Session date: 10/21/2015

Series: Patient Aligned Care Teams

Session title: How Much Burnaout Among Primar Care Teams Associated with Staffing and Workload?

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Interviewer: Okay, we are at the top of the hour, so at this time I would like to introduce our speaker. We are lucky enough to have Dr. Christian Helfrich joining us today. He is the co-chair of Organization & Management Working Group at the PACT Demonstration Lab Coordinating Center located in the VA Puget Sound Healthcare system, and also a core investigator for the Seattle Denver Coin, and lastly a research assistant professor in the Department of Health Services at the University of Washington. I would like to thank you for presenting for us today, Christian. Are you ready to share your screen?

Christian Helfrich: I am, thank you, Molly.

Interviewer: Absolutely and we are good to go.

Christian Helfrich: All right, just waiting for my screen to come up. Is it showing?

Interviewer: Yeah, we have it.

Christian Helfrich: Okay, great. Well, thank you everybody for joining the webinar today. I would like talk with you about some research that we have done on primary care in the VA and the association of staffing and workload measures with burnout among primary care personnel. This work is conducted as Molly said as part of initial evaluation of the VA patient centered medical home initiative, which start in April 2010. The patient centered medical home is thought to improve quality of care, especially for patients with chronic complex conditions that require management over time. It is thought to be a potential mechanism to better use limited resource or control costs. That is has been a particular interest outside of the VA community. It is also a thought to potentially decrease burnout among primary care personnel by creating a more positive work environment and ideally to attract doctors to primary care careers.

In the VA, the medical home initiative is characterized by a number of areas of focus. There was an emphasis, has been an emphasis on expanded access to care including non-face to face modalities such as secure messaging and telephone consultations, an emphasis on team based care with the formation of primary care teamlets in which a primary care provider is teamed with a nurse care manager, a clinical associates such as an L.P.N., L.V.N., or medical technician, and an administrative clerk. That teamlet together with the help from a broader array of medical professionals including clinical pharmacists, social workers, primary care based mental health providers, that they provide care, comprehensive care for a panel of patients. There is a focus on continuity so that when a patient has contact with the system, it is with that primary care teamlet and there is some continuity within the team of managing the care for the patient. The primary care, the patients that are in medical home and the VA also is focused on leveraging electronic tools, as I mentioned, using future messaging. There has been an emphasis on using the electronic medical record to manage specialty care referrals, particularly again with electronic consultation in which primary care provider can use the medical record to send in a request to a specialist and have it answered via the medical record potentially streamlining care or ensuring that when the patient sees a specialist, they have the requisite laboratory tests conducted for example, and an emphasis on population health tools such as measures of patient probability of having hospitalization or death at a certain period of time. Something can alert the primary care provider to a patient that could be having trouble. Supporting this team-based model has an increase in primary care staffing. At the beginning of the initiative, there were approximately 2.3 full time equivalent team members for every full time equivalent provider. The goal has been to raise that to 3.0 full time equivalents for every full time provider. Since the initiative started in 2010, to support that model, there have been over 1,000 R.N. care managers hired in the VA.

One of the things that we have been particularly interested in tracking and understanding is burn out among primary care employees. Burnout is an occupational condition characterized generally by three domains: emotional exhaustion, that is a feeling like work is so onerous that you may not be able to go on; depersonalization is the feeling of distance or disattachment with your colleagues and with the people you serve, the patients; and a low sense of personal accomplishment or professional self-efficacy, the feeling like maybe what you do does not make a difference or maybe you are not very good at what you do.

Work related burnout is very common in U.S. primary care. There was a survey in 2012 that actually representative survey of physicians that concluded that among providers in a primary care field in family medicine and general internal medicine, burnout prevalence exceeded 50 percent. The figures from work in nursing has been similar for primary care. A number of factors have been researched previously and found to be associated with burnout. In fact, it has particular relevance for the patients in the medical home. working on a team and good physician-nurse relationships characterized by respectful interactions and open length of communication, those have been found to be associated with lower rates of burnout and are protective of burnout. Conversely, disruptive change in the workplace can contribute to burnout and specifically the clinical domain is working overtime and insufficient clinical staffing to manage workload has been associated with higher rates of burnout.

In the context of the VA, this may be particularly critical because we have seen an increase in the number of patients cared for in outpatient settings and the total number of outpatient visits over the past six years. On the left hand side of this graph, you can see the number of annual outpatient visits in the VA in the millions. On the right hand side, those numbers indicate the number of patients, the unique patients ween in outpatient visits. You can see that from fiscal year 2010 to fiscal year 2015, the number of outpatient visits has increased from 67 million to 81.2 million. While the number of patients seen in outpatient settings has increased by 5.5 in fiscal year 2010 to 6.1 million in fiscal year 2015. At the same time, we have seen an increase in the rate of employee turnover in primary care. These are the turnover rates or loss rates by fiscal year 2009 to 2015. There has been a steady increase, just to draw you attention to the green line and the red line. The green line is the voluntary quit rate. Those are people who leave presumably for another position and retirement rate, both have gone up. The lines dip in 2015. I just got these data two weeks ago. That was at the very beginning of the current fiscal year. The 2015 fiscal year ended in September. These data are almost certainly incomplete for the 2015 fiscal year. I expect that quit rate will actually much higher for 2015, likely continuing the trend of high turnover in primary care.

Burnout is also critical because of other outcomes associated with it. Clinician burnout in a number of studies and across a range of studies has been found to be associated with worse patient safety and lower patient satisfaction. It also has consequences to the workplace in employees. Burned out employees are more likely to leave their jobs, which entails hiring and training employees. They also take sick leave more frequently, and their personal lives suffer with relationship problems and depression at higher rates. As part of the national evaluation of the patient centered \_\_\_\_\_ [00:09:12] at the VA, we have conducted a number of surveys to understand the extent and limitation of the patient centered medical home model and also a factor such as burnout. In 2012, we conducted one of these surveys and found measures of team based care such as delegation within the primary care teamlet and staffing to the three full time equivalents for every full time equivalent provider to be associated with lower burnouts and protective of burnout. We also assessed measures in terms of panel size, the team panel size, and how sick the patients were, the patient comorbidity on those panels and found no association. However, with the workload data, we were not able to match those data to individual teamlets. We only had those data at a clinic level. We were testing the association of the average clinic panel size or the average number of panels at the clinic that were over capacity and the average patient comorbidity of the clinic with individual primary care team members burn out and had found no association. There was little variation in both panel size and patient comorbidity within the clinics. We think that there may be association that we just could fit together with the analysis. We also did not have measures of turnover on the teamlet or working overtime, which we think also are associated. We thought that would be associated perhaps. In 2014, we repeated the survey and had a measure of primary care teamlet identifier allowing us to link up those survey data with teamlet specific panel size and patient comorbidity there. We also had measures of turnover and working overtime in the 2014 survey.

In brief, we had previously analyzed and reported on the changes between 2012 and 2014. I will just review those findings very quickly. There is an archive cyber center on reporting these findings in greater detail. We found that from 2012 to 2014 that our overall burnout rate did not change significantly. However, it did change significantly for providers unadjusted burnout going from 45 percent among primary care providers in 2012 to 50 percent in 2014. We also found that certain measures of PACT implementation significantly increased from 2012 to 2014. The proportion that respondents who said that they served on a teamlet that was staffed to these 3:1 ratio, so three full time equivalent team members for every full time equivalent provider increased around 50 percent in 2012 to 65 percent in 2014. When we looked at respondents by occupation, like provider nurse care manager, clinical associate, administrative associate, we found a similar response changes increases across the floor of occupations. We found that the primary care providers reported that they relied on their team for accomplishing a range of clinical duties. We asked for teams clinical responsibilities and activities. For these, the proportion of primary care providers said that they relied on their team a great deal increased significantly. For example, in 2012, 59 percent of primary care providers reported that they relied on their team a great deal for receiving messages from patients and 45 percent reported that they relied on their team a great deal for resolving messages from patients. Those numbers increased to 73 percent for receiving messaging from patients in 2014 and 57 percent for resolving messages from patients

Finally, we found a significant increase in the proportion of nurses and administrative clerks who reported they spend a majority of their time, three quarters or more or their time in work that is well suited to their turning or well matched to their training. When we asked, for example, nurse care managers in 2012, what proportion of their time they spent on work well suited to their training, 48 percent reported the highest category, greater or equal to 75 percent of their time was spent on work well matched to their training. That had increased to 60 percent in 2014. Similarly, among administrative associates and administrative clerks, it was 58 percent rather in 2012 and that increased to 71 percent in 2014. There were not significant increase for providers or clinical associates.

Again, in 2014, we had the possibility of assessing workload and staffing, we had the association with burnout at the teamlet level. That was the goal of our present analysis. The dependent variable for this analysis is burnout. We measured it with a single item of burnout measure that was used in transitional work life study. It has five categories. Each are descriptive. They ask the respondent to define burnout for themselves. The cut off for burn out or the score at which one screams positively for burn out is level three or category three. “I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.” This item, we previously validated it against what is widely considered the gold standard for burnout. The measure of burnout \_\_\_\_\_ [00:15:32] this item is a good representation of the emotional exhaustion subscale of the Burnout Inventory. If you remember, as I mentioned, burnout is generally defined as emotional exhaustion, depersonalization, and professional inefficacy. The emotional exhaustion subscale is the one that is most frequently linked to outcomes such as patient satisfaction and safety.

The independent variables included how long they worked for the VA, how much experience the respondent has had with PACT, how many years they have been in PACT, if they belong to more than one PACT teamlet, if their PACT teamlet or is there one that they primary work with is staffed at the recommended ration of three full time equivalent team members to every full time equivalent provider. If the PACT team has provider appointments available outside of traditional business hours? How long has the PACT teamlets worked extended hours during the week and weekends. If they worked extended hours, if they worked those extended hours together as a teamlet at least 80 percent of the time. If they have had any changes on their team, any changes for a team of goals in the past 12 months.

We also had measures again for the administrative data from the primary care management module, which is where patients are placed onto panels assigned to PACT teamlets of providers. We used data from the primary care management module to identify whether or not the primary care team panel was over capacity. We also included the Gagne score, which is a comorbidity score based on 20 disease indicators and has been previously validated as we took the average Gagne score from patients on the panel. Then we also assessed whether or not the primary care team was based at a medical center based outpatient clinic or a community based outpatient clinic, or CBOC.

Analysis with the multivariable analysis using a maximum likelihood logistic mixed effects to predict the likelihood of burnout for respondents. The analysis was performed at the respondent level with administrative data for the respondent’s teamlet. We clustered the logistic analysis at the teamlet level. The 2014 survey had a total of 4.610 respondents in four teamlet occupations. Of the 8,114 teamlets that are in the primary care management module, that it where patients are assigned to teamlets or panel, 2,809 of those teamlets had at least one respondent, so 34.6 percent. The total primary care outpatient clinics in the VA, 935 outpatient clinics in the VA 687 or 73.5 percent had at a least one respondent. We do not have a firm denominator because of the way the survey is connected so we do not have a response rate for individuals.

Overall, we found six of the independent variables significantly associated with burnout. Five of them are here in bold: being on a fully staffed teamlet was significantly associated with adjusted analyses with lower odds of burnout. Having changed in the past year on a teamlet, turnover in one or more of the teamlet members was associated with higher burnout. Working extended weekend hours, but not extended hours during the week, was associated with higher burnout. Having a panel over capacity was associated with higher odds of burnout. Working out among those who worked extended hours, if they worked those extended hours with their teamlet, that was associated with lower odds of burnout. Being assigned to multiple teamlets, again, working extended hours during the week, average patient comorbidity on the panel, and being at the VA Medical Center based outpatient clinic as opposed to community based outpatient clinic was not associated with higher odds of burnout.

Duration of experience with PACT, which I will review shortly, was associated with higher odds of burnout. Those working longer in the PACT model, had higher odds of burnout. I will review that in a moment.

What are the differences in burnout associated with these measures? This table depicts the odds of burnout, the proportion of predicted burnout by occupational, primary care provider, nurse care manager, clinical associate, and associate for the different independent variables. For example, for a primary care provider, that is the first column who is on a fully staffed team like the first two rows, if they are on a fully staffed team, their probability of burnout is 34 percent. If their teamlet is not staffed 3:1 ratio, their odds of burnout are 48 percent. Similarly, for nurses, that is the next column over. Their odds for burnout in a fully staffed team is 28 percent. If they are not on a fully staffed teamlet, their odds of burnout are 41 percent. You can see that there are similar differences across the four-team occupations. That final column all roles is the total among all respondents, the odds of burnout if they are on a fully staffed team is 27 percent. If they are not on a fully staffed teamlet, the odds of burnout are 40 percent. For change on a teamlet, the effects are slightly smaller. For providers, we see that the odds of burnout if they have not had any change on their teamlet in the past 12 months, the odds of burnout are 35 percent, whereas if they have had any change on a teamlet in any of the roles, the odds of burnout are 46 percent. You can see there are similar differences across the four-teamlet occupations and the differences in burnout if they experience any turnover in their teamlet in the past 12 months. Again, that last row, all roles, shows the combined results of where we find overall if respondents were on a team where there was no change in the past 12 months, they had 28 percent chance of having burnout, whereas it was 39 percent if there was some change in one of these teamlet roles in the past 12 months. Panel overcapacity, that is the third row, we again smaller differences, but still significant differences. If their panel is not overcapacity, if it was within capacity, physicians had a 39 percent chance of burnout versus 43 percent chance of burnout if the panel was over capacity. Again, across the four-teamlet occupations, we see similar differences than with the combined effect. You can see the odds of burnout were 31 percent if the panel was within capacity versus 36 percent if the panel was overcapacity.

Finally, working extended and weekend hours, the bottom three rows there, if the respondent never worked extended hours, so did not work extended hours during the week or on the weekends for physicians or primary care providers, the odds of burnout were 30 percent, 24 percent for nurses, 18 percent for clinical associates, 24 percent for administrative clerks, and 24 percent overall across all respondents. If they worked extended hours during the week, but not the weekend. That is the next row for primary care providers the odds have increased to 41 percent. They increase to 34 percent for nurses, 26 percent for clinical associates, and 34 percent for administrative associates or administrative clerks. Increased overall to 34 percent for occupations. Similar increases across the board for occupations. Finally, if they work extended hours during the weekends, it increased to 53 percent for providers, 46 percent for nurse care managers, 37 percent for clinical associates, and 45 percent for administrative clerks and an increase overall of across all respondents to 45 percent. We are going to see similar increases in the odds of burnout but when we got from not working extended hours to working extended hours during the week, to working extended hours on the weekends. That difference between not working extended hours and working extended hours during the weekends is a significant increase.

We also looked at some combined effects. What if the respondent was on a fully staffed team but had no experienced any change in the past 12 months. Well, for a physician, primary care providers, that includes nurse care managers, physician’s assistants, as well as physicians. The odds of burnout were 28 percent. Conversely, if a primary care provider within a teamlet that was not fully staffed and had experienced some change in one of their numbers in the past 12 months, their odds of burnout were 52 percent. We see similar differences across the board occupations. Across all four of the occupations, the odds of burnout, if they were on a fully staffed team that had any experienced any change in the past 12 months, the odds of burnout were 23 percent. They were double if the respondent was on a team, which was not fully staffed and had experienced some change in the past 12 months, so 46 percent or 23 percent to 46 percent.

What about over capacity and being on a fully staffed team? If a respondent was on a teamlet where their panel was within capacity and the teamlet was fully staffed, primary care provider burnout was 30 percent, for a nurse care manager, it is 26 percent. For a clinical associate, it was 23 percent. For administrative clerks, 20 percent. Overall, across all roles, 25 percent. If, however, they were on a teamlet where the panel was overcapacity and the teamlet was not fully staffed for primary care providers, that burnout probability increased to 48 percent. Nurse care managers increased to 44 percent. Clinical associates, it increased to 39 percent and for administrative clerks to 35 percent. Overall, across the four roles, it increased to 42 percent, so from 25 percent to 42 percent.

Then overcapacity and team change, if the respondent was on a team again where the panel was within capacity and not over capacity and there was no change, no turnover on the team within the past 12 months, for primary care providers the odds of burnout was 32 percent, for nurse care managers 27 percent, for clinical associates 24 percent, and for administrative clerks 21 percent, across all roles, it was 26 percent. If they, however, were on a team where the panel was over capacity and where there had been change in the teamlet for the past 12 months, that increased to 48 percent for primary care providers, 43 percent for nurse care managers, 38 percent for clinical associates and 34 percent for administrative clerks and 41 percent across all respondents. From 26 percent burnout to 41 percent of burnout for panel overcapacity and change on the teamlet. The finally, that last row, the combination of the three together, if they were on a fully staffed team, FST, where there was no change in the teamlet, and the panel was within capacity for primary care providers, the odds of burnout were 27 percent, nurse care managers 22 percent, for clinical associates 16 percent, and for administrative clerks 21 percent. Across all roles, the probability for burnout was 21 percent. If they were on a team that was not fully staffed, but had been change on the team and the panel was overcapacity, the odds increased to 57 percent for primary care providers, 49 percent for nurses, 40 percent clinical associates, and 49 percent for administrative clerks, or 49 percent overall, so from 21 percent burnout to more than doubling to 49 percent burnout.

As I mentioned, length of experience with PACT was also significantly associated with burnout. We had four categories, less than six months being involved in PACT and the PACT model, six months to one year, one to two years, and two or more years. As a steady increase overall and with the cross roles, it goes from 22 percent burnout in the lowest category, less than six months, to 30 percent in the six months to one year, to 41 percent for one to two years, then 42 percent for the two plus years. When we look at what is in each of the teamlet roles, what we see though is a steady increase of with experience of PACT within each role. For example, with nurse care managers, it goes from 27 percent to 32 percent, to 37 percent to 43 percent. There is a steady increase in odds of burnout with the longer duration in working in the PACT model.

There are some important limitations to understand when interpreting these data. We do not have any controls. There were no non-PACT VA primary care clinics that we could compare these to. We know that there are—we have a very strong evidence of a secular trend in increasing burnout in primary care generally in the U.S. These were cross sectional analyses. We have not examined, for example, changes in panel size or changes in patient comorbidity in subsequent odds of increased burnout. There is also significant risk of non-response bias. We have been able to look at the administrative data on nonrespondents. The teamlets where we did not have a respondent in the survey, those non-responding teamlets had higher patient complexity Gagne scores were significantly higher, substantially higher for non-respondents. Non-respondents were more likely to be located at a VA medical center. Non-respondents actually had slightly smaller adjusted panel size than the respondents. Then within the teamlets, we could also have selection bias. What I mean by that is, 65 percent of the teamlets were represented by just a single respondent. Depending on their profession, they may not reflect the prospective in expansion of all team members. The 67 percent of the teamlets also had respondents in just a single role. For example, the perhaps a junior nurse care manager is assigned to the same teamlet, responding to that survey, but members of the other role.

Overall, what have we found? We found that is significantly lower for primary care employees in this cross sectional analysis when they are on a teamlet that is staffed to the 3:1 ratio. That is three full time equivalent team members, nurse care managers, clinical associate, and administrative clerk for every full time equivalent provider. When there has been no turnover in the teamlet in the previously 12 months. There are no changes in those four teamlet roles. When the panel is within capacity, when they are newer to PACT, have less experience with the PACT initiative, when they do not work extended hours on the weekends, and if they do work extended, when they work those extended hours together with their teamlet. When we looked at their combined effects of these factors, the risk of burnout in the \_\_\_\_\_ [00:32:21] were in a fully staffed team with no turnover in a panel within capacity not working extended hours and weekends. The risk of burnout predicted by this is less than half the current employees in the universe condition where they are on a team with faculty staff there there has been turnover and a lower capacity working extended hours on the weekends. We did not find burn out associated with patient comorbidity, working on multiple teamlets, or working extended hours during the week. Again, as we noted in the limitations, we have evidence of significant selection basis. That may be the reason we do not find an association with patient comorbidity. We had by representation of respondents, from those panels, would hire patient comorbidity, perhaps we would see an association.

I would like to acknowledge the extensive work attribution of my colleagues, Blake Wood, and Walter Clinton and the rest of the PACT coordinating center. Many people worked on this. I would be happy to take any questions and also hear people’s thoughts on comments on these findings.

Moderator: Great, thank you so much, Christian. We do have lots of great pending questions. So those of you that joined us after the top of the hour to submit your question or comment, just use the control panel on the right hand side of the screen. You can click the plus sign next to the word question. That looks on the dialogue box and you can submit your questions or comments there. We will get to them in the order that they are received. Starting off, just so you know, this is referencing slides ten and 11. I am not sure if you want to go back. Should not the burnout rate that only increased slightly on slide ten have gone down with the increased of fully PACT implementation rates shown in slide 11?

Christian Helfrich: Oh yeah, absolutely, no. that is a great question. Actually, with that, we have and this is an analysis that is still ongoing. In fact, as I mentioned, I think we have strong, if not conclusive evidence that there is a secular trend, an increasing burnout in primary care. What I mean by that is the overall and primary care, both in the VA and outside the VA, the burnout for a number of reasons is increasing. For example, let us respond to this particular question, when we adjust for fully staffed teamlet, when we ask the question if the proportion of respondents in 2014 who are on a fully staffed team, if that had remained at the same level, at 50 percent, as it was in 2012, what would the burnout rate be? It would have been significantly higher. What we think is that that increase in the staffing ratio actually did mitigate burnout. The problem is that the secular trend in increasing burnout essentially swamps the fact of the increase in staffing. We think that the burnout rate would have increased significantly more in 2014 had this increase in staffing not occurred.

Moderator: Thank you for that reply. The next question referencing slide 20, when you refer to a panel over capacity, are you referencing greater than the 85 percent goal or the over the X 1,200?

Christian Helfrich: Yeah, over 1,200 adjusted for provider type and for STE, not the 85 percent. That is a good clarification.

Moderator: Now, is the burnout inventory assessment readily available for people to download?

Christian Helfrich: Yes, you mean the measure, just the survey measure? Yes, it is. That is one of—there are a couple of reasons why I think that this single item measure is a very good option for assessing burnout. One is because it is not proprietary. You can use it without obtaining a license. The second reason is it is very easy to interpret essentially the values of those response categories define burnout for you whereas the for the \_\_\_\_\_ [00:37:11] inventory based on frequency of symptoms. There have been a number of shorter versions of the MVI. It becomes very confusing at that point what frequency of the symptoms qualify as screening positive for burnout. I highly recommend that single item measure.

Moderator: Thank you. The next question is covering two or three teams considered greater if they are partial teams such as 8.6, 8.1, and 0.2?

Christian Helfrich: Can you repeat that question? I am not sure I quite follow.

Moderator: Yeah, is covering two or three teams considered greater if they are partial teams such as 8.6, 8.1, and 0.2

Christian Helfrich: I apologize. I am not sure that I understand the question. I am going to do my best. If the person can just followup and clarify. One thing I will note is just in terms of the assignable teamlets, that is all we ask if they were just asked if they were assigned to multiple teamlets. We did ask respondents in terms of answering questions about their teamlets, if they were obviously the \_\_\_\_\_ [00:38:38] staffed at the 3:1 ratio. We asked them to respond for the teamlet that they primarily worked with. If they were working three quarters of the time with one team and one quarter of the time with another teamlet, we asked them to respond for the three quarters teamlet. I do not know if that answers the question, the person had.

Moderator: Okay, it looks like they wrote in and I asked that question, the part that was if a person covers one full time versus two to three teams that do not even total a full 1,200 panel group.

Christian Helfrich: I apologize. I am not quite following. I would welcome that individual please followup with me by email because I just want to answer your question. Feel free to followup by email.

Moderator: That sounds good. Just another quick reminder, please do use complete sentences and avoid abbreviations in acronyms as I am not a subject expert. We like to get these asked and answered in the most timely possible way. Okay, moving on. That person is welcome to contact Christian offline. This is please note that Ms. Leanne Fleming—never mind. That is for me. Do you have any sense if these data hold true for special population PACT teams that can be structured slightly different per the PACT handbook? For instance, lower panel sizes, etc., for example geriatric PACTS, homeless PACTS, serious mental illness?

Christian Helfrich: Yeah, no that is a great question. These respondents do include members of those special PACTS. I do not recall off the top of my head what proportion. I do remember vaguely that we did not have watch numbers of respondents from the specialty PACTS or the special population PACTS. I do not think that we could replicate these analyses in those subgroups. These findings do include a small number of them. I would be hesitant to conclude in any definitive way that these findings definitely do or definitely do not apply. They certainly I would not include conclude that they definitely do not apply to the specialized PACTS, but I would be hesitant to say that they definitely do apply. Again, we did include them in the panel, too

Moderator: Thank you for that response. The next question we have, have you ever considered or measured impact of alert system and other non-face to face workload? For example, review of outside records, review and answer home care orders, etc., as significant variables contributing to primary care provider burnout?

Christian Helfrich: That is a great suggestion. We did not include that in this survey. Thank you for suggesting that, because actually there is a team headed by the VA, Healthcare Analysis and Information Group, that is developing another iteration of this survey. That is definitely feedback that we can take back to them. We did in 2012, we did ask a number of questions about factors that were barriers to delivery of optimal patient centered care and included in those were some structured items. Included in those were the volume of both CPRS reminders and clinical alerts, not the TPRS or electronic medical record system. Both of those were in the top three or four barriers that were rated by individuals with CPRS view alerts being the single highest rated barrier. The one that highest proportion responded said it limited their ability to deliver optimal patient centered care a great deal. That is a great suggestion to look at that in the future as a factor that affects burnout. We had not previously looked at that.

Moderator: Thank you for that reply. The next question, what were the parameters—sorry, this one is also a little hard to get through. What were the parameters on slide 22 for EA, variable under optimal versus double variable deficit?

Christian Helfrich: Okay, can you read that one to me again?

Moderator: Yeah, what were the parameters on slide 22 for EA variable under the optimal versus a double variable deficit?

Christian Helfrich: EA?

Moderator: Maybe they meant AA? I am not sure. Well, again, we can have them write in for further clarification.

Christian Helfrich: Yeah, please do, whoever asked that, just followup with me by email. I would love to answer your question.

Moderator: Great, what is the staff ratio for PACTS?

Christian Helfrich: If by staff ratio, do you mean the teamlet members? The idea is that there is a full time equivalent nurse care manager, a full time equivalent clinical associate, medical technician, L.P.N., L.V.N., and a full time administrative clerk for every full time physician, nurse practitioner, physician’s assistant. I do not know if that answers that question.

Moderator: Thank you. Often have to cover retiring physician panel. This increases workload without reflecting on your panel size. This increases burnout.

Christian Helfrich: That is a great point and then you for alerting us to that. That is not something that we assessed. Yeah, it is not something that I was aware of. Again, that is good information for us as we go forward and do further analyses. We will see if there some way we can incorporate that into the future analyses.

Moderator: Thank you. The next question we have is there a database where we can locate our Gagne scores? I apologize if I just butchered that word.

Christian Helfrich: Yes, the Gagne scores are, I believe, this is where I reflect my reliance on my colleagues. I believe that the Gagne scores are available through TCMM or can be determined by using the primary care management module and other data from the electronic medical record. If that individual will followup and email me, I would like to put you in touch with our analyst, Walter Clinton, who can answer that question.

Moderator: Thank you very much. Lots of great pending questions. Are there any plans to include location as a variable? I would expect that rural versus urban areas would different significantly, with rural areas being more likely to experience burnout.

Christian Helfrich: Again, that is a great suggestion. That is not something that we have looked at yet, but excellent suggestion. That is something we will consider for future analyses. The one thing I will note, that is a challenge as I mentioned, in many cases, we are dealing with small numbers of respondents when we get down to smaller facilities. That does present a challenge in terms of getting a reliable measure of burnout from a smaller facility. If you have just a few respondents, there is just a lot more variability and it becomes difficult to really reliably test associations. Excellent suggestion and something to look into.

Moderator: Thank you. This is a comment we have. As PACT teams in newly renovated CBOCs, for those of you not in the VA, that is any community based outpatient clinic. As PACT teams in newly renovated CBOCs, PACT teams are beginning to sit together in a collocated space, for instance a private office that will soon be eliminated. This might be an idea for a future study as more CBOCs are built in this design required by the next Office of Primary Care for all new CBOCs. I would hypothesize that their scores would be even better due to increased communication.

Christian Helfrich: Very interesting. Again, thank you for drawing our attention to that change and that is again something that we can look into if there are panels available for us to assess that.

Moderator: Thank you. A lot of people are asking if they can download these excellent presentation slides. Yes, you already have the link in the reminder email you received this morning. If results were shared back to the participants, primary care leaders, what methods did you use?

Christian Helfrich: Yes, we have been sharing these results starting with preliminary results. Then as we were finding the findings and analyses, we shared these results with Gordon Schechman who was with patient care services and Richard Stark who is with the Office of the Under Secretary for Management Operations. We did that primarily through the sharing both a set of slides and a narrative report and giving a brief presentation and giving them a chance to ask questions, make comments, make suggestions about how we looked at this data. Dr. Schechman and Dr. Stark have been heavily involved with both this specific analysis and with the PACT evaluation more broadly since the very start with routine contact with the evaluation team.

Moderator: Thank you for that reply. We are down to our last half a dozen or so. If results were shared—no we got that one. What are the panel members that were utilized for the nurse practitioner and physicians?

Christian Helfrich: If I understand that question correctly, we used in determining panel over capacity we used a figure of 1,200 patients per full time equivalent physician. It was adjusted down for nurse practitioners and physician associates. I may have this wrong, but I believe that the number for nurse practitioners and physician associates was 900 patients, but I could be incorrect. Again, if you followup with me by email or \_\_\_\_\_ [00:51:20] analyst on this analysis, we can get that question a definitive answer for you.

Moderator: Wonderful, thanks. So now that we now a majority of burnout is attributed to being over panel, changes to teamlet, and working extended hours, what is a proposed way to fix it?

Christian Helfrich: Yes, that is a great question. I think this is just one piece of information that the operational leadership is going to have to take into account in trying to map a way forward. I think this certainly suggests that there is a possibility to mitigate burnout through addressing workload, addressing panels that are over capacity, through the teamlets are properly staffed at ratio. I think we also have to be cautious about over interpreting or relying too much on these findings. Again, these are cross sectional. I think we have a lot of evidence, again, that there is a secular trend of increasing burnout in primary care and increasing turnover in primary care. Just as an example, that issue of turnover on the teamlet, there may not be an immediate obvious way of decreasing the turnover on a teamlet. You have seen, as I presented in the background, we have seen a steady increase, gradual, but steady increase in the turnover rate in the primary care. I think that has been mirrored in the primary care setting in the community. I think there are some broader issues. Again, this suggests that it may be possible to significantly mitigate the probability of burnout by ensuring staffing and ensuring the workload levels are not excessive. I think this is still one piece of data that the leadership is going to have to incorporate it to a whole bunch of other broader data and obviously than resource constraint.

Moderator: Thank you. Next question, the negative impact of the clinic hours outside of the workweek is so bad, why continue to offer the weekend clinics? The clinic utilization data is low on those same clinics.

Christian Helfrich: I really cannot comment on that because I do not know the situation in individual clinics. It sounds like for the person posing the question, in their clinic maybe those weekend utilization hours are low. It may be that sounds like a situation where there might be an argument for eliminating those hours as a way of reducing the probability of burnout. From our data, and from the announcements we have done so far, I cannot comment on whether or not, for example, in other clinics the utilization is low or what the issues might be with ensuring access for veterans to be getting in to be seen in a timely fashion. That is an interesting issue to raise.

Moderator: Thank you. Okay, let us see. Any thought about extending the study of spurt of burnout to specialty care? Specialty care providers do not have the staffing of PC and have multiple professional responsibilities.

Christian Helfrich: That is a great idea. It was beyond the scope of the patient centered medical home evaluation. There are other opportunities for analyzing that. Actually one thing for researching and for operational staff who are interested in this issue, perhaps, the VA in the past several years, in 2013 had to assess burnout in all employee survey. That is a survey that was sent out to all of the employees. You can actually access those data on the VSSC website. I cannot remember what the SSC stands for. Again, I am happy to send a link to you. You can get them generally to a facility level. It is a bit more difficult to get granular assessment for that, but you can certainly look among occupations including medical specialty occupations.

Moderator: Thank you for that reply. Christian, I do have a few people that have written and this is very applicable to your talk expressing concerns about their particular role in their PACT panel. I am assuming that this would not be the proper venue to ask you, but perhaps they could write it in during our feedback survey which is read closely by the PACT cyber seminar coordinators or would you like to attempt to address those or do you have a person that they should bring them to, maybe their team panel leader? I am not sure what the roles are.

Christian Helfrich: Yeah, please, if anyone wants to, again, reach out to me, I would be happy to hear what their experience is. If there is someone that I can direct you to, I would be happy to hear that.

Moderator: Would you like me to read those aloud or would you like them to contact you offline?

Christian Helfrich: Yes, contact me offline, that would be great. Thank you.

Moderator: Okay, sounds good. Thank you. I definitely wanted to address their concerns, but I did not know if this was the proper venue. Okay, on the total loss rate, quit rate, retirement rate, etc., on slide seven, the FY15 numbers are in. While quit rate was slightly up, the retirement rate went slightly down. The total loss rate went slightly down. Expect these to change slightly when HR actions from late September are updated in the system in mid-November. Also, there are background filters human capital analysts at VA conventionally use such as excluding trainees, medical residents, volunteers, etc., from these sorts of rates. Email me if you like. I am happy to consult on this and appreciate this excellent work. I will be happy to pass his email along to you or if you would like, he can email you offline. Your call.

Christian Helfrich: Yeah, if you could pass his email on to me, I would appreciate that. I would welcome the input and just to reemphasize, what the individual just said, those 2015 data are incomplete, the reporting of those loss rates will have additional data come in. we definitely expect those lines to go up.

Moderator: Thank you. Let us see. Just reading through these really quick. We also have PACT providers covering clinics in other CBOCs and covering PCMI, which also increases burnout. Thank you for that comment.

Christian Helfrich: PMCI, I believe they are talking about primary care mental health integration.

Moderator: Thank you.

Christian Helfrich: I apologize, I have another meeting I need to join. I can answer one more question.

Moderator: All right, the rest are just suggestions so I will read the last one. You may also consider looking at rates in comparison of rate in providers such as team leaders or chief medical officers compared with those of the 1,200 panel providers.

Christian Helfrich: Good suggestion.

Moderator: Thank you for those comments. Thank you so much, Christian, for joining us. You are welcome to drop off. I am going to take just a second to put up one last slide to address our attendees. Is there anything you would like to say before you head out?

Christian Helfrich: Just you know a big thanks again to everyone for joining and to my colleagues on the demonstration lab, PACT demonstration lab coordinating team. They did so much of this work and to our operational partners who have been very supportive and collaborative. Thank you, Molly, for moderating.

Moderator: Always, it is a pleasure to work with you. Thanks for lending your expertise to the field. I do release you from this cyber seminar. You are free to go.

Christian Helfrich: Thanks, goodbye.

Moderator: Thanks, for our attendees, you do see up on your screen, there is a new initiative being pushed out by our leadership. It is called VA Polls. It is a great way to connect with your colleagues. We can continue the conversation about PACT burnout on this forum, as well as any other research topics you would like to bring up. This is a way to talk to your colleagues or we can address the presenters with future questions. All you need to do is sign up using your VA email address. You can start by joining the HSRND at cyber seminar site that I have up on your screen. Again, please do check VA Polls. It is being pushed hard by leadership. It is an excellent resource with much functionality. We will be emailing you an invitation to join the HSRND cyber seminar site. We do sure hope to see you there to continue collaborations and suggestions and questions. At this point in time, I am going to redirect all of those people whose comments did not get addressed to please contact Christian offline. He is very open to taking followup questions, but he did have to get to another meeting, but please do contact him. I am going to close out this session now. If you will take just a moment to fill out the feedback survey that will pop up on your screen, we much appreciate it. We do look very closely at your responses. It helps us decide which sessions to support in the future. Thank you very much. This does conclude today’s HSRND cyber seminar. Thank you.

[End of audio]