

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL ACADEMIC CABINET

December 15, 2020

8:00 – 9:00 am

Meeting URL: <https://umich-health.zoom.us/j/273697793>

Members: Drs. Brown, Lumeng, Jeruss, Kolars, Kunkel, Mulholland, Spahlinger, Zink, Matt Comstock, Teri Grieb, Sonya Jacobs, Amanda Thatcher, and Diana Witowski\*

Guests: Drs. Collins, Mangrulkar, McKean, along with Lauren McGee and Brad Densen

Staff: Tim Keeler

*\* expected absence \*\*expected to leave early*

1. Medical Student Mental Health – 45 min
2. Hot Topics/Matters Arising – 15 min

# **Medical Student Mental Health Revamp Proposal December 2020**

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## Table of Contents

<b><i>Executive Summary</i></b>	<b>3</b>
<b><i>Our Stories</i></b>	<b>6</b>
<b><i>Background</i></b>	<b>9</b>
<b>National Literature</b>	<b>9</b>
<b>Internal Data</b>	<b>9</b>
<b>Additional Internal Data</b>	<b>14</b>
LCME Independent Student Analysis	14
MiStep Data	15
<b>Internal Programs</b>	<b>16</b>
<b>Opt-Out Literature</b>	<b>18</b>
<b>Peer Institutions</b>	<b>18</b>
<b>Analysis</b>	<b>20</b>
<b><i>Alternatives Vetted</i></b>	<b>22</b>
<b>MARI Expansion</b>	<b>22</b>
<b>GradCare for All Medical Students</b>	<b>22</b>
<b>My MD-to-Be and Early Alert</b>	<b>22</b>
<b>Interactive Screening Program</b>	<b>23</b>
<b>Penn Cobalt</b>	<b>24</b>
<b><i>Recommendations</i></b>	<b>25</b>
<b>Our Proposal</b>	<b>25</b>
Institutional Priorities	25
Medical Student Mental Health Services	25
Documentation	27
Academic Impact and Special Situations	27
M-Checks Opt-Out Screening	27
<b>Budget</b>	<b>29</b>
Phased Expansion of Medical Student Mental Health Program	29
Full Medical Student Mental Health Program Expansion	30
Budget Explanation & Justification	31
<b><i>References:</i></b>	<b>33</b>
<b><i>Appendices</i></b>	<b>35</b>
<b>Appendix A: Additional Figures from Internal Needs Assessment</b>	<b>35</b>
<b>Appendix B: Testimonials</b>	<b>38</b>
Obstacles to Utilizing Resources	38
<b>Appendix C: Sample M-Check Email</b>	<b>43</b>

## Executive Summary

Enhancing clinician and trainee well-being has been a focus of many institutions, including our own, over the past decade. The University of Michigan Medical School (UMMS) took first steps in supporting medical student well-being with the relocation of Medical Student Mental Health (MSMH) services to the main medical campus in July 2019 and the establishment of the Michigan Medicine Wellness Office. Despite these steps, significant gaps and challenges remain. In this proposal, we highlight three stories shared by current and former students at UMMS, and, while providing national and local data, issue a set of recommendations with commensurate resources that better reflect our institution's mission statement.

Our medical students have described multiple barriers to accessing adequate, affordable mental health care while attending UMMS. Of the many stories collected, three recurring themes stand out. Lisa's story details the significant obstacles present when attempting to obtain mental health care at UMMS, such as insurance coverage and other barriers to care, leading to **increased stress**, exacerbating her underlying depression. Claire describes how the underdiagnosis of her mental health issues negatively impacted her **academic trajectory and graduation timeline**. Noah's **death by suicide** demonstrates the need to universally assess all students' mental health, including those who outwardly mask their struggles. Countless stories like these highlight a **pattern of barriers to care**, which are demonstrated in these narratives and in the objective data here within.

Medical students are struggling with mental health and well-being both nationally and here at UMMS. The national prevalence of depression or depressive symptoms amongst medical students is estimated to be 27.2%, and suicidal ideation has an estimated 11.1% prevalence. Yet, only **15.7% of those students that screen positive for depression seek treatment**.

In July 2020, an internal needs assessment of the classes of 2020-2023 was conducted, evaluating student burnout, knowledge and utilization of professional mental health services offered through UMMS, as well as any barriers to access. It was found that nearly half of all medical students endorsed **symptoms of burnout**. Additionally, 80.8% of students acknowledged that they had been **concerned about their emotional well-being** during their medical school career, with 66% sharing that they have had a diagnosed or perceived mental health concern since starting medical school. Data showed that 37% of these students have never sought out help for their concerns, citing several preventative barriers such as lack of time, cost, stigma, and fear of negative career repercussions. Despite being one of the primary services for medical students, 34.9% of students stated they have never heard of the MSMH program. Furthermore, 77.9% of students believed **UMMS should be doing more** to support its students' mental health and well-being. Additional internal data, including the Independent Student Analysis and MiStep study, support the conclusions of this survey, highlighting a significant need for student mental health services in the face of growing mental health concern amongst all classes.

Our current mental health infrastructure is under-resourced, leading to significant gaps in care for students. Though student academic counselors can support students and connect them to

resources, mainly the MSMH program, they do not serve as mental health therapists and they are expressly prohibited from providing therapeutic counseling in their roles. The current MSMH program consists of access to a psychiatrist, by appointment only. However, as private insurance must be used, this has created significant financial barriers to its use. Through the current MSMH program, there is no access to a therapist. Students are able to access university-wide resources such as Counseling and Psychological Services (CAPS) and University Health Service (UHS) which, though free, are short-term therapy solutions that are often understaffed, difficult to access, and nonspecific to medical student needs. If long-term therapy is needed, students are referred out to overwhelmed community therapists, making securing an appointment a difficult to impossible task.

To best serve our medical students, an annual **universal, opt-out mental health screening (M-Checks)** and a **robust two-phase expansion of mental health services** are necessary. This phased expansion would position UMMS as a national leader in medical student mental health and well-being. Alternative solutions were explored but were ultimately deemed inadequate to address the underlying issues experienced by medical students.

The principle of using an **opt-out model** has been well-demonstrated amongst screening military service members, and it has recently been demonstrated to be successful for both medical residents and medical students. The Keck School of Medicine of the University of Southern California has had success with its recently-implemented opt-out mental health check-ins for all first-year students, which achieved 95% engagement in its first year. The M-Check process will involve students filling out a mental health screening survey and subsequently meeting with a therapist to review the results and discuss their needs. Domains screened by this validated survey include depression, burnout, sleep, generalized anxiety, eating disorders, alcohol and substance use disorders, post-traumatic stress disorder, and supplemental screenings for other domains for those interested. Implementation alongside a revamp of the mental health resources will enable in-house, rapid follow-up for students who require a psychiatric or psychotherapeutic care referral.

**Documentation** for all visits, including M-Checks, will be within the OCWR platform. Students who seek psychiatric care will have minimal documentation in MiChart with “see outside medical record for full visit notes,” but psychiatrists will process medication prescriptions through MiChart. This will be done to both maintain confidentiality and lessen the concern that grading faculty will have access to students’ records.

The goal of **Phase 1** of this program is to enable a limited rollout of M-Checks and allow students up to six therapy visits and up to two psychiatry visits for each acute short term need at no cost to students, while simultaneously issuing community or Michigan Medicine referrals, allowing students to work with their insurance to ensure coverage in a less urgent timeframe. The expansion of the MSMH program would transition into living under the Office of Counseling and Workplace Resilience (OCWR), where the rest of Michigan Medicine is able to access mental health care services. The necessary staffing for this first phase would include **2.5 full-time-**

**equivalent (FTE) therapists, 0.6 FTE psychiatrists, and 1 FTE staff person** for clinical and student support.

**Phase 2** of this program would allow for complete roll-out of the M-Check screening, and provide adequate staffing to serve medical students across their time at UMMS in a more robust capacity. This will require **4.0 full-time-equivalent (FTE) therapists, 1.0 FTE psychiatrists, and 2.0 FTE staff personnel**. The full M-Check program would allow for 7 dedicated times throughout the curriculum to check in with students during especially stressful times, and transition points. This full medical student mental health program aims to **align with best practices in medicine and level the playing field** among our colleagues in other Michigan Medicine graduate and post-graduate programs.

Improving access to mental health services for our medical students is well-aligned with our Medical School's strategic pillars, specifically our people and care pillars, our Medical School's mission, and our University's broader mission. From the UMMS Strategic Plan, in order to **continue recruiting, developing, and retaining the best learners**, we should provide services in line with our peer institutions' offerings. To continue providing outstanding patient care, we must **care for our care providers**, including students. Medical students are entering a high-risk profession for depression and suicide, yet they are reluctant to seek treatment, resulting in delay of treatment with worse outcomes and greater costs to medical schools, health care systems, and society in the future. Our health system has been **transforming health** for the millions of Michiganders we serve - we should aspire to do the same for our students by implementing the M-Check program and revitalizing our MSMH program. We aim to be the preeminent institution in developing providers who will challenge the present and enrich the future: we must work to **destigmatize mental healthcare and invest in our students of today**, who will be our physicians and leaders of tomorrow.

## Our Stories

### **Barriers to Access: Lisa's Story \***

*I first sought mental health care during my clinical year when I realized my academic performance was suffering; I was studying but could not retain the information I was trying to learn. Outside of the clinical environment, I felt very isolated and would often cry. As an out-of-state student, **I had no social support**, and my working-class family could not understand the struggles I was experiencing. Ironically, on my Family Medicine rotation, I recognized that we were treating patients for many symptoms I was experiencing myself: sleep loss, difficulty concentrating, anxiety, worthlessness, and guilt for doing things outside of studying that I enjoy. Many of these things were driven by my own perfectionism as a medical student and the impostor syndrome I was feeling every day. I was anxious about not knowing what type of career in medicine I wanted to pursue. I had no idea what rotations I was going to schedule in the Branches. I had not begun any research. **I felt like I was miles behind my classmates**. I could not talk about this with my fellow students or faculty for fear that they might think I was weak, so **I made the difficult decision to seek mental health care**.*

*I originally tried to get psychiatric help by calling the phone number advertised on the medical school website for the Medical Student Mental Health Program. However, because the program did not accept my insurance, my initial appointment would cost \$400, and I could not bring myself to schedule the appointment. I was beyond frustrated. As a student, **I was entrusted with the responsibility of providing care to patients at Michigan Medicine but was not able to receive care myself**. The closest option for receiving mental health care that my insurance would cover was in Detroit, which was not possible with the schedule of a clinical student. After talking to my parents who told me they would help financially, I scheduled my first appointment at the University of Michigan.*

*Ironically, I was on my psychiatry rotation **on the day of my first appointment**, and **the resident I was working with would not let me leave for the appointment**, even though I went through the proper avenues for requesting time off to attend a medical appointment. I did not feel comfortable talking to the resident about how challenging it was for me to schedule this appointment in the first place or what this appointment was for. I remember running out of the VA as quickly as possible to drive to the University of Michigan for my appointment and showing up overwhelmed and late, but I was still able to be seen.*

***Once I overcame the numerous barriers and sought mental health treatment for depression, my confidence improved**, I was able to decide upon a specialty, and my shelf exam scores rose. I know that **I am not alone in this experience** and that **there is more that we can do** if we come together to share our stories.*

Lisa's story demonstrates how difficult utilizing current mental health resources can be for students lacking proper insurance coverage and time while under immense stress. It highlights the importance of ease of access to affordable mental health care. Initial no-cost-to-student psychiatric evaluation and therapy may reduce or eliminate these barriers and decrease time to treatment for the many students who this story represents.

\*The pseudonym Lisa was randomly chosen for this anonymized story

### **Repercussions of Diagnosis: Claire's Story**

*I entered medical school like many other bright, young minds; full of excitement and nervousness. Prior to coming to UMMS, I was always top of my class; academics came easily to me. However, **I began struggling with the intensity of the medical school curriculum almost immediately.** I failed one of my first sequence quizzes and **could feel myself falling behind.** I thought it was just because of the difficulty of medical school, not realizing that the degree of struggle was actually largely due to a worsening of my depression and anxiety, something that had never affected my schoolwork in the past. **The pace of the curriculum left me drained.** One failed sequence turned into three, and I was notified I was under academic warning. I was in absolute shock. I had always self-identified as an intellectual capable of conquering anything I set my mind to, and this was just not me. I met with school administrators, who warned me that if I failed another sequence, my medical school career could come to an end. I was **strongly encouraged to go on leave of absence, though no specific resources regarding my mental health were offered at that time.***

*During that year, I worked extremely hard on my personal struggles and returned to school feeling ready to tackle the curriculum. I successfully finished my pre-clinical work and moved into the clinical realm. Unfortunately, **the time demand of clerkships left no room for personal care, and I stopped seeing my psychiatrist,** even though I knew it meant foregoing self-care. The pressures surrounding the need to focus on academics coupled with limited resources and support for how to attend recurring medical appointments while on rotation made these conflicting demands seem impossible to balance. But, mentally **I felt healthy and thought I would be able to push forward without my psychiatrist.** However, over the course of my 3-month surgery rotation, some of those familiar struggles were resurfacing. **The negative impact of my mental health was creeping into the academic sphere once again,** culminating in me failing the surgery shelf. Again, an academic committee became involved to decide whether or not I would be allowed to stay enrolled. Although by the start of the next clerkship I had rectified many of these issues, I was forced to take another few months off while my case was being reviewed. With the blessing of the executive committee, I returned to the clinical trunk, though I was off-cycle, which forced me to take another year off prior to starting the branches. During each of these disruptions, I had to meet with many people from the Office of Medical Student Education (OMSE), ranging from my counselor, the Dean of Student Services, financial aid and the registrar. **I still feel unclear about how this will impact my residency application, my future state licensure, and my career.** I have talked to so many people who feel the same, and have put off seeing a mental health professional for fear of negative career implications.*

Claire's story demonstrates the monumental academic negative impact of being under-diagnosed in a culture that values pure dedication, unquestioned commitment and academic prowess, over one's own mental health. There is a lack of understanding of what is confidential and what is recorded in a student's formal educational record. There is a lack of knowledge of what may be revealed in the Dean's letter and to residency programs. This demonstrates the need of separation of therapeutic counseling from academic counseling.



### **A Culture of Don't Ask, Don't Tell: Noah's Story**

*This past summer, Michigan Medicine lost one of its own. **Noah Cutler's death by suicide** sent shockwaves of grief, sadness, and frustration throughout the student body, the faculty and administration, and the wider community. By his own account, Noah had a happy life with great friends, a supportive and loving family, and greatly enjoyed medical school. His easy smile regularly radiated throughout the halls of Taubman Library. In a letter to his parents, he strongly denied that any external factors, such as COVID-19 or medical school stress, caused him to take his life. **Nobody, not even those closest to him, had any inkling of his long, internal struggle.***

*The sudden loss of our friend Noah prompts many questions: What could we have done differently? How many others are silently struggling? And what can we do better going forward? **These are the fundamental questions that drive this proposal.** For Noah, medical school was not the most proximate cause of his mental health struggles, but for many of our fellow students, the stress and pressure of school directly exacerbate the mental health issues that many students struggle with. Medical school will always induce some stress, but **we can change the narrative of how medical schools handle and treat the mental health of their students.** We have the mission, expertise, and resources to change the trajectory of someone's life for the better by investing in their mental health on their journey to becoming a physician. **Any given person's struggle may not always be our fault, but it is our responsibility to help them,** especially those who we do not know are struggling.*

Noah's poignant story reveals the need to normalize and prioritize mental health care for all; creating a community that values preventative and ongoing mental health care of its members. The enormity of his loss for our community is indescribable. In-depth opt-out mental health screening for all medical students may have caught Noah's struggles before they became fatal, and will destigmatize seeking care for other students who may also be silently struggling.

## Background

### National Literature

It is well known that medical training is one of the most intense and stressful experiences most trainees will face in their lives. Evidence suggests that medical students, residents, and physicians experience high rates of depression, suicidal ideation, and burnout.<sup>1,2</sup> Medical students have the highest rates of burnout, depression, and suicidal ideation among the three groups and are more likely to display symptoms of depression compared to other age-matched U.S. college graduates.<sup>3</sup> The prevalence of depression or depressive symptoms amongst medical students is estimated to be 27.2% and suicidal ideation has an estimated prevalence of 11.1%, yet only 15.7% of those students that screen positive for depression seek treatment.<sup>1</sup> Stigma remains a major concern for those who do not seek care, with common concerns being confidentiality, loss of confidence from colleagues, and career repercussions. Other major barriers include lack of time, convenience, and concerns about cost.<sup>4,5</sup> Research has shown that interventions aimed at reducing barriers such as convenience and time commitment have increased mental health care utilization, so how can we translate this into an intervention for future physicians?<sup>6</sup>

Physicians reporting symptoms of burnout, fatigue, and suicidal ideation are more likely to have reported a major medical error in the preceding three months.<sup>7</sup> Independent studies have found the costs related to physician turnover and reduced clinical hours secondary to burnout to be significant - approximately \$4.6 billion per year, or around \$7,600 per employed physician each year at an institutional level.<sup>8</sup> As we will outline below, our proposal will not only aid students during their medical school careers, but will financially benefit Michigan Medicine as an institution by expanding ease and access to care for students, residents, and faculty alike.

### Internal Data

The following internal data was collected in June 2020 by Lauren McGee and Cayla Pichan, with analytic assistance from Jackie Kercheval.

The conversation surrounding improvements for student mental health resources has been ongoing for years. In 2019, a Wellbeing Steering Committee was created within the medical school “To create and foster well-being in graduate medical education at UMMS as we all strive to be at our best in serving our patients and in supporting each other.” One of the student leads, current M4 Jackie Kercheval, began a competition to gather student-submitted ideas on wellness initiatives for their System-Wide Approaches sub-committee. There were many wonderful ideas generated for pre-clinical and clinical years, but the one that ended up winning is shown here (Figure 1).

Clarity of mental health resource availability	Improving access to and dispelling confusion regarding mental health resources for medical students by creating a web-based platform of resources.	<p>The author proposed a few options for addressing this:</p> <ul style="list-style-type: none"> <li>• Website/flowchart/pictogram to delineate available psychiatric and counseling options, costs, insurances + co-pays, sliding-scale services, service hours</li> <li>• Surveys to address what students need/want resource-wise</li> <li>• Potentially hire a med student-specific counselor, like at other professional schools</li> <li>• Educate counselors, advisors, and anyone else who would need to be aware of the resources available to medical students</li> </ul>
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Figure 1. Winning idea in a wellness proposal competition, submitted by Cayla Pichan.

Cayla Pichan authored this proposal, and of the nearly 300 students voting on these ideas, this received the most number 1 votes. One of the major components of this proposal was to conduct a needs assessment survey of students to explore student burnout, quality of life, prevalence of mental health concerns, decision to seek treatment, and satisfaction/room for improvement with current resources. Data of this type had not currently existed, so Cayla Pichan and Lauren McGee, with the support of Dr. Kirk Brower, Chief Wellness Officer of Michigan Medicine, obtained IRB approval (HUM00183042). This internal needs assessment survey was disseminated in June 2020 to students in the graduating classes of 2021-2023, as well as MSTP students, those on leave of absence (LOA), and members of the recently graduated class of 2020. The following pages outline the results of this survey.

Demographics

Of the 307 responses (response rate of 52.5%), 201 were female, 102 were male, 3 identified as transgender and 1 preferred not to answer. The responses were fairly even amongst currently enrolled students; we also had 28 responses from current PGY-1s (class of 2020), MSTP students, and those on LOA (Appendix A, Figure A1). Race and ethnicity data were also collected (Appendix A, Figure A2).

Burnout

Students answering a validated single question measure of burnout showed that 48.2% of respondents are burned out. A stratified breakdown of the burnout responses can be seen in the appendix (Figure A3). When these responses were stratified by graduating year, the proportion of burnout was significantly higher amongst pre-clinical and clinical students (59.1% and 66.3%, respectively). The lowest reported levels of burnout were seen in M4 and PGY-1 respondents (36.3% and 25.0%, respectively) (Table 1).

Response category	Class of 2023		Class of 2022		Class of 2021		MSTP		LOA		PGY-1	
	N	%	N	%	N	%	N	%	N	%	N	%
Not burned out	27	40.9%	38	45.8%	58	63.7%	10	55.6%	4	40.0%	21	75.0%
Burned out	39	59.1%	55	66.3%	33	36.3%	8	44.4%	6	60.0%	7	25.0%
Answer not provided	0	0.0%	1	1.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	66	--	83	--	91	--	18	--	10	--	28	--

Table 1. Internal Needs Assessment Levels of Burnout by Class.

Emotional Wellbeing

Multiple questions were deployed to gauge medical student well-being broadly. When asked “Have you been concerned about your emotional well-being at any point during your time in medical school?”, **80.8% of students responded “Yes.”** (n=248). Students were asked about time for personal/family life (Appendix A, Figure A4). This question was followed more specifically by asking, “Have you had concerns about your mental health during medical school, either diagnosed or perceived? This includes both new and previously diagnosed mental health concerns.” Again, the response was staggering: **66% stated “Yes”** this applied to them (n=203) (Figure 2). Only 63% of these students (n=128) responded saying they did seek some sort of treatment (Figure 3). However, this still leaves 37% of students attempting to manage their concerns without help.

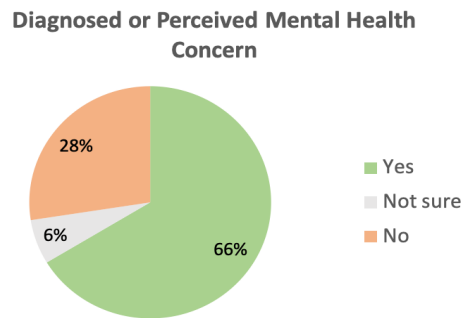


Figure 2. Student answers in response to “Have you had concerns about your mental health during medical school, either diagnosed or perceived? This includes both new and previously diagnosed mental health concerns.”

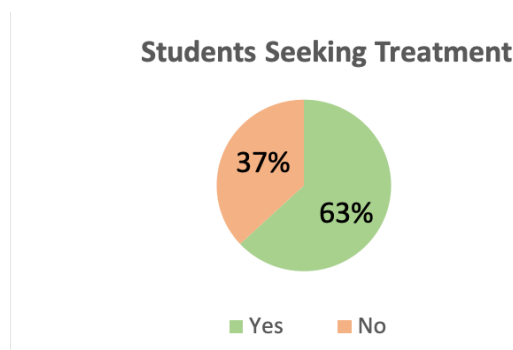
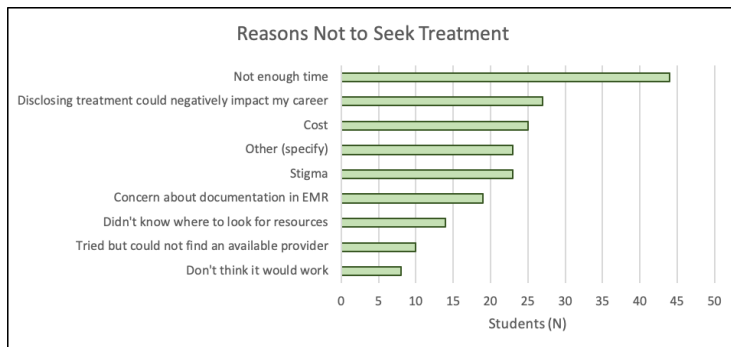


Figure 3. Although 63% of students responded that they are seeking treatment for mental health concerns, 37% are trying to manage their issues without treatment.

### Barriers to Care

Students who reported they did have concern about their mental health but did not obtain treatment were asked what prevented them from doing so (Figure 4). The largest barrier by far was time, with students feeling that their schedule did not accommodate consistent treatment. The second most reported obstacle was concern about how seeking treatment would affect their career. Based on free text responses, students believed that they might be forced to disclose prior treatment or psychiatric history in residency or licensing interviews. They also worry that their history with mental health treatment may be involuntarily disclosed for residency or licensing interviews by members of administration to other institutions, effectively damaging their career opportunities. Third was cost; many students either attempted to receive care and were deterred by insurance issues and financial concerns or did receive care and were dealt a massive and unexpected medical bill that prevented them from ever returning. Students were additionally concerned about the stigma surrounding mental health treatment and documentation, were unable to locate current resources, were uncertain about treatment efficacy, or tried and could not find available providers. Specific testimonials regarding students' barriers to care can be read in Appendix B.



