Improving Provider Retention through Addressing Burnout at a Federally Qualified Health Center: A Quality Improvement Initiative

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Improving Provider Retention through Addressing Burnout at a Federally Qualified Health Center: A Quality Improvement Initiative

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Abstract

**Background:** Primary care providers employed by federally qualified health centers (FQHC) working with underserved populations experience high levels of burnout as patients are often medically complex, face healthcare disparities and societal stigmas. The aim of the project was to alleviate burnout and improve provider retention through introduction of organizational support measures. Participants involved were healthcare providers, as well as nurse management and senior leadership.

**Methods:** The quality improvement approach for this project utilized the Plan-Do-Study-Act (PDSA) cycle and a driver diagram to guide the selected interventions. Interventions were based on categories from Mayo’s Clinic’s Nine Organizational Strategies to Promote Engagement and Reduce Burnout. This project concentrated on three primary areas: leadership, workflow and administration, and collaboration. To gauge effectiveness of the interventions, a modified version of the Mini Z survey was administered to providers before the implementation of the interventions to establish baseline burnout within the organization. The same modified Mini Z survey was redistributed post-intervention featuring additional questions to assess the impact of the implemented strategies. Data focusing on the top three departure reasons were collected from providers who left the organization within the last two and a half years to identify recurring themes and patterns for a comprehensive understanding of factors influencing provider turnover.

**Results:** There was a notable reduction in job related stress as from 69% pre-intervention to 60% post-intervention. A significant improvement was identified in the time spent at home on the electronic medical record (EMR) from 93% of providers reporting an excessive or moderately high amount of time pre-intervention to 60% post-intervention. The likelihood of provider departure within the next two years remained consistent pre- and post-intervention at 33%.
Commonly cited reasons for departure were deficiencies in communication from leadership, systemic challenges, and broader organizational issues.

**Conclusions:** The project did not directly result in improved provider retention or reduced burnout however, it provided a platform to analyze organizational shortcomings and initiate actions in these critical areas. This project serves as an initial step for organizations to explore more comprehensive strategies and implement measures aimed at enhancing provider satisfaction and well-being with the ultimate goal of retaining valuable providers.

*Keywords:* Burnout, Quality Improvement, Healthcare Providers, Retention, Engagement
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Improving Provider Retention through Addressing Burnout at a Federally Qualified Health Center:  
A Quality Improvement Initiative

Primary care providers (PCPs) experience high levels of burnout as the demands of the healthcare system in the United States are rapidly increasing. Since primary care is the entry point for all individuals to receive care, this places immense pressure on PCPs as the demand grows and workforce shortages are on the rise. Burnout is often caused by a significant workload and expanding expectations which leads to high stress, poor work-life balance, and job dissatisfaction. The World Health Organization (2019) defines burnout as,

“a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one’s job or feelings of negativity or cynicism related to one’s job; and reduced professional efficacy.”

Approximately one in five primary care providers would like to leave healthcare or reduce their hours as a result of burnout (Olson et al., 2019).

Most healthcare in the United States is provided by primary care practices (Abraham et al., 2020). In 2021, the Health Resources and Services Administration (HRSA) reported that federally qualified health centers (FQHCs) provided care to approximately 30 million people across the United States (Health Resources & Services Administration, 2022). Health care facilities providing care to underserved populations tend to have shortages of staff due to perceived social complexity of patients, disparities in healthcare, and societal misconceptions. FQHCs often provide care to diverse clientele with additional needs that can be mentally and emotionally straining on nurses, medical assistants, and providers.
Many healthcare organizations tend to target the individual with a focus on promoting resiliency and mindfulness rather than organizational improvements such as workload adjustments, cultivating teamwork and involvement in organizational decision making (DeChant et al., 2019). Mayo Clinic reported that most healthcare systems view burnout as an individual’s responsibility and tend to choose interventions that focus on stress management and/or mindfulness and resilience which do not account for systemic issues causing the symptoms of burnout providers are experiencing (Shanafelt & Noseworthy, 2017). The American Medical Association has commented that organizational interventions may be less frequently conducted due to concerns with cost and complexities associated with these changes (Smith, 2017). It is time for this to change as burnout is correlated with a need for systemic organizational change; workplace environments with a focus on teamwork, inclusion, and adaptive practices revealed a higher level of engagement, lower rates of turnover and burnout among providers (Hung & Chen, 2017). It is imperative that healthcare providers feel valued and can care for their patients without imposing a burden on their own well-being.

**Problem Description**

Provider (doctor of medicine [MD]/doctor of osteopathic medicine [DO], physician assistant [PA], advanced practice registered nurse [APRN] or nurse practitioner [NP]) burnout and subsequent provider turnover in primary care is a prevalent issue caused by limited financial compensation, lack of organizational support, and better career opportunities. Approximately 60% of primary care providers in the United States report burnout, which is higher than most other specialties (Willard-Grace et al., 2019). Rates of provider turnover in primary care are significantly higher in underserved populations and community health centers (Willard-Grace et al., 2019). Specifically providers at FQHCs experience a burnout rate approximately 11% higher
than providers at independent practices (Nelson, 2021). Provider turnover has negative effects on patient outcomes due to disruptions to continuity of care, lack of rapport with a regular PCP, and increased use of emergent care/specialty services. Provider burnout at Greater Seacoast Community Health (GSCH), a FQHC in the seacoast area of New Hampshire, needs to be addressed to improve job satisfaction, employee engagement, and retention.

A preliminary survey, conducted in summer 2023 was distributed to providers at GSCH to assess baseline rates of satisfaction and burnout (Figure 1). Approximately 82% (n=15) of providers responded to the pre-intervention survey. Forty percent of the respondents experienced symptoms of burnout and 69% of providers experienced a great deal of stress directly related to their job. It was also revealed that 80% had poor or marginal control over their workload and 93% spend excessive amounts of time using the electronic medical record system. The last question in the survey addressed the intent to leave the organization within the next two years; 33% responded ‘yes’, 27% responded ‘maybe,’ and 40% responded ‘no.’ Common themes were found in providers’ concerns including scheduling inadequacies (wrong provider, inappropriate time for appointment), limited control over schedule, patient complexity, staffing shortage, and information technology (IT) issues.
Figure 1

Modified Mini Z Burnout Survey Results (summer 2023)

44% of providers are satisfied with their current job

69% experience a great deal of stress due to their current job

93% experience poor/marginal control over their workload

33% feel their values are aligned with leadership

73% feel their care team works well together

40% of providers experience burnout

33% of providers plan on leaving within the next two years

Adapted from (Institute for Professional Worklife, 2020)
To address employee concerns GSCH implemented a program called Restoring Resilience on Location© in 2022 (Appendix A) which consisted of individual counseling or coaching sessions, acupuncture, auriculotherapy, and additional resources in monthly all staff meetings. The current survey asked providers their thoughts on the Restoring Resilience on Location© program with about half the providers not utilizing the resources, some felt that it did not align with their work schedule, or they did not have time to participate, and others felt it was of limited benefit and did not address systemic concerns leading to burnout. Although only 40% of the providers are feeling symptoms of burnout at this time the subsequent responses demonstrate that this number will increase without intervention due to systemic concerns.

Available Knowledge

Provider turnover in any healthcare setting is costly and has negative impacts on quality of patient care and job satisfaction rates. When there are high rates of turnover, additional workplace demands are placed on the remaining providers and they are not often compensated for these additional responsibilities leading to burnout (Willard-Grace et al., 2019). FQHCs often face high rates of turnover because providers are working in a challenging position with limited workplace supports. Organizational culture is a vital component of a provider’s wellbeing at the workplace and is considered to be responsible for approximately 50% of their success (Hall et al., 2010). Healthcare providers are incentivized through value-based programs like Merit-based Incentive Payment System (MIPS) authorized through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (CMS, 2021), but these incentives do not account for their quality of life or give them enough of an incentive to stay in their position.

Bodenheimer and Sinsky (2014) published an expert level opinion piece discussing shifting from the Institute for Healthcare Improvements (IHI) Triple Aim Approach to a
quadruple aim approach that encompasses care of the provider while also suggesting evidence-based improvement strategies to implement these interventions. Their research recognized that primary care practices are unable to achieve the IHI Triple Aim Approach to improving healthcare quality as it lacks an aim to successfully support the provider (Bodenheimer & Sinsky, 2014). A national survey found 87% of physicians felt the number one cause of burnout was related to paperwork and administration causing increased stress (Bodenheimer and Sinsky, 2014). Their expertise suggests implementation of team structure, standardization of workflow, and improved training to decrease burnout, as well as address gaps regarding patient expectations and the capacity of primary care. It is estimated approximately 4.25 FTE staff per physician is necessary for a well-functioning patient-centered medical home (Bodenheimer & Sinsky, 2014). Support from medical assistants, nursing, and clinical support staff is necessary for providers to be successful in their role as one individual does not have the capacity to provide comprehensive care, as well as additional resources for their patients. This piece emphasizes how crucial it is for organizations to be caring for providers when pushing for improved quality improvement (QI) benchmarks.

Organizational leadership needs to be at the forefront of addressing burnout and provider retention efforts as organizations must acknowledge this as a problem within the system. Mayo Clinic recognized burnout as a systems issue and developed nine strategies that target the various factors that contribute to burnout (Figure 2). These nine strategies include, 1. acknowledge and assess the problem, 2. harness the power of leadership, 3. develop and implement targeted work unit interventions, 4. cultivate community at work, 5. use rewards and incentives wisely, 6. align values and strengthen culture, 7. promote flexibility and work-life integration, 8. provide
resources to promote resilience and self-care, and 9. facilitate and fund organizational science (Shanafelt & Noseworthy, 2017).

**Figure 2**

*Key drivers of burnout and engagement in physicians.*

(Shanafelt & Noseworthy, 2017, p. 131)

Implementation of these nine strategies has proven to shift physicians from burnout to engagement at Mayo Clinic. Engagement is defined as, “the positive antithesis of burnout and is characterized by vigor, dedication, and absorption in work” (Shanafelt & Noseworthy, 2017, p. 131). Shanafelt and Noseworthy (2017) also found the same factors influence both burnout and engagement. The factors they identified included workload and job demands, efficiency and resources, meaning in work, culture and values, control and flexibility, social support and community at work, and work-life integration. Each of these categories are influenced by individual, workplace, organizational, and national factors (Shanafelt & Noseworthy, 2017). The implementation of these factors has been effective at the Mayo Clinic where physicians experience burnout at a rate of two-thirds less than the national average (Shanafelt &
Noseworthy, 2017). The use of these interventions while thought to be “cost prohibitive,” are inexpensive and provide significant benefit (Shanafelt & Noseworthy, 2017).

Workplace supports and team-based care are organization-based interventions that may significantly reduce provider burnout. PCPs working in team-based care environments noted improved team efficiency and indicated this as a protective factor against burnout (Hall et al., 2010). Team-based care is defined as two or more health care professionals working together to care for patients (Dai et al., 2020). This collaborative method shifts the workload leaving more time for the provider to focus on medical decision making and leads to an improvement in job satisfaction (Song et al., 2017). Willard-Grace et al. (2014) conducted a cross-sectional survey design study to examine the relationship between team structure, culture, and emotional exhaustion of PCPs. The survey sampled 231 primary care providers (50% physicians, 37% resident physicians, and 13% NPs/PAs) in primary care clinics with approximately 83% of these providers working part time. Job dissatisfaction was correlated with job related stress and only 9% of providers who reported burnout were also satisfied with their job (Willard-Grace et al., 2014). Providers working with the same group of staff regularly reported stronger team culture and less exhaustion (p < 0.001) (Willard-Grace et al., 2014).

