



## Clinician burnout and satisfaction with resources in caring for complex patients<sup>☆</sup>



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### ABSTRACT

**Objective:** To describe primary care clinicians' self-reported satisfaction, burnout and barriers for treating complex patients.

**Methods:** We conducted a survey of 1554 primary care clinicians in 172 primary care clinics in 18 health care systems across 8 states prior to the implementation of a collaborative model of care for patients with depression and diabetes and/or cardiovascular disease.

**Results:** Of the clinicians who responded to the survey ( $n=709$ ; 46%), we found that a substantial minority (31%) were experiencing burnout that was associated with lower career satisfaction ( $P<.0001$ ) and lower satisfaction with resources to treat complex patients ( $P<.0001$ ). Less than 50% of clinicians rated their ability to treat complex patients as very good to excellent with 21% rating their ability as fair to poor. The majority of clinicians (72%) thought that a collaborative model of care would be very helpful for treating complex patients.

**Conclusions:** Burnout remains a problem for primary care clinicians and is associated with low job satisfaction and low satisfaction with resources to treat complex patients. A collaborative care model for patients with mental and physical health problems may provide the resources needed to improve the quality of care for these patients.

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## 1. Introduction

The care of complex patients with both mental health conditions such as depression and chronic medical problems such as diabetes and/or cardiovascular disease is of increasing importance as the number of patients with these conditions continues to rise [1]. Physicians are being pressed to provide more complex care in increasingly fast-paced primary care clinics, often without adequate resources to meet growing patient needs. The resulting stress creates the potential for job dissatisfaction and burnout [2]. Medical care for complex patients that emphasizes a collaborative model of care, including both mental

and physical health conditions, has a substantial evidence base as a more effective and efficient way to care for these patients [3–7]. This type of team-based care may also decrease the stress inherent to caring for complex patients and thus reduce the resulting decreased job satisfaction and burnout [8,9].

Symptoms of burnout, characterized by emotional exhaustion, depersonalization, and loss of meaning in work, affect up to one in three physicians and can have significant negative consequences for both physicians and the patients they treat [10–12]. Studies of physician burnout have found increased substance use and medical errors along with decreased satisfaction among their patients [13–15]. Physician burnout and decreasing job satisfaction are also of growing concern given their strong association with staff turnover and intent to leave medical practice [16]. The literature in this area has a number of limitations including small samples of primary care practitioners from single practices or practices concentrated in specific areas of the United States, the focus on MD/DOs only as survey respondents, and very little information about how burnout and dissatisfaction are related to the complexity of the patients they treat.

The purpose of this paper is to address some of these limitations by describing job satisfaction, burnout and satisfaction with resources to

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treat complex patients for primary care clinicians in 18 medical groups with 172 clinics across 8 states prior to the implementation of a collaborative model of care for patients having depression and diabetes and/or cardiovascular disease. Clinicians were also questioned about their perceptions regarding the use of a collaborative care model to help in the management of such complex patients.

## 2. Methods

### 2.1. Background

This study was part of a larger U.S. initiative to improve health outcomes in patients with depression and diabetes and/or cardiovascular disease through collaborative care: COMPASS (Care of Mental, Physical, and Substance-use Syndromes). This initiative was implemented across 8 partner organizations and 18 medical groups with 172 clinics in 8 geographically diverse states from 2012 to 2015. The details of the initiative have recently been published [17]. The project was reviewed and approved by the institutional review board at each participating organization.

### 2.2. Participants and settings

Prior to the implementation of COMPASS, surveys were sent to all physicians, nurse practitioners (NPs), and physician's assistants (PAs) ( $n=1554$ ) who were providing primary care to COMPASS patients in Minnesota, Colorado, Southern California, Washington, Michigan, Pennsylvania, Florida and Massachusetts. The number of primary care clinics within participating medical groups ranged from 1 to 21, with 1–81 primary care clinicians in each clinic ( $M=10.9$ , median=6). Consent was obtained at the time of the survey.

### 2.3. Clinician survey

The survey consisted of 12 questions that asked about satisfaction with current resources, perception of ability to provide quality treatment for complex patients and barriers to improving care, burnout, satisfaction with their careers and their attitude about the potential helpfulness of a collaborative care model for treating complex patients. Satisfaction with career was measured by the single item, "How satisfied are you with your career in medicine" that was used in the Health Tracking Physician Survey [18] using a 5-point Likert scale ranging from very dissatisfied to very satisfied. Satisfaction with resources for caring for complex patients was measured using the single-item question: "How satisfied or dissatisfied are you with the resources currently available to treat patients with both depression and chronic medical conditions (diabetes or heart disease) in your practice?"

