Exploration of career choices and job satisfaction among early career pediatricians

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Department of Pediatrics, University of Wisconsin School of Medicine and Public Health
Disclosures

• No Disclosures
Background

- Factors inherent to physician job satisfaction change over the course of a career.
- Early career physicians (ECPs) experience both personal and professional stressors:
  - Establishing practice/post training position
  - Physiologic/common time for pregnancy, childbirth, and adoption
  - Work may not yet align with values/goals, compared to mid or late career pediatricians
  - Generation differences: focus on time for non-work aspects of life
# Early Career Pediatricians

<table>
<thead>
<tr>
<th>TABLE 5</th>
<th>Personal and Work Factors Associated With Satisfaction With Career as a Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal factors</strong></td>
<td></td>
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<tr>
<td>Excellent/very good self-reported health</td>
<td>2.17&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Have children</td>
<td>0.98</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>0.54&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sad or depressed in last 12 mo</td>
<td>0.22&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td><strong>Work factors</strong></td>
<td></td>
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<tr>
<td>≥4 y at current position</td>
<td>3.17&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Physician colleagues are important source of personal support</td>
<td>2.87&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autonomy in making clinical decisions</td>
<td>2.22&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Adequate resources for patient care</td>
<td>1.70&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Variables in the model that were not significant: having children, race, International Medical Graduate, has current educational debt, meets federal exercise recommendations, ≥1 negative life events in last 12 mo, primary position, ≥50 work hours per week. aOR, adjusted odds ratio; CI, confidence interval.

<sup>a</sup> Significant result.
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)
40% of women physicians go part-time or leave medicine within six years of completing residency

- 23% of women were not working full time (3.6% male physicians)
- 31% of women with children were not working full time (4.6% males)
Research Gap and Study Objective

- What early career choices are pediatricians making?
- Can we have a more nuanced understanding of their career satisfaction?
- What differences exist related to sex and parenthood status?
Methods

- National data collected from a cohort of ECPs via 2019 survey, as part of the longitudinal **AAP Pediatrician Life and Career Experience Study**
- Cohort: 2016-2018 residency graduates
- Respondents asked about personal and work characteristics and satisfaction with job aspects (4-point Likert scale)
- Sex measured: male, female, self-describe
- Hours worked: Do you currently work reduced or part-time hours?
- Chi-squared tests examined relationships of sex and parenthood with fellowship training, part-time hours, and measures of job satisfaction
## Results

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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<tbody>
<tr>
<td>N=830, 90%</td>
<td>response rate</td>
</tr>
<tr>
<td>33%</td>
<td>in fellowship training</td>
</tr>
<tr>
<td>11%</td>
<td>part-time work</td>
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<tr>
<td>75%</td>
<td>female (0 responded “self-describe”)</td>
</tr>
<tr>
<td>43%</td>
<td>parents (no statistical difference by sex)</td>
</tr>
</tbody>
</table>
Fellowship training

BY PARENTHOOD STATUS

Parent
Without Children

P < 0.001
Fellowship training

BY SEX

Female 31
Male 39

P<0.05
Figure 1. Percent of early career pediatricians reporting they are in FELLOWSHIP TRAINING

<table>
<thead>
<tr>
<th>Respondents with children</th>
<th>Respondents without children*</th>
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<tbody>
<tr>
<td>23%</td>
<td>51%</td>
</tr>
<tr>
<td>26%</td>
<td>*p&lt;0.01</td>
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</tbody>
</table>

Source: AAP Pediatrician Life and Career Experience Study (PLACES)
2016-2018 Residency Graduates Cohort, 2019 data; *p=0.01
All female vs male (31% vs 39%, p<0.05); all with children vs without children (24% vs 40%, p<0.001)
Among all female, with children vs without children (23% vs 36%, p<0.001)
Among all male, with children vs respondents without children (26% vs 51%, p<0.001)
Part-time work

BY PARENTHOOD STATUS

Parent  Without Children

P<0.01
Part-time work

BY SEX

Female  Male

19  6

P < 0.01
Figure 2. Percent of early career pediatricians reporting they are working PART-TIME OR REDUCED HOURS

Respondents with children*

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
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</thead>
<tbody>
<tr>
<td>30%</td>
<td>5%</td>
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</table>

*P<0.001

Respondents without children

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
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<tbody>
<tr>
<td>10%</td>
<td>7%</td>
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</table>

Source: AAP Pediatrician Life and Career Experience Study (PLACES) 2016-2018 Residency Graduates Cohort (post-training only), 2019 data; *p<0.001
All female vs male (19% vs 6%, p<0.01); all with children vs without children (24% vs 9%, p<0.001)
Career satisfaction

Figure 3. Percent of early career pediatricians reporting they are COMPLETELY OR SOMEWHAT SATISFIED

<table>
<thead>
<tr>
<th></th>
<th>Flexibility for work-life balance</th>
<th>Job earnings</th>
<th>Opportunities for learning and growth*</th>
<th>Recognition at work*</th>
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<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
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<tr>
<td></td>
<td>69%</td>
<td>74%</td>
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<td></td>
<td>64%</td>
<td>66%</td>
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<tr>
<td></td>
<td>83%</td>
<td>91%</td>
<td>*p&lt;0.05</td>
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<tr>
<td></td>
<td>76%</td>
<td>83%</td>
<td>*p&lt;0.05</td>
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</tbody>
</table>

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

Parenthood status did not predict any categories of career opportunity satisfaction.
Summary

• Among ECPs, \textit{parenthood} and \textit{sex} predicted likelihood of attending fellowship during early career
  • There was no sex difference in fellowship training among \textit{pediatricians with children}

• \textbf{Female sex} and \textit{parenthood} were associated with part-time work
  • There was no sex difference in part-time work among \textit{pediatricians without children}

• \textbf{Female ECPs} were less likely to be satisfied with \textit{opportunities for learning and growth and recognition at work}
Parenthood, sex and part-time work

• Female sex and parenthood:
  • Female pediatricians do majority of household work, especially related to caregiving (Starmer 2016)
  • Societal expectations for role in caregiving
  • Female pediatricians carry and deliver biologic children
  • Often, female pediatricians breastfeed infants*

• Parental satisfaction of US physicians: associated factors and comparison with the general US working population (Shanafelt 2016)
  • Women physicians were more likely to see job as negatively impacting relationship with their children
Another way to frame the issue is that leaning in when you have significant caregiving responsibilities requires an intensive support structure at home and lots of flexibility at work. Think about simple physics. Imagine a tree leaning over the water.
Part-time work

• Benefits:
  • Decreased risk of burnout
  • More time for self, family
  • Form of “control” of schedule

• Issues:
  • Stigma
  • Choice vs “forced”
  • Do part-time workers actually work part-time?
  • What is the impact on long-term career, professional fulfillment?
  • Workforce
Marginalized individuals in medicine

- Gendered expectations
- Values-misalignment
- Discrimination
- Bias
- Harassment
- Invisible work
- Minority tax
- Larger household workload (esp caregiving)
- Pay inequities
Limitations

- Survey study
- Data not yet adjusted for other variables
- More detailed information delineating experience based on sex and gender are needed
Future Steps

• Broaden the body of research to examine physician well-being across sex and gender spectrums, avoiding binaries and equating sex and gender

• Work to better understand the contexts in which gender and sex influences choices to work part-time, and how those choices correlate to professional and personal well-being

• Understand how intersectionality (experience of multiple identities that suffer marginalization and oppression) relates to early career choices and professional well-being
Acknowledgements

PLACES is supported by:

The American Academy of Pediatrics

Thanks to the PLACES Project Advisory Committee and to all the PLACES participants!
Understanding the Impact of COVID-19 on Faculty Needs for Childcare & Eldercare, Flexibility and Work/Life Balance

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Executive Director, Population Health Management & Physician Engagement
Brigham and Women’s Physicians’ Organization
October 7, 2021
Disclosures

• No disclosures
Working in healthcare was hard.

Before COVID.

### About 3 in 10 health-care workers say they have considered no longer working in health care

Q: As a result of the covid-19 pandemic, have you considered no longer working in health care, or not?

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<tr>
<th></th>
<th>0</th>
<th>20</th>
<th>40</th>
<th>60</th>
<th>80</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
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<td></td>
<td>71%</td>
<td></td>
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</tbody>
</table>

Note: “No opinion” not shown.

What did we do?

Offered Physician Focus Groups on Childcare/Eldercare, Flexibility & Work/Life Balance during COVID

Seven virtual focus groups offered to all physicians at varied times.
Facilitated groups met from September 14-25, 2020, including 80 physicians from 13 departments.

Main themes that emerged:
• Access to COVID testing problematic
• Difficulty attaining flexibility
• Additional childcare support & options needed
• Backup systems for physicians lacking
• Work/life boundaries blurred
• Value your physician workforce and reduce moral distress
Access to COVID testing

What we heard:
• Current testing criteria and lack of availability creates barriers for physicians working due to childcare, as well as increases the chance of missing work.
• Physicians reported that some departments were allowing time off for testing while others were asking physicians to use their personal time.

Subsequent Actions:
• Brigham leadership reviewed COVID testing time off policies of each department to ensure equity and implemented changes to create alignment. All departments instituted policy not requiring physicians to use personal time for testing.
• Access to free asymptomatic employee testing was quickly implemented across Mass General Brigham system. Access to linkages to testing for family members was improved via Occupational Health but there may be additional opportunity to improve.
Flexibility isn’t there

What we heard:

• Flexibility is extremely difficult to attain in real practice as a physician faculty member at the Brigham.

• Flexible work arrangements, when offered at all, are not consistent and made available by all leadership.

Subsequent Actions:

• Leadership working to create a culture that consistently offers more flexibility and does not penalize those who opt for flexible work arrangements.

• Flexibility is being integrated into departmental planning to ensure that it is available to be accessed.

• Increased virtual visit availability for physicians.
What we heard:

• The Brigham Health/ Mass General Brigham childcare options do not meet the needs of the physician community. Other local options do not suffice either.

• Access, availability, convenience, affordability all lacking.

• Childcare vs. eldercare needs are very different and require different solutions that take into account predictability of need, type of need, location, etc.

Subsequent Actions:

• Mass General Brigham expansion of child care coverage in partnership with Bright Horizons, including new locations and expansion of backup child care center availability and access.

• Subsidized childcare was rolled out during the pandemic.
What we heard:

- We do not have good backup systems to support our physicians with unexpected issues.
- Lack of systems impacts physicians every day as they don’t feel that they can take care of themselves without hurting their coworkers who will be negatively impacted if they call out.

Subsequent Actions:

- Brigham Leadership Operations Committee reviewed the policies of each department to:
  - Ensure that backup systems for ambulatory clinics, scheduled shifts, and surgery/procedures are in place
  - Optimize system for minimizing negative impacts for patients and staff when last minute sick or other call outs occur
What we heard:
• Physicians feel pressured to maintain productivity despite unprecedented conditions, and work/life boundaries have all but disappeared.

Subsequent Actions:
• Leadership reviewed vacation/time off policies of each department to ensure equity and access to time off
• Senior leaders led a culture change to reduce unnecessary early and late meetings
• Brigham Faculty Development & Wellbeing continues to pursue strategies to improve job doability and shorten work days:
  - Offering 1:1 Epic trainings, and InBasket and Epic Upgrade support
  - Implementing new scribe options to reduce documentation burden
  - Offering flexible BWELL MD grant program to fund system improvement and/or wellbeing projects at the local level to improve efficiency and work life
What we heard:

- Physicians are not feeling appreciated by the organization for their extraordinary contributions to COVID care and ramp up of care all while maintaining the “regular care”.
- Appreciation efforts to date fell short of expectations.
- Physicians frequently feel pulled between caring for their patients and caring for the rest of their lives (themselves, childcare, eldercare, community, etc.)

Subsequent Actions:

- Recognizing that *perceived gratitude* is a key driver of burnout at Brigham (as evidenced by 2017 & 2019 survey results), leadership agreed upon appreciation as a focal area for FY21.
- Developed pulse appreciation survey to better understand how physicians would like to receive appreciation.
- Explore ways to mitigate moral distress via discussion in multiple forums.
Brigham Pulse Survey on Physician Appreciation

Objectives:
• Understand our physicians’ perception of our current appreciation efforts
• Learn about how our physicians would like to be appreciated
• Create a plan to improve physicians’ perceived appreciation (a driver of burnout at Brigham)

• Brief 5 question survey, 2-3 minutes to complete
• 1600 participants randomized into 6 waves, which will be administered through 2021
• Waves 1-3 completed, February, June & September 2021
  • Sent to 896 physicians so far, 349 responses (40% response rates)

• Key themes include need for greater appreciation from direct supervisors/leaders and continued focus on investing in job doability -- invitation to view more results on the poster by Victoria Ostler and our team here at this conference
Conclusions

Focus groups provide direct, timely & effective communication with physicians. Strong value to participants voicing their opinions and concerns, debriefing and sharing ideas with their peers and being heard by leadership.

There are important differences between childcare and eldercare and organizations need to provide flexible, robust solutions for each.

Access to testing early-on in the pandemic (and continuing throughout as payers change coverages) has been crucial.

Integrating flexible work arrangements into departmental planning will make it possible for more flexibility to be offered and accessed by faculty.

Continued need to support physicians in setting and maintaining boundaries to support work/life balance.

Further explore which ways of expressing gratitude resonate best with our physicians, as well as how to effectively mitigate moral distress.
Burnout and Professional Fulfillment Related to the Rapid Uptake of Telehealth Due to COVID-19

Kristine Olson, MD MSc, Chief Wellness Officer, Yale New Haven Hospital
Scott Sussman, MD, Director, Telehealth, Yale New Haven Health
Mickey Trockel, MD PhD, Principal, Stanford Medicine, WellMD
Tait Shanafelt, MD, Chief Wellness Officer, Stanford Medicine, WellMD
Christine Sinsky, MD, VP Professional Satisfaction American Medical Association
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:

The COVID-19 necessitated the rapid and dramatic change of healthcare delivery, shifting from in-person to virtual care.

In one year (2019-2020), due to the COVID-19 pandemic, Yale New Haven Health System increased the number of video visits from 316 to 511,320 per year (1618x)!

This study is perhaps the first of its kind to evaluate the impact of pandemic-driven telehealth, a disruptive innovation necessitating rapid uptake, on physicians’ level of professional fulfillment and burnout.
Aims:

Immediately after the first wave of COVID-19 pandemic...

1. What proportion of physicians use telehealth?
2. What proportion of telehealth use was due to the pandemic?
3. Was the transition difficult?
4. Is it adequate for patient care?
5. How does telehealth affect productivity?
6. What is the level of satisfaction with telehealth?

7. Which telehealth support structures were perceived to be adequate or inadequate in facilitating the encounter: patient access, patient exam, communicating and coordinating care, logistics?

8. How do these experiences related to professional well-being – burnout and professional satisfaction?

9. How do these telehealth experiences differ by specialty?
Methods:

The telehealth survey was part of the annual medical staff work-life well-being assessment taken September-October 2020, after the first wave of the COVID-19 pandemic which began in the USA March 2020.

Screening questions for all survey takers:

Do you use tele-health?
- Yes
- No

Due to COVID-19, have you used tele-health for the first time?
- Yes
- No

My transition to tele-health has been...
- Extremely easy
- Somewhat easy
- Neither easy nor difficult
- Somewhat difficult
- Extremely difficult

Level of satisfaction with tele-health is....
- Extremely satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Extremely dissatisfied

Logic takes telehealth users to sub-survey to assess their telehealth experience:
In your opinion, is tele-health adequate for most patient care encounters...

- Strongly agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Strongly disagree

Because of tele-health, the number of patients that I can see in a workday has been...

- Much more
- Somewhat more
- About the same
- Somewhat less
- Much less
To support your tele-health practice, did you have adequate....

Extremely inadequate
Somewhat inadequate
Neither adequate nor inadequate
Somewhat adequate
Extremely adequate

Centralized call center
Scheduling Assistance
Virtual Rooming Assistance
Integration into the EHR
Ability to add multiple people to the eVisit (ex. family, providers, interpreters, scribes)
Ability to get information typically procured by physical exam
IT Support and Technical Troubleshooting
Training on compliance, risk, billing, documentation
Ability to care for all patients without excluding any populations
Ability to communicate and coordinate care easily without miscommunication or mishap
Question for all survey takers:

The amount of digital screen time that I have everyday is....

- Appropriate
- Neither appropriate nor inappropriate
- Slightly inappropriate
- Moderately inappropriate
- Extremely inappropriate
Results:

The sample compared to the reference population:
By department, proportionally similar.
By hospital, over representation of the main academic hospital (62% v 58%)
By practice model, over representation of academic physicians

The sample that responded to the telehealth screening question “do you use telehealth” is demographically similar to the overall sample.

Figure 1: Inclusion Criteria
Only Attendings Physicians and Advanced Practice Providers who use telehealth were included in the sample (excluding physicians in training: residents and fellows)
Table 1: ATTENDING PHYSICIANS EXPERIENCE WITH THE PANDEMIC-DRIVEN RAPID UPTAKE OF TELEHEALTH

use, pandemic-driven use, satisfaction, ease, adequacy, productivity, features, burnout, fulfillment.

<table>
<thead>
<tr>
<th>Independent Predictor (ATTENDING PHYSICIANS ONLY N=1160)</th>
<th>Response:</th>
<th>Freq.</th>
<th>(%)</th>
<th>% Burnout</th>
<th>BO OR (CI)</th>
<th>% Prof Fulfillment</th>
<th>PF OR (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use tele-health?</td>
<td>Yes</td>
<td>731</td>
<td>(63.0)</td>
<td>33.7</td>
<td>-</td>
<td>42.6</td>
<td>-</td>
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<tr>
<td></td>
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<td>P=0.74</td>
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<td></td>
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<td>P=0.864</td>
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<tr>
<td>Due to COVID-19, have you used tele-health for the first time?</td>
<td>Yes</td>
<td>662</td>
<td>(90.9)</td>
<td>34.8</td>
<td>0.55 (0.30-1.00)</td>
<td>41.5</td>
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<td>P=0.048</td>
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<td>P=0.509</td>
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<tr>
<td>My transition to tele-health has been...</td>
<td>Somewhat difficult - Extremely difficult</td>
<td>108</td>
<td>(14.9)</td>
<td>50.9</td>
<td>0.43 (0.28-0.64)</td>
<td>43.8</td>
<td>1.65 (1.06-2.58)</td>
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<td>P=0.025</td>
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<td></td>
<td>Somewhat - Extremely dissatisfied</td>
<td>186</td>
<td>(26.0)</td>
<td>42.9</td>
<td>0.59 (0.42-0.83)</td>
<td>39.0</td>
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<td>P=0.002</td>
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<td>P=0.300</td>
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<tr>
<td>Level of satisfaction with tele-health is</td>
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<td></td>
<td>Somewhat disagree - Extremely disagree</td>
<td>319</td>
<td>(44.3)</td>
<td>32.5</td>
<td>-</td>
<td>42.3</td>
<td>-</td>
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<td>P=0.556</td>
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<td></td>
<td>P=0.985</td>
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<tr>
<td>tele-health adequate for most patient care encounters</td>
<td>Somewhat - Much less</td>
<td>145</td>
<td>(20.3)</td>
<td>35.9</td>
<td>-</td>
<td>44.6</td>
<td>-</td>
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<td>P=0.539</td>
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<td></td>
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<td></td>
<td>P=0.538</td>
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<tr>
<td>Because of tele-health, the number of patients that I can see in a workday has been...</td>
<td></td>
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<tr>
<td>FEATURES: To support your tele-health, did you have adequate...</td>
<td>Extremely - Somewhat inadequate</td>
<td>295</td>
<td>(44.2)</td>
<td>41.2</td>
<td>0.49 (0.36-0.68)</td>
<td>33.8</td>
<td>1.77 (1.28-2.44)</td>
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<td>P=0.001</td>
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<td>P=0.000</td>
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<td>Centralized call center</td>
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<tr>
<td></td>
<td>Extremely - Somewhat inadequate</td>
<td>266</td>
<td>(39.4)</td>
<td>44.0</td>
<td>0.49 (0.36-0.68)</td>
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<tr>
<td></td>
<td>Extremely - Somewhat inadequate</td>
<td>244</td>
<td>(39.4)</td>
<td>40.9</td>
<td>0.63 (0.46-0.89)</td>
<td>34.3</td>
<td>1.62 (1.16-2.26)</td>
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<td></td>
<td>Integration into the EHR</td>
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<tr>
<td></td>
<td>Extremely - Somewhat inadequate</td>
<td>186</td>
<td>(27.6)</td>
<td>41.9</td>
<td>0.64 (0.46-0.88)</td>
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<td>Ability to add multiple people to the eVisit</td>
<td>261</td>
<td>(39.3)</td>
<td>49.0</td>
<td>0.63 (0.46-0.88)</td>
<td>36.7</td>
<td>1.41 (1.01-1.95)</td>
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<td>Ability to get information typically procured by physical exam</td>
<td>191</td>
<td>(28.7)</td>
<td>33.6</td>
<td>-</td>
<td>39.4</td>
<td>1.41 (0.99-1.99)</td>
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<td>Extremely - Somewhat inadequate</td>
<td>263</td>
<td>(39.4)</td>
<td>39.9</td>
<td>0.69 (0.50-0.96)</td>
<td>35.3</td>
<td>1.56 (1.13-2.16)</td>
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<td>Training on compliance, risk, billing, documentation</td>
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<td>Ability to care for all patients without excluding any populations</td>
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<td>(52.7)</td>
<td>38.1</td>
<td>0.70 (0.51-0.97)</td>
<td>38.0</td>
<td>1.41 (1.03-1.93)</td>
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<td>Ability to communicate and coordinate care easily without miscommunication or mishap</td>
<td>214</td>
<td>(31.9)</td>
<td>41.6</td>
<td>0.64 (0.46-0.89)</td>
<td>36.8</td>
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<td>P=0.033</td>
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<td></td>
<td>Ability to communicate and coordinate care easily without miscommunication or mishap</td>
<td>259</td>
<td></td>
<td></td>
<td>0.51 (0.39-0.67)</td>
<td>35.4</td>
<td>2.20 (1.71-2.84)</td>
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<td>P=0.008</td>
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<td>SCREENTIME: The amount of digital screen time that I have everyday is...</td>
<td>716</td>
<td>(64.2)</td>
<td>39.8</td>
<td>0.51 (0.39-0.67)</td>
<td>35.4</td>
<td>2.20 (1.71-2.84)</td>
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<td>P=0.000</td>
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</table>

Table 3: Standard descriptive statistics are shown to describe the frequencies and proportions for each item's responses. The proportion of burnout or professional fulfillment is presented if there was a statistical significance between the dependent and independent variables (BO or PF) was established by logistic regression adjusted for adjusted for age, race, gender, specialty, delivery network to establish associations (OR). If the result is not statistically significant, "NA" is presented.