FQHCs must provide patients with comprehensive services including primary care, dental, mental health support, and social work services. Providers typically are the link between these services and the patient. Olayiwola et al. (2018) conducted a cross sectional survey that evaluated the relationship between clinic capacity to address patient’s social needs and PCP burnout within three health systems; a total of 359 PCPs (physicians, nurse practitioners, physician assistants) completed the Maslach Burnout Inventory (MBI). Results of the MBI indicated 23% of PCPs met the criteria for low professional efficacy, 51.2% for high exhaustion,
and 40.1% for high cynicism (Olayiwola et al., 2018). It was identified that PCP’s who perceived their clinic having both capacity and resources to support patients’ social needs have less burnout and reported higher levels of professional efficacy (p < 0.01), lower exhaustion (p < 0.05), and cynicism (p < 0.05) (Olayiwola et al., 2018).

Working in primary care was identified as the number one predictor of burnout in a systematic review of 21 studies (Abraham et al., 2020). Workplace setting, i.e., hospital owned and FQHCs had higher rates of burnout compared to privately owned practices. Heavy workloads, which was defined as PCPs with larger than recommended panel sizes, caused an increase in work-related stress that was associated with higher levels of burnout and increased PCP turnover (Abraham et al., 2020). A patient panel for a full time primary care physician is approximately 2,500 patients (Harrington, 2022). The Journal of the American Board of Family Medicine estimates that for a provider to care for this many patients they would have to work an estimated 21.7 hours per day to provide appropriate care (Harrington, 2022). Rates of burnout were similar between physicians (25.1%) and NPs/PAs (22.6%) (Abraham et al., 2020). Strong organizational culture, consistent teams (p < 0.001), and incorporation of behavioral health services were predictors of lower levels of burnout (Abraham et al., 2020). If a provider feels they can accomplish their job, then they are more likely to stay in their position.

Another point of consideration is promoting provider collaboration. Shields, Jennings, and Honaker (2020) conducted a prospective study over three years of 1476 providers across 250 healthcare settings that evaluated a multidisciplinary approach to decreasing provider burnout and improving provider well-being in a metropolitan community. This was accomplished through implementation of a well-being task force that focused on provider engagement and growth, workflow and office efficiencies, relationship building, and communication. Since
implementation of the well-being task force provider turnover decreased by 30% from 2017-2019 (Shields et al., 2020).

The research clearly identifies burnout as a systemic issue rather than an individual problem correlated with resiliency. Addressing organizational factors leading to burnout is thought to be an effective strategy to improve job satisfaction and in turn retention rates. In summary, the factors causing burnout are modifiable and often influenced by the organization.

**Rationale**

Mayo Clinic has extensively studied burnout among healthcare providers and clinicians employed by their organization. The providers and clinicians experienced burnout at two-thirds the national rate as a result of the organization recognizing burnout as a systems issue and implementation of nine organizational strategies dedicated to alleviating burnout (Shanafelt & Noseworthy, 2017). The nine strategies focus on the drivers of burnout: workload and job demand, efficiency, and resources, meaning in work, culture and values, control and flexibility, social support and community at work, and work-life integration. These domains combat burnout on a multilevel approach. Mayo Clinic notes that these interventions can be cost-effective and recognizes the impact that the investment can make (Shanafelt & Noseworthy, 2017).

This methodology is in line with the Organizational Support Theory which highlights how employees’ perception of the organization and how they feel their organization values their personal well-being and their professional performance (Kurtessis et al., 2017). Kurtessis et al. (2017) discuss that in organizations with greater rates of perceived organizational support it is more likely that employees feel valued, are more committed to their organization and its goals, and well-being is improved.
The Institute for Healthcare Improvement identifies strategies for successful quality improvement interventions. This project utilized a driver diagram (Figure 3) and the Plan-Do-Study-Act (PDSA) cycle (Figure 4). The driver diagram used the aim as a basis to identify driving factors, secondary factors, and potential interventions. This will be used as a map while the PDSA cycle will take the interventions into action. The PDSA cycle provides the groundwork for enacting intervention, reviewing the results, modification based on data, and resuming the cycle for continued success (Institute for Healthcare Improvement, 2017).

**Specific Aims**

The global aim of this project is to reduce burnout while improving provider retention through implementation of organizational supports. More specifically this project identified baseline burnout in the organization through reviewing results of a modified Mini-Z Burnout survey. The results of the survey guided interventions focusing on different areas within Mayo Clinic’s Nine Strategies for Reducing Provider Burnout. The three areas this project focused on are leadership, workflow and administration, and collaboration (Table 1). The purpose was to reduce the likelihood of providers desiring to leave their current role in the next two years.
Table 1

*Responses from Pre-Intervention Mini Z Burnout Scale.*

<table>
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<tr>
<th>Question</th>
<th>Responses</th>
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<tr>
<td>Overall satisfaction with job</td>
<td>Agree: 44% Disagree: 31%</td>
</tr>
<tr>
<td>Great deal of stress due to job (agree, strongly agree)</td>
<td>69%</td>
</tr>
<tr>
<td>Symptoms of burnout (definitely, won’t go away, completely)</td>
<td>40%</td>
</tr>
<tr>
<td>Control over workload (poor, marginal)</td>
<td>80%</td>
</tr>
<tr>
<td>Time for documentation (poor, marginal)</td>
<td>93%</td>
</tr>
<tr>
<td>Work atmosphere description (busy, hectic/chaotic)</td>
<td>60%</td>
</tr>
<tr>
<td>Professional values alignment with leadership</td>
<td>Agree: 33% Neither agree nor disagree: 40% Disagree: 27%</td>
</tr>
<tr>
<td>Degree that care team works efficiently together (satisfactory, good, optimal)</td>
<td>73%</td>
</tr>
<tr>
<td>Amount of time spent on EMR at home (moderately high, excessive)</td>
<td>93%</td>
</tr>
<tr>
<td>Plan to leave within the next two years</td>
<td>Yes: 33% Maybe: 27% No: 40%</td>
</tr>
</tbody>
</table>

Leadership was chosen because 27% of providers did not feel that their professional values were well aligned with those of leadership and 40% neither agreed nor disagreed. In the open-ended questions of the preliminary survey, providers expressed a desire for leadership to be more transparent, allow for provider input in daily organizational operations, listen to provider
concerns and follow up using closed-loop communication, address staffing concerns, and accountability. Mayo Clinic emphasizes the importance of executive leadership involvement and sustained interest in its success with promoting provider engagement and reducing burnout. Steps one and two of Mayo Clinic’s Nine Organizational Strategies include acknowledgement and assessment of the problem, as well as “harnessing the power of leadership” (Shanafelt & Noseworthy, 2017, p. 135). Without involvement of senior leadership, it would not be possible to make organizational changes.

Workflow was an area many respondents cited as an area of concern. Approximately 80% of providers reported poor or marginal control over their workload, 60% reported a busy or hectic/chaotic work environment, and 93% reported spending a moderately high or excessive amount of time working on the EMR at home. All the above listed concerns can be improved through workflow changes. GSCH implemented a new EMR in July of 2022 which was a great opportunity to improve current workflows and create a more efficient workflow with upgraded technology. Initially, implementation of a new EMR can worsen burnout, but EMR improvements were found to have a positive impact overall (DeChant et al., 2019).

Collaboration has been identified as having an impact on burnout. The results of the Mini-Z opinions surrounding leadership and common themes pointed towards opportunities for improvement. Providers need to be allowed time to work with leadership and their care team to make changes within the organization. Seventy-three percent of providers felt their team worked efficiently together already so the focus was placed on optimizing this and building a relationship between providers and leadership. Collaboration needs to take place for changes to occur, to identify workflow issues, and to promote discussion within the organization.
Methods

Context

GSCH is a network of community health centers providing comprehensive care to over 20,000 patients on the Seacoast of New Hampshire and surrounding areas. The network includes Families First Health & Support Center in Portsmouth and Goodwin Community Health in Somersworth. Strafford County Public Health Network and SOS Recovery Community Organization also are affiliated with GSCH. Services are inclusive and provided regardless of ability to pay, recovery-friendly, LGBTQ-affirming, and trauma informed. On average NPs and PAs see 14 to 18 patients a day and physicians (MD/DO) see 18 to 22. The patient population is mostly low-income individuals with complex medical and social variables. Many providers also see patients struggling with substance abuse disorders. Often patients are unable to get the resources and care they need as they are faced with many social and financial barriers. It can be taxing on providers as they are dedicated to getting their patients the care they need despite socioeconomic and systemic barriers. Providers go above and beyond to ensure their patients’ needs are met. Being a primary care provider is a stressful job as PCPs are the hub for all the care a patient receives. It becomes even more challenging when the patients require a high level of multidisciplinary support. This contributes to burnout as well as organizational structure that is lacking in stable processes and protocols.

The project team consisted of the Doctor of Nursing Practice (DNP) student as team lead, the site medical director at Families First who was the practice mentor, chief operating officer (COO) of GSCH, and the DNP faculty partner at the University of New Hampshire. The nurse manager, nurse in charge of the medical assistants (MAs), and providers at Families First were also involved in interventions for site specific changes. The COO was the main liaison for communications between providers and senior leadership. The COO met with the team lead,
facilitated communications to other members of senior leadership, and provided data regarding costs of turnover and past interventions. At Families First, a weekly meeting was instated. The nurse manager assisted the team lead with coordinating weekly meetings and kept minutes. The nurse lead was on the organization’s workflow committee and communicated proposed changes at the meetings. The nurse responsible for the MAs was able to communicate updated workflow processes (refills, standardization of nurse visits, etc.) to the MAs and nursing staff. The physician involved came to weekly EMR meetings to assist with workflow changes. She also helped communicate these changes with other providers who were not in office on days when the meeting was held.

**Cost Benefit Analysis**

In 2022, GSCH spent $51,038.70 on a resiliency program, Restoring Resilience on Location®, for all staff employed in January 2022 and lasted through December 2022. The focus of the program was on physical and emotional professional wellness. The program included individual counseling sessions, acupuncture, auriculotherapy, and other resources provided in monthly all staff meetings. The program was offered to all employees of GSCH and was overall deemed a success. The final report from the developing company stated that utilization of the program increased throughout the contract period and participants were grateful GSCH offered the program and they felt heard within the individual counseling sessions. Participants experienced symptoms of stress, anxiety, difficulty sleeping, fatigue, tension in upper back/neck, and difficulties with focus and concentration. Some of these symptoms improved with acupuncture and auriculotherapy. The preliminary survey showed about half of the providers did not utilize these resources as it did not align with their work schedule or they did not have time
to participate, and others felt it was of limited benefit and did not address systemic concerns leading to burnout.

