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RESEARCH

Well-being Content Inclusion in Pharmacy Education Across the United States and Canada

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Objective. To describe the landscape of well-being content inclusion across schools and colleges of pharmacy in the United States and Canada through identification of content implementation, incorporation, and assessment.

Methods. A cross-sectional survey was distributed to all accredited schools and colleges of pharmacy in the United States (n=143) and Canada (n=10). Survey questions included curricular and cocurricular timing, frequency, assessment strategies, and support for well-being initiatives, using a framework of eight dimensions (pillars) of wellness to categorize content.

Results. Descriptive data analyses were applied to 99 completed surveys (65%), 89 (62%) in the United States and 10 (100%) in Canada. Well-being content was most prevalent within the cocurricular realm and incorporated into didactic and elective more than experiential curricula. The most content came from intellectual, emotional, and physical pillars, and the least content came from financial, spiritual, and

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environmental pillars. Less than 50% of schools and colleges of pharmacy include well-being within their strategic plans or core values. Funding is primarily at the level of the university (59%) or the school or college of pharmacy (59%). Almost half of respondents reported inclusion of some assessment, with a need for more training, expertise, and standardization.

Conclusion. Survey results revealed a wide range of implementation and assessment of well-being programs across the United States and Canada. These results provide a reference point for the state of well-being programs that can serve as a call to action and research across the Academy.

Keywords: pharmacy education, well-being, health, wellness, curricular inclusion

INTRODUCTION

Well-being is defined as an optimal and dynamic state allowing people to achieve their full potential, while *wellness* is the quality or state of being in good health.[1,2] Health care professionals face significant well-being challenges, and these difficulties begin among health care professional trainees.[3-6] Facets of well-being, specifically emotional health, lend to greater self-efficacy in accomplishing academic goals.[7-10] Existing literature outlines approaches such as stress reduction education used by schools and colleges of pharmacy to improve well-being within their curricula and health care settings.[11,12]

In 2019, several pharmacy organizations convened to develop strategic actionable recommendations to improve well-being within the profession as outlined in the Enhancing Well-Being and Resiliency Among the Pharmacist Workforce: A National Consensus Conference.[13] Eleven out of 50 recommendations specifically related to academia. As a result, in 2020, the American Association of Colleges of Pharmacy (AACP) Well-Being and Resiliency Community (WBRC) was formed to promote well-being education, initiatives, and assessment within pharmacy academia.

Despite dedicated conversations on a national level for a systems approach to well-being, there is a paucity of literature regarding the current state of well-being efforts within schools and colleges of pharmacy.[14] The objective of this study was to describe well-being content, implementation, and assessment across all schools and colleges of pharmacy in the United States and Canada.

METHODS

The WBRC convened a workgroup with participants from the United States and Canada to develop a survey intended to gather data regarding current well-being efforts. The workgroup divided into subgroups for each of 10 potential survey sections, and formulated questions. The well-being and wellness framework used in the survey was adapted from the Substance Abuse and Mental Health Services Administration's eight pillars of wellness as the most inclusive way to categorize well-being content.[15] Pillar definitions and examples were included as an appendix to provide clarity to survey participants based on expert opinion, experience, and extant literature.

The survey was delivered with the following companion documents: the appendix of well-being pillar definitions and examples and a Word document of the survey to allow respondents the opportunity to identify and gather the necessary information before survey completion.

Given the large scope of the project, the survey was divided into three subsurveys: curriculum overview, experiential education, and faculty development. The surveys and companion documents were tested for face and content validity by examining readability, ease, navigation, and clarity by seven WBRC members prior to dissemination.

Only the curriculum overview subsurvey is described in this manuscript. This survey contained the following six sections: demographics (12 items); faculty/staff involvement and resources (four items, regarding personnel, dedicated faculty/staff, and advanced credentials); program resources (four items, regarding institutional support for self-care well-being programs, funding sources, inclusion in strategic plan/core values); curricular and cocurricular content (19 items, regarding overall program inclusion [two items], specific topic inclusion by pillar [eight items], place, timing, and delivery methods for each pillar [eight items], and certificate training [one item]); assessment strategies (two items, including tool, frequency, and type); and well-being support and potential barriers (one table, 15 items, answered on a five-point Likert scale of "strongly disagree" to "strongly agree" including the option to answer "unable to rate").

The three subsurveys were distributed via email to well-being representatives, identified from AACP resources and self-identification from the AACP WBRC, at 143 US and 10 Canadian pharmacy schools and colleges (153 total) with a link to the survey in Qualtrics (Qualtrics International Inc). The survey was deemed exempt by the Concordia University Wisconsin Institutional Review Board and the Research Ethics Board at the University of Alberta. Data collection began in December 2020, with monthly reminders to nonresponders through April 2021.

All statistical analyses were conducted using SPSS Statistics version 27 (IBM Corp). Data from Canadian

institutions, (all four-year programs), were analyzed with data for the US four-year programs. Descriptive analyses were used to summarize data for categorical and continuous variables. Student *t* test or chi-square test was used to analyze continuous and categorical data, respectively. A Fisher exact test was used to compare US and Canadian data with categorical variables. For all tests of significance, a two-tailed alpha value was set at .05.

RESULTS

A total of 99 completed surveys were analyzed out of 153 invited programs (response rate 65%) after removing five duplicates. Of these, 89 (62%) were from the United States and 10 (100%) from Canada. There were no significant differences between US and Canadian schools and colleges of pharmacy. Most participating US institutions (96%) and all Canadian schools and colleges of pharmacy were accredited. Most schools and colleges of pharmacy (58%) were older than 25 years and on a single campus (77%). Over half of participating institutions were public (58% US and 100% Canadian institutions), 42% private, and 1% public or private historically black colleges and universities. Most of the responding schools had four-year programs (80%) and a Doctor of Pharmacy (PharmD) class size between 51-150 students. Prior to the COVID-19 pandemic, 90% of programs offered all in-person curricular delivery. During the COVID-19 pandemic, most (80%) programs moved to a hybrid remote and in-person delivery, with 60% delivering remote teaching synchronously. Well-being activities were included in less than half of the strategic plans and core values of universities (30%) and schools and colleges of pharmacy (41%) and in less than a quarter of department goals (24%). Institution descriptors are available in Table 1.

Nearly all respondents indicated their schools had some form of cocurricular initiatives related to well-being. When asked to indicate all possible initiatives, 95% of respondents reported student-driven initiatives, 81% included staff-directed initiatives, and 66% reported using on-demand/asynchronous workshops. About 42% of respondents indicated that cocurricular initiatives occurred at least two to four times/year.

Although the inclusion of well-being activities within the pharmacy curricula varied, the majority (90%) reported well-being content offered through the university at-large. Within schools and colleges of pharmacy, content was most frequently integrated within electives (>50%) for three- and four-year programs. Common didactic areas for well-being content included required courses, standalone courses, longitudinal course series, and integration across multiple courses. Focused experiential training (from the curricular overview survey) was the area with the least inclusion. See Figure 1 for a breakdown by three-year, four-year, and six-year program data. Three-year programs reported more well-being content in electives and longitudinal course series than within required didactics. Six-year programs reported the least curricular incorporation, with zero inclusion within integrated courses, longitudinal course series, focused experiential training, or interprofessional educational activities. Within four-year programs, the largest cohort, students' first professional year (P1) included well-being content in didactic courses and focused interprofessional educational activities (∼35%). The P2 and P3 years offered the most elective well-being content (∼48%).

Most schools and colleges of pharmacy indicated they did not offer any well-being certificate training programs. When offered, the most common program was Mental Health First Aid training (31%), followed by Question-Persuade-Refer (QPR) Gatekeeper Training for Suicide Prevention (21%), The Jed Foundation training (8%), and state/provincial boards of pharmacy training programs (7%).[16,17] Most were delivered via cocurricular experiences (33%) and elective courses (20%). Four-year programs had a higher number of certificate trainings offered, mostly (42%) in P3.

Based on the total number of specific topics offered, averages across curricula for all pillars are represented from highest to lowest in Table 2. The didactic and elective curricula included the same top pillars with slight variations in rank: intellectual, emotional, physical, occupational, and social. The least represented in any area of the curricula were financial, spiritual, and environmental (<20%). The top well-being topics within each pillar covered by >60% respondents included self-awareness (75%), self-care (68%), critical reflection (67%), diversity and inclusion of minority students (63%), and stress management (63%). See Appendix 1 for specific percentages across each topic. Canadian schools had a significantly lower financial inclusion, with no need to cover student loan payback planning. Experiential well-being content was limited overall, with intellectual (17%) being the most covered pillar (Figure 2). In the four-year programs (n=79), well-being content was included in 7% of introductory pharmacy practice experiences (IPPEs) and 18% of advanced pharmacy practice experiences (APPEs). In three-year programs (n=10), three schools reported APPE inclusion and two within IPPEs. No six-year programs (n=10) reported well-being in experiential training.

Approximately 50% of surveyed programs reported using tools to assess well-being. Of those, 17% completed these assessments once overall, 37% annually, 34% several times throughout the program, and 12% twice annually. Eighty one percent of programs completed assessments in the didactic years versus 19% in the

Table 1. Demographics, Personnel Engagement, and Funding Sources of Responding Schools

	All S/COP (N=99), No. (%)	Public US programs (n=47), No. (%)	Private US programs (n=42), No. (%)	Canadian programs[a] (n=10), No. (%)
Program length				
3 years	10 (10)	1 (2)	9 (21)	0 (0)
4 years	79 (80)	42 (89)	27 (64)	10 (100)
6 years	10 (10)	4 (9)	6 (14)	0 (0)
Annual student enrollment				
<50	11 (11)	3 (6)	7 (17)	1 (10)
51-100	44 (44)	18 (38)	23 (55)	3 (30)
101-150	31 (31)	21 (45)	8 (20)	2 (20)
>151	12 (12)	4 (9)	4 (10)	4 (40)
Age of school				
≤5 years	5 (5)	2 (4)	3 (7)	0 (0)
6-10 years	18 (18)	5 (11)	13 (31)	0 (0)
11-25 years	19 (19)	4 (8)	13 (31)	2 (20)
>25 years	57 (58)	36 (77)	13 (31)	8 (80)
Campus design (single campus)	76 (77)	30 (64)	37 (88)	9 (90)
Faith-based	20 (20)	0 (0)	20 (48)	0 (0)
Personnel engagement				
Dedicated person for oversight of student WB initiatives	36 (37)	19 (40)	13 (31)	4 (40)
Dedicated student WB committee/working group	37 (37)	19 (40)	15 (36)	3 (30)
Staff/faculty with formal credentials related to student WB	76 (77)	36 (77)	33 (79)	7 (70)
Funding source for WB activities				
University resources	58 (59)	27 (57)	23 (55)	8 (80)
School/college resources	58 (59)	26 (55)	25 (60)	7 (70)
Student fees	28 (28)	16 (34)	7 (17)	5 (50)

Abbreviations: S/COP=schools and colleges of pharmacy; WB=well-being.
[a] All Canadian programs are public.

experiential year. Among these schools and colleges of pharmacy, the most assessed topics were perceived stress (n=57) and overall well-being (n=50). Schools and colleges of pharmacy reported using the following validated assessments: Maslach Burnout Inventory, My Well-Being Index, DISC assessment, StrengthsFinder, Perceived Stress Scale (PSS), Duckworth Grit Scale, and AACP Graduating Student Survey. Other respondents reported using internally developed tools to assess a variety of well-being topics (eg, overall well-being, perceived stress, coping strategies, mindfulness, and intellectual wellness).

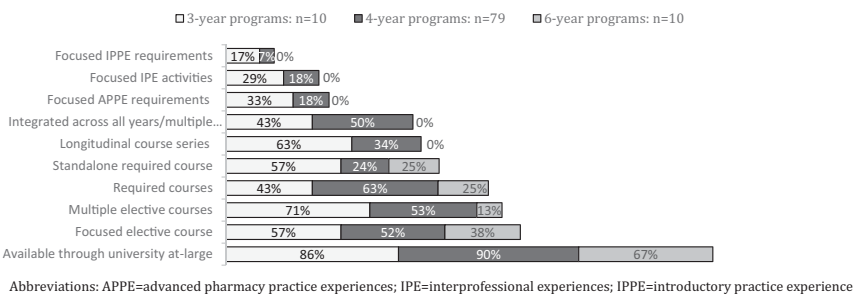

Figure 1. Curricular Inclusion of Well-being Content by Program.

Table 2. Specific Well-being Topic Frequency of Inclusion by Pillar

Pillar	Overall frequency, average[a] %	Reported topic inclusion		
		Covered at >40% of institutions	Covered at 20%-39% of institutions	Covered at <20% of institutions
Intellectual	34	Self-awareness; critical reflection; mindfulness; mindset	Core values; meditation; grit; gratitude neuroscience and wellness	Memory-enhancing games; internal narrative; breathing
Emotional	32	Self-care; stress management; emotional intelligence; personality inventory	Self-compassion; kindness; coping; imposter syndrome identification of purpose	Perfectionism
Physical	30	Exercise/physical activity; sleep hygiene; nutrition/dietary; meditation	Preventative medicine; yoga	Aromatherapy; biofeedback; heart math; medication safety
Occupational	28	Resiliency; burnout prevention; balance	Project management; procrastination	Personal safety; essentialism; bullying; second victim training; assisting students in distress
Social	26	D&I minority students; building community connection; D&I LGBTQA+ students	Community support groups; D&I Indigenous students; D&I first-generation students	Unplugging and meaningful conversations
Financial	19	Dealing with student loans; budgeting	Managing money; developing financial goals saving money; retirement planning	Investing
Spiritual	19		Acts of service; incorporation into patient care courses; meditation; exploration of values/beliefs; gatherings and services	Traditions, prayers; personal practices; fasting
Environmental	12		Community improvement; recycling	Organizing space; making positive environmental impact; decluttering; eco-conscious living; energy conservation

Abbreviations: D&I=diversity and inclusion; LGBTQA+=lesbian, gay, bisexual, transgender, queer (or questioning), asexual (or allied), plus (others).

[a] Average calculated from total coverage within didactic, elective, experiential, and cocurricular.

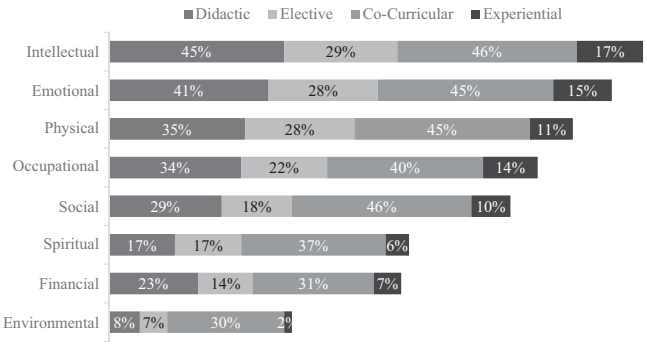

Figure 2. Curricular Inclusion of Pillars: What is Covered and Where.

Regarding resources, 37% of respondents reported having a dedicated person or committee/working group to oversee all student well-being initiatives. (Table 1) The dedicated person varied between administrators, faculty, and staff. Committees and groups included faculty (92%), staff (82%), and students (77%), and they met monthly (49%) or as needed (36%). Over half (58%) reported personnel participating in well-being initiatives out of goodwill, volunteering, or self-directed efforts. Although 78% of schools and colleges of pharmacy reported having personnel with credentials related to well-being (eg, wellness certified, Mental Health First Aid, lifestyle medicine), approximately one-third of respondents indicated that their dedicated well-being person did not have specific well-being credentials. Credentials held by committee members included mental/behavioral health (48%), yoga instructor (21%), and board certification in psychiatric pharmacy (BCPP) (38%).

Most (74%) institutions provided support or counseling programs separate from health coverage policies or employee assistance programs. Nearly all programs (93%) offered institution-level counseling programs for students, where a large majority (>80%) offered well-being education and exercise programs (access to gyms, vouchers for decreased gym membership fees), and over half (56%) offered time-out options (eg, quiet spaces, walking trails). For faculty and staff, the top three well-being programs offered at the institution level were education programs about wellness/maintaining well-being (77%), exercise programs (74%), and counseling programs (63%). Other notable offerings included time-out options (50%), health programs such as annual physician evaluations (47%), and hydration programs (40%).

University (59%) and schools and colleges of pharmacy (59%) resources were the most common primary funding sources for well-being activities, along with student fees (28%). Numbers were similar between public and private institutions. Grant funding from internal (3%) and external (5%) sources was reported as available yet not used and could be viable opportunities for future consideration.

Based on a five-point Likert scale, 71% of respondents strongly agreed or agreed that their institution has an overall culture of well-being, including role models to help others learn (69%) and/or a dedicated champion to lead initiatives (52%) (Table 3). In addition, 47% reported widespread interest among faculty, with 56% having access to training in general and 54% reporting access to experts for training. Although 73% strongly agreed or agreed that they have leadership support, only 61% had central administration support from the university at-large, and less than half (45%) reported faculty/staff involvement being recognized as service to the college.

Some barriers to well-being did arise. Over half of surveyed programs (58%) did not have adequate space or curricular time; 39% did not have trained personnel to teach these initiatives nor a defined leadership team to help direct these initiatives (32%) or collaborative student interest (32.9%). Financial support for wellness initiatives was reported by only 27% of respondents (indicating strongly agree or agree), while another 41% strongly disagreed or disagreed to having this support.

DISCUSSION

Approaches to prioritization, implementation, and assessment of well-being initiatives vary across schools and colleges of pharmacy in the United States and Canada. There is a need to address barriers to providing quality well-being initiatives consistently across didactic, experiential, and cocurriculums. In addition, well-being initiatives need to be enhanced and assessed at both the university level and the school/college of pharmacy level. The findings of our study confirm results of a study by Folz and colleagues, which reported prevalence of wellness programs at US schools and colleges of pharmacy.[18] Both surveys included a similar and representative sampling of private and public institutions with consistency in class size among schools and colleges of pharmacy (50-100 students). Our study had a higher response rate overall (32% vs 65%).

Folz and colleagues used six dimensions of wellness (environmental and financial were not assessed), while our study specified eight.[19] Similar to our study, Folz found high inclusions of the intellectual, emotional, physical, and social pillars, whereas the spiritual pillar was less incorporated.[19] The intellectual domain topics included observable and measurable behaviors such as self-awareness, self-reflection, mindfulness, mindset, and meditation. Similarly, the emotional pillar included measurable variables such as self-care, stress management, emotional intelligence, and personality

inventory. Occupational wellness was ranked higher in our results, possibly reflecting the shift of focus to workload and burnout during the COVID-19 pandemic. In addition, social activities received increased attention potentially due to health disparities emphasized by the number of growing social movements and awareness. The evolution of social change makes it timely for pharmacy education to continue to expand diversity and inclusion of minority and LGBTQ+ (lesbian, gay, bisexual, transgender, queer [or questioning], asexual [or allied], plus [others]) students and build community connections. Both occupational and social activities have been included within organizational strategies to reduce burnout.[20] Both surveys found most well-being content being taught/applied in the cocurriculum, while experiential training had the least amount of well-being content. Limited well-being content offerings in experiential training highlights the need for more attention and development in programs, as the stress levels encountered by students in experiential learning environments are similarly encountered in residency training, with results showing higher depression, hostility, and dysphoria observed in residents.[21-23] Both areas could serve as a starting point for programs to consider.

Assessment of well-being pillars and topics were variable across schools and colleges of pharmacy with a lack of standardization. Most reporting programs completed assessments multiple times throughout student academic progression, though only one-half reported using specific well-being assessments. Challenges exist regarding well-being assessments including time, survey fatigue, perception of lesser importance than curricular therapeutic/science topics, and cost to program of accessing and administering multiple validated tools. While there is the caveat that components of well-being need time and practice to identify measurable change, assessment is needed to determine the success of programs, and all stakeholders including faculty, staff, and students should be included. A balanced, intentional approach is best suited for assessment of well-being topics, which aligns with recommendations from the Accreditation Council for Pharmacy Education and the National Academy of Medicine.[13,14]

In addition, the National Academy of Medicine recommends a systems approach to professional well-being, specifically enacting change in health professional learning environments to mitigate burnout, enhance well-being, and reduce stigma.[14] In order to enact meaningful change, there needs to be programmatic support from an organizational level. Data suggest that organizational priorities and programmatic changes positively impact student mental health and wellness.[23-25] Our study indicated that less than half of universities, schools and colleges of pharmacy, and departments include well-being activities as part of their strategic plans and/or core values. When well-being is prioritized as an organizational commitment, opportunities to address personnel, time, and financial resource allocation become more feasible.[26]

To enact a systems approach to well-being, large-scale organization and programmatic-level changes appear necessary. Additionally, the limited number of dedicated personnel for well-being programs compels faculty and staff to participate out of goodwill. To prioritize well-being, schools and colleges of pharmacy could consider reevaluating workload and promotion criteria to encourage faculty to enact well-being initiatives. The large presence of university-level well-being programs could be helpful in alleviating some of the abovementioned barriers, namely related to personnel, time, and funding at the schools and colleges of pharmacy. Finally, there are gaps in optimal assessment and improvement of well-being programs. Useful practices for assessing well-being programs could be identified to support schools and colleges of pharmacy to make informed decisions regarding the quality and quantity of well-being initiatives to ensure strategic goals are met.

These study results need to be viewed considering known limitations of survey research. First, the length of this survey, including the breadth and depth, may have led to survey fatigue and a risk of inadequate reporting across all areas of the curriculum. Second, survey data were collected during the early COVID-19 pandemic, which may not reflect changes made later in response to the pandemic. Finally, there may have been over or underreporting of well-being content by respondents due to social desirability bias or limited access or knowledge of current initiatives. As a point of clarification, this manuscript reported experiential data gathered from the curricular overview survey. More data will be forthcoming from the separate experiential subsurvey.

With a better understanding of the current state of well-being programs, there are opportunities to further expand, refine, and evaluate well-being initiatives across the Academy. These results note that the majority of participating schools and colleges of pharmacy have some well-being initiatives, yet there is still much to be done in creating inclusive learning environments that positively impact the well-being of future pharmacy trainees. Additionally, differences in well-being implementation based on program length can be further delineated.

The results of this survey can serve as a baseline of well-being initiatives and motivation to enhance well-being programs across the country. These findings can help well-being advocates and leaders self-assess current initiatives, model inventories, content coverage, and types of assessments in comparison with other programs. For some, this means first-time implementation or significant overhaul. For others, the results may affirm what they are already doing. Schools and colleges of pharmacy need to

Table 3. Responses to the Survey Questionnaire on Culture of Well-being Support and Barriers at US and Canadian Schools/Colleges of Pharmacy[a]

Survey questionnaire statement[b]	Strongly agree, %	Agree, %	Neutral, %	Disagree, %	Strongly disagree, %	Mean (SD)[c]
Our program has leadership support[d]	36.5	37.6	18.8	3.5	1.2	4.1 (0.9)
Our program has central administration support from the university at-large[e]	24.4	37.2	20.9	4.7	5.8	3.9 (1.2)
Our school/college has an overall culture of WB support[e]	22.1	48	15.1	10.5	3.5	3.8 (1.0)
The faculty and staff have access to training regarding WB[d]	21.2	34.1	20.0	18.8	3.5	3.6 (1.2)
Our program has access to experts who help train our faculty and staff on WB initiatives[d]	21.2	32.9	15.3	22.4	5.9	3.5 (1.3)
Faculty/staff involvement in mental health and WB committee work is recognized as service to the college[d]	21.2	24.7	23.5	20.0	4.7	3.6 (1.3)
Our program has role models to help others learn WB[e]	20.9	48.8	16.3	10.5	1.2	3.9 (1.0)
Our program has a dedicated champion to lead initiatives[e]	16.3	36.0	22.1	17.4	4.7	3.5 (1.2)
Our program has a defined leadership team to help direct these initiatives[e]	12.9	20.0	23.5	31.8	8.2	3.1 (1.3)
Our program has trained personnel to teach these initiatives[f]	10.7	17.9	29.8	32.1	6.0	3 (1.2)
There is widespread interest amongst faculty[d]	7.1	38.8	28.2	17.6	4.7	3.4 (1.1)
Our program has good financial support for these initiatives[e]	5.8	20.9	27.9	30.2	10.5	3 (1.2)
Our program has collaborative student interest[d]	3.5	29.4	44.7	12.9	9.4	4.1 (1.0)
There is adequate space/time in our curriculum[d]	2.4	17.6	21.2	47.1	10.6	2.6 (1.0)
Religious views are a source of conflict regarding choices/inclusion for wellness programs[d]	0	2.4	14.1	34.1	36.5	2.3 (1.6)

Abbreviations: WB=well-being.

[a] Participants responded to questionnaire items using the following five-point Likert scale: 5=strongly agree, 4=agree, 3=neutral, 2=disagree, 1=strongly disagree.

[b] Responses do not add up to 100% as some respondents unable to rate.

[c] Higher mean values indicate greater level of agreement.

[d] Responses from 85 programs.

[e] Responses from 86 programs.

[f] Responses from 84 programs.

prioritize well-being initiatives in their strategic plans and allocate resources (eg, funds, personnel, and time) to enhance implementation and assessment. Other considerations may include new faculty and/or staff hires and workload redistribution.

Additionally, this report serves as a call to action for the Academy. Recent inclusion of well-being initiatives within the 2021-2024 AACP strategic priorities (Strategic Priority #4: Achieving Well-being for All) is a step in the right direction.[27] Continued emphasis and providing faculty and staff with training and resources are necessary to enable schools and colleges of pharmacy to achieve these priorities. There are also opportunities to learn from other health care profession academies that report successful well-being outcomes as they continue to emerge.[11,12,25]

Lastly, this study opens the door for future research and collaboration. There is a paucity of literature regarding the results of the various well-being assessments being done across schools and colleges of pharmacy that can stimulate quality improvement of current initiatives. We can partner together to identify well-being best practices and determine strategies to overcome barriers.

CONCLUSION

This large-scale assessment of well-being programs in schools and colleges of pharmacy provides a broad overview of well-being initiative implementation across the United States and Canada; however, barriers to implementation and assessment have been identified. Influential factors to consider that can promote well-being among our learners include infrastructure resources, frequency and depth of well-being content coverage, measures of assessment, and sustainability. This survey provides a reference for the state of well-being programs that can be monitored over time. These results also represent a call to action for increased awareness, support, and research across the Academy to generate more knowledge, resource exchange, and consistency amongst schools and colleges around this issue.

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Appendix 1. Inclusion of Well-being Content by Pillars and Topic[a]

Pillars 1-4	Topic	Frequency of inclusion (%)
Intellectual	Self-awareness	75
	Critical Reflection	67
	Mindfulness	57
	Mindset	45
	Core Values	39
	Medication	39
	Grit	33
	Gratitude	30
	Neuroscience and Wellness	29
	Memory-Enhancing Games	9
	None	3
	Other: Internal Narrative, Breathing	2
Emotional	Self-care	68
	Stress Management	63
	Emotional Intelligence	60
	Personality Inventory	49
	Self-compassion	35
	Kindness	35
	Coping	35
	Imposter Syndrome	33
	Identification of Purpose	22
	Perfectionism	19
	None	3
Occupational	Resiliency	60
	Burnout Prevention	57
	Balance	46
	Project Management	33
	Procrastination	29
	Personal Safety	18
	Essentialism	7
	Bullying	6
	None	6
	Second Victim Training	2
	Other: Assisting Students in Distress	1
Physical	Exercise/Physical Activity	56
	Sleep Hygiene	54
	Nutrition/Dietary	47
	Meditation	45
	Preventative Medicine	31
	Yoga	30
	Aromatherapy	10
	None	7
	Biofeedback	5
	Heart Math	5
	Other: Med Safety	4

(*Continued*)

Appendix 1. (*Continued*)

Pillars 1-4	Topic	Frequency of inclusion (%)
Social	D&I of Minority Students	63
	Building Community Connection	60
	D&I of LGBTQ+ Students	54
	Support Groups in the Community	37
	D&I of Indigenous Students	36
	D&I of First-Generation College Students	33
	None	5
	Other: Unplugging and Meaningful Conversations	1
Spiritual	Acts of Service	35
	Incorporation into Patient Care	30
	Meditation	29
	Exploration of Values/Beliefs	27
	Gatherings/Services	20
	Traditions	18
	Prayer	17
	Personal Practices	14
	None	8
	Fasting	5
Financial	Dealing with Student Loans	60
	Budgeting	40
	Managing Money	39
	Developing Financial Goals	39
	Saving Money	24
	Retirement Planning	21
	Investment Strategies	17
	None	14
	Other: Unsure	1
Environmental	Community Improvement	30
	Recycling	21
	None	21
	Organizing Space	10
	Making Positive Environmental Impact	7
	Decreasing Clutter	6
	Eco-conscious Living	6
	Energy Conservation	4
	Other	1

Abbreviations: D&I=Diversity and Inclusion; LGBTQ+=lesbian, gay, bisexual, transgender, queer (or questioning), plus (others).
[a] Data from 99 programs.