GME Well-Being and Burnout Prevention Roadmap

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Virginia Mason Franciscan Health

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Introduction

Physician burnout, depression, and suicide remain critical challenges within graduate medical education. The current state reveals opportunity to standardize and enhance the delivery of wellbeing and burnout prevention education and resources across our 15 VMFH GME programs.

- Absence of standardized education curriculum to ensure consistency of delivered content
- Wide variation of current education and events by various programs
- Program directors feel uncertain about their own ability to guide and teach about how to access resources
- Residents and fellows perceive not knowing where to find resources

Project Aim

Provide GME program leaders and trainees with ready-made tools supporting facilitation of education on developing skills on well-being self awareness and burnout prevention. The centrally supported curriculum will flex to program variation and will be continually assessed for relevance, efficacy and adequacy.

Project Design

Hold a four day Rapid Process Improvement Workshop (RPIW) with key stakeholders using the Virginia Mason Production System (VMPS). During this time, our goal was to Implement deliverables and Plan-Do-Study-Act (PDSA) with successive remeasures at 30, 60 and 90 days. Additional strategies may require further Kaizen Improvement events.

Intervention

During our RPIW, we identified 4 themes for improvement:

- Mentorship
- Resident Development
- Digital Resources
- Human Connection

Through small group discussion, we developed multiple tools within those themes. These included:

- Improving and centralizing website resources
- Creating a badge buddy
- Creating a PD Roadmap
- Creating a Wellbeing and Burnout Slidedeck for PDs to present to trainees
- Improve guidance and transparency around Wellness Milestone Scoring

Front side

Back side

Preliminary Results

Target Progress Report (TPR)

Metric (units of measurement)	Baseline	Target	Day 2	Day 3 (RPIW only)	Day 4 (RPIW only)	Final	30 days 04/12/26	60 days 05/12/26	90 days 06/11/26	90 days; improved over baseline?	Percent Change (link to percent change calculator)
#1 Quality Measure (%) Percent of residents who rate their current knowledge about wellbeing preservation / burnout prevention & access to resources as fair, poor, or very poor.	68%	0%	68%	68%	68%	68%					TBM
#2 Quality Measure (%) Percent of Program Leaders who rate access to tools and resources providing instruction/guidance for residents/fellows on maintaining wellbeing fair, poor, or very poor.	65%	0%	65%	65%	65%	65%					TBM
#3 Quality Measure (%) ACGME Professionalism Milestone "Self Awareness and Help-Seeking". Percent of scores that are less than 3 at the end of the PGY1 year and at any 6 month interval of PGY2 and above.	13%	0%	13%	13%	13%	13%					TBM
Environmental, Health & Safety (5S) Measured as a Level from 1 to 5 (there is no level 0), as described in the **5S Achievement Grid or Audit Tool.**	Level 1	Level 4	Level 1	Level 1.5	Level 2.5	Level 2.5					50%
Set-up Reduction (Time spent preparing to provide the next product or service) (Simulated) - observe time it takes for PD's to locate specific resources. 1) How to initiate a LOA; 2) Contact info for EAP (Lyra) Services; 3) Locate benefit Information?	Unable = 50% Able: Mean Total TIme = 3:23 min	9 minutes or less	Unable = 50% Able: Mean Total TIme = 3:23 min	Unable = 50% Able: Mean Total TIme = 3:23 min	Unable = 50% Able: Mean Total TIme = 3:23 min	Unable = 50% Able: Mean Total TIme = 3:23 min					

Our preliminary results demonstrate opportunity for improvement. We plan for system wide implementation of tools in April 2026. Follow up with interval surveys to track our progress.

Barriers

- Tackling the nuance of Wellbeing
- Limitation of accessing resources while off-site
- Limitation of speciality specific allowable time away
- Succinctly deliver and showcase materials to program leadership and trainees site wide

Discussion & Next Steps

Resident and Fellow burnout has been well established as an area of concern. The VMPS enabled rapid development of new tools and encouraged incorporating feedback in real time. We identified obstacles around electronic resources and the need for future continued effort to combat this issue.

Our next steps include implementation through a Program Director Retreat in April 2026, 30 Day Kaizen Report Out Event in April 2026, and follow up trainee surveys.

Remediating the Struggling Learner

Chanteau Ayers, Alexandra Hubbell, Tyler Schwiesow, Hayden Smith, William Yost

INTRODUCTION & BACKGROUND

Our institution has recently had several program directors/associate program directors who are new to residency leadership. There have been instances when programs with struggling learners have sought direction from the Graduate Medical Education (GME) office. We have policies in place on how to address and appeal an adverse decision and non-promotion/suspension/termination. However, we do not seem to have a satisfactory remediation policy in place.

AIM/OBJECTIVES

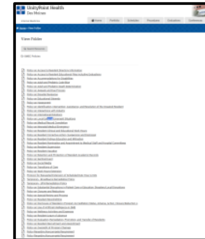
To develop a tool kit that program directors can use for identifying, diagnosing, strategizing, managing, and documenting pathways to remediation that avoids adversarial relationships. This potential process will make the struggling learner a partner in their formation. We will address issues such as professionalism, fitness for duty evaluations, diagnosing the learner, developing a strategy to improve performance, and emphasizing the learner as a partner in the process.

ORGANIZATION ALIGNMENT

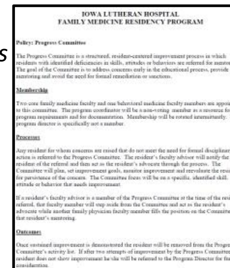
Best practices ensure remediation processes are consistently applied and remain cooperative and collegial for all parties involved. Such actions align with our FOCUS values and are paramount in providing the best care to communities we serve.

