FROM AWARENESS TO ACTION

Jennifer Breen Feist, JD  &  J. Corey Feist, JD, MBA
Co-Founders
American Conference on Physician Health
October 7, 2021
OUR SISTER:

DR. LORNA BREEN
OUR SISTER:

DR. LORNA BREEN
OUR SISTER:

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OUR SISTER:

DR. LORNA BREEN
“Maybe stories are just data with a soul.”

Brené Brown
OUR RESPONSE TO A CRY FOR HELP

The Dr. Lorna Breen Heroes’ Foundation
Co-Founded in June 2020
501(c)3 Non-Profit Foundation

Mission & Vision
Dedicated to reducing burnout of health care professionals and safeguarding their well-being and job satisfaction

We envision a world where seeking mental health services is universally viewed as a sign of strength for health care professionals.
OUR REACH

- 300+ Articles Sharing Our Story
- 11 Publications Co-authored
- 60+ Panels/Keynotes
- 20 Podcasts
- 3K Social Media Followers
- 1 DNC Convention Appearance
Vital Signs: The Campaign to Prevent Physician Suicide

Physicians have one of the highest suicide rates of any profession. More than half of physicians know a physician who has either considered, attempted or died by suicide in their career. It’s estimated that one million Americans lose their physician to suicide each year. We can all help prevent physician suicide.
Our Impact

By the Numbers:
Over 100 Million Reached Worldwide
By the Clinicians:
“Today I want to say how thankful I am that the Heroes Foundation exists….Lorna’s death was what pushed me to get help. The details of which I still don’t talk about because I continue to fear it will be held against me…Every time I see a picture of her, I see myself. I see my residents. I see my colleagues.”
By the Caregivers of our Clinicians:

“If you ever wondered about the immediate impact of the work you are doing or whether it’s necessary to share Lorna’s story and the specific conversations you had with her, please know that it saved this client’s life. She is safe now because I was able to recognize the similarities in what Lorna told you. Thank you.”
Removing Barriers & Ensuring Consistent Support at the federal level

The Dr. Lorna Breen Health Care Provider Protection Act
• Unanimously Passed in the US Senate
• House Energy & Commerce now preparing to vote
• 120+ Cosponsors
• 80+ Endorsements
• $140 M in Funding - HRSA $$ Allocating NOW

TAKE ACTION: Contact Members of the US House of Representatives
ACTION & ADVOCACY

Removing Barriers & Ensuring Consistent Support at the state & local levels

6 Known Barriers

• Malpractice Insurance
• Legal Discovery in Malpractice
• Medical Plan Design
• State Licensure
• Hospital Credentialing
• Commercial Insurance

Jennifer & Corey Feist, US News & World Report, Sept. 9, 2021

TAKE ACTION: Complete the “Facts vs. Myths” Institutional Report Card
NYAM ANNUAL AWARDS
Innovators in HEALTH
Virtual Event
TUESDAY, NOVEMBER 9
4:00PM - 5:00PM ET
REGISTER NOW

ACTION & ADVOCACY

SPECIAL REMARKS
Anthony Fauci, MD, Director, NIAID

HONOREES
Kizzmekia S. Corbett, PhD
Jennifer Breen Feist, JD
J. Corey Feist, JD, MBA
James Flynn, MS
Barney S. Graham, MD, PhD
William Gruber, MD
Katalin Karikó, PhD
Reed Tuckson, MD, FACP
Drew Weissman, MD, PhD

The Dr. Lorna Breen Heroes’ Foundation
Jennifer Breen Feist, JD
J. Corey Feist, JD, MBA
"We need real solutions that work for people like Lorna. She was the canary in the coal mine for us, and for many people. We don’t need to make our canaries stronger. We need to redesign the coal mine."

J. Corey Feist, Time, Sept. 22, 2021
AWARENESS & EDUCATION

All In WellBeing First for Healthcare

A call to action by:

FIRST RESPONDERS FIRST

THRIVE GLOBAL

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

CAA Foundation

J&J
A call to action by:

FIRST RESPONDERS
FIRST

In collaboration with:

American Association of Colleges of Nursing
The Voice of Academic Nursing

American Hospital Association
Advancing Health in America

AMERICAN NURSES FOUNDATION

CHARM
The Collaborative for Healing and Renewal in Medicine

NATIONAL BLACK NURSES ASSOCIATION, INC.

The Schwartz Center
FOR COMPASSIONATE HEALTHCARE
What is ALL-IN?

ALL IN WellBeing First for Healthcare is a call to action by #FirstRespondersFirst and the Dr. Lorna Breen Heroes’ Foundation, in collaboration with leading health organizations and associations.

Our ambition is to energize a transformative cultural shift that accelerates progress and promotes meaningful action and accountability.
What does ALL-IN aim to do?

1. Advance a state where the well-being of the healthcare workforce is prioritized and individual healthcare workers feel valued and supported so they can sustain their sense of purpose and meaning in their work.

2. Make beneficial progress against persistent mental health and well-being challenges that disadvantage our healthcare workers, and therefore, our healthcare systems and the future of public health.
How will ALL-IN achieve its aims?

**Convene**
and unite experts that are advancing healthcare workforce well-being solutions

**Accelerate**
a culture shift that prioritizes healthcare workforce well-being and creates systems of accountability

**Amplify**
and recognize role models within healthcare leadership who have prioritized healthcare workforce well-being and mental health through inspirational storytelling

**Provide**
financial resources to healthcare organizations to implement clinician well-being solutions and/or further scale promising practices

**Share data**
among health leaders to drive transparency, collaboration and effective strategies on well-being and resilience

**Advocate**
for public policy solutions that address systemic needs to improve well-being and mental health for our nation’s health workforce
ALL-IN Membership Structure

Tier 1 Collaborators: LEAD

• Professional Associations and organizations on the forefront of advancing healthcare workforce well-being as a priority
• Responsibilities include advising on vision and priorities + structure and distribution of the ALL IN Fund

Tier 2 Contributors: SHARE

• Healthcare organizations, practitioners, vendors and consultants who bring promising and scalable solutions
• Responsibilities include contributing ideas to a “resiliency marketplace” in which members share promising practices, playbooks and resources + leveraging technical expertise and networks

