Wellness Activities on National Level

Arthur S. Hengerer, MD

Pandion Conference

November 14, 2018

LEWIN'S LAW - 1936

B=f (P+C)

Behavior = Function (Person + Environment)

System (Physician + Health System)

Wellness

CULTURE CHANGE

Opening Remarks

- **I don’t have the answers BUT will give you some insight**

1 Wellness focus has changed from the individual to systems

2 There is no single solution: example the Conceptual Model

3 There is system wide stress now evident and fixing one underlying problem doesn’t fix the system

4 Within a system different groups are progressing and solving problems at different rates so don’t build bridges.

5 Will requires leadership at top to gain traction

- **What have we learned to change this direction? Change Culture!**

Where are the issues and how are we addressing them?

Today we have system wide stress so fixing one underlying problem does not fix the system and the resulting burnout.

If it had been easy to do it could have been solved a long time ago.

A good process requires a general statement of what causes what and why.

Now there is a well organized effort to address the what and why factors of burnout at an individual and more importantly system approach

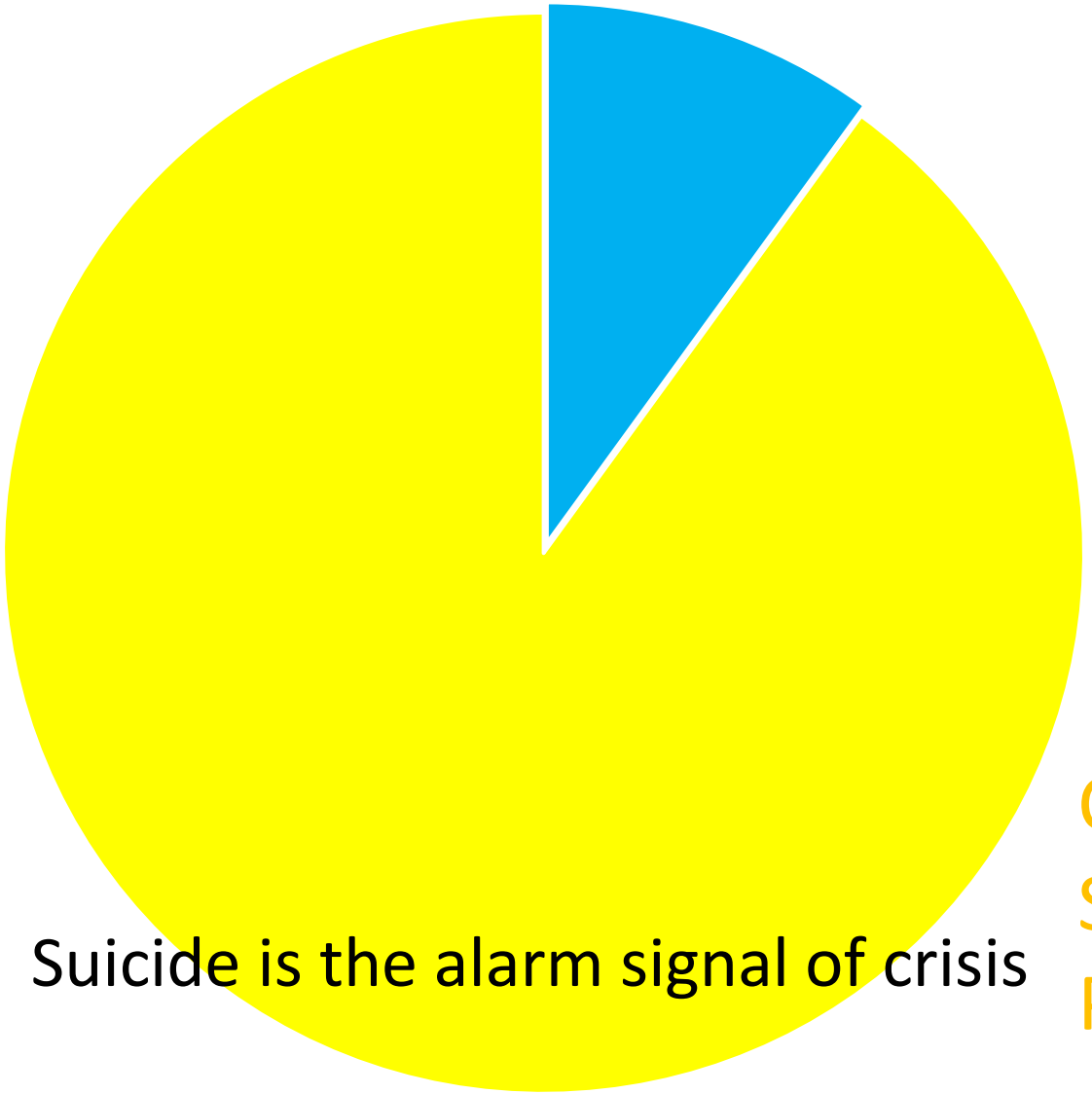
It’s Not a Problem But a Dilemma

Providers

10%

Self Care
Work/Life Balance
Wellness
Resilience

Cognitive
Performance



System Design

90%

Triple Aim
or
Quadruple Aim

Cost
Service
Patient Satisfaction

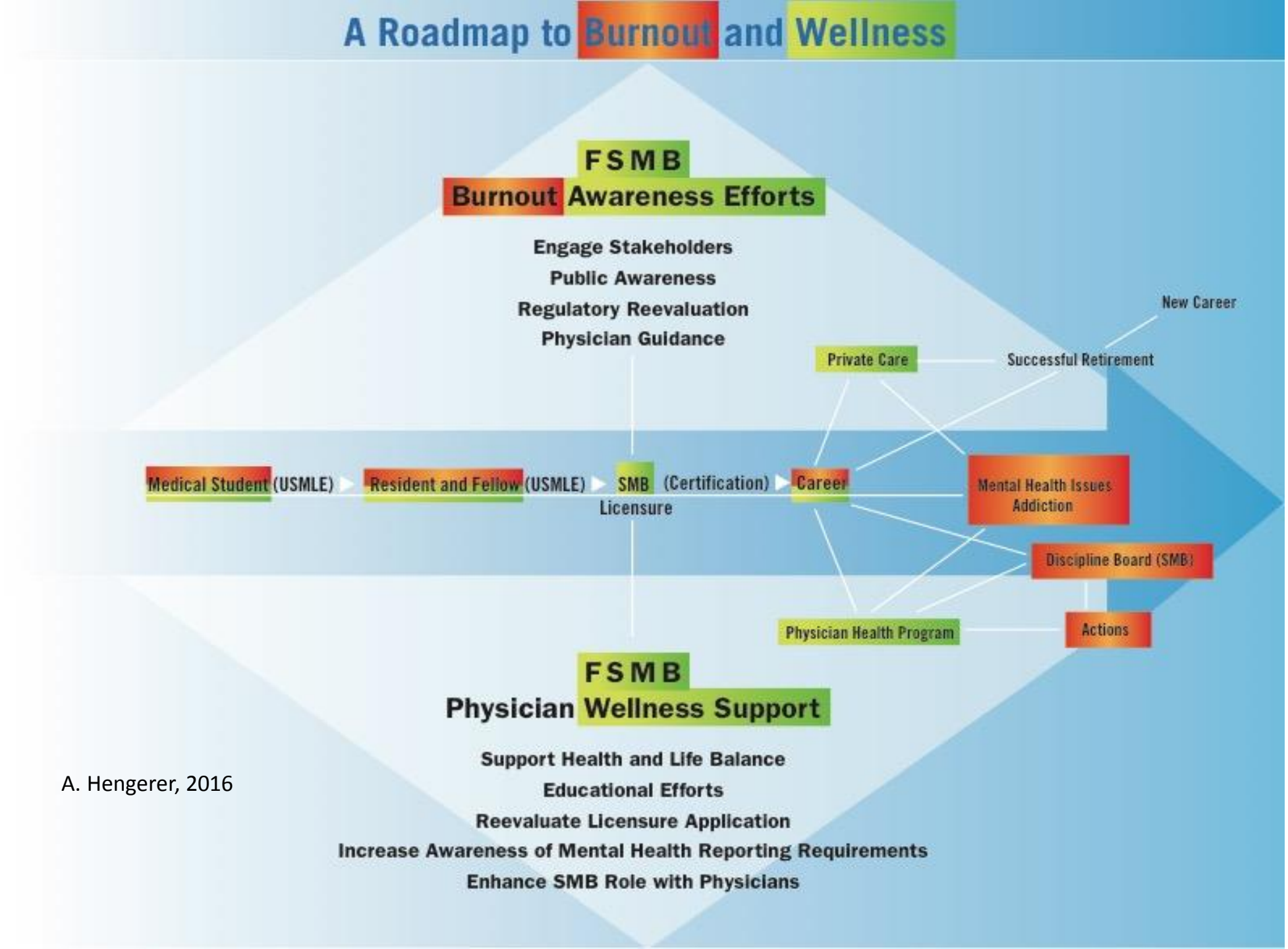
Suicide is the alarm signal of crisis

Culture Change: What needs to happen?

- **Leadership**
- **Finances**
- **Communication**
- **Autonomy**
- **Teamwork**
- **Research and Data**

Personal efforts towards wellness

- **Federation of State Medical Boards**
  - **Past Chair of Board 2017-2018**
  - **Chair Workgroup on Burnout and Wellness**
  - **Changes in guidelines on medical license applications**
- **Professional Medical Conduct Board Activities**
  - **Addressing Burnout when considering misconduct**
  - **Efforts to change punitive image of the office**
  - **Physician Health Program (CPH in NYS)**
- **National Academy of Medicine: "Action Collaborative"**
  - **Structure and mission of the project**
  - **Conceptual model design and Knowledge Hub**
  - **Various activities in progress**
  - **Changing the Culture and the "Culture of Silence"**



A. Hengerer, 2016

Federation of State Medical Boards Work group

- 14 National Organizations Involved
- Drafted a Report with national feedback
- 25 recommendations in the resulting resolution drafted
- Guidelines approved by the House of Delegates in April 2018

Stakeholder Summit

The Joint Commission

NATIONAL ACADEMY OF MEDICINE

AOA AMERICAN OSTEOPATHIC ASSOCIATION

AAMC

MAYO CLINIC

NPSF National Patient Safety Foundation®

UNIVERSITY of ROCHESTER MEDICAL CENTER

AMA AMERICAN MEDICAL ASSOCIATION

Federation of State Physician Health Programs

ACGME

American Hospital Association®

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

HealthIT.gov Advancing America's Health Care

Federation of STATE MEDICAL BOARDS

License Application Question Design

- Trigger point for many stakeholders in healthcare
- Each state has its own application questionnaire and requirements
- Questions addressing disease or impairment can cause deferral or avoidance of help and treatment
- Physicians may feel compelled to submit inaccurate responses, thereby defeating public protection goals of questions

Illness vs. Impairment

Illness is the existence of a disease. Impairment is a functional classification and implies the inability of the person affected by disease to perform specific activities.

FSPHP Policy: Physician Illness vs. Impairment

"Impairment is the inability of a licensee to practice medicine with reasonable skill and safety as a result of a mental disorder, physical illness or condition, or substance-related disorders"

FSMB Policy on Physician Impairment

"Physical or mental health conditions that interfere with a physician's ability to engage safely in professional activities can put patients at risk, compromise professional relationships, and undermine trust in medicine."

AMA Ethical Opinion 9.3.2

Licensing Process

45 of 52 Licensure Applications reviewed contained questions about applicant mental health

Polfliet, S. *J AAPL* 2008; 36(3)

Presence of questions about mental health or substance use may cause physicians to avoid or delay treatment

Schroeder R, et al. *Acad Med* 2009; 84(6)

"Women physicians report substantial and persistent fear regarding stigma which inhibits both treatment and disclosure"

Gold K, Andrew L et al. *Gen Hosp Psychiatry* 2016; 43

Licensing Process

69% of physicians surveyed who were experiencing symptoms of burnout were significantly more likely to avoid seeking treatment if required to report this on licensing applications or renewals

Survey of NY Licensees by FSMB and MSSNY

N.B. NY does not currently include any questions about mental health or substance use on licensing applications

Medical License Applications

- **Significant issue in the NAM collaborative and the House of Medicine**
- **New guidelines proposed for initial and renewal applications by FSMB draft**
- **Follows the recommendations of the APA and ADA**
- **Recommendation that only need to report issues of mental health if currently Impaired.**
- **“Safe Haven” policy for care**
- **Opportunity to impact stigma and avoiding treatment**
- **Allows for opportunity to view Burnout and Impairment differently and for decisions of Licensure, Discipline and PHP in the SMB**
- **Avoids unintended consequences**
- **Potentially impacts health of the physician and the public**

FSMB License Application Recommendations

- **Ensure differentiation between illness (diagnosis) and Impairment**
- **Not seek information of past impairment (>2years)- BUT focus on if currently impaired is preferred**
- **Address mental health in same manner as physical health**
- **Create a “safe haven” opportunity without public disclosure**

FSMB License Application Recommendations

- **Question Guideline from APA and ADA:**

“Are you currently suffering from any condition for which are not being appropriately treated that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?”

(Yes/No)

Goal of question changes

- **Encourage physicians to seek help early**
- **Remove the stigma of admission of need for help**
- **Change the perception's of the medical board from always punitive**
- **Improve the well-being of the physician**
- **Healthy physician helps give quality care to patients**
- **Find evidence that it will result in protecting the public**
- **Role of "Duty to Report"**

Legislative Regulatory Laws and Actions

- State Medical Board of Licensure and Discipline
- Board of Professional Medical Conduct

Future Considerations

- **Changing application questions on mental health is only a first step**
- **Clarify distinction between Burnout/Depression cases from actual misconduct so without punitive actions**
- **Encourage self care without repercussions by the SMB**
- **Work with PHPs to collect data on referrals and licensing and discipline trends**
- **Work toward a collaborative and supportive environment**
- **Look to PHPs to help develop effective programs with involvement of others to oversee efforts through**
  - **Medical Society – State or Local**
  - **Specialty Societies**
  - **Health Systems**
- **Make a system so that physicians feel safe**

Future Considerations

- **Revalidation process in UK (appraisal and self reflection portions)**
- **Steps to make SMB be less punitive**
- **Investigation Process**
  - **Evaluate practice environment**
  - **Use Maslach Burnout Inventory**
  - **Include corrective action in monitoring program**
  - **Insist on establishing wellness and work life balance**
- **Use prospective data to identify problems early**
- **Data to determine the relationship between burned out and disciplined physicians**
- **Standardize and align SMB and PHP**
- **Hospital Credential Committees have similar issue**

Physician Health Programs Roll

- **Program structures vary by states in over site and reporting (safe haven policy)**
- **Physician can self refer or directed to enter by discipline board**
- **Monitor physicians with mental health and addiction problems**
- **Protects physician from public disclosure of actions**
- **Once issue stabilized can return to practice with monitoring**
- **This true in about 90+% of those who enter programs**
- **At times may also require a CCE to offer diagnostic assistance – how process works**

National Academy of Medicine

Action Collaborative on Clinical Well-Being and Resilience

nam.edu/clinicianwellbeing

Leadership Advances

- **NAM “action collaborative” initiative with 65 participants moves problem from multiple silos to now a national connectivity**
- **In 2019 a NAM Consensus Study: “System Approaches to Improve Patient Care by supporting physician well-being”**
- **Chief Wellness Officer in the C suite**
- **Shanafelt Article: “Exec. Leadership and Physician Well-being: 9 Strategies to Promote Engagement and Reduce Burnout”**

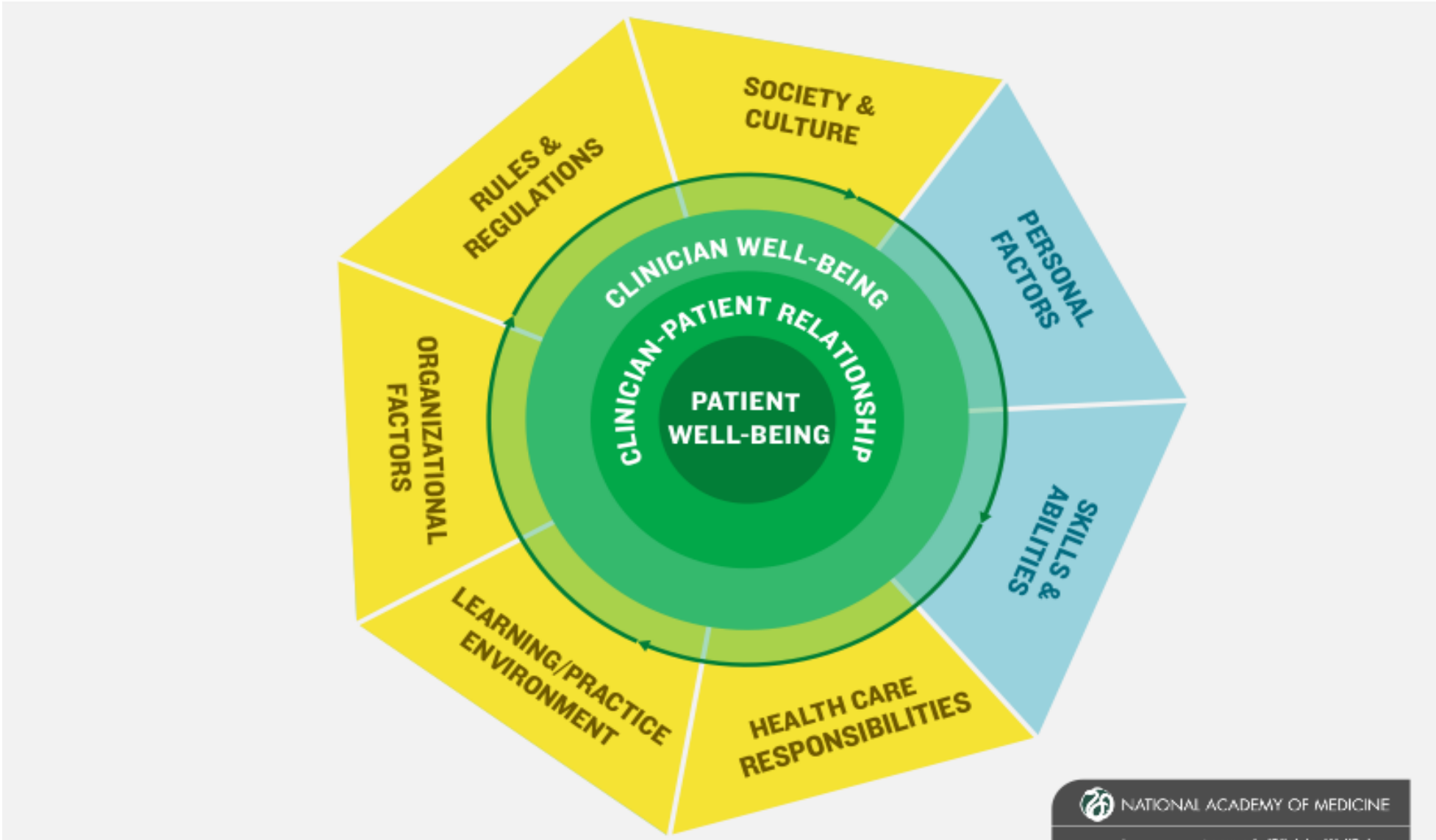
Design of Project

Four Work Groups created:

- **Conceptual Model**
- **Research Data and Metrics**
- **External Factors and Workflow**
- **Messaging and Communications**

FACTORS AFFECTING CLINICIAN WELL-BEING AND RESILIENCE

This conceptual model depicts the factors associated with clinician well-being and resilience; applies these factors across all health care professions, specialties, settings, and career stages; and emphasizes the link between clinician well-being and outcomes for clinicians, patients, and the health system. The model should be used to understand well-being, rather than as a diagnostic or assessment tool. The model will be revised as the field develops and more information becomes available. Subsequent layers of the model, and an interactive version of the model, are in development in conjunction with the Action Collaborative's other working groups and will be made available shortly.



EXTERNAL FACTORS

SOCIETY & CULTURE

- Alignment of societal expectations and clinician's role
- Culture of safety and transparency
- Discrimination and overt and unconscious bias
- Media portrayal
- Patient behaviors and expectations
- Political and economic climates
- Social determinants of health
- Stigmatization of mental illness

RULES & REGULATIONS

- Accreditation, high-stakes assessments, and publicized quality ratings
- Documentation and reporting requirements
- HR policies and compensation issues
- Initial licensure and certification
- Insurance company policies
- Litigation risk
- Maintenance of licensure and certification
- National and state policies and practices
- Reimbursement structure
- Shifting systems of care and administrative requirements

ORGANIZATIONAL FACTORS

- Bureaucracy
- Congruent organizational mission and values
- Culture, leadership, and staff engagement
- Data collection requirements
- Diversity and Inclusion
- Harassment and discrimination
- Level of support for all healthcare team members
- Power dynamics
- Professional development opportunities
- Scope of practice
- Workload, performance, compensation, and value attributed to work elements

LEARNING/PRACTICE ENVIRONMENT

- Autonomy
- Collaborative vs. competitive environment
- Curriculum
- Health IT interoperability and usability/Electronic health records
- Learning and practice setting
- Mentorship program
- Physical learning and practice conditions
- Professional relationships
- Student affairs policies
- Student-centered and patient-centered focus
- Team structures and functionality
- Workplace safety and violence

HEALTH CARE RESPONSIBILITIES

- Administrative responsibilities
- Alignment of responsibility and authority
- Clinical responsibilities
- Learning/career stage
- Patient population
- Specialty related issues
- Student/trainee responsibilities
- Teaching and research responsibilities

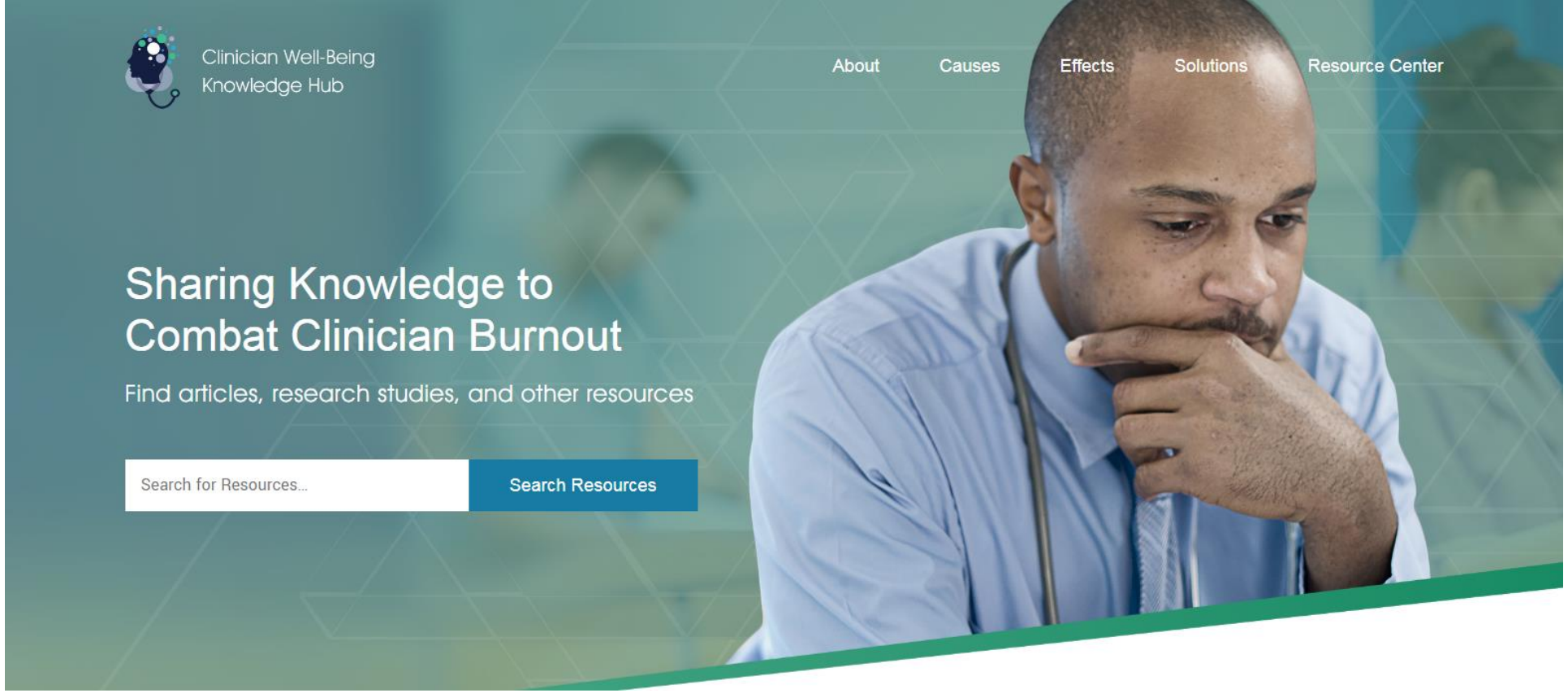
INDIVIDUAL FACTORS

PERSONAL FACTORS

- Access to a personal mentor
- Inclusion and connectivity
- Family dynamics
- Financial stressors/economic vitality
- Flexibility and ability to respond to change
- Level of engagement/connection to meaning and purpose in work
- Personality traits
- Personal values, ethics and morals
- Physical, mental, and spiritual well-being
- Relationships and social support
- Sense of meaning
- Work-life integration

SKILLS & ABILITIES

- Clinical Competency level/experience
- Communication skills
- Coping skills
- Delegation
- Empathy
- Management and leadership
- Mastering new technologies or proficient use of technology
- Optimizing work flow
- Organizational skills
- Resilience
- Teamwork skills



Healthy clinicians provide better patient care.
Let's build a better system that helps clinicians thrive.

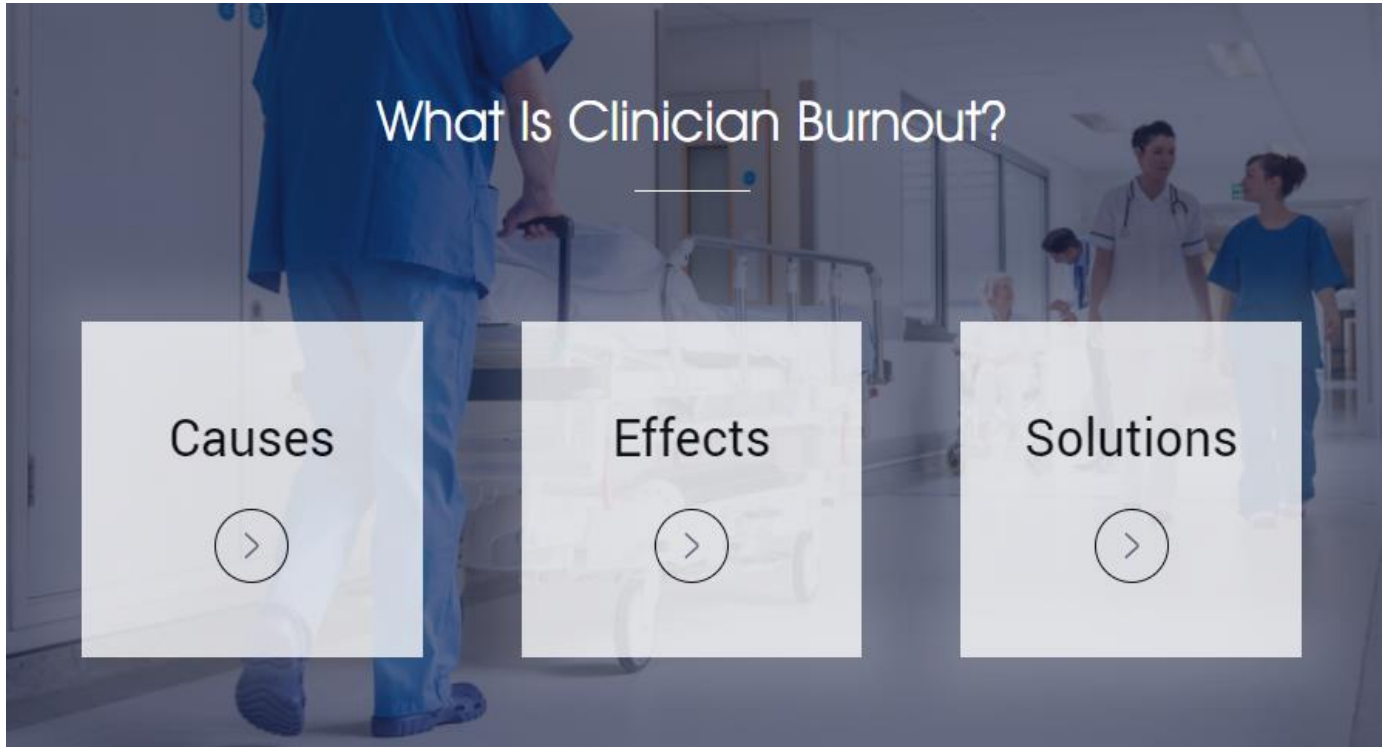
nam.edu/clinicianwellbeing

National Academy of Medicine
Action Collaborative on
Clinician Well-Being and Resilience

NATIONAL ACADEMY OF MEDICINE

Knowledge Hub is organized around three main topics

- **Causes:** Organizational factors, learning environment, practice environment, society and culture, personal factors, rules and regulations
- **Effects:** Safety and patient outcomes, clinician well-being, turnover and reduction of work effort, health care costs
- **Solutions:** Organizational strategies, measuring burnout, individual strategies



Making the Case for a Chief Wellness Officer

"In order to direct a robust program serving large cohorts of physicians and other healthcare providers, it is vital to have an experienced leader as a guide to facilitate system-wide change to a culture of well-being and implement evidence-based interventions to improve outcomes. A leader with the authority, budget, and scope to implement such an ambitious agenda should reside within the executive team, or C-suite - Chief Wellness Officer (CWO).

Here, we make the case for a Chief Wellness Officer as a collective of former and current Deans of health professional schools, CEOs of health systems, and faculty members that have committed to the creation of CWO positions. We also include three current chief wellness officers from Stanford, Ohio State and the Icahn School of Medicine at Mount Sinai. "

NAM Publications

- “The Person-Centered Health Information System: Vision and Call to Action”
- “Pragmatic Approach to Organizations to Measure Health Care Professional Well-Being”
- “Implementing Optimal Team-Based Care to Reduce Clinical Burnout”

Summary:

- Assume a leadership role to solve a problem

  BOTH Physician + Administration
- The priorities will not be the same
- Those not involved in decisions usually not strong supporters of initiatives = communication
- Determine what clinical efforts required and where can find support = team based care
- Develop strategy for success = autonomy
- Culture change is not easy it involves people with multiple ideas and opinions
- Remain passionate and focused on the goal

National, State, County, URMC Wellness Update

Michael R Privitera MD, MS

Professor of Psychiatry

Medical Director, Medical Faculty and Clinician Wellness Program

University of Rochester Medical Center

Chair, Medical Society of the State of New York Committee on Physician Wellness and Resilience.

Medical Society State of New York

Task Force on Physician Stress and Burnout

Projects	Status
Statewide Survey (November 2016); FSMB 2^0 analysis of data 2017	Done, data used in NONY and submitted for publication.
Website Development & Content (Physician Burnout Library)	Operational http://www.mssny.org/ Practice resources. Physician Burnout Library
Presentations Development/Speakers Bureau	Presentations built, starting Speaker's Bureau Feb 1, 2018
1. To individuals	
2. To healthcare system admin	
3. To other healthcare stakeholders	
Articles in MSSNY "News of New York" 1. Personal and Public Health issue 2. State of the State- survey findings 3. Individual interventions 4. Organizational Interventions 5. Advocacy	All published NONY & MSSNY website
Peer support program development	Best Practices done, operationalizing
Coaching resource development	Not done
Outreach collaborations	
• Residents	Yes, one conference
• Liability companies, Malpractice Carriers	Yes. Presentations to 3.
• Patient advocacy	Not yet
• Hospital systems (GNYHA, HANYS)	Yes, conf. planned with both.
• Multi Stakeholder Position Statement	Not yet
• Medical Students Allopathic & Osteopathic	Yes, Med schools of NYS and member of TF

MSSNY Presentation Framework

Core Burnout Situation in Healthcare	Key Facts on Impact of Burnout	Audience Focus	Key Points	Key Interventions
A personal and public health issue. **Threat to the healthcare system.** **Public aware** **Work stressors that contribute to burnout:** **-Excessive work load (physical cognitive emotional)** **-Lack of control** **-Poor balance between effort and reward** **-Lack of community** **-Lack of fairness** **-Value conflict.** **Often, our most ideal doctors are at the highest risk for becoming burned out.**	54% MDs in US have significant Burnout. Increased 9 % in 3 years. <u>Three criteria:</u> **Emotional exhaustion, Callousness, Decreased Efficacy** affect patient care in multiple negative ways. <u>Related to:</u> Increased medical errors, malpractice claims, disruptive behavior, personal medical claims, divorce, substance abuse, depression, suicide, heart disease, decreased patient satisfaction, decreased patient adherence	**Individuals (Healthcare Professionals)**	Start out with high resilience, but worn down by occupation. Taking care of self not only important to self but for ability to do good work. Systemic issues will take longer to address.	Awareness, Self-care. Setting personal boundaries on hours worked, Getting help, protective confidentiality laws, mindfulness, yoga, resilience training, 3 Good Things, Gratefulness journaling. Online and in person resources. Peer Support, Coaching, Employee Assistance Program (EAP), mental health care.
		Health Care System Administration	80% of stressors are systemic. Impact is pervasive, financial, safety, quality. Leadership understanding of factors and taking action is critical. Employees fearful to speak up, fear of retribution (feedback sanction).	Quadruple Aim Framework of Healthcare (Cost, Quality, Patient Experience + 4th Aim= **Experience of providing care, with relevant Human Factors considerations**). Wellness Initiative Strategic Planning Work Group Anonymous survey, anonymous feedback systems. Measure clinician wellbeing (PWBI, Mini Z 2.0, etc.). Tie these into quality and safety metrics Challenge the culture of endurance and culture of silence. Encourage better physician/ administrator relationships. Confidentiality in clinicians obtaining help and not having to report their MH treatment history on credentialing.
		Other Healthcare Stakeholders	80% of stressors are systemic. Multiple external contributions to this. Need for collaboration with clinician groups in anticipating unintended consequences of mandates imposed. More consideration of co-occurring forces and initiatives that may compete with their own.	Encourage collaborative relationships with clinician groups. More awareness of accountability for downstream cumulative effects of mandates from decision-makers. First Do No Harm philosophy must apply to any individual or agency that touches the clinician-patient relationship. Organizational and systemic decisions (blunt end of care) have been known to be the cause of latent factors in errors of patient care and clinician burnout. Advocacy, effect on legislation, policy, culture. Working with MSSNY, AMA, medical societies. Self-Care aspect of getting involved as volunteer in these activities

Physician Wellness and Resilience Resources

Reference Articles

- Resources for Employers
- Resources for Those Responsible for Creating or Leading Wellness Programs
- Resources for Treating Physicians
- Resources for Individuals Feeling the Effects of Stress Or Burnout

Articles written by MSSNY Burnout Task Force

1. Physician Burnout as an Individual and Public Health Issue: The need to reassess best use of resources
2. Physician Burnout - The State of the State: MSSNY Task Force on Physician Stress and Burnout Survey Findings
3. Burnout Reduction for the Individual Clinician
4. Physician Burnout - Systemic/Organizational Issues and Solutions - A Roadmap for Leaders
5. Burnout: Advocacy Efforts

Links to numerous National Level Resources

American College of Physicians Physician Burnout and Wellness Information and Resource (ACP)

American Medical Association Steps Forward for Improving Joy in Practice (AMA)

Collaborative for Healing and Renewal In Medicine (CHARM) (CHARM)

National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience (NAM Action Collaborative)

National Academy of Medicine Clinician Well-Being Knowledge Hub (NAM Knowledge Hub)

https://www.mssny.org/MSSNY/Practice_Resources/Physician_/Physician_Burnout_Library

Top 10 Work Related Stressors in Physicians

Answered: 1,178 Skipped: 13

Rank Order Stressor	Description	% Responses	# Responses (Total # Respondents = 1183)
1	Length and degree of Documentation Requirements	65.99%	786
2	Extension of Workplace into Home Life (E-mail, completion of records, phone calls)	58.27%	694
3	Prior Authorizations for: Medications/Procedures/Admissions	54.74%	652
4	Dealing with difficult patients	51.89%	618
5	EMR functionality problems	51.05%	608
6	CMS/State/Federal laws and regulations	44.33%	528
7	Lack of voice in being able to decide what good care is	40.39%	481
8	Hospital/ Insurance company imposed Quality Metrics	38.87%	463
9	Dealing with difficult colleagues	31.49%	375
10	Requirement for increased CME/ Maintenance of Certification	31.49%	375

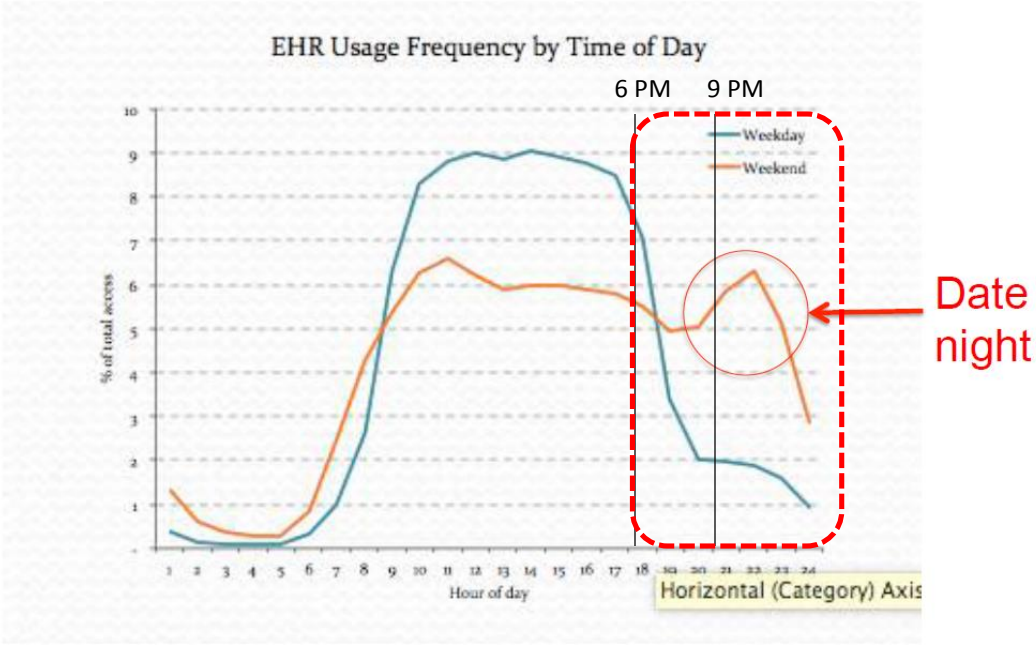
NYS physicians survey **MSSNY 2016**

EMR Work Bleeds into Home Life

Decreasing recharge time, family time.

- Physicians spend **more than 10 hours per week** interacting with the EHR after they go home from the office, on nights and weekends.

"Pajama Time"
Sat nights belong to Epic



Efficiency- Over 40 hrs. work/week:

- **(35% efficacy)** [#]

Extension of workplace into home life*:
(EHR documentation, phone calls, e-mails)

- ↓Job satisfaction (r = -0.155, $p < 0.001$)
- ↑Job stress (r = 0.252, $p < 0.001$)
- ↑Burnout (r = 0.230, $p < 0.001$).

Excessive/ moderately high time on the EHR at home*

- ↑ odds of burnout by 46% ($p < 0.05$)

Work Home Conflict (WHC)[^]:
'The need to perform both work and personal related tasks/ responsibilities simultaneously resulting in *conflict between work and home'.*

	Recent WHC	No recent WHC
Burnout	47.1%	24.0% [+]
Depression	50.4%	26.6% [+]
Seriously contemplating Separation or Divorce	14.0%	8.6% [+]
[+] p<0.0001		

EHR Usage Courtesy of Christine Sinsky MD, VP for Clinician Satisfaction, AMA & Brian Arndt MD, University of Wisconsin.

[#] Levitin DJ. The Organized Mind. Plume Press 2014

* Privitera MR, Atallah F, et al. 2018 Journal of Hospital Administration. Vol. 7(4) 52-59. 2018

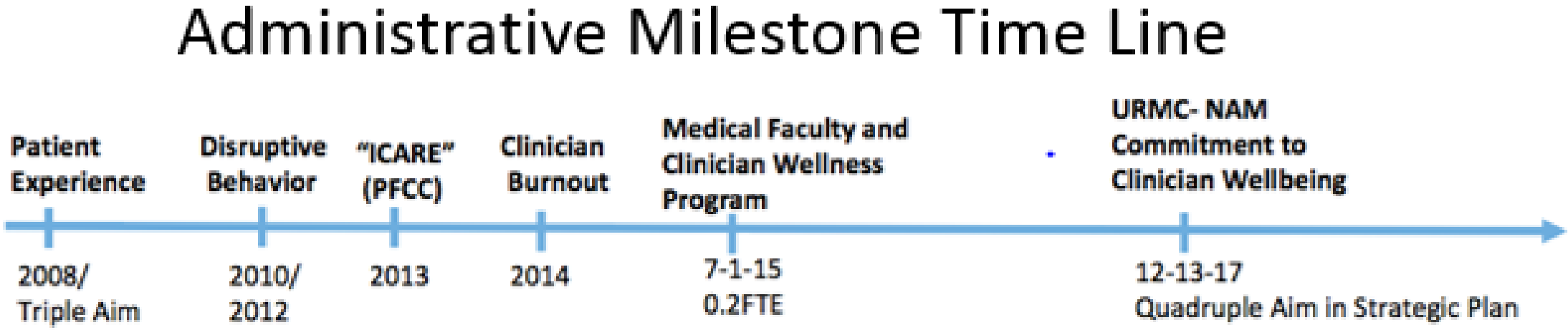
[^] Dyrbye LN, Sotile W, et al. J Gen Intern Med 2014 Jan;29(1):155-61

Monroe County Medical Society

Ensuring physician input on the practice of medicine in multiple venues:

- MCMS Quality Collaborative
  - Tailoring national/regional guidelines to fit this community and our physicians.
  - Advocating for reduction of Prior Authorization requirements–
- Advocating in Albany
- Compendium of online and community resources for burnout reduction
- Collaborating with Health Systems, Payers, ACOs
  (via 70 community committees and 5 boards)

URMC Evolution Toward Clinician Wellness



Burnout Interventions

Individual interventions must be paired with organizational interventions

Organizational

- **Overcome the medical culture of endurance**
- **Leadership style and concern is effective**
- **Establish: Wellness Initiative Strategic Planning Work Group**
- Include **human factor issues** in healthcare delivery
  - **The Quadruple Aim Framework:**
    - Costs, Quality, Patient experience, and **Fourth Aim: Experience of providing care.**
- **Understand the front line problems:**
  - **Anonymous survey** to learn key pain points
  - **Round table discussion** of findings
  - **Leadership commitment to action**.
- **Encourage stronger administrator/physician partnerships, with participatory management**
- **Use clinician wellness and career satisfaction metrics**
  - Tie these into quality of care, reduction of malpractice, errors, and patient satisfaction.
- **Organize completion of all mandatories, regulations**
- **No reporting of seeking mental health care on**:
  - licensure
  - malpractice carrier
  - credentialing applications or renewals.
- **Confidentiality** in seeking help

Individual

- Encourage recognition of Burnout
- Wellness Seminar series as “safe place’
- Normalize self care
- Normalize boundaries between work and home despite technology
- Multiple individual interventions available
  - Mindfulness
  - Resiliency training
  - Gratefulness
  - 3 Good Things
  - Yoga
  - Coaching
  - Employee Assistance- Wellness Division
  - Self Help websites and literature
  - Peer Support
  - Clinician ombudsman to have work/life balance representation
  - Diet, exercise

Medical Faculty and Clinician Wellness Program (MFCWP) and Partners

MFCWP Program

- **Wellness Seminar Series** (11 per year)
  - Titles validate stress and encourage safe place to discuss stress.
- **Academic Mentorship and central resource for departments and division based efforts.**
- **Internal Website**: Resources for 24/7 access, videos of seminars
- **Multiple Department Grand Rounds** (19)
- **Individual Chair and Chief Tour** (10)
- **Anonymous Survey**:
  - 3 Departments and all APPs

Data from Survey, seminar evaluations, literature

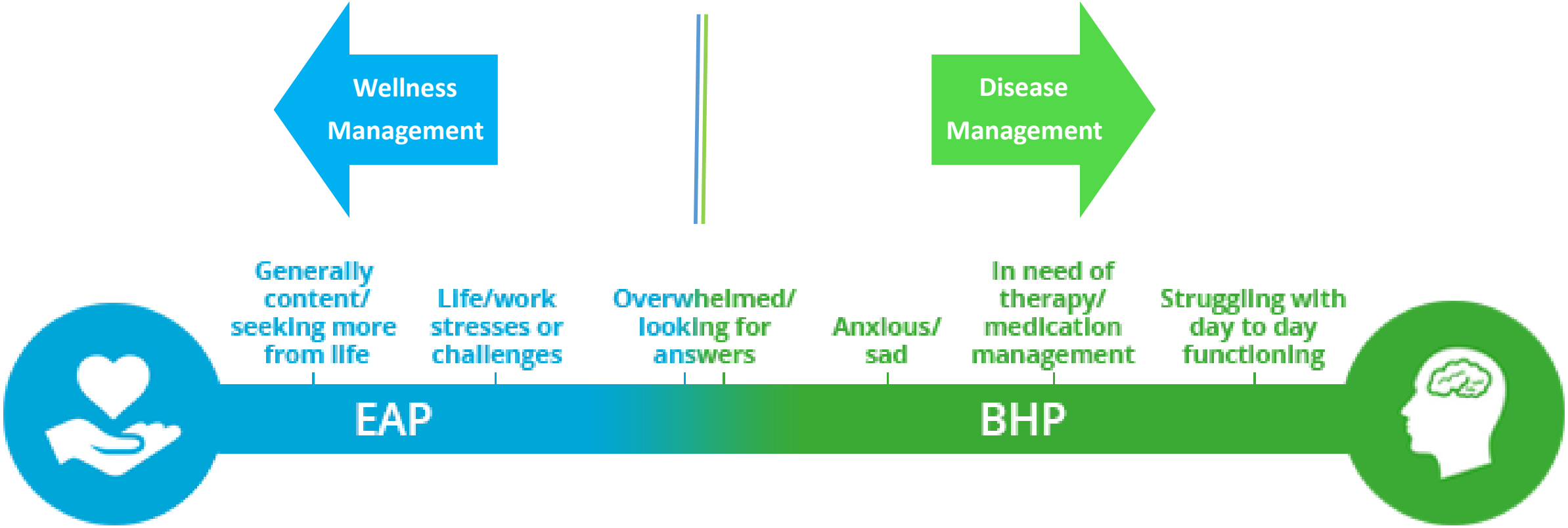
- **Wellness Strategic Planning Work Group**
  - Survey evaluation and processing of results
  - Think Tank
  - List of recommendations to senior leadership January 2017
- Wellness Coaching expansion: preventive and remedial
- Visiting Speakers:
  - Alan Rosenstein MD MBA
  - Christine Sinsky MD
- Medical Staff Office Project to organize mandatories
- 2 Visit Clinical Consultation of Clinicians (partnering with EAP)
- Department Model: Participatory management. Constituency input into problem solving.
- Organizational Structural Products:
  - Provider Advisory Committee
  - Ambulatory Medical Directors Committee
  - Scope of Practice Committee
  - Wellbeing Index –measurement.

Ongoing collaboration & synergy

URMC Internal Partners

- Faculty Development Office
- EMR Provider Satisfaction Campaign and HIT Innovation
- URMC Strategic Planning Office
- Patient Experience Office
- Quality and Patient Safety Office
- Patient Advocacy Reporting System (PARS)
- Employee Assistance Program
- Behavioral Health Partners
- Existing Wellness Initiatives
- Resident Wellness (CLER Initiative ACGME)
- Occupational Medicine
- Healthy Living Center

Wellness & Disease Management



- **Life-Work Connections/ EAP (475-0432)**
- **Behavioral Health Partners (276-6900)**

Spectrum of Options for Occupational Stress and Burnout URMC

1. Self-referral/ **prevention driven**
2. Clinical or administrative referral/ **event driven**
3. In house referral from other entry.

Wellness Management

Disease Management

"Wellness House"

Education

Well-U Physical Health and stress education

Healthy Living Center

Center for Employee Wellness (CEW) from SON

Grand Rounds

Wellness Seminar Series

Mindful-ness Program

Mobile Wellness Consult-ation Support Depart-ments And Divisions

Medical Faculty and Clinician Wellness Program Website Self Help Intranet Videos Internal and External

Clinician Experience

Clinician Experience Activities Social Events Appreciation Events

Stress Reduction Interventions from Wellness Work Group PWBI, PAC Amb Med Dir.

EAP Onboarding individual sessions (Anesthesia residents)

Coaching

Communication Coaching McDaniel et al. Team building Dealing with Difficult people Building general communication skills

Wellness Counselling

Employee Assistance Program (EAP) for personal and work related issues

SON Disease Management (School of Nursing)

Behavioral Health Partners (BHP)

Healthy Living Center Smoking cessation and Stress Management Division

EAP referral

BHP referral

2 Visit Physician Clinical Consultation

UNIVERSITY of ROCHESTER MEDICAL CENTER

National Academy of Medicine (NAM) Action Collaborative on Clinician Wellbeing-

URMC Commitment Statement

URMC Key Points:

1. Top Priority, major pillar of Strategic Plan
2. Embrace Quadruple Aim as institution
3. Measurement (PWBI)
4. Team Based Documentation
5. EHR Governance and Optimization
6. Developing Resilience skills: **Individual and with leadership training** on Human Factors/Ergonomics needed in today's rapidly changing Healthcare system.

URMC statement uploaded to NAM website: December 13, 2017, link: https://nam.edu/initiatives/clinician-resilience-and-well-being/commitment-statements-clinician-well-being/

URMC Wellness Strategic Planning Work Group "Blueprint" as of August 2018: Decrease Burnout –Improve Wellness

Year 1

Medical Faculty and Clinician Wellness Program

Wellness Strategic Planning Work Group
Phase I = Clinicians

1st Stage Project Focus

1. EMR Provider Satisfaction Campaign-.
2. Mobile team: Consultation and support to Chairs, Division Chiefs, Center Heads.
3. Coaching (Preventative)
4. Continued Wellness seminars
5. Medical Staff Office Project (requirement organization)
6. Leadership In-services
7. Wellness representation in all new clinician initiative groups
8. Resident Specific Issues with CLER
9. Clinician Wellbeing Measurement as Quality Indicator

Year 2

Phase II (hold)
Wellness Strategic Planning Work Group
Clinicians
Additionally Includes:
Researchers
School of Nursing Faculty
Nursing Practice
Social Work
CMO
Occupational Medicine
Human Resources
EAP
Well–U
BHP
Biometric Screening
Healthy Living Center
Quality and Safety

Subcommittees:

- Phase I Clinicians
- Resident Wellness

2nd Stage Project Focus

1. Constituency input into workflow solutions
2. Constituency input into Leadership ratings.
3. Strategy Group for stronger clinician/administrator partnerships
4. Integrate wellness efforts with disruptive behavior reduction efforts
5. Workflow and Scope of Practice committee
6. Wellbeing measurement for other sectors
7. Quadruple Aim Focus as Medical Center

Year 3

3rd Stage Project Focus

1. Wellness as quality indicator
2. Zero Tolerance but spectrum of Interventions wellness integrated with disruptive interventions (PARS based)
3. Exosystem program development (ways to reduce stress on family life outside medicine)
4. Examine Shadow Work (unseen, unmeasured, unpaid jobs that fill your day)
5. Dept. level wellness efforts

Year 4

- Chief Wellness Officer
- Organizational Health Focus
- Organizational Ergonomics and Individual (Neuro)cognitive Ergonomics approach
- Vast array of wellness programs for
  - Medical Faculty
  - Clinicians
  - Residents
  - Medical Students
  - Researchers
  - Nursing Practice
  - Social Work
  - School of Nursing Faculty
  - Trainees
  - Staff
- Wellness Impact on all Medical Center Operations
- Wellness representative on all new initiative committees
- Integration into usual HR operations
- EAP
- BHP
- Coaching
- Education

Key=> Active Started Not started

Physician Wellbeing Index (PWBI)

1. **Research supported by AMA and Mayo Clinic**
2. **Predicts risks for:**
   - **Low Mental Quality of Life**
   - **High Fatigue**
   - **Increased chance of Suicidal ideation**
   - **Poor Career Satisfaction**
   - **Intent to Leave current Job**
   - **Intent to reduce clinical work hours**
   - **Chance of self perceived recent medical error.**
3. **Brief self assessment; regular intervals; individually and anonymously connects to resources for help.**
4. **Provides context for what is typical for physicians versus higher risk for serious repercussions**
5. **Early intervention opportunities.**
6. **Aggregate data available to institution, divisible by departments/ divisions.**
7. **Next year, add Process Improvement Module: Allows write-in answers to questions.**

Dyrbye L, Satele D, Sloan J, Shanafelt T D. Utility of a Brief Screening Tool to Identify Physicians in Distress. J. Gen Intern Med. November 6, 2012. pp 421-427

Wellbeing & Graduate Medical Education Update: URMC Activities

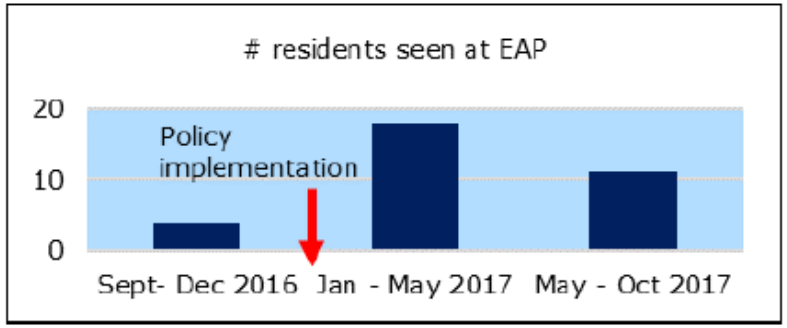
- **2018 Annual Resident & Fellow Wellbeing Report**
  - institutional, GME, & departmental wellbeing activities & action plans
  - Data from first annual **PWBI screening** and **Mandatory EAP program**
  - URMC data on workplace safety & injury

- **August 2018 PWBI Intake screening for all new interns & fellows**
- **October 2018 PWBI annual screening for all trainees**

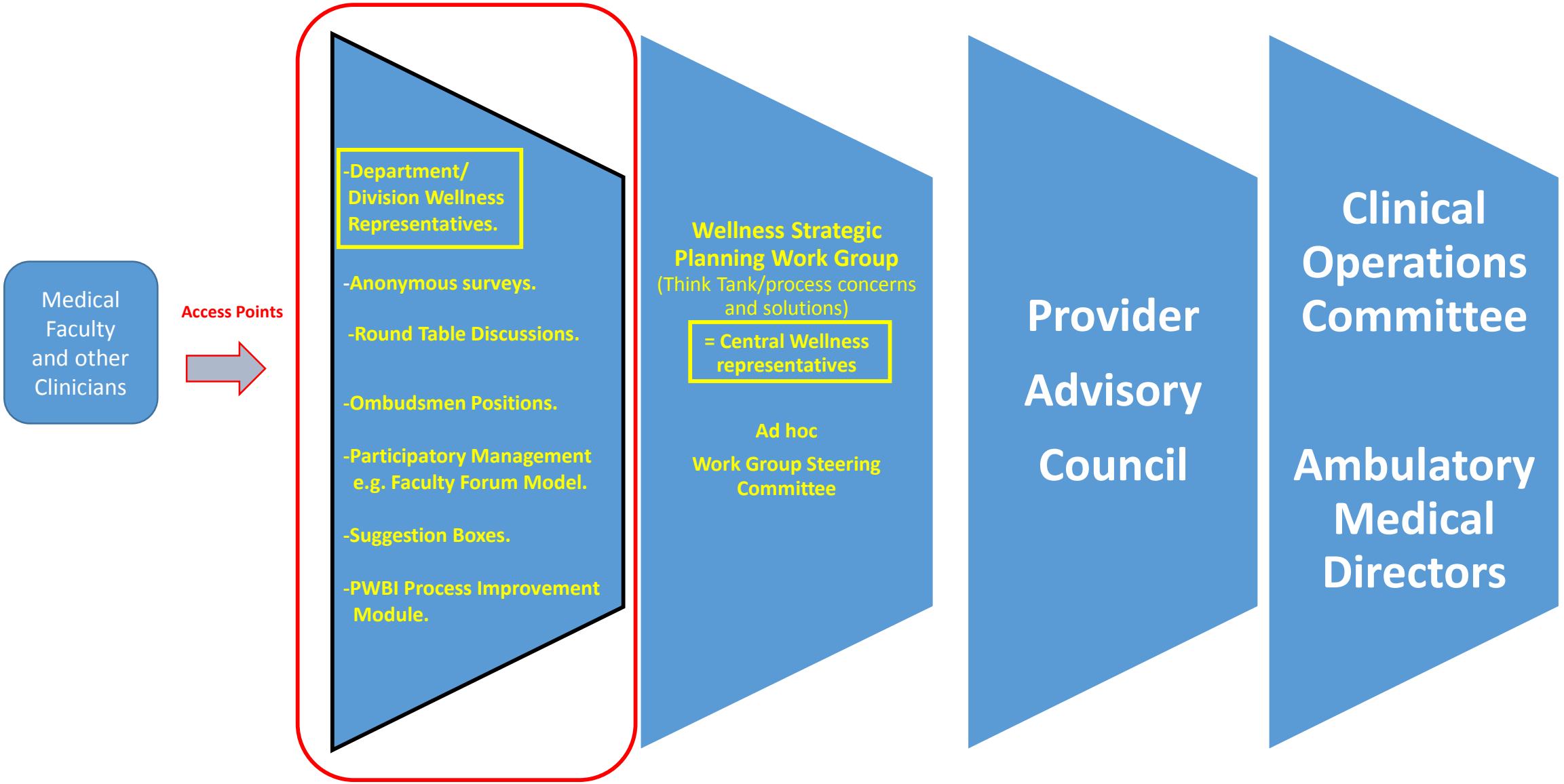
- **2018-19 Action Smart Goal:**
  - 100% of all training programs will incorporate into their wellbeing activities 1 activity in each of the AMA's 6 areas key to wellness:
    1. nutrition
    2. fitness
    3. emotional health
    4. preventive care
    5. financial health
    6. mindset & behavior adaptability.

Mandatory Wellness Assessment for Residents in Academic Crisis

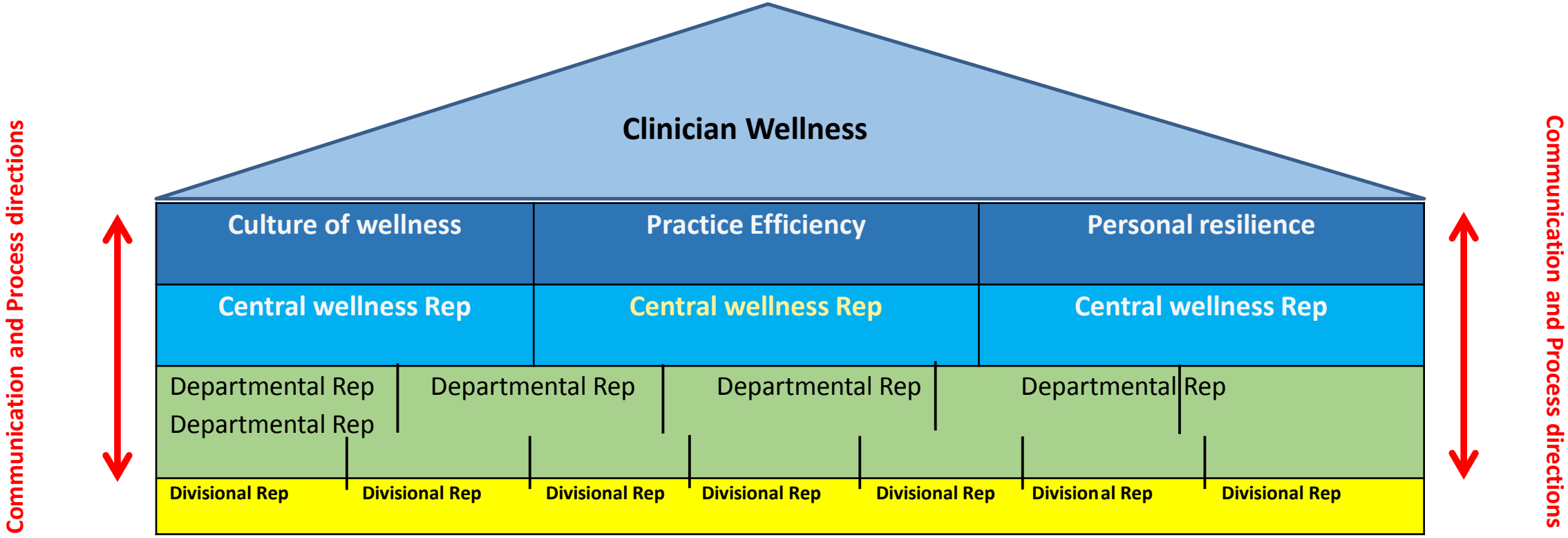
- Trainees **previously given the option** to **pursue wellness assessment** and often with strong recommendation.
- In incident reviews, **serious consequences occurred to residents** who chose not to take part in wellness assessment.
- GME in partnership with EAP, BHP, Department of Psychiatry and Office of Counsel **developed and implemented a policy requiring referral of all trainees entering or progressing through a disciplinary process to EAP**.
- **Program Directors could also trigger mandatory EAP consultation for performance issue that may lead to probation if not resolved.**



URMC Wellness Structures to Reduce Clinician Occupational Stress



Communication and Process Structure:
Department/ Division-based Wellness with Central Institutional Wellness efforts.



EMR Governance & More Access Points: URMC Structures to Reduce Occupational Stress