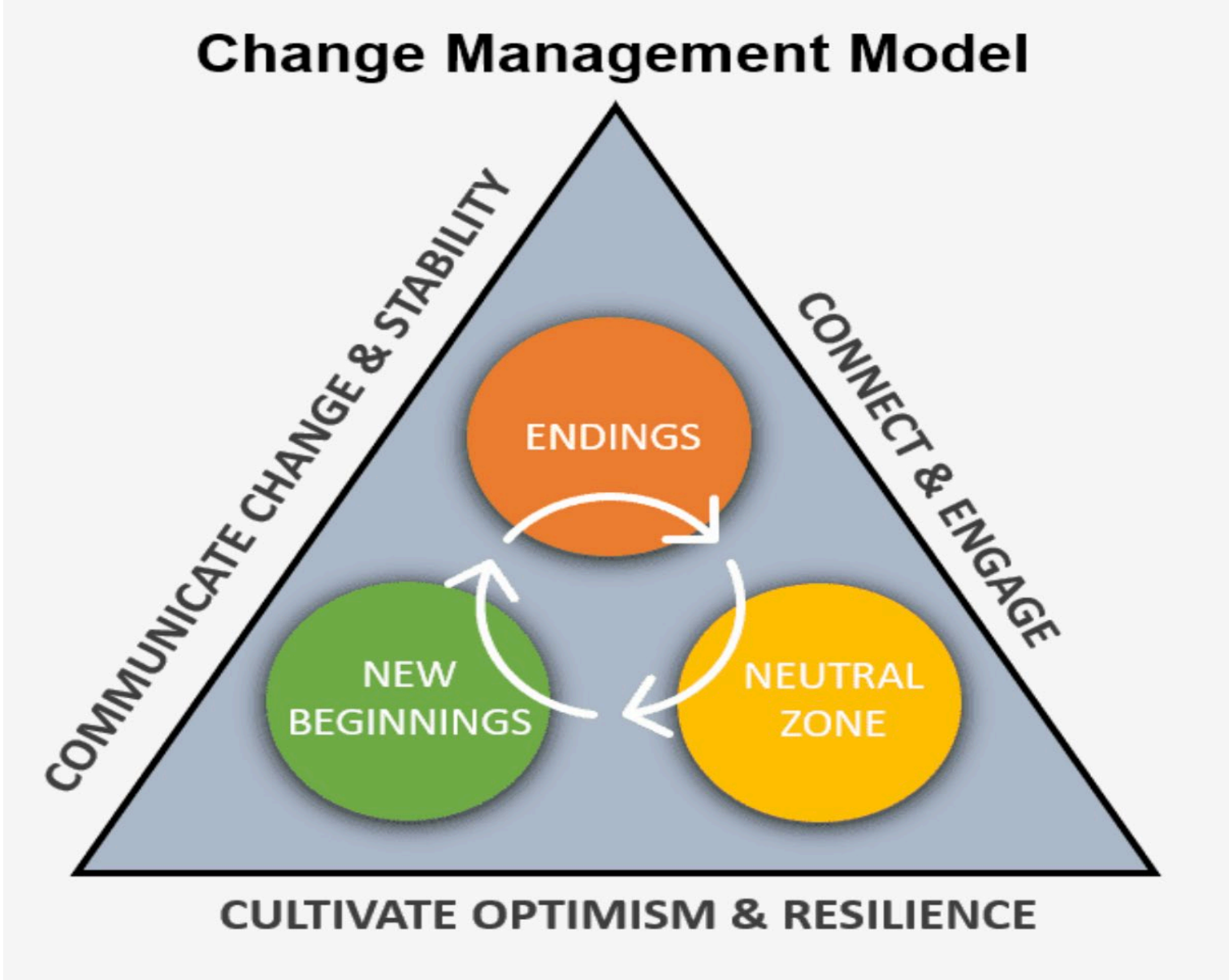
Consider Employee Point of View

Listen to Feedback

Clearly Define Changes

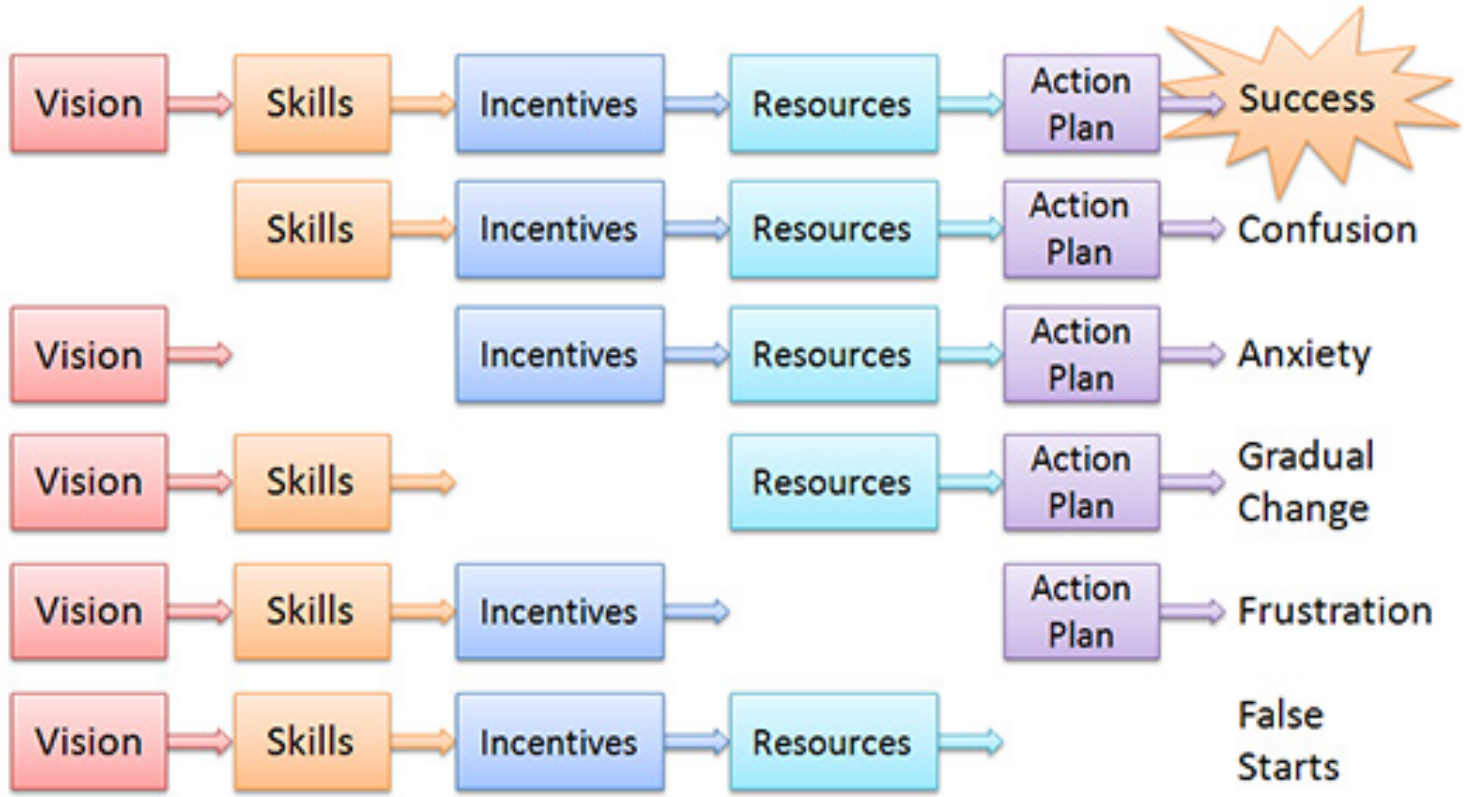
Present Change as Choice

Supplemental to Other Models

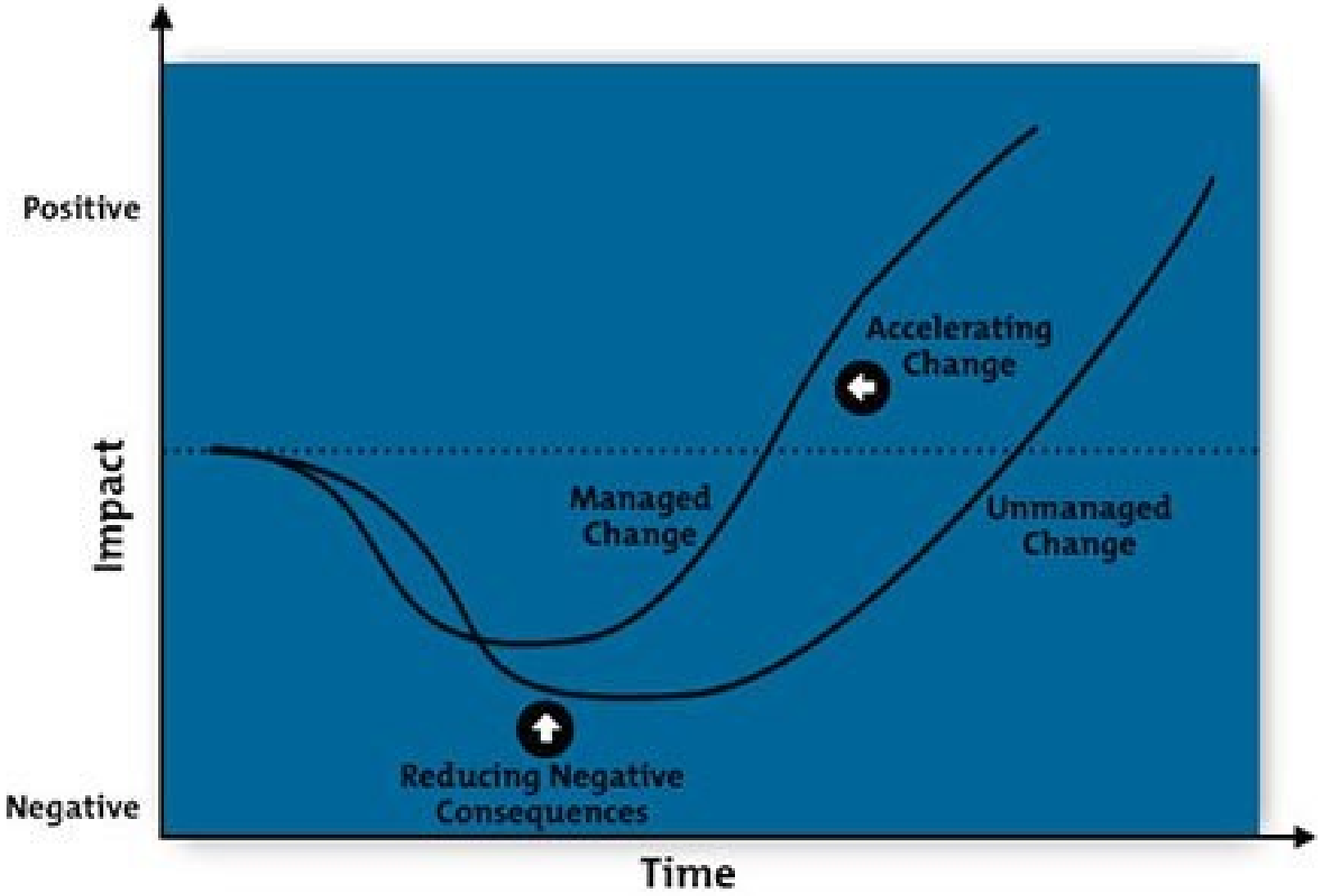


https://www.impactgrouphr.com/insights/change-management-best-practices-during-covid

THE ELEMENTS OF CHANGE



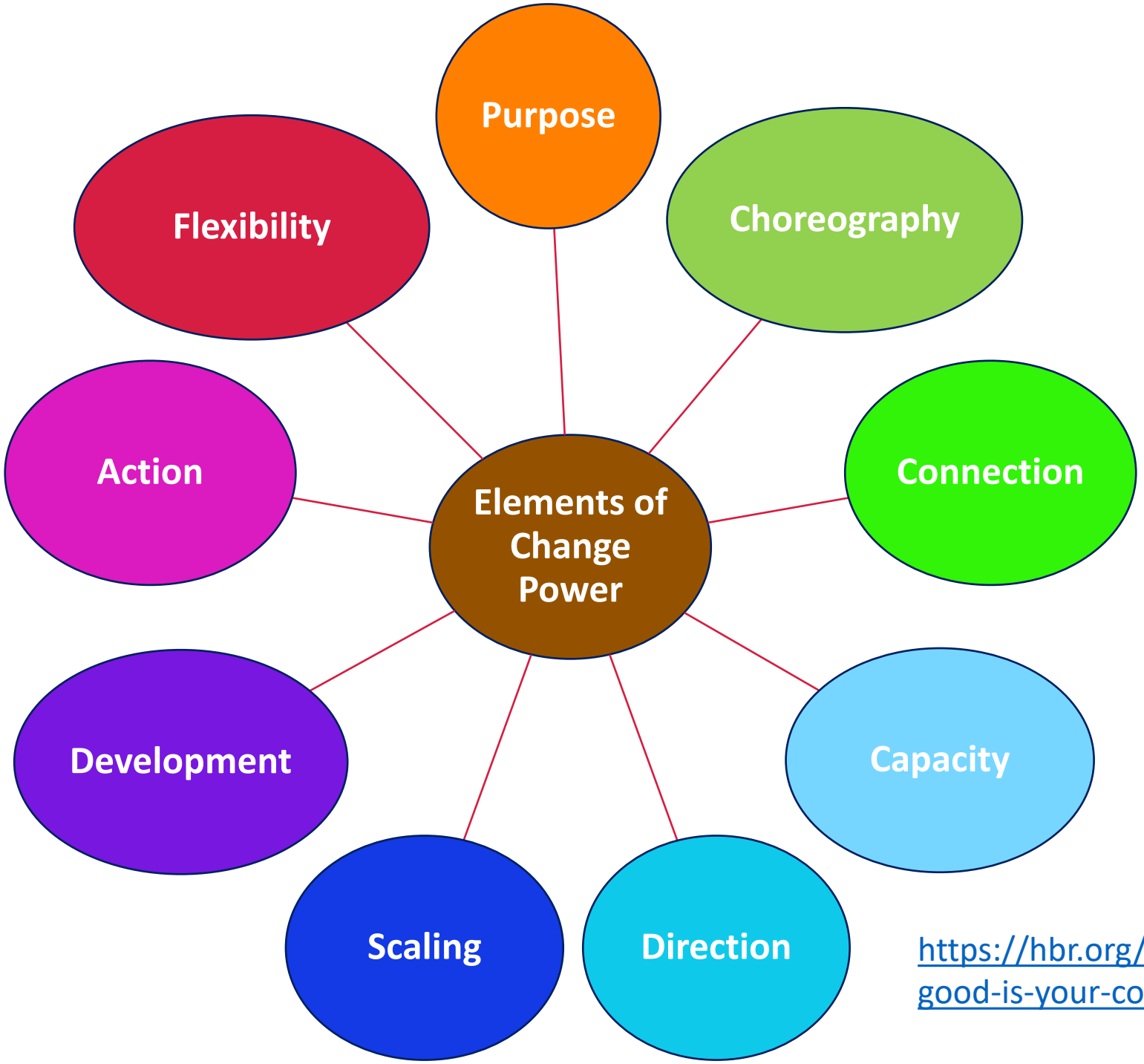
WELL-BEING



Mindtools.com

PROMOTING WELL-BEING

CHANGE MANAGEMENT

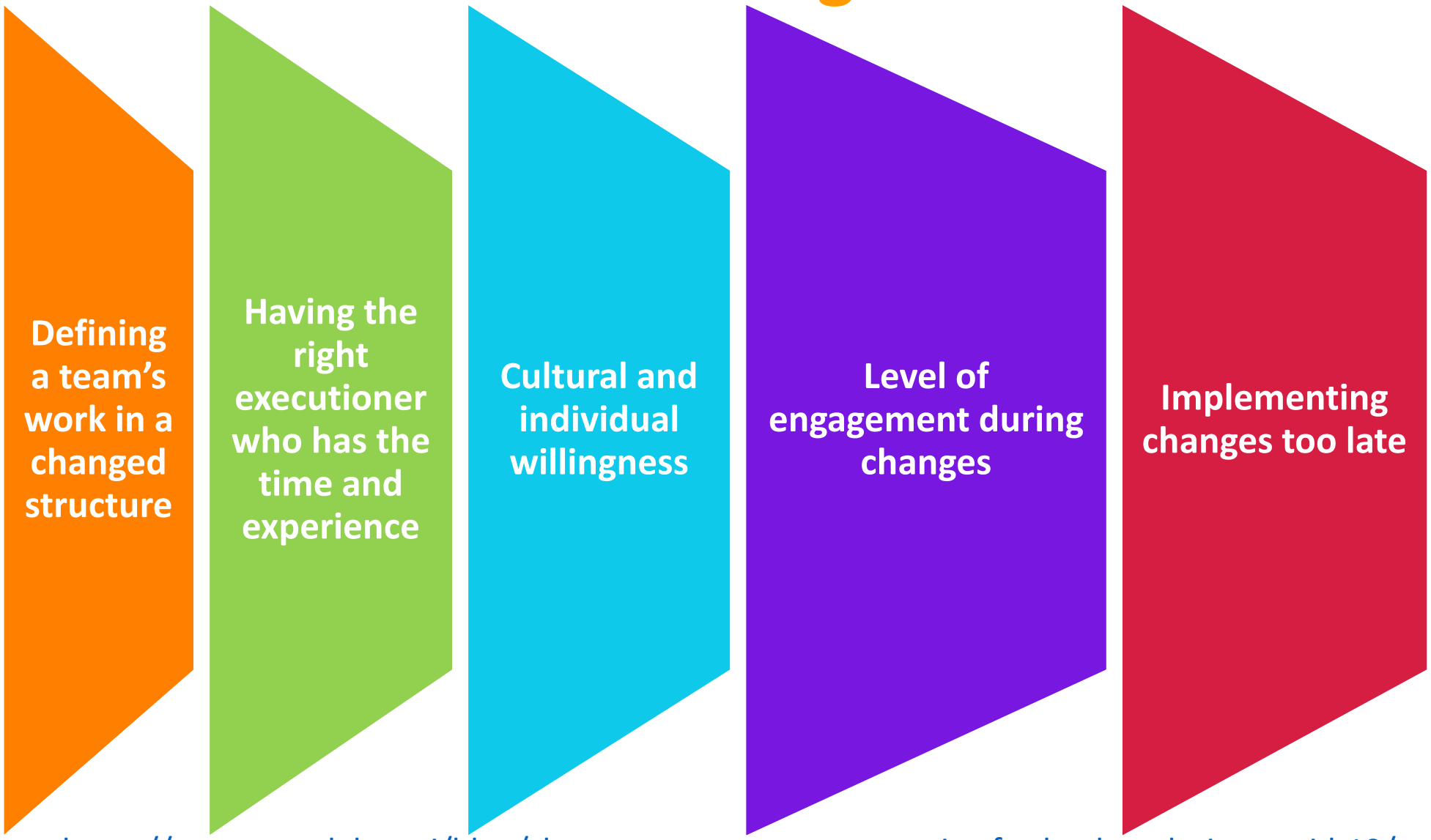


https://hbr.org/2021/07/how-good-is-your-company-at-change

Effective Change Management Strategies for Leaders During Covid-19

https://www.peoplebox.ai/blog/change-management-strategies-for-leaders-during-covid-19/

Top 5 Change Management Challenges Faced by Leaders During Covid-19

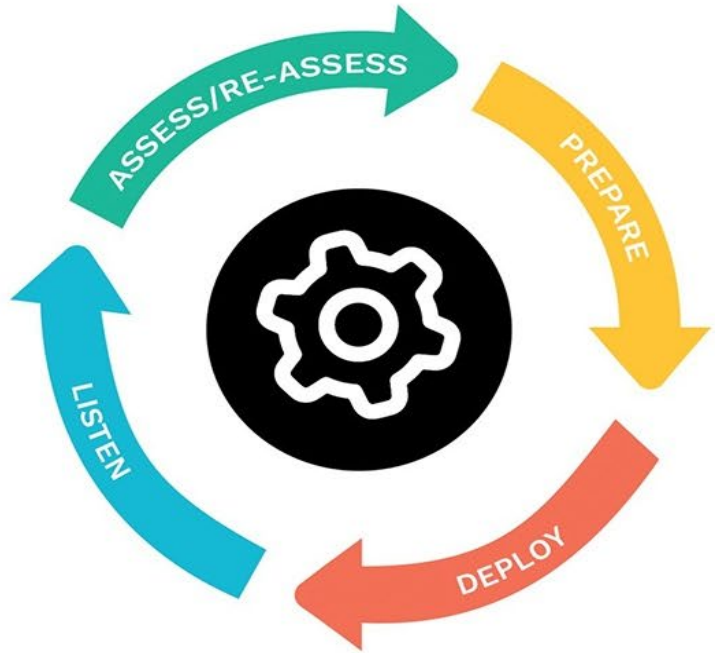


https://www.peoplebox.ai/blog/change-management-strategies-for-leaders-during-covid-19/

ASSESS
- Define future state
- Address readiness for change

RE-ASSESS
- Measure impact
- Evaluate results
- Adjust

LISTEN
- Solicit from all levels
- Respect all voices
- Celebrate successes
- Mitigate resistance



CONTINUOUS FEEDBACK LOOP

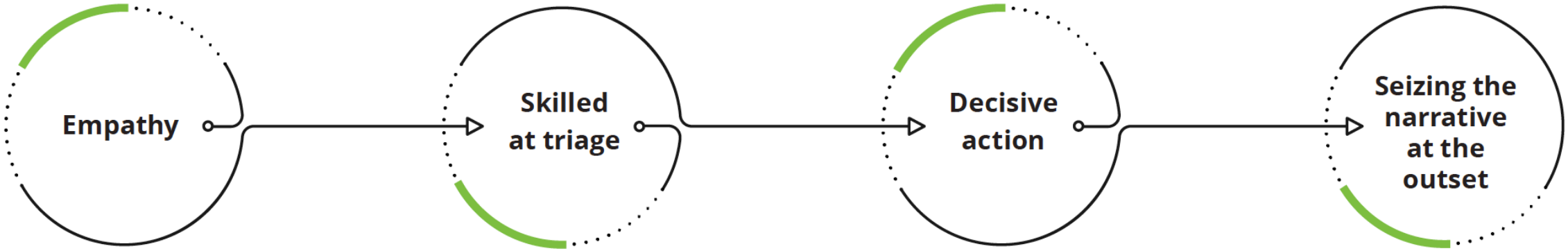
PREPARE
- Define success criteria
- Assemble cross-functional team
- Align stakeholders
- Develop tailored approach

DEPLOY
- Engage leaders, managers, champions
- Clear & consistent messaging
- Tools & technology
- Employee training
- Manager training

Agile Change Management

Engages with, and responds to, the individual at all levels of the organization

Resilient Leadership in Action



To be able to put themselves in the shoes of employees, customers, and their broader ecosystems and consistently connect and communicate with them.

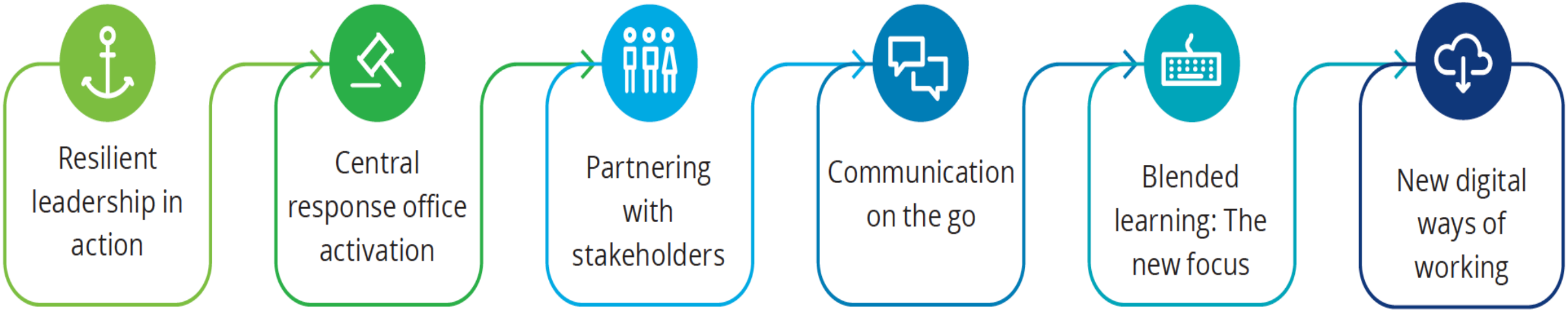
To be able to stabilise their organisations to meet the crisis at hand while also finding opportunities amidst constraints.

To be able to take decisions with courage based on imperfect information. Leaders need to take quick actions to ensure physical, emotional, and financial security for the workforce and communities.

To be transparent about current realities (including what they don't know) while also painting a compelling picture of the future that inspires others.

https://www2.deloitte.com/in/en/pages/human-capital/articles/in-hc-combating-covid-with-an-agile-change-management-approach.html

Change Management Approach to Navigate Through COVID-19



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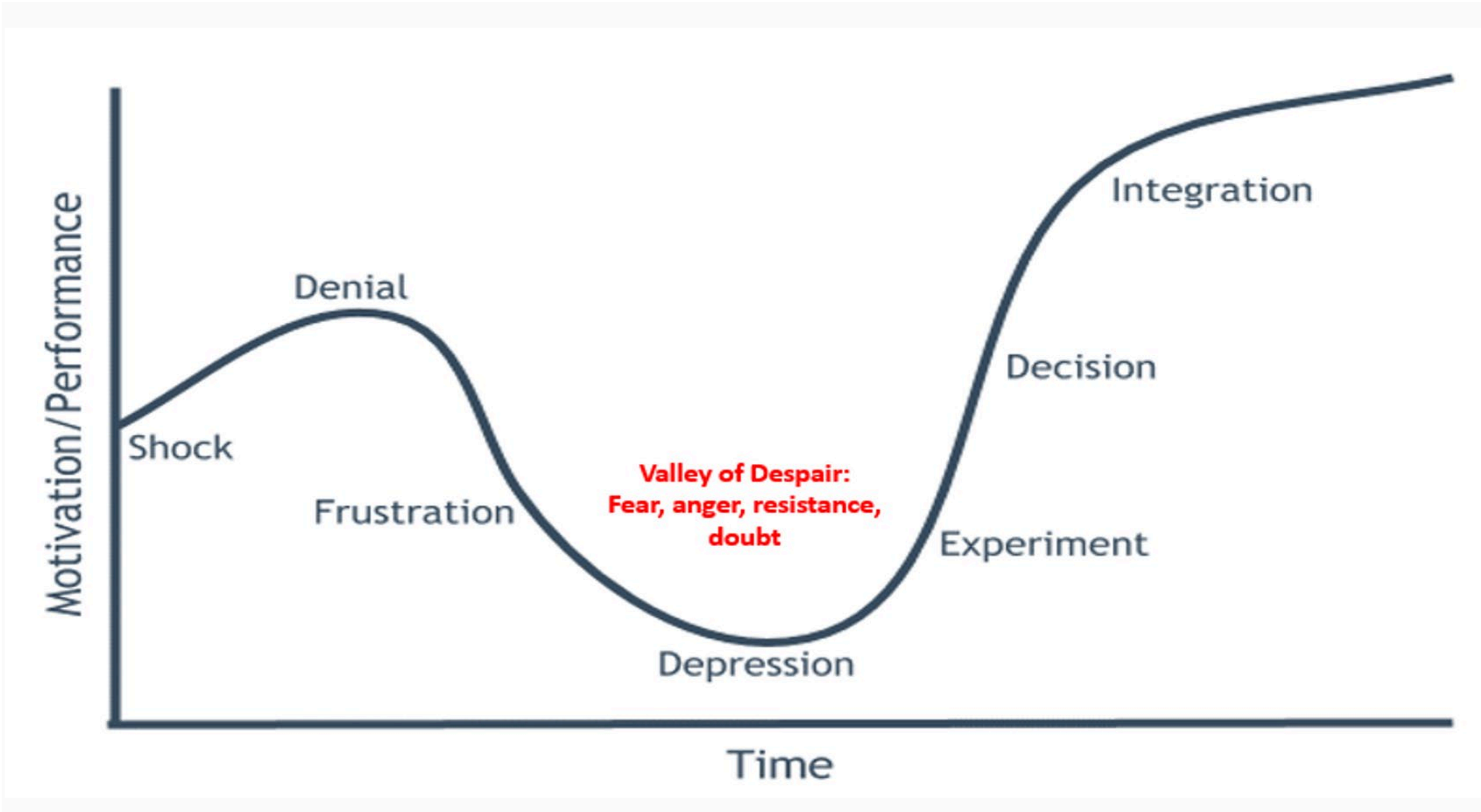
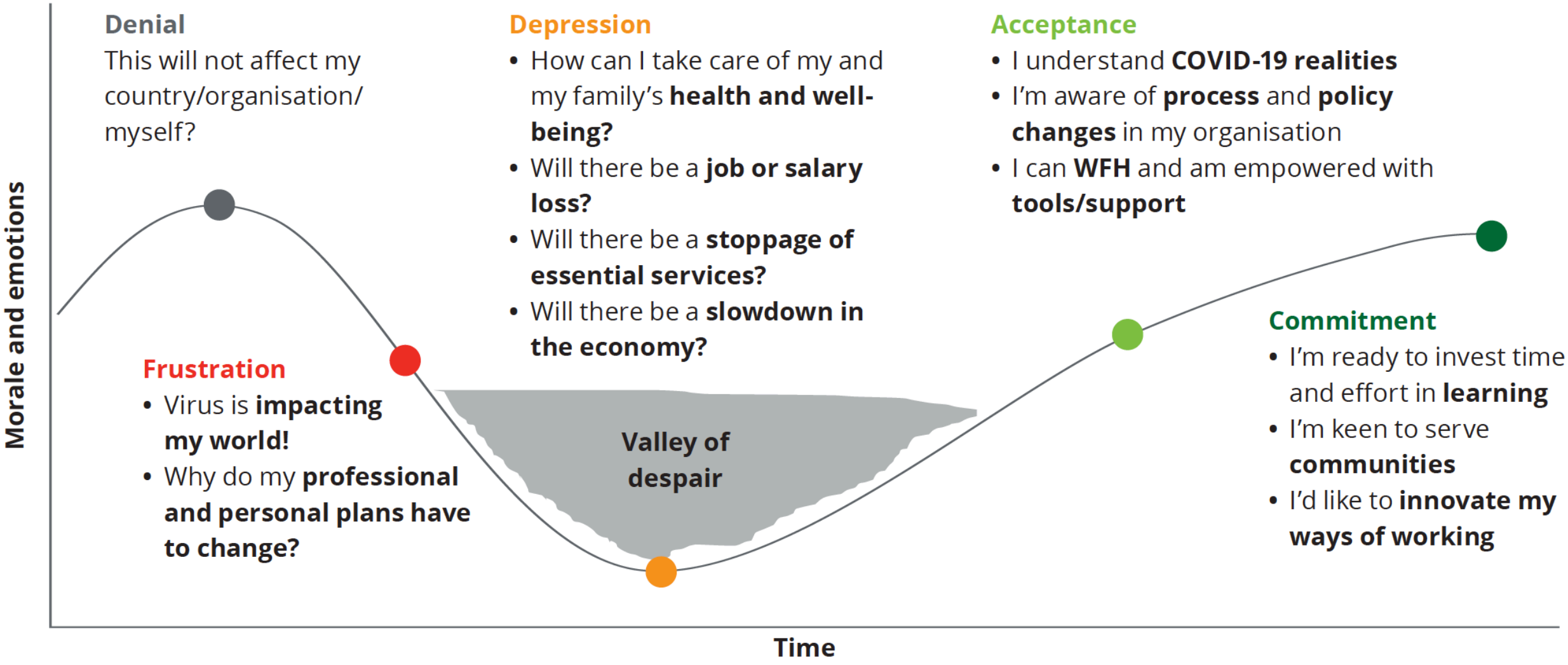


https://www.revgenpartners.com/insight-posts/change-management-in-times-of-crisis/

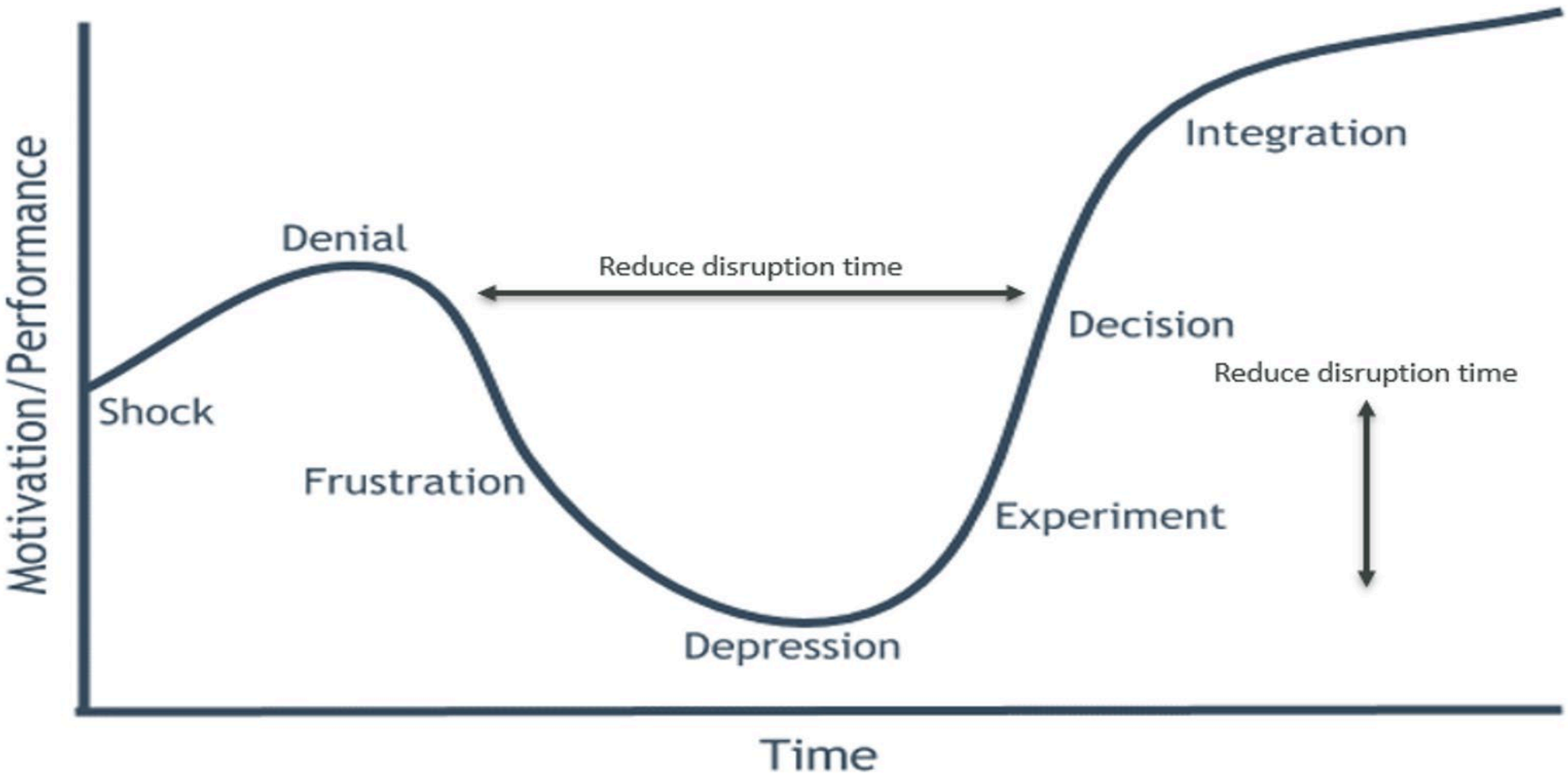
COVID-19 Change Curve



Note: Adapted from Kubler-Ross change curve

https://www2.deloitte.com/in/en/pages/human-capital/articles/in-hc-combating-covid-with-an-agile-change-management-approach.html

The goal of change management?



https://www.revgenpartners.com/insight-posts/change-management-in-times-of-crisis/

Use of the ADKAR® and CLARC ® Change Models to Navigate Staffing Model Changes During the COVID-19 Pandemic

Julie Balluck, MSN, RN, NEA-BC, Elizabeth Asturi, MSN, RN, NE-BC, and Vicki Brockman, DNP, RN, NE-BC, NEA-BC

Balluck J, Asturi E, Brockman V. Use of the ADKAR® and CLARC ® Change Models to Navigate Staffing Model Changes During the COVID-19 Pandemic. *Nurse Lead*. 2020;18(6):539-546. doi:10.1016/j.mnl.2020.08.006

Table 1. ADKAR Change Management at Texas Health Resources

	Questions to Ask Yourself	Action Steps to Take	Without ADKAR You Will See…	With ADKAR You Will Hear…
A *Awareness*	What is the nature of the change? Why is the change needed? What is the risk of not changing?	Draft effective and targeted communications Share the why and the vision Provide ready access information	More resistance from employees Lower productivity	I understand why…
D *Desire*	What's in it for me (WIIFM)? How is this a personal choice Will I decide to engage and participate?	Demonstrate your commitment Advocate for change Engage influencers to foster employee participation and involvement	Higher turnover Delays in implementation	I have decided to…
K *Knowledge*	Do I understand how to change? Where can I be trained on new processes & tools? How do I best learn new skills?	Provide effective training with the proper context Facilitate education for, during, and after the change Create job aides and real-life applications	Lower utilization or incorrect usage of new processes and tools Greater impact on customers and partners	I know how to…
A *Ability*	Am I demonstrating the capability to implement the change? Am I able to achieve the desired change in performance or behavior?	Facilitate coaching by managers, supervisors, and subject matter experts Offer hands-on exercises, practice and time Eliminate any potential barriers	Sustained reduction in productivity	I am able to…
R *Reinforcement*	What actions can I take to increase the likelihood that this change will continue?	Celebrate successes individually and as a group Reward and recognize early adopters Give feedback on performance and accountability	Employees will revert to old ways of doing work The organization creates a history of poorly managed change	I will continue to…

Leading Change to Address the Needs and Well-Being of Trainees During the COVID-19 Pandemic

Pnina G. Weiss, MD; Su-Ting T. Li, MD, MPH

From the Department of Pediatrics, Yale, Yale School of Medicine (PG Weiss), New Haven, Conn; and Department of Pediatrics, University of California Davis (S-TT Li), Sacramento, Calif
The authors have no conflicts of interest to disclose.
Address correspondence to Su-Ting T. Li, MD, MPH, Department of Pediatrics, University of California Davis, 2516 Stockton Blvd, Sacramento, CA 95817 (e-mail: sutli@ucdavis.edu).
Received for publication May 8, 2020; accepted June 1, 2020.