INTERVENTIONS/CHANGES

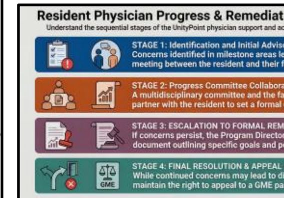
Initial steps included acquiring Institutional Review Board approval and locating and placing relevant documents on an accessible online Medical Education location.



Figures: *Examples of existing materials collected from programs, used to understand and define current Practices.*



IOWA LUTHERAN HOSPITAL
FAMILY MEDICINE RESIDENCY PROGRAM



Interventions will include clearly defining the general remediation process, which will involve stakeholder participation and feedback.

MEASURES

Initial Measures: will mostly include process goals…
- Defining remediation process
- Creating universal materials
- Receiving and modifying materials given feedback
- Implementing materials

Mid-Term Measures*: may include additional surveying of residents/faculty on process knowledge*

Long-Term Measures*: may include re-reviewing processes after future remediations have occurred.*

PRELIMINARY RESULTS

Remediation Survey (#Faculty/#Resident)	Full Sample (n=81)	Faculty (n=37)	Residents (n=44)
Emergency Medicine (8/22)	9 (11%)	5	4
Family Medicine (14/24)	11 (14%)	6	5
General Surgery (21/22)	11 (14%)	7	4
Internal Medicine (7/34)	16 (20%)	5	11
Pediatrics (17/21)	20 (25%)	7	13
Podiatry (10/3)	5 (6%)	5	0
Psychiatry (8/17)	8 (10%)	2	6
Transitional Year (0/4)	1 (1%)	0	1

Review of Historic Remediations (past 19 years); n=16*

9 Professionalism	6 Patient Care
3 Medical Knowledge	3 Substance Abuse
2 Interpersonal Comm	

**Resident may have had > 1 deficiency documented*

Remediation Policy Downloads since Survey
- *Faculty: 15/85*
- *Residents: 14/135*

NEXT STEPS

1. *Create flowchart and define processes*
2. *Conduct focus groups to review new materials and get input*
3. *Final survey of residents/faculty to collect knowledge, attitude and practices data and serve as advertisement of changes*

Enhancing the Clinical Learning Environment with D.U.E.T.: Dual User Evaluation and Training

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OhioHealth Doctors Hospital Family Medicine Residency

OhioHealth

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Introduction: Background & Context

Family medicine clinics (FMCs) in residency are unique ambulatory clinical learning environments where high-quality formative feedback is essential for resident growth. In the FMC, multiple residents see patients scheduled within specific appointment times and are precepted at a maximum ratio of 4:1. This can create time-based challenges within the resident faculty precepting dynamic.

Data collected from our Family Medicine ACGME program surveys and internal Program Evaluation Committee surveys identified feedback as an opportunity for improvement. Faculty feedback mechanisms demonstrated a gap within the ambulatory precepting space. Residents reported variable and inconsistent feedback from attendings and a perception that the clinic is not clinical learning environment.

An Artificial Intelligence (AI) agent was piloted to assess if AI-generated feedback analyses could provide residents and faculty preceptors with more objective assessment of what occurred within the ambulatory precepting interaction. The pilot demonstrated feasibility within the FMC.

Aim, Objectives & Alignment

Aim: Improve precepting efficiency and effectiveness in an ambulatory FMC through AI generated feedback analysis.

Objectives:

1. Assess perceptions of feedback in the current clinical learning environment and potential utility of AI analysis.
2. Implement and measure faculty utilization of the One-Minute Preceptor's five microskills
3. Enhance the efficiency and effectiveness of precepting through the support of AI generated feedback analyses.

Alignment: OhioHealth has developed institutional goals to adopt advanced technology, improve feedback, and enhance education.

Interventions & Changes

Develop a generative AI agent (D.U.E.T) integrated into the native OhioHealth IT environment. [In process]

Provide a development session on the One-Minute Preceptor (OMP) five microskills to faculty. [Completed]

Create an integration workflow within the ambulatory precepting space. [In process]

Collect baseline data

Utilization of the OMP microskills

Efficiency and effectiveness of the encounter

Incorporation of SDoH, IDT, and OPP/OMT

Implement education based on AI supported metrics and analysis

*SDoH: Social drivers of health. IDT: Interdisciplinary team. OPP: Osteopathic Practices and Principles. OMT: Osteopathic Manipulative Medicine.

Measures

Outcome Measures:

- Percent of faculty precepting encounter utilizing each microskill
- Resident rating of AI enhanced feedback analysis utility

Process Measures:

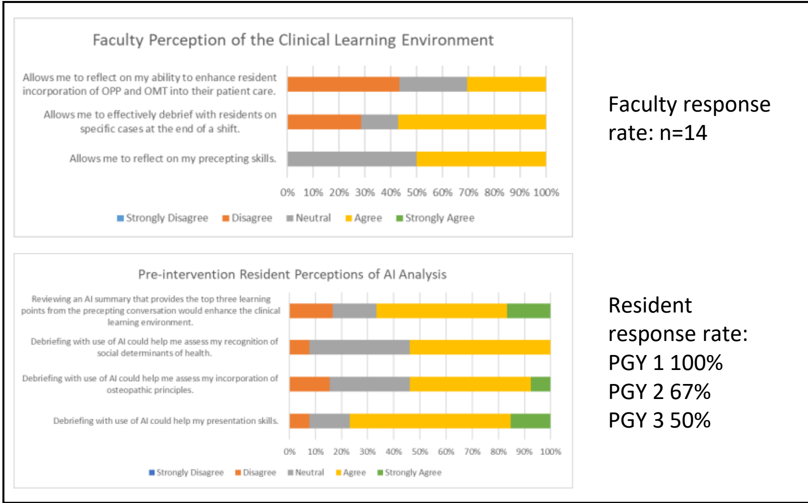
- Duration of precepting encounters – resident and faculty sided
- Length and focus of feedback provided
- Resident engagement with the analytics dashboard