*Figure 4. Students who reported they did have concern about their mental health but did not obtain treatment were asked what prevented them from doing so. Respondents could check all statements that applied, with a free response option.*

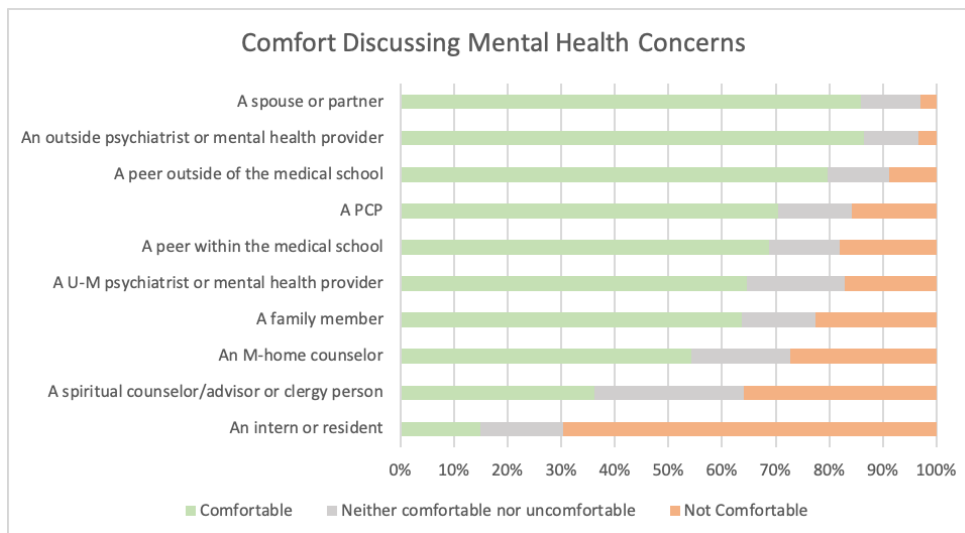
Treatment Acquisition

Students were asked a series of questions pertaining to knowledge of available resources, where they have or would receive care if needed, and satisfaction of resources that have been utilized. Students were asked about whether or not they knew about services listed on the medical student gateway website (Appendix A, Figure A5), as well as satisfaction if utilized (Appendix A, Figure A6).

Despite being the primary referral option for students and having been included in several emails prior to the release of this survey, 34.9% of students stated that they have never heard of the MSMH program (n=107). Students who did seek treatment overwhelmingly said they used either the MSMH program or their own community therapist. Students were largely satisfied with the MSMH program and personal therapists, though somewhat less satisfied with the MSMH program. Several students used free text response options to share their experiences (Appendix B). Those who were satisfied with the services reported that it worked very well. But for those that it failed, we received an overwhelming number of stories - students who were not able to establish continuity of care, insurance not covering visits leading to massive and unexpected medical bills, and lack of time given constraints within our clinical schedule.

Comfort Discussing Mental Health Concerns

Students then rated whether they were comfortable, neutral, or not comfortable discussing a mental health concern with several individuals, the results of which are ordered from most to least comfortable top to bottom (Figure 5). Students feel most comfortable talking about their concerns with a spouse or partner, a provider not affiliated with Michigan Medicine, or a peer not within the medical school. Perhaps as expected, students are the least comfortable talking with interns or residents as these are individuals directly providing student evaluations. Notably, nearly 30% of respondents would not feel comfortable going to their M-Home counselor (n=83).



*Figure 5. Students were asked to rate whether they were comfortable, neutral, or not comfortable discussing a mental health concern with several individuals, which is ordered from most to least comfortable top to bottom.*

### Mental Health Care - Factors Most Important to Students

Students were asked to expand on the personal level of importance of several aspects of mental health treatment. Responses are ordered in terms of frequency in which students answered “extremely important” or “very important” for each item, proceeding left to right in terms of importance (Appendix A, Figure A8). Overall, most important to students is the quality of service, scheduling ease, and having flexibility in terms of appointment times. The most popular vote for extremely important overall was guaranteeing that seeking mental health care would have no negative impact on their future career. Cost and appointment expediency were still important to over 75% of students. Of less importance was MiChart documentation and office location.

### Student Suggestions

Students then responded yes or no to the question, “Do you believe UMMS should be doing more to support the mental health and well-being of its students?” **77.9% of students said yes** (n=239), 16% had no opinion, and 6.2% said no. Students were given the opportunity to provide free text responses to the question “What specific suggestions do you have regarding how UMMS can improve professional mental health services for its students?” and 182 unique responses were captured. A sampling of these testimonials can be found in Appendix B.

### Top Five Suggestions

1. Time off/more flexibility in pre-/clinical year: (41)
2. Fewer wellness events, more focus on curricular/systems level change (busy work, pace of M1 curriculum, pass/fail M2, fewer contact hours, reduce competition, etc): (38)
3. Dedicated therapist not affiliated with the medical school (32)
4. Regularly occurring opt-out check-ins and mental health screenings (32)
5. Free/reduced cost access to unlimited therapy: (30)
6. Clarified/updated resources that are navigable and up-to-date: (28)

### Additional Internal Data

#### LCME Independent Student Analysis

In addition to this data, the Independent Student Analysis, conducted as part of the Liaison Committee on Medical Education (LCME) accreditation process, administered a survey in January 2019 to the classes of 2019, 2020, 2021, and 2022, had an 85.1% response rate. This robust survey found that 29.3% of students had initiated treatment for a **new or worsening mental health concern**. This is in contrast to the internal needs assessment, where 63% of students had initiated treatment for **diagnosed or perceived mental health concerns**. While the LCME data was able to capture the number of students with new and acute needs, it missed students receiving treatment for known or stable mental health concerns. Taking these students into account, the internal needs assessment demonstrates that there is likely a higher percentage of students seeking mental health treatment than previously thought, and therefore a greater need for expanded services.

MiStep Data

OMSE continues to conduct the MiStep study, tracking the well-being, resiliency and perceived stress of matriculating students at the beginning and ending of their M1 year and end of M2 year. These results further emphasize the above data and demonstrate two important concepts: 1) students, in general, are actually matriculating to medical school every year with lower measured well-being indices and higher perceived stress, and; 2) these wellness measures are worsening to greater extents for each new class as they move from the end of their M1 to M2 years.

**Class of 2024 End of M2 vs End of M1 vs Matriculation**

	End of M2 (2022)		End of M1 (2021)		Matriculation (2020)		Change
	Mean	N	Mean	N	Mean	N	
Well-Being Index <sup>1</sup>					0.58	154	
Resiliency <sup>2</sup>					8.68	156	
Perceived Stress Scale (PSS) <sup>3</sup>					12.48	156	

**Class of 2023 End of M2 vs End of M1 vs Matriculation \***

	End of M2 (2021)		End of M1 (2020)		Matriculation (2019)		Change
	Mean	N	Mean	N	Mean	N	
Well-Being Index <sup>1</sup>			3.08	59	0.89	108	2.19
Resiliency <sup>2</sup>			8.61	60	8.96	109	-0.35
Perceived Stress Scale (PSS) <sup>3</sup>			18.08	59	11.56	112	6.52

**Class of 2022 End of M2 vs End of M1 vs Matriculation \***

	End of M2 (2020)		End of M1 (2019)		Matriculation (2018)		Change
	Mean	N	Mean	N	Mean	N	
Well-Being Index <sup>1</sup>	3.87	67	3.36	73	0.77	133	2.59
Resiliency <sup>2</sup>	8.27	67	8.47	73	8.52	135	-0.05
Perceived Stress Scale (PSS) <sup>3</sup>	19.05	66	16.41	71	11.40	138	5.01

**Class of 2021 End of M2 vs End of M1 vs Matriculation**

	End of M2 (2019)		End of M1 (2018)		Matriculation (2017)		Change
	Mean	N	Mean	N	Mean	N	
Well-Being Index <sup>1</sup>	3.67	54	3.01	82	0.77	141	2.24
Resiliency <sup>2</sup>	8.51	55	8.62	82	8.86	147	-0.2371
Perceived Stress Scale (PSS) <sup>3</sup>	16.55	53	13.93	82	11.43	147	2.5014

**Class of 2020 End of M2 vs End of M1 vs Matriculation**

	End of M2 (2018)		End of M1 (2017)		Matriculation (2016)		Change
	Mean	N	Mean	N	Mean	N	
Well-Being Index <sup>1</sup>	3.02	59	2.70	133	0.64	145	2.06
Resiliency <sup>2</sup>	8.68	59	8.31	133	8.82	148	-0.516
Perceived Stress Scale (PSS) <sup>3</sup>	16.39	57	14.61	132	10.82	149	3.7873

1. Well-Being Index: All questions are answered using a simple yes/no format. One point is assigned for each "yes" answer with summary scores on the 7item index ranging from 0(lowest risk) to 7 (highest risk)
2. Resiliency: sum of 2 items. Higher score better adaptability. Scale: 1=not true at all; 2=rarely true; 3=sometimes true; 4=often true; 5=true nearly all of the time
3. Perceived Stress Scale: sum of all 10 items (4, 5, 7 & 8 reverse coded). Higher score more stressful. Scale: 0=never; 1=almost never; 2=sometimes; 3=fairly often; 4=very often.

\* Sampling strategy was updated in 2020 to an intention random sample of half the class. In previous years sampling was done by self-selection - open to the full class

Figure 6. MiStep Data for medical students from the past 5 years.



## Internal Programs

### Medical Student Mental Health Program:

The MSMH psychiatrist has partially protected time to see medical students, but none of the visits are funded through the medical school. Medical students must reach out to the program's administration to make an appointment, and the appointment goes through the individual's insurance. Not all insurance plans are covered, and the initial visit can cost up to \$400 out-of-pocket. These visits are treated like any other UM visit and are documented in MiChart. Appointments are made during usual working hours and are not available on evenings or weekends. Students with acute situations are seen within 24-48 hrs and every effort is made to see other students within 7-10 days, however because of complexities of medical student schedules and lack of evening and weekend flexibility, students typically wait 3-4 weeks for an initial appointment.

### Academic Counselors

During onboarding, medical students are told that their house counselors are one major resource available to utilize when they are struggling both academically and personally. The house counselors are an excellent source of support for students, especially when facing academic challenges. However, the house counselors, some of whom are licenced therapists, are expressly prohibited from providing therapeutic counseling services. Counselors are able to navigate students to the MSMH psychiatrist, CAPS, or community therapy programs.

### House Officer Mental Health Program (HOMHP):

Since its inception in 1996, the Michigan Medicine House Officer Mental Health Program has provided a range of mental health services to all University of Michigan residents and fellows. There is a 0.4 FTE funded psychiatrist, as well as administrative support provided through the department of Psychiatry. The HOMHP provides an initial no-charge psychiatric evaluation by an attending physician, and this initial consultation is not documented in MiChart. Ongoing treatment is subject to standard insurance copays. For the majority of house officers, who have UM Premier Care as a benefit of employment, the copayment is \$25 per appointment. Appointments are made during usual working hours and appointments are not available on evenings or weekends. The appointments are conducted in a confidential location in the hospital, avoiding travel and facilitating scheduling with minimal impact on work schedules.

### Office of Graduate and Postdoctoral Studies Mental Health Resources:

Students studying under the Office of Graduate and Postdoctoral Studies (OGPS) have access to 1.6 FTE therapists who provide brief, individual and group coaching and counseling for trainees. OGPS counseling services are meant to provide assessment, referral, consultation and short-term individual counseling to all OGPS trainees on personal, emotional, family and academic/work-place issues. The OGPS counseling office's treatment philosophy is based on a *brief, solution-focused treatment model*, which translates into **up to 3-6 counseling sessions per year** per student. If a student would like to work with someone on an ongoing basis, Dr. Hagadone, Mental Health & Wellness Counselor, will provide referrals to appropriate University and/or community resources.

Office of Counseling and Workplace Resilience (OCWR):

The OCWR provides compassionate, confidential mental health services to Michigan Medicine employees, including faculty, staff and house officers and fellows. These services include no-cost counseling with therapists (up to 6 visits) with documentation outside of MiChart. Appointments are available during the workday, as well as evenings and weekends. OCWR offers online screening tools for a number of mental health conditions. OCWR also helps the community with traumatic events by providing group sessions to process such challenging circumstances.

Kelcey Stratton, PhD, Program Manager for Resilience and Wellbeing Services within OCWR, is piloting the Michigan Medicine Opt Out Wellbeing Consultation Support Program for residents. The program is in its first year and includes 65 Internal Medicine interns and 21 Neurology residents. The program is titled, “Confidential well-being/coaching sessions” and is advertised as wellness coaching. There has been overall positive feedback from the participating residents thus far. Details include:

- One time, 1 hour long session per person over Zoom
- Interns fill out screening through REDCap at the beginning of call, then results are reviewed together
  - PHQ9, GAD7, Professional Fulfillment Index
- Residents are able to ask about current concerns and goal set for the year
- Possible referral to OCWR or HOMHP
- No documentation anywhere, appointment list and time kept only
- Anticipating 2 FTE for screening of all 1200 residents and fellows

Other campus resources:

Campus resources rarely utilized by students include CAPS, UHS and the Mary A. Rackham Institute (MARI). These services can provide counseling at reduced rates for medical students but were not designed to serve the special needs of medical students. Given that these programs serve several thousand undergraduate and graduate students, barriers such as long wait times, inconvenient access for medical students, and counselors unfamiliar with the unique stressors of medical school render these programs unfeasible for consistent use.

Local resources:

There are several local centers who have been variably available to students. Unfortunately, many local mental health resources are not accepting new patients, and do not have the needed off-hours scheduling that most medical students require to participate in therapy. In the wake of the COVID-19 pandemic, even fewer therapists are currently accepting new patients compared to years past, making initiation of therapy increasingly challenging. All of these services require full payment out of pocket if insurance is not accepted. There are a few clinics that have made exceptions for the medical students and have graciously designed easier ways for medical students to access services. However, these fill up quickly, and students are still subject to existing insurance barriers.

## Opt-Out Literature

While some institutions have provided confidential access to professional mental health services at no-cost to students, these services are more commonly available as an opt-in option, where students and trainees are responsible for seeking out care, scheduling an appointment, and attempting to find a time in their busy schedule to attend this appointment.<sup>9</sup> The utilization rate of such mental health programs among medical trainees is 25%.<sup>9</sup> An intervention that not only addresses the major barriers to treatment, but also mitigates the additional stress of seeking out care is thus of the utmost importance.<sup>9</sup>

A promising intervention is an opt-out mental health screening. Opt-out programs have already demonstrated success in other areas of healthcare, such as vaccine deployment.<sup>10</sup> By including this mental health screening as a necessary annual or bi-annual healthcare intervention, not only will students not have to sacrifice their limited personal time and finances, but it will also normalize receiving mental health care, framing it as a part of routine health maintenance.<sup>11</sup> Early data from an “opt-out” mental health screening program for medical residents has demonstrated success, with an attendance rate of 93%.<sup>12</sup> Through implementation of this type of program within medical schools, students would be connected with services before a potential crisis, providing the foundation for easier and possibly earlier access when help is required the most, in addition to setting the precedence for mental health treatment throughout their careers.<sup>13</sup>

## Peer Institutions

Upon discussion with multiple peer institutions that have already implemented a mental health program, the common thread amongst all of them was that the initial program structure was not as robust as initially hoped for because of inadequate staffing. Our proposed program structure and staffing models are in part informed by discussions with these peer institutions and the data that they collected on the effectiveness of their own programs.

The insight and advice obtained highlighted some of the deficits in their programming, and allowed us to construct our own robust program meant to avoid repeating their mistakes.

## USC Keck School of Medicine

Students at the Keck School of Medicine (Keck) receive mental health care through the Graduate Student Health Clinic as well as the Medical Student Wellness Program. The Graduate Student Health Clinic serves all 5,000 graduate students at USC. This program is staffed by 5 therapists and 1 psychiatrist. The Medical School Wellness Program, created as an adjunct to the above program and serving only the medical school’s 750 students, includes 2 full time psychologists and no psychiatrist. Two FTE psychologists are adequate for staffing a brief model of care (6-8 sessions) for about  $\frac{2}{3}$  of their students, with about  $\frac{1}{3}$  of their students still needing to utilize the Graduate Student Health Clinic to obtain mental health care. Their initial vision was to provide ongoing care for all 4 years; however, this has not yet been feasible due to staffing constraints.

The Keck School of Medicine (Keck) also developed Keck Checks, after which M-Checks are being modeled. Their opt-out screening program utilizes an anonymous 20 to 30-minute survey containing 12 gold-standard screening tools, which M1 students complete during a designated protected time once annually. Once the survey is complete, next step recommendations are provided anonymously. Although the survey is not mandatory, with this opt-out model they have achieved 95% participation from their first-year students.

Additionally, their 2 FTE psychologists complete in-person Keck Checks, which are 15 minute opt-out checks done once a year for the first-year students, and opt-in for M2s and M3s. This program is run by two psychologists from their wellness program, and they ask structured questions related to depression, anxiety, substance misuse, suicidal ideation, academic performance, and social support. At the end of the appointment, students are scheduled for an intake appointment with a psychologist or therapist as needed. They have found that students who opt-out of the program are more likely to decompensate from a mental health perspective in subsequent years of schooling.

Keck has recognized that this program, while necessary, has many downfalls, most notably that the two psychologists are not enough, and that running this program at the pace needed for it to be successful at this FTE takes an extreme emotional toll on the psychologists.

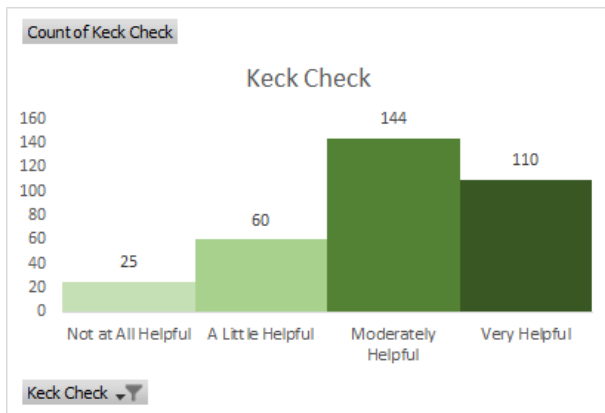


Figure 7. Spring 2020 Keck Check helpfulness rating, n = 339



Figure 8. Spring 2020 USC Keck Counseling Utilization

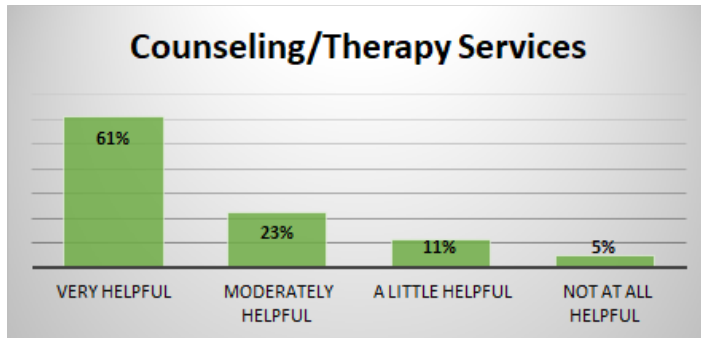


Figure 9. Spring 2020 USC Keck Counseling Usefulness

### Mayo Clinic School of Medicine

The 2,000 students and residents at Mayo School of Medicine have just 1 FTE psychologist and feel that they are woefully understaffed. Prior to the pandemic, they were in the process of looking to hire 8-10 full time counselors to meet the needs of the students. They originally started with “unlimited” sessions but quickly became overrun and had to put a limit on appointments by only offering short term crisis counseling. The students also have access to their Employee Assistance Program, which is similar to our OCWR. There are only 3 full-time counselors for all faculty, staff, house officers, and students, which results in a wait time for an initial appointment in 2-4 weeks. Research suggests that these groups may not seek mental health services due to time constraints, concerns about confidentiality and professional impact, and perceived stigma. There is not a hard limit to the number of sessions, but it is strictly for acute, short-term work only.

They also offer 15-minute meet-and-greets on an opt-in basis to discuss the logistics of their services and answer any questions that the student may have. No questions are asked about the student’s mental health and no risk assessment is done. About 60% of the students choose to opt-in to this service. They had no psychiatric services to address urgent needs. Based on discussions with Mayo School of Medicine, it is evident that the MSMH program would need to have 4 full-time psychologists and a full-time psychiatrist in order to meet the projected student need.

### Analysis

The reality of high burnout, depression, and suicide rates amongst physicians and physician trainees seems to be common knowledge amongst the general public. Both national and internal data show that medical students are struggling with mental health concerns and are not having their needs met. A majority of students at UMMS are concerned about their emotional and mental health and believe that UMMS should be doing more to support the mental health and well-being of our students.

Students are feeling burned out, and many have known or suspected mental health concerns. While many students get treatment, the medical school is still not reaching over a third of students who may need help. For those who choose not to get help, time, cost, stigma, fear of negative career impacts, and awareness of resources are the most commonly listed barriers to

care, similar to observations made through other institutional studies. Not having affordable, sustainable access to services and the lack of an environment in which students feel comfortable seeking these services has already had dire consequences for our student population as evidenced by our MiStep results, internal needs assessment, and tragic death by suicide of one of our students.

So where do we go from here? We can address these issues with many of the solutions students have offered themselves in this survey. For students that don't seek treatment, we can implement required, opt-out check-ins that every medical student participates in yearly at no cost. By taking the burden of seeking care away from students, we may be able to reach more students who need help earlier in the year. Lastly, by building protections into these check-ins, we can address several student concerns with mental health care. By dedicating counselors specifically for medical student needs, we can improve issues of access and concerns of time. By hiring counselors not affiliated with OMSE or who do not document within MiChart, we can also address concerns of confidentiality and fear of negative consequences.

When thinking about the various aspects of this program, we turn to factors students deem most important for their mental health care. These factors include the quality of service, ease of scheduling, and having flexibility in terms of appointment times. The aspect of greatest overall importance was guaranteeing that seeking mental health care would not have a negative impact on their future career. Cost and appointment expedience were still important to over 75% of students. Aside from the internal needs assessment, results from the MiStep study show that UMMS students are generally matriculating with increasingly worse well-being scores, which only deteriorate further by the end of their pre-clinical and clinical years.

It is critical to support our medical students' mental health and **opt-out mental health screenings** would serve to destigmatize mental healthcare, better introduce students to available mental health resources, and increase rates of both diagnosis and referrals. The principle of using an opt-out model has been well-demonstrated in both medical residents here at UMMS recently, and medical students at Keck School of Medicine with a 95% engagement rate for the first year opt-out screening. To best serve our medical students, a **robust two-phase expansion of mental health services** and annual **universal, opt-out mental health screening (M-Checks)** is necessary. These changes would position UMMS as a national leader in medical student mental health and well-being.

It is evident that the medical school needs to create a more robust program to support the mental health and well-being of its physician trainees. In constructing this program, all of these pieces of evidence have influenced the discussions and decisions regarding our proposal. Although this will require a significant investment, UMMS can work with the Academic Cabinet to find the funds to make this service no-cost to students.

## Alternatives Vetted

### MARI Expansion

MARI provides counseling and psychiatric services for all faculty, staff and students, as well as their families. MARI University Psychological Clinic works through individual insurance and does not have sliding scale payment options. Some medical students utilize their services currently, but many of the same barriers exist as in other community services, such as long wait times and insurance barriers. MARI does not utilize MiChart for documentation and is not connected to Michigan Medicine. As a result, MARI providers have more limited insight into the medical school as compared with OCWR providers. Additionally, MARI's location on E Main St involves moderate transit time from the medical school. Proximity was deemed more important than MiChart charting to medical students, both as a consensus of this workgroup as well as through survey results. Due to this, we have pursued integration into the existing Michigan Medicine program, OCWR.

Although MARI does not have the immediate focused comprehensive services that this workgroup is trying to develop, discussions with the director opened a door for us to consider integration with this clinic if needed. MARI faculty are willing to discuss incorporation of medical student services into their program if we face challenges integrating into OCWR.

### GradCare for All Medical Students

Medical students are offered GradCare for themselves and their families. Currently students with GradCare only receive \$45/month supplementation, which amounts to about \$160,000 annually. If our institution decided to completely cover GradCare, which has good mental health coverage, for all students this would cost approximately \$2.5 million annually. This still would not solve the problem of a lack of mental health providers capable of accommodating the needs of our medical student community and additional access, privacy and stigma concerns.

### My MD-to-Be and Early Alert

From the Center for Supportive Relationships (through its Founder and Scientific Director, Eran Magen, PhD), two wellness programs were evaluated, Early Alert and My MD-to-Be. The combined package of programs costs \$20,000 per year.

The first, Early Alert (<http://www.earlyalert.me/home/>), is an opt-in text message-based program by which students receive weekly text messages asking them about different domains of wellness. Students respond via a scale of 0-10 (0 = extremely bad, 5 = neutral, 10 = extremely good). The response is received by an automated system. If a student responds in a poor state of wellness or falls below their own 'baseline,' the program 'flags' the student and notifies an Early Alert psychologist for further evaluation of the student's safety and crisis response needs. The program will also provide immediate resources and referrals to the 'flagged' student. Resources and crisis response algorithms are determined in partnership with individual school's Student Services teams. This service is used by medical schools at the University of Pennsylvania, West Virginia University, Wright State University, USF, the University of Arizona, UNLV, Nova

Southeastern University, and Quinnipiac University. Wayne State University has been a recent participant in the program, and conversations were had with the Dean for Students at Wayne State (Dr. Margit Chadwell) and with students who have opted into the program. While the administrative perspective was overall positive, student response was highly variable. Some students that had initially opted into the program subsequently left because of lack of sophistication in the automated texting as well as feeling the frequency of text messaging was too high. While this program seems to function well as a tool to monitor student wellness over time, it does not address the goals of this proposal or improve any barriers to care as outlined above.

My MD-to-Be is the second program from the Center for Supportive Relationships. This program is an opt-in online program that helps strengthen medical student's support networks. The program emails resources about the medical school training process to the student's parents, spouses, or friends, so the student's support network can better understand what their loved one is experiencing. Topics might include the White Coat Ceremony, what it's like to be in the cadaver lab, what is happening in a given week or month of the curriculum or studying for Step 1. While this program has potential benefits for UMMS students, it again does not address the needs outlined in the survey data collected from UMMS students.

### Interactive Screening Program

This program is an anonymous online screening program created by the American Foundation for Suicide Prevention to identify individuals in distress and connect them with mental health services and recourses. The program hosts a Self-Check Questionnaire, which includes 37 items related to depressive symptoms, substance use, suicidal ideation, self-harm, and current treatment, among others, and takes under ten minutes to complete. The program does not diagnose, but instead analyzes the questionnaire and places each individual into one of four tiers which corresponds to how quickly a counselor will respond to the individual. After the questionnaire is completed, an on-campus UMMS staff member would review the results and prepare a personalized response that offers support, feedback, and recommendations for next steps. This program allows for anonymity, which may limit the ability of counselors to help an individual student with their specific situation. This program has a low overall response rate based on other schools utilizing this program, averaging <15% response, the majority of whom are classified as high-risk individuals.

This program does not quite meet the goals of our proposal, and still requires time and personnel to make the program work. Although the integration of screening tools into one online platform that is accessible to counselors is a benefit, it does not take away any administrative burden of assessing those surveys. The program also lacks the flexibility for customization.



Interactive Screening Program Outline

AFSP Provides	We Are Responsible For
<p><b>Website development</b>, customized for us</p> <ul style="list-style-type: none"> <li>Secure and maintained separately from our IT system</li> </ul>	<p><b>Program fees</b> (one-time development fee of \$5,000, annual license fee of \$5,000)</p>
<p><b>Training</b> for counselors</p> <ul style="list-style-type: none"> <li>Online (COVID friendly)</li> </ul>	<p><b>Program personnel</b></p> <ul style="list-style-type: none"> <li>ISP counselors</li> <li>ISP coordinator</li> <li>Back-up counselors</li> <li>Administrative staff (optional)</li> </ul>
<p><b>Tech support</b>, 24/7</p>	<p><b>Treatment/referral network</b></p>

Penn Cobalt

Michigan Medicine, including the Wellness Office and OCWR are engaging with the creators of Penn Cobalt, an interactive platform that we would use to host regular opt-out M-Checks and link medical students to mental health resources directly through online scheduling with therapists. Students would also have the option to complete additional self-initiated opt-in screenings anonymously. Penn Cobalt is innovative and customizable for individual institutions, programs, and users, which can be adapted for the needs of our medical students. This program has already been expanded for use at Northwestern and will likely become integrated into several other prominent healthcare systems in the future. Notably, this program grew to 5,000 users in the first 30 days at Penn, and is currently used by more than 16,000 faculty, residents, students, and patients with favorable reviews from initial feedback.

This program has great potential for use at UMMS and Michigan Medicine. The total estimated cost of this is at least \$50,000; this would be a one-time cost incurred by the adopting institution. The basic platform would be free for all users, with subscription-based access to some programming such as group therapy sessions and peer networks. UMMS would highly utilize this program if it was adopted, and the MSMH program would contribute \$20,000 toward these costs. This program satisfies many of the needs set forth by our student surveys: Cobalt is an easily accessible and navigable resource that is of no cost to students, allows students to quickly locate available providers, and saves time with the option for virtual appointments.

Please navigate to this resource at your convenience: <https://www.penncobalt.com/>



## Recommendations

### Our Proposal

#### Institutional Priorities

Improving access to mental health services for our medical students is well-aligned with our Medical School’s strategic pillars, specifically our people and care pillars, our Medical School’s mission, and our University’s broader mission. To continue recruiting, developing, and retaining the best learners, we should uphold our mission and provide services in line with those provided by our peer institutions. To continue providing outstanding patient care, we must care for our health care providers, including medical students. Our healthcare system has been transforming health for the millions of Michiganders we serve, and we should aspire to do the same for our own students through implementation of the M-Check program and revitalization of our MSMH program. If we aim to be the preeminent institution in developing providers who will challenge the present and enrich the future, we must work to destigmatize mental health care and invest in our students of today, who will be our physicians and leaders of tomorrow.



Lead Nationwide Change	Care for our Students	Reduce Barriers to Care
<p>(1) Be the #1 Medical School in the nation for reducing student mental health burden through implementing screening and improving access to mental health services in medical school</p> <p>(2) Invest in our people </p>	<p>(1) Practice and normalize preventative medicine for mental health in medical students</p> <p>(2) Destigmatize mental healthcare utilization </p>	<p>(1) Encourage risk-free, no-cost pursuit of mental healthcare</p> <p>(2) Lead the way with M-Checks, an opt-out mental health screening program</p>

#### Medical Student Mental Health Services

New psychological and psychiatric providers will work within the OCWR framework, including utilizing their documentation system. It is vital to have a diverse group of therapists, and thus the search committee will emphasize the importance of the hiring of candidates who reflect the diversity of our student body. This includes, but is not limited to the following: women, persons of color (specifically those who identify as Black, Hispanic, and/or Native American), LGBTQIA+ individuals, a variety of abilities and disabilities, and those sensitive to the specific needs of first generation/low-income (FGLI) students.

In order to best serve the mental health and wellness needs of our medical students, a robust, phased program is necessary. With appropriate funding and infrastructure, UMMS would be the “leader and best” when it comes to caring for our students in all aspects of their wellness. Please see below our proposal for a phased program. At a minimum, phase 1 will level the playing field with our colleagues by providing medical students the same services that residents and our peers in other professional programs are already receiving, alongside the implementation of M-Checks. At a glance, mental health services will be provided to all medical students, including MSTP students and students on Leave of Absence who are planning on returning within the year, with minimal barriers to care, such as affordable cost and adequate follow up.

### Phase 1: M-Check and Stop-Gap Services

- 2.5 FTE Therapists; this allows for a limited M-Check program with only one check a year for the M1s and M2s, not providing essential service to half of our student body; all students will have access to up to 6 therapy visits\* for each acute short term need while support staff finds adequate follow up mental health services in the community as needed. This will allow time to find care covered by the student's insurance or that has sliding-scale options that are affordable\* for the student. See below for description of this M-Check program;
  - \*The limit of 6 therapy visits may be exceeded in the circumstance that there are delays in establishing the student with a permanent therapist in the community.
- 0.6 FTE Psychiatrist; one initial and one follow up no-cost to student visit; students will see this psychiatrist if there is not a primary care physician who is willing to take over management of mental health medication or if the condition necessitates the expertise of a psychiatrist; services will be provided until the staff person is able to find a community physician who is willing to accept a new patient with their specific insurance. Students who continue to see the psychiatrist will be required to use insurance after the first 2 visits.
- 1.0 FTE Staff Person; time would be split between clinical support and support for students who need help navigating mental health resources in the community, coordinating insurance coverage, and finding resources that are accepting new patients.

### Phase 2: Full Medical Student Mental Health Program

- Increase to 4.0 FTE therapists total, exclusively for medical students
  - Therapy sessions will be provided to students at no-cost with no set limit; if a student wishes to receive follow up care outside of this program, a staff person will help facilitate finding a provider who is willing to accept a new patient with their specific insurance, and is affordable for the medical student.
- Increase to 1.0 FTE psychiatrist exclusively for medical students
  - Students will have access to the psychiatrist for medication management. If the student wishes to seek care outside of the program, support staff will help investigate viable options for medication management in the community that are affordable for the medical student.
- 2.0 FTE support staff for the clinicians and support for students who need help navigating mental health resources in the community, coordinating insurance coverage, and finding

\*Affordability is to be determined by the medical student and does not involve investigation through Financial Aid, much like many clinicians accept sliding scale off of honor code, we will trust our students to be able to make the determination between affordable and not affordable.

resources that are accepting new patients. The administrators would be responsible for managing schedules, and would also be responsible for providing the support that we would otherwise receive from nursing and care management teams (if we were using MiChart):

- Managing appointment scheduling
- Following up with a student if they no-show for an appointment
- Ensuring students are not lost to follow up if they cancel an appointment
- Fielding medication refill requests
- Doing medication prior authorizations
- Helping students interface with pharmacies for any issues that might arise
- Helping students navigate their prescription insurance coverage
- Managing any form or letter requests
- Obtaining records from prior psychiatric providers
- Coordinating care with other current medical providers
- Obtaining records from emergency room visits or hospitalizations if they occur
- Helping students find a new psychiatric provider after graduation
- Sending records to new psychiatric providers

### Documentation

All mental health visits will be documented within the OCWR platform. If a student sees the medical student mental health psychiatrist, their visit will be documented in MiChart with “See outside medical record for full visit notes”, but medication prescriptions will be processed through MiChart.

### Academic Impact and Special Situations

MSMH services will not cover escalated mental health needs amounting to enrollment in partial hospitalization programs, psychiatric hospitalization, electroconvulsive therapy, or medication costs. Students will need to utilize their own health care coverage for these services.

Any student who utilizes a MSMH program professional will not be penalized academically for disclosing concerns around mental health or substance use. All mental health providers will be held to the field standards for when to breach confidentiality.

### M-Checks Opt-Out Screening

Intelligent, high functioning individuals often have excellent innate coping skills for compensating with challenges, though this can be a double-edged sword. While this helps maintain a high level of academic engagement, it can also often result in detrimental suppression of classic symptoms of mental unwell and illness. Medical students often present with more severe symptomatology because of delay in seeking help, due to their ability to compensate, potentially maladaptively. As noted previously, there is significant institutional cost associated with mental unwellness. M-Checks are informed by this notion and are meant to identify mental health concerns and symptoms earlier on in the course of unwellness to mitigate downstream consequences for both the individual and the institution.

M-Checks are opt out check-ins and are for medical students to touch base with a mental health professional throughout their medical school career. The structure of this program is to have each student fill out a mental health screening survey, with a follow up appointment with a therapist to review the survey results and discuss any needs that the student might have. This survey will include instruments, which are detailed below. Each of the domains surveyed have been shown to be highly prevalent in the medical trainee population.

Students will be emailed at the beginning of each M-Check block with their scheduled check-in time, as well as instructions on how to reschedule their appointment, if needed. Students will be given a 30-minute protected time slot to complete the survey 1-2 weeks before their appointment. For the M1s, this will be built into their lecture schedules. For clinical students, rotations will be notified in advance that the student will need this time off.

See Figure 10 for a proposed timeline of when each of the M-Checks would occur throughout the curriculum.

**Instruments**

Students will be surveyed on the following domains based on validated tools that have been adapted for optimal use at our institution:

*Depression, Burnout, Sleep, Generalized Anxiety, Eating Disorders and Alcohol and Drug Use Disorders, Post-Traumatic Stress Disorder*

Students will be given the opportunity to complete supplemental screenings within the following domains, if interested:

*Obsessive Compulsive Disorder, Social Anxiety, Panic Disorder, Cognitive Distortions, Imposter Syndrome, Obsessive Compulsive Personality Disorder*

These survey instruments are meant to inform the student’s discussion with their therapist. If any of the screening tools flag as positive, the therapist can use their clinical judgment to administer additional diagnostic questionnaires in order to determine if specific treatment is needed. Survey results will only be visible to the student and the therapists. Only generalized, anonymized data will be shared with the OMSE in order to inform any curricular/program changes that will improve the emotional and mental well-being of medical students.

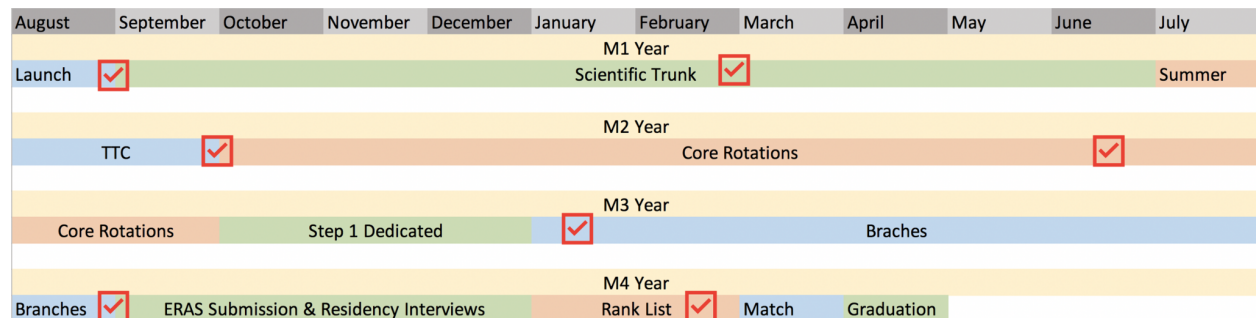


Figure 10. Proposed M-Check Timeline across all four year

Budget

Phased Expansion of Medical Student Mental Health Program

Staffing	Year 1		Year 2		Year 3		Year 4		Year 5	
	Salary	Fringe	Salary	Fringe	Salary	Fringe	Salary	Fringe	Salary	Fringe
.60 Psychiatrist	132,000	28,657	135,300	29,373	138,683	30,108	142,150	30,860	145,703	31,632
.40 Psychiatrist Y2			88,000	19,105	90,200	19,583	92,455	20,072	94,766	20,574
1.0 Counselor	80,000	26,136	82,000	26,789	84,050	27,459	86,151	28,146	88,305	28,849
.60 Counselor Y1/1.0 Y2	43,200	14,921	72,000	24,868	73,800	25,490	75,645	26,127	77,536	26,780
.50 Counselor Y2			38,000	13,125	38,950	13,453	39,924	13,789	40,922	14,134
1.0 Counselor Y3					68,000	23,487	69,700	24,074	71,443	24,676
1.0 Counselor Y3					72,000	24,868	73,800	25,490	75,645	26,127
1.0 Admin Coord	50,000	20,650	51,250	21,166	52,531	21,695	53,845	22,238	55,191	22,794
1.0 Admin Coord Y3					50,000	20,650	51,250	21,166	52,531	21,695
Subtotal	305,200	90,364	466,550	134,427	668,214	206,793	684,919	211,963	702,042	217,262
Non-Salary Program Supplies - Copies/Paper, Office Supplies, Toner, Kitchen Supplies, Pagers	Expense 5,000		Expense 5,000		Expense 5,150		Expense 5,150		Expense 5,300	
Travel/Prof Development *3,000/staff counselor for 1 conf	12,000		12,000		12,240		12,240		12,500	
Subtotal	17,000		17,000		17,390		17,390		17,800	
Total	412,564		617,977		892,397		914,272		937,104	

\*assumes 2.5% merit increase

Medical Student Mental Health Proposal

Full Medical Student Mental Health Program Expansion

<u>Staffing</u>	Year 1		Year 2		Year 3		Year 4		Year 5	
	Salary	Fringe	Salary	Fringe	Salary	Fringe	Salary	Fringe	Salary	Fringe
.50 Psychiatrist	110,000	23,881	112,750	24,478	115,569	25,090	118,458	25,717	121,419	26,360
.50 Psychiatrist	110,000	23,881	112,750	24,478	115,569	25,090	118,458	25,717	121,419	26,360
1.0 Counselor	68,000	23,487	69,700	24,074	71,443	24,676	73,229	25,293	75,059	25,925
1.0 Counselor	72,000	24,868	73,800	25,490	75,645	26,127	77,536	26,780	79,475	27,450
1.0 Counselor	76,000	26,250	77,900	26,906	79,848	27,579	81,844	28,268	83,890	28,975
1.0 Counselor	80,000	26,136	82,000	26,789	84,050	27,459	86,151	28,146	88,305	28,849
1.0 Admin Coord	50,000	20,650	51,250	21,166	52,531	21,695	53,845	22,238	55,191	22,794
1.0 Admin Coord	50,000	20,650	51,250	21,166	52,531	21,695	53,845	22,238	55,191	22,794
Subtotal	616,000	189,803	631,400	194,548	647,185	199,412	663,365	204,397	679,949	209,507
Non-Salary Program Supplies - Copies/Paper, Office Supplies, Toner, Kitchen Supplies, Pagers, etc	Expense 5,000		Expense 5,000		Expense 5,150		Expense 5,150		Expense 5,300	
Travel/Prof Development *3,000/staff counselor for 1 conf	12,000		12,000		12,240		12,240		12,500	
Subtotal	17,000		17,000		17,390		17,390		17,800	
Total	822,803		842,948		863,987		885,152		907,256	

\*assumes 2.5% merit increase

## Budget Explanation & Justification

Medical students are a unique population distinctly at risk for mental health concerns compared to their non-medical peers, entering a high-risk profession for depression and suicide, yet they are reluctant to seek treatment, resulting in delay of treatment with worse outcomes and greater costs to medical schools and society. Our institution is not immune to these challenges, as outlined extensively throughout this proposal. By investing in medical student wellness at the earliest level of training, the future payoff can be massive for individuals, institutions, and society who will benefit from residents and faculty physicians who are more productive and less likely to suffer from burnout, depression, job turnover, or suicide. In the class of 2020, 22% of UMMS students continued their medical education at Michigan Medicine.<sup>14</sup> Institutions that undergo proactive changes to bolster student and trainee mental health must weigh the short-term costs associated with program startup and maintenance with the long-term benefits of a thriving and productive workforce.

Without early screening, identification and treatment referral, costs of depression and other mental health disorders will carry into residency training. Using depression as an example, the cost to residency programs and academic institutions adds up quickly, with presenteeism-related costs (the costs of employees who are not fully functioning in the workplace because of an illness, injury or other condition) at \$10,367.93 higher per resident with worsening depressive symptoms than their peers.<sup>15</sup> With about 1200 residents at an average rate of 15.8% of those having increasing depressive symptoms, this adds up to \$1,953,318 additional costs to our institution alone.<sup>2</sup>

Another way of looking at this could be to look at costs of depression for absenteeism and presenteeism, which in the U.S. are estimated at \$5914 per person.<sup>16</sup> Based on our own assessments at the University of Michigan, at any given point, approximately 30% of students are being treated for new or worsening mental health concerns. This would cost roughly \$1,419,000 in productivity per year based on the 800 students at UMMS. Medical students are not generating revenue with their productivity, but they are rather consuming medical school resources (e.g., Student Services faculty and staff time, counseling, leave processing, financial aid adjustments, Competency Committee review and faculty time, and so on).

If our institution decided to completely cover GradCare, which has good mental health coverage, for all students this would cost approximately \$2.5 million annually. Currently students with GradCare only receive \$45/month supplementation, which amounts to about \$160,000 annually. This still would not solve the problem of a lack of mental health providers capable of accommodating the needs of our medical student community and additional access, privacy and stigma concerns.

While not a measurable outcome for this program proposal directly, preventing suicide is always a goal of treating mental disorders. Therefore, any justification for mental health spending must include some discussion of this goal and the cost of suicide. Suicide is one of our profession's



occupational hazards, and the only cause of death that is greater in U.S. physicians than in the general population.<sup>17</sup> It is estimated that between 300 and 400 physicians die by suicide each year in the U.S. Moreover, rates of suicide are disproportionately higher in female than male physicians (2.3 times and 1.4 times the rates in the general population, respectively).<sup>18</sup> In the general population, the rates of suicide are projected to increase through at least 2030.<sup>19</sup> Without action by our profession starting in medical school, there is no reason to believe they will not increase in physicians as well.

It is estimated that suicide and suicide attempts in the U.S. in 2013 cost \$93.5 billion, 97% of which was due to indirect costs from productivity losses (e.g., from premature death or lost time from injuries). While difficult to extrapolate to physicians, their productivity losses on average would be higher per suicide given the impact of their productivity for their patients. An example of the human capital required to respond to a suicide can be found within our UMMS community.

Following a suicide in the rising M2 class at Michigan Medicine, OMSE formed a Crisis Response Team that convened for 22 meetings (1-hour each) from 7/17 to 9/24/2020. If we estimate that each of these meetings cost \$640 conservatively, this will add up to \$14,080, not inclusive of the countless hours outside of these specific meetings to help the community heal and grow from this horrific event. If UMMS took a proactive, rather than reactive approach, and invested this amount of resources in each of the 800 students, this would cost the institution upwards of \$11,250,000 annually. This proposal is asking for less than 10% of this investment.

Further, we must address the cost to our reputation and brand. The University of Michigan brand is recognized to be one of the most valuable assets we possess, along with our people. It is widely recognized by patients and prospective students, residents, staff and faculty. Beyond the added cost of untreated mental health disorders in lack of productivity for medical students and rising residents themselves, long lasting implications of poor mental health include loss of recruitment, potential bad press, negative word-of-mouth, brand degradation, and negative climate contribution to burnout and decreased productivity of faculty and staff. This is not insignificant, noting our brand positioning to be “prestige for the public good”.

Our community has experienced an unfathomable loss. How we as a medical community choose to respond to this loss will reflect the character of our establishment and our true commitment to transform the mission of our institution. When asked how we responded to this tragic loss of life, the worst response we can give is that we reacted, but ultimately did not change anything. We have the opportunity to rise as national leaders in wellness and embody our declaration as the leaders and best, and we hope our work can start with your support of this proposal today.

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# Appendices

## Appendix A: Additional Figures from Internal Needs Assessment

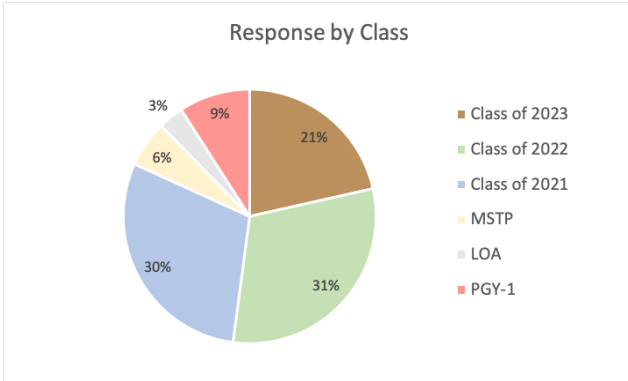


Figure A1. Distribution of responses by class year, collected from internal needs assessment in June 2020.

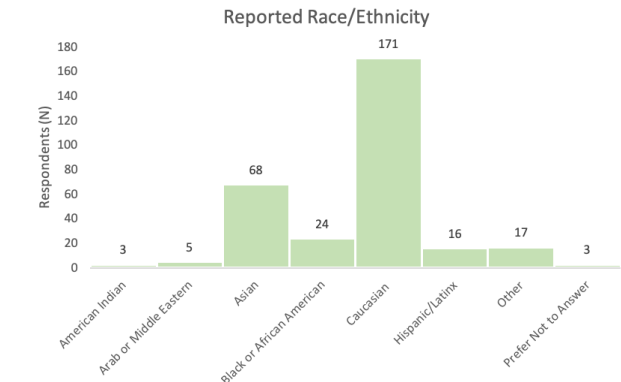


Figure A2. Distribution of race and ethnicity among responses collected from internal needs assessment, June 2020.

Response	N	%
I enjoy my work/schooling. I have no symptoms of burnout	21	6.8%
Occasionally, I am under stress and I don't always have as much energy as I once did, but I don't feel burned out	137	44.6%
I am definitely burning out and have one or more symptoms of burnout, such as physical and/or emotional exhaustion	110	35.8%
The symptoms of burnout that I'm experiencing won't go away. I think about frustrations at work/school a lot.	27	8.8%
I feel completely burned out. I am at the point where I may need some changes or may need to seek some sort of help.	11	3.6%
Answer not provided	1	0.3%



Response category	N	%
Not burned out	158	51.5%
Burned out	148	48.2%
Answer not provided	1	0.3%

Figure A3. Levels of burnout based on specific responses across all respondents. Respondents answer this single item question on a five-point scale. A response of  $\leq 2$  signifies no symptoms of burnout, while  $\geq 3$  equates to one or more symptoms of burnout. Overall, 148 students (48.2%) reported at least one symptom of burnout, with 158 (51.5%) stating they do not feel burned out.

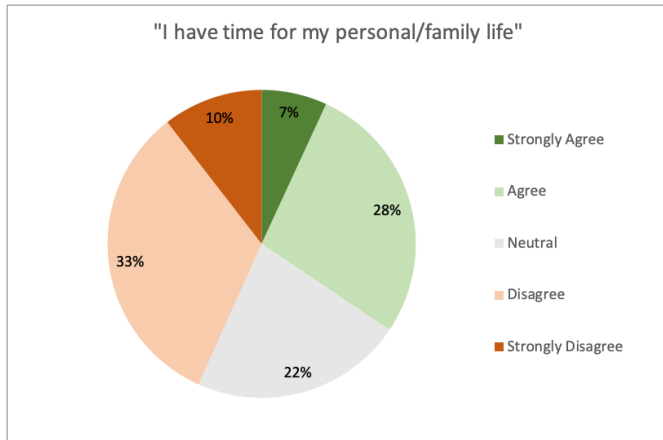


Figure A4. Students were asked to determine whether their work schedule leaves them enough time for personal/family life. Responses were on a five-point Likert scale from strongly disagree to strongly agree. More students disagreed with this statement (43% vs. 34.2% respectively).

	Medical Student Mental Health Program		Huron Valley Consultation Services		CAPS		PES		UHS		Peer Support Advocacy	
	N	%	N	%	N	%	N	%	N	%	N	%
I have heard of this service	183	59.6%	37	12.1%	267	87.0%	263	85.7%	234	76.2%	260	84.7%
I have heard of this but did not know mental health services were offered through it	16	5.2%	10	3.3%	5	1.6%	4	1.3%	55	17.9%	24	7.8%
I have not heard of this service	107	34.9%	257	83.7%	34	11.1%	38	12.4%	17	5.5%	22	7.2%
Did not respond	1	0.3%	3	1.0%	1	0.3%	2	0.7%	1	0.3%	1	0.3%

Figure A5. Student knowledge of mental health resources available for medical student use.

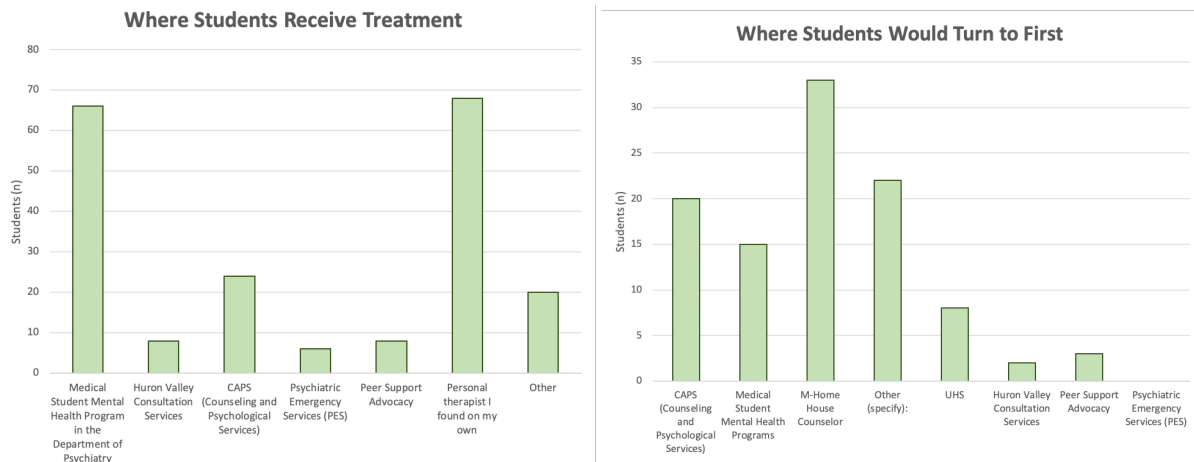


Figure A6. Students with self-reported mental health concerns who have received treatment responded to which services they have used, either currently or in the past (left). Students with no self-reported mental health concerns answered which service they would turn to first if necessary (right).

## Medical Student Mental Health Proposal

	Medical Student Mental Health Program		Huron Valley Consultation Services		CAPS		PES		Peer Support Advocacy		Personal therapist	
	N	%	N	%	N	%	N	%	N	%	N	%
Extremely satisfied	22	34.9%	2	33.3%	5	29.4%	1	25.0%	2	28.6%	35	55.6%
Somewhat satisfied	25	39.7%	2	33.3%	6	35.3%	0	0.0%	5	71.4%	21	33.3%
Neither satisfied nor dissatisfied	3	4.8%	1	16.7%	1	5.9%	1	25.0%	0	0.0%	3	4.8%
Somewhat unsatisfied	3	4.8%	0	0.0%	3	17.6%	0	0.0%	0	0.0%	1	1.6%
Extremely dissatisfied	8	12.7%	1	16.7%	2	11.8%	2	50.0%	0	0.0%	3	4.8%
Other (explanation)	2	3.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
<i>Total</i>	<i>63</i>		<i>6</i>		<i>17</i>		<i>4</i>		<i>7</i>		<i>63</i>	

Figure A7. Students who had previously accessed resources or were currently utilizing them were asked which programs they used and how satisfied they were with the outcome. Data regarding Huron Valley, CAPS, PES, and Peer Support were limited.

	Quality of service	Ease of scheduling appointments	Appointment flexibility	No negative career impact	Cost	Expedient appointment	No MiChart	Office location - Med school	Office location - Hospital
Extremely important	60.9%	60.6%	62.9%	77.2%	54.1%	45.9%	27.7%	14.7%	13.0%
Very important	31.6%	30.9%	27.7%	12.7%	25.4%	33.2%	21.5%	28.0%	25.1%
Of average importance	5.5%	6.8%	7.5%	4.9%	15.0%	16.6%	23.8%	36.2%	42.7%
Of little importance	0.7%	0.3%	0.7%	2.0%	3.6%	2.6%	12.7%	11.4%	9.4%
Not at all important	0.3%	0.3%	0.3%	2.3%	1.0%	0.7%	13.0%	8.8%	8.8%

Figure A8. Students were asked to expand on the personal level of importance of several aspects of mental health treatment. Responses are ordered in terms of frequency in which students answered “extremely important” or “very important” for each item, proceeding left to right in terms of importance.

## Appendix B: Testimonials

### Obstacles to Utilizing Resources

#### *Continuity of Care*

"I was able to meet with a psychiatrist rather quickly, but I was immediately referred to a community therapist and there was **no move toward creating a long-term treatment relationship...**"

"The quality of care...was excellent, but **there was no continuity** (I only saw the provider once)..."

#### *Insurance Issues*

"It **took a long time to make an appointment...**I know many med students who couldn't access psychiatrists due to insurance issues."

"...my **insurance did not cover the visit** so I was unable to see a psychiatrist. The administrator for the program was...not very responsive and hard to reach."

#### *Cost*

"The website lists that the first visit would be a free consultation—this is absolutely NOT true. **I was charged over \$250 for the visit** and was not provided with any diagnosis, talk therapy, or medication..."

"I absolutely loved the provider I saw...[but] I was stuck with an absolutely **enormous medical bill that no one warned me about...**"

"It would be great if psychiatric services were available to med students at little or no cost. When I saw Dr. Votta, even though I have insurance from a large national insurance agency, **I had to pay \$400 out of pocket**, making this service virtually inaccessible to me in the future. **I don't want to have to choose between a mental health crisis and financial crisis.**"

#### *Lack of Time*

"...the barriers to access this program have not been addressed and make it inaccessible...**we have no official scheduled time to take medical appointments...**the program only takes specific kinds of insurance..."

"**I feel like I'm constantly drowning in the scientific trunk curriculum**, and if you take a deferral on a quiz it just sets you back for the next quiz. I felt like I hardly had time to take care of myself and to reach out and get help. **I felt suicidal** which is why I ended up getting help but i should have gotten help long before then when the depressive symptoms started **but I didn't really have time to make an appointment because I was so overwhelmed with school**. I wish we also talked about physician suicide and depression for often and made it more normal to talk about it peers. I still am not sure if I should mention it to people that I'm depression/was suicidal for a while."

"It was satisfactory when i had time to go, but i **no longer can make it due to my clinical schedule**"

"I don't think the medical school thinks about how students can practically seek out and follow-up with the resources the school provides for them. **It is nearly impossible to make an appointment with a healthcare provider while in school because a lot of work/presence is required during weekday business hours** and not all of these services have appointments that work with our clinical schedules and/or not all of the people in charge of our clinical rotations are flexible or understanding in needing to

take time off for these things. There are maybe 2 psychiatrists who see medical students AND house officers, and this is not enough. House counselors, while appreciated, are not an adequate substitute for professional psychiatric care or therapy; and there is a significant conflict-of-interest in their role since they are employed by the medical school and are under the supervision of the deans/administration.”

“There needs to be more dedicated time recognizing the issue at hand, the school needs to place more emphasis on the importance of mental health and well being, and they need to provide us more time to prioritize this. **I do not feel supported by this school.**”

“Please, please offer the medical students in-house therapists in the way psychiatrists are offered through the Mental Health Program. Students are constantly directed to this resource and I myself have utilized this resource, but follow-up is not possible if you would like to pursue (or are recommended to pursue) non-pharmacologic treatments, such as therapy. Additionally, **students NEED protected time to take medical appointments**, especially in second year; a major component of most therapy options is regular appointments, and this is simply not possible with the current model of M2 year. **Just as SPOM created universal time away from clinic, it is possible and necessary to incorporate protected time for students in their work weeks.** Additionally, in the same way students are required an initial check-in with their house counselor M1 year, there should be an initial check-in with a trained mental health specialist; this way, students may not need to continue following-up with the specialist as the year progresses but they have direct access if needed and the stigma of seeking resources is highly reduced as it is required rather than on the student themselves. Medical professionals have some of the highest rates of anxiety, depression, and suicide in any field (so high in fact, we are taught about it as an essential component of the first year curriculum) and yet wellness initiatives are offered to students rather than evidence-based medical treatments, including sustainable access to these treatments. **Mental health cannot be substantially addressed in medical school unless it is integrated into the structure rather than offered as an adjunctive.**”

“My main issue is time and bandwidth. Unless the number of hours students are required to be in the hospital during normal business hours decreases I don't see there being much else that can be done to help. **If I had the time I probably would feel comfortable seeing someone, but if I don't have the time to see them consistently then I don't see the point in going through the work to establish with them in the first place.** It should almost be something that is built into the students' schedule. If every single student had one half-day per month that was required they took off for mental health reasons this would open up time for students to consistently see a mental health provider and/or do other mental health related things during this time. For example, you'd have to be excused every morning of the 5th of the month for mental health/wellness. This way it doesn't change each rotation and regardless of what you are on you get that time off.”

#### *Lack of Available Providers*

“**The list of therapists I was provided were all not taking new patients.** At the very least, if the UM mental health program provides a list, it should have up to date information.”

“The wait list to see a counselor/therapist through UHS is months. The service might as well not exist for most people, especially when they are experiencing a crisis—and in such cases, it is taken as a given that **seeking help through PES is tantamount to torpedoing your education and career.**”

#### *Resources are Confusing/Policies are Unclear*



"I think the med school can make its mental health services more well-advertised and accessible. I also think **the policy for student privacy/protection should be clearly explained**. I also think the med school should carve out time in the schedule for students to be able to schedule health appointments (both psychiatric and otherwise). Personally, I think all students should be given a mental health provider upon starting at any higher ed institution. That way it decreases both the stigma and effort associated with establishing psychiatric care. This also allows prophylactic mental health interventions."

"Give students basic information about their rotations (where/when to show up, etc.) >24h prior to starting, **tell the counselors not to tell students that they shouldn't seek mental health treatment**, stop recommending the Medical Student Mental Health program as the only option (a lot of insurance does not cover it)."

### *Stigma*

"I think it should be mandatory for all students to meet with someone within the first few months of M1 year. This would allow everyone to have a resource they are aware of and familiar with, outside of the school structure, that they can access if they need help. **It should not require a massive undertaking to figure out your insurance and understand which resources you can access or afford**. If someone is feeling overwhelmed by school or other things they will struggle to find the time to dedicate to interpreting these things."

"I think the biggest problem is that **there is a huge stigma around speaking to a therapist** or seeking help. There are plenty of support resources available to medical students once things are going poorly or once the medical student has identified their own need for mental health support. I think to reduce the stigma associated with seeking mental health support, Michigan should have a program where everybody has a mental health therapist provided to them at baseline for OPT-OUT sessions. **We have tons of opt-in mental health services, but again this just adds to the stigma of going to see a therapist - it means something is wrong when you decide to use these services**. As health professionals, we would never tell people to wait to take care of their physical health until something is seriously wrong. We advocate preventative care, health maintenance exams, working out and eating healthy regularly - all to prevent physical health decline. **We love proactive medicine for our physical bodies, but we as an institution only have reactive mental health services**. We should be trying to proactively support students by having semi-frequent check ins that are OPT-OUT instead of OPT-IN to reduce to stigma."

"Change everything. **Only one psychiatrist is available, takes Medicaid, and is not a person of color**. It was tough even getting connected to her with our schedules, and I had to try multiple times, which is tough for a medical student in any year. As her patient, **I have seen many other medical students coming in and out of her office, which is a stark violation of their privacy**. This is unacceptable. CAPS and Psych EM services are not valid options to offer students for mental health treatment and are disrespectful to list."

"I think access is there, but during clinical years, it took intentional effort on my part to go to therapy etc, and so **establishing a culture where that is the norm would be nice**. I also think if we are talking about wellness, autonomy is HUGE in that. Things like **knowing your schedule sooner than the night before you start a rotation would have done more for me than any of my therapy appointments** (and I love therapy)."

"There need to be more one-on-one "opt-out" mental health services. **The hardest part of seeking care for me has always been getting over the shame and difficulty of first reaching out when I need help**. In

the high-achieving atmosphere of medical school, this is even harder. I am lucky to have ended up at PES last year after trying to power through severe depression. If counseling and mental health evaluation in a safe setting were built into our schedules at least once or twice a year, it would make this initial step so much easier. In my experience, group mental health sessions in medical school have been ineffective in helping me whatsoever.”

### *Curricular/Institutional Barriers*

“don't have the same counselor for mental health and for academic things (house counselor), have separate counselors and encourage students to check in regularly, even require check-ins; make the mhome office a more welcoming place for students to come drop in and chat - have couches/counselors available in the front part for instance; the BIGGEST ISSUE in my opinion is the pace of the M1 curriculum. no amount of support is going to address those fundamental issues. UMMS needs to make changes to its curriculum. **There is no reason for students to be so stressed out the first year when there is so much free time in the branches**”

“I believe many of the current initiatives focus on equipping students with mental health tools, such as discussions around regular exercise and importance of sleep. However, I think this misses the mark because there is something fundamentally wrong with medical training when you look at the unacceptable rates of suicide and depression. **I had all of the tools at my disposal, many protective factors and tried my best to do "self care" regularly my M1 year and still became depressed and had suicidal ideation.** I think bigger topics such as workload, demand on schedule, rising cost of medical school paired with high interest rates and competitiveness within medical should be better addressed. I would **remove many of the busy work assignments we had M1 year** (i.e. IDP goals, speech class, 360 evaluation), reduce frequency of testing, and end flex testing as it is isolating. On clinical rotations, I would give us a set number of vacation days that we can choose when we take them (obviously with parameters like not stacking them all in one three week rotation).”

“UMMS needs to make it EASY for students to obtain mental healthcare. Right now, it requires making many calls during weekday business hours and trying to figure out costs with insurance. For example, **it took me 3 calls and 3 emails to book an appointment with Dr. Votta.** UM should have a team of psychiatrists specifically for medical students (almost like house counselors) that are available for long-term therapy, even weekly sessions if necessary. This service should absolutely be free of charge or included in tuition. **I am embarrassed that something like this is not already part of our culture at a medical school that has had so many issues with this in the recent and distant past.** Students often get the sense that admin is worried solely about the bottom line when they seek out university-based services and are charged ridiculous fees (or in my experience, are simply sent elsewhere for care). It's so important to make these resources easily accessible and affordable or free. **It's on admin to reduce all the hoops they've created for students to jump through in order to care for their own mental health!**”

“I'm tired of the wellness resources repeatedly thrown in our faces by administration to appease our need for mental health support. **Listing off mental health resources at the end of an email discussing the suicide of a classmate does very little to fix any real situation.** The issues in medical school creating mental health problems are incredibly large and complex and cannot easily be solved. **What the medical school can do to help is this: give medical students access to high quality, free, and readily available therapy.** We need to have a list of community therapists with experience in dealing with mental health problems faced by medical students, residents, and physicians. These therapists need to have late hours and weekend hours to accommodate our clinical schedules and immediate openings at all times. **These therapists can't be involved with Michigan Medicine** - having our mental health records in MiChart is

incredibly uncomfortable in an already vulnerable space. And these therapists must be paid for in some way by the medical school. Honestly, **this is the only way I would ever take the medical school seriously in their effort to fix the mental health issues that pervade our community** as evidenced by recent events.”

“I think our school needs to focus on its culture of emphasizing high academic achievement. I'm not saying it is not important for students to do well and work hard, but **there are underlying pressures from our school on having excellent grades, step scores and extensive extracurricular involvement that contributes to medical student stress and anxiety**. Learning medicine is stressful enough, but when the pressure of being the best is placed on students (whether this is meant or not) it makes this even harder. How do we encourage students to do their best without having to stress that maybe their best isn't good enough by our school's standards.”

“**Mental health services provided by psychiatrists we work with on rotations makes no sense...** ie Dr. Votta was my Psych attending.”

“**The structure of the curriculum is not conducive to wellness**. It is a hyper competitive environment with high achieving students who don't know where to look, whether it would affect us to seek help, etc. I don't know if curriculum change is a feasible change but I don't think it's currently set up to let its students be well.”

“In my opinion, the solution to wellness is not addition of things (ie more resources, more activities, more snacks etc). It's the opposite- things need to be removed. There is so much unnecessary material and activities in both the pre clinical and clinical curriculum that could just be eliminated which would do wonders for wellness. **Wellness means time away from working, so we need to look to cut things out and not add more**, even if they are in the name of student well-being.”

“Get at the source of the problem and redesign the curriculum to provide more personal time for students to recharge and invest in their well-being. For example, cut out the useless required sessions, provide longer school breaks etc especially with our condensed curriculum. For clinical rotations, reduce the required number of hours, give more weekends off, and give all students their holiday breaks and make sure to communicate this with residents/faculty because otherwise it won't make a difference. **The thought that a medical student needs to work the same hours as a paid provider and is expected to spend a significant amount of time studying when they get home after a long shift is dangerous;** students will have plenty of time in residency to get used to the demands of their field.”

## Appendix C: Sample M-Check Email

Dear \_\_\_\_\_,

Welcome to the University of Michigan Medical School.

You are among the first group of MS1s invited to sign up for your M-Check. You have been preliminarily assigned a time slot for this M-Check but you are able to reschedule this if it is not convenient for you\*\*\* These M-Checks will be occurring from \*\*\*.

### What are M-Checks?

M-Checks are opt-out mental health check-ins that occur throughout your medical school career and consist of mental health screenings followed by a visit with a clinical psychologist. The survey results and appointments are housed under the Medical Student Mental Health (MSMH) Program, which is part of the Michigan Medicine Office of Counseling and Workplace Resilience. This program was developed out of a student-run effort to revamp the MSMH program and provide better wellness programming.

### Why M-Checks?

Medical school is an exciting journey but one that also comes with many challenges and stressors. This challenging environment leads to the reality that many medical students will experience depression, anxiety, and burnout at some point in their medical school career. Students may also have a difficult time seeking out the help they need, especially given the stigma that still exists around mental health in medicine. Michigan Medicine is committed to making mental health a priority within our community and ensures that students get the support they deserve. One of the first steps we have taken is to incorporate regular mental health checks throughout your time as a medical student. We hope these M-Checks will provide a resource to access any help you may need throughout your time at Michigan Medicine.

### What to expect

You will be provided with a link to complete an online screening survey 1-2 weeks prior to your scheduled appointment. This survey will take approximately 20 minutes to complete. You will be given protected time in your schedule to complete this prior to your appointment. Your results will be visible to yourself and the MSMH therapist you have been paired with. You will meet with your therapist for approximately 15 minutes. You will review your screening results together, and discuss any concerns that you may have. It is appropriate to talk about things like stress, social anxiety, issues with your partner, family concerns, health problems, sexuality, doubts about your career path, or frustration with the school or particular persons.

This session is meant to help you, not the therapist or school. Being as honest as you can will allow you to get the most benefit as possible. You will be directed to resources and will be given the opportunity to make a follow up appointment.

The appointment will be 15 minutes in duration. Please sign on to the virtual platform or arrive at the office 5 minutes early.

Directions for logging on: \_\_\_\_\_ Directions to the office: \_\_\_\_\_

How to reschedule

Switching date/time:

Switching to virtual visit:

Privacy

The M-Checks are not operated through the Office of Medical Student Education (OMSE) and will have no bearing on your academic record. All information you provide in your visit will be kept completely confidential, and will be documented in the OCWR. Following mental health professionals across the field, this confidentiality may only be broken with your explicit permission or when there is an imminent risk of harm to self or others. You are not required to disclose these visits or other mental health care you seek as a result of these visits to any future residency programs or state licensing boards.

If for any reason you do not wish to participate in this M-Check, please contact \_\_\_\_\_. If you have already met with a MSMH therapist or a private therapist since starting medical school, you do not need to attend your M-Check, and can inform the office in order to cancel your appointment.

Thank you and we look forward to meeting with you!