Tier 3 Members: LEARN AND IMPLEMENT

• Individuals advocating for and amplifying our call to action, healthcare systems and organizations committed to learning more and implementing solutions
• Will make either an individual or organizational commitment to publicly declare: the role of the organization and individuals in investing in and cultivating an environment of well-being; clearly define goals to improve the well-being of the workforce; OR contribute to and utilize the tools and resources offered through ALL IN
ALL-IN Member Benefits

• **Curated resources** on organizational resilience and well-being for the healthcare workforce, categorized by organizational needs and interests

• **Interactive community** platform to exchange information, foster collaboration, and spark new ideas

• **Convenings and webinars** featuring experts and leaders on well-being solutions for the healthcare workforce

• **Eligibility to participate in grant funding** to implement and scale organizational well-being programs through the ALL IN Fund

• **No cost to participate**
ALL-IN Financial Support

We also welcome the contributions of individuals and organizations who would like to support ALL-IN.

Donations will support the implementation and scaling of successful and sustainable solutions that improve the resilience and well-being of the healthcare workforce.

Visit www.Allinforhealthcare.org to learn more and join the 200+ individuals & organizations who are part of our campaign.
THANK YOU!

TEXT ‘LORNABREEN’ TO 44-321
FOR MORE INFORMATION
Healing the Healers
Prioritizing Physician Health and Well-Being
October 7, 2021

Dr. Nadine Burke Harris, MD, MPH, FAAP
Surgeon General of the State of California
Objectives

1. Recognize the ways that physicians can be sensitized to current stressors based on their life experiences including Adverse Childhood Experiences.
2. Explain how understanding your stress response offers a playbook for prevention and treatment of toxic stress.
3. Describe how addressing ACEs and providing a trauma informed approach can protect us all from the health effects of chronic stress.
Physicians Need PPE Against Toxic Stress
Addressing the Reality

- High stress work environment
- Increased workload
- Electronic health records developed for billers, not patients or providers
- Unprecedented level of scrutiny (quality metrics, patient satisfaction scores, measures of cost)
- Increased workplace violence
- Inherent perfectionism in conflict with imperfect system

- Rapidly expanding medical knowledge base
- Reduced physician autonomy
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- New regulatory requirements (meaningful use, e-prescribing, medication reconciliation)
- Rising patient dissatisfaction
- Burden of patient’s emotional needs and suffering

Adverse Childhood Experiences

**Abuse**
Physical, emotional, or sexual
- Physical
- Emotional
- Sexual

**Neglect**
Physical or emotional
- Mental Illness
- Physical
- Emotional

**HOUSEHOLD CHALLENGES**
Growing up in a household with incarceration, mental illness, substance misuse or dependence, absence due to separation or divorce, or intimate partner violence
- Incarceration
- Intimate Partner Violence
- Substance Misuse or Dependence
- Parental Separation or Divorce
61.6% of US adults have ≥ 1 ACE
15.8% have ≥ 4 ACEs

ACEs Dramatically Increase Risk for 9 of the 10 Leading Causes of Death in the U.S.

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The Stress Response System

- **Stress Response System**
  - **HPA Axis**
  - **Sympathoadrenal Medullary System**

**Diagram Details**
- **Stressor**
- **Amygdala**
- **Locus coerulescens**
- **Hypothalamus**
- **AVP**
- **CRH**
- **Pituitary gland**
- **ACTH**
- **Adrenal cortex**
- **Adrenal medulla**
- **Peripheral organs, glands, vessels**
- **CORTISOL**
- **EPINEPHRINE**
- **norepinephrine**

**Feedback Loops**
- **Negative feedback**
Adverse Childhood Experiences can generate chronic activation of the stress response system.

Toxic stress is a physiological response.
## Spectrum of the Stress Response: Positive, Tolerable, and Toxic

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*Fig. 2.* Spectrum of the stress response: positive, tolerable, and toxic.
The Toxic Stress Response Defined

“The Toxic Stress Response Defined

“prolonged activation of the stress response systems that can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years…”
Recognizing Other Risk Factors for Toxic Stress

A circumstance, exposure, or condition with documented associations with increased likelihood or susceptibility of development of the toxic stress response.

In addition to ACEs, **other risk factors for toxic stress include poverty, exposure to discrimination, and exposure to the atrocities of war.**
## Biological Systems Disrupted by Toxic Stress

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<td><strong>Immunologic; Inflammatory</strong></td>
<td>Increased inflammatory markers, especially Th2 response; inhibition of anti-inflammatory pathways; gut microbiome dysbiosis</td>
<td>Increased risk of infection, auto-immune disorders, cancers, chronic inflammation; cardiometabolic disorders</td>
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<td><strong>Endocrine; Metabolic</strong></td>
<td>Changes in growth hormone, thyroid hormone, and pubertal hormonal axes</td>
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<td>Changes to leptin, ghrelin, lipid and glucose metabolism, and other metabolic pathways</td>
<td>Increased risk of overweight, obesity, cardiometabolic disorders, and insulin resistance</td>
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<td><strong>Epigenetic; Genetic</strong></td>
<td>Sustained changes to the way DNA is read and transcribed</td>
<td>Mediates all aspects of the toxic stress response</td>
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<td>Telomere erosion, altered cell replication, and premature cell death</td>
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Potential Mechanisms of Intergenerational Transmission of Adversity

**Parent ACEs**
- Stress hormones
- Neuro-endocrine, immune, metabolic dysregulation
- Parent behavior
- Social determinants of health

**Parent TOXIC STRESS**
- Historical and cultural trauma

**Parent Factors**
- Ability to conceive
- Epigenetic changes in stress system genes
- Parent health (mental, physical)

**Preconception and In Utero Factors**
- Pregnancy loss; poorer pregnancy outcomes
- Epigenetic changes in stress system genes
- Telomere shortening
- Fetal HPA axis dysregulation
- Fetal autonomic nervous system dysregulation

**Postnatal Factors**
- Child neuro-endocrine, immune, metabolic dysregulation
- Child health (mental, physical)
- Child microbiome
- Child behaviors
- Social determinants of health
- Cultural/historical influences