Likert scaling dichotomized:
- Somewhat difficult - Extremely difficult versus Extremely easy - Neither easy nor difficult, Much more - About the same versus Somewhat - Much less, Extremely - Somewhat inadequate versus Neither adequate/inadequate - Extremely adequate, Slightly - Extremely inappropriate versus Appropriate - Neither appropriate/inappropriate
63.0% of attending physicians used telehealth (OR: BO -; PF -)

90.9% of users used for the first time due to the pandemic (OR: BO 0.55, CI 0.30-1.00; PF -)

Pandemic-driven...

• **74.0%** had no dissatisfaction (OR: BO 0.70, CI 0.51-0.97; PF -)

• **85.1%** had no difficulty transitioning (OR: BO 0.43, CI 0.28-0.64; PF 1.65, 1.06-2.58)

• **55.7%** had little concern it as adequate for patient encounters. (OR: BO -; PF -)

• **79.7%** felt they could see the same number or more patients (OR: BO -; PF-)

...telehealth
• 47.3% care for all patients without excluding any populations (OR: BO 0.70, 0.51-0.97; PF 1.41, CI 1.03-1.93)

• 71.3% information typically procured by exam (OR: BO -, PF -)

• 60.7% add multiple people to the visit (OR: BO 0.64, CI 0.46-0.89; PF 1.41, CI 1.01-1.95)

• 68.1% communicate and coordinate, no mishap (OR: BO 0.64, CI 0.46-0.89; PF -)

... did not report telehealth was inadequate at this time.
• 65.8% call center (OR: BO 0.49 CI 0.36-0.68; PF 1.77 CI 1.28-2.44)

• 60.6% scheduling assistance (OR: BO 0.49 CI 0.36-0.68; PF 1.70 CI 1.23-2.35)

• 64.6% virtual rooming (OR: BO 0.63, 0.46-0.89; PF 1.62 CI 1.16-2.26)

• 60.6% IT and technical support (OR: BO 0.69, 0.50-0.96; PF 1.56, 1.13-2.16)

• 66.2% training on risk, compliance, billing, doc (OR: BO -; PF 1.47, CI 1.06-2.07)

• 72.4% Integration into the EHR (OR: BO 0.64, CI 0.46-0.88; PF 1.46 , CI 1.02-2.08)

... did not report telehealth was inadequate at this time.
Of all attending physicians:

64.2% felt their daily screen time was inappropriate

Range 40.3% - 78.3% across all specialties

(OR: BO 1.96, 1.49-2.58; PF 0.45, 0.35-0.59)
Table 2: BY SPECIALTY: ATTENDING PHYSICIANS EXPERIENCE WITH THE PANDEMIC-DRIVEN RAPID UPTAKE OF TELEHEALTH

Use, use pandemic-driven use, satisfaction, ease, adequacy, productivity, burnout, fulfillment. Summary on next slide.

<table>
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<tr>
<td>Attendings Physicians</td>
<td>195</td>
<td>134</td>
<td>195</td>
<td>86</td>
<td>68</td>
<td>110</td>
<td>156</td>
<td>185</td>
<td>109</td>
<td>183</td>
<td>82</td>
<td>1</td>
<td>1503</td>
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<tr>
<td>Do you use tele-health?</td>
<td>Yes</td>
<td>111</td>
<td>(76.6)</td>
<td>33 (30.8)</td>
<td>136 (87.2)</td>
<td>58 (79.2)</td>
<td>41 (78.9)</td>
<td>51 (55.4)</td>
<td>100 (88.5)</td>
<td>21 (13.7)</td>
<td>59 (77.6)</td>
<td>114</td>
<td>(83.8)</td>
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<tr>
<td>SAMPLE SIZE (using telehealth = yes)</td>
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<tr>
<td>Yes</td>
<td>111 (94.6)</td>
<td>27 (81.8)</td>
<td>129 (96.6)</td>
<td>56 (96.4)</td>
<td>39 (95.1)</td>
<td>48 (94.1)</td>
<td>76 (76.8)</td>
<td>18 (85.7)</td>
<td>57 (96.6)</td>
<td>101 (89.4)</td>
<td>5 (83.3)</td>
<td>1 662 (90.9)</td>
<td>728</td>
</tr>
<tr>
<td>No</td>
<td>1 (5.4)</td>
<td>3 (18.2)</td>
<td>3 (4.4)</td>
<td>0 (0)</td>
<td>1 (2.9)</td>
<td>1 (2.1)</td>
<td>0 (0)</td>
<td>1 (5.3)</td>
<td>1 (1.7)</td>
<td>1 (1.8)</td>
<td>4 (7.7)</td>
<td>1 145 (14.1)</td>
<td>96</td>
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<tr>
<td>My transition to tele-health has been</td>
<td>Somewhat - Extremely difficult</td>
<td>19 (17.1)</td>
<td>8 (24.2)</td>
<td>20 (14.9)</td>
<td>9 (15.8)</td>
<td>6 (14.6)</td>
<td>6 (12.0)</td>
<td>14 (14.0)</td>
<td>1 (4.8)</td>
<td>8 (13.8)</td>
<td>17 (14.9)</td>
<td>0 (0)</td>
<td>1 108 (14.9)</td>
</tr>
<tr>
<td>My transition to tele-health has been</td>
<td>Somewhat - Extremely dissatisfied</td>
<td>28 (25.9)</td>
<td>10 (31.3)</td>
<td>42 (31.3)</td>
<td>12 (20.7)</td>
<td>14 (35.9)</td>
<td>7 (14.0)</td>
<td>18 (18.4)</td>
<td>4 (20.0)</td>
<td>24 (37.2)</td>
<td>0 (0)</td>
<td>1 186 (26.0)</td>
<td>70</td>
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<tr>
<td>Level of satisfaction with tele-health is</td>
<td>Somewhat - Extremely dissatisfied</td>
<td>46 (42.6)</td>
<td>13 (40.6)</td>
<td>70 (51.9)</td>
<td>21 (36.2)</td>
<td>21 (51.9)</td>
<td>16 (31.4)</td>
<td>33 (33.7)</td>
<td>8 (13.8)</td>
<td>31 (53.3)</td>
<td>1 (16.7)</td>
<td>1 319 (44.3)</td>
<td>720</td>
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<td>tele-health adequate for most patient care encounters</td>
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<tr>
<td>Somewhat less – much less</td>
<td>17 (15.9)</td>
<td>5 (16.3)</td>
<td>28 (20.7)</td>
<td>11 (19.0)</td>
<td>17 (43.6)</td>
<td>3 (5.9)</td>
<td>15 (15.3)</td>
<td>0 (0)</td>
<td>8 (13.8)</td>
<td>39 (48.7)</td>
<td>2 (15.4)</td>
<td>1 145 (20.3)</td>
<td>716</td>
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<tr>
<td>Because of tele-health, the number of patients that I can see in a workday has been...</td>
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<tr>
<td>Centralized call center</td>
<td>Extremely - Somewhat inadequate</td>
<td>39 (39.0)</td>
<td>12 (38.7)</td>
<td>56 (43.1)</td>
<td>19 (34.6)</td>
<td>13 (38.2)</td>
<td>33 (64.7)</td>
<td>40 (47.1)</td>
<td>7 (38.9)</td>
<td>18 (35.3)</td>
<td>57 (53.3)</td>
<td>1 (20.0)</td>
<td>1 295 (44.2)</td>
</tr>
<tr>
<td>Scheduling Assistance</td>
<td>Extremely - Somewhat inadequate</td>
<td>40 (39.6)</td>
<td>10 (32.3)</td>
<td>47 (36.2)</td>
<td>17 (30.9)</td>
<td>12 (34.3)</td>
<td>28 (54.9)</td>
<td>38 (44.2)</td>
<td>5 (27.8)</td>
<td>18 (33.3)</td>
<td>50 (46.3)</td>
<td>1 (20.0)</td>
<td>1 266 (39.4)</td>
</tr>
<tr>
<td>Virtual Rooming Assistance</td>
<td>Extremely - Somewhat inadequate</td>
<td>40 (39.2)</td>
<td>11 (35.5)</td>
<td>64 (49.6)</td>
<td>18 (33.3)</td>
<td>15 (45.5)</td>
<td>18 (35.3)</td>
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<td>17 (20.2)</td>
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<td>35 (32.4)</td>
<td>2 (33.3)</td>
<td>1 244 (36.4)</td>
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<tr>
<td>Integration into the EMR</td>
<td>Extremely - Somewhat inadequate</td>
<td>33 (32.0)</td>
<td>11 (35.5)</td>
<td>36 (27.5)</td>
<td>14 (25.9)</td>
<td>12 (35.3)</td>
<td>15 (29.4)</td>
<td>19 (22.4)</td>
<td>8 (44.4)</td>
<td>10 (18.9)</td>
<td>26 (24.1)</td>
<td>2 (33.3)</td>
<td>1 186 (27.6)</td>
</tr>
<tr>
<td>Ability to add multiple people to the eVisit</td>
<td>Extremely - Somewhat inadequate</td>
<td>47 (47.5)</td>
<td>12 (38.7)</td>
<td>55 (43.0)</td>
<td>17 (32.1)</td>
<td>13 (37.1)</td>
<td>21 (41.2)</td>
<td>26 (30.6)</td>
<td>9 (50.0)</td>
<td>18 (34.0)</td>
<td>40 (38.1)</td>
<td>2 (13.3)</td>
<td>1 261 (39.3)</td>
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<tr>
<td>Ability to get information typically procured by physical exam</td>
<td>Extremely - Somewhat inadequate</td>
<td>68 (66.0)</td>
<td>22 (71.0)</td>
<td>107 (82.3)</td>
<td>38 (70.4)</td>
<td>27 (57.0)</td>
<td>37 (72.6)</td>
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<td>78 (72.9)</td>
<td>4 (66.7)</td>
<td>1 191 (28.7)</td>
</tr>
<tr>
<td>IT Support and Technical Troubleshooting</td>
<td>Extremely - Somewhat inadequate</td>
<td>50 (50.5)</td>
<td>13 (41.9)</td>
<td>71 (55.0)</td>
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<td>13 (37.1)</td>
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<td>18 (21.4)</td>
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<td>Training on compliance, task, billing, documentation</td>
<td>Extremely - Somewhat inadequate</td>
<td>37 (36.6)</td>
<td>13 (41.9)</td>
<td>55 (42.0)</td>
<td>18 (32.7)</td>
<td>10 (27.8)</td>
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<td>33 (30.8)</td>
<td>1 (16.7)</td>
<td>1 228 (33.8)</td>
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<tr>
<td>Ability to care for all patients without excluding any populations</td>
<td>Extremely - Somewhat inadequate</td>
<td>62 (60.8)</td>
<td>16 (51.6)</td>
<td>73 (55.7)</td>
<td>31 (56.4)</td>
<td>19 (54.3)</td>
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<td>7 (38.9)</td>
<td>22 (41.5)</td>
<td>54 (50.5)</td>
<td>1 (16.7)</td>
<td>1 355 (52.7)</td>
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<tr>
<td>Ability to communicate and coordinate care easily without miscommunication or mishap</td>
<td>Extremely - Somewhat inadequate</td>
<td>33 (32.4)</td>
<td>12 (40.0)</td>
<td>46 (35.4)</td>
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<td>31 (36.5)</td>
<td>5 (27.8)</td>
<td>14 (26.9)</td>
<td>32 (30.2)</td>
<td>0 (0)</td>
<td>1 214 (31.8)</td>
</tr>
<tr>
<td>The amount of digital screen time that I have everyday is...</td>
<td>Slightly - Extremely inappropriate</td>
<td>89 (62.7)</td>
<td>66 (64.1)</td>
<td>113 (74.8)</td>
<td>43 (70.5)</td>
<td>36 (78.3)</td>
<td>61 (69.3)</td>
<td>72 (66.7)</td>
<td>60 (40.3)</td>
<td>43 (60.6)</td>
<td>90 (69.2)</td>
<td>43 (66.2)</td>
<td>1 716 (64.2)</td>
</tr>
</tbody>
</table>

Legend: Med-gen=general internal medicine, hosp-ICU = hospitalist & adult intensive care, med-proc=procedure-based internal medicine, med-ambulatory=cognitive-based ambulatory specialties, ped-gen=general pediatrics, ped-spp=pediatric specialties, non-pt facing=radiology, laboratory medicine, pathology anesthesia; surgery=all surgical fields including ob/gyn, urology, neurosurgery, otorhinolaryngology, ophthalmology, dentistry, podiatry, em=emergency medicine, other=other, per respondent
Most difficult transition (24.1%): 🤔

Least satisfied with telehealth (35.9-31.3): 📊

Least adequate for patient care (53.9%-51.9%): 🌐

See fewer patients (43.6%, 34.8%): ⚒️

Most needing inclusive: 41.0-60.8% across specialties (except ER, esp. gen med)

Most need to add people to the visit: (50%, 47.5%)

Most need to coordinate: (40.0%, 36.5%)
Specialties least likely to use telehealth (9-30%): 80% of other specialties use telehealth (except general pediatrics 55%)

Most satisfied with telehealth:

Able to see more patients:

Centralized call center (63.7-47.1%):

Scheduling assistance (54.9-44.2%):

Virtual rooming assistance (49.6-45.5%):

Integration into EHR: 22-44% across specialties, esp.

IT and technical support: 21.4-55.0% across specialties, esp.

Compliance, risk, billing, documentation training: esp.
Discussion and Implications:

A majority of physicians have now used telehealth, 90% were introduced to telehealth due to the pandemic. There is optimism and opportunity for telehealth to improve access to care, communication and coordination of care, equally across populations and inclusive of patient’s multiple caregivers. It presents exciting potential to spur new home-based technologies to provide information traditionally acquired through an in-person assessment and physical exam. Telehealth will benefit from infrastructure for easy coordination through a call-center, scheduling, virtual rooming, seamless integration into the EHR, support from IT technical support, billing and compliance.

Based on analysis by specialty, efforts might be applied strategically to optimize the experience based on the needs of the type of care to be delivered to create an exceptional outcome and patient experience.
Limitations and Conclusions:

The circumstances under which this survey was conducted was unique, between the first and second wave of the historic COVID-19 pandemic. The volume of telehealth encounters were rapidly ramped up from 316 to 511,320 per year (1618x). 63% of attending physicians reported using telehealth, 90% of those were using telehealth for the very first time due to the pandemic. This cross-sectional study is a snapshot of this heroic effort during a once in a lifetime historic event. These circumstances cannot be reproduced, it remains to be seen if these finding are static under conditions.

Due to this massive global pandemic-driven disruptive innovation on a global scale, healthcare delivery is forever changed. Telehealth is now integral to the practice of medicine. The experience reflected in this cross-sectional study can propel iterative improvement of telehealth. The work-life well-being of a large proportion of the medical workforce (and their patients) is impacted by the function or dysfunction of this new delivery model.
In these times, the healthcare community heals sharing memories, grief, hopes, dreams.

Share your story here-->
Shine your light at Yale New Haven Hospital
Disclosures

• No disclosures
Enhancing Teamwork Through Development of Medical Assistants

Katherine Bulava, MBA, MA, PMP
Andrea Sikon, MD, FACP, ACC, BCC
Cleveland Clinic
Background

- High turnover, paucity of candidates and the need for extensive on the job training of MAs have resulted in reduced team cohesion and high levels of physician frustration.
- We posited that as critical members of the care team, we need to set MAs up for success by giving the tools to excel at the job.
- We also posited that providing more support could help us attract and retain MAs.
- Our study to provide enhanced MA training was supported by a Practice Transformation grant from the American Medical Association (AMA).
Study Aims

• Increase MA and physician job satisfaction
• Decrease MA and physician burnout
• Increase physicians’ efficiency of practice
Methods

- 16 week training curriculum for MAs
- Two, two-hour training sessions per week
- After work hours
- Delivered by the local community college and our organization’s EHR specialists
Methods: The curriculum

- Professionalism – appearance, courtesy, appropriate behaviors, and an introduction to cultural competence
- Effective Communications for Outpatient Care
- Data gathering, Documentation and Reimbursement
- The Electronic Health Record (EHR)
- Applications of EHRs
- Pharmacology for outpatient care
- Order entry
- Expanding rooming and discharge protocols
- Quality improvement outcomes
- Health and wellness/complementary integrative medicine
- Informational workflows
## Methods

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Interval</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA skills assessment</td>
<td>Before and after training</td>
<td>MAs</td>
</tr>
<tr>
<td>Mini-Z burnout assessment</td>
<td>Before training After training 6 months later</td>
<td>Physicians MAs</td>
</tr>
<tr>
<td>Multiple EHR data points around usage and efficiency</td>
<td>Before training After training 6 months later</td>
<td>Linked to Physicians</td>
</tr>
<tr>
<td>Qualitative interviews</td>
<td>Midway through the training</td>
<td>Physicians</td>
</tr>
<tr>
<td>Feedback session</td>
<td>Last session of training</td>
<td>MAs</td>
</tr>
</tbody>
</table>
MA Demographics

By your own definition, are you full or part time at your practice?

- Full-time: 85.7% Control (N=7), 100.0% Intervention (N=8)
- Part-time: 14.3% Control (N=7), 0.0% Intervention (N=8)

Please indicate which of the following best describes your medical specialty?

- Family Medicine: 28.6% Control (N=7), 37.5% Intervention (N=8)
- Internal Medicine, General - Primary Care: 71.4% Control (N=7), 50.0% Intervention (N=8)
- Other Non-Surgery related specialty: 12.5% Control (N=7), 12.5% Intervention (N=8)

How many years after training have you been in practice?

- 1-5 years: 57.1% Control (N=7), 37.5% Intervention (N=8)
- 6-10 years: 14.3% Control (N=7), 14.3% Intervention (N=8)
- 11-15 years: 25.0% Control (N=7), 25.0% Intervention (N=8)
- More than 15 years: 14.3% Control (N=7), 14.3% Intervention (N=8)
# Key Findings

**Objective (1): Increase MA and Physician job satisfaction**

## Physician Satisfaction with Current Job

### Control Group

<table>
<thead>
<tr>
<th>Survey Type</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (N = 8)</td>
<td>37.50%</td>
<td></td>
<td></td>
<td>62.50%</td>
<td></td>
</tr>
<tr>
<td>Interim (N = 8)</td>
<td>25%</td>
<td>12.50%</td>
<td>50%</td>
<td></td>
<td>13%</td>
</tr>
<tr>
<td>Post (N = 9)</td>
<td>11.1%</td>
<td></td>
<td>77.8%</td>
<td></td>
<td>11.1%</td>
</tr>
</tbody>
</table>

### Intervention Group

<table>
<thead>
<tr>
<th>Survey Type</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Agree Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (N = 8)</td>
<td>20.00%</td>
<td></td>
<td></td>
<td>50.00%</td>
<td>30.00%</td>
</tr>
<tr>
<td>Interim (N = 8)</td>
<td>25.00%</td>
<td></td>
<td>37.50%</td>
<td></td>
<td>37.50%</td>
</tr>
<tr>
<td>Post (N = 10)</td>
<td>22.2%</td>
<td></td>
<td>44.4%</td>
<td></td>
<td>33.3%</td>
</tr>
</tbody>
</table>

*Overall, I am satisfied with my current job:*
Key Findings

Objective (1): Increase MA and Provider job satisfaction

MA mini-z scores by question

*Mini Z not validated in MA population
Key Findings

Objective (2): Increase MA and physician job satisfaction and decrease burnout

Physician Necessary Patient Time

Control Group

Baseline Survey (N = 8)
- Strongly disagree: 25.0%
- Disagree: 37.5%
- Neither agree nor disagree: 37.5%

Interim Survey (N = 8)
- Strongly disagree: 37.5%
- Disagree: 37.5%
- Neither agree nor disagree: 12.5%

Post Survey (N = 9)
- Strongly disagree: 11.1%
- Disagree: 33.3%
- Neither agree nor disagree: 44.4%

Intervention Group

Baseline Survey (N = 7)
- Strongly disagree: 42.9%
- Disagree: 14.3%
- Neither agree nor disagree: 34.3%

Interim Survey (N = 8)
- Strongly disagree: 25.0%
- Disagree: 12.5%
- Neither agree nor disagree: 37.5%

Post Survey (N = 10)
- Strongly disagree: 40.0%
- Disagree: 30.0%
- Neither agree nor disagree: 30.0%
Key Findings:

Objective (2): Increase MA and physician satisfaction and decrease burnout

Physician Resources for Optimal Care

Do you have the resources you need to provide optimal care?