Weiss PG, Li ST. Leading Change to Address the Needs and Well-Being of Trainees During the COVID-19 Pandemic. *Acad Pediatr*. 2020;20(6):735-741. doi:10.1016/j.acap.2020.06.001

Table 2. Examples of How to Lead Educational Change During the COVID-19 Pandemic Using Kotter's 8 Steps to Leading Change Framework

Kotter's 8 Steps to Leading Change	Examples of Leading Change During the COVID-19 Pandemic
1. Establish a sense of urgency - SWOT analysis (strengths, weaknesses, opportunities, threats)	COVID-19 pandemic disrupts in-person direct patient care and education Trainee duration of training remains unchanged Public continues to expect graduation of competent physicians Strengths – Dedicated faculty interested in education, clinical care, and trainee wellness Weaknesses – Lack of telemedicine and tele-education Opportunities – Leverage telemedicine and tele-education to improve education for trainees Threats – Mandated physical distancing; ACGME and ABP requirements
2. Form a powerful guiding coalition - Include pertinent stakeholders - Emphasize teamwork	Program leadership (program director, associate program directors, coordinators, chief residents) Chair, Designated Institutional Official Faculty Trainees
3. Create a vision - Vision to direct change effort - Strategies to achieve vision	Keep trainees safe Deliver excellent patient care Educate our next generation of pediatricians Strategies: Leverage telemedicine and tele-education to deliver excellent patient care and educate our trainees while minimizing infection risk
4. Communicate the vision - How will you communicate vision and strategies?	Communicate frequently and regularly Use multiple communication modalities (email, teleconference, texts, postings, etc.) Create on-line repository of most up-to-date information Acknowledge plans evolve Be transparent about reasons behind changes

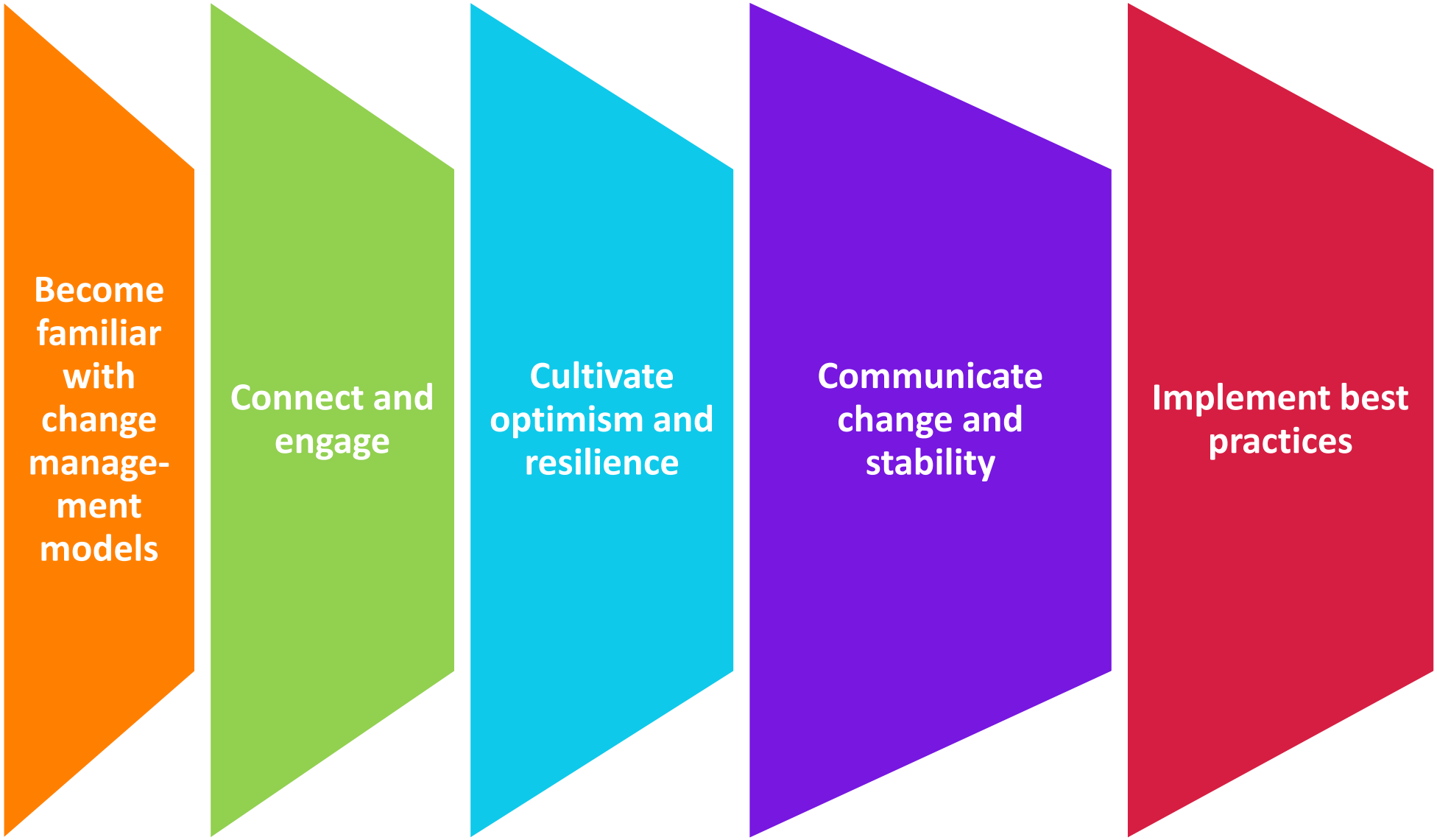
Table 2. Examples of How to Lead Educational Change During the COVID-19 Pandemic Using Kotter's 8 Steps to Leading Change Framework

Kotter's 8 Steps to Leading Change	Examples of Leading Change During the COVID-19 Pandemic
5. Empower others to act on the vision - Identify/get rid of obstacles to change - Change systems/structures that undermine vision - Encourage risk taking - Use guiding coalition as role models	Empower faculty and trainees to engage in interactive distance learning modalities and telemedicine Provide faculty development in best practices for telemedicine and tele-education Install teleconferencing software, microphones and video cameras on existing computers Encourage members of guiding coalition to experiment with tele-education
6. Plan for and create short-term wins - Plan for visible performance improvements - Create those improvements - Recognize/reward others involved in those improvements	Front-load didactic schedule with faculty willing to experiment with novel tele-education modalities Work closely with faculty to implement interactive remote teaching Recognize faculty who effectively utilize novel ways to engage learners with tele-education
7. Consolidate improvement and produce still more change - Build on momentum to change systems, structures, and policies that don't fit vision	Share best practices of how faculty engage with learners remotely Advocate for changes in your local institution Advocate within APPD, COPS, and COMSEP for flexibility for programs/trainees to meet ACGME, ABP, LCME requirements
8. Institutionalize new approaches - Make it a habit by articulating the relationship between the new behaviors and success - Plan for succession by developing new leaders	Provide feedback to faculty about learner response to changes Develop faculty champions

APPD indicates Association of Pediatric Program Directors; COPS, Council of Pediatric Subspecialties; COMSEP, Council on Medical Student Education in Pediatrics; ACGME, Accreditation Council for Graduate Medical Education; ABP, American Board of Pediatrics; and LCME, Liaison Committee on Medical Education.

CASE SCENARIOS

SUMMARY


Become familiar with change manage-ment models
Connect and engage
Cultivate optimism and resilience
Communicate change and stability
Implement best practices

Saadia.Akhtar@mountsinai.org

Maria.Moreira@dhha.org

ACPH 2021

American Conference on Physician Health™

AMA AMERICAN MEDICAL ASSOCIATION

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Disclosures

We have no disclosures to report.

The Role of the CWO in the COVID-19 Pandemic: Lessons Learned to Promote Post-Traumatic Growth

Chantal Brazeau, MD

Kirk Brower, MD

Kristine Olson, MD

Steven B. Bird, MD

Jennifer Berliner, MD

American Conference on Physician Health

ACPH 2021

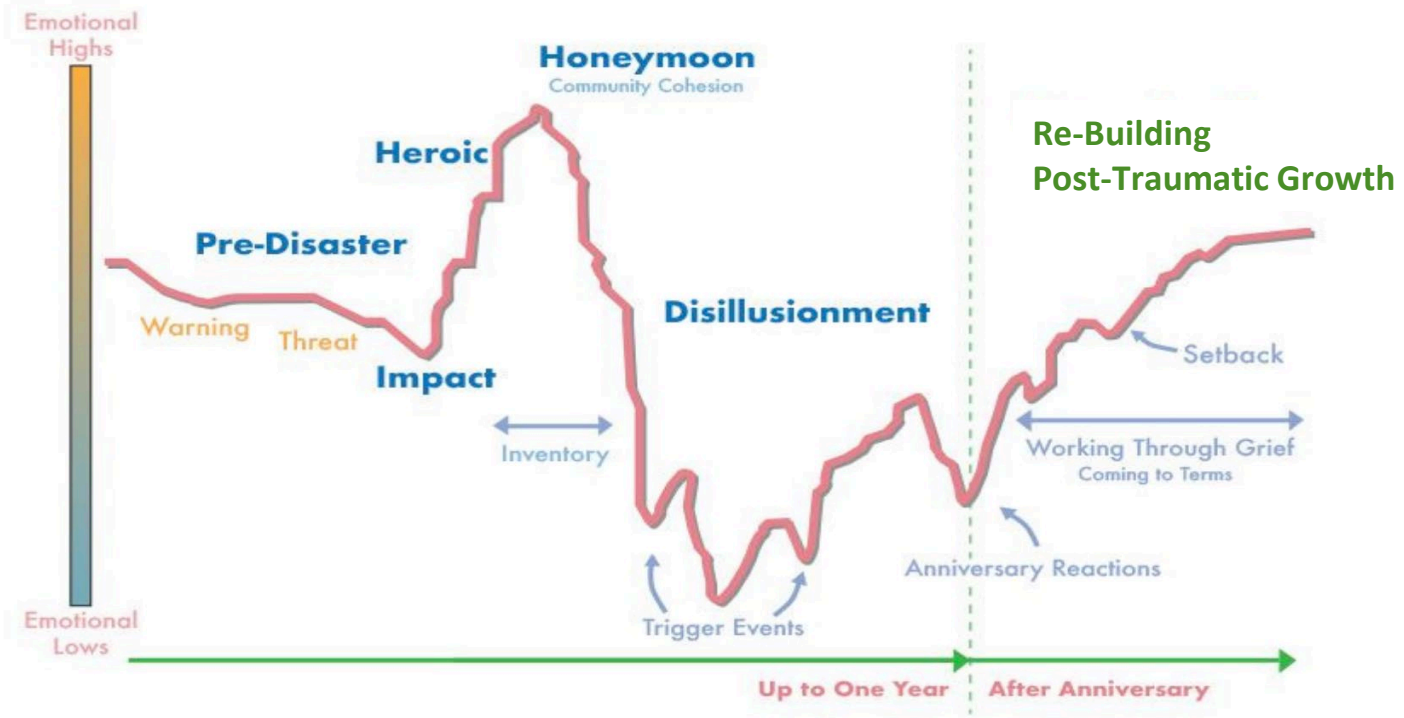
Learning Objectives

- Describe different stages of the pandemic and common challenges faced by health care organizations (HCOs)
- Describe the five domains of post-traumatic growth
- Describe how lessons learned from addressing these challenges represent opportunities for post-traumatic growth at their own HCOs

Timeline

- Introductions; domains of post-traumatic growth; our struggles and lessons learned *15 min*
- Post-traumatic growth domains small group exercise *15 min*
- Report out of each table; think about a high yield opportunity at your organization *20 min*
- Share one opportunity for growth for your organization that you will pursue/advocate for *5 min*
- Final reflections and key discussion points *5 min*

Community Phases of Disaster Response



Adapted from Zunin & Myers as cited in DeWolfe, D. J., 2000. Training manual for mental health and human service workers in major disasters **(2nd ed., HHS Publication No. ADM 90-538). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.**

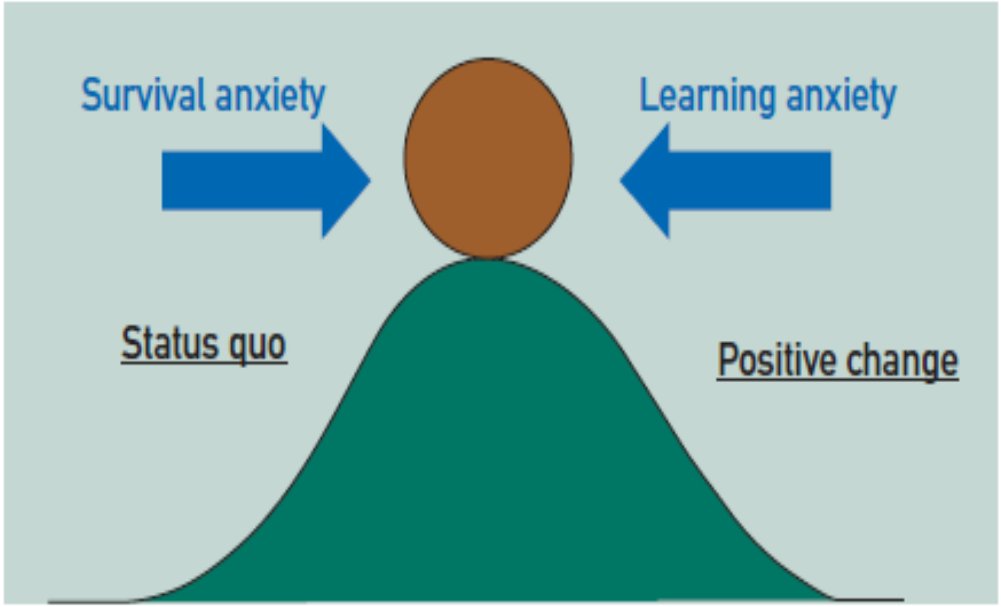
COVID-19

Brought attention to well-being

Can promote change and…

re-evaluation of missions and core values

Sustained Stress
disrupts status quo



New Initiatives
can pave the way

Healing the Culture of Medicine Shanafelt et al Mayo Clinic Proc. 2019;94 (8); 1556-1566

Post-traumatic Growth

"A positive psychological change experienced as a result of a struggle with highly challenging life circumstances"

How can we encourage the path to growth?

Olson et al. JAMA 2020;324 (18):1829-1830
Art: National Academy of Medicine: Expressions of Clinician Well-Being

5 Domains of PTG

Improved relationships: How can we engage in deeper discussions to facilitate trust and support of well-being?

Openness to new possibilities: Can adverse consequences and opportunities inspire growth and innovation?

Greater sense of strength: How can we emerge stronger from changes that were needed?

Stronger sense of humanity: Can this experience foster humanity, connections, community; transcends; larger than one institution

Gratitude: What is truly important? How can we express authentic gratitude?

Adapted from Olson et al, 2020;324(18):1829–1830

	Our struggles	Lessons Learned	Effect	PTG
Rutgers Biomedical and Health Sciences	Silos of well-being resources	Need organized approach to collate and disseminate	Networking/ connections/ discussions about well-being	Improved, deeper relationships
Michigan Medicine	People coming in sick/ not taking care of ourselves	Need for work/home flexibility	Survey to understand why people come to work when they should not	Openness to new possibilities/growth
UPMC	Clear and regular communications Need for stronger partnerships to address staff support needs	Brought attention to staff needs	Discussions about staff support	Greater sense of strength
Yale Medicine	Initial fear/uncertainty	People stepped forward with talents	Discoveries that helped the world	Stronger sense of humanity/larger than one institution
U. Mass Memorial Health	Not feeling appreciated (from Heroes to Zeros)	Make it easy to give public recognition	Increased appreciation felt	Gratitude/what is important

Small group exercise

- **Improved (deeper) relationships:** How can leaders and health professionals engage in honest, transparent, and two-way communication to facilitate support and mutual trust post-pandemic?
- **Openness to new possibilities:** Consider both adverse consequences and opportunities to assess the pandemic's impact; how can they inspire innovation, improvement, and growth?
- **Greater sense of strength:** How can HCOs emerge stronger from changes and responses that were necessary during the pandemic?
- **Stronger sense of humanity:** What is most important within the organization? How can this experience help develop connections with others, create community, foster altruistic solutions and values within and outside the organization? (Transcendent value- a purpose larger than self)
- **Gratitude:** For what is the organization grateful as a result of the pandemic? Does it show authentic appreciation to its workforce? What are reasons to be optimistic?

Small group exercise

Report out!

Share Opportunities for Growth to Pursue
Advocate for

Final Reflections

- Start with the struggle and move to the path forward
- Don’t force growth - move through grief
- Genuine gratitude is powerful
- Be compassionate toward yourself and colleagues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Results and Resources for
Addressing the Challenges of Women Physicians: The Organizational Approach

Diane Sliwka, MD

Chief Physician Experience Officer, UCSF Health

Professor of Medicine, Division of Hospital Medicine, UCSF

Diane W. Shannon, MD, MPH, ACC

Physician Coach and Author

Shannon Coaching for Life

Challenges Observed by Workshop Participants

- More childcare, eldercare, and domestic tasks
- Ideas not respected as much as male colleagues
- Not recognized for informal, unpaid leadership
- Different communication styles are not heard/appreciated as much
- “Complaints” are viewed differently (whining rather than strategic thinking)
- No or few women in C-suite/decision-making positions
- Paternalism—assuming women won’t be able to fulfill a position due to domestic tasks and therefore not offering opportunities
- Structural inequities: what roles/tasks are valued (more valued roles tend to be filled by men)

Ideas for Initiatives: PICK Chart Results

Differentiates initiatives by low to high impact/payoff and by low to high difficulty of implementation

High Impact/ Low difficulty

- Schedule a dinner with leaders to talk about gender equity
- Create listening groups
- Develop a leadership program for women that also advances diversity (easy only if you have diverse leaders to guide and support the program)

High Impact/Medium Difficulty

- Taking steps to look at and advance DEI also
- Develop a peer support/mentorship program (especially important for trainees)
- Take steps to support community building

High Impact/High Difficulty

- Develop a transition-back-to-work program with a designated navigator
- Change time templates to reflect care complexity (women physicians tend to care for patients with more complex conditions, to talk about psychosocial concerns, and to spend longer per patient)
- Culture change—especially around who we grow as leaders

Results from Poll on Action Steps

Write down one idea you'd like to bring back to your organization and the first action step you will take:

- Get a list of new faculty and onboard re wellness resources at our institution
- Lead with compassion by asking the leaders to a lunch forum to discuss ways to have more women on the podium at grand rounds Then set this lunch meeting to be quarterly
- Finalize the New Parent Resource Guide - Action Item: regroup our team to complete intranet/resource build
- Take the first step in making a new contact to expand my network of collaborators in my organization
- Women's Book or Dinner Club to build community
- Equlity#Equity. Print the slide and use it in meetings
- Give physicians (female or male) who take care of Irritable Bowel Patients (IBS) more time or wRVU credit per patient because the IBS patients tend to prefer female physicians and yet these patients take longer and are more complicating and challenging.
- Invite male executive and clinical leaders to our 50 Ways to Fight Bias workshops
- Plan to bring a discussion into Executive leadership and board (mostly men) to get their involvement but to clarify that we need strategies surrounding Womens leadership qualities, not to look like men
- Research HR policies/ procedures in other institutions—how are they handling micro aggressions/ sexual harassment? Has anyone figured out a way that works?
- Start allyship group
- Optimizing daily physician workflows during schedule transitions such as medical leave, personal leave, sabbatical leave or general PTO
- Also 12 weeks parental leave. If UCSF a sister organization can do it there is no reason UCSD cannot!
- Ask my coaching clients (as appropriate to the coaching): how has gender affected your career? Female and male, both.
- Sending out a best practices sheet of recruiting women in residencies : will send an email to DIO to encourage this with an attached tip sheet as a first draft.
- By next Tuesday, I will check our HR dashboard and display the ratio of female/male supervisors by department compared to their ratio of female/male staff at our next hospital meeting.
- In conjunction with office of faculty affairs, create mid-career women’s leadership program. Must make it easy for them to participate (dedicated clinical time off to attend).
- Emergency childcare contract for employees Will discuss with my chief
- Gather together the key stakeholders to explore Lactation RVUs by Dec 20, 2021.
- Partner with EID leaders to explore a women’s mentorship program.
- Idea: adjust standard appointment time for women physicians who get a larger number of difficult patients. First step: bring the idea to our all-male leadership. 😔
- At Wellness Taskforce meeting advocate for the lactation RVU program. Several departments offer something similar at UCSD but it is not a universal program. The fact that UCSF has this in place will be a compelling argument for leadership.
- Get my relationship based leadership course on my website with CME.

- Incorporate mentorship program into our peer support program- discuss with quality officer
- Create session on issues facing female physicians & being an ally for resident/fellow professional development series.
- We have already done much work on evaluating the lactation policy at our organization. We need to take it across the finish line and continue to advocate at high levels. I will email and set up meetings to continue to advocate
- Create a platform for women physicians
- Contact my friend in DEI to see who is the lead for gender equity work so I can collaborate with them and bring them these ideas from the conference.
- Policy navigator - see if there is someone existing like this in our organization. Consider what it would take to make this feasible.
- Create female physician leadership curriculum
- The lactation and RVU idea
- Advocate for 12 weeks parental leave

UCSF Resources

- Women and UIM* Leadership Data Stories Link
- Lactation Support Program
  - UCSF Newsletter post Link
  - KevinMD blog post Link
- WISE Women Learning Groups Link
- Child Bearing and Child Rearing Leave Policy Resources Link
- Best Practices for Gender Inclusiveness Link

*Underrepresented in Medicine

Other Resources

- Innovations: Getting Rid of Stupid Stuff
  - Ashton M. Getting Rid of Stupid Stuff. N Engl J Med. 2018 Nov 8;379(19):1789-1791. Link
  - Video from Annals of Internal Medicine. Link
- Leadership Engagement: Immersion Day at Mission Health Link
- Cohort Coaching: Novant Leadership Development program Link
- AMA Steps Forward module: Creating the Organizational Foundation for Joy in Medicine™ Link
- White paper discussed in session: *The Challenges Women Physicians Face: What's Needed to Shift from Striving to Thriving.* To request a copy, email diane@dianeshannon.com

Our Contact Information

Diane.Sliwka@ucsf.edu

Diane@dianeshannon.com

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GETTING OFF THE STRUGGLE BUS: Creating an Exceptional Faculty Experience For Academic Physicians

PRESENTERS

Heather R. Walker
Social Scientist
University of Utah Health, Medical Group Analytics
Twitter: @Heather_RoseW

Kim Clark
Director, Education & Faculty Development at University of Utah Health

Wendy Hobson-Rohrer, MD
Associate Vice President for Health Science Education at University of Utah Health

Agenda

- Introduction to the Exceptional Faculty Experience (EFE) Project
- Six Degrees of Separation Activity (pairs)
- Results from the EFE Project
  - Expert tips
- Struggle Bus Group Activity
- Wrap up and Q & A

Exceptional Faculty Experience Project

BACKGROUND

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BACKGROUND

- Borrowed from Exceptional Patient Experience framework (Parchman et al, 2017; Perriera et al, 2019)
- Faculty retention is key
- Current research framed in past or present

Parchman ML, Henrikson NB, Blasi PR, et al. Taking action on overuse: Creating the culture for change. *Healthcare*. 2017;5(4):199-203. doi:10.1016/j.hjdsi.2016.10.005
Perreira TA, Perrier L, Prokopy M, Neves-Mera L, Persaud DD. Physician engagement: A concept analysis. *J Healthc Leadersh*. 2019;11:101-113. doi:10.2147/JHL.S214765

WHAT HAPPENS WHEN WE LOOK FORWARD INTO AN IDEAL FUTURE?

PURPOSE

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GOALS

We had two objectives:

1) to unpack the future-based ideal conditions that would lead to an exceptional faculty experience for our faculty; and
2) to build a theoretical model of what that exceptional faculty experience would look like.

RESEARCH QUESTIONS

Two research questions guided this work:

1. What are the dominant elements identified by faculty as pillars of an exceptional faculty experience?
2. What can be done to increase excellence within faculty experience?

METHODOLOGY

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DESIGN & METHODS

- Exploratory mixed-methods
- SenseMaker® Technology
- Iterative item development over 13 months
- Data analysis
  - Quantitative = simple statistical analysis
  - Qualitative = inductive thematic analysis

PAUSE FOR AN ACTIVITY

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ACTIVITY

Step 1: Quick write independently

Create a list of 5 things that would make your experience as an academic physician truly exceptional experience/workplace

ACTIVITY

Step 1: Quick write independently

Create a list of 5 things that would make your experience as an academic physician truly exceptional experience/workplace

Step 2: Share your list with the person sitting next to you

ACTIVITY

Step 1: Quick write independently

Create a list of 5 things that would make your experience as an academic physician truly exceptional experience/workplace

Step 2: Share your list with the person sitting next to you

Step 3: Write the overlapping things between your lists on post-it notes (1 thing per sticky)

RESULTS FROM THE EXCEPTIONAL FACULTY EXPERIENCE PROJECT

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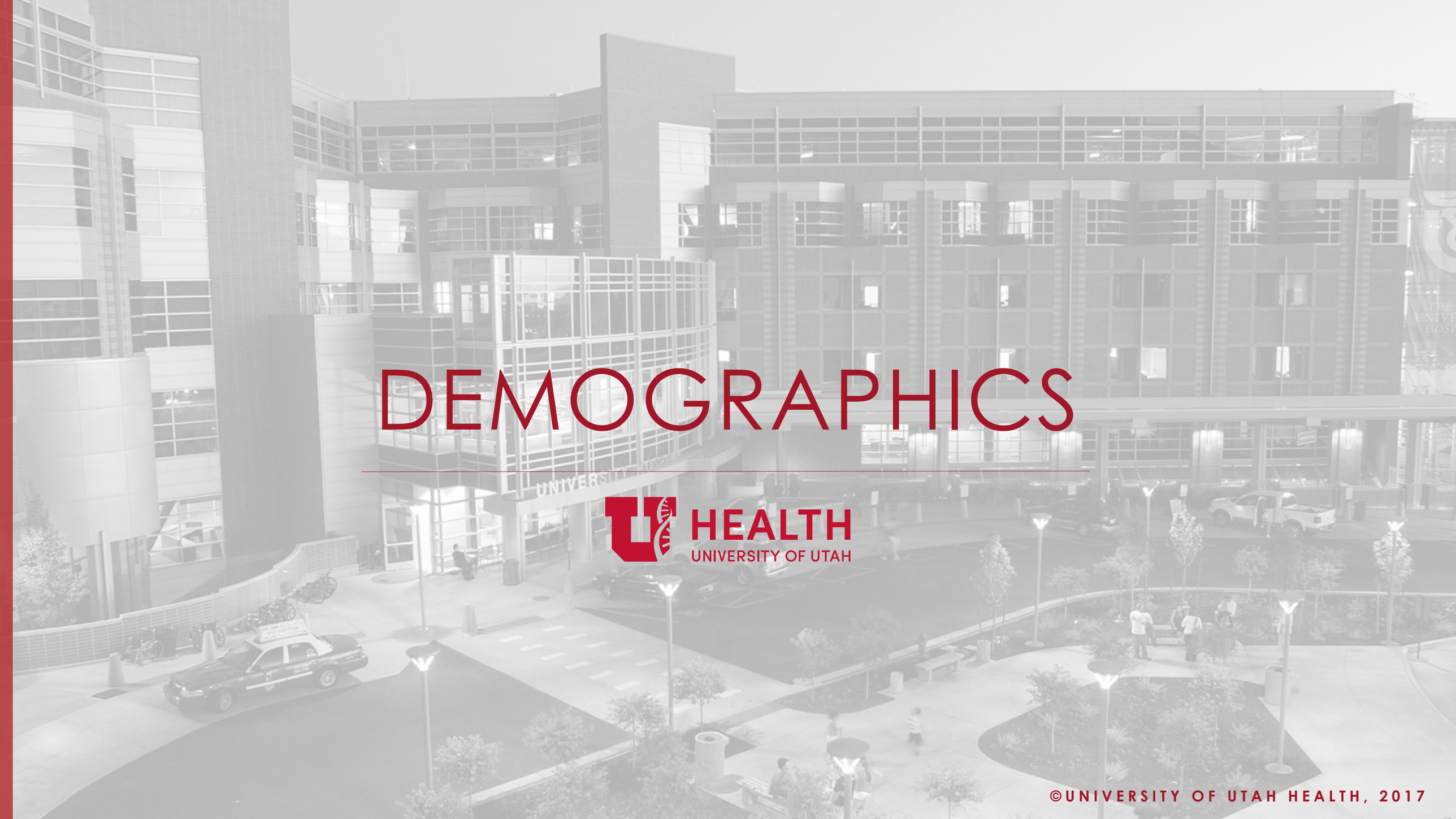

DEMOGRAPHICS

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EMERGENT THEMES

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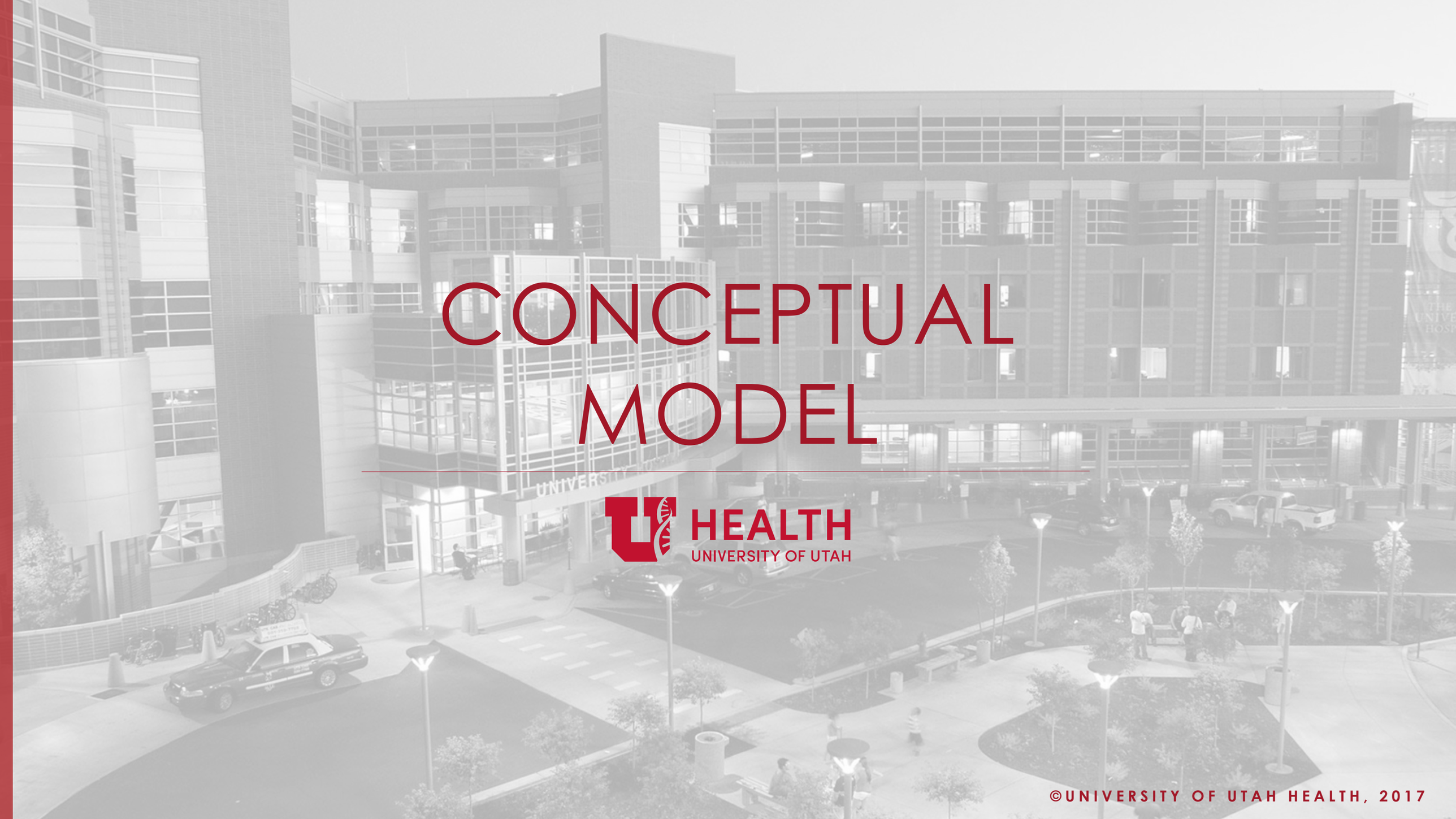

CONCEPTUAL MODEL

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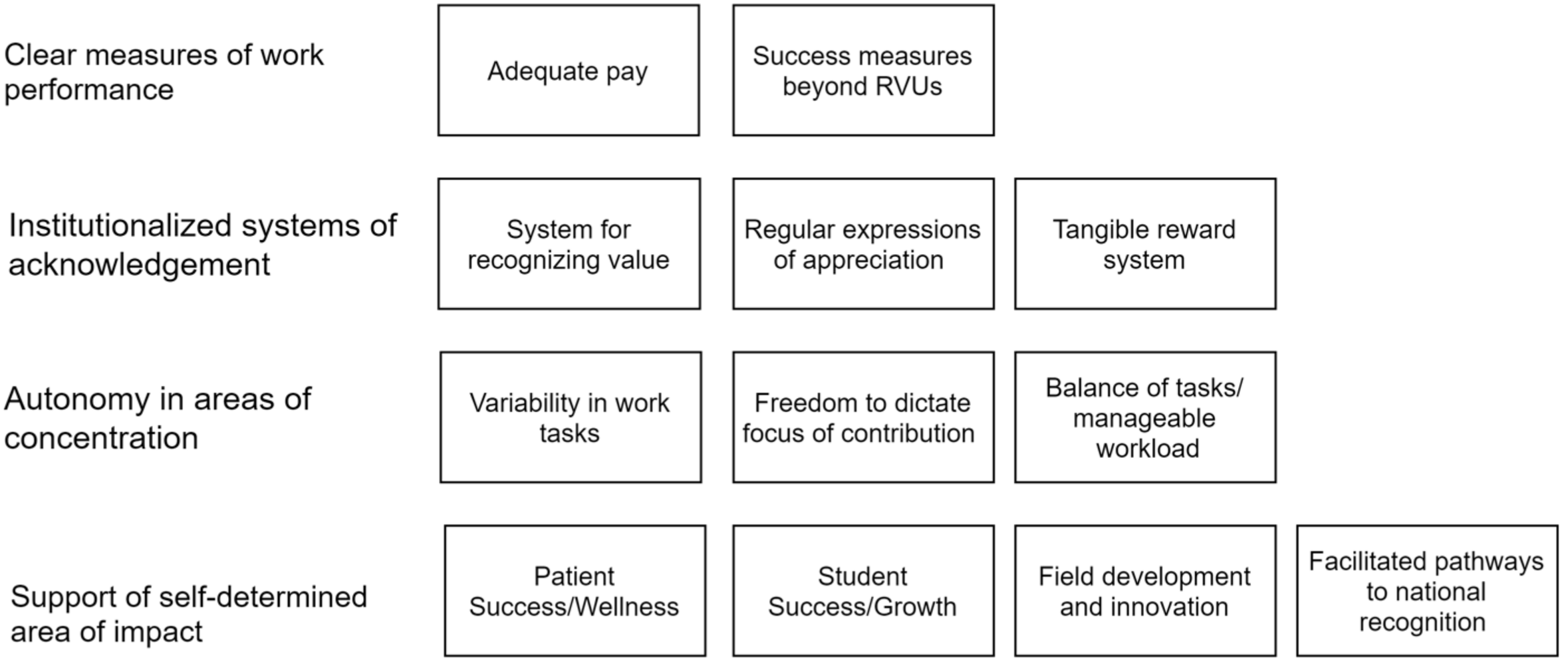
An Exceptional Faculty Experience: A Recipe

Clear measures of work performance	Adequate pay	Success measures beyond RVUs		
Institutionalized systems of acknowledgement	System for recognizing value	Regular expressions of appreciation	Tangible reward system	
Autonomy in areas of concentration	Variability in work tasks	Freedom to dictate focus of contribution	Balance of tasks/ manageable workload	
Support of self-determined area of impact	Patient Success/Wellness	Student Success/Growth	Field development and innovation	Facilitated pathways to national recognition
Adequate and effective administrative support	Designated administrative support	Manageable administrator workload	Ability to work at top of license	High performing institution
Organized forums for collaboration	Mentorship and mentoring opportunities	Peer learning communities	Freedom to pursue interdisciplinary research	Cooperative work culture
Diverse and inclusive workforce	Diversified hiring tasks forces	Equitable access to opportunities	Anti-racist institutional initiatives	
Psychological Safety	Planned opportunities to provide feedback	Protections from repercussions after providing feedback		

An Exceptional Faculty Experience: A Recipe



Adequate and effective administrative support	Designated administrative support	Manageable administrator workload	Ability to work at top of license	High performing institution
Organized forums for collaboration	Mentorship and mentoring opportunities	Peer learning communities	Freedom to pursue interdisciplinary research	Cooperative work culture
Diverse and inclusive workforce	Diversified hiring tasks forces	Equitable access to opportunities	Anti-racist institutional initiatives	
Psychological Safety	Planned opportunities to provide feedback	Protections from repercussions after providing feedback		

ACTIVITY

Sourcing our collective wisdom to get off the struggle bus

QUESTIONS?

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Disclosures

No Disclosures

Joy & Meaning in Medicine

A Multidimensional Approach to Physician Support During a Pandemic

ACPH 2021

Amanjot Sethi, MD
Director of Wellness Operations
The Permanente Medical Group

PERMANENTE MEDICINE®
The Permanente Medical Group

Learning Objectives

Evaluate	potential strategies to implement support mechanisms within your organization
Identify	specific forms of pandemic-related support that are valued by physicians
Consider	expanding applicable resources to support physicians' wellness and mental health

Total Performance Strategy

What is JAMM?

JAMM | Strategic Framework

Culture

- Measurement
- Leadership development
- Community and camaraderie
- Psychological safety
- Recognition
- Professional development
- Physical environment
- TPMG values and mission

Practice Support

- Reduction of clerical burden
- Support staff engagement
- Process improvement
- Technology
- Teamwork
- Communication
- Flexibility and autonomy

Personal Wellness

- Personal health
- Well-being and EAP
- Resilience
- Mindfulness
- Gratitude
- Volunteerism
- Diverse wellness programs

Defining JAMM

JAMM is more than the absence of burnout -- **it is about connections to meaning and purpose.**

JAMM is not just the responsibility of the individual.

JAMM is a result of having systems that are optimized to support our practice.

JAMM impacts all we hope to achieve- exceptional care experience, operational excellence, and outstanding quality.

Enhancing **JAMM**

Supporting our **PEOPLE**

Navigating challenges **TOGETHER**

A time of unprecedented stressors

Personal health & safety concerns

Increased patient anxiety

Loss of normalcy

Vaccine hesitancy

Social unrest

Moral distress

Family stressors

Operational demands

Environmental challenges

Ongoing surges

Method/Approach

COVID-19 Physician Support Taskforce

Comprised of leaders from command center, wellness teams, operations, well-being, EAP and Physician HR

Understand the evolving pandemic-related needs

Strategize how best to deploy the robust resources, programs, and support personnel already in place

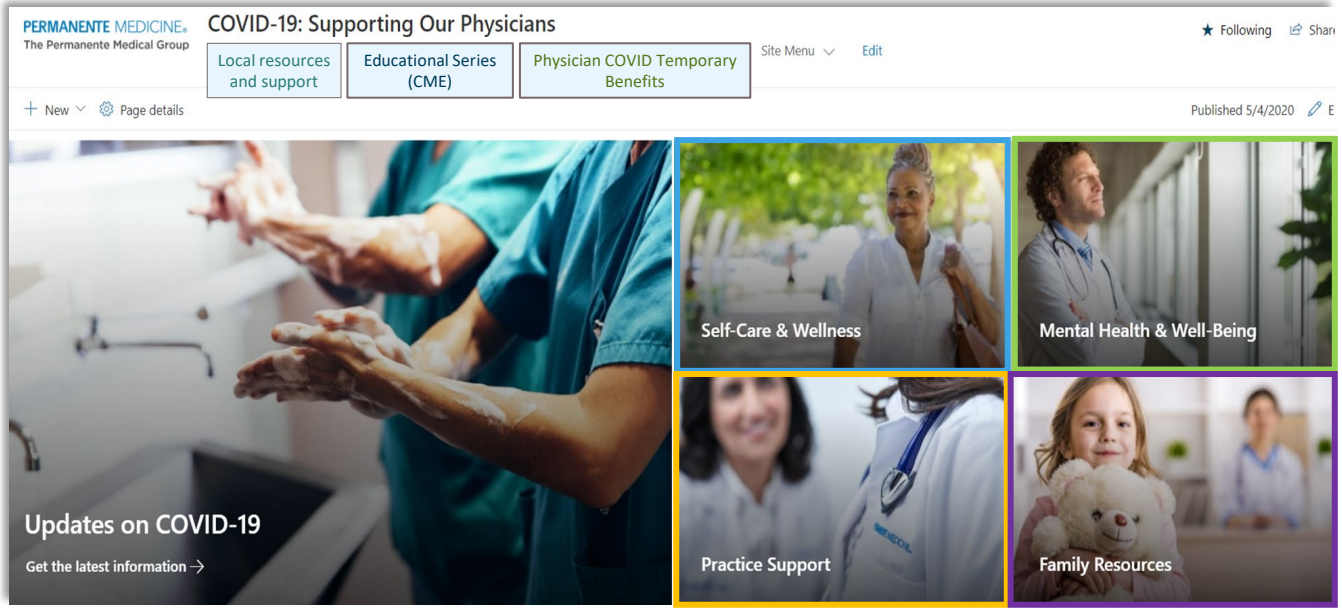
Generate new proposals for physician support

JAMM & Physician Support | Website

Links to Local Physician Health & Wellness sites and contact info for your local PHW, Well Being, and Communication Consultant leads

Information on upcoming Virtual JAMM Series and CRC&I sessions and recordings of past events.

Information on temporary benefits being offered to physicians during the pandemic.



Mindfulness, resilience & gratitude, health & wellness resources

Physician Wellbeing, EAP and Mental Health Line information

Resources & tools for working remotely, video visit, & patient communication.

Resources for parenting support and offerings for medical providers.

