The ACGME Second Symposium on Physician Well-Being: Commitment to Change

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ABSTRACT SUBMISSIONS
WELLNESS ASSESSMENT AND SUPPORT FOR RESIDENTS IN THE ACADEMIC DISCIPLINARY PROCESS

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Faculty and Staff Involved in Initiative: Erin Duecy MD MS (OB-GYN Residency Director, Chair of Resident Wellness Committee), Diane Hartmann MD (Senior Associate Dean for Graduate Medical Education) with representatives from the Graduate Medical Education Committee, Department of Psychiatry, Employee Assistance Program, and Office of Counsel. University of Rochester.

Background: Residents and fellows are high-performing hard-working individuals at the pinnacle of their training and on the cusp of entering independent practice. Facing performance issues or entry into the formal academic disciplinary process is not only unexpected but may be an entirely new experience for which the trainee has no level of preparedness or coping skills. Most programs have policies in place to require wellness evaluations and support programs for trainees in crises such as mental illness or substance abuse. This has not traditionally been the case for trainees entering the academic disciplinary process which is no less a crisis for the trainee involved and which could have a career and life altering outcome. Other professions have progressed more quickly in understanding and incorporating the need for assessment and reflection after a crisis event. For example, police officers involved in an on-the-job shooting do not return to duty until a wellbeing evaluation is completed and assesses them as ready to return to work. Similarly, pilots do not fly after a crash until they are similarly assessed. This recognition of wellbeing as the key to safety and success after a crisis event is equally applicable to physicians for whom academic performance issues may be the most stressful event they have faced in their professional lives thus far. The desired outcome of the academic disciplinary process is for the trainee to understand and correct performance issues so they can succeed in the program. How can we expect to do this without understanding and promoting the wellbeing of the trainee? The stress, shame, grief, fear, and anger that flavor receipt of such devastating news may make it immediately impossible for the trainee to fully understand the concerns expressed and, over time, negatively impact their ability to make progress toward resolution of the issues. Additionally, trainees under such extreme stress may not be able to make clear positive decisions about accessing wellness support even though it has been suggested and is readily available. At University of Rochester, we have a well-established Employee Assistance Program (EAP) commonly accessed by faculty, trainees, and staff for acute needs. They not only provide immediate support but can help identify resources for coaching & coping and rapid access to behavioral health if needed. After examining our disciplinary process as a high impact factor in the clinical learning environment, we decided to leverage our existing EAP to create a parallel wellness assessment and support program to help our trainees facing educational crises. We believe that a trainee must feel supported and have resources to help them cope with the crisis in order to succeed.

Objectives: • Mandatory wellness assessment should be formally & mindfully incorporated in parallel to the institutional disciplinary process for residents and fellows. • The option for a trainee in educational crisis to decide whether to pursue wellness assessment should be converted to a process-neutral requirement thereby minimizing the stress, shame, fear, grief, and anger that impact decisions to access self-care. • Residents and fellows should be provided with an opportunity to receive confidential individualized support, strategies for stress management, rapid access to behavioral health if needed, and resources available to help them succeed in their program. • Program directors should be provided with a mechanism to ensure their trainee will have the opportunity outlined above. • Wellness assessment for residents and fellows should be normalized as an institutional standard of care.

Methods: Policy Development: A series of discussions was held with representatives from Graduate Medical Education, the Department of Psychiatry, the Employee Assistance Program, and the Office of Counsel to discuss optimization of trainee wellness within the disciplinary process. Issues impacting policy development included: trainee confidentiality, legality of such a requirement, common use of required wellness assessments at crisis points in other professional settings, need to maintain neutrality & independence of the employee assistance program within the process, maintenance of independence of the disciplinary process and the wellness assessment requirement, communication between EAP and programs to confirm compliance, and expected number of events per year & adequacy of resources to
handle the new requirement. The Office of Counsel opined that such a requirement was within legal requirements based on equal application to all trainees at the institution. The most important issue discussed was the importance of providing every opportunity to ensure the wellness and safety of our trainees at a time of crisis. An important aspect of these discussions was the differing experiences and viewpoints brought to the table by each party that informed the final product. The key to the success of these discussions was the mutual agreement of all parties that the reasons for developing such a policy were valid and high-stakes. Brief Outline of Policy:  • All trainees entering academic probation or upon dismissal/non-renewal of their contract will be required to meet with EAP once. Performance issues identified by the program director that may lead to probation if not resolved may trigger a required EAP meeting based on the program director’s assessment of needs.  • At the conclusion of the academic performance meeting with the program director (or other designated representative), the requirement for a meeting with EAP as per GME policy will be reviewed.  • For trainees entering academic probation or informed of termination/non-renewal of contract, EAP will be physically present for immediate introduction to the trainee. They will be provided a private space to meet and will discuss the option to proceed immediately with the required meeting or to schedule the meeting within a timeframe agreed upon by all parties.  • For required EAP meetings triggered by pre-probation level performance issues, the trainee may be referred to EAP with a timeframe for the expected meeting to occur. At the program director’s discretion, EAP may be requested for immediate introduction as above.  • For a trainee that progresses through multiple academic transition stages, a meeting is required at each stage (triggering performance issue identified by program director, probation, and dismissal/nonrenewal of contract).  • EAP will provide written notice to the program director that the required meeting occurred. If a meeting does not occur within the designated timeframe, EAP will notify the program director.

Results/Outcomes/Improvements: The policy was adopted and added to the Residency and Program Director’s Handbooks. The policy is addended with a FAQ section for program directors addressing practical implementation and including an outline of how to discuss the requirement with the trainee. A separate FAQ section for trainees was created to introduce the requirement, reasons for the policy, and reassurance about confidentiality. Data routinely collected for the monitoring of disciplinary processes in our programs will now include documentation of implementation of this policy. This data will inform long-term monitoring of compliance, efficacy, and impact of the policy.

Significance/Implications/Relevance: This presentation meets the recommended abstract categories of commitment to change, implemented well-being programs, resources to promote well-being or identify residents at risk, culture-system change, and collaboration.  • Trainee Wellbeing: Recognition of the impact of the disciplinary process on trainee wellbeing and the imperative to provide assessment and support at times of educational crisis.  • Clinical Learning Environment: Normalization of wellness as a key factor in trainee performance & success.  • Clinical Learning Environment: Multi-disciplinary approach to addressing trainee wellbeing. Active partnership with non-GME faculty & staff in development of the clinical learning environment. Although not explicitly stated in the policy or discussion above, our hope is not only to create an environment that increases the chance for trainee success to but to try and reduce the likelihood of trainee self-harm or suicide which is a national concern and tragedy. This policy provides at least 3 opportunities for a trainee to understand and access resources aimed at helping them succeed in their program through the typical stages of an academic disciplinary process and to cope with the impact on their personal life and career. We are all painfully aware that no matter what we do physician suicide is unlikely to become a never event and that there are more factors involved in the decision to commit suicide or self-harm than an institution can assume the responsibility for. But we are committed to identifying any window of opportunity to change a course with devastating consequences for a trainee, their family & friends, and our community.

Plans for the Future: This policy development project has highlighted additional areas of the learning environment and disciplinary process that may benefit from multi-disciplinary evaluation and improvement; discussions are underway. Expanding the conversation and those included in the evaluation and optimization of our clinical learning environment will open new opportunities for excellence and a feeling that the clinical learning environment is the responsibility & privilege of the entire institution.
Additional Comments: This type of intervention does not lend itself well to traditional statistical evaluation due to the low incidence of implementation of the disciplinary process, confidentiality issues, and need to focus on the trainee’s and program’s needs during educational crises rather than on collection of data points. However, we believe that the sharing of attempts at improving the learning environment and disciplinary processes even in the absence of any known ability to provide hard outcomes data is morally indicated and valuable as a stimulant to development of initiatives consistent with the University of Rochester’s motto “Meliora” - ever better.
IMPACT OF A COURSE IN MIND-BODY MEDICINE ON MINDFULNESS, PERCEIVED STRESS AND EMPATHY IN MEDICAL STUDENTS AND FACULTY

Primary Author: Aviad Haramati, PhD, Georgetown University School of Medicine

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Background: Reports from various sources suggest that burnout is prevalent in the medical profession, affecting over half of primary care practitioners in the US, with higher rates in certain specialists (Arch Intern Med 172(18): 1377-1385, 2012). The elements that define burnout include “emotional exhaustion”, “depersonalization” and a “low sense of accomplishment.” This trend may begin earlier with the observed decline in empathy during medical student training (Acad Med 86(8): 996-1009, 2011). Several studies have shown that student distress is associated with decreased empathy, decreased quality of care and, with unprofessional conduct and less altruistic values (J Am Med Assoc 304(11): 1173-1180, 2010). Certainly, the educational program leading to the medical degree has several elements that contribute to student stress (academic, financial, social, etc.). However, part of the problem could also relate to the lack of tools provided students and faculty to manage stress and the absence of curricular interventions to address self-awareness and self-care.

Objectives: Our goals were: 1. To determine whether participation in a mind-body medicine (MBM) course would enhance mindfulness and affect medical students’ stress and empathy. 2. To study the impact of serving as a mind-body facilitator on the participating faculty and staff.

Methods: Georgetown University School of Medicine (GUSOM) offers an 11-week course to expose first-year medical students to mind-body approaches (e.g., meditation and guided imagery). The sessions also include sharing openly and listening without judgment. Two groups of first year medical students (n=118) completed the surveys before and after the course. Instruments included: Perceived Stress Scale (PSS), Freiberg Mindfulness Inventory (FMI), Positive and Negative Affect Scale (PANAS), and the Interpersonal Reactivity Index (IRI). To assess the impact on facilitators, 62 facilitators, trained by the GUSOM MBM Program, were invited to participate in the study. Participants completed two validated surveys: Freiburg Mindfulness Inventory, FMI (n=41); and Perceived Stress Scale, PSS (n=40), and a 6-item open-ended questionnaire addressing aspects of professional identity (n=42).

Results/Outcomes/Improvements: In the students, significant increases (P<0.001) were observed in mindfulness (FMI), positive affect (PANAS) and empathic concern (IRI), while declines were seen in perceived stress (PSS) and negative affect (PANAS). Furthermore, the changes in perceived stress and affect were significantly correlated (P<0.001) with improvements in mindfulness. Regarding the facilitators, facilitators’ scores were significantly lower on PSS and higher on FMI compared to normative controls (p<0.05), and the two parameters were inversely correlated (-0.46, p<0.01). Qualitative analysis of written responses indicated that the facilitators experienced more mindful awareness and improved self-care, as well as an increased sense of control and clarified priorities.

Significance/Implications/Relevance: Participating in a MBM course is effective in enhancing traits such as mindfulness, positive affect and empathic concern, while reducing students’ perceived stress and negative affect. Further, the mindfulness level was an important predictor for the changes in perceived stress. Fostering mindfulness through an experiential MBM course may decrease student stress and enhance emotional intelligence. Such curricular interventions may promote better physician-patient communication and improve the quality of health care. MBM facilitation has a positive impact on the professional identity of facilitators through improved communication, connection, empathy and self-confidence, in addition to reducing perceived stress and enhancing mindful awareness. These results support the inclusion of such relationship-centered educational offerings in the training and/or core academic experience of physicians and other health professionals.
Plans for the Future: Georgetown University Medical Center has embraced the mind-body initiative as an important element to foster student and faculty self-awareness and self-care. To date (since 2002), over 3,000 students and faculty have participated in at least one semester of this course. Many have taken advanced level courses. Further, the program has expanded to other schools within the University (Law, Business and the School of Foreign Service). At the Medical Center, we plan on continuing to expand the program, train more faculty and staff facilitators and expand the research aspect to better understand the changes that are occurring and their implications for the health of students and faculty.


Website: https://som.georgetown.edu/medicaleducation/mindbody
WELL-BEING POP UPS: A SIMPLE COST EFFECTIVE INTERVENTION FOR RESIDENT WELLBEING

Primary Author: Dink Jardine, MD, Naval Medical Center Portsmouth

Faculty and Staff Involved in Initiative: Jardine, Dinchen, MD, Naval Medical Center Portsmouth, VA; Held, Jenny, MD, Naval Medical Center Portsmouth, Schollnberger, Ellie Marie, MD, Naval Medical Center Portsmouth

Background: Physician burnout is well understood and appreciated as a looming crisis within our health care environment. Many excellent interventions have been proposed for directly addressing the environmental contributions to burnout and for improving resilience of those in those environments. Smaller, resource constrained institutions may have difficulty implementing more encompassing programs but would benefit from low cost interventions with immediate impact. Following the ACGME convened Symposium on Physician Wellbeing in November of 2015, one of the authors sought to create a resident led committee to focus on resident wellbeing specifically at her home institution. As an unfunded entity without a formal description within a federal institution, there were significant challenges to implementing larger programs and initiatives. In an effort to achieve an early success from which to build capability and awareness, we sought to implement an effective, cost conscious intervention for maximal benefit in a medium sized institution's graduate medical education (GME) programs with unique restrictions on fund appropriations. The resident led Wellbeing Committee developed the idea of "Wellbeing PopUps" to create interest in and promote easy interventions as a way of getting started along a larger wellbeing culture change.

Objectives: - Have an immediate impact on resident sense of wellbeing in a relatively cost constrained environment - Keep costs to less than $500 - Create early success from which to build capacity and support

Methods: The concept of "Wellbeing PopUps" used several unique, eye catching interventions placed in strategic locations over a one week period. Ten brightly colored buckets (orange) were placed simultaneously in locations where residents were most likely to see them: GME dedicated office and lounge spaces, common 'backdoor' corridors to ward floors, near commonly located call rooms and immediately outside of academic spaces. Over the course of a week, four interventions appeared once per day with activities designed to immediately impact the residents and to raise awareness of the need to focus on physician and resident wellbeing. Each intervention is described below. Attitude of Gratitude: Free cards were provided to trainees with a chalkboard sign stating, "Have an ATTITUDE of GRATITUDE!! Did someone make your day? Was it another intern or resident, a faculty member, a nurse, your spouse? Let them KNOW!" The chalkboard moved throughout the hospital the entire week. Bubble Time Out: The tubs were filled with brightly colored bubble solution bottles with a sign describing how deep breathing is a known relaxation technique and that blowing bubbles can mimic deep breathing exercises. Refuel Minute: The tubs were filled with healthy protein snacks that included cards with contact information for the institution's stress management and peer support organization. Color Break: Coloring books were separated into individual sheets with colored pencils and crayons for trainees to use right there or to take back to their desk for later use.

Results/Outcomes/Improvements: While objective measures of resident wellbeing were not assessed for this intervention, anecdotal responses were all very positive. During the one week intervention, 250 protein bars and over 200 gratitude cards were distributed. Two card recipients found the organizers to tell them how moved they were to receive cards from the trainees. Total cost for a medium institution with eight training programs and approximately 250 residents was $412 including the value of approximately $200 in donated items. Several of the items are reusable and will be used in future similar interventions.

Significance/Implications/Relevance: Often the hardest part of any intervention is taking the first step. By developing a low cost, immediately noticeable and fun intervention, awareness of physician wellbeing rose within the institution. These small successes have elevated the interventions the resident led Wellbeing Committee has chosen to undertake in the coming year and the committee's size has nearly doubled.
**Plans for the Future:** A repeat of the "Wellbeing PopUps" will occur before the next symposium. As awareness of those activities has grown, small funding sources and resource neutral interventions like therapy animals have been identified. Building on their prior success, the committee now has 3 new initiatives moving forward for the coming academic year including an opportunity to assess the current status of resident burnout to allow for evaluation of intervention success in the future.

**Additional Comments:** Thank you for the opportunity to submit our small success. It has been a great learning experience for all involved!
TOWARD PREVENTING PHYSICIAN SUICIDE: INCORPORATING THE INSIGHTS OF THOSE THEY LEAVE BEHIND

Primary Author: Michael Myers, MD, SUNY Downstate Medical Center

Faculty and Staff Involved in Initiative: NA

Background: It is estimated that 300-400 physicians (and an unknown number of medical students) die by suicide each year in the United States. Despite much research on personal and workplace stressors, personality traits, psychological vulnerabilities, and psychiatric illnesses in doctors, the published literature is sparse on information gleaned from those who know physicians best. In January 2015, the author began interviewing the family members, medical colleagues, intimate friends, therapists, and patients of doctors who have died by suicide. The work is ongoing and at this time, 55 interviews have been conducted with a data base of 39 decedents in the United States, Canada and England. The interview format is invitational, semi-structured and comprehensive. Thirteen have been conducted in person and 29 by telephone. Duration has ranged from 45 minutes to 2 hours. All participants have signed a consent form granting permission for their observations to be used in scientific research.

Objectives: 1) understand the ways in which stigma works against timely and effective life-saving treatment of ill physicians; 2) discuss the insights gleaned from the loved ones of doctors who have killed themselves; 3) describe systemic, diagnostic and therapeutic changes that will help to save lives of symptomatic physicians

Methods: Qualitative study of “survivors” of 39 physician decedents Survivors = family members, medical colleagues, employers, training directors, therapists and patients of decedents 55 interviews (18 in person, 37 by telephone) Semi-structured interview format Interview duration 45 minutes to 2 hours Signed release obtained from all interviewees

Results/Outcomes/Improvements: Findings thus far are: 1) a significant minority of physicians killed themselves without ever receiving an assessment or treatment by a health professional; 2) for those who sought treatment, stigma was profound and adversely affected the therapeutic alliance and treatment adherence; 3) there are perceived shortcomings of some physician health programs (overemphasis on substance use disorders and the abstinence model, neglect of comorbid mental health conditions, lack of psychiatric consultation); 4) split treatment (medication prescribed by a psychiatrist and psychotherapy by a psychologist or clinical social worker) can fail and contribute to suicide; 5) under diagnosis of the despair is not uncommon (attributed to the individual not being completely honest and forthcoming plus the psychiatrist not suspecting or probing); 6) physician loved ones are often not being interviewed by treating professionals for collaborative information or psychoeducation; 7) in some decedents, there is emergent psychosis with agitation, profound insomnia, delusional and constrictive thinking in the hours or days just prior to the death; 8) after the suicide, some loved ones felt the treating professionals were available to them and empathic, others felt shunned and abandoned; 9) a universal wish on the part of interviewees to help prevent suicide in doctors.

Significance/Implications/Relevance: The author concludes that these observations have relevance for instituting change in primary, secondary and tertiary prevention of suicide in physicians. A message from the families was the pressing need for more basic education about warning signs of worsening illness and suicide for doctors themselves and their families. Making changes that are rooted in sorrow and tragedy will help to restore hope and joy in medicine.

Plans for the Future: This research is the substrate of my next book. Working title is: "Why Physicians Kill Themselves: Lessons Learned from Their Families and Others Who Cared."

Additional Comments: These findings were presented at the recent International Conference on Physician Health in Boston on Monday September 19, 2016.

Website: www.michaelfmyers.com
SCHEDULED DISCUSSION GROUPS IN INTERNAL MEDICINE RESIDENCY CURRICULUM

Primary Author: Patrick Cocks, MD, NYU School of Medicine

Faculty and Staff Involved in Initiative: Patrick Cocks, MD, Barbara Porter, MD MPH & Margaret Horlick, MD NYU School of Medicine

Background: To combat the potential for maladaptive responses to the stress of residency, the NYU Internal Medicine residency program instituted training year-specific discussion groups that meet at regular 6 week intervals. These group meetings were designed to provide time and space for reflection about the experience of being a resident.

Objectives: Our objectives were to: 1) change internal medicine residency culture to value the role of sanctioned reflective discussion; 2) highlight commonly encountered, challenging topics such as the imposter syndrome, implicit bias, patients' deaths, and burnout during training; and 3) develop longitudinal and supportive peer relationships amongst residents.

Methods: We instituted training-year specific discussion groups which occurred every six weeks during protected academic time. Each group consisted of seven residents and was facilitated by an internal medicine program director. There was longitudinal continuity among the resident group and their facilitator. Each group met 8 times over the course of the academic year. Each session had specific learning objectives depending on the topic covered. During the academic year 2015-2016, topics discussed during the eight sessions were: 1. Imposter Syndrome 2. Responding to Loss 3. Humor in Our Workplace 4. Pride in Our Work 5. Resilience 6. Doubt and Confidence (for second year residents) and Leaving your Continuity Practice (for third year residents) 7. Implicit Bias in Clinical Practice 8. Transitions and Taking Stock of Our Training The structure of the sessions varied and could include brief preparatory reading, in-session reading, in-session writing and unstructured discussion. Readings included short stories, poetry, essays, news articles, and medical literature.

Results/Outcomes/Improvements: Both residents and facilitators have reported to us on the value of these groups. Informal feedback from residents has included acknowledgement that residency leadership values reflective time, gratitude for the time with peers and resultant relationship development, and engagement by the topics. Our program director facilitators have noted appreciation for the time to hear the residents’ perspective, a renewed understanding of the resident experience, and increased fulfillment in their role in resident education and development.

Significance/Implications/Relevance: We have observed unique perspectives to discussion material based on where each cohort is in their training, and we are curious about whether there are defined “developmental stages” in the second and third years of residency. We have also observed a strengthening of peer relationships and an appreciation by residents for multiple voices in a group.

Plans for the Future: Our next steps are to continue development of this curriculum to be a two-year, repeating curriculum; to formalize facilitator debriefing in order to qualitatively assess content discussed during sessions and learn more about our observations of “developmental stages of residency”; and to identify time in the intern curriculum to have intern specific discussion groups as well. Dedicating time for reflection demonstrates the program leadership’s belief in the role of reflection and peer support as essential to the professional development of residents.
The COSGP Mental Health Awareness Task Force – One Year of Activity

Primary Author: Caleb Hentges, OMS III, Council of Osteopathic Student Government Presidents

Faculty and Staff Involved in Initiative: Tyler Cymet, DO, Associate Vice President, Medical Education, AACOM; Stephen Shannon, DO, MPH, President, AACOM; Alissa Craft, DO, MBA, Vice President, American Osteopathic Association

Background: In Fall 2015, osteopathic medical student leaders recognized that students were struggling with mental health issues but felt unable to obtain care for reasons including a negative perception from the faculty and staff, impact on obtaining graduate medical education, and long term effects on medical licensure. Perhaps even more importantly, students cited a fear of being considered a failure – if they were unable to manage their own feelings of depression, anxiety, and more; how would they be able to care for patients suffering with similar issues. The Council of Osteopathic Student Government Presidents (COSGP) took the lead and established a Mental Health Awareness Task Force (MHATF). The MHATF was the brainchild of Maureen McAteer, a student at Marian University College of Osteopathic Medicine (MU-COM) in Indiana. McAteer says she was inspired to pursue the issue after a friend, an MD student in residency, committed suicide.