Balancing Measures:

- Faculty workload perception
- Resident perception of cognitive load in feedback sessions

NI X Meeting Two: April 17-18, 2026

Results: Preliminary



Faculty response rate: n=14

Resident response rate:
PGY 1 100%
PGY 2 67%
PGY 3 50%

Discussion

The pilot supports feasibility of the model from residents, faculty, and leadership. Implementation and subsequent analysis will determine the overall impact on teaching behaviors, learning perception, and the quality of the FMC's clinical learning environment.

Surveyed faculty demonstrated mixed perceptions of the FMC's current clinical learning environment. Pre-implementation survey of faculty perceptions of AI analysis utilization is recommended.

Resident responses were mostly positive regarding the perceptions of AI analysis incorporation into precepting interactions. Surveying resident perceptions of the current FMC's clinical learning environment is needed to assess a pre-intervention baseline.

AI-generated feedback could offer a scalable approach to enhancing clinical teaching by making feedback more consistent, efficient, and data-informed.

Our World, Our Health

Kelly Robertson, MD, Grace DiPersio, MD, Heather Z. Sankey, MD, MMEL

Baystate Health
UMass Chan Medical School
AiAMC Alliance of Independent Academic Medical Centers
National Initiative

Introduction: Background & Context

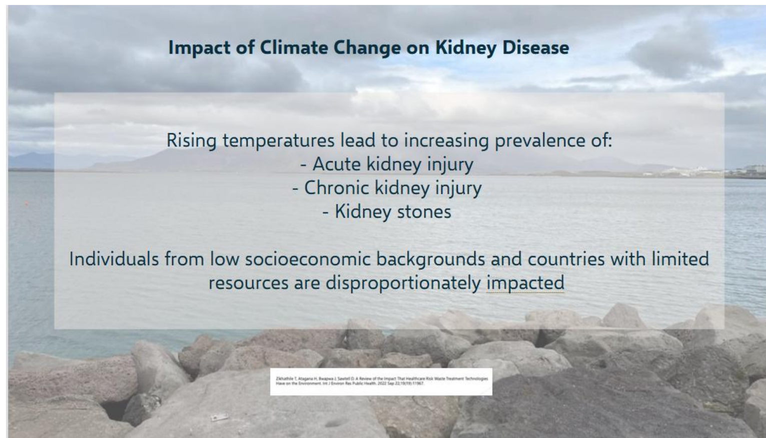
- Our health and our environment are deeply connected. Clean air, safe water, stable climates, and healthy ecosystems all support human well-being and impact health. At the same time, healthcare processes and decisions can have an environmental impact, either positive or negative.
- This project will improve the knowledge base that healthcare providers have explaining possible cause and effect based on sharing trusted information. It will help identify gaps in provider knowledge and improve comfort with discussing our understanding of how our environment can impact our health—and how healthier choices for people can also mean healthier choices for the planet and vice versa. The goal is to build awareness and encourage actions that create safer, more sustainable, and healthier futures for everyone.

Aim/Objectives/Alignment

- Assess provider knowledge base before and after an educational intervention.
- Assess provider comfort level with discussing the impacts of the environment on health conditions or the impact of health care on the environment
- Encourage individuals to make changes to improve their impact on the environment and to help mitigate the effects of climate change on health.
- Broaden understanding of the relationship between patient care, the environment, and health of patient.

Interventions/Changes

- Educational power point slides developed to be added to talks given throughout the department
- Presentation at Departmental Business Meeting to introduce the project and survey administered

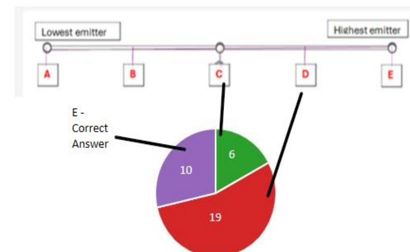


Measures

- Pre and Post Survey to assess knowledge
- Number of educational slides used and in which venues

Results: Preliminary

- IRB waiver attained
- Pre-Survey completed by 35 people so far
- Slides used in 3 presentations so far
- Interest from other areas in expanding the project
- Sample question: "If the healthcare industry was a country, where would it fit in the ranking of top carbon emitters in the world?"



Discussion

- Increase the number of people completing the pre-survey by posting the QR code and raising awareness.
- Pro-actively reach out to speakers about adding a slide to their talk
- Expand to nursing, the midwifery education program and the department of pediatrics

Integration of Social Determinants of Health Tools and AI Support in the Resident Clinic

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Kaiser Permanente Northern California Undergraduate and Graduate Medical Education

Introduction: Background & Context

Social Determinants of Health (SDOH) significantly shape health outcomes, yet inconsistent screening in our clinic leaves social needs unmet—contributing to preventable acute care use, poor chronic disease control, and health inequities. Limited visit time, competing priorities, and data integration challenges create barriers. For residents, this limits training in social context and resource navigation. AI tools could identify SDOH in real time and prompt tailored referrals, enhancing both care delivery and education.