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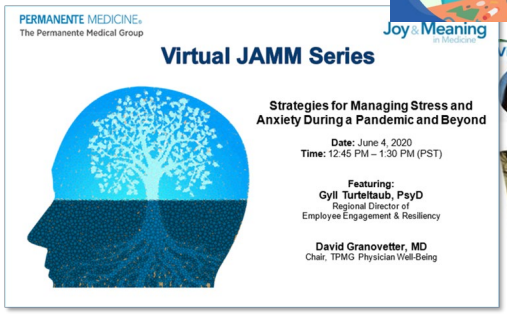
JAMM | Enhanced COVID-19 Benefits

- COVID financial benefits
- Childcare grants & resources
- COVID-19 support website
- Physician Well-Being support
- Physician Health & Wellness virtual events
- Virtual Mindful Medicine program
- Virtual parenting support offerings



https://sp-cloud.kp.org/sites/PhysicianCOVIDResources

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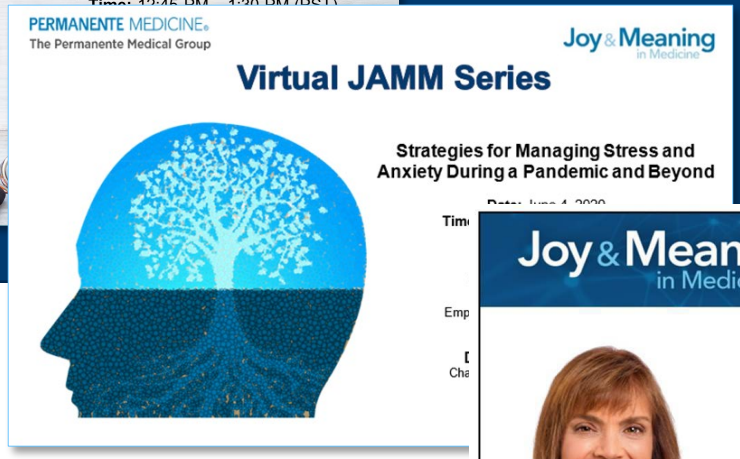
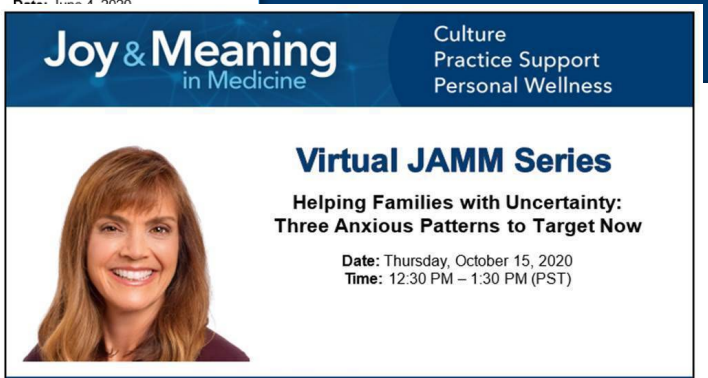
JAMM | Virtual Series

- Navigating stress, anxiety and mental health support
- Parenting during the pandemic
- Professional development
- Healthy eating & lifestyle
- Practice support





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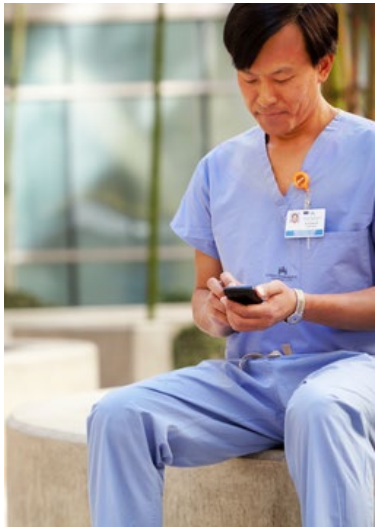
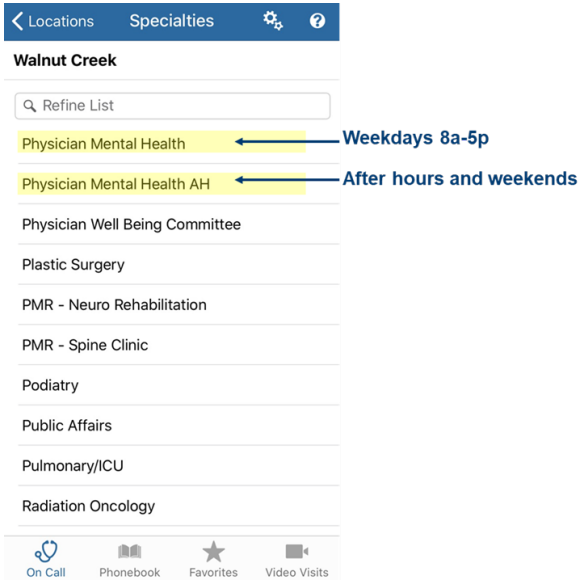
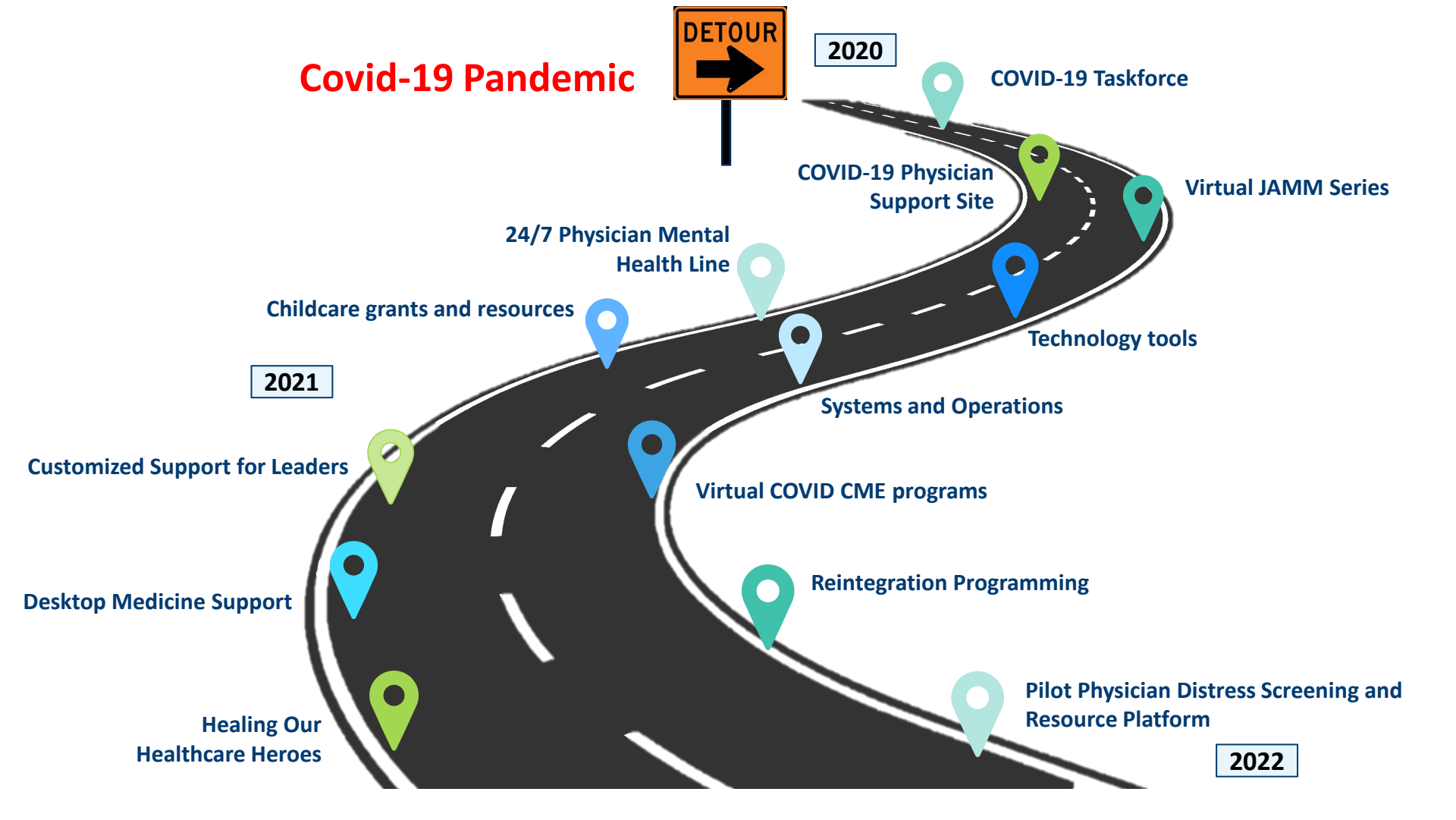
Physician Mental Health Line

24/7 rapid triage line providing confidential assessment and linkage to appropriate resources and care based on need and physician preference



- **Accessed through messaging app**
- **Internal referrals**
  - Fast track referrals to psychiatrist or therapist
- **External referrals**
  - Immediate referrals to virtual therapy platforms, external psychiatrist or therapist



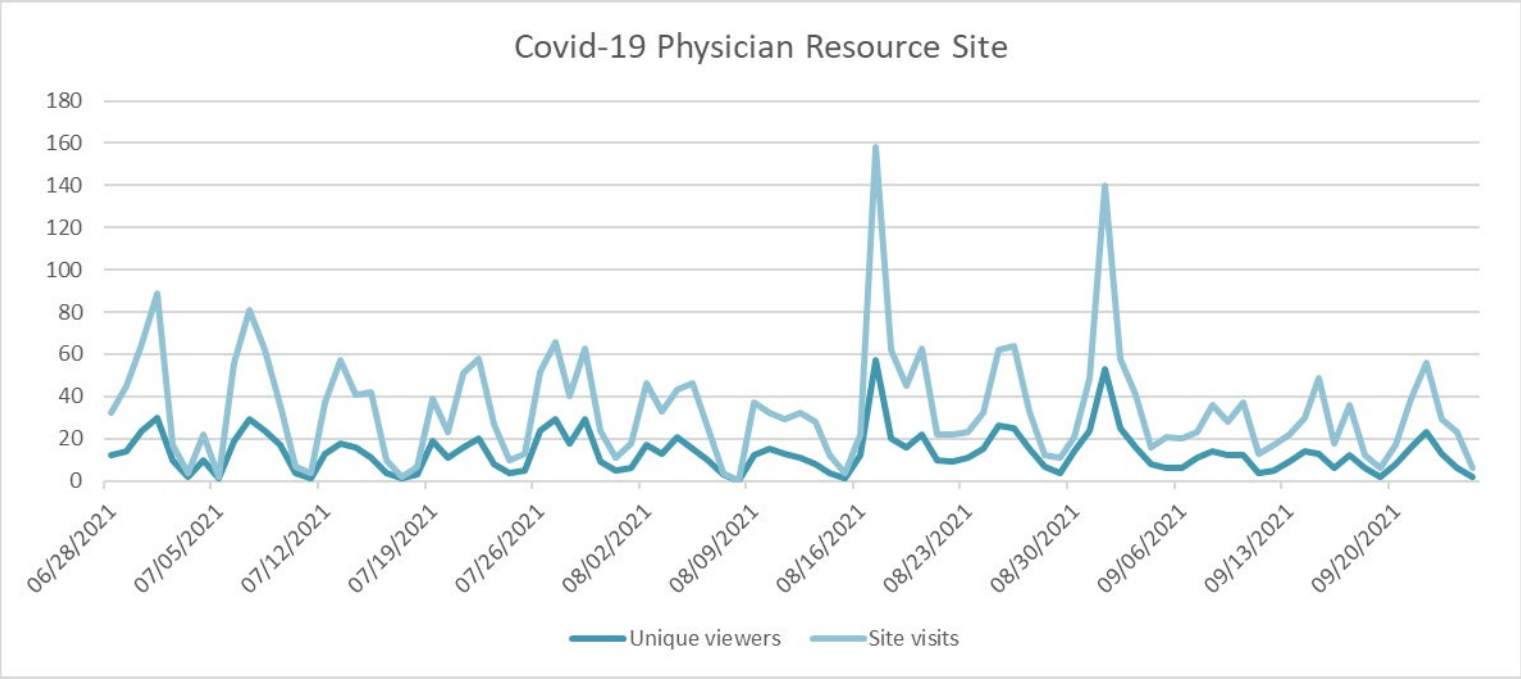

Covid-19 Pandemic
DETOUR
2020
COVID-19 Taskforce
COVID-19 Physician Support Site
Virtual JAMM Series
24/7 Physician Mental Health Line
Childcare grants and resources
Technology tools
2021
Systems and Operations
Customized Support for Leaders
Virtual COVID CME programs
Desktop Medicine Support
Reintegration Programming
Healing Our Healthcare Heroes
Pilot Physician Distress Screening and Resource Platform
2022

Results

JAMM & Physician Support | Website

- Site went live April 2020
- Communicated through various stakeholders
- Served as central source for clinical and well-being resources

JAMM & Physician Support | Website



JAMM | Education Events

Virtual JAMM Series

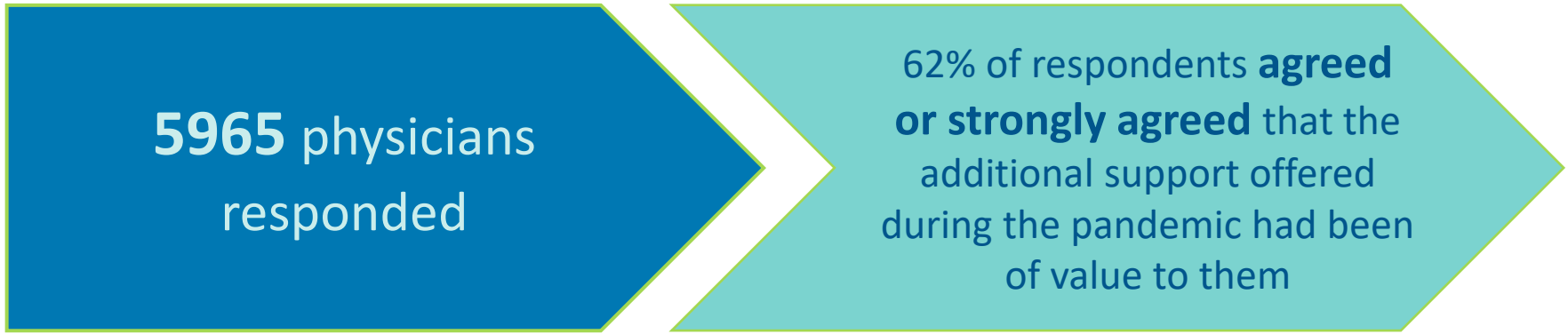
- Began May 2020
- More than 1,000 physicians attended the inaugural live virtual wellness presentation

Practice and Technology Support for the Virtual World

- Launched in September of 2020
- Over 99% of physicians completed

Physician Support – Perceived Value

- JAMM survey deployed in late 2020
- Included questions about the perceived value of pandemic-specific support



Joy & Meaning in Medicine

THANK YOU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Disclosures

- We have nothing to disclose

Medical Student Mental Health

Student Burnout, Treatment Acquisition, and Barriers to Care at a Single Institution

Presented by Claire Collins & Cayla Pichan

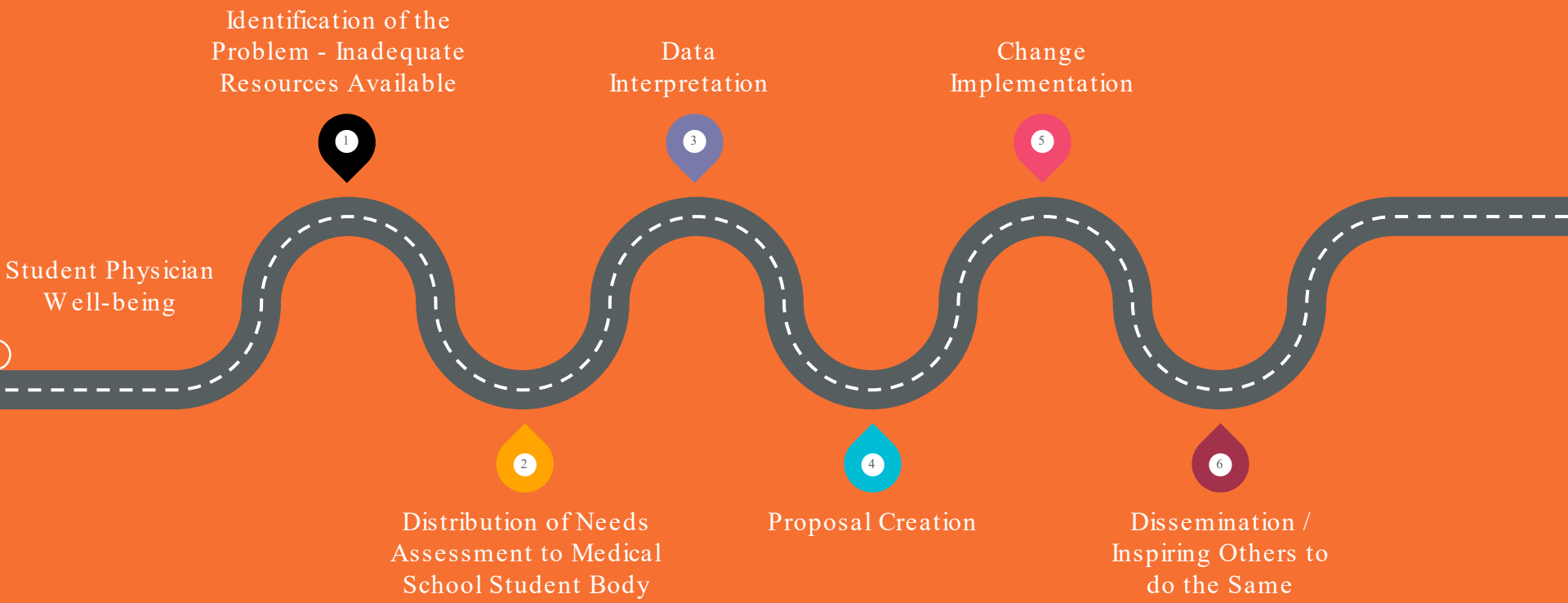
It's Not Me, 2017
Charlie and Eddie Proudfoot

Learning Objectives/Agenda

Bird Cage, 2020
Marcia Diaz

1. Burnout distribution among medical student years offers opportunity for targeted improvement & interventions.
2. What are the barriers? And how are we trying to overcome them?
    a. Why is targeted programming needed?
    b. Early intervention is vital.
    c. Consistent intervention is needed throughout training.
3. Applicability to faculty and resident training programs.

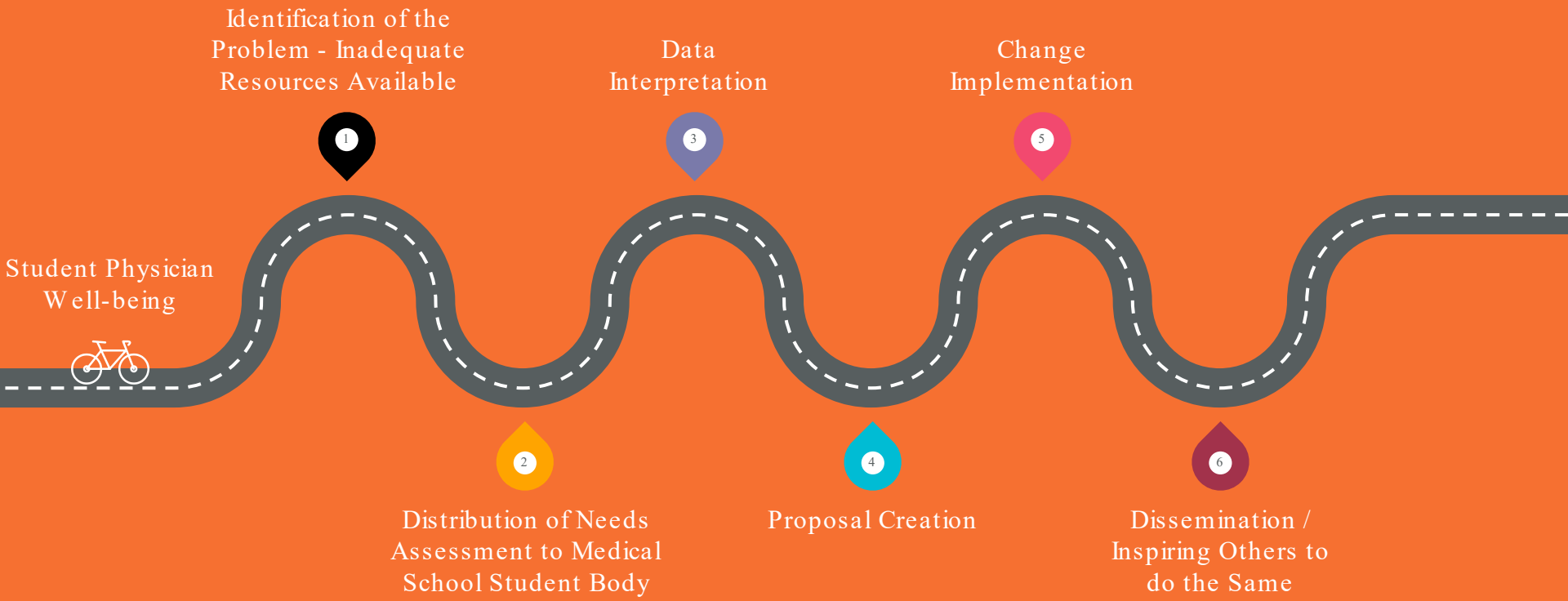
Our Journey


Identification of the Problem - Inadequate Resources Available
1
Data Interpretation
3
Change Implementation
5
Student Physician Well-being
2
Distribution of Needs Assessment to Medical School Student Body
4
Proposal Creation
6
Dissemination / Inspiring Others to do the Same

A Far Too Common Story

No Hopeless, 2007
Yoshitomo Nara

Our Journey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Trending Unwell

Medical Students in the United States

50% of students

Experience burnout[1]

10% of students

Experience suicidal ideation[1-3]

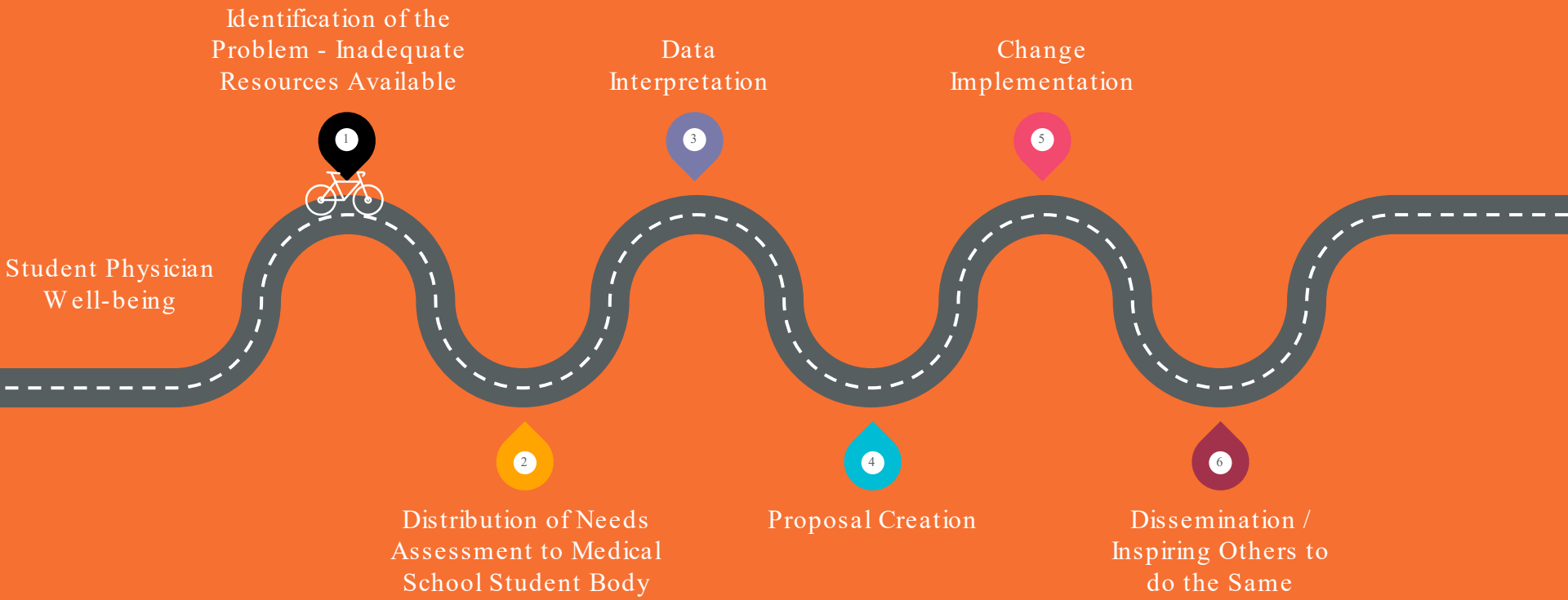
1/3 of students

Experience depression[4]

<13% of students

Seek treatment[4]

Our Journey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Proposal Creation
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Asking the Right Questions

Student Well-being

- Burnout
- Emotional well-being
- Mental health

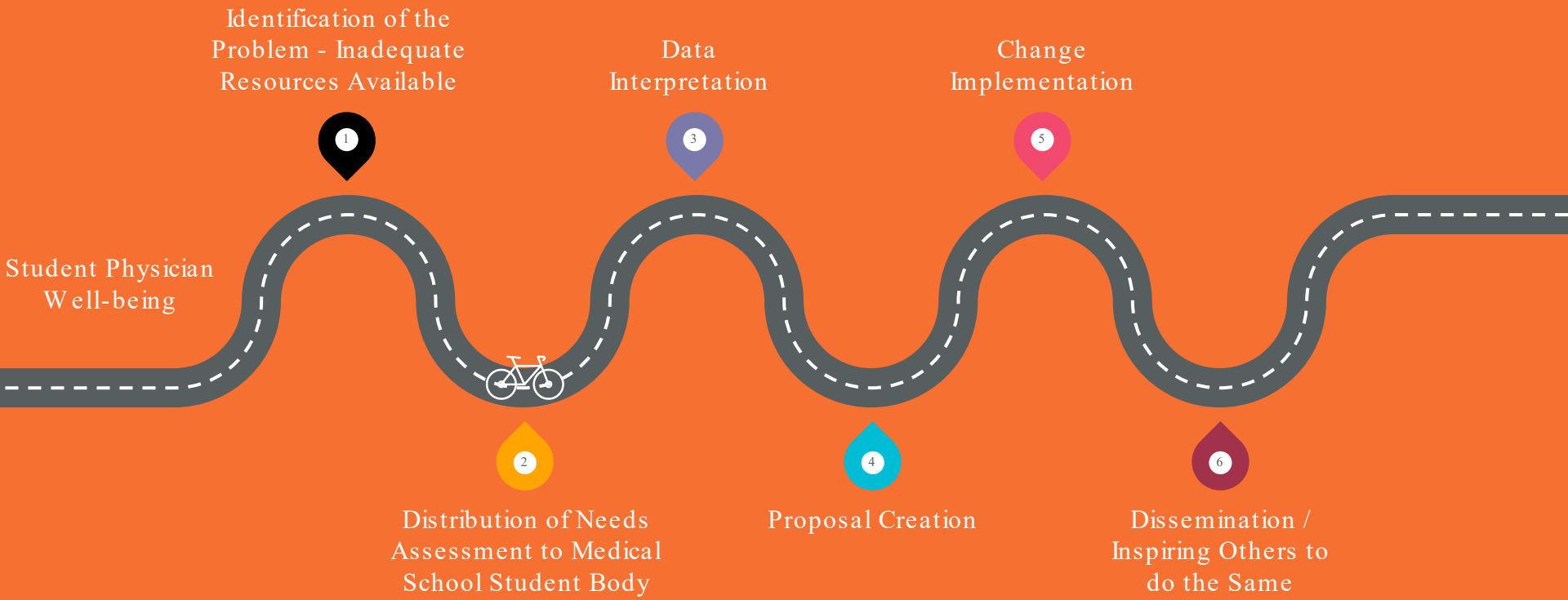
Barriers to Care

- Time
- Cost
- Stigma

Satisfaction with Current Services

- Internal services
- External services

Our Journey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Needs Assessment

588 Students Received the Survey

312 Students Responded

82% Reported Concern for Well-being

Emotional Well-being, Burnout, and Satisfaction with Current Resources

82% of students

Had concern for their emotional well-being

2x more burnt out

Pre-clinical and core clinical students

78% of students

Believed the school should be doing more

37% did not seek treatment

77

participants identified barriers to obtaining care

“

“…the barriers to access this program have not been addressed and make it inaccessible…we have no official scheduled time to take medical appointments”

“

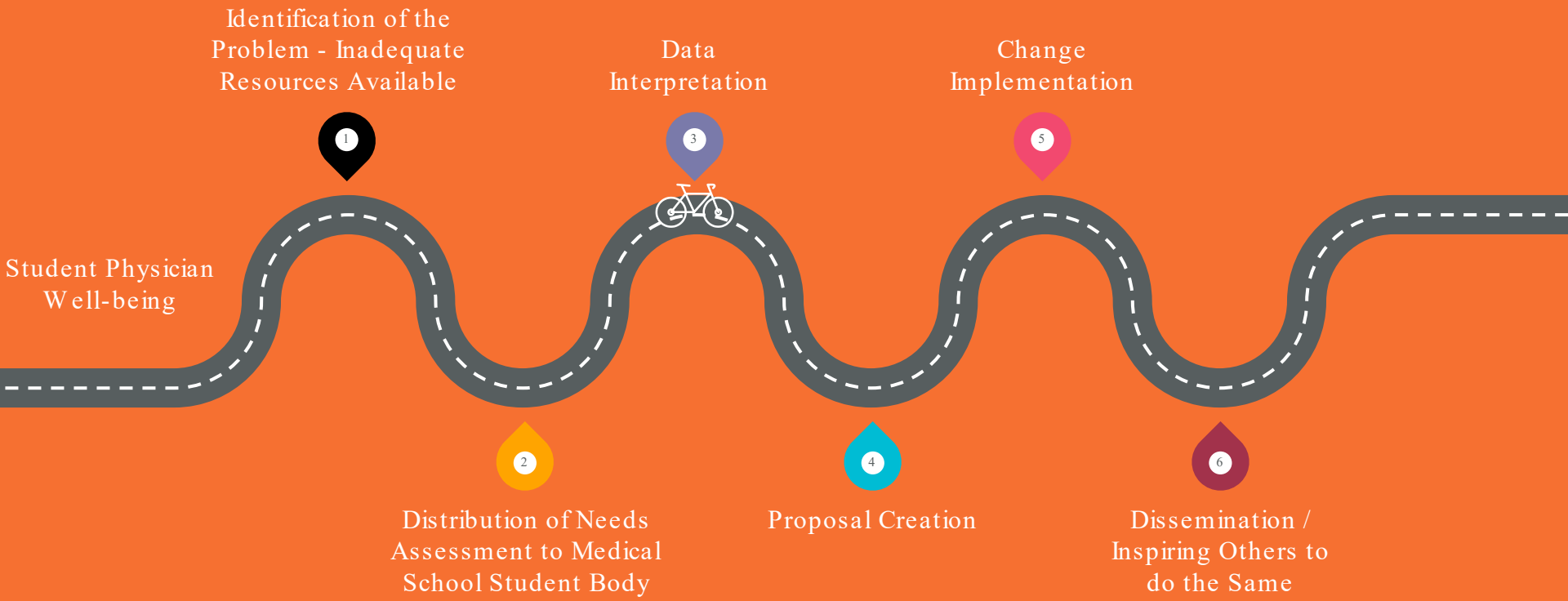
“I absolutely loved the provider I saw…[but] I was stuck with an absolutely enormous medical bill that no one warned me about…”

“

“There needs to be more one-on-one ‘opt-out’ mental health services. The hardest part of seeking care for me has always been getting over the shame and difficulty of first reaching out when I need help. In the high-achieving atmosphere of medical school, this is even harder.”

“I felt like I was constantly drowning in the scientific trunk curriculum … I hardly had time to take care of myself… I felt suicidal which is why I ended up getting help, but I should have gotten help long before when the depressive symptoms started but I didn't have time because I was so overwhelmed with school. I wish we talked about physician suicide and depression more often and make it more normal to talk about it [with] peers. I still am not sure if I should mention it to people that I'm depressed or was suicidal for a while.”

Our Journey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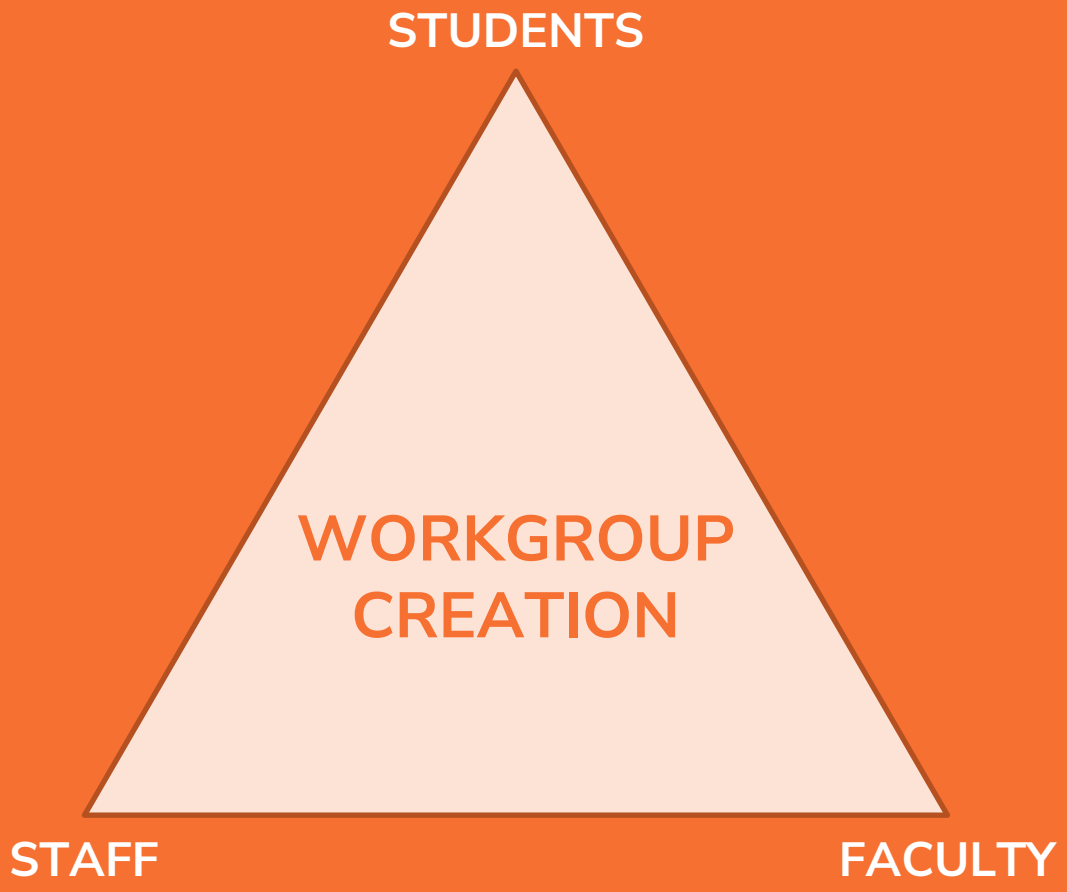
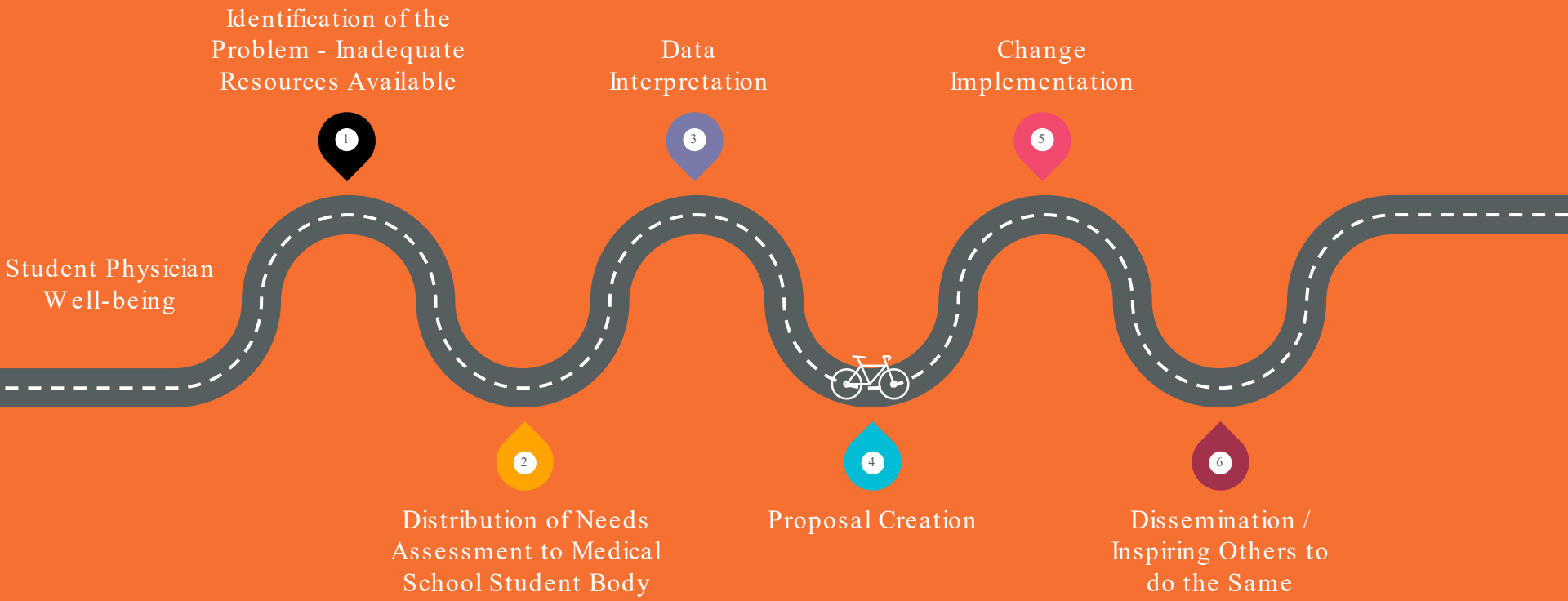

STUDENTS
WORKGROUP CREATION
STAFF
FACULTY

Matching Our Student Need

Our Journey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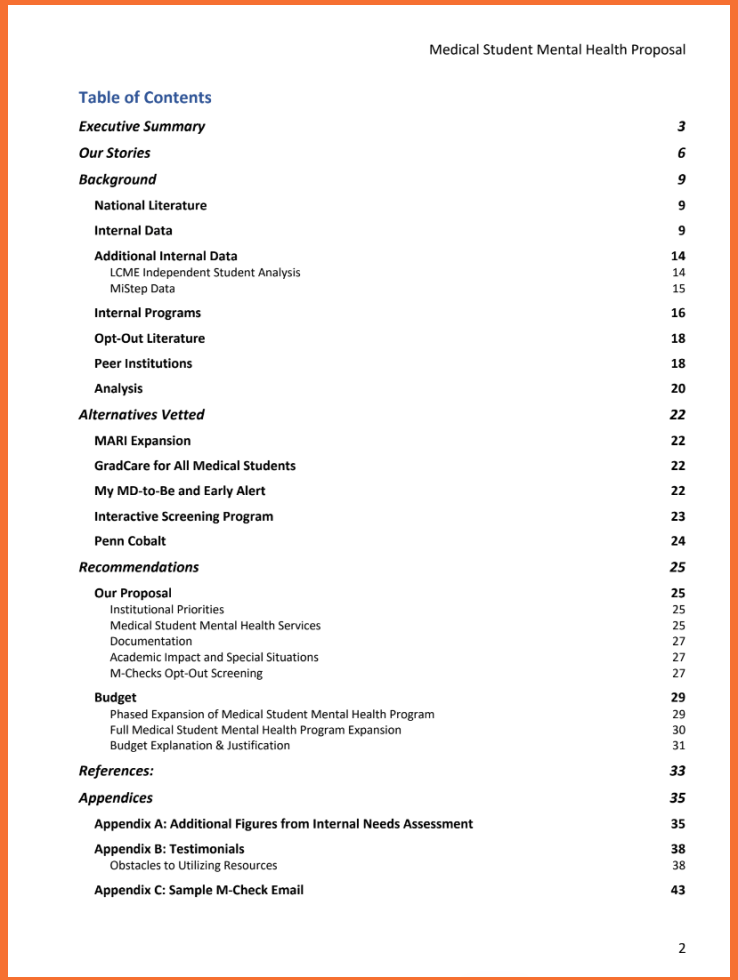
An in-depth proposal was created outlining:

- Current state of our students' mental health and well-being
- National colleagues
- Vetted alternatives
- Program proposal