Burnout was measured using a single-item from the *Minimizing Error, Maximizing Outcomes* (MEMO) provider survey [19]. The five response categories included the following: (1) I enjoy my work, I have no symptoms of burnout; (2) occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out; (3) I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion; (4) the symptoms of burnout that I'm experiencing won't go away, I think about frustration at work a lot; and (5) I feel completely burned out and often wonder if I can go on, I am at the point where I may need some changes or may need to seek some sort of help.

Primary care clinicians were also asked about barriers to improving care for complex patients. There were four categories of barriers: limited clinic resources, accessing specialty care, patient attitudes and "other." Clinicians were also asked about their view of the potential helpfulness of a collaborative care model for complex patients using the question "How helpful would you find a chronic disease management model where another primary care team member (e.g., a nurse, NP, mental health consultant) would help you co-manage patients with both

depression and chronic medical conditions?" Although patient attitudes were not defined explicitly for the respondents, this barrier was meant to reflect patient-related beliefs and attitudes about their chronic conditions (such as not accepting the diagnosis of depression or not wanting to take a medication because of the side effects) [20].

### 2.4. Procedures

A central data collection center provided an online data tool to gather information (names, e-mails and phone numbers) about all clinicians who were caring for COMPASS patients in primary care settings at each of the participating sites. An introductory e-mail was sent to these clinicians 1 week before the electronic survey. Following this initial introductory e-mail, another e-mail was sent to the targeted clinicians with a link to the electronic survey. To insure that clinicians read these e-mails, they were sent directly by each of the health care organization's senior leadership. If clinicians did not respond, a follow-up reminder e-mail was sent twice 8 days apart with telephone follow-up for nonrespondents to encourage survey completion. This is a standard practice used to improve response rates in challenging populations. As soon as the response rate from any clinic reached 60%, further attempts at follow-up were discontinued. Local COMPASS implementation teams were also encouraged to notify their primary care teams of the web-based survey.

### 2.5. Analyses

Sample characteristics and responses were described using frequencies and percentages. Spearman correlation coefficients described linear relationships among ordinal variables. Clinician ratings were dichotomized into the categories per question: moderate or very satisfied with career in medicine and with resources to treat complex patients vs. not; very good or excellent quality care provided to complex patients vs. not; any perceptions of burnout vs. none; and a co-management model for chronic disease perceived as very helpful vs. not. Chi-square statistics were used to quantify bivariate relationships between clinician ratings and respondent characteristics.

## 3. Results

### 3.1. Survey respondents

Of the 1554 surveys clinicians who were outreached to complete the survey, 709 completed the survey for a response rate of 45.6% ( $M=57.3\%$ , median=62.9% across COMPASS groups). Respondents were 50% male with 82% having an MD/DO degree. Sixty-five percent were family physicians and 57% of respondents had 11 years or greater of medical practice experience (see Table 1).

### 3.2. Satisfaction

The majority of primary care clinicians (85%) were moderately to very satisfied with their career in medicine and health care (see Table 2), with a higher percentage of PAs/NPs moderately to very satisfied (95%) relative to MD/DOs (82%) ( $\chi^2(1) = 10.66$ ,  $P<.002$ ). Across all clinician respondents, a large percentage (65%) were somewhat or very satisfied with their current resources for treating complex patients. The more satisfied clinicians were in their careers, the more satisfied they were with their resources to treat complex patients ( $r=0.22$ ,  $P<.001$ ). When specifically asked about providing care for complex patients with depression and other chronic conditions, less than half (41%) of clinicians rated their ability to provide care as very good or excellent, and 21% said it was only fair to poor. MDs/DOs (43%) and male clinicians (45%) rated their ability to provide quality care for complex patients higher than did NPs/PAs (31%) ( $\chi^2(1) = 4.94$ ,  $P<.03$ ) and female clinicians (35%) ( $\chi^2(1) = 8.01$ ,  $P<.005$ ). Clinicians who were more satisfied with their careers were more likely to rate their ability to treat complex

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