The Medicus Integra© Award: A Qualitative Program Evaluation

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Introduction

The Medicus Integra© Award (MIA) is best described as a consultative assessment and acknowledgement of the efforts of hospitals, clinics, and related healthcare organizations to address the escalating phenomenon of physician burnout. Medicus Integra© is Latin for "whole physician." This reflects the goal of the Medicus Integra Award given to organizations that create a context in which physician wholeness and wellbeing are supported. The award was conceived, developed, and administered by the Coalition for Physician Wellbeing and consists of a documented organizational self-study based upon defined criteria. Completion and submission of the self-study is followed by an in-person, onsite visit conducted by two knowledgeable and experienced surveyors, at least one of whom must be a physician. The MIA criteria consist of four categories (See Table 1). Assessment of organizational performance includes both metric and narrative elements.

Table 1. *Medicus Integra assessment categories*

Business & Quality	Electronic medical record, workplace, turnover, engagement
Culture	Professionalism, communication, medical ethics
Learning	Leadership, teamwork, whole person care
Resilience	Accountability, coaching, relationship, spirit

Since its inception, the MIA assessment has been administered to 15 healthcare institutions, including hospitals, physician groups, and entire healthcare systems. The COVID-19 pandemic put MIA assessments on hiatus for over two years. Now, interest in this assessment is

increasing as healthcare organizations attempt to stem the growing tide of burnout among physicians.

We offer a qualitative program evaluation of the first two rounds of MIA assessments which has been used to refine the award process and demonstrate how institutions have used the MIA assessment findings in subsequent practice, structure, and organizational policy.

Method

In 2021 the Coalition for Physician Well-Being staff invited representation from all organizations that underwent the MIA assessment since the inception of the award. From these, eight institutional representatives agreed to participate in an online interview. Structured qualitative interviews were used to gather program evaluation data following Greene's program evaluation approach (1994). Participants were asked questions about their decision to undergo the MIA assessment, their experience across MIA assessment preparation and award assessment site visit, how their organization responded to the assessment findings, and organizational use of the MIA assessment findings. (see Appendix for Schedule of Questions).

Interviews were recorded and transcribed verbatim, anonymized, and analyzed using thematic coding (Gibbs, 2007). All transcripts were first read to obtain an overview of the experience of the participant and notes were taken regarding salient comments and elements of experience. Transcripts were then compared across all participant experiences to identify both common and outlier experiences. In order to reduce subjectivity, the data was analyzed by two experienced investigators in program evaluation and qualitative inquiry. Themes were developed and findings were then carefully reviewed to be certain that participant experiences were accurately reflected in the findings. The findings themes represent the chronological experience

of the survey experience. Loma Linda University Human Subjects Review determined that the study was exempt from institutional review.

Sample

Eight individuals who agreed to participate included two non-physician wellness administrators, three hospital administrators, and three physicians, representing community hospitals, a physician group, and an academic medical center. Physicians across these organizations were contracted or employed, with medical staff ranging from 100 to 1300 physicians. Interview duration ranged from 30 – 80 minutes.

Decision to participate

Participants were asked what prompted them to engage in the MIA assessment. All interviewees expressed curiosity regarding their organization's overall physician wellbeing, which motivated them to participate. One administrator described her reason for participating: "I wanted to put us on the map, in that, though we're small, we're paying attention to our physicians' needs." Another specified the need for assessment outside of his institution to validate the recently designed wellness program, add credibility and administrative support for his growing department. The majority of participants selected the Medicus Integra Assessment© because of their knowledge of the Coalition for Physician Well-Being or the individuals affiliated with it. The inclusion of organizational mission, values, and whole person care appealed to those whose context was a faith-based institution or system such as Advent Health, Dignity Health and Loma Linda University Health. Several participants noted that these elements were insufficient in several physician surveys previously used to evaluate employee satisfaction or professional fulfillment.

Prior instruments included surveys such as those of Press Ganey (Cambria, Basile, Youssef, et al., 2019), the Studer Group (Studer, 2006), the Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety Culture (CAHPS, 2023), the Maslach Burnout Inventory (Schaufeli Bakker, Hoogduin, Schaap, Kladler, 2001), and the Physician Wellness Self-Assessment Tool (Paolini, Gibney, Bogue, 2014). Two organizations created what they described as "simple online wellbeing surveys." Three sites had never administered a physician wellbeing survey.

Leadership in five organizations quickly supported the MIA assessment. Three leadership teams were reportedly hesitant to engage: one due to lack of awareness of physician well-being needs at his institution and two who questioned the usefulness of the assessment process. However, all were eventually willing to obtain feedback about their programs and structures to support wellbeing.