Restoring Resilience on Location provided GSCH with recommendations based on the results of the Attitudes Related to Trauma-Informed Care (ARTIC) survey and aggregate data from the program; the recommendations were individual employee support, inter/intra-departmental communication and support, and organizational culture and leadership. The report stated that the work done by GSCH staff has, “high potential for traumatization” and there is need to provide support to staff (Kolgin & Tracy, n.d.). It was recommended for GSCH to continue to promote self-care, offer resources for self-care, and ongoing access to individual supports for “post COVID recovery” and staffing shortages (Kolgin & Tracy, n.d.). For inter/intra-departmental communications and support it was stated that during the contract period there was a high demand for departmental meetings for conflict resolution and a common theme identified was an “organizational culture of indirect communication” (Kolgin & Tracy, n.d.). Dr. Kolgin and Dr. Tracy (n.d.) recommended GSCH hire a consultant to address communications, team building, and culture. The final recommendation was to focus on organizational culture and leadership. Throughout the contract period the following themes were recognized; high stress levels with a noted barrier of insurance deductibles hindering staff from connecting with counselor, ‘toxic positivity’ when staff express problem to leadership feeling that they were dismissed or comparing organization to other places, and a multi-directional lack of connection between leadership and staff (Kolgin & Tracy, n.d.). Recommendations placed a focus on promoting employee engagement, addressing employee concerns with active listening and acknowledgment, encourage a culture of well-being, and training/education for senior leadership.
Although Restoring Resilience on Location was considered an overall success for those who utilized the program it did not seem to reach providers and there is more work to be done.

The organization was unable to provide data regarding the cost of provider turnover including cost of recruitment, onboarding, and other associated expenses. This information is not readily available or tracked regularly. A Human Resources (HR) report from August 2023 showed a total turnover rate of 33.8% with a retention rate of 66.2% of all GSCH staff from 7/1/2022 to 6/30/23. During this time there were two open provider positions within GSCH. The organization is planning to hire a recruitment firm to hire a new provider which was recently quoted at the cost of $45,000. The COO did share the organization has spent approximately $20,000 within the year on recruitment of a new graduate physician. The national estimated cost of NP/PA turnover ranges from $85,832 to $114,919 per provider (Hartsell et al., 2020). The COO is working with HR to develop a process to track these costs.

The cost of athenaOne is variable year to year as it based on three percent of annual net patient revenue. In 2022 net patient revenue was approximately $22.1 million. If annual net patient revenue is about the same in 2023 the EMR would cost approximately $663,000 for the year.

Interventions

A modified version of the Mini Z Burnout (Appendix B) survey was distributed to providers via UNH Qualtrics Survey Tool at both Goodwin Community Health and Families First. The survey was administered in June 2023 offering preliminary data that was used for the improvement project which took place from June 2023 to October 2023. The post surveys (Appendix C and Appendix D) were administered in October 2023 after interventions took place.
A driver diagram (Figure 3) was created based on survey responses to identify factors causing burnout within both facilities. This diagram aims to reconnect providers with the mission, vision, and values while honoring their quality of life and passion behind the practice.

The mission of GSCH is,

“To deliver innovation, compassionate, integrated health services and support that are accessible to all in our community, regardless of ability to pay.” (GSCH, 2021). The vision is, “To provide everyone in our community an opportunity to live a long and healthy life.” All which are carried out with the values, “Integrity, Respect, Compassion, Excellence, Collaboration.” (GSCH, 2021).

**Figure 3**

*Reducing Provider Burnout Driver Diagram*
The proposed interventions were based on three categories: leadership, administration/workflow, and collaboration. Leadership focused on identifying behaviors of leaders that contribute to and alleviate burnout. For workflow/administration the organization implemented a new EMR in July of 2023. Collaboration intended to promote provider engagement through implementation of a weekly workflow meeting at Families First.

**Intervention 1: Leadership**

Mayo Clinic identified leadership as an integral part of reducing burnout in organizations (Shanafelt & Noseworthy, 2017). There was limited communication between medical providers and leadership at GSCH. The first step was building a bridge to communicate with leadership on a regular basis utilizing a “closed loop” communication style as this ensures awareness of changes, accountability, and follow through.

**Intervention 2: Workflow and Administration**

The EMR was outdated, and workflow was not conducive to productivity or a reasonable workload. GSCH was using athenaFlow. This was updated to athenaOne on July 18, 2023. The EMR greatly impacts a provider’s workflow and amount of time spent working outside of office hours. AthenaOne offers more integrated workflow processes to reduce amount of manual entry, time searching for orders (i.e., referrals, imaging, pharmacies, etc.), and less burden on support staff, MAAs, and nurses, to improve the likelihood that they can assist providers more throughout the day. AthenaOne is web-based which means improved overall speed of the system and less chance for system downtime. The previous EMR was slow as it needed to connect to a virtual desktop leading to frequent interruptions in workflow.
**Intervention 3: Collaboration**

GSCH already conducted monthly provider meetings for providers at both sites to discuss current issues and changes. Both sites, Goodwin and Families First, provide the same services, but workflow varies from one site to the other as Families First has significantly less staff. A site-specific provider meeting at Families First was implemented to promote provider collaboration and increase provider involvement in organizational operations.

For additional insight into retention, the team lead asked all providers who had left the organization over the last two and a half years their top three reasons for leaving the organization. This information is vital for senior leadership as it identifies areas in need of improvement to ameliorate provider retention efforts.

**Study of the Interventions**

The ‘Plan, Do, Study, Act’ (PDSA) model (Figure 4) from IHI was used to guide interventions selected for this QI proposal. IHI defines the PDSA cycle by, “developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act)” (IHI, 2021). This is applicable to the proposed interventions because job satisfaction and burnout levels are only testable through redesigning interventions to ensure effectiveness. No change is the perfect solution the first time it is tried, and it is possible to improve these enacted changes through feedback and reinvention.
Figure 4

*Plan-Do-Study-Act (PDSA) Cycle*

(How to Improve | IHI - Institute for Healthcare Improvement, n.d.)

The ‘Plan’ stage consisted of a pre-intervention study completed by GSCH providers to establish baseline burnout. Survey results were reviewed with the COO, Chief Medical Officer (CMO), and practice mentor to recognize areas for improvement within the organization. Three focus areas were chosen based on results and focuses identified based on Mayo Clinic’s Nine Organization Strategies. The three areas are as follows: leadership, workflow and administration, and collaboration. A driver diagram (Figure 2) was created to show common themes for improvement opportunities. Prior to proceeding with proposed interventions this was reviewed and approved by the UNH Department of Nursing Quality Review Committee.

During the ‘Do’ stage weekly site-specific meetings at Families First were conducted to promote collaboration and improve workflow during implementation of the new EMR. These
meetings also fostered an environment for providers to suggest ideas to senior leadership to meet provider needs.

The ‘Study’ stage focused on comparing and pre- and post-intervention survey results, as well as preparing a data packet for leadership to promote ongoing changes and interventions.

Lastly, in the ‘Act’ stage, results were reviewed with senior leadership and providers. The project lead joined the Continuous Quality Improvement (CQI) Committee and became an EMR superuser to aid in ongoing improvement efforts within GSCH.

Measures

A modified version of the Mini Z Burnout survey was distributed to providers via UNH Qualtrics Survey Tool at Goodwin Community Health and Families First both pre- and post-intervention. Responses were anonymous to maintain provider confidence and privacy. The Institute for Professional Worklife states on their website that the Mini Z survey is allowed to be utilized for research and educational functionalities (Institute for Professional Worklife, 2020).

The Mini Z survey was chosen as it measures factors associated with burnout and is externally validated against the Maslach Burnout Inventory which is widely used to measure burnout in healthcare workers (Linzer et al., 2020). The Mini Z survey was adapted from the Physician Work Life Study and the Minimizing Error, Maximizing Outcome (MEMO) Study by Dr. Mark Linzer (Institute for Professional Worklife, 2020). The Mini Z has been assessed for reliability and validity through Dr. Linzer’s studies at the Hennepin County Medical Center. The ten items assessed in questions 1-10 had a Cronbach’s alpha of 0.8 and a correlational factor analysis (predictor variables and burnout) determined a p < 0.001 which means the findings are statistically significant (Linzer et al., 2016).
The first ten questions of the Mini Z survey evaluate job satisfaction, stress, work environment (chaos, teamwork), value alignment with leadership, and EMR (proficiency, time associated with documentation, and time spent at home) (Institute for Professional Worklife, 2020). Additional questions were added regarding leadership, EMR, scheduled versus actual hours worked per week, and if the provider planned on leaving the organization within the next two years. Demographics, role, and years of experience were not included in data analysis as risk factors associated with burnout. The American Board of Family Medicine (ABFM) report that recent studies show high rates of burnout in family physicians and that female physicians have a higher likelihood of reporting burnout compared to male physicians (American Board of Family Medicine, 2023). ABFM (2023) also reported that females make up 55% of residents in family medicine so it is difficult to identify if females are experiencing burnout at higher rates or if it is that there is a higher concentration of females overall. There is not a significant amount of data regarding reasons why female physicians experience higher rates of burnout and ABFM has developed the Sustaining Women in Medicine (SWIM) project to explore factors associated with burnout and interventions to alleviate burnout in female family physicians (American Board of Family Medicine, 2023).

**Pre-Intervention Survey**

The same modified Mini Z Burnout survey (Appendix B) was distributed to providers at both Goodwin and Families First. The survey was distributed via UNH Qualtrics Survey Tool in June 2023. Risk factors of burnout (stress, control over workload, work environment), values alignment with leadership, EMR (proficiency/time spent at home), and teamwork were measured using a 5-point Likert scale using strongly agree (5) to strongly disagree (1), poor (1) to optimal (5), and excessive (1) to minimal/none (5). Additional questions regarding leadership and prior
organizational efforts to reduce burnout were added to explore if provider opinions identified common themes. A section for comments was added for providers to express any additional thoughts or suggestions to account for variables that may not have been captured within the structured survey questions.

**Post-Intervention Survey**

The post-intervention modified Mini Z Burnout survey (Appendix C and D) was distributed to providers at both Goodwin and Families First through UNH Qualtrics Survey Tool in October 2023. Each site had a different survey link as the only intervention at Goodwin was the rollout of athenaOne. Families First implemented a weekly site-specific meeting that focused on adaptations to the EMR, workflows, and policies. The first 13 questions were the same as the pre-intervention survey, as well as the question regarding a monthly meeting with senior leadership. The Families First providers were also asked what workflow changes were most effective.

**Provider Departure Reasons**

Provider departure reasons were collected by reaching out to providers who had left the organization or submitted their resignation over the last two and a half years. To protect provider privacy, responses were anonymized and examined for recurring patterns and common themes.

**Analysis**

Quantitative and qualitative data were analyzed using descriptive statistics to show effectiveness of the interventions. Statistical analysis could not be performed due to the low sample size of participants. Pre- and post-intervention surveys were compared to analyze developments, improvements, and changes after implementation of the study. Answers from open-ended questions were utilized to draw common themes among providers.
Ethical Considerations

Approval from the Institutional Review Board for the Protection of Human Subjects in Research (IRB) was not necessary for this QI proposal as no protected health information or patients were involved in the gathering or reporting of data. There are no conflicts of interest to report. Anonymity was kept with survey responses and reporting of results. Data were reported in aggregate.