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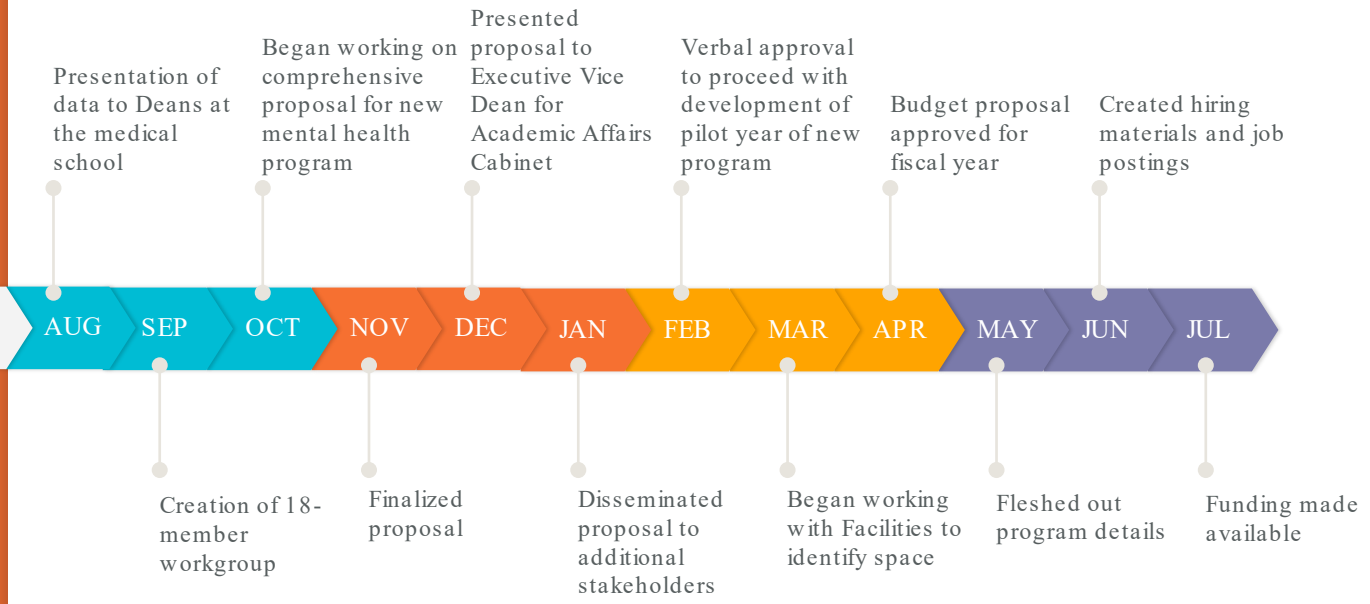
Timeline

2020-2021



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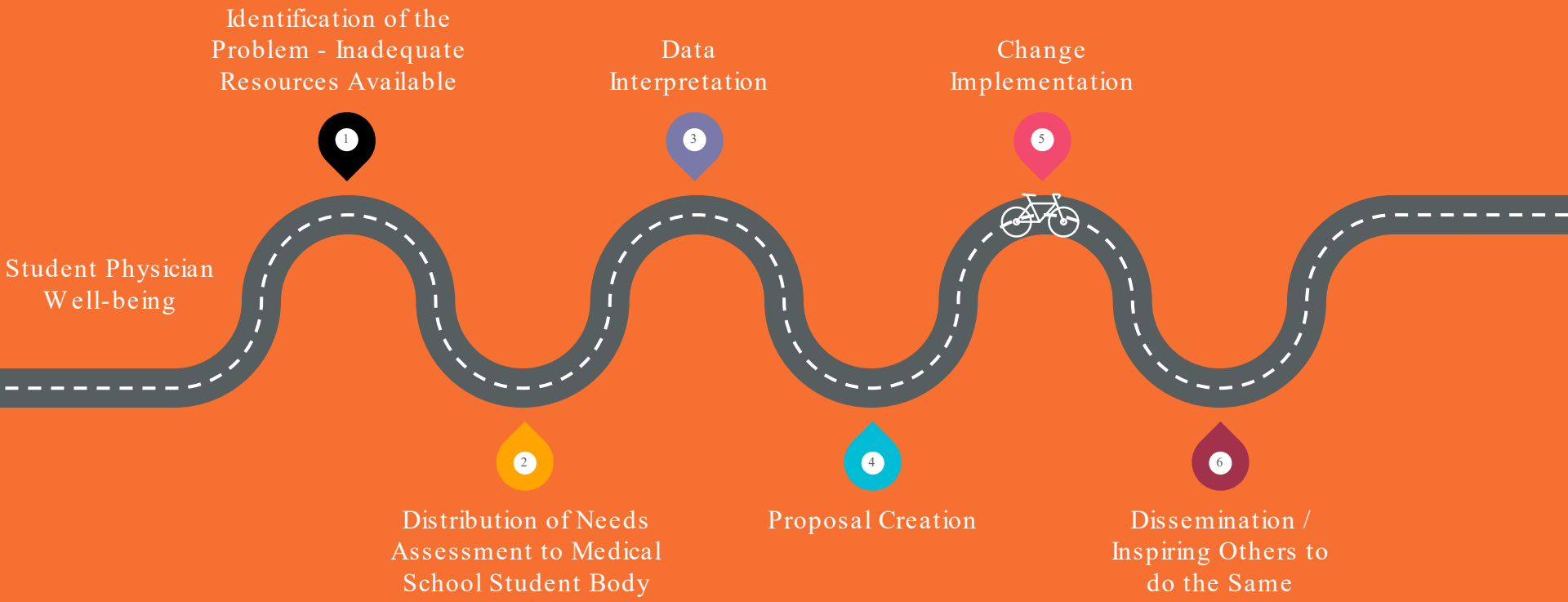
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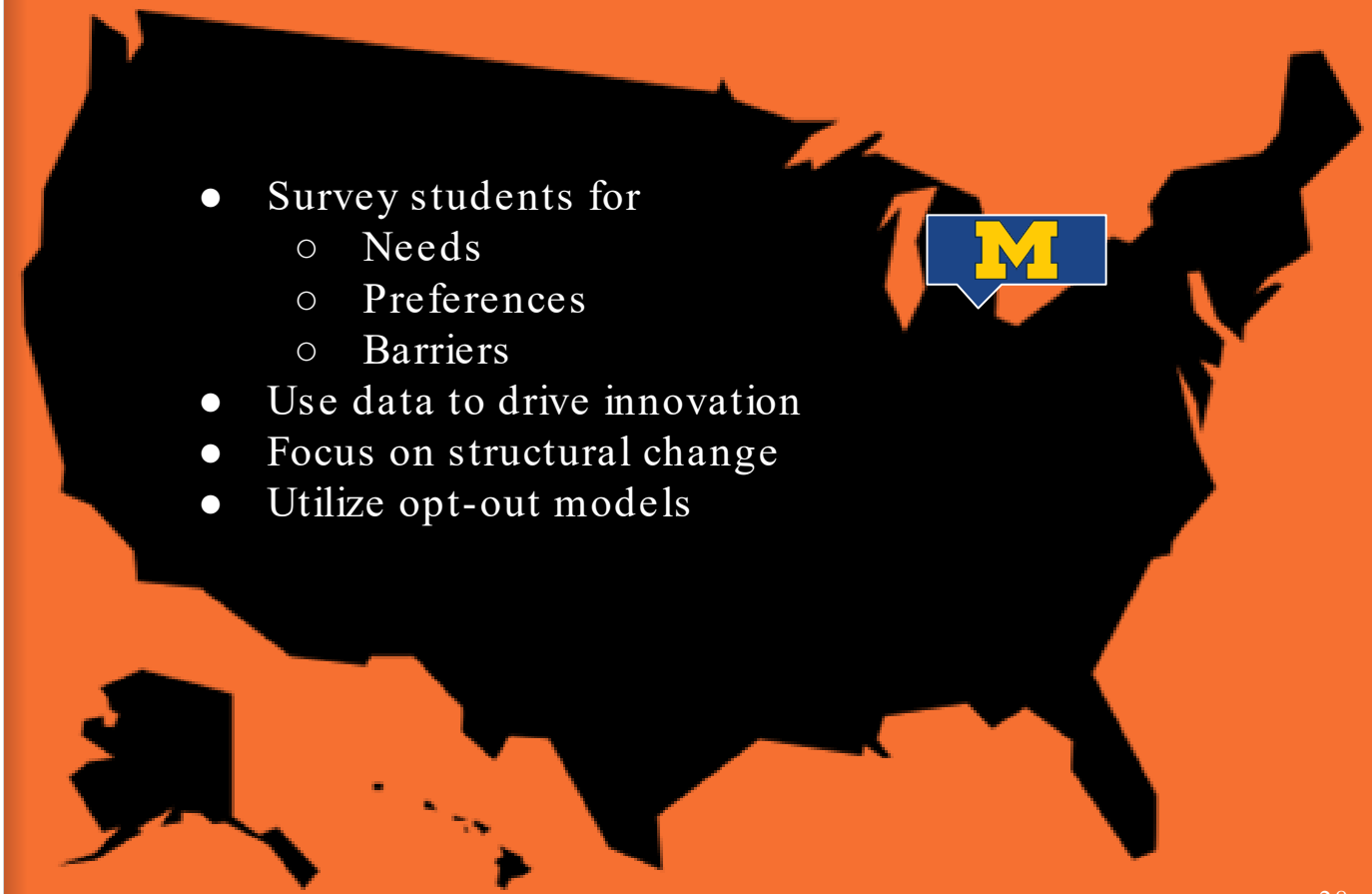
Your Program

What are some things you can take away from today to encourage your institution to support necessary changes for your medical students, residents and faculty?



- Survey students for
  - Needs
  - Preferences
  - Barriers
- Use data to drive innovation
- Focus on structural change
- Utilize opt-out models

Let's Reflect

Training of the Purple Spirit, 2017
Kim Noble

Medical Student Mental Health Program (MSMHP)

Lead Team Members

Erin McKean, MD
Assistant Dean of Student Services
Co-Chair of MSMHP Team

Claire Collins
Founder and Co-Chair of MSMHP Team

Cayla Pichan
Co-Chair of MSMHP Team
Co-PI for Data Acquisition

Lauren McGee, MD
Co-PI for Data Acquisition
Former Co-Chair of MSMHP Team

Kirk Brower, MD
Chief Wellness Officer
Co-PI for Data Acquisition

Jennifer Votta, MD
Lead Psychiatrist

Kathleen Robertson, MS, RN
Director, Office of Counseling & Workplace Resilience

Christine Neejer, MSW, MA, PhD
Medical Student Academic Counselor

Brad Densen, MPH
Administrative Director
Office of Medical Student Education

Reggie Beasley, MA
Program Manager for Medical Student Program,
Office of Health, Equity & Inclusion

Ali Hammoud, MD
Student Member

Aliya Moreira
Student Member

Ally Grossman, MSW
Student Member

Austin Taylor
Student Member

Daniella Ortiz
Student Member

Matthew Friedland
Student Member

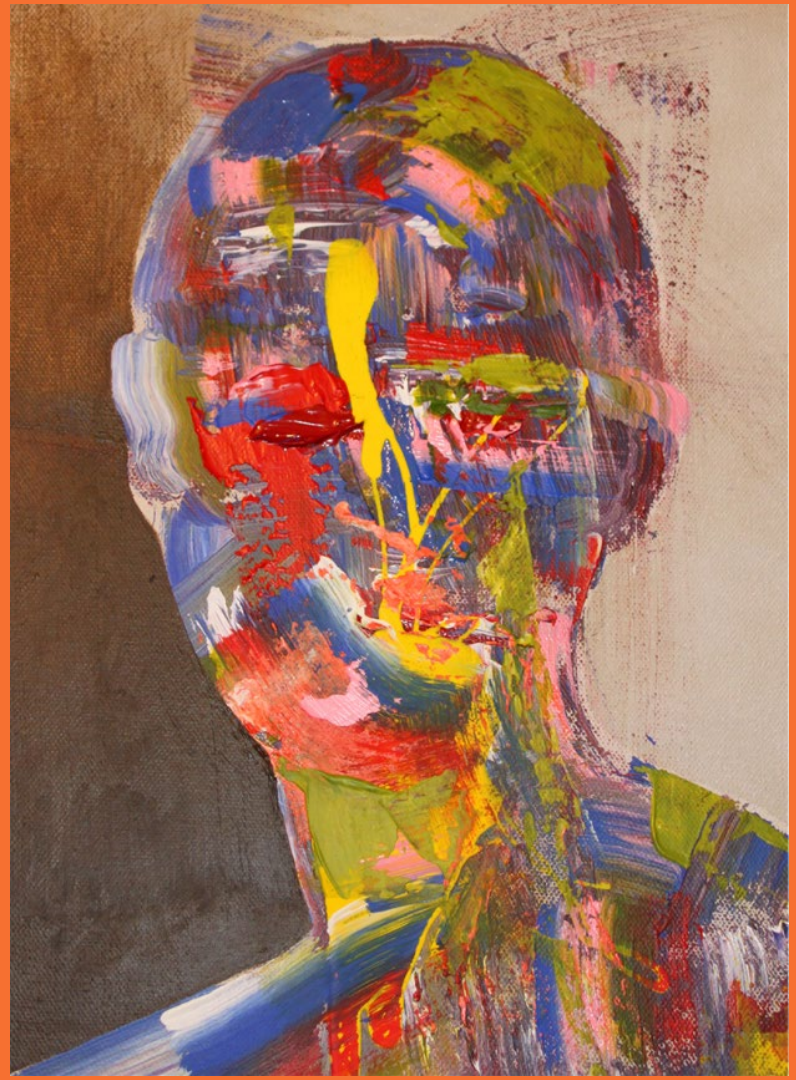
Haley Talbot-Stetsko
Student Member

Kasey Cox, MS
Student Member

Thank You

Cayla Pichan
cmpichan@med.umich.edu

Claire Collins
cmwelsh@med.umich.edu



Mixed up Model, 2017
Eddie and Charlie Proudfoot

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MAYO CLINIC

Stanford MEDICINE

CHANGES IN CLINICIAN WELL-BEING AND NEEDS OVER TIME DURING THE COVID-19 PANDEMIC AND THE INCREASED BURDEN ON FEMALE CLINICIANS

Presented by:
Suzanne Pertsch, MD
P.T. Koenig, MD
Laurie Gregg, MD

Suzanne Pertsch, M.D., Ellis Dillon, Ph.D., Cheryl Stults, Ph.D., Sien Deng, Ph.D., Meghan Martinez, M.P.H., Amaka Agodi, B.S., Nina Szwerinski, M.S., P.T. Koenig. M.D., Melissa Hanley, B.S., Sarina Le Sieur, B.A., Jill Kacher Cobb, M.D., Laurie Gregg, M.D.

No Disclosures

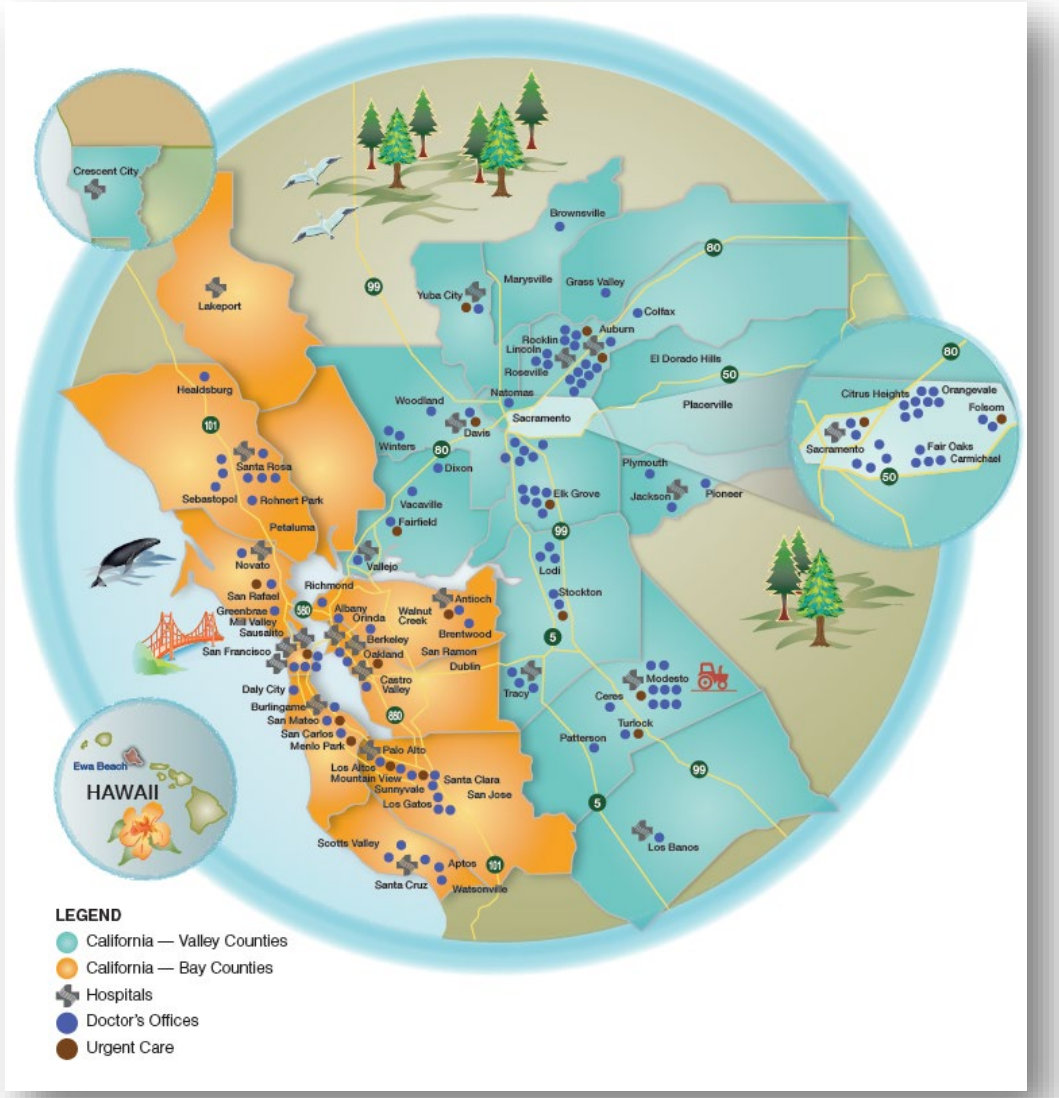
Suzanne Pertsch, MD

P.T. Koenig, MD

Laurie Gregg, MD

Sutter Health

- Based primarily in Northern California
- Not-for-profit healthcare network
- ~3.28 million active patients
- 9 medical groups and 23 hospitals
- 14,000 physician/APC's



Pulse Survey Purpose

- Express appreciation
- Gather meaningful information
- Escalate concerns
- Share across the system
- Drive data driven tactics

Methods/Approach

Survey

- Clinical and research team developed a survey measuring 5 domains:
  - Burnout (using a validated single-item measure)
  - Leadership
  - Safety at work
  - Caregiving
  - What can be done to support clinicians?

Approach

- Emailed survey to clinicians (physicians and advanced practice clinicians-APCs) in 17 Sutter Health hospitals and 8 affiliated medical groups
- Summer 2020 survey was distributed by Sutter Health research team
- Fall 2020 survey distributed by research team and NRC Health
- Analyzed between group differences using two-sided Chi-square test

Survey Sample

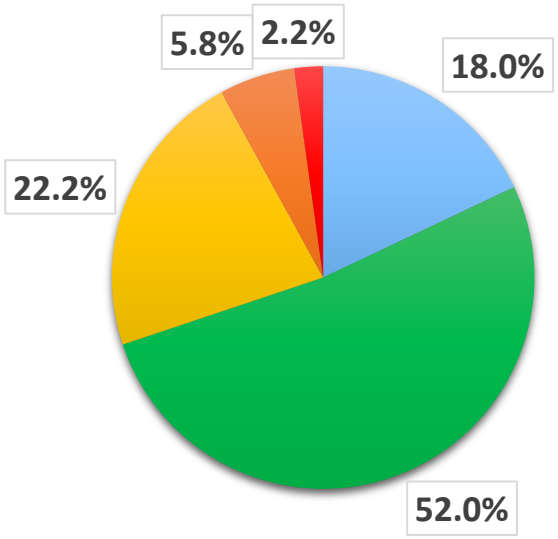
	Summer 2020 (June – Aug.)	Fall 2020 (Oct. – Dec.)
Surveys distributed	10,916	9,318
Completed surveys	3,470 (31.8%)	4,556 (48.9%)
Gender		
Male	1,606 (46.3%)	2,386 (52.4%)
Female	1,708 (49.2%)	1,913 (42.0%)
Age		
<35	253 (7.3%)	347 (7.6%)
35-44	1005 (29.0%)	1351 (29.6%)
45-54	970 (28.0%)	1302 (28.6%)
55-64	740 (21.3%)	934 (20.5%)
65+	348 (10.0%)	441 (9.7%)
Unknown	154 (4.4%)	181 (4.0%)

Note: 413 survey participants with unknown gender excluded from gender subgroup analysis

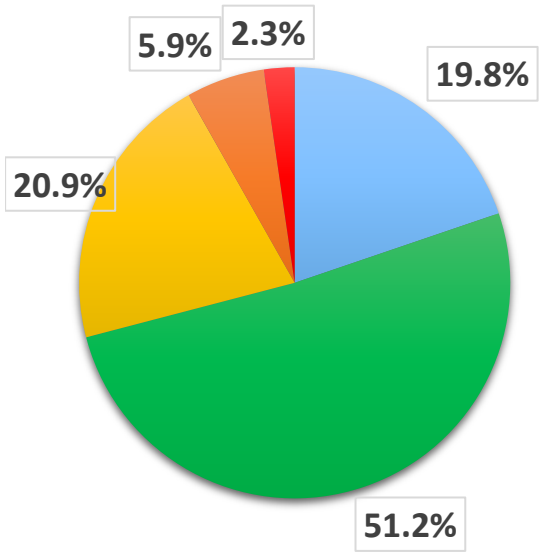
Gender Differences

Percent of Clinicians Reporting Burnout Overall and by Gender

Summer: 30.1%



Fall: 29.0%



1. I enjoy my work. I have no symptoms of burnout.
2. Occasionally under stress, but I don't feel burnout.
3. I am definitely burning out.
4. The symptoms of burnout won't go away.
5. I feel completely burned out and often wonder if I can go on.

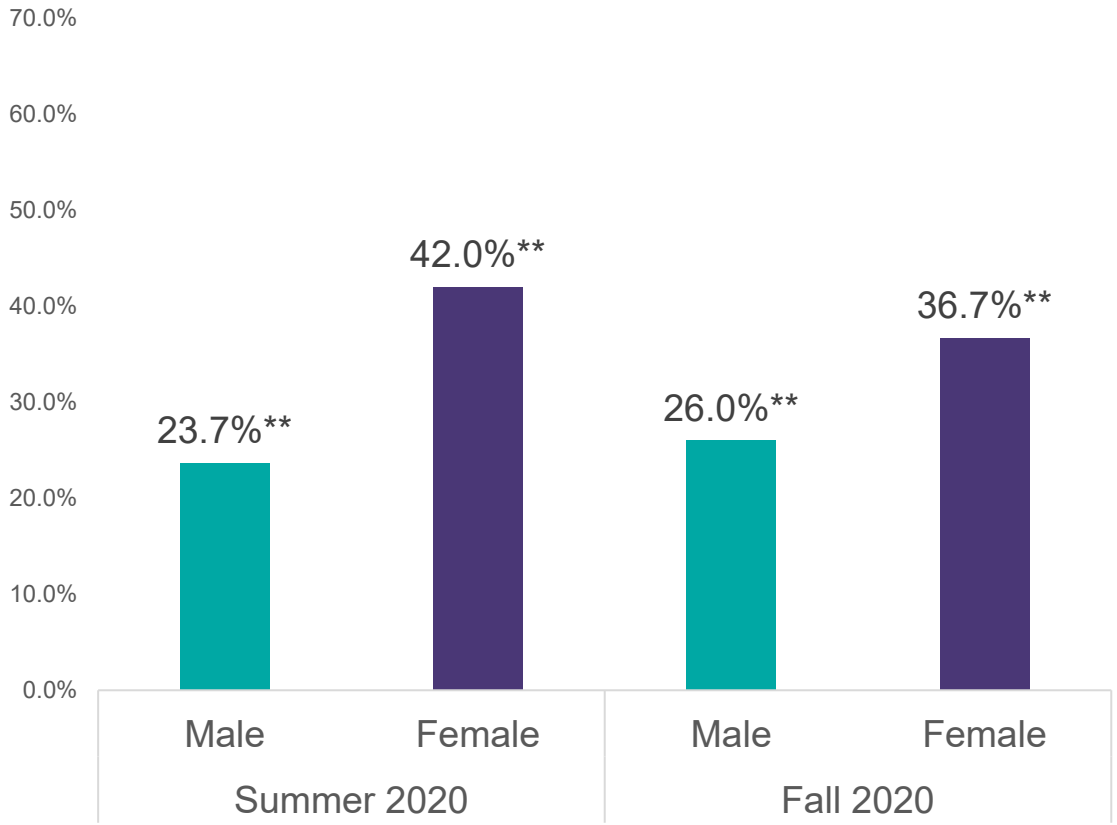
** p ≤ 0.001

NOTE: Burnout defined as those selecting 3, 4, or 5.
No significant difference in overall burnout between Summer and Fall.

Differences by Gender

My childcare or caregiving responsibilities are impacting my work

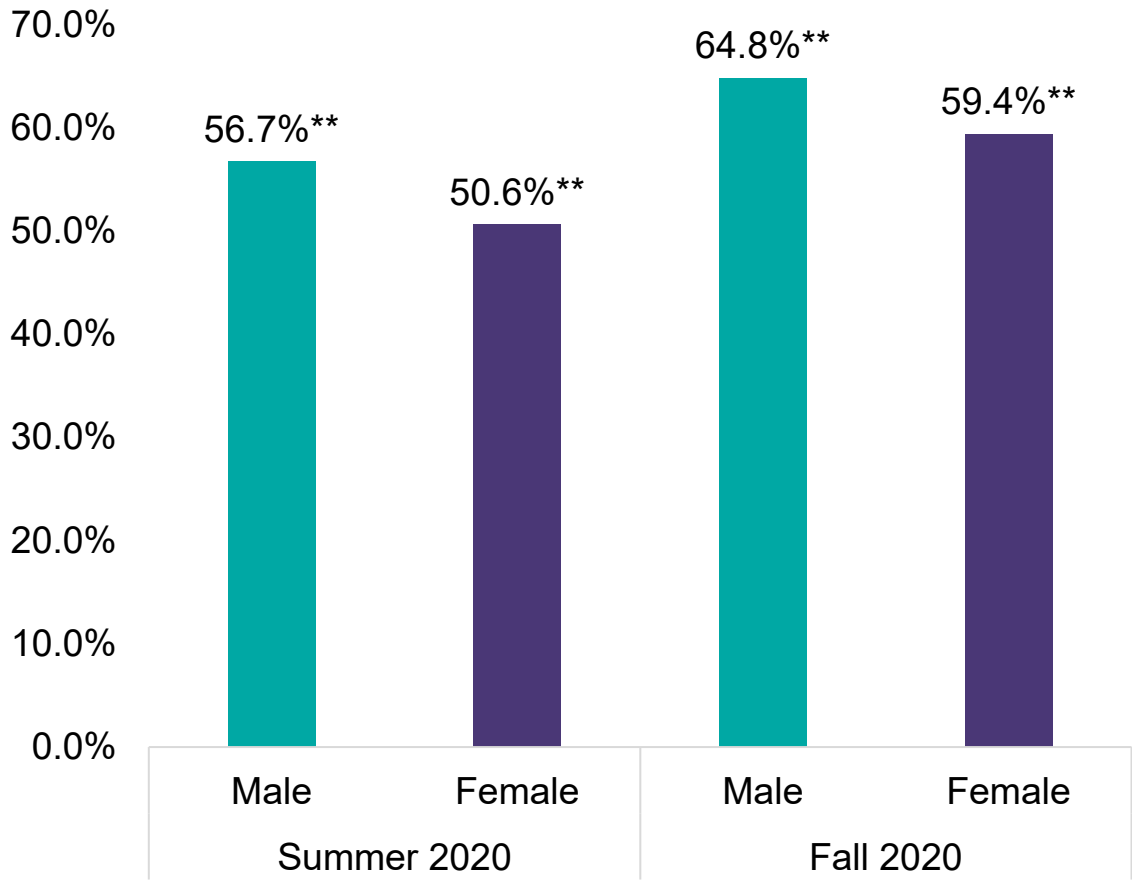
Percent Responding Agree or Strongly Agree



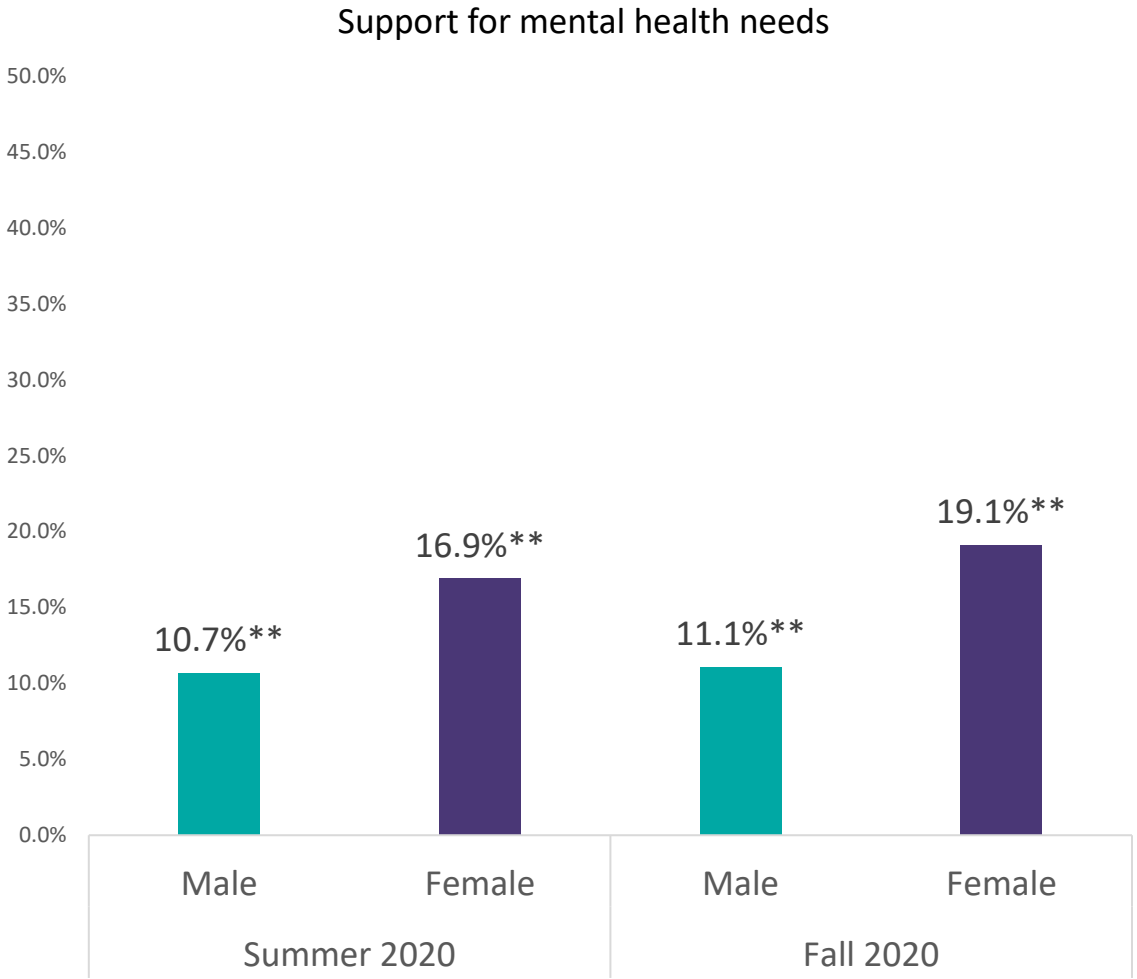
** p ≤ 0.001

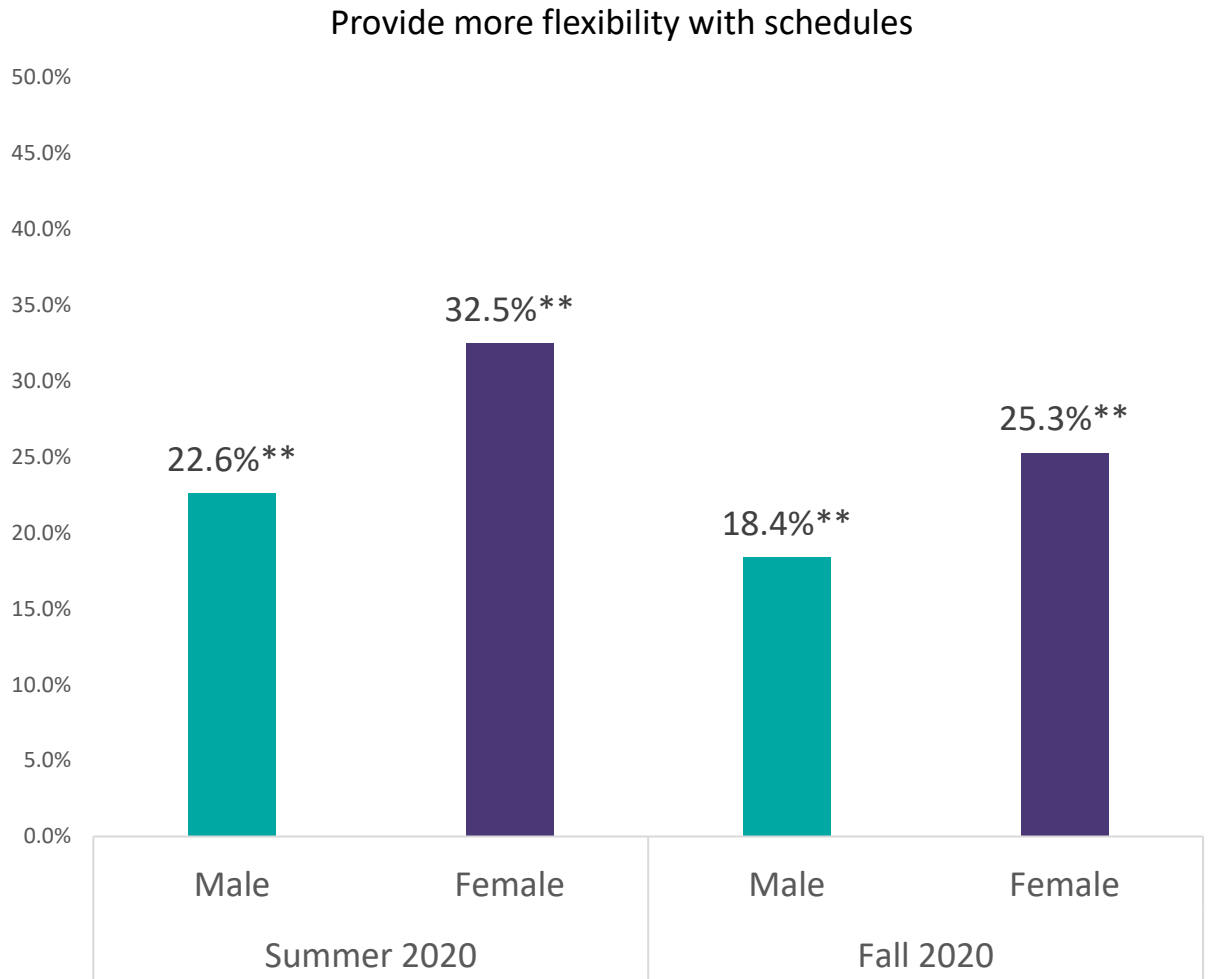
I believe my concerns will be acted upon

Percent Responding Agree or Strongly Agree



Differences by Gender





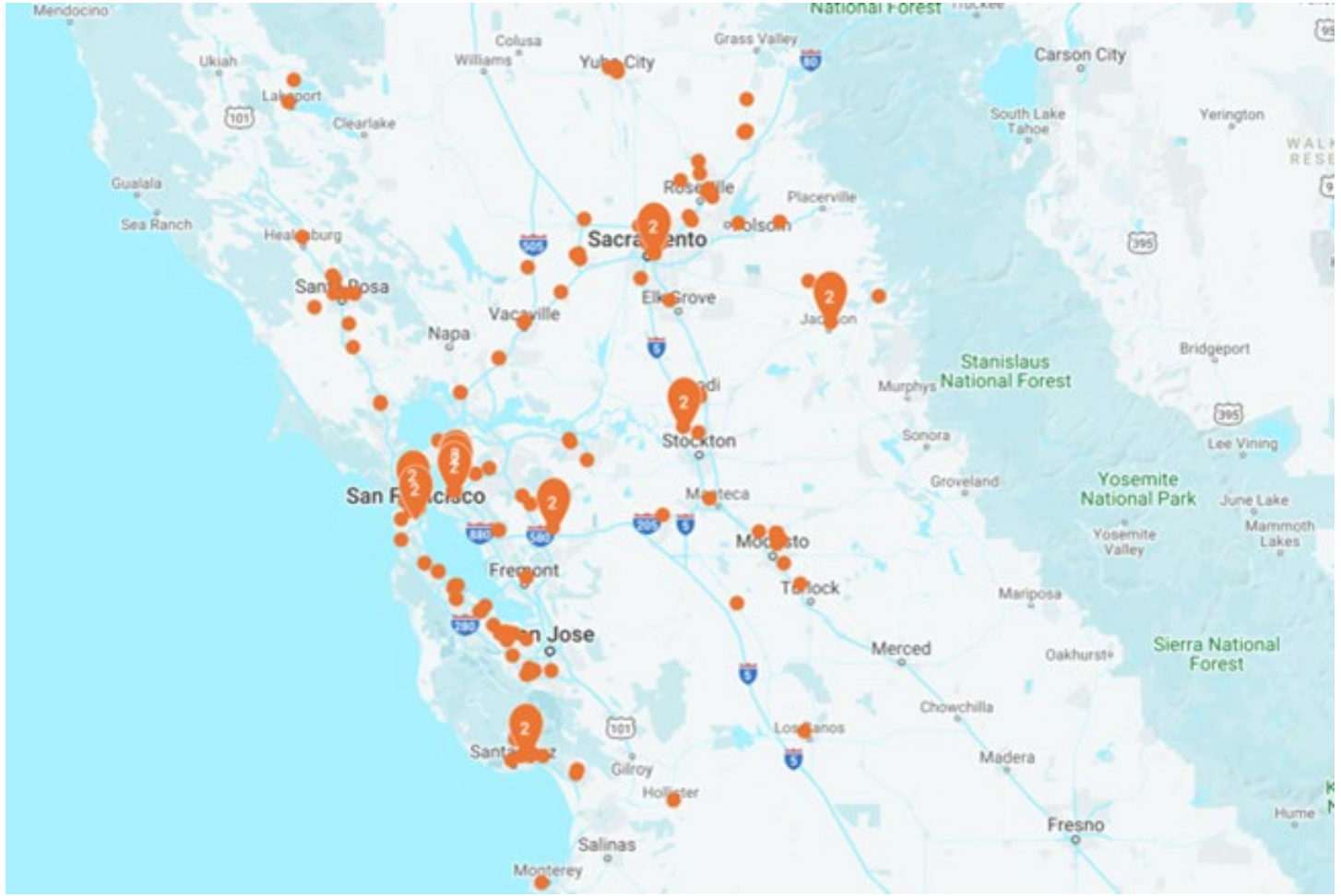
** p ≤ 0.001

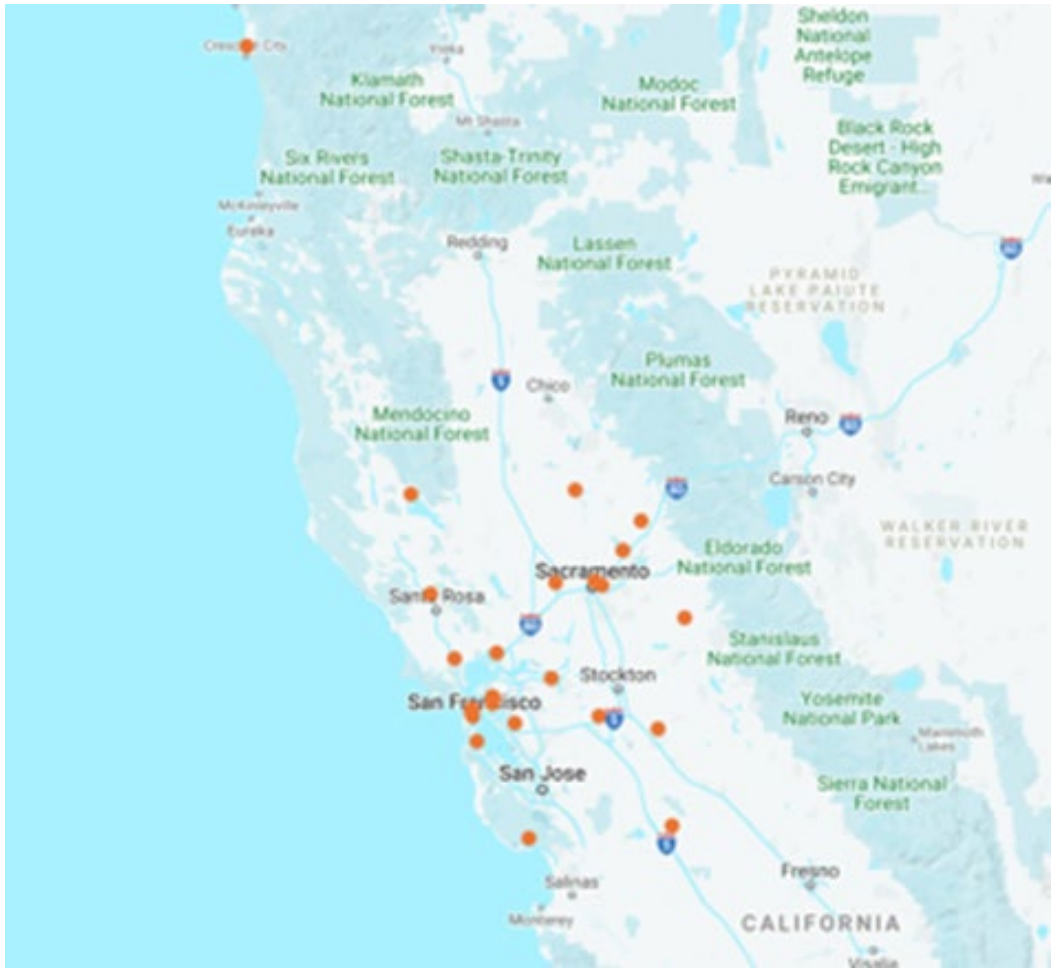
Summary Gender Differences

Gender Differences (women vs. men)

- Burnout was much higher for women in both summer and fall
- Women desired more support with schedule flexibility and mental health support
- Women were more impacted by caregiving responsibilities

BIG TASK: BIG GEOGRAPHY





Action Plan - Ambulatory

- PPE Supplies
- Childcare/PUI Housing
- Flexible Schedules
- Mental Health Support
- Fast Access Psychiatric Care
- Mental Health Resources in EHR
- Senior Leadership Collaboration

Action Plan - Inpatient

- EAP for All
- Mental Health Resources
- Peer Support Programs
- System Wellness Committee
- Leadership Training
- Newsletters

Examples

FAST ACCESS

Sutter Health Joy of Work Team, in partnership with the nonprofit 'Mind to Mindful', is proud to offer expedited access to psychiatry services for clinician well-being at Sutter-affiliated Medical Groups and IPA's.

Caring for patients is challenging. It can be hard to maintain our own well-being, and also to ask for help.

Fast Access provides our clinicians a quick and confidential way to get immediate support during the times when they might need it the most.

How does it work?

Call [redacted] and ask to leave a message for Dr. Mark Levine. Dr. Levine will contact you to arrange an appointment with a psychiatrist who is ready and willing to see our clinicians when the need arises.

For assistance please call 1-[redacted]

Joy of Work

FAQ's:

Is this a free service?

No, but all psychiatrists are covered through your Medical Group insurance. You would be responsible for your applicable co-pay/deductible based on your plan design.

Is the psychiatry group part of Sutter or Sutter EAP?

No. Psychiatrists from several private practice groups are participating in this program.

How is this different than EAP?

We have a vibrant EAP that already provides great access to therapy services but doesn't include psychiatry. We've partnered with a psychiatry group to provide expedited access to our clinicians.

Will I need to be seen in person?

The plan is for most clinicians accessing the program to be seen virtually for the clinician's convenience and also given distance and COVID considerations.

Is this for our patients, or for us clinicians?

Fast Access is for our clinicians in Sutter-affiliated medical groups and IPA's. Please don't direct your patients to the above number, unless they are a clinician (physician or APC) in one the groups or IPA's.

Is this for emergency psychiatric services?

No, for emergent psychiatric needs please go to an ER or call 911.

Free and Confidential Resources

Physician Support line: 1-888-409-0141
Suicide Prevention lifeline: 1-800-273-8255 (TALK)
Crisis text line: text TALK to 741741
CMA's 24-hour Physicians Confidential Assistance Line: 1-213-383-2691
Front Line Workers Counseling Project: fwcp.org
Peer Coaching from the CMA: https://www.cmadocs.org/wellness/care4caregivers or 1-800-241-2466

Free and Confidential Resources available to our Medical Staff (all Physicians and APCs at SMCS)

EAP: 1-800-477-2258 or www.sutterhealth.org/eap.
Well Being Committee: 916 887-1294
Peer Support: 916-887-1294 or email PeerSupportSMCS@sutterhealth.org

Next surveys September and October…
19-20 months into COVID Pandemic

Thank You…. Questions/Comments

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Relationship between gender and sacrifices made for career among early career pediatricians

Presenter Name: Sarah Webber
Institution: University of Wisconsin School of Medicine & Public Health; Email: sawebber@wisc.edu

Sarah Webber, MD; Bobbi J Byrne, MD; Amy J Starmer, MD, MPH; Chloe A Somberg, BA; Mary Pat Frintner, MSPH

DEPARTMENT OF Pediatrics
UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE AND PUBLIC HEALTH

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Disclosure

Sarah Webber has documented no financial relationships to disclose or Conflicts of Interest (COI) to resolve.

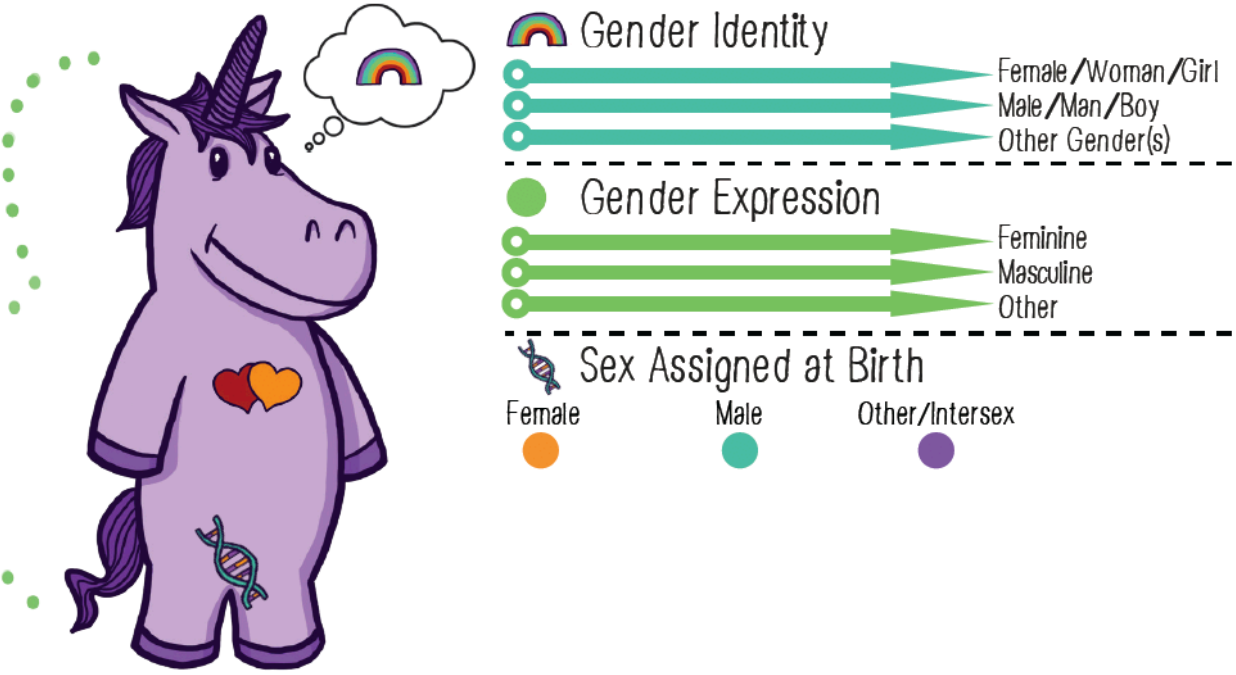
Background

- There is growing awareness of the intersection of equity and physician well-being
- Studies suggest that **gender and sex identities** are of particular importance:
  - Women physicians reported more problems with work-life integration (Tawfik et al 2021)
  - Female pediatricians experienced a more significant increase in burnout prevalence compared to men from 2012-2016 (21%-39% % vs 18%-26%) (Cull et al 2018)
  - Among early career pediatricians, female pediatricians reported lower career satisfaction (Starmer et al 2016)

TERMINOLOGY

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



arn more, go to:
.transstudent.org/gender

gn by Landyn Pan and Anna Moore

Much of the physician workforce research has used sex and gender interchangeably and as a binary.

Discussion of data and studies to date is limited by this.

Today, I aim to use inclusive language when able.

Women will be used as a gender term that includes everyone who identifies as such (may include cis or trans gender women)

What is driving these sex and gender inequities?

Women in Medicine – evidence to date

Burnout

- Gendered expectations by patients (women expected to spend more time and have better communication skills compared to male colleagues

Professional fulfillment

- Values mis-alignment, particularly in academic medicine
- Experience of discrimination and bias
- Invisible work
- Minority tax

Work-life intersection

- More household work
- Primary physical experience of pregnancy and childbearing
- Lower pay (fewer resources to outsource work)
- More likely to delay childbearing

Women in Medicine – evidence to date

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Work-life intersection

- More household work
- **Primary physical experience of pregnancy and childbearing**
- Lower pay (fewer resources to outsource work)
- **More likely to delay childbearing**

Whether these trends exist in pediatrics, and to what extent they are related to personal and professional well-being, is unknown

Study purpose

1) Examine personal and work characteristics of early career pediatricians by self-identified sex
2) Describe **personal sacrifices** pediatricians made related to **partnering and parenthood**
3) Explore **relationships between sex, married/partnered, and parenthood and sacrifices made for career and whether career impacted starting a family**
4) Examine relationships of such sacrifices with career satisfaction.

Methods – Data Collection

A program of the American Academy of Pediatrics

- Ongoing longitudinal study of pediatrician cohorts
- Participants are surveyed 2 times a year:
  - Longitudinal survey
  - **Pulse survey (topic selected by participants)**

- 2016-2018 residency graduates cohort (Early Career Pediatricians)
- 2019 Fall Pulse Survey
- Subset of Likert-scale questions asking about personal sacrifices made for career

Methods - Variables

- **Predictors:**
  - Self-assigned **sex** (Female, Male or Self-describe)
  - **Married/partnered** status
    - Married, civil union, or living with partner
    - Never married or not living with partner, divorced, separated, widowed
  - **Parenthood** status (Children vs No children)

Methods - Data Analysis

Chi-squared tests analyzed **sex**, **partnered** and **parenthood** differences in responses to:

QUESTION	COMPARISON
"To what extent have you made sacrifices in your personal or family life for the sake of your career?"	A lot VS Some and None
"My career has been worth the sacrifices I made in order to become a physician"	Strongly agree and Agree VS Disagree and Strongly agree

Methods - Data Analysis (Subgroups)

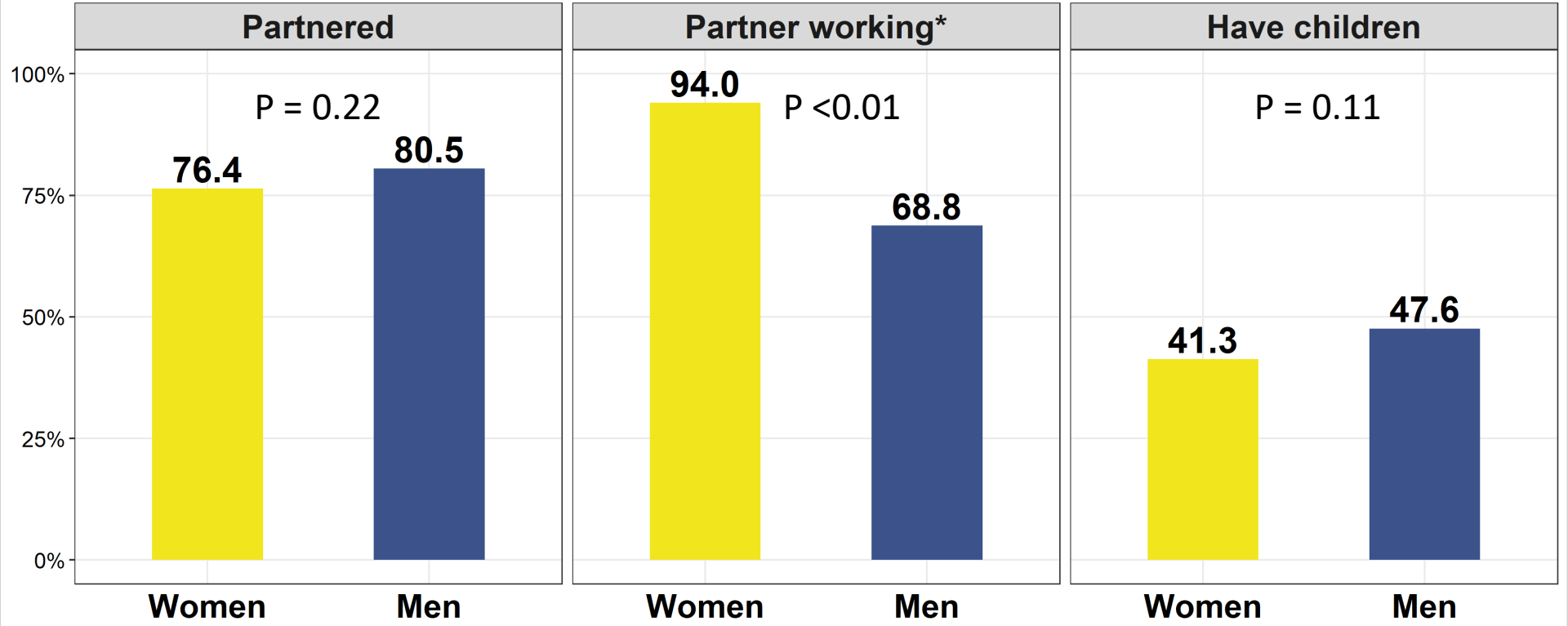
Chi-squared tests analyzed **sex** differences in responses to:

SUBGROUP	QUESTION	COMPARISON
Parents	"Did you delay starting a family because of you training or job responsibilities?"	Yes VS no
	"To what extent have you made sacrifices in the following areas of your life for your career?"	
No children	Whether or not to have children	A lot VS Some and None
No partner	Finding a partner	

Results

- 90% of the cohort participated in survey (830/918)
- Mean age = 33 years
- 75% female (n=620), 25% male (n=210)
- 77% partnered
- 43% had children
- 33% in fellowship training

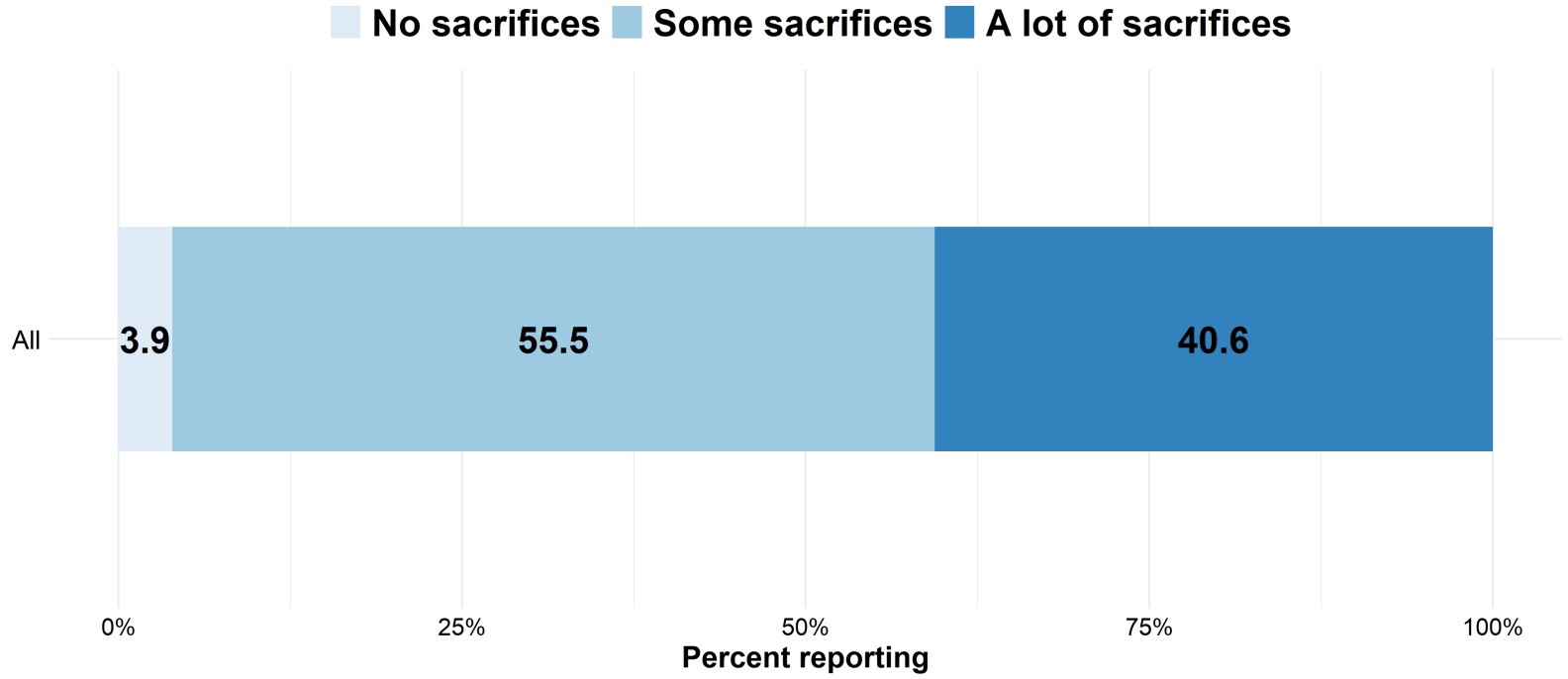
Demographic characteristics of early career pediatricians by gender: Percent reporting



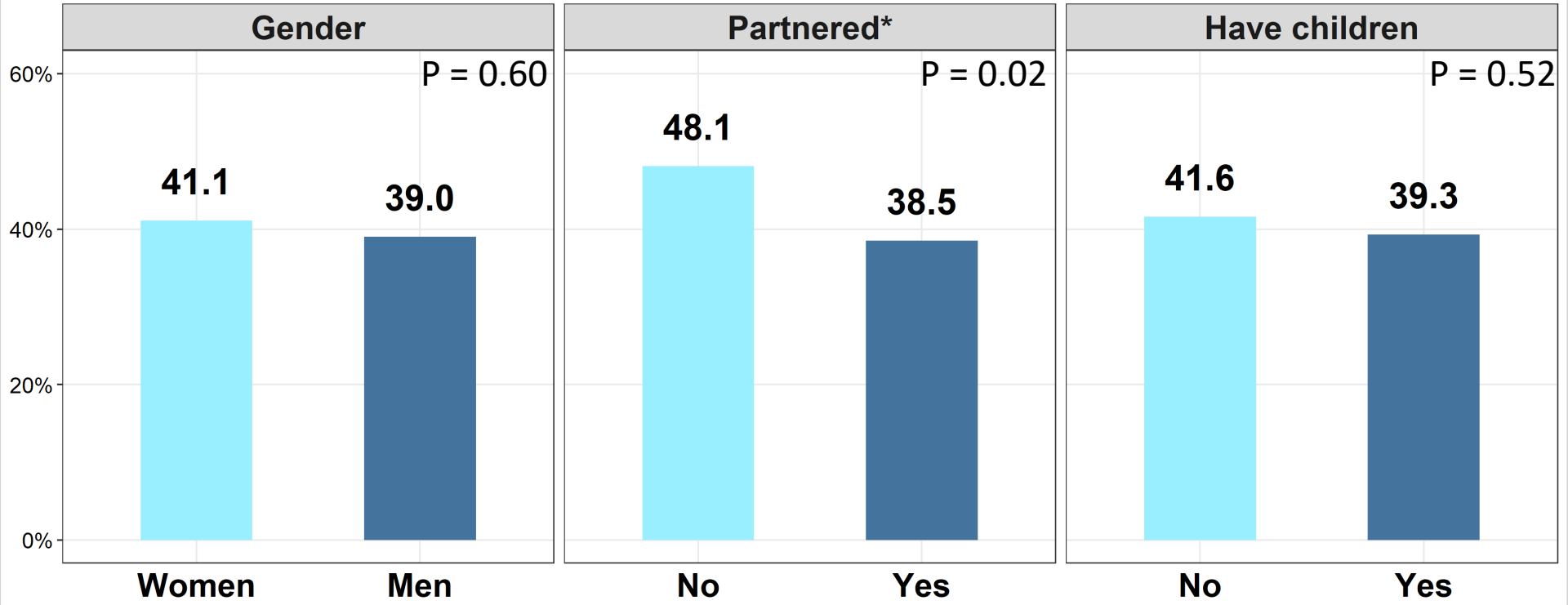
Source: AAP Pediatrician Life and Career Experience Study (PLACES);2016-2018 Residency Graduates Cohort, 2019 data (n=830)
*Among pediatricians with partners; p<0.001

Men were more likely than women to be in fellowship training and work more than 50 hours/week. There were no gender differences in work setting or area

To what extent have you made sacrifices in your personal life for your career?

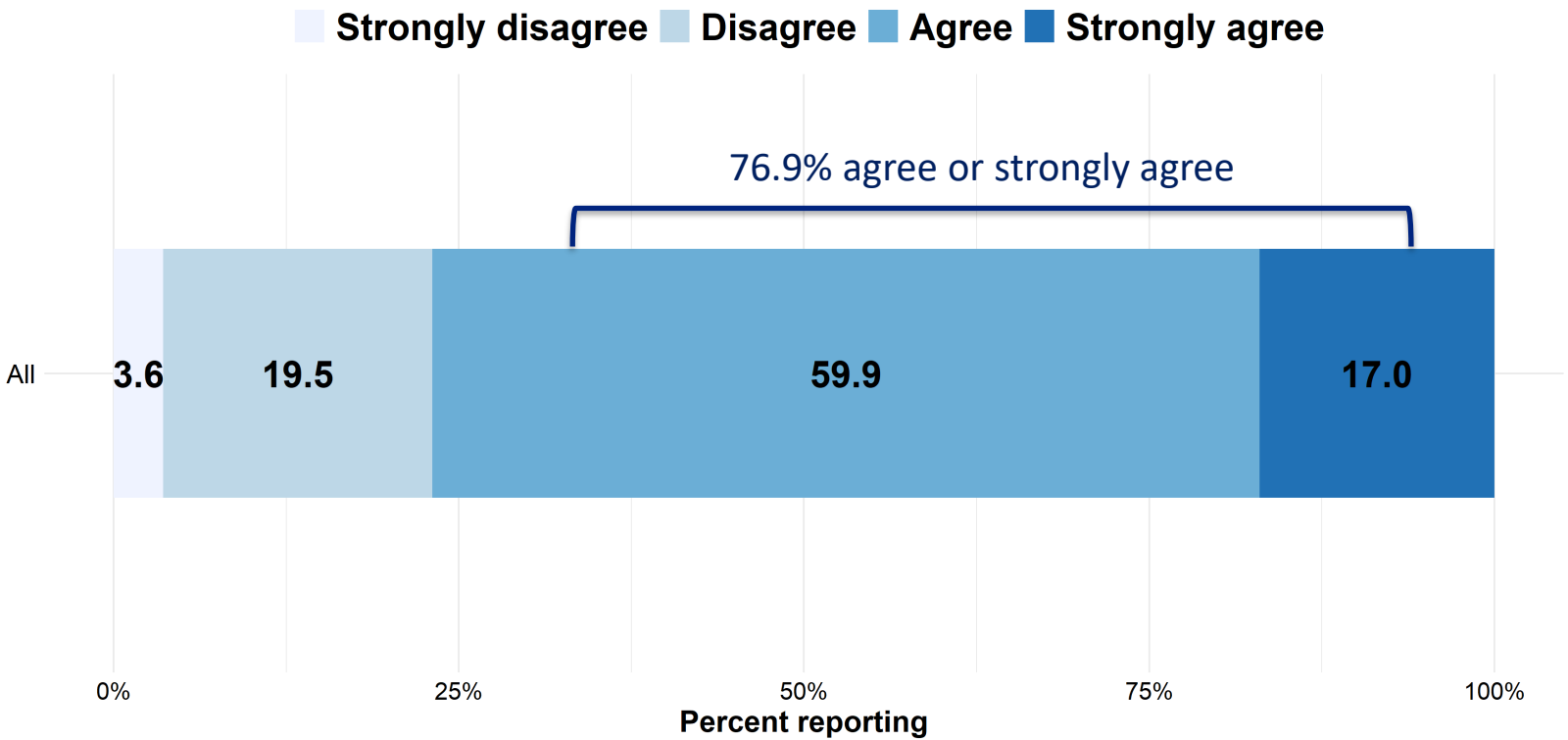


To what extent have you made sacrifices in your personal life for career? Percent reporting 'A lot'

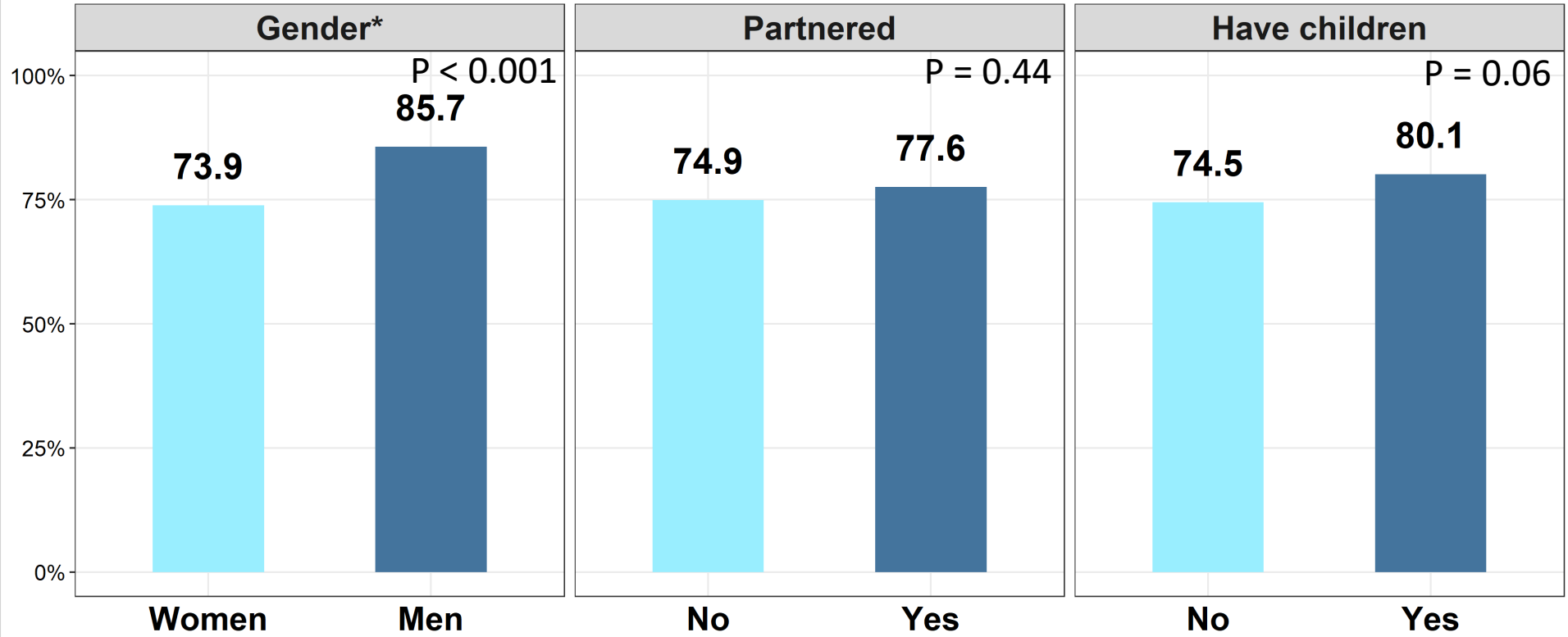


Source: AAP Pediatrician Life and Career Experience Study (PLACES) 2016-2018 Residency Graduates Cohort, 2019 data; *p<0.05

My career has been worth the sacrifices made to become a physician

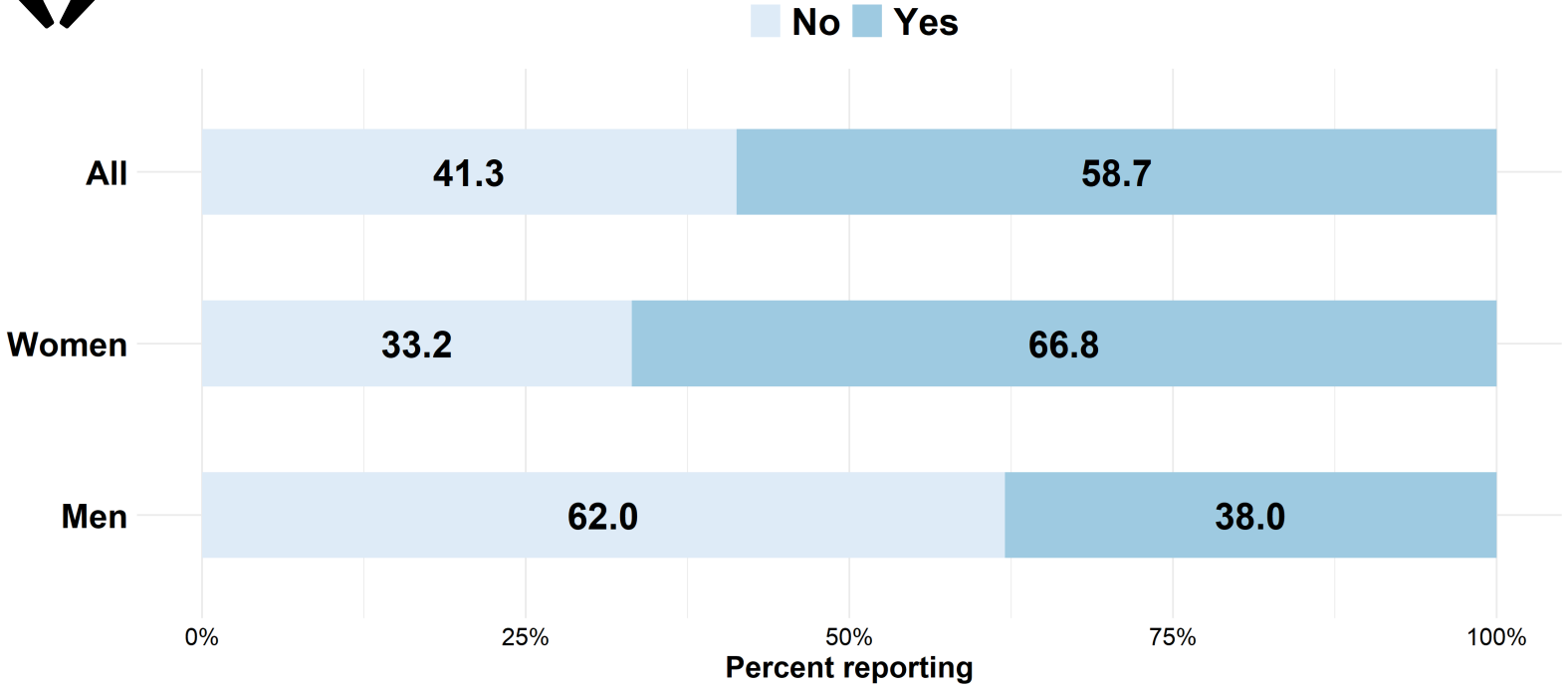


My career has been worth the sacrifices to become a physician: Percent reporting 'Strongly Agree' or 'Agree'



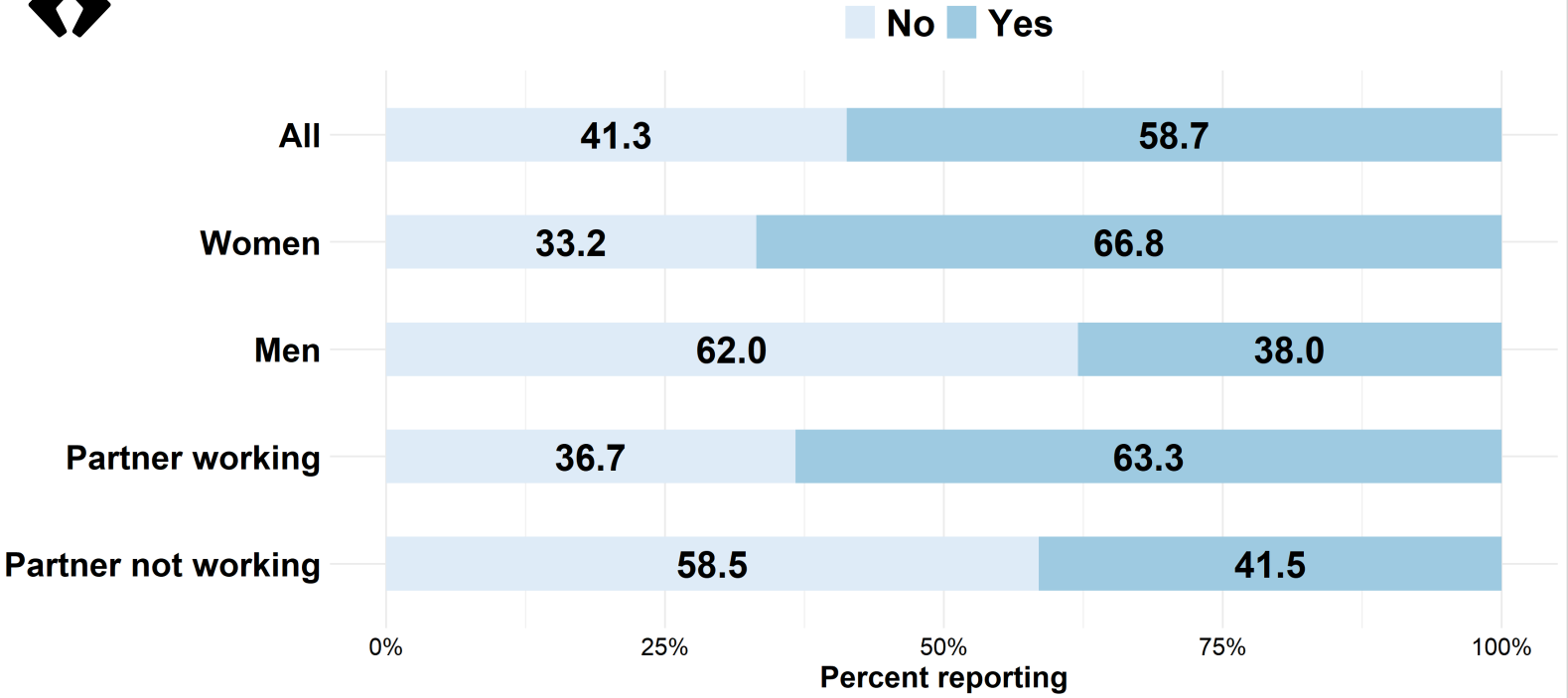
Source: AAP Pediatrician Life and Career Experience Study (PLACES); 2016-2018 Residency Graduates Cohort, 2019 data. *p<0.001

Among early career pediatricians with children...Did you delay starting a family because of your training or job responsibilities?



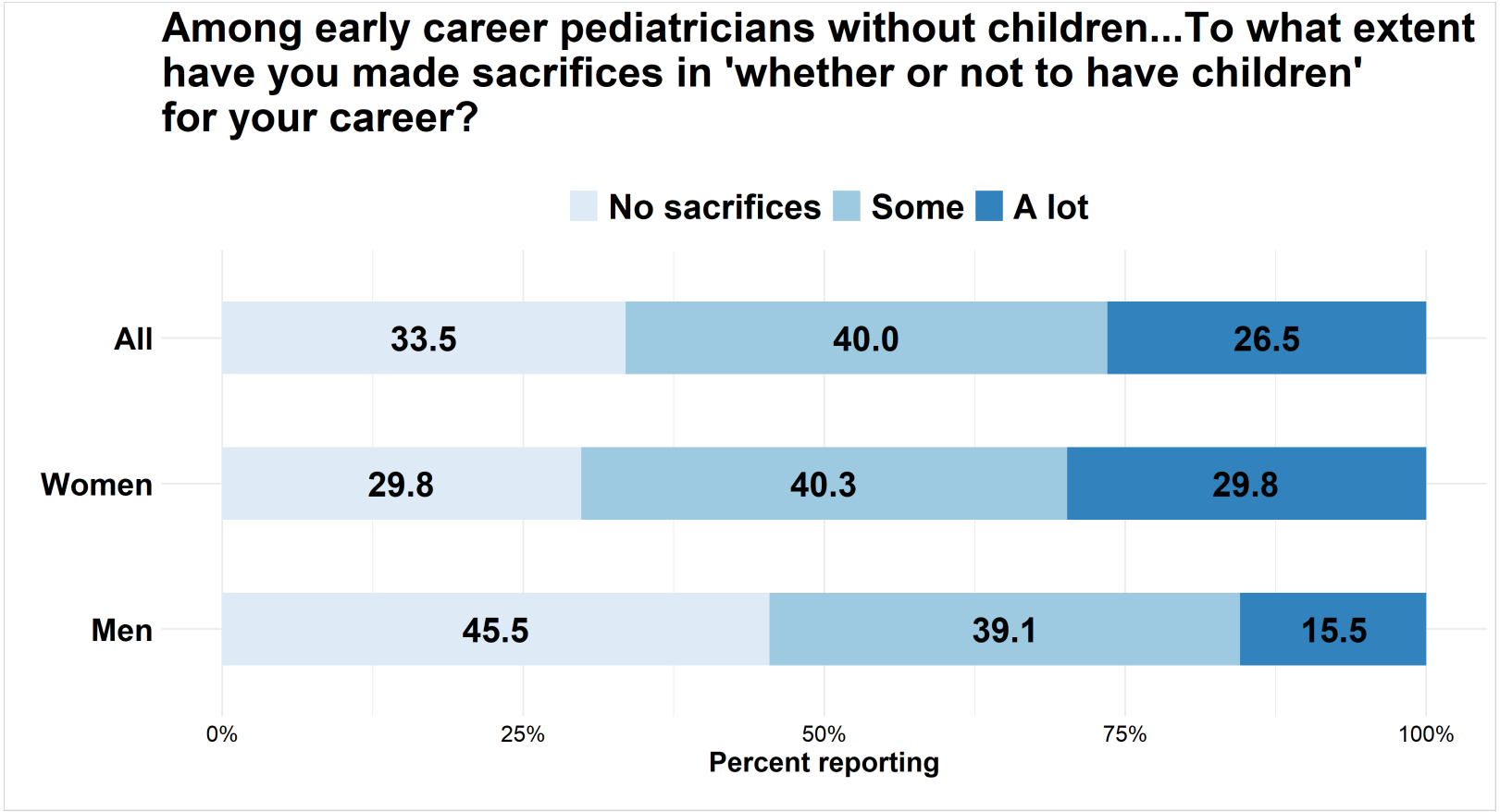
Women were more likely to report "Yes"
$p < 0.001$

Among early career pediatricians with children...Did you delay starting a family because of your training or job responsibilities?



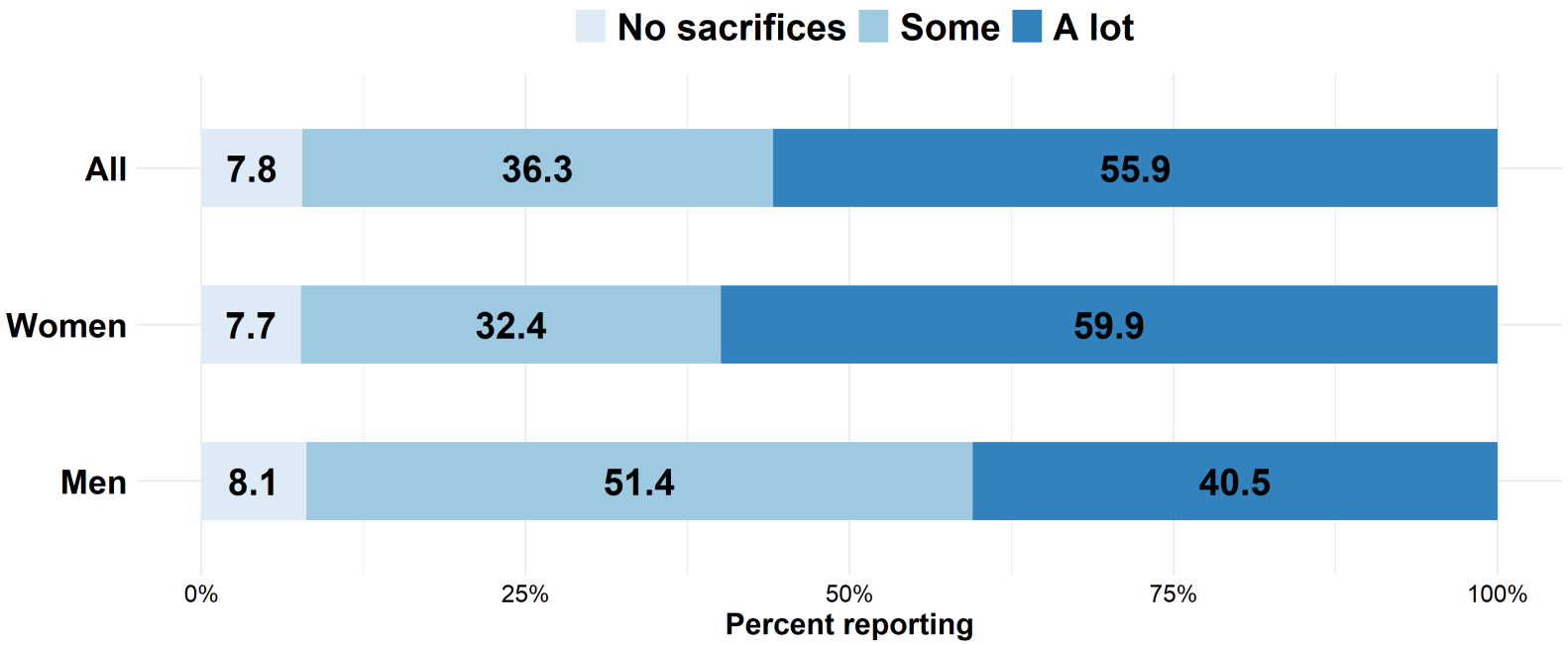
Women were more likely to report "Yes" $p < 0.001$

Partner working were more likely to report "Yes" $p < 0.01$



Women were more likely to report “A lot” $p < 0.01$

Among early career pediatricians without partners...To what extent have you made sacrifices in 'finding a spouse, partner or significant other' for your career?



Women were more likely to report “A lot” p =0.04

Summary

- More than half (58.7%) of pediatricians with children delayed starting a family due to work or training responsibilities. Women > men
- Compared to men, **women pediatricians** without children were more likely to report making sacrifices related to whether to have children due to career.
- **Single pediatricians** were more likely to report “a lot” of personal sacrifices made for career. **Single women** more often reported they made sacrifices in finding a spouse or partner for their career compared to single men.
- While 76.9% of participants felt their career was worth the personal sacrifices, almost a quarter (23.1%) did not. **Women** more likely not feel their career was worth the sacrifices compared to men.

Why is this important?

Limitations

- Data not adjusted for other variables
- Longitudinal data or follow up studies are needed to understand how perception of sacrifices made in early career and training relate to professional and life satisfaction over the long term and likelihood of leaving medicine
- Study may underestimate regrets regarding deferment of having children given young age of cohort (mean=33)

Discussion

- Women perceive more sacrifices related to partnership and childbearing
  - Women face a finite number of reproductive years
  - Previous studies have shown women are less likely to perceive institutions as “family friendly”
  - Women physicians more likely to have full time working spouses

- System changes like paid parental leave may improve gender disparities in personal sacrifices made for career

- Future work should better understand the personal sacrifices unique to women early career physicians and investigate interventions to support personal life and family planning during training and early career

Acknowledgements

PLACES is supported by:

The American Academy of Pediatrics

Thanks to the PLACES Project Advisory Committee and to all the PLACES participants!

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Relationship between gender and sacrifices made for career among early career pediatricians

Presenter Name: Sarah Webber
Institution: University of Wisconsin School of Medicine & Public Health; Email: sawebber@wisc.edu

Sarah Webber, MD; Bobbi J Byrne, MD; Amy J Starmer, MD, MPH; Chloe A Somberg, BA; Mary Pat Frintner, MSPH

Pediatric Academic Societies Annual Meeting, May 1, 2021

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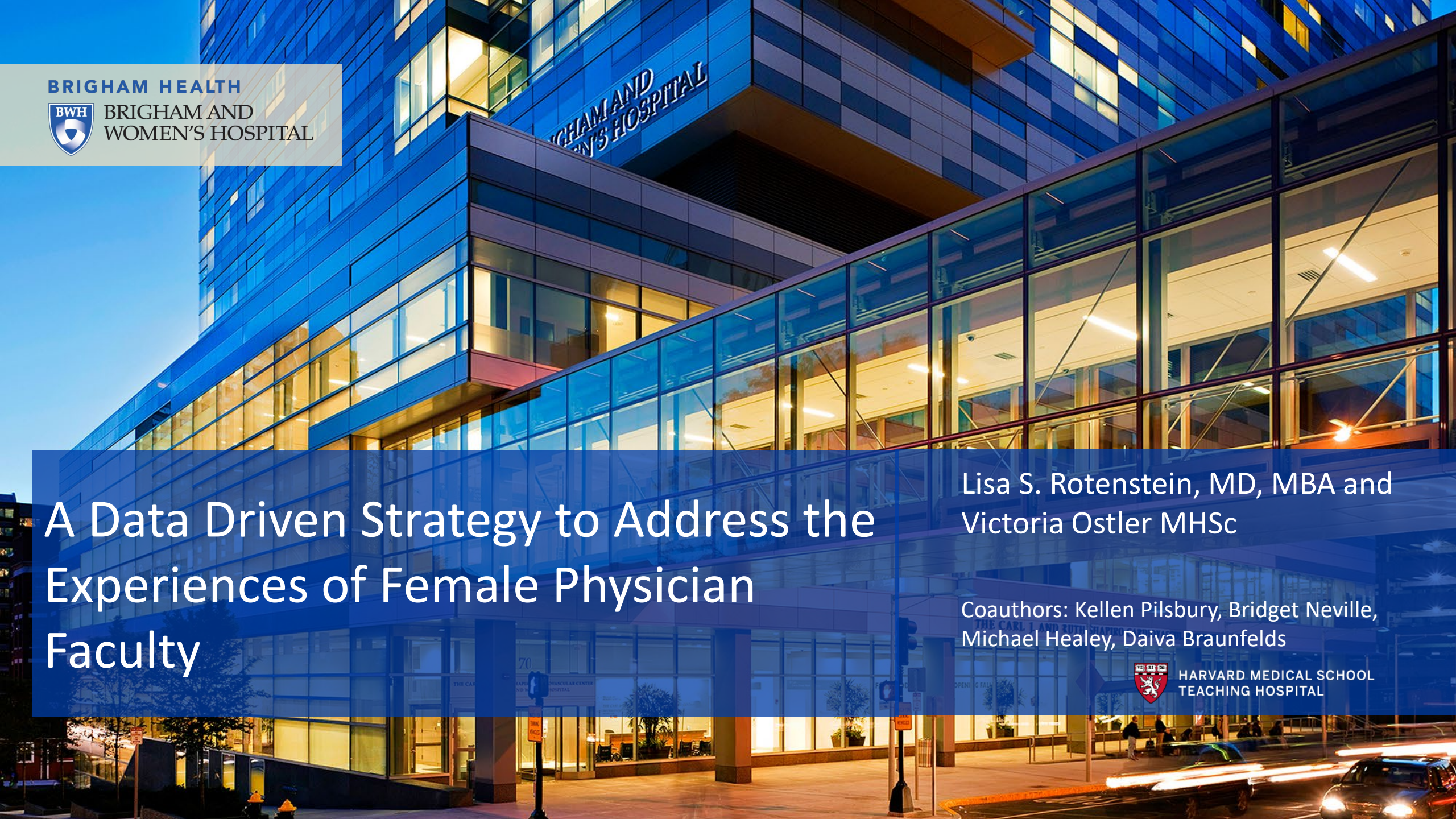


BRIGHAM HEALTH

BRIGHAM AND WOMEN'S HOSPITAL

A Data Driven Strategy to Address the Experiences of Female Physician Faculty

Lisa S. Rotenstein, MD, MBA and Victoria Ostler MHSc

Coauthors: Kellen Pilsbury, Bridget Neville, Michael Healey, Daiva Braunfelds

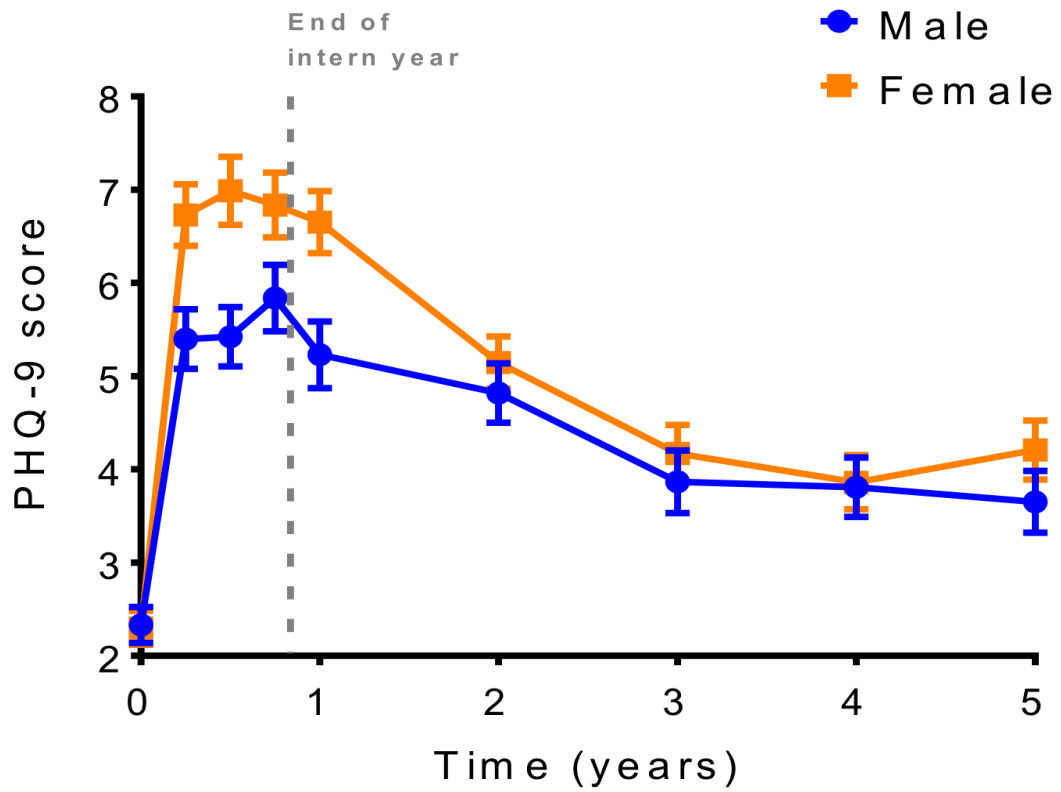
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Background

- Burnout is a critical issue affecting modern physicians.
- It has negative effects on healthcare practice and workforce availability.
- Female physicians have significantly different experiences in the workforce than male physicians.

Source: Guille et al. JAMA Intern Med. 2017;177(12):1766-1772.

Gender differences in work-family conflict



Source: Guille et al. JAMA Intern Med. 2017;177(12):1766-1772.

Gender differences in time on the EHR

Table 2. Adjusted Association of Female Sex With EHR Use Metrics[a]

EHR use metrics	All physicians (N = 997)		Surgical specialty (n = 305)		Medical specialty (n = 692)	
	Female sex, % change (95% CI)	*P* value	Female sex, % change (95% CI)	*P* value	Female sex, % change (95% CI)	*P* value
Minutes in system per day on unscheduled days	47 (34-60)	<.001	36 (17-59)	<.001	39 (26-55)	<.001
Minutes in system per day outside of scheduled hours	48 (33-65)	<.001	39 (15-68)	<.001	43 (26-62)	<.001
Minutes in system per day outside of 7 AM to 7 PM	61 (43-81)	<.001	35 (16-94)	.002	47 (30-66)	<.001
Total minutes in system per day	33 (24-42)	<.001	41 (24-61)	<.001	21 (13-31)	<.001

Abbreviation: EHR, electronic health record.

[a] Separate models were fit with each EHR use metric as an outcome, and a log-transformation was applied to each outcome during modeling. Each coefficient has been exponentiated and is represented as percentage change of the outcome variable associated with female vs male sex. All models are adjusted for the following covariates: years since completion of training, mean number of problems on patient problem list, and percentage of days with appointments.

Source: Tait et al. JAMA IM. 2021;181(2):288-290.

Salary differences among dept chairs

Table 2. Sensitivity Analyses on Salary by Sex

Sensitivity Analysis	No. of Chairs	Sex Difference in Salary [M-F] (95% CI), $	*P* Value	F Cents per M Dollar (95% CI), $[a]	*P* Value
All individuals[b]	514	67 517.05 (13 474.29 to 121 560.80)[c]	.02	0.87 (0.71 to 1.03)	.12
Excluding potentially erroneous salaries[b]	214	119 072.50 (49 427.39 to 188 717.70)[c]	<.01	0.76 (0.58 to 0.95)[c]	.02
Adjustment for publications and NIH grants[d]	257	63 632.25 (2757.13 to 124 507.40)[c]	.04	0.85 (0.72 to 0.98)[c]	.03
Adjustment for publications, NIH grants, and state salary database[e]	257	47 230.82 (−11 969.39 to 106 431)	.11	0.88 (0.76 to 1.00)[c]	.045

Source: Mensah et al. JAMA IM. 2020;180(5):789-792

Gender differences in harassment & bias

Table 1. Self-reported Experiences of Gender Bias, Advantage, and Sexual Harassment of K08 and K23 Career Development Awardees

	Reporting, No. (%) [95% CI]		Estimate Difference, % (95% CI)	
	Women (n = 493)	Men (n = 573)	Women vs Men	*P* Value[a]
Respondents who perceived gender-specific bias in the academic environment[b]	343 (69.6) [65.3-73.6]	125 (21.8) [18.5-25.4]	48.0 (42.7-53.3)	<.001
Respondents who reported they personally experienced gender bias in professional advancement[c]	327 (66.3) [62.0-70.5]	56 (9.8) [7.5-12.5]	57.0 (52.1-61.8)	<.001
Respondents who reported they personally experienced gender advantage in professional advancement[d]	129 (26.2) [22.3-30.3]	118 (20.6) [17.4-24.1]	5.6 (0.5-10.8)	.08
Respondents who reported they personally experienced harassment[e]	150 (30.4) [26.4-34.7]	24 (4.2) [2.7-6.2]	26.5 (22.1-30.9)	<.001

[a] *P* value adjusting for specialty, race (majority vs minority), and years in faculty position.

[b] This item asked, "Do you perceive any gender-specific biases or obstacles to the career success or satisfaction of faculty by gender in your work environment (ranging from 1 [no, never] to 5 [yes, frequently])?" Responses of 3, 4, and 5 were considered affirmative.

[c] This item asked, "In your professional career, have you ever been left out of opportunities for professional advancement based on gender (1, yes; 2, probably; 3, possibly; 4, probably not; 5, no)?" Responses of 1, 2, and 3 were considered affirmative.

[d] This item asked, "In your professional career, have you had increased opportunities for professional advancement based on gender (1, yes; 2, probably; 3, possibly; 4, probably not; 5, no)?" Responses of 1, 2, and 3 were considered affirmative.

[e] This item asked, "In your professional career, have you encountered unwanted sexual comments, attention, or advances by a superior or colleague (yes or no)?" Responses of "yes" were considered affirmative.

Source: Jagsi et al. JAMA. 2016;315(19):2120-2121.

Aims

- To characterize rates of burnout and professional fulfillment among female physician faculty.
- To characterize domains in which the experiences of female faculty differ from those of male faculty.
- To develop and evaluate targeted programming.

Methods

- In Summer 2019, we administered an adaptation of the Stanford Physician Wellness Survey to all clinical faculty at Brigham and Women's Hospital.

- Brigham and Women's Hospital is an academic medical center affiliated with Harvard Medical School.

Methods

- The Physician Wellness Survey includes:
  - Validated measures of:
    - Burnout
      - A combination of emotional exhaustion and interpersonal disengagement
    - Professional fulfillment
      - Measure of satisfaction and meaning at work

Methods

Assessment of culture of wellness, personal resilience, practice efficiency factors

Methods

- Chi-squared tests were used to compare burnout and professional fulfillment rates by gender.

- T-tests were used to compare ratings of culture of wellness, personal resilience, and efficiency of practice factors.

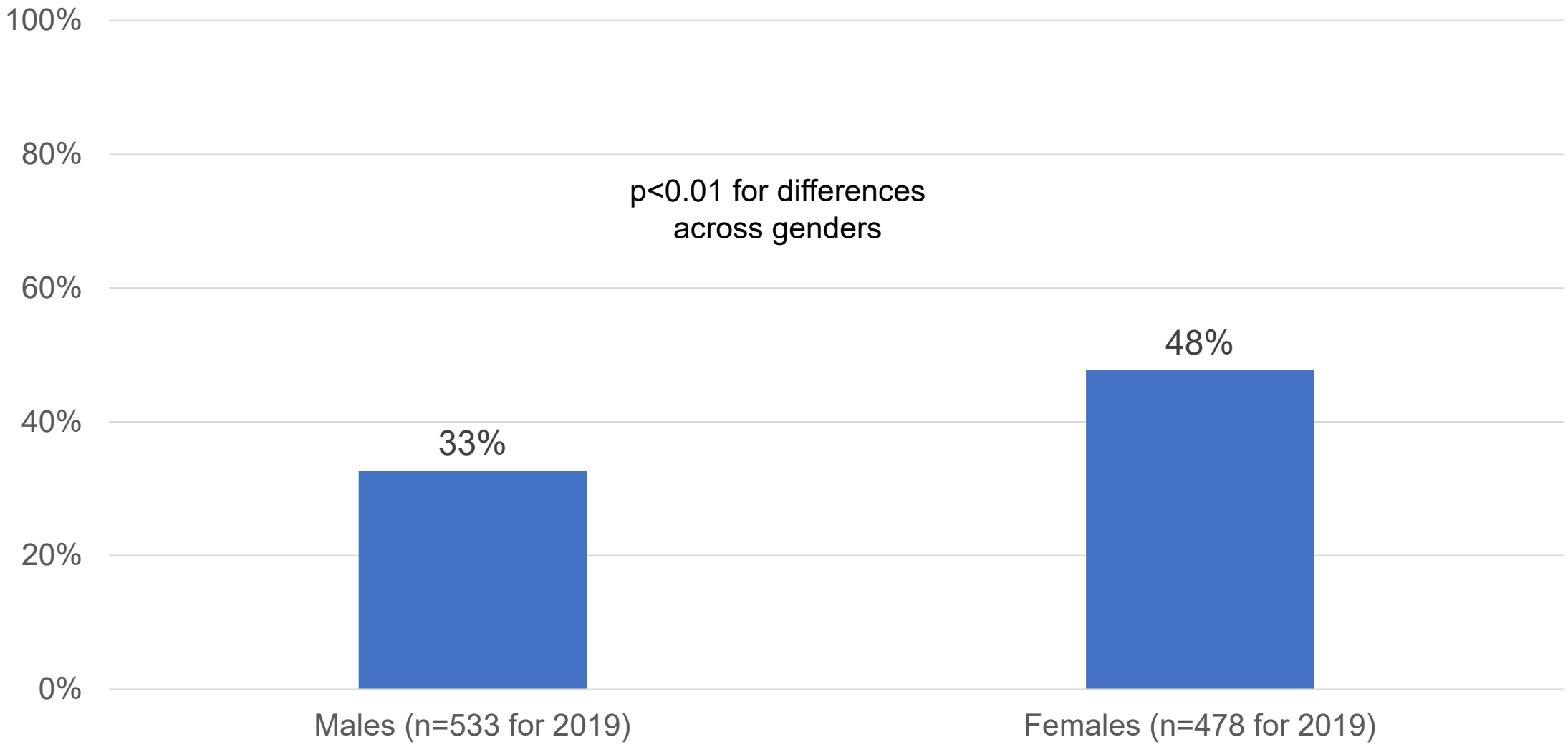
Methods

- Based on these and prior survey findings, we launched five coaching programs for female faculty.
- Participants were surveyed about program perceptions post-participation.
- We have additionally developed programming to address other drivers relevant to female faculty.

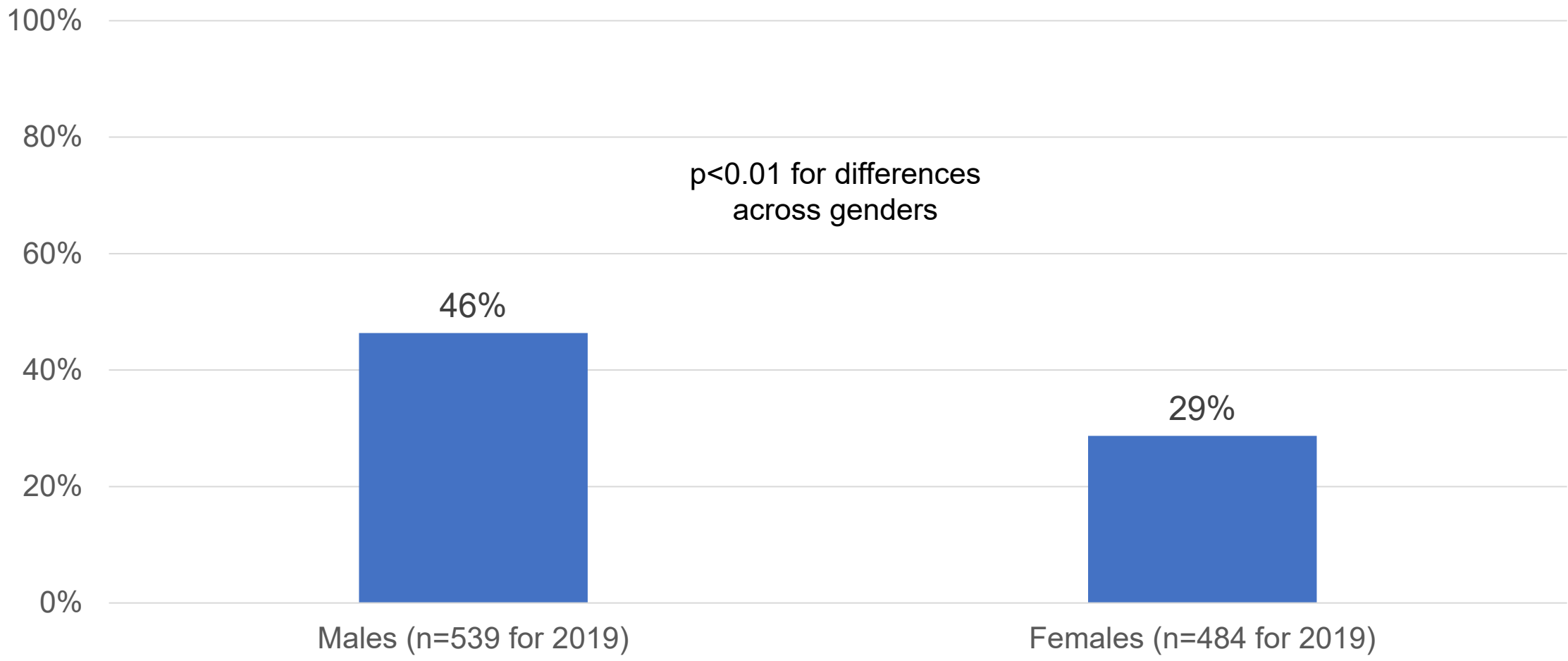
Results

- Overall sample consisted of:
  - n = 1,070 physician respondents (50% response rate)
  - 44.7% female faculty and 55.3% male faculty

Burnout Rates by Gender



Professional Fulfillment Rates by Gender



Gender Differences in Contributors

Domain/Question
Self-compassion (all domains)
Organizational leadership (both chair and direct supervisor)
Negative effect on personal relationships
Feeling like contributing professionally at work (e.g., patient care, teaching, research, and leadership)

Gender Differences in Contributors

Domain/Question	Area of Opportunity
Self-compassion (all domains)	Coaching programs
Organizational leadership (both chair and direct supervisor)	Department-level mentorship & sponsorship programs
Negative effect on personal relationships	Facilitating work-life integration (coverage systems, In Basket support)
Feeling like contributing professionally at work (e.g., patient care, teaching, research, and leadership)	Highlighting & facilitating paths to advancement Celebrating clinical work

Female Faculty Coaching Programs

In 2019-20 we launched 5 Female Faculty Coaching Programs with 135 participants

Offering	Program Focus/Description	Target Participants	Participants
Valor	Individual leadership development and performance	Early-mid level career	40
Clearly Organized	Use of technology and time management	All career levels with high clinical load	54
Peak Performance	Peer support and individual coaching	Early-mid level career	23
Great on the Job	Group networking and peer development	Mid-senior level career that hold a leadership position	20
Coaches Collaborative	Improving communication and conflict management, building team leadership skills, developing resilience, and enhancing professional satisfaction	All career levels	18

Coaching Programs Participant Survey Highlights

Coaching programs were of high value to participants
76% would participate in a future coaching program

Program/Coach

79% thought the coaching programs were relevant to their career

74% thought their coach was skilled

61% thought the programs met their expectation

Impact

63% found the coaching programs improved their professional goals and personal development

70% found the coaching programs improved their personal wellbeing

Ongoing Initiatives

- Female Faculty Network
- Professional Development Offerings
- Department Specific Initiatives – BWell Grants
- Job Doability Initiatives
- Awards Programs
- Mentorship & Sponsorship Initiatives

Female Faculty Network

- Monthly sessions focused on specific career interests
  - Dual purpose of highlighting success female faculty and creating community
  - Sessions thus far have included:
    - How to Be an Ally for Female Faculty
    - Clinical Excellence
    - Clinical Research
    - Healthcare Administration

Professional Development

- Offered to all faculty, but many have substantial relevance to female faculty
  - Taking ownership of your career
  - Leading with emotional intelligence
  - Email management
  - Time management

Department Specific Initiatives

- Our BWell MD Grant Program facilitates local innovation. Projects of particular relevance to female faculty:
  - Administrative support for academic tasks relevant to scholarship and promotion
  - Peer mentoring programs & digital mentorship platform
  - Academic coaches for promotion
  - New parents coaching
  - Think tank about flexible working for hospital-based specialties
  - Female faculty book club

Awards Programs

- The Brigham and Women's Physicians Organization's Pillar Awards recognize physicians who excel in teaching, mentorship, clinical care, and more!

Conclusions

- Female physician faculty have significantly higher burnout rates and lower professional fulfillment rates.

- They have lower ratings of self-compassion, organizational leadership, feelings of professional contribution, and impact of work on personal relationships.

Conclusions

- Targeted programming consisting of coaching, professional development opportunities, and networking opportunities may serve as a starting point for addressing these differences.

- Future work should assess the impact of targeted programming on the wellbeing of female faculty.

Questions and Discussion

No disclosures

Disclosures

No disclosures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BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

Drivers of Burnout and Professional Fulfillment Among Academic Medical Faculty

Lisa S. Rotenstein, MD, MBA and Victoria Ostler MHSc

Coauthors: Anu Gupte, Bridget Neville, Stuart Lipsitz, Daiva Braunfelds, Michael Healey

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Background

- Burnout is a critical issue affecting modern physicians.
- It has negative effects on healthcare practice and workforce availability.

Aims

- We sought to characterize rates of burnout and professional fulfillment at an academic medical center.

- In order to inform potential interventions, we sought to characterize factors associated with burnout & professional fulfillment in our population.

Methods

- In Summer 2019, administered an adaptation of the Stanford Physician Wellness Survey to all clinical faculty at Brigham and Women's Hospital.

- Brigham and Women's Hospital is an academic medical center affiliated with Harvard Medical School.

Methods

- The Stanford Physician Wellness Survey includes:
  - Validated measures of:
    - Burnout
      - A combination of emotional exhaustion and interpersonal disengagement
    - Professional fulfillment
      - Measure of satisfaction and meaning at work

Methods

Assessment of culture of wellness, personal resilience, practice efficiency factors

Methods

- Comparisons of burnout and professional fulfillment rates by gender and academic rank via GEE clustered by department.

- Multivariable linear regression used to explore the relationship between burnout & professional fulfillment scores and culture of wellness, personal resilience, and efficiency of practice factors.

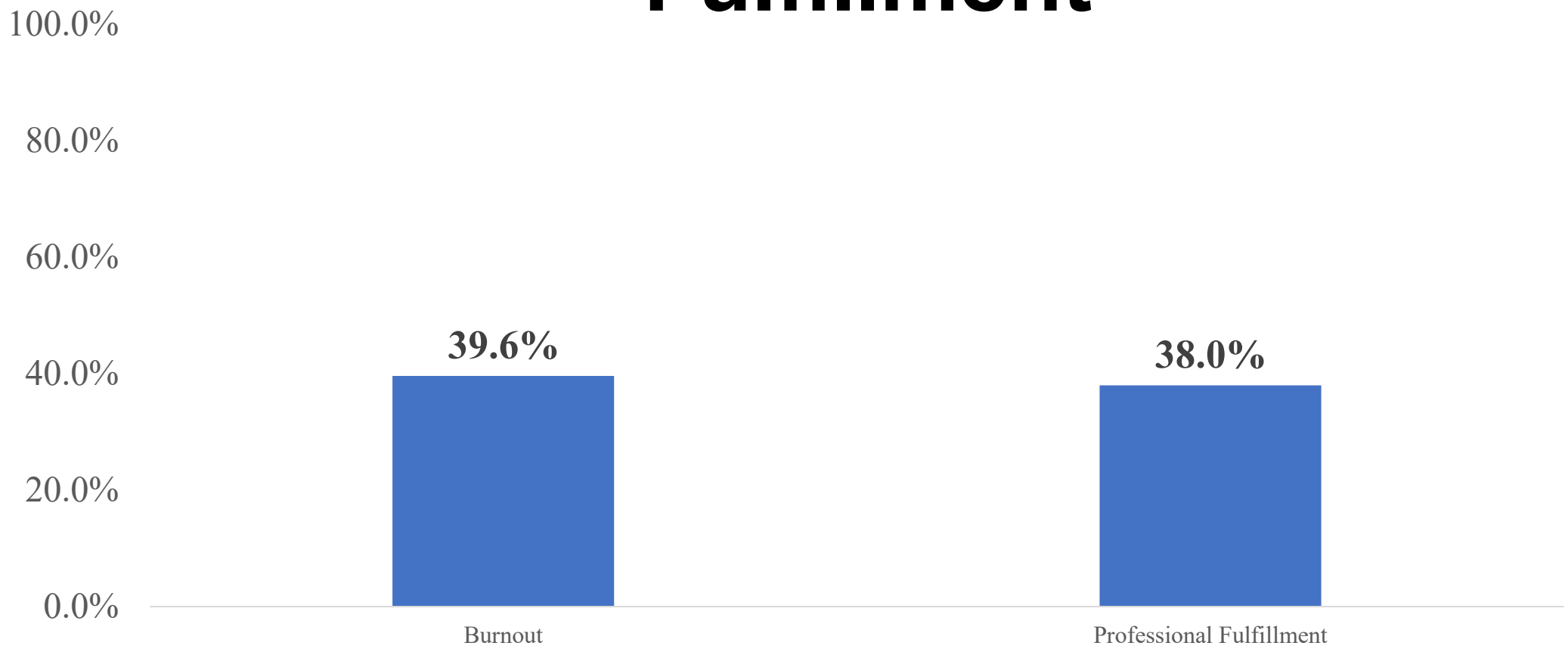
Methods

- We developed targeted programming based on what survey results revealed about the needs of our faculty members.

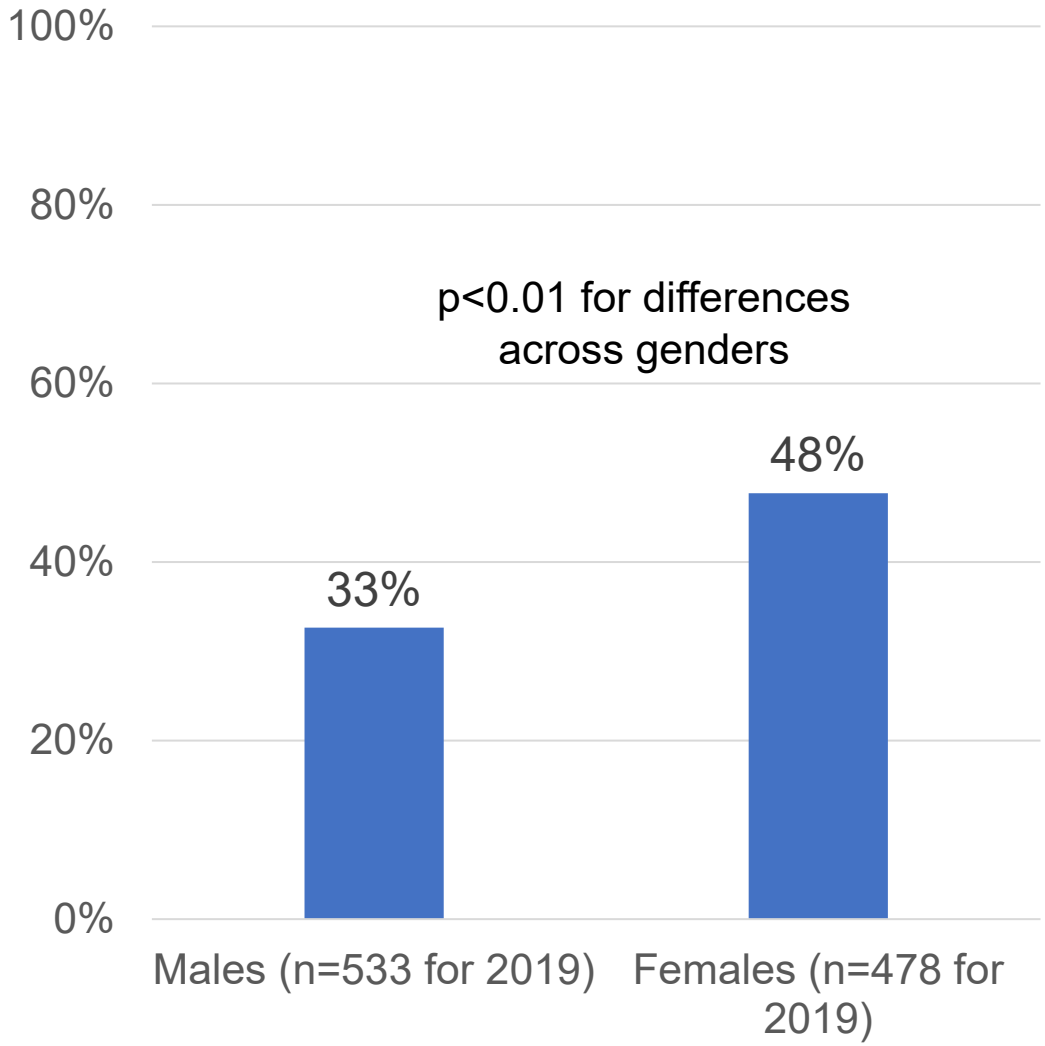
Results

- Sample: n = 1,070 physician respondents (50% response rate)
- Gender: 44.7% female and 55.3% male
- Rank: 36.5% instructors, 27.9% assistant professors, 13.1% associate professors, 10.7% full professors
- Medicine, anesthesiology, radiology most represented departments

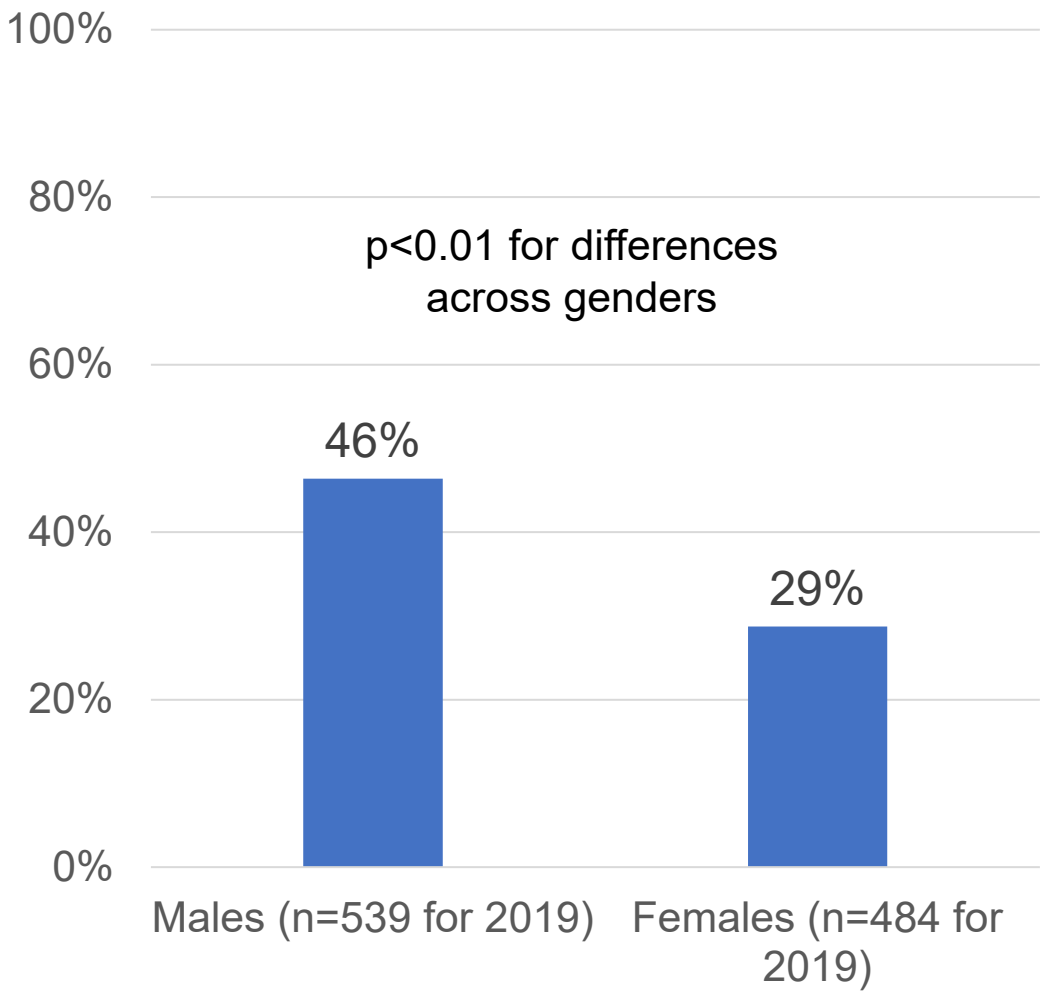
Overall Burnout & Professional Fulfillment



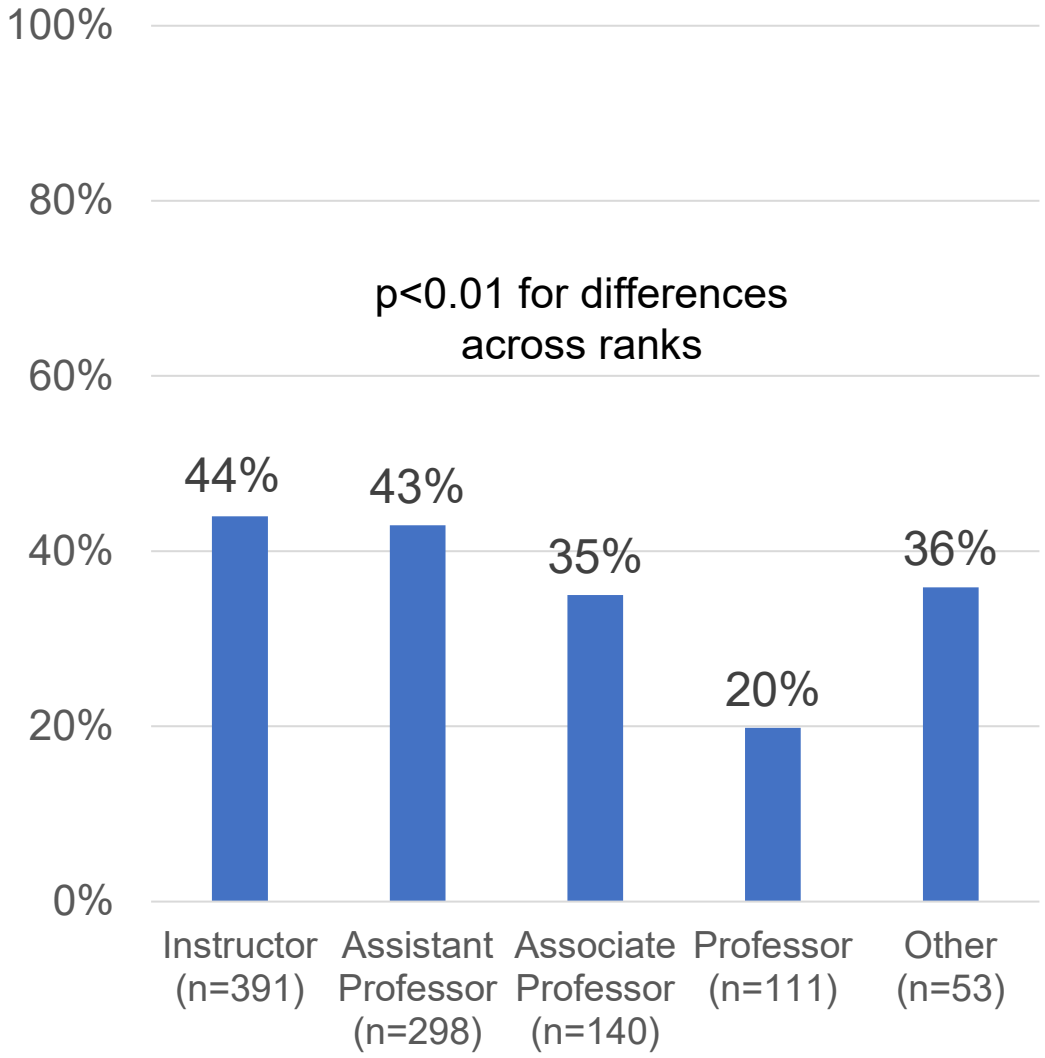
Burnout Rates by Gender



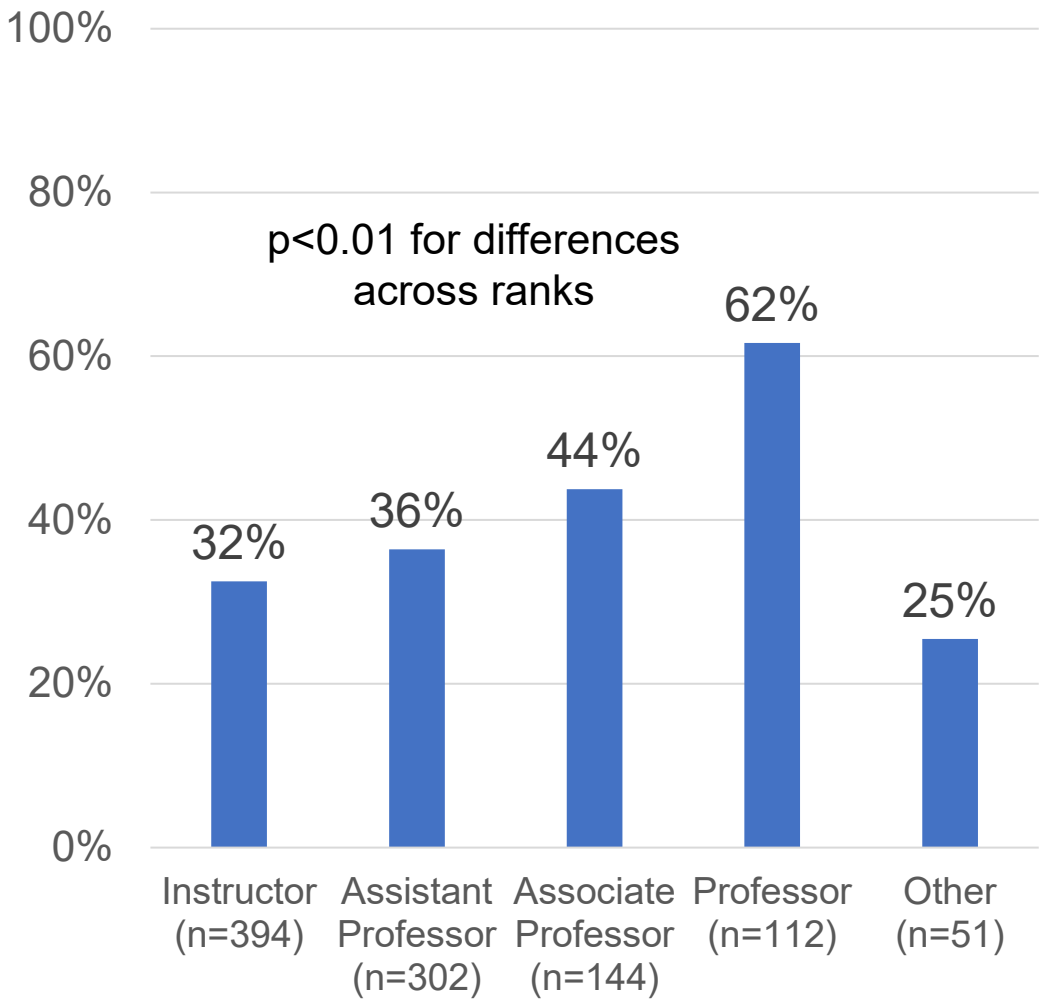
Professional Fulfillment Rates by Gender



Burnout Rates by Rank



Professional Fulfillment Rates by Rank



Predicting Burnout

Variable	*Relative Percent*	*P-value*
Self-Valuation	-8.7%	<0.001
Sleep related Impairment	6.2%	<0.001
Organizational/Personal Values Alignment	-3.5%	<0.001
Perceived Gratitude	-2.8%	<0.001
Organizational Leadership	-1.6%	0.01

*Model controls for age and gender.