Preparation

All participants described the process of gathering the material for the MIA as labor intensive, "a lot of work" and "a little overwhelming." Most participants asked support staff to compile the requisite assessment information, and two participants singlehandedly collected and organized the materials. The final MIA documentation content ranged from a one-inch packet to three three-inch binders. Participants described anxiety about underdeveloped aspects of their organization's physician well-being plans that they had not considered prior to this time, such as the learning aspect of physician wellbeing or the inadequate staffing for their wellness efforts. One participant feared that because their programs were so new their recent positive changes might not be evident to the assessors. Three participants had not considered the business management as a physician wellbeing issue while another pointed out that the business category

"is where the EMR sits and where the engagement survey sits." Three individuals remarked that preparing for the MIA allowed their wellness staff to learn more about the role of other departments such as nursing, quality control, and compliance in physician wellbeing.

The Assessment Process

The MIA team met with medical and nursing leadership, toured medical campuses and physician spaces, and spoke with physicians unannounced. Participants reported that the assessment interviews allowed them to see and hear from others in their organization whose work supported physician wellbeing. Several expressed surprise about existing efforts about which they had little knowledge until the assessment. Participants described the overall MIA assessment process in glowing terms: "refreshing, fantastic," "gentle and gracious," "thorough," "collegial, very knowledgeable, open, complementary," "marked by appreciative inquiry." One administrator reflected on the sense of validation the assessment provided for his wellness efforts: "…I've been waiting for somebody to ask me about this!" One participant expressed concern that he would not be able to explain the breadth of the institution's wellness programming adequately, and others expressed concern that the assessment team would encounter medical staff who were skeptical of wellbeing programs, or were apathetic about the project.

At the end of the assessment day, the team provided informal, preliminary feedback to site leadership. Participants described these comments as, "kind, very encouraging of what was already in use." The team pointed out key stakeholders who could support wellness in the future Poor performance in any given area was used to generate problem-solving and suggest incremental improvements. "At no time did we feel like this was a derogatory conversation." "It was actually a validating process…they were so kind and supportive….it was an easy win and an

acknowledgement of [our work].” The team pointed out areas in which to improve institutional practices and commended sites for positive organizational contributions to physician wellbeing already in place. “It gave us ideas and credibility.” “It reassured…the medical staff that the administration did care about our wellbeing.”

Post-Assessment Impact

Formal written feedback was sent from the Coalition assessors to the physician wellbeing leadership within a month of the assessment. After these were presented to organizational leadership, participants described numerous changes were made in the institutions based on the assessment. One site constructed a team to improve electronic medical record use both during and after work hours. Funding improvements resulted in other settings to increase wellbeing staff positions, wellness champions, and outreach experiences for physicians. Other changes included the development of a physician spouse engagement group, childcare provision, creating physician spaces such as a lunch room and committee rooms, improving physician onboarding processes, creation of a supportive physician impairment group and policies, holding town hall meetings, revising code of conduct, and holding Schwartz Rounds® (Stevens, 2015), or Finding Meaning in Medicine (Zwerling, 2003) groups, and a physician-clergy dialogue group.

The majority of participants reported that the Medicus Integra model provided them with a framework against which they can intentionally consider their own programming, and articulate the need for various institutional staff who can appropriately address each domain. For several participant sites, the Medicus Integra model became the framework that supported changes in services. Several reported that their administrators therefore began to conceptualize physician needs and behaviors in “much less punitive” and “more sensitive” ways as they recognized the larger context of the physician experience.

Wellbeing programs were energized due to the sense of validation, encouragement, and individualized recommendations they received. One group operationalized the CEO's "open door policy" to a formalized bi-directional communication process so that new hires could understand and access the CEO as needed. One organization began highlighting their wellbeing resources during recruitment. A wellbeing champion reflected that now during C-suite meetings, she is asked to underscore wellbeing efforts and needs in order to garner greater support. This comment was reflected in several others' reports that the MIA gave their work credibility both to the physicians whom they served, but also with the administrators. The MIA process was used by another organization to strengthen their JCAHO assessment. Another wellbeing officer stated that the Medicus Integra model has brought together organizational leadership to consider how they can continue to build on their current wellbeing offerings and reportedly stated, "[The Medicus Integra Award] is a roadmap to better ourselves."

Participants in an academic medical center and a physician group pointed out that they had to extrapolate the MIA experience to fit their unique venues. For example, physician meeting places across several sites was not a priority for a large medical group. An academic training center suggested assessing training centers' compliance with, and success instituting, regulations by the ACGME as well as the added teaching burden on physicians would be worthwhile issues in future assessments of like organizations. These suggestions are currently under discussion to improve the overall applicability of the MIA across diverse physician practice venues.

Evaluator Observations

After each interview, field notes were written to record observations during the interview and comments made after the formal interview ended. All but one participant expressed enthusiasm about the outcome of the MIA process. This participant reported that her

organization's leadership seemed to believe that receipt of the award indicated that their physician wellbeing efforts were sufficient, contrary to her perspective as the wellbeing champion who was aware of both unmet physician needs and areas for organizational growth.