Results

A total of 22 GSCH providers were asked to participate in the pre-intervention Modified Mini Z Survey. Approximately 18 providers responded but only 15 of these responses were complete. Between the pre- and post-intervention surveys three providers left the organization and four providers put in their three months’ notice for departure. Three new providers were hired during the intervention period but were not asked to participate in the survey as this may have impacted results. The remaining 19 GSCH providers were asked to participate in the post-intervention Mini Z Survey. Only ten providers participated and of those responses nine were complete. A timeline of the project is shown in Figure 5 below.
Figure 5

Project Timeline

Demographics

Providers (MD/DO, NP, PA) at GSCH participated in the pre- and post-intervention surveys. Residents and providers who had been at the organization for less than six months were not included in the QI project. Full time equivalent (FTE) ranged from per-diem to full time and years of experience spanned from one to over 20 years. Approximately 64.3% of participants were physicians (MD/DO), 28.6% NPs, and 7.1% PAs. Providers are predominantly female (78.6%) and 21.4% male. Table 2 details participant demographics pre- and post-intervention.
Table 2

Demographic Information

<table>
<thead>
<tr>
<th>Role</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician (MD/DO)</td>
<td>9 (64.3)</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Nurse (NP)</td>
<td>4 (28.6)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Physician Associate (PA)</td>
<td>1 (7.1)</td>
<td>1 (11.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 years</td>
<td>4 (28.6)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>4-5 years</td>
<td>3 (21.4)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>5-10 years</td>
<td>2 (14.3)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>11-15 years</td>
<td>2 (14.3)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>16-20 years</td>
<td>0 (0)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>20+ years</td>
<td>2 (14.3)</td>
<td>1 (11.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>11 (78.6)</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>Male</td>
<td>3 (21.4)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Non-binary</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Undisclosed</td>
<td>1 (7.1)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

*Note. pre-intervention N= 15 (100%), post-intervention N=9 (100%)*

Burnout

**Pre-Intervention**

The pre-intervention Modified Mini Z Survey measured the baseline level of burnout among providers at GSCH. Question three (Appendix B) asked providers to choose their level of burnout ranging from (1) no symptoms of burnout, (2) under stress, but I don’t feel burned out, (3) I am definitely burning out, (4) the symptoms of burnout won’t go away to (5) I feel completely burned out. At baseline, 40% of providers experienced a level of burnout from 3 to 5.
Overall job satisfaction was approximately 44% of providers answering either agree or strongly agree. Stress levels were measured with 69% of providers answering either agree or strongly agree if they felt a great deal of stress due to their job. Work atmosphere was defined as busy or hectic/chaotic by 60% of providers.

The survey also contained two open ended questions asking about stressors and what could be done to minimize stress and provider views of the Restoring Resilience on Location© program (Appendix B). Common sources of provider stressors were related to scheduling, patient complexity, communication, inadequate staffing, and concerns related to the EMR (excessive number of items on desktop, time spent charting). Providers suggested they would like to have more control over their schedules, increasing support staff, and organizational accountability. As for provider views on resilience resources about half of the respondents did not utilize the Restoring Resilience on Location© program as they felt it did not align with their work schedule or that they did not have enough time to participate. Others felt it was of limited benefit and cited burnout as a systemic issue rather than a personal issue.

**Post-Intervention**

As a product of unfortunate circumstances, burnout increased to 70% post-intervention (Figure 6), from the pre-intervention level of 40%. Between June and October three providers resigned from the organization and an additional four gave their three months’ notice for departure. This is likely partially attributable to the increase in overall burnout as patient volume stayed the same and remaining providers became responsible for additional patients during this time. This correlated with now 90% (previously 60%) of providers reporting a busy or hectic/chaotic work atmosphere.
Interestingly levels of job-related stress decreased from 69% to 60%. Overall job satisfaction decreased from 44% to 30% between June and October. Job related stress may have decreased as new providers were hired and athenaOne was implemented. Scheduled versus actual hours worked remained similar pre- and post-intervention (Figure 7).
Intervention 1: Leadership

The team lead met with the COO over the course of project timeline. The goal of meeting with senior leadership was to build a bridge between providers and management as multiple providers stated they would like to be asked for their input regarding organizational operations and proposed changes in the preliminary survey. The first meeting consisted of a review of baseline data as shown in Figure 1 and Table 1. The team lead explained it is not possible for providers to discuss concerns with senior leadership during clinical time as their focus is on their patients and the tasks in front of them. The COO proposed that he could meet with the providers at a scheduled time if they thought this would be advantageous. The post-intervention survey asked providers if they felt a scheduled monthly meeting with leadership would be beneficial 62.5% reporting a monthly meeting with senior leadership would be beneficial. The goal was to set aside a time for this rather than have the meeting be during lunch or before/after work hours.
Regular meetings have not yet commenced. During the project timeline the COO transitioned roles and is now the new CEO.

The pre-intervention Modified Mini Z Survey asked providers what leadership could do to decrease burnout. Responses echoed similar responses including follow through with communication, organizational accountability, additional/well trained support staff, and collaboration (Table 3).

**Table 3**

*Suggested Actions Leadership Could Take to Decrease Burnout*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>Show action is being taken on complaints, avoid gift giving to reduce negativity, responding to incident reports, acknowledging situation</td>
</tr>
<tr>
<td>Appreciation</td>
<td>Value providers work, pay attention to provider’s physical and mental health over revenue</td>
</tr>
<tr>
<td>Communication</td>
<td>Listen to provider suggestions/concerns, closed loop communication</td>
</tr>
<tr>
<td>Compensation</td>
<td>More administrative time, reevaluation of administration time ratio, better salary</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Ask for input on daily running’s of the organization</td>
</tr>
<tr>
<td>Environment</td>
<td>Improved work environment, stop toxic workplace habits</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Fewer patients/day, improve patient access (sometimes routine follow up appointments do not get scheduled)</td>
</tr>
<tr>
<td>Staffing</td>
<td>Hire more support staff, improve training of clinical support staff, supporting staff to work at full scope of practice for their license, teach support staff to act on items prior to sending to provider (e.g., calling pharmacy to see if there are refills on a script), better hiring process, develop strategies to retain staff</td>
</tr>
</tbody>
</table>
The preliminary survey revealed 26.7% of providers did not feel their values aligned with those of leadership, 40% neither agreed nor disagreed, and 33.3% felt their professional values did align with leadership. Post-intervention results showed 11.1% strongly disagreed, 44.4% disagreed, and 44.4% agreed. Table 4 compares results from June 2023 to October 2023. In August of 2023 the clinical site director at Families First resigned from the organization which may have impacted results.

Table 4

*Professional Values Align with Leadership*

<table>
<thead>
<tr>
<th>Values Align with Leadership</th>
<th>June 2023</th>
<th>October 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>0%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Disagree</td>
<td>26.7%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>40%</td>
<td>0%</td>
</tr>
<tr>
<td>Agree</td>
<td>33.3%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The post-intervention survey added an open-ended question that inquired if a monthly meeting with senior leadership would be beneficial. Of the surveyed providers, 62.5% reported a monthly meeting with senior leadership would be beneficial. Providers also commented that they felt this would aid in aligning organization actions with provider and patient needs. Results are detailed in Table 5.
Table 5

*Monthly Meeting with Senior Leadership*

<table>
<thead>
<tr>
<th>Response</th>
<th>Reasons</th>
<th>Comments</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Currently there is disconnect between providers and leadership, meetings would help align actions with provider needs</td>
<td>Include CEO, CMO, and providers</td>
<td>5 (62.5)</td>
</tr>
<tr>
<td>Neutral</td>
<td></td>
<td>Concerns that leadership will not be open to change/suggestions</td>
<td>2 (25)</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>1 (12.5)</td>
</tr>
</tbody>
</table>

*Note.* N= 8 (100%)

**Intervention 2: Workflow and Administration**

On July 18, 2023, athenaOne went live at GSCH. With any significant change there are learning curves and a possibility that operations may present more challenges before improvements are noted. The organization had an EMR Steering Committee that contained staff from different departments in the organization that met regularly to prepare for the rollout and mitigate issues during the transition. The team lead was not part of this committee prior to rollout but became a superuser to assist providers with the new system and make changes within the system to better fit organizational workflows and provider preferences. For the first few weeks, patient volume was decreased, and Athena staff were in both clinical settings to provide support to all staff. The Modified Mini Z Survey inquired about control over workload, time for documentation, amount of time spent on the EMR at home, and proficiency with the EMR. With the previous EMR 80% of providers felt they had poor or marginal control over their workload, 93% reported poor or marginal time for documentation, and 93% spent an excessive or
moderately high amount of time on the EMR at home. With athenaOne 90% reported poor or marginal control over their workload, 80% reported poor or marginal time for documentation, and 60% spent an excessive or moderately high amount of time on the EMR at home. Control over workload is influenced by factors other than the implementation of the EMR and was likely impacted by the departure of multiple providers over the intervention period as well. Proficiency of use with the EMR being good or optimal remained the same at 66.7% of providers both pre- and post-intervention. Table 6 details the above discussed results.

**Table 6**

*Survey Questions Related to EMR*

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control over workload (poor, marginal)</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Time for documentation (poor, marginal)</td>
<td>93%</td>
<td>80%</td>
</tr>
<tr>
<td>Amount of time spent on EMR at home (moderately high, excessive)</td>
<td>93%</td>
<td>60%</td>
</tr>
<tr>
<td>Proficiency of use (good, optimal)</td>
<td>66.7%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

Providers were asked two open-ended questions regarding implementation of athenaOne. One question asked if implementation of athenaOne improved their daily workflow and the other question asked for suggestions to improve upon athenaOne. Only 22.2% of providers felt implementation of athenaOne had a positive impact and 44.4% reported it had a negative impact. The 33.3% that neither felt it was negative or positive cited that there is always a learning curve with a new system. AthenaOne significantly decreased the time at home spent on the EMR by
33%. Table 7 cites reasons providers felt positively or negatively with implementation of athenaOne.

Table 7

*AthenaOne Impact on Daily Workflow*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Reasons</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impact</td>
<td>Notes more efficient, faster system, easier appointment prep</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Neutral</td>
<td>Learning curve with system change</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Negative impact</td>
<td>More clicks, routing of documents poorly organized, slower to review labs/imaging, increase of unnecessary documents</td>
<td>4 (44.4)</td>
</tr>
</tbody>
</table>

*Note. N= 9 (100%)*

Providers suggested that athenaOne would be improved if the system eliminated duplicate documents (i.e., labs, imaging, consult notes), consult notes were labeled by the system or medical records, and if the routing processes were improved (send certain documents to nurse or MA if not needed to be viewed by the provider). Providers also noted that current procedural terminology (CPT) codes should not need to be inputted by provider when ordering tests. Quality measures were mentioned as well. Providers stated there should be a process for entering and tracking QI measures like breast, colon, and cervical cancer screenings. The team lead joined the Continuous Quality Improvement (CQI) committee to further address these concerns. The committee meeting was held on October 16 which was four days prior to the close of the post-intervention survey so no improvements were able to be implemented prior to the post-intervention survey.

**Intervention 3: Collaboration**

A weekly meeting to discuss EMR, workflow, and policies was implemented in June 2023. Every Friday the team lead, nurse manager, nurse in charge of the MAs, and a full-time
provider (MD) met. Notes were taken and each member followed up on assigned tasks. In June, new patient issues, processes for hospital follow up appointments, call center issues, panel sizes, and a transition plan for when the pediatrician left were discussed. Intake process for new patients was reviewed including inquiring about insurance and connecting the insurance coordinator if needed, ensuring records were received, and that the patient was aware of what services are offered prior to initial appointment. It was ultimately decided new patients would be paused due to two providers leaving the organization and an additional two giving their notice with planned departure prior to end of 2023.

In July of 2023 the desktop coverage process for provider vacations was reviewed. It was determined that urgent items and refills should be addressed the same day. Frequency of check in and time allotted for coverage was discussed as well. The nurse manager discussed this at the organizational clinical workflow meeting that she regularly attended. At the monthly provider meeting it was discussed that coverage would not be given unless the provider would be out for three or more consecutive days. Time allotment was still being discussed.