Aim/Objectives/Alignment

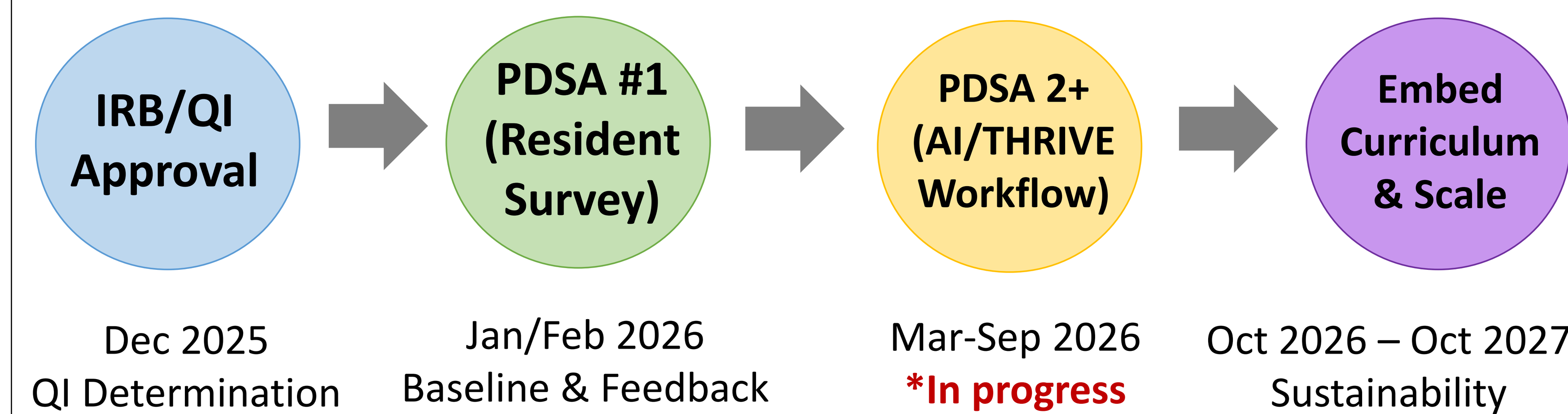
Improve identification and integration of Social Determinants of Health (SDOH) in clinic workflows to enhance outcomes and reduce health inequities.

- Assess current SDOH data collection and identify workflow barriers.
- Pilot AI tools that detect SDOH in real time and suggest resource referrals.
- Measure effects on unmet social needs, referral rates, and chronic disease outcomes.
- Strengthen resident education on assessing SDOH and connecting patients to community resources

Project Alignment with Organization

- Integrates SDOH into care and training
- Promotes equity, innovation, and community impact
- Builds on community medicine and health equity strengths
- Creates a unified workflow for social needs
- Uses AI to enhance learning and streamline care

Interventions/Changes



Dec 2025 QI Determination | Jan/Feb 2026 Baseline & Feedback | Mar-Sep 2026 *In progress | Oct 2026 – Oct 2027 Sustainability

Measures

- SDOH screening completion rate and proportion of visits with documented SDOH in the EHR.
- Referral and follow-up rates to community/social resources for identified needs.
- Resident pre/post survey scores on confidence, knowledge, and perceptions of the SDOH learning environment
- Stakeholder feedback from leadership, faculty and residents on integration of SDOH screening and referral processes in the residency clinic and alignment with organization.
- Identification of continued SDOH learning opportunities

Results: Preliminary

PDSA #1: Baseline Survey Results (*n = 18 Family Medicine residents*)

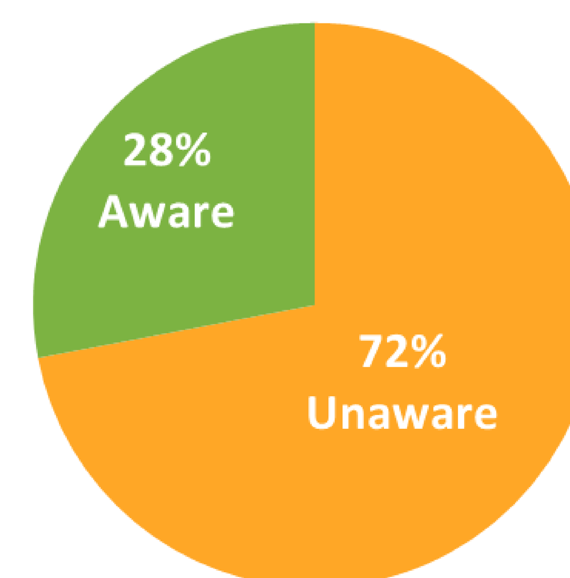
SCREENING & DOCUMENTATION GAPS

83% Ask SDOH of <25% of pts

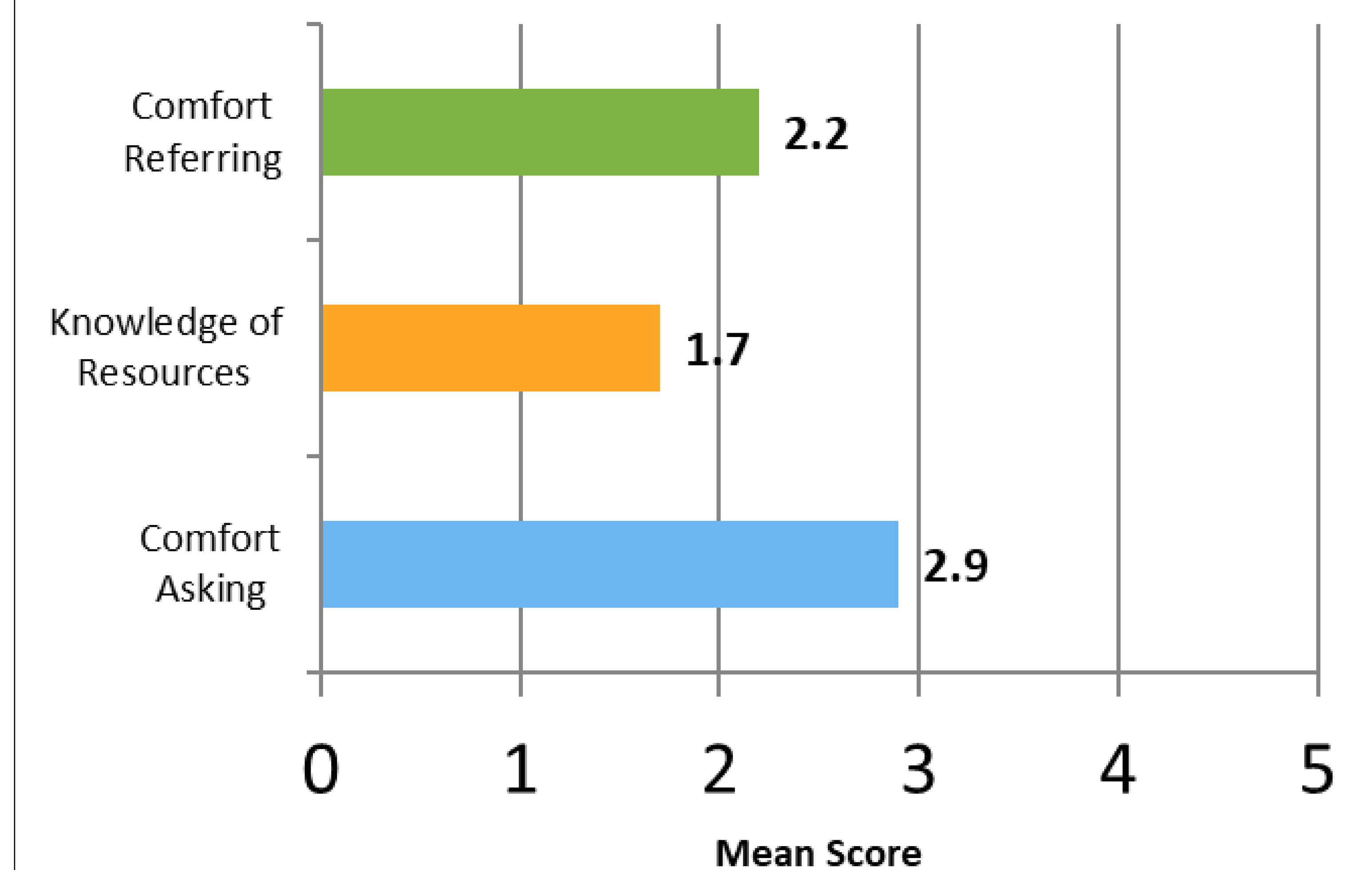
89% Rarely/Never document SDOH

72% Made no referrals in month

KP THRIVE Tool Awareness



Results: Preliminary (cont.)



Discussion

Next steps

- Finalize SDOH workflow (KP THRIVE screening, documentation, referrals)
- Select and pilot AI/decision-support tool for KP infrastructure
- Run PDSA cycles to test workflow and measure rates
- Embed SDOH training into resident curriculum

Current challenges

- Choosing feasible AI tool that integrates with existing systems
- Designing team-based workflows that fit time constraints
- Creating practical SDOH training for faculty and residents

Improving Code Blue Performance: Changes in Internal Medicine Resident Confidence and Safety Event Metrics After an Educational Algorithm

Cleveland Clinic Akron General

Samuel Wiles, MD; Cheryl Goliath, PhD; Jeffrey Solomon, MD; Trisha Kick; Adina Brett-Morris, PhD; Emma Humphrey, DO; FNU Anamika, MD

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

Introduction/Background

- *IM residents have less exposure to code blue events and lack confidence in leading resuscitations*
- *Simulation training improves confidence and skills*
- *Simulation also helps identify and prevent latent safety threats[LST]*

Aims/Objectives

1. Increase comfort levels among Internal Medicine (IM) residents in Cleveland Clinic Akron General (CCAG) involved in code blue events.

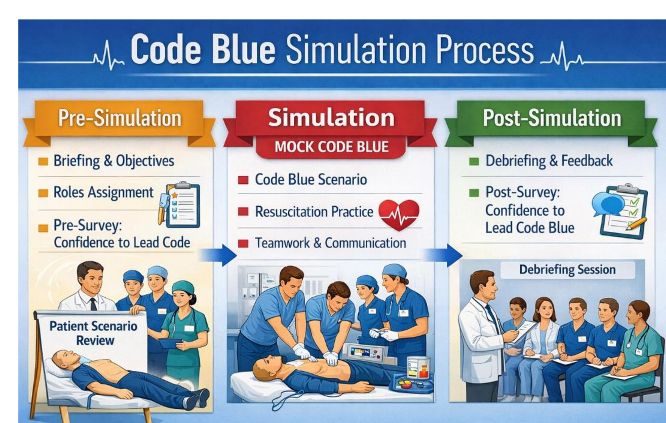
2. Increase the medical knowledge of CCAG IM residents in the management of code blue scenarios.

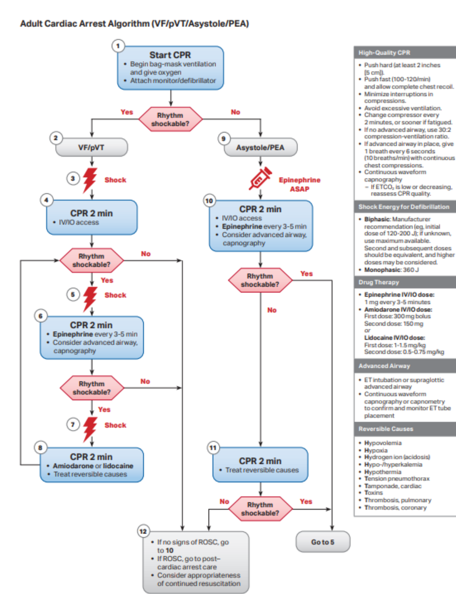
3. Identify and decrease latent safety threats (LST) events in IM inpatient floors.

4. Improve the safety events reporting process in the IM Department at CCAG.

Interventions/Changes

- *Structured simulation-based mock training session from Jan 2026 to Sep 2026*
- *5-8 residents per session, one assigned as leader*
- *Each resident attends at least 2 mock codes*
- *15-minure presession lecture on algorithms*
- *Pre- and post surveys assess confidence and medical knowledge*
- *This project was approved by CCAG IRRB and the Cleveland Clinic Simulation and Advance and skills Center*





Measures

- *Comparing pre and post confidence levels (Figure 1) and medical knowledge assessment scores (Figure 2).*
- *In situ simulation use of American Heart Association "Get with the Guidelines" resuscitation metrics*
- *Comparing LST reported in SERS 9 months pre-intervention vs intervention period*
- *Paired t-test or Wilcoxon for data analysis*

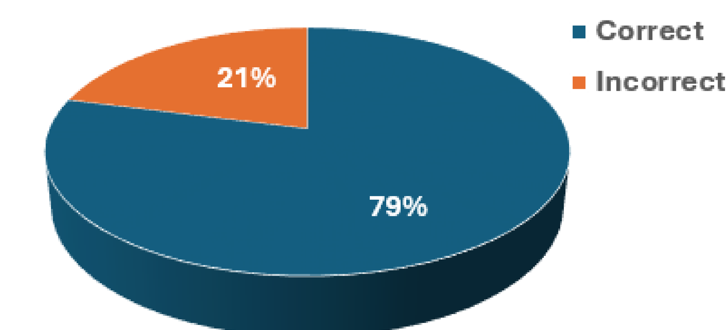
Measures

Figure 1. pre-survey confidence levels

Figure 2. Medical knowledge questionnaire

Results: Preliminary

- *34 out of 41 IM residents filled the medical knowledge questionnaire*



Discussion

Current state:

- *Approval granted by the Simulation Research Oversight Committee*
- *Pre-surveys filled by the residents*
- *Mannequin and code cart prepared for mock codes*

Next Steps:

- *Starting simulation sessions*
- *Monitoring LSTs during mock codes*
- *Comparing pre and post simulation scores*
- *Feedback will be collected at the session's end*

Structured Discussions About Professionalism As Trust

Aurora Health Care
Now part of ADVOCATEHEALTH

AiAMC Alliance of Independent Academic Medical Centers

National Initiative

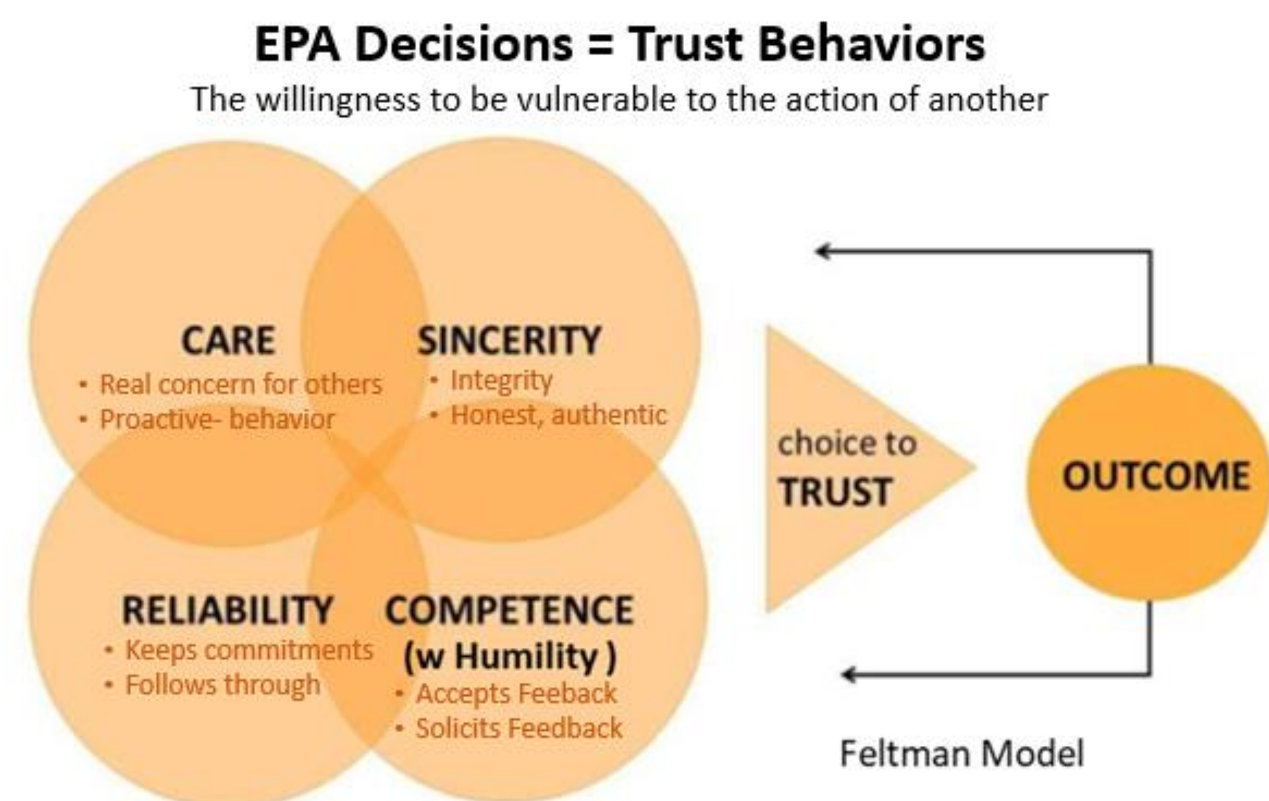
D Simpson PhD; T La Fratta MBA; K Ouweneel MBA; W Lehmann MD, MPH; J Bidwell MD; J O'Brien MD; K Agard CMP, PMP;
N Salvo MD; E Santana C-TAGME; D Hamel MD; W MacDonald MD; K Patel DO; S Caudle MD; L Delfinado MD; D Irby MDiv, PhD

Introduction: Background & Context

- **Unprofessional behavior[1-3]**
  - Adversely affects learning and team functioning
  - Increases avoidable pt complications - malpractice claims
  - Lower professionalism milestone and communication ratings is associated with lower patient experience results 1-year post graduation in adult primary care specialties
- **Entrusted Professional Activities (EPAs)**
  - Variables associated with entrustment decisions[4] parallel dimensions of trust[5-6] = (un)professionalism behaviors

EPA Decisions = Trust Behaviors

The willingness to be vulnerable to the action of another



Feltman Model

Aim | Alignment

- **Aim:** To reframe the ability to analyze and discuss professional behavior as enTRUSTment focusing on consequences of adverse behaviors on patient care, teamwork, and one's own growth and development
- **Align: Culture of Safety & Work Environment Survey**
  - Building on AH's 2024 focus on psychological safety, 2026 shifting to strengthening trust as "trust sustains our work relationships over time" → team level action plans

Selected References

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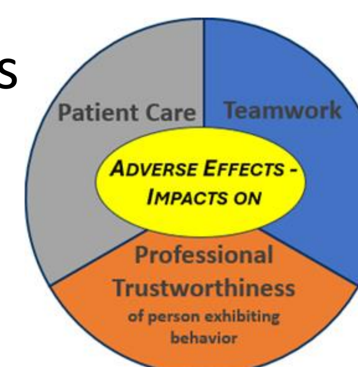
Interventions | Changes

1. 20-Item Professionalism Needs Assessment

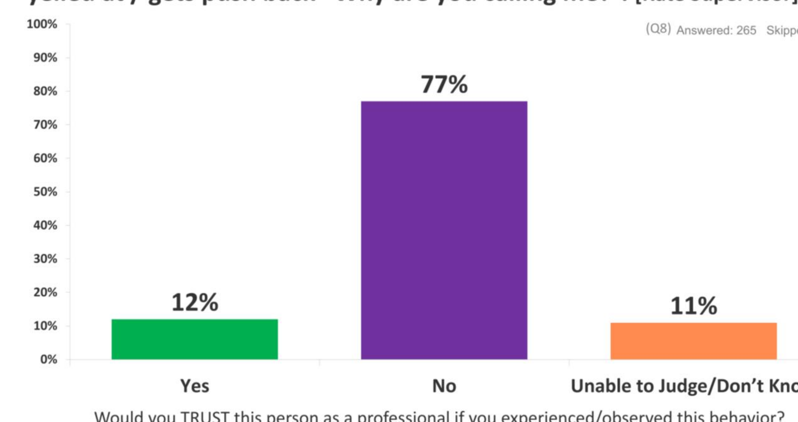
A. Listed behaviors exhibited by different clinical and/or administrative individuals in our med educ programs
B. Present a behavior: Take days off/no show without alerting program
C. Rate degree to which you would TRUST this person as a professional if you experienced/observed this behavior

2. 30-90 Minute Interactive/Facilitated Discussions

A. 10-20 MIN: Background including evidence re: adverse effects of unprofessional behavior
B. 30-45 MIN: Facilitated sm group discussions
  - Presented needs assessment survey behavior
  - 1/3 of group assigned to list adverse effects
  - Debriefed with quick poll
  - Shown needs assessment data - surprised?
  - Repeat with another behavior



C. 10-15 MIN: Large group debrief and quick evaluation



Measures: Pre | Post

A. Needs Assessment [Landscape Analysis 1 time only]

B. Resident Evaluation of Teaching Pre-Post
- Demonstrated respect for me as a trainee
- Promotes and champions PROFESSIONALISM (Treats colleagues with, courtesy/respect; high integrity; accountable for actions…)

C. Professionalism Milestones

D. ACGME Resident/Fellows Survey – Professionalism

E. ACGME Faculty Survey

F. Culture of Safety and Work Environment Survey

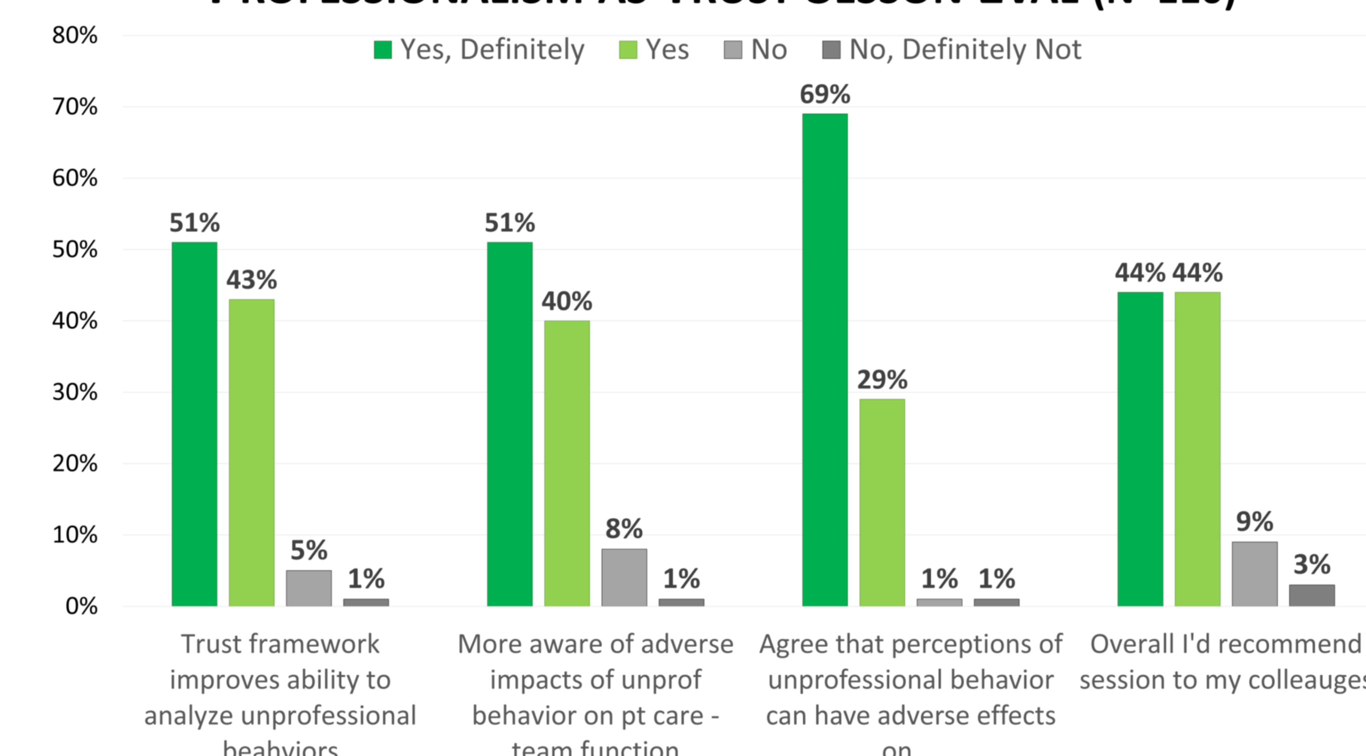
G. # Professionalism Concern Cards in Med Hub
- Ob/Gyn & Fam Med already submit

Results: Preliminary

1. Professionalism Needs Assessment Survey[7]
- N=265 responses ; 0.84 reliability (Cronback's Alpha)

2. Interactive/Facilitated Discussions
- 3 Sessions 77% (N=110/143) held in February 2026
  - GMEC Retreat (N=66), GME wide noon conference (N=49), Fam Med Residency Annual Meeting (N=28 no facilitators included)

Professionalism as Trust Sesson Eval (N=110)

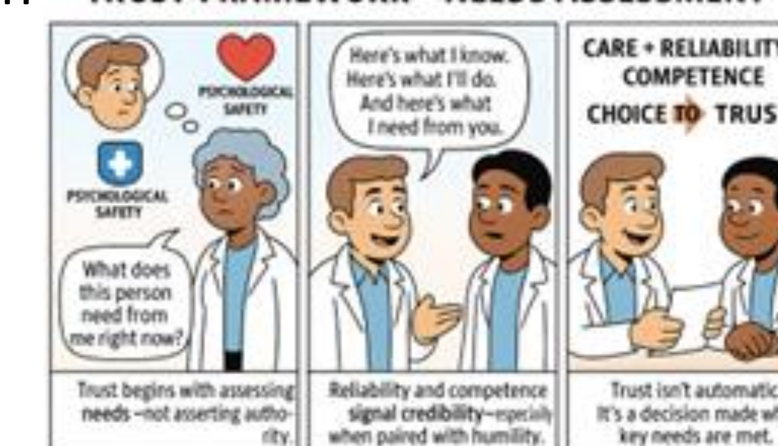


Discussion

Next Steps

- Revise small group strategy including how to:
  - Assure group has participants with mixed roles
  - Incorporate more challenging vignettes
- Train-the-Trainers > Workgroup members
- Convert background section to educ graphic novelette
- Disseminate to programs
- Pre-Post Data analysis

Trust Framework = Needs Assessment



Challenges

- How to assure that small groups have diverse roles perspectives
- Faculty Participant: "*Well intended but an exercise in the obvious…the people who need to hear this are the people who are exhibiting the behaviors.*"