Dr. Jennifer Myers opened at 11:41AM and reviewed the upcoming agenda with the Committee.

A committee members suggested that the group invite the new Provost next year. It was then suggested that the committee asks Dean Jameson in January to address what it may mean for the faculty under the new leadership of Provost Wendell Pritchett.

Dr. Myers introduced Dr. Michael Parmacek, Chair of the Department of Medicine, Thomas Gakis, Chief Operating Officer of Medicine and Michael Cella, Associate Chief Operating Officer of Medicine.

Dr. Parmacek opened by presenting a progress report on the DOM Faculty Well-Being Program.

We have given this presentation 16 times and we want to collect feedback. There was a project that began about two years ago which grew from our annual reports that we request from all of our divisions. We decided to do a SWOT analysis. Under the threat category, a majority of faculty reported a high level of burnout. It was so uniform and prioritized that we decided to take this on at a departmental level. Many of the issues are systemic and too large for divisions to take on. The department may be able to provide help, but this needs to be taken on institutionally. We need to look at the root cause. This cannot be solved in one year or even three years. Medicine, over the last twenty five years has fundamentally changed and in so many ways. The cumulative impact of those changes has caused the issue.

The Department of Medicine put together a working group, expanding beyond the department of Medicine.

Thomas Gakis, Chief Operating Officer:
I will provide a recap of how the program started to develop.
Commitment - Department commitment to assess faculty burnout and wellbeing across the divisions with the aims of:
1. Identifying programs where burnout is greatest
2. Develop and begin to execute on interventions aimed at reducing burnout in programs of high prevalence
3. Develop an over-arching multi-year (3+ yr.) effort across the DOM

2017 Work Construct was developed and piloted to share best practices.

Over a period of time, there was contextual inquiry and thematic synthesis including interviewing faculty, shadowing faculty, shadowing nurses and other staff, and interviewing patients.
FINDINGS: 10 key contributors to burnout
1. Change in the relationship between doctor and patient
2. Faculty are juggling multiple jobs in and out of the office
3. Faculty jobs are emotionally and physically intense
4. Faculty suffer from metric fatigue
5. Inflexible clinical scheduling (no realistic scheduling)
6. Specialists are acting as care coordinators
7. Clinical staffing concerns
8. Documenting drives workflow
9. Little nuisances become big issues
10. The space doesn’t support the work

Dr. Aggarwal applauded the department for listening to the faculty members and taking action in regards to metric fatigue. The monthly emails have been updated so that faculty members receive only patient ratings and not their ranking with their peers.

We have received support from the health system and the school side because we have kept this data driven and we are going to prove that this works. The turnover cost is very high and if we put money up front, we will be saving in the long run.

Our 5 imperatives:
1. Eliminate low value added activities
2. Create realistic, flexible schedules
3. Create and maintain delightful work environments
4. Refocus management practices & business model
5. Build resilience

Michael Cella will go into the work in the operations.

Best Practice Clinic Workflow:
When we look in our clinics, it is inconsistent on how our clinical staff are working. We created a best practices for clinic workflow so each clinic can be more consistent and physicians are working to the top of their practice.
In all of our clinics, we took the best practice workflow and timed everyone. You cannot complete the workflow if you do not have the staff to support it. We completed the staffing analysis tool to parse out what staff members complete in each clinic. We found that if we were to implement the best practices work flow, clinics would automatically be understaffed.
After clinics were staffed properly, we had a training process for the best practices clinic flow.
When you install this workflow, we identified 14 EMR tasks that MDs and APPs were completing that we shifted towards MAs, CSAs, and RNs. We saved MDs and APP 28 minutes.
Stacy Hirsch, in Department of Operations.

I will speak on Practice Deconstruction and Reconstruction.

We have to re think the clinic design. To start, we shadowed physicians, nursing, other staff, interviewed patients.

Hypothesis: Through symptom and lab monitoring outside of the clinic, we can match patients to an appropriate treatment level, enabling more flexibility during clinical hours and fewer long in person appointments each day.

Running a series of pilots:
Expecting to surpass our 90 minute saving goal and saving 120 minutes in the following ways.
Top of Scope – saving 28 minutes
NPV triage (e-consult) 35-70 minutes
Documentation (chart preparation + in visit charging) 60-120 minutes

Dr. Parmacek pointed out that the practice at 3701 Market Street is in a program where behavioral services must be provided at the same practice site. This has given the physicians more time to focus on general internal medicine while psychiatrists can focus on behavioral health.

Dr. Myers asked if the department sees that I am saving 90 minutes a day, does that mean that I will be scheduled with more patients?

No. The goal is that those 90 minutes will be used for tasks that you typically do for two hours at home. Hopefully those two hours that you spend at night closing charts will actually be completed during the day.

Dr. Aggarwal asked what the plan is to roll out to other divisions besides Rheumatology? And do you anticipate doing contextual inquiries in each division?

Because of the feedback, we met with all of the divisions and their faculty. People want solutions quicker. We are always engaged with other divisions to start some of the groundwork. We will go back and do some contextual inquiry but the frameworks will be helpful so we can speedup solutions.

Dr. Morrisey asked how the department is spreading this information?

Dr. Parmacek - We have spoken to all CPUP department chair, FOCUS group, MFSSC and we are continuing to get out there. I will say that departments are listening, there is great interest. It’s hard to say what departments will proceed and also how they will take this issue on.

Is anyone using SCRIBES? Yes, we have 4 pilots going on right now.

Dr. Barg asked how will you know if something has worked?

Dr. Parmacek - The survey is sent to the faculty. Annual Faculty Engagement Survey and the Faculty Climate Survey. We get under 50% responses. My division chiefs have an incentive plan this year. They are responsible for getting faculty members to complete these surveys. Lisa Bellini is mandating a rigorous process for receiving the reasons people leave Penn.
What incentives are you providing for certain populations? For example, women, single parents, people of color?
My hope is that everyone will benefit and more will benefit especially those who are hampered by these issues.

Despina Kontos noted that physician wellbeing is focused on MDs but PhDs have issues too. Because of MD burnout, research faculty are struggling in various ways: how do we work with MDs and get MDs to participate in Research?
Radiology is starting a Research Faculty Wellness Committee, I am chairing. We do have some MD/PhD in our committee.
It would be interesting to see what comes of the physician well being and translate it to PhD.
The burnout effects productivity and the mission of the University.

Vicki Mulhern announced to the committee that FAPD is taking on Onboarding for Research as an initiative for this year.

Dr. Morrisette - Our power here as part of the faculty senate is to bring this presentation back to the department, the chair and a newsletter to translate to our own departments.