Reaching Out to Distressed Residents, Fellows, and Faculty through the Resident and Faculty Wellness Program Interacting Screening Program

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"Reaching Out to Distressed Residents, Fellows, and Faculty through the Resident and Faculty Wellness Program Interacting Screening Program"
Short Title: Reaching Out
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Sponsor: OHSU (Graduate Medical Education)

Purpose/Aims:

A recent survey of 7000+ US physicians indicated that almost half of all physicians are struggling with clinical levels of burnout, 38% with clinical depression, and 6% with suicidal ideation in the past 12 months (Shanafelt et al., 2012). Similar rates of burnout and distress are present among medical trainees (e.g., Prins et al., 2007; Schwenk et al., 2010). Patient care, physician-patient communication, and physician career satisfaction and retention are negatively impacted by untreated physician distress (e.g., Wallace et al., 2009). Of particular concern, rates of suicide among male physicians are somewhat higher than males in other professions and are at least 2 times higher among female physicians when compared to their nonphysician female counterparts (Center et al., 2003; Schernhammer, 2005). US physicians who killed themselves were unlikely to have received adequate treatment for their depression and/or substance abuse—even though they had health insurance and presumably knew about appropriate interventions for mental health problems (Gold et al., 2012). Many medical trainees and physicians in practice appear to avoid counseling or taking psychiatric medication due to concerns about possible stigma, confidentiality/privacy, cost, accessibility/time, reportability to state licensing/credentialing bodies, and helpfulness of counseling with their stressors (Guile et al, 2010; Givens Tija, 2002).

In 2004, OHSU Resident Wellness Program was created to address and remove known barriers to medical residents and fellows receiving counseling and psychiatric medication services. On-site, quickly accessible, free, confidential counseling was provided by clinicians expert in treating medical providers. Educational outreach efforts to clarify that counseling is not reportable to state medical boards—impairment is reportable—were conducted with faculty and medical trainees. In presentations to trainees, faculty and faculty leaders, RWP clinicians described how counseling was helpful to many of their colleagues and how normal and appropriate this level of self-awareness and self-care are for health care providers. The utilization rate of the Resident Wellness Program in 2004-05 was 6% of all residents/fellows and then rose to 17% of residents/fellows in 2012-2013—suggesting that the program was reaching a larger group of distressed medical trainees. Several years ago at the request of faculty members, the program was expanded to include offering services to full-time SOM faculty and was renamed the Resident and Faculty Wellness Program (RFWP). Faculty utilizations rates have yet to be evaluated.

Two years ago Ey and colleagues (2013) conducted an anonymous, online questionnaire of OHSU residents and fellows (response rate of 71%) and found most residents/fellows knew about the program and were "somewhat to very likely" to access the RFWP if needed. Thirteen percent of the residents and fellows, however, indicated that they would be unlikely to access services if they were distressed. When all trainees were asked about possible barriers to accessing counseling, fewer were concerned about stigma, confidentiality, reportability, and helpfulness than medical students and residents surveyed in other academic medical centers (e.g., Guile et al., 2010; Givens Tija, 2001) but perceived barriers to counseling were reported by at least 20% of the trainees. Being uncertain about how to take time out of duty hours to come for an appointment continued to be the largest interfering factor with accessing the RFWP—especially among women and primary care residents. By contrast, ethnic minority residents and male residents expressed more concerns about whether counseling would be helpful in addressing residency/fellowship related stressors (Ey, Moffit, Kinzie, Choi & Girard., 2013). Although the RFWP staff have tried to address these concerns each year through orientations to new trainees and faculty and workshops to various residency programs and departments, there appear to be a group of residents, fellows, and probably faculty (they were not included in this 2011 survey) who continue to be uncomfortable and/or unwilling to seek professional help if distressed.

Following the suicide of a female resident two years ago at OHSU, the RFWP staff searched for additional ways to reach residents and faculty who continue to be unaware of the seriousness of their level of distress and risk and/or to be highly concerned about possible barriers to treatment. Of note, in the general population, the most distressed patients typically report the greatest concerns about seeking mental health treatment (Kushner Sher, 1989). Most patients who died due to suicide met criteria for a psychiatric diagnosis at the time of the suicide (Hirschfeld et al, 1997) and most college students who killed themselves were unlikely to have been in treatment at the time (e.g., Gallagher, 2005) . Although population wide screening for suicidal ideation may not directly prevent suicide, screening for risk factors for suicide (e.g., prior attempts, current depression and substance abuse), is associated with increased likelihood to receive treatment and may prevent more negative outcomes (Gaynes et al., 2004).

According to theories such as motivational interviewing and stages of change (Prochaska et al., 1992; Vogel et al., 2007), individuals change health behaviors when the benefits (e.g., being less stressed) outweigh the risks (e.g., concerns about confidentiality of treatment). Educational programming to promote the benefits and counter the perceived risks of counseling did increase adults' motivation to get professional help (Vogel et al., 2007). Distressed physicians' motivation to seek help following an educational intervention has not been evaluated but organizations such as the American Foundation for Suicide Prevention, ACGME (2012), and the AMA (2011) have developed policies and programming to educate physicians about the importance of treating depression and reducing suicide risk in themselves and their colleagues.

A "best practices" suicide prevention program in 50+ US universities, the American Foundation for Suicide Prevention's Interactive Screening Program (ISP), was identified by the RFWP clinicians as a possible avenue by which to reach distressed OHSU trainees and faculty and encourage them to get help. The "Stress and Depression Questionnaire" is an anonymous, online screening tool for stress,

depression, substance abuse, eating disorders, and suicide risk. Responses are scored and ranked according to level of distress and risk with Tier 1 representing "high risk, high distress" and Tier 2 "moderate distress, less risk" and Tier 3 "low or no distress or risk". RFWP clinicians will monitor responses, provide prompt communication back to the participants with information about how they scored, resources available to them, address any questions/concerns they might have and invite them to set up an appointment at the RFWP (if distressed). A similar size academic medical center to OHSU, UCSD, administered this survey to all medical students, residents, fellows, and faculty (13% completed it) and the majority eventually seen by clinicians indicated that they never would have sought help if they had not received feedback on the ISP and been encouraged to come in for evaluation/treatment (Moutier et al., 2012). Being able to anonymously dialogue with a clinician about their specific situation and questions appeared to persuade some participants to come in for an evaluation or accept a referral. This academic medical center did not have an in-house counseling program for residents and faculty like the OHSU RFWP—UCSD trainees received an initial evaluation from a clinician and then were provided with community referrals. Their participation rate of 13% is similar to rates of participation in the ISP in undergraduate populations (e.g., Haas et al., 2008). We hypothesize that our highly visible and utilized RFWP may lead to a higher ISP participation rate among the residents, fellows, and faculty.

Although the ultimate goal is to save lives (i.e., reduce the rate of suicide among medical trainees and faculty), the low base rate of suicide in a population (Rodgers et al., 2007) does not allow us to evaluate whether the implementation of the ISP at OHSU will lead to a drop in suicide rates at our institution. Even using patient suicidal ideation and attempts as outcomes is problematic as this information can be difficult to gather unless the patient is actively involved in treatment at the time. Rather in the present study we propose to measure the effectiveness of our suicide prevention program by trying to measure proxy variables to suicide risk—increasing protective factors and decreasing risk factors (Goldney, 2005). Specifically, we are seeking to decrease known risk factors (e.g., identify and intervene with untreated depression, substance abuse, high level of stress) and increase protective factors (e.g., promote self-awareness, receipt of support and resources and delivery of mental health services if needed).

Our aims are to:

- reduce known risk factors of untreated psychological distress (e.g., depression, high stress level, substance abuse) by encouraging all residents, fellows, and SOM faculty to complete a self-assessment of their level of stress and risk using the ISP and then offer professional help through a personalized message/dialogue that directly addresses any concerns/barriers about seeking help at the RFWP and offers resources for better coping;

- increase self-awareness in mildly/moderately distressed trainees and faculty who fill out the ISP and offer preventive/early intervention educational resources via the ISP on topics that are relevant to them (based on their responses);

- evaluate whether all RFWP patients (ones who come to the program via ISP and other referral sources) report decreased psychological distress, burnout, and risk of suicide across treatment;

- asses RFWP participants' levels of psychological distress, flourishing, burnout, and risk of suicide across treatment;
- assess at intake whether intent to quit medicine, training program or faculty position within the next 12 months is associated with level of client's distress, burnout, demographics and is a factor in seeking treatment;

- assess level of satisfaction with the RFWP educational outreach workshops, consultation to department leaders (and referral of their trainees and/or faculty), and clinical services provided to distressed trainees and faculty.

Research Questions:

1. How many trainees and faculty participate in the online, anonymous ISP survey and review the clinician's response to their surveys? In addition, how many highly distressed/high risk (Tier 1) trainees and faculty communicate anonymously with the RFWP clinician (via the dialogue function) and accept referrals or come in for an in-person evaluation?
2. How representative are the ISP participants of the overall OHSU population of SOM trainees and faculty, Providence and Legacy residents that could have participated?
    a. Hypothesis: we hypothesize a greater overall participation rate from OHSU, Providence, and Legacy trainees and OHSU faculty than seen with UCSD SOM (13%) due to our greater utilization rate at the RFWP,and visibility as an on-site program and the higher response rate to our 2011 anonymous survey (71% among residents/fellows). We are uncertain how many Tier 1 respondents will communicate with our clinicians and agree to services—this question is exploratory.
    b. Exploratory question re: representativeness—we hope that our participants will be similar to the overall Providence, Legacy and OHSU population so that results will be more generalizable.
3. What is the relationship among level of distress (ISP tiers), type of symptoms reported on ISP and willingness to seek treatment? Is participation in the ISP (as reported in 1st session intake questionnaire) related to response to treatment (change in distress and burnout ratings and risk level, attendance of sessions)?
    a. Hypothesis: level of distress/risk on the ISP will be positively related to greater willingness to accept referrals or make appointment . We are uncertain if participation in the ISP per self-report on intake paper work will led to different treatment response than others seen at our program. We are uncertain whether respondents with certain symptoms (e.g., substance abuse, suicide risk) may be anxious about communicating with us and to come in for an in-person meeting—this question is exploratory.
4. How helpful were components of the ISP (getting feedback on level of distress, being able to dialogue with clinician re: concerns, and having specific resources offered) according to participants in the ISP who came for initial intake at RFWP?

a. Prior ISP studies with undergraduate and graduate samples (e.g., Haas et al., 2008) would suggest that the online dialogue with a clinician re: concerns will be rated as especially helpful and instrumental to ISP participants who eventually sought treatment.

5. How many residents, fellows, and faculty show significant change in their levels of distress and burnout while in treatment at the RFWP? What demographic variables (gender, ethnicity), training/work variables (trainee/faculty status, type of program, year of training are associated with change in distress and burnout ratings across treatment?
6. Is dose of treatment (# of sessions over 12 month period) associated with lower risk of quitting training program, leaving faculty position or leaving clinical medicine as a field?
7. At intake, what is the association between descriptive variables (i.e., demographics, programmatic factors), level of distress, burnout, and intent to quit medicine and/or training program or faculty position? Is dose of treatment (number of sessions over a 12 month period) associated with lower risk of quitting training program or faculty position?
    a. Questions about intent to quit will be based on Boroff et al. measure used by employers and now being used in healthcare setting (e.g., OHSU Pulse Survey).
    b. Status in training program, faculty position will be based upon clinician rating in last session.
8. How do consumers of RFWP services compare to the overall Providence, Legacy and OHSU population of trainees and SOM faculty in terms of demographics, program type? Are they representative?
    a. Hypothesis: This first question is exploratory as little research exists on specific rates of recovery (e.g., decrease in distress) in health care providers in counseling/coaching. In general outpatient clinics, there are no gender or racial/ethnic differences in response to high quality mental health services (e.g., Lambert , 2007).
    b. Hypothesis: the 2nd question—prior studies with a general population would suggest that women and primary care physicians, will be more likely to have sought counseling.
9. What is the level of client satisfaction reported by trainees and faculty seen for individual treatment at the RFWP or department leaders who have consulted with the RFWP staff re: referrals?
    a. Hypothesis: this question is exploratory.

Procedures

ISP Protocol: The OHSU, Providence, and Legacy SOM leadership will announce to the SOM faculty, residents, and fellows and Providence and Legacy residents that the "Stress and Depression Questionnaire" (ISP) is now part of Providence's and OHSU's commitment to promote the well-being of trainees and faculty. Note: effective 7/1/21, Legacy residents/fellows will no longer be seen through RFWP so they will no longer be invited to enroll in this study. Throughout the year, the RFWP clinicians will visit SOM departments/program to introduce the ISP and present a 45-60 minute workshop/Grand Rounds on stress and depression in health care providers. Shortly after each presentation to a department, an email invitation (with a link to the secure ISP website) will be sent to all faculty,

residents, and fellows in that department inviting them to fill out a 10 minute anonymous online questionnaire about their level of stress, depression, substance use, eating disorder issues, current treatment status, and risk for suicide. The respondent will be asked to create a username and password that only he/she will know –so he/she can log back on to the website to see the clinician's response to the survey. This website will explain the rationale for the questionnaire, explain that the website is not a crisis intervention service but will provide crisis hotline numbers and information about how to contact the RFWP staff for urgent consultation. At the end of the questionnaire, the respondent will be given the option of giving an email address so that they can be informed when the RFWP clinician has posted a response on the secured ISP website (they then log on with their user name and password). Students will be reminded that their email address is encrypted to protect their identity and is never available to anyone (including the RFWP clinicians). If respondents do not wish to give their email address, they will be asked to return to the ISP website link 24-48 hours after completing the questionnaire to log on with their username and password to look up the clinician's response to them. The ISP staff found that 90% of all respondents in prior studies with the ISP chose to give their email address and those who did not give their email address were significantly less likely to look up the clinician's response on the website (Haas and Mortelli, personal communication, 2013). Therefore, a decision was made to give respondents an option to include their email address so they will automatically receive a notice from the computer when the clinician has posted a response to their ISP measure or a response to their questions re: seeking help.

When the ISP has been completed by an individual, the ISP computer immediately analyzes the responses on the questionnaire and classifies the questionnaire into 3 Tiers according to level of distress on the PHQ-9 (a standard depression screen) and level of suicide risk with Tier 1 (highest risk) and 3 (lowest risk). Clinicians are able to review answers to each question and the open-ended question re: recent stressors. The ISP protocol requires clinicians to respond to Tier 1 respondents within 24 hours, Tier 2 in 36 hours and Tier 3 in 48 hours. The clinician sends a response specific to the respondent's tier, introduces himself/herself (provides email, pager) and offers responses. For Tier 1 and 2 respondents, the clinician will urge them to schedule an in-person meeting via official OHSU email or the clinician's pager. For Tier 3 respondents, the clinician may offer an in-person meeting and/or educational/preventive resources (e.g., websites/handouts via the message posted). All respondents will be given the option to dialogue further with the clinician about any concerns/questions they might have via posting responses on the ISP website to the clinician and respondent. Once the clinician posts a response, the computer accesses the respondent's encrypted email address and send a notification that a response is available for viewing. Several reminders will be sent automatically to Tier 1 and 2 students and then 15 and 30 days after the clinician's response is posted. If they did not contact the clinician, a final brief update questionnaire is sent to the respondent to ask about how he/she is doing in the past few weeks and ask about possible reasons for not responding the clinician's invitation to dialogue or meet. Respondents can dialogue with the RFWP clinician as frequently as they need to although the goal is to address their concerns and facilitate them coming in for an in-person evaluation at the RFWP.

An ISP database will be created with this de-identified data for each participant that completes the ISP and will include the responses on their ISP, Tier status, any communications between the participant

and the RFWP clinician and whether he/she accepted a referral for services and expressed willingness to schedule an in-person evaluation at the RFWP. Note: no identifying information will be included in the ISP database other than gender, broad categories of year of training or faculty status, broad category of age and type of program (e.g., primary care vs. nonprimary care). If the participant reveals his/her name in any communications with the RFWP clinician, this data will be deleted from the ISP database. Appointments will be scheduled outside of the ISP system by instructing the participant to contact the RFWP clinician directly via OHSU email and at that time revealing who they are.

At the first in-person or telehealth (during modified operations under COVID-19, all RFWP visits became telehealth) appointment at the RFWP, the client will be asked to review and sign a (1.) consent form to participate in treatment at the RFWP and (2.) a research consent form. Clients may be given a copy of the research consent form to review and then be given the option to sign the research consent form in subsequent sessions. The research consent form will include wording that the client is giving permission for retrospective data (prior to signature on research consent form) to be included in the study. Due to all visits now being telehealth, the intake paperwork and research consent forms are presented and reviewed in the telehealth session and client then can complete them and email them back to the clinician via secure OHSU email.

RFWP Client Outcomes Protocol: After completing (1.) an informed consent to be in treatment at the RFWP and (2.) a research consent form, all patients being seen at the RFWP (referred by ISP, other referral sources or self-referred) will be asked to complete a brief measure of a level of distress, burnout, level of risk and treatment history and needs. Specifically, the ACORN (a psychometrically sound, standardized 13-item measure of psychological distress within the past 2 weeks) and 2 screening questions for emotional exhaustion and depersonalization from the Maslach Burnout Inventory (MBI) will be given at the first session and subsequent sessions to measure client progress in treatment. The Maslach Burnout Inventory (MBI) is a psychometrically sound measure often used with health professionals; West and colleagues (2009) found that 2 items are highly predictive of physician burnout as a quick screen. Clinicians will review with their patients how they responded to these questionnaires—as one indicator of their response to treatment. This type of regular brief assessment and collaborative discussion with patients about their progress in mental health treatment has been shown to be highly effective in preventing patients from prematurely terminating from treatment and in facilitating the delivery of tailored, relevant interventions with patients (e.g.,https://psychoutcomes.org; Lambert, 2004). Patients will also complete the Flourishing Scale (a positive psychology measure that asks about whether patients feel their activities are meaningful, whether they feel optimistic about their future, feel respected). This measure is correlated with life satisfaction.

Patients also will be invited out to fill out a psychometrically sound measure of patient satisfaction, the Client Satisfaction Questionnaire (CSQ-8; Atkinson, 1979) on their level of satisfaction with services at the RFWP. They will be asked to fill the CSQ-8 out anonymously and mail back the survey or put it in a locked drop box in the waiting room areas.

Note: At the time of treatment, clients will be asked if they completed the ISP and whether it was helpful to get feedback on their level of distress and to be able to dialogue with a clinician. **Data Collection**

Sample and Measures

ISP Sample of Residents, Fellows, and Faculty: All OHSU residents and fellows (approximately 800 annually) and all full-time (0.5 FTE) faculty (approximately 3000) will be sent via OHSU email a link to the ISP survey following the RFWP clinician's presentation of the Stress and Depression workshop to their department. Note: only residents, fellows and full-time SOM faculty will be included as they are the only ones who are eligible for services through the RFWP (we don't have capacity to provide services to all adjunct faculty). All Legacy residents (approximately 90 a year) will be invited by RFWP clinicians (during workshops/orientation to these groups) to participate in completing the ISP.Note: new Legacy residents/fellows effective 7/1/21 will no longer be enrolled. All Providence residents (approximately 90 a year) will be invited by RFWP clinicians (during workshops/orientation to these groups) to participate in completing the ISP. *RFWP Client Outcomes Sample:* All patients seen at the RFWP (to start with IRB approval) will be invited to participate in the research study—estimated to be 200-300 annually that are seen at the program. This estimate is based on 17% of 800 OHSU residents/fellows and approximately 2% of 3000 SOM faculty utilizing services through the RFWP in 2012-13. Increased outreach efforts through this proposed project "Reaching Out" will likely raise the visibility of the RFWP (especially among faculty) and lead to a slightly higher number of faculty and medical trainees utilizing future RFWP annually.

All clinical data are entered into an encrypted ACCESS clinical records database that only RFWP clinicians have permission to access. Participants who also complete the Research Study Consent Form will have the following clinical data exported into a research database for analyses: RFWP Subject ID number* randomly assigned (by computer) to the resident, fellow, or faculty member at time of intake,

- demographic and work/training program information (gender, year of birth, ethnic/race, year of training if relevant, resident/faculty status, type of program/specialty) from the "Personal History and Data Form" completed by the patient in the first meeting
- reason for referral, referral source, knowledge of RFWP
- psychological, suicide, and medication history (if relevant) based on clinical interview
- participation in the ISP and ratings of helpfulness of the ISP components (in "Personal Health History and Data Form")
- clinician ratings of patients' sources of stress, interventions and referrals provided in session
- client self-report of current level of distress (ACORN) and burnout (MBI emotional exhaustion and depersonalization items),
- at intake, client rating on intent to leave medicine, intent to leave training program (resident/fellow) or faculty position (faculty clients) in next 12 months,
- client self-report of Professional Fulfillment Index (PFI; Trockel et all, 2018)—new measure of physician professional fulfillment and burnout
- number of sessions, year of sessions,

- clinician ratings of patient's current suicide risk, risk to others and patients, and reasons for seeking treatment, clinician rating of whether client left program or faculty position prematurely,
- client self-report on Flourishing Scale (Diener and Biswas-Diener, 2009)
- whether they are experiencing COVID-19 related stress or have experienced a recent trauma (per clinician rating)

The *RFWP Subject ID is generated randomly by a separate RFWP appointment book database and stored in a master list with the patient's name and year of birth in a separate, encrypted ACCESS database that only Drs. Moffit, , Kesserwani, Ey and Soller have permission to access. One RFWP psychiatrist, Dr. Mark Kinzie, is the program director of Psychiatry, so he will not have access to this database (master list with names, id) in case there were psychiatry residents or faculty listed as patients of the RFWP. All psychiatry residents and faculty are seen by the other providers not Dr. Kinzie.

A separate, anonymous measure of patient satisfaction, the Client Satisfaction Questionnaire (CSQ-8; Larsen, Attkinsson, Hargreaves, and Nguyen, 1979) will be given out in the clinic and patients asked to complete separately and mail back or put in a locked box in the waiting room area (to be collected by RFWP clinicians to review at a later date). This 8-item Likert scale questionnaire measuring clients' satisfaction with counseling (RFWP) is a psychometrically sound (Cronbach alpha of .92 in Larsen, 1979) measure of client satisfaction in outpatient mental health settings that is significantly correlated with similar measure of client satisfaction with services and is predictive of client attendance and client symptom relief (Attkisson & Zwick, 1982). A total score of satisfaction is created based on the sum of individual items.

Sample of Department Leadership: All Program Directors (PDs) and chairs will be mailed annually a modified version of the CSQ-8 (given successfully in a prior survey of program directors in 2011) to assess their knowledge of the RFWP and ISP initiative and satisfaction with the RFWP as a service to their trainees and faculty. The expected number surveyed will be approximately 100. The surveys will be anonymous and only aggregate, de-identified data will be presented for purposes of data analysis and publication.

SOM Summary Data

In order to conduct analyses comparing participants in the ISP surveys and participants in the RFWP to the overall Providence and Legacy trainee and OHSU SOM trainee and faculty population, some summary SOM data will be provided to the researchers by the Dean's Office and Graduate Medical Education data analyst. Specifically, deidentified, summary data will be gathered starting in 2014 annually until the end of the project. Data requested will be:

Number of residents, fellows, primary SOM faculty,

% women/men,

% ethnic/racial groups,

average age in trainee, faculty groups,

number of trainees, faculty in 5 specialty groups (primary care, hospital based, surgical, peds/IM specialty, other)

Vulnerable Populations:

There are no vulnerable populations included in this study as all residents, fellows, faculty, and department leadership are assumed to be mentally competent and able to respond to the English language survey (since they are working full-time and functioning as health professionals at OHSU).

Consent and Measures to Protect Subjects' Privacy

Per federal and state law regarding providing confidential psychological services, all residents, fellows, and faculty seen for treatment at the RFWP will complete an informed Consent to Treatment and a separate Research Study Consent.

All RFWP outcomes data included in the research study, ISP data, and department leadership surveys will be de-identified and only aggregated data reported in analyses for purposes of quality improvement and research presentations and publications. No protected health information will be included in any analyses. No genetic information is gathered in any of the protocols. Subjects who do not wish to participate in the outcomes research study through the RFWP also may decline to complete the measures of distress (ACORN), burnout (MBI screen) or client satisfaction (CSQ). In addition, to help protect research subjects' privacy, the researchers obtained a Certificate of Confidentiality for this **study data and the repository it will be stored in**. from the National Institutes of Health. With this Certificate, the researchers cannot be forced to disclose information that may identify research subjects, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. The researchers will use the Certificate to resist any demands for information that would identify research subjects, except as explained below:

The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). Subjects will be informed that a Certificate of Confidentiality does not prevent them or a member of their family from voluntarily releasing information about the subjects or their involvement in this research. If an insurer, employer, or other person obtains subjects' written consent to receive research information, then the researchers may not use the Certificate to withhold that information. However, if we learn about abuse of a child or elderly person or that research subjects intend to harm themselves or someone else, or about certain communicable diseases, we will report that to the proper authorities.

Compensation: Participants in the ISP or RFWP services will not be compensated for their participation. Both programs are seen as a benefit to participants in terms of increasing self-awareness and offering free resources and counseling as needed. There will be no benefit to participating in the research other

than the knowledge that they may be helping the investigators to determine how to best help other distressed health care providers.

Costs: there are no additional costs to subjects for their participation. All RFWP services are offered free of charge to eligible SOM faculty and all residents and fellows (the program is funded 100% by GME/OHSU hospital) and the Faculty Practice Plan.

Process for Withdrawing/Termination: At any point during the ISP protocol (filling out the ISP survey, dialoguing with the RFWP clinician online), ISP participants can choose to not accept referrals and withdraw from participation without any consequences. For example, even if participants report being high risk (Tier 1), they are anonymous so the RFWP clinician would not be able to identify for who they are and would simply encourage them to come in for an in-person evaluation or access crisis intervention services in the community. Numbers to community and national hotlines and urgent consultation to the RFWP staff are posted on the ISP website for OHSU participants.

In the RFWP program, participants being seen in-person or virtually (via telehealth) can withdraw from treatment and/or from the research study at any time without penalty. The RFWP is a voluntary service and does not provide mandated treatment or fitness for duty treatment/evaluations. If there are imminent concerns for the RFWP participant's safety or others' safety (e.g., patient safety), the participant is informed (in the first meeting and consent form) that the RFWP clinician may break confidentiality and communicate with the participant's family members/emergency contact and/or program director/chair to assess safety concerns. A RFWP participant may be asked to take a leave of absence and have a fitness for duty evaluation before returning to duty if there are significant concerns about their ability safely practice as a health care provider.

Statistical Analyses:

Statistical analyses will be conducted by Dr. Soller and her research team and will consist of descriptive analyses (e.g., frequencies, means, standard deviations), correlational analyses, and some multiple regression analyses to determine whether participation in the ISP is predictive of engagement in treatment and recovery from depression, substance abuse, or suicide risk. In addition, pre-post comparisons of risk, distress and burnout levels will be conducted in relation to demographic and treatment factors for all participants in the RFWP. Additional analyses will be conducted comparing participants to overall Providence and OHSU SOM populations on demographics to see if samples are representative of their institution's eligible population.

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