Objectives: The primary goal of the MHATF is to create increased awareness of mental health issues for medical students, residents, and physicians.

Methods: The COSGP appointed Executive Board members to serve as leaders for the MHATF, identifying ambassadors on each osteopathic medical school campus. Through this network, the group committed to bring mental health awareness to the forefront in the areas of education, advocacy, and accreditation.

Results/Outcomes/Improvements: Since the MHATF was established, the awareness level of the issue has increased to the point where the American Osteopathic Association House of Delegates passed House Resolution H-334-A/2016: Proposed Creation of a Mental Health Task Force within the AOA establishing an American Osteopathic Association Physician Wellness Taskforce. In addition to this achievement, the MHATF has sponsored the Day of Wellness on every osteopathic medical school campus, participated in Suicide Prevention Day, and developed the Save400 Campaign – named for the estimated 400 medical students, residents, and physicians who take their own lives each year. The MHATF also produced a video called "What You Don’t See" featuring osteopathic medical students discussing mental health issues (https://www.youtube.com/watch?v=KBnapibqQyQ).

Significance/Implications/Relevance: The work of the MHATF has led to a tremendous awareness of this issue in the osteopathic medical education, advocacy, and accreditation areas. The AACOM Board of Deans addresses the topic of Wellness and Resilience for students and faculty at each of their meetings. The Save400 Campaign has garnered attention during advocacy events such as DO Day on the Hill 2016. And, recently, the Commission on Osteopathic College Accreditation has proposed new standards to ensure that all medical students have access to 24 hour a day/ 7 day a week confidential mental health care both on campus and while completing clinical rotations.

Plans for the Future: The MHATF is looking to complete qualitative studies of the impact of medical education and training on osteopathic medical students wellbeing, both physically and emotionally, including the impact of the learning environment at both the undergraduate and graduate medical education levels.

Website: http://www.aacom.org/cosgp/mentalhealth
Primary Author: Jo Shapiro, MD, Brigham and Women's Hospital, Harvard Medical School

Faculty and Staff Involved in Initiative: Jo Shapiro, MD, FACS Director, Center for Professionalism and Peer Support Brigham and Women's Hospital Harvard Medical School Boston, MA

Background: We recognized that our hospital’s mission would only be fully realized by supporting the wellbeing of those doing the important work of clinical care, education and research. Such wellbeing is predicated on a psychologically safe and respectful work environment. To that end, in 2008 we established the CPPS to strengthen and support a culture of trust explicitly predicated on mutual respect for individuals, teams, the institution, and patients and their families.

Objectives: The mission of the CPPS is to encourage a culture that values and promotes mutual respect, trust, and teamwork by: 1. Supporting colleagues in emotionally stressful situations such as medical errors 2. Training in professionalism, conflict resolution and giving difficult feedback 3. Establishing a safe space for reporting concerns

Methods: To achieve this, we established several key programs, including professionalism education, accountability process for professional behavior, and a robust peer support program. We have also piloted resilience programs such as mindfulness and communities of trust in the Courage and Renewal model.

Results/Outcomes/Improvements: We published data regarding our professionalism initiative: Shapiro J, Whittemore AW, Tsen LC. Instituting a culture of professionalism: the establishment of a center for professionalism and peer support. Jt Comm J Qual Patient Saf 2014; 40(4):168-177. To summarize, there was a significant improvement in the behavior of a vast majority of those physicians about whom professionalism concerns were raised. In addition, the professionalism training sessions were highly regarded.

Significance/Implications/Relevance: We have helped multiple institutions - nationally and internationally - develop peer support programs.

Plans for the Future: We are in the process of studying the efficacy and impact of the peer support program. In addition, we are analyzing updated data from the professionalism initiative.

Website: www.brighamandwomens.org/cpps
PEDIATRIC BUDDY PROGRAM COHORT 3 WELLNESS PROGRAM

Primary Author: Beth Payne, MAEd, C-TAGME, LSSBB, The University of Texas Health Science Center at San Antonio

Faculty and Staff Involved in Initiative: (14) Interns (5) Seasoned Nurses Haneme Idrizi, MD, Beth Payne, MAEd, C-TAGME, and Michelle Arandes, MD

Background: In 2014, strained physician and nurse relationships following a large scale hospital transition of the Pediatric Residency Program at The University of Texas Health Science Center San Antonio (UTHSCSA) led to the development of an interprofessional project entitled The Pediatric Buddy Program. This program pairs pediatric nurses and interns to promote a collaborative clinical work environment and develop IPE focused Quality Improvement (QI) projects that have an overarching goal of improving patient care and safety. Each Cohort is given a set of topics to select from as a group decision for their team project. The first cohort was CLER focused projects on the inpatient clinical services and the second cohort reviewed medical student orientation needs on each service and implemented new processes to ensure there were open communication at all levels. Cohort 3 was given topics under the Wellness umbrella.

Objectives: Creating a positive cultural shift and driving change in the clinical learning environment through nurse-intern interprofessional collaborative driven projects.

Methods: Each cohort is given a set of topics for their required QI project. The 2016 cohort (3) will focus all projects around wellness. The focus is through the lens of wellness and how it affects patient care and patient safety. These are not specific fixes to people or services but instead changed behaviors and greater insight into their specific topic area. Each team has one nurse and two or three interns depending on the topic. The topics they were given this year are as follows: Time Management and Organizational Skills, Stress and Burnout Management, Bullying in the Workplace, Managing different personalities through Conflict Resolution, and Communication styles and techniques. Each team has a leadership mentor to assist in all stages of team formation and project development. To begin the conversation there were several activities that occurred during orientation to prepare the team for their wellness conversations. We began by introducing them to the topic of wellness as shown at the ACGME wellness symposium. Next, we worked on forming their teams through trust activities and open discussion. Then we asked them to create an Intern/Nurse letter to self to answer the question “why I became a doctor or nurse?” These letters are used to remind the groups why they chose their profession on bad outcome days. Finally, we developed their communication skills through our standard buddy program orientation agenda. Each team will follow the same steps in qualitative research planning. Identify Project Theme (listed above) and select specific research question. Complete Literature Review on the topic Develop Survey Questions Develop Interview Questions Compile and Review Literature Review, Survey and Interview Data for Themes Create a 60 minute Grand Rounds lecture for entire department following a designated project and presentation rubric. Completion of group evaluations and self-reflective journaling – these tools allow them to offer formative feedback in an appropriate context and the self-reflection allows for true insight into their current wellness state against their desired state. The program offers mandatory Dinner Didactics for the teams to meet learn and discuss their topics with protected time. The topics are scaffolded alongside the projects to allow for experiential and real time learning. The final team presentations follow a rubric with at least one interactive activity and one handout/card – must use up to 3 teaching methods. All project should address the following aspects: levels of learners, generational differences, previous experience all while looking at Wellness inside and outside of medicine, and creating a culture of IPE communication (Focus on barriers and stigmas that exist in nurse/intern communication that could hinder patient care.)

Results/Outcomes/Improvements: The overall goal for this cohort is to create a nurse/intern built presentation/curriculum/handout with a focus on overall wellness. Cohort 3 began June 2016. Each group will evaluate their team and presentation effectiveness; specially transfer of knowledge, with results due June 2017. Pre and post knowledge and exposure data will be compiled and analyzed at this time. Expected completion Spring 2017.
Significance/Implications/Relevance: The projects will serve as our first set of formal curriculum on wellness topics that are created and driven FOR the trainee BY the trainee. Overall trainee, faculty and staff involvement in the health of our program is pivotal in its continued success. Wellness is a culture change and must start with the current and next generation of physicians and nurses.

Plans for the Future: The Pediatric Buddy Program will continue annually with new interns, nurses and project goals. These wellness presentations will be placed on our curriculum webpage for future use and viewing.
CEO CLINICAL LEARNING ENVIRONMENT INNOVATION AWARDS PROGRAM

Primary Author: Elizabeth Gaufberg, MD MPH, The Arnold P Gold Foundation/Harvard Medical School/Cambridge Health Alliance

Faculty and Staff Involved in Initiative: Elizabeth Gaufberg MD MPH, Director of the Arnold P. Gold Foundation Research Institute, Associate Professor of Medicine and Psychiatry, Harvard Medical School/the Cambridge Health Alliance Maren Batalden MD MPH, Associate Chief Quality Officer at the Cambridge Health Alliance, Assistant Professor of Medicine, Harvard Medical School Patrick Wardell, Chief Executive Officer at the Cambridge Health Alliance Richard Pels MD, Director of Graduate Medical Education at the Cambridge Health Alliance, Assistant Professor at Harvard Medical School

Background: The ACGME’s Clinical Learning Environment Review (CLER) program evaluates resident participation in institutional quality and safety priority setting and improvement project implementation. The current CLER focus areas directly aligned with resident wellbeing include professionalism and fatigue management/mitigation. Additionally, empowerment and positive experiences with improvement projects can be presumed to boost resident morale. The Cambridge Health Alliance (CHA), which sponsors 7 ACGME accredited training programs, engaged institutional senior leadership to sponsor a small grants program that provides funding for resident-led improvement projects in humanism/wellbeing and/or quality and safety within the clinical learning environment. The Arnold P. Gold Foundation provided funding for the project.

Objectives: Our CEO Clinical Learning Environment Innovation Awards program was designed to: 1. Engage our CEO and the other members of the senior leadership team in GME and enable them to see trainees as agents of positive institutional change 2. Empower trainees to identify and improve aspects of their own clinical learning environment 3. Enhance the likelihood of resident project success with a framework provided by the structure of a small grants program 4. Reduce burnout and enhance well-being via resident empowerment as change agents

Methods: A request for proposals was issued to all GME trainees and formative feedback was provided on initial letter of intent. Trainees submitted final proposals using a template based on the Institute for Health Care Improvement’s Model for Improvement including a budget (totaling no more than $3000), a timeline, and a formal agreement between the trainee, a faculty mentor and the relevant training program director. Residents with funded proposals received project technical assistance through an internal center for evaluative health sciences. Residents prepared posters for CHA’s academic poster session and final reports at the end of the academic year. Project outcomes were reported to the CHA Graduate Medical Education Council, Academic Council and Board of Directors.

Results/Outcomes/Improvements: Nine projects in AY 2014-15 and eight projects in AY 2015-16 were funded. Projects areas included: 1) resident-facing quality of life/wellness projects; 2) relationship-building projects; 3) clinical improvement projects; and 4) patient care innovation projects. Trainees report learning about the challenges of leading institutional change – securing support from relevant leaders, building multidisciplinary collaboration, managing logistics and overcoming obstacles. They also report pride in their achievements, an enhanced sense of efficacy and appreciation for institutional support. Senior leaders and board members have valued trainees’ perspectives and involvement in change.

Significance/Implications/Relevance: In collaboration with other efforts to ensure that trainees are encouraged to play active roles in shaping quality, safety and humanism within their clinical learning environment, a relatively easy-to-administer small grants program can result in: 1) targeted improvements in the clinical learning environment; 2) skill building, morale enhancement and enhanced sense of efficacy for trainees; and 3) increased partnership between graduate medical education and institutional senior leadership.

Plans for the Future: We are in the process of selecting our 2016-17 grantees and will include up to date information in the poster. A logic model detailing short-term, intermediate-term and long-term anticipated outcomes will be
embedded within the poster. We plan to undertake more explicit evaluation of the impact of program participation on resident wellbeing in the future.

**Additional Comments:** The Gold Foundation would be interested in exploring the possibility of collaborating with the ACGME to disseminate this model.
USING A PHYSICIAN WELL-BEING ACTIVITY INVENTORY AS PART OF AN ANNUAL PROGRAM EVALUATION (APE): A MODEL FOR PROMOTING AND OVERSEEING WELL-BEING ACTIVITIES IN RESIDENCY AND FELLOWSHIP PROGRAMS

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Background: Addressing physician well-being is central to promoting both a healthy and thriving work force, and for ensuring higher-quality and safer care for our patients. Two years ago we developed a strategic plan to engage our 135 residency and fellowship directors in deliberate design of well-being plans for their programs. Recognizing that while institutional leadership was critical, much of the activities that would change culture and practice would need to take place at the departmental level. Furthermore, programs developed by Program Directors in collaboration with their faculty members and residents were more likely to be effective and sustainable. We therefore focused our work on supporting program directors to implement change in their own departments. As it was unlikely that a single plan would fit all types of programs, we developed a physician well-being activity inventory to prompt consideration of types of activities and guide design of a well-being plan in each residency and fellowship program. We used the Annual Program Evaluation (APE) to promote and evaluate these activities as part of our institutional action plan and oversight process.

Objectives: Our goal was to promote culture change progressively, in stages, rather than to have a large top-down edict in one year. To this end, we aimed: 1. To develop and disseminate an inventory of well-being activities which program directors can use to design their program-specific well-being plan. 2. To use the inventory results as a metric for a. program review by the GMEC Well-Being Subcommittee with results fed to the GMEC Evaluation Subcommittees, and b. well-being activities across the institution 3. To use the inventory results as a means to collect, evaluate, and disseminate well-being activities throughout the institution.

Methods: The program-specific well-being inventory includes the following domains: use of institutional resources, departmental culture and leadership, development of a departmental model of well-being, departmental orientation, written policies, curricular elements, addressing clinical care challenges, mentorship/advising programs, promoting community, faculty development, and crisis management. Our strategic plan included inventory development, PD retreat activities, faculty development workshops, GMEC reports, and Annual Program Evaluation (APE) questions. We were purposeful in starting with only a few questions in the 2015 APE and then increasing the number and granularity of responses of well-being questions in the 2106 APE. Details of our strategic plan are below: 1. Development of a program-specific well-being activity inventory. 2. Completion of this inventory by PDs in a ½ day well-being session focused on development of well-being plans at the 2015 Program Director retreat. 3. Using the 2015 Annual Program Evaluation (APE) to query PDs about their well-being plan development. 4. Using this information as part of our institutional dashboard and evaluation subcommittee process. 5. Conducting focused interviews on well-being activities with core Program Directors led by the GMEC Well-Being Subcommittee. 6. Reporting on activities of the Well-Being Subcommittee at each GMEC meeting. 7. Mid-year PD faculty development workshops on well-being activities. 8. Presenting a Well-Being Workshop to further promote program-specific activity planning at the 2016 PD Retreat. 9. Using the inventory to develop questions on the 2016 APE to further investigate the nature of well-being activities in each program at NYP. 10. Analyzing the APE data by the GMEC Well-Being Subcommittees to provide feedback and inspire on-going work. 11. Developing an institution-wide tool kit of activities available to the NYP community to foster ongoing work in each of the inventory domains and encourage development of new initiatives.
**Results/Outcomes/Improvements:** We believe these activities are changing our culture to one in which well-being activities are considered essential to residency and fellowship program management and health. Results of the 2015 APE to three binary (yes/no) questions related to well-being activities were: 1. Do you have a departmental well-being plan? (72% Yes) 2. Does your department offer wellness activities/programs in which residents participate? (81% Yes) 3. Did your department sponsor faculty development related mental health/well-being? (64.5% Yes) The 2016 APE included 23 questions based on the well-being inventory and required a narrative summary of any initiative that a program reported doing. Our APEs are due on October 15, 2016 and the well-being activity section will be analyzed by the time of the poster presentation.

**Significance/Implications/Relevance:** Developing a structured inventory of program-specific activities can help program directors develop a well-being plan which fits their context, including specialty/subspecialty culture, departmental culture, and developmental/educational stage of their residents. The APE is a useful tool for integrating well-being inventory questions and allowing central oversight of these activities. The tool has been disseminated through publication (Konopasek, L, Slavin, S. “Addressing Resident and Fellow Mental Health and Well-Being: What Can You Do in Your Department.” Journal of Pediatrics. 167(6), December 2015. 1183-1184.e1), national and regional workshops and an ACGME Webinar (Konopasek L, Bernstein C. Combating Burnout, Promoting Physician Well-being: Building Blocks for a Healthy Learning Environment in GME, July 2016). The inventory is currently posted on the ACGME website. Workshop participants have evaluated the inventory as very useful in structuring their thinking and promoting on-going work in their home institutions. Furthermore, suggestions from workshop participants have enhanced the inventory tool.

**Plans for the Future:** We are eager to evaluate the results of the well-being questions on the 2016 APE and to build our institutional tool kit of well-being activities. We will have an analysis of the APE well-being sections available by the time of the 2016 ACGME Symposium on Physician Well-Being. We are currently designing a survey instrument to use the inventory to assess activities across other institutions to provide a snap shot of the state of well-being initiatives and to help identify activities for further dissemination.
PARTNERING TO PROMOTE WELLBEING - UTILIZING CROSS-INSTITUTIONAL RESOURCES

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Background: For many years, the GME enterprise at Vanderbilt University Medical Center has been working closely with our Health and Wellness Office (led by Dr. Mary Yarbrough) to promote wellbeing among our residents/fellows, faculty, and staff. VUMC Health and Wellness has as its mission to engage employees with innovative programs that maximize productivity and wellbeing. We think about our wellness programming in the context of the World Health Organization's Healthy Workplace Framework (Physical Work Environment, Psychosocial Work Environment, Personal Health Resources, and Enterprise Involvement in the Community) and how our various program/departmental/institutional offerings fit into each of these 4 components of a health workplace and meet the needs of our faculty, staff, and trainees.

Objectives: 1. To engage our community in programs that maximize productivity and wellbeing. 2. To understand how the various programs we offer fit into a healthy workplace framework (i.e., "Health and Wellness Portfolio") and address any gaps found. 3. To promote active participation in wellbeing programming and utilization of personal physical and mental health resources offered.

Methods: Our Health and Wellness Program for Faculty & Staff maintains its own website, clearly delineating its wellbeing resources through its 3 major arms: Occupational Health, Heath Plus, and Work/Life Connections and all of the services are clearly made available to all of our house staff, faculty, and staff. For the new residents and fellows, our commitment starts on day one at House Staff Orientation ("Health and Wellness Happy Hour") and is woven into the culture, through events throughout the year ranging from those events focused on physical health (e.g., "Flulapalooza" our one-day flu vaccination event that still holds the Guinness World Record for Most Vaccinations Given in 8 Hours) to those centered on maintaining health personal relationships (e.g., Matters of the Heart and our Vanderbilt Housestaff Alliance). Based on feedback from our House Staff Advisory Committee (HSAC), we have recognized a deficiency in residents maintaining proper dental care and are working to address this issue. Finally, we also work with our housestaff to create organizations and interests groups that meet their personal and professional needs. Two examples of this would be our Vanderbilt Housestaff Alliance (VHA) and our Minority Housestaff for Academic and Medical Achievement (MHAMA) organizations. VHA is a non-profit social and service organization composed of the spouses and significant others of Vanderbilt house staff whose mission is to promote friendship among members, to foster a supportive environment, and to serve the Nashville community. MHAMA is an organization comprised of Vanderbilt house staff and advisors who are committed to 1) creating opportunities for the advancement of underrepresented house staff by providing opportunities for mentorship, networking and professional development; 2) increasing the presence of underrepresented faculty and house staff by being actively involved in the recruitment process and by helping to create an environment that promotes retention and satisfaction of our current minority faculty and house staff, 3) giving back to the community through community service events and sponsorship of lectures which promote increased awareness of minority health issues, and 4) enhancing the experience of minority residents by allowing them to network across subspecialties, develop camaraderie and support through a shared experience, and provide a forum of expression outside of the professional environment, to help with personal balance and overall well being.

Results/Outcomes/Improvements: 1) Our Health and Wellness program has been recognized with many awards, including the ACOEM Corporate Health Achievement Award, the C. Everett Koop National Health Award, Innovation in Reducing Health Care Disparities, and Healthier Tennessee Workplace recognition. In both 2014 and 2015, Global Healthy Workplace named Vanderbilt University second in the world based on its programs to enhance the physical and
mental health and safety of employees throughout Vanderbilt University and VUMC. With thirty-three countries participating and more than 80 applicants, VUMC was the only academic medical center selected as a finalist. We would highlight a couple of outcomes results. Over 80% of our house staff voluntarily participate in our Go For the Gold program, which provides health promotion and prevention services focused on advancing healthy behaviors. Our Work/Life Connection’s Faculty and Physician Wellness Program (FPWP) meets the needs of professionals coping with stress, depression, addiction, and other emotional and behavioral issues. Performance coaching enhances professional skill sets, such as active listening, compassionate and empathic communications, mindfulness, emotional intelligence, and maintaining work/life balance. Since the program’s inception, over 3000 faculty and resident physicians (90% self-referred) have received care. 2) We also have organized a resident "Dental Day" on November 1, 2016 with our Department of Oral Surgery to facilitate residents getting proper dental exams and cleanings. 3) VHA and MHAMA continue to be strong organizations within our institution for its members. Accomplishments and initiatives of these two programs can be found on their websites (see "additional comments").

**Significance/Implications/Relevance:** Our commitment to wellbeing remains strong and is of vital importance to our work at VUMC. Our ability to maintain this commitment and to strengthen it relies on our partnerships across many aspects of the medical center. For example, in addition to the strong linkages between Health & Wellness and GME, we have created a strong linkage between the GME office and the Office of Alumni Affairs, which also devotes significant time and energy to resident wellbeing initiatives. Examples of this partnership include, but are not limited to: 1) co-sponsoring the GME orientation picnic for all new house staff and their families, 2) providing tickets to residents/fellows (and their families) to sporting events, and 3) co-sponsoring GME's initiative to distribute the book "When Breath Becomes Air" to allow entering residents and fellows (see Plans for the Future).