Predicting Professional Fulfillment

Variable	*Relative Percent*	*P-value*
Organizational/ Personal Values Alignment	4.3%	<0.001
Sleep related Impairment	-4.3%	<0.001
Perceived Gratitude	3.8%	<0.001
Organizational Leadership	1.3%	<0.001

*Model controls for age and gender.

Supporting Our Faculty to Address Drivers

Perceived Gratitude

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S Physicians Organization

Driver description: Faculty's perceptions over the last 2 weeks of their colleagues appreciating their contributions to the team, things they do for patients and coworkers, and having them as a coworker.

The following survey questions are associated with this driver
My colleagues and coworkers appreciate…
• the work I do for my patients
• my contributions to our team
• things I do for them
• having me as a colleague or coworker

Available internal resources

For questions/suggestions please reach out to BWPOFDW@bwh.harvard.edu

Provider	Programs	Description
BWPO Faculty Development & Wellbeing	Coaching Programs	The aim of the coaching programs is to empower faculty at all stages of career development, and set a path for career growth by enhancing and promoting leadership, professional coaching, time management and peer support.
	The Brigham to Table Program	The goal of the Brigham to Table is to encourage and inspire Brigham Health faculty to connect with one of the most valuable assets of our institution: their colleagues.
	The Brigham Faculty Pillar Awards	Brigham Faculty Pillar Awards are peer recognition awards and are awarded to BWH faculty in recognition of achievement in one, or more, of the five pillars of academic life: Mentorship/Teaching, Education, Research, Community Service, and Diversity & Inclusion.
	BCRISP Project: PRISE	This pilot program in the Dept of Emergency Medicine is a physician driven peer recognition program funded BCRISP and aims to is to leverage social and professional recognition as well as micro incentives to cultivate a culture of collaboration and camaraderie.
Brigham Health	Physician Recognition Awards	Awarded to faculty for their contributions to clinical leadership, innovation, patient care and community service
	Minority Faculty Career Development Award	The BWH Minority Faculty Career Development Award is granted annually to support the development of early-career underrepresented minority academicians.
Mass General Brigham	Employee Recognition & Awards	For details regarding eligibility criteria please check following links • Partners in Excellence (PIE) Awards • Employee Service Recognition (Milestone Years of Service)

Peer initiatives and suggested reading related to perceived gratitude

- MGH Dept of Medicine: Wall of Gratitude
- Taking Care of Our Caregivers
- One Solution to Physician Burnout: Appreciation

Targeted Interventions

Adapted from the Stanford WellMD Professional Fulfillment Model

Addressing EHR Burden	Operational & Workflow Improvement	Local Department Solutions	Culture	Personal Wellbeing	Professional Development

Targeted Interventions

- Wellbeing Conversations
- B-Well Grant Program
- Professional Development Programs
- EHR Optimization Portfolio
- Job Do-Ability Initiatives
- Female Faculty Network

Wellbeing Conversations

- Sleep
- Work-Life Integration
- EHR Optimization
- Perceived Appreciation

Professional Development

Specialized offerings

- Brigham Leadership Program
- Specialized Coaching

By nomination/recommendation, opportunities for mid-to-senior level professional development.

Facilitated peer groups

- Female Faculty
- URM
- Career Phase
- Career Track

Offers interested physicians/faculty with a shared interest targeted sessions, discussion and community.

Professional Development Mini Courses

- Managing Change
- Virtual Workplace
- Time Mgmt
- Diversity Equity & Inclusion

Series of individual offerings, grouped by theme. Take 1, or take all.

Integrate into mini courses to make wellbeing "mainstream"

Individual Coaching

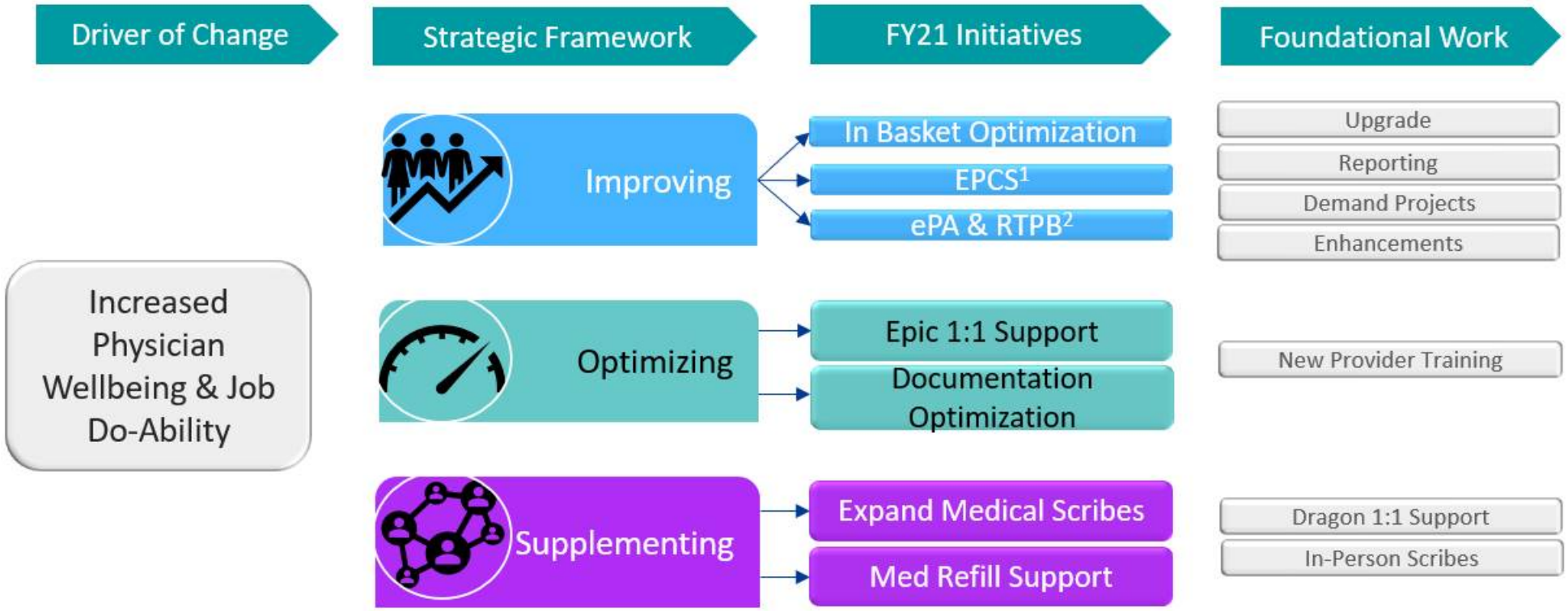
Cohort 3 – Feb/Mar start

Cohort 4 – Sep start

Toolkit to Reduce Burnout

The foundation: Services, resources/referrals, and courses/skill building to support physical, mental & financial health, work-life balance and job doability.

EHR Optimization



1. EPCS: Electronic Prescribing for Controlled Substances
2. ePA: Electronic Prior Authorization; RTPB: Real-Time Pharmacy Benefit

B-Well MD Grant Program

Culture	Organizational work environment, values and behaviors that promote self-care, personal and professional growth, and compassion for ourselves, our colleagues and our patients.
Systems Improvement	Systems and workflows (both IT and non-IT) that contribute to a physician's ability to deliver efficient and effective high quality care.
Personal Wellbeing	Individual skills, behaviors, and attitudes that contribute to physical, emotional, and professional well-being.

Job Doability Initiatives

- Weekend nurse pager coverage

- On the horizon:
  - Job optimization coaching
  - Enhancing virtual care workflows
  - Easing the burden of documentation

Conclusions

- Burnout and professional fulfillment are prevalent among academic medical faculty.
- Prevalence varies with gender and rank.
- Identification of the factors associated with these phenomena can inform targeted interventions to enhance the experiences of academic medical faculty.

Questions and Discussion

Disclosures

No disclosures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Developing an Instrument to Assess Teamwork in Healthcare

Kristine Olson, MD MSc, Chief Wellness Officer, Yale New Haven Hospital

Tait Shanafelt, MD, Chief Wellness Officer, Stanford Medicine, WellMD

Christine Sinsky, MD, VP Professional Satisfaction American Medical Association

Mickey Trockel, MD PhD, Principal, Stanford Medicine, WellMD

Disclosures

- Dr. Shanafelt royalties from Mayo Clinic related to the Well-being Index And Participatory Management Leadership Index, for the book Mayo Clinic Strategies to Reduce Burnout: 12 Actions to Create the Ideal Workplace. Honorarium for speaking/advising.
- Dr. Sinsky is employed by the American Medical Association. The opinions expressed in this article are those of the author(s) and should not be interpreted as American Medical Association policy.

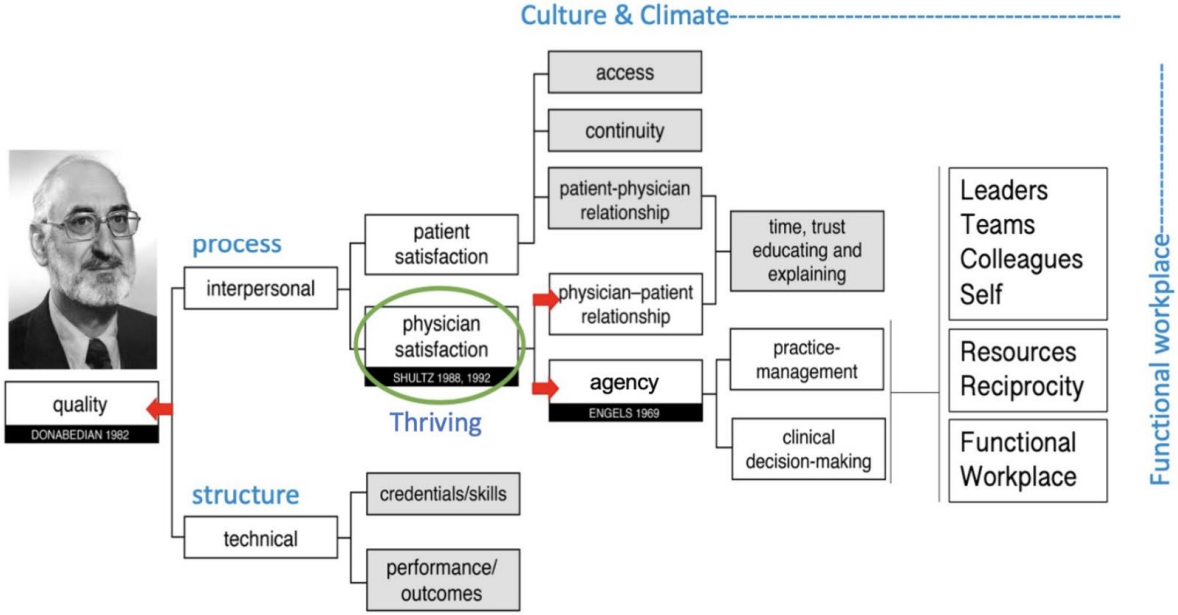
Background

In Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-being, National Academy of Medicine recommended improving interprofessional teamwork to reduce burnout. Previously, in To Err is Human, they attributed 70% of medical errors to faulty communication, coordination, and collaboration. Teamwork has been suggested to be a ”core competency” for healthcare professionals, and it is recognized by the AMA Joy in Medicine Health System Recognition Program. Optimal teamwork may improve clinician well-being and access to a safe high-quality patient experience by high-performing professionals (quadruple aim).

Teamwork research has grown in the last decade as described in multiple recent systematic reviews and meta-analysis in the last few years, with many identifiable gaps in our understanding. Among the gaps are clear definitions of teamwork and differentiation between input, process, output in assessment. Previously we reported ineffective teamwork was associated with burnout, we seek to better understand of what is perceived as “optimal teamwork”.

Nam, 2020 ; IOM 1997; Al Jabri 2019; AMA Joy in Medicine Recognition Program; Maynard 2014; Olson 2017; Olson ACPH 2019; AHRQ SAQ TeamSTEPPS, Lencioni 2002; ; Amoroso, 2021; Etherington, 2021; Horlait, 2021;Kuzovlev, 2021;Lapierre, 2020;Malik, 2020; Marks 2001; Maynard, 2015; Schmutz, 2019;Wooding, 2020; Yaqoob Mohammed Al Jabri, 2021; Olson 2017

PROFESSIONAL FUNCTION AND FULFILLMENT



Donabedian Model updated by Barr 1995, updated by Kristine Olson 2012

Olson K. *Why Physician's Professional Satisfaction Matters to Quality Care.* New York, NY: Department of Medicine, Clinical Epidemiology and Health Services Research., Weill Cornell Medicine, Graduate School of Medical Sciences; 2012.

Culture and Climate

- Leadership
- Collegiality
- Teamwork
- Belonging

Work-place Efficiency

- Hassle Factor (flow)
- Hustle Factor (load and pace)

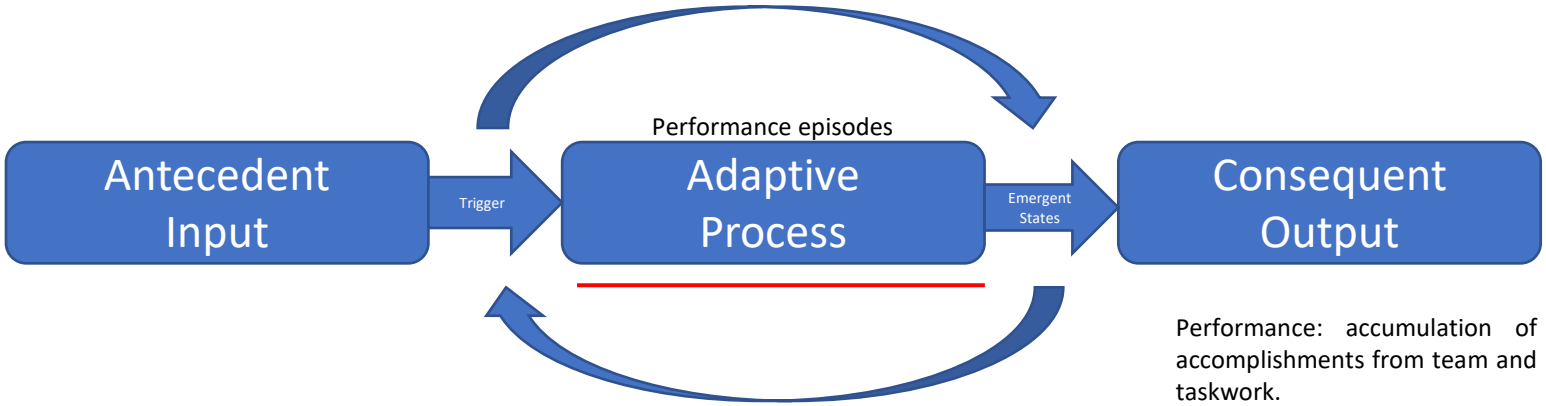
Personal Resiliency

- Work-life Balance
- Job-crafting
- Peer Support
- Resilience and Thriving

Bohman 2017, Olson 2019

Teamwork Process:

>2=people interdependent abilities and resources adapting in performance episodes



Performance: accumulation of accomplishments from team and taskwork.

Adapt-Transition (structure. engage.): mission, goals, roles
Monitor-Action (process. empower.): goals, system, team, coordination (results, accountability)
Manage-Interpersonal (culture. belong & believe): conflict, confidence, cognitive constructs/emotions (trust, commitment)
Emergent states.

Amoroso, 2021; Etherington, 2021; Horlait, 2021; Kuzovlev, 2021; Lapierre, 2020;Malik, 2020; Marks 2001; Maynard, 2015; Schmutz, 2019;Wooding, 2020; Yaqoob Mohammed Al Jabri, 2021

Aims:

1. Toward an instrument to assess teamwork inclusive of important aspects of the adaptive process, and exclusive of other factors such as antecedent inputs and consequent outputs (eg. quadruple aim, patient care), such that the adaptive teamwork process itself could be isolated and studied across disciplines and settings, intervened upon, assessed in combination with instruments specific to other antecedent factors and consequent outputs of organizational culture, structure, process, performance.
2. Understand teamwork factors associated with perceptions of optimal teamwork.
3. Evaluate how teamwork and teamwork factors are associated with professional wellbeing (professional fulfillment and burnout).

Method:

The teamwork instrument was developed to assess the adaptive process of teamwork, informed by the current understanding of the team process, consensus of themes based on existing teamwork scales in healthcare, influenced by Lencioni's model of Five Dysfunctional Teams and SAQ TeamSTEPPs (the predominant scale in healthcare), related themes clustered for brevity, without presumed antecedent input factors or consequential outputs, such that the adaptive process of teamwork itself could be measured independently in models across various settings and disciplines. The 20-items were scored on a 5-pt Likert scale of agreement. Associations tested by Pearson's chi-square and logistic regression (adjusted for age, race, gender, specialty, delivery network). Exploratory factor analysis.

Due to space constraints, a single-item was used to assess "our teamwork is optimal", on a 5pt Likert scale of agreement.

The PFI (Professional Wellbeing Index) was used to assess professional fulfillment and burnout.

Lencioni 2002; AHRQ SAQ TeamSTEPPS; Amoroso, 2021; Etherington, 2021; Horlait, 2021; Kuzovlev, 2021; Lapierre, 2020;Malik, 2020; Marks 2001; Maynard, 2015; Schmutz, 2019;Wooding, 2020; Yaqoob Mohammed Al Jabri, 2021

Engaged:

- Our goals are well-aligned in everything we do.
- Our roles, abilities, and scope of work are clear without assumption.
- Decisions about operations are explicit and information is transparent and clearly communicated.

Empowered:

- We maintain a transparent score card of success for which we share responsibility.
- Everyone maintains situational awareness, anticipates and responds to the needs of others.
- Accountability is clear and upheld fairly.
- Members of the clinical team do their job in a way that makes it easier for me to do mine.
- I do my job in a way that makes it easier for others to do theirs.

Scored on 5-point Likert scale of agreement (strongly disagree → strongly agree)

Belong and Believe:

- Recognition (good and bad) is fairly distributed, without favoritism or politics.
- Conflict resolution is direct without need for venting, triangulating, or being artificial.
- We collaborate rather than compete
- No one is reluctant or holds back in offering to assist
- There is mutual support beyond self-interest or judgement.
- Psychological safety exists to address and learn from honest mistakes.
- Questioning attitudes are welcome and all opinions are respectfully considered.

Scored on 5-point Likert scale of agreement (strongly disagree → strongly agree)

Other:

- We are adequately staffed to function as a team. (antecedent)
- I am involved in setting expectations for the clinical team. (antecedent)
- I am involved in selecting the people on the clinical team. (antecedent)
- I feel supported by the frontline clinical staff (emergent)

Scored on 5-point Likert scale of agreement (strongly disagree → strongly agree)

Results:

September-October 2020
Covid-19 Pandemic
between first and second wave,
during "transformation" to resume operations

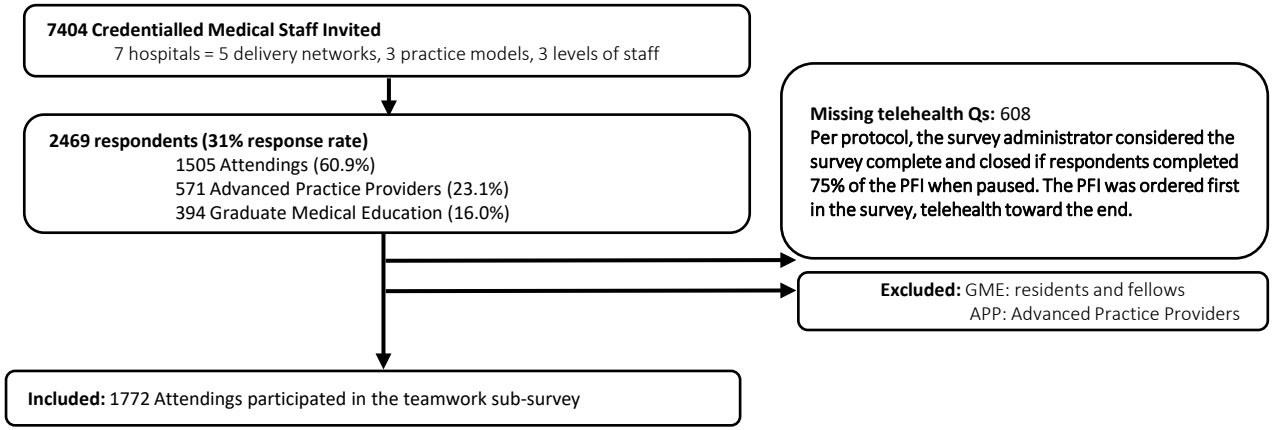


Figure 1: Inclusion Criteria
Of 7414 medical staff invited to participate, 2317 completed the PFI. Of the1910 who completed the teamwork assessment, 1172 were attending physicians who were included in the analysis.

Summary, next slide.

Toward Understanding and Assessing Teamwork in Healthcare

WHAT IS OPTIMAL TEAMWORK. ASSOCIATIONS WITH BURNOUT. (Attending Physicians Only) All factors statistically significant in relation to optimal teamwork and burnout. (p value <0.0001). Orthogonal rotation shows clustering themes, explains 89% variance. Cronbach alpha 0.96. Univariate unadjusted odds ratios.	Responses	Mean (+/-SD)	Optimal Teamwork	Professional Fulfillment	Burnout
				OR	OR
Optimal Teamwork	1172	3.63 (1.11)		1.75 (1.51-2.04)	0.57 (0.50-0.66)
There is mutual support beyond self-interest or judgement.	1165	3.90 (1.00)	7.18 (5.41-9.54)	2.25 (1.87-2.70)	0.50 (0.42-0.59)
Everyone maintains situational awareness, anticipates and responds to the needs of others.	1164	3.66 (1.00)	5.51 (4.32-7.03)	2.24 (1.88-2.67)	0.51 (0.43-0.60)
Our goals are well-aligned in everything we do.	1166	3.66 (1.08)	8.56 (6.58-11.9)	2.16 (1.82-2.55)	0.53 (0.45-0.61)
No one is reluctant or holds back in offering to assist.	1168	3.78 (1.07)	4.68 (3.74-5.85)	1.92 (1.63-2.26)	0.53 (0.46-0.62)
We collaborate rather than compete.	1169	4.06 (0.99)	5.35 (4.16-6.88)	1.92 (1.61-2.29)	0.53 (0.45-0.62)
Our roles, abilities, and scope of work are clear without assumption.	1167	3.63 (1.10)	6.25 (4.85-8.05)	2.05 (1.75-2.41)	0.63 (0.55-0.73)
Questioning attitudes are welcome and all opinions are respectfully considered.	1165	3.77 (1.06)	3.85 (3.12-4.74)	2.28 (1.91-2.72)	0.53 (0.46-0.62)
Psychological safety exists to address and learn from honest mistakes.	1162	3.73 (1.02)	3.57 (2.90-4.41)	2.29 (1.91-2.74)	0.55 (0.46-0.64)
Psychological safety exists to disagree or challenge without fear of backlash, politics, or retribution.	1164	3.60 (1.10)	3.12 (2.59-3.77)	2.23 (1.88-2.64)	0.53 (0.45-0.61)
Conflict resolution is direct without need for venting, triangulating, or being artificial.	1159	3.39 (1.14)	3.23 (2.68-2.89)	2.14 (1.83-2.51)	0.53 (0.45-0.61)
Members of the clinical team do their job in a way that makes it easier for me to do mine.	1159	3.73 (1.06)	4.73 (3.75-5.96)	2.43 (2.03-2.91)	0.53 (0.45-0.62)
I do my job in a way that makes it easier for others to do theirs.	1162	4.16 (0.76)	3.14 (2.47-3.99)	2.21 (1.77-2.76)	0.58 (0.47-0.72)
I feel supported by the frontline clinical staff	1161	3.97 (0.95)	3.86 (3.07-4.85)	2.25 (1.89-2.73)	0.55 (0.47-0.65)
Decisions about operations are explicit and information is transparent and clearly communicated.	1160	3.34 (1.19)	2.69 (2.29-3.16)	1.91 (1.66-2.21)	0.58 (0.51-0.67)
We maintain a transparent score card of success for which we share responsibility.	1144	3.33 (1.11)	2.42 (2.05-2.85)	1.99 (1.70-2.32)	0.62 (0.53-0.71)
Accountability is clear and upheld fairly.	1150	3.48 (1.12)	3.26 (2.71-3.92)	2.25 (1.91-2.65)	0.51 (0.44-0.60)
Recognition (good and bad) is fairly distributed, without favoritism or politics.	1154	3.47 (1.11)	2.84 (2.37-3.39)	2.17 (1.84-2.55)	0.48 (0.41-0.56)
We are adequately staffed to function as a team.	1159	2.97 (1.34)	2.07 (1.81-2.38)	1.76 (1.55-1.99)	0.61 (0.54-0.69)
I am involved in setting expectations for the clinical team.	1156	3.41 (1.24)	1.77 (1.55-2.02)	1.63 (1.43-1.86)	0.62 (0.54-0.70)
I am involved in selecting the people on the clinical team.	1149	2.89 (1.40)	1.49 (1.33-1.68)	1.34 (1.21-1.50)	0.82 (0.73-0.91)

Mean on Likert scale of agreement 1-5. All items statistically related to optimal professional fulfillment, and burnout (Pearson's chi square p<0.001 for all items). Logistic regression adjusted for age, race, gender, specialty, delivery network to establish associations (OR).

Teamwork composite score including factors determined by EFA with Eigenvalues >1, factor loading >0.6 (= loading on to one factor, eliminating "setting expectations", "selecting teammates", "adequate staffing" with factor loading <0.6). 17-items retained. Avg interitem covariance 0.73. Cronbach alpha 0.97 KMO 0.9703

	Responses	Mean (+/-SD)	Professional Fulfillment	Burnout
Teamwork Composite Score (Average, Likert 1-5)	1899	3.64 (0.87)	3.73 (3.09-4.49)	0.31 (0.25-0.36)

	Responses	Mean (+/-SD)	Professional Fulfillment	Burnout
Teamwork Composite Score (Sum Total, 17-85)	1899	61.5 (14.79)	1.08 (1.07-1.09)	0.93 (00.93-0.94)

Optimal Teamwork (single-item)

Interdisciplinary teamwork (with nursing) as assessed by attending physicians, 5pt Likert scale →optimal.
All 20 items were statistically significant in association with optimal teamwork. These had the strongest association.

Engaged:

- Our goals are well-aligned in everything we do. **8.56** (6.58-11.9)
- Our roles, abilities, and scope of work are clear without assumption. **6.25** (4.85-8.05)

Empowered:

- There is mutual support beyond self-interest or judgement. **7.18** (5.41-9.54)
- Everyone maintains situational awareness, anticipates and responds to the needs of others. **5.51** (4.32-7.03)

Belong and Believe:

- We collaborate rather than compete. **5.35** (4.16-6.88)
- No one is reluctant or holds back in offering to assist. **4.68** (3.74-5.85)

Emergent State:

- Members of the clinical team do their job in a way that makes it easier for me to do mine. **4.73** (3.75-5.96)

Professional Fulfillment and Burnout (PFI)

Interdisciplinary teamwork (with nursing) as assessed by attending physicians, 5pt Likert scale (-->optimal).
All 20 items were statistically significant in association with optimal teamwork. These had the strongest associations.

Emergent state:

- Members of the clinical team do their job in a way that makes it **easier for me** to do mine. **2.43** (2.03-2.91)
- I feel **supported** by the frontline clinical staff **2.25** (1.89-2.73)

Empowered: team monitoring

- **Accountability is clear** and upheld **fairly**. **2.25** (1.91-2.65)

Belong and believe: trust, psychological safety

- Psychological safety exists to address and **learn from honest mistakes**. **2.29** (1.91-2.74)
- **Questioning attitudes are welcome** and all opinions are respectfully considered. **2.28** (1.91-2.72)
- There is **mutual support** beyond self-interest or judgement. **2.25** (1.87-2.70)
- Burnout was most associated with **recognition (good and bad) is fairly** distributed without favoritism or politics, **0.48** (0.41-0.56).

Conclusions:

“Optimal teamwork” was most strongly associated with factors related to clear goals and roles, interdependencies, and being fully engaged in the collaboration.

Professional fulfillment was most strongly associated with the likely emergent state of effective teamwork (feeling supported), and a culture of trust and psychological safety to support vulnerability and openness to constantly learn and adapt (fair accountability, learn from mistakes, ability to differ, etc) – belong and believe.

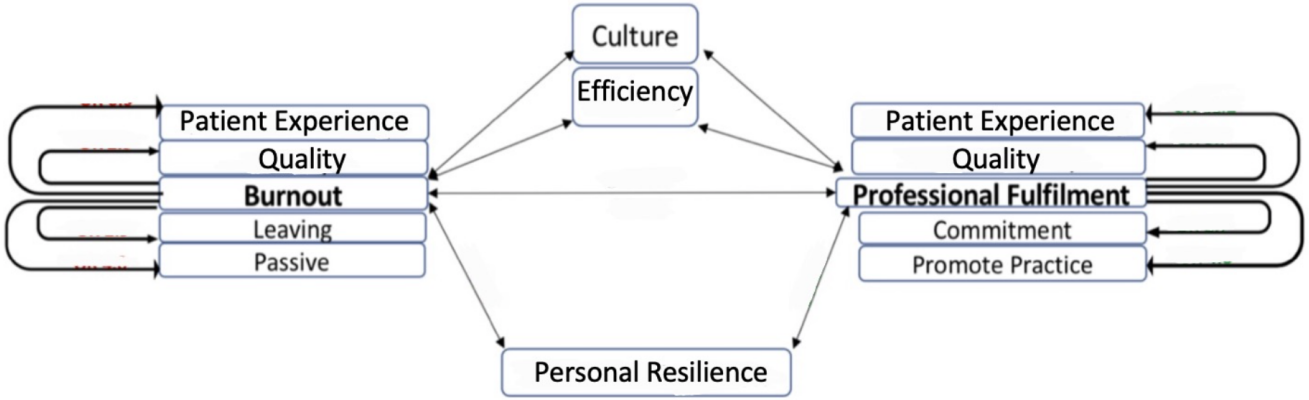
Burnout was most associated with injustice (unfair recognition – good and bad), which was also significantly related to “optimal teamwork” and professional fulfillment.

Discussion: Teamwork Scale Development

Teamwork composite score including factors determined by EFA with Eigenvalues >1, factor loading >0.6 (= loading on to one factor, eliminating ”setting expectations”, “selecting teammates”, ”adequate staffing” with factor loading <0.6). **17-items retained.** Avg interitem covariance 0.73. **Cronbach alpha 0.97**, KMO 0.9703. (Using the 2469 sample.) The composite score of optimal teamwork was significantly associated with well-being (OR: PF 3.73, BO 0.31)

- The 3 items eliminated in exploratory factor analysis are likely antecedent factors rather than factors specifically related to the adaptive process of teamwork (establishing team members, expectations, staffing levels), and reasonable to exclude.
- The factor “I feel supported” is likely an emergent state, indicative of effective teamwork. It may be considered for exclusion. Related, the factors regarding whether I and others do jobs to make it easier for the other may be conceptually redundant with factors of “mutual support” and “situational awareness” to assist one another. These may be considered for exclusion.
- Key concepts that may be lacking include whether all goals are oriented to one overarching ‘mission’, ‘system monitoring’ to ensure resources to support the mission and goals within current realities, optimal ‘coordination’ of resources, ‘managing emotions’ (eg. frustration, exhaustion), and providing ‘confidence/motivation’. These will be considered for further scale development.
- The word “clinical” could be removed so the scale can be used more universally across healthcare settings.

(Scale under-development, expect further refinement before complete.)



Kristine Olson, MD MSc et al.

This model depicts the relationship between culture, practice efficiency, and personal resilience with burnout and professional fulfillment, and between burnout and professional fulfilment, thus the patient experience, high-quality, retention/engagement/cost.[1-3]

1. Bohman B, Dyrbye L, Sinsky C, Linzer M, Olson K, Babbott S, Murphy ML, Purpur deVries P, Hamidi M, Trockel M. Physician well-being: the reciprocity of practice efficiency, culture of wellness, and personal resilience. *NEMJ Catalyst.* 2017;3(4).
2. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med.* 2014;12(6):573-576.
3. Olson K. *Why Physician's Professional Satisfaction Matters to Quality Care.* New York, NY: Department of Medicine, Clinical Epidemiology and Health Services Research., Weill Cornell Medicine, Graduate School of Medical Sciences; 2012.


In these times, the healthcare community heals sharing memories, grief, hopes, dreams.
DIGITAL DISK
数字圆盘
ديسك رقمي
DISCO DIGITAL
Share your stories, memories, and experiences.
Share your story here-->
Shine your light at Yale New Haven Hospital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ACPH 2021

American Conference on Physician Health™

AMA AMERICAN MEDICAL ASSOCIATION

MAYO CLINIC

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No Disclosures

Stumbling upon Wellness

Pearls and Pitfalls when starting a new division Wellness Committee

Joseph Diaz MD and Arthi Balu MD
Co-Directors for Wellness
Division of General Internal Medicine
UC San Diego Health

Who we are

- Joseph Diaz
- Assistant Clinical Professor - 2 yrs
- .75 cFTE (0.25 admin)
- San Diego last 5 yrs
- Surfer dilettante
- Palm Tree Fanatic

- Arthi Balu
- Staff physician and Clinician-Educator - 5 yrs
- 0.875 cFTE (0.125 admin)
- Former teacher

UCSD Division of General Internal Medicine

- 2 clinic sites
- 30 faculty physicians/Total cFTE = ~21
- Additional division members @ VASDH
- Compensation: salaried + value based incentives
- Outpatient care of patients 18+ years old

Workshop Goals

- Share our experience developing a physician Wellness Committee within an academic medical center

- Use our experience to distill the fundamental steps to starting a physician Wellness Committee

- Learn the common pitfalls that can plague new Wellness Committees

- Leave with a strategic plan to start a Wellness Committee appropriate for your clinical practice

Role of the Wellness Committee

"The purpose of a program on well-being is to assess, develop expertise, coordinate and lead the organization's efforts related to engagement and professional fulfillment"

Building a Program on Well-Being: Key Design Considerations to Meet the Unique Needs of Each Organization

Tait Shanafelt, MD, Mickey Trockel, MD, PhD, Jon Ripp, MD, MPH, Mary Lou Murphy, MS, Christy Sandborg, MD, and Bryan Bohman, MD

Reflect - why are you starting a Wellness Committee?

- Moral-ethical case
- Business case
- Regulatory case

Getting Started

- Decide who you are serving
- Our primary focus - **physicians** in our university based academic outpatient practice

Assess Needs

The Patient Health Questionnaire-9 (PHQ-9)

Maslach Burnout Inventory - Human Services Survey (MBI-HSS) for Medical Personnel

Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout

[illegible] D. Shanafelt, MD, and John H. Noseworthy, MD, CEO

Dimension			National benchmarks for US physicians	Comparisons with the general population	Relevant to other health care workers[a]	Shown to correlate with relevant outcomes[b]	Select references
Achievement/professional fulfillment							
• Meaning	Physician Job Satis…			–	No	Yes	20,31,43,51
• Professional satisfaction	Empowerment at Work			–	Yes	–	52,53
Burnout							
• Exhaustion	Maslach Burnout I…				Yes	Yes	7-10,22,39,54,55
• Cynicism	Oldenburg B…				Yes	–	47,56
• Inefficacy							
Engagement							
• Vigor		9				–	57
• Dedication							
• Absorption							
Fatigue							
		9	–				58
		8	–	–			59
		10	–	Yes			60,61
	6	8 or 12 or 36	–	Yes	Yes		62,63
		1-10	–	–	Yes	–	64
		9	Yes[c]			Yes	65-67
		16				–	68

Copenhagen Burnout Inventory

Oldenburg Burnout Inventory

Table 2 …sional Fulfillment Index (PFI) reliability estimates, sensitivity to chang… …ch Burnout Inventory (MBI) sca…

PFI measure	Cronbach's α	Test-retest reliability	Sen…	… detect change …related impairment: …C (95% CI)	Correlation with closest MBI equivalent
Work exhaustion	0.86			0.67 (0.60–0.74)	0.72 (EE)
Interpersonal disengagement	0.92			0.64 (0.57–0.72)	0.59 (DP)
Overall burnout scale	0.92			0.68 (0.62–0.76)	0.71 (EE + DP)
Professional fulfillment	…		.28	0.62 (0.54–0.70)	0.46 (PA)

A Brief Instru… Assess Both Burnout and Professional Fulfillment in P…sicians: Reliability and Validity, Including Correlation with Self-Reported Medical Errors, in a Sam… of Resident and Practicing Physicians

Mickey Trockel[1] · Bryan Bohman[1] · Emi Lesure[2] · Maryam S. Hamidi[1] · Dana Welle[2] · Laura Roberts[1] · Tait Shanafelt[1]

…otional quality of life, and physical quality of life.

Pick One!

AMA
Mini Z
Well-Being Survey

Stanford Professional
Fulfillment Index

Maslach Burnout Inventory - Human Services
Survey (MBI-HSS) for Medical Personnel

Considerations when choosing a survey tool:

- Focus– burnout vs engagement/fulfillment vs mental health
- Validated
- Can compare to national benchmarks
- Anonymous, confidential
- Method of distribution
- Length
- Frequency of administration
- Cost

Solicit Leadership Support

- We organized meetings with key leadership (Chief of Primary Care Operations, Division Chief, Clinical Service Chief)

- Used data from our Wellness Survey to make the case for organizational support

- Be clear on what you need to be successful (time/money)

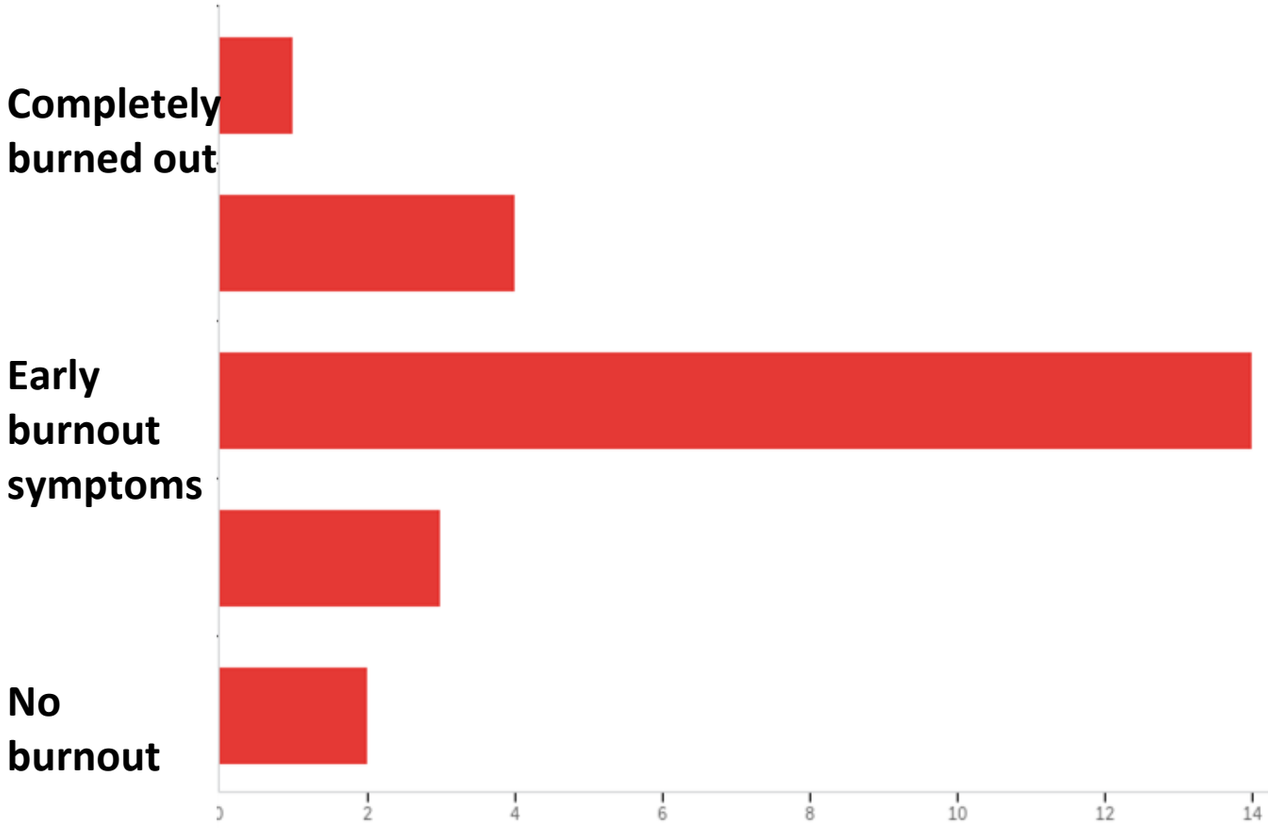
Develop your Team

- We recruited 8-10 physician volunteers to join our Wellness Committee
- Qualities to consider: diverse, engaged, able to commit time and energy

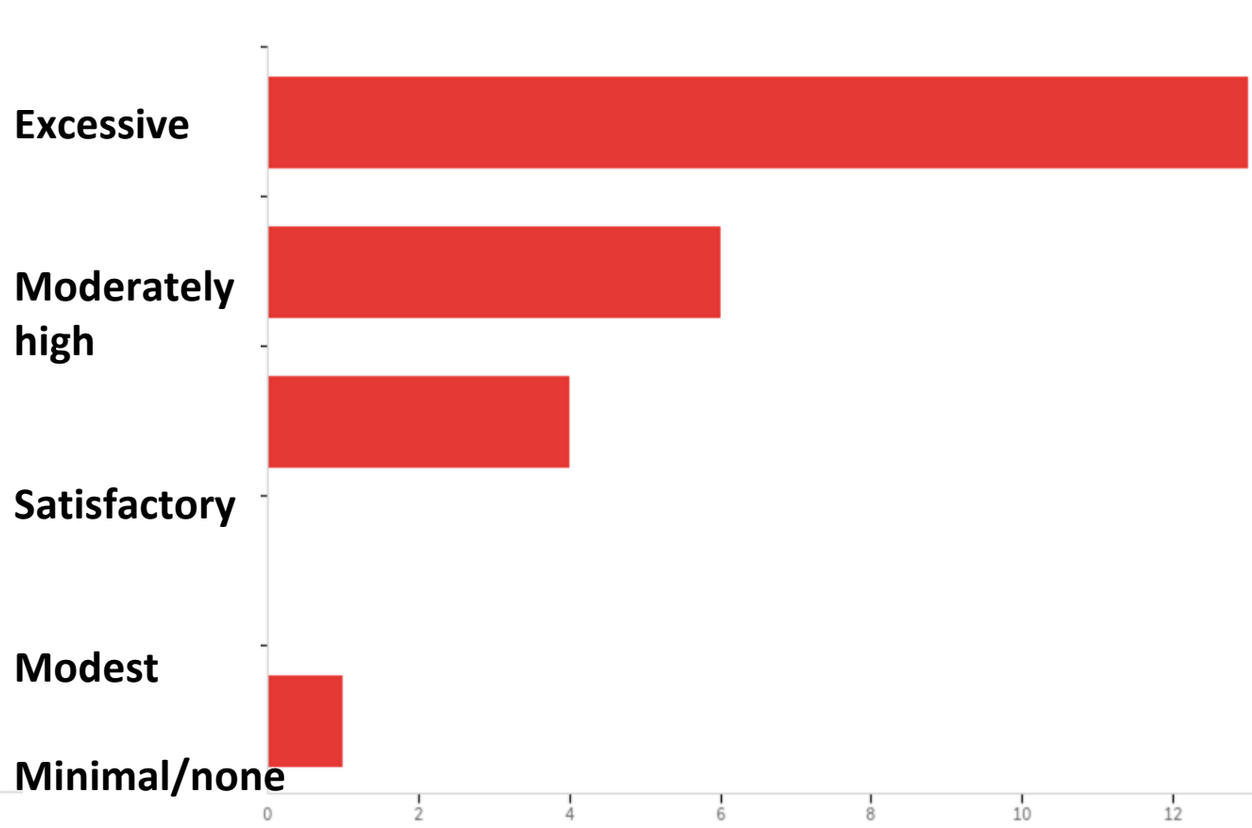
Create a Charter

Review your data!

Using your own definition of “burnout,” please choose one of the numbers below



The amount of time I spend on documentation is



Use your data to inform your priorities

Institutional/Organizational drivers of burn out

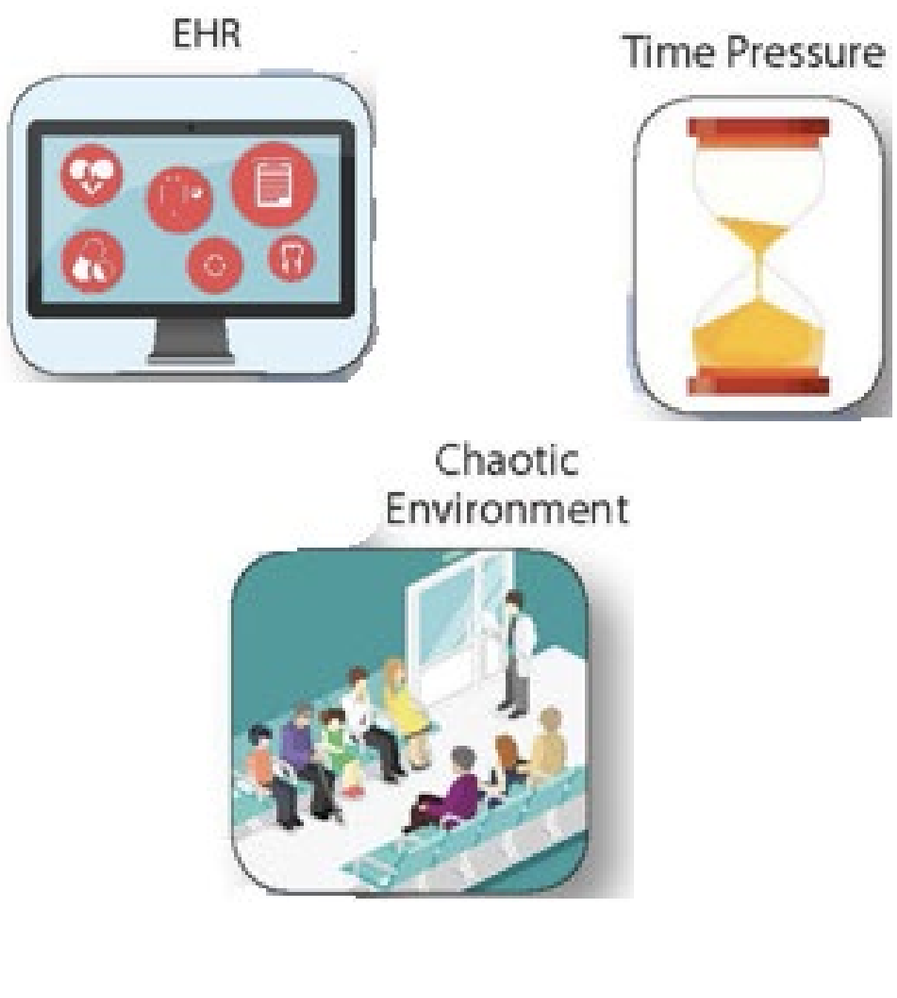


Image courtesy of ahrq.gov

Building Personal Resilience and Community

So what did we do?

- Disseminated Wellness resources
- Created opportunities for socially distanced community building

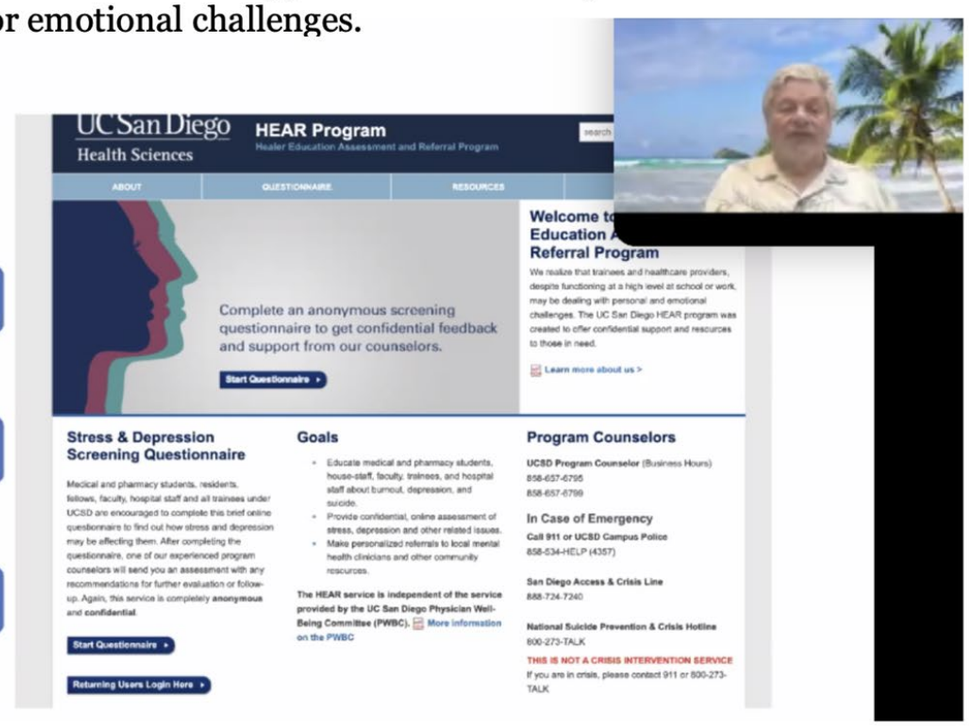
UCSD Hear program provides confidential support for healthcare providers and trainees dealing with personal or emotional challenges.

HEAR
wellbeing@ucsd.edu
https://www.ucsdhear.org

Courtney Sanchez, LCSW
- (858) 657-6795
- cos006@health.ucsd.edu

Rachael Acardi, LMFT
- (858) 657-6799
- raccardi@health.ucsd.edu

Sidney Zisook, MD
- (858) 249-1371
- szisook@health.ucsd.edu



THE EUDAIMONIA

Volume 1 / Issue 1

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PHYSICIAN, HEAL THYSELF

Primary care medicine is tough. From the wide array of clinical scenarios that we see on a daily basis to the hectic schedules, EMR demands, COVID19 uncertainties, late nights documenting, and so on, it is no wonder that our burnout rates are higher than the national average.

We can promote physician wellness with systemic/structural changes or personal/physician-directed changes. Most of us will agree that structural changes are more efficacious in mitigating burnout, and research bears this out. There are many efforts being made to address these systemic issues, such as developing strategies to minimize inbox burdens, but these can be frustratingly slow to come in to effect.

In the meantime, we can also find some relief with self-care to help improve wellness. There are numerous strategies out there, from mindfuln
appropri
Wellness
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Mindfuln
strategy t
see if ther

Physicia
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we can co
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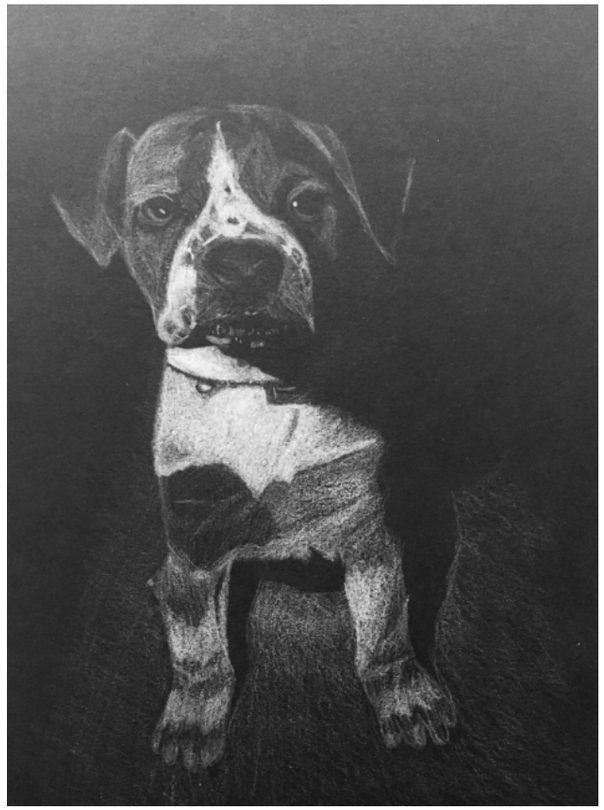
concept c
efforts we
sense of c
enjoyed c

Be well,
-GIM We



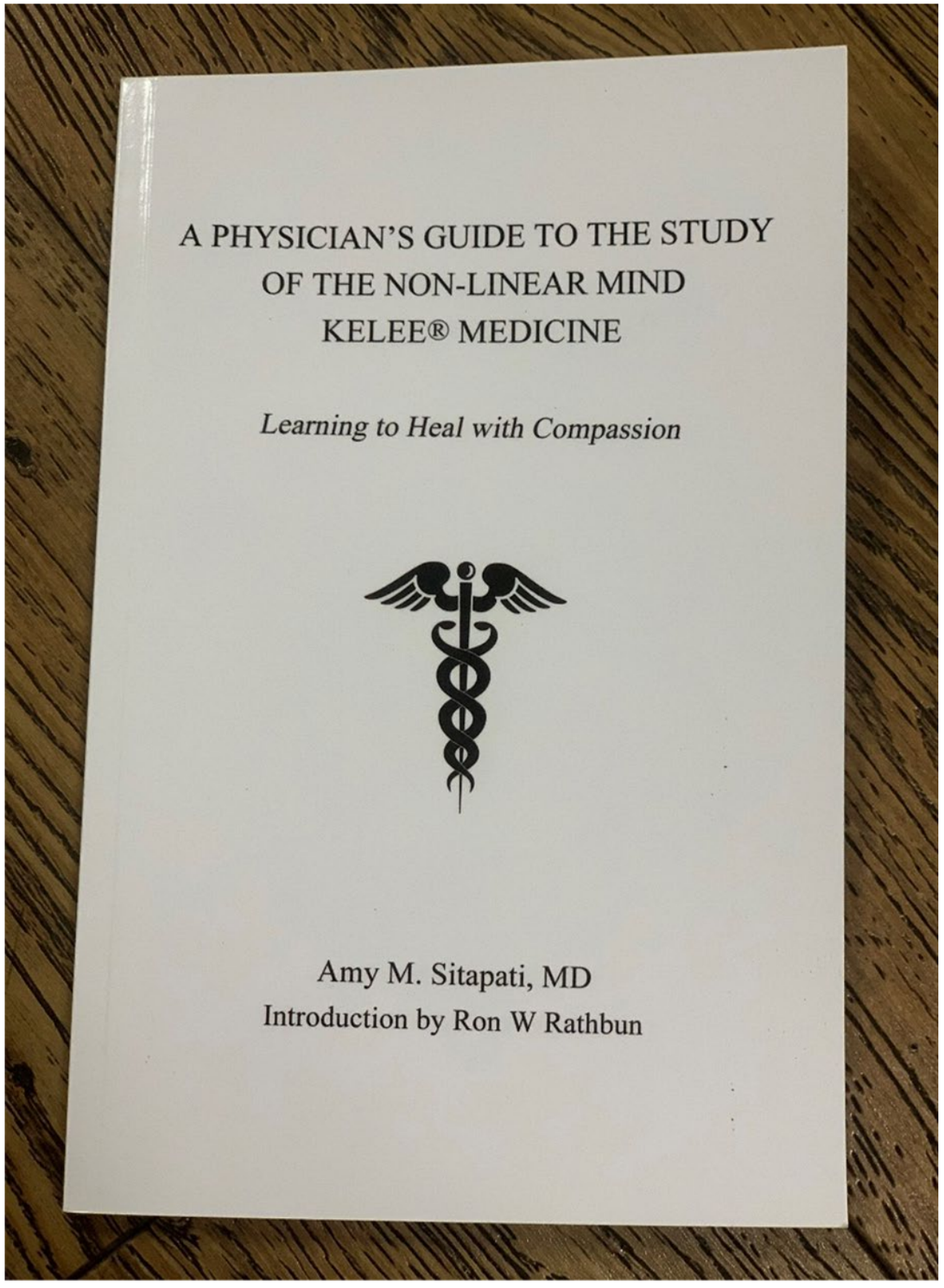
Book Club

Wellness Speaker Series

Neil Farber, MD

"Serendipity: Ready, Set, Go! Recognizing and Utilizing Unexpected Events to Enhance Your Career and Life."

Wednesday, February 24th at 12:15 pm



GIM FIRST ANNUAL PEER APPRECIATION

PIGLET NOTICED THAT EVEN THOUGH
HE HAD A VERY
SMALL HEART,
IT COULD HOLD
A RATHER LARGE
AMOUNT
OF GRATITUDE.

- A.A MILNE

"The Friendly Face/Pod Morale Booster"

What about organizational change?

- We became involved in a non face-to-face workgroup with key decision makers in leadership
- Created an on-boarding document to aid new hires
- Advocated for a trial of all 30 minute visits at one of our practice sites
- We are starting to develop a formal mentorship program for our new docs

Book Club

Zoom Social Events

Wellness Newsletter

Physician Recognition

EMR Workgroup

Advocate for Template Change

Improved On-boarding

Peer Support
Text Outreach

Directory of Wellness Resources

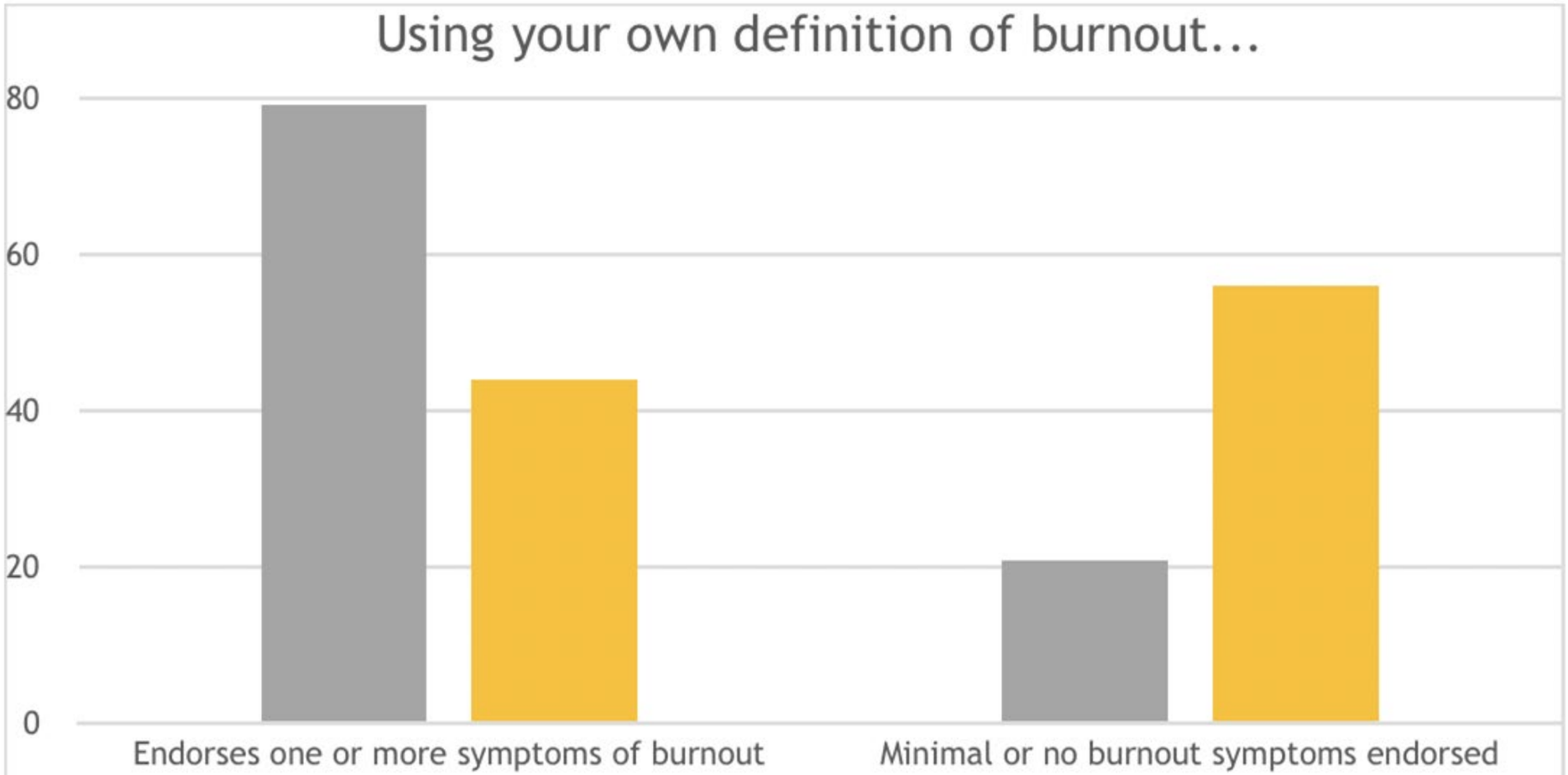
Wellness Speaker Series

Image courtesy of Stanford WellMD

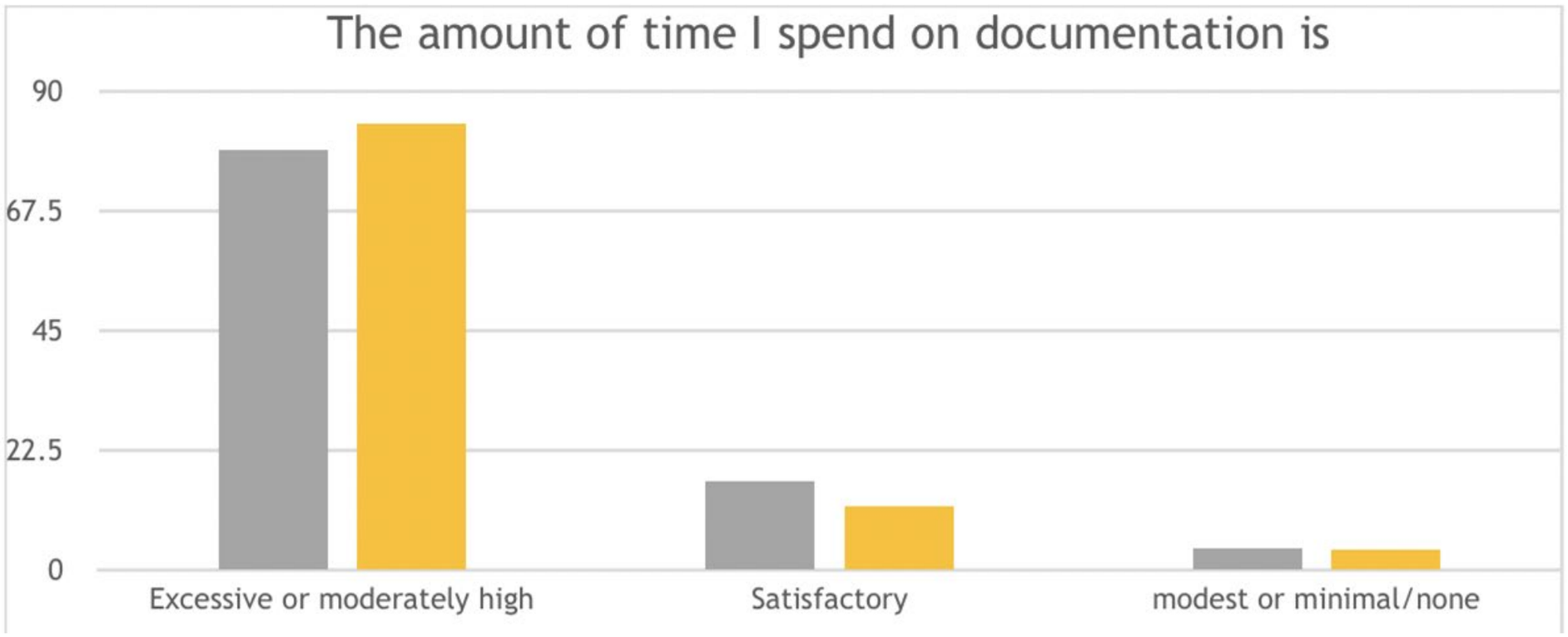
Keep re-evaluating

- Track wellness
  - We continue to administer our wellness survey quarterly

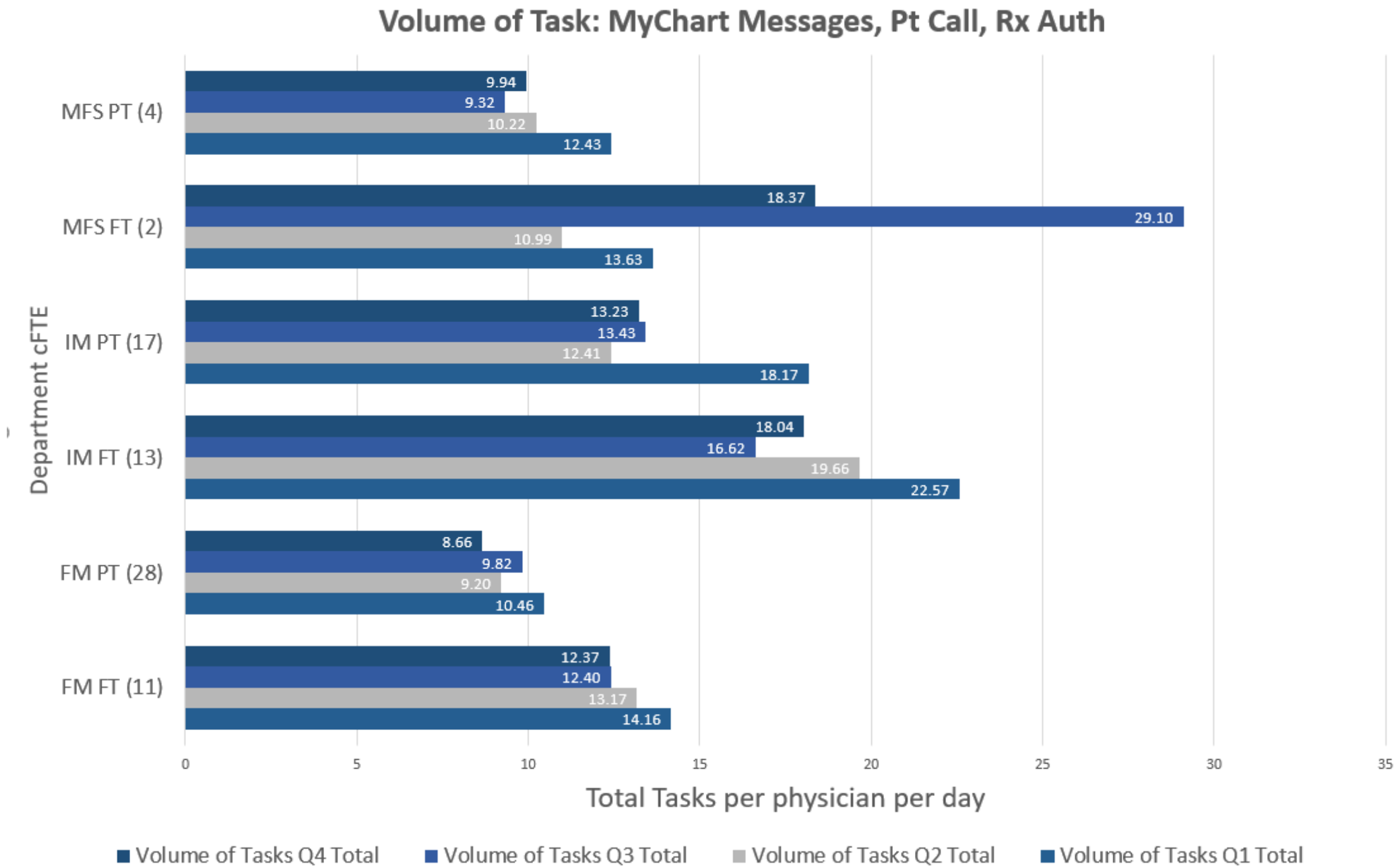
  - Make time to review/analyze the results of your surveys and re-prioritize your planned initiatives as needed


Using your own definition of burnout...
80
60
40
20
0
Endorses one or more symptoms of burnout
Minimal or no burnout symptoms endorsed

I


The amount of time I spend on documentation is
90
67.5
45
22.5
0
Excessive or moderately high
Satisfactory
modest or minimal/none

Review Additional Markers of Wellness



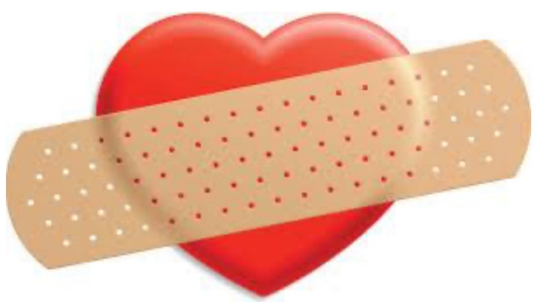
Network!

Stay Flexible

Keep Learning

Compassion Institute™

Stanford WellMD Physician Well-being Director Course



First Aid for the First Responder

ACPH 2021
AMERICAN CONFERENCE ON PHYSICIAN HEALTH℠

Reflect

Avoid these 3 common pitfalls!

- Don’t skip over having a charter/concrete goals
- Don’t spread yourself too thin or neglect your own wellness
- Don’t talk yourself into doing everything for free

Can we break this down to the essentials?

5 steps…

1._____

2._____

3._____

4._____

5._____

Making your own Strategic Plan

- Small group breakout!

Closing and questions

Special thanks to:

-UCSD GIM Colleagues
-Heather Hofflich MD; Ottar Lunde MD; Amy Sitapati MD
-Jennie Wei MD and Simone Kanter MD
-Byron Fergerson MD
-Ming Tai-Seale PhD, MPH
-Matthew Satre MBA
-The late Lawrence Friedman MD

Our contact info:
Arthi Balu - abalu@health.ucsd.edu
Joseph Diaz -jod018@health.ucsd.edu

Leaders can improve their physicians' morale through participatory management:

The Coaching for Engagement Program

Diana Dill EdD, *Working Together For Health*SM
Karim Awad MD, Clinical Affairs, Atrius Health
Les Schwab MD, Les Schwab Coaching and Atrius Health
Ken Kraft PhD

How you handle supervisory conversations has a bigger impact than you think!

Agenda

4:30 Review the rationale for participatory management

4:35 Describe our program and results

4:40 Four high-impact participatory management tools:
learn, watch, practice

5:20 Costs and benefits of encouraging participatory management
in your own setting

Gallup's ***6 questions**** the most important issues to the most engaged employees across industries

- *In the last seven days, have I received recognition for good work?*
- *Does my supervisor, or someone at work, care about me as a person?*
- *Is there someone at work who encourages my development?*
- *Do I know what is expected of me at work?*
- *Do I have the resources I need to do my work right?*
- *Do I have the opportunity to do what I do best every day?*

* Buckingham 2016

Mayo Clinic's definition of "participatory management"*

My manager—

- *Holds career development conversations with me*
- *Empowers me to do my job*
- *Encourages me to suggest ideas for improvement*
- *Treats me with respect and dignity*
- *Provides helpful feedback and coaching on my performance*
- *Recognizes me for a job well done*
- *Keeps me informed about changes taking place here*
- *Encourages me to develop my talents and skills*

* Shanafelt 2015

The *Coaching for Engagement Program**

Results:

- The department moved towards more participatory management
- Individual physicians felt more engaged with work
- Chiefs felt more engaged and less burned out
- Chiefs felt they had solved some difficult supervisory problems

* Awad, Dill, Schwab 2019

Four high-impact participatory management tools to learn, watch, and practice…

The best* supervisory conversations are:

- EMOTIONALLY CONNECTED
- PSYCHOLOGICALLY SAFE
- EMPOWERING
- OPTIMISTIC

*promote engagement and well-being

The best supervisory conversations are 1. EMOTIONALLY CONNECTED*

WE FEEL POSITIVE AND CARED FOR when the other person--

- Pays full attention to us
- Puts themselves in our shoes

WE FEEL ACTIVELY BAD when the other person acts--

- Disengaged
- Out of sync

* Boyatzis 2005, Frederickson 2013, Riess 2018, Cooperider and Whitney 2012

QUICK SCRIPT:
To build an emotional connection:

- **Be warm**
- **Listen with full attention to what the other person is experiencing**:
  Ask yourself: *What are they experiencing, and why?*
- **Paraphrase what you have heard:**
  I hear you say your experience is ___ in response to ___
  e.g. I hear you say you feel frustrated by the late add to your schedule
- **Followup questions:**
  What does this mean to you?
  What pleased you/upset you the most about this?

The best supervisory conversations are 2. PSYCHOLOGICALLY SAFE*

WE FEEL SAFE WHEN-

- We know what to expect and have given consent to it
- we are free to think out loud, to speculate, to express ourselves fully
- where we won't lose face or be rejected if we ask for help, acknowledge a problem, admit mistakes, seek feedback, or disagree
- There is a baseline assumption of good will

WE FEEL UNSAFE WHEN--

- the purpose and rules of the conversation are ambiguous or unknown
- Or it has been demonstrated that it is not safe to express ourselves

* Garvin and Edmondson 1999, Edmondson and Lei 2014, Duhigg 2017

QUICK SCRIPT:
To establish psychological safety:

- **Set the person at ease by letting them know what to expect from the conversation. Describe:**

  purpose of the conversation

  roles you each will take

  process you'll follow

  e.g. *I'd like to talk briefly about covering for Dr X while she's out, and reach a conclusion about what you can do*

  why don't you start by telling me your availability, I'll add what I know, then we can discuss any gaps

- **Don't argue. Show curiosity about pushback or negative expression**

The best supervisory conversations are 3. EMPOWERING*

WE ARE EMPOWERED WHEN ALLOWED/ENCOURAGED to-

- choose where to invest ourselves and how
- align with what genuinely rewards us e.g. accomplishment, finding a solution, developing a skill, making a connection etc.

WE ARE DISEMPOWERED/MADE HELPLESS when--

- We are told what to do
- Rewards are external e.g. salary, status, praise, etc.

* Deci and Ryan ongoing, Dill and Gumpert 2012

QUICK SCRIPT:
ASK, DON'T TELL! Some ways to Empower:

- **Encourage self-awareness**:
  (e.g. *how are you doing with the new protocol*?)
- **Encourage self-assessment:**
  (e.g. *what did you do, specifically, that worked*? *What made it work?)*
- **Encourage choice and self-initiation:**
  (e.g. *What would you do differently next time*?)
- **Encourage identifying intrinsic motivation:**
  (e.g. *what would it mean to you to try that out*?)
- **Encourage identifying resources:**
  e.g. *how would you like me to help*?)

The best supervisory conversations
4. PROMOTE OPTIMISM:*

- Positive emotional states benefit our functioning in general
- Frequency of positive emotional states is what matters
- We have control over our emotional state, when we change the focus of our attention
- Focusing on positive experiences lifts our mood
- Asking questions helps direct the other person's attention

* Seligman 2012, Frederickson 2009

QUICK SCRIPT:
focus on positive experiences:

- **Reflect back in time:**
  (e.g. *what went well*? *What helped you do well*?)

- **Reflect on today:**
  (e.g. *what is working now?* What's making it work?)

- **Project forward in time:**
  (e.g. What might you accomplish this year that would be especially meaningful to you?)

What are the costs and benefits of encouraging participatory management in your own setting?

Thank you!

Diana Dill EdD
DrDianaDill@gmail.com

Karim Awad MD
Karim_Awad@AtriusHealth.org

Les Schwab MD
Leslie_Schwab@atriushealth.org

Ken Kraft PhD
KKraftphd@gmail.com

References

Available on request to:

DrDianaDill@gmail.com