<table>
<thead>
<tr>
<th>Control Group</th>
<th>Intervention Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Control (N=7)</td>
<td>Baseline Intervention (N=4)</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>66.7%</td>
<td>62.5%</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>33.3%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Interim Control (N=7)</td>
<td>Interim Intervention (N=8)</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>53.3%</td>
<td>75.0%</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>46.7%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Post Control (N=9)</td>
<td>Post Intervention (N=9)</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>44.4%</td>
<td>88.9%</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>55.6%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

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Key Findings:

Objective (3): Increase the physician’s ability to effectively and efficiently treat patients

Physician qualitative interviews showed:

- Strengthened MA communication with the patient
- Strengthened MA communication about the patient to the physician
  - Enhanced communication during rooming meant physicians had a clearer picture of the patient’s needs at the onset of the visit
- MA assistance in rooming and order entry was appreciated
- Improved EHR and order entry proficiency
  - Several physicians noted they learned new short-cuts from their MAs
Key Findings:

Objective (3): Increase the physician’s ability to effectively and efficiently treat patients

The MA pre/post skills assessment showed:
- MA EHR knowledge increased

The Usage and efficiency data from the EHR showed:
- The study group closed more visits on the same day
Highlights

• Enriched MA professional behaviors
• Strengthened communications with patients and the team
• Enhanced rooming
• Improved EHR and order entry proficiency
Participant Comments

“The top thing I learned was better communication with my provider. Pending orders and allowing him to discuss with the patient what was needed vs what was not needed. That has helped to catch missed health maintenance items and things that have needed to be updated. This has improved our patient care, our patient satisfaction scores and ACO metrics as well.”

“I appreciate that my MA is being more assertive, particularly with order entry. She’s gained confidence in all aspects of her work.”

“I’ve noticed the differences. She’s been really great about listening to the patient and being proactive about rooming and confident about closing the loop on follow-up questions that come up at discharge. I recently had a patient pull me aside to tell me they love my MA.”

“He definitely learned some new tricks in EPIC and he’s brought that knowledge back and taught me how to find things more efficiently as well.”
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large organization</td>
<td>Small cohort</td>
</tr>
<tr>
<td>Participants remained in the study through the duration</td>
<td>Single health system experience</td>
</tr>
<tr>
<td>Use of multiple measures</td>
<td>Recruitment criteria resulted in an MA cohort already considered highly skilled</td>
</tr>
</tbody>
</table>
Conclusions

• Additional tailored training can positively impact burnout, job satisfaction and efficiency of practice for MAs and their physician partners.
• Inclusive recruitment criteria will result in a larger participant pool
• Knowing your stakeholders is critical
• There are differences between MA certification criterion and what is useful in practice
• State regulations and our organization’s interpretation of them lead to restrictions on what MAs can do without a written and signed order by a physician or APP. This has shaped a culture of what MAs can NOT do instead of what they CAN do.
Version 2.0

• Partnered internally with our Nursing Education team to deliver a more tailored curriculum
• Offered classes during the workday and virtually
• Increased participation by making an effort to be more inclusive in selection criteria
• Engaged the physicians in recruitment and in several of the education sessions
• Narrowed curriculum to remove superfluous elements:
• This year’s class of 30 MAs completed their training on September 18th; outcomes pending
Considerations for the future

• Considering incorporation into continuing education training currently available internally for MAs

• Educational content needs to be adapted by specialty

• Nursing and MA shortages make it more difficult to pull people out for training
Thank you!

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Disclosures

» No Disclosures
Psychological Impact of the COVID-19 Pandemic on Frontline Health Care Workers in NYC: A Longitudinal Analysis of Consequences & Opportunities

AND

Protective factors against psychological distress among frontline health care workers facing COVID-19: Exploring personal behaviors and system factors

Lauren Peccoralo, MD, MPH
Sr. Associate Dean for Faculty Well-Being and Development
Icahn School of Medicine at Mount Sinai
(on behalf of Jordyn Feingold, MD & Halley Kaye-Kauderer, MD)
Background: Rates of MH symptoms and burnout in HCW during COVID surge

**Hero Registry in US HCW:**
- 14,600 Convenience sample of healthcare workers
- April 10 to July 31, 2020.
- 3.2% nurses, 18.4% physicians, 30.3% high risk for COVID-19

**Outcomes:** 51% stressed, 38% worried, 21% sadness, 41% burned out

**HWC Study in China**
- 1257 of 1830 HCW, 68.7% RR
- Jan 29 to Feb 3, 2020,
- 60.8% nurses, 39.2% physicians, 41.5% frontline health care workers

**Outcomes:** 50.4% Depression, 44.6% anxiety, 34% insomnia and 71.5% distress
- Nurses, women, frontline health care workers \(\rightarrow\) higher rates
- Direct diagnosis, treatment, and care of patients with COVID-19 \(\rightarrow\) with a higher risk of symptoms of depression, insomnia, anxiety, distress

Forrest et al. J Gen Intern Med. 2021 Mar
Lai et al. JAMA Netw Open. 2020 Mar 2
Research Questions

What are the psychological consequences experienced by MSH front line health care workers during the COVID-19 pandemic and what demographic, occupational and COVID-Related factors are associated with these outcomes (at the time of the first surge and 7 months later)? [1, 3]

What personal restorative factors are associated with lower rates of mental health symptoms? [2]

What is the rate of Post-traumatic Growth (PTG) and what factors and mental health symptoms were associated with PTG 7-months post-surge? [4]
**Methods**

**Design & Setting**
- Cross-sectional Surveys
- 1st Survey
  - Over 4 weeks
  - During pandemic surge: April- May ‘20
- 2nd survey
  - Over 6 weeks
  - During upswing cases: Nov ‘20- Jan ‘21

**Participants**
- 6,026 frontline MSH health care workers recruited
  - Physicians: House staff, Attendings
  - Patient-facing RNs
  - APPs (NP/PA)
  - Others: Chaplains, SWs, Dietitians

**Outcomes**
- COVID-19-related (PTSD)
- Major Depressive Disorder (MDD)
- Generalized Anxiety Disorder (GAD)
- Burnout
- Post Traumatic Growth

**Analysis Plan**
- Bivariate analysis
- Multivariable logistic regression
- Relative importance analyses of associated demographic/ exposure factors
Study Timeline (2020-2021)

New reported cases by day

8,000 cases
6,000
4,000
2,000

Baseline survey period

Follow-up survey period

Note: The 14-day average is the average of a day and the previous 13 days of data.

Source: New York Times
Emotional Response by Phases of Disaster

Main Outcome Measures

- **Significant symptoms of COVID-related-PTSD***: PCL4-5 >= 8
- **Significant symptoms of MDD***: PHQ-8 >= 10
- **Significant symptoms of GAD***: GAD-7 >= 10
- **Burnout (Outcome)**: Mini-Z >= 3
- **Post Traumatic Growth**: PTGI-S
  - The Posttraumatic Growth Inventory-Short Form: PTG = “moderate,” “great,” or “very great,” Any PTG = PTG in >=1 of 5 domains

* Symptoms of all three disorders ascertained at time point 1 over the last 2 week; time point 2, PTSD was over 1 month

  * DSM 5 PTSD requires symptoms > 1 month
  * DSM GAD requires symptoms > 6 months

Weathers, 2013; Shin et al. 2019; Spitzer et al. 2006; Rohland, et al. 2004; Cann at al 2010
Sample Survey Items – Independent Variables

**Personal Factors:** Age, sex, relationship status, history of mental health diagnosis (yes/no), level of perceived personal medical risk, Profession, Years in practice, Pre-pandemic burnout*

**COVID-19 Exposure Factors:** Access to Personal Protective Equipment (PPE), Number of colleagues fallen ill/ hospitalized / in the ICU/ died, Number of friends/loved ones fallen ill/ hospitalized / in the ICU/ died, Difficult decisions prioritizing patients, Preparedness to Care for COVID patients, Work/life balance challenges

**Protective Factors:** Engagement in restorative behaviors, feeling valued/supported at work, hospital leadership, work-related pride, meaning, inspiration

* A rating of >/= 4 (at least once a week) on either item of 2-item Maslach Burnout Inventory (depersonalization, emotional exhaustion)

West, et al, 2012
Research Question 1

What are the psychological consequences experienced by MSH front line health care workers during the COVID-19 pandemic and what demographic, occupational and COVID-Related factors are associated with these outcomes (at the time of the first surge)?
Key Results: Time 1

- **Response Rate**: 55.8% (n=3,360 of 6,026)
- **Sample analyzed**: 76.8% (n=2,579)

(Based on frontline responsibilities and providing information related to the 3 outcomes: 38% nurses, 24% Attendings, 17% Residents/Fellows, 13% NP/PAs, 7% others)

1,005 (39.0%) screen positive for at least 1 outcome

42% Sample = Pre-Pandemic Burnout

### Respondents who screened positive by number of outcomes

- **317 (12.3%)**
- **285 (11.1%)**
- **403 (15.6%)**

**NUMBER OF RESPONDENTS MEETING SCREENING CRITERIA FOR EACH OUTCOME**

- **MDD**
  - 683 (26.6%)
- **GAD**
  - 642 (25.5%)
- **PTSD**
  - 599 (23.3%)
COVID-related Factors Associated with Acute MH Symptoms

- Lack of Adequate PPE
- Total COVID Personal Exposures
- Death of a Colleague
- Colleagues Hospitalize/ICU
- Difficult Decisions Reg COVID Pts
- Not Adequately Prepared for COVID Care
Occupational Factors Associated with Acute MH Symptoms

- Fewer Years in Practice
- Not Feeling Valued at Work
- Lower Perceived Support from Leadership
- Not Feeling Inspired at Work
- APPs/Nurses

Feingold, et al, Chronic Stress, 2021
Results: Most Important Factors by Symptom Cluster

PTSD- COVID

Married Partnered
Support Hosp Leaders
Torn btwn Pts-Family
Household Fearful
Non-Attending
Burnout Past Yr

Anxiety

Prepared for Covid tasks
Support Hosp Leaders
Medical Risk
Household Fearful
Torn btwn Pts-Family
Burnout Past Yr

Depression

Married Partnered
Support Hosp Leaders
Medical Risk
MH History
Torn btwn Pts-Family
Burnout Past Yr

Feingold, et al, Chronic Stress, 2021
Research Question 2

What personal restorative factors are associated with lower rates of mental health symptoms?
Restorative Behaviors Associated with Lower risk Acute MH Symptoms

- Hours of Sleep x Leadership Support
- Exercise
- Artistic Activities x Valued by Supervisor
- Positive Emotion Focused Coping

Kaye-Kauderer, H, et al. Submitted
Restorative Behaviors Relative Importance Analyses Results

- COVID-related stressors: 17.3%
- Sleep x leadership support: 17.3%
- Artistic activities x valued by close supervisor: 4.4%
- Avoidant coping: 4.4%
- Profession: 4.4%
- Valued by close supervisor: 4.4%
- Self suff coping x valued by leadership: 4.4%
- Married/partnered: 4.4%
- Exercise: 4.4%
- Gender: 4.4%
- Years experience: 4.4%
- Mindfulness: 4.4%
- Hobbies x camaraderie: 4.4%
- Artistic activities: 4.4%

Relative Variance Explained (%)
Restorative Behaviors: Sleep Hours x Leadership Support

Effect of Sleep Hours x Leadership Support and Probability of Screening Positive for Psychological Distress

Prevalence of a positive screen for MDD, GAD, and/or PTSD in the full sample
Restorative Behaviors: Physical Activity

Effect of Physical Activity and Probability of Screening Positive for Psychological Distress

Prevalence of a positive screen for MDD, GAD, and/or PTSD in the full sample
Study: TIME 2

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
Research Question 3

What are the psychological consequences experienced by MSH front line health care workers during the COVID-19 pandemic and what demographic, occupational and COVID-Related factors are associated with these outcomes (7 months later)?
Key Results: Time 2

- **Response Rate: 30.5% (n=786 of the original 2,579)**
  38% nurses, 23% Attendings, 23% Residents/Fellows, 14% NP/PAs, 5% others

**RESPONDENTS SCREENING POSITIVE FOR BURNOUT OR MH SYMPTOMS AT BASELINE AND FOLLOW-UP**

![Bar chart showing prevalence of burnout, MDD, GAD, or PTSD at baseline and follow-up, with error bars. All significant p<0.01.](chart.png)
### Psychological Distress Symptom “Trajectory”

<table>
<thead>
<tr>
<th>Psychological Distress symptoms at <strong>baseline</strong></th>
<th>Psychological Distress symptoms at <strong>follow-up</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>“no symptoms” 475 (60%)</td>
<td>“new-onset symptoms” 35 (4%)</td>
</tr>
<tr>
<td>“remitted symptoms” 150 (19%)</td>
<td>“chronic symptoms” 126 (16%)</td>
</tr>
</tbody>
</table>

*Psychological Distress = screened positive for at least ONE of the symptoms clusters: MDD, GAD, PTSD*
## Results

### Multivariable Analysis

Multinomial logistic regression model predicting a persistent course of psychological distress in health care workers on the frontlines of the COVID-19 pandemic

<table>
<thead>
<tr>
<th></th>
<th>Persistent distress vs. No/Low distress</th>
<th>Persistent distress vs. Remitted distress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$R^2=0.55$</td>
<td>$R^2=0.31$</td>
</tr>
<tr>
<td></td>
<td>RRR (95%CI)</td>
<td>RRR (95%CI)</td>
</tr>
</tbody>
</table>

### Demographic and occupational characteristics

- **Female gender**
  - Persistent distress: $2.30 (1.17-4.53)^*$
  - No/Low distress: $1.93 (0.92-4.05)$

- **Have children**
  - Persistent distress: $0.56 (0.27-1.15)$
  - No/Low distress: $1.48 (0.69-3.21)$

- **RN vs. other profession**
  - Persistent distress: $1.73 (0.98-3.06)$
  - No/Low distress: $1.11 (0.61-2.00)$

- **History of psychiatric disorder**
  - Persistent distress: $2.36 (1.29-4.30)^{**}$
  - No/Low distress: $2.85 (1.46-5.56)^{**}$

- **Past-year burnout**
  - Persistent distress: $3.95 (2.36-6.60)^{***}$
  - No/Low distress: $1.62 (0.93-2.79)$

- **Years in practice**
  - Persistent distress: $0.97 (0.93-1.02)$
  - No/Low distress: $0.95 (0.91-0.99)^*$

### COVID-19-related variables

- **Acute surge stressors**
  - Persistent distress: $1.43 (0.90-2.27)$
  - No/Low distress: $0.89 (0.55-1.46)$

- **Post-acute surge stressors**
  - Persistent distress: $1.39 (1.04-1.86)^*$
  - No/Low distress: $1.79 (1.30-2.46)^{***}$

- **Infection-related concerns**
  - Persistent distress: $1.35 (1.03-1.78)^*$
  - No/Low distress: $1.03 (0.77-1.38)$

- **Family-related concerns**
  - Persistent distress: $1.54 (1.13-2.11)^{**}$
  - No/Low distress: $0.70 (0.50-0.98)^*$

- **Work-related concerns**
  - Persistent distress: $1.71 (1.27-2.29)^{***}$
  - No/Low distress: $0.97 (0.71-1.31)$

### Psychosocial characteristics

- **Positive dispositional characteristics**
  - Persistent distress: $0.72 (0.55-0.94)^*$
  - No/Low distress: $0.97 (0.73-1.29)$

- **Feeling valued/supported at work**
  - Persistent distress: $0.71 (0.54-0.93)^*$
  - No/Low distress: $0.86 (0.65-1.15)$

- **Perceived social support**
  - Persistent distress: $0.89 (0.81-0.97)^{**}$
  - No/Low distress: $0.90 (0.82-0.99)^*$

### Restorative behaviors

- **Sleep hours**
  - Persistent distress: $0.81 (0.64-1.04)$
  - No/Low distress: $0.85 (0.66-1.09)$

### Coping strategies

- **Socially-supported coping**
  - Persistent distress: $1.31 (0.89-1.93)$
  - No/Low distress: $0.73 (0.48-1.10)$

- **Avoidant coping**
  - Persistent distress: $1.72 (1.13-2.63)^*$
  - No/Low distress: $1.26 (0.81-1.97)$

---

Note. Distress=psychological distress (positive screen for MDD, GAD, and PTSD symptoms*), RRR = Relative Risk Reduction, RN- Registered Nurse. Statistically significant association: *$p<0.05$; **$p<0.01$; ***$p<0.001$
**Post Hoc Analysis of Acute and Post-Acute Surge Variables**

**Persistent distress vs. No/Low distress** | RRR (95% CI)
---|---
**Acute Surge Variables**
**Worries**
- Worries about infecting colleagues | 1.23 (1.01-1.53)
- Worries about the effect of the pandemic on personal relationships | 1.66 (1.29-2.14)
- Worries about not being able to do enough for COVID-19 patients | 1.51 (1.16-1.95)

**Coping**
- Substance use | 2.68 (1.13-6.3)
- Behavioral disengagement | 3.02 (1.08-8.47)
- Dispositional optimism | 0.73 (0.61-0.86)

**Value/Support**
- Felt valued by leadership | 0.72 (0.55-0.95)
- Felt emotional support | 0.67 (0.53-0.84)

**Post-Acute Surge Variables**
- Having to make difficult decisions prioritizing COVID-19 patients | 3.52 (1.60-7.75)
- Medically high risk | 4.50 (1.53-13.33)

**Persistent distress vs. No/Low distress** | RRR (95% CI)
---|---
**Acute Surge Variables**
- Felt emotional support | 0.69 (0.54-0.88)

**Post Acute Surge Variables**
- Medically high risk | 4.44 (1.42-13.89)

**New distress vs. No/Low distress** | RRR (95% CI)
---|---
**Acute Surge Variables**
- Caring for patients who died | 1.71 (1.03-3.89)

**Post Acute Surge Variables**
- Medically high risk | 2.52 (1.43-6.37)

---

**Note.** Distress=psychological distress (positive screen for MDD, GAD, and PTSD symptoms); RRR = Relative Risk Ratio; 95%CI=95% confidence interval.
Factors Associated with (+) Screen $\Psi$ symptoms at both time-points:
Persistent Distress (n=126, 16.0%) (vs no/low symptoms)
Factors Associated with (+) Screen \( \Psi \) symptoms at both time-points: Persistent (\( n=126, 16.0\% \)) (vs remitted symptoms)

Lower Emotional Support Acute Surge
Prior Psychiatry Diagnosis
Years in Practice
Medically High Risk Post-Acute

Relative Variance Explained %
Factors Associated with (+) Screen \( \Psi \) symptoms at timepoint 2: New Onset (n=35, 4.0%) (vs no/minimal symptoms)

- High Medical Risk: 4.7%
- Female: 12.1%
- Pre-pandemic burnout: 13.7%
- Years in Practice: 23.7%
- Cared for Patients Died: 45.8%

Relative Variance Explained
## Burnout “Trajectory”

<table>
<thead>
<tr>
<th>Burnout at <strong>baseline</strong></th>
<th>Burnout at <strong>follow-up</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>“no burnout”</td>
<td>350 (45%)</td>
</tr>
<tr>
<td>“new-onset burnout”</td>
<td>129 (17%)</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>“remitted burnout”</td>
<td>82 (11%)</td>
</tr>
<tr>
<td>“chronic burnout”</td>
<td>222 (28%)</td>
</tr>
</tbody>
</table>
Research Question 4

What is the rate of Post-traumatic Growth (PTG) and what factors and mental health symptoms were associated with PTG 7-months post-surge?
Post-Traumatic Growth Defined

- Post Traumatic Growth

“A positive change experienced as a result of the struggle with a major life crisis or a traumatic event.” (https://ptgi.uncc.edu/what-is-ptg/)

“The experience of individuals whose development, at least in some areas has surpassed what was present before the struggle with crises occurred.” (Tedeschi and Calhoun, 2004)
Post-traumatic Growth Rates and Descriptives

- **76.8%** Sample -> at least moderate levels of PTG

- Most prevalent types:
  - Appreciation of life 67%
  - Improved relationships 49%
  - Personal strength 44%

- Profession:
  - NP/PAs (85.1%) > RNs (83.8%) > Residents/Fellows (70.1%) > Attendings (68.0%).
Post-traumatic Growth (PTG) Areas by PTSD Symptoms

1. Feingold, et al, J Affective Disorders, 2021
Post-traumatic Growth and Other Factors

Factors Associated with PTG
- Non-White race/ethnicity (White/nonHispanic) OR=0.63 (0.41-0.96)
- Positive emotions (inspiration) OR=1.24, 95%CI=1.02-1.53
- Severity of intrusive thoughts about the pandemic OR=1.25, 95%CI=1.02-1.53
- Dispositional gratitude OR=1.35, 95%CI=1.02-1.78
- Inspired by role-models OR=1.74, 95%CI=1.26-2.41

Elements of PTG associated with lower odds of burnout and PTSD Sx
- Spiritual Growth
  - 44% lower odds Burnout OR=0.56, 95%CI=0.35-0.90
  - 52% lower odds PTSD OR=0.48, 95%CI=0.24-0.99
- Improvements in Relationships
  - 36% lower odds Burnout OR=0.64, 95%CI=0.43-0.97

Feingold, et al, J Affective Disorders, 2021
Summary of Results:

- Prevalence during acute surge: higher than general population pre-pandemic
- Associated with MH Symptoms (MDD, GAD, COVID-rel PTSD) during surge
  - Personal Factors: previous MH, med risk, profession, family worry
  - Covid Related Exposures: lack PPE, close COVID illness, death
  - Occupational Factors: leadership support, prepared for role
  - Restorative Behaviors: sleep x leadership support, exercise > 4 days/week
- Prevalence at 7month follow up
  - Decreased mental health symptoms, increased burnout
  - 4 Trajectories: Persistent, Remitted, New-Onset, No/Minimal Distress
- Associated with Persistent Distress:
  - Vs no/min: greater worries about relationships, pre-pandemic burnout, lower dispositional optimism, emotional support and value by hospital leadership;
  - Vs remitted: lower emotional support, fewer years in practice, past psychiatric disorders
- PTG Prevalence: 76.8%
  - Associated with severity of PTSD symptoms, gratitude, positive emotions, role models
Limitations

- Single institution design limits generalizability
- Modest response rate and sample size in time 2 limit the power and ability to detect differences
- Due to brevity of survey brief, several factors could not be assessed that may contribute to persistent distress (e.g., pre-pandemic trauma history).
- Recall and perceptual bias
- Limited to only 2 time periods that might not reflect a dynamic pandemic
- 2nd survey was at the beginning of another surge so might not only reflect long term effects of acute surge
- Small number in the new-onset distress group limits statistical power
Discussion

**Implications:**

- Health care organizations should aim to assess drivers and implement system-wide programs to reduce burnout, improve leadership support, promote a culture of psychological safety, and provide resources to support positive coping and processing of work-related traumatic events.
- Immediate supervisors might be the ideal group to promote the alignment of personal-organizational values, show support and encourage self-care through role modeling.
- Specific initiatives like limiting work hours (to encourage sleep) and encouraging physical activity may promote workplace well-being.
- Interventions that help HCW work through trauma using realistic optimism, gratitude and role modeling may foster PTG and promote FHCW Mental Health.
Acknowledgments

Study Team:

Jordyn H. Feingold, MAPP, Lauren Peccoralo, MD, Chi Chan, PhD, Carly Kaplan, BS, Halley Kaye-Kauderer, BA, Steve Southwick, MD, Dennis Charney, MD, Jaclyn Verity, MPH, Alicia Hurtado, MD, Larissa Burka, RN, James W. Murrough, MD, PhD, Saadia Akhtar, MD, Jonathan DePierro, PhD, Shumayl Syed, BS, George Loo, MD, Adriana Feder, MD, Robert H. Pietrzak, PhD, MPH, Jonathan Ripp, MD, MPH

Talent Development and Learning, OWBR, OFD, Mount Sinai Doctors and C2C

All the faculty & staff at the Mount Sinai Hospital who helped us administer the survey

All the faculty & staff at the Mount Sinai Hospital who completed the survey

Peccoralo, L, et al. A Prospective Cohort Study of the Psychological Consequences of the COVID-19 Pandemic on Frontline Healthcare Workers in New York City. Submitted
Questions?
Disclosures

• Dr. Akhtar has no conflicts of interest to disclose.
• Dr. DePierro has no conflicts of interest to disclose.
• Dr. Peccoralo has no conflicts of interest to disclose.
• Dr. Ripp has no conflicts of interest to disclose.
Meeting the Psychosocial Needs of the Health Care Workforce During the COVID-19 pandemic

Jonathan DePierro, PhD
Jonathan Ripp, MD, MPH
Saadia Akhtar, MD
Lauren Peccoralo, MD, MPH
Objectives and Agenda:

OBJECTIVES:
1. Identify psychosocial needs and stressors of healthcare workers
2. Create flexible mental health and psychosocial support programming
3. Identify individual and structural factors supporting health care worker resilience

AGENDA:
• Lessons from the COVID-19 Pandemic
• Needs Assessment: Small Group Discussion (#1)
• Personal Factors and Mental Health
• Culture of Efficiency of Practice
• Creating Solutions at Your Institution: Small Group Discussion (#2)
• Closing Comments
Mount Sinai Health System at a Glance

**SEVEN MEMBER HOSPITAL CAMPUSES**

1. **Beth Israel Medical Center**
   - Having remained true to its 100-year-old mission, this 566-bed hospital provides compassionate, high-quality care to patients across a broad range of specialties.
   - 260 First Avenue
   - New York, NY 10003

2. **Beth Israel Brooklyn**
   - This 212-bed community hospital has many redesigned facilities, and provides high-quality primary and specialty care.
   - 3201 Kings Highway
   - Brooklyn, NY 11234

3. **The Mount Sinai Hospital**
   - Founded in 1852, this 1,371-bed facility is one of the nation's oldest and most respected tertiary- and quaternary-care teaching hospitals.
   - One Gustave L. Levy Place
   - New York, NY 10029

4. **Mount Sinai Queens**
   - This 235-bed hospital serves residents of western Queens with high-quality outpatient, inpatient, and emergency services.
   - 25-10 30th Avenue
   - Long Island City, NY 11102

5. **New York Eye and Ear Infirmary**
   - Founded in 1820 as the nation's first specialty hospital, this 69-bed facility is a leader in the care of all diseases of the eyes, ears, nose, and throat.
   - 310 East 14th Street
   - New York, NY 10003

6. **Roosevelt Hospital (St. Luke's-Roosevelt Hospital Center)**
   - Founded in 1871, this 806-bed community and tertiary-care hospital has renowned clinical programs and strong partnerships with federally qualified health centers.
   - 1000 Tenth Avenue
   - New York, NY 10019

7. **St. Luke’s Hospital (St. Luke’s-Roosevelt Hospital Center)**
   - Since its founding in 1847, this 529-bed hospital has been the principal health care provider for the communities of West Harlem and Morningside Heights.
   - 1111 Amsterdam Avenue
   - New York, NY 10025

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**ONE LEADING MEDICAL SCHOOL**

- **Icahn School of Medicine at Mount Sinai**
  - As one of the nation’s top medical schools, Icahn School of Medicine at Mount Sinai is accelerating the discovery of cutting-edge research and medicine across the Mount Sinai Health System.
  - One Gustave L. Levy Place
  - New York, NY 10029
Office of Well-being and Resilience at ISMMS

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

▶ “Our mission is to drive change by promoting initiatives aimed at removing barriers to your well-being and reconnecting you with the meaning of your work.”
Office of Well-being and Resilience

Team Structure

Chief Wellness Officer

- Associate Dean for GME Well-being
  - GME Well-being Champions
  - GMEC Wellness Subcommittee
- Associate Dean for Faculty Well-being
  - Faculty Well-being Champions
- Associate Dean for UME Well-being
  - Wellness Advisors
  - Advisory Board
- Associate Dean for Graduate School Well-being
  - Wellness Advisors
  - THAW
What is the role of the Chief Wellness Officer?

The Health Care Chief Wellness Officer: What the Role Is and Is Not

Jonathan Ripp, MD, MPH, and Tait Shanafelt, MD

Responsibilities of the Chief Wellness Officer (CWO)

- Measure well-being, burnout, and professional fulfillment across the organization
- Measure the efficiency of the practice environment and identify opportunities to improve it
- Engage members of the organization while working to create the optimal practice environment
- Assess the organizational culture and identify dimensions of culture that require strengthening
- Provide relevant and actionable data to other leaders
- Develop an organization-wide action plan for improving clinician well-being
- Determine what resources are necessary, advocate for those resources, and develop a business case and a path to secure those resources
- Identify hot spots and provide guidance, recommendations, tactics, and support to those areas
- Develop system-wide resources for individuals to improve well-being
- Develop system-wide resources to support individuals in distress
- Develop system-wide resources to help leaders develop behaviors that promote the well-being of those they lead
- Advocate for clinician well-being in organizational decision making
- Influence other leaders’ thinking and sense of shared ownership of clinician well-being

Responsibility of the CWO and his or her team; CWO is accountable.
Responsibility of senior leaders in the organization; all senior leaders are accountable.

- Measure
- Listen and Partner to help “steer the ship”
- Provide Expert Guidance
- Advocate
- Educate and Raise Awareness
- Perhaps some “Program Delivery”

Ripp et al. Academic Medicine. 2020
Community Phases of Disasters

- Pre-Disaster
  - Warning
  - Threat
  - Impact

- Heroic
  - Community Cohesion

- Honeymoon

- Disillusionment
  - Inventory
  - Trigger Events

- Reconstruction
  - A New Beginning
  - Setback
  - Working Through Grief
  - Coming to Terms
  - Anniversary Reactions

- Up to One Year
- After Anniversary
Physician Well-Being Hierarchy of Needs

1. Basics
   - I’m hydrated, have access to food, and time to eat
   - I’ve had enough sleep
   - I have access to bathrooms
   - I have no depression or anxiety
   - I am free of substance use
   - I do not have suicidal thoughts
   - I have time and space to breast feed

2. Safety
   - I’m physically safe
   - My patients are safe
   - My job is secure & future predictable
   - I am not hassled by IT, the EHR, or bureaucracy
   - Objects and processes work
   - Cultural violations are addressed

3. Respect
   - I am noticed and appreciated
   - I am connected
   - My compensation reflects appreciation
   - There is a basic level of mutual respect and inclusion
   - My family time is respected

4. Appreciation
   - I have time, autonomy and resources to heal patients
   - I have time to think and contribute

5. Heal Patients and Contribute
   - Start here
The Pandemic Curve and Associated Stressors

Wave 1
1) Fear for Basic Needs
   • When/what will I eat?
   • How will I be kept safe and keep others safe?
   • Who will care for my children?
   • How will I get to and from work?

2) Uncertainty
   • How long will this workload continue?
   • Will I be able to do the job if redeployed?
   • Will I be supported by my employer?
   • Will I be able to make the difficult decisions?

3) Processing Experiences
   • Grief and loss
   • PTSD or PT Growth
   • Catching one’s breath and time to reflect
   • Impact of societal upheaval around racial injustice

Wave 2
4) Exhaustion
   • Re-traumatization and Limited Reserve
   • Workforce Turnover
   • Leaders Working Increased Intensity >1 year with no Break

Source: New York Times

Viewpoint
April 7, 2020

Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic

Tait Shanafelt, MD; Jonathan Ripp, MD, MPH; Mickey Trockel, MD, PhD

Author Affiliations | Article Information

JAMA. Published online April 7, 2020. doi:10.1001/jama.2020.5893

Table. Requests From Health Care Professionals to Their Organization During the Coronavirus Disease 2019 Pandemic

<table>
<thead>
<tr>
<th>Request</th>
<th>Principal desire</th>
<th>Concerns</th>
<th>Key components of response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hear me</td>
<td>Listen and act on health care professionals’ expert perspective and frontline experience and understand and address their concerns to the extent that organizations and leaders are able</td>
<td>Uncertainty whether leaders recognize the most pressing concerns of frontline health care professionals and whether local physician expertise regarding infection control, critical care, emergency medicine, and mental health is being appropriately harnessed to develop organization-specific responses</td>
<td>Create an array of input and feedback channels (listening groups, email suggestion box, town halls, leaders visiting hospital units) and make certain that the voice of health care professionals is part of the decision-making process</td>
</tr>
<tr>
<td>Protect me</td>
<td>Reduce the risk of health care professionals acquiring the infection and/or being a portal of transmission to family members</td>
<td>Concern about access to appropriate personal protective equipment, taking home infection to family members, and not having rapid access to testing through occupational health if needed</td>
<td>Provide adequate personal protective equipment, rapid access to occupational health with efficient evaluation and testing if symptoms warrant, information and resources to avoid taking the infection home to family members, and accommodation to health care professionals at high risk because of age or health conditions</td>
</tr>
<tr>
<td>Prepare me</td>
<td>Provide the training and support that allows provision of high-quality care to patients</td>
<td>Concern about not being able to provide competent nursing/medical care if deployed to new area (eg, all nurses will have to be intensive care unit nurses) and about rapidly changing information/communication challenges</td>
<td>Provide rapid training to support a basic, critical knowledge base and appropriate backup and access to experts</td>
</tr>
<tr>
<td>Support me</td>
<td>Provide support that acknowledges human limitations in a time of extreme work hours, uncertainty, and intense exposure to critically ill patients</td>
<td>Need for support for personal and family needs as work hours and demands increase and schools and daycare closures occur</td>
<td>Provide support for physical needs, including access to healthy meals and hydration while working, lodging for individuals on rapid-cycle shifts who do not live in close proximity to the hospital, transportation assistance for sleep-deprived workers, and assistance with other tasks, and provide support for childcare needs</td>
</tr>
<tr>
<td>Care for me</td>
<td>Provide holistic support for the individual and their family should they need to be quarantined</td>
<td>Uncertainty that the organization will support/take care of personal or family needs if the health care professional develops infection</td>
<td>Provide lodging support for individuals living apart from their families, support for tangible needs (eg, food, childcare), check-ins and emotional support, and paid time off if quarantine is necessary</td>
</tr>
</tbody>
</table>
# NEEDS Assessment

<table>
<thead>
<tr>
<th>Identified Concern</th>
<th>Stakeholders</th>
<th>Current Related Resources</th>
<th>Gaps</th>
<th>Potential Solution(s) to Address Gap</th>
<th>Resources Needed</th>
</tr>
</thead>
</table>
Small Group Breakout: Needs Assessment

- What is the current state at your institution?
- What are the biggest challenges currently?
- What are your current supportive and mental health resources?
- Share with your group
Improving Healthcare Worker Well-Being Peri-Pandemic

Workplace Culture

Personal Factors and Health

Mental Health Support

Workplace Efficiency and Function

Professional Fulfillment and Meaning in Work
Pandemic Stressors and Strategies to Respond

Wave 1
1) Provide Basic Daily Resources
   • Food (free and subsidized)
   • PPE Clarity
   • Childcare resource
   • Transportation and Parking

2) Communication
   • Weekly wellness messages
   • Town Halls
   • Transparency

3) Psychosocial & Mental Health
   • Support Groups
   • Crisis Phone Lines and Telepsychiatry
   • Mental Health “PPE”
   • Frontline Relief

Wave 2
4) Addressing Exhaustion
   • Directed Leadership Support
   • Encouraged or Mandated Breaks
   • Addressing Workforce Shortages
   • Acknowledging it’s “OK to NOT be OK”

Source: New York Times
Mental Health and Support

- Address pre-pandemic burnout
- Treat pre-existing MH illness
- Increase Access to Mental Health Care
- Reduce stigma & consequences for help seeking behaviors and creating a culture of “asking for help and checking in”
- Address Grief

Offered:
- Crisis care
- Debriefing/Rounding
- Peer Support (Buddy System)
- Spiritual Care
- Facilitated Groups
- One on One Support
- Center for Stress Resilience and Personal Growth
Personal Factors and Health

- Ensure Basic Needs and Safety MET
  - Food
  - Financial support
  - Adequate PPE/scrubs
  - Treat underlying medical conditions

- Personal Strategies
  - Exercise > 4x /week
  - Sleep > 7 hours
  - Artistic hobbies
  - Positive emotional coping strategies
  - Avoid substance use coping
Mount Sinai Frontline Relief Program
Snack Stations & Well-Being Centers

- Interactive recharge rooms
  - immersive spaces with music, scent, meditative visual elements, lighting and sound
- Nourishment and rest areas
- Facility Dog Visits
Long-term Response

Center for Stress, Resilience and Personal Growth

- Opened in June of 2020 as a resource for all Mount Sinai faculty, staff, and students

- Focus is on improving resilience and mental health through individual and group level interventions

- Services
  - Evidence-based resilience workshops
  - Wellness Hub app (Golden et al, 2021)
  - 14 treatment visits (CBT/IPT/med management), with minimal out of pocket costs. >2,000 visits since October 2020
CSRPG Resilience Workshops

5 topics:

- Meaning and Purpose
- Social Support/Role Models
- Facing Fears/Active Coping
- Self-Care
- Realistic Optimism

- Integrated into MSHS residency/fellowship wellness curricula
- Collaborate with nurse leadership to make staff on medical floors available to attend

Workplace Efficiency and Function

1. Improve team-based **care, communication** and **comradery**

2. Ensure adequate **resources** and **training** for new roles

3. Provide up to date **protocols & EHR templates** for standardized treatment

4. Telehealth solutions

Panagioti et.al. Controlled Interventions to Reduce Burnout in Physicians: JAMA Int Med 2017
Include: Empower and Control over Environment

Workplace Culture

1. Engage the **whole team** in *identifying solutions*

2. Flexible **scheduling** & adequate **PTO**

3. **Leadership**

Cultivating Well-being: Core Leadership Skills

- **Include**: Engage and include all, create a safe environment
- **Inquire** (and Listen): Ask for feedback and listen
- **Inform**: Authentic, transparent communication
- **Develop**: All staff have a professional development plan
- **Recognize**: Express gratitude and appreciation

AMA Steps Forward Cultivating Leadership https://edhub.ama-assn.org/steps-forward/module/2774089#resource
Staff Support Guide for Leaders

Rounding by leadership is critical to addressing uncertainty and decreasing stress and burnout. At its core this means being present, transparent, genuine, receptive, and empathetic. It does not mean being a therapist for your employees. The framework below has proved useful in supporting staff and team members.

*Adapted from Hartford Healthcare Leadership Rounding & Shanafelt, Ripp & Trockel, 2020, JAMA

**Hear Me & Respond To Me**
- Use check-in and check-out routine each day with staff as an open forum to hear concerns and provide information (e.g. beginning and end of shift huddles)
- Ask open ended questions (e.g. “what are you worried about the most?”)
- Follow up on staff concerns, even if you have no answers yet or the issue cannot be resolved.
- Consider self-disclosure where appropriate (e.g. by sharing your own questions and personal concerns)

**Protect Me**
- Ask about safety concerns and provide up-to-date information. Staff Safety Hub

**Prepare Me**
- Acknowledge good adherence to COVID-related and more longstanding safety protocols

**Support Me**
- Assure that staff have the resources they need to do their jobs and/or clearly acknowledge resource issues. Staff Resources
- Acknowledge that everyone is affected in some way by the pandemic. A survey in March and April of 2020 of MSH frontline workers showed that 39% experienced symptoms of depression, anxiety, or posttraumatic stress.
- Educate yourself about the continuum of stress responses, both for yourself and your workers:

---

**STRESS CONTINUUM MODEL**

<table>
<thead>
<tr>
<th>READY</th>
<th>REACTING</th>
<th>INJURED</th>
<th>CRITICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing OK: Sense of mission, healthy sleep, problem solving/critical thinking, healthy sleep, effective and in control, coping well</td>
<td>Transient, more mild distress: Mild anxiety, problems with focus, worry, problems feeling joy and happiness</td>
<td>Increasing severity and risk: Sleep issues, numbness, burnout, disengagement, physical symptoms, exhaustion</td>
<td>Persistent distress: Insomnia, hopelessness, panic, anxiety, depression, substance use, thoughts of suicide</td>
</tr>
</tbody>
</table>

Adapted from: Nash (2011), US Marine Corps and Navy Operational Stress Continuum Model: A Tool for Leaders
Coaching and Mentoring: Inquire, Listen, Develop, Support

- Coaching: facilitating self-discovery
- Mentoring: sharing expertise

- Coaching: a questioning approach
- Mentoring: an advisory role
Recognize: Value to Engagement

VALUE

ENGAGEMENT

PRIDE

RECOGNITION
Well-Being Staff Resources During COVID-19

The well-being of our faculty and staff is critical to help us meet the challenge of COVID-19. Find the resources you need—from basic needs like childcare and food, to your mental health and spiritual needs.

For help or guidance in navigating any of the Well-Being Resources, including information on basic needs, general psychosocial support for you and your family, referrals to the appropriate mental health treatment services, and more, please call the Resource Navigation Phone Line at [masked]. The line is open and staffed 7am-8pm.

- Basic Needs & Self Care During COVID-19 for Staff
- Mental Health & Psychosocial Support During COVID-19
- On the Ground Support for Frontline Workers

https://www.mountsinai.org/about/covid19/staff-resources/well-being
ARTICLE

The Evolving Role of the Chief Wellness Officer in the Management of Crises by Health Care Systems: Lessons from the Covid-19 Pandemic

Kirk J. Brower, MD, Chantal M.L.R. Brazeau, MD, Sharon C. Kiely, MD, MPM, Elizabeth C. Lawrence, MD, FACP, Heather Farley, MD, MHCDS, FACEP, Jennifer I. Berliner, MD, Steven B. Bird, MD, Jonathan Ripp, MD, MPH, Tait Shanafelt, MD

Vol. 2 No. 5 | May 2021
DOI: 10.1056/CAT.20.0612

Effort – Impact Matrix

- "Quick Wins"
- "Major Projects"
- "Fill Ins"
- "Thankless Tasks"
Small Group Breakout: Creating solutions

Share with your group

- Identify solutions based on presentation that might fit problems
- Consider the Effort/Impact Matrix in choosing your solution(s)
- Share with your group
Questions?
Exploration of career choices and job satisfaction among early career pediatricians

Sarah Webber, MD; Assistant Professor, Director of Well-being
Department of Pediatrics, University of Wisconsin School of Medicine and Public Health
Disclosures

• No Disclosures
Background

• Factors inherent to physician job satisfaction change over the course of a career
• Early career physicians (ECPs) experience both personal and professional stressors:
  • Establishing practice/post training position
  • Physiologic/common time for pregnancy, childbirth, and adoption
  • Work may not yet align with values/goals, compared to mid or late career pediatricians
  • Generation differences: focus on time for non-work aspects of life
# Early Career Pediatricians

## TABLE 5 Personal and Work Factors Associated With Satisfaction With Career as a Physician

<table>
<thead>
<tr>
<th></th>
<th>aOR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent/very good self-reported health</td>
<td>2.17&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.34–3.53&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Have children</td>
<td>0.98</td>
<td>0.51–1.88</td>
</tr>
<tr>
<td>Female</td>
<td>0.54&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.32–0.92&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sad or depressed in last 12 mo</td>
<td>0.22&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.11–0.46&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Work factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥4 y at current position</td>
<td>3.17&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.95–5.14&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Physician colleagues are important source of personal support</td>
<td>2.87&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.79–4.60&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Autonomy in making clinical decisions</td>
<td>2.22&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.30–3.77&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Adequate resources for patient care</td>
<td>1.70&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.06–2.71&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Variables in the model that were not significant: having children, race, International Medical Graduate, has current educational debt, meets federal exercise recommendations, ≥1 negative life events in last 12 mo, primary position, ≥50 work hours per week. aOR, adjusted odds ratio; CI, confidence interval.

<sup>a</sup> Significant result.
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).
Why women leave medicine

Amy Paturel, MS, MPH, special to AAMCNews

October 1, 2019

• 40% of women physicians go part-time or leave medicine within six years of completing residency
  • 23% of women were not working full time (3.6% male physicians)
  • 31% of women with children were not working full time (4.6% males)
Research Gap and Study Objective

- What early career choices are pediatricians making?
- Can we have a more nuanced understanding of their career satisfaction?
- What differences exist related to sex and parenthood status?
Methods

- National data collected from a cohort of ECPs via 2019 survey, as part of the longitudinal AAP Pediatrician Life and Career Experience Study
- Cohort: 2016-2018 residency graduates
- Respondents asked about personal and work characteristics and satisfaction with job aspects (4-point Likert scale)
- Sex measured: male, female, self-describe
- Hours worked: Do you currently work reduced or part-time hours?
- Chi-squared tests examined relationships of sex and parenthood with fellowship training, part-time hours, and measures of job satisfaction
# Results

<table>
<thead>
<tr>
<th>N=830, 90% response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>33% in fellowship training</td>
</tr>
<tr>
<td>11% part-time work</td>
</tr>
<tr>
<td>75% female (0 responded “self-describe”)</td>
</tr>
<tr>
<td>43% parents (no statistical difference by sex)</td>
</tr>
</tbody>
</table>
Fellowship training

BY PARENTHOOD STATUS

Parent  Without Children

24  40

P<0.001
Fellowship training

BY SEX

Female: 31
Male: 39

P < 0.05
Figure 1. Percent of early career pediatricians reporting they are in FELLOWSHIP TRAINING

<table>
<thead>
<tr>
<th>Respondents with children</th>
<th>Respondents without children*</th>
</tr>
</thead>
<tbody>
<tr>
<td>23%</td>
<td>51%</td>
</tr>
<tr>
<td>26%</td>
<td>36%</td>
</tr>
</tbody>
</table>

* Female  Male

Source: AAP Pediatrician Life and Career Experience Study (PLACES)
2016-2018 Residency Graduates Cohort, 2019 data; *p=0.01
All female vs male (31% vs 39%, p<0.05); all with children vs without children (24% vs 40%, p<0.001)
Among all female, with children vs without children (23% vs 36%, p<0.001)
Among all male, with children vs respondents without children (26% vs 51%, p<0.001)
Part-time work

BY PARENTHOOD STATUS

P<0.01

Part-time

Parent | Without Children
---|---
24 | 9

P<0.01
Part-time work

BY SEX

Female Male

19 6

P<0.01
Figure 2. Percent of early career pediatricians reporting they are working PART-TIME OR REDUCED HOURS

<table>
<thead>
<tr>
<th>Respondents with children*</th>
<th>Respondents without children</th>
</tr>
</thead>
<tbody>
<tr>
<td>*P&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td>10%</td>
</tr>
<tr>
<td>5%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: AAP Pediatrician Life and Career Experience Study (PLACES)
2016-2018 Residency Graduates Cohort (post-trainees only), 2019 data; *p<0.001
All female vs male (19% vs 6%, p<0.01); all with children vs without children (24% vs 9%, p<0.001)
Parenthood status did not predict any categories of career opportunity satisfaction.
Among ECPs, **parenthood** and **sex** predicted likelihood of attending fellowship during early career

- There was no sex difference in fellowship training among *pediatricians with children*

**Female sex** and **parenthood** were associated with part-time work

- There was no sex difference in part-time work among *pediatricians without children*

**Female ECPs** were less likely to be satisfied with **opportunities for learning and growth and recognition at work**
Parenthood, sex and part-time work

- Female sex and parenthood:
  - Female pediatricians do majority of household work, especially related to caregiving (Starmer 2016)
  - Societal expectations for role in caregiving
  - Female pediatricians carry and deliver biologic children
  - Often, female pediatricians breastfeed infants*
- Parental satisfaction of US physicians: associated factors and comparison with the general US working population (Shanafelt 2016)
  - Women physicians were more likely to see job as negatively impacting relationship with their children
“Another way to frame the issue is that leaning in when you have significant caregiving responsibilities requires an intensive support structure at home and lots of flexibility at work. Think about simple physics. Imagine a tree leaning over the water”
Part-time work

• Benefits:
  • Decreased risk of burnout
  • More time for self, family
  • Form of “control” of schedule

• Issues:
  • Stigma
  • Choice vs “forced”
  • Do part-time workers actually work part-time?
  • What is the impact on long-term career, professional fulfillment?
  • Workforce
Marginalized individuals in medicine

- Gendered expectations
- Values-misalignment
- Discrimination
- Bias
- Harassment
- Invisible work
- Minority tax
- Larger household workload (esp caregiving)
- Pay inequities
Limitations

• Survey study
• Data not yet adjusted for other variables
• More detailed information delineating experience based on sex and gender are needed
Future Steps

• Broaden the body of research to examine physician well-being across sex and gender spectrums, avoiding binaries and equating sex and gender

• Work to better understand the contexts in which gender and sex influences choices to work part-time, and how those choices correlate to professional and personal well-being

• Understand how intersectionality (experience of multiple identities that suffer marginalization and oppression) relates to early career choices and professional well-being
Acknowledgements

PLACES is supported by:
The American Academy of Pediatrics

Thanks to the PLACES Project Advisory Committee and to all the PLACES participants!
ACPH 2021
American Conference on Physician Health™
Understanding the Impact of COVID-19 on Faculty Needs for Childcare & Eldercare, Flexibility and Work/Life Balance

Daiva Braunfelds, MBA, MPH
Executive Director, Population Health Management & Physician Engagement
Brigham and Women’s Physicians’ Organization
October 7, 2021

Brigham and Women’s Hospital
Founding Member, Mass General Brigham

American Conference on Physician Health ACPH 2021
Disclosures

• No disclosures
About 3 in 10 health-care workers say they have considered no longer working in health care

Q: As a result of the covid-19 pandemic, have you considered no longer working in health care, or not?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Note: “No opinion” not shown.

What did we do?

Offered Physician Focus Groups on Childcare/Eldercare, Flexibility & Work/Life Balance during COVID

Seven virtual focus groups offered to all physicians at varied times.
Facilitated groups met from September 14-25, 2020, including 80 physicians from 13 departments.

Main themes that emerged:
• Access to COVID testing problematic
• Difficulty attaining flexibility
• Additional childcare support & options needed
• Backup systems for physicians lacking
• Work/life boundaries blurred
• Value your physician workforce and reduce moral distress
What we heard:

- Current testing criteria and lack of availability creates barriers for physicians working due to childcare, as well as increases the chance of missing work.
- Physicians reported that some departments were allowing time off for testing while others were asking physicians to use their personal time.

Subsequent Actions:

- Brigham leadership reviewed COVID testing time off policies of each department to ensure equity and implemented changes to create alignment. All departments instituted policy not requiring physicians to use personal time for testing.
- Access to free asymptomatic employee testing was quickly implemented across Mass General Brigham system. Access to linkages to testing for family members was improved via Occupational Health but there may be additional opportunity to improve.
What we heard:

• Flexibility is extremely difficult to attain in real practice as a physician faculty member at the Brigham.

• Flexible work arrangements, when offered at all, are not consistent and made available by all leadership.

Subsequent Actions:

• Leadership working to create a culture that consistently offers more flexibility and does not penalize those who opt for flexible work arrangements.

• Flexibility is being integrated into departmental planning to ensure that it is available to be accessed.

• Increased virtual visit availability for physicians.
What we heard:

• The Brigham Health/ Mass General Brigham childcare options do not meet the needs of the physician community. Other local options do not suffice either.

• Access, availability, convenience, affordability all lacking.

• Childcare vs. eldercare needs are very different and require different solutions that take into account predictability of need, type of need, location, etc.

Subsequent Actions:

• Mass General Brigham expansion of child care coverage in partnership with Bright Horizons, including new locations and expansion of backup child care center availability and access.

• Subsidized childcare was rolled out during the pandemic.
Need backup systems for physicians

What we heard:

• We do not have good backup systems to support our physicians with unexpected issues.

• Lack of systems impacts physicians every day as they don’t feel that they can take care of themselves without hurting their coworkers who will be negatively impacted if they call out.

Subsequent Actions:

• Brigham Leadership Operations Committee reviewed the policies of each department to:
  - Ensure that backup systems for ambulatory clinics, scheduled shifts, and surgery/procedures are in place
  - Optimize system for minimizing negative impacts for patients and staff when last minute sick or other call outs occur
What we heard:
• Physicians feel pressured to maintain productivity despite unprecedented conditions, and work/life boundaries have all but disappeared.

Subsequent Actions:
• Leadership reviewed vacation/time off policies of each department to ensure equity and access to time off
• Senior leaders led a culture change to reduce unnecessary early and late meetings
• Brigham Faculty Development & Wellbeing continues to pursue strategies to improve job doability and shorten work days:
  - Offering 1:1 Epic trainings, and InBasket and Epic Upgrade support
  - Implementing new scribe options to reduce documentation burden
  - Offering flexible BWell MD grant program to fund system improvement and/or wellbeing projects at the local level to improve efficiency and work life
What we heard:

- Physicians are not feeling appreciated by the organization for their extraordinary contributions to COVID care and ramp up of care all while maintaining the “regular care”.
- Appreciation efforts to date fell short of expectations.
- Physicians frequently feel pulled between caring for their patients and caring for the rest of their lives (themselves, childcare, eldercare, community, etc.)

Subsequent Actions:

- Recognizing that perceived gratitude is a key driver of burnout at Brigham (as evidenced by 2017 & 2019 survey results), leadership agreed upon appreciation as a focal area for FY21.
- Developed pulse appreciation survey to better understand how physicians would like to receive appreciation.
- Explore ways to mitigate moral distress via discussion in multiple forums.
Brigham Pulse Survey on Physician Appreciation

Objectives:
- Understand our physicians’ perception of our current appreciation efforts
- Learn about how our physicians would like to be appreciated
- Create a plan to improve physicians’ perceived appreciation (a driver of burnout at Brigham)

- Brief 5 question survey, 2-3 minutes to complete
- 1600 participants randomized into 6 waves, which will be administered through 2021
- Waves 1-3 completed, February, June & September 2021
  - Sent to 896 physicians so far, 349 responses (40% response rates)

- Key themes include need for greater appreciation from direct supervisors/leaders and continued focus on investing in job doability -- invitation to view more results on the poster by Victoria Ostler and our team here at this conference
Conclusions

Focus groups provide direct, timely & effective communication with physicians. Strong value to participants voicing their opinions and concerns, debriefing and sharing ideas with their peers and being heard by leadership.

There are important differences between childcare and eldercare and organizations need to provide flexible, robust solutions for each.

Access to testing early-on in the pandemic (and continuing throughout as payers change coverages) has been crucial.

Integrating flexible work arrangements into departmental planning will make it possible for more flexibility to be offered and accessed by faculty.

Continued need to support physicians in setting and maintaining boundaries to support work/life balance.

Further explore which ways of expressing gratitude resonate best with our physicians, as well as how to effectively mitigate moral distress.
Healing Breaths: Harnessing SKY Breath Meditation to Promote Individual Physician Resilience and Organizational Connectedness during a Dual Pandemic

Gitanjali Persaud, MSc  
Christiane Corriveau, MD MEd  
Hemant Sharma, MD MHS

Children’s National Hospital  
Clinician Well-being Program
Learning Objectives

• Examine the evidence base underlying physiologic benefits of SKY Breath Meditation for professions dealing with acute and chronic stress.

• Experience the real-time impact of hands-on application of breathing techniques.

• Discuss the implementation and evaluation of the virtual SKY Breath Meditation program at an academic children’s hospital during the pandemic, including its impact on individual resilience and organizational culture.
Disclosures

• All research presented was conducted at Children’s National Research Institute independent of the Art of Living Foundation.

• SKY Breath Meditation workshops were offered by the Art of Living Foundation at no cost to all US healthcare professionals at the outset of the COVID-19 pandemic.

• No funding was received from outside sources for this research.

• Gitanjali Persaud is a trained volunteer instructor of breathwork techniques with the Art of Living Foundation.
Checking in with You
Four Key Components of your Organizational Well-being Blueprint

Sustainability

Rapid Iterative Experimentation

Cultural Transformation

Foundational Programs

| Safety Net Resources for Distressed Clinicians | Group- or issue-specific Resources | Self-care and wellness promotion | Leadership Development | Collegiality and Community | Assessment of Well-being | “Pebbles in the Shoe” |

SKY Breath Workshops

1. SKY Breath (yogic breathing practices)
2. Cognitive re-framing
3. Interactive narrative storytelling in small-group breakout sessions

SKY: “Sudarshan Kriya”
(Su=proper, Darshan=vision, Kriya=purifying action)

- Ujjayi pranayama: slow deep breathing with prolonged exhalation
- Bhastrika pranayama: forced inhalation and exhalation
- Cyclical breathing: slow, medium, and fast cycles of breathing
SKY Breath Meditation:

“The most powerful technique I’ve learned”

– James Nestor, author of BREATH, New York Times Bestseller
SKY is associated with Decreased Levels of Stress Hormone Cortisol

- Study population: 60 inpatients with alcohol dependence
- Randomized to SKY versus standard of care for 2 weeks
- Outcomes measured at baseline and 2 week post:
  - Beck Depression Inventory (BDI)
  - Morning plasma cortisol and ACTH levels
- In both groups, reductions in BDI scores and cortisol levels occurred, but significantly more so in SKY group.

In both groups, plasma cortisol (and ACTH) fell after two weeks, but significantly more so in SKY group.

Reduction in BDI scores correlated with that in cortisol in SKY but not in control group.

Fig. 1. Relation between BDI score and plasma Cortisol reductions over two weeks. ■ SKY (n=30); □ Control (n=22): plasma cortisol levels rose in eight controls (not represented in the illustration); in all these individuals the BDI score reduction was less than 70%.

SKY is associated with significant decreases in Clinical & Non-clinical Depression

SKY significantly reduces major depressive disorder as effectively as anti-depressant drug therapy.

SKY reduces everyday blues (non-clinical depression) by one third in four weeks.


Significant decrease in Major Depression following inadequate response to antidepressants

• Study population: 25 patients at Univ of Pennsylvania with MDD depressed despite > 8 weeks of antidepressant therapy

• Randomized to SKY versus waitlist control

• SKY arm showed significant reductions in Hamilton depression rating scale versus control at 30 and 60 days

• SKY arm also with significantly decreased anxiety levels

Significant reduction in PTSD among combat veterans

- 21 veterans randomized to SKY versus waitlist control
- Significant reductions in PTSD in SKY group at 1 week and persisting to 1 year

SKY is associated with longer duration of slow wave (restful) sleep

- SKY practitioners spent three times as much of their total sleep time in deeper sleep (slow wave sleep), than controls.

SKY and Cardiovascular Outcomes: Heart Rate, Blood Pressure, Cholesterol

* - p value < 0.0001

SKY Practitioners EEG: “Relaxed Alertness”

Significant increase in beta wave activity in SKY practitioners versus control in regions associated with heightened mental alertness/focus

Progressive increase in alpha wave activity during SKY breathing associated with relaxation

Breathwork Practice!!

*Pranayam = Housing of the Life Force Energy*

**Yogic Breathing**

**Bhramari Pranayam**
(“Bee Breath”)
Due to the strong evidence supporting SKY’s efficacy, Children’s National Hospital implemented the Living Well Program for a pilot group of 27 HCPs in 2019.

Participants reported significant declines in anxiety and depressive symptoms, as well as reduced emotional exhaustion, a key burnout domain.

<table>
<thead>
<tr>
<th>Table 2. Mean Burnout Scores, Pre- versus Post-Intervention</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Emotional Exhaustion†</td>
</tr>
<tr>
<td>Depersonalization ‡</td>
</tr>
<tr>
<td>Personal Accomplishment ‡‡</td>
</tr>
</tbody>
</table>
SKY Breath Workshop: Virtual Implementation as part of Pandemic Response

In Spring and Summer 2020, as a rapid response to the dual pandemics of COVID-19 and structural racism, Children’s National approached the Art of Living Foundation’s Healing Breaths Program to offer virtual workshops to its healthcare professionals.

• Overwhelming Response: 287 CNH HCPs participated in a total of 9 workshops offered over 3 time periods:
  - 35% Medical staff
  - 16% Nursing
  - 49% non-medical staff, non-nursing

• Workshop Logistics:
  - 2.5-hour session/day over 3 consecutive days
  - 100% virtual conducted online via Zoom
  - Taught by trained instructors from Art of Living Foundation
Lessons Learned

• Marketing:
  o Timing was right as staff were actively seeking help
  o Compelling video and written testimonials from colleagues and co-workers

• Schedules:
  o Most popular times were weekday evenings (Tues-Thurs 7pm-9:30pm)
  o Nightly homework after each session (practice of techniques and self-reflection)

• Virtual technology:
  o Small group breakout sessions (3 participants/session) were interactive and fostered deep connection
  o Trained instructors interacted directly with all participants in larger group sessions (up to 30 participants/session)
  o Participants reported enhanced privacy and comfort in learning techniques in their own home
  o Staff who were isolated and working from home could interact and connect with others

• Follow-up:
  o Daily follow-up allowed for practices to become firmly established
Virtual SKY Workshops: Key Outcomes

Study population: 99 HCPs from across the US who participated in virtual SKY Breath Meditation workshops as part of the Healing Breaths program in Spring-Summer 2020.

Prevalence of Burnout and Sleep Satisfaction Pre- (Day 1) versus Post-Intervention (Day 3)

- Self-Reported Burnout:
  - Pre-Intervention: 32.6%
  - Post-Intervention: 19.1%
  - p = 0.03

- Sleep Satisfaction:
  - Pre-Intervention: 58.6%
  - Post-Intervention: 81.8%
  - p < 0.001
Virtual SKY Workshops: Key Outcomes

**Professional Dedication Scores**
Pre- (Day 1) versus Post-Intervention (Day 3)

- **Pre-Intervention**: Score = 5.38
- **Post-Intervention**: Score = 5.91
- **p-value**: 0.002

**Anxiety Scores**
Pre- (Day 1) versus Post-Intervention (Day 3)

- **Pre-Intervention**: Score = 46.7
- **Post-Intervention**: Score = 35.4
- **p-value**: <0.0001

*Professional Dedication:* Being involved in one's work, finding meaning in one's work, being challenged, and experiencing a sense of enthusiasm, inspiration, and pride.

*Anxiety:* A cut-off score of 40 is commonly used to define probable clinical levels of anxiety.
Narrative Storytelling Practice!

Think about a positive experience you had as a result of the pandemic.

Tell your partner that story in 4 minutes. How are you going to grow and sustain that going forward?

Switch.

Share.
Qualitative Feedback

Theiline T. Gborkorquelli, MD, MHS, FAAP, General Pediatrician, Children’s Health Center at THEARC

“This has been an absolutely amazing, amazing life-changing experience... A lot of us deal with very sick patients, with very needy families... and we just give, give, give and it’s hard to give into ourselves. But this course really makes you think about self-care in a different way... That feels so good to know that I have something that I can take with me and do day after day and know that it works.”

Cath Bollard, MD, MBChB, Director, Center for Cancer and Immunology, Director, Program for Cell Enhancement and Technologies for Immunotherapy

“The first night was all euphoria. And the last two nights, a sense of calm and peace... This was really a transformative experience for me.”

Dianna Abney, MD, Medical Director, Pediatric Health Network

“This course has invigorated me... If someone were to ask me what I’d say about this course, I’d say it’s something every person at the hospital should take!”

Eileen Walters, MSN, RN, CPN, Program Manager, Beyond the Spectrum Autism Behavioral Communication support (ABCs) Program

“The breathing is improving my health and it’s improving my body’s ability to heal and to be strong and to be present in the moment.”

Dominique Charlot-Swilley, Ph.D., Early Childhood Innovation Network, Children’s Health Center – Anacostia

“This course has been really exceptional. It really affirms how we have to take time to pause and engage in self-care... It allows you to be able to engage in self, in order to be able to give to others. We talk about burnout, compassion fatigue, secondary traumatic stress, and this allows us to gain tools in combating these issues. Thank you for allowing us to receive this wonderful blessing!”
Gratitude for Institution

“The most important thing is that investment from our employer to offer this to us especially during this time of the pandemic – to really care about our health, wanting us to be present and to be there for our patients.”

Torin Creppy, President, Safe Kids Worldwide

Connection and Cohesion

“I have worked as a nurse at Children’s for over 30 years, and I have never felt as connected to my colleagues as after this course.”

Kathy Dubois, MSN, RN, NPD-BC, HEC

Self-care for Leaders

“We invest so much into our work at Children’s National, and to be having this opportunity that’s invested in us to make sure that we’re doing well, is such a huge opportunity and I am very thankful for that. I really do recommend our executive leaders and others to definitely participate in this.”

Desiree de la Torre, Director, Community Affairs & Pop. Health
Acknowledgments

Thank you to the Art of Living Foundation’s Healing Breaths Program

https://www.healingbreaths.org/
Thank You!

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Disclosures

We have no disclosures to report.
So, You Want to Be a CWO?

- Elizabeth C. Lawrence, MD
- Chantal Brazeau, MD
- Heather Farley, MD, MHCDS
- Sharon C. Kiely, MD, MPM, FACP
- Kristine Olson, MD, MSc
- Jon Ripp, MD, MPH
Learning Objectives

1. Discuss the range of Chief Wellness Officer (CWO) job responsibilities, competencies and positions in organizational structure.
2. Explain what a CWO role is and what it is not.
3. Develop an outline of a CWO job description for home institution.
Agenda

• Overview/Introductions  (10 minutes)
• Small group work (one of three groups)  (15 minutes)
• Large group debrief  (10 minutes)
• Independent work on CWO job description  (10 minutes)
• Large group discussion, conclusions, key takeaways  (10 minutes)
We each...

• ...carry the title of CWO - some of us are also deans for wellness;
• ...have at least 0.5 FTE dedicated to our role;
• ...were appointed to our role in 2018, 2019, or 2020;
• ...are responsible for surveying wellness
<table>
<thead>
<tr>
<th>Institution</th>
<th>Christiana Care</th>
<th>Hartford HealthCare</th>
<th>Mount Sinai</th>
<th>Rutgers Biomedical and Health Sciences</th>
<th>UNM</th>
<th>Yale</th>
</tr>
</thead>
<tbody>
<tr>
<td>CWO reports to</td>
<td>Chief People Officer</td>
<td>Chief Clinical and Chief Administrative Officer</td>
<td>Dean of the School of Medicine</td>
<td>Senior Vice-Chancellor of Clinical Affairs and Chief Academic Officer Vice-Deans</td>
<td>Dean of the School of Medicine</td>
<td>Deputy Chief Medical Officer for Health System</td>
</tr>
<tr>
<td>CWO has independent budget</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Responsible for programming for this many people</td>
<td>14,500</td>
<td>33,000</td>
<td>About 9000 students, trainees and faculty.</td>
<td>Programming: 3,500</td>
<td>Assessment: 14,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Population served</td>
<td>All employees and medical dental staff</td>
<td>Physicians, APP’s Residents Nurses Employees</td>
<td>Faculty physicians and research scientists, house staff, medical and graduate students, research Post-Docs</td>
<td>Physicians Faculty various prof. Scientists/educators Residents</td>
<td>Medical students, house staff, clinical faculty</td>
<td>Medical staff: Attendings, Advanced Practice Providers, House Staff</td>
</tr>
<tr>
<td>Total FTE designated for wellness (does this include administrative support?)</td>
<td>10.4 (includes admin)</td>
<td>3.5 (includes – admin)</td>
<td>5.9 (includes - admin)</td>
<td>Granted from other cost centers</td>
<td>3.75 (includes 1.0 admin)</td>
<td>Granted from other cost centers</td>
</tr>
<tr>
<td>Key partners in work</td>
<td>HR, DEI, IT, Quality &amp; Safety, Medical Affairs, Risk Management, Communications, GME, Employee Health, Patient Experience, Organizational Excellence, Organizational Development, executive cabinet</td>
<td>HR, DEIB, Experience, Informatics, Ed/OD, Communications &amp; Marketing, Strategy, GME, Research, Medical Staff Services, Clinical Affairs, Quality/safety, Risk Management, Medical Group, Captive</td>
<td>Deans of UME, GME, Grad School, Department Chairs, Hospital Presidents and CMOs, HR, Office of Diversity and Inclusion, Patient Experience, Informatics Leadership, Communications &amp; Marketing, Behavioral Health, Operations Leaders</td>
<td>School Deans, Dept. Chairs, Behavioral Health, Clinical Affairs, Hospital CEO/CQO, communications, IT</td>
<td>Office of Education, Office of Faculty Affairs, Human Resources, Office of DEI, IT, Communications, Quality/safety, GME, Learning Environment Office</td>
<td>5 DN CMOs, APPEx, GME, 3 Practice Models, Clinical Affairs, Dept Chairs, Wellness Leads, HR, DEI, CMOs, Operations, Policy &amp; Compliance, Psychiatry/Psychology/Behavioral Health, Occupational Health, Communications &amp; Marketing, Med Staff Admin, Risk Management, Patient Experience</td>
</tr>
</tbody>
</table>
Small group work: elaborate CWO work

- A key responsibility of the CWO is to ensure that professional well-being is a major consideration in all decisions that impact workflow, work environment and institutional culture. While this is a central premise, you have just heard various forms this can take at different organizations.

- **Group specific tasks:**
  - Group 1: create a list of responsibilities that you believe a CWO should have.
  - Group 2: describe the organizational structure and list key strategic partnerships with entities within the organization that are needed to support the work of a CWO.
  - Group 3: create a list of competencies, skill sets and experiences that you would recommend for a CWO.
Debrief, key themes from small group work
Responsibilities:

Strategic partnerships:

Competencies:
Independent work: write your job description
Debrief, key themes from independent work
KEY TAKEAWAYS:

- Strong case can be made to invest in the CWO
- The CWO is fast becoming a standard member of the C-suite.

To be effective:

- At least 50% FTE
- Reports to Senior Organizational Leadership (e.g. CEO, Dean, etc.)
- Is positioned to have influence within organization
- Some CWO’s are hired from inside the organization, others from outside - can impact resources, role, expectations
KEY TAKEAWAYS:

- There are an emerging set of roles and responsibilities. There is tension in this growth process. At a minimum the CWO is responsible for:
  - Well-being measurement and,
  - Consultation on how to direct organizations toward optimal workforce well-being
- Much of the success of the role relies on strong interpersonal/communications and leadership skills
KEY TAKEAWAYS:

- Well-Being touches every aspect of a healthcare organization
  - Breadth of role changes over time
    - For some, defining what the CWO should NOT may be as important as defining what they should do
    - For others, being as inclusive as possible and expanding the role has led to success
  - CWO’s need to remember to create a sustainable role
- Budget/Resource needs are dictated by constituency size and scope of the work
KEY TAKEAWAYS:

One day, the CWO role will be as accepted and expected as the CQO, CEO, CMO, COO and other C-suite roles
Questions, Conclusions

Thank you for your engagement.
Disclosures

No Disclosures
Physician Task Force on Communication, Culture and Engagement

Tara Sanft, MD
Chief Patient Experience Officer
Smilow Cancer Hospital, Yale Cancer Center
New Haven, CT
American Conference on Physician Health, October, 2021
Background

Burnout in oncology is common

It is associated with costly outcomes

Interventions require investment

How do you address institutional culture?

- Burnout is defined as an occupational-related syndrome characterized by: physical and emotional exhaustion, cynicism/depersonalization, and low sense of professional accomplishment.
- Multiple oncology-specific risk factors associated with an increased susceptibility for the development of burnout may trigger personal and professional consequences.
- Addressing clinician burnout by promoting oncology clinician well-being needs to be tackled at the individual level and organizational level.
- At the individual level, oncology clinicians have an important role in identifying symptoms, acquiring resilience skills, and building positive relationships with colleagues.
- At the organizational level, leadership must optimize the clinical practice environment and institutional culture in order to promote clinician well-being.

Hlubocky ASCO educ book 2016; Williams Health Care Manage Review 2001; Dewa BMC Health Serv Res 2014;; Zang BMC Health Serv Res 2011
“Burnout is toxic for patients as well as physicians, because it’s associated with loss of empathy, impaired job performance, and increases in medical mistakes.”

“The problem of burnout will not be solved without addressing the issues of autonomy, competence, and relatedness.”
Smilow Cancer Network
Largest cancer care delivery in Connecticut

• 15 locations
• 115 physicians (31 med onc “main campus”, 16 heme, 58 “care center”, 4 neuro onc, 6 palliative care)
• 8,000 new cases
• 236,000 visits annually
• 90,000 treatment visits
• 48% of newly diagnosed patients in Connecticut
High Burnout, Low Professional Fulfillment in Oncology

Highest Odds Ratio:
• Leadership Seek “Buy-In”
• Leadership Respond to Input
• Team Documentation
• Control Patient Volume
• Self-Compassion
• Excess EMR
• EMR use at home
To help tackle healthcare worker burnout, start talking about it

Healthcare staff are working through immense loss, grief and uncertainty to provide care during the Covid-19 pandemic. As organizations think about how to support their staff, speakers at a MedCity INVEST panel said they must first talk about it openly and provide a safe space for workers to discuss their feelings.

By ANUJA VAIDYA

It’s never been discussed before....so just need to start somewhere
• Of all the things that can boost emotions, motivation, and perceptions during a workday, the single most important is making progress in meaningful work.

• People are more creative and productive when their inner work lives are positive.
Communication Culture Engagement Task Force

Facilitated working group with goal of recommending changes to leadership
World Cafe

- Appreciative Inquiry approach to problem solving
- A conversational process permitting productive discussion around critical questions
- Dream what’s possible
- Remove barriers

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

Symposium on Physician Well-Being

November 17-18, 2015

Summary and Proposal to the ACGME Board of Directors
To my knowledge, this is the first project to use the World Café method to address culture, engagement or burnout in oncology.
The World Café Approach

1. Intro June 19
2. Brainstorms June 26
3. Deep Dive July 10
4. Deep Dive July 24
5. Recommendations Aug 14
6. Recommendations Aug 28
Ground Rules

• Create a safe space for confidential discussions
• Speak from your experience
• Time for everyone to speak and participate
• All ideas welcome, nothing too big or too small

Consider:
• Immediate
• 1-3 years
• 5+ years
Session 1: Share Experience

• Person: Tell us about an experience that was deeply meaningful for you
• People: Tell about a mentor in your life, how did this person talk to you, make you a part of the vision, motivate you to do work
• Environment: tell me about a time you felt you belonged to a group
Session 2, 3, 4: Brainstorm Ideas

One year from now Smilow has world class communication, what words describe it?
Digest into Themes

- **Goal of communication determines best method** → Dissemination of information (email) vs. conversation (meeting)

- **Importance of multi-directional communication** → Less presentations, more dialogue

- **Environment** → Creating a safe space where people feel comfortable communicating honestly
• **Flexible** ➔ Everyone is multi-dimensional and has different needs for work-life balance.

• **Patient-Centered** ➔ Patients come first. Good feeling when patients speak well of Smilow.

• **Supportive** ➔ Importance of aligning values between leadership and employees. Having each other’s back.
Brainstorm: Engagement

Imagine that a year from now, we are exactly where we want to be with physician engagement. What are the three biggest things we've accomplished between now and then?

- **Connected**
  - Smaller is better
  - Relationships matter
  - Proximity and exposure fosters this feeling

- **Respect**
  - Valued different roles
  - Be asked to give input
  - Focus on positive

- **Supportive**
  - Team approach to care delivery
  - Time to communicate across disciplines
  - Pride in our work

- **Value and recognition**
  - Everyone has different roles. Want to feel appreciated for differences, want to hear “thank you”

- **Venues matter**
  - Easier to engage in small groups, retreats, social gatherings, in clinic

- **Satisfaction**
  - Empowered to focus on work that is motivating, be a part of decision-making process, shared sense of purpose and mission
“Work is like a marriage, it needs to be a two-way street, bi-directional.”

“I feel recognition of others has been more positive since COVID.”

“Our team did a great job integrating but at the review I was told I needed to attend more tumor boards. The message is: you are not good enough.”

“We need clear portals of communication. If your suggestions go nowhere, you give up.”

“I just got a text from a surgeon “my team is waiting in the ED for your patient,” I feel pride in this teamwork.”

“Getting paid fairly is a sign of respect.”
<table>
<thead>
<tr>
<th>Implement programmatic initiatives and policies that promote the relevancy and meaning at work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide protected time for physicians to meet with a small number of physicians to discuss teams related to increased meaning at work</td>
</tr>
<tr>
<td>Launch a series of webinars on culture and engagement</td>
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<tr>
<td>Provide communication, awareness, and uncomfortable lines of sight training</td>
</tr>
<tr>
<td>Update the career center “My Journey” to reflect the values of the organization</td>
</tr>
<tr>
<td>Form focused working groups to survey educators about how to identify and mentor all potential leaders of future physician engagement</td>
</tr>
<tr>
<td>Funding is necessary for tracking physician engagement via MYMD as part of the engagement rewarded program</td>
</tr>
</tbody>
</table>

| Implement strategies to reduce turnover and promote retention |
| Example Include: |
| Enhance the physician onboarding experience to include formal peer coaching support |
| Increase opportunities to provide skills feedback on staff experience (e.g., interviews, retention, and surveys staff experience, leadership accreditations) |
| Enhance “real-life” mentoring/teaching opportunities as physicians can map their path for meeting their personal and professional needs |

| Develop team-based/localized interventions |
| Examples Include: |
| Create opportunities for local teams (e.g., main campus, care centers, delivery networks) to identify and prioritize the drivers that are most important to the work of the unit/practice and can be rapidly applied to reduce burnout (e.g., Team Huddles) |
| Provide resources for more formal team-building that focuses on connections with colleagues, communication, role alignment, and puts the patient first |
| Explore innovative ways to structure team work and processes so staff feel supported and connected |
| Document and share best practices from team assessments (e.g., Pharmacy—why it works and how to implement those practices in other areas) |
| Create structure for common clinical issues to be discussed and solutions facilitated (e.g., scheduling) |

| Develop policies that promote flexibility and work-life balance |
| Example Include: |
| Provide physicians with flexible options to tailor their work effort, schedules, and how they work |
| Make enhancements to optimize the clinic scheduling process |

| Structure rewards and incentives to facilitate both individual and organizational health |
| Example Include: |
| Incorporate dimensions in the physician compensation model that prioritize the compassionate and humanistic parts of medicine |
| Explore alternative compensation models for team-based care |
| Positive recognition from leadership through personalized letters and emails about a job well done (e.g., Pharma letter thanking MD) |
| Celebrate/trophy achievements and milestones (e.g., new hires, promotions, degrees) |

---

**Survey Request Sent:**
- Tues 8/4/20
- Mon 8/10/20
- Tues 8/11/20
Recommendation Prioritization Survey Results

N=16 (80% Response Rate)

- Develop policies that promote flexibility and work-life balance: 330 points
- Develop team-based/localized interventions: 310 points
- Structure rewards and incentives to facilitate both individual and organizational health: 285 points
- Implement strategies to reduce turnover and promote retention: 275 points
- Create additional opportunities to solicit feedback, encourage multidirectional communication, and include faculty in decision-making: 255 points
- Implement programmatic initiatives and policies that promote relatedness and meaning at work: 145 points

Points Assigned
**Session 5: Impact/Ease Exercise**

**Develop team-based/localized interventions**

<table>
<thead>
<tr>
<th>#</th>
<th>Example</th>
</tr>
</thead>
<tbody>
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<td>5</td>
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</tr>
</tbody>
</table>
**Next Steps (Green-immediate, Blue-6-12 months, Black-difficult without leadership)**

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**Low Hanging Fruit**

- Enhance "real life" mentorship/coaching opportunities so physicians can map their path for reaching full potential personally and professionally
- Enhance the physician on-boarding experience to include formal peer coaching/support
- Suggestion box
- More dialogue, less presenting at faculty mtgs, town halls etc.
- Allow faculty to submit agenda items for faculty meeting
- Provide protected time for physicians to meet with a small cohort of colleagues to discuss topics related to improved meaning in work
- Launch a speaker series on culture and engagement
- Provide communication, sensitivity and unconscious bias training
- Launch a writers retreat/workshop
Recommendation Summary
Autonomy, Competence, Relatedness

- Flexibility and work-life balance
- Team-based/localized interventions
- Structure rewards and incentives differently
- Low hanging fruit from 4-6
## Low Hanging Fruit

<table>
<thead>
<tr>
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</table>
2021 Mini Session Framework
Recommendation-based Discussion

Session 1
Overview and Special Guests

Session 2
Literature Review and Discussion

Session 3
Recommendations report to Leadership
Mini Session 1: Flexibility

1.1 Make enhancements to optimize the clinic scheduling process

1.1.A. More work should be done to understand clinic operations to identify best practices (50% feel clinic works well for them) and opportunities for improvement (50% do not)

1.1.B. Share information regarding physician scheduling tasks, mode of communication preference and comments to inform system-wide scheduling transformation efforts (Ambulatory Transformation Committee).

1.1.C. Build a culture that supports adequate time off. Additional work should be done to identify barriers to taking time off

1.2 Provide Physicians with flexible options to tailor their work efforts, schedules and how they work

1.2.A. As it relates to inpatient service time, we recommend adopting policies that promote flexibility including a choice of 1 or 2 week rotations and start of rotation on Saturday.

1.2.B. As it relates to inpatient service time, holidays should be covered in a manner that is equitable and fair, we recommend equal distribution independent of years at Yale or rank. Volunteers should be welcomed and recognized.

1.2.C. Inpatient attendings should communicate with outpatient attendings frequently and further work needs to be done on standardizing the approach (ie interval, role and mode of communication).
Mini Session 2: Compensation

**Compensation Model**

- Higher base, lower incentives is better for well-being
- Additional protected time (FTE) for academic doctors is welcomed (0.9 is a start, would appreciate more recognized time (0.8))
- Administrative stipends should be understandable and equitable regardless of gender or rank
- Stipend data should be available and transparent

**Communication**

- Compensation statements should be accompanied with explanation so that information is easily understood. Should align with Dean’s Office and reflect appropriate benchmarks
- Information on compensation by gender should be reviewed with sections on an annual basis
- Raises should be communicated clearly
- Provide opportunities for confidential feedback from those on comp plan
- Consider ombudsperson to be present at annual reviews
# Mini Session 3: Teamwork

## Communication
- Encourage frequent and efficient team communication through collaborative interactions
- Define a clear process to discuss, track and resolve issues locally
- Foster an “critical conversations” environment that is built on trust and open communication so everyone has a voice (listen+action)
- Best practice is managers who are frequently visible, listen with intent to address issues, follow up and transparency on what can change and what cannot

## Staffing
- Promote workplace efficiencies by ensuring adequate staffing and administrative resources
- Large “units” (i.e. many roles involved in care of one patient) make seamless teamwork difficult
- Best practice is when there is a sense of ownership of patient; when team is clearly aligned and working together

## Role clarity & expectations
- Clearly define roles/responsibilities for each member on the specific team (e.g., leader, manager, scheduler.) Leadership matters- good leaders update team frequently and are transparent in goals
- Outline team expectations for common clinical practice scenarios and problem solving (e.g., repeated phone calls, response times, full in-baskets)
- Design and promote structures meant to empower teammates to problem solve (best practice is regular meetings to discuss common inbasket themes in order to educate and build consensus on advice given to patient)
- Define who is responsible for responding to issues raised in clinic
**Low Hanging Fruit**

Enhance "real life" mentorship/coaching opportunities so physicians can map their path for reaching full potential personally and professionally.

Enhance the physician on-boarding experience to include formal peer coaching/support.

Suggestion box

More dialogue, less presenting at faculty mtgs, town halls etc.

Provide protected time for physicians to meet with a small cohort of colleagues to discuss topics related to improved meaning in work.

Launch a speaker series on culture and engagement.

Provide communication, sensitivity and unconscious bias training.

Allow faculty to submit agenda items for faculty meeting.
Wellness Survey Results

- Burnout
  - 2019: 55%
  - 2020: 26.7%
  - Decrease: 49%

- Professional Fulfillment
  - 2019: 24%
  - 2020: 42.2%
  - Increase: 57%
<table>
<thead>
<tr>
<th>Organizational Efficiency of Practice&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Organization-wide SD to Benchmark&lt;sup&gt;*&lt;/sup&gt;</th>
<th>Effect on Professional Fulfillment&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Effect on Burnout&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Helpfulness&lt;sup&gt;8&lt;/sup&gt;</td>
<td>0.04</td>
<td>Medium</td>
<td>Small</td>
</tr>
<tr>
<td>Minimal EHR Hassles&lt;sup&gt;8&lt;/sup&gt;</td>
<td>-0.18</td>
<td>Small</td>
<td>Medium</td>
</tr>
<tr>
<td>Optimize Physician Task Load&lt;sup&gt;7&lt;/sup&gt;</td>
<td>-0.16</td>
<td>Negligible</td>
<td>Small</td>
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</table>

<table>
<thead>
<tr>
<th>Organizational Culture of Wellness&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Organization-wide SD to Benchmark&lt;sup&gt;*&lt;/sup&gt;</th>
<th>Effect on Professional Fulfillment&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Effect on Burnout&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Leadership Behaviors&lt;sup&gt;9&lt;/sup&gt;</td>
<td>0.27</td>
<td>Large</td>
<td>Small</td>
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<tr>
<td>Organizational/Personal Values Alignment&lt;sup&gt;8&lt;/sup&gt;</td>
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<td>Medium</td>
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<td>Perceived Gratitude&lt;sup&gt;f&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Control of Schedule&lt;sup&gt;8&lt;/sup&gt;</td>
<td>0.21</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>COVID-19 Organizational Support</td>
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<td>Medium</td>
<td>Small</td>
</tr>
<tr>
<td>Minimal Negative Impact of Work on Personal Relationships&lt;sup&gt;y&lt;/sup&gt;</td>
<td>-0.12</td>
<td>Large</td>
<td>Large</td>
</tr>
<tr>
<td>Minimal Depression&lt;sup&gt;g&lt;/sup&gt;</td>
<td>0.15</td>
<td>Large</td>
<td>Medium</td>
</tr>
<tr>
<td>Minimal Anxiety&lt;sup&gt;h&lt;/sup&gt;</td>
<td>0.27</td>
<td>Small</td>
<td>Small</td>
</tr>
<tr>
<td>Self-Valuation&lt;sup&gt;i&lt;/sup&gt;</td>
<td>0.29</td>
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<td>Medium</td>
</tr>
<tr>
<td>Minimal Sleep-Related Impairment&lt;sup&gt;l&lt;/sup&gt;</td>
<td>-0.06</td>
<td>Medium</td>
<td>Large</td>
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</table>

*All variables are benchmarked against longitudinal physician data from the Physician Wellness Academic Consortium institutions who have administered this survey, except for gratitude, impact of work on personal relationships, and physician task load (standardized 2019 data).
Considerations

- Pandemic hit 3 months before task force started
- Communication was increased across the system during that time
- Work from home became more acceptable and popular
- We cannot compare task force members’ burnout and fulfillment to the wider cancer center faculty (Burnout metrics not specific for our group)
<table>
<thead>
<tr>
<th>Feedback</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt proud to be a member of the task force</td>
<td>81%</td>
</tr>
<tr>
<td>We met our goals to make recommendations</td>
<td>88%</td>
</tr>
<tr>
<td>I am able to effectively contribute</td>
<td>81%</td>
</tr>
<tr>
<td>I can think of a change made based on the task force</td>
<td>70%</td>
</tr>
<tr>
<td>Task force has support of key stakeholders</td>
<td>50%</td>
</tr>
</tbody>
</table>
“Collaboration with peers and seeing that we share the same struggles, concerns and priorities.”

“Getting to meet other people, shared vision; encouraging to feel that we can make change.”

“The actual participation was most valuable—discussing issues that are relevant to daily work life with colleagues and strategizing on how to overcome challenges.”

“What was most valuable to you?

“To be surrounded by people who share common goals and that we can make a difference as a group. It makes you feel like your voice is listened to, I hope also heard by the leadership.”

“To be surrounded by people who share common goals and that we can make a difference as a group. It makes you feel like your voice is listened to, I hope also heard by the leadership.”
A world cafe-style task force fosters connections and allows for dreaming about what could be.
Leadership buy-in remains a challenge in the face of change.
Consensus-driven recommendations provide a sense of collective vision and agency.
Where do we go from here?
Thanks!

Team:
Nara Sinanis
Anna Raso
Laurene Goode
Jeffrey Dewey, MD
Kristine Olson, MD, MPH
Task force participants
Charlie Fuchs, MD
Roy Herbst, MD

Questions:
Tara Sanft
tara.sanft@yale.edu
ACPH 2021
American Conference on Physician Health™
Disclosures

No Disclosures
Crowdsourcing Wellness
Using Voice of the Physician to Improve Wellness Metrics

- **Kara Martin, MD**
  Hospitalist, Innovation Lead

- **Angela Ippolito, PHR**
  Chief People Officer, Vice President Human Resources

- **Michelle Adzhemyan, MHA, FACHE**
  Director, Strategy & Acceleration
The Southeast Permanente Medical Group

- **Multi Specialty Medical Practice** that exclusively provides care to members of Kaiser Foundation Health Plan (GA)
- **1,158 employees** - 929 clinicians, 229 admin staff
- **Mission:** To provide high quality affordable health care to our members and the communities we serve
Our Journey: **Wellness** and Innovation

- **Vision**: To be the premier model for employee and clinician health and wellness

- **Mission**: To educate, inspire and empower our medical group to make healthy lifestyle decisions
Our Journey: Wellness and **Innovation**

- **Innovation** introduced to region in 2017: “we are a design-oriented team of professionals obsessed with wowing patients and staff through human-centered innovation”

- **Human Centered Design (HCD)** is a problem-solving methodology that puts customers/needs at center of all steps of problem-solving process
Crowdsourcing

• **How:**
  • Brought three “problems” to the Group
    • One was Wellness, plus two others
    • We asked for a vote…and the people spoke!

• **Why:**
  • Fun!
  • Increases Engagement
  • We needed their input
  • Effective Tool when dealing with large teams that are separated by space and time
  • Creates a forum where leaders can see the engagement

• **What:**
  • Social media meets Suggestion Box
Clinician Wellness

If you are currently taking TPSM at a place of joy?

- 63 Ideas Posted
- 102 Views
- 181 Comments
- 627 Votes

Campaign Sponsor

Idea流

ALL STAGES
IDEE
SELECTED IDEAS
COMPLETED IDEAS

Whole foods plant based cafeteria

Lunch options at the MOSRA are 1. bring your own, or 2. order from food. Google has multiple cafeterias in their corporate buildings with gourmet chef offerings. If we were to add this, we need to make sure that these are actually restaurants that will be picked up in the middle of the day. I would add 1 idea to this shift, of adding a cafe for the whole food plant-based diet.

children mid-day emergencies/appointments

Our concierge service Time-Squared is fantastic resource but they will NOT have anything to do with children. My 10 year old son was ill and needed to be picked up in the middle of the day. I tried to call this, but had no luck. I tried to call them from my phone, but that didn’t go anywhere. My child was at another emergency room with other children.

correct back line office numbers

When I need to call another MD at another office, there is often not an easy way to contact them. The back line numbers or direct lines are sometimes hard to find, and when you do get a real person, it can be difficult. We need an easy way to contact these important people.

Specialized Phone Line For Providers

Our clinic has a specialized phone line to call when they need to get in touch with a specific provider. This is a great way to ensure that patients can reach the provider they need to speak to, and it helps to streamline communication within the clinic.
Voice of the Customer

- “This (childcare) would be such a wonderful addition to support a working physician.”
- “Many people come to Kaiser for the focus on wellness. Many physicians are also transplants out of state with no family here to help. I’d say backup childcare is one of the most stressful issues that is always on my mind.”
- “In my informal conversations with my colleagues, many send their children to a daycare, but get in the same bind as me when a child becomes ill or there is an issue w the school.”
- “I’d be less concerned with a “fit” and more concerned w having a trusted adult who will keep my kids safe during our gaps in care.”
- “Kids tend to get sick when everyone else gets sick – cold and flu season, when Kaiser needs its doctors at their highest performance to deal with volume!”
- “I would like to see a background-checked child care company partner with Kaiser for last minute child care needs (example having a sick child) if they can come over to watch the child rather than me closing clinic that day and staying home.”
What did we do?
Learnings from This Process
Wellness Survey Scores

Overall Wellness Composite Score - All TSPMG Employees Trending

- 2016: 66%
- 2017: 74%
- 2018: 75%
- 2019: 74%
- 2020: 78%

Crowdsourcing Campaign began

Solutions and Implementation

The Southeast Permanente Medical Group
Bright Horizons Childcare Benefit Data

- 100 employees registered (9% of TSPMG population)
- 466 fulfilled uses over 18 months – prevented employees from having to take day off
- 56 people cared for
- 87% of care requested was in-home child care
- Pareto rule (top 20% of users had 63% of the uses)
- Customer feedback – “Adrina is absolutely the best sitter I have had from Bright Horizons or anywhere. She has a lovely, calm demeanor, and has gone above and beyond, helping my son with his online learning. I decided to use my entire Bright Horizons balance on her. She helped my son do and turn in a diorama project, among other assignments. He was literally last in the class behavior and is now first! He is so happy.”
Conclusion

- **HCD is effective**
  - Use of HCD to increase Recognition score on Engagement survey

- **Crowdsourcing is beneficial**
  - Voice of the Customer: Power of the People
  - Builds culture of Psychological Safety and Trust – deep listening, open transparency of ideas

- **Employee wellness is a perfect forum for engaging voice of the customer**
  - Makes it visible
  - People are helping to create it – enforces culture of wellness
  - Led to effective results
Wellness Survey Questions

1. The leaders in my organization are role models for health.
2. Provides an environment that supports health and wellness.
3. Recognizes practicing health behaviors.
4. Does a good job informing progress towards workforce wellness goals
5. My supervisor encourages me to take care of my health.
6. Trust that KP will make decisions to support health and well being.
7. People encourage each other to take care of their health.
Recognition Question

1. In the last seven days, I received recognition or praise for doing good work.

Score for Recognition Question- All TSPMG Employees Trending

- 2015: 46%
- 2016: 47%
- 2017: 51%
- 2018: 51%
- 2019: 57%
- 2020: 56%
“I NEED TO HAVE A FULFILLING JOB”: A QUALITATIVE STUDY OF PROFESSIONAL WELL-BEING IN SURGEONS
BACKGROUND
BURNOUT IN SURGEONS

• Surgeons with burnout have been found to have less job satisfaction and are more likely to retire early.8,9

• Generally, burnout has been linked to decreased quality of life and increased substance abuse and suicide.10e13
Talking About Physician Burnout

• Provider burnout is often framed as a failing of the individual.

• Our study frames provider burnout as a problem of systems and environmental circumstances.
HOW WE TALK ABOUT SURGEON BURNOUT

• Protective factors against burnout
• What leads to professional fulfillment & how do we foster that?
THERE ARE FOUR AIMS OF THIS STUDY:

1) understand factors that lead to surgeon well-being and professional fulfillment;
2) use identified themes to build a conceptual model;
3) use knowledge gain to implement changes within our institution; and
4) Disseminate relevant findings so that institutions like ours may prioritize and operationalize strategies to improve surgeon well-being.
METHODS
• Purposive sampling
• 32 semi-structured 30-60 minute interviews
  – (varying career lengths, specialties within surgery, and positions)
• Interview designed for bi-directional flow of information
• Dual coding of data to identify emergent themes
• Built conceptual model from themes
RESULTS
### Table 2
Participant characteristics (n = 32).

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>37.5%</td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>62.5%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>27</td>
<td>84.3%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>6.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>6.2%</td>
</tr>
<tr>
<td><strong>Rank</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Professor</td>
<td>15</td>
<td>46.9%</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>8</td>
<td>25%</td>
</tr>
<tr>
<td>Professor</td>
<td>9</td>
<td>28.1%</td>
</tr>
</tbody>
</table>
TEN EMERGENT THEMES

- autonomy at work
- adequate time to pursue personally meaningful non-clinical endeavors
- team cohesion and connectedness
- clearly defined organizational structures
- ease of communication
- Metrics of success not limited to financials
- Celebration of individual value and contributions
- Diverse and inclusive workplace
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• ease of communication
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• Celebration of individual value and contributions
• Diverse and inclusive workplace
ADMIN SUPPORT

• Overarching concepts of adequate and clearly structured *administrative support* and accountability overlaid all emergent themes and subthemes
THE IMPACTS OF COVID-19

- At the team and individual levels
- Exacerbates underlying issue of insufficient social connectedness

“right now ... the people I used to struggle with I'd love to see again to be honest with you”
CONCEPTUAL MODEL
PYRAMID DESIGN

Surgeon wellness and fulfillment

Individual
- Time to pursue non-clinical endeavors
- Freedom to pursue interests beyond patient care

Team
- Social connections
- Clear organizational structure
- Ease of communication

Institution
- Metrics of success not limited to financials
- Celebration of individual value and contributions
- Diverse and inclusive workplace

Staff support to work at the top of license

Clear and defined administrative support
RESULTS- ACTIONS

• One new shared AA
• New faculty to reduce call/clinical burden (acute care)
CONCLUSIONS
1. Well-being research benefits from qualitative interviewing methods that encourage community-building rather than transactional exchanges.

2. Our conceptual framework of professional fulfillment distributes responsibility rather than focusing solely upon individuals.

3. Administrative and staff support are key for well-being intervention because they underpin all other protective factors.
Do Practicing Healthcare Providers Suffer More Symptoms of Anxiety and Depression Than the General Public?

Harry Doernberg, MM, and Anees Chagpar, MD, MSc, MPH, MA, MBA

Yale School of Medicine
Disclosures

Harry Doernberg:
- No disclosures

Anees Chagpar:
- Board of Directors: Protean BioDiagnostics
- Consultant: Puma Diagnostics, Athenex, Sanofi, Novartis, Guardant Health, Lumicell
Background

- Burnout has been recognized among health care workers
- Prevalence of depression and anxiety vs. general population poorly understood
- We sought to determine whether “health diagnosing and treating practitioners” who provide direct patient care, were more likely to report these symptoms than the general population
Methods

• National Health Interview Survey (2018)
  • Face-to-face survey conducted annually by the CDC
  • Designed to be representative of the entire US civilian non-institutionalized population
  • Largest source of health information of the American public

24,780 → 243,155,441 people in the population

• Asked occupation, and for healthcare workers, whether they were involved in direct patient care
  • Encompasses physicians, nurses, other healthcare professionals
  • 2.49% of respondents
Symptoms of Depression and Anxiety

- Asked about frequency of symptoms of depression and anxiety in the last 30 days
  - So sad nothing could cheer them up (All the time, Most of the time, Some of the time, A little of the time, None of the time)
  - Restless or fidgety (All the time, Most of the time, Some of the time, A little of the time, None of the time)
  - Hopeless (All the time, Most of the time, Some of the time, A little of the time, None of the time)
  - That everything was an effort (All the time, Most of the time, Some of the time, A little of the time, None of the time)
  - Worthless (All the time, Most of the time, Some of the time, A little of the time, None of the time)

- How much did these feelings interfere with daily life?
  - A lot
  - Some
  - A little
  - Not at all
## Results: Bivariate Analysis

<table>
<thead>
<tr>
<th></th>
<th>PHCPs*</th>
<th>General Population</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>7.52%</td>
<td>12.05%</td>
<td>0.007</td>
</tr>
<tr>
<td>Restlessness</td>
<td>16.51%</td>
<td>21.65%</td>
<td>0.021</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>3.86%</td>
<td>7.44%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Everything an effort</td>
<td>12.45%</td>
<td>18.86%</td>
<td>0.001</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>2.83%</td>
<td>6.32%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Interference in life</td>
<td>81.10%</td>
<td>75.30%</td>
<td>0.012</td>
</tr>
</tbody>
</table>

* PHCPs; Practicing health care providers
**Results: Multivariate Analysis**

<table>
<thead>
<tr>
<th>Condition</th>
<th>OR</th>
<th>Confidence Interval</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>1.05</td>
<td>0.65-1.70</td>
<td>0.830</td>
</tr>
<tr>
<td>Restlessness</td>
<td>0.87</td>
<td>0.63-1.20</td>
<td>0.395</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>0.88</td>
<td>0.52-1.51</td>
<td>0.654</td>
</tr>
<tr>
<td>Everything an effort</td>
<td>0.81</td>
<td>0.57-1.17</td>
<td>0.270</td>
</tr>
<tr>
<td>Worthlessness</td>
<td>0.81</td>
<td>0.44-1.49</td>
<td>0.495</td>
</tr>
<tr>
<td>Interference in life</td>
<td>1.39</td>
<td>1.01-1.88</td>
<td>0.041</td>
</tr>
</tbody>
</table>

* Controlling for age, race, education, income, gender, insurance status and region
Limitations

- Reporting bias
- Could not corroborate reported symptoms with actual diagnoses of depression and anxiety
- Could not discern within group differences
  - Different specialties
  - Different career stages
Conclusions

- PHCPs experience symptoms of anxiety and depression at similar rates to the general public when controlling for sociodemographic factors.
- However, they are more likely to state that these feelings adversely affect their life or activities.
- Suggesting that the practice of healthcare itself may intensify the impact of these feelings.
MENTAL HEALTH RISK AMONG HEALTHCARE WORKERS DURING THE COVID PANDEMIC

OCTOBER 7, 2021
ELLEN MORROW, MD, MS
MEDICAL DIRECTOR, RESILIENCY CENTER
LEARNING OBJECTIVES

1. Learn about the rates of mental health symptoms among healthcare workers during the COVID-19 pandemic

2. Learn about risk factors for increased mental health symptoms among healthcare personnel

3. Consider priorities for health systems in reducing stress among employees during a pandemic
BRIEF MENTAL HEALTH SCREEN

- 8 minutes
- In redcap
- IRB approved

- PTSD
- Depression
- Anxiety
- Relationship health
- Moral distress
RAISE STUDY (RESILIENCE AND ADAPTATION IN STRESS)

- **Design:**
  - Six wave longitudinal
  - One month intervals
  - (April-Oct 2020, then May 2021)

- **Study 1:** First Responders

- **Study 2:** University of Utah Health
  - Cross sectional, N = 2,246
  - Response rate 10%

PI: Andrew Smith Ph.D.
Dept. Psychiatry

# SAMPLE DEMOGRAPHICS: HEALTHCARE

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>312</td>
<td>19.0</td>
</tr>
<tr>
<td>Female</td>
<td>1229</td>
<td>79.8</td>
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<tr>
<td><strong>Race</strong></td>
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<td></td>
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<tr>
<td>White</td>
<td>1470</td>
<td>89.6</td>
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<tr>
<td>Minority or Multi-Racial</td>
<td>171</td>
<td>10.4</td>
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<tr>
<td><strong>Ethnicity</strong></td>
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<td></td>
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<tr>
<td>Hispanic/Latinx</td>
<td>129</td>
<td>7.9</td>
</tr>
<tr>
<td>Not Hispanic/Latinx</td>
<td>1497</td>
<td>92.1</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>39.65</td>
<td>11.69</td>
</tr>
<tr>
<td>SD</td>
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<td></td>
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<td><strong>Profession</strong></td>
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<td></td>
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<tr>
<td>Nurse or APN</td>
<td>527</td>
<td>45.9</td>
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<tr>
<td>Attending Physician, Resident, or Fellow</td>
<td>184</td>
<td>16.1</td>
</tr>
<tr>
<td>Clinical Staff (i.e., Technician, Therapist), Mental Health Professional, or Pharmacy</td>
<td>282</td>
<td>24.6</td>
</tr>
<tr>
<td>Other</td>
<td>154</td>
<td>13.4</td>
</tr>
<tr>
<td><strong>Provide Direct Patient Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1150</td>
<td>70.5</td>
</tr>
<tr>
<td>No</td>
<td>481</td>
<td>29.5</td>
</tr>
</tbody>
</table>
### Proportion of frontline workers who exceeded risk threshold

<table>
<thead>
<tr>
<th></th>
<th>Clinical providers (HCW)</th>
<th>Non-clinical staff (HCW)</th>
<th>Emergency Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute trauma sx</td>
<td>35.9</td>
<td>44.6</td>
<td>14.4</td>
</tr>
<tr>
<td>Depression</td>
<td>26.3</td>
<td>30.5</td>
<td>20.1</td>
</tr>
<tr>
<td>Anxiety</td>
<td>36.3</td>
<td>41.0</td>
<td>16.1</td>
</tr>
<tr>
<td>Risky alcohol use</td>
<td>21.9</td>
<td>22.6</td>
<td>30.6</td>
</tr>
</tbody>
</table>
PRIMARY FINDINGS FOR 5 MENTAL HEALTH RISKS

- **Acute traumatic stress:** 25-30%
  - High rates compared to other contexts (SARS, typical non-crisis times)
  - Higher than in our firefighter/first responder sample

- **Anxiety** (23%) and **depression** rates (17%) similar to our first responder sample.

- **Alcohol use:** 31% above risk threshold, also similar to first responder sample
Smith et al., in press, Shechter et al., 2020; Greene et al., 2021; Lai et al; 2020
ASSOCIATIONS: PREDICTORS (PANDEMIC-RELATED STRESSORS)

- Logistic regression stratified by professional role (clinical or non-clinical)

- Having an *immunocompromised household member* significantly increases risk all five mental health outcomes (acute traumatic stress, depression, anxiety, and insufficient sleep).

- Having an *immunocompromised condition (self)* increases risk of depression and anxiety.
PREDICTORS (PANDEMIC-RELATED STRESSORS)

- Being in a management role over direct care providers increases risk for higher acute traumatic stress reactions.

- **Number of positive cases** has inverse relationship with mental health: as case numbers increase, risk for acute stress, depression, anxiety go down.

- **Non-clinical staff** have higher risk for acute traumatic distress when compared to clinical providers.
DEMOGRAPHIC PREDICTORS OF MENTAL HEALTH SYMPTOMS

- Female
- Minority status
- Younger
**METHODS/SAMPLE**

- **HCWs**: 76% female, 40yo, 91% Euro-Amer, 70 | 30% direct care/non-clinic faculty/staff
- **Emergency Resp**: 81% male, 43yo, 70 | 13 | 17% fire, law, healthcare
HOW DO RESILIENCE & RISK CHANGE ACROSS TIME?
Depression Risk Trajectories, Healthcare Workers
April 2020 – May 2021

MONTH 1
MONTH 4
MONTH 12

PHQ-2 Average Scores

N=101
N=47
N=111
N=152

RESISTANT
RESILIENT
DELAYED ONSET
PERSISTENT VULNERABILITY
PTSD Risk Trajectories, Healthcare Workers
April 2020-May 2021

- Resistant
- Resilient
- Delayed Onset
- Persistent Vulnerability

MONTH 1
- N=101

MONTH 4
- N=47

MONTH 12
- N=111
- N=152
Anxiety Risk Trajectories, Healthcare Workers
April 2020 - May 2021
Griffin, Langenecker, Love, Wright….Smith, In
Preparation
OCCUPATIONAL HEALTH OUTCOMES

• Burnout, Engagement, Intent to leave

• Regression
  – Demographics
  – Peri-pandemic mental health risks
### Occupational Health Prediction, from May 2020 to May 2021

#### Occupational Burnout May 2021 (higher = worse)

\[ F_{7, 491} = 14.22, \ p = .003, \ n = 498 \]

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>p</th>
<th>Partial correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.122*</td>
<td>&lt;.001</td>
<td>-.18</td>
</tr>
<tr>
<td>Gender (0 = f, 1 = m)</td>
<td>.140*</td>
<td>.88</td>
<td>.01</td>
</tr>
<tr>
<td>Race (0 = white, 1 = any minority)</td>
<td>-2.141*</td>
<td>.03</td>
<td>-.09</td>
</tr>
<tr>
<td>ACEs (childhood adversity)</td>
<td>.303*</td>
<td>.01</td>
<td>.11</td>
</tr>
<tr>
<td>Anxiety severity in May 2020</td>
<td>1.457*</td>
<td>&lt;.001</td>
<td>.29</td>
</tr>
</tbody>
</table>

#### Turnover Intentions in May 2021 (higher = worse)

\[ F_{7, 507} = 3.13, \ p = .003, \ n = 514 \]

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>p</th>
<th>Partial correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.023*</td>
<td>.04</td>
<td>-.09</td>
</tr>
<tr>
<td>Gender (0 = f, 1 = m)</td>
<td>.068</td>
<td>.87</td>
<td>.01</td>
</tr>
<tr>
<td>Race (0 = white, 1 = any minority)</td>
<td>.218</td>
<td>.63</td>
<td>.02</td>
</tr>
<tr>
<td>ACEs (childhood adversity)</td>
<td>.075</td>
<td>.16</td>
<td>.06</td>
</tr>
<tr>
<td>Anxiety severity in May 2020</td>
<td>.26*</td>
<td>.006</td>
<td>.12</td>
</tr>
</tbody>
</table>

#### Work Engagement/Fulfillment in May 2021 (higher = better)

\[ F_{7, 504} = 7.11, \ p = .001, \ n = 511 \]

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>p</th>
<th>Partial correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.050*</td>
<td>&lt;.001</td>
<td>.16</td>
</tr>
<tr>
<td>Gender (0 = f, 1 = m)</td>
<td>-.134</td>
<td>.74</td>
<td>-.02</td>
</tr>
<tr>
<td>Race (0 = white, 1 = any minority)</td>
<td>.797</td>
<td>.07</td>
<td>.08</td>
</tr>
<tr>
<td>ACEs (childhood adversity)</td>
<td>-.021</td>
<td>.69</td>
<td>-.02</td>
</tr>
<tr>
<td>Anxiety severity in May 2020</td>
<td>-.441*</td>
<td>&lt;.001</td>
<td>-.21</td>
</tr>
</tbody>
</table>
CONCLUSIONS

• To help reduce pandemic-related stress on HCWs, accommodations for those who are immunocompromised

• Anxiety and younger age associated with worse occupational health

• Ongoing work needed to understand how to support health and resilience of healthcare workers
THANK YOU!

Scott Langenecker  Andrew Smith
Tiffany Love        Amy Locke
Chip Benight        Megan Call
Brandon Griffin     Miranda Olff
Hannah Wright       Patricia Kerig
Kotaro Shoji
CONTACT

uofuhealth.org/resiliencycenter

Ellen.Morrow@hsc.Utah.edu
ACPH 2021
American Conference on Physician Health™
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”
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)

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

* D. Shanafelt, MD, and John H. Noseworthy, MD, CEO

| Maslach Burnout Inventory (MBI-HSS) for Medical Personnel |

| Copenhagen Burnout Inventory |

| Oldenburg Burnout Inventory |
Pick One!

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:

- Excessive
- Moderately high
- Satisfactory
- Modest
- Minimal/none

The amount of time I spend on documentation is
Use your data to inform your priorities

Institutional/Organizational drivers of burnout

Building Personal Resilience and Community

Image courtesy of ahrq.gov
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

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• (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
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, COVID-19 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 into effect.

In the meantime, we can also find some relief with self-care to help improve wellness. There are numerous strategies out there, from mindful appropriateness.

Physicians are responsible for our burn patients. We can use positive $c$ inaugurating $c$ concept $c$ efforts $w$ to $a$ $e$ $Joyed$:

Be well,
-GHM
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
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
Peer Support
Text Outreach
Zoom Social Events
Wellness Newsletter
Physician Recognition
Book Club
EMR Workgroup
Advocate for Template Change
Improved On-boarding

Professional Fulfillment
Culture of Wellness
Efficiency of Practice
Personal Resilience

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...

Endorses one or more symptoms of burnout

Minimal or no burnout symptoms endorsed

The amount of time I spend on documentation is

Excessive or moderately high

Satisfactory

Modest or minimal/none
Review Additional Markers of Wellness

Volume of Task: MyChart Messages, Pt Call, Rx Auth

- MFS PT (4)
  - Volume of Tasks Q4 Total: 9.94
  - Volume of Tasks Q3 Total: 9.32
  - Volume of Tasks Q2 Total: 10.02
  - Volume of Tasks Q1 Total: 12.43

- MFS FT (2)
  - Volume of Tasks Q4 Total: 18.37
  - Volume of Tasks Q3 Total: 13.63
  - Volume of Tasks Q2 Total: 10.99
  - Volume of Tasks Q1 Total: 29.10

- IM PT (17)
  - Volume of Tasks Q4 Total: 13.25
  - Volume of Tasks Q3 Total: 13.43
  - Volume of Tasks Q2 Total: 12.41
  - Volume of Tasks Q1 Total: 18.17

- IM FT (13)
  - Volume of Tasks Q4 Total: 19.86
  - Volume of Tasks Q3 Total: 18.04
  - Volume of Tasks Q2 Total: 16.62
  - Volume of Tasks Q1 Total: 22.57

- FM PT (28)
  - Volume of Tasks Q4 Total: 9.32
  - Volume of Tasks Q3 Total: 8.66
  - Volume of Tasks Q2 Total: 9.20
  - Volume of Tasks Q1 Total: 10.46

- FM FT (11)
  - Volume of Tasks Q4 Total: 12.40
  - Volume of Tasks Q3 Total: 12.37
  - Volume of Tasks Q2 Total: 13.17
  - Volume of Tasks Q1 Total: 14.16

Total Tasks per physician per day
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*℠
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

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!

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References

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Disclosure(s)

Holly Montjoy, MD- Local CCO shareholder in Klamath Falls, OR (Cascade Health Alliance)
Innovative Wellness Curriculum Development: How to create programs for diverse settings relevant to both learners and established providers.

California Oregon Medical Partnerships to Address Disparities in Rural Education and Health
Objectives

Describe the development and design of the COMPADRE wellness curriculum

Experience and gain tools to teach a part of the COMPADRE wellness curriculum

Design or improve Your own custom wellness curriculum/ infrastructure based on the COMPADRE model
Agenda

- **Introduction**
  - What is COMPADRE Wellness?
  - Development/design of the curriculum
  - Goals and rationale

- **Experience Curriculum: Origin Stories**
  - Practice community building/wellbeing program

- **Improving/Creating an Individualized Infrastructure**
  - Pair and share with a structured worksheet

- **Questions and Wrap-up**
INTRODUCTION
What is... COMPADRE

- AMA Reimagining Residency Grant in 2019
- Prepare selected medical students and residents for long-term practice in under-resourced settings
- **31 total residency programs and 2 medical schools** (OHSU and UC Davis)
- Programs located across Oregon and Northern CA
To prepare culturally competent, collaborative and resilient physicians ready to practice in rural, tribal and urban underserved communities in Oregon and Northern California to minimize healthcare disparities.
VISION
Transforming disparities and improving health outcomes.
Benefits to medical students:
- Early access to clerkships
- Strong relationships with residency programs
- Chances of securing residency in OR or CA

Benefits to residents/medical students:
- Understand and serve vulnerable populations
- Develop strong community ties
- Participate in immersion experiences
- Share with a peer learning community
- Practice prioritizing wellness
Building Blocks

- Wellness needs assessment
- Faculty wellness champion network
- Core wellness curriculum, videos, facilitator’s guides: Origin Stories, Belonging, Resilience, Purpose
- CANVAS learning platform
- Peer Support Training
Evaluation

- Annual wellness champion focus groups
- Annual wellness survey tools that reflect curriculum goals:
  - Mayo Well-Being Index
  - Perceived Cohesion Scale
  - Mindful Self-Care Scale
Challenges:

- Large number of programs
- Variable needs
- Identifying wellness champions
- Supporting all residents (small programs)
- Identifying research tools
- COVID pandemic
Joy Moments

- Meeting many talented, interprofessional faculty
- Building a learning community to create “best practices”
- Shared vision
- Peer support network
Wellness Curriculum

• Origin Stories
• Belonging
• Resilience
• Purpose
Origin Stories
1. Write “Story of your name?” (4min)

2. Pair and share, read what you wrote (4min)

3. Large group reflection (10min)
   • What was it like to write your story?
   • What was it like to read/tell your story?
   • What was it like to receive or listen to another’s story?
CREATING: Your plan
ACPH 2021: COMPADRE Wellness Program Worksheet

Who am I trying to impact?
- Interdisciplinary vs multidisciplinary
- Learners, attendings, administration, staff
- Virtual vs live participants
- Other:

What is the purpose of my wellness program?

Why is this important?

My inventory. Consider: budget, personnel, engagement, leadership support/endorsement, autonomy, protected time, etc.
- What resources do I have already to support my goals?
- What are the main barriers to my success? Consider: competing demands, culture, etc.
- What additional resources will I need?
ACPH 2021: COMPADRE Wellness Program Worksheet

What are three actions items to support me in bringing my wellness initiatives forward? Think: *SMART Goals.

- Connect with a fellow participant?
- Bring ideas to leadership?
- Explore a certain area related to wellness?
- ???

How will I know I’ve made my desired impact?

* SMART Goals: Specific (simple, sensible, significant). Measurable (meaningful, motivating). Achievable (agreed, attainable). Relevant (reasonable, realistic and resourced, results-based). Time bound (time-based, time limited, time/cost limited, timely, time-sensitive).
Questions and Wrap Up
Thank you!
Culture and Experiences Regarding Pregnancy and Child Rearing Among Residents and Fellows

Judith C Ukabam, MD
Disclosures

• No disclosures
Objectives

- Background
- Research Questions
- Methodology
- Findings
- Discussion
• Data obtained from ACGME survey of residents and fellows from academic years 2015-2016 and 2016 – 2017

• Of those that responded with comments and reported their gender:
  • 2016 survey
    • Females: 44.2%
    • Males: 52.6%
    • Children at home: 25.95%
    • Pregnant or have a pregnant partner: 6.63%
  • 2017 survey
    • Females: 44%
    • Males: 52.9%
    • Children at home: 24.15%
    • Pregnant or have a pregnant partner: 6.1%
• How is pregnancy and child rearing perceived among fellows and residents?
• What experiences do residents and fellows report?
• Does the perceived culture and experiences surrounding pregnancy/childbirth correlate with self reported well being measures and overall program satisfaction among residents and fellows?
Methodology

• Initial search terms: pregnant, child, kid, family
• Initial categories: Pregnant, Family, Children, quotes (negative vs positive vs mixed)
• Secondary search terms: paternity, maternity, baby
• Tertiary search terms: breast feed, pump, son, daughter, mother, father
## Definitions

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>pregnant</td>
<td>Reported being pregnant or contemplating becoming pregnant</td>
</tr>
<tr>
<td>family</td>
<td>Reported having a family with or without details</td>
</tr>
<tr>
<td>child, children, kid, baby, son, daughter</td>
<td>Reported having a child or children</td>
</tr>
<tr>
<td>mother, father, parent</td>
<td>Reported being a parent</td>
</tr>
<tr>
<td>maternity, paternity or parental leave</td>
<td>Reported issues concerning parental leave</td>
</tr>
<tr>
<td>Breast feeding, pumping</td>
<td>Reported breast feeding or pumping</td>
</tr>
</tbody>
</table>
## Definitions

<table>
<thead>
<tr>
<th>Experience Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Experiences</td>
<td>respondents reported having strong support from faculty, staff, or residents in their programs, programs had clear caregiver policies, or programs that had cultures that were friendly to parents</td>
</tr>
<tr>
<td>Negative Experiences</td>
<td>respondents reported having poor support from faculty, staff, or residents in their programs, programs possessed unclear or poorly supported caregiver policies, or negative interactions with their program</td>
</tr>
<tr>
<td>Mixed/Neutral Experiences</td>
<td>respondents described both negative and positive experiences, identified areas for improvement without elaboration, described negative experiences but explicitly attributed them to a cause unrelated to obligations to their program or program policies</td>
</tr>
</tbody>
</table>
## Findings

<table>
<thead>
<tr>
<th>Gender</th>
<th>Negative Comments (243)</th>
<th>Positive Comments (45)</th>
<th>Neutral/Mixed Comments (68)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>78 (69%)</td>
<td>9 (8%)</td>
<td>26 (23%)</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>155 (67.4%)</td>
<td>34 (14.8%)</td>
<td>41 (17.8%)</td>
</tr>
<tr>
<td><strong>Unspecified gender</strong></td>
<td>10 (76.9%)</td>
<td>2 (15.4%)</td>
<td>1 (7.7%)</td>
</tr>
</tbody>
</table>
## Findings

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Negative Comments</th>
<th>Positive Comments</th>
<th>Neutral/Mixed Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Medicine</strong></td>
<td>49 (66.2%)</td>
<td>1 (1.35%)</td>
<td>24 (32.4%)</td>
</tr>
<tr>
<td><strong>Family Medicine</strong></td>
<td>18 (52.9%)</td>
<td>12 (35.3%)</td>
<td>4 (11.8%)</td>
</tr>
<tr>
<td><strong>Surgery – General</strong></td>
<td>10 (47.6%)</td>
<td>6 (28.6%)</td>
<td>5 (23.8%)</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td>13 (61.9%)</td>
<td>5 (23.8%)</td>
<td>3 (14.3%)</td>
</tr>
<tr>
<td><strong>Obstetrics and Gynecology</strong></td>
<td>10 (76.9%)</td>
<td>2 (15.4%)</td>
<td>1 (7.7%)</td>
</tr>
<tr>
<td><strong>Psychiatry</strong></td>
<td>17 (73.9%)</td>
<td>2 (8.7%)</td>
<td>4 (17.4%)</td>
</tr>
</tbody>
</table>
Findings

• Female stressors
  • Contemplating pregnancy
  • Pregnancy
  • Post partum and breast feeding

• Male stressors
  • Finances
  • Separation from family
FEMALE STRESSORS
“Very worried about provisions for maternity leave in the future. Not currently expecting, but hope to during residency and it is all a bit unclear to me what rights we have for parental leave (and I feel unspoken pressure not to ask).”

“Pregnancy is considered a burden and residents are afraid of being pregnant. The first question of the PD when she hears you are pregnant is are you keeping it?”

“Upper level admin are very vocal about how they don't think female residents should be allowed to have families or become pregnant during residency. This does not affect me personally but feels wrong on many levels.”

“Am concerned that am unable to get pregnant as my program would poorly accept it as there is no redundancy in terms of residency scheduling”
“I am pregnant now in the last year of my residency and I have had very minimal support or understanding from my chiefs and my program director. My pregnancy is seen as an inconvenience to them which I do not think is a healthy environment to be in. I am literally counting down the days of my residency. I honestly think it is sad that at the end of my training I really question whether I would do this again if I could go back.”

“The respect for women general surgery residents who get pregnant during training is dismal. Personally haven’t been pregnant, but hear countless stories and observed 2 women in my program suffer in their education due to biased opinions from faculty regarding their choice to get pregnant.”

“Over the past three years I have been denied available educational days to attend a conference on the basis of pregnancy (presumably pregnant women have no need to further their education), discouraged from accepting a coveted and contested internal moonlighting position on the basis of intention to become pregnant”
Post partum and breastfeeding: Negative Experiences

• “It is very difficult to balance home and work life as a resident. I had a baby at the end of medical school and started internship with a 3 month old infant at home. My program was completely inflexible in helping me to spend more time with my child. I am changing programs to a different residency at the end of the year because of this bad experience.”

• “I have received lower marks on evaluations from a few specific attendings while breastfeeding because I had to excuse myself to pump breast milk. I know it was because I was absent for the time to pump because it was actually written in the comments that my priorities were inappropriate because often I had other things I had to leave and do. “
Post Partum and Breastfeeding: Positive experiences

• “I had a baby at the beginning of my 2nd year and only ever had positive reactions to the news. I was accommodated for all appointments and allowed 6 weeks home after delivery without adding to my residency time. They are highly supportive of my desire to exclusively breastfeed and I am provided with adequate time, a safe location to pump, and an area to refrigerate my milk. I have never felt anything but well supported as a human being and now as a mom at my residency program. 10/10 would recommend to every student considering family medicine and would recommend other programs follow this model. I think I'll be a little sad to graduate because it is such a great work environment. I'm not sure I'll find another quite like it in my career.”

• “I had a baby 2 months before graduating from medical school ... That being said, I believe my program is unique in that they promote work-life balance as much as they can, and have been very flexible with my need to take pumping breaks at work. I don't think many other programs would have been "survivable" in my situation just based on anecdotes I have heard from interns at other TY or prelim programs.”
MALE STRESSORS
“Residency and fellowship does not support trainees with children. It is incredibly difficult to raise children and go through residency and fellowship and my wife stays at home with our children, but does not bring in an income. This means we live just above the poverty level and still required family and private loans just to pay our basic bills with two cars paid off and a modest rent of $1,000 per month. “

“My student debt is crippling. I have more than $250,000 in student loans from undergrad and medical school. I would quit medicine if I could, but the only way I can pay off this debt is to keep going. I miss my family. I work so much I barely see my children. I feel like a prisoner.”

“As I am hitting my 30s, now married with a 2-year-old and another baby on the way, the extra $30-50k per year would be going a long way. Living paycheck to paycheck is ridiculous for the amount I have invested in my education and for the critical care that I provide on a daily basis. (And, money is tight not because we’re trying to get a better Porsche. It’s because our monthly budget of rent, food, and phone/internet exhausts my salary.)”
TIME AWAY FROM FAMILY

• “I feel guilty every single day about not having more time for my children, and when I am home I feel so physically and emotionally exhausted it is hard for me to be present in any meaningful way. I often worry whether my absence and emotional state during the residency experience will leave lasting scars on my children.”

• “It's difficult with children as I am typically gone during the times they are awake and so it's disheartening when your young children go long periods of time without seeing you / you seeing them. Side effect of training that's difficult to avoid, unfortunately”

• “Work-life balance can be a challenge in residency. I've had days on the wards where I didn't see my daughter for up to 3-4 days in a row. I've also had my wife come to the hospital on long-call days to bring dinner for the team. She brings my 2-year-old daughter so I can get to see her at least once per day. Also, I get to show off my little girl to the team. She is always very popular!”
Relation to the Conference theme “Achieving the quadruple aim: Resilient systems in times of crisis”
• The 4th goal of the Quadruple Aim is to improve the work life of health care providers
• Emphasis is currently on improving work flow for established providers
• Can be expanded to address needs of pregnant and breast feeding providers
• Can be expanded to address needs of residents and fellows
Questions?

Comments?
Thank you
Waiting on the World to Change:
The long view of the development of burnout in physician trainees

Heather Kirkpatrick, Ph.D., ABPP
Mark Vogel, Ph.D., ABPP
Ascension Genesys Hospital
Disclosures

• No Disclosures
Objectives

- observe a common pattern of development of burnout in the PGY1 year of residency training.
- consider that this pattern is quite stable in our 15 years of data collection.
- to engage in implications of this long cohort study.
Physician trainee burnout is well established, approaching 50%-75%.

Burnout in trainees is a concern, as practice patterns (medical and personal/wellbeing) are often crystallized in residency.

Dyrbye & Shanafelt (2016)
Dyrbye, West, Satele, Boone, Tan, Sloan & Shanafelt (2014)
West, Shanafelt & Kolars (2011)
Most studies find that rates of burnout increase significantly during the first year of residency.

One longitudinal study and found that first-year residents’ risk of burnout was 18.9% by February.\(^1\)

Another surveyed residents longitudinally twice per year through residency and found burnout increased from 17% to 46% during the first year and then stabilized at that level until the last measurement mid-senior year.\(^2\)

Similarly, cross-sectional studies report the highest burnout scores in the PGY-2 year\(^3,4\).

\(^1\) Doolittle & Windish (2015); \(^2\) Pantaleoni et al., (2014); \(^3\) Jovanović et al., (2016); \(^4\) Kealy, Halli, Ogrondiniczuk, & Hadjipavlou, (2016)
Background

- ACGME has brought increased focus to prevention of burnout, routinely monitored in CLER visits\(^1\)
- Field is moving from documenting to intervening\(^2\)
- Has this worked?
- What would success look like?

\(^1\)Weiss, Bagian & Wagner (2014)
\(^2\)Shea & Bellini (2017)
Research Question & Hypothesis

- Has the frequency and intensity of burnout changed over time?
- Is there a change in the development of burnout in successive cohorts of PGY1 residents?
Methods

• All PGY1 (about 40 per year) at our institution from 2005-2019 were surveyed for burnout

• PGY1 from broad base of training programs
  • Family Medicine
  • Internal Medicine
  • Surgery
  • Orthopedic Surgery
  • Emergency Medicine
  • Obstetrics/Gynecology
  • Podiatry
Methods

- PGY1 surveyed quarterly (Jun, Oct, Jan, May)
  - 625 participants invited
  - 587 completed measures
  - 94% response rate

- Measures included
  - Maslach Burnout Inventory
  - Physician Wellness Inventory
  - Areas of Work Life Study
  - Multidimensional Scale of Perceived Social Support
  - Trait Emotional Intelligence Questionnaire—Short Form
Methods

- Maslach Burnout Inventory (MBI)
  - Emotional Exhaustion (EE)
  - Depersonalization (DP)
  - Personal Accomplishment (PA)
Results

n= 587 across 15 years studied
EE over time and Moving average of EE scores
DP over time and Moving average
PA over time and moving average of PA scores
Results—Paired samples t-test (n=375)

- EE: $p<.000$
- DP: $p<.000$
- PA: $p<.000$
Results—Paired samples t-test (n=375)

<table>
<thead>
<tr>
<th></th>
<th>Mean EE</th>
<th>Mean DP</th>
<th>Mean PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>14.24 (8.11)</td>
<td>6.00 (4.61)</td>
<td>37.41 (6.12)</td>
</tr>
<tr>
<td>Q4</td>
<td>24.28 (11.62)</td>
<td>10.31 (6.57)</td>
<td>33.91 (7.39)</td>
</tr>
</tbody>
</table>
Patterns of scores for each cohort reveal remarkable consistency regarding the development of burnout across the PGY1 year.

Resident physicians experience changes in burnout across the PGY1 year, beginning with low levels of burnout, and ending with average levels of burnout.

Personal accomplishment scores appeared to endure better than the other facets of burnout.

The pattern of burnout development has been stable for 15 years, indicating that the field of medicine has yet to improve the educational experience with respect to preventing burnout for young trainee physicians.
Discussion

- ACGME has brought increased focus to prevention of burnout, routinely monitored in CLER visits\(^1\)
- Field is moving from documenting to intervening\(^2\)

- Has this worked?
- What would success look like?

\(^1\)Weiss, Bagian & Wagner (2014)
\(^2\)Shea & Bellini (2017)
References


References