**Plans for the Future:** We continually look for new opportunities to enhance our offerings. Beginning with house staff orientation 2017, all entering residents and fellows will receive the book "When Breath Becomes Air," the story of a neurosurgery resident diagnosed with Stage IV lung cancer, at orientation with discussion seminars scheduled in the fall and spring to discuss the book and their own experiences of balancing personal and professional life.

**Additional Comments:** Our Health & Wellness website is http://healthandwellness.vanderbilt.edu/. The website for our Vanderbilt Housestaff Alliance, our organization for spouses and significant others of house staff is: http://www.mc.vanderbilt.edu/root/vumc.php?site=gme&doc=2780. The website for MHAMA, our Minority Housestaff for Academic and Medical Achievement, is: https://medschool.vanderbilt.edu/mhama/.


RESIDENTS’ PERCEPTIONS OF THE CLINICAL LEARNING ENVIRONMENT AND PROFESSIONALISM IN 14 REPRESENTATIVE US ACADEMIC HEALTH CENTERS

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Background: Residency training is a pivotal time in the development of a physician. In their three or more years of training, residents are immersed in the culture and behavioral norms of their attending faculty. At the same time, they model behaviors and expectations for the medical students that they supervise. Whereas the culture for faculty and the “hidden curriculum” for medical students have been studied, there exists no similar documentation or data base for residents, despite calls for attention. Leaders in residency training have proposed the need to consider and assess the role of residency culture, because it is the culture of everyday life that fosters or inhibits residents’ ability to develop into competent and compassionate physicians, and develop the six core competencies stipulated by the Accreditation Council for Graduate Medical Education (ACGME), the accrediting body for U.S. residency training programs. In a recent initiative, the ACGME Clinical Learning Environment Review (CLER) recognized the critical role that the culture or clinical learning environment plays in the training of physicians and the provision of safe, high quality patient care. Meeting the goals outlined in the six domains of ACGME’s CLER (patient safety; quality improvement; transitions in care; supervision; duty hours oversight, fatigue management and mitigation; and professionalism) will depend, in large part, on the institution’s culture. For example, is the culture perceived as trustworthy such that residents can report a medical error to superiors without fear? Are residents likely to admit when they are too tired to function safely? Do residents feel that their ethical and moral values are shared and modeled by their faculty and by the teaching institution? A wealth of studies conducted over the past six decades documents the harrowing nature and stress of residency training. There is currently renewed national interest in resident well-being and recognition of the tragically high suicide rates in U.S. residents. To complement existing initiatives and as a foundational step to foster improvement in residency programs, we report the development and steps to determine the valid use of a C-Change questionnaire to document and measure the clinical learning environment, professionalism, and the culture of residency programs. The National Initiative on Gender, Culture and Leadership in Medicine: C-Change (for culture change) has developed and validated the C-Change Faculty Survey (CFS) to document the culture of academic medicine from faculty perspectives. We minimally adapted the CFS for use with residents to document their culture and the clinical learning environment and professionalism from residents’ perspectives.

Objectives: 1) Develop a reliable and practical instrument, the C-Change Resident Survey (CRS) to document the clinical learning environment, professionalism and the culture of residency programs; 2) Present construct validity evidence of the CRS; 3) Evaluate differences in perceptions of various demographic subgroups of residents.

Methods: The C-Change Resident Survey (CRS) was developed by adapting the reliable and well-validated use of the C-Change Faculty Survey (CFS), which measures 12 dimensions of the culture of academic medical centers and has been used extensively throughout the US, as well as in Canada and the UK. Measure: The 10-minute, 78 item CRS measured resident perceptions of 13 dimensions of the culture: Vitality; Self-efficacy in Career Advancement; Institutional Support; Relationships/Inclusion/Trust; Values Alignment; Ethical/Moral Distress; Respect; Mentoring; Leadership Aspirations; Work-life Integration; Gender Equity; Under-represented in Medicine Minority (URMM) Equity; and Competencies. Additionally, the CRS collected information from respondents on gender, sexual orientation, race/ethnicity, age, country of origin of their medical degree, presence of children at home younger than age 18 years, and year of post-graduate training. Sample: C-Change selected a purposeful diverse sample of U.S. residency programs at 14 US sites/health systems, which varied by geography, program size, population served, and institutional sector (public or private). We included 34 residency programs (all years of training) across 3 specialties (Internal Medicine, Pediatrics and General Surgery) at the 14 sites. In 2015, the CRS was sent electronically to all residents (2,452) in the 14 sites including all PGYs.
in Internal Medicine (IM), General Surgery (GS) and Pediatrics (PEDS). We measured the internal reliability of each of the 13 dimensions of the culture, and evaluated response process, content validity and construct validity by assessing relationships predicted by our conceptual model and prior research. Results were provided to program directors and designated institutional officers in aggregated form only.

Results/Outcomes/Improvements: 1,708 residents completed the survey. Overall response rate was 70%, (IM: 72%, PEDS: 69% and GS: 65%). Of respondents, 879 (51%) were female, and 269 (16%) were members of URMM groups. Cronbach alpha coefficients for each dimension of the culture ranged from 0.79 - 0.89. There were significant differences in dimensions scores across institutions within each specialty (P<0.001). There were also significant differences in dimension scores across specialty within the same institution (P<0.001). Evidence of validity was supported through good response process and the demonstration of several relationships predicted by our conceptual model. As predicted based on our conceptual model and previous research, Vitality scores were highly correlated with Relationships/Inclusion/Trust (r = .57, p<.001), Values Alignment (r = .57, p<.001), and Work-Life Integration (r = .60, p<.001), but negatively correlated with Ethical/Moral Distress (r = -.54, p<.001). The rich dataset showed that residents valued their work, but many responses were of concern, e.g., 50% self-reported burnout; 21% of residents agreed with: “I have been reluctant to express my opinions for fear of negative job consequences” and 32% agreed with: “I often feel the need to hide what I really think.”

Significance/Implications/Relevance: The CRS is a reliable (and to our knowledge, the first of its kind) quantitative assessment of the clinical learning environment and professionalism for residents. The findings within the dimensions of the culture suggest that programs do not optimally facilitate well-being of many residents. Enhancing resident vitality and well-being requires attention to resident relationships and feelings of trust and inclusion, values alignment and work-life integration. The culture of residency programs is important for optimal clinical care, resident well-being and medical education in US AHCs. Results could be used to facilitate and monitor improvements in the learning environment and well-being of residents.

Plans for the Future: C - Change continues analyses of data from the 34 residency programs including: identification of dimensions of the culture and other attributes that predict resident vitality and well-being, and the experiences of resident subpopulations including female residents and residents from URRM groups. C - Change is gathering information from the 34 programs regarding how the survey findings were used in their programs/sites and about implemented change activities to benefit residents. C - Change is an action research initiative and helps develop and implement change activities for faculty and residents at the program sites.

Additional Comments: The Culture of Residency project was made possible by support from the Arnold P. Gold Foundation and matching funders.

Website: http://cchange.brandeis.edu
BUILDING A NATIONAL CONSORTIUM (THE PEDIATRIC RESIDENT BURNOUT-RESILIENCE STUDY CONSORTIUM) TO BETTER UNDERSTAND AND PROMOTE PEDIATRIC RESIDENT WELLNESS

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**Background:** Background: Multiple studies have demonstrated that burnout is associated with poor health, sleep disturbances and impaired job performance in residents and suboptimal outcomes in their patients. Prior studies of burnout in pediatric resident have been limited to single center reports and noteworthy gaps remain in understanding individual and local factors as well as protective factors that could be targeted for future interventions.

**Objectives:** Goal & Objectives: The goal of the Pediatric Resident Burnout-Resilience Study Consortium (PRB-RSC) is to improve pediatric resident resilience, compassion, and confidence in providing calm, compassionate care and wellness. The PRB-RSC objectives: 1) include describing the epidemiology and relationships between burnout, resilience, empathy, and confidence in providing compassionate care in pediatric and medicine-pediatric (P/M-P) residents over time and 2) providing a platform to test interventions that positively impact burnout, resilience, empathy, compassion and wellness in P and M-P and generate evidence that might be useful in addressing similar concerns on all residents and fellows.

**Methods:** Methods: The PRBRC now includes 40 centers with P and M-P programs that provide a representative sample of the over 200 program in the US. 34 programs participated in the initial PRB-RSC study which consisted of an anonymous online survey of their residents in April-May of 2016 via APPD LEARN. The study included individual demographic factors, recent work characteristics and standardized measures of burnout, stress, mindfulness, self-compassion, empathy, sleepiness, and resilience. The second study involved 31 programs from Study 1 and correlated individual resident burnout and other characteristics with performance as measured by ACGME milestones filed on these residents by programs in June 2016.

**Results/Outcomes/Improvements:** Results: The initial results of the PRB-RSC have been gratifying. Study 1 generated an overall response rate of 62% (1693/2723 eligible residents) with 28/34 programs delivering >50% completion rate. For the P and M-P residents, overall rate of burnout was 56% with prevalence of burnout in M-P at 73% in first year decreasing to 49% in fourth year and for P at 59% in first year decreasing to 48% in third year residents. Residents who were burned out reported significant differences in several personal attributes including increased stress and decreased overall mental health, empathy, mindfulness, resilience, self-compassion, and compassion. Study 2 involved 1494 residents at 31 programs and demonstrated that residents with burnout scored lower on all 21 Pediatric Milestones compared with those without burnout with the most impact on first year residents.

**Significance/Implications/Relevance:** Conclusions: A consortium has been successfully developed to serve as a platform to address key issues of burnout and wellness in P and M-P residents. The PRB-RSC has provided a vehicle to show that burnout was common in this nationally representative sample of pediatric residents, was differentially associated with year of training and associated with personal attributes including increased stress and decreased overall mental health, empathy, mindfulness, resilience, self-compassion, and compassion. Burnout significantly impacts resident performance as measured by Milestones. The PRB-RSC is now primed to serve as a platform for design and execution of important interventions to improve the well-being of P and M-P residents.

**Plans for the Future:** Plans for Future: The PRB-RSC is now in the process of analysis of the initial 2 studies to better understand important relationships between burnout, resilience and other factors in P and M-P residents. The impact of these and other factors on performance will also be explored. Plans are underway to repeat the broad study at the
same sites in April-May 2017 to provide a crucial longitudinal assessment of P and M-P residents. Lastly, interventional trials are now being designed using important items as defined by the initial 2 cross-sectional studies and relying on PRB-RSC sites to provide appropriate intervention and control sites. The continued support of APPD LEARN in data collection and analysis is a key feature in the success of the PRB-RSC to date and in the future.

**Website:** http://pedsresilience.com/
APPROACHING WELLNESS - STRATEGIES AND TOOLS INSTITUTIONAL RETREAT FOR GRADUATE MEDICAL EDUCATION

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Background: Leadership for Graduate Medical Education at the University of Texas Health Science Center in San Antonio (UTHSCSA) organized a half day Wellness Retreat for institutional faculty, coordinators and staff involved in the education of resident and fellow learners, with participation by leadership from the San Antonio Uniformed Services Health Education Consortium (SAUSHEC). This retreat included a presentation by the American Foundation for Suicide Prevention (AFSP) on their Interactive Screening Program (ISP) that both institutions plan to implement this fall of 2016. Members of the UTHSCSA Institutional Wellness Subcommittee participated in the creation of the retreat and facilitation of small group sessions.

Objectives: Retreat Participants will be able to: 1. List relevant Statistics for Physician and Resident-Trainee Burnout, Depression and Suicidal Ideation and how they are interconnected 2. Describe the essential role that Behavioral Health providers serve in promoting resilience among trainees, providing coaching and when needed referrals for residents experiencing distress 3. Understand the role and function of the Interactive Screening Program from the AFSP. 4. Participate in Case Studies involving issues of faculty and resident morale, burnout, depression, or suicidal ideation 5. Learn about the use of Mindfulness Practices to help ameliorate the effects of stress, anxiety, burnout and depression

Methods: The retreat made use of multiple learning activities and tools to include Power Point presentations, short video vignettes, an interactive webinar, individual screening inventories for the large group, small group case studies and a luncheon with demonstrations and guided imagery on Mindfulness. All participants were provided with a flash drive with important articles, tools to promote resilience, wellbeing and included presentations.

Results/Outcomes/Improvements: Support was obtained for hiring two Behavioral Health Providers within the Office of Graduate Medical Education from the Dean of the School of Medicine. Purchase and Implementation approved for the AFSP Interactive Screening Program. The program will be administered and managed by the Behavioral Health providers for the screening of trainees within our institution by January 1, 2017. Participation by trainees is voluntary and anonymous. Creation and distribution of a "Wellness Toolbox" to the Program Directors and Coordinators of all GME programs within the Institution to assist them in promoting resilience and wellness of trainees and their faculty mentors. Development of an Action Plan for the institution and affected department in the event of a resident death due to trauma or suicide

Significance/Implications/Relevance: This Wellness Retreat was the fruition of MANY separate initiatives within the Institutional Wellness and Resident Work Life Subcommittee of GME. This subcommittee continues to be the locus for Wellness-based activities for residents, fellows and faculty educators within the institution. The Subcommittee has continued to work within the institution on Faculty Development through its collaboration with the GME Subcommittee on Education, and for the broader faculty, staff and community providers through its association with the Institutional Center for Medical Humanities and Ethics. In addition, we are working in conjunction with our primary hospital partner, University Hospital System through its wellness committee, its Center for Caring and members of the Quality and Patient Safety Department to enhance our clinical learning environment. The subcommittee continues to work closely with our military colleagues at the San Antonio Military Medical Center on joint presentations and programs.

Plans for the Future: The Wellness and Resident Work Life Subcommittee and the Education Subcommittee will be hosting a joint meeting in October to begin to develop onboarding tools for new faculty on teaching techniques and
robust feedback and evaluation of learners. In addition we hope to create and distribute materials to be used by Core Faculty in promoting resilience in their resident learners. We will be working with the Center for Medical Humanities and Ethics to bring a national speaker on Mindfulness from the Center for Mindfulness established by John Kabat-Zinn in Worcester, Massachusetts and potentially establishing an institutional program to promote the ideals of mindfulness in clinical practice. Later this year, we hope to extend some of these concepts and tools to community physicians through a presentation at the Bexar County Medical Society.

Additional Comments: The ACGME Wellness Symposium has been an essential component for the distribution of knowledge, guidance and encouragement for our institutional wellness programs. It is my hope that the ACGME will continue to take a leadership role through the yearly hosting of this symposium, and its collaboration across the House of Medicine on this important area of focus.
THE ROLE OF REFLECTION IN RESIDENCY

Primary Author: Hasan Bazari, MD, Massachusetts General Hospital

Faculty and Staff Involved in Initiative: Dr. Meridale Baggett, Dr. Merranda Logan and Dr. Hasan Bazari, all from the Massachusetts General Hospital, Boston.

Background: The role of reflection in residency and the attenuation of burnout is not known. We know that burnout affects medical student, interns, residents, fellows and faculty and no one is immune to it. Internship has been studied extensively and 20% start the year burnt out and by the end of the year, 80% qualify loosely for burnout and 50% would qualify by stricter criteria. We have burnout data from 2009 and 2011 from our own program and it would be interesting to compare the rates this year with prior rates.

Objectives: To study the rate of burnout among interns in 2016-2017 and compared to 2009 and 2011 cohorts that were trained under a similar circumstances except in 2011 the work hours were identical to the present. The 2011 did slightly better compared to 2009 but the differences did not reach statistical significance.

Methods: The Maslach Burnout Inventory will be administered in May/June 2017 and will be done anonymously.

Results/Outcomes/Improvements: If the results are different there are three substantial changes in the program that could explain the results. 1. The work load is much less than in 2011 and work load is the major stressor for residents. 2. The coaching program is fundamentally different in that all interns in the first week have someone who is their coach and is career wise different form their chosen field. 3. Time for reflection which is implemented in intern year and consolidated in the years two and three. In orientation, there is 2 hour session followed by three 1 hour sessions through the year. In addition there is an intern retreat away from the hospital in which the letters that they wrote to themselves are given back to them. These sessions are repeated in the second and third years.

Significance/Implications/Relevance: If the Maslach Burnout Inventory is representative of what is unique about medical training, the implications are tremendous. It would imply that the one of those three was playing a role perhaps all three. Alternatively factors other than the mentioned ones could play a role. The next stage could be a dissection of the factors that are inherent in medicine that make it hard and yet rewarding.

Plans for the Future: The Maslach Burnout Inventory (MBI) is a useful scale and has the advantage of having been administered before in 2009 and 2011. The results are hard to predict and easy to speculate on. We will await the measurements of 2017 before reaching a conclusion.

Website: http://www.massgeneral.org/medicine/swartz-initiative.aspx
ASSESSING WORKPLACE CULTURE AND IDENTIFYING TARGETS FOR CREATING A POSITIVE LEARNING CLIMATE

Primary Author: Pedro Tanaka, MD, PhD, MACM, Stanford University School of Medicine

Faculty and Staff Involved in Initiative: Natalya Hasan-Hill, MD, Stanford University School of Medicine, Alex Macario, MD MBA, Stanford University School of Medicine

Background: The health of our society depends on quality care delivered by engaged providers who can work together in an increasingly complex and technologically-driven environment. However, our providers are suffering from physical, mental, and emotional exhaustion. Burnout rates are startlingly high, especially in the next generation. 40-80% of anesthesiology residents report current burnout, which is potentially undermining their professional development, placing patients at risk, and contributing to personal consequences, including broken relationships, depression, anxiety, and even suicidal ideation. Historically, burnout prevention and treatment has focused on individual attributes. Our residency program has a robust wellness program that provides mindfulness-based stress reduction training and peer support networks. However, broadening our approach and analyzing the culture, learning and work environments in which we are nurturing the next generation of anesthesiologists is necessary to fully understand the nature of the problem and arrive at effective solutions.

Objectives: The purpose of this study is to assess the experiences and behaviors of the interdisciplinary OR team, comprised of people with different social, cultural, educational, and professional backgrounds. Eliciting both quantitative and qualitative data about how these factors might contribute to the MOR culture will help to target areas for intervention to create a more positive learning climate.

Methods: Project Description This project utilized a comprehensive survey to identify organizational, workplace (including negative acts such as bullying), and personal behaviors and experiences that contribute to provider engagement and the learning climate of the primary operating room area at a large academic medical center where anesthesiology residents spend up to half of their training experience.

Results/Outcomes/Improvements: Findings 236 of operating staff completed the survey, with a 50-60% response rate across anesthesiology and surgical residents and attendings, nurses, and scrub techs. Anesthesiology residents reported alarmingly low rates of belongingness (28%), satisfaction with conflict resolution (29%), and overall satisfaction with work environment (47%). They reported high rates of work-related stress (51%), negative emotional/mental health (49%), and negative physical health (83%). In comparison, surgical residents reported markedly higher rates of belongingness (56%), satisfaction with conflict resolution (55%), and overall satisfaction with work environment (68%). They reported significantly lower rates of work-related stress (40%) and negative emotional/mental health (27%). Negative acts, including bullying and disrespectful behaviors, were reported by all groups, though especially by surgical and anesthesia residents. In each category, anesthesia residents noted increased frequency and had lowest rates of formal reporting or confrontation. Qualitative analyses still being processed.

Significance/Implications/Relevance: Discussion Our survey results underscore factors in the environment that are contributing to resident disengagement and dissatisfaction. Building a positive learning climate based on respect, humility, enthusiasm and support requires that educators understand factors that are detracting from this ideal. This presentation will include details regarding instrument, further survey findings, and potential solutions, including novel approaches to conflict management based on compassion research and formal training of all operating members in establishing a positive learning climate.
SOCIAL SUPPORT NETWORK OUTREACH: A NO-COST INTERVENTION TO IMPROVE RESIDENT WELL-BEING

Primary Author: Benjamin Kennedy, MD, Children’s Hospital of Philadelphia

Faculty and Staff Involved in Initiative: Benjamin C Kennedy, MD, The Children’s Hospital of Philadelphia; Mimi Levine, MD, New York Presbyterian Hospital; Lalita A Abhyankar, MD, New York Presbyterian Hospital; Matthew Goldman, MD, New York Presbyterian Hospital; Lyuba Y Konopasek, MD, New York Presbyterian Hospital

Background: Physician well-being has received an increasing amount of attention, largely as the field is coming to appreciate the great toll that burnout, depression, and suicide are taking on medical trainees. Due to the time commitment of training, residents are seen most by their colleagues, and sometimes seldom seen by their preexisting social supports. There has been an effort to encourage doctors to take care of one another, and although this is certainly worthwhile, a resident’s colleagues may not be the group best equipped to prevent, assess, and intervene on that resident’s signs of burnout or depression. Each resident’s preexisting social support network (family, friends, significant other) knows the resident better, is more motivated to assist that particular resident, and may encounter fewer barriers to intervention than the resident’s colleagues. Most members of the general public are not well versed in the epidemic of burnout, depression, and suicide in residency, and it is easy to imagine a resident’s social supports assuming that the depressed resident’s isolation, for example, is simply a normal consequence of the consuming nature of medical training. It would therefore be advantageous for the preexisting social support network of each resident to be educated about the stress, burnout, and depression that can be associated with residency to improve communication and emotional support, and to reduce barriers to intervention.

Objectives: 1. To educate residents and their preexisting social support network about the stresses of residency and the association of burnout and depression with residency. 2. To improve communication and support among residents and their loved ones, and to reduce barriers to members of the support network asking about stress, burnout, or depression. This would hopefully lead to less progression of these conditions. 3. To educate residents and their loved ones about available resources for mental health care and healthy habits. 4. To demonstrate to residents and their loved ones that their colleagues at their institution care about their well-being.