In August 2023 the team reviewed panel sizes and how to extract reports in the new EMR, onboarding plan for the new NP, medication refills, policy for patients arriving late, problem list transferring from legacy EMR to new EMR, and workflow for updating preventative screenings in athenaOne. The team developed a list of what tasks needed to be completed for the new NP to have a smooth transition which was reviewed with HR to ensure the NP would be able to complete necessary tasks upon starting. Medication refills were a safety concern as there was a black out period from May 1, 2023, to July 17,2023 meaning that any changes to the medication during this time was not transferred into athenaOne. The team developed a process for the MAs to follow when preparing refills. The process consisted of double-checking dose,
last fill of medication, ensure correct pharmacy is loaded, checking if refills were present on the previously sent script. The nurse who oversees the MAs communicated this process change with them and it was implemented immediately. The late patient policy was reviewed which states if a patient is more than 5 minutes late for a 15-minute appointment or more than 10 minutes for a 30-minute appointment they may not be seen. This does not include pregnant women or children. It was decided that it is provider discretion to see the patient. Patients could choose to wait to see if the next patient does not show up or reschedule. During the morning huddle providers communicated with their MA which patients they would see regardless of whether they were late to avoid wasting time with additional communication between the front desk, MA, and provider. The process for chronic no-show patients was also discussed with no conclusion.

The team examined how to communicate results with patients (i.e., labs and imaging). In athenaOne lab results are shown with the order group or office visit they were ordered in rather than in a separate case or note. This causes confusion if a patient does not answer the phone or calls to ask about their results as the individual in the call center would not be able to see that an attempt to reach the patient was made and if a plan was attached to the lab results. This created multiple open cases and made it challenging to find necessary information. The team lead and MD decided it would be best to open a patient case to review the lab results and plan. This lessened the number of duplicate cases related to the same issue.

In September 2023 refill timeline, morning huddle, nurse visits, involuntary transfer of care policy, triage process, and medication contracts for controlled substances were reviewed. The refill process was reviewed again including what MAs needed to do to prepare scripts, as well as sending scripts per standing orders and the expected timeline was reviewed with the MAs. Morning huddle process was reviewed again, and this was communicated to the MAs by
their supervisor. The team lead and physician proposed that blank copies of medication contracts for controlled substances be in each room so providers can review and complete the contract when prescribing the medication. Medication contracts can then be scanned into patient charts by medical records.

The team lead and MD expressed concerns regarding patients with behavioral issues. The nurse manager reviewed the policy at the meeting, and it was decided it would be beneficial to proceed with behavior contracts for patients who threaten staff, verbally abuse staff, and act inappropriately based on information detailed in the involuntary transfer of care policy. The nurse manager was tasked with reviewing the process with the CMO.

The triage process is detailed in Figure 8. The goal was to improve unnecessary routing of documents to providers and limit interruptions during clinical hours.

**Figure 8**

*Triage Process*

- **Uncomplicated triage**
  - Triage completed by nurse and appointment is scheduled. Note is routed to provider seeing the patient.
  - If patient is advised to go to urgent care due to lack of appointment availability the note is routed to PCP for signature.

- **Complicated triage**
  - If nurse advises emergency department then note is held to triage desktop to follow up the next day and schedule follow up appointment if needed.

- **Provider input needed for triage**
  - Route note to PCP if they are in office. If PCP not in office then nurses should alternate routing to in house providers.
  - Nurses should check in with providers at lunch and prior to end of day if they have not received answer.
In October 2023 the team discussed proposed plan for prenatal patients when prenatal provider leaves in December, notes from front desk staff, and provider assignments. The plan for prenatal patients was in review. All new patients, including prenatal, were placed on a temporary pause at Families First until further notice as remaining providers are absorbing departing providers patients, and the organization is in process of hiring additional providers. The front desk often sends providers notes after outreaching to patients to schedule. Three outreaches should be attempted, and note does not need to be sent to provider. This helped reduce the number of unnecessary documents on providers’ desktop. Referral requests were also reviewed as patients call in asking for a referral. The team relayed to the office manager that if a patient calls asking for a referral they must ask the patient the reason for the referral prior to sending to note to PCP. Provider panel assignments were also reviewed. The team determined the PCP should not be changed in the system until the provider is notified and is reviewed with the new PCP. If a female patient is asking for female PCP they should be asked if they are okay with seeing male provider for primary care and female for gynecological exams, etc. The new NP is a male and many female patients have asked to switch to a female provider causing the panels of remaining female providers to grow rapidly. It was found that many female patients were okay with seeing a male for routine care and only would prefer a female for gynecological exams.

The post-intervention survey asked Families First providers what workflow changes they have found most effective. Table 8 summarizes the responses and new processes.
### Table 8

**Effective Workflow Changes at Families First**

<table>
<thead>
<tr>
<th>Provider comments</th>
<th>Process change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication refill process</td>
<td>MAs need to write date of last fill, when next fill is due, last office visit, and next scheduled office visit in refill request for controlled substances. Closing patient case with refill request unless there is an additional item to be addressed to cut down on desktop documents.</td>
</tr>
<tr>
<td>Morning huddle with team</td>
<td>MA and nurse are present to discuss plan for day (immunizations, point of care testing, if social work or behavioral health is needed, etc.). Provider tells MA which patients they will see if patient arrives more than 10 minutes late.</td>
</tr>
<tr>
<td>Pausing new patients</td>
<td>With multiple providers leaving there are not enough providers to adequately care for patients. Collectively decided to pause new patients during this time. Eases burden of overscheduling on current providers.</td>
</tr>
<tr>
<td>Nurse triage and nurse visits</td>
<td>Triage: reviewed with nursing staff what should be a 15 versus 30-minute visit, setting a check in time for non-urgent triage questions to minimize interruptions. Nurse visits: standardizing process for INR and blood pressure checks, if any concerns or result is out of range nurse needs to review with in-house provider.</td>
</tr>
</tbody>
</table>

### Provider Departure

Both the preliminary and post-intervention surveys asked providers their intent to leave within the next two years. Results were similar in June of 2023 and October of 2023. In June of 2023, 33% of providers reported they planned to leave the organization within the next two years and in October 30% of providers reported intent to leave within the next two years. Three of the
providers who completed the post-intervention survey gave their three months’ notice during the course of the project. Table 9 shows pre- and post-intervention responses.

**Table 9**

*Intent to Leave Within Two Years*

<table>
<thead>
<tr>
<th></th>
<th>June 2023</th>
<th>October 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to leave within the next two years</td>
<td>Yes 33%</td>
<td>Yes 33.3%</td>
</tr>
<tr>
<td></td>
<td>Maybe 27%</td>
<td>Maybe 33.3%</td>
</tr>
<tr>
<td></td>
<td>No 40%</td>
<td>No 33.3%</td>
</tr>
</tbody>
</table>

The team lead reached out to all providers who have left the organization over the last two and half years and asked their top three reasons for leaving GSCH. Provider experience ranged from one to 45 years. Multiple providers reported a poor quality of life due to an overwhelming workload stemming from operational and systems issues. Another provider reported a decrease in job satisfaction resulting from a lack of enjoyment and subpar healthcare delivery. Providers noted feeling dismissed by their supervisors and leadership when no progress updates or results were relayed back to them.

Providers also cited patient safety concerns. Incidences like being made to see patients when the EMR was down, requiring providers to double check every prescription prepared by MAs (correct pharmacy, quantity, fill date, medication accuracy), inadequate response to near miss situations, and using personal responsibility for errors instead of systems-based approach. Lack of available specialists, poor referrals process for urgent referrals leaving patients waiting a long time to see specialist and PCP managing complex conditions in interim. Not receiving test results (i.e., stress test, imaging, etc.) leaving the provider exhausted trying to follow up and receive results of previously ordered testing. These chronic issues also led to poor patient experience.
One provider discussed the daily view versus the global view of their job describing how if your daily view is clouded with workflow issues, overwhelming number of items on your desktop, and poor systems processes that your global view is negatively affected leading to decreased levels of job satisfaction. Mismanagement contributed to disappointment and chronic fatigue. Table 10 lists themes and examples derived from provider interviews.

Table 10

*Departure Reasons*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>Salary does not reflect providers being primary revenue generators for the organization, inadequate administrative time</td>
</tr>
<tr>
<td>Patient safety</td>
<td>Missing records (i.e., results of testing ordered by PCP, consult reports, ED/UC visits), no follow up with incident reports, concerns not fully addressed, workflow issues</td>
</tr>
<tr>
<td>Workload</td>
<td>Too many uncompensated hours, patient population has high medical and psychosocial complexity, inefficient EMR routing and document classification, unrealistic expectations</td>
</tr>
<tr>
<td>Senior Leadership</td>
<td>Unresponsive to provider concerns, poor communication, and lack of follow up, lack of support, dismissive of concerns and provided “band-aid solutions”, short term financial view, too many chief positions for size of organization, unprofessional communication and conduct, lack of appreciation and acknowledgement</td>
</tr>
<tr>
<td>Operations</td>
<td>Scheduling (appointment booked with wrong provider, lack of provider input with scheduling preferences, appointments booked inappropriately), chaotic work environment, previous medical records scanned in incorrectly, inability to address poor performance appropriately</td>
</tr>
<tr>
<td>Data Integrity</td>
<td>Inability to run reports for QI incentives, inactive patient information (i.e., emergency room visit, urgent care visit, etc.) being sent to organization due to charts not being inactivated after a set time period, provider panel inaccuracies</td>
</tr>
<tr>
<td>Systems Issues</td>
<td>Lack of coverage/desktop management for provider time off, too many clicks to complete tasks within the EMR</td>
</tr>
</tbody>
</table>
Discussion

Summary

Acknowledging that the providers are experiencing burnout and leaving GSCH was a key component of this QI project. Presenting senior leadership with provider specific data regarding burnout, suggested improvements, and departure reasons of prior providers is essential for the organization to evolve and retain providers. Two positive outcomes emerged from this project. First, there was a reduction in job related stress decreasing from 69% of providers answering strongly agree or agree pre-intervention to 60% post-intervention. Second, a marked improvement was observed in the amount of time providers reported spending on the EMR at home. In the pre-intervention survey 93% of providers reported they spent an excessive or moderately high amount of time on the EMR at home. Post-intervention this decreased to 60% of providers reporting spending an excessive or moderately high amount of time on the EMR at home. These results show progress in addressing concerns related to workload management.

The aim of this QI project was to reduce the likelihood of providers leaving the organization within the next two years. However, the likelihood provider departure did not change post-intervention, as 33.3% of providers reported they plan to leave the organization within the next two years, which was consistent with the pre-intervention report of 33%. The outcome exemplifies the complex challenges involved in addressing provider retention and burnout.

This QI project highlighted the systemic nature of burnout and the influence of leadership on this issue. Although this project did not directly improve provider retention or reduce burnout, it created an opportunity for leadership to analyze organization shortcomings and initiate action in these areas. It serves as a starting point for GSCH to explore more comprehensive strategies and implement measures to enhance provider satisfaction, well-being, and ultimately striving to
retain valuable providers. Additionally, this project invites leadership to reestablish a connection with providers and foster better alignment of values. Both leadership and providers share a common goal: to provide the best care possible for patients. This shared objective serves as a unifying force and a renewed commitment to the organization’s mission of delivering high quality healthcare.

**Interpretation**

The three areas this project focused on were leadership, workflow and administration, and collaboration.

**Leadership**

It was clear there was a significant disconnect between providers and senior leadership within the organization. Providers expressed feeling undervalued, unappreciated, and often dismissed by leadership. Recognizing the need to bridge this divide, the primary objective was to engage leadership in collaborative efforts with providers. As of June 2023, only 33.3% of providers believed their professional values aligned with those of leadership. By October this alignment increased to 44.4%. Conversely, the proportion of providers who reported disagreement or strong disagreement with values alignment with leadership rose from 26.7% pre-intervention to 55.5% post-intervention. This shift in perceptions may be attributed to role changes and provider departures during this time.

To further address this issue and promote collaboration the goal is to establish a regularly scheduled meeting for providers with senior leadership. This initiative has garnered support, as 62.5% of providers reported they would find this to be beneficial post-intervention. These meetings aim to create a platform for transparent communication and mutual understanding to fostering a more collaborative and productive work atmosphere.
According to Shanafelt and Noseworthy (2017) the first step in making progress towards reducing provider burnout is to acknowledge and assess the problem. This QI project has accomplished that goal. The next steps based on Mayo Clinic’s guidelines are to harness the power of leadership and develop and implement targeted interventions (Shanafelt & Noseworthy, 2017). The data culminated by this project gives senior leadership the information necessary to embark on strategies two and three. This opportunity also acknowledges that providers face unique challenges and fosters space for changes in alignment with Mayo Clinic’s fourth strategy which is to cultivate community at work (Shanafelt & Noseworthy, 2017).

Lastly, this plan was cost effective. Many organizations feel that interventions to reduce burnout are expensive which is not the case (Shanafelt & Noseworthy, 2017). The pre-intervention survey asked providers what actions leadership could take to reduce burnout. The most suggested course of action was to prioritize accountability, closely followed by the importance of consistent and effective communication. Both actions come at no cost. While other suggested actions, such as hiring additional support staff, reevaluation of the administrative time ratio, and increasing salaries entail expenses, it is important to note that the most frequently recommended actions come at no cost.

**Workflow and Administration**

The implementation of athenaOne EMR system proved to be beneficial for providers even with the anticipated learning curve that accompanies systemic change. There was a significant improvement in the amount of time providers spent working on the EMR at home with only 60% of providers reporting they spent an excessive or moderately high amount of time on the EMR at home compared to 93% pre-intervention. Bodenheimer and Sinsky (2014) stated 87% of providers identified paperwork and administrative tasks as the primary contributor to
burnout, as well as causing increased stress. Post-intervention there was a 10% increase in providers reporting poor or marginal control over their workload. It is important to consider this increase may be influenced by a high rate of provider departures, which could have placed more stress on remaining providers.

It is essential to acknowledge the success of the new EMR may be somewhat limited due to the relatively short duration of this project. Systemic changes often involve an adjustment period, and the full extent of the benefits may not have been fully realized within the project’s timeframe.

**Collaboration**

Families First implemented a weekly meeting aimed at addressing challenges associated with the new EMR, workflow, and processes. These regular meetings served as a platform to discuss a range of topics and provided a forum for addressing concerns within the office environment. Families First faced many challenges during this project. In July of 2023 an experienced pediatrician resigned; in August the clinical site director resigned and in September two providers submitted their three months’ notice. The most impactful changes from these meetings included enhancements to the medication refill process, particularly regarding how MAs prepared scripts. It has been estimated that standardization of prescription refills can save providers up to five hours per week (Bodenheimer & Sinsky, 2014). Morning huddles were adjusted to improve communication and coordination among the team. Issues related to late patient arrivals were addressed and the policy was reviewed. Families First paused taking new patients due to multiple provider departures and shifting of panels to be able to continue to provide high quality care to our existing patients. The standardization of the nurse triage process and nurse visit contributed to streamlining and improving the healthcare delivery process. The
implementation of a multidisciplinary well-being task force that addresses provider engagement and growth, workflow/office efficiencies, relationship building, and communication has proven to enhance provider well-being and decreased turnover by 30% (Shields et al., 2020). These modifications collectively fostered a more efficient and effective working environment at Families First.

Limitations

This project encountered various limitations which should be considered when interpreting the results. These limitations included time constraints, limited sample size, healthcare setting, and challenges posed by provider departures. The project’s timeline was relatively short which restricted the depth of data collection and the extent to which interventions could be reexamined in multiple PDSA cycles. The project took place at a FQHC. This setting’s uniqueness makes it challenging to compare to provider experiences with those in larger or different healthcare environments, limiting the generalizability of the findings. The limited sample size posed challenges with data analysis and limited availability of methods.

The most significant challenge was the departure of three providers from GSCH during the project with an additional four providers submitting their three months’ departure notices. While three new providers were hired during the project period and the hiring of another provider is expected in early 2024, the remaining providers experienced a shift in workload. The newly hired providers (defined as those with less than six months experience at the organization) were not included in the data analysis.

With more time available the project could have incorporated more PDSA cycles to account for the experiences of the newly hired providers and further refinement of interventions. These limitations must be considered when interpreting the project’s outcomes.
Conclusions

While this project did not succeed in reducing burnout among providers or improving provider retention rates it served as a valuable platform for uncovering persistent issues within the organization and highlighting areas for improvement. The time constraints and high rate of provider turnover during the project period limited the extent to which further research and improvements could be completed.

The ideas proposed as part of this project are both sustainable and innovative, proving a foundation for future initiatives. GSCH can consider sharing its findings and experiences with other FQHCs to establish a support network aimed at promoting provider engagement and systemic improvements. Recognizing the substantial work that lies ahead to mitigate burnout, foster provider engagement, and reduce provider turnover, it is important to acknowledge that this QI project has helped set the stage for continued progress in these areas. The organization is prepared to continue this journey of improvement building upon insights gained during this project.

Mayo Clinic states that, “organizations measure the things that they believe are critical to achieving their mission.” (Shanafelt & Noseworthy, 2017, p. 133). To ensure the successful future of GSCH measurement of provider satisfaction, burnout, and associated factors should be measured annually, compared with patient satisfaction scores, and presented to the board. This should be done using standardized tools that compare with national data benchmarks (Shanafelt & Noseworthy, 2017). Ideally, GSCH should pursue a High Reliability Organization (HRO) model. The Agency for Healthcare Research and Quality defines the characteristics of a HRO as preoccupation with failure, reluctance to simplify, sensitivity to operations, deference to expertise, and a commitment to resilience (Agency for Healthcare Research and Quality, 2019).
By utilizing this framework awareness of potential problems encourages action and resolution based upon systems thinking (Agency for Healthcare Research and Quality, 2019).

Leadership training should also be considered. FQHCs provide care to complex populations that often face health disparities and socioeconomic barriers. This means providers are often placed in high stress and high stakes situations that impact their mental health and well-being. Leadership needs to be equipped to face the challenges that accompany this. Brené Brown has developed a program called “dare to lead’ that focuses on bravery and creating a culture of courage, as well as operationalizing values (Brown, 2023). The values of GSCH are integrity, respect, compassion, excellence, and collaboration (Greater Seacoast Community Health, n.d.). It is vital for the organization to understand how these values are can be translated into specific and observable behaviors (Brown, 2023).

The mission of GSCH is, “To deliver innovative, compassionate, integrated health services and support that are accessible to all in our community, regardless of ability to pay.” (Greater Seacoast Community Health, n.d.). Without dedicated providers, the fulfillment of this mission is unattainable. Providers are instrumental in ensuring the organization’s mission is realized, making their well-being and job satisfaction a top priority.
References


Kolgin, Dr. A., & Tracy, Dr. E. (n.d.). Greater Seacoast Community Health Restoring Resilience on Location© January 1, 2022-December 31, 2022 Final—Aggregate Data Summary & Recommendations (p. 10) [Final - Aggregate Data Summary & Recommendations].


Appendix A

Resilience & Hope
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603.343.1623
CustomerRelations@ResilienceandHope.com

“Specializing in Professional Wellness & Resiliency”

Greater Seacoast Community Health
Restoring Resilience on Location®
January 1, 2022-December 31, 2022
Final - Aggregate Data Summary & Recommendations

It has been a pleasure to work with everyone at GSCH. This contract has by far been one of our most utilized to date. The internal marketing/promotion of the program was exceptional and should receive credit for its contribution to the program’s success. The receptivity of the staff with each program component was outstanding.

To avoid duplicating information, we have not repeated all the information contained in Quarters 1-4 reports. We encourage the review of those documents as well, for additional details. This summary report highlights key recommendations.

Report Sections:
1. Overall Summary
2. Recommendations
3. List of TIPs Meetings/Newsletter Topics Addressed Throughout The Year
4. Contracted Services Final Detailed Data

As always, we remain available to answer questions, meet with leadership and look forward to future opportunities to support GSCH and its employees.

Sincerely,

Dr. Andrea Kolgin, DAIH, Dipl.Ac (NCCAO®), Lic.Ac., LCPC, LADC, NCC

Dr. Elizabeth Tracy, PsyD, LICSW, LCSW, A.A.E.T.S
Overall Summary

- Overall, this program was a considerable success. The initial usage was robust and actually increased throughout the contract period, with each quarter showing increased requests for individualized appointments. Unique to this contract demand actually increased as employees realized the program would be ending.
  A. The numbers for quarter 3 remained remarkably high given that traditionally, there is almost always a dip in the summer, when people are taking vacations and/or children are no longer in school.
  B. In quarter 4 there were actually more appointments scheduled for individual sessions than any other quarter. As with quarter 3, however, there were incomplete appointments, difficulties with appointment confirmations, missed or forgotten appointments or late notice cancellations at an approximate rate of 30%. Although some of the cancellations in quarter 4 were attributed to illness or weather, the predominant reason for incomplete scheduling or canceled/missed appointments was due to work conflicts (see recommendations).
  C. Those employees who had not utilized the program until the last quarter, without exception, expressed regret at not having accessed the program sooner as they felt it was invaluable.

- The overall program focused on both physical and emotional professional wellness.

- Stress response symptoms (emotional/physical) impacting overall wellness and resilience:
  - Stress, anxiety, agitation/irritability & emotionality
  - Difficulty with sleep
  - Somatic tension & pain – especially neck, shoulders & upper back
  - Overall fatigue, lack of energy & depletion
  - Difficulty with concentration/ focus & memory
  - Increased awareness, acknowledgement and requests for assistance with “crash & burn/let down effect” symptoms

- Both Acupuncture and Auriculotherapy were very well received and utilized. In fact, auriculotherapy was offered as a free extension by Resilience & Hope throughout the contract period in the Dover office.
  A. Employees described an increased ability to concentrate and focus at work, increased energy, and improved sleep. Additionally, they reported decreased physical tension and pain, anxiety, and irritability.
  B. Employees said that along with the increased/decreased symptoms noted above, utilization of the acupuncture points taught in the TIP’s meetings, auriculotherapy and acupuncture sessions, resulted in their feelings of increased ability to cope with ongoing workplace stress.

- Almost without exception, employees expressed gratitude toward the organization for sponsoring this program.

- Employees expressed a sense of feeling heard, valued, and supported within Resilience & Hope’s individual sessions/consultations. In addition, they expressed relief in having a space and time to focus on self-care.
The program provided individual support to every level of the organization across the various sites.

Employees demonstrated active carryover of skills and strategies taught during the TIPs meetings and individual support sessions.

Employees who needed additional ongoing support or whose issues were outside the scope of the contract, were connected to community-based providers/organizations.

Appointments were available evenings and weekends, allowing employees to arrange individual support sessions outside of work hours. The availability of virtual sessions further increased scheduling flexibility.

Some employees used email to receive ongoing support - meeting the goal of multiple touchpoints.

The topic of Crucial conversations was added to the TIPs meetings after the demand for department meetings remained an unmet need (see recommendations).

The ARTIC survey recommendations were intentionally considered and integrated throughout the individual consultations, departmental, and TIPs meetings. For example:

A. Learning how trauma negatively affects the brain and the body and how this relates to problem behaviors e.g., miscommunication, verbal aggressiveness and difficulty with critical conversations related to problem solving.

B. In addition to highlighting the importance of resilience and self-care, using trauma informed strategies, employees learned skills to promote workplace success.

C. Throughout the program, employees developed a common language to assist in understanding the impact of caring for and working with individuals with a trauma history.

D. The program provided a framework which normalized individual traumatic experiences, both personally and professionally, encouraging seeking support and responding with empathy.

RECOMMENDATIONS:

We have identified three core areas for recommendations which highlight ongoing unmet needs from relevant areas of the ARTIC survey and the Restoring Resilience on Location© Program.

1. Individual Employee Support
2. Departmental inter/intra Communication & Support
3. Organizational Culture & Leadership

1. INDIVIDUAL EMPLOYEE SUPPORT

The work done by GSCH staff has high potential for traumatization. Now, more than ever, directly supporting staff in a meaningful measurable way is critical. Programs such as, Restoring Resilience on Location© are foundational to creating an organization of healthy dedicated employees who are resilient to traumatic events and can therefore provide exceptional patient care to, undoubtedly, our communities' most vulnerable people.
A. This program focused on mitigating the impact of COVID-19 on employees, increasing their ability to cope and providing additional coping resources. Now as the world transitions into the recovery phase and, given the feedback from employees, a program like Restoring Resilience on Location\textsuperscript{5} focused on recovery would be strongly encouraged and be welcomed by employees.

B. Furthermore, implementation of sustained employee support programing through organizational interventions that provide continued opportunities which allow for, promote, and make access to self-care, is a vital aspect for employees’ success in the workplace (ARTIC/Self-Efficacy at Work subscale 4). Research indicates that when organizations offer these types of programs as a part of their ongoing workplace culture it supports professional resilience and fosters provider wellbeing. Organizational interventions are proven to be more effective than individual employee “self-care” practices and may be protective in nature, augmenting employees’ overall ability to cope with stress. This type of programming would ideally become part of the ongoing employee benefits.

1. One organizational intervention that would address stress related physical and emotional symptoms would be an acupuncturist onsite at least one day weekly. The following types of acupuncture would accommodate larger numbers of employees and based on the results from this contract, would be highly utilized.
   i. Auriculotherapy (ear acupuncture).
   ii. “Community style” acupuncture can accommodate larger numbers of employees at a time in the same room. Employees could have acupuncture done on easily accessible arms, feet and ears, while sitting in chairs for approximately 15-30 minutes.

2. Ongoing access to individual support for employees is another critical intervention for post COVID recovery and during sustained staffing shortages (see also organizational recommendations).

2. DEPARTMENTAL INTER/INTRA COMMUNICATION & SUPPORT

During the contract period, the demand for departmental meetings far exceeded the available number of sessions. It became clear that this both inter and intra departmental communication is an area of great concern for both leaders and employees.

One identified theme was an expressed organizational culture of indirect communication within teams and between teams. This may or may not be an aspect of the “silo effect” (this was not directly evaluated). Providing education about how to address disharmony, miscommunications, and differences of opinions through the lens of win/win might increase cooperation and further organizational objectives.

According to the ARTIC survey recommendations a goal is to create work teams that “promote relationships within the team and encourage everyone to have a voice... and utilize
effective conflict management.” Further goals include “building a culture in work teams that it is okay to not know, share mistakes and learn from the team… and [encourage team members] to ask for and accept help.” Finally, effective work teams “build a safe and supportive workplace culture where staff can talk openly about their triumphs and struggles and get support for their work.”

Therefore, it is strongly recommended that GSCH engage a consultant/trainer who would meet with departments to address INTERdepartmental communication, culture and team building as well as INTRAdepartmental communication, workflows, and culture.

3. ORGANIZATIONAL CULTURE & LEADERSHIP

Fostering a positive work environment in healthcare is instrumental in helping an organization thrive and achieve its goals in multiple ways including:

Promotes employee engagement. Engaged employees are more committed to their work, take pride in their roles, and are more likely to go the extra mile to ensure the organization's success.

Enhances job satisfaction and reduces burnout, leading to higher staff retention rates. Retaining experienced and skilled healthcare professionals reduces recruitment costs and maintains continuity in patient care.

When healthcare professionals feel supported and valued, they are more likely to provide high-quality patient care. Positive attitudes and job satisfaction translate to improved patient experiences and outcomes.

Satisfied employees are better able to manage their tasks, collaborate with colleagues, and handle challenges effectively, leading to overall improved organizational performance.

In challenging times, such as during a pandemic or a healthcare crisis, a positive work environment can help healthcare professionals stay resilient and cope better with stress and uncertainties.

1. High stress levels were identified throughout the contract period indicating a high need for ongoing counseling/support. A noticeable barrier for employees who needed ongoing counseling/support was multiple reports of unmet insurance deductibles. Thus, one recommendation is to make ongoing behavioral health care access more financially feasible for all employees. This might occur by:
   i. Establishing a low/no behavioral health deductible
   ii. Increasing Employee Assistance Program (EAP) sessions annually
   iii. Contracting with a similar type of program as Restoring Resilience on Location© which includes individual sessions/consultations

2. People who work for an organization such as GSCH typically do so primarily as a ‘calling’ or are generally committed to ‘the mission.’ Throughout the contract, a theme
developed of ‘toxic positivity’ where employees reported trying to inform leaders of ongoing issues and felt they were met with blame/shame for being the ‘problem’. Others reported feeling dismissed and their problems denied, by supervisor/leaders’ implied “it’s worse somewhere else” comments. Comparing GSCH to worse situations doesn’t encourage growth or improvement. Instead, the organization should strive to create the best possible work environment for their employees, even if other agencies are struggling more.

Ignoring/dismissing employee complaints can lead to higher turnover rates, reduced productivity, and a negative reputation as an employer. When employees feel that they cannot affect change or make a difference, employees become hopeless and morale drops. These employees will either become disgruntled and spread negativity throughout the organization or eventually leave, adding to the stressful existing staffing shortages.

When employees provide feedback/suggestions for/about changes, it is critical that the organizational leaders practice active listening, respond by acknowledging the reality of the struggles, and be explicit about the steps being taken by the organization to address the issue. If a remedy is not currently in process, the leaders should discuss their intent to escalate the employees’ concerns. Addressing concerns in a compassionate and constructive manner will strengthen the organization in the long run.

As with the ARTIC survey recommendations for supervision “to establish a safe and supportive climate to openly discuss difficulties of the work… allocate resources for training and supervision.” it is recommended that the organization:

i. Engage in reflective supervision training on all levels and make it part of the culture that supervision is a critical necessity and is to be prioritized.

ii. Train leaders that employee well-being matters: Emphasize that employee well-being is crucial for a healthy and productive work environment. Just because other agencies might be facing worse situations doesn't invalidate the need to address issues within the organization. This type of response is a form of toxic positivity.

iii. Encourage leaders to foster a positive work culture where employees feel comfortable speaking up about their concerns.

3. It is important that all leaders recognize and value the importance of every employee’s role and to have taken the time to grasp the responsibilities and contributions that each employee makes to the organization. It is critical for all leaders to fully comprehend the intricacies and the complexities of all positions, including the unique challenges employees face, the skills required, and the level of dedication needed to perform their duties effectively.
The ARTIC survey addresses leader empathy and communication by stating “Treat the staff as you want them to treat the clients... validate staff’s challenges during cultural change process... focus on staff strengths and balance accountability and flexibility.”

Throughout the contract there has been an expressed feeling of disconnect between supervisors, leaders and their employees in both directions. When employees feel supervisors/leaders don’t understand the complexity of their job and the negative impact that ongoing struggles/changes have on their position, the rate of stress and burnout rises. In addition, there is reduced job satisfaction, higher turnover rates and patient care becomes compromised. Understanding the contributions and concerns of employees can lead to a more engaged and motivated workforce, improved patient outcomes, and better overall organizational performance. Additionally, when employees know that leaders fully understand and value their positional challenges, it allows the organization to fully hold each individual accountable for job performance expectations.

i. Monitor workloads and excessive demands on staff including working outside contracted hours to “fill the gap” when the workload is excessive and/or staffing shortages.

ii. Foster a collaborative approach to decision-making. Involve employees from all departments in the planning process and seek their feedback. This can lead to more thoughtful changes and better outcomes. When there are changes in policies, procedures, technology, or timelines they can affect employees’ daily tasks and responsibilities and can add to their workload, create inefficiencies, or lead to frustrations in delivering patient care. Furthermore, acknowledging these frustrations and accommodating the struggles, as much as possible, will promote better acceptance and transitions.

iii. Whenever possible, propose solutions or alternative approaches that address the concerns of direct care providers while still achieving the organization’s goals. This proactive approach demonstrates that you’re invested in finding a balance between all stakeholders’ needs.

iv. Offer training and educational opportunities to senior leaders to help them gain a better understanding of all employees’ roles and challenges. One suggestion is to have leadership spend a day “helping” in each department. The “tone” of these helping days should be to grasp a comprehensive understanding and use it as an opportunity to not only observe but listen. Care should be taken to make sure that it is not perceived by staff as punitive or an opportunity to “discover” shortcomings.
TIPs Meetings/Newsletter Topics Addressed Throughout The Year

January - Program Outline & Intro to the Impact of Stress on Autonomic Nervous System (mini meeting)

February - The Impact of COVID-19 on the Sympathetic Nervous System (Fight, Flight & Freeze) Part 1

March - The Impact of COVID-19 on the Sympathetic Nervous System (Fight, Flight, Freeze & Appease) Pt 2

April - Replenishing When Depleted

May - Sympathetic Overload & Communication

June - The Let Down Effect aka Crash & Burn

July - Professional Vulnerability (Part 1) & Vulnerability to Heat & Stress

August - Professional Vulnerability (Part 2) & Transitions

September - The Impact of Financial Stress & Boosting Immunity

October - Crucial Conversations (Part 1) & Traditional Chinese Medicine (TCM) strategies to assist with the onset of cold/flu symptoms

November - Critical Conversations (Part 2) & Computer Overuse: Forward Head Posture Syndrome & Computer Eye Vision Syndrome

December - TIPS for Maintaining Balance through the Holiday Season
### Contracted Services Final Detailed Data

<table>
<thead>
<tr>
<th>Service</th>
<th>Contract Specifications</th>
<th>Summary of Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Meetings</td>
<td>Contracted to provide up to a total of 3 meetings / 3-4 hours.</td>
<td>Pre-contract, within contract scheduled meetings and spontaneous meetings/consults fulfilled this service.</td>
</tr>
</tbody>
</table>
| TIPs Meetings                                | Contracted to provide up to a total of 12 meetings / 12-18 hours.                       | Total number of virtual meetings provided = 12  
Total number of hours = 34  
Total number of contacts with GSCH staff = 899                                                                 |
| Department Meetings                          | Contracted to provide up to a total of 10 meetings / 10-15 hours.                      | Total number of virtual & in-person meetings provided = 18  
Total number of hours = 27.75  
Total number of contacts with GSCH staff = 90  
**Unmet need - requests from departments far exceeded contract total.**                                                                 |
| Individual Support/Consultation with referrals to ongoing counseling as needed. | Contracted to provide up to a total of 400 hours of support sessions for all GSCH staff and facilitate referrals to longer term counseling. | Total number of hours = 405.25  
Total number of scheduled/structured virtual & in-person support sessions = 300**  
**Does not include 'on-the-fly/in-the-moment' consultations that occurred whenever a Resilience & Hope person was present at a GSCH site.  
Additionally, this number does not include 'in session' consultations by another provider.  
Referrals for additional counseling/support were made to community-based providers.                                                                 |
| Auriculotherapy                              | Contracted to provide up to 72-75 hours.                                               | Within the contracted 3-month period total number of actual hours (onsite) = 50 **  
Does not include the 2 hours weekly reserved for GSCH staff at Resilience & Hope in the Dover office during the initial 3 months (total of 24 hours). |
| Access to Resilience & Hope Resource Library | Unlimited access to provider wellness newsletters and resource libraries. | Employees were provided individualized worksheets, handouts, and information sheets from the Resilience & Hope resource libraries. In addition, to a larger extent, topics were researched and personalized handouts were created and provided to meet specific staff concerns.

All newsletters have been uploaded to the GSCH website where existing and new employees can access them.

Upon request, from new employees, all newsletters were sent via email or printed. |
<table>
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<tbody>
<tr>
<td>Quarterly Reporting</td>
<td>Although not specified in the contract, a request was made to have aggregate data submitted each quarter.</td>
<td>Prepared and submitted detailed quarterly reports including aggregate data, including up-to-date contract totals, as well as summary and themes.</td>
</tr>
</tbody>
</table>
Appendix B

Modified Mini Z Burnout Survey

Answer the following questions as truthfully as possible to determine your workplace stress levels and how they measure up against others in your field. There are two sections of questions in this survey about your experience with burnout and your practice environment. This survey is adapted from the Mini Z burnout survey from the American Medical Association.

For questions 1-10, please choose the answer that best describes your experience with burnout.

<table>
<thead>
<tr>
<th>Question</th>
<th>1. Overall, I am satisfied with my current job</th>
<th>2. I feel a great deal of stress because of my job</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Using your own definition of “burnout,” please circle one of the answers below:</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>I enjoy my work. I have no symptoms of burnout.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>I feel completely burned out. I am at the point where I may need to seek help.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.</td>
<td>My control over my workload is</td>
<td>1 Poor</td>
</tr>
<tr>
<td>5.</td>
<td>Sufficiency of time for documentation is</td>
<td>1 Poor</td>
</tr>
<tr>
<td>6.</td>
<td>Which number best describes the atmosphere in your primary work area?</td>
<td>1 Calm</td>
</tr>
<tr>
<td>7.</td>
<td>My professional values are well aligned with those of my department leaders.</td>
<td>1 Strongly disagree</td>
</tr>
<tr>
<td>8.</td>
<td>The degree to which my care team works efficiently together is</td>
<td>1 Poor</td>
</tr>
<tr>
<td>9.</td>
<td>The amount of time I spend on the electronic health record (EHR) at home is</td>
<td>1 Excessive</td>
</tr>
<tr>
<td>10.</td>
<td>My proficiency with EHR use is</td>
<td>1 Poor</td>
</tr>
</tbody>
</table>

Tell us more about your stresses and what we can do to minimize them:
What can leadership do to decrease burnout?
What are your views on the resilience trainings provided and counseling? Have you utilized these resources? If so, did you find them beneficial?

Comments:

Your clinical practice

<table>
<thead>
<tr>
<th>For the following, please tell us about yourself and your practice. Please fill in the blanks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you: MD/DO NP PA Other (specify):</td>
</tr>
<tr>
<td>Location: GCH FF</td>
</tr>
<tr>
<td>How many hours do you work weekly (scheduled)?</td>
</tr>
<tr>
<td>Estimated actual hours worked:</td>
</tr>
<tr>
<td>Number of years in your current role:</td>
</tr>
<tr>
<td>Do you plan on leaving your current role within the next two years?</td>
</tr>
<tr>
<td>Gender: Male Female Non-binary Prefer not to say</td>
</tr>
</tbody>
</table>

Thank you for completing the Modified Mini Z survey.
Appendix C

Modified Mini Z Burnout Survey (post)

Goodwin- The only intervention at your site was implementation of athenaOne.

Answer the following questions as truthfully as possible to determine your workplace stress levels and how they measure up against others in your field. There are two sections of questions in this survey about your experience with burnout and your practice environment. This survey is adapted from the Mini Z burnout survey from the American Medical Association.

<table>
<thead>
<tr>
<th>For questions 1-10, please chose the answer that best describes your experience with burnout.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, I am satisfied with my current job</td>
</tr>
<tr>
<td>1 Strongly disagree</td>
</tr>
<tr>
<td>2 Disagree</td>
</tr>
<tr>
<td>3 Neutral</td>
</tr>
<tr>
<td>4 Agree</td>
</tr>
<tr>
<td>5 Strongly agree</td>
</tr>
<tr>
<td>2. I feel a great deal of stress because of my job</td>
</tr>
<tr>
<td>1 Strongly disagree</td>
</tr>
<tr>
<td>2 Disagree</td>
</tr>
<tr>
<td>3 Neutral</td>
</tr>
<tr>
<td>4 Agree</td>
</tr>
<tr>
<td>5 Strongly agree</td>
</tr>
</tbody>
</table>

3. Using your own definition of “burnout,” please circle one of the answers below:

a. I enjoy my work. I have no symptoms of burnout.
b. I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.
c. I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.
d. The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.
e. I feel completely burned out. I am at the point where I may need to seek help.
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>My control over my workload is</td>
<td>Poor</td>
<td>Marginal</td>
<td>Satisfactory</td>
<td>Good</td>
<td>Optimal</td>
</tr>
<tr>
<td>5.</td>
<td>Sufficiency of time for documentation is</td>
<td>Poor</td>
<td>Marginal</td>
<td>Satisfactory</td>
<td>Good</td>
<td>Optimal</td>
</tr>
<tr>
<td>6.</td>
<td>Which number best describes the atmosphere in your primary work area?</td>
<td>Calm</td>
<td></td>
<td>Busy, but reasonable</td>
<td></td>
<td>Hectic, chaotic</td>
</tr>
<tr>
<td>7.</td>
<td>My professional values are well aligned with those of my department leaders.</td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neither agree nor disagree</td>
<td>Agree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>8.</td>
<td>The degree to which my care team works efficiently together is</td>
<td>Poor</td>
<td>Marginal</td>
<td>Satisfactory</td>
<td>Good</td>
<td>Optimal</td>
</tr>
<tr>
<td>9.</td>
<td>The amount of time I spend on the electronic health record (EHR) at home is</td>
<td>Excessive</td>
<td>Moderately high</td>
<td>Satisfactory</td>
<td>Modest</td>
<td>Minimal/none</td>
</tr>
<tr>
<td>10.</td>
<td>My proficiency with EHR use is</td>
<td>Poor</td>
<td>Marginal</td>
<td>Satisfactory</td>
<td>Good</td>
<td>Optimal</td>
</tr>
</tbody>
</table>
Has implementation of the athenaOne EMR decreased your actual hours worked (weekly)?
  Scheduled hours:
  Actual hours worked (estimated):

Has implementation of the athenaOne EMR improved your daily workflow?

Any suggestions/comments related to athenaOne EMR?

Do you feel a monthly scheduled meeting with senior leadership would be beneficial? This time will not be during lunch or before/after work hours. It will be blocked time built into schedule.

Comments:

**Your clinical practice-**

<table>
<thead>
<tr>
<th>Are you: MD/DO</th>
<th>NP</th>
<th>PA</th>
<th>Other (specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of years in your current role:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you plan on leaving your current role within the next two years?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gender: Male Female Non-binary Prefer not to say

Thank you for completing the Modified Mini Z post intervention survey.
Appendix D

Modified Mini Z Burnout Survey (post)

Families First- Multiple interventions were implemented; weekly site-specific workflow meetings, monthly leadership meeting (start date to be determined), athenaOne roll out, and workflow changes.

Answer the following questions as truthfully as possible to determine your workplace stress levels and how they measure up against others in your field. There are two sections of questions in this survey about your experience with burnout and your practice environment. This survey is adapted from the Mini Z burnout survey from the American Medical Association.

For questions 1-10, please chose the answer that best describes your experience with burnout.

| 1. Overall, I am satisfied with my current job | 1 Strongly disagree | 2 Disagree | 3 Neutral | 4 Agree | 5 Strongly agree |
| 2. I feel a great deal of stress because of my job | 1 Strongly disagree | 2 Disagree | 3 Neutral | 4 Agree | 5 Strongly agree |

3. Using your own definition of “burnout,” please circle one of the answers below:
   a. I enjoy my work. I have no symptoms of burnout.
   b. I am under stress, and don’t always have as much energy as I did, but I don’t feel burned out.
   c. I am definitely burning out and have one or more symptoms of burnout, e.g., emotional exhaustion.
   d. The symptoms of burnout that I am experiencing won’t go away. I think about work frustrations a lot.
   e. I feel completely burned out. I am at the point where I may need to seek help.
<table>
<thead>
<tr>
<th></th>
<th><strong>Question</strong></th>
<th><strong>Rating Options</strong></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>My control over my workload is</td>
<td>1 Poor</td>
<td>2 Marginal</td>
<td>3 Satisfactory</td>
<td>4 Good</td>
</tr>
<tr>
<td>5.</td>
<td>Sufficiency of time for documentation is</td>
<td>1 Poor</td>
<td>2 Marginal</td>
<td>3 Satisfactory</td>
<td>4 Good</td>
</tr>
<tr>
<td>6.</td>
<td>Which number best describes the atmosphere in your primary work area?</td>
<td>1 Calm</td>
<td>2</td>
<td>3 Busy, but reasonable</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>My professional values are well aligned with those of my department leaders.</td>
<td>1 Strongly disagree</td>
<td>2 Disagree</td>
<td>3 Neither agree nor disagree</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>The degree to which my care team works efficiently together is</td>
<td>1 Poor</td>
<td>2 Marginal</td>
<td>3 Satisfactory</td>
<td>4 Good</td>
</tr>
<tr>
<td>9.</td>
<td>The amount of time I spend on the electronic health record (EHR) at home is</td>
<td>1 Excessive</td>
<td>2 Moderately high</td>
<td>3 Satisfactory</td>
<td>4 Modest</td>
</tr>
<tr>
<td>10.</td>
<td>My proficiency with EHR use is</td>
<td>1 Poor</td>
<td>2 Marginal</td>
<td>3 Satisfactory</td>
<td>4 Good</td>
</tr>
</tbody>
</table>
Has implementation of the athenaOne EMR decreased your actual hours worked (weekly)?
  Scheduled hours:
  Actual hours worked (estimated):

Has implementation of the athenaOne EMR improved your daily workflow?

Any suggestions/comments related to athenaOne EMR?

What workflow changes have been most effective?

Do you feel a monthly scheduled meeting with senior leadership would be beneficial? This time will not be during lunch or before/after work hours. It will be blocked time built into schedule.

Comments:

**Your clinical practice**-
For the following, please tell us about yourself and your practice. Please fill in the blanks.

<table>
<thead>
<tr>
<th>Are you:</th>
<th>MD/DO</th>
<th>NP</th>
<th>PA</th>
<th>Other (specify):</th>
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<td>Number of years in your current role:</td>
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<tr>
<td>Do you plan on leaving your current role within the next two years?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gender: Male  Female  Non-binary  Prefer not to say

Thank you for completing the Modified Mini Z post intervention survey.