Physicians & ACEs

- 300 practicing physicians in 4 Northern California counties
- 49% had at least one ACE
- 9% had 4 or more ACEs
- Most common ACEs:
  - 22%: depressed family member, mentally ill or attempted suicide
  - 18%: living with someone who was a problem drinker, alcoholic, or who used street drugs
Physical, psychological, and occupational consequences of job burnout: A systematic review of prospective studies


doi: https://doi.org/10.1371/journal.pone.0185781.g003
The Opportunity:

What is predictable is preventable AND treatable
Toxic Stress is Amenable to Treatment

- New opportunities to more precisely interrupt the toxic stress response, break the intergenerational cycle of ACEs and toxic stress, and promote an intergenerational cycle of health.
- Early intervention can improve brain, immune, hormonal, and genetic regulatory control of development.
- Treatment of toxic stress in adults may prevent transmission of neuro-endocrine-immune-metabolic and genetic regulatory disruptions in offspring.
The ACEs Aware Initiative

- Training primary care clinicians on how to screen for ACEs and toxic stress
- Medicaid (Medi-Cal) payment for conducting ACE screenings for children and adults
- Focusing on buffering supports and providing trauma-informed care
- Building cross-sector networks of care to support children and families
Now more than ever, we need Trauma Informed Care.

- Public Health Emergencies Highlight Urgent Need for Effective Buffering Systems and Supports

- Multiple simultaneous public health emergencies
  - COVID-19 pandemic
  - Impacts of climate change – including wildfires
  - Sharper focus on the deep-rooted systemic racism in our society

- Vulnerable and systematically overlooked communities bear the brunt of each new crisis

Trauma-informed systems have never been more important!
Trauma informed care is not just good for patients, it’s good for physicians!

- Establish the physical and emotional safety of patients and staff
- Build trust between providers and patients
- Recognize the signs and symptoms of trauma exposure on physical and mental health
- Promote patient-centered, evidence-based care
- Ensure provider and patient collaboration by bringing patients into the treatment process and discussing mutually agreed upon goals for treatment
- Provide care that is sensitive to the patient’s racial, ethnic, and cultural background, and gender identity
An Effective Response to ACEs & Toxic Stress Requires Prevention at All Levels

**Primary Prevention** efforts target healthy individuals and aim to prevent harmful exposures from ever occurring.

**Secondary Prevention** efforts involve screening to identify individuals who have experienced an exposure and aim to prevent the development of symptoms, disease, or other negative outcomes.

**Tertiary Prevention** efforts target individuals who have already developed a disease or social outcome, and aim to lessen the severity, progression, or complications associated with that outcome.
ACE Screening Purpose

• Identifies patients at risk for toxic stress and ACE-Associated Health Conditions
• Universal and routine screening promotes health equity
• Enables prevention, early detection, and early intervention
• Improves treatment of ACE-Associated Health Conditions
• Helps primary care clinical teams identify additional health care and social service supports that patients/families may need to address toxic stress
Primary Care Clinical Response to ACEs and Toxic Stress

1. Applying principles of **trauma-informed care**.
2. Supplementing usual care for ACE-Associated Health Conditions by providing **patient education** on toxic stress and offering **strategies to regulate the stress response**.
3. Validating existing **strengths and protective factors**.
4. **Referrals** to patient resources or interventions, such as educational materials, social work, school agencies, care coordination or patient navigation, community health workers.
5. **Follow-up** as necessary, using the presenting ACE-Associated Health Condition(s) as indicators of treatment progress.
Evidence-Based Strategies for Regulating the Toxic Stress Response
Growing Networks of Care in Communities

- A Network of Care is a group of **interdisciplinary** health, education, and human service professionals, community members, and organizations;

- Supports families by providing access to **evidence-based “buffering” resources** and supports; and

- Helps to **prevent, treat, and heal** the harmful consequences of toxic stress.
Look to the Future – California is Leading the Way

- Children’s behavioral health initiative
- ACEs public education campaign
- Trauma-informed care training for educators
- Coverage of community health workers through Medi-Cal
- Additional ACEs research grant funds through Precision Medicine Initiative
- Investments in HIT/HIE infrastructure
No Sector or State is Sufficient Alone
Help Ourselves
As We Have
Helped So Many
Others
Learn More About ACEs & Toxic Stress

✓ Take the free, 2-hour online ACEs Aware Training at ACEsAware.org/training

✓ Check out the CA Surgeon General’s Roadmap for Resilience at osg.ca.gov/sg-report
  
  ○ 12 briefs summarizing key themes, including Prevention Strategies in Early Childhood Supports and Social Services.
Use Evidence-Based Tools & Strategies

Patient-facing materials now available!
Join or Build a Network of Care in Your Community

- **Read the Network of Care Roadmap** to learn more about growing cross-sector networks at [www.ACEsAware.org/network-of-care](http://www.ACEsAware.org/network-of-care)

- **Join and grow Networks of Care in your community**
30-Day Prevalence of Daily Use of Cigarettes, by Grade 1976 - 2018

Lead Exposure: Prevention Approaches

Death Rates for HIV Disease for All Ages

NOTE: HAART is highly active antiretroviral therapy.
SOURCE: CDC/NCHS, Health, United States, 2013, Figure 24. Data from the National Vital Statistics System.
THANK YOU!

Questions?
Contact
info@ACEsAware.org
HEALING THE HEALERS
Prioritizing Physician Health and Well-Being

October 7, 2021

Dr. Nadine Burke Harris, MD, MPH, FAAP
California Surgeon General
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PHYSICIANS NEED PPE AGAINST TOXIC STRESS
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ADVERSE CHILDHOOD EXPERIENCES

Abuse
Physical, emotional, or sexual

- Physical
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Neglect
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Growing up in a household with incarceration, mental illness, substance misuse or dependence, absence due to separation or divorce, or intimate partner violence

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61.6% OF US ADULTS HAVE ≥ 1 ACE
15.8% HAVE ≥ 4 ACEs

ACEs Dramatically Increase Risk for at least 9 of the 10 Leading Causes of Death in the U.S.

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THE STRESS RESPONSE SYSTEM

The Stress Response System includes both the HPA Axis and the Sympathoadrenal Medullary System. When a stressor is perceived, it triggers the following sequence:

1. Amygdala and Locus Coeruleus
2. Hypothalamus
   - AVP
   - CRH
3. Pituitary gland
   - ACTH
4. Adrenal gland
   - CORTISOL
5. Sympathetic neurons
6. Adrenal medulla
   - EPINEPHRINE
   - NOREPINEPHRINE

Negative feedback loops are also present to regulate the response.
CHILDHOOD ADVERSITY, BIOLOGICAL CHANGES, AND ADULT OUTCOMES

Adverse Childhood Experiences can generate chronic activation of the stress response system.

Toxic stress is a physiological response.
**STRESS RESPONSE**

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**Fig. 2.** Spectrum of the stress response: positive, tolerable, and toxic.
TOXIC STRESS RESPONSE DEFINED

“prolonged activation of the stress response systems that can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years…”

-- The National Academies of Sciences, Engineering and Medicine
RECOGNIZING OTHER RISK FACTORS FOR TOXIC STRESS

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<td>Increased inflammatory markers, especially Th2 response; inhibition of anti-inflammatory pathways; gut microbiome dysbiosis</td>
<td>Increased risk of infection, auto-immune disorders, cancers, chronic inflammation; cardiometabolic disorders</td>
</tr>
<tr>
<td>Endocrine; Metabolic</td>
<td>Changes in growth hormone, thyroid hormone, and pubertal hormonal axes</td>
<td>Changes in growth, development, basal metabolism, and pubertal events</td>
</tr>
<tr>
<td></td>
<td>Changes to leptin, ghrelin, lipid and glucose metabolism, and other metabolic pathways</td>
<td>Increased risk of overweight, obesity, cardiometabolic disorders, and insulin resistance</td>
</tr>
<tr>
<td>Epigenetic; Genetic</td>
<td>Sustained changes to the way DNA is read and transcribed</td>
<td>Mediates all aspects of the toxic stress response</td>
</tr>
<tr>
<td></td>
<td>Telomere erosion, altered cell replication, and premature cell death</td>
<td>Increased risk for disease, cancer, and early mortality</td>
</tr>
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</table>
Potential Mechanisms of Intergenerational Transmission of Adversity

Parent ACEs
- Stress hormones
- Neuro-endocrine, immune, metabolic dysregulation
- Parent behavior
- Social determinants of health

Parent Factors
- Ability to conceive
- Epigenetic changes in stress system genes
- Parent health (mental, physical)

Preconception and In Utero Factors
- Pregnancy loss; poorer pregnancy outcomes
- Epigenetic changes in stress system genes
- Telomere shortening
- Fetal HPA axis dysregulation
- Fetal autonomic nervous system dysregulation

Postnatal Factors
- Child neuro-endocrine, immune, metabolic dysregulation
- Child health (mental, physical)
- Child microbiome
- Child behaviors
- Social determinants of health
- Cultural/historical influences

Health impact to parent
Health impact to child

PHYSICIANS AND ACES

300 practicing physicians in 4 Northern California counties:
- 49% had at least one ACE
- 9% had 4 or more ACEs

Most Common ACEs:
- 22%: depressed family member, mentally ill or attempted suicide
- 18%: living with someone who was a problem drinker, alcoholic, or who used street drugs
Physical, psychological, and occupational consequences of job burnout:
A systematic review of prospective studies

THE OPPORTUNITY:

What is predictable is preventable AND treatable
TOXIC STRESS IS AMENABLE TO TREATMENT

• New opportunities to more precisely interrupt the toxic stress response, break the intergenerational cycle of ACEs and toxic stress, and promote an intergenerational cycle of health.
• Early intervention can improve brain, immune, hormonal, and genetic regulatory control of development.
• Treatment of toxic stress in adults may prevent transmission of neuro-endocrine-immune-metabolic and genetic regulatory disruptions in offspring.
The ACEs Aware Initiative

- Training primary care clinicians on how to screen for ACEs and toxic stress
- Medicaid (Medi-Cal) payment for conducting ACE screenings for children and adults
- Focusing on buffering supports and providing trauma-informed care
- Building cross-sector networks of care to support children and families
NOW, MORE THAN EVER, WE NEED TRAUMA INFORMED CARE

• Public Health Emergencies Highlight Urgent Need for Effective Buffering Systems and Supports

• Multiple simultaneous public health emergencies
  - COVID-19 pandemic
  - Climate change – including wildfires
  - Deep-rooted systemic racism in our society

• Vulnerable and systematically overlooked communities bear the brunt of each new crisis

• Trauma-informed systems have never been more important!
TRAUMA INFORMED CARE IS NOT JUST GOOD FOR PATIENTS, IT’S GOOD FOR PHYSICIANS!

• Establish the physical and emotional **safety** of patients and staff
• **Build trust** between providers and patients
• **Recognize** the signs and symptoms of trauma exposure on physical and mental health
• Promote **patient-centered, evidence-based care**
• Ensure provider and patient **collaboration** by bringing patients into the treatment process and discussing mutually agreed upon goals for treatment
• Provide care that is sensitive to the patient’s **racial, ethnic, and cultural background, and gender identity**
Primary Prevention efforts target healthy individuals and aim to prevent harmful exposures from ever occurring.

Secondary Prevention efforts involve screening to identify individuals who have experienced an exposure and aim to prevent the development of symptoms, disease, or other negative outcomes.

Tertiary Prevention efforts target individuals who have already developed a disease or social outcome, and aim to lessen the severity, progression, or complications associated with that outcome.

AN EFFECTIVE RESPONSE TO ACES & TOXIC STRESS REQUIRES PREVENTION AT ALL LEVELS
ACE SCREENING PURPOSE

- Identifies patients at risk for toxic stress and ACE-Associated Health Conditions
- Universal and routine screening promotes health equity
- Enables prevention, early detection, and early intervention
- Improves treatment of ACE-Associated Health Conditions
- Helps primary care clinical teams identify additional health care and social service supports patients/families may need to address toxic stress
Primary Care Clinical Response to ACES and Toxic Stress

- Applying principles of trauma-informed care.
- Supplementing usual care for ACE-Associated Health Conditions by providing patient education on toxic stress and offering strategies to regulate the stress response.
- Validating existing strengths and protective factors.
- Referrals to patient resources or interventions, such as educational materials, social work, school agencies, care coordination or patient navigation, community health workers.
- Follow-up as necessary, using the presenting ACE-Associated Health Condition(s) as indicators of treatment progress.
EVIDENCE-BASED STRATEGIES FOR REGULATING THE TOXIC STRESS RESPONSE
A Network of Care is a group of interdisciplinary health, education, and human service professionals, community members, and organizations; supports families by providing access to evidence-based “buffering” resources and supports; and helps to prevent, treat, and heal the harmful consequences of toxic stress.
LOOK TO THE FUTURE–California is Leading the Way

- Children’s behavioral health initiative
- ACEs public education campaign
- Trauma-informed care training for educators
- Coverage of community health workers through Medi-Cal
- Additional ACEs research grant funds through Precision Medicine Initiative
- Investments in HIT/HIE infrastructure
NO SECTOR OR STATE IS SUFFICIENT ALONE
HELP OURSELVES AS WE HAVE HELPED SO MANY OTHERS
Take the free, 2-hour online ACEs Aware Training at ACEsAware.org/training

Check out the CA Surgeon General’s Roadmap for Resilience at osg.ca.gov/sg-report

- 12 briefs summarizing key themes, including Prevention Strategies in Early Childhood Supports and Social Services.
USE EVIDENCE-BASED TOOLS AND STRATEGIES

Patient-facing materials now available!
JOIN OR BUILD A NETWORK OF CARE IN YOUR COMMUNITY

- Read the Network of Care Roadmap to learn more about growing cross-sector networks at www.ACEsAware.org/network-of-care

- Join and grow Networks of Care in your community

| Healthcare | Public Health | Social Services | Early Childhood | Education | Justice |
30-Day Prevalence of Daily Use of Cigarettes, by Grade 1976 - 2018

Lead Exposure: Prevention Approaches

Death Rates for HIV Disease for All Ages

NOTE: HAART is highly active antiretroviral therapy.
SOURCE: CDC/NCHS, Health, United States, 2013, Figure 24. Data from the National Vital Statistics System.
THANK YOU!
We are (Not) All Perfectly Fine....

How high-stakes personal narratives will change our culture.

Dr. Jillian Horton

BA, MA, MD, FRCPC (Internal Medicine)

Associate Professor, Internal Medicine

Director, Alan Klass Health Humanities Program and Physician and Learner Wellness

Associate head, Professionalism, Dept. of Internal Medicine

Rady Faculty of Health Sciences, University of Manitoba
Conflicts

I receive consulting fees from the Canadian Medical Association (via Joule) for leading physician wellness program development.

I sit on the board of directors of the Arnold P. Gold Foundation Canada.

Land acknowledgment

The University of Manitoba campuses are located on the ancestral lands of the Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, and on the homeland of the Métis Nation.
Learning goals:

Create an opportunity for personal reflection

Discover why stories are an effective mechanism for engagement

Explore common social and psychological barriers that often prevent physicians from sharing the personal narratives that can affect culture change
“What if this *is* the story?”
Why are we wired to listen to stories?

Photo: Kelly Hearson
“We learn best—and change—from hearing stories that strike a chord within us... 

...those in leadership positions who fail to grasp or use the power of stories risk failure for their companies and for themselves.”

- John Kotter, Harvard Business School Professor, author of *Leading Change*
Courage and Mental Health: Physicians and Physicians-in-Training Sharing Their Personal Narratives

Stress, distress, and symptoms of depression and anxiety are common among medical students, residents, and physicians. Physicians are at risk for suicide, with women, nonmajority-identifying individuals, and members of certain specialties being particularly at risk. Suicide is a leading cause of death among residents in programs accredited by the Accreditation Council for Graduate Medical Education and is a tragic occurrence in medical students as well.

The existing well-being crisis in the health professions is now accentuated by a parallel crisis of emotional and physical harm associated with COVID-19. Clinician well-being is thus a growing priority for health care leaders, policymakers, and other decision makers capable of bringing about system-level change. A broad range of strategies help reduce the stigma of speaking up about mental health issues and obtaining care. Dr. Darrell G. Kirch, former president of the Association of American Medical Colleges, shares his mental health journey and asks all of us in academic medicine—especially struggling learners—to open up about our own mental health challenges to improve lives and potentially to save them.

Christopher T. Veal describes how, as a medical student, certain personal stressors brought him very close to ending his life. And an anonymous author shares a personal story of overcoming depression as a medical student.

Breaking the Silence

Journals often publish personal stories related to professional challenges and overcoming them. The column A Piece of My Mind, published in JAMA, allows many other doctors overcoming their own challenges. The same author, in another piece, walks us through her “relatively new self-harming disorder,” caught between her own expert, objective medical knowledge, and her own “intolerable emotions.” Bravely, she describes reaching out for help and, ultimately, healing.

A physician describes how his own vulnerability and openness with colleagues reveals their compassion and understanding. After giving a grand rounds lecture telling his story of addiction, depression, and recovery, he received a standing ovation and hundreds of emails that shared others’ strengths and triumphs. Another writer shares her experience with depression in medical school and the “admission of humanness” that is confiding with family, friends, and colleagues.
We are primed for stories.

Attention spotlight is “metabolically costly”

We boost spotlight brightness for safety, things that interest us

Tension in stories suggests we might learn

Sustained attention transportation, resonance

https://greatergood.berkeley.edu/article/item/how_stories_change_brain
There is a *pro-social* impact of *well-crafted* stories:

“TRANSPORTATION” → EMOTIONAL SIMULATION → OXYTOCIN → EMPATHY

https://greatergood.berkeley.edu/article/item/how_stories_change_brain
What risks did I perceive in telling my story?

- PHI – legal woes?
- Social pain
- “Medical Privilege”
But there was also a risk in not telling it.
My name is Adam. I am a human being, a husband, a father, a pediatric palliative care physician, and an associate residency director. I have a history of depression and suicidal ideation and am a recovering alcoholic. Several years ago, I found myself sitting in a state park 45 minutes from my home, on a beautiful fall night under a canopy of ash trees, with a plan to never come home. For several months, I had been feeling abused, overworked, neglected, and underappreciated. I felt I had lost my identity. I had slipped into a deep depression and relied on going home at night and having barriers detours suffering people away from the help they desperately need — costing some of them their lives.

Last year, I decided I could no longer let depression dictate my life. I decided to do something about it. I sought help, and I am now on the road to recovery. I have shared my story with others, and I have learned that many physicians are experiencing similar challenges. I have found that speaking openly about my struggles has helped me connect with others and has given me the courage to continue my journey towards recovery.

I am a committed family physician, skilled researcher and respected leader at my university. And I suffer from depression. Why is that so difficult to write?

Apparently, I am not alone. According to the recent CMA National Physician Health Survey, 33% of physician respondents screened positive for depression and some are sharing their stories. Many of the physicians who discuss their mental health journeys, however, do so through the rearview mirror. Disclosure seems to happen mostly after the fact, when people have successfully navigated a path toward healing. The reasons for this are self-evident: stigma, fear of reprisals from regulators, and the challenge of speaking eloquently when all of one’s energy needs to be directed toward just getting through the day. It makes sense. But is this really the best way? I think that earlier disclosure can have benefits, ones I discovered on my own journey.

It was October 2015. My mom's chemotherapy schedule intensified, and I needed more time than I
Finding the courage to tell your narrative.
Five paths to finding narrative courage:

Decide what you want to accomplish

Don’t let others unilaterally define professionalism

Internalize other ways of knowing

Brace yourself first

Be prepared to rewrite the ending
1. Decide what you want to accomplish.
“People underestimate that it’s a craft. That writing is a job and I’m not just doing it to exorcise my demons, I’m doing it to elicit a response from the reader and to accomplish something.”

-Roxanne Gay
Forget about our 'lanes.' It’s time for doctors to flood the freeways.

Jillian Horton: We spend much of our lives tending to the aftermath of failed social policies, afraid to engage. This is our call to speak out.

By Jillian Horton
November 1, 2020
2. Don’t let others unilaterally define “professionalism”

https://www.fridakahlo.org
MS-246 Mechanical

CAUTION
ROOM MAY CONTAIN SPECIAL HAZARDS
SEE BACK OF DOOR FOR DETAILS

CAUTION
ROOM MAY CONTAIN SPECIAL HAZARDS
SEE BACK OF DOOR FOR DETAILS

Photo: Len Minuk
Italian police cook pasta for elderly couple heard 'crying with loneliness'

Four Italian policemen have been praised on social media after they cooked a simple meal of pasta for a distressed elderly couple.

The Rome police officers were responding to a neighbour’s calls that cries had been heard coming from inside their apartment.
Frida Kahlo: The Gisèle Freund Photographs,
published by Abrams
Selective Vulnerability

“.....opening up to your team while still prioritizing their boundaries, as well as your own.

(“Would it help me to hear this from the leader of my organization?”)

https://hbr.org/2019/02/how-leaders-can-open-up-to-their-teams-without-oversharing

Neuron

3. Internalize other ways of knowing
RANGE
WHY GENERALISTS TRIUMPH IN A SPECIALIZED WORLD

DAVID EPSTEIN
AUTHOR OF THE SPORTS GENE

"I loved RANGE."
-Malcolm Gladwell
Critical thinking

Emotional Attunement
4. Brace Yourself First
Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians

Michael S. Krasner, MD
Ronald M. Epstein, MD
Howard Beckman, MD
Anthony L. Suchman, MD, MA
Benjamin Chapman, PhD
Christopher J. Mooney, MA
Timothy E. Quill, MD

Primary care physicians report alarming levels of professional and personal distress. Up to 60% of practicing physicians report symptoms of burnout, defined as emotional exhaustion, depersonalization (treating patients as objects), and low sense of accomplishment. Physician burnout has been linked to poorer quality of care, including patient dissatisfaction, increased medical errors, and lawsuits and decreased ability to express empathy. Substance abuse, automobile accidents, stress-related health problems, and marital and family discord are among the personal consequences reported. Burnout can occur early in the medical educational process. Nearly half of all third-year medical students report burnout and there are strong associations between medical student burnout and suicidal ideation.

Context Primary care physicians report high levels of distress, which is linked to burnout, attrition, and poorer quality of care. Programs to reduce burnout before it results in impairment are rare; data on these programs are scarce.

Objective To determine whether an intensive educational program in mindfulness, communication, and self-awareness is associated with improvement in primary care physicians’ well-being, psychological distress, burnout, and capacity for relating to patients.

Design, Setting, and Participants Before-and-after study of 70 primary care physicians in Rochester, New York, in a continuing medical education (CME) course in 2007-2008. The course included mindfulness meditation, self-awareness exercises, narrative about meaningful clinical experiences, appreciative interviews, didactic material, and discussion. An 8-week intensive phase (2.5 h/wk, 7-hour retreat) was followed by a 10-month maintenance phase (2.5 h/mo).

Main Outcome Measures Mindfulness (2 subscales), burnout (3 subscales), empathy (3 subscales), psychosocial orientation, personality (5 factors), and mood (6 subscales) measured at baseline and at 2, 12, and 15 months.

Results Over the course of the program and follow-up, participants demonstrated improvements in mindfulness (raw score, 45.2 to 54.1; raw score change [Δ], 8.9; 95% confidence interval [CI], 7.0 to 10.8); burnout (emotional exhaustion, 26.8 to 20.0; Δ = 6.8; 95% CI, −4.8 to −8.8); depersonalization, 8.4 to 5.9; Δ = 2.5; 95% CI, −1.4 to −3.6; and personal accomplishment, 40.2 to 42.6; Δ = 2.4; 95% CI, 1.2 to 3.6); empathy (116.6 to 121.2; Δ = 4.6; 95% CI, 2.2 to 7.0); physician belief scale (76.7 to 72.6; Δ = −4.1; 95% CI, −1.8 to −6.4); total mood disturbance (33.2 to 16.1; Δ = −17.1; 95% CI, −21.9 to −12.3); and personality (conscientiousness, 6.5 to 6.8; Δ = 0.3; 95% CI, 0.1 to 5 and emotional stability, 6.1 to 6.6; Δ = 0.5; 95% CI, 0.3 to 0.7). Improvements in mindfulness were correlated with improvements in total mood disturbance (r = −0.39, P < .001), perspective-taking subscale of physician empathy (r = −0.31, P < .001), burnout (emotional exhaustion and personal accomplishment subscales, r = −0.32 and 0.33, respectively; P < .001), and personality factors (conscientiousness and emotional stability, r = −0.29 and 0.25, respectively, P < .001).

Conclusions Participation in a mindful communication program was associated with short-term and sustained improvements in well-being and attitudes associated with patient-centered care. Because before-and-after designs limit inferences about intervention effects, these findings warrant randomized trials involving a variety of practicing physicians.

JAMA. 2009;302(12):1284–1293

www.jama.com

Photo: Jillian Horton
One of my biggest “a-ha” moments:

Focused attention and emotional self-regulation practices help achieve system change because they fortify us so we can survive long enough to change things for others.
We don’t need more resilient canaries. But we sure need resilient people to get the canaries out.
5. Be willing to rewrite the ending.
“Survivorship bias” in physician narratives

“The areas on these planes that hadn’t been hit likely represented where other planes had been hit and not made it home. So those were the areas that should be reinforced.”

https://blogs.bmj.com/bmj/2020/11/30/all-of-us-have-a-survivorship-bias-in-regard-to-how-we-were-trained-in-medicine/
“Yes, but it made us stronger....”


Wellcome Collection CC-BY
What the human being is best at doing is interpreting all new information so that their prior conclusions remain intact.”

- Warren Buffett

“The Narrative Fallacy…”

IN MY SECRET LIFE I HAD PASSIVE SUICIDAL IDEATION.

I THOUGHT ABOUT KILLING MYSELF EVERY DAY.

SOMETIMES I FANTASIZED ABOUT HANGING MYSELF WITH MY STETHOSCOPE FROM THE DUCT IN THE CALL ROOM.

IT WAS ALREADY KILLING ME ANYWAY.
@jillianhortonmd
Jillian.Horton@umanitoba.ca

We Are All Perfectly Fine
A Memoir of Love, Medicine and Healing

“Profound and compassionate… Jill Horton offers deep reflections on the private suffering of the healing professions. A must-read.” — Dr. Ron Epstein, author of Attending
A National Strategy for Clinician Wellbeing: A Way Forward

Christine K Cassel MD
American Conference on Physician Health 2021
Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being

October 2019
A Problem That Was Always There Comes out of the Shadows

National Attention
Public Media
Professional and Trade Press
Educational Institutions
Delivery Systems
Professional Associations
Regulatory Organizations
Health System Improvement
Study Sponsors

- Accreditation Council for Graduate Medical Education
- American College of Occupational and Environmental Medicine
- American Hospital Association
- Arnold P. Gold Foundation
- Association of American Medical Colleges
- BJC HealthCare
- Cedars-Sinai Medical Center
- The Doctors Company Foundation
- Duke University Hospital
- Gordon and Betty Moore Foundation
- Johns Hopkins Health System
- Josiah Macy Jr. Foundation
- Keck School of Medicine of USC
- Medical College of Wisconsin
- Montefiore Medicine
- The Mont Fund
- The Ohio State University
- The State University of New York System
- Tulane University
- University of Florida
- University of Illinois Hospital and Health Sciences System
- University of Massachusetts Medical School
- University of Michigan
- University of New Mexico Health Sciences Center
- University of Utah Health
- University of Virginia Medical Center and
- University of Virginia School of Medicine
- Vanderbilt University Medical Center
- Washington University School of Medicine
- Yale School of Medicine
- Yale New Haven Health System
<table>
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<tr>
<th>Committee Members</th>
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<tr>
<td><strong>Pascale Carayon, PhD (Co-chair)</strong></td>
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<tr>
<td>University of Wisconsin – Madison</td>
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<tr>
<td><strong>Saranya Loehrer, MD, MPH</strong></td>
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<tr>
<td>Institute for Healthcare Improvement</td>
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<tr>
<td><strong>Christine Cassel, MD (Co-chair)</strong></td>
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<td>University of California, San Francisco</td>
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<td><strong>Lex MacNeil, DDS</strong></td>
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<td>Midwestern University, Downers Grove</td>
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<td><strong>Elisabeth Belmont, JD</strong></td>
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<td>Emory Healthcare</td>
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<td><strong>M. Lynn Crismon, PharmD</strong></td>
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<td>The University of Texas at Austin College of Pharmacy</td>
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<td><strong>Cynda Rushton, PhD, RN</strong></td>
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<td><strong>Tait Shanafelt, MD</strong></td>
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<td><strong>Pooja Kinkhabwala, DO</strong></td>
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<tr>
<td>Larkin Community Hospital</td>
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<td><strong>George Thibault, MD</strong></td>
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<td>Josiah Macy Jr. Foundation (retired)</td>
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<td><strong>Vindell Washington, MD</strong></td>
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<tr>
<td>Blue Cross Blue Shield of Louisiana</td>
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<td><strong>Matthew Weinger, MD</strong></td>
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<td>Vanderbilt University</td>
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**NASEM Staff**
- Laura Aiuppa
  - Study Director
- Marc Meisnere
- Rajbir Kaur
- Heather Kreidler
- Sharyl Nass
- Toby Warden
What is Clinician Burnout?

• The World Health Organization defines burnout as a problem associated with chronic workplace stress; it is not an individual mental health diagnosis, nor the same as depression.

• Burnout: emotional exhaustion, depersonalization, and low sense of professional efficacy.

• A chronic imbalance of high job demands and inadequate job resources can lead to burnout.

Burnout

- Poorer quality of care; more medical errors
- Decreased patient satisfaction
- Less productivity

Personal
- Alcohol and substance use
- Depression
- Suicide

Professional
- Physician turnover

A SYSTEMS MODEL OF CLINICIAN BURNOUT AND PROFESSIONAL WELL-BEING

OUTCOMES
Clinician Burnout
Professional Well-Being

CONSEQUENCES for:
Patients
Clinicians
Health Care Organizations
Society

LEARNING AND IMPROVEMENT
Collective and coordinated action across all levels of the health care system – front line care delivery, the health care organization, and the external environment is needed.
6 Goals to Reduce Burnout and Foster Professional Well-Being

Goal 1 Create Positive Work Environments

Goal 2 Create Positive Learning Environments

Goal 3 Reduce Administrative Burden

Goal 4 Enable Technology Solutions

Goal 5 Provide support to Clinicians & Learners

Goal 6 Invest in Research
Implementation

• **Build infrastructure** for a well-being system that has adequate organizational resources, processes, and structures; continually learns and improves; and is accountable.

• **Design reward systems** that align with organizational and professional values to support professional well-being.

• **Nurture organizational culture** that supports change management, psychological safety, vulnerability, and peer support.

• **Use human-centered design processes** to co-design, implement and continually improve solutions and interventions that address clinician burnout.
Enter Covid-19

New demands: lack of knowledge
Infection risk; inadequate PPE
Inadequate resources for care: rationing
Unprecedented mortality rates
Stark inequities
Moral distress/Moral Injury
Divisive social attitudes, politics
The Clinician Well-Being Collaborative Overview

- Established in 2017 as a **public-private partnership** committed to reversing trends in clinician burnout

- **Over 60 key players** in US healthcare System and **over 200 Network Organizations** to include **diverse groups working together**:
  - Academia
  - US Government
  - Health care system leaders
  - Health care professionals
  - Professional and specialist organizations
  - Education and accrediting bodies
  - Health IT companies
  - Payers

- **Co-Chairs**:
  - Dr. Victor Dzau (NAM)
  - Dr. Vivek Murthy, US Surgeon General (HHS)
  - Dr. Darrell Kirch (AAMC)
  - Dr. Thomas Nasca (ACGME)

- **Steering Committee**:
  - US Government
  - Healthcare Industry leaders, professionals
  - Education and accrediting bodies
  - Professional and specialist organizations
Working Group Goals: Supporting and Driving Change Together

**2017-2020**
- Engage healthcare executive leaders
- Break the Culture of Silence by tackling help-seeking stigma among clinicians
- Identify/Promote use of Organizational Promising Practices and Metrics
- Improve Workload and Workflow
- Implementing recommendations on 2019 Consensus Report Recommendations
- Post-2020 Sustainability

**2021-2022**:
- Build a National Strategy
- Lead a comprehensive approach to addressing the needs of clinicians resulting from COVID-19
- Identify and develop tools to implement promising practices
Timeline of Planned Working Group Activities (work in progress)

Phase 1 – Development of National Strategy and Mobilization

- Convening with CMS, payers, delivery systems
- Launch Resource Compendium + Conduct Pre Questionnaire
- Convening on Embedding Well-Being as a Value
- Convening 2 (e.g., accred.)
- Convening 3 (e.g., health IT innov.)
- Publication on lessons learned from COVID

Target date to deliver a National Strategy

Prioritize giving feedback on the National Strategy

Communications campaign activities TBD

Phase 2 - Dissemination and Handoff of National Strategy

- Conduct Post Questionnaire + Analyze Results
- Public Collaborative meeting / town hall

- JUL 2022
- AUG 2022
- SEPT 2022
- OCT 2022
- NOV 2022
- DEC 2022
Is “Quality of Care” a Burden or a Benefit: Examining the Accountability Framework

*Documentation requirements

*Too many measures and too many measurers: CMS, insurers, NCQA, TJC, Certifying Organizations, Healthgrades, Yelp! etc, etc.

*What is measured is what matters: volume, checkboxes, not compassion or creativity

• Policy leaders: align and coordinate
• Allow innovation from information technology
Technology Innovations

- Voice recognition software
- Video recognition software
- Information technology middleware applications
- Data for Public Health

*Preparedness/Adequate Supplies
*Accurate and complete data availability
*Collaboration between systems
*Consistent supportive public messages
*Crisis Standards of Care
Download the report & view more resources:
http://nam.edu/clinicianwellbeingstudy

Action Collaborative on Clinician Wellbeing and Resilience
www.nam.edu
What Contributes Most to Your Burnout?

- Too many bureaucratic tasks: 58%
- Spending too many hours at work: 37%
- Lack of respect from administrators/employers, colleagues, or staff: 37%
- Insufficient compensation/reimbursement: 32%
- Lack of control/autonomy: 28%
- Increasing computerization of practice: 28%
- Lack of respect from patients: 17%
- Stress from social distancing/societal issues related to COVID-19: 16%
- Government regulations: 14%
- Stress from treating COVID-19 patients: 8%
Social Contract: A Role for Everyone

Role of government: public health
Role of government: health care delivery
Support of communities
Support of institutions
Support from our own profession
TO DO LIST

• Leadership: optimize workflow, normalize help and support

• Advocacy: ensure supplies and clear, consistent public messages

• Clinicians; respect one another. Reach out. Recognize the power of team support

• Everyone: use these lessons to re-engineer a system that works better

• Your thoughts??
6 Goals to Reduce Burnout and Foster Professional Well-Being

Goal 1 Create Positive Work Environments
Goal 2 Create Positive Learning Environments
Goal 3 Reduce Administrative Burden
Goal 4 Enable Technology Solutions
Goal 5 Provide support to Clinicians & Learners
Goal 6 Invest in Research
Implementation--toolbox

• Institutional leadership
• What are the five things “I can do”? 
Factors Affecting Clinician Well-Being and Resilience
A SYSTEMS MODEL OF CLINICIAN BURNOUT AND PROFESSIONAL WELL-BEING

OUTCOMES
- Clinician Burnout
- Professional Well-Being

CONSEQUENCES for:
- Patients
- Clinicians
- Health Care Organizations
- Society

LEARNING AND IMPROVEMENT