Methods: The Resident Forum (RF) at our institution, led by the Designated Institutional Official, is a group of residents that facilitates collaboration among residents and fellows within and across specialties and advocates for improvement in education and trainee well-being. Inspired by the first ACGME Symposium on Physician Well-Being, and with the rationale delineated in the Introduction above, the RF undertook the writing of a communication directed at the social support networks of residents. The RF deliberated on several topics about how best to reach out to these loved ones of residents. Regarding these topics, members of the RF felt there is merit to both or several answers to the following questions, and for this reason, the questions are enumerated below. Which of the following terms should be included: Stress, Burnout, Depression, Suicide? From whom should the communication be sent (resident or institution)? Should it be mailed or emailed? Should it be sent only to interns or to everybody? Should it be sent multiple times throughout the year? Should it include the phone numbers to the emergency hotlines and mental health services? Should there be a link to an institutional website? Should tips on healthy habits be included? The RF and our institution’s GME Committee deliberated on these topics and developed a consensus communication.

Results/Outcomes/Improvements: Nuances of the questions raised in the Methods section above will be discussed, and the final communication will be presented. Briefly, the after the concept was introduced to new residents during orientation, an email was sent to all residents reiterating the initiative and providing several links to articles and videos about physician well-being and burnout. This email included the text of the communication to the social supports, to be forwarded by each resident to his or her support network. It included the terms stress, burnout, and depression, but not suicide. It did not include direct links to institutional websites or phone numbers to mental health services, but indicated that those are available to each resident. Tips on healthy habits were also included.
Significance/Implications/Relevance: Though the epidemics of physician burnout, depression, and suicide have received much attention, and many implemented interventions have been directed at healthcare workers within hospital systems, this is the first report to our knowledge of an intervention designed to systematically utilize, at an institutional level, the vast and powerful resource of the residents’ own family and friends to attempt to improve resident well-being.

Plans for the Future: Analysis, enhancement, and dissemination of this initiative have already begun. Analyses will include proportion of residents who sent the communication, how many supports each resident used, and what types of relationships composed each resident’s support network. Analyses will also include subjective surveys of whether residents thought the email may have had an impact, conversations it may have triggered with loved ones, and how the email made them feel about the topics of physician well-being, burnout, and their institution’s interest in these topics. Enhancements may occur after analyses, attempts to improve rate of use, or due to more planning time and further discussion prior to the next academic year. Dissemination is planned to occur at other institutions where members of the forum have gone on to practice, through the ACGME, by presentation at the Second ACGME Symposium on Physician Well-Being, and by publication in the GME literature.
THE AMERICAN ACADEMY OF PEDIATRICS (AAP) RESILIENCE IN THE FACE OF GRIEF AND LOSS CURRICULUM

**Primary Author:** Janet Serwint, MD, Johns Hopkins University School of Medicine

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**Background:** While a career in pediatrics can bring great joy and satisfaction, it can also be challenging and lead to burnout and potential depression. Resilience and adaptive skills can help pediatric providers transform times of anxiety and grief into rewarding professional experiences.

**Objectives:** The development of a resilience curriculum that addresses the professional attitudes, knowledge and skills needed to thrive despite the many stressors inevitable in clinical care.

**Methods:** The need for resilience training was voiced by the AAP Section on Medical Students, Residents and Fellows. A working group of educators from institutions across the country used current literature, best practice guidelines, personal experiences and adult learning principles to create the curriculum. After undergoing vigorous peer review, the curriculum was published by the AAP and housed on the AAP website.

**Results/Outcomes/Improvements:** The curriculum is relevant to pediatric practitioners across the educational continuum and can be completed individually or facilitated in small or large groups. Each of the 14 modules includes a facilitator’s guide, a PowerPoint presentation, an annotated bibliography and a toolbox with cases, videos, interactive exercise and narratives to allow reflection, discussion and development of skills through practice and coaching. Cases are based on common professional and life experiences and provide the specificity and context that adult learners seek. The case-based approach makes the curriculum particularly relevant to practice and allows learners to use past experiences to better understand various conceptual frameworks. The modular structure allows learners to progress sequentially through the curriculum or choose portions most relevant to their personal needs. The first portions of the curriculum address the knowledge and skills needed to approach disclosure of life altering diagnoses and spiritual humility when talking with families and patients of different ages. The second portion focuses on the provider’s responses to difficult patient care experiences and strategies needed to maintain their own well-being both in the moment and long term.

**Significance/Implications/Relevance:** The AAP Resilience curriculum merges the intellectual and emotional aspects of patient care. It addresses the knowledge, attitudes and skills required to provide high quality of care under challenging circumstances and offers active and intentional ways to maintain personal wellness and resilience.

**Plans for the Future:** The AAP Resilience Curriculum is one intervention that will be implemented and studied through the APPD-LEARN study, “Defining key factors in burnout and resilience in pediatric residents and the relationship to performance”. This Consortium is currently collecting baseline data from over 1000 pediatric and medicine-pediatric residents with planned outcome measures of personal health, perceived stress, compassion, burnout, resilience, spirituality and career satisfaction.
THE COLLABORATIVE FOR HEALTH AND RENEWAL IN MEDICINE (CHARM): A NATIONAL COLLABORATIVE TO PROMOTE RESIDENT AND STUDENT WELL-BEING

Primary Author: Jonathan Ripp, MD, MPH, Icahn School of Medicine at Mount Sinai

Faculty and Staff Involved in Initiative: Jonathan Ripp, MD, MPH, Icahn School of Medicine at Mount Sinai (Co-Founder/Co-Chair); Hasan Bazari, MD, Massachusetts General Hospital (Co-Founder/Co-Chair); Mukta Panda, MD (Chair, CHARM Faculty Development Subgroup)

Background: Job burnout is highly prevalent in graduate medical trainees. Numerous demands and stressors drive the development of burnout in this population leading to significant and potentially tragic consequences, not only to the trainee, but also the patients for whom they provide care. The Collaborative for Healing and Renewal in Medicine (CHARM) is a group of medical educators, leaders at academic medical centers and experts in burnout research and interventions designed to promote trainee wellness, recently formed with the support of the Alliance for Academic Internal Medicine (AAIM). CHARM’s mission is to gather best practices, promote investigation of the impact of trainee burnout, develop tools for educators to address trainees in distress and advocate for the recognition and inclusion of initiatives that foster well-being among trainees within graduate level training programs. Working collaboratively with other professional organizations and accrediting bodies, CHARM hopes to promote a culture of graduate medical education that accounts for the impact of training on the trainee and helps to sustain physicians over a full career.

Objectives: • Establish a database of “Best Practices” • Disseminate Best Practices Modules for Faculty Development • Promote Research Investigation and Dissemination of Best Practices in Well-Being Research Methodology • Advocate for the recognition and inclusion of resident and student well-being initiatives in medical schools and residency programs

Methods: • Establishing a database of Best Practices – CHARM members in the Best Practices subgroup are in the midst of compiling an annotated bibliography, including citations from the published as well as the grey literature, with the intent of identifying an "open access platform" to make these references available to all who find them useful in promoting trainee/learner well-being. This database will serve as an updated and comprehensive listing of the approaches that target job burnout in resident trainees. • Disseminating Best Practices Modules for Faculty Development – One of CHARM’s primary goals will be to serve as an expert panel that releases recommendations for best practices (a “toolbox”) in the area of student and resident physician well-being and burnout prevention. This will include published documents, dissemination at the professional society level (e.g. symposia, precourses, etc.), and the generation of "open access" modules to aid in the increased establishment of well-being programs for trainees and students. • Research Investigation and Dissemination of Best Practices in Well-Being Research Methodology – CHARM members will develop and disseminate a perspective on Best Practices in Well-Being Research Methodology. The Research subgroup will also propose the creation of a multi-center research platform to study the impact of interventions aimed at decreasing resident burnout. • Advocate for the recognition and inclusion of resident well-being initiatives – CHARM will work to develop partnerships with professional organizations and develop dialogues with accrediting bodies in order to advocate for the inclusion of well-being initiatives into residency program and medical student curricula, ultimately driving “culture change” at the institutional and national level.

Results/Outcomes/Improvements: CHARM formed officially in January 2016 and established an initial set of deliverables organized according to its subgroup structure as follows: • Advocacy/Dissemination Subgroup: Publication of a Consensus Statement. Currently this manuscript is under review with anticipated publication in early 2017. • Best Practices Subgroup: a detailed repository of (EBM) best practices that address resident well-being, promotes health and wellness in the form of an Annotated bibliography for Program Directors, Associate Program Directors and other faculty interested in Trainee Wellness. This annotated bibliography is presently in draft form, the contents of which will be presented at a 2017 Society of General Internal Medicine Annual Conference special symposium. • Faculty Development/Tool Kit Subgroup: Multiple modules have been proposed to address the following topics:
How to manage "residents in distress"?

How to identify burnout/problem residents?

The first module was presented in workshop form at the October 2016 Association of Program Directors in Internal Medicine Skills Development Conference.

Research Subgroup: Initial Plan for a multi-center inter-institutional resident well-being and distress research platform including proposal for an initial study and exploration of potential grant support. This initial goal has been placed on hold, while the group has been focusing and is in the midst of developing a manuscript that addresses Best Practices in Well-Being Research Methodology. This manuscript is expected to be ready of submission for publication by the end of 2016.

**Significance/Implications/Relevance:** In CHARM's inaugural year, the group has grown to include over 50 leaders in medical education with the combined goal of driving the discussion and disseminating the evidence-based tools to address resident and learner well-being. The group's members have or will have presented their work at 4 different professional societies, will hopefully have 2 manuscripts published and the drafts of several toolkit modules completed. CHARM has also successfully partnered with like-minded groups within the American Medical Association, the American College of Physicians, the Arnold Gold Foundation and the Alliance for Academic Internal Medicine (AAIM).

**Plans for the Future:** CHARM hopes to increase its deliverables, share its products through the identification of an appropriate "open-access" platform, establish the beginning of a research platform and share its collective knowledge with the ultimate goal of improving the work lives of our medical students and trainees.

**Website:** [http://www.im.org/p/cm/lfd/fid=1403](http://www.im.org/p/cm/lfd/fid=1403)
A STRATEGIC FRAMEWORK FOR A GME INSTITUTIONAL WELLNESS PROGRAM

Primary Author: Woodson Jones, M.D., San Antonio Uniformed Services Health Education Consortium

Faculty and Staff Involved in Initiative: Christopher J. Nagy, MD, San Antonio Uniformed Services Health Education Consortium (SAUSHEC), San Antonio, TX. John C. Hunninghake, MD, SAUSHEC Justin G. Peacock, MD, SAUSHEC Donna G. Schwabe, PhD, Brooke Army Medical Center  Woodson S. Jones, MD, SAUSHEC

Background: In 2014, the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) suffered an intern death by suicide. The impact of this tragic event led to a number of remarkable grass root initiatives on the part of faculty, residents and programs to address physician well-being. The SAUSHEC Executive Committee determined the need for Subcommittee of the Graduate Medical Education Committee (GMEC) in Physician Wellness to develop a strategic approach to ensure efficiency and effectiveness of effort in addressing issues surrounding physician well-being. One of the first orders of business for the SAUSHEC Physician Wellness Subcommittee was to establish a charter, which included a strategic plan for improving physician well-being in the clinical learning environment.

Objectives: Mission: Strategic, operational and tactical planning for the Graduate Medical Education Committee in its campaign to prevent burnout and improve physician wellness at SAUSHEC. Objective 1: Improve AWARENESS through education and assessment Objective 2: Provide ASSISTANCE to our physicians through prevention and intervention Objective 3: ADVANCEMENT of knowledge through research and quality improvement

Methods: The SAUSHEC Physician Wellness Subcommittee (PWS) developed operational and tactical strategies for meeting the objectives as well as prioritization of the strategies after meeting with key stakeholders. The following represents the operational and tactical approaches to meeting the desired objectives. Objective 1: Improve AWARENESS through education and assessment Operation 1.1: EDUCATE our physicians on burnout and elements of wellness Tactic 1.1.1: Annual SAUSHEC suicide prevention orientation for new trainees Tactic 1.1.2: House Staff Council (HSC)-sponsored quarterly speakers Tactic 1.1.3: Implementation of a Wellness curriculum (institutional and/or program-level) Operation 1.2: ASSESS our culture of wellness & identify “at-risk” physicians Tactic 1.2.1: Initiate suicide risk factor screening Tactic 1.2.2: Implement institution-wide assessment of burnout using a validated assessment tool Tactic 1.2.3: Assess the institution’s overall climate through an assessment survey Objective 2: Provide ASSISTANCE to our physicians through prevention and intervention Operation 2.1: Offer INTERVENTION to “at-risk” physicians and those having difficulty Tactic 2.1.1: Support and advertise a wellness-based behavioral health service for residents and physicians (i.e., The GME Harnessing Adaptive Resident Behavior for Occupational Resilience (HARBOR Program). Tactic 2.1.2: Institution screening program for physicians w/ suicide risk factors Tactic 2.1.3: Ensure identification of and aide offered to providers involved in significant adverse patient safety events (i.e. Healthcare Resolutions Program) Tactic 2.1.4: Use of SAUSHEC to elevate major systems-based issues that negatively impact physician well-being to health system and participating sites’ leadership Operation 2.2: Promote/encourage burnout PREVENTION Tactic 2.2.1: Institutional efforts (i.e., curriculum, partnership with University of Texas Health Science Center Wellness Subcommittee) Tactic 2.2.2: Program efforts (i.e., wellness retreats, mentorship, wellness champions) Tactic 2.2.3: Individual efforts (i.e., sleep, exercise, prayer/meditation) Objective 3: ADVANCEMENT of knowledge through research and quality improvement Operation 3.1: Conduct RESEARCH regarding burnout and physician wellness Tactic 3.1.1: Design protocols Tactic 3.1.2: Collect data Tactic 3.1.3: Publish/present findings Operation 3.2: Study impact of wellness on health-system QUALITY Tactic 3.2.1: Establish measurable/actionable quality indicators Tactic 3.2.2: Collect outcomes data based on burnout and physician wellness

Results/Outcomes/Improvements: The Physician Wellness Subcommittee (PWS) outlined objectives and strategies. This brought enhanced communication, prioritization and coordination between the various individuals, programs and organizations engaged in physician well-being. The strategic plan prioritized SAUSHEC’s approach to address this complex issue. For instance, the PWS initially prioritized the assessment and intervention for depression and “at-risk” residents (Operation 1.2, Tactic 1.2.1 & Operation 2.1, Tactic 2.1.1, 2.1.2) rather than assessment and prevention of
burnout. This was important because the institutional resources of time, money, personnel and effort were needed to implement the Interactive Screening Program (ISP) from the American Foundation For Suicide Prevention, sustain the HARBOR program from potential external threats and launch the “Let’s Talk About It: Physician Depression and Suicide” video and small group sessions. The House Staff Council (HSC) gained greater institutional exposure, support, coordination and advertisement for the quarterly wellness talks. These now have been elevated to prime time during institutional Grand Rounds slots. In coordination with the PWS, the HSC is planning a “Wellness/Resiliency Annual Conference Day” in the Spring of 2017. The roll-out plan for the “Let’s Talk About It” sessions was vetted through the PWS as one of its primary SMART plans for this academic year. The PWS then presented the plan to the GMEC and gained approval for systematic presentation of the sessions to all of the training programs with anticipated completion by early 2017. The “Let’s Talk About It” initiative (Advancement Objective 3), as a GMEC-endorsed SMART QI initiative, gained the Assistant Dean for Research’s and DIO’s support for an expedited review by the Institutional Review Board. Further, faculty and HSC members have gained financial support to present initiatives outside our institution. HSC leaders have presented some of the efforts to the leadership of the National American College of Physicians Resident and Fellow Members, which resulted in the development of a specific presentation at the their next national meeting that highlights the “Let’s Talk About It” initiative.

**Significance/Implications/Relevance:** The SAUSHEC PWS strategic framework for an institutional level physician and resident well-being program can be readily adapted by other institutions. The framework of awareness, assistance and advancement gives structure without reducing flexibility, depending upon the identified needs and resources available at the institution level. The structure also allows for prioritization and a coordinated approach to improving wellness across the clinical learning environment.

**Plans for the Future:** As identified objectives are met and become codified in our operational practices, the PWS will implement the tactics outlined in the strategic plan (i.e., Tactics 1.2.2, 1.2.3). In the third year the focus will move toward Operation 3.2.
SHARING PERSPECTIVES ACROSS A STATE: WORKSHOP DISCUSSION COMBATING BURNOUT AND PROMOTING PHYSICIAN WELL-BEING TO PROMOTE A HEALTHY LEARNING ENVIRONMENT IN GME

Primary Author: David Kountz, MD MBA, Jersey Shore University Medical Center (on behalf of the New Jersey Council of Teaching Hospitals)

Faculty and Staff Involved in Initiative: Lyuba Konopasek, MD, New York Presbyterian Medical Center; David Kountz, MD, Jersey Shore University Medical Center; Deborah Briggs, RN, New Jersey Council of Teaching Hospitals

Background: The Academic Affairs Council (AAC) of the New Jersey Council of Teaching Hospitals consists of DIOs, Directors of Medical Education and Program Directors from among the 76 teaching hospitals in New Jersey. The group meets quarterly in a central location to discuss common challenges facing member organizations to share perspectives and learn best practices. Some discussions are led are by members, others by guest presenters. Given the importance of physician well-being, this was chosen as the topic for the July 2016 meeting. Lyuba Konopasek, MD, DIO at New York Presbyterian, led the discussion.

Objectives: The objectives of the presentation were provided by Dr. Konopasek in advance. They were: 1. To Identify key factors contributing to resident stress, burnout, well-being, and resilience 2. Differentiate between burnout and depression 3. Describe resources and interventions 4. Discuss the development of a well-being plan in your institution

Methods: The session lasted for approximately two hours and included a mix of didactics and discussion. Dr. Konopasek provided background information on the definition of burnout; contributing factors to burnout among residents and physicians; depression in internship; learning environment stressors, and resilience strategies utilized by experienced physicians. Throughout the presentation the group spent time in small groups discussing their own perspectives on these issues and creating a program well-being plan; for example, Balint/process groups. Each attendee was asked to share what he/she did to maintain resilience.

Results/Outcomes/Improvements: The program was approved for Category I CME and all attendees evaluated the program as good or excellent. The interactive nature of the program was especially well received, as was hearing from an individual with significant credibility in the field. Sharing perspectives from colleagues from across the state was also viewed favorably; PDs and DIOs realized that they were "not alone" in their anxiety regarding how to conduct a workplace assessment and help raise the visibility of this issue in their own institutions.

Significance/Implications/Relevance: Discussion of burnout, depression, and physician suicide can be uncomfortable, particularly in a small institution. Sharing perspectives with colleagues outside of the walls of the hospital is a particularly useful strategy for a topic such as this, and is something that can be replicated in other settings.

Plans for the Future: The AAC will continue to discuss "lessons learned" regarding burnout at future meetings, as well as initiatives undertaken by various members after Dr. Konopasek's presentation.
A. PROJECT 1: PROMOTING A CULTURE OF TRAINEE WELL-BEING: THE CREATION OF SAFE AND TRUSTWORTHY SPACES FOR OURSELVES, OUR LEARNERS AND OUR COLLEAGUES

B. PROJECT 2: PROMOTING THE “R” IN RVU-RELATIONSHIP VALUED UNIT ENHANCING HEALTH CARE PROVIDER ENGAGEMENT

Primary Author: Mukta Panda, MD FACP, University of Tennessee, College of Medicine Chattanooga

Faculty and Staff Involved in Initiative: Project 1: Department of medicine residents, students, Chief resident and program Leadership. Project 2: Dr M Panda (Lead), Dr Jan Keys and Dr W Jackson (CNO and CMO EHS); Dr R Fore (Dean UTCOMC), Dr R Qayyum (Medical and Research Director);Dr Campbell (Associate Dean UTCOMC); Dr Lambiase (Chair Medicine). These are the main committee members. addition we have a subgroup with representative leaders from each department.

Background: Project1: Learners enter training with altruism and commitment to patient care; yet studies show a high proportion of first-year residents suffer burnout. There is growing enthusiasm among medical educators to formalize and emphasize training in resiliency to decrease burnout. The training environment often does not allow residents to optimally reflect on their experiences, one suggested component of resiliency building. Physicians engaged in self-awareness demonstrate lower burnout and compassion fatigue and more frequently engage in relationships with "exquisite empathy." As leaders and educators in medicine, we are asked to guide our learners with courage, resilience and wisdom, and create an environment in which we ourselves and our learners’ are able to retain their commitment while also openly expressing their concerns, honor our own experiences and not lose sight of the core values that brought us to medicine. Project 2: Implementing strategies to improve provider wellness can help the organization save money, improve the quality of care provided to patients, improve morale and maintain satisfied providers.

Objectives: Project 1. We conduct the Rejoicing, Rejuvenating & Relaxing in Residency (RRRinR) program which promotes creation of a trustworthy space allowing attendees the opportunity to be authentic and reflective. Sessions provide an encouraging environment to share information with other residents, faculty and healthcare workers from diverse backgrounds. Specifically we - discuss an approach to the creation of a safe and trustworthy space which allows authentic work experiences, the formation of trusting relationships, a trustworthy community and a culture of transformation. - Provide and demonstrate self-awareness tools to promote reflection and enhance resilience and well-being. - Highlight and list strategies to promote awareness of safe and treasured space within the daily hustle and bustle which nurtures the spirit and is a sanctuary. Project2: Wellness efforts can save money by retaining providers. High turnover is costly—$250,000 per provider—and stressful for the providers that stay.1 • Providers who practice in happier, less stressed environments also provide better quality care. They tend to make fewer medical errors and are more engaged in their work than stressed out providers.2 • A sincere commitment to addressing wellness needs can foster trust between administrators and providers. Your demonstration of genuine concern for the wellbeing of our providers will help support collaborative partnerships that can facilitate problem solving in times of conflict, crisis or change. • Promoting provider wellness is gaining more and more attention from diverse audiences around the country. Developing well-tested, innovative provider wellness programs and tools can position you and your organization as leaders in this area, improve recruitment and retention and enable you to serve as a positive example to other organizations.