Two points were quickly apparent across the interviews: (1) Five of the eight participants described a sense of isolation in their task of championing wellbeing efforts at their respective organizations because they were the sole drivers of all physician wellbeing initiatives. Three explained that their ability to provide wellbeing services was challenging because of limited organizational support, and in one case, administration's lack of awareness of the unique challenges physicians face that impacted their wellbeing. (2) The COVID-19 pandemic halted or significantly limited many wellbeing initiatives in more than half of the participants' organizations. This was due to pandemic related revenue decreases, inability to gather in groups, increase in workload for many physicians, and greater prioritization of staying home to recover from work. Several wondered aloud if the organization would be able to rebuild a robust wellness program after such institutional losses. Participants commented on their sense of isolation during the pandemic and were pleased to connect with the interviewer since they had limited exchanges with others outside a narrow range of people. All expressed curiosity about how other MIA sites had made changes or performed after their respective assessments.

Discussion

Program evaluation is a critical element of program development. This evaluation was conducted to understand the participant and organizational impacts of the MIA assessment process. We considered that readers would find it most helpful to hear the experiences in the words of MIA assessment participants in a qualitative format, rather than try to extrapolate significance from a quantitative sample size that lacks statistical power.

This program evaluation highlights the value of external MIA assessors in examining institutional wellness programs. Organizations may become inured to "the way things are done here" and fail to consider other initiatives and alternative delivery mechanisms. Each participant expressed appreciation for the opportunity to view their program through the eyes of outside evaluators. In particular, having their strengths, creativity, and existing programs recognized and praised, was heartening. Preparation for the MIA assessment was perhaps best described as a validation process of their organization's commitment for physician wellbeing and mission. The MIA assessment process offered an opportunity for organizational collaboration within healthcare systems to identify areas for growth and build on resources already in place. Participants largely felt valued and supported by the site assessment teams.

Participants in this study were enthusiastic in their description of assessment preparation and preliminary announcement of their earned MIA designation. Several pointed out that since the assessment their enthusiasm has decreased, but they have been thinking more objectively and realistically about required organizational elements that promote wellbeing and what can be accomplished in their setting. This initial enthusiasm is a common experience of employees after achieving a workplace award. In a nationwide study of registered nurses, Ulrich, Buerhaus, Donelan, Norman, and Dittus (2007) described a waning of enthusiasm and increased focus on operations of those in institutions that already received Nurse Magnet status, as compared to those preparing for the award site visit.

Several of the MIA designated organizations allocated more funding to support physician wellbeing programming, and several participants reported that external recognition of their efforts gave them greater credibility and resources across their organization. Others reframed policies and sought direct information from their physicians to learn how they could address their

needs. Several participants expressed gratitude for the MIA four-quadrant model that they used thereafter to guide institutional planning. The suggestions to address ACGME compliance and teaching physician experience, along with adapting the assessment for physician groups, were brought to the Coalition for adaptation and inclusion in subsequent site assessments.

This qualitative program evaluation has some limitations. The findings emerged from eight interviews and cannot be extrapolated to all organizations. Second, findings are the result of self-report of events that took place between three to five years earlier. Third, participants in these interviews reflected on the first assessments performed by the Coalition for Physician Well-being. While the assessments followed a clear procedure, there may have been some minor changes in the site visits as the assessors became more efficient with the process.

Conclusion

As the United States continues to recover from the COVID-19 pandemic, healthcare organizations recognize the impact of trauma and moral injury on their physicians. In the current climate where resources may be scarce, all wellbeing efforts must be fully justified within organizations. The Medicus Integra Award offers a model to provide for the wellbeing needs of their physicians. The results from the current study indicates that attention to physician wellbeing benefits program leaders, physicians, and organizations.

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Appendix

Schedule of Questions

1. When did your organization have its MIA assessment?
2. Before MIA: how did you evaluate the wellbeing of your physician workforce?

   Probe: How effective was that form of evaluation?
3. What was the discussion of the C-suite/administrators as they considered the MIA assessment?

   Probe: What made your organization decide to have the MIA assessment?
4. Can you tell me what your experience was like as you prepared for the MIA assessment?

   Probe: Did you have any particular insights or notice anything about your organization that you were worried would become evident in the assessment?

   Probe: Was there any particular MIA quadrant (learning, resilience, culture or business) that raised consideration or interest in your administrators or your wellness staff as you prepared?
5. What was the MIA site visit experience like for you and your organization?
6. Is there any way you wish the survey had been different, or captured other types of data or experience in a meaningful way?

   Probe: Were there any positive features that you wished could have been captured on the survey?
7. What was your experience of getting the assessment findings and presenting it to or discussing it with your administrators/C-suite?
8. Which quadrant was the most difficult, or the most helpful, or that brought the most insight to your administration?

9. Has your organization made any changes in policy, protocols, or practice due to the assessment?
10. Have the award designation or subsequent wellbeing efforts had any particular impact by the COVID-19 pandemic?
11. What would you say has the overall value been to your organization of going through the MIA assessment?
12. Is there anything that I didn't ask about the assessment or award process that you'd like to share?

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