Methods: Project 1:The Circle of Trust® approach is used to promote an encouraging environment for personal sharing of information among learners, faculty, leaders and healthcare providers (HCP) from different backgrounds. This is distinguished by principles and practices intended to create a process of shared exploration where people can find a safe space to nurture personal and professional integrity and the courage to act on it. Participants comprehend the importance of reflection in their own ability to deal with multiple demands of professional life and empathize with the needs of colleagues. One of the practices of the Circle of Trust approach is a “third thing”: something that can be focused on together. We often use poems, wisdom stories, or music as a doorway into reflection on a question of
importance. In it are several invitations to reflect and to facilitate the creation of a disciplined yet nurturing space for taking an inner journey in community. Project 2: Our strategy involves interventions at the individual, departmental and institutional level as outlined below. Individual: Baseline survey of burnout and resiliency and physician engagement - Develop a menu of resiliency practices: • task oriented coping focus • mindfulness • self-care Department: Baseline survey of burnout and resiliency and physician engagement - • work containment • effort-recovery model boundaries • develop support structure Promote Personal Accomplishment • providing safe, quality, and accountable patient care • valuing role modeling Prevent Depersonalization and Emotional Exhaustion • educating and advocating for patients • prioritizing self-care Organization: Baseline survey of burnout and resiliency and physician engagement - • Focus on patient satisfaction quality, safety and mission • Shared Value alignment with all constituents, stakeholders and leaders • Make self-care a part of medical professionalism • Quarterly half day Health Institute sessions • Affirmations Steps to prevent burnout 1. Establish wellness as a quality indicator for organization 2. Start a wellness committee with wellness champions (Academic, Clinical, Institutional) 3. Annual wellness survey monitoring 4. Meet regularly with leaders and/or staff to discuss data and interventions to promote wellness 5. Initiate the selected interventions at each level 6. Repeat the survey within the year to re-evaluate wellness 7. Seek answers within the data, refine the interventions and continue to make improvements (adapted from AMA)

Results/Outcomes/Improvements: Project 1. Cranley NM, Cunningham CJ, Panda M. Understanding time use, stress and recovery practices among early career physicians: an exploratory study. Psychol Health Med. 2015 Jul Summary: Among residents who attended at least one RRRRS (N = 40), the number of RRRRS attendances was significantly and negatively related to: Perceived pressure-related stress (r = -.42, p < .01) General fatigue (r = -.36, p < .05) Burnout component of exhaustion (r = -.33, p < .05) Both pressure- and threat-stress are significantly associated with recovery needs, fatigue, and burnout Threat-stress is worse, also being negatively associated with general health (r = -.20, p < .05) Active coping is significantly negatively associated with most indicators of strain, while avoidance coping is positively associated with all forms of strain We need to do a better job of strengthening active coping skills among residents. Project 2: Just completed the Baseline survey of burnout and resiliency and physician engagement and have a 34% response rate. The data are being analysed and will be classified by level of training, status, speciality, demographics etc. We will share the data with the committee and departmental champions and facilitate interventions at each level based on data and evidence.

Significance/Implications/Relevance: With these projects we hope to transform the culture that helps health care providers and organizations to • Strengthen resilience and well-being with new tools that help you to reflect and act upon what matters most. • Create trustworthy relationships that lead to improved collaboration and effectiveness and help you feel more capable of dealing with difficult problems. • Use new approaches to listening and asking questions so that you can be more present with yourself, your patients and your colleagues. • Learn to manage the complexities and tensions between your work and the health care system without being overwhelmed by them. Our hope is for an improved system of health care that promotes developing authentic, compassionate and respectful healers, educators and leaders who can create alignment and a shared sense of purpose in the organization.

Plans for the Future: Continue to review the results and methods and build on the efforts. Through involvement in AAIM, ACGME, AMA, CHARM-continue to work at a state and national level collaboratively.
CREATING A WELL ENVIRONMENT FOR TRAINING PHYSICIANS AT UTHSCSA VIA A TOOLKIT FOR PROGRAM COORDINATORS

Primary Author: Beth Payne, MAEd, C-TAGME, LSSBB, The University of Texas HSC at San Antonio

Faculty and Staff Involved in Initiative: Director Academic Programs, Manager Academic Programs, Dean of Student Admissions

Background: The ever increasing loss of physicians due to death by suicide is now at the forefront of many universities and hospitals as they face this previously quiet topic. The two areas of concern for all physicians, but especially those in training, are depression and burnout. The Program Coordinator is often the first responder to identifying a change in behavior or possibly even the receiver of help seeking information from the trainee that could help identify and stop bad outcomes. Therefore, it is imperative that the Coordinator have the training and tools to properly assist the trainee, the program leadership and the program in creating an environment of wellness and at the same time become prepared to handle possible crisis related issues as they arise. Target Audience and Sponsors: Program Coordinators and Administrators for UME, GME and assistance staff

Objectives: The overall objectives are to create a toolkit for PC’s throughout the country to use in times of need when approached by a wellness concern. Alongside the toolkit will be a literature based training packet on identifying issues, dealing with difficult situations, and appropriate steps to take in resolving any wellness issues that may arise in the training program.

Methods: *Gain IRB approval for survey distribution and interview dialogues. Initial Needs Assessment: Send a survey to all Texas based Program Coordinators as well as the national list serve for Pediatric PC’s to collect personal experience stories, gain an understanding of generalized steps to follow in the event of an “unwell” moment and generate interest in participation in our pilot program. Data Collection: Conduct a literature review of all available sources on the topic of wellness, burnout and depression in both inside and outside of medicine. Once literature review is complete then begin to review the needs assessment. Interviews: Once the survey information is analyzed and the literature review is complete in support of that data then interviews will be held with voluntary participants to gain insight into how to create a positive wellness culture here at UTHSCSA specifically. These interviews will encompass all levels of leadership as change must occur from the top down as well as the bottom up. The main questions asked during these open ended qualitative interviews will be: What can WE do to help our trainees? What actions have a positive effect on my well-being? What actions have a negative effect on my well-being? What are some items we could focus on to improve the current climate of wellness? Give characteristics of burnout and ask PC’s – are YOU burned out? Reprogramming in bulk is ineffective therefore we will not use basic modules to change a culture. Online modules ARE NOT “wellness” therefore we would like to embed our information into daily activities and curriculum. By using a literature based packet with links to videos, readings and activities PC’s throughout the country will be able to implement a basic program of wellness in their institutions. One specific tool we are creating will allow for wellness review during the bi-annual CCC meetings as an early identifying tool. With a positive culture shift we should be able to create resilience plans to avoid burnout.

Results/Outcomes/Improvements: Expected to launch Winter 2016 with a project pilot ready to implement by Spring 2017

Significance/Implications/Relevance: The significance of creating and offering a wellness packet to PC’s speaks to the dedication of our profession to ensuring the current and next generation of trainees are prepared to deal with the stress of the medical world. Given the increased loss of life due to death by suicide the relevance of this packet is in and of itself a pivotal tool that can, if promoted, lead to a national understanding of trainee, faculty and staff mental health and wellness needs.

Plans for the Future: By winter 2017 our team hopes to complete a scholarly poster showing program improvement as well as a workshop on implementation of these tools using role play and TBL on teaching wellness techniques.
EMERGENCY MEDICINE WELLNESS WEEK; A PROFESSIONAL SOCIETY PROMOTES WELLNESS

Primary Author: Sandra Schneider, MD, American College of Emergency Physicians

Faculty and Staff Involved in Initiative: Jay Kaplan, M.D., FACEP Immediate Past-President, ACEP Vice Chair, Emergency Services, Ochsner Health System, New Orleans, LA  Kathleen J. Clem, MD, FACEP Chief Medical Officer Vice President Florida Hospital East Orlando  Julia M. Huber, MD, FACEP Attending Physician Harrison Memorial Hospital Emergency Department Chair, Well-Being Committee, 2016-2017  Rita A. Manfredi, MD, FACEP Associate Professor of Clinical Emergency Medicine Department of Emergency Medicine The George Washington University  Arlene S. Chung, MD, MACM Assistant Program Director Mount Sinai Emergency Medicine Residency  Sandra M Schneider MD FACEP Associate Executive Director, American College of Emergency Physicians Professor, Emergency Medicine Hofstra Northwell School of Medicine

Background: Emergency Medicine has one of the highest reported rates of burnout of all of the medical specialties, with some recent studies citing rates as high as 55%. While The American College of Emergency Physicians has long promoted wellness through our Well-being Committee and Wellness Section, it was clear to us that more could be done.

Objectives: We introduced a Wellness Week for emergency medicine providers to focus on the need to improve our well-being and resilience. We hoped that through an organized activity, we could reach our members with information about their own health and wellness.

Methods: The American College of Emergency Physicians, recognizing the importance of wellness in our profession, organized the first annual Emergency Medicine Wellness Week, which took place from January 24 to January 30, 2016. Members of our College along with our State Chapters were invited to participate. In addition, invitations were sent our international emergency medicine organizations. Wellness Week had three major themes – physical care of self, connections with friends and family, and career enhancement. A website was created and contained a pledge card that could be downloaded with ideas which included combatting burnout and augmenting resiliency. Individuals could sign up for 5 daily emails, each of which contained 2 ideas to enhance their own well-being. Videos were created by our members depicting their own well-being message. We also engaged social media with tweets and blogs to help promote the message.

Results/Outcomes/Improvements: Our webpage had 3710 unique views with 43% of the viewers signing up for the daily emails. 35% emailed the page or link to a friend. This page was the most viewed page during the week. Daily email messages were sent to 452 participants on the first day. By the end of the week this had climbed to 572 participants, with about 25% going to non-members. The rate of opened emails was about 50% per day. Tweets earned 2700 impressions over the month with a high of 400 in one day during the week. Our activities were mentioned in our own publications, AMA Wire, Forbes Magazine, the newsletters of 10 of our state chapters, several publications of the Emergency Medicine Resident Association, on the website of several health care systems, several blogs (AKOSMED, ALIEM), and one private business (BodyFit). The Emergency Medicine Association of Turkey created a website and celebrated the week with us.

Significance/Implications/Relevance: Physicians, in general, often neglect their own personal well-being. Emergency physicians, faced with shift work and a high stress environment, have a high rate of burnout. It is the duty of the professional societies to provide their membership with information that will help build resiliency. The American College of Emergency Physicians has created many resources, but until now has struggled to engage its membership in personal wellness. The first Annual Emergency Medicine Wellness Week provided an effective tool to engage emergency physicians.

Plans for the Future: Emergency Medicine Wellness Week will be an annual event. We look forward to engaging with other emergency medicine organizations as well as other emergency care providers such as nurses, paramedics, and advanced practice providers. We have planned a Wellness Summit for all emergency medicine organizations February 9-
10, 2017. Our goal is to create a toolbox of approaches and tactics both at an institutional level and personal level to improve recognition of burnout and disseminate both pro-active and responsive ways to improve resilience. We hope to encourage other international emergency medicine organizations to promote wellness, using our resources as they wish.

**Website:** [www.acep.org/emwellnessweek](http://www.acep.org/emwellnessweek)
WHERE ARE WE AND WHERE SHOULD WE GO? A WELLNESS INVENTORY OF RESIDENTS/FELLOWS

**Primary Author:** Miriam Bar-on, MD, University of Nevada School of Medicine

**Faculty and Staff Involved in Initiative:** Miriam Bar-on, MD, University of Nevada School of Medicine; Sandhya Wahi-Gururaj, MD, MPH, University of Nevada School of Medicine

**Background:** Physician wellness and/or burnout are in repeatedly in the news especially for residents/fellows in training. Multiple studies have been published on these topics and they are the focus of many retreats, program director workshops, program director society and graduate medical education leaders’ meetings. At the Physician Wellness Symposium, participants were asked to commit to a project or task that would move wellness at their institution forward. The project at the University of Nevada School of Medicine (statewide) involved developing a Wellness Inventory. The purpose was to determine the status regarding wellness programming and to serve as a needs assessment for the institution.

**Objectives:** • Assess residents’/fellows’ awareness of their own wellness and that of their colleagues • Determine what wellness activities are currently occurring in the institution’s training programs • Seek advice from the trainees as to what wellness activities would be beneficial to them • Start an institutional plan for a wellness curriculum and/or process

**Methods:** A 21 item wellness inventory was developed by the internal medicine program director and the associate dean for graduate medical education and DIO. The inventory was sent electronically via Survey Monkey to 374 residents/fellows. Data were collected including: demographic information i.e. program and level of training, as well as inquires about well-being, burnout status, departments’ wellness initiatives and what activities would be most beneficial for them. The majority of items were forced answer questions, however, open text boxes were provided for narrative comments.

**Results/Outcomes/Improvements:** The inventory was sent out in April 2016 with weekly reminders. A response rate of 61% or 227 residents/fellows completed the inventory. The majority of respondents were residents and represented the distribution of residents between Las Vegas and Reno. The fellows’ response rate was 3%. The responses from PGY1, 2 and 3 are approximately equal ranging from 28.3% to 31.8% and again follow the distribution of residents. Responses for PGY4 and greater than PGY5 are also similar at 5.4% and 5.6% respectively. While 93% of trainees have thought about their well-being, 85% are satisfied with their status which reflects the level of burnout (using the two validated questions from the Maslach Burnout Inventory). Resident/fellow wellness is assessed formally and informally during semiannual meetings and by feedback from co-residents/fellows. In looking at the programs’ culture or environment of wellness in programs, 77% stated there was a culture of awareness, but only 50% of programs have a wellness initiative. Components of wellness initiatives included social events 86%, lectures 76%, peer mentoring 39%, interactive workshops 28%, time management sessions 22% and mindfulness training 21%. As would be predicted, trainees responded that social events had the biggest impact on them followed very distantly by lectures. Trainees responded that increased interdisciplinary social events should be the focus of an institutional wellness program followed by the write-in request for gym facilities or free/reduced cost gym memberships. Formal departmental or interdisciplinary aspects of a curriculum did not receive a favorable response with a direct quote “mandatory events only increase burnout”.

**Significance/Implications/Relevance:** The data collected provided valuable information about the current status of resident/fellow wellness and/or burnout at the school of medicine. Considering the state of transition at the school, the data were reassuring although improvements can and should be made. The data were shared at a GMEC meeting for discussion with the programs’ leadership. Input from the residents/fellows as well as the program directors/coordinators will help guide the development of resources both educationally and socially.
Plans for the Future: The first step was to introduce wellness topics quarterly into the monthly Interdisciplinary Grand Rounds – September IDGR focused on mindfulness. To support program directors, a web page with resources to facilitate the customization of their individual initiatives is under construction borrowing from both the ACGME and the AAMC pages. Additional social events are being added to the calendar with the first large event in the end of October and one has also been scheduled for the end of January. Wellness has risen to everyone’s level of consciousness. As the Las Vegas residents transition to a new school, Wellness Wednesdays are on the horizon.
WELLBEING IN MEDICAL RESIDENCY

Primary Author: Hasan Bazari, MD, Massachusetts General Hospital

Faculty and Staff Involved in Initiative: Meridale Baggett MD, Merranda Logan MD, Jonathan Ripp MD and Hasan Bazari, MD.

Background: Burnout is rampant in the medical literature and is quickly becoming the number one formidable target of the profession. The etiology of burnout has been variously attributed to various factors such as the number of work hours, the burgeoning documentation requirements, the legal requirements, the computerization of medicine, the stresses of practice, the decrease in reimbursement to name a few.

Objectives: To verify in a medical residency the following: 1. The level of burnout in May/June 2017. 2. What factors determine the level of burnout exists in the residency? 3. The root cause of the level of burnout as perceived by medical residents. 4. To compare the incidence of burnout in 2 major medical residencies in New York and Massachusetts.

Methods: The Maslach Burnout Inventory will be administered in May or June of the year when the residents will have a final determination of the kind of year they have had and about 1/3 to 1/4 of them will have finished their final year of training. Additional questions will be asked regarding their plans for further training.

Results/Outcomes/Improvements: The results will be compared to the 2009 and 2011 surveys with respect to burnout rates, which approached 70-80% among interns and it will be compared with the juniors and seniors. If there is a decrease in the burnout among residents, including interns then there are at least three domains in which improvements could have occurred: 1. The schedule has gotten a little lighter in terms of team sizes with more attention to caps and work hours. 2. The coaching at Massachusetts General Hospital has become more consistent. 3. The reflection sessions have been remained constant. Additional factors may be identified that also have changed in the interim that are contributing to the decrease in burnout. The identity of the Program Director and Chief of Medicine at both institutions has changed.

Significance/Implications/Relevance: The initial scope of the process to simply ask the question as to whether burnout has decreased, or not. If it has decreased, then the scope of the question increases to ask why and that is going to be fascinating in terms of possibilities. We will compare the results of MGH and Mt. Sinai. If they are concordant it is likely that it is one of the factors or an unassociated factor such as the program director or chief of medicine. If it discordant then the call for much larger studies would result.

Plans for the Future: The results are hard to predict and harder to speculate on. The presumption is that eventually burnout will become a thing of the past but it may be inherent in Medicine. That desire and responsibility for other's lives and the weight of the burden may be too much for us to bear. The real course of burnout may be to slowly peck away at the burden of burnout until it is at least in the tolerable range.

Website: www.partners.org
A CURRICULUM ON MAKING HEALTHY CHOICES

Primary Author: Edwin Zalneraitis, M.D., University of Connecticut Pediatric Residency Program

Faculty and Staff Involved in Initiative: Edwin L. Zalneraitis, M.D., Christine Skurkis, M.D., Sharon Smith, M.D., Mark Gfreenstein, M.D. University of Connecticut Pediatric Residency Program at Connecticut Children's Medical Center

Background: The decline in physician well-being, with its origins in medical school and residency, culminating in mid-career and beyond, has resulted in increasing burnout, depression, leaving the profession early and suicide. Key contributing factors in wellness are self-care (maintenance & renewal), connectedness & work environment. Resident curriculum should evolve to address all 3 domains of influence.

Objectives: To provide pediatric residents with an integrated, longitudinal curriculum that teaches them by which they can learn to make healthy choices. Address resident well-being in concert with faculty well-being to promote a personally and professionally healthy and successful teacher-learner dyad. Introduce strategies that can be sustained, as a life-long pattern of activities, to maintain personal and professional well-being.

Methods: Established a resident and faculty work group to monitor and address physician well-being. Created a Social Activities Committee (SAC) with resident Co-chairs and funding for activities. Annual session for all residents to review and update the making of healthy choices, recording a Maslach Burnout Inventory score and engaging in group problem solving. Each PL group retreat revised to address self-care by morning-long mindfulness sessions and promoting connectedness in afternoon group recreational activities. Series of varied renewal activities during a lunch at the start of each rotation. Flexible time off policy was implemented to begin addressing the work environment issues. Menu of support services, including confidential and unlimited access to mental health care, was developed and promoted. Department-funded consultation to evaluate current status in wellness and further enhance activities for both residents and faculty.

Results/Outcomes/Improvements: SAC held their first events. Participation & tracking of burnout were accomplished. One resident sought help for a rising Burnout score. Highly favorable feedback was received on resident mindfulness sessions. Resident interest in group activities increased and morale was improved. Support services were confidentially accessed by 25% of residents. Flex time was used by 38% of residents. Departmental consultation scheduled and faculty collaboration included.

Significance/Implications/Relevance: Wellness can be favorably influenced by creating a set of activities over time that address the areas of self-care, connectedness & the work environment. Efforts can be initiated during residency, with resident exposure to health habits may be effective over the course of careers.

Plans for the Future: Expand the menu of activities. Identify or develop additional assessment methods. Formal curriculum evaluation. Track measures of wellness: entry, completion of residency, & longitudinally among graduates. Assess curriculum satisfaction among. Identify other areas to address.

Additional Comments: Assessment of the effort is important and our assessment will be: Needs assessment: resident & faculty surveys. Review of work group efforts to develop and maintain healthy habits in self-care, connectedness and the work environment. Track utilization of resources developed. Review trends in Maslach Burnout scores. Monitor need for and provision of interventions. Track faculty and resident surveys for reduced burnout & improved faculty satisfaction.
CREATING A CULTURE OF WELLNESS: A MULTI-SPECIALTY HOUSESTAFF WELLNESS COMMITTEE AND NEEDS ASSESSMENT

Primary Author: Steven Brown, MD, FAAFP, University of Arizona College of Medicine - Phoenix

Faculty and Staff Involved in Initiative: Steven R. Brown, MD, University of Arizona - Phoenix; Caitlin Lee, DO, University of Arizona - Phoenix; Evan Werk, MD, University of Arizona - Phoenix, Kristine Goto, PhD, University of Arizona - Phoenix;

Background: Physician wellness is receiving increased national attention. Physicians have high rates of burnout and depression, and the national rate of physician suicide is unacceptable. Lack of physician wellness leads to an unhealthy workforce and therefore deeply impacts public health. Depression and burnout often starts early in training. Habits and behaviors for a lifetime of healthy practice can be learned in residency. The ACGME and a national group of resident leaders have called for increasing attention to wellness in training. (Daskivich TJ, et al. Promotion of wellness and mental health awareness among physicians in training: perspective of a national, multispecialty panel of residents and fellows. JGME 2015;March:143-147).

Objectives: Understanding the importance of wellness in residency training, we sought to: 1. Create a multispecialty Wellness Committee at our institution 2. Promote a supportive culture of wellness across specialties and residency and fellowship programs at our institution 3. Conduct a housestaff wellness needs assessment to prioritize wellness efforts 4. Gather support from hospital administration to implement a comprehensive wellness program for residents and fellows at our institution

Methods: • Creation of multispecialty wellness team • Brainstorming and planning retreat for resident, fellow, and faculty leaders across the institution • Wellness needs assessment of residents and fellows • Assess availability of barrier-free counseling for residents and fellows • Creation of new special social event “Candlelight Capers” • Introduction of wellness at resident and fellow orientations June 2016 • Plan future interventions to promote a culture of wellness across specialties

Results/Outcomes/Improvements: • Large teaching hospital in Southwest with 244 residents and 49 fellows in 8 residencies and 7 fellowships. • Multispecialty wellness team is created and holds regular meetings Specialties actively involved in committee: Family Medicine (chair), Internal Medicine, Toxicology, Obstetrics/Gynecology, Medicine/Pediatrics, Psychiatry, Undergraduate and Graduate Medical Education administration. o Positions of actively involved team members: Acting DIO, program directors (5), psychology faculty (1), other faculty (1), residents and fellows (7), medical school faculty and administration (2), GME administration (2). • Housestaff have access to free counseling through Employee Assistance Plan but there may be barriers (perceived or real) to utilization of this important resource. • Needs assessment of residents and fellows conducted 3/31-4/17/16: o Response rate 43% (127/293) o 83% report wellness is “very important.” o 63% “agree” or “strongly agree” that: The culture of our institution supports my wellbeing. o 96% are “very willing” or “somewhat willing” to participate in efforts to improve wellness. o 76% report there is a faculty, and 92% report there is a co-resident or colleague they can speak to about wellness. o 41% report struggling with depression or anxiety this year.

55% of the total barrier (43%) is time constraints o When asked to assign $100 to various wellness interventions, the division was as follows: Improving the physical space 44% family oriented resources 33% related improvements 19% increased access to counseling/mental health services 7% social events o Data can be reported on 9 other questions and "open ended" feedback responses. • “Candlelight Capers” Multispecialty Resident, Fellow, Faculty formal dinner/dancing event planned for March 2017 supported by funds from Medical Staff.

Significance/Implications/Relevance: Multispecialty medical education leadership at our institution is engaged in the challenge of addressing resident wellness. Residents and fellows are also actively engaged in our planning process. The results of our needs assessment survey show that wellness is important to housestaff, and many have struggled with depression or anxiety but many do not seek help. Most housestaff have a colleague or faculty member they can speak to about wellness but at least 8% do not. The importance of mentorship is emphasized by Daskivich, et. al. Wellness
intervention priorities for residents and faculty include physical space and food improvements. This confirms the finding of Salles, et al at the Stanford General Surgery program and was not immediately recognized by our committee as a priority prior to the survey. (Salles A, Liebert CA, Greco RS. Promoting balance in the lives of resident physicians: A call to action. JAMA Surg 2015;150(7):607-8) We have initiated conversations with hospital administration to prioritize wellness space for housestaff, especially in design of new hospital. Space planning meetings are ongoing. Guided by our collaboration, a similar group and needs assessment has been completed at Phoenix Children's Hospital, a major local site for pediatric training. Lessons learned from our needs assessment and initiative could be implemented widely across teaching settings.

**Plans for the Future:** • Continue space design/planning discussions • Continue discussion with local medical school and administration for availability of barrier-free counseling • Communication efforts (newsletter, email, social media, etc.) • Program-specific interventions to increase mentorship, “wellness days,” and time to see primary care physician or other health appointments. • Regular Wellness committee meetings and reporting to Graduate Medical Education Committee • Social and family-related events
PERCEIVED VALUE OF A PROGRAM TO PROMOTE SURGICAL RESIDENT WELL-BEING

Primary Author: Claudia Mueller, PHD, MD, Stanford University

Faculty and Staff Involved in Initiative: Arghavan Salles, MD, PhD, Washington University School of Medicine; Cara A. Liebert, MD, Stanford University School of Medicine; Micaela Esquivel, MD, Stanford University School of Medicine; Ralph S. Greco, MD, FACS, Stanford University School of Medicine; Claudia Mueller, PhD, MD, Stanford University School of Medicine

Background: The demands of surgical residency are intense and threaten not only trainees’ physical wellness, but also risk depression, burnout, and suicide. Our residency program implemented a multi-faceted Balance in Life program designed to improve residents’ well-being.

Objectives: The purpose of this study is to evaluate the program utilization and perceived value by residents.

Methods: Residents (n=56, 76% response rate) were invited to participate in a voluntary survey from December 2013 to February 2014 regarding utilization, barriers to use, and perceived value of six program components (refrigerator, After Hours Guide, psychological counseling sessions, Resident Mentorship Program, Class Representative System, and social events). Means and standard deviations were calculated for overall responses, as well as by gender and PGY-level.

Results/Outcomes/Improvements: The most valued components of the program were the refrigerator (mean=1.39) and the psychological counseling sessions (mean=2.42), followed by social events (mean=2.52), the Resident Mentorship Program (mean=3.21), the Class Representative System (mean=3.38), and the After Hours Guide (mean=3.90). Junior residents valued the psychological counseling sessions more than senior residents (means=2.12 vs. 3.08, p=0.02). When residents were asked how they would allocate $100 among the different programs, the majority was allocated to the refrigerator ($54.31), social events ($26.43), and counseling sessions ($24.06).

Significance/Implications/Relevance: This study demonstrates that a multi-faceted program to improve the well-being of trainees is feasible, highly valued, and positively perceived by the residents.

Plans for the Future: We plan to quantify the effectiveness and longitudinal impact such a program has on resident depression, burnout, and other psychological factors.
PROMOTING AN IMPROVED LEARNING ENVIRONMENT AND TRAINEE WELL-BEING BY ADDRESSING MISTREATMENT OF LEARNERS

Primary Author: Catherine Kuhn, MD, Duke University Health System

Faculty and Staff Involved in Initiative: David A. Turner, MD, Duke University Hospital, Lisa Pickett MD, Duke University Hospital, William Richardson MD, Duke University Hospital, Kate Buretta MD, Duke University Hospital, Kyle Rehder MD, Duke University Hospital, Catherine Kuhn, MD, Duke University Health System

Background: A healthy learning environment, which is supportive of the learning process, and promotes inquiry and thoughtful discussion, is critical for optimization of satisfaction in the workplace, mitigation of burnout, and ultimately, patient safety. However, data suggests that nearly 2/3 of GME residents and fellows experience mistreatment during training. (1) Approximately four years ago, an increasing number of graduates from the GME programs at Duke reported that given a choice, they would not return to Duke for training, and the primary reason provided for this decision was "lack of a friendly educational environment". Simultaneously, several reports were received by GME leaders of episodes of serious mistreatment of GME trainees. Investigation of the specific incidents revealed that the culture in some programs was not supportive of raising concerns, and the degree of mistreatment in those programs was more pervasive than initially suspected. Discussions revealed that underreporting of mistreatment was very common, and that a significant number of trainees did not know what to do about mistreatment they experienced or witnessed. Analysis of this problem indicated that existing reporting mechanisms were insufficient to intercede appropriately in programs or departments where there were concerns.

Objectives: The purpose of this initiative is to improve the learning environment through: 1) Creation and dissemination of clear expectations regarding the appropriate treatment of learners 2) Development and implementation of a GME-specific, easy-to-access reporting site where episodes of perceived mistreatment could be reported either in an anonymous or identified fashion 3) Establishment of a committee to review and address reports of mistreatment 4) Partnership with the UME and faculty communities to create a comprehensive approach to learner mistreatment

Methods: A policy on the appropriate treatment of GME learners was developed, approved by the GMEC, endorsed by health system leaders including clinical department chairs, and disseminated. A confidential reporting site for concerns about mistreatment was launched. This site allowed either anonymous or identified reporting and is accessible through multiple access points, including the institutional GME website, the login page of the Resident Management System, and multiple program websites. The Graduate Medical Education Committee on the Appropriate Treatment of learners (GME-CAT) was also established to review and address trainee reports of mistreatment. This committee includes GME leaders, program directors, faculty, trainees, and the Chief Medical Officer (CMO) of the hospital, who chairs the faculty Clinical Peer Review Committee. Additionally, the Associate Director of GME reviews all GME-related reports filed in the institution’s safety reporting system. Periodic updates about the activity of the GME-CAT is shared with appropriate work groups in the institution, including the GMEC, Sponsoring Institution’s governing body, and Clinical Chairs group. Additionally, the institutional and program results on a locally-administered GME survey is shared annually with program directors, vice chairs for education, and clinical chairs, and is a topic for discussion in the Annual Program Evaluation feedback process conducted by the GME staff for relevant programs. Other elements of our comprehensive approach to the learning environment are a parallel process in the medical school, including a policy and committee to address student mistreatment, and a health system Professionalism Accountability Program which addresses faculty professionalism issues.

Results/Outcomes/Improvements: The GME-CAT has received 38 reports through its site in the 16 months since inception. The distribution of type of concern reported includes: 47% rude/dismissive behavior, 29% inappropriate comments (gender, race, sexual), 11% threat of retaliation, 3% personal tasks, 3% physical abuse (hitting), 3% inappropriate touching, 5% other. Sources of mistreatment have included faculty, nurses, advanced practice providers, and other GME trainees. Only one reported case was felt by the committee to not represent mistreatment. First-time
reports involving GME trainees are reported to the program director for resolution, which can include counseling by the Office of Institutional Equity when appropriate (e.g. inappropriate racial or sexual comments). Egregious cases by faculty are referred by the CMO to the department chair and/or for Clinical Peer Review, and less serious cases are referred for a peer intervention through the faculty professionalism initiative. Cases involving nursing or advanced practice providers are referred to the appropriate managers and leaders. Over the past three years (2014-2016), the institutional GME survey has revealed a decrease in the percentage of trainees who report experiencing mistreatment from other trainees, from 18.1 to 11.9% (p=0.007). The percentage of trainees experiencing or witnessing mistreatment who reported the mistreatment increased in the same time, from 16.2 to 34.4% (p=0.0001). For those who did not report mistreatment, there was a decrease pre- to post- intervention in the % endorsing the following reasons: Did not think it would make a difference (from 72 to 65%), or who feared retaliation for reporting (from 35 to 29%). In the medical school, the average frequency of reported mistreatment reached its lowest level in ten years. For medical students, historically residents and fellows were the most frequent source of mistreatment, but in 2016, residents were no longer the most common source of mistreatment, replaced by faculty, and the number of reports of resident mistreatment dropped significantly. The frequency of GME trainee reports of experienced or witnessed mistreatment by faculty over the same periods has not declined.

**Significance/Implications/Relevance:** Addressing mistreatment effectively is a complex process which requires attention at many levels, and cultural change takes time. As we developed parallel systems to address this for our undergraduate and graduate medical education learners, it became clear that continued integration of these efforts, and inclusion and maturation of a process to address problematic faculty behavior is essential to continued progress. We are encouraged that the percentage of residents who report episodes of mistreatment has increased, perhaps reflecting trust in the confidentiality and integrity of the GME-CAT process. A similar approach could be implemented at any institution.

**Plans for the Future:** We would like to develop an interprofessional approach to improving the learning environment by expanding efforts addressing mistreatment beyond the physician learner group to include other professionals in the clinical environments. Our institution administers a work culture survey on an ongoing, periodic basis. GME trainees and clinical faculty participate in the survey. Consideration of survey results will allow identification of clinical units that are performing well, and those with opportunities for improvement. Utilization of the work culture survey, in conjunction with other data points such as the ACGME resident and faculty surveys should help the institution address problematic clinical service areas and importantly, identify service areas that reflect best practices in collegial team work. This will ultimately enhance trainee, faculty and staff achievement and workplace satisfaction, and ultimately improve patient safety.

DEVELOPING THE ROLE OF A HOUSE STAFF MENTAL HEALTH SERVICE IN PHYSICIAN WELL-BEING INITIATIVES: FROM CONTEMPLATION TO ACTION

Primary Author: Laurel Mayer, MD, Columbia University Irving Medical Center

Faculty and Staff Involved in Initiative: Laurel Mayer, MD, Director, House Staff Mental Health Service, Columbia University Irving Medical Center Bret Rutherford, MD, Associate Director, House Staff Mental Health Service, Columbia University Irving Medical Center Lyuba Konopasek, MD, DIO, New York-Presbyterian Hospital Matthew L Goldman, MD, MS, PGY-III in Psychiatry, Columbia University Irving Medical Center

Background: The ACGME First Symposium on Physician Well-Being promoted awareness, at the national level, of the mental health issues related to medical training. The conference organizers assembled and educated a critical group of stakeholders, and highlighted the need to organize and centralize (both between and within institutions) efforts in order to promote more efficient dissemination of initiatives. Attendees were personally charged to return to their home institutions and move from contemplation to action.

Objectives: Through the House Staff Mental Health Service at a large, urban, academic institution, our goal was to foster collaboration and expansion of resident and fellow mental health (including well-being) initiatives across the medical center campus.

Methods: We worked collaboratively with the DIO, identified faculty and residents to assemble a list of existing or potential resident well-being-focused opportunities, and identified short-term and longer-term initiatives for implementation.

Results/Outcomes/Improvements: Hospital leadership, faculty, fellows and residents collaborated to develop a long-term strategy for improving trainee well-being. Successful short-term initiatives included securing increased funding for the House Staff Mental Health Service due to significant increases in utilization of the Service by residents/fellows, representation on a newly-formed, hospital-sponsored Resident Well-Being Committee (composed of representatives from faculty, program directors, chaplains, residents, House Staff Mental Health service), resurrection of the Resident Forum (a regular meeting run by residents for residents), and increased educational opportunities on well-being related topics (e.g. House Staff Orientation, Departmental Grand Rounds, noon conferences, local and national medical and psychiatric society meetings). A number of departments had independently begun resident “well-being” groups, and we organized group supervision for the facilitators of those groups to share their experiences. Relatedly, the directors of the House Staff Mental Health Services from two other large academic medical centers in the NY area now meet regularly to discuss service utilization, challenging cases and offer support to each other. Recognizing the importance of research and the need for systematic data collection on mental health related issues in medical trainees, we reached out to Dr. Srijan Sen, PI of the Intern Health Study, and interns at our (and other major NY) institution(s) are now invited to participate in his seminal Intern Health Study.

Significance/Implications/Relevance: With the increasing awareness of the need to concretely address resident mental health and well-being issues, there is much that can done to promote successful intra- and inter-institution collaborations.

Plans for the Future: Continue to expand short-term initiatives (e.g. speakers bureau, departmental well-being groups) and begin promotion of longer-term initiatives including much-needed longitudinal and treatment-focused research.
STRATEGICALLY ADDRESSING PHYSICIAN WELLNESS AND RESILIENCY IN PEDIATRIC GME: A PRELIMINARY REPORT

Primary Author: Franklin Trimm, MD, University of South Alabama

Faculty and Staff Involved in Initiative: The Association of Pediatric Program Directors (APPD) Strategic Planning Committee and APPD Board of Directors

Background: APPD serves pediatric graduate medical education (GME) programs by leading the advancement of education to ensure the health and well-being of children. Membership includes residency and fellowship program directors, associate program directors, coordinators and chief residents. Many department chairs and DIO’s are also members. Its 3000 members represent approximately 200 pediatric residency programs and 800 pediatric subspecialty fellowship programs. APPD recently underwent a strategic planning process to identify priorities for the next five years of advancing pediatric GME. Concern about trainee and faculty wellness has been a growing concern amongst APPD members. Variable expertise and resources at individual GME programs made implementing shared "best practices" to address these concerns difficult.

Objectives: 1. Strategically incorporate resident well-being into a national program director organization. 2. Utilize the resources of a national GME leadership organization to implement wellness strategic priorities. 3. Disseminate strategies to individual GME programs and measure impact.

Methods: A facilitated organizational strategic planning process was utilized to develop a 2016-2020 strategic plan for APPD. Expected products of the process included core goals for the organizations, further refined by specific activities and expected, measurable outcomes.

Results/Outcomes/Improvements: Vision 2020, the new strategic plan for APPD, includes a core priority of Personal and Professional Development. A focus area for this priority is Wellness & Resilience of all members, and secondarily, trainees. A small working team of APPD members and leaders who participated in the strategic planning process (Champion Team) have detailed the organizational needs and resources, strategies and approaches, a preliminary implementation plan, and evaluation strategies to measure results. A call has gone out to all APPD members with information about this priority, along with the remaining Vision 2020 priorities for individuals to apply to work on implementation teams for each priority. The Personal and Professional Development Champion Team will review applications and select a Project Team that will be charged with refining the strategies, implementation and measurement of outcomes. In the interim, faculty development on wellness and resilience has been developed by APPD members and presented at the 2016 Pediatric Academic Societies Meeting, and a half-day, practical session on wellness and resilience was developed and presented at the 2106 Fall APPD Meeting

Significance/Implications/Relevance: Incorporating wellness and resilience into the strategic priorities and plans of a national GME leadership organization facilitates dissemination of needed information about the importance of incorporating wellness strategies into pediatric GME experiences, focuses the resources and expertise of the organization on improving the wellbeing of trainees, leaders and faculty on developing, adapting and implementing effective strategies for a variety of training environments, and enhances the measurement of efficacy of interventions.

Plans for the Future: The Project Team for Wellness and Resiliency will be fully appointed and develop more specific strategies for APPD to implement and refine the outcome measures to be evaluated. Practices and outcomes will be shared throughout APPD membership and beyond the organization through submission of projects to regional and national meetings.
FEASIBILITY OF A COMPREHENSIVE WELLNESS AND SUICIDE PREVENTION PROGRAM: A DECADE OF CARING FOR PHYSICIANS IN TRAINING AND PRACTICE

Primary Author: Sydney Ey, Ph.D., Oregon Health and Science University

Faculty and Staff Involved in Initiative: Sydney Ey, Ph.D. Mary Moffit, Ph.D. J. Mark Kinzie, M.D., Ph.D. Patrick H. Brunett, M.D.

Background: Comprehensive treatment models reduce distress and suicide risk in military, university and community populations but are not well studied with medical trainees and physicians in practice. Physicians face unique internal and external barriers which limit access to psychological or psychiatric treatment—barriers that contribute to high rates of burnout, depression and suicide.

Objectives: Aims Our goal is to report on the feasibility and utilization of a wellness and suicide prevention program for residents, fellows, and faculty in an academic health center (AHC).

Methods: This program provides individual counseling, psychiatric evaluation, and wellness workshops for residents/fellows (N=906) and faculty (N=1400). Demand for services is demonstrated by the participation rate of eligible trainees. Acceptability within the target population is examined in a 2011 anonymous survey in which trainees (N =116; 97% participation) and program directors (N=23; 88% participation) rated their satisfaction. Startup costs and funding sources to sustain a wellness program are outlined.

Results/Outcomes/Improvements: Utilization of services grew from five percent in this program’s first year (2004-05) to a high of twenty five percent of eligible trainees and six to eight percent of faculty in 2013-14. Trainees and program directors reported a high level of satisfaction with this wellness program. Funding for clinic space and clinical staff (2.4 FTE) is provided by the hospital via the Graduate Medical Education budget.

Significance/Implications/Relevance: Contrary to prior research on residents’ accessing counseling on site, the majority of this AHC’s trainees indicated a willingness to access our program on-site, reported fewer barriers and when they did seek treatment reported a high level of satisfaction. Training program leaders, key promoters of our services, also expressed satisfaction with the RFWP. Demand for services increased each year. Almost 20% of trainees in the last year participated in our program—a rate higher than national rates of utilization of 10.4% for university counseling centers and 13.4% for US adults. Of note, 6.5% of employees in our AHC accessed the Employee Assistance Plan (EAP) in 2015. Similar to another AHC’s successful outreach effort, the highest rates of RFWP utilization occurred during the launch of our suicide prevention initiative. Treatment barriers do still exist. Specifically, demanding clinical schedules continue to be the most frequently endorsed barrier to accessing treatment by trainees even after our GME office mandated that programs allow trainees to attend personal or family health care appointments on a quarterly basis. Trainees typically schedule RFWP meetings outside of these protected blocks of time due to the urgency of their need. After the RFWP relocation to a more remote location in January 2014, trainee visits declined 26.5% while faculty visits increased 30%—suggesting time away from clinical duties may be more of a barrier for trainees. Alternatively, the decline in trainee utilization rate in 2014-15 may be a return to baseline after the suicide prevention initiative and screening launched in 2013-14. Trainees’ average number of visits per year steadily decreased from the first four years of our program even though no limits were placed on treatment duration. One possible explanation may be that a broader range of trainees with different levels of need are now accessing our program and some may require a briefer duration of treatment than earlier participants in RFWP. During orientation, trainees are encouraged by RFWP staff and their program leadership to “not wait for a crisis” to access counseling. In addition, as utilization increased, scheduling follow up appointments with RFWP clinicians may have become more difficult. In 2015, our program increased clinician FTE to offer more scheduling options. In the past decade, we have seen encouraging signs of a paradigm shift in our AHC. Certainly the ongoing funding of this program and visible promotion of this resource by GME and health system leadership has sent an important message to trainees and faculty. Faculty leaders make strong supportive statements at Grand Rounds, voicing the importance of physician well-being, and disclosing that they benefited from the RFWP. Greater connectedness and
support from peers may help distressed physicians be more willing to seek professional help and also reduce the risk of suicide.31 Limitations Since these results are from one institution, the feasibility of this model may not generalize to other AHCs. Satisfaction ratings may not include a representative group of RFWP participants over the ten years of our program. Actual outcomes such as reductions in suicide risk require a larger sample in order to detect changes due to the low base rate of suicide. Engagement in treatment, however, is an important proxy variable for reducing suicide risk. Future research is needed to identify which physicians in training and practice engage in a wellness program and as a result demonstrate enhanced personal and professional efficacy. Conclusions Specifically designed to support our physician colleagues – at all stages of their careers--this on-site comprehensive wellness program was accessed by a significant number of physicians, highly rated, and invested in by this AHC for over ten years.

**Plans for the Future:** Treatment Engagement and Response: To examine more closely: * who are the residents, fellows and faculty who seek treatment through our program either as a result of our suicide prevention protocol (the AFSP's Interactive Screening Protocol) or due to other referral sources, and * do highly distressed residents and faculty (e.g., with suicidal ideation) engage in our treatment and shows signs of recovery on standard measures of distress and burnout administered in each treatment session. New Peer Support Program launch: To evaluate a new preventive/early intervention program to address a major risk factor for physicians during training and in practice-- coping with a serious adverse and/or unexpected patient event, litigation, or professional setback--by offering trained peer support shortly after the incident. With training and consultation with Brigham and Women's Hospital’s Center for Professionalism and Peer Support Director, Dr. Jo Shapiro, we launched a peer support program for residents, fellows, and faculty. Five months into this program, the response has been overwhelmingly positive with an average of 6 referrals a month--suggesting there is a real need for this additional resource for our residents and faculty.
IMPROVING SECOND YEAR MEDICAL STUDENT MENTAL HEALTH BEFORE THE USMLE STEP 1 EXAMINATION

Primary Author: Stuart Slavin, MD, MEd, Saint Louis University School of Medicine

Faculty and Staff Involved in Initiative: Stuart Slavin, MD, MEd, Saint Louis University School of Medicine John Chibnall, PhD, Saint Louis University School of Medicine

Background: Mental health of medical students continues to be a significant concern as students suffer from high rates of depression, anxiety, and burnout. The Saint Louis University Medical Student Mental Health Initiative has led to dramatic improvements in mental health of first year medical students over the past seven years through a number of curricular changes and introduction of a resilience and mindfulness curriculum. Mental health of second year students as measured just before they start their six week study period for Step 1 has shown more modest improvement. Efforts were targeted over the last two years to improve the mental health of our students as they faced this examination.

Objectives: The primary objective was to provide enhanced support for students leading up to the Step 1 examination in the hope that it would decrease symptoms of depression and anxiety of students as they prepared for the exam.

Methods: The intervention consisted of four components: 1. Optional confidential screening of students for depression and anxiety at four points during the first and second year of medical school. Students who screened positive were contacted by mental health professionals. 2. Focused sessions on managing stress given in the last two months of the second year and strong encouragement to students to seek individual help if they felt like they were going to be very stressed. 3. Messaging from administration that how they handled the stress could have a significant impact on their score. 4. Messaging from administration of the positive track record of SLU students on the exam. Depression (CES-Depression scale) and anxiety (Spielberger Anxiety Scale) scores for the class at the end of the second year were compared to previous classes at SLU.

Results/Outcomes/Improvements: Following are results from the past nine years for mental health of SLU students at the end of the first and second year. Moderate- Severe Depression Symptoms (Percent of Class)  MS1  MS2  2008 27% 28% 2009 27% 35% 2010 19% 17% 2011 18% 18% 2012 11% 16% 2013 14% 17% 2014 8% 21% 2015 4% 20%  2016 6%  Moderate- Severe Anxiety Symptoms (Percent of Class)  MS1  MS2  2008 56% 58% 2009 54% 61% 2010 44% 61% 2011 30% 39% 2012 31% 46% 2013 43% 44% 2014 23% 47% 2015 14% 47%  2016 14% 20%

Significance/Implications/Relevance: The interventions designed to help medical students manage the stress inherent in the USMLE Exam produced dramatic decreases in depression and anxiety symptoms of medical students exposed to the mental health interventions compared to previous cohorts not exposed to these interventions. These interventions were easy to implement and required little in the way of financial resources or curricular time. Considering the evidence of mental health problems during medical school and the clear stress that Step 1 is causing students across the US, other medical schools may want to explore instituting similar programs.

Plans for the Future: We plan to continue to support our pre-clinical students and will look for other ways to continue to improve their mental health and well-being. Our efforts will now be primarily targeted at trying to expand and develop initiatives to maintain this positive mental health through the third and fourth year of medical school.
Primary Author: Alexander Ommaya, DSc, AAMC

Faculty and Staff Involved in Initiative: Darrell Kirch, MD, AAMC Eric Weissman, AAMC Alexander Ommaya, DSc, AAMC

Background: The AAMC’s Council of Faculty and Academic Societies (CFAS) has been significantly engaged in the growing focus on wellness and resilience in academic medicine. The AAMC established the Council of Faculty and Academic Societies (CFAS) in 2013 to serve as a bidirectional conduit of engagement between medical school faculty and the association. CFAS offers an opportunity to bring the voice of medical school faculty (150,000 nationwide) to the conversation, helping to shape the direction and activities of the AAMC and its member institutions. CFAS also has representation from 81 academic societies. CFAS reps are clinicians, basic scientists, established chairs, and junior faculty. They provide clinical care, conducts groundbreaking research, keep various departments and projects at their institutions running, and are engaged collectively in nearly all aspects of academic medical structure. CFAS has several representatives actively involved in research and practices to mitigate physician and researcher burnout – including a number of nationally recognized experts in the area. Through its ongoing Faculty Resilience Working Group, CFAS representatives and the council’s leadership have explored numerous peer-reviewed articles on the subject, along with highlighting techniques, practices, and programs unique to academic medical centers that would be useful to professionals across the field. The topic remains a broadly discussed element at all of CFAS conferences, and CFAS have taken effective steps to create an ongoing forum to disseminate and promote materials to the academic medicine community focused on wellness. Additionally, CFAS representatives provide a strong voice for academic faculty within the AAMC’s governance and leadership structures since the chair and chair elect also serve on the AAMC Board of Directors. CFAS experts have been deployed to discuss the topic among other members of the AAMC’s constituency, including a recent Executive Development Seminar for new department chairs and associate deans. There are also a several sessions planned at the upcoming AAMC Annual Meeting focused on the topic.

Objectives: Collaboratively identify barriers and opportunities concerning clinician wellness and resilience with academic medicine leadership, clinicians, faculty, staff, and other stakeholders.

Methods: Meetings and other convening activities with faculty, clinical and academic leadership, federal agencies, academic societies, and other stakeholders.

Results/Outcomes/Improvements: The online resource, www.aamc.org/wellbeing, has been created. Much of the seed content in this publically available resource originated at the 2016 AAMC Leadership Forum, a two-day meeting that brought together prominent experts and leaders in academic medicine to explore the overall theme of wellbeing and resilience for physicians. Additionally, AAMC leadership has been instrumental in creating a National Academies Action Collaborative on wellness and resilience. The Clinician Wellbeing and Resilience Action Collaborative will seek to highlight potential interventions and collaborative approaches which address issues of burnout, wellness, and resilience. The Collaborative will seek to understand these problems across the continuum of training and clinical practice and include explorations of the learning environment and health systems. The National Academies of Medicine is currently seeking sponsorship from 30 organizations who attending a planning meeting in July 2016. The AAMC has also developed a development course being a resilient leader which will be available annually.

Significance/Implications/Relevance: The National Academies Action Collaborative on wellness and resilience will raise awareness of burnout, resilience, depression, and suicide. It will also be a springboard to collective action by a wide group of stakeholders. The AAMC is also continuing discussions on this topic with the Council of Faculty and Academic Societies and other constituent groups.

Website: www.aamc.org/wellbeing
THE ROAD TO RESILIENCE: ONE PEDIATRIC RESIDENCY PROGRAM’S APPROACH

Primary Author: Janet Serwint, MD, Johns Hopkins University School of Medicine

Faculty and Staff Involved in Initiative: Janet R. Serwint, MD, Lauren Kahl, MD, Helen Hughes, MD, MPH, Jeffrey Fadrowski, MD, MHS, Thuy Ngo, DO, MEd

Background: Pediatric residency is a time of exponential learning with exposure to both rewarding and stressful experiences. In view of the high burnout rates during residency, strategies are urgently needed to try to prevent or mitigate the development of burnout. The ACGME has suggested that training programs address burnout with strategies both at the individual and institutional level given that the high prevalence rates suggest that this is a systemic problem.

Objectives: To describe one pediatric residency program’s approach to incorporating initiatives that boost resident’s resilience and overall well-being as a means of enhancing their job satisfaction and reaping the rewards from their work.

Methods: We identified resident well-being as a Pediatric Residency Program priority area for the past 2 academic years, 2015-present. Our approach was through programmatic residency-wide initiatives to benefit individuals and teams and we actively sought resident input into the process.

Results/Outcomes/Improvements: Wellness strategies were identified by our residents at both the individual and the programmatic level. At an individual level, each resident was asked to complete an annual well-being individualized learning plan to set goals that were reviewed with their advisors. At a programmatic level, enhancements have included efforts to promote reflection and debriefing, encourage self-care, and enhance joy both inside and outside of the work environment. A monthly seminar named Afterwards uses narrative medicine to help participants reflect on patient care related experiences. We have had an annual death and bereavement seminar for PL-2 residents which is a day long program to gain skills in sharing life altering diagnoses, understand perspectives of parents and focus on physician self-care. We have also continued monthly debriefing sessions during the final week of the NICU and PICU rotations and encouraged just-in-time debriefing sessions for sentinel events as they occur. For the past 2 years we have organized a Resident Appreciation Week, which includes multi-disciplinary acknowledgement by faculty, continuity preceptors, nursing, social work and child life staff to demonstrate appreciation to the residents. Activities include scheduled social events such as lunches, happy hour, game night and massages. To further enhance our programmatic interventions, we developed a Resident Wellness Committee in July 2015. This is a resident run committee composed of a self-selected group. Committee meetings have allowed identification of key areas, and brainstorming about activities and implementation. Multiple wellness indicators have been identified and reflected in sub-committees. Areas of focus identified by our Wellness Committee included personal health, physical workspace, personal and emotional support, gifts and apparel, social planning and family support. The health subcommittee aims to enhance the personal health of residents by the development of a primary care provider list, providing protected time for health maintenance, providing healthier food options at noon lunches and having physical activity challenges with team competitions. The physical workspace subcommittee was successful in relocating 2 resident workrooms from windowless, crowded spaces to those that had windows and adequate seating for the entire team and organized, regular cleaning of call rooms and workrooms. The personal/emotional subcommittee enhanced regular debriefing sessions during NICU and PICU, increased impromptu debriefings for sentinel events and clinical challenges and helped disseminate ways to access mental health services. The gift/apparel subcommittee identified clothing options as important in further enhancing socialization, comradery and pride in their residency program among the residents. We purchased lanyards, performance tops and jackets with the program logo displayed. We continued to promote social interaction between residents and faculty by organizing social activities including happy hours, game nights and web-based announcements of a directory for group activities such as restaurant outings, hikes, and co-ed athletic events. To address family resources for housestaff with children we are developing a directory with child care options, resources for sick day care,
available pediatricians and potential playgroups. We have created Wellness Wednesdays, a monthly commitment to wellness at noon which may include having lunch outside, guided meditation, yoga, etc.

**Significance/Implications/Relevance:** As the rate of resident burnout increases despite duty hour changes, additional strategies at both the individual and programmatic level are needed to try to mitigate burnout. We describe a variety of interventions which have been endorsed and developed by our program leadership and pediatric residents.

**Plans for the Future:** We are participating in the national Pediatric Resident Burnout Consortium and plan to qualitatively and quantitatively evaluate the impact of these interventions.
MENTAL HEALTH ACCESS FOR RESIDENTS AND FELLOWS: AN INNOVATIVE NEW PROGRAM ADDRESSING CONFIDENTIALITY, PRIVACY, COST, TIMELINESS AND QUALITY OF CARE

Primary Author: Joan Anzia, MD, Northwestern University/McGaw


Background: McGaw GME and the hospital Physician Health Liaison had, since 2008, been increasingly concerned about providing timely resident access to quality, accessible and confidential mental health consultation and services. Previously McGaw had contracted with an outside organization to provide these services, but residents and fellows rarely used their services. The reasons this service was not used were those that are well-known obstacles to medical trainees in need of assistance: problems with accessibility, quality of triage and treatment options, and confidentiality. The Physician Health Liaison and McGaw leadership believed that when medical trainees and physicians ask for help, they need it immediately, if not yesterday. We believed that physicians optimally need to be seen initially by physicians (psychiatrists) for triage and treatment referral. We believed that our trainees need to see the best-trained psychiatrist and mental health providers. We believed that our trainees needed access to early morning and evening hour appointments, with providers located within a few blocks of the hospital, and that their consultations must be absolutely confidential. We also believed that all program directors needed faculty development programing in promoting resilience as well as recognizing burnout, depression, and other mental health symptoms and syndromes. We believed that education about wellness, recognizing burnout and depression, needed to be provided in robust format at the beginning of training to all trainees, and that all trainees needed to meet provider(s) in person during that orientation process, to further address stigma and normalize the process of accessing care.

Objectives: 1) To assertively decrease the common barriers to trainees' seeking care: stigma, lack of time, affordability, and concerns about privacy and confidentiality. 2) To create a new program of mental health services for all McGaw residents and fellows that embodies the values of quality, timeliness, accessibility, privacy, confidentiality and affordability....with a culture that is sensitive to physicians-in-training. 3) To reduce stigma through assertive education for all trainees, program directors, and hospital leadership about physician wellness, burnout and depression. 4) To choose a dedicated housestaff physician wellness liaison who would have a regular presence for the trainees and become known as a person for trainees to trust and rely upon.

Methods: 1) In January 2016, we created the position of Housestaff Program Wellness Liaison; a physician/psychiatrist who is contributing services faculty member in the community, familiar with McGaw training culture, and dedicated to physician wellness. Ashley Bassett, M.D., a former Chief Resident in McGaw's Adult Psychiatry Program who has been in practice near the hospital for five years, was hired for this role. 2) Dr. Bassett provides 24/7 access via a Google hotline to all residents and fellows; she provides phone consultation and triage within 12 hours. When indicated she will meet with the trainee on campus at the trainee's location of choice, or in her professional or McGaw offices. If necessary she can begin immediate supportive psychotherapy and pharmaco therapy. 3) We recruited specific group mental health practices in the nearby community (within 3 blocks of the medical center) whom we judged as providing excellent quality mental health treatment and who accepted our trainees' BC/BS insurance plans. We negotiated agreements with these practices to prioritize our trainees for the earliest possible appointments (same day if necessary) and early morning and evening hours. 4) We ensured that Dr. Bassett maintains complete privacy of her trainee contacts, and only reports number of contacts to GME. 5) We developed an extensive PR campaign within GME and the medical center to introduce Dr. Bassett to all trainees, program directors, and hospital leadership. This included website information, blast emails, and personally introducing Dr. Bassett at department and leadership meetings. 5) Dr. Bassett gives presentations on wellness, burnout, depression and our mental health services at McGaw trainee orientation in July. She also gives regular presentations at resident retreats and program director meetings and retreats. 6) Dr. Gaurav
Agarwal was commissioned with developing faculty development materials on wellness, burnout and depression for all McGaw program directors.

**Results/Outcomes/Improvements:** Although Dr. Bassett's position has only been in place for nine months at McGaw, the numbers of trainees seeking consultation and treatment started in double digits within the first month and have continued to increase monthly, requiring her - and us - to work together to find additional mental health practice groups in the area to provide treatment for trainees. We can report numerical outcomes in poster format. McGaw resident leadership reports that trainee response to the program has been overwhelmingly positive; we will be formally surveying trainees soon. Faculty development programming for program directors is just being launched, so it is too early to measure outcomes of that initiative.

**Significance/Implications/Relevance:** We believe that our new model of mental health services may ultimately prove to be a "best practice" for GME programs - and also a feasible one - in that it addresses many of the common obstacles to medical trainees seeking treatment, and it also fosters an environment in which a designated leader in resident wellness is "one of the community" of graduate medical education and residents. The cost of this service is comparable to the much-less-utilized outside service that was previously in place.

**Plans for the Future:** We plan to further expand the role of the Housestaff Wellness Liaison, so that she has an even greater presence at McGaw events and educational programs. We plan to further develop and expand educational programs in wellness for all program directors and core faculty.

**Additional Comments:** This program is new, and will necessarily be shaped and modeled by outcomes and experience. However, it’s clear to us - in the overwhelmingly positive response that Dr. Bassett has generated among our trainees - that choosing the right person for the role is crucial. Often the first thing that residents say when they meet her is "Oh, you're just like us - you're so normal!" - which speaks to past stigma. The fact that she is a former Chief Resident from McGaw who understands their training experiences and culture is a major benefit.

**Website:** http://mcgaw.northwestern.edu/current-housestaff/medical-plan-wellness
RESIDENCY WELLNESS: CHANGING CULTURE THROUGH EXPERIENTIAL LEARNING

Primary Author: Patrick Cocks, MD, NYU School of Medicine

Faculty and Staff Involved in Initiative: Margaret Horlick MD, Barbara Porter MD, Lou Miller, MD, Sandra Zabar MD NYU School of Medicine

Background: There has been renewed attention on the identification and care for house staff who suffer from mental illness and burnout. However, given the continued stigma of these conditions, house staff often do not seek help in these situations and faculty often lack the knowledge and skills in approaching struggling housestaff officers. In an innovative approach to faculty development, we have used group OSCEs to develop these skills, training faculty and chief residents to identify these housestaff officers, engage them in conversation and activate resources requires targeted faculty development. We have developed a workshop that leads residents, chief residents and faculty through an experiential faculty development session. We begin with an interactive discussion of the impaired physician and the epidemiology of substance abuse, burnout and mental illness in our profession. Participants then experience a group OSCE with cases of struggling trainees. In debriefing the cases and the group OSCE experience, participants will learn the skills need in recognition and response to a colleague in need.

Objectives: 
• Describe the role of faculty and chief residents in identifying and assisting struggling trainees
• Recognize problem behaviors in trainees and effectively discuss their concerns with a trainee who may be impaired
• Describe our Resident Wellness OSCE and OSTE cases in the context of our wellness curriculum
• Recognize the utility of experiential educational methods in the discussion of resident wellness

Methods: 
• We begin with an interactive discussion of the impaired physician and the epidemiology of substance abuse, burnout and mental illness in our profession. Participants will then experience a group OSCE with three cases of struggling trainees. The cases included standardized trainees who evidenced alcohol abuse, depression, and adjustment disorder and who had varied insight and willingness to accept help. The group aspect of the OSCE allows for peer to peer learning and deepens the conversations around the issues.
• Faculty observers and standardized learners provide direct faculty feedback. In debriefing the cases and the group OSCE experience, participants will learn the skills needed to lead their own session.

Results/Outcomes/Improvements: Curricular “real estate” communicates importance of the topic to stakeholders All of our residents and chief residents have participated Similar language and message for all trainees Disseminated resources

Significance/Implications/Relevance: Residents have identified colleagues and while we do not have direct of evidence of this effect, we believe the ongoing conversation and acknowledgment of this issue, is advancing our Program’s culture of wellbeing.

Plans for the Future: We are expanding our workshop to include Chief Residents and faculty from local institutions (Stony Brook University, Albert Einstein and Cornell University)
DEPRESSION AND THE TOXIC LEARNING ENVIRONMENT IN GME: RELATING BELITTLEMENT AND HUMILIATION TO A DEPRESSION SCREEN IN A NATIONAL, MULTI-SPECIALTY SURVEY

Primary Author: Nicholas Yaghmour, MPP, ACGME

Faculty and Staff Involved in Initiative: Nicholas A. Yaghmour, MPP, ACGME DeWitt C. Baldwin, Jr., MD, ACGME

Background: The ACGME requires programs to promote resident well-being in supportive educational environments. Much of the current literature, however, continues to report high rates of depression and burnout in medical residents. Despite ongoing national and local efforts, many residency programs fail to prevent the belittlement and humiliation of their residents.

Objectives: 1) Discuss the prevalence of resident mistreatment and clinical depression in medical residents and fellows. 2) Explain the association of resident mistreatment with resident well-being. 3) Implement local and national interventions to reduce the incidence of resident belittlement and humiliation, given the strong evidence that these interventions will likely improve resident well-being.

Methods: From January through May of 2016, residents and fellows were presented with an optional, anonymous survey including a 2-item depression screen (PHQ-2) and querying experiences of belittlement or humiliation.

Results/Outcomes/Improvements: Over 12,000 residents and fellows responded: 25% were PGY1’s, 24% PGY2’s, 24% PGY3’s, 15% PGY4-PGY7’s, and 12% were fellows. Forty-six percent of respondents were female, 51% were male, and 3% declined to provide gender. Sixty-three percent of respondents graduated from an allopathic medical school, 27% graduated from medical school outside of the USA and Canada, and 10% graduated from an osteopathic medical school. Using PHQ-2 scores of 3 or greater to represent a positive depression screen, 10.3% of respondents screened positive for depression. No significant gender differences were observed (Odds ratio of Females to Males: 1.11, 95% Confidence Interval of 0.97-1.26). Twenty-seven percent of respondents reported at least one instance of being belittled or humiliated within two-weeks of completing the survey, with 4% reporting being belittled or humiliated on 7 or more days of the past two weeks. Female respondents were 30% more likely than males to report one or more belittlement or humiliation experience (OR 1.3, 95% CI 1.2-1.4). Respondents reporting at least one belittlement or humiliation experience were 4.6 times more likely to screen positive for depression (OR 4.6, 95% CI 4.0-5.2). Male respondents reporting belittlement or humiliation were nearly 6 times more likely to screen positive for depression (OR 5.8, 95% CI 4.8-7.1), while female respondents were nearly 4 times more likely to screen positive for depression (3.8, 95% CI 3.1-4.6).

Significance/Implications/Relevance: High rates of resident depression and burnout as well as the experiences of belittlement and humiliation in medical residency have been consistently emphasized in the literature. To date, no published work has statistically related the mental health of residents to the learning environment. In this report, the high association between resident mistreatment and depression suggests that decreasing the prevalence of resident mistreatment may have a positive impact on the mental health of residents. Promoting supportive educational environments at the programmatic and institutional levels would appear to serve the goal of further fostering resident well-being.

Plans for the Future: We will continue to study these associations each year, as well as examine trends in the data over the course of multiple years.

Additional Comments: If given the opportunity to present this data with slides, we would be able to further explore differences among specialties, level of training, and even by the different sources of belittlement and humiliation (patients, faculty, other residents, nurses).
GME HARBOR INITIATIVE: CREATING A SAFE PLACE FOR RESIDENT MENTAL HEALTH SERVICES

Primary Author: Donna Schwabe, PhD, San Antonio Uniformed Services Health Education Consortium

Faculty and Staff Involved in Initiative: Donna G. Schwabe, PhD, San Antonio Uniformed Services Health Education Consortium; Theresa M. McKay, MD, San Antonio Uniformed Services, Health Education Consortium; Jones, Woodson S., SAUSHEC DIO/Dean

Background: Following the suicide of a resident in August of 2014 at the San Antonio Uniformed Services Health Education Consortium (SAUSHEC), a physician wellness program was formally implemented to provide behavioral health treatment services and other wellness programming to the Graduate Medical Education (GME) community. Prior to the resident’s death by suicide, no clear pathway existed at SAUSHEC for trainees and/or physicians to obtain needed behavioral health care. Existing wellness programming focused exclusively on improving nutrition, sleep hygiene, and level of physical activity. The GME Harnessing Adaptive Resident Behavior for Occupational Resilience (HARBOR) is a self-referral program developed to provide a confidential, non-stigmatizing pathway for GME and physician providers to improve their behavioral health and occupational functioning without fear of negative consequences on their training or careers.

Objectives: GME HARBOR is a wellness-based behavioral health service founded on the mission of providing confidential, compassionate care and psychoeducational services to the Graduate Medical Education and physician population at SAUSHEC. While wellness programs for physicians and residents that focus on improved nutrition, sleep, and exercise have been shown to reduce burnout and the incidence of medical mistakes, GME HARBOR takes this one step further by offering services designed to increase self-awareness, improve coping and communication skills, enhance time management, and emphasize the importance of optimal self-care and obtaining social support.

Methods: Prior to the formal development of the GME HARBOR program, the number of residents and physicians seeking behavioral health care was limited and referrals were made on an ad hoc basis. After the formal launch of GME HARBOR in January 2015, a brochure was developed and distributed through the Graduate Medical Education Committee (GMEC), Program Coordinators forum, and presentations to the House Staff Council. Additionally, GME HARBOR was introduced to incoming trainees at orientation in June 2015. Exposure to GME HARBOR’s services was also achieved through advocacy for residents’ behavioral health issues at clinical competency meetings, the GMEC, and in consultation with program directors.

Results/Outcomes/Improvements: In academic-year July 2015 through June 2016, the number of interns, residents, fellows, and staff physicians seeking behavioral health care through GME HARBOR more than doubled. The need for hospitalization of residents decreased in the second half of the academic year and diagnoses became less severe. Collaboration with GME HARBOR on resident and physician wellness was sought from a another GME training institution in the community Additional, presentations on resilience, burnout, and well-being were requested frequently by residency programs and House Staff Council. As a result of the success of GME HARBOR’s behavioral health orientation to incoming trainees, a film was made using the same presenters highlighting the importance of beginning more candid dialogue on physician depression and suicide and reducing the stigma of appropriate help-seeking.

Significance/Implications/Relevance: A dedicated behavioral health program for residents and physicians such as GME HARBOR appears to increase appropriate help-seeking by convenient proximity, destigmatizing promotional materials (e.g., brochure, film, presentations), assurance of confidentiality, and personal involvement on the part of its staff. GME HARBOR was staffed at SAUSHEC primarily by one psychologist and one psychiatrist. However, other behavioral health providers such as social workers and psychiatric nurse practitioners may be equally effective. Access to at least one enhanced level of behavioral health care, such as a day-treatment program, also appears important. One possible implication of increased utilization of a program such as GME HARBOR is lower levels of burnout and increased resilience and overall well-being among residents and physicians.
Plans for the Future: GME HARBOR has initiated implementation of the American Foundation for Suicide Prevention’s Interactive Screening Program (ISP). Set to launch this fall, the ISP provides a confidential, anonymous platform for residents and physicians to engage in screening of their mental health, interact with a behavioral health professional, and obtain needed services and/or referrals. Additionally, the film made based on the trainee orientation referenced above, known as “Let’s Talk About It: Physician Depression and Suicide,” has been launched in a performance improvement initiative within SAUSHEC residency programs. The film is being shown to each residency program along with small group discussions, followed by gathering feedback on its effectiveness in promoting open dialogue, confronting stigma, and encouraging appropriate help-seeking for depression and suicide among physicians.
THE JOY INITIATIVE: INSTITUTIONALIZED PROGRAMMING AT MICHIGAN STATE UNIVERSITY TO ENHANCE EMOTIONAL RESILIENCE AND WELL-BEING FOR MEDICAL TRAINEES

Primary Author: Miko Rose, D.O., Michigan State University

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Background: Every year, the United States loses approximately 400 physicians to suicide, the equivalent of an entire medical school. (1) Medical students are at higher risk for development of some psychiatric disorders than the general population and suicidal ideation amongst them is estimated to be as high as 11.2 to 20%. (2, 3) Medical student burnout is estimated at 49-51% throughout the course of medical education. (4) Burnout that continues into medical residency is directly correlated with higher incidence of medical errors and decreased compassion in patient care. (5) A majority of research on physician wellness focuses on “burnout” and prevalence of depression and anxiety amongst physician populations, with emphasis on a disease-based model of mental health. Although all medical schools provide a course in psychiatry and make some attempt at giving students insight into behavioral issues as related to patients, traditional curricula ignore these humanistic and psychological issues as they pertain to each medical student’s own development. Residency curricula are even less attuned to these issues. Taking steps beyond endurance into a positive state of wellness and thriving amidst challenges, also known as "positive psychiatry," has yet to be discussed, particularly in the context of institutionalized medical training. With an emphasis on strengths-based interventions, the authors of this study investigated the impact of mindfulness and positive-focused cognitive behavioral therapy for medical trainees. Mindfulness meditation has been demonstrated to decrease symptoms of anxiety, including when provided in training sessions for medical students. (6) Cognitive Behavioral Therapy and Positive Psychology exercises have proven effective in decreasing depression symptoms and improving positive attitude and happiness/outlook on life, for the clinically ill and for people without pathology. (7,8) The goal of this study was to examine the efficacy of mindfulness and positive psychiatry interventions on medical student levels of happiness, anxiety, and overall well-being.

Objectives: Learning Objective 1: Participants will be able to identify and describe risks of untreated “burnout” in student and physician populations. Learning Objective 2: Participants will be able to describe basic tenets of positive psychiatry and challenges of shifting from a pathology driven to strengths-based approach designed to promote joy and emotional resilience. Learning Objective 3: Participants will learn how to work with trainees using various techniques, including: life purpose visualizations, mindfulness relaxation exercises and happiness-focused interventions.

Methods: The authors of this workshop conducted a pilot research study incorporating elements of strengths-based cognitive behavioral therapy and mindfulness that demonstrated the efficacy of a 10-week happiness intervention for medical students. Resident physicians created and taught 60-minute weekly classes for 10 weeks to medical students at Michigan State University. Half of each class was devoted to mindfulness training, and the other half of each session was devoted to positive psychiatry/cognitive behavioral therapy interventions. The Beck Anxiety Inventory (BAI), The Fordycce Happiness Scale, and the Authentic Happiness Inventory were used to assess the impact of the intervention. Surveys were administered at the onset, midpoint and termination of the 10-week intervention. Control data was collected from medical students who did not participate in the class sessions.
Results/Outcomes/Improvements: Pilot study Results The mean BAI scores of participating (intervention) students declined from 13.8 at the first session (SD=8.1) to 6.8 (SD=6.8) after the last session [p=0.007, 95% CI (-8.089,-1.711), df=9, SD=4.4]. The mean Authentic Happiness Inventory Scores of participating (intervention) students improved, increasing from 79.2 (SD=9.6) to 87.3 (SD=13.9); [p=0.046, 95% CI (0.186, 16.214), df=9, SD=11.2]. There was a statistically significant difference between female and male Authentic Happiness Inventory scores, with female mean scores increasing 13.3 points higher than that of male mean scores, p=0.007, 95% CI (5.061, 21.605), df=7, SD (female)=4.676, SD (male)=5.586. This study demonstrated efficacy in increasing well-being and decreasing levels of anxiety in medical trainees. Post-study Outcomes Soon after the Joy Initiative pilot intervention study, the medical school administration provided support and funding for continuing the project. In addition, the pilot study lead resident physician received a grant from the American Psychiatric Association to focus on minority medical student quality of life. Since these monthly “Joy Initiative Focus Group” meetings began, changes have been made on an administrative level. As a direct result of conversations during these meetings, a new medical college staff position was created, a Program Officer for Outreach and Inclusion, with duties including coordinating and providing administrative support to continue the Joy Initiative monthly meetings. An additional administrative support staff person was also later added to assist with this project. Student representatives from the medical school diversity committee began to take a lead role in organizing the Joy Initiative events and a minority student event related to the Joy Initiative was incorporated into student orientation activities for incoming medical students. The Joy Initiative Focus Group meetings continue on a monthly basis with average attendance ranging from 50-70 students across 3 campus sites. In addition, the interventions used in this pilot study are now incorporated into formal elective classes offered at both the osteopathic and allopathic medical schools at Michigan State University, (“Happiness and Emotional Resilience Training for Health Care Providers Elective,” Course PSC 591 301, Michigan State University College of Osteopathic Medicine; “Resilience and Happiness Promotion for Health Care Providers,” HM 590 Section 304, Michigan State University College of Human Medicine). Resident physician and staff trainings are also being offered to select programs throughout the university.

Significance/Implications/Relevance: From this study, we have developed an easily deployable programmatic intervention to help students and residents discuss and address their own burnout issues. This intervention has helped sensitize physicians to think about how medical training might be affecting their own mental health.

Plans for the Future: To reach more resident physicians, the next initiative for this project is the development of interactive training materials that can be accessed online, asynchronously. In addition, to allow access for non-Michigan State University training programs—these classes will be offered via online live monthly classes. These trainings will be available for programs outside of Michigan State University to gain access. This initiative will create increased collaboration between training institutions, and increase access for medical trainees across disciplines.

RESIDENCY RETREATS: LEARNING RESILIENCE THROUGH EMOTIONAL INTELLIGENCE

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Background: There is an epidemic of physician burnout in the United States, and it has a pervasive and negative effect on all aspects of medical care including, but not limited to, career satisfaction and overall physician wellbeing. The 2015 Medscape Physician Lifestyle Survey reported an even higher burnout rate – 46 percent of physicians, up from 38.9 percent in the 2013 survey. There is an alarming rate of burnout and mounting stress among physicians in all levels of training, from residency through attending level careers. Awareness of the risks of burnout, depression, learner mistreatment, and suboptimal learning environments is increasing in academic medicine. One approach to enhancing and fostering resilience in the work place is the concept of Emotional Intelligence (EI); a set of four emotional skills that promote resilience and adaptive function during stressful situations for men and women.

Objectives: Within the Christiana Care Health System (CCHS), the Internal Medicine Residency program has taken strides to tackle the issues of residency burnout, stress and depression. Through a progressive and innovative perspective, the program has allotted time for all same-year residents to participate in a two-day retreat focused on EI and resiliency.

Methods: The Christiana Care Internal Medicine retreat curriculum has been revised to incorporate a framework that assists residents with developing emotional intelligence and resilience skills. This curriculum is a longitudinal curriculum that spans over all three years of residency. In the first year, the retreat will emphasize self-awareness and self-management skills. In this retreat, interns will start to identify the factors that make up their personality and how they respond to people who are different from them. In the second year, the emphasis will be on reflection on how their individual traits and emotional intelligence can lead to fear, frustration, and anger. They will then go on to reflect on the places that build resilience in their lives with discussion on acceptance, empathy and joy. This will be within the context of social structures and relationship management. In the final retreat, residents will continue their discussion on relationship management with a session on conflict resolution and learning how to build relationships. They will then complete the curriculum with a session that empowers them to identify the support systems in their lives that promote work life balance and their own personal resilience.

Results/Outcomes/Improvements: The retreats have not been implemented yet so data/results are not available. We aim to assess resident’s acknowledgment and conceptualization of emotional intelligence, self-awareness, self-management, and resiliency through survey format and individual/group feedback.

Significance/Implications/Relevance: Emotional intelligence comprises a set of four emotional skills that enhance the ability to perceive emotion up through managing emotion. EI can facilitate resilience and grant psychological and physiologic responses to help mitigate the stress process. The Internal Medicine program as CCHS has taken strides to allow the instrumentation and development of these skills through dedicated retreat time for its residents in an overall effort to promote health and wellness within the program and at large.
THE WEST VIRGINIA PHP EXPERIENCE EDUCATING MEDICAL STUDENTS AND RESIDENTS

Primary Author: Brad Hall, MD, WV Medical Professionals Health Program Inc. / Federation of State Physician Health Programs

Faculty and Staff Involved in Initiative: P. Bradley Hall, M.D., WV Medical Professionals Health Program/Federation of State Physician Health Programs Norm Ferrari, M.D., Vice-Dean for Education & Academic Affairs, West Virginia University School of Medicine Clay Marsh, M.D., Vice-President & Exec. Dean for Health Sciences, West Virginia University School of Medicine

Background: Each year as Executive Medical Director of the WV Physicians Health Program, I present a 1.5 hr lecture to the entire second year class and later in the year during orientation to the entire incoming class of residents on the signs and behaviors of potential impairment and the physicians health program. Topics covered include potential impairment, the physician "human-ness", mental illness, substance use disorders, suicide, burnout and resilience with real statistics of the WVMPHP.

Objectives: 1-Provide an overview of the content of the annual lecture provided to medical students and residents. 2-Recognize the applicability to multiple disciplines within the healthcare professional population. 3-Understand the role of the Federation of State Physician Health Programs and the availability of physician health programs in the overwhelming majority of states.

Methods: Powerpoint presentation began on an annual basis a few years ago and has been included as a regular portion of the physical diagnosis course for all 2nd year medical students. It has also been included as part of orientation for all incoming WVU residents.

Results/Outcomes/Improvements: The culture of WV University School of Medicine has changed to prevention, earlier intervention and support of students and residents in need. Referrals to the WVMPHP have increased significantly.

Significance/Implications/Relevance: The culture of medicine in "we are our brother's keeper" and physicians like other non-physicians suffer the same conditions. In addition to the knowledge of assistance and guidance, should the need arise the stigma toward self, colleagues and patients can shift toward one of improved physician health and public safety as the careers continue.

Plans for the Future: Continue the same lectures, keeping up to date with current trends and statistics and potentially expanding on programs within the medical schools toward more student and resident health and wellbeing.

Additional Comments: A one hour Powerpoint presentation could capture the overall content of the usual student/resident presentation without going into excessive detail as I would during the presentation. 10-15 minutes about the Federation of State Physician Health Programs and their membership programs maybe helpful to your audience in accessing PHPs to assist with educational needs related to student and resident health and wellbeing. The link below is to the WVMPHP website homepage where the 1.5 hour web course providing CME to nurses and physicians may be accessed. There is also a link to the collaborative web course meeting the legislative mandated 3-hour CME for Best Practices and Proper Prescribing.

Website: www.wvmphp.org
EXPLORING MEDICAL RESIDENT ENGAGEMENT AND BURNOUT - QUALITATIVE RESEARCH STUDY

Primary Author: Susan Orrange, PhD, University at Buffalo Jacobs School of Medicine and Biomedical Sciences

Faculty and Staff Involved in Initiative: Susan M. Orrange, PhD, University at Buffalo; Julia Colyar, PhD, University at Buffalo

Background: Engagement with difficult challenges at work, a component of resilience, is a key to enhancing quality of care and compassion among physicians. Engagement in higher education learning environments is related to persistence and academic success, and engagement in work has been described as the opposite to burnout. Many studies confirm high burnout levels among residents and show that burnout impacts work performance and patient safety. Yet current literature has limited information on how residents meaningfully engage within their learning environments to persist, succeed, and flourish in learning and work despite individual and organizational challenges.

Objectives: This qualitative interview study was designed to determine how residents engage within their training programs, as both learners and employees, and how engagement elements relate to burnout. It explored the cognitive, emotional, and behavioral ways residents are involved in their educational and job practices.

Methods: Individual interviews were conducted with ten pediatrics and obstetrics-gynecology residents, using engagement concepts from higher education and psychology to inform the design of the questions. Interviews were audiotaped, transcribed, and analyzed using open coding, preliminary development of themes, focused coding, and final theme construction.

Results/Outcomes/Improvements: Qualitative data analysis revealed several interconnected themes. Personal and environmental elements interact in a way that includes and extends elements of established models of student and work engagement, and also adds to the existing resident well-being literature. Personal elements include feelings of personal responsibility, development of autonomy, and celebrations of achievement. Environmental elements include rapid shifts in responsibility throughout training progression, pervasiveness of training, and the importance of a supportive environment in a hierarchical setting. The resident teaching role also featured prominently as a way residents meaningfully engage in learning activities, extending ideas of engagement presented in the higher education and work engagement models.

Significance/Implications/Relevance: By gathering individual perspectives of residents, this research begins to establish a definition of engagement in residents that is more complex and nuanced than simply involvement or participation. Work-related engagement components, such as control, choice, feedback, sustainable workload, efficacy, and learning opportunities are important to residents, and blend with learning engagement concepts such spending time and effort in meaningful learning tasks, clear pathways to learning, a supportive environment, shared responsibility, and interactions with peers and faculty. These findings will be helpful in developing effective pedagogical strategies to fully engage residents in their work and learning experiences, which continues as a priority identified by the ACGME. This study will catalyze further research to deeply examine how engagement elements impact learning and humanistic development in order to facilitate the integration of resident engagement into health professions education, clinical learning environments, accreditation standards and healthcare policy.

Plans for the Future: A team of five researchers at the University at Buffalo received a “Mapping the Landscape, Journeying Together: 2016-2018 Literature Review Grant” from the Arnold P. Gold Foundation to explore the topic, “Engagement in residency: A systematic, meta-narrative literature review.” The goal of this Gold Foundation project is twofold: provide support for a review of the literature to understand current evidence, fill gaps in knowledge and create a research-informed agenda for change; and form a community of practice to make positive change in the field of humanism in healthcare.
CREATING A CULTURE CODE: RESIDENCY RETREAT TO DEFINE OUR VALUES

**Primary Authors:** Audra Williams, MD, MPH, PGY-2; Jonathan Lichkus, MD, MPH, PGY-3 (Lawrence Family Medicine Residency)

**Faculty and Staff Involved in Initiative:** Wendy Barr, MD, MPH, Program Director

**Background:** Burnout in residency is a well-known phenomenon that affects all physicians and residency programs. A unique challenge for residents in our program is learning to work with our medically and socially underserved patient population. The Lawrence Family Medicine Residency (LFMR) is based in Lawrence, MA and serves predominantly Spanish-speaking immigrant families from the Dominican Republic. Residents who match with LFMR are expected to not only learn how to be a resident and physician, but also to learn a new language and culture.

Our wellness and behavioral health curriculum provides a wide array of programs to promote resident well-being. Our schedule includes weekly behaviorist-led support group for interns, Balint for seniors, and monthly wellness sessions dedicated to facilitated meditation, yoga, goal-setting, or journaling. In addition, we have an annual overnight retreat that includes all residents and their families. We also have two half-day Wellness retreats per year for residents and core-faculty.

This year, one half-day retreat was dedicated reflecting on the motivation that brought us to family-medicine and to the Lawrence community. Using a model based on appreciative inquiry, residents and faculty created our first “Culture Code” [1]. The idea was inspired by other progressive organizations, most notably, ‘Possible,’ a US non-profit that delivers health care in rural Nepal [2].

**Objectives:**

1. Create a residency retreat that would foster wellness
2. Design a Culture Code that documents our values and expresses how we approach our work every day

**Methods:** Residents and core faculty members were invited to participate in this four-hour retreat. The session was divided into the following three parts:

1) ‘*Fill your glass*’: Participants were paired, and given 5-10 minutes to discuss what attracted them to Lawrence, the story that describes the time you were most connected with or proud of Lawrence, and to name three aspirations for the future of our program. Each member shared their partner’s responses to the group.

2) **Define who we are:** In groups, we chose words to describe what values currently exist in our program, what kind of residents we want to attract, and what changes need to be made in our culture. The words were submitted to create a ‘word cloud’ to display the responses.

3) **Create the Culture Code:** We brainstormed themes that define us, which resulted in the categories of forward-thinking, advocacy/social justice, support, patient care, joy and fulfillment, community, and improvement. Five participants self-selected to each group, and completed the phrase, “When we are at our best, we...”. After about twenty minutes, phrases were written on posters, and each group read aloud their phrases to the rest. Participants were given seven stickers to place next to the phrases on the various posters that rang most true to them. The eight phrases with the most votes (by sticker-count) were to be included in the culture code.

**Results/Outcomes/Improvements:** Residents and faculty found resilience in reflecting on our shared passions and values. By working and brainstorming together, we were able to find meaning in the long hours and hard work we put into our daily jobs. The final culture code resulted as follows:

*Lawrence Family Medicine Culture Code*

- We learn to become the doctors our patients and communities need
- We partner with our community and speak up and show up for those who can’t
We see the big picture—and dream bigger
We acknowledge our own limits and collaborate openly
We learn family medicine from family physicians
We never stop learning
We inspire, support, and learn from each other
We challenge systems of injustice

Significance/Implications/Relevance: We feel that with the stress of long hours and heavy work-loads, we as residents and faculty members as well may not take time to remember what brought them to Family Medicine and to Lawrence in the first place. Spending time reflecting on our common mission helped us remember that we are working together in solidarity toward the same goals. Having the Culture Code now serves as a reminder to us when we may feel overwhelmed or burned-out in our work, to not only remember why we dedicate so much of our lives to our work, but also how to do so.

Plans for the Future: We plan to share our Culture Code with community members, other healthcare organizations, and future interested applicants to demonstrate our shared values. With passing time, we will continue to re-evaluate our Culture Code, and perhaps in several years with new classes of residents, we may re-think our chosen code and update as necessary to fit the ever-evolving residency.

Website: lawrencefmr.